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B9:
Volume to Value: How Do We Sustain a Patient Focus?

IHI 18th Annual Summit
April 21, 2017

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Objectives

After this presentation, participants will be able to:
1. Describe the ways in which inappropriate quality measures cause harm to patients, primarily through opportunity costs and wasteful overtreatment
2. Understand the ideal features of next-generation quality metrics and share their ideas for meaningful examples of such measures
3. Identify strategies for aligning core elements of patient-centered care (respect, compassion, collaboration, etc.) with the need to provide “value” in health care
I am attending this session...

...the room in Orlando, Florida
Remotely, via live

What is your professional role?

Physician
Nurse
Behavioral Health Clinician
PT/OT/Speech Therapist
Administrator/Manager

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Agenda

• US healthcare characterized by low value
• Strategy: ↓ cost and ↑ quality
• Challenge: who defines quality?
• A “Quality” Morning in Practice
• Most current measures are problematic because they:
  – lack evidence that they correlate with better (meaningful) outcomes for patients
  – cause harms
  – promote waste
  – reduce health care provider satisfaction
  – are not sufficiently patient-centered
• Ideal features of quality measures
• Maintaining a focus on patient-centered care
• Strategies

Life Expectancy at Birth and Health Spending per Capita, 2011

2015 data:
Life Expectancy
US rank: 31

2015 data:
US : $9451
**Why Reform: US Overall Ranking**

<table>
<thead>
<tr>
<th></th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Ranking</strong> (2013)</td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td>5</td>
</tr>
<tr>
<td>Effective Care</td>
<td>3</td>
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<tr>
<td>Safe Care</td>
<td>7</td>
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<td>Coordinated Care</td>
<td>6</td>
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<td>Patient Centered Care</td>
<td>4</td>
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<tr>
<td>Access</td>
<td>9</td>
</tr>
<tr>
<td>Cost Related Problem</td>
<td>11</td>
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<tr>
<td>Timeliness of Care</td>
<td>5</td>
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<tr>
<td><strong>Efficiency</strong></td>
<td>11</td>
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<td><strong>Equity</strong></td>
<td>11</td>
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<tr>
<td><strong>Healthy Lives</strong></td>
<td>11</td>
</tr>
<tr>
<td>Health Expenditures /Capita, 2011</td>
<td>$8,508</td>
</tr>
</tbody>
</table>

http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

**MACRA (QPP) Timeline**

Measurement began January 1, 2017!
QPP Quality Measures 2017

- **ACO: 31 measures**
  - 8 patient/caregiver experience
  - 10 care coordination/patient safety
  - 5 at-risk populations
  - 8 preventive health
- **MIPS: Choose 6**
  - Total: 271
  - Primary Care: 65

DynaMed focus

Diabetes eye exam
Diabetes poor control
HTN control
ASA use for IVD
Depression remission @ 12 mos.

Continuum of Payment Methods:
Moving to Value-Based Payments

Global Payments
Bundled Payments
FFS and Care Management Fee
Fee-for-Service (FFS)
Accountable Care Organizations

• Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients.
• Payments linked to quality improvements that also reduce overall costs.
• Reliable and progressively more sophisticated performance measurement


Payment Reform

Demands

Value

Equals: Plus

Low Costs

High Quality

Current Measures

Care That Matters

... to patients!
Care That Matters

High Quality

Current Measures

Often miss the mark:
• Don’t respect individual patient factors and preferences = not patient-centered
• Undermine motivation and professional autonomy
• Lead to waste and harms

Ring true and therefore:
• Enhance meaning and fulfillment for clinicians
• Enhance intrinsic motivation
• → Increase joy and performance

Value

Low Costs

Equals: Plus

High Quality

Care That Matters

Current Measures

Payment Reform

Demands

Allows for

Produces
Context:

- Payment schemes influence health care delivery.
- Payment schemes are rapidly evolving to value-based models.
- This requires measurement and reporting of quality.
- Rigorous application of EBM principles has improved clinical decision-making.
- Many quality measures have not been similarly evaluated.

Why it Matters:

- Health care systems are likely to “follow the money,” prioritizing activities that help them score well on their quality measures.
- Many quality measures do not correlate with outcomes that matter, such as better health, lower costs, and better experience of care.
- There is growing evidence that many quality measures cause harms, including direct injury to patients and waste.
A “Quality” Morning in Practice
This AM’s Schedule (December 4)

• 63 yo male for diabetes f/u
• 38 yo smoker with ? sinusitis
• 53 yo woman for a physical
• 17 yo female with dysmenorrhea
• 82 yo man with falls

63 yo male for f/u diabetes

• Hx: HTN, neuropathy, nephropathy, depression, poor oral health status, smoking; overwhelmed by complex medication regimen (7 different meds) with resulting poor adherence
• BP **161/98**
• Not on a statin

Relevant measure: PQRS #438:
• Percentage of patients aged 40-75 years with diabetes and LDL 70-189, who were on statin therapy

Problems:
Uncertain benefit
Potential harms from statin
Distraction/Opportunity costs
63 yo male for f/u diabetes

Management options:
• Prescribe a statin and focus visit on reasons to take this at expense of addressing other concerns → “pass” measure
• Don’t prescribe a statin. Instead:
  – Calculate and discuss anticipated benefits/harms from statin → shared decision-making
  – Employ patient-centered approach to identify patient’s goals and priorities
    • Motivational interviewing to help achieve goals
    • Diabetes education as appropriate

17 yo female with dysmenorrhea

• Hx: severe menstrual cramps with heavy bleeding x >6 months. Two months ago: prescribed oral contraceptive, which has helped. Never sexually active.

Relevant measure: MIPS #310:
• Percentage of women 16-24 years old who were identified as sexually active* and who were tested for Chlamydia.

*Includes women prescribed contraception

Problems:
Unnecessary testing
Clinician/patient interests conflict
17 yo female with dysmenorrhea

Management options:
- Order Chlamydia test → “pass” measure
- Don’t order Chlamydia test → “fail” measure

Potential Harms Associated with Unnecessary Testing
- False positive result and subsequent cascade
- Wasteful effort (patient and health care team)
- Waste of resources; increased cost
- May communicate mistrust, thereby harming relationship
- Ordering clinician feels “dirty” or immoral, prioritizing personal interest over interest of patient

→ Contributes to burnout
53 yo woman for “physical”

- Hx: Negative mammogram at age 50; no Fam Hx breast cancer. Caring for elderly father and her grandchildren (daughter with substance abuse problem). Insomnia. Clinician suspects undiagnosed depression +/- anxiety and substance abuse.

Relevant measure: NQF 2372:
- Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the past 2 years

Management options:
1. Schedule mammogram.
2. Tell patient “You are due for a mammogram” and ask “Is it OK if we schedule it?”
3. Engage patient in shared decision-making which includes discussion of potential benefits and harms of mammography.
4. Ignore mammogram issue.

N.B.: Clinician only gets “credit” if she has mammogram.
Harms: Opportunity Costs

• Patient would likely benefit from:
  – more thorough Hx
  – supportive counseling
  – referral for supports, and
  – possibly medication(s) for anxiety +/- depression
• All of these are likely higher priority than mammogram

82 yo man with falls

• Hx: HTN on HCTZ 25 mg daily, lisinopril 40 mg daily, and metoprolol succinate 100 mg daily
• BP 142/90. Pulse 60.

Relevant measure: MIPS #236:
• Percentage of patients 18-85 years old with HTN whose BP was < 140/90 at the last measurement by an eligible clinician
82 yo man with falls

Management options:
1. Intensify treatment by adding a 4th medicine.
2. Record a lower BP, e.g., 138/89. "Gaming"
3. Focus on all factors which may be contributing to falls – including current meds. Consider decreasing meds. The “right” care

... but ... you fail the measure
A Patient’s View of Quality:

- I can get an appointment
- I am treated with dignity and respect
- I am as involved as I want to be in decisions about my care
- As a person with long term condition/s I have a care plan that I was involved in creating
- I know who is coordinating my care, and they do it well
- As a carer/relative, I feel involved and supported
- The help and treatment I get makes me feel better
- I feel in control of my daily life
- As a bereaved person I feel that my dying relative was treated with dignity and respect
- As a bereaved person I feel that services worked well together in the last few months of my dying relative’s life.


<table>
<thead>
<tr>
<th>Suggested Patient-Centered Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medication reconciliation in home after discharge</td>
</tr>
<tr>
<td>• Home visits for indicated patients and coordinated care to meet their needs</td>
</tr>
<tr>
<td>• Screening for and addressing fall risk</td>
</tr>
<tr>
<td>• Patient self-assessment of health status (change over time)</td>
</tr>
<tr>
<td>• Reduction of food insecurity</td>
</tr>
<tr>
<td>• Ability to chew comfortably and effectively with dentition</td>
</tr>
<tr>
<td>• Vision assessment and correction in place (e.g., patient has satisfactory glasses)</td>
</tr>
<tr>
<td>• Hearing assessment and correction in place (e.g., patient has satisfactory hearing aids)</td>
</tr>
<tr>
<td>• Reduction in tobacco use</td>
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<tr>
<td>• Reliable access to home heating and cooling</td>
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<tr>
<td>• Reliable transportation to appointments</td>
</tr>
<tr>
<td>• Provision of effective contraception</td>
</tr>
<tr>
<td>• Effective addiction care</td>
</tr>
<tr>
<td>• Effective chronic pain care</td>
</tr>
</tbody>
</table>

