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AAHKS Symposium: Patient Reported Outcome Measures: This is your New Reality

What Quality Metrics Is My Hospital Being Evaluated on and What Are the Consequences?



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ABSTRACT

Quality, experience, and cost are important indicators of value to patients. However, stakeholders have yet to reach agreement on how to define quality and which measures should be used to assess quality. Measures that have been used to assess quality in health care include structural, process, patient experience, efficiency, and outcomes measures. Payers and other quality rating organizations use a combination of measures to rate or rank hospitals on the quality of care they provide. These ratings can be strictly informational or can be used to steer patients, for contracting between payers and providers, and more recently, for adjustments to reimbursements. Physicians and hospitals have a crucial role to play in the development of quality measures that are used to measure and improve value. Consensus on quality measures will facilitate meaningful comparisons across providers and insights that will enable improvements in the value of care we deliver to our patients.

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Despite spending more per capita on health care than any other country, the United States consistently ranks lower than other high-income countries on health outcomes and quality measures such as safety, care coordination, and patient-centered care [1]. There is a clear need to improve the value patients derive from our health care system. Value in health care has been defined as health outcomes achieved per health dollar expended [2]. New and emerging payment models, such as bundled payments, seek to reward hospitals and physicians for the value of care they provide to patients as opposed to the volume of care. In order for these initiatives to be successful in improving outcomes and slowing the growth of health spending, stakeholders must first agree on which outcomes to measure and how to measure them.

Various organizations have undertaken efforts to measure—and publish—quality metrics for hospitals and physicians, such as US News & World Report (best hospitals rankings) [3], Consumer Reports (hospital ratings), and ProPublica (surgeon scorecard) [4]. Payers (public and commercial) also rate hospitals and publish results to steer their customers toward providers that offer higher quality and lower cost care. For example, Blue Cross Blue Shield (BCBS) designates certain hospitals as Blue Distinction Centers based on their expertise and efficiency in delivering specialty care

and allows their beneficiaries to search specifically among those distinction centers [5]. Sites like Yelp, Healthgrades, and Zocdoc allow patients to assign star ratings to doctors or hospitals based on their own experiences. The quality assessments offered by these stakeholders vary greatly based on types of measures included, data sources for those measures, and how the assessments of quality are ultimately used.

Types of Quality Measures

Each rating organization uses a different set of measures and scoring system to arrive at an overall quality rating or ranking. Quality measures can be categorized into several types: structural, process, patient experience, efficiency, and outcomes measures (Table 1) [6]. Structural measures are characteristics of a hospital's delivery system such as whether they have adopted meaningful use of electronic health records, have a defined leadership structure with clinical and nonclinical representation, or staffing ratios such as nurse-to-patient ratio. Structural measures are easy to define and measure, but often difficult to change. The evidence of the impact of structural factors such as electronic health record adoption on health quality is mixed [7–11]. Process measures reflect regular operating processes and steps in care delivery such as postoperative venous thromboembolism prophylaxis. Benefits of process measures include that they are easy to define and measure, objective, and actionable. The association of process measures with

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Table 1
Quality Measurement Domains.

Type of Measure	Example	Benefits	Limitations
Structural	Adoption of EMR (eg, meaningful use)	- Easy to define - Difficult to manipulate	- Correlation with quality, outcomes?
Process	SCIP measures (eg, Abx, DVT prophylaxis)	- Easy to define - Actionable - Allow feedback	- Clinical relevance - Correlation with quality, outcomes?
Patient experience	HCAHPS, Press Ganey	- Patient focused	- Influenced by patient expectations and engagement
Efficiency	Utilization of services, length of stay, margins	- Easy to measure	- Correlation with quality?
Outcome	Complications (eg, infection), readmissions, reoperations, PROs	- Best measure of quality	- Difficult to measure - Risk adjustment - Limited feedback - Lag time

HCAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems; PRO, patient-reported outcome; SCIP, Surgical Care Improvement Project; Abx, antibiotics; DVT, deep vein thrombosis; EMR, electronic medical record.

clinical outcomes is also mixed, with some studies showing strong correlations and others suggesting limited or no correlation [12–14]. Patient experience measures such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores are patient focused and patient reported. However, these measures can be influenced by patient expectations and engagement [15,16] and are not linked to specific providers, thereby limiting how actionable the information may be. Efficiency measures such as length of stay and profit margins are easy to measure, but their use as a proxy for quality has been questioned [17].

