CHAPTER 3

Medicare's role in supporting and motivating quality improvement

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Chapter summary

There is wide variation in the quality of health care in the United States, and the pace of quality improvement has been frustratingly slow. As the largest single purchaser of health care, Medicare has a responsibility to induce and support quality improvement. The Commission has recommended numerous payment changes to create a business case for quality, which should encourage quality improvement. These changes include pay for performance, payment penalties for excessive hospital readmissions, and a pilot to test medical homes. In addition, the Commission has recommended that performance data be publicly reported to further motivate better quality, both by stimulating professional pride and by enabling beneficiaries to make more informed choices about where they receive their care (Medicare Payment Advisory Commission 2008).

Payment incentives and public reporting alone may not be sufficient to induce the magnitude of quality improvement needed. Some providers simply may not know how to improve care. Quality improvement is difficult, particularly when it requires coordination among various provider types during a patient's episode of care, management of a highly complex organization, or coping with the challenges of serving a rural or a low socioeconomic population. Accordingly, some providers need technical assistance. Medicare is in a position to facilitate an exchange of expertise, so that the innovations and culture of the nation's high-performing providers can be exported to

In this chapter

underperforming providers, who, despite the best of intentions, endanger too many Medicare beneficiaries with substandard care.

Medicare's Quality Improvement Organization (QIO) program recently began an effort to focus on assisting low performers. This focus has several advantages and raises several implementation issues in delivering technical assistance for quality improvement, such as which measures should be used to identify low performers. Other changes to the program could also be contemplated. For example, there may be advantages to allowing entities besides the current QIOs (e.g., high-performing providers, professional associations, consulting organizations) to receive Medicare support as technical assistance agents serving low performers. Under an alternative quality improvement model, low performers could choose which entity would be best suited to provide them Medicare-supported technical assistance.

Another way Medicare can stimulate quality improvement is by reforming its conditions of participation (COPs)—the minimum standards that certain provider types are required to meet to participate in Medicare. Providers, state governments, and the federal government collectively spend millions of dollars annually preparing for and conducting surveys to ensure compliance with these standards, yet it is unclear how much these efforts have accelerated the pace of change. Various options exist that could reenergize the survey and certification process, including updating the COPs to align them with current quality improvement efforts, imposing intermediate sanctions for underperformers, creating higher standards that providers could comply with voluntarily to be designated publicly as a high performer, and using performance on outcomes measures (e.g., mortality rates) as a criterion for providers to be eligible to perform certain procedures.

Modifying the COPs in tandem with providing targeted technical assistance may introduce a balance of incentives that could accelerate quality improvement and make health care safer for Medicare beneficiaries. ■

Whether beneficiaries survive an illness or avoid a preventable, debilitating complication can depend on where and from whom they receive care. Accordingly, Medicare has a responsibility to induce and support improvement in the quality and efficiency with which care is delivered.

Improvement in care has been slow. It takes, on average, 17 years for the results of clinical trials to become standard clinical practice (Balas and Boren 2000). Adoption of the "checklist" approach to reducing central line infections that was implemented successfully in Michigan hospitals and publicized widely has not been fully implemented in the vast majority of hospitals (Leape 2010). Some of the nation's leading physician voices on quality have recently lamented the too frequent reluctance of physicians to rely on proven practice guidelines to inform their practice style and save lives (Swensen et al. 2010). In addition, a recent survey of hospital boards found that none of the boards of low-performing hospitals thought their hospitals were poor performers—in fact, 58 percent thought they had better or much better quality than the average hospital (Jha et al. 2009).

Performance on quality measures varies widely, with differences of two- to threefold across states on many measures, including mortality, morbidity, and complications (Kroch et al. 2007). The Institute of Medicine (IOM) and others estimate that tens of thousands of lives could be saved each year if providers delivered safer care (Kohn et al. 1999).

Medicare has multiple ways to induce quality improvement; one of the most powerful is through payment incentives. The Commission has recommended numerous changes intended to align financial incentives with the provision of high-quality, efficient care. The Commission has also recommended that performance on quality measures be publicly disclosed as a further effort to motivate and support improvement. Some experts argue that publicly disclosing performance data is even more important than financial incentives (Leape 2010). In the last decade, CMS has begun publicly reporting quality data for hospitals, nursing homes, home health agencies, and dialysis providers; these data are submitted by the providers.

Medicare has other levers to support and encourage improvement. First, through its Quality Improvement Organizations (QIOs) in each state, Medicare can give providers technical assistance to help them change practice patterns and improve quality and efficiency. While management of the QIO program continues to evolve to address past problems, the Commission's review of the literature and discussions with stakeholders suggest that alternative approaches to technical assistance may be worth considering.

Second, Medicare could better leverage its conditions of participation (COPs)—standards for provider entry to and continued participation in the program—to accelerate quality improvement. A combination of improved technical assistance from QIOs and the inclusion of regulatory consequences under COPs could introduce a balance in incentives and accountability that lowers the risk of avoidable harm to Medicare beneficiaries.

To simplify the discussion of quality improvement, we use hospitals to illustrate key concepts, but the principles discussed here apply to all provider types. We recognize, however, that quality improvement efforts and COPs (as well as conditions for coverage that apply to nonhospital providers) vary by provider category and that tailoring technical assistance and oversight to specific aspects of the providers' services is appropriate.

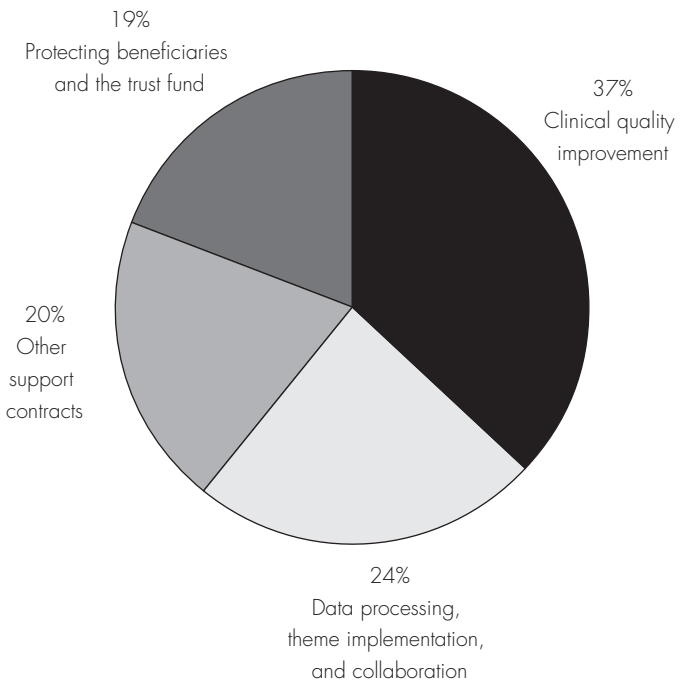
Background

Quality Improvement Organizations

In the current three-year (2008–2011) contracting cycle, Medicare is spending $1.1 billion (about $366 million annually) to support the functions of QIOs, which CMS defines as improving quality of care for beneficiaries, protecting the integrity of the Medicare trust fund by ensuring that Medicare pays only for services that are necessary, and addressing individual beneficiary complaints (Centers for Medicare & Medicaid Services 2008). There are 41 organizations that hold 53 contracts to provide QIO services in all 50 states, Puerto Rico, the Virgin Islands, and the District of Columbia. Most are nonprofit entities. The QIO program also funds several QIO support centers, which serve as national resources to QIOs in carrying out their responsibilities.

The role of QIOs has changed over time. Early on, QIO predecessors (Peer Review Organizations) were responsible for identifying individual cases of unnecessary or substandard care that might be driving up costs. In 1992, the focus changed, partly spurred by the IOM's recommendations, so that their primary role shifted from identifying individual clinical errors to providing technical

FIGURE 3–1 **Allocation of spending in the Quality Improvement Organization budget**



Source: Fiscal year 2011 President's budget.

assistance, particularly in data collection and performance feedback and in fostering internal quality improvement. The sense was that "fear and adversarial relations … [would] cripple quality-improvement efforts" (Jencks and Wilensky 1992). By 1999, every Peer Review Organization was required to produce measurable statewide improvement in select clinical areas (e.g., diabetes, breast cancer, acute myocardial infarction (AMI)). Now, QIOs are largely measured on how they improve the quality of care of the providers they directly assist.

Each scope of work (SOW)—the three-year contracting cycle with QIOs—emphasizes somewhat different tasks or approaches to quality improvement. For example, the eighth SOW cycle focused on four strategies to improve quality: measurement and reporting, health information technology (HIT), redesign of care processes, and change in organization culture and management. It also included projects like preventing hospital admissions from a nursing home and improving transition of care across settings, which were intended to help develop an evidence base for what works.