Problems with Health Care Quality Measures

- There are **too many**
  - Administrative burden
  - Opportunity costs
- They often **assess the wrong things** ...
  - By design: Surrogate endpoints
  - Unintentionally: Subject to gaming
- Most are **not sufficiently patient-centered**
- Sometimes they **create conflict** between the interests of the patient and those of the clinician
- They are often **applied inappropriately**:
  - Used in P4P
  - Don’t account for locus of control
  - Ignore social determinants of health and risk adjustment

Measurement Proliferation

- **546 distinct performance measures**
- Among 23 health plans serving 121 million commercial enrollees (= 66% of national commercial enrollment)
- Despite common areas of focus: CVD, DM, preventive services


**Federal agencies use 1700 measures.***

**DATAWATCH**

**US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures**

Each year US physician practices in four common specialties spend, on average, **785 hours per physician** and more than **$15.4 billion** dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.

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**EXHIBIT 1**

Hours spent per physician per week dealing with external quality measures, 2014

- 15.1 hours per week
- Physicians: 2.6 hours
- = 9 patients not seen

The current system is far from being efficient and contributes to negative physician attitudes toward quality measures.

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*Health Affairs, 35, no.3 (2016):401-406*
## Harms Associated with Inappropriate Performance Measures

- **Direct harms to patients**
  - Falls associated with hypotension, hypoglycemia
  - False positives associated with excessive screening
  - Overdiagnosis/overtreatment of indolent conditions identified by screening

- **Wasteful testing**
  - Excess A1cs, Mammography, etc.

- **Opportunity costs**
  - Spending resources (time, $) on unhelpful activities makes those resources less available for more meaningful activities

- **Physician burnout**

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“Our businesslike efforts to measure and improve quality are now **blocking the altruism**, indeed the love, **that motivates people to enter the helping professions.** While we’re figuring out how to get better, we need to tread more lightly in assessing the work of the professionals who practice in our most human and sacred fields.”

---

“Demoralizing physicians”

“Tethering physicians’ rewards to box checking and redundant documentation risks both substituting insurers’ priorities for patients’ goals and demoralizing physicians. Pay for performance can crowd out intrinsic motivation that keeps us doing good work even when no one is looking. A growing body of behavioral economics research indicates that when preexisting motivation is high, monetary incentives often undermine performance on complex cognitive tasks.”


Current “Quality” Metrics ...

- Are too numerous
- Are often inappropriately applied at the level of individual clinicians
- Lack evidence that they correlate with better health
- Compromise the patient-physician relationship
- Contribute to provider burnout
- Motivate diversion of resources and efforts away from more meaningful interventions
- Do not typically address harms associated with overtreatment
- Were often developed by prioritizing expediency
Streetlight Effect = Observational Bias

A policeman sees a drunk man searching under a streetlight and asks what he has lost. The drunk says he lost his keys, and they both look under the streetlight together.

After a few minutes, the policeman asks, “Are you sure you lost them here?”

The man replies, “No, I lost them in the park.” The policeman asks, “why are you searching here?”

The drunk replies, "this is where the light is."
Quality measures should …

- Be based on solid evidence that they correlate with better outcomes:
  - Better health
  - Lower costs
- Be applied in a manner that respects the fact that individual patient factors (including patient preference) sometimes supersede population-level recommendations
- Not create situations in which the doctor’s interests conflict with those of the patient
- Be applied at the appropriate level

Quality measures should be applied at appropriate levels

- “Aligning payment systems and incentives with triple aim goals for organizations makes sense.”
- “Complex incentive programs for individual clinicians … are confusing, unstable, and invite gaming.”

Harms (and Waste) in Healthcare

Direct Injury
- Adverse effects associated with appropriate Tx
- Adverse and “desired” effects associated with inappropriate Tx: Overdiagnosis, Overtreatment:
  - Treating risk factors
  - Treating to address surrogate measures
  - Treating indolent conditions

Opportunity Costs
- Spending resources (time, $) on unhelpful activities makes those resources less available for more meaningful activities

Pursuit of poor quality measures can drive all of these
Care That Matters

- A group of clinicians committed to better health for our patients and appropriate stewardship of health care resources.
- We seek to achieve these outcomes through advocacy regarding a new generation of health care quality measures.
- Appropriate quality measures ...
  - are supported by evidence that they correlate with better health.
  - do not create situations in which the doctor’s interests conflict with those of the patient
  - acknowledge the importance of individual patient factors and promote shared decision-making

Carethatmatters.org

Table 1. Ways targets distort care (see S1 Table for further detail and references).

