How Consumers Can Choose Quality in Value-Based Health Care

written by Theresa Hush | October 3, 2019

In our last article on how Quality should be reflected in Value-Based Health Care, we looked at the problematic route of quality measurement and reporting. The intent to develop payment for quality has resulted in a complex measurement system that produced provider-specific performance scores across hundreds of measures, yet has failed to advance achievement of better health care outcomes. The system creates flexibility for providers by allowing choice of measures, which eliminates consumers' ability to see differences among providers.

The quality agenda needs to mature. In its developmental period, there was a need to achieve consensus on the standard of care and outcome criteria. Providers were not initially on board with public measurement, so there was a slow, voluntary, and specialty-specific implementation. The idea that fairness required universally applied quality measurement was a common theme, and many early clinical integration efforts focused on all-physician measurement.

Quality Must Be Linked to Consumer Knowledge and Information

If providers should be paid based on Value, however, Quality must be refocused on goals that are calibrated to the central question of Value. That is, can consumers choose health care services wisely if they have the right data on outcomes and cost?

There is a corollary to this question of consumer choice, for every choice of health care services also involves a choice of providers who will deliver such services: Can consumers choose health care providers based on data that shows their specific quality and cost?

Granted, these questions assume that the central focus of Value-Based Health Care should be on the consumer/patient—not just as a beneficiary, but also as a decision-maker. That shift in consumer roles is key to the emerging plan for Quality as part of VBHC, and whether it works to advance care for patients.

Restated CMS Value Goals Give Consumers a Central Role in Quality

A few days ago, CMS released comments that summarized its redefined concepts for Value as four goals, all of which touch on Quality:

> Transform patients into empowered consumers.
> Enable health care providers to be accountable patient navigators of the health system.
> Pay for outcomes and expand payment of episodic payments.
> Prevent disease before it occurs.

A recent development in VBHC is the use of “consumer” language. Consumerism is concerned with shopping and choosing, understanding Value components of Quality and Cost. Even in defining providers as “accountable patient navigators,” CMS is specifying that the provider role is *to help patients choose* based on benefit (quality and outcome) and cost.

The agency further defined how these goals should be reflected in its fact sheets on payment models, with specific reference to the changing role of patients (to be consumers) and providers (to be navigators), emphasizing the need for transparency through interoperability, data, and a revised focus for quality measurement.

Indeed, along with redefining Value, CMS is proposing a major simplification of quality measurement beginning in 2021 with a redraft of MIPS quality measurement to focus on “what matters.” There is no doubt that MIPS has not met its goals. Critics charge that too many quality performance measures make it impossible to compare physicians, all of whom have freedom to choose different quality metrics—a conclusion reached by Medpac, the congressional Medicare Payment Advisory Commission, in 2017. The truth of this is irrefutable.

In addition to significantly reducing the number of quality measures for physicians, CMS has proposed using claims data to evaluate quality, focusing on core primary conditions and major specialty episodes, and reducing burdensome data gathering for clinicians.

Can Consumers Recognize Health Care Quality Now?

It is the rare consumer who is educated and informed enough to make wise health care purchasing decisions. Smart consumer decisions involve more than transparency and interoperability. Consumers must have the ability to determine quality in order to participate in Value—including quality of provider and appropriateness of treatment.

Consumers’ ability to decide treatment options based on Value are limited by medical literacy, coverage, ability to pay, and information from the provider. Few would disagree that the current system is plagued by shortage of face time between physicians and patients, which impacts ability to decide well. Good data on outcomes and costs of treatments is not readily available to consumers if providers don’t supply it. Also unavailable is data that validates provider expertise in achieving outcomes through enough volume and a standard of care.

Physicians cannot be navigators of medical decisions unless they have centralized data to provide to patients. Decision-oriented patient education is rarely provided now, and is, at best, oral.

