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Folder Title:
Quality

Stack:	Row:	Section:	Shelf:	Position:
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Quality of Care

- Practice guidelines
- Performance monitoring and state certification of plans to assure access and quality
- Encounter based data to assess quality of services
- Additional research into content of care (prevention) and delivery of care patterns (health services research), outcomes and quality
- Special fund for academic health centers
- Regional professional foundations
- Decrease in inappropriate use of medical services e.g. emergency rooms
- Focus on individual responsibility

Sample Quality Report Card

Sample Performance Measures	Plan A	Plan B	National Health Board Goal
Consumer Satisfaction			
Enrollees very satisfied with plan	85%	40%	-
Enrollees very satisfied with primary care physician	90%	50%	-
Enrollees leaving plan last year	5%	13%	-
Access to Care			
Time to initial visit with primary care doctor	15 days	60 days	10 days
Patients with serious heart condition seeing cardiologist	30%	5%	25%
Appropriate Use of Medical Care			
Pregnant women receiving early prenatal care	70%	50%	98%
Rate of complete immunization (children age 2-5)	75%	50%	99%
Annual mammography rate (women over 50)	50%	40%	90%
Success of Medical Care			
Death rate after heart attack	6%	35%	5%
Low birthweight babies (percent of all births)	8%	10%	2%

Surveys

- Plan by plan surveys
  - Households
- National and State level surveys
  - Employers
  - Providers
  - Health insurers and plans

Survey Content

- Access
- Out of plan use
- Satisfaction
- Disenrollment
- Health Status

Implications and Future Directions

- Data ownership
- Privacy and access
- Improving choice with information
- Population-based focus
- Enhanced quality data
- Uniformity over diversity
- New technology vision

Purposes of Data

- Planning, policy, evaluation and research
- Payments for health services
- Assessing and improving quality
- Cost of clinical and administrative functions
- Public health
- Improving consumers' choices

Administrative Data Systems

- Universal health security card
- Uniform health data sets
- Electronic formats and standards
- Electronic data networks
- Regional data centers
- Unique identification numbers
- Privacy protection
- Point of service information systems

Information System Objectives

- Administration at all levels
- Quality and evaluation
- Support public health objectives

Information System Components

- Administrative Data System
- Survey Program
- Public Health Data

Privacy Protection

- National Privacy Committee
- Privacy Standards
- Prohibited Disclosures
- Prohibited Uses of Unique Identifier
- Guaranteed Individual Rights
- Civil Monetary Penalties
- National Privacy Legislation

Types of Data

- Enrollment and disenrollment
- Clinical encounters
- Administrative and financial transactions
- Characteristics of regional and corporate alliances
- Benefits, utilization, quality management
- Additional information determined by the Board

ACADEMIC HEALTH CENTERS--QUALITY

QUESTION:

One of the great things academic medical centers have to offer is quality. Quality really has to be assured by a continuous process. Money aside, the decisions about the allocation of initial training slots will largely be made by a national council. The concern of many is that this process of allocation will not assure us that academic medical centers will have the capacity to fulfill their duties in terms of providing lifelong education.

ANSWER:

During the last few decades the half life of scientific information has gotten progressively shorter. It has become clear that residency training is merely the first installment on what must be a lifelong process. Thus far, continuing education has been developed in a way that is largely entropic. The Health Security Act will establish an integrated program of lifelong learning for health professionals.

First, Regional Professional Foundations will be established as non-profit consortia that will include academic health centers, schools of public health, other schools for health professionals, and members of the delivery system--alliances, health plans and practicing physicians. These regional professional foundations will be funded to develop programs in lifetime learning that will keep health professionals abreast of new knowledge, techniques and roles as technology and societal demands change.

A National Quality Consortium will also be formed from representatives of academic health centers, schools of public health and other schools for training health professionals. Operating on the national level, its job will be to oversee the development and funding of the regional professional foundations, to establish programs for lifelong education and to advise the National Quality Management Program on education, research and related quality issues.

