From the Editor

Quality Matters… In Fact It's All That Matters!

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As the Founding Executive Director of the University of the Sciences in Philadelphia's Health Policy Institute, Dr. Stefanacci is building on his recent tenure as a Centers for Medicare and Medicaid Services (CMS) Health Policy Scholar. In that role, he spent a year working on policy development and implementation of the Medicare Part D Pharmacy Benefit, particularly regarding access issues for frail elders.

Dr. Stefanacci has a long and passionate history in long-term care (LTC). Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes over a decade as a medical director of a large primary care private practice, a full risk provider group, a Medicare + Choice (M+C) HMO, and a Program for All-inclusive Care for the Elderly (PACE) initiative in Philadelphia.

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Dr. Stefanacci serves on the board of trustees at A.T. Still and previously for the National PACE Association. He also is an active member of the American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and American Geriatrics Society (AGS). Recently, he was recognized as an American Geriatrics Society Fellow (AGSF). In addition to writing and lecturing extensively, Dr. Stefanacci serves on the editorial boards of *Caring for the Ages, LTC Interface, Jefferson's Health Policy Newsletter, The Journal of Quality Healthcare,* and *Assisted Living Consult.*

Although most healthcare providers would state without question that their primary focus is quality, it increasingly appears not to be the case for some. Instead, the focus more and more is on dollars.

The Institute of Medicine (IOM)[1] continues to state that the quality of health care is poorer than it should be, and that progress in improving health care has been limited. Despite many promising findings from healthcare initiatives to date, quality improvement research is a relatively new field that rarely yields consistent results. Flaws in the currently used research literature and methods have been identified, but agreement on ways to address these flaws has been missing.

So if we're not focusing on quality improvements, what are we focusing on and why?

Improving Education

For starters, there continues to be a knowledge gap among patients and providers. One of the principle objectives of *Medicare Patient Management* is to expose these gaps and work to narrow them. It really is a classic case of "you don't know what you don't know." Case in point is with vaccinations—we assume patients understand why vaccinations are necessary and that physicians are able to achieve ideal vaccination rates within their patient population. But because of gaps in knowledge by both patients and physicians, opportunities for preventing many diseases are lost (stay tuned for a 3-part series on vaccinating adults that will begin in the November/December issue of *MPM*).

Beefing Up the Systems

Besides knowledge gaps, there are system gaps. We need to improve these gaps through use of electronic health records (EHRs) and electronic prescribing (eRX). Use of eRX could save Medicare as much as $29 billion over the next 10 years and prevent almost 2 million medication errors. It has been recommended that Congress require physicians who participate in Medicare to use eRX for Part D plans and that the program offer bonuses to physicians (valued at $7 bil-

lion over 10 years) to help them purchase and maintain the computer hardware and software required for these technologies. For now, however, the Centers for Medicare and Medicaid Services (CMS) is only providing rules and guidance, not financial support, for implementing the electronic systems.

Electronic transmission and sharing of information has been a major focus for CMS, evident in the proposed Medicare rule for eRX. This rule proposes to adopt standards for an eRX drug program for Medicare Part D plans under Title I of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The proposed standards are being tested for consistency with the MMA objectives of patient safety, quality of care, and efficiencies and cost savings in the delivery of care (see *HHS Road Tests eRX Standards,* on page 25 of this issue).

EHRs are another electronic interface that has been proposed to improve quality and reduce deaths from medical errors. President George W. Bush has called for EHRs for most Americans, and the US Department of Health and Human Services (HHS) has a 10-year plan to computerize health care. Two years ago, CMS released an evaluation version of VistA-Office Electronic Health Record (Vista-Office), an adaptation of the Veterans Health Administration EHR technology. The version, stated CMS, would "allow for an evaluation of VistA-Office EHR and an assessment of its effectiveness in private physicians offices."[2] To date, few physicians have accepted this offer to evaluate the software because, in part, doing so would require a large expenditure for hardware and implementation to make an EHR effective in a practice setting.

