HealthData Management | Roundtable

Measuring Performance in a Value World:

Industry Leaders Provide Their Take on Overcoming Myriad Challenges

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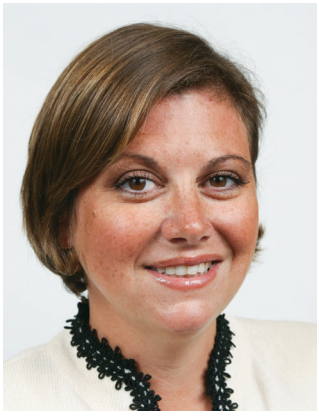

MODERATOR

Danielle Fugazy
Contributing Editor,
HDM, SourceMedia

While questions loom regarding the fate of the Affordable Care Act, one thing is certain. Value-based care has staying power. As such, healthcare organizations are moving toward the adoption of models that base payments on care outcomes, not on the volume of services delivered. In fact, 50% of healthcare systems already are getting some or most of their reimbursement as part of value-based payments that put providers at risk for the cost and quality of care, according to a survey of healthcare payer and provider leaders conducted by KPMG, a global consulting firm.

As a result, healthcare organizations, now more than ever before, are being asked to measure performance. Indeed, a variety of organizations – from payers to quality groups to government regulators – are requiring healthcare organizations to evaluate performance and care outcomes as part of the value-based payment process. As such, care providers need to collect, analyze and report on various performance metrics. Challenges associated with operating under this new model abound – as healthcare organizations try to ascertain what measures are most meaningful; how to engage physician in the development and use of quality measures; how to engage consumers in quality initiatives; and how to best leverage technology to best support value-based care initiatives. To gain insight into these challenges, Health Data Management recently hosted variety of thought leaders together to offer their perspectives. 3M Health Information Systems, Inc., sponsored the event. Highlights from the roundtable discussion, which was held in New York City in early September, are presented here.

PARTICIPANTS

Danielle Fugazy, Moderator, Contributing Editor, Health Data Management, SourceMedia

Kimberly Bodine, DNP, RN, Senior Director, Applied Clinical Informatics, Tenet Healthcare

M. Joseph Grennan Jr., MD, MA, FACHE, Regional Medical Director, UPMC Northern Region

Patrick McGill, MD, Vice President for Clinical Strategy Community Health Network and Physician Partner, VillageMD

Gordon Moore, MD, Senior Medical Director, Clinical Strategy & Value Based Care, Health Data Science Group, 3M Health Information Systems, Inc.

Katherine Schneider, MD, President and CEO, Delaware Valley Accountable Care Organization

Terri Steinberg, MD, Chief Health Information Officer, Vice President, Population Health Informatics, Christiana Care Health Services

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Fugazy: What metrics should healthcare organizations be using to measure performance under emerging value-based care models?

Schneider: The metrics an organization uses depends on what purpose they are trying to serve. The metrics an organization picks, how they pick them and how they set thresholds should be directly tied to what they are trying to accomplish. Sometimes, as with many ACOs, metrics are used to make sure an organization is passing some sort of quality standard to get access to savings from a payor. That's very different from using metrics to support performance improvement. And, then, there's the third use case of trying to differentiate high from low performers.

Moore: The challenge is that healthcare organizations can only measure so many things because it's exhausting to look at everything for every clinician all the time. Therefore, the metrics are often honed down. Then, providers are judged on 12 metrics – and that seems absurd because it doesn't provide a full picture. For example, the value of reporting on the delivery of an A1C or even an aggregate for the diabetic population doesn't seem as valuable as reporting on more comprehensive outcomes such as the rate of hospitalization or emergency room department visit rates for people with chronic conditions.

Fugazy: What is stopping or discouraging physicians from buying into performance metrics?

"The challenge is that healthcare organizations can only measure so many things because it's exhausting to look at everything for every clinician all the time."

Gordon Moore

McGill: The frustration from frontline clinicians stems from the fact that they are often graded on moving targets and evaluated on process measures, not outcomes. To increase buy-in, we have to get away from grading or rating each individual provider because we really should be looking at how the system performs and overall patient outcomes.

