


Reporting Quality To Your Board and Senior Management

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Overview


- Board of Directors and Quality
 - Questions for Senior Management
 - Quality of Care and Payment
 - Physician Quality Reporting Initiative
 - Quality Audits/Monitoring
 - Tips for Education/Reporting
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BOARD OF DIRECTORS AND QUALITY

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- Directors have an oversight function and a decision-making function.
 - Directors have basic governance obligation to guide and to support executive membership in the maintenance of quality of care and patient safety. This includes assisting hospital management in assessing various quality of care concepts.
 - Directors also have duty to oversee compliance program which often includes various quality of care issues.
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- Board of Directors often oversee the medical staff of a hospital. As such, they have a duty to make sure that its medical staff members are doing all that they can to provide quality care.
 - Because the Board oversees a hospital, the governing board may be assuming ultimate responsibility for the quality of medical care provided by an institution.
 - Boards are increasingly setting quality policies and goals rather than just merely being recipients of quality reports.
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- The board should develop an understanding of the relevant quality and patient safety issues and then determine how an organization can meet these goals.
 - Board has duty to formulate and to adopt rules and policies to ensure quality of care for all patients.
 - Board should have policies that address problematic behavior that undermines the quality of medical care by an institution.
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- Board members need to develop competencies in quality and patient safety issues.


- Monitoring quality and patient safety issues is key to promoting corporate compliance.



- Boards should consider having quality reports given by the quality director/risk manager (or equivalent position) so that all directors know how a hospital is performing with respect to certain clinical quality indicators.

- Boards should consider implementing quality models that increase transparency by improving quality and decreasing costs.


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- The quality reports given to the Board of Directors should show how a hospital is currently performing under National Quality Forum (NQF) endorsed measures. The report should also have comparisons on how the hospital has performed in past quarters as well as CMS's average for the NQF endorsed measures:
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Typically, the areas reported on are

- **Congestive Heart Failure**
 - Adult smoking/cessation advice
 - Left ventricular function assessment
 - ACE inhibitor or angiotensin-receptor blocker (ARB) for left ventricular systolic dysfunction
 - Discharge instructions


 - **Acute Myocardial Infarction**
 - Aspirin on arrival
 - Aspirin prescribed at discharge
 - Beta blocker on arrival
 - Beta blocker on discharge
 - ACE or ARB
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- Community-Acquired Pneumonia
 - Oxygenation assessment
 - Pneumococcal vaccine
 - Antibiotic received within four hours of arrival
- Surgical Care Improvement Project
 - Antibiotic within one hour of incision
 - Antibiotic D/C 24 hours post op/48 hours open heart surgery
 - Antibiotic selection
- Acute Inpatient Falls
- Patient Satisfaction Survey Results



- In 2007, hospitals were required to report publicly on 24 measures to receive full Medicare payment
- Currently, that number is 37
- In 2010, it will rise to 55
- Board members will need to know, “How is our hospital accountable to the community?”



Questions for Senior Management

- What are the goals of the quality program?
 - How do we measure and improve the quality of care for our patients?
 - Is there a commitment to quality in our organization?
 - Is the compliance program incorporated into the quality program?
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Commitment to Quality

- Clinical Quality
 - Do you measure, analyze and track quality indicators (including adverse events)?
 - Do you set performance improvement priorities (high risk, high volume, problem prone)?
 - Do you perform quality assessments and audits?
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QUALITY OF CARE AND PAYMENT

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- The National Quality Forum (NQF) defines “never events” as errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.
 - Never events are typically characterized as:
 - Unambiguous-clearly identifiable and measurable, and feasible to be used in a reporting system.
 - Serious-resulting in death or loss of a body part, disability, or more than transient loss of a body function, and
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Any of the following:


- Adverse,
- Indicative of a problem in the facility's safety systems, and/or
- Important for public credibility or public accountability




- Studies have shown that never events add significantly to Medicare hospital payments, ranging from an average of an additional \$700 per case for treatment of decubitus ulcers to \$9,000 per case to treat postoperative sepsis. Another study concluded that medical errors may account for 2.4 million extra hospital days, \$9.3 billion in excess charges (for all payers), and 32, 600 deaths.


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- Effective October 1, 2008, CMS required healthcare facilities to code for conditions that are “present on admission” in order to differentiate them from complications arising out of poor quality of care. This is done by hospitals assigning one of five present-on-admission indicators to all principal and secondary diagnosis codes.

