

# SOW News

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## AHRQ Releases 2007 National Healthcare Quality and Disparities Reports

### *Modest Health Care Quality Gains Outpaced by Spending*

The quality of health care improved by an average 2.3 percent a year between 1994 and 2005, a rate that reflects some important advances but points to an overall slowing in quality gains, according to the annual reports released by the Agency for Healthcare Research and Quality (AHRQ).

The improvement rate, reported in AHRQ’s 2007 *National Healthcare Quality Report* and *National Healthcare Disparities Report*, is lower than the 3.1 percent average annual improvement rate reported in the 2006 reports. Those reports measured trends between 1994 and 2004.

Quality improvement rates are lower than widely documented increases in health care spending. The Centers for Medicare & Medicaid Services (CMS) estimates health care expenditures rose by a 6.7 percent average annual rate over the same period.

“Health care quality is improving only modestly, at best,” said AHRQ Director Carolyn M. Clancy, MD. “Given that health care spending is rising much faster, these findings about quality underscore the urgency to improve the value Americans are getting for their health care dollars.”

Each year, AHRQ’s companion *Quality* and *Disparities* reports update national trends in the delivery of health care. The analyses measure quality and disparities in four areas: effectiveness of care, patient safety, timeliness of care, and patient centeredness.

The 2007 reports—the fifth edition since the reports’ inaugural release in 2003—show some notable gains, such as improvements in the care of heart disease patients. When measuring what portion of heart attack patients received recommended tests, medications, or counseling to quit smoking, the reports found an average 5.6 percent annual improvement rate from 2002 to 2005.

Measures of patient safety, meanwhile, showed an average annual

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improvement of just 1 percent. That modest improvement rate reflected such measures as what portion of elderly patients had been given potentially harmful prescription drugs and how many patients developed post-surgery complications.

The reports also showed some reductions in disparities of care according to race, ethnicity, and income. For example, while Hispanics remain more likely than whites to get delayed care or no care at all for an illness, that disparity decreased between 2000/2001 and 2004/2005. In addition, while black children between 19 and 35 months old remain less likely than white children to receive all recommended vaccines, that disparity also decreased.

Overall, however, many of the largest disparities remain. Black children under 18 are 3.8 times more likely than white children to be hospitalized for asthma. New AIDS cases are 3.5 times more likely among Hispanics than whites. Among pregnant women, American Indians or Alaska natives are 2.1 times less likely to receive first trimester prenatal care.

AHRQ's *Quality and Disparities* reports, which are mandated by Congress, are read widely by policymakers, health care analysts, public health advocates, health insurers, journalists, and consumers. This year's *National Healthcare Quality Report* synthesizes more than 200 quality measures, which range from how many pregnant women received prenatal care to what portion of nursing home residents were controlled by physical restraints. The *National Healthcare Disparities Report*, meanwhile, summarizes which racial, ethnic, or income groups are benefiting from improvements in care.

The 2007 reports draw on data from more than three dozen databases, most sponsored by federal health agencies. Among the findings:

- More than 93 percent of heart attack patients received the recommended hospital care in 2005, up from about 77 percent in 2000/2001. The percentage of heart attack patients who were counseled to quit smoking increased from about 43 percent in 2000/2001 to about 91 percent in 2005.
- A lack of health insurance may have significant

impacts on health care quality. For example, only 18 percent of people without insurance went to the dentist at least once in the previous year compared with 51 percent with private insurance. Only 38 percent of uninsured women received mammograms in the past two years compared with 74 percent with private insurance.

