

**Oregon Health Policy Board
Health Incentives and Outcomes Committee, Quality and Efficiency Subcommittee
AGENDA**

September 9th 2010, 10:00 am – 12:00 pm

**Northwest Health Foundation
221 NW 2nd Ave, Bamboo Room
Portland, Oregon 97209**

#	Time	Item & Related Materials	Presenter(s)	Action Item
1	10:00	Welcome		
2	10:05	Approval of August 12 meeting summary	Glenn Rodriguez	X
3	10:05	Health Policy Board updates Update from Payment Reform Subcommittee	Gretchen Morley Lynn-Marie Crider	
4	10:20	Proposed priorities, measures, and resources for Payment Reform Subcommittee <ul style="list-style-type: none"> ▪ Suggestions from small workgroup on quality, safety, effectiveness ▪ Suggestions from small workgroup on patient-centeredness ▪ Connecting to Payment Reform proposals and next steps 	Tom Syltebo Mary Minitti Lisa Angus	X
5	11:20	Strategies and action steps beyond payment reform	All	
6	11:50	Public Comment	Glenn Rodriguez	
7	12:00	Adjourn		

If you experience problems calling in, please contact: Judy Morrow 503-373-1538 or Lisa Angus 503-779-6844.

Meeting Materials:

1. Agenda
2. August 12 meeting summary
3. Payment reform-related recommendations from the quality, safety, effectiveness group
4. Payment reform-related recommendations from the patient-centeredness group (summary)
5. Resources and measures from the patient-centeredness group
6. Connection points: PR straw proposals and Q&E measurement recommendations
7. Measurement and reporting strategies for improving health care

Next Meetings

- FULL Incentives & Outcomes Committee meeting Wednesday September 22, 1 – 4:30 pm, Northwest Health Foundation
- Quality & Efficiency Subcommittee meeting Thursday October 14, 10 am – noon, Northwest Health Foundation

**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.

QSE Group Suggestions for Payment Reform 9-7-10

The quality, safety, effectiveness workgroup suggests the following priority areas, quality improvement approaches, and measures to the Payment Reform Subcommittee. These suggestions are offered as first-round proposals with the expectation that the range of topics would broaden in the future as payment reform and quality improvement work progresses.

HOSPITAL RECOMMENDATIONS

o **Skin injuries (e.g. pressure ulcers) and falls**

Rationale: NPP priorities; federal priorities (both are CMS no-pay events); events are high total cost to hospitals (even if reimbursement impact of CMS no-pay policy is sometimes low because of filters and exclusions); Events are frequent enough that small numbers aren't usually a problem

Approach: Work with nursing leadership in the state; use participation in National Database of Nursing Quality Indicators (NDNQI) as first step/structural measure (CMS now asks about participation in a systematic clinical database registry for nursing-sensitive care as part of annual quality reporting for hospital payment updates – RHQDAPU).

Measures:

	Skin injuries	Falls
Structure	– Existence of rules or protocols for the prevention of pressure ulcers	– Existence of rules or protocols for identifying patients at risk of falls
Process	– Percentage of patients with documented assessment of skin for breakdown (AMDA) ¹	– Percentage of eligible patients documented as having a fall risk, using an accepted risk assessment tool
Outcome	– Stage 3 or 4 pressure ulcers acquired after admission to a health care facility (OR PSC/CMS) ²	– Patient death or serious physical injury associated with a fall while being cared for in a healthcare facility (OR PSC/CMS) ² – Rate of inpatient falls with injury per 1,000 patient days (ICSI) ³

o **Readmissions**

Rationale: Are a measure of defects in coordination of care; cross-setting issue.

Approach: Measures should be global because the quality defects in this area aren't specific to a given condition, but will then need some case-mix adjustment; align with emerging national consensus on how best to measure this – 30 days seems to be most common timeframe.

Measures: Align with 3M algorithms for potentially preventable readmissions, as state will be using 3M software.

o **Acquired infections**

Rationale: NPP priority; national and state momentum; opportunity to further NSQIP (National Surgery Quality Improvement Program).

Approach: Take lead from state program - use CDC's National Health and Safety Network (NHSN) for reporting.

Measures: Follow state program – see pages 106 and 107 of this document:
http://www.oregon.gov/OHPPR/docs/HCAIAC/Report_HAI_Final.pdf for current and proposed future measures

o **CMS Core measures**

Rationale: National alignment.

Approach: Give hospitals flexibility – have them choose focus areas and measures that meet their improvement needs or the needs of their patient populations. Use participation in relevant quality improvement program, collaborative, or reporting initiative either as minimum qualification/floor for participation (as in Michigan BCBS example) or as bonus; use CMS measures as outcomes.

