

Testimony to the Health IT Policy Committee  
Quality Measures Workgroup  
Panel 3: Consumers/Patients/Payers

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Thank you for the invitation to provide testimony as part of the Consumers, Patients and Payers panel for the Quality Measures and Clinical Quality Workgroups. It has been my opportunity to be a member of the Quality Measures workgroup plus the Patient and Family Engagement Tiger team.

As background, my professional experience has increasingly focused on understanding and addressing the non-provider or “demand side” for health services shared by these constituencies, and especially the consumer and patient perspectives.

I am a physician trained in Internal Medicine, Hematology, and Medical Oncology.

For over 20 years I also practiced population medicine at Kaiser Permanente (KP). I served as Executive Director for KP’s Care Management Institute where we focused on implementing improvements in chronic condition care and demonstrating their value through performance measurement.

More recently I have been the KP Medical Director for Health and Productivity Management Programs, working directly with multiple major national employers to develop and implement programs and capabilities to improve the health and productivity of their employee populations. While at KP I participated on leadership groups forming organizational strategy about public reporting of performