

Top 12 Healthcare Quality Concerns in 2012

Cheryl Clark, for HealthLeaders Media , January 4, 2012

Which quality issues will provoke the most influential changes in healthcare in 2012? Or, which ones will most rapidly accelerate the graying of chief quality officers' hair? There are so many, it's hard to pick the most significant. We interviewed quality experts around the country to glean the most influential and then picked a dozen.

Here's the list:

1. Patient experience scores hinge on "always" responses

The value-based purchasing sweepstakes have begun, with the first performance period for clinical process of care and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) questions scheduled to end March 31. Payment adjustments will begin for patients discharged as of Oct. 1, and the winners and losers will then be revealed.

What makes many hospitals and clinical nurse managers most nervous, however, is that the patients responding to these surveys must reply "Always," in order for the hospital to get credit for high quality patient experiences. Responses "Sometimes," or "Usually" aren't going to cut the mustard.

"How often did nurses listen carefully to you?" "How often did doctors treat you with courtesy and respect?"
"How often was your pain well controlled?"

"Always."

And by the way, Jan. 4, 2012 is the data submission deadline for patients discharged in July, August and September, 2011.

2. Physician Compare

As if providers didn't already have enough to worry about with Medicare, Medicaid and private insurer payment reductions, electronic medical record and meaningful use compliance, disclosing payments from durable equipment and pharmaceutical companies and yes – remembering to answer their patients' e-mails. Now they have something else to fret about.

As of this New Year's Day, according to the Patient Protection and Affordable Care Act, the official reporting period begins for physician performance on quality and patient experience measures for physicians enrolled in Medicare on [Physician Compare](#).

Starting "no later than" next New Year's Day, 2013, the Health and Human Services Secretary shall "implement a plan" to make publicly available on Physician Compare a huge number of quality scores.

They include measures from the Physician Quality Reporting Initiative, an assessment of each physician's patients' health outcomes and their functional status, an assessment of the continuity and coordination and care and care transitions including episodes of care and resource use, efficiency, patient experience and patient, caregiver and family engagement, safety, and effectiveness and timeliness of care.

And if all that weren't enough, the HHS secretary gets to publish other information on Physician Compare he or she determines appropriate.

3. Thirty-day Readmissions

A number of decisions forthcoming this year focus on how the Centers for Medicare & Medicaid Services will determine those hospitals with higher rates of readmissions for congestive heart failure, pneumonia and heart attack diagnoses. One question is whether the agency will compare a hospital's readmission rates with just those within that hospital's state, or whether each hospital will be compared with the entire country as a whole.

The first option would guarantee that some hospitals in each state would receive negative reimbursement adjustments (CMS prefers that we not use the word penalty), even if those hospitals have far lower readmission rates than hospitals with the highest rates.

Another issue up for consideration is the risk adjustment criteria, whether payers including private insurance companies will begin looking at all-cause readmission rates and whether scheduled readmissions will continue to be included in the equation.

The penalties start at 1% for Medicare DRG discharges on or after Oct. 1, 2012, increase to 2% on or after Oct. 1, 2013 and to 3% on or after Oct. 1, 2014.

How hospitals, physicians, discharge planners, nurse case managers, skilled nursing facilities and in-home health services agencies will work together to avoid the "blame game" when a patient does end up as an "avoidable" readmission will be interesting to watch.

Look for providers and federal regulators to talk more about "all-cause" readmissions, or to include additional diagnoses such as hip replacements gastrointestinal resections, and eventually to lengthen the watch period to 60 or 90 days.

How aggressively will hospitals and doctors stress the need for patients to comply with physician appointments and medication regimens? Will hospital staff dare to tell patients that if there is a preventable readmission, it make the hospital look bad and hurt the bottom line?

4. Outcome measures versus process measures

The science of testing outcomes versus surrogate "process" measures will evolve, but this year and years to come, much more rapidly.

Starting in FY 2014, CMS will include 30-day mortality measures in value-based purchasing incentive payment algorithms. But don't expect publicly reportable outcome measures to stop there.

As James La Belle, Corporate VP of Quality, Medical Management and Physician Co-Management for Scripps Health explained, perhaps more meaningful metrics might include those covering "functional status," such as how quickly or completely a patient's cognitive function is restored, how far they can walk without assistance or how soon they can return to work. How long before the patient could say life was back to normal?

5. Meaningful Use

With the impending release of the Stage 2 Meaningful Use final rule, physicians and others have no more excuses to delay learning and installing software and computerized physician order entry systems.

If you listen closely, you will hear their cries, that they have been turned from being doctors to being typists. That they hardly ever get to see their patients because their heads are blocked by a computer monitor. Quality wonks will want to see evidence that these systems are time-efficient and not intimidating.

Look for applications that use hand-held tablets that are not just patient and doctor friendly, but actually fun to use and may make documentation seem more like a game.

6. Release of the Medicare claims database

Without much fanfare, CMS on Dec. 5 released its final rule governing how it would release, and who might obtain, access to its enormous claims database. This is a goldmine for any public or private entity that wants to "datadive" into numbers to evaluate cost as well as performance.

CMS' final rule specifies that those selected to receive this information – and CMS will pick which ones – are expected to "increase the transparency of provider and supplier performance, while ensuring beneficiary privacy." It is to be used to evaluate performance of providers and suppliers on quality, efficiency, effectiveness measures as well as use of resources.

The only catch is that the data may not be used by itself, but must be combined with health plan or other provider claims and quality information for performance measurement.

