Quality & Efficiency Subcommittee of the Health Incentives & Outcomes Committee
Meeting Summary – DRAFT

June 10, 2010
10:00 am – noon

Subcommittee members in attendance
Glenn Rodriguez, Chair
Seth Bernstein (by phone)
Dan Clay
Ken House (by phone)
Jim Russell
Rachel Solotaroff
Thomas Syltebo
Joe Zaerr

Incentives & Outcomes members in attendance
John Worcester

Staff in attendance
Jeanene Smith
Lisa Angus
Nicole Merrithew

Subcommittee members not in attendance
Nancy Clarke
Laura Etherton
James Kahan
Mary Minniti
Brett Sheppard

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Dr. Rodriguez convened the meeting at 10:05.

The subcommittee approved the summary of its May 13th meeting.

The committee briefly discussed a visual showing how the core measures it recommends would reflect Oregon's triple aim and also how they might be connected to a broader or more detailed set of measures for a given topic. Comments during this discussion included:

- The visual is a good reflection of the group's direction but should reflect that the subcommittee's work is ongoing and that the set of core measures will develop and change over time as better measures are identified or new data sources become available.

- The subcommittee may recommend some measures that are aspirational in two senses:
    - methods or data sources currently available for tracking the measure are not ideal
    - it may be difficult for providers or systems to achieve the desired level of performance for a given measure
- The subcommittee must give careful consideration to the infrastructure needed at the delivery system level to track or report on measures *and* to make the to changes needed to improve performance.
- Suggestions for ensuring that the recommended measures are not too far ahead of current resources and infrastructure for improvement included:
    - Following the model of the Patient-centered Primary Care Home Standards Committee by recommending measures in tiers
    - Attempting to identify the critical features that enable the kind of quality transformation that the Committee is hoping to see and incorporating these into guidelines that accompany the recommended measures
    - Coordinating closely with other committees to make sure that recommendations align
    - Aligning with the priorities of national bodies and large payers so that the resources and requirements coming from those entities support the quality improvement that this group hopes to see.

The subcommittee heard a progress update from each of the small groups working on initial proposals for measures: patient-centeredness, access, and equity; cost & efficiency; and effectiveness and safety.

<u>Patient-centeredness</u>
The group is looking at four major areas for measurement, all from the patient perspective:

- Access – possible measures along the lines of what the Patient-centered Primary Care Home Standards Committee suggested
- Patient activation – possibly using Judith Hibbard's Patient Activation Measure (PAM) scale as the metric
- Patient experience (particularly experience of care across/between providers or from a care team)
- Patient health outcomes (general health status, quality of life, and functional status)

Suggestions and comments from other subcommittee members included:

- Consider measures of shared decision-making, perhaps as a sub-set of patient activation and engagement
- The PAM may not be ideal for those with less than a high-school education or outside a research setting

- Consider whether commonly used patient experience measures (like CAHPS) might capture aspects of patient activation
- Consider patients' perception of safety

Cost & efficiency

This group is looking at a mix of broad, overall cost measures and measures of cost or efficiency in specific parts of the system:

- Global per capita cost
    - Then breakdowns of per capita cost for regions, specific populations, or particular parts of the system (inpatient, Rx, etc.)
- Specific measures of overuse or waste
- Measures of cost or efficiency across episodes of care

Suggestions and comments from other subcommittee members included:

- The all-payer, all-claims database currently in development will be key to capturing many of these costs
- Broaden the category of overuse to include inappropriate use or under-use of preventive care, which leads to greater costs in the long term; appropriate use might be the overall category
- Consider ways to measure hidden costs, like the uncompensated time spent by providers trying to get prior authorization for a x-ray or a prescription, or coordinating a specialist referral – these may be efficiency measures
- Efficiency measures may coordinate well with payment reform work, e.g. incentives to encourage providers to use email rather than bringing patients into the clinics, to make the most efficient use of resources

Quality, effectiveness, safety

As a first step, this group took the core attributes of a medial home identified by the Patient-centered Primary Care Home Standards Committee (access, accountability, coordination, continuity, comprehensive whole-person care, and patient-centeredness) and walked them across different settings: primary care, specialty care, hospitals, health plans, and population health. Members of this small group noted that the table is still developmental; mental health settings, for example, are not reflected.

Suggestions and comments from other subcommittee members included:

- While the table seems like a useful organizing framework for the subcommittee, care should be taken to ensure that it doesn't lead to reinforcing existing silos (e.g. between primary and specialty care).
- Distinguishing between the kinds of things that should be measured and improved at the delivery system level (primary care, hospitals, etc.) vs. the health plan level may be helpful.

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The subcommittee discussed next steps for measure development. Each small group will continue to develop specific proposals for metrics in their respective areas. Groups were encouraged to think about scope and about measures that would rise to the level of a core recommended set. Key points during this discussion included:

- It would be very helpful to know of changes coming (e.g. Medicare Advantage quality incentives) that might be big and powerful enough to prompt investments in quality improvement infrastructure at the health plan level. Investment in this infrastructure would help support the subcommittee's goals for quality improvement. Such changes might be related to payment, regulation, or accreditation.
- When groups identify an important topic that cannot be accurately or appropriately measured now, one option is to measure what is being done in that area (e.g. entity regularly assesses patient satisfaction) rather than actual performance or score.

Public Comment

Dr. Allen Weiland, currently a consultant to the Oregon Health Authority, commented that he was impressed with the subcommittee's thoughtful approach. As groups begin to populate the framework discussed, Dr. Weiland encouraged them to consider and note the data source, reliability, and accessibility of each proposed measure.

Dr. Rodriguez adjourned the meeting at 11:50.

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