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HEALTHCARE BUSINESS INTELLIGENCE

# The Growing Importance and Expansion of Quality Reporting



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# Healthcare providers have reported quality measures

data to governmental agencies, accreditation bodies and other entities for many years. Most programs start as voluntary submissions without financial incentives or penalties. Private payers create various financial incentives linked to quality measures, however these programs were generally based on the payer's enrollees and therefore do not scale nationally. CMS and The Joint Commission both introduced quality reporting programs that have been implemented nationally. CMS requires submission of quality data across multiple settings of care, with Hospital Quality Reporting (HQR) and Physician Quality Reporting System (PQRS) being the most recognized for hospitals and physicians respectively. Until recently these programs operated in the so called Pay for Reporting (P4R) framework in which financial incentives or penalties were linked only to successful reporting of quality data without taking actual performance into account. Public reporting of quality data on the CMS web sites Hospital Compare and Physician Compare were the only places where performance scores mattered.

With the roll out of Value Based Purchasing (VBP) for hospitals and Value Based Payment Modifier (VBPM) for physicians, CMS has taken a big step towards true Pay for Performance (P4P). A portion of provider revenue will now be adjusted upwards or downwards based on their relative performance on quality and cost measures. Although hospitals and physicians will not feel the full impact of these programs until the 2017 payment year, it is worth noting that the payment year adjustments are based on data generated from patient care almost two years prior to the payment year, i.e. calendar year 2015 in this case. The Joint Commission too has introduced a performance driven recognition through its Best Performing Hospitals annual ranking of all participating hospitals. With stakes as high as these, it is no wonder that quality measurement itself is also getting a lot of attention.

The foundation of modern healthcare quality measurement can be traced to the 1960's when Avedis Donabedian introduced the structure/process/outcome (SPO) model. Its premise that better organizational structures lead to improved processes, which in turn result in better patient outcomes, has remained foundational for most quality

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measurement frameworks. Structure refers to a healthcare facility's organization and resources directed at patient care including human resources and infrastructure. Electronic Health Records (EHR's) are now considered a part of critical infrastructure. Process refers to treatments and interventions recommended by evidence based or consensus guidelines. These tend to be the most common types of quality measures used to measure provider performance. Since it is equally important to know why an indicated intervention was not done, e.g. a drug not given due to patient allergy,

these measures tend to require extensive human data abstraction from charts contributing to provider burden. The recent push for widespread adoption and “meaningful use” of Electronic Health Records (EHRs) through the ARRA/HITECH legislation holds the promise to reduce this abstraction burden on providers through the use of electronic clinical quality measures (eCQM’s). Patient data needed for these quality measures would be a byproduct of documentation by clinicians in their normal workflow of care delivery, eliminating human chart abstraction. Finally outcomes are consequences of a patient’s interaction with the healthcare system such as measures of mortality, morbidity and functional status. Since outcomes depend on a patient’s underlying illness burden as much or sometimes even more than a provider’s quality of care, these measures often require some form of risk adjustment based on a provider’s patient mix.

Most measures used in national programs undergo a rigorous and transparent endorsement process managed by the National Quality Forum (NQF). This ensures that the endorsed measures have been tested for validity, reliability, feasibility and scientific acceptability prior to national implementation. There are currently more than 800 NQF endorsed structural, process and outcomes measures across the six National Quality Strategy (NQS) domains of care.

CMS also uses outcome measures to track patient satisfaction. Hospitals are required to regularly survey and submit to CMS data about patient care experiences through the HCAHPS survey. A similar survey CG-CAHPS has recently been introduced for larger physician group practices. Although a very high percentage of patients now use the internet for health information the use of quality measures data in consumer decision making is still relatively small. CMS has implemented a five star ranking system for Nursing homes in order to make public reporting of quality data more user friendly. The Joint Commission also reports quality measures data on Qualitycheck.org web site and publishes annually a list of Top performing hospitals that meet high performance thresholds on a subset of Core measures designated as accountability measures.

In summary, providers of health care should embrace not only quality measurement but improvement as a core business objective. Pay for performance and public reporting of quality measurement data will be an important component of reimbursements in the future. An infrastructure to support timely monitoring of quality data including EHR based quality measures will be essential as chart abstracted measures are replaced with electronic clinical quality measures through CMS and TJC measure alignment initiatives.