

SOW News

In This Issue

Inquiring Case Management Minds Want to Know	2
CMS Notifications for Data Collection . . .	3
Abstraction/Validation Updates	3
New MedQIC Fact Sheets	4
CMS to Investigate Cutting Payment for 'Never Events'	5
Invalid Record Selection	5
New Treatments for Smoking Cessation	5
Premier Teleconference: Leveraging Technology to Improve Heart Failure Performance	6
HSAG Acute Care Team Contact Information	6

CAHPS Hospital Survey

Overview

The intent of the CAHPS Hospital Survey, also known as HCAHPS, is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. While many hospitals collect information on patient satisfaction, there is no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. In order to make "apples to apples" comparisons to support consumer choice, it is necessary to introduce a standard measurement approach. HCAHPS can be viewed as a core set of questions that can be combined with a customized set of hospital-specific items. HCAHPS is meant to complement the data hospitals currently collect to support improvements in internal customer services and quality-related activities.

Three broad goals have shaped the HCAHPS survey. First, the survey is designed to produce comparable data on the patients' perspectives on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for

(Continued on page 2)

Transition to QualityNet Completed

CMS has completed the transition between the QNetExchange and QualityNet Web sites. This is the public home page for providers and QIOs involved in data collection, validation, and reporting. Initially, the old link will automatically redirect visitors to the new home page, www.QualityNet.org. Eventually, the old link for QNet Exchange.org will no longer work at all. If you have any bookmarks, favorites, or desktop icons, it is advisable to change the Web site address to <http://www.QualityNet.org>.

the public investment. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey will be credible, useful, and practical. This methodology and the information it generates will be made available to the public.

HCAHPS Development

The Centers for Medicare & Medicaid Services (CMS) has partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency in the Department of Health and Human Services, to develop HCAHPS. The HCAHPS survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, and discharge information); 4 items to skip patients to appropriate items; 3 items to adjust for the mix of patients across hospitals; and 2 items to support congressionally-mandated reports.

In May 2005, the 27-item HCAHPS survey was formally endorsed by the National Quality Forum (NQF), which represents the consensus of many health care providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations. In December 2005, the Federal Office of Management and Budget gave its final approval for the national implementation of HCAHPS for public reporting purposes. More information about HCAHPS can be found at: <http://www.cms.hhs.gov/HospitalQualityInits/>.

Inquiring Case Management Minds Want to Know

Some Arizona hospitals have had success linking case management to improvement of hospital core measures. If your hospital works with case management to improve core measure results, we are interested in hearing more about your model. Contact Suzanne Powell (spowell@azqio.sdps.org) to share your model.

Mode Experiment

CMS has initiated a large-scale study to investigate whether the four approved modes of survey administration (mail, telephone, mail with telephone follow-up, and active interactive voice response [IVR]), as well as the mix of patients a hospital serves, systematically affect survey results. A representative sample of hospitals is participating in this experiment.

“Dry Run”

A short “dry run” of the survey is currently being conducted to provide hospitals and survey vendors the opportunity to gain first-hand experience collecting and transmitting HCAHPS data—without the public reporting of results. Using the official survey instrument and the approved modes of implementation and data collection protocols, hospitals and survey vendors will collect HCAHPS data for eligible patients discharged in April, May, and/or June and report it to CMS. All hospitals that intend to participate in HCAHPS must take part in the dry run for at least one month. The data collected during the dry-run phase will not be publicly reported.

National Implementation

Collection of HCAHPS data for the public reporting of results will begin in October 2006. Hospitals will voluntarily implement HCAHPS under the auspices of the Hospital Quality Alliance (HQA), a private/public partnership that includes the major hospital associations, government, consumer groups, measurement and accrediting bodies, and other stakeholders who share a common interest in improving hospital quality. The first public reporting of HCAHPS results, which will encompass eligible discharges from October 2006 through June 2007, is slated for late 2007. HCAHPS results will be posted on the Hospital Compare Web site, found at <http://www.hospitalcompare.hhs.gov>, or through a link at <http://www.medicare.gov>.

Role of the QIOs

At this time, the role of Medicare-contracted Quality Improvement Organizations (QIOs) in the implemen-

tation of HCAHPS entails the following:

- If asked by hospitals or survey vendors for information about HCAHPS, refer them to hcahps@azqio.sdps.org or 1.888.884.4007.
- If the QIO detects incorrect or questionable information about HCAHPS in marketing materials, promotional materials, or other sources, notify CMS at hospitalcahps@cms.hhs.gov.
- Keep abreast of HCAHPS news and developments by regularly checking the “What’s New” section of the HCAHPS Web site at <http://www.hcahponline.org>.
- Assist hospitals in the state that need to register with QualityNet prior to submitting HCAHPS data.

