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## Letter from VP, Physician Operations, Don Lloyd

### WHAT ARE THE MEDICARE EHR INCENTIVES IN THE STIMULUS PACKAGE?

Medicare incentive payments will be based on an amount equal to 75% of the HHS secretary's estimate of allowable charges, up to \$18,000 for the first payment year. Practices are eligible to report first year data for payment starting as early as January 2011 for payment in 2011. The sum is \$15,000 if the first payment year is 2013 and \$12,000 if the first payment year is 2014. No matter what the calendar year, the payments from thereon are \$12,000 in year two; \$8,000 in year three; \$4,000 in year four and \$2,000 in year five. Each qualifying physician in your medical group can receive a maximum of \$44,000 over a five year period. The last year you can receive payments is 2016.

### Who is eligible for the incentives?

Eligible physicians are defined as medical doctors, dentists, podiatrists, optometrists and chiropractors. Hospital-based physicians such as pathologists, anesthesiologists, emergency physicians or hospitalist are not eligible for the EHR incentives. Physicians practicing in government designated health professional shortage areas, can receive a 10 percent additional payment.

To qualify for Medicare incentives, your practice must be a "meaningful" EHR user. Your EHR program must use the following:

- E-prescribing
- Demonstrate information exchange
- Report clinical quality measures

If your practice does not adopt a qualifying EHR, you will be penalized.

Beginning in 2015, CMS, the Centers for Medicare & Medicaid Services, will reduce Medicare payment for physicians' services who are not meaningful EHR users. The reductions are as follows:

- 2015: 1% reduction in the Medicare allowable
- 2016: 2% reduction
- 2017: 3% reduction

HHS is authorized to increase penalties further beginning in 2019, but they cannot exceed 5%. If you are interested in learning more about the EHR incentives, please contact Magnolia Practice Solutions at 662.293.1688.

Respectfully,

Don Lloyd, VP, Physician Operations



COMPACT ACTION BRIEF: A Roadmap For Increasing Value In Health Care

# Preventing Medication Errors: A \$21 Billion Opportunity

## Opportunity

Preventable medication errors: \$21 billion in wasteful health care spending



Nationally, serious preventable medication errors occur in 3.8 million inpatient admissions and 3.3 million outpatient visits each year.<sup>2,3</sup> In its report *To Err Is Human*, the Institute of Medicine estimated 7,000 deaths in the U.S. each year are due to preventable medication errors.<sup>4</sup>

### The High Cost of Preventable Medication Errors

#### Cost Data for Medication Errors

- Inpatient preventable medication errors cost approximately \$16.4 billion annually.<sup>5</sup>
- Outpatient preventable medication errors cost approximately \$4.2 billion annually.<sup>6,7</sup>
- Due to the lack of current and reliable data, the \$21 billion opportunity in wasteful healthcare spending represents a conservative estimate of the cost of preventable medication errors.

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## Solutions

7 million annual inpatient admissions and outpatient visits involving serious medication errors are potentially avoidable

Using care coordination strategies, interdisciplinary teamwork, and computer technologies can significantly reduce preventable medication errors. These interventions increase the availability of data, provide clinical decision support, engage the patient, and improve the accuracy of prescriptions.

### Patient Care Improvements

#### Improving Care Coordination

- **Communication:** Improved communication among physicians, pharmacists, and nurses prevented 85 percent of serious medication errors.<sup>15</sup>
- **Care Teams:** Including a pharmacist on routine medical rounds led to a 78 percent reduction in medication errors.<sup>16</sup>
  - Adding a pharmacist to a physician rounds team in an intensive care unit led to annual savings of \$270,000.<sup>17</sup>
- **Patient-Informed Decisionmaking:** Active engagement of patients and family caregivers with the care team, use of patient safety checklists, and

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## Drivers for Change

- ➔ Incentive Payments
- ➔ Care Coordination
- ➔ Accreditation/Certification

Overall reduction of medication errors requires a multipronged approach, ranging from financial incentives to organizational and care delivery improvements that address the root causes of these errors.

### Action Steps

#### Incentive Payments

- Assist health professionals and hospitals in adopting clinical IT tools (e.g., EHRs, e-prescribing, CPOE, and eMAR), achieving "meaningful use" standards (drawn from HIT Policy Committee recommendations), and earning federal incentive payments.
- Provide private and state payer-based financial incentives to:
  - Providers using evidence-based practices that reduce medication errors.
  - Providers using EHRs that generate key patient medication information (e.g., active medication lists, medication allergy lists).

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## COMPACT ACTION BRIEF: A Roadmap For Increasing Value In Health Care

### Preventing Medication Errors: A \$21 Billion Opportunity

#### Opportunity continued

##### Why Do Medication Errors Occur?

###### Prescription Mistakes

- 37 percent of preventable medication errors result from dosing errors.<sup>5</sup>
- 11 percent of preventable medication errors result from drug allergies or harmful drug interactions.<sup>9</sup>
- 22 percent of preventable medication reconciliation errors occur during admissions, 66 percent during transitions in care, and 12 percent during discharge.<sup>10</sup>
- Due to the high volume of medications dispensed, approximately 100 undetected dispensing errors can occur each day.<sup>11</sup>

###### Fragmentation of Care

- A survey of primary care physicians found that only 13 percent of them communicated with a pharmacist regarding new prescriptions.<sup>12</sup>

###### Lack of Information Technology (IT) Infrastructure

- Only 4 percent of physicians reported having EMR systems that were described as fully functional and had a prescribing function.<sup>13</sup>
- 32 percent of physicians in ambulatory care settings use electronic prescribing.<sup>14</sup>

#### Solutions continued

increased awareness of publicly reported hospital safety records can help reduce preventable medication errors.