TALKING POINTS ON QUALITY MANAGMENT
THE HEALTH SECURITY ACT

THE CURRENT SYSTEM

Today, there are as many different quality performance tools and procedures as there are health plans. Some businesses also administer their own quality assurance programs and may use different measures. Others may hire expensive consultants to do it for them. By not standardizing the quality performance measurements, insurance companies and others interested in quality are micromanaging the health care system, and creating an unmanageable paper trail. In addition, these practices are intruding on the provider's ability to do his/her job-- treating the patients.

Complexities of Current System

- States employ their own certification standards, which government employees update year after year, and whose measures differ across the country.

- Use of different measures of quality is duplicative and is not standardized. Quality measurements differ according to performance measures which can be:

    - provider based
    - health plan based
    - employer based
    - state based

- Medicare administers PROs (professional review organizations) Programs, which increase the complexity of quality assurance.

- CLIA Requirements regulate even the simplest laboratories and procedures

- Quality management is done case-by-case, and is labor-intensive

National Quality Management Program

- Slims State bureaucracies

- Eliminates need for individual states, providers, health plans and employers to develop own standards. Provider standards will eventually be uniform nationally

- Empowers States to certify health plans based on quality

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- Uses statistically-based measures of quality (from new data system) can be used easily and uniformly

- Eliminates Medicare PROs

- Grants CLIA Exemptions for simple laboratory examinations and procedures

National Quality Management Council

Comprised of 15 members appointed by the President

- establishes national measures of quality which will replace the many variations

- advises the National Health Board on its findings including an evaluation and impact of these quality standards in ensuring quality of care and reducing burden on health care providers.

- publishes quality performance measures in a Quality Report Card.

  Examples:

  consumer satisfaction; ensuring adequate access to care (including waiting times for primary care appointments); appropriate use of medical care (such as immunization and mammogram rates) and success of medical care (such as survival rates of heart attack patients).

National Quality Consortium

Comprised of 11 members appointed by the Board, advises the Council and AHCPR:

- Establishes programs for continuing education for professionals

- Advises on research priorities;

- Oversees development and funding of regional professional foundations and advises the Board on the definition of demarcation regions);

- consults the Council on selection of national measures of quality performance;

- Members: Academic health centers, schools of public health or other schools defined in Public Health Service Act

Regional Professional Foundations

- Academic and advisory in nature
- Perform continuing education and disseminate quality information to plans and health care providers at a commuity level.
- Essential for continuous quality improvement and provider collaboration.
- Members: Academic Health Centers, schools of public health, health plans, providers and members from regional and corporate alliances are eligible for membership.

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QUALITY

TITLE V, Subtitle A
(page 823)
QUALITY MANAGEMENT AND IMPROVEMENT

The Health Security Act establishes a National Quality Management Program (NQMP). The NQMP is designed to improve quality, effectiveness and appropriateness of care services and access to such services on a National level.

The NQMP is administered by a fifteen member **National Quality Management Council (the Council)**. The Council reports to the National Health Board on its findings and activities and makes recommendations in consultation with representatives of users and providers and administrators of health care.

The Council:

- Develops national measures of quality performance including access, appropriateness of care, health outcomes, health promotion, prevention and consumer satisfaction.
- Develops and approves plan-by-plan and State-by-State consumer surveys, administered by the Administrator of the Agency for Health Care Policy and Research (AHCPR)
- Recommends to the Board to establish performance goals for alliances, plans and providers, to be updated annually
- Evaluates the impact of reform on quality and access to care for consumers
- Provides an annual report to Congress and to each alliance which:
    - outlines in standard format the performance of regional and corporate alliances and health plans;
    - discusses State and National trends; and
    - presents data for each health alliance from consumer surveys
- Directs the Administrator of AHCPR to develop and update clinical practice guidelines that:
    - establish standards and procedures to be used by providers to help in determining most effective prevention, diagnosis, treatment and clinical management;
    - establish a national guideline clearinghouse; and
    - includes information on risks, benefits and costs for alternative strategies
    - the guidelines may be submitted to the Council for evaluation and certification using the above standards which may then be used by the Secretary in the pilot

Quality, cont'd

program which applies practice guidelines to medical malpractice liability.

- Establishes standards and procedures for evaluating clinical appropriateness of protocols used to manage health services utilization

- Establishes and oversees requirements for membership and internal operations for **regional professional foundations** which perform continuing education and disseminate quality and innovative information to plans and health care providers. The foundations:

  - must include at least one Academic Health Center. Other eligibles are schools of public health, health plans, regional and corporate alliances and health care providers
  - demarcation regions are set by the National Health Board

- directs AHCPR to support and establish priorities for research related to the quality measures.

