

# SOW News

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### July Hospital Workgroup (HoW) Meeting Cancelled

The HoW meeting scheduled for July 12 has been cancelled. The next meeting is scheduled for October 11. For more information, contact [Suzette Gerhart](#).

## Engaging Physicians in a Shared Quality Agenda

As part of its Innovation Series, the Institute for Healthcare Improvement (IHI) recently released a white paper titled “Engaging Physicians in a Shared Quality Agenda.” The role of active support by physicians in the development and implementation of quality and safety interventions cannot be minimized. Engaging those physicians has become more and more of a challenge as the health care arena evolves. The white paper provides insight and guidance for health care organizations to build a plan for physician engagement.

The IHI relates that the current climate of health care can place the physician in competition with the hospital. This change is only one of the realities that organizations need to understand to keep pace with the health care evolution that affects physicians.

The IHI framework includes six components that are key to success. They include:

1. Discover common purpose.
2. Reframe values and beliefs.
3. Segment the engagement plan.
4. Use “Engaging” improvement methods.
5. Show courage.
6. Adopt an engaging style.

The first component challenges hospitals to recognize that physicians are interested in quality, just not with the same mindset that hospitals have. To engage physicians, administrators must recognize that outcomes and time are key components to physician quality concerns.

Administrators need to stop regarding physicians as customers of their organization and begin to regard them as partners. Physicians also need to reframe their belief that they only need to be concerned about their individual patients; they too have responsibility for the system performance of the hospital.

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Prioritizing and sequencing a plan of engagement is the third component. Hospital teams need to identify specific task responsibilities that can only be accomplished by physicians and engage them in those activities. Identify the tasks that require physician participation versus the tasks in which physician input is useful but not required.

Engaging physicians includes understanding their thought processes and appealing to their natural sense of curiosity and their desire to learn. The IHI provides guidance on how to use data to engage physicians in system improvements, not just individual improvements.

Showing courage, the fifth component of the plan, speaks to using the Medical Executive Committee and Board of Trustees to implement interventions. The IHI gives an example of how one hospital administrator dealt with a problem involving timely medical records completion by taking the drastic step of suspending its trauma surgeon for two weeks. According to the administrator, that step sent an important signal that said, “We’re serious about patient safety and quality practices.”

It’s important to recognize that physicians often do not engage around business or management methods in the same way that business people or other professionals do. The sixth component focuses on understanding physician values to develop a collaborative effort to improve quality.

The IHI does not limit the paper to hospital changes; physicians are also challenged to change. “[The] creation of a new relationship—a real partnership—raises serious expectations and responsibilities for the physician partners as well. To engage effectively, physicians must overcome the challenges that lurk in some common physician behaviors and take on their new responsibilities responsibly.”

Included in the white paper is an assessment tool for hospitals to use as a prompt for thinking and preparing for engaging physicians.

A template for an action plan is also included in the paper.

To download *Engaging Physicians in a Shared Quality Agenda*, go to <http://www.ihl.org/IHI/Results/WhitePapers/EngagingPhysiciansWhitePaper.htm>.

## Arizona Providers Will Soon Face RAC Audits

The 2003 Medicare reform law established a three-year Recovery Audit Contractor (RAC) demonstration program in three states—California, Florida and New York. RACs are the first Medicare contractors to be paid only when they find Medicare errors—both overpayments and underpayments, though so far RACs have found far more overpayments.

CMS has considered the program to be such a success—hundreds of millions of dollars in overpayments have been identified and recovered from providers—that the 2006 Tax Relief and Health Care Act mandated the extension of RACs to all states by 2010. CMS is way ahead of the game, with some RACs setting up shop in mid-2007. CMS plans to have RACs in place in all states by 2008.

To select RAC contractors for all the states outside the pilot, “CMS plans to [conduct] a new full and open competition,” a CMS spokesman says. A few exceptions: Massachusetts was added into Connelly Consulting’s existing contract for New York under the pilot (and beyond). South Carolina has been added to the contract held by HealthData Insights, which is the RAC for Florida. Arizona has been added to the contract held by PRG-Schultz International, the RAC for California. RACs may start in these states in early fall.

## Abstractor Update

Keeping current with abstraction changes can be a challenge. The Specification Manual, Quest, and HSAG are resources that can be used for abstraction clarification. Another resource is MedQIC. These MedQIC updates will be useful to abstractors.

