Provider Quality Metrics

Educational Briefing

Executive Summary

Provider clinical quality is increasingly being measured and publicized. Progressive providers have long tracked clinical performance, but systematic efforts to measure hospital and physician quality began in the 1990s. In the last five years, financial consequences have increasingly been attached to quality scores. The ongoing movement toward greater performance accountability is reshaping clinical processes and financial strategy, creating new opportunities for vendors.

Why are Quality Metrics a key issue for providers?

Providers use quality measures to track their performance on their mission of providing high quality health care. Poor performance on quality measures can result in negative public perception, lost business, and no accreditation. While efforts to improve clinical quality are perennially important, these metrics received additional sway when the Affordable Care Act (ACA) linked clinical quality to Medicare reimbursement. While the need to report large quantities of measurements to a series of entities currently challenges providers, increasing use of electronic medical records should make the capture and reporting of quality metrics easier.

How do Quality Metrics work?

In 1966, Avedis Donabedian identified three interconnected dimensions of quality – structure, process, and outcomes – which affect the overall level of services. Structure is most fundamental and is the measure of the resources which the hospital has at its disposal. Next, process captures the actual care delivered. Finally, structure and process largely determine the outcomes of care.

Donabedian Model Components

Structure	Process	Outcomes
• Infrastructure	• Care Practices	• Mortality
• Physician Quality	• Coordination	• Readmissions
• Accreditation	• Individualization	• Patient Satisfaction
• Patient Health	• Service Delivery	• Quality of Life

In the 1990s, both governmental and non-governmental groups began to push for expanded health care quality measurement. While there is overlap, each of these groups focuses on different aspects of structure, process, and outcomes. On the **structure** side, The Joint Commission (TJC) and National Committee for Quality Assurance (NCQA) play an important role in the accreditation of hospitals and health plans, respectively.[1] These accreditations are based on hospital facility and physician resources and the usage of evidence-based care processes. More recently, both organizations have started to incorporate more clinical metrics into their decision-making.

Two agencies within the Department of Health and Human Services (HHS) establish health care quality metrics for the nation's providers. The first of these agencies, the Agency for Healthcare Research and Quality (AHRQ), mainly focuses on improving hospital care **processes**. Through a combination of data and resources, the AHRQ makes the case for providers to perform procedures in the most clinically effective manner. In addition the AHRQ also maintains publicly-available databases that measure health care cost, utilization, and quality.

The ACA allowed the second HHS agency, the Centers for Medicare and Medicaid Services (CMS), to take a larger role incentivizing hospital quality. CMS mostly focuses its resources on measuring and improving hospital outcomes. Through the Hospital-Acquired Condition Reduction, Value-Based Purchasing, and Hospital Readmissions Reduction Program initiatives, CMS adjusts payments to hospitals based on the results of the care they provide. In addition, CMS addresses data collection structure through the IT-adoption program Meaningful Use, in which providers must track and report "clinical quality measures" using electronic records. The agency has added financial bite to its proposals, adjusting its total payments to hospitals by several percentage points based on performance on each of these initiatives, potentially affecting each hospital's bottom line by over $10 million a year.

1) Today known as The Joint Commission, the same organization was previously known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and was founded in 1951.

July 2017

Source: Donabedian, Avedis, "Evaluating the Quality of Medical Care", The Milbank Memorial Fund Quarterly Vol. 44, No. 3, 1965; Advisory Board Research and Analysis

How do Quality Metrics affect providers?

Clinical

Quality metrics have encouraged hospitals to focus not only on the quality of care they provide, but also on managing chronic conditions and ensuring patient recovery after discharge. Whether hospitals gather metrics for CMS, for private payers, or to fulfill accountable care organization requirements, hospitals and physicians are increasingly collaborating to improve institutional results.

Financial

The tying of Medicare reimbursement to quality metric performance has increased the financial incentive for hospitals to improve on quality metrics. These incentives have also monetized improvements in quality, allowing hospitals to attach a certain dollar value to each readmission or patient experience survey. This not only increases the importance of products and services viewed as clinically superior, but has also allowed for hospitals to focus limited resources on the quality improvements that will most impact their hospital's bottom line.

