CAPP

COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES

An affiliate of the AMGA Foundation

A Roadmap to Meaningful Health Care Quality Measurement

PART 1 OF IMPLEMENTING HEALTH SYSTEM IMPROVEMENT

PREAMBLE

During the 2016 election season, the Council of Accountable Physician Practices urged political candidates at all level to focus on three critical health policy issues.[1] These issues — or platforms — can support a better health care delivery system and should be at the top of every policymakers' health care agenda:

- **VALUE-BASED PAYMENT**
- **ROBUST AND COORDINATED USE OF HEALTH INFORMATION TECHNOLOGY**
- **IMPROVED AND HARMONIZED QUALITY MEASUREMENT AND REPORTING**

In this brief, the first in a three-part series entitled "Implementing Health System Improvement," the physician leaders of CAPP provide more detailed guidance to newly-elected officials and members of the administration about how to move forward on one of these issues: quality measurement and reporting.

KEY POINTS

- Quality measurement and reporting are foundational to achieving a health care system that is higher-quality as well as more efficient and patient-centered than what most Americans experience today. However, the uncoordinated growth of quality measurement initiatives has created multiple parallel systems with hundreds of measures that place an unsustainable burden on health care providers. Information produced by these systems does not contribute meaningfully to improved health and wellbeing and is not easily understood by consumers.

- A more meaningful quality measurement system would have two key characteristics, compared to today's non-system: fewer measures and better measures, focusing on clinical areas where there is good evidence that improvements in performance translate into improvements in health.

- A set of two dozen or so measures in a limited number of domains — including prevention and chronic disease management — would provide meaningful quality information that is actionable for physicians and patients. Moving the field forward in this way will require physician leadership and a strong, interoperational health information technology infrastructure.

- It is critical that physicians and other stakeholders continue to advance the science of outcomes (as opposed to process) measurement, focusing on outcomes that are meaningful to patients — for example, return to normal functioning after illness.

- Policymakers must encourage the continued streamlining and synchronization of quality measurement and reporting across public programs. They can also influence private sector quality measurement, both through examples set in public programs, and by convening stakeholders to agree on a more meaningful set of measures that could be used by all.

INTRODUCTION: MEANINGFUL QUALITY MEASUREMENT TRANSCENDS "REPEAL AND REPLACE"

Quality measurement and reporting are foundational to achieving better value from our health care system. With much of health policymakers' attention focused on efforts to "repeal and replace" the Affordable Care Act (ACA), it is important to remember that *any* coverage system that serves our country must reinforce a health care delivery system that is higher-quality and safer, as well as more efficient, convenient, patient-centered, and affordable than what most Americans experience today. We cannot achieve that vision until we can consistently and accurately recognize high-quality care when we see it. In many ways, however, the quality-measurement endeavor in our country has become unwieldy, producing information that is not actionable, does not contribute meaningfully to improved health and wellbeing, and is not easily understood by consumers. Fixing this system must be a top priority for all health care stakeholders, and especially for policymakers.

This brief represents the insights of the Council of Accountable Physician Practices (CAPP), a coalition of America's highest-performing medical groups and health systems. In it, we provide a high-level roadmap to improving the health care quality measurement endeavor in the U.S., and we urge stakeholders not to abandon this important effort. Quality measurement is difficult and fraught with tradeoffs, but we believe passionately that it must be improved, not abandoned.

THE QUALITY MEASUREMENT "SYSTEM" – AND WHAT AILS IT

Quality measurement is vital to physicians' ability to provide the very best care, and it is deeply ingrained in the infrastructure of each of the CAPP medical groups and health systems. In addition, without quality measures that are consistent and clear: patients can't make good choices about their own care; policymakers can't evaluate the success of legislative and regulatory changes; and those who pay for health care (insurers, employers, and governments) can't determine if they are getting good value for their money. It is no wonder that all of these stakeholders demand quality information from physicians and other providers – as they must.

Prominent examples of stakeholders' quality measurement systems include (among others):

- Medicare's newly-established measure set for physicians, created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which will go

into full effect in 2019. Under this system, most physicians who are not participating in an Alternative Payment Model (APM), will report on up to six measures, chosen from a list of over 200 provided by the Centers for Medicare and Medicaid Services, available here[2];

- The Healthcare Effectiveness Data and Information Set (HEDIS) from the National Committee for Quality Assurance, which is used widely to measure the quality of public- and private-sector health plans and — by extension — their providers. The 2017 measure set, including the measures that are specific to physicians, is available here.[3]

- Multiple region- or state-specific measure sets promulgated by collaboratives of public and private employers and health care systems, such as the Integrated Healthcare Association[4] in California or the Wisconsin Collaborative for Health Care Quality.[5]

Individually, each of these systems is valuable. However, the uncoordinated growth of quality measurement systems across *all* stakeholders has created multiple parallel systems that place an unsustainable burden on health care providers and do not serve their original purpose — to improve health and wellbeing. There is widespread, bipartisan agreement that the current quality measurement "system" is no system at all; it is fragmented, redundant, burdensome to providers, and does not provide consumers with an accessible means by which to understand and compare provider quality.

