Medicare Tools for Quality

Sean Tunis MD, MSc

Chief Medical Officer, CMS

Director, Office of Clinical Standards and Quality

The Quality Colloquium at Harvard University

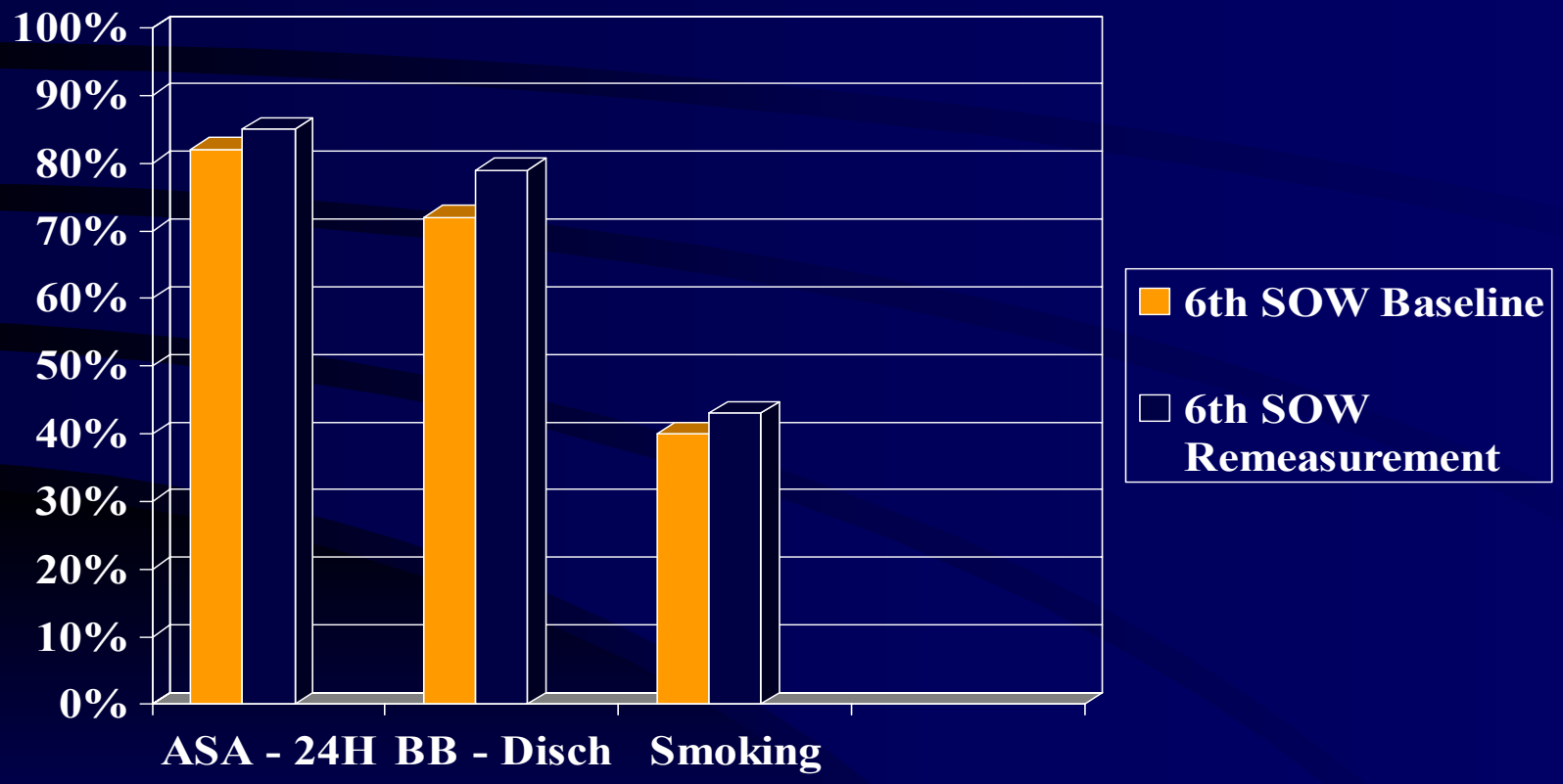
August 25, 2003

Overview

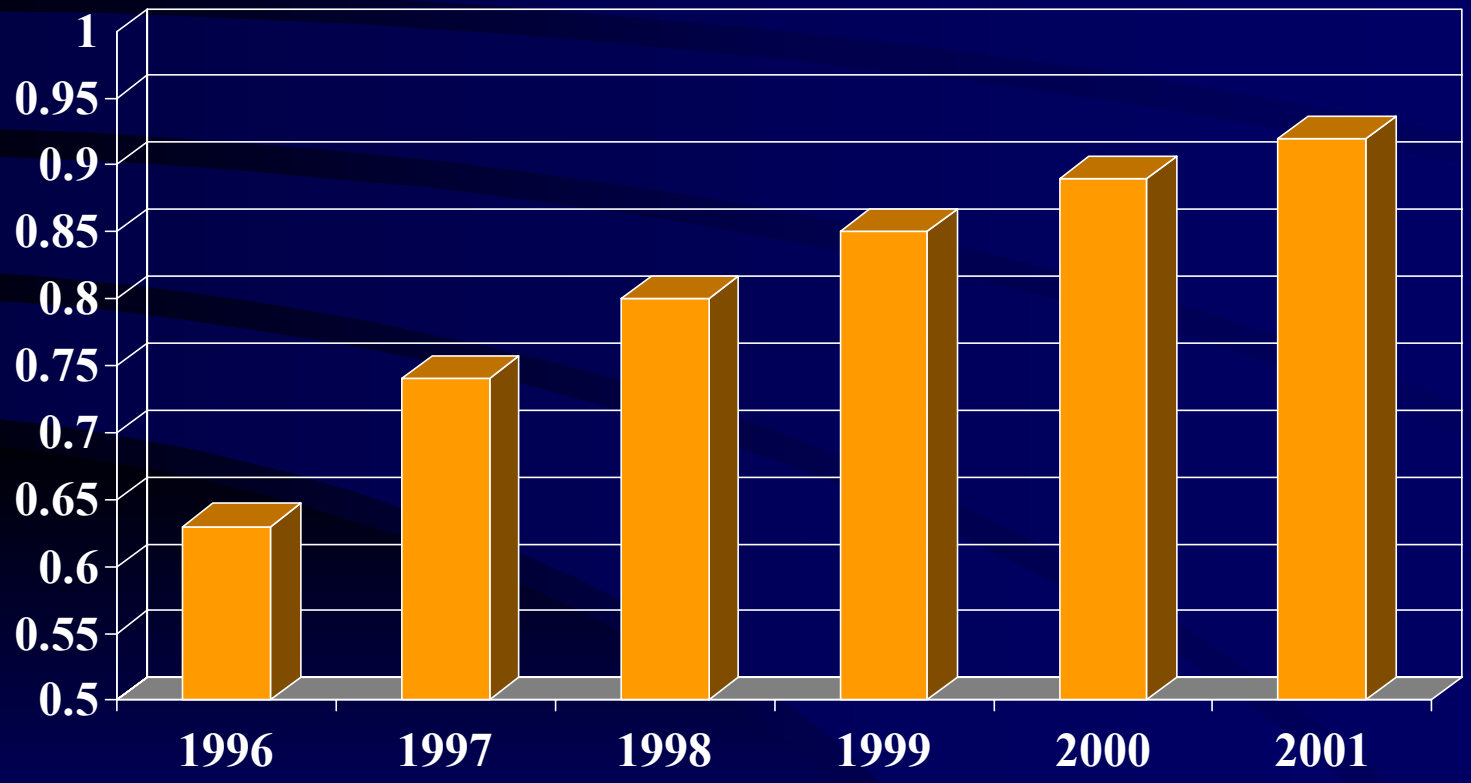
- How are we doing at improving quality?
- Why have we not done better?
- The Medicare quality tool chest
- Public report of quality data
- Promoting information technology
- Financial incentives for quality
- Coverage and reimbursement

How Are We Doing At Improving Quality?