Thus, our first task in achieving Quality must be to address how to get valid data to consumers. To cite just one high profile example, the failure of the University of North Carolina Children’s Hospital to reveal mortality data about its pediatric heart program, even as staff cardiologists expressed concerns about surgical outcomes, should make us pause to ensure that the basic requirements of adequate volume, public reporting of mortality and other quality outcomes, and patient-reported outcome data contribute to consumers' ability to decide.

If the MIPS program is reduced to a set of core measures, how are patients to determine a particular provider's quality if it falls outside that arena? We must ensure that consumers have the data to see quality and compare outcomes between providers.

Every payment system—including Risk—has incentives to provide or deny care, or to vary the regimen. Under provider risk, we need to ensure that consumers have an independent and neutral source of data to evaluate whether they are being "navigated" inappropriately—along with an appeals process for consumer complaints, which will undoubtedly occur.

Five Essentials of Consumer-Oriented Quality Measurement

For VBHC to empower consumers, Value must embody measurement of consumers' access to care when they need it and their ability to make quality-based choices about treatment and providers. Time, often categorized separately as part of "patient experience," is a quality indicator to consumers. These five essentials should drive consumer-oriented quality measurement in VBHC:

1. Standardized data to determine quality and engagement potential with providers should be available to consumers and patients.

Patients should be able to know basic provider practices prior to committing to care and to see data that reveals accessibility and emergency room usage. Additionally, safeguards under risk payment should be established to ensure that higher risk or older patients are not shunted away from the practice in an attempt to avoid risk. Tops on the list of standardized data that should be available:

- Average time to appointment for established patient;
- Off-hours access for covering provider, yes or no;
- Electronic health record access for patient;
- Patient lab results posted in EHR annually, yes or no;
- Use of EHR for provider-patient communication;
- Patient use of Emergency Room care, Per Member Per Month (PMPM), for primary and medical specialties;
- Patient use of Emergency Room care within two weeks of procedure, Per Episode

(procedural specialists);

Number of patients dismissed or refused care in practice when the practice accepts new patients.

2. Quality of core outcomes should measure improvement over time, rather than absolute values of instance-based intermediate outcomes, for both primary care and medical specialties.

Improvement is an indicator of whether the provider and patient are working together to improve outcomes. This, in turn, is a function of physician-patient communication and decision-making, and commitment to improvement.

3. Specialty episodes should use a standard unit for evaluating specialty procedural and management quality and costs.

For procedures, patient-reported outcomes on functionality at various times from a procedure (e.g., eight weeks, six months, and one and three years from the procedure);

For medical patients, improvement of key outcomes should be measured over time.

4. Clinical data harvested from EMRs should populate outcome measures.

This should be integrated with billing or claims data to identify patient episodes or services. However, quality data should also not be dependent totally on EMR and claims data, but must incorporate measures of physician engagement, communication, and feedback loops from physicians and patients.

5. Core clinical outcomes reporting should form the backbone of quality measurement.

Organizations should be held responsible for internally measuring processes to meet standard of care in primary and specialty medicine:

Core clinical outcomes should include mortality, procedural complications, and repeat procedures, as well as clinical outcomes and patient-reported functionality.

Process measure results should be submitted to a qualified registry or data vendor for validation, in a process similar to audited financial statements.

All core clinical and process measure results should be posted on provider websites and in patient promotional marketing.

The objectives of quality measurement in VBHC, while lessening the burden on physicians, must create Value for the consumer. Outcomes measurement can be streamlined, but still be even more clinically relevant, and can be standardized for comparison of providers. More is needed, however, for ensuring that patients’ access to services and communication with physicians—important indicators of engagement and quality—are part of the quality measurement process.

While the importance of moving to Value-Based Health Care can’t be overstated, modifications to the existing system must be applied gradually, and performance results measured. The reform of quality measurement creates potential risk to consumers and patients by moving away from measurable processes of care, even if unwieldy. This is especially relevant at a time when consumers face an increasingly consolidated health care industry where they bear more cost but have weaker relationships with providers. Replacement measures should be tested and implemented, with consumers playing a key role in the process.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image: Debora Bacheschi