Dimensional INSIGHT®

GENERATING CONSENSUS AND TRUST
FOR QUALITY MEASUREMENT TO SUPPORT VALUE-BASED CARE

Written by Jennifer Bresnick

Quality measurement is an integral part of value-based care, yet providers and payers both struggle to define meaningful metrics and leverage quality measurement data to effectively improve care.

With more and more revenue shifting into payment models that require all stakeholders to agree on performance and quality, the industry is facing the daunting task of defining accurate, impactful measures to guide the delivery of high-quality care.

Creating consensus and trust around quality measurement will require active collaboration from both payers and providers. Both entities will need to reexamine their processes, health IT tools, and data governance strategies in order to rise to the challenges of changing reimbursement structures.

NAVIGATING A HIGHLY CHALLENGING PAYMENT ENVIRONMENT

The healthcare industry's ongoing journey to value-based reimbursement is requiring stakeholders to solve innumerable puzzles and overcome daunting technical, clinical, and cultural challenges.

In many areas, the transition away from fee-for-service is happening at a brisk pace. Organizations are moving steadily into alternative payment models and other value-based arrangements in partnership with public and private payers.

In 2016, traditional fee-for-service payment only accounted for 43 percent of healthcare dollars, says[1] the Health Care Payment Learning & Action Network (LAN). Just under 60 percent of the nation's payments were related to shared savings and shared risk, pay-for-performance models, bundled payments, or population-based reimbursement.

Payment structures may be changing quickly, but many providers and payers feel as if they are unready and ill-equipped to excel in this new environment.

Communication between the two groups is still lacking, attendees at the 3rd Annual Value-Based Care Summit hosted by Xtelligent Healthcare Media indicated.

Analytics tools and actionable insights are unevenly distributed, performance is burdensome to measure, and broad consensus around how to define basic terms such as "quality" and "value" often feels as if it is light-years away. And while most conference participants expressed confidence that value-based care is worth the struggle, the rules of the road about quality measurement and reporting may still be too imprecise to be effective.

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"We're completely missing the ability to measure as we go and make sure that our decisions correspond to positive outcomes," said George Dealy, Vice President of Healthcare Applications at Dimensional Insight.

"We need to reduce the lag time between making the decision and understanding the impact of that choice. That's the only way we will be able to innovative quickly and meaningfully, tailor our protocols and best practices, and connect process measures to outcomes. That consistency is also required to measure one organization against another."

Accurate, trustworthy, and well-defined quality measurement is at the core of the relationship between payers and providers in the value-based care setting. Payers require providers to meet certain benchmarks related to processes and outcomes before providers can earn incentives, shared savings, or bonuses.

But as the industry commits further to these relationships, it is becoming increasingly clear that more work is required to set mutually beneficial expectations around quality, outcomes, and the measurement of provider performance.

"We are on the cusp of a new era that is forcing us to ask different questions about our healthcare system," said panelist Jennifer L. Bright, MPA, Executive Director of the Innovation and Value Initiative (IVI), during a discussion of the challenges and opportunities of quality measurement.

"Healthcare is no longer about the number of pills prescribed or the volume of procedures completed. It's about what we're doing as an industry to improve the quality of life. In order to get to the heart of that, we need to refine our approach to quality measurement."

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THE PROLIFERATION OF LOW-VALUE QUALITY MEASURES

The idea of quality measurement is nothing new to the healthcare industry. Providers, payers, consumer advocacy groups, regulators, and patient safety watchdogs have been using various metrics to reward excellence and caution poor performers for decades.

However, as performance has become more closely tied to reimbursement, the number of different metrics, measures, benchmarks, targets, and goals has exploded.

There is no single, centralized body responsible for designing, disseminating, and governing quality measures, noted Misty Roberts, MSN, Clinical Quality Officer in the Office of the CMO at Humana.

And there is no unified process for payers to agree upon a core set measures—and a single set of definitions for those measures—across the variety of independently developed performance-based contracts.

