

SPAHQ winter 2003 update

NEWSLETTER OF THE SOUTHEASTERN PENNSYLVANIA ASSOCIATION OF HEALTHCARE QUALITY

VOL. 2 ISSUE 1

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.

SPAHQ housekeeping

Please be aware that returned checks for insufficient funds are expensive to both you and us. Please be aware that the treasurer will notify you when this occurs. Unfortunately our bank charge associated with this will be charged back to the SPAHQ member.

president's message

Mary Ellen Reilly, MS, MT

Happy Holidays to all!!! It's hard to believe that we are closing the doors on 2002 already!! We had a very busy year in the Delaware Valley with our SPAHQ group – We presented two conferences – one in the Spring which covered Quality Improvement and Clinical Effectiveness, as well as, and Guidelines on Improving Customer Satisfaction. In addition the networking groups for UM/Case Management and Quality improvement each met several times for informal networking sessions. These events were well attended and the feedback is that the events were value added for our membership. As we have stated on numerous occasions, that is the reason for the existence of SPAHQ- to provide educational and networking opportunities to share the wealth of knowledge that we have among our membership.

We are currently planning our SPAHQ annual business meeting which will be held on January 22, 2003 at the Health

Partners facility in Center City. At this time we would like to solicit input from our membership as to what topics they would like us to include in next year's conferences – so let your creative juices flow and see what you can come up with. Our theme for the annual business meeting will be around team building. We will have a professional facilitator provide us with a few "easy to replicate" exercises that our membership can bring back to the workplace to utilize in their every day operations. To make the meeting a little more fun, we have chosen a SuperBowl party theme. We will actually be providing each participant in the meeting with a chance to win some very nice prizes related to the outcome of the big game. Look for a flyer to come out shortly. Mark the date – January 22nd in the morning . In the meantime, try to snag a few moments over the Holidays to relax and recoup, then onto 2003 with all of its challenges. Happy Holidays to All from your SPAHQ Board.

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 Carsonsr@tuhs.temple.edu

SPAHQ Fall Conference Summary: “Rules of the Road...Regulatory Requirements and Expectations”

QIP, MCARE, HIPAA – What are the regulations? What do we need to do to become compliant? When are the deadlines? What’s everyone else doing?

Many of these questions were answered during the SPAHQ Fall Conference on November 12, 2002. Chester-Crozer Medical Center graciously hosted the event. About 50 attendees were provided with the information and tools needed to help us implement these challenging regulations. This program was an antidote for the stress that always accompanies new regulations!

Building Your Relationship with the New QIO—QIP’s Collaborative Model of QI

A team of representatives from Pennsylvania’s new Quality Improvement Organization, Quality Insights of Pennsylvania (QIP) provided an overview of their organization and the CMS 7th Scope of Work. QIP is a subsidiary of the West Virginia Medical Institute and serves as the QIO for Pennsylvania, Delaware and West Virginia. QIP is responsible for collaboratively improving care provided to Medicare beneficiaries as outlined in the CMS 7th Scope of work. The 7th Scope of work focuses on three tasks: clinical quality improvement, public reporting of data, and case review activities. Clinical Quality improvement activities have been defined for hospitals, home health agencies, long term care, physician offices, and Medicare + Choice organizations. Public reporting on quality of care is planned starting with long-term care in November 2002 and home health agencies in February 2003.

For hospitals, QIP will implement QI projects for CHF, Acute MI, pneumonia, and surgical site prevention. Many of the project measures mirror the JCAHO Core measures. Baseline data will be collected by QIP abstracting staff, with

the goal of hospital self-generated data by the end of the 7th scope of work.

The Beneficiary Complaint Response program utilizes a case management approach to provide consistency of review and improved beneficiary satisfaction. A mediation process is being developed to allow for all parties to present views with an attempt to agree on a resolution. This voluntary process is proposed for spring of 2003.

The Hospital Payment Monitoring Program (HPMP) mirrors KEPRO’s PEPP program. QIP staff will perform medical necessity, DRG validation, and quality of care reviews on cases received from CDAC’s. InterQual criteria will be used. Technical denials will be issued if the requested medical record is not received in 31 days. Other beneficiary protection activities will continue, including, HINN/NODMAR review, EMTALA review, Higher Weighted DRG review, and annual monitoring of physician acknowledgment statements.

For more information about Quality Insights of Pennsylvania, call 1-877-346-6180 or access their website at www.qipa.org.

Act 13 – Patient Safety: Where are we now that it’s November?