The most direct measures of quality are outcome measures. Outcome measures include complications, readmissions, reoperations, and patient-reported outcomes (PROs), among others. In orthopedic surgery, PROs which assess pain, functional status, and quality of life are arguably the most clinically relevant measures of quality. For instance, a patient with severe osteoarthritis elects to undergo knee arthroplasty to relieve pain, regain function, and improve quality of life. However, most orthopedic surgeons and hospitals are still not collecting PROs before and after surgery to understand whether these treatment goals were achieved [18].

Collecting outcome measures (including PROs) involves several barriers that must be addressed [19]. First, outcome measurement often requires additional resources such as infrastructure, personnel, and time. This is particularly true for PRO measures. Outcomes also need to be risk adjusted to account for patient factors (eg, demographics and comorbidities) and treatment factors (eg, type of anesthesia). In addition, there is usually a lag time between care delivery and reporting of outcomes measures, thus making the reported data less usable. Finally, although the information outcomes provide is most directly associated with quality, such measures may leave unanswered *why* a poor outcome was observed or reported. For these reasons, structural and process measures are often used over outcome measures despite their more tenuous and distant connection to quality.

As a result of a shift to value-based payment methodologies where payment is linked to the quality of care delivered, many of these barriers are being actively addressed by hospitals and cloud-based technology companies. For example, several health systems (including University of Utah and University of Rochester) have built system-wide PROs collection capabilities in the outpatient and inpatient settings [20], whereas many of the hospitals participating in the National Surgical Quality Improvement Program (NSQIP) are

automating collection of many 30-day clinical outcome variables required by NSQIP [21]. In parallel, cloud-based technology companies are developing online and mobile applications to enable customized, low-burden collection of PROs and eliminating the time lag by making the results available to the care team for real-time for use in the clinic visit.

Use of Quality Measures in Hospital Rankings

Payers and other quality rating organizations use a combination of measures to rate or rank hospitals on the quality of care they provide. In some cases, these ratings are strictly informational; in other cases, they can be used to steer patients, for contracting between payers and providers, and more recently, for adjustments to payer reimbursements.

U.S. News & World Report has ranked medical centers for the past 25 years [22]. The information from U.S. News & World Report is publicly available and for informational purposes only. Hospitals are ranked by specialty (eg, cardiology, orthopedics) based on structural, process, outcomes, and efficiency measures [23]. The most heavily weighted factor in their ranking is 30-day mortality rate. A combination of structural and efficiency factors such as nurse staffing, patient volume, and use of certain evidence-based technologies also factor highly into their rankings. A hospital's reputation among specialists carries significant weight as well. Finally, each hospital is assigned a patient safety score based on measures such as injuries during surgery, major bleeding after surgery, and other Agency for Healthcare Research and Quality Patient Safety Indicators [24]. U.S. News & World Report also rates hospitals for some common procedures including hip and knee arthroplasty, by categorizing them as high performing, average, or low performing. Other rating organizations such as Consumer Reports and ProPublica similarly provide ratings of hospital and provider quality for informational purposes only.

An example of a quality initiative used to steer patients is the BCBS Blue Distinction Program. In this program, hospitals that meet certain quality and efficiency measure standards receive the distinction of being designated as a center of excellence. These centers are then included in a database where BCBS customers can search for centers of excellence in their geographic region. Example measures used by BCBS to determine Blue Distinction include existence of multidisciplinary team and care pathways (structure), average length of stay (efficiency), percent of patients discharged home (outcome), and assessment of functional outcomes (process). In this BCBS program, there are no additional payments to Blue Distinction Centers, and patients are not required to receive their care at a Blue Distinction Center of Excellence. However, certain organizations, such as California Public Employees' Retirement System, have made regional Blue Distinction Centers the exclusive option for their health maintenance organization enrollees [25]. Other centers of excellence benefit designs in which payers contract with particular hospitals and physicians that have met quality screening criteria for certain procedures exist as well. One example of this model is EmployerDirect—a company that provides a supplemental health care benefit for employers by directing planned medical procedures to high-quality providers. More specifically, EmployerDirect uses outcome and cost measures to identify high-quality providers and hospitals, prenegotiates prices for episodic procedures (eg, total joint arthroplasty, spinal fusion, valve replacement, cholecystectomy, and so forth), and then contracts with employers to direct their covered lives to those high-quality providers. In this model, patients are channeled to hospitals that provide high-quality care and are willing to discount their prices in exchange for the higher volume of patients [25].

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