The American Health Care Landscape

How Does Quality Fit In?

Rohit Bhalla, MD, MPH
Senior Vice President, Chief Clinical and Quality Officer
Stamford Health

UHF / GNYHA Clinical Quality Fellowship Program
March 14, 2024

GREATER NEW YORK HOSPITAL ASSOCIATION & UNITED HOSPITAL FUND
CLINICAL QUALITY FELLOWSHIP PROGRAM

Disclosure

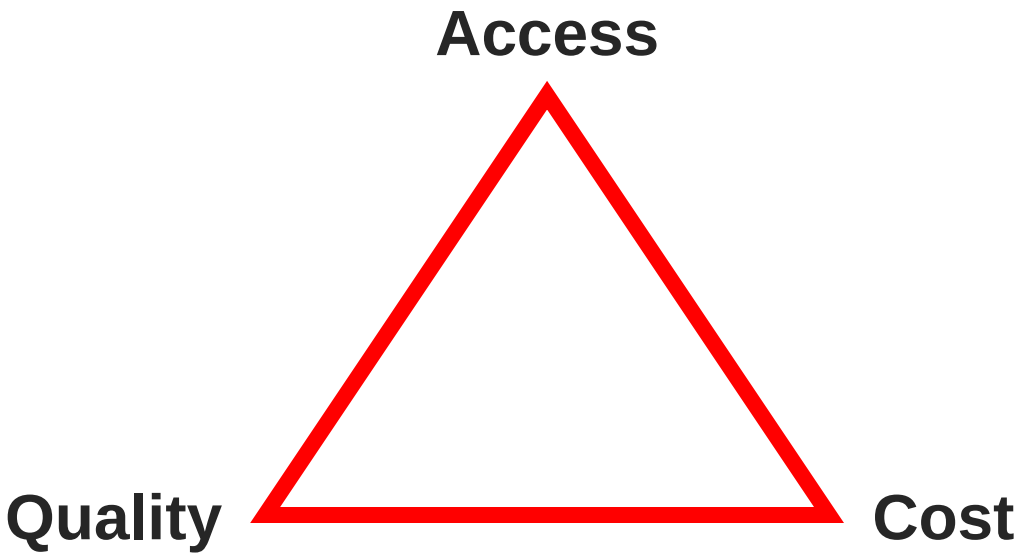
- Rohit Bhalla has no conflicts to disclose.

Overview

- Quality and the health care landscape
- Quality and health care reform
- Is quality in the US working?
- Quality in and after the COVID pandemic

Financial Disclosures: None

The Health Care Triangle



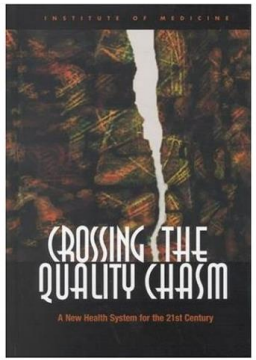
Institute of Medicine: Quality

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"

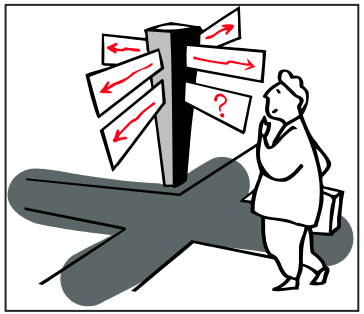
Aims for 21st century health care

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



Source: Crossing the Quality Chasm, IOM, 2001

A “P” Soup Approach



Politicians

Purchasers

Payers

Patients

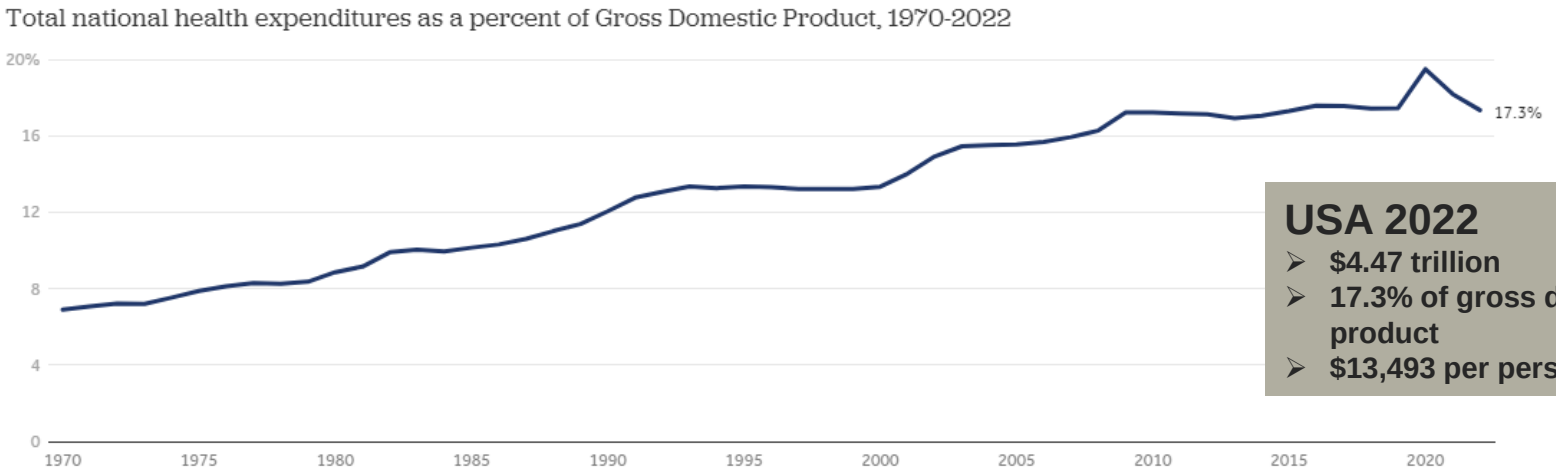
Police
(Regulators)

Providers

Product manufacturers

(Professors)

Health spending as a share of GDP fell to pre-pandemic levels in 2022



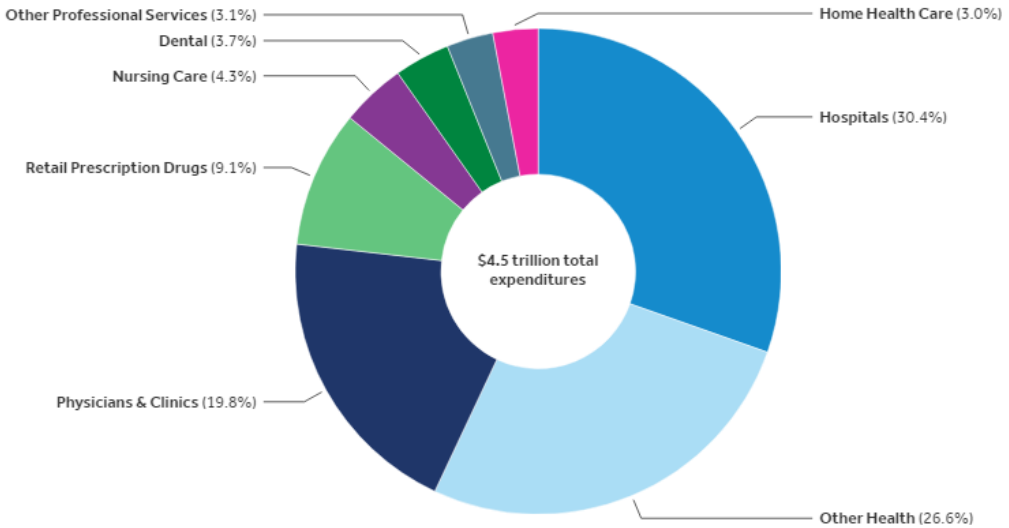
USA 2022

- **$4.47 trillion**
- **17.3% of gross domestic product**
- **$13,493 per person**

Available at, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures%20as%20a%20percent%20of%20Gross%20Domestic%20Product,%201970-2022. Accessed February 19, 2024.

Hospital and physician services represent half of total health spending

Relative contributions to total national health expenditures, by service type, 2022



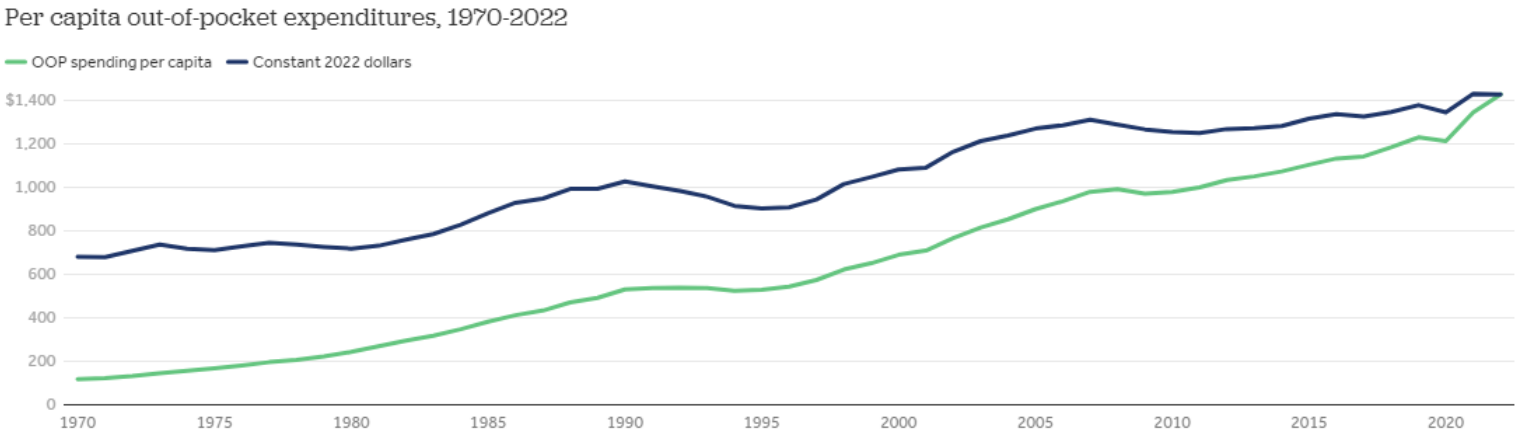
Note: "Other Health" includes spending on durable and non-durable products; residential and personal care; administration; net health insurance; and other state, private, and federal expenditures. "Other professional services" includes spending for services provided by chiropractors, optometrists, physical, occupational, and speech therapists, podiatrists, private-duty nurses, and others. Nursing care represents expenditures for nursing care facilities and continuing care retirement communities.

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

Peterson-KFF
Health System Tracker

Available at, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Relative%20contributions%20to%20total%20national%20health%20expenditures,%20by%20service%20type,%202022. Accessed February 19, 2024.

Per capita out-of-pocket expenditures increased in 2022



Note: 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) data • Get the data • PNG

Peterson-KFF Health System Tracker

Available at, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Relative%20contributions%20to%20total%20national%20health%20expenditures,%20by%20service%20type,%202022. Accessed February 19, 2024.

Most people with medical debt owe over $1,000

Share and estimated number of adults with medical debt, by the amount of debt they owe, 2021

Debt amount	Percent (among adults with medical debt)	Estimated number of adults with medical debt
$251-$500	13%	2.7 million
$501-$1,000	16%	3.3 million
$1,001-$2,000	18%	3.7 million
$2,001-$5,000	25%	5.0 million
$5,001-$10,000	13%	2.7 million
More than $10,000	14%	2.9 million
All adults	100%	**20.4 million**

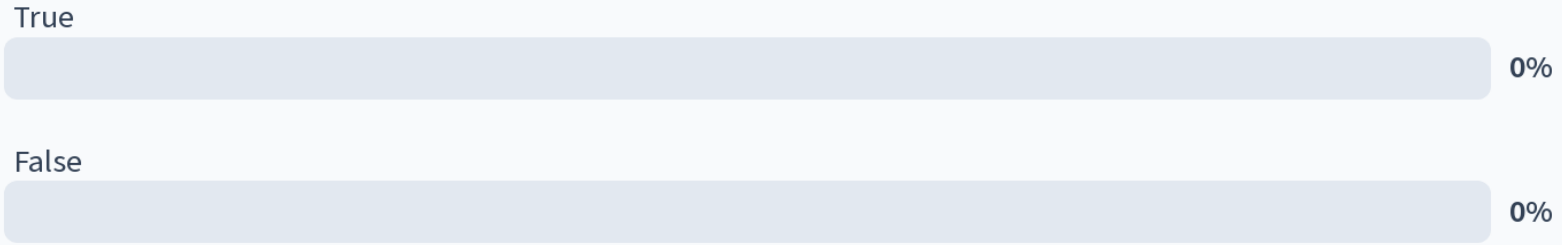
Note: Percentages may not add to 100% due to rounding.

Source: KFF analysis of the Survey and Income and Program Participation (SIPP) • Get the data • PNG

Peterson-KFF Health System Tracker

Available at, https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/#Share%20and%20estimated%20number%20of%20adults%20with%20medical%20debt,%20by%20the%20amount%20of%20debt%20they%20owe,%202021. Accessed February 19, 2024.

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



Life expectancy (2021) and per capita healthcare spending (2021 or nearest year, PPP adjusted)

Country	Life expectancy ▲	Health spending, per capita
United States	**76.1**	**$12,914**
United Kingdom	80.8	$5,387
Germany	80.9	$7,383
Austria	81.3	$6,693
Netherlands	81.5	$6,190
Belgium	81.9	$5,274
Comparable Country Average	**82.4**	**$6,003**
France	82.5	$5,468
Sweden	83.2	$6,262
Australia	83.4	$5,627
Switzerland	84.0	$7,179
Japan	84.5	$4,666

Notes: See Methods section of "How does U.S. life expectancy compare to other countries?"

Source: KFF analysis of CDC, OECD, Japanese Ministry of Health, Labour, and Welfare, Australian Bureau of Statistics, and UK Office for Health Improvement and Disparities data • Get the data • PNG

Peterson-KFF
Health System Tracker

Available at, https://www.healthsystemtracker.org/brief/the-state-of-the-u-s-health-system-in-2022-and-the-outlook-for-2023/#Total%20deaths%20in%20the%20United%20States%20from%20COVID-19%20and%20other%20leading%20causes,%202020-2022. Accessed February 11, 2023.

The NEW ENGLAND JOURNAL of MEDICINE

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Who Is at Greatest Risk for Receiving Poor-Quality Health Care?

Steven M. Asch, M.D., M.P.H., Eve A. Kerr, M.D., M.P.H., Joan Keesey, B.A., John L. Adams, Ph.D., Claude M. Setodji, Ph.D., Shaista Malik, M.D., M.P.H., and Elizabeth A. McGlynn, Ph.D.

ABSTRACT

BACKGROUND

American adults frequently do not receive recommended health care. The extent to which the quality of health care varies among sociodemographic groups is unknown.

METHODS

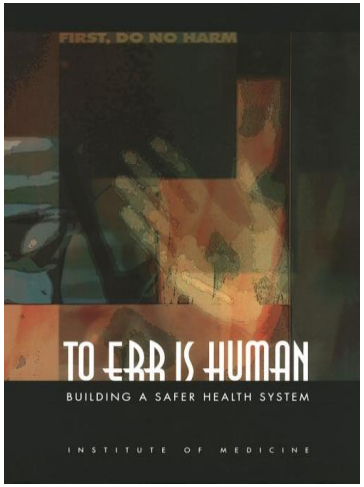
We used data from medical records and telephone interviews of a random sample of people living in 12 communities to assess the quality of care received by those who had made at least one visit to a health care provider during the previous two years. We constructed aggregate scores from 439 indicators of the quality of care for 30 chronic and acute conditions and for disease prevention. We estimated the rates at which members of different sociodemographic subgroups received recommended care, with adjustment for the number of chronic and acute conditions, use of health care services, and other sociodemographic characteristics.

From RAND Health, Santa Monica, Calif. (S.M.A., J.K., J.L.A., C.M.S., S.M., E.A.M.); the Veterans Affairs Greater Los Angeles Health Care System and the Department of Medicine, David Geffen School of Medicine, UCLA — both in Los Angeles (S.M.A.); the Veterans Affairs Center for Practice Management and Outcomes Research, Veterans Affairs Ann Arbor Health Care System, and the Department of Internal Medicine, University of Michigan Medical School — both in Ann Arbor, Mich. (E.A.K.); and the Department of Medicine, Division of Cardiology, University of California, Irvine (S.M.).

N Engl J Med 2006;354:1147-56.

"Overall, participants received 54.9 percent of recommended care."

Asch, et al. N Engl J Med 2006;354:1147-1156

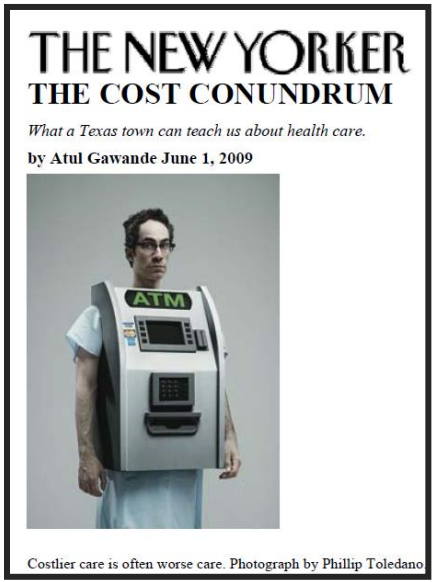


"Health care in the United States is not as safe as it should be--and can be…as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented…"

Institute of Medicine, 1999

CLINICAL QUALITY FELLOWSHIP PROGRAM

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$


THE NEW YORKER

THE COST CONUNDRUM

What a Texas town can teach us about health care.

by Atul Gawande June 1, 2009

Costlier care is often worse care. Photograph by Phillip Toledano

"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."

Public Hospital Report Cards

HOSPITAL SAFETY SCORE

A HOSPITAL SAFETY SCORE

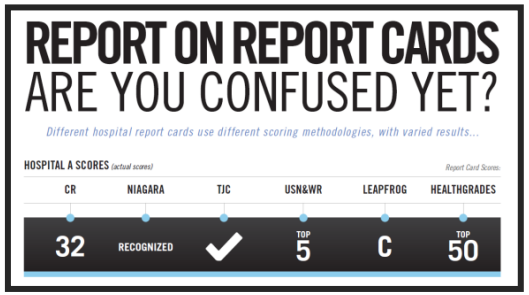
B HOSPITAL SAFETY SCORE

C HOSPITAL SAFETY SCORE

D HOSPITAL SAFETY SCORE

F HOSPITAL SAFETY SCORE

SP SCORE PENDING HOSPITAL SAFETY SCORE



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U.S.News & WORLD REPORT
HONOR ROLL
2019-20

healthgrades™
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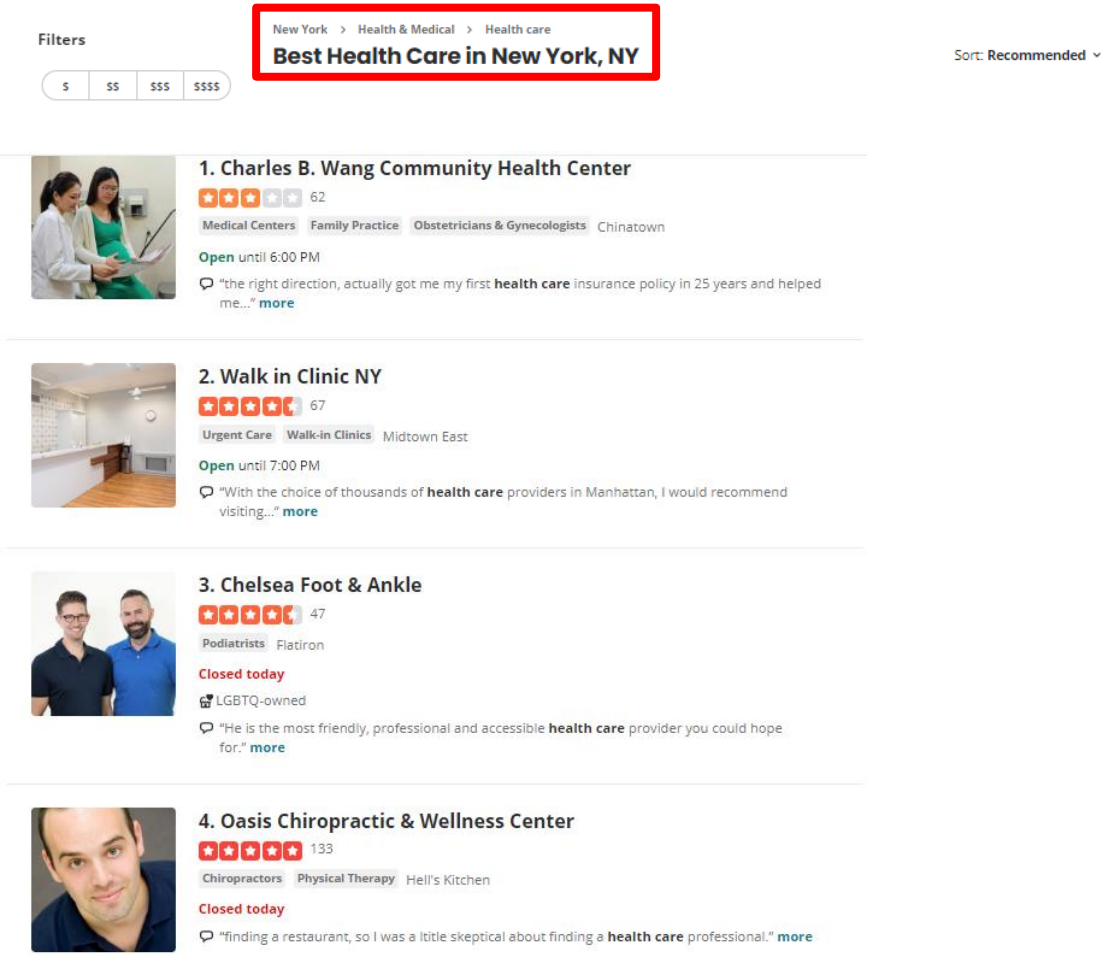
Reality?