"There are simply too many measures for most organizations to even keep track of, never mind implement effectively," Roberts said. "In the National Quality Measures Guidelines Clearinghouse, there are about 2,500 quality measures. In the CMS Quality Measures Inventory, there are around 2,100 used for various programs. The National Quality Forum has 1,100 measures, about 600 of which are endorsed."

"There are multiple measures attempting to address the same topic. Sometimes they are duplicates; sometimes they vary very slightly from one another. Sometimes a clinical guideline from a professional society changes, so the measure is updated but the old version is not removed. That can very easily lead to confusion for everyone trying to understand what good performance really looks like."

Not even the Government Accountability Office (GAO) has been able to fully define the scope of the problem, let alone begin to address it. In a 2016 report[2], the federal agency stated that "the full extent of quality measure misalignment is unknown." Citing previous industry research, GAO said the number of measures correctly aligned in certain state Medicaid programs is as low as 13 percent.

In 2013, a study[3] from AHIP showed only five percent of quality measures were used by more than half of health plans participating in commercial value-based care arrangements, GAO added. The vast majority of the 546 measures included in the study were only used by a small portion of payers, leaving providers with the challenge of coordinating individualized reporting across multiple payment models.

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When interviewed by GAO in 2016, the authors of the AHIP study stated that the challenge is likely to have become significantly more complex in the intervening years due to the unchecked proliferation of measures.

Adding to the problem is the fact that many existing measures focus on processes and not outcomes, pointed out Dealy.

Process measures focus on the concrete steps that build towards comprehensive care, such as if a patient received a screening or was started on a medication. Process measures usually have a yes or no answer, which can help to create structured data, but do not necessarily contribute to actionable insights, he said.

"There is some sense in the industry that measures are the end-point. All you have to do is collect that data and send it off to someone else, and your job is finished," he said. "But that isn't the case if you want to use quality measurement to inform decision-making within your organization."

Outcomes measures, which gauge whether an individual has experienced a positive result, are often lacking in performance measurement programming, said Dealy. "We're monitoring the steps and the checkpoints, but we're not looking sufficiently at what those processes produce. If we don't add outcomes to our view of quality measurement, then we're just creating numbers for the sake of creating numbers."

Redesigning quality measures to incorporate both processes and outcomes could help to reduce duplicative reporting while answering key questions about the effectiveness of care, suggested Roberts.

"There are multiple measures around hemoglobin A1C, for example," she said. "Some of them are process measures that ask if the patient had his A1C tested. But then we have a measure that asks if the patient's A1C is under control."

"Well, clearly the provider wouldn't know if the A1C is under control or not if they didn't test it. So in effect, that outcomes measure actually incorporates the process measure without requiring two different actions to record the information."

Looking even further into the value-based future, healthcare organizations may be able to condense their measurement activities into an even smaller package.

"If we can conduct enough research to strongly link A1C control to fewer ED visits or fewer hospitalizations, maybe we don't need as many process measures to act as checkpoints along that value chain," Roberts said.

Creating more comprehensive measures will ensure that providers are collecting the right data to identify potential gaps in care or opportunities for improvement without overwhelming the workflow with repetitive tasks and time-consuming reporting.

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WORKING COLLABORATIVELY TO REDUCE QUALITY MEASURE CLUTTER

Reducing the number of low-value, duplicative, or outdated measures is an important first step for easing the burdens on providers and creating clarity, said Roberts.

At Humana, a review of the company's 1,100 quality measures identified approximately 700 duplicate or inconsistent metrics, she explained. "After establishing a more robust governance model, we were able to reduce those measures to around 208 key quality measures," Roberts said. "That's an 80-percent reduction—a reduction that will strengthen the value of what we have and hopefully eliminate some of the complexity around working with us on value-based care initiatives."

Humana is not the only organization that has recognized the need for change.

The "Meaningful Measures" framework[4] from CMS, introduced to support providers participating in MACRA and the Quality Reporting Program (QPP), is intended to serve as a roadmap for prioritizing impactful measurement in key areas of quality and outcomes. The initiative is designed to support the key goals of overall healthcare quality improvement, including empowering patients, delivering effective preventive care, and eliminating disparities in access and outcomes.

Other key stakeholders are also working to narrow the pool of potential quality measures and encourage alignment across the public and private payer communities.

In June of 2018, the American Medical Group Association (AMGA) endorsed[5] a core set of 14 standardized measures to serve as a springboard for more streamlined—and therefore less expensive—quality measurement. The association cited a $15.4 billion annual cost for quality reporting among four common physician specialties, adding that physicians spend hundreds of hours each year on reporting that has not necessarily been proven to improve quality.

The National Quality Forum (NQF) has also advocated for fewer, less burdensome measures. The NQF's Measure Applications Partnership (MAP) recently released a series of reports[6] urging CMS to examine its existing measure sets for metrics that may inadvertently encourage overutilization or repeated services, as well as measures that are not consistent across multiple quality reporting programs.

In addition to the MAP, NQF oversees the Core Quality Measures Collaborative, which includes executives from commercial payers and several large professional societies. The group, originally convened by AHIP, is working to develop coordinated measure sets for primary and specialty care. Collaborative approaches to trimming down low-value quality measures are essential for creating trust and generating consensus, added Bright.

"Trust is the missing piece of value-based care in general, and it is clear to see how that manifests in quality measurement," said Bright. "Very few stakeholders currently understand the methodology behind the industry's decision-making. Patients don't know how to judge quality, and that's partly because providers and payers aren't entirely sure how to measure it, either."

"If we continue to make siloed decisions in a back room hidden from view, we can't possibly bridge the trust gaps between payers, providers, policymakers, and patients. Communicating the reasons behind decision-making is essential, and that will start with an agreement around what we want to achieve in terms of quality and value."

Ultimately, strong partnerships, full transparency, and robust governance are the only way forward, agreed Dealy.

"We can't make progress if we don't understand what we're trying to accomplish to begin with," he said. "Governance will be key every step of the way towards our goals."

"It doesn't take much disparity between two definitions or two similar measures to create a massive financial or quality gap. That's not going to be sustainable in a value-based world. Simply put, we need to learn faster and apply those lessons consistently across the entire care continuum."

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LEVERAGING HEALTH IT TOOLS TO CREATE A SINGLE SOURCE OF TRUTH

Performing well in an atmosphere of misalignment can be challenging, Dealy acknowledged. But organizations that are proactive about governance, both internally and in collaboration with business partners, will be able to succeed with their objectives.

"Developing organizational governance is not always easy, especially if resources are scarce and the people who need access to data don't have the right tools at their disposal," he said. "Using analytics and governance tools to give every stakeholder the access they need to collaborate and agree on all the definitions will be essential for creating consensus and moving forward in a coordinated manner."

Healthcare organizations should focus on a few key governance tasks in order to achieve positive results, he explained.

Automate the collection of data and create self-service analytics capabilities

Automated data collection and self-service analytics capabilities can help to bridge the gaps between an organization's goals and their existing resources, Dealy said.

"Not every user is going to want to dive down deep into the metadata and dig into the definitions and data sets used to create them. But for the people in your organization who do need that information, access and visibility are key," he asserted.

"That metadata is as important as the analytics that come out from it. If you can't agree on the underlying reasoning for a quality measure, what use is that metric for identifying outcomes and opportunities for change?"

Expose the underlying logic behind quality measurement

Creating opportunities for discussion and the exchange of ideas can ensure that internal stakeholders agree on the construction and expected results of a particular measure.

In turn, that consensus can equip providers with the insights they need to negotiate with payers, validate their performance, or improve their processes.

"A unique tool like Measure Factory® allows organizations to compile and aggregate data from the heterogeneous sources required to create measures," Dealy explained.

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Dimensional Insight's Measure Factory provides the basis for governance processes and enables collaboration around a single source of truth for quality measurement.