Measures:

- CMS core measures meeting Chassin’s accountability criteria are listed on page 3 of: http://www.nejm.org/doi/suppl/10.1056/NEJMs1002320/suppl_file/nejms1002320_appendix.pdf
- Suggestions for quality improvement program, collaborative, or reporting initiative participation include:
 - Oregon NSQIP Consortium
 - Oregon Hospital Collaborative to reduce healthcare acquired infections
 - Others needed

SPECIALTY RECOMMENDATIONS

o **Imaging appropriateness**

Rationale: NPP priority; national and state momentum.

Approach: TBD - especially difficult to get handle on issue in inpatient and ED settings

Measures:

Structure	- TBD
Process	- NQF has six imaging efficiency standards currently out for member voting, see: http://www.qualityforum.org/projects/imaging_efficiency.aspx#t=2&s=&p=6%7C . Most are process measures, i.e.: <ul style="list-style-type: none"> ▪ Appropriate Pulmonary CT Imaging for Pulmonary Embolism ▪ Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury ▪ Preoperative Evaluation for Low-Risk Non-Cardiac Surgery Risk Assessment ▪ Cardiac stress imaging not meeting appropriate use criteria (3 measures) - <i>[Placeholder for shared decision making or other patient-centered metrics]</i>
Outcome	- Placeholder for OHLC measure on high-end imaging for radiculopathy – see also low back pain <ul style="list-style-type: none"> - <i>Emergency cardiac imaging?</i> - <i>Head CTs in ERs (developmental)</i>

o **Low back pain tx / spine surgery appropriateness**

Rationale: NPP and local priority; high cost for PEBB; potential for useful physician profiling and intervention; good area for consumer education and shared decision-making.

Approach: Incent appropriate early intervention and conservative tx prior to imaging; improve alignment between provider payment and consumer co-pays and benefits.

Measures:

Structure	<ul style="list-style-type: none"> - Evidence-based guidelines for tx of low back pain are in place - Participation in relevant quality improvement program - <i>[Placeholder for shared decision making or other patient-centered metrics]</i>
Process	<ul style="list-style-type: none"> - Measures of appropriate work-up and advice for low pain patients (NQF)⁴ - Use of Imaging Studies for Low Back Pain (HEDIS / QCorp 2011)⁵ - <i>[Placeholder for forthcoming OHLC measure on high-end imaging for radiculopathy – see also imaging appropriateness]</i> - Appropriate use of epidural steroid injections (NCQA)⁶ - <i>[Placeholder for shared decision making or other patient-centered metrics]</i>
Outcome	<ul style="list-style-type: none"> - Relative Resource Use for People With Acute Low Back Pain (HEDIS) - Back surgery rates (plan level measure) - Functional status post surgery (ICSI)⁷ - <i>[Placeholder for shared decision making or other patient-centered metrics]</i>

○ **Maternity care/c-sections**

Rationale: Difficult issue but huge area for Medicaid; good area for patient-centered and shared-decision making approaches; NPP priority.

Approach: Take transparency and shared decision-making approach rather than specifying target rate; report cesarean rates by hospital; separate hospitals with and without high-risk programs (peri- or neonatology)

Measures:

Structure	<ul style="list-style-type: none"> - Existence of evidence-based protocol for c-section use, with respect for patient decision-making - Participation in relevant quality improvement program?
Process	- <i>[Placeholder for shared decision making or other patient-centered metrics]</i>
Outcome	- Primary cesarean delivery rate (AHRQ IQI) ⁸

○ **Joint replacement**

Rationale: NPP priority

Approach: TBD

Measures:

Structure	- TBD
Process	- <i>[Placeholder for shared decision making or other patient-centered metrics]</i>
Outcome	<ul style="list-style-type: none"> - HEDIS measures of utilization of: <ul style="list-style-type: none"> ▪ Total hip replacement ▪ Total knee replacement

○ **Cardiac diagnostic studies and PCIs**

Rationale: NPP priority

Approach: TBD

Measures:

Structure	- TBD
Process	- NQF has six imaging efficiency standards currently out for member voting, 3 of which are about appropriate use of cardiac stress imaging, see: http://www.qualityforum.org/projects/imaging_efficiency.aspx#t=2&s=&p=6%7C . - TBD
Outcome	- HEDIS measures of utilization of: <ul style="list-style-type: none"> ▪ Percutaneous transluminal coronary angioplasty (PTCA) rate ▪ Coronary artery bypass graft (CABG) rate

PRIMARY CARE

The group suggests the following as priorities among the standards and measures already identified by the Oregon Patient centered Primary Care Home Standards Advisory Committee:

Priorities for Access

1. In-person and telephone access measures should be foundational/part of base payment
2. Electronic access is the next level

Measures:

	In-person and telephone access	Electronic access
Structure	<ul style="list-style-type: none"> - PCH provides continuous access to clinical advice by telephone (OR PC²) - PCH offers appointments at least 4 hours weekly outside traditional business hours (OR PC²) 	<ul style="list-style-type: none"> - Individual physicians provide patients with clinical summary of each office visit / hospitals provide electronic copy of discharge instructions upon request (CMS MU)⁹ - Provide patients with timely electronic access to their health information (CMS MU)¹⁰ - Send reminders to patients (per patient preference) for preventive and follow-up care (CMS MU)¹¹ - On request, provide patients with an electronic copy of their health information (CMS MU)¹² - PCH provides at least one option for electronic access, such as secure email or a secure web portal (OR PC²)
Process	<ul style="list-style-type: none"> - PCH tracks and reports a standard measures of appointment access (OR PC²) 	-
Outcome	<ul style="list-style-type: none"> - Standardized appointment access measure (e.g. days to 3rd next available appointment) - Patient experience access measure (e.g. were you able to get an appointment as soon as you wanted one?) 	-

Priorities for Accountability

1. Tracking and reporting of clinical quality indicators (measures 1-3 under this standard); align with CMS meaningful use measures.