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### Personnel Changes Within Your Organization

Per the CMS contract agreement between Medicare providers and QIOs, hospitals must keep their contact information up-to-date with HSAG. The Hospital-QIO Liaisons have a pivotal role and it is their responsibility to inform HSAG of any changes in contact information (i.e., names, titles, and e-mail addresses) for the following CMS-designated points of contact:

- Administrator or CEO
- Hospital-QIO Liaison
- Physician Chairperson of the Quality Assurance Committee
- Medical Director/Chief Medical Officer/Chief of Staff
- Chief Financial Officer
- Grievance or Beneficiary Complaint Coordinator

Hospitals are responsible for coordinating and communicating Quality Improvement Organization (QIO) issues between departments and must supply HSAG with any changes to the above names and titles within 30 days of the change. This is important so that both HSAG and the hospital are assured that critical and time-sensitive information reaches the appropriate person for a given subject, as designated by the hospital Administrator or CEO.

If you have any questions about the CMS-designated points of contact within your organization, want to know who is on file as the points of contact at your facility, or have changes to report, please contact [Suzette Gerhart](#) at HSAG.

- About 26 percent of adults with basic disabilities—those disabilities that challenge mobility or other basic functions—received delayed care or no care at all compared with about 11 percent of people without disabilities. About 23 percent of seniors with disabilities took inappropriate medications compared with 13 percent of seniors without disabilities.
- Among people who needed treatment for illicit drug use in 2005, only 18 percent of adults between the ages of 18 and 44 actually got treatment. Only 11 percent of children between 12 and 17 got treatment. These rates have remained about the same since 2002.

The *Quality and Disparities* reports are available online at [www.ahrq.gov/qual/qdr07.htm](http://www.ahrq.gov/qual/qdr07.htm), by calling 1.800.358.9295, or by sending an e-mail to [ahrq-pubs@ahrq.hhs.gov](mailto:ahrq-pubs@ahrq.hhs.gov). The *Quality* report serves as the basis for AHRQ's upcoming State Snapshots, which come out each spring and detail how health care quality trends vary from state to state.

## MARCH is DVT Awareness Month

### *How well do you protect your patients?*

A common but underdiagnosed medical condition, deep vein thrombosis (DVT) affects approximately 2 million Americans each year. It occurs when a blood clot forms in one of the body's large veins, usually in the lower limbs, leading to either partially or completely blocked circulation.

Complications of DVT, such as pulmonary embolism (PE), are a major cause of death in the United States, killing more people than AIDS, breast cancer, and highway accidents combined.

Some experts believe the incidence of DVT and PE may be higher because diagnosis is difficult and often missed. Although fatal PE may be the most common preventable cause of hospital death in the United States, preventive therapy is administered to only one-third of hospitalized patients with risk factors for blood clots, according to a recent multicenter study.

“Blood clots in the veins deep within the legs are more difficult to diagnose because symptoms are

present in only 50 percent of patients,” said Samuel Z. Goldhaber, MD, director of Venous Thromboembolism Research Group and Cardiac Center's Anticoagulation Service at Brigham and Women's Hospital, Boston; associate professor of medicine, Harvard Medical School; and co-chair of the Council for Leadership on Thrombosis Awareness and Management. “An increased awareness among health care professionals and the public regarding the risk factors and triggering events of DVT may lead to prevention and treatment of the condition.”

When a clot escapes into circulation and becomes lodged in the lungs and obstructs the pulmonary artery or its branches, it can cause sudden death.

Because a number of other conditions—such as muscle strains, skin infections, and phlebitis (inflammation of veins)—display symptoms similar to DVT, the condition is best diagnosed with specific tests such as venography, impedance plethysmography (IPG), and venous ultrasonography.

Certain individuals carry an increased risk for developing DVT, although it can occur in almost anyone. Some risk factors include:

- Acute medical illness
- Patients undergoing major orthopedic surgery, such as joint replacements, who remain immobile in bed after an operation
- Cancer and chemotherapy treatment
- Chronic heart or respiratory failure
- Paralysis
- Inherited or acquired predisposition to clotting
- Obesity
- Pregnancy
- Use of birth control pills
- Postmenopausal hormone replacement therapy
- Advanced age
- Immobility caused by long-distance travel

But DVT is not unstoppable or untreatable. Effective prophylaxis and treatment options exist for both DVT