Medicare officials acknowledged in a statement that the final rule governing access to this treasure trove ends a situation that has been "frustrating" to providers and employers, consumers, and health care quality advocates.

7. Drug shortages and grey market vendors

Quality leaders are looking nervously at all the drugs that they can't get or can't afford to get because of price gouging – as much as 4500% – by grey-market vendors, and what drugs can be safely substituted. The problem involves the word "safety."

According to a survey from the purchasing and quality group Premier Healthcare Alliance, the number of drugs with exceptionally high markups because of scarcity numbered only about 50 five years ago. But now the number is approaching 400.

"When these drugs are bought and sold across state lines, moved in whole or partial lots, repackaged and relabeled, resulting in a complex web of transactions involving dozens of trading partners, (it makes) it almost impossible to determine the supply source or authenticity," said Premier's COO Mike Alkire during a news conference in mid-August.

In a [commentary](#) for HealthLeaders Media online April 15, Alkire wrote:

"Drug shortages present a danger to public health. In hospitals, a shortage may delay necessary medical procedures. Substitution of similar medications, if available, may lead to errors and adverse events, especially if prescribers are unfamiliar with the alternative products' dosing and potential interactions with other drugs."

8. ICD-10

Our list would not be complete without a tip of the hat to [ICD-10 adoption](#) efforts, scheduled to go into high gear later this year in anticipation of the Oct. 1, 2013 date for the big switch.

Quality and chief information officers say this effort is monopolizing large chunks of their workday, even as the costs for installing and understanding the system make everyone nervous.

Down the line, however, ICD-10 data will gather power with volume datasets and enable providers to capture much more precise information on patients' conditions and procedures. It will be tougher for hospitals to lump patients into more severe categories, a current practice that may enable higher reimbursement, will more

quickly identify fraud, waste and abuse in healthcare and will enable better hospital and physician quality comparisons.

9. Emergency department speed, accuracy

Much of what happens to patients in hospital settings happens to them first in the ED. So it matters a lot how long they have to wait to be seen, how long it takes to correctly diagnose them with labwork, imaging or other functional tests, and how long it takes to process the paperwork, get them in an inpatient bed and provide whatever medications or procedures they need.

But until very recently, there have been very few ways in which ED quality has been formally measured, other than in time to antibiotic for a pneumonia patient, or door to balloon for heart attack patients.

That is about to dramatically change. In the next year, the Centers for Medicare and Medicaid Services will require hospitals to begin tracking and reporting their median times for two National Quality Forum benchmarks in emergency care.

1. The number of minutes between the "door," the time the patient arrives at the ED to the moment they "depart" the premises of the ED to be admitted to the hospital
2. The time between the moment a decision is made by the ED physician to admit the patient to a hospital bed to the time the patient departs the ED and is actually placed in an inpatient bed, a period sometimes referred to as "[boarding](#)."

Look for these results to become publicly reported on [Hospital Compare](#). For now, CMS has not said it will impose a payment adjustment or penalty for slower hospitals, but that may come with future Outpatient Prospective Payment System rules, perhaps the one released for 2013.

Along the way, hospital emergency room providers, including physicians and nurses, are gathering consensus over terminology, so that everyone means the same thing when a patient is said to come in the "door."

10. End-stage renal disease quality measures

Last month, the federal government released the first round of payment penalties for dialysis centers with lower scores on quality measures and one in three, or 1,300 of the 5,000 dialysis centers in the country made the list. This is a big deal for all providers

This is huge, because more than a half a million patients in the United States are on dialysis, and the federal government pays the bill for 453,000 who lack private insurance, at an average cost of between \$57,639 and \$77,506 per patient per year as of 2008. More quality measures will be added to the formula in 2014.

11. Medication management

Making sure that providers who treat patients who need to be on multiple medications for multiple conditions talk to other members of the team to make sure the patients, especially the elderly, are not being prescribed harmful combinations.

A recent report in the [New England Journal of Medicine](#) study found that 100,000 seniors a year require costly, emergency hospitalization because of misuse and adverse reactions to of prescription drugs, with four medications responsible for 67%, either alone or in combination.

Additionally, keeping patients compliant with their regimen, communicating with pharmacies, and making sure that patients are on the correct medications when they're discharged from the hospital — not necessarily the same ones they took before they were admitted – will be an increasing [challenge for providers](#).

12. Waste, fraud, and abuse

In November of 2010, the Office of Inspector General's [report](#) found that of nearly one million Medicare beneficiaries discharged from hospitals in just one month – October of 2008 – one in seven experienced an adverse event and nearly half of those were preventable medical errors, substandard care and inadequate patient monitoring and assessment. This is one category of avoidable spending.

Another is the fact that far too many patients are getting unnecessary procedures, including surgery or undergoing care with the use of new "better" technology that really isn't.

In his address at the Institute for Healthcare Improvement forum in Orlando last month, outgoing CMS administrator Don Berwick, MD, called it "overtreatment – the waste that comes from subjecting people to care that cannot possibly help them – care rooted in outmoded habits, supply-driven behaviors, and ignoring science."

What the Patient Centered Outcomes Research Institute, PCORI, does this year when it begins to prioritize its research hospitals projects may make some providers nervous, especially if the results of that research throw doubt on a key line of service or major device acquisition.

That's our list, although undoubtedly there are other worthy candidates we could have included. Can you suggest others? If so, please do so in the comment section below or send me an e-mail. Maybe we'll have enough for a sequel.