In the current ninth SOW cycle, QIOs are to focus on beneficiary protection, patient safety, prevention, and care transitions. As part of patient safety, QIOs are focusing on reducing rates of methicillin-resistant *Staphylococcus aureus* infections, pressure ulcers in nursing home patients, and physical restraint use in nursing homes; improving inpatient surgical safety and heart failure treatment in hospitals and drug safety; and providing technical assistance to nursing homes.[1] In addition, QIOs in states that successfully competed for additional work are to focus on the following tasks: reducing disparities in preventive services, promoting seamless transitions across settings, and slowing the progression of chronic kidney disease to kidney failure and improving clinical care to all kidney patients.

In the ninth SOW, CMS changed aspects of its management of the program in response to concerns and problems about the program noted by the IOM, Government Accountability Office, and members of the Congress. It is using management information tools, such as milestones and project tracking, to monitor the effectiveness of QIO activities. In addition, QIOs are expected to focus their interventions across the spectrum of provider types as well as low performers. CMS has also made changes to inject greater competition into the program. It awarded funding for certain subnational tasks competitively. In addition, in seven of the QIO jurisdictions, where the QIOs' prior performance on the eighth SOW contract did not require renewed contracts, CMS conducted an open competition for the contract, in conformity with federal acquisition law. As part of that, CMS awarded a QIO contract to one new contractor (Centers for Medicare & Medicaid Services 2008).

The breadth of the QIO program's mission and budget extends well beyond technical assistance to providers. In the ninth SOW cycle, only 37 percent of total funding is devoted to clinical quality improvement. Another 19 percent is dedicated to protecting beneficiaries and the trust fund. Data processing, theme implementation, and collaboration receive 24 percent and other support contracts receive the remaining 20 percent (Figure 3-1). The IOM has raised concerns about the oversight and evaluation of the effectiveness of spending for support contracts and other quality activities performed outside of QIOs (Institute of Medicine 2006).

QIO funding comes through an apportionment directly from Medicare's Hospital Insurance and Supplementary Medical Insurance trust funds rather than an annual appropriation.

The apportionment process allows the Department of Health and Human Services (HHS) and the Office of Management and Budget to determine the program's needs and how much will be used from the trust funds.

Conditions of participation

COPs are the minimum standards that many types of providers are required to meet to participate in the Medicare program. To ensure that the COPs are met, both initially and periodically, providers are surveyed by either a private accrediting entity (approved by CMS) or state-designated surveyors.

COPs are tailored to each applicable provider type and have been in place since Medicare began covering the relevant service. Most categories of providers are subject to COPs or conditions for coverage; a significant exception is physicians. As initially conceived, the standards were largely statements of what a provider must do or have to make quality possible; they do not guarantee that quality is present (Sprague 2005).

COPs mainly require that certain physical and management structures are in place. For example, requirements for hospitals apply to areas such as the governing body; patients' rights; the medical staff; nursing services; medical records; pharmaceutical, laboratory, and radiology services; utilization review; discharge planning; infection control; and emergency services.

The standards have evolved somewhat. In 1986, less prescriptive but broader COPs were adopted. New conditions included infection control, surgical and anesthesia services, and quality assurance. Despite these improvements, more changes may be needed. The Commission has identified a number of areas where COPs could be strengthened (as discussed in this chapter) and has heard from other experts that COPs have not evolved to reflect the latest thinking on quality improvement, particularly with respect to the importance of provider teamwork, communication across sites of care, and evolution in the management of integrated systems.

The Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission) is the largest accrediting organization of the nation's hospitals. It accredits about 80 percent of hospitals, with most of the rest being accredited by state agencies.[2] Its surveys are now unannounced and occur at two- to three-year intervals (between 18 and 39 months). The survey process has several components. Hospitals are required to perform periodic self-evaluation and collect quality data and submit the results of both to the Joint Commission. During the on-site survey, the accrediting staff interviews hospital staff about compliance with the Commission's standards, which largely mirror the COPs but also include national patient safety goals. These goals focus on providers' progress on widely identified safety issues, such as avoiding wrong site surgery, promoting hand washing as part of infection control, and having better communication among the care team.

In addition to interviews of the staff, ascertaining compliance is achieved by selecting "tracer" patients and examining the course of their care while in the hospital. Using tracer patients allows surveyors to view a hospital's practices from the patient's perspective and assess things such as whether lab results are returned to the right physicians in a timely way and whether the pharmacists play an active role in medication reconciliation on a real-time basis. Unfortunately, this approach does not allow a look at the entire discharge planning process because it limits the view to patients hospitalized at the time of the survey.

There is some federal oversight of accreditors. The Secretary of HHS has the authority to conduct "validation" surveys in a random sample of Joint Commission–accredited hospitals each year. In addition, CMS conducts "allegation surveys," or complaint investigations. They are more common than validation surveys but more limited in scope. They look only at the condition relevant to the complaint.

Most hospitals are either accredited or approved by state surveyors. For the Joint Commission, 94.7 percent of hospitals that applied for accreditation received it in 2008. Another 4.6 percent received "conditional accreditation" (Tucker 2010).

How can Medicare best provide technical assistance to providers?

To a great extent, quality improvement should be part of every provider's mission; it is a requirement in Medicare's COPs for hospitals. It should not be considered an "extra" function that needs separate funding. Yet some providers simply may not have the knowledge to undertake the breadth of initiatives that are required, or they may face a particularly challenging environment. The task at hand is made that much more difficult when improvement requires

coordination among various provider types during a patient's episode of care, management of a highly complex organization, or coping with the challenges of serving rural or low socioeconomic patients. Because the consequences of these challenges adversely affect the quality of care for beneficiaries, Medicare has a role in supporting providers' quality improvement efforts. What should this role be and how should it be executed?

Choosing this juncture to consider technical assistance

We raise the issue of technical assistance at this time for three reasons. First, while management of the QIO program has recently been reformed as part of the ninth SOW, it has a history of not being able to demonstrate its effectiveness and even now, based on our interviews with various experts and stakeholders (e.g., hospital administrators, academics, health plan executives, staff of independent quality organizations), the expertise of its contractors is perceived as uneven and, in some cases, unequal to the task. Second, the landscape of quality improvement providers has changed over time, with a growing number and variety. This change raises the opportunity for more types of entities to constructively contribute to quality improvement and possibly merit support from the Medicare program in their efforts to reach low performers. Third, a variety of federal programs exist to improve the quality of care, and in some cases the coordination between them is not at all clear. The recent health care reform law, the Patient Protection and Affordable Care Act of 2010 (PPACA), calls for the Agency for Healthcare Research and Quality (AHRQ) to create a national strategy for quality improvement. The role of QIOs should be considered carefully as to how their efforts can best complement (and be complemented by) other programs, such as patient safety organizations, AHRQ grant programs that fund quality improvement efforts, and the newly created Health Information Technology Regional Extension Centers.

The perception and performance of QIOs

QIOs are partway through implementing the ninth SOW, which includes numerous reforms to address concerns raised in the past, most specifically by the IOM in 2006. While these changes are promising (an evaluation of QIOs' performance under the ninth SOW is not yet available), current perceptions of stakeholders and the history of the program suggest that exploring options for the structure of the program could be constructive.

In the Commission's recent conversations with numerous stakeholders and experts (e.g., hospital administrators, academics, health plan administrators, staff of organizations dedicated to improving quality), many mentioned their concerns that QIO performance is uneven across the nation and that some did not have the staff expertise or analytic infrastructure to take on the assigned role. Some suggested that the QIOs' impact is constrained by their motivation to perform to the terms of the contract and, accordingly, they are less likely to be innovative and a source of energy in their leadership. Future demonstrated success of QIOs could prove these perceptions wrong and alter the image that QIOs have developed, but these perceptions are a factor worth consideration in assessing the potential of the program to drive change, particularly when the vast majority of QIO contractors remains the same from contract to contract.

Historic performance also highlights the challenges of operating the QIO program and producing measurable results. In 2006, an IOM panel, tasked by the Congress with evaluating the QIO program, concluded that "given the lack of consistent and conclusive evidence in scientific literature and the lack of strong findings from the committee's analyses, it is not possible to determine definitively the extent of the impact of the QIOs and the national QIO infrastructure on the quality of health care received by beneficiaries" (Institute of Medicine 2006). The IOM review not only looked at the literature but also included site visits and phone interviews with QIO leaders.

An evaluation of the QIO program by NORC (formerly the National Opinion Research Center) for the HHS Assistant Secretary for Planning and Evaluation in 2007 also painted a troubling picture. For example, it found a "paucity of activity- or intervention-specific information available in public resources, particularly related to the seventh SOW. In several cases, no substantive information on any specific project could be found for a given QIO and subtask … efforts to locate details on projects that were identified by name often proved futile and while most QIOs stated that they currently or have previously participated in national or local quality improvement initiatives, specific details as to the QIOs' scope or role in the initiatives were generally unavailable" (Sutton et al. 2007).