###### Reconciling Medications

- **Pharmacist Follow-Up:** Patients who received pharmacist follow-up calls were 88 percent less likely to have a preventable medication error resulting in an ED visit or hospitalization.<sup>18</sup>

###### Enhancing Technology Interventions

- **Electronic Prescribing:** e-Prescribing systems reduced medication errors by approximately 85 percent.<sup>19</sup>
  - Utilizing e-prescribing systems in ambulatory care settings netted cost savings of \$403,000.<sup>20</sup>
- **Bar Code Electronic Medication Administration System (eMAR):** Verifying the correct drug dosage with eMAR technology led to a 51 percent reduction in medication errors.<sup>21</sup>
  - Within a large academic hospital, the use of pharmacy barcodes led to annual savings of \$2.2 million.<sup>22</sup>
- **Computerized Physician Order Entry:** CPOE with clinical support reduced serious medication errors by 81 percent.<sup>23</sup>

#### Drivers for Change continued

- Encourage providers to participate in the CMS Electronic Prescribing (eRx) Incentive Program.

###### Care Coordination

- Adopt Joint Commission recommendations for medication reconciliation, ensuring that medications are reconfirmed and reviewed with the patient at each transition in care.<sup>24,25</sup>
- Empower patients and family caregivers to manage their medications by keeping PHRs and personal medication lists and informing them about medications' purpose, effects, and side effects.<sup>26</sup>

###### Accreditation/Certification

- Have specialty societies encourage providers to participate in the CMS Physician Quality Reporting Initiative (PQRI) for documenting current medications in the medical record.
- Set standards and require public reporting of medication errors as a condition for state licensure.
- Certify providers as trained and proficient in teamwork.

This series was produced in collaboration with NEHI ([www.nehi.net](http://www.nehi.net))

#### Notes

##### Opportunity

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## P and T at a Glance

### **Drug Shortages:**

**Demerol Injection** - This product is unavailable from the manufacturer. The manufacturer has not provided a reason for the shortage. We are unable to order any strengths of the ampules we usually have available. There is no definite date when these will be available. We have been able to sporadically get some strengths of Demerol, but supply is limited.

**Robaxin Injection** - This product is unavailable. The manufacturer has not given a reason for the shortage and does not have an estimated release date. We have a very small amount available at this time, but once it is used we will not have any of this product until the manufacturer can

supply it. Injectable alternatives include Norflex (orphenadrine) and injectable benzodiazepines. The oral product is still available and is unaffected by this shortage. Oral therapy should replace parenteral therapy as soon as clinically possible.

**Darvocet/ Darvon** – As you have probably heard by now, the FDA has requested that manufacturers of propoxyphene cease production due to adverse cardiac effects. This product has been removed from formulary at MRHC and returned to the wholesaler. This product will no longer be dispensed to patients at MRHC. There are many oral alternatives to Darvocet and Darvon.

### **Antibiogram:**

New antibiograms have been printed and published. One will be placed in each physician mail box so be looking for these. As always there will be extra copies available in the pharmacy department. The antibiogram data covers the time period from September 1, 2009 through August 31, 2010.



## Corporate Compliance

### ADVANCE BENEFICIARY NOTICE

An Advance Beneficiary Notice ("ABN") is a written document that a Medicare provider gives to a patient before certain services are provided. It is a waiver of liability that shifts the financial responsibility directly to the patient. The provider provides this Notice when it believes that Medicare will not pay for some or all of the services because they are judged to not be "reasonable and necessary," and the ABN is generated automatically upon the patient registering for the service/procedure. Providers who expect payment of services to be denied by Medicare must advise the patient before services are given that the patient may be fully responsible for the payment. This does not always mean that the patient must pay for the services personally. The patient could use other insurance coverage such as a group plan, Medicaid, or other federal or non-federal payment source to pay for the service. The provider is required to give this notice in a timely fashion every time it thinks that Medicare will deny payment. If the provider does not provide a valid ABN in situations where one is required and Medicare does not reimburse for the service and/or procedure, MRHC will not be allowed to then bill the patient.

The ABN form we use here at MRHC is CMS-R-131. The form is separated into the following items:

1. Patient identification information;
2. The notice that Medicare may not pay for the specific service being performed;
3. The item or the service being denied;
4. The reason the provider is predicting Medicare will deny payment;
5. The estimated cost of the service;
6. The selection of Options 1, 2 or 3 indicating whether to go ahead with the item or service or not;
7. The date and patient or patient representative's signature.

We really need your help so that we can provide the needed services and/or procedures for your patients. There are certain NCDs (National Coverage Determinations) and LCDs (Local Coverage Determinations) that show what Medicare has determined as the medical necessity requirements for services and/or procedures which MRHC performs. The NCDs and LCDs can be accessed at the following website: <https://www.cms.gov/medicare-coverage-database/>. For example, if you put the CPT code for an Echo, which is 93306, into this Medicare

database, it will generate the diagnoses codes that meet medical necessity either through a NCD or a LCD. You can then compare this to the diagnoses that you have documented in your medical record. Please understand that we are not telling you that you cannot order tests that do not meet Medicare's medical necessity guidelines, however, this will generate an ABN and the patient then has the right to decline the service and/or procedure.

We are attempting to check medical necessity at the time of scheduling so that we can contact your office to see if there are additional diagnoses documented in your medical record that will support medical necessity as outlined in the NCDs or LCDs. If there are, our clerk/tech will then ask that this diagnosis(s) be placed on your order and refaxed. However, unscheduled tests cannot be checked for medical necessity until the patient arrives at registration.

Our ultimate goal is to provide all of the services and/or procedures to your patients in a timely manner. Please contact me if you have any questions regarding the ABN process.

Renee Bullard, 293-7673  
Compliance/Risk Management