Quick Facts about HCAHPS

- HCAHPS will result in the first truly national, standardized, publicly reported benchmark of hospital patients’ perspectives of their care.
- Participation in HCAHPS is voluntary.

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!

- All short-term, acute care, nonspecialty hospitals are invited to participate.
- Hospitals may use an approved survey vendor or collect their own HCAHPS data.
- Hospitals may either integrate the HCAHPS items within their own patient satisfaction survey, or implement HCAHPS as a separate, stand-alone survey.
- The survey can be conducted in four modes: mail, telephone, mail with telephone follow-up, or active IVR .
- Hospitals will survey a random sample of live discharges who were 18 or older at admission, had an inpatient overnight stay, and had a nonpsychiatric diagnosis.
- Hospitals should survey patients monthly and submit data to CMS (via QualityNet) on a monthly or quarterly basis.
- Hospitals are asked to provide 300 completed surveys for each public reporting period; for smaller hospitals, as few as 100 completed surveys are needed for public reporting.
- CMS will adjust HCAHPS data prior to public reporting for mode and patient-mix effects.
- Hospitals can maintain a copy of their HCAHPS data and may analyze it as they wish; however, the only “official” HCAHPS data will be reported on the Hospital Compare Web site.
- Hospitals may preview their HCAHPS results prior to public reporting.

Abstraction/Validation Updates

By Karen Gallagher, RN

Quality Improvement Project Leader, Ohio KePRO

The following changes in abstraction will be made starting with July 2006 discharges. It is critical that you use the appropriate specification manual for each quarter.

(Continued on page 4)

AMI

Contraindication to beta-blocker (BB) at discharge: MD/NP/PA documentation of a BB hold or discontinuation during the hospitalization constitutes a clearly implied reason for not prescribing a BB at discharge.

Heart Failure

With cases where there is conflicting documentation in reference to the same/most recent test, and there are one or more numeric ejection fractions (EFs) in combination with one or more narrative descriptions of left ventricular systolic dysfunction (LVSD), take the numeric EF over narrative LVSD description(s).

Pneumonia

Transfer from another ED: This will no longer exclude the case from PN2, PN4, and PN7 measures.

In order to be included in the pneumonia (PN) population, each case will have a working diagnosis of PN and documentation of a chest x-ray or CT scan that indicates PN within 24 hours prior to hospital arrival or anytime during the hospitalization. The ED physician's documentation would take precedence over a radiologist's interpretation of a chest x-ray, even if the radiologist's report was in place prior to admission.

Influenza vaccination status: Allowable value = 6: Vaccine not available to hospital, due to shortage of vaccine (ONLY if there has been an official memo from the Centers for Medicare & Medicaid Services [CMS] or the Joint Commission on the Accreditation of Healthcare Organizations [JCAHO]).

Comfort Measures Only: Inclusions = DNR Comfort Care (verbiage comfort care)

Exclusions = DNR CC (if the term CC is not defined in the medical record)

A "direct admit" is a patient who is admitted from his or her usual place of residence (home, nursing home, assisted living center, etc.) directly to a floor/unit through an order of his or her physician. A "direct admit" is not a patient who was seen in the emergency department.

SCIP Infection

SIP-3 has been revised to allow for CABG and other Cardiac Surgery procedures to discontinue antibiotics "within 48 hours" instead of "within 24 hours."

AMI and Pneumonia

Arrival date/time: A face sheet is no longer an acceptable source. The only acceptable sources are:

- Any ED documentation.
- Nursing admission assessments/admitting notes.
- Observation records.
- Procedure notes.
- Vital signs graphic records.

Pneumonia and SCIP Infection

Antibiotic date, route, time, name—a new approach: Collect only three doses of each antibiotic from hospital admission through postop. If an abstractor chooses to abstract EACH dose, that is acceptable.

(Continued on page 5)

New MedQIC Fact Sheets

To find one of the five new/updated fact sheets on MedQIC go to:

<http://www.medqic.org/dcs/ContentServer?cid=1137346740682&pagename=Medqic%2FListingPages%2FMainListingTemplate&parentName=TopicCat&level3=Other+Resources&resetSessionForTopic=Yes&c=MQPARENTS>

The fact sheets include:

- AMI Diagnosed Late Fact Sheet
- ACEI/ARB Contraindications Fact Sheet
- Discharge Instruction Fact Sheet
- Hydralazine/Nitrates for Heart Failure in Black Patients Fact Sheet
- ACE Inhibitor in Heart Failure Patients with Renal Insufficiency Fact Sheet

Antibiotics received, prior to arrival: Listed as “current” or “home meds” should be concluded as taken within 24 hours unless there is documentation to support otherwise. (The intent of this measure has not changed; this is a clarification.)

