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# Flex Program News

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## 340B Program: A Possibility for CAHs?

The 340B Program is a federal program that enables disproportionate share hospitals (DSHs) to purchase drugs at a discount. It is administered by the Pharmacy Affairs Branch of HRSA. Hospitals with a DSH adjustment greater than 11.75% are eligible for the program, and may save an average of 25% on all outpatient pharmacy purchases.

Of 56 hospitals qualified under the current program, 19 are in North Carolina. One of them, a hospital with 19 acute care beds that does a large volume of outpatient oncology, initially estimated a cost savings of slightly more than 1 million dollars per year. Early results seem to support the estimate. The median among all participating hospitals in North Carolina is closer to half a million dollars per year.

Even though the program has been around for approximately ten years, it wasn't until the new provisions of the Medicare Modernization Act of 2003 that rural hospitals could qualify for a DSH of up to 12% and therefore be eligible for 340B. Critical access hospitals (CAHs) are not eligible for the 340B Program because the legislation clearly states that program eligibility is based on the DSH percentage. CAHs are not entitled to receive DSH payments; therefore, the percentage is not computed for CAHs.

Why are CAHs excluded from this program? Many believe it was an unintended consequence of the 2003 legislation, and a simple amendment to the statute is all

that would be required to rectify the situation. The same data from the cost report that determines the DSH percentage for 'prospective payment system' hospitals is also reported by the CAH. The hospital's fiscal intermediary, if required, could just as easily determine the "prospective DSH percentage" for the CAH. It would be understood that the DSH computation for CAHs is to determine 340B eligibility and not for payment purposes. Interested parties in Oregon and other states are talking with their members of Congress and, hopefully, a future *Flex Program News* story will soon announce that the oversight has been resolved.

Special thanks to Serge Dihoff, North Carolina Office of Rural Health and Jeff Spade, North Carolina Hospital Association, for this information.

Application materials and guidelines for the 340B program are posted on the Pharmacy Affairs website, <http://bphc.hrsa.gov/opa/default.htm>. (The 'Disproportionate Share Hospital' link is the best starting point.) The site specifies the eligibility criteria, the application process, and the required certifications, FAQs, databases and the various rules and regulations.

The Public Hospital Pharmacy Coalition, [www.phpcrx.org](http://www.phpcrx.org), is the primary advocacy resource for DSHs and the 340B program. The '340B Drug Discount Program' link is the most informative. The site includes sample application letters, policy briefs and an excellent summary of the 340B criteria.

## Oregon Hospital Quality Awards

*Recognizing Oregon hospitals for excellence and achievement in inpatient care*

The Oregon Office of Rural Health, in collaboration with OMPRO and the Oregon Association of Hospitals and Health Systems (OAHHS), is pleased to announce this call for applications for the *2005 Oregon Hospital Quality Awards*.

The awards will recognize hospitals for excellence in inpatient care and for improving care using innovative methods or tools. All eligible hospitals must demonstrate improvement in the quality measures for one or more of the clinical areas recognized by the Centers for Medicare & Medicaid Services (CMS): [acute myocardial infarction](#), [heart failure](#), [pneumonia](#), and [surgical infection prevention](#).

Hospitals are eligible for awards in one of two categories:

- **Award of Excellence**, for hospitals achieving improvement in all [quality improvement measures](#) in at least one clinical area.

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- **Award for Innovation**, for hospitals achieving improvement in all [quality improvement measures in at least one clinical area](#) using an innovative approach or tool set.

All hospitals must submit a completed application and provide data that fulfills one of two criteria for each quality measure:

- achieve and sustain a 90 percent or higher performance rate for discharges in four consecutive quarters
- demonstrate a 10 percentage-point improvement from baseline to re-measurement

The Office of Rural Health and OMPRO will present the awards at the Annual Oregon Rural Health Conference, in Sunriver, November 3 - 5, 2005. OMPRO will create a press release about each hospital's award and will announce the winning hospitals and their improvement projects in Quality Quarterly, OMPRO's newsletter, and on the OMPRO web site, [www.ompro.org/index.html](http://www.ompro.org/index.html).

Applications and measure data are due to OMPRO by **May 31, 2005**. To request an application packet or for more information, call Connie Mueller, RN, CPHQ, quality improvement specialist, at 503-382-3964.

Sponsored by [OMPRO](#), [Oregon Association of Hospitals and Health Systems](#), and the [Oregon Office of Rural Health](#).

## QI Improves Cardiac Services for Region

Quality improvement encompasses many different activities for critical access hospitals (CAHs). For Becky Larsen, Quality Improvement Director for Samaritan Pacific Communities Hospital and Samaritan North Lincoln Hospital, it means coordinating a multi-hospital project that optimizes the care of patients suffering from acute coronary syndrome.

In 2003 there was a perception that cardiac patients taken to either Samaritan Pacific Communities Hospital (SPCH) in Newport or Samaritan North Lincoln Hospital (SNLH) in Lincoln City were not being assessed and transferred rapidly enough to the cardiac care unit at Good Samaritan Regional Medical Center (GSRMC) in Corvallis. Melissa Swancutt, ICU and Cardiac Rehabilitation Nurse Manager at SPCH, proposed that a team be formed to address this concern.

This perception was important to Samaritan Health Services, as a higher proportion of the patient population in Lincoln County is elderly, and therefore more prone to cardiac problems. Medical professionals also know that rapid identification of symptoms, access to treatment and definitive treatment in a cardiac cath lab yield the best outcome for a patient.

A small group of stakeholders including SPCH and SNLH ICU and ED Nurse Managers, ENS personnel, physicians and the Cardiovascular Consultants of Oregon at GSRMC, examined the medical records of acute coronary syndrome transfer cases from the 2003 calendar year. Assessing each case step-by-step, all data points were measured and the process was broken down minute-by-minute to determine current cardiac practice and transfer patterns. After studying cases at

each hospital, the group found ample opportunity for improvement.

This study revealed that patients' average time to seek treatment for symptoms was much longer than expected. The assessment time at the initial hospital, both SPCH and SNLH, was quite varied and not specific to a particular type of acute coronary syndrome. The length of time from decision to transfer and requesting an ambulance through local dispatch was prolonged, as was the time interval for the ambulance to pick up the patient at the hospital. However, drive time for the ambulance to GSRMC was shorter than anticipated and, upon arrival, transfer to the cath lab was immediate.

The primary stakeholders decided to convene a larger taskforce, which became known as the Cardiac Performance Improvement Team, or the "PI Team." "Participants in the PI Team include physician champions from affected hospital departments, ICU managers, and the Cardiovascular Consultants of Oregon, our cardiologist group at GSRMC," explained Larsen. Local emergency medical services personnel and a community relations representative were also members of the team.

The Performance Improvement Team addressed the clear need to conduct a community education program to get patients to seek care at the first sign of a heart attack. By increasing the public's awareness of cardiac symptoms and how rapid access to care increases the rate of survival, time between the incident and arrival at the hospital could be shortened. Education also targeted local physicians, encouraging them to educate their patients on preventive health services, symptoms of heart attack, and the available care options. The community education project involved health screenings and interviews of experts on local radio

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shows and in newspaper articles, press releases, and patient education materials. Cardiac care is one of Samaritan Health Services' signature services, and they devoted many resources to the public education campaign.

To shave off assessment time during the initial emergency room visit, the PI Team put into practice standardized cardiac care modules at both SPCH and SNLH. The emergency rooms now use standard tests and data points to determine if a patient will need to be transferred. "With these assessments we can determine quickly if the patient will have to be transferred or not," notes Larsen of the new emergency room algorithm assessments. Rapid treatment options and stabilization procedures that meet EMTALA requirements and compliance issues are now standard as well.

The EMS community addressed the availability of vehicles to respond to hospital transportation requests by adding an additional ambulance. This addition in Lincoln County helped to eliminate delays in transferring patients to GSRMC. "The EMS community really stepped up quickly to this issue, and decreased one delay point," says Larsen.

"There is a lot of excitement around the project, and an unmatched spirit of cooperation throughout the PI Team,"



*A team of physicians, nurses, emergency medical personnel, and quality improvement staff from Samaritan facilities, Pacific West Ambulance, and Central Oregon Coast Fire & Rescue formed the Cardiac Performance Improvement Team in 2003 to evaluate patient awareness, hospital treatment practices, and patient transfer processes in Lincoln County. The team's primary goals are to educate the public and staff, optimize patient care, improve treatment time, and decrease transfer time. Members of the team, pictured from left, are Vince Stafford-EMS, Tony Mooney-EMS, Kim Montagne-NP, Melissa Swancutt-RN, Diane Craft-RN, Willa Espinoza-RN, Russ Harper-EMS, and Randall Bream-M.D. Other members of the team include Dr. M. Halferty, Dr. J. Watkins, Dr. A. Forsyth, Dr. R Oksenholt, and Becky Larsen-RN.*

said Larsen. "Members of the PI Team are pleased to see the changes in cardiac care at all three hospitals. It is very exciting to be working with a multi-hospital project and to see our actions getting results."

The project is still very new, and will continue through 2007. Each quarter data is re-assessed to improve the timing of cardiac procedures and make the process more efficient. "Cardiac care is a rapidly evolving field and continued diligence related to quality will be a concern long after this particular project concludes," notes Larsen. The quality improvement project taken on by these CAHs has changed the level of care for patients in the region. Melissa Swancutt has been invited by the American Hospital Association to present this initiative to the members of the National Rural Health Governing Council in Portland at the end of February.

For more information on the Samaritan Health Services Cardiac Performance Improvement Team please contact Becky Larsen, Quality Improvement Director for Samaritan Pacific Communities Hospital and Samaritan North Lincoln Hospital, at [blarsen@samhealth.org](mailto:blarsen@samhealth.org). Information

on Quality Improvement for critical access hospitals is available on the Office of Rural Health web site, [www.ohsu.edu/oregonruralhealth](http://www.ohsu.edu/oregonruralhealth), or by contacting Sandra Assasnik at [assasnik@ohsu.edu](mailto:assasnik@ohsu.edu).

## Don't Forget...

The 3rd Annual NW Regional Critical Access Hospital Conference: CAH Quality & Sustainability is March 23, 2005 at the Red Lion Hotel at the Park, Spokane, WA. Brochures are available at [NW Regional Critical Access Hospital Conference](#) (pdf). For more information, contact Cathi Lamoreux, [lamoreux@wsu.edu](mailto:lamoreux@wsu.edu), 509 358-7509, or 800 279-0705.