



Improving Health Care Through Transparency & Performance Measurement

A Message Handbook

December 2014

Consumer-Purchaser
ALLIANCE

Better information. Better decisions. Better health care.



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PREFACE

The Improving Health Care Through Transparency and Performance Measurement Message Handbook was created by the Consumer-Purchaser Alliance to facilitate consistent messaging about the importance of evaluating efforts to improve the quality and affordability of health care in America. Moreover, the handbook has messaging, facts, and figures to help tell the story of how, by improving transparency, accountability, and quality we can put patients in the driver seat and improve health care.

The handbook's messages and proof points provide a quick reference and guide for writing talking points, speeches, letters, articles, presentations, or other communications. Sources are referenced with endnotes, so users who want to explore the topic on their own may do so. The research is current as of the publication date, and the handbook will be reviewed continually to update the facts and figures or to reflect changes in the quality measurement landscape.

These messages are drawn from publicly-available research, including the *Aligning Forces for Quality* communities and the Robert Wood Johnson Foundation, in addition to the Alliance's own experience working with leading consumer organizations, employers, and labor organizations.

ABOUT THE CONSUMER-PURCHASER ALLIANCE

- The Consumer-Purchaser Alliance is a broad coalition of consumer groups, labor organizations, and employers dedicated to improving the quality and affordability of health care. The Alliance's mission is to put the patient in the driver's seat—to share useful information about provider performance so that patients can make informed choices and purchasers can reward the best performing providers.
- The Alliance promotes the use of performance measures aimed at increasing transparency, accountability, and quality; promotes payment models that reward value; encourages collaboration between public and private sectors; and amplifies the voices of consumers and purchasers in the health care system.
- The Alliance establishes [criteria for meaningful and usable measures](#) of performance; collaborates with experts serving on decision-making committees and workgroups; develops, endorses and implements health care performance measures that meet the needs of patients and their families; and influences public policy through comments on proposed regulations and requests for information.

GENERAL PERFORMANCE MEASURE TALKING POINTS

- The performance of hospitals and doctors varies widely.
- When Americans go to the doctor, it's essentially a coin-toss whether they will get the care medical experts recommend for specific conditions—that is, the right care delivered to patients when they need it. U.S. adults get 55 percent of recommended care¹, and children get 47 percent.²
- As many as 91,000 Americans die each year because they don't receive the care medical experts recommend for chronic conditions, such as high blood pressure, diabetes, and heart disease.³
- If your grandmother lived in Bend, Ore., she'd likely spend nine or 10 days in the hospital during the last two years of her life. If she lived in Manhattan, she'd spend nearly a month in the hospital during the same period. These kinds of variations are even more striking for chronically ill patients in the last six months of life. An elderly person with chronic illness in Ogden, Utah, would likely see the doctor 13 or 14 times in the last six months of life. In New Brunswick, N.J., the same elderly person would see a doctor nearly every three days, or 53 times, during those last six months.⁴
 - A woman in her late 60s living in Oklahoma is far less likely to get regular mammograms than a woman the same age in Massachusetts. In fact, 58 percent of female patients aged 65–69 in Oklahoma got regular mammograms from 2009 through 2010, compared to 76 percent in Massachusetts. The national average was 65.4 percent.⁵
- A strong set of meaningful and usable performance measures are necessary to determine whether new models for care delivery and payment are improving health outcomes, improving affordability, reducing variations, and improving efficiencies.⁶
- Who do performance measures help?
 - **Patients** can make informed decisions about their care.
 - **Purchasers** can make informed coverage decisions.
 - **Providers** can improve the quality of care they deliver.
 - **Health plans** can reward providers based on the quality of care and patient outcomes rather than on volume of service.
- Patients have the right to know about the quality and cost of their health care. This starts with ensuring patients have access to the information necessary to make informed decisions about where they can get the best care.
- While many health reform initiatives promote patient-centered and coordinated care, current measurement efforts are mostly provider-centric and heavily weighted toward institutional care. The Alliance supports measures that reflect the interests, needs, functional status, and social/financial preferences of consumers.

MEASUREMENT 101

Why do we measure?

- The quality and cost of care delivered to patients varies greatly from provider to provider, from state to state, from region to region, and from country to country.
- While a growing number of medical professionals, people, and purchasers are interested in improving the quality of care, we lack the information necessary to properly assess the performance of large parts of our health care system.
- We cannot improve what we do not measure.
- People have a right to information that helps them better understand their care and compare its quality and cost. We also know that people are desirous for easily accessible quality information, recognizing that 72% of internet users have looked online for health information; 52% of smartphone users have used it to look up health information.⁷
- Poor quality endangers the health and lives of patients and wastes billions of dollars a year.⁸

How do we measure?

- The quality of health care is currently being evaluated based on patient care guidelines developed by physicians, researchers, and other experts.
- Quality measures assess care delivered to a large number of patients so that differences among patients do not skew the results.
- While administrative data sources lack clinical details that may be important in assessing the quality of care, they have historically been the major source for testing and developing measures. The advent of electronic health records and clinical registries holds the promise of making it easier to collect standardized data on outcomes of care. Many issues must first be resolved, however, to standardize these records and to enable the electronic exchange of clinical information.
- Patients, families, and caregivers are important sources of information for assessing quality and providing the necessary data to develop scientifically proven measures of patient experience. Such measures, as well as other clinical outcomes, help explain quality based on the *results* that are achieved by the care provided (e.g., was pain relieved for the hip replacement surgery patient and were they able to walk more easily again?).

Who do we measure?

We need to measure how well care is coordinated for and centered around patients within and across all parts of the health care and delivery systems, including:

- Accountable care organizations
- Patient-centered medical homes
- Exchanges
- Health plans
- Hospitals
- Physicians
- Home health care
- Nursing home care

What do we measure? What should we measure?

