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Reflections on Governance Oversight of Ambulatory and Outpatient Quality and Safety

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Next year will be the 25th anniversary of the Institute of Medicine's report, *To Err is Human* that launched the "modern" hospital quality and safety movement.

While there remains plenty of opportunity for improving governance processes for quality and safety oversight, hospitals and their boards have come a long way since the IOM report. In the early 2000s, a multi-hospital system asked me to present to each of their local hospital boards and leadership on governance responsibility for quality oversight. At the time, it was a relatively new idea. One can argue that the first systematic efforts to improve healthcare quality and performance began with Florence Nightingale's efforts in the 1850s to improve surgical care during the Crimean War. Abraham Flexner's 1910 report on medical education in the United States transformed how physicians were trained and licensed. The IOM report was not the first and will not be the last to push for safer and more effective care. How we think about the governance of quality and patient safety will continue to evolve.

Since the IOM report, quality and safety monitoring by community hospitals and health system boards has become a routine part of the governance process—routine in the same sense that board review of financial reports is routine. Both are critical governance processes and it can be argued that the definition of fiduciary responsibility has expanded to include quality and safety performance. Like finance committees, most governing boards now have standing quality committees that review quality and safety reports in detail and report a summary to the full board. While we are not at the same level of standardized formatting and reporting as hospital financial data, quality data and reporting is evolving in that direction. Value-based and pay-for-performance payment systems

depend on quality and performance data to determine payment. It is reasonable to expect that as value-based payment systems become the standard, there will be an increase in quality auditing to verify the quality data on which payment is based. Just as external financial auditing and Medicare cost reporting shaped healthcare accounting policy and pushed standardized hospital financial reporting, increased "quality auditing" will likely accelerate the standardization of quality data collection and ultimately standardize reporting formats.

While the selected measures and emphasis vary from hospital to hospital, governance oversight of quality and safety is largely based on quality and process measures collected and reported to CMS. Most boards also routinely review measures that link to financial reimbursement (like readmission rates) and patient safety and sentinel event reporting that conforms to Joint Commission standards. Governance quality scorecards and reports also routinely include measures of patient satisfaction and/or experience, infection control, employee engagement, health equity, population health, and care access (wait times). Even though approximately 80 percent of a typical community hospital's total patient encounters are "outpatient," meaning patient visits to clinics and ambulatory services, insight into the quality and safety of ambulatory care is limited.

Quality Reporting in the Outpatient Setting

There are valid reasons why outpatient quality measurement and safety monitoring and reporting lag the inpatient setting. **First, inpatient hospital care is generally more complex and intensive than ambulatory or physician office care and thus a potentially greater risk for patients and staff.** Where there is similar risk—like same-day surgery or outpatient cancer infusion therapy—hospitals tend to extend the same patient safety practices and policies regardless of setting. Examples include surgical time-outs in same-day surgery facilities, dual medication/pharmacy verification processes, patient risk assessments and fall prevention, central line protocols, and infection prevention procedures. Board review of safety and quality metrics associated with complex services generally meets the intent of governance oversight and monitoring regardless of location or inpatient/outpatient status. However, where the perceived risk for immediate patient harm is low, monitoring of quality and safety performance is generally less intense.

I use a simple story when teaching high-reliability concepts: "The Navy can safely and reliably land a plane on an aircraft carrier in a storm but has great difficulty reliably delivering the mail." My apologies to the Navy mail handlers, but the same is true in healthcare—where there is perceived potential major or immediate harm, we set up safeguards to prevent and or mitigate harm if it does occur and we can reliably measure and report on those processes. But when the risk is perceived to be low, not so much.

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We also tend to view some forms of harm in the ambulatory setting—like falls—through the lens of premises and property risk and liability rather than viewing a fall as a failure in patient care. When patient harm related to care does occur, it is generally delayed in onset and may not be transparent. By example, a patient that suffers an infection, catches a communicable disease, or perhaps experiences an adverse drug event after an outpatient visit is less likely to be visible to the hospital and unlikely to be noted and reported within the hospital data system unless the patient requires additional care to mitigate the harm. Thus, many patient safety or harm events that originate in an outpatient or clinic setting are never visible to the provider or the health system and cannot be easily captured by existing monitoring systems.

Second, most hospitals do not have dedicated infrastructure and resources to collect and monitor outpatient quality and safety measures because most outpatient measures are not reported to CMS or to other external regulators. External reporting is a driver of increased infrastructure and if a hospital does not have to report, it is unlikely to make the investment in infrastructure. There are exceptions of course. The CMS hospital dataset does include a few ambulatory measures; some Medicare and Medicaid payment programs as well as some insurers may require reporting of certain physician care and process measures as part of a value or pay-for-performance payment system. The lack of quality reporting infrastructure may also be related to the fact that hospitals and health systems are relatively new to the game of employing physicians and operating physician practices. Forty years ago, direct physician employment was rare outside of academic and public hospitals. Today, over 70 percent of physicians in the U.S. are employed directly or indirectly by hospitals and health systems. Hospitals must now deal with physician performance issues—whether ethical, operational, or clinical—as part of the employment agreement. Most hospitals are still playing catch up on the infrastructure and specific management skills required to effectively and efficiently operate physician clinics.

