

# Quality Matters



A Publication of the Monroe County Medical Society Physician Quality Collaborative

May 2011 Vol. 2 No. 5

## SAFE COMMUNICATION: UNIVERSAL PRECAUTIONS

According to the Institute of Medicine's *To Err is Human*, 98,000 deaths occur yearly because of medical errors and poor doctor-patient communication, along with lack of adequate treatment monitoring and follow up, is one of the root causes of this. Limited health literacy is a hidden epidemic affecting health status, health outcomes, health care use and health care costs. Low health literacy affects not only those with general low literacy, but also those who are extremely literate in their own areas of expertise but who have difficulty understanding medical terminology. As self-care demands on patients increase, so does the importance of clear communication between health care providers and patients.

"Responsibility for recognizing and addressing the problem of limited health literacy lies with all healthcare professionals", according to a Committee Opinion of ACOG, published in the May issue of *Obstetrics & Gynecology*. "Physicians, nurses, social workers- everyone in the health care field – must make sure that patients fully understand their health condition and their treatment, as well as the importance of taking their medications exactly as directed. We simply can not assume that a patient understands because s/he nods her head or because we think she seems educated." When patients are asked "Do you understand?" they are likely to be too embarrassed to admit they do not.

The National Quality Forum recommends teach-back as a top patient safety practice and using it has been found to be associated with better outcomes. Clinicians can do this by asking patients to restate in their own words what they have heard. Clinicians should also avoid excessive information -- most patients WILL NOT remember more than three messages; speak slowly and avoid medical jargon; pick handouts with simple words, short sentences and lots of white space; and read handouts with the patient and circle important parts.

Many patients are called "noncompliant" because they haven't followed their doctor's recommendations, but this may be because they don't understand what is expected of them.

**Additional Sources:** AMA Health Literacy Toolkit; G. Meyer MD and L. Arnheim MPA "The Power of Two: Improving Patient Safety Through Physician-Patient Communication" *Family Practice Management* 2002.

## HEALTH CARE PERSONNEL & Tdap

On 2/23/2011 the CDC Advisory Committee on Immunization Practices issued a provisional recommendation that all health care personnel, regardless of age, receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since their last Td dose. For the complete recommendation, go to our website.

## NEW GUIDELINES

CDC & NIH **Guidelines to Protect Patients from Bloodstream Infections**

ADA's 2011 **Standards for Medical Care in Diabetes**.

American Association of Clinical Endocrinologists **Guideline for Developing a Diabetes Comprehensive Care Plan**.

ACOG Committee on Obstetric Practice **Statement about Home Birth**

American College of Cardiology/AHA Clinical **Guidance for Controlling High Blood Pressure in the Elderly**

Institute for Clinical Systems Improvement **Diagnosis and Management of COPD**

Visit <http://qualitycollaborative.mcms.org> to access these.

## PROPOSED HOSPITAL RULE AIMS TO IMPROVE QUALITY OF INPATIENT CARE

On April 19<sup>th</sup>, CMS issued a proposed rule that would revise policies and payment rates for general acute care hospitals that are paid for inpatient services under the Inpatient Prospective Payment System, effective for discharges in FY 2012 that is on or after Oct. 1, 2011.

The proposed rule would strengthen the relationship between payment and quality. It includes a proposal to select three new "measures of readmission" -acute myocardial infarction or heart attack, heart failure, and pneumonia to be part of the new Hospital Readmissions Reduction Program under which payments to certain hospitals will be reduced because of excess readmissions. These adjustments would apply to discharges on or after Oct. 1, 2012. It would expand the quality measures that hospitals must report under the Hospital Inpatient Quality Reporting Program in order to receive the full update to the standardized amount in FYs 2014 and 2015. CMS is proposing that hospitals that do not successfully report the quality measures will receive updates currently projected to be -0.5 percent. The proposed rule would add for FY 2012 one category of conditions to the list of hospital acquired conditions (HAC): Acute Renal Failure after Contrast Administration, for purposes of the HAC payment policy. The policy prevents hospitals from being paid at an enhanced rate for treating a beneficiary if the sole reason for the higher payment is the occurrence during the hospital stay of one of the HAC. The proposed rule would also make changes to the Hospital Inpatient Quality Reporting (IQR) measures to be reported for FY 2014 and FY 2015 payment updates. The changes would increase the IQR measure set to 73 measures. For more information on this go to <http://qualitycollaborative.mcms.org> under Quality: Hospitals.

## EPRESCRIBING (eRX)

The countdown continues in terms of prescribers needing to eRX in order to avoid a penalty. The Centers for Medicare and Medicaid are requiring each prescriber (including nurse practitioners and physicians assistants who prescribe) to electronically prescribe for at least 10 visits between January 1-June 31, 2011 to avoid a 1% penalty for 2012. Only practices that have applied and been accepted to be a CMS group practice before January 31, 2011 are eligible to meet the eRX requirements for group practices which vary depending upon the size of the group practice. There are a few exemptions to the penalty: eligible professionals who have fewer than 100 Medicare Physician Fee Schedule (PFS) cases that fall into a certain list of encounter codes; professionals whose allowable Part B Medicare PFS charges for these represent less than 10% of their total Part B Medicare PFS charges, those residing in certain rural areas without sufficient internet access and those with limited available pharmacies.

Due to the pushback CMS has received on this requirement, CMS is "retaining the right" to make changes to the requirement that physicians eRX for 25 visits between January 1-December 31, 2011 to avoid the 2013 penalty.

The American College of Physicians reports that physicians have found the free eprescribing system available through the National E-prescribing Patient Safety Initiative to be worthwhile. For further information about the free eprescribing system go to: [www.nationalerx.com](http://www.nationalerx.com). For further information about ePrescribing go to our website, <http://qualitycollaborative.mcms.org> under Quality.

## BEST QUALITY PRACTICES IN HOSPITALS

The Healthcare Association of New York State's (HANYS) Pinnacle Award for Quality and Patient Safety is a forum which recognizes organizations playing a leading role in promoting health care quality and patient safety. *Leading the Quest for Quality: 2010 Profiles in Quality Improvement and Patient Safety* is a compendium of submissions for this award that met HANYS' publication standards. Pinnacle Awards were made to hospitals in 4 categories: multi-entity, large hospital, small hospital, and specialty or division-based. Information in this compilation is divided into the following areas: clinical care; operations; patient safety and specialty care. Go to: [http://www.hanys.org/quality/docs/pinnacle/2010\\_pinnacle\\_award.pdf](http://www.hanys.org/quality/docs/pinnacle/2010_pinnacle_award.pdf) or our website for a copy of the publication.

## MEANINGFUL USE (MU) ATTESTATION CALCULATOR

CMS has recently launched the Meaningful Use Attestation Calculator to help Medicare professionals and eligible hospitals to determine if they have met all of the objectives and their associated measures for MU. After entering their core and menu measure MU data, the calculator will display whether a provider has met the necessary criteria for these objectives. For more information, visit our website.

## APPROPRIATE SCREENING TESTS FOR DIABETIC NEPHROPATHY

Diabetic nephropathy occurs in 20-40% of diabetic patients and is the leading cause of end-stage renal disease.<sup>1</sup> Persistent albuminuria in the range of 30-299 mg/24 hour is the earliest stage of diabetic nephropathy in type 1 diabetes and a marker for the development of nephropathy in type 2 diabetes.<sup>2</sup> Microalbuminuria is also a well established indicator of increased risk for cardiovascular and chronic kidney disease.

The Community-wide Diabetes Guidelines mirror those of the ADA and the National Kidney Disease Education Program in recommending an annual test to assess urine albumin excretion in patients with at least 5 years of type 1 diabetes and in all type 2 diabetic patients. Due to variability in urinary albumin excretion, 2 of 3 specimens within a 3 to 6 month period should fall within the microalbuminuric or macroalbuminuric range to confirm classification.

Definitions of abnormalities in albumin excretion

Category	Spot collection (ug/mg creatinine)
Normal	<30
Microalbuminuria	30-299
Macroalbuminuria	≥300

The preferred method of screening for albuminuria is the measurement of the albumin-to-creatinine ratio in a random spot collection. This ratio corrects for variations in urinary concentration due to hydration and provides a more convenient method of assessing protein and albumin excretion. Twenty-four hour collection and timed specimens are not necessary.

Measurement of a spot urine for albumin by immunoassay or dipstick test specific for microalbumin (i.e. spot protein) without simultaneously measuring urine creatinine is less expensive, but susceptible to both false negative and positive results due to variations in urine concentration. The ADA does not endorse screening for nephropathy using a urine dipstick test.

Current performance on obtaining an annual nephropathy screening in type 1 and 2 diabetics in Monroe County is about 50% (Medicare fee-for-service plans) which is below national standards.<sup>3,4</sup> Much of this is related to non-optimal labs being performed.

The website of the MCMS Quality Collaborative provides information on managing care for diabetics; the Greater Rochester Practice Association (GRIPA) also provides tools on the GRIPA Connect Portal.

### References:

1. American Diabetes Association Standards of Medical Care in Diabetes. *Diabetes Care*, 34(1):S11-S61; January 2011.
2. National Kidney Foundation. K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification. National Kidney Foundation. 2002.

If you wish to receive this directly (electronically) email [mjmilano@mcms.org](mailto:mjmilano@mcms.org).