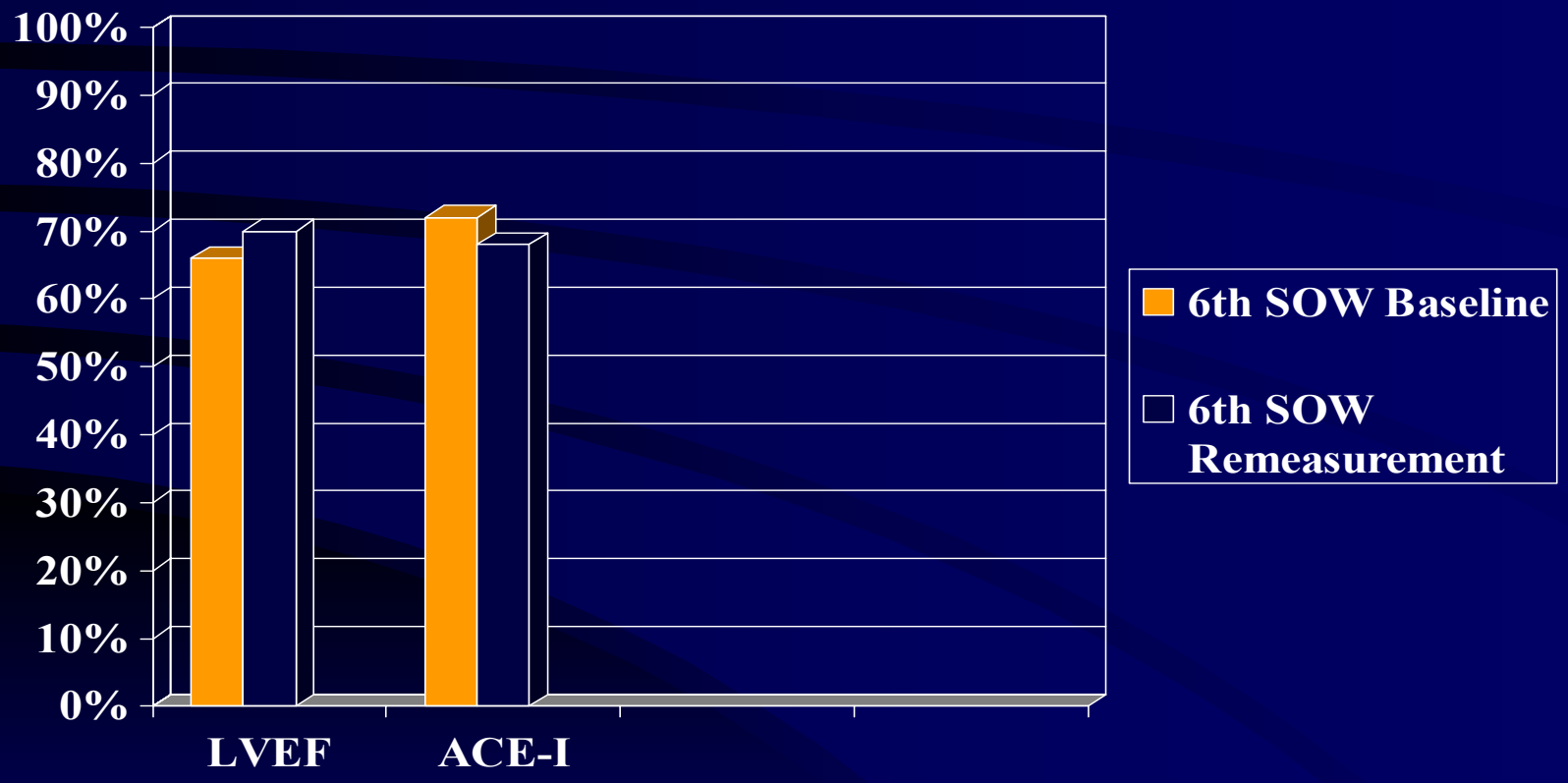
Improving Care in Hospitals: 7th SOW MI Measures



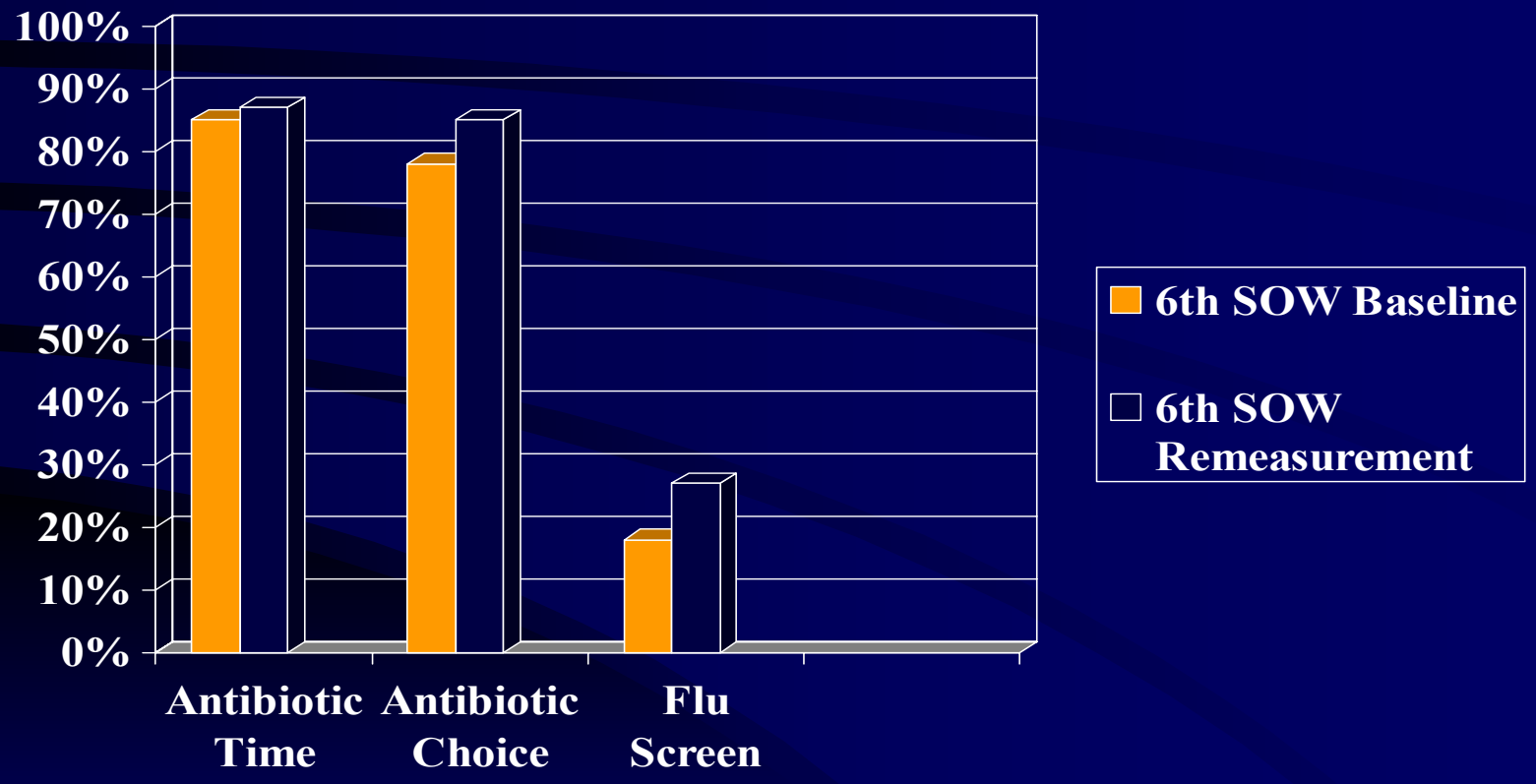
HEDIS Quality Compass Beta Blocker/MI Rate – Commercial Plans



