

SOW News

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CMS Announces FY2006 Rate Increases for Inpatient Stays in Acute Care Hospitals

Acute care hospitals that report selected quality data will receive a 3.7 percent increase in payment rates for inpatient services under a final rule issued by the Centers for Medicare & Medicaid Services (CMS). This increase is 0.5 percentage points above the market basket projected in the proposed rule published last May. Aggregate payments to Inpatient Prospective Payment System (IPPS) hospitals in fiscal year (FY) 2006 are expected to increase by \$3.3 billion over 2005.

The final rule also reduces the outlier threshold to \$23,600 in 2006, from \$25,800 in 2005. The outlier threshold is used to determine how much a hospital's costs for a particular case must exceed the DRG payment before extra payments will be made for the case. As a result of the lower threshold, it will be easier for hospitals to qualify for additional payments in 2006.

Only those hospitals that are participating in Medicare's quality reporting initiative will receive the full 3.7 percent increase. As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act, or MMA), hospitals that do not submit quality information will receive an update that is 0.4 percentage points lower, or 3.3 percent. However, CMS expects that, as in 2005, the overwhelming majority of acute care hospitals will participate in the quality reporting program in 2006.

The final rule enhances the voluntary quality reporting program by including requirements that improve the accuracy of the reported data. In order to receive the full payment for FY2006, hospitals must correctly abstract and report clinical data on 10 quality measures relating to the treatment of heart attack, heart failure, and pneumonia cases for two consecutive quarters.

CMS projects that the combined impact of the 3.7 percent inflation update and other changes (such as the expansion of the postacute transfer policy, Medicare payment for outliers, etc.) being adopted in the final rule will yield an average 3.5 percent increase in payments for operating costs for urban hospitals in FY2006, while rural hospitals will see an average increase of 3.3 percent.

The final rule also revises nine cardiovascular surgery DRGs that account for over 700,000 Medicare discharges per year. In response to public comment, and consistent with recommendations by the Medicare Payment Advisory Commission (MedPAC), CMS is making these revisions so Medicare's payments better recognize severity of illness. The changes announced in the final rule will differentiate cardiac surgery patients based on whether they have a "major cardiovascular condition."

The final rule also expands the number of DRGs that are subject to the postacute care transfer policy. This policy reduces payment to the hospital when the patient is transferred after a short stay to a postacute care setting that provides most of the patient's care. The purpose of this policy is to protect Medicare from paying for the same care twice: once as part of the hospital's payment for the DRG, and then as a separate payment to the postacute facility.

The final rule reduces the share of Medicare's inpatient hospital payments that are attributable to hospital labor costs from 71.1 percent to 69.7 percent for hospitals in areas that have labor costs greater than the national average. The result would be a very small reduction in the rates paid to these hospitals. For all other hospitals, the statute requires the labor-related portion of Medicare's inpatient hospital rates to equal 62 percent. Any savings associated with the proposed change in the labor-related portion of Medicare's rates will be returned to all hospitals nationally through a higher base rate of payment.

Finally, the final rule defines how a Critical Access Hospital (CAH) that was designated by a state as a "necessary provider" can retain that status after relocating its facility. The Medicare Modernization Act of 2003 eliminated the authority of states to designate CAHs as "necessary providers." This

designation allowed a CAH to be situated less than 35 miles from the nearest hospital. However, the MMA did not specify how existing CAHs with necessary provider status should be treated if they relocate.

The final rule will appear in the August 12, 2005, *Federal Register*. The new policies and payment rates will become effective October 1, 2005. For more information, visit the CMS Web site at <http://www.cms.hhs.gov/providers/hipps/default.asp>. For details on modified cardiac DRGs to improve payment, go to the following URL: <http://www.cms.hhs.gov/media/press/release.asp?Content=1526>

August 15, 2005: First Quarter Data Deadline Submission

The cutoff date for submitting 1st Quarter 2005 data to the warehouse is fast approaching. If you use a JCAHO vendor, please work with the vendor to see that your data has been successfully transmitted. CART users that experience any difficulty should contact Suzette Googins at (602) 745-6299. There are reports available on QualityNet Exchange for all users to run (under "Feedback Reports") that you can use to verify that the number you abstracted is the number in the warehouse. A detail report will also help you troubleshoot any problem cases that may exist. Remember, this 1st Quarter 2005 discharge data begins a new cycle for the Medicare annual payment update, FY2007.

Medication Reconciliation Round-Table Discussion

A WebEx round-table presentation on medication reconciliation (MR) was recorded at Health Services Advisory Group (HSAG) on July 13 and featured a panel of Arizona clinicians who have implemented MR in the hospital setting. The 35-minute presentation, titled "Medication Reconciliation—Reconciliation Realities," was the last in a series of WebEx presentations related to patient safety and MR developed by HSAG's Hospital Workgroup

(HoW) subcommittee to assist hospitals with the process of MR across care settings.

