

SOW News

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HoW to Meet in January

The Arizona Hospital Workgroup (HoW) will meet on January 11, 2007, 10:00 a.m. – 2:00 p.m., in the Carter Marshall Conference Center at Health Services Advisory Group. **See page 6 for more information.**

CMS Publishes Final Patients' Rights Rule

Use of Restraints and Seclusion; Better, More Extensive Training of Staff Required

Health care workers who employ physical restraints and seclusion when treating patients must undergo new, more rigorous training to assure the appropriateness of the treatment and to protect patient rights, according to a regulation published in the *Federal Register* by the Centers for Medicare & Medicaid Services (CMS).

The patients' rights regulations set forth, as a condition of participation (CoP) in the Medicare and Medicaid programs, the expectation that health care facilities will protect the rights of patients. These protections are part of Medicare's revised CoP requirements that hospitals must meet. The requirements apply to all participating hospitals—including short-term, psychiatric, rehabilitation, long-term, children's, and alcohol/drug treatment facilities.

To address concerns about the improper use of restraints and seclusion—and in response to the 4,000 public comments received on the interim final rule—the final regulation strengthens the staff training standard and specifies components of the training. The rule also expands the category of practitioners who may conduct patient evaluations when a restraint or seclusion tactic has been implemented.

CMS currently requires that a patient be evaluated “face-to-face” within an hour of being restrained or secluded for the management of violent or self-destructive behavior. Prior to this rule, these actions had to be reviewed within that hour by a physician or “other licensed independent practitioner (LIP).” The new rule expands that list to include a trained registered nurse (RN) or physician assistant (PA). The rule requires, however, that—when an RN or PA performs the 1-hour-rule evaluation—the physician or other LIP treating that patient be consulted as soon as possible.

The basic rights specified in the regulation include patients' right to

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notification of their rights in regard to their care, privacy and safety, records confidentiality, and freedom from the inappropriate use of all restraints and seclusion—in all hospital settings.

The intent of this regulation is to ensure the protection of each patient's physical and emotional health and safety. Under the new regulations, hospitals must provide the patient or family member with a formal notice of rights at the time of admission.

These rights include freedom from restraints and seclusion in any form when used as a means of coercion, discipline, convenience for the staff, or retaliation.

Stricter standards for when a health care facility must report the death of a patient associated with the use of restraints and seclusion have also been adopted with this rule.

The regulation will become effective on February 6, 2007.

5 Million Lives Campaign

*This article originally appeared in the December 2006 issue of **Safe & Sound News**, published by the Arizona Hospital and Healthcare Association, and is reprinted here with permission.*

“No one in health care can feel comfortable with the magnitude of infections, adverse drug events, and other complications that hospital patients endure,” said Dr. Don Berwick, CEO of the Institute for Healthcare Improvement. “We can, and we will, equip all willing health care providers with the tools they need to make the motto “First, do no harm” a reality.

On December 12, the Institute for Healthcare Improvement (IHI) announced an initiative to prevent 5 million incidents of medical harm nationwide over a 24-month period ending December 9, 2008. The 5 Million Lives Campaign will ask U.S. hospitals to adopt up to 12 interventions to prevent harm, including 6 which were adopted by hospitals participating in the IHI's 100,000 Lives Campaign. The six new interventions are focused on:

- Preventing infections due to methicillin-resistant *Staphylococcus aureus* (also known as MRSA, a

type of “staph” bacteria that are resistant to many antibiotics).

- Reducing harm from high-alert medications (medications that have the highest risk of causing injury when misused).
- Adopting Surgical Care Improvement Project interventions.
- Preventing pressure ulcers.
- Improving care for congestive heart failure.
- Involving hospital boards of directors in quality improvements.

The six new initiatives and the “Getting Started Kits” for this new campaign will be introduced to Arizona's hospitals at the Arizona Patient Safety Officer/QI Director Workgroup meeting being held on Tuesday, January 23, 2007. Each of the six initiatives will be reviewed, providing hospitals with a basic understanding of each initiative and helping them to decide where to start.

Please register so an adequate supply of materials can be prepared. To register, contact Kathy Fisher-DeLisle at kdelisle@azhha.org.

Date: Tuesday, January 23, 2007

Time: 11:00 to 4:00—Lunch included

Agenda: 11:00–1:45—5 Million Lives Overview
2:00–4:00—Patient Safety Officer Work Group

Location: 2901 N. Central Ave., Suite 900, Phoenix
Questions? Call Barb Averyt at 602.445.4321 or e-mail baveryt@azhha.org

Risk-Standardized, 30-Day Mortality Measures

On November 6, the Centers for Medicare & Medicaid Services (CMS) and its Hospital Quality Alliance (HQA) partners announced their upcoming plans for public reporting of risk-standardized, 30-day mortality measures on the *Hospital Compare* Web site in June 2007. The data includes all Medicare hospitalizations between July 1, 2005, and June 30, 2006, with a principal hospital discharge diagnosis of acute

myocardial infarction (AMI) or heart failure (HF), for all acute care and critical access hospitals (CAHs) in the nation. A plan to add a 30-day mortality measure for pneumonia to the public reporting process is contingent upon National Quality Forum (NQF) endorsement of that measure.

CMS and its HQA partners stated they will begin reporting the risk-standardized mortality measures “in the interest of high-quality, patient-centered care, and accountability” and in compliance with the Deficit Reduction Act (DRA) of 2005. Publicly reporting mortality measures, the two groups said, can illustrate the variation in patient outcomes across the country and create a visible incentive for hospitals to find ways to improve patient short-term survival.

The CMS 30-day, risk-standardized AMI and HF mortality measures were developed by a team of clinical and statistical experts from Yale and Harvard universities. The HQA has approved these measures as appropriate for public reporting. The measures have also been endorsed by the NQF, a voluntary standard-setting, consensus-building organization representing providers, consumers, purchasers, and researchers.

The 30-day mortality measures will be calculated by CMS using the administrative claims data already submitted by hospitals under the Medicare program. Thus, hospitals will not need to submit new or additional information to CMS or to the QIO Clinical Data Warehouse.

Prior to the national implementation of mortality measures public reporting in June 2007, CMS is conducting a “dry run” of the process to familiarize hospitals with the measures and allow them to submit comments and questions on the resulting reports. The dry run will include the issuance of reports containing hospital data from 2003 for acute care hospitals with applicable data from that period. All other hospitals—including CAHs—will receive access to a mock report. This is because the data used to generate mortality rates for the dry-run reports did not include CAHs. However, CMS plans to include data from CAHs in the June 2007 reporting.

In order to implement these measures, CMS has contracted with Colorado Foundation for Medical

Care (CFMC), Colorado’s Quality Improvement Organization (QIO). Questions about the public reporting of mortality measures may be sent to CFMC at mortalitymeasures@coqio.sdps.org.

HCAHPS Implementation

The national implementation of the CAHPS Hospital Survey (HCAHPS) commenced on October 1, 2006. Approximately 2,800 hospitals are now collecting HCAHPS survey data from their eligible discharges and will soon begin to submit data to CMS via QualityNet Exchange. HCAHPS is an HQA-endorsed measure.

Beginning with fiscal year 2008, there will be an additional incentive for eligible hospitals to participate in HCAHPS. Hospitals that are subject to IPPS payment provisions (RHQDAPU-eligible “subsection [d] hospitals”) must meet the new reporting requirements in order to receive their full IPPS annual payment update (APU) for fiscal year 2008. IPPS hospitals that fail to report the required quality measures (which include the HCAHPS patient perspective survey) in a form and manner, and at a time, specified by the U.S. Department of Health and Human Services Secretary could, for FY 2008, receive an APU that is reduced by 2.0 percentage points. Non-IPPS hospitals can voluntarily participate in HCAHPS. However, neither participation nor nonparticipation in HCAHPS will affect the APU of non-IPPS hospitals.

In order to qualify for the full APU in FY2008, hospitals that are currently participating in HCAHPS by collecting survey data and submitting it to the QualityNet Exchange warehouse should continue doing so throughout 2007. In addition, these hospitals must submit a pledge form in Summer 2007, stating their intention to participate from July 2007 forward. More details pertaining to the pledge form will be provided at a later date.

For specific questions that individual hospitals

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HCAHPS Contact Information

Phone: 888.884.4007

E-mail: HCAHPS@azqio.sdps.org

Web site: www.HCAHPSonline.org

have about HCAHPS, QIOs are being asked to refer their hospitals to Heath Services Advisory Group (HSAG)—the technical assistance contractor for HCAHPS—at hcahps@azqio.sdps.org or call 1.888.884.4007.

How Hospitals Can Join HCAHPS in 2007

Hospitals that are NOT currently participating in HCAHPS must take the following steps in order to join HCAHPS in July 2007, which will be the next and final opportunity to do so for the FY2008 APU period.

- If a hospital intends to self-administer the HCAHPS survey, it must attend the Introduction to HCAHPS Training to be offered via Webinar, January 22–26, 2007.
 - Online registration for the January training is now available on the HCAHPS Web site, www.hcahpsonline.org.
 - The registration period for this training will end on January 10, 2007.
 - The requirements necessary for a hospital to self-administer the survey are listed in the HCAHPS Quality Assurance Guidelines, available on the HCAHPS Web site.
- If a hospital chooses to contract with a vendor to administer the HCAHPS survey on its behalf, it must select an approved survey vendor from the list available on the HCAHPS Web site.
 - Hospitals that intend to contract with an approved survey vendor are encouraged to begin making arrangements soon.
 - Please note: The survey vendors that are approved to administer HCAHPS may be different than the vendors that submit clinical data for hospitals.
 - Hospitals that contract with an approved survey vendor for HCAHPS are not required to attend the January 2007 Introduction to HCAHPS Training, but are encouraged to do so.
- ALL hospitals that are self-administering the survey must attend HCAHPS Refresher Training, via Webinar, in May 2007.

- ALL hospitals that intend to join HCAHPS in July 2007 must first participate in a Dry Run in March 2007.
 - Information about the Dry Run can be found on the HCAHPS Web site.
- ALL hospitals that intend to join HCAHPS in July 2007 must submit dry run data from March 2007 to the QualityNet Exchange data warehouse by July 13, 2007.
- ALL hospitals that intend to participate in HCAHPS in July 2007 must submit a pledge form in Summer 2007 stating their intention to participate. The date the pledge will be due will be announced later.
- Finally, ALL hospitals that intend to join HCAHPS in July 2007 must administer the survey and collect and submit HCAHPS data on a continuous basis from July 1, 2007, forward.

Detailed information on the HCAHPS initiative—including a list of approved vendors, the file specifications, and data submission protocols—is available on the HCAHPS Web site, www.hcahpsonline.org.

Preventing Fatal Heparin Overdoses

The Institute for Safe Medication Practices recently cited a case in which three premature infants died after receiving an overdose of heparin. According to ISMP, this may have occurred because heparin vials containing 10,000 units/mL were placed in an automated dispensing cabinet where vials containing 10 units of heparin per mL were normally kept. The vials looked somewhat similar, and the nurses did not notice that the ones that were taken from the cabinet actually contained 1,000 times more heparin than they expected.

ISMP notes that errors in filling automated dispensing cabinets are common, and so it is important to double-check the contents of these cabinets before they leave the pharmacy. The ISMP Alert lists several other steps to help prevent these kinds of errors. For example:

- Consider which medications might be removed from automated dispensing cabinets for safety's sake, especially in those cabinets that are used for high-risk patients such as neonates and children.

- Take steps to minimize look-alike packages and labels. When possible, do not stock items on nursing units that require further preparation before administration.
- Consider bar coding for medication administration management systems throughout the hospital, if not already in place. Even if bedside scanning is not being used, dispensing cabinet vendors provide bar code systems to make sure the right medications are stocked in these cabinets.

Additional Information

ISMP Medication Safety Alert! Infant Heparin Flush Overdose, September 21, 2006: <http://www.ismp.org/Newsletters/acutecare/articles/20060921a.asp>

Accessed from <http://www.accessdata.fda.gov/psn/transcript.cfm?show=58#7>

New on MedQIC

For your convenience, here is a partial list of items that have been posted recently to MedQIC.

Henry Ford Hospital's Experience with Surgical Infection Prevention (presentation):

This teleconference features Jack Jordan of Henry Ford Hospital. He spoke on interventions and strategies that led to their success on the SCIP measures.

<http://www.medqic.org/dcs/ContentServer?cid=1163010485153&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

CMS Leadership Summit: Moving Hospitals from Good To Great (presentations):

On Sept. 28, 2006, CMS and the Oklahoma Foundation for Medical Quality (OFMQ) sponsored a summit on the impact of hospital leadership on quality improvement. Thought leaders in health care quality explored the latest research, knowledge, and strategies to create culture change from the top down.

<http://www.medqic.org/dcs/ContentServer?cid=1163010513220&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

Rural Health Annotated Bibliography, October 2006 (literature):

<http://www.medqic.org/dcs/ContentServer?cid=1141844567180&pagename=Medqic%2FMQLiterature%2FLiteratureTemplate&c=MLiterature>

Upcoming WebEx Presentations**QNet Exchange Reports**

Tuesday, January 9, at 10:00 a.m.

The national Hospital Reporting QIO Support Center will be presenting a WebEx, "Accessing and Utilizing QualityNet Exchange Reports," on January 9 at 10:00 a.m., MST. In addition to a live demonstration on the existing reports, they will cover new and improved reports that will help hospitals monitor their status for public reporting and the Annual Payment Update.

It's not too late, if you register by 3:30 p.m. on Monday, January 8. For more information, please contact Suzette Gerhart at 602.745.6299 or sgerhart@azqio.sdps.org.

HSAG WebEx: Avoiding SCIP Abstraction Pitfalls

HSAG will present a live WebEx conference on January 18 regarding pitfalls to avoid when abstracting medical records for the SCIP quality measures. These measures include those required for the 2008 Annual Payment Update (APU). There will be a brief presentation of SCIP, followed by questions and answers previously submitted to HSAG.

If you are unable to attend the conference, the session will be recorded and available for viewing later. If you are not able to utilize the WebEx, but want to listen to the conference, please contact Suzette Gerhart at sgerhart@azqio.sdps.org to arrange to receive a copy of the slides.

Directions for Accessing the Conference

Event: Avoiding SCIP Pitfalls During Data Abstraction

Date: Thursday, January 18, 2007

Time: 2:00–3:00 p.m., MST

Event Password: SCIP Pitfalls

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Teleconference: 1.888.742.8686

Teleconference Access Code: 8901979

Please follow these instructions to join the event:

1. Click on or go to <https://ifmcevents.webex.com>.
2. Locate your event.
3. Click on the “Join Now” link to the right of the event or click on the name of the event.
4. Enter your name and e-mail address.
5. Enter the Event Password: SCIP Pitfalls.
6. Click on “Join”—If you are prompted to install the WebEx client, click “Yes” and select “Install Using JAVA.”
7. Call in to the teleconference number for the audio portion. The number is 1.888.742.8686. The access code is 8901979.

Please join us at least 15 minutes prior to the presentation. If this is your first time using WebEx, please allow extra time to ensure the automatic system set-up has been properly established. (If you are using a dial-up connection, this automatic set up may take up to 15 minutes. High speed connections typically

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!

take less than one minute to install the plug-in.) This is a one-time download, and future connections will be much quicker. You do not need to dial in to the teleconference until close to the actual start time of your event.

If you have any questions or problems accessing the meeting, please call the IFMC WebEx Helpline at 515.440.8555.

January Hospital Workgroup Meeting

The January Hospital Workgroup Meeting (HoW) will be held on Thursday, January 11, 2007, 10:00 a.m. to 2:00 p.m.

Mr. Christopher Stevens—Executive Director, Arizona Quality Alliance, and Chairman, The Alliance for Performance Excellence, Inc.—will be our featured speaker. Mr. Stevens will be discussing how to assess for performance gaps. Additional agenda items will include HSAG updates, data validation issues, review of the 2008 APU requirements, and other items.

If you would like to attend and have not yet sent an RSVP notice, please contact Suzette Gerhart at sgerhart@azqio.sdps.org

Don't Delay, Hospitals Told, In Getting Ready For NPIs

Failure to adequately prepare for the advent of the National Provider Identifier (NPI) will have a significant impact on provider reimbursement, says Beth Keith, CHAM, senior management consultant for ACS Healthcare Solutions.

Rejected claims, delayed reimbursement, and potentially lost reimbursement will result, Keith cautions, if providers don't take the appropriate steps.

All health care providers covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), whether individuals or organizations, must obtain an NPI for use in identifying themselves in HIPAA standard transactions, she says.

A 10-digit numeric identifier that does not expire or change, the NPI must be used exclusively by May

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23, 2007, to identify covered health care providers in standard health care transactions by HIPAA-covered entities, such as providers completing electronic transactions, health care clearinghouses, and large health plans. Small health plans must use only the NPI by May 23, 2008.

The identifier is used to ensure that medical claims are processed in a timely manner and payments are made correctly.

Keith advises hospitals to get ready for the change by making sure the following things have been done:

- NPI numbers have been obtained for all required providers.
- Existing provider master files have been cleaned and corrected.
- A crosswalk with NPI numbers and UPIN, payer identifiers, etc., for all providers has been mapped.
- Dual NPA numbers and existing provider numbers are ready for testing claims submission to Medicare fiscal intermediaries, clearinghouses, and electronic billing vendors from Oct. 2, 2006, through May 22, 2007.

The change affects providers' information technology systems, as well as their reimbursement, Keith points out, in that current claims-processing systems must accommodate the NPI identifier—in addition to current payer identifiers—from now until May 23, 2007.

From: *Hospital Access Management*

Medical Record Documentation Guidelines

by Howard Pitluk, MD, MPH, FACS, Medical Director, HSAG

Clear and timely documentation promotes quality care, supports medical necessity, increases coding accuracy, reduces liability risk, and improves compliance with Medicare and other payers' billing requirements.

The patient's medical record informs other health care providers, both inside and outside the hospital, about the medical history of the patient. In addition, it serves as the basis for hospital and provider reimbursement, serves as a record of events for legal proceedings, and provides information needed by quality assurance and peer review committees, licensing and regulatory agencies, and other interested parties related to the quality of care the patient

received. Consequently, it is important that all entries be legible and signed with the date and time.

History and Physical

Chief Complaint establishes medical necessity in a concise statement based on the patient's own words.

History of Present Illness outlines the location, quality, severity, duration, timing, context, and modifying factors of complaint, treatment attempts, co-morbidities, and pertinent Medical, Surgical, Social, and Family History.

Medications includes prescription and OTC remedies.

Allergies and Intolerances require a description.

Past Medical and Surgical History

Health Maintenance

Immunization History

Family History

Social History includes social/economic, sexual, and substance use/abuse issues. Discuss frailty, advanced directives, and disposition challenges as well.

Physical Exam should include vital signs, appearance (i.e., level of distress, frailty), and mental status, as well as abnormal findings and pertinent negatives.

Data available and pending at time of admission should be noted.

Impression should outline the provisional diagnoses, differential diagnosis for symptoms (e.g., "rule-outs"), and rationale for Inpatient or Observation Admission status.

Plan outlines the evaluation and treatment strategy, any limitations (e.g., family or patient requests), and discharge planning initiation.

Orders

Physician Orders must include admission status: **Outpatient**, or **Observation**, or **Inpatient**.

Orders must also designate the physician(s) responsible for continuing care.

Progress Notes and Procedures

Progress Notes address the response to care (im-

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proved, well-controlled, resolving, resolved or inadequately controlled, worsening, failing to change), changes in condition, abnormal test results, new diagnoses, conditions ruled out, and treatment plan revisions.

Responses to discharge planners, utilization nurses, etc., and comments on ‘contradictory’ observations by allied health professionals should be discussed.

If admitted to Observation, include rationale and tentative plan for discharge over the next 12–48 hours. Alternatively, the reason for conversion to Inpatient Admission should be clear.

Invasive Procedures should be supported by rationale, informed consent, medical clearance, complete anesthesia record, detailed operative notes, and post-anesthesia recovery notes.

Discharge Summary (and Addenda)

The discharge summary should be dictated or hand-written at the time of discharge. Components should include:

Principal Diagnosis—the reason, after study, chiefly responsible for the admission.

Secondary Diagnoses—all conditions coexisting at/af-

ter admission that affect treatment and/or length of stay.

Principal Procedure—most related to principal diagnosis. May be performed for definitive or diagnostic care.

Secondary Procedures—all other procedures, may be performed for definitive or diagnostic care.

Hospital Course—outlines presentation, treatment, procedures, results, and outcome. Describes results of testing and consultation, including those that confirm principal diagnosis, level of function, and appropriateness of discharge timing.

Medication List—must include dose and instructions. (“Resume Home Meds” is NOT ACCEPTABLE.)

Discharge Instructions—include diet, activity, wound care and weight monitoring (disease specific), caregiver instructions, and follow-up plans detailing providers, time interval(s), and what to do if symptoms worsen.

Acknowledgement—of discharge instructions by patient or caregiver.

Discharge Summary Addenda—may be needed to discuss test results/actions taken and/or revision of diagnoses resulting from response to medical records clarification queries.

HSAG Acute Care Team Contact Information

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