

CTAHQ NEWS

A PUBLICATION OF THE CONNECTICUT ASSOCIATION FOR HEALTHCARE QUALITY

MESSAGE FROM THE PRESIDENT

By Chris Scully

Happy Holidays to you and your family! 2012 has begun and my first quarter as President of CTAHQ has flown by in a flash. My term began with a record setting snow storm that canceled Halloween for most of the state. Many of us were tested personally and professionally with the lack of power for days coupled with the cold weather. In an upcoming educational session, we will start the evening with a discussion around lessons learned regarding the storm and the week that followed. I believe we can all benefit from our collective experiences. The discussion can also include our Hurricane experiences that were similar and different at the same time. So, keep a look out for information on our next program.



The week prior to the storm, National Healthcare Quality Week was celebrated October 16th through the 22nd. I think the theme “United in Quality” with the logo of the multi-colored pencils all aligned together is symbolic of the way Quality Professionals have to work together to achieve positive results within our organizations. Each year, the organization receives a proclamation from the governor recognizing National Healthcare Quality Week. The application was initiated in September and sadly, due to timing was not processed. As an opportunity for improvement, we have added the responsibility to the President Elect’s role description for processing in August of each year. I apologize and hopefully, it was a one time slip.

Membership Drive

At the December 7th Board meeting, our report card listed 23 applications received. CTAHQ ended fiscal year 2011 with a total of 80 members. The Board discussed strategies to increase membership and to strongly encourage members to send in their applications prior to the end of the calendar year. Membership dues allow CTAHQ to plan and provide educational sessions throughout the year and to offer scholarships to NAHQ. If you haven’t sent in your application for the 2011-12 fiscal year, please send in your application to **Natalie Vinhais** soon. At future educational sessions, mem-

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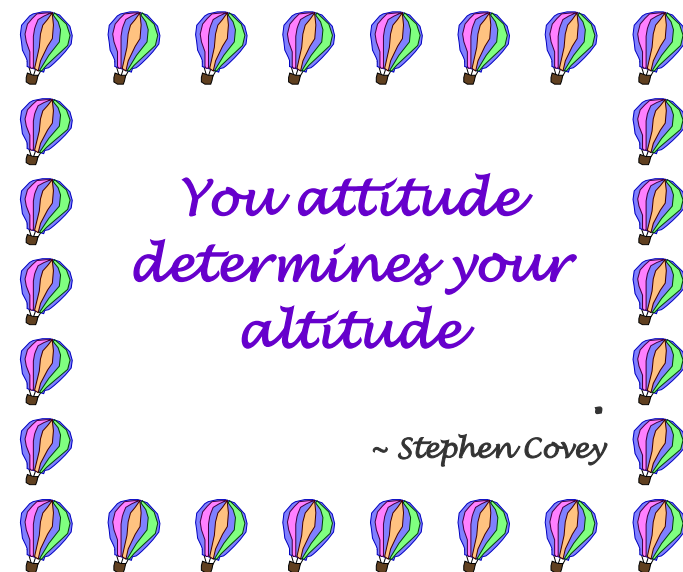
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bership applications will be available at the registration table. We have also added the opportunity this year for members to donate \$5 towards scholarships when sending in their annual dues. This additional opportunity along with our fundraising efforts at each meeting assists in helping to offset the cost of the scholarship. So far, two members participated in the \$5 donation to scholarships. Thanks **Sue Wrubel** for participating along with me. In every newsletter, we will recognize other members who have made donations to the scholarship fund.

Board Members/Team Leaders

At the start of each fiscal year, openings occur for Team Leaders positions as members step up in the organization into Board level positions. One position currently available is the role of Team Leader for the Awards Committee. This position has been held by Terri Savino for several years and Terri has done a wonderful job with the selection process for the Gail Glover Award that is awarded at our annual meeting in June. We are also looking for new members to participate in standing committees not as Team Leaders but as “helping hands”. The standing committees include: Education, Communication, Public Relations/Historian, Nominating, Membership and Awards. Please contact any of the Board Members if you have interest in joining. Small commitments of time or volunteering for a specific project are available. Thanks for your consideration.



**Grant Applications being accepted
until April 30, 2012**

Career Development Grant

The HQF Career Development Grant is awarded to a NAHQ member who has been employed in the healthcare quality field for at least 5 years and holds CPHQ certification. The grant is valued at \$1,000, which can be used for travel and registration expenses for attendance at either a NAHQ CPHQ Review Course or the annual educational conference. One grant will be awarded annually.

