THE TRUTH ABOUT DATA COLLECTION AND QUALITY OF CARE:
What Every Provider Needs to Know

Given the popularity of the movie “Sicko,” the issue of healthcare reform has reached a new peak. Within the debate, it is generally accepted that improved quality of care means healthier patients, less waste and reduced costs. Although few would argue with this line of thinking, defining “quality of care” and then tying it to reform and reduced costs is no easy task. And when failing to meet quality measures can lead to financial penalties, the stakes are high. As the quality debate rages, what issues should providers address now?

First, get up to speed quickly on federal and state initiatives designed to measure quality. These initiatives are sprouting like mushrooms. Some are well known, such as Medicare’s Hospital Compare project, under which data are collected and publicly shared on process of care measures that show how often hospitals provide certain recommended care for patients being treated for a heart attack, heart failure, pneumonia, or for patients having surgery. The Joint Commission also collects performance and outcome data for many uses. In addition, providers are subject to long-standing state and federal disease-reporting requirements. But there are many other public and private reporting programs in the planning or early implementation stages that may change the way providers do business.

Second, make sure you are familiar with the data you report. Pennsylvania has been a hotbed of activity regarding the quality issue, and may suggest things to come for other states. Pennsylvania law mandates that Pennsylvania hospitals report data to the Pennsylvania Healthcare Cost Containment Council (PHC4), a quasi-governmental agency. Several months ago, PHC4 made national headlines by reporting that for 2005, there were nearly 20,000 cases in which patients were treated for hospital-acquired infections (HAIs), requiring 394,129 treatment days and costing $3.5 billion. On July 20, 2007, following much wrangling over the scope of the HAIs reporting requirements and the reliability of the data collected, the PHC4 reporting program was amended to require that providers report HAIs to PHC4, as well as to the CDC, using the CDC’s data collection system (to avoid duplication), and, significantly, requires payors to reimburse for the costs of screening admitting patients for infections. Also, as of 2009, Pennsylvania Medicaid will begin distributing extra payments to facilities that achieve a 10% reduction in HAIs. Delaware also passed a law on HAIs in July. Based on Pennsylvania’s experience, providers must know what they’re sending and why they’re sending it. Although providers have been furnishing data for years to the Joint Commission and others, there has been less concern about the reliability and consistency of the data, until now. Only several years ago, PHC4 was asking for general data-dumps from Pennsylvania hospitals, and hospitals were complying. Now, hospitals must know the content of the data and how to correct bad data. Also, they must be conversant in the quality standards being applied to the data. In the Pennsylvania case, how is an HAI defined? Is an HAI under a state or private payor reporting standard different from one imposed under another? How about medical errors? The Joint Commission requires that hospitals report “sentinel” events, but other systems call them “serious” or “avoidable” events. What are these events and are they the same or different? Cutting off the wrong limb is an obvious example of a serious or avoidable event – how about a bad drug reaction? A patient abuse complaint?

Third, know who will have access to your data, including whether the data will be made publicly available. An uproar occurred several years ago when the Joint Commission was planning to sell individual hospital data to 14 Blue Cross Blue Shield plans without the hospitals’ permission. That plan was quickly shelved, but the Joint Commission is committed through its performance measurement and other initiatives to making data available in order for consumers and others to assess hospital performance. The disclosure and further use of data raise questions about privacy and misinterpretation downstream. Concerned about misuse of data, the New York state attorney general recently sent a pre-litigation warning letter to United Healthcare requesting that it refrain from publishing a ranking of physicians based on cost and quality issues. The AG is worried that the list will be driven by cost and, thus, be misleading to the consumer.

Fourth, and finally, act quickly on any quality issues that arise in the institution. Since most Joint Commission, Medicare and other quality review programs are designed to easily spot patterns or high-profile cases that suggest poor quality, make sure that your institution uses its own tools to measure quality issues. Federal and state governments and payors have reiterated their pledges to root out fraud, including substandard care, in the healthcare system. Payors have suggested that they will begin withholding monies for care that was delivered as a result of an HAI or error caused by a provider. Don’t wait until they come after you – in the interest of good patient care and operational management, clean your own house now.

If you have a question on this material, or would like to discuss legal services, please contact us at healthcare@duanemorris.com.

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