Source: yelp.com, Accessed February 11, 2023

Patient and “Consumer” Choice

Choice

- □ Geography
- □ Health Plan

Practical

- □ Cost
- □ Mobility
- □ Health literacy
- □ Rationality

The Sveriges Riksbank Prize in Economic Sciences in Memory of Alfred Nobel 2017
Richard H. Thaler

Share this: 47

Richard H. Thaler - Facts

© Nobel Media III: N. Elmehed

Richard H. Thaler

Born: 1945, East Orange, NJ, USA

Affiliation at the time of the award: University of Chicago, Chicago, IL, USA

Prize motivation: "for his contributions to behavioural economics"

Prize share: 1/1

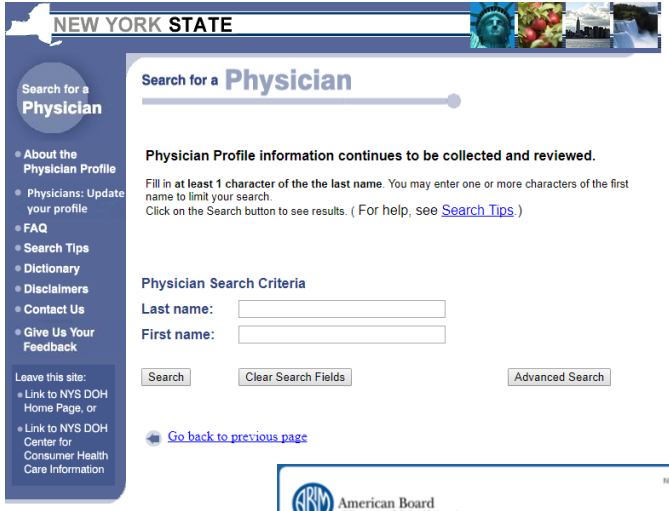
“…limited rationality, social preferences, and lack of self-control…these human traits systematically affect individual decisions as well as market outcomes.”

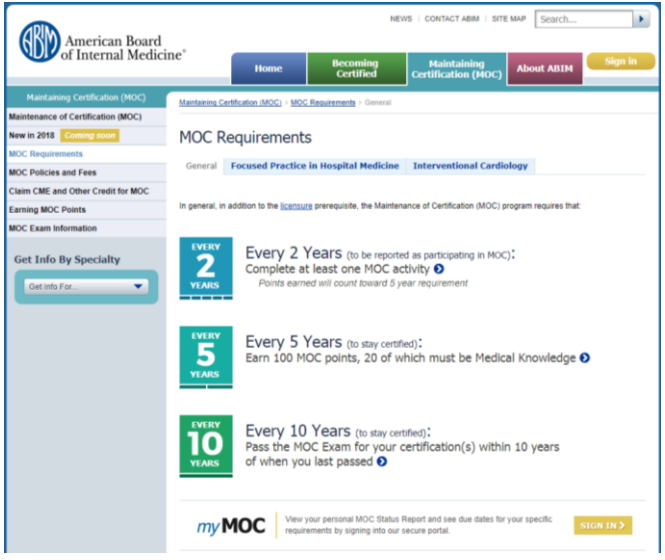
Source: “Richard H. Thaler - Facts". Nobelprize.org. Nobel Media AB 2014. Web. 11 Oct 2017.
http://www.nobelprize.org/nobel_prizes/economic-sciences/laureates/2017/thaler-facts.html

The Police (Regulation)

The Quality Room

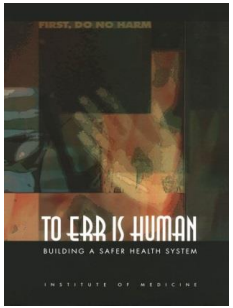
Individual Providers and Quality





“Recent” Quality Milestones

1999



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

2003

Medicare Modernization Act

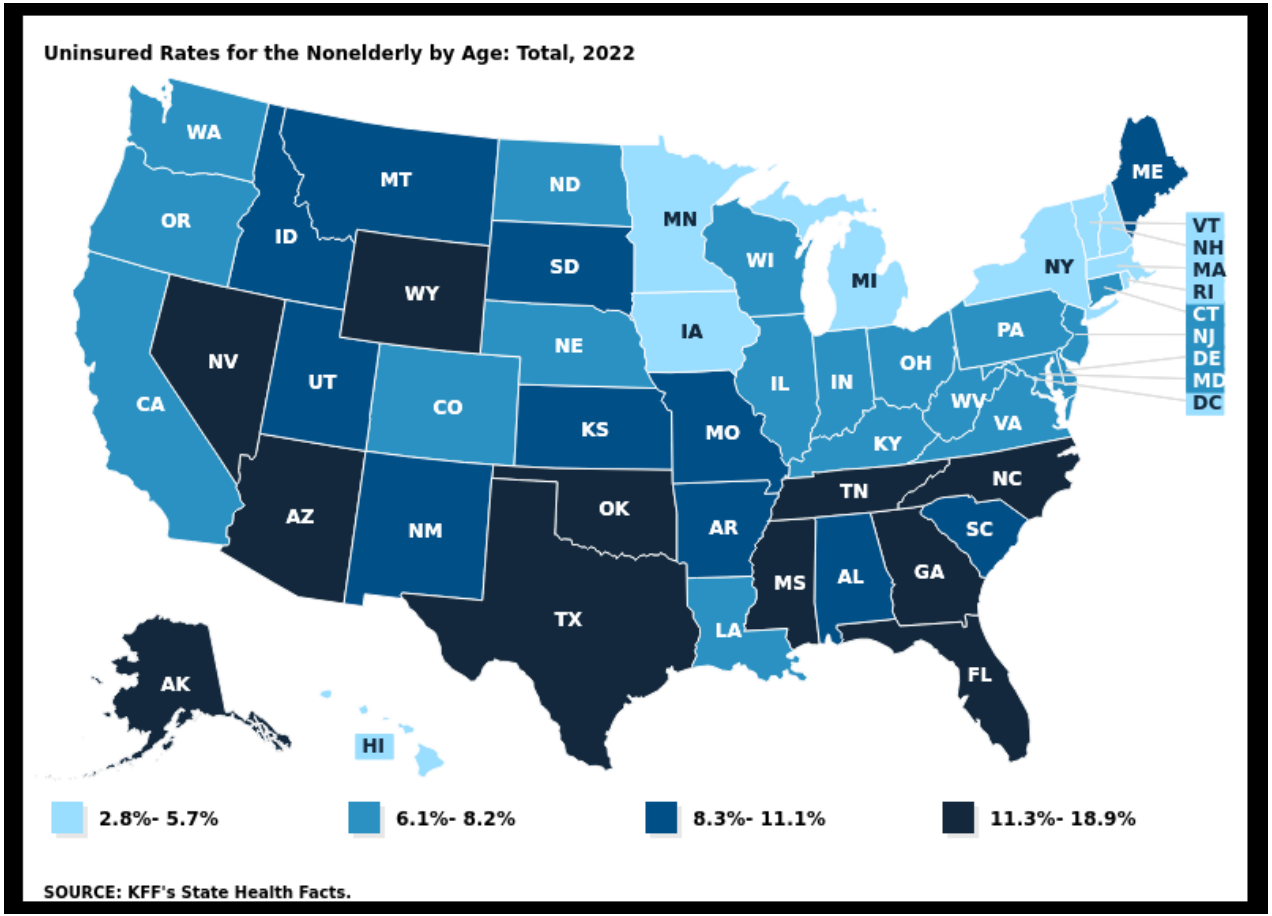
- Public reporting
- Pay for performance
- National Quality Forum growth
- Patient experience

2010

Affordable Care Act

- Value based payment
- Accountable care
- Delivery system reform efforts

CLINICAL QUALITY FELLOWSHIP PROGRAM



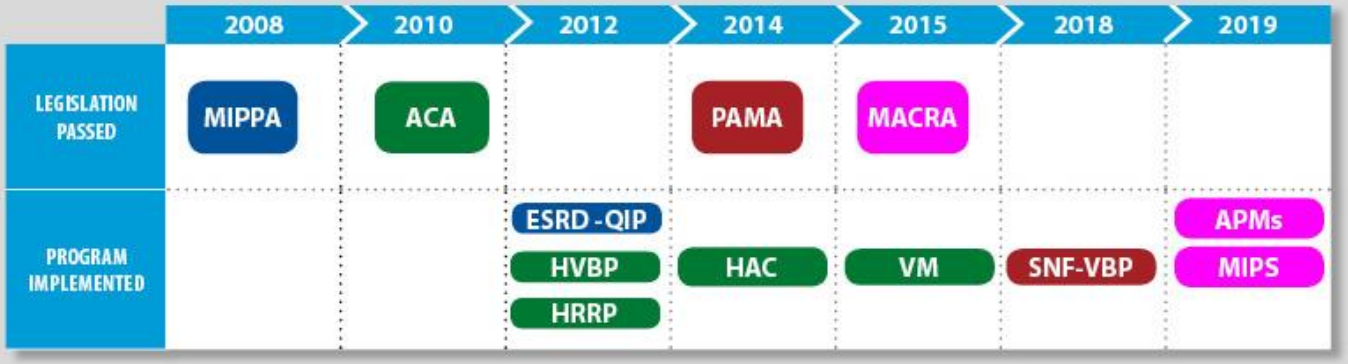
Available at, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-age/?activeTab=map&currentTimeframe=0&selectedDistributions=total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed February 19, 2024

FEDERAL QUALITY PROGRAMS
ORIGINATED OR CONTINUED VIA THE AFFORDABLE CARE ACT

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

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

VALUE-BASED PROGRAMS



LEGISLATION

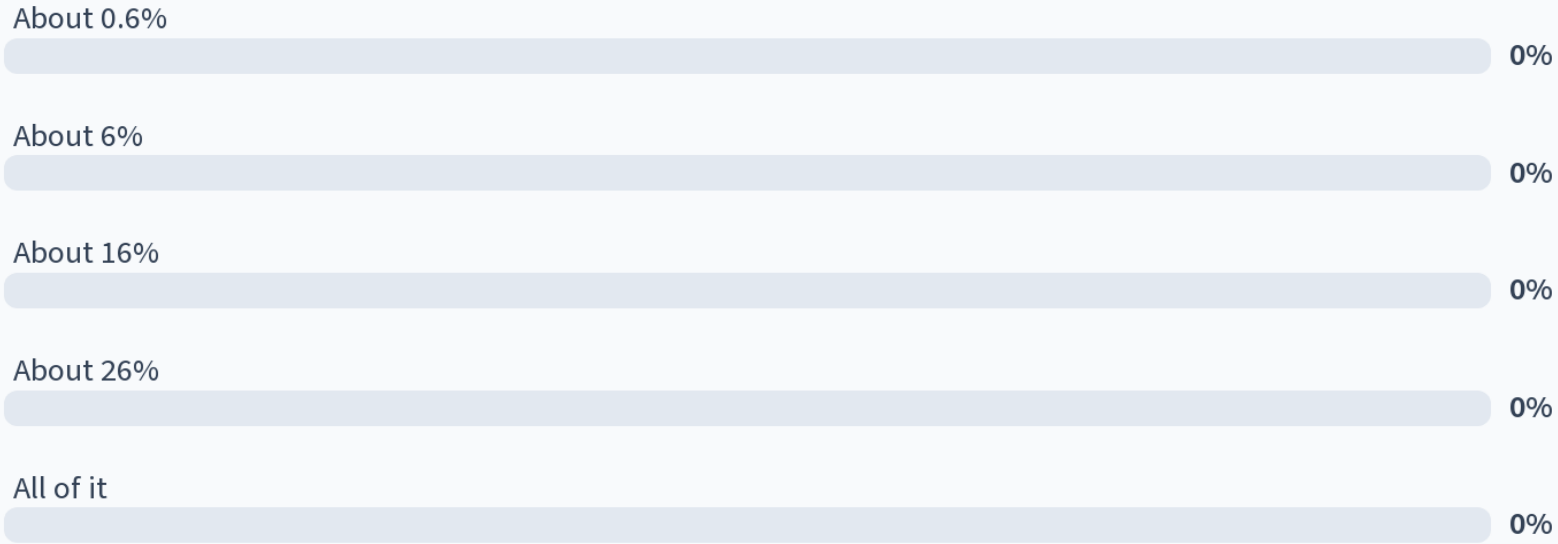
ACA: Affordable Care Act
MACRA: the Medicare Access & CHIP Reauthorization Act of 2015
MIPPA: Medicare Improvements for Patients & Providers Act
PAMA: Protecting Access to Medicare Act

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
HVBP: Hospital Value-Based Purchasing Program
MIPS: Merit-Based Incentive Payment System
VM: Value Modifier or Physician Value-Based Modifier (PVBM)
SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

Source: Centers for Medicare and Medicaid Services. Available at, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html. Accessed February 19, 2024

What percent of reimbursement can a hospital lose under the ACA's Quality Programs?



