Advancing Population Health: Achieving National Priorities for Quality Improvement, Core Metrics, and Shared Accountability

Bonnie Zell, MD, MPH
Senior Director, Population Health
National Quality Forum

Ninth National Quality Colloquium
Harvard University
August 18, 2010
National Quality Forum Mission

- Improve the quality of American healthcare by setting national priorities and goals for performance improvement

- Endorse national consensus standards for measuring and publicly reporting on performance

- Promote the attainment of national goals through education and outreach programs
Quality Enterprise Functions: Contributions of NQF

Establish National Priorities
Two dimensional framework:
• National Priorities Partnership
• Top 20 conditions

Identify Measure Gaps
• Agenda for Measure Development and Endorsement

Measure Development

Endorse Measures, Practices, and SREs
• Over 600 measures covering all settings, including Safe Practices and SREs

Build Data Platforms
• Health Information Technology Expert Panel

Publicly Report Results
• Guidance for performance reporting on safety
• MAPs & Dashboard

Align Payment and Other Incentives
• Analysis of measurement implications of various payment reform models

Improve Performance
• Webinars
• Measures database

Evaluate
• Measure use evaluation
Why Set National Priorities?

- Current state of performance measurement is a cacophony of well-meaning but uncoordinated signals
- National priorities help align strategies and efforts of multiple groups around common goals for improvement
- Drive fundamental change in the delivery system
Criteria for Selecting the Priorities

- High Impact Areas
  - Reduce Disease Burden
  - Remove Waste
  - Eradicate Disparities
  - Eliminate Harm

© National Priorities Partnership

www.qualityforum.org
National Priorities

- Population health
  - Key preventive services
  - Healthy lifestyle behaviors

- Safety
  - Hospital-level mortality rates
  - Serious adverse events
  - Healthcare-Acquired Infections

- Care Coordination
  - Medication reconciliation
  - Preventable hospital readmissions
  - Preventable emergency department visits

- Patient/family engagement
  - Informed decision-making
  - Patient experience of care
  - Patient self-management

- Palliative Care:
  - Relief of physical symptoms
  - Help with psychological, social and spiritual needs
  - Communication regarding treatment options, prognosis
  - Access to palliative care services

- Overuse
  - 9 major areas
Drivers of Change

- Performance Measurement
- Public Reporting
- Payment

COLLABORATIVE, ACTION-ORIENTED STRATEGIES

- Infrastructure (Information Technology & Workforce)
- Applied Research
- Accreditation & Certification
• Drive toward higher performance
• Shift toward composite measures
• Measure disparities in all we do
• Harmonize measures across sites and providers
• Promote shared accountability & measurement across patient-focused episodes of care:
  - Outcome measures
  - Appropriateness measures
  - Cost/resource use measures coupled with quality measures, including overuse
Measurement Facilitates

- Measurement is necessary, but insufficient to achieve quality

- Provides information about performance useful for selecting providers with high quality (consumers, purchasers, health plans)

- Provides information about outcomes and processes useful to providers for identifying areas that need improvement and changes in care processes/systems
Patient-Focused Episodes of Care Model

**Population at Risk**

**Evaluation & Initial Management**

**Rehabilitation & Follow-up Care**

**End of Episode**
- Risk-adjusted health outcomes (i.e. mortality & functional status)
- Risk-adjusted total cost of care

**Appropriate Times Throughout Episode**
- Determination of key patient attributes for risk adjustment
- Assessment of informed patient preferences and the degree of alignment of care processes with these preferences
- Assessment of symptom, functional, and emotional status
Patient-Focused Episodes of Care Model

- Patient-focused orientation
  - Follows the natural trajectory of care over time
- Directed at value
  - Quality, costs, and patient preferences
- Emphasizes care coordination
  - Care transitions and hand-offs
- Promotes shared accountability
  - Individual, team, system
- Addresses shared decision making
  - Attention to patient preferences
- Supports fundamental payment reform
  - Bundled payment for the episode of care
Episodes Model Measurement Domains

• Patient-level outcomes (better health)
  - Morbidity and mortality
  - Avoidance of complications (e.g., HAIs)
  - Functional status
  - Health-related quality of life
  - Patient experience of care

• Processes of care (better care)
  - Technical
  - Care coordination and transitions
  - Alignment with patients’ preferences

• Cost and resource use (overuse, waste, misuse)
  - Total cost of care across the episode
  - Indirect costs
Defining Population Health

**World Health Organization (WHO):**

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

**Institute of Medicine (IOM):**

- State of well-being and capacity to function in the face of changing circumstances

- Positive concept emphasizing social and personal resources as well as physical capabilities

- Shared responsibility of healthcare providers, governmental public health and a variety of actors in the community
Defining Population Health

University of Wisconsin - School of Medicine and Population Health

• Body of scientific disciplines interested in study of distribution and determinants of health and disease states in a population

• Approach to health that seeks to step beyond the individual-level focus of traditional clinical and preventive medicine by addressing a broad range of factors that impact health on a population-level

