Incorporating Pay for Performance into a Strategic Plan

Current and past P4P initiatives have focused on improving quality and reducing costs—two key factors in gaining a competitive advantage. Therefore, hospital planners should incorporate P4P initiatives into the strategic plan. Strategic planners should routinely monitor their CMS Hospital Compare quality scores to raise them to the level of CMS's P4P incentives. If their scores are already at that level, they should focus on driving them up further to maximize rewards and reimbursement; the higher the quality, the greater the reward. Planners need to allocate money to invest in programs and new technology that will help the hospital increase its quality scores. In areas where quality is poor and unlikely to change, the strategic planner should consider closing the service so that patient safety is not jeopardized and the hospital is less likely to incur malpractice suits.

Mayo Clinic is an outstanding example of an organization that has incorporated P4P into its strategic planning process. It routinely evaluates new business initiatives that could enhance the quality of care it provides. Demonstrating its ability to prepare for the future well in advance, Mayo even benchmarks its quality and efficiency performance against P4P standards that have been developed but are not scheduled to be implemented until several years from now.

Donabedian and Quality

Avedis Donabedian (1966), a physician considered the father of quality assurance in healthcare, defined **quality** as a reflection of the goals and values currently adhered to in the medical care system and the society in which it exists. This definition signifies that no one common criterion exists on which to measure healthcare quality. For this reason, he introduced the **Donabedian framework**, a model for evaluating the quality of medical care based on three criteria: structure, process, and outcomes.

Structure includes the environment in which healthcare is delivered, the instruments and equipment providers use, administrative processes, the qualifications of the medical staff, and the fiscal organization of the institution. Access to care may also be considered part of the structure component.

Process considers how care is delivered. For example, healthcare quality could be evaluated according to the appropriateness and completeness of information obtained through review of a patient's clinical history, physical examinations, and diagnostic tests; the provider's explanation of and reason for her diagnosis and recommended therapy; the physician's technical competence in performing diagnostic and therapeutic procedures, including surgery; evidence of preventive management in health and illness; coordination and continuity of care; and acceptability of the care to the patient (Donabedian 1966). By studying the process indicators of quality, judgments can be made whether medicine was practiced appropriately and addressed the patient's needs.

Outcomes, the most discussed measure of quality, include recovery, restoration of function, and survival. These quality indicators are some of the most frequently reported and widely understood. Other outcome indicators are patient satisfaction, physical disability, and rehabilitation. Although the latter are more complicated to assess, they remain the ultimate validation of healthcare quality (Donabedian 1966).

In 2014, scholars examined whether the VBP performance scoring system correlates with hospital-acquired conditions needing quality improvement (Spaulding, Zhao, and Haley 2014). They reported that while the VBP measures are covering process, structure, and outcomes, these measures do not correlate with an improvement in hospital-acquired conditions. This result could mean that we are not measuring the correct processes, or that the outcome measurements do not reflect the quality we are trying to achieve. Which is more important—promoting an incentive system that lacks a clear indication of the outcomes that health systems should be measuring, or changing the process measures to ensure that the outcomes organizations care about are actually being measured (Spaulding, Zhao, and Haley 2014)? Future healthcare leaders must answer this interesting question.

The three pillars of structure, process, and outcomes need to be addressed collectively to achieve optimum quality of care. As described above, each aspect influences the others. For example, a patient with a broken bone needs access to a qualified physician and an appropriate facility for treatment, and the care he receives should meet preestablished standards. A positive outcome of healing with no complications after treatment is expected but should also be measured. If that outcome is not achieved, then an examination of the structure (qualifications and experience of the physician and facility) and process (were standards followed?) is needed. If any one of these aspects is lacking, the others are negatively affected and optimum quality is not achieved.

Quality
Standard of healthcare provision that reflects the goals and values currently adhered to in the medical care system and the society in which it exists.

Donabedian framework
Model for evaluating the quality of medical care based on three criteria: structure, process, and outcomes.

Defining Quality

No single definition of healthcare quality exists, nor is there a single method of measuring quality in healthcare. Numerous judgments of its meaning, measurement, and value have been made. As a result, quality is difficult to define, measure, and apply in a health services setting. While scholars agree on some of the underlying quality issues in healthcare, they differ dramatically in their ideas about where these issues stem from and how to address them.

Access to healthcare for all Americans is paramount in the quality literature. The ACA was more about access and insurance reform than healthcare reform. Among other concerns, the law addresses having enough physicians for consumers, particularly in rural areas. Before any discussion about quality, physicians and hospital beds must be adequate to people's need for care.

The consumer's ability to choose a physician or care setting is another focal point. The rise of health maintenance organizations (HMOs) in the 1990s, with their limited network plans, left some consumers worried about choice. However, millions of people enroll in high-quality managed care plans such as Kaiser Permanente, which limit customers to physicians employed by these companies. Patients do not complain about a restrictive network when they always have first-rate providers. The ACA insurance exchange program gives consumers choices along a range of plans, from bronze, with a narrow network and lower premiums, and the platinum plan, with a broader network and higher premiums. Some insurance plans could offer narrow networks with poor-quality providers, but healthcare planners need to ensure that Americans receive high-quality care despite choosing a narrow network (Emanuel 2014).

Comparative Outcomes

In the early 1900s, Dr. Ernest Codman, a pioneer surgeon and advocate of healthcare reform, researched healthcare quality by measuring quality outcomes. His *end results theory* advocated measuring patient care to assess hospital efficiency and to identify clinical errors or problems. The American College of Surgeons adopted his theory as a minimum quality standard. On the basis of this theory, the college created the Hospital Standardization Program, which later evolved into the Joint Commission on Accreditation of Healthcare Organizations (now simply The Joint Commission). Codman also believed in public reporting of quality, a concept first taking hold today, a century later. The American Hospital Association also has encouraged providers to establish quality assurance programs to audit outcomes of care. The most comprehensive evaluation of hospital quality today is the CMS Hospital Compare report, which assesses hospital quality performance, measures changes in quality over time, and evaluates the patient experience.

The initial purpose of measuring the quality of healthcare outcomes and processes was to help patients make informed healthcare decisions. While research shows that Americans rate quality as the most important factor when choosing a health plan, studies also show that most do not understand their options well enough to make an informed choice. However, today's consumer is becoming more informed and considers the advantages and risks of recommended treatments. Healthcare organizations must understand, define, and measure quality of care as well as gather data from the patient's perspective for use in patient decision making. While patient satisfaction is not the only indicator of quality care, it is a significant goal. Providers could achieve exemplary clinical outcomes but have negative patient satisfaction scores if they have poor interpersonal skills or lack sensitivity to cultural differences among their patients.

Public and private groups, such as the National Committee for Quality Assurance (NCQA), have developed tools for measuring and reporting healthcare quality. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS; see Highlight 12.3) and the Healthcare Effectiveness Data and Information Set (HEDIS; see Highlight 12.4) are two examples. Many hospitals use HCAHPS to assess patient satisfaction and HEDIS to measure clinical performance in the outpatient setting.

Quality Metrics

Growing Demand for Quality-Related Data

Demand for quantitative data on healthcare quality is growing. P4P programs use these data to recommend quality measures, design financial incentives, and create measurement systems. As with Leapfrog, some payers are using clinical quality measures while negotiating contracts and designing benefits to adjust patient cost sharing and

direct patients toward higher-performing hospitals (Carrier and Cross 2013). Because chronic conditions account for 86 percent of medical costs, payers stress the importance of gathering data on chronic care. They also stress the importance of using quality measures based on peer-reviewed national standards of care. Because analysis of quality data can take more than a year, there may be delays in reporting hospital quality and paying timely P4P bonuses (CDC 2015).

HIGHLIGHT 12.3 Hospital Consumer Assessment of Healthcare Providers and Systems

HCAHPS (typically pronounced "H-Caps") is a survey used to measure patient experiences with healthcare providers. Use of this standardized survey allows patient experiences to be compared with those of other patients across the United States. All patients are asked the same questions, and all results are measured according to the same rating scale. Without a standardized survey, comparisons of quality of care would be inaccurate.

The survey focuses on several areas:

- How well nurses communicated with patients
- How well doctors communicated with patients
- How responsive hospital staff were to patients' needs
- How well caregivers managed patients' pain
- How well caregivers explained patients' medications to them
- How clean and quiet the hospital was
- How well the caregivers gave discharge instructions
- Overall satisfaction rating of their hospital stay

CMS implemented the HCAHPS survey in October 2006, and the first public reporting of HCAHPS results occurred in March 2008. The survey, its methodology, and the results it produces are in the public domain and can be found on the Hospital Compare website. Since July 2007, hospitals receiving Medicare payments must collect and submit HCAHPS data to receive their full annual payment. The ACA requires HCAHPS to be included among the measures used to calculate value-based incentive payments in the VBP program.

However, while reporting requirements and transparency efforts have proliferated over the past 20 years, employers often find it difficult to determine what hospital quality measures are important, how to interpret and use quality information in a meaningful way, and how to present useful information to their consumers (Carrier and Cross 2013). Use of consistent sources with transparency of measurement methods is important in developing a quality improvement plan.

HIGHLIGHT 12.4 Healthcare Effectiveness Data and Information Set

In 1991, NCQA created the HMO Employer Data and Information Set to help measure the quality of care at healthcare institutions. HEDIS has undergone four name changes while maintaining the same acronym; the name was changed to Healthcare Effectiveness Data and Information Set in 2007.

According to NCQA (2014), 90 percent of health plans use HEDIS to monitor quality. HEDIS consists of 81 measures across five domains of care:

1. Effectiveness of care
2. Access to and availability of care
3. Experience of care
4. Utilization and relative resource use
5. Health plan descriptive information

Healthcare institutions are evaluated on how well they perform on the 81 measures. Examples include asthma medication use, persistence of beta-blocker treatment after a heart attack, control of high blood pressure, comprehensive diabetes care, breast cancer screening, antidepressant medication management, childhood and adolescent immunization status, and childhood and adult weight or body mass index assessment (NCQA 2014). NCQA collects the data from healthcare organizations and uses them to calculate national benchmarks and set standards for NCQA accreditation.

HEDIS is used by employers and consumers to compare health plans and identify those most appropriate for their needs. Because the measures reported to HEDIS are specific (all organizations report the same measurements), healthcare organizations across the nation can be easily compared.

As discussed previously, many public reports are using data from CMS's Hospital Compare website (www.hospitalcompare.hhs.gov). This website has a consumer orientation, providing information on how well hospitals provide recommended care to their patients. Hospital Compare allows the public to select up to three hospitals to compare quality measures related to heart attack, heart failure, pneumonia, surgery, and other conditions. These measures are organized by

- patient survey results;
- timely and effective care;
- readmissions, complications, and deaths;
- use of medical imaging;
- linking quality to payment; and
- Medicare volume.

The demand for data has pushed the implementation of electronic health records (EHRs), and meaningful use initiatives have furthered that effort. Hospitals must plan for the resources required to meet these demands. Clinicians will complain that "it's not good enough that I document it; I need to document it someplace where we can capture it for reporting" (Eisenberg et al. 2014). To minimize the burden on clinicians, a combination of clinical knowledge and technological expertise is required to implement manually intensive steps so that hospitals can begin to use EHR-specific quality measures (Amster et al. 2014).

Agency for Healthcare Research and Quality

AHRQ, whose mission is to produce evidence that helps make healthcare safer and higher quality—as well as more accessible, equitable, and affordable—is a division of the US Department of Health and Human Services (HHS). The agency also works with HHS and other industry partners to make sure that the evidence is understood and used (Kronick 2015). Its programs and software are free and publicly available for download on the AHRQ website (www.ahrq.gov). The Inpatient Quality Indicators are part of a set of software modules of AHRQ quality indicators developed by the Stanford University–University of California, San Francisco, Evidence-Based Practice Center and the University of California, Davis, under a contract with AHRQ. The Inpatient Quality Indicators were originally released in 2002. Hospital administrative data related to mortality, utilization, and volume reflect quality of care inside hospitals. AHRQ collects data on inpatient mortality for certain procedures and medical conditions; utilization of procedures for which there are questions of overuse, underuse, and misuse; and volume of procedures for which some evidence suggests that a higher volume of procedures is associated with lower mortality (AHRQ 2015).

Patient Safety

The Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Health System*, published in 1999, described the problems surrounding patient safety. The report listed six aims designed to improve safety. Healthcare must be (1) safe, (2) effective, (3) patient centered, (4) timely, (5) efficient, and (6) equitable. These six aims underscore the fact that healthcare is a service delivered to a patient who is also the customer. While some of the IOM aims (such as safety, effectiveness, and fiscal efficiency of services) can be statistically measured on the basis of mortality and morbidity rates, other factors (such as patient centeredness, timeliness, and equitability) are best evaluated through research and patient satisfaction surveys. The Joint Commission publishes National Patient Safety Goals that it expects hospitals to address when pursuing accreditation (see Highlight 12.5).

Safety Goals that it expects hospitals to address when pursuing accreditation (see Highlight 12.5).

Other Quality Considerations

Workforce

An unintended consequence of an emphasis on quality is a rise in the cost of nursing services and ancillary staff. Studies have shown that patient outcomes improve with increased patient-to-nurse ratios (Spaulding, Zhao, and Haley 2014). Hospitals with poor nurse staffing (more than four patients per nurse) have higher rates of risk-adjusted 30-day mortality and failure to rescue in surgical patients (Wiltse Nicely, Sloane, and Aiken 2012). Each additional patient added to a nurse assignment results in a 7 percent increase in mortality (Aiken et al. 2002). Studies have shown that nursing retention is an important factor in maintaining a skilled nursing staff (Harrison and Ledbetter 2014).

Healthcare is a labor-intensive field. Healthcare organizations require a well-designed infrastructure for supporting nurses and other staff to maximize quality outcomes. But proper staffing may come at a price that is contrary to maintaining a lower expense base. How do healthcare leaders find the balance between quality and appropriate staffing? Research on workforce issues can help organizations determine the number of staff members, mix of expertise, and level of experience necessary to providing optimal care.

HIGHLIGHT 12.5 National Patient Safety Goals, 2015

1. Improve the accuracy of patient identification
2. Improve the effectiveness of communication among caregivers
3. Improve the safety of medication use
4. Reduce the harm associated with clinical alarm systems
5. Reduce the risk of healthcare-associated infections
6. Identify safety risks inherent in the patient population
7. Use the Universal Protocol for preventing wrong-site, wrong-procedure, and wrong-person surgery

Source: Data from The Joint Commission (2014).

Magnet Recognition

The American Nurses Credentialing Center (ANCC) is the sponsor of the Magnet Recognition Program, which recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice (see Highlight 12.6). Studies have shown that organizations that pursue or achieve Magnet recognition have improved patient outcomes, patient satisfaction, and nurse satisfaction. Approximately 7 percent of all hospitals in the United States have achieved ANCC Magnet Recognition status (ANCC 2015). Organizations may consider achieving Magnet status to be a strategic goal in improving **nurse-sensitive patient outcomes**—patient outcomes that improve if there is a greater quantity or better quality of nursing care (e.g., pressure ulcers, falls, intravenous infiltrations).

Nurse-sensitive patient outcomes
Changes in health status that are dependent on nursing interventions.

Patient Engagement

Research suggests that empowering patients to actively process information, to decide how that information personally affects them, and then to act on those decisions is a key driver behind healthcare improvement and cost reduction (Hibbard, Greene, and Overton 2013). A **therapeutic alliance** is a partnership between patient and providers that involves collaboration and negotiation to arrive at mutual goals.

HIGHLIGHT 12.6 Magnet Recognition Program Model Components

- Transformational leadership
- Structural empowerment
- Exemplary professional practice
- New knowledge, innovations, and improvements
- Empirical outcomes

Source: Data from ANCC (2015).

Therapeutic alliance
Partnership between patient and providers that involves collaboration and negotiation to arrive at mutual goals.

Employee Satisfaction

Efforts to create higher employee satisfaction have very desirable outcomes for patients, including increased patient satisfaction, improved care quality, and increased patient loyalty. Satisfied employees contribute to the growth of an organization. Employee satisfaction is measured through in-house surveys that allow employees to communicate concerns, ask questions, or evaluate their employer.

Accreditation

Healthcare quality is also maintained through accreditation, which is a standardized method of ensuring that quality processes are consistent throughout healthcare. Examples of accrediting organizations include The Joint Commission, which accredits acute care hospitals; the American Society of Clinical Pathology, which accredits laboratory systems on the basis of the Clinical Laboratory Improvement Amendments passed by Congress in 1988; and the American College of Surgeons, which accredits trauma centers.

Balanced Scorecards

Most organizations have established a dashboard or scorecard that reflects current quality measures along with financial performance. Balancing the two (hence the *balanced* scorecard) can improve the value frontier of the organization. Moving beyond sharing data at an organizational level to public reporting has raised the stakes in maintaining quality care. Transparency of data has become an expectation for consumers. It may be the most powerful factor in changing the behavior of healthcare providers and caregivers. Public image and competitive spirit can contribute to striving for the best outcomes (Spaulding, Zhao, and Haley 2014).

SUMMARY

Federal healthcare policymakers and state regulators have concerns about the negative impact that reduced reimbursement for healthcare services, low hospital occupancy, and poor efficiency can have on the quality of healthcare. They also recognize that the aging population, the ACA-induced increase in the number of insured patients, and investments in healthcare technology will continue to drive up healthcare costs. By operating in a manner consistent with evolving healthcare policy and the quality standards set forth by value-based purchasing programs, hospitals can receive financial and other rewards (e.g., a reputation for excellence), all of which will place them in a stronger competitive position.

EXERCISES

Review Questions

1. From your own experience as a patient, provide an example of high-value healthcare.
2. Discuss the three pillars of Donabedian's model for healthcare quality assurance. Does this model have practical applications today, given the current focus on healthcare value?
3. What are the roles of the following groups in the healthcare value improvement process: boards of directors, senior leaders, physicians, employees, and payers?
4. Imagine you are a hospital executive and you want to improve your organization's value proposition. What areas do you need to assess to develop an improvement plan?

assess to develop an improvement plan?

Coastal Medical Center Exercise

In Appendixes C and G of the Coastal Medical Center (CMC) comprehensive case study, Hospital Compare data are provided for CMC and its competitors in the local market. How does CMC's quality compare to that of its competitors? List five areas in which CMC's value could be improved.

Coastal Medical Center Questions

1. Should CMC expect to receive a P4P bonus for its quality scores?
2. Should VBP be incorporated into CMC's strategic planning process? Outline a process that will allow CMC to take advantage of future VBP initiatives.
3. What type of organizations should CMC use as benchmarks?
4. How will you know whether the CMC plan to increase healthcare value is a success?

Individual Exercise: Local Community Quality and Patient Satisfaction Comparative Analysis

Access the Hospital Compare database for your community and find the state and national quality standards, then use the data to answer the following questions.

1. Compare three hospital organizations in your community and, based on the information, make recommendations for which hospital you would use for the following service lines: emergency care, cardiac treatment, and surgical procedures.
2. Based on the other quality and outcomes metrics discussed in Chapter 12, list other websites and databases that may provide additional information on the hospital organizations in your community.
3. Based on your analysis, does one particular organization in your community consistently exceed state, national, and local performance metrics? If so, would you recommend this organization to your family and friends?

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