2. Medication management should be a second focus; use HEDIS and CMS meaningful use measures.

Measures:

	Track and report clinical quality indicators	Medication management
Structure	<ul style="list-style-type: none"> – Report clinical quality measures to CMS or states [if state has the option, align specific measures with Q-Corp reporting] (CMS MU)¹³ – Generate list of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach (CMS MU)¹⁴ 	<ul style="list-style-type: none"> – Enable functionality for drug-drug and drug-allergy interaction checks (CMS MU)¹⁵
Process	–	<ul style="list-style-type: none"> – Annual monitoring for patients on persistent medication (4 HEDIS measures)¹⁶ – Use of high-risk medications in the elderly (HEDIS)¹⁶
Outcome	–	<ul style="list-style-type: none"> – Percentage of members 65 and older whose medications were reconciled within 60 days of discharge (HEDIS)

Priorities for **Comprehensive, Whole-Person Care**

1. Offering mental health services (measure 3 under this standard) should be prioritized, although all are important.

Measures:

	Provision of mental health and substance abuse services
Structure	<ul style="list-style-type: none"> – PCH documents (OR PC²): <ul style="list-style-type: none"> ▪ Screening strategy for mental health and substance abuse conditions ▪ Onsite and local referral resources ▪ Actual or virtual co-location with specialty mental health or substance abuse providers
Process	<ul style="list-style-type: none"> – Anti-depression medication management – acute and continuous phase (2 HEDIS measures)¹⁷ – PCH demonstrates improvement in the number of active patients screened for mental health issues (OR PC²)
Outcome	–

Priorities for **Continuity**

1. Association of patient with a personal clinician or team should be first priority.

Measures:

	Association with personal clinician ¹⁸ or team
Structure	–
Process	– PCH tracks and reports the percentage of active patients assigned to a clinician or team (OR PC ²)
Outcome	– PCH meets a benchmark or demonstrates improvement in proportion of visits where patient sees assigned clinician or (OR PC ²)

Priorities for **Coordination & Integration**

1. Prioritize care planning items (measure 6) as a practical first step.

2. Second priority should be the medical neighborhood items (measures 4 and 5); further measure development is needed in this area.

Measures:

	Association with personal clinician ¹⁹ or team	Medical neighborhood
Structure	<ul style="list-style-type: none"> – Generate list of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach (CMS MU)²⁰ – Maintain up-to-date problem list of current and active diagnoses (CMS MU)²¹ – Maintain active medication list (CMS MU)²¹ – Report clinical quality measures to CMS or states (CMS MU) [if state has the option, align with Q-Corp collection & reporting plans for 2011 and beyond]¹³ 	<ul style="list-style-type: none"> – Implement capability to electronically exchange key clinical information among providers and patient-authorized entities (CMS MU)²²
Process	–	–
Outcome	–	–

Priorities for **Patient and Family-Centered Care** not addressed here – see material from small workgroup on patient-centeredness.

¹ American Medical Directors Association (AMDA). Percentage of patients with a pressure ulcer or pressure ulcer risk with documented periodic assessment for specific risk factors.

² Oregon Patient Safety Commission; CMS no-pay/never event

³ ICSI – Institute for clinical systems improvement

⁴ Process measures include documentation of initial assessment including specific items, advice against bed rest, advice to maintain normal activity, and patient education, see: http://www.qualityforum.org/Measures_List.aspx#k=low%2520back%2520pain&e=1&st=&sd=&s=&p=1

⁵ NCQA HEDIS use of imaging studies for low back pain: percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis

⁶ Percentage of patients with back pain who have received an epidural steroid injection in the absence of radicular pain AND those patients with radicular pain who received an epidural steroid injection without image guidance (overuse measure, lower performance is better).