CMS to Investigate Cutting Payment for ‘Never Events’

On May 18, Mark McClellan, MD, PhD, Centers for Medicare & Medicaid Services (CMS) Administrator, announced as part of testimony on Capitol Hill that the agency is investigating ways that Medicare can help to reduce or eliminate the occurrence of “never events.” The National Quality Forum defines “never events” as those that are clearly identifiable, preventable, with serious consequences for patients, and indicative of a patient safety problem in a health care facility—surgery on the wrong body part, for example.

In the notification, CMS said “reducing or eliminating payments for ‘never events’ would mean more resources could be directed toward preventing these events rather than paying more when they occur. The Deficit Reduction Act represents a first step in this direction, allowing CMS, beginning in FY 2008, to adjust payments for hospital-acquired infections.” The

agency said it is reviewing its administrative authority to reduce payments for “never events” and will work with Congress on legislative steps that can be taken. CMS plans to “partner with hospitals and other health care organizations in these efforts,” the notification said. CMS also recently released a new fact sheet on “never events.” It is available at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863>

New Treatments for Smoking Cessation

Nicotine replacement therapies—including nicotine patch, gum, and lozenge—have been used for several years and do significantly help motivated tobacco users to quit. However, concern about weight gain is a common barrier to quitting, especially for women. A recent study at the University of Minnesota of postmenopausal women smokers who quit using the nicotine patch demonstrated that they gained less weight than women on placebo, even though they did not reduce their calorie or fat consumption and maintained the same physical activity level. [*Addictive Behaviors*, 30(7):1273–1280, 2005]

Most nicotine replacement therapies are available over the counter, without prescription. Tobacco users who are ready to quit can get a 50 percent discount on the patch, gum, or lozenge from the Arizona Smokers Helpline at 1.800.556.6222 or through projects funded by the Arizona Department of Health Services Tobacco Education and Prevention Program. [<http://www.azdhs.gov/phs/tepp/index.htm>]

New Cessation Pharmacotherapies

Varenicline is a new drug just approved by the FDA in May 2006; varenicline is designed to activate the nicotinic receptors in the body to reduce both the severity of the smoker’s craving and the withdrawal symptoms from nicotine. Varenicline is being sold under the trade name Chantix. [<http://www.fda.gov/bbs/topics/NEWS/2006/NEW01370.html>]

Rimonabant is a drug that has shown some promise in clinical trials for treatment of smoking and obesity; this drug targets the endocannabinoid system in the

Invalid Record Selection

Due to the impact of an “Invalid Record Selection” on a hospital’s validation score, CMS and the Hospital Reporting QIOSC are supplying additional information to assist QIOs and providers. The Clinical Data Abstracting Centers (CDAC) will select the status of “Invalid Record Selection” if any of the following on the submitted medical record do not match what was requested:

- Admission Date
- Discharge Date
- Birthdate

Additional information regarding validation and its processes can be located at <http://www.QualityNet.org> in the Hospital/Data Validation section.

brain. However, to date, it has not been approved by the FDA. [<http://www.medscape.com/viewarticle/471358?mpid=26077>]

Behavioral therapies and social support are keys to helping tobacco users to quit and stay quit. As most tobacco users require multiple quit attempts before they quit for good, by delivering a personal, relevant, brief tobacco cessation message, clinicians can help move a patient closer to a successful cessation attempt. Multiple interventions by multiple health professionals are even more effective than one clinician alone.

Free continuing education Brief Tobacco Intervention Skills Certification and Basic Skills Instructor Workshops taught by The University of Arizona HealthCare Partnership (HCP) faculty are available at a variety of locations throughout Arizona. The workshops offer free CEU/CME and are funded by the Arizona Department of Health Services Office of Tobacco Education & Prevention.

For HCP program information, visit <http://www.healthcarepartnership.org>.

For the HCP calendar of events, visit <http://research.sbs.arizona.edu/hcpcalendar/month.php>.

For the On-Line Learning Center/Tobacco Treatment

Specialist, go to <http://www.aztreattobacco.org>.

Contact the HCP at hcpinfo@u.arizona.edu or 520.318.7253 x 116.

Premier’s Monthly Teleconference Series

Advisor Live is Premier’s monthly teleconference series providing important health care measurement information. There is no charge to participate.

Join *Advisor Live* for the next session, *Leveraging Technology to Improve Heart Failure Performance*, on June 7, 2006, at 2–3 p.m. EST.

The presenter is Randall E. Williams, MD, FACC, CEO of Pharos Innovations, LLC.

This program will cover:

- Overview of the cost and quality conundrum of heart failure care.
- How the Chronic Care Model can be employed for both clinical and operational process redesign.
- Where patient-provider communications technologies can be used to achieve improved clinical and financial outcomes for heart failure care.

Register online at:

<http://www.premierinc.com/advisorlive>

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