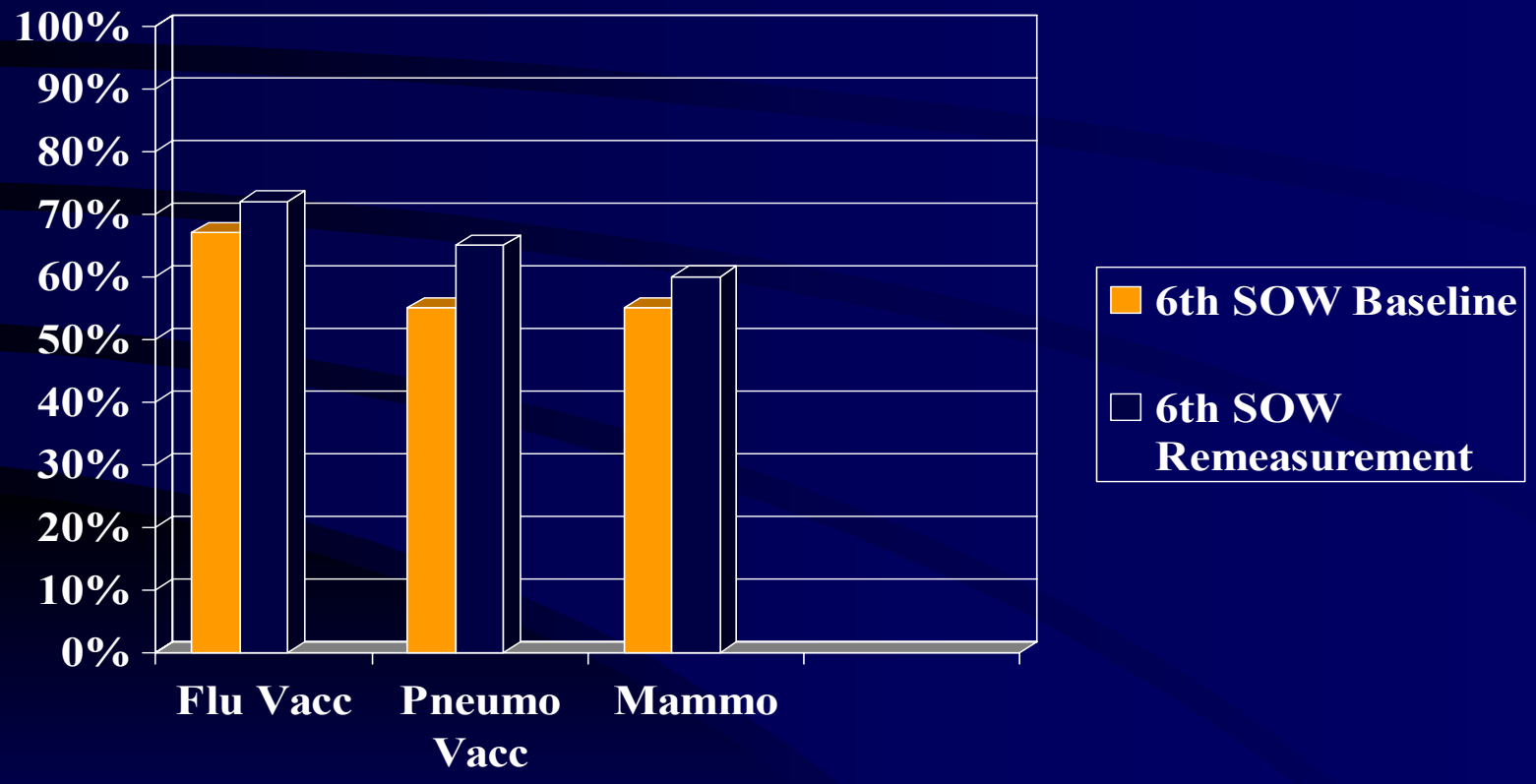
Improving Care in Hospitals: 7th SOW CHF Measures



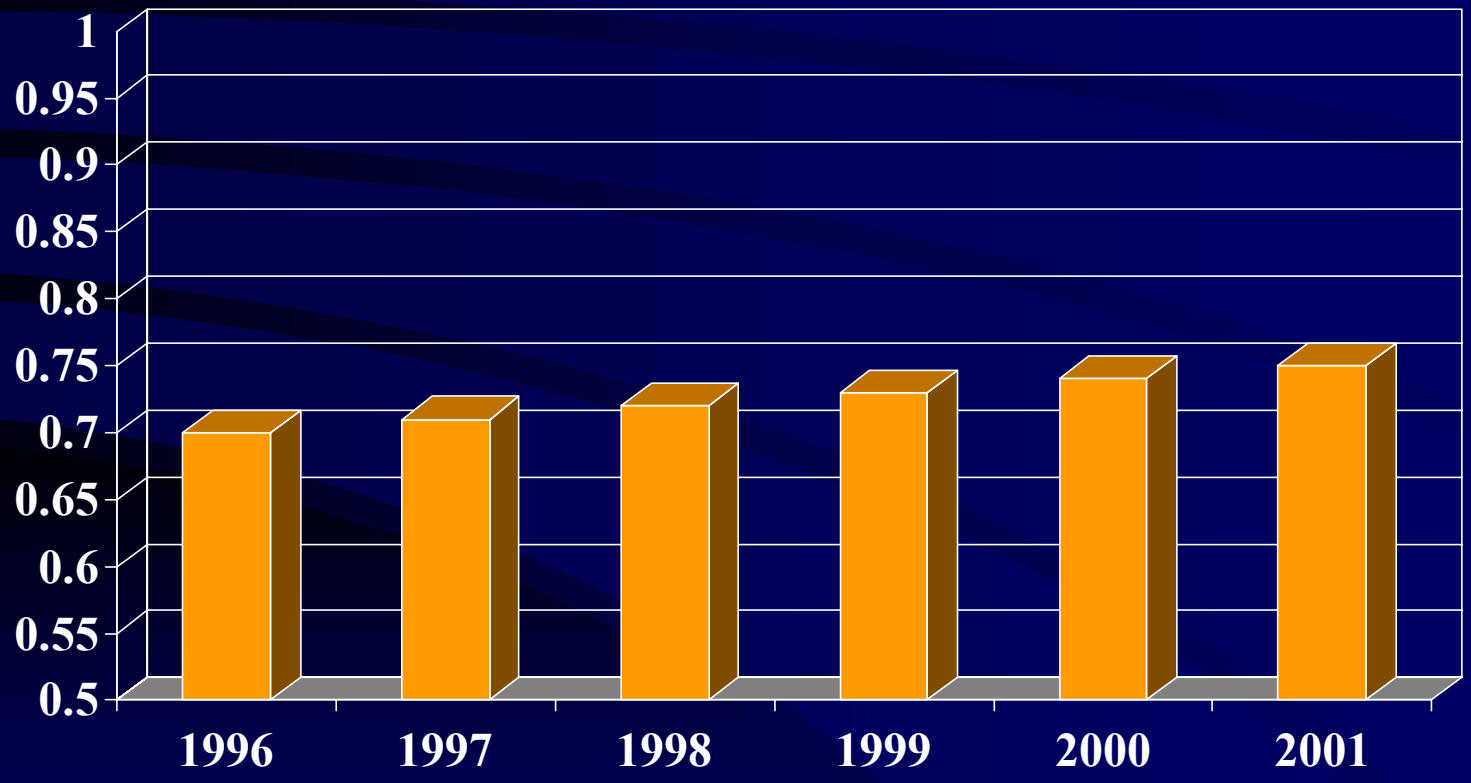
Improving Care in Hospitals: 7th SOW Pneumonia Measures



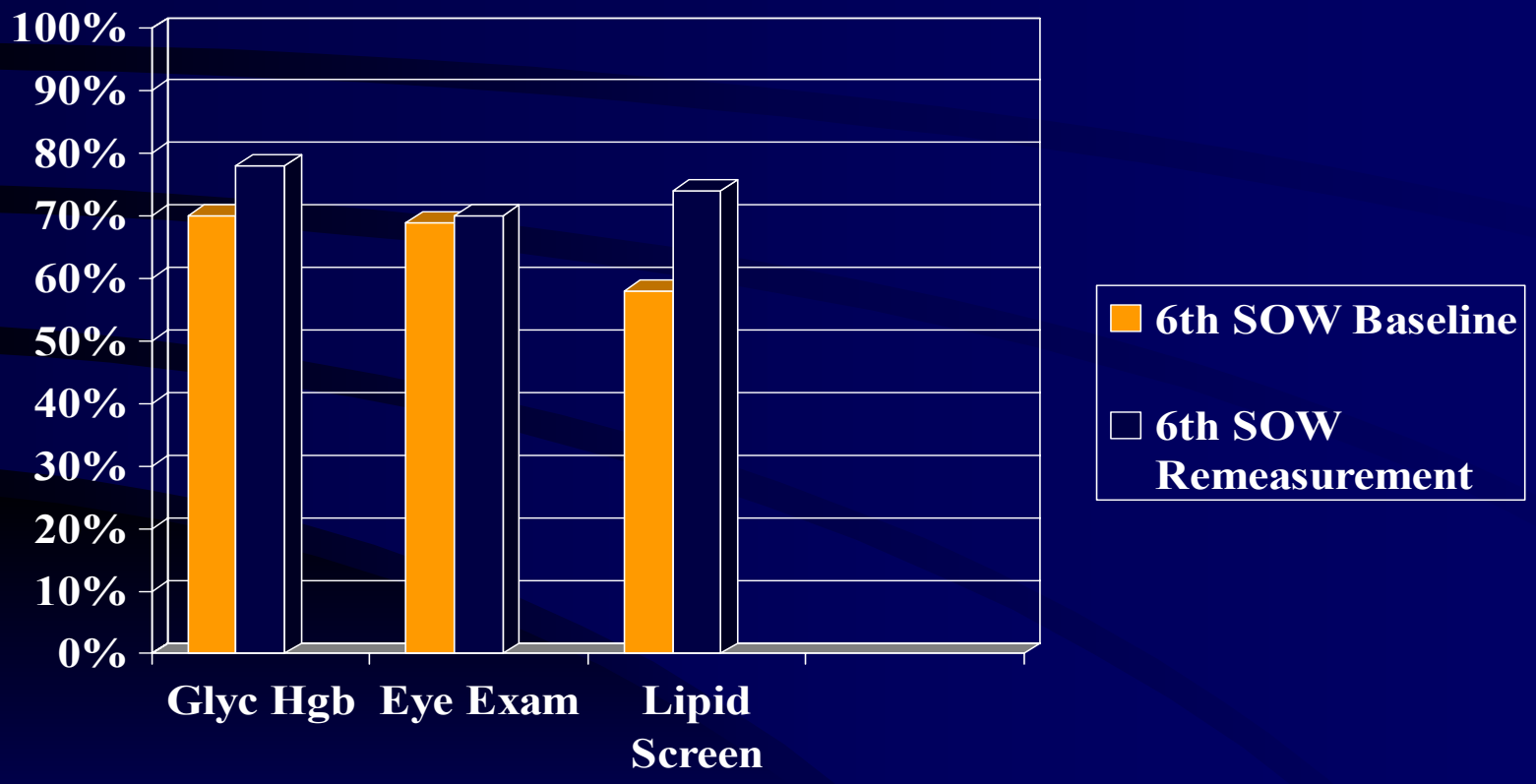
Improving Care in Physician Offices: 7th SOW Preventive Measures



