



CEEQNET

Health Care Quality Newsletter 2004

Dear partners of the CEEQNET project,

as you are all aware of, the main aim of our project is to share best practices for the improvement of all the health care services our respective facilities provide to our patients. There is a multitude of activities targeted on improvement of quality, accessibility, efficiency, efficacy, safety and timeliness of the services we are providing. The core product of our efforts (the identification and appropriate use of some core measures which can be extracted from the already used databases of our respective health care facilities) would be useless, unless we are able to interpret the measures in the context of our health care systems and assure appropriate processes leading to improvement in the work we are doing. In order to facilitate the process of reflection and reorientation of some of our everyday efforts, please accept the following newsletter (which will be produced periodically) as a service to all members of our community – „ to find out what's going on in other places and organizations“. We sincerely hope, that you will (if you have lists of significant links relating to performance and quality management in health care, or if you can provide or point to significant documents) all actively collaborate in the production of our future newsletters. We are more than eager to receive any of your comments that will help us to develop this newsletter into a useful resource not only for you, but also for any health care facilities you may be collaborating with.

Sincerely yours

*Michaela Taborska (assistant to CEEQNET Project Leader)
Ales Bourek (Project leader)*

*Please be so kind and send your comments and suggestions to
Michaela.taborska@gmail.com*

This newsletter keywords:

health care indicators, reports, hospitals, EHR (electronic health records), surveys, European, spending

<i>New tool of the National Committee for Quality Assurance</i>	2
<i>New Jersey releases first annual report on hospital care</i>	2
<i>URAC plans to convene a research and focus group to explore new quality benchmarks</i>	2
<i>New JCAHO web site regarding quality checks</i>	3
<i>NCQA releases Quality Compass®2004 and Updated Quality Dividend Calculator</i>	3
<i>A few medical conditions account for large share of health spending growth</i>	3
<i>The results of the Sixth Annual MRI Survey of EHR Trends and Usage for 2004 are now available... 4</i>	
<i>Health monitoring programme : Funded project 2002 : "European Emergency Data Project - EMS-Data-Based health surveillance system"</i>	4
<i>Health monitoring programme : Funded project 2001 : "ECHI 2 - European Community Health Indicators (Phase 2)"</i>	5

July – September 2004

New tool of the National Committee for Quality Assurance

<http://www.ncqa.org/PhysicianQualityReports.htm>

NCQA's Recognized Physician Directory allows you to identify physicians in your area who demonstrate a high level of performance in providing care

NCQA announced that a new online tool and a new arrangement with the GeoAccess division of Ingenix, a leading supplier of physician directory information, will make NCQA-supplied information about doctor quality readily available to tens of millions of consumers. The forthcoming data on doctor quality are drawn from physician recognition programs in the areas of diabetes and cardiac/stroke care. To earn recognition, physicians must meet rigorous quality and performance standards. Historically, little such information has been available.

New Jersey releases first annual report on hospital care

<http://web.doh.state.nj.us/hpr/>

The New Jersey Department of Health and Senior Services unveiled the state's first annual hospital quality report, which rates hospitals' performance on eight measures of care for heart attack and pneumonia. The measures are among those used in the national Quality Initiative led by the AHA and others, and among those required for a full Medicare payment update starting next year through the Medicare Modernization Act. The report is based on data from 82 hospitals, which treated 16,000 heart attack patients and 28,000 pneumonia patients over a nine-month period last year. New Jersey Hospital Association President and CEO Gary Carter said the report will complement hospitals' ongoing quality improvement efforts and urged consumers to use the report along with information from hospital Web sites, friends and neighbors, and physicians to learn about their hospitals' quality of care. "As valuable as this data is, no single study should be used to judge the overall quality of health care in New Jersey," he said.

URAC plans to convene a research and focus group to explore new quality benchmarks

<http://www.urac.org/default.asp?navid=home&pagename=default>

URAC plans to convene a research and focus group to explore new quality benchmarks for health information technology (HIT), including the possible development of standards addressing electronic health records and HIT systems infrastructure.

URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

New JCAHO web site regarding quality checks

<http://www.qualitycheck.org/>

The Joint Commission has had a longstanding commitment to providing meaningful information about the comparative performance of accredited organizations to the public. In 1994, the Joint Commission first published organization-specific Performance Reports. In 1997, Quality Check®, a directory of Joint Commission accredited organizations and performance reports, became available on the website. In 2004, Quality Reports — containing merit badge achievements, Hospital Quality Measures and other core measure data — replaced Performance Reports, although historical Performance Reports are still available.

The improvements continued in 2005 with a redesign of Quality Check. The process included extensive testing and input from consumer focus groups and stakeholders, including four advisory groups and state hospital associations. An online survey was also posted on the Joint Commission website. The feedback was used to refine and clarify Quality Reports for both health care professionals and the public.

NCQA releases Quality Compass®2004 and Updated Quality Dividend Calculator

<http://www.ncqacalculator.com>

The National Committee for Quality Assurance (NCQA) has released the latest update to its comprehensive database of health plan performance information, Quality Compass® 2004. The database includes information on NCQA Accreditation and plan-specific results on HEDIS® and CAHPS® measures, data sets that measure clinical performance and member satisfaction, respectively. A measure of flu shot rates for adults is included in this year's edition of Quality Compass for the first time. This year's data was reported by 262 health plans that cover more than 60 million Americans collectively.

A few medical conditions account for large share of health spending growth

<http://www.healthaffairs.org/>

The 15 most costly medical conditions accounted for about half of the growth in health care spending between 1987 and 2000, largely due to more people being treated for those conditions and to more expensive and effective drugs and technologies, according to a study published by Health Affairs. Five conditions -- mental disorders, cerebrovascular disease (such as stroke and cerebral ischemia), pulmonary disease and diabetes -- accounted for 31% of the growth. "If we really want to get a handle on rising health care costs, we need to analyze what it is we're spending money on, instead of where we're spending the money," said lead author and

economist Kenneth Thorpe. "By focusing on a disease-based analysis of spending, we can compare the medical benefits we are purchasing."

The results of the Sixth Annual MRI Survey of EHR Trends and Usage for 2004 are now available

<http://www.medrecinst.com/pages/latestNews.asp?id=115>

The results of the MRI Survey of EHR Trends and Usage are available to download (see below) at no cost. A total of 808 individuals responded to the survey. However, to increase relevancy and reduce bias, responses from vendors, consultants, and payers are not included in the results. Therefore, the results that follow include only provider responses with a total database size of 436. The data includes responses from April 30th through June 11th, 2004. The EHR Survey includes the results from all sixteen questions in the survey, including the first four demographic questions.

The MRI Survey of EHR Trends and Usage reveals insights into the:

- Motivations driving the need for Electronic Health Record systems
- EHR applications and functions being implemented or planned
- IT platforms used to support EHR applications
- EHR configurations for different environments
- Data capture methods being employed
- Major barriers to implementing EHR systems
- Mobile/Wireless healthcare priorities, applications, platforms, and concerns

Health monitoring programme: Funded project 2002 : "European Emergency Data Project - EMS-Data-Based health surveillance system"

http://ec.europa.eu/comm/health/ph_projects/2002/monitoring/fp_monitoring_2002_exs_07_en.pdf

Related project from the emergency care area, final report available

As the principle result, there were five key indicators defined and recommended to be included in the European Community Health Indicators (ECHI) short list:

- Unit hours ELS + BLS + ALS per 100,000 inhabitants (with 3 sub-indicators for ELS, BLS and ALS)

Indicator for Health System/ Resources

- Response time (with 2 sub-indicators: 90% percentile and percentage \leq 480 sec)

Indicator for Health System / Performance

- Rate of highest priority responses per 100,000 inhabitants

Indicator for Health System/ Utilisation

- Rate of FHQ diagnoses per 100,000 inhabitants (with 5 sub-indicators: cardiac arrest incidents,

severe trauma incidents, severe breathing difficulties, cardiac chest pain incidents and stroke incidents)

Indicator for Health Status / Mortality; Morbidity

- Rate of ALS interventions per 100,000 inhabitants (with 3 sub-indicators: assisted ventilation,

intubation and iv drug administration)

Indicator for Health System/ Performance

Additional indicators that can be applied universally were identified as future recommendations.

An outstanding example of a clearly identified, defined and essential indicator is "Time to First Shock". It marks the interval between collapse after cardiac arrest and application of the first defibrillatory shock in patients suffering from ventricular fibrillation. The time period determines the chances of good neurological recovery and/or survival after cardiac arrest and is therefore considered to be one of the most crucial indicators for EMS performance. The pilot study revealed

significant limitations regarding availability and comparability of this key indicator, so it was not included in the list of recommended EMS key indicators.

Unless there is a focus on prevention and public health for FHQ conditions, EMS demand will rise due to demographics and morbidity and the health-care burden will increase. A European declaration of emergency care rights needs to be made and supported by a template for minimum standards for a European EMS system.

Health monitoring programme: Funded project 2001: "ECHI 2 - European Community Health Indicators (Phase 2)"

http://ec.europa.eu/comm/health/ph_projects/2001/monitoring/fp_monitoring_2001_frep_08_en.pdf

Related project aimed at healthcare indicators, final report available

As a follow-up of ECHI-1, the ECHI-2 project has expanded the indicator list, with input from many projects under the Health Monitoring Programme and recently the Public Health Programme. This has resulted in (1) the 'long list', which consists of an inventory of indicators structured within a robust conceptual frame, but with recognized imbalances reflecting specific areas covered by HMP projects; (2) the concept of 'user-windows' which allows for the interest-oriented selection of subsets of indicators; (3) the shortlist, which is selected as a subset from the long list for first priority implementation; and (4) a web-based application (I CHI-2, International Compendium of Health Indicators) in which the ECHI indicators are listed, with their definitions, along with the indicators used by Eurostat (rather as 'statistical indicators'), WHO-Europe (in the HFA database) and the OECD (OECD health data). Thus, the project has served two functions: first to develop a list of items and indicators for more comparable data collection among EU Member States, and second, to act as a sort of co-ordinating momentum or 'umbrella', integrating the results of a variety of projects into a common structure.