- **Measures Changes for April 1, 2007, Discharges** (Inpatient CoP call, March 2007): This presentation recording and handouts cover the pneumonia and SCIP measure changes for April 1, 2007, discharges. <http://www.medqic.org/dcs/ContentServer?cid=1176726289940&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>
- **Discharge Instructions Fact Sheet** (updated): This fact sheet has been updated to reflect information on

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how to abstract discharge instructions and discharge medications from the medical record. Effective for 4/1/07+ discharges—Specifications Manual for National Hospital Quality Measures Version 2.2. <http://www.medqic.org/dcs/ContentServer?cid=1110810218438&pagename=Medqic%2FOtherResource%2FOtherResourcesTemplate&c=OtherResource>

- **Reperfusion Performance Measures for AMI Fact Sheet** (updated): This May 2007 fact sheet illustrates Reperfusion Performance Measures for AMI and also highlights some frequently asked questions. <http://www.medqic.org/dcs/ContentServer?cid=1168867284510&pagename=Medqic%2FOtherResource%2FOtherResourcesTemplate&c=OtherResource>
- **Fact Sheets for Diagnostic Uncertainty, Identified Pneumonia Pathogen, and Chest X-Ray for Discharges 4/1/07+**: <http://www.medqic.org/dcs/ContentServer?cid=1182785078698&pagename=Medqic%2FOtherResource%2FOtherResourcesTemplate&c=OtherResource>

### Abstractor Information: Flagging Medical Records

CMS has released these instructions regarding flagging or identifying information within medical records when the record has been requested for validation:

“Providers are to refrain from flagging, highlighting, or identifying abstraction information in any way in the medical record prior to sending the record to the CDAC for validation. The CDAC will disregard these types of actions during the adjudication process. The CDAC abstractor will review the medical record as if he or she was the original abstractor.”

At this time, there is no penalty for flagging the records.

### Important Message from Medicare

Beginning July 2, 2007, hospitals must deliver the revised version of the Important Message from Medicare (IM) CMS-R-193 (an existing statutorily required notice) to explain discharge appeal rights.

Within two calendar days of the day of admission, hospitals must issue the IM and obtain the signature

of the Medicare beneficiary or his or her representative to indicate that he/she received and understood the notice.

As soon as possible prior to discharge, but no more than two days before discharge, the IM, or a follow-up copy of the signed IM, must also be provided to each Medicare beneficiary. Thus, in cases where the delivery of the initial IM occurs more than two days before discharge, hospitals will deliver a follow-up copy of the signed notice to the Medicare beneficiary as soon as possible prior to discharge, but no more than two days before discharge.

For Medicare beneficiaries who request an appeal, the hospital (or health plan if applicable) will deliver a Detailed Notice. CR5622 also revises the Medicare Claims Processing Manual, Chapter 30 (Financial Liability Protections) by deleting Sections 80.0–80.3 from Chapter 2 (Admission and Registration Requirements) and by adding Sections 200.0–200.3 to Chapter 30 (Financial Liability Protection), and this is included as an attachment to CR5622. These additional sections of the manual include examples of the IM and the Detailed Notice, along with detailed specifications regarding the contents of these notices and when the notices should be given to Medicare inpatients.

The official instruction, CR5622, issued to your fiscal intermediary (FI) and Part A/Part B Medicare Administrative Contractor (A/B MAC) regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1257CP.pdf> on the CMS Web site. Providers should ensure that appropriate clinical and administrative staff members, including physicians, are aware of these new notice requirements.

The new notification requirements for hospitals came about as part of a settlement reached in the Weichardt v. Leavitt lawsuit, which contested the legitimacy of the previous hospital notice procedures. The settlement required the Centers for Medicare & Medicaid Services (CMS) to publish a new rule setting forth revised discharge notice requirements for hospital inpatients who have Medicare.

The final rule, CMS-4105-F: Notification of Hospital

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Discharge Appeal Rights, was published on November 27, 2006 ([http://www.access.gpo.gov/su\\_docs/fedreg/a061127c.html](http://www.access.gpo.gov/su_docs/fedreg/a061127c.html)). The new notice requirements contained in the final rule must be implemented beginning July 2, 2007.

More information about the final rule and the notices can be found on the CMS Web site at [http://www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp).

In addition, CMS established a Questions and Answers (Q&As) document on its BNI Webpage regarding the final rule (Notification of Hospital Discharge Appeal Rights (CMS- 4105-F)), and this Webpage can be found at <https://www.cms.hhs.gov/BNI/Downloads/CMS-4105-FINAL%20RULE%20Qs%20and%20As%2004%2003%2007.pdf>

If you have additional questions, please contact your Medicare FI or A/B MAC at its toll-free number, which may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/Call-CenterTollNumDirectory.zip>.

