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More alignment of measures on horizon — but not soon enough for many QPs

Slight differences in many measures causes 'waste and inefficiency'

When performance measures required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare & Medicaid Services (CMS) were completely aligned, many quality professionals breathed a sign of relief. Staff no longer had to collect data for two different measurement sets. But for many in the quality field, non-harmonization of measures is still a major headache.

Many hospitals report quality data to dozens of different entities in addition to CMS and JCAHO, including state organizations, QIO data warehouses, health insurers, vendors, and others. In many cases, measures are very similar but not identical. "It is really getting difficult with the data demands and the multiple and sometimes contradictory reports," says **Joanne Lee**, director of case management and quality improvement at Sacred Heart Hospital in Allentown, PA.

For example, in addition to CMS and JCAHO requirements, the hospital is required by the state to report demographic and clinical data to the Pennsylvania Health Care Cost Containment Council on a quarterly basis on mortality, readmissions within 31 days, infections, length of stay, and charges.

"What I see happening right now is that data are getting reported in various formats. This is confusing to both hospitals and consumers," says Lee. "I am currently seeing this with the core measures versus the JCAHO ORYX reports. They have the same numbers, yet the reports do not look a bit alike and almost appear contradictory at times."

Measures that are slightly different mean that data have to be collected twice or several times. "There is always just a little bit of difference, but the bottom line is, it's the same patient," says **Jerod M. Loeb**, PhD, JCAHO's executive vice president for research. "It really does represent incredible duplication of efforts, and you can read that as waste and inefficiency from the hospital's perspective."

The goal is to collect data once in a standardized manner to be used by any entity that needs it for whatever purpose, whether accountability, public reporting, or pay for performance. "The word of the day is harmonization," says Loeb. "The thing we're all looking to avoid is chaos. The key

message here is that we understand the problem, and we are all working together now to address this."

Added to the problem is data being presented through various companies, based mostly on claims or public data which is usually several years old, says Lee. "Worse than the redundant data collection is the redundant data analysis that QI departments must do when these reports are published," says Lee. "I believe that optimal organizational quality can only be achieved through integration — and that includes data integration."

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Editor: **Staci Kusterbeck**, (631) 425-9760.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).

Editorial Questions

For questions or comments, call **Staci Kusterbeck** at (631) 425-9760.

Efforts are in the works to reduce redundant data collection. The AQA alliance/Hospital Quality Alliance steering committee, formed to better coordinate quality measurement and transparency programs pertaining to hospitals, physicians, and other health care providers, now has a measure harmonization workgroup. The group is looking at various physician and hospital measures that address the same aspect of quality, such as health care-acquired infections, but have slightly different measure specifications.

"Where alignment of specifications and definitions is desirable to reduce burden and produce more actionable information for quality improvement purposes, the workgroup is facilitating discussions between the various measurement stewards to achieve harmonization," according to **Janet M. Corrigan**, PhD, MBA, chair of the measure harmonization workgroup and president and CEO of the Washington, D.C.-based National Quality Forum.

The workgroup already has identified alignment of measures that can be accomplished over the next three to six months, as well as longer-term alignment to occur over the next 18 to 24 months.

For instance, definitions were aligned for the terms used in the numerators of the smoking cessation measures that mean essentially the same thing across the various hospital and ambulatory measures, including "intervention," "strategy," "medication," and "advice or counseling." In the longer term, to harmonize with the outpatient approach, CMS and JCAHO have discussed developing a measure on smoking cessation that would include all hospitalized patients.

"As hospital- and physician-level measurement continues to evolve and mature, quality professionals will benefit most from this alignment activity occurring as early in the process as possible," says Corrigan.

However, having a multitude of measures specified differently has been a significant problem for some time and will not be solved quickly. In the short term, there will be modifications made to some measures to bring them into better alignment, but significant changes are also coming.

"The harmonization effort is trying to ask, 'How do we fix a problem looking backwards, which was created by siloed efforts?'" says Loeb. "There is easy stuff that can be done very quickly and harder stuff that will take a lot of complex thought and negotiation."

The concept of harmonization transcends the

hospital setting and is being looked at across the continuum of care. "What has happened is, as the hospital and ambulatory arenas have both blossomed in measurement, in many cases the same clinical condition is being addressed," says Loeb. "The problem is that the patient doesn't really care what setting he or she is in — they are looking for good care, and we are looking to measure the quality of care." He gives the example of heart failure, which is treated in both the acute care and ambulatory setting.

For real progress to occur, there will need to be some compromise. "Ultimately, there is no perfect measure. At the end of the day, somebody is going to have to say, you know, it's probably okay to leave it like this even if that means we have to retrofit something," says Loeb. "The argument is often 'Don't make me change this because it will cost money.' But if you don't change it, the money being wasted right now is going to continue to pour down the drain. It's more costly not to change it."

A second dilemma is how to avoid this problem in the future, as new measures continue to be developed by various groups. When measures are developed, a single expert panel representing the whole continuum of care needs to be involved, as opposed to "dueling expert" panels for ambulatory and inpatient care, says Loeb. "That is a whole separate issue, to make sure that we don't create more of the problem downstream," he says. "We need to be sure that any future expert panels are appropriate for presentation to all the relevant parties."

What you can do now

Clearly, alignment of existing quality measures is going to take time to sort out. In the meantime, some quality professionals are developing tools to present these data more clearly to administrators. "Quality's role is to analyze and present these multiple formats to the hospital and medical staff and explain the differences," says Lee.

To do this more effectively, Lee is developing an external data report card showing requirements of the various agencies, the hospital's rates, and the actual format that the data are reported on by these multiple agencies, to present to the hospital's medical executive and quality committees. "I hope that it gives hospital and medical leadership an overview of our performance, indicating the areas that we excel in and those areas that we need to focus on," says Lee. "Our data are used by at least six agencies that we know of."

