

SoW News

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CMS Releases Final Decision Regarding RHQDAPU

The August 1, 2006, *Federal Register* Notice contains the Centers for Medicare & Medicaid Services (CMS) final decision for the new requirements for Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU). These decisions are based upon Section 5001 of the 2005 Deficit Reduction Act and public comment. The entire document can be accessed at the [CMS Web site](#) (click on the link). Pages 588–657 of the 1468-page document address the final decision. The document includes comments and CMS’ responses. Hospitals may find the comment and response portions of the document helpful in understanding rationale, methodology, and motivation for decisions surrounding RHQDAPU. The highlights below are only intended as a brief overview and contain only information pertaining to fiscal year 2007. Information surrounding issues beyond fiscal year 2007 will be discussed in the September issue of *SoW News*. Health Services Advisory Group’s Acute Care Team is available to assist you in understanding the notice.

Conclusions (p. 655)

Conclusions based upon the 2005 Deficit Reduction Act and stakeholder comments include:

- The APU reduction for RHQDAPU nonparticipation will be increased to 2.0 percentage points from 0.4 percentage points.
- The expanded quality measure set was adopted as proposed (see below).
- Reporting the expanded quality measures will begin with July 1, 2006, discharges. The deadline for hospitals to submit data for this quarter will be February 15, 2007.
- The final deadline for hospitals to complete and send the revised “Reporting Hospital Quality Data for Annual Payment Update Notice of Participation” form to their respective Quality Improvement Organizations (HSAG is Arizona’s QIO) is no later than August 15, 2006. [*If you have not yet submitted your revised participation*

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form to HSAG, contact Charlie Chapin or Suzette Gerhart.]

Expanded Measure Set (pp. 605–606)

Acute Myocardial Infarction (AMI)

- (AMI-1) Aspirin at arrival
- (AMI-2) Aspirin prescribed at discharge
- (AMI-3) ACE inhibitor (ACE-I) or angiotensin receptor blockers (ARBs) for left-ventricular systolic dysfunction
- (AMI-4) Adult smoking-cessation advice/counseling
- (AMI-5) Beta blocker at discharge
- (AMI-6) Beta blocker prescribed at arrival
- (AMI-7a) Thrombolytic agent received within 30 minutes of hospital arrival
- (AMI-8a) Percutaneous coronary intervention (PCI) received within 120 minutes of hospital arrival

Heart Failure (HF)

- (HF-1) Discharge instructions
- (HF-2) Left-ventricular function assessment
- (HF-3) ACE inhibitor (ACE-I) or angiotensin receptor blockers (ARBs) for left-ventricular systolic dysfunction
- (HF-4) Adult smoking-cessation advice/counseling

Pneumonia (PN)

- (PN-1) Oxygenation assessment
- (PN-2) Pneumococcal vaccination status
- (PN-3b) Blood culture performed before first antibiotic received in hospital
- (PN-4) Adult smoking-cessation advice/counseling
- (PN-5b) Initial antibiotic received within 4 hours of hospital arrival
- (PN-6) Appropriate initial antibiotic selection
- (PN-7) Influenza vaccination status

Surgical Care Improvement Project (SCIP)

- (SCIP-1) Prophylactic antibiotic received within 1 hour prior to surgical incision
- (SCIP-2) Prophylactic antibiotics discontinued within 24 hours after surgery end time

New Procedures (pp. 595–597)

In addition to the revised Reporting Hospital Quality Data for Annual Payment Update Notice of Participation form (bullet 4, Conclusions) new forms and procedures will be found in the RHQDAPU section of QualityNet (formerly known as QNet Exchange).

Stakeholder Comment/ CMS Response: SCIP Data Collection (pp. 609–610)

Stakeholder Comment: Stakeholders were concerned about the added resources necessary to collect and report SCIP data.

CMS Response: CMS is required to begin to adopt the baseline set of performance measures as set forth in the 2005 IOM report, which include the SIP/SCIP measures. CMS weighed the burden for the hospital to report additional quality data for the measure against the benefits of addressing recognized gaps in quality and providing beneficiaries with useful information on the quality of hospital care.

