Ensuring the Benefits of Public Reporting and Pay-for-Performance Programs Outweigh the Unintended Consequences

PATRICIA DONOVAN: This is Patricia Donovan from the Healthcare Intelligence Network. Today I am speaking with Dr. Dale Bratzler, medical director of the Hospital Interventions Quality Improvement Organization Support Center and the Hospital Quality of Care Measures Special Study. Dr. Bratzler is presenting at HIN's audio conference on, "Ensuring the Benefits of Public Reporting and Pay-for-Performance Programs Outweigh the Unintended Consequences." Thank you for joining me today Dr. Bratzler.

DR. DALE BRATZLER, MEDICAL DIRECTOR OF THE HOSPITAL INTERVENTIONS QUALITY IMPROVEMENT ORGANIZATIONS SUPPORT CENTER: It's my pleasure.

PATRICIA DONOVAN: To begin with, I would like to talk for a moment about the results of the University of Pennsylvania's School of Medicine Study that was released in December 2006. The study found that mortality rates of patients being treated at hospitals that ranked high on a CMS website of quality of care measures were only slightly better than mortality rates for patients being treated at the lowest ranked hospitals. Do these findings tell us anything about the health care industries' focus on these ratings?

DR. DALE BRATZLER: I thought it was a very good study and truly the results of the study from the University of Pennsylvania were not surprising. So in that study basically they demonstrated that high performance on the current process of care measures that are reported on hospital compare predicted only slightly differences in mortality rates between hospitals. And this again is just simply not surprising. So let's talk acute myocardial infraction, for example. Currently, the Medicare Program and the Joint Commission and others have 8 core measures that we focus on for

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acute MI care. Essentially 4 aspects of care that happen at the time the patient is admitted, essentially care in the emergency department, and 4 things that focus on care that's given to the patient at least either at the end of the stay or at the time of hospital discharge. The current measures that are used, these core measures completely ignore all of the other aspects of care that are given to the patient during the hospital stay.

So for instance, we have no measures of quality for what happens during the patient's stay if they're in the intensive care unit. We currently have no reported measures of quality that focus on the quality of care that's given to a patient who is in the cardiac cath lab. We don't look at the subsequent floor care of the patient, once they leave the intensive care unit after a myocardial infraction. We currently have no processes of care that focus on the care that the patient gets at the time of the actual discharge. We know whether or not they may have gotten some discharge instructions about things such as smoking counseling but we really don't know how well the patient understood their discharge instructions, whether they took their medications, whether they followed up on the outpatient basis. So the fact that these in patient process of care measures don't well predict mortality are differences between hospitals with respect to mortality wasn't surprising because we focus on such a limited amount of hospital care with the current core measures that are publicly reported.

PATRICIA DONOVAN: Thank you doctor. If you can just follow up on that, on the discharge aspect there, that seems to be a point where some of these transitions in care do go awry. Do you have any recommendations for what should happen at that point?

DR. DALE BRATZLER: Yes, so we think this is actually one of the really hottest areas of current research in the quality improvement world and that's focusing on the continuum of healthcare of patients and in particular focusing on transitions

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of care. We know that commonly patients are given instructions at the time of discharge. But often times, they really don't understand them very well. They may not understand what medications they're supposed to take. They may not clearly understand when they're supposed to follow up with their primary care physician. And researchers have developed survey instruments that have demonstrated that when you survey patients after they leave the hospital, and demonstrate that they really did not understand their discharge instructions. They're more likely to be readmitted to the hospital. So we think there has to be much, much more emphasis on aspects of care that may result in better transitions from the in patient setting to subsequent levels of care. For instance, some investigators right now are looking into specific efforts to go into the patient's home and follow up and do medication reconciliation once they get home, make sure they really do understand their discharge instructions, that they've filled their prescriptions that they've made appointments to follow up with their primary care physician. Some are using home health agencies for this type of activity. It's just very, very important that we ensure that that transition from the inpatient setting to the subsequent outpatient of other setting of care goes smoothly. That there's good communication of all the information the patient needs, their family, and other care givers need to subsequently provide care to the patient.

PATRICIA DONOVAN: Thank you doctor. Just getting back to the quality initiative. Hospitals often encounter skepticism or resistance from physicians on staff when they begin to publicize their quality ratings. What education and/or cultural change has to occur in order to engage physicians and get their support and avoid some unintended consequences in that area?

DR. DALE BRATZLER: I actually think that cultural change is slowly happening as more and more health care providers now are clearly aware that there is this demand for accountability for health care. So we know that consumers payers, policy makers and

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others are insisting that we start measuring and reporting the quality of health care. That it's transparent. So I actually find increasingly that physicians, nurse and other health care providers understand that the quality of care that they give will be evaluated and likely publicly reported. So I think the first thing is just understanding, making sure that medical staff understand that transparency in health care quality I think is here to stay. It's not going to go away. The best way to deal with it is to focus on the systems that assure good quality of care for the patient. The other things that I think are helpful, I think it's increasingly interesting that more and more people who set policy within institutions such as a hospital are involved in thinking about quality and driving and demanding quality actually focusing on quality of care. So for me it's been quite interesting watching the interaction of hospital boards around quality.

We know now from a number of studies that in high performing hospitals there's typically a great deal of engagement of the hospital board of directors in quality and how does that drive the culture? Well I think culture has to be absolutely driven from the top of the organization, that it has to become evidence throughout the entire organization that quality of care is really a priority for the institution. And that's a policy that the board can set. They can hold people accountable in management from the CEO to the Chief Medical Officer and others to understand that quality is really job one for the organization. That patient outcomes are the business of the organization and setting that culture that permeates the entire institution that everybody understands that their primary responsibility is to provide high quality care, really can help change that culture.

And finally I think other ways that culture can really be driven is by mechanisms that we've known for some time to be very useful. Identifying physician champions, peers on the medical staff and others that really care about the quality of care, that

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understand the performance measures, the evidence that supports them and specifically help to drive performance improvements through education of their peers through example helps to drive quality improvement. One of the things that we've been concerned about for some time is that the desire to achieve high levels of performance on some of these measures of quality can potentially relate in unintended consequences. What we really hope through the measurement development process and quality measurement and quality reporting is that providers that care really focus on giving the best possible care to the patients and if they do that, they'll typically score very well on the performance measures.

PATRICIA DONOVAN: Do you think this concept of quality is trickling down to the medical schools as well?

DR. DALE BRATZLER: I think so perhaps not as quickly as we would like. We certainly know that from a variety of studies including one that the Institute of Medicine published sometime back showed that one of the things that we really need to think about in medical education is teamed based training. In other words, for so long, most of the training of healthcare professionals, nurse, physical therapists, physicians and others has been done in silos with little interaction during the actual training.
And yet at day one of their practice of physician is thrown into a setting where they're now supposed to go in and work with nurses, physical therapists, dieticians, and others and have little consistent exposure to real team building skills that they need to actually provide high quality care for patients.

So there's a growing recognition that in medical education and when I say medical education I include physicians nurses, other health care professionals, there needs to be actual building of team based skills to work together to really ensure high quality care for patients. Let's face it there's too much to remember in medicine today. No one can do it by themselves. You have to

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pull people together working as teams really to achieve high levels of quality care.

PATRICIA DONOVAN: Thanks Dr. Bratzler. On that note, in fact, in pulling the University of Pennsylvania study, at their medical school their publication, cover story is on the team based training that's part of their medical school program now.

DR. DALE BRATZLER: I think team based training is going to be absolutely essential in getting to really high levels of care. I mean in many of the areas that we focus on for measuring quality now in the Medicare program and others, we know that the institutions that really do well on these performance measures have stay down in teams and figured out the best way to provide consistent care to the patient. So they no longer rely on memory but that high quality is built into the daily routine of care.

PATRICIA DONOVAN: I see. Thank you. And finally doctor, I have one question and that is do you have any advice or resources for consumers who are reviewing this quality data to help them navigate this information and avoid of the direct or indirect harm that you've been discussing?

DR. DALE BRATZLER: There's certainly a proliferation of reports on quality of care in health care. Some that are quite credible and others that although they may be good measures of quality, often times are built in what we'd call a black box, in other words we don't know the methodology for the performance measurements. So it's challenging to know whether it really provides good measures of quality of care. So where do I recommend the consumers go? Well there are groups that I think are very important. Certainly there have been many organizations that have been routinely providing data on quality of care for quite some time. I think those are very, very valuable. The Joint Commission for example, on hospital care, The Hospital Quality Alliance, The Hospital Compare website that resides on

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the CMS website, Nursing Home Compare, Dialysis Compare are other sites that CMS has that helps provide real credible information about the quality of dialysis service, nursing home services and again hospital services on hospital compare.

Another thing that I always advise consumers to think about is that when they look at quality measures ideally they're looking at measures that have the endorsement of the national quality forum. The national quality forum endorsement essentially means that the measure is in the public domain, that the methodology for the performance measure is open, that it can be easily accessed. And so I think it's very, very important for consumers to look for measures that have that seal of approval if you will, and that would be endorsement by the National Quality Forum. Certainly there are other organizations that provide quality metrics, the National Committee on Quality Assurance for Health Plans I think is very useful information. So again finding credible sources, organizations that have been in the business of measuring quality for many years that have been releasing reports that have taken the time to take their performance measures through the process of getting endorsement by the National Quality Forum is a good place to start to get so you know you have good measures of health care quality.

PATRICIA DONOVAN: Thank you doctor. Those are all the questions that I have today. I wanted to thank you for being with us. And we look forward to hearing more from you during the audio conference.

DR. DALE BRATZLER: It would be my pleasure.

PATRICIA DONOVAN: To register or get more information about this conference, please call 1-888-446-3530. This is Patricia Donovan for the Healthcare Intelligence Network.

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