ADVANCING HEALTH CARE QUALITY IN 2007 AND BEYOND

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President
National Committee for Quality Assurance
Today’s Discussion

- About NCQA
- How Did We Get Here?
- A Measurement Success Story
- The Way Health Care Ought to Work
- Where Do We Go From Here?
NCQA: A Brief Introduction

- Private, independent non-profit health care quality oversight organization
- Measures and reports on health care quality
- Committed to measurement, transparency and accountability
- Unites diverse groups around common goal: improving health care quality
NCQA: A Brief Introduction

- Quality Measurement
  - HEDIS, CAHPS

- Accreditation, Certification, Recognition
  - Health Plans, Physicians and Physician Groups, Health Care Organizations (such as DM providers)

- Public Reporting
  - State of Health Care Quality, America’s Best Health Plans, Healthchoices.org, third-party partnerships

- Research
  - Quality measures development
  - Cultural disparities in health care
A MEASUREMENT SUCCESS STORY:
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK
1996

National average: 62.6%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

1997

74.1%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK
1998

79.7%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK
1999

National average: 85.0%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

2000

National average: 89.4%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK
2001

92.5%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

2002

93.5%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

2003

94.3%
BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

2004

96.2%
THE WAY HEALTH CARE OUGHT TO WORK
WHAT IS THE SYSTEM SUPPOSED TO DO?

A: Move people from right to left—and keep them there

A value-based health care system

Source: HealthPartners
THE TRINITY OF CARE: GOOD CARE DOESN’T EXIST WITHOUT ALL THREE

QUALITY

ACCESS

AFFORDABILITY
The Fundamentals of Quality Improvement

• Measurement
  - We can’t improve what we don’t measure

• Transparency
  - Quality data must be translated into understandable, actionable reports for consumers and purchasers

• Accountability
  - Once we can measure we can hold everyone accountable for improvement
WHERE DO WE GO FROM HERE?
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• Promote WELLNESS
• Nurture the EVIDENCE BASE
• Reform PAYMENT
• Reform ACCOUNTABILITY
• Address END-OF-LIFE CARE
• Maximize return on LIMITED RESOURCES
PROMOTE WELLNESS

• The primary function of the health care system is to keep people healthy
  • We must re-emphasize primary care
  • The “medical home” needs to be further defined and promoted
  • The patient needs to be activated
NURTURE THE EVIDENCE BASE

• Gaps in evidence abound
• Even where evidence has been developed, there are too few tools to translate knowledge into practice
• Appropriateness of care needs further study – it’s tightly linked to quality
MEASURING APPROPRIATENESS AT THE PROVIDER LEVEL: NCQA’S BACK PAIN RECOGNITION PROGRAM

• Released in late January
• Identifies providers that deliver evidence-based, patient-centered care for back pain
• Heavy emphasis on appropriateness of care; measures assess whether providers pursue a conservative course of treatment
  - Appropriate imaging for acute low back pain
  - Repeat imaging studies
  - Appropriate use of epidural steroid injections
  - Advice against bed rest
Figure ES-1. International Comparison of Spending on Health, 1980–2004

Average spending on health per capita (SUS PPP)

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom

Total expenditures on health as percent of GDP

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom

PAY-FOR-PERFORMANCE: A PROMISING START

• Not a silver bullet—a useful tool to correct the disincentives in the current system

• Payers are right to be leery of additive payments

• How it’s done is just as important as whether it’s done
  – Based on recognized measures
  – Developed in conjunction with providers
  – Measurement and payment functions kept separate
  – IHA’s P4P project a model for doing it the right way
REFORM ACCOUNTABILITY

• Where does accountability reside? The enterprise level? The individual level?

• Whose job is it to do what?

• How do we design units of measurement to encourage effective, efficient care?
POPCULATION-LEVEL ACCOUNTABILITY: A CASE STUDY

Percutaneous Coronary Interventions
Age-sex-race adjusted rate of PCI discharges per 1000 enrollees in 2003

Each dot represents the rate in one of the 306 U.S. Hospital Referral Regions

PCI RATES OVER TIME:
ELYRIA vs. THE REST OF OHIO

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ADDRESS END-OF-LIFE CARE

• We need a framework to address end-of-life care
• Tremendous cost, quality issues
• Hospice underutilized

• Discussion of end-of-life issues can be difficult
  - CHCF: 70% of Californians have not put their end-of-life wishes in writing

MAXIMIZE RETURN ON
LIMITED HEALTH CARE RESOURCES

• 46 million Americans uninsured
  - Reducing wasteful spending a moral, public health imperative

• Health is an asset, but we don’t treat it like one

• Shifting/lowering costs without addressing quality as well won’t be enough

HOW MUCH HEALTH DO WE GET FOR OUR HEALTH CARE DOLLAR?
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• Relative Resource Use measures calculate risk-adjusted observed cost/expected cost for critical conditions:
  – Cardiac conditions, diabetes, asthma, COPD, low back pain, hypertension
  – These conditions account for 60% of all spending

• Along with related quality results, allows for plan-to-plan comparisons on value
PREREQUISITES TO MOVING THE VALUE AGENDA FORWARD

- NEW, FORWARD THINKING
- STAKEHOLDER COMMITMENT
- COOPERATION/COLLABORATION
- PROCESS REENGINEERING
- POLITICAL WILL
- COURAGE
- HELMET