Information Use as the Pay for Performance Criterion

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Costs of Long-Term Care

The New York Times December 19, 2005 (p. A32)

> "A graying population and the fiscal woes of Medicaid are forcing the nation to reconsider how best to provide long-term health care for the aged and disabled. States are experimenting with ways to reshape their long-term care programs, the National Governors Association has proposed measures to restrain Medicaid spending for the needy and encourage greater use of private insurance, and Congress is moving to close loopholes that allow some well-off Americans to hide assets so as to qualify for Medicaid. The flurry of activity won't come close to solving the nation's long-term care problems, but it usefully highlights how far the country is from seriously confronting this issue - either through public programs or private insurance."

Accountability for Long-Term Care

- New York Times. WHITE PLAINS, Dec. 15, 2005 – "Elijaha, nearly 3, and David Jr., 20 months, were found in blistering hot water that came pouring from the tub, their tiny frames pale and scorched from head to toe. The autopsy said the boys had died of second- and third-degree burns and their body temperatures were nearly 110 degrees. County records and interviews with officials reveal a portrait of a troubled family with a history of child neglect. … Mr. M.…turned on the shower faucet that morning and then deliberately locked the boys in the bathroom, a form of cruel punishment that apparently brought him to the attention of social workers two years earlier."
- "One caseworker…who was later fired, admitted … that she had not seen the boys for nearly 60 days before they died, even though she had been required to visit the home once every two weeks. Her supervisor…now faces disciplinary action for failing to keep tabs on her."

Quality of Long-Term Care

In 2000, the Institute of Medicine enumerated preventable medical errors in the U.S.:

"…more people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516)…Total national costs (lost income, lost household production, disability and health care costs) of preventable adverse events (medical errors resulting in injury) are estimated to be between $17 billion and $29 billion…"

Fragmentation of Long-Term Care

In 2000 and 2001, the Institute of Medicine linked preventable errors to fragmented health care:

"The decentralized and fragmented nature of the health care delivery system (some would say 'nonsystem') also contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety.

Even within hospitals and large medical groups, there are rigidly defined areas of specialization and influence. For example, when patients see multiple providers in different settings, none of whom have access to complete information, it is easier for something to go wrong than when care is better coordinated."

Long-Term Care Plan

In 2005, the Institute of Medicine (IOM) recommended that the oncologist provide the patient, at the end of primary treatment, with a comprehensive case summary and follow-up *cancer survivor care plan*.

The recommended care plan specifies clinical guidelines for posttreatment care, measurement of plan adherence and patient outcomes, and care plan implementation. Patient and informal caregiver *preferences* shape care plan design and *health information technology* (HIT) facilitates implementation.

Specialized HIT Applications

Through application specialization, conventional HIT fragments knowledge related to a patient's long-term health care.

The California HealthCare Foundation envisions one software application combining multiple functions related to a patient's long-term care plan, including:

- Free-form charting
- Lab and pharmacy data feeds
- Practice management
- Automated reminders
- Population-level analysis
- Standard and custom data elements
- Ad hoc querying

Enterprise-Centric HIT Applications

Public policies regarding HIT are split between frameworks that Winkelman and Leonard (2004) labelled as physician-centered and patient-centered.

We use the term *enterprise-centric* to denote the majority of HIT applications intended for health care enterprises including solo and group professional practices, hospitals, and health insurance payers.

We use the term client-centric, for HIT applications intended for individual recipients of health and human services.

Enterprise-centric systems tend to aggravate already fragmented health care information and services.

Client-Centric HIT Applications

Client-centric applications, although rare, offer a means of supporting informal caregivers and professional care coordinators in their implementation of long-term care plans.

The IOM 2000 report put it this way, "…the provision of care to patients by a collection of loosely affiliated organizations and providers makes it difficult to implement improved clinical information systems capable of providing timely access to complete patient information…"

Personal Health Record (PHR)

The PHR represents a step in the direction of client-centric application design.

In 2005, Tang and Lansky distinguished between a *view* PHR, a *freestanding* PHR, and a *complete* PHR.

The *view* PHR is totally enterprise-centric, giving the patient only a glimpse of some information in the provider's EHR (e.g., WebMD, pamfonline.org).

The totally client-centric *freestanding* PHR gives the patient software that is not connected to providers' EHRs and bears "the risk of data-entry errors, misunderstandings, and incompleteness" (e.g., followme.com).

The Complete PHR

The *complete* PHR is a balanced integration of client- and enterprise-centric frameworks. Tang and Lansky describe the so-called complete PHR as "the Holy Grail to which President Bush and the IOM aspire," a "complete PHR…allow[s] patients to capture information from every health care source, to enter their own information and share it with providers, and to fully control the use of the information."

A unique example of what Tang and Lansky call the complete PHR is the Caregiver Alliance Web Services™ client account (or Caregiver client account) (caregiveralliance.com).