WHAT WOULD MEANINGFUL QUALITY MEASUREMENT LOOK LIKE?

A meaningful quality measurement system has two key characteristics, compared to the non-system in place today: fewer measures and better measures.

Fewer Measures

Health care providers produce hundreds, if not thousands, of largely duplicative measures that may address similar issues, using slightly different methodologies. Medical practices report that their physicians and staff spend just over 785 hours per physician per year dealing with external quality measures – sufficient time to care for an additional nine patients per week.[6] Much of the time and resources spent responding to redundant measurement requirements could be better spent on direct patient care.

The proliferation of measures can also negatively impact physician-patient interactions. Knowing that his or her practice must comply with a lengthy list of measures, a physician may be forced to touch superficially on a wide array of issues during a single office visit, rather than having time to delve deeply into one or two issues that are most important to the patient.

It is imperative that stakeholders prioritize quality measures so that physicians can focus deeply and meaningfully on a limited number of high-impact clinical areas. In recent years, several multi-stakeholder groups have issued reports recommending a drastic winnowing-down of existing measures –including the public/private Core Quality Measures Collaborative's seven domains (with dozens of measures in each).[7] These efforts are important, but we must go further. A set of two dozen or so measures in a limited number of domains — including prevention and chronic disease management — would allow for meaningful quality reporting.

This is not to say that there aren't other, equally important clinical areas in which we must measure and improve quality. But for external reporting purposes, we must start with a limited set of measures that allow us to focus on areas where there is good evidence that improvements in performance translate into improvements in health. (Physician groups can, and indeed must, continue to measure and report *internally* on a wider set of measures to support continuous quality improvement, but this activity is distinct from the external quality measurement reporting endeavor and its overwhelming administrative burden.)

Better Measures—High-Impact, Evidence-Based

Not only must we reduce the number of measures to which physician practices are subject, we must also ensure that the measures we retain are the right ones. The initial focus for external reporting must be on areas where there is strong evidence that process improvements lead to clear improvements in population health and wellbeing. Examples include: immunization rates, colon cancer screening rates, use of beta-blockers in patients with heart failure, and control of lipids and blood pressure in diabetics.

Another important piece of ensuring the right measures is being nimble enough to change directions if the technology or science changes rapidly. For example, the Centers for Disease Control and Prevention recently recommended that 11- to 12-year-olds receive two doses of Human Papilloma Virus vaccine at least six months apart, rather than the previously recommended three doses.[8] However, many quality reporting systems have not changed their standard, so that a medical practice complying with the clinical recommendation of two doses may be penalized financially for failing to meet the measurement standard of three doses.

Finally, even as we focus on the best evidence-based, process-related measures, we must also advance the science of outcomes measurement, focusing in particular on outcomes that patients care about. For example, rather than only measuring whether an asthmatic adult received proper medication (a process measure), we should measure whether he suffered an acute asthma-related traumatic event or died (outcomes measures) and, ideally, whether treatment allowed him to continue his daily three-mile walks to and from work (a patient-centered outcomes measures).

One challenge in shifting from process to outcomes measures is the long time horizon required for many outcomes to become apparent. Health care buyers make purchasing decisions in one-year increments, an artifact of the one-year insurance cycle. Patients may switch plans and doctors each year, making it difficult to attribute high-quality, longer-term outcomes to the practice that originally provided the care.

Another challenge in measuring outcomes is the question of accountability. Many important, longer-term outcomes depend not only on the quality of care provided by the physician, but also on the actions of the patient, which can be heavily influenced by a supportive and patient-focused care team. For example, a doctor can prescribe a statin for a patient at risk of heart attack or stroke, but the important outcome (avoidance of either of those events) also depends on whether the patient takes the statin and whether he modifies his diet and physical activity over time. To focus on such long-term outcomes, we must rethink "who" should be measured; in this case, not just the doctor, but also the team responsible for impacting the patient's behavior – which might include a pharmacist, a nutritionist, a social worker, etc.

This type of integrated, longer-term measurement of outcomes is more feasible within the context of integrated systems such as ours, than it is throughout most of the fragmented U.S health care delivery system. As such, it may not yet be time to move toward broad use of these measures. Nevertheless, stakeholders must continue to advance the science of this type of measurement.

CRITICAL SUPPORTS: PHYSICIAN LEADERSHIP AND INFORMATION TECHNOLOGY

The road to more meaningful quality measurement is littered with obstacles; two important tools are critical to overcoming them: strong physician leadership, and the right information technology infrastructure.