Most board members and hospital leaders are surprised to learn that outpatient quality measures largely predate most hospital inpatient quality and safety measures thanks to the expansion of HMOs and managed care plans in the 1980s. In the early 1990s in response to the explosive growth of HMOs and to refute a popular myth that HMO plans and their employed physicians provided low-quality care, the NCQA[1] was established and created a dataset known as HEDIS (Health Effectiveness Data and Information Set) to monitor and provide transparency to employers and consumers on HMO and health plan performance. As hospitals are required to submit the hospital dataset to CMS as a condition of participation in Medicare, health plans and insurers have a similar incentive

1 National Committee for Quality Assurance is a 501c3 organization established in the early 1990s to improve care provided by physicians and through managed care organizations. It developed the HEDIS data set as well as accreditation programs for HMOs and physician practices.

to collect and report HEDIS measures to CMS if they want to offer Medicare Advantage plans. Other than to meet a managed care contractual obligation, hospitals and health systems generally do not collect, monitor, or report HEDIS measures and data unless the data is required for a pay-for-performance or value-based payment system. Even then, such measures are not generally included in quality reports to the board unless they are linked to some specific improvement effort.

Improving Governance Quality Oversight for Outpatient Care

The question remains how leadership and governing boards should oversee quality and safety for the 80 percent of hospital business that is outpatient. I think there are two paths that should be pursued simultaneously.

The first path is continuing to expand traditional hospital inpatient quality and safety performance measurement and reporting to all settings where complex care is delivered. That means that the surgical care performance and process quality measures collected in the inpatient setting should also be collected in the ambulatory surgery setting. Infusion centers, freestanding emergency departments, GI centers, invasive diagnostic imaging facilities, and chemotherapy centers—anywhere complex care is provided—are all candidates for requiring the same quality and safety performance standards and reporting that exist in the inpatient hospital setting. Reporting and monitoring of performance should be based on type of care delivered instead of setting or patient classification. I think most hospitals and boards are already moving in this direction.

Some advocate expanding the HEDIS measures and reporting system. I do not believe that is the correct strategy for most hospitals—too much detail without context. Under current payment systems, it is unlikely that the value of the HEDIS information exceeds the cost of collecting and reporting. But, if hospitals move to capitated payment systems and become at risk for the volume of care delivered as well as the quality of care, then the value equation shifts and the collection of HEDIS measures will be required—just as they are required today for Medicare Advantage plans. However, even in the capitated risk scenario, I do not think we should reflexively report HEDIS measures to the board. More measures do not mean better governance.

Instead, I propose a second path. Governance of outpatient and clinic quality requires a shift in focus away from process measures to a focus on desired outcomes. In my view, there are four outcome questions governing boards should ask about quality and performance in the ambulatory and clinic setting:

1. **Patient satisfaction:** What percentage of patients "would recommend"?
2. **Quality performance:** What percentage of the eligible providers we employ received the maximum quality or pay-for-performance bonus in the last cycle?
3. **Access:** What percentage of patients were scheduled within a specified standard for that practice or service? (appointment availability)
4. **Clinical effectiveness:** What percentage of patients received the right care? (care according to guidelines and standards)

Key Board Takeaways

- Continue to expand traditional hospital inpatient quality and safety performance measurement and reporting to all settings where complex care is delivered.
- Shift the focus away from process measures to desired outcomes. Outcome questions that governing boards should ask about quality and performance in the ambulatory and clinic setting include:
  - What percentage of patients "would recommend"?
  - What percentage of the eligible providers we employ received the maximum quality or pay-for-performance bonus in the last cycle?
  - What percentage of patients were scheduled within a specified standard for that practice or service? (appointment availability)
  - What percentage of patients received the right care? (care according to guidelines and standards)
  - How productive is the service or practice compared to standards or expectations?
  - What percentage of providers in our clinics utilize MyChart (or other EHR applications) to communicate with patients?
  - Is performance in our outpatient and ambulatory services equitable across the patient populations we serve?

Patient satisfaction is an obvious dimension for governance review and not difficult to collect. Boards should want their employed providers to maximize their possible compensation and measuring the percentage of providers who receive the maximum quality bonus is a proxy for quality program participation. A scheduling metric or standard helps to set expectations about access. Finally, a measure of "right care" for selected

cohorts of patients (like diabetic patients) is foundational. As a board member, I don't want to know how many diabetic patients received foot or eye exams—I want to know the outcomes like the percentage of diabetic patients who achieve and maintain A1c levels below a specified target. Right care can be defined as an outcome such as A1c levels or by the effective deployment of standardized elements of care or a "care bundle." Boards do not need to know the individual elements and details—instead they need to know what percentage of patients received the "right care" as defined by *all* the elements of care in the care protocol or bundle.

There are three additional questions that might be useful in the governance review of outpatient and clinic quality:

- How productive is the service or practice compared to standards or expectations? In doing my research for this article, I spoke to several colleagues around the country and reviewed the ambulatory measures collected by their organizations. One colleague who leads the physician enterprise for his health system noted that there is a correlation between productivity and performance across other quality dimensions like satisfaction and clinical quality. He noted that when there is poor physician efficiency, all other measures tend to be low and when productivity is high, performance across other dimensions tends to also be high.
- What percentage of providers in our clinics utilize MyChart (or other EHR applications) to communicate with patients? After investing untold millions in EHR technology, this question is linked to his organization's strategies to increase patient access and communication. I suspect that many other boards might be interested in whether their investments in technology have led to increased patient access, satisfaction, and quality.
- Is performance in our outpatient and ambulatory services equitable across the patient populations we serve? Just as in inpatient care, boards need to look at the outpatient data stratified by race, ethnicity, income, and zip code to ensure that care is equitable and disparities in care are addressed.

The Governance Institute thanks Michael D. Pugh, M.P.H., President, MdP Associates, LLC, for contributing this article. He can be reached at michael@mdpassociates.com. Michael would also like to thank his colleagues who contributed and shared their insights into governance and the measurement of quality performance in an outpatient setting: Maulik Joshi, Dr.P.H., President and CEO, Meritus Health; Mitchell Schwartz, M.D., Chief Physician Executive, Luminis Health; and Jodi Vanderpool, Vice President of Quality Operations, St. Lukes Health System.