These losses are applicable to which payments?

Medicaid payments

0%

Medicare payments

0%

Commercial payments

0%

All payments

0%

NATIONAL CLINICAL EFFECTIVENESS RESULTS

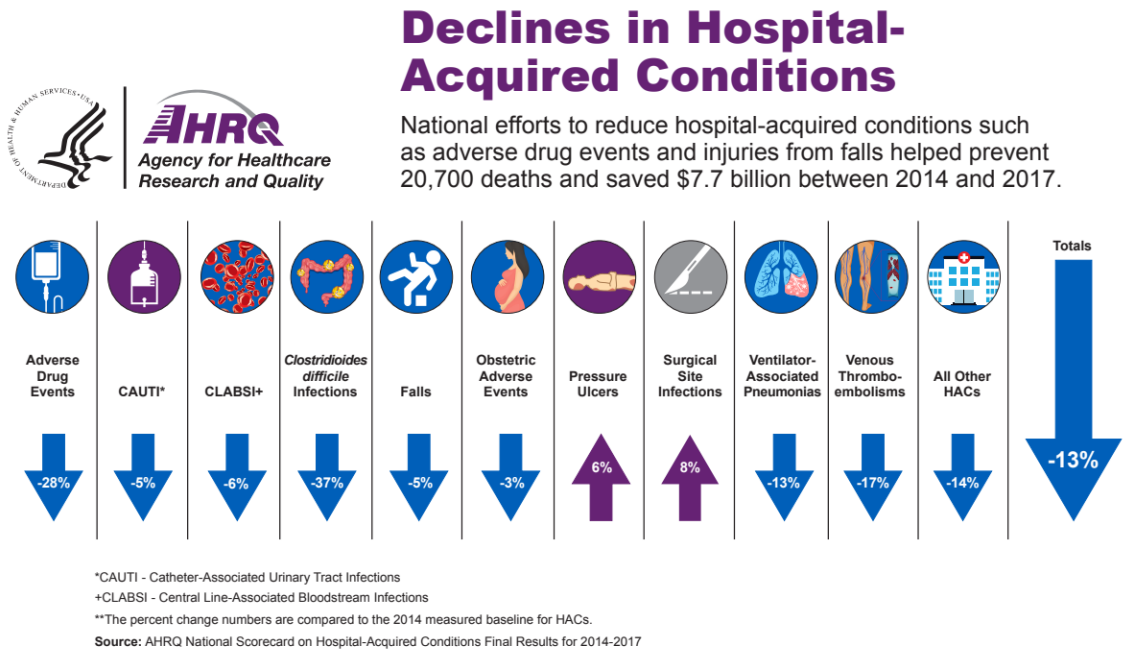
Table 2. Performance Rates for Process-of-Care Measures among Patients Hospitalized for Acute Myocardial Infarction, Heart Failure, or Pneumonia, According to Race or Ethnic Group, 2005 and 2010.*

Process-of-Care Measure	Whites			Blacks			Hispanics		
	2005	2010	Adjusted Change, 2005–2010†	2005	2010	Adjusted Change, 2005–2010†	2005	2010	Adjusted Change, 2005–2010†
	percent		percentage points (95% CI)	percent		percentage points (95% CI)	percent		percentage points (95% CI)
Acute myocardial infarction									
Administration of aspirin at arrival	95.3	98.9	3.8 (3.6–3.9)	94.5	98.4	4.1 (3.7–4.5)	95.4	98.7	3.4 (2.9–4.0)
Administration of aspirin at discharge	95.8	98.9	3.4 (3.2–3.6)	93.8	98.1	4.5 (4.0–4.9)	93.9	98.3	4.6 (3.8–5.4)
Administration of ACE inhibitor or ARB for LVSD	83.3	96.4	13.5 (12.9–14.0)	84.0	96.9	13.2 (12.2–14.2)	82.0	96.0	14.3 (12.4–16.2)
Smoking-cessation counseling	92.8	99.6	7.2 (6.7–7.6)	89.0	99.6	10.8 (9.5–12.1)	86.1	99.6	13.6 (11.3–16.0)
Administration of beta-blocker at discharge	94.8	98.6	3.9 (3.7–4.2)	93.7	98.2	4.6 (4.2–5.1)	93.0	98.2	5.3 (4.5–6.2)
Use of PCI within 90 min after arrival at hospital	43.4	91.7	49.1 (47.9– 50.3)	29.2	86.3	57.6 (55.1–60.2)	34.1	89.7	56.4 (53.4–59.3)
Heart failure									
Provision of discharge instructions	58.6	89.6	31.0 (30.0–32.1)	56.7	89.8	32.9 (31.4–34.5)	52.1	91.3	39.1 (36.1–42.1)
Assessment of LVF	89.5	98.0	8.0 (7.6–8.3)	90.7	98.4	7.1 (6.6–7.6)	89.2	98.1	8.1 (7.1–9.1)
Administration of appropriate ACE inhibitor or ARB for LVSD	81.4	94.4	13.8 (13.3–14.3)	85.4	96.1	11.4 (10.8–12.0)	83.1	95.3	12.8 (11.3–14.3)
Smoking-cessation counseling	83.1	98.5	15.5 (14.8–16.2)	83.0	99.0	16.0 (14.7–17.3)	77.2	98.8	21.7 (18.6–24.7)
Pneumonia									
Administration of antibiotic within 6 hr	89.9	96.2	6.3 (6.0–6.5)	84.6	94.0	9.4 (8.8–10.0)	84.7	94.4	9.7 (8.8–10.5)
Administration of appropriate antibiotic	80.2	92.7	12.6 (12.2–13.0)	79.2	93.3	13.8 (13.1–14.6)	78.9	93.7	14.6 (13.4–15.9)
Blood culture within 24 hr in ICU	83.8	96.2	12.5 (12.0–13.0)	87.2	96.8	9.5 (8.7–10.3)	87.3	96.7	9.2 (7.9–10.5)
Blood culture before administration of antibiotic	83.9	96.4	12.7 (12.3–13.0)	80.7	95.4	14.7 (14.0–15.5)	81.1	95.4	14.4 (13.4–15.3)
Smoking-cessation counseling	78.9	97.7	18.9 (18.2–19.6)	77.2	98.2	21.1 (19.6–22.6)	71.4	97.7	25.8 (23.3–28.4)
Pneumococcal vaccination	63.9	94.5	30.6 (29.7–31.4)	49.1	91.5	42.4 (40.8–44.0)	47.5	93.0	45.7 (42.7–48.7)
Influenza vaccination	57.9	92.9	35.2 (34.4–36.0)	43.9	89.5	45.7 (44.2–47.2)	43.7	91.4	47.7 (45.4–49.9)

Source: Trivedi AN, et al. Quality and Equity of Care in U.S. Hospitals. NEJM. 2014;371:2298-308.

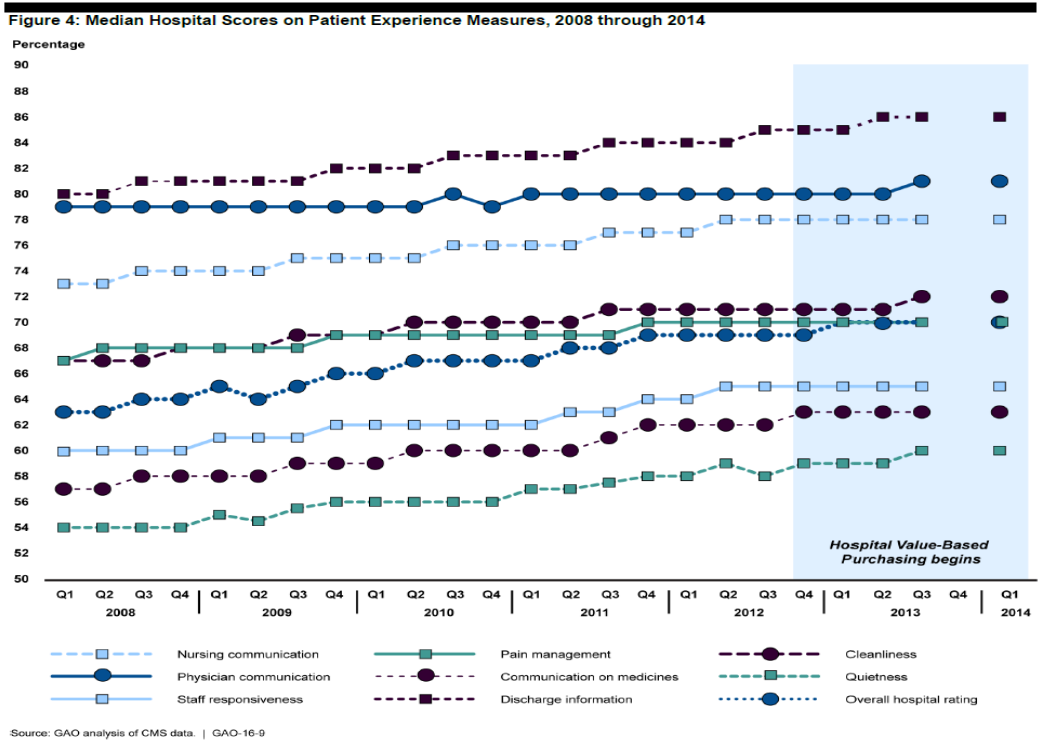
Hospital Acquired Conditions

National Results, 2014-2017



Source: Declines in Hospital-Acquired Conditions. Content last reviewed July 2020. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/data/infographics/hac-rates_2019.html. Accessed February 20, 2024

