Final Assessment Report
Part 1: Overall Findings

Inpatient Safety Performance and Organizational Assessment

Contract No.:
HHSI236201300048A

Project No.:
2404-001

Submitted To:

Indian Health Service
Attn: Paula Slyker
Contracting Officer's Representative
Phoenix Indian Medical Center
Phoenix, AZ 85004

Submitted By:

Econometrica, Inc.
7475 Wisconsin Avenue, Suite 1000
Bethesda, MD 20814

May 14, 2014

ECONOMETRICA, INC.

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Ms. Paula Slyker
Contracting Officer's Representative
Phoenix Indian Medical Center
Phoenix, AZ 85004

Reference: Contract No. HHS1236201300048A: "Inpatient Safety Performance and Organizational Assessment."

Dear Ms. Slyker:

Econometrica is pleased to submit this Final Assessment Report: Part I – Overall Findings to the Indian Health Service (IHS) as required under the above-referenced contract.

If you wish to discuss any aspect of this submission, please feel free to contact me at (240) 395-2271 or Mark Stewart at (301) 657-9883, ext. 205.

Sincerely,

Econometrica, Inc.

Thomas R. Jackson
Vice President

cc: Dr. David Civic/IHS
Ms. Kathy Langwell/Sundance Research Institute
Mr. Mark Stewart/Econometrica, Inc.
Contract File

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Section 1: Background and Purpose

1.1: Background

Improving the quality of care in Indian Health Service (IHS) inpatient settings and ambulatory care is a continuing goal of IHS. IHS has finalized Intra-Agency Agreements with the Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Innovation (CMMI) to participate in the Partnership for Patients (PfP) initiative. PfP was established with the goals of making inpatient hospital care safer and improving transitions between care settings to prevent patient complications that result in hospital readmissions. Key elements of the PfP include Hospital Engagement Networks (HENs) across the country that help identify effective solutions to reduce hospital-acquired conditions and improve patient safety, as well as the Community-Based Care Transitions Program (CCTP) to improve care transitions and reduce readmissions to hospitals.

Econometrica, Inc., was contracted by IHS to provide training and technical assistance (T/TA) for the 28 IHS hospitals participating in the PfP initiative, including assessing current data capabilities for establishing a baseline and for reporting changes for the 10 PfP hospital-acquired conditions and readmissions, plus in the two focus-area measures (i.e., leadership and patient/family engagement) over time; assessing current quality improvement (QI) activities related to these measures and internal needs for training and technical assistance for quality improvement; providing assistance to improve data capabilities in targeted areas to ensure accurate and comparable measure reporting across all 28 hospitals; and developing, facilitating, and providing training, learning sessions, and technical assistance that will assist the IHS hospitals to design and implement QI initiatives to achieve desired changes in the key PfP quality measures.

Interviews have been completed with the 28 IHS inpatient facilities to date.

1.2: Purpose of This Report

The assessment phase of this project included site visits and telephone interviews with the 28 IHS PfP hospitals. The information collected from each hospital focused on data capabilities for reporting PfP quality measures; factors that may hinder the ability to produce these measures; current quality monitoring and QI activities related to the PfP; and needs for training and technical assistance that will assist individual hospitals and the IHS Hospital Consortium to produce valid quality measurement data and design and implement effective strategies for quality improvement focused on the PfP focus areas.

This report provides the overall results of the assessment. It provides a summary of findings for the 28 hospitals and recommendations for training and technical assistance that would provide support and assistance to the PfP initiative. Individual hospital assessments will be completed and submitted to each hospital for review and discussion as the second component of reporting on the assessment phase.

In Section 2 of this report, we briefly summarize our assessment approach and process and describe the data collection process. Section 3 presents findings of the assessment of hospitals'

reporting on PfP measures and challenges in reporting identified by interviewees. QI initiatives related to the PfP measures that are or have been conducted by the participating hospitals are described in Section 4 as well as the T/TA needs identified through the assessment and by individual hospital participants. The final section summarizes key findings and recommendations for training and technical assistance.

Section 2: Assessment Approach

2.1: Overview

The objectives of the Assessment Phase of the project included:

- Assess data capabilities at each of the 28 hospitals for reporting PfP quality measures and identify factors that may hinder their ability to produce these measures.
- Assess current activities, procedures, policies, quality monitoring, and QI activities related to the PfP focus area at each hospital and identify potential areas where the individual hospital (and all hospitals in the Consortium) could benefit from technical assistance and additional education and training for QI.
- Identify each hospital's current awareness and participation in PfP-focused learning opportunities, preferred modes of technical assistance and educational sessions, as well as self-identified areas for targeted training and education.
- Develop recommendations for training and technical assistance that will assist individual hospitals as well as the Consortium to produce valid quality measurement data and design and implement effective strategies for QI targeted to the PfP focus areas.

The approach to the assessment was developed with recognition of the unique characteristics and challenges that IHS hospitals must overcome and address to successfully participate in the PfP, including limited resources; small hospital size and low occupancy rates; difficulties in recruiting clinical, IT, and statistical staff; and a patient population that is generally in poorer-than-average health. Our approach addresses these issues to provide a comprehensive and responsive methodology for assessment of capacity and provision of information and data that will assist individual IHS hospitals and the IHS Hospital Consortium to participate in and benefit from participation in the PfP.

2.2: Assessment Tool

The initial activity for the assessment phase of the project was development of an Assessment Tool that would be used to gather information on PfP participation, reporting, QI initiatives, and T/TA needs from each of the participating hospitals. Discussions with the IHS project team and review of data and background materials provided input to the development of the Assessment Tool. Key areas for data gathering and assessment identified for inclusion in the Assessment Tool were:

- Data collection and reporting of the PfP measures, including challenges and TA needs to support and improve data tracking, data entry, and reporting.

- Quality management (QM)/QI related to PfP measures, challenges, and TA needs to support and improve QM and QI related to PfP objectives.
- Participation in PfP network and learning opportunities, including T/TA needs and preferred methods of T/TA delivery.

In addition, the project team developed a Descriptive Profile format for compiling data for each individual hospital's characteristics and assessment findings. Appendix A contains the Assessment Tool and the Descriptive Profile format.

2.2: Site Visit and Telephone Interview Approach

The assessment plan required site visits and telephone interviews with all 28 IHS hospitals within a 3-month time period. A team of at least two staff members conducted each of the assessments, whether onsite or by telephone, to ensure that detailed notes were available to prepare individual hospital assessments as well as the overall summary assessment. Site visits were conducted to eight of the hospitals; the remaining 20 assessments were conducted via a 2-hour telephone interview with hospital staff. Key hospital staff suggested for participation in the assessments included:

- Service Unit Director/Chief Executive Officer (CEO)
- Hospital Administrator (if separate from CEO)
- Chief Medical Officer
- Quality Manager
- Director of Nursing
- IT/Data Manager/Clinical Advisory Committee (CAC)

Table 2.1 summarizes the assessment schedule and type of assessment for each of the 28 IHS hospitals.

Table 2.1: Site Visits and Telephone Interviews Conducted With 28 IHS Hospitals

Hospital	Type of Interview	Date of Interview
Blackfeet	Site visit	November 14, 2013
Claremore	Site visit	November 19, 2013
Acoma-Canoncito-Laguna (ACL)	Site visit	November 20, 2013
Gallup	Site visit	November 22, 2013
Rapid City/Sioux San	Site visit	December 2, 2013
Pine Ridge	Site visit	December 3, 2013
Red Lake	Site visit	December 11, 2013
Cass Lake	Site visit	December 12, 2013
Whiteriver	Telephone	December 20, 2013
Mescalero	Telephone	December 30, 2013
Shiprock	Telephone	December 30, 2013
Chinle	Telephone	January 6, 2014
Standing Rock/Fort Yates	Telephone	January 7, 2014
Santa Fe	Telephone	January 15, 2014
Fort Belknap	Telephone	January 16, 2014
Crownpoint	Telephone	January 17, 2014

Hospital	Type of Interview	Date of Interview
Winnebago	Telephone	January 17, 2014
Rosebud	Telephone	January 22, 2014
Eagle Butte	Telephone	January 23, 2014
Sells	Telephone	January 24, 2014
Phoenix Indian Medical Center (PIMC)	Telephone	January 27, 2014
Belcourt	Telephone	January 28, 2014
Parker	Telephone	January 28, 2014
Lawton	Telephone	January 29, 2014
Hopi	Telephone	January 31, 2014
Zuni	Telephone	February 7, 2014
San Carlos	Telephone	February 20, 2014
Crow/Northern Cheyenne	Telephone	February 27, 2014

Section 3: Assessment of PfP Measures and Issues

3.1: Data Collection Methods and Issues Identified

The assessment interviews with the 28 IHS hospitals asked about data collection and reporting methods for each of the PfP measures. The discussion revealed a wide variety of data collection methods, including:

- WebCident.
- Manual chart review.
- Manual review of department logs.
- Reports at the time of occurrence/identification.
- Utilization of iCare, QMan, and VGEN to search Resource and Patient Management System (RPMS) data.

Hospitals with low occupancy rates tended to rely more heavily on manual chart review or reports of individual events from nursing staff at the time an instance of harm is observed.

Although many sites have developed methods to collect data from RPMS, there are relatively few instances of measures that are reported without some degree of manual chart review to verify the timing or some other specifics related to reportable events. For example, a hospital that uses RPMS to identify all patients with a bloodstream infection might rely on manual chart review to determine which patients with infections also had central lines. A few sites felt they had been highly successful in developing data abstraction methods: Pine Ridge created ways to use QMAN to pull data for CLABSI, CAUTI, and ADEs; Whiteriver uses VGEN to pull data for a variety of measures.

While discussing data collection and reporting methods, a number of concerns related to reporting were identified, including:

- Confusion over inclusion or exclusion criteria for specific measures.
- Confusion about how denominators differed between measures both across PfP measures (e.g., total days vs. days with line) and between measures for other reporting (e.g., NHSN).

- Uncertainty about whether cases were being identified accurately under current data collection methods.
- Inconsistency over whether hospitals were considered exempt for reporting VAP, CLABSI, and/or EED.
- Indication that some hospitals may be reporting "0" numerators without doing any data collection or chart review because a specific action is not allowed (elective delivery) under hospital policy.

Table 3.1 summarizes data collection methods used by hospitals for each PfP measure and issues raised during the hospital interviews.

Table 3.1: Data Collection Methods and Challenges by Measure

Measure	Data Collection Methods	Problems/Challenges
Readmissions	• National Data Warehouse (NDW)	• Clarification about the index admission and all-cause 30-day readmissions to any hospital. • Confusion regarding whether or not to track and report same DRG and/or same hospital readmission. • Concerns regarding inappropriate classification of a readmission. • Lack of community resources hinders successful transitions. • Role of "social" admissions and end-of-life.
Falls	• WebCident	• Rating injury severity.
ADE	• WebCident • Manual chart review • QMan search of RPMS • VGEN search of RPMS • Flag for low Accucheck results • Alerts from medication dispensing machines • Alerts for critical lab values indicating hypoglycemia or an elevated INR	• Confusion over what constitutes an event for the anticoagulation measure (e.g., INR range and "non-compliance"). • Lack of knowledge about how to run reports in RPMS for low glucose or elevated INR. • Lack of knowledge about searching pharmacy records in RPMS. • Lack of correct keys to run RPMS searches. • Do WebCident reports capture ADEs that are not caused by medication errors?
CAUTI	• Manual chart review • QMan search by diagnosis code • Infection control log • VGEN search for positive urine cultures	• Denominators need to be clarified (catheter patients and catheter days).
CLABSI	• Manual chart review • QMan search by diagnosis code • VGEN search for positive blood cultures	• Clarification of reporting requirements for hospitals that transfer out all patients with central lines. • Denominators need to be clarified (CL patients and CL days).

Measure	Data Collection Methods	Problems/Challenges
SSI	• Manual chart review • Surgical log	• Direction on how to report if no surgical suite (e.g., "Not applicable") in Comment Box required. • Clarification needed of reporting requirements for hospitals that very rarely perform surgeries that qualify under this measure. • Confusion over inclusion and exclusion criteria. • Concern that infections are being over-identified.
VAP	• ICU log book	• Clarification needed of reporting requirements for hospitals that transfer out all patients on ventilators.
PrU	• Manual chart review • RPMS search by diagnosis code • Reported manually at time of occurrence	• Volume of notes or assessments for manual chart review. • Uncertainty about whether searching RPMS for diagnosis codes is sufficient, or if cases are being under-identified.
VTE	• Manual chart review • RPMS search by diagnosis code • CART system search by diagnosis code • Reported manually at time of occurrence	• Sites request alignment with CMS VTE measure. • Confusion over exclusion criteria.
EED	• Manual chart review • OB log book	• Clarification needed for reporting requirements for birth centers and/or hospitals that are limited to low-risk births. • Hospitals may be reporting "0" numerators automatically or not reporting at all because they "don't allow elective deliveries."

3.2: Assessment of Individual PfP Measures and Reporting Issues

Review of findings from discussions with hospital interviewees about individual PfP measures identified a number of areas that are of concern for accurate reporting and that could be addressed through additional training and technical assistance.

Readmissions: Although only one hospital is reporting on the Readmissions Alternate Measure, most hospitals are examining the readmission data they receive from the NDW and comparing it to their internal information regarding readmissions. Many hospitals described confusion related to identifying the index hospitalization, treatment of admissions with the same diagnosis versus an unrelated diagnosis, and the treatment of same hospital versus different hospital readmissions. In addition, some hospitals found readmissions in their NDW data that they felt were improperly classified. For example, one hospital identified a transfer to another facility that was listed as a

readmission. These classification issues may be a result of misidentifying the index hospitalization.

Concerns over the impact of social admissions and admissions for alcohol withdrawal were common among the IHS hospitals participating in PfP. The presence or absence of any exclusion criteria for these types of admissions should be clarified.

Falls: The most consistency in data collection is seen with the Falls measure, where all reporting hospitals are utilizing WebCident. In general, hospitals believe the WebCident system is being utilized appropriately to document falls and, in many cases, the average daily census is low enough that staff members are aware when a fall occurs. No hospitals expressed concern over data collection related to falls. However, comments related to the injury categories for falls (A-I) indicate that additional training regarding what constitutes a minor injury may result in more accurate reporting.

Adverse Drug Events (ADE): Hospitals describe a wide variety of data collection methods for the ADE measures. Use of WebCident reports and manual chart review either alone or in combination with RPMS searches are common. RPMS records are searched using QMan and VGEN. While some hospitals take the approach of using RPMS to identify patients with abnormal lab values and then reviewing charts to identify the cause, others work in the other direction, looking for specific medications in RPMS, and then reviewing charts for adverse events. A few hospitals utilize their medication dispensing machines to trigger an alert when they dispense medications that are used to treat hypoglycemia or an elevated INR. When discussing the anticoagulation measure, one hospital reported that an INR out of range was not included in the numerator because the patient did not take the warfarin medication and the hospital felt it "wasn't their fault." Others receive an alert when Accucheck blood glucose testing devices detect hypoglycemia. In some facilities, critical lab values automatically trigger review and reporting.

Due to the large number of diabetic patients treated at IHS hospitals, data collection for the hypoglycemia measure can be time-consuming when manual chart review is required. While hospitals have developed many different approaches to search electronic data for the ADE measures, a standardized approach would make data more comparable between sites, and access to the appropriate keys and search queries would reduce the burden of collecting data for these measures. In addition, it is unclear whether WebCident reports related to ADEs are made when the ADE is not related to a medication error. If only medication errors are reported, relying on WebCident reports is inadequate for accurate reporting of the ADE measure.

Catheter-Associated Urinary Tract Infections (CAUTI): Hospitals reporting CAUTI rely heavily on manual chart review. Some hospitals are able to narrow the charts that require review by using RPMS to identify all patients with Foley catheters, and then doing chart reviews to identify infections. Others search RPMS for positive urine cultures and then review charts to identify which patients with infections had Foley catheters. One hospital collects CAUTI data by manually reviewing infection control logs.

The only concern identified related to CAUTI data reporting was one hospital that was reporting all patient discharges instead of catheter discharges for their denominator.

Central Line-Associated Bloodstream Infections (CLABSI): Data collection methods for CLABSI were very similar to those utilized for CAUTI. While manual chart review is often required, some hospitals are able to narrow the list of charts to review by searching RPMS for bloodstream infections or patients with central lines.

While one hospital was identified as reporting incorrect denominators for CLABSI, the more common concern for this measure relates to which hospitals are exempt from reporting. Not all hospitals that transfer patients with central lines report being exempt from this measure, while other hospitals report being told they do not need to report because they do not have very many patients with central lines. Clarification of the correct reporting procedures for facilities that transfer out patients with central lines will be important moving forward.

Surgical Site Infection (SSI): All hospitals reporting SSIs utilize manual chart review or manual review of surgical logs to generate their reports for this measure. The hospitals expressed some confusion about the inclusion and exclusion criteria for SSI, and one site was concerned that SSIs were being over-identified by their data abstractor, who was not a part of the surgical department. Some hospitals that rarely perform surgeries included under this measure are not reporting at all, instead of reporting denominators of zero. Clarifying the desired reporting for hospitals in this category could increase the number of hospitals reporting the SSI measure.

Ventilator-Associated Pneumonia (VAP): Minimal information was collected on VAP reporting. One hospital reports using their ICU log book to identify VAP, and another reports that the Infection Control department is in charge of reporting. The one concern identified with VAP reporting relates to which hospitals are exempt from reporting. Not all hospitals that transfer patients with ventilators report being exempt from this measure. Clarification of the correct reporting procedures for facilities that transfer out patients on ventilators will be important moving forward.

Pressure Ulcer (PrU): PrUs are being identified by manual chart review and through RPMS search by diagnosis code. A few hospitals with low patient numbers state that PrUs should be reported as they are identified by nursing staff. This is an area for concern, because if the person who identifies the PrU fails to report it to the person responsible for collecting PfP data and no other chart review is being conducted, PrUs will be under-reported.

Even when the census is low, manual chart review for PrUs can be very time-consuming because skin assessments are typically documented multiple times each day of an inpatient stay. It is unclear whether searching RPMS for diagnosis codes is adequate to identify PrUs or whether they are being under-reported. One hospital has implemented a QI project around proper identification of PrUs and was invited to join an early Collaborative Learning Network session online.

Venous Thromboembolism (VTE): Hospitals are utilizing manual chart review, as well as searches of RPMS and the CMS Abstraction & Reporting Tool (CART) system by diagnosis code to identify VTEs. A few hospitals with low patient numbers state that VTEs should be reported as they are identified by nursing staff. This is an area for concern, because if the person

who identifies the VTE fails to report it to the person responsible for collecting PfP data and no other chart review is being conducted, VTEs will be under-reported.

Hospitals have reported some confusion over the exclusion criteria for VTE reporting. Additional confusion and frustration is caused by the differences between PfP and CMS reporting criteria for VTEs. If the reporting for PfP could align better with the CMS measure, it would reduce the time and effort required.

Early Elective Delivery (EED): Data collection for EEDs is conducted manually through chart review or review of OB logs. No hospitals report using RPMS or any other automated reporting method for this measure. The main area of concern related to the EED measure is the lack of consistency around which hospitals should be exempt from reporting. Facilities and capabilities for delivering babies vary between the hospitals we spoke with, ranging from birth centers that strictly deal with natural childbirth to labor and delivery units that describe themselves as only handling low-risk births to facilities that offer inductions and C-sections. It seems logical that birth centers that do not ever offer induction could be exempted from reporting this measure. However, clarity is needed for facilities that offer induction but have a policy against inducing electively. They may benefit from closer analysis of induced labor to see if the policy is being adhered to.

Section 4: Quality Improvement Initiatives

QI initiatives related to the PfP measures were of interest for this project for two reasons: (1) documenting the response of hospitals to participation in PfP and monitoring the specific PfP measures and (2) identifying hospitals that have implemented effective QI initiatives that may be able to provide information and experience on improving specific PfP measures to other IHS hospitals.

4.1: Summary of QI Initiatives Related to PfP

We discussed quality improvement issues and specific PfP QI initiatives underway with each of the 28 hospitals interviewed. Overall, nearly half of the hospitals identified one or more QI initiatives related to PfP that they had implemented. Nine of the 28 hospitals (32 percent) had implemented QI directed toward reducing Falls and Readmissions. Four had implemented QI initiatives focused on ADE/Hypoglycemia, and three had implemented QI initiatives focused on CAUTI. Other QI initiatives implemented by one or two hospitals were directed to improving VTE, PU, CLABSI, and SSI (see Table 4.1).

Table 4.1: Hospitals Reporting QI Initiatives Related to PfP Measures

Type of QI Initiative	Number/Percentage of Hospitals	Specific Hospitals
All Hospitals Reporting PfP QI	14 (50%)	ACL, Claremore, Gallup, Hopi, Parker, Lawton, Mescalero, PIMC, Pine Ridge, Santa Fe, Sells, Whiteriver, Winnebago
Falls	9 (32%)	ACL, Gallup, Hopi, Lawton, Parker, PIMC, Santa Fe, Sells, Winnebago

Type of QI Initiative	Number/Percentage of Hospitals	Specific Hospitals
Readmissions	10 (32%)	ACL, Cass Lake, Gallup, Lawton, Mescalero, PIMC, Pine Ridge, Santa Fe, Whiteriver, Winnebago
ADE	4 (14%)	Hopi, PIMC, Pine Ridge, Sells
VTE	2 (7%)	Gallup, Sells
PrU	2 (7%)	Gallup, Claremore
CAUTI	3 (11%)	Claremore, Hopi, Sells
CLABSI	1 (4%)	Claremore
SSI	2 (7%)	Sells, Claremore

The specific type of QI initiatives implemented to address a specific area varied. QI initiatives aimed at reducing Falls implemented by **Lawton** included establishing a Fall Team, conducting a fall risk assessment with patients, and instituting hourly rounding. This QI was initiated some time ago and resulted in a decrease in the number of falls. **Sells** has implemented an assessment of fall risk for inpatients, has a safety officer who works closely with nursing, and is expecting to buy equipment that will help patients to ambulate. **PIMC** completely revamped their Falls program, transitioning to the Hendricks II Fall Risk Model, and claim the lowest level of falls ever due to assertive hourly rounding and emphasis on improved care. **Santa Fe** reported their inpatient falls were 24 percent in 2010 and 0 percent in 2013 due to the success of their program, and they are currently looking for an outpatient fall assessment tool to use in their ambulatory settings.

Similarly, approaches designed to reduce readmissions to hospitals were varied. **ACL** has developed a program that assigns an R.N. case manager to visit patients in the hospital to identify their post-discharge needs and assign a PCP for follow-up. Following discharge, public health nurses and/or CHRs do a home visit to discharged patients with high levels of needs. The hospital works with Tribal social services to arrange for home-delivered meals and firewood, if necessary. CHRs provide transportation to medical appointments and assist with obtaining DME. **Gallup** reported that it is targeting the discharge process to improve communications among inpatient, primary care, community services, the patient, and patient caregiver. The pharmacy performs medication reconciliation prior to discharge. Gallup noted that further improvement goals include locating an appropriate screening tool to identify risk factors for readmission. **Mescalero** reported that their readmission QI is being implemented through adoption of Project Re-Engineered Discharge (RED), a well-developed care transition model, which requires nurses to call discharged patients within 3 days of discharge to check on progress and to schedule follow-up appointments. **PIMC** is also implementing Project RED. **Sells** uses the Institute for Healthcare Improvement's State Actions on Avoidable Readmission (STAAR) change package to identify factors related to readmissions and to identify areas for improvement. Analysis showed that 25 percent of readmissions are related to poor living conditions and social factors and 20 percent are related to lack of caregiver for the discharged patient. Improvement focused on initial risk assessment of patients, post-discharge telephone calls by public health nurses to follow-up on education and discharge instructions, and pharmacy follow-up telephone calls within 72 hours to answer any questions about medications.

Success in addressing other measures include the ADE program at PIMC, which they completely revamped according to evidence-based literature, and **Claremore's** PrU protocol that requires

hourly rounding, hourly repositioning for chair-bound patients, and turning every 2 hours for bed-bound patients. The staff stresses good diet and hydration and skin inspection on every shift, and they have adopted a new form to document PrUs on admission.

The types and range of QI initiatives underway within the 28 hospitals indicate that participation in PfP is eliciting focused interventions to address the PfP measures. However, with the exception of Falls and Readmissions, few hospitals have implemented QI initiatives for more than one or two PfP measures. Also, approximately half of the hospitals did not report specific QI initiatives targeting the PfP measures.

4.2: Other Quality-Related Issues

Interviewees were asked about the extent to which they had engaged patients and/or the community in QI initiatives. Seven hospitals reported that they had processes in place for engaging and/or activating patients to participate in health care, ranging from including patients in committees that review and identify processes to improve care to employing a patient advocate to making efforts to engage families of patients being discharged from the hospital to ensure post-discharge care needs are met. Several hospitals mentioned that Service Unit patients with diabetes are provided support, education, and services to increase patient activation and healthful lifestyles that could reduce complications and risk of hospitalizations. Ten of the hospitals mentioned that they made efforts to obtain community input and involvement with the hospital system. Examples given included having Tribal leadership, Tribal health directors, and community members participate as members of a guiding or advisory committee, consultation with the Tribes they serve, having a community liaison, having community members participate in strategic planning, and participating in community events and community health projects. A few interviewees noted that they have made efforts to obtain community engagement but have not been successful.

Section 5: Training and Technical Assistance Needs

During site visits and telephone interviews with the 28 IHS hospitals, the Econometrica/Sundance Research Institute team asked the PfP interviewees to discuss specific T/TA needs related to PfP that could be useful to their staff. Some of the T/TA requests reflect generic needs for assistance at these facilities, such as general RPMS training, improving third-party collections, documentation training, help in meeting Joint Commission accreditation standards, and staff recruitment and retention support. Other T/TA requests indicated a significant level of alignment related to PfP measures and participation among the participating hospitals. The categories of T/TA requests to support PfP fall into the following general areas:

1. Data collection and reporting.
2. Work effort.
3. Refinement of specific measures.
4. Best practices for QI initiatives.

We also found that a few of the hospitals assessed are relatively uninformed about PfP and data collection and reporting requirements. These sites stressed that they are unclear about where

reports should be sent, when reports are due, and what formats need to be used. A couple of sites said that they were unaware of the PfP, indicating that basic communication about the program and processes has been inadequate for them. Additional outreach, training, and technical assistance to bring these hospitals into PfP and to help them begin to participate fully are needed.

5.1: Data Collection and Reporting

Most facilities have struggled to determine the best methods for collection of data to report PfP measures, with a number of facilities pointing out that standardized collection procedures and best practice methods across facilities would be very helpful. Development of a standardized database to facilitate analysis of data was also identified as useful. One site suggested a Web-based system, while numerous sites felt that established methods applied consistently across sites with ongoing training would be preferred. This is especially relevant due to the common high turnover among staff assigned to PfP data collection and reporting among many of the hospitals. Standardized data, data collection procedures, data analysis, and reporting would facilitate transitions when turnover occurs and might also facilitate more regular reporting by staff in small facilities with multiple responsibilities and limited time to devote to PfP data collection and reporting.

A majority of the hospital interviewees mentioned a need for assistance in designing queries or developing more sophisticated queries from RPMS. Similarly, interviewees stated that they need training on procedures to access the key for areas of RPMS necessary to collect data for specific measures.

Interviewees were also interested in learning how to use the data they are reporting for PfP in a meaningful way. Very small facilities pointed to the narrow reporting of small numbers and small denominators (mostly zeroes) as indicating the reports have no real value to them, while others felt that the data could be meaningful if they knew how to present it for specific audiences as well as make the reports look better. Additionally, many facilities pointed out that alternate measures could be reported that would be more meaningful for their scope of services. Examples given were expanded drug categories for ADEs and collecting data on ambulatory procedures that are much higher volume than inpatient procedures and services in most of these hospitals.

The alternate measure of days between events is widely acknowledged as a good alternative for rare events, but only one hospital is doing one alternate measure (i.e., Cass Lake reporting discharges that do not result in a readmission between discharges that do result in a readmission).

5.2: Work Effort

The level of effort that is required for hospitals to collect and report data on performance measures to PfP and other entities is significant and often strains limited resources. Manual chart reviews are common in most facilities, particularly for conditions and procedures that are not coded into the RPMS; most sites indicated that they review records to identify catheters, central lines, ventilators, PrUs, and surgery patients. Conditions that are not coded (such as PrUs) require review of the nurses' notes to identify appropriate patients. A number of sites suggested that the RPMS EHR be modified with templates to collect specific information.

The IHS hospitals participating in PfP report they are required to collect and report the same or similar conditions and measures to a number of different entities, including PfP, CMS, CDC, and GPRA, as well as to their State. Although many of the measures are similar, the definitions of the measures to be collected and reported are not consistent for each of the entities and report criteria vary. As a result, the hospital staff responsible for reporting have to develop methods to extract, analyze, and report performance measures multiple times to meet slightly different requirements. For example, one site stated that it must maintain two separate databases for VTE in order to segregate the many exclusions reporting entities have created.

Some facilities pondered if IHS has control over some of the PfP definitions and could better align the definitions to reduce the collection and reporting burden. Overlap in reporting was specified in particular for VTE, EED, and Readmissions, while standardized methods of collection and automation of reports and queries were identified as highly desirable.

5.3: Specific Measures

In order to make the PfP measures more relevant to the IHS hospitals, interviewees suggested training and technical assistance to address specific measures, including:

- *ADE:* A system for automating collection of the two ADE measures would be useful. Additionally, some interviewees noted that they have adverse events related to other drugs and that collecting and reporting on specific drug events more relevant to individual hospitals could be more meaningful.
- *VTE*: Training and technical assistance to reconcile differences among reporting entities that complicate data collection and reporting or redefinition of the PfP measure to be consistent with the definitions required by other entities would facilitate reporting of this measure.
- *Falls:* Training focused on best practices and fall prevention protocols would be useful for QI initiatives.
- *Readmissions*: Several of the participating hospitals are attempting to identify the root cause for readmissions and indicated that training and technical assistance that supports root cause analysis would be useful. In addition, some hospitals suggested that training on best practices for preventing readmissions and technical assistance for developing QI initiatives to address this issue would be helpful. Specific concerns were raised about the high number of alcohol-related admissions and readmissions and developing strategies for preventing readmissions for this patient population. In addition, mobility of the American Indian/Alaska Native population contributes to admission/readmission to multiple facilities and this complicates monitoring of readmissions; a method for sharing patient information across IHS hospitals would be helpful for data collection and reporting of readmissions.
- *PrU and CLABSI:* Several hospital interviewees noted that they were not clear on the appropriate denominators for PrU and CLABSI and suggested additional training was needed to clarify this issue for both measures.

- *Other T/TA areas of interest:*
    - One hospital requested training on best practices for OR/surgical procedures, Emergency Department patient flow, and ICU restraints.
    - Several hospitals mentioned that training and technical assistance on best practices and QI strategies to increase patient/family engagement and patient activation would be useful.

Several IHS hospital interviewees also raised the issue of ambulatory care measures under the PfP as more useful to their facilities. IHS hospitals for the most part provide higher volumes of outpatient services than inpatient days. Interviewees expressed interest in the development of outpatient measures (similar to PfP) targeted at improving patient care as more relevant to their mission.

5.4: Best Practices and QI Initiatives

Many of the hospital interviewees were interested in training and technical assistance that would provide them with understanding of best practices for improving their performance on the PfP measures and quality of care for their patients. While this interest was broad across all of the PfP measures, several hospitals specifically mentioned training and technical assistance on best practices and QI strategies to increase patient/family engagement and patient activation would be useful.

Resources available on the HealthCare Communities Web site have limited value for many of the small sites because they lack knowledge of the Web site and described searching for the assistance they need as time-consuming and frustrating. In addition, some sites are unable to attend webinars due to meeting conflicts and have limited time to review materials that could have value. With new staff assigned data collection and reporting responsibilities and the "many hats" nature of employment in small facilities, concise and targeted training modules on best practices and methods could provide essential information on an as-needed basis.

5.5: Summary of Training and Technical Assistance Needs Identified by Hospitals

Table 5.1 summarizes the training and technical assistance identified and requested by IHS hospital participants in the PfP, by category and the specific sites reporting these needs.

Table 5.1: Identified Training and Technical Assistance Needs

Category	Specific Hospitals Requesting T/TA
Data Collection and Reporting • Standardized methods • Database for analysis • How to use data • Help with queries • More sophisticated queries • Meaningful use of data • RPMS training • RPMS access across facilities	ACL Claremore Crow Crownpoint Eagle Butte Ft. Yates Gallup Lawton PIMC Pine Ridge Rapid City Rosebud Santa Fe Whiteriver
Work Effort/Coordinating/Reducing Duplication in Reporting to Different Entities	ACL Belcourt Chinle Claremore Gallup Lawton Parker Pine Ridge Rapid City Sells Whiteriver Zuni
Specific Measure: ADE	Claremore Ft. Yates Mescalero Rapid City Rosebud
Specific Measure: VTE	Claremore Gallup Pine Ridge Rapid City Rosebud
Specific Measure: Readmissions	ACL Crownpoint Eagle Butte Gallup Lawton Northern Navajo
Specific Measure: Falls	Santa Fe

Category	Specific Hospitals Requesting T/TA
Best Practices for QI Initiatives	ACL Chinle Claremore Crow Ft. Yates Lawton Mescalero Northern Navajo Pine Ridge Rapid City San Carlos
Additional T/TA on PfP to Facilitate Participation of Hospitals Not Aware/Engaged and/or Not Reporting All Measures	Crownpoint Eagle Butte Ft. Belknap Parker Pine Ridge Rosebud

The specific T/TA needs reported by participating IHS PfP hospitals in this section are combined with the information reported in Section 3 and Section 4 to identify the full range of T/TA needs compiled through the assessment process.

Section 6: Summary of Training and Technical Assistance Needs Identified

T/TA needs identified can be grouped into two categories: (1) T/TA needs that are general to all or most IHS PfP hospitals and can be provided through group learning events and (2) T/TA needs that are specific to one or a few hospitals and can be provided through one-on-one or other targeted assistance. Review of the findings of the hospital assessments suggests that the following types of training and technical assistance related to PfP are needed generally by all or most hospitals (see Table 6.1).

Table 6.1: Training and Technical Assistance Needed by Most IHS PfP Hospitals

Category	Specific Needs
Clarification of PfP measure definitions, inclusion/exclusion for reporting	• Consistent definitions; education on understanding the definitions. • How to "harmonize" measures reported differently to various entities. • What to look for in anticoagulation measures • VTE exclusion criteria. • CART reviews and utilization reviews overlap in EED, VTE, and readmissions.

Category	Specific Needs
Data collection strategies, standardized processes, templates to reduce burden	• Access to required RPMS keys. • Efficiencies in collection and reporting. • Consistent collection procedures. • More sophisticated RPMS queries. • Training modules to address staff turnover. • Share patient RPMS information across facilities. • Software to make data reports look better. • How to present data in meaningful ways. • Automate data collection. • Standardized database. • Chart templates in RPMS for PfP measures.
Quality improvement strategies, best practices for improvement on specific PfP measures	• Contributing factors for readmission (root causes). • Alcohol withdrawal as readmission issue. • Adverse drug events. • Patient and family engagement, patient activation, motivating lifestyle changes. • Protocols for fall prevention. • Ambulatory care quality measures. • Web-based system to measure culture and patient safety.

Individual hospitals and small groups of hospitals may require one-on-one training and technical assistance on specific issues that are unique to their circumstances or due to their lower level of awareness and participation in PfP to date. Table 6.2 outlines the types of training and technical assistance requested by these hospitals.

Table 6.2: Training and Technical Assistance Requested by IHS PfP Hospitals

Category	Specific Needs
Outreach and additional training on PfP objectives, benefits, and participation requirements	• Objectives and benefits of participation. • Requirements for participation. • Where to obtain current forms. • Who and where to obtain additional information and submit data.
Targeted TA on data collection, analysis, and reporting for specific PfP measures	• More sophisticated RPMS queries. • Hands-on RPMS training. • Practice with iCARE. • Setting up denominators. • Have forms default to zero value or other method to report no change. • How to use pharmacy records for ADE. • Capture INR values over 4; how to associate critical INR with warfarin prescription. • Clarification on when they do not have to report measures. • Denominators for CAUTI and CLABSI.

Category	Specific Needs
Targeted TA on QI strategies, development of QI initiatives, and monitoring of QI outcomes for specific PfP measures	• Improving staff awareness and engagement. • Help with PDSAs. • How to associate diabetic patients with specific medications. • OR/surgical procedures success/adverse outcomes. • Patient flow in the emergency department. • ICU and restraints.

Delivery of training and technical assistance on topics of general relevance to all IHS PfP hospitals can be accomplished primarily through group learning sessions. However, a number of hospital interviewees noted that the scheduling of these events may often conflict with regular work-related activities and meetings. Several interviewees suggested that all learning sessions be scheduled well in advance to facilitate participation and avoid conflicts. In addition, it was recommended that these trainings be made available in a format that would permit hospital staff to obtain the information provided through listening to recordings and reviewing presentation materials at a more convenient time. This would also permit access to these learning sessions at a later time when hospital staff decide to pursue specific issues or discover a need for review of specific processes or correction of identified problems.

Delivery of training and technical assistance needed by one or a small group of hospitals can be accomplished through scheduled site visits, which would permit more hands-on problem identification and technical assistance, or through preparation of training materials targeted to specific requirements and presented and discussed by telephone. More in-depth discussion of individual hospitals' T/TA requirements related to PfP and methods of delivery will be provided in the forthcoming Assessment Report for Individual PfP Hospitals.

Appendix A: Assessment Tool and Descriptive Profile

Assessment Tool

Categories of Interviewees:

- Service Unit Director/Chief Executive Officer (CEO)
- Hospital Administrator (if separate from CEO)
- Chief Medical Officer (CMO)
- Quality Manager
- Director of Nursing
- IT/Data Manager/Clinical Advisory Committee (CAC)

Topics for Discussion:

- Data Issues.
    - How data collection is working for measures being reported by hospital: document process for tracking the measures, data entry, and reporting; identify software being used; limitations/challenges for reporting.
    - For measures not being reported (where relevant service is provided by hospital): reasons why not reporting; what would be needed by site to enable reporting.
    - Level of participation in PfP and activities related to data issues and reporting: how participation has been helpful in developing and implementing systems for data tracking, entry, reporting to meet PfP objectives.
    - Determine whether they are satisfied with performance.
    - Identify technical assistance needs identified by interviewees to support and improve data tracking, data entry, reporting related to PfP objectives.
- Quality Management/Quality Improvement Infrastructure Issues.
    - Determine level of exposure/experience with QI (e.g., IHI IPC).
    - Discuss level of support received from others (e.g., IHS Area offices).
    - Document current QM/QI structure and resources within the hospital/Service Unit.
    - Discuss and obtain examples of QM data being generated by system and process for reviewing and identifying opportunities for improvement.
    - Limitations/challenges for QM/QI within site.
    - Level of participation in PfP and activities related to QM/QI: how participation has been helpful in developing and implementing QM and QI activities to meet PfP objectives.
    - Technical assistance needs identified by interviewees to support and improve QM and QI related to PfP objectives.

- Participation in PfP network and learning opportunities.
    - Extent of participation overall.
    - Level of family/patient engagement (e.g., Advisory Committees).
    - Who do you call for help with data/measures?
    - Do you talk with other IHS facilities? Who? How often?
    - Is there someone here who is well-connected with people at other organizations/facilities?
    - Perceptions of usefulness of PfP network and learning opportunities.
    - How has participation and learning been used? Limitations/challenges to implementing new approaches.
    - Areas for learning/education that would be of greatest value for staff.
    - Preferred mechanisms for TA and learning sessions.

Descriptive Profile

Indian Health Service Hospital:

Characteristic	Hospital Description
Hospital PfP Liaison Name and Contact Information	
Year Hospital Established	
Geographic Area Served	
Hospital Beds	
Hospital Discharges 2012	
Occupancy Rate 2012	
Services Available – General	
PfP Services Available	
Number of Physicians	Medical: Surgical: Other:
Number of Staff FTE, by Type of Personnel	▪ Service Unit CEO ▪ Hospital Administrator ▪ RNs ▪ LPNs ▪ Pharmacists ▪ Allied Health: ▪ Other Health: ▪ IT/Data Management/CAC: ▪ Data Entry: ▪ Medical Records ▪ Billing ▪ Other:
Shared Staff With Service Unit Clinic(s):	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	
PfP Measures Reported and Number of Months Reported, by Measure	
Number of PfP Measures Not Reported (for Services Offered Within the Hospital)	

Final Assessment Report
Part 2: Individual Hospital Assessment Report

Inpatient Safety Performance and Organizational Assessment

Contract No.:
HHSI236201300048A

Project No.:
2404-001

Submitted To:

Indian Health Service
Attn: Paula Slyker
Contracting Officer's Representative
Phoenix Indian Medical Center
Phoenix, AZ 85004

Submitted By:

Econometrica, Inc.
7475 Wisconsin Avenue, Suite 1000
Bethesda, MD 20814

May 14, 2014

ECONOMETRICA, INC.

ECONOMETRICA, INC.

May 14, 2014

Ms. Paul Slyker
Contracting Officer's Representative
Phoenix Indian Medical Center
Phoenix, AZ 85004

Reference: Contract No. HHS1236201300048A: "Inpatient Safety Performance and Organizational Assessment."

Dear Ms. Slyker:

Econometrica is pleased to submit this Final Assessment Report: Part 2 – Individual Hospital Assessment Report to the Indian Health Service (IHS) as required under the above-referenced contract.

If you wish to discuss any aspect of this submission, please feel free to contact me at (240) 395-2271 or Mark Stewart at (301) 657-9883, ext. 205.

Sincerely,

Econometrica, Inc.

Thomas R. Jackson
Vice President

cc: Dr. David Civic/IHS
Ms. Kathy Langwell/Sundance Research Institute
Mr. Mark Stewart/Econometrica, Inc.
Contract File

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Final Assessment Report
Part 2: Individual Hospital Assessment Report

Background and Purpose

Background

Improving the quality of care in Indian Health Service (IHS) inpatient settings and ambulatory care is a continuing goal of IHS. IHS has finalized Intra-Agency Agreements with the Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Innovation (CMMI) to participate in the Partnership for Patients (PfP) initiative. The PfP initiative was established with the goals of making inpatient hospital care safer and improving transitions between care settings to prevent patient complications that result in hospital readmissions. Key elements of the PfP include Hospital Engagement Networks (HENs) across the country that help identify effective solutions to reduce hospital-acquired conditions and improve patient safety, as well as the Community-Based Care Transitions Program (CCTP) to improve care transitions and reduce readmissions to hospitals.

Econometrica, Inc., was contracted by IHS to provide training and technical assistance (T/TA) for the 28 IHS hospitals participating in the PfP initiative, including assessing current data capabilities for establishing a baseline and for reporting changes for the 10 PfP hospital-acquired conditions and readmissions, as well as the two focus-area measures (i.e., leadership and patient/family engagement) over time; assessing current quality improvement (QI) activities related to these measures and internal needs for T/TA for quality improvement; providing assistance to improve data capabilities in targeted areas to ensure accurate and comparable measure reporting across all 28 hospitals; and developing, facilitating, and providing training, learning sessions, and technical assistance that will assist the IHS hospitals to design and implement QI initiatives to achieve desired changes in the key PfP quality measures.

Purpose of This Report

The assessment phase of this project included site visits and telephone interviews with the 28 IHS PfP hospitals. The information collected from each hospital focused on data capabilities for reporting PfP quality measures; factors that may hinder the ability to produce these measures; current quality monitoring and QI activities related to the PfP; and needs for T/TA that will assist individual hospitals and the IHS Hospital Consortium to produce valid quality measurement data and design and implement effective strategies for quality improvement targeted toward the PfP focus areas.

The Overall Assessment Report: Part 1, submitted to IHS on February 28, 2014, provided a summary of findings for the 28 hospitals and recommendations for T/TA that would provide support and assistance to the PfP initiative. Individual hospital assessments are reported in Part 2 of the Assessment Report. These Individual Assessment Reports provide a brief summary of the highlights of each individual hospital's participation in the PfP program and identified the specific hospital T/TA needs that emerged from the site visit or interview conducted with that hospital.[1]

[1] A description of the assessment approach is provided in the Overall Assessment Report: Part 1.

We summarize the assessment findings for each individual hospital, including a brief description of the hospital and its location; awareness of and participation in the PfP; PfP data reporting status and T/TA needs related to data reporting; PfP QI initiatives conducted or underway; and other T/TA needs. We also summarize the T/TA recommendations for each hospital that have been identified through the assessment. A detailed Descriptive Profile is provided for every hospital. Because these were informed by the telephone interviews, the table is not complete for every hospital if, for example, they did not have a reply. The final element of each individual hospital report is a summary analysis of current PfP data reporting. Specifically, this highlights any inconsistencies between the tables reported by the Performance Evaluation Contractor (PEC) for the PfP and the internal IHS data reporting progress table.

Aberdeen/Great Plains Area Office

- *Eagle Butte Hospital/Cheyenne River Health Center – Eagle Butte, SD*
- *Ft. Yates/Standing Rock IHS Hospital – Ft. Yates, ND*
- *Pine Ridge Hospital – Pine Ridge, SD*
- *Quentin N. Burdick Memorial Health Care Facility – Belcourt, ND*
- *Rapid City Indian Hospital – Rapid City, SD*
- *Rosebud Indian Hospital – Rosebud, SD*
- *Winnebago Indian Hospital – Winnebago, NE*

Eagle Butte Hospital/Cheyenne River Health Center

1: Assessment Summary

1.1: Overview of Eagle Butte Hospital

In 2011, the Eagle Butte Hospital in Eagle Butte, SD, was replaced with a newly constructed alternative rural health center. This is a modern, technologically advanced facility with enough space and staff to provide an expanded level of health care services specifically designed to meet the needs of the 9,600-user population of the Cheyenne River Service Unit, which is about the size of the State of Connecticut. Patients travel more than 70 miles to receive services at the hospital.

The new facility has an eight-bed acute-care nursing unit, emergency room, expanded outpatient department, dental, community health department, and a full array of ancillary (including mammography) and support services. Additionally, several tribally operated 638 programs are incorporated into the new facility. The Cheyenne River Sioux Tribe, through a 638 contract with IHS, operates four satellite health stations that offer basic ambulatory services at Cherry Creek, Red Scaffold, Swiftbird, and Whitehorse.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

The CEO is aware of the program and reports are regularly made to committees.

1.2.2: PfP Measures: Reporting Status and Challenges

- Eagle Butte is reporting on falls, adverse drug events (ADEs), catheter-associated urinary tract infections (CAUTI), pressure ulcers (PUs), and venous thromboembolism (VTE). They do not report surgical site infections (SSIs), early elective deliveries (EEDs), ventilator-associated pneumonia (VAP), or central line-associated bloodstream infection (CLABSI).
- Readmission rates have been over 20 percent for 4 months, which needs to be discussed at an upcoming inpatient meeting. There are some discrepancies between the National Data Warehouse (NDW) and their data; they suspect that patient transfers are being recorded as readmissions.
- Falls are tracked using WebCident, with reports going to the Director of Nursing.
- ADEs are tracked with manual chart review, which is manageable with their volume.
- CAUTI is tracked by the infection control nurse working with the Quality Assurance and Performance Improvement (QAPI) Coordinator; they perform manual chart review. ER uses the ERF system.
- PUs are tracked through a manual chart review, which is time-consuming because there is a skin assessment noted for every shift, so they are considering creating a reporting system/flag.
- VTE data is obtained from the Resource and Patient Management System (RPMS).

- Patient and Family Engagement consists of community members participating in strategic planning. Patients and family members participate in the discharge planning process but there is no special emphasis on patient activation.

1.2.3: Quality Improvement Initiatives Related to PfP

The QAPI Coordinator has been at Eagle Butte since April. She has been participating in the PfP webinars, including those covering pressure ulcers and readmissions and wishes there were more participation from the service unit in the webinars. Their readmission rate is a problem they need to learn more about. Eagle Butte was an Improving Patient Care (IPC)-3 site and continues on with a Quality Improvement Learning Network (QILN). IPC was well-received by patients, but they struggle with maintaining adequate staffing, which challenges them in achieving the goals of the medical home model—only two of the possible eight physician positions are currently filled.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Eagle Butte Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Lack of engagement.	• Training on improving patient safety.
Data Collection and Reporting	
• Manual chart review.	• Creating queries; RPMS templates.
• Patient transfers and readmission.	• NDW process change.
QI Initiatives Related to PfP	
• Readmission reduction.	• Best practices.
General/Other	
• Recruitment and retention in rural areas. • Wishes Service Unit participated more in webinars.	

3: Descriptive Profile

Indian Health Service Hospital: Eagle Butte Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Johnna Watt – QAPI Coordinator since 4/13, Director of Nursing for 7 years, total of 14 years with IHS
Year Hospital Established	2011
IHS Area Office	Great Plains
Geographic Area Served	Cheyenne River Reservation in SD
User Population	9,500
Hospital Beds	• # beds: 8 nursing, 2 birthing • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	0.2–0.3
Services Available–General	Outpatient clinics, ER, ambulance service.
PfP Awareness at Facility	• General: • Leadership: CEO is aware. Make reports to committees.

Characteristic	Hospital Description
PfP Services NOT Available	No L&D and no surgery
Number of Physicians	• Medical: 2 • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	6 vacant MD positions
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan. 2012–June 2013 • ADE: Jan. 2012–June 2013 • CAUTI: Jan. 2012–June 2013 • CLABSI: • SSI: • VAP: • PU: Jan. 2012–June 2013 • VTE: Jan. 2012–June 2013 • EED:
Reporting Method – Readmissions	Readmission rates have been over 20% for 4 months. She needs to discuss this at an upcoming inpatient meeting. There are some discrepancies between NDW and their data; patient transfer might possibly have been coded as a readmit.
Reporting Method – Falls	WebCident; reports go to Director of Nursing.
Reporting Method – ADE	Manual chart review, which is manageable with their volume
Reporting Method – CAUTI	Infection control nurse works with QAPI Coordinator. Performs manual chart review. ER uses ERF system.
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	Manual chart review, but this one is more difficult because there is a skin assessment noted for every shift. Considering creating a reporting system/flag.
Reporting Method – VTE	Pull data from RPMS.

Characteristic	Hospital Description
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	
QI Measures Implemented due to PfP	
Patient, Family, and Community Engagement	Community members participate in strategic planning. No special work on patient activation. They do participate in the discharge planning process.
Strength Area	
Training and TA Needs Identified	Wishes there were more participation from the service unit in the webinars. Readmission rate is a problem they need to learn more about.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Eagle Butte:

- CLABSI shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but is shown as reporting for ~2 years on the IHS Data Reporting Progress Chart.

Ft. Yates Indian Hospital/Standing Rock IHS Hospital

1: Assessment Summary

1.1: Overview of Ft. Yates Indian Hospital

The Fort Yates Hospital, located near the Missouri River at Fort Yates, ND, is a fully accredited 12-bed hospital that provides inpatient, outpatient, emergency, dental, behavioral health, optometry, and dialysis services (eight stations); they do not have a surgical suite, use ventilators, or offer labor and delivery. Dental care is provided in the main clinic at the hospital. They operate a clinic at McLaughlin and health stations at Cannonball, Bullhead, and Wakpala. They provide health care for 11,000–12,000 population residing on the Standing Rock Reservation: one-third in North Dakota and two-thirds in South Dakota. Ft. Yates has a high staff turnover rate, with 23 of 113 positions vacant.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

They describe PfP awareness as low; they submit the data but have not gone any further or done anything with the information.

1.2.2: PfP Measures: Reporting Status and Challenges

- Ft Yates is only reporting readmissions and falls; they utilize WebCident to record falls.
- They are putting processes in place to report on the anticoagulation ADEs.
- They do not have any data because they do not have any patients; their average daily census last year was 0.005. A new nurse starting in February will allow them to cover the night shift and start admitting patients again.
- Patient and family engagement is challenging; they were required to have a community member participate for IPC-4, but no community member would agree to participate. They do, however, use patient activation techniques with their diabetic patients.

1.2.3: Quality Improvement Initiatives Related to PfP

- There is a concerted effort at the hospital to embrace the concept of "hospital-wide." While all departments conduct monitoring, the hospital needs to move on to the next phase—expanding QI initiatives hospital-wide and acting on the data. Each nurse is doing his or her own PI project; specific quality/PI projects include hand washing and monitoring critical values for the anticoagulation clinic. They visited all their facilities to assess safety issues such as steps, doorways, and accessibility. They are also printing patient rights paperwork for distribution.
- They conduct annual training on QAPI.
- Ft Yates was involved in IPC-4, but they could not respond quickly enough and they determined that it did not work well for them due to their small size and low volume.
- Ft Yates works with their State QIO frequently, using them as a resource for finding outside contacts. They have also utilized a QAPI trainer from CMS.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Ft. Yates Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Little knowledge.	• Training on patient safety; how to use measures.
Data Collection and Reporting	
• ADE	• Would like assistance in setting up their process.
• Forms	• Would like forms to default to zero, or have some method for reporting no change.
QI Initiatives Related to PfP	
• Process improvement.	• How to use data to support quality.
General/Other	
• Recruitment and retention.	

3: Descriptive Profile

Indian Health Service Hospital: Ft Yates Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	George Walker, Standing Rock
Year Hospital Established	1964
IHS Area Office	Great Plains
Geographic Area Served	Located near the Missouri River at Fort Yates, North Dakota
User Population	11,000–12,000
Hospital Beds	• # beds: 12 • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	.0005
Services Available–General	Dental, ER, outpatient clinic, inpatient, mental health, dialysis
PfP Awareness at Facility	• General: low • Leadership: CEO is aware and joined call in the last 20 minutes.
PfP Services NOT Available	No surgical suite, ventilators, or labor & delivery
Number of Physicians	• Medical: 2 full time, (1–4 contractors for ER) • Surgical: 0 • Other: 3 (plus additional 1–3 contractors)

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Total FTEs: 113 • Service Unit CEO: 1 • Hospital Administrator: 1 • RNs: 21 • LPNs: 3 • Pharmacists: 7 • Allied Health: 0 • Dental: 5 • Behavioral Health: 5 • IT/Data Management/CAC: 2 • Data Entry: 3 • Medical Records: 2 • Billing: 2 • Other: 53
Shared Staff With Service Unit Clinic(s)	0
Staff Turnover Rate, by Type of Personnel	23 current vacancies
Current Staff Vacancies, by Type of Personnel	Medical Staff, Nursing, Finance, Security, Housekeeping, Property and Supply, Maintenance, Medical Records, Dental
Quality Management/QI Manager/Staff, Number and FTE	1
Software Systems and Database Capacity	• RPMS: • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: • ADE: • CAUTI: • CLABSI: • SSI: • VAP: • PU: • VTE: • EED:
Reporting Method – Readmissions	
Reporting Method – Falls	Utilize WebCident
Reporting Method – ADE	They are putting processes in place to report on the anticoagulation ADEs.
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	
Reporting Method – VTE	
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	Not reporting: ADE (x2), CAUTI, CLABSI, PU, or VTE
Discrepancies on Reporting	Falls: Say they are reporting, but not in file
QI Measures Implemented due to PfP	

Characteristic	Hospital Description
Patient, Family, and Community Engagement	• They were required to have a community member participate for IPC-4, but no one agreed to participate. • The Tribal Health Director does attend hospital meetings. • CHRs. • CEO attends community district meetings. • Do work on patient activation with their diabetes patients.
Strength Area	
Training and TA Needs Identified	• Wonder if the forms could default to zero values, or if there could be another way to report "no change." • Assistance with best practices while they are preparing to report on ADEs. • Reported overlap of HAI measures with NHSN.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Ft. Yates:

- Readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart but are shown as reporting for ~4 years on the IHS Data Reporting Progress Chart.
- ADE, CAUTI, and CLABSI are shown as "2–Engaged in work related to HAC AND submitting data to the IHS HEN," but Ft. Yates is not currently reporting any measures.

Pine Ridge Hospital

1: Assessment Summary

1.1: Overview of Pine Ridge Indian Hospital

Pine Ridge Hospital is located on the Pine Ridge Indian Reservation in southern South Dakota. It serves a Sioux Indian population of more than 17,000 people. The hospital is licensed for 45 beds, and it staffs 29 medicine beds and 10 OB beds. The average daily census is about 14 patients. Services include general medicine, inpatient pediatrics, labor and delivery, general surgery, dental, the Kyle and Wanblee Health Centers, and three health stations (Allen, Manderson, and Porcupine).

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Awareness of PfP appears to be good. A wide variety of staff participated in our site visit, including leadership. They state that they participate in PfP webinars when they can, and they learned about monitoring the use of D-50 and vitamin K as markers for possible ADEs from one learning session. They asked about getting recordings of the webinars so they can watch on their schedule and stop the recording as needed for discussions.

1.2.2: PfP Measures: Reporting Status and Challenges

- Pine Ridge has reported on Falls, ADEs, and CAUTI. They mention reporting on CLABSI and SSI, but their October 2103 reporting spreadsheet does not contain data for those measures.
- The hospital has not collected or reported any data on PUs, VTE, or EED. They explained that they did not realize those measures existed, and asked where they could get the most up-to-date reporting spreadsheet. In addition, they state that they do not offer elective deliveries, so they wonder if they should be exempt from reporting EED. They also have not reported on VAP, but they were aware of this measure. Since they only use ventilators for transfers, they asked whether they should be exempt, or if they should report zeroes.
- Falls are entered into WebCident by the person who witnessed or discovered the fall. Reports go to the safety officer, who is in charge of reporting statistics.
- For ADEs, the pharmacy uses QMan to search RPMS for blood sugars below 50 and INRs over 4. It is difficult to make sure they are using all of the right codes to identify cases. Overall, the required reporting has given them a better awareness of ADEs.
- CLABSI and CAUTI are also identified using QMan by Infection Control. Medical records helped get the correct diagnosis codes identified. The numbers are low for central lines, so they are afraid they might be missing something. Staff on hand at the meeting confirmed that they do not do many central lines and suggested sending an alert with the chart number whenever a central line is placed.

- SSI is identified by manual chart review. There are two surgeons who perform 50–60 surgeries per month. Infection control consults and readmissions help identify patients with infected wounds.
- They are interested in learning more about patient engagement. They do use community members for safety drills, but they do not have much available infrastructure for getting the community together. They have health fairs and a mobile clinic that goes into the community, to powwows, and other events. Asking about engagement sparked a good conversation about potential ways they could improve, such as a community advisory group, including patients on Hepatitis C treatment and TB treatment committees, etc.
- In general, they do not feel as if they know how to use the data they have collected. The hospital staff needs RPMS training in general, as well as help with any programs to automate data collection for PfP. Ideally, they would like to see data abstraction programs written by someone from IHS who is an expert in RPMS. They requested a master list of who they are required to report to and when for all of their different reporting activities, as well as a database they can use to drop in all data collected from RPMS, so they can collect it once and analyze it in different ways for the different agencies they have to report to.

1.2.3: Quality Improvement Initiatives Related to PfP

- To address ADEs, they analyze the cause each time D-50 or vitamin K are pulled from their Omnicell medication dispenser.
- To reduce readmissions, the pharmacy conducts a follow-up phone call within 72 hours to discuss medications and follow-up appointments. There is a new case manager who follows transfers out from the ER and Health Home patients.
- In general, much of their quality monitoring and quality improvement is focused around their ER because of existing problems there. The CEO and Deputy CEO oversee the QAPI supervisor. The QAPI supervisor oversees Risk Manager, PI, Safety, Infection Control, and the Patient Advocate, who all oversee applicable department heads.
- They do participate in the IPC initiative, and they submit data but have not been monitoring progress with goals yet. In addition, they report data to GPRA, Health Home–State Medicaid program, IQR (CMS), State QIO, EMTALA Monitoring, and Meaningful Use quality measures.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Pine Ridge Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Requested recordings of webinars.	• Provide links to recordings as they become available, as well as any existing event archives.
Data Collection and Reporting	
• Requested master list of reporting requirements for to all agencies.	• Work with IHS to find or develop a master list of reporting requirements.
• Requested master database for all RPMS data.	• Discuss specific requirements with the hospital and examine feasibility of creating the database they request.
• RPMS training and PfP specific RPMS programs.	• Identify available training opportunities, and share search techniques used at other facilities during learning sessions for each measure.
• Are they exempt for EED and VAP?	• Clarify that they do not need to report VAP if vent patients are always transferred. Get more details about availability of induction to clarify whether they are exempt from EED.
• No CLABSI or SSI data on reporting spreadsheet.	• Verify whether data are present on most recent submission, and work with site to coordinate data submission if it is absent.
QI Initiatives Related to PfP	
• Would like to learn more about patient and family engagement.	• Identify best practices and work with hospital to identify opportunities to improve engagement.
General/Other	
• They would like to see programs written by someone from IHS who is an expert in RPMS.	

3: Descriptive Profile

Indian Health Service Hospital: Pine Ridge Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Francine Parmenter – Performance Improvement Coordinator
Year Hospital Established	Approximately 1955, with a new building built in 1994
IHS Area Office	Great Plains
Geographic Area Served	Pine Ridge Indian Reservation in southern SD.
User Population	• Sioux Indian population of more than 17,000
Hospital Beds	• # beds: 45 • # staffed beds: 29 acute, 10 OB
Hospital Discharges 2012	
Occupancy Rate 2012	14

Characteristic	Hospital Description
Services Available–General	• General medicine • Inpatient pediatrics • Labor & delivery • General surgery • Dental • Kyle and Wanblee Health Centers • 3 health stations (Allen, Manderson, and Porcupine)
PfP Awareness at Facility	• General: • Leadership:
PfP Services NOT Available	• Ventilators – only for transfers • Labor & delivery – no elective deliveries
Number of Physicians	• Medical: 38-40 • Surgical: 2 • Other:
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: 3 • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	6: QAPI supervisor oversees Risk Manager, PI, Safety, Infection Control, and the Patient Advocate
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 18 mo. Jan. 2012–June 2013 • ADE: 3 mo. Apr. 2013–June 2013 • CAUTI: 6 mo. Jan.–Junes 2013 • CLABSI: 0 – not reporting • SSI: 0 – not reporting • VAP: 0 – not reporting • PU: 0 – not reporting • VTE: 0 – not reporting • EED: 0 – not reporting
Reporting Method – Readmissions	
Reporting Method – Falls	Falls are entered into WebCident by person who witnessed/discovered the fall. Reports go to the safety officer, who is in charge of reporting statistics.
Reporting Method – ADE	Pharmacy uses QMan to search RPMS for blood sugars below 50 and INRs over 4.

Characteristic	Hospital Description
Reporting Method – CAUTI	Identified using QMan by Infection Control. Medical records helped identify the correct diagnosis codes.
Reporting Method – CLABSI	Identified using QMan by Infection Control. Medical records helped identify the correct diagnosis codes.
Reporting Method – SSI	Identified by manual chart review. Infection control consults and readmissions help identify patients with infected wounds.
Reporting Method – VAP	
Reporting Method – PU	
Reporting Method – VTE	
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	5 or 6 – CLABSI, SSI, VAP, PU, VTE, and EED
Discrepancies on Reporting	• R,Y,G progress sheet shows 6 mo. of reporting for VAP, CLABSI, and SSI, but their data spreadsheet is blank for these measures. • Ventilators are only used for transfers. Should they be exempt? • Mention reporting methods for CLABSI but the data reporting spreadsheet is blank. • Mention reporting methods for SSI but the data reporting spreadsheet is blank.
QI Measures Implemented due to PfP	• ADEs – Analyzes cause each time D-50 or vitamin K are pulled from their Omnicell medication dispenser.
Patient, Family, and Community Engagement	• Do use community members for safety drills, but they do not have much infrastructure for getting the community together. • Do have health fairs and a mobile clinic that goes into the community, to powwows, etc. • Pharmacy provides a follow-up phone call within 72 hours to discuss medications and follow-up appointments. • There is a new case manager who follows transfers out from the ER and Health Home patients. • Asking about engagement sparked a good conversation about potential ways they could improve, such as a community advisory group, including patients on Hep C treatment and TB treatment committees, etc.
Strength Area	• Have developed ways to use QMan to pull data for CLABSI, CAUTI, and ADEs.

Characteristic	Hospital Description
Training and TA Needs Identified	• Additional education on which measures are required and where to obtain up-to-date reporting forms. The site did not realize reporting on PU, VTE, or EED was required for PfP. • They have L&D but do not offer elective deliveries; they need clarification on whether they should be reporting on this measure. • Would like to learn more about patient and family engagement. • The hospital staff needs RPMS training in general and help with any programs to automate data collection for PfP • They would like to see programs written by someone from IHS who is an expert in RPMS. • Help with harmonizing measures where they are doing duplicative reporting—requested a list of everyone they need to report to, and when. • Requested a database they can use to put all data collected from RPMS so they can collect it once and analyze it in different ways for the different agencies they have to report to. • Requested recordings of webinars. • RPMS training and PfP specific RPMS programs. • Should they be exempt for VAP? • No CLABSI or SSI data on reporting spreadsheet.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Pine Ridge:

- EED is shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but is not an "X" on the IHS Data Reporting Progress Chart.

Quentin N. Burdick Memorial Health Care Facility

1: Assessment Summary

1.1: Overview of Quentin Burdick Memorial Health Care Facility

The Quentin N. Burdick Memorial Health Care Facility located in Belcourt, ND, serves a population of approximately 13,100 Chippewa beneficiaries. In addition to inpatient care, the hospital provides general surgery, podiatry, ENT surgery, obstetrics, pediatrics, and CAT scan. The outpatient department offers basic services and specialty clinics with contracted specialists. The dental program has a full clinic at the hospital. The facility also includes a mental health department, which consists of three clinical psychologists, a psychiatric nurse practitioner, and a psychiatrist.