⁷ Percent of patients with a previous visual analog scale (VAS) pain scale rating of 4 or higher and an Oswestry score of 20 or higher that had a reduction of the Oswestry score by at least 30 percent at six weeks

⁸ AHRQ Inpatient Quality Indicator: cesarean delivery rate excluding presentation, preterm delivery, fetal death, multiple gestation diagnosis codes

⁹ Core item – standard for office visits is 50% of patients receive summary within 3 days; standard for hospitals is 50% of patients who request electronic discharge info receive it

¹⁰ Menu item - standard is more than 10% of patients get access within 4 days of EHR update

¹¹ Menu item - standard is more than 20% of patients over 64 or under 6 are sent appropriate reminders

¹² Core item – standard is more than 50% of requesting patients electronic copy within 3 business days

¹³ Core item – standard is attestation of aggregate numerator and denominator data for 2011 and electronic submission of measures for 2012

¹⁴ Menu item – standard is demonstrating generation of at least one list

¹⁵ Core item – standard is that functionality is enabled

¹⁶ See: <http://qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?orgid=8&objid=14912>

¹⁷ Acute: Percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (12 weeks); Continuous: percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).

¹⁸ Note: clinician as used here does not imply a particular profession or level of training

¹⁹ Note: clinician as used here does not imply a particular profession or level of training

²⁰ Menu item – standard is demonstrating generation of at least one list

²¹ Core item – standard is that more than 80% of patients have at least one item recorded as structured data

²² Core item – standard is performing at least one test of this capability

DRAFT

Patient-centeredness Group

DRAFT Executive summary of suggestions for Payment Reform Subcommittee

The Subcommittee believes that patient activation and engagement are foundational elements of a high-performing health system. The following are recommendations for using payment reform as a vehicle to make health care delivery in Oregon more patient-centered:

1. Require tracking of each key domain of patient activation and engagement listed below in every payment reform initiative, regardless of clinical focus or care delivery setting. (Suggestions of validated metrics are included in a companion document. Note that some measures may cover more than one domain.)
2. Consider an incentive for the entire “bucket” of patient-centered care, e.g. grant preferred provider status in public contracting to providers and practices that can demonstrate achievement of at least one structural measure in each domain of patient activation and engagement.
3. For reforms with a particular connection to one or more domains of patient activation and engagement (e.g. using shared-decision making to reduce over-utilization of care for preference-sensitive conditions), refer to the companion document for:
 - 3.1. Metrics that can be used as standards for participation, as reward criteria, or as means of evaluating the reform’s impact; and
 - 3.2. Patient and provider resources that can be used in design or implementation of the reform initiative.

The six key domains of patient activation identified by the group are:

- **Patient- and family-centered care**
Patients and families are involved in practice design and improvement.
- **Self-management support**
Patients have the resources and support they need to take an active role in managing their diseases and improving their health. Patients are assessed for and coached with goal of improving their level of activation.
- **Shared decision-making**
Patients and families receive timely, complete, accurate, and unbiased information in order to effectively participate in care and decision-making.
- **Respect for patient values, preferences, and expressed needs**
Patient and family knowledge, values, beliefs and cultural backgrounds are respected in the planning and delivery of care.
- **Care coordination**
Patient information, needs, and preferences are shared between providers and settings to reduce the potential for harm and waste.
- **Patient experience of care**
Providers and organizations assess and make efforts to improve the overall patient experience of care.

Patient activation and engagement – Core domains, potential measures, and associated resources

Domain: Patient- and family-centered care

Suggested metric options:

Patient- and family-centered care measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
Organization has method to recruit, mentor and utilize advisors [patients/families] in meaningful ways to help design, provide input to health care services	X			X			
Patient/Family Advisors provide ongoing input on quality improvement efforts		X		X			
% and/or number of advisors involved in providing ongoing input/participation on committees and/or improvement teams			X	X			

Resources:

- Institute for Patient and Family Centered Care, see: <http://www.ipfcc.org/>
- Oregon Healthcare Quality Corporation has contracted with PeaceHealth to develop a statewide learning network on this topic

Domain: Self-management support

Suggested metric options:

Self-management support measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From OR PC ² Standards Advisory Committee							
PCPCH documents patient/family education and self management efforts (OR PC ²)	X				X		
PCPCH meets benchmark of patients receiving relevant self-management materials (OR PC ²)			X		X		

Self-management support measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From NRC+Picker patient experience survey							
Did the provider explain what to do if problems or symptoms continued, got worse, or came back?		X		X			
Did someone explain the purpose of any prescribed medicines in a way that you could understand?			X	X			
Did someone tell you about side effects the medicines might have?		X		X			
Did you get as much information about your condition and treatment as you wanted from your health care provider?		X		X			
Did your provider explain why you needed tests in a way that you could understand?			X	X			
Did someone tell you how you would find out the results of your tests?		X		X			
Did someone tell you when you would find out the results of your tests?		X		X			
After the tests were done, did someone explain the results in a way that you could understand?			X	X			
Did you know who to call if you needed help or had more questions after you left your appointment?		X			X	X	
From CMS Care Transition Measures (CTM-3)							
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.			X				X
When I left the hospital, I clearly understood the purpose for taking each of my medications.			X				X
From AHRQ CAHPS tools							
Percentage of adult inpatients who reported whether they were provided specific discharge information (H-CAPHS)		X					X
Note: New CG-CAHPS items currently being tested lifestyle and the role of the care team in supporting the patient in making changes and accessing community resources. A chronic condition version survey is similar but much more targeted on patient understanding of their							

