

# Improving Quality & Efficiency

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## Update on National Performance Improvement Initiatives

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# Summary

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- Context: Pressure to Reform
- Overview of major reforms
- Focus on Pay for Performance
  - Congress
  - The Administration
  - Private Sector
- Key Issues in P4P

# What is Quality?

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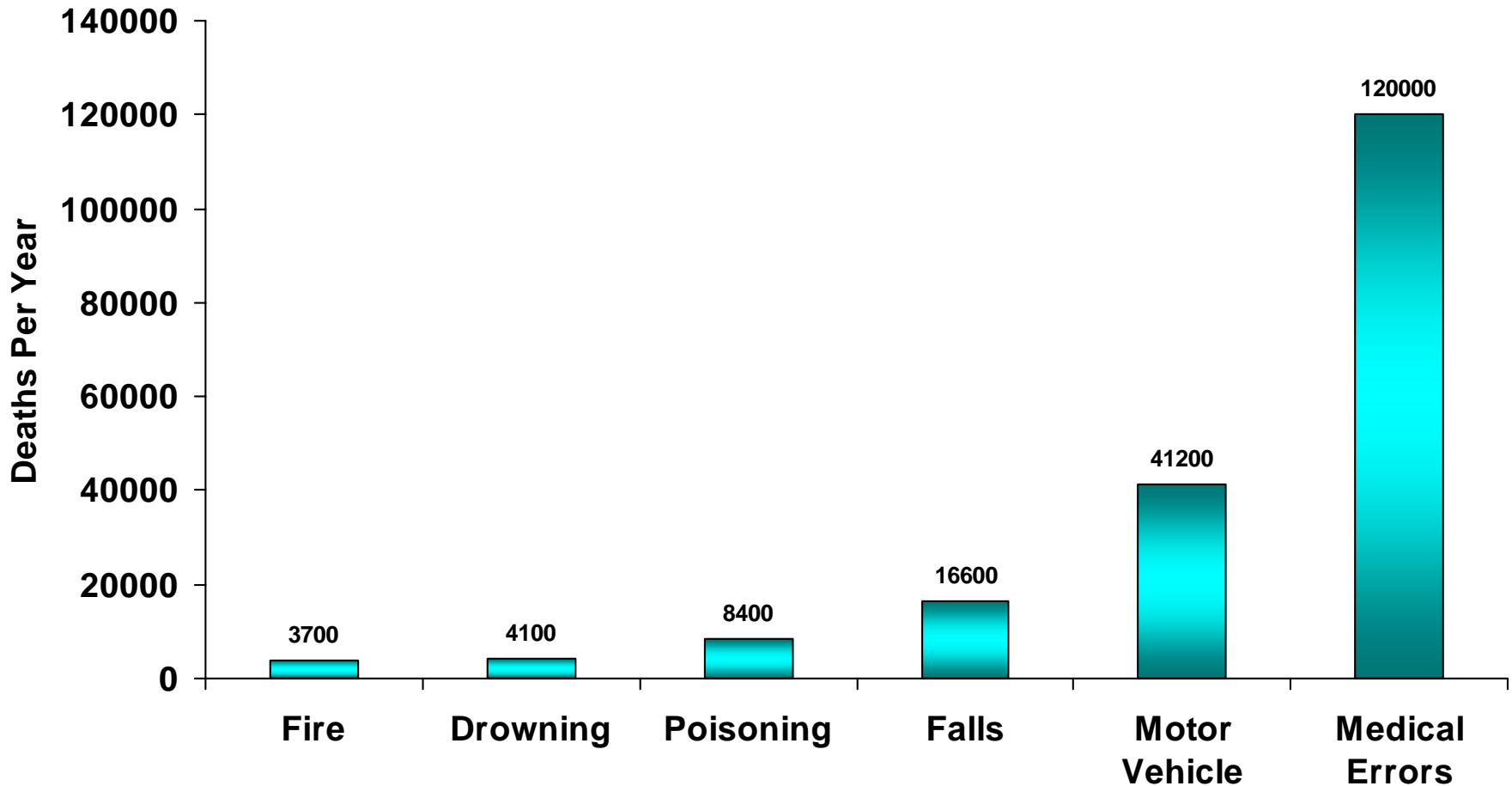
- IOM Definition:
  - *“the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”*
- I.E.: Every patient receives the right care every time.

