Ambulatory Service Line Introduction

Harriet Aronow, PhD

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The NPSF report proposes eight recommendations for achieving total system safety and calls for action by government, regulators, health professionals, and others to place higher priority on patient safety science and implementation. The eight recommendations are as follows:

1. Ensure that leaders establish and sustain a safety culture
2. Create centralized and coordinated oversight of patient safety
3. Create a common set of safety metrics that reflect meaningful outcomes
4. Increase funding for research in patient safety and implementation science
5. Address safety across the entire care continuum
6. Support the health care workforce
7. Partner with patients and families for the safest care
8. Ensure that technology is safe and optimized to improve patient safety

Collaborating and Leading: **Nurses are needed to lead** and participate in ongoing reforms to the health care system, to direct research on evidence-based improvements to care, to translate research findings into practice, to be full partners on the health care team, and to advocate for policy change. Nurses in leadership positions contribute their unique perspective and expertise on issues such as health care delivery, quality, and safety. The committee recommends that the Campaign work to expand efforts and opportunities for interprofessional collaboration and leadership development. The Campaign also should encourage nurses to serve in executive and leadership positions—including those at health care systems, insurance companies, government agencies, and advisory committees—such that they may be involved in the redesign of health care delivery and payment systems.

Improving Data: There are major gaps in understanding numbers and types of health professionals, where they are employed, and what roles they fill. Yet this knowledge is critical to support new models of health care delivery and improve patient care. The committee recommends that the Campaign use its strong brand and partnerships to help improve data collection. The Campaign should play a role in convening, supporting, and promoting collaboration among organizations and associations to consider how they might create more robust data sets and how certain data sets can be organized and made available to researchers, policy makers, and planners. The federal government and states also should play a role by expanding existing data collection activities to better measure and monitor the role of nurses in the health care workforce.
Strategic Collaboration with AAACN

CALNOC and the American Academy of Ambulatory Care Nursing Announce Partnership to Develop New Ambulatory Nurse Sensitive Indicators

New measure sets will empower ambulatory care nurses to use evidence-based information for improvement.

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SAN RAMON, CA (PRWEB) DECEMBER 16, 2015

The Collaborative Alliance for Nursing Outcomes (CALNOC), the nation’s first nursing quality indicators database, today announced an important collaboration with the American Academy of Ambulatory Care Nursing (AAACN). The collaboration will expand CALNOC’s national database of nursing quality indicators beyond acute care hospitals into the ambulatory care setting for the benefit of patient safety and quality.

An estimated 1 billion ambulatory visits occur in the U.S. each year, with most care today provided outside of hospitals. However, much of the work done to date in patient safety addresses hospital care. The Free from Harm report recently released from the National Patient Safety Foundation advocates for more work to be done to prevent harm beyond the hospital setting. The collaboration between CALNOC and AAACN addresses this need and will help ambulatory care nurses to use evidence-based information across outpatient health care settings to increase patient safety and quality of care.

“It is now more important than ever to pursue this work and further validate the critical role and need for registered nurses in ambulatory care settings,” said Cynthia Nowicki Hnatiuk, EdD, RN, CAE, FAAN, Chief Executive Officer of AAACN. “This new collaboration with CALNOC will provide new ways to measure and improve performance in ambulatory care.”

Tony Sung, Chief Executive Officer of CALNOC, said, “This collaboration is an exciting and important step toward the goal of keeping all patients safe and improving healthcare quality. CALNOC has expertise in measures development, and AAACN is known for its strength in ambulatory care, together we can make significant progress toward safer healthcare.”

The two organizations are expected to first begin measure development with a pilot testing phase. Look for the new measure set to be ready for wide use in the first half of 2016.
Ambulatory Nursing-Sensitive Measure Development: It’s A Journey.

Do the difficult things while they are easy and do the great things while they are small. A journey of a thousand miles must begin with a single step.

Lao Tzu
(Ancient Chinese philosopher and poet)
Nursing-Sensitive Indicators in Ambulatory Care

EXECUTIVE SUMMARY

Ambulatory nursing care can be difficult to comprehend in all its complexity.

In August 2013, the American Academy of Ambulatory Care Nursing commissioned a task force to identify nursing-sensitive indicators specific to ambulatory care settings.

Given the great variation in settings, staff mix, patient populations, role dimensions, skill sets, documentation systems, and resources, determining metrics that apply across the entire continuum of care is a daunting task.

However, it is incumbent upon nurses to define the metrics that will promote the value of the registered nurse in ambulatory practice and care coordination.

Once initial measures are identified, piloted, and validated, the infrastructure can be created for ongoing benchmarking and collaboration.

The long-term goal is to leverage professional nursing practice, based in the ambulatory care setting, to improve quality, safety, and cost in health care.

NOTE: This column is written by members of the American Academy of Ambulatory Care Nursing (AAACN) and edited by Emily M. Shilman, MSN, RN, BC. For more information about the organization, contact AAACN, 200 Holly Avenue, Suite 30, Pittsfield, MA 01201-6640, (413) 256-2300, (413) AMBUL-NURS, FAX (413) 589-7652, E-mail: aacnacl@comcast.net, Website: http://AAACN.org.

Rachel Sark
Margaret F. Mastal
Ann Marie Matlock
The ASC Quality Collaboration (ASC QC) is a cooperative effort of organizations and companies interested in ensuring that ASC quality data is measured and reported in a meaningful way. The ASC QC was formed early in 2006 to initiate the process of developing standardized ASC quality measures.

2007: five ASC QC facility-level measures were endorsed by the NQF:
- Patient Burn
- Prophylactic IV Antibiotic Timing
- Patient Fall in the ASC
- Wrong Site, Side, Patient, Procedure or Implant
- Hospital Transfer/Admission

2008: a sixth ASC QC facility-level measure was endorsed by the NQF:
- Appropriate Surgical Site Hair Removal
# Phase I: Initial Measure Set
## Ambulatory Surgery Centers & Procedure Units

<table>
<thead>
<tr>
<th>Phase I Structure of Care</th>
<th>Phase I Process of Care</th>
<th>Phase I Outcomes of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator Volumes:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Number of patient onsite visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Number of procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Operating room minutes for ASC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Scheduled or unscheduled telephone or video/computer appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wrong:</strong> Site, Side, Patient, Procedure, Implant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staffing Hours per Volume</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- LVN/LPN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Unlicensed Assistants (CMA/PCT/Nurses Aid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other licensed staff (PT, OT, RD, MSW, LCSW, etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- APN</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Burns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stratify by hospital based or free standing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stratify by predominately adult or pediatric</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Falls</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Injury Falls</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Transfer/ Admission</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Proprietary and Confidential to CALNOC
Benchmarking measure sets at a unit level within a hospital, at the hospital level (by unit type or total facility), for entire health systems, by hospital type, or geographic areas............including the ED

<table>
<thead>
<tr>
<th>Structural Measures</th>
<th>Process Measures</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Hours per Patient Day/Delivery/ ED encounter</td>
<td>- Risk Assessment for Falls, Pressure Ulcers, and Skin Integrity</td>
<td>- Fall Rates</td>
</tr>
<tr>
<td>- Skill Mix</td>
<td>- Protocol Implementation for Fall and Pressure Ulcer Prevention</td>
<td>- Injury Fall Rates</td>
</tr>
<tr>
<td>- Ratios of patients to licensed staff</td>
<td>- Restraint Use</td>
<td>- Hospital Acquired Pressure Ulcers Prevalence</td>
</tr>
<tr>
<td>- Use of Contract Staff</td>
<td>- Medication Safe Practices</td>
<td>- Medication Error Rates</td>
</tr>
<tr>
<td>- Sitter Utilization</td>
<td>- Patient/Bed Turnover</td>
<td>- ED Left Without Being Seen or Before Treatment Complete</td>
</tr>
<tr>
<td>- ED Boarder rate</td>
<td>- ED Arrival &amp; Admit Decision to Departure</td>
<td>- NHSN HAI: CLABSI, CAUTI, MRSA and C.Difficile</td>
</tr>
<tr>
<td>- Nurse education, certification, and years of experience</td>
<td></td>
<td>- HCAHPS</td>
</tr>
<tr>
<td>- Staff voluntary turnover</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Ambulatory: Data Collection

![Data Entry Form]

**Collaborative Alliance for Nursing Outcomes**

**Fall 2015 CODEBOOK Supplement**

**Ambulatory Measures Definitions and Coding Instructions**

**Patient Populations:**
New Service Line Ambulatory Care

**Unit Type:**
Ambulatory Surgery Centers Procedure Units

Proprietary and Confidential to CALNOC
Enrolling Your Surgery/Procedure Units in CALNOC

Sample Ambulatory Unit Identification Code Sheet

The Unit Identification Code Sheet below is provided for your convenience and to help you understand the type of information you will be asked to provide on the CALNOC website. You will be able to see and edit your unit entries as appropriate on the website.

List each unit that will be participating in Ambulatory Care Surgery/Procedure Center data collection by name. CALNOC will assign that unit a number that will become its ID code. **Next, code the unit descriptive information as described above.**

<table>
<thead>
<tr>
<th>Unit Name</th>
<th>Unit Numeric Code</th>
<th>Unit Type</th>
<th>Unit/Center Affiliation</th>
<th>Predominant Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>List each unit by the name you routinely use.</td>
<td>CALNOC automatically assigns unit code</td>
<td>All will be Ambulatory Surgery or Procedure Center</td>
<td>Hospital-Based or Freestanding</td>
<td>Pediatric</td>
</tr>
<tr>
<td>1</td>
<td>Surg/Proc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Surg/Proc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Surg/Proc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Surg/Proc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Surg/Proc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Surg/Proc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Surg/Proc</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Skill Mix and Patient Care Hours

**RN Nursing Care Hours:** Total number of productive hours worked by all registered nurses with direct patient care responsibilities.

**LVN Nursing Care Hours:** Total number of productive hours worked by all licensed vocational nurses (known in some states as Licensed Practical Nurses) with direct patient care responsibilities.

**Non RN/LVN Caregiver Care Hours:** Total number of productive hours worked by other Unlicensed Assistants (e.g., Certified Medical Assistant, Patient Care Technician, Nurses Aide). Exclude unit clerks, monitor techs, and others with no direct patient care responsibilities.

**APRN Care Hours:** Total number of productive hours worked by advanced practice nurses employed by the unit/center. Include Certified Nurse Anesthetists, Clinical Nurse Specialists, Nurse Midwives, and Nurse Practitioners in this category. Exclude APRNs that work as providers for the medical staff as physician extenders.

**Other Licensed Professional Hours:** Total number of productive hours worked by other licensed professionals employed by the unit/center. Examples of other licensed professionals include physical/occupational therapists, neuropsychologists, physician assistants, licensed radiologic technologists, registered dieticians, medical social workers and licensed clinical social workers.
**Total Patient Visits:** May be called by different names – e.g., registrations, admissions, encounters. Our general definition for one visit will be a bundled patient encounter: The patient crosses the threshold, registers, several things may happen to him/her while in the visit (including being sent to lab or x-ray, having one or more procedure/surgery), and then he/she is discharged and leaves the unit/center. This is ONE visit. **Visits is the denominator for all measures and MUST be submitted.**

**No Shows/Cancellations:** Patients who cancel visits/appointments at the last minute or do not show up for their scheduled appointment, not permitting replacement.

**Total Surgeries/Procedures:** An “unbundled” count of procedures/surgeries performed in the center/unit for the entire month. There may be more than one procedure in a patient visit.

**Total OR/Procedure Room Minutes for Surgeries/Procedures:** The total amount of time patients spent in the OR/Procedure Room over the entire month. It is the summed amount of time in minutes the patients were actually in the OR or Procedure Suite – using the elapsed time between the time recorded for patient “in room” and “out of room.”
“Wrongs”: Wrong Site, Side, Patient, Procedure, Implant: “Surgery performed on the wrong body part”, “surgery performed on the wrong patient”, and “wrong surgical procedure performed on a patient” all are endorsed as serious reportable surgical events by NQF and reflect adherence to “Universal Protocol”. CALNOC calculated rate = “Wrongs” per 1000 patient visits.