- Many quality measures assess processes of care to determine how often patients with a specific condition receive the evidence-based care. For example, what percentage of patients with diabetes have their blood sugar and blood pressure measured?
- While process measures help us understand at a surface level whether proper care was provided, they do not tell us anything about the state of the patient's health following receipt of health care services (i.e., the percentage of diabetic patients whose blood sugar and blood pressure are within a medically healthy range).
- Measures of clinical outcomes (e.g., mortality, hospital readmissions, functional status, etc.), care coordination, patient experience, appropriateness of recommended care, resource use, and total cost of care represent essential opportunities to evaluate the value of health care and the most meaningful areas of focus for performance measurement.
- Measures assessing patients' experience in obtaining needed care, also known as patient-reported outcomes, are widely acknowledged as a missing ingredient in the nation's effort to develop a truly patient-centered health care system.
- Measurement at the individual physician level is key to reinforcing professional motivation for quality improvement, provides meaningful information for patients to use in choosing physicians, and identifies variation and improvement areas that existing research has demonstrated would otherwise be masked by higher levels of aggregation.

How are measured results used?

- The results of measures must be shared with **patients** and the **public** to help them:
 - Understand what they are getting for their health care dollar and make the most informed choices.
 - Choose a health plan that consistently provides high-quality care and service.
 - Choose health care providers who deliver high-quality care and service.
 - Demand improvements in care and service.
- The results of measures must be shared with **purchasers** to help them:
 - Reward high-quality performance.
 - Create incentives for improvement.
 - Choose the best health plans to serve the needs of employees and their families.
- The results of measures must be shared with **providers** so they can:
 - Compare their performance with their peers.
 - Identify opportunities to improve their care.
- The results of provider network measures must be shared with **health plans** so they can:
 - Work to improve the services they provide to their members.
 - Share best practices and create incentives for improvement.

TOPIC-SPECIFIC MESSAGING

As previously noted, this handbook will be reviewed and continually updated to support the current quality environment. In the meantime, the contents that follows focuses on issues that have received high levels of attention from the media and the consumer and purchaser communities in recent years, including:

- [Accountability Spurs Improvement](#)
- [Cost and Price Transparency](#)
- [Avoidable Readmissions](#)
- [Risk Adjustment for Sociodemographic Factors](#)
- [Improving Patient Engagement and Experience of Care](#)
- [Using Patient-Reported Outcomes and Patient-Reported Outcome Measures](#)
- [Patient Safety](#)
- [Clinical Data Registries](#)
- [Health Information Technology](#)

Accountability Spurs Improvement

- Measurement and transparency are necessary to drive improvement in our health care system; hence the saying, “you can’t improve what you don’t measure.”⁹
- Value-based purchasing requires that physicians, hospitals, and other entities be held accountable for health outcomes and work in collaboration with consumers to identify opportunities for innovation, coordination, and care redesign to achieve those outcomes.¹⁰
- Studies show public reporting initiatives can stimulate quality improvement.
 - A synthesis of 11 studies that assessed the effect of publicly releasing performance data on quality of care suggests that public reporting helps providers improve their performance.¹¹
 - Peter Pronovost, a national leader in reducing health care-acquired infections, attributes the successful 41 percent decrease in central-line blood infections between 2008 and 2011 to public reporting programs that spurred action among senior-level hospital management.¹²
 - In a study of physicians who have been publicly reporting performance data on diabetes since 2004, researchers found that public reporting encouraged clinics with no prior quality improvement experience to “get off the sidelines” and engage in initial improvement activities.¹³

- In a study of public reporting of health care performance by the Wisconsin Collaborative for Healthcare Quality, 15 of 17 medical groups surveyed said they prioritized at least one quality improvement intervention because of public reporting. Providers also improved performance on each of the reported measures, such as cholesterol control and breast cancer screening.¹⁴
- Payment policies can also drive improvement in the quality of care by holding physicians and hospitals accountable for care outcomes.
 - For example, within its first two years, Medicare’s end-stage renal disease Quality Incentive Program supported significant improvements among the majority of dialysis facilities on three key measures—patient survival, dialysis adequacy and anemia management.¹⁵

Accountability Spurs Improvement: Claim vs. Response

Claim: Reporting is burdensome for providers, especially given the large number of measures out there.

Response: The real burden is on patients and employers, who are forced to make important decisions about their health or the health of their employees without vital information on cost and quality.

Despite the large number of measures often cited as being available, meaningful measures of outcomes, including appropriateness of care, patient experience, care coordination, and affordability are scarce. To reduce the burden on providers, we favor the substitution of simple process measures with more meaningful measures of patient outcomes. Providers stand to benefit from meaningful performance measurement that can help them identify opportunities for improvement and track successes.

Claim: Patients won’t use the information.

Response: With the exception of patient experience data and a few clinical outcome measures, we have not provided patients with information that allows them to make judgments about the quality of care.

Quality information is not readily available at the level at which patients and purchasers need it, such as at the primary care practice group or individual specialist level.

Patients understand the concepts of cost and quality in health care when it is presented to them in a meaningful way.¹⁶ They also express a desire for information to support their health care decision-making.¹⁷

Cost and Price Transparency: Quality and Cost Information is Critical

- In 2012 the United States spent \$2.8 trillion (17.2 percent of the entire economy) on health care costs. National health expenditures (NHE) are projected to grow at an average rate of 5.7 percent from 2013 through 2023, with national health spending projected to account for 19.3 percent of the Gross Domestic Product (GDP) by 2023. This is based on a predicted rate of growth that is 1.1 percentage points faster than the expected average annual growth rate for the GDP.¹⁸
- About one-third of all health-care spending — \$785 billion — goes to things that aren't making us any healthier, according to an Institute of Medicine study published in 2012.¹⁹
- Further, consumers are asked to bear higher health care costs, particularly through the increasing use of high-deductible health plans (also called consumer-directed health plans). Nearly half of large employers (48%) now offer and 23% of covered employees (regardless of employer size) are enrolled in this type of plan.²⁰ These plans are a result of employers experiencing higher premiums and needing to manage costs, while continuing to offer employee benefits.
- “Over 20% of American adults are struggling to pay their medical bills, and three in five bankruptcies will be due to medical bills. Medical bills can completely overwhelm a family when illness strikes.” Kaiser Family

Foundation analysis from 2012 showed that even among the insured, in low and high deductible plans, 24% to 34% of respondents had difficulty paying medical bills at all or over time.

- Health care is like no other major sector of the U.S. economy. The lack of information about price and quality prevents purchasers and consumers from being able to answer the most basic questions when they purchase services: Who does a good job? What does it cost?
- Cost information is critical and needs to be paired with quality information to provide information on value. There is little benefit for consumers and purchasers to know they can afford a plan or treatment without knowing if what they're buying is worth it.

Cost and Price Transparency: Claim vs. Response

Claim: *There are studies that show consumers do not use quality information, so why do we need to prioritize cost information for them too? We are already collecting so much information; it is hard to keep up with it all.*

Response: *Consumer interest and investment in effectively managing their healthcare dollars is steadily growing. The impact of healthcare costs on American households has dramatically increased over the years and they need transparent information to make the right decisions for themselves and their families. Healthcare costs are the leading cause of personal bankruptcies in U.S., with almost 2 million in 2013.²¹*

Claim: *Historically, health professionals have not been trained to discuss cost with patients. Our job is to focus on the clinical characteristics of the patient.*

Response: *The healthcare enterprise can no longer ignore that cost plays a role in patients' decision-making and can ultimately affect their physical health. A Kaiser Family Foundation survey conducted in 2011 found that because of cost concerns, 50% of survey respondents relied on "system work arounds" like home remedies instead of seeing a doctor, cut pills in half or skipped medicine, skipped a recommended medical test or treatment, etc. When clinical resources cost them more, patients do not use them (which in turn impacts outcomes) – this is shown in a study where better asthma control and adherence to prescribed medicines are associated with lower asthma-related resource use and charges.²² Cost issues like these have real implications on patients' health.*

Claim: *Sharing of contracted rates is proprietary information.*

Response: *While it is true that there may be legal hurdles to reporting prices, such as contractual obligations that prevent health plans from disclosing their negotiated rates with providers, these are not insurmountable. Increasingly states are requiring this information to be revealed, through prohibition of "gag clauses" and all-payer claims databases. Moreover, consumers and purchasers have a right to know how much they might pay for health care. When patients have access to cost for three common medical services – laboratory tests, advanced imaging services, and office visits – both consumers and purchasers can save money.²³*

Avoidable Readmissions

- Addressing avoidable readmissions is a necessary step in improving patient safety and lowering health care costs. One in five Medicare patients discharged from the hospital are readmitted within 30 days, putting patients at increased risk of complications or infections and accounting for approximately \$15 billion in excess Medicare spending each year.²⁴
- The Centers for Medicare & Medicaid Services reported that the 30-day, all-cause readmission rate dropped to 17.8 percent in 2012 after averaging 19 percent for five years. This translated into 70,000 fewer readmissions. Real people received better health care at a lower cost.²⁵ This change supports the notion that linking financial incentives to standardized quality metrics has and will continue to drive significant improvements in patient outcomes and reduce unnecessary costs to the system.
- In 2013, The Commonwealth Fund and the Institute for Healthcare Improvement convened many of the nation's leading experts on the measurement and improvement of hospital readmissions, and reached the unanimous conclusion that Medicare should be addressing the fragmented care, harm, and confusion that unnecessary hospital readmissions represent for patients. While the group did discuss the imperfections of

current readmissions measures included in Medicare programs, they agreed that these measures provide a valuable foundation on which to build a better policy.²⁶

- Quality Improvement Organizations have been particularly successful at reducing avoidable admissions and readmissions in recent years. The American Health Quality Association that, according to data made available by the Centers for Medicare and Medicaid Services (CMS), Quality Improvement Organizations (QIOs) have avoided 27,000 preventable readmissions, as well as 95,000 hospitalizations, in a three year period from October 2010 to March 2013. Moreover, the QIO communities have achieved a 13.22% reduction in hospital readmissions for Medicare beneficiaries and have surpassed the national average of decrease of hospital readmissions of 12.55%.²⁷
- One can attribute the success of QIOs in reducing readmissions to their multidisciplinary approach, involving teams of physicians, nurses, and others in healthcare workers in the community to help patients “remain healthy long after they leave the hospital”. This longitudinal approach to care, along with the QIOs’ ability to cater to specific community needs, make community organizations like QIOs essential for safe and successful care transitions.²⁸
- As the QIOs have demonstrated, reducing avoidable readmissions does not happen in a silo and requires a multifaceted approach to improving patient care. A study published in the *Journal of the American Medical Association* demonstrates the effect that widespread community engagement and quality improvement interventions can have on care transitions and reducing readmissions. In a group of 14 demographically and economically diverse communities that implemented quality improvement initiatives, the study saw a 5.7% decrease in readmissions and 5.74% decrease in hospitalizations per 1000 Medicare beneficiaries over 2 years.²⁹

Avoidable Readmissions: Claim vs. Response

Claim: *There isn’t a clear relationship between the care provided to the patient in the hospital and readmission rates.*

Response: *A study drawing a distinct connection between avoidable readmissions and several markers of clinical quality helps demonstrate the link between care provided in the hospital and patients’ ultimate outcomes post-discharge. In particular, the study found that hospitals in the highest quartile for surgical volume had significantly lower readmission rates than hospitals in the lowest quartile. Additionally, hospitals with the lowest surgical mortality rates had a significantly lower readmission rate than hospitals with the highest mortality rates.³⁰*

While hospital surgical quality is important, quality care goes far beyond the surgical table. The discharge process for any condition can be particularly complicated for patients, families, and caregivers, and requires that providers take responsibility for helping them navigate the next steps in their care to avoid unnecessary readmissions.

Claim: *Hospitals will run away from the problem by refusing to admit patients, providing them with emergency services that will not count as admissions, and/or sending them home. All of these options increase the chances that patients will return with more complications.*

Response: *Many hospitals are stepping up to the challenge. Supported by the right financial incentives, hospital leaders are organizing systems of care that didn’t exist before to help patients get the care they need after they leave the hospital. In short, hospitals are responding to what Nancy Foster, an executive at the American Hospital Association, calls “a national symbol to health care providers that here is an area where you can do better.”³¹*

Claim: *Medicare’s Hospital Readmissions Reductions Program, which penalizes hospitals for excessive readmissions, places hospitals at great financial risk and may even lead to hospital closings. In particular, safety net hospitals are at an increased and unfair disadvantage, as they tend to experience a disproportionately high number of readmissions due to the fact that they serve a greater population of low socioeconomic status patients.*

Response: *Despite concerns among hospitals about their bottom line, the average hospital was fined less in the second year of the Medicare Readmissions Program than in the first. The total national penalty was \$53 million less despite the 2 percent maximum penalty.³² Moreover, a recent study shows that overall, American hospitals have increased their operating margins by billions of dollars, even*

after taking bad debt and charity care into account.³³ These facts, along with data demonstrating actual decreases in avoidable readmissions, means that hospitals are making real progress in improving care and are able to do so even considering the financial obligations applied by this particular federal program.

