Report from the Front Lines

QUALITY METRICS AND REPORTING IN VALUE-BASED CARE

SPONSORED BY:

Critical Conversations℠

Report from the Front Lines

QUALITY METRICS AND REPORTING IN VALUE-BASED CARE

As part of its ongoing series of Critical Conversations on the changing health care environment, the American Hospital Association (AHA) and its strategic business enterprise, AHA Health Forum, invited clinicians, hospital administrators and other health care staff to Boston to discuss the challenges of quality metrics tracking and reporting. Presentations included a look at the current regulatory landscape by representatives from the AHA and other field experts, as well as firsthand accounts of how hospitals and health systems are navigating the road ahead.

This is a volatile time in health care. Hospital and health system executives — as well as clinicians and other staff — face unprecedented pressures and uncertainty around health care reform, reimbursement variations, evolving technology and regulatory requirements.

But amid these unknowns, one thing seems clear: Value-based care and quality measurement and reporting are here to stay, said Akin Demehin, director of policy, the American Hospital Association.

Despite the ongoing debate in Congress about the Affordable Care Act and the relative merits of different repeal-and-replace options, Demehin said, "none of the quality or pay-for-performance programs that were put in place by the ACA or MACRA have been touched by the various proposed legislation," he said, a sign of bipartisan support for value-based care. Nearly 10 percent of hospital Medicare payments are tied to quality and electronic health record (EHR) use.

It's a simple enough concept on the surface — making sure that health care dollars are well-spent and result in high-quality care for patients. Who could argue with that? But the implementation of value-based care is anything but simple. And the complications begin with the collection and reporting of quality data.

In May 2017, clinicians, health care administrators and other representatives from hospitals and health systems in New England gathered to talk about challenges and solutions for quality reporting. The nearly 40 attendees represented various departments and backgrounds, from quality or performance improvement to information technology and compliance and risk management. No more than two or three people in the room shared the same title.

Although participants came from different hospitals in terms of size, community and socio-economic status, common themes emerged: choosing measures, dealing with multiple formats and EHRs, extracting data, getting staff on board, creating actionable data and, ironically, finding time for performance-improvement projects.

Cheryl Bardetti, manager, quality improvement and infection control, Newton-Wellesley Hospital in Newton, Mass., said, "The common denominator is a lack of resources and constant struggle. It feels good to be in the room with others who understand that struggle, but also hear from presenters [from hospitals] where it all works out."

Patrick Gannon, vice president and chief quality officer at Southcoast Health System in Fall River, Mass., put it this way, "We're all in the same boat, drowning in a sea of measures."

How did we get in this boat?

The rationale for measurement centers around three goals: improvement, transparency and provider accountability. "There's little debate about the goals," Demehin said, "but much more debate about how we get there and how to strike the right balance between achieving these goals and the burden on providers to participate." Demehin helps to shape the AHA's advocacy and policy around quality-measurement issues. The AHA's objective, he said, is to develop "pay-for-performance measures that matter and focus the energy where we'll get the most value," while minimizing unintended consequences and developing a sustainable health system.

MEASURE FOR MEASURE: REPORTING OPTIONS

With the alphabet soup of regulations and incentives, and the various choices for participation, just sifting through the reporting options and figuring out what route is best presents a host of challenges for providers. The Medicare Access and CHIP Reauthorization

Act of 2015 (MACRA) may have consolidated three separate programs into one system, but it still has two tracks and many choices involved. Providers must decide how much to report, what to report and how to report it.

Zahid Butt, M.D., founder and CEO of Medisolv, a company that develops medical quality reporting software, recommends that providers look at their goals and expectations: Do you want to do the bare minimum to avoid the 4 percent penalty or do you want to go all in and maximize bonuses? "If I were still in practice, I would want the bonuses by getting on the high end of the readjustment formula," he said, pointing out that those who do have the potential for three times the adjustment. However, some hospitals and health systems may not have the infrastructure in place to go for the maximum reward.

Even choosing the measures to report can be difficult when reporting as a group of clinicians, especially at academic medical centers with a wide variety of specialties. As Jill Bradford Shuemaker, R.N., senior clinical informaticist at Virginia Commonwealth University Health System, (VCUHS) explained, VCUHS has more than 700 physicians and hundreds of midlevel providers representing 200-plus specialties, with less than 10 percent in primary care. "Finding meaningful measures across that breadth of providers is challenging," she explained.

The sheer volume of measures can be overwhelming. The hospitals at the Critical Conversations meeting were tracking between 150 and 300 measures — sometimes more. Michigan Health Information Network Shared Services in East Lansing looked at the measures in the different national programs (Physician Quality Reporting System, electronic Clinical Quality Measures, Quality Rating System, Healthcare Effectiveness Data and Information Set and Medicaid), and only nine overlapped.