"Ideally, you want to have your subject matter experts (SMEs) as deeply involved in the creation and deployment of measures as possible," he continued. "Technologists are great, and they are very valuable, but they don't have the same perspectives as your SMEs in the trenches."

Close the gaps between technical design and daily use

Creating measures that truly align with the realities of clinical care requires consistent input from end-users, Dealy stressed.

"There are often differences between what a developer thinks should happen and what a clinician thinks should happen. We have seen those gaps create certain problems with workflows before in other areas of the health IT world," he said.

"After several iterations of Measure Factory, Dimensional Insight has found that we need the end-users to have input from the very beginning. The people who are going to be making decisions based on the tool absolutely have to be involved in creating it."

Combining robust internal governance and collaborative decision-making with the broader industry's efforts to reduce the burdens of quality measurement will produce results, Dealy believes.

More trustworthy, actionable quality measurement insights from the organizational level will be able to support payers, policymakers, and standards organizations as they fine-tune the quality reporting landscape.

"Truly effective quality measurement has to incorporate insights from the provider level about how to balance processes and outcomes," said Dealy. "With Measure Factory, an organization can be sure that the process is starting out on a foundation of trust, which can then filter upwards into contracting and performance incentives."

Analytics and reporting that allow users to ask the right questions and collaborate with the data scientists who can identify the answers are necessary for succeeding with value-based care and quality measurement programs.

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MOVING FORWARD COLLABORATIVELY INTO EFFECTIVE QUALITY MEASUREMENT

Healthcare providers, payers, and policymakers must come to an agreement on the value and volume of quality measures to complete the transition away from fee-for-service reimbursement.

Meaningful, trustworthy, and accurate measures are a foundational component of initiatives rewarding providers for high performance and positive patient outcomes, yet misalignment and confusion over quality measurement are still common.

The industry must continue to reduce barriers to collaboration and increase transparency around clinical and financial decision-making in order to achieve the promises of value-based care, said Bright.

"Communicating the 'why' behind decisions about payment and performance is really essential," she stressed. "We have some work to do when it comes to creating the environment in which to have those conversations, but we are certainly making good progress by exchanging ideas about how to chart the way forward."

Collaboration and cooperation will accelerate the development of consensus around quality measurement, patient outcomes, and how to reward providers for high performance, agreed Roberts.

"Sharing and aggregation of data is essential, because we can't do this alone," said Roberts. "The payers can't do it alone. The providers can't do it alone. We have to all work together. We have to look outside of our own viewpoints on the patient to create a truly holistic picture."

"The first step will be leveling the playing field in terms of what we're expecting and what we're measuring. When we achieve that shared environment of trust, it's going to drive those outcomes that we are all searching for."

CONCLUSION

Achieving the collaboration and consensus required to drive truly effective quality measurement across the care continuum will require a mix of health IT tools, innovative data management strategies, and new incentives for delivering impactful, high-quality care.

As healthcare providers and payers move deeper into the value-based reimbursement environment, getting proactive about implementing governance and embracing transparency around quality measurement will be a key component of success.

By leveraging health IT tools and having open conversations with peers, the healthcare industry will be able to achieve the promises of value-based care, concluded Dealy.

"Self-service analytics and democratized decision-making are the underlying competencies for success," he said. "Measure Factory allows organizations to generate and access insights quickly while setting the ground rules for trust and that will equip them to deliver optimal care in a performance-based financial environment."

SOURCES

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ABOUT **JENNIFER BRESNICK**

Jennifer Bresnick

Director of Editorial, HealthIT Analytics

Jennifer is the lead editor for HealthITAnalytics.com. She is a graduate of Mount Holyoke College with a major in history. In addition to her interests in healthcare data management and systematic improvement, she is a novelist, amateur target archer, and avid crochet enthusiast.

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For more information, please visit www.dimins.com.

60 Mall Road
Burlington, MA 01803

t: 781.229.9111
www.dimins.com

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