



Incorporating Patient Perspectives in Measuring Quality and Value

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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Centers for Medicare and Medicaid Services

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Medical Director of Quality and Health Policy
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FRIDAY, MARCH 13, 2015

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen
Senate Office Building)*

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Patients and providers have much at stake in the January announcement by the U.S. Department of Health and Human Services (HHS) that it intends to tie 85 percent of Medicare fee-for-service payments to value or quality by 2016. This plan represents an acceleration of the ongoing efforts by the Centers for Medicare and Medicaid Services (CMS) to move from paying for volume to paying for value. How this is done will affect the way providers—individuals and organizations—are paid, and influence efforts under way to restructure health care delivery and to give patients greater control.

Measuring quality and calculating value rely on a complicated process of defining metrics and collecting and analyzing data in ways that both reward performance and support changes in care delivery. Health information technology (IT) plays an increasingly important role, even as stakeholders continue to wrestle with the challenge of interoperability among IT systems. Quality determinations are based, in part, on clinical care measures from a variety of sources, most prominently the National Quality Forum and NCQA (National Committee for Quality Assurance). Another important component involves measures drawn from patient surveys regarding the care they received. Though the tools used to elicit and report it are continually evolving, patient feedback already plays a significant role in provider compensation.

The trend away from paying for volume to paying for value is not limited to Medicare. The employer-based group Catalyst for Payment Reform's 2014 national scorecard showed that 40 percent of payments by commercial health plans were designed to encourage health care providers to deliver higher-quality care, compared with 11 percent a year earlier.¹

REFLECTING THE PATIENT PERSPECTIVE

"Patient-centeredness" was one of the six aims for a 21st-century health system set forth by the Institute of Medicine in 2001.² The term has no universally accepted definition; a variety of metrics and mechanisms are employed in efforts to discern and document it. Efforts to measure quality have moved from a fairly basic evaluation of **patient satisfaction** to a more structured consideration of the **patient experience** of care.

The best-known patient experience instrument is the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a

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family of surveys used by a variety of public and private programs to measure experience across defined domains.³ For example, the version of CAHPS for clinicians asks for patients' assessments of their ability to get timely appointments, care, and information; how well providers communicate; whether office staff are helpful, courteous, and respectful; and overall ratings of providers. Surveys are designed to generate information available only from the patient. Standardization is aimed at ensuring comparability across settings and times. A survey may relate to a particular incident or episode of care, or look back over a period of time. CMS factors CAHPS data into a variety of payment formulae, including payments to accountable care organizations, Medicare Advantage plans, hospitals, nursing homes, and physicians.

Patient-reported outcomes is a measurement approach still coming to maturity. Patients are questioned not about their experience with processes of care ("did the doctor talk to you?" etc.), but about the results of their treatment in terms of function, comfort, social well-being, and the like. **Goal-oriented care** is another developing approach, entailing discussion and agreement between patient and clinician on a treatment plan that reflects the patient's goals and preferences. Asking questions such as "Were your goals met?" is particularly appropriate to chronic care, where multiple conditions may pertain and cure may not be possible.

Other evolving concepts include **patient engagement** and **patient activation**, where patient willingness to be actively involved in health care planning and treatment can be ascertained and encouraged. Higher levels of engagement and activation are associated with more successful self-management of chronic conditions, higher adherence to drug regimens, and other indicators of favorable health status.⁴

Apart from CAHPS, these approaches remain largely aspirational in the United States' health care system. Clinicians and researchers are still learning how to measure patient involvement and priorities. At the same time, they must be aware that not all patients may want, or be capable of exercising, the same degree of control over their care.

REFINING THE FEEDBACK PROCESS

CMS requires clinicians participating in various federal programs to report on specified performance measures, including some that

relate to patient experience of care. As Secretary Burwell wrote in *The New England Journal of Medicine*, HHS recognizes “the need to continue to reach consensus on the quality measures used and address issues related to risk adjustment in these new models.”⁵

Do quality measures reflect what is important to both patients and clinicians? How rapidly is the science of quality measurement developing, and what are the current capacities to collect, analyze, and marshal it in the service of high-quality care?

While generally welcoming information that will help them deliver better care, physicians complain about the number of specific and non-uniform quality measures required of them by payers including CMS, states, and health plans. Receiving timely and actionable feedback from payers has been an issue, as has appropriate risk adjustment. Those caring for socioeconomically disadvantaged patients, for example, seek some recognition of the social determinants of their patients’ comparatively poor health—factors often beyond a clinician’s control—and warn of the perpetuation of health care disparities related to those factors.⁶

Many clinicians are also concerned about the use of patient experience measures, on the grounds that sample sizes can be too small to be meaningful and one or two dissatisfied patients can wreak havoc on a physician’s scores.

CMS aspires to consensus on a core set of measures to be used by all, to have patients involved at all levels of measure development, and to make quality information available in patient-friendly form. Some analysts have suggested that many provider concerns could be ameliorated by the collection of more data, seeking feedback from all patients (via electronic medical records) rather than only those who choose to respond to a survey.⁷

Public reporting of quality information has increased over time. CMS offers comparative information on health plans, hospitals, and physicians, though its Physician Compare tool is only beginning to incorporate quality data along with information about a physician’s education, practice locations, and Medicare status. At a local level, consortia such as those established under the Robert Wood Johnson Foundation’s Aligning Forces for Quality program make public reporting a key component of their quality improvement initiatives. The degree to which patients make use of such reports is difficult to gauge. Unless looking for a measure directly relevant to their medical condition, most patients are unlikely to take the time to pore through a compendium of individual quality measures.