The **National Quality Consortium**, comprised of 11 members appointed by the Board, advises the Council and AHCPR:

<u>The National Quality Consortium:</u>

- Establishes programs for continuing education for professionals
- Advises the Council and AHCPR on research priorities;
- Oversees development of regional professional foundations and defines demarcation regions with the advice of the National Quality Consortium;
- advises Council on funding of regional professional foundations;
- consults the Council on selection of national measures of quality performance;
- advises Board and the Council on duties of Board or Council; and
- <u>members:</u>
  - 5 must represent academic health centers
  - 6 others from schools of public health or other schools defined in Public Health Service Act

Alliance responsibilities in Quality Assurance:[1]

- Disseminates information to consumers on quality and access for aid in selection of plans
- Disseminates information on quality performance of health plans and health care providers from Council reports
- Negotiates with health plans for continual improvement on performance and quality

Health Plans responsibilities in Quality Assurance:

- Measure and disclose quality information used by participating States and regional and corporate alliances in which the plan does business and furnish reports on quality to the Council

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[1] While not mentioned in Title V, Quality Assurance is listed under Title I, Section 1201 (page 93) concerning State role in Certification of alliance health plans in which: States shall establish and publish criteria for Certification of plans with respect to:

A. Quality
B. Financial Stability
C. Capacity to deliver Comprehensive benefits

- o assure that health plans and providers meet health plan certification procedures
- o Monitor performance of state-certified regional alliance health plans
- o Assure adequate access to **choice** of plans including a plan at or below the weighted average premium for plans in regional alliance.
- o use performance reports by NQMC
- o establish an Omdudsman program within each alliance as described in Title I, Section 1326 (pg147)

Quality, cont'd

Other Issues addressed in Quality section:

Elimination of CLIA requirement for certificate of waiver for simple laboratory examinations and procedures.

INFORMATION SYSTEMS

QUESTION:

How will the new health information systems in the Health Security Act work? Who will have access to the data? What information will be collected at the plan level? What will be the role of doctors, consumers, and plans in developing and monitoring data systems?

ANSWER:

The Act would establish a new health information system to support health care reform and simplify administration. An electronic data network would be established linking plans, alliances, States and the federal government with regional data centers.

The health information system would include the following information:

- enrollment data,
- premium and insurance transactions data,
- claims and encounter data, and
- such additional data as the Board may determine.

Most health and medical information about an individual would remain with the individual's health care provider and plan. Alliances and plans would maintain enrollment data for their own use transmit a limited amount for use by the regional data center on a periodic basis. In addition, alliances would use the network to transmit data on premium transactions to the regional data center to assist in premium and subsidy management. In addition, alliances would use the network to transmit data on premium transactions to the regional data center to assist in premium and subsidy management.Similarly, health plans would collect a variety of medical encounter information for their own use and transmit some of that encounter information - in the form of a uniform minimum health data set - to the regional data center.

The regional centers would process and analyze the data, and would provide a variety of information services to plans, alliances, States and the federal government. While the enrollment and premium data would be available for health care administrative uses, the medical encounter data would be made available only in statistical form. Individually identifiable health information would not be released outside the health information system except with the written authorization of the individual and in accordance with disclosure polices developed by the Board.

National privacy protection standards and legislation would assure that individuals would have much greater control over the disclosure and use of their health information than they do now, and enjoy much greater protection against abuses of health information than they now enjoy.

To assure wide consultation in the development of the information system and privacy protection policies, a National Privacy and Health Data Policy Council would be established to advise the National Health Board. The Council would have broad representation including providers, consumers, plans, alliances, public health representatives, privacy experts and others.

INFORMATION ON HEALTH SECURITY CARDS

QUESTION

According to the President's plan, everyone would be issued a Health Security Card? What information will the card contain? How will it be used? Who will have access to the information on the card?

ANSWER

Every citizen and legal resident will receive a Health Security Card. The card would contain a minimal amount of information intended solely to demonstrate enrollment in a plan and describe insurance coverage.