# Quality in US Health Care

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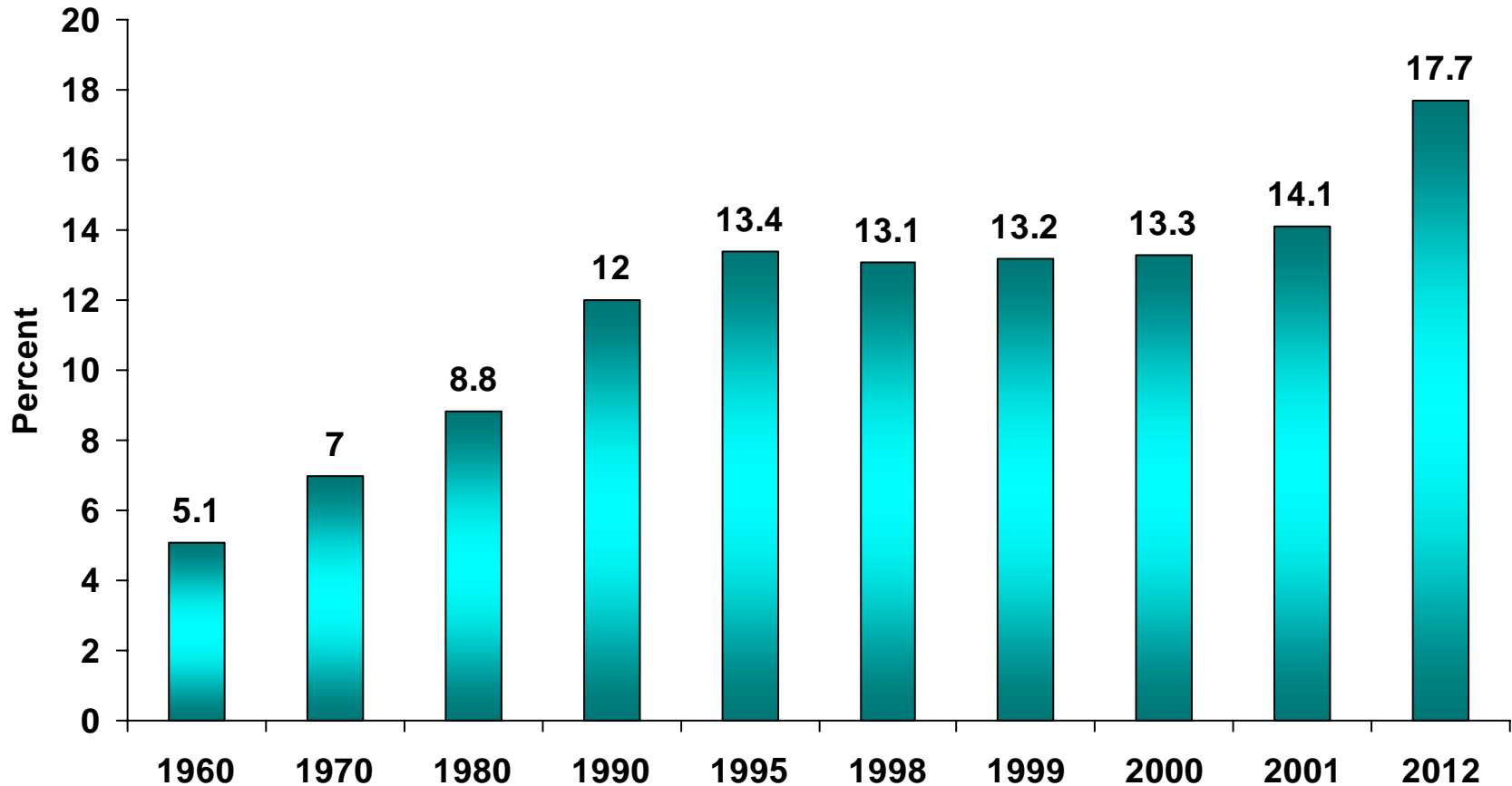
- Americans receive only 55% of the care recommended for their conditions
  - Translation of medical research into practice is slow—average of 17 years
- Preventable medical errors in hospitals cause 120,000 deaths per year
- 1.5m preventable adverse drug events every year (IOM, 2006)

# Deaths Per Year



Source: *National Safety Council, 1998; Lucian Leape, MD; Philadelphia Inquirer.*

# Health Care Expenditures as % of GDP



# Major Causes of Poor Quality

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- Unsafe Systems: 9 in 10 quality problems caused by system of care
  - Systems redesign needed
  - Health IT and health information exchange can help
- Physicians are human:
  - amount and complexity of new information is beyond bounds of human cognition
  - Health IT is one tool
- US Reimbursement System doesn't reward quality of care
  - Current payment based on volume
  - Keeping patients healthy is not financially rewarded



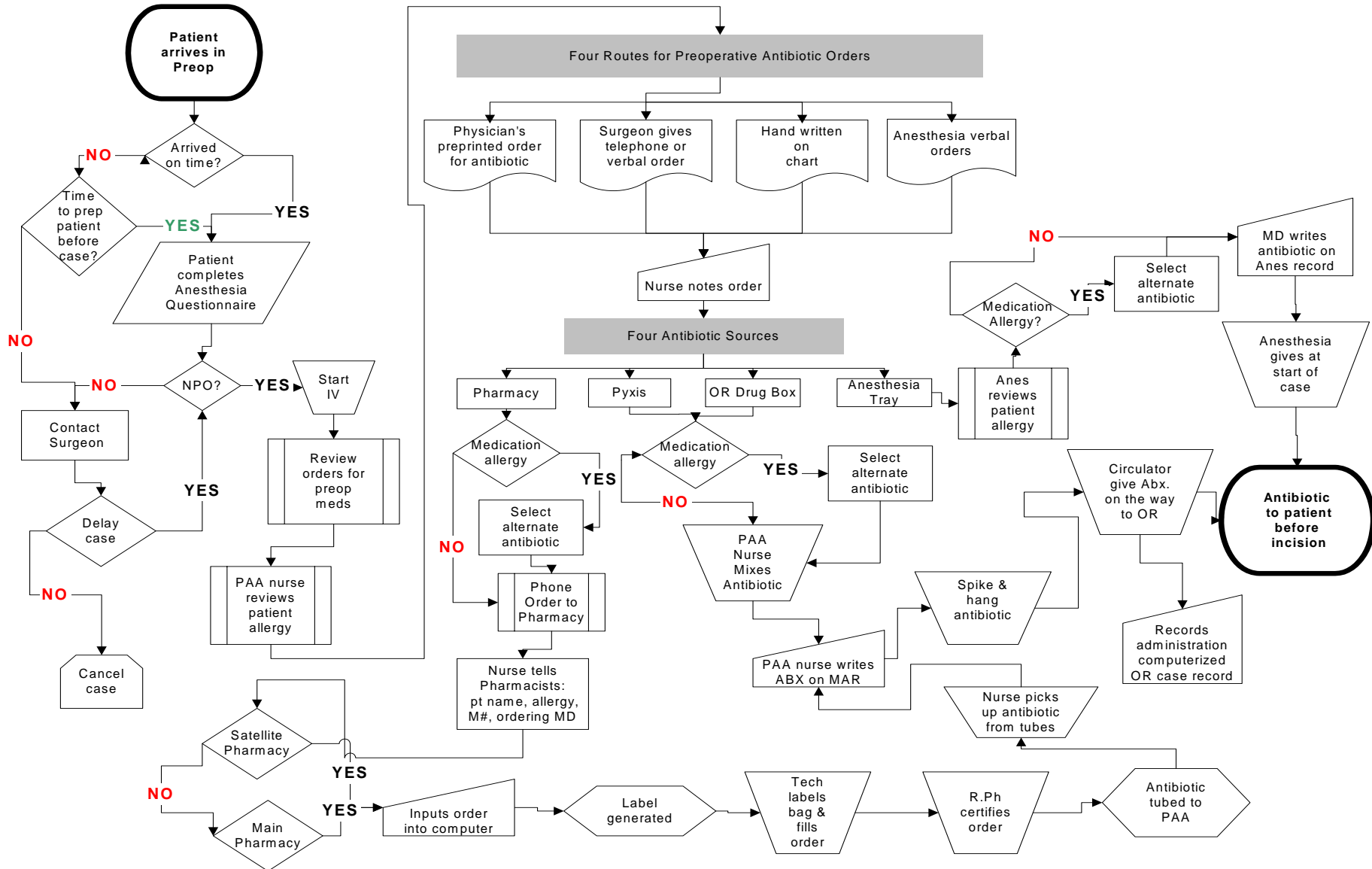
# Paper Kills

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Amber 4/2/02

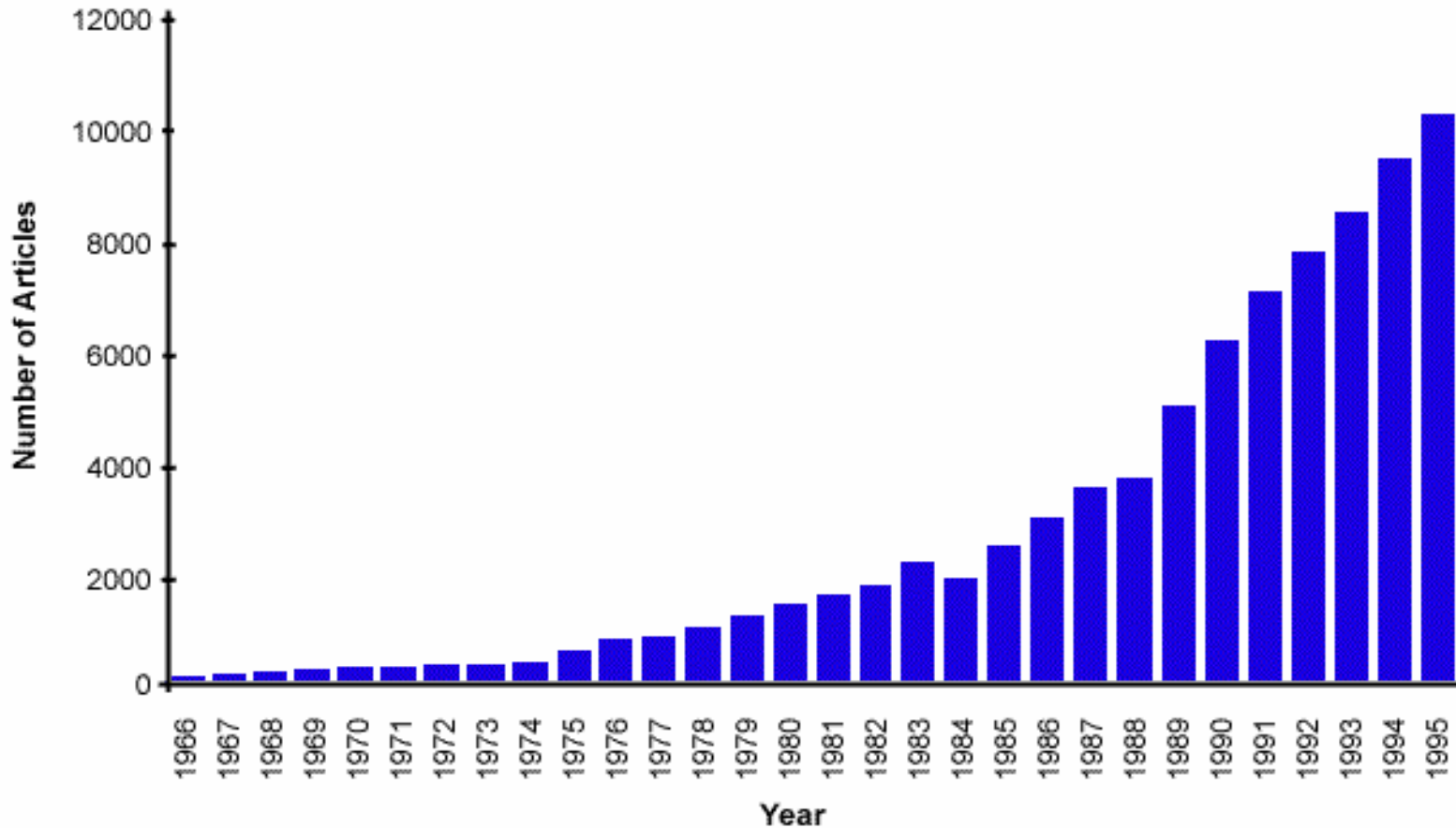
Paper is killing people!

# Systems of Care are Complex



# Medical Information Pace Increasing

FIG. 1. Articles published from randomized controlled trials: 1966 to 1995



Source: Chassin, M.R., *Milbank Quarterly*; 76 (4) 1998, p.565-91

# Good News: Quality Pays

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- Premier Hospital Demonstration Project:
- If clinicians followed best clinical practices, they can:
  - Prevent 5,700 deaths
  - Avert 8,100 complications
  - Avoid 10,000 hospital readmissions
  - Save \$1.35 billion per year
- Problem: Much of the savings accrues to payers, not the hospital.

# Result?

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Medical errors

+ poor quality

+ high costs

+ realization that quality saves money

= **Pressure to reform the system**

# Major Reforms under Discussion:

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- Health IT and Health Information Exchange
  - Address quality & efficiency via systems redesign
- Public Reporting of Quality Data
- Transparency – Cost & Quality data
- Pay for Reporting
- Pay for Use
- Pay for Performance (P4P)
  - Demand and Reward quality care
- Consumer Strategies: differential co-pays, shared savings, public reporting on cost & quality (transparency).

# Pay for Performance:

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- Linking some part of provider reimbursement to their performance on valid measures of clinical quality (and efficiency)

## Administration on P4P:

- P4P can help three areas:
  1. Inform Consumer Choice
  2. Reward Quality
    - And the investment it takes to get there
  3. Identify Opportunities to Improve

# Pay for Performance:

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## 1. Process Measures

- Completion of tasks or recommended treatments known to improve outcomes.
- E.g. Current set of 10 annual payment update measures reported to CMS

## 2. Outcomes Measures

- Ultimate results of care, such as patient health status

## 3. Structural Measures

- Resources assembled to deliver care, such as personnel, facilities, materials, information systems

## 4. Patient Experience Measures

- E.g., Hospital Consumer Assessment of Health Plans Survey (HCAHPS)

## 5. Efficiency Measures

- Cost of care associated with a specified level of quality.

# P4P at the National Level

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## Key Players:

### 1. Congress

- Health care costs and safety problems put payment reform on Congress's Radar

### 2. The Administration

- Committed to reducing costs, improving quality but lacks authority for national P4P

### 3. Private Sector

- Laboratory for innovation; home to much payer data

# Congress

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- Three bills specifically on P4P in last Congress:
  - S. 1356, HR 3617, S. 1481
- S. 1932 – Deficit Reduction Act of 2005
  - Passed; Included P4P Provisions
- Current Issue Driving Debate: SGR
  - Physicians currently scheduled for 5.1% cut for 2007

# Key Points in Past P4P Bills:

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- Require Secretary of HHS to develop process, structural, and patient experience measures
- Require measures to be risk-adjusted
- Require creation of NQF-like body
  - Private, non-profit entity to build consensus and receive public comment on proposed measures
- Require input from external stakeholders
  - Organized medicine, quality organizations, etc. House bill requires specialties to submit own measures
- 2 of 3 bills cover all care settings, including plans. House bill covers physicians only.

# Deficit Reduction Act 2006

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## Hospital-Acquired Infections:

- October 1, 2007: hospitals required to report any secondary diagnosis of a patient at admission in order to receive payment
- HHS Secretary, with CDC, shall select diagnosis codes for at least two conditions that, when paired with secondary diagnosis code, result in assignment to a higher DRG.
- Codes must be
  - for high volume and/or high cost cases,
  - result in a higher payment when paired with a 2ndary diagnosis,
  - describe conditions that could reasonably be prevented by using evidence based guidelines.
- As of October 1, 2008, for the selected conditions/codes, if a secondary diagnosis code was not present at admission, then the case will not be eligible for a higher DRG payment.

# Deficit Reduction Act of 2006

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- **Expanded hospital public reporting**
  - MB minus 2 percentage points (vs. .4%)
  - Secretary can expand and replace current measures to include
    - Process, structure, outcome, patient experience, efficiency & cost of care
- **Secretary to develop plan for hospital P4P to begin in 2009**
  - Consider thresholds for improvement & public reporting.
  - Develop process for selecting quality & efficiency measures

# Congress & the AMA

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- Signed agreement December 2005
- In exchange for SGR fix, AMA to propose 140 measures
  - Covering 34 clinical areas
  - By end of 2006 – AMA Reports they are on track.
- Agreed to report data to feds in 2007
  - At least 3-5 measures per physician
  - AMA notes physicians “should receive” add-on payment for reporting

# Congress & the AMA

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- Questions remain:
  - One year fix or permanent?
  - What Congress will require in exchange for SGR fix?
    - One proposal: (Energy & Commerce Committee)
      - Block 5.1% cut
      - .5% update in 2007
      - .25% bonus for reporting quality data
  - Will Congress address SGR in “Lame Duck” session?

# Congress: The Future

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- Institute of Medicine P4P Report: Sep. 21
- Key Findings:
  - P4P promising, evidence base is lacking
  - Incentives can be powerful stimulus
    - Incentives alone not enough without health IT, public reporting, consumer incentives, technical assistance, etc.
  - Phased-in approach
    - Selected settings, small level of existing funds, specific measures, with active learning system.

# Key Players: the Administration

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## CMS committed to P4P

- Four Broad Strategies for Quality:
  1. Measure and Report
  2. HIT Use
  3. Process Redesign
  4. Transforming Organizational Culture
- Three mechanisms today:
  1. Reporting Initiatives
  2. Quality Improvement Organizations (QIOs)
  3. Demonstration Projects

# 1. Physician Voluntary Reporting Initiative (PVRP)

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- Initiative began Jan. 2006 –
  - Registration began October 2006
- Creation of temporary HCPCS Codes (G-Codes)
  - Physicians report G-Codes on claims, receive feedback via reports on quality from CMS.
  - 16 measures (starter set)
  - Reporting is NOT public
  - EHRs intended to be future method for data collection

# PVRP

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- Oct. 19<sup>th</sup>, 2006:
  - Reports indicate CMS planning link PVRP to payment
    - Likely mechanism if Congress acts on SGR
  - CMS source says plan similar to Energy & Commerce Committee plan
- Oct. 17<sup>th</sup>, 2006:
  - CMS announces additional 86 measures covering 32/39 specialties
  - Starter set to expand by mid-2007
  - Will include efficiency measures

# Reporting Initiatives Cont'd: Price Transparency

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**Aug 22<sup>nd</sup> Executive Order Directs Federal Agencies To:**

**1. Increase Transparency In Pricing.**

- Share with beneficiaries information about prices paid to providers for procedures.

**2. Increase Transparency In Quality.**

- Share with beneficiaries information on the quality of services provided by health care providers.

**3. Encourage Adoption Of Health IT Standards.**

- Use improved health IT systems to facilitate the rapid exchange of health information.

**4. Provide Options That Promote Quality And Efficiency In Health Care.**

- Develop and identify approaches that facilitate high quality and efficient care.

# The Future

There is no way today for a patient to compare the value of health care choices. In the future, people will get information that will allow them to compare cost, quality, and related facts necessary to find high-quality, low-cost health care. Likewise, physicians and hospitals will have the comparative information they need to improve.

## Surgical Care Consumer Guide

Search Results: **Hip Replacement**

### Summary

Average Cost in Network Facility: \$11,249 - \$15,895

Out of Network Facility : \$18,889 - \$23,460

[What's included in the cost?](#)

Results sorted by: Quality

Sort by:

### Key

Quality: ★★★★★ Highest | ★ Lowest

Cost: \$ Least Expensive | \$\$\$\$ Most Expensive

Patient Assessment: ★★★★★ Highest | ★ Lowest

Distance (miles)	Facility Name	Patients per year	Quality	Cost Estimate	Insurer Pays	Patient Pays	Patient Assessment of Care
6.2	Good Samaritan Hospital 1111 E. Samaritan Drive Tampa, FL 22222	232	★★★★★	\$ \$15,895	90% (\$14,306)	10% (\$1,590)	★★★★★
13.2	All Saints Medical Center 123800 All Saints Way Tampa, FL 22122	86	★★★★★	\$\$\$ \$20,700	80% (\$16,560)	20% (\$4,140)	★★★★
25.6	Clearwater General 14280 Bay Drive Clearwater, FL 22131	400	★★★	\$ \$15,895	85% (\$13,511)	15% (\$2,384)	★★
26.3	Tampa Hip Hospital 1400 East Tampa Boulevard Tampa, FL 22211	170	★★★	\$\$\$ \$20,700	75% (\$15,525)	25% (\$5,175)	★★★★
27.3	Orthopedic Clinical Hospital 1444 Goodie Drive St. Petersburg, FL 22113	432	★★	\$ \$11,600	70% (\$8,700)	25% (\$2,900)	★
33.2	Valley General Hospital 1400 Tampa Bay Way Tampa Bay, FL 22031	135	★	\$\$\$\$ \$22,000	70% (\$15,400)	30% (\$6,600)	★★

\* Sample for illustrative purposes only.

# AQA Pilots on Transparency

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## “Better Quality Information for Medicare Beneficiaries” (BQIMB) Pilots

- Six Sites

1. California Cooperative Healthcare Reporting Initiative
2. Massachusetts Health Quality Partners
3. Indiana Health Information Exchange
4. Minnesota Community Measurement
5. Phoenix Regional Healthcare Value Measurement Initiative
6. Wisconsin Collaborative for Healthcare Quality

- Test methods for aggregating public & private payer data

- to publicly report on cost & quality

- Future influence on P4P:

- Data collection, measurement, reporting

## 2. Quality Improvement Organizations

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- Medicare-funded, performance-based contract
  - Largest federal investment in quality improvement
    - Budget less than 0.1% of Medicare spending
  - Implemented in states by a private contractor, QIO
  - Working hand-in-hand with providers
    - Nursing homes, home health, hospitals, physicians, health plans, pharmacies

# QIOs & P4P

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- #1 role: Help providers perform well
  - Help providers improve in and across all settings
  - Help 5% of physicians adopt & use HIT for transformation (DOQ-IT)
    - Builds data collection infrastructure for P4P
  - Focus on physicians treating underserved patients (address access issues under P4P)
  - Assistance with public reporting, transparency
  - Work directly with MA Plans to support creation of incentive and/or P4P programs
  - Resource utilization patterns; efficiency?

# 3. CMS P4P Demonstrations

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- Premier Hospital Quality Incentive Demo
  - (Operational since 2003)
- Physician Group Practice Demo
  - (Operational since 2005)
- Medicare Health Care Quality Demo
  - (Open Solicitation)
- Nursing Home P4P Demo
  - (RFI)
- Medicare Care Management Demo
  - Operational. Only small practice P4P, HIT Demo.
- BQIMB Pilot – (MA, IN, MN, AZ, WI, CA)
  - Sites selected.
- More at <http://cms.hhs.gov>

# Private Sector

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- Over 100 programs to date
  - In various operational phases, varying designs
  - Bridges To Excellence, Leapfrog, United, IHA, etc.
- P4P tends to take root in areas with large medical groups, integrated systems or IPAs
  - Difficult for smaller practices to invest required resources for improvement
- Variable nature affects reward size:
  - For meaningful rewards, more payers must participate
    - Must pass cost/benefit analysis to get doc participation
- Private initiatives help inform national debate

# Coming Together: Trends for Physicians

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- Hospital path is good indicator for providers:
  - Voluntary reporting alliance, tied to payment, larger % at stake, Secretary developing plan for P4P.
- Physician Payment Formula Needs Fixing by Congress
- Physician Voluntary Reporting Program
- AQA Pilots will include ambulatory data on cost & quality
- Big push for Health IT
  - Needed for best performance measurement
  - DOQ-IT, HIE, NHIN
- Methodological issues – UPIN, risk adjustment

# National Trends vs. Louisiana Redesign

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- LA Health Care Redesign Collaborative:
  - Transparency
    - Public Reporting on Quality & Cost
  - Health IT
  - Health Information Exchange
  - Medical Home Model
    - Aligned reimbursement
  - QIO in Medicaid

# Issues in P4P

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- Design Issues Remain:
  - Size of reward & number of participating payers
  - Pay for target vs. improvement
  - Measures (type & alignment); adverse selection?
  - Provision of technical assistance
- Get beyond the money - P4P must include:
  - Technical assistance
  - Public reporting & incentivized consumers
  - Engage and incentivize lower performing providers
- Health IT and HIE needed
  - Data collection, care coordination, etc.

# Issues in P4P

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- Is P4P really reform?
  - Doesn't get at root of payment system
- Not a lot of evidence indicating it will work
  - Advocates argue it makes too much sense not to work
  - Other efforts to examine and reform payment system underway:
    - Ex: PROMETHEUS

# Change

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*“Change is hard. Change is hardest on those caught by surprise. Change is hardest on those who have difficulty changing too. But change is natural. Change is not new. Change is important.”*

-- David Schlesinger  
Global Managing Editor  
Reuters

# For More Information:

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- <http://www.ahqa.org>

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