• Focus on ways to reduce health inequities among population groups by exploring factors such as the environment, social structures, resource distribution, and other key determinants of health.
“Health of Individuals and Populations Within Their Communities”
How Population Health Happens

• Health happens:
  - one person at a time
  - one day at a time
  - one decision at a time

• Within the context of where and how people live:
  - where they work, learn, play, shop
  - influenced by their level of education, income, employment
  - determined by their access to healthy food, safe environments, available transportation, healthcare services

• Health does not happen primarily within healthcare sector:
  - it happens within the context of each person’s life -
    – their cultural, social, and economic frameworks modified by their values and priorities

• Individuals aggregate to populations
Defining Populations

Determined by defining boundaries of individuals:

- Racial, ethnic, disease specific, life-stage, level of poverty
- Health system’s population of patients
- Health insurer’s population of patients across health systems
- Clinician’s entire practice of patients
- Segment of a clinician’s practice
  - Patients with depression or adolescents or elderly....
- Geographic region - county, city, neighborhood or block
- Healthcare resource utilization
  - high utilizers
Determinants of Health

Figure 1. Determinants of Health and Their Contribution to Premature Death.
Adapted from McGinnis et al.\textsuperscript{10}
Healthy People in Healthy Communities: Actors in the Public Health System

IOM, The Future of the Public’s Health in the 21st Century, November 2002
The Expanded Chronic Care Model: Integrating Community Health Context
Bring population level *assessments* into healthcare:

- Query healthcare data to understand populations (patients with depression, DM, life-stage, etc.)
- Utilize publically available data to understand community context (GIS mapping)
- Integrate healthcare and public health data
Bring population level *strategies* into healthcare:

- Targeted outreach for screening and follow-up after visits by population segments
- Suggest available community-level resources targeted to specific populations
- Disseminate newsletters to segments with population-specific health-related information
- Partner with community stakeholders (schools, businesses, faith-based, pharmacies, policy-makers)
IN ADDITION TO ASSESSING:

“Did Alissa complete her depression assessment and leave her appointment with her symptom-management plan, counseling appointments and Zoloft prescription?

ALSO ASK:

How many individuals that we care for in our practice have completed a mental health assessment in the past 12 months?

What % of our patients with depression have completed a mental health assessment in the past 12 months and have a symptom-management plan, counseling or community-support plan and indicated medications ordered (composite measure)?
Should other sectors in the community that significantly influence health status, in addition to healthcare, have accountability for health in their communities?

How might we connect performance measures in healthcare with activities in other sectors? (school nurses)
EXPANDING OUR FRAME FROM:
“Why does this patient have this disease or condition at this time?” (Asthma as an example)

TO INCLUDE:
“What population circumstances are the underlying causes of the disease or condition incidence in this population?”
Principles

1. Build all systems around the individuals/people within their communities

2. Align aims, measures and initiatives across communities through partnerships and coalitions

3. Utilize all intersections of each individual and the personal healthcare delivery system to address clinical preventive services, provide health promotion information and support (physical activity, healthy diet, tobacco cessation, ETOH moderation) and health literacy, link to community resources and with specific conditions consider related implications for family and broader community

4. Utilize intersections of places where individuals spend their time to impact their health - schools, businesses, pharmacies, groceries, parks

5. Promote ‘Health in all Policies’
   - Health impact considered in all policy decisions in a community
   - Health and well-being are primary goals of each community and impacts are measured in key sectors

6. Develop shared accountability recognizing no one sector can provide all necessary services or health-promoting conditions alone - shared accountability between healthcare, governmental public health and key community stakeholders
Potential Healthcare Roles

- Invest Community Benefit dollars in collaboration with other health systems in a region/community and in partnership with other key sectors such as governmental public health.

- Utilize healthcare delivery system reach, influence, expertise and resources for public policy influence at community level.

- Participate in and support infrastructure of community-level coalitions to align priorities and investments.

- Set example as employer
  - Healthy food available and promoted
  - Exercise opportunities provided and encouraged
  - Benefits that cover prevention.
NQF Opportunities

- Broaden scope of endorsement process steering committee members and call for measures
- Measures of shared-accountability
- Principles of population health applied to National Priorities Partnership future work
- HIT Tools to query healthcare data/data mining to better understand population health at the community level
- Integrate healthcare and public health data
A Health System: Health Protection for Life!

- Safer Healthier People
- Vulnerable People
- Affected People without Complications (undiagnosed, asymptomatic)
- Affected People with Complications

Public Health Network
Healthcare Delivery System

Health Protection: Health Promotion, Prevention, and Preparedness

Disease Care

Centers for Disease Control and Prevention
NQF Annual Conference February 23 - 25, 2011
Population Health Theme
Washington, DC

http://www.qualityforum.org/

Bonnie Zell, MD, MPH
Senior Director, Population Health
National Quality Forum
bzell@qualityforum.org