That balance is appropriate and valuable on three levels, given the potential improvements in surgical site infections that can occur through proper antibiotic use. It is estimated that over half of the 127,000 surgical site infections that are contracted by Medicare beneficiaries were preventable (Best WR, Khuri SF, et al.; Identifying Patient Preoperative Risk Factors and Postoperative Adverse Events in Administrative-Databases: Results from the Department of Veterans Affairs National Surgical Quality Improvement Program, *J Am Coll Surg*, 2002;194:257–266).

SCIP measures are designed as a framework to help hospitals organize and coordinate care. Evidence has shown that when hospitals change their internal systems to reliably deliver the care mandated in the

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SCIP measures, they are more efficient and safer for patients. For example, a nationwide collaborative dedicated to improve the processes of care outlined in the proposed SCIP infection measures demonstrated a significant reduction in surgical site infection (Dellinger EP, Hausmann SM, et al., Hospitals Collaborate to Decrease Surgical Site Infections, *Am J Surg*, 2005 Jul;190(1):9–15). Reliable processes of care aimed at assuring the correct deep venous thrombosis prevention, as outlined in the proposed SCIP VTE measures, “markedly reduced” the rates of these complications in patients at risk (Kucher N, Koo S, et al.; Electronic Alerts to Prevent Venous Thromboembolism Among Hospitalized Patients, *N Engl J Med*, 2005;352:969–77).

**Stakeholder Comment/CMS Response:
Risk-Adjusted Data (p. 621)**

Stakeholder Comment: Stakeholders felt that data should be risk adjusted.

CMS Response: The set of measures currently reported on Hospital Compare are process measures for

**CMS Notifications for Data Collection:
Have You Subscribed?**

To receive CMS e-mail notifications on important and timely information related to public reporting, data collection, validation, quality improvement, and CMS requirements, go to <http://www.qualitynet.org/> and click on “Auto-Notification” in the bottom left corner. There are three separate notification lists that cover:

- Information on enhancements and new releases.
- Notification of timeline or process/policy modifications.
- Important alerts about applications and initiatives.

HSAG recommends subscribing to all three CMS notification lists. The number of messages you receive will be small, but the information is often vital. Even the CART list pertains to non-CART hospitals. Remember: The CDAC validates your medical records with CART. Don’t be in the dark—subscribe now!

which no risk adjustment is needed, since they are constructed to reflect the proportion of cases in which a patient received the care that is appropriate for his or her clinical needs. The measures are constructed to exclude cases for which an intervention would not be appropriate.

Comments and Responses related to HCAHPS begin on page 623.

CMS will be implementing the HCAHPS survey beginning in October 2006 as part of the Hospital Quality Alliance. Information on the survey can be found at http://www.cms.hhs.gov/HospitalQualityInits/30_HospitalHCAHPS.asp. CMS is planning to offer additional training and dry-run opportunities for hospitals that will join the HCAHPS initiative after October 2006.

**Stakeholder Comment/CMS Response:
Data Collection (pp. 632–633)**

Stakeholder Comment: Stakeholders were concerned that JCAHO-participating hospitals are not required to submit the data regarding all 21 measures found in the proposed rule.

CMS Response: CMS is required by the DRA to begin to adopt the measures as specified in the 2005 IOM report. CMS believes that the measures selected are appropriate because these quality measures will:

1. Provide useful and valid information about hospital quality to the public.
2. Provide hospitals with a sense of predictability about public reporting expectations.
3. Begin to standardize data and data collection mechanisms.
4. Foster hospital quality improvement.

Stakeholder Comments and CMS Responses related to data validation begin on page 635.

**Stakeholder Comments/CMS Response:
Assisting Hospitals to Pass Validation (pp. 636–637)**

Stakeholder Comment: Stakeholders felt that CMS
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should consider a validation process that would focus resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis.

CMS Response: QIOs, on behalf of CMS, work to assist hospitals with all aspects of hospital reporting activity. QIOs are available to provide training and assistance to those hospitals experiencing difficulty passing the validation thresholds. This training and assistance is designed to improve the validation scores of hospitals with failing validation scores through better performance measurement techniques and medical record documentation.

**Stakeholder Comments/CMS Response:
Validation Appeal (pp. 641–642)**

Stakeholder Comment: Stakeholders suggested that CMS review, on a case-by-case basis, any instance in which a hospital's payment would be put in jeopardy because of the validation process.