Self-management support measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
condition, medication use and lifestyle changes and the role/helpfulness of the care team to provide support to them.							
Additional measures							
Patient Activation Measure (PAM) – 13 item scale developed by Judy Hibbard of U of O.			X	X			
Organization measures patient activation using standardized survey to provide appropriate interventions/support to patient		X		X			
Organization measures and improves the activation levels of patients over time			X	X			

Resources:

Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey
- Care Transition Measure (CTM-3 used by CMS or longer version: CTM-15)

Tools for providers or patients:

- Living Well with Chronic Conditions – Oregon Public Health Division chronic disease self-management program includes leader training and patient workshops, see: <http://www.oregon.gov/DHS/ph/livingwell/index.shtml>
- Coaching for Activation website (Insignia Health, Portland) has several resources, see: <http://www.insigniahealth.com/products/coaching.html>
- Motivational interviewing and related techniques can improve patient self-management skills. Resources in this area include:
 - Foundation for Medical Excellence has a number of trainings on physician-patient communication, see: <http://www.tfme.org/> (Contact: Barry Egener)
 - Oregon project to incorporate screening for alcohol and drug misuse into primary care is using a very brief variant of M.I. called the "brief negotiated interview," see their curriculum at: <http://www.sbirtoregon.org/>
 - Group has the names of several local contacts for more information

Domain: Shared decision-making

Suggested metric options:

Shared decision-making measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From NRC+Picker patient experience survey							
Were you involved in decisions about your care as much as you wanted?			X	X			
Did the provider ask you about how your family or living situation might affect your health?		X		X			
From Press-Ganey patient experience survey							
Degree to which you and your family were able to participate in decisions about your care			X	X			
From OR PC ² Standards Advisory Committee							
Organization provides materials to patients that outlines their role as member of care team		X					
Organization meets benchmarks of % patients receiving educational materials on PCH and patient roles and responsibilities			X				
Note: New CG-CAHPS items being tested include items about the quality of the interaction patient and provider have about treatment choices, pro/cons, both medication and treatment choices. Some emphasis on why patient might not want to do each of the treatments and if provider asked what patient’s opinion was.							
Additional measures							
Organization/provider provides and discusses information on alternative treatment choices prior to scheduled surgery or procedure		X		X			
Organization uses/provide evidence based shared decision making programs to patients/families as part of its delivery of care	X			X			
Organization/provider is able to include information about the cost of services in the process of obtaining informed consent	X			X			
Organization tracks use of preference sensitive care	X			X			

Shared decision-making measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
Use of preference-sensitive care is neither significantly above or below standards for patient demographics			X	X			

Resources:

Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey

Tools for providers or patients:

- Foundation for Informed Decision-making has a series of preference sensitive aids/programs, see: <http://www.informedmedicaldecisions.org>
- Ottawa Health Decision Centre has an inventory of many decision aides for physical health care and a certification program see: <http://decisionaid.ohri.ca>
- Dartmouth-Hitchcock Medical Center Decision Support Center has established an on-site decision-support center for patients and also provides limited on-line resources, see: <http://www.dhmc.org>
- SAMSHA shared decision-making resources for mental health, see: <http://mentalhealth.samhsa.gov/consumersurvivor/shared.asp>
- Health Dialogue is a vendor for shared decision-making programs and also source of information and evidence on motivational interviewing and other techniques, see: <http://www.healthdialog.com/Main/default>

Domain: Respect for patient values, preference, expressed needs

Suggested metric options:

Measures of Respect for Values, Preference, Expressed Needs	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From Press-Ganey patient experience survey							
Degree to which your choices were respected to have		X		X			

Measures of Respect for Values, Preference, Expressed Needs	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
family members/friends with you during your care							
Degree to which staff respected your family’s cultural and spiritual needs		X		X			
From OR PC ² Standards Advisory Committee							
Organization identifies the patient’s preferred language and has resources to respond to needs	X				X		
From NRC+Picker patient experience survey							
Did your health care provider treat you with respect and dignity?			X	X			
From CMS Care Transition Measures (CTM-3)							
The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.			X				X
From AHRQ CAHPS tools							
Percentage of patients who report that their doctors communicated well (CG-CAHPS)			X		X	X	

Resources:

Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey
- Care Transition Measure (CTM-3 used by CMS or longer version: CTM-15)

Tools for providers or patients:

- Navigating Patient- and Family-Centered Care Rounds: A Guide to Achieving Success (Medical College of Georgia, Center for Patient- and Family-Centered Care), see: <http://www.mcg.edu/centers/cpfcc/PFCCRoundsGuidebook.html>
- *Additional resources in progress ...*

Domain: Care Coordination

Suggested metric options:

Measures of Care Coordination	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From Press-Ganey patient experience survey							
Staff explained role in care		X		X			
From OR PC ² Standards Advisory Committee							
PCH assigns individual responsibility for care coordination and tells each patient the name of the team member responsible for coordinating care	X				X		
PCH demonstrates that people acting as care coordinators have received specific training in care coordination functions	X				X		
From NRC+Picker patient experience survey							
If you needed another visit with another health care provider, did the staff do everything they could to make the necessary arrangements?		X		X			
From NQF consensus standards on care coordination							
Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)		X					X
Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)		X					X
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care])		X				X	
From AHRQ CAHPS tools							
Percentage of patients who reported how often their doctor's office followed up on results for blood tests, x-rays or any other tests ordered (CG-CAHPS)		X			X	X	
Percentage of inpatients who reported whether they		X					X

Measures of Care Coordination	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
were provided specific discharge information (H-CAHPS)							
<p>Note: New CG-CAHPS items currently being tested include:</p> <ul style="list-style-type: none"> ▪ Questions indirectly query the role of this provider in helping patient access care outside their office. ▪ Questions identify the patient’s perception of the provider’s knowledge of care received from specialists ▪ Focus on role of provider in helping patient get counseling for mental health or substance abuse issues. ▪ Questions about the ability of provider to follow-up on tests, diagnoses and referrals outside their office 							
From Client perceptions of coordination questionnaire (Australia)							
How often were [are] you confused about the roles of different service [health care] providers [you see]?		X		X			
How often did [do] you seem to get conflicting advice from service [health care] providers?		X		X			
How often did [does] your GP [primary care provider] seem to be communicating with your other providers		X			X		
From CMS Care Transition Measures (CTM-3)							
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.			X				X
When I left the hospital, I clearly understood the purpose for taking each of my medications.			X				X

Resources:

Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey
- Care Transition Measure (CTM-3 used by CMS or longer version: CTM-15)
- CPCQ - Client perceptions of coordination questionnaire (Australia), see: www.ncbi.nlm.nih.gov/pubmed/12930046
- Forthcoming NQF consensus standards on care coordination, see: http://www.qualityforum.org/projects/care_coordination.aspx#t=2&s=&p=8%7C5%7C

Tools for providers or patients:

- Care Management Plus (OHSU & David Dorr) - care managers and information systems to improve the quality of care for seniors and patients with chronic illnesses, see: <http://caremanagementplus.org/>
- National Transitions of Care Coalition, see: <http://www.ntocc.org/>
- Care Transitions Program (Dr. Eric Coleman) at the University of Colorado has an intervention program, some patient and provider tools, and details on the 3- and 15-item version of the Care Transition Measure, see: <http://www.caretransitions.org/>

Domain: Patient Experience of Care

Suggested metric options:

Measures of Patient Experience of Care	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From Press-Ganey patient experience survey							
Degree to which the staff supported your family throughout your health care experience		X		X			
Degree to which staff respected your family’s cultural and spiritual needs		X		X			
From OR PC ² Standards Advisory Committee							
Entity conducts a patient experience survey	X				X		
Entity uses results of patient experience survey to improve care		X			X		
Entity uses standardized patient experience survey and can compare performance to benchmarks			X		X		
From NRC+Picker patient experience survey							
During your clinic visit, was your family or someone close to you involved in your care as much as you wanted?			X	X			
When you saw your health care provider, did he or she give you a chance to explain the reasons for your visit?		X		X			

Measures of Patient Experience of Care	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
Did the provider listen to what you had to say?		X		X			
Did you have questions about your care or treatment that you wanted to discuss but did not?		X		X			
If you and your provider didn't talk about your questions, was it because... (mark all that apply) embarrassed, forgot, I didn't have time, provider didn't have time, too many interruptions/no privacy, no questions		X		X			
From AHRQ CAHPS tools							
Percentage of patients who reported that their provided communicated well (H-CAHPS or CG-CAHPS)			X	X			
Note: New CG-CAHPS items currently being tested have strong emphasis on whether efforts were made to check for patient understanding and provider's knowledge of patient values, beliefs about health							
Additional measures							
Organization has way to identify who patient identifies as family and the degree they want them involved in care decisions	X			X			

Resources:

Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey

Tools for providers or patients:

- *In progress ...*

Connection Points: Payment Reform straw proposals and Quality & Efficiency measurement recommendations 9.9.10

****DRAFT ONLY – for discussion – Subcommittee recommendations still in development ****

Payment Reform Subcommittee recommendations in plain text
Quality & Efficiency Subcommittee recommendations in italics

