



Maryland Association for Healthcare Quality

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PRESIDENT'S MESSAGE

Dear MAHQ Members,

I wish to extend Greetings and Happy Spring to members of the Maryland Association of Healthcare Quality. A great big thank you also goes to our Past President, Robin Craycraft. Robin worked with Board members and our new President Elect, Gayle Hurt, to significantly expand educational opportunities for MAHQ members, including a new Webinar series in 2011. I also wish to personally thank Robin for her ongoing mentorship. Also, a warm welcome goes to new Board members: Cathy Gallo, Elaine Frazier, and Judy Slevin!



Already in 2011, MAHQ has initiated a webinar series on quality improvement, held a Healthcare Quality Management Review and Study Session for certification as a professional in healthcare quality (CPHQ), and has scheduled our Spring educational conference on May 24, 2011 (Hold the Date!). We thank our Educational Committee Chair, Peter Libby, for his endless commitment to those efforts!

Why are these important BENEFITS as a member of MAHQ? Anyone who works in healthcare knows that amazing change is underway - in policy, in technology, in clinical care advancements, in patient safety, and in health information systems and electronic health records. It has never been more important to stay informed and be knowledgeable about transitions into new care policy and technology in order to be effective in your job and advance your career. Certification as a healthcare professional and the supporting continuing education have had a significant and direct impact on my own career over time. That is the Mission of MAHQ, to support the development of healthcare quality professionals through education and communication among our membership. Another thank you to our Membership Committee Sally Morris!

As part of strategic planning in 2011, we will look for opportunities to enhance networking amongst our membership and between local and regional stakeholders in quality. We will also be working with our webmaster and Past President, Cheri Wilson, to enhance our website. We strongly encourage members to participate in scheduled MAHQ activities, contribute to our published newsletters, make suggestions for new activities or events, and attend our Board meetings - held the fourth Thursday of each month at Rams Head Tavern in Savage, Maryland.

As a healthcare professional who has recently also been a patient, I can attest we still have a lot of work ahead to improve our health care system. But there are innovative and evidenced-based approaches underway to improve the quality of care for all US citizens. I look forward to working with you within MAHQ, our communities, and on a national level to make a difference in health outcomes. Wishing you a productive, successful, safe and happy year with MAHQ.

Barbara A. Dailey, RN,BSN, MS, CPHQ

IN THE SPOTLIGHT: Barbara A. Dailey, RN, BSN, MS, CPHQ

Barbara Dailey is the Deputy Director for the Division of Quality, Evaluation, & Health Outcomes at the Center for Medicare & Medicaid Services (CMS), and is a certified professional in health care quality (CPHQ). Barbara is responsible for supporting the Director/Chief Quality Officer in quality improvement efforts for Medicaid and the Children’s Health Insurance Programs (CHIP). This includes several innovative Medicaid grant programs, improving neonatal health outcomes, and providing technical assistance to States on managed care quality reporting, State Medicaid and CHIP quality improvement strategies, EPSDT services, vaccination programs, and emerging issues in health care reform – including performance measurement and health information systems and exchange. Barbara serves on multiple national advisory committees for Federal and National stakeholder health care quality improvement initiatives.

Barbara’s clinical experience includes pediatric oncology and neonatal intensive care. Prior to joining CMS, Barbara served as Quality Manager for a national Medicaid health care consulting firm, and was Senior Regional Quality Advisor for CIGNA HealthCare. She has coordinated Strategic Planning for the Johns Hopkins School of Public Health, and was the research project coordinator for the nation’s first childhood cancer screening project for the Johns Hopkins School of Medicine.

Barbara has been a certified professional in health care quality since 2003, and joined MAHQ in 2008. She was elected to the MAHQ Board of Directors as a Member-At-Large in 2009, President-Elect in 2010 and President for 2011.

Evolving National Policies on Non-payment for Provider-Preventable Conditions, including Health Care Acquired Conditions - Can They Improve Care?

