

# The Future of Quality Measurement and Improvement

IHA Pay for Performance Summit

*March 4, 2015*



NATIONAL  
QUALITY FORUM

# A Look Back: A young, but rapidly growing movement

'95

'00

'10

EARLY  
1990's

Healthcare  
Effectiveness  
Data and  
Information  
Set (HEDIS)

Integrated  
Healthcare  
Association  
(IHA) founded

1998

Report  
from  
President's  
Advisory  
Commission  
on Consumer  
Protection  
and Quality  
in the  
Health Care  
Industry.

GOOGLE  
LAUNCHES

1999

NQF  
launches in  
September

Institute  
of Medicine  
publishes  
*To Err is  
Human*

2001

Institute  
of Medicine  
publishes  
*Crossing  
the Quality  
Chasm*

IHA's  
California  
Pay for  
Performance  
program

2004

CMS value-  
based  
purchasing

FACEBOOK  
LAUNCHES

TWITTER  
LAUNCHES

2010

Patient  
Protection  
and  
Affordable  
Care Act

*Growth of value-  
based purchasing*

# Creating Rapid Change: What might the future hold?

'15

'20

**2011**

Measure Applications Partnership established

National Quality Strategy

IHA Medicare Five-Star Reporting of Physician Organizations

**2014**

PCAST report calls for better measures, big data and analytics

**2015**

Considering endorsement for intended use

Harvesting and incubating better measures

**2016**

Public-private alignment (health plans/CMS)

Big data sources

Interoperability

**2017**

Predominant move to e-measures

Measures of system performance

Digital advances in patient surveys

State-federal alignment

**2018-2020**

Accelerate value-based purchasing?

Other payment models?

*Increasing emphasis on reducing cost*

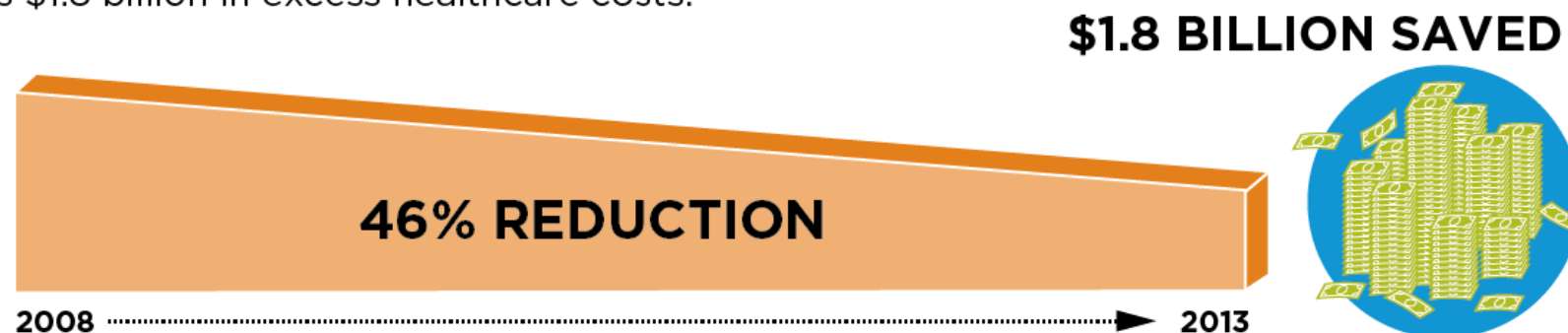
## NQF's Unique Role

- **Gold Standard for Quality**—endorses best healthcare quality measures
- **An Essential Forum**—420 organizational members and more than 800 volunteer leaders that span healthcare
- **Advisor**—to CMS and Congress on quality measurement
- **National Quality Leadership**—convenes private and public sector leaders to reach consensus on healthcare's leading complex issues

# National Quality Results—Making Care Safer

## WHY MEASURES MATTER

For the past eight years, CLABSI initiatives have saved as much as \$1.8 billion in excess healthcare costs.\*



