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.

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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