CMS Response: CMS believes that the current validation process provides a reliable estimate of abstraction accuracy on an annual basis. CMS and its contractors work closely with the CDAC regarding issues that are raised by hospitals about the validation processes. If a hospital identifies an issue where it believes that its validation score is incorrect, CMS conducts a comprehensive review.

Dr. Bratzler Addresses PPV Concerns

The following is from an e-mail message by Dale Bratzler, DO, MPH. Dr. Bratzler is the medical director of the CMS Hospital Quality Improvement Organization Support Center (QIOSC). In the message, he answers two frequently asked questions about the pneumococcal polysaccharide vaccine (PPV) performance measure (PN-2). The questions asked were:

1. Some MDs don't want their patients to have PPV because they believe that a sufficient titer will not be achieved if the patient is acutely ill. Is there any evidence to support/refute this?
2. There is also a concern about revaccinating patients

who may already have been vaccinated. The *Medicare Claims Manual* states that if a patient is "certain" she or he "was vaccinated in the last 5 years, the vaccine should not be given." This makes sense to me, but will a patient's certainty (without a date) pass muster for hospital reporting?

Dr. Bratzler's response:

Remember that PPV in Medicare age group patients is only recommended to be given once. So, if the patient reports that he or she has had the vaccine (regardless of when), the case will pass the performance measure. Any prior vaccination, regardless of date, passes the measure.

Second, the Advisory Committee on Immunization Practices is clear about unknown vaccination status; if the patient does not know about past vaccination, he or she should receive the vaccine. PPV is incredibly safe with exceptionally rare risk of any significant adverse effect other than a local injection site reaction. The injection site reaction is more common in younger patients who have been recently vaccinated and is less common in the elderly.

Finally, there are absolutely no data to support that patients in an acute care setting won't have an adequate antibody response to PPV. Inpatient vaccination with PPV is recommended by CDC (ACIP), the Infectious Diseases Society of America, and others. National performance measures from CMS and JCAHO are developed and publicly reported—it was written into the Medicare Modernization Act. Inpatient vaccination has become the standard of care.

Updated CART Abstraction Resources

The topic-specific resource documents for the CMS Abstraction & Reporting Tool (CART) have been updated to support CART 4.0 for July 1, 2006, through September 30, 2006, discharges. The updated documents are available on the QualityNet Web site; select Data Collection (CART) under the Hospitals tab, and then CART Abstraction Resources in the left sidebar of the new screen.

Transfer from a CAH

Abstractors are asked to provide the admission source of patients when abstracting medical records. One of the provided choices is “Transfer from a Critical Access Hospital.” In Arizona, there are 12 Critical Access Hospitals (CAHs). They are:

- Benson Hospital
- Copper Queen Community Hospital
- Hopi Health Care Center
- Hu Hu Kam Memorial Hospital
- Fort Yuma (IHS)
- Parker (IHS)
- Northern Cochise Community Hospital
- Page Hospital
- Sage Memorial Hospital
- Southeast Arizona Medical Center
- Wickenburg Community Hospital
- Winslow Memorial Hospital

Infection Prevention

One of the most basic tasks in health care can be responsible for preventing infections; the health care provider need only wash his or her hands. Dr. Donald Goldman offers an editorial opinion about hand

NNii Resource Kit for Health Care Professionals

The National Network for Immunization Information’s (NNii) provides a free comprehensive kit to help health care providers discuss immunization with their patients. The kit provides accessible information on everything from immunization recommendations to common questions and concerns. All materials are the product of extensive research with parents, physicians, nurses, immunization experts, and risk communication specialists. The toolkit can be accessed at http://www.immunizationinfo.org/assets/files/pdfs/KIT_FULL.pdf.

washing in the *New England Journal of Medicine*, July 13, 2006, Vol 355:121–123. “System Failure versus Personal Accountability—The Case for Clean Hands” can be found at <http://content.nejm.org/cgi/reprint/355/2/121.pdf>.

Influenza Update

The June 2006 National Influenza Summit newsletter, is available at <http://www.ama-assn.org/ama1/pub/upload/mm/36/summitnewsletter1.pdf>.

