Building The Capacity to Improve Health Care Quality & Value: Examples & Lessons From Across the Country

Dennis P. Scanlon, Ph.D.
Associate Professor of Health Policy & Administration
The Pennsylvania State University

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Outline

- My Background
- Defining the goals and scope of the QI workgroup
  - What problems need fixed?
  - A framework for approaching the workgroup's charge
- 'Theory of Change'
  - Various models of behavior change and their assumptions and evidence base
- Examples of QI initiatives from around the country
- Key takeaways and implications for Quality Institute Workgroup
- Questions and Discussion

My Background

- Health Economist & Health Services Researcher
- Faculty Member at Penn State for 11 Years
- Health Systems Improvement Research
  - Role of information, incentives, and behavior change in improving health systems outcomes
- Examples of projects
  - Employers (GM, Boeing, NBCH)
  - Health Plans (BSCA, Highmark)
  - Quality Measurement (HEDIS, CAHPS, HCUP)
  - Accrediting Bodies (NCQA, JCAHO)
  - State Medicaid Programs (SC, AK, NC, RI)
  - Provider Organizations (CareSouth, Monroe)
  - Regional Initiatives
    - Aligning Forces for Quality (RWJF)
    - Regional Quality Initiative (CHCS)

What Needs Fixed?

- Institute of Medicine Error Report (1999)
  - 44,000 to 98,000 deaths per year due to preventable inpatient medical errors
- Institute of Medicine Quality Report (2001)
  - Serious quality problems exist in all sectors of health care (inpatient, outpatient, acute, chronic, etc.)
  - Overuse, Underuse, Misuse
  - Fundamental system changes are needed
- McGlynn et al. (2003)
  - On average, American's receive recommended care and treatment 50% of the time
- Zhan & Miller (2003)
  - Significant variation in the impact of inpatient medical injuries on mortality, length of stay, and charges

What Needs Fixed?

- AHRQ's National Healthcare Disparities Report (2005)
  - Significant "inequality in quality" in U.S.
  - Differences by race, ethnicity & socioeconomic status
- Increasing trends in chronic illness, obesity & overweight, childhood obesity and poor health behaviors
- Poor Value for Health Care Expenditures
  - MBGH/Juran Institute Report (2002) estimated the cost of poor quality of care ~ $1,800 per employee/year
  - Some experts estimate that as much as 30% of health care expenditures are due to waste/inefficiency

Defining the Goals and Scope: Choosing Where to Focus

- IOM's Six Domains for Quality Improvement
  - Safety
  - Effectiveness
  - Patient Centeredness
  - Timely
  - Efficient
  - Equitable
- Care Type
  - Acute care
  - Ambulatory care
  - Prevention
  - Long term care
  - End of life care

Defining the Goals and Scope: Choosing Where to Focus

- Care Providers
  - Hospitals
  - Health systems
  - Physicians (individuals, groups)
  - Nurses
  - Other non-physician clinical practitioners
- Care Providers
  - Health plans
  - Nursing homes
  - Home health
  - Pharmacy
  - Community and social service agencies

Defining the Goals and Scope: Choosing Where to Focus

- Quality Improvement Organizations
  - Purchaser groups
  - Provider groups
  - Health plan groups
  - State governments
  - Federal government
  - Multi-stakeholder coalitions
- Quality Improvement Strategies
  - Market based approaches
  - Collaborative QI approaches
  - Patient/Consumer education/engagement
  - Regulatory approaches
  - Mixed model approaches

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Market Based Approaches
   - Demand side driven
     - Value based purchasing
     - Consumer choice
   - Market share penalties
   - Role of incentives and need for payment reform (e.g., P4P)
   - Information & transparency to improve market functioning

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Collaborative Quality Improvement Approaches
   - Supply side driven
   - Best practice sharing
   - Continuing education & training
   - Individual & organizational self interest vs. common good
   - Continuous quality improvement and practice re-design
   - Funding for QI investments

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Patient/Consumer Engagement
   - Both supply & demand side driven
   - Responsibility of patients for prevention, self management and responsibility
   - Education about patient role and resources to support patient activation and decision making
   - Expanded role for public health agencies, employers, and community/consumer agencies/advocates

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Regulatory Approaches
   - Accreditation
   - Licensure
   - Continuing education requirements
   - Audit and review
   - Public accountability & transparency

QI Strategies & Theory of Change: Assumptions, Evidence & Examples

1. Mixed Model Approaches
   - Combines elements of:
     - Market based approaches
     - Collaborative QI approaches
     - Patient/Consumer engagement
     - Regulatory approaches
   - Multi-stakeholder community based initiatives
     - “Stakeholder Alignment”

A Framework for the QI Workgroup

- Specify the following, including relevant weights:
  - QI domain(s)
  - Care type(s)
  - Providers
  - QI strategies
  - QI organizations
- Consider examples and options
  - What are local strengths?
  - What have others done?
  - Evidence base and assumptions for options
- Develop a logic model or "theory of change"
- Assess costs and feasibility
- Be realistic about time horizon

Importance of Being Transparent About Assumptions & Evidence

- There is more anecdotal evidence than scientific evidence for many proposed reform programs
- Existing scientific evidence is often based on activities of non-representative stakeholders
- Costs and benefits often depend on important details such as time horizons, provider capacity, reimbursement mix, etc.
- 3 Examples
  - Pay for Performance
  - Tiered consumer incentives
  - Supply chain market 'approaches'

CALIFORNIA HEALTH PLANS PAY OVER $55 MILLION TO PHYSICIAN GROUPS FOR REACHING IHA PAY FOR PERFORMANCE MEASURES

IHA NEWS RELEASE

OAKLAND, Calif., February 14, 2007 – Traditional approaches to physician compensation don't reward appropriate care, but California's pioneering **P4P program realigns incentives**. It **supports the need of physicians** to have uniform performance measures against which to gauge important indicators of quality, while also **providing consumers with valuable information** to guide their choices," said Donald J. Rebhun, MD, chairman elect of IHA's board of directors.