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and PE. With early treatment, patients with DVT may reduce their chances of developing PE to less than 1 percent. Resources for DVT prevention include:

- Translating VTE Guidelines Into Practice: [www.hsag.com/vte](http://www.hsag.com/vte)
- American Medical Directors Association—DVT Clinical Corners: [www.amda.com/tools/clinical/dvt.cfm](http://www.amda.com/tools/clinical/dvt.cfm)
- American Venous Forum: [www.venous-info.com](http://www.venous-info.com)
- Case Management Adherence Guidelines for VTE: [www.cmsa.org/portals/0/pdf/CMAG\\_DVT.pdf](http://www.cmsa.org/portals/0/pdf/CMAG_DVT.pdf)
- Coalition to Prevent DVT: [www.preventDVT.org](http://www.preventDVT.org)
- Society of Hospital Medicine—VTE Prevention Collaborative: [www.hospitalmedicine.org](http://www.hospitalmedicine.org)
- Vascular Disease Foundation: [www.vdf.org](http://www.vdf.org)
- Venous Resource Center: [www.venousdisease.com](http://www.venousdisease.com)

## Changes in the Specifications Manual

Remember that beginning with April 1, 2008, discharges, the Specifications Manual used for abstraction has been revised. To download the latest version, go to <http://www.qualitynet.org/dcs/ContentServer?cid=1141662756099&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page>.

## The History and Evolution of Health Care Quality Improvement

The first presentation in the new Quality Basics for Providers Series—*The History and Evolution of Quality*—presented by Nancy West, RN, MPH, CPHQ, is now posted on MedQIC ([www.medqic.org](http://www.medqic.org)).

This session is an overview of the history and evolution of quality improvement in health care. Learn about the events and the individuals that shaped health care quality improvement into a specific discipline.

The Quality Basics for Providers Webinar series is tailored for health care staff who are new to the quality improvement field or for those who are seeking to expand their knowledge.

Please click on the following link to access the pre-

sentation: <http://medqic.org/dcs/ContentServer?cid=1200602383402&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>.

## The Risky Business of Quality

The Arizona Association for Healthcare Quality (AzAHQ) is pleased to present the 2008 Spring Conference: “The Risky Business of Quality.” This educational opportunity will be held on April 18, 2008, from 8:30 a.m. to 4:30 p.m., at the San Marcos Golf Resort in Chandler, Arizona. The meeting will include an Introduction to Risk Management, Enterprise Risk Management, Using Data, and Claims Management. In the afternoon, presentations will be made by two Arizona hospitals on projects in which Risk Management participated to improve safety and quality.

More information regarding “The Risky Business of Quality” and sign-up for the 2008 Spring Conference is available at [www.azahq.org](http://www.azahq.org).

## Quality Experts on the Air

If you haven’t yet heard Eugene Litvak, PhD, discuss his compelling ideas on how to streamline health care

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## Medicare Provider Information

To view HSAG’s new Medicare Provider Web page that contains information about fee-for-service and Medicare Advantage benefits, visit <http://www.hsag.com/providers>.

The page contains information on:

- The beneficiary notices initiative (BNI).
- Managed care appeals and grievances.
- Sample notice forms (downloadable).
- The *Federal Register* BIPA regulation.

## Medicare Beneficiary Rights

All Medicare beneficiaries have the right to appeal their discharge from a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. For more information, go to <http://www.hsag.com/azmedicare> or call 1.800.359.9909.

delivery using classic operations management strategies such as variability theory, now is your chance. Litvak is featured in a satellite broadcast through ReachMD. To listen to this 12-minute podcast, go to <http://www.reachmd.com/xmsegment.aspx?sid=2121>.

## 9th Scope of Work

HSAG is preparing for its 9th Scope of Work (SOW) Medicare-contract cycle (August 2008–July 2011). Under the 9th SOW, Quality Improvement Organizations (QIOs) will focus on four main themes: Beneficiary Protection, Patient Pathways (Care Transitions), Patient Safety, and Prevention. In addition, the QIOs will be required to help Medicare promote three overarching themes: adopt value-driven healthcare, support the adoption and use of health information technology, and reduce health disparities in their communities.