Andrea Tull, director of reporting and analytics at Massachusetts General Hospital in Boston, said one of the biggest challenges is that none of the measures is static. "As soon as you get used to a measure, it's gone." Some are complicated from an information technology standpoint, she added, and require coordination of various committees and processes to streamline them. Changes in the measures or the reporting mechanism may require intervention from an already too busy IT department. And, perhaps most frustrating of all, required measures don't always align with what is best for physicians or even patients.

EXTRACTING DATA

Choosing measures to track and report can be tough, but extracting the data from the EHRs can be an even bigger hurdle. One small psychiatric hospital reported that at least six different EHRs were in use by its providers, each with its own way of storing and organizing data. Lawrence (Mass.) General Hospital — with fewer than 200 beds — has more than seven EHRs. Even hospitals where everyone is on the same system still have significant issues and challenges in extracting data. Keeping up with data collection during the transition among EHR systems adds another layer of complexity to the process.

"Reporting should be straightforward, but it isn't," said Butt, warning providers not to wait until the last minute to try to collect and compile data for reporting purposes.

Small details can make a big difference in how data are pulled, Butt explained. For example, a condition must have a start date and an end date — leave out one and it won't be counted in the quality report. Another complication is that when patients receive care in more than one setting, the data may not track correctly.

VCUHS was ahead of the game, adopting EHR in the 1970s, then converting to a contemporary vendor in 2004; however, EHR maturity often complicated eCQM reporting, explained Bradford Shuemaker. Numerous customizations have been made. Many health systems are similar to VCUHS in that they use multiple HIT vendors, and many of them have not fully adopted standard data nomenclature. For example: Instead of creating one field for blood pressure that could be utilized in multiple applications, there are multiple fields for documenting blood pressure based on clinical needs; therefore extracting blood pressure data to report is complex and challenging.

Addressing these issues takes a close working relationship between the IT and quality departments, and careful assignment of responsibilities to each of those departments. Bradford Shuemaker pointed to a key decision made by the quality director at VCUHS to assign oversight of the eCQM program to the quality department, rather than to IT. Although both departments are involved in the collection of the data, the purpose is focused on quality, not technology.

Having the right expertise is also necessary for outside vendors who bid to assist with quality metrics and reporting. Bradford Shuemaker said after two eCQM vendor implementations, VCUHS was meeting Meaningful Use requirements to submit eCQMs, but still did not have accurate, actionable data. With support of both executive and quality leaders, the goal to produce meaningful, useful eCQM data led VCUHS to once again change vendors. The new vendor solution, Medisolv's Encor, pulls data from data tables, providing the flexibility necessary to meet VCUHS requirements.

Readmissions: Making Penalties Fairer

One of the first examples of Medicare pay-for-performance, the Hospital Readmissions Reduction Program launched in October 2012. National readmissions rates have dropped significantly as hospitals innovated and coordinated care to help patients stay out of the hospital once released. "The reduction is real, and the trend is in the right direction," said Akin Demehin, director of policy, the American Hospital Association.

Despite the drop in readmissions, financial penalties for hospitals continue to rise, with more than 78 percent of hospitals penalized in fiscal year 2017. For most hospitals, the penalty comes in at just under one percent, but nearly 50 hospitals in the country got the full 3 percent penalty.

Unfortunately, the hospitals that have seen the highest penalties have tended to be those that serve low-income populations, revealing one of the biggest conundrums of value-based care. Readmission rates — and post-hospitalization health outcomes in general — depend not only on care at the hospital, but also living conditions and patients' access to care after a hospital stay. Patients in high-income areas have more resources and more supports to continue their recovery in their own homes and communities.

"The way it stands, we're not giving hospitals more money to improve outcomes; we're actually penalizing them. It makes it hard to get out of the cycle," said Zahid Butt, founder and CEO of Medisolv.

Finding a fix for this inequity is not easy, but an upcoming change in the readmissions policy is an important first step. Demehin pointed out that the 21st Century Cures Act includes a requirement for CMS to assess penalties by placing hospitals in peer groups based on how many Medicare/Medicaid dual-eligible patients they serve. This adjustment approach will affect readmission penalties starting in FY 2019. Dual-eligibility is a proxy for the socio-demographic status of patients and communities.

Demehin pointed out that the 21st Century Cures Act includes a formula for CMS to use to readjust penalties based on socio-economic factors. Another potential fix is to group hospitals in peer groups based on the number of Medicare/Medicaid dual-eligible patients served.

"How do you account for resource differences across hospitals?" asks Demehin. That's a question that remains unanswered for now. "Socio-economic status adjustment is just one tool in the toolkit," he said. ●

Several hospitals had recently transitioned all clinicians to one of the leading EHRs, but were still struggling with data collection. Customization of the system — which may be necessary to meet clinicians' needs — can complicate data collection. As a result, many hospitals that have standardized on one system are still depending on nurse chart extractors who pull the data manually or at least recheck the system-extracted data to ensure accuracy. One hospital representative said that it will be at least 18 months before the facility moves to automated extraction.

Mary O'Neill, M.D., emergency department physician and medical director at Milford (Mass.) Regional Medical Center, said that many clinicians resist the structured documentation needed for collecting and analyzing specific measures. She recommended employing scribes to make sure the data go in the right place. "It's a fix that we can do before the perfect, interoperable world," she said.

