Nassau-Suffolk Hospital Council, Inc.

Quality News

A Publication of the Nassau-Suffolk Hospital Council, Inc.

May 2012 Vol. 2 No.3

Enhancing quality and patient safety is a team effort which cuts across all provider settings and domains: primary care, inpatient care and other settings; physician, nursing, quality management, patient safety, performance improvement, compliance, risk management, information services and governance. Please circulate this publication to others so that your system/hospital leadership and department heads all will have a solid foundation upon which to enhance the quality of your patient care.

NOTE: *This issue includes a fourth page, **our primary care corner**, focusing on quality improvement issues related to primary care.*

NYS Commissioner of Health Speaks at NYS Partnership for Patients Meeting

Early this year, the Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA) began implementing the New York State Partnership for Patients program (NYSPFP). This two- to three-year quality improvement initiative, one of many national initiatives funded by a CMS grant, focuses on reducing hospital-acquired conditions by 40% and preventable readmissions by 20%. The NYSPFP had its official kickoff meeting on March 14th for the 170+ New York hospitals that agreed to participate in the initiative.

The NYSPFP receives guidance from its Statewide Advisory Committee, which held its first meeting on March 26th. During this meeting, Nirav Shah, MD, NYS Commissioner of Health, spoke about the State's support of the project. In addition, Dr. Shah challenged hospitals to insure that the hospitals' executive leadership and Board of Directors all have similar knowledge and understanding about key patient safety incidents and issues; and that hospitals collect and report to these two groups data on patient safety trends, the effect of EMRs on quality, and the frequency and types of hospital acquired conditions (HACs) like sepsis. He noted that the use of intensivists and surgeons would be beneficial to reducing HACs, as would fully engaging medical staff and primary care and partnering with non-acute care or inpatient facilities like long-term care and ambulatory surgery centers. Finally, he recommended that hospitals develop a systemic plan for empowering and engaging consumers.

New York State Hospitals and Quality

During the NYSPFP kick off meeting, HANYS and GNYHA laid the groundwork for the participating hospitals and provided them with the New York State's rankings on the key quality indicators.

READMISSIONS	HOSPITAL-ACQUIRED CONDITIONS	PATIENT SATISFACTION
50th in the country	43rd in the country	50th in the country
NYS rate =22.4%	NYS rate=1.812/1000 discharges	NYS score = 64.2%
Top state performer = 18.7%	Top state performer = 1.214/1000 discharges	Top state performer = 75%

Proposed Rules for the Electronic Health Records (EHR) Incentive Program

The last issue of Quality News provided some information about the March 7th Proposed Rules for the EHR Incentive Program. Below is additional information, which clarifies several points. For FFY 2013, CMS has proposed that eligible hospitals be required to submit information on each of the 15 Clinical Quality Measures finalized for FFY 2011 and 2012. Beginning with FFY 2014, CMS has proposed that hospitals (regardless of whether they are in Stage 1 or Stage 2 of Meaningful Use) submit a total of 24 Clinical Quality Measures from a menu of 49 measures. Most of the proposed new measures have the same name as current Medicare Inpatient Quality Reporting (IQR) or The Joint Commission (TJC) measures. However, the data sources and specifications for e-measures differ from IQR or TJC measures. The following proposed seven measures for the EHR incentive program are new quality measures for CMS: newborns screened for hearing loss before hospital discharge; first temperature measures within one hour of admission to the NICU; first NICU temperature < 36 degree C; proportion of infants 22 to 29 weeks gestation treated with surfactant who are treated within two hours of birth; pain assessment on admission to the PICU; PICU periodic pain assessment and healthy deliveries. One additional measure proposed as an EHR Incentive Program Stage 2 Clinical Quality Measure is the Outpatient Quality Reporting measure: ED-3 Median Time from ED Arrival to Departure for Discharged ED Patients. The final rule is expected by August, 2012.

Proposed Changes to Quality Measures in Released Rule

On April 24, CMS released a Proposed Rule on the Medicare Hospital Inpatient Prospective Payment System (PPS) and FY 2013 Rates … and Quality Reporting Requirements. Below is a summary of the proposed changes.

MEDICARE INPATIENT QUALITY REPORTING

Affecting Payment for FFY 2015:

Removal of These Measures

- SCIP-VTE-1 Surgery patients with recommended VTE prophylaxis orders

Hospital Acquired Conditions Measures: (claims- based measures only, not NHSN measures)

- Air embolism
- Blood Incompatibility
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Falls and Trauma
- Foreign Object Retention From Surgery
- Manifestations of Poor Glycemic Control
- Pressure Ulcers III/IV
- Vascular Catheter Associated Infections

Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator Measures:

- PSI-06 Iatrogenic Pneumothorax
- PSI-11 Post Operative Respiratory Failure
- PSI -12 Post Operative PE or DVT
- PSI-14 Postoperative Wound Dehiscence
- PSI-15 Accidental Puncture or Laceration

AHRQ Inpatient Quality Indicators:

- IQI-11 Abdominal Aortic Aneurysm Repair Mortality
- IQI-19 Hip Fracture Mortality Rate
- IQI-91 Mortality for selected medical conditions

Addition of These Measures

- *Hip/knee complication rate following Elective Primary Total Hip or Knee Arthroplasty*
- *Hospital 30-day All- Cause Risk Standardized Readmission Rate following Elective Total Hip or Knee Arthroplasty*
- *Hospital 30-day All-Cause Unplanned Readmission Rate For Eligible Conditions*
- *Elective delivery prior to 39 weeks gestation (chart abstracted)*

To HCAHPS: 3-item care transition measure
Upon discharge:

- *staff took preferences of patient/family into account in deciding needs*
- *patient had a good understanding of the things s/he was responsible for managing*
- *patient clearly understood the purpose of medications*

Additional Patient Question to HCAHPS Survey

- *Questions asking if patient was admitted through the ER and how patient would rate his/her mental or emotional health*

Affecting Payment for FFY 2016:

All of the above plus:

- *Indication of Use or Lack of Use of Safe Surgery Checklist*

Proposed Changes to Quality Measures (cont.)

HOSPITAL VALUE-BASED PURCHASING

Affecting Payment for FFY 2015

Removal of Measures

- SCIP-Inf-10 Surgery Patients w/Perioperative Temperature Management
- SCIP-VTE-1

Addition of Measures

- Clinical Process of Care Measure: AMI-10 Statin Prescribed at Discharge
- Outcome Measures: PSI-90, the AHRQ composite of patient safety and CLABSI, Central Line-Associated Blood Stream Infection
- Efficiency Domain: Medicare spending per beneficiary 3 days before to 30 days post discharge baseline period 5/1/11-12/31/11; performance period 5/1/13-12/31/13

Performance and Baseline Periods for Measures for FFY 2015

- All Clinical Process of Care measures except AMI-10 have performance periods 1/1/13-12/31/13
- Patient Experience of Care Domain: Baseline period Calendar Year 2011; Performance Period Calendar Year 2013
- Outcome Domain: Mortality Measures Baseline 10/1/10-6/30/11; Performance period 10/1/12-6/30/13 and
  AHRQ PSI composite: Baseline 10/15/10-6/30/11; Performance period 10/15/12-6/30/12 and
  CLABSI measure: Baseline 1/26/11-12/31/11; Performance period 1/26/13-12/31/13

Domain weighting for FFY 2015 Hospital VBP

- Clinical Process of Care-20%
- Patient Experience of Care-30%
- Outcome- 30%
- Efficiency-20%

Affecting Payment for FFY 2016:

- All of the above except for CLABSI measure

Other Proposed Changes to Hospital VBP for FFY 2016 Payment

Dividing measures into six rather than four domains. Current four domains are: Clinical Process of Care; Patient Experience of Care, Outcome and Efficiency. Proposed six domains: Clinical Process; Person/Caregiver-Centered Experience and Outcome; Efficiency and Cost Reduction; Care Coordination; Safety; and Community/Population Health.

HOSPITAL-ACQUIRED CONDITIONS

There are 10 current categories of Hospital-Acquired Conditions (HACs) which effect hospital payment from Medicare. Hospitals are not paid the additional costs associated with these conditions unless the conditions were present on admission. These conditions are: Air embolism; Blood Incompatibility; Catheter-Associated Urinary Tract Infections; Falls and Trauma; Foreign Object Retention From Surgery; Manifestations of Poor Glycemic Control; Pressure Ulcers III/IV; Vascular Catheter Associated Infections; Surgical Site Infections Following Coronary Artery Bypass Graft, Bariatric Surgery For Obesity, or Certain Orthopedic Procedures; and Deep Vein Thrombosis/Pulmonary Embolism Following Total Knee Replacement and Hip Replacement.

The proposed rule would add:

- to the Vascular Catheter-Associated Infection HAC category two diagnosis codes: Bloodstream Infection Due to Central Venous Catheter and Local Infection Due to Central Venous Catheter
- two new HACs Condition: Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) Procedures AND Iatrogenic Pneumothorax with Venous Catheterization.

HCAHPS

An integral part of the health care team is the patient. Engaging the patient in improving his/her health care is a challenge involving changing the way we speak to patients in order to ensure that they fully understand what we are saying. It also involves focusing more on the consumer perspective and the consumer experience. The Centers for Medicare and Medicaid Services require hospitals to use HCAHPS scores, standardized questions for hospital inpatients, as a tool for improving quality, safety and the patient experience of care. There is mounting evidence of a relationship between patient experiences and hospital readmissions within 30 days, measures of hospital quality and patient safety, and clinical quality and inpatient mortality in acute myocardial infarction. The HCAHPS survey contains 27 questions including questions concerning nurse communication, doctor communication, medication communication, responsiveness, pain management and discharge information.

This year, HANYS has partnered with the Health Research and Educational Trust of the American Hospital Association and AHRQ to implement a five-month HCAHPS learning network curriculum. The curriculum is providing practical tools and resources to help hospitals use HCAHPS results for improving quality, safety and the patient's experience of care. To access more information about the HANYS program, click here or go to www.hanys.org, under quality/ clinical and operational issues. For a comprehensive listing of resources to help improve your patients' experience of care, read *The Health Care Leader Action Guide to Effectively Using HCAHPS,* Health Research & Educational Trust, Chicago, March 2012 by clicking here or going to www.hpoe.org.

NOTE: as of October 1, 2013, as part of Hospital Value-Based Purchasing, a hospital's annual update factor will be partly dependent upon HCAHPS scores.

Patient-Centered Care Resources from AHRQ

The eighth podcast in an AHRQ series focused on patient-centered care and quality improvement features Wendy Leebov, president and CEO of Leebov Golde & Associates discussing communication strategies that health professionals can use to significantly enhance patients' experience with care. Other podcasts in this series include: *Practical Strategies for Gathering Feedback Directly from Patients; Identifying Areas to Improve; Advancing Quality Through Teamwork at Multiple Levels; and the Case for Improving Patient Experience*. To access these click here or go to the CAHPS website at www.cahps.ahrq.gov.

Health Care Leaders Action Guide: Hospital Strategies for Reducing Preventable Mortality

In Federal Fiscal Year 2014, Hospital Value-Based Purchasing will include quality measures related to mortality: AMI 30-day risk adjusted all cause mortality; Heart Failure 30-day risk adjusted all cause mortality; and Pneumonia 30-day risk adjusted all cause mortality.

In March 2011, the Health Care Educational Trust released "Health Care Leaders Action Guide: Hospital Strategies for Reducing Preventable Mortality."

This guide is a comprehensive compilation of a number of electronic resources including case studies and those on general topics, the use of checklists, bundled protocols, multidisciplinary teams and communication tools, structural processes for mortality review and articles on reducing preventable mortality.

Click here or go to www.hpoe.org to download a copy of this.

National Health Care Decisions Day

Does your facility or practice make an active effort to encourage patients to complete a health care proxy form? Do you have copies of your patients' forms in their charts? Have you completed your own health care proxy form designating someone to speak for you in the event that you cannot speak for yourself? Many individuals have not taken the necessary steps to ensure that their health care wishes are honored when they cannot speak for themselves. Appointing a health care "agent" or spokesperson, talking to him/her about your wishes, and completing a health care proxy form are all necessary and easy steps to making sure that the appropriate safeguards are in place.

Advanced care directives are not just for older adults or those terminally ill. Any one of us could find ourselves suffering a traumatic health event resulting in our families battling for the right to make health care decisions honoring our wishes. The three women whose names are most prominent in the end of life field - Karen Ann Quinlan, Nancy Cruzan or Terri Schiavo - were all in their 20s.

