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LITERATURE REVIEW

Systematic literature review: An analysis of administrative strategies to engage providers in hospital quality initiatives ☆

Ellen Suelflow*

Nurse Anesthetist, Aurora Health Care, Milwaukee, WI, USA

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Provider;
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Abstract
Provider engagement in hospital quality initiatives is receiving increased attention in a pay-for-performance era. The traditional hospital-physician alignment structure has not promoted provider engagement in system-wide quality initiatives. This systematic literature review analyzes provider engagement strategies. Selected articles were required to introduce administrative strategies that engage providers in hospital quality initiatives. A PubMed search uncovered 196 articles using the following keywords: "provider* OR physician*, AND hospital*, AND quality, AND engage*. Providers were defined as physicians, fellows, residents, physician assistants, or advanced practice nurses. The following filters were applied during the search: English language, humans, and published in the last 5 years. A total of 45 articles met the inclusion criteria. The reported strategies comprised financial incentives, public or private reporting, removing barriers, provider leadership, and hospital-provider alignment. Each reported strategy demonstrated gains within a quality initiative. However, it remains unclear whether these surrogate measures reflected provider engagement or other phenomena.

Contents

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*Correspondence address: N66W4905 Cedar Reserve Circle, Cedarburg, WI 53012, USA. Tel.: +1 2623890256.
E-mail address: ellen_suelflow@me.com

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Background

In March 2010, President Obama signed into law the Affordable Care Act (ACA), which established the hospital Value-Based Purchasing (VBP) program. Hospital VBP links Medicare reimbursement to performance on specific system-wide quality metrics. On October 1, 2012, the hospital VBP program administered by the Centers for Medicare and Medicaid (CMS) became effective. Hospital VBP is budget-neutral. CMS pays monetary incentives to high-performing hospitals and penalizes low-performing hospitals. Since the hospital VBP program only affects Medicare hospital reimbursement, this places the burden on hospital leadership to improve scores, not providers [1].

Pay-for-performance programs such as hospital VBP are not going away. More than 40 commercial-payer programs now exist [2]. In 2014, CMS added 13 outcome measures comprised of 3 mortality measures, 8 hospital-acquired condition measures, and 2 Agency for Healthcare Research and Quality composite measures to hospital VBP. While the current hospital VBP program does not provide large financial incentives for hospitals to improve quality, by 2017 the percentage of Medicare payments at risk will have increased from 1% to 2% [3]. With expansion into commercial payers, an increase in the number of quality metrics, and greater financial incentives, the impact pay-for-performance has on hospital reimbursement will continue to grow.

One of the fundamental approaches to improve hospital performance in quality is provider engagement. The Advisory Board Company [4] defines engagement as a provider who "self-identifies as part of the organization and is personally motivated to help the organization succeed." Evidence suggests a provider hesitation to participate in system-wide quality improvement initiatives. In a 2007 survey, members of the American College of Physician Executives reported only 34% of their physicians supported hospital quality improvement projects [5]. In a 2005 study, less than 10% of physicians, nurses, and clinical staff reported confronting a colleague when concerned with behavior or clinical judgment that could cause harm [6]. The 2010 CMS Physician Quality Reporting System and Electronic Prescribing Incentive Program Experience Report revealed that only 47.9% of anesthesiologists, 34.7% of nurse anesthetists, 11.6% of obstetricians, and 10.7% of nurse midwives participated in this voluntary pay-for-reporting program [7].

The traditional hospital-physician alignment structure has not promoted provider engagement in system-wide quality initiatives. Historically, the physician relied on hospital resources to deliver care to his patients while the hospital depended on physicians to admit and care for them. There were no financial ties. The move towards ambulatory services with physician economic involvement created a further division between the physician and the hospital [8]. In addition, the current fee-for-service reimbursement structure rewards volume over value. This payment structure does not encourage physician and hospital collaboration on system-wide quality initiatives.

By law, the ultimate responsibility for hospital quality of care rests with the hospital board. The board carries out this responsibility by establishing strategic goals, tracking performance, and following up on corrective actions. In a 2006 survey of hospital leaders on board oversight of quality, less than half of the CEOs responding revealed that the governing board was effective in this function [9]. The board delegates much of the quality of care responsibility to the organized medical staff through the Medical Executive Committee (MEC). The MEC promotes hospital quality of care through the peer review process and credentialing. The CMS Conditions of Participation and The Joint Commission (TJC) support this arrangement. However, most physicians today do not acknowledge their collective responsibility for hospital quality and assume this is the responsibility of hospital administration. In addition, legal risks and due process have limited the power of the organized medical staff to affect quality of care to restricting or revoking provider privileges through the peer review process [10]. The peer review process fails to address clinical process issues and does not create an opportunity to learn from medical errors. The peer review process essentially examines whether the provider met the standard of care and is competent. It is not a clinical performance evaluation using quality metrics [5].

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