<table>
<thead>
<tr>
<th>Predictable Distortion</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritizing faster care for healthier people</td>
<td>Focus on moving a healthy patient’s systolic blood pressure from 141 mm Hg to 128 mm Hg, thereby crossing the 140 mm Hg threshold, rather than help someone with a heart attack history improve from 180 mm Hg to 155 mm Hg.</td>
</tr>
<tr>
<td>Overtesting</td>
<td>Repeat colon cancer screening too early if prior test not billed for by current insurer; evidence of excess testing [27]. Frequent testing of low-density lipoprotein (LDL) or hemoglobin (Hgb) A1c levels despite no known health benefit.</td>
</tr>
<tr>
<td>Distortion of informed consent</td>
<td>Test all age-eligible adolescents for chlamydia even if they deny sexual activity.</td>
</tr>
<tr>
<td>Overmedication</td>
<td>Use antihypertensive medication other than metformin to lower HgbA1c levels in type 2 diabetes, despite limited evidence of benefit and significant risk of harm [21, 22].</td>
</tr>
<tr>
<td>Distraction from patients’ needs</td>
<td>Focus on surrogate markers rather than what is meaningful to the patient (which is likely not a performance measure).</td>
</tr>
<tr>
<td>Fixed sense of actual impact</td>
<td>Follow performance measure that is incentivized rather than a meaningful one, such as smoking cessation, which is not incentivized.</td>
</tr>
<tr>
<td>Privilege process rather than experience of care</td>
<td>Certify that a stated well-child visit has happened, not that it was thoughtful, compassionate, effective, and meaningful.</td>
</tr>
<tr>
<td>Expansion of denominator of those who are considered “at-risk”</td>
<td>Include patients who marginally meet criteria for diabetes or hypertension, thus increasing the proportion of patients with mild, easily controlled disease and assuming that practices have greater proportions of patients who meet a performance measure.</td>
</tr>
</tbody>
</table>

http://journals.plos.org/plosmedicine/article?id=info:doi/10.1371/journal.pmed.1001902
## Comparison of typical performance measures and author recommendations.

<table>
<thead>
<tr>
<th>Current Approaches</th>
<th>Recommended Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binary (cut-point) thresholds of risk</td>
<td>Continuous measures of risk</td>
</tr>
<tr>
<td>Surrogate outcomes</td>
<td>Patient-centered outcomes</td>
</tr>
<tr>
<td>No accounting of staff effort required to impact</td>
<td>Accounting of staff effort</td>
</tr>
<tr>
<td>performance measure</td>
<td></td>
</tr>
<tr>
<td>Lack of emphasis on shared decision-making and</td>
<td>Individualization and shared decision-making as a</td>
</tr>
<tr>
<td>elicit patient preferences</td>
<td>default expectation</td>
</tr>
<tr>
<td>No articulation of NNT, NNH, NNS</td>
<td>Transparency and referencing of NNT, NNH, NNS</td>
</tr>
<tr>
<td>Measures focused on individual risk factors</td>
<td>Aggregate risk measures</td>
</tr>
<tr>
<td>Isolated morbidities</td>
<td>Recognition that multimorbidity may modify or</td>
</tr>
<tr>
<td></td>
<td>invalidate some measures in individuals</td>
</tr>
<tr>
<td>No accounting for social determinants of health</td>
<td>Inclusion of social determinants of health</td>
</tr>
<tr>
<td>Multiple metric sources with varying biases and</td>
<td>Single, independent, transparent, unbiased source</td>
</tr>
<tr>
<td>transparency</td>
<td></td>
</tr>
</tbody>
</table>

* NNT: number needed to treat; NNH: number needed to harm; NNS: number needed to screen

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An evidence-based analysis of health care quality measures is necessary to:

- Inform the selection of measures that should be prioritized
- Foster a more deliberate approach to the creation, assessment, and implementation of health care quality measures
- Facilitate advocacy for:
  - Adoption of more meaningful measures, i.e., those that are likely to induce improvements in health or costs
  - Retirement of poor measures that may contribute to waste and harms

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http://journals.plos.org/plosmedicine/article?id=info:doi/10.1371/journal.pmed.1001902
Criteria for appropriateness of a quality measure:

1. Convincing evidence that action changes clinical outcome.
2. Convincing evidence that desirable consequences outweigh undesirable consequences (including consideration of quality measure implementation).
3. The population is adequately specified, including appropriate exclusion criteria.
4. The intervention is adequately specified.