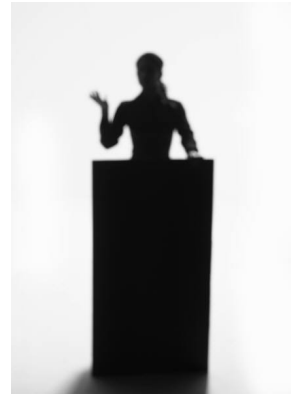
[2012 Career Development Grant applications](#)

New Quality Professional Grant

The HQF New Quality Professional Grant is awarded to a NAHQ member who has been employed in the healthcare quality field less than 2 years and is not yet a CPHQ. The grant is valued at \$1,000, which can be used for travel and registration expenses for attendance at either a NAHQ CPHQ Review Course or the annual educational conference. One grant will be awarded annually.

[2012 New Quality Professional Grant applications](#)

Education Team Report By Kate Betancourt



Happy New Year to one and all! It's hard to believe that 2012 is upon us already. I hope that you all had a little time to rest and enjoy the holidays with friends and family. My husband and I were happy to have all three of our children home for several days, and are slowly watching them head back to their respective academic lives. It's an adjustment as they leave, and then, slowly...it will be OK.

It was wonderful to see so many of you at our December program. We heard from three of our members with great information from the September NAHQ program. Linda Elgart, our Kathy Adamo scholarship winner, shared feedback on common pitfalls and challenges in maintaining a safe hospital environment. There was quite a discussion following her presentation, when colleagues shared EOC war stories; excellent tools that we can all use to carry the banner of environmental safety as we educate staff back at our own shops. Terri Savino discussed ways in which we can engage stakeholders in the quality dialogue by representing information using conceptual maps, cognitive maps and Roam's four-step visual thinking process. This was a fresh perspective for some of us "seasoned" professionals in the room! And our President, Chris Scully, demonstrated how the use of a Vector of Measures display can provide enhanced meaning when discussing performance gains and challenges, especially with senior leaders. In addition to these presentations, there was ample networking and sharing on a variety of topics. We learn so much from each other as we share a casual meal and conversation, no?

The Education Team continues to discuss how we can best meet your learning needs. There is a strong recommendation to resurrect the pre-program networking sessions of yore. Members expressed that they enjoyed the opportunity to interact in this format of casual, facilitated discussion. We are interested in hearing about topics of interest. Please forward your thoughts and ideas to any Board member.

Up next...

While the date has not yet been confirmed, we are very excited that member **Anne Huben-Kearney** has agreed to present her NAHQ program on *Patient Safety and the Use of Social Media*. Our tech savvy children (and even some of us "old-timers") increasingly look to these data sources that a mere 5 years ago seemed fleeting...*Facebook* posts, blogs and tweets; oh my. Anne is sure to provide us with an important perspective that will inform our actions going forward.

As always, we would like to hear from you with future program suggestions. If there is content that you are delivering in your own work environments and you'd be willing/interested in presenting for the CTAHQ members, please contact me. We have a vast collective wisdom among us – let's tap into that!

Wishing you all good health in 2012. With apologies to any skiers out there, may the 40 degree, snow free days continue...



Top 12 Healthcare Quality Concerns in 2012

Which quality issues will provoke the most influential changes in healthcare in 2012? Or, which ones will most rapidly accelerate the graying of chief quality officers' hair? There are so many, it's hard to pick the most significant. We interviewed quality experts around the country to glean the most influential and then picked a dozen.

Here's the list:

1. Patient experience scores hinge on "always" responses

The value-based purchasing sweepstakes have begun, with the first performance period for clinical process of care and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) questions scheduled to end March 31. Payment adjustments will begin for patients discharged as of Oct. 1, and the winners and losers will then be revealed.

What makes many hospitals and clinical nurse managers most nervous, however, is that the patients responding to these surveys must reply "Always," in order for the hospital to get credit for high quality patient experiences. Responses "Sometimes," or "Usually" aren't going to cut the mustard.

"How often did nurses listen carefully to you?" "How often did doctors treat you with courtesy and respect?" "How often was your pain well controlled?"

"Always."

And by the way, Jan. 4, 2012 is the data submission deadline for patients discharged in July, August and September, 2011.

