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Healthcare Quality Watch

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NEWS BRIEFS FOR MANAGERS AND OPINION LEADERS

IPRO

Improving Healthcare for the Common Good®

IPRO Awarded Major Contract Renewal

IPRO's three-year Medicare Quality Improvement Organization (QIO) contract will be renewed automatically, based on the organization's having met all performance targets in the workplan that ends July 31, 2011. IPRO's statewide performance in New York is particularly noteworthy in as much as it was one of only two QIOs in the nation to have been assigned all three special projects that were awarded selectively in addition to the core work of the "9th Scope of Work." The core themes are beneficiary protection, patient safety and prevention, while the three special "sub-national" themes address care transitions, prevention disparities and chronic kidney disease prevention. In his February 10 notification letter to IPRO, CMS Office of Clinical Standards and Quality Acting Director Dennis C. Wagner offered appreciation for "your continued efforts to improve the quality of healthcare for Medicare beneficiaries." For information on the draft "10th Scope of Work" which will begin August 1, 2011, please see "Feds Publish Expansive QIO Workplan" on page 2 of this issue of *Quality Watch.*

Please join us for IPRO's 27th Annual Membership Meeting on Tuesday, June 7th at the LaGuardia Marriott in East Elmhurst, NY. This event includes a complimentary luncheon and a ceremony honoring quality improvement specialists from across New York State. To register, visit http://ipro.org/annualmeeting or call Joan Ragone at (516) 209-5262.

Business Group Targets Primary Care Screening

An IPRO effort that generates confidential reports to primary care physicians is having a positive impact on breast cancer and cervical cancer screening rates, according to a new document from the Northeast Business Group on Health (NEBGH), formerly the New York Business Group on Health. Under a program which began in 2008, physicians in Northern and Central New Jersey receive reports from IPRO analyzing their performance on prevention measures. In 2010, a total of 1,275 reports were sent out to physicians participating in networks operated by CIGNA, EmblemHealth, HealthNet, Horizon Blue Cross Blue Shield of New Jersey, Oxford and United Healthcare. "…Physicians who receive aggregated performance information information tend to improve their rates of breast cancer and cervical cancer screening," according to Laurel Pickering, MPH, NEBGH Executive Director. NEBGH has just released two documents analyzing the performance of area health plans and physicians, on a range of performance measures including prevention, behavioral health and chronic care management. For more information, visit the organization's website at www.nebgh.org.

EHR Systems No Panacea—Authors

While electronic health records (EHRs) hold great promise for supporting improvements in quality in the primary care setting, providers will need to significantly upgrade their knowledge of systems and/or hire additional staff in order to maximize effectiveness. That's the conclusion of a case study book chapter just published by experts at the Primary Care Development Corporation, an "early adopter" primary care practice in the Bronx called Uptown Medical Group (UMG), and IPRO. The chapter analyzes UMG's participation in quality improvement projects requiring the ability to "measure, assess and optimally use" EHR data. The authors conclude that workflow redesign is crucial so that practices understand how to accurately query data systems, how to engage in data mapping that captures

all orders and referrals that have taken place, as well as the need to expunge from denominators cases representing patients who move, leave providers or expire. "The automation of clinical encounters doesn't equate to improved health care outcomes," the authors warn, while noting that EHR systems are essentially tools that support better aggregation of patient data. (Johnson-Ingram D, Ortiz Y, Woods KB, Silver A (2010). Case Study: A small primary care practice's experience in assessing quality with data obtained from an electronic health record in K Ong (ed) *Medical Informatics: An Executive Primer* (second edition, Chapter 17 p.287-297). HIMSS, Chicago.