The literature on the effectiveness of the QIO program does not present a consensus (Sutton et al. 2007). Moreover, many of the studies are plagued by

methodologic obstacles, including questionable data, selection bias, spurious attribution due to numerous confounding factors, and the inability to isolate and define experimental and control groups (Sutton et al. 2007). These types of obstacles challenge the evaluation of other quality programs as well and are not singular to the evaluation of QIO interventions (Institute of Medicine 2006).

Studies on the impact of individual QIO quality improvement show that some interventions have been more effective than others and can catalyze improvements in process measures and to a lesser degree outcomes measures in care settings (Sutton et al. 2007). For example, an examination of a pressure ulcer prevention project conducted by the Texas QIO concluded the project's intervention—assigning quality improvement teams to participating facilities—was associated with a reduction in the occurrence of pressure ulcers (Abel et al. 2005).

QIO leaders dispute a perception problem and point to the results of a 2008 survey of 470 hospitals, or about 11 percent of hospitals, where 89 percent of them responded that QIOs had a very positive or somewhat positive influence on their hospitals (Cohen et al. 2008). This level of positive responses exceeded that given to any other type of quality improvement organizations.

Another consideration in the perception of QIOs is the somewhat conflicting role they have as both a quality improvement organization and a regulator. QIOs still have a role in reviewing providers' care and issuing corrective plans when they find problems.[3] The dual nature of their role could make providers less likely to view QIOs as purely collaborative partners in quality improvement.

Emergence of private sector organizations and initiatives focused on quality improvement

More organizations are getting involved in quality improvement, creating the opportunity for more types of entities to possibly merit support from the Medicare program in their efforts to reach low performers. While the efforts of these organizations are promising, like QIOs, many have not demonstrated conclusively that their initiatives have improved care nationally. Many, but not all, charge for their services.

Some of the relatively new entrants in the market are national organizations. The Institute for Healthcare Improvement (IHI), created in 1991, has organized large national campaigns to reduce medical errors (e.g., "5 million lives campaign"), sponsored numerous collaborative efforts on both quality (e.g., transforming care at the bedside) and efficiency (e.g., improving flow through acute care settings), and hosts conferences.

In September 2009, the Joint Commission launched its Center for Transforming Healthcare, which states as its aim "to solve health care's most critical safety and quality problems." It intends to work with select hospitals and health systems to discover underlying causes of problems and develop targeted solutions and to share proven solutions with the more than 16,000 health care organizations it accredits. It began with promoting hand hygiene and has continued with improving hand-off communications (Joint Commission 2009b).

A number of trade associations and provider alliances have also emerged as quality improvement resources for providers. For example, Premier has launched a collaborative of 160 hospitals it calls QUEST to help "springboard hospitals to a new level of performance." QUEST pools data from all participants to establish hospitals' baseline performance and enables sharing of best practices to improve performance (Premier 2010). The University HealthSystem Consortium, with a membership of 107 academic medical centers, also promotes quality improvement among its members by enabling them to benchmark themselves against similar hospitals on a variety of measures, reporting relative performance within the group, and providing technical assistance conferences (University HealthSystem Consortium 2010). As widely reported, the Michigan Hospital Association demonstrated strong leadership in coalescing its members around an initiative to reduce the incidence of central line infections, with great success (Pronovost et al. 2006).

To name a few of the initiatives among physician associations, we note that the American College of Cardiology has initiated a "door to balloon" campaign to improve the efficacy of treatment for heart conditions and a "hospital to home" initiative to reduce readmissions for cardiac patients (Antman and Granger 2010). The American College of Surgeons has the National Surgical Quality Improvement Program, which allows comparisons of hospitals in the program and provides them with the tools, reports, analyses, and support to make quality improvements (American College of Surgeons 2006). The Society of Hospital Medicine, whose membership is

hospitalists, has launched "Project Boost," which helps hospitals exchange information and mentor one another in an effort to reduce preventable readmissions (Society of Hospital Medicine 2010).

Need for coordination among federal quality improvement programs

The recently passed health care reform legislation, PPACA, requires HHS to establish a national strategy to improve the quality of health care services, delivery of health care services, health outcomes, and the health of the overall population. As part of that strategy, HHS will implement these priorities at local, state, and federal levels to ensure that providers utilize best practices that focus on efficiency and quality, reduced medical errors, improved medication management, improved emergency care, reduced hospital readmissions, and increased patient education with regard to treatment options. The law also establishes the Interagency Working Group on Health Care Quality to improve quality measures and increase collaboration between federal departments.

This type of initiative should be an opportunity to assess how other federal health improvement programs and Medicare's QIO program should coordinate with one another. In particular, over the last several years, AHRQ's role in funding facilities and providers to improve quality and spread innovation has increased. For example, in 2006 it launched a program called Accelerating Change and Transformation in Organizations and Networks (ACTION). According to AHRQ, "ACTION promoted innovation in health care delivery by accelerating the development, implementation, diffusion, and uptake of demand-driven and evidence-based products, tools, strategies and findings. ACTION develops and diffuses scientific evidence about what does and does not work to improve health care delivery systems" (Agency for Healthcare Research and Quality 2006).

ACTION is organized around 15 large partnerships between AHRQ and 15 prime contractors (e.g., RAND, RTI, Indiana University). ACTION participants span all states and include health plans, physicians, hospitals, long-term care facilities, ambulatory care settings, and other health care sites. Each partnership includes health care systems with large databases, clinical and research expertise, and the authority to implement health care interventions. Projects are designed, implemented, and evaluated on a rapid cycle basis; they are awarded under separate task orders and are completed within 15 months on average.

As part of this project, AHRQ has recently funded hospital associations in 10 states to reduce central line infections, modeled on the success of the Michigan Hospital Association's initiative. From 2006 to 2008, AHRQ made 58 ACTION project awards with total funding of $30.2 million (Palmer 2008).

Evaluation of a previous AHRQ project that had similar characteristics found that diffusion across sites was rare over the period studied (Gold and Taylor 2007). AHRQ indicates that it has addressed this lack of diffusion in the ACTION program by emphasizing projects with broad applicability and potential scale. How findings are diffused beyond these sites to nonparticipating facilities is also important, however. AHRQ has a website to make its findings publicly available (Palmer 2008).

In addition, AHRQ has the authority to implement the 2005 Patient Safety Act, which created Patient Safety Organizations (PSOs). PSOs are entities that meet certain criteria and apply for the designation. To receive the designation, the entity's primary activity must be conducting activities to improve patient safety and health quality, such as disseminating recommendations, protocols, or information on best practices. A prime motivation for this designation is to allow providers to voluntarily report information on their care delivery on a privileged and confidential basis to allay fears that the information could be used against them in medical liability cases. Seventy-nine organizations are currently listed (Agency for Healthcare Research and Quality 2010). Newly enacted legislation calls on PSOs to work with hospitals with high rates of preventable readmissions.

The PPACA also calls on the Center for Quality Improvement and Patient Safety at AHRQ to study best practices and support their diffusion. This center is also authorized to award technical assistance grants to a variety of organizations (including providers and the Joint Commission) to provide technical assistance for quality improvement.

Opportunities for coordination also exist between the QIO program and the Office of the National Coordinator for Health Information Technology (ONC) at HHS, which is tasked with leading the national effort to support adoption of HIT and promote the exchange of information

to improve care. Among other things, the ONC is implementing the HIT regional extension center program to provide HIT technical assistance to providers on a regional basis. Some QIOs have successfully competed to offer assistance under this program (Department of Health and Human Services 2010).

Another indication that there is an opportunity for more coordination in quality improvement funding is the large percentage of the QIO program budget devoted to support contracts and not to directly support QIO clinical quality improvement activities (as discussed on p. 78). QIOs have noted that, while this type of funding may be supporting worthwhile projects, they object to the Medicare Trust Fund money being diverted to other projects, which reduces funding for their core activities (Reichard 2008). Spending on noncore activities is a growing part of the QIO program budget and the IOM has noted that there is no accountability for how this category of money is spent (Institute of Medicine 2006).

In considering ways to better coordinate quality improvement efforts, it is worth noting that the IOM discussed the option of transferring the QIO program to a different federal entity (i.e., AHRQ, Veterans Administration). Among the advantages of such an approach are that it would free CMS to focus on measurement and payment issues and to pursue a strong regulatory approach (when necessary) without fear of jeopardizing providers' willingness to participate in quality improvement. The IOM also noted that other federal agencies might better manage the program. Disadvantages included "the loss of the QIO apportionment, which supports other quality related projects." The IOM report also observed that moving the QIO program outside of CMS would jeopardize coordination between QIOs and the CMS offices responsible for public reporting, COPs, Medicaid, SCHIP, and Medicare payment (Institute of Medicine 2006).

Policy considerations in provision of technical assistance

In considering how Medicare can encourage diffusion of best practices and a culture of patient safety, this section discusses the advantages of focusing on low performers and explores the implementation issues that arise in pursuing this policy. Second, we reconsider the current infrastructure for delivery of technical assistance and contemplate the possibility that greater flexibility—in who provides the assistance, who chooses the assistance agent, and what the assistance is used for—is needed to stimulate real change. Increased flexibility can precipitate innovation, allow for local needs to be met, generate organizational buy-in, and allow for multiple sources of funds to be used synergistically. Increased flexibility, however, requires strong accountability, and for this reason it is useful (although not necessary) to consider these policy options in tandem with our discussion of conditions of participation.

