Are We Making Progress in Narrowing the Quality Chasm in the US?

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December 7, 2011
Outline of Talk

- US performance a decade ago
- Effects of three policy options
- An updated view of performance
- One example of what it takes to significantly improve quality
Determining the Size and Nature of the Quality Chasm
Overview of Community Quality Index Study

- 13,275
- 1996-2000
- 6712
- 2.6
- 439
- 16

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We Constructed an Opportunity Score

Score = \frac{\text{# of times recommended care was delivered}}{\text{# of opportunities to deliver recommended care}}
On Average, About Half of Recommended Care for Adults Is Delivered

McGlynn et al, 2003
Quality of Care for Cardiopulmonary Problems Varied Widely

Coronary artery disease
Hypertension
Heart failure
Stroke
Chronic lung disease
Asthma
High cholesterol
Pneumonia
Atrial fibrillation

% of recommended care delivered

McGlynn et al., 2003
Significant Variation Existed in Management of Adults’ General Medical Problems

McGlynn et al., 2003

% of recommended care delivered
Children Received Less than Half of Recommended Care

Mangione-Smith et al., 2007
Quality for Children Also Varied by Condition

- Colds/Flu
- Allergies
- Acne
- Fever
- Immunizations
- Urinary Tract Infec
- Vaginitis/STDs
- Asthma
- Well Child
- Diarrhea
- Adol Prev Services

% of recommended care received

Mangione-Smith et al., 2007
Well, That May be True Nationally, but Care in My Community is Better
We Examined Quality in Varied Markets

- Seattle
- Orange County
- Phoenix
- Little Rock
- Indianapolis
- Cleveland
- Greenville
- Miami
- Newark
- Boston
- Syracuse
- Lansing
And Found You Weren’t Safe Anywhere…

- Boston
- Cleveland
- Greenville
- Indianapolis
- Lansing
- Little Rock
- Miami
- Newark
- Orange Co
- Phoenix
- Seattle
- Syracuse

% of recommended care delivered

Kerr et al., 2004
And Found You Weren’t Safe Anywhere…

% of recommended care delivered

Kerr et al., 2004
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And Found You Weren’t Safe Anywhere…

Kerr et al., 2004

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And Found You Weren’t Safe Anywhere…

Kerr et al., 2004

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Some People May Have Problems With Quality, But My Care is Great
No One Is Immune From Quality Deficits

- Gender:
  - Male
  - Female

- Race:
  - White
  - Black
  - Hispanic
  - Other

- Age:
  - 18-30
  - 31-64
  - 65+

% of recommended care delivered
Money Doesn’t Buy Quality

$50K
$15-50K
<$15K

Private, nonmanaged
Managed care
Medicare
Medicaid
No insurance

% of recommended care delivered
Study Was Critical for Stimulating Forward Movement

- Breaking through denial that quality was substandard
  - Nationally
  - In diverse communities
  - For all people

- Allowed solutions to be entertained and tested
What Policy Options Have We Tried to Improve Quality in the US?

- Public reporting of performance
  - Centers for Medicare & Medicaid Services (CMS)
  - Agency for Healthcare Research & Quality
  - Private purchasers

- Pay-for-performance
  - CMS, private

- Investment in electronic health records
Public Reporting
How Does Public Reporting Work?

Consumers

Information

Providers

Consumer Choice

Quality Improvement

Improved Processes & Outcomes

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What Do We Know About the Effect of Public Reporting?

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<tr>
<th>Entity</th>
<th>Effects on Consumer Choices</th>
<th>Quality Improvement Efforts</th>
<th>Clinical Outcomes</th>
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So, Is It Worth It?

- Public reporting is the right thing to do
- But it may not have large effects by itself
  - Other factors (financial incentives) still dominate
  - Biggest impact likely on providers rather than consumers
  - Continuing work on the implementation of these programs is necessary
Pay-for-Performance (P4P)
What Is Pay-for-Performance?

- Pay-for-Performance (P4P) programs use financial incentives to motivate hospitals and doctors to increase adherence to best practices.
- Providers receive differential payments based on performance on a set of specified measures:
  - Clinical quality
  - Resource use (efficiency)
  - Patient experience
  - Information technology use or capabilities
P4P Is Not a New Idea

“If a physician makes a large incision with an operating knife and cures it, or if he opens a tumor (over the eye) with an operating knife, and saves the eye, he shall receive ten shekels in money.”

“If a physician makes a large incision with the operating knife, and kills him, or opens a tumor with the operating knife, and cuts out the eye, his hands shall be cut off.”

-- Code of Hammurabi, 1750 B.C.
What Do We Know about Pay-for-Performance?

- Little evaluation of pay for performance (P4P) has occurred
- The handful of published studies show modest positive results
- P4P program design matters in terms of program impact
- P4P alone is unlikely to solve quality and cost problems, but may be useful when combined with other policy levers
P4P Generated Slightly Greater Improvements than Public Reporting

Comparison of Performance on Composite of 10 Measures: Q4 2003-Q3 2005

Premier P4P hospitals

CMS P4R hospitals

$\Delta = 2.8\%$ points after adjusting for hospital differences*

*Study by Lindenaur et al., 2007 (*New England Journal of Medicine*)

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Did P4P Having an Impact in the UK?


\[\Delta = 4\% \text{ points for asthma, } 6\% \text{ points for diabetes}\]

Performance rate (%)

- Coronary heart disease
- Diabetes
- Asthma

*Study by Campbell et al., July 12, 2007 (New England Journal of Medicine)
Challenges in Implementing P4P

- **Data**: Under-investment in data infrastructure for population management and real-time monitoring can hinder system-level change.

- **Operational infrastructure**: P4P programs require properly resourced operational infrastructure.

- **Absence of available measures to support P4P**: In near term, with a small number of performance measures, providers will use stop-gap fixes rather than reengineer care processes.
Health Information Technology (HIT)
What’s The Theory?

- All modern industry uses information technology to manage knowledge, processes
- Complexity of medicine has increased exponentially
- Many-to-many matching problem better handled by computers than human brains
What Do We Know About the Effect of HIT on Quality?

- Systematic review (Chaudry et al, 2007)
  - 257 studies met inclusion criteria
  - 25% of studies from 4 academic centers
  - Benefits include increased adherence to evidence-based medicine, enhanced surveillance and monitoring, decreased medication errors
  - Questions about generalizability beyond the benchmark institutions
What Do We Know (cont.)?

- **UK Early Adopter Experience (Sheikh et al, 2011)**
  - All 377 NHS hospitals expected to adopt health information technology by December 2010 but just 20% had done so
  - Variety of challenges encountered
    - Need to shift from “implementation” focus to “process of adoption”
  - Could be either “best case” or “worst case” analysis
What Do We Know (cont.)?

- **Impact on quality improvement** (Jones et al, 2010)
  - Basic systems provide small improvement in performance for 3 conditions
  - Upgrades, improvements slow improvement

- **Heterogeneity of experience**
  - Hard to assess the technology & its use on a broad scale
  - Led U.S. to develop standards for “meaningful use”
So Has the US Made Progress on Quality Performance?

- Agency for HealthCare Research and Quality (AHRQ) tracks 250 indicators nationally & produces an annual report
- Until this year organized around the Institute of Medicine 6 domains of quality
- Measures not collected on a single population – “repurpose” existing data:
  - Focus on 8 clinical areas: cancer, diabetes, end stage renal disease, heart disease, HIV/AIDS, maternal & child health, mental health & substance abuse, respiratory diseases
Most Quality Indicators Tracked Nationally Are Improving

But median rate of improvement is only 2.3% per year
Why Is Quality Improvement So Hard?
There Is No Single Solution

- Measurement alone is not enough to drive improvement
- Financial incentives, especially when small relative to overall payment, isn’t enough
- Health information technology is an enabler but it cannot create the will to change
- Improvement needs to be imbedded in front line operations
VA Combined Reporting, Incentives, Health Information & Showed Better Performance

Asch et al, 2004
Greatest Differences Found in Metrics & Conditions Included in VA System

Asch et al., 2004
It Takes A System...to Improve Quality
Core Capabilities for Kaiser’s Performance Improvement System

- Leadership priority setting
- Systems approach to improvement
- Measurement capability
- Learning organization
- Improvement capability
- Culture
Creating Tools for Care Teams

- **Proactive Office Encounter**
  - All members of health care team collaborate to produce reliable care
  - Integrates processes, tools, and workflows to pro-actively address each member’s preventive and chronic care needs before, during, and after each encounter.

- **Standardized Proactive Panel Management**
  - A standardized and centralized process where the healthcare team supports physicians in managing their panel of patients.
  - Identify patients with key, actionable care gaps, and provide patient-specific recommendations to help close key care gaps outside of a face-to-face encounter* especially, for those patients not actively seeking care.
**Decision Support Tools Available for a Range of Care Needs**

Serve as a Decision Support Tools in addressing the best care for our members while improving clinical quality outcomes

<table>
<thead>
<tr>
<th>Proactive Office Encounter (POE) &amp; Standardized Proactive Panel Management (SPPM) Pre-Encounter, Encounter, Pediatrics, Oncology, Obstetrics &amp; SPPM Checklists Available</th>
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<th><strong>Lab Screening Due</strong></th>
<th><strong>Immunizations Due</strong></th>
<th><strong>Chronic Condition Initiatives</strong></th>
<th><strong>Cancer &amp; Other Screenings</strong></th>
<th><strong>Questionnaires &amp; Health Education</strong></th>
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<td>Diabetes H/E Class Needed</td>
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<td>Healthier Living Class Needed</td>
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Teams Can Create Different Reports With Data Updated Daily
Medical Group Directors Can View Physician-Specific Performance
### Teams Can View Care Needs of Their Panel of Patients

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<th>Enrolled in HTN</th>
<th>Asthma</th>
<th>CVD</th>
<th>CAD</th>
<th>CKD</th>
<th>HTN</th>
<th>Dystrophies</th>
<th>Missing Lab</th>
<th>ACEI Exposed</th>
<th>ACEI Intolerance flag</th>
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<th>Last NY</th>
<th>MA-1 Date</th>
<th>MA-1 Result</th>
<th>Last Serum Creatinine Date</th>
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Team Can Identify Patients by Risk and Opportunity Category
Opportunities to Close Care Gaps Clearly Identified
Commercial HEDIS Rankings 2011 – Effectiveness of Care

KP Ranked in the Top 10

1. Weight Assessment for Children
   BMI Percentile
2. Adult BMI Assessment
   Appropriate Treatment for Children w/URI
3. Controlling High Blood Pressure
   Comprehensive Diabetes Care
   LDL Control <100

4. Chlamydia Screening in Women
   Annual Monitoring for Patients on Persistent Meds
   Diuretics
   Medical Assistance w/Smoking Cessation
   Discussing Strategies

5. Appropriate Testing for Children w/Pharyngitis
   Cholesterol Mgmt. for Patients w/Cardiovascular Conditions
   LDL Screening

6. Cholesterol Mgmt. for Patients w/Cardiovascular Conditions
   LDL Control <100
   Antidepressant Medication Mgmt.
   Effective Acute Phase

7. Cervical Cancer Screening
   Avoidance of Antibiotic Treatment in Adults w/Acute Bronchitis
   Comprehensive Diabetes Care
   Eye Exams

8. Pharmacotherapy Mgmt. of COPD Exacerbation
   Bronchodilator

9. Cholesterol Mgmt. for Patients w/Cardiovascular Conditions
   ACE or ARB

10. Weight Assessment for Children
    BMI Percentile
    Comprehensive Diabetes Care
    Medical Attention for Nephropathy

Source: Center for Healthcare Analytics – Department of Quality and Care Delivery Excellence
Cervical Cancer Screening Rate Up and Unnecessary Testing Down

- HEDIS Pap - IQR
- PAPA Overutilization Rates - Overall

- 2006: 82.0%
- 2007: 85.6%
- 2008: 86.6%
- 2009: 86.1%

- 2006: 33.9%
- 2007: 21.6%
- 2008: 12.6%
- 2009: 8.8%
Approaching 100% On Many Joint Commission Core Measures

Source: Quality and Risk Management/TJCCore Measures, May 2011
Better Than National Average Hospital Mortality Rates

Source: Quality and Risk Management/KP Insight May 2011
Concluding Thoughts

- Establishing that a gap existed in quality was essential to motivate action
- Research has been vital to evaluate “good ideas” for closing the gap
- Systems approaches that combine multiple options most likely to succeed