Medicare's role in motivating and supporting quality improvement

Anne Mutti

November 5, 2010

Overview

- Can Medicare better leverage its technical assistance program and conditions of participation to accelerate quality improvement?
- Today's panel will address options to improve these policy levers
  - Robert Wachter
  - Christopher Queram

Possible changes to technical assistance program

- Target assistance to low performing providers
- Measure performance largely on outcomes (includes measures of “systemness”)
- Change contract structure to engage low performers
  - Grant goes to low performers; they select assistance agent
  - Create an on-line marketplace to enable providers to shop for assistance agents

Possible technical assistance changes (cont.)

- Broaden the criteria for technical assistance agents
- Allow flexibility in the way technical assistance is provided
- Pair flexibility with accountability (e.g., intermediate sanctions for continued low performance)

Possible changes to conditions of participation

- Create voluntary higher standards
- Create mandatory outcomes-oriented standards for select services
- Create intermediate sanctions
- Update COPs to align them with current quality improvement efforts

Perspective from Quality Improvement Organizations

- Measuring effectiveness of QI interventions is difficult for any organization
- Little turnover in the entities that are QIOs can be a positive
- QIOs are constrained by declining funding
- Key advantage of QIOs is their local presence and their ability to convene providers to tackle systems issues.

Panel discussion

- Christopher Queram, President and Chief Executive Officer at the Wisconsin Collaborative for Healthcare Quality
- Robert Wachter, MD, Professor and Associate Chairman of the Department of Medicine at the University of California, San Francisco

Envisioning New Models to Drive Improved Health and Health Care

Chris Queram

President & CEO

Wisconsin Collaborative for Healthcare Quality

November 5, 2010

WCHQ

Wisconsin Collaborative *for* Healthcare Quality

About the Wisconsin Collaborative for Healthcare Quality

Vision

We bring coherence to the use of performance measures, thereby dramatically impacting the health of Wisconsin's residents and the value of health care services

Mission

Through strong partnerships, the Wisconsin Collaborative for Healthcare Quality advances and brings meaning to performance measurement activities that make health care better and more affordable, and lead to healthier people and communities

Activities

Prioritize, develop, synthesize and promote the use of performance measures that improve the quality of care, improve the health of populations, and reduce per capita costs of health care

Guide the collection, validation and analysis of data related to these measures while leveraging the power of electronic health records

Publicly report comparative measures of performance within and across the continuum of Wisconsin's healthcare organizations and systems

Share the best practices of stakeholders' that demonstrate improvements to people's health and healthcare systems

Member Organizations

Wisconsin health systems, physician groups, hospitals and health plans

Approx. 40% of all WI physicians (5,200) & 50% of WI primary care physicians (2,000)

Aurora Advanced Healthcare
Aurora Health Care
Aurora UW Medical Group
Bellin Health
Columbia St. Mary's
Dean Clinic
Fort HealthCare
Franciscan Skemp Healthcare - Mayo Health System
Froedtert Health
Gundersen Lutheran Health Services
Luther Midelfort - Mayo Health System
Marshfield Clinic
Medical College of Wisconsin
Mercy Health System
Meriter Health Services
Monroe Clinic
Prevea Health
ProHealth Care
QuadMed
Sacred Heart Hospital
Saint Joseph's Hospital (Marshfield)
St. Mary's Hospital (Madison)
ThedaCare
West Bend Clinic – Froedtert Health
UW Hospital and Clinics
UW Medical Foundation
Wheaton Franciscan Healthcare

A Perspective on Quality Improvement Organizations (QIOs)

- Lack of flexibility, adaptability due to CMS contractual constraints
- Lack of “constancy of purpose”
- Disconnect between local priorities and national agenda
- Inherent limitations of externally-mandated interventions

A Perspective on Conditions of Participation (COP)

- Lack of accountability for performance
- Lack of appreciation for the primacy of culture as an enabler of improvement
- Lack of integration of physician and organizational roles

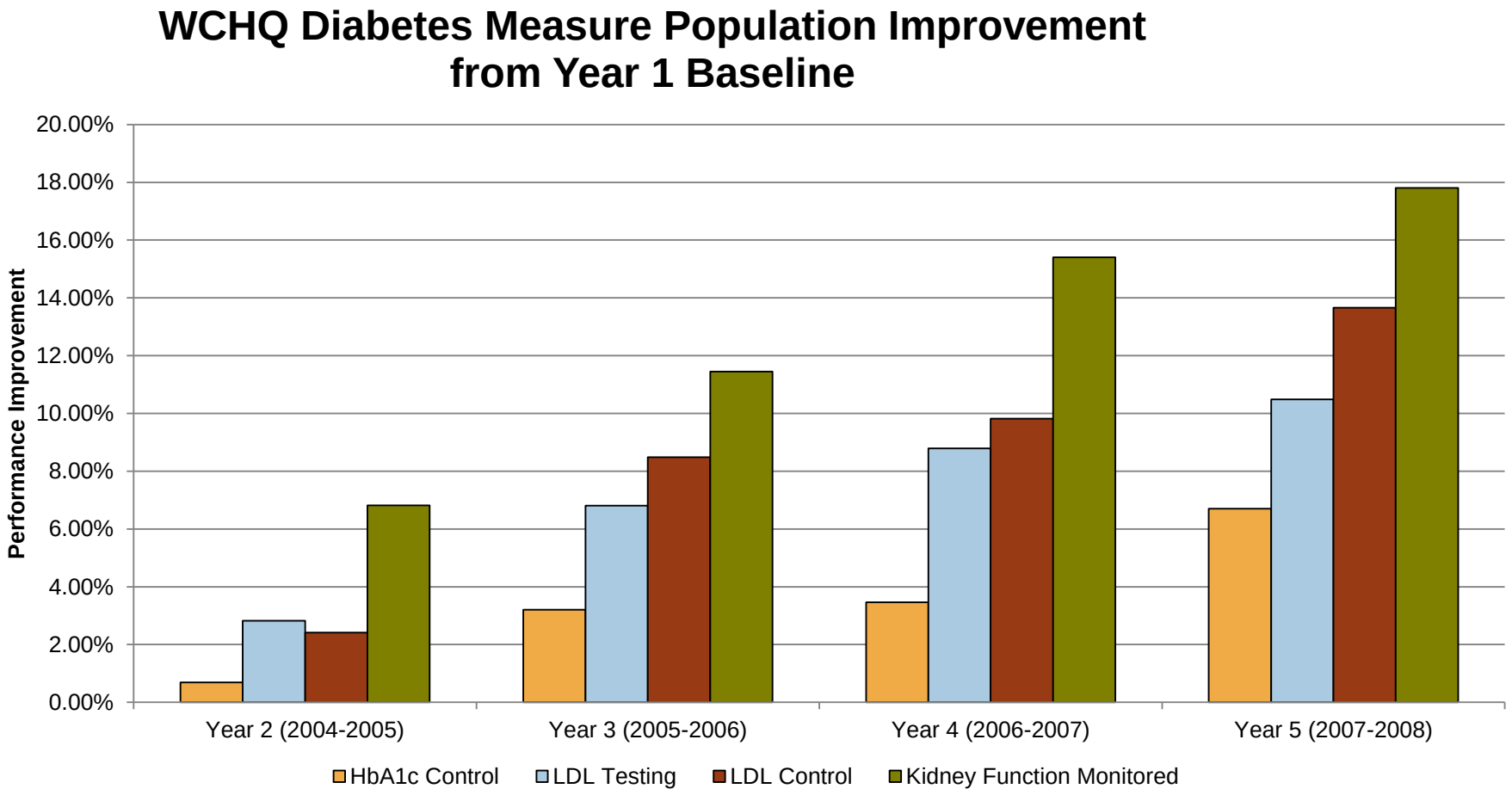
The time is right for innovation and experimentation

- Broaden the criteria for who can serve as “technical agents”
- Pair flexibility with accountability for improvement in outcomes and health status
- Adopt intermediate sanctions for persistently low-performing organizations

An Alternative Model: Regional Health Improvement Collaboratives

- Non-Profit, Local/Regional/State-wide
- Multi-Stakeholder, Private/Public Sector
- Core Functions
  - Comparative performance measurement / reporting (quality and cost)
  - Facilitate collaborative learning
  - Consumer engagement
  - Promote/support payment reform
- Partnership with translational and patient-centered outcomes researchers
  - Change how research questions are developed to make results more useful
  - Spread the results of research faster by creating feedback loops
  - Example: Partnership between WCHQ and UW Health Innovation Program

And, observational evidence indicates this model impacts care delivery



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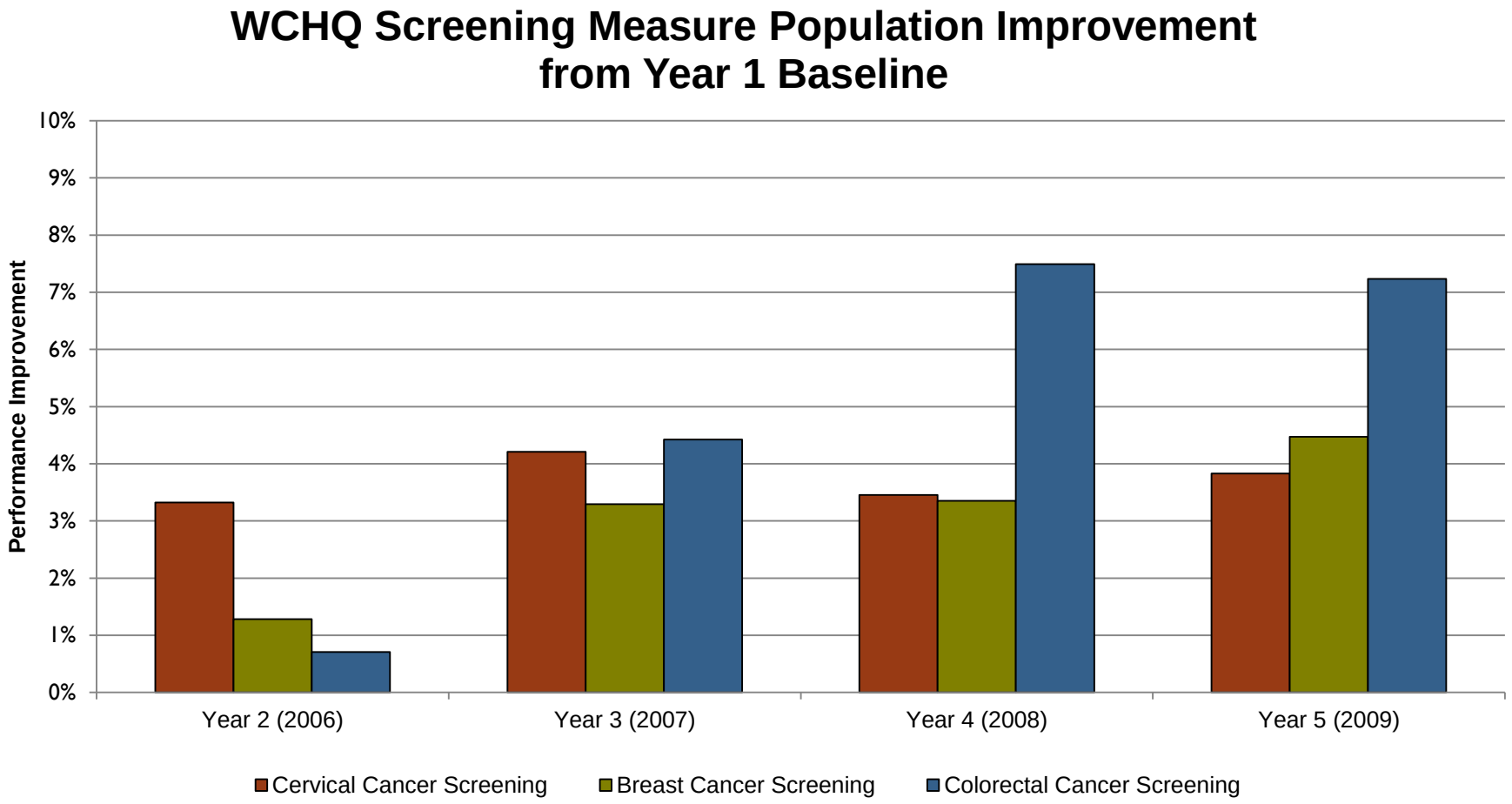
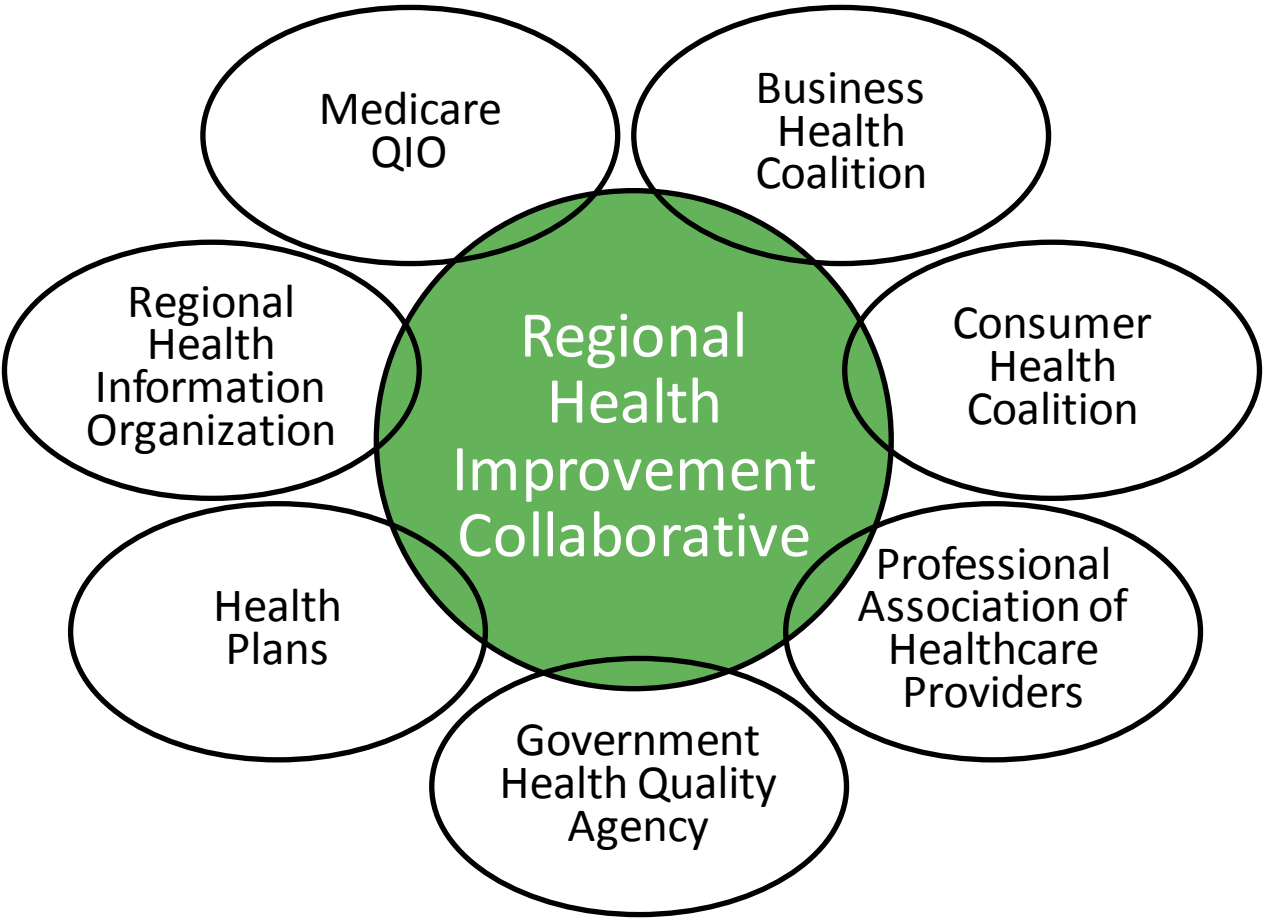


