American Hospital Association

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September 20, 2004

Mark McClellan, M.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 443-G
Washington, DC 20201

Dear Dr. McClellan:

On behalf of the American Hospital Association's (AHA) 4,700 member hospitals and health care systems, and our 31,000 individual members, we appreciate this opportunity to comment on the draft report for the 8th Scope of Work for the Quality Improvement Organizations (QIOs).

Actively Pursue Coordination

We commend you for seeking to assist providers in improving specific areas of care as well as the infrastructure needed to support better quality of care. In the report, you select specific priority areas in which the QIOs would focus efforts to achieve major change. The report proposes that hospitals focus on adult immunizations and surgical complications. Other organizations also are working with hospitals and clinicians to affect change in immunizations and surgical complications, including the Centers for Disease Control and Prevention, state public health agencies, the American College of Surgeons and various surgical subspecialty organizations. In fact, one focus of the Hospital Quality Alliance, in which both The Centers for Medicare and Medicaid Services (CMS) and AHA participate, is surgical infection prevention measures.

While having several influential organizations focus attention on specific opportunities for improvement can be useful, it also can be counterproductive if activities are not coordinated. If these different organizations advocate disparate measurement activities or provide contradictory advice on strategies likely to yield significant improvement, hospitals and clinicians likely will become confused or frustrated, and improvement efforts will flounder. Even if few substantive differences exist among the measures and improvement strategies being offered, hospitals and clinicians may perceive the multiplicity of efforts as redundant or discordant, and will be less likely to participate.

The Surgical Care Improvement Project (SCIP) provides an opportunity to solve this problem by coordinating measurement activities and improvement advice. In the SCIP, CMS is partnering with a number of stakeholder organizations to achieve substantive reductions in the number of individuals who suffer potentially catastrophic complications from surgery. The QIO efforts under the 8th Scope of Work will extend the work of the SCIP to the front lines of care. While currently only a few QIOs are involved in the SCIP, **we urge CMS to make sure that all QIOs are informed about SCIP, and all SCIP partners are informed about the QIO activities**.

Similarly, we urge CMS to develop a relationship with other organizations that are actively seeking to improve adult immunization rates so that all activities will be coordinated.

Competitive Subcontracting

We applaud CMS' desire to ensure QIO excellence, and the agency's willingness to ensure that hospitals and other providers have access to assistance from other organizations for those tasks that a QIO has performed unsatisfactorily. In the draft of the 8th Scope of Work, CMS states that if a QIO's previous performance has been less than excellent on a subtask, then it must competitively subcontract the work to another organization designated by CMS. We appreciate the clear signal this sends that CMS is serious about ensuring that providers and Medicare beneficiaries get the best possible assistance from the QIOs. It seems only fair, however, that QIOs be given the opportunity to improve their performance. **We suggest that CMS re-word this provision to stipulate that any QIO that fails to achieve excellence in the performance of a subtask in the 7th Scope of Work must either demonstrate that it is making substantive changes that are likely to enable it to achieve excellent performance on the subtask or must competitively subcontract the work on the subtask.**

QIOs have been an important part of hospital care improvement efforts, and this is reflected in the relationship of trust and collaboration that exists between the organizations. This relationship is developed through much contact between the QIO and the hospital. Thus, it may be important for the organization that is awarded a subcontract for any subtask to be either relatively close to the hospital, or be able to show how it will provide on-site assistance to the hospitals. **We encourage CMS to consider this as it reviews any proposed subcontracting arrangements.**

Assistance with HCAHPS

HCAHPS, the new Agency for Healthcare Research and Quality/CMS hospital patient survey instrument soon will be incorporated into our joint efforts to collect and publish data on hospital quality. While it is highly likely that hospitals and patient survey vendors will need education and assistance in conducting this new survey and submitting the data we desire to the QIO data warehouse, nothing in this proposed scope of work tasks QIOs to assist with this important effort. **We urge CMS to consider how the QIOs might assist in HCAHPS data collection, and, of equal importance, how they might assist hospitals' performance improvement.**

Task 1c1: Hospital

The proposed performance measures that would be used to assess how well QIOs assist hospitals include a requirement that 25 percent of hospitals report the expanded set of measures used by the Hospital Quality Alliance. While this is an important issue, a more critical aspect may be

that hospitals are using the information to make a difference for the patients they serve. **CMS should re-write this, and assess QIOs on how well they assist hospitals with their efforts to improve performance on these additional measures**.

The proposed criteria for assessing QIO performance also calls for an 8 percent reduction in the gap between current performance and perfection on the surgical care improvement measures. This baseline data apparently will be collected for the 2nd quarter of 2004, but it is unclear how many hospitals currently are providing data on surgical care complications. We anticipate that the number will increase when 3rd quarter 2004 data is submitted, because hospitals then will be asked to send in the data as part of the Hospital Quality Alliance. **We suggest that CMS reconsider what would constitute an adequate baseline of data for this assessment.**

Task 1C2: Rural/Low Volume Hospitals

QIOs are required to help rural and low-volume hospitals submit data on quality measures tailored to reflect the care given in this type of facility. The AHA currently is working with a number of organizations and researchers to identify an appropriate set of measures for these facilities. Because of CMS' involvement in those discussions, we expect the product will be used to help CMS determine which measures will be included in the work of the QIOs.

If you have questions or need further clarifications about our comments, please call me or Nancy Foster, senior associate director, at (202) 626-2337.

Sincerely,

Rick Pollack
Executive Vice President