Panel 2 Questions

- **What measures would be meaningful in supporting consumers/patients in health and care decisions?**

- **Starts with understanding what patients want and how they define "patient-centered" care**

Definitions

- **Institute of Medicine**
  - Care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.
- **Planetree**
  - An approach to the planning, delivery and evaluation of care grounded in mutually beneficial partnerships among providers, patients and families. It redefines relationships in health care.

Definitions (cont.)

- **Consumers & consumer orgs**
  - Whole person care
  - Coordination and communication
  - Patient support and empowerment
  - Ready access

"Whole Person" Care

- Patients viewed as **whole person** rather than collection of body parts
- Clinicians take time to really know and **remember** patients
- Clinicians understand the **full range of factors** affecting a patient's ability to get and stay well
- Treatment recommendations align with patients' **values, life circumstances, preferences**

Coordination and Communication

- A **"go-to" person** to navigate system, and help patients understand their condition and what they need to do
- Providers organized in **teams**
- Help **choosing specialists** and getting appointments in a timely manner
- Ensuring **other providers** have patient's information ahead of time
- Help patients **understand** results recommendations
- Smooth **transitions** between settings

Patient Support and Empowerment

- Expanding patients' and caregivers' **capacity** to get and stay well (self-efficacy)
- Support for **self-management** - tools and services that help patients and caregivers better manage their conditions
- Patient **partnership** with clinicians – choosing treatment options, goals, plans, team members, etc.
- **Trust and respect** – patient preferences, physical and emotional comfort, and privacy

Ready Access

- Expand **access** beyond 5 minute phone call or 7 minute office visit
  - eVisits, secure messaging, tele-medicine, etc.
- Getting **appointments** promptly
- Keeping **wait times** brief; and having care team members available when needed
- **Accommodating** limited physical mobility, cognitive impairment, language barriers, or cultural differences

Measures that Matter (examples)

- **Whole Person, High Quality Care:**
  - Patient-reported outcomes (ex: functional status)
  - Readmissions
  - Condition-specific composites
  - Concordance with values and preferences
- **Coordination and Communication**
  - Care Transitions Measure (CTM-3)
  - How well doctors talking to each other
  - MU: transmit (and receive) summary of care record
- **Patient Support and Empowerment**
  - Patient Activation (PAM)
  - Decision quality/shared decision making
  - Support for self management (tools, goals, etc.)
- **Ready Access**
  - Wait times
  - Language services
  - Cost of care measures
  - Structural measures of access (after hours, online, etc.)

CAHPS

Patient-Centered Feedback

"At my last visit, I saw Dr. Anderson for pain management for Fibromyalgia and Crohn's Disease and I always bring in a **piece of paper which I keep on my computer and update** as I go in.

He goes over the drugs I need refilled and lets me know if there are newer, better ones in his opinion and when I suggested a generic drug recommended by my insurer, Dr. Anderson explained to me what the two drugs were not the same, and recommended that I stay on the more expensive one.

I am fortunate enough to be able to do just that, and I know that when he sees me, Dr. Anderson **knows and remembers** all that we have gone through together. He speaks to me as if **I'm his only patient that day**, refills my prescriptions that need to be hand carried, and **smiles when I make a joke**. And he shows **respect** to all his nurses and staff. Dr. Anderson IS Burke Family Practice. My husband, adult children and I will continue to be in his care for as long as possible. I had my blood work done right upstairs at the lab and it came back in 3 days. **I go in and my blood pressure goes down**, **I smile** and know that **I'm going to get well.**"

Gaps and Barriers

- **Many measures are too basic or non-existent**
- **Improving performance on meaningful measures often requires clinicians to do things they aren't paid for under FFS**
  - Care Coordination, Functional Status, Patient Activation, Cost of care/efficiency
- **Improving performance often requires culture shift**
  - Viewing patients as center of system, inviting their involvement in quality improvement
- **Measures also require infrastructure**
  - EHRs
  - Patient reported data platforms (surveys, mobile tech, tele-health)
  - Individual-level physician reporting
- **Is there a business case for developing or strengthening these measures?**
  - Who invests and why?
  - Critical importance of consumers and purchasers "at the table" in measurement enterprise
- **Must address patients' low expectations**
  - Current measures uninspiring

Another Take on Gaps

- **RAND: Develop/refine quality measures that apply to 11 payment reform models:**
  1. Health **outcome measures** that can be used to assess the health status of populations, including patients' quality of life and safety outcomes, such as avoiding harms that can be caused by health care.
  2. Quality measures that examine the way care is **coordinated** among providers.
  3. Programs that can be used to assess the **participation of patients** and their caregivers in their care.
  4. Measures that can be used to assess the **structure** of health systems, including the quality of care management and the use and functionality of electronic health records.
  5. Measures of **disparity**: measures that monitor access to care and detect whether providers are turning away high-risk or medically-complicated patients.

RAND Study: http://www.rand.org/news/press/2011/02/22/index1.html

CPDP Measure Criteria

- **Consumers and purchasers need better measures for**
  - Helping consumers choose health care providers, plans, etc.
  - Engaging patients in decisions about their care
  - Giving providers information to improve care
  - Enabling purchasers and health plans to reward providers who achieve good outcomes
  - Evaluating whether new models of care are improving outcomes

Consumer-Purchaser
DISCLOSURE PROJECT

Better information. Better decisions. Better health.

CPDP 10 Criteria

1. Make consumer and purchaser needs a priority in performance measurement
2. Use direct feedback from patients and families to measure performance
3. Build a comprehensive “dashboard” of measures that gives a complete picture of care received

CPDP 10 Criteria (cont.)

4. Focus on areas of care where the potential to improve outcomes, effectiveness and efficiency is greatest
   - Follow lead of HHS National Quality Strategy, NPP, MAP, etc.
5. Ensure that measures generate the most valuable information possible
   - Don't over-adjust for risk, masking true variations in care
   - Combine process measures into patient-centered composites
   - Capture lab values and vital signs on a continuous scale
     - e.g., HbA1c < 7,8,9 or ?
   - Capture data for disparities analysis
6. Include all patients fitting appropriate clinical criteria in measure denominator populations – avoid overly broad exception categories

CPDP 10 Criteria (cont.)

7. Construct measures that assess whether treatment recommendations are followed
8. Replace documentation (check-box) measures with measures of results and patient understanding
9. Measure performance at all levels (especially individual), reflecting **shared accountability**
10. Minimize burden; collect data efficiently

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DISCLOSURE PROJECT

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High Level Example of Breadth

The Patient-Centered Measure Dashboard

Better Health	Better Care	Lower Cost
• **Clinical outcomes of treatment** • **Patient reported outcomes of treatment**	• **Appropriateness of care** (i.e., underuse, overuse, misdiagnosis) • **Patient experience with care** • **Patient activation and engagement** • **Care coordination and care transitions** • **Effective use of health information technology (HIT) by patients and care providers**	• **Total cost to and expenditures by (1) the patient; (2) the insurer; and (3) the health care system:** – Over the course of a year – Per case or acute episode. • **Efficiency of resource use**

Note: Many of the identified measure types may fit into more than one section of the three-part aim.

For More Information

www.nationalpartnership.org

www.healthcaredisclosure.org

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