In addition to the CMS and JCAHO measures, Lee is including data from the New Jersey Quality Report in her report card. "I have a section that compares our state data to the state and region averages, by diagnosis," she says. "I also have data from a third party payer that includes core measure compliance as well as specific quality indicators. Again, I compare our results to their state and national network numbers."

Right now, the smartest thing for quality professionals to do is prepare for the measures "coming down the pike" that you'll soon be required to report, advises **Denise Remus**, RN, PhD, vice president for clinical informatics of Premier Inc., based in Charlotte, NC.

"One of the best gauges for measures that will be used nationally is to watch the work of the Hospital Quality Alliance," Remus says.

The Deficit Reduction Act of 2005 requires CMS to implement a value-based purchasing plan beginning fiscal year 2009, and commercial payers already are linking payment to quality in regional and national initiatives, notes Remus. "Hospitals need to be focused on increasing their quality, not only to better serve their communities, but to adhere to government legislation," says Remus. "The current health plan environment includes more consumer-directed health plans and increasing accountability. The current quality measures only cover a small subset of inpatient services, so additional measures are being encouraged."

She points to initiatives like the Surgical Care Improvement Project and the Hospital Care Quality Information from the Consumer Perspective Survey, which will broaden the quality information available to purchasers, payers, and consumers.

But quality professionals should consider going a step further and actually become involved in the research activities and review of proposed new P4P measures, advises Remus. "There are several opportunities for input into national policy and measurement programs," she says. She recommends the following:

- **Pay attention to calls for public comment from JCAHO, CMS, and NQF.** These organizations often issue requests for comment in response to proposed measure sets and proposed rules.
- **Serve as a member of a technical advisory panel or committee.**

• **Shadow P4P projects such as the CMS/Premier Inc. Hospital Quality Incentive Demonstration**, the first national project of its kind designed to determine if economic incentives to hospitals are effective at improving the quality of inpatient care. "In this instance, inclusion in the project is no longer available and they won't be eligible to obtain reimbursement from CMS," says Remus. "But any hospital can shadow the project as if they were participating, and gain valuable insights and information from over 250 participating hospitals regarding P4P."

Quality professionals have an opportunity to not only proactively scan the national environment regarding new measures, standards and practices, but directly impact the overall outcome by consistently responding on behalf of their organizations when public comment or hospital-specific feedback is requested, says **Cheri Throop**, RN, MHSA, RHIT, CPHQ, director of measures, standards and practices at the Texas Medical Institute of Technology.

This means organizations already have assessed their key strategic priorities, populations served, and percentage of those included within their approved standardized care guidelines or pathways, says Throop.

Always provide comments or feedback to national organizations' request for public comment as it relates to your organization's strategic priorities and impact to populations served, advises Throop.

"Embed nationally endorsed or approved measures into your hospital's existing performance improvement program as a proactive approach ahead of a national requirement," recommends Throop.

"You can also strategically launch or re-energize improvement strategies focused on care systems in these particular areas," Throop says. "This helps the organization move from focusing on measuring and monitoring, to meeting requirements for proactive care management."

Along with providing feedback when measures or standards are being field-tested, consider participating in regional, state, national, or systemwide collaborative initiatives focused on improving quality and reducing harm. "The output from these efforts includes standardized measures with targets for improvement," says Throop. Many of these measures ultimately are submitted to national organizations for their consideration for endorsement or approval.

"Take advantage of opportunities to engage in research activities offered by organizations as a field-tester or testbed," says Throop. "Hospitals engaging in these activities have a head start on what may ultimately be required."

[For more information, contact;

Joanne Lee, Director, Case Management/Quality Improvement, Sacred Heart Hospital, 421 Chew St., Allentown, PA 18102. Telephone: (610) 776-4886. E-mail: jlee@SHH.ORG.

Cheri Throop, RN, MHSA, RHIT, CPHQ, Director, Measures, Standards & Practices, TMIT. Telephone: (816) 283-3622. E-mail: cheri_throop@tmit1.org. Web: www.safetyleaders.org] ■

How does your hospital really measure up?

Standardization of data reporting needed, experts say

Many organizations currently rank hospitals using publicly reported quality data. But this information can be confusing and even conflicting, since each entity is measuring different aspects of quality, using different methodologies for different purposes.

As more quality data become available to hospitals and the public, there is a need for someone to "grade the graders," says **Jerod M. Loeb**, PhD, JCAHO's executive vice president for research. "This whole world of measurement and public reporting has been growing explosively of late," he notes. "And one of the problems is, where do you look for credible information? How do you assess the credibility of what you are seeing?"

Quality at your hospital may be very highly ranked on one listing, but on the bottom of another list. "It really is kind of silly when a hospital is rated number one in cardiac care by rating service A, number 10 by rating service B, and is not even on the list of rating service C," says Loeb.

It's true that different entities need to portray the same data in different ways. "We, for example, as an accreditor, have certain needs to fulfill," says Loeb. "We want to take data and turn it into information and allow it to be used by various stakeholders in various ways." For this reason, it's acceptable to use different methodologies as long as they are based on the same data and also, that the methodology is transparent, says Loeb.

Some of the hospital rankings are based on subjective opinions such as surveys or reputation, as opposed to hard data, he adds.

In a 2005 report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, the Washington, DC-based Institute of Medicine recommended that provider achievement be reported "in ways that are both meaningful and understandable to consumers." But with so many different methodologies being used, this is hardly the case, say experts in the quality field.

"It seems to me we have too may people reporting numbers and not enough understanding of what the numbers, percentages, or stars really mean," says **Patti Muller Smith**, RN, EdD, CPHQ, a Shawnee, OK-based consultant working with hospitals on performance improvement and regulatory compliance. "There will be some effort to standardize public reporting, but that may be a while in coming."

What's being measured?

Before sharing results on how your hospital did on a given ranking, know exactly what the particular reporting source is measuring, such as cost-effectiveness or compliance with evidence-based treatment practices for specific diagnoses. "The second thing that is important to understand is what group of hospitals and providers are included in the sample from which the information or statistics have been gathered," says Muller-Smith.

For example, CMS is looking at payment issues with the goal of achieving high quality, cost-effective care for the population it covers at a reasonable cost. These data drive efforts to ensure that patients are receiving the appropriate services, in the appropriate setting, and in a timely manner, to achieve the best possible outcome, says Muller-Smith. "As a major payer for health care, CMS basically sets the reimbursement levels and other payers follow their lead," she says.

Many other reporting companies look at similar information but focus on patient mortality and morbidity as well as cost-effectiveness. "The quality professional must be sure that their internal data gathering matches up with the benchmark data they are looking at from an outside organization," advises Muller-Smith.

Since most health care consumers aren't familiar with DRG determination or reimbursement practices, measures looking at cost-efficiency and appropriate levels of care are geared toward providers, not patients, says Muller-Smith. "I think mortality, morbidity, infection rates, and patient safety will be prime indicators from the public's perspective," she says.

Use results as 'road map'

The Leapgrop Group recently started its own "Top Hospitals" list, based on results from its Hospital Quality and Safety Survey, a national rating system of more than 1,200 hospitals based on answers to questions about performance on key patient safety activities.

According to **Catherine Eikel**, Leapfrog's Hospital Rewards program director, unlike other performance designations, Leapfrog's list focuses entirely on the National Quality Forum's Best Practices for Safer Healthcare. Top-rated hospitals demonstrate excellence in patient safety activities, including staffing ICUs with intensivists and treating certain high-risk procedures.

Use the survey results as a "road map" for strategic planning around patient safety initiatives, advises Eikel. "Hospital-based quality professionals can use our survey as a tool as they develop their patient safety initiatives, to see where their facility may have room to improve quality and patient safety," she says.

Consumers increasingly are accessing the information, according to Eikel. "We see this through the increasing number of employers and health plans that use Leapfrog's performance information in their member education strategies and the increasing number of organizations that use Leapfrog's performance information in consumer decision support tools," she says.

HealthGrades' annual Hospital Quality in America Study ranks more than 5,000 hospitals using a risk-adjustment methodology focused on outcomes. According to its researchers, there is a 69% greater chance of mortality for Medicare patients at low-rated hospitals compared with highly rated hospitals.

This "quality chasm" between the best and poorest-performing hospitals has grown by approximately 5% since last year's study, even as overall mortality rates have improved by nearly 8%, according to the report.

"Every hospital has strengths and weaknesses and should leverage their strengths to improve their weaker areas," says **Samantha Collier**, vice president of medical affairs for HealthGrades. "It is imperative to understand where you are relative to the large gap between the top and bottom

performing groups, and what you need to do to move towards the top. This can only be done with regular performance benchmarking and feedback to relevant stakeholders with a call to action."

Solucient's "100 Top Hospitals: Benchmarks for Success" study measures organizationwide performance and is meant to be a tool for boards and executives to improve performance across the whole organization. A balanced scorecard approach helps leaders improve clinical performance, operations, growth in service to the community, financial performance, and hospital systems, says **Jean Chenoweth**, senior vice president for performance improvement and Top 100 Programs for Solucient.

"Executives, board members, and quality professionals involved in cross-functional improvement teams should make sure that hospital systems, as well as caregiver performance, are considered as possible causes for poor performance," she says. "That's what makes a difference."

In this way, the best possible solutions can be identified to make permanent changes, says Chenoweth. According to a recent Governance Institute/Solucient study, more than 80% of hospitals boards have set a goal of improving performance on core measures. "Boards are paying attention to core measures."

Reporting to consumers

But with all the data available to the public, are health care consumers getting the message? "That's the million dollar question," says Chenoweth. Although Solucient's study is geared toward health care professionals, not consumers, they do help hospitals to convey the meaning of the scores to their community.

"That is what all national agencies are all struggling with today — AHA, NQF and the federal government and all the various quality alliances: How do we get people to understand what different report cards are for and what they mean?" says Chenoweth. "Now we're entering a new phase in which I think all publishers of report cards must accept greater responsibility for communicating what the report card means."

The greatest source of confusion is that different studies measure different things, says Chenoweth. "When data are published about hospitals, you have to ask: What are they trying to measure?" she says. "For example, core measures are designed to be a minimum standard which reflects use of evidence-based treatment for a few specific disease entities. In essence, core measures address whether hospitals are paying attention to evidence-based medicine."

The 100 Top Hospitals program uses nine performance measures to help hospital boards assess comparative performance of their organization. "We do not provide specific data to consumers. That is very different from JCAHO, HealthGrades, US News, Hospital Compare, and Leapfrog," says Chenoweth. "Solucient's hospitalwide scorecard measures what the organization does, not just the nurse or doctor who touches the patient."

However, new results show that although Solucient and JCAHO are measuring different things, the highest-scoring hospitals on both measurement sets were very highly correlated, according to Chenoweth.

"We are very pleased about that, because what we are measuring with the 100 Top study is whether the organization as a whole is functioning well, and thus, whether leadership is having an impact," says Chenoweth. "Our hypothesis, as a result of finding the strong correlation between these two, is that a high score on a hospitalwide scorecard reflects a strong internal infrastructure that is responsive to leadership priorities for improvement — in this case, a priority for improvement of clinical performance as gauged by core measures."

The results indicate that higher-ranked hospitals can change more quickly than other organizations because of infrastructures that allow faster improvement, she explains. "The direct link between evidence-based care and goals set by hospital leadership says that actions of quality improvement teams make a real difference that touches real patients," says Chenowith. "It says that the infrastructure which quality improvement professionals are a part of is important. What they do matters."

