Quality is Indicated

By

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Introduction: Quality Indicators in the News

A February 22, 2005, Chicago Tribune article reported that an American Health Quality Association study had found that roughly half of major surgery patients did not receive appropriate prophylactic antibiotic treatment while they were in the hospital. According to the report, hospital were studied for such quality indicators as receiving the right drug, receiving the drug within 60 minutes of incision, and stopping drug within 24 hours after surgery.

A study published in July 27, 2005 issue of the Journal of the American Medical Association reports that preventive care services provided by physicians vary by practice size and revenue sources. The researchers used as quality indicators for their study the provision of diabetic eye exams to older patients, mammograms, colon cancer screenings, and flu and pneumonia vaccinations. The study found that practices with fewer Medicaid patients were more likely to provide preventive services. Larger practices, graduates of U.S. or Canadian medical schools, and practices with technology to generate preventive care reminders were also more likely to provide preventive care.

Hospital Compare

Although these two examples are not directly related to rehabilitation, they are typical of a trend that will soon overtake all aspects of healthcare delivery: mandated quality indicators. For inpatient units and outpatient departments of acute care hospitals the trend has already arrived. On April 1, 2005, CMS launched its Hospital Compare Website. Like Nursing Home Compare and Home Health Compare, Hospital Compare allows consumers to compare how participating hospitals performed on certain quality measures. The quality indicators that consumers will use to compare hospitals on the web site are for heart attacks, heart failure care, and pneumonia care.

Superficially these three diseases would not seem to relate to rehabilitation. However, one must consider how consumers will use the Hospital Compare Web site. Just as with the Nursing Home and Home Health Compare Web sites, consumers will utilize the site to make choices about elective visits to hospitals regardless of their specific health problem. The number of patients coming into the hospital by virtue of a determination made from Hospital Compare, in turn, will affect referrals from other hospital units and departments to rehabilitation.

The Physician Focused Quality Initiative

Of more immediate relevance to outpatient rehabilitation providers is CMS' launch of its Physician Focused Quality Initiative. This initiative will impact any rehabilitation provider that works within a physician's practice, such as a rehabilitation clinic, or relies on referrals from physicians. The Initiative Includes:

- The Doctors Office Quality Project
- The Doctors Office Quality Information Technology Project
- Several Other Demonstration Projects and Evaluation Reports

According to CMS, the Doctors' Office Quality (DOQ) project "is designed to develop and test a comprehensive, integrated approach to measuring the quality of care for chronic disease and preventive services in the doctors' offices." The Medicare Quality Improvement Organizations (QIOs) in Iowa, California, and New York, under the auspices of CMS, are involved developing the DOQ Project's quality indicators and data collection standards. The DOQ's measures focus on chronic conditions and preventive care that are prevalent in the Medicare population and treated in primary care. The DOQ project goals are to assess quality of care in the doctors' offices, and assess the feasibility of collecting data using a defined quality measurement set.

The DOQ project will use a quality measurement set that is made up of three components:

1. Clinical Performance Measures for coronary artery disease, diabetes mellitus, heart failure, hypertension, osteoarthritis and preventive care;
2. A Patient Experience of Care Survey, which will include appointment access, continuity of care, communication, health promotion, interpersonal treatment, office staff, and integration of care; and
3. Physician Practice Connections (PPC), which will collect information from doctors' office staff on clinical information systems. This tool will evaluate three categories of standards:

    i. Clinical Information Systems
    ii. Patient Education Support and
    iii. Care Management

CMS states that, "The DOQ project will develop and test a measurement set that will assess quality in doctors' offices. This will lead to a standard measures set for use in doctors' offices." The Quality Indicators for DOQ Project will be measures of the percentage of chronic disease patients who receive various treatments and tests depending on the condition for which they are being treated.

The Physician Practice Connections utilizes three overlapping sets of standards to measure the effect of information technology on healthcare quality. Clinical information systems/evidence-based medicine standards are used to determine how the practice

uses information to keep track of patients' treatments, follow up on tests, check medications and use researched standards of care. Patient education and support standards are used to determine how the practice uses resources and referrals to help patients manage their own health and how the practice measures and improves quality, and care management standards are used to determine how the practice actively helps patients with chronic conditions and patients with very complex problems maximize their health and prevent hospitalization.

For rehabilitation providers who work in a physician’s office clinic setting, the impact in those states whose QIOs participate in the DOQ project is obvious. The physician’s office will focus on satisfying the mandated quality indicators, which in turn will bring a quality focus to the rehabilitation staff. Even rehabilitation providers who work outside the physician office setting will feel the effects of the quality project. A focus on preventative care quality will eventually affect the overall health of patients that the physician’s refer to after care providers. It remains to be seen whether this will result in more or fewer patients being referred to rehabilitation or whether the types of patient being referred to rehabilitation will change.

Pay-for-Performance: The Coming Wave

While the final impact of quality initiatives like the DOQ project and Hospital Compare on the rehabilitation industry remains to be seen, there is little question that a key component of the push for quality measures will soon overtake every aspect of the healthcare: Pay-for-Performance.

Government mandated pay-for-performance is now in the formative stages. On July 29, 2005, Senator Charles Grassley (R-Iowa) announced that he would introduce legislation that would apply pay-for-performance measures to Medicare broadly. Senator Grassley’s bill is modest in scope and would begin Medicare’s pay for performance efforts with an incentive approach. His bill would take 1 – 2 % of Medicare payments to hospitals and physicians and redistribute them to entities that meet quality benchmarks. The bill would require the Department of Health and Human Services to develop and implement value-based purchasing programs for Medicare. Hospitals would be rewarded for meeting threshold levels of quality.

As the push for quality measures grows, we can expect that pay-for-performance programs will grow both in scope and effect. At some point, healthcare providers will not only be rewarded for meeting quality indicators, they will be “punished,” probably by means of financial disincentives or even financial penalties, for failing to meet those measures. As the name, Pay-for-Performance suggests, those providers who score higher on the pay-for-performance quality measures will earn higher reimbursement from government programs like Medicare and Medicaid. Thus, compliance with the pay-for-performance mandated quality indicators will be crucial for financial solvency.

Moreover, as programs like Hospital Compare become more entrenched with the public, the quality indicators utilized by those programs will have indirect monetary effects on

healthcare providers. For physicians, consumers will look for staff membership in hospitals that score highly on the quality indicators when choosing a physician. Those physicians, in turn, will become the major source of referrals to rehabilitation.

Mandated quality indicators at some point will also form part of the conditions of participation for government programs. Medicare already requires hospitals to participate in QIOs, which review patient records for potential quality of care issues
It is likely that some or all of the quality indicators mentioned today will become standards for program certification by Medicare.

In sum, Quality Indicators will not only effect reimbursement and the ways in which healthcare is delivered, they will also directly affect a care giver's ability to participate in the healthcare industry.

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