Hospitals that are designated as critical access facilities, certain cancer hospitals, and places with too few cases to be accurately measured are not included in this program, and therefore are not at risk of unfair penalties. Additionally, hospitals that serve vulnerable populations and are included in the program have demonstrated innovative strategies to reduce readmissions and in many cases, have had 30-day readmission rates lower than national averages.³⁴ For example, New York Methodist Hospital, a CMS Community-Based Care Transitions Program site, has received numerous recognitions for their excellent work in care transitions. In particular, New York Methodist has achieved rates of 30-day readmissions for heart attack, heart failure, and pneumonia below the national average through strategies aimed at accurate and ongoing communication with family caregivers across the continuum with regard to medication and plans of care.³⁵ Similarly, UT Health Northeast successfully reduced readmissions to their facility by more than 20 percent between August 2012 and February 2013 using a multi-disciplinary approach to care, including enhanced access to palliative care and social supports during the discharge process.³⁶

Risk Adjustment for Sociodemographic Factors

- Performance measurement should enhance our ability to identify and eliminate disparities – a key concern is that adjusting for sociodemographic factors will obscure our capacity to see differences in outcomes for disadvantaged and at-risk populations.
- Risk adjustment could produce a number of unintended consequences, such as (1) masking disparities in the outcomes of care for disadvantaged populations, (2) reducing incentives for providers to adapt the care they provide in ways that meet the needs of disadvantaged patients, (3) lowering the expectations that providers can and should provide high quality, patient-centered care for all patients, regardless of their sociodemographic characteristics, (4) accepting a different standard of care and perpetuating poorer health outcomes for those with difficult life circumstances, and (5) limiting accountability to only that which is directly under the provider’s control instead of galvanizing the medical community to coordinate care across providers and engage with the communities they serve to meet patient needs.
- It is extremely important that measurement not promote a cramped definition of what constitutes the provision of good quality care by providers. We have evolved well-beyond the point of defining good care as simply following established standards within the confines of the care setting. We increasingly strive for patient- and family-centered care, recognizing that such care is essential to achieving the good outcomes we seek for all populations. Providers are increasingly learning how to “meet their patients where they are,” recognizing the role of non-medical factors, and adapting care practices to address patients’ needs and circumstances.
- Collecting sociodemographic information is challenged by the lack of readily available, high quality data. Without federal support, these challenges are likely to delay the development of meaningful outcome measures if these measures cannot be used without sociodemographic risk adjustment.

Risk Adjustment for Sociodemographic Factors: Claim vs. Response

Claim: *Current policy is unintentionally weakening the network of providers that serve disadvantaged populations, which could end up worsening disparities.*

Response: *It is true that providers cannot control all aspects of patient outcomes and that patient choices, life circumstances, sociodemographic factors and the availability of community resources can all contribute to outcomes. Nonetheless, many safety net providers are now achieving significant improvements in outcomes among patients facing very challenging life circumstances (outside of the healthcare system). This progress could be seriously undermined by the position that adjusting for sociodemographic factors achieves a “truer” picture of the quality of care providers deliver. For example – BCBS-MA showcases significant improvement among providers serving disadvantaged patient populations. Of the 18 providers evaluated, the two providers serving the first and third most vulnerable patient cohort, achieved the first and second highest relative improvement in 30-day all cause readmission rates during the evaluation period. Such significant*

achievements demonstrate the ability of safety net systems and providers to work in new ways to improve their care coordination efforts in order to achieve meaningful improvements in important outcomes like readmissions.

Claim: The current measurement environment largely does not allow SDS risk adjustment, which presents two potential problems: (1) reduced resources for providers who serve disadvantaged patients, and (2) unwillingness of providers to serve disadvantaged patients as a result of payment implications of federal quality programs, such as the Hospital Readmissions Reduction Program.

Response: These two problems are related to payment policy, not measurement methodology. Policy makers should consider alternate payment strategies (e.g. stratification, peer-grouping) to address these problems and to ensure that providers serving disadvantaged populations have adequate resources to deliver care and improve quality. Policy makers should encourage the development of an incentive program that rewards those who do the best at caring for sicker and more disadvantaged patients, rather than simply implementing a technical adjustment to performance measures that may reduce the penalties to those caring for proportionately larger populations of patients with difficult life circumstances.

Improving Patient Engagement and Experience of Care

- There is evidence to support that patients who are more engaged in their health care have better care experiences than their less engaged counterparts.³⁷ More specifically, a study from an integrated health system in Minnesota found that among a sample of more than 5,000 patients, those at the highest level of patient activation rated their primary care providers 10 percent to 14 percent higher than patients at the lowest level of activation seeing the same providers.³⁸
- In virtually every other service industry, the focus is on ensuring that customers have positive experiences. We firmly believe that this should be a goal shared by the health care industry. Health care is more complex than just “happy” patients. It’s about the correlation between good communication and better health outcomes. We know that effective communication leads to better quality outcomes through:
 - Greater patient capacity to follow treatment regimen
 - Greater trust in provider
 - Greater continuity of care with provider
 - Reduced malpractice litigation
 - Positive effects on emotional health, symptom resolution, and pain control
 - Fewer diagnostic tests and referrals
 - Improved patient and physician satisfaction³⁹

Importance of Patient Engagement and Experience of Care: Claim vs. Response

Claim: Patient experiences do not reflect clinical outcomes.

Response: “Clinicians who resist growing demand to cede some of their authority and to accept health data from patients would be wise not to ignore changing expectations, for the sake of better care. Transparency breeds trust. Trust between patients and clinicians breeds outcomes,” said Dr. Susan Woods, director of patient experience for connected health at the Veterans Health Administration.

