FYI...

The Commitment to Caring Quality Expo will feature 57 projects highlighting UNC Health Care commitment to improve care, patient safety, and patient satisfaction. Please join us this Friday, Oct. 24, from 2 - 6 p.m. in the Women’s Hospital Lobby and Women’s Conference Rooms 3&4. Click here to view an electronic copy of the program. The Quality Expo is sponsored by the Department of Patient Safety and Performance Improvement. Click here to add to your calendar.

Large crowds are expected on Franklin Street Friday, Oct. 31, for the annual Halloween celebration. The Town of Chapel Hill will be implementing a traffic control plan that could cause significant traffic congestion around UNC Hospitals. Many roads will be blocked or restricted down to one lane starting between 7:30 PM and 8:00 PM. Please advise your staff working Halloween night to allow plenty of time to arrive at work and to plan to access UNC Hospitals from the South via Manning Drive, Mason Farm Road, or Columbia Street. Also remind your staff to have their UNC Health Care ID them, as the University will be charging for event parking for visitors coming into town.

Contingency plans have been developed for this event and include EMS access to UNC Hospitals should Manning Drive become too congested. For additional information on UNC Health Care's Halloween preparations please contact the UNC Health Care Emergency Preparedness Coordinator, Dalton Sawyer at 966-6429.

Announcements

- 2008 Norma Berryhill Distinguished Lecture - Richard C. Boucher, Jr., MD, presents, "The UNC Cystic Fibrosis Center: A vehicle for understanding and curing CF Lung Disease," Oct. 28, at 5:30 p.m. at the Carolina Club. Click here to add to your calendar.

- Flu season is here. Vaccinate yourself and your patients. Nurses have a standing order to administer flu shots to eligible inpatients, but it is still helpful to request the vaccine via an order or a reminder to the nurse.

- Absentee and early voting information - Early voting is now in progress. Please remind your patients of their options to use either absentee or early voting. Click here for full details on both absentee and early voting, including a list of addresses and phone numbers for the Board of Elections in each North Carolina county. This information may also be useful to employees who would like to vote in advance.

From the President...
Pay for performance (P4P) programs hold the promise of stimulating improvements in care. They now also impact UNC Hospitals and UNC P&A reimbursement, potentially preserving and adding tens of millions of dollars annually to the revenue that supports our public mission. Picking up from my column of October 10th, today's P4P topic is so-called "core measures" of quality for inpatient care. If you have been reading recent columns, you know that these core measures of quality now determine part of our reimbursement from Medicare and from Blue Cross Blue Shield of North Carolina.

In the case of Medicare, the core measures have been a large part of Medicare's "pay for reporting" program since 2005. The Performance Improvement Department collects data on patients whose discharge diagnosis falls into one of four categories: Acute Myocardial Infarction; Heart Failure; Pneumonia; and certain surgical procedures. For each of these categories, we track and report our success in delivering several components of care. The best way to learn more about each of these individual components is to go to our new quality web site.

Medicare has also decided that it wants to measure our overall success in caring for a patient with, say, acute myocardial infarction. To do this, Medicare has come up with something called an "optimal care score" (also known as an all-or-none score). The optimal care score is calculated for each patient. For a given patient, Medicare says: Did this patient get all of the elements of care for which she was eligible during this hospitalization? If yes, we get a point for being successful. If no, we get zero credit for successful treatment of that individual patient. What this means is, we could provide six out of seven of the elements of care that Medicare measures for an acute MI patient, but if we miss the seventh element, we get no credit for successfully treating that patient. This method does not weigh the relative importance of the individual components of care; they all matter the same to Medicare. Thus if we perform a successful angioplasty but fail to document that we counseled the patient to quit smoking, we get zero credit for successfully caring for that patient during their hospital stay. Whatever you think about this methodology, it is here to stay. The North Carolina Hospital Association recently began to publish optimal care scores for the hospitals across our state.

Medicare intends to use optimal care scores as it transitions from a pay for reporting scheme to a true pay for performance program. In other words, beginning very soon, Medicare will reduce its DRG payments to hospitals if those hospitals fall below a certain threshold of success in caring for patients with the above-listed conditions, and the threshold for success will be defined using optimal care scores.

Even more acutely, these optimal care scores for core measures form a large component of our new quality partnership with BCBS. A few weeks ago I wrote about the measures that we developed collaboratively with BCBS. The core measures are an equally heavily weighted set of measures that will help determine our future reimbursement.

For Medicare and BCBS, we must follow very specific and rigid rules for abstracting data from our records. That makes physician and nurse documentation extremely important in the measurement process. It also means that the data abstraction is done retrospectively, and we don't learn our final performance scores until several months after the relevant data collection period. However, we have begun internally to perform concurrent review of records, both in an effort to improve our performance while our patients are still hospitalized, and also to provide more timely feedback about our performance in delivering these components of care. We are working to make our estimated optimal care scores, using data abstracted concurrently, available on our web site. I say estimated because the ultimate abstraction of data for Medicare and BCBS utilizes a random sample of charts, whereas our concurrent review attempts to capture as close as possible to 100% of patients whom we expect to have the relevant diagnoses or procedures.

Ultimately, all pay for performance programs are about improving care. On our web site, and occasionally in these columns, my staff and I will continue to try to address in more detail some of the work that is taking place to improve care for patients with "core measures" diagnoses, and other key clinical conditions.