The WebEx round-table presentation featured Barb Averyt, Program Director—Safe and Sound, Arizona Hospital and Healthcare Association (AzHHA); Linda McCoy, Director of Clinical Patient Safety, Banner Good Samaritan Medical Center; Eric Nelson, Director of Pharmacy, Mayo Clinic—Arizona; and Lorraine Olshelski, Vice President of Care Management, Abrazo Health Care. Panelists discussed issues surrounding getting started with a MR process, the use of computers in MR, challenges of implementation, using Plan-Do-Study-Act (PDSA) cycles, and useful resources.

The presentation also highlighted the MedForm—a form designed to assist patients in tracking their at-home medications—which will be launched statewide for use by all consumer and health care professionals in September.

The latest MR presentation is hosted on the QualityNet Exchange e-Learning Center at <https://ifmcevents.webex.com> under Recorded Events. In addition, HSAG’s Acute Care Project Web site, <http://acute.hsag.com/medrecon>, contains instructions on how to access the WebEx presentations, as well as copies of the slide presentations and related MR materials.

AzHHA Supports Medication Reconciliation September 1 Seminar

By January 1, 2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will require that all accredited hospitals have a system in place for medication reconciliation. Coincidentally, medication reconciliation is also one of six initiatives in IHI’s *100k Lives Campaign*. The topic will be addressed at “Some is Not A Number, Soon Is Not A Time: Medication Reconciliation, Are You Ready,” an AzHHA seminar that will take place September 1 at the Orange Tree Golf Resort in Scottsdale. The program will provide attendees with education and tools to meet JCAHO’s January deadline. In a session titled “Examples of Excellence,” attendees will learn how several organizations from around the country have overcome barriers and successfully addressed

medication reconciliation. In addition, participants will be among the first to receive Arizona’s Universal Medication Reconciliation form, dubbed “The Med Form.” The seminar will feature guest speaker Peter Pronovost, MD, PhD, who will discuss the “science of safety” and share his experience with medication reconciliation at Johns Hopkins. For more information, visit www.azhha.org/public/education/programs/edu_programs.cfm or e-mail edservices@azhha.org.

AHRQ Study: Americans Frequently Visit Doctors for Treatment of Adverse Drug Events

More than 4.3 million visits to physicians’ offices, hospital outpatient departments, and hospital emergency departments in 2001 were for treatment of adverse drug effects, up from 2.7 million in 1995, according to a new study by researchers from the Agency for Healthcare Research and Quality (AHRQ). The study, “Ambulatory Care Visits for Treating Adverse Drug Effects in the United States, 1995–2001,” was published in the July issue of the *Joint Commission Journal on Quality and Patient Safety*. In 2001, 74 percent of all visits for treating adverse drug effects were made to physicians’ offices, 20 percent to hospital emergency departments, and 6 percent to hospital outpatient departments. Antibiotics and other anti-infectives were most frequently associated with visits for adverse drug effects, followed by hormones and other synthetic substitutes. The most frequent adverse effects suffered include dermatological symptoms, such as a skin rash, followed by gastrointestinal symptoms, such as nausea, vomiting, and abdominal pain. These rates were higher for people aged 65–74 years and were more prevalent in women. A print copy of the study is available by sending an e-mail to ahrqp@ahrq.gov.

[This information was accessed from the August 2, 2005, Issue #174 of the *AHRQ Electronic Newsletter*.]

Hydralazine/Nitrates for HF in Black Patients

Based upon the results of the recent African American Heart Failure Trial (A-HeFT), the U.S.

Food and Drug Administration (FDA) has approved the drug BiDil for use in the treatment of heart failure in self-identified black patients. BiDil is a fixed dose combination of two drugs, hydralazine and isosorbide dinitrate, that are individually available in generic form. In response to both the publication of the A-HeFT results and the FDA approval of BiDil, CMS and JCAHO have published a “Measures Fact Sheet.” (A link to the “Measures Fact Sheet” can be found in the What’s New box at <http://acute.hsag.com>.)

The study’s impact on the CMS/JCAHO ACE/ARB recommendations for use in HF can be summarized as follows:

1. A-HeFT was performed in the context of contemporary medical therapy for heart failure, including nearly universal use of ACE-inhibitors or ARBs. Thus, BiDil was shown to be an important addition to ACE-inhibitor or ARB therapy in patients selected for the trial.
2. A-HeFT did not demonstrate (and was not constructed to demonstrate) that black patients fail to benefit from ACE-inhibitors or ARBs. Existing guidelines recommend the use of ACE-inhibitors in the absence of contraindications in all patients with LVSD, regardless of race.
3. A prior study designed to compare the combination of hydralazine/nitrates with ACE inhibitors demonstrated the superiority of ACE-inhibitors.

Based upon the current evidence, including the A-HeFT results and the FDA decision resulting from the study, the current quality measures for ACE-inhibitors or ARB in patients with heart failure and LVSD will not change.