Regional healthcare improvement collaboratives have important differences



Source: Network for Regional Healthcare Improvement

- Are led/governed by multiple stakeholders
- Establish direction through consensus
- Implement actions through voluntary cooperation, not government mandates
- Focus on improving healthcare quality and value
- Have flexibility to address the myriad of issues supporting system transformation

Examples of Regional Health Improvement Organizations

- Aligning Forces for Quality
- Chartered Value Exchanges
- Network for Regional Healthcare Improvement

Regional Health Improvement Collaboratives are Growing in Number

Members of the Network for Regional Healthcare Improvement (www.NRHI.org)

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Midwest Health Initiative
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative

- Puget Sound Health Alliance
- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange

Source: Network for Regional Healthcare Improvement

Medicare's Role in Supporting and Motivating Quality Improvement: *Nurturing a Value Market*

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Things That Have Worked Better Than I Would Have Predicted

- Transparency is remarkably effective
  - Mechanism is shame & pride, not consumerism
- A dynamic, evidence-based, trusted set of quality/safety metrics can drive change
  - Core measures, never events, NPSGs, bundles
- Integrated delivery organizations have a staggering advantage over “99-1” ones
- Once there’s a business case to improve quality/safety, organizations seek help

America's Best Hospitals: the 2009-10 Honor Roll

U.S.News & WORLD REPORT

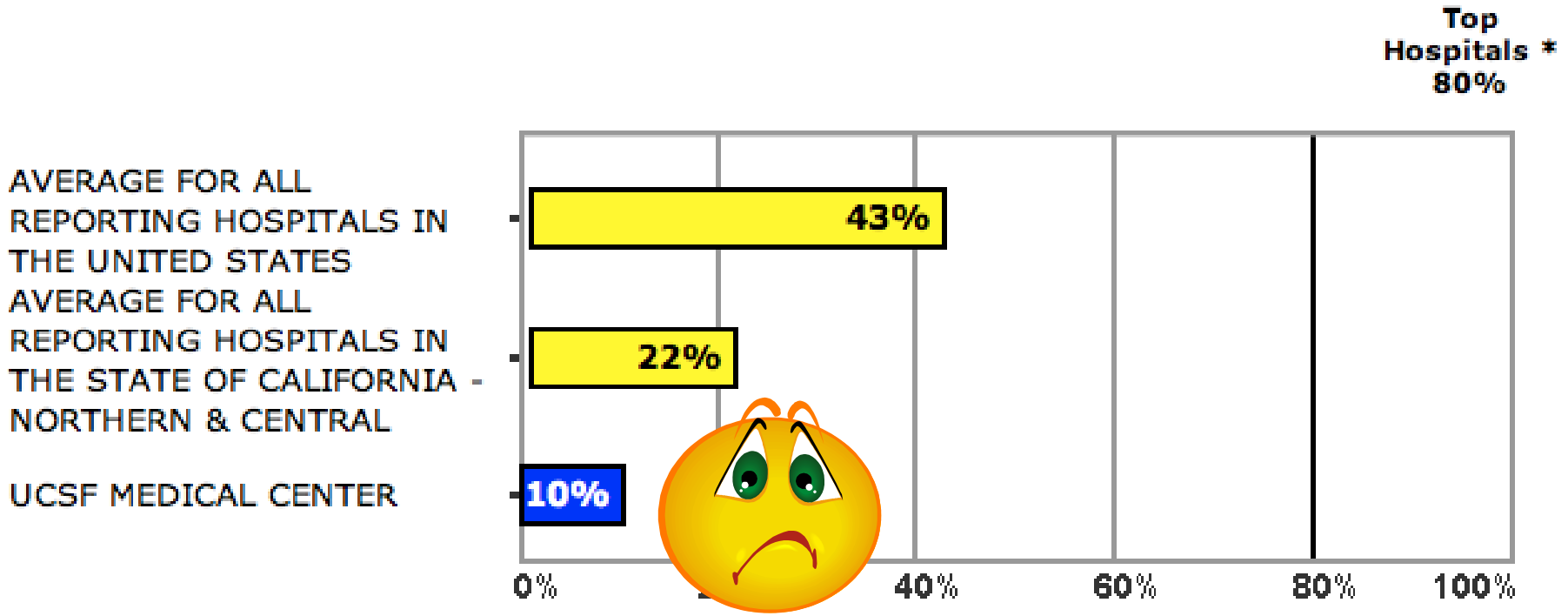
US News & World Report 2009-10

Rank	Hospital	Points
1	Johns Hopkins Hospital, Baltimore	30
2	Mayo Clinic, Rochester, Minn.	28
3	Ronald Reagan UCLA Medical Center, Los Angeles	26
4	Cleveland Clinic	26
5	Massachusetts General Hospital, Boston	25
6	New York-Presbyterian University Hospital of Columbia and Cornell	24
7	University of California, San Francisco Medical Center	
8	Hospital of the University of Pennsylvania, Philadelphia	
9	Barnes-Jewish Hospital/Washington University, St. Louis	17
10	Brigham and Women's Hospital, Boston	17
10	Duke University Medical Center, Durham, N.C.	17

That's Nice, But…

Percent of Pneumonia Patients Given Pneumococcal Vaccine

2003 data



* Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 80% rate or better.

www.hospitalcompare.hhs.gov

