Anexas Consultancy Services

Module 2: Quality Review and Accountability (QRA)

Welcome to Quality Review and Accountability (QRA)

In this module, we'll explore:

- The importance of Quality Review and Accountability to healthcare quality efforts in a healthcare organization
- Quality related organizations: voluntary, mandatory, awards and incentives based
- Assessment of Practitioner Proficiency
- Patient Experience
- Value-based Payment Models
- Implement and evaluate quality initiatives that impact reimbursement.

Role of HQP in transforming health system to business model

The healthcare quality professionals are playing an increasingly central role in transformation of the health system to a business model designed to reward cost efficient, quality care that improves patients outcomes

What is QRA (Quality Risk Assessment)

Healthcare as big business

- Accounts for 17% of nation's Gross Domestic Product (GDP) as of 2022
- HQP plays role in ensuring their organization meets or exceeds the measures for value-based care
- In 2020 medical errors were third leading cause of death in the U.S.

Healthcare waste defined as:

- Failure of care delivery
- Failure of care coordination
- Overtreatment
- Low-value care

Accountability Imperative

- Value-based care
- Public reporting of data (Transparency)
- Pay for performance

Accountability Imperative

Value-based care

- Reward high quality and lower cost through financial incentives and shared savings that can boost an organization's operating margin.
- Principles: shared risk, improved public health, lowered cost.

Public reporting of data (transparency)

- Foundation of transparency.
- Holds stakeholders accountable through publication of quality measure results.
- Quality measures for physicians, hospitals, health systems, and payers.

Pay-for-performance

Strategies adopted by government and private payers.

- Designed to optimize performance and align clinical outcomes with financial incentives.
- Based on performance derived from combination of measures of efficiency and effectiveness.

Specific role of an HQP in QRA

- Quality professionals are a critical asset relative to a contract negotiation.
- Data Driven negotiation.
- Leverage payer and provider data assets
- Ongoing payer/provider communication

Specific role of an HQP in QRA

Quality professionals are a critical asset relative to contract negotiations

- Advises on contracted services measures and data.
- Ensures that data for quality metrics are attainable, meaningful to providers, and appropriate to organization.

Data driven negotiations

- Demonstrate the unique value of data and they are a critical asset relative to contract negotiations for organization and its capacity for improvement.
- Data used to focus on centers of excellence and recent performance improvement success.

Be realistic about impending drivers that could compromise efforts to improve.

Specific role of an HQP in QRA

Leverage payer and provider data assets

- Data rich in claims for millions of bills, physician notes, appointments, procedures, and diagnostic testing.
- Large volume of data aids in the development of benchmarks, research, utilization of services, etc.
- Can provide valuable insights that providers can use to inform, educate, and help change behaviors of physicians and patients.

Ongoing payer/provider communication

- Eliminating gaps in care requires:
- Ongoing communication and coordination among providers to align care across care settings.
- Payers to engage stakeholders in prevention and wellness.
- Increasing a patient's knowledge to manage their own health.

External Quality related organisation

- There are several external quality related organisations that provide frameworks for quality standards and best practices.
- As a healthcare quality professional having a good understanding of these organisations and associated programmes will act as a guide and applying quality standard at your organisation.
- When selecting an organisation or programme to use, make sure that they align with your organisational quality strategic plan and will help your organisation achieve its quality care goals.

Types of external quality related organisation

- Awards
- Voluntary
- Mandatory

Awards or Designation

Awards or Designation

These organisations have programmes that award healthcare organisations that have shown improvement in quality of care or meet a specific set of quality standards as set by the organisations.

Voluntary

Voluntary organisations are recognised as leaders in quality definition and best practices . These organisations are essentials to providing guidance in quality of care benchmarks and standards.

Mandatory

Mandatory organisations are government run. These organisations provide guidance and standards to ensure the safety of both medical staffs and patients .

Organisations that provide award/ designations

NQAP (National Quality Assurance Program)
Baldridge
Magnet Recognition Program

Recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice.

5 criteria components:
- Transformational leadership
- Structural empowerment
- Exemplary professional practice
- New knowledge, innovation, and improvement
- Empirical quality results

Organisations that have voluntary participation

NQF

NAHQ

AHRQ

Leapfrog

IHI

WHO

HMD

Organisations that have mandatory participation

- OSHA –Occupational safety and Health Act
- HIPAA – Health Insurance Portability and Accountability Act
- Skilled Nursing facility quality reporting programme

Evaluating External Quality Programme

- How do you know that which external quality programmes are best for your organisation?
- When looking at each organisation we've discussed earlier, review the programme components and criteria and assess the applicability of the model in your organisation.
- Once you identify the programmes you wish to pursue, put together a team to conduct assessment against the award criteria, looking at your organisation's processes.
- Make a recommendation on whether to use the quality model and whether you are a candidate for the award. You should evaluate
  - Program components
  - Criteria
  - Reputation
  - Track record
  - Relevance to your organizations objectives

Evaluate compliance with internal and external requirements

External evaluation

Provides an assurance that healthcare facilities have quality systems in place.

Level of performance is compared to established standards.

Contributes to:

Quality improvement

Risk mitigation

Patient safety

Improved efficiency and accountability

Sustainability of healthcare system.

Internal and external evaluation

Supports evidence based approach to practice of care delivery.

Inform decisions about the effectiveness of a service and changes to be considered for improved delivery.

Medical management: Clinical practice, guidelines , pathways and outcomes

The concept of medical management includes evidence-based practice, clinical guideline and clinical pathways and also important to recognise as you evaluate compliance with internal and external requirements .

Evidence –based practice

Evidence based practice is the integration of clinical expertise, patient values and the best research evidence into the decision making process.

Clinical guidelines

Clinical guidelines are recommendation for patients care that are derived from a systematic review of evidence as well as the assessment of the benefits and the harms of the alternative care options.

Clinical Pathways

Clinical pathways are used as a multidisciplinary tool. They are based on evidence based practice for specific groups of patients. These clinical pathways are usually specific to that healthcare facility or system .

Value based payment methods

Performance based payment models

Performance based payment models have reshaped the healthcare landscape. With an increased focus on transparency of and accountability for, healthcare quality outcomes, cost and value. It is essential that the healthcare quality professional understand how current and emerging payment methods impact quality improvement processes, outcomes measurements, cost and reimbursements.

The transition for traditional fee for service payment has been fuelled primarily by CMs, launching many programmes that shift payments towards value. As a result the health care system across the country are redesigning their delivery models to embrace value based care and while the scope and pace of change may vary.

Specific role of an HQP in QRA (Quality Risk Assessment)

- Transparency
- Characteristics of value-based payment programs
- Incentives and penalties
- Quality metrics

Specific role of an HQP in QRA

Transparency

Public reporting drives transparency and accountability

Patient-centered care: Patients partner with providers in decisions about their care and treatment.

Better visibility = improved quality with lower cost

Hospital price transparency rule: clear accessible pricing information online.

Characteristics of value-based

Prompts the industry to promote greater accountability for lowering cost, improving population health, and improving patient experience.

Pay-for performance strategies optimize performance and align clinical outcomes with financial incentives.

Value-based reimbursement: high quality + lower cost = $$$

Specific role of an HQP in QRA

Incentives and penalties

Expectations of quality outcomes from government agencies, public reporting groups, accreditation agencies, and third-party payers.

Third-party payers introduced the practice of non-payment for conditions that could have been prevented, formerly never events

Important for quality, safety, and performance improvement initiatives prioritization

Quality metrics

Quality measures used in payment models to determine reimbursement. Organizations evaluated based on specific quality measures.

Plan for acquiring data, structuring measures, and process for reporting

Government payors

CMS (Centre for Medicare and Medicaid Services) testing models to provide financial incentives for quality:

- Quality bonuses
- Discrete episodes of care
- Full capitation - patient centered medical homes
- Integrated Accountable Care Organizations (ACOs)

State Medicaid programs - waivers, managed care contracts

Value based payment programme: Impact on HQP

Quality is on the critical path to profitability

HQP must understand the impact of the quality measures on reimbursement and development of a plan for:

- Acquiring the data
- Structuring the measures
- Establishing a cadence of reporting
- Instilling a sense of urgency around performance improvement
- Contract modeling tools enable detailed analyses at the service line, department, and physician level.
- Strong collaboration between the quality, managed care, and financial leaders.