Steinberg: Doctors also feel that they're being asked to do things that are pretty much outside of their control. For example, giving a patient a prescription to get a mammogram doesn't necessarily mean the patient will follow through. It's also pretty easy to disenfranchise doctors from the process when they feel that they are part of a team but yet they're the ones who are being judged and they are responsible for delivering the outcome, which is really out of their control. And, they're feeling really trod upon—when they are being asked to embrace 50 different measures.

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Grennan: My system's physician practices deal with a multitude of payers and each payer has its own set of metrics and targets. Even if a given metric is shared by a couple of payers, the targets can differ. This presents a major operational and data management challenge.

Bodine: Some metrics, such as the electronic clinical quality measures are undervalued by clinicians due to something as simple as a naming convention. While the eCQMs are retooled versions of the chart abstracted measures, the results will not fully align with the parallel versions of the metric with the same name. As a result, there is a high level of distrust in the outcomes, since clinicians do not understand how the differences in data sources, allowable medications and timing of care provided, can impact performance rates.

"The frustration from frontline clinicians stems from the fact that they are often graded on moving targets and evaluated on process measures, not outcomes."

Patrick McGill

Fugazy: What strategies can organizations take to get physicians more engaged with the performance measures that support value-based care?

Steinberg: To help get physicians on board with quality measures, don't ask them to do multiple things at the same time. At our organization, we don't really ask our doctors to meet several measures. Instead, we support them in their practice in an embedded care management model. So the doctor is not really running after the measures but the doctor is learning about each measure, one after another, in a way that makes it meaningful and important.

Grennan: For many years, I have provided the inpatient physicians with whom I work scorecards that communicate broad metrics such as length-of-stay, readmission rates, and mortality rates. And what I've learned is that physicians have a tremendous capacity for self-correction if they're approached respectfully and with a clear explanation of the sources and relevance of the data in such reports. Also, when I share these reports with the medical staffs I emphasize that the individual physicians should focus on his or her group's performance given the nature of contemporary medical practice. It's very important that the doctors understand these metrics are a tool to improve patient care and clinical outcomes and are not intended to be punitive.

Schneider: To get physicians excited about performance measurement, you need to offer them transformative tools to do a better job and not just tell them to beat their horse harder and it'll run faster—because I think they're at the point where they really can't go any faster. It's hard to get clinicians excited about initiatives that focus on documentation but aren't perceived as truly impacting care of the patient. But if you go with a care- transformation model, then they will engage. For example, your organization can get colonoscopy rates up not by just chasing people down and sending them more prescriptions but by actually having a collaborative model that enables a primary care group to make direct colonoscopy referrals to a gastro-intestinal group.

Bodine: Physicians are also more likely to become engaged with quality measures if they have a say in their development. The measure stewards need to involve clinicians in the measure development process and determine the best way to compensate us for taking the time to assist in the creation of metrics that actually capture the quality of care that is being provided. This could be something as simple as a reduction in the number of measures that are reported for organizations that participate in the measure development process.

Fugazy: What makes physicians/providers continue to hold onto measures. In other words, what can make performance measures "stick?"

Steinberg: You need to ensure that the providers embrace the measures as meaningful in terms of outcomes. For example, physicians need to see the connection between performance on hemoglobin A1C measures and hospital admissions.

Schneider: The whack-a-mole effect emerges when performance measures are very tactical and simply require providers to go after various items on a checklist. What's needed are measures that truly tie to system improvements. As such, care providers are more likely to see the purpose and won't feel like they are just chasing down random measures.

McGill: The measures need to be related to the work that providers should be doing, based on their clinical role. There are certain things that staff members with

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minimal medical training can do. For example, staff members with minimal clinical background can take vital signs or record allergies. When you get to the really complex measures, that's where you need your physicians, nurse practitioners and surgeons – because these professionals can understand the necessary clinical variation. Actually, in my opinion, if a physician has to order an A1C, an eye exam or colon cancer screening, the system has failed.

Fugazy: How can organizations make sure that quality measures are actually performing as intended – and improving care outcomes?

Grennan: You always have to ask: Do these quality measures really matter? That's the elephant in the room. I know of physician organizations that have 150 measures running in the background and I have to wonder how much of this measurement positively affects clinical quality, patient, safety, and the economics of care.

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Kimberly Bodine

Bodine: Organizations do need to continue to evaluate the quality metrics being collected, as well as assess validity of the clinical registries in which they are participating. While registries can provide insight into the effectiveness of interventions or the quality of care provided, data collection is time intensive and may not yield quality data. As a result, all metrics need to be reevaluated to ensure they have the expected impact on care outcomes.

