

Performance Based Care

Improving Quality While Containing Costs

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Disclosures

- None related to this presentation

Peoria



OSF HealthCare



Primary Goal of Health Care

"Patient relief—here defined as the cure or prevention of disease and the relief of physical and emotional suffering—is the primary goal of health care. ...Practitioners, supported by health care delivery organizations of various types, apply medical knowledge through care processes to individual patients, with the aim of solving those patients' health problems and relieving their distress."

Richard Bohmer, MD
 "Designing Care" Harvard Business Press, 2009

How are we doing?

- Adults in the US received 54.9% of recommended care:
 - Acute care 53.5%
 - Care for chronic conditions 56.1%
 - Preventive Care 54.9%

• The Quality of Health Care Delivered to Adult in the United States
 McGlynn, E. A. et al NEJM 2003; 348:2635-45

Current Systems of Care

- "Out of Control"
- "Inefficient"
- "Unsafe"
- "Poor Quality"
- Patchwork of poorly connected or unconnected parts.
- System has just developed over time and isn't a "system" at all.

US "System"

- Criticized for excess utilization
- Appropriate care frequently not provided
- Providers are paid for units of care (wRVUs) delivered independent of quality or achieved outcomes
- Perversely, poor outcomes may actually generate more payment due to rehospitalizations, or more procedures to correct complications

US "System"

- Care reliability is inconsistent
- Mistakes/Errors are not uncommon
- Fragmentation of delivery systems
 - Who is in charge of care?
- Best Practice Guidelines:
 - Often based on equivocal evidence
 - Often ignored
 - Poorly applied
 - Translation to actual use is difficult and slow paced

3 Fundamental Issues with Care Delivery

- 1 We don't know what to do!**
The knowledge does not yet exist.
- 2 We know what to do but don't apply it!**
We don't do what we know.
Wide variability in utilization.
We may utilize services that afford no benefit.
Benefit of Checklist/ Guideline approach may prevent omissions and work toward "perfect care".
- 3 We know what to do and then do what we know.**
However we don't do it correctly!

Process of Care

- In many instances there are still large gaps in our knowledge.
- Some processes are certainly more obvious and reproducible.
- However others are more obscure and complex and lead to lengthy evaluations.
- Matching knowledge to the patient often requires repeated testing—resulting in trial and error or essentially our care approach becomes a series of "experiments" with each patient evaluated.
 - The "Gregory House Phenomenon"

How can this guy still practice???



Reform Strategies

- Mandates from payers, regulators
 - ? Improve care or limit utilization (e.g. RBM's)
- Public reporting
 - Modest influence to this point on physician or patient behavior.
- Oversight by state licensing, hospital medical staff offices and specialty societies etc :
 - Aimed at identifying and reacting to care failures as opposed to failure avoidance.

What may work

- Databases that allow us to collect data regarding outcomes and allow us to compare our performance against overall observed results.
 - NCDR
 - STS Database
- Allows individual sites of care to look at the care process and hopefully improve care.

Pay for Performance

- Emerged in late 1990s.
- Ideally rewards lead to improved care/quality.
- Generally payer designed and targeted at Primary Care for preventive care in outpatient settings.
- Also looks at OP management of chronic diseases.
- Usually only a small component of providers total compensation currently.

Care Redesign

- Requires infrastructure such as EMR.
- Asks for strict adherence to guidelines.
- Application of specified care processes.
- Reliable delivery of consensus derived or evidence based "best practices".
- Future payment reform may help drive this by moving from a piecemeal formula to outcomes driven results.

How is this achieved?

- Physicians and hospitals work together.
- Physicians and nurses lead the process.
- Health Information Technology is employed.
- All interests are aligned:
 - Patient
 - Physician
 - Hospital
 - Payer

Who has done this?

"We have long known that some places, like Intermountain Healthcare in Utah or the Geisinger Health System in rural Pennsylvania, offer high quality care at costs below average."

President Obama
Sept. 9, 2009

Geisinger HealthSystem

- Located in Central and NE Pennsylvania
 - 650 physicians
 - Insurance Plan with 210,000 members
 - Early adoption of EHR (Epic) in 1995
 - 8 cardiac surgeons (20% of compensation based on achievement of predefined goal including measures of clinical care quality)
- **ProvenCare®**
 - Provider Driven
 - Attempt at evidenced based pay for performance
 - Integrated delivery system
 - Utilizing electronic health record
 - Goal to improve outcomes and reduce resource use
 - Goal to fundamentally alter reimbursement incentives

Operational Flows

- Improving reliability and safety in health care is about designing consistent operational flows.
- An electronic health record is a tool to help create consistent designs, but is not itself the answer.
- Sustained improvement does not rely on: "I'll remember to do it the next time", also does not rely on vigilance and hard work.
- Operational flows make sure that the care we all know should be provided, happens every time.

Geisinger ProvenCare® CABG

- CV Surgeons came together to evaluate care processes.
- All had different care patterns.
- Reviewed current published guidelines and literature
- Surgeons identified a core of 40 items as "best practice" elements of care.
- Baseline measurement of these elements showed compliance with all 40 steps only 59% of the time.

ProvenCare® CABG--40 Elements of Care

1. **Preadmission documentation:**
 - a. ACC/AHA indication
 - b. Screening for and consultation re: IM/IV involvement
 - c. Treatment options and patient preference
 - d. Need for warfarin (anterior MI or wall motion abnormality)
 - e. Current user of clopidogrel or warfarin?
 - f. Screening for stroke risk
 - g. Carotid doppler (if the test is indicated)
 - h. Vascular surgery consultation (if indicated)
 - i. Ejection fraction
 - j. Screening for need to use intra-aortic balloon pump (IABP)
 - k. Screening using epi-aortic echo (as indicated)
 - l. Patient withheld clopidogrel/warfarin for 5 d preoperatively?
2. **Operative documentation:**
 - a. Patient received correct dosing of beta-blocker (preoperative)
 - b. Correct use of intra-aortic balloon pump (preoperative 3 postoperative)
 - c. Preoperative antibiotic (within 60 min of incision; Vancomycin within 120 min)
 - d. Blood cardioplegia (on-pump patients)
 - e. Epi-aortic echo of the ascending aorta and the peer consult
 - f. Intraoperative hyperglycemia screening
 - g. Correct insulin management (as indicated; per protocol)
 - h. Use of LIMA for LAD grafting

3. Postoperative patient documentation:

- a. Anteroapical MI within prior 7 d; postoperative echo
- b. Monitoring for atrial fibrillation for 48 h
- c. Anticoagulation therapy (as indicated)
- d. Antibiotic administered (postoperative for 24–48 h)
- e. Aspirin (6 hours postoperative or 24 h postoperative)
- f. Beta-blocker (within 24 h postoperative)
- g. Statin administered (postoperative)
- h. Surgical debridement and revascularization of any sternal wound infection
- i. Plastic surgery consult regarding ongoing management of sternal wound
- j. Tobacco screening and counseling

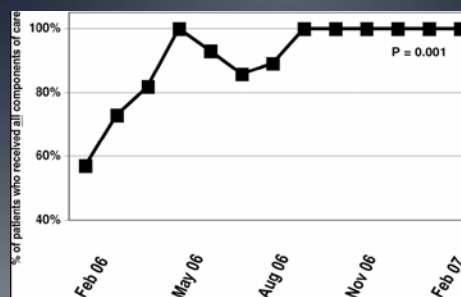
4. Discharge documentation:

- a. Referral to cardiac rehabilitation
- b. Discharge medications (eg, beta-blocker)
- c. Discharge medication: aspirin
- d. Discharge medication: statin

5. Post-Discharge documentation:

- a. Patient correctly taking beta-blocker?
- b. Patient correctly taking aspirin?
- c. Patient correctly taking statin?
- d. Patient correctly administering anticoagulant?
- e. Did patient resume smoking?
- f. Patient enrolled in cardiac rehabilitation?

Reliability with Elements of Care



Casale, AS. Annals Surgery 2007; 813-827

Geisinger-ProvenCare® CABG Clinical Outcomes

	Before ProvenCare® (n=132)	ProvenCare® (n=321)	% Improvement
In-hospital mortality	1.5 %	0.3 %	80 %
Patients with any complication (STS)	38 %	33 %	13 %
Patients with >1 complication	8.4 %	5.9 %	30 %
Atrial fibrillation	24 %	21 %	13 %
Neurologic complication	1.5 %	0.9 %	40 %
Any pulmonary complication	7 %	5 %	29 %
Re-intubation	2.3 %	0.9 %	61 %
Blood products used	24 %	22 %	8 %
Re-operation for bleeding	3.8 %	2.8 %	26 %
Deep sternal wound infection	0.8 %	0.3 %	63 %
Readmission within 30 days	6.9 %	5.6 %	20 %

- ### Geisinger ProvenCare® CABG Financial Outcomes
- Hospital:**
- Net revenue grew 12.3%
 - Direct cost grew only by 5.6%
 - Contribution margin grew 17.6%
 - Total inpatient profit per case improved \$1946
- Health Plan:**
- Cost 4.8% less per case for GHS CABG with ProvenCare® than it would have without
 - Cost 28 to 36% less for CABG with GHS than other providers

- ### Clinical Process Redesign Components of a System of Care
- Established Techniques**
- Guideline Development
 - Education
 - Measurement
 - Timely Feedback of Data
 - Patient Education
- New Techniques**
- Delegated Team Responsibilities
 - Strategies to Pull Patients into Care
 - Non Office Visit Based Care
 - EMR Reminders
 - Pay for Performance

- ### Workflow Principles
1. Automate work that can be done outside of an office encounter.
 2. Distribute work that is done at an office visit to trained non-physician staff when possible.
 3. Create reminders and EMR tools to enhance the reliability and efficiency of care provided at the office encounter.

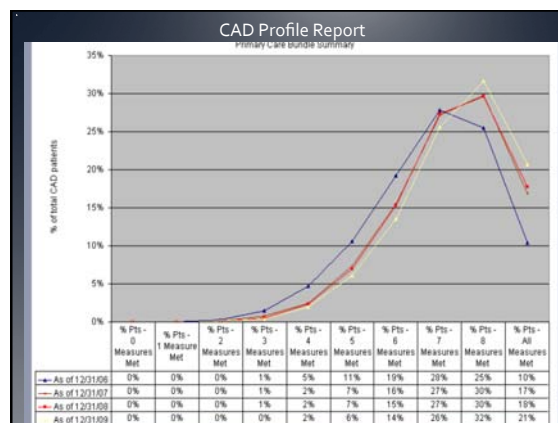
- ### Use of All or None Measures
- Measures the percentage of patients who receive all related services, not the scores of the individual measures.
 - Better reflects the patient's interest and desires – to have all recommended care provided.
 - Encourages a systems approach to achieving all goals rather than work on one measure at a time.
 - Gives a more comprehensive scale for tracking systemic improvements.

All or None Measure

Goal	Non-Smoker	Influenza Immunization	HgbA1c <7	BP < 130/80	LDL < 100	Complete Bundle
Patient 1	Green	Red	Green	Red	Green	Red
Patient 2	Green	Green	Green	Red	Green	Red
Patient 3	Green	Green	Green	Green	Green	Red
Patient 4	Green	Green	Red	Green	Green	Red
Patient 5	Red	Green	Green	Green	Green	Red
Percentage	80%	80%	60%	60%	60%	0%

Even if individual criteria have great results, when calculated as an All or None metric – the need to work differently (systems of care) becomes evident

Improving CAD Care for 14,714 Patients				
	9/06	3/07	12/08	12/09
CAD Bundle Percentage	8%	11%	18%	21%
% LDL <100 or <70 if High Risk	38%	37%	45%	48%
% ACE/ARB in LVSD,DM, HTN	65%	66%	73%	76%
% BMI measured	79%	86%	98%	99%
% BP < 140/90	74%	74%	76%	78%
% Antiplatelet Therapy	89%	91%	91%	92%
% Beta Blocker use S/P MI	97%	97%	96%	97%
% Documented Non-Smokers	86%	86%	87%	87%
% Pneumococcal Vaccination	80%	80%	86%	87%
% Influenza Vaccination	60%	74%	74%	76%



Geisinger Lessons Learned

- It is possible to improve patients' health while reducing costs.
- Requires change in care delivery model.
- Assisted by an EMR.
- Change is not easy.
- Needs active engaged providers with an empowered team that is physician led.

Lessons Learned II

- Transitions of care create specific gaps and opportunities.
 - Example: Heart Failure readmissions
- Patients with very complex conditions need very close follow up through every system of care.
 - Case managers in physician offices
 - Utilization of Home Care providers
- Payment alignment will foster the implementation of these practices.

Summary

- Our current system results in suboptimal care.
- Current payment system does not encourage us to change our pattern of care delivery substantially.
- Looking at our care processes and following the evidence that is available should improve quality and ultimately reduce costs to the system.
- Providers need to prepare now to change our approach to care for our patients.