Simplify Payment		
<p>Standardize payment methods (not amounts) to Medicare</p>	<ul style="list-style-type: none"> ○ Medicare DRG payment method for inpatient care at IPPS hospitals including <ul style="list-style-type: none"> ▪ weights ▪ non-payment for hospital-acquired conditions ▪ and outlier payments ○ Medicare APC payment method for outpatient care at OPPOS hospitals ○ Medicare APC payment method for care at ambulatory surgery centers ○ Standardization to be required by statute ○ How soon can this be done? 	<p><i>No Quality & Efficiency Subcommittee recommendations with direct connection to Payment Reform proposal at left.</i></p>
Increase Care Coordination, Efficiency, and Quality		
<p>Pay for performance</p>	<ul style="list-style-type: none"> ○ Pilot pay-for-performance programs (restructured payment – not payment in addition to current payment) ○ Align pay-for-performance metrics across payers (voluntary with OHA taking lead to identify metrics) ○ Extend policy of non-payment for health care acquired conditions by applying Medicare hospital payment policy to physician payment 	<ul style="list-style-type: none"> ○ <i>Align performance measures with CMS core measures, using only those that meet accountability criteria (Chassin NEJM article 2010).</i> ○ <i>Incorporate participation in relevant quality improvement program, collaborative, or reporting initiatives into P4P (e.g. Michigan BCBS example)</i> ○ <i>Suggested focus areas for P4P, by setting:</i> <ul style="list-style-type: none"> ▪ <i>Hospital: Readmissions; healthcare acquired infections; falls and pressure ulcers; other CMS core measure areas</i> ▪ <i>Specialty care: Low back pain treatment/spine</i>

		<p><i>surgery appropriateness (incent appropriate early intervention and conservative tx prior to imaging); shared decision-making in general;</i></p> <ul style="list-style-type: none">▪ <i>Cross-setting: Care coordination – align with CMS meaningful use criteria as first step</i>
Episode Payment Pilots	<ul style="list-style-type: none">○ Include acute care pilots that hold providers responsible for a period 30-90 days post-hospital discharge (e.g., heart attack, hip replacement)○ Include chronic care pilots that pay providers for care for a discrete period of time (e.g., low back pain, congestive heart failure)○ Include pilots that require involvement of primary and specialty physicians, rehabilitation professionals, hospitals, and post-acute care settings○ Experiment with types of payment<ul style="list-style-type: none">▪ Case rates▪ FFS with gainsharing where costs are kept below a target○ Require care coordination agreements to participate in pilots○ Include evaluation plan in all pilots	<ul style="list-style-type: none">○ <i>Suggested focus areas for episode payment pilots:</i><ul style="list-style-type: none">▪ <i>Low back pain treatment/spine surgery</i>▪ <i>Joint replacement</i>▪ <i>Maternity care</i>▪ <i>Cardiac care</i>○ <i>Pilot evaluation plans should include assessment of the impact of episode payments on patient activation & engagement.</i>
Primary Care Home pilots	<p>The OHA should establish a robust system of base payments for patient-centered primary care homes that provides sufficiently large incentives for practices to support modification of their practices and delivery of primary care home services to OHA-covered individuals</p>	<ul style="list-style-type: none">○ <i>Priority standards and measures for base payment should be:</i><ul style="list-style-type: none">▪ <i>Access: In-person and telephone access</i>▪ <i>Accountability: Tracking and reporting of clinical quality indicators – align with CMS meaningful use measures and Q-Corp metrics for 2011-13</i>▪ <i>Comprehensive: Offering mental health and</i>

		<p><i>substance abuse services</i></p> <ul style="list-style-type: none">▪ <i>Continuity: Association of patient with a provider or provider team</i>▪ <i>Coordination and integration: care planning items</i>▪ <i>Person and family-centered care: Some minimum tracking in each key domain of patient-centeredness identified by Q&E Subcommittee</i> <p><i>See Q&E working group documents for more detail on suggested measures in each area.</i></p>
Care coordination (service) agreements	<ul style="list-style-type: none">○ Agreements between primary care and specialty care practices (and hospitals) describing responsibilities, including specialist responsibility to provide specialty consultation in lieu of or before referral○ Primary care practices must have them to get base payment○ Practices must have them to participate in episode payment pilots○ Offer specialty physicians new payment codes for consultations (controversial)○ Other incentives	<ul style="list-style-type: none">○ <i>Potential priorities for care coordination agreements:</i><ul style="list-style-type: none">▪ <i>Medication management</i>▪ <i>Coordination between primary care & behavioral health care specialists</i>○ <i>Incorporate expectations and responsibility for patient-centered care in coordination agreements, particularly:</i><ul style="list-style-type: none">▪ <i>Shared decision-making</i>▪ <i>Patient activation & engagement</i>▪ <i>Support for patient self-management</i>○ <i>Incorporate/align with elements of CMS meaningful use criteria on clinical information exchange between providers</i>
Increase Patient Involvement		
Patient Shared Decision-Making	<ul style="list-style-type: none">○ Make patient involvement a key element of a primary care home○ Make use of evidence-based shared decision-making tools part of the care process described in care coordination agreements	<ul style="list-style-type: none">○ <i>Potential priorities for shared decision-making:</i><ul style="list-style-type: none">▪ <i>Low back pain treatment/spine surgery appropriateness</i>▪ <i>Joint replacement</i>▪ <i>Maternity care / c-sections</i>○ <i>See material from Quality & Efficiency Subcommittee workgroups for patient and provider resources on shared decision-making</i>

