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IPRO

Experts in Defining and Improving the Quality of Health Care

Health Care Quality Watch

MONTHLY NEWS BRIEFS FOR MANAGERS AND OPINION LEADERS

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Congress should create a National Quality Coordination Board (NQCB), housed at the highest levels of the U.S. Department of Health and Human Services, with the power to mandate the measures to be used to evaluate the performance of providers across all settings, according to a new report from a blue ribbon panel of the Washington DC-based Institute of Medicine. Modeled on the Federal Reserve Board, members of the NQCB would be appointed by the President, with terms staggered to avoid the influence of political parties. With annual funding in the range of $100-200 million, the NQCB would constitute "a relatively small investment with great potential to enhance the value and improve efficiency throughout the health care delivery system," according to report authors. The report, released December 1st, recommends that once empanelled, the NQCB immediately ratify a starter set of existing performance measures addressing ambulatory care, acute care, managed care, long term care, end-stage renal disease, mortality and functional status. The report says that in general the quality measures now in use throughout the U.S. are too "provider-centric" and that more measures are needed that address systems-change and that are population-based. The report is the first in a series of three addressing health care quality issues. Forthcoming volumes will evaluate the Quality Improvement Organizations and the future of Pay-for-Performance Initiatives. For more information, visit IOM's Web site at *www.iom.edu*.

Medicare's Hospital Payment Monitoring Program (HPMP) includes review/abstraction of medical records. These review results are used to compute national and state payment error rates, which are monitored by the Centers for Medicare & Medicaid Services (CMS). The Clinical Data Abstraction Center (CDAC) requests the medical records from the hospitals. The hospitals must provide these medical records to the CDAC (Computer Sciences Corporation (CSC) (DynKePRO) within thirty days of the date of request, i.e., the "due date." When a medical record is not received at the CDAC within the 30-day time frame, a technical denial must be issued by IPRO. The technical denial notice alerts the Fiscal Intermediary to recover payment from the hospital based solely on the fact that the medical record was not provided for review. Several actions have been initiated by IPRO over the last few years to remind hospitals of the technical denial process and to encourage timely submission of requested medical records. These have included administrative memoranda, written correspondence, distribution of hospital-specific lists of cases that resulted in technical denials, and follow-up telephone calls to outlier hospitals. Unfortunately, many hospitals in New York continue to receive technical denials. These technical denials are a contributing factor in the increasing payment error rate for New York. Currently the statewide error rate has risen to nearly 7%, necessitating more aggressive actions to eliminate these errors. Therefore, IPRO will continue to monitor all technical denials on a quarterly basis. Hospitals that fail to submit records in a timely fashion will be asked to submit process improvement plans. To read the entire November 16th "Administrative Memo" on this topic, visit the Professionals Section of *www.ipro.org*. For additional information, contact Dr. Kathy Terry, Senior Director, Data Analysis & Evaluation, Medicare/ Federal Health Care Assessment at 516-209-5226.

As part of its 8th Scope of Work contract with the Centers for Medicare & Medicaid Services (CMS), IPRO invites hospitals across New York State to join one or more collaborative "Identified Participant Groups" (IPGs). Four IPGs will be established, each focusing on a discrete quality improvement initiative: Appropriate Care Measures (ACM); Surgical Care Improvement (SCIP); Health Information Technology (HIT); and Rural Organizational Culture Change (OSCC). Participating hospitals will receive ongoing support and technical assistance from IPRO at no charge, and have the opportunity to network with other institutions via JENY, IPRO's online community of practice. Hospitals may elect to participate in any or all of the first three IPGs; the OSCC IPG is limited to rural or critical access institutions. For more

information about the program, currently in the recruitment phase, visit *http://providers.ipro.org/index/focused-qi-ipg*.

Top performing hospitals participating in the Premier Hospital Quality Incentive demonstration are sharing $8.85 million in Medicare bonus payments, based on first-year results in the national pay-for-performance initiative. Overall, for the more than 265 hospitals participating in the demonstration, composite quality improvement scores have improved in all five areas of measurement (management of acute myocardial infarction, heart failure, pneumonia, bypass surgery and hip and knee replacements). Hospitals performing in the top 10 percent for one of the conditions received a two percent bonus on Medicare payments for that condition. Hospitals in the second 10 percent get a one percent bonus. In year three of the demonstration, the worst performing 10 percent of hospitals are slated to receive a two percent reduction in payments for a given condition, with hospitals in the next lowest performing group receiving a one percent reduction in Medicare payments in a given area. "We are seeing that pay-for-performance works," said CMS Administrator Mark B. McClellan, MD, PhD, in a November 14th statement. "We are seeing increased quality of care for patients, which will mean fewer costly complications — exactly what we should be paying for in Medicare." Of the nine New York hospitals on the list of top performers, four are members of the North Shore/ Long Island Jewish Network (University Hospital at Glen Cove, Long Island Jewish Medical Center, University Hospital at Plainview and Staten Island University Hospital). The others are Lakeside Memorial Hospital in Brockport, Arnot Ogden Medical Center in Elmira, Bon Secours Community Hospital in Port Jervis, Rochester General Hospital in Rochester and St. Anthony Community Hospital in Warwick. For more information on the initiative, visit *www.cms.gov*.

Two new reports examine the short and long-term prospects for public reporting of physician performance on quality measures as well as using those findings for purposes of "pay-for-performance." The first, "Using Administrative Data to Assess Physician Quality and Efficiency" examines public and private-sector approaches to measuring physician performance, using administrative data and data derived from medical records. Authors suggest that widespread adoption of electronic health records in a way that permits standardized reporting "may take a decade or more" and that there is a "near term interest" in using easily available administrative data to analyze physician performance. The second report, "Aligning Physician Incentives" analyzes the way performance reporting has evolved in California, and examines such topics as the degree to which measure sets analyze the performance of individual physicians versus the groups in which they operate. The second report also suggests linking physician pay-for-performance bonuses with direct investment in adoption of clinical information systems. Both reports were developed by the Pacific Business Group on Health and Lumetra, the Quality Improvement Organization (QIO) for the state of California. Copies are available for download at *www.pbgh.org*.

Nearly one in three visits to an emergency room in the U.S. is for care that isn't urgent, and the rates at which Americans use emergency rooms increased by 26% between 1993 and 2003, according to a new federal report designed for consumers. The Congressionally-mandated *Health Report to the American People,* produced by the nonpartisan Citizens' Health Care Working Group convened by HHS Secretary Michael O. Leavitt, reports that African-Americans used emergency rooms at a rate that's 89 percent higher than whites, although use for non-urgent problems was comparable for both groups. The use of emergency rooms was found higher for Medicaid recipients than for private-pay patients, Medicare beneficiaries and individuals with no insurance at all. The report is available at *www.CitizensHealthCare.gov*. Readers are urged to respond to the report in writing. The Group's telephone number is 301-443-1502.

IPRO CEO Theodore O. Will and Senior Vice President Harry M. Feder have been named Fellows of the New York Academy of Medicine. Founded in 1847, the New York Academy of Medicine works to improve public health in urban environments through research, education, advocacy and prevention. Will and Feder join the ranks of several IPRO staffers who are Academy Fellows: Jack A. DeHovitz, MD; Frank E. Iaquinta, MD; and Pascal J. Imperato, MD, MPH & TM. Visit *http://www.nyam.org* for information about Academy initiatives.

Health Care Quality Watch is published monthly by IPRO's **Department of Communications & Corporate Development.** IPRO is a not-for-profit organization that works with public and private sector clients to analyze and improve the quality of health care. For further information, contact:

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