**> 50,000 lives saved from total reductions in hospital acquired infections**

# National Quality Results—A Better Start

## RESULTS

**2014**

Leapfrog survey shows that early elective deliveries (EED) dropped from 17 to 4.6% between 2010 and 2013

**73% IMPROVEMENT**

2010

2013

**...AND RESEARCH SHOWS THAT**  
Reducing EEDs to less than 2% will avoid approximately

**500,000 NICU DAYS**

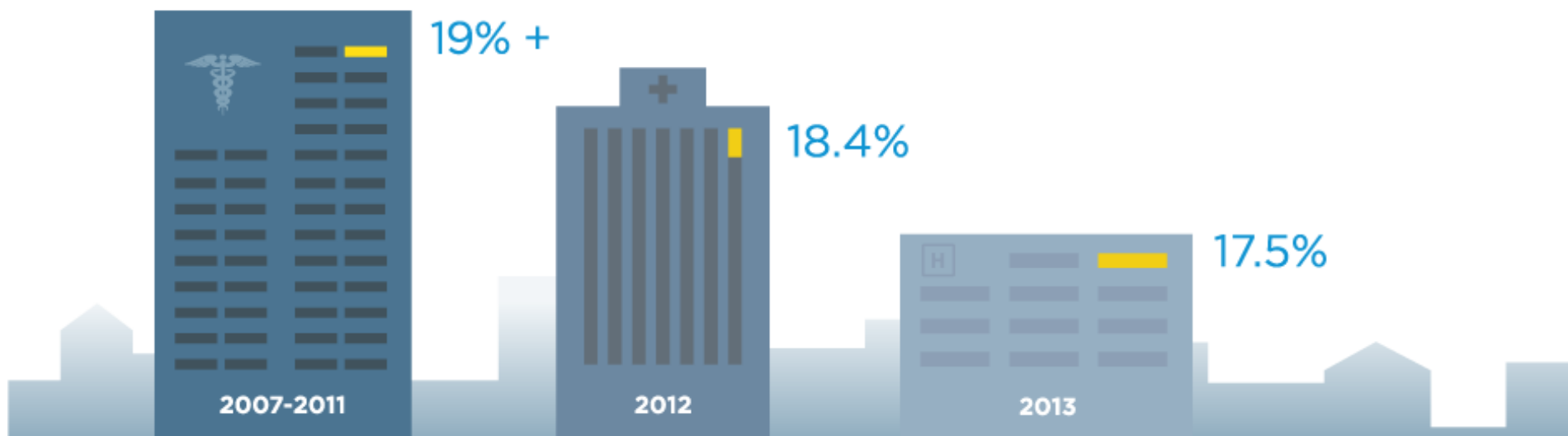
**SAVE  
\$1B**



**IN HEALTHCARE  
COSTS ANNUALLY**

# National Quality Results—Healing at Home

## Hospital Readmission Rates



**More Medicare beneficiaries are healing at home rather than returning to the hospital.**

# HHS Focus on Quality

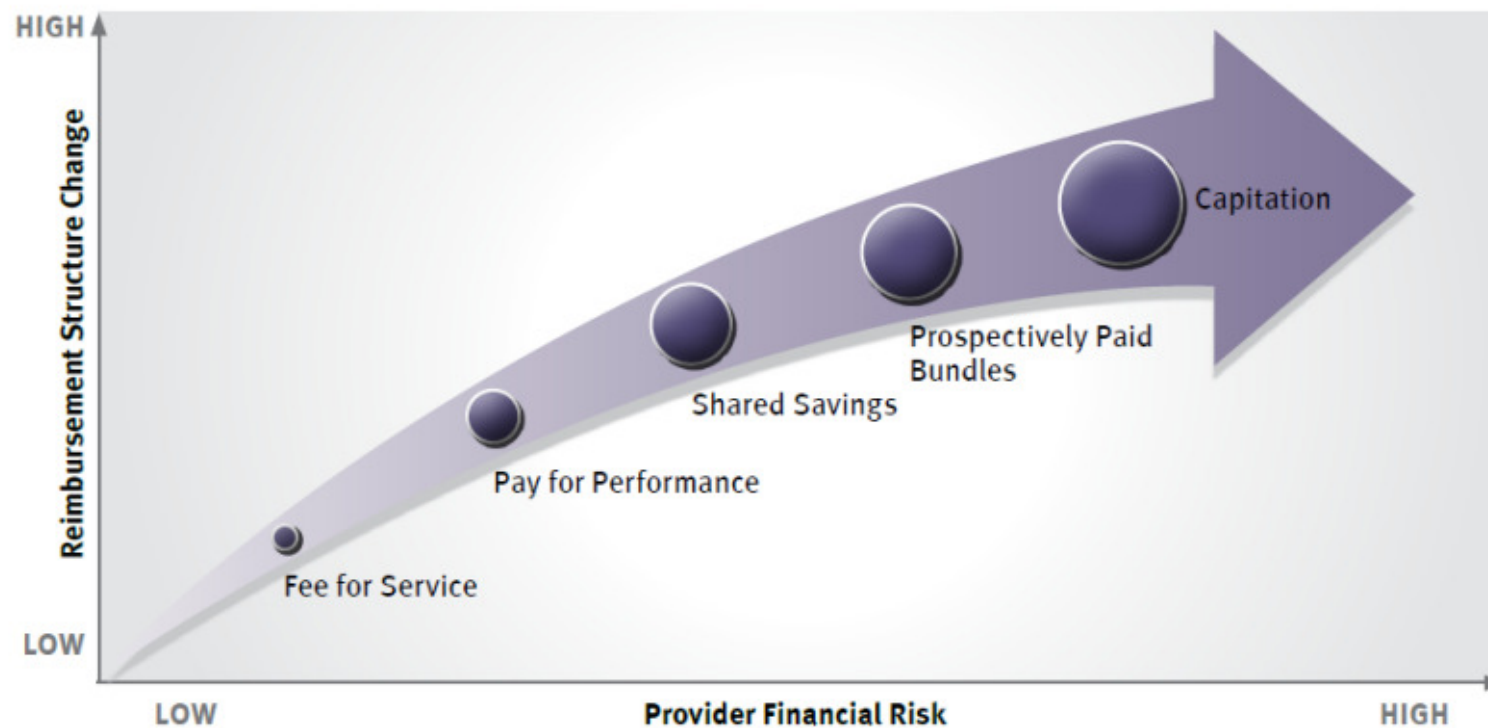
HHS is focused on moving the US health system toward paying providers for quality, rather than quantity of care.

## 2015-2018 HHS Goals

- 30% of fee-for-service Medicare payments to be tied to quality or value through ACOs or other alternative payment models by the end of 2016; 50% achieved by 2018
- Overall, 85 % of all Medicare payments to be tied to quality or value by 2016; 90% by 2018



# Evolving payment and risk structures



**Good measures are increasingly important at each stage.**

# Tensions in Measurement

- Between a few good outcome measures for accountability and process measures to guide improvement
- Between burden for providers/clinicians and comprehensiveness for consumers/purchasers.
  - Today, clinicians wrestling with high stress, low morale, and low confidence in data and measurement
- Between system level measurement and individual clinician level measurement.
- Between a small set of measures and having metrics that meet the needs of different specialists and settings

# A Quality Measure Vision

- Align measures to reduce burden and accelerate improvement; end duplication within and across settings and providers
  - Reduce cacophony of “look-alike measures”
- Identify more measures that are actionable, meaningful, and lead to better health outcomes
- Advance measurement to accurately and reliably assess value
- Achieve consistency and rigor in consumer information
  - Hospital Rankings (*Health Affairs*, March 2, 2015)

# Key Issues in Realizing this Vision

- Leveraging new technology and big data to advance measurement science
- Ensuring measures capture quality differences, such as by adjusting for sociodemographic (SDS) factors.
- Attributing results to specific providers (hospital, medical group, individual clinician)
- Fully engaging consumers in understanding and advancing quality