Every Organization Needs Its Golda Meir Moment…

Don’t be humble.
You’re not that great

Things That Have Worked Less Well Than I Would Have Hoped

- Bureaucratic, static, and non-harmonized quality measures are unhelpful, even counter-productive
  - *Good* description of many of the Medicare COPs
- In a dynamic and robust QI ecosystem, nimble, connected, often virtual organizations add great value
  - IHI, some specialty/regional collaboratives, others
  - *Not* a good description of most QIOs

In This Environment, Medicare Should…

- Drive systems to produce "value"
  - P4P is not the only mechanism to promote this
  - Don't underestimate transparency, and yes, even professionalism as drivers
    - MDs may be as important as the system (board certification, "PhysicianCompare")
- Promote more integration (ACOs, etc)
  - Some facilitation, combined with value pressure
- Abandon static, non-harmonized measures
- Promote capacity building: well meaning poor performers may not know how to succeed

For Example, Medicare Could Save Many Lives By…

- Abandoning COPs that:
  - Are nitpicky, trivial, vague, arbitrary
  - Create an inspector/inspected environment
  - Not aligned with TJC, states and others
- Adopting requirements that are meaningful:
  - >90% of hospital discharge summaries must available to the follow-up provider within 48 hrs
  - Hospitals have audited hand hygiene rates > 90%

What About the QIOs

- A monopoly of regional QIOs might have made sense when:
  - Poor performers had no pressure to improve
    - Need to "push" QI in their direction
  - Face-to-face meetings were the main connector
- Today…
  - Business case for safety/quality drives organizations to *seek* improvement
  - Web, telecommuting allows distance learning/collaboratives

Medicare Should Consider…

- Giving poor performing organizations resources to "buy" support
  - QIOs compete for the business
- Creating accountability among giving and receiving organizations: a QI "market"
  - Reporting outcomes of these collaborations
  - Reporting satisfaction of provider organizations

The Bottom Line: Supporting a Healthcare Value Market

- The “value market” is extraordinarily dynamic and getting more so
- Medicare must continue to drive this market
- In this market, 80s-style highly prescriptive, non-evidence based laundry lists of COPs are a painful distraction from the real work
- In this market, provider organizations will seek out help; their choices should be as modern and dynamic as their needs