The facility completes a "Patient Culture of Safety" survey annually using an AHRQ tool for data collection.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

They have not implemented much facility-wide education regarding PfP, as they have focused on the team that is responsible for data collection and reporting. The Director of Nursing, Clinical Director, and CEO are aware of PfP and are supportive.

1.2.2: PfP Measures: Reporting Status and Challenges

- Quentin Burdick is reporting information on readmissions, falls (1/12–7/13), ADE (Hypoglycemia only: 1/12–7/13), CLABSI (1/12–7/13), and PUs (7/13). They are not reporting on CAUTI, SSI, VAP, VTE, and EED.
- Readmissions are reported on monthly, as well as 1–30-day readmissions. The monthly report is reported to everyone, including medical staff.
- Falls are reported by the Safety Officer using WebCident; he receives the fall reports and investigates each case. They believe falls are being reported accurately in WebCident. ADE–Hypoglycemia is reported through their "critical lab results." Lab staff members call the nurse to notify of critical lab values, and then there is a time limit to notify the physician. They do not know why there was a high cluster of events early in their reporting. The nurse educator who conducted that reporting left in August. This high cluster may be due to the way the numbers were collected. A pharmacist has now been brought on to the team, who will collect data on (1) who has received medications under this measure and (2) who has diabetes.
- They have reported zeroes for the ADE–Anticoagulation measure all along. They will investigate this further, because the data was pulled by their CACs and a pharmacist is now involved.
- CAUTI reporting consists of only a denominator because there have been no adverse events. There have not been many patients with Foley catheters on the floor. Most are surgery patients who had C-sections. There is one patient in-house with a long-term

catheter. They are reporting catheter days in the "catheter discharges" column (C) on the reporting spreadsheet.

- The CLABSI measure has a reporting error that associated 2013 events with 2014 dates. They have submitted an updated report.
- They are planning to report on SSI; staff has recently been assigned this measure, but they have questions about the surgeries to be included. Since most surgeries are dental, C-sections, or hernias and not major abdominal surgery, they believe they do not have any reportable surgeries. They were advised to report the zero denominators when they do not do any applicable surgeries in order to document that they have a surgical suite and are looking at the measure to ensure they have no events to report.
- VAP measures are considered not applicable because they are only using ventilators for transfers.
- Information on PUs have only been reported since July 2013, but they are not currently collecting data on PUs. They will most likely use RPMS and then chart review. They received clarification that this measure is only for hospital-acquired PUs; the only ones they have encountered have been transfers from a rehabilitation or other facility.
- VTE has been reported since August 2013. Case Management looks for this measure through the CART system by diagnoses. Some have come up under secondary diagnoses, but none meet the reporting criteria for PfP.
- Case Management also reviews for EEDs. While there have been cases in the past, there have been none since they began reporting.
- EED, readmissions, and VTE are measures that overlap in their reporting to CART and UR.
- The facility believes that CAUTI, VAP, SSI and VTE are not applicable to them; they have been instructed to report zero denominators in some cases but not in others. They also are not collecting PU data and believe they have not had any acquired in their facility.
- Culturally, extended families are involved in care, so they have had to conduct little activity in patient and family engagement. They have simply implemented SBAR for nurse bedside reporting.

1.2.3: Quality Improvement Initiatives Related to PfP

- The hospital has QAPI indicators related to all of the PfP measures and have had them for an extended period of time. There are currently no specific areas of concern or QI initiatives related to PfP.
- QAPI meets monthly, and each department has two indicators they report on quarterly. Patient safety, ADEs, and falls are standing issues. Areas of concern are reported quarterly, but there are none right now.
- The State QIO has a contract with CMS to provide education for IHS facilities. They help with data abstraction, CMS compliance, standardized order sets, a train-the-trainer program, HCAHPS, and changes to the CART system.

- They have attended some PfP webinars and found them valuable. They have involved their pharmacists as a result, and they like learning how other hospitals are collecting their data.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Quentin N. Burdick Memorial Health Care Facility

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• No general staff knowledge of the PfP.	• Methods to inform staff of the program.
• Patient and family engagement is not occurring.	• Methods to engage patients, caregivers, and the community in health care.
Data Collection and Reporting	
• Requirements for reporting.	• Clarification on when measures do not have to be reported and when to report zero denominators when there are no events.
• ADE measures.	• Best practices.
QI Initiatives Related to PfP	
• No QI initiatives related to PfP.	• Best practices, perhaps for readmission reduction and fall prevention.

3: Descriptive Profile

Indian Health Service Hospital: Quentin N. Burdick Memorial Health Care Facility

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Lynelle Hunt, Director of Nursing, Quentin N. Burdick Memorial
Year Hospital Established	1977
IHS Area Office	Great Plains
Geographic Area Served	North Central ND
User Population	• 13,100
Hospital Beds	• # beds: 26 • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	8
Services Available–General	OB/GYN, pediatrics, surgery, medical, dental, day surgery
PfP Awareness at Facility	• General: They have not implemented much facility-wide for PfP. They have focused on the team that is responsible for data collection and reporting • Leadership: The Director of Nursing, Clinical Director, and CEO are aware and very supportive.
PfP Services NOT Available	Central Lines , ventilators, labor & delivery, catheters, reportable surgeries

Characteristic	Hospital Description

Number of Physicians	• Medical: 3 (hospitalists)
	• Surgical: 1 (general)
	• Other:
	  ○ 7 FP
	  ○ 3 ER
	  ○ 2 OB
	  ○ 1 Ped
	  ○ 1 Psych
	  ○ 1 NP psych
	  ○ 3 clinical psych
	  ○ 8 midlevel
	  ○ 3 dentists
	  ○ 2 optometrists

Number of Staff FTE, by Type of Personnel	• Total: 284 • Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	20–25: total staff should be 304
Quality Management/QI Manager/Staff, Number and FTE	Infection Control, Safety; QAPI meets monthly and each department has two indicators they report on quarterly. Patient safety, ADEs, and falls are standing issues. Areas of concern are reported quarterly, but there are none right now.
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes. Their EHR is a hybrid system, because they have a variety of paper forms that are not available in the EHR, such as the transfer record, surgical consents, and forms for narcotic use in labor and delivery. Some require an actual signature. They are working with the QIO on better integration.

Characteristic	Hospital Description
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: Jan. 2012–Aug. 2013 • Falls: Jan. 2012– July 2013 • ADE : Jan. 2012 –July 2013 • CAUTI: Jan. 2013–Aug. 2013 • CLABSI: Jan. 2013–Aug. 2014 (Original file transfer had incorrect dates—corrected to Jan. 2012–Jan. 2014) • SSI: • VAP: • PU: July 2013 • VTE: • EED:
Reporting Method – Readmissions	They compile a monthly report and also monitor the 1–30 day readmissions. The monthly report is shared with everyone, but especially medical staff.
Reporting Method – Falls	Safety Officer reports on falls using WebCident. He receives the fall reports and investigates each case. They believe falls are being reported accurately in WebCident.
Reporting Method – ADE	• Hypoglycemia: Reported through "critical lab results." Lab calls the nurse to notify of critical lab values and then there is a time limit to notify the physician. They do not know why there was a high cluster of events early in their reporting. The nurse educator who conducted that reporting left in August. This high cluster may be due to the way the numbers were collected. A pharmacist has now been brought on to the team, who will collect data on (1) who has received medications under this measure and (2) who has diabetes. • Anticoagulation: reporting zeroes all along. They will investigate this further, because the data was pulled by their CACs and a pharmacist is now involved.
Reporting Method – CAUTI	Reporting a denominator, but there are no events. They confirmed that they have not had any. There are not many patients with Foley catheters on the floor. Most are surgery patients (C-sections). There is one patient in-house with a long-term catheter. They are reporting catheter days in the 'catheter discharges' column (C) on the reporting spreadsheet.
Reporting Method – CLABSI	There was a reporting error that associated 2013 events with 2014 dates. There is an updated report.
Reporting Method – SSI	A new person has recently been assigned this measure, but she has questions about the surgeries included. They mostly do dental, C-sections, hernias, etc., not major abdominal surgery. Advised to report the 0 denominators when they do not do any applicable surgeries, so that we know they have a surgical suite. Looking at the measure to ensure they have no events to report.
Reporting Method – VAP	Just using ventilators for transfers. Not applicable.

Characteristic	Hospital Description
Reporting Method – PU	Started reporting in July 2013, but they are not currently collecting data on PUs. They will probably use RPMS, and then chart review. Clarified that this measure is just for hospital-acquired PUs. All have been transfers from a rehabilitation or other facility.
Reporting Method – VTE	Has been reported since August 2013. Case management looks at this through the CART system by diagnoses. Some have come up under secondary diagnoses, but none meet the reporting criteria for the PfP.
Reporting Method – EED	Also reviewed by Case Management. Have had cases in the past, but not since they began reporting.
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	Wrong year for CLABSI
QI Measures Implemented due to PfP	They have attended PfP webinars and found them valuable. They have involved their pharmacists as a result, and they like learning how other hospitals are collecting their data.
Patient, Family, and Community Engagement	They have not engaged much with the community. They could share information about the PfP at recruiting events. They would like to know if there is a pamphlet available about the PfP designed for families. They have implemented SBAR for nurse bedside reporting, and the patient and family are involved in the process. Culturally, extended families are very involved in care.
Strength Area	They do complete a "Patient Culture of Safety" survey annually using and AHRQ tool for data collection.
Training and TA Needs Identified	Overlapping Measures – CART reviews and Utilization Review – overlaps include EED, readmissions and VTE

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Belcourt/Quentin N. Burdick/Turtle Mountain:

- VTE, PU, and EED shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but are shown as reporting for ~2 months on the IHS Data Reporting Progress Chart.
- SSI is shown as "2–Engaged in work related to HAC AND submitting data to IHS HEN" but is shown as "X" on the IHS Data Reporting Progress Chart.

Rapid City Indian Hospital

1: Assessment Summary

1.1: Overview of Rapid City Indian Hospital

Rapid City Indian Hospital serves Indians in Rapid City, SD, and surrounding areas. It is located in an urban area rather than a reservation. The hospital sees many patients from other service units because many tribal members travel to Rapid City to attend events such as the Black Hills Powwow and the Lakota Nation Invitational as well as to visit family members or shop.

The hospital is licensed for nine beds but is only staffed for two. General medical, emergency department, adult and pediatric outpatient clinic, prenatal care, dental, optometry, laboratory, x-ray, pharmacy, and physical therapy services are available. They do not offer surgery or labor and delivery, and they very rarely have central lines.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

The PfP lead has been participating in the PfP conference calls since July, and she says that the calls are an interesting way to find out how and what other hospitals are doing. Unfortunately, the time of day is bad because it runs through lunch. She would like to know if the webinars are recorded, and if so, if there is a list with titles that describe the topics covered so she knows which ones would apply to them.

The hospital is struggling with the amount of time required to collect PfP data and a lack of funding or staffing. The data set is mostly zeroes, so they do not know how to make it useful. They would like some training on how to present data and provide feedback to the staff at the point of care.

1.2.2: PfP Measures: Reporting Status and Challenges

Rapid City Indian Hospital has reported 7 months' worth of data for falls, ADEs, CAUTI, PUs, and VTE. They have not done any reporting since July 2013, but they do intend to catch up. The hospital is exempt from reporting on SSI, VAP, and EED. They are not reporting on CLABSI, and they explained that they have discussed the rarity of central lines at their facility with the staff at headquarters and were told they did not need to report for the CLABSI measure. They do insert peripherally inserted central catheter (PICC) lines and are curious whether they should be reporting these. Both of these issues need clarification.

Data on falls are collected through WebCident. Data for all other measures are collected through manual chart review. Infection control does have a way to pull device-associated infections through RPMS, but the staff members collecting PfP data do not know how to do it. They are not sure how to run queries in RPMS and are not sure which measures could be accurately captured using electronic data. They need general RPMS help as well as help with ay programs that can automate data collection.

Engagement with the community is a topic for improvement that the executive committee has been concerned about. They do feel that they do a good job with engaging families in pediatrics, as well as inpatients because of their low inpatient volume. They think Transforming Care at the Bedside would be a good fit for their facility to improve engagement in the future.

1.2.3: Quality Improvement Initiatives Related to PfP

The executive leadership is responsible for holding a QAPI meeting monthly, chaired by the CEO. Each department reports its QAPI data on a quarterly basis, and the supervisors in each department are responsible for specific monitors and reporting.

Falls are one PfP measure that the hospital has monitors in place for. They perform a fall assessment at admission and have hourly rounding for high-risk patients.

Rapid City participates in IPC, and they have been part of a QILN since 2007. They also report quality measures to GPRA, Health Home (State Medicaid program), and their QIO. There is some duplication between measures like VTE and ADE. A different staff member is responsible for this data collection.

They are addressing readmissions by including discharge planning in their admission template and have discharge planning rounds in the morning. Discharge planning policies are currently being revised to move everything into the EHR so it is more multidisciplinary and everyone can access the notes.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Rapid City Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Lack of awareness of data/results.	• Training on how to deliver feedback to staff/point of care.
Data Collection and Reporting	
• Do PICC lines count in the CLABSI measure?	• Clarify for inclusion criteria for CLABSI.
• Should they be reporting zeroes for CLABSI since they rarely have central lines, or should they be exempt from reporting this measure?	• Clarify whether they are exempt from reporting.
• Since the data set is mostly zeroes due to low volume, is there a way this is going to be made useful to them?	• Introduce alternative measures for rare events.
• Need clarification on the ADE–Anticoagulation measure.	• Clarify inclusion criteria and address any specific questions related to ADEs.
• Duplication for VTE and ADE measures with other reporting.	• Look at ways these measures could aligned with other reporting requirements.
QI Initiatives Related to PfP	
• TCAB as a future initiative.	• Connect with IHS facilities that participated in TCAB pilot to provide guidance.

Issue/Challenge	T/TA Recommendations
General/Other	
• Training on how to present data, e.g., what types of reports or graphs are appropriate for different types of data. • Need general RPMS training	

3: Descriptive Profile

Indian Health Service Hospital: Rapid City Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Sara Bear – Supervisory Clinical Nurse Executive - Inpatient
Year Hospital Established	
IHS Area Office	Great Plains
Geographic Area Served	Located in the Rapid City, SD, in an urban area not on a reservation
User Population	
Hospital Beds	• # beds: 9 • # staffed beds: 2
Hospital Discharges 2012	
Occupancy Rate 2012	<2
Services Available–General	• General Medical • Emergency Department • Adult and Pediatric Outpatient Clinics • Prenatal Care • Dental • Optometry • Laboratory • X-Ray • Pharmacy • Physical Therapy
PfP Awareness at Facility	• General: • Leadership:
PfP Services NOT Available	• Surgery • Ventilators • Labor & delivery • Very rarely has central lines
Number of Physicians	• Medical: • Surgical: • Other:

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: Yes, but do not know how to use for PfP • RPMS EHR: Yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 7 mo. Jan.–July 2012 • ADE: 7 mo. Jan.–July 2012 • CAUTI: 7 mo. Jan.–July 2012 • CLABSI: 0 – not reporting • SSI: 0 – exempt • VAP: 0 – exempt • PU: 7 mo. Jan.–July 2012 • VTE: 7 mo. Jan.–July 2012 • EED: 0 exempt
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident
Reporting Method – ADE	Manual chart review
Reporting Method – CAUTI	RPMS
Reporting Method – CLABSI	N/A – not reporting
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	Manual chart review
Reporting Method – VTE	Manual chart review
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	1 – not reporting CLABSI, but reports that this is due to discussion with Regena Dale about their very rare use of central lines.
Discrepancies on Reporting	• CLABSI is marked as not reporting, but this might need to be changed to exempt.
QI Measures Implemented due to PfP	• Fall monitors, assessments, and hourly rounding for high risk. • Discharge planning in their admission template and have discharge planning rounds in the morning.

Characteristic	Hospital Description
Patient, Family, and Community Engagement	• Feel that they do a good job with engaging families in pediatrics as well as inpatients because of their low inpatient volume. • Are going to be assisting in the community elder Christmas party. • Include discharge planning in their admission template and have discharge planning rounds in the morning. • Think Transforming Care at the Bedside (TCAB) would be a good fit for their facility to improve engagement in the future.
Strength Area	
Training and TA Needs Identified	• RPMS training in general, and help with any programs to automate data collection for PfP. • Training on how to report data, e.g., what types of reports or graphs are appropriate for different types of data. • How to deliver feedback to staff/point of care • Clarification about what they are supposed to be looking for related to the ADE–Anticoagulation measure. • How to make data meaningful when it is mostly zeroes. • Do PICC lines count in the CLABSI measure? • Should they be reporting zeroes for CLABSI since they rarely have central lines, or should they be exempt from reporting this measure? • Duplication for VTE and ADE measures with other reporting. • TCAB as a future initiative.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Rapid City/Sioux San:

- Readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but is shown as reporting for ~4 years on the IHS Data Reporting Progress Chart.
- All other measures are shown as "0–Providing services to which the HAC is relevant, but is not participating."

Rosebud Indian Hospital

1: Assessment Summary

1.1: Overview of Rosebud Indian Hospital

Rosebud Indian Hospital is located on the Rosebud Indian Reservation in southern SD. It serves the Rosebud Sioux and any enrolled member of any federally recognized tribe. Some of the patients they serve are outside of the reservation. The hospital is certified for 35 beds, including pediatrics and OB. A clinic is located inside the facility as well as an ER. Internal medicine, pediatrics, OB, OB/GYN surgery, mental health, optometry, and dental services are available.

There were 1,590 admissions in 2013, with an average daily census around 10. There are approximately 220 staff members, including 52 nurses and 10 physicians. Turnover is a challenge, and the QI position is currently vacant so someone is contracted into it.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Awareness of PfP is poor at Rosebud. The individual responsible for reporting learned about PfP through an email from the CEO a few months ago, which stated that she needed to complete the PfP reports and contained a list of what was required. She received information about the PfP Web site and webinars, but unfortunately she has another meeting that conflicts with the meetings. Additionally, there are some communication issues over what is required. Certain reports are only available to specific staff, and they are not providing the reports or data so the PfP spreadsheet can be completed. The staff responsible for reporting must be more informed about what to report and when. Receiving an email about a "final notification" is intimidating when they did not receive any prior notice. They requested a 101 class, because other sites seem much more advanced.

1.2.2: PfP Measures: Reporting Status and Challenges

- Rosebud is currently up-to-date on reporting for readmissions, falls, and CAUTI through December 2013. They have the 2013 data for EED, but they have not completed the report. They also have not reported on ADEs, PU, or SSI.
- They are exempt from reporting on CLABSI and VAP.
- Information on falls and ADEs is reported through WebCident, but there is limited access to the ADE reports.
- CAUTI data are available on RPMS, but accessing the necessary information is labor-intensive.
- The OB department is not on the EHR system, so they need to conduct manual counts. There is a registration book for all labors and deliveries, including logging newborns. The log is examined and all deliveries at or before 38 weeks are reviewed to determine why the delivery was early. Sometimes the log contains all of the required information, but sometimes chart review is required.

- The inpatient supervisor should be providing data on PUs, but this measure has not been reported. They do a whole-skin assessment upon patient admission and document any skin breakdown. At-risk patients are examined and documented with skin condition.
- Information for SSIs is collected and reported for other programs, but not yet for PfP.
- The hospital has compiled brochures for teaching patients about patient and family engagement so that training starts as soon as patients are admitted. There is significant outpatient instruction regarding medication and disease processes. The EHR has assisted with patient education and handouts.
- They generally need more education around the measures.

1.2.3: Quality Improvement Initiatives Related to PfP

Rosebud does not have any QI initiatives related to PfP. The quality management position is vacant, so someone is contracted into the position. They provide reports to NHSN on CAUTI, and drug resistant organisms, and they report infectious diseases to the state. CAUTI reporting is different between the NHSN and PfP, which makes it harder. If the two reports interconnected, that would be easier. Medical records also does a CART report that has a lot of similar information in it which gets sent from the hospital to the Area Office. Overall, they wonder why they are reinventing the wheel.

They are participating in the IPC initiative. There is an outpatient committee which has weekly meetings, and they have developed teams and are rearranging the outpatient department.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Rosebud Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Low participation/cooperation with data collection.	• Educate staff with data access about importance and goals of PfP. • Assist with developing alternative methods to access data.
• Feel uninformed about what to report and when.	• Orient to PfP resources available on the Web, where to find most recent reporting forms, and when to submit reports.
Data Collection and Reporting	
• Needs more education around the measures and specifically the readmission measure, where she is unclear about how to handle detox admissions.	• Identify existing resources on individual measures and provide training on definitions for specific measures.
• Duplication of reporting to other agencies.	• Assess where reporting is duplicated and work with IHS to identify ways to align measures.
QI Initiatives Related to PfP	
• No QI in place for PfP.	• Assist with identifying areas for improvement and best practices related to those measures.
General/Other	
• Staff got a late start and need PfP 101 because they feel that other hospitals are ahead of them.	

3: Descriptive Profile

Indian Health Service Hospital: Rosebud Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Deb Sully – Infection Control/Employee Health, IHS 20 years, Rosebud 6 years, and 3 years in current role
Year Hospital Established	1950s, with new hospital in the 1990s
IHS Area Office	Great Plains
Geographic Area Served	Rosebud Indian Reservation in southern SD.
User Population	• Rosebud Sioux and any enrolled member of any federally recognized tribe. Some are outside of the reservation
Hospital Beds	• # beds: 35, including pediatrics and OB • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	Approx. 10
Services Available–General	• Labor & delivery • Inpatient pediatrics • Outpatient clinic inside the facility • ER • Mental health • Optometry • Dental • Internal medicine • Pediatrics • OB/GYN surgery – no general surgeons right now
PfP Awareness at Facility	• General: There is not good awareness. Learned she needed to do the reporting through an email. The general awareness is low. There are some communication issues around what people actually need to do. • Leadership: The CEO is aware because she forwards the emails on to Deb.
PfP Services NOT Available	• Ventilator – not used for inpatients. • Central lines.
Number of Physicians	• Medical: 10 • Surgical: • Other:

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Total Staff: 220 • Service Unit CEO: 1 • Hospital Administrator: • RNs: 52 • LPNs: • Pharmacists: 7 (+3 pharm techs) • Allied Health: • Other Health: Midlevels – 10; Dentists – 5; Mental Health 3; Optometrist - 1 • IT/Data Management/CAC: 2 • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	• ER nursing: 6 (Just hired nurses to cover 4 of these positions) • Physicians: 2 • PA: 2 • Outpatient nursing: 1 • Inpatient: 2 • Hospital Administrator: 1
Quality Management/QI Manager/Staff, Number and FTE	1 – Position is currently vacant, so someone is contracted into it.
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes, but OB still uses paper charts and logs.
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 16 mo. Jan. 2012–Apr 2013 • ADE: 0 – not reporting • CAUTI: 16 mo. Jan. 2012–Apr 2013 • CLABSI: 0 • SSI: 0 – not reporting • VAP: 0 • PU: 0 – not reporting • VTE: 0 – not reporting • EED: 0 – not reporting
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident
Reporting Method – ADE	Available from WebCident, but lacks access to reports.
Reporting Method – CAUTI	RPMS
Reporting Method – CLABSI	N/A – exempt
Reporting Method – SSI	Collected for other reporting, but not reported to PfP yet
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	
Reporting Method – VTE	

Characteristic	Hospital Description
Reporting Method – EED	L&D is not on EHR. There is a registration book for all labors and deliveries, including logging newborns. She reviews the delivery log and finds all of the ones at or before 38 weeks. Sometimes the log contains information on why the delivery was early, but she also has to review the chart. Has not been reported yet.
Number of PfP Measures Not Reported (for services offered within the hospital)	5 – ADEs, SSI, PU, VTE, EED
Discrepancies on Reporting	None
QI Measures Implemented due to PfP	None
Patient, Family, and Community Engagement	• They have put together many brochures for teaching patients so training starts as soon as patients are admitted. • There is also a significant amount of outpatient instruction related to medication and disease processes. The EHR has helped with patient education and handouts.
Strength Area	
Training and TA Needs Identified	• Needs to be more informed about what to report and when. • Needs more education around the measures and specifically the readmission measure, where she is unclear about how to handle detox admissions. • Needs "PfP 101" class so they can catch up to everyone else. • Way to interconnect reporting for NHSN and PfP. • Need more internal support at the facility. Low participation/cooperation with data collection. • No QI in place for PfP.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Rosebud:

- ADE is shown as "2–Engaged in work to HAC AND submitting data to IHS HEN" on the PEC Chart, but is shown as reporting for 0 months on the IHS Data Reporting Progress Chart.

Winnebago Indian Hospital

1: Assessment Summary

1.1: Overview of Winnebago Indian Hospital

Winnebago Indian Hospital is located in Winnebago, NE, which is approximately 20 minutes south of Sioux City, IA. They serve the Winnebago and Omaha Tribes, which have over 10,000 members, as well as the urban Indian population in Sioux City, Omaha, Lincoln, and Sioux Falls, which means they provide services to people living in three States.

The new hospital opened in 2004. It is a 13-bed facility that offers inpatient, dental, optometry, public health nursing, and emergency room services. In addition to the IHS services available, there are also a variety of valuable tribal health programs available.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

PfP is very new to the staff at Winnebago. Everyone at the hospital wears several hats, and they have been more focused on "putting out fires" than collecting data. In general, they feel that there are more urgent things to do than collect numbers. Despite limited awareness, staff members say they have attended PfP webinars and have found them useful.

1.2.2: PfP Measures: Reporting Status and Challenges

Currently, Winnebago is only reporting on readmissions with data from the NDW. The hospital could potentially report on falls, ADEs, CAUTI, CLABSI, PU, and VTE. They do not offer surgery, ventilators, or labor and delivery, so they are exempt from reporting on SSI, VAP, and EED. The hospital does use WebCident for falls and has RPMS and EHRs that they could utilize for data abstraction and reporting.

With regard to patient and community engagement, Winnebago has an updated strategic plan with both the Winnebago and Omaha Tribes, and they meet with both tribes monthly. They have an active Patient Advocate, and the outpatient nurses have access to tribal members who can meet with patients.

1.2.3: Quality Improvement Initiatives Related to PfP

Winnebago Indian Hospital has fall monitors in place. In addition, medications are monitored by the pharmacy, and the infection control nurse tracks infection measures. The Clinical Director is working on reviewing each readmission. No specific improvement process was identified pertaining to these monitors.

For their general QI, they use performance improvement monitors throughout the facility and perform root cause analysis and PDSAs. They have been participating in IPC for 2–3 years with the medical home model, and they are currently working on empanelment, which is 30–40-percent complete. Unfortunately, high turnover is impacting their progress.

Their State QIO, CIMRO, comes in monthly and investigates issues such as the ER, transfers, and patient flow. They have identified a low acuity rate in the ER, and they must work to provide these patients a more appropriate level of care. They have an evening clinic, but there are many no-shows to appointments. In addition to the work with their QIO, they are also reporting to CMS, GPRA, and the Great Plains Area Office.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Winnebago Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• New to PfP	• Introduction to aims and importance of PfP, and where to get information on an ongoing basis.
Data Collection and Reporting	
• Only reporting readmissions	• Assistance with establishing data collection methods for other measures
QI Initiatives Related to PfP	
• Has monitors in place for falls, drugs and infections	• Assist with identifying QI processes to address issues identified with these monitors

3: Descriptive Profile

Indian Health Service Hospital: Winnebago Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Brenda Provost – Alternates as DON, Inpatient Supervisor, 20 years IHS, 14 years Winnebago
Year Hospital Established	
IHS Area Office	Great Plains
Geographic Area Served	Located in Winnebago, NE, which is only 20 minutes south of Sioux City, Iowa. Serves the Winnebago and Omaha Tribes and the urban Indian population in Sioux City, Omaha, Lincoln, and Sioux Falls.
User Population	
Hospital Beds	• # beds: 13 • # staffed beds:
Hospital Discharges 2012	
Occupancy Rate 2012	1.9
Services Available–General	• Inpatient • Dental • Optometry • Public Health Nursing
PfP Awareness at Facility	• General: PfP is very new to them. Everyone at the hospital wears several hats, and they have been more focused on "putting out fires." There are more urgent things to do than collect numbers. • Leadership:
PfP Services NOT Available	• Surgery • Ventilators • Labor & delivery

Characteristic	Hospital Description
Number of Physicians	• Medical: • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	Do RCA, PDSAs, update binders quarterly
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: Only reporting readmissions through NDW. • Falls: 0 • ADE: 0 • CAUTI: 0 • CLABSI: 0 • SSI: 0 • VAP: 0 • PU: 0 • VTE: 0 • EED: 0
Reporting Method – Readmissions	
Reporting Method – Falls	N/A
Reporting Method – ADE	N/A
Reporting Method – CAUTI	N/A
Reporting Method – CLABSI	N/A
Reporting Method – SSI	N/A
Reporting Method – VAP	N/A
Reporting Method – PU	N/A
Reporting Method – VTE	N/A
Reporting Method – EED	N/A
Number of PfP Measures Not Reported (for services offered within the hospital)	6 – Falls, ADEs, CAUTI, CLABSI, PU, VTE
Discrepancies on Reporting	
QI Measures Implemented due to PfP	• Clinical director is working on reviewing each readmission. • Monitors are in place for falls.

Characteristic	Hospital Description
Patient, Family, and Community Engagement	• They have updated their strategic plan with both reservations. • Meet with both tribes monthly. • Patient advocates. • Outpatient nurses have access to tribal members who can meet with patients. Tribal programs are "great."
Strength Area	
Training and TA Needs Identified	• New to PfP. • Only reporting readmissions. • Has monitors in place for falls, drugs, and infections, needs QI.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Winnebago:

- Readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but are shown as reporting for ~4 years on the IHS Data Reporting Progress Chart.

Albuquerque Area Office

- *Acoma-Canoncito-Laguna Hospital, Acoma-Canoncito-Laguna, NM*
- *Mescalero Indian Hospital – Mescalero, NM*
- *Santa Fe Indian Hospital – Santa Fe, NM*
- *Zuni Indian Hospital – Zuni, NM*

Acoma-Canoncito-Laguna (ACL) Hospital

1: Assessment Summary

1.1: Overview of Acoma-Canoncito-Laguna (ACL) Service Unit

The Acoma-Canoncito-Laguna Service Unit provides health care services to the three tribal groups in the immediate area: the Acoma Pueblo (population 3,500), the Laguna Pueblo (5,500), and the Canoncito Navajos (1,100). The total land owned by all three tribes equals approximately 740,00 acres.

The Acoma-Canoncito-Laguna Service Unit consists of the ACL Hospital in Acomita and health centers at Laguna and Canoncito. The hospital provides general medical, pediatric, and obstetric inpatient care with nine beds. ACL also houses a dialysis unit and the New Sunrise Regional Treatment Center, a residential program for adolescents.

The hospital offers a full range of outpatient and dental services as well as several specialty clinics, utilizing a combination of direct and contract services. Full diagnostic and treatment facilities support outpatient care. Well-baby, diabetic, prenatal, and general medical clinics are scheduled weekly.

The partnership between the Acoma-Canoncito-Laguna Service Unit and the tribes it services is the key to their success in identifying the health problems of the community and then working to resolve them.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

ACL Hospital staff members are aware of the 2010 start of the PfP, that their agreement was signed in 2013, and that they have made formal application for IPC-5. Their CEO has only been in place since January but is familiar with the PFP from prior employment with Gallup. Their team is excited about implementing various areas of improvement because the initiative supports their efforts to make hospital care safer and more reliable and the ACL mission, vision, and values to improve the health and wellness of the people with community participation.

Carolyn McKeown, Nurse Educator, is responsible for quality assurance, Joint Commission accreditation, compliance, PfP, complaints, and infection control. She is new to the position but has been with the Corps for 24 years, 12 of which has been spent at ACL.

The Five Focus Areas of their process improvement include:

1. *Improving access to care* – Increasing wound care, brought in podiatry, hired a pediatrician, and increased services in Canoncito, pediatric dental, and optometry.
2. *Building towards excellence* – Improving capacity that started with renovating the waiting area in support of their master plan to improve clinic flow.

3. *Maximize human resources* – Filling acting positions and looking at the business plan to ensure they are hiring the positions needed; looking at the capacity of each individual to ensure they are working within their scope of care. They meet weekly with Area Office HR in Albuquerque to address their rural recruitment and retention issues.
4. *Investing in communication partnership* – Improving their IT structure; they have one position on site, get backup from the Area office, and are hoping to recruit another IT position in the next year.
5. *Financial excellence* – Supporting business office functions and fiscal management.