Financial Impacts of Select Quality Metric Programs

Organization/Program	Quality Focus	Financial Incentives for Providers
The Joint Commission (TJC)	Health Care Provider accreditation (most states)	Incentives: Accreditation Penalties: Non-accreditation (loss of business)
Hospital Readmissions Reduction Program	30-day Readmissions Rates for select conditions	Incentives: None Penalties: Up to 3% of all Medicare payments
Hospital-Acquired Condition Reduction Program	Avoidable care conditions ("never events")	Incentives: None Penalties: Up to 1% of all Medicare payments
Value-Based Purchasing	Clinical process of care, patient experience, outcomes, efficiency	Incentives: Up to 2% of all Medicare payments (2017) Penalties: Up to 2% of all Medicare payments (2017)
Meaningful Use	Preventative care, chronic disease management, imaging screens	Incentives: Payouts for early adopters Penalties: Up to 1% of all Medicare payments, as well as other penalties for late adopters

Operational

Providers increasingly need to develop internal processes and roles to effectively capture and report data.

Source: Advisory Board Research and Analysis

The Joint Commission

Educational Briefing

Executive Summary

Founded in 1951, The Joint Commission (TJC) is an independent, not-for-profit organization that accredits and certifies hospitals and other types of health care organizations and providers. It is the largest health care accrediting body in the US. Providers often display the Joint Commission "Gold Seal of Approval" to indicate accreditation. The Joint Commission's goal is to improve health care quality. To meet this goal, it creates performance standards that providers must meet to achieve accreditation or certification. Because The Joint Commission was previously known as The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), providers occasionally refer to it by its earlier acronym JCAHO (pronounced "jay-co").

4,023 General, children's, long-term, acute, psychiatric, rehabilitation and specialty hospitals accredited

77% US hospitals currently accredited by The Joint Commission

Why is The Joint Commission a key issue for providers?

Providers put great stock in Joint Commission accreditation for several reasons. In many states, accreditation or certification is linked to or required for state licensure. Also, the public often views accreditation and certification as quality indicators. If a provider loses accreditation, it can result in negative community perceptions and lost business. For these reasons, providers often employ or seek guidance from accreditation experts.

How does The Joint Commission work?

To earn accreditation status, a hospital must undergo an on-site, unannounced survey by a Joint Commission survey team and pay a subsequent fee. To maintain accreditation, a hospital must go through this process once every three years.

The survey team assesses the hospital's compliance with performance standards based on their observations, interviews, and reviews of documentation provided by the hospital. Based on these assessments, TJC makes an accreditation decision. The accreditation decision categories are: Preliminary Accreditation, Accreditation, Accreditation with Follow-up Survey, Contingent Accreditation, Preliminary Denial of Accreditation, and Denial of Accreditation.

In the last decade, TJC has shifted towards using what it calls "accountability measures" for assessing a hospital's performance. These evidence-based measures are divided into four categories: research, proximity, accuracy, and adverse effects. TJC provides a full list of these measures.

In addition to hospital accreditation, TJC also provides certification services for disease-specific and palliative care programs and staffing firms.

Accountability Measure Criteria	Description
Research	• Scientific evidence shows that performing this process improves health outcomes.
Proximity	• Performing this care process is closely related to the health outcome. • There are few clinical processes that occur in between this measure and the health outcome.
Accuracy	• The measure correctly evaluates whether the process has been provided or not.
Adverse Effects	• Employing the measure has few risks of unintended adverse effects.

Source: Advisory Board Research and Analysis, The Joint Commission, http://www.jointcommission.org/.

How does The Joint Commission affect providers?

Clinical

TJC provides an objective assessment of clinical quality and communicates with providers about key areas of improvement on issues that affect specific organizations and those which impact large numbers of providers nationally. Because TJC's standards focus on the implementation of evidenced-based care processes that lead to positive patient outcomes, meeting these standards may improve the quality of care by reducing variation in clinical processes.

Joint Commission Performance Areas for Hospitals

- ✓ Environment of Care
- ✓ Emergency Management
- ✓ Human Resources
- ✓ Infection Prevention and Control
- ✓ Information Management
- ✓ Leadership
- ✓ Life Safety
- ✓ Medication Management
- ✓ Medical Staff
- ✓ National Patient Safety Goals
- ✓ Nursing
- ✓ Performance Improvement
- ✓ Provision of Care, Treatment, and Services
- ✓ Record of Care, Treatment, and Services
- ✓ Rights and Responsibilities of the Individual
- ✓ Transplant Safety
- ✓ Waived Testing
- ✓ Survey Process

Financial

TJC accreditation can strengthen the community's confidence in the hospital's treatment and services. In some cases, accreditation may also reduce liability insurance costs. Additionally, several quality metrics are now tied to Medicare reimbursement, increasing the financial incentives for hospitals to improve on quality metrics.

Operational

The Joint Commission provides operational frameworks for service-line structures, evidence-based strategies, and management. Because of this, operational changes may affect both clinical and administrative processes.

Source: Advisory Board Research and Analysis, The Joint Commission, http://www.jointcommission.org/

HCAHPS: Patients' Perspectives of Care Survey

Educational Briefing

Executive Summary

The Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS, pronounced "H-caps") survey was developed collaboratively by Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research & Quality (ARHQ). The survey aims to produce data about patient experience of care that allows for objective and meaningful comparisons of hospitals. The questions address topics that are important to consumers, create new incentives for hospitals to improve quality of care, and enhance provider accountability in health care by increasing transparency of the quality care. Included as a component of the Value-Based Purchasing program, CMS uses provider HCAHPS survey results to positively or negatively adjust individual hospitals' Medicare reimbursement.

Why is the HCAHPS survey a key issue for providers?

The HCAHPS survey measures patient experience. HCAHPS survey scores are an indication of the level of service provided by an organization, contribute to its reputation, and have reimbursement implications for providers. Traditionally, consumers have "consumed" and not "shopped" for health care services. However, more consumers are moving or being forced to move to high deductible health plans. As a result of this increased financial commitment, patients are more engaged in their health care decisions. Experience is one of the many ways consumers are weighing their options. Under Value-Based Purchasing (VBP), HCAHPS accounts for 30% of the TPS in FY 2015 and 25% in FY 2016 and FY 2017.

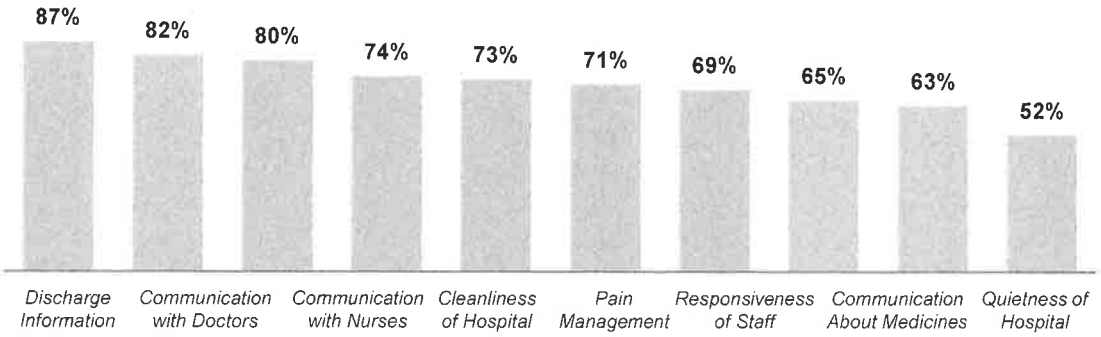
How does HCAHPS work?

The survey asks for patient feedback in several areas, including communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information, among others. A random sample of discharged adult patients across medical conditions are asked to answer 27 questions pertaining to their most recent hospital stay. Patients taking the survey must be 18 years or older and have had at least one overnight stay in the hospital as an inpatient, but are not required to be Medicare beneficiaries. The questions are administered to patients by mail, telephone, mail with telephone follow-up, or interactive voice recognition. Hospitals submit collected data to CMS for analysis. The Patient Experience Domain Score for each hospital is determined by summing the hospital's HCAHPS Base Score (0-80) and HCAHPS Consistency Score (0-20). CMS publicly reports HCAHPS scores on its Hospital Compare website.

Summary of HCAHPS Survey Results

Average "Top Box" Score for Hospitals

July 2017 (October 2015 to September 2016 Discharges)



Source: Source: Hospital Consumer Assessment of Healthcare Providers and Systems, "July 2017 Public Report: October 2015-September 2016 discharges", available at: http://www.hcahpsonline.org/Files/July_2017_Summary%20Analyses_States.pdf; Advisory Board interviews and analysis.

How does HCAHPS affect providers?

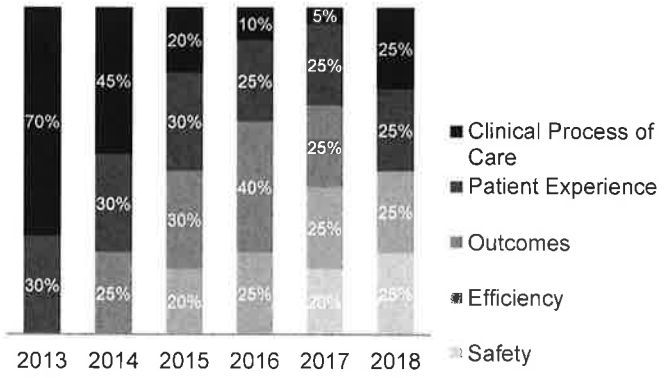
Clinical

Clinical staff must communicate effectively with patients to perform well on HCAHPS surveys. Doctors' and nurses' ability to listen and respond to patient needs play an integral role in scoring. Questions on the survey specifically address patients' perspectives on nurse care, physician care, pain management, and discharge information and instructions. Clinical staff are beginning to focus on managing pain properly, and educating discharged patients and their family members to enable post-discharge health management. The public reporting of HCAHPS scores is meant to create an incentive for providers to increase quality of care.

Financial

HCAHPS scores impact provider finances by figuring into their Medicare reimbursement determination. A provider's HCAHPS score decides their Patient- and Caregiver-Centered Experience of Care/Care Coordination Score, which comprises 25% of a provider's Total Performance Score (TPS) under Value-Based Purchasing (VBP) for FY 2016. A provider's TPS is compared to their own historical baseline TPS and to a nationwide benchmark. Whichever comparison is more favorable to the provider is used to calculate any adjustment to the provider's base operating DRG payment from CMS.

VBP Domain Weighting
(with year of starting consideration)



Operational

Patient satisfaction is becoming increasingly important, creating a need for new provider leadership roles. Many providers have created a new C-suite level role – the chief patient experience officer. Chief patient experience officers coordinate patient experience enhancement plans and benchmark initiatives to develop and test new approaches to satisfy patients. From facility design to staff training, the chief patient experience officer is tasked with ensuring patient satisfaction throughout hospital stays.

Source: CMS; Advisory Board Research and Analysis

Evidence-based Practice

Educational Briefing

Executive Summary

Evidence-based practice (EBP) is the explicit use of the best available medical evidence in making clinical decisions. Needing to improve cost efficiency and boost care quality, providers are investing significant time and resources into the creation and adoption of EBPs. These practices guide clinicians in providing patients with the right care, at the right level, at the right time.

Why is Evidence-based Practice a key issue for providers?

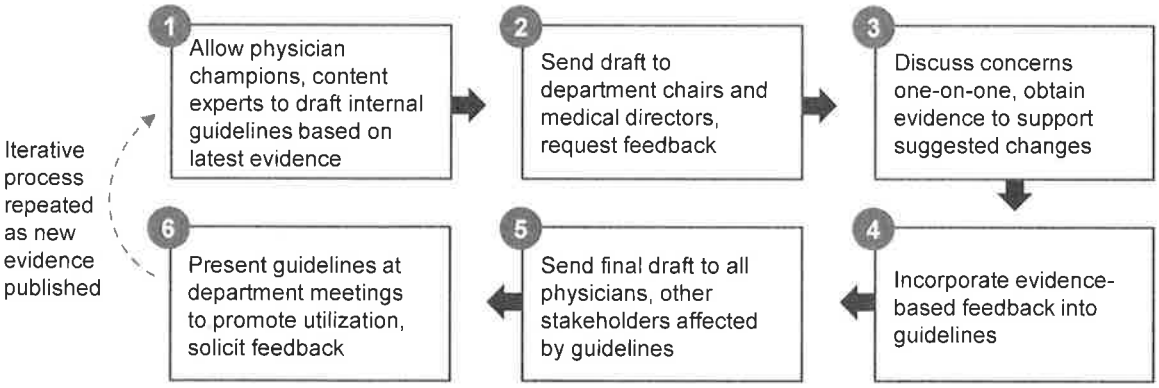
As providers assume greater cost accountability, it is more important to define and execute evidence-based standards of care that promote quality and efficiency gains. EBP optimizes patient outcomes, since all patients are cared for in a manner supported by medical evidence and clinical expertise. Additionally, adopting EBP is one of the primary mechanisms for reducing the growth of inpatient costs. Though the impact varies by situation, EBP can improve efficiency by preventing undesirable clinical outcomes and reducing unnecessary utilization (e.g., diagnostic tests, procedures, pharmacy) through care standardization, leading to an overall reduction in cost per case and length-of-stay.

How does Evidence-based Practice work?

Providers derive EBP from the integration of three components:

EBP Component	Description
Patient Values and Preferences	A patient's unique beliefs, concerns, expectations, and values
Clinical Expertise	A clinician's cumulated experience, education, and clinical skills
External Research Evidence	Research that is clinically relevant and conducted using a sound methodology

Providers are building protocols supported by a range of evidence, from randomized controlled trials to clinical consensus among an organization's providers. Whether EBP standards are based on clinical trials or common practice, they represent a general agreement on how to deliver care (and appropriately use resources) within a given clinical area. Providers generally follow six steps to form their evidence-based clinical guidelines:



May 2014

Sources: Advisory Board Research and Analysis; Duke University Medical Center Library and UNC Health Sciences Library.

How does Evidence-based Practice affect providers?

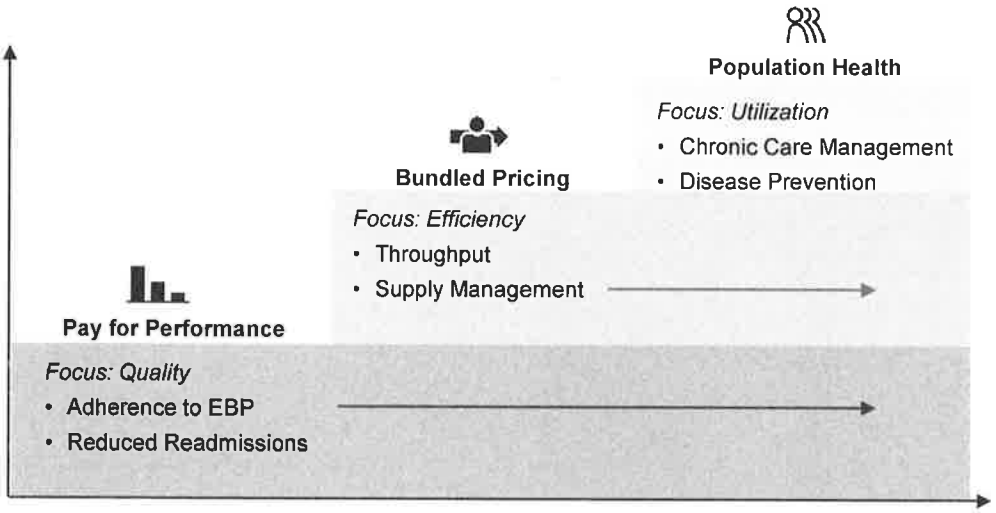
Clinical

The integration of EBP's three components into clinical decisions enhances the opportunity for optimal clinical outcomes. EBP promotes the implementation of research and evidence into the practice of patient care, which positively elevates a provider's quality standards. Also, providers can prevent under- and overtreatment through care standardization, which positively impacts clinical outcomes.

Financial

Providers are assuming more cost accountability under payment reform, and EBP is a key to succeeding under the various value-based purchasing payment models. To varying degrees, all of the models link finances to quality, making adoption of EBP critical to providing the highest standard of care to all patients in the most efficient way possible. Evidence-based organizations manage their costs better, because clinical best practices focus on appropriate utilization rather than wastefulness, which results in direct savings.

EBP's Impact on Value-based Purchasing Payment Models



Operational

Providers must ensure clinicians across the organization consistently follow evidence-based guidelines in order to achieve optimal quality and efficiency benefits. Organizations who have achieved this "culture of adherence" to evidence-based practices have infrastructure and processes in place to support the following four focus areas:

1. Prioritization – efforts are ranked in order of the greatest opportunities for quality and efficiency gains
2. Correctness – evidence-based guidelines are from trustworthy sources of the most up-to-date clinical evidence
3. Adherence – providers surround clinicians with effective messaging, data, and other supports to promote EBP uptake
4. Scalability – a provider's infrastructure supports organization-wide standardization

Source: Advisory Board Research and Analysis