Feds Publish Expansive QIO Workplan

Medicare-funded Quality Improvement Organizations (QIOs) will engage in a number of high-profile initiatives meant to bring and sustain dramatic improvements in quality at the statewide level, according to the three-year draft "Scope of Work," representing activities slated to begin August 1, 2011. The document unveiled this spring by the Centers for Medicare & Medicaid Services' Office of Clinical Standards & Quality promises a robust effort at improving safety in hospitals and nursing homes, upgrading seniors' use of Medicare-covered preventive services, enhanced technical assistance for provider performance reporting and supporting better transitions between care settings. Under the workplan, QIOs will continue to be responsible for handling appeals of provider-generated notices of non-coverage/discontinuance of service as well as quality-of-care complaints lodged by patients and families. New activities include conducting promotional campaigns with seniors and families, engaging in locally determined needs assessments and coalition-based action plans, and using social media platforms to reach stakeholders, practitioners and beneficiaries. In general, the authors propose dramatic improvements in quality on a statewide basis, rather than incremental improvements involving relatively small groups of participating providers. The draft workplan is available at www.cms.gov by clicking on the "Quality of Care" button.

GAO Analyzes Coverage Denials

A six-state study of external appeals of coverage denials by managed care plans and insurers indicates that privately insured patients are able to reverse or revise adverse decisions in 23% to 54% of cases. The analysis by the United States Government Accountability Office (GAO) shows California and Maryland with the highest single reversal/revision rate (54%), followed by Florida (49%), Connecticut (40%), and Ohio (23%). The sixth state—New York—reports three different rates for 2009; an HMO rate of 38%, and non-profit indemnity insurer rate of 41% and a commercial insurer rate of 42%. The GAO study also looks at internal appeals filed by privately insured patients against insurers and HMOs in four states, finding a range of reversals of 39% to 59%. In commenting on the GAO findings, the U.S. Department of Health & Human Services notes the difficulty of determining the total percentage of internal and external appeals of coverage determinations, given what was previously a "patchwork" of appeals protections at the state level. The new health reform law extends external appeals rights to millions of privately insured Americans previously not covered, due to ERISA rules governing self-insured companies and groups. IPRO currently conducts independent external appeals in 17 states and District of Columbia.

National Quality Strategy Highlights QIOs

Quality Improvement Organizations (QIOs) have an important to role to play in the National Strategy for Quality Improvement in Health Care, according to authors of the framework document released March 21. The Affordable Care Act requires the Secretary of Health and Human Services to establish a national strategy and to update it annually with agency-specific performance goals and objectives. The first iteration of the Strategy was undertaken with input for more than 300 groups and individuals representing a variety of interest groups as well as non-specialists. The three overarching aims of the strategy are better care, healthy people/communities and affordable care. In order to achieve these aims, the Strategy articulates six priorities that address (1) reducing harm, (2) engaging persons and families as partners, (3) promoting coordinated care, (4) preventing and treating leading causes of mortality, starting with cardiovascular disease, (5) working with communities to promote best practices, and (6) making care more affordable by spreading adoption of new service delivery models. The Strategy describes QIOs as among the critical elements of the infrastructure necessary to support the priorities. The Strategy emphasizes the role QIOs have in disseminating research evidence and working cooperatively with providers in a number of settings including hospitals, nursing homes, and home health agencies. To read the Strategy, visit www.ahrq.gov/workingforquality.

Feds Publish Accountable Care Organization Plan

The U.S. Centers for Medicare & Medicaid Services (CMS) has released a long-awaited proposed rule implementing the Accountable Care Organization (ACO) provisions included in the Affordable Care Act. The proposed rule outlines a process whereby providers who coordinate care for a set number of Medicare beneficiaries are permitted to share in program savings that may result. CMS is proposing that ACOs provide care to at least 5,000 beneficiaries. For more information, visit www.gpoaccess.gov/fr/ and search for Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations.

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We welcome your comments and suggestions.
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IPRO is a national organization providing a full spectrum of healthcare assessment and improvement services that foster more efficient use of resources and enhance healthcare quality to achieve better patient outcomes. For more than 25 years, IPRO has been highly regarded for the independence of its approach, the depth of its knowledge and experience, and the integrity of its programs. IPRO holds contracts with federal, state and local government agencies and corporate clients, in more than 33 states and the District of Columbia. A not-for-profit organization, IPRO is headquartered in Lake Success, NY.