Welcome to APTA’s podcast series on value-based care, which explains how value is measured in the provision of health care, and describes different aspects of the Quality Payment Program, including the Merit-based Incentive Program, or MIPS, and Advanced Alternative Payment Models, or Advanced APMs. Episode 3 is Why Do We Need Quality Measures? To get the most from this episode, you may want to check out earlier episodes first.

I’m Heather Smith, APTA’s Director of Quality.

The health care system is moving from volume-based payment to value-based payment. One of the components of the value equation is quality, and measuring quality is a critical part of assessing value. Quality measures can help physical therapists understand the quality of the care they deliver, and they also can help payers and other providers understand the value of physical therapy across the care continuum.

The Centers for Medicare and Medicaid Services defines quality measures as tools that help measure or quantify health care processes, outcomes, patient perceptions, and organizational structure that are associated with the ability to provide high-quality health care. While the ultimate measure of value is the outcome of care, measuring other aspects of quality are important in examining and ensuring that the best outcomes are achieved.

Four types of quality measures are used in health care: Process, Structural, Patient Experience or Perception, and Outcome. Let’s take a closer look at them.

First, process measures assess the health care services being provided. Often, process measures look at adherence to recommendations for clinical practice based on evidence. For this reason, process measures are sometimes referred to as check-box measures, as the measure simply assesses whether or not the clinician did the activity.

An example of a process measure is the pain assessment and follow-up measure that PTs reported in the former PQRS, which is now part of the MIPS program. This measure determines if the PT has documented that he or she made a clinical assessment for the presence or absence of pain using a standardized tool. This measure is supported by evidence-based best practice.

Process measures are incredibly useful in encouraging change within clinical practice. For example, a national analysis of Medicare functional limitation data shows that only one-third of all cases include functional limitation data at evaluation and discharge. Because complete functional data is necessary to determine functional change for the episode of care, we want to increase compliance with functional data collection. APTA is developing a quality measure that looks at the percentage of episodes that include completed functional data in the documentation to improve the compliance rate in functional data collection.

Second, structural measures look at a feature of a health care organization or clinician relevant to its capacity to provide health care. Although structural measures are not commonly included in quality-reporting programs, they are frequently used by facilities or organizations. And because they look at the features of an organization or facility, their measures may be different, depending on the entity being measured. An example of a structural measure is the ratio of providers to patients.
Third, measures of patient perception are reports from patients about their observations of and participation in health care. This is an important measure, since value in health care should be focused on the customer. A classic example of this type of measure is a patient satisfaction survey, also categorized as patient-reported outcome measures. This is 1 reason patient-reported outcome measures are gaining attention at the national level in the shift to value-based payment.

Fourth are outcome measures. Outcome measures examine a patient’s state of health resulting from care. Because they often reflect the impact of multiple interventions provided by an entire care team, as well as the cumulative impact of multiple processes of care, these measures may be complex. They can look at intermediate outcomes that occur at certain time points in care or over a longer period of time. Because the underlying health status varies between patients being treated for the same condition, outcome measures must be risk-adjusted to ensure that patients with different risk factors are compared accurately on a measure. For instance, in looking at the outcomes for 2 total knee replacement patients—one patient without comorbidities, the other with congestive heart failure, morbid obesity, and uncontrolled diabetes—the outcomes may look different, as the patients are different. Risk adjustment is critical to ensure that providers who may have more-complex patients are accurately compared with those who have less-complex patients.

APTA is developing physical therapy-based outcome measures that will help the profession demonstrate its contribution to overall care. Such physical therapy quality measures are critical to demonstrating the value physical therapists bring to the health care system, and they are necessary to successfully move to value-based payment.

The APTA Physical Therapy Outcomes Registry will play a huge role in quality measure development for PTs. One of the primary goals of the registry is to demonstrate the value of physical therapist services throughout the lifespan and across all settings.

The registry can assist PTs using quality measures to improve clinical practice and demonstrate their value. As we move rapidly into a value-based payment system, tools like the registry will be critical to our success.

This has been Episode 3 of the podcast series on value-based care. To find all episodes of this series, go to www.apta.org/MACRA/. You also can find these and all APTA podcasts on iTunes by searching APTA Podcasts or by going to www.apta.org/Podcasts. Thanks for listening.

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