



Pairing Cost and Quality to Assess Value

Why is Quality Important?

The RAND study evaluates the prices paid by private health plans to hospitals in comparison to the amount Medicare pays for the same services. While a critical factor in determining the value of care, information about prices alone is inadequate; inexpensive care delivered ineffectively can be both dangerous and wasteful. The highest value health care is both high-quality and lower cost.

For a full picture of value, quality data must be presented alongside or integrated with cost data. However, quality is less precise and more difficult to measure than prices or cost. An industry has emerged that evaluates the quality of care delivered by health care providers, primarily hospitals, but also in the outpatient setting and at the physician level. These evaluations are designed to help providers improve the quality of care they deliver and make informed referrals for their patients, to help patients choose a provider, and to help employers and other health care purchasers and payers design provider networks, health care benefits and other strategies.

There are multiple measures and sources of information that claim authority on how well health care providers perform on quality measures. The federal government measures and reports quality for the Medicare program. Several states measure the quality of care, a small subset of which report results on public websites. Private nonprofit and for-profit organizations also measure (and sometimes report) the quality of care in different ways.

Which quality measures should you examine?

Health care “quality” is challenging to define because it encompasses so many dimensions of the care delivery system in an effort to determine whether a patient was treated with the highest standards of care. There are literally hundreds of published quality measures; however, most fall into a handful of categories:

- **Safety measures** evaluate adherence to established safety practices and outcomes such as rates of hospital-acquired infections and injuries.
- **Timeliness measures** gauge how quickly patients receive necessary care, such as emergency department wait times.
- **“Appropriateness” measures** examine whether the patient was properly treated, as opposed to over- or under-treated, and whether the patient received necessary screenings, immunizations or counseling.
- **Outcomes measures** assess how well the patient fares following care, including rates of complications, readmissions and mortality from specific conditions or procedures.
- **Patient satisfaction and patient experience measures** ask the patient about their experience during treatment from a customer satisfaction and a quality of care perspective.

Finally, quality measures should also be examined for **equity across populations**, ensuring that care does not vary because of personal characteristics other than health status, such as gender, race, geography, etc.

All the dimensions of quality are important, but the sheer volume of nationally-recognized measures can leave purchasers struggling to determine which matter most when it comes to identifying which providers deliver better care and better value for the health care dollar. Purchasers need to know the performance of health care providers on quality measures to make value-oriented choices in the design of provider networks and benefits, to hold providers accountable for their performance through financial incentives, and to determine if innovations in health care delivery and payment are working.



The fact is, the measures that matter depend on the purpose for which they are being deployed. Each stakeholder – employers and other health care purchasers, patients, providers, health plans - may gravitate toward different measures based on their priorities or needs. Health care performance measurement serves multiple purposes, including:

- Highlighting opportunities for **improvement** and tracking progress over time;
- Supporting value-based **payment** models that reward health care providers that deliver high quality care and/or reduce costs;
- **Informing decisions** made by consumers and purchasers about which providers deliver the highest value and where to seek care, promoting provider competition on value; and
- Policy maker **design, monitoring, and evaluation** of payment and delivery reform programs to maximize the intended effects and minimize potential unintended effects, such as limitations on access to care.

The following resources are designed to help employers evaluate which measures offer the most reliable and meaningful information on care quality, according to the end-user's goals and purpose:

- CPR Quality Measures that Matter Webinar recording ([link](#)) and Action Brief ([link](#))
- Buying Value Measure Selection Tool ([link](#))- a suite of tools intended to assist state agencies, private purchasers and other stakeholders in creating health care quality measure sets.

What are the sources of quality information?

Many vendors offer quality scorecards that benchmark hospitals against each other, and mark their year over year improvement. All rating systems aim to quantify hospital safety and quality, and most examine complication, mortality and readmission rates. However, vendors weight and evaluate different factors; no two are alike. Several quality scoring systems make their rankings and methodologies free and patient-facing, while others are only available for purchase. Rating systems also differ in their scope – some only evaluate whole hospitals, while others also evaluate hospitals on specific conditions and procedures, such as joint replacement or cancer care. Additionally, some rank all hospitals in one list, while others stratify into multiple ranked lists based on hospital size, teaching status, specialty, or urban versus rural location.

Among the free, patient-facing reports are those from The Leapfrog Group, US News & World Reports, Healthgrades Top Hospitals, and the Centers for Medicare & Medicaid Services (CMS) Star Rating system. CMS creates displays care appropriateness measures, mortality, complication and readmission rates for specific conditions, and patient experience. The Leapfrog Group generates two scores for each hospital – one for safety and one for outcomes. Leapfrog's safety data is largely self-reported. Leapfrog stratifies hospital outcomes by hospital type, allowing a more accurate comparison of peer hospitals. Healthgrades is notable for its procedure- and condition-specific granularity, as it assesses outcomes for many procedures that other raters do not. However, Healthgrades uses outcome measures alone, which may paint an incomplete picture of quality. US News & World Reports has a more comprehensive set of process, quality and patient experience measures, which are updated frequently, along with its methodology. Uniquely, US News also includes a "reputation score" in its ranking, asking physicians where they would be comfortable sending challenging cases. CMS, Healthgrades and The Leapfrog Group use Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) as a component of their outcomes reporting. PSIs were created for internal progress measurement and not for between-hospital comparisons thus their use in rating systems has recently fallen out of favor. Free ratings are generally not risk-adjusted. Rating systems for purchase tend to use different measures or methodologies that distinguish them from their free counterparts.