Quality Interventions Available on MedQIC

The Medicare Quality Improvement Community (MedQIC, pronounced med-quick) is a national knowledge forum for health care and quality improvement professionals. It provides easy access to quality improvement resources and a community of professionals sharing knowledge and experiences to

accelerate health care quality improvement across the nation.

In 2004, MedQIC was redesigned through a partnership with the Institute for Healthcare Improvement (IHI) to use a structure and organization similar to www.IHI.org. The redesigned MedQIC was publicly launched in 2005 and is refined continually to meet its end-users’ needs.

MedQIC fosters a community-based approach to quality improvement. The information found on MedQIC includes interventions that can change processes, structures, or behaviors in health care settings. In addition, various tools, literature, and success stories are available for MedQIC users to study and implement in their own quality improvement efforts. Topics for improvement include: AMI, HF, immunization, pneumonia, rural and critical access hospitals, and surgical infection prevention

MedQIC offers providers resources they need to conduct quality improvement interventions. Some of these resources come from sources outside of the QIO community. As a rule, copyrighted materials will not be placed on MedQIC unless the permission has been obtained from the copyright holder.

MedQIC is sponsored by CMS to support and promote its Medicare Quality Improvement Program and its contractors, the Quality Improvement Organizations (QIOs), in helping Medicare providers deliver the right care to every Medicare beneficiary, every time.

Access MedQIC at <http://www.medqic.org>. There is no fee for use and no required registration.

Spend Time Learning from a WebEx Presentation

WebEx presentations are available for live, interactive, or previously recorded viewing. The programs appear as a PowerPoint presentation with the speaker discussing the slides as if he or she were standing in front of a conference room. The Iowa Foundation for Medical Care (IFMC) is CMS’s WebEx meeting service provider. The site contains a wide variety of topics, including clinical, process improvement, and informational presentations.

To access a recorded event:

1. Open Internet Explorer.
2. Type in <https://ifmcevents.webex.com> and hit Enter.
3. On the left side of the screen, click on Recorded Events.
4. Locate the name of the event.
5. Click on the View button.
6. Enter information as prompted.
7. To relocate the WebEx Player box from the center of the screen, please do the following:
 - a. Left click and hold on the words “WebEx Player” in the top left corner of the box.
 - b. Drag the box down to the bottom of the screen or to one of the corners.

In addition to the series of presentations on medication reconciliation, viewers may find the following useful:

- SIP/SCIP WebEx—Moving to Reliability
 - Presented by Dale W. Bratzler, DO, MPH, Principal Clinical Coordinator, Oklahoma Foundation for Medical Quality, and James Liljestrand, MD, MPH.
- Creating a Culture of Change
 - Presented by William C. Rupp, MD.
 - The session discusses experiences of culture change and lessons learned.
- Nuts and Bolts of Patient Safety in the ED
 - Presented by Rahul K. Khare, MD.
 - Evaluate, define and identify patient safety issues specific to the ED environment.
- QNet Exchange 101
 - Presented by Earl Kurashige and Paula Parsons.
 - Viewers can learn how to use the File Exchange and Search and register new user accounts.
- Transformational Improvement in AMI Care and Best Practices for Difficult Indicators
 - Presented by Richard Gray, MD, and Patricia Lucken, RN, MSN, PHN, FNP-C.
- Timely Receipt of Antibiotics for PN Diagnosis: Rationale, Interventions & Overcoming Obstacles.
 - Presented by Dale W. Bratzler, DO, MPH, Principal Clinical Coordinator, Oklahoma Foundation for Medical Quality.
 - Dr. Bratzler discusses rationale, possible process changes, and how to overcome barriers.

AHRQ Offers New Patient Safety Web Site

AHRQ's new national Web site—<http://psnet.ahrq.gov/>—is a valuable gateway to resources for improving patient safety and preventing medical errors. It is the first comprehensive effort to help health care providers, administrators, and consumers learn about all aspects of patient safety. The Web site includes summaries on tools and findings related to patient safety research; information on upcoming meetings and conferences; links to articles, books, and reports; and a listing of annotated bibliographies. Physicians, nurses, hospital administrators, and others can customize the site around their unique interests and needs through the Web site's unique “My PSNet” feature.

HF Outpatient Program Free to Patients

Heart-Partners, a pilot project that began in February and will run for three years, aims to identify and address changes in a patient's condition before complications require hospitalization. The project is being conducted by Heart-Partners, a collaborative group. The project is modeled after a successful smaller program. The pilot project has four elements: daily weight monitoring, a drug plan, access to nurses, and a cardiologist consult with the participant's doctor. The pilot program is open at NO CHARGE to patients with heart failure who are enrolled in traditional fee-for-service Medicare. It is not open to people who are members of a Medicare managed-care plan. For additional information, contact Lynda Ellington at 602-690-5690 or lynda.ellington@qmedinc.com. To read an article about Heart Partners, go to http://www.tucsoncitizen.com/index.php?page=local&story_id=072104a4_chfstudy_2_boxes

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