**Clinician Perspectives’ of Quality Measures in Varied Health Care Systems**

**Quality Measurement Enhancement Project (QMEP)**

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**Abstract**

*Background* The current system of measuring healthcare quality in Minnesota has evolved over time, from the early days of the Buyers’ Club, to Minnesota Community Measures (MNCOM), to our current situation where the state legislature wants to use quality measures to reimburse clinics, in its effort to “pay for performance”. In spring 2017, the state legislature tasked MN Department of Health to create a framework for quality processes. One useful step in this process is to elicit primary care clinicians’ perspectives, experiences and insights into the current approach of clinical quality measures (QMs) and into an improved future system.

*Overall Research Objective*

Identify primary care clinicians’ perspectives about factors that influence quality healthcare measures when they work in safety net clinics (SNCs) compared to when they work in non-safety net clinics (NSNCs), and their perspectives about improving the current quality metric system.

*Qualitative Research Methods and Analysis*

Qualitative methods of 4 key informant interviews and 3 focus groups with 10 primary care clinicians who had worked at both safety net and non-safety net primary care clinics. Two researchers (KACP and MST or KACP and LMO) interviewed each key informant for 1.5 hours, and led 2-hour focus group discussions following an open-ended questionnaire guide. The audiotaped interviews and focus groups were transcribed, coded, and summarized by the 3 interviewers. Subsequently, the full research team reviewed the codes and the summaries, identified the main themes, created an overall analysis, and wrote the results.

*Results*Four major themes emerged

#1: Current QM scores are influenced more by patients and clinic systems than by clinicians

#2: Collecting data about QMs is not the same as measuring quality healthcare

#3: Current QMs are not how patients define quality healthcare

#4: Future QMs need to consider patients’ health goals and systems must not be punitive

*Conclusion*Primary care clinicians who have worked both in SNCs and NSNCs assess that the current system does not truly measure quality health care and does not fairly represent which clinics provide superior care. Rather, it publicly elevates high resource clinics that have created systems to prioritize what is measured and whose patients have low burden of social-structural determinants over low-resource clinics that have fewer resources to focus on just those things that are measured and whose patients have high burden of social-structural determinants of health. Overall, the current QMs are tied to social inequities; they are based on inequitable research, are chosen by inequitable processes, and mix results with societal inequities. Aligning payment with these measures ensures continued inequities. If payment is going to be aligned with performance, a new comprehensive approach to measuring quality needs to be designed that measures quality healthcare, and is equitable and fair.

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**Research Methods**

**Overall Research Objective**

Identify primary care clinicians’ perspectives about factors that influence their quality health measurements when they work in safety net clinics (SNCs) compared to when they work in non-safety net clinics (NSNCs), and their perspectives about improving the current quality metric system.

**Specific Research Aims**

1. Identify primary care clinicians’ assessmentsof differences in their quality measure scores at different clinic systems, including to what extent patient factors, clinic factors, and clinician factors contribute to different quality scores.
2. Identify primary clinicians’ perspectives on existing clinic quality measures, including influence on medical care and their health care decisions for patients.
3. Identify primary care clinicians’ thoughts about patients’ perspectives, including how patients would define and measure quality health care.
4. Identify primary care clinicians’ assessmentsof an improved quality measuring process, including what measures could accurately measure their quality.

**Qualitative Methods**

Qualitative methods included in-depth face-to-face key informant (KI) interviews with 4 family physician and focus group (FG) discussions with 10 primary care clinicians. All 14 primary care participants had worked at both safety net and non-safety net primary care clinics. Two researchers (KACP and MST or KACP and LMO) interviewed each key informant for 1.5 hours, and led 2-hour focus group discussions following an open-ended questionnaire guide (Appendix #1). In addition, each participant completed a demographic questionnaire (Appendix #2).

**Analysis**

The audiotaped key informant interviews and focus groups were transcribed verbatim. The 3 interviewers (KACP, MST, LMO) agreed upon a coding tree created from the structure of the interview questions, and then used the coding tree to code each transcript, and write summaries of the main parent nodes. One interviewer (KACP) reviewed all of the codes for all the transcripts, and placed the summaries onto a spreadsheet. Then the five researcher team members (3 interviewers joined by SLP and LSO) read the transcripts, reviewed the codes and the summaries, identified the main themes corresponding to each research objective, created an overall analysis, and wrote the results.