2. Physician Compare

As if providers didn't already have enough to worry about with Medicare, Medicaid and private insurer payment reductions, electronic medical record and meaningful use compliance, disclosing payments from durable equipment and pharmaceutical companies and yes – remembering to answer their patients' e-mails. Now they have something else to fret about.

As of this New Year's Day, according to the Patient Protection and Affordable Care Act, the official reporting period begins for physician per-

formance on quality and patient experience measures for physicians enrolled in Medicare on Physician Compare.

Starting "no later than" next New Year's Day, 2013, the Health and Human Services Secretary shall "implement a plan" to make publicly available on Physician Compare a huge number of quality scores.

They include measures from the Physician Quality Reporting Initiative, an assessment of each physician's patients' health outcomes and their functional status, an assessment of the continuity and coordination and care and care transitions including episodes of care and resource use, efficiency, patient experience and patient, caregiver and family engagement, safety, and effectiveness and timeliness of care.

And if all that weren't enough, the HHS secretary gets to publish other information on Physician Compare he or she determines appropriate.

3. Thirty-day Readmissions

A number of decisions forthcoming this year focus on how the Centers for Medicare & Medicaid Services will determine those hospitals with higher rates of readmissions for congestive heart failure, pneumonia and heart attack diagnoses. One question is whether the agency will compare a hospital's readmission rates with just those within that hospital's state, or whether each hospital will be compared with the entire country as a whole.

The first option would guarantee that some hospitals in each state would receive negative reimbursement adjustments (CMS prefers that we not use the word penalty), even if those hospitals have far lower readmission rates than hospitals with the highest rates.

Another issue up for consideration is the risk adjustment criteria, whether payers including private insurance companies will begin looking at all-cause readmission rates and whether scheduled readmissions will continue to be included in the equation.

The penalties start at 1% for Medicare DRG discharges on or after Oct. 1, 2012, increase to

2% on or after Oct. 1, 2013 and to 3% on or after Oct. 1, 2014.

How hospitals, physicians, discharge planners, nurse case managers, skilled nursing facilities and in-home health services agencies will work together to avoid the "blame game" when a patient does end up as an "avoidable" readmission will be interesting to watch.

Look for providers and federal regulators to talk more about "all-cause" readmissions, or to include additional diagnoses such as hip replacements gastrointestinal resections, and eventually to lengthen the watch period to 60 or 90 days.

How aggressively will hospitals and doctors stress the need for patients to comply with physician appointments and medication regimens? Will hospital staff dare to tell patients that if there is a preventable readmission, it make the hospital look bad and hurt the bottom line?

4. Outcome measures versus process measures

The science of testing outcomes versus surrogate "process" measures will evolve, but this year and years to come, much more rapidly.

Starting in FY 2014, CMS will include 30-day mortality measures in value-based purchasing incentive payment algorithms. But don't expect publicly reportable outcome measures to stop there.

As James La Belle, Corporate VP of Quality, Medical Management and Physician Co-Management for Scripps Health explained, perhaps more meaningful metrics might include those covering "functional status," such as how quickly or completely a patient's cognitive function is restored, how far they can walk without assistance or how soon they can return to work. How long before the patient could say life was back to normal?

5. Meaningful Use

With the impending release of the Stage 2 Meaningful Use final rule, physicians and others have no more excuses to delay learning and installing software and computerized physician order entry systems.

If you listen closely, you will hear their cries, that they have been turned from being doctors to being typists. That they hardly ever get to see

their patients because their heads are blocked by a computer monitor. Quality wonks will want to see evidence that these systems are time-efficient and not intimidating.

Look for applications that use hand-held tablets that are not just patient and doctor friendly, but actually fun to use and may make documentation seem more like a game.

6. Release of the Medicare claims database

Without much fanfare, CMS on Dec. 5 released its final rule governing how it would release, and who might obtain, access to its enormous claims database. This is a goldmine for any public or private entity that wants to "data dive" into numbers to evaluate cost as well as performance.

CMS' final rule specifies that those selected to receive this information – and CMS will pick which ones – are expected to "increase the transparency of provider and supplier performance, while ensuring beneficiary privacy." It is to be used to evaluate performance of providers and suppliers on quality, efficiency, effectiveness measures as well as use of resources.

The only catch is that the data may not be used by itself, but must be combined with health plan or other provider claims and quality information for performance measurement.

Medicare officials acknowledged in a statement that the final rule governing access to this treasure trove ends a situation that has been "frustrating" to providers and employers, consumers, and health care quality advocates.

