



# Partnering To Improve Health Care Quality And Safety

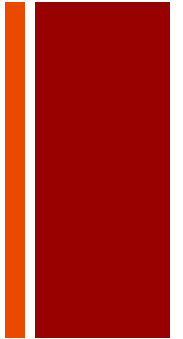


**By Susan Dentzer  
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Robert Wood Johnson Foundation**

**The Twelfth National Quality Colloquium  
September 20, 2013**

# **+ This Presentation at a Glance**

- **The United States face a number of health and health care challenges – one reason for the Affordable Care Act**
- **Ongoing opportunities to improve quality and safety**
- **Where are we making progress and where are we not?**
- **An agenda for more change**
- **Some conclusions**






+ First, a story....

# + Once upon a time, there was a “country”...

**With an economy the size of France: \$2.7 trillion...**



MAFBICA

**With tens of millions of unhealthy people – and life expectancy below that of 28 of the world’s richest countries...**

**Where every day, a group of the natives “experimented” on others by subjecting them to “medical care,” about half of which has no evidence suggesting that it works...**

**Where adverse events that occurred in the course of this “care” were among the top ten causes of death annually...**

**Where tens of millions didn’t get care they needed and tens of thousands died each year as a result...**

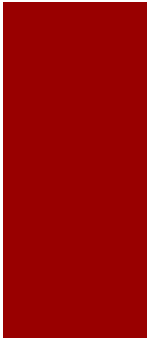
**And partly because of the cost of the flawed care it does provide, the country was possibly going broke!**

# What would you do with this country?

- **Send in the Marines?**
- **Send in the International Monetary Fund?**
- **Send in Amnesty International?**
- **Other?**



**+ We know this country's identity...**

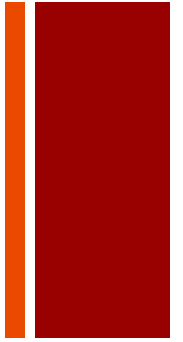
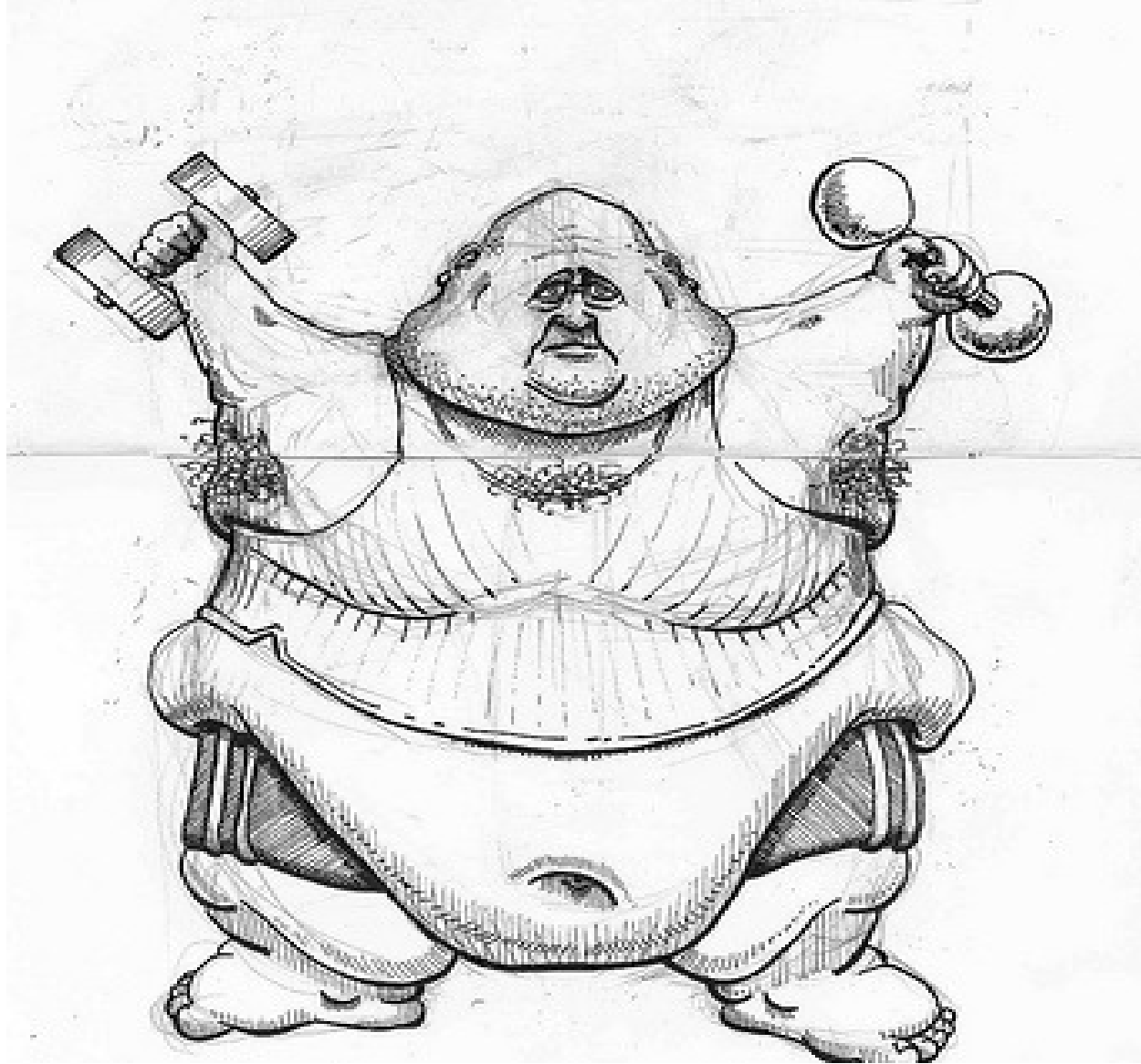


# What The US Did In 2010...



**...Enact the Affordable Care Act**

# + A Heavy Lift?







**Donald Berwick, MD  
Former Administrator  
Centers for Medicare  
and Medicaid Services**

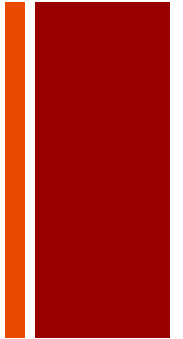
## **The Triple Aim**

- **Better health**
- **Better health care**
- +** ➤ **Lower cost**
  
- **Core principle now at heart  
of major U.S. payment and  
delivery system reform  
efforts**



**Better Health Care**

# **+ “Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century”\***



- **US health care not sufficiently**
  - **Safe**
  - **Effective**
  - **Patient Centered**
  - **Timely**
  - **Efficient**
  - **Equitable**

**\*Source: Institute of Medicine, 2001**

# **+ How are we doing today?**

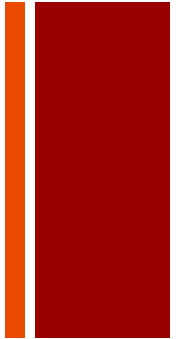
## **Better, but still challenged**

- **Safe? -- 1 in 3 hospital admissions associated with an adverse event; 40 wrong-site surgeries weekly**
- **Effective? – IOM estimates that about half of care provided lacks direct evidence that it works**
- **Patient Centered? – ask someone with a major illness, like advanced cancer**
- **Timely? – estimated 1 in 4 diagnoses wrong**
- **Efficient -inadequate management of care transitions estimated to account for \$25 billion to \$45 billion in wasteful spending in 2011**
- **Equitable – racial and ethnic disparities; 50 million uninsured**

# + **Key Safety Issues**

## ◆ **Hospital acquired infections down**

- **“Never event” penalties**
- **Partnership for Patients**
- **Proactive efforts, such as Keystone Project**



# + Key Safety Issues

- **MRSA infections down, according to CDC**
- **In 2011, total US MRSA infections estimated at 80,400 -- more than 30,000 than in 2005.**
- **Invasive MRSA infections with onset at the hospital dropped the most, with a 54 percent decline**
- **Community-associated infections dropped 5 percent.**
- *Source: JAMA Internal Medicine, published online, Sept. 16, 2013*

# + **Key Safety Issues**

- **Concerns about new “superbugs”**
- **Hand hygiene compliance – better, but suboptimal nationwide**



# **+** Wrong Site Surgery

- **Joint Commission Center for Transforming Healthcare**
- **Targeted Solutions Tool: created to help organizations identify, measure and reduce risks in key processes**
- **Project included Lifespan system in Rhode Island, other hospitals, ambulatory surgery centers**
- **Organizations were able to reduce risks by making changes in scheduling, pre-op procedures and operating room**
- **Examples: illegible handwriting on surgery booking forms replaced by printed documents**
- **Only surgeon marks site and must do so in pre-op holding; only uses approved surgical site marker, not stickers, e.g.**

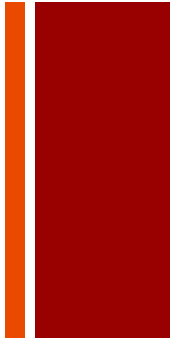






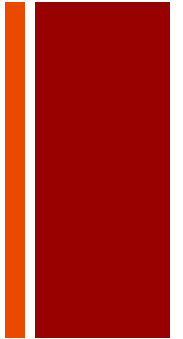
## **“Most Challenging Requirements”**

- **Top five Joint Commission requirements most frequently identified as “not compliant” in first half of 2013 for accredited organizations and certified programs**
- **55 percent of hospitals were not compliant with requirements to maintain complete and accurate medical records for each patient**
- **47 percent of hospitals did not reduce the risk of infections associated with medical equipment, devices and supplies**
- **22 percent of nursing and rehab centers did not comply with CDC hand hygiene guidelines**
- **38 percent of ambulatory care sites did not safely store medications**
- **53 percent of critical access hospitals did not maintain fire safety equipment**



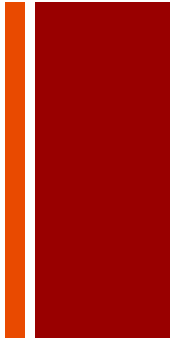
# **+ Health Care Worker Safety**

- **Health care workers experience rates of nonfatal occupational injury and illness that exceed even construction and manufacturing industries**
- **Attributes that create unsafe conditions for patients also do the same for workers**
- **Reverse also true**
- **Case in point: steps to prevent falls by patients; injuries from sharps**
- **Source: Joint Commission Monograph, “Improving Patient and Worker Safety”**



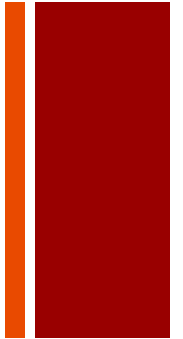
# + “Amenable mortality:” US falling further behind Europe

- **Amenable mortality = deaths that should not occur in the presence of timely and effective health care**
- **Comparison of amenable mortality in the United States compared to those in France, Germany, and the United Kingdom between 1999 and 2007.**
- **Overall, amenable mortality rates among men from 1999-2007 fell by only 18.5 percent in the United States compared to 36.9 percent in the United Kingdom.**
- **Among women, the rates fell by 17.5 percent and 31.9 percent, respectively.**
- **US deaths from circulatory conditions—mainly, cerebrovascular disease and hypertension – were the main reason.**
- **Source: Nolte et al, *Health Affairs*, September 2012**





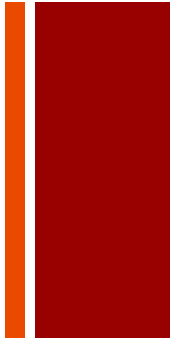
## **Care Coordination/Avoidable hospital use**



- **Advanced Illness/End of Life**
- **Half of older Americans (51%) visited emergency department in last month of life; 77% of those seen in ED admitted to hospital**
- **68% of admitted died in hospital**
- **Americans' broad preference is to die at home**
- **Emergency department use in last month of life rare when enrolled in hospice one month before death**
- **Source: Alexander K. Smith et al, "Half of Older Americans Seen In Emergency Department In Last Month of Life; Most Admitted To Hospital, And Many Die There," Health Affairs, June 2012**

## **+ Variability, even among “the best”**

- **“A Collaborative Of Leading Health Systems Finds Wide Variations In Total Knee Replacement Delivery And Takes Steps To Improve Value”**
- **“High Value Healthcare Collaborative”, including Cleveland Clinic, DHMC, Denver Health, Intermountain, Mayo (more since added, including University of Iowa)**
- **Pooled data to examine differences in primary total knee replacements (total US costs 2008 = \$9 billion)**
- **Found substantial variations in such metrics as hospital lengths-of-stay; longer operating times associated with higher .complication rates**
- **Used findings to alter care, including more coordinated management for complex patients**



# + Comparison among institutions

Metric	A	B	C	D	E	Total
Mean LOS	3.6	4.2	3.9	3.3	3.2	3.2
Median LOS	3	4	3	3	3	3
By MD # of procedures (annual) 0-99	3.6	3.8	4.4	3.5	3.3	3.5
200+	--	--	3.4	3.0	2.8	2.9
Surgery on Mon.	3.6	4.2	3.7	3.2	2.9	3.1
On Fri.	3.6	--	4.3	3.4	3.0	3.3



**31.2% difference, low to high**

**16% difference**

# **+** Waste in Health Care: The Savings Opportunity

- **Six categories of waste estimated to equal 21% to 34% of all US health spending (estimated \$558 billion to \$910 billion annually)**
- **Overtreatment – subjecting patients to care that can't possibly help them, and may be harmful**
- **Failures of care coordination – what happens when patients fall through the cracks, e.g., unnecessary hospital readmissions**
- **Failures in execution of care processes – e.g., not doing things known to be effective, such as infection control**

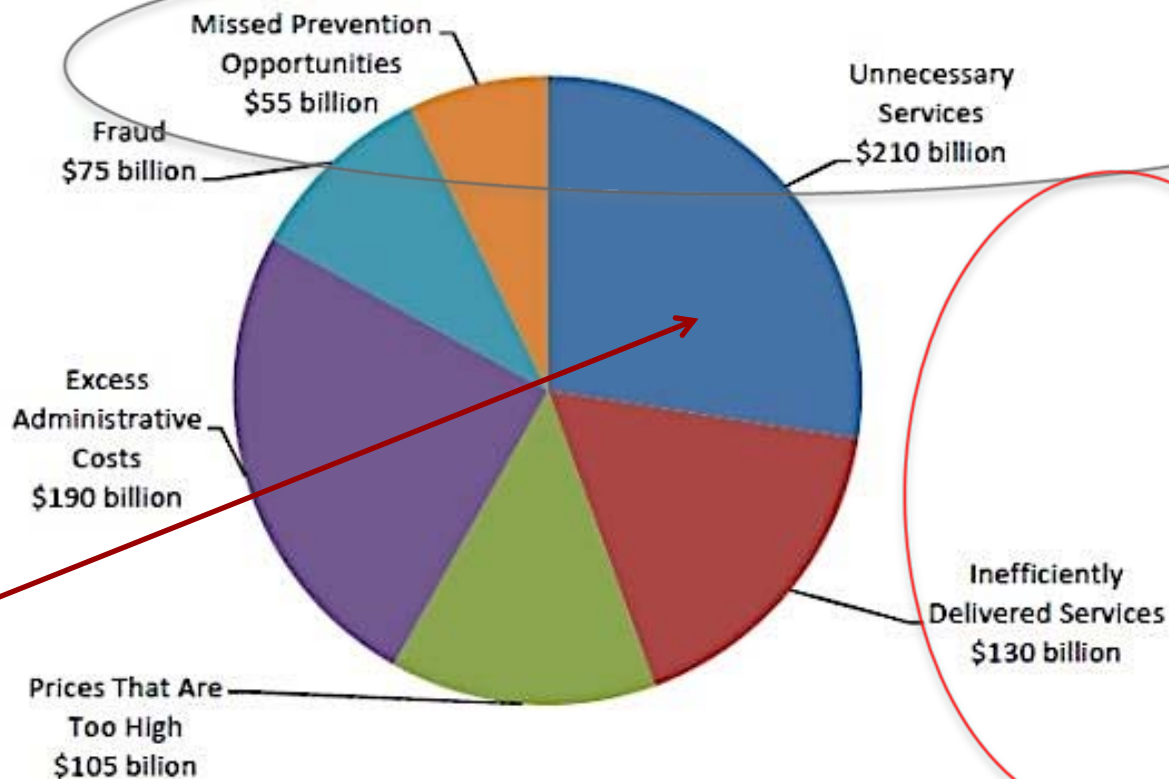
Source: Donald M. Berwick and Andrew D. Hackbarth, “Reducing Waste in Health Care Spending,” , *Journal of the American Medical Association*, April 11, 2012.

# BEST CARE AT LOWER COST



**Institute of  
Medicine  
Study Released  
September 2012**

The Path to Continuously Learning  
Health Care in America

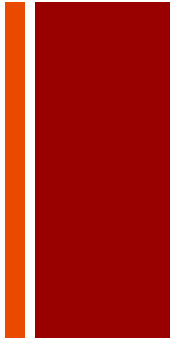


**Targets of  
Opportunity  
For Savings**



# + “Choosing Wisely” Campaign

- **Launched by American Board of Internal Medicine Foundation**
- **More than 35 specialty societies participating**
- **Developed lists: *Five Things Physicians and Patients Should Question* – for each**
- **Examples: colonoscopy; imaging for a headache; pre-term induction of labor; white blood cell growth factors or colony-stimulating factors (CSFs) to boost white blood cells during cancer chemotherapy**
- **[www.choosingwisely.org](http://www.choosingwisely.org)**



# + **Payment Innovation: Improving Value And Affordability**

## **Old Model**

**Reward unit cost**

**Inadequate focus on  
care efficiency and  
patient centeredness**

**Payment for unproven  
services; limited  
alignment with  
quality**

## **New Model**

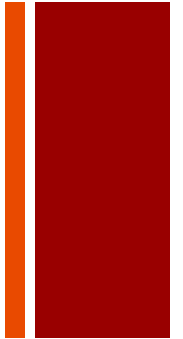
**Reward health  
outcomes and  
population health**

**Lower cost while  
improving patient  
experience**

**Improve quality,  
safety and evidence**



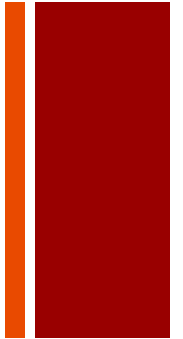
# Simplified Structure of Health Reform



- Move away from **classic fee-for-service** payment – paying for “piece work” when we should pay for “packages”
- Pay health care providers in **new ways** to spur delivery system reform, reward quality, enhance patient care, get rid of waste and slow the growth of health spending
- Innovations in care delivery and payment, such as **Accountable Care Organizations and Patient Centered Medical Homes**
- Various pilot and demonstration projects, some new, some building on experiments tried in previous administrations

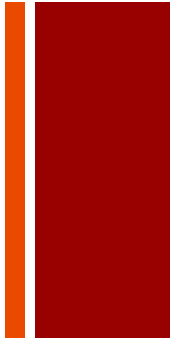
# + Innovations under CMS

- **Accountable Care Organizations, including**
- **Medicare Shared Savings Program (244 organizations)**
- **Pioneer program (23 participants; 9 additional organizations just left program, of which 7 converted to MSSP)**
- **“Advance Payment” ACOs (30 participants)**
- **Total of more than 4 million Medicare beneficiaries participating in all Medicare ACO’s = 7-8 percent of entire fee-for-service portion of program**
- **33 quality metrics**



# + New Pioneer ACO Results, 7.16.13

- **Illustrate successes and challenges**
- **13 of 32 plans saved money (\$87 million gross)**
- **Shared savings = \$33 million for Medicare**
- **Two plans lost money (\$4 million)**
- **Per beneficiary costs grew 0.3 percent versus 0.8 percent for matched beneficiaries**
- **All boosted the quality of care over traditional FFS Medicare and earned quality incentive payments**
- **TK plans did not share savings; 9 left program**
- **7 of the 9 switched to the Medicare Shared Savings ACO's, which aren't expected to move toward capitation**
- **Change is hard, but possible**



# Accountable Care Organizations

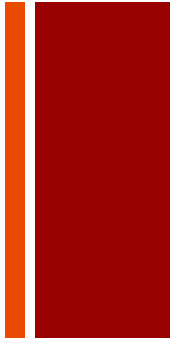
## ACO Principles

- Put the patient and family at the center
- Have a memory about patients over time and place
- Attend carefully to handoffs, especially as patients journey from one part of the care system to another.
- Manage resources carefully and respectfully
- Be proactive
- Be data-rich..
- Innovate in the service of the Triple Aim: better and better patient care, better population health, and lower cost through improvement.
- Continually invest in the development and pride of its own workforce, including affiliated clinicians.

## + **ACOs in Private Sector – e.g., Blue Shield of California**

- **Launched pilot ACO with Dignity Health (formerly Catholic Health Care West) and Hill Physicians in January 2010 for 41,000 CalPERS employees and dependents**
- **Global budget; shared upside and downside risk**
- **Tactics included eliminating unnecessary care, such as excessive bariatric surgery; coordinating processes such as discharge planning; reducing variation in practices and resources; reducing pharmacy costs**
- **2010-11 combined results: \$37 million in savings to CalPERS; compounded annual growth rate for per member per month costs was ~ 3% vs. ~7% for everyone else**

# **+ Medical homes in Private Sector**



- **Alabama Health Improvement Initiative Medical Home Pilot – Blue Cross Blue Shield of Alabama**
- **Health plans in Maryland, Pennsylvania, Ohio, elsewhere reporting savings from medical homes**
- **E.g., in Maryland, CareFirst reported 2.7% savings in health costs for its 1 million members in 2012**
- **E.g., Highmark in Pennsylvania: inpatient acute admissions down 9%; 30-day readmissions down 13%**



# **+ Performance-based Innovations under CMS**

- **Programs to reduce unnecessary readmissions**
- **Partnership for Patients, Community-Based Care Transitions program (organizations paid an all-inclusive rate per eligible discharge based on cost of care transition services)**
- **Medicare penalties: hospitals above certain ratios for 30-day readmissions in 3 conditions (heart attack, heart failure, pneumonia) begin to be penalized under Medicare in October 2012**
- **Readmissions rates in Medicare dropped 1 percentage from an average of 19 percent during 2008-2011 to 17.8 percent in 2012, according to CMS**
- **Declines largest in hospitals participating in Partnership for Patients.**
- **Source: Economic Report of the President, 2013**

**+ Throwing It Up Against The Wall  
To See What Sticks?**

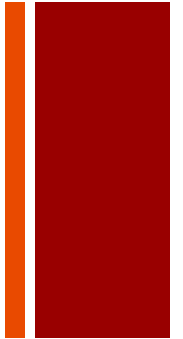


# **+ Need for High Reliability Organizations in Health Care**

- **High reliability = failure free operation over time, according to Institute for Healthcare Improvement**
- **Can be calculated as inverse of failure rate**
- **E.g., Six Sigma organization would have no more than 3.4 errors in every 1 million events**
- **Requires massive culture change; probably cannot be induced via payment changes and penalties alone**

# **+ Case Studies Show the Way**

- **St. Vincent's Medical Center, an Ascension Hospital in Bridgeport, Connecticut**
- **One of a number of Ascension hospitals that experienced declines in avoidable mortality and injury**
- **E.g., in 2010, pressure ulcers system-wide were 94% below national average**
- **Ingredients of change:**
  - **Highly visible CEO and staff living safety as a core value**
  - **Lifetime learning mindset**
  - **Story-telling and transparency**
  - **Daily huddles; “mindfulness”**
- **Source; Joint Commission monograph, “Improving Patient and Worker Safety”**

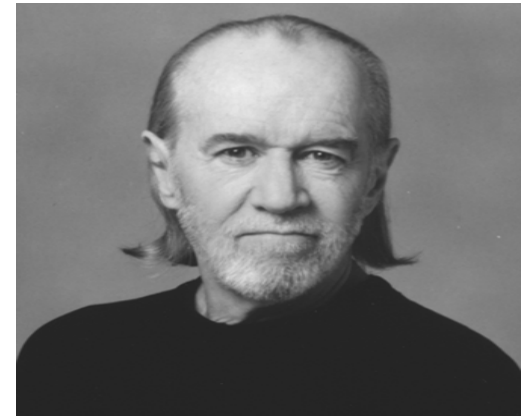




# Some Conclusions



**“I don’t believe there’s any problem in this country, no matter how tough it is, that Americans, when they roll up their sleeves, can’t completely ignore.”**



**The Late Comedian  
George Carlin**

**“The Americans always do the right thing...after they’ve exhausted all the other alternatives.”**



**Sir Winston Churchill**



**“Those who say it can’t be done are usually interrupted  
by others doing it.”**

**--the late James Baldwin, American novelist, essayist  
and playwright**





## **The Final Verdict on National Health Reform?**



**“Somebody has to do something, and it’s just incredibly pathetic that it has to be us.”**

**--the late Jerry Garcia of the Grateful Dead**



The End