Focusing assistance on low performers

CMS has introduced a policy of focusing its technical assistance on low-performing providers in the QIOs' latest SOW. The logic for this approach is multipronged, but implementation raises some design issues.

Advantages Focusing technical assistance on low-performing providers has several advantages. First, it helps address the problem of uneven quality that makes some Medicare beneficiaries vulnerable to the hazards of poor care. By informing poor performers of the proven techniques and innovations of the leading edge of providers, QIOs can reduce variation in the quality of care Medicare providers deliver. Moreover, because low-performing providers tend to care for proportionately more minority and poor patients, this focus could be an effective strategy in closing racial and socioeconomic disparities in care (see text box, pp. 84–85).

Second, targeting technical assistance can help providers with resource and knowledge constraints to respond to new payment policies. CMS already reduces payments to hospitals when avoidable complications occur during the inpatient stay and denies payments to hospitals for treatments in which unacceptable errors, known as "serious reportable events" (sometimes also referred to as "never events"), occur.[4] Also, the PPACA will penalize hospitals for high risk-adjusted readmission rates and, in the context of pay for performance, for poor risk-adjusted performance on a range of quality measures starting in 2012. These payment policies are intended to provide a financial incentive for hospitals to improve their quality of care.

The Commission recognizes that caring for patients with certain disadvantages (e.g., low income, low health care literacy, lack of social support, language barriers)—many of whom live in areas with little access to primary care—challenges providers' ability to effectively manage care over time. Targeted technical assistance could help providers address these challenges. This approach—

Targeting low performers may reduce racial and socioeconomic disparities in care

Improving quality of care among the lowest performing providers has the advantage of addressing persistent racial and socioeconomic disparities in care—disparities that have no place in 21st century American medicine.

Minority beneficiaries often receive health care from providers found to deliver lower quality care. For example, the Commission's research finds hospitals that serve relatively high proportions of minority and low-income Medicare beneficiaries have higher readmission rates than hospitals serving fewer minority beneficiaries. Because of the concentration of minority beneficiaries served by poorly performing providers, efforts to improve the performance of low performers should disproportionately benefit minority patients.

However, targeting technical assistance to low-performing providers would not necessarily address racial or socioeconomic gaps in care that arise from the same providers treating their minority and nonminority patients differently. The literature does not suggest this situation is a main source of disparities in care.

Racial patterns in the selection of providers

Minorities tend to receive most of their care from a limited number—20 percent to 25 percent—of the nation's physicians and hospitals (Bach et al. 2004, Jha et al. 2007, Jha et al. 2008). For physician services, Bach and colleagues analyzed Medicare claims data for Part B services provided in 2001 and found that 22 percent of primary care physicians accounted for roughly 80 percent of all physician office visits by African American Medicare beneficiaries, while the remaining 78 percent of primary care physicians accounted for 78 percent of the visits by white patients.

For hospital care, Jha and colleagues found that the top 25 percent of hospitals (about 1,100 hospitals) with the largest volume of African American patients provided care for nearly 90 percent of all elderly African American patients (Jha et al. 2007). There was further concentration within this quartile—the 5 percent of hospitals (222 hospitals) with the highest volume of African American patients accounted for almost 44 percent of the total volume of elderly African American patients. By comparison, the top 5 percent of hospitals with the highest volume of white patients cared for 23 percent of all white patients.

A similar pattern exists for Hispanic beneficiaries. The 5 percent of hospitals (227 hospitals) with the highest volume of elderly Hispanic patients cared for about 51 percent of all patients in that grouping, and the top quartile of hospitals (1,137 hospitals) with the largest proportion of Hispanic patients provided care for more than 90 percent of all elderly Hispanic patients in 2004 (Jha et al. 2008).

Providers serving a high portion of minority and economically disadvantaged populations have lower quality

Physicians treating African American beneficiaries were somewhat (but statistically significantly) less likely to have obtained board certification in their primary specialty than physicians treating white patients (77.4 percent compared with 86.1 percent); these physicians also were more likely to report that they could "not always" provide access for their patients to high-quality subspecialists, diagnostic imaging, nonemergency hospital admissions, and high-quality ancillary services (Bach et al. 2004). These findings are supported by other survey-based research that, while not focused exclusively on Medicare patients (and thus the findings are affected by factors such as patients' insurance status and coverage), shows primary care physicians treating predominantly minority patients were more likely to report difficulties providing high-quality care (e.g., getting referrals to high-quality specialists and spending enough time with patients) (Reschovsky and O'Malley 2008).

In a study of hospital quality of care, Jha and colleagues found that the top 25 percent of hospitals with the largest volume of African American patients had slightly lower performance on acute myocardial infarction quality measures and modestly lower performance on pneumonia quality measures than hospitals with a low volume of African American patients. They found no difference in congestive heart failure measures.

(continued next page)

Targeting low performers may reduce racial and socioeconomic disparities in care

Similarly, hospitals with high proportions of Hispanic patients had lower performance on quality indicators for all three conditions than hospitals with low proportions of elderly Hispanic patients.

Several other studies that examined disparities in the quality of one or more processes of inpatient care also found that large portions of the measured differences in quality between white and minority patients are accounted for by differences in the hospitals where the patients received their care (Barnato et al. 2005, Bradley et al. 2004, Gaskin et al. 2008, Groeneveld et al. 2005, Hasnain-Wynia et al. 2007). Among African American beneficiaries in a market with high racial segregation, the risk of admission to a high-mortality hospital was 35 percent higher than for whites in the same market (Sarrazin et al. 2009). Another study found that risk-adjusted mortality after acute myocardial infarction is significantly higher in hospitals that disproportionately serve African Americans (Skinner et al. 2005). A newly published study examined whether a hospital performs a high volume of 17 services for which a positive volume–outcome relationship has been documented. The researchers found that African American patients of all ages and insurance types in the New York metropolitan area from 2001 to 2002 were significantly less likely than white patients to use a high-volume hospital for all but one of the services examined, and Hispanic patients were less likely than whites to use high-volume hospitals for 15 of the 17 services (Gray et al. 2009). The observed differences in the use of high-volume hospitals did not seem to be accounted for by proximity (minorities actually tended to live closer to the high-volume hospitals) or insurance status (the differences persisted among patients with the same insurance coverage). The authors speculate that the most likely explanation for the observed patterns pertains to the physician a patient first sees for treatment and the referral process that follows.

Socioeconomic status also plays an important role in contributing to racial and ethnic disparities in access to and quality of care. Studies have found that racial and ethnic minorities are generally poorer than whites and are more likely to have family incomes near the federal poverty level. Low socioeconomic status usually is associated with substandard access to care, fewer community resources, and higher mortality (Cohen et al. 2003, Stewart and Napoles-Springer 2003). In an analysis of six common, high-risk surgical procedures for Medicare beneficiaries, researchers found that patients with lower socioeconomic status experienced significantly higher rates of risk-adjusted mortality than patients with higher socioeconomic status. Like racial and ethnic disparities in hospital and surgical care, disparities among beneficiaries from different socioeconomic groups seem to be driven by differences among the hospitals where patients receive treatment. At hospitals whose patients have the lowest average socioeconomic status, patients of both high- and low-status groups are more likely to die, while at hospitals whose patients have the highest average socioeconomic status, patients of both high- and low-status groups are less likely to die (Birkmeyer et al. 2008). Although socioeconomic status and race and ethnicity are related, researchers have found that when they control for socioeconomic status, racial and ethnic health care quality disparities are reduced but not eliminated (Barr 2008, Chassin 2002, Cohen et al. 2003).

Providers with high readmission rates tend to serve a high proportion of minority beneficiaries

In our own analyses of racially disparate care, we found that hospitals with high risk-adjusted readmission rates had a different racial and ethnic patient mix than their lower readmission rate counterparts (see online Appendix 3-A at http://www.medpac.gov). Hospitals in the top quintile of risk-adjusted readmission rates for 2005 through 2007—roughly 400 acute care hospitals and critical access hospitals—have, on average, a significantly higher percentage of minority Medicare patients than all other hospitals (Table 3-1, p. 86). This finding holds true for the aggregate comparison of all minority Medicare admissions by total count of admissions and proportion of admissions. These highest readmitting hospitals also have higher admissions counts and percentages of African American and Hispanic patients.

(continued next page)

Targeting low performers may reduce racial and socioeconomic disparities in care

TABLE 3–1 **Hospital percentage of Medicare admissions by race/ethnicity, 2007**

	Top quintile readmissions (mean)	Bottom four quintiles readmissions (mean)
White	72%*	86%*
Minority	29*	14*
African American	23*	10*
Hispanic	6*	2*

Note: *Statistically significant difference (p = 0.01) between hospitals in the top quintile of risk-adjusted readmission for 2005–2007 and other hospitals.

Source: MedPAC analysis of 2005–2007 MedPAR data.

Hospitals with the highest risk-adjusted readmission rates for the 2005–2007 period also differed from their counterparts on certain socioeconomic characteristics. Hospitals in the top quintile of readmission rates had, on average, a significantly higher percentage of disproportionate share hospital (DSH) funds and a greater likelihood of falling into the top quartile of DSH percentage. Additionally, these hospitals had a greater share of Medicaid days (data not shown). While DSH percentage and share of Medicaid days are imperfect proxies for the socioeconomic status of patients at a given hospital, our findings suggest that hospitals with the highest risk-adjusted readmission rates may serve a lower income population than hospitals with lower readmission rates.

While this seems to support the broad finding that minorities and low-income individuals receive care at lower quality institutions, causality cannot be determined. On one hand, minorities and low-income individuals may receive poorer quality care because they concentrate in low-performing institutions. Conversely, these institutions may report lower quality because they treat a challenging population in a community with a weak outpatient care infrastructure (see online Appendix 3-A at http://www.medpac.gov). ■

maintaining uniform standards and providing technical assistance—stands in contrast to an alternative approach that would lower quality benchmarks for hospitals caring for a high proportion of poor and minority patients as a way to lessen the likelihood they would be financially penalized. Such an approach essentially endorses a lower standard of care for a sizeable portion of poor and minority patients and ultimately may perpetuate care disparities.

Experience of the Medicare Premier Hospital Quality Incentive Demonstration suggests that when low-performing hospitals are provided support and a financial incentive, the performance gap between high and low performers can narrow substantially, if not be eliminated. In 2003—the year before implementation of the demonstration program—hospitals with a high share of poor patients had lower scores than hospitals with a low share on composite quality measures of care for AMI, congestive heart failure (CHF), and pneumonia. In 2007, the scores for the hospitals with a high share of poor patients across all three care composites had increased significantly more than the other hospitals, almost entirely eliminating the quality measure differentials that existed at baseline (Jha et al. 2009). Premier offered technical assistance to providers throughout the demonstration by helping them understand how they compared to other hospitals and informing them of strategies to improve their performance.[5] While encouraging, policymakers should consider these results with some caution, given that the hospitals participating in the demonstration self-selected and may not represent all low-performing hospitals.[6]

A third advantage of focusing on low performers and those with financial constraints is that it may minimize the likelihood that public resources would displace equally effective private sector resources. High-performing providers likely already have the resources necessary to make investments leading to high-quality care. Providing additional assistance to them effectively subsidizes their success using scarce public resources. Poor performers

may be less likely to take advantage of private sector technical assistance because of financial constraints that arise from a challenging environment (e.g., rural setting, low-income population) or a lack of commitment to improving quality.

Similarly, a focus on low performers may avert duplication with other federal initiatives through AHRQ that focus on identifying best practices and encouraging entities to function as technical assistance agents.

Design considerations Several design choices arise in pursuing an approach that focuses technical assistance primarily on poor performers. The first choice concerns the metrics to be used to measure quality or performance for the purposes of identifying which facilities should be eligible for additional assistance. Currently, CMS establishes quality priorities for the QIO program (e.g., nursing home pressure ulcers, improving surgical safety and care for heart failure, the use of physical restraints in nursing homes and hospitals) and identifies poorly performing providers for some of them.[7] The advantage of being specific is that proven quality improvement strategies can be implemented quickly to address these problems and thus save lives immediately, while fostering a culture of quality improvement at the facility. IHI used this type of strategy in its 100,000 Lives Campaign to improve patient safety; it identified six areas for improvement (e.g., rapid response teams, medication reconciliation) and provided practical tools to quickly implement changes (Bodenheimer 2007).

Under an alternative approach, low performers could be identified based on their performance on more general outcomes measures, such as rates of mortality, potentially avoidable complications, infections, and readmissions as well as patient experience measures. Ideally, at least some of these measures would evaluate performance across the hospital and not be specific to a condition or a department. Other measures, such as the community's emergency department use and admission rates, could also be considered, as they are indicators of whether the community has adequate access to primary care. Access to primary care is central to promoting health among beneficiaries and is an aspect of the health care delivery system that pioneering hospitals have been able to influence.[8]

The advantage of using risk-adjusted outcomes measures is that they define quality more broadly and more meaningfully for patients than intermediate outcomes measures or process measures. As Swensen and colleagues noted, "The bureaucracies required to track enough process measures for broad-based transformation of outcomes would be oppressive and expensive. A system that rewards better patient outcomes while encouraging innovation would be more efficient and effective. Furthermore, given that nearly 20% of all medical diagnoses are incorrect, rewarding a correct process (possibly for an incorrect diagnosis) makes less sense than recognizing our ultimate goal: superior outcomes for patients" (Swensen et al. 2010).

Using outcomes measures also allows providers flexibility in which quality improvement strategies they employ. For some, reducing patient mortality may require that they focus on strategies to align hospital and physician incentives in a way that promotes hand washing to prevent infections. For others it may be that certain HIT projects need to move to the top of the queue so that high-risk patients are identified upon admission. And for still others, it may require retraining staff on implementing checklists in the intensive care unit or operating room. A combination of these strategies may be necessary.

In addition, focusing on broad outcomes challenges facilities to work with their data and use self-assessment tools to identify targeted improvement strategies that affect hospital-wide performance. While some may not be accustomed to working with detailed performance data, the ability to do so may be key to precipitating genuine culture change.

There are three potential disadvantages of this approach. First, some facilities may not be sufficiently facile with using their performance data and assessment tools to identify the root causes of their problems, which delays their response in implementing effective improvement strategies. Second, the ability to risk-adjust outcomes measures may not be considered sufficiently precise to accurately compare hospital performance. Third, measuring the effect of Medicare's technical assistance may be difficult to tease out, compromising public oversight of the use of these funds.

A second design issue concerns whether assistance should be directed to low performers that do not face particular challenges, such as financial constraints, a high proportion of poor patients, or operating in a rural setting. Without such challenges, it may be reasonable to expect providers to improve performance without additional federal resources.

A related issue is whether assistance should focus on any particular provider types (e.g., physicians, hospitals, nursing homes). It could be argued that small physician practices and freestanding nursing homes would be good candidates for technical assistance, as they lack the infrastructure and economies of scale to implement quality-improving strategies on their own. Hospitals not part of a system or consortium may also be less likely to implement quality improvement. A counter argument is that Medicare should devote its technical assistance resources to promoting the formation of integrated delivery systems that are more likely to be able to deliver quality care efficiently. The integrated nature of these organizations can allow for better coordination of care and alignment of incentives across providers, particularly if payment changes such as those envisioned under accountable care organization proposals are enacted (Medicare Payment Advisory Commission 2009).

Similarly, another design question is whether Medicare should devote its quality improvement resources to providers that serve a high proportion of Medicare beneficiaries (e.g., hospices vs. ambulatory surgery centers, hospitals that care for a high volume of Medicare beneficiaries vs. hospitals with a low volume of Medicare beneficiaries). Or is Medicare's obligation to improve care regardless of the proportion of beneficiaries receiving care from the provider?

Another design question is whether assistance should be targeted to individual providers or whole communities, including a mix of providers and patient advocates. Targeting assistance to communities would take into account the fact that some quality issues are not specific to an individual provider. All providers in a community would benefit from improvements in communications, for example. Convening providers who normally do not meet to discuss systems issues can be a valuable form of technical assistance. There are limitations, however, to directing assistance to communities instead of providers. First, a "community" cannot be held accountable and many do not identify themselves as an entity with the capacity of collectively organizing quality improvements. Second, performance can vary greatly within the community, which suggests that not all the factors underlying low performance are shared across a community. In addition, technical assistance to one hospital could still lead to convening of providers. For example, reducing a hospital's readmission rate could well require reaching out to post-acute care providers, community physicians, and possibly other hospitals to address coordination issues.

Options for delivery of technical assistance

Who should provide technical assistance to low-performing providers or communities, and who should select which technical assistance agent can best meet their needs? For example, should CMS continue the QIO program as currently structured, relying on its core cadre of organizations that currently function as QIOs? Or should it designate other types of entities to provide the assistance? Or should providers or communities needing the assistance be provided a grant with which to obtain the technical assistance they think might best suit them?

Each option is explored below, but one overarching point is worth making at the outset. Providers need access to data on their performance compared with others. The data are necessary to evaluate whether new ideas produce genuine quality improvements, encourage successful sites of care to continue their work, and challenge slower adopters to make changes. Medicare currently posts performance data on its website that allow hospitals and nursing homes (and certain other types of providers) to compare their performance with others, but it does not report providers' patterns of care by episodes—information that can be key to improving care transitions but not possible for individual providers to ascertain on their own. An expert panel assembled by the Commission on October 22, 2009, to reflect a range of stakeholders strongly voiced the need for Medicare to make episode data available to providers on a timely basis to aid improvement efforts. Concerns about preserving provider and patient privacy would also need to be addressed in making this information a successful tool for quality improvement.