The 14 interviewees were:

* 9 women and 5 men
* 10 European-Americans, 2 African Americans, 1 Asian-American, 1 Latino-American
* 11 family physicians, 2 adult nurse practitioners, 1 internal medicine physician
* All had worked in both SNCs and NSNCs
5 moved from NSNCs to one or more SNCs
5 moved from SNCs to one or more NSNCs
2 moved from SNCs to NSNCs to SNCs

1 moved back and forth between SNCs and NSNCs

**Results:**

Four major themes emerged from the discussions about the four research aims.

*#1: Current QM scores are influenced more by patients and clinic systems than by clinicians*

*#2: Collecting data about QMs is not the same as measuring quality healthcare*

*#3: Current QMs are not how patients define quality healthcare*

*#4: Future QMs need to consider patients’ health goals and systems must not be punitive*

**Theme #1: Current QM scores are influenced more by patients and clinic systems than by clinicians**

Differences in quality scores between safety net clinics (SNCs) and non-safety net clinics (NSNCs) are due to a combination of factors: patient populations, clinic systems, clinicians, and the quality measures themselves. And these factors are influenced by factors that can be labeled “social-structural determinants of health (SSDoH)”, social structure of health care institutions, and culture—specifically biomedical culture and patients’ culture.

***Patient Population’s Contributions to QM scores***

The major difference in quality scores between SNCs and NSNCs is the patient populations who attend those clinics. Two overlapping types of issues contribute to the differences in patient populations: socio-structural issues and cultural issues.

Socio-structural Issues:

Patients at all clinics deal with social-structural issues that influence health, which are often labeled Social-Structural Determinants of Health (SSDoH). The challenging SSDoH factors that participants described as adversely affecting QMS (and are known to have a negative influence on health) include the following:

* Low socio-economic status
* Unstable employment, seasonal employment, or multiple low-wage jobs that require large amount of time
* Unstable and poor quality housing
* Unsafe neighborhoods
* Neighborhoods with many fast food places and liquor stores, and few grocery stores
* Low formal education
* Low literacy and low health literacy
* Preferred language other than English (ELL)
* Low accessible, reliable and convenient transportation
* Low rates of insurance/ Low rates of private insurance/ High rates of being uninsured
* Legal issues (i.e., related to housing, person to person conflicts, accused of crimes, immigration or residency status, etc)
* Food insecurity
* Limited clothing and footwear
* Limited access to affordable safe places for physical activity
* High burden of chronic disease

Currently in our society, SNCs have more patients with a larger burden of social-structural issues while NSNCs have more patients with smaller burden of social-structural issues. However, some large NSNCs have specific clinics in geographic locations that may see a higher proportion of people with larger SDOH burden. This imbalance of patient population significantly contributes to higher quality metric scores at NSNCs and lower quality metric scores at SNCs and specific clinics within NSNCs.

Cultural Issues:

In addition, a patients’ culture—beliefs, values, and behaviors—influences their responses to their health, the health care system, and health care recommendations. Given the heterogeneity and flexibility of culture, there are not specific aspects of anyone’s culture that contribute to higher or lower scores on quality measures. Rather, it is the incongruence or disconnection between people’s cultural group and biomedical culture that can contribute to quality scores. Whether people belong to groups that had recently arrived (i.e., immigrant or refugee groups) or that have undergone long-term effects of slavery, colonialism, and/or discrimination, it is the incongruence between what the biomedical culture expects people to do in order to be healthy, and what people’s culture expects them to do to take care of themselves that is the cause of the underlying disconnection. In addition, since an ideal goal for many cultures is not individual advancement but is family and community advancement, then the clinical focus on individual health can contribute to a disconnection between patients’ culture and biomedical culture.

Consequences of Structural & Cultural Issues:

Patients’ structural and cultural issues have consequences for quality measures scores at SNCs, NSNCs, and specific clinics within NSNCs, depending upon where patients receive their primary care.

