The Quality Movement

Incorporating it in fellowship training

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Presentation Outline

- What is quality of care and how did we get here
- How will this affect the fellows in the clinical practice of rheumatology in the (near) future
- How can you (the program director) incorporate quality in the training of fellows

A Brief History of Medicine

The Era of the Physician

The Era of the Patient

The Era of the Payer

The Era of Quality Improvement

Prior to 1965

1965-1983

1983-1999

1999 -

Medicare 1965

DRG 1983

The Quality Movement

The Era of the Physician

The Hippocratic tradition: benevolent paternalism: “speak to the patient carefully and adroitly, concealing most things.”

The Supreme Physician

- Enjoyed a position of authoritative, unquestioned power
- Had direct and intimate contact with people in their daily lives
- Was present at the critical transitional moments of existence
- Served as an intermediary between science and private experience

Paul Starr, The Social Transformation of Medicine in America, 1982

Patients: More Options, More Rights, More Expectations

- Medical Insurance
  - Blue Cross Blue Shield 1930
  - 1940-1960: Growth in the Health Insurance Market
- Informed consent
  - The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research is established in 1974
- The patient as the “empowered consumer”
  - “Patient centered care”
  - “Patient expectations”

The Era of the Patient 1965-1983

- President Johnson signing the Medicare program into law, July 30, 1965
- At the bill-signing ceremony President Johnson enrolled President Truman as the first Medicare beneficiary and presented him with the first Medicare card

DHEW – SOCIAL SECURITY ADMINISTRATION

488-40-6969-A

APPLICATION FOR ENROLLMENT
in the
Supplementary Medical Insurance Program
Under the Social Security Act

PLEASE READ THE ENCLOSED LEAFLET

Harry S Truman
Independence, Missouri

Do not write in the space above

TO GET MEDICAL INSURANCE → CHECK [X] YES

The Federal Government will pay half the cost of this insurance. Your share of the cost ($3) will be deducted from your monthly social security benefits.

IF YOU DO NOT WANT THIS MEDICAL INSURANCE → CHECK [ ] NO

SIGN HERE

Signature by mark (X) must be witnessed below.

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The Rise of the Patient

- In 1965 Medicare provided health care coverage to 19 million elderly Americans
- Medicare Part B premiums were $3/month
- In 2001 Medicare had 40 million beneficiaries
- Expenditure in 2001 was $242.4 billion
- Leading diagnoses
  - hypertension, osteoporosis, chronic obstructive pulmonary disease, asthma, diabetes, heart disease and stroke

Medicare: Effects of the Program

- A threatened boycott of Medicare and Medicaid by the AMA did not materialize, and Medicare went into effect in 1966
- Program recipients were free to purchase their care from private providers at whatever fee those providers customarily charged
- Medicare maintained relatively little control over the quality and cost of the services they received
- The program proved to be far more expensive than its framers anticipated
- Medicare created an expanded market for health services

Cost Containment: The Era of The Payer 1983-1999

- The rising cost of all health care during the 1970s and 1980s, dramatically reflected in growing Medicare budgets, provoked widespread debate
- In 1973 the Nixon administration passed the HMO act
  - $375 million to held develop HMOs
- To control Medicare costs a "prospective payment" system was initiated in 1983
- Medicare payment rates were set in advance for each medical diagnosis

Diagnosis Related Groups (DRG)

- Until October 1982 Medicare made retrospective payments for health care
- DRGs ushered in a system of prospective payments
- The hospital was paid a specific amount for each patient treated, regardless of the number or types of services provided
  - The hospital was rewarded for reducing the cost of treating a patient over the entire course of the hospital stay
- Per-case payment
  - Encouraged the hospital and its physicians to consider explicitly the benefits of additional services against their added costs

DRGs: Implications for Quality Assurance and Utilization Review

- Admission would be encouraged
- Length of stay would be reduced
  - Premature discharge
- Quality of care may suffer
- These fears spawned the quality assurance movement

The HMO Backlash of the Mid-90s

- Federal and state legislation
- Lawsuits naming HMOs as defendants
- Statewide electoral-initiative drives
- Horror stories in the mass media
- The emergence of physician-run HMOs to compete with HMOs run by corporate executives
- Drive for medical savings accounts to draw patients away from HMOs