## Medicare Plans to Stop Paying for 6 Hospital-Acquired Conditions

### *Five New Quality Measures Will Be Required in 2008.*

A newly proposed ruling from the Centers for Medicare & Medicaid Services, set to go into effect in October 2008, would deny Medicare payment for six costly and sometimes deadly preventable hospital-acquired conditions.

The initial six conditions include: pressure ulcers, two hospital-acquired infections (catheter-associated urinary tract infections and Staphylococcus aureus septicemia) and three “never events” (air embolism, blood incompatibility, and object left behind in surgical patient).

The proposal comes in response to a 2003 Medicare Modernization Act requirement that the secretary of Health and Human Services choose at least two hospital-acquired conditions that are (1) high cost, high volume, or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and

(3) are reasonably preventable through application of evidence-based guidelines. Beginning in FY 2009, cases with these conditions would not be paid at a higher DRG unless they were present on admission. In addition to the six initial conditions described in the ruling, CMS is seeking public comment on seven additional conditions.

The proposed rule would also add five new quality measures, which would bring to 32 the number of measures hospitals would need to report in FY 2008 in order to qualify for the full market basket update in FY 2009. The five proposed measures include 30-day mortality for Medicare patients with pneumonia and four additional measures relating to surgical care improvement. In addition, the proposed rule seeks input concerning other measures that could be added for FY 2009 and beyond.

“Taken together, these two initiatives will significantly improve the quality and reliability of care delivered in the nation’s hospitals, said CMS Acting Administrator Leslie V. Norwalk. “These reforms represent CMS’ continued push to become a more active purchaser of high quality care for Medicare beneficiaries.”

Medicare will issue its final regulation August 1.

## 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.

## Important Update to the National Provider Identifier (NPI)

The Medicare Learning Network newsletter, *MLN Matters*, article #MM5081, discusses what provider identifiers Medicare will report on remittance advice transactions under Stage 2 of Medicare's NPI implementation. The article has recently been revised to note that the processes will change as Medicare moves to Stage 3 implementation of the NPI, and to emphasize that providers need to review and understand the impact of Stage 3 on remittances as discussed in the *MLN Matters* article #MM5452, which can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf> on the CMS Web site. The revised version of MM5081 can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5081.pdf>.

## Recent Additions to MedQIC

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

### *Immunizations*

**The National Pneumonia Project—An Introduction for Inpatient Nurses** (presentation): This presentation is a nursing continuing education module on the National Pneumonia Project. It gives inpatient staff nurses ideas on how they can impact their facility rates. <http://www.medqic.org/dcs/ContentServer?cid=1176726306514&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

**Nurse Education—The Final Step to Improving Pneumovax Compliance** (presentation): This presentation was created to advance the knowledge and understanding of nursing staff in an effort to break through misconceptions held by nurses regarding the pneumococcal vaccination. A unique approach around "Mis-conceptions = Missed Opportunities." <http://www.medqic.org/dcs/ContentServer?cid=1176726306297&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

### **Adult Inpatient Vaccination—A Discussion of**

**Medical Necessity and Safety** (presentation): This is a presentation for staff nurses on adult inpatient vaccination. <http://www.medqic.org/dcs/ContentServer?cid=1176726295956&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

### *SCIP*

**Q&A on VTE and VTE Measures** (Inpatient CoP call, May 2007): <http://www.medqic.org/dcs/ContentServer?cid=1176726353527&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

**VTE Prophylaxis Pocket Card** (tool): This pocket card was developed to allow users to identify what prophylaxis is needed for various types of surgery. <http://www.medqic.org/dcs/ContentServer?cid=1176726306714&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools>

### *Heart Care*

**ACC's D2B Measurement** (Webinar): This Webinar *(Continued on page 6)*

### **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!

was hosted by the American College of Cardiology in June 2007. <http://www.medqic.org/dcs/ContentServer?cid=1182785083742&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

### Quality Improvement

**Measures Collection Tool:** This is a new collection tool to use in collecting data for the 24 measures, including SCIP. A brief instruction sheet is included for one-time setup along with a .zip file containing the tool. <http://www.medqic.org/dcs/ContentServer?cid=1182785073571&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools>

**Bridging the Quality Gap—What is the Largest Contributing Factor to your Organization Becoming a Top Performing Hospital and How do You Get There Quickly?** (presentation): The Premier health care alliance and CareScience hosted a national teleconference on May 22, 2007, featuring industry experts discussing the role of hospital executive leadership in improving hospital quality and patient care. <http://www.medqic.org/dcs/ContentServer?cid=1182785074601&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

### ROSC

Premier Tool for the AHRQ Hospital Patient Safety Tutorial: <http://www.medqic.org/dcs/ContentServer?cid=1179933961989&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations>

### Update: Health Care Quality and Patient Safety Literature

The articles references below are gleaned from the Agency for Healthcare Research and Quality's Patient Safety Network. Each link will provide more details on the article, including how to obtain the full text.