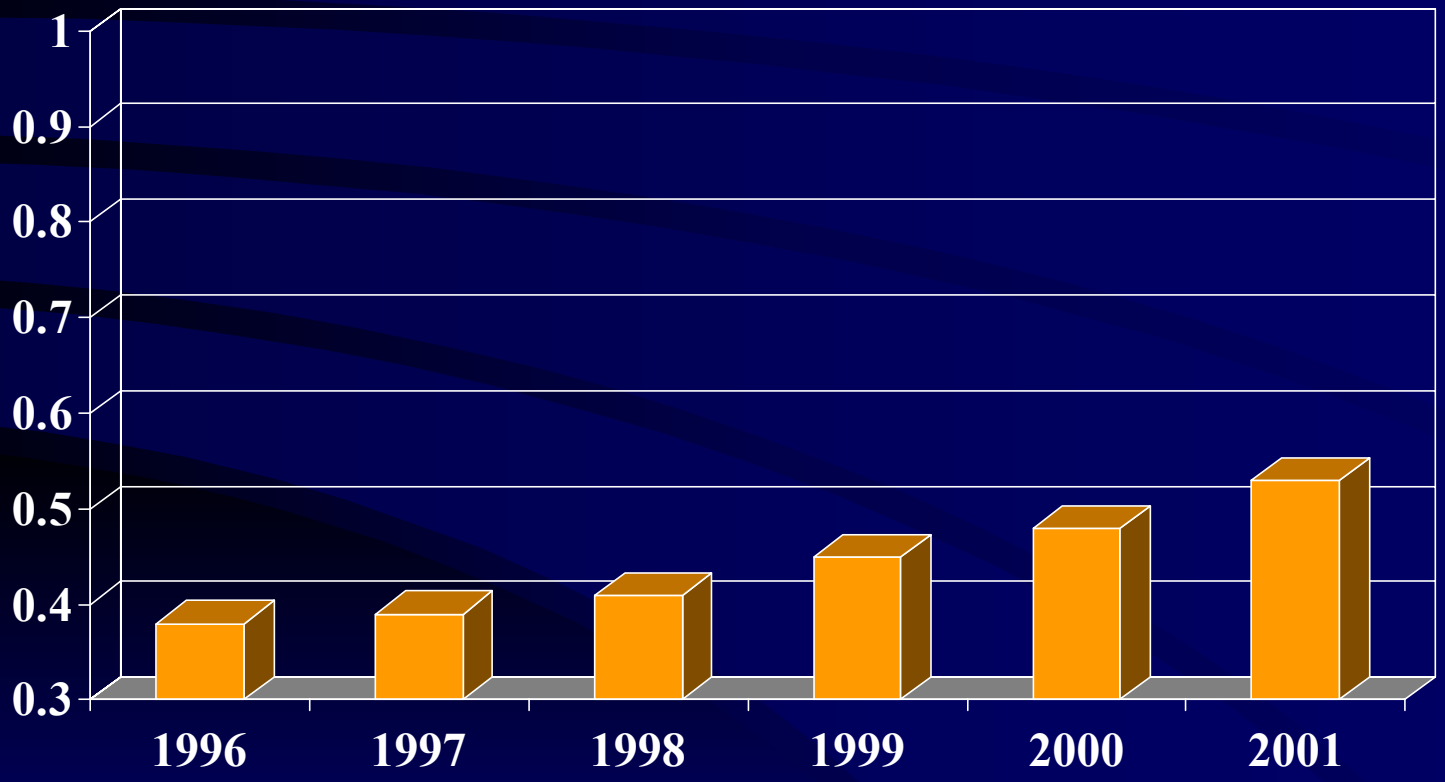
HEDIS Quality Compass Mammography Rate – Commercial Plans



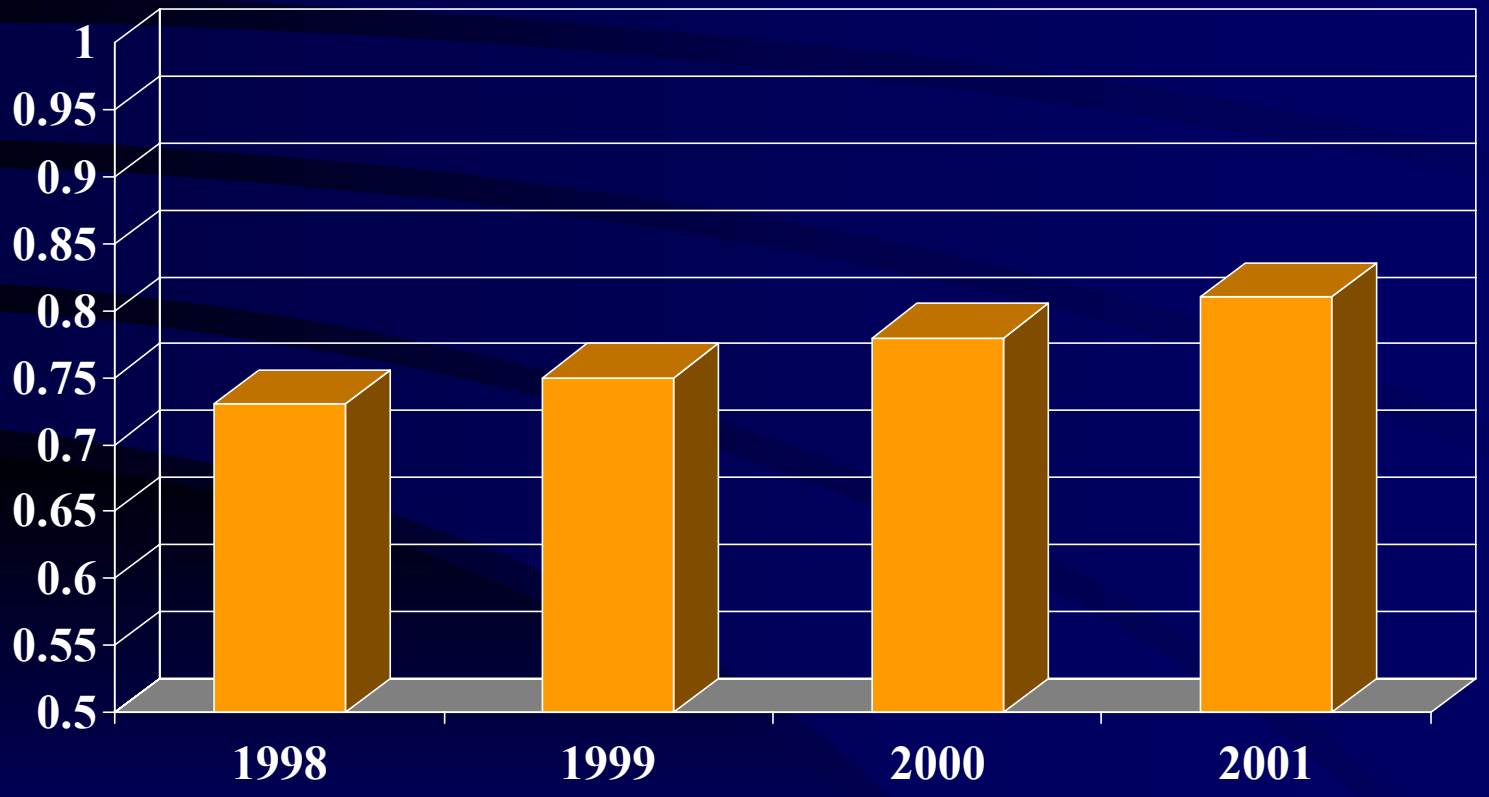
Improving Care in Physician Offices: 7th SOW Diabetes Measures



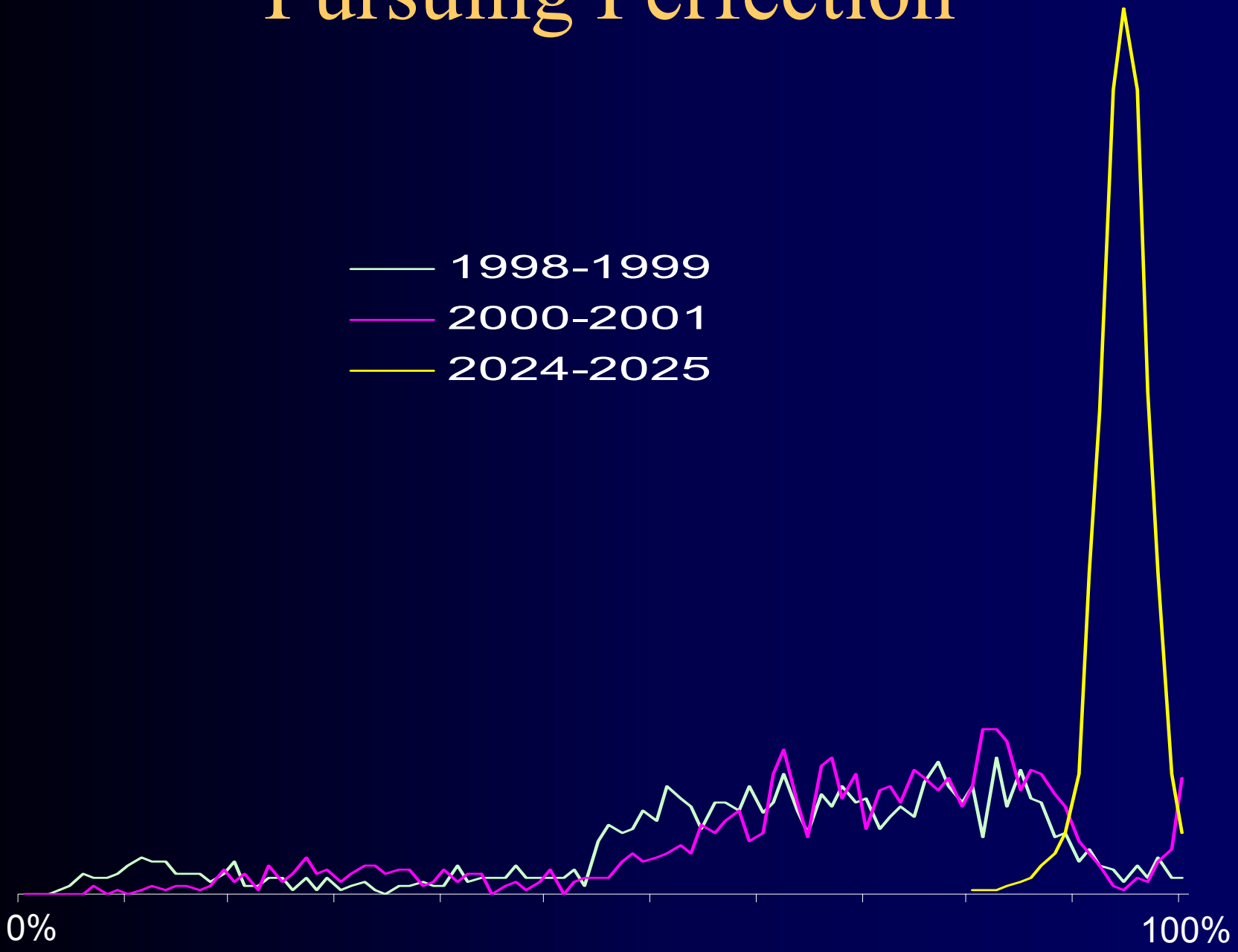
HEDIS Quality Compass Diabetic Eye Exam Rate - Commercial Plans



HEDIS Quality Compass HbA1c Exam Rate - Commercial Plans



Pursuing Perfection



The Dartmouth Atlas of Health Care

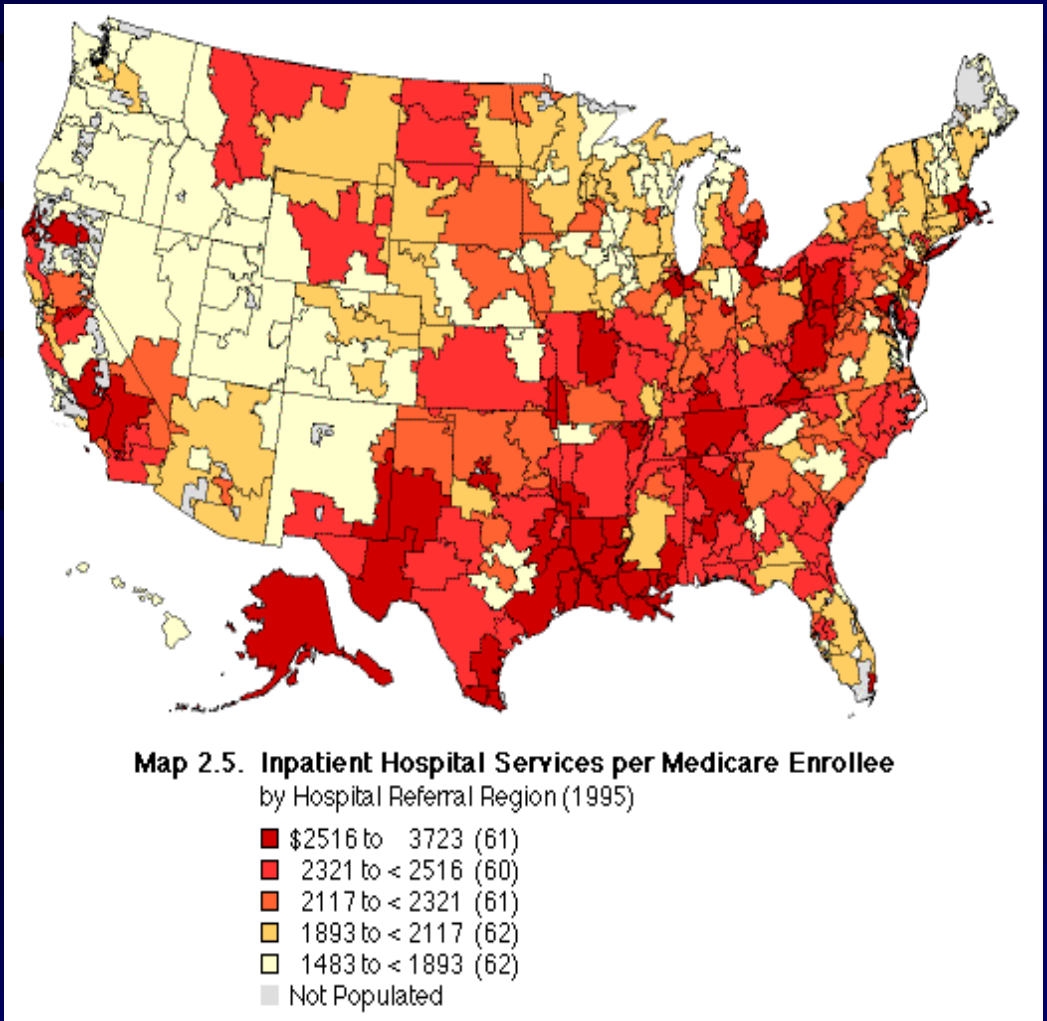
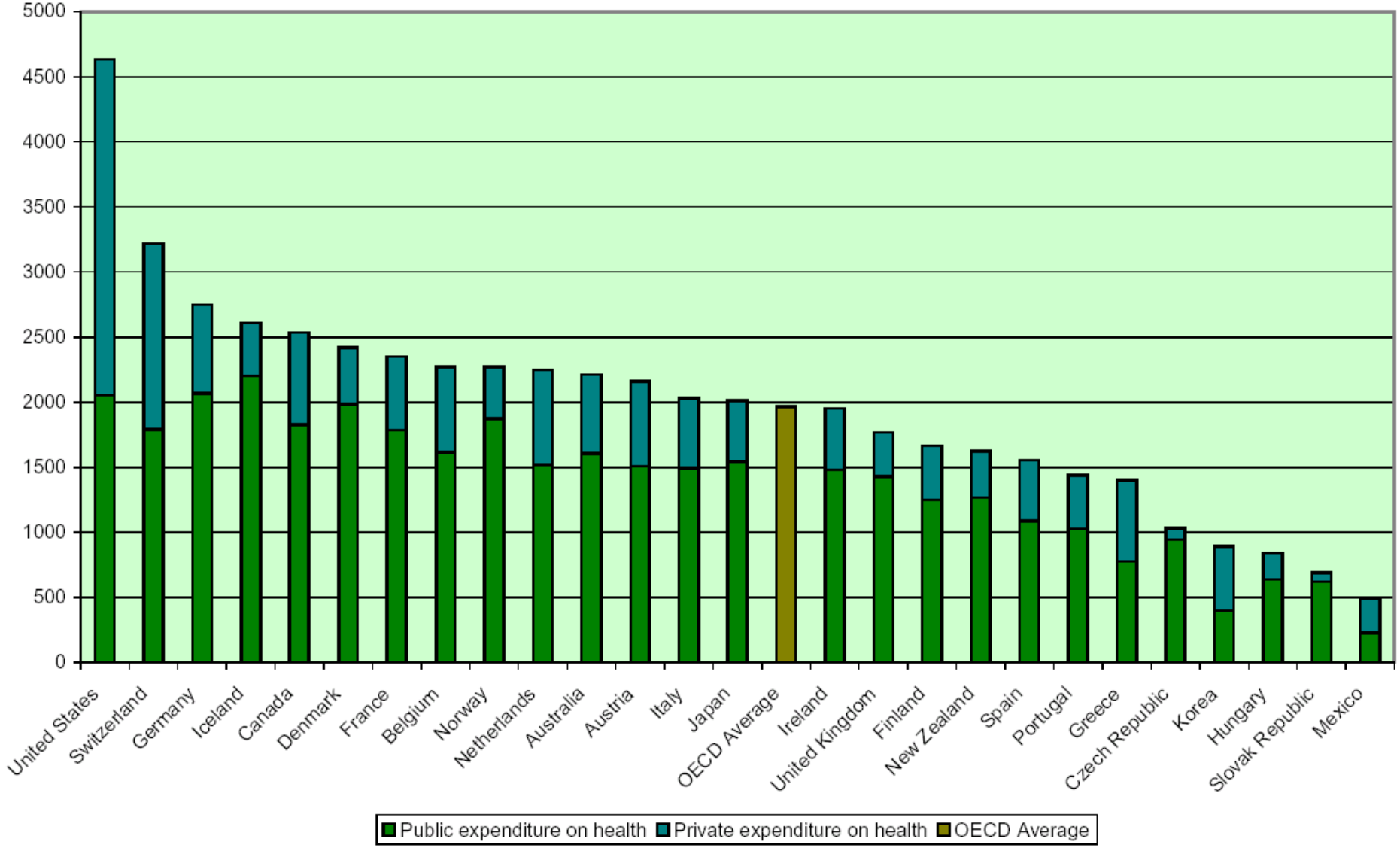


