

Ask the Experts

In this and future issues of MPM, we ask a panel of experts to comment on a pressing issue of the day. Watch for these panel discussions, and let us know if you have any suggestions regarding experts you would like to hear from or questions you would like to see addressed.

The Centers for Medicare & Medicaid Services (CMS) believes that the ability to measure and evaluate quality is important in the delivery of quality care, and is committed to developing reporting and payment systems that will support and reward quality. We asked our experts:

“How do you define and measure quality, and how does your measure of quality compare to the CMS measure?”



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TLC HealthCare™ Quality Improvement Organization Inc. currently monitors health care issues for over 20 health care entities across the United States. Instead of concentrating on how quality is defined, we assist long-term care facilities, skilled nursing facilities, hospitals, and other health care settings by consistently measuring and counting quality data over time. We then analyze and provide guidance in areas of concern. Thus, our focus is on the quality of the process rather than on the individual components of what is being analyzed.

Without computerization, the transfer of meaningful data to a central location is unlikely. Additional issues would arise that would further challenge the reporting and payment system. For example, if the quality of the process was not accurately established at the outset, you would see a shift in patient responsibility. Would the endocrinologist be rewarded for caring for the difficult-to-control diabetic patient who the internist sent to him? Would the family practitioner be held to the same standards as the internist for similar conditions?

The ability to collect this information requires time, education, expertise, and finances not usually available to the typical physician or group practice. In addition, the issue of resources would arise as the larger, well-established, integrated physicians' practices with computerization and data collection systems would be rewarded over those without such systems.

CMS can begin the process of quality improvement by paying for participation rather than paying for performance. There are too many variables that cannot be accounted for in the CMS process that would quickly derail the system. CMS needs to identify and measure a few established protocols. Preventive guidelines are the best way for them to do this. While CMS is interested in outcomes, the variables that need to be accounted for are too numerous for most physicians. By paying for participation, physicians could earmark funds toward computerization that would more easily advance the goals of “quality” care over time.



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The Joint Commission on Accreditation of Healthcare Organization (JCAHO) adheres to the widely accepted definition of quality as described in the 1990 Institute of Medicine

Report on Health Care Quality. It collaborates with others, particularly the Hospital Quality Alliance and CMS, to identify specific quality measures and priority areas for quality measurements. In addition, JCAHO supports greater transparency through the provision of valid and reliable information on health care quality via quality tools, such as “Hospital Compare.” Hospital Compare (www.hospitalcompare.hhs.gov) has quality measures on how often hospitals provide some of the recommended care to get the best results for most patients. The data displayed on Hospital Compare related to heart attacks, heart failure, surgical infection prevention, and pneumonia were identified and developed by multiple stakeholders, and are endorsed by the National Quality Forum (NQF).

Nearly 4,000 JCAHO-accredited hospitals nationwide collect data on these clinical measures. Information on these medical conditions, as well as on pregnancy and pregnancy-related conditions, is available without charge on “Quality Check®” (www.quality-check.org), the comprehensive consumer guide to nearly 15,000 JCAHO-accredited health care organizations and programs throughout the United States.



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Evercare provides health plans for our country’s aging, vulnerable, disabled, and chronically ill. We measure quality of care by desired health outcomes, and measure data most relevant for the population we serve. While in general, we support the efforts of CMS to define and publicly report quality measures for Medicare beneficiaries, some of the measures and outcomes we measure may be different from those collected by CMS.

1. Clinical quality indicators and outcomes: Our measures focus on the management of

multiple chronic illnesses, geriatric syndromes and comorbidities, restoration and preservation of function, quality of life, and comprehensive and continuous advanced care planning. For institutional members, we monitor 30 clinical indicators similar to the MDS-QIs developed by CMS, including the prevalence of falls, pressure ulcers, restraint use, weight loss, etc. Clinical indicators for community-based members focus on preventive services—vaccinations, screening for specific chronic illnesses, and assessment of risk for falls—as well as emergency room visits and hospital admission rates

2. Member/family and provider satisfaction: We regularly survey members and/or their families and physicians to determine their satisfaction with staff and programs.

3. Identification and reduction of avoidable medical costs: Our 20 years of experience in nursing home care shows that our approach to preventive and holistic care reduces hospitalizations and emergency room visits, demonstrably improves health outcomes, and decreases health care costs. The value of this approach has been well documented. One study showed that Evercare reduced hospitalizations by 45% and emergency room visits by 50%, while reducing the incidence of pneumonia, influenza, and other acute illnesses in nursing homes. Similar success has been achieved for members of our community-based plans.



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CMS does not have a single or simple approach to quality. It has a “quality improvement roadmap” that explicates the Institute of Medicine’s definition that “high-quality care is care that is safe, effective, effi-

cient, patient-centered, timely, and equitable.” ECRI, a nonprofit health services research agency, agrees. However, we also view quality as an attribute of a medical product, service, or culture. This is natural given our historic role in evaluating and comparing cost, safety, and performance of medical products, assessing clinical procedures, and providing guidance and information tools to reduce risks in health care delivery. The first 2 attributes—those relating to medical products and services—can be improved in more readily measurable ways than the third. Changing culture is more difficult to achieve in health care institutions or systems, just as it is in world politics, but it is more enduring than simpler changes. A political history of the last century, or a history of the delivery of medical services over the past 100 years, could be written from the perspective of cataloging successful and unsuccessful attempts at cultural change. At ECRI, we link creating a culture of quality with generating and deploying an unbiased evidence base for many product and service improvements, and with supporting the ability to instill and measure aspects of cultural change. A deceptively simple example of the latter is a recent project in which we supported the board of trustees of an extremely large health system that sought to catalog and continually monitor its vast array of quality initiatives. The effort engaged board executives and frontline clinical staff. Cultural change in this and other efforts is about altering mentality, as well as key structural and operational attributes of programs. Culture in medical care, or more broadly in society, is richly textured, cumulative, and self-sustaining. Real cultural change cannot be imposed through episodic and often disconnected quality improvement programs. We believe that CMS’ roadmap may contribute meaningfully to binding quality to culture through its direct impact and its influence on others. We will work so that ECRI’s initiatives do so as well. MPM