7. Drug shortages and grey market vendors

Quality leaders are looking nervously at all the drugs that they can't get or can't afford to get because of price gouging – as much as 4500% – by grey-market vendors, and what drugs can be safely substituted. The problem involves the word "safety."

According to a survey from the purchasing and quality group Premier Healthcare Alliance, the number of drugs with exceptionally high markups because of scarcity numbered only about 50 five years ago. But now the number is approaching 400.

"When these drugs are bought and sold across state lines, moved in whole or partial

lots, repackaged and relabeled, resulting in a complex web of transactions involving dozens of trading partners, (it makes) it almost impossible to determine the supply source or authenticity," said Premier's COO Mike Alkire during a news conference in mid-August.

In a commentary for HealthLeaders Media online April 15, Alkire wrote:

"Drug shortages present a danger to public health. In hospitals, a shortage may delay necessary medical procedures. Substitution of similar medications, if available, may lead to errors and adverse events, especially if prescribers are unfamiliar with the alternative products' dosing and potential interactions with other drugs."

8. ICD-10

Our list would not be complete without a tip of the hat to ICD-10 adoption efforts, scheduled to go into high gear later this year in anticipation of the Oct. 1, 2013 date for the big switch.

Quality and chief information officers say this effort is monopolizing large chunks of their workday, even as the costs for installing and understanding the system make everyone nervous.

Down the line, however, ICD-10 data will gather power with volume datasets and enable providers to capture much more precise information on patients' conditions and procedures. It will be tougher for hospitals to lump patients into more severe categories, a current practice that may enable higher reimbursement, will more quickly identify fraud, waste and abuse in healthcare and will enable better hospital and physician quality comparisons.

9. Emergency department speed, accuracy

Much of what happens to patients in hospital settings happens to them first in the ED. So it matters a lot how long they have to wait to be seen, how long it takes to correctly diagnose them with labwork, imaging or other functional tests, and how long it takes to process the paperwork, get them in an inpatient bed and provide whatever medications or procedures they need.

But until very recently, there have been very few ways in which ED quality has been formally measured, other than in time to antibiotic for a

pneumonia patient, or door to balloon for heart attack patients.

That is about to dramatically change. In the next year, the Centers for Medicare and Medicaid Services will require hospitals to begin tracking and reporting their median times for two National Quality Forum benchmarks in emergency care.

1. The number of minutes between the "door," the time the patient arrives at the ED to the moment they "depart" the premises of the ED to be admitted to the hospital

2. The time between the moment a decision is made by the ED physician to admit the patient to a hospital bed to the time the patient departs the ED and is actually placed in an inpatient bed, a period sometimes referred to as "boarding."

Look for these results to become publicly reported on Hospital Compare. For now, CMS has not said it will impose a payment adjustment or penalty for slower hospitals, but that may come with future Outpatient Prospective Payment System rules, perhaps the one released for 2013.

Along the way, hospital emergency room providers, including physicians and nurses, are gathering consensus over terminology, so that everyone means the same thing when a patient is said to come in the "door."

10. End-stage renal disease quality measures

Last month, the federal government released the first round of payment penalties for dialysis centers with lower scores on quality measures and one in three, or 1,300 of the 5,000 dialysis centers in the country made the list. This is a big deal for all providers

This is huge, because more than a half a million patients in the United States are on dialysis, and the federal government pays the bill for 453,000 who lack private insurance, at an average cost of between \$57,639 and \$77,506 per patient per year as of 2008. More quality measures will be added to the formula in 2014.

11. Medication management

Making sure that providers who treat patients who need to be on multiple medications

for multiple conditions talk to other members of the team to make sure the patients, especially the elderly, are not being prescribed harmful combinations.

A recent report in the *New England Journal of Medicine* study found that 100,000 seniors a year require costly, emergency hospitalization because of misuse and adverse reactions to of prescription drugs, with four medications responsible for 67%, either alone or in combination.

Additionally, keeping patients compliant with their regimen, communicating with pharmacies, and making sure that patients are on the correct medications when they're discharged from the hospital — not necessarily the same ones they took before they were admitted — will be an increasing challenge for providers.

12. Waste, fraud, and abuse

In November of 2010, the Office of Inspector General's report found that of nearly one million Medicare beneficiaries discharged from hospitals in just one month — October of 2008 — one in seven experienced an adverse event and nearly half of those were preventable medical errors, substandard care and inadequate patient monitoring and assessment. This is one category of avoidable spending.