[For more information, contact:

Jean Chenoweth, Senior VP, Performance Improvement and 100 Top Hospitals Programs, Solucient, 5400 Data Ct., Ann Arbor, MI 48103. Telephone: (734) 669-7941. Fax: (734) 769-6544. E-mail: jchenoweth@solucient.com

Patti Muller-Smith, RN, EdD, CPHQ, Administrative Consulting Services, Box 3368, Shawnee, OK 74802. Telephone: (405) 878-0118. E-mail: mullsmi@aol.com.] ■

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Sutter Health disease management, case management programs strike balance for best patient outcomes

'What are primary needs?' is operative question

The successful integration of case management and disease management is the latest step in the ongoing evolution of the Sutter Health Sacramento Sierra Region Care Management Programs, says **Jan Van der Mei**, RN, the region's continuum case management director.

The program began more than a decade ago with a centralized nurse/social work model that was then called geriatric care coordination, later became chronic care coordination, and is now known simply as care coordination, Van der Mei notes.

The team is composed of registered nurses located within the physician office setting and medical social workers and health care coordinators who work with patients and their families to provide a comprehensive plan of care, she explains. The team facilitates ongoing contact with both the patient and the primary care physician to make sure all issues regarding the patient's health care are addressed as quickly and completely as possible, Van der Mei adds.

The first disease-specific program was added in 2002, she says, with the management of patients with heart failure, and expanded to include those with asthma (2003) and diabetes (2005).

The Care Management Programs support two physician groups and an independent physicians association (IPA), as well as five hospitals in the region, Van der Mei notes. "They're paid for by both the hospital and the physician groups, because all benefit."

Unlike with outside companies that monitor patients for physician groups or health plans, she says, "we have been asked to provide care management for our physicians as part of the medical group structure. We have access to the chart and can make medication adjustments using guideline-based protocols."

Rather than simply telling the physician that a patient is getting worse, she says, "we can really make a difference to the patient."

The challenge in the latest phase of the Sutter Health Care Management Programs, Van der Mei continues, was to "identify a way to work together to provide disease management and care coordination and not cause total confusion."

Part of that challenge, she says, was avoiding having three different case managers overseeing the care of a patient who, for example, had heart failure and diabetes along with psychosocial problems.

"It was a gradual process, as we identified patients with heart failure who were originally referred to the program because they had issues with transportation or caregiver support," Van der Mei says. "So when we started the heart failure program, we put the patient there and then figured out if that program or care coordination manages the patient. We did it by asking, 'What are the primary needs?'"

Van der Mei describes a typical scenario:

"Say Nora, a heart failure case manager, is making her scheduled monthly call to Mrs. Jones, and Mrs. Jones tells her, 'I don't know what my weight is, because I am having trouble reading the number on the scales, and by the way, I am out of my medication and have signed up with Medicare Part D and don't know how to get my prescription filled.'

"Nora realizes she has a patient who is stable but who won't stay that way if she doesn't continue to monitor her weight and take her medications, but Nora is a heart failure case manager and has another appointment in 15 minutes."

After asking Mrs. Jones how she is doing and determining that she is not short of breath, Van der Mei continues, Nora asks the patient if it's OK if she calls the case manager who works with her physician. The case manager in the office, Linda, will then call Mrs. Jones and help her figure out what to do, Nora explains to the patient.

"After Linda calls," Van der Mei says, "she may do a home assessment or she may see Mrs. Jones when she comes in for a physician visit: Does she need an eye exam? Is the print too small?"

When Mrs. Jones' condition is stable, she adds, she will just get calls from Nora, the heart failure nurse. If the nurse identifies other problems, Van der Mei notes, or if the patient needs to be considered for hospice care, for example, Nora can make the referral or can talk to Linda about the issue, and Linda can talk to Dr. Smith.

Once Mrs. Jones is able to read the scale and handle her prescriptions, Van der Mei says, she goes back to Nora.

"So they collaborate," she says. "Who is the primary case manager is based on what is happening. If patients have comorbidities, like diabetes and heart failure, they have one of the case managers who is proficient in both diseases."

Case managers who handle more than one disease have a smaller caseload, she notes.

"The point is that the disease-specific case manager is really managing the disease, but because they have time constraints, they need support from the care coordination nurse with other issues," Van der Mei says. "You never deal just with the disease. There are always psychosocial issues."

As program staff worked to arrive at the appropriate care strategies, she says, they tried having patients with multiple needs remain in only one program, while closing them out of the other. In some instances, Van der Mei adds, the heart failure team would close out a case, turning the patient over to the care coordination team.

"If the patient got closed out from the heart failure program because so much else was going on," she notes, "then the heart failure was not managed as well, because care coordination is a more general team, not really focusing on the disease itself. So it worked out better to have the disease-specific program open and call in care coordination as needed."

One of the things Sutter Health did to enhance the quality and consistency of case management, Van der Mei says, was to identify 75 common syndromes or processes and list all the resources and interventions that might be used to address them.

"They were not necessarily diagnoses, but they could be," she explains. "We might identify all the things one would do if the patient had arthritis or was cognitively impaired, or had a fall. Intervention might be information on a support group or community resources."

Also included are processes patients should be familiar with, Van der Mei notes. "One of our goals for the program is to be sure to address advance care planning for all of our patients so they put into place an advance directive, so advance care planning is one of the categories.

"If the patient is cognitively impaired, the goal is to have a safe environment," she adds. "The interventions would include how to identify the degree of impairment and what tests the case manager should use to determine that. You would need safety measures, ways of indicating they might forget where they are.

"We've identified the potential interventions, so case managers should have everything they would consider doing for the patient in a list," Van der Mei says. "All of the identified interventions might not be indicated, but this enables a new case manager to be aware of the things they might consider for someone with the identified problems."

Sutter Care Management Programs have had success using specially trained support staff, rather than social workers or nurses, to do some of the monitoring calls, Van der Mei points out.

"When they identify problems," she adds, "the call is escalated to an RN, who does an assessment and determines what action to take. The support staff are able to do ongoing monitoring of stable patients in a fairly cost-effective way."

These employees are trained in-house, with an

extensive orientation that includes scripting for patient calls and very clear parameters for when a nurse needs to be called, Van der Mei notes.

The combined programs managed more than 9,000 patients in 2006, with a total of 31 full-time equivalents (FTEs), she says. Some employees, particularly those in disease management, work in more than one program, Van der Mei adds.

Patient outcomes have been very positive, she says, and continue to improve. "Our outcomes include not only utilization measures but quality measures as well. We can clearly demonstrate that we've made a difference with our heart failure patients. There are fewer ED visits and fewer hospital visits compared to those who are not in the program, and our patients are on the appropriate drugs for their conditions."

It has always been true of patients in the care coordination program that they are healthier, have fewer visits to primary care physicians, and are able to remain in their own homes longer, Van der Mei adds. "Sometimes we have more home health visits and more durable medical equipment [DME] costs, because we make sure that patients have a cane, walker, or wheelchair."

JCAHO seal of approval

The Sutter Care Coordination Program, Sutter Heart Failure Telemanagement Program, and the Sutter Asthma Management Program received disease-specific care (DSC) certification in November 2003 and 2005 from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Van der Mei notes.

The Sutter Diabetes Management Program, which began in July 2005, will be up for certification in 2007, she adds.

"[Certification] is somewhat like accreditation, although not so complicated," Van der Mei explains. Requirements center around "how you deliver or facilitate care, that you use outcome measurements to make program improvements, and that your programs support and encourage self-management by patients."

There also are certain program management guidelines, Van der Mei says, including, for example, that the leadership roles in the program be clearly defined.

JCAHO's DSC certification is designed to evaluate disease management and chronic care services provided by health plans, disease management service companies, hospitals, and other care delivery settings, according to information on the agency's web site (www.jointcommission.org).

The evaluation and resulting certification decision is based on an assessment of:

1. compliance with consensus-based national standards;
2. effective use of established clinical practice guidelines to manage and optimize care;
3. an organized approach to performance measurement and improvement activities.

Disease-specific care services that successfully demonstrate compliance in all three areas are awarded certification for a one-year period. After the first year, a one-year extension can be granted, contingent on the submission of an acceptable assessment by the organization of continued compliance with standards and performance measurement and improvement activities. ■

CMS discharge rule requires revision

Revised version of 'Important Message' required

A potentially onerous hospital discharge rule proposed in April 2006 by the Centers for Medicare & Medicaid Services (CMS) is significantly less burdensome in its final form.

The new rule, released Nov. 29, 2006, will require hospitals to issue a revised version of the Important Message from Medicare that fully explains patients' discharge rights. Rather than issuing a second and different notice 24 hours before discharge as was proposed, hospitals will issue the Important Message within two days of admission, answer any questions, and get the signature of the patient or his or her representative on the notice.

Hospitals will be required to provide a copy of the signed notice before the patient leaves the hospital, but not more than two days before the departure. For short stays, this means the copy of the notice need be provided only once.

CMS has said that it will be developing the revised notice text, but before submitting it to the Office of Management and Budget for public comment and paperwork clearance will test it with beneficiary focus groups. The rule becomes effective July 1, 2007.

Opponents of the proposed rule had noted that it would add more bureaucracy to an already complicated and confusing discharge

process for a patient population — generally more than age 65 — that needs assistance and guidance.

Proponents, meanwhile, had contended that the Important Message is not timely notice because it is not issued close enough to discharge.

The American Hospital Association (AHA) had expressed several concerns about the proposed rule, including that it would have the unintended consequence of unnecessarily extending the hospital stays of Medicare patients by an extra day because hospitals often cannot predict the date of discharge one day in advance.

"By requiring that [the notice] be rendered after the discharge decision is made and yet 24 hours before discharge, you end up in many cases keeping people another day," noted **Ellen Pryga**, AHA's director of public policy development. "With diagnosis-related groups, hospitals don't get paid for that."

Another concern was that the proposal was written in an "alarmist" way, Pryga said not long after it was issued. She said it would have created the impression that it was likely the patient would be sent home too soon and should automatically be asking a quality improvement organization to review the decision.

In other action, CMS has finalized its proposal to relax four requirements or conditions that hospitals must meet to participate in the Medicare and Medicaid programs.

That final rule, effective Jan. 26, 2007, gives hospitals up to 30 days before a patient's admission or 24 hours after admission to complete a medical history and physical examination, and allows more health care professionals to perform the exam. The record of the exam must be entered into the patient's medical record within 24 hours after admission.

In addition, the rule provides that all verbal orders given by a medical professional must be recorded within 48 hours in the patient's record by the medical professional or another practitioner responsible for the patient's care.

Previously, verbal orders could be entered in the medical record only by the physician who issued them.

The regulation also requires hospitals to secure all drugs and biologicals and, finally, permits any individual who is qualified to administer anesthesia, rather than just the person who administered it, to conduct the post-anesthesia evaluation. ■

AHRQ to request evaluation of pay-for-quality programs

Project seeks to identify best practices

The Agency for Healthcare Research and Quality (AHRQ) issued a notice in the October 24, 2006, *Federal Register* that it intends request permission from the Office of Management and Budget to conduct an evaluation project on pay-for-quality programs.

The proposed project, "Evaluation of the Implementation and Impact of Pay-for-Quality (P4Q) Programs," would assess if quality improves on the measures used in P4Q programs in health care safety net settings and whether the programs lead to unintended consequences. The project also would seek to identify best practices in P4Q programs. Information for the project would be collected through a survey of physicians participating in P4Q programs and through interviews with up to six key managerial staff (physicians, office managers, practice leaders, etc.) at each target site regarding program design, implementation, and impact. ■

Most hospitals support pay for performance

Findings based on 2005 survey

Nearly all hospitals support the Centers for Medicare & Medicaid Services (CMS) in moving forward with a pay-for-performance program over the next few years, but selecting the right measures will be a critical element of future success, according to a new report by Mathematica Policy Research. The findings are based on a 2005 survey of hospital executives that Mathematica conducted for CMS, which explored hospitals' views on a future CMS pay-for-performance initiative and the quality measures it should include. Most hospitals participating in the Hospital Quality Alliance supported using that program's original 10 measures or a modestly expanded set of measures, while most hospitals participating in the CMS/Premier Hospital Quality Incentive Demonstration favored using or expanding that program's 35 measures. ■

Survey coordinator: 'Point person' for preparedness

Hospitals are increasingly adding new role

Keeping up with the ever-increasing requirements of regulatory and accreditation groups is proving too much for many hospital-based quality professionals. To address this, some hospitals are creating "survey coordinator" roles, with a single individual acting as the point person for accreditation requirements.