As part of the 9th SOW, QIOs will also be required to offer help to specific nursing homes and hospitals that have not recently performed well on important quality measures.

## Arizona Association for Healthcare Quality

The Arizona Association for Healthcare Quality (AzAHQ) is an organization committed to assisting healthcare quality professionals develop their full potential. Toward that end, AzAHQ provides educational programs, workshops, meetings, newsletters, and a Web site ([www.azahq.org](http://www.azahq.org)) to help meet professional needs.

Joining AzAHQ also provides opportunities to get to know professional colleagues, share concerns, and discuss issues and ideas for quality improvement planning on topics such as:

- Discharge planning.
- Root cause analysis.
- Utilization management.
- Third party payers.
- Risk management.
- CQI/TQM/Lean thinking.
- Case management.
- Informatics.
- Disease management.

- Alternative health care.

Additionally, AzAHQ will be represented at the upcoming NAHQ 33rd Annual Educational Conference September 14–17, 2008, at the J.W. Marriott Desert Ridge Resort and Spa located in Phoenix, Arizona.

Membership and other AzAHQ organizational information is available at [www.azahq.org](http://www.azahq.org). Questions may be directed to Jeanne Stueland at [jstueland@shc.org](mailto:jstueland@shc.org) or 480.882.6593.

## A Conversation with Leland Fairbanks, MD: Smoke-Free Arizona, Present and Future

*Reported by Wendy Burk, Associate Editor, The University of Arizona HealthCare Partnership.*

For Dr. Leland Fairbanks, president of Arizonans Concerned About Smoking (ACAS), Inc., and recipient of the 1998 Family Physician of the Year Award from the Arizona Academy of Family Physicians, the commitment to work for smoke-free laws began in the 1950s when, in his words, “no one else was willing to do it.” Fifty years later—and six months after the pas-

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### **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.quality-net.org/> and click on “Auto-Notification” in the left navigation pane. There are four separate notification lists (including one for the Hospital Outpatient Quality Data Reporting Program) 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 four 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!

sage of Proposition 201, which prohibits smoking in most indoor public places—the nation’s “Smoke-Free Hospital Doctor” sat down to talk about smoke-free hospitals, tobacco cessation for nurses, and Arizona’s smoke-free future.

*Tell us about tobacco cessation and nurses.*

LF: At the time of the first U.S. Surgeon General’s report on smoking, 60 percent of physicians and 30 percent of nurses smoked. Today, only 2 percent of family physicians smoke, but rates for nurses are not much improved.

*How can individual nurses and health care systems motivate change?*

LF: Nursing is an honored profession. Nurses can dare to point out to each other the need to end the negative role modeling of nurses who smoke. Use the teachable moments: when a colleague confides, “I have to take a shower after smoking before I can pick up my baby,” for example. Make it a family affair to help colleagues quit.

A proven health care systems policy is the smoke-free campus policy, which includes no smoking indoors, on the grounds, or near entrances. The Mayo Clinic’s research shows that the smoke-free campus policy has done more to help employees quit than any other measure.

*What was your “A-ha” moment as an advocate for smoke-free laws and policies?*

LF: In 1957, I was an intern with the U.S. Public Health Service in New Orleans. The wards were full of tobacco smoke. When I asked one of my lung disease patients about quitting smoking, he sobbed that he had only three things to look forward to: his oxygen tank, his next cigarette, and his death.

A few years earlier, the 1954 Brown vs. Board of Education Supreme Court decision showed me the importance of civil rights advocacy. My experiences as an intern taught me that antismoking legislation is a civil rights issue. Everyone has the right to breathe clean air.