Physicians Must Lead The Quality Measurement Endeavor

All stakeholders have a role to play in improving health care quality measurement, from modeling the necessary streamlining of measures, to sharing best practices, to participating in collaborative efforts. In undertaking this important work, we urge stakeholders to rely heavily upon the guidance of physicians themselves. In particular, physicians in groups such as those represented by CAPP — the large, multispecialty group practices — are well positioned to help evaluate the central tradeoff inherent in the quality measurement endeavor, between inclusivity and manageability.

Ideally, we would measure the quality of everything we do. In reality, we must focus on those areas with the biggest impact on population health and in which we have the best ability to effect change. With large patient populations, strong information technology systems, and robust quality improvement processes in place, CAPP members and others like us have the tools to help stakeholders understand which measures add value to the care we provide, and which do not.

The Right Information Technology Infrastructure

We cannot hope to improve the quality measurement endeavor until we strengthen the health information technology (HIT) infrastructure that supports it. Specifically, a lack of HIT system interoperability and data exchange across payers and providers can lead to inaccurate measurement. For example, a provider group may be held accountable by a payer for the percentage of patients that receive a flu vaccination, but some of those patients will receive a vaccination at school or at a retail site. In most cases, that information cannot be shared with the provider responsible for those patients, so the provider's data will show that the vaccine was not received.

As we noted in our 2016 policy agenda for political candidates, this fragmentation of information is not tolerated in any other industry and cannot be tolerated in health care.[9] That is why improved and coordinated use of HIT is not only necessary for more rational quality measurement and reporting; it is also one of our three platforms for delivery system improvement.

A CALL TO ACTION: POLICYMAKERS' ROLE

The delivery system is irreversibly on the path to measuring health care quality; as physicians, we urge policymakers to stay that course. None of us can afford to give up on quality measurement simply because it is hard — and it is, indeed, very hard. There are no perfect measures, given constraints of time, money, information systems, and even the insurance cycle. Nevertheless, we can do a better job of identifying the highest-value measures — those that give us the most actionable information to improve patient outcomes without becoming paralyzed by bureaucracy.

Policymakers must now play an important, four-fold role. First, they must ensure that health insurance markets reward quality and patient satisfaction, rather than avoidance of risk. Second, and in that context, they must encourage the continued streamlining and synchronization of quality measurement and reporting across public programs. The bipartisan Medicare Access and CHIP Reauthorization Act helped push us in that direction, but we must go further, as we have illustrated in this brief. Third, policymakers must make quality and patient satisfaction data easily accessible to consumers, so that those programs with the best outcomes are appropriately rewarded, as in the Medicare Advantage Star-rating process. Finally, government can also influence private sector quality measurement, both through example, and by serving as a convener. Government can bring together public and private payers with physicians and other stakeholders — at both the state and federal levels — to agree on a limited set of high-value measures that all will prioritize.

Ultimately, we won't transform health care in this country until policymakers hear the voices of patients as loudly as those of other stakeholders. A more meaningful quality measurement system is a critical step in that direction.

WHAT IS THE COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES?

The Council of Accountable Physician Practices is a coalition of physicians leading the nation's highest-performing medical groups and health systems. We believe we are better together. All of the CAPP members are physician-led, multispecialty medical groups or systems — places where doctors from all disciplines practice together and learn from one another, backed by integrated services, systems, data, and technology. We recognize the importance of the patient-doctor relationship and know that, together, we can achieve the highest quality and ensure that patients come first.

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1 Council of Accountable Physician Practices. *What Every Candidate Should Know About Health Care.* 2016. Available at: http://accountablecaredoctors.org/wp-content/uploads/2016/08/CAPP_2016_CandidatesPrimer.pdf.

2 Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. Final Rule. 81 Fed Reg 77008, 11/4/2016, (see page 77558), https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm#page-77558.

3 National Committee for Quality Assurance. *HEDIS 2017*, http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017.

4 See: http://www.iha.org.

5 See: http://www.wchq.org .

6 LP Casalino, et al, "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures," *Health Affairs*, March 2016 vol. 35 no. 3, pp. 401-406, available at: http://content.healthaffairs.org/content/35/3/401.abstract.

7 Centers for Medicare and Medicaid Services. CMS and major commercial health plans, in concert with physician groups and other stakeholders, announce alignment and simplification of quality measures. Press Release, 2/16/2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-16.html.

8 Centers for Disease Control and Prevention. CDC recommends only two HPV shots for younger adolescents. Press Release, 10/19/2016, https://www.cdc.gov/media/releases/2016/p1020-hpv-shots.html.

9 Council of Accountable Physician Practices. *What Every Candidate Should Know About Health Care*. 2016. Available at: http://accountablecaredoctors.org/wp-content/uploads/2016/08/CAPP_2016_CandidatesPrimer.pdf.