<p><i>Patient Activation generally</i></p>	<p>No Payment Reform Subcommittee recommendations with direct connection to Quality & Efficiency proposal at left.</p>	<ul style="list-style-type: none">○ <i>Consider an incentive for the entire “bucket” of patient-centered care, e.g.:</i><ul style="list-style-type: none">▪ <i>Grant preferred provider status in public contracting to providers and practices that can demonstrate achievement of at least one structural measure in each domain of patient activation and engagement.</i>○ <i>Require tracking of each key domain of patient activation and engagement identified by Q&E Subcommittee in every payment reform initiative, regardless of clinical focus or care delivery setting</i>
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DRAFT

OREGON HEALTH AUTHORITY

Measurement & reporting strategies for improving health care in Oregon

Draft for discussion only

Incentives and Outcomes
Quality & Efficiency Subcommittee Meeting
September 9, 2010

1

Oregon Health Authority

OREGON HEALTH AUTHORITY

Where We Are

2

Oregon Health Authority

Our health care delivery system is unsustainable

- Many different systems exist and are often uncoordinated, unnecessarily complex, and inefficient
- Systems frequently lack the information, infrastructure, and incentives necessary to relate services to health outcomes
- As a result, health care is frequently of poor quality – not safe, timely, effective, efficient, patient-centered nor equitable – and
- High cost - per capita health spending has risen faster than CPI and personal income for decades and total health spending consumes an ever-growing % of GDP

3

But we can't correct or reward what we can't identify...

- Measurement of performance is fragmented and partial, making system-wide quality improvement efforts difficult
- The fee-for-service payment system contributes to this difficulty by failing to link payment to achievement of desired outcomes.

4

Achieving the Triple Aim requires measurement and reporting strategies that drive delivery system transformation

Patients, purchasers, providers, and policymakers need appropriate information and tools to help them reach Oregon's triple aim goals:

- Improving the lifelong health of Oregonians
- Increasing the quality, reliability, and availability of care for all Oregonians
- Lowering or containing the cost of care so it's affordable to everyone

Where We Are Going

Transparency and Accountability

- Consumers, providers, health system leaders and policy makers have the quality information they need to make better decisions and keep delivery systems accountable

Value-based Purchasing

- In combination, new payment systems and quality and efficiency standards contain costs by emphasizing value and outcomes instead of rewarding volume

Collaboration and Transformation

- Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve health

How We Get There

Notes

- Following slides contain high-level strategies for Committee reaction
- Strategies listed are ones that have been mentioned in Committee or small group discussions with a few staff additions

Transparency & Accountability

-
1. Identify measurement & reporting priorities, metrics
 - Round out list of priority areas and recommended measures beyond those already identified for payment reform initiatives
 - Common definitions and data specifications; common data elements & methods for risk adjustment (?)
 2. Standardize and encourage widespread adoption of metrics
 - Require quality reporting from private sector (perhaps around particular topics or initiatives) while also protecting providers from multiple competing reporting requirements
 - Incent or otherwise support some of the optional meaningful use criteria that align with priority areas of quality and efficiency
 3. Build capacity to measure what is important, e.g.:
 - Migrate towards outcomes-based performance measurement (rather than claims- or encounter-based measurement)
 - Explore standardization of methodology for collection of patient experience (and activation?) data
 - Develop better methods of measuring efficiency within and across care settings

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Transparency & Accountability, con't

Phase 2

4. Strengthen public reporting infrastructure
 - Identify entity for centralized data collection and public reporting (consult with HITOC re: making this a centralized service of statewide HIE?)
 - Incorporate cost and quality data into consumer plan selection process in Exchange

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Value-based Purchasing

Phase I

1. Tie relevant quality & efficiency standards to payment reform initiatives (Payment Reform Subcommittee)
 - See small workgroup material and Connection Points document for more specific recommendations
2. Incorporate relevant quality & efficiency standards into public healthcare purchasing contracts (Purchasers' Committee)

Phase 2

3. As measurement capacity matures, identify acceptable methods and tools for provider comparison or benchmarking
4. Use relevant quality & efficiency standards and comparative information on providers to inform decisions about provider eligibility for participation in Exchange, benefit design, cost-sharing requirements, etc.

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Collaboration and Transformation

- Phase I
 - 1. Support measurement and quality improvement capacity at provider and system levels
 - Establish a statewide learning network to improve provider skills and knowledge to make care more patient-centered
 - 2. Leverage federal reform funding or resources to support provider-level QI capacity in priority areas
- Phase 2
 - 3. Incorporate a robust feedback loop into reporting requirements and infrastructure so that providers have comparable and actionable information on cost and quality

Discussion Questions

- Are high-level strategies heading in the right direction?
- Is general sequence of strategies appropriate?
- Flag areas of disagreement
- Who and how? Any specific recommendations as to actor (e.g. OHA) or mechanism (e.g. statute)?
- Additions or other edits