Chart 1: Per capita expenditure on health, 2000, in US$ PPPs (1)



Desirable added Medicare benefits

- outpatient prescription drugs
- expanded screening / prevention
- coordinated chronic care, disease management
- long-term care
- telemedicine
- improved access in rural and inner-city locations
- higher payments to providers
- new diagnostic and therapeutic technologies

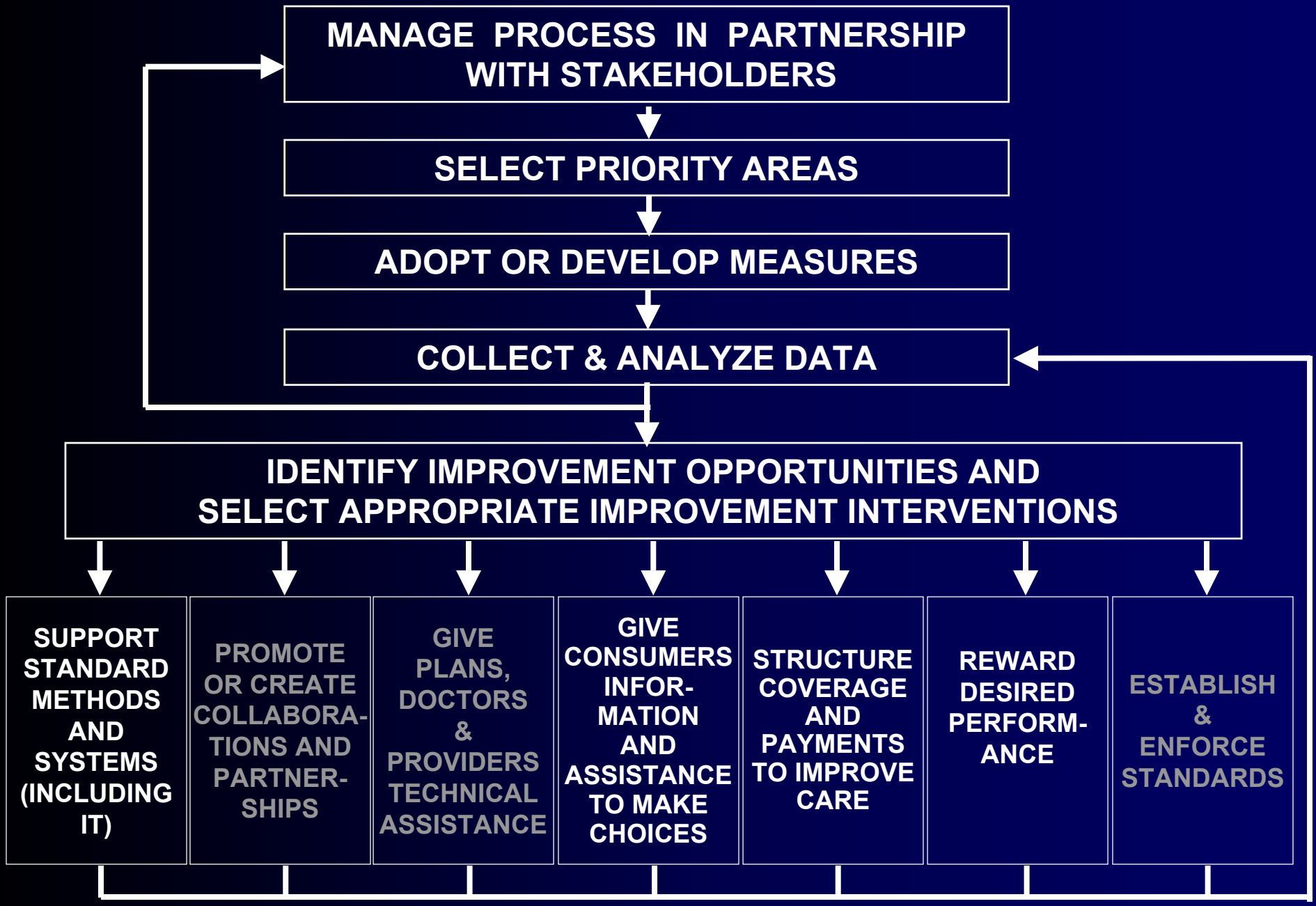
Why Has Quality Not Improved More?

1. We are in denial regarding the magnitude and severity of healthcare system problems.
2. We have cultivated experts instead of systems while technology, knowledge, and system complexity have outstripped the capacities of individual experts.
3. Self-care is essential in chronic disease, but the healthcare system strongly resists becoming patient-centered.

Why Has Quality Not Improved More?