Motivated by the P4P program, physician groups in 2005 reported screening about **60,000 more women for cervical cancer**, testing nearly **12,000 more diabetics**, and administering approximately **30,000 more childhood immunizations** than during the previous year for their patients enrolled in participating health plans.

The New York Times

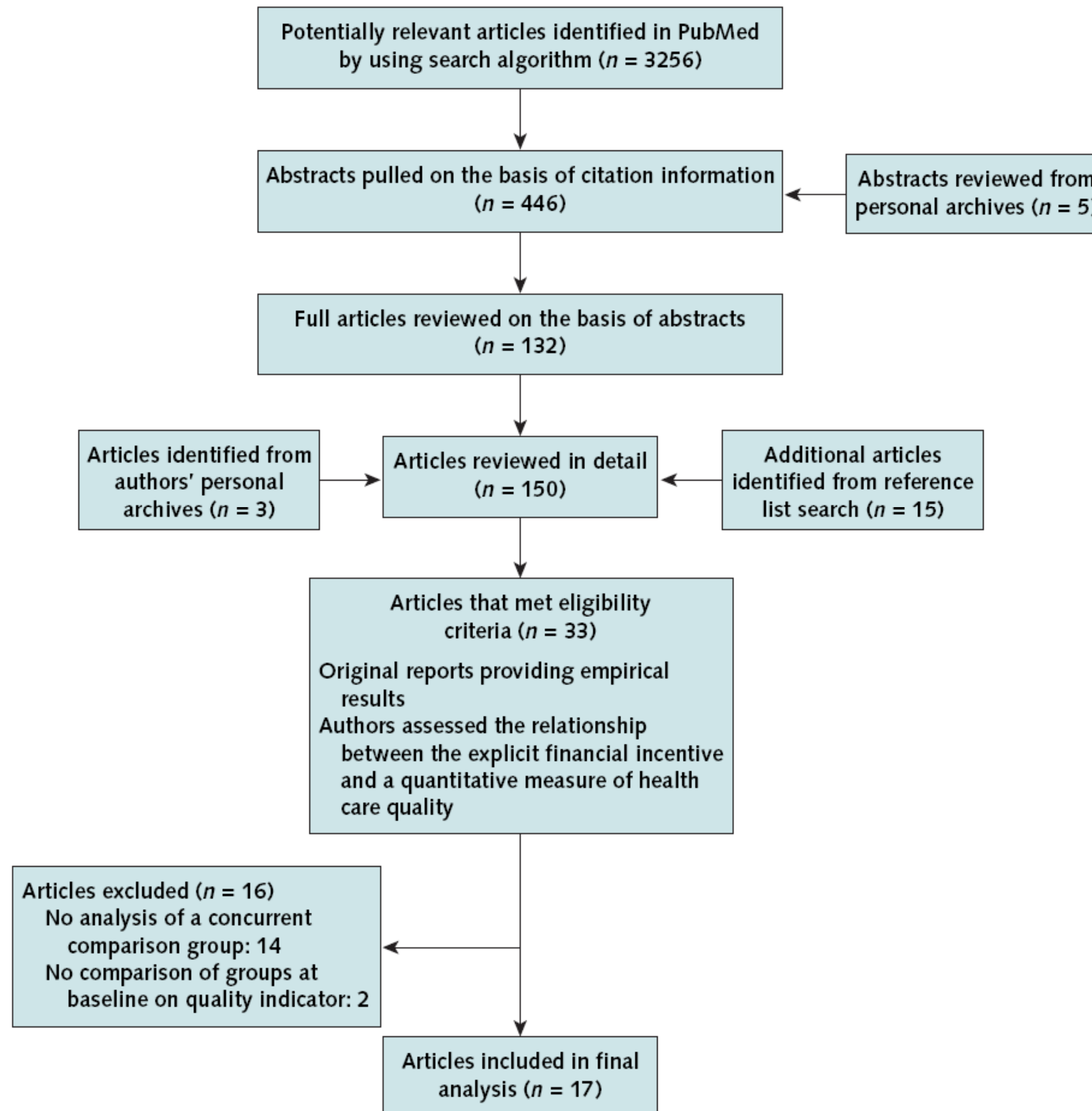
Bonus Pay by Medicare Lifts Quality

By REED ABELSON
Published: January 25, 2007

The 266 hospitals participating in a Medicare experiment that pays them more to follow medical recommendations have steadily **improved the quality** of patient care.

Medicare officials also emphasize that the vast **majority of hospitals were able to deliver better care**. “We continue to see improvement, quarter by quarter, in this cohort of hospitals,” said Herb Kuhn, the acting deputy administrator for Medicare.
The hospitals experienced nearly **1,300 fewer deaths** in treating heart attack patients, and they have generally been able to **score higher on quality measures** than the rest of the nation’s hospitals.

Figure. Studies published between 1 January 1980 and 14 November 2005 and evaluated for inclusion in the systematic review of explicit financial incentives for health care quality.



Selections »
Selections Plus »
Traditional Medical Plan
» Union
» Nonunion
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» **Hospital Safety Incentive**
» Pharmacy
» FAQs
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Hospital Safety Incentive

The Traditional Medical Plan has a network hospital benefit of 95% for **certain union groups**. However, if you choose a network hospital that meets certain patient safety standards, your benefit is 100%. This is the hospital safety incentive. *In order to be eligible for the hospital safety incentive, your hospital must meet the patient safety standards defined below on the date you are admitted to the hospital.*

Patient Safety Standards

These patient safety standards were developed by The Leapfrog Group, a nonprofit organization focused on preventing medical mistakes. The three standards are aimed at reducing medical errors, improving the quality of patient care and ultimately saving lives. They are:

Computerized Physician Order Entry (CPOE) - Electronic prescribing systems are in place to coordinate physician orders with patient information and automatically check for errors or problems.

Intensive Care Unit Physician Staffing (IPS) - Intensive care units are staffed with specialists who focus on the care of critically ill and injured patients.

Evidence-based Hospital Referral (EHR) - Hospitals with extensive experience with certain procedures have been shown to have better outcomes for patients.

How the Incentive Works

The hospital safety incentive is based on a patient's primary diagnosis and applies to inpatient and outpatient services (including emergency room services) that are billed by the hospital. Most charges not billed by the hospital will be paid at 95%. For example, if the hospital contracts for laboratory services, and the laboratory bills for services received at the hospital, then services are not part of the hospital safety incentive and will be paid at 95%.

Find A Hospital

If you are having one of the procedures listed below, the hospital must meet the EHR standard for you to receive the 100% hospital safety incentive. Your physician can assist you in determining if your procedure is an EHR procedure. Select your procedure from the list below to find out which hospitals qualify for the hospital safety incentive:

Current Benefit Year
July 1, 2004 thru June 30, 2005

- Abdominal Aortic Aneurysm
- Coronary Artery Bypass Graft
- Esophagectomy
- High-risk Delivery
  - Expected birth weight less than 1500 grams,
  - Gestational age less than 32 weeks or
  - Prenatal diagnosis of major congenital anomaly
- Pancreatic Resection
- Percutaneous Coronary Intervention

New Benefit Year
Beginning July 1, 2005

- Abdominal Aortic Aneurysm
- Coronary Artery Bypass Graft
- Esophagectomy
- High-risk Delivery
  - Expected birth weight less than 1500 grams,
  - Gestational age less than 32 weeks or
  - Prenatal diagnosis of major congenital anomaly
- Pancreatic Resection
- Percutaneous Coronary Intervention

All other medically necessary inpatient and outpatient services must be billed by a hospital that meets both the CPOE and IPS standards in order for the 100% hospital safety incentive to apply. Select the link below to find hospitals that qualify for the 100% hospital safety incentive.

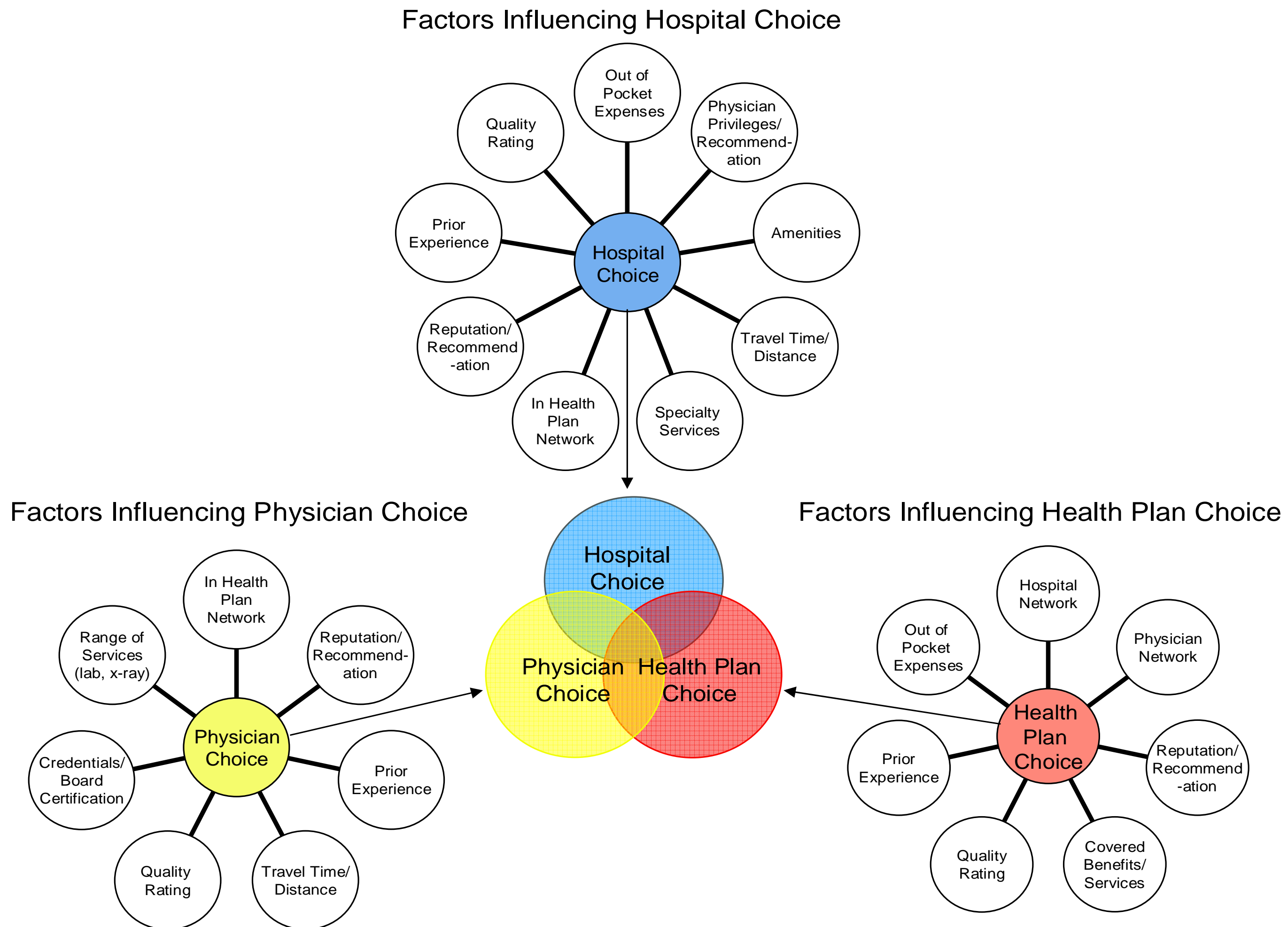
Current Benefit Year
July 1, 2004 thru June 30, 2005

