



*Strengthening Oklahoma's Safety Net,
One Community At A Time*

Board Bulletin

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Quality Initiatives Demand Attention: Part 1

Policymakers are eager to reverse our nation's current trend of escalating health care costs and substandard patient outcomes. One measure taken by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) was the release of an educational publication in September 2007 entitled *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors*. This resource guide and companion publications demonstrate OIG's resolve to improve quality – especially in organizations participating in federal programs receiving federal dollars.

What's Behind the Push for Improved 'Quality Improvement'

- ◆ **Cost, Cost, Cost** – America is the worldwide leader in health care costs with current expenditures exceeding \$2 trillion. That number is expected to double within the next decade. In FY2006, the federal government spent \$600 billion on Medicaid and Medicare. “Baby boomers” nearing Medicare age worsen the problem.
- ◆ **Wide Variation in Health Care Delivery** – Medicare data shows an unexplainable variation in the delivery of care across the nation. Policymakers want to know why high quality care is not consistently delivered to all Americans. When 37 key indicators for the five health care system dimensions (quality, access, equity, outcomes and efficiencies) were scored, the U.S. received a 66 out of a possible 100. The Commonwealth Fund reports indicate three factors contributing to health care system failure: 1) underuse of beneficial services; 2) overuse of procedures that are not medically necessary; and 3) preventable mistakes that cause patient injury.
- ◆ **Public Outcry** – The Institute of Medicine (IOM) stated, “The American health care delivery system is in need of fundamental change...Between the healthcare we have and the care we could have lies not just a gap, but a chasm.” Health care is recognized by business leaders as a priority in discussions regarding the economy. Consumers are better educated with access to health care provider quality assessments via the Internet.

Tension Leads to Change

- ◆ **Reimbursement Strategies** – *Voluntary* reporting mechanisms to identify quality issues were instituted by the Medicare Modernization Act of 2003. This was followed by the Deficit Reduction Act of 2005 in which reimbursement was dependent on a *mandatory* review of 23 quality measures. New federal rules effective October 1, 2008, will end Medicare payments for additional costs of certain preventable conditions, hospital-acquired infections and medical errors that occur in inpatient settings. Clearly, policymakers are using reimbursement strategies to incentivize health care providers to improve quality and thereby reduce costs.
- ◆ **Program Expectations** – Section 330 community health centers (CHCs) are directed by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) Policy Information Notice (PIN) 98-23 to engage in continuous quality improvement and performance measurement. CHC grantees are encouraged to participate in the National Health Disparities Collaborative to improve patient outcomes. The March 2007 HRSA Update regarding Quality and Data Strategy included establishment of a core set of clinical performance measures and promotion of evidence-based practices aimed at improving CHC quality. The CHC Uniform Data System (UDS) reporting tool has been revised to better capture quality and patient outcome data.
- ◆ **Compliance Enforcement** – OIG has made enforcement a priority using administrative remedies (that include federal oversight and penalties) and even incarceration for serious offenses. Organizations providing substandard care can be excluded from federal programs. Because CHCs depend heavily on Medicare and Medicaid reimbursement, compliance is critical to protect participation in both programs. The Deficit Reduction Act of 2005 provided increased funding for State Medicaid Fraud Units permitting the hiring of an additional 100 full-time employees to investigate fraud.

Unquestionably, the current environment demands that CHC boards elevate quality improvement to top priority status. To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of www.okpca.org.

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