4. Healthcare information technology is years, even decades, behind other industries.
5. We operate a culture of secrecy which makes performance information as unavailable to providers and practitioners as to the public.
6. Reimbursement has not been adequately linked to evidence of effectiveness and quality of care
7. Spending on quality has not been a sufficiently high priority
8. It is not that easy to do

WHAT CMS CAN DO TO IMPROVE QUALITY



Partnership: Common Understanding of Goals is Key

Selected Medicare Quality Tools

- Public reporting of quality data
- Promoting information technology
- Financial incentives for quality
- Coverage linked to evidence of effectiveness
- Technical assistance through QIO infrastructure to support all above

Comparative Quality Information on www.medicare.gov

- Medicare Health Plan Compare - 1999
- Dialysis Facility Compare - 2001
- Nursing Home Compare - 2002
- Home Health Compare – 2003
- Hospital Compare – 2004

The Quality Initiatives - Nursing Home

- 4 prongs (common to all public reporting)
  - consumer info
    - Empowers consumer to make informed choices
    - stimulates institutions to improve
  - quality improvement technical support
  - partnerships
  - oversight
- National launch November 2002
- Measures: currently 10 outcomes measures

The Quality Initiatives - Home Health

- same 4 main prongs
- Phase I (8 states) launched May 2003
- National launch Fall 2003
- Measures: currently 11 outcomes measures

The Quality Initiatives - Hospital

- Going national with voluntary effort: *The Quality Initiative: A Public Resource on Hospital Performance*
- A partnership with hospitals, consumer and private purchaser advocates, NQF, others
  - Phase I: starter set of measures
  - Phase II: HCAHPS
  - Phase III: tbd* (more measures, mandatory?)
- Pay for quality demonstration

Starter Set of Clinical Measures

- **Heart Failure**
  - **Left ventricular function assessment**
  - **ACE Inhibitor for LVSD**
- **AMI (heart attack)**
  - **Aspirin at arrival and at discharge**
  - **Beta-Blocker at arrival and at discharge**
  - **ACE Inhibitor for LVSD**
- **Pneumonia**
  - **Initial antibiotic timing**
  - **Pneumococcal vaccination**
  - **Oxygenation assessment**

HCAHPS

- Standardized survey questions to provide information on patient perceptions of care
- Current: draft survey being tested in 3-State Pilot
- Final: will be shorter, and will be different
- Builds on input from science, and from 9 different vendors
- Aim for core set of questions to be added to existing vendor products, so that existing vendor relationships can continue
- Multiple opportunities for input

Selected Medicare Quality Tools

- Public reporting of quality data
- Promoting information technology
- Financial incentives for quality
- Coverage linked to evidence of effectiveness

Promoting IT Adoption and Use

- Promote IT standards
- Promote systems availability, affordability, functionality
- Increase motivation of providers

Promote IT Standards

- Need IT standards to assure that systems can exchange information and that newer systems can extract information from those they replace
- Consolidated Health Informatics group (HHS, VA, DOD) is adopting standards for federal agencies and recommending their use in private sector
- First set of standards has been adopted in the areas of lab test results, imaging, prescriptions, devices, and data transmission; second set in process
- Federal license for SNOMED - July 1, 2003

Promote Availability of High Quality, Standards-Based Affordable Systems

- Stimulate private sector
  - EHR functional standards
    - IOM recommendations by September
    - HL7 model and standards Sept – January
  - Offer quality, affordable or public domain systems
    - VistA
    - QIO registry
    - ? PDA-based system for nursing homes

DOQ-IT: Approach

- Specify IT system functionality requirements
  - Full EHR *or*
  - E-Rx, e-lab results management, e-registry
- Recruit practitioners to adopt
- Provide implementation assistance
  - Technical issues
  - Workflow redesign
- Receive electronic data from practitioners and provide improvement assistance
- Provide special payments to spur adoption

Selected Medicare Quality Tools

- Public reporting of quality data
- Promoting information technology
- Financial incentives for quality
- Coverage linked to evidence of effectiveness

Financial Incentives: Premier

- Pilot effort to pay for better quality
- Announced July 2003
- Participating Premier hospitals will report 35 quality measures
  - AMI, CHF, TKR, THR, Pneumonia, CABG
- ~300 of 500 Premier hospitals expected
- Top 10% for each condition will get 2% DRG bonus; top 20% will get 1%
- Up to $7 million per year in bonus payments
- Top 50% hospitals for each condition will be listed on cms.hhs.gov

Perspective Online™ Hospitals

An Example: Coronary Artery Bypass Graft Measures

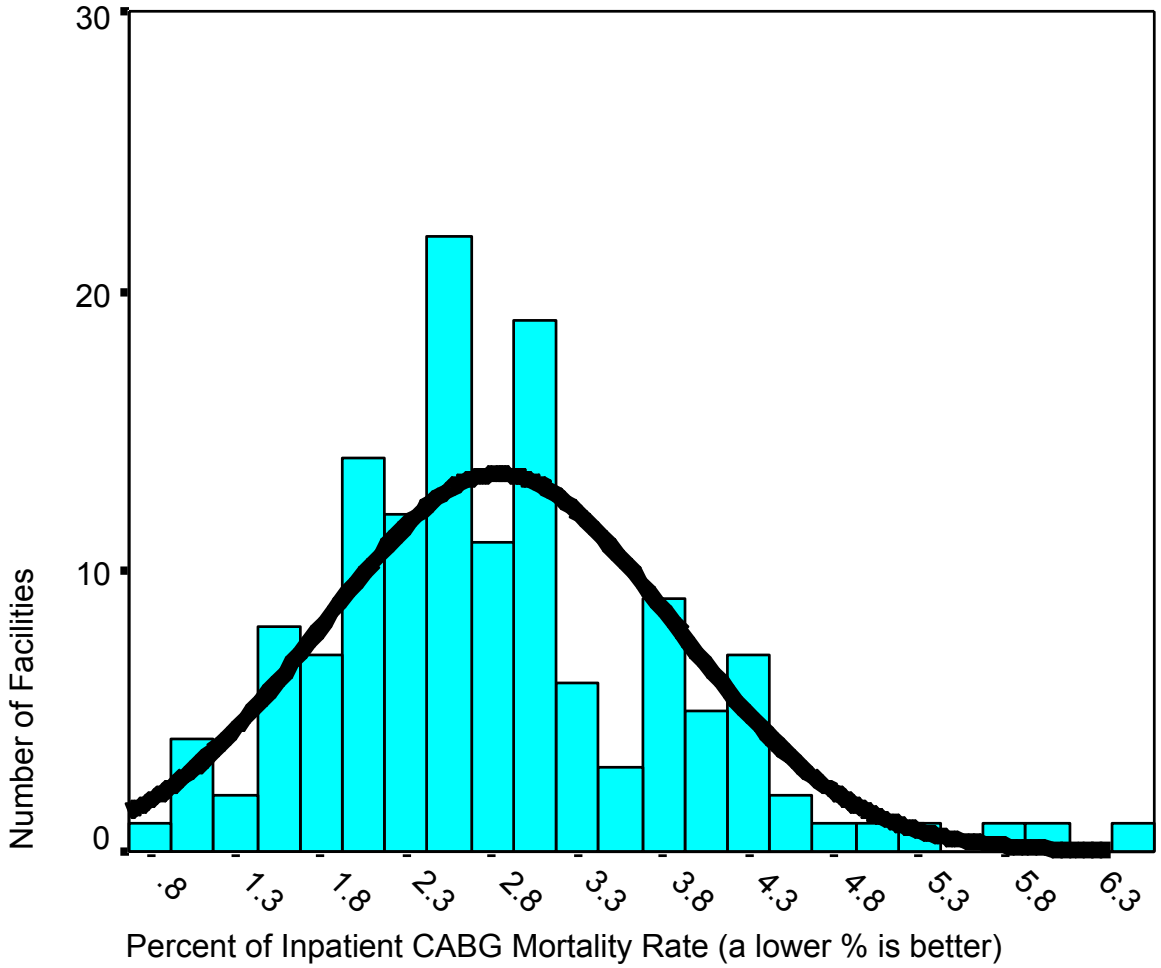
- Aspirin prescribed at discharge
- CABG using internal mammary artery[1]
- Prophylactic antibiotic received within one hour prior to surgical incision[1,2]
- Prophylactic antibiotic selection for surgical patients[1,2]
- Prophylactic antibiotics discontinued within 24 hours after surgery end time[1,2]
- Inpatient mortality rate[3]
- Post operative hemorrhage or hematoma[4]
- Post operative physiologic and metabolic derangement[4]

[1] National Quality Forum measure
[2] CMS 7th Scope of Work measure
[3] Risk adjusted using 3M APR-DRG methodology
[4] AHRQ patient safety indicator

An Example: Inpatient CABG Mortality Rate

If all hospitals improve to top performance levels, mortality rates will drop by 1%.

An estimated **220 lives per year will be saved**, if all hospitals in the HQI project attain top performance levels.