*Healthcare 411. Mistake proofing the healthcare environment.* Rockville, MD: Agency for Healthcare Research and Quality. May 23, 2007. <http://psnet.ahrq.gov/resource.aspx?resourceID=5412>

“Nurse working conditions and patient safety outcomes.” Stone PW, Mooney-Kane C, Larson EL, et

al. *Med Care.* 2007;45:571-578. <http://psnet.ahrq.gov/resource.aspx?resourceID=5389>

“The frequency of missed test results and associated treatment delays in a highly computerized health system.” Wahls TL, Cram PM. *BMC Fam Pract.* May 22, 2007;8(1):32 [Epub ahead of print]. <http://psnet.ahrq.gov/resource.aspx?resourceID=5387>

### Research Findings: Focus on the Brain's Role in Nicotine Addiction

Damage to a small region known as the insula—deep inside the brain—seems to eliminate the urge to smoke, a surprising discovery that may lead to new methods to treat addiction.

A study of patients with lesions in various regions of the brain, due to stroke or other injury, indicates that a significant number of those with damage to the insula were able to quit easily—no cravings, no nicotine patches, not even a conscious desire to quit.

“The quitting is like a light switch that went off,” said Dr. Antoine Bechara of the University of Southern California, who scanned the brains of 69 smokers and ex-smokers to pinpoint the region involved. “This is very striking.”

“What this study shows unequivocally is the insula is a key structure in the brain for perceiving the urges to take the drug,” said Dr. Nora Volkow, director of the National Institute on Drug Abuse and a longtime investigator of the brain's addiction pathways. The research was published in *Science* on 1/26/2007.

While some patients reported they completely lost the urge to smoke, brain damage isn't a treatment option for people trying to quit. Future research may include temporarily altering brain function with pulses of magnetic energy, called “transcranial magnetic stimulation” to see if it's possible to focus such magnetic pulses on the insula. Pharmacotherapies may be developed that specifically target the insula.

According to Bechara, while there are other brain and nervous system structures that relate to pleasure pathways and addiction, the insula discovery doesn't contradict that work; this discovery adds to our knowledge of how addiction affects the brain.

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The HealthCare Partnership at The University of Arizona provides continuing education and certification programs, as well as an online learning center with resources for tobacco dependence treatment. For more information and a calendar of events, visit [www.healthcarepartnership.org](http://www.healthcarepartnership.org), e-mail [hcpinfo@u.arizona.edu](mailto:hcpinfo@u.arizona.edu), or phone 520.318.7253 ext. 162.

For information regarding many tobacco control free state resources, visit [www.betobaccofree.org](http://www.betobaccofree.org) or phone 1.602.364.0824.

For information about telephone counseling, free face-to-face community quit tobacco programs, and discounted medications to help tobacco users to quit, call the Arizona Smokers' Helpline (1.800.55.66.222) or visit [www.ashline.org](http://www.ashline.org).

## HCAHPS Data Submission Deadline

July 13, 2007, is the data submission deadline for patients discharged in January, February and March 2007. The March 2007 Dry Run data must also be submitted by this date. All data submissions (XML file format and Online Data Entry Tool) must be successfully submitted by 11:59 p.m. Central Daylight Savings Time on this date.

## Spotlight on a Team Member



**Suzanne Anders**, RN, BSBA, CPHQ, is HSAG's Clinical Quality Specialist for many of Arizona's acute care hospitals. She has been working in quality improvement at HSAG since 1998, continues to work in the acute care environment, and brings over 20 years of clinical nursing experience to her work.

Her current role at HSAG includes assisting hospitals with implementing intervention activities involving the CMS performance measures. She is the Arizona project lead for the CMS Surgical Care Improvement Project (SCIP) Identified Participant Group (IPG). She also facilitates the Hospital Workgroup (HoW) meetings and is the editor of the monthly newsletter, *Scope of Work News*.

Suzanne's health care passion is patient safety. She has presented at local and state conferences on a variety of topics related to patient safety including, "What Pez Can Teach Us About Patient Safety." She is pursuing a masters degree in Healthcare Innovation at Arizona State University.

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