When quality metrics don't actually drive quality

By Gale Pryor | May 30, 2017

In a freewheeling conversation about healthcare leadership through a time of unprecedented volatility, 18 health system executives discovered a common dilemma. They're required to measure quality, but the standards they use — driven by payers and regulation — often don't reflect the care that actually drives outcomes.

That gulf between reporting and reality was a focus of the roundtable discussion, held at athenahealth on May 16 and led by Harvard Business School Professor Nancy Koehn. The participants, chief executives who steer everything from 1000-physician acute-care hospitals to regional ACOs, are all in the process of navigating their organizations from volume to value.

Most agreed that the metrics required for reimbursement — and widely accepted as benchmarks for performance — provide useful guidance and differentiation for patients, referral sources, and prospective employees.

Still, those metrics, said one executive in the room, "are not how any of us would define quality."

Quality measurement, as it's usually defined, suffers from a few big problems, says Jessica Sweeney-Platt, executive director of research at athenahealth. It's overweighted on process metrics such as documentation of screenings and tests, she says, because "outcomes metrics are hard to define and even harder to track in our fragmented information system."

Complexity is another challenge, Sweeney-Platt says; providers often have to choose from lists of hundreds of metrics for quality reporting. And those metrics often don't reflect the basis for most patient decisions.

"While healthcare organizations laser in on mammography rates and blood pressure control," she says, "patients make their decisions — at least for primary care — on the basis of service, access and convenience."

The patient's definition

Citing their own internal patient surveys, many roundtable participants concurred that patients don't define quality through standard measurements. Most assume their providers' clinical skills are excellent — and they don't have access to data that would tell them otherwise, anyway.

Other aspects of care, therefore, shape patients' perceptions of quality: How is the food served by the hospital? Is parking close to the entrance? Does every provider they encounter know their names and stories? Were their doctors and nurses kind to them?

Those perceptions, the executives said, drove patients' willingness to stay engaged in their care. But engagement also depends on patients' ability to navigate all of the other challenges in their lives.

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The leaders in the room shared innovative, even unorthodox, investments they are making to address the social determinants of health — and achieve better outcomes. They embed mental health providers in primary care practices via telehealth. They buy refrigerated trucks to deliver food to patients and air conditioners for asthma patients with repeated ED visits. They offer patients rides to appointments and allow providers to make home visits.

"It takes us less time to drive to visit a geriatric patient in our ZIP code than it does for that patient to undress in an exam room," said one.

But these initiatives are rarely reimbursable. As one participant said, "quality cannibalizes revenues."

The value of culture

That's where leadership comes in, said Koehn, the author of "Forged in Crisis: The Power of Courageous Leadership in Turbulent Times."

Healthcare leaders, responsible for their organizations' financial and clinical success, must decide how to employ their resources — and connect their vision, culture, and operations — to achieve their own definition of quality, while simultaneously meeting the quality requirements of payers and regulators.

One way to drive quality, executives said, is to focus on the work of nurses and staff — who are at the core of the patient experience in hospitals, and the most powerful driver of patients' perceptions of quality care.

"Nurses are the key in my organization," said one participant, "and, also, where I have the lowest engagement and most struggles."

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So a leader's job, Koehn said, is to develop a culture that engages those frontline workers, and drives an organization toward delivering empathy as well as physical care.

"People are thirsty for organizations that lift them," Koehn said. "Yet we treat culture as a soft asset, so we slightly depreciate it."

Making the link between patient experience, patient retention, and quality metrics is just as important for physicians, the healthcare executives agreed. One primary care physician, who leads a physician organization, defined quality as retention: If a patient hugs him at the end of a visit, "I've retained a revenue source for my system."

Other participants noted that quality is driven by operations: Ensuring that patients have a consistent, reliable experience whenever they return for care.

To driv both operations and culture, Koehn said, healthcare leaders need to promulgate a clear, compelling vision. One executive offered a model vision statement: "World class care by people who care about you."

The revenue dilemma

While the prospect of a quality-based healthcare system is inspiring, many executives said, the rush to reach it is risky. Participants acknowledged the challenges of shifting an organization that's steeped in an old system, dependent on fee-for-service revenue — and largely at the mercy of payers who set reimbursement standards.

So any shift in healthcare standards, participants said, must be weighed against the bills to be paid

and the lives to be saved today. Said one leader in the room: "We are driven by the tyranny of the urgent."

The big challenge for healthcare in the future, Sweeney-Platt agrees, is to move beyond a concept of quality that begins and ends with individual metric sets.

Decades of research into service-intensive industries, she says, suggests that true quality is a function of interconnected capabilities that focus on providing staff members with the tools, resources, information, and latitude they require to do their jobs at the top of their abilities.

In healthcare, she says, that means boosting the capability of physicians, clinical workers, and staff — "ensuring that providers have what they need to deliver the care that their patients need and expect" — and expecting that patient loyalty and engagement will follow.

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