Articles within the newsletter provide information about the 2005–06 influenza season, projection of the 2006–07 influenza vaccine supply, a JCAHO announcement regarding an infection control standard that includes influenza vaccinations to staff, and other influenza-related topics.

JCAHO Requires Flu Vaccination Program

The Joint Commission on Accreditation of Health care Organizations (JCAHO) has announced the approval of an infection control standard that requires accredited organizations to offer influenza vaccinations to staff, which includes volunteers and licensed independent practitioners with close patient contact. The standard will become an accreditation requirement beginning January 1, 2007, for the Critical Access Hospital, Hospital, and Long Term Care accreditation programs. The press release is available at http://www.jointcommission.org/NewsRoom/NewsReleases/nr_06_13_06.htm.

Talking About Tobacco

“Remember, we are talking about life and death . . . it isn’t just that you are talking about a disease that smokers get that all of a sudden . . . is going to polish them off. Getting from health to death, for a smoker, is one miserable existence.”

—Former Surgeon General C. Everett Koop, 1989

What can you do to help get your patients off this deadly track? How can you talk to someone who is

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addicted to nicotine, one of the most addictive drugs known, and get them to start thinking about quitting?

Extensive research conducted in many inpatient and outpatient settings confirms that what you say does make a difference! Advice to quit from a health care provider can be a very powerful influence in helping a patient make the decision to quit. Using the Five-A model—Ask, Advise, Assess, Assist, and Arrange—you can provide an effective intervention.

Do you:

- Want to learn how?
- Want to learn more about brief and intensive interventions?
- Want to help your patients find a way off this deadly track?

The HealthCare Partnership at the University of Arizona invites you to learn the methods and techniques to help “Save a Life!”

Treatment Certification Programs

The HealthCare Partnership at The University of

Arizona will offer pre-conference workshops in conjunction with the 2006 Coalition for a Tobacco-Free Arizona 4th Annual Conference—“Best of the West: Educating, Training, and Collaborating on Tobacco Control.” Register for the September 7–8 conference at <http://www.tobaccofreeaz.org> or contact Jill Gomez at jgomez@azafp.org.

Learn best practices to deliver an integrated Five-A Model Brief and/or Intensive tobacco cessation intervention to help “Save a Life.” Certification workshops will be held in Tempe on September 5–6. To register or to obtain more information, visit the HealthCare Partnership registration Web site at <http://www.healthcarepartnership.org/ctfa2006>. If you have questions, contact Dena Omar at denaomar@email.arizona.edu or call 520.318.7253, ext. 160, or 520.954.1178.

Visit the HealthCare Partnership Web site and online calendar for additional certification workshop opportunities: <http://www.healthcarepartnership.org>.

Programs and workshops are sponsored by the Arizona Department of Health Services and The University of Arizona.

HSAG Acute Care Team Contact Information		
Howard C. Pitluk, MD, MPH, FACS Medical Director hpitluk@hsag.com 602.665.6143	Suzanne Anders, RN, BSBA, CPHQ Clinical Quality Specialist IPG Lead for SCIP sanders@azqio.sdps.org 602.665.6171 or 520.661.9370	Suzette Gerhart (formerly Googins), BA Administrative Assistant II sgerhart@azqio.sdps.org 602.745.6299
Suzanne K. Powell, RN, BSN, MBA, CPHQ, CCM Director, Acute Care/QI Program spowell@azqio.sdps.org 602.665.6109	Judith Richard, RN, MS, CPHQ Clinical Quality Specialist IPG Lead for ROSC jrichard@azqio.sdps.org 602.665.6116	Health Services Advisory Group, Inc. 1600 East Northern Avenue, Suite 100 Phoenix, Arizona 85020-3983 Phone: 602.264.6382 Fax: 602.241.0757 www.hsag.com
Charlie A. Chapin, MS, CHCA Director, Decision Support Lead for Data Collection and Validation cchapin@azqio.sdps.org 602.665.6107	Susan Sumwalt, RN, MA, CPHQ Clinical Quality Specialist IPG Lead for ACM and SIOC ssumwalt@azqio.sdps.org 602.665.6176	Hospital Quality Improvement Web Site http://acute.hsag.com

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