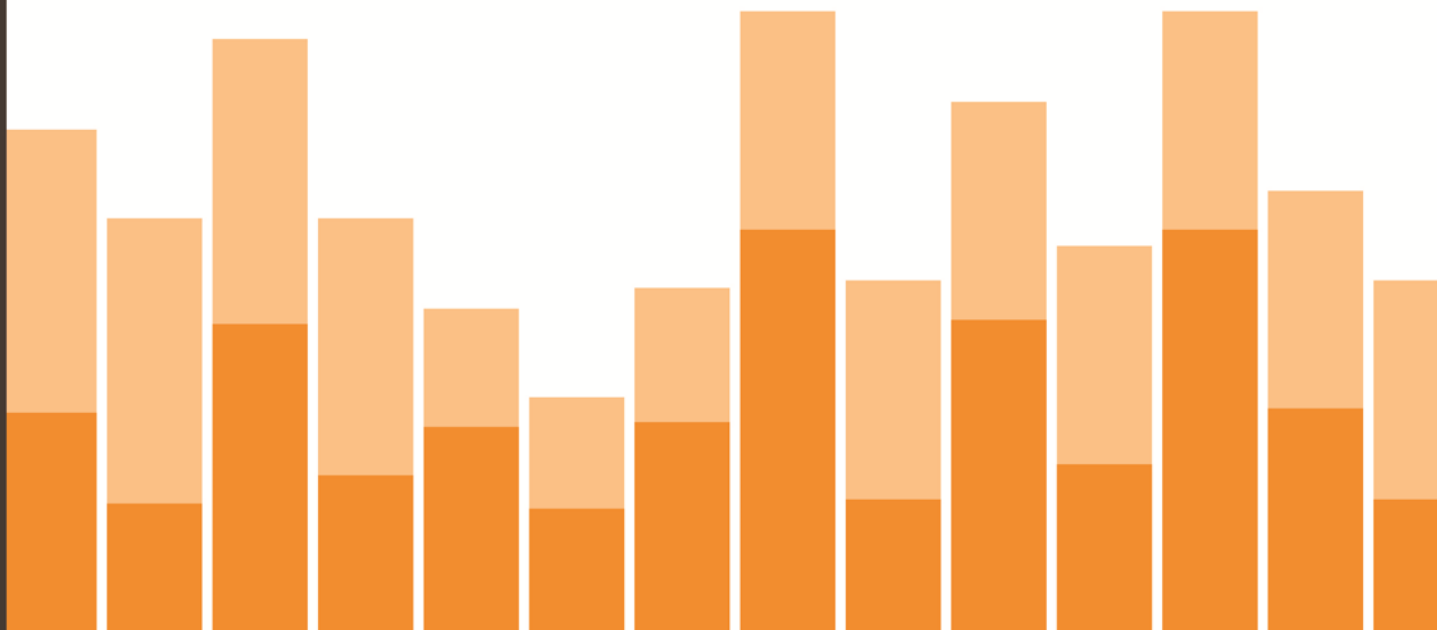


AMERICAN  
HEALTH  
POLICY  
INSTITUTE

# Transforming Health Care Quality Measurement and Reporting

Alina M. Czekał, MPH

2017



**American Health Policy Institute** (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and AHPI serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit [americanhealthpolicy.org](http://americanhealthpolicy.org).

**About the Author** Alina M. Czekai, MPH, is the Director of Program Initiatives at Health Transformation Alliance (HTA) and a founding member of the organization's team. At the HTA, she focuses on the development of high-performing, value-based medical solutions and supports the development of the organization's broader strategy. She was previously the Chief of Staff at AHPI, where she managed the think tank's research and policy agenda around the impact of today's health policy environment on large U.S. employers. Prior to AHPI, Alina worked at The Leapfrog Group where she sparked her interest in health care quality. She was a Mercatus Center Frederic Bastiat Fellow and she earned a BA in health policy from the University of Rochester and an MPH with a focus in health policy from The George Washington University Milken Institute School of Public Health.