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HEALTH STORY PAGE

The HMO backlash

Survey finds skepticism about managed-care motives

November 5, 1997
Web posted at: 5:04 p.m. EST (2204 GMT)

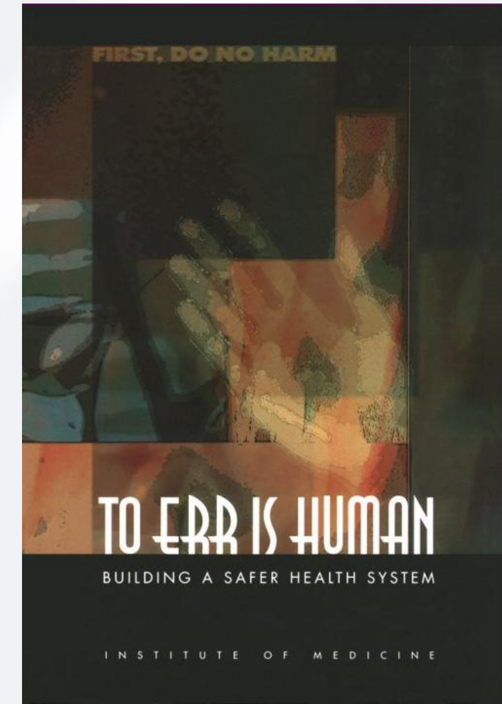
From Correspondent Jeff Levine

(CNN) -- In general, people are pleased with their personal medical coverage, but those who belong to a health maintenance organization tend to believe their HMO cares more about saving money than it does about them, a survey found.

HMO

The ERA of Quality Improvement 1999 -

- In 1999, the Institute of Medicine published "*To Err is Human*"
- Drew attention to how tens of thousands of Americans die each year from medical errors
- Effectively put the issue of patient safety and quality on the radar screen of public and private policymakers
- The Agency for Healthcare Research and Quality (AHRQ) was created



What is Quality

"…the application of medical science and technology in such a way as to maximize health benefits without increasing health risks…"