Submitted by Barbara Dailey, RN, BSN, MS, CPHQ

In 2002, the National Quality Forum released the “Serious Reportable Events in Healthcare: A Consensus Report”, which listed 27 adverse events that were designated as “serious, largely preventable and of concern to both the public and health care providers”. The events listed in that report became recognized as “never events”. The report was updated in 2006, and has just completed another national panel review to update the report in 2011.¹ This work had significant implications for public policy as the Medicare program began addressing “never events” through national coverage determinations on what payments would be allowed for Medicare services to beneficiaries.

A significant policy change in 2005 under Section 5001 of the Deficit Reduction Act

(DRA) provided new authority for the Secretary of Health to develop, implement, and monitor quality measures and other actions to ensure the quality of hospital care under Medicare.ⁱⁱ This included requirements for the Secretary to select, in consultation with the Centers for Disease Control (CDC), diagnosis codes that met certain criteria to be considered health care acquired conditions (HACs), including some infections. The DRA amended the Social Security Act to prohibit payment to hospitals for certain HACs and also required the Secretary of Health to develop a plan for Medicare hospital value-based purchasing commencing fiscal year 2009.

The Centers for Medicare & Medicaid Services (CMS) provides the largest health care coverage in the United States through the Medicare and Medicaid programs. Medicare is fully administered by the Federal government as a national program. Medicaid, however, is a program with Federal grants to States to provide medical assistance to persons with limited income and resources. Medicaid provides health benefits for our most vulnerable population, and many of those individuals have multiple, complex health conditions. Medicaid is administered by individual States, and eligibility and benefits can vary in each State. There were no provisions in the DRA to address health care acquired conditions for Medicaid. CMS did, however, encourage States to adopt their own payment prohibitions on Medicaid provider claims for HACs to coordinate with Medicare non-payment through a general guidance letter to State Medicaid Directors.ⁱⁱⁱ

So Congress integrated payment approaches with quality of care for Medicare hospital services through the DRA. Over the past two years, however, there have been significant policy changes on broader quality issues - with increased attention on data collection and reporting on quality of care in general for the Medicare and Medicaid programs.

A new Medicaid pediatric quality measures program is being implemented by CMS in collaboration with the Agency for Healthcare Research and Quality as a result of the Children's Health Insurance Program Reauthorization Act of 2009.^{iv} This program will develop measures for States to voluntarily assess quality of care and health outcomes for services to children and adolescents received under Medicaid or the Children's Health Insurance Program, but the measures will apply for any health care delivery system or coverage entity.

The Health Information Technology for Economic and Clinical Health (HITECH) provision under the 2009 American Recovery and Reinvestment Act provides unprecedented authority and funding for eligible Medicare and Medicaid providers to collect information on quality of care through meaningful use of electronic health records.^v

Most recently, the Patient Protection and Affordable Care Act (Affordable Care Act) included multiple provisions to address quality of care for both Medicare and Medicaid, including: implementation of a Medicaid adult quality measures program, development of a national quality strategy for health care, and addressing health care acquired conditions in Medicaid - including a potential focus on outpatient care delivery.

On February 17, 2011, CMS released a Federal Register Notice Proposed Rule for public comment regarding the Medicaid Program for "Payment Adjustment for Provider-Preventable Conditions Including Healthcare Acquired Conditions".^{vi} This proposed rule provides background on the Medicare Program quality improvements and current listing

of Medicare HACs which includes conditions such as: catheter associated urinary tract infection, foreign object retained after surgery, stage III and IV pressure ulcers, falls and trauma, to name just a few. This proposed rule specifically addresses Section 2702 of the Affordable Care Act to implement Medicaid payment adjustments for HACs. This includes the requirement to review State practices that prohibit payment and where appropriate, incorporate those practices into Medicaid regulation. That review found that 29 States did not have existing non-payment policies at the time of the review.