They may be more likely to consult composite ratings, such as the star system employed for Medicare Advantage plans and nursing homes and now being expanded to delivery modes such as dialysis facilities and home health.

It will take time to sort out all the activity intended to lead to patient-centered, higher-quality, more efficient care. Many involved in these efforts are enthusiastic and optimistic, and certainly no one argues that these are not worthy goals. But there is skepticism apparent as well, leading (for example) The Incidental Economist's Aaron Carroll to lament the lack of evidence linking quality measurement to outcomes⁸ or *Modern Healthcare's* Merrill Goozner to characterize value-based rhetoric as "vaporware."⁹ How long the redesign process takes, and how smoothly it proceeds, remain to be seen.

SESSION

This Forum session is a follow-up to a November 2014 meeting,¹⁰ at which the Forum began an examination of efforts to incorporate the patient voice in quality measurement and system redesign. The previous session featured health policy leaders who addressed the evolution of patient-centeredness in a context of health system reform, the proliferation of health IT, and related advances. This session offers another look at the range of related activities in which CMS seeks to play a leadership role. **Kate Goodrich, MD, MHS**, director of the Quality Measurement and Health Assessment Group in the Center for Clinical Standards and Quality at CMS, will talk about activities under way and how they are being evaluated, along with some new initiatives being contemplated. All are intended to work toward system reform, CMS's national quality strategy, and patient integration into medical decision making.

While it is unrealistic to expect one person to speak on behalf of all fellow patients or clinicians, the Forum has asked two people with much relevant experience to comment both as individuals and as members of organizations seeking an enhanced role for patients in quality improvement. **Donna Cryer, JD**, president and chief executive officer of the Global Liver Institute, will share what she has learned as a liver transplant recipient and from working with patient and physician groups, health care companies, and government agencies to ensure that patient views are heard. **Frank Opelka, MD**, is both executive vice president of health care and medical education redesign for the Louisiana State University health system and medical director of Quality and Health Policy

for the American College of Surgeons. He will provide a physician's view of working with patients and payers to improve quality, noting especially how clinician leaders in health IT are looking to use it more effectively to assess patient access to care, treatment progress, and the development of personalized care plans.

KEY QUESTIONS

- What sources of information on the quality of providers' health care are available to patients?
- What mechanisms exist for patients to communicate quality concerns—personal or general—to CMS and other payers?
- What provisions should be made for patients who do not want to take an active role, or are incapable of doing so?
- To what extent should quality measures focus on individual physicians as opposed to groups? What about care teams that include physicians and other professionals?
- What are the data collection and reporting burdens on physicians and others? How might these be ameliorated?
- What types of measures are most effective in driving clinician behavior?
- What are the advantages and disadvantages of a top-down versus bottom-up approach to paying for quality, that is, to payer- versus provider-generated quality programs? What is the likelihood that clinicians can and will take the lead in this process?

ENDNOTES

1. Catalyst for Payment Reform, "2014 National Scorecard and Compendium on Payment Reform," www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard.
2. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, <https://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx>.
3. For more information on CAHPS, see Lisa Sprague, "Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys: Assessing Patient Experience," National Health Policy Forum, The Basics, December 18, 2014, www.nhpf.org/library/the-basics/Basics_CAHPs_12-18-14.pdf.

4. See, for example, David M. Mosen *et al.*, “Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions?” *Journal of Ambulatory Care Management*, 30, no. 1 (January/March 2007): pp. 21-29, http://journals.lww.com/ambulatorycaremanagement/Abstract/2007/01000/Is_Patient_Activation_Associated_With_Outcomes_of.5.aspx.
5. Sylvia M. Burwell, “Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care,” *New England Journal of Medicine*, January 26, 2015, www.nejm.org/doi/full/10.1056/NEJMp1500445.
6. For the National Quality Forum’s 2014 recommendations on risk adjustment for sociodemographic factors, see www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.
7. See, for example, Thomas Lee, “Better picture of patient experience requires more data, wiser use of it,” *Modern Healthcare*, February 9, 2015, p. 25, www.modernhealthcare.com/article/20150207/MAGAZINE/302079979/better-picture-of-patient-experience-requires-more-data-wiser-use-of.
8. Aaron Carroll, “We really want to pay for quality, but it’s so darn hard,” *The Incidental Economist* on the *AcademyHealth Blog*, February 7, 2015, <http://blog.academyhealth.org/wereallywanttopayforquality/>.
9. Merrill Goozner, “Beware vaporware on value-based care,” *Modern Healthcare*, January 31, 2015, www.modernhealthcare.com/article/20150131/MAGAZINE/301319984/beware-vaporware-on-value-based-care.
10. Lisa Sprague, “Patient-Centered Care, Payment, and Policy: The Leading Edge,” *National Health Policy Forum, Forum Session*, November 17, 2014, www.nhpf.org/library/details.cfm/2973.