## Contents

<b>Executive Summary</b> .....	1
<b>Introduction</b> .....	2
<b>What Employers Want</b> .....	3
Harmonization: Don't Add More Measures, Add the Right Measures .....	3
Emphasize Principles, Not Measures .....	4
Innovate Together .....	6
<b>Conclusion</b> .....	6
<b>Endnotes</b> .....	7

## Executive Summary

There are upwards of 6,000 quality measures in health care today, costing the health system an estimated \$15.4 billion annually in physician reporting.<sup>1</sup> Among those are many siloed quality improvement efforts system-wide, but no standardized defined set of measures or primary data sets that identify the quality of an individual clinician or a facility. The significant increase in quality measures speaks to the growth of quality improvement efforts over the past decade. Despite these efforts, the health outcomes and quality of care associated with these many quality measures has not improved nearly at the same rate of increase as the resources pumped into the system to develop, collect, and report metrics. Medical errors remains the third-leading cause of death in the United States, indicating that the nation is not nearly where it needs to be in terms of health care quality.<sup>2</sup>

To conduct these quality improvement efforts, there are now a plethora of organizations with missions committed to health care quality improvement. There is, however, a lack of clarity and concentration of these efforts. With multiple parties measuring quality, and in the absence of an all-encompassing database that houses critical health care information from all sources (e.g. medical claims, electronic medical records (EMRs), employment data, patient-reported information, biometrics, etc.), even if measures are very similar, the fragmented view only allows for a slice of the physician or hospital's data and therefore a slice of the population (e.g. Medicare claims or commercial health plan claims). To address this disturbing disconnect between efforts and results will require a number of steps, including: harmonization of the key measures and their collection methodology and definition; continuation of aligning efforts and activity; organizing measures in a fashion that is actionable; and tying measurement to organizational and national goals that can be achieved.

Large U.S. employers, who provide health care coverage to 177 million Americans, have a strong interest in improving the quality of health care.<sup>3</sup> For employer payers, improved quality directly correlates to the improvement of the value of the care they purchase, so they have a unique interest in holding providers accountable for total care costs and health outcomes.<sup>1</sup> From their perspective, the health care system needs not another quality measure, but instead, simplification and prioritization of key metrics, agreement on how to collect and measure metrics (e.g. risk adjustment methodology), transparency, and the sharing of data between the health care provider and payer. Employers want only the most useful measures identified for their population. Many of the measures available publicly today are measures from the Centers for Medicare & Medicaid Services (CMS) which are lacking in conditions such as pregnancy, childhood, asthma, and obesity—all conditions that drive health care dollars spent in the employed population. Additionally, employers want measures that are not just based upon condition management, but condition *prevention*, such as body mass index (BMI) action plans, pre-diabetes, and pre-hypertension. Beyond clinical conditions and outcomes, employers are also interested in measures that quantify absenteeism and presenteeism, quality of life and functionality status, and appropriateness of care.

Measurement and analysis is key for improvement and quality in any sector. The health care system demands simplification and harmonization of measurement, enhancement of system-wide adaptation of real-time health care provider engagement, and streamlined innovation around what are known as “measures that matter.”

---

<sup>1</sup> For the purposes of this paper, the term “payer” refers to employer payers.

## Introduction

Modern health care quality measurement methods trace back to a 1966 report by Avedis Donabedian, *Evaluating the Quality of Medical Care*, which outlined the key elements that must be quantified to adequately measure health care quality: structure, process, and outcomes (Figure 1)<sup>4</sup>. Health care quality measures of these types are used to assess the full continuum of health care delivery, measuring at the provider, group, and facility and hospital levels—and more recently, post-acute facilities and other resources in the patient’s community.

Health care quality improvement policies and initiatives in the United States have a rich history, with initial health care quality public policies linking to Medicare efforts in the 1960s to hold doctors accountable for the care they were administering with tax-funded dollars. In 1999, the foundational Institute of Medicine (IOM) report, *To Err is Human*, followed by *Crossing the Quality Chasm*, brought significant public awareness to the problems associated with the quality of health care in the nation and continues to serve as a widely-cited impetus for change.<sup>5</sup> Within the past several decades, groups such as the National Quality Forum (NQF), The Leapfrog Group, The Joint Commission, Catalyst for Payment Reform (CPR) and the Health Care Transformation Task Force have worked to improve quality and value and have sought to link private and public sector efforts. America’s health plans operationalize Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS measures, to evaluate performance on important dimensions of health care delivery. The U.S. Department of Health and Human Services (HHS), too, has encouraged private and public collaborations through efforts such as the Health Care Payment Learning and Action Network, the State Innovation Model (SIM) grants, the Physician Quality Reporting System (PQRS), and others.