National Healthcare Decisions Day was Monday, April 16th. As health care providers we must lead the way in demonstrating the importance of completing an advanced care directive and working with our staff and patients in doing the same. For more information, click here or see state specific resources at www.nhdd.org.

Medicare Annual Wellness Visit and Risk Assessments

In 2012, CMS required physicians to use a Health Risk Assessment (HRA) as part of the required Medicare Annual Wellness visit (AWV). The purpose of the HRA is to systematize the identification of health behaviors and risk factors for a physician to develop a personalized prevention plan with the patient. CMS does not currently require a specific HRA but the Centers for Disease Control and Prevention developed a 52-page framework for the HRA noting that the HRA must be written at a sixth grade literacy level and be designed so that most patients can complete it in 20 minutes or less.

The American Academy of Family Physicians recently published an article outlining the benefits of using HowsYourHealth (HYH), a free online assessment tool developed by Dartmouth Medical School. HYH offers two interactive questionnaires that meet the requirements for the AWV: a brief questionnaire (at www.medicarehealthassess.org) which asks the required questions and summarizes the results for the physician/practice as a personalized action plan; and a longer questionnaire available at www.medicarehealthassess.org and at www.howsyourhelath.org which offers a more comprehensive health assessment. The latter adds to the required items of the AWV a full assessment of the patient’s problems and priorities (asking the patient both “what is the matter” and “what matters”) and requires more time to complete. But it also offers more information to patients and practices and is available for patients of all ages. There is no charge for the use of either questionnaire. Practices that wish to customize the assessment, receive real-time aggregate information and use a patient- loaded register can do so by paying a small fee to support further development of the tools.

HYH provides complete health assessment, feedback and self management support. It has been endorsed by the Institute for Healthcare Improvement, the Commonwealth Fund and the Mayo Clinic and has been used extensively in Chicago, Illinois; Long Beach, California and the state of New Jersey.

New Cervical Cancer Screening Guidelines Announced

In March 2012, both the United States Preventive Services Task Force and the American Cancer Society, in concert with the American Society of Colposcopy and Cervical Pathology and the American Society for Clinical Pathology, released separate, updated cervical cancer screening guideline recommendation statements. Notable differences from previous guidelines include a recommendation against screening women less than 21 years of age for cervical cancer and the option of a lengthened five-year screening interval for those women aged 30-65 screened with a combination of Pap testing and human papillomavirus (HPV) testing.

2013 eRx Payment Adjustment

Individual eligible professionals and group practices participating in the eRx Group Practice Reporting Option (GPRO) who are NOT successful electronic prescribers AND do not satisfy the exclusion criteria or qualify for a hardship exemption will be subject to a 1.5% payment adjustment on their Medicare Part B services provided in 2013.

To avoid the 2013 eRx payment adjustment, eligible professionals must have successfully e-prescribed in 2011 or need to report to CMS via claims. The latter requires the professional to report the G8553 code via claims for at least 10 billable Medicare Part B Physician Fee Schedule services provided January 1, 2012 through June 30, 2012, regardless of whether the claim contains coding in the eRx measures denominator. Electronic prescribers using the eRx GPRO must report the G8553 code for 625 - 2,500 unique Medicare Physician Fee Schedule encounters (depending upon the number of eligible prescribers in the practice) regardless of whether the claim contains coding in the eRx measures denominator.

On March 1, 2012, the Centers for Medicare and Medicaid Services (CMS) re-opened the Quality Reporting Communication Support Page to allow eligible professionals and CMS-selected group practices the opportunity to request a significant hardship exemption to avoid the 2013 eRx payment adjustment. **The Communication Support Page will accept hardship exemption requests now through June 30, 2012. Those who have received a previous hardship exemption must reapply as the exemption is subject to annual renewal.**

Initial Core Set of Quality Measures for Medicaid Eligible Adults

Earlier this year, CMS published a final rule establishing an initial core set of quality measures for Medicaid-eligible adults for voluntary use by state Medicaid agencies. These 26 measures cover areas such as prevention and health promotion, management of acute and chronic conditions, care coordination, family experiences of care and availability. The majority of these measures are measures currently being used in various federal and public sector programs including the Physician Quality Reporting System and the National Committee for Quality Assurance. For a list of these measures email Mary Jane Milano at mmilano@seagatealliance.com .