OFFICE OF GOVERNOR RONNIE MUSGROVE
INTEROFFICE MEMORANDUM

TO: SIMMONS

FROM: RILEY

SUBJECT: RELEASE BY MEDICARE OF STATE SPECIFIC PERFORMANCE OF NATIONAL QUALITY OF CARE INDICATORS

DATE: 10/3/00

CC: MADER
FILE

Per the Governor's request of September 29, I have reviewed information provided to Dr. Cole by Jim McIlwain, President of Information and Quality Healthcare. The Journal of the American Medical Association (JAMA) will issue a HCFA article tomorrow releasing baseline data for a monitoring system to assess the quality of care in fee-for service Medicare. The article provides state rankings on 24 clinical indicators related to six critical disease areas selected by Medicare – heart attack, breast cancer, diabetes, heart failure, pneumonia and stroke. The results show that there are gaps in care for older Americans and the article will list Mississippi as 50th out of 52 in the rankings.

Jim McIlwain/Information and Quality Healthcare served as Mississippi's Peer Review Organization (PRO) for this study. PROs assist physicians and hospitals identify areas for improvement and steps for such improvement. McIlwain provided questions and answers to the JAMA article – he did not provide actual report data other than the attached. I highlight the following point from his comments:

No one really knows why the quality of care varies so greatly by state. Sometimes there are conflicting Medicare policies, such as some Medicare carriers covering certain tests and other carriers not covering them, but PROs can intervene to correct problems or inconsistencies. Its also important to keep in mind that the JAMA article indicates that "the differences in average performance among states and regions are modest compared to the overall need for improvement." As to whose fault it is that care is substandard in some areas, McIlwain points out that delivery of health care is complicated and that many personnel must interact for patient care. Pointing fingers won't spur better performance. PROs analyze delivery of care and assist these personnel by identifying opportunities for care to be improved, but don't use a regulatory or enforcement approach.

Less than 1/10th of all Medicare expenditures is earmarked for quality improvement. For the first time in the history of American health care, we have a coordinated national campaign aimed at reducing disparities in the quality of care for Medicare beneficiaries. Medicare began its quality improvement efforts in 1996 and focused its collective power of the PROs, hospitals and physicians a year ago to improve care in these six critical areas.

McIlwain said that he would generally say Medicare beneficiaries generally receive good, high quality care. Gathering this information to guide Medicare efforts is essential to improving the

performance of our health care system. Total Medicare spending for nearly 40 million beneficiaries in 1999 was about $213 billion, or just under $5,500 per beneficiary. Seniors in every state can increase the quality of care they receive by taking responsibility for their own health care (screening mammograms, flu shots, etc.)

McIlwain did not provide any comments on the attached data, but it appears as if Mississippi has made significant progress in these six areas, but is just not providing care at a comparable level to other states. Improvements include:

- Atrial fibrillations: increase to 100% use of best testing lab procedure (INR) to gauge the effectiveness of anticoagulation medications
- Treatment of acute stroke: 50% reduction in unnecessary blood pressure treatments
- Pneumonia: 12% increase in obtaining a blood culture before medications are given
- Acute myocardial infarction: 15% increase in use of aspirin and 12% increase in use of beta-blockers
- Diabetes: 8% in obtaining a lipid profile and 17% increase in obtaining a dilated eye exam