Donabedian, 1980

What is Quality

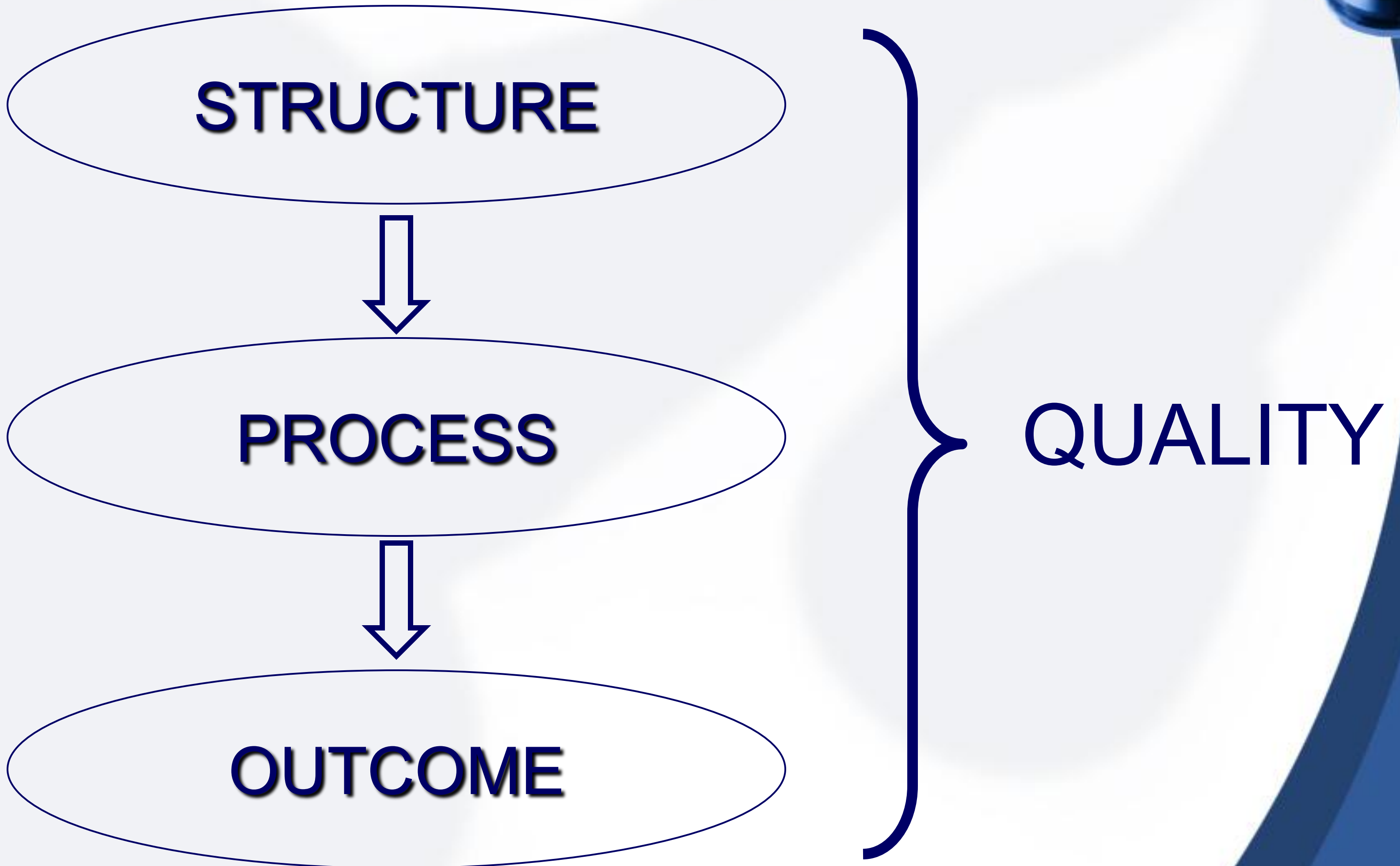
"The degree to which health service for individuals and populations increase the likelihood of desired health outcome and are consistent with current professional knowledge"

Institute of Medicine, 1990

What is Quality Measurement

- A set of objective assessments designed to measure how well health care-providers and health care systems adhere to evidence-based standards to achieve desired health outcomes
- The current spotlight in the health care environment is increasingly focused on using clinical data to
  - measure quality
  - demand accountability
  - cultivate an information-rich health care marketplace

Quality Domains



Structural Measures of Quality

- Organizational elements (Physicians and Hospitals)
  - Credentialing
  - Staffing ratios
  - Patient care committees
  - Infection control committee
- Form the basis for accreditation, licensure, certification of health care organizations and medical education
  - The Joint Commission
  - ACGME

Process Measures of Quality

- Encounter between patient and physician or hospital
- Quantify the delivery of recommended procedures or services that are correlated with desired outcome in a specific population group
  - e.g. RA – DMARD use
- Useful in comparing individual providers, communities or larger geographic areas

Outcome Measures of Quality

- Patients’ subsequent health status
- Used to capture the effect on an intervention on
  - Control of a chronic condition
  - Specific clinical findings
  - Patients’ perceptions of care
- e.g. Rheumatoid arthritis care
  - Percentage of patients with low disease activity

Additional Quality Domains

- Access to care
  - the provision of timely and appropriate health care
- Patient experience
  - patient's perception of quality of care
- Efficiency of care
  - relationship between clinical performance and resource use

Ideal Quality Measures

- Scientifically sound
- Relevant and important
- Potential for improvement
- Adjusted for confounding factors
- Care attributable to the individual physician
- Feasible to collect
- Representative of the activities of the specialty

Skepticism About Quality Improvement

- Quality improvement is “cost containment” in disguise
- The emphasis on “gaps in care” is designed to embarrass physicians
- Physicians expect a high standard of evidence that measuring quality improves outcomes
- Physicians worry that “report cards” will not reflect their case mix
- Providers may unconsciously avoid the sickest patients

