

SPAHQ *fall 2002* update

NEWSLETTER OF THE SOUTHEASTERN PENNSYLVANIA ASSOCIATION OF HEALTHCARE QUALITY

VOL. 1 ISSUE 2

OUR MISSION

The Southeastern Pennsylvania Association for Healthcare Quality is dedicated to improving the quality of healthcare and promoting the professional growth and development of healthcare professionals by advancing the practice of quality management in healthcare organizations.

OUR VISION

The Southeastern Pennsylvania Association for Healthcare Quality is committed to being a leader and source of expertise in healthcare quality in the Southeastern Pennsylvania region.

membership update

SPAHQ's current 2002 membership totals 92; 85 individual members and 7 corporate members. The 2002 Membership Directory was distributed to all members in June. The directory was sent via email for members with email addresses, and regular mail for those who do not have email. If you have not received a new listing please let us know. Has your address, email, or other contact information changed? If so, contact

Sue Detwiler,
SPAHQ Membership Chair at
sdetwile@uphs.upenn.edu, or
610-983-1236, so we can update
our records.

president's message

Mary Ellen Reilly, MS, MT

As we approach the beautiful season of Fall this year, we can't help but be saddened as we reflect on the events of this time last year. Reflecting on such a senseless tragedy can be confusing and even paralyzing. Just a small suggestion that was passed on to me recently that might help. In times like these, we seem to fare better as people if we take a step out of ourselves toward others, rather than to reflect inward. Each time you feel saddened or overwhelmed by the senselessness of it all...say a prayer for those who were lost, or...perform a small act of kindness to someone of a different backgroundor more long term, identify a group who is working toward peace and justice and see if you can become involved in some way. Eventually, these little actions will spread to others and there will be hope for us "as a people."

Onto SPAHQ..... we have several exciting events coming up which are outlined later in this newsletter. I hope you will find them valuable. First, the next QI and UM subgroup meetings have been scheduled detailed later in this newsletter). Thank you to Connie

Connell and Nancy McMann for organizing the subgroup meetings. I attended the first UM group and we shared lots of helpful ideas. I understand that the Quality group reviewed JCAHO survey expectations and that group is anxious to meet again.

The other excitement is the annual SPAHQ Fall conference coming up on November 12 (more later on in the newsletter). This is an all day event so mark your calendars!! By the time you leave the Fall conference you will understand the expectations around ACT 13. You will have met the team from our new Peer Review Organization—Quality Insights of Pennsylvania—and last, but not least, you will have all the tools you need to implement an HIPAA Privacy Program. Our goal in planning this conference was to identify topics that were relevant to our membership's areas of responsibility and to provide the members with concrete tools and action plans to make their jobs a little bit easier. Come network and meet other professionals who struggle with the same issues that you do. Look for announcements about registration for the Fall conference shortly.

email group

We have established an email group for our organization called The SPAHQ Group as a method of communicating and networking. It is an excellent method for posting job-related questions, sharing information, and keeping abreast of current issues within our industry.

If we have your current email address, you should have received an invitation to join the group. Please be aware, to join, you needed to hit the "REPLY" button. You will not be added to the list unless you reply that you would like to join. If we do not have your email address and you would like to join, please email sdetwile@uphs.upenn.edu

Important addresses:

To post a message to the group:

SPAHQgroup@yahoogroups.com

To subscribe:

SPAHQgroupsubscribe@yahoogroups.com

contributions

If you would like to contribute an article to the newsletter, please contact

Steven R. Carson (215) 707-2771 or
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Joint Commission 2003 National Patient Safety Goals

The Joint Commission will be implementing their set of National Safety Goals effective January 2003. The new standards represent recommendations from the Sentinel Event Advisory Group for improving patient safety in health care organizations. The goals and associated recommendations target a broad spectrum of patient safety issues, which have been notable over the past years in the general media. The issues will have an impact on each health care organization and those disciplines, which provide patient, care. The Joint Commission 2003 National Patient Safety Goals and associated recommendations are:

1. Improve the accuracy of patient identification.

- a. Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.
- b. Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active—not passive—communication techniques.

2. Improve the effectiveness of communication among caregivers.

- a. Implement a process for taking verbal or telephone orders that requires a verification "read-back" of the complete order by the person receiving the order.
- b. Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

3. Improve the safety of using high-alert medications.

- a. Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium

chloride >0.9%) from patient care units.

- b. Standardize and limit the number of drug concentrations available in the organization.

4. Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

- a. Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
- b. Implement a process to mark the surgical site and involve the patient in the marking process.

5. Improve the safety of using infusion pumps.

- a. Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

6. Improve the effectiveness of clinical alarm systems.

- a. Implement regular preventive maintenance and testing of alarm systems.
- b. Assure that alarms are activated with appropriate settings and

are sufficiently audible with respect to distances and competing noise within the unit.

Commencing with 2003, organizations which do not implement the recommendations or an acceptable alternative will be subject to Type I recommendations. Alternatives can be implemented provided that they are approved by the Sentinel Event Advisory Group and will be communicated through the JCAHO Perspectives publication. It is anticipated that each year new goals will be established for future years; however, the number of goals and recommendations will be limited to six (6) and will not exceed 12 recommendations. For more information the JCAHO web site is an excellent resource of what is new at the JCAHO. (www.jcaho.org/news+room/index.htm)

Reference

Joint Commission on Accreditation of HealthCare Organizations, 2003 National Patient Safety Goals, World Wide Web, August 25, 2002, jcaho.org.

Meeting Announcements

Quality Subgroup: The first meeting of the Quality improvement subgroup was held on July 10, 2002 at Elkins Park Hospital. Nancy McMann from Warminster Hospital gave a presentation on the recent JCAHO survey at her facility. The presentation included highlights of new standards in each CMAH chapters, and how the surveyors evaluated evidence of compliance with each. There was a good discussion about the various topics, with several of those in attendance preparing for survey in the next 12 to 18 months.

The group agreed that they would like to continue networking and explore other topics; sharing responsibility for presentations. The next meeting will be held at Einstein Medical Center, October 22, 2002, 3 – 5 p.m. Location will be emailed to subgroup members. Topics for discussion may include Patient Safety, JCAHO Staffing Effectiveness or other timely topics. Nancy is working on a survey to distribute to subgroup members to identify desirable topics and interested presenters. You can forward any suggestions to nancy.mcmann@tenethealth.com. New members are always welcome.

Tiered Health Plans and the New Consumerism

by Eileen Young

Are consumers unknowingly driving the newest type of health plan to hit the market or are tiered health plans going to force patients to be more thoughtful consumers of health care? Or could employers be driving both?

After nearly a decade of reduced growth in health care spending, we are experiencing the highest increases since the early '90s. Employers have seen an unprecedented rise in the percent of their total operating budget that is spent on health care. Employers have already passed costs on to their employees in the way of co-pays and deductibles but it hasn't changed employee behaviors regarding health care consumption. This cost shifting of health care expense to the employee is presently the biggest issue in collective bargaining.

A new option that insurers and consultants are bringing to the employer is the tiered health plan. In a tiered plan, the employee's co-pay and deductible is graduated based on the cost (published charges) of the facility they choose to utilize for their health care. Typically, facilities are placed in quartiles or tiers with names such as 'affiliate' or 'choice' according to their charge for services. This tiering can be done based on unit cost, case mix adjusted unit cost or episodic treatment, such as the cost of a CABG or TJR. Employees could be responsible for zero to several hundred dollars for an episode of care depending on the facility they choose. While physicians have yet to be ranked, consultants have gone into some market areas and rated their practice. If this type of plan is embraced be assured physicians will be placed into tiers as well.

Managed Care Plans that have ventured into this model are struggling with how to balance quality and cost. So far, cost has been the primary driver. Providing a meaningful measure of qual-

ity the consumer can understand has always been a challenge for plans, providers, employers and the government alike. Quality measures being considered to rank facilities are: clinical quality measures (such as in Evidence Based Medicine programs), scope of services, access to care and customer satisfaction.

Some of the insurers currently offering tiered plans are PacifiCare, HealthNet, Cigna, United Health Group and Humana. Locally, Aetna offers a tiered product called HealthFund. There are many virtues to such a plan design but unless the plans can respond to some of the challenges there will be repercussions. Blue Cross of California was forced to shelve its plan after several facilities in a market area dropped their contracts when BC could not address the issue of quality.

This 'consumerism' approach empowers the employee to direct how they spend their health care dollars. It puts the power of decision-making back into the hands of the patient and provider. It forces the provider to be responsive and responsible to the patient and, hopefully, focuses the provider on quality such as we see with Evidence Based Medicine and the LeapFrog Group initiatives.

There are other concerns in addition to the lack of good information on quality and cost of health care when considering a tiered health plan. Consumers at the lower end of the salary scale may be excluded from the highest priced, most technologically advanced care. Health status varies greatly amongst the population with six percent of users accounting for sixty-two percent of the claims. A safety net for catastrophic cases must be in place. Lastly, even if we can come up with a fair and accurate measure of quality, how do we educate consumers in this

country in the face of issues like access to information and health literacy?

Let us not forget the virtues of such plans. The people of this great nation have strong feelings about their health care; they want the best and they want choice. No one size fits all. It is no surprise that we are all more careful when spending our own money. Consultants predict a ten to fifteen percent reduction in utilization when consumers share thirty percent of the cost.

While HMO enrollment has slowed or even decreased, PPO enrollment has continued to rise. Many employer self insured plans are 'PPO-like' and the concept of tiered plans fits nicely with the PPO percent of charge contract structure. Markets such as ours that are heavily dominated by two large insurers and per diem contracts make it very challenging for an employer to utilize a tiered plan and actually realize savings. Even if an employee chooses a 'lower charge' provider, if the plan still pays per diems there is no real cost savings to the employer.

Lastly, if tiered plans do flourish in this region, providers will need to collectively normalize the wildly different charge structures in place across our institutions.

In the end, whether the employer or the employee is driving the advent of tiered plans, all of us, managed care plans, providers and employers need to be focused on the needs of the consumer, providing them with quality care for the best cost and protecting the right of all consumers to have access to that quality care. As quality professionals, case managers and utilization review coordinators, that is already part of our mission but a tiered system would really bring it into sharp focus day by day, patient by patient.

HIPAA – What is it, how does it affect us?

There is no doubt over the last years, that the gray cloud of HIPAA has been discussed in our organizations. Whether it is in relation to educating ourselves, ignoring it, believing that it will go away or in some organizations extraordinary plans for software and policies to establish an infrastructure for what was believed to be the final rule, HIPAA is a part of our lives. On August 14, 2002, the Federal Government published in the Federal Register the final version of the privacy regulations. Incorporated into the final rule:

- Patients must give specific authorization before entities covered by this regulation could use or disclose protected information in most non-routine circumstances, such as releasing information to an employer or for use in marketing activities. Doctors, health plans and other covered entities would be required to follow the rule's standards for the use and disclosure of personal health information.
- Covered entities generally will need to provide patients with written notice of their privacy practices and patients' privacy rights. The notice will contain information that could be useful to patients choosing a health plan, doctor or other provider. Patients would generally be asked to sign or otherwise acknowledge receipt of the privacy notice from direct treatment providers.
- Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before sending them marketing materials. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- Specifically, improvements to the final rule strengthen the marketing language to make clear that covered entities cannot use business associate

agreements to circumvent the rule's marketing prohibition. The improvement explicitly prohibits pharmacies or other covered entities from selling personal medical information to a business that wants to market its products or services under a business associate agreement.