1. People with a heavier SSDoH burden deal with challenging structural issues that require them to use a lot of their energy towards meeting their basic needs (i.e., food, shelter, safety, etc.), whereas people with smaller SSDoH burden use less of their energy to meet their basic needs. Hence, people with larger burdens have less energy and patients with smaller burdens have more energy to attend to health-related or health care issues. People with these burdens may have to prioritize actions for health and health care lower than other necessary activities and competing priorities in their lives.
2. Quality measure scores (particularly for chronic diseases like type 2 diabetes mellitus, vascular diseases, and asthma, but also to a lesser extent for all the quality measures) require patient engagement, patient activation, or patient self-management. These attributes are more difficult for people with high structural burdens and cultural incongruencies with mainstream health care institutions. Overall, it is more challenging for some patients to engage in bio-medically defined self-management processes that are necessary to improve quality metrics.
3. People with SSDOH burden and cultural dissonance have lower agency to implement healthcare recommendations for health, whether lifestyle changes like diet and exercise, taking medicines, getting cancer screening tests, or stopping tobacco use.
4. People with higher SSDoH burden are more at risk for mental health distress, substance use, and chemical dependency, which negatively affect all quality health metrics as well as the specific mental health measures.
5. People with low literacy, language barriers, and less education in particular may have less proficiency in managing health care systems, be less pro-active getting their healthcare needs met, and be less likely to obtain preventive health care than acute care visits.
6. Cultural dissonance with health care culture can contribute to people’s lower use of health care services, rejection of health care practices, or diminished or non-implementation of health care recommendations—all of which lower quality health care metrics at their clinics.

***Clinic Systems’ Contributions to QM Scores***

Multiple health care system issues influence NSNCs to have better quality scores than SNCs:

1. The majority of NSNC patients have consistent insurance. Generally, NSNCs do not attract people without insurance; they do not have reduced fees, or discount programs for people without insurance; and their charges are generally too expensive for people without insurance to afford. Having insurance significantly allows patients to follow medical recommendations more easily than patients without insurance.
2. NSNCs’ financial resources allow their administrators to create systems, use resources, and create organizational structures to improve QMs.
	1. Clinic administrators and managers have tracked, analyzed, and displayed data, showing the quality metric data to providers and other staff members to support specific clinic processes and behaviors.
	2. They have created various systems to act on the data, with staff members (nurses, medical assistants, community health workers, pharmacists, patient educators, patient navigators, care coordinators, etc) supporting the providers; monitoring population metrics; meeting with patients or contacting individual patients to obtain specific information, order specific tests, or act in certain ways that align with the measures.
	3. They have adopted EMR modifications to identify and display aspects of the quality measures that patients are missing and patient registries to display and allow ease of contacting patients about needed actions.
	4. They have created competitions within their organizations, contrasting individuals, teams, and clinics, to get people to strive for excellent scores.
	5. They have created financial incentives for clinicians, connecting performance on quality measures with bonuses and/ or compensation.
	6. Some had started intense pilot quality processes to identify most successful clinic flow processes, and then dispersed the successful processes to other clinics.
3. As health care organizations, NSNCs generally are motivated to increase QMs for several reasons:
	1. Their mission to improve the health of their patients or their members.
	2. Their desire to increase their competitiveness in the health insurance marketplace so that businesses (and individuals) will buy their insurance plans and chose their networks.
	3. Their reputation amongst individuals and businesses.
	4. Their financial bottom line.
4. These multiple efforts have affected quality scores.
5. Quality metrics are higher than in clinic systems that do not have these types of activities.
6. In some clinics and systems, “non-compliant” or “difficult” patients are encouraged to see other clinicians or attend other clinics, so that “bad” patients with low quality scores are concentrated.
7. In some systems, some clinicians have felt “shamed” by the public nature of displaying metrics and institutional pressure to perform for the metrics, even when the institutions state that the purpose is to help people learn and improve.
8. In some systems, the financial reimbursement processes have been transparent and in others, not completely transparent.
9. Some NSNCs have created high-resourced specialty clinics aimed at high-need high-cost patients in order to improve quality and reduce cost, with the added benefit of removing these low-quality measure patients from the overall primary are clinic metrics.
10. In addition, the history of how different health care systems have developed and changed over time is relevant to understanding their approach to health care metrics, health care processes, and interactions with clinicians.

Similarly, several interrelated clinic issues influence SNCs and specialty clinics within NSNCs to have worse quality scores than NSNCs.

