

(Music)

Mark Masselli: This is Conversations on Health Care, I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret there's a new sheriff in town.

Margaret Flinter: A new sheriff?

Mark Masselli: That's right, long time Microsoft Executive Kurt DelBene has been tapped by the White House to take over from Jeff Zients who took command at healthcare.gov back in the fall.

Margaret Flinter: Well I think that Jeff Zients really did an amazing job in what was a remarkably narrow timeframe, but I think the White House is right on this one Mark. A highly respected tech guru innovator probably just what the situation needs long term to fully resolve all the issues and get that credibility back into the organization.

Mark Masselli: DelBene is an expert in triage he loves complex problems to solve and he's fast. He'll be targeting a few important issues.

Margaret Flinter: Well one thing that was clear Mark is that the White House had to move beyond the beltway I think they learn the hard way that a tech savvy consumer expects websites to function well and really this was important stuff.

Mark Masselli: But we have to remind ourselves we're still in those early days and problems once identified are being fixed.

Margaret Flinter: And once all these millions of American health consumers navigate the rate through the insurance systems, many will be seeking a home for their health care and that bakes the question, how the consumers know which practices are quality practices.

Mark Masselli: Margaret O'Kane is the Founder and President of the National Committee for Quality Assurance which is dedicated to improving health care quality across the spectrum.

Margaret Flinter: And CQA is one of the leading organizations helping to a credit practices which (inaudible 1:29) to the highest quality standards.

Mark Masselli: Lori Robertson, Managing Editor of FactCheck.org's stops by looking to another misstatement about health policies spoken in the public domain. But no matter what the topic you can hear all of our shows by going to CHC Radio.

Margaret Flinter: And as always if you have comments please email us at chcradio.com or find us on Facebook or Twitter because we love hearing from you. And we'll get to our interview with Margaret O'Kane in just a moments.

Mark Masselli: But first here is our producer Marianne O'Hare with this week's headline news.

(Music)

Margaret Flinter: I'm Marianne O'Hare with this Health Care Headlines. The numbers are racking up in states where insurance exchanges have been running smoothly and there has been a push to educate consumers about the health insurance exchanges. There are significant numbers to report, the New York State close to 700,000 residence there have completed online applications and more than 300,000 residence are signed up for full insurance coverage. And in Washington state they're cheering not just the Super Bowl win the state rivals Vermont for the percentage of eligible population signing up for coverage through the state exchange better than 33% at last check. The state system was quite adaptable when the exchange open in October 1st in Washington, no one could logon instead they made an executive decision to take the whole site down, fix the problems then reboot when they knew they could handle the volume. They also chose to limit the scope of what the exchange site could do and decided they'd add more bells and whistles as the system could handle more complexity. He says other exchanges could benefit from their own experience.

And smoking and kids it's where they two often meet and once hooked it's a struggle to quit. The FDA is launching a campaign targeting the group that could be prevented from picking up the habit the first place within approach that might get through to a teenager namely long before smoking kills you it makes you prematurely ugly, yeah shows effects of smoking causing wrinkle skin, yellow teeth and not to mention the out of pocket cost to the average smoker. Well teen smoking is down overall there are an estimated 10 million at risk teens deem most likely to pick up the habit. The 110 million dollar campaign launched last week, I'm Marianne O'Hare with these Health Care Headlines.

(Music)

Mark Masselli: We're speaking today with Margaret O'Kane, President and Founder of the National Committee for Quality Assurance, a not for profit organization aimed at improving health care quality in health plans medical practices and patient centered specialty practices. Ms. O'Kane has served as the co-chair of the National Priorities Partnership and is a board member of the foundation for informed decision making in the American Board of Medical Specialties. She was elected a member of the institute of medicine in 1999 and receive a 2009 Picker Institute Individual Award for excellence in the advancement of patient centered care. She was named three times as one of the top 25 women in health care by modern health care. Margaret welcome Conversations on Health Care.

Margaret O'Kane: Happy to be here.

Mark Masselli: You know, you launched the National Committee for Quality Assurance back in 1990 with the goal of improving health care quality through measurement transparency and accountability and at that time there was very little infrastructure in place for monitoring health system. So I assume you had to start

from the ground up to create that infrastructure. Tell our listeners what the genesis of NCQA was and tell us about the many evaluative systems you've put in place.

Margaret O'Kane: When I started I, you know, I had work for five years as a respiratory therapist in a hospital and I think that's where I really was – let's just say I was impressed with how many opportunities to improve the quality of health care there were. And so I went back to graduate school and it was very interesting to me that what we had in terms of quality infrastructure at the time was kind of an inspection model. So doctors reading each other's charts, people walking around looking for bad things but really not much in terms of an affirmative idea of what supposed to be happening. So I think there were the ingredients for that in practice guidelines that had been developed for a preventive services and for some chronic diseases and, you know, these are diseases that are so common that they touch millions of Americans and the opportunity to get the care better and get the health of those people better was kind of just sitting there waiting to happen. So I think it's a time when we started to talk about quality and trying to get something going that wasn't a research project. We were fortunate that Fortune 500 Companies were doing their own quality improvement and the private was really trying to figure out what are we trying to accomplish, how do we know if we're doing it and then how do – what do we need to do to make it better. And so they had been doing it in corporate America and they were surprised when they went to talk to health plans that they would say well how are you doing taking care of your people with diabetes. And the plans would say we're doing great and they would say well how many do you have and they've said well we don't know. So, you know, it just became very clear that there was a lot of confusion and a lot of assumption that things were going well when nobody actually had any information.

Margaret Flinter: Mm-hmm, well it's so interesting to look into the science of health care quality measurement. But, at the National Committee of Quality Assurance you develop the tools that helped practices get onboard with their own quality improvement assessments, tell us about some of those tools that you developed and how you sort of realize that you needed to give people the tools to look at their own practices in a effective way, and of course of some of this really predates our electronic health record systems which made it a huge challenge.

Margaret O'Kane: Yeah I mean absolutely the work we were doing was long before most organizations had electronic health records. And, you know, organizations had quality improvement to varying degrees and a typical one was how many of our kids got their shots on time. Well it turns out that if you're not really specific about how you count, you have to kind of get very specific in order to have measures that you can compare one organization to another and that's one of the very key points about quality. So when we developed the health care effectiveness data and information set that allowed people to compare how am I doing compare to others.

Mark Masselli: You know the Affordable Care Act is laying the foundation for applying incentives for improving such things as accountability transparency in health care and now we're seeing the growth of patient centered medical homes and accountable care organizations which of course relying heavily on sharing data to improve outcomes. NCQA has been an early supporter of those models potential to

improve outcomes, how are these new shared risk models changing quality improvement landscapes?

Margaret O’Kane: Well when I think about how – how do you go about improving quality, one of the real important keys is to make it clear to everybody what their job is and where their responsibility extends to. With the patient center medical home it’s a bunch of criteria of how a primary care practice needs to be organized to systematically look at the people that it takes care of or its panel of patients. And make sure that the care they’re getting is coordinated, you know, so typically people will be seeing more than one doctor, and if each doctor is operating in a vacuum that doesn’t come together in a way that is coherent around every patients. It’s actually access I mean we know that often people don’t go to the doctor because it’s hard to get there so, one of our subject standards is around appointment access and there also has to be 24/7 access to clinical advice. Team base care, you know, the doctor doesn’t have to do everything so if the practice is following me and I have diabetes and my numbers are really not very good and I’m at risk for all the terrible complications of diabetes that can be broken up into nurses can take care of that health coaches can help with that. So team base care is another really important feature but everybody has to be really clear about what they’re job is. Figuring out who are my high risk people and what am I going to do to try to keep them as healthy as possible, and how empower them to take care of themselves. I mean the old model was, you would come in for whatever reason, you know, you sprayed your ankle so you go to the doctor and at that point they might look at your other numbers and see if you are up-to-date on your test and so on if you’re lucky. But this is a much more proactive way of managing the panel of patients, it’s the way things really ought to happen and it’s the way that you can be sure that everybody gets the care that they need and not more – of the care than they need. You know, we also look for the practices to be looking at their own quality, doing the kind of studies we talked about, they can be part of a collaborative or they can do it on their own. But there are, you know, when you look at our standards which are very detailed, there are many places to look for opportunities to improve or how am I doing.

Margaret Flinter: Well Margaret it struck me when NCQA first release their patient center medical home standards and in your subsequent revisions that in many ways you’re laying out standards which for most American primary care practices perhaps were more aspirational at the time, were team based care and some of those closing the loops on referrals, coordinate a care where not yet the standard of practice and of course we’ve seen so much progress over these couple of years. But now the NCQA has a new group around the standard setting and I understand that NCQA is one of only two organizations permitted by federal law to a credit plans in the new health insurance exchanges under the Affordable Care Act. We can share with our listeners what kind of quality measures are you asked to focus on in accrediting those insurance plans the consumers are going to be purchasing?

Margaret O’Kane: So our health plan accreditation was actually how we get started in quality. So we’ve been accrediting health plans since about 1993, so the exchange plans are just a new version of the health plans that we’re accrediting so we – you know, we started out, we went to Medicare and we said look what we’ve done here and don’t you think it’s really important to have some better quality information about Medicare. And they then contracted with us to collect data about

Medicare health plans and also they recognize our accreditation program. That's part of the beauty of what we do, you know, it's a consistent set of expectations that different payers can really rally around and, you know, so all of our committees in our board have multiple stakeholders and, you know, when you get to a common definition of this is what quality looks like then you can send a really coherent message to the plans about what they need to be doing and we're recognized in 38 states now, so performance measurement is a part of that accreditation so the (inaudible 12:50) measures which we're looking at how am I doing with my preventive services, how am I doing with people that have chronic diseases in my population of my meeting standards of care. And then another important element is there's a survey and the patients are asked, what's it like to be a member of this plan, do you get access to care when you need it, how is it working with the doctors that are available and so forth. So it's a very, very comprehensive look and now the newest iteration is with the exchanges, but that's not really new for us.

Mark Masselli: We're speaking today with Margaret O'Kane President of the National Committee for Quality Assurance, not for profit organization aimed at establishing better quality in health plans, medical practices and patient centered specialty practices. Margaret I wanted to sort of pull the thread on that concept of quality, you've been sort of talking about models of care all based on evidence based data out there and you've sighted some organizations that seem to have really gotten around to the sort of right model and two that we know well the Denver Health System in Colorado and Griffin Hospital in Connecticut. Tell us why these organizations stand out and any others who might come out to mind as well?

Margaret O'Kane: Well I'm thinking about the community health center inc. in Connecticut which is a level three patient center medical home that's a one of 6762 patient center medical homes that we've recognized nationwide. So there are many, many organizations that have kind of signed on for this because if you organized systematically and you measure systematically, you're going to get better quality than if you're just kind of unclear about what you're trying to achieve. So that way you can get some real clarity if you're a community health center or a primary care practice that the things that I'm working on are important things.

Margaret Flinter: And another area that we have been watching very carefully and are curious about your insights into is that of telemedicine or Telehealth as we tend to call it. Now over 200 telemedicine, Telehealth networks across the country, being utilized by over 300 hospitals and care centers in a wildly different ways and I know you've said that quality telemedicine and mobile health initiatives are going to be a big part of improving coordinated patient centered care and tell us from your perspective the essential role that telemedicine is going to play in the patient centered medical home, what's the work you're doing in that area?

Margaret O Kane: I think that the possibilities of Telehealth are really extraordinary I mean one application is, you know, if I am out in the country I just heard a better project in New Mexico where the university clinic is supporting primary care practices all over the state. Many of them led by nurse practitioners or PA physician assistance. They're actually working with the team on the ground and doing it through teleconferencing and so forth. And tracking outcomes and they're cure rate for Hepatitis C is kind of like 45% which is really extraordinary as good as the

universities own cure rate. So, it extends of the reach of our current delivery system out to more remote areas so, that's number one. I think if you think about the patient that's home bound and so forth. It also offers the opportunity to allow patients to be in their home to be monitored by the system without having to come in or drive for hours to get there. So, health in the home I think is going to be a great new model that we're going to have maybe extends the current capabilities of delivery system into places that we haven't thought of as sights of care but, really that can be. And I think we will always want to know is it clear who is responsible for what, so we would have kind of structural standards and then what are the outcomes that they're getting and what is the patients experience with this. So, the logic that we have just pretty much similar it's being really clear about how it needs to be organized and then having the patients to tell us how it is going.

Mark Masselli: Margaret I want to give a shout out on Sanjiv Arora who runs that program and we've worked with Sanjiv we actually modeled that up in our training folks around the country as well and –

Margaret O'Kane: He's a terrific visionary I think.

Mark Masselli: He is as great visionary and -- but, I want to talk a little bit about our provision in the Affordable Care Act that will compile customer responses to the online insurance. Market places and that data will start to be available in 2015 and the NCQA has launched a new program of distinction in patient experience reporting in which patients report on their own care experience. Tell us about this vital aspect of quality measurement in health care as the consumer is encouraged to share their feedback.

Margaret O'Kane: This is one of the new frontiers of health care I mean I think often we kind of fall into patterns of behavior that are not necessarily what the patient would have designed if they had the opportunity. So, getting the feedback from patients whether it's at the practice level, which is what our patient distinction, patient experiences to level for that, or whether it's at the health plan level or whether it's about the exchange. It's really important for us to constantly hear from people about what work, what didn't work, what could be better and so forth. So, I think that there's been all too much internal debate in health care about whether that is quality or not but, in many industries whatever the customer wants is quality. So, you know, getting that voice and getting that feedback of what it's like to be a patients and whatever the systems is absolutely a pillar of our work and of everybody else's work and quality I think.