Moore: There was a study in the National Service in the United Kingdom, which has a unified health record. They had about 150 measures that they were applied to the general practice of their primary care. Years later, however, when they focused on cardiovascular care, they realized improvements in metrics around lipid prescribing and other related measures. At the same time, other measures would stay the same or drift down.

Steinberg: Doctors are competitive creatures and everybody wants to know what the test questions are and wants to get an "A" on the exam. And that's just who providers are. So it's important to make these measures visible. So you roll out a manageable number of measures and keep performance a top of mind issue. But you focus sequentially on the "measure of the month" or the clinical program that's most important.

Fugazy: What are the challenges associated with accounting for patient behavior or the patient's response with respect to performance measures?

McGill: Many metrics are not patient centric. So a provider might have a conversation with a patient but for whatever reason, the patient still doesn't want to close the "quality care" gap. The physician might be providing patient-centric care but the performance measures don't recognize this.

Schneider: Pediatric immunization is a good example. It's a touchy subject, but providers are being held accountable to ensure that a high percentage of their patient population is fully vaccinated, for good evidence-based reasons including public health. But they have patients who just refuse. So, do they just dismiss those patients from the practice altogether because they are being penalized for non-adherence, which in this case is by explicit choice? This issue is about more than just performance incentives, but they complicate it further and even erode trust in the relationship.

Bodine: Part of the issue relates to measures that are seemingly created in a vacuum. While some measure stewards may use a sampling of patients in the development process, the metrics are rarely patient-centric. As a result, measures involving patient behavior are rarely created to illustrate the factors that are important to a patient, that signal the successful management of their acute or chronic illnesses. Instead they focus on clinician actions and disregard the healthcare goals that are most important to an individual patient.

Steinberg: It's also about what happens between visits. So we try to hang all of the ornaments on the Christmas tree during the visit—but the optimal time to address some of these health issues is between visits. At our organization, we try to expose the status of the measure to the members or patients. If you let people know what they're supposed to be doing and give them the opportunity to do it, then you are more likely to close care gaps and meet the quality performance metrics.

Grennan: There's another unanticipated consequence of improved patient engagement —

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"You need to ensure that the providers embrace the measures as meaningful in terms of outcomes."

Terri Steinberg

the cost of care can increase. Good care is expensive. For example, earlier in my career, I served as a medical director with a major health plan. I helped the sales teams convince big employers to pay an incremental $2.50 per member per month for a health coaching program. These initiatives actually increased the rates of mammography and colonoscopy, which was great, but this also raised the company's health care costs for that year. From the perspective of the private and public sector organizations paying the bills, another problem is the lag between investment and return as it can be years before there's any clinical or financial benefit from these efforts — diabetics can do just fine for a long time until their eyes and kidneys deteriorate. So, with the current state of health care performance measurement it is hard to justify with the payers and employers who are paying the bills that these interventions are worthwhile because outcomes, which are what count, can take years to manifest.

Fugazy: Healthcare providers are now being held to multiple sets of standards from multiple organizations. Will the industry ever reach a point where providers are held to one common set of standards?

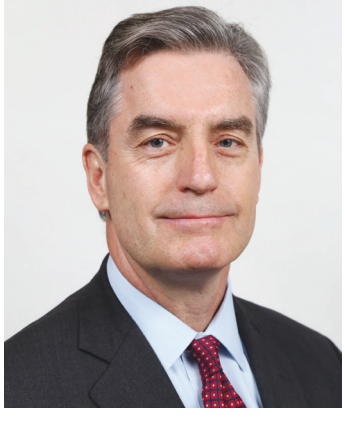
McGill: Different payers have different metrics, different targets for those metrics and different reasons for capturing. So will we ever get there? Probably not if healthcare providers do not take an active role in determining the metrics and targets. It needs to be a collaborative partnership between the payer and the entity about what are the quality metrics and the targets. If a provider is at 20%, and the payer sets a target at 80%, the chances that the provider will hit that are slim to none. So let's put a target at 30%. That's achievable and could show progress in the right way instead of continuously hitting providers with the 80% that they are never going to achieve. It is also a good idea to have an improvement bonus as well. Look, everybody wins if you take the clinician or the group at the bottom quartile and find a way to move them up.