Another is the fact that far too many patients are getting unnecessary procedures, including surgery or undergoing care with the use of new "better" technology that really isn't.

In his address at the Institute for Healthcare Improvement forum in Orlando last month, outgoing CMS administrator Don Berwick, MD, called it "overtreatment — the waste that comes from subjecting people to care that cannot possibly help them — care rooted in outmoded habits, supply-driven behaviors, and ignoring science."

What the Patient Centered Outcomes Research Institute, PCORI, does this year when it begins to prioritize its research hospitals projects may make some providers nervous, especially if the results of that research throw doubt on a key line of service or major device acquisition.

That's our list, although undoubtedly there are other worthy candidates we could have included. Can you suggest others? If so, please

do so in the comment section below or send me an e-mail. Maybe we'll have enough for a sequel.

Cheryl Clark is a senior editor and California correspondent for HealthLeaders Media Online.



What's news on the Web

(click on the blue [hotlinks](#) to access the website)

[AG sues healthcare service firm for alleged patient privacy violations](#)

Personal health data on thousands of Minnesota patients was shared with a debt collection company that shouldn't have access to such information.....

[Multitasking Doctor Imperils Patient, Case Study Says](#)

A 56-year-old man with dementia was admitted to a medical center. His feeding tube needed to be removed from his stomach. It's a common enough procedure that went fine. But then things went terribly wrong. The culprit: a smartphone...

[Report Finds Most Errors at Hospitals Go Unreported](#)

WASHINGTON — Hospital employees recognize and report only one out of seven errors, accidents and other events that harm [Medicare](#) patients while they are hospitalized, federal investigators say in a new report.

Meaningful Use— Final Rule for Stage 2 Due Soon

As the new year begins, all eyes are on the proposed rule for stage 2 of the meaningful use program, which is expected in February. A final rule is expected this summer.

This will be a crucial year for the program and its participants. Stage 1 will enter its second year, adoption of the released stage 2 requirements will begin and discussion on stage 3 will be underway.

In tandem with the release of stage 2 rule, vendors and providers, implementation specifications, and certification criteria that EHRs must meet to be used in the program.

While stage 1 was meant to be a relatively easy launching pad for the program, stage 2 is expected to ramp up in difficulty, leading to more extensive changes in your facility.

The elective menu set items from stage 1—such as asking patients to complete advanced directives—are expected to become requirements in stage 2. Many of the measure thresholds will increase, and some new measures likely will be added.

A stage 1 requirement that will continue to challenge hospitals this year is providing patients with timely electronic access to certain medical information.

Under HIPPA organizations had up to four weeks to prepare a record for release (with one extension allowed). But stage 1 calls for select information to be released to the patient as an electronic copy within three days of request.

This acceleration creates a need for providers to redesign the entire record creation process, affecting everything from physician documentation to transcription contracts and billing.

One highly anticipated aspect of the stage 2 will be the start date. Throughout 2011, calls increased for the Center for Medicare and Medicaid Services to delay stage 2. With the final rule expected in the summer and the phase set to begin in October for hospitals and January

2013 for professionals, many vendors and providers argue they would have no time to prepare.

In November that pressure was relieved for one group, at least, when hospitals and eligible professionals who joined stage 1 in 2011 learned they would receive an extra year to meet stage 2 requirements. They will be on the same 2014 deadline as those providers who joined the program in 2012.

NQF Looks at CMS Quality Measures, Releases Pre-Rulemaking Report

A group assembled by the National Quality Forum (NQF) [released a report](#) this week identifying the most important quality measures under consideration for use by CMS in the coming regulatory cycle. Spanning eighteen federal programs, CMS is considering 368 quality measures in order to evaluate nursing homes, hospitals, diabetes facilities and other providers. Members of the Measure Applications Partnership (MAP) looked at each of 368 measures using a framework that considered a number of factors like:

- The program measure set adequately addresses each of the National Quality Strategy priorities;
- The measure set adequately addresses high-impact conditions relevant to the program's intended populations (e.g., children, adult non-Medicare, older adults, or dual eligible beneficiaries); and
- The program measure set promotes alignment with specific program attributes, as well as alignment across programs.