# Complex Measurement Science Questions

## ■ Risk adjustment for sociodemographic factors

### VIEWPOINT

## Quality Measures and Sociodemographic Risk Factors To Adjust or Not to Adjust

- Attribution
- Comparability
- Intended Use

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JAMA.

the potential for socially disadvantaged economic status.

blatant prescription

the potential influence of sociodemographic risk on health and health care, this policy of not including risk adjustment, adopted by the Centers for Medicare & Medicaid Services (CMS) and others, potentially results in unfair comparisons among clinicians, hospitals, and other health care organizations.<sup>1</sup>

Two health care trends have likely spurred reexamination of this policy. The first reflects a trend toward measuring patient outcomes (eg, hospital readmissions) rather than care processes (eg, smoking cessation counseling).<sup>2,3</sup> Process measures largely under hospital or clinician control, such as drug administration during hospitalization, are little influenced by social determinants of health (ie, patient life circumstances, community, and community resources). In contrast, outcomes such as patient hospital readmission mortality are more strongly influenced by "social risk."<sup>4</sup> Ignoring these effects can produce misleading conclusions about comparative performance.<sup>5,6</sup> Secondly, clinicians serving disadvantaged patients may appear worse on quality measures than they really are, and those serving more affluent patients may appear better than they really are.

The second trend is payment for performance for hospitals, clinicians, and other entities, eg, accountable care organizations (ACOs).<sup>7,8</sup> This trend creates the potential for greater financial penalties for hospitals, clinicians, and ACOs caring for socially disadvantaged patient populations. The 2006 policy could have the paradoxical effect of exacerbating health care disparities by depriving safety-net hospitals and clinicians of resources needed to provide quality care, making the public appearance that hospitals and clinicians caring for disadvantaged patients are low quality, and as a consequence, generating perverse incentives to avoid serving disadvantaged patients or communities.<sup>9</sup>

In response to these concerns about fairness, the HITECH Act (CMS) convened an expert panel to reconsider its policy. The panel considered the questions of whether, when, and how to adjust measures used for "accountability applications" (ie, reporting of quality and pay for performance) for sociodemographic risk factors. The panel sought to balance possible unintended consequences of adjustment, includ-

tion against adjustment of performance measures for patient sociodemographic factors should be revised.<sup>1</sup> This conclusion was based on review of scientific evidence documenting that sociodemographic factors function as confounders (ie, a third factor that distorts the causal relationship between 2 other variables) for performance measures (particularly for outcome measures) and that appropriate statistical adjustment typically does not mask true poor performance between hospitals, clinicians, or other entities. The panel also recognized that the precision and degree of confounding by patient sociodemographic factors differ depending on the measure. The panel concluded that blanket adjustment of performance measures also would not be appropriate.

### Measure-by-Measure Determination

The panel recommended a measure-by-measure determination of the appropriateness of sociodemographic adjustment based on 2 criteria. First, there would be a conceptual relationship between the more sociodemographic factor and outcome or process of care reflected in the measure. For example, adjusting rates of hospital central-line infections would not be appropriate because sociodemographic factors are presumed to have little relationship with these factors. Under processes leading to infection are largely under the control of the hospitals whose performance is being measured. On the other hand, glycemic control as a measure of physician performance should be considered for adjustment. Glycemic control is affected not only by individual care but also by social risks or patient behavior and community resources, even when clinicians have relatively little direct influence.

Second, there should be empirical evidence that sociodemographic factors affect a measure. The panel did not specify a threshold or cutoff for degree of association, but recommended that the same criteria used for inclusion of clinical risk factors in adjustment models be used for sociodemographic factors. For example, the observed effect (ie, effect or empirical evidence) of the relationship of sociodemographic factors with a given measure would indicate that adjustment is unnecessary or inappropriate.

JAMA. December 24/31, 2010. V 304(26). Pages 34-35.

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# Getting to Measures that Matter: Reduce Variation and Enhance Innovation