- CPOE and IPS Hospitals

New Benefit Year
Beginning July 1, 2005

- CPOE and IPS Hospitals

Conceptual Framework for Studying Tiered Hospital Benefit Programs

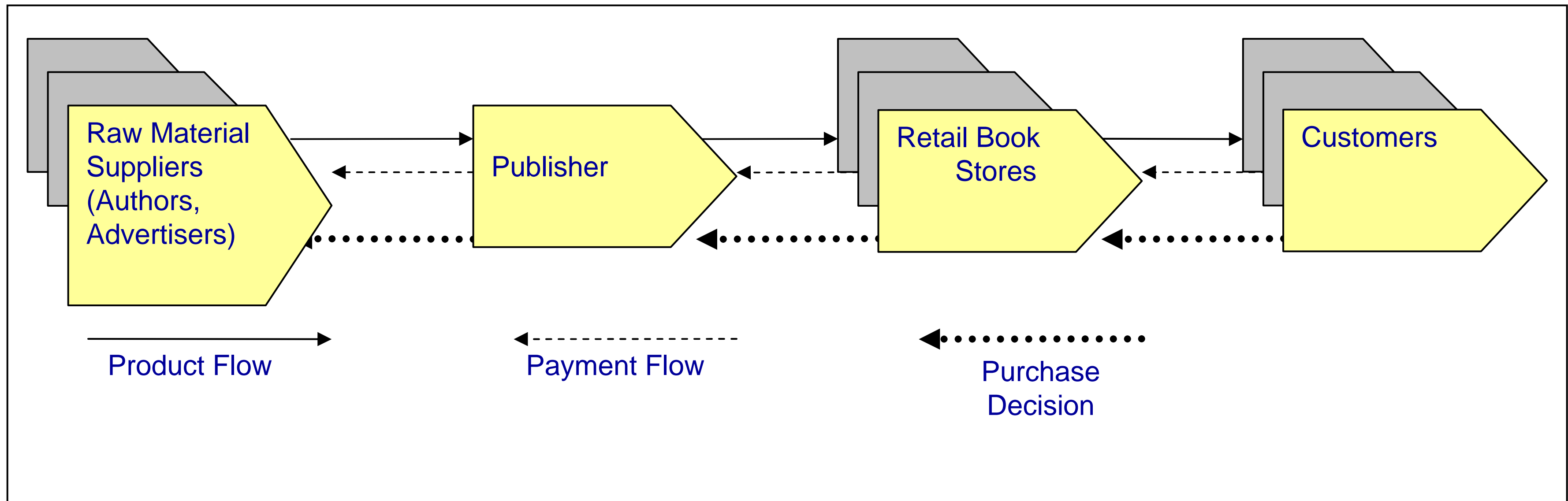


Boeing Study Key Takeaways

- If physician-patient relationships dominate and physician hospital privileges are limited, then a financial incentive geared towards consumers may have little impact
  - More effective alternative approaches may include hospital or physician incentives
- What dollar amount would it take to get patients to consider doctor and hospital switching?
  - Study was not designed to answer this question
- What is the optimal timing of incentive program implementation when few providers meet the preferred tier initially?
  - From the plan, employer, and payer perspectives
  - Choices must be convenient for patients and include a significant number of physicians as in the CABG example

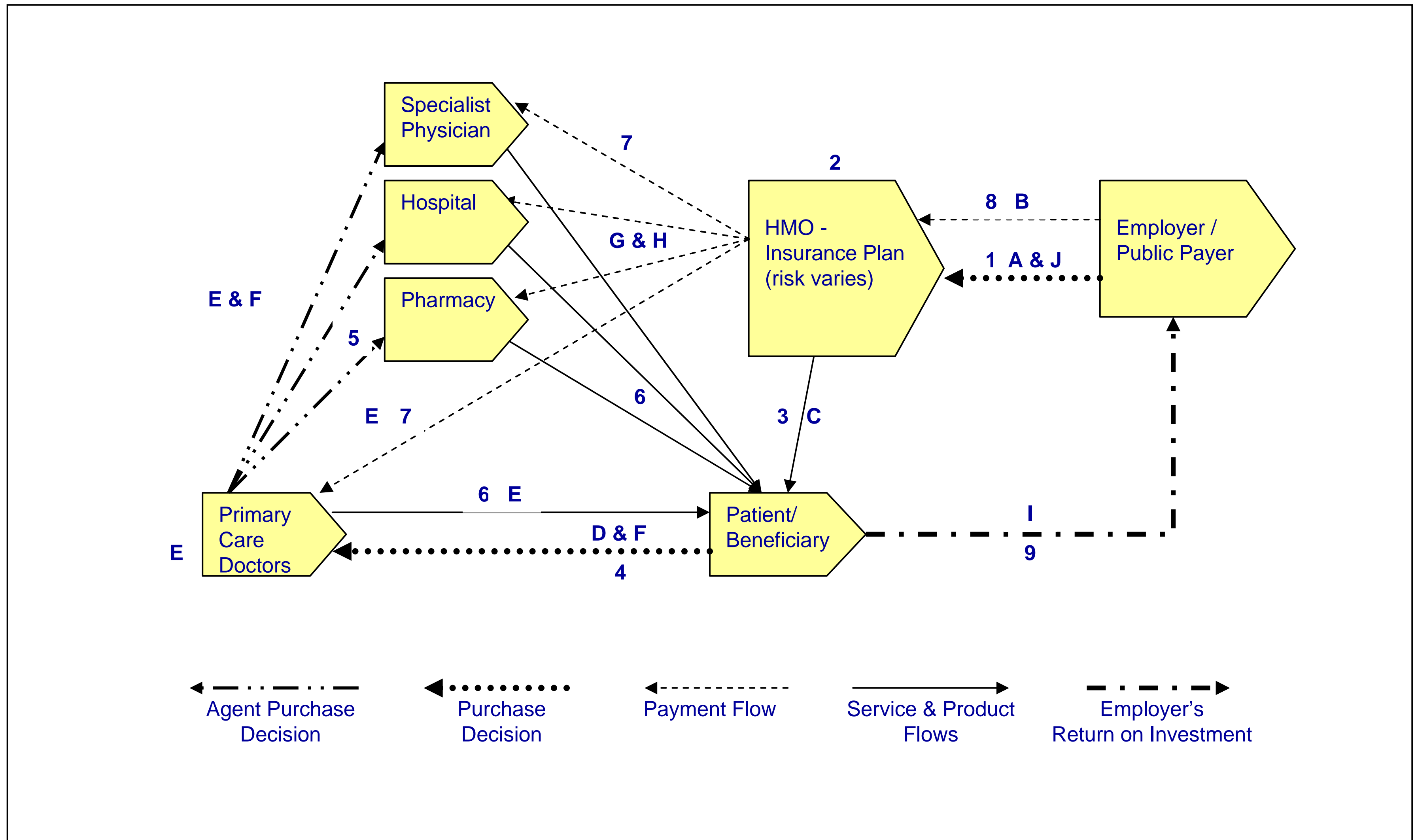
Market Based Efforts to "Align Incentives"