Alternative payment models : Risk sharing

Upside risk

In upside risk providers share savings with the payers if the cost of care is below the benchmark. If the cost of care exceeds the benchmark, providers will receive none of the shared savings but they are not penalised. Medicare shared saving programme(MSSP) and Accountable Care Organisations(ACOs) are upside risk models .

Downside risk

In downside risk, providers who exceeds the financial benchmark for patient or care episodes must refund the payers for all or a portion of the expense.

Two sided risk

In two sided risk upside and downside risks are combined. Some examples is the comprehensive end stage renal disease care model and the oncology care model.

Accountable care organization

- Accountable Care Organization or ACOs are groups of doctors, hospitals and other health care providers, who come together voluntarily to give coordinated high quality care to the medical patients they serve.
- Coordinated care helps ensure that patients, especially those with enduring and chronic illness, get the right care at the right time with the goal of unnecessary duplication of services and preventing medical errors.
- ACOs use alternative payment model and the provider reimbursements to quality metrices and reductions in the cost of care.

Performance measurement

- Process Variability
- Patient Contribution
- Trends and Patterns
- Performance Measurement
- Waste in healthcare Benchmarks
- Multidimensional analysis Benchmarks

Compare results to state and national benchmarks for insight on:

  - Magnitude of improvement
  - Urgency for change
  - Resources needed

Documentation : CMS quality metrices

- Uses quality measures in quality improvement, pay for reporting, and public reporting.
- Quality measures quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems associated with ability to provide high-quality healthcare and/or relate to one or more quality goals.

Documentation : CMS quality metrices

Goals include effective, safe, efficient, patient- centered, equitable, and timely care.

CMS quality measures will be evaluated based on the documentation of the elements of care. Risk adjustment may not be possible without complete and accurate documentation.

Goals of healthcare quality:

- Safe
- Effective
- Efficient
- Patient-centered
- Equitable
- Timely

The above are the Six Domains of Healthcare Quality

- Definition

Documentation : CMS quality metrices

- The culture of patient safety should be systemic, identifying and mitigating risk as a matter of practice to reduce harm to patients.
- Patients receive treatment to effectively manage their condition based on best available evidence and current best practices.
- Waste in healthcare delivery such as over-use of services, patient flow bottlenecks, and poor supply management result in unnecessary costs to the organization and the consumer.
- Care should be individualized for each patient considering social determinants of care and other factors.
- Appropriate care should be delivered to all regardless of race, ethnicity, language, sexual orientation and gender identity.

Example

Reduce barriers that delay timely treatment, diagnosis, or preventative care.

Measure Example

Perioperative pulmonary embolism or deep vein thrombosis rate.
Fall rates in hospitals or Long-Term Care facilities.
Preventative care measures Readmission rates
Antibiotic use for child earache
% chest X-rays for asthma patients
Patient Experience measures on provider/nurses communication
% Medicaid beneficiaries
Number of referrals
Wait times for an appointment with a provider in their office.
Wait time for behavioral health services.

Documentation : Clinical informatics

- Expertise in clinical documentation is a key success factor in the utilization of Electronics Health Records (EHS) for quality measure reporting.
- Clinical informatics focuses on how data is acquired, structured, stored, processed, retrieved, analyzed, presented and communicated.
- Clinical informatics specialists (or informaticists) understand how data must be structured in such a way that it can be retrieved for reporting and analytics.
- The healthcare quality professional in partnership with clinical informatics optimizes how data are retrieved for accuracy, annual updates for evidence based medicines, code sets and measure logic.

Assessment of practitioners proficiency

Assessment of all levels of practice including physicians, should be done regularly to ensure that quality of care is maintained across departments. This is done to prevent never events and to ensure patient safety.

Focused Professional Practice Evaluation (FPPE)

The purpose of the FPPE is to demonstrate the current competency of the medical practitioner to deliver safe affective care . This is time limited process where the organization evaluates and confirm current competence for all requested privileges and any issues with delivery of care.

