The American Health Care Landscape

How Does Quality Fit In?

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Stamford Health

UHF / GNYHA Clinical Quality Fellowship Program
March 17, 2022
Overview

• Quality and the health care landscape
• Quality and health care reform
• Is quality in the US working?
• Quality in a pandemic era

Financial Disclosures: None
The Health Care Triangle

Access

Quality

Cost
Institute of Medicine

Quality

Definition

• “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”

Aims for 21st century health care

– Safe
– Timely
– Effective
– Efficient
– Equitable
– Patient-centered

Source: Crossing the Quality Chasm, IOM, 2001
A “P” Soup Approach

- Purchasers
- Patients
- Police (Regulators)
- Product manufacturers
- Payers
- Providers
- (Professors)
Total national health expenditures, US $ Billions, 1970-2019

2020:
➢ $4.1 trillion
➢ 19.7% of gross domestic product

-Hartman M, et al, Health Affairs, Jan ‘22

Notes: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

Source: KFF analysis of National Health Expenditure (NHE) and BEA data • Get the data • PNG

Year-over-year growth in health services spending, Q1 2010 - Q3 2020

Note: Does not include spending on social assistance

Source: KFF analysis of Quarterly Services Survey (QSS) • Get the data • PNG

Average annual growth rate for select service types, 1970 - 2019

Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

Health consumption expenditures per capita, U.S. dollars, PPP adjusted, 2020 or nearest year

<table>
<thead>
<tr>
<th>Country</th>
<th>Expenditure ($USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$11,945</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$7,138</td>
</tr>
<tr>
<td>Germany</td>
<td>$6,731</td>
</tr>
<tr>
<td>Netherlands</td>
<td>$6,299</td>
</tr>
<tr>
<td>Austria</td>
<td>$5,699</td>
</tr>
<tr>
<td>Sweden</td>
<td>$5,754</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>$5,736</td>
</tr>
<tr>
<td>France</td>
<td>$5,564</td>
</tr>
<tr>
<td>Belgium</td>
<td>$5,458</td>
</tr>
<tr>
<td>Canada</td>
<td>$5,370</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$5,268</td>
</tr>
<tr>
<td>Australia</td>
<td>$4,919</td>
</tr>
<tr>
<td>Japan</td>
<td>$4,691</td>
</tr>
</tbody>
</table>

Notes: U.S. value obtained from National Health Expenditure data. Data from Australia, Belgium, Canada, Japan, and Switzerland are from 2019. Data for Australia, France, and Japan are estimated. Data for Austria, Canada, Germany, Netherlands, and Sweden are provisional. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of National Health Expenditure (NHE) and OECD data • Get the data • PNG

Overall, participants received 54.9 percent of recommended care.

"Health care in the United States is not as safe as it should be--and can be...as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented..."

Institute of Medicine, 1999
"El Paso County, eight hundred miles up the border, has essentially the same demographics... Yet in 2006 Medicare expenditures (our best approximation of over-all spending patterns) in El Paso were $7,504 per enrollee—half as much as in McAllen. An unhealthy population couldn’t possibly be the reason that McAllen’s health-care costs are so high."
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2011, 2016, and 2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Worker Contribution Increase</th>
<th>Employer Contribution Increase</th>
<th>Total Premium Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$4,129</td>
<td>$10,944</td>
<td>$15,073</td>
</tr>
<tr>
<td>2016</td>
<td>$5,277</td>
<td>$12,865</td>
<td>$18,142</td>
</tr>
<tr>
<td>2021</td>
<td>$5,969</td>
<td>$16,253</td>
<td>$22,221</td>
</tr>
</tbody>
</table>

20% Total Premium Increase
28% Worker Contribution Increase
13% Worker Contribution Increase

We spend more on health care than we do on defense!

A. True
B. False
Public Hospital Report Cards

Report on Report Cards
Are you confused yet?
Different hospital report cards use different scoring methodologies, with varied results...

Hospital & Scores (alphabetical)

CR    NAIGARA    TIC    USHWR    LEAPFROG    HEALTHGRADES

32 Recognized  Top 5  C  Top 50

HOSPITAL SAFETY SCORE
A
B
C
D
F
Score Pending
“Consumer” Choice Constraints

Choice
• Geography
• Health plan

Practical
• Cost
• Health literacy
• Rationality

“By exploring the consequences of limited rationality, social preferences, and lack of self-control, he has shown how these human traits systematically affect individual decisions as well as market outcomes.”

The Police (Regulation)

The Quality Room
Some Recent Quality Milestones

1999

As many as 98,000 people die in hospitals each year as a result of medical errors...

• Joint Commission
• National Patient Safety Goals
• Quality measure proliferation
• “Never” events

2003

Medicare Modernization Act

• Public reporting
• Pay for performance
• National Quality Forum growth
• Patient experience

2010

Affordable Care Act

• Value based payment
• Accountable care
• Delivery system reform efforts
KFF Uninsured Rates for the Nonelderly by Age | KFF

Timeframe: 2019

Available at, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-age/?activeTab=map&currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed February 17, 2022.
## Federal Quality Programs
Originated or Continued via the Affordable Care Act

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Inpatient Quality Reporting Program</th>
<th>Value Based Purchasing</th>
<th>Readmissions Reduction</th>
<th>Hospital Acquired Conditions Reduction</th>
<th>Physician Quality Reporting System → MACRA → QPP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital</td>
<td>Hospital</td>
<td>Hospital</td>
<td>Hospital</td>
<td>Ambulatory</td>
</tr>
<tr>
<td>Inception Year</td>
<td>CY 2004</td>
<td>FFY 2013</td>
<td>FFY 2013</td>
<td>FFY 2015</td>
<td>CY 2007 (PQRS) CY 2017 (MACRA)</td>
</tr>
<tr>
<td>Current Measures</td>
<td>&gt; 50</td>
<td>~ 20</td>
<td>~ 6</td>
<td>~ 6</td>
<td>&gt; 300</td>
</tr>
<tr>
<td>Focus Areas</td>
<td>Care processes, costs, experience, outcomes, patient satisfaction, efficiency, readmission, volume</td>
<td>Clinical care processes, experience, outcomes, patient satisfaction, efficiency</td>
<td>CABG, COPD, heart attack, heart failure, joint replacement, pneumonia</td>
<td>Complications, infection rates</td>
<td>Specialty specific quality measures</td>
</tr>
</tbody>
</table>

- Excludes related state programs
- Excludes programs in health plan, long term care, home health, and other settings
VALUE-BASED PROGRAMS

**LEGISLATION PASSED**

- **2008**: MIPPA
- **2010**: ACA
- **2012**: PAMA
- **2014**: MACRA

**PROGRAM IMPLEMENTED**

- **2008**: ESRD-QIP, HVRP
- **2010**: HAC
- **2012**: VM
- **2014**: SNF-VBP
- **2015**: APMs
- **2018**: MIPS

**LEGISLATION**

- **ACA**: Affordable Care Act
- **MACRA**: the Medicare Access & CHIP Reauthorization Act of 2015
- **MIPPA**: Medicare Improvements for Patients & Providers Act
- **PAMA**: Protecting Access to Medicare Act

**PROGRAM**

- **APMs**: Alternative Payment Models
- **ESRD-QIP**: End-Stage Renal Disease Quality Incentive Program
- **HACRP**: Hospital-Acquired Condition Reduction Program
- **HRRP**: Hospital Readmissions Reduction Program
- **HVB**: Hospital Value-Based Purchasing Program
- **MIPS**: Merit-Based Incentive Payment System
- **VM**: Value Modifier or Physician Value-Based Modifier (PVBM)
- **SNF-VBP**: Skilled Nursing Facility Value-Based Purchasing Program

What Percent of Reimbursement Can a Hospital Lose Under the ACA’s Quality Programs?

• A. About 0.6%
• B. About 6%
• C. About 16%
• D. About 26%
• E. All of it!

The losses above are applicable to Medicare payments only.

A. True
B. False
### National Clinical Effectiveness Results

Table 2. Performance Rates for Process-of-Care Measures among Patients Hospitalized for Acute Myocardial Infarction, Heart Failure, or Pneumonia, According to Race or Ethnic Group, 2005 and 2010.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>percent</td>
<td>percentage points (95% CI)</td>
<td></td>
<td>percent</td>
<td>percentage points (95% CI)</td>
<td></td>
<td>percent</td>
<td>percentage points (95% CI)</td>
<td></td>
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<tr>
<td>Acute myocardial infarction</td>
<td></td>
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<td></td>
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<tr>
<td>Administration of aspirin at arrival</td>
<td>95.3</td>
<td>98.9</td>
<td>3.8 (3.5–3.9)</td>
<td>94.5</td>
<td>98.4</td>
<td>4.1 (3.7–4.5)</td>
<td>95.4</td>
<td>98.7</td>
<td>3.4 (2.9–4.0)</td>
</tr>
<tr>
<td>Administration of aspirin at discharge</td>
<td>95.8</td>
<td>98.9</td>
<td>3.4 (3.2–3.6)</td>
<td>93.8</td>
<td>98.1</td>
<td>4.5 (4.0–4.9)</td>
<td>93.9</td>
<td>98.3</td>
<td>4.6 (3.8–5.4)</td>
</tr>
<tr>
<td>Administration of ACE inhibitor or ARB for LVSD</td>
<td>83.3</td>
<td>96.4</td>
<td>13.5 (12.9–14.0)</td>
<td>84.0</td>
<td>96.9</td>
<td>13.2 (12.2–14.2)</td>
<td>82.0</td>
<td>96.0</td>
<td>14.3 (12.4–16.2)</td>
</tr>
<tr>
<td>Smoking-cessation counseling</td>
<td>92.8</td>
<td>99.6</td>
<td>7.2 (6.7–7.6)</td>
<td>89.0</td>
<td>99.6</td>
<td>10.8 (9.5–12.1)</td>
<td>86.1</td>
<td>99.6</td>
<td>13.6 (11.3–16.0)</td>
</tr>
<tr>
<td>Administration of beta-blocker at discharge</td>
<td>94.8</td>
<td>98.6</td>
<td>3.9 (3.7–4.2)</td>
<td>93.7</td>
<td>98.2</td>
<td>4.6 (4.2–5.1)</td>
<td>93.0</td>
<td>98.2</td>
<td>5.3 (4.5–6.2)</td>
</tr>
<tr>
<td>Use of PCI within 90 min after arrival at hospital</td>
<td>43.4</td>
<td>91.7</td>
<td>49.1 (47.9–50.3)</td>
<td>29.2</td>
<td>86.3</td>
<td>57.6 (55.1–60.2)</td>
<td>34.1</td>
<td>89.7</td>
<td>56.4 (53.4–59.3)</td>
</tr>
<tr>
<td>Heart failure</td>
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<tr>
<td>Provision of discharge instructions</td>
<td>58.6</td>
<td>89.6</td>
<td>31.0 (30.0–32.1)</td>
<td>56.7</td>
<td>89.8</td>
<td>32.9 (31.4–34.5)</td>
<td>52.1</td>
<td>91.3</td>
<td>39.1 (36.1–42.1)</td>
</tr>
<tr>
<td>Assessment of LVF</td>
<td>89.5</td>
<td>98.0</td>
<td>8.0 (7.6–8.3)</td>
<td>90.7</td>
<td>98.4</td>
<td>7.1 (6.6–7.6)</td>
<td>89.2</td>
<td>98.1</td>
<td>8.1 (7.1–9.1)</td>
</tr>
<tr>
<td>Administration of appropriate ACE inhibitor or ARB for LVSD</td>
<td>81.4</td>
<td>94.4</td>
<td>13.8 (13.3–14.3)</td>
<td>85.4</td>
<td>96.1</td>
<td>11.4 (10.8–12.0)</td>
<td>83.1</td>
<td>95.3</td>
<td>12.8 (11.3–14.3)</td>
</tr>
<tr>
<td>Smoking-cessation counseling</td>
<td>83.1</td>
<td>98.5</td>
<td>15.5 (14.8–16.2)</td>
<td>83.0</td>
<td>99.0</td>
<td>16.0 (14.7–17.3)</td>
<td>77.2</td>
<td>98.8</td>
<td>21.7 (18.6–24.7)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Administration of antibiotic within 6 hr</td>
<td>89.9</td>
<td>96.2</td>
<td>6.3 (6.0–6.5)</td>
<td>84.6</td>
<td>94.0</td>
<td>9.4 (8.8–10.0)</td>
<td>84.7</td>
<td>94.4</td>
<td>9.7 (8.8–10.5)</td>
</tr>
<tr>
<td>Administration of appropriate antibiotic</td>
<td>80.2</td>
<td>92.7</td>
<td>12.6 (12.2–13.0)</td>
<td>79.2</td>
<td>93.3</td>
<td>13.8 (13.1–14.6)</td>
<td>78.9</td>
<td>93.7</td>
<td>14.6 (13.4–15.9)</td>
</tr>
<tr>
<td>Blood culture within 24 hr in ICU</td>
<td>83.8</td>
<td>96.2</td>
<td>12.5 (12.0–13.0)</td>
<td>87.2</td>
<td>96.8</td>
<td>9.5 (8.7–10.3)</td>
<td>87.3</td>
<td>96.7</td>
<td>9.2 (7.9–10.5)</td>
</tr>
<tr>
<td>Blood culture before administration of antibiotic</td>
<td>83.9</td>
<td>96.4</td>
<td>12.7 (12.3–13.0)</td>
<td>80.7</td>
<td>95.4</td>
<td>14.7 (14.0–15.5)</td>
<td>81.1</td>
<td>95.4</td>
<td>14.4 (13.4–15.3)</td>
</tr>
<tr>
<td>Smoking-cessation counseling</td>
<td>78.9</td>
<td>97.7</td>
<td>18.9 (18.2–19.6)</td>
<td>77.2</td>
<td>98.2</td>
<td>21.1 (19.6–22.6)</td>
<td>71.4</td>
<td>97.7</td>
<td>25.8 (23.3–28.4)</td>
</tr>
<tr>
<td>Pneumococcal vaccination</td>
<td>61.9</td>
<td>94.5</td>
<td>30.6 (29.7–31.4)</td>
<td>49.1</td>
<td>91.5</td>
<td>42.4 (40.8–44.0)</td>
<td>47.5</td>
<td>93.0</td>
<td>45.7 (42.7–48.7)</td>
</tr>
<tr>
<td>Influenza vaccination</td>
<td>57.9</td>
<td>92.9</td>
<td>35.2 (34.4–36.0)</td>
<td>43.9</td>
<td>89.5</td>
<td>45.7 (44.2–47.2)</td>
<td>43.7</td>
<td>91.4</td>
<td>47.7 (45.4–49.9)</td>
</tr>
</tbody>
</table>

Hospital Acquired Conditions
National Results, 2014-2017

Declines in Hospital-Acquired Conditions

National efforts to reduce hospital-acquired conditions such as adverse drug events and injuries from falls helped prevent 20,700 deaths and saved $7.7 billion between 2014 and 2017.

*CAUTI - Catheter-Associated Urinary Tract Infections
+CLABSI - Central Line-Associated Bloodstream Infections

**The percent change numbers are compared to the 2014 measured baseline for HACs.

Source: AHRQ National Scorecard on Hospital-Acquired Conditions Final Results for 2014-2017

Patient Experience, 2008 - 2014

Figure 4: Median Hospital Scores on Patient Experience Measures, 2008 through 2014


Source: GAO analysis of CMS data. | GAO-16-9
Figure 1-4
Risk-adjusted changes in unplanned readmission rates by condition, 2008–2016

Note: HRRP (Hospital Readmissions Reduction Program), PPACA (Patient Protection and Affordable Care Act of 2010), COPD (chronic obstructive pulmonary disease), AMI (acute myocardial infarction). The pneumonia measure reflects the expanded definition used starting in fiscal year 2016, which includes simple pneumonia, aspiration pneumonia, and sepsis with pneumonia as a secondary diagnosis.

Source: MedPAC analysis of Medicare claims files for Medicare fee-for-service beneficiaries ages 65 or older.
Hospital-level risk-standardized mortality rates in the 30 days after hospital admission for stroke, acute myocardial infarction, and heart failure, among Medicare patients age 65+.

Source: Centers for Medicare & Medicaid Services, Hospital Compare datasets (available at: https://data.medicare.gov/data/hospital-compare) and Medicare Hospital Quality Chartbook (September 2014)

Adding Up Value Programs
New York Region, FY 2020

Adding Up Value Programs
New York Region, FY 2021

From 1989 – 1992, the in-hospital observed mortality rate of isolated CABG surgery in New York State was 3.11%.

Beyond the Hospital...

CMS Authorized Programs & Activities

- Reducing & Preventing Health Care Associated Infections
- Reducing & Preventing Adverse Drug Events
- Community Living Council
- Multiple Chronic Conditions
- National Alzheimer’s Project Act
- Partnership for Patients
- Million Hearts
- National Quality Strategy
- Data.gov

- Accountable Care Organizations
- Community Based Transitions Care Program
- Dual eligible coordination
- Care model demonstrations & projects
- 1115 Waivers

- Fraud & Abuse Enforcement

- National & Local decisions
  - Mechanisms to support innovation (CED, parallel review, other)

- Hospital Inpatient Quality Hospital Outpatient
- In-patient psychiatric hospitals
- Cancer hospitals
- Nursing homes
- Home Health Agencies
- Long-term Care Acute Hospitals
- In-patient rehabilitation facilities
- Hospices

Source: Centers for Medicare and Medicaid Services. Available at, 
Accountable Care Organizations

Key Points

“A set of providers associated with a defined population of patients, accountable for the quality and cost of care delivered to that population”

Source: http://www.medpac.gov/chapters/Jun09_Ch02.pdf

Triple Aim

– Experience
– Health
– Cost

“...three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care...”

CMMI Innovation Projects
New York, as of February 2022

Does Care Management Reduce Health Spending?

A. Yes
B. No
C. It depends...
Evidence on Medicare Shared Savings Program ACOs 2013-2015

In the first 3 years of the program, a total of 428 ACOs served 9.7 million beneficiaries...

Evidence on Bundled Payment Programs

“Twenty studies that we identified through search and screening processes showed that bundled payment maintains or improves quality while lowering costs for lower extremity joint replacement, but not for other conditions or procedures.”

Quality and Safety During the COVID-19 Pandemic

CMS Announces Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

Mar 22, 2020  |  Data: Hospitals. Quality

Today, the Centers for Medicare & Medicaid Services (CMS) announced unprecedented relief for the clinicians, providers, and facilities participating in Medicare quality reporting programs including the 1.2 million clinicians in the Quality Payment Program and on the front lines of America’s fight against the 2019 Novel Coronavirus (COVID-19).

Specifically, CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The action comes as part of the Trump Administration’s response to 2019 Novel Coronavirus (COVID-19).
# The Pandemic and Hospital Acquired Infections

<table>
<thead>
<tr>
<th></th>
<th>2020 Q1</th>
<th>2020 Q2</th>
<th>2020 Q3</th>
<th>2020 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>-11.8%</td>
<td>27.9%</td>
<td>46.4%</td>
<td>47.0%</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>-21.3%</td>
<td>No Change</td>
<td>12.7%</td>
<td>18.8%</td>
</tr>
<tr>
<td><strong>VAE</strong></td>
<td>11.3%</td>
<td>33.7%</td>
<td>29.0%</td>
<td>44.8%</td>
</tr>
<tr>
<td><strong>SSI: Colon surgery</strong></td>
<td>-9.1%</td>
<td>No Change</td>
<td>-6.9%</td>
<td>-8.3%</td>
</tr>
<tr>
<td><strong>SSI: Abdominal hysterectomy</strong></td>
<td>-16.0%</td>
<td>No Change</td>
<td>No Change</td>
<td>-13.1%</td>
</tr>
<tr>
<td><strong>Laboratory-identified MRSA bacteremia</strong></td>
<td>-7.2%</td>
<td>12.2%</td>
<td>22.5%</td>
<td>33.8%</td>
</tr>
<tr>
<td><strong>Laboratory-identified CDI</strong></td>
<td>-17.5%</td>
<td>-10.3%</td>
<td>-8.8%</td>
<td>-5.5%</td>
</tr>
</tbody>
</table>

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**Infection Control & Hospital Epidemiology (2022), 43, 12–25**  
doi:10.1017/ice.2021.362

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**Original Article**

**The impact of coronavirus disease 2019 (COVID-19) on healthcare-associated infections in 2020: A summary of data reported to the National Healthcare Safety Network**


*Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia, 1Leidos, Atlanta, Georgia, 2CACI, Atlanta, Georgia and 3Oak Ridge Institute of Science and Education, Oak Ridge, Tennessee*
COVID-19 and Health Care Workers

The Atlantic

‘No One Is Listening to Us’

More people than ever are hospitalized with COVID-19. Health-care workers can’t go on like this.

By Ed Yong

Homelia Navarro is comforted by Michele Younkin, a nurse, while sitting at the bedside of her dying husband. (Joe C. Hong / AP)
“Why Should We Be Concerned About Burnout Among Health Care Professionals?"

Quality and Safety

There are cross-sectional studies of physicians that suggest a significant effect on quality and risk of medical malpractice suits...The relationship between burnout and medical error is likely bidirectional...studies have found that as mean emotional exhaustion levels of physicians and nurses working in intensive care units rose, so did standardized patient mortality ratios...”

In general, we found that resignation rates were higher among employees who worked in fields that had experienced extreme increases in demand due to the pandemic, likely leading to increased workloads and burnout.”

Source: Cook I. Harvard Business Review, September 15, 2021
The Quadruple Aim

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD1
Christine Sinsky, MD2,3

1Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California San Francisco, San Francisco, California
2Medical Associates Clinic and Health Plan, Dubuque, Iowa
3American Medical Association, Chicago, Illinois

“...Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.”

On the Quality Horizon?

**Quality Measures**
- Shift from inpatient to non-hospital measures
- Usage of physician specific measures
- Allowance for socioeconomic variables
- Accounting for the impact of workforce well-being

**Value Based Payment**
- Spread to non-hospital settings
- Limits of financial downside based on quality

**Delivery System Change**
- Critical evaluation of existing models
- Next generation care models
  - Bundled payment
  - Direct contracting
  - Chronic care models

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Xavier Becerra, JD  
HHS Secretary (as of 3.18.21)

Chiquita Brooks-LaSure  
CMS Administrator (as of 5.25.21)
US Health Care Landscape and Quality

Settled

• Quality is important to all stakeholders
• Quality is firmly intertwined with costs / value
• Inpatient quality measures are decelerating
• ACA quality programs have been effective
  – Clinically
  – Financially
  – Politically “unifying”

Unsettled

• Relevance of quality data to consumer choice
• Can data outweigh cost and accessibility?
• The future of delivery system change programs
• Impact of vertical integration on delivery system change
• Workforce support, as a mediator of quality
Thank You!