Example of a Simple Supply Chain Adapted from Porter



**Source:* Michael E. Porter. *Competitive Advantage: Creating and Sustaining Superior Performance. Copyright 1985, 1999. Adapted with permission of the Free Press, a division of Simon and Schuster.*

A Simplified Health System Supply Chain from a Payer's Perspective



Health Care Excellence → Cost Savings

- **Empirical studies and actuarial research**
- **Adherence to evidence-based clinical guidelines results in:**
  - Improved patient health
  - Improved productivity and reduced absenteeism
  - Reduced overall health care costs
  - E.g., Diabetes care excellence → $300-$400 per pt cost savings
- **Concept behind Bridges to Excellence**
  - Give ½ of projected cost savings per patient to physicians as reward for health care excellence
  - Reward to these top physicians will incentivize other physicians to change practice patterns

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Employer (Payor) Perspective: Improved Effectiveness Leads to Cost Savings

Incentives	→	Greater Effectiveness	→	Healthier Patients	→	Cost Savings
$		Preventive Screening Disease Management Clinical Information Systems		Fewer Complications Fewer Medical Errors		Reduced Health Care Costs Increased Productivity

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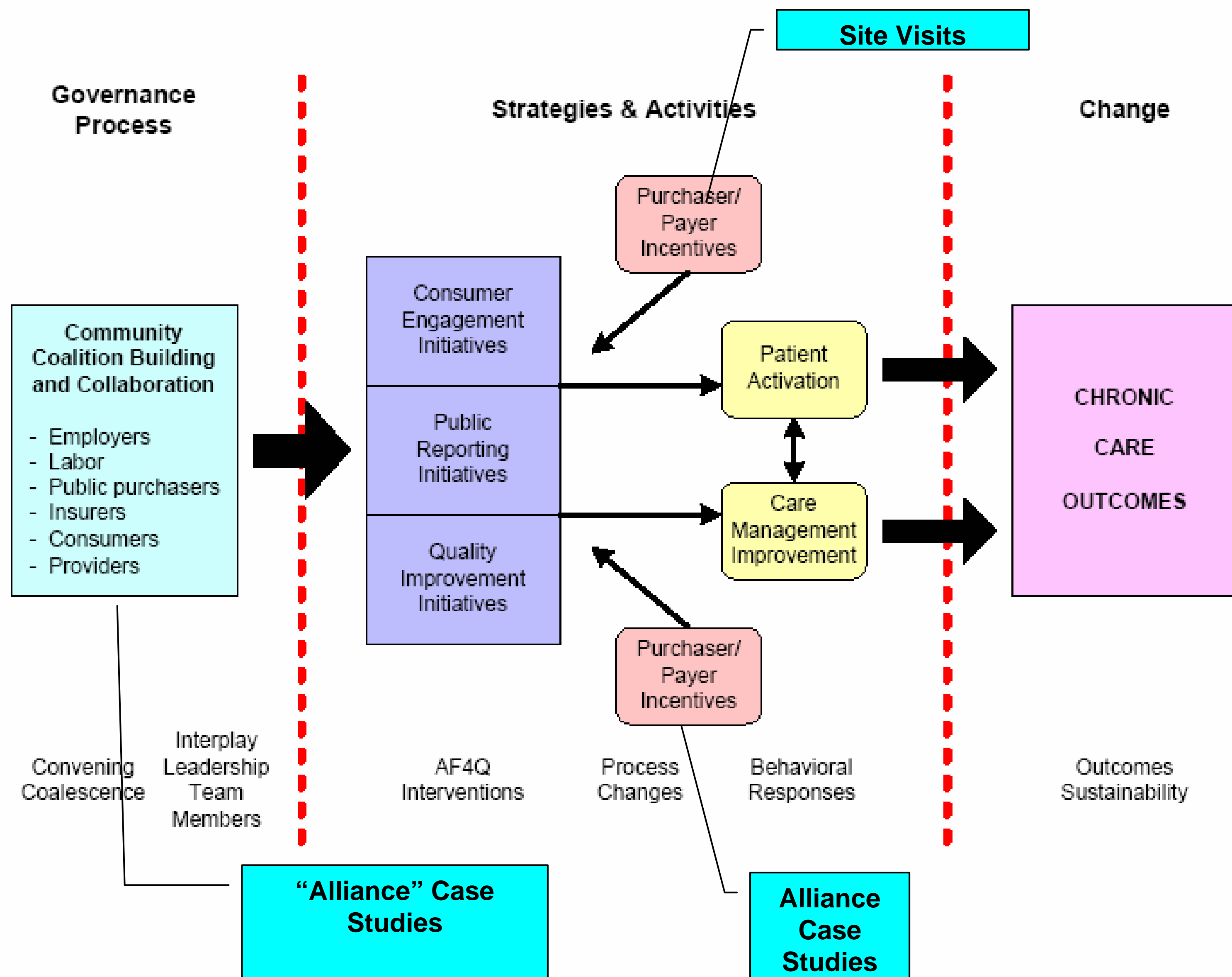
“Theory of Change” and Logic Model Development

- A graphic depiction of the sequence of interventions and the expected effect of those activities
- Helpful in clarifying expectations regarding ‘cause and effect’ and in being more explicit about assumptions and uncertainty
- Useful for explaining the ‘logic’ of recommendations to stakeholders
- Examples
  - AF4Q
  - North Carolina Regional Quality Improvement Project