Steinberg: I'll play the devil's advocate. If I'm the payer, I want to get to the point that I identify my centers of excellence. I'm not interested in funding the 20%. And I think that's a real payer perspective.

Schneider: Payers are coming around, though. It has changed a lot from every payer coming in with completely different standards. Standards are much more open now. There might be 150 measures, but providers are allowed to pick one, pick three, pick seven, and giving us much more latitude.

Bodine: For the sake of this discussion, I would take this to the next step. There isn't just a disparity among the metrics provided by payers, accreditation organizations and registries. There is also disagreement among providers on what the industry standard should be to address specific healthcare concerns. Until the involved stakeholders begin working together, a common set of standards may remain out of reach.

Fugazy: Are performance metrics and the use of technology actually translating into better care outcomes?



"What I've learned is that physicians have a tremendous capacity for self-correction if they're approached respectfully and with a clear explanation of the sources and relevance of the data in such reports."

M. Joseph Grennan Jr.

Grennan: Not yet, we are moving too fast. We are building the airplane while trying to fly it. All these performance measures are being pushed out from the payers, consultants, and regulatory and government agencies at an unsustainable pace. While almost all these measures are plausible, most have not been properly vetted, "pressure tested" in the real world. So, we need to hit the reset button. Ideally, a coalition

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of providers, insurers, and regulators need to develop a prioritized list of bona fide patient care issues that need to be addressed and can be addressed with current technology and knowledge. This probably will mean agreeing on one set of metrics and holding it up as the standard because there are too many choices out there now, particularly in the health plan world.

Bodine: At this point the technology is still in its infancy stage. Most clinicians have higher expectations for their on-line search engine than from their certified electronic health record technology. However, that does not mean that the CEHRT cannot be utilized to track improvement, such as the avoidance of duplicate testing, medication errors and improved interdisciplinary collaboration. These are foundational expectations of a CEHRT that we can all track toward improved outcomes.

Fugazy: What role can technology play in the increased adoption of quality measures – and ultimately in improving outcomes?

Moore: Technology can help to create a supportive environment. For example, natural language processing engines can assist with coding, eliminating the need for surgeons to have to point and click and use pull-down menus which drive them nuts. They really don't want to be doing those things; they want to be doing surgery. Fortunately, organizations can make life so much easier for clinicians with good technology. It's important, however, for the technology, the processes and the workflow to be embedded into a provider's system to make it easy to support quality reporting and performance improvement with the goal of better outcomes for patients.

Steinberg: Process redesign is very important. I struggle with my own organization looking at process re-design activities, we're implementing a new ambulatory EMR. Every healthcare system needs one to redesign care around the new models and it's just, where the rubber hits the road is the difference between strategy and execution.

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Katherine Schneider

Grennan: Process redesign is nothing new. I think where we've gone off the tracks is that the technology integral to many clinical processes has been oversold as being more of solution than it really is. In the physician's office, the effect of a new measure is that the IT folks jury-rig the existing EMR with yet another dropdown screen and this invariably leads to a further impairment in workflow. Truly comprehensive process redesign, in which EMR effectively supports the doctors and nurses caring for patients, is needed.

McGill: We spend a lot of time gearing up and building up to install an EMR, but what we should be doing is changing the workflows. Organizations need to look at workflows and decide how to best register the patient, room the patient, who can enter orders and document care. Then, the technology needs to be designed to support that workflow.

Moore: I have maybe a Pollyannaish take on it but I think technology can play a powerful role in that if it's well-designed and flexible enough to enable better workflow. With technology, there's a capacity for understanding that's beyond human nature. When you think about the oceans of information in healthcare and there's so much chaff to the wheat that we have difficulty first defining what's important and second recognizing how to go after it. For example, a study in Canada that looked at appropriate management of congestive heart failure but researchers couldn't find echo cardiograms in 50% of the patients with CHF, which begs credulity. But then you realize that documentation of the echo cardiograms was dictated in the note and undiscoverable because computers were not able to extract it. Now, however, we're on the cusp of being able to solve some of these problems with artificial intelligence. Consider some of the work that Kaiser Permanente has done. They have an immense analytics shop, in a single instance of their EMR and that have the ability to look within and see with large denominators what's happening and come to conclusions that have terrific scientific validity. That is fascinating to me and it's possible because you're able to extract and glean some conclusions from data.

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