There is a Problem

- A gap exists between what we know and what we do
  - DMARD use in RA*
    - DMARD use in 27,710 RA cases in British Columbia, Canada
      - 84% by rheumatologists
      - 40% by internists
      - 10% by family physicians
  - TB screening before initiating anti-TNF therapy**
    - 856 outpatients received anti-TNF therapy
    - 27% had a tuberculin test

*Lacaille D. Arthritis Rheum. 2005 Apr 15;53(2):241-8
**John H. Clin Med 2009 Jun; 9(3):225-30

Why the quality movement cannot be ignored

- Accreditation of health care organizations is increasingly determined by quality metrics
- Maintenance of certification will include more emphasis on demonstrating quality of care
- Demonstrating quality improvement is now part of the ACGME expectations
- Most fellows will be employed by existing health care organizations and are less likely to be self-employed
- Physician reimbursement will be increasingly determined by performance measurement on quality indicators

External Stakeholders in the Quality Arena

Group	Activities Relevant to ACR Members
Physician Specialty Societies	Quality measures development and physician recognition programs
Medical Certification Boards	Continuous Professional Development, Practice Improvement Modules
Public health care insurers (Medicare)	Physician Quality Reporting Initiative (PQRI)
Private health care insurers	Measurement programs with incentives and disincentives to health care providers
Employers and other health care purchasers	Pay-for-Reporting and Pay-for-Performance
Quality Measure Accreditors (Joint Commission, NQF, NCQA)	Endorsement and approval of measurement sets
ACGME	Fellowship accreditation

Quality Measurement and Physician Reimbursement

Pay for Performance

Pay for Performance

- Britain's National Health Service
  - 25% of the GP's income determined by performance on 146 quality indicators
- The Bridges to Excellence Program
- IHA Rewarding Results
- Anthem Blue Cross and Blue Shield Plan
- Medicare's Physician Quality Reporting Initiative
  - Established in 2007 with 74 measures and 1.5% bonus
  - In 2009 an RA Measures Group was added – bonus 2.0%

The Need to Consolidate Quality Measurement

- The application of quality measurement is uncoordinated and duplicative
- Health providers of all types are engaged in costly and redundant reporting activities to meet the demands of
  - Government agencies
  - Accreditation groups
  - Commercial insurers

The Need to Consolidate Quality Measurement

- Providers serving patients with multiple sources of coverage are burdened by the need to supply the same data to more than one agency
- Each new added measure often presents conflicts in methodology, reporting and implementation

Reducing the burden of reporting

Passive Information Capture

Uniform Requirements

Point of Care

Integrated Systems

Timely reimbursement

The ACR and Quality

- The ACR has a Quality of Care Committee
  - Development of Guidelines
  - Defining Disease Criteria
  - Assessing developing and endorsing Quality Measures
  - Monitoring Drug Safety

The ACR and Quality

- The ACR has developed a consensus statement with regard to
  - sponsoring quality measures
  - endorsing quality measures
  - developing quality measures
- The ACR is using a proactive approach with the larger quality movement by adopting the position of defining quality of care for its membership
- The ACR has developed a Registry

The ACR's Rheumatology Clinical Registry (RCR)

The ACR Registry Initiative

- Rheumatology Care Registry
  - PQRI and other Quality Measures
  - ABIM performance improvement module (PIM) for maintenance of certification
  - Point of care disease registry

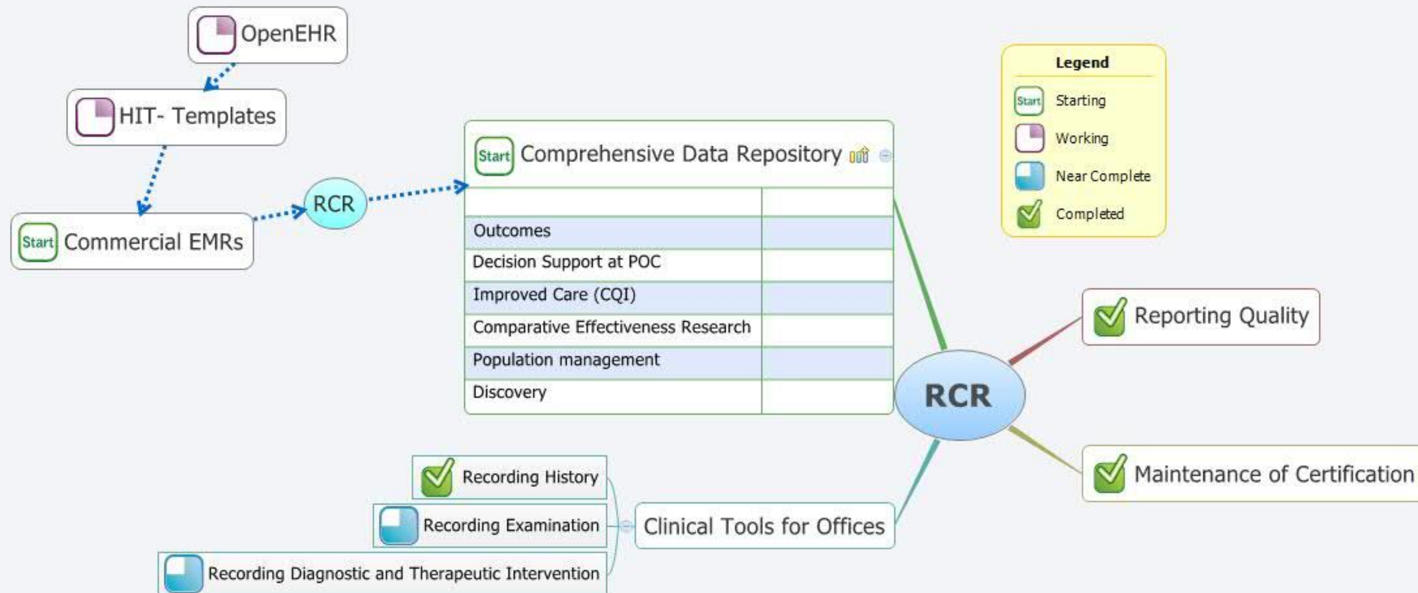
RCR Components

- Quality Measurement (QM Subcommittee)
  - Current focus is on PQRI
  - Includes ability to submit PQRI data to CMS
- Performance Improvement Module (PIM)
- Patient Data Collection (Clinical Registry)

RCR Concept

- Streamline collection of data to serve all 3 modules (and future modules)
- Leverage Health Information Technology to prevent duplication of recording/reporting requirements
  - Develop interoperability with EMR’s
- Allow information to be collected at the point of care
- Permit the seamless addition of future modules