1. Generally, SNCs serve patient populations who are uninsured, under-insured, or are publicly insured. This results in having fewer financial resources to create clinic processes to provide approaches that are aimed specifically at improving quality measures.
2. SNCs’ lower financial resources than NSCs.
	1. They have a lower support staff to clinician ratio, and therefore fewer people to assist clinicians with the actions that could increase QM scores.
	2. They have higher staff turnovers, from a combination of lower salaries/ benefits, more patient needs, and more stressful clinic processes.
	3. Some SNCs have more chaotic clinic systems, which are less-organized, less-functional, or even dysfunctional.
3. SNCs have fewer resources and processes to track population health and QMs.
	1. While the federal government has required FQHCs to track population health for many decades, lack of financial resources has led to their not been at the cutting edge of population health processes, with EMRs, collecting EMR data, tracking and displaying quality measures, and hiring staff to contact patients about healthcare needs. Nonetheless, now many FQHCs are implementing these types of systems.
	2. They are historically “behind the curve” of creating clinic-based and population-based systems to respond to quality measures, given the lack of financial resources that NSNC systems have had to create new clinic processes and given lack of financial incentives aimed at gaining a larger share of the insurance market.
	3. The clinician payment/reimbursement system affects number of patients seen annually (FQHCs have set national standards for patients seen by clinician type). This may affect length of patient care appointments (15- 20 minutes/ patient), even though the need for time can be greater.
	4. There is a parallel between SNCs and their patients. Similar to patients, SNCs are trying to survive; they use the vast majority of their resources for basic health care services, with very little resources left over for intense management of other services that could be aimed at improving quality metrics.
4. SNCs have more patients with high burden of SSDOH.
	1. Staff members spend more time and energy on patient’s multiple social, physical, and mental health needs, and thus have less time and energy to spend on meeting the specific quality measures.
	2. Clinicians often need more time than at other clinics to deal with patient’s social issues (i.e., disparate language, low literacy, transportation, lack of insurance, inability to pay for medicines) and cultural issues (lack of congruence with medical and QM agenda) in patients from refugee, immigrant, and ethnic minority groups.
	3. The clinician payment/reimbursement system affects number of patients seen annually (FQHCs have set national standards for patients seen by clinician type). This may affect length of patient care appointments (15- 20 minutes/ patient), even though the need for time can be greater.
5. Primary care clinics within high-resourced NSNCs that care for patients with high SSDOH burdens have lower quality metrics than other clinics in their health care system. Hence, it seems that even if SNCs had similar resources to NSNCs resources, the return on those investments would not be as great, given the patient population’s issues.

***Clinicians’ Contributions to QM Scores***
Differences in clinicians’ quality scores at NSNCs and SNCs do not seem to be due to clinicians’ having variable knowledge, skills, and abilities. Rather, these disparate scores are due to variations in the systems that support clinicians to utilize their clinical skills, and differences in the patient populations served at these clinics. Clinicians are motivated to participate in clinic processes that are designed to increase quality care measures because it is the “right thing to do”—because the measures and the processes fit with their professional mission to provide quality care for patients. In addition, clinicians at NSNCs have financial incentives (from bonuses to a percentage of their salary based on performance), and have social incentives (from public face-saving to shaming to competition, when clinicians’ scores are routinely published in the clinics). In these ways, clinicians’ increased work efforts and partnering with their staff team members can lead to higher quality scores and more personal financial rewards. In contrast, clinicians at SNCs do not have financial incentives, as their payment is not based on performance; and their social incentives may be different, in choosing to serve the community at that SNC.

Indeed, there may be differences in clinicians’ willingness to work at SNCs than NSCs given lower resources, less administrative and staff support, higher rates of clinician turnover, and higher patient needs.

Overall, clinicians have the smallest role to play in the differences of quality scores, and clinicians’ professional abilities are the smallest piece in scores between SNCs and NSCNs.

**Theme #2: Collecting data about QMs is not the same as measuring quality healthcare**

***Assessments of Current Quality Measures***

Current quality healthcare measures can be valuable, but they are not to be confused with measuring quality healthcare. QMs are valuable when they are based on evidence-based medicine (i.e., blood pressure and glycemic control), when they are consistent with professionals’ mission to improve people’s health, and when they provide clinicians with a population-based perspective, which can prevent patients from “falling through the cracks”. QMs are not valuable when they result in clinicians’ taking empty actions that are “just clicking boxes” (i.e. weight counseling), when the measure is impossible for their patients to meet (i.e., depression for patients with high SSDOH burden), or when they take clinic visit time away from connecting with patients’ focusing on their lives and health.