- Patients generally will be able to access their personal medical records and request changes to correct any errors. In addition, patients can request an accounting of non-routine uses and disclosures of their health information.

HHS's privacy regulation is designed to enhance the protections afforded by many existing state laws. Stronger state laws and other federal laws continue to apply, so the federal regulation provides a national base of privacy protections. The standards for covered entities apply whether its patients are privately insured, uninsured or covered under public programs such as Medicare or Medicaid.

Most covered entities have until April 14, 2003, to comply with the patient privacy rule; under the law, certain small health plans have until April 14, 2004, to comply. To help people prepare for and meet the rule's requirements, HHS's Office for Civil Rights (OCR) will continue to conduct outreach and education targeted to health plans, health care providers, consumers and others affected by the privacy regulation.

These efforts include developing appropriate technical assistance materials, which may include fact sheets, handbooks and other materials, as well as responding to frequently asked questions. HHS also will hold national educational conferences in the fall to address issues related to key parts of the privacy regulation. Technical assistance materials will be posted on OCR's privacy rule website at www.hhs.gov/ocr/hipaa/.

Case Management Impact:

Organizations have begun to address the patient education and consent issues

related to the communication of health information. This may be accomplished either at the time of admission or at some time during the patient's stay. The impact on the case manager from a day to day perspective will be significant. Often our staffs are in the position of communicating patient information to external vendors for discharge planning purposes. This process alone without consent will be a violation of the HIPAA. Areas that we need to target include the transmission of patient health care information for nursing home, skilled nursing, home care placements and the like.

The Rule requires covered entities to provide patients with notice of the patient's privacy rights and the privacy practices of the covered entity. The notice requires direct treatment providers to make a good faith effort to obtain a patient's written acknowledgment of the notice of privacy rights and practices. The final Rule promotes access to care by removing mandatory consent requirements that would inhibit patient access to health care while providing covered entities with the option of developing a consent process that works for that entity.

What To Do:

Educate yourself, your department, your organization if necessary. Find out what plans your organization is making to be compliant under these new regulations. If you are not part of a HIPAA task force in your organization, you need to be on it or be an active contributor to the committee, making sure they understand the extent that your department routinely communicates patient information, as well as by what methods. While April seems far away...it's NOT. There is a tremendous amount of material on the Department of Health and Human Services web site. The site can be accessed at www.hhs.gov/news/press/2002pres/hipaa.

Reference:

U.S. Department of Health and Human Services, HSS Fact Sheet, August 9, 2002.

SPAHQ officers for 2002

SPAHQ officers are here to serve the membership. Feel free to reach out to become an active member of our organization.

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Meeting Announcements

Case / Utilization Management Subgroup: The first meeting of the Case /Utilization management subgroup met on June 6, 2002, at Temple University Hospital. The session was primarily an introductory session discussing our potential impact and the benefit of meeting on a routine basis. There were several new members from Friends Hospital, Temple Continuing Care Center and Hahnemann Hospital. The next meeting will be held on Thursday, October 17, 2002, at 2:00 p.m. Location will be communicated to members. Please forward any suggestions for agenda items to Connie Connell at connelc@temple.edu

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Fall Conference

The annual Fall SPAHQ Conference will be held November 12, 2002, at Crozer Hospital. The day will include a series of presentations and panel discussions by distinguished colleagues from around the city. The topics for the morning will include a review of Act 13- the Patient Safety Act and the implications/expectations for hospitals. The second presentation will be given by a representative of the new peer review organization—Quality Insights of Pennsylvania—including a review of their plans and expectations of the QIO for the coming year. Afternoon session includes a presentation on the application of the HIPAA standards followed by a panel discussion of individuals responsible for the implementation of the HIPAA standards at their respective facilities. The goal is to share the tools and processes that each has utilized at their respective institutions to develop their programs. A brochure will be e-mailed to each of our members shortly. Feel free to invite non-members at your facility who may be interested in any of the conference topics.