*What’s next for smoke-free hospitals?*

LF: General hospitals, which have long done well as smoke-free indoor facilities, are appropriately moving to

the next level: the smoke-free campus. The smoke-free campus ensures, for example, that someone who has just gotten emergency treatment for asthma will not have to walk through a cloud of smoke on the way out the door.

*Now that Proposition 201 (the Smoke-Free Arizona Act) is the law, what’s next for ACAS, Inc.?*

LF: We will support legislation requiring self-extinguishing cigarettes to reduce house fires and wildfires in our state. We also commend the efforts of the Southwest Navajo Nation Tobacco Education and Prevention Program to promote smoke-free casinos in the Navajo Nation and in any casino where employees breathe secondhand smoke. No one should have to choose between their health and their job.

To support the efforts of ACAS, Inc., e-mail Dr. Fairbanks at [acasinc@msn.com](mailto:acasinc@msn.com).

For more information about Arizona’s certification and continuing education programs for brief and intensive tobacco dependence treatment interventions, as well as the QUITZone Program supporting tobacco-free campuses, visit [www.healthcarepartnership.org](http://www.healthcarepartnership.org) or send a request to [hcpinfo@email.arizona.edu](mailto:hcpinfo@email.arizona.edu).

## The Leadership of Innovation: Sustaining the Path to Excellence

*The following is an excerpt from an article written by Tim Porter-O’Grady, DM, EdD, APRN, FAAN; Associate Professor and Leadership Scholar, Arizona State University Masters of Healthcare Innovation Program. The entire article is available at <http://archive.constantcontact.com:80/fs094/1101985890950/archive/1101986211303.html>.*

It goes without saying that clinical and technological innovations in health care in the past 25 years have grown at a quantum rate. The transformation of clinical health care technologies and interventions has outstripped almost every other aspect of health service. The problem is, however, that while the technology of intervention has been enhanced, the quality of the health of the nation has not. The recent report of the Commonwealth Fund, comparing the United States health status with the health status of other major Western nations, was certainly strong testament to the fact that there is little relationship between the innovation of clinical intervention and the quality of health of

the people of the United States. Apparently, for all the high cost and intensity of innovation related to clinical intervention, such innovation has done nothing to measurably alter the major indicators of the overall health of the people of the nation.

This reality raises the question regarding the relationship between leadership and innovation in health care. As faculty was conceiving the framework for the [ASU] Masters of Health Innovation program, the emphasis on leadership was affirmed as a foundation for the program's design. Faculty observed that there was a great deal of innovation unfolding in health care, yet, not much of it reflected coordination of the intersection between innovation and public policy, priorities, systems, governance, and social and human dynamics. It is here where the elements of leadership make a significant difference and do the necessary work to assure that the choices, direction, priorities, and applications of technology and innovation in health care create both an environment for relevant creativity and innovation that actually improves the overall health and quality of life of the U.S. and the global community.

### AZHHA to Launch MRSA Initiative

On Thursday, May 15, 2008, the Arizona Hospital and Healthcare Association's Safe & Sound initiative will kick off a statewide initiative that addresses the growing concerns about MRSA: "Preventing MRSA: It's in our hands."

This launch event will be held at Rawhide Western Town at Wild Horse Pass in Chandler on Thursday, May 15, 2008, from 9:00 a.m. to 2:30 p.m.

In an effort to encourage full statewide support and participation in this initiative, the registration price has been greatly reduced thanks to the generous sponsorship of Blue Cross Blue Shield of Arizona, an independent licensee of the Blue Cross and Blue Shield Association. The per-person registration price is \$30.

Suggested attendees include CNOs, IC nurses, QI directors, PSOs, nurse educators, environmental services, and pharmacists. Seating is limited, so please coordinate with your hospital leadership for attendance.

To register, contact Kathy De Lisle at [kdelisle@azhha.org](mailto:kdelisle@azhha.org). Address initiative questions to Barb Averyt at [baveryt@azhha.org](mailto:baveryt@azhha.org) or 602.445.4321.

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