Patient Burns: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation, (e.g. warming devices, prep solutions, electrosurgical unit or laser). CALNOC calculated rate = patients with burns per 1000 patient visits.

Falls: Total number of visits in the month in which the patient fell one or more times within the surgery center or procedure unit. CALNOC calculated rate = patients who fell per 1000 patient visits.

Number of Falls with ANY Injury: Count of all falls that occurred in the center/unit during the entire month that resulted in an Injury Level of “minor” or greater, including assisted and repeat falls (in the same patient in one patient visit). CALNOC calculated rate = injury falls per 1000 patient visits.

Number of All Cause Hospital Admissions/Transfers from Unit/Center: The count per month of any ASC/Procedure Unit visit requiring a hospital transfer or admission upon discharge (transfer, direct admission, or 911 call). CALNOC calculated rate = hospital admissions per 1000 patient visits.
CALNOC
Ambulatory Care Service Line
Sample Reports
SUMMARY REPORT

This is a “service line” report. Each “unit type” would be listed with summary statistics for all measures for each unit type. At this time, Ambulatory Surgery/Procedure Center unit type is shown. As we add unit types, this report will show them, too.
Data intentionally removed.
COMPARISON REPORTS - EXAMPLES

Every measure is available to be selected in this report format. Comparison is at the facility level, with summary statistics available on page 2 of the report.
Data intentionally removed.
UNIT-SPECIFIC BENCHMARK REPORT

Each Facility can run reports on individual Ambulatory Surgery/Procedure Center “units”. One unit may be selected, or the report may be run for all units. The example shows data for a “blinded” facility and “blinded” unit name.
Data intentionally removed.
# CALNOC Quarterly Submission Schedule

## CALNOC Data Submission and Reporting Deadlines

(Deadlines are the same each year.)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>All Data for All Service Lines</th>
<th>Reports Available on CALNOC Website*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CALNOC Upload to NDNQI(^1)</td>
<td>All Other CALNOC Submitters</td>
</tr>
<tr>
<td></td>
<td>Due Date</td>
<td></td>
</tr>
<tr>
<td>Jan-March</td>
<td>May 1</td>
<td>May 8</td>
</tr>
<tr>
<td>Apr-June</td>
<td>August 1</td>
<td>August 8</td>
</tr>
<tr>
<td>July-Sept</td>
<td>November 1</td>
<td>November 8</td>
</tr>
<tr>
<td>Oct-Dec</td>
<td>February 1</td>
<td>February 8</td>
</tr>
</tbody>
</table>
Phase II: 2016
• Phase I measures incorporated into CALNOC benchmarking repository.
• Ambulatory “Users” Group to advise future unit types and settings.

Phase III:
• Development of volume or workload measure that captures care coordination or navigation activities in collaboration with AAACN to capture encounters in which the nurse is directly engaging with the patient/family or with another provider in evaluating patient status, formulating plan of care, measuring goal attainment and determining treatment outcomes.
• Incorporate metrics already gathered by Magnet Journey facilities as well as other endorsed measures that have evolved. For example, RN education, certification, years of experience, and voluntary staff turnover are already captured for those on the Magnet Journey and can be incorporated into benchmarking registries as these evolve.
• Consideration of previously endorsed measures:
  ▪ Documentation of current medications
  ▪ Medication Reconciliation
  ▪ Pain assessment and follow up
  ▪ Advanced Care Plan for Age 65+
  ▪ Fall Risk Assessments (for the home environment) and Plan of Care
  ▪ Pending Diagnostic Tests
  ▪ Ambulatory CAHPS (Consumer assessment of Healthcare Providers & Systems)
  ▪ Avoidable admissions
Also for Ambulatory........

EMERGENCY DEPARTMENT SERVICE LINE
Data intentionally removed.

Variation between low/high volume hospitals and trauma/non-trauma hospitals as expected except with contracted staff – non-trauma facilities use more registry.