 - CMS has stopped paying for the following conditions:
 - Bedsores
 - Falls
 - Object left after surgery
 - Surgical-site infections
 - Blood incompatibility
 - Urinary tract infection from catheters
 - Poor blood glucose control
 - Deep vein thrombosis or pulmonary embolism
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- Following in the steps of CMS, some of the nation’s largest insurers, including Wellpoint, Cigna and Aetna, announced they would stop paying for medical errors that are the most preventable.
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- Hospitals believe that the insurers' strategy could drive up medical costs as hospitals absorb or pass on the expense of introducing the safety and screening procedures needed to help avoid mistakes.


 - Insurers believe their efforts will trigger safety improvements and savings for patients.
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- Aetna is beginning to stipulate in hospital contracts up for renewal that it will no longer pay nor let patients be billed for care made necessary by medical errors.

 - The Recovery Audit Contractor (RAC) Program is likely to start up again in 2009. RAC may identify certain payments as improper and may push for collection from such institutions.
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PHYSICIAN QUALITY REPORTING INITIATIVE [PQRI]

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- PQRI is a quality reporting system with an incentive payment for reporting data or quality measured for covered professional services delivered to Medicare beneficiaries.
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- Participants can choose to report data on either individual members or on groups of measures that capture a number of data elements about common care processes for diabetes, kidney disease and preventative medicine.

 - Medicare proposed a cut of 10% to the physician fee schedule for 2008, redirecting payments to PQRI. Congress delayed implementation to July 1, 2008.
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- Some examples of the 119 quality measures included in the 2008 PQRI include:
 - Inappropriate antibiotic treatment for adults with acute bronchitis
 - Electrocardiogram performed for non-traumatic chest pain
 - Inappropriate use of bone-scans for staging low-risk prostate cancer patients
 - Patients who have major depression disorder who are assessed for suicide risks
 - Plan of care for urinary incontinence in women aged 65 years and older
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- In April 2008, CMS announced new options for participating in the PQRI program, including an option for eligible professionals to submit quality measures data to CMS through a qualified, established clinical data registry.
 - Hospitals should educate physicians on how to report on performance measures
 - Although currently voluntary, most consider this a precursor to a mandatory pay-for-performance program
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QUALITY AUDITS


QUALITY MONITORING




Quality Auditing

- ❑ Health care facilities should perform a quality audit.
 - ❑ A quality audit focuses on quality of care and the legal risks they pose.
 - ❑ A quality audit has greater focus on Medicare conditions of participation rather than traditional billing rules.
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- ❑ The audit looks at processes about quality reporting. For example, does the hospital track quality reporting indicators? Does it have a quality improvement plan surrounding an issue if the results are not that good?
 - ❑ The audit would also examine quality of care issues in utilization review, board involvement and oversight, cross-department communication, medical staff and relevant laws related to quality.
 - ❑ A quality and legal risks audit is the first step a hospital should take to understand and address quality-of-care issues.
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- ❑ Quality audits should be composed of hospital quality measures which will indicate how well a hospital provides care for its patients. Some measures such as heart conditions, pneumonia care, surgical infection prevention, and performance of certain heart surgeries have proven to be the most useful indicators of quality care; however, a hospital's overall quality cannot be based on these measures alone.

 - ❑ In determining whether standards were met regarding recommended treatment regimes, measures count only those patients for whom the treatment is deemed appropriate. The measures will tell how many of the patients who should have received a particular treatment actually received it.
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- ❑ The quality assessments are based on care that a patient should receive upon arrival at a hospital, care that should occur during the hospital stay, and the advice or instructions that patients should receive when discharged from the hospital.

 - ❑ Departments of Health may also look at outcome measures which refer to what happens to a patient as a result of the treatment received. Since every patient has different levels of illness, the health department has used a risk-adjusted mortality rate to take individual disparities into account.
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Quality Monitoring

- Identify how many events have occurred that pose serious patient safety issues
 - Monitor hospital acquired conditions
 - Assess the quality of credentialing and privileging
 - Monitor peer review practices
 - Assess the patterns of malpractice claims
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Education/Reporting

- Board of Directors: Combine reporting with education
 - Senior Management: Make sure they understand the quality initiatives and understand their responsibilities
 - Medical Staff: Report on their quality indicators (core measure compliance, patient satisfaction scores) and educate them regarding quality initiatives and federal regulations related to healthcare
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Sample Reporting Tools

- Core Measures
 - System Reporting
 - Patient Satisfaction
 - Sample Board of Directors Education
 - Compliance/Quality Report to Senior Management
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