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Interview with Cindy Barnard, MBA, MSJS, on quality in health care

Cindy Barnard, MBA, MSJS, is the vice president of quality for Northwestern Memorial Health Care in Chicago and oversees quality efforts at the systems of four hospitals, ranging from a 984-bed academic medical center to a 100-bed community hospital, and two large multispecialty medical practice groups.

A certified professional in health care quality, she is also a research associate professor at the Northwestern University Center for Health Care Studies and serves as faculty for the Master's degree program in health care quality and patient safety. Cindy engages with physicians, administration patients, and payers to understand their unique concerns regarding what constitutes quality care. I recently sat down with Barnard to get her perspective on what we really mean by health care quality.

COLLINS: How would you define health care quality?

BARNARD: There is a national consensus definition that comes from the Institute of Medicine's 2001 report: "Crossing the Quality Chasm." That definition includes the domains of safety, timeliness, efficiency, effectiveness, equity and what they call patient-centeredness. In the non-health care world, typically the word quality means "suitability of the product or service for the needs of the consumer or customer"; this is a detailed way of answering that question in health care.

COLLINS: What do patients and caregivers associate with the term health care quality?

BARNARD: When you look at the literature on patient centeredness in health care, the domains you will find are communication, compassion and hotel functions such as cleanliness, food and parking. However, that is certainly not a complete view of what patients and families think of quality. A big factor that influences perceived quality is in the communication component—both how health care providers speak to patients and how they did or did not give patients information, but also how they coordinated care and then spoke to patients about it. For example, if one doctor did an imaging study and then another health care provider didn't even know that study had been performed, let alone what the findings were, then patients do not feel that their care was high quality and safe. I think handoffs, transitions and communication are going to emerge as major themes in what patients think of quality.

COLLINS: Payers, health care providers and hospitals often consider quality from unique perspectives. What common quality theme or themes do you think all of these stakeholders could agree on?

BARNARD: There is some consensus on a set of measures distinguished for their feasibility; however, these are not necessarily optimal measures of quality. Most private payers look to National Quality Forum (NQF) endorsement as evidence that a measure is reasonable. Such measures may not be optimal—the feasibility of data collection has driven a lot of these consensus decisions. The majority of measures around hospital-acquired conditions, patient safety indicators and quality indicators are constructed on the basis of claims data.

There's ample literature showing that when you do a really thorough quality study that these measures do not provide a comprehensive assessment of what really happened. They are being used as a proxy until such time as we have richer measures which will likely be derived from electronic medical records. Hospitals and health care systems have demonstrated that they can comply with

federal "meaningful use" requirements, meaning that our electronic medical records can produce quality measures.

Beginning next year, the Centers for Medicare and Medicaid Services (CMS) will require reporting on electronic clinical quality measures (ECQMs) that are similarly derived from the electronic medical record. Under this program, providers must be able to show they can both produce the measure and achieve a degree of performance. Although private payers have developed their own versions of metrics, the domains are similar—both CMS and private payers are thinking about readmissions, length of stay, infections and mortality. I would anticipate in the years to come as the industry gets a little bit further advanced in measurement and as these ECQMs emerge they will probably cohere around a library of common measures.

COLLINS: What is the biggest barrier to improving health care quality?
BARNARD: I would say accurate measurement is the first barrier. However, even when we can pinpoint a deficiency, aligning stakeholders and driving change using our rather rudimentary medical record systems and limited experience in process engineering are bigger barriers. Joint Commission President Mark Chassin has said that the single biggest problem in American health care is the lack of robust process improvement expertise. I think there's great truth to that, although the lack of data really needs to be up there at the same level.

COLLINS: Is there a difference between quality and patient safety?
BARNARD: They are certainly aligned and both are produced as the result of robust and reliable systems executed by competent people with adequate resources in a fair and just work environment or culture. Quality means you deliver the right care every time and safety means freedom from accidental injury in the process of receiving care. However, there is a blurred boundary between them—for instance, if you don't deliver the correct diagnosis, you are heading into a patient safety problem.

COLLINS: How can health care providers, payers, health care systems and hospitals best work together to improve health care quality?
BARNARD: The ideal scenario would involve the development of grand common measures aimed at incentivizing the right behaviors without contributing to unintended consequences.

A good example of a measure leading to unintended consequences comes from an experiment almost 30 years ago in Rochester, New York, where a payer published cardiac surgery mortality and complication rates. The immediate fallout from that was that some cardiac surgeons refused to operate on high-risk patients—that's an unintended consequence. Mortality and complication rates for public transparency and accountability need to be properly risk-adjusted.

If we all could agree on well-designed measures that truly matter, then we could partner with our payers to roll them out across electronic health record vendors and regions. Some of this work is advancing thanks to a provision of the Affordable Care Act that requiring payers to devote at least 85 percent of their premium dollars on the delivery and improvement of health care. As a result, some payers began putting money aside to fund innovative work in health care improvement.

COLLINS: Measurement is a necessary process in a quality program and payers are working to define the structure of value-based payment systems. However, physician compensation in the present environment is often more driven by measures of productivity rather than quality. Do you have any insight into how value-based compensation systems could best be structured to better align productivity with quality?
BARNARD: I think that we need to focus more on the process: did the doctor do everything humanly possible and do it in a way that was, as objectively as we can measure, competent? If so, then we accept the fact that the patient may or may not comply and that such noncompliance could adversely impact metrics that are out of the practitioner's control.

However, the current payment models that are value-based tend to reflect compensation for RVUs and quality. Typically, the argument you hear is, yeah, we know these aren't very good measures, we know there could be a selection bias, we know we're going to run the risk of possibly making a doctor

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look worse when they have a lot of noncompliant patients but the quality adjustment is only a small proportion of their payment, it's not going to really drive behavior to an appreciable degree.

Well, my argument is, if it's not going to drive behavior then why are you using it? It doesn't mean we shouldn't put anything at risk; there are group practices that are experimenting with this and trying to learn from it. But we need to recognize that there are real potential unintended consequences from linking reimbursement to performance on inadequately risk-adjusted measures.

COLLINS: What suggestions do you have for interventional radiologists in particular who are interested in demonstrating and improving the quality of care that they can provide to patients, payers and hospitals?

BARNARD: I think that interventional radiologists would want to be thinking about measures that are truly within individual practitioners' control and that could be applied without unintended consequences. What things would incentivize the health care team to work together to deliver the best outcome to the patient?

One of the topics with particular relevance to interventional radiology that I'm most interested in is appropriateness: how do we make sure that we're doing the right procedure for the right patient at the right time?

Another metric that has been used in the past is tracking the rate of conversion of a minimally invasive to an open procedure. This speaks a little bit to the dilemma of whether we followed the right thought process before we brought this patient in for a procedure.

In addition, I would encourage IRs to move toward measures that look at long-term patient-reported outcomes. This entails asking the patient, "Did you ultimately get better in the ways that were important to you?" That is the longer term Holy Grail of quality: are we collaborating well with our patients to target the outcomes they want, and then delivering those outcomes reliably and without unanticipated complications?

Overall, this is an extraordinarily exciting time to be working in health care quality.