The statute also requires that Medicaid, at a minimum, recognize Medicare's list of HACs. More importantly and for the first time, *the Medicaid program will consider evidenced-based policy in reviewing health care acquired conditions that include provider-preventable conditions outside of the inpatient setting.* Medicare has a longer history in developing a quality improvement approach to health care using quality measurement and assessment of health care acquired conditions related to inpatient care and nursing facilities. Congress has now provided the authority for Medicaid to leverage that knowledge and program success to address the needs of our most vulnerable individuals - and to look beyond hospital services. CMS is required to release the final rule on this provision by July 2011.

The key now, to make a true difference in quality of care and health outcomes, is to integrate these multiple policy efforts on patient safety, quality measurement, quality improvement, and payment so that they align for minimal burden to States and providers, but use evidenced-based measurement that provides knowledge and information that is actionable for the right reasons. Add in meaningful use of electronic health records that will feed information to improve clinical decision-making - and we truly will be given the opportunity to function under a new health care system. *Member comments and reaction to this article are encouraged!*

From NAHQ E-News



Deaths from HAIs Reduced, Ventilator-Associated Pneumonia Rates Drop in Michigan ICUs

Two just-released studies demonstrate a significant reduction in death rates from healthcare-associated infections (HAIs) and a drop in the incidence of ventilator-associated pneumonia in Michigan hospital intensive care units (ICUs). The studies evaluated an innovative quality improvement initiative funded by the Agency for Healthcare Research and Quality (AHRQ).

The initiative, known as the Keystone Project, targeted ways to improve patient safety in ICUs. The quality improvement initiative is called the Comprehensive Unit-Based Safety Program (CUSP). It includes tools to improve communication and teamwork among ICU staff teams and to implement practices based on CDC guidelines, such as checklists and hand washing, to reduce rates of catheter-related bloodstream infections and ventilator-associated pneumonia. The program also measures whether ICUs reduce HAIs and reports

these results to help improve patient care.

"Impact of a Statewide Intensive Care Unit Quality Improvement Initiative on Hospital Mortality and Length of Stay: Retrospective Comparative Analysis," published in the February 1, 2011, issue of the *British Medical Journal*, is the first study to link CUSP programs to lower death rates. The study details reductions of death rates in Michigan ICUs associated with the application of CUSP in the Keystone Project. Researchers found that a person's chance of dying decreased by about 24% in Michigan after the program was implemented, compared to hospitals in surrounding Midwestern states where the program had not been implemented.

The second study, published February 17, 2011, in *Infection Control and Hospital Epidemiology*, includes data from 112 ICUs in Michigan. Hospital staff in those ICUs reduced the rate of pneumonia in patients on ventilators by more than 70% by using a targeted quality improvement initiative funded by AHRQ. This reduction in the rate of ventilator-associated pneumonia was sustained for the duration of the study's follow-up, a period of up to 2.5 years.

HAIs are the most common complication of hospital care and one of the top 10 leading causes of death in the United States. The financial burden attributable to these infections is estimated to be between \$28 and \$33 billion in excess healthcare costs each year.

In recent years, the Department of Health and Human Services (HHS) has ramped up its efforts to fight HAIs. The AHRQ-funded Keystone Project, which has now been expanded nationwide, is part of this HHS-wide effort to address HAIs. For more details on these efforts, see the HHS Action Plan to Prevent Healthcare-Associated Infections, available at www.hhs.gov/ash/initiatives/hai/index.html.

Joint Commission Q&A

Question: Has The Joint Commission made changes to the medication reconciliation National Patient Safety Goal (NPSG)? If so, when are they effective?

Answer: Yes. The Joint Commission Board of Commissioners approved revisions to the NSPG on medication reconciliation for all accreditation programs (except laboratories), effective July 1, 2011. See the revised NPSG on the Joint Commission [website](#). This new and substantially streamlined version of the goal spotlights critical risk points in the process. In addition, the goal was moved from NPSG 8 to NPSG 3, which addresses other issues of medication safety. Please 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.

Before making modifications to the goal, the Joint Commission gathered feedback from a wide variety of customers and stakeholders, including a baseline survey to obtain the field's perception of problems with the NPSG

- focus groups with accredited customers across accreditation programs
- a task force on medication reconciliation funded by the Agency for Healthcare Research and Quality and sponsored by the Society of Hospital Medicine
- relevant Joint Commission advisory committees

- a follow-up field review that had 1,780 responses from individuals and organizations.

The Joint Commission recognizes that there are several problems inherent to medication reconciliation that cannot be easily resolved within the current infrastructure of healthcare. Of particular concern is that organizations cannot be confident that the medication information provided by the patient is complete and accurate. Another issue is that some physicians are reluctant to be responsible for medications prescribed by other prescribers. Nevertheless, because of patient safety concerns, the Joint Commission believes that it is important for organizations to attempt to achieve the basic expectations of the revised goal. It is anticipated that specific requirements in the medication reconciliation goal will evolve over time with advances in healthcare information systems.



How would several hundred dollars help advance your professional development? The Healthcare Quality Foundation (HQF) is accepting applications for individual grants through **Friday, April 29**. The team is looking to award grant funds to up to 14 candidates this spring. Applications are available for the Leadership Development Grant, the new Quality Professional Grant, the Career Development Grant, and Certification Grants, 10 of which will be awarded. Learn more about the [HQF grants and submit your application](#) today.

MAHQ Collaborative Web Series with the Quality Indicator Project

The Maryland Association of Healthcare Quality launched the first in four part collaborative web series with the Quality Indicator Project, “Quality Basics”. The session featured a high level overview of healthcare quality foundations and followed by featured speakers from Maryland hospitals. As the first venture into web based education, we have worked through the technical challenges and are looking forward to the next session in the series on Value Based Purchasing. Mark your calendars for May 12 from 2 p.m. – 3 p.m.!

WELCOME TO NEW MEMBERS

The MAHQ President Barbara Daily and your Board of Directors extend a hearty welcome to the following new members:

Sandra Adams, Cynthia Burton, Tony Calabria, Kay Conley, Veronica Falcone, Wendy Gary, Ella Giles, Janet Hampson, Patti Klingel, Victoria Meyer, Vickey Richardson, Linda Smith, Valerie Sommer, Sharon Stewart, Ellen Weston, Carmen Winston, Robert Yocubik and Donna Zoldi.

DID YOU KNOW.....

.....We encourage you to submit an article, which may be about an interesting session or seminar that you have attended, your recent experience with JCAHO, project results, study or research results, or anything that would be of interest to quality professionals. If you submit an article that is published in the newsletter, you will receive a complimentary conference registration to be used during the upcoming year (excluding the CPHQ review course). Please email your submission to the Newsletter Committee

Chair Laura Schwartze at laura.schwartze@hughes.net

BOARD MEETINGS OPEN TO MEMBERS

Board of Director's meetings is held monthly, ten months of the year. Meetings are usually held on the fourth Thursday evening of the month in rotating locations, for the convenience of the Board members. Some meetings are now conducted via teleconference. We welcome the attendance and input of the general membership, at all meetings. Contact any Board Member by email for information and directions. Verify the location and time on the morning of the meeting.

**MARYLAND ASSOCIATION FOR HEALTHCARE QUALITY
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ⁱ http://www.qualityforum.org/projects/hacs_and_sres.aspx, accessed 3/20/11

ⁱⁱ <https://www.cms.gov/HospitalAcqCond/Downloads/DeficitReductionAct2005.pdf>, accessed 3/20/11

ⁱⁱⁱ <http://www.cms.gov/SMDL/downloads/SMD073108.pdf>, accessed 3/20/11

^{iv} <http://www.ahrq.gov/chipra/>, accessed 3/20/11

^v <https://www.cms.gov/ehrincentiveprograms/>, accessed 3/20/11

^{vi} <http://edocket.access.gpo.gov/2011/pdf/2011-3548.pdf>, accessed 3/20/11