PHR-EHR Integration

The “holy grail” denotation indicates that the so-called complete PHR might meet the interdependent needs of patients, family caregivers, health care providers, enterprises, and payers.

The Caregiver system is a HIPAA-compliant, client-centric integration of patient-controlled PHRs (Caregiver client account) and provider-controlled EHRs (Caregiver provider, enterprise, and alliance accounts).

For long-term care recipients, informal caregivers, and professional care coordinators, the integrated PHR-EHR Caregiver system may prove to be the holy grail.

Long-Term Care Performance Deficits

- Cross-national surveys indicate U.S. performs relatively poorly from patient perspective (Hussey et al., 2004).
- Regional differences in end-of-life spending were not associated with better outcomes or satisfaction (Fisher et al., 2003).
- Differences in intensity of services for MI, colorectal cancer, and hip fracture were associated with no or small differences in care quality and patient outcomes (Fisher et al., 2004).
- Racial and ethnic minorities receive lower-quality care (routine and specialty) regardless of insurance or income (IOM, 2002).
- Of the nearly 70% of physicians who operate in small practices, less than 25% use computer-generated treatment reminders (Reed & Grossman, 2004).
- Study tracking posthospital transitions for 30 days after discharge among national sample of Medicare beneficiaries found that 61% of care episodes resulted in 1 transition; 18%, 2; 9%, 3; 4%, 4+ (Coleman, et al., 2004).
- Only one-third of elderly received recommended treatment for depression; only one-quarter of elderly diabetics received a recommended annual dilated eye exam (Leatherman & McCarthy, 2005).

IOM 2006 Current Performance Measures

- Lack of comprehensive measures
  - Address efficiency, equity, patient-centeredness
- Narrow time window
  - Measure quality, costs, outcomes longitudinally
- Provider-centric focus
  - Individual patient-level measurement
- Narow focus of accountability
  - Report measures not unique to specific providers

IOM 2006 Health Insurance Programs

- Lack coverage for care coordination, non-visit-based communication, patient education, support services
- Lack performance incentives
  - Many private purchasers and health plans are implementing pay for performance linking modest provider payments to performance across a number of measures
- Piecemeal payment investment promotes overuse of needless services and little incentive for IT use
- Accountability void. No health care professional assumes responsibility for ensuring that all appropriate services (and only those) are received.

IOM 2006 Design Principles

1. Comprehensive measurement
2. Evidence-based goals and measures
3. Longitudinal measurement
4. Supportive of multiple uses, stakeholders
5. Measurement intrinsic to care
6. Central role for patient's voice
7. Patient-, population-, systems-levels
8. Shared accountability
9. Learning System
10. Independent and sustainable

IOM 2006 Starter Set, Long-Term Care Performance Measurement

- CMS Minimum Data Set (MDS) 3.0 for nursing home resident assessment and care screening
  - Activities of Daily Living
  - Pain
  - Pressure sores
  - Restraint use
  - Depressed, anxious
  - Incontinence
  - Indwelling catheters
  - Bedfast
  - Ambulatory
  - Urinary tract infections
  - Weight loss
  - Delirium symptoms
- CMS OASIS Home Health Agency Patient Outcome
  - Ambulation/locomotion
  - Transferring
  - Toileting
  - Pain interfering with activity
  - Bathing
  - Management of oral medications
  - Upper body dressing
  - Stabiliation in bathing
  - Acute care hospitalization
  - Emergent care
  - Confusion frequency

Continuity of Care Record (CCR)

- The CCR is a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare encounters. It provides a means for one provider to aggregate all of the pertinent data about a patient and forward it to another practitioner.
- The CCR data includes a summary of the patient's health status (e.g., problems, medications, allergies), basic information about insurance, advance directives, care documentation, and the patient's care plan.
- To ensure interchangeability of electronic CCRs, the ASTM active standard, E2369-05, specifies XML coding for a CCR structured electronic format.

Overview: Long-Term Care Information Use as the Pay for Performance Criterion

- A regional health information organization adopts an integrated PHR-EHR system (such as Caregiver Alliance Web Services).
- All elders and disabled receiving long-term care services (Medicare and Medicaid) get Caregiver client accounts. Patients, family caregivers, and all health and human service providers get continuously audited, need-to-know client, provider, and enterprise account privileges.
- Each client account includes a long-term care plan (e.g., the CCR), repeated measures of long-term care performance (e.g., MDS, OASIS), and automated alerts triggered by suboptimal performance data.
- Providers' and supervisors' activities in the Caregiver system (for routine compliance with practice guidelines and to modify care plans in response to performance alerts) are automatically and continuously quantified. Resulting individual-level data are used as the basis for performance reviews, merit increases, and bonuses within healthcare enterprises. Resulting enterprise-level data are used as the basis for profit sharing returns from the regional organization to member enterprises.

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