CATALYST FOR PAYMENT REFORM

The Quality Measures That Matter

Action Brief

As stewards of the health care programs offered to 56% of Americans, employers and other health care purchasers are understandably concerned about the value—the combination of both quality and cost—they are getting for their health care spending. To achieve higher value, there has been a flurry of activity spurred by the private and public sectors alike to reform how we deliver and pay for care in the United States.

Catalyst for Payment Reform (CPR) has been tracking the portion of health care payments that are value-oriented—aspiring to improve the quality of care. In its 2014 National Scorecard on Payment Reform, CPR found that 40 percent of payments to physicians and hospitals were value-oriented, up from 11 percent in 2013. However, there is a dearth of evidence that these changes will lead to higher value care.

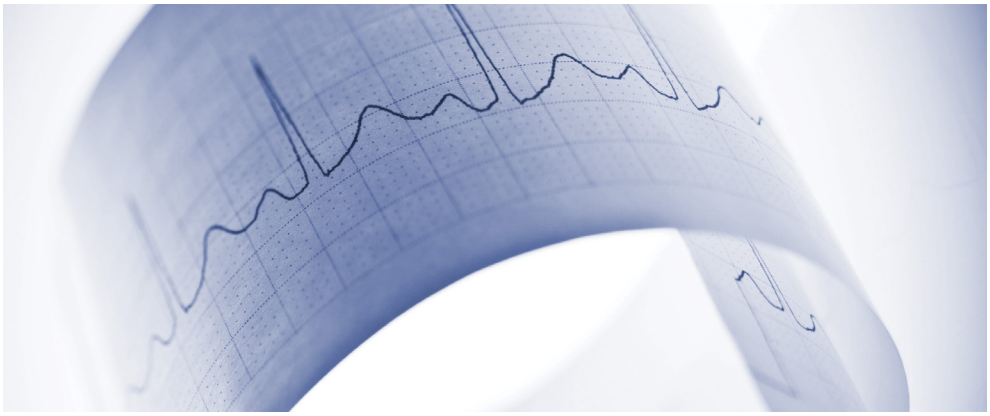
The cost reduction aspect of payment and delivery models has been a major focus for stakeholders. And there are ways to measure whether costs have decreased or at least remained steady, though drawing causality can be difficult.

However, when it comes to implementing health care delivery and payment reforms to improve the quality of care, employers and other health care purchasers often ask, "which quality measures matter?" Most quality measures in wide use today are the ones that are easiest to measure and often reveal little variation in performance across providers. There are far more measures not yet in wide use, some of which might be better at addressing the areas where health care purchasers in the commercial market are getting the poorest value for their health care dollars. Emerging payment and delivery models require new types of measures to encourage and reward improvement in clinical quality, patient-centeredness, care coordination, and population health management, along with the cost of care. Selecting the right measures from the multitude that exist today is challenging, but critical.

WHY EMPLOYERS AND OTHER PURCHASERS CARE

Annual increases in health care costs have posed great challenges for those that purchase health care on behalf of employees. Employers also shoulder the burden of poor employee health in the forms of reduced productivity and lost days from work. For over fifteen years, we have had strong evidence that the quality and safety of health care in the U.S. is uneven. Over the last five years, evidence has mounted that we also pay wildly different amounts for the same services from different providers regardless of the quality. That means poor value for the dollar, not to mention needless suffering on the part of patients.

Given this, employers and other health care purchasers have a strong focus on whether new payment and delivery models lead to better quality health care for their



Health care performance measurement serves multiple purposes, including:

- Highlighting opportunities for **improvement** and tracking progress over time;
- Supporting value-oriented **payment** models that reward health care providers that deliver high quality care and/or reduce costs;
- **Informing decisions** made by consumers and purchasers about which providers deliver the highest value and where to seek care, promoting provider competition on value; and,
- Policymaker **design, monitoring, and evaluation** of health care delivery and payment reform programs to maximize the intended effects and minimize potential unintended effects, such as limitations on access to care.

employees. Purchasers need measurement information to encourage consumers to make high-value choices, to hold providers accountable for their performance through payment models, and to determine if innovations in health care delivery and payment are working.

By engaging in the health care system and basing health care purchasing decisions on quality – with an understanding of the measures that matter the most – purchasers can play an integral role in improving the value of health care services.

EMPLOYER PRIORITIES FOR QUALITY MEASUREMENT

Employers want quality measures that address the areas where they are spending the most and where the care their populations receive varies significantly on quality and cost—a clear sign of poor reliability and value in the marketplace.

CPR commissioned an analysis of commercial claims data by the Health Care Incentives Improvement Institute (HCI[3]) to identify such areas. Based on the analysis, there are 12 clinical areas where the most health care spending occurs and where the greatest variation lies in quality, safety and costs. Many of these are obvious and familiar (listed alphabetically): arrhythmia, asthma, breast cancer, coronary artery disease, depression, diabetes, gastrointestinal endoscopy, hypertension, low back pain, osteoarthritis, pregnancy, and upper respiratory infection. Some of these clinical areas are consistent with those that matter to Medicare, but others are not. The good news is that there are measures available today – though some are still rarely used—that could make a difference in these priority areas. They simply haven't been emphasized enough.

Following the spirit of the Strategic Framework Board's guidance, CPR's goal here is to create parsimony in measurement in ways that meet the needs of employers and other health care purchasers; we did not create any new measures, but identified available measures that might be the most useful to purchasers at this time.[1]

CRITERIA TO IDENTIFY THE QUALITY MEASURES THAT MATTER

Together with Discern Health, CPR identified the best available quality measures for these priority areas, along with the best measures to assess the performance of the health care system in broader ways, such as care coordination, prevention, patient experience and safety measures.[2,3] To identify a parsimonious set of quality measures

1 McGlynn EA (2003) Selecting Common Measures of Quality and System Performance. Medical Care. 41:I-39-I-47

2 IOM Vital Signs 2.0 report. http://iom.nationalacademies.org/Reports/2015/Vital-Signs-Core-Metrics.aspx.

3 McClellan et al. Accountable Care Measures for High Cost Specialty Care and Innovative Treatment. 2014.

that evaluate the performance of health care providers in priority clinical areas as well as cross-cutting aspects such as patient experience and preventive services, CPR used the following criteria, with an emphasis (though not reliance) on measures endorsed by the National Quality Forum (NQF).

- A primary evaluation of candidate measures against criteria critical to purchasers, such as age of the population addressed (working age under 65 and dependents), level of analysis (provider), setting (ambulatory and acute), and measure type (outcomes preferred)
- A secondary evaluation of candidate measures against descriptive criteria including data source (e.g., claims, clinical, patient-reported), coverage of National Quality Strategy (NQS)[4] priorities (e.g., patient-centered care, population health, patient safety), differentiation in provider performance (known variability or gap in quality), alignment across programs (public and private), and sensitivity to disparities in care

A PRIORITY MEASURE SET

The CPR Employer-Purchaser Priority Measure Set (Table 1) consists of 30 measures. We selected the measures with attention to alignment with other programs to the extent it makes sense given our focus on the commercial population; all of these measures have been successfully implemented in one or more programs. Additionally, we identified cross-cutting measures, which may apply to several or all clinical conditions. For example, survey measures of patient experience (a measure of patient-centered care) are applicable to persons receiving care from almost any provider. However, assessment of body-mass index (an obesity prevention measure) is an important factor in many, but not all, conditions. Using cross-cutting measures can reduce the need for multiple condition-specific measures.

HOW CAN PURCHASERS UTILIZE THE PRIORITY MEASURE SET?

Employers and other health care purchasers can use the Priority Measure Set in a number of ways:

- To orient themselves to which clinical areas need the greatest attention
- To determine whether their existing or prospective health plan partners are using the quality measures that matter in their health care delivery and payment reform programs, (including potentially tying payment to performance on the measures and/or using the measures to evaluate the impact of their programs)
- To serve as a benchmark for assessing the quality measures in use in consumer transparency tools
- To inform direct contract negotiations with health care providers for alternative payment approaches, such as bundled payment or shared savings

The Priority Measure Set can also strengthen employers' and other health care purchasers' voices in the quality debates by arming them with information about which measures matter most for addressing high-priority clinical areas and cross-cutting topics. Purchasers can refer to the CPR Employer Purchaser Guide to Measure Selection for examples of how to use the Priority Measure Set.

It is important to note that the various purposes and uses of measures may require different types of measures, and various stakeholders have different perspectives on measurement. For example, purchasers and consumers want information about overall health outcomes to guide their decision-making and to hold providers accountable, while clinicians and health plan managers want actionable information from process of care measures to track adherence to professional standards and progress on improvement activities.