FPPE- Six areas of competence

- FPPE looks at six areas of general competencies:
  - Patient care - Are they competent at delivering patient care?
  - Medical or clinical knowledge- do they demonstrate current medical and clinical knowledge related to their specialty?
  - Practice based learning and improvement – do they demonstrate they are growing and improving in their practice?
  - Interpersonal and communication skill- are their communication skills such that it enhances care given and transitions of care?
  - Professionalism- do they demonstrate professionalism in all of their activities?
  - System based practice--- is their delivery of care systems based or siloed care?

Ongoing Professional Practice Evaluation(OPPE)

Key aspects:

Profiles based on performance.

- Profiles provided to each physician or provider on regular basis.
- Organizations may use risk- adjusted software.
- Evidence based practice determines metrices used.
- Data are timely and accurate.
- Profiles are process and outcome focused.
- Physician data are grouped by specialty type specific diagnosis.
- Physician leaders talk directly with medical staff about the data.

Medical Peer review

Definition:

- Evaluation of an episode of care by one's peers to improve the quality of patient care or the use of healthcare resources.
- All providers are assessed during the FPPE and OPPE processes for evaluation of the totality of a clinician's care.
- Medical peer review is an evaluation of an episode of care, such as adverse event or pattern of postoperative complications.
- Confidentiality is critical to ensure integrity of the process.

Effective peer review process

There are a few key things to be aware of in peer review. We look at all input during this process.

Consistent

- Peer review conducted according to defined procedures.
- Each reviews follows the same standards and procedures to ensure integrity.

Defensible

- Clear rationale is provided for all decisions including use of evidence based practice and current clinical standard.

Balanced

- Minority opinions and views of the person being reviewed are considered and recorded.
- The provider being reviewed is stable to provide patient information and their reasoning for actions taken.

Documenting Peer reviews

There are things you must consider as you are documenting Peer reviews.

- First access and circumstances are defined by policies and procedures.
- You will want to know your state requirements for protection.
- Generally they are held as confidential. Contact your legal representative as needed.
- Medical Peer reviews are not part of the credential file and must be stored in a separate file and the software used has the limited access/It is critical to keep peer review information confidential and as protected from discovery as much as possible based on state law. In addition minutes are also usually protected information.

Practitioner Profile and Data

Performance –based method of assessing professional behavior of individual practitioners

- Data from various elements of care of provider's patients.
- Tracks outcomes and manage costs.
- Based on performance and benchmarks and provided to each practitioner on a regular basis.
- Direct interaction between physician and medical staff leadership about results.

Data are meaningful to practitioners and easily accessed.

- Medical staff/ clinical leadership determine metrices
- Data are timely and accurate.
- Risk adjustment algorithms

Quality data for practitioner

There is a portion of practitioner file that contains Quality data. This may include

- Reports of disruption with staff or patients.
- Adherence to best practices, policies and procedures and medical staffs bylaws.
- They must be kept separate for all other files and/or locked according to your state laws for confidentiality because it may be discoverable if located with other files.

Identification of reportable events

Reportable events

- Guided by applicable regulatory and accrediting bodies for an organization (State/local health departments/offices of healthcare quality, accrediting bodies like NCQA, The Joint Commission)
- Comply with the reporting requirements and timelines for follow-up required.
- Make the best use of data and information.
- Look at aggregate data such as infection rates, unscheduled return to surgery.

Sentinel

Sentinel events includes

- A patient safety event (not primarily related to the natural course of the Patient's illness or underlying condition that reaches a patient and result in death.
- Severe harm (Regardless of duration of harm)
- Permanent harm(regardless of severity of harm)

Confidentiality

Confidentiality of Quality and Performance Improvement Activities

List of records to remain confidential:

Committee minutes of:

- Quality
- Safety
- Performance Improvement activities

Maintaining confidentiality of records extends to entire quality, safety, and performance improvement

Patient experience

- Ultimately the one who determines if they have received quality care is the patient.
- To ensure that all the patients are receiving the care they expect and deserve from their healthcare organization, regular surveys should be conducted of patients and their recent hospital and health organization experiences.
- Regular surveys should be conducted of patients and their recent hospital and health organization experiences.