It's Still HCFA

It's not just dollars that stymy implementation of innovative systems to improve quality. "Old habits are hard to break," as the adage goes. Although CMS was renamed from the Health Care Finance Administration (HCFA), it remains true to that previous name. The key word is *finance*.

Increasingly CMS' focus on finance has wrestled control of medical decision making from physicians and given it to payers. In the past, determination of "medically necessary care" was the responsibility of physicians caring for patients. That is unfortunately no longer the case. An example is Medicare Part D. Determination of access to Part D is made not by physicians but by the payers. Access is limited to on-label use of medications, which can significantly restrict use of promising medications for some diseases and for pain medications such as Actiq, Fentora, and Zofran. These medications are approved for limited treatment of cancer patients and are otherwise not covered if prescribed outside this narrow use.

HCFA—rather, CMS—dictates that care is provided through pay-for-performance programs. The Physician Quality Reporting Initiative (PQRI), which started on July 1, 2007, was met with limited enthusiasm by its physician audience. This program establishes a financial incentive for physicians and other health practitioners who voluntarily participate in a quality reporting program. Eligible professionals who successfully report data for a designated set of quality measures may earn a bonus payment of 1.5% (subject to a cap) of total allowed charges for covered Medicare physician fee services provided during the reporting period of July 1, 2007, to December 31, 2007. The bonus will be issued in a lump sum in mid-2008.

The 2007 PQRI quality measures relate to important processes of care that are linked to improved healthcare quality outcomes. There are currently 74 measures that can be reported, but some are specific to certain specialties.[3] The concern is that, although the measures are framed around quality, their use may come at the price of cuts in physician reimbursement. It is highly likely

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that next year's nearly 10% decrease in physician reimbursement will be moved to 0 for those who report the quality data. Although these incentives are discussed solely in the context of quality, they are really about spending less on physician services.

Many of the quality measures are questionable at best. For example, while evaluation of mental status in patients with community-acquired bacterial pneumonia is valuable for seniors who may have dementia, it is of questionable benefit in an 18-year-old patient. Some other measures cover the patently obvious—for example, checking vital signs for community-acquired bacterial pneumonia. PQRI needs to focus on promoting true quality measures through providing additional resources, not by shifting dollars down.

Taking Charge

Given the current barriers, how can clinicians take charge of their patients' clinical care? The answer may be an organized effort by clinicians to educate their patients about Medicare while also encouraging them to ask their legislators to provide the necessary system to deliver medically necessary care. These organized efforts are most efficiently and effectively accomplished through established groups; however, even among such groups, one needs to make sure the motivation is purely related to quality care.

Some arguments for improving quality care are falsely painted as being about quality when, in fact, they are about dollars. Many professional societies argue that expanding the scope of practice for certain healthcare professionals will decrease quality, but behind their arguments lurks concern over their own financial well-being. Health care has come to be viewed as a zero-sum game in which there can only be winners at the hands of losers. In the 1950s the American Medical Association (AMA) argued that osteopaths should not be given the same rights and privileges as allopathic physicians because their care may be of lesser quality. More recently the AMA is fighting the expanded use of convenient care clinics where nurse practitioners are often the major providers of care.

Other associations have made the same cry. The American Medical Directors Association (AMDA)—while working to expand its number of nurse practitioner (NP) members—continues to argue against an expanded scope of care for NPs within skilled nursing facilities. At some point, societies need to move from simply fighting to protect their turf to doing what is best for patient outcomes.

Some organizations such as the Quality Improvement Organization (QIO) and the American Geriatric Society (AGS) truly focus on improving quality (see *Medicare Record Review: Ensuring Quality of Care* on page 20 of this issue). For example, AGS is currently headed by a pharmacist and welcomes many different professions as members and leaders. AGS is truly an interdisciplinary group with a clear focus on quality. Likewise, *MPM* will continue to lead by providing the resources to fill gaps in quality care and identify where the fight needs to be taken to improve quality care.

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