1.2.2: PfP Measures: Reporting Status and Challenges

- ACL has been reporting information on six measures to the PfP since January of 2013: ADE, CAUTI, falls, PUs, VTE, and readmissions.
- ACL has proposed a standardized protocol for VTE that is being medically reviewed. They also instituted a risk assessment tool, established standardized orders and documentation, and performed chart audits. Their numerators are zero because the measure is defined as patients affected in the facility, so patient transfers are not counted.
- CAUTI numbers are small, as they have limited catheter use. They conduct chart review manually to determine how many days a patient has a catheter. They believe it would be helpful to have an RPMS button that would extract the information needed for a report.
- Falls information is collected using WebCident, so it is fairly easy to obtain and there is an icon in RPMS for reporting falls. All falls are discussed at safety meetings, and the information then goes to a supervisor for investigation. They use an evidence-based assessment tool and employ a protocol for patients with fall risk. Because 80–90 percent of falls are unwitnessed, they work on analyzing a fall with a series of questions that determines whether the patient was identified as at risk, gets the patient's perceptions about the nature and cause of the fall, and develops a follow-up plan in order to avoid fall risk in the future.
- PU measure reporting focuses on stage three and four PUs; ACL claims they do have PUs but not at that level. They perform a Braden skin assessment daily on every patient, document observations in the record, have a protocol to prevent ulcers from progressing, and employ a certified wound care nurse.
- The readmissions report can be printed from the NDW. ACL notes that if a patient is transferred, they are not calculated into the rate and they are not clear what happens in these circumstances. There were three to four readmissions in the month prior to the site visit in November 2013, with the most common reasons being abdominal pain and infection. They believe the IHS readmission data is higher than the 12 percent they assume when looking at the CHS data. They would like to obtain access to their patient data from other IHS facilities for both readmission purposes and for tracking and treating drug-seeking behaviors.

1.2.3: Quality Improvement Initiatives Related to PfP

They no longer use observation days and worry about social admissions in which patients stay in the facility for hospice and respite, because the home is unsuitable or the patient has no caregiver.

The PfP reporting requirements have led to tightening discharge protocols; the RN case manager visits patients in the hospital prior to discharge to talk to discuss their needs in the community, ensure they are assigned a primary care provider, and arrange for their equipment needs. Public health nurses and CHRs visit the homes of high-acuity patients who need assistance, review their discharge notes, and arrange transportation to medical appointments. Home-delivered meals and firewood are provided by tribal social services.

ACL quality assurance staff worry about the duplication of reporting and the amount of work involved to complete the process. They are working on finding efficiencies due to the limited number of staff available. They feel it would be optimal to have established methods for collecting and reporting the data as well as better definitions.

The ACL Environmental Care Committee meets monthly on safety, emergency management, and other quality issues. The committee reviews the two or three incident reports likely to be filed in a month. They are concerned about drug errors, which could number as high as 10 in a month; wrong doses given is the major issue, omission of a dose or late dose are more rare.

Other quality measures include moving to bar coding, adopting wristbands that can be scanned for patient information, and establishment of a Coumadin clinic.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Acoma-Canoncito-Laguna Hospital

Issue/Challenge	T/TA Recommendations
Data Collection and Reporting	
• Inefficiencies in data collection and reporting.	• Standard practices requested.
• Definition differences for measures.	• Alignment of definitions.
• Excessive time involved in collection of data for PfP measures reporting.	• Icons/template in RPMS for measures that require manual record reviews.
QI Initiatives Related to PfP	
• Access to patient information.	• RPMS information from other IHS facilities.
• Drug errors.	• Methods to prevent incorrect dosing.
General/Other	
• Best Practices: ACL has invested effort into improving discharge processes and in-home support to prevent readmissions, established standardized protocols for VTE and falls. • ACL is moving to bar coding and "smart" patient wristbands. • ACL wants to improve medical necessity documentation for inpatient admission and is concerned about billing for social admissions and potential penalties from RAC auditors.	

3: Descriptive Profile

Indian Health Service Hospital: Acoma-Canoncito-Laguna Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Carolyn McKeown – Nurse Educator, QA, Joint commission, compliance, PfP, complaints, infection control 12 years at ACL, new to position (24 years Corps)
Year Hospital Established	1978
IHS Area Office	Albuquerque
Geographic Area Served	West Central New Mexico
User Population	• Serves the three Tribal groups in the immediate area: the Acoma Pueblo (population 3,500), the Laguna Pueblo (5,500), and the Canoncito Navajos (1,100).
Hospital Beds	• # beds: 9 • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	4
Services Available–General	general medical, pediatric, dialysis on site, adolescent residential treatment program
PfP Awareness at Facility	• General: • Leadership: CEO there since January but familiar with PfP from previous employment with Gallup. Excited about implementing various areas.
PfP Services NOT Available	Surgery, labor and delivery, central lines, ventilators
Number of Physicians	• Medical: • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: 208 (75% clinical) • Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: 1 • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	• Have rural recruitment and retention issues.
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	• 1: Have life safety measures, hazardous communication, security assessment, ventilation report, utilities, infection control reports, refrigerator checks, radiology exposure readings.
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes

Characteristic	Hospital Description
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan.–Sept. 2013 • ADE: Jan.–Sept. 2013 • CAUTI: Jan.–Sept. 2013 • CLABSI: • SSI: • VAP: • PU: Jan.–Sept. 2013 • VTE: Jan.–Sept. 2013 • EED:
Reporting Method – Readmissions	• Have access to NDW, can print readmission report. If patient is transferred from here they are not calculated into the rate; not clear what happens when patients are transferred. UR worksheet counts any patient admitted, discharged, and readmitted. Thinks there were 3-4 readmissions in past month; most common reasons were abdominal pain, infection. IHS readmission data is higher than the 12% they assume; they look at CHS data.
Reporting Method – Falls	• WebCident is where all falls are entered, so it is easy to get. Have had WebCident for many years; there is an icon in RPMS for reporting falls. All falls are discussed at safety meeting and goes to supervisor for investigation. We have an evidence-based assessment tool, protocol for patients with fall risk.
Reporting Method – ADE	
Reporting Method – CAUTI	• Numbers are small as we have limited catheter use here. Two categories—one on all days; does chart review manually to see how many days patient has catheter.
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	• Focus on stage three and four; do have ulcers but not at that level. Have a nurse obtaining certification for wound care. Facility does Braden skin assessment daily on every patient; this is documented. Has protocol to prevent ulcers from progressing.
Reporting Method – VTE	• Working on VTE; have proposed standardized protocol being medically reviewed. Institute a risk assessment and establish standardized orders and documentation. Perform chart audits. Medical patients are at high risk—10 to 26% at risk for VTE. Numerators are zero because it is defined as patient affected in the facility; CMS different in that they want everyone assessed. Patient transfers are not counted.
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	• Said they were working on VTE but they have been reporting.

Characteristic	Hospital Description
QI Measures Implemented due to PfP	• Falls: We want to do an inpatient assessment and fix those things that can be modified. 80–90% of falls are unwitnessed. Want to work on analyzing the fall; determine whether the patient identified was at risk, problem-solve about avoiding the fall in the future, create a follow-up plan, and solicit the patient perspective on the fall.
Patient, Family, and Community Engagement	• All of the partnerships we do with communities, e.g., tribal consultation, the diabetes program coordinated with Acoma and Laguna, the coordination with the State, the Vaccine for Children.
Strength Area	• Building towards excellence: Capacity—renovated waiting area; have master plan to improve clinic flow. Facility opened 1978. • Readmissions: PHNs and CHRs go into the home of the most ill people post-discharge and those who were high acuity while in hospital and who need assistance; provide transportation to medical appointments and assist with provision of durable medical equipment. RN case manager visits them in the hospital and talks to them about their needs; try to assign to PCP while there and arrange equipment. Home-delivered meals are provided by tribal social services; they can also arrange firewood. • PfP has led to tightening discharge protocols, making phone calls; this comes together with IPC, Joint Commission and others. • Regarding medication: Moving to bar coding; have wristbands that can be scanned for patient information. Have Coumadin clinic. • Best practices are helpful; have an evidence-based practice nurse. • Improving access to care: increasing wound care, brought in podiatry, hired pediatrician, provide services in Canoncito, pediatric dental, optometry. • Maximize human resources: filling acting positions and look at business plan to see if hiring for the positions needed. Look at capacity of each individual to ensure they are working within scope of care. Also patient care improvement issues. Meet weekly with Area Office HR in Albuquerque. • Investing in communication partnership: IT structure. They have one position on site and get backup from Area office. Hoping to recruit for another IT position in the next year. Involved with NM quality organization, collaborate with hospitals and State-based QIO Health Insights)—they monitor our hospital quality reporting for CMS, educate on measures, did a thorough patient safety assessment. GPRA measures. • Strong leadership from CEO.

Characteristic	Hospital Description
Training and TA Needs Identified	• Trying to improve documentation. RAC pulled charts 2009–2011—they took $150,000 back last year— lack of adequate documentation for medical necessity for the admission. We also have to worry about social admissions; think they should not bill for that; admit for hospice, respite, home is unsuitable, have no care provider. • Curious when CMS will stop paying for hospital acquired infections; need an update on that, an in-service so we understand what is happening and when. • Worry about duplication of reporting and the amount of work to complete the process; working on efficiency. Have limited staff to handle issues. Would be helpful to have established ways to report the data; PHX area should have better definitions—right now they say just put in the data and we will figure it out later. • Information needed for PfP reporting is in notes in RPMS and not in a field that is report-capable. Would be helpful to have a monthly reportable form that could be pulled. Possible to change RPMS to include reportable fields related to PfP so that charts do not have to read to extract the necessary information. • Would like access to patient records from another IHS facility—we get patients from other locations and have been told for years we will be able to get records but has not happened. Concern also about patients who are seeking medication for abuse purposes; that is a patient safety issue and would like to be able to get that information for behavioral health. RPMS is mounted on each facility's server. Think access to other facility's RPMS patient data is possible but do not know approval is granted.

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies reported between the PfP Data Reporting Progress for the 2013 Chart and the HEN Monthly Reporting Chart.

Mescalero Indian Hospital

1: Assessment Summary

1.1: Overview of Mescalero Indian Hospital

Mescalero Indian Hospital is located on the Mescalero Apache Reservation in New Mexico. It serves about 7,000 members of the Mescalero Apache Tribe, as well as people from El Paso, Cherokee, and Comanche from Texas. The hospital has 13 beds and had about (b) (3) (A) discharges in 2012. Services include prenatal care, walk-in, family practice, and visiting endocrinologist clinics. They do not have an ER, operating rooms, or labor and delivery. The hospital has seen a dramatic decrease in admissions recently, and they are considering whether they need inpatient services.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Both the CEO and Director of Nursing are aware of PfP and support the initiative. The new Clinical Director is starting to get up to speed, and one other clinician is going to be learning more and getting involved. They try to attend the PfP calls and learned about Project RED from a call on readmissions.

1.2.2: PfP Measures: Reporting Status and Challenges

- Mescalero is currently reporting on falls, ADEs, CAUTI, PUs, and VTE. They are exempt from reporting on CLABSI, SSI, VAP, and EED.
- They are reviewing all admissions and discharges and comparing the readmissions they find to the NDW reports. There are only one to two readmissions to other facilities, and no discrepancies have been found in the NDW data.
- Falls are reported through WebCident, and the Director of Nursing is responsible for closing out reports.
- ADEs were originally collected through the lab, which ran a report in RPMS. For 2013, they have been able to check each admit for the medications due to the low census. The person doing ADE data collection recently received a pharmacy key for RPMS, so she will be able to run reports.
- Information on CAUTI, PU, and VTE is collected through manual chart review. They search by ICD-9 codes, then check notes and admission and discharge diagnoses.
- They are working on patient and family engagement by trying to engage families of discharging patients if they are willing. They also conduct a medical committee meeting that includes a tribal council member and community health clinic members.
- They would like to learn more about ADEs and how to search through pharmacy records in RPMS.

1.2.3: Quality Improvement Initiatives Related to PfP

Mescalero has been working on their readmissions using Project RED, and they are at the beginning stages of implementation. They are working with CHF patients through home visits, and a nurse is conducting follow-up calls within three days of discharge. There is also an HHA in neighboring community.

They do not work with their State QIO. They have participated in 1 year of IPC.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Mescalero Indian Hospital

Issue/Challenge	T/TA Recommendations
Data Collection and Reporting	
• Wants more information on ADEs and how to search pharmacy records in RPMS.	• Will provide introduction to data collection procedures for ADE during webinar and will identify other RPMS training opportunities. Consider connecting with PIMC for assistance.

3: Descriptive Profile

Indian Health Service Hospital: Mescalero Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Lt. Theresa Treas-Cornelius – moving to a Public Health Nurse position, at Mescalero 11 years
Year Hospital Established	
IHS Area Office	Albuquerque
Geographic Area Served	
User Population	• 7,000 members of the Mescalero Apache. Also serves people from El Paso, Cherokee, and Comanche from TX.
Hospital Beds	• # beds: 13 • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	3
Services Available–General	• Prenatal • Walk-in • Family practice • Visiting endocrinologist clinics
PfP Awareness at Facility	• General: • Leadership: CEO and Director of Nursing are aware of PfP and supportive. New Clinical Director is starting to get up to speed.
PfP Services NOT Available	• Surgery • Ventilators • Labor & delivery • Central lines
Number of Physicians	• Medical: 2 • Surgical: • Other:

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: 14 • LPNs: • Pharmacists: 2 • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	6 physician vacancies
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS - Yes • RPMS EHR - Yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 20 mo. Jan. 2012–Aug 2013 • ADE: 20 mo. Jan. 2012–Aug 2013 • CAUTI: 20 mo. Jan. 2012–Aug 2013 • CLABSI: 0 – exempt • SSI: 0 – exempt • VAP: 0 – exempt • PU: 20 mo. Jan. 2012–Aug 2013 • VTE: 20 mo. Jan. 2012–Aug 2013 • EED: 0 – exempt
Reporting Method – Readmissions	Looking at all admissions and discharges; comparing to NDW reports.
Reporting Method – Falls	WebCident; Director of Nursing is responsible for closing out.
Reporting Method – ADE	Originally collected through the lab, who ran a report in RPMS. For 2013, she has been able to check each admit for the meds due to the low census. Recently received pharmacy key for RPMS so she can run reports.
Reporting Method – CAUTI	Manual chart review
Reporting Method – CLABSI	N/A – exempt
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	Manual chart review for ICD code, notes, and admission and discharge diagnosis.
Reporting Method – VTE	Manual chart review – look at ICD code, notes, and admission and discharge diagnosis.
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	0
Discrepancies on Reporting	None

Characteristic	Hospital Description
QI Measures Implemented due to PfP	Readmissions: Using Project RED – beginning stages of implementation. Working with CHF to do home visits. Nursing conducts follow-up calls within 3 days of discharge
Patient, Family, and Community Engagement	• Try to engage families of discharging patients if they are willing • Have a medical committee meeting that includes a tribal council member and community health clinic members
Strength Area	Implementing Project RED to address readmissions.
Training and TA Needs Identified	How to go through pharmacy records in RPMS to collect ADE data.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Mescalero:

- PU is shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but is shown as reporting for ~2 years on the IHS Data Reporting Progress Chart.

Santa Fe Indian Hospital

1: Assessment Summary

1.1: Overview of Santa Fe Indian Hospital

Santa Fe Indian Hospital is located in Santa Fe, NM. The hospital serves nine pueblo tribes, as well as the Urban Indian population around Santa Fe. They currently have four inpatient beds and two observation beds, although they did have more in the past and were downsized. They do not do surgery or deliveries, and they had fewer than (b) (3) (A) discharges in 2012. Services include an urgent care and three satellite clinics.

The hospital has a well-developed inpatient fall prevention program that has reduced falls with injures. They are currently receiving significant help related to PfP.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

The CEO and staff at Santa Fe are aware of PfP; they discuss PfP issues with their governing body and during morning rounds. It is mandatory so they feel like they have an option, and they take it seriously. PfP work involves more than only monitoring admissions.

They do attend the PfP webinars, and they were able to adopt a readmission form from one of them. They also attend many CMS webinars, including one on leadership that was excellent.

1.2.2: PfP Measures: Reporting Status and Challenges

- Santa Fe Indian Hospital is currently reporting on falls, ADEs, PU, and VAP. They are exempt from reporting on CAUTI, CLABSI, SSI, and EED.
- Falls are reported through WebCident; however, due to small inpatient numbers they usually are already aware if there is a fall. The Safety Officer receives the reports, and they conduct an assessment based on the information.
- The ADE measures are collected by a pharmacist through the RPMS.
- PUs are tracked through daily reports. They do not usually have patients in the facility long enough to develop one.
- VTE data are pulled from RPMS, and any related therapy is tracked that way as well. This data are not on their October 2013 reporting spreadsheet.
- They do not use ventilators for inpatients, so they should be exempt from this measure. However, there is data in the October 2013 data spreadsheet for VAP, and it is unclear what the denominators represent. Perhaps this is the missing VTE data, reported on the wrong tab.
- In the area of patient and family engagement, they educate patients and involve the families, especially if the patient is a child or the adult has a caretaker. They make sure to present discharge information. The discharge planner collaborates well with the patients and the families.

- According to staff, there is talk that IHS might close the inpatient ward because of the low volume. At that point, the PfP measures would not apply. In the meantime, the numbers are so small that one incident would make their rates look very bad.

1.2.3: Quality Improvement Initiatives Related to PfP

Santa Fe Indian Hospital has QI processes in place for readmissions. They started by collecting data and bringing the information to the governing body and clinical director. They have had five readmissions in the past year, and they are doing 100 percent chart reviews using a form from the PRO in Pennsylvania. Issues have been identified with documentation, patient education, activation, medication management, care planning, discharge instructions, end-of-life issues, and recurring triggers. They use this information on readmissions in their Ongoing Professional Practice Evaluation (OPPE).

The hospital has a good policy on inpatient assessment for falls, but they are still seeing outpatient falls and want to standardize the outpatient fall assessments with a tool. They started recording fall data in 2010, and falls with injury were at 24 percent. In 2013, there were 0 percent falls with injury. The Safety Officer works closely with nursing, and the hospital is investigating buying equipment that will help patients ambulate.

In addition to their work on PfP measures, they are working on the IPC initiative and are in the process of empaneling patients at one of their clinics. They have seen better care with empanelment, and they are cleaning up data on the medical home assignments.

They also work with their State QIO to collect information on VTE, pneumonia, and heart failure. In addition, they report HCAHPS measures and infection control measures.

They state that they are receiving significant help right now, but they might be interested in other protocols on fall prevention.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Santa Fe Indian Hospital

Issue/Challenge	T/TA Recommendations
Data Collection and Reporting	
• VTE numbers are not on spreadsheet, but VAP numbers are, despite not using ventilators in house.	• Check most recent data sheets to see if this issue is resolved. If not, work with staff to determine what is being reported for VAP and to establish procedures for getting VTE data reported properly.
• Challenges of working with data for small numbers of patients and events.	• Introduce alternate measures.
QI Initiatives Related to PfP	
• Interested in fall-prevention protocols.	• Assist with identifying outpatient fall protocols or connecting with a hospital that has an established program in place.
General/Other	
• Ambulatory measures would be more relevant. Staff reported concern that inpatient ward may be closed due to low volume.	

3: Descriptive Profile

Indian Health Service Hospital: Santa Fe Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Betty Peppion – Quality Manager, with IHS for 30 years, Santa Fe since 2009.
Year Hospital Established	1955
IHS Area Office	Albuquerque
Geographic Area Served	Santa Fe, NM
User Population	• Serve 9 pueblo tribes; population is "pretty large." • The Santa Fe urban Indian populations also use the facility.
Hospital Beds	• # beds: 4 inpatient, 2 observation (had more, but were downsized) • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	2
Services Available–General	• Inpatient • Urgent care • Outpatient which includes 3 satellite clinics
PfP Awareness at Facility	• General: Talk about it on morning rounds. Think that nursing and Betty are aware – think it is mandatory so they do not have an option, and they take it seriously. PfP work involves more than only monitoring admissions. • Leadership: Think they are aware of PfP, but they do not have much of a workload as they are largely ambulatory care. Discuss it at governing body.
PfP Services NOT Available	• Surgery • Labor & delivery • Ventilators – only used for transfers
Number of Physicians	• Medical: • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: 12–13 • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other: 2 NP, 1 PA
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	

Characteristic	Hospital Description
Quality Management/QI Manager/Staff, Number and FTE	1 – Quality Manager is only person in department, but department heads participate in QI process using PDSAs.
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 21 mo. Jan. 2012–Sept. 2013 • ADE: 21 mo. Jan. 2012–Sept. 2013 • CAUTI: 0 – exempt • CLABSI : 0 – exempt • SSI: 0 – exempt • VAP: 21 mo. Jan. 2012–Sept. 2013 • PU: 21 mo. Jan. 2012–Sept. 2013 • VTE: 0 • EED: 0 – exempt
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident; Safety Officer reports and we conduct an assessment based on the information.
Reporting Method – ADE	Pharmacist on team collects all of the data through the RPMS system and reports to TNT committee; pharmacist is currently away on leave.
Reporting Method – CAUTI	N/A – exempt
Reporting Method – CLABSI	N/A – exempt
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	
Reporting Method – PU	Keep track of them through daily reports. State they do not have patients there long enough to develop one.
Reporting Method – VTE	Pull data from RPMS and keep track of therapy on that. Ask around to see what they might be taking as a precaution.
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	• Have been reporting on VAP, but say they do not use ventilators for inpatients. Unclear what the denominator they are listing represents. • Hospital and R,Y,G spreadsheet indicate reporting for VTE, but data reporting spreadsheet is blank for this measure.

Characteristic	Hospital Description
QI Measures Implemented due to PfP	• Readmissions: Had 5 this past year and they are doing 100% chart reviews. Use a form from the PRO in Pennsylvania to identify issues with documentation, patient education, activation, medication management, care planning, discharge instructions, end-of-life issues, recurring triggers. Use it in OPPE, and review showed one patient who fell out for discharge planning and documentation. There were two planned readmissions, and no fall out on the other two. • Falls: They have an effective policy on inpatient assessment for falls, and they are investigating how they assess that and make it known to all areas involved with patient flow. We want to standardize the outpatient fall assessments with a tool. Started recording fall data in 2010 – falls were 24% and in 2013 there were 0% falls with injury, so they decreased harm in that area. The safety officer works closely with nursing and they are investigating buying equipment that will help patients ambulate. One problem area was communication—when they started looking at falls they asked patients to call the nurse to get up, but it did not happen so now they are watching them closely; there was only one inpatient fall in 2013.
Patient, Family, and Community Engagement	• Educate patients and involve the families, especially if the patient is a child or the adult has a caretaker. • They make sure to present discharge information and the discharge planner conducts a significant amount of education. The discharge planner collaborates well with the patients and the families.
Strength Area	• Experience using a tool to examine readmissions. • Well-developed inpatient fall prevention with reduction in falls.
Training and TA Needs Identified	• Would like other protocols on fall prevention • There is talk that IHS might close the inpatient clinic, so the PfP deliverables will not apply. • Ambulatory care measures would be much more relevant. • VTE numbers are not on spreadsheet, but VAP numbers are, despite not using ventilators in-house. • Challenges of working with data for small numbers of patients and events.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Santa Fe:

- VAP are CAUTI are shown as "Z–Hospital does not provide services related to this HAC" and VTE and PU are shown as "0–Providing services to which the HAC is relevant, but is not participating" on the PEC Chart, but are shown as reporting for ~2 years on the IHS Data Reporting Progress Chart for every measure except CAUTI, CLABSI, SSI, and EED.

Zuni Indian Hospital

Section 1: Assessment Summary

1.1: Overview of Zuni Indian Hospital

Zuni Indian Hospital is located 150 miles Southwest of Albuquerque. The Zuni-Ramah Service Unit serves the people of Zuni Pueblo and the Ramah Navajo community. The Zuni community has a census population of 11,000 and a hospital-user population of 14,000, with 42,000 charts. The hospital is licensed for 37 beds and staffs 15. In total, there are 202 employees, with 16 medical doctors and 50 nurses. There are over 102,000 outpatient visits per year, and there were (b) (3) (A) inpatient discharges in 2013.

Acute care, emergency room, adult and pediatric care, low-risk obstetrics, physical therapy, mental health, radiology, and laboratory services are available. The hospital has achieved a *Baby-Friendly Hospital* designation, and is participating in the fifth round of the IPC-5 initiative.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Awareness of PfP was reported as poor, and this was largely attributed to the number of different initiatives Zuni Indian Hospital participates in. In addition to PfP, they also participate in reporting for CMS, GPRA, IPC, and EHR measures. The addition of PfP has been overwhelming with their current level of staffing.

They did assign a different group of staff to work on the PfP measures; however, the same information is also being reported to CMS, causing repetition. The interview participants requested the establishment of a central data hub or clearinghouse to reduce the duplication of efforts. Alignment of measures between reporting agencies would also help reduce workloads.

Overall, they described their facility as “underfunded” and stated that they are asked to “do more with less [resources].”

1.2.2: PfP Measures: Reporting Status and Challenges

- Zuni Indian Hospital is currently reporting data on five PfP measures: readmissions, falls, PUs, VTE, and EED. They are not reporting on ADEs, CAUTI, or CLABSI. They are currently exempt from reporting on SSI and VAP.
- Readmission data are drawn from the NDW. Although alternate measures have been discussed, no reporting on the alternate measure for readmissions is being conducted at this time.
- Falls are reported through WebCident, which they have been using since 2013. If patients are admitted with a PU, a new Chief Pharmacist is now working at the facility, so they may be able to start reporting for this measure.
- The site is exempt from reporting on VAP because they only use ventilators for stabilization and transport. However, they do have a surgical suite and perform some

surgeries. It is unclear if they never perform procedures, which would meet the inclusion criteria for SSI measure, or if those procedures are simply rare. Clarification on this issue will be important to improving reporting data quality going forward.

- They state that they only handle low-risk OB and have not had any EEDs. Clarification on whether induction is ever available at the hospital is needed, because they may actually be exempt from reporting the EED measure.
- For patient and community engagement, the facility provides quarterly Pueblo of Zuni updates. They respond to telephone inquiries. Various disciplines partner with the tribes for community education, and the hospital makes an effort to contact them. In addition, health education was conducted with 638 tribal members.

1.2.3: Quality Improvement Initiatives Related to PfP

The hospital reports that they do not have any QI initiatives in place related to the PfP measures, although readmissions have been reviewed sporadically. They have not worked with their State QIO. They did have one or two admissions that were deemed medically unnecessary in 2012 during RAC audits. They identified transportation problems related to patients who needed to come in for IV antibiotics and began using observation stays for those patients as a result.

They do report having other areas that need QI outside of PfP and state that there are many opportunities to improve care and safety outside of the initiative.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Zuni Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Not enough staff time/resources available.	• Central data clearinghouse requested.
• Duplication of effort.	• Alignment with other reporting requirements.
Data Collection and Reporting	
• Only performs low-risk OB services.	• Clarification on availability of induction, whether they should be exempt from this measure.
• Has OR but is exempt from SSI reporting.	• Clarification of whether qualifying surgeries are ever performed and, if so, how they can collect data on them.

3: Descriptive Profile

Indian Health Service Hospital: Zuni Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Rebecca (Becky) Grizzle – PI, with IHS since 1988 and with the Zuni Indian Hospital since 1994.
Year Hospital Established	1975
IHS Area Office	Albuquerque

Characteristic	Hospital Description
Geographic Area Served	Western edge of central New Mexico. 150 miles southwest of Albuquerque. The Zuni-Ramah Service Unit serves the people of Zuni Pueblo and the Ramah Navajo community.
User Population	• 14,000
Hospital Beds	• # beds: 37 • # staffed beds: 15
Hospital Discharges 2012	[redacted]
Occupancy Rate 2012	3.8
Services Available–General	• Acute Care • Emergency Room • Adult care • Pediatrics • Low-Risk Obstetrics • Community Service • Community Health Nurse • Diabetes • Nutrition • Dental • Physical Therapy • Podiatry • Laboratory • Mental Health • Women's Health • Pharmacy • X-ray • Disability • Mammography • Ultrasound
PfP Awareness at Facility	• General: Poor because of multiple, different initiatives • Leadership:
PfP Services NOT Available	• Surgery – do perform some surgeries • Ventilators
Number of Physicians	• Medical: 16 • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: 202 • Service Unit CEO: • Hospital Administrator: • RNs: 50 • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	

Characteristic	Hospital Description
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	Pharmacy: 3
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: • RPMS EHR:-
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 8 mo. Jan.–Aug. 2013 • ADE: N/A not reporting • CAUTI: N/A not reporting • CLABSI: N/A not reporting • SSI: N/A exempt • VAP: N/A exempt • PU: 8 mo. Dec. 2012–July 2013 • VTE: 8 mo. Dec. 2012–July 2013 • EED: 9 mo. Dec. 2012–Aug. 2013
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident
Reporting Method – ADE	
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	If patients are admitted with PU, they are watched and none are developed in-house.
Reporting Method – VTE	
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	3 – ADEs, CAUTI, CLABSI,
Discrepancies on Reporting	• States they only do low-risk OB. Does this mean no inductions/sections? Should they be exempt? • Do have an OR but are exempt from SSI.
QI Measures Implemented due to PfP	• None
Patient, Family, and Community Engagement	• There are quarterly Pueblo of Zuni updates on attributes of the facility. • The facility responds to telephone inquiries. • Health Education was conducted with 638 tribal members. Rebuild and doing DM Education and women's health and dental. • Reminder calls for outpatients created a decrease in the no show rate. • Various disciplines partner with the tribes for community education and the hospital makes an effort to contact them.
Strength Area	• Baby-Friendly Hospital designation

Characteristic	Hospital Description
Training and TA Needs Identified	• A central data hub or clearinghouse should be established because there is too much repetition between PfP and CMS measures. • Not enough staff time/resources available. • Only performs low-risk OB – should they be exempt? • Has OR but is exempt from SSI reporting.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Zuni:

- EED is shown as "Z–Hospital does not provide services related to this HAC" on the PEC Chart, but are shown as reporting for 9 months on the IHS Data Reporting Progress Chart.
- PU and VTE are shown as "0–Providing services to which the HAC is relevant, but is not participating" while both have been reported for ~1 year on the IHS Data Reporting Progress Chart.

Bemidji Area Office

- *Cass Lake Hospital – Cass Lake, NM*
- *Red Lake Hospital – Red Lake, NM*

Cass Lake Hospital

1: Assessment Summary

1.1: Overview of Cass Lake Hospital

Cass Lake Hospital serves the 9,372 members of the Leech Lake Band of Ojibwe (*Gaa-zagaskwaajimekaag Ojibweg* in the Ojibwe language) located in Minnesota. The Band's land base is the Leech Lake Indian Reservation, comprising 11 communities defined in the tribal constitution, aggregated into three districts.

Cass Lake Hospital is a small, 11-bed, critical access hospital in Cass Lake, MN, with a total staff of 150 full-time positions offering family practice, internal medicine, podiatry, optometry, dentistry, and pediatrics and specialty clinics including OB/GYN and Surgery.

Cass Lake was a part of IPC, has applied to be in the QILN, and has instituted many process improvements for ambulatory care. They also work with the tribes to coordinate the provision of care.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

CEO awareness is good; however, awareness by general staff is not as pronounced. Because of the low patient census and its status as a critical access hospital, many measures are not relevant for the hospital.

1.2.2: PfP Measures: Reporting Status and Challenges

- Cass Lake began reporting on all PfP measures in January 2013, even though many measures have zero numerators (EED, PU, VAP, VTE, SSI).
- Readmissions have received considerable time and effort. Because the hospital is small, they know each readmitted patient and described contributing factors as patient non-compliance, lack of support, cancer diagnosis, homelessness, and discharging AMA.
- PU concerns include the high rate of MRSA (46 percent of cultures)—which has been increasing the past 2 years—so they are culturing all wounds and are participating in a MRSA surveillance initiative.
- Community involvement includes meetings related to domestic violence in which community advisors are involved as well as the Public Heart Emergency Response Team dealing with prescription drug abuse, homelessness, developing an assisted living facility, and advising Head Start. They have also conducted a community education campaign regarding screening for hepatitis C.
- Cass Lake would like some training on best practices for PU data collection and reporting.

1.2.3: Quality Improvement Initiatives Related to PfP

No specific QI initiatives related to PfP were identified by the Cass Lake staff. Cass Lake is mainly involved in quality improvement related to outpatient services. Subsequent to the IPC, they created teams to empanel patients (internal medicine, family medicine, and diabetes). The team approach has been so successful that they have incorporated it into inpatient care as well.

They have made significant effort to increase adult screening for hepatitis C, since they were well below the national and IHS standards, and they have increased monthly screening from 36 to 112.

Together with a spread team that includes tribal members, which meets onsite, they have increased the percentage of patients within range HbA1C (from 21% to 75%); education and training efforts have also resulted in a 50-percent decrease in blood pressure, improved lipids, and average weight loss by increasing patient involvement and support and employing patient stories and experiences. They have also increased diabetic foot screenings by training an LPN to conduct them, which has increased referrals to the podiatrist and tripled the educational efforts on foot care.

Other activities are aimed at increasing patient awareness of the importance of preventive health care in order to decrease their clinic no-show rate, which is 75 percent.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Cass Lake Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Increase general staff awareness.	• Best practices.
Data Collection and Reporting	
• Pressure ulcer data collecting and reporting.	• Best practices.
• Readmissions.	• Best practices.

3: Descriptive Profile

Indian Health Service Hospital: Cass Lake Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Roberta Williams – 30 yrs. / 1½ yr. @ C.L.
Year Hospital Established	1930s
IHS Area Office	Bemidji
Geographic Area Served	Leech Lake Indian Reservation in MN
User Population	9,372
Hospital Beds	13 beds/11 beds+2 cribs; 13 swing beds; has requested reduction to 4 beds
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	0.5 average daily census
Services Available–General	Family Practice, Internal Medicine, Podiatry, Optometry, Dentistry and Pediatrics; Specialty Clinics including OB/GYN and Surgery

Characteristic	Hospital Description
PfP Awareness at Facility	• General: • Leadership:
PfP Services NOT Available	No CLABSI, SSI, VAP, EED
Number of Physicians	• Medical: 2 MD, 2 NP • Surgical: • Other: 5 dentists, 1 ophthalmologist, podiatrist
Number of Staff FTE, by Type of Personnel	• Total: 150 • Service Unit CEO: • Hospital Administrator: • RNs: 2 • LPNs: 3 • Pharmacists: 9 • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: 1 coder Other: 1 RN care coordinator
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan.–Aug. 2013 • ADE: Jan.–Aug. 2013 • CAUTI: Jan.–Aug. 2013 • CLABSI: Jan.–Aug. 2013 • SSI: Jan.–Aug. 2013 • VAP: Jan.–Aug. 2013 • PU: Jan.–Aug. 2013 • VTE: Jan.–Aug. 2013 • EED: Jan.–Aug. 2013
Reporting Method – Readmissions	
Reporting Method – Falls	
Reporting Method – ADE	
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	
Reporting Method – VTE	
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	
QI Measures Implemented due to PfP	
Patient, Family, and Community Engagement	

Characteristic	Hospital Description
Strength Area	Working on readmissions
Training and TA Needs Identified	Cass Lake would like some training on best practices for PU data collection and reporting. Could use assistance on readmission work.

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies reported between the PfP Data Reporting Progress for 2013 Chart and the HEN Monthly Reporting Chart.

Red Lake Hospital

1: Assessment Summary

1.1: Overview of Red Lake Hospital

Red Lake Hospital is located on the Red Lake Indian Reservation in northern Minnesota. The reservation population is about 6,100 people, and the hospital's user population is 9,783. The hospital, which was built in 1981, is licensed for 23 beds. It employs about 220 staff, and offers inpatient, emergency room, optometry, dental, and pharmacy services.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

During a tour of the facility, staff were asked if they knew what PfP was, and most did not. The CEO is aware, and participated in the visit.

1.2.2: PfP Measures: Reporting Status and Challenges

Red Lake is reporting on falls, ADEs, and VTE. They are exempt from reporting on SSI, VAP, and EED. They have not had any CAUTI or CLABSI events to report, and they have not reported on PUs.

Falls are reported through WebCident. The pharmacy is significantly involved with their data collection for ADEs.

1.2.3: Quality Improvement Initiatives Related to PfP

QI work is being conducted around readmissions, which are mainly driven by CHF and social issues. Readmissions information is shared with an interdisciplinary team during the morning report and with the community health supervisor. Follow-up includes home visits. The hospital reports zero readmissions since September 2013.

In addition to this work related to PfP, they report core measures to CMS, and they have participated in IPC.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Red Lake Hospital

Issue/Challenge	T/TA Recommendations
General/Other	
• Majority of care at Red Lake is outpatient.	

3: Descriptive Profile

Indian Health Service Hospital: Red Lake Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Mary Ann Cook – DON, with IHS and Red Lake for 28 years; Charmaine Branchaud (Diabetes Mellitus coordinator) is secondary contact.
Year Hospital Established	1981 and added on through 2011
IHS Area Office	Bemidji
Geographic Area Served	Red Lake Nation in MN
User Population	• 9,783
Hospital Beds	• # beds: 23 • # staffed beds:
Hospital Discharges 2012	
Occupancy Rate 2012	1
Services Available–General	• Inpatient • ER • Optometry • Dental • Pharmacy
PfP Awareness at Facility	• General: Most staff did not know what PfP was. • Leadership:
PfP Services NOT Available	• Ventilators • Labor & delivery • Surgery
Number of Physicians	• Medical: • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: Approximately 220 • Service Unit CEO: • Hospital Administrator: • RNs: 6–8 • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR:

Characteristic	Hospital Description
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 20 mo. Jan. 2012–Aug. 2013 • ADE: 20 mo. Jan. 2012–Aug. 2013 • CAUTI: 0 – not reporting • CLABSI : 0 – not reporting • SSI: 0 – exempt • VAP: 0 – exempt • PU: 0 – not reporting • VTE: 20 mo. Jan. 2012–Aug. 2013 • EED: 0 – exempt
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident
Reporting Method – ADE	Pharmacy very involved with data collection
Reporting Method – CAUTI	N/A – not reporting
Reporting Method – CLABSI	N/A – not reporting
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	N/A – not reporting
Reporting Method – VTE	
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	3: CAUTI, CLABSI, PU
Discrepancies on Reporting	None
QI Measures Implemented due to PfP	
Patient, Family, and Community Engagement	
Strength Area	Strong CEO engagement; long and active history with IPC; good understanding of QI principles; Ms. Branchaud retiring 4/30/14, but transition planning is underway.
Training and TA Needs Identified	Clarity regarding readmissions: denominator for reporting and understanding NDW data.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Red Lake:

- PU is shown as "0–Providing Services to which the HAC is relevant, but is not participating" on the PEC Chart and shown as participating, but not reporting for 0 months on the IHS Data Reporting Progress Chart.

Billings Area Office

- *Blackfeet Community Hospital – Browning, MT*
- *Crow/Northern Cheyenne Indian Hospital – Crow Agency, MT*
- *Ft. Belknap Indian Hospital – Harlem, MT*

Blackfeet Community Hospital

1: Assessment Summary

1.1: Overview of Blackfeet Community Hospital

First opened in Browning, Montana in 1937, the Blackfeet Community Hospital has since been transformed into an expansive modern-day 110,000-square-foot 25-bed comprehensive health care facility. Located in the western portion of the 1.5 million acre Blackfeet Indian Reservation where Browning is home to over 7,000 descendants of the Ampska Pikuni Nation and bordering Glacier National Park, the hospital picturesquely sits in the shadows of the "Backbone of Mother Earth" or what is more commonly known as the "Shining" Mountains of the rugged Northern Rockies.

Outpatient dental and optometry services are available 5 days per week. The facility also has inpatient pharmacy capabilities, including an automated outpatient pharmacy department filling up to 1,200 prescriptions per day. A daily Women's Health Center provides both prenatal and postnatal care 5 days per week, and a 24/7 OB/GYN department averages 200 to 210 newborns per year. An OR department provides surgical services for both outpatient and inpatient procedures, with a full-time general surgeon and contracts with other sub-specialties.

The hospital offers a full time diabetic clinic with daily Podiatry consultations and boasts of a sophisticated eight-bay emergency room equipped with a rooftop helipad transfer complex along with an urgent care/ same day appointment clinic delivering emergent and urgent care for slightly more than 131,000 patient encounters per annum. The facility contracts with other larger medical centers within the northwest to meet the needs of those patients experiencing severe trauma and or requiring critical care.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

The site described awareness of the PfP as "low."

1.2.2: PfP Measures: Reporting Status and Challenges

Blackfeet has been reporting all measures except VAP since April 2013.

1.2.3: Quality Improvement Initiatives Related to PfP

No specific QI activities related to PfP have been undertaken. It is perceived as a reporting activity.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Blackfeet Community Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
Hospital staff assigned to PfP asked staff during the hospital tour if they knew what PfP was and there was low awareness.	Increase promotion of the PfP activities and importance of patient safety.
Data Collection and Reporting	
Reported challenges with different definitions for measures vs. CMS CORE. GPRA, NHSN, etc.	T/TA plan will consider possible synergy between definitions.
QI Initiatives Related to PfP	
No specific activities undertaken.	Participation will be encouraged.

3: Descriptive Profile

Indian Health Service Hospital: Blackfeet Community Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Myra Magee and Susan Head
Year Hospital Established	1936/1960/~1980s
IHS Area Office	Billings
Geographic Area Served	Blackfeet Indian Reservation. Browning, MT
User Population	7,000 descendants of the Ampska Pikuni Nation
Hospital Beds	• # beds: 25 • # staffed beds:
Hospital Discharges 2012	
Occupancy Rate 2012	
Services Available–General	• Inpatient • L&D • Women's Health • Pharmacy • Podiatry • Cardiology • Surgery
PfP Awareness at Facility	• General: • Leadership:
PfP Services NOT Available	• None
Number of Physicians	• Medical: • Surgical: 2 • Other:

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Total: 206 • Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: 3 • Pharmacists: 2 • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: 1 • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 5 mo. Apr.–Aug. 2013 • ADE: 5 mo. Apr.–Aug. 2013 • CAUTI: 5 mo. Apr.–Aug. 2013 • CLABSI: 5 mo. Apr.–Aug. 2013 • SSI: 5 mo. Apr.–Aug. 2013 • VAP: 0 – not reporting • PU: 5 mo. Apr.–Aug. 2013 • VTE: 5 mo. Apr.–Aug. 2013 • EED: 5 mo. Apr.–Aug. 2013
Reporting Method – Readmissions	
Reporting Method – Falls	
Reporting Method – ADE	
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	
Reporting Method – VTE	
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	1 – VAP
Discrepancies on Reporting	Discrepancy in number of months reported between data sheet and R,Y,G progress sheet for all measures.
QI Measures Implemented due to PfP	
Patient, Family, and Community Engagement	
Strength Area	
Training and TA Needs Identified	

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies reported between the PfP Data Reporting Progress for 2013 Chart and the HEN Monthly Reporting Chart.

Crow/Northern Cheyenne Indian Hospital

1: Assessment Summary

1.1: Overview of Crow/Northern Cheyenne Indian Hospital

The Crow/Northern Cheyenne Indian Hospital is a 24-bed critical access hospital in Southeastern Montana that offers outpatient care as well as 24-hour urgent care to approximately 6,300 enrolled patients, with about 200 staff. Services include optometry, dental, physical therapy, and behavioral health, with a full-service lab and radiology open during clinic hours. They are hoping to open labor and delivery within a year and expand their surgical capabilities; they mostly perform pediatric and dental surgery and simple tests and procedures that can be done in day surgery.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

The PfP contact and CEO has retired. The new QA incumbent had not seen the reporting templates yet, but knew that they exist, and participated in some PfP events when hired. They have engaged with the IPC four years ago and have engaged in a few steps but staffing issues have been a significant challenge.

1.2.2: PfP Measures: Reporting Status and Challenges

- The QA position has been vacant for quite a while, and many types of reporting have not been done in years. The hospital is not reporting on any measures, although five are applicable to them and should be reported (falls, CAUTI, ADE, PU, and VTE). They do not use ventilators and think EMS is still bagging patients, and they have never seen a central line in chart reviews. They have had some births in their ER. They do have many patient transfers. They have not had any HAIs in the past few months.
- The facility has WebCident, but is not recording falls.
- PHNs conduct a significant amount of activity directed toward patient and family engagement; health educators provide training, especially with diabetes. Including family in the care is a priority, because sometimes decisions get deferred to family and everyone involved needs to be informed.

1.2.3: Quality Improvement Initiatives Related to PfP

The QA position has been vacant for many years. The facility is not actively engaged in the PfP, although the new QA person agreed to become engaged.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Crow/Northern Cheyenne Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Lack of awareness.	• PfP education and engagement in events.
Data Collection and Reporting	
• Lack of familiarity with RPMS.	• Needs RPMS query training.
• Not reporting any measures.	• Total training on PFP data collection and reporting requirements.
QI Initiatives Related to PfP	
• Process improvement.	• Engagement with process improvement.
• Lack of staff.	• Recruitment and retention strategies.

3: Descriptive Profile

Indian Health Service Hospital: Crow/Northern Cheyenne Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Lanette Perkins – QA Performance Improvement, 8 mo. this time, and 3 years previously at an IHS outpatient facility
Year Hospital Established	1995
IHS Area Office	Billings
Geographic Area Served	Serves Crow and Northern Cheyenne Tribes. South of Billings. Serves patients as far south as Sheridan, WY. About 100-mile radius.
User Population	• 10,000
Hospital Beds	• # beds: 24 • # staffed beds: <5
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	1–2
Services Available–General	• Inpatient • Day surgery • ER
PfP Awareness at Facility	• General: Facility is more focused on IPC. • Leadership:
PfP Services NOT Available	• Surgery, but OR should reopen soon. • CLABSI • Ventilators • Labor & delivery; hoping to reopen later this year.
Number of Physicians	• Medical: 9 • Surgical: 1 • Other: 5 dentists

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Total: Approximately 200 • Service Unit CEO: • Hospital Administrator: 1 • RNs: 36 • LPNs: 6 • Pharmacists: 6 • Allied Health: 4 • Other Health: 34 • IT/Data Management/CAC: 4 • Data Entry: 5 • Medical Records: • Billing: 4 • Other: CFO
Shared Staff With Service Unit Clinic(s)	None
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	CEO, Director of Nursing, QAPI Manager, Nurses 2, Pharmacist 1
Quality Management/QI Manager/Staff, Number and FTE	1 – QA Performance Improvement
Software Systems and Database Capacity	• RPMS - Yes • RPMS EHR - Yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 0 – not reporting • ADE: 0 – not reporting • CAUTI: 0 – not reporting • CLABSI: 0 – exempt • SSI: 0 – exempt • VAP: 0 – exempt • PU: 0 – not reporting • VTE: 0 – not reporting • EED: 0 – exempt
Reporting Method – Readmissions	
Reporting Method – Falls	
Reporting Method – ADE	
Reporting Method – CAUTI	
Reporting Method – CLABSI	N/A – exempt
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	
Reporting Method – VTE	
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	5 – Falls, CAUTI, ADE, PU, VTE
Discrepancies on Reporting	None
QI Measures Implemented due to PfP	None
Patient, Family, and Community Engagement	• PHNs do a lot of that, and health educators provide training, especially with diabetes. • Including family in the care is a priority, because sometimes decisions get deferred to family and everyone involved needs to be informed.

Characteristic	Hospital Description
Strength Area	• Primary PfP contact has prior experience in case management that could be helpful in working on readmissions.
Training and TA Needs Identified	• How to extract data from RPMS.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Crow:

- Readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart but are shown as reporting for ~4 years on the IHS Data Reporting Progress Chart.
- Crow is currently not reporting any other measures.

Ft. Belknap Indian Hospital

1: Assessment Summary

1.1: Overview of Ft. Belknap Service Unit

Fort Belknap Service Unit operates a 6-bed critical access hospital located at the Fort Belknap Agency, Harlem, MT, and a satellite health clinic located in Hays, approximately 35 miles away. The 6-bed critical access hospital provides the majority of the health care for all Gros Ventres, Assiniboines, and eligible Native American patients on and near the Fort Belknap Reservation, a user population of about 7,000 people. The reservation is approximately 675,336 acres, or 1,200 square miles, in Blaine and Phillips counties. In addition, there are 29,731 acres of tribal land outside the Reservation boundaries

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

The individuals interviewed indicated that they were unaware of the PfP and the activities necessary for participation.

1.2.2: PfP Measures: Reporting Status and Challenges

Staff members said they are unaware of the PfP, have never heard about the program, and said they are not reporting any information related to PfP to anyone.

The Ft. Belknap Hospital's usual inpatient occupancy rate is 1.2 per month. As a critical access hospital, they can keep patients for 96 hours, and then they can be transferred, discharged, or held over. Ft. Belknap does not provide ultrasound, OB, hospice, or PT services. They offer dental, optometry, pharmacy, mammography, and nutrition services and operate two specialty clinics— pediatrics and telemedicine for mental health.

During the interview, the staff said some of the measures sounded familiar but they are wondering if they are exempt from reporting because they are a critical access hospital. They feel they might be able to report on falls and ADEs; they use WebCident to record falls in the facility.

In terms of patient and family engagement, they have no patient participation on boards. They only have a governing body, and there is no one from outside on the board. They do not have a discharge planning nurse, but they do have IPC teams with nurses as case managers. They were involved with the IPC in the past, with the PCMH initiative, and now they continue to run their clinic that way. Patients do like the system according to their "We Care" surveys.

The staff felt they did not need technical assistance if it would require just another form to fill out.

1.2.3: Quality Improvement Initiatives Related to PfP

The RN interviewed stated she is the QA department. She said she queues up QA reports from RPMS and runs them but could not describe the reports. She said they are taking some steps to reduce falls but did not want to discuss them.

Ft. Belknap has a relationship with their State QIO, and they go to meetings and training programs. The State has a grant for quality and leadership. They participate in their dashboard and clinical benchmarks study. They do share data yearly on numbers of patients, ER visits, pneumonia, finances, and some data similar to PfP, such as readmissions. The State is very organized as far as what they want, when it is due, and how to report it. If the IHS PfP reporting is as easy, they can do it.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Ft. Belknap Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Complete lack of knowledge of PfP.	• Engagement and training.
Data Collection and Reporting	
• Not reporting any measures.	• Training on data collection and reporting methods; training about forms and reporting time frame.
QI Initiatives Related to PfP	
• Readmissions.	• Best practices and protocols.
• Falls.	• Best practices and protocols.
General/Other	
• They would like training on third-party collections.	

3: Descriptive Profile

Indian Health Service Hospital: Ft Belknap Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Desiree Bell – RN in Quality Assurance.
Year Hospital Established	
IHS Area Office	Billings
Geographic Area Served	Ft Belknap Reservation, MT
User Population	7,000
Hospital Beds	• # beds: 6 • # staffed beds:
Hospital Discharges 2012	
Occupancy Rate 2012	1.2/month
Services Available–General	Critical access hospital: keeps patients 96 hours; mostly OP services—dental, optometry, pharmacy, mammography and nutrition.
PfP Awareness at Facility	• General: None; they never heard of PfP. • Leadership: None.
PfP Services NOT Available	Surgery, L&D, ultrasound, OB, hospice or PT
Number of Physicians	• Medical: 6 • Surgical: • Other: 5 Midlevel staff

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: 15 • LPNs: • Pharmacists: 4 • Allied Health: • Other Health: • IT/Data Management/CAC: 1 • Data Entry: • Medical Records: • Billing: • Other: 2 psychologists
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	5%
Current Staff Vacancies, by Type of Personnel	Psychiatrist
Quality Management/QI Manager/Staff, Number and FTE	RN in Quality Assurance (not familiar with PfP)
Software Systems and Database Capacity	• RPMS: yes • RPMS EHR: yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: • ADE: • CAUTI: • CLABSI: • SSI: • VAP: • PU: • VTE: • EED:
Reporting Method – Readmissions	
Reporting Method – Falls	Report to Safety Officer and governing body. Have made some policy changes regarding falls but did not want to share the information at this time.
Reporting Method – ADE	
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	
Reporting Method – VTE	
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	All
Discrepancies on Reporting	No reporting
QI Measures Implemented due to PfP	None
Patient, Family, and Community Engagement	None
Strength Area	
Training and TA Needs Identified	PfP training generally; third-party collections

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Ft. Belknap:

- EED, CLABSI, and SSI are shown as "Z–Hospital does not provide services related to this HAC" on the PEC Chart, but are shown as providing services, but not reporting on the IHS Data Reporting Progress Chart.

Navajo Area Office

- *Chinle Comprehensive Health Care Facility – Chinle, AZ*
- *Crownpoint Health Care Facility – Crownpoint, NM*
- *Gallup Indian Medical Center – Gallup, NM*
- *Northern Navajo Medical Center – Shiprock, NM*

Chinle Comprehensive Health Care Facility

1: Assessment Summary

1.1: Overview of Chinle Comprehensive Health Care Facility

The Chinle Comprehensive Health Care Facility (CCHCF) is based in Chinle in a remote, 1,000-square-mile area in northeast Arizona along the New Mexico border. The CCHCF is a 30-bed hospital that serves as the health care hub for the region; they also operate an outpatient facility, two health centers, and two clinics. They provide health care for 37,000 Navajo patients annually and offer services in family practice, pediatrics, internal medicine, OB/GYN, pharmacy, and rehabilitation including speech, occupational and physical therapies, and audiology. They do not offer specialty services. They have a nine-bay emergency department.

Chinle participated in the IPC and continues process improvement initiatives into the emergency department and inpatient unit.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Awareness of PfP varies within the hospital, and leadership was described as limited and requiring additional education. The inpatient managers are aware of the PfP, and there is monthly collaboration between clinical and improvement teams.

1.2.2: PfP Measures: Reporting Status and Challenges

- CCHCF is reporting on 8 of 11 measures, including readmissions (NDW), falls, CAUTI, CLABSI, SSI, VAP, PU, and VTE. They are not reporting EED and two ADEs (hypoglycemia and anticoagulation).
- CCHCF medical staff has questions and doubts about some of the data and measures reported. This is especially true for the SSI measure. The SSI data were presented to the team last month, and the perception was that the reported number of events was too high. The group reviewed every case and felt only two were legitimate SSIs for the PfP measure. They believe the CMS definition of SSI is very limited; they tried to apply it to all surgeries but feel it resulted in misidentification of SSIs by the data abstractor. They only perform one of the five surgeries counted in PfP.
- Medical staff has similar issues with the VAP measure.
- CCHCF staff believe the ADE measure is defined too narrowly to be useful to them; they have a significant number of medication errors but these errors are not related to hypoglycemia or anticoagulation.
- In terms of patient and family engagement, patients and families participate in improvement teams. They also have a new community liaison, mostly related to the ACA, and produce a monthly newsletter distributed to the communities.
- Because the PfP targets rare denominators and even rarer numerators, they measure many things that are not very useful to the hospital and for highlighting areas for QI.

- They believe that the concept of having a central data collection person was flawed and that data should be collected by someone "closer to the measures" and who has a more complete understanding of the processes and events.
- CCHCF would like to see the PfP measures align as much as possible with CMS measures, but CMS measures keep changing (VAP was mentioned as an example). They would like consistent measure definitions and data collection procedures, clear definitions in the system and people who understand definitions clearly, consistent hypoglycemia definitions, more sophisticated queries, clinical validation of events, and training on best practices for data collection.

1.2.3: Quality Improvement Initiatives Related to PfP

CCHCF recently lost most of their QI staff to retirement, including the nurse data abstractor who was conducting all of the PfP collection; there was limited training at handoff so there is a need for additional training and support to assist them to identify and implement QI measures related to PfP. In the absence of the QI staff, others have reviewed the measures being collected and have many questions and concerns about the appropriateness of what they are doing.

CCHCF has reported NHSN data since September; they also report CMS core measures, GPRA, and meaningful use data. They have internal measures that they track for their strategic plan.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Chinle Comprehensive Health Care Facility

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• General and leadership awareness could be improved.	• Best practices.
Data Collection and Reporting	
• More timely CMS data.	• Possible options.
• Standardized reporting methods.	• Possible options.
• Measures were reviewed and there is concern collection has been done inappropriately.	• Training on effective practices for collection and reporting, including designing queries.
• They want to work on readmissions using available resources.	• Best practices to prevent readmissions for IHS and tribes.
• More relevant measures (ADE drugs monitored).	• Adopt measures more meaningful to the services they provide.
• Alignment of measures and definitions across reporting entities (e.g., hypoglycemia definitions <70 vs <50).	• Possible options.
QI Initiatives Related to PfP	
• Loss of staff.	• Training module.

3: Descriptive Profile

Indian Health Service Hospital: Chinle Comprehensive Health Care Facility

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Dr. Kevin Rand – 25 years IHS/Chinle
Year Hospital Established	1982
IHS Area Office	Navajo
Geographic Area Served	Central Navajo Reservation (Arizona)
User Population	37,000
Hospital Beds	# beds: 30
Hospital Discharges 2012	(b) (3) (A) [redacted]
Occupancy Rate 2012	10–24
Services Available–General	Outpatient at 5 sites, inpatient adult and pediatrics, general surgery, OB-GYN, emergency room, family practice, internal medicine, OB/GYN, rehabilitation (including speech, occupational, and physical therapies), and audiology
PfP Awareness at Facility	• General: Awareness varies, need education. – They started with IPC and then rolled that structure into ER and inpatient improvement. – The HEN committee meets twice a month to look at measures and decide what to work on. – The inpatient managers are aware of the PfP. – They spent the first year collecting data and are now working on improvement. – There is monthly collaboration between clinical and improvement teams. • Leadership: Limited.
PfP Services NOT Available	None
Number of Physicians	• Medical: 30 primary care. • Surgical: 12 (including general surgeons, OB-GYNs, and anesthesiologists). • Other: Optometrists, dentists, PAs, APNs, psychologists, rehabilitation medicine professionals.
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: 1 • Hospital Administrator: 8 executive committee • RNs: 120 • LPNs: 2 • Pharmacists: 14 • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:

Characteristic	Hospital Description
Shared Staff With Service Unit Clinic(s)	None
Staff Turnover Rate, by Type of Personnel	Not measured
Current Staff Vacancies, by Type of Personnel	25% Vacancy rate (medical staff)
Quality Management/QI Manager/Staff, Number and FTE	QM Director – Vacant QM Data Abstractor – Vacant QM Performance Improvement Coordinator - Vacant • The data abstractor nurse was reporting on all of the PfP measures – there was some training at handoff, but more is definitely needed. • They want to reduce readmissions and improve transitional care by working together with resources available (PH nursing, case managers w/in week of discharge).
Software Systems and Database Capacity	• RPMS: Yes. • RPMS EHR: Nearly done transitioning to an EHR, but a few departments are still using paper.
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan. 2012–May 2013 • ADE: • CAUTI: Jan. 2012–June 2013 • CLABSI: Jan. 2012–June 2013 • SSI: Jan. 2012–June 2013 • VAP: Jan. 2012–June 2013 • PU: Jan. 2012–June 2013 • VTE: Jan. 2012–June 2013 • EED:
Reporting Method – Readmissions	
Reporting Method – Falls	
Reporting Method – ADE	• Anticoagulation denominator = 4, numerator = 0–1. • RPMS, VGEN- Query (V=Visit), Charts/EHR. • Not reporting on hypoglycemia or anticoagulation. • Separate meeting to track drug errors. • More significant number of errors when looking at all types. • Feel there are other “more important” ADEs not in PfP.
Reporting Method – CAUTI	
Reporting Method – CLABSI	

Characteristic	Hospital Description
Reporting Method – SSI	• Medical staff have questions/doubts about some data, especially SSIs. • The data was presented last month, and they think it is way too high. • The group reviewed every case and felt only 2 were legitimate SSIs for the PfP measure. • Medical staff has similar issues with the VAP numbers. • They feel that the concept of having a central data collection person is flawed and that they need data collected by someone "closer to the measures." • They wonder if anyone at IHS reviews the actual data.
Reporting Method – VAP	
Reporting Method – PU	
Reporting Method – VTE	
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	ADE
Discrepancies on Reporting	• The CMS definition of SSI is very limited. – They tried to apply it to all surgeries, but they believe it resulted in misidentification of SSIs by the data abstractor. – They only perform one of the 5 surgeries counted in PfP. • ADE is also very narrow—they have a significant number of medication errors, but they are not related to hypoglycemia or anticoagulation. • PfP measures looking at rare denominators and even rarer numerators—they measure many things, but not much of it is useful.
QI Measures Implemented due to PfP	None reported.
Patient, Family, and Community Engagement	• Patients and families participate in improvement teams. • They have a new community liaison, mostly related to the ACA. • Monthly newsletter.
Strength Area	

Characteristic	Hospital Description
Training and TA Needs Identified	• They would like to see the PfP measures align as much as possible with CMS measures, but CMS measures keep changing, especially with VAP. • Want consistent measure definitions and collection procedures. • Clear definitions in system and people who understand definitions clearly. • More timely data as CMS data seem old once they receive it and therefore "useless." • Feel narrow reporting and small denominators/numerator are useless. • Inconsistency with hypoglycemia definitions (e.g., <70 vs <50). • Need more sophisticated queries. • Need module due to staff transition. • Want clinical validation of events. • How to do data collection and how to get "good" data.

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies reported between the PfP Data Reporting Progress for 2013 Chart and the HEN Monthly Reporting Chart.

Crownpoint Health Care Facility

1: Assessment Summary

1.1: Overview of Crownpoint Health Care Facility

The Crownpoint Health Care Facility, located in northwest New Mexico on the eastern edge of the Navajo Reservation, is 60 miles northeast of Gallup and 80 miles south of Farmington. It is a 19–20 bed facility that serves 16 of the 32 Eastern Navajo Chapters, with a user population of 6,000. The service unit also operates two clinics—one to the east in Pueblo Pintado and one to the south off I-40 in Thoreau.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

General awareness of PfP is limited because staffing shortage and other priorities have made the quality measures/program a lower priority. Executive staff and the CEO know PfP is important and support it, but they have not made it a priority. The CEO might not fully understand the interdepartmental collaboration that is necessary to collect data and report the PfP measures.

1.2.2: PfP Measures: Reporting Status and Challenges

Crownpoint does not perform surgery or operate an ICU. They provide services in ambulatory care, laboratory, radiology, ER, optometry, nursing support, behavioral health, dental, and pharmacy. They operate a seven-bay ER and provide labor and delivery services but only for low-risk pregnancies; complicated deliveries go to Gallup, Northern Navajo, or Albuquerque. They had approximately 41 deliveries last year; they do not do any early deliveries, so they were not reporting EED but can if necessary. Diabetes and pneumonia are areas of concern for their population. The majority of diabetes education funds are contracted with the Navajo Nation.

Readmissions are a challenge because they cannot open the files from NDW that they receive. Crownpoint uses chart review of utilization and discharge planning to determine what may be contributing to readmissions. They hope the data abstractor will be able to track and pull all of these data for them once one is hired. They are particularly interested in determining whether they are discharging patients too soon and whether observation stays are because of "medical necessity" or social admissions. An additional concern is whether extended stays are being utilized properly—they have patients who have stayed up to 30 days. The service unit is very rural, many patients do not have central heat, and they cannot get to the hospital as often as they should due to transportation issues, so they stay as social admissions. Alcohol withdrawal is also a readmission issue, and they do not have any local treatment facilities. Some patients travel from Las Cruces, which is approximately 6 hours away, which makes it challenging to engage families to participate in the treatment process.

They used to have a swing bed, but they could not staff it with the PT, OT, and other specialty services required. They are considering reapplying, because it is needed as a step-down for many patients with social issues. They make a significant number of referrals to nursing homes in Gallup and Farmington and one that is Navajo-run. Some individuals use the hospital as a hospice, but there are actual hospice services available out of Albuquerque. They have been

working on improving their discharge assessment to make it more usable and as appropriate as possible.

Falls are tracked using WebCident. The Safety Officer has been "very, very much on top of it." The largest problem has been with noncompliant patients who are on fall precautions but who do not ring the nurse when they need to get up.

ADE data is pulled from RPMS by the infection control nurse, who then goes to the charts to verify the information. There was an incident in which heparin was discontinued, but the protocol was not followed and no labs were drawn overnight. A WebCident was entered, and a teaching point was identified regarding the protocols and training for all of the ER doctors. They have prioritized doing more PDSAs for medical staff.

CAUTI/CLABSI data are collected by the infection control nurse (only reported for 2 months).

PU data have not been reported. They know they have had one PU this month, but they would not have known about it if the infection control nurse had not been called in on another issue. They are working with the inpatient supervisor on PU procedures. They do not have a skin PU training session this week. They will try to do retrospective data collection on this measure but will discuss whether it should only be prospective.

1.2.3: Quality Improvement Initiatives Related to PfP

Crownpoint has a quality division, but it is not formal because they have not updated their organizational structure. Quality Improvement consists of seven positions: (1) the supervisor, (2) safety and emergency management, (3) utilization and case management, (4) infection control and employee health, (5) patient advocate, (6) data abstracter (new and vacant), and (7) secretary. The supervisor reports to the executive committee on a monthly basis, as well as to the supervisors and general staff primarily on GPRA and CMS core measures. PfP is included in new employee orientation. She lets the staff know what measures for PfP are being reported and how they are doing on those measures.

The QI Supervisor has been responsible for PfP since the hospital started working on it. She has had difficulty developing an understanding of the program, structuring it, and setting up the denominators. Interpreting the data has also been difficult, because there are not that many events or that many patients in the denominator.

The QI Supervisor is also facilitating the strategic plan, which is focused on two main goals: (1) organizational structure and (2) patient flow and systems. The employee turnover is high in inpatient and nursing. They recently selected a new Chief Nurse Executive; the last one left a year ago and there have been two to three interim people in this position. The nurse supervisor position has had turnover as well, which has caused a consistency problem.

Crownpoint started with IPC-3 but was very inconsistent in participation. When the 18-month period ended, they dropped it due to problems with space and housing. The hospital is overflowing, and they do not have space to expand services and organize things according to IPC requirements. They only have five housing vacancies, and many more professional staff

vacancies than that. Because of this, they skipped IPC-4 and IPC-5, but they are looking into the QILN now and plan to join the February 13 conference call.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Crownpoint Health Care Facility

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Knowledge could be improved.	• Executive training on improving patient safety.
Data Collection and Reporting	
• Access to readmission reports.	• NDW training.
• Data collection training.	• Procedures and protocols for effective data collection; PfP 101 training on the program and denominator use.
QI Initiatives Related to PfP	
• Readmission reduction.	• Best practices; advice on alcohol readmissions.
• Skin integrity program.	• Best practices.
• PfP resources.	• Assistance in accessing materials from webinar, using the Web site.

3: Descriptive Profile

Indian Health Service Hospital: Crownpoint Health Care Facility

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Cecelia Belone – Director of Quality Management since Feb. 2013
Year Hospital Established	
IHS Area Office	Navajo
Geographic Area Served	NW New Mexico on the eastern edge of the Navajo Reservation; 60 miles NE of Gallup and 80 miles south of Farmington
User Population	30,765
Hospital Beds	• # beds: 32 • # staffed beds: 19–20
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	6 (been as high as 9 AVD)
Services Available–General	Do have ambulatory care, lab, radiology, ER (~5,000/year), optometry, nursing support, behavioral health, dental, and pharmacy. 7-bay ER. Do have OB, but only for uncomplicated deliveries.
PfP Awareness at Facility	• General: Limited, because limited staffing and other priorities have made the quality measures/program a lower priority. • Leadership: Executive staff and CEO know it is important and support it, but are not prioritizing it. The CEO might not understand the interdepartmental collaboration that is necessary to work on the measures.

Characteristic	Hospital Description
PfP Services NOT Available	Surgery, ICU, EED
Number of Physicians	• Medical: 7–8 • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: 383 • Service Unit CEO: • Hospital Administrator: • RNs: 48 • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other: 3 CNMs, 7NPs, 1 podiatrist
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	17.5% (4 physician)
Current Staff Vacancies, by Type of Personnel	Employee turnover is high in inpatient and nursing.
Quality Management/QI Manager/Staff, Number and FTE	Quality Improvement consists of seven positions: (1) the supervisor, (2) safety and emergency management, (3) utilization and case management, (4) infection control and employee health, (5) patient advocate, a (6) data abstracter (new and vacant), and a (7) secretary.
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Inpatient and ambulatory but not ER.
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan 2012: Aug 2013 • ADE: Jan: August 2013 • CAUTI: Jul-Aug 2013 • CLABSI: Jul-Aug 2013 • SSI: • VAP: • PU: • VTE: • EED:
Reporting Method – Readmissions	She cannot open the report.
Reporting Method – Falls	They are using WebCident. The safety officer has been "very, very much on top of it." The largest problem has been with noncompliant patients who are on fall precautions but do not ring the nurse when they need to get up.
Reporting Method – ADE	Infection control nurse pulls data from RPMS, then goes to the charts to verify. They had an incident where heparin was d/c'ed, but the protocol was not followed and no labs were drawn overnight. A WebCident was entered, and a teaching point was identified regarding the protocols and training all of the ER doctors about the protocols.
Reporting Method – CAUTI	Data is collected by the infection control nurse.

Characteristic	Hospital Description
Reporting Method – CLABSI	Data is collected by the infection control nurse.
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	Data has not been reported. They know they have had one pressure ulcer this month, but they would not have known about it if the infection control nurse had not been called in on another issue. They are working with the inpatient supervisor on pressure ulcer procedures. They do not have a skin program in place, but they probably need one. This is a training issue. They did participate in the pressure ulcer training session this week. They will try to do retrospective data collection on this measure, but we will discuss whether it should just be prospective
Reporting Method – VTE	They do not have any.
Reporting Method – EED	They do not have any.
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	CAUTI/CLABSI reported only 2 months.
QI Measures Implemented due to PfP	
Patient, Family, and Community Engagement	There is not much patient/family engagement. Just established patient advocate in 2012 in response to a CMS finding, responding to patient complaints and grievances. Moving in direction of patient safety and starting a committee to address some community representation. They do send out community safety messages.
Strength Area	

Characteristic	Hospital Description
Training and TA Needs Identified	• Difficulty understanding of the PfP program, structuring it, and setting up the denominators. • Interpreting the data has been difficult, because there are not that many events and there are not that many patients in the denominator. • The standing Wednesday call is a good time. Would like an email with a link to the slides from the PU session, because they think they will be a good teaching tool. • Alcohol withdrawal is also a readmission issue, and they do not have any treatment facilities. Las Cruces is about 6 hours away, and this makes it hard to engage families to participate in the treatment process. • They are looking at what may be contributing to readmissions. Utilization review/dc planner is looking at this data right now, through chart review. If they are discharging patients too soon, is it because of "medical necessity" and extended stays not being utilized properly? They have patients who have stayed up to 30 days. They are very rural, and many patients do not have central heat and cannot get to the hospital as often as they should due to transportation issues; they stay as social admissions. The hospital used to have swing bed, but they could not staff it with the PT, OT, and other specialty services they need to make it work.

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies between the "PfP Data Reporting Progress for 2013" and the "HEN Monthly Reporting Template."

Gallup Indian Medical Center

1: Assessment Summary

1.1: Overview of Gallup Indian Medical Center

Gallup Indian Medical Center (GIMC) is in Gallup, NM, a border town off the Navajo Nation reservation. The hospital opened in 1961 and is very dated, expensive to operate, and is number one on the IHS facility replacement list. GIMC has 78 beds. In 2012, it had 13,986 inpatient days, (b) (3) (A) discharges, and 297,690 outpatient visits. They have 35 dental chairs and had 22,557 dental visits. GIMC has 1,123 employees, of which 64 are commissioned corps. They employ 70 physicians, 227 RNs, and 12 dentists. GIMC offers services in internal medicine, cardiology, anesthesia, OB/GYN, general surgery, orthopedics, ophthalmology, ENT, radiology, pathology, pediatrics, psychiatry, emergency medicine, and urology.

In FY12 the user population was listed at 43,360, but they think the census is over 44,000 and user population over 50,000. GIMC works with 17 Chapters (lowest level of Tribal government); their health board represents all of the Chapters. They provide services to 17.5 percent of the total Navajo population of 247,203. The GIMC campus is the main clinical and service hub for the Gallup service unit, which offers all of the PfP services. They receive many crossover patients coming from other service units such as Crownpoint and Chinle, because people come into town to visit family and then come to the facility.

GIMC is committed to patient safety and process improvement and is probably the leader in quality improvement of all the IHS hospitals. As one example, they worked with a team of 37 hospitals nationwide on VTE prophylaxis protocol and were the first to implement it.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Excellent; GIMC is actively embracing PfP.

1.2.2: PfP Measures: Reporting Status and Challenges

GIMC has an interdisciplinary team working on VTE that collaborates with 37 hospitals nationwide on VTE prophylaxis protocol; they were the first to implement the protocol. In 2010, they drafted P&Ps and the protocol, had these approved through various committees (which took 3 months), and began educational efforts. They brought in outside experts, such as those from the University of New Mexico, and provided educational sessions for pharmacists who are well-placed to do intervention since they see patients directly when they come in and are conducting consultation. The rate of prophylaxis went up rapidly; however, they had significant trouble getting the physicians on board.

VTE reports are not automated for the six VTE measures reported to CMS; this requires manual audits for the different measures every month. PfP and CMS monthly reporting are separate numbers and differently defined specifications. CMS looks more at patient care such as teaching and construction. Manual review entails reviewing each chart to see if the event occurred in the hospital, if they came to the hospital with the VTE, and if they had been in the hospital within

the last 30 days. They determined that they need to corroborate with the patient when the event occurs.

VTE interventions include decreasing the unnecessary use of heparin and prophylaxis in conjunction with surgery. The Joint Commission requires EHR inclusion since they will have no paper orders as of January 1, 2014, so they created a template for the EHR, which is highly effective. Their goal is 90-percent coverage; to achieve that they need buy-in from surgeons and orthopedic physicians who are using aspirin guidelines for prophylaxis rather than the ACP guidelines.

All falls are reported in WebCident and are analyzed to determine the cause of the fall, how to prevent similar falls, and ensure the policy was being followed. The majority of falls were unwitnessed. Analysis of what the patient was doing when they fell shows 28 percent going to the bathroom; 20 percent walking to clinic; 13 percent leaving hospital; 7 percent getting a drink; 7 percent getting up from toilet and transfer to/from bed; and 13 percent agitated/restless or pacing (mostly alcohol withdrawal). A copy of the falls analysis is given to the supervisor. They started fall prevention education in 2012 at the safety fair and now provide monthly education for new employees (including janitorial) at orientation.

GIMC uses a form that was obtained from a Joint Commission article that covers all areas and includes an action plan, but they will change it for patients with falls related to substance abuse, as they discovered a lack of communication among the nursing staff. They are also involving the pharmacy. They performed an RCA prompted by serious injuries on medical/surgical units in 2013 and discussed findings with the Nursing PI and supervisors. Falls are a part of the safety huddles that occur every morning on incidents from the prior week.

PU coding issues were discovered, as there were zero reported incidents. They are involving the wound care nurse until they get the coding issues resolved.

Other improvements identified as needed were (1) wound and skin guidelines, (2) a need for a Pressure Ulcer Policy (refer to wound care nurse, refer to nutritionist, accurate coding, report to CMS), (3) improved nurse documentation and education, and (4) continual education for RNs provided by the wound care RN.

They think that because the numbers of patients are so small, it is hard to gauge the excessive anticoagulation benchmark. The inclusion criteria for the ADE anticoagulation measure cover many different medications, but the only medication that GIMC is reporting events for is warfarin. There should be some way to indicate that they are only monitoring ADEs associated with that specific drug. There are few starting that drug as inpatients so they are working on inpatient training. They have 20 pharmacists who work on the floors and 8 who work in anticoagulation. They discovered that the ADE information is coming from the IHI Medical Module tool, and it is difficult to get reports to give the same information when compared to VGEN. Because of the difficulty with determining which is correct, they are concerned that they are not tracking appropriately.

Hypoglycemia was not previously tracked, so there is no history. They can pull VGEN info on patients admitted with diabetes, but this is labor-intensive since 90 percent of patients have diabetes. To review each chart, they have to examine numerous lab documents to obtain results for primarily finger sticks. They were using the PfP reporting spreadsheet instructions prior to April, but they were not capturing all of the patients until they started chart reviews.

The CMS readmission report for 2012 identified 367 30-day readmissions to GIMC in 2013—180 with the same diagnosis. Of these, 142 were Medicare and 110 had no alternate resources. They produce quarterly readmission reports, which cover length of stay and geographic area. Observation stays are 1–2 percent and are going up gradually. They are gathering feedback from RAC on medical necessity documentation for observation stays. They would like to have data to identify readmissions with same and different diagnosis, as well as readmissions to other facilities. They want to get information from the IHS data warehouse on all IHS facilities.

With regard to patient and family engagement, they want to focus on how to get everyone, from the Executive Management Team to front-line staff, involved. The PHNs and Traditional Healers put together a model 4 years ago that shows how Navajos keep themselves and their communities well; they want to use that model to improve quality. The traditional Navajo concept of wellness, harmony, and balance includes a ceremony that is a blessing wave to rebalance one's life. Every human being should maintain harmony and balance with their nature; if they are out of balance, they will seek a traditional ceremony to restore the balance. The four cardinal directions conform with the director's priorities – growth, respect and trust, relationship strengthening, and care of relatives. The Medicine Men works side-by-side with the physician because they reinforce what the doctor tells them as well as perform rebalancing ceremonies.

1.2.3: Quality Improvement Initiatives Related to PfP

The GIMC QI team includes Hospital PI accreditation, Nursing PI, Medical PI team, Ancillary PI (each service), and safety and infection control. They are driven by the yearly Infection Control Risk Assessment (ICRA); from the assessment they develop an infection control plan that lays out what they will monitor this year in accordance with CDC standards.

With respect to readmissions, GIMC plans to improve discharge planning using a high-risk screening tool, but there is some resistance necessitating education to get everyone on board. The departments tend to segregate themselves, and when suggestions for change are made, the reaction is negative if it involves more work. It is important to provide education to all of the staff on the importance of each change to improving overall quality at the hospital.

Improvements to the discharge process will integrate communication among inpatient, primary care, community services, the patient, and the patient caregiver. A template was proposed but the support was not there as staff felt there were many redundancies with OIC assessment already in use. There are a number of triggers for consults, which are automated in RPMS. They found a form they like from Minnesota based on the interdisciplinary team getting together on rounding and considers identified issues necessary for discharge. They will also need to determine a method of triggering specific referrals for needs in the home on discharge such as equipment, PHN visits, etc. They feel it is essential to screen patients to identify high-risk factors—frequent flyers, high-risk diagnosis, psychosocial issues, and no caregiver or family support. They

conduct mediation reconciliation but it needs to be a collaborative effort with nursing involved. They are proposing to become relicensed with Nolan Care Guidelines.

They initiated a PU task force in March, performed a gap analysis, and started with NPUAP guidelines. They looked at RPMS data and compared with the unit patient lists and discovered discrepancies so pulled all records from 2012, obtained results, and discussed with coding. Their process addressed physician assessment, diagnosis on admission sheet, discharge summary, accurate coding, and whether wound and nutrition consultations were requested. The coders said the physicians were not putting PUs on discharge summaries, they were not reviewing nurse notes, and there are missing diagnosing elements on the A sheets (summary sheet that includes diagnoses and procedures). They provided education on the notes of the wound care nurse and shared results with Medical Executive Team, and a decision was made to have coders provide real-time feedback to physicians.

The Infection Control Committee makes policy changes that make sense to address identified issues and trends. They strive to use best practices that are nationally accepted. Their internal focus is broader and not limited to four national standards. They implemented a number of standards such as central line insertion protocol, surgical care improvement process, ventilator bundle, disinfecting IV hub caps, CAUTI initiative, and antibiotic stewardship.

Patient-centered data collection feeds into quality improvement at GIMC, where they are receiving medical care data, ancillary care data, and nursing care data. All staff members are talking to the patient and family; patient-centeredness is core to the strategic plan including using culturally sensitive terms. All the information goes to the Quality Improvement Team; reports go to CDC and PfP as well as internal stakeholders (staff and patients/families). Infection control reporting is aligned between CDC and PfP; they simply make another spreadsheet for reporting the same information. They think that PfP should improve their collection. They would also like to see sharing of patient information across IHS facilities, which would help nationally because the people are very nomadic and travel to many locations.

Data gathering used to be labor-intensive to get the overall bed count, ICU bed statistics, surgery reports, OB-GYN monthly case reviews, and microbiology monthly reports (get every positive blood culture). Recently, they have significantly improved their data collection methods. They identify those charts that need to be reviewed, enter information into spreadsheets, and report findings to CDC and PfP. They review more standards than is required and report bimonthly to the Infection Control committee to bring trends to their attention. They have found that the number of CLABSI events is up this year.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Gallup Indian Medical Center

Issue/Challenge	T/TA Recommendations
Data Collection and Reporting	
• Alignment of ICD-9 codes.	• Does IHS have flexibility, and can they alter definitions to match other required reporting?
• Manual review.	• More EHR automation.
• VTE.	• Report automation.

Issue/Challenge	T/TA Recommendations
QI Initiatives Related to PfP	
• Readmissions.	• Best practices and staff engagement; coordination with Tribal programs.
• Pressure ulcers.	• EHR template.

3: Descriptive Profile

Indian Health Service Hospital: Gallup Indian Medical Center

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Sandra Becenti – Health Resource Division Director, responsible to security, advocacy, Quality Management, patient issues, safety. 13 years in Gallup, 32 years with IHS
Year Hospital Established	1961
IHS Area Office	Navajo
Geographic Area Served	Part of Navajo reservation
User Population	43,360
Hospital Beds	• # beds: 78 • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	
Services Available–General	Internal Medicine, Cardiology, Anesthesia, OB/GYN, General Surgery, Orthopedics, Ophthalmology, ENT, Radiology, Pathology, Pediatrics, Psychiatry, Emergency Medicine, and Urology
PfP Awareness at Facility	• General: Excellent • Leadership: Excellent
PfP Services NOT Available	None
Number of Physicians	• Medical: 70 • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: 1,123 • Service Unit CEO: • Hospital Administrator: • RNs: 227 • LPNs: • Dentists: 12 • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	

Characteristic	Hospital Description
Quality Management/QI Manager/Staff, Number and FTE	QI team includes Hospital PI accreditation, Nursing PI, Medical PI team, Ancillary PI (each service), safety and infection control.
Software Systems and Database Capacity	• RPMS: yes • RPMS EHR: hybrid
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: Jan. 2012–Aug. 2013 • Falls: Jan. 2012–Aug. 2013 • ADE: Jan. 2012–Aug. 2013 • CAUTI: July 2012–Aug. 2013 • CLABSI: Jan. 2012–Aug. 2013 • SSI: Jan. 2012–Aug. 2013 • VAP: Jan. 2012–Aug. 2013 • PU: Jan. 2012–Aug. 2013 • VTE: Jan. 2012–Aug. 2013 • EED: Jan. 2012–Aug. 2013
Reporting Method – Readmissions	Monitor by unit; ICU has highest rate but their beds are limited.
Reporting Method – Falls	WebCident. Majority of falls were unwitnessed; rely on WebCident. Track what the patient was doing when they fell: 28% going to the bathroom; 20% walking to clinic; 13% leaving hospital; 7% getting drink; 7% getting up from toilet and transfer to/from bed; 13% agitated/restless or pacing (mostly alcohol withdrawal).
Reporting Method – ADE	VGEN and chart review
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	Manual chart review
Reporting Method – VTE	Reports are not automated; six VTE measures reported to CMS; she audits for the different measures every month. Have to look at each chart to see if the event occurred in the hospital. Look at each patient profile to determine if they came to the hospital with the VTE and if they had been in the hospital in the last 30 days. It depends on the coders and what information they have entered. When working on it determined need to corroborate with patient to determine when the event occurred.
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	None
Discrepancies on Reporting	None

Characteristic	Hospital Description
QI Measures Implemented due to PfP	• VTE: worked on team of 37 hospitals nationwide on VTE prophylaxis protocol; were the first to implement. Decreased unnecessary use of heparin, start and stop prophylaxis in conjunction with surgery, omission of DVT orders. We created a template for the EHR which is very effective. Gathering data: used to be labor intensive, get overall bed count, ICU bed statistics, surgery reports, OB-GYN monthly case reviews and microbiology monthly reports (get every positive blood culture). Identify those charts that I need to look at, enter information into spreadsheets and report to CDC and PfP. If he finds trends he brings them to the attention of those who need to know. • Readmission: Target improving discharge process to integrate communication among inpatient, primary care, community services, the patient and the patient caregiver; perform med reconciliation but need to screen for risk factors. • PUs: initiated a pressure ulcer task force in March, performed a gap analysis, and started with NPUAP guidelines. They looked at RPMS data and compared with the unit patient lists and discovered discrepancies so pulled all records from 2012, got results, and discussed with coding.
Patient, Family, and Community Engagement	• They want to focus on how to get everyone—from the Executive Management Team to front-line staff—involved. • The PHNs and Traditional Healers put together a model 4 years ago that shows how Navajos keep themselves and their communities well; they want to use that model to improve quality. • The four cardinal directions conform with the director's priorities: growth, respect and trust, relationships strengthening, and care of relatives. The Medicine Men work side-by-side with the physician because they reinforce what the doctor tells them as well as perform rebalancing ceremonies.
Strength Area	• Worked on nationwide VTE prophylaxis initiative. • Implemented a number of infection control standards and bundles including a CAUTI initiative. • Well-developed method for analyzing falls and causes. • Pressure Ulcer task force identified data issues and methods for improvement.

Characteristic	Hospital Description
Training and TA Needs Identified	• VTE: Alignment between PfP monthly reporting and CMS reporting, as the specifications are defined differently for PfP. • Misalignment of ICD-9 codes and the PfP—is this IHS-defined or CMS-defined? If there is flexibility, should match other reporting requirements.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Gallup:

- VTE, PU, EED, and Readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart but are shown as reporting for ~2 years on the IHS Data Reporting Progress Chart.

Northern Navajo Medical Center

1: Assessment Summary

1.1: Overview of Northern Navajo Medical Center

Northern Navajo Medical Center (NNMC) is located in Shiprock, NM, in the Four Corners area of the United States where New Mexico, Arizona, Colorado, and Utah meet. The hospital serves approximately 45,500 Native Americans, the majority being members of the Navajo Tribe. The hospital is licensed for 75 beds and staffs 64, and there were 2,000 admissions in 2013. The hospital employs a total staff of approximately 1,200.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

NNMC's awareness of PfP is described as "fair." They have participated in PfP calls and webinars when they can and said that the best practice webinar on readmissions with Jane Brock was excellent.

1.2.2: PfP Measures: Reporting Status and Challenges

- NNMC is reporting all measures for at least 17 months. They collect data on falls through WebCident and also track days in between falls.
- ADE information is also available through WebCident. They also perform a search for a diagnosis of diabetes, check the pharmacy records for diabetic medication, and then do a chart review for adverse events.
- Infection control and the Risk Manager work on VAP. The Risk Manager also collects data on VTE through RPMS. PU data are collected through chart review.
- EED data are collected by reviewing the OB log. The hospital states that they only allow induction for medical reasons.
- For patient and community engagement, the hospital had 2–3 community partners for IPC. They have worked on improving communication around adverse events. They also have an advisory health board made up of the 13 Chapters in Shiprock Service Area.

1.2.3: Quality Improvement Initiatives Related to PfP

NNMC has conducted a major QI initiative around SSI, because of increased infections in 2013. They have also participated in a statewide VTE initiative. In addition, they started a multi-disciplinary performance improvement group in 2012 and redesigned patient discharge materials for heart failure patients. They also addressed some issues with the misuse of observation stays through provider education. NNMC participates in a Navajo-wide Quality Managers Group and has worked on a regional collaborative to reduce *C. difficile* infections through improved handoff communication, changes in isolation signage, and environmental cleaning.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Northern Navajo Medical Center

Issue/Challenge	T/TA Recommendations
General/Other	
• Would like to see hospitals be more open and share on more than PfP measures.	
• More topics on OR/Surgical procedures and Success/Adverse Outcomes.	
• Best practices in ER/Pt flow and ICU and restraints.	
• Would like assistance with accreditation issues.	

3: Descriptive Profile

Indian Health Service Hospital: Northern Navajo Medical Center

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Pauline Stubberud – Dir. Quality Services, 30 years IHS, 24 years Shiprock
Year Hospital Established	1950s
IHS Area Office	Navajo
Geographic Area Served	Shiprock, NM, is located in the Four Corners area of the United States where New Mexico, Arizona, Colorado, and Utah meet.
User Population	• Approximately 45,500 Native Americans mostly Navajo Tribally enrolled live in the Service Unit.
Hospital Beds	• # beds: 75 • # staffed beds: 64
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	
Services Available–General	
PfP Awareness at Facility	• General: Fair • Leadership:
PfP Services NOT Available	• N/A
Number of Physicians	• Medical: • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: Approximately 1,200 • Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	

Characteristic	Hospital Description
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 18 mo. Jan. 2012–June 2013 • ADE: 17 mo. Jan. 2012–May 2013 • CAUTI: 17 mo. Jan. 2012–May 2013 • CLABSI: 17 mo. Jan. 2012–May 2013 • SSI: 17 mo. Jan. 2012–May 2013 • VAP: 17 mo. Jan. 2012–May 2013 • PU: 18 mo. Jan. 2012–June 2013 • VTE: 18 mo. Jan. 2012–June 2013 • EED: 19 mo. Jan. 2012–July 2013
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident
Reporting Method – ADE	WebCident. Search for diagnosis of Diabetes, check pharmacy for diabetic med, Chart review for adverse events.
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	Done by Infection/Risk Manager
Reporting Method – PU	Chart review
Reporting Method – VTE	Done w/Risk Manager via RPMS
Reporting Method – EED	OB log reviewed
Number of PfP Measures Not Reported (for services offered within the hospital)	0
Discrepancies on Reporting	1–2 month discrepancy for months of data reported between data sheet and R,Y,G progress sheet for ADEs, SSI, VAP, and PU
QI Measures Implemented due to PfP	
Patient, Family, and Community Engagement	• Had 2–3 Community Partners for IPC—DM and Counseling Center. • Adverse Events—Improving Communication. • Advisory Health Board—each of 13 Chapters in Shiprock Service Area.
Strength Area	
Training and TA Needs Identified	• Would like to see hospitals more open and share on more than PfP measures. • More topics on OR/Surgical procedures and Success/Adverse Outcomes. • Best Practices in ER/Pt. flow and ICU and restraints. • Would like assistance with accreditation issues.

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies between the "PfP Data Reporting Progress for 2013" Chart and the PEC's HEN Monthly Reporting Template.

Oklahoma Area Office

- *Claremore Indian Hospital – Claremore, OK*
- *Lawton Indian Hospital – Lawton, OK*

Claremore Indian Hospital

1: Assessment Summary

1.1: Overview of Claremore Indian Hospital

Claremore Indian Hospital is a 46-bed teaching hospital accredited by the Joint Commission located in Claremore, OK, which is the county seat of Rogers County, part of Tulsa metropolitan area. The hospital serves 17 tribes that are primarily Cherokee Indians, of which there are 317,000 in the State of Oklahoma.

Claremore hospital has embraced the quality improvement aspects of PfP and has initiated many improvements subsequent to reporting and tracking the measures.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Claremore claims that awareness of the PfP is good.

1.2.2: PfP Measures: Reporting Status and Challenges

- Claremore has reported on 10/10 measures for 19–20 months
- Falls are submitted through WebCident, and causes are investigated for each fall by the Safety Officer; additionally, the EOC committee reviews reports monthly.
- ADE–Hypoglycemia is challenging them because the report they are running for hypoglycemia is returning results from the entire Oklahoma Area, not just their hospital. They also would like information regarding how to associate diabetic patients with specific medications and a critical INR with warfarin prescription.
- VTE reporting is challenging because there are so many exclusion criteria; due to these varying criteria for various reporting entities, they need to run excluded and included codes and make two databases.
- They do utilize the RPMS EHR and have access to VGEN, PGEN, and iCare, but they report having a hard time getting the correct RPMS keys to run the reports they need, and RPMS reports do not seem to produce data as consistently as ICare.
- In terms of patient and family engagement, Claremore has included patients on committees in the past on a rotating basis; they report they have good rapport with patients.

1.2.3: Quality Improvement Initiatives Related to PfP

Claremore staff reported extensive QI initiatives focused on PfP measures. These include:

- *ADE–Anticoagulants:* They operate an outpatient anticoagulation clinic, which is staffed by the same staff that sees inpatients. The pharmacy program writes inpatient orders for diet, daily INR checks, and separate orders for each day's warfarin dose. A patient education packet is given to the patient to review 1–2 days before expected discharge and

subsequently discharge teaching is provided, with dietary staff conducting separate instruction.

- *VTE Protocol:* Patients are assessed for risk factors for clotting vs. bleeding to determine the need for VTE prophylaxis level: CBC and BMP are checked for all patients on LMWH and UFH and PTT for patients on unfractionated heparin. Walking is encouraged to reduce risk.
- *SSI:* Approximately 10 surgeons perform 125–140 surgeries per month, of which 12–15 are PfP-reportable procedures, including open hysterectomy, colon, and C-section. They use Operational Plan Risk Assessment to determine the areas of risk, which is based on a matrix developed by Stanford. They have identified problem areas of traffic patterns, clean areas, skin prep, and sterile technique and set a PfP goal for SSI of <1%. They have provided staff training.
- *CLABSI:* They identified that the central line kit in use was incomplete and required staff to obtain other supplies to meet APIC regulations. They found a complete central line kit that would meet their needs available for purchase from Centurion.
- *CAUTI:* They identified that they were stocking latex Foley catheters, which have a higher risk of organism aggregation; they switched to silicone and saw an immediate decrease in the number of CAUTI events.
- *Falls:* A Safety Management Plan is updated annually. The Environment of Care Committee performs a risk assessment annually. They determined that most falls occur in the outpatient setting. Risk factors identified include the use of stools in ER to help patients climb onto beds; to address this, they ordered new, lower beds. They also found that broken chairs in the waiting area were creating fall hazards; these have been repaired/removed, and are all being replaced.
- *PU:* PU protocol requires hourly rounding, Q1H repositioning for chair-bound patients, and Q2H turning for bed-bound patients. They inspect skin on every shift, stress good diet and hydration, and introduced a new form to document PUs upon admission.
- *Readmissions:* They conducted an RCA on readmission in 2005 and started CHF clinic in response to the results. They identified gaps in knowledge and the need to work on distinguishing observation versus inpatient admission status for physicians. They have noted that the highest cause for readmissions now is alcohol withdrawal; these patients often leave AMA when admitted and then bounce back, impacting readmission rates. To address this, they are looking at risks/policies related to admitting or letting people leave when they come to the ER in withdrawal without medical indications for admission.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Claremore Indian Hospital

Issue/Challenge	T/TA Recommendations
Data Collection and Reporting	
• ADE reports returning information for the entire OK area.	• Assistance in refining reports.
• VTE exclusion criteria; management of multiple databases.	• Best practices in data collection.
• ADE anticoagulant needs an automated way to capture all INR values over 4. • Do not know how to associate a critical INR with warfarin prescription.	• Best practices in data collection.
• Access to RPMS keys.	• Training on access methods; definitions of data available for each key.
• Need hands on training with RPMS and how to run searches.	• Query training.
• iCARE.	• Training and practice.
QI Initiatives Related to PfP	
• Plan, do, study, act (PDSA).	• Help with best practices and how to PDSA.

3: Descriptive Profile

Indian Health Service Hospital: Claremore Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Christine Gilliam, PI Officer Christine.Gilliam@ihs.gov Suzanne Chrisco-Wilcox, CNM 918-342-6252 Suzanne.Chrisco-Wilcox@ihs.gov
Year Hospital Established	1977
IHS Area Office	Oklahoma
Geographic Area Served	Claremore is county seat of Rogers County, part of the Tulsa metropolitan area.
User Population	
Hospital Beds	• # beds: 46 • # staffed beds:
Hospital Discharges 2012	
Occupancy Rate 2012	
Services Available–General	
PfP Awareness at Facility	• General: • Leadership:
PfP Services NOT Available	None
Number of Physicians	• Medical: • Surgical: • Other:

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: yes • RPMS EHR: yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan. 2012–Aug. 2013 • ADE: Jan. 2012–Aug. 2013 • CAUTI: Jan. 2012–July 2013 • CLABSI: Jan. 2012–July 2013 • SSI: Jan. 2012–July 2013 • VAP: Jan. 2012–Aug. 2013 • PU: Jan. 2012–Aug. 2013 • VTE: Jan. 2012–Aug. 2013 • EED: Jan. 2012–Aug. 2013
Reporting Method – Readmissions	
Reporting Method – Falls	• Falls are submitted through WebCident, and causes are investigated for each fall by Safety Officer. • EOC committee reviews monthly.
Reporting Method – ADE	
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	
Reporting Method – PU	
Reporting Method – VTE	• VTE reporting is challenging because there are so many exclusion criteria. • Need to run excluded and included codes and make two databases.
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	

Characteristic	Hospital Description

QI Measures Implemented due to PfP	• Falls: A Safety Management Plan is updated annually.
	• Environment of Care Committee performs risk assessment annually. Several problem areas were identified:
	  o Most falls are in outpatient.
	  o Stools were being used in ER to help patients climb onto beds; ordered new lower beds.
	  o Chairs in waiting area were broken and creating fall hazards; chairs have been repaired/removed and are all being replaced.
	• ADE–Anticoagulants
	  o They have an outpatient anticoagulation clinic staffed by the same staff that sees inpatients.
	  o Pharmacy program writes inpatient orders for diet, daily INR checks, and separate orders for each day's warfarin dose.
	  o Patient education packet is given 1–2 days before expected discharge to review before discharge teaching is performed.
	  o Dietary department does its own teaching.
	• CAUTI: Identified fact that they were stocking latex Foleys, which have a higher risk of organism aggregation.
	  o Switched to silicone—saw immediate decrease in CAUTI.
	• CLABSI: Identified fact that central line kit in use was incomplete; required staff to use other supplies to meet APIC regulations.
	  o Sometimes these supplies were out of stock.
	  o Found a complete central-line kit that would meet their needs available for purchase from Centurion.
	• SSI: 10 surgeons total; 125–140 surgeries per month.
	• 12–15 PfP procedures per month: open hysterectomy, colon, C-section.
	• Use Operational Plan Risk Assessment to determine areas of risk.
	  o Based on a matrix developed by Stanford.
	  o Identified problem areas—traffic patterns, clean areas, skin prep, sterile technique.
	  o Set goal for SSI of <1%.
	  o Conducted staff training.
	• PU: Protocol in place requires hourly rounding.
	  o Q1H repositioning for chair-bound patients; Q2H turning for bed-bound patients,
	  o Stress good diet and hydration,
	  o Inspect skin on every shift,
	  o New form to document PUs upon admit introduced.
	• VTE: Patients assessed for risk factors for clotting vs. bleeding.
	  o Assessment determines need for VTE prophylaxis level.
	  o CBC and BMP checked for all patients on LMWH and UFH.
	  o Also check PTT for patients on unfractionated heparin
	  o Walking is encouraged.