Boarding variation amongst units and rates by types of ED:

- 0.80 <3000 visits/month
- 2.46 > 3000 visits/month
- 1.11 non trauma
- 2.08 trauma
Processing Patients

• Processing ED admissions – low volume hospitals better than CMS average, high volume higher
  • arrival time until admission
  • decision time until admission
• As expected, trauma ED and high volume ED admit more patients to the hospitals but preliminary trend is decreasing admission rates (14%-19% in 2015).
Patients Leaving the Emergency Department:

- Left Without Being Seen (LWBS)
- Left Before Treatment Complete (LBTC)
- Left Against Medical Advice (AMA)

For All Types
- Higher rates in high volume departments
- Non-trauma departments with higher LWBS
- Great variation between hospitals within all department types or volumes
  - Outliers
  - median values better comparison
NEW OPPORTUNITY FOR BENCHMARKING
Partners in patient safety and quality.
Strategic Alliance with Advisory Board

• Leveraging data for hospitals working with both the Advisory Board and CALNOC.

• Development of Executive Dashboard integrating clinical outcomes, Nurse Engagement and Customer Experience (HCAHPS) on the Unit Level.

• Pilot testing with Cedars, Kaiser, Virginia Mason & Legacy.
New Opportunity to Understand Patient Experience and Staff Engagement

Proposed Metrics for Quarterly Nursing Unit Dashboard
Combining Data across CALNOC, Advisory Board Survey Solutions, and HCAHPS

A Holistic View of Nursing Unit Performance

<table>
<thead>
<tr>
<th>Clinical Quality</th>
<th>Productivity</th>
<th>Staff Engagement</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Percent of patients with hospital</td>
<td>• Percent of patients in</td>
<td>• Percent of nurses who are engaged</td>
<td>• Percent of patients who strongly agree they understood</td>
</tr>
<tr>
<td>acquired pressure ulcers, Category II+</td>
<td>survey with sitter</td>
<td>• Percent of nurses who agree/strongly agree that</td>
<td>their care when they left the hospital</td>
</tr>
<tr>
<td>• All injury falls per 1000 patient days</td>
<td>• Percent contract hours of</td>
<td>“I receive the necessary support from employees in</td>
<td>• Percent of patients who reported</td>
</tr>
<tr>
<td>• CAUTI rate per 1000 urinary catheter days</td>
<td>care</td>
<td>other units/departments to help me succeed in my</td>
<td>that their nurses always</td>
</tr>
<tr>
<td>• CLABSI rate per 1000 central line days</td>
<td>• Patient (bed) turnover as</td>
<td>work”</td>
<td>communicated well</td>
</tr>
<tr>
<td>• Percent of patients who reported that</td>
<td>percentage of total patient</td>
<td>• Percent of nurses who agree/strongly agree that</td>
<td>• Percent of patients who reported</td>
</tr>
<tr>
<td>they always received an explanation of what</td>
<td>days</td>
<td>“Training and development opportunities offered by</td>
<td>that their pain was always well</td>
</tr>
<tr>
<td>any new medication was for</td>
<td>• RN hours per patient day</td>
<td>my organization have helped me to improve”</td>
<td>controlled</td>
</tr>
<tr>
<td></td>
<td>• Total hours per patient</td>
<td>• Percent of RNs with BSN+</td>
<td>• Percent of patients who reported</td>
</tr>
<tr>
<td></td>
<td>day</td>
<td>• RN voluntary turnover as a percentage of total RN</td>
<td>that they always received help as</td>
</tr>
<tr>
<td></td>
<td></td>
<td>employees</td>
<td>soon as they wanted</td>
</tr>
</tbody>
</table>
<pre><code>                                         |                             |                                                     | • Percent of patients who gave their hospital a rating of   |
                                         |                             |                                                     | 9 or 10 on a scale from 0 (lowest) to 10 (highest)          |
</code></pre>
Data intentionally removed.
- Save the Date - October 23 – 25  Monterey Plaza Hotel & Spa

2016 CALNOC CONFERENCE

Laying Track as We Go... Building on Flo’s Legacy

Celebrating 20 Years of Service

Aquarium Anyone?

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