Quality Health Care

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Centers of Excellence

The term “Center of Excellence” has been widely used and in many different ways. The basic concept behind health care centers of excellence is that a provider who specializes in a particular type of program or service can produce better outcomes. One example of a center of excellence program is the National Cancer Institute's (NCI) cancer center program that was created in 1971 to establish regional centers of excellence in cancer research and patient care. The NCI cancer center designation is an official designation. Providers must meet certain criteria and demonstrate excellence in research, cancer prevention and clinical services. NCI designation helps institutions compete for both research dollars and patients.

The term “Center of Excellence” has also been used by many without official designation. Some providers of care simply proclaim themselves centers of excellence. This is especially true for specialty hospitals that have been proliferated in many parts of the country. While these facilities may specialize in a particular service, there may not be clinical evidence demonstrating that the care they provide is superior. Similarly, insurers may include "Centers of Excellence" in their networks, but the extent to which these facilities have met established performance benchmarks is not always clear. While some insurers go to great length to identify the highest quality providers for certain services, others may establish a "Center of Excellence" primarily to concentrate volume to achieve more favorable payment rates.

Much of the literature on Centers of Excellence has focuses on the relationship between volume and outcomes. Results are varied, but studies generally demonstrate that better outcomes are associated with high volume for an array of different procedures and conditions. In addition to volume/outcomes as an indicator of performance, some organizations have identified implementation of certain patient safety practices such as Computerized Physician Order Entry (CPOE) as possible standards for Center of Excellence designation.

A number of initiatives have been nationally implemented to determine how to best use these evolving performance measures to improve patient outcomes. One initiative requires public disclosure of health quality data. New York has been a leader by requiring public disclosure of quality measure of cardiac surgery. The US Department of Health & Human Services has begun to publicly disclose hospital and nursing home data in order to help consumers make more informed choices. Other initiatives undertaken by employers and insurers have used financial tools, such as waiving copayments or simply excluding providers that don't meet standards from networks, to encourage employees to use providers they have identified as centers of excellence.

NY State must take a hard look at how centers of excellence are established in reforming the State’s health care system. Any designation of an institution as a Center of Excellence must be based on objective measures for which there is clear evidence of improved outcomes. In addition, any efforts to direct patient volume to such centers must also consider the impact on other providers.

Improving Quality

There has been much focus in recent years on the variation in health care quality across the country. Numerous articles have addressed the lack of uniform standards of care, the need for efforts to promote evidence based practice, the incidence of medical errors, social, economic and cultural disparities in care, and the importance of centers of excellence in assuring quality outcomes. While New York State has some of the finest health care institutions in the world and has lead the country in establishing health care quality improvement measures, clearly more can be done in this area.

While hospitals and nursing homes perform numerous quality improvement studies and projects, they have limited financial incentives to do so. Furthermore, the methodologies New York State uses to determine reimbursement for hospitals and nursing homes actually reward poor performance. Under Medicaid's Diagnosis Related Groups (DRG) system, hospitals may be paid more for surgical cases in which complications arise than for those without complications. Further, the existing nursing home reimbursement system provides little incentive for nursing homes to avoid hospital admissions of their patients.

New York State lacks a systematic approach to health care quality improvement. Any effort to reform the New York healthcare system must include a focus on quality improvement. "Right-sizing" the system without considering quality improvement would represent only partial reform. Comprehensive reform of the system must include reform of provider reimbursement to reward excellent service and reductions in medical errors. It is important to note that while investing in improving quality generally yields benefits to consumers and payers, the initial cost is born predominantly by providers. This issue must be addressed to assure that providers have the resources necessary to improve performance.

A critical goal of health care reform is to assure that our health care dollars are spent wisely. Configuring our health care system most efficiently while achieving the best possible health care outcomes is essential to achieving this goal.

Pay for Performance

Pay for Performance (P4P) initiatives reward providers for delivering high-quality care. Major initiatives include Medicare's P4P program, and the Bridges to Excellence Program: Rewarding Quality Across the Healthcare System.

- Medicare – Centers for Medicare and Medicaid Services (CMS) recently initiated a three-year demonstration project that provides financial rewards to hospitals demonstrating high-quality performance in five acute care areas: heart attack, heart failure, pneumonia, coronary artery bypass surgery and hip and knee replacements. Medicare reimbursement is adjusted based on a hospital's performance in these areas. CMS has also increased payments to hospitals that report specific quality outcomes data, and is establishing similar programs for physicians.

- Bridges to Excellence - This program is a national effort to improve quality of care by creating programs around three principles: (1) reengineering care processes to reduce mistakes will require investments, for which purchasers should create incentives; (2) significantly minimizing defects (misuse, underuse, overuse) that will result in a reduction of waste and inefficiencies; and (3) increasing accountability and quality improvement by disclosing comparative provider performance data to consumers.

  Three programs have been developed based on these principles. (1) The Physician Office Link enables physician office sites to qualify for bonuses based on implementation of specific processes that will reduce errors and improve quality. (2) The Diabetes Care Link enables physicians to achieve a one- or three-year recognition for high performance in diabetes care, and physicians can receive up to $80 a year for each participating patient with diabetes. (3) The Cardiac Care Link enables physicians to achieve a three-year recognition for high performance in cardiac care, and physicians can receive up to $160 for each cardiac patient. Both the Diabetes Care Link and Cardiac Care Link will likely save employers sufficient money to cover the cost of these programs. Notably, the Capital District Region in New York State, comprising of employers including General Electric, Price Chopper, Hannaford Bros., and Verizon, was the first region to have all three Bridge's programs available.

New York Medicaid has also incorporated P4P principles in the establishment of premiums for Medicaid Managed Care plans. An increase in premium of up to 1% is available to those providers who demonstrate high-quality performance, measured by select QARR/HEDIS measures. Health Plan Employer Data Information Set (HEDIS) and Quality Assurance Reporting Requirements (QARR) measure performance on important aspects of preventive, acute and chronic healthcare issues.

Legislation

Legislation passed this spring established a Department of Health Commissioner's Workgroup to develop clinical measures of quality. This workgroup consist of both providers and payers. In addition, the legislation established a grant program to fund demonstration projects that would use the metrics developed by the Workgroup. These measurements will be based on the

Medicare and Bridges to Excellence quality improvement programs. Regional coalitions of multiple payers will be formed to measure and reward providers who deliver high-quality care. A total of $10 million has been allocated over two years to seed the development of a P4P program and the systematic implementation of P4P demonstration projects.

Literature

The following is a list of selected articles on quality pertinent to the Commission's discussions:

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Berthiaume, John T., M. D.; Tyler, Patricia A., R. N., C.C.R.N; Ng-Osorio, Jacqueline, M. P. H., and LaBresh, Kenneth A., M. D. Aligning Financial Incentives With "Get With The Guidelines" to Improve Cardiovascular Care. The American Journal of Managed Care. 2004; 10:501-504.

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