RCR – A Work in Progress

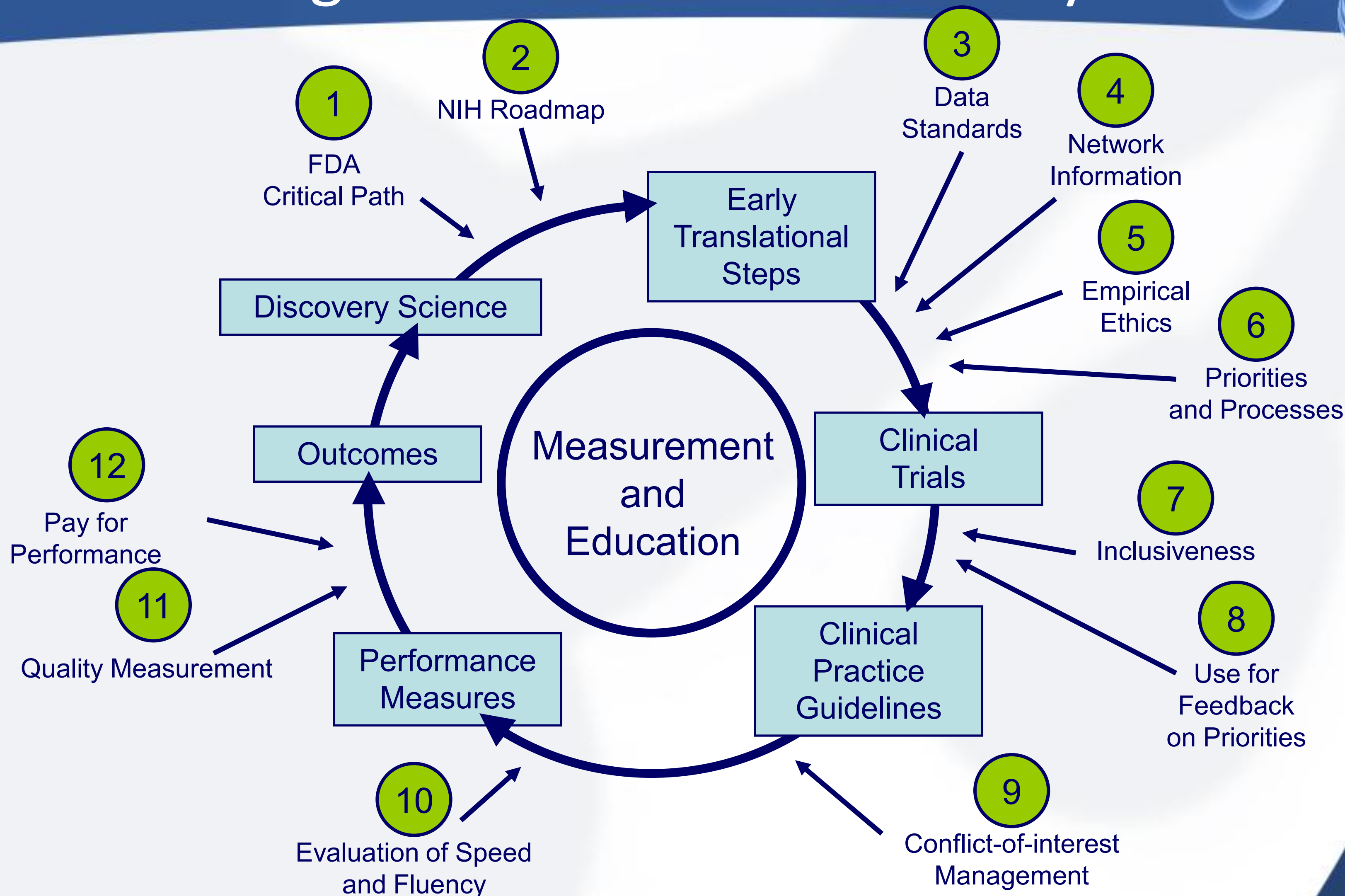


ACR Registry Mission

- The ACR will develop and support an accessible, protected, and affordable shared clinical database of musculoskeletal and rheumatic diseases that will serve the ACR members by providing systems for:
  - Continuous improvement in patient care delivery
  - Continuous improvement in practice/clinic efficiency
  - Quality performance reporting
  - Application for certification or maintenance of certification
  - Longitudinal monitoring of our diseases and interventions

Incorporating Quality in Fellowship Training

The Cycle of Quality in Learning Health Systems: Generating Evidence to Inform Policy



Adapted from Califf RM et al, Health Affairs, 2007

Key Steps

- Develop an understanding of the concept of Quality
- Prepare fellows to document and report quality measures
- Redesign fellow clinical workflows
- Engage fellows in quality improvement projects

Quality Improvement Projects

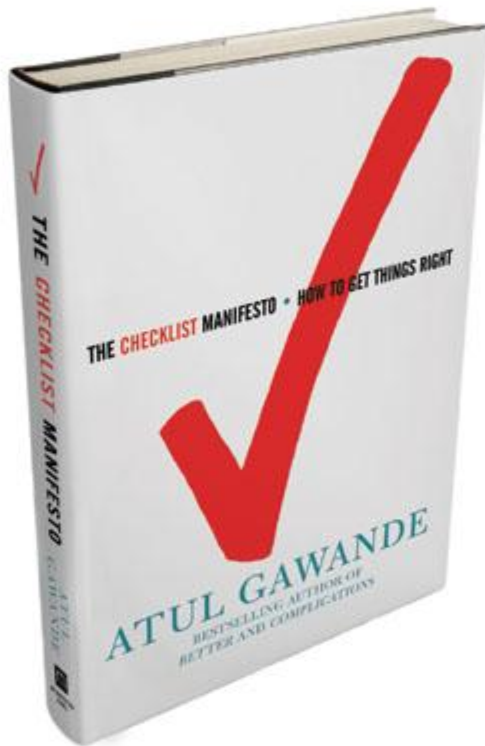
1 → Identify a Quality Gap

2 → Develop a Clinical Process to Close the Gap

3 → Educate Stakeholders

4 → Use Structured Data for Quality Improvement

The Checklist Manifesto - Gawande



The Checklist Manifesto

- Gawande begins by making a distinction between errors of ignorance (mistakes we make because we don’t know enough), and errors of ineptitude (mistakes we made because we don’t make proper use of what we know)
- Failure in the modern world, he writes, is really about the second of these errors, and he walks us through a series of examples from medicine showing how the routine tasks have now become so incredibly complicated that mistakes of one kind or another are virtually inevitable:
- it’s just too easy for an otherwise competent doctor to miss a step, or forget to ask a key question or, in the stress and pressure of the moment, to fail to plan properly for every eventuality.

Stages in Fellowship Training

- Unconsciously Incompetent
  - They don’t know what they don’t know
  - They use written sources extensively
  - *Introduce a check list*
- Consciously Incompetent
  - They know what they don’t know
  - They look up information frequently
  - *Refine the check list*

Stages in Fellowship Training

- Consciously Competent
  - Getting fluid with diagnosis and management
  - Have mastered most common clinical scenarios
  - *Can forget the checklist*
- Unconsciously Competent
  - Enjoy challenges
  - They know when to break the rules
  - *Risk of abandoning the checklist*

Clinic Workflow (for rheumatoid arthritis)

- Create the right patient intake forms (paper or electronic portal)
- Train ancillary staff to transfer information to the EMR (if applicable)
- Design the right provider templates (capture the 7 ACR core measures) + MDHAQ or HAQ-II
  - Patient global assessment
  - Patient pain score
  - Functional assessment
  - Tender joint count
  - Swollen joint count
  - Acute phase reactant(s)
  - Provider global assessment
- Consider use of a disease activity measure
  - (Rapid, DAS 28, SDAI, CDAI etc.)

Medicare PQRI - RA Measures Group - 2009

- DMARD use
- Functional Assessment
- Estimation of Prognosis
- Measurement of Disease Activity
- TB testing prior to TNF based therapy
- Glucocorticoid Management

Making an RA Checklist

- How was the diagnosis of RA made
  - Serology, radiographs, joint counts, ESR, CRP etc
- What is patient’s prognosis
- What is the current disease activity
- What is the patient’s functional status
- What comorbidities does the patient have
- Is health maintenance current
- Are immunizations current
- Hepatitis B risk factors
- Latent TB testing and risk factors
- Risk factors for deep fungal infections
- History of cancer
- History of demyelinating disorders
- History of recurrent infections
- Pregnancy and lactation issues
- Glucocorticoid induced osteoporosis prevention
- Drug monitoring
- Interval radiographs

Summary

- We are in the era of quality improvement
  - Transparency, accountability, patient centeredness
- Quality of care can be measured
  - Structure, process, outcome, access, efficiency, patient satisfaction
- Quality is a system property
  - Working harder will not improve quality
  - Changing the system can
- Quality measures have become ubiquitous
  - Have been shown to affect outcome positively
  - Inherent methodology limitations are being overcome through technology improvements
  - Pay for performance may overcome provider resistance

The Future

- Quality based incentives will account for a substantial proportion of physician reimbursement
  - Structural measures
    - Fitness to serve as a physician
      - Credentialing, CME
    - Access to care
  - Process and efficiency measures
    - Prescribing habits, utilization of appropriate tests, administration of indicated drugs
  - Outcome measures
    - Readmission rates, operative mortality, patient satisfaction, control of chronic diseases
- Physicians will get detailed report cards
- Physician ratings will be publicly reported

Conclusions

- The measurement of quality in the rheumatic diseases is being increasingly sought by government and commercial payers
- System redesign needs to occur at the local and national level to ease the transformation of data collection, analysis and reporting
- Incorporation in to training programs must begin to occur soon!