Robert S. Muscalus, DO, the Pennsylvania Physician General, and Lori McLaughlin, JD, MSW, Chief Counsel for the Department of Health, provided a status report of the patient safety activities related to Act 13 of 2002. The Medical Care Availability and Reduction of Error Act, was signed on March 20, 2002 and applies to ambulatory surgery centers, birth centers, and hospitals. The act requires the reporting of serious events, incidents, and infrastructure failures, and establishes an unprecedented state Patient Safety Authority. Close to 100% of required

entities have submitted their Patient Safety plans as required. The 11 member Patient Safety Authority has assembled and has drafted their bylaws. The Patient Safety Authority will contract with a for-profit or registered non-profit entity to collect, analyze and evaluate the event and incident data that is reported. They will receive and evaluate contractor recommendations regarding changes, trends, and improvements in health care practices. In turn, they will issue recommendations to medical facilities. The Authority will also notify medical facilities if a health care worker has filed an anonymous complaint. They report annually to the General Assembly and the Department of Health.

Essential Elements of a HIPAA Implementation Plan

Beth Morris, CPC, the Regulatory Project Manager for Crozer-Keystone Health System, summarized the HIPAA “rules of the road.” Simply stated, HIPAA requires the protection of patient information via standardized transaction code sets and identifiers, the adherence to patient privacy rights, and implementation of safeguards to protect patient information. All patient information is protected – oral communications, paper information and electronic information. Reasonable safeguards must be in place to protect the privacy of patient information. The Office of Civil Rights will enforce the rule and non-compliance can result in fines and jail time. CKHS has formed a Privacy Committee, established privacy subgroups, conducted self-assessments to identify high-risk work practices. Employee and physician training are being conducted via newsletters, booklets, and other job-specific training. It is important for all managers to know the privacy rule and the standards that impact you most.

HIPAA Tools and Applications

Fall Conference participants had the benefit of leaving the conference with a valuable HIPAA “toolbox.” The toolbox was a compilation of examples compiled from many organizations, which were discussed during the final session of the program. A panel of HIPAA experts reviewed the information provided in the toolbox. Sample privacy policies, patient rights notices, algorithms to help interpret the rule, job descriptions, self-assessments, and self-learning modules were discussed during the panel discussion. This information-sharing session helped to clarify many of the issues that have left us scratching our heads for several months. While there is still so much to accomplish to achieve HIPAA compliance, this information-sharing session provided excellent advice and practical tools to aide in this monumental task. Here are a few helpful HIPAA resources:

CMS website:
www.cms.hhs.gov/hipaa
Free listserve:
<http://aspe.hhs.gov/admsimp/lnotify.htm>
CMS HIPAA Hotline:
1-866-282-0659
CMS E-Mail Box: askhipaa@cms.hhs.gov

Vendor Demonstrations:

Conference attendees were able to view displays and demos of several healthcare-related services during breaks and lunch. Thanks to the following vendor-sponsors:

*Canopy Systems/Extended Care
Care Science
Holland Glen
Home Solutions
Kindred Health Care
Medisys, Inc.
Neighbor Care*

Watch for the next SPAHQ educational program! We hope to see you there!

CMS — Publishes revised appeals process for comment.

November 15, 2002 Federal Register contained a proposed rule to standardize the appeals process for handling all Medicare Part A and Part B claims. The intended rule is designed to reduce decision making time frame at all levels of the Medicare administrative appeals system.

Under the rule, providers would be allowed to file for administrative appeal of Medicare initial determinations to the same extent as beneficiaries, but nonparticipating providers, physicians, and other suppliers would continue to follow current appeals policies. Historically, providers have had limited rights to appeal Medicare initial determinations. The rule also calls for the establishment

of “qualified independent contractors” (QIC), that would reconsider contractors’ initial determinations or re-determination of benefits.

In addition, the proposed rule would revise the time limits for filing appeals and give beneficiaries the right to request an expedited determination when they disagree with a provider’s decision to discharge them or terminate services. Currently, this right to expedited reviews only exists for hospital discharges.

Comments on the proposed rule are due January 14, 2003. To read the proposed rule, go to http://www.access.gpo.gov/su_docs/fedreg/a021115c.html

OIG tackling Observation Charges

In October 2002, the OIG published a report of an audit they had completed on the appropriateness of observation charges. While the report is focused on one specific health care organization the review focused on observation services that did not meet Medicare Criteria. Key findings included:

- No Physician’s Order on the medical record for observation.
- Inpatient Services Billed as outpatient.
- Need for observation Services not documented.
- Pre-op orders for convenience.

As a reminder observation services are allowable, only when provided by the order of a physician or another authorized individual by State licensure laws and hospital staff bylaws to admit patients or order outpatient tests. To see allowable services refer to section 230.6 A of the hospital manual and 3112.8 in the intermediary manual published by CMS. Prior to August 2000 observation

services were reimbursed on a cost basis, however with the start of outpatient prospective payment system, observation payments were included as part of the new payment system. CMS will only reimburse separately for observation services as they relate to chest pain, asthma and congestive heart failure.

For more information on the audit and background of the OIG audit refer to <http://oig.hhs.gov/oas/reports/region7/70102094.pdf>

HEDIS 2002: Lessons Learned

Barbara G. Rebold, RN, MS, CPHQ

HEDIS®, the Health Plan Employer Data and Information Set, is a tool developed by the National Committee for Quality Assurance (NCQA) to measure performance of managed care organizations (MCOs). NCQA is one of the accrediting bodies with an accreditation program for MCOs. More than half of all MCOs in the United States participate in NCQA's accreditation programs while over 90% of the plans measure their performance using HEDIS®.

Managed care plans have quality improvement programs that address the quality and safety of clinical care and service. HEDIS® provides a useful tool for defined measurements, which can be compared across plans and includes measures in effectiveness of care, access to care, use of services, satisfaction with care, cost of care and health plan stability.

Each year, MCOs begin the data collection process using three methods – administrative, hybrid and survey. Administrative data includes the MCO's claims databases as well as other administrative data sources such as laboratory, radiology and pharmacy claims. Hybrid includes use of medical record review to supplement selected measures administrative data. Hybrid is used for data that is incomplete for claims such as immunizations, management of hypertension, diabetes care and doctor visits. HEDIS measures often go back over several years when a member may not have been a part of your MCO causing a gap in your information. Also, since many managed care organizations use capitation for primary care services, the claims or encounter database may be incomplete. Survey is used for satisfaction measures, flu shots, and advice to smokers on smoking cessation.

The first lesson is to get an early start. The data collection process begins as early as possible to allow for the medical record reviews and audit where applicable and continues over a 6 to 9 month period. This year the HEDIS process at our MCO started with planning in November and data collection through May with final reporting of measures by

June. The earlier the administrative data is ready, the longer you have for medical record review.

Medical record review is not a straightforward process. As members move around and change physicians frequently, some data may require multiple visits to different offices or facilities. Depending on the measure it may be useful to go to the specialist rather than the primary care physician or it may be more useful to go to the hospital records rather than the specialist. In our HMO we found that going to the hospital first was the most useful for several measures. Since most hospitals now have laboratory, radiology, clinic and office visit notes and inpatient medical record notes available as electronic medical records, we were able to do a large majority of our review at a terminal in the hospital's medical records department.

Medicaid MCOs in Pennsylvania that participate in the HealthChoices mandatory managed care program and all Medicare MCOs are required to report their HEDIS results. The Medicaid results are reported to the Pennsylvania Department of Public Welfare. The Medicare results are reported to the Centers for Medicare and Medicaid Services (CMS). Since the reporting deadlines are in June, most MCOs are doing their medical record reviews at the same time, usually between February and May. Offices and facilities are receiving multiple requests for access to their offices and records and will naturally want to do this in an organized fashion so as to prevent interruption in patient care as well as assurance of confidentiality. If the MCO begins as early as possible, more flexibility will be available to meet the needs of the offices as well as the data collection needs of the MCO.

The second lesson is to identify a project owner and involve all of the appropriate departments in a steering committee from the very beginning. This project cannot be handled by one department. It involves Quality Management, Utilization Management, Provider Relations, Member Relations, Claims, Enrollment, Information Services, Communications and Government

Relations, and therefore requires project management. The department leader directly responsible for the results of the measures and for improvements should be the project owner. The project manager should report directly to the project owner. We formed a steering committee with a senior staff level representative from each of these departments. A project plan was developed for each of the major aspects of the project, administrative data pull, member satisfaction survey, medical record review and audit. Subcommittees for each major aspect handled the operational aspects. The steering committee had overall responsibility for project planning, scheduling, monitoring and interdepartmental coordination. We used project-planning software to monitor the project and found it helpful to show correct scheduling, project steps and critical tasks.

Finally, it is essential to stay in frequent communication with any vendors and governmental oversight staff. We used vendors for administrative data, medical record review, the satisfaction survey and the audit. We had weekly meetings with each vendor through May beginning in January. We found it necessary to have daily conference calls with our medical record vendor from April through May. Most importantly, we kept in contact with our auditors and we were very open with them about the barriers we were encountering along the way. We found that this set up a collaborative relationship rather than an adversarial one. They helped us through many of our issues and were able to offer solutions.

There were many more lessons learned but I wanted to touch on the top three. These three served us well throughout the project and were the foundation for a strong team and structure so that all problems were quickly solved and unable to derail the entire project.

Reference:

www.ncqa.org
HEDIS 2002 Technical Specifications, Volume 2, , NCQA, Washington, DC, 2001.