4 National Strategy for Quality Improvement in Health Care. www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf

TABLE 1: CPR EMPLOYER PURCHASER PRIORITY MEASURE SET

CLINICAL AREA	MEASURE TITLE
Pregnancy	Elective Delivery
	Cesarean Section
	Healthy Term Newborn
Hypertension	Controlling High Blood Pres
Low Back Pain	Use of Imaging Studies for Low Back Pain
	Average Change in Functional Status following Lumbar Spine Fusion Surgery
Diabetes	Optimal Diabetes Care (Composite Measure)
Depression	Antidepressant Medication Management
	Screening for Clinical Depression and Follow-Up Plan
	Depression Response at 6 months-Progress Towards Remission
Osteoarthritis	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip/Knee Arthroplasty
Breast Cancer	Breast Cancer Screening
	Oncology: Cancer Stage Documented
Arrhythmia	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy
Asthma	Asthma: Pharmacologic Therapy for Persistent Asthma
Coronary Artery Disease	Statin Therapy for Patients with Cardiovascular Disease
	Optimal Vascular Care
Gastrointestinal Endoscopy	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use
	Colorectal Cancer Screening
Upper Respiratory Infection	Appropriate Treatment for Children with Upper Respiratory Infection
CROSS-CUTTING TOPIC	**MEASURE TITLE**
Person Centeredness	CAHPS Clinician and Group Surveys (CG-CAHPS)-Adult, Child
	HCAHPS
Population Health	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
	Childhood Immunization Status
Care Coordination	Hospital-Wide All-Cause Unplanned Readmission Measure
	Documentation of Current Medications in the Medical Record
Patient Safety	Proportion of Patients with a Chronic Condition Who Have a Potentially Avoidable Complication During a Calendar Year
	Patient Safety for Selected Indicators (Composite Measure)

IMPLEMENTATION CHALLENGES

Gaps Remain

Gaps exist in the measures available for many of the high-priority clinical areas. While it is important for employers and purchasers to promote use of the best available measures, it is equally vital to address unmet improvement opportunities by helping to fill measure gaps. Employers and purchasers can facilitate development of priority measures through collaboration with measure development organizations, such as medical professional societies, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA).

The NQF is also launching a Measure Incubator initiative to stimulate the development of priority measures where today there are gaps. CMS is required under the Medicare Access and CHIP Reauthorization Act of 2015 to issue a plan for measure development in May 2016, which will present an opportunity for purchasers and other stakeholders to comment on priorities for measure development and funding. Together we can build the measures we need for achieving the value we seek from health care spending.

Feasibility Issues

The ability to generate results for quality measures and the accuracy of that information depends on the availability and quality of the underlying data sources. Even the most innovative measures are useless unless the data can be collected efficiently and the results are reliable. Whether a measure is feasible primarily depends on whether the infrastructure for collecting the required data is readily available.

Given the range in feasibility of collecting data from various sources and the range in the complexity of measures, purchasers should expect that the ability of providers to report on specific measures will vary in the near term. It is also likely that provider frustrations with inadequate reporting infrastructure will continue to grow. But purchaser frustrations over lack of accountability and improvement are also real. Purchasers should use market forces to encourage development of the necessary means to report the most important health care quality measures, even when development of the data collection infrastructure must evolve over a period of years. In addition, purchasers should encourage shorter turn-around time between data collection and public reporting to produce more timely results.

In light of these dynamics, it is important for purchasers and providers to work together to get to the measures that matter. One option for collaboration would be through joint purchaser and provider pilot projects to test implementation of the measures that are more difficult to report.

CONCLUSION

The Priority Measure Set provides a critical resource for employers and other health care purchasers who want to engage in strategies to improve the quality and affordability of health care. We hope it will also help generate greater alignment among transparency and health care delivery and payment reform efforts regarding which quality measures they use. Alignment of measures with the NQS across programs is essential because it can strengthen the quality signal, highlighting what is most important to understand about quality, and decrease data collection burden on providers. In addition, when all stakeholders focus on mutual objectives, success in achieving those objectives may be more likely and happen more quickly.

ABOUT US

Catalyst for Payment Reform is an independent, non-profit corporation working on behalf of large employers to catalyze improvements in how we pay for health services and to promote better and higher-value care in the U.S.

ACKNOWLEDGEMENTS

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