The card would include the following information:

- the identity of the individual to whom the card is issued including a unique identifier;
- the applicable health plan in which the individual is enrolled;
- any supplemental health insurance policy, and
- such additional information as the Board determine is necessary.

The card would not include any sensitive medical information. The Health Security Act expressively forbids the use of the card or the unique identifier for any purpose other than health care, and includes very strong civil monetary penalties and criminal sanctions for misuse of the card or the unique identifier. The card would not be a "smart" card, a credit card or a national identification card.

The individual's complete medical records would remain at the provider and plan level, where they will only be available to health professionals who have a need to see them.

HEALTH INFORMATION SYSTEMS - PRIVACY

QUESTION:

The new health information systems included in the President's plan will manage enormous amounts of data including clinical encounter information on each beneficiary. What protections does the plan have to ensure privacy?

ANSWER:

The President's plan recognizes the critical importance of protecting the privacy of individual health information. Accordingly, the plan outlines a national framework for privacy protection of health information which would provide citizens:

- much greater protection and control over the use and disclosure of their own health records than they enjoy now (Currently, although the public believes otherwise, there are very few protections over health record information at the federal or State level), as well as
- rigorous protections against many of the current abuses of information contained in health records.

Most of the clinical information collected on patients would remain at the provider and plan level. Only a minimum amount of data, contained in uniform data sets such as the standard encounter data set, would leave the plan to become part of the overall information system and network.

The National Health Board, advised by a National Privacy Council, would be required to develop and promulgate standards for privacy and security of individually identifiable information in the system. The standards would have to incorporate certain principles:

- information could not be disclosed outside the system without the written consent of the patient;
- the disclosure of individually identifiable information would be restricted to the minimum necessary to accomplish the intended purpose; and
- no individually identifiable information could be provided by a plan or alliance to set premiums based on risk adjustment factors.

Individuals would be guaranteed certain rights concerning the use of information contained about them in the system including:

- the right to know whether any individual or entity uses or maintains individually identifiable information about them and for what purposes the information is maintained;
- the right to access to information - including the

right to see the information, to copy it and to have a notation made in the information about any amendment or correction requested by the enrollee; and

- the right to notice about use of information, including a written statement concerning the purposes for which information they provide may be disclosed.

The unique identification number could not be used to link health information with other sources of data about the individual. In addition, individually identifiable health care information could not be used in making employment decisions.

The Board would subsequently be required to submit a detailed proposal for national privacy legislation to the President and the Congress. The proposal would include a code of fair information practices to advise enrollees of their rights with respect to health information. Civil monetary penalties and criminal sanctions would be established to enforce the privacy standards and protect against abuses.

MEDICARE PEER REVIEW

QUESTION:

The Health plan calls for the Medicare Peer Review Organization Program to be repealed once the National Quality Management Program is implemented. How will the timing on this work? Why would you want to repeal this wonderful program?

Answer:

- Quality is one of the fundamental tenets the President has laid down for health reform. The Peer Review Organization program will not be repealed until the National Quality Management Program is implemented. The National Quality Management Program, along with other aspects of reform that increase access to care, should lead to the ongoing, significant improvement of health care quality in the United States.

- The Peer Review Organizations, through their current participation in the Health Care Quality Improvement Initiative, are gaining valuable experience that should serve them well in the new world of health reform. Many States, alliances, health plans, and providers are likely to seek assistance on methods for achieving continuous, measurable quality improvement under the Health Security Act's National Quality Management Program.

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Quality Management: The Health Security Act

Existing Quality Assurance is Broken

- Multiple Forms
- Burdensome Utilization Review
- Process Manuals
- Emphasis on Sanctions

$\neq$ Improved Quality

Concerns with Quality

- Consumers are generally satisfied with quality of care, but:
  - Both consumers and policymakers lack information on quality
- Quality may be threatened with increased cost containment

Current Trends in Quality of Care Management

- Movement away from quality assurance toward quality improvement
- Focus on outcomes rather than process measures
- Emphasis on a strong scientific base
  - Outcomes and effectiveness research
  - Clinical practice guidelines
  - Technology assessments
  - Quality measures
- Patient/consumer demand for information to improve decision making