***How Current Quality Measures Affect Medical Care Systems***

Primary care clinic transformation with processes such as health care home and team based care has occurred concurrently with QMs, which support improved QM scores. Overall, clinicians are willing to engage in clinic processes aimed at improving quality measures when the measures are consistent with improving patient health, and are frustrated with clinic processes that they experience as an administrative burden that make a data point increase that improve the scores, but do not improve patients’ health.

Specific clinic processes that focus on increasing QM scores include public displays of clinician specific data within clinics and clinic specific data within large healthcare systems. While participants were accustomed to having public data displays when working at NSNCs, no one had had that experience at SNCs. Their response to public displays varied. One person was particularly expressive about the positive nature of competition between individual providers, teams, and clinics, and another person was expressive about how data can help providers make significant strides in understanding their patient panel and making changes to improve care. A few were neutral, accepting it as part and parcel of the current healthcare environment. However, most participants expressed discontent with the negative consequences of publicly displayed data and tying compensation, performance review, and even termination to quality measure scores, calling these tactics “shaming”, “unfair”, and “punitive”. These processes are seen as unfair because of the inequalities of providers’ patient populations, which leads to inequities of provider workloads and ability to meet measures. These inequities exist in specific clinics within large healthcare systems, given their geographic location and patient populations with high SSDOH burden, and within clinics given differences in patient panels between providers.

***How Current Quality Measures Affect Patient Care***

Clinicians and clinic systems have improved patient care metrics by developing clinic system workflows that integrate processes aimed at QMs. Changes in clinic processes and electronic medical records alerts can ensure that patients have cancer screening, have heard about tobacco cessation resources, have been counseled about weight, diet, and exercise, or are connected with additional resources to address their chronic disease management.

In addition, focusing on QMs can also adversely affect patient care.

1. Clinicians may focus their attention on things that are measured rather than things that are not measured. This can paradoxically improve quality care at NSCs where patient improvement may be more congruent with the measures and constrain quality care at SNCs where patients’ needs may be more dissonant with the quality measures.
2. They may “cut corners” in order to avoid being overworked, trying to find the easiest way to make the numbers better rather than creating lasting changes in health.
3. They may shuttle patients with low scores (sometimes labeled as “non-compliant”) elsewhere, perhaps to other clinicians who may be more “kind-hearted” or have language or cultural skills, to other clinics in a system, or to SNCs.
4. They may spend more time per patient during clinic visits to deal with the multiple issues related to QMs in order to make QM scores better. Hence, they spend more personal time outside of clinic hours (evenings, weekends), completing charts.
5. Some clinicians may “burnout’ from increased demands and from spending more time and energy on quality measure agendas than on patients’ preferences.
6. They may choose to decrease their clinic hours in order to manage the increased workload after work hours, which leads to less patient care access.
7. Quality is a process that is constantly negotiated in the provider-patient relationship. This relationship is easier when there is congruence between patients and biomedicine’s culture, and is harder and requires more energy when there is incongruence between patients and biomedicine’s culture.

**Theme #3:** **Current QMs are not how patients define quality healthcare**

***Patients’ Definitions of Quality***

Participants felt that most patients are unaware of current quality outcomes measures, their scores, their doctors’ scores, or their clinics’ scores. They speculated if any patients know, perhaps it is patients from high socio-economic class backgrounds who attend NSNCs. And if patients know about scores, they felt that most patients would agree that the measures do not measure what is most important to quality. They felt that while patients might not disagree with the current measures (do not smoke tobacco, take medicines to control chronic diseases, screen for cancer, etc), they would define quality healthcare by their subjective sense of well-being, feeling respected by their doctors/ nurses/ clinics, and being in trusting relationships with health care providers. Participants expressed a desire for a new health care evaluation system, where patients are involved with evaluating the health care system outcomes based on their own definitions of health and quality of health care.

**Theme #4: Future QMs need to consider patients’ health goals and systems must not be punitive**

***Clinicians’ Definitions of Quality***

All participants had their own personal definitions of quality healthcare, which were similar. Generally, they asserted that quality of health is best defined by patients, however patients define health: by their symptoms, their goals, and their ability to function, in contrast to the quality measures that define quality of health by achievement of threshold numbers, and in contrast to the current assessment of patient satisfaction. In addition, they asserted that patients should define healthy goals and quality of health in partnership with their healthcare providers, as patients turn to the healthcare system for assistance and as clinicians bring useful information from biomedicine, evidenced-based medicine and guidelines for patients to consider. This synergy requires cooperation, and an effective patient-clinician relationship, where patient engagement is more than compliance, and more than a change in vocabulary from compliance to adherence to a joint agreement. As such, these primary care participants asserted that the pillar of quality healthcare is continuity in relationships between patients and their doctors—specifically trusting, respectful relationship where patents are heard, understood, respected, validated, and assisted in getting quality healthcare, and where clinicians learn from patients.

***Clinicians’ Recommended Changes to Healthcare Quality Measurement System***

Generally, true improvements in healthcare quality measures cannot just be achieved with medical actions inside clinics, but require societal and community actions outside of the clinics, as that is where the societal inequities are influencing health. Clinics need to connect patients with community resources, and these resources need to find ways to address social and structural determinants of health, from housing to jobs to healthy neighborhoods.

In order to avail themselves of healthcare services within clinics, all people need health insurance, whether a universal health care plan or innovative processes and payment mechanisms so that basic medical care is available to everyone. Within clinic systems, clinic processes need to support patient/provider relationships, elicit and respond to patients’ social and cultural needs, as well as respond to patients’ definitions of health and wellbeing and desires for healthcare. Specifically, system redesign processes where clinic staff members work together as team members in streamline processes to share the workload could continue, but with a focus on patients’ defined goals rather than a focus on increasing QM scores. The current processes that are aimed at increasing scores have a double negative effect of not focusing on patients’ health and on increasing pressure on clinicians.

Participants expressed a need for the current quality measures to be dramatically improved.

1. New quality measures need to be patient-centric. They need to be consistent with people’s personal definitions of health and self-defined goals. As such, they would inherently reflect and consider patient’s SSDOH burden that currently impedes people’s ability to achieve high QM scores. These measures would go beyond patient satisfaction into patient experience of their health, their healthcare, and their relationship with their clinician. They should be contextual and analogue, not reduced to numerical responses. While few people had specific details about how to measure these beyond “quality of life measures”, one participants made reference to PROMIS and the VA patient-centric approach.

2. Clinicians should partner with patients to present evidence-based medicine recommendations for health goals, but these recommendations need to be based on medical data gathered from all populations. Currently, guidelines that inform the quality measures are based on evidence-based medicine population data that was generally conducted on mainstream populations.

3. The quality measure goals should be relative improvements rather than absolute numbers, so that patients, clinicians, and clinics are evaluated on the progress they make to improve healthcare outcomes.

4. The processes and the consequences of reporting should not be punitive. They should not be punitive to individual clinicians, such as being tied to people’s jobs, salaries, and reputation. They should not be punitive to clinics or clinic systems, such as differential payments. They should not lead to clinicians’ being overworked or overburdened, which defeats the purpose of trying to improve quality because when clinicians are stressed, they do not provide patient-centered quality work, and if they respond by decreasing their work schedule, this results in decreased access, which is punitive to patients.

5. Changing the biomedical model to be more congruent with culturally specific patient/ family/ community orientation would be a dramatic step forward. Ultimately, creating a new quality system that takes into account patients’ personal and cultural definitions of wellbeing and quality outcomes would require a revolution.

***Clinician Responses to Clinic Payments Based on QM scores***While acknowledging that the healthcare system is changing to “pay for performance” processes and concrete performance measures are a necessary component, participations are concerned about the inequity of a clinic-based financial payment system that is tied to QM scores. They are concerned that the consequence of the inequality in healthcare and healthcare quality measures will lead to the neediest clinics serving the neediest patients, and that these clinics will receive the least amount of money, when they need more money to respond to patient population needs. Potential approaches included: utilizing risk adjustment mechanisms to take into account the challenges that clinics and providers face whose patients have high SSDOH burden; rewarding relative improvement in quality scores rather than attainment of an absolute threshold number; tying measures to continuity relationships with patients as patients attempt to meet their health goals.

**Summary**

This qualitative study of individual interviews and focus groups with 14 primary care clinicians who have worked both in SNCs and NSNCs reveal four themes about the study’s aim to elicit primary care clinicians’ perspectives, experiences and insights into the current approach of clinical quality measures (QMs) and into an improved future system.

*#1: Current QM scores are influenced more by patients and clinic systems than by clinicians*

The difference in quality measure scores between non-safety net clinics (NSNCs) and safety-net clinics (SNCs) are due to multiple factors. *NSNCs and their clinicians* have higher quality metrics because their patients are more able to act in concert with the quality measures; the health care systems have used their higher financial resources to create clinic teams, clinic workflows, EMR processes, and adjunct patient education approaches that specifically address the measures; and clinicians are financially and socially incentivized to act in order to increase the measure results. *In contrast, SNCs and their clinicians* have lower quality metrics because their patients have higher burden of SDOH, which pulls their energy and resources away from health and health care; their diverse patient populations have cultural backgrounds that can be incongruent with healthcare culture; they have not had the clinic financial resources to develop teams, workflow processes, and systems specifically aimed at metrics; clinician and staff energies are diverted from quality metrics to deal with other aspects of patient care (language, health literacy, forms to deal with medical-legal-social issues, etc.); and clinicians have not been financially incentivized to complete quality metrics. *In between are specific clinics within NSNC systems* that have lower scores than their other clinics in their system because they serve patients with high SDOH, and generally higher scores than SNCs because they have more system resources. It is in these clinics that individual providers feel the punitive nature of linking QM data with job performance and financial remuneration.

*#2: Collecting data about QMs is not the same as measuring quality healthcare*While focusing on QMs have resulted healthcare processes aimed at improving these measures, it has also adversely affected patient care. Clinicians have prioritized those aspects of care over other aspects (including those which patients may define as more important), have “clicked boxes” for measurement sake, “cut corners” to avoid being overworked, worked more hours (which has contributed to professional dissatisfaction and burnout), shuttled low-scoring patients to other providers or other clinics, put up with shaming processes of public displays of data, taken financial hits in their base salaries, or even lost their jobs.

*#3: Current QMs are not how patients define quality healthcare*Most patients know nothing about the current QM system. Patients would not necessarily define quality healthcare by numbers or cut-off values or scores on reports or percentages of attainment of certain numbers; for most patients, these are too remote from their lived experiences. Rather, most patients would define quality healthcare by their subjective sense of well-being, feeling respected by their doctors/ nurses/ clinics (particularly about the social-cultural aspects of their lives), and being in trusting relationships with healthcare providers.

*#4: Future QMs need to consider patients’ health goals and systems must not be punitive*

Participants expressed a need for the current quality measures to be dramatically improved. New quality measures need to be patient-centric (tied to their personal health definition and personal health goals that reflect people’s social and cultural realities), and they need to recognize that trusting, respectful patient-clinician relationships are a pillar of quality healthcare. People mentioned quality of life measures, including PROMIS and VA patient-centered approach, as possible approaches. Also, outcomes of QM reporting should not be punitive for individual clinicians or for clinics that care for patients with high SSDOH burdens. All participants were concerned about a clinic payment system tied to unequal quality measures, because clinics serving the neediest patients would get the least amount of money. Options included developing risk adjustment mechanisms and evaluating relative improvements rather than absolute achievements.

**Discussion:**

Current quality measures are embedded in American social inequities.

* *The quality measures are based on the social inequities of research.* Many of the measures are grounded in evidence-based medicine, whose data has been generated from population studies done on majority white Americans (or even white men). As such, they do not represent recommendations based data collected from for all other populations.
* *The quality measures are an un-equitable tool, as they measure unequal processes.* The patients at NSNCs who do better on these measures have low SSDOH burden and understand diseases, treatment processes, and clinical systems in more similar ways to doctors, while patients at SNCs and NSNCs who do worse on these measures have high SSDOH and understand health and diseases in more disparate less congruent ways than their biomedical practitioners. In addition, patients with low SSDOH have lives that allow them to be more engaged partners with clinicians, and spend more energy and money on their health and their healthcare than patients with high SSDOH.
* *The quality measures were selected by inequitable social processes.* Initially, the QMs were chosen by corporate executive officers (mostly white majority American men) who were purchasing health insurance for their employees in order to help them choose “quality health insurance”. As such, QMs were a technique to evaluate the quality of the product in balance with the cost in order to make a wise financial decision. Given this beginning, quality measures are a product of free market capitalism. Then, other agencies adopted and adapted them, with an aim to improve quality health care, and turned to evidence-based medicine. Subsequently, state government officials chose which measures to use to compare clinic and clinician performance. Indeed, the quality measures had not been selected with input from patients, the Minnesota populace, or sub-populations living with the highest levels of disparities in health.
* In short, the current quality measures were chosen by healthcare insurers and payers and supported by biomedical data. The disparate results are reflected by the privilege of the insured, educated, middle and high social-economic class white Minnesotans whose lower SSDOH and congruence with biomedical systems contribute to their higher QM scores. The current quality system quantifies the biomedical view and the hierarchical American society into a “quality score” that shows lower class people at the bottom and higher-class people at the top, in congruence with social inequities.
* *Aligning payment with these measures ensures continued inequities,* as the high-performing well-financed clinics will continue to excel while low-performing poorly-financed clinics will continue to do poorly.

