

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

**August 12, 2010
10:00 am – noon**

Subcommittee members in attendance

Glenn Rodriguez, Chair
Seth Bernstein
Nancy Clarke
Laura Etherton
James Kahan
Mary Minniti
Jim Russell
Thomas Syltebo
Joe Zaerr

Incentives & Outcomes Committee members in attendance

John Worcester

Staff in attendance

Jeanene Smith
Gretchen Morley
Lisa Angus
Lynn-Marie Crider
Nicole Merrithew

Subcommittee members not in attendance

Dan Clay
Ken House
Brett Sheppard
Rachel Solotaroff

Dr. Rodriguez convened the meeting at 10:00.

The subcommittee approved the July 8th meeting summary with some corrections regarding member attendance.

Updates

- The Incentives & Outcomes Committee is scheduled to present draft recommendations to the Health Policy Board in October. The expectation is that the Committee will deliver recommendations for payment reform, how to measure that reform, and next steps for moving it forward. Within this, the Quality & Efficiency Subcommittee's focus should be on indicators.

- The task of identifying higher-level indicators for a statewide Scorecard is now very much intertwined with the Health Policy Board's development of its overall strategic plan (also referred to as the Blueprint or the Comprehensive Plan). Board members will be taking a more active role in development of a Scorecard but staff will make sure that Subcommittee work to date feeds into the process and will circle back with Subcommittee members.
 - The idea of having hierarchies of measures is something that can be passed on to the Board for consideration but may not be feasible within the timeframe of creating a Scorecard this fall. However, the Subcommittee could suggest hierarchies and any other next steps for improvement of the Scorecard in future iterations.
 - A suggestion was made to see what could be drawn from the AHRQ state snapshot indicators. They are helpful for cross-state comparisons but less so for in-state variation.

Indicators for payment reform initiatives

Glenn Rodriguez reviewed the Payment Reform Subcommittee's principles as presented at the full Committee meeting in mid-July. Some stronger language on patient-centeredness may be added as a result of discussion at that meeting.

Payment Reform Subcommittee staff gave an overview of preliminary work going on in the three payment reform staff advisory groups: hospital, physician specialty, and primary care. The intention behind having these 3 groups is not to replicate silos but to divide the work in a reasonable way and to look at particular deficiencies; there is an expectation that some proposals would cut across the three groups.

Primary Care

- This group is refining and developing implementation plans for the Patient-Centered Primary Care Home Advisory Committee's standards, trying to identify what kind of payment method would work best to promote each standard.
- The question of whether clinic or individual performance would be the basis for payment on any P4P items is still under consideration.
- Likely request to the Quality & Efficiency Subcommittee will be to help identify high priority items and to flesh out the measurement approach for those. Not all standards may be feasible or measurable initially.
- There is a need for both evaluative measures (i.e. measures to assess the impact of moving from FFS payment to a new model) and operational measures (i.e. if some part of payment will be based on performance, how will that performance be measured?). Structural measures are also useful as first step items.

Hospitals and Specialty Care

The groups are thinking about what delivery system changes they would like to incent. Suggestions to date include:

- Pilots of bundled payments for episodes of acute care – these would require evaluation of efficiency, care coordination, and patient outcomes, so Quality & Efficiency Subcommittee input on an evaluation plan or relevant measures would be enormously helpful.
- Some straightforward pay-for-performance in the hospital setting, possibly around readmissions and hospital-acquired infections; Quality & Efficiency Subcommittee input on priorities would be helpful.
- Specialty Committee is thinking about patient shared decision-making approaches to tackle appropriate utilization and would appreciate any Quality & Efficiency Subcommittee expertise on that topic, particularly around processes rather than specific tools.

The groups have some ideas but have not yet settled on clinical conditions as targets for the range of different payment reform proposals under consideration. Staff have assembled a matrix of potential conditions and a large number of criteria that might be used to prioritize among those conditions; the Quality & Efficiency Subcommittee may have thoughts on those criteria. (Matrix was included in the Payment Reform Subcommittee meeting materials.)

Key points from subsequent discussion included:

- Quality & Efficiency Subcommittee can make strong contributions in the area of appropriateness, evidence-based care, and patient centeredness and shared decision-making.
- A number of the approaches will require targeting or benchmarking around cost and pricing, highlighting the need for efficiency measures.
- The target matrix criteria document is a very useful tool. However, it suggests different foci depending on which players' perspectives are applied, so it will be necessary to be clear about whose problem we are trying to solve. Future iterations may also need some translation so that the columns are comparable in scale.
- The Dartmouth Atlas top 10 cost items should be included in the matrix.

For the task of identifying quality and efficiency priorities and measures to pair with payment reform initiatives, the Subcommittee agreed to collapse its three small advisory groups into two: patient-centeredness and quality/safety/effectiveness. In the absence of specific topical foci from the payment reform groups, the group agreed to draw on the goals of the National Priorities Partnership, with the option of working in other important but underrepresented topics (e.g. mental health) where necessary.

Next steps for quality measurement

Beyond indicators for payment reform, part of the Subcommittee's charge is to make recommendations for moving quality measurement and improvement forward in the state. Subcommittee members looked very briefly at a straw list of strategies for using measurement & reporting to improve healthcare quality and commented that it was a

good start but that the structure should be flipped: identify the change strategy (e.g. transparency) first, then list potential measurement strategies to drive that change.

Dr. Rodriguez adjourned the meeting at noon.