Source: Premier, Inc. 2002 Perspective Online™ dataset – based on 550 hospitals

Selected Medicare Quality Tools

- Public reporting of quality data
- Promoting information technology
- Financial incentives for quality
- Coverage linked to evidence of effectiveness

Reasonable and Necessary

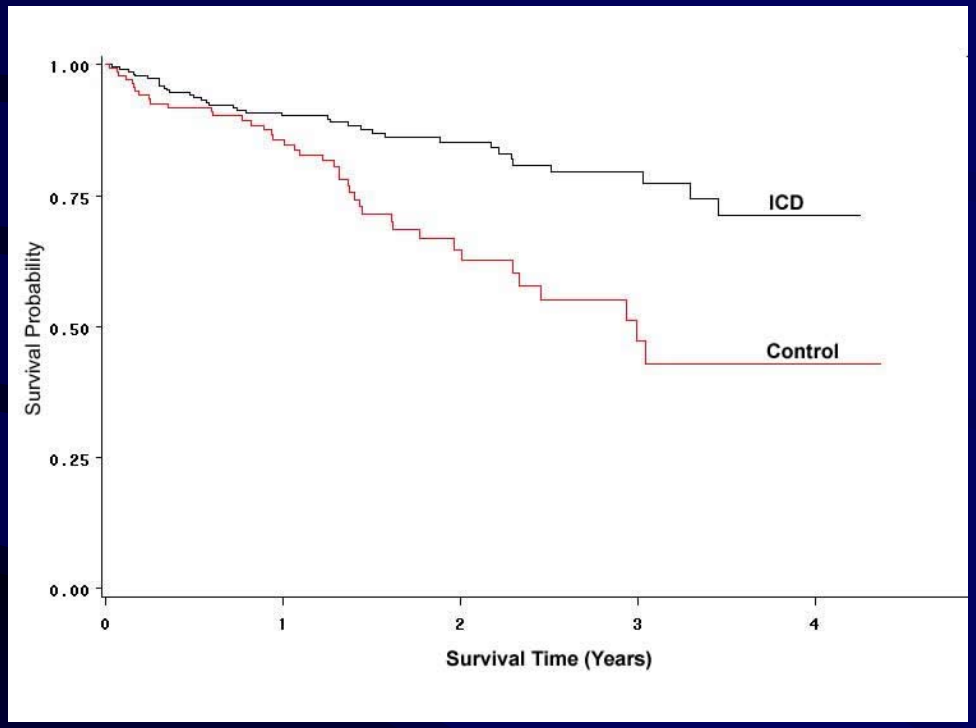
- Safe and effective (per FDA, if applicable)
- Adequate evidence to conclude that the item or service improves net health outcomes
  - emphasis of outcomes experienced by patients
    - function, QoL, morbidity, mortality
  - generalizable to the Medicare population
  - as good or better than current covered alternatives
- High cost and/or small benefit generally looked at carefully (context matters)
- Evidence assessed using EBM framework

EBM: Definition

"...Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and patho-physiologic rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research."

Evidence-Based Medicine Working Group, JAMA (1992)

Kaplan-Meier Estimates of the Survival Probability in MADIT II for Patients with QRS > 120 ms

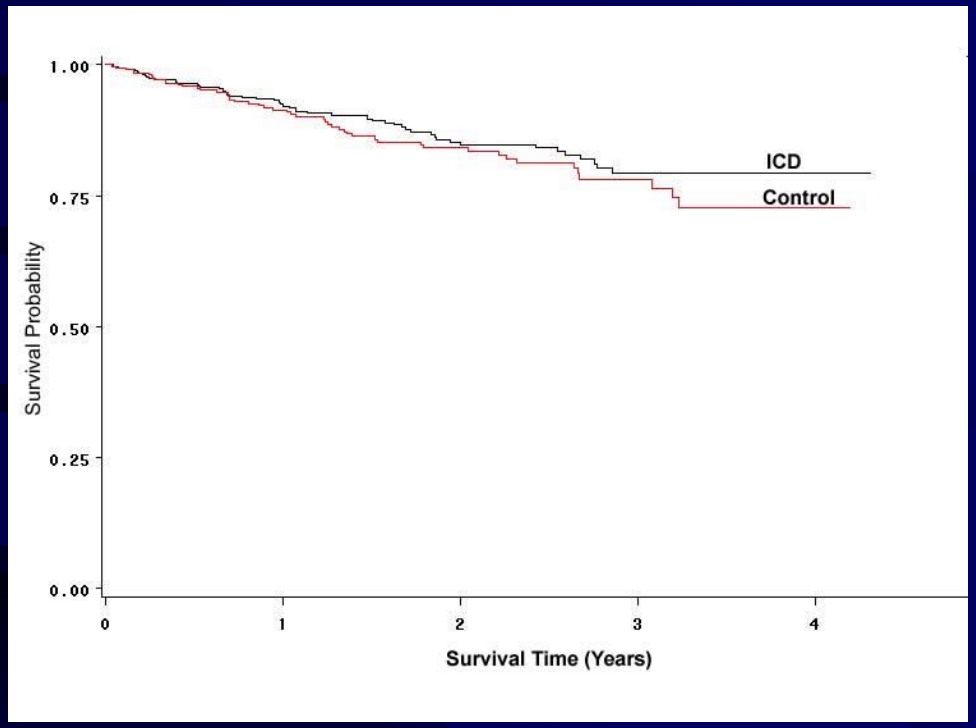


p-value=0.001

Patients with pacemakers were excluded.
CMS analysis of the MADIT II dataset supplied by Guidant.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Kaplan-Meier Estimates of the Survival Probability in MADIT II for Patients with QRS ≤ 120 ms

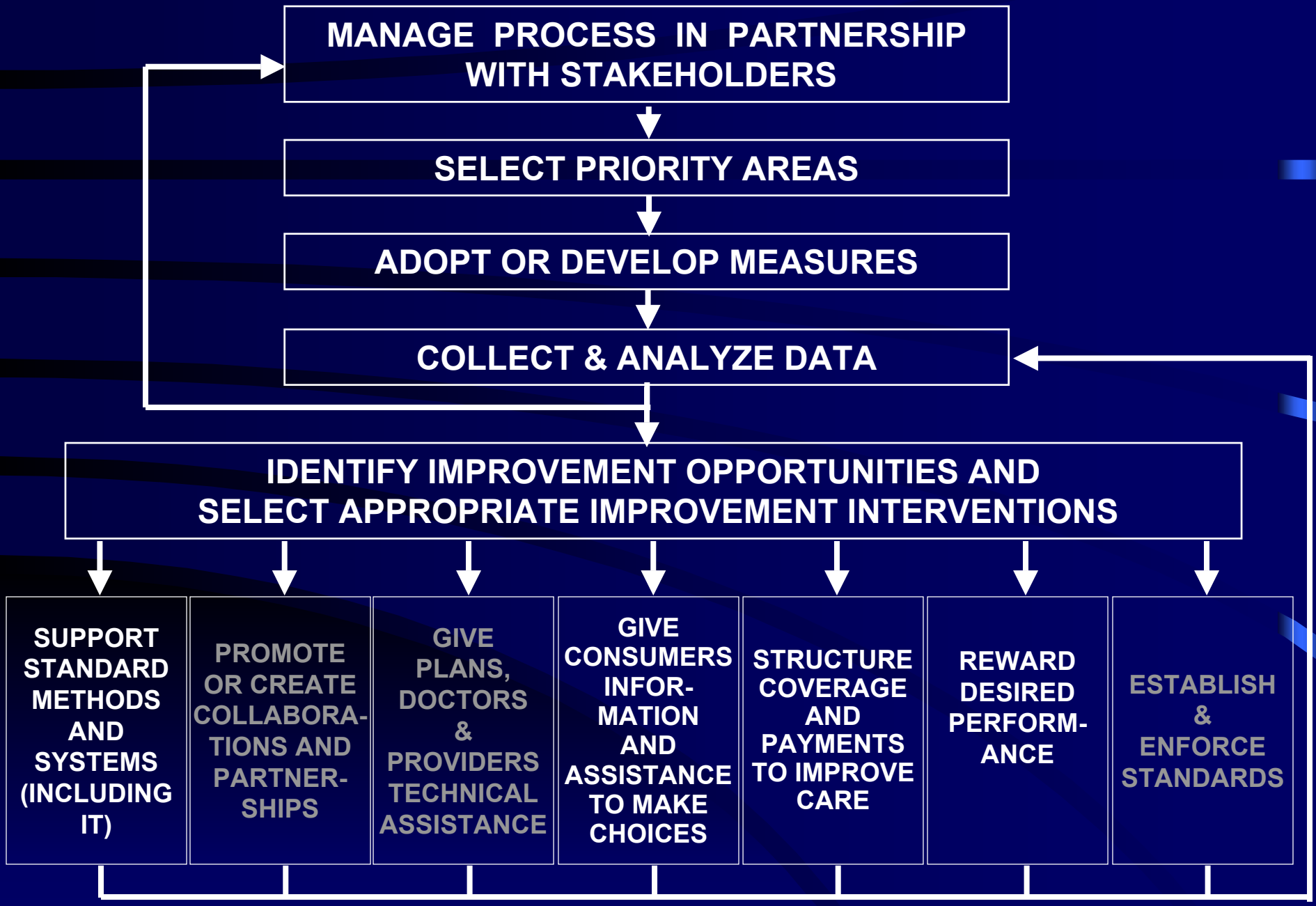


p-value=0.25

Patients with pacemakers were excluded.
CMS analysis of the MADIT II dataset supplied by Guidant.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

WHAT CMS CAN DO TO IMPROVE QUALITY



Pursuing Perfection