MAP concluded that 45 percent of the quality measures do not align with NQS precepts and they could not be supported by the public-private partnership. Meaningful Use was among the eighteen CMS programs MAP looked at, reviewing 92 measures. Map supports the inclusion of 67 clinical quality measures that are NQF-endorsed, and suggests 25

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[Proposed National Patient Safety Goal \(NPSG\) addressing overuse of treatments, procedures, and tests for the Hospital and Critical Access Hospital Accreditation Programs.](#)

Start Date: November 29, 2011

End Date: January 24, 2012

There is growing concern related to the overuse of various treatments, procedures, and tests in health care. The Joint Commission defines overuse as the use of a health service in circumstances where the likelihood of benefit is negligible and, therefore, the patient faces only the risk of harm. Seen from this perspective, overuse is a safety and quality problem. Additionally, research has demonstrated that overuse occurs with significant frequency in the United States.

To address this serious safety and quality problem, The Joint Commission is proposing a new National Patient Safety Goal (NPSG) on the topic of overuse and is seeking input from the field. Please review the goal, and then provide comments using one of the methods listed below.

Easy to Read 2012 National Patient Safety Goal Handouts Available

[Behavioral Healthcare](#)

[Hospital](#)

[Long Term Care](#)

[Standard IC.02.04.01 Influenza Vaccination for Licensed Independent Practitioners and Staff](#)

December 2, 2011

This voice recorded slide presentation focuses on revised Standard IC.02.04.01 Influenza Vaccination for Licensed Independent Practitioners and Staff, for Critical Access Hospitals, Hospitals and Long Term Care accreditation programs. This revised standard will go into effect on July 1, 2012. During the presentation each of the nine elements of performance will be reviewed.

[Revision to MM.02.01.01](#)

Prepublication Standard - Revision to MM.02.01.01- The hospital selects and procures medications.

Effective 7/1/2012



[Joint Commission 2012 Survey Activity Guide for Healthcare Organizations](#)

Certification Grant available NAHQ Members

The HQF Certification Grant awards financial assistance to healthcare quality professionals who have not yet attained the CPHQ credential by sponsoring their examination fee.

These grants are awarded twice year in January and July. 14 grants will be awarded in 2012: 7 in February and 7 in August.

Completed [2012 Certification Grant applications](#) are due at the NAHQ office by January 31, 2012, or July 31, 2012.



Sandra P. Donahoe, CPHQ, MBA, FACHE
Director of Organizational Excellence / Special Projects at the UConn Health Center. Sandra recently attained Fellowship designation with the American College of Healthcare Executives.

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measures currently not NQF-endorsed be submitted for endorsement. MAP also suggests that HHS establish a process in Meaningful Use that will allow clinicians to receive credit for electronically reporting measures through PQRS, provided the measures are in the Meaningful Use program. The panel's recommendations are not binding on CMS, but they are likely to be influential. This is the first time the government has asked an outside group to make recommendations on quality measures it is considering, before the government formally proposes them. After the panel reviews public comments, it will submit a final report to CMS on February 1.

Connecticut Association for Healthcare Quality 2010-2011 Board of Directors/Team Leaders

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CTAHQ News

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Connecticut Association for Healthcare Quality
Membership Renewal Application
2011-2012

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INCLUDE AN E-MAIL ADDRESS**

Please complete all applicable areas:

New Member **Renewal**

Name: _____ Title: _____

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NAHQ Member **Yes** **No**

CPHQ **Yes** **No**

Primary Area of Responsibility (check all that apply)

Type of Organization

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> UM/Case Management | <input type="checkbox"/> Infection Control | <input type="checkbox"/> Acute care | <input type="checkbox"/> Home Care |
| <input type="checkbox"/> Risk Management | <input type="checkbox"/> Home Services | <input type="checkbox"/> Subacute | <input type="checkbox"/> Consulting |
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| <input type="checkbox"/> Corporate Compliance | | <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Other _____ |

Individual Membership \$55.00

Organizational Membership \$110.00 – 3 applications from the same institution

**In addition to my membership fee, I would like to donate \$5.00 towards the CTAHQ Kathy
Adamo Scholarship Fund
(Please submit together)**

Check Amount: _____ Payment Check Number: _____

Who is funding your membership? **Employer** **Self**

Please make check payable to CTAHQ and mail to:

Natalie Vinhais
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Trumbull, CT 06611

January	February	March	April	May
Newsletter		7 Educational Program	Newsletter	
June	July	August	September	October
Annual Business Meeting	Newsletter		20-23 NAHQ 37th Annual Educational Conference Tampa, FL	

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