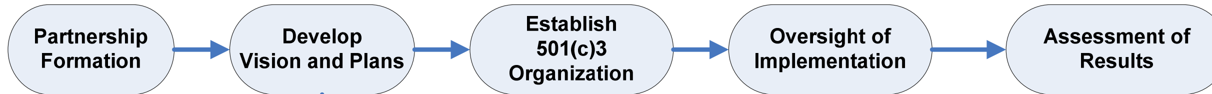
AF4Q Evaluation: Logic Model



North Carolina RQI Logic Model

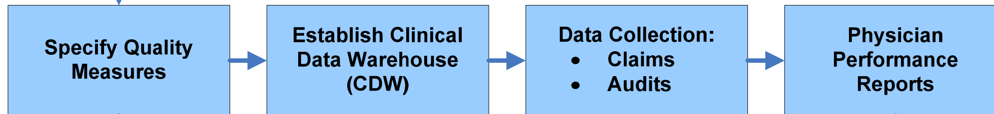
Evaluation level

RQI Partnership



Quality Improvement Strategies

Evidence-Based Practices and Measures & Health Information Technology



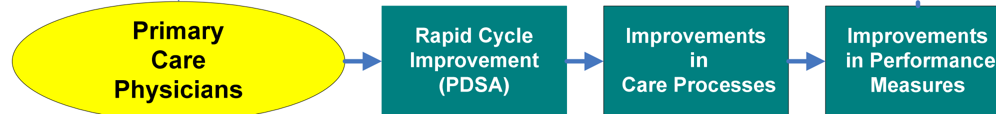
Continuous Quality Improvement

Feedback

Consulting Services

Comparative Reports & Registry Information

Chronic Care Delivery System



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Start

2 Years

Examples of QI Efforts from Other States and Communities

- Examples may be useful for the Delivery System Committee and the Quality Institute Work Group
- Note the diversity of approaches, including variation in domains, care types, providers, QI strategies and QI organizations
- Local market and historical context are very important!
  - Physician practice organization in Twin Cities, MN

Pacific Business Group on Health- At a Glance

- Typology: Purchaser group
- Primary strategy: The “market”
- Focus:
  - Domain: Safety, provision of evidence based care, cost
  - Care type: Acute care, ambulatory care
  - Unit: Hospitals, physicians, health plans

Pacific Business Group on Health-History

- The Pacific Business Group on Health (PBGH) formed in 1989
- Business coalition of 50 purchasers that seeks to improve the quality and availability of health care while moderating cost
- Members spend nearly $10 billion annually to provide health care coverage to more than 3 million employees, retirees and dependents
- PBGH is a 501(c)3 corporation

Pacific Business Group on Health Activities

- **Transparency**
  - **Medical Groups and Physicians-** Promote advancements in provider performance reporting through work with the Integrated Healthcare Associations Pay-For-Performance project and through Physician Measurement efforts. The latter includes designation as one of six national pilots to work with Centers for Medicare & Medicaid Services (CMS) and the AQA Alliance to pilot the collection and reporting of physician-level performance information.
  - **Hospitals-** The Leapfrog Patient Safety Initiative is focused on encouraging consumer decision-making at the hospital level. Health plans have played an important role in encouraging hospitals to participate in this effort, and doctors will have a key role in advising their patient's on hospital choice.
  - **Health Plans/Medical Groups-** The California Healthcare Quality Report Card provides standardized, comparative information on health plans. Since 2001, PBGH has served as a vendor, providing technical expertise and helping the Office of the Patient Advocate build on existing tested measures rather than start from scratch.

Pacific Business Group on Health Activities

- Quality Measurement and Improvement
  - **Disease Management Effectiveness Program-** Evaluates existing disease management programs against criteria endorsed by national experts.
  - **The Silicon Valley e-Health Pilots-** Seek to enhance patient-doctor communication and tested new ways to reimburse physicians for e-visits.
  - **CALINX, the California Information Exchange-** Effort by California purchasers, plans and providers to collaborate in the development of standards for the exchange of health care information.

Pacific Business Group on Health Activities

- Policy Development & Advocacy – Areas of Focus
  - Care quality measurement
  - Provide consumer with useful quality and price information
  - Reward providers for doing a better job
  - Adopt health information technology
  - Re-engineer how care is delivered
  - Reduce disparities in quality of care
  - Building healthcare value

Institute for Clinical Systems Improvement (ICSI)- At a glance

- Typology: Provider group (with health plan funding)
- Primary strategies: Clinical quality improvement
- Focus:
  - Domain : Provision of evidence based care
  - Care type: Ambulatory care
  - Unit of focus: Providers

Institute for Clinical Systems Improvement- History

- An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans in Minnesota
- Founded in 1993 by HealthPartners Medical Group, Mayo Clinic and Park Nicollet Health Services
- Has 62 members and is funded by all six Minnesota health plans. The combined medical groups and hospital systems represent more than 7,600 physicians

Institute for Clinical Systems Improvement- Activities

- Scientific Groundwork for Health Care
  - Clinicians from member organizations survey scientific literature and draft health care recommendations based on the best available evidence
  - Subjected to an intensive review process that involves physicians and other health care professionals from ICSI member organizations before they are made available for general use
  - Examples
    - Care Guidelines
    - Order sets and protocols
    - Technology Assessments

Institute for Clinical Systems Improvement-Activities

- Support for Improvement
  - Events, tools and offerings of support to ICSI member organizations used to aid members in quality improvement structure, knowledge, and progress towards achieving their aims
  - Examples
    - Patient Education Resources
      - Disease-specific education materials developed by ICSI member groups that may be downloaded and distributed
    - Summary Reports
      - Documentation of strategies and lessons learned within participating member organizations in the improvement of a process of care, clinical outcome, satisfaction of care, or waste reduction

Institute for Clinical Systems Improvement-Activities

- Summary Reports Examples
  - Chest Pain (Acute) Initiative at Park Nicollet Health Services
  - Colon Cancer Screening Rate Improvement at CentraCare
  - Advanced Access in a Multi-Specialty Group (RiverWay Clinics)
  - Advanced Access Changes to Improve Mammography Waiting Time & Rates at North Clinic
  - Access to Care Improvement at Four Medical Groups