Research conducted by Duke University’s Fuqua School of Business looked at 30-day readmission rates at more than 2,000 hospitals and found that patient experience scores were more closely linked with reduction in readmissions than they were with clinical performance measures.⁴⁰

Another study published in *New England Journal of Medicine* in October 2008 stated, “Across U.S. hospitals, there is a consistent, positive relationship between patient-reported experiences and the quality of care, suggesting that the aims of providing patient-centered care and ensuring high clinical standards can be met simultaneously.”⁴¹

Claim: Patient experience is not within the provider’s control.

Response: Widespread implementation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures reflects a growing recognition that providers can affect patient experience through factors beyond care processes—such as teamwork,

leadership, and culture. CAHPS addresses cross-cutting issues that are important to patients, families, and caregivers. They continue to demonstrate capacity to transform both qualitative and quantitative aspects of performance and care delivery. For example, a study of CAHPS for the hospital setting (HCAHPS) found that a patient's care experience was closely associated with quality of clinical care for four conditions: acute myocardial infarction, congestive heart failure, pneumonia, and prevention of surgical complications. This same study noted that patient care experience ranged widely across regions: 72 percent of patients in Birmingham, Alabama gave 9 or 10 ratings, compared to 50 percent of patients in East Long Island, N.Y.⁴² Thus, we know that there is a link between patient's experience of care and outcomes, and that there is huge variation in patient experiences across the country.

Controlling the patient's experiences and outcomes should be viewed as an opportunity to collaborate with all members of the care team (including patients, families and caregivers) to provide truly patient-centered care.

Using Patient-Reported Outcomes (PROs) and Patient-Reported Outcomes Measures (PROMs)

- Patient-reported outcomes are the results of health assessments designed to obtain information from patients related to their health or behavior.
- PROs reflect issues that are important to patients and provide a valuable perspective that cannot be obtained from other data sources (e.g., severity of pain, physical functioning). They can complement, but not replace, clinical outcomes.
- When embedded in systematic care processes, PROs open up new opportunities for patient engagement (e.g., care management, shared decision-making) and performance improvement. When patients are informed and effective managers of their health, this can lead to improved patient satisfaction but also improved clinical outcomes and lower health care costs.^{43,44,45}
- Patient-reported outcome measures are PROs that are aggregated for an accountable health care entity (e.g., clinician, hospital, ACO). In contrast to other performance measures, PROMs show a change over time, e.g., physical functioning measured before and after knee surgery. While there are lots of PROs, there are very few PROMs.

Importance of Patient-Reported Outcome Measures: Claim vs. Response

Claim: *It is not fair to providers to hold them accountable for patient-reported outcome measures.*

Response: *Providers correctly argue that outcomes are often influenced by factors other than treatment by a provider (patient behavior, for example). But that doesn't mean providers should not be assessed via outcome measures, including patient-reported outcome measures. Many other industries face the measurement challenge of multiple factors influencing an outcome (e.g., a commercial airline's average on-time record is affected by weather conditions). Moreover, providers are considered trusted advisors and have a strong influence over their patients' behavior.*

Claim: *Patient-reported outcomes are not ready to be implemented in clinical practice.*

Response: *PROs have been in use for many years in academic research, clinical trials, and more recently for performance measurement, feedback, and public reporting in other countries, such as the United Kingdom and Sweden. CMS routinely measures functional health status and tracks PROs through its Medicare Health Outcomes Survey. PROs also are being used by some of the nation's leading health care systems, such as Dartmouth-Hitchcock, and PRO performance measures are being built into regional reporting programs, such as Minnesota Community Measurement. Once methods are established to integrate PROs into clinical workflow, PRO data collection can be more practical and commonplace.*

Claim: *Patient reported outcomes are subjective measures so they should not be used in accountability programs.*

Response: *Patient reported outcomes address aspects of health that are important to patients and cannot be obtained from other sources. For example, patients are the experts on how well they can function (e.g., climbing stairs), their experience of symptoms (e.g., fatigue, nausea), and how they feel (e.g., scared, anxious). These are not a replacement for clinical outcomes, but can add to a fuller picture of understanding a patient's health status. In a comparative study of two patient-reported data systems, interviews with patients and*

clinicians pointed to the benefits of patient-reported outcomes in supporting effective decision-making, patient engagement, communication, and, ultimately, improved health outcomes.¹

Patient Safety

- Hospital-Acquired Conditions (HACs), such as infections, pressure ulcers, and sepsis, are a source of significant patient burden and cost. However, 87% of hospitals do not follow evidence-based guidelines that would contribute to their prevention.⁴⁶
- It is estimated that nearly 12,400 central line-associated bloodstream infections occurred in 2011, costing CMS approximately \$26,000 per patient. Additionally, about 75,000 people die each year from these and other hospital-acquired infections.⁴⁷ Together, these infections cost the U.S. health care system as much as \$45 billion annually.⁴⁸
- Beyond infections, evidence has demonstrated that other preventable hospital-acquired conditions are happening all too frequently. For example, patients suffered from over 262,000 falls while in the hospital in 2010. Also, patients acquired approximately 97,000 cases of postoperative pneumonia.⁴⁹ A 2011 study of Medicaid patients in the state of Texas also found that at least one complication occurred during 6 percent of adult stays and that complications overall added \$88.7 million (4.2 percent) to hospital costs.⁵⁰
- CMS recognizes HACs as a leading cause of mortality accounting for twice as many deaths as those from HIV/AIDS and breast cancer combined.⁵¹
- To address this problem, we need policies that recognize and reward hospitals that publicly report data and develop strategies to improve quality. As a result of multistakeholder improvement efforts and changes in CMS' public reporting requirements for HACs, we are already seeing promising signs of progress, including:
 - 9% decrease in HACs from 2010 to 2012⁵²
 - In 2012 alone, reductions in HACs is estimated to have prevented 15,000 deaths and saved \$3.2 billion.⁵³
 - Significant improvements in six specific HACs from 2010 to the 4th quarter of 2013. Incidence of Ventilator-Associated Pneumonia decreased by 53%, Early Elective Delivery by 65%, Obstetric Trauma rate by 16%, Venous Thromboembolic (VTE) complications by 13%, falls and trauma by 15%, pressure ulcers by 25%.⁵⁴
- Collecting and reporting Hospital-Acquired Conditions (HAC) data is one piece of a bigger pie. Preventing HACs requires hospitals to pursue all opportunities to evaluate and monitor the effect of prevention practices on infection rates, and enhance patient safety. Hospitals have employed strategies to respond to infections by working to:
 - Integrate hospital-specific infection rates into a hospital's website in a way that is easy to understand.
 - Provide education, training, and ongoing support to hospital infection reporting staff.
 - Evaluate the relationship between infection prevention personnel resources and surveillance activities, infection rates, and prevention projects.
 - Collaborate with other department staff to investigate outbreaks and evaluate emerging trends.
 - Consult with all members of the care team to identify risk factors and prevention strategies to reduce hospital-acquired conditions. For instance, addressing malnutrition has been shown to decrease the incidence of pressure ulcers by 25%, overall complications by 14%, avoidable readmissions by 28%, and reduce overall patient average length of stay by two days.^{xi}
 - Continue to require, refine, and report hospital-specific HAC indicators to allow consumers to make informed choices.

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Importance of Patient Safety: Claim vs. Response

Claim: Hospitals endure significant administrative costs incurred in reporting the incidence of hospital-acquired conditions.

Response: The real issue is the tremendous burden on consumers and their families when they receive unsafe and substandard care. Both the human and the financial cost are enormous, and that is largely ignored in the debate over hospital quality.

Many hospitals understand the burden faced by patients who have to live with the enormous pain and suffering related to HACs and many are achieving terrific success with innovative practices to reduce HACs. For example, hospitals participating in the Premier QUEST collaborative are meeting significant goals associated with reducing harm. QUEST hospitals have steadily improved to cut their rates, preventing an estimated 17,991 potential patient safety events since 2010.⁵⁵

Claim: Hospitals are concerned that the HACs are not, by definition, “measures,” and that they have not gone through the National Quality Forum (NQF) endorsement process.

Response: While the Alliance supports and contribute to the NQF process, we believe that in the case of HACs, reporting a rate of occurrence is the highest priority in order to provide patients with essential patient safety information.

Several HACs—such as central line-associated blood stream infections and catheter-associated urinary tract infections—have been endorsed by NQF and are being used by CMS. However, that does not negate the need for transparency on incidence of occurrence for all of the HACs.

Claim: HACs could potentially mislead or confuse consumers due to irregularities in the coding of data used to calculate these rates.

Response: The Alliance acknowledges the importance of improving coding practices, but these technical issues are not new, and are long overdue for remedy. Coding irregularities should not stand in the way of improving transparency on patient safety, as the accuracy of coding isn't the only thing relevant to the calculation of performance measures. If codes are accurate enough for provider reimbursement, one can assume they are also accurate enough for performance measurement.

Clinical Registries: Better Information

- Registries are important tools in the advancement of a high value, patient-centered health care system. Electronic clinical registries are typically used by clinicians to manage patients with chronic conditions or, in surgical specialties, to evaluate different procedures and devices and to compare performance with their peers. In addition to their role in care management and quality improvement, registries can serve as a rich source of data for performance measures in accountability programs, such as public reporting and payment. While registries may contain a mix of measures that include some that are useful for quality improvement and care management, there are others that are not suitable for accountability.
- Registries can serve as useful “test beds” for measure development and to garner the information needed to submit measures to NQF for endorsement. Below are some key principles to ensure that registries meet the needs of consumers and purchasers when used in accountability programs.
 - Ideally, a registry should publicly report the performance measures of interest to consumers and purchasers – such as appropriateness, clinical and patient-reported outcomes, patient safety, patient experience and coordination of care – at the individual clinician, small practice group and hospital levels, although many registries are yet to operate at this level.
 - Registry governance by a multi-stakeholder board should include meaningful representation by consumers and purchasers
 - Accountability programs should not give credit for registry participation alone, unless there is a staged commitment to use measures from the registry for payment or public reporting in the near future.

- Registries should electronically interface with other data sources, including both EHRs and other sources of data not included in the EHR (e.g., imaging, product bar code, other settings).
- Denominator populations for registry-produced performance measures should include all relevant patients under the provider’s care, whether publicly or privately insured.
- Numerators and denominators for accountability measures should be made publicly available to facilitate use in multiple programs (e.g., regional public reports).
- Registries should include patient-generated data. “The use of patient-generated health data supplements existing clinical data, filling in gaps in information and providing a more comprehensive picture of ongoing patient health. It can:
 - Provide important information about how patients are doing between medical visits.
 - Gather information on an ongoing basis, rather than only at one point in time.
 - Provide information relevant to preventive and chronic care management.”⁵⁶

Clinical Data Registries: Claim vs. Response

Claim: *Registries were developed for internal use by clinicians for quality improvement. The information was not intended to be publicly reported and used for payment incentives.*

Response: *Using registry data for public reporting and payment programs has the potential to minimize the operational burden for the clinician, as he/she would not need to fulfill any separate data entry. Further, the clinical information in registries is superior to administrative claims-based information. The use of registry data for measurement in accountability programs would provide richer information on quality of care provided.*

Health Information Technology

- Health IT is the essential foundation for measuring quality of care, including improved health outcomes for individuals and populations. Furthermore, allowing providers to share health information electronically helps reduce health care costs through the avoidance of medical errors and unnecessary or duplicative services.⁵⁷
- Office- and hospital-based electronic health records (EHRs) do not provide all of the data needed to evaluate quality of care, especially for new models that are oriented to improve care coordination and the attainment of better health outcomes. We need to encourage health information collection and exchange across a broader spectrum than the individual doctor’s office and hospital settings. EHRs and clinical registries will become primary sources of data on quality as these functionalities become universally adopted by the health care system. These clinical data systems also need to incorporate patient-generated data, such as patient-reported outcomes, if they are to fully support patient-centered care.
- The chief advantages of EHRs are (1) integrity and reliability of the data and (2) efficiency and reduction of burden on providers. Using information that is electronically recorded for patient care to measure quality reduces burden on providers. In terms of data reliability, most experts would agree that when the same data are used for measurement as for patient care, they are more accurate than coded billing data or data that are separately coded for quality measurement. Also, efficiency is enhanced by enabling electronic access to clinical data that are key to measuring outcomes, adjusting for patient risk, etc.
- The current generation of EHRs do not incorporate the functions necessary to support emerging care models and policy objectives (e.g., easy to use by clinicians, ensures completeness of data, pushes reminders/provides decision support to clinicians, collects patient-reported data, etc.). In particular, interoperability between different EHR products is still limited, thereby hindering the ability to examine a patient’s care across separate components of the delivery system. The EHR incentive program requirements and CMS incentive and penalty programs are critical to addressing these issues and improving the functional capabilities of our health

care system. In the meantime, EHRs must be regarded as one node in a network of data sources that, together, shed light on the patient's overall experience and health outcomes.

Importance of Health Information Technology: Claim vs. Response

Claim: *Electronic systems do not reduce waste in the system; in fact, they create more work for providers.*

Response: *There is evidence that hospital IT adoption has led to faster, more accurate communication and streamlined processes that have improved patient flow, reduced duplicative testing, and sped up responses to patient inquiries.*

EHRs support a more coordinated approach to care across the continuum, allowing for:

- *Better integration among providers by improved information sharing.*
- *Viewable and up-to-date medication and allergy lists.*
- *Order entry at point of care or off-site.*
- *Standardization of data, order sets, and care plans helping to implement common treatment of patients using evidence-based medicine.*
- *Access to experts for rural health care providers by sharing best practices and allowing for specialized care through telemedicine.*
- *Population management trended data and treatment and outcome studies.*
- *More convenient, faster, and simpler disease management.*

Claim: *Data security and patient privacy are put at risk when data is shared among providers.*

Response: *There are many ways HIT can enhance privacy. A number of policies and regulations establish privacy and security as a priority for EHR implementation and use. For example, "meaningful use" of EHRs requires that providers conduct security risk assessments and correct identified security deficiencies as part of their risk management process.*

Claim: *Health IT is time-consuming and complicated to implement.*

Response: *While implementing an EHR system requires changes in clinical processes and workflow, there are clear examples of successful implementation, as well as indicators that implementation has increased dramatically:*

- *In 2003, fewer than 5 percent of hospitals and less than 1 percent of doctor's offices in the U.S. had any form of electronic records. By 2012, 85 percent of hospitals and almost 60 percent of doctors had electronic records.⁵⁸*
- *Hospital adoption of at least a basic EHR system more than tripled since 2009, increasing from 12 to 44 percent.⁵⁹*
- *There is an increasing trend for the adoption of EHR systems in ambulatory care settings. More specifically, there was more than a 10 percent increase in the number of physicians' offices with fully functional EHR systems between 2009 and 2011.⁶⁰*

Moreover, there is evidence to suggest the upfront effort has paid off and is contributing to improved patient outcomes:

- *Four years after installing an EHR system, diabetes and hypertension control among patients increased from 73 percent to 97 percent.⁶¹*
- *According to Premier Inc.'s QUEST collaborative data, thanks to data sharing efforts its 352 member hospitals have saved 136,375 lives and \$11.65 billion over five and a half years.⁶²*

Claim: *Health IT can make care less patient-focused.*

Response: *Nearly 8 in 10 physicians (74 percent) reported that using EHRs has enhanced overall patient care.⁶³*

There is evidence that patients feel more confident in the quality of care they are receiving if their doctor offers paperless record services in an electronic medical record (EMR). As part of a recent survey, only 6 percent of respondents were not satisfied with their doctors' use of the EMR system.⁶⁴ Similarly, patients are often more engaged as a result of EHRs and other information technology systems that promote increased engagement in their care. For example, the Open Notes Initiative conducted a quasi-experimental trial of primary care practices that allowed patients access to visit notes over secure Internet portals, and found that 99 percent of patients wanted open notes to continue at

the end of the trial and all participating doctors agreed. Moreover, the experiment demonstrated the benefits of utilizing information technology as an engagement tool, as participating patients accessed notes frequently and reported clinically relevant benefits in doing so.⁶⁵

As providers increasingly begin using EHRs and other forms of health IT during clinical encounters, it is important to balance screen time and face time with patients. A recent study published in the *Journal of General Internal Medicine* shows that medical interns spend about 40 percent of their time on computer-related tasks and about 12 percent of their time with patients.⁶⁶ Patients, families, and other personal caregivers should be included in computer-related tasks, as appropriate. For example, if a physician is reviewing a patient's medication history on the computer, the physician could invite the patient to join, or turn the computer screen toward the patient. In the medication reconciliation process, physicians could ask the patient to confirm whether the listed medications and doses are correct, to the patient's knowledge. Using technology in concert with patients and families will cultivate better patient-provider relationships, and enhance the care process.

Claim: Patients are unlikely to use / take advantage of online access to their health information.

Response: A recent survey by the National Partnership for Women & Families found that respondents whose doctor has an EHR and who have online access to their health information in that EHR see greater value in EHRs for both their providers and themselves. In fact, when patients have online access to their health information, 80 percent use it. Individuals with EHRs used online access their health information to help them in at least three ways: (1) Personally find and correct errors or incomplete information in their medical record; (2) Understand their health condition better; and (3) Keep up with their medications.⁶⁷ Online access has the potential to be used on a more widespread basis if providers and technology vendors partner with patients in designing and selecting the functionality most useful to them.