Examples of Current Trends

- Professional Review Organizations (PRO's) as an example of quality improvement
- Rand appropriateness measures
- Radical prostatectomy of little benefit for the treatment of prostate surgery
- 1200 clinical practice guidelines developed annually
- Clinical practice guidelines mandated by certain states
- Blue Cross to make technology assessments public
- Several major managed care organizations have released report cards

Quality Management in the Health Security Act

- The Health Security Act addresses quality management in five ways
  - Information for consumer choice
  - Tools for quality improvement
  - Regional professional foundations
  - Basic consumer protections
  - Streamline existing quality assurance
- Structural Components

Standardized Information on Quality

- A Quality Report consisting of five categories and approximately 50 performance measures will be published on each health plan. These reports will assist consumers in choosing their health plans. The categories are listed below:
  - Access to care
  - Appropriateness of care
  - Outcomes of care
  - Satisfaction with care
  - Disease prevention
- National Quality Management Council identifies measures and sets performance goals for all Health Plans
- Annual updates
- Measures based on routinely collected data or small samples

Quality Report Card

Alliances collect data on the qulaity of all plans they offer and publish an annual "Quality Report Care" to help consumers choose among plans.

Sample Performance Measures	Plan A	Plan B	National Health Board Goal
Consumer Satisfaction			
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Death rate after heart attack	6%	35%	5%
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Tools for Quality Improvement

- Because they are critical to quality improvement, the Health Security Act authorizes augmentation of the following:
  - Outcomes and effectiveness research
  - Technology assessment
  - Clinical practice guideline development
  - Research on methodologic issues related to quality
  - Prevention research
- Dissemination of information to Health Plans and Alliances:
  - Standards for clinical practice guidelines
  - Clearinghouse and certification process for clinical practice guidelines

Community Based Tools for Quality Improvement: Regional Professional Foundations

- Develop Programs in Lifetime Learning
- Disseminate Information
  - Best clinical practices
  - Quality improvement techniques
  - Clinical practice guidelines
  - Research findings
- Foster collaboration
- Develop patient education to enhance participation in decision making
- May apply for research funds

Consumer Protection:

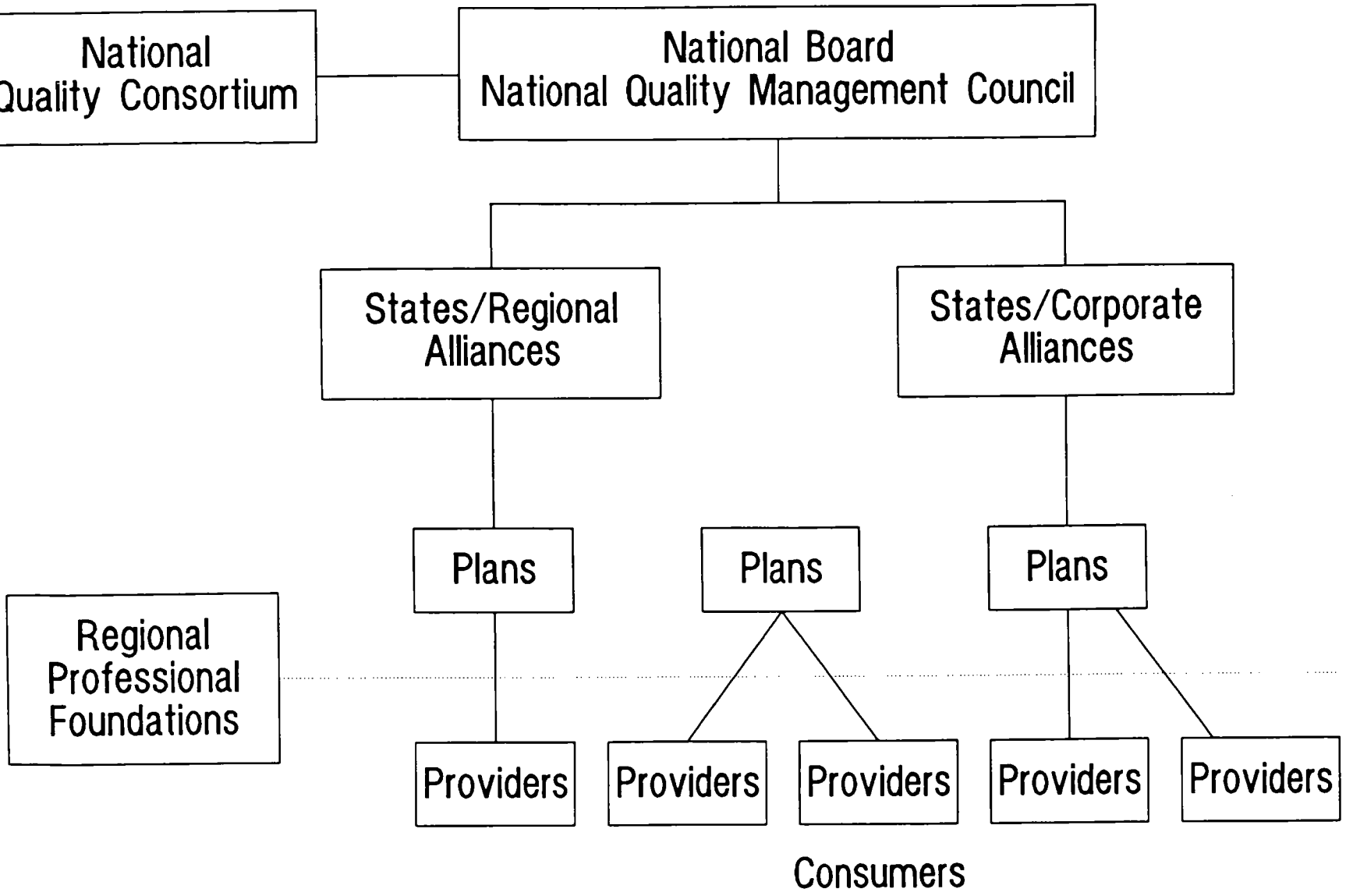
The Health Security Act protects consumers by requiring the following of all Health Plans:

- Fiscal soundness
- Truth-in marketing
- Disclosure of consumer rights and responsibilities
- Confidentiality
- Grievance procedures
- Disenrollment for cause
- Disclosure of utilization management
- Data management and reporting

Streamlining Existing Quality Assurance

- Minimum Federal standards that are performance based will be established for institutions
- By coordinating agencies, hospitals and health care providers will have only one annual quality related survey
- Medicare Peer Review Organizations (PROs)
- Clinical Laboratory Improvement Act (CLIA):
  - Eliminates registration requirement of exempted labs
  - Establish a new category of moderately complex tests
  - Revise personnel standards
  - Refocus proficiency testing

Structural Components



Improving the Quality of Care: The National Quality Management Council

- Identifies or develops the core set of quality measures annually
- Sets performance goals for the core set of measures
- Supports research, technology assessments, clinical practice guidelines in accordance with the 5 year priority list for measure development
- Evaluates the impact of health care reform on quality of care
- Uses the regional data network to obtain data on quality of care
- Reports on national performance annually
- Funds regional professional foundation

Role of States

- Certify health plans
- License institutions based on national performance standards
- Monitor the accessibility of benefits provided by plans

Roles of Alliances

- Prepare the Quality Report
- Disseminate information and educate consumers on quality
- Use market power to improve quality of care
- Run an ombudsman office to resolve consumer complaints and disenrollment requests

Improving Quality of Care: National Quality Consortium

- Comprised of representatives from academic health centers and schools for training health professionals
- Establish continuing education programs
- Advise the NQMC
  - Research priorities
  - Development and funding of Regional Professional Foundations
  - Selection of quality measures

QUESTION: How is CLIA (Clinical Laboratory Improvement Act) changed under health care reform?

ANSWER:

- As you know, under current CLIA statute and regulations, laboratories performing only waived tests are exempt from inspection. Under the President's proposal, such laboratories would no longer be required to register with HCFA or pay a registration fee.

- CLIA is amended to provide an exemption from any CLIA requirements (including payment of fees and registration) for labs performing simple procedures, i.e. waived labs.

- "Simple procedures" remain defined in the current law as those which have an insignificant risk of an erroneous result, including those which -
  - o have been approved by FDA for home use;
  - o employ simple methodologies with a negligible likelihood of producing erroneous results; or
  - o no reasonable risk of harm exits if performed incorrectly.