CULTURE SHIFT

Reporting as a hospital or health system requires more than EHR systems that talk to each other. It also requires that staff members become comfortable with the idea and the language of quality reporting and learn new ways of working across departments. It's a shift as fundamental as the one made several years ago when hospitals and health systems put additional focus on patient safety, one participant pointed out.

Forging a partnership between quality and IT teams is just the beginning of the culture shift needed to implement quality data collection and reporting at hospitals and health systems. Many of the hospitals reported fragmentation, duplication and lack of communication among hospital departments that hampered quality data collection and reporting.

Annette Roberts, director of quality at Milford Regional, reported having 44 different quality committees. "Nobody is sharing what they're doing," she said. "There's a lot of duplication." Ben Asfaw, vice president of quality, South Shore Hospital in South Weymouth, Mass., said they had 69 quality committees at his facility, but recently had "knocked it down to 13."

VCUHS recognized that an important part of the process would involve team-building efforts, workflow adjustments and improving communication among departments. "Silos were not going to make us successful," said Bradford Shuemaker. And while incentives and penalties may help, "ultimately, the carrot and the stick are not going to outweigh doing the right thing" for patients and for clinical processes.

The first step was to meet clinicians and other staff where they were and only suggest changes to workflow when it made clinical sense, following guidelines from the clinicians' specialty groups and best practice evidence. For example, although one of the measures assesses screening for depression, VCUHS expects all physicians to practice according to best practice evidence, resulting in some specialists collecting limited mental health information, instead of collecting more comprehensive data solely for reporting purposes.

They also made it as easy as possible to properly document the measures. For example, a measure requires physicians to document why they choose not to order a venous thromboembolism (VTE) prophylaxis so this is captured during the physician's ordering workflow; saving clicks meant staff were more apt to enter necessary data.

Several hospitals have integrated education about quality measures into orientation for front-line staff. Others have required or recommended that staff take web-based classes developed by the Institute for Healthcare Improvement on the purpose and best practices for quality measurement and reporting.

For providers, that means understanding that quality reporting isn't just an exercise in data collection — it's the first step toward compensation based on outcomes and value in health care.

"Quality is not just a nice thing to have," Asfaw added. "First and foremost, it's for the patient." But it also has huge financial implications, Asfaw pointed out. One percent may not sound like a lot until you're talking about 1 percent of $100 million. "That's a lot of money on the hook. It's not about the dollars, but the dollars get people's attention."

ACTIONABLE INFORMATION

Part of getting leadership, clinicians and staff involved in quality metrics is providing actionable, clinically relevant information and keeping them informed about progress on quality measurements. But when providers, administrators and other stakeholders need different pieces of information, how do you create a dashboard that is actionable without being overwhelming?

Some of the ideas presented at the Critical Conversations meeting included:

- Instead of reporting on many different measures, South Shore Hospital suggests **ELEVATING JUST A FEW FOR SPECIAL FOCUS AND GOAL SETTING**. Once a goal is attained, then move onto another set of measures.

- **CELEBRATE SMALL SUCCESSES.** Set linear progression goals and show progress toward the goals so staff don't become as accustomed to seeing results in the red.

- Instead of showing the number of incidents (such as central line-associated bloodstream infections), show the number of days since the last incident. This gives staff a **WINNING STREAK** that they can work to perpetuate.

- Provide clinicians with **DATA THAT MAKE A DIFFERENCE** to their practices and the patients. In addition to tracking required measures, VCUHS asks clinicians for the measures that matter to them and then provides those data so that they can track their own progress.

Lord Kelvin, a Scottish mathematician and physicist, reportedly said, "If you cannot measure it, you cannot improve it." That is clearly the goal of all of the effort put into quality metrics: to analyze quality data and identify solutions that lead to better care. For example, Amy Hu, application architect at Lowell General Hospital, said her organization has tried using predictive analytics to look at readmission trends and identify frequent users of emergency services so it can adjust the treatment plan and services to help prevent the next ED visit.

Not all hospitals have the bandwidth to launch these projects. "We don't have the resources to do ad hoc performance improvement projects," said one participant. "We have to spend our time on the 172 measures that we don't have a choice about."

"We're still spending a lot of time coordinating data rather than looking at what the data are telling us," said another.

Participants expressed hope that as they're able to move away from manual extraction and data checks and toward automated and accurate reporting, they'll have time to launch more ambitious performance improvement projects.

As Lord Kelvin pointed out, the first step in improvement is measurement. ●

CRITICAL CONVERSATIONS ON THE CHANGING HEALTH CARE ENVIRONMENT

In May 2017, the American Hospital Association invited clinicians, health care administrators and other representatives from hospitals and health systems to participate in a Critical Conversation about improving quality of care and meeting regulatory requirements. Also participating were representatives of a selection of organizations whose solutions have been exclusively endorsed by the AHA. Here's a list of our sponsors: