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Healthcare Quality Watch

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NEWS BRIEFS FOR MANAGERS AND OPINION LEADERS

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IPRO Authors Analyze Medication Reconciliation

A systems-based approach to medication reconciliation can support substantial reductions in hospital readmission rates, a reduced risk of adverse drug events and more cost-effective service delivery, according to a new journal article by authors at IPRO's Albany NY office, and at Seton Home Health Care and Seton Health/St. Mary's Hospital in Troy NY. Scheduled for publication in the November/December issue of *Home Healthcare Nurse,* the article describes collaboration among patients/families, admitting nurses and hospital pharmacists to compile an accurate list of medications patients were taking at home prior to hospital admission. These lists are reconciled with any findings available from the Regional Health Information Organization (RHIO) database, so that physicians writing hospital admitting orders have all relevant information available to them. At discharge, physicians compare lists of previously identified home medications to lists of medications administered during hospitalization. As an additional precaution, pharmacists review the same previously identified in-home medication lists against lists of in-hospital prescriptions. Pharmacists also provide in-person drug counseling to patients when required. In the outpatient setting, home care nurses making initial post-discharge home visits have access to hospital pharmacists, should they have questions or concerns about medications or medication interactions. Over the course of the project, medication discrepancies fell from 81% during a six month period at the beginning of the project, to 65% for a six month period toward the end of the project. And while findings don't demonstrate a direct correlation between interventions and readmissions, Seton Home Health Care has seen its acute care hospitalization rate drop from a recent 34% to 28% for the 10-month period ending in 2010. Findings are part of a three-year special Care Transitions project undertaken by IPRO and thirteen other QIOs that concluded last July. For electronic access to the full text of "A System-Based Medication Reconciliation Process" due in print format later this fall, visit www.homehealthcarenurseonline.com.

Online Publisher Assesses Hospital Quality

Nearly a quarter of a million U.S. lives could have been saved over a recent three-year period if all Medicare patients were treated in the highest-performing hospitals, according to a new report from HealthGrades, the online healthcare publisher. HealthGrades argues that 240,040 Medicare patient lives could have been saved from 2008 to 2010 had hospitalizations occurred at the nation's finest hospitals. HealthGrades awards five stars to facilities it believes are superior; three stars are given to facilities judged to perform as expected, while one star facilities are viewed as poor performers. Performance is based on risk-adjusted mortality rates using claims data for 18 procedures and diagnoses, with another ten procedures evaluated on the basis of complication rates. The new report permits evaluation of individual hospitals against each of the 28 performance measures; the report also permits users to compare performance among neighboring cities. For more information visit www.HealthGrades.com.

Kaiser Foundation Examines Managed Care

The vast majority of states with Medicaid managed care plans (MCOs) now produce public reports on quality, according to a comprehensive survey just out from the Kaiser Commission on Medicaid and the Uninsured. Over three-fourths of the 36 states with MCOs publish quality reports, with 16 now producing actual "report cards." All states with MCOs state that they require HEDIS measure reporting as well as patient experience reporting. Almost half (16 of 36) require that plans be accredited by such groups as the National Commission for Quality Assurance, URAC or the Accreditation Association for Ambulatory

Health Care. Under federal regulation, states with Medicaid managed care plans are obliged to engage the services of an independent External Quality Review Organization (EQRO), tasked with assessing plans' compliance with access requirements as well as other responsibilities. EQROs also conduct clinical studies and examine plans' performance improvement activities. These typically address such areas as improving birth outcomes, access to pediatric subspecialists, use of emergency rooms, smoking cessation and care coordination. IPRO currently holds EQRO contracts with the states of New Jersey, Louisiana, New York, Kentucky, Nebraska, Pennsylvania, and Rhode Island, as well as Puerto Rico. For a copy of *"A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey,"* visit the Kaiser Family Foundation's website at www.kff.org.

Feds Issue Final Shared Savings Regulation

The final federal language implementing a key Medicare shared savings initiative includes substantial changes that ought to increase provider participation in the program. That's according to an article by CMS Administrator Donald M. Berwick, MD that appeared in the October 26 *New England Journal of Medicine*. Under the Accountable Care Organization (ACO) model mandated by the recent healthcare reform law, risk-sharing provider groups can receive a portion of the savings achieved by providing coordinated, high-quality and cost-effective care to seniors. The draft implementing language published last March would have relied on retrospective assignment of beneficiaries to ACOs, holding provider groups accountable for 65 quality measures and requiring that half of network primary care physicians be "meaningful users" of electronic health records (EHRs) by the second year of the program. The final federal rule published in October permits preliminary prospective assignment to ACOs, reduces the number of quality measures to 33 and removes "meaningful use" of EHRs as a condition of participation in the program. "Taken together," writes Berwick, the changes in the final rule "create a more feasible and attractive on-ramp for a diverse set of providers and organizations to participate as ACOs." The full text of the article, as a well as a chart demonstrating key changes in the final rule, are available at http://goo.gl/ibccd.

State Task Force Addresses Healthcare Disparities

New York's Medicaid program should cover primary and secondary chronic disease prevention and treatment, according to recommendations released October 20 by a State Health Disparities Work Group. Convened as one of ten Medicaid Redesign Team (MRT) Workgroups empanelled to make recommendations to Governor Cuomo, the Disparities Group emphasizes the need for pre-diabetes treatment, home-based asthma assessments, environmental testing for lead poisoning and reimbursement for automated blood pressure cuffs for home use. The Work Group notes the federal health reform law permits States to provide recommended preventive services with no cost-sharing requirements for Medicaid recipients. Pre-diabetes affects one in three adults, with an estimated 40 percent of individuals with the condition going on to develop diabetes. The Work Group states that individual and group lifestyle counseling can result in a 58% success rate in delaying or preventing the onset of diabetes. The Workgroup makes a number of other recommendations, addressing such issues as streamlining access to emergency services, emphasizing disparities at teaching facilities, promoting language-accessible prescriptions and ensuring transparency in the use of charity care funding. For reports on these and other recommendations from Workgroups, visit the MRT website at www.health.ny.gov.

Agency Offers Draft of New Hospital Quality Rules

A new version of the hospital quality standards known as "Conditions of Participation" will enhance patient safety and save $900 million a year by eliminating unnecessary regulations, say two senior officials with the Centers for Medicare & Medicaid Services (CMS). The draft Conditions released October 19 for a 60-day comment period are requirements for hospitals that wish to participate in Medicare and Medicaid—failure to meet the standards can result in a facility being terminated from receiving public funding. Writing in the October 18 *Journal of the American Medical Association,* Patrick H. Conway, MD, MSc and Donald M. Berwick, MD, MPP say revisions will improve communications during care transitions, permit a single governing body to oversee a multi-institution health system, and do away with a requirement for stand-alone nursing plans that are different from other care plans. Also, the proposed rule would broaden the definition of hospital medical staff to include all state-licensed practitioners, including advanced practice nurses. The article "Improving the Rules for Hospital Participation in Medicare and Medicaid" is available for download at http://goo.gl/zh1yN. The proposed rule is available at www.regulations.gov.

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We welcome your comments and suggestions. Please forward them to the Editor, Spencer Vibbert, at svibbert@ipro.org.

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