ANECDOTES OF MEASURING

Wisconsin Collaborative for Healthcare Quality

- A study published in *Health Affairs*, conducted by the Wisconsin Collaborative for Healthcare Quality on the effect of public reporting found compelling evidence that public reporting led to improved performance in Wisconsin.⁶⁸ The study found:
 - 15 of 17 medical groups said they prioritized at least one quality improvement intervention because of public reporting.
 - Providers improved performance on each of the reported measures, such as cholesterol control and breast cancer screening.
 - In 2007, 62.3 percent of patients with diabetes who received care at participating practices got the recommended blood sugar tests, eye exams, and lipids tests – compared to 58.1 percent of patients with diabetes who received care in other practices in Wisconsin.⁶⁹
 - Medical groups reported that seeing performance data motivated them to act, as practices wanted to be identified as top providers and avoid being at the bottom of the list.
 - Those in the collaborative also outperformed the rest of the providers in Wisconsin on two diabetes measures and a breast cancer screening.
- The Wisconsin Collaborative for Healthcare Quality noticed a wide variation in colorectal cancer screening rates among its member organizations, ranging from 63 to 80 percent.⁷⁰ The alliance created a member-led project team to review barriers and gaps to care, and outlined interventions so every organization could improve its rates to 70 percent or higher. Interventions included using electronic health records to flag patients who were behind in their screenings and calling or sending letters to eligible patients to remind them to schedule appointments. The alliance is on its way to achieving this goal, with 80 percent of members currently at the improvement target.

TriHealth Physicians Group

- The TriHealth Physicians Group in West Chester, Ohio saw that it achieved average scores for the care it provided to diabetes patients.⁷¹ Determined to be above average, the practice manager ran reports several

times a week to see which patients needed to be in better control of their diabetes. Those in good control were celebrated with certificates, while those who were struggling received extra attention, such as nutrition counseling or fitness support.

- The study found that the practice's score rose 20 points to 48 percent the following year on the five reported measures for diabetes care, the highest improvement rate of any reporting practice in the area.⁷²

Health Improvement Collaborative

- To gain physician buy-in around public reports, the Health Improvement Collaborative vetted its diabetes measures through its Physician Leadership Group.⁷³ More than 600 local physicians participated by voluntarily providing patient data on the D5 measures. The collaborative then provided each of the reporting practices with their D5 scores, as well as a community-wide score to serve as a benchmark.
 - The study found an increase of the average rate for diabetes care on all five measures from 28 percent in 2010 to 30 percent in 2012.⁷⁴ The collaborative expects this number to increase to 32 percent by 2015.

Better Health Greater Cleveland

- When reviewing its annual diabetes data, Better Health Greater Cleveland noticed that practices with the highest rates of pneumonia vaccination among diabetes patients were part of the MetroHealth System. The alliance reached out to MetroHealth to find out what it was doing to deliver optimal care. It learned that the system developed a set of interventions using a team approach and asked MetroHealth to share its protocols at a community-wide meeting so that others could replicate them.⁷⁵
 - MetroHealth's protocols spurred vaccination rates to jump from 27 to 70 percent in the first year and 90 percent in the following two years.
 - Once MetroHealth shared the protocols with others in the community, vaccination rates in practices in other health systems climbed from 70 to 82 percent in three years.

Minnesota Community Measurement

- After learning in the 2009 report from Minnesota Community Measurement (MNCM) that only 47 percent of the clinic's patients received the recommended care for vascular disease, the Ellsworth Medical Clinic in Ellsworth, Wis., empowered its lab technicians to check for missing tests in physicians' orders. The clinic's receptionist began contacting patients about needed visits or screenings, and encouraged the diabetes educator to follow up with patients to ensure they were following their treatment plans.⁷⁶
 - In 2010, 68 percent of patients at the Ellsworth Medical Clinic received Optimal Vascular Care, a 20 percent improvement, which gave the clinic the highest rating of all 433 clinics in MNCM's 2010 report.
- The Fairview Rosemont Clinic in Rosemont, Minn., learned firsthand how public reporting touches patients' lives when the clinic's nurses began calling female patients who did not receive recommended Pap, breast, and colon screenings. The clinic aimed to improve its scores in reports published by MNCM. Jean Shanley and Amanda Franco were among the women who received these reminders and, because of the nurse's calls and subsequent screening, both learned they had cancer early enough to get successful treatment.⁷⁷
- In 2008, CentraCare, a clinic in Becker, Minn., was not pleased with its percentage of patients who were receiving optimal care. Just 5 percent of their diabetes patients were receiving proper care as outlined by state guidelines. Just two years later, the clinic proved the value in measurement and reporting, and became the second highest scoring care facility in Minnesota for diabetes management, according to the MNCM.⁷⁸

Massachusetts Health Quality Partners

- In 2012, Massachusetts Health Quality Partners (MHQP) released patient experience ratings of primary care physician groups, covering nearly 500 practices in Massachusetts. The ratings of 329 adult practices and 158 pediatric practices are drawn from MHQP's statewide patient experience surveys, which have been conducted and publicly reported on by MHQP since 2006.
 - Dr. Lester Hartman of Westford Mansfield Pediatrics was surprised to see his patient experience scores were lower than expected. He conducted his own survey by sending out an email to his patients. When he received the same scores by his own calculation, he decided to make a change. By implementing better processes around electronic health records and taking steps to increase preventative programs, reduce wait times, improve access to urgent care, and make test results more accessible, the practice was able to improve its scores on nearly every measure between the 2007 and 2009 reports.⁷⁹

Employer Examples

Maine Health Management Coalition

- Maine Health Management Coalition (MHMC) works with local employers to use quality data to design health plan benefits and encourage informed decision-making. The State Employees Health Commission uses the data to tier hospitals and providers based on the quality of care provided. Co-payments and deductibles are waived for employees who get their care from hospitals and primary care practices that have a “preferred” status. The tiering created competition among the providers and spurred quality improvement efforts.⁸⁰
 - As a result, Maine hospital participation in Leapfrog increased from 18 to 36 (all acute care hospitals in Maine), and medication safety scores improved by 127 percent in the first year and 13 percent in the subsequent two.⁸¹
 - Physician practices with the highest quality ratings increased by 31 percent as the practices obtained more quality designations to be included in the preferred network.⁸²
- MHMC worked closely with The Jackson Laboratory to help them realize they were spending significantly more on benefits than similar employers in the region, including 50 percent higher hospital costs. The Jackson Laboratory used the data from the coalition's quality reports to redesign its benefit plan. They offered lower co-pays for visits to “preferred” doctors, full coverage for certain surgeries and lab tests with “preferred” providers, and lower out-of-pocket costs for in-network hospitals. In one year, the company reduced health care costs per enrollee by nearly 20 percent.⁸³

NOTES

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