The health care industry has long been committed to doing better for patients. What is known today as the health care quality “movement” was pioneered many years ago by practitioners in the field who sought to streamline processes to improve patient and community health. Today, the mission of health care quality improvement remains solid, but the stakeholders involved and the scope of focus has significantly expanded. Now, the government, quality rating organizations, health care providers, insurance companies, consumers, and employers comprise the dynamic stakeholder environment. The competing interests and demands of stakeholders, coupled with the ever-shifting health care environment, present numerous challenges ahead. Each stakeholder brings a critical perspective to the health care quality debate. The employer perspective, however, is unique, and often under-represented in policy discussions.

**Figure 1: Quality Measure Domains**

**Structural Measures:** Structural measures quantify the organizational structures, policies, and activities of a health care facility, such as referring patterns or patient volume. Material and human resources are also included in the structural measure domain. A health care facility’s performance on structural measures has a positive association with the overall health care quality of a facility.

**Process Measures:** Process measures focus on the practical, diagnostic, procedural, and other regular activities carried out by health care providers. These measures examine if a provider delivered the right care to a patient, and are quantifiable by the rate of adherence to evidence-based treatment protocols. Examples of process measures include diabetes testing in a primary care visit, administering Beta Blockers after a heart attack, or screening for depression. When process measures are accurate and can be attributed to a single provider or team, they can be strong indicators of the quality of care that were received by a patient. These types of measures are the focus of many health care quality improvement efforts—at both the local provider and national levels—and are used as effective tools for provider behavior change.

**Outcomes Measures:** Outcomes measures in health care quality measurement are the only measures that truly quantify the effect that health care has on the patient. These measures include morbidity and mortality rates, length of stay calculations, readmission rates, and patient experience, such as patient satisfaction and post-operative functional status. While structural and process measures are important, outcomes measures are of critical importance to patients and those involved in their care—including caregivers, health care providers, and payers.

## What Employers Want

The rising cost of health care and continuing to provide health benefits in today's policy environment is one of the biggest challenges facing corporations today. In fact, it remains one of the factors that impedes on U.S. corporations' ability to compete overseas. In a survey of large U.S. employers, health care quality was rated as a topic of highest priority to their companies.<sup>6</sup> Employers have a unique interest in improving health care outcomes and value as they are responsible for the health care of much of the U.S. population. According to a recent study by the American Health Policy Institute, large U.S. employers spend \$578.6 billion annually in providing health coverage for 177 million employees, retirees, and dependents.<sup>7</sup>

In their role as the fiduciary, employers are not only paying the bulk of the employees' health care claims, but they also steer employees and their families to providers and facilities through incentive or disincentive benefits design. Many also share third party information they may have available on provider cost and quality in order to assist employees in their decision making and to promote health care consumerism, though this limited information does not give patients a complete picture of quality and cost of health care. The benefits departments at companies around the nation are on the front lines of fielding calls from their employees when there is a health event in the family, directing family members' next steps and advising how to fund their medical care. The vitality of any company is dependent on the productivity of the workforce, hence the priority of presenteeism and absenteeism markers. The health of their associates and their families is a key priority for corporations, thus, they have a strong interest in health care quality improvement, cost reduction, and care coordination efforts.

### **1. Harmonization: Don't Add More Measures, Add the Right Measures**

There are upwards of 6,000 health care quality measures in effect today. A recent study from leading health care quality and safety physician experts found that only 10 percent of 844 hospitals rated as a high performer by one rating system were rated as a high performer by any of the other hospital ratings system.<sup>8</sup> Thus, quality measures, as they are reported today, may generate more confusion than clarity when used to help choose where to go for medical care.<sup>9</sup> Many of these measures are attempting to capture the same health care process or outcome, and some of the differences may be slim. The proliferation of measures is nonetheless confusing to patients, providers, and payers.

In order for quality measures to provide value, there must be a reduction of measures and a harmonization of measures in use. Efforts to do so are underway, and recently, the Core Measure Collaborative, led by America's Health Insurance Plans (AHIP) and its member plans Chief Medical Officers in collaboration with CMS and NQF worked to reach consensus on core quality measures through a multi-stakeholder process. While these efforts are a critical step in the right direction, they demand broader participation from key stakeholders. Such efforts are only going to be successful if there is consensus in using the core measures by all—private insurers and CMS—and if they contain meaningful measures for both Medicare and commercial populations.

There are many hospital and provider ratings organization in the public realm that are working to bring key health care quality information to patients and their families. While transparency is critical for health care consumerism and informed decision-making, these websites and tools can oftentimes deliver conflicting information. Each quality reporting organization utilizes different rating

methodologies, which is particularly concerning for the public consumer-facing websites that seek to steer patients to hospitals or providers.

There are too many measures in the system today, but the right ones are not always used or do not exist. For 99 percent of U.S. patients, the ultimate outcome of their surgery or treatment is not reported back to the physician administering the treatment and it remains in a surgical registry untouched by those who delivered the care.<sup>10</sup> There is also a demand for bolder measures that could truly revolutionize the system, including more surgical and specialty outcomes measures. For example, cancer screening measures are commonly tracked, reported, and used in reimbursement designs; however, more revolutionary measures are needed, such as those which assess oncology surgical outcomes, complication rates, functionality status, and if the procedure has to be re-done, or if an additional procedure is required. These types of measures have significant variation across facilities and providers and have the greatest implications for both the patient and payer from the cost and quality perspective, yet the measures are not transparent. Procedural outcomes measures are collected by national registries for public health and research purposes, yet they are rarely operationalized for consumer, or even physician purposes. Physicians oftentimes lack the critical incentives to demand transparency from these registries to assess their performance, thus this information often remains in a black box.

Patient experience measures include quantification of functional status, quality of life, pain, and time back to work or recreational activities. According to Dr. Marty Makary, surgeon and author of *Unaccountable*, “As a country, we’ve chosen to spend billions on medical technology and new drugs, but we’ve been cheap when it comes to measuring performance accurately and fairly. As a consequence, the field of health care has focused on what’s easy to measure, rather than things that are important to patients.”<sup>11</sup> Comprehensive patient-reported outcomes and patient-experience data, which measure how a patient feels and perceives their care and treatment, are significantly lacking. These measures are the “tip of the iceberg” when it comes to outcomes measurement and are of the most importance to patients, yet they are seldom measured and reported today.

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is a patient satisfaction survey required by CMS for all hospitals in the United States that attempts to capture and report this information, however, its value and effectiveness are debated. *Patients* should be the ones determining how the satisfaction of their care is measured. The closer the source of the data is to the patient, such as from the patient’s recollection of their own experience or from their clinical charts and real-time EMR themselves, the better, as such data can help depict the truest picture of an individual’s health.

## **2. Emphasize Principles, Not Measures**

While health care quality measurement and transparency is critical to drive behavior toward improvement, it is not enough to improve quality and advance broader value changes in health care. In a recent article in the *Journal of the American Medical Association (JAMA)*, “The Quest to Improve Quality: Measurement is Necessary but Not Sufficient,” the authors make the case that you can weigh yourself every day but if you do not change your diet and exercise routine, you likely won’t see any change on the scale. Using these measures to inform broader strategies, such as value-based purchasing, is key.

Value-based purchasing efforts, including provider risk sharing arrangements that tie provider performance to their total compensation, have begun to move the needle on health care quality. These efforts operationalize key sets of measures and often have providers select measures by which they

want to be measured and held accountable. A challenge with many of these efforts, however, is the fact that the hospital leadership and the providers themselves are often determining the measures to be used. Or measures are “assigned” to the provider entities, as demonstrated in government-based initiatives such as PQRS or the Medicare Access and CHIP Re-Authorization Act (MACRA). When stakeholder alignment is not constant across all quality efforts, incentives for performance can be skewed. Additionally, in many pay-for-value arrangements, bonus payments are attributed throughout the group so the reward is not always directly paid to the providers who have truly earned it.

Employers, in developing health care plans for employees and their dependents are focused on principles that look at the patient as a whole—from the health, financial, social, and emotional perspectives. Some of the most important principles to large U.S. employers include emphasis on health and preventive care, delivering culturally and linguistically appropriate care and services, and promotion of patient-provider shared decision making (Figure 2).

In addition to extrinsic incentives and advanced reimbursement strategies, the system should consider a true change in mindset that sees the doctor-patient relationship as the focal point. There are multiple examples in which clinicians have made rapid, important improvements to care completely without external financial incentives. From a policy perspective, this source of motivation can be encouraged by providing access to real-time, accurate data that show clinicians opportunities for improvement and give routine, timely feedback on progress. It is critical to consider how measurement can support internal improvement efforts and help foster the patient-provider relationship.

The focus should be the creation and deployment of health care quality measures that can improve this relationship and mutual accountability—and improve health care. This change will come not in the creation of more measures, but will come by selecting the right measures. Organizations also need to focus on ways to automate data collection, the creation of databases and analytics to use the data, and transparency in reporting across the health care continuum.

Dr. Don Berwick, former head of CMS, discusses the tensions and challenges to getting to that point: “One story is about connecting, about relating, growing together. The other is about processing—next patient, next patient, next patient—and we’re caught in that space where the tension, I think, between the beauty of a real healing relationship and the best of care as production. I don’t know how we got here, but I do know that the tension is nearly unbearable, and if were not careful, it can break us.”<sup>12</sup>

Figure 2: Principles Employers Want to See in Health Care
Emphasis on health and preventive care, not just sick care
Total cost of care
Adequate access to care including after-hours clinical advice, utilization of physician extenders, and technology enabled alternatives to physical visits (e.g. email, virtual visits over a secure network, etc.)
Care coordination and care management to ensure accountability
Active monitoring and documentation of prescribed and filled medications for clinical appropriateness, safety, and prescription adherence
Promotion of patient-provider shared decision making and self-care, implementation of evidence-based decision support, and utilization of technological solutions to promote quality health outcomes and consideration of total cost of care
Screening for mental health conditions, including depression, and substance abuse with appropriate referrals to behavioral health specialists
Patient satisfaction and quality of life
Avoidance of unnecessary care, waste, and overuse
Adherence to appropriate pain management practices
Reduction of adverse events within 30 days of a procedure
Delivering culturally and linguistically appropriate care and services
Ensuring clinically appropriate referrals to specialists, coordination of care, and follow up
Monitoring and track clinical health outcomes for quality, utilization, safety, appropriateness of care, and functional status
Absenteeism and presenteeism, return to work



### **3. Innovate Together**

In the private sector, hospitals, insurance carriers, and employers have all been playing their own role in developing innovations that will improve health care quality. These innovations include unique payment methodologies that incentivize performance improvement; direct contracting with high-performing providers; and developing bundled payments for key, common health events such as pregnancy. Paying for value and tying provider payment to performance on health care quality metrics will take efforts further, but it should not be considered the “be all and end all” in quality improvement. The true opportunity takes place, however, when the competing forces come together to collaborate on new and groundbreaking initiatives.

Large U.S. employers have a strong interest in moving health care quality into the future and cannot wait for government to fix the broken system. Recognizing the importance of collaborating with players along the health care supply chain, the Health Transformation Alliance (HTA), a cooperative of America’s largest employers, was established last year with a mission of transforming the employer-based health care system and disrupting the health care supply chain status quo. The Alliance will serve as part of each company’s health strategy, bringing increased innovation, better analyses and data, as well as greater leverage in how corporations obtain coverage for their workforce. “The American health care delivery system is a patchwork of complicated, expensive and wasteful systems,” said Marc Reed, the chief administrative officer of Verizon. “We’ve done what we can as individual companies. By joining together, we can do more. We need to stop applying bandages to the system and address what’s fundamentally wrong.”<sup>13</sup>

The HTA, representing more than six million lives and \$24 billion annual health care spend, will pool the data, resources, and expertise of its member companies to gain leverage and create an organization whose sole focus will be to ensure the health care needs of employees are being met more effectively and efficiently. The power of the combined data, expertise, and health care passion of this group might be what the system needs to address the significant gaps in health care quality measurement and bring the country into the next era of health care value.

With America’s largest employers at the table together demanding harmonization of quality measurement and system-wide attention to principles that are of importance to their employees, their efforts will be worth watching.

## **Conclusion**

Today, there is no dearth of efforts or resources devoted to health care quality. As this paper shows, one problem is that there are too many competing and misaligned efforts currently in the system. The challenges ahead will be to align efforts and activity, developing and organizing measures in a fashion that is actionable and meaningful for patients, and tying measurement to organizational and national goals that can be achieved.

