



Coordinating Public and Private Sector Efforts to Improve Healthcare Quality and Performance

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27 July 2011

Outline

- ∅ Part 1: Attributes of a high performance healthcare system
- Part 2: Requirements for reform and improvement
- Part 3: The US Department of Veterans Affairs transformation
- Part 4: Implications for Australia and key stakeholders

U.S. Institute of Medicine *Crossing the Quality Chasm* (2001)

- Safe: avoids injuries
- Effective: services based on scientific knowledge; avoids underuse and overuse
- Patient-centered: responsive to individual patient preferences, needs, and values
- Timely: reduces waits and delays
- Efficient: avoids waste [value]
- Equitable: across gender, ethnicity, geographic location, and socioeconomic status

Commonwealth Fund's Framework for a High Performance Health System (2006)

- Quality and Safety
 - the right health care; avoids underuse, overuse and misuse
 - safe, reliable
 - coordinated
 - patient-centered: timely, excellent service, active and informed patients
- Access to Care
 - universal participation
 - financial protection, established benefits, affordable
 - equitable

Commonwealth Fund's Framework for a High Performance Health System (2006)

- Efficient, High Value Care
 - efficient
 - right time, right setting
 - ongoing evaluation of new technologies; defined processes for introduction, surveillance, reevaluation
- System Capacity to Improve
 - investment in innovation and research
 - information infrastructure
 - effective educational system
 - rapid response to threats and disasters
 - culture of improvement
 - balance between autonomy and accountability

Summary of desired features

1. Safe and reliable
2. High-quality, effective, evidence-based
3. Patient-centered, excellent service
4. Timely, accessible
5. Efficient, cost-effective, high-value
6. Equitable
7. System is technologically advanced, research- and improvement-oriented, balancing autonomy and accountability

Challenges and barriers to improvement

Observers offer many explanations for lack of progress in reform, pointing to deficits in domains such as:

- Knowledge, skills
- Motivation, incentives
- Leadership, commitment
- Culture, norms
- Effective solutions, evidence, information
- Resources: funding, staffing, capital

Identifying key barriers to reform: Insights from quality improvement research

- ž Local, regional and national reform and improvement efforts have generally failed to achieve significant, persistent change
- ž Most efforts produce limited or partial impact (e.g., on mediating factors).
 - *“Intervention physicians displayed improved knowledge and attitudes but no change in clinical practices.”*

“Necessary but not sufficient conditions”

- ž Most health care practices are highly stable and embedded in a dense network of influences and constraints related to knowledge, beliefs, attitudes, norms, habits, systems, incentives, expectations, etc.
- ž Eliminating one or two constraints eliminates one or two constraints, leaving many others

Outline

Part 1: Attributes of a high performance healthcare system

∅ Part 2: Requirements for reform and improvement

Part 3: The US Department of Veterans Affairs transformation

Part 4: Implications for Australia and DoHA

Requirements for clinical practice change

1. Valid, legitimate (accepted) evidence
2. Evidence of deviations
3. External expectations, interest (monitoring), pressure
4. Etiology of practices, deviations
5. Information, evidence, education
6. Professional norms
7. Feasible methods/systems

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TIME

FROM THE MAGAZINE

Sunday, Aug. 27, 2006

How VA Hospitals Became The Best

No longer a nation's shame, veteran care is acing competitors

By DOUGLAS WALLER

Most private hospitals can only dream of the futuristic medicine Dr. Divya Shroff practices today. Outside an elderly patient's room, the attending physician gathers her residents around a wireless laptop propped on a mobile cart. Shroff accesses the patient's entire medical history--a stack of paper in most private hospitals. And instead of trekking to the radiology lab to view the latest X-ray, she brings it up on her computer screen. While Shroff is visiting the patient, a resident types in a request for pain medication, then punches the SEND button. Seconds later, the printer in the hospital pharmacy spits out the order. The druggist stuffs a plastic bag of pills into what looks like a tiny space capsule, then shoots it up to the ward in a vacuum tube. By the time Shroff wheels away her computer, a nurse walks up with the drugs.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care

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ABSTRACT

BACKGROUND

In the mid-1990s, the Department of Veterans Affairs (VA) health care system initiated a systemwide reengineering to, among other things, improve its quality of care. We sought to determine the subsequent change in the quality of health care and to compare the quality with that of the Medicare fee-for-service program.

Overview of the Veterans Health Administration

- Largest component of VA (benefits, cemeteries, healthcare)
- Budget over \$25 billion; 5.2 million unique patients annually
- Total staff 200,000 FTEs – including over 10,000 MDs, 50,000 nurses
- Total sites: over 1,300 – including 172 medical centers, 871 clinics, 207 counseling centers, 134 nursing homes
- Patient population is older (49% over 65), sicker, poorer (70% annual incomes less than \$26,000), predominantly male

VHA's transformation

- Dramatic improvements in quality, safety, efficiency and reputation since 1995:
 - doubling of patient population with decrease in staffing;
 - decrease in cost per patient;
 - industry-leading quality and safety, technology, care management processes, management policies
- Continuous (*if incomplete*) stream of research, trade press and general media coverage of the transformation
- Key questions include “why” and “how”

Motivation and overall governance

- US national healthcare reform effort, “near-death” of VHA
- Visionary, committed, creative leadership
- Taxpayer support
- Strong academic and research linkages
- Active and trusting (generally speaking) stakeholders (VSOs, Congress, medical schools)
- Coordinated, comprehensive, broad strategy for change

Key elements of transformation strategy

- Extensive diagnosis (Kizer 1999, Table 1)
- Participatory planning and governance (leaders, staff, unions, medical schools)
- “Top-to-bottom” reorganization
 - $\frac{3}{4}$ VISNs: decentralization, continuity
 - $\frac{3}{4}$ CBOCs
 - $\frac{3}{4}$ Integrations: economies of scale, continuity
 - $\frac{3}{4}$ Primary care, team-based care, telephone triage
- Financing reform: VERA (capitation)
- IT: computerized records, reminders, bar coding
- Performance measurement and incentives

Summary of desired features

1. Safe and reliable
2. High-quality, effective, evidence-based
3. Patient-centered, excellent service
4. Timely, accessible
5. Efficient, cost-effective, high-value
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Dimension 1. Safe and reliable

- National Center for Patient Safety established in 1999 to “develop and nurture a culture of safety throughout the Veterans Health Administration”
- “a bright star in the constellation of safety practice, with system-wide implementation of safe practices, training programs, and the establishment of 4 patient-safety research centers” (Leape and Berwick, “Five years after to err is human: What have we learned?” JAMA 2005)
- VHA safety policies and processes are exceptional (Longo et al, JAMA 2005); valid comparative data appear to be unavailable (Rosen et al, Medical Care 2005)

Dimension 2.

High-quality, effective, evidence-based

- VHA out-performs private sector in adherence to a broad range of evidence-based recommendations (Asch 2004; Kerr 2004)
- VHA out-performs private sector on all 17 NCQA criteria (VHA Dec 2005)
- Comprehensive clinical practice guidelines, quality measurement and feedback, performance contracting
- Electronic medical records with computerized reminders
- Extensive research-based technical assistance (QUERI, HSR&D) for measurement; case-mix adjustment; quality gap diagnosis; improvement program design, implementation and evaluation

Dimension 3.

Patient-centered, excellent service

- University of Michigan ACIS: VA patient satisfaction score 83 (of 100) inpatient and 80 outpatient vs. 73 and 75 private sector
- Extensive customer service training, performance incentives
- Continuous VA and VSO patient surveys
- My HealtheVet patient education and informed consent system (shared decision making)
- Office of Care Coordination

Dimension 4. Timely, accessible

- Growth in CBOCs (leading to doubling in patient enrollment)
- Significant reductions in appointment waiting times
- Advanced Clinic Access (ACA) improvement collaborative with IHI
- Ongoing efforts to reduce time to first appointment
- Budget-related debates over co-pays, eligibility rules

Dimension 5.

Efficient, cost-effective, high-value

- 10-year doubling in patient enrollment and increase in visits with 2% decrease in overall staffing
- VHA and Medicare cost-per-patient equal in 1996; comparable data for 2004 show 26% lower cost for VA (VHA 2004; Medicare 2005)
- Significant reduction in inpatient care
- System-wide formulary (pharmacy benefits management system), contracting, standardization
- Reductions in duplicate testing, unnecessary care, etc.

Dimension 6. Equitable

- Racial/ethnic and socioeconomic disparities smaller in VHA than private sector
- Extensive equity/disparities measurement but limited programmatic efforts

Dimension 7. Technologically advanced, improvement-oriented, balanced

- VISTA, CPRS, MyHealtheVet
- Office of Quality and Performance; Quality Enhancement Research Initiative; IHI Collaboratives, National Surgical Quality Improvement Program (NSQIP)
- Continuous patient, staff surveys, External Peer Review Program
- Office of Research and Development, Health Services Research and Development Service: *Service-Directed Research*, Clinical Practice Guideline Council
- Office of Patient Care Services: field-based national clinical policy groups (Strategic Healthcare Groups)

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Reforming national health systems: Diagnosis

- ž Review current performance to identify gaps in performance
- ž Assess current conditions and identify gaps in required conditions
- ž Identify barriers and facilitators to change

Requirements for clinical practice change

1. Valid, legitimate (accepted) evidence
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Reforming national health systems: Planning and action

- ž Identify and convene stakeholders, develop collaborative plan
- ž Launch, stimulate, support and coordinate
 - (a) mutually reinforcing efforts by
 - (b) professional societies, government, business, voluntary health organizations, payors, etc. directed at
 - (c) multiple levels (patient, clinic, delivery system, policy)