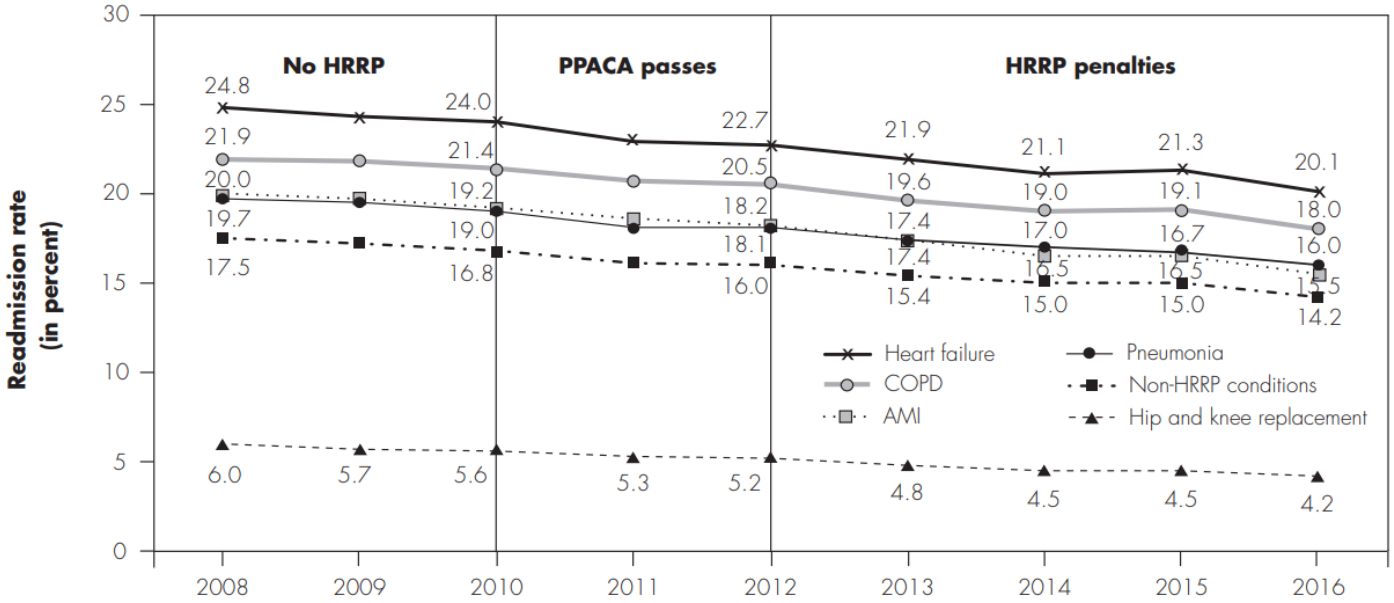
Patient Experience, 2008 - 2014



Source: US Government Accountability Office. GAO-16-9: October 1, 2015. http://www.gao.gov/products/GAO-16-9?source=ra. Accessed February 20, 2024.

FIGURE 1–4

Risk-adjusted changes in unplanned readmission rates by condition, 2008–2016

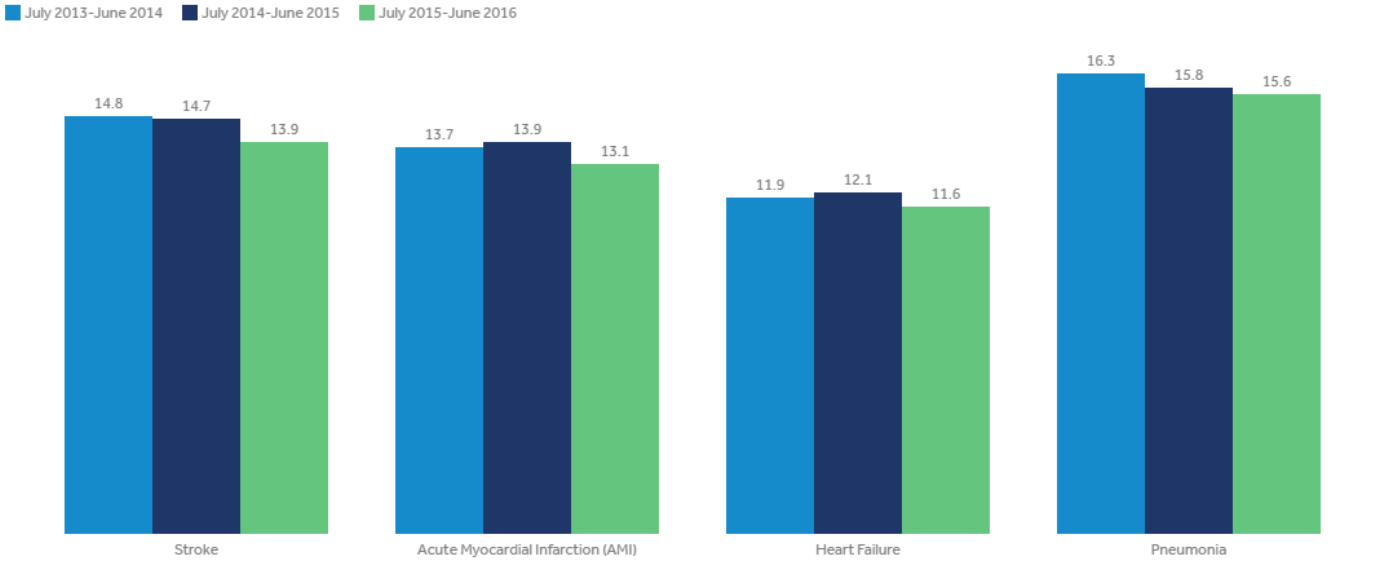


Note: HRRP (Hospital Readmissions Reduction Program), PPACA (Patient Protection and Affordable Care Act of 2010), COPD (chronic obstructive pulmonary disease), AMI (acute myocardial infarction). The pneumonia measure reflects the expanded definition used starting in fiscal year 2016, which includes simple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

Source: Medicare Payment Advisory Commission. Mandated report: The effects of the Hospital Readmissions Reduction Program. June 2018.

Median hospital risk-standardized mortality rates in the 30 days after hospital admission for pneumonia, stroke, acute myocardial infarction (AMI), and heart failure, among Medicare patients age 65+



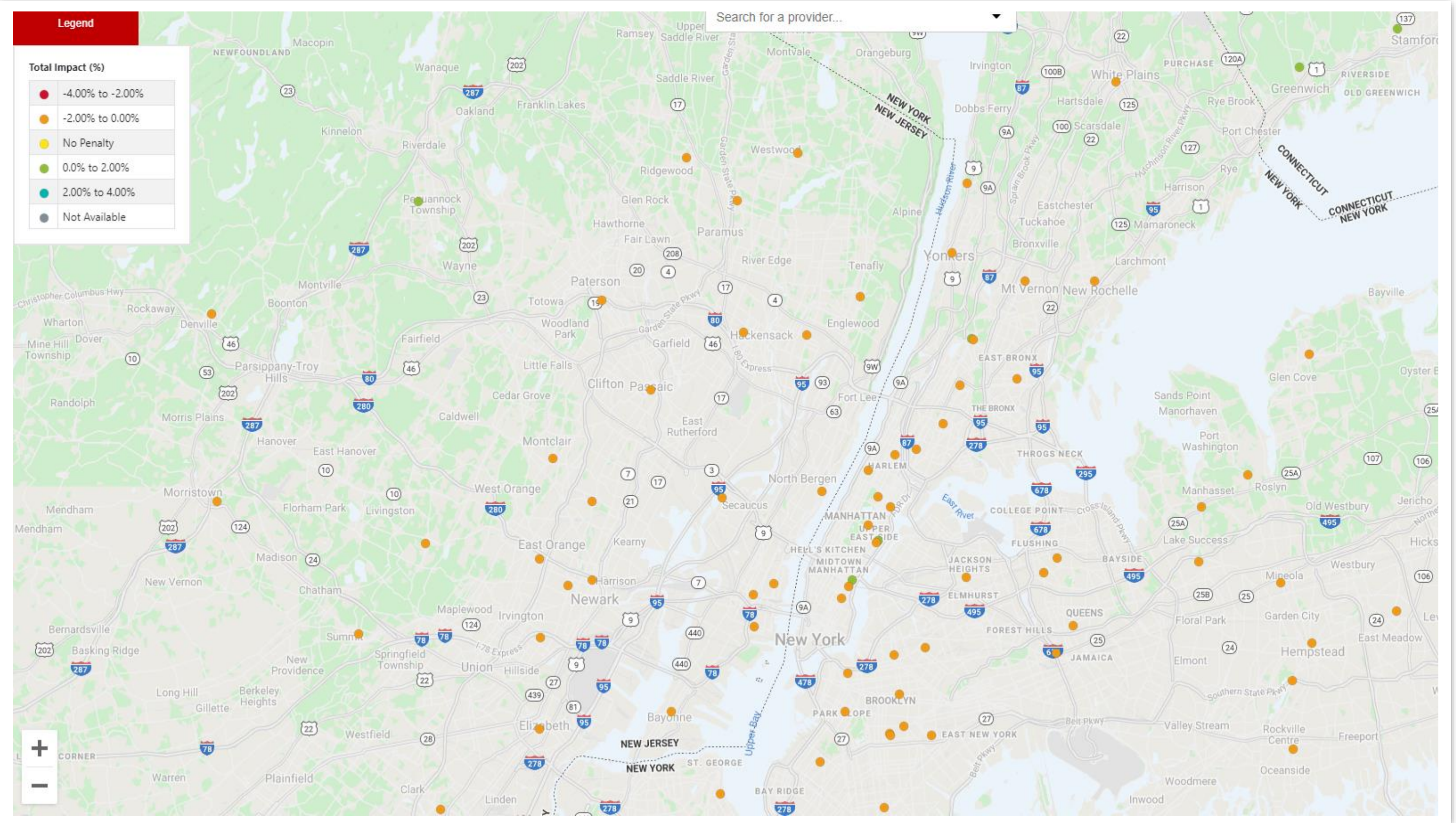
Source: Kaiser Family Foundation analysis of data from the Centers for Medicare & Medicaid Services, Hospital Compare datasets and Medicare Hospital Quality Chartbook (Accessed November 15, 2018).
• Get the data • PNG

Peterson-KFF
Health System Tracker

Source: Available at, https://www.healthsystemtracker.org/indicator/quality/30-day-mortality-following-certain-admissions. Accessed February 17, 2023

Adding Up Value Programs

New York Region FY 2020

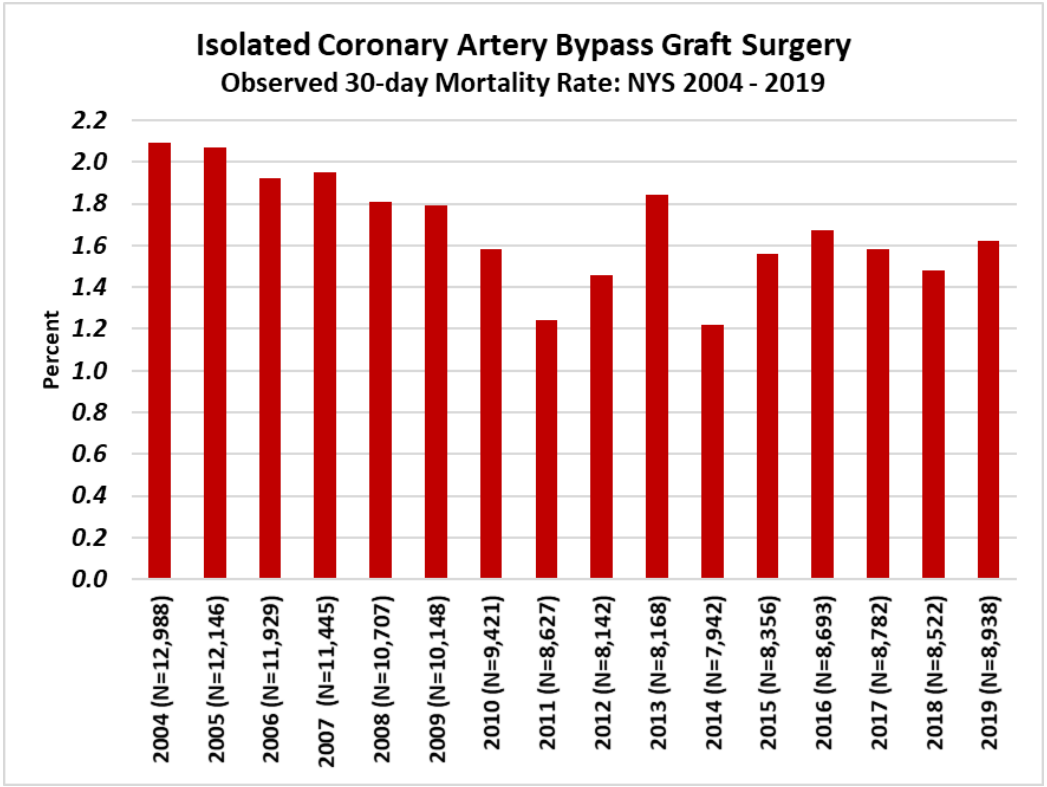


Source: Advisory Board. National pay-for-performance map. Available at, https://www.advisory.com/research/health-care-advisory-board/resources/2013/pay-for-performance-map. Accessed January 10, 2020.

Public Reporting vs. Payment

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

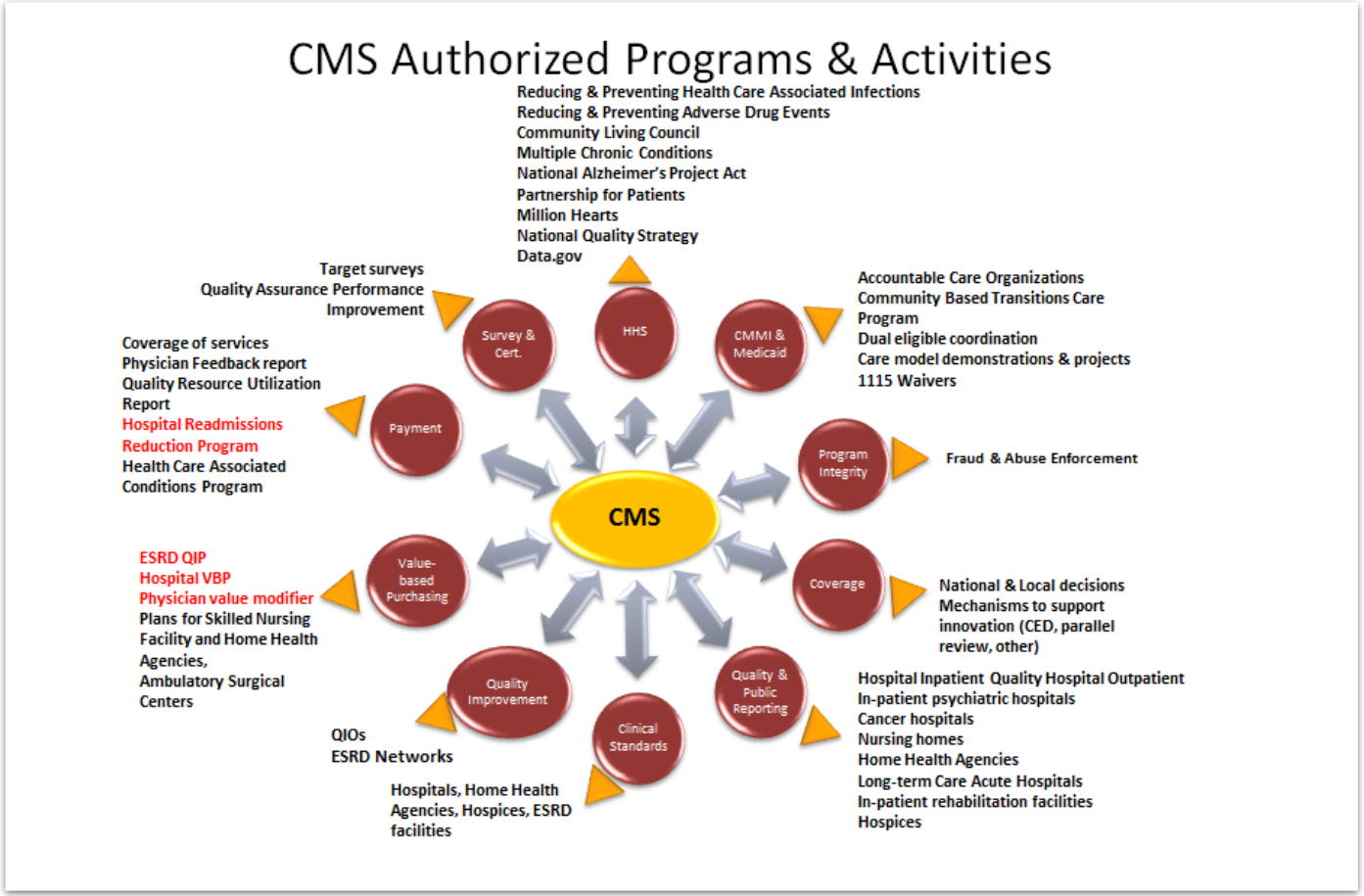
Source: Hannan EL, et al. *Ann Thorac Surg.* 1994;58:1852-7.



ADULT CARDIAC SURGERY
in New York State
2017-2019

NEW YORK STATE Department of Health

Beyond the Hospital…



Source: Centers for Medicare and Medicaid Services. Available at, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs. Accessed February 20, 2024

Accountable Care Organizations

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

MEDPAC *Advising the Congress on Medicare issues*

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

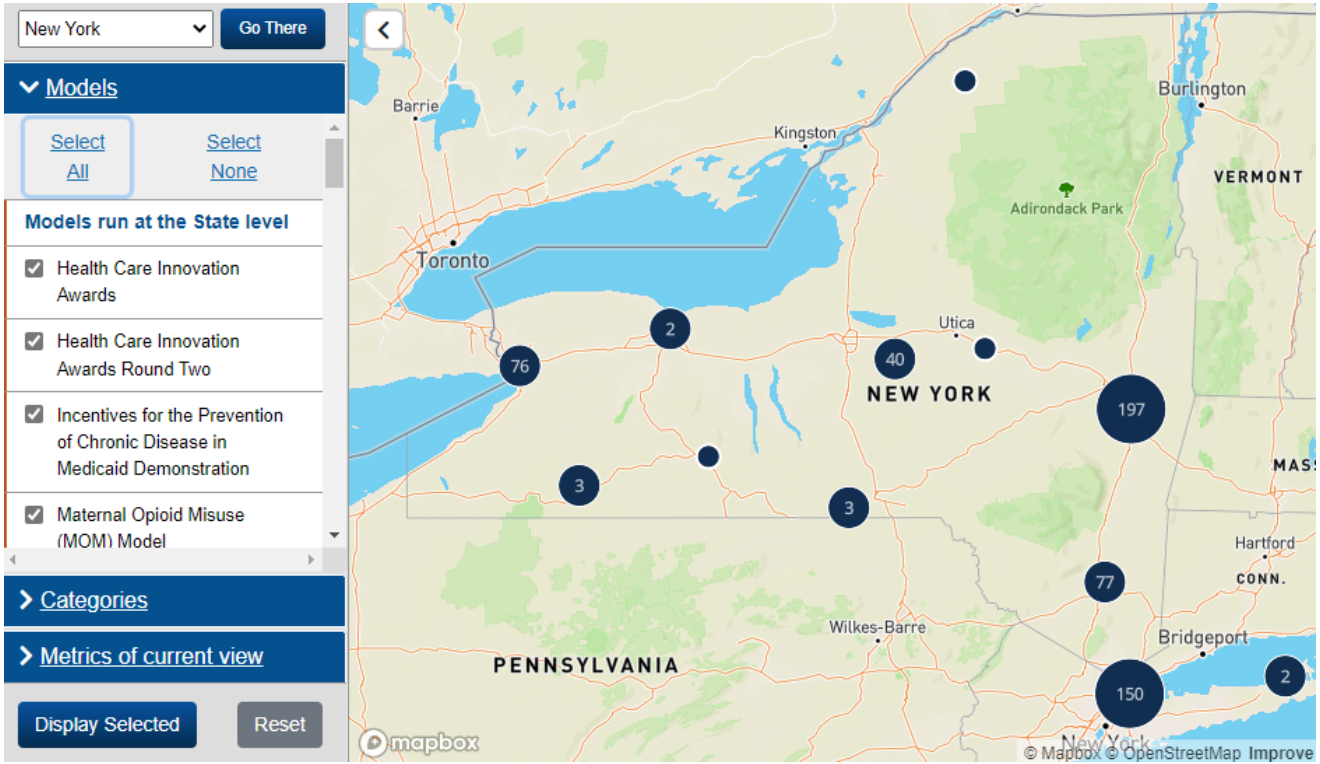
Triple Aim

- Experience
- Health
- Cost
- "…three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care…"

Berwick DM, et al. *Health Affairs*. 2008:759-769

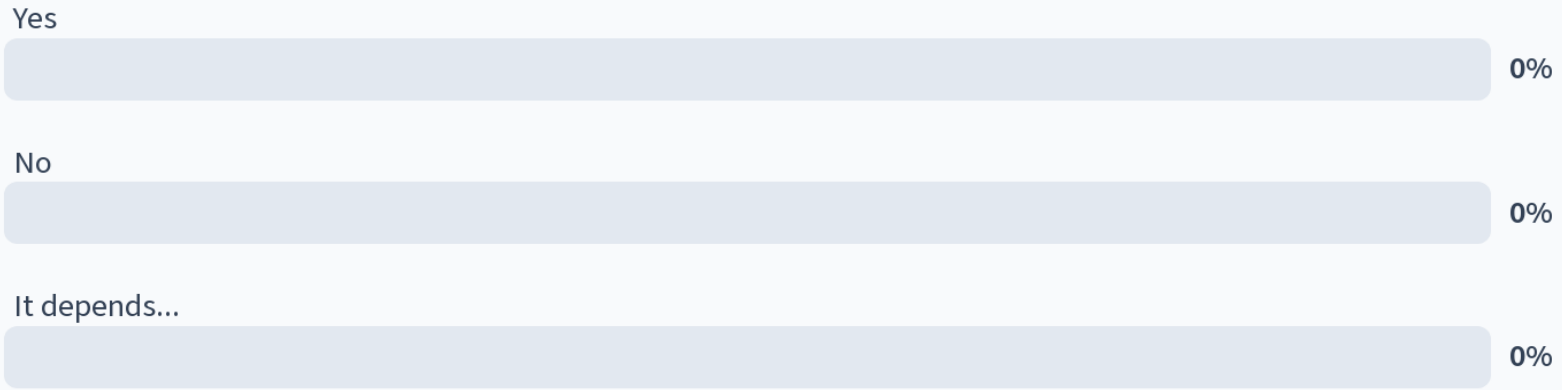
CMMI Innovation Projects

New York, as of February 2023



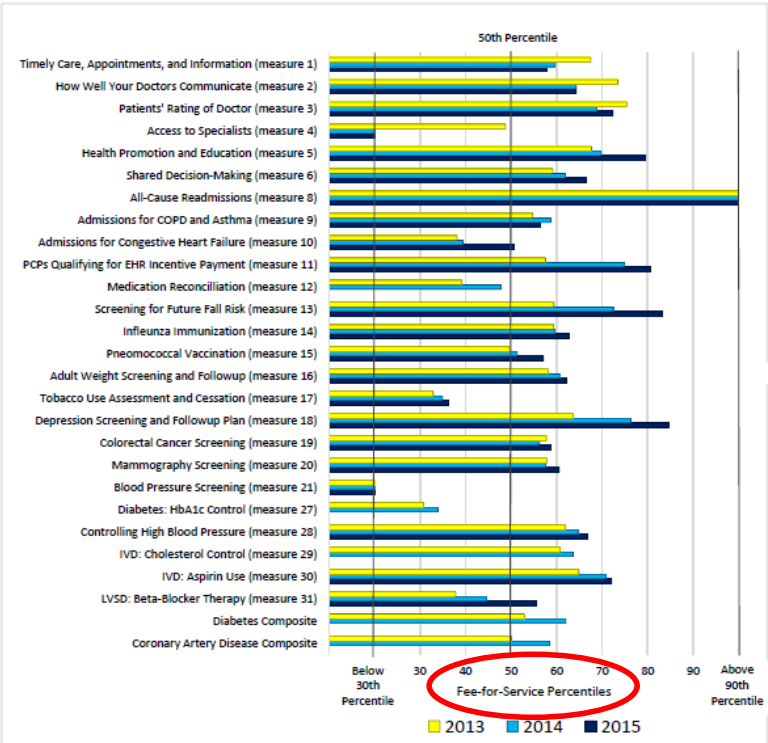
Source: Center for Medicare & Medicaid Innovation. http://innovation.cms.gov. Accessed February 17, 2023.

Does care management reduce health spending?



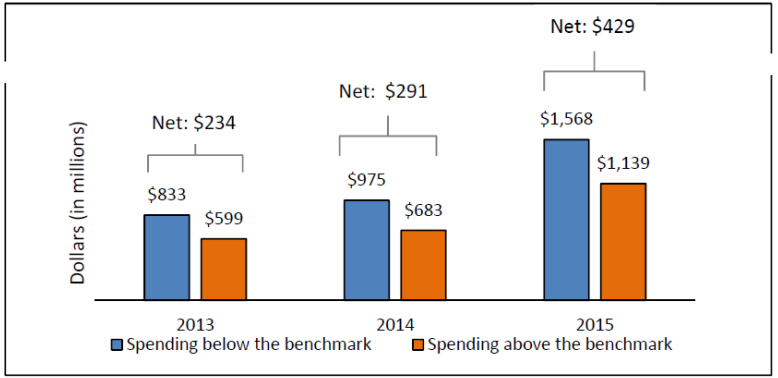
EVIDENCE ON MEDICARE SHARED SAVINGS PROGRAM ACOs 2013-2015

Exhibit C-1: ACOs' Performance on Quality Measures Compared to Fee-for-Service Providers, 2013 to 2015



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

Exhibit 5: ACOs' Medicare Spending Above and Below Their Benchmarks, 2013 to 2015 (in millions)



Source: OIG analysis of ACO spending data, 2017.

Source: Department of Health and Human Services, Office of Inspector General. Medicare program shared savings accountable care organizations have shown potential for reducing spending and improving quality. Publication OEI-02-15-00450, August 2017.

Bundled Payment Programs…

HealthAffairs

REVIEW ARTICLE

The Impact Of Bundled Payment On Health Care Spending, Utilization, And Quality: A Systematic Review

"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."

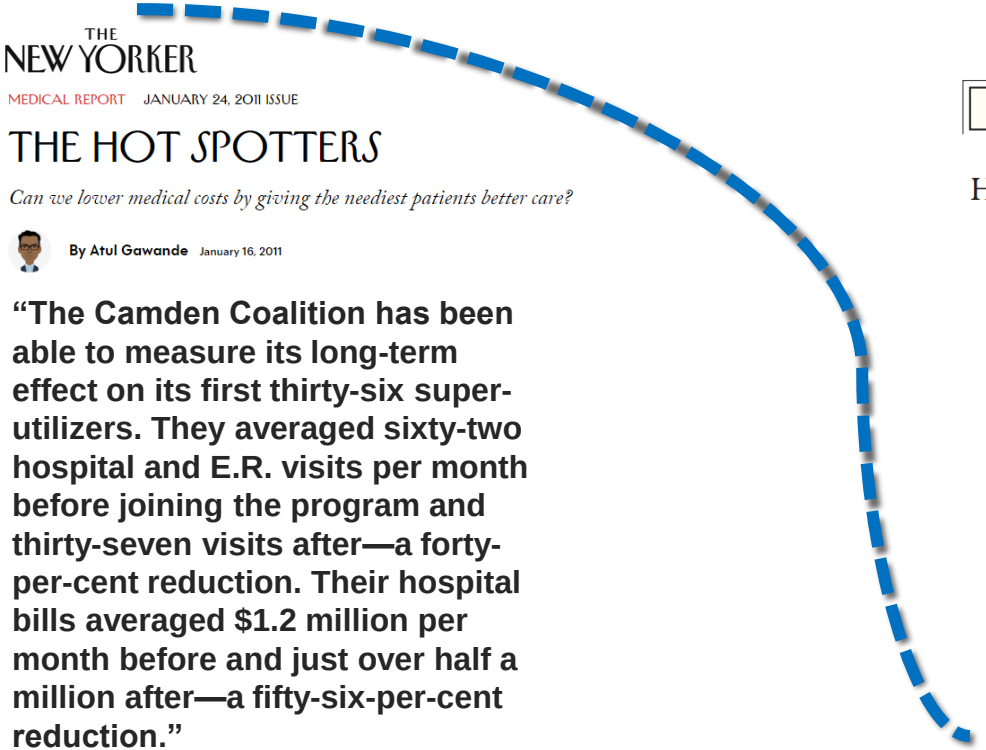
Source: Agarwal R, et al. Health Affairs. 2020. 39(1):50–57

EXHIBIT 2

Summary of results from 20 studies that compared a bundled payment model and fee-for-service reimbursement, by study outcome

Outcome	Direction of outcome	ACE	BPCI	CJR	Overall
HEALTH CARE SPENDING					
Episode payments	–	0/2	5/12	1/3	6/16
Spending by type					
Inpatient hospitalization	–	0/2	3/8	0/1	3/10
Postacute care period	–	1/1	2/2	—[a]	3/3
Institutional postacute care	–	—[a]	1/1	1/1	2/2
Skilled nursing facility	–	0/2	3/4	1/1	4/6
Inpatient rehabilitation facility	–	0/2	3/5	1/1	4/7
Long-term acute care hospital	–	0/1	0/3	0/1	0/4
Home health agency	+	0/2	3/6	0/1	3/8
UTILIZATION					
Discharge to:					
Postacute care facility	–	—[a]	5/9	2/3	7/12
Home health agency	–	—[a]	2/5	0/2	2/7
Home or self-care	+	—[a]	1/5	0/1	1/6
Length-of-stay					
Inpatient	–	1/1	7/11	1/2	8/13
Postacute care facility	–	—[a]	1/4	1/2	2/6
QUALITY					
All-cause readmission rate	–	1/2	4/14	1/3	6/18
Complication rate	0	1/1	—[a]	3/3	4/4
Mortality	0	1/1	2/2	1/1	4/4
Emergency department visits	0	1/1	3/3	2/2	5/5
UNINTENDED CONSEQUENCES					
Risk selection or case complexity	+	—[a]	1/3	0/2	1/5
Volume	–	—[a]	3/3	2/2	5/5

Evidence on Complex Care Management



THE NEW YORKER

MEDICAL REPORT JANUARY 24, 2011 ISSUE

THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

By Atul Gawande January 16, 2011

"The Camden Coalition has been able to measure its long-term effect on its first thirty-six super-utilizers. They averaged sixty-two hospital and E.R. visits per month before joining the program and thirty-seven visits after—a forty-per-cent reduction. Their hospital bills averaged $1.2 million per month before and just over half a million after—a fifty-six-per-cent reduction."

The NEW ENGLAND JOURNAL of MEDICINE

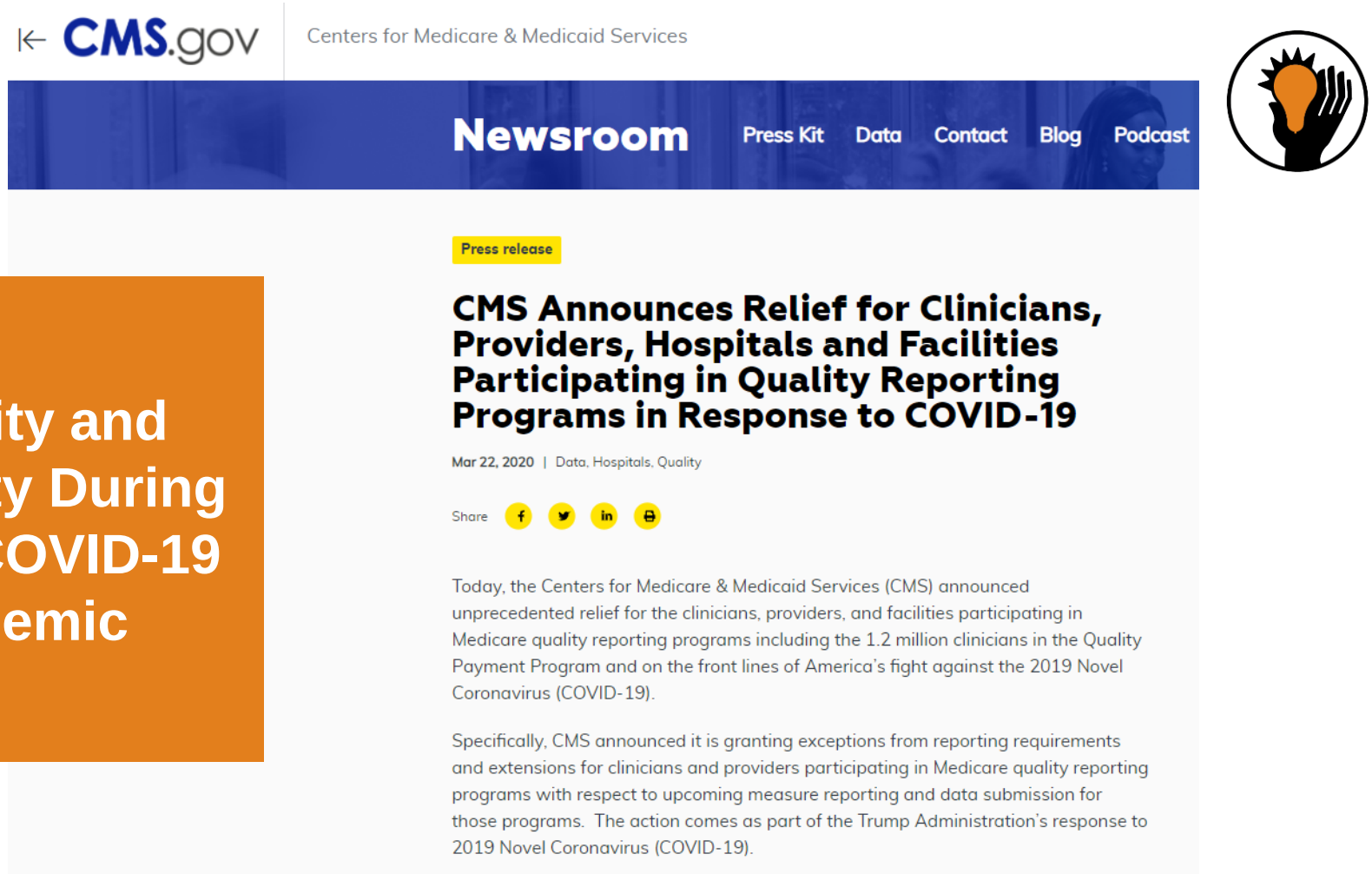
SPECIAL ARTICLE

Health Care Hotspotting — A Randomized, Controlled Trial

"In this randomized, controlled trial involving patients with very high use of health care services, readmission rates were not lower among patients randomly assigned to the Coalition's program than among those who received usual care."

