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Spring 2011

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2011 Spring Conference
Friday, April 15th
Register Now!
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Arizona Association for Healthcare Quality

www.azahq.org

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Benchmarking with State Data

The Fall AzAHQ educational session was an eye-opener for quality professionals in Arizona. We learned about the data that the Arizona the State Department of Health Services collects on inpatient visits from every non-Federal hospital in the State. And we saw examples of how that data can be used for use for a variety of purposes – including calculating benchmarks.

Many AZ hospitals already own a software system that will also allow the aggregate data to be analyzed. It is often the same product used to submit the data to the State. Vendors who offer these programs using AZ's data include Aspen Healthcare Metrics and Intellimed. If you don't know if your facility has a program to access the data a good place to start would be the person who submits the data to the state on your organization's behalf.

Using the state data, you can get recent, relevant and timely benchmarks for the entire state or a subset of hospitals you'd like to compare against. You can also see how your hospital looks compared to other hospitals. This information is used by other companies (such as HealthGrades.com) so it is wise to know what your patients will be seeing when they look for quality data about your facility.

Suppose you were looking at your hospital's rate of complications for a surgical procedure. Since only a few procedures have national databases, this can be a challenge. With the state data, however, you only need to identify the procedure code(s) you're interested in, and the complication codes you'd like to evaluate and you can get a comparison benchmark rate.

Benefits of using State Data to benchmark include:

- Timely. Data is typically available to end users 3-4 months after the bi-annual collection period ends.
- Precise. The user defines the population, ensuring an accurate comparison group.
- Relevant: Data can be segmented by specific facilities, counties, etc. to meet specific benchmarking needs.

Next time you need a benchmark for your performance project, consider turning to the State Data as a source.

Current Trends In Healthcare Quality

- Jennifer Wolfe-Pearce

Quality and CME: Bridging the Gap

Quality professionals may be forming even closer collaborative relationships with their facility's Continuing Medical Education (CME) department. As the result of new rules implemented by the American Board of Medical Specialties (ABMS), CME must now be directly linked to metrics that measure clinical quality improvement.

To facilitate effective and compliant CME programs, CME and Quality staff should work together to plan future CME topics. It is also critical to work with the presenters to ensure their content will directly address the related performance measures.

Obviously, organizations use multiple strategies to achieve improvement, with CME being only one of them. But well planned and executed CME can meet the new ABMS requirements while improving quality of care for patients.

These guidelines are part of the ABMS Maintenance of Certification (MOC) program. This is one of the topics at the April 15th AzAHQ educational session that will be presented by Dr. James Burke. Be sure to sign up and learn more about how these new standards will impact your organization!

ICD-10

The US healthcare system is getting a long-awaited upgrade to a new International Classification of Diseases (ICD) system. After being on the ICD-9 system since 1979, CMS has mandated that claims filed after October 1, 2010 use the new classification system.

One of the earliest challenges for quality professionals will be re-defining reports currently written using ICD-9 diagnosis and procedure codes. Unfortunately, there is no direct, simple crosswalk between the two versions. General Equivalence Maps (GEMs) have been created. But they are neither 100% accurate, nor do they allow cross-walking cleaning in a reverse direction (e.g., from ICD-10 back to ICD-9)l. As the following example demonstrates, the translation can be quite complex in some cases.

Another complexity is while CMS requires billing with ICD-10 codes after the go live date, this mandate does not require other payers to accept bills with ICD-10 codes. Because of the cost of conversion, some players, such as AHCCCS and Worker's Compensation in Arizona have stated they will not convert. This means providers who bill with any ICD codes will have to be able to bill with both ICD-9 and ICD-10 into the foreseeable future.

So is there any bright side to this transition? The answer is a resounding **yes**! Once implemented, ICD-10 will provide a level of granularity that will be a boon for quality improvement. A few examples of new information that could not be easily obtained from administrative data in the past include laterality detailed descriptions for body parts, and accurate information about the technology or approach utilized (e.g., robotics).

If you aren't already involved in your organization's ICD-10 planning efforts, now would be a good time to get more involved. By preparing carefully for this transition, the quality professional will be in an excellent position to start taking advantage of the rich data ICD-10 will provide.