As large U.S. employers provide health care to 177 million Americans, they have a strong interest in improving health care quality. Given the paramount role employers play as the facilitator of an employee’s interaction with the health care delivery system and insurance industry, employers are in a prime position to lead collaboration and innovation efforts. Tackling health care quality improvement in the ever-shifting health care environment will continue to be a challenge, but a change in approach that adds the right measures, focuses on principle over measurement, and promotes innovative collaboration over individual efforts will help bring about much needed transformation.

## Endnotes

- <sup>1</sup> Casalino, L. P., Gans, D., Weber, R., Cea, M., Tuchovsky, A., Bishop, T. F., . . . Evenson, T. B. (2016). US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures. *Health Affairs*, 35(3), 401-406. doi:10.1377/hlthaff.2015.1258
- <sup>2</sup> Makary, M. A., & Daniel, M. (2016). Medical error—the third leading cause of death in the US. *Bmj*, l2139. doi:10.1136/bmj.l2139 Accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/27143499>
- <sup>3</sup> Jessica C. Barnett and Marina S. Vornovitsky, “Health Insurance Coverage in the United States: 2015,” U.S. Census Bureau, Table 1, September 2016.
- <sup>4</sup> Donabedian, A. (2005). Evaluating the Quality of Medical Care. *Milbank Quarterly*, 83(4), 691-729. doi:10.1111/j.1468-0009.2005.00397.x
- <sup>5</sup> Committee on Quality Health Care in America, Institute of Medicine. (2001). *Crossing the quality chasm : a new health system for the 21st century*. Washington, D.C.: National Academy Press.
- Kohn, L. T., Corrigan, J., & Donaldson, M. S. (2000). *To err is human: Building a safer health system*. Washington, D.C: National Academy Press. Retrieved at: <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf>
- <sup>6</sup> Internal poll, American Health Policy Institute, 2016.
- <sup>7</sup> National Health Expenditure Data, Centers for Medicare & Medicaid Services, Sponsor Highlights, Table 1, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>;  
Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2012*, September 2013, available at <http://www.census.gov/prod/2013pubs/p60-245.pdf>
- <sup>8</sup> Austin, J. M., Jha, A. K., Romano, P. S., Singer, S. J., Vogus, T. J., & And, R. M. (2015, March 01). National Hospital Ratings Systems Share Few Common Scores And May Generate Confusion Instead Of Clarity. Retrieved from <http://content.healthaffairs.org/content/34/3/423.full>
- <sup>9</sup> Catalyst for Payment Reform, “CPR Employer-Purchaser Guide to Quality Measure Selection,” Retrieved at: [http://www.catalyzepaymentreform.org/images/CPR\\_Employer-Purchaser\\_Guide\\_to\\_Quality\\_Measure\\_Selection\\_2015-10-23.pdf](http://www.catalyzepaymentreform.org/images/CPR_Employer-Purchaser_Guide_to_Quality_Measure_Selection_2015-10-23.pdf)
- <sup>10</sup> Lyu, Heather (2016). Prevalence and Data Transparency of National Clinical Registries in the United States. *Journal for healthcare quality*. 38 (4), p. 223 - 234. (ISSN: 1062-2551)
- <sup>11</sup> Makary, M. (2015, December 28). Why our health care system is broken (Opinion). Retrieved from <http://www.cnn.com/2015/12/22/opinions/makary-health-care-system/>
- <sup>12</sup> Stempniak, M. (2015, December 11). Don Berwick Offers Health Care 9 Steps to End Era of 'Complex Incentives' and 'Excessive Measurement' Retrieved April 28, 2017, from <http://www.hhnmag.com/articles/6798-don-berwick-offers-health-care-9-steps-to-transform-health-care>
- <sup>13</sup>Health Transformation Alliance. “One Year Later, a Group of Leading Private Sector Companies Is Working to Fix a Broken Health Care System.” Retrieved at: [http://htahealth.com/docs/press/Private\\_Sector\\_Health\\_Care\\_Reform\\_Moves\\_Ahead.pdf](http://htahealth.com/docs/press/Private_Sector_Health_Care_Reform_Moves_Ahead.pdf)