Characteristic	Hospital Description
Patient, Family, and Community Engagement	• Have included patients on committees in the past on a rotating basis. • Report good rapport with patients.
Strength Area	
Training and TA Needs Identified	• Need hands-on training with RPMS on how to conduct searches. • More practice with iCare. • Information about what "keys" they need to run necessary reports through RPMS. • Help with PDSAs and best practices related to the PfP measures. • RPMS reports do not seem to produce consistent data. • Hypoglycemia is challenging because the report they are running for hypoglycemia is returning results from the entire Oklahoma Area, not just their hospital. ○ Also want to know how to associate diabetic patients with specific medications. • ADE: Need an automated way to capture all INR values over 4. • Do not know how to associate a critical INR with warfarin prescription—is this a lack of knowledge about running reports?

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Claremore:

- EED is shown as "Z–Hospital does not provide services related to this HAC" on the PEC Chart, but is shown as reporting for ~2 years on the IHS Data Reporting Progress Chart.
- PU is shown as "1–Engaged in work related to HAC, but not submitting to IHS HEN, but is shown as reporting for ~2 years on the IHS Data Reporting Progress Chart.

Lawton Indian Hospital

1: Assessment Summary

1.1: Overview of Lawton Indian Hospital

The Lawton Indian Hospital, established in 1923, is a 26-bed hospital (currently staffed for 15 beds) that is located in the southwest corner of Oklahoma. Lawton provides health services to 23,000 beneficiaries from seven tribes—Caddo, Delaware, Comanche, Apache, Ft. Sill Apache, Kiowa, and Wichita—and operates two ambulatory clinics, in Anadarko (40 miles from Lawton) and Carnegie (27 miles west of Anadarko).

The facility offers inpatient care including general surgery, gynecology, internal medicine, and pediatrics, as well as outpatient services in medicine, dentistry, pharmacy, radiology, laboratory, nursing, optometry, podiatry, and audiology. They do not operate an ICU or offer labor and delivery services.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

They believe people are aware of the PfP because they have discussed it at meetings.

1.2.2: PfP Measures: Reporting Status and Challenges

- They get readmissions from NDW but they do not know when they will get it and if people are transferred out. They run reports on RPMS then check the charts, so it requires a fair amount of manual effort.
- Falls are recorded and tracked in WebCident. The fall team performs a huddle after a fall to investigate the event.
- ADE reporting on hypoglycemia and anticoagulation is initiated by matching a list of diagnoses with admitted patients, then searching RPMS and reviewing the records. Most patient files are on the EHR, but the hospital still has some paper records.
- CAUTI reporting began in July 2012. Infection Control staff collects data using NHSN guidelines and have done this for many years for Joint Commission. They can run a list on RPMS but do chart reviews since the census is so small.
- CLABSI data is acquired through chart review, comparing patients with central lines against NHSN guidelines. Chart review is possible because they have few central lines.
- Infection Control performs SSI chart reviews. They report hysterectomies and abdominal surgeries to CMS and follows all surgeries for 30 days to see if infection develops.
- VAP is not an issue; patients needing ventilators are transferred. Lawton has CPAP and no ICU.
- PU tracking is performed by running an RPMS diagnostic report for all patients; if there is a positive at admission or discharge, they consult the record to see when the PU was acquired.

- VTE tracking is also conducted by running diagnosis codes against all inpatients and then pulling the chart to determine whether the patient was admitted with the VTE or developed the VTE while an inpatient.
- EED is not reported because they stopped deliveries 6–7 years ago. Live births at the facility are the result of emergencies.
- In terms of patient and family engagement, they have a hospital governing body from IHS Area and a Tribal Health Board that meets monthly; they also have projects such as the Kids Carnival last August involving all the tribes (back-to-school health fair—200 children, 500 people altogether), the Education Fair in the spring when the fire department and police come to provide information on fire prevention, tornado evacuation, and other safety measures. They work with the tribes and use all of their resources to provide training for the hospital and the community.
- In terms of engaging individual patients, they are considering a diabetic measure monitored for the Area Office (hemoglobin 9.5). They want to get patients to be more compliant and engaged in the process by dealing with the lifestyle changes they need to make. They are considering having special diabetes clinic and group education classes. They do have a diabetes program to engage people in exercise, use the gym, and go on group walks. One of their fall initiatives is to give family members a pamphlet for patients at risk.

1.2.3: Quality Improvement Initiatives Related to PfP

Lawton Quality Improvement includes performance improvement, risk management, compliance, GPRA, and Joint Commission. The UR nurse conducts utilization review and discharge planning. They report GPRA to the OK Hospital Association for CMS and HCAHPS. The PI has a safety program on falls and injuries (staff and patients), pharmacy medication errors, ADE, and intensive patient satisfaction surveys. They examine nurse call-back times, perform RCAs and failure analysis, and issue a 70-page QI report every quarter.

Lawton has a fall team and decreased the number of falls 2 years prior to PfP. They are closing in on 3.4 falls, with some small variance. They have instituted hourly rounding, special socks, new beds, and a new screening and assessment process and tool.

Readmissions are being addressed with a discharge planning team, which has revised the discharge planning committee and the way they conduct discharges. The discharge planner meets daily with patients and the nurse on the floor to look at barriers that prevent the patient from going home, and a pharmacist performs call-back 2 days after discharge to reconcile medications. The pharmacy medication reconciliation call to patients is something they learned about on a webinar and implemented. While they try to have anyone available on the team attend webinars, they are a small organization with people wearing many hats, making it difficult to find the time.

SSI and CAUTI numbers are low, so there has not been a need for many initiatives on those two measures.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Lawton Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Increase general awareness.	• Best practices.
Data Collection and Reporting	
• Data collection methods.	• Queries and other methods to reduce manual review.
QI Initiatives Related to PfP	
• Patient engagement.	• Best practices on patient activation, compliance and lifestyle changes.

3: Descriptive Profile

Indian Health Service Hospital: Lawton Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Michael Holmes – Director of Quality, IHS 19 years, Lawton 4; Primary PfP contact
Year Hospital Established	1923
IHS Area Office	Oklahoma
Geographic Area Served	Southwest corner of OK
User Population	23,000
Hospital Beds	• # beds: 26 • # staffed beds: 15
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	7
Services Available–General	Surgery; full range of ambulatory —BH, dental, optometry, PT, cardiology consults, rheumatology, OB-GYN, internal medicine, pediatrics, behavioral health. Two ambulatory clinics, Anadarko (40 miles from Lawton), Carnegie (27 miles west of Anadarko); small inpatient and large ambulatory population
PfP Awareness at Facility	• General: Think people are aware. Difficult to have meetings with everyone who needs to be there. They have talked about it but hard to get everyone together. • Leadership:
PfP Services NOT Available	No ICU, no L&D
Number of Physicians	• 40 on staff: 2 surgeons, 3 FP, 3 FP midlevels, internal 2 MD and 2 midlevels, 2 podiatrists, 2 pediatricians, 2 MD in women's clinic, 2 midlevels, 1 psychiatrist, 2 dentists, 1 pediatric dentist, 1 oral surgeon, 1 optometrist, 1 psychiatrist, 2 anesthesiologists, hospitalist, ER doctors . • Anadarko 2 FP, 1 Pediatrician, 1 PA and I ANP. • Carnegie: 1 MD optometrist goes 2 times a week, as does the podiatrist.

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Total: 286 • Service Unit CEO: • Hospital Administrator: • RNs: 60–65 • LPNs: • Pharmacists: 12 at Lawton, 3 Anadarko, 1 at Carnegie • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	75
Quality Management/QI Manager/Staff, Number and FTE	Have PI, risk management, compliance, GPRA, and Joint Commission. UR nurse does utilization review and discharge planning. They report GPRA, report to OK Hospital Association for CMS, HCAHPS. PI has safety program on falls and injuries (staff and patients), pharmacy medication errors, ADE, and intensive patient satisfaction surveys. Have been looking at nurse call back times. Do RCAs and failure analysis. 70-page QI report every quarter.
Software Systems and Database Capacity	• RPMS: • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan. 2012–Aug. 2013 • ADE: Jan. 2012–Aug. 2013 • CAUTI: July 2012–July 2013 • CLABSI: Jan. 2012–July 2013 • SSI: Jan. 2012–July 2013 • VAP: Jan. 2012–July 2013 • PU: Jan. 2012–Aug. 2013 • VTE: Jan. 2012–Aug. 2013 • EED: Jan. 2012–Aug. 2013
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident; a fall team that does a huddle after a fall.
Reporting Method – ADE	Reporting on hypoglycemia and anticoagulation: Go through the hospital with list of diagnoses against admitted patients; match to diagnoses and investigate in RPMS. Review records. Most on EHR, but still some paper records.
Reporting Method – CAUTI	Reporting since July 2012; collect using NHSN guidelines and have done this for many years for Joint Commission. Infection Control collects the information. They can run a list on RPMS but do chart reviews since census is so small.

Characteristic	Hospital Description
Reporting Method – CLABSI	Have few central lines; look for patients with central lines and do chart review and also use the NHSN guidelines.
Reporting Method – SSI	Infection Control also does chart review. Reports to CMS for hysterectomies and abdominal surgeries—follow all surgeries for 30 days to see if infection develops.
Reporting Method – VAP	Do not use ventilators. Have CPAP, no ICU; if patients need a ventilator they are transferred.
Reporting Method – PU	Do that by looking for diagnosis, run on RPMS for all patients; if positive for admission or discharge, look at record to see when the PU was acquired.
Reporting Method – VTE	Run diagnosis codes against all inpatients and then pull chart to see if admitted with or developed while inpatient.
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	Stopped deliveries 6–7 years ago; live births are emergencies only
QI Measures Implemented due to PfP	• Have fall team and decreased the number of falls two years prior to PfP. Getting close to 3.4 falls, some small variance. Have instituted hourly rounding, special socks, fall risk assessment includes people who are detoxing, new beds, new screening, and assessment process and tool. • Readmissions: working on discharge planning team; revised discharge planning committee and the way discharges are done. Meet daily with patients with discharge planner; nurse on floor and look at barriers that prevent them going home; pharmacist does call-back 2 days after discharge to reconcile medications. • Have PfP committee hours and look at interventions others are doing and try to bring those into place

Characteristic	Hospital Description
Patient, Family, and Community Engagement	• They have a hospital governing body from IHS Area and a Tribal Health Board they meet with monthly; other projects include the Kids Carnival last August involving all the tribes (back-to-school health air— 200 kids, 500 people altogether). Have Education Fair in the spring—fire and police come to provide information on fire prevention, tornado evacuation. Work with tribes and try to use all of their resources to provide training for staff and the community. • Individual patients: Considering a diabetic measure monitored for Area Office—hemoglobin A1c of 9.5. Need to get patients to be more compliant and engaged in the process by dealing with the lifestyle changes they need to make. Beginning work on creating a special diabetes clinic and group education classes. Have a diabetes program to engage people in exercise, use the gym, group walks.
Strength Area	
Training and TA Needs Identified	• If there is any way to better collect data they would like to learn about it. Get readmissions from NDW but do not know when they will receive it. If people are transferred out, hard to get information on that. • Run reports on RPMS then have to check the charts. so is a fair amount of manual effort. • Would like to hear about engagement of patients on compliance with treatment (blood pressure and diabetes) because they need to take their medications and change lifestyle; teach and educate but patients need to make lifestyle changes. Wear many hats as limited staff at small facility and everyone is busy, so it is hard to get things done. Looking for anything that will make data collection easier

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies reported between the PfP Data Reporting Progress for 2013 Chart and the HEN Monthly Reporting Chart.

Phoenix Area Office

- *Hopi Health Care Center – Hopi, AZ*
- *Parker Hospital – Parker, AZ*
- *Phoenix Indian Medical Center – Phoenix, AZ*
- *San Carlos Indian Hospital – San Carlos, AZ*
- *Whiteriver Indian Hospital – Whiteriver, AZ*

Hopi Health Care Center

1: Assessment Summary

1.1: Overview of Hopi Health Care Center

The Hopi Health Care Center is located on the Hopi Reservation and serves approximately 7,000 people from both the Hopi and Navajo tribes. This Service Unit site was selected for its central accessibility, where most residents can reach the Center within 30 to 45 minutes. The facility is an accredited critical access hospital offering a 2-bed birthing unit, a 4-bed medical/surgical adult/pediatric unit supported by a staff of 12 physicians and 3 physician extenders. The hospital provides general family medical care, surgical follow-up, and pediatric and obstetric services. An eye clinic, staffed by two optometrists, provides refraction and general eye care. Seven dentists stationed at the Center and at a satellite clinic provide dental services. Major trauma, acute surgical emergencies, and high-risk obstetric patients are transported to Tuba City Indian Medical Hospital, Chinle Hospital, Phoenix Indian Medical Center, or to several contracted health facilities.

Hopi Health Care Center began their falls prevention program before the PfP and provides enhanced discharge planning that links patients to social services and makes a follow-up appointment before the patient leaves the facility.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Hopi Health Care Center reports general PfP awareness as fair but leadership awareness as absolute.

1.2.2: PfP Measures: Reporting Status and Challenges

- Hopi Health Care Center does not perform surgeries but performs low-risk deliveries; they utilize central lines and ventilators only for transport. They are reporting on falls, CAUTI, and ADEs.
- WebCident is used for falls reporting, and each patient is assessed on admission. They are reporting falls in the inpatient area only; they have implemented bed alarms and feel that they have a good falls program in place. Their falls program was in place before the PfP but they would like to do more.
- ADE is tracked with a laboratory package for hypoglycemia and with pharmacy tracking of anticoagulation patients.
- Patient and family engagement includes community partners on the Governing Board and housing tribal programs at the facility. They also have dialysis in house contracted by the hospital. They have a baby-friendly OB environment with public health nurses making home visits within 5 days of delivery for wellness checks. All inpatient discharges include social services assessment and clinic appointment for follow-up care.

1.2.3: Quality Improvement Initiatives Related to PfP

Quality management consists of the Director and the Safety Officer. Hopi participated in the IPC and implemented the medical home model; three teams worked on the project using iCare data. QI initiatives specific to PfP measures include the following:

- Excessive cases of hypoglycemia were noted by the new supervisor of the inpatient unit, and a new protocol and policy were developed and implemented to address this issue.
- CAUTI policy and tracking are working well, with the exception of indwellings without a UA completed.
- Falls – Each patient is assessed on admission; Hopi installed bed alarms and expanded facility-wide with PfP but want to further improve their fall prevention program.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Hopi Health Care Center

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Build general awareness.	• Best practices.
Data Collection and Reporting	
• Readmissions	• Best practices.
QI Initiatives Related to PfP	
• Falls	• Best practices.

3: Descriptive Profile

Indian Health Service Hospital: Hopi Health Care Center

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	LeeAnn Beach – Acting CNE, IHS 13 years/Hopi 2 years
Year Hospital Established	
IHS Area Office	Phoenix
Geographic Area Served	Hopi Reservation, AZ
User Population	7,000 Hopi and Navajo
Hospital Beds	• # beds: 4 medical, 2 birthing • # staffed beds:
Hospital Discharges 2012	
Occupancy Rate 2012	
Services Available–General	General family medical care, surgical follow-up, pediatric and obstetric services, vision, dental
PfP Awareness at Facility	• General: Fair • Leadership: Absolute
PfP Services NOT Available	Surgery, central line, ventilators
Number of Physicians	• Medical: • Surgical: • Other:

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: • RPMS EHR: L&D paper only, ED 50%
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: Jan. 2012–May 2013 • ADE: Jan. 2012–May 2013 • CAUTI: Jan. 2012–Mar. 2013 • CLABSI: • SSI: • VAP: • PU: • VTE: • EED:
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident
Reporting Method – ADE	• Using lab package for hypoglycemia. • Pharmacy tracks anticoagulation patients.
Reporting Method – CAUTI	
Reporting Method – CLABSI	
Reporting Method – SSI	
Reporting Method – VAP	Transport only
Reporting Method – PU	
Reporting Method – VTE	Transport only
Reporting Method – EED	
Number of PfP Measures Not Reported (for services offered within the hospital)	
Discrepancies on Reporting	

Characteristic	Hospital Description
QI Measures Implemented due to PfP	• Hypoglycemia: Protocol and policy developed and implemented. • CAUTI policy and tracking working well, with the exception of indwellings without UA completed. • Falls: Reporting on inpatient only; good falls program in place; assessment is done on admission; bed alarms installed; risk stratify; using falls program facility-wide because of PfP.
Patient, Family, and Community Engagement	Community partners on Governing Board.
Strength Area	
Training and TA Needs Identified	PfP awareness and best practice training for readmissions and falls.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Hopi:

- Readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but are shown as reporting for ~4 years on the IHS Data Reporting Progress Chart.
- ADE is shown as "2–Engaged in work related to HAC AND submitting data to the IHS HEN" but is not shown as reporting on the IHS Data Reporting Progress Chart.

Parker Hospital

1: Assessment Summary

1.1: Overview of Parker Hospital

Parker Hospital is a 15-bed critical access hospital located in Parker, AZ. Their user population is 4,700, which includes five tribes in the Colorado River Service Unit. They have outpatient facilities in three States (California, Arizona, and Nevada), which creates some challenges for them in areas such as billing for services. They do not offer surgery, labor and delivery, ventilators, or an ICU. Their average daily census is one to two patients, who are admitted mostly for wound care. There are a total of 268 staff members, including a new data abstractor nurse who is working on PfP.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Awareness of PfP at Parker is generally good, and the CEO is very involved. The biggest challenge is staff not realizing how it impacts them, so a presentation was recently given to the supervisors about what PfP is and how it can be helpful. They are very grateful to have access to Frank Stein, who is very knowledgeable about PfP and provides education to the staff in the clinic.

Parker staff members have participated in several of the PfP calls and webinars. They have also accessed the Web site but had a hard time sifting through the information to find something useful to their facility.

Despite good awareness, they need some clarification on when to report and who to send their reports to. They are not sure they are getting all of the information they need.

1.2.2: PfP Measures: Reporting Status and Challenges

- Parker is currently reporting ADEs, CAUTI, PUs, and VTE. They say they have reported for a full year, but the October 2013 reporting spreadsheet only shows 5 months of data. They are exempt from reporting CLABSI, SSIs, VAP, and EEDs. They have not reported falls.
- In general, they are concerned with the definitions for the reporting. They have been confused and are concerned about whether they have always used the correct definitions, rather than adding unnecessary things.
- A statistician was collecting all of the data for the Chief Nursing Officer, but they do not know what procedures were used. A new nurse data abstractor will now be doing the data collection.
- In the area of patient and family engagement, they have whole care case management under patients' rights and advocacy. They have a health board meeting every month and also meet with other communities to keep them informed about what they are doing.

1.2.3: Quality Improvement Initiatives Related to PfP

The only quality improvement identified related to the PfP is a falls program. They also have unrelated QI initiatives such as Rapid Response.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Parker Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Uncertain about when and who to report to.	• Clarify reporting deadlines and provide contacts and instructions for submission.
Data Collection and Reporting	
• New data abstractor is replacing statistician who was doing data collection.	• Provide education about measures and the PfP.
• Concerned about definitions for measures.	• Walk through questions about individual measures one on one or in a small group.
• Reporting sheet does not contain full year of data they state they have reported.	• Check most recent reporting spreadsheets for data, and if it is not there, work with hospital on procedures to ensure that collected data are reported properly.

3: Descriptive Profile

Indian Health Service Hospital: Parker Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Sherry Killingsworth – Chief Nursing Officer, IHS for 18 years, Parker for 18–19 months
Year Hospital Established	Current building is 12 years old.
IHS Area Office	Phoenix
Geographic Area Served	Parker, AZ, is a border town. Outpatient facilities in three States (California, Arizona, and Nevada), which creates some challenges. Critical access hospital.
User Population	• 4,700 – about 15 tribes. The reservation population is a mix of Hopi, Navajo, Chemehuevi, Hualapai, Havasupai, and Fort Mojave.
Hospital Beds	• # beds: 15 • # staffed beds:
Hospital Discharges 2012	
Occupancy Rate 2012	1–2
Services Available–General	• Outpatient clinics in three States.
PfP Awareness at Facility	• General: They have Frank Stein (one of the PfP gurus), so they are grateful to have access to him and his partnership. He provides education to the staff in the clinic. They just showed a PowerPoint presentation to the supervisors about what PfP is and how helpful it can be. • Leadership: CEO is very involved with PfP.

Characteristic	Hospital Description
PfP Services NOT Available	• Surgery • Ventilators • Central lines • Labor & delivery
Number of Physicians	• Medical: 9 • Surgical: • Other: 3 NPs
Number of Staff FTE, by Type of Personnel	• Total: 268 • Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: 3 • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: • RPMS EHR:
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 0 – not reporting • ADE: 5 mo. Jan.–May 2013 • CAUTI: 4 Mar.–June 2013 • CLABSI: 0 exempt • SSI: 0 – exempt • VAP: 0 – exempt • PU: 5 mo. Jan.–May 2013 • VTE: 5 mo. Jan.–May 2013 • EED: 0 – exempt
Reporting Method – Readmissions	
Reporting Method – Falls	
Reporting Method – ADE	Podiatrist/statistician was pulling data for all measures, but person on call does not know how. Now have new data abstractor nurse.
Reporting Method – CAUTI	Podiatrist/statistician was pulling data for all measures, but person on call does not know how. Now have new data abstractor nurse
Reporting Method – CLABSI	N/A – exempt
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	Podiatrist/statistician was pulling data for all measures, but person on call does not know how. Now have new data abstractor nurse

Characteristic	Hospital Description
Reporting Method – VTE	Podiatrist/statistician was pulling data for all measures, but person on call does not know how. Now have new data abstractor nurse
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	1 – Falls
Discrepancies on Reporting	• Hospital says they have reported for a year, but data spreadsheet shows 4–5 months.
QI Measures Implemented due to PfP	• Fall prevention program that was put into place.
Patient, Family, and Community Engagement	• Whole care case management under patients' rights and advocacy. • Health board meeting every month; second Wednesday of each month. They have one every other Wednesday with the other communities. We give updates on everything we are doing. They give feedback on how the community is seeing us. • Education on infectious disease.
Strength Area	
Training and TA Needs Identified	• Education about the definitions for the measures. • Education on when to report and whom the report should go to. • New data abstractor is replacing statistician who was doing data collection. • Reporting sheet does not contain full year of data they state they have reported.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Parker:

- VTE, PUs, and readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but are shown as reporting for <1 year on the IHS Data Reporting Progress Chart.

Phoenix Indian Medical Center

1: Assessment Summary

1.1: Overview of Phoenix Indian Medical Center

Phoenix Indian Medical Center (PIMC) is located in Phoenix, AZ. It shares a campus with NIH, which occupies the fifth floor of the building. They are licensed for 127 beds and staff between 40 and 60 beds; the average daily census is 31 to 32 patients. The hospital serves a user population of 68,000 people, including six tribes representing about 15,000 people. The rest are urban Indians.

They have a large same-day surgery program and a good ambulatory service. Internal medicine and family practice doctors serve the outpatient clinics, and hospitalists do the inpatient work. In total, there are about 1,100 full-time staff members, with a turnover of 34 percent in 2013.

A PIMC pharmacist developed the method for collecting ADE data, which is described in the instructions tab on the reporting spreadsheet. They also have an excellent wound care team and procedures related to PUs.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

Leadership is aware of PfP because Performance Improvement reports the data to the Quality Council, which the executive team attends, as well as to the Governing Body. Despite their awareness, staff members state that their executives need to learn that not everything is available as a canned RPMS report or even as a report they can design and pull from a computer. Chart review is necessary and it takes time. They need more awareness of the resources required. They cannot just "wish" for change; they need people with the right competencies and resources.

They do attend webinars, but the owners of the data do not always participate when they probably should. There are so many other duties people need to perform. They did learn that their readmission rate is very low and learned about how data are collected from the NDW.

1.2.2: PfP Measures: Reporting Status and Challenges

- PIMC is reporting data for all of the PfP measures, and they are not exempt for any measure. For readmission, they get data from their State QIO. Falls data are collected through WebCident.
- ADE data are collected by the Assistant Chief of Pharmacy using RPMS pharmacy data. A data report is pulled on all patients with diabetes, and then they look for hypoglycemic events. The same process is used with excess anticoagulation. Their pharmacist developed the method for pulling ADE reports for PfP, and this is the basis of the instructions in the reporting spreadsheet.
- CAUTI data are collected by the Infection Prevention program. They go through the RPMS system and manually check the records for every patient with a Foley to find infections. They put all the catheter patients together manually to count catheter days.

CLABSI is done the same way, except they search for patients with central lines instead of Foleys.

- For SSI, PIMC tracks their small bowel procedures. They use a system to log all surgeries in detail, and they use this log then check microbiology reports and track each patient back for 30 days.
- Because of the low utilization of ventilators, VAP data are collected from an ICU log, and they check daily for ventilator patients.
- PU data are collected and submitted by the wound care nurses on a monthly basis. They have two dedicated wound care staff, and every patient receives an assessment using the Braden scale on admission.
- For VTE, PIMC has created a computer template using ICD-9 codes to search RPMS.
- The Director of Maternal Child Health reviews 100 percent of deliveries. They do not offer elective inductions or C-sections so there are no EEDs. In general, they find that overdue babies are more of a challenge for their facility.
- At this point, they feel like they either need more time or need someone else to do the data abstraction so that they have time to work with the data. In addition, software to make the data look "prettier" would be nice.
- In the area of patient and family engagement, PIMC has a community public health program, because they are metropolitan and there is no reservation. They have a tribal advisory group that deals with the six service unit tribes that are on average an hour away from PIMC. There is an area Master Plan that all tribes contributed to, and tribal members are invited to governing board meetings. They do not really have a "community" and struggle to find a way for the urban Indians to navigate. They conducted a survey that the executive committee went off campus to get comments for and they got 1,300 responses.
- There is a lot of patient engagement going on in primary care, and communication with nursing is a big one there. They have found that patients really like to talk to their nurses, and since inpatient is really trying to do that, their HCAHPS results have increased. They are engaging patients in rounds and trying to reduce noise. They also try to have a lenient approach to families contributing to health care at admission and on surgery floors.

1.2.3: Quality Improvement Initiatives Related to PfP

PIMC has implemented QI initiatives for several PfP measures. They already have relatively low readmission rates, but they are implementing Project RED to bring their rate down further.

They are also completely revamping the falls program. They were using Morse but are now transitioning to the Heindrich II scale. Nurses can order a sitter. They now have the lowest number of falls ever for their facility, and they think it will drop to zero soon. Staff attributes this decrease to more assertive hourly rounding and more emphasis on improving care.

In order to address hypoglycemic events, they completely revamped their sliding-scale insulin using current evidence-based literature, and for PUs, they standardized all of their wound care materials and supplies.

PIMC says that their numbers of harm events for PfP are really low, and they might need to do something else that better represents the challenges they are having. Examples include looking at all falls, as opposed to just falls with harm. They expressed a need to look at turnaround time for lab, radiology, wait time in the ED, and wait time for transfer. Things like that would have meaningful alignment with improving quality for their patients.

According to PIMC staff, quality discussions get drowned out by the "problem of the day" as well as other requirements such as GPRA, the 10th Scope of Work, and Joint Commission surveys. In general, PIMC tends to be a resource for other IHS hospitals because they are so large. One of their issues involves needing to know how to use the data and present it to others in a meaningful way.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Phoenix Indian Medical Center

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Poor executive-level awareness of resources required for PfP.	• Invite executive staff to leadership-oriented PfP events.
Data Collection and Reporting	
• Would like software to present data better.	• Identify any software solutions available in the IHS system.
• Does not offer elective induction or C-section.	• Clarify whether this makes them exempt for reporting EED.
• Have identified other measures that would be more useful to them.	• Share possible modifications to measures or alternative measures with IHS leadership.
General/Other	
• If someone could abstract the data so that they have time to analyze and do something with it, that would be helpful.	

3: Descriptive Profile

Indian Health Service Hospital: Phoenix Indian Medical Center

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Ty Reidhead – CEO
Year Hospital Established	1970
IHS Area Office	Phoenix
Geographic Area Served	Tri-state area of Arizona, Nevada, and Utah
User Population	• User population is 68,000 AI/AN, 6 tribes representing 15,000 people – the other 50,000 are urban Indians.
Hospital Beds	• # beds: 127 • # staffed beds: 40–60

Characteristic	Hospital Description
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	ADC is 37.95, including NIH research; 31–32 not research.
Services Available–General	• Large same-day surgery program (85% of surgeries) • Internal medicine • Family practice • Labor & delivery • Orthopedics • Anesthesia
PfP Awareness at Facility	• General: Lots of awareness. • Leadership: PI reports to the Quality Council, which the Executive Team attends; Governing Board meets quarterly and PfP data are presented to them.
PfP Services NOT Available	None
Number of Physicians	• Medical: 37 • Surgical: 22 • Other: 53
Number of Staff FTE, by Type of Personnel	• Approximately 600 clinical staff; total FTEs 1,100 • Service Unit CEO: • Hospital Administrator: • RNs: 188 • LPNs: 18 • Pharmacists: 40 • Allied Health: 3 • Physicians: 112 • Other Health: 37 • IT/Data Management/CAC: 15 • Data Entry: 22 • Medical Records: 32 • Billing: 28 • Other: PT Registration and Benefit Coordinators – 65 • Other Support Staff: Approximately 568
Shared Staff With Service Unit Clinic(s)	Nursing and physician staff at Salt River Clinic.
Staff Turnover Rate, by Type of Personnel	37% turnover—mostly among low-level support staff.
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	6
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes

Characteristic	Hospital Description
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 8 mo. Jan.–Aug. 2013 • ADE: 8 mo. Jan.–Aug. 2013 • CAUTI: 8 mo. Jan.–Aug. 2013 • CLABSI: 8 mo. Jan.–Aug. 2013 • SSI: 8 mo. Jan.–Aug. 2013 • VAP: 7 mo. Jan.–July 2013 • PU: 8 mo. Jan.–Aug. 2013 • VTE: 8 mo. Jan.–Aug. 2013 • EED: 7 mo. Jan.–July 2013
Reporting Method – Readmissions	Get info from QIO.
Reporting Method – Falls	WebCident; acting Director of Nursing meets with all the nurse managers on falls.
Reporting Method – ADE	Assistant Chief of Pharmacy uses RPMS pharmacy data, looks at data report on all patients with diabetes, and then looks for hypoglycemic events; the same with anticoagulation—pulls similar type of report.
Reporting Method – CAUTI	Infection Prevention program collects this for CMS and CDC. Done through RPMS system, through laboratory, manual process. Looks at every patient with Foley; looks for infections. Puts it all together to track catheter days.
Reporting Method – CLABSI	Done through RPMS system, through laboratory, manual process. Looks at every patient with central line; looks for infections.
Reporting Method – SSI	Have a system (In System) where all surgeries are entered in great detail; she looks at this and microbiology and traces the patients for 30 days.
Reporting Method – VAP	Checks every day for any ventilators; have a book in ICU where everything is tracked.
Reporting Method – PU	100% check using Braden scale for every admission. Wound care nurse sends stats every month.
Reporting Method – VTE	Have created a computer template using ICD-9 codes; also extract and report to CMS. Use RPMS, looks for codes and have zero.
Reporting Method – EED	The Director of Maternal Child Health reviews 100% of deliveries.
Number of PfP Measures Not Reported (for services offered within the hospital)	0
Discrepancies on Reporting	• 1–2-month discrepancy between months of data in reporting spreadsheet and R,Y,G progress sheet for all measures except CLABSI and SSI. • Only does induction or C-section when there is a high-risk event. Some sites with L&D are exempt when they state this, and others are not.

Characteristic	Hospital Description
QI Measures Implemented due to PfP	• Readmissions: Project RED is being implemented; getting pieces together to implement it, which should take readmissions down lower. • ADEs: Got sliding-scale insulin completely revamped using current evidence-based literature. • Falls: Completely revamping falls program to transition to Heindrich II scale; will retrain staff. Nurses can order sitter. Now the lowest number of falls ever. Staff attributes this to more assertive hourly rounding and more emphasis on improving care.
Patient, Family, and Community Engagement	• Have a community field health, public health program, since we are metropolitan and there is no reservation. • Have a tribal advisory group that deals with the six service unit tribes that are on the average an hour away from here. They are rural. • Have an area Master Plan that all tribes contributed to. • Try to have a lenient approach to families contributing to health care at admission and on surgery floors. • Tribal members are invited to governing board meetings. We do not really have a "community" and struggle to find a way for the urban Indians to navigate. Navajos are 40% of our users and they are not even part of our service unit. • Had a survey; executive committee went off campus to get comments; got 1,300 surveys. • There is a lot of patient engagement going on in primary care; communication with nursing is a big one there. We have found that patients really like to talk to their nurses, and since inpatient is really trying to do that, our HCAHPS results have increased because they are engaging patients in rounds and trying to reduce noise.
Strength Area	• Their pharmacist invented how the RPMS reports are done for ADEs for PfP (basis of instructions in reporting spreadsheet). • They have created a dashboard for PfP that contains a graph, narrative and any PDSA for each measure.

