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Economic Evaluation of Quality Improvement Interventions Designed to Prevent Hospital Readmission
JAMA Internal Medicine (05/30/17) Nuckols, Teryl K.; Keeler, Emmett; Morton, Sally

Researchers from Cedars-Sinai Medical Center and RAND Corporation sought to systematically assess economic evaluations of quality improvement (QI) interventions intended to reduce hospital readmissions. To do so, they calculated the risk difference and net costs to the health system in 2015 U.S. dollars, where weighted least-squares regression analyses tested predictors of the risk difference and net costs. A database search yielded 50 unique studies, including 25 studies in populations limited to heart failure (HF) that included 5,768 patients, 21 in general populations that included 10,445 patients, and 4 in unique populations. Fifteen studies lasted up to 30 days while most others lasted 6–24 months. Based on regression analyses, readmissions declined by an average of 12.1 percent among patients with HF and by 6.3 percent among general populations. The mean net savings to the health system per patient was $972 among patients with HF, while the mean net loss was $169 among general populations, reflecting nonsignificant net differences. Among general populations, interventions that engaged patients and caregivers were associated with greater net savings. The researchers concluded that multicomponent QI interventions can be effective at reducing readmissions relative to the status quo, although net costs vary. Interventions that engage general populations of patients and their caregivers may offer greater value to the health system, but the implications for patients and caregivers are unknown.

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NCQA Joins Leading Health Groups Urging CMS to Offer MACRA Credit for Clinicians
National Committee for Quality Assurance (05/15/17)

Ten national health organizations, including the National Committee for Quality Assurance (NCQA), are calling on the Trump administration to offer credit for advanced alternative payment model (APM) arrangements within Medicare Advantage (MA) as part of the Medicare Access and CHIP Reauthorization Act (MACRA). The health groups sent their proposal in a letter to Health and Human Services Secretary Tom Price. "NCQA is proud to partner with these esteemed organizations that together are focused on the value-based agenda," says NCQA President Margaret E. O'Kane. "Providing APM credits for doctors participating in advanced payment models under Medicare Advantage will encourage value-based arrangements and advance the nationwide movement to reward clinicians for the value of the care they provide, rather than the volume of care." In their letter, the organizations—which also include the Healthcare Leadership Council, Health Care Transformation Task Force, National Coalition on Health Care, and the Blue Cross Blue Shield Association—ask Price to "level the playing field and afford risk adjustments in the MA the same credit under MACRA as risk arrangements in traditional Medicare."

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Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians
Annals of Internal Medicine (05/02/17) Erickson, Shari M.; Rockwern, Brooke; Koltov, Michelle

Tasks that become burdensome may vary from payer to payer and often result from not using documentation that already exists in the medical record. The American College of Physicians (ACP) has developed a framework and taxonomy for evaluating the impact of new and existing administrative tasks. The ACP's Medical Practice and Quality Committee developed these positions and recommendations. For instance, the ACP calls on stakeholders external to the physician practice or health care clinician environment, including payers, oversight organizations, vendors, and suppliers, to provide financial, time, and quality-of-care impact statements for public review and comment. Tasks deemed to have a negative effect on quality and patient care, unnecessarily question physicians, or increase costs should be challenged, revised, or removed entirely. Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved, according to the ACP's framework. The ACP also recommends that stakeholders—including public and private payers—collaborate with professional societies, frontline clinicians, patients, and electronic health record vendors to seek performance measures that minimize unnecessary clinician burden, maximize patient and family centeredness, and integrate the measurement of and reporting on performance with quality improvement and care delivery. In addition, the ACP calls for rigorous research on the effect of administrative tasks on the health care system in terms of factors such as quality, time, and cost.

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High-Price and Low-Price Physician Practices Do Not Differ Significantly on Care Quality or Efficiency
Health Affairs (Quarter 2, 2017) Vol. 36, No. 5, P. 855; Roberts, Eric T.; Mehrotra, Ateev; McWilliams, J. Michael

New research shows no significant differences in care quality and efficiency of care between high- and low-price physician practices. The study, from researchers at Harvard Medical School, looked at the relationship between physician practice prices for outpatient services and practices' quality and efficiency of care. Practices were classified as high- or low-price based on commercial claims data. The researchers also used national data from the Consumer Assessment of Healthcare Providers and Systems survey and linked claims for Medicare beneficiaries to compare high- and low-price practices in the same geographic area in terms of care quality, utilization, and spending. When compared with low-price practices, the high-price practices were larger and received more than one-third higher prices. While patients at these practices reported much higher scores on some measures of care coordination and management, they did not differ substantially in their overall care ratings, other domains of patient experiences, receipt of preventive services, acute care use, or total Medicare spending. According to the researchers, the findings call "into question claims that high-price providers deliver substantially higher-value care."

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To Curb Medical Errors, Physicians Must Be Better Trained to Admit Mistakes
Science Daily (05/19/2017)

In a paper published in *Medical Education*, Dr. Neha Vapiwala at the University of Pennsylvania and Jason Han, a fourth-year student in the university's Perelman School of Medicine, call for better education and training on the psychological challenges related to error disclosure. Vapiwala and Han identify two cognitive biases that tend to interfere with error disclosure: fundamental attribution error, or a tendency to overestimate one's own role in a situation, and forecasting error, a tendency to overestimate the impact and duration of negative consequences while underestimating the ability to recover from those circumstances. They offer several strategies to overcome these patterns of thought, such as incorporating standardized patients to teach various behavioral and coping mechanisms. Virtual reality is another potential tool that can offer immersive and realistic technology to supplement traditional curricula. The researchers also recommend implementing a professional standard for trainees, including a formal evaluation of the skills needed to disclose and cope with medical errors. This standard would further normalize error disclosure and make it a common practice among physicians and trainees. "Administrators must make a shift from asking 'who is at fault' to asking 'why' and 'how' did a situation occur, creating a culture that embraces error disclosure and seeks to solve the many systematic factors that lead to an error in the first place," Vapiwala adds. "This approach will not only normalize error disclosures but also help us better understand why they happen so we can prevent more of them in the future."

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