Margaret Flinter: Well, Margaret I really appreciate your organizations directive which sounds pretty simple but, we know it's very complex and that is to measure, analyze, improve, repeat.

Margaret O'Kane: Yeah.

Margaret Flinter: Measure, analyze, improve, repeat –

Margaret O'Kane: That's it.

Margaret Flinter: And you've applied this method across so many platforms in health care and have been doing this for a couple of decades, perhaps you can share with us, maybe a significant success story we're applying this ideas that's had a dramatic impact on quality improvement.

Margaret O'Kane: Well, I mean I think about the organizations that we recognize and, you said before that when we put out our patients centered medical home standards, it was like some people thought we had landed from Mars because they feel so hard and they said really you expect us to do this. And yet we have practices out there that have so far exceeded our expectations and who are now telling us this is what ought to be thinking about for the next iteration. So, we see practices absolutely transformed -- one of the points that I didn't address that you asked about was changing the payments system. One of the things I think people don't realize is that if you pay people fee for service they really only get paid for doing the things that the fee for service covers and really kind of constrains them to do things that you might need like transportation of people in community health centers that really are not billable. So, by offering patient center medical homes a care management fee, payers have really freed them up to kind of meet the patient where the patient's needs are and they've just really -- they continued to astound us in terms of their level of aspiration on what they do for their patient so it's fantastic.

Mark Masselli: We've been speaking today with Margaret O'Kane, President of the National Committee for Quality Assurance, not for profit organization aimed at improving health care through measurement, transparency in accountability. You could learn more about their work by going through ncqa.org Margaret thank you so much for joining us on Conversations on Health Care.

Margaret O'Kane: My pleasure.

Mark Masselli: At Conversation on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an-award winning journalist and managing editor of FactCheck.org a nonpartisan, nonprofits consumer advocate for voters that aim to reduce the level of deception in US politics. Lori what have you got for us this week?

Lori Robertson: Well President Obama recently gives his state of the union address and he made one false statement about the Affordable Care Act. The President Bush did that because of the Affordable Care Act, more than nine million Americans have signed up for private health insurance or medicare coverage. But that total includes Medicaid renewals, not just new enrollees who sign up because of the law. Here are the components of the nine million figure, 3 million Americans who have chosen insurance plans on the federal or state market places an estimated 3.1 million young adults under age 26 who join their parents plan because of the law's requirement. And 6.3 million who were determined eligible for Medicaid in the children's health insurance program from October through December. But the administrator of the centers for Medicare and Medicaid services said when announcing that number, that it included new eligibility younger extended coverage, eligibility under prior law and quote in some states medicare renewals and groups not affected by the health care law. So not, everyone was a new enrollee who gave Medicaid coverage because of the expansion of Medicaid or even because they

were previously eligible, but encouraged to sign up because of the ACA. Some unknown numbers of those 6.3 million are renewing their already existing coverage. Obama overstated the laws impact. And that's my fact check for this week, I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the countries major political players and is a project of the Annenberg Public Policy Center at the University Of Pennsylvania. If you have a fact that you'd like checked, email us at chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on conversations on Health Care.

(Music)

Margaret Flinter: Each week, conversations highlight a bright idea about how to make wellness apart of our communities and to everyday lives. Walking sound simple but it's tricky business when you've lost a limb and with the proliferation of IED explosions in our recent wars in Iraq and Afghanistan. We've seen the devastating effects of these injuries too frequently. But all of these amputees have spurt a new Russian science to build a better prosthetic, none average, amputees take a fall at least once a year because of a lack of proficiency of the artificial limb to function naturally. Scientist at Michigan Tech had developed a computerized bionic limb that pivots and rotates just like a natural ankle would.

Men: the ankle can move more than just to up and to down. It allows the wearer to turn more naturally.

Margaret Flinter: Professor (inaudible 23:41) lead developer on the team says it would really makes all the difference here is that their bionic limb has computer sensors on the bottom of the foot. That alerts the limb to potential changes in gait.

Men: When we walk, the ankle adapts to different terrain, so if you have the same kind of mechanism in the ankle that we have eventually it allows better stability for the amputees

Margaret Flinter: They're working with the amputees from the Iraq and Afghanistan conflicts because there are so many varying degrees of injury to test the limbs adaptability.

Men: It has cable so it allows us to move the electric on motors that are in the device. This is a good flexibility because it prevents focusing all the weight in the area of the lost limb.

Margaret: A bionic artificial limb that uses advance micro processors to facilitate more natural walking for amputees improving their safety as well as their dignity and quality of life. Now that's a bright idea.

(Music)

Margaret Flinter: This is conversations on health care; I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli, peace and health.

Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University. Streaming live at www.wesufm.org and brought to you by the Community Health Centre.