Example of ICD-9 to ICD-10 Mapping	
ICD-9 Code	ICD-10 Codes
555.9 Regional enteritis of unspecified site	K5090 Crohn's disease, unspecified, without complications K50911 Crohn's disease, unspecified, with rectal bleeding K50912 Crohn's disease, unspecified, with intestinal obstruction K50913 Crohn's disease, unspecified, with fistula K50914 Crohn's disease, unspecified, with abscess K50918 Crohn's disease, unspecified, with other complication K50919 Crohn's disease, unspecified, with unspecified complications

President's Message

Over the past few years, our association has grown into a strong organization both in membership and financially. We provide diverse educational conferences based upon membership feedback and are always open for suggestions.

We have a dedicated team of elected quality professionals on the AzAHQ Board of Directors who have experience in all aspects of the healthcare industry:

Board Position	NAME	Credentials	Employer	Title
President	Jeanne Stueland	R.N., BSN, MPA, CPHQ	Scottsdale Health Care	Consultant, Quality Outcomes
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Communications Team Lead-Elect	Elizabeth Maish	BSN, MSN, CPHQ	Joint Commission Resources	CSR Lead Consultant
Education Team Lead	Michelle Bagford	RN, MA, CPHQ	Phoenix VA Healthcare System	Associate Chief Nurse
Education Team Lead-Elect	Sallie Weems	MBA, CCMEP	Catholic Healthcare West	Program Manager
Membership Team Leader	Stephen Burroughs	RN, BS, BSN	United Healthcare - Arizona Physicians IPA	Clinical Manager of Prior Authorization
Membership Team Lead-Elect	Carolyn Marquart	RN	Marana Health Center	Director of Quality Improvement
Member at Large	Andrew Kopolow	MPA, MSW, CPHQ	Arizona Department of Health Services	Special Projects Advisor
AzAHQ Association Manager	Holly Grems	RN, BS, BSN, MHA, CPHQ	John C Lincoln Health Network	QM Analyst, QA Coordinator

The Board of Directors recently met and tentatively identified dates for upcoming educational conferences and general membership meetings. These are:

- **4/15/11 (full day conference & general membership meeting)**
- **6/10/11 (1/2 day conference)**
- **11/4/11 (full day conference & general membership meeting).**

Please save the dates & mark your calendars! We will keep you posted on the chosen topics and locations as soon as more information is available.

If you are not a current member of AzAHQ, please consider joining. It's a great way to network, receive CEUs and keep current with the ever-changing healthcare industry. If you are a member, thank you for your support!

Sincerely,

Jeanne Stueland RN, BSN, MPA, CPHQ

President – AzAHQ 2010 - 2011

Joint Commission Spotlight

The *New* National Patient Safety Goal on Reconciling Medication Information (NPSG.3.06.01)

- Elizabeth Maish

Adverse Drug Events and Adverse Drug Reactions continue to cause significant harm to patients in the United States. There are far too many statistics to list that relate to the serious harm that Adverse Drug Events or Reactions can cause; however knowing that medication errors alone, occurring either in or out of the hospital, are estimated to account for 7,000 deaths each year in the United States casts a sobering light on this aspect of care. Harm from Medication errors or reactions in the 100's of thousands every year. This is very serious business, and accordingly should be treated with the greatest level of oversight and monitoring available.

As the adult population becomes older and more medically frail, their medication regimens have become increasingly more complex and lengthy. This can create a good deal of confusion on the part of the patient and serious care coordination gaps for healthcare providers. The safety risks are glaringly obvious. Historically, the goal to reconcile medications, albeit a well accepted concept, has been extremely onerous for most healthcare entities to implement. The concurrent implementation (partial or full) of an Electronic Medical Record has complicated the efforts of many organizations, while questions of role accountabilities within the process have never been fully defined. The challenges of implementing the process were noted by the Joint Commission both during Accreditation Survey processes as well as feedback from a number of varied healthcare organizations. The NPSG was revised after extensive field review.

Note that NPSG.03.06.01 replaces Goal 8 (08.01.01, 08.02.01, 08.03.01 and 08.04.01) and its related elements of performance. The new National Patient Safety Goal on Reconciling Medications will be scored effective July 1, 2011 for the **ambulatory, behavioral health care, critical access hospital, home care, hospital, long term care, and office-based surgery accreditation programs**. The new version of the NPSG places a spotlight on critical risk points in the medication reconciliation process. The new Goal compliments existing standards and when fully implemented, supports compliance to a great number of standards and their EPs. The following standards relate to the new goal.