Characteristic	Hospital Description
Training and TA Needs Identified	• Want to know how to use the data and present it to others in a meaningful way. • If someone could abstract the data so that they have time to analyze and do something with it, that would be helpful. • Software to make the data look "prettier" would also be nice. • Poor executive-level awareness of resources required for PfP. • Does not offer elective induction or C-section—should they be exempt from EED? • Possible changes in measures; have identified others that would be more useful to them.

4: Summary Analysis of Hospital's Data Reporting Status

There are no discrepancies between the IHS "PfP Data Reporting Progress for 2013" and the PEC's "HEN Monthly Reporting Template."

San Carlos Indian Hospital

1: Assessment Summary

1.1: Overview of San Carlos Indian Hospital

San Carlos Indian Hospital is located in the town of San Carlos on the San Carlos Apache Indian Reservation in East-Central Arizona. They serve about 12,000 patients with 8 inpatient beds. The hospital had (b) (3) (A) discharges in 2012 and an average daily census of 0.5 to 0.8. They will be moving to a new, larger facility this year, and this will present increased challenges with staffing. The tribe has announced its intent to take over the hospital, but how this will happen is unclear at this point.

The hospital is eager to improve their recruiting and retention, and they identified several other areas where they would like assistance moving forward.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

San Carlos staff described the awareness of PfP at their facility as "zero." There is a lack of management support and direction to get people together to talk about the initiative. High turnover has also impacted awareness because some of the people championing it are now gone. The current PfP lead has only been responsible for it since last week. Recruitment and retention is an issue they would like help with.

San Carlos did participate in the WebHSOPs webinar, but they would like a different date and time so that they can get more people to participate. Unfortunately, staff members have been uninterested in calls they have attended because the content did not apply to them. Because of their workload, they need to be sure they have the key people related to the topics discussed on the correct calls. It would be helpful to have a list of topics ahead of time so that they have enough time to decide who should attend them.

1.2.2: PfP Measures: Reporting Status and Challenges

- According to San Carlos Indian Hospital staff, they submitted PfP data to Area at the end of December to close out the year. They are reporting on readmissions, falls, ADEs, CAUTI, CLABSI, PUs, and VTE. They do not offer surgery, ventilators, or labor and delivery, so they are exempt from reporting on SSI, VAP, and EED.
- The hospital had four readmissions in 2013. The most common cause was cellulitis and infections in diabetic patients. They identify the readmissions themselves and review each case in the electronic health record (EHR). They have not used the alternate measure for readmissions.
- Falls are reported through WebCident. They look over the reports and direct them to the correct department to make sure any process changes are made. Cases are discussed with Quality Council or Risk Management.

- ADEs are also reported through WebCident, including dosing mistakes. Anticoagulation clinic is suspended for "issues." Pharmacy is involved in anticoagulation events. Low Accu-Chek results are a flag for hypoglycemia.
- For CAUTI, infection control has a log for all admissions that lists anyone who comes in with a Foley and who gets one in the hospital. They pull all Foley charts to look for infections on arrival and discharge.
- Anyone who needs a central line is transferred out, so they are reporting a 0 numerator and a denominator of all admissions. If the hospital never keeps central line patients, they should be exempt from reporting on this measure.
- For both PU and VTEs, the Nurse Manager would report, due to low census. So far, they have not had any incidents to report for these two measures.
- As a result of our conversation about the measures being reported, the hospital states that they need to make sure they are reporting the right denominators for some of the measures.
- They have worked on engaging the community through workshops on contract health and the Affordable Care Act (ACA). They use patient satisfaction surveys and get input about change through the Tribal Health Board.

1.2.3: Quality Improvement Initiatives Related to PfP

San Carlos added VTE prophylaxis to the chart template in the EHR so it cannot be avoided. They are doing a chart review for VTE risk for every patient and providing appropriate prophylaxis.

The facility also reports to NHSN, and they use chart review to collect data for those measures. They have done some work with their State QIO in the past, but not in the last 3 to 4 quarters. They have also attempted to participate in the IPC initiative, but they have failed because of turnover.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: San Carlos Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Turnover is causing poor awareness.	• Assist with identifying recruitment and retention strategies used at other small rural hospitals.
Data Collection and Reporting	
• Reporting CLABSI, but transfer out central line patients.	• Clarify whether hospital should be exempt from this measure.
• Uncertainty over whether they are reporting correct denominators.	• Help review data reported and provide education on all measures with incorrect denominators.
QI Initiatives Related to PfP	
• Looking for best practices for diabetes care.	• Identify best practices related to diabetes care, with particular attention to practices related to the hypoglycemia measure.

Issue/Challenge	T/TA Recommendations
General/Other	
• Interested in learning about pros and cons of having a diabetic clinic. • Inpatient census is low, and outpatient is their focus. • Interested in webinar on recruitment and retention. • Would like a webinar on exact policies that are needed to make Joint Accreditation or AAA.	

3: Descriptive Profile

Indian Health Service Hospital: San Carlos Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Nimmy Mathews – Pharmacist, Acting Quality Assurance Officer for 2 mos.
Year Hospital Established	1963, new hospital 2014
IHS Area Office	Phoenix
Geographic Area Served	Apache Reservation
User Population	• 14,000–15,000 workload (staffing based on 12,000)
Hospital Beds	• # beds: 8 now; new hospital will also have 8 but can expand up to 16. • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	0.5–0.8
Services Available–General	• Inpatient • Laboratory • ER • OB/GYN clinic • Surgery clinic • Podiatry • PT • Dental • Dietary • Optometry • Pharmacy • Radiology
PfP Awareness at Facility	• General: Zero. Partially due to turnover. Some of the people championing it are now gone. Nimmy has only been responsible for PfP since last week. There are too many other jobs to be done. • Leadership: There is a lack of awareness; management is making people get together to talk about it.
PfP Services NOT Available	• Surgery • Ventilators • Labor & delivery • Central lines
Number of Physicians	• Medical: 4 permanent; 5 contract; 1 CD; 1 Deputy CD • Surgical: 0 • Other: 1 podiatry; 1 optometrist

Characteristic	Hospital Description
Number of Staff FTE, by Type of Personnel	• Total: 174 now; new hospital calls for 400 • Service Unit CEO: • Hospital Administrator: • RNs: 40 • LPNs: • Pharmacists: 9 • Allied Health: Lab, 11; Radiology, 5; Physical Therapy, 2 • Other Health: Dietary, 4 • IT/Data Management/CAC: 3 • Data Entry: • Medical Records: 13 FTE/1 HIMS/1 Coding sup/5 Coders • Billing: 0 FTE/1 temp until March • Other:
Shared Staff With Service Unit Clinic(s)	7 shared providers with PIMC (OB, Rheumatology, Cardiology, Audiology, Nephrology, General Surgery, and Ophthalmology)
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	3 – Quality Manager, case management, patient advocate
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 8 mo. Jan.–Aug. 2013 • ADE: 8 mo. Jan.–Aug. 2013 • CAUTI: 8 mo. Jan.–Aug. 2013 • CLABSI: 8 mo. Jan.–Aug. 2013 • SSI: 0 – exempt • VAP: 0 – exempt • PU: 8 mo. Jan.–Aug. 2013 • VTE: 8 mo. Jan.–Aug. 2013 • EED: 0 – exempt
Reporting Method – Readmissions	Finds the readmissions themselves and reviews in the EHR.
Reporting Method – Falls	WebCident. Look over the reports and direct them to the correct department.
Reporting Method – ADE	WebCident. Dosing mistakes are put into WebCident as well. Low Accu-Chek results are a flag for hypoglycemia.
Reporting Method – CAUTI	Infection control has a log for all admissions that lists anyone who comes in with a Foley and who gets one in the hospital. They pull all Foley charts to look for infections on arrival and discharge.
Reporting Method – CLABSI	Does not offer central lines, so they are reporting a numerator of 0 and a denominator of all discharges.
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	Nurse Manager would report, due to low census.

Characteristic	Hospital Description
Reporting Method – VTE	Nurse Manager would report, due to low census.
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	0
Discrepancies on Reporting	• We have data through August, but hospital states it is complete through December. • Reporting on CLABSI, but they do not provide central lines. • Reporting admissions instead of device days for CAUTI/CLABSI and inpatient days for PUs.
QI Measures Implemented due to PfP	Put VTE prophylaxis in their chart template so it cannot be avoided.
Patient, Family, and Community Engagement	• Conduct workshops in the community on contract health and ACA and also visit schools. • Patient satisfaction surveys. • Get input about change through the health board. Meet with the tribes 2–3 times per week.
Strength Area	• Willing to offer any support they can to other hospitals.
Training and TA Needs Identified	• Clarification of denominators for PUs and CAUTI/CLABSI. • Need clarification on whether they should be exempt for CLABSI because anyone who needs a line is transferred out. • Interested in webinar on recruitment and retention, as well as exact policies that are needed to make Joint Accreditation or AAA. • Best practices for diabetes care, particularly about whether or not to have a diabetic clinic. • Turnover is causing poor awareness. • Inpatient census is low, and outpatient is their focus. How can PfP be more relevant?

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for San Carlos:

- CLABSI is shown as "Z–Hospital does not provide services related to this HAC," and all other measures are shown as "0" or "1" on the PEC Chart, but are shown as reporting all but SSI, VAP, and EED for ~1 year on the IHS Data Reporting Progress Chart.

Whiteriver Indian Hospital

1: Assessment Summary

1.1: Overview of Whiteriver Indian Hospital

Whiteriver Indian Hospital was built in 1977 and is located about 3 miles north of Whiteriver, AZ. Geographically, it is a large reservation; the Cibecue satellite clinic is an hour drive from the hospital. The facility serves the White Mountain Apache Tribe, with a population of about 16,000.

They have 36 inpatient beds, with adult and pediatric patients housed in the same ward. They have a small inpatient census, typically 16 to 18, but in flu season it has gone as high as 27. Most rooms are ward rooms with multiple patients, so for infection control they have had to be very careful about what patients they can put together.

The hospital has a birthing center that handles low-risk OB patients and performs about 10 deliveries a month. They have two operating rooms, and they perform orthopedic surgeries, wound care, and dental procedures. Outpatient services include family practice, dental, optometry, podiatry, orthopedics, healthy heart (diabetes), IV infusion, and pacemaker clinic. Total staff for both inpatient and outpatient services is about 450.

The facility works with other hospitals in their area and have experience providing assistance to San Carlos Indian Hospital and Hopi Health Care Center with PfP measures.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

According to Whiteriver staff, they have not done “a really good sell” for PfP. This is probably due to the fact that they wear many hats and have a lot of projects going on. They just started reporting data to their governing body on a quarterly basis. They also have PfP data in their data mall dashboard, and they report to department heads. The department heads are aware of PfP but might not know exactly which measures are included.

Doing this work is pretty overwhelming to the staff because they have so many other duties. They report not having the time to give this initiative the attention that it deserves. The facility is old, and they are trying to hold things together. Despite these challenges, they report that they usually attend PfP webinars and have tried to use the PfP Web site.

1.2.2: PfP Measures: Reporting Status and Challenges

- Whiteriver staff state that they are currently reporting on readmissions, falls, ADEs, CAUTI, CLABSI, PUs, and VTE. They are exempt from reporting on VAP and EED.
- They are currently not reporting on SSI. Although they do have ORs, they state that they do not do any of the eligible procedures included under the SSI measure. Clarification is needed on whether Whiteriver should be exempt from reporting this measure.

- RPMS reports are available on 30-day readmissions and are run on a monthly basis. However, they do not have information on patients readmitted to other facilities. They have tried to track patients who visited the emergency department, were referred to another hospital, and then admitted to Whiteriver, but the transfer log is huge and it was too time consuming. The State tracks information on readmissions, so they are trying to partner with them.
- For falls, Whiteriver uses WebCident to collect data on the number of falls and then uses RPMS to calculate the number of patient days for the denominator.
- For the ADE measures, they use VGEN to pull out excessive anticoagulation data from RPMS, and they use QGEN for hypoglycemia. They say this is relatively simple because there is not a huge use. The pharmacist looks at the data daily. With the EHR lab package, they can automatically pull up the labs that they want. The numbers are very small, so they feel it is important to check daily to stay on top of it.
- The hospital went for a long period of time without an infection prevention program, so they are finding it really difficult to collect information for CAUTI and CLABSI. The fellow there now is doing a good job, but trying to find a way to collect past data has been a real challenge.
- To collect the data on CAUTI, they run a VGEN query looking for microbiology reports. Specifically, they look for positive urine cultures amongst inpatients, then identified those associated with a Foley catheter. According to the staff, they are a little behind on reporting their data for the CAUTI measure, and they state that they have data as far back as April 2013. It is unclear how many months of data have actually been reported for PfP, because the data collection spreadsheet from October 2013 is blank for this measure.
- For CLABSI, they have struggled to collect the necessary information, especially for older data. The previous infection control person had a system for collecting the number of device days, but she left a year ago. They can still get the number of device days by manually collecting the information on wards, but the number of infections is more difficult. They use VGEN to look for microbiology reports, and cross-reference infections to patients with central lines. Since the person collecting the data for this measure is often on the wards, she usually knows if someone has a line removed due to infection, but she thinks they should be able to pull this information out of RPMS.
- PU data are collected using a VGEN report. They get the number of inpatient days and discharges from RPMS and the number of PUs from ICD-9 codes (707) entered by coders after discharge. Then chart review is performed to see if the patients identified came in with a PU. There is concern that the switch to ICD-10 will create confusion and problems with this process.
- VTEs are identified by a pharmacist and reported to the PfP lead. They are not sure how those data are collected.
- For patient and community awareness, Whiteriver Public Health Nursing does a lot of health promotion and radio announcements and meets with the tribes quarterly. They have monthly community awareness, and they work with schools and have branched out to the high school on teen pregnancy. The tribes held a strategic planning last month;

executives are there at those meetings. Pharmacy is also working on home visits for patients with chronic medical management problems.

- Whiteriver would really like to see data collection standardized across hospitals, because they find some of the instructions and messages confusing. They feel like the expectations are still vague in some areas, and they need someone with clinical knowledge to tell them very specifically what they need to collect. At this point, they are spending too much time at their desks collecting data and not enough time in the field working on issues.
- They would like to see other hospitals share their successes during the collaborative learning sessions and the opportunity to pose questions to the field of participants and hear what they have come up with. They have had these types of opportunities with IHI, but not with IHS. They feel like the PfP Web site contains a lot of useful information, but obtaining passwords is cumbersome. They would like to see the Web site opened up so everyone can use it more easily and arranged so they could work specifically with the other IHS hospitals. IHS has a competitive atmosphere by Area, and they would like to see how they are doing compared to other hospitals or regions.
- In general, they feel like they have no idea how to do the data collection effectively, and they have only recently started learning how to use RPMS.

1.2.3: Quality Improvement Initiatives Related to PfP

Whiteriver recently hired a Performance Improvement Officer and permanent QM staff. They present QM data on a dashboard that is available to staff. They also put up data sent from the NDW so that when QM takes over the readmission measure, they will have all of this data. Within their group, they also have a task force that works on readmissions, and they have access to the NDW reports.

They are experimenting with a "Brain Board" that will help with a variety of measures—this is an internal list of patients, names, ages, diagnoses, precautions, central line, Foley, saline lock, no IV access, isolation precautions, etc. This helps them assign staff but has also become a data collection tool as well.

They have identified some potential problems with PU data collection, including the fact that staff might note an ulcer but not realize that it is new if the patient already had preexisting PUs. They tried having staff document PUs in WebCident, but it did not work as well as it does for falls.

Pharmacy is working on home visits for patients with chronic medical management problems. They are also looking at high-risk patients to try to improve the number of case managers available to work with them.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Whiteriver Indian Hospital

Issue/Challenge	T/TA Recommendations
PfP Awareness and Knowledge	
• Difficulty accessing relevant material on PfP site.	• Orient staff to PfP Web site and any areas of particular relevance to IHS hospitals. Assist any team members who lack access to Web site.
• Find some of the PfP messages and instructions confusing.	• Identify available documentation/instructions, and work with site to clarify any specific areas of confusion.
Data Collection and Reporting	
• Concerns over conversion to ICD-10 for PU data collection.	• Identify relevant ICD-10 codes for RPMS searches.
• Difficulty collecting past data for CAUTI and CLABSI.	• Train staff to do relevant queries in RPMS.
• Says they report CAUTI, but there is no data in the reporting spreadsheet.	• Verify if there is a more recent data report or if the data are not getting transferred to the spreadsheet.
• State they do not do procedures included for SSI, but they are marked as not reporting this measure.	• Clarify whether they should be exempt for this measure.
QI Initiatives Related to PfP	
• Documentation for PUs.	• Identify tools and best practices for identifying and documenting new PUs.
General/Other	
• Would like the opportunity to hear other sites share their successes. • Would like to see how they are doing with measures in comparison to other IHS facilities.	

3: Descriptive Profile

Indian Health Service Hospital: Whiteriver Indian Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Francine Davis – Assistant Nursing Supervisor, 24 years IHS, 2.5 years Whiteriver
Year Hospital Established	1977
IHS Area Office	Phoenix
Geographic Area Served	Hospital is in White River, AZ. Geographically, it is a large reservation; the Cibecue satellite clinic is an hour drive from the hospital.
User Population	16,000 members of White Mountain Apache Tribe.
Hospital Beds	• # beds: 36 adult and pediatric beds • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	16–18, higher in flu season

Characteristic	Hospital Description
Services Available–General	• Adult and pediatric inpatient care. • Surgery – Ortho, wound care, and lots of dental. • Birth center – Low-risk only, no C-sections, transfer for failure to progress. • Outpatient clinic with dental, optometry, podiatry, ortho, healthy heart (diabetes), IV infusion, pacemaker, iron transmittal, peds/pediatric cardiology. • ER. • Satellite clinic.
PfP Awareness at Facility	• General: Have not done a really good sell, probably their fault since they wear many hats and have lots of projects. They just started reporting to the governing body on a quarterly basis. They have PfP on our data mall dashboard. • Leadership: Report to department heads; aware of measures, but perhaps not that there are ten of them.
PfP Services NOT Available	• Labor & delivery – Only have a birth center that handles low risk, with no inductions or C-sections. • Ventilators • Surgery – Have an OR, but do not do any of the surgeries that count for this measure.
Number of Physicians	• Medical: • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: 450 • Service Unit CEO: • Hospital Administrator: • RNs: 180 nurses; not all are RNs • LPNs: • Pharmacists: 23 • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: • Billing: • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	Nursing has high turnover.
Current Staff Vacancies, by Type of Personnel	
Quality Management/QI Manager/Staff, Number and FTE	
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes

Characteristic	Hospital Description
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 10 mo. Dec. 2012–June 2013 • ADE: 10 mo. Oct. 2012–June 2013 • CAUTI: ? 0 on data reporting spreadsheet • CLABSI: 10 mo. Oct. 2012–June 2013 • SSI: 0 • VAP: 0 – exempt • PU: 2 mo. June–July 2013 • VTE: 5 mo. Mar.–July 2013 • EED: 0 – exempt
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident and RPMS.
Reporting Method – ADE	VGEN for anticoagulant, and QGEN for hypoglycemia, Lab EHR package.
Reporting Method – CAUTI	VGEN report for inpatients with positive urine cultures, then manually check which ones had Foley.
Reporting Method – CLABSI	VGEN to identify lab reports, then manual chart review.
Reporting Method – SSI	N/A – not reporting
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	VGEN report on number of inpatient days and discharges from RPMS and the number of PUs from codes (707) entered after discharge, then manual chart review to see if they came in with a PU.
Reporting Method – VTE	Unknown – data comes from a pharmacist.
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	None
Discrepancies on Reporting	• Says they report CAUTI, but there is no data in the reporting spreadsheet. • SSI is marked 0, but they do not do eligible surgeries—should they be exempt or report zeroes? • CLABSI: Data reported does not include all harms (# or patients with line) denominator, but they are collecting that info now.
QI Measures Implemented due to PfP	• Readmissions – Task force looks at readmissions.
Patient, Family, and Community Engagement	• Public Health Nursing does a lot of health promotions and radio announcements; meets with tribes quarterly. • Monthly community awareness. • Work with schools and have branched out to the high school on teen pregnancy. • Breastfeeding encouragement. • Pharmacy is working on home visits for patients with chronic medical management problems. • They are also looking at high-risk patients to try to improve the number of case managers available to work with them. • The tribes held strategic planning last month; executives are there at those meetings.
Strength Area	• Have experience providing assistance to San Carlos and Hopi with PfP measures. • Ability to utilize VGEN to pull data for a variety of measures.

Characteristic	Hospital Description
Training and TA Needs Identified	• Collecting past data for CAUTI and CLABSI. • Standardized data collection methods for all measures. • Need access to more sections of PfP site—open it up to everyone so each person does not need a password. • Would like to hear sites share successes. • Would like to see how they are doing in comparison to other IHS facilities. • Find some of the PfP messages and instructions confusing. • Concerns over conversion to ICD-10 for PU data collection. • Says they report CAUTI, but there is no data in the reporting spreadsheet. • State they do not do procedures included for SSI, but they are marked as not reporting this measure. • Documentation for PUs.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Whiteriver:

- CAUTI, VTE, and PU are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but are shown as reporting for ~2 years on the IHS Data Reporting Progress Chart.

Tucson Area Office

- *Sells Hospital – Sells, AZ*

Sells Hospital

1: Assessment Summary

1.1: Overview of Sells Hospital

Sells Hospital is located 72 miles west of Tucson, and the area it serves is the size of Connecticut. The hospital serves the Tohono O'odham Nation with a membership of 26,000, as well as about 1,200 beneficiaries who cross the border from Mexico.

The hospital has 14 beds and had approximately (b) (3) (A) discharges and (b) (3) newborns in 2012. Services include an ER, 24-hour pharmacy, and three ambulatory health centers: San Simon, which is located 45 miles west; Santa Rosa Health Center, which is northeast of San Simon; and San Xavier Health Center, which is adjacent to the Tucson Area Office. They are staffed by about 450 FTEs including contractors and students.

The hospital has a well-developed quality assurance process and is working on quality improvement related to several PfP measures.

1.2: Partnership for Patients Participation, Reporting Status, and Challenges Encountered

1.2.1: Awareness and Participation in PfP

According to Sells Hospital staff, raising awareness about PfP was not a huge challenge because their general communication structure allowed them to share the goals and objectives. Although priorities shift over time, for the most part awareness has not been a challenge.

Attendance at the PfP webinars is mandatory for quality assurance staff, and they also attend the CMS Community of Practice (COP) webinars. When there is a learning opportunity available to expand the knowledge base, the Quality Assurance Officer shares it with the entire service unit. They found the readmission webinar very valuable, and they like hearing speakers' experiences.

1.2.2: PfP Measures: Reporting Status and Challenges

- Sells Hospital started tracking data in January of 2013. They had reporting already in place and repackaged it for PfP. The hospital is currently reporting on falls, ADEs, and CAUTI. They are exempt from reporting CLABSI, SSI, VAP, and EED.
- Falls are collected through WebCident, and reports go to the Safety Officer, Risk Manager, and Nurse Executive. That report triggers staff to go into the system to see what happened.
- ADEs are also recorded in WebCident, and the reports go to the Chief of Pharmacy and his deputy who is doing the data collection for the ADE measure. The pharmacy submits the final data for PfP. However, there are no data for ADEs on the October 2013 reporting spreadsheet, so the process for getting the data entered into the spreadsheet for reporting needs to be reviewed.
- CAUTI data are collected by infection control through chart review. All of the charts are electronic.

- They are not reporting on PUs or VTE. However, they do have the data collected, and they do not know why it has not been submitted for PfP yet. PU data are also collected through chart review, and VTE is collected through RPMS.
- Sells has a number of initiatives for patient and community engagement. For IPC, they invited the community to participate in monthly collaborative meetings to identify resources and ways to maximize those resources in order to meet patient and family needs. They partnered with the tribe on IPC; there is a lot of overlap of PfP and IPC. The CEO takes the lead on the Patient Advisory Council (in place for 10+ years); the reservation is divided into 12 districts, and representatives from the districts bring forth concerns quarterly. In this way, the community can have input.
- They are challenged by the fact that the reporting tool keeps changing. As soon as they get one spreadsheet figured out and completed, there is a new version available.

1.2.3: Quality Improvement Initiatives Related to PfP

The Quality Assurance division at Sells is headed up by the Division Director and includes a Compliance Officer, infection control, utilization review, Safety Officer, and employee health nurse.

The hospital is looking at readmission data using the IHI STAAR change package, which they feel is more helpful than just doing a chart review. Using STAAR, they found some problem areas, including the fact that 25 percent of readmissions are related to poor living and social factors and 20 percent are due to lack of caregiver. They have asked their public health nurse to assess patients at the time of admission to classify risk of readmission. They also make post-discharge calls to follow up on patient education on discharge instructions, and pharmacy makes phone calls within 72 hours of discharge to make sure there are no medication questions. There is also a case manager in the urban area who sees patients in Tucson.

In addition to their internal work on readmissions, they have an MOA in place to partner with the Nation on the community health services they provide (home health, etc.) to allow for more continuity of care. They are working on an agreement to get tribal staff access to the electronic health record as well. The tribe also recently got into nurse case management and hired two new nurses whom the hospital oriented.

For ADEs and falls, they created incident sheets that are useful for bringing the entire team together to review incidents.

For CAUTI, they have recommended the CDC checklist and have implemented a seamless system of catheter and bag. They also have an anti-thrombolytic prophylactic care initiative in place to address VTE.

Sells Hospital has a committee made up of service unit supervisors who meet monthly to share data and track factors for accreditation as well as PfP data. The meeting is well attended and they have written reports so they can respond to the data. They also do unannounced data collection (tracer activities) in which they track individual patients to see how processes are working and if practice reflects current policy.

They currently submit data to the State QIO, which they analyze and report back on. In addition, they have been participating in IPC since the pilot in 2006.

2: Summary of Individual Hospital T/TA Recommendations

Table 2.1: Training and Technical Assistance Needs: Sells Hospital

Issue/Challenge	T/TA Recommendations
Data Collection and Reporting	
• Say they are reporting ADE but spreadsheet is blank.	• Verify whether there is data in newer data files, and if not, work to clarify procedure for getting data from pharmacy to the reporting spreadsheet.
• Not submitting available data for PU and VTE.	• Assist with developing procedure for getting data from point of collection to the final reporting spreadsheet.
General/Other	
• Wants webinars related to Government mandates and other changes such as ICD-10. • Cannot correlate the numbers requested and how they match the CDC and CMS definitions. • Interested in a Web-based system that can help measure culture of safety and patient safety.	

3: Descriptive Profile

Indian Health Service Hospital: Sells Hospital

Characteristic	Hospital Description
Hospital PfP Liaison Name and Tenure on PfP	Diana DeLeon – QA Officer at IHS and Sells for 6.5 years
Year Hospital Established	1961
IHS Area Office	Tucson
Geographic Area Served	72 miles west of Tucson; the area served is the size of the State of Connecticut
User Population	• Serve the Tohono O'odham Nation with membership of 26,000. They also have some beneficiaries who live on the Mexico side of the border (1,200).
Hospital Beds	• # beds: 14 • # staffed beds:
Hospital Discharges 2012	(b) (3) (A)
Occupancy Rate 2012	4.3
Services Available–General	• ER • 24-hour pharmacy • 3 ambulatory health centers: 45 miles west is San Simon, which opened in 2008 and has 25 employees; northeast of that is the Santa Rosa Health Center with 20 employees; and adjacent to Tucson Area Office is the San Xavier Health Center. • PT
PfP Awareness at Facility	• General: When first started raising awareness, it was not a huge challenge; the communication link structure allowed us to share the goals and objectives so it was not a huge struggle. Priorities shift, but for the most part it has not been a challenge. • Leadership:

Characteristic	Hospital Description
PfP Services NOT Available	• Surgery: No OR, but do receive post-surgical patients from Tucson. • Labor & Delivery: Only do deliveries when they come in while in active labor. • Ventilators • Central lines: Do not place them, but do get some patients from other facilities with central lines.
Number of Physicians	• Medical: 22 – 1 vacancy • Surgical: • Other:
Number of Staff FTE, by Type of Personnel	• Total: 450 FTE (380 without contractors and students) • Service Unit CEO: • Hospital Administrator: • RNs: • LPNs: • Pharmacists: 30–35 • Allied Health: • Other Health: • IT/Data Management/CAC: • Data Entry: • Medical Records: 30–35 • Billing: 12 • Other:
Shared Staff With Service Unit Clinic(s)	
Staff Turnover Rate, by Type of Personnel	
Current Staff Vacancies, by Type of Personnel	1 physician
Quality Management/QI Manager/Staff, Number and FTE	6 – Division Director, as well as Compliance Officer, infection control, utilization review, Safety Officer, and employee health nurse.
Software Systems and Database Capacity	• RPMS: Yes • RPMS EHR: Yes
PfP Measures Reported and Number of Months Reported, by Measure	• Readmissions: • Falls: 3 mo. Feb.–Apr. 2013 • ADE: 0 – not reporting • CAUTI: 3 mo. Jan.–Mar. 2013 • CLABSI: 0 – exempt • SSI: 0 – exempt • VAP: 0 – exempt • PU: 0 – not reporting • VTE: 0 – not reporting • EED: 0 – exempt
Reporting Method – Readmissions	
Reporting Method – Falls	WebCident; reports go to Safety Officer, Risk Manager, and Nurse Executive.
Reporting Method – ADE	When there is an incident, it is registered in WebCident; goes to Chief of Pharmacy and his deputy who is doing the ADE. Pharmacy submits final data.
Reporting Method – CAUTI	Infection control collects through chart review. All electronic charts.
Reporting Method – CLABSI	N/A – exempt

Characteristic	Hospital Description
Reporting Method – SSI	N/A – exempt
Reporting Method – VAP	N/A – exempt
Reporting Method – PU	Done through chart review. Have data; do not know why it is not reported.
Reporting Method – VTE	Done through RPMS. They do have data; not sure why it is not reported (Diana says she has not seen any numbers on VTE).
Reporting Method – EED	N/A – exempt
Number of PfP Measures Not Reported (for services offered within the hospital)	2 – PU and VTE, but they say they have data available on both of those measures and are not sure why they are not being reported.
Discrepancies on Reporting	• Say they are reporting for ADEs for >3 mo., but the data reporting spreadsheet contains no data. • # of months of reporting are discrepant between sources for falls and CAUTI. • Have PU data collected and do not know why it is not being reported.
QI Measures Implemented due to PfP	• Readmissions: Looking at readmission data using the IHI STAAR change package; look at the process that is more helpful than just doing a chart review. Found some problem areas they addressed: factors for readmission included chronic disease, encephalopathy, and seizures. 25% of readmissions are related to poor living and social factors and 20% to lack of caregiver. They have asked their public health nurse to assess patient at time of admission to classify risk of readmission and make post-discharge calls to follow up on patient education on discharge instructions. Pharmacy began phone calls within 72 hours of discharge to make sure there were no questions. Case manager in the urban area who sees patients in Tucson; great liaison/mediator when we discuss patients every Tuesday. Partnership with Tribal Nation is really important in improving health care outcomes; they recognize the need for case manager training and have recently hosted several modules in training. • ADE/falls: Created incident sheets. • System side (Federal) and tribal community MOA to partner with the Nation on the community health services they provide (home health, etc.) to allow for more continuity of care. • CAUTI: Recommended the CDC checklist and implemented a seamless system of catheter and bag. • SSI: Recommended checklist; do not do surgery but get post-op patients. • VTE: Anti-thrombolytic prophylactic care initiative.

Characteristic	Hospital Description
Patient, Family, and Community Engagement	• For IPC, they invited the community to participate in monthly collaborative meeting to identify resources and ways to maximize those resources in order to meet patient and family needs. • Partnered with the tribe on IPC and Diana is co-lead with the tribes; there is a lot of overlap of PfP and IPC. • CEO takes the lead on the Patient Advisory Council (in place 10+ years); reservation divided into 12 districts, and quarterly representatives from the districts bring forth concerns—patient complaints, services that are not being addressed; in this way the community can have input.
Strength Area	• Developed on their own post-fall and ADE incident sheets that are helpful in bringing in the entire team. • Well-developed QI process around investigating readmissions and taking action to address causes.
Training and TA Needs Identified	• When there are mandates and changes, it would be good to have more webinars to phase in changes. Need to be aware and be on the same page, such as ICD 10 coming in October. • Cannot correlate the numbers requested and how they match the CDC and CMS definitions. When they put numbers in the graph, they would like to understand what each means in relation to each other. • Are there Web-based systems that can help us measure culture and patient safety? • Say they are reporting ADE but spreadsheet is blank. • Not submitting available data for PU and VTE.

4: Summary Analysis of Hospital's Data Reporting Status

The Indian Health Service PfP Leadership team at Phoenix Indian Medical Center keeps a table of "PfP Data Reporting Progress for IHS HEN" and the PfP PEC tracks "HEN Monthly Reporting." A comparison of the two reports found the following inconsistencies for Sells:

- Readmissions are shown as "1–Engaged in work related to HAC, but not submitting data to IHS HEN" on the PEC Chart, but are shown as reporting for ~4 years on the IHS Data Reporting Progress Chart.