

FAQ

# QUALITY CYCLE MANAGEMENT



## What is Quality Cycle Management?

Quality Cycle Management is a business process used by health systems engaged in value-based care agreements with government and private payers. These provider organizations are striving to understand and manage the relationship between the quality of care, its costs, and its contribution margin. The common denominator among the factors in the value equation is health outcomes.

## When did quality begin to impact the health system's financial picture?

Quality has long been a key indicator for health systems. But until revenue from value-based care contracts reached the tipping point (about 3 percent of income for large health systems), it wasn't a KPI for the Chief Financial Officer. Now that it has, active management of the quality cycle has become vital to the profit mix for delivery systems.

## How is Quality Cycle Management different from revenue cycle management?

Revenue cycle management is the process healthcare organizations use to account for revenue generated under fee for service reimbursement models. The cycle is kicked-off with an encounter – typically an appointment at a clinic, or the admission to hospital – and ends with reimbursement regardless of the health outcome.

In contrast, quality cycle begins when a patient's life is attributed to a primary care physician and it continues until there is a change in attribution. Therefore, it is in the health systems interest to continuously monitor patient health and proactively coordinate care to avoid unnecessary medical events and costs.

## How is Quality Cycle Management IT related to revenue cycle management IT?

Revenue Cycle Management IT systems account for all the administrative and clinical activities that contribute to the capture, management, and collection of revenue associated with the encounter.

Quality Cycle Management IT systems provide analytic insights on health and financial risk in the population. Unlike standalone analytics solutions, QCM IT combines analytic insights with the tools needed to act, including care plans, programs, and communications – the key features of an advanced care coordination platform.

## Who is interested in or affected by Quality Cycle Management?

Staff across the organization perform quality cycle tasks including contract negotiation and performance review, population risk stratification, gap-in-care review, care plan design, service line demand-and-capacity planning, patient outreach, education and counseling. The entire C-suite is attuned to Quality Cycle Management because these are the functional areas that contribute to health and financial outcomes.

Executives are turning to the CFO to quantify the economic value of quality improvement. Finance has answered the call with complex excel models, built one-at-a time by highly skilled (read: expensive) analysts. At best, their reports provide views of prior-year results against performance measures. Managers can see if they are winning or losing. But the key drivers are not apparent.

## Where are the operational levers that control the quality cycle?

Performance in value-based care contracts is inextricably linked to healthcare quality and resource utilization. The latter is well-understood because the inputs and outputs are internally controlled. The former is problematic because payers rarely supply provider organizations with performance data that includes the details necessary to see the root cause of variation.

When payer data are systematically merged with internally generated data, a more complete and timely view of health system performance to contract objectives is possible. An analytics tool purpose-built for the quality cycle focus management attention on the areas of health and financial risk in the population.

Just as important, it will identify the operational levers that drive variation in care delivery – namely, the clinics, the providers, and the resources they use.

## Why is care coordination vital to improving the Quality Cycle?

Value-based care analytics will identify opportunities for improvement. To realize it, the care team must be enabled to collaborate using an intelligent care plan, one that converts analytic insights to care team action. Effective care coordination spans the care coordination continuum, connecting the key touchpoints between patient, provider, community health and social services to the information and communication services they need to close priority care gaps and maximize reimbursement in the value-based care contract.

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