Source: Finkelstein A, et al. N Engl J Med 2020;382:152-62.

Quality and Safety During the COVID-19 Pandemic



CMS.gov | Centers for Medicare & Medicaid Services

Newsroom Press Kit Data Contact Blog Podcast

Press release

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

Share

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

	2020 Q1	2020 Q2	2020 Q3	2020 Q4
CLABSI	↓ −11.8%	↑ 27.9%	↑ 46.4%	↑ 47.0%
CAUTI	↓ −21.3%	No Change[1]	↑ 12.7%	↑ 18.8%
VAE	↑ 11.3%	↑ 33.7%	↑ 29.0%	↑ 44.8%
SSI: Colon surgery	↓ −9.1%	No Change[1]	↓ −6.9%	↓ −8.3%
SSI: Abdominal hysterectomy	↓ −16.0%	No Change[1]	No Change[1]	↓ −13.1%
Laboratory-identified MRSA bacteremia	↓ −7.2%	↑ 12.2%	↑ 22.5%	↑ 33.8%
Laboratory-identified CDI	↓ −17.5%	↓ −10.3%	↓ −8.8%	↓ −5.5%

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

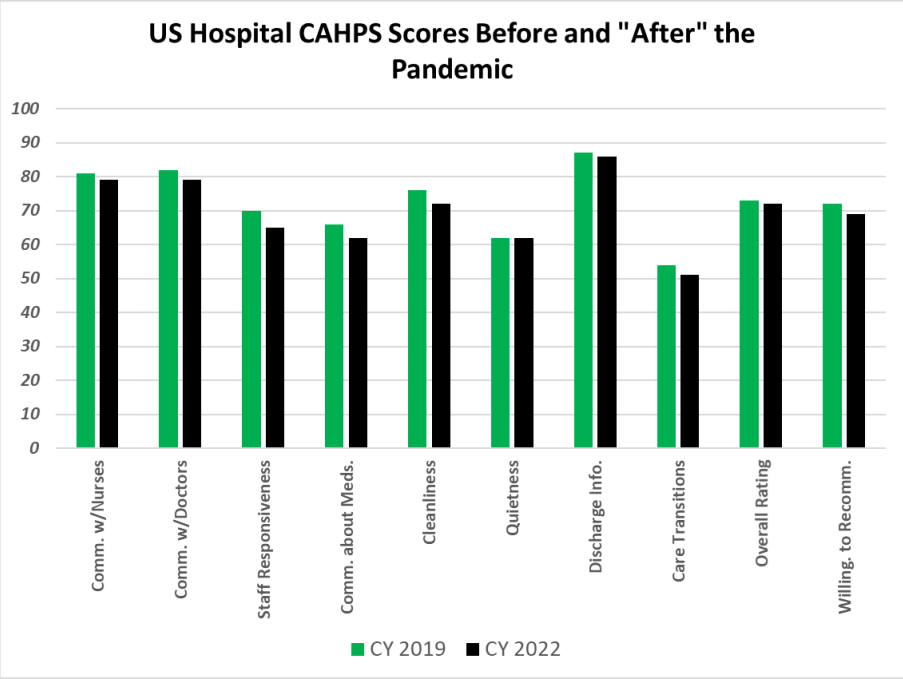
Original Article

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

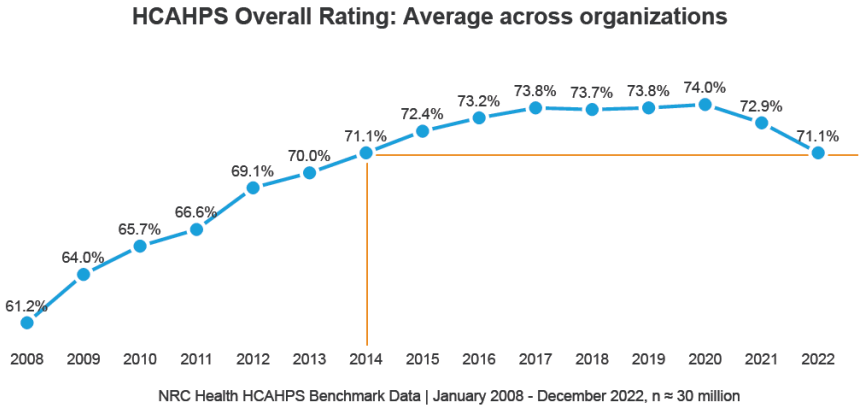
Lindsey M. Weiner-Lastinger MPH[1], Vaishnavi Pattabiraman MSc, MS, MPH[1,2], Rebecca Y. Konnor MPH[1,3], Prachi R. Patel MPH[1,3], Emily Wong MPH[1,2], Sunny Y. Xu MPH[1,3], Brittany Smith MPH[1,4], Jonathan R. Edwards MStat[1] and Margaret A. Dudeck MPH[1]

[1]Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia, [2]Leidos, Atlanta, Georgia, [3]CACI, Atlanta, Georgia and [4]Oak Ridge Institute of Science and Education, Oak Ridge, Tennessee

Patient Experience
Before and "After" the Pandemic



Source: https://hcahpsonline.org/en/summary-analyses/previous-summary-analyses-documents/, and Bhalla R. Accessed February 20, 2024.



Source: Moving the HCAHPS Needle. NRC Health. March 2023 [NRC Clients Only]

COVID-19 and the Quality Officer

Modern Healthcare

NEWS DIGITAL HEALTH INSIGHTS OPINION EVENTS & AWARDS MULTIMEDIA DATA CENTER

Home > Safety & Quality

March 08, 2022 05:00 AM

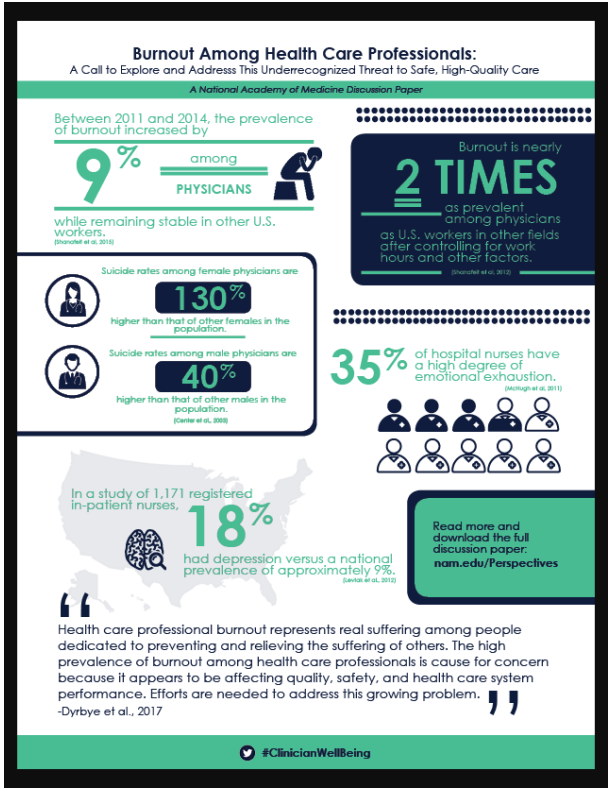
Rising up: C-suite relies on chief quality officers through pandemic

LISA GILLESPIE

TWEET SHARE SHARE EMAIL REPRINTS

Source: https://www.modernhealthcare.com/safety-quality/pandemic-elevates-chief-quality-officers-importance?utm_source=modern-healthcare-am-tuesday&utm_medium=email&utm_campaign=20220307&utm_content=article1-headline. March 8, 2022

The Health Care Work Force



"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…"


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

Source: Dyrbye, L. N., T. D. Shanafelt, C. A. Sinsky, P. F. Cipriano, J. Bhatt, A. Ommaya, C. P. West, and D. Meyers. 2017. Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201707b

The Quadruple Aim

REFLECTION

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

Thomas Bodenheimer, MD[1]
Christine Sinsky, MD[2,3]

[1]Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California San Francisco, San Francisco, California

[2]Medical Associates Clinic and Health Plan, Dubuque, Iowa

[3]American 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."

Ann Fam Med 2014;12:573-576. doi: 10.1370/afm.1713.

Revisiting the Harvard Medical Practice Study

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Safety of Inpatient Health Care

David W. Bates, M.D., David M. Levine, M.D., M.P.H.,
Hojjat Salmasian, M.D., Ph.D., M.P.H., Ania Syrowatka, Ph.D., David M. Shahian, M.D.,
Stuart Lipsitz, Sc.D., Jonathan P. Zebrowski, M.D., M.H.Q.S.,
Laura C. Myers, M.D., M.P.H., Merranda S. Logan, M.D., M.P.H.,
Christopher G. Roy, M.D., M.P.H., Christine Iannaccone, M.P.H., Michelle L. Frits, B.A.,
Lynn A. Volk, M.H.S., Sevan Dulgarian, B.S., B.A., Mary G. Amato, Pharm.D., M.P.H.,
Heba H. Edrees, Pharm.D., Luke Sato, M.D., Patricia Folcarelli, Ph.D., R.N.,
Jonathan S. Einbinder, M.D., M.P.H., Mark E. Reynolds, B.A.,
and Elizabeth Mort, M.D., M.P.H.

"Adverse events were identified in nearly one in four admissions, and approximately one fourth of the events were preventable.."

Source: N Engl J Med 2023;388:142-53.

Health Care Disruptors

Why 2022 Will Be a Year of Disruptor Differentiation

Data & Insights / AHA Center for Health Innovation Market Scan

“If 2021 will be remembered as the great expansion of retail health care, 2022 is likely to be defined as the year of disruptor differentiation. The massive push by CVS Health, Walgreens, Amazon and Walmart to scale primary care services — in person, virtually and in some cases at home — rapidly took shape last year.”

Source: American Hospital Association. https://www.aha.org/aha-center-health-innovation-market-scan/2022-01-11-why-2022-will-be-year-disruptor-differentiation. Accessed, February 20, 2024.

ON THE QUALITY HORIZON…

Xavier Becerra, JD
HHS Secretary (as of 3.18.21)

Chiquita Brooks-LaSure
CMS Administrator (as of 5.25.21)

Quality Measures

- Non-hospital
- Physician-specific
- Allowance for socioeconomic variables
- Integration of health equity

Value Based Payment

- Evolving in non-hospital settings
- Limits of financial downside
- How to measure equity
- How to pay for equity

Macro Forces

- Workforce shortage and resilience
- EHR interoperability
- Artificial intelligence
- Vertical integration and “Disruptors”
- Innovation: in the eye of the beholder?

Hospital Health Equity Standards, 2023

Centers for Medicare and Medicaid Services

- Strategic priority
- Data on demographics and social determinants
- Performance measures
- Quality improvement collaboratives
- Board, CEO, and leadership engagement

The Joint Commission

- Accountable individual
- Data on social needs
- Stratified performance measures
- Action plan for disparities
- Communication to key stakeholders

US Health Care Landscape and Quality

Settled

- Quality is important to all stakeholders
- Quality is firmly intertwined with costs and value
- Inpatient quality measures stagnant
- 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
- Workforce support, as a mediator of quality
- Impact of vertical integration on quality

THANK YOU!

GREATER NEW YORK HOSPITAL ASSOCIATION & UNITED HOSPITAL FUND

CLINICAL QUALITY FELLOWSHIP PROGRAM