Pittsburgh Regional Health Initiative (PRHI)- At a glance

- Typology: Multistakeholder group
- Primary strategies: Mixed: Market and clinical quality improvement
- Focus:
  - Domain: Safety, provision of evidence-based-care
  - Care type: Ambulatory care, Acute care
  - Unit: Physicians, hospitals, nurses

Pittsburgh Regional Health Initiative – History and Structure

- Regional consortium of medical, business, and civic leaders to address healthcare safety and quality improvement as a social and business imperative
- Includes the institutions and individuals that provide, purchase, insure and support healthcare services in the Pittsburgh region
- Nonprofit operating arm of the Jewish Healthcare Foundation with funding from local corporations, foundations, health plans and government contracts and grants

Pittsburgh Regional Health Initiative - Activities

- Perfecting Patient Care (PPC)
  - Using the Toyota Production System as a model, PRHI developed a quality improvement method for clinical settings
  - Aims to eliminate errors, inefficiency and waste in complex systems through continuous improvement and standardization of work practices
    - Supported much of the ground work for PA's Hospital Acquired Infection reporting system, including ROI analysis
  - Practices are taught at an 'open university' or as on-site customized training

Pittsburgh Regional Health Initiative - Activities

- Chronic Care Improvement
  - PRHI has been dedicated to improving the delivery of chronic care since 2000, when it commissioned region-specific data on diabetes indicators for Southwestern Pennsylvania
  - Two working groups, representing multiple stakeholders, formed around Diabetes and Depression to study the data and take action
  - As they explored how to improve the delivery of care to people with those two conditions, they quickly discovered that the barriers to be removed were common to both disease states.
  - By 2003 the two groups had combined into one: the Chronic Care Model Action Group
  - Efforts in 2007 turned to one of the most enduring barriers: the current payment system for healthcare delivery

Pennsylvania Health Care Cost Containment Council (PHC4)- At a glance

- Typology: State government
- Primary strategies: The "market"
- Focus:
  - Domain: Provision of evidence-based-care, safety, cost, equity
  - Care type: Ambulatory, acute care, efficiency
  - Unit of focus: Providers, hospitals, health plans

Pennsylvania Health Care Cost Containment Council - History

- Independent state agency, formed under Pennsylvania statute (Act 89, as amended by Act 14)
- Responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay
- Funded through the Pennsylvania state budget and receives revenue through the sale of its data to health care stakeholders

Pennsylvania Health Care Cost Containment Council - History

- Strategy to contain costs is to stimulate competition in the health care market by:
  - Providing comparative information about the most efficient and effective health care providers to individual consumers and group purchasers of health services
  - Providing information to health care providers that they can use to identify opportunities to contain costs and improve the quality of care they deliver

Pennsylvania Health Care Cost Containment Council - Activities

- Responsibilities
  - Collect, analyze and make available to the public data about the cost and quality of health care in Pennsylvania
  - Study, upon request, the issue of access to care for those Pennsylvanians who are uninsured
  - Review and make recommendations about proposed or existing mandated health insurance benefits upon request of the legislative or executive branches of the Commonwealth

Pennsylvania Health Care Cost Containment Council - Activities

- Data Collection
  - Collects over 3.8 million inpatient hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers in Pennsylvania
  - Data is collected on a quarterly basis
  - Collects data from managed care plans on a voluntary basis

Pennsylvania Health Care Cost Containment Council - Activities

- Examples of Reports
  - Hospital Performance Report 2006
  - Choosing a Medicare Advantage Plan for 2008
  - Hospital Financial Analysis 2006
  - Cardiac Surgery in Pennsylvania 2005
  - PHC4 Research Brief - Clostridium difficile Infections in Pennsylvania Hospitals

PHC4 - Coronary Artery Bypass Graft - Mozilla Firefox

File Edit View History Bookmarks Tools Help

http://www.phc4.org/cabg/?year=2005

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Cardiac Surgery in Pennsylvania 2005

The Interactive Database can be searched by either hospital or surgeon.

Once selected, the hospital and surgeon specific pages will display the number of cases, statistical ratings for in-hospital mortality, 30-day mortality, 7-day and 30-day readmissions, and post-surgical length of stay. When a hospital is selected the average charge, average commercial payment and average Medicare payment are also displayed.

Please make your selection from the list boxes below.

Hospital

Statewide
Abington Memorial
Albert Einstein
Allegheny General

Go!

Surgeon

Michael A. Acker
V. Paul Addonizio
Dahlia M. Alspaugh
John S. Anastasi

Go!

Hold down **"Ctrl"** Key to select multiple Hospitals or Surgeons

View Other Years

2005 2004 2003 2002 2000

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Done

start Rhapsody Penn State WebMa... PHC4 - Coronary A... F:\ Microsoft PowerPoi... 4:44 PM

Cardiac Surgery in Pennsylvania 2005

Symbol Legend

- ● Significantly higher than the expected rate.
- ◉ Not significantly different than the expected rate.
- ○ Significantly lower than the expected rate.
- NR Not Reported (too few cases).