Option for CMS to continue contracting with current types of entities as QIOs Currently, CMS designates QIOs to serve each state through a competitive process. A subset of the QIOs may be competitively designated to focus on additional priorities, such as the 14 QIOs working to reduce preventable readmissions as part of CMS's care transitions initiative. QIOs identify providers to work with and their performance is measured along several different dimensions, depending on the specific task in the SOW.

Despite concerns about the effectiveness of the QIO program, the current approach to technical assistance, in principle, has some distinct advantages. First, the current QIO infrastructure has the appeal of making

available a geographically dispersed source of technical assistance and could be an ideal conduit for national efforts to disseminate quality improvement information. The IHI recruited select QIOs as part of its 100,000 Lives Campaign to function as "nodes" in disseminating quality information. Recent legislation authorizing investment in HIT also creates an extension agent network, presumably to address the need for a standing cadre of independent HIT assistance agents.

Second, the current QIO approach could allow the entities to focus on improving community health and as such address community needs comprehensively across providers and across quality improvement priorities (Brock 2009). A third advantage of the QIO structure is that the types of organizations currently eligible to be QIOs are independent from providers. When strictly adhered to, this independence can help avoid concerns about commingling of funds or the appearance of conflicts of interest.

If policymakers find the advantages of the current structure valuable, they may want to consider aspects of the QIO program that could be strengthened. Perhaps there are ways to stimulate a more entrepreneurial and innovative culture. Some QIOs report feeling restricted in their ability to be innovative and responsive to the needs of the communities due to micromanagement by CMS (Sutton et al. 2007). The challenge, however, is that the current program is also under pressure to demonstrate measureable improvement. This emphasis, while reasonable, can stifle the flexibility needed for the desired cultural change.

Option for CMS to contract with other entities to offer technical assistance Under this option, the Congress would change the law to allow more types of entities to contract as QIOs. Current law requires QIOs to serve an entire state and be either a "physician-sponsored" or a "physician-access" organization. These designations require specific thresholds for the number of physicians in the organization's ownership or membership. If these constraints were lifted, other entities, such as independent quality organizations, high-performing facilities or networks of providers, professional societies, and trade associations, among others, could potentially participate.[9]

Among the advantages of such a change are that these entities could stimulate the competitiveness of the program and allow the program to draw on the expertise in the field broadly, while also stimulating innovation among the current panel of QIOs. It could also allow for a better match between providers and agents of technical assistance. Some entities could provide assistance for a subset of quality problems but not others or for certain regions but not others. Similarly, some new types of QIOs might be able to offer assistance to one type of provider (e.g., rural hospitals) because of their unique qualifications but not others.

This approach has several disadvantages. First, the variability in participants would add complexity to administration of the QIO program. With more participants and more variation among them, measuring performance and comparing it with others would increase evaluation challenges. Second, because these organizations have commercial interests in marketing their services and would not have to maintain the distance from clients currently required in the QIO program, oversight of the integrity with which the funds were used could be more challenging. Third, while this approach reflects a significant shift in management of the program, it retains the current relationship in which providers are passive in assignment of the technical assistant agents. CMS would continue to make the selection in compliance with federal acquisition laws and various other statutory requirements that govern the selection and appeals process.

Option for providers to receive funds and determine the entity to provide technical assistance An alternative approach is for the government to provide a grant for technical assistance directly to the provider instead of funneling funds to QIOs. In turn, providers would be required to use that funding to obtain the assistance from a qualified organization of their choice. Current QIOs could compete with other entities to be the choice of providers in the market for assistance. One advantage of this approach is that it confers responsibility for performance improvement to the provider and, as such, could stimulate providers' commitment to improvement and better engage senior managers whose involvement can be so important to quality improvement (Bodenheimer 2007, Keroack et al. 2007). It also avoids some of the bureaucratic and statutory challenges associated with management of the QIO program, allowing providers more flexibility in identifying the areas they need to improve and choosing the technical assistant agent best able to address their needs.

Ideally, this approach harnesses the power of market forces as technical assistance agents have to prove their worth to consumers (i.e., health care providers) rather than

to the government. Taking out the role of government may appeal to providers uncertain not only of the government's expertise but also of its motivation; the government (directly and through its contractors) plays multiple roles simultaneously—payer, regulator, and quality improvement agent—and these roles can conflict.

To protect the taxpayer investment and provide some assurances that the money is being directed to reputable organizations, some constraints could be placed on what types of entities would be eligible to provide technical assistance. CMS could create a marketplace of technical assistance agents meeting certain standards, providing specific information about their areas of expertise and links to websites for further information. It could also post reviews of technical assistance providers by other providers who have used their services.

Nevertheless, this approach does not guarantee success and offers less ability to formally evaluate the effectiveness of technical assistance funding than the current approach. If the market fails to produce technical assistance agents that can provide a product of genuine value to providers, technical assistance resources will be wasted. This risk may be abated by having financial incentives for providers to improve quality (as have been recently enacted as part of health care reform) or intermediate sanctions as part of the survey process for compliance with the COPs. Under pressure, providers may be more engaged and savvy consumers.

Another issue concerns whether grants to providers sacrifice the economies of scale that QIOs can offer when they conduct conferences or collaboratives to address common quality problems. These economies may allow QIOs under the current structure to assist more providers than under this model where grants go to the low-performing providers or communities. It is possible, however, that providers or communities could opt to work with technical assistance agents that offer collaboratives or other types of group-learning forums and still capture efficiencies.

Under approaches that move away from having a limited, stable mix of QIO contractors, the question remains as to whether QIOs would retain their other responsibilities, such as handling beneficiary complaints, other case reviews, and system-wide quality improvement activities. Responsibility for these activities could be reassigned to other parts of CMS or to claims administration contractors, or it could be maintained with the current QIOs.

Use of conditions of participation to further motivate quality improvement

Although COPs have the potential to influence the quality of care provided to Medicare beneficiaries, the standards and the survey process that enforce them can likely be better leveraged to improve the performance of low performers as well as higher performers. For low performers, particularly those receiving technical assistance, clearly stated expectations and accountability for meeting those expectations can provide additional motivation to improve. For higher performers, the opportunity to meet performance criteria indicative of high quality and efficient care could resonate with their desire to distinguish themselves in the marketplace.

Effectiveness of current COPs and oversight

Several stakeholders we interviewed expressed concern that the COPs reflect a limited aspect of quality. The link between having certain structural requirements and process measures in place and having a culture of patient safety and quality improvement that produces good outcomes is tenuous. For example, the COP requirement for surveyors to affirm that hospitals' plan for patients' discharges may produce a less meaningful view of quality than if the COP required surveyors to review surveys that asked recently discharged patients if they understood what problems to look for, how to take their drugs, and who to call if they had a problem.

Studies have focused on the efficacy of COP enforcement, primarily through the accreditation process, rather than on a correlation between standards and quality outcomes.

Studies on the effectiveness of the accreditation and survey process provide mixed results. Studies have found little correlation between accreditation and general hospital mortality and no differences in rates of medication error between accredited and nonaccredited hospitals (Barker et al. 2002, Griffith et al. 2002). The media have also raised questions about the rigor or value of the surveys, citing a variety of examples where, following a Joint Commission's accreditation of a facility, glaring examples of poor care surfaced (Gaul 2005). Other studies raise relevant concerns, although they do not specifically reference the accreditation process, such as why so few boards are aware of their hospitals' relative performance on quality measures and how so many medication errors have occurred.

On the plus side of accreditation, one study of beneficiaries hospitalized for AMI found that accredited hospitals had higher scores on process measures (more likely to use aspirin, beta-blockers, and reperfusion therapy) and lower 30-day mortality rates than nonaccredited hospitals. (Considerable variation existed within accreditation categories, indicating that accreditation levels, which have since been modified, have limited usefulness (Chen et al. 2003).) Another study found Joint Commission accreditation to be associated with better outcomes for patients with AMI and CHF treated in rural hospitals compared with nonaccredited rural hospitals (Morlock et al. 2005). Researchers have found that the Joint Commission's national patient safety goals have led hospitals to focus on widely identified quality issues (Devers et al. 2004).

A recent opinion piece in *Health Affairs* praised some of the Joint Commission's improvements in the last several years (i.e., the national patient safety goals, the tracer methodology, and unannounced surveys) but expressed concern that "once low-hanging fruit has been picked" its approach is "ill-suited to drive progress in complex, nuanced areas." It cites as evidence the difficulty the Joint Commission had in creating a patient safety goal on medication reconciliation, concluding that the Joint Commission implemented the standard prematurely (Wachter 2010).

Because the Joint Commission accredits such a large share of the nation's hospitals while variation continues to exist in the level of quality provided, accreditation standards could be considered too inclusive to sufficiently promote quality care. This situation in part reflects the nature of the COPs, which do not cover accountability for health outcomes. It may also reflect the Joint Commission's educational role, as providers have up to 60 days to correct infractions detected in the course of a survey to earn accreditation status.

Policy options to maximize COP effectiveness

Several options exist for modifying the COPs in ways that could encourage providers to improve health care quality and value and enable beneficiaries to make more informed choices. These options include updating COPs to align them with current quality improvement efforts, creating interim sanctions, and developing voluntary or mandatory outcome-oriented requirements.

Update COPs to align them with current quality improvement efforts

If the COPs were updated in line with current quality improvement efforts, there would be greater opportunity to influence providers' adoption of recommended clinical practices and processes of care. The National Quality Forum recommends that CMS and the Joint Commission continue to review and update their accreditation standards for "currency, consistency, and alignment" (National Quality Forum 2004). Some possible areas for updating are discussed below.

The challenge of updating the COPs would be to avoid making the requirements so prescriptive that they did not allow for productive innovation. In addition, as a practical matter, promulgating regulatory changes is time-consuming and costly, while CMS is understaffed and underfunded. Therefore, to make COPs a more effective tool for quality improvement, consideration should be given to investing in a new process for making timely updates to both the COPs and their accompanying guidance on implementation and allowing input from the public on their development.

Encourage boards of directors to focus on quality improvement A recent study found that 66 percent of hospital boards thought their quality scores on the Joint Commission core measures or with Hospital Quality Alliance measures were better or much better than the typical U.S. hospital. As noted earlier, none of the boards of low-performing hospitals thought that their hospitals' quality was worse than the typical hospital: 58 percent of low-performing hospitals reported their performance to be better or much better (Jha et al. 2009). This finding is alarming, particularly because the COPs require that the board be involved in quality improvement. One solution could be for the COPs to be more specific and binding to encourage boards to better embrace their responsibilities. For example, board members could be required to document that they are aware of their hospital's relative performance on quality measures. Both National Quality Forum and the HHS Office of Inspector General (together with the American Health Lawyers Association) have published papers calling for greater board involvement (Callender et al. 2007, National Quality Forum 2004).

As part of this reform, it may also be important to focus responsibility on the boards of systems in addition to boards of the individual hospitals. The governing body at the system level may have control over more resources that could be devoted to quality improvement than individual hospitals.

Improve the discharge process For example, the COPs could require that hospital staff go over a discharge checklist with patients to increase the likelihood that they know how to care for themselves at discharge and decrease the chance they will be readmitted. They could require that follow-up appointments for community care be arranged before the patient is discharged or that providers use the teach-back approach to promote greater knowledge about self-care. These requirements would be in addition to existing ones that require a hospital to counsel patients and family members and prepare them for post-hospital care; supply lists of local Medicare-participating post-acute care providers; transfer or refer patients, along with appropriate medical records, for follow-up and ancillary care as needed; and reassess its discharge plans to ensure they are responsive to patients' needs at the time of discharge.

Demonstrate that physicians are participating in patient safety activities and are accountable Physician leaders have called for more accountability and consequences for physicians, saying that "as long as transgressions carry no risk of penalty, some providers ignore the rules, believing that they are not at risk for the mistake the practices are designed to prevent, that they are too busy to bother, or that the practice is ineffective" (Wachter and Pronovost 2009). To encourage hospitals to monitor physician actions in the hospital for appropriateness, the COPs could require hospitals to demonstrate that physicians are accountable for patient safety.

This type of requirement can vary in its stringency. On one side of the spectrum, the COPs could require that the hospital demonstrate that physicians participate in activities such as using checklists or team-based training (Livingston 2010). Further along the spectrum in rigor, the COPs could require that hospitals develop their own penalties for clinicians' failure to adhere to safe practices, such as failure to practice hand hygiene, marking the surgical site to prevent wrong-site surgery, or using the checklist when inserting central venous catheters (Wachter and Pronovost 2009).

The COPs could be strengthened to ensure that surveyors review hospitals' commitment to implementing an effective physician peer review process. Given how few doctors are reported to the National Practitioner Data Bank and the persistent culture of concealing medical errors, there is reason for concern that hospitals do not adequately monitor whether their physicians are practicing appropriate medicine (Levine and Wolfe 2009). Examples of physicians in Redding, California, and more recently in Towson, Maryland, performing unnecessary cardiac surgeries are reminders that monitoring is necessary.

Expand COPs to directly address efficiency Currently, the COPs require hospitals to perform quality improvement projects and demonstrate improvement. The standards are not prescriptive about the focus of the projects (e.g., reducing infections, better communication) but require that projects have objectives that surveyors can verify. One option would be to create a similarly structured requirement that hospitals perform process reengineering projects that are intended to reduce waste of hospital resources. Among other things, process improvements can achieve efficiencies by improving throughput and avoiding duplication of services (e.g., multiple imaging) or avoidable expenses (e.g., opening sterilized surgical supplies that ultimately are not used). Such improvements are likely to improve quality as well as efficiency but may not appear a priority among quality projects.

While, in theory, providers already have an incentive to reduce waste during patients' inpatient stays under Medicare's payment policy, it may not always be achieved. This outcome may in part be because hospitals are complex organizations with many competing priorities. It may be that the goal to maintain or increase the revenue stream requires that facilities focus on launching new service lines or buying state-of-the-art equipment rather than analyzing the inner workings of front-line staff to identify process improvements (e.g., a better maintenance schedule for portable oxygen machines, moving the supply cabinet) that eliminate resource-intensive (and quality compromising) "work arounds." Equipment failures and facility limitations have been identified by front-line staff as one of the most significant impediments to efficient and quality care, yet these types of deficiencies tend to attract little attention (Tucker et al. 2008).

IHI has launched programs on improving efficiency and reducing waste to complement its more quality-focused initiatives. It finds that changes in the current economic environment and mounting evidence that better care can come at lower cost provides the case for "the systemic identification and elimination of waste, while maintaining or improving quality." The aim therefore is "primarily financial; any positive impact on quality, while desired is secondary." Incorporated in IHI's vision of waste reduction is the need for organizations to establish a specific waste reduction aim in cost reduction terms (e.g., 1 percent to 3 percent of operating expenses per year). IHI calls hospitals that systematically address waste "industry pioneers" and

offers examples of strategies to reduce waste, including improvements in staffing (e.g., lower turnover, higher productivity, safer care), patient flow, and supply chain management, as well as as ways to reduce mismatched services (e.g., offering palliative care in the intensive care unit) (Martin et al. 2009).

Create intermediate sanctions

One problem with enforcement under the current survey and accreditation process is that the consequence for failing to pass the accreditation or survey criteria is so extreme—exclusion from the Medicare program—that such action is rarely taken. Intermediate consequences or sanctions that had a real possibility of being imposed could induce providers to improve care and make the accreditation and survey process more effective. A 1990 IOM study recommended that intermediate sanctions be adopted (Institute of Medicine 1990).

There are a range of types of intermediate measures. Under one approach, low-performing providers could be identified publicly, either solely through their performance on process or outcomes measures or in tandem with survey results. Already, under Medicare's Special Focus Facility program, nursing homes designated as deficient are identified publicly.[10]

Under another approach, COPs could require low performers to receive technical assistance. With respect to hospitals, for example, if insufficient improvement was found after some period of time the COPs could require that hospital boards submit a corrective action plan and require each member to verify the board's role in its implementation. The plan would need to be approved by CMS to avert exclusion from the program. Corrective action plans could describe the types of activities the hospital would pursue as well as any management changes the hospital was planning. More aggressive steps could also be contemplated. For example, CMS could prohibit hospitals from performing elective procedures in a given service line for some period.[11]

Given that the research suggests leadership is central to cultivating a quality culture and the evidence that boards of low-performing hospitals are unaware, requiring board involvement may trigger the needed cultural change. This combination of carrots (i.e., technical assistance, particularly if it comes in the form of a grant) and sticks (e.g., board implementation of a correction action plan or a moratorium on elective procedures) would strengthen the motivation of providers to adopt the quality innovations suggested through technical assistance.

Create voluntary higher standards

A more rigorous set of standards for which compliance was voluntary could be created that would allow providers meeting these standards to publicly distinguish themselves as high performers. Ideally, these standards could rely heavily on outcomes measures. If providers found the designation as a high performer valuable, more could be induced to meet a higher standard of care. Over time, depending on providers' response, the higher standard could become the new floor. To the extent that beneficiaries used this information in selecting their providers, more beneficiaries could receive higher quality care.

Several organizations have experimented with creating standards that providers could meet voluntarily to earn a designation that could be used publicly for marketing. Generally, the organizations reported improvements in quality.