- MM.01.01.01—The hospital plans its medication management processes.
- MM.05.01.01—A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.
- MM.06.01.01—The hospital safely administers medications.
- PC.02.02.01—The hospital coordinates the patient's care, treatment, and services based on the patient's needs.
- PC.02.03.01—The hospital provides patient education and training based on each patient's needs and abilities.
- PC.04.01.05—Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.
- PC.04.02.01—When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.
- RC.01.01.01—The hospital maintains complete and accurate medical records for each individual patient
- PC.04.01.05—Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.
- PC.04.02.01—When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.
- RC.01.01.01—The hospital maintains complete and accurate medical records for each individual patient

The intent of the new goal is to focus on specific high risk points: Upon admission, as the care plan is developed, as the patient's care, diagnosis, disease progresses and resolves and the discharge process. This over arching concept logically applies to most health care settings. Additionally, the goal seeks to allow more latitude on the part of the organization to determine reconciliation processes in non-24 hour settings.

NPSG.3.06.01: Maintain and communicate accurate patient medication information

- **EP1 Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented; a list may be used for documentation, but a separate list is not required.**

  Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.

  Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

- **EP 2 Define the types of medication information to be collected in non–24-hour settings and different patient circumstances.**

  Note 1: Examples of non–24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.

  Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose

- **EP3 Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.**

  Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. (See also HR.01.06.01, EP 1)

- **EP4 Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter.**

  Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.

- **EP5 Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.**

  Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

Most regard this goal as "easier said than done". The work to develop a new or improved reconciliation process requires a disciplined approach, one that involves staff, medical staff , leadership and a defined Performance Improvement methodology like PDCA or LEAN. The time spent on understanding current status and defining the barriers to compliance cannot be understated, therefore, it is recommended that a thorough gap analysis of the current process in *all affected areas* of the organization be conducted. The definition of role accountabilities, exploration of innovative models in the literature, and launching a pilot process (with measures) are also essential to the success of this critical safety process.

National News

NAHQ National Conference…Coming to a State Near You!

The National Association for Healthcare Quality (NAHQ) 36th Annual Educational Conference will be held in Sacramento, California on September 15th-18th. Registration opens soon. Visit www.nahq.org for more information.

Core Measures Corner

- Darlene Ceccarelli

Two of the leading causes of hospital complications and death are deep venous thromboembolism (DVT) and pulmonary embolism (PE). Nationally, an estimated 600,000 DVT's and 300,000 deaths from fatal PE occur annually, often after the patient has been discharged.

Venous thromboembolism (VTE) prophylaxis is a newer collective term to describe mechanical and chemical DVT and PE prevention therapies. Mechanical VTE prophylaxis consists of compression hose (TED stockings) and/or sequential compression devices (SCDs)/intermittent pneumatic compression devices. For most patients however, this is inadequate VTE protection, due to inconsistent use of devices and/or improper fit of stockings. Chemical prophylaxis with Lovenox, Heparin, or other anticoagulants offers the best protection from blood clots, unless significant contraindications exist, such as increased bleeding risk.

Both surgical and medical patients should have a risk assessment completed and prophylaxis initiated within 24 hours of admission or change in status, such as end of surgery. For several years now, CMS (Medicare)'s ***Surgical Care Improvement Project Core Measure Set*** requires hospitals to report on how often surgical patients receive the appropriate treatment and if started on a timely basis. This year CMS also began collecting similar data on medical patients.

Keeping your patients safe means ensuring VTE risk is identified and addressed in the patient's plan of care, with direct, early communication with physicians as needed.

Register Now for the Spring Conference!

Online registration is available now for the AzAHQ 2011 Spring Conference on April 15th. Just visit www.azahq.org and click on "Education." This session offers an agenda packed with current hot topics in healthcare quality. Further your professional knowledge while earning 7 CPHQ credits! This session features five highly-qualified speakers and a diverse agenda. Make plans to attend today!

Topics include:

2011 ABMS – Maintenance of Certification

Joint Commission Standards Update

Patient Care Practice Improvement in the ED: A Model for Physician Engagement

AzAHQ General Membership Meeting

The Healthy Aging Initiative

2011 Medical Staff Standards Review

AMA PI-CME – The Road to Collaboration

2011 AzAHQ Board of Directors

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