Conemaugh Valley Memorial

Hospital	# of Cases	Mortality Rate		Readmission Rate		Length of Stay	Average Charges	Average Payments Commercial	Average Payments Medicare
		In - Hospital	30 - Day	7 - Day	30 - Day				
Conemaugh Valley Memorial									
CABG without Valve	309	○	◉	◉	◉	4.8	$62,053	$23,476	$28,233
Valve without CABG	50	◉	◉	◉	◉	5.4	$89,906	$40,429	$36,666
Valve with CABG	64	◉	◉	◉	◉	6.8	$106,836	$35,368	$38,863
Total Valve	114	◉	◉	◉	◉	6.1	$97,952	$38,482	$37,914

Choose Another Hospital / Surgeon

Quality Improvement Organizations (QIOs)- At a glance

- Typology: Federal government
- Primary strategies: Clinical quality improvement
- Focus:
  - Domain: Provision of evidence-based-care, safety, cost, access
  - Care type: Ambulatory care, acute care
  - Unit of focus: Providers, hospitals, health plans

Quality Improvement Organizations

- QIOs work with consumers and physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly patients from underserved populations
- The Program also safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care

Quality Improvement Organizations Activities

- The 9th Round SOW work themes:
  - Beneficiaries protection (case review)
  - Prevention
  - Patient safety
  - Care coordination/patient pathways
  - The six IOM QI domains
- Cross-cutting themes:
  - Promoting the use of health information technology and electronic health records
  - Reducing health care disparities
  - Emphasizing value in health care

Important National Trends

- There are lots of important activities and changes happening nationally by public and private entities that are important to understand as you develop the plan for Oregon's Quality Improvement Institute
- Examples
  - NQF and QASC
  - DHHS' "Value Exchanges"
  - CMS' P4P
  - Advanced Medical Home
  - RWJF's 'Aligning Forces for Quality' and 'Regional Market Strategy'
  - CHCS' Regional Quality Initiative

Measure Development : National Quality Forum (NQF)

- Private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting.
- Primary function is to “endorse” national quality measure

National Quality Forum-Activities

- Examples of endorsed measures:
  - Acute care
    - Cross cutting measures
    - Clinician level measures
    - Condition specific measures
    - Patient experience
    - Safety
  - Ambulatory care
    - Condition specific measures
    - Patient experience
    - Prevention measures

Note: See http://www.qualityforum.org/pdf/lsEndorsedStandardsALL08-14-07corrected.pdf for full list of acute care and ambulatory care measures

National Quality Forum- Other Priority Areas

- Also developing measures and standards for (examples):
  - Cancer care
  - Health IT structural measures
  - Emergency care
  - Home health care patient experience
  - Immunization quality
  - Therapeutic drug management
  - Laboratory medicine communication
  - Nursing-sensitive care

DHHS: Value Driven Health Care Initiative

- Established in response to August, 2006 executive order calling for increased quality, efficiency within healthcare system
- Four cornerstones:
  - Interoperable Health Information Technology (Health IT Standards)
  - Measure and Publish Quality Information (Quality Standards)
  - Measure and Publish Price Information (Price Standards)
  - Promote Quality and Efficiency of Care (Incentives)

Source: Department of Health and Human Service: Value Driven Health Care Home, available at: http://www.hhs.gov/valuedriven/, accessed July 31, 2007.

“Value Exchanges”

- Multistakeholder organizations that bring together purchasers, providers, health plans, consumers to advance four cornerstones of Value Driven Health Care Initiative in local communities
- Align varied strategies, interests of multiple community players
- “Formally” recognized by DHHS via application process
- Can participate in “Learning Network” through Agency for Healthcare Research and Quality (AHRQ) to support their work

Source: Department of Health and Human Service: Value Driven Health Care Home, available at: http://www.hhs.gov/valuedriven/, Accessed July 31, 2007.

CMS Hospital Value-Based Purchasing

- Proposal announced April, 2007
- Starting in October 1, 2008, proposed to replace present pay-for-reporting structure
- All hospitals eligible to receive a specified percent of payment based on performance
- Incentive system based on performance and improvement

DHHS, "Hospital Value Based Purchasing," available at:http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPOptions.pdf, accessed July 31, 2007.

CMS Physician Quality Reporting Initiative (PQRI)

- Medicare physician pay for reporting program
- Starting July 1, 2007 physicians can earn 1.5% bonus for reporting quality
- CMS pay-for-reporting programs tend to be precursor to pay-for-performance programs

Source: Centers for Medicare and Medicaid Services, available at: http://www.cms.hhs.gov/PQRI/, accessed July 31, 2007.

CMS Premier Demonstration

- Initiated in March 2003
- 260 hospitals report on 33 measures
- Payments/Penalties
  - Hospitals performing in top two deciles receive 1–2%
  - Underperformers penalized 1–2% of Medicare payment
  - Payments average $72,000 per hospital
- Demonstration has been extended for three more years

Source: Premier, Inc., available at: http://www.premierinc.com, accessed July 31, 2007.

RWJ Aligning Forces for Quality (AF4Q)

- Grants provided to communities to align key forces, including health care providers, health care purchasers, and health care consumers
- Alliances work on three activities:
  - Quality improvement
  - Quality reporting
  - Consumer engagement
- Expanding focus to include inpatient care, nursing, and disparities in 2008
- Quality Corporation in Oregon is one of 14 selected communities

Advanced Medical Home

- American College of Physicians (2006) calls for voluntary certification and recognition of primary care and specialty medical practices as "advanced medical home"
- "Advanced medical home acknowledges that the best quality of care is provided not in episodic, illness-oriented, complaint-based care -- but through patient-centered, physician-guided, cost-efficient, longitudinal care that encompasses and values both the art and science of medicine."

Source: American College of Physicians, **The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care, 2006.**

Key Attributes

- Care Model: Organize the delivery of care for all patients according to the Wagner's Care Model
- Patient Centered Care: Coordinate care in partnership with patient and family
- Enhanced Access– Provide convenient access not only through face-to-face visits but also via telephone, email, and other modes of communication
- Evidence Based Care: Adopt and utilize of evidence based care and decision support tools
- Self-Management Support: Help patients perform self-management and provide resources to do so
- Patient Tracking: Adopt and implement of health information technology to promote quality of care
- Performance Feedback: Participate in programs that provide feedback on the performance of the practice and the providers

Source: American College of Physicians, **The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care,** 2006.

Conclusion

- There is no “silver bullet”
- How best to compliment existing QI efforts in Oregon, and the policy mandate to change?
  - Further examine QI inventory to assess areas of overlap and categorize strategies
  - Build on existing alignment strategies
  - ‘Bricks & Mortar’ vs. ‘Virtual’ Institute?
- Importance of efficiency expectations
  - How is value defined?
- The importance of fundamental reimbursement change?
- Pilot studies and research can be important tools
  - But requires a longer time horizon