- The Blue Cross Blue Shield Association (BCBSA) operates a Blue Distinction program for select conditions, including bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery, and transplants. Voluntarily, facilities can demonstrate they meet the quality criteria, composed of structure, process, and outcomes measures by reporting their own data to BCBSA. BCBSA has made more than 1,600 designations of distinction across 46 states, including about 500 designated centers for knee and hip replacement, 420 for cardiac care, and 83 for transplants. The program has not been formally assessed, but BCBSA reports anecdotes of facilities responding to the incentives by allocating more resources to quality improvement of certain departments and new participation in national registry programs, such as the Society of Thoracic Surgeons or the American College of Cardiology programs. Facilities that meet the Blue Distinction criteria have lower mortality rates and lower episode costs for the selected conditions (Izui and Flamm 2010).
- UnitedHealthcare has a Premium Designation Program for cardiac care and designates high-quality, efficient specialty physicians and hospitals. It reports that preliminary data indicate an average savings of $3,500 per cardiac episode at these hospitals compared with other hospitals in the area.

This program builds on the success of the Premium Network program, which focuses on transplants, rare cancers, and congenital heart disease and is managed by an affiliate of UnitedHealthcare. Patients who received care from designated providers under that program were found to have higher survival rates and less costly care (UnitedHealthcare 2010).

- The National Committee for Quality Assurance (NCQA) has used voluntary standards in the past, allowing its members to demonstrate coordination-of-care efforts. NCQA reports that the health plans that met the standards found the distinction valuable. As evidence, one of these plans took out a full-page ad in the *New York Times* touting the distinction. Subsequently, those standards were incorporated into the health plan accreditation requirements (Torda 2010).

- The Joint Commission has a Disease-Specific Care Coordination Program (for more than 29 conditions) as well as an "advanced level of certification" in seven clinical areas (e.g., primary stroke center, chronic kidney disease). To be certified, programs must demonstrate compliance with consensus-based national standards and safety goals, effective use of clinical practice guidelines, and an organized approach to performance measurement and improvement activities (Joint Commission 2009a).

Two levels of COP designation, such as gold and platinum, could be advantageous to consumers, who are less likely to distinguish among providers by poring over statistics on various performance measures. One important design consideration would be whether the higher standards should be service-line specific, hospital wide, or system wide. Having publicly reported performance data available on an aggregated basis (in addition to more disaggregated data) could attract the attention of senior managers with the most control over allocation of resources and ultimately encourage them to invest in ways to export innovations to other parts of the organization. This approach to performance reporting would help minimize the chances that innovations stay isolated in just one unit of a hospital or in just one flagship hospital of a multihospital system.

Create mandatory outcomes-oriented standards for select services

The COPs could possibly be used to address the concern that Medicare fails to adequately direct patients to better quality providers for certain high-cost and complicated procedures. One option would be to amend the COPs to incorporate outcomes or volume criteria for select services, much like it does for transplant centers, restricting payment for certain services to providers that demonstrate sufficient volume and quality.

The COPs for transplant services differ from COPs for other services and are more proactive in ensuring quality. In addition to requirements for quality improvement programs and notifying patients about their rights, transplant centers also have requirements for their clinical experience and patient outcomes. Transplant centers must generally perform an average of 10 transplants per year. In addition, CMS will compare each transplant center's observed number of patient deaths and graft failures one year post transplant with the center's expected number using the most recent Scientific Registry of Transplant Recipients center-specific report. If observed patient survival or graft survival rates are below expected (and fail certain other statistical tests), CMS will not consider survival rates acceptable.

CMS issued the outcomes-based COPs for transplant centers in 2007 in an effort to maintain state-of-the-art practice and standardize requirements for transplant centers nationwide. Previously, performance standards for a transplant center were organ specific and based on localized outcomes in each service area. This situation raised concerns about variation in a localized outcomes measure, which prompted the requirement for uniform transplant center COPs in the Organ Procurement Organization Certification Act of 2000 (Centers for Medicare & Medicaid Services 2005).

Mandatory higher standards, such as outcomes and volume criteria, would likely be most appropriate for complex and costly procedures, which are not normally needed on an urgent basis. Certain cardiac procedures, such as coronary artery bypass graft, and certain orthopedic procedures may be the types of procedures for which this approach may be appropriate.

The possible disadvantages to this option are that it requires consensus about the evidence governing the criteria, beneficiaries may have to travel farther to access certain services, and such restrictions create barriers to entry for new providers and could therefore stymie a competitive marketplace. ■

Endnotes

1 In January 2009, CMS announced that it was concluding QIO work on reducing pressure ulcers in hospitals. It noted that all 53 QIOs recruited hundreds of hospitals to work to reduce pressure ulcers, but after 18 months of work overall rates of pressure ulcers "remained relatively low across the nation"—a rate too low for this initiative "to bring about a substantial national-level impact on hospital safety" (Centers for Medicare & Medicaid Services 2010).

2 The American Osteopathic Association and DNV Healthcare, Inc. accredit a small portion of the nation's hospitals.

3 As part of their work under the beneficiary protection theme in the SOW, QIOs are required to conduct case reviews on quality-of-care complaints by beneficiaries and conduct certain utilization reviews, among other things. QIOs are also required to perform quality improvement activities (QIAs). A QIA is defined as an activity initiated by the QIO that requires: (a) an identified provider to articulate a plan or activity to improve an identified quality concern and (b) the QIO to follow up to ensure that the plan is complete or the action has been taken (Centers for Medicare & Medicaid Services 2008). QIOs must identify at least one QIA with an impact that is system wide. As an example, IPRO, the QIO serving New York, has found "that many of the issues identified and confirmed through the case review process relate to concerns that impact/can impact a patient's readiness for discharge as well as increase the potential for readmission. [The] findings include such things as failure to address abnormal laboratory results obtained prior to discharge as well as unclear or incomplete discharge instructions" (IPRO 2009).

4 As of October 1, 2008, Medicare does not assign an inpatient hospital discharge to a higher paying Medicare severity–diagnosis related group (MS–DRG) if the only secondary diagnosis on the claim for the stay is one or more of eight selected hospital-acquired conditions (HACs) and if the condition was not present at admission. In those cases only, Medicare will pay the hospital as though the secondary diagnosis (the HAC) were not present, in effect not paying the hospital to treat the HAC. However, the nonpayment applies only when the specified HACs are the only secondary diagnoses on the claim; if the claim has at least one non-HAC secondary diagnosis that qualifies as a complication or comorbidity (CC) or a major complication or comorbidity (MCC), the claim is paid under a higher paying MS–DRG classification.

The Commission has expressed its concern that Medicare's current HAC payment policy does not give a strong enough incentive for hospitals to eliminate the subset of HACs known as "serious reportable adverse events" (also referred to as "never events"), such as a foreign object retained after surgery, air embolism, blood incompatibility, stage 3 or stage 4 pressure ulcers, and falls or other injury trauma. For these HACs, the Commission suggests that the presence of the HAC upon discharge should bar assignment to a higher paying MS–DRG regardless of whether any other CCs or MCCs are on the claim for that inpatient stay.

5 One independent evaluation of the experience of four hospitals participating in the Medicare Hospital Quality Incentive Demonstration (HQID) noted that the local QIOs worked with the participating hospitals on the HQID project. According to this study, the four hospitals participating in the demonstration formed a collaborative workgroup in the early stages of the project that included the hospital system's corporate quality management department, representatives from Premier, and representatives from the QIOs that worked with the four participating hospitals in Kentucky and Ohio (Grossbart 2006).

6 Another program that could offer insights about the effectiveness of targeting assistance to low performers is the Nursing Homes in Need initiative, which is part of the ninth SOW and requires that QIOs work with a poor-performing nursing home each year of the three-year contract. A final evaluation is not available.

7 For other quality priorities in the ninth SOW, CMS does not identify low performers or require QIOs to focus on low performers. These priorities include improving drug safety, reducing methicillin-resistant *Staphylococcus aureus* infections, care transitions, and prevention.

8 See the Commission's March 2010 meeting transcript at http://www.medpac.gov for the testimony by Denver Health and Parkland Hospital for examples on how they have improved outpatient and community care.

9 One possible model could be similar to the proposed Medicare Chronic Care Practice Research Network, a group of 12 health care provider and research organizations, which stated its mission as "to serve as the leading national resource available to advance the science and operational standards of care management for the chronically ill Medicare population, with special focus on their widespread adoption and relevance to new and improved payment policies." This model was discussed in the Commission's June 2009 report, and while the Commission found problems with the policy design of the specific proposal, the notion of a network of providers being funded directly as a change agent represents an alternative way for QIOs to fund improvements.

10 The Special Focus Facility program provides for close monitoring of poorly performing nursing homes across the country.

11 Other aggressive approaches have been authorized for deficient nursing homes. When a nursing home is cited with one or more deficiencies that constitute immediate jeopardy to resident health or safety, the law allows for "federal temporary management." The temporary management appointed by CMS has full authority to hire, terminate, or reassign staff; spend nursing home funds; alter nursing home procedures; and otherwise manage a home to achieve its objectives. In reviewing the program, the Government Accountability Office found that most homes under temporary management (15 between 2003 and 2008) corrected deficiencies in the short term, although some continued to have compliance issues in the longer term.

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