**Limitations**

As with all qualitative research, the limited number of people interviewed limits the generalizability of the results. In this study also, there was not equal representation from all of the major NSNCs or all of the SNCs; the clinics were located in the metro area and did not include rural areas; and people’s historical experiences of SNCs and NSNCs means that they were not comparing current quality practices within these clinical systems. Nonetheless, participants’ assessments of the difference between SNCs and NSNCs were similar and hence, were summarizable.

**Conclusion**

Primary care clinicians who have worked both in SNCs and NSNCs assess that the current system does not truly measure quality health care and does not fairly represent which clinics provide superior care. Rather, it publicly elevates high resource clinics that have created systems to prioritize what is measured and whose patients have low burden of social-structural determinants over low-resource clinics that have fewer resources to focus on just those things that are measured and whose patients have high burden of social-structural determinants of health. Overall, the current QMs are tied to social inequities; they are based on inequitable research, are chosen by inequitable processes, and mix results with societal inequities. Aligning payment with these measures ensures continued inequities. If payment is going to be aligned with performance, a new comprehensive approach to measuring quality needs to be designed that measures quality healthcare, and is equitable and fair. **Appendix #1:**

**Open-Ended Question Guide for KI Interviews and Focus Groups**

I. Compare and contrast Minnesota Community Measures quality data taken from where you have worked, both large health care system/s (X clinic/s) and safety-net clinic/s (Y clinic/s).

1. Your clinic/s from large healthcare system

Look at/ think about the quality measure results.

From your experience, what do you think is contributing to your/ this clinic’s high/er scores?
Probes: Patient factors. Clinic resources/ structure/ flow. Clinician factors. Community factors.

1. Your safety net clinic/s

Look at/ think about the quality measure results.

From your experience, what do you think is contributing to your/ this clinic’s low/er scores?
Probes: Patient factors. Clinic resources/ structure/ flow. Clinician factors. Community factors.

1. Impact of quality measures on health care

What do these differences in quality measures mean to you?
How do they affect you, your ability to care for patients?
How have these quality measures affected your work, or your health care system?

How have these quality measures affected your interactions with patients, and your medical decisions?

1. An improved future system of quality

What does quality mean to you? If you were to design your own system, what quality measures would be important to you?

Based on your experiences, what do you think is needed to improve health quality measurements? What measures could accurately measure health care quality?
What clinic resources or services could improve quality measures, particularly for patients living with complex social determinants of health?

In the foreseeable future, clinic/ provider payments could be based on/ influenced by the disparity results. What do you think about this?
What do you think about “risk adjusting” the reported numbers by patients’ characteristics, such as social determinants of health? What ideas do you have, to get this done?

1. Patient perspectives about quality

What have your patient said about quality? What does quality mean to them?

Do patients distinguish between process quality measures and outcome quality measures?
What quality outcome measures are most important to patients?
What resources or services do they say they need, to improve their health/ and healthcare quality scores?

**Appendix #2:**

**Demographic Questionnaire**

Please answer the following questions:

1. What is your age? \_\_\_\_ years
2. What is your gender? \_\_\_\_\_Female \_\_\_\_\_Male \_\_\_\_\_Other
3. What is your profession/s? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Where and when did you graduate?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Professional Work History:
Please answer the following questions about your professional jobs, in temporal order.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Where(Clinic name, city, state) | What kind of system? | Job title | How long did you work there?  | Why join? Did quality measures influence your decision to join? | Why leave? Did quality measures influence your decision to leave?  |
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