Patient experience

- Patient experience is the full range of interactions with the healthcare system.
- Ultimate goal of patient-centered care begins with understanding of the patient experience.
- Patient perception of care is often measured with survey tools.
- Some patient surveys are used for Pay for Performance.

Performance Measurement

Tools for measuring the Patient Experience

- Hospital CAHPS (Consumer Assessment of Healthcare Providers and Systems)
- CAHPS home and community based services survey
- Emergency Department CAHPS
- Home Health CAHPS

Implement and evaluate quality initiatives that impact reimbursements

- The landscape of quality measure programs associated with value-based care requires diligence on the part of the healthcare quality professional to maintain a current understanding of the programs and how those impact the organization .
- The healthcare quality professional brings unique skills to advise leadership on the costs and the benefits of focusing on quality initiatives that impact reimbursement.

Prioritizing performance improvement initiatives

- **Consideration of external environment**: In planning for and prioritizing performance improvement initiatives, the organization must consider the external environment relative to rewarding or penalizing organization and providers based on specific outcomes.
- **Role of regulatory groups**: We have discussed earlier that regulatory groups such as government agencies, public reporting groups and the third party payers have implemented the use of incentives and penalties to prioritize quality, safety and performance improvement initiatives in healthcare organization.
- **Example of public reporting group like Leapfrog**:The Leapfrog group is one example of public reporting group that uses an incentive system to reward healthcare organizations for superior healthcare practices.

CMS Hospital Readmissions Reduction Program

Aims to encourage hospitals to improve patient care by reducing payment for excess readmissions in six, 30-day, procedure specific, risk-adjusted categories.

Six categories:

- Acute myocardial infarction
- Chronic obstruction pulmonary disease
- Heart failure Pneumonia
- Coronary artery bypass graft surgery
- Elective primary total hip arthroplasty and/or
- Total knee arthroplasty

CMS Hospital Acquired Condition Reduction Program

CMS Hospital Acquired Condition Reduction Program

- Aims at reducing the payment for all Medicare discharges for hospitals in the worst performing quartile for HACS.
- Hospitals with a total HAC score greater than the 75th percentile receive a 1% payment reduction.

Know the audience

- The leaders of most healthcare organizations consist of professionals from multiple disciplines that come together to make decisions.
- HQP has unique perspective because of the multidisciplinary interactions that must occur to gain consensus.
- Decisions often viewed through organizational lens of cost. HQP must have an understanding of healthcare finance.

Build a common vocabulary

- Differences in medical abbreviations and different acronyms may be confusing across the healthcare organizations. Some healthcare organizations prohibit acronym use. Ex: Joint Commission's Do Not Use list .
- A different vocabulary used across financial disciplines can impede the intent and understanding of a conversation.

Reframe positive outcomes

- Positive psychology suggests that viewing events through a positive lens and focusing on best practices will improve overall business outcomes.
- Guide your team to keep a positive focus on patient care toward improving business outcomes

Storytelling

- Narrative medicine uses a patient-centered approach to understanding various areas of the patient experience
- Role of HQP is to present a collective patient story and motivate multiple stakeholders to take an action that improves the value of care provided.

Foundation for improving healthcare quality.

- Role of HQP is to find and tell the story in a way that is meaningful to stakeholders and decision makers.

Congratulations!

You've completed the module on Quality Review and Accountability.

- We discussed what Quality Review and Accountability entails and it's importance to health organizations and maintaining quality of care.
- We explored the different healthcare quality organizations that are voluntary, mandatory, and those that provide awards to organizations that provide exceptional care. We explored how to apply the standards, best practices and other information from the quality-related organizations discussed.
- We discussed various value-based payment programs such as Quality-based Payment Programs, Alternate Payment Programs, and Accountable Care Organizations (ACOs). We also looked at the impact that Value-based payment programs have on the Health Quality Professional.
- We discussed how to evaluate compliance with internal and external requirements to ensure that your organization is providing the best quality of care. We discussed the importance of evaluating the performance of physicians and other staff to ensure that best practices are being provided and unnecessary mistakes are being minimized.
- Finally, we looked at how to evaluate and implement quality initiatives that impact reimbursement and what factors play a part of medical reimbursement.