- All 4: Appropriate
- 1 and 2, but not 3 or 4: Modification Suggested
- Not 1 or 2: Inappropriate

**MIPS Primary Care (n=65)**

- Met Criteria
- Modification Suggested
- Criteria Not Met

Per DynaMed Plus analysis, March 2017
Next Steps

- Grade measures with a standardized rubric that considers:
  - Evidence of impact
  - Clarity of criteria for numerator and denominator
  - Harms
  - Waste
  - Gameability

- Use grades to:
  - Help clinicians choose their own measures
  - Influence prevailing measures (CMS):
    - Eliminate poor ones
    - Develop and offer better ones

---

**Annual Call for Measures and Activities** *(from CMS*)

- The process allows clinicians and organizations ... to identify and submit quality measures. *(Submission deadline June 30, 2017)*
- Based on stakeholder feedback, we generally select measures and activities that are determined to be applicable, feasible, scientifically acceptable, reliable, valid at the individual clinician level and do not duplicate existing measures and activities for notice and comment rulemaking. This means that a recommended list of new measures and activities are publicly available for comment for an established period of time. Comments received through the rulemaking process are evaluated before a final selection.
- A final annual list of measures and activities for MIPS eligible clinicians will be published in the Federal Register no later than November 1 of the year prior to the first day of a performance period. This means that MIPS quality measures for performance periods in 2018 will be posted by November 1, 2017.
- CMS provides an opportunity for stakeholders to provide input on proposed measures via the notice and comment rulemaking to establish the annual list of quality measures. Additionally, CMS is required by statute to submit new measures to an applicable, specialty-appropriate peer reviewed journal.

The Quality measures performance category focuses on measures in the following domains:

1. Clinical care
2. Safety
3. Care Coordination
4. Patient and Caregiver Experience
5. Population Health and Prevention
6. Affordable Care

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* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MIPS/CallForMeasures.html

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**CMS wants** our input
If you hear the phrase "patient-centered," what comes to mind?

Start the presentation to activate live content

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The 10 "rules," please select the 3 that you consider most valuable or important:

Start the presentation to activate live content

If you see this message in presentation mode, install the add-in or get help at PHIE.com/app.
“Rules” to guide interactions with patients, organized by five elements that produce patient-centered interactions:

**Respect:**
1. Every patient should be respected as an expert in herself/himself.
2. The patient’s goals related to health and health care should be elicited and clarified; achieving these goals should be the primary focus of care provided.

**Expertise:**
3. Interventions suggested by clinicians should always be based on the best available evidence.
4. Honesty, humility, and transparency are essential; areas of uncertainty should be disclosed and the potential harms of health care interventions should be acknowledged.

**Communication:**
5. Shared decision-making should be the “default” approach to clinical decisions. Some patients may prefer a more passive role; this should be respected.
6. Clinicians are responsible for creating opportunities for shared decision-making; patients should make decisions informed by the relevant medical facts and their own values and preferences.

**Partnership:**
7. A key part of our work is to promote patient engagement and activation.
8. Clinical encounters should be approached as a dialog between two experts: the clinician who has medical knowledge and expertise and the patient who is an expert in herself/himself and has a unique set of personal and cultural values and preferences.

**Compassion:**
9. Patients don’t care how much you know until they know how much you care.
10. Listen – generously and with compassion.

---

**Discussion Questions**

1. How will you align patient-centered care (respect, compassion, collaboration, etc.) with the need to provide “value” in health care?
2. What are you currently doing at your organization to address patient centered quality metrics in your “homes?”
3. What is working well? What are some best practices you have identified?
4. What are you worried about? What are some barriers and challenges?
5. How should we respond when “quality” metrics conflict with patient-centered care?
6. What questions do you still have?

Discuss at your table for 10 - 15 minutes.
You decide which questions you want to address.
Get Involved

• [http://www.carethatmatters.org/](http://www.carethatmatters.org/)
• [http://lowninstitute.org/](http://lowninstitute.org/)
  – Right Care Alliance Primary Care Council
• [http://www.choosingwisely.org/](http://www.choosingwisely.org/)
• High-Value Care: [https://hvc.acponline.org/](https://hvc.acponline.org/)
• National Physicians Alliance: [http://npalliance.org/](http://npalliance.org/)

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