During the 2005-2006 budget cycle at Oregon Health & Sciences University Hospitals and Clinics in Portland, a decision was made to centralize the coordination of regulatory readiness into the role of one person. The title for this role is manager of accreditation and regulation, and the former "quality and regulatory program" is now called the "quality program."

"This decision was based largely on the recognized complexity of ongoing readiness for an unannounced Joint Commission survey," says **Christine Samuelson Slusarenko**, MS, RN, director of medical affairs/quality management/employee health. "The organization sought one source for readiness planning, messages, and standards interpretation."

One individual reports to this role, a person who historically assumed responsibility for licensure activities and regulatory liaisons with the department of health for the hospitals and clinics. "This has been a natural fit of activities in a reporting relationship," says Slusarenko."

The organization has a medical affairs/quality management department whose scope includes the hospitals and clinics. This department includes quality, infection control, and credentialing, clinical risk and safety, and employee health programs.

Until last year, responsibility for regulatory management issues and readiness for the Joint Commission, CMS, and the state of Oregon's department of health resided with the six quality specialists and their manager, in a quality and regulatory program within the medical affairs/quality management department. Overall direction for readiness and standards interpretation was the responsibility of the department director.

The person recruited for the new role came with many years of regulatory and compliance experience in another health care system and is a clinician. "The first responsibility for this role was the submission of the organization's periodic performance review [PPR] in September 2006," says Slusarenko. "The action plans coming from that submission are now driving the organization's readiness activities."

For the hospital, the new role has been an effective and efficient way to manage, monitor, and communicate ongoing readiness. Since the reporting relationship has remained within the medical affairs/quality management department, responsibility for communication and monitoring of readiness activities has become a natural extension of everyone's role within the department, says Slusarenko.

With one source communicating with the administrative team and medical executive committee, there is increased clarity in the organization's readiness status and necessary action items. Quality specialists are provided weekly information to teach and reinforce as they liaise with the units, ancillary departments, and committees to which they are assigned. "One source refers to the topic or message that is being imparted," says Slusarenko. "Standards are interpreted by one person rather than many."

At Wellspan Health in York, PA, a nurse currently is in training as JCAHO survey coordinator within the quality department. "JCAHO may not be the entire job function within this position," says **Sandra Abnett**, director of quality. "They may also coordinate the state licensing surveys and could be asked to perform other job functions within the quality department."

The JCAHO survey coordinator works with the clinical support areas, nursing and environment of care directors to coordinate internal monthly meetings to keep up with the clinical and EOC standards, respectively. The role acts as the lead coordinator to help with keeping the team up to date on new standards, coordinating the annual PPR, completing survey application, coordinating correction action plans, and acting as the hospital liaison to JCAHO.

"We feel that at least one person should be the lead person who knows a little about everything, and the point person for everyone at the hospital to contact regarding accreditation," says Abnett.

[For more information, contact:
Sandra Abnett, Director of Quality, Wellspan Health, 1001 South George Street, York, PA 17405-7198. Telephone: (717) 851-5869. E-mail:

sabnett@wellspan.org.

Christine Samuelson Slusarenko, M.S., R.N, Director, Medical Affairs/Quality Management/ Employee Health, Oregon Health & Science University Hospitals & Clinics, 3181 S.W. Sam Jackson Park Road Mail Code MBS, Portland, OR 97239-3098. Telephone: (503) 494- 6459. Fax: (503) 494-8492. E-mail: slusaren@ohsu.edu.] ■

Restraint and seclusion: CMS issues new rule

New regulations allow for face-to-face evaluation

Hospitals failed to report 44 of 104 documented deaths related to restraint and seclusion to the Centers for Medicare & Medicaid Services (CMS) between 1999 and 2004, according to a September 2006 report from the Department of Health and Human Services Office of Inspector General. (For a complete copy of the report, go to http://oig.hhs.gov/oei/reports/oei-09-04-00350.pdf.)

The report urges CMS to seek legislation for intermediate sanctions for hospitals that fail to report these deaths. "I don't think that hospitals are intentionally avoiding the CMS reporting requirements," says **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates. "It's quite likely many quality managers weren't aware of the requirement."

The focus in hospitals is often on meeting Joint Commission standards, and CMS regulations can get overlooked, says Spath. "For quality managers, this report reinforces the importance of being familiar with CMS regulations," she says. "There are elements in the CMS regulations that aren't covered by the JCAHO standards, and reporting restraint- or seclusion-related deaths is one of them." Another difference is the definition of restraint: The CMS regulations cover both physical or medication-induced restraints, whereas the Joint Commission's standards only apply to physical restraints.

Now, new regulations from CMS, part of its final rule on patients' rights, impose stricter standards for when a facility must report a death associated with the use of restraints or seclusion. (To download a complete copy of the final rule, go to http://www.cpidirections.com/AA/Advisories.htm and click on "Medicare/ Medicaid Final Rule: Patients' Rights – Restraints & Seclusion.")

When a patient dies while being restrained either physically or chemically, or while in seclusion, the quality or risk manager must be notified immediately, says Spath. "The case should be evaluated to determine if it meets the CMS definition of a reportable event," she says.

The reporting window is short — within one business day after the event — so prompt evaluation of the case is necessary. "The hospital cannot wait for completion of the root cause analysis investigation to determine whether or not the patient's death is a result of restraint or seclusion," says Spath.

The new regulations have a new requirement: That deaths occurring within one week after a restraint episode must be reported to CMS. "This expanded reporting requirement may be challenging. Quality or risk managers will need to recognize the potential link between a patient's death and prior restraint situation," says Spath.

An added twist to the new CMS regulations is the requirement that staff must document in the patient's medical record the date and time the death was reported to CMS, she says. "Documenting reports of events to outside agencies is not usually done in this manner and will require a change in usual practices," she says.

Other changes in regs

More rigorous training for health care staff who employ restraints and seclusion to curb violent or self-destructive behavior is required by CMS. "We have special programs put on by risk management and security on how to handle out-of-control patients," says **Ann D. Law**, RN, outcomes specialist at Covenant HealthCare in Saginaw, MI. "I believe those classes will need to be given to larger groups and more frequently." Currently, training is given by security staff twice a year to staff in the emergency department and critical care units.

The CMS rule also adds trained registered nurses and physician assistants to the category of practitioners who may conduct the "face-to-face" evaluation required within an hour of a patient being restrained or secluded. However, the nurse or physician assistant performing the evaluation must consult a physician or other licensed independent practitioner as soon as possible.

"Anything we can do to curtail any danger

associated with restraints is worthwhile. We will certainly follow the new regulations and adjust our policies accordingly," says **Nancy Hersch**, psychiatric nursing director at Sacred Heart Hospital in Allentown, PA. "We also just instituted a more comprehensive program for safety training including restraints, and we now train a wider group of staff than previously."

The current regulations requiring a physician to see the patient within one hour are very challenging to comply with, says Hersch. "This is very difficult because of the availability of the physicians," says Hersch. "I am sure that we will amend our policy to include nurse and physician assistant interviews."

For the same reason, many organizations will do likewise. "I would suspect that we will entertain the idea of adding the RN to the category of those who may conduct the face-to-face," says **Kristine Von Ruden**, RN, the organization's quality improvement specialist and Joint Commission coordinator at La Crosse, WI-based Franciscan Skemp-Mayo Healthcare System. "However, I am sure this will generate great discussion."

Quality professionals must ensure that there is appropriate documentation to support that the standards and Conditions of Participation are being followed, says **Patti Muller-Smith**, RN, EdD, CPHQ, a Shawnee, OK-based consultant working with hospitals on performance improvement and regulatory compliance. Specifically, documentation must show that staff are trained in the use of restraints, the reason for use of restraints, contact with the primary physician, and monitoring of the patient.

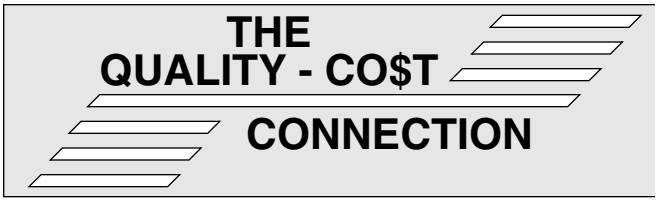
"Restraints are used as a last resort to manage patient behavior and provide a safe care environment for patients as well as staff," says Muller-Smith. The documentation requirements are often viewed as a burden on staff, but they are a critical element in order to demonstrate safe patient care is being provided, she adds.

"Both JCAHO and CMS have been focusing on this area over the last few years," says Muller-Smith. "The surveyors always want to see patient charts where the patient has been restrained and look at staff training, communication between the physician and direct care giver and the validity of requiring restraints. Since communication is a hot issue, this may be the area that gets attention."

It's especially important to document the reason for restraint, says Muller-Smith. "Most hospitals have found that they don't have huge numbers of patients with disruptive behavior in acute care. Restraint that is used for the patient's safety does not fall under the same guidelines," she says. For example, "restraint" doesn't include devices that hold the patient for the purpose of routine physical examinations or diagnostic tests, or to protect the patient from falling out of bed. However, the CMS regulations do address the patient's right to be "free from restraint or seclusion of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff."

"This may be causing more problems if not clearly and carefully read, since the basic intent is to protect patients from inappropriate restraint practices — not those that are clearly intended to keep the patient from harm," says Muller Smith.

Once again, documentation is a key issue, says Muller-Smith. "If a patient does become disruptive or a danger to the staff or himself, the other guidelines become important," she says. "Communication with the physician, using least restrictive methods first and close monitoring of the patient while restrained, must be documented." ■



Share automation-enabled error stories with staff

Task management to become increasingly important

By Patrice Spath, RHIT
Brown-Spath & Associates
Forest Grove, OR

In a perfect world the people who care for patients would never make a mistake and the operations of a health care facility would be under complete control at all times. There would be no unplanned, undesirable events, and no accidents, incidents, or inefficiencies. Unfortunately, such perfect control does not exist. Every human action taken in the provision of health care services is an opportunity for error. An action may be a visible act, such as

raising the patient's bedrails; an internal process, such as reading the patient's health record; or even a lack of activity, such as omitting the procedural step of checking the patient's allergy history.

A common patient safety improvement strategy is automation. Automation refers to a wide range of technological advances that are used by health care professionals during the provision of patient services. Automation can be divided into two classes: perceptual devices and controlling devices. Perceptual devices help practitioners better understand the environment. For example, an automated telemetry device that emits a signal when a patient's heart rhythm is erratic helps people know that the patient is in need of immediate assistance. The telemetry device does not control the patient's heart rhythm. Another general type of automation is used for controlling purposes. This type of automation contrasts with the perceptual device because it enhances the practitioner's ability to diagnose or treat the patient, rather than merely perceive the patient's current state. An example of a controlling device is a computerized order entry that prevents the practitioner from ordering a medication to which the patient has an allergy. Implantable pacemakers are automated devices that actually control a patient's heart rhythm. Automation includes, but is not limited to: electronic records, electronic communication, electronic patient monitoring equipment, electronic medication dispensing devices, computerized decision support systems, physician order entry, web-based applications, and hand-held wireless devices.

Compared with other industries, health care has been slow to embrace new technologies. This has resulted in avoidable errors and, in some instances, significant patient harm. Public sentiment and external forces such as the Leapfrog Group have become a catalyst for adoption of automated solutions to patient safety problems. It's true that automating patient care tasks can potentially diminish common slips or mistakes. However, automation itself introduces a different class of hazards into the health care workplace. Health care professionals must understand the risks of automation-enabled errors so that significant problems can be avoided.

The addition of automated devices may create the opportunity for errors that had not been possible in the past or increase the chance of previously existing errors to occur. The use of

CE *questions*

1. Which is recommended regarding quality professionals and performance measures?
   A. "Shadow" pay-for-performance projects to gain insights from other organizations.
   B. Participate in field testing of proposed measures.
   C. Respond on behalf of your organization when public comment is requested.
   D. All of the above.
2. What did a recent study by Solucient report regarding performance improvement and organizations?
   A. Hospitals with good performance improvement infrastructure didn't follow evidence-based practices.
   B. Hospital leadership practices did not correlate at all with the use of evidence-based care.
   C. There was a link between evidence-based care and goals set by hospital leadership.
   D. Hospitals with good leadership didn't give evidence-based care.
3. Which of the following is accurate regarding new CMS requirements for restraint and seclusion?
   A. No notification is needed for deaths potentially related to restraint which occur over 24 hours later.
   B. Staff must document in the patient's medical record the date and time a restraint-related death was reported to CMS.
   C. A physician is the only practitioner who can conduct the evaluation required within an hour of a patient being restrained or secluded.
   D. It is no longer necessary to document the reason for restraint.
4. Which must occur when a patient dies while being restrained or in seclusion, to comply with CMS requirements?
   A. The case should be evaluated to determine if it meets the CMS definition of a reportable event.
   B. case should be reported within 30 days.
   C. Prompt evaluation is not needed if no immediately apparent safety issues are identified.
   D. The hospital can wait for completion of its root cause analysis investigation to report the event.

Answer Key: 1. D; 2. C; 3. B; 4. A

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

automation may make task management more difficult for caregivers, possibly leading to unsafe conditions. Task management refers to the process by which a human manages his or her available sensory and mental resources in a dynamic, complex, safety critical environment in order to accomplish multiple tasks that are competing for his or her limited quantity of attention. Many health care practitioners work in highly complex or rapidly changing environments (e.g. intensive care unit, emergency department, operating room, emergency medical services, etc.). In these environments people must prioritize tasks because they do not possess the necessary resources to simultaneously execute all the tasks that demand their attention. Introduction of automation into these environments can create new opportunities for errors. Automated systems can:

- Increase demands on users' memory.
- Cause users to be uncertain as to where and when they should focus their attention.
- Make it difficult for users working in teams to share the same situational awareness.
- Impair mental models of the system.
- Increase workload during high-demand periods.
- Limit the users' ability to develop effective strategies for coping with task demands.
- Increase stress and anxiety.
- Increase the potential for confusion.

Even when automation works as intended, the systems that support the automated processes can fail. Some hospitals have invested in electronic bar coding systems for medication administration. All patient medications are labeled with the patient's unique bar code identification (ID).

No medication is supposed to be given until the patient's ID is scanned with a portable scanner and found to match the bar code on the medication. If there is not a match, medication administration is delayed until the problem is resolved.

This sounds like a fairly foolproof system; however, there are numerous anecdotes of how caregivers are using "workarounds" or shortcuts that over-ride the safety aspects of these systems. Despite technological advances, preventing mistakes will always depend on the vigilance and safe practices of individuals. Human carelessness or noncompliance with safeguards can render useless the very systems designed to avert mistakes.

Automation presents no clear detriment to patient safety. However, with the addition of any new technology comes the potential for new types of human errors and system failures. For instance, an error during patient registration might be perpetuated throughout the hospitalization by the information systems and be more difficult to correct than with paper-based systems. The safety problems that are introduced by new technologies are not insurmountable.

It is important that quality managers gather information about automation-induced errors and share that information with caregivers. Use storytelling, based on incidents that have occurred in your facility, to constantly remind staff of the

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

■ Learn from the close calls of other organizations

■ How to use P4P to stimulate quality improvement

■ Make your hospital a "testbed" for piloted measures

■ Obtain the skills quality professionals can't do without

safety hazards of automated patient care devices. By learning about these errors, staff will soon discover that automation can create new mishaps that are potentially more serious than those we are seeking to avoid. Vigilance and continued analysis of the cause of errors is important. ■

Joint Commission posts potential NPSGs

The Joint Commission on Accreditation of Healthcare Organizations has posted potential 2008 National Patient Safety Goals (NPSG) requirements and implementation expectations for field review by home care agencies.

Potential NPSGs considered for home care include:

- Addition of new requirements related to anticoagulation therapy as part of the goal to improve medication safety.
- Addition of a new goal to prevent patient harm associated with health worker fatigue.
- Addition of a new goal to prevent catheter and tubing misconnections.

The potential goals will be posted through Jan. 26, 2007. Go to www.jointcommission.org/Standards/FieldReviews/ to see the potential goals and the field review form. ■

CMS expands preventive service coverage

The Centers for Medicare & Medicaid Services (CMS) has expanded coverage for preventive services such as diabetes screening. Beginning Jan. 1, 2007, CMS is increasing payments for services that affect people with diabetes. Payments to physicians for some of the most frequently billed face-to-face doctor/patient services has increased and access for rural and underserved areas also has been enhanced. Preventive services, such as abdominal aortic aneurysm screening, have been added to the initial Medicare exam and colorectal screening procedures have been excluded from the Part B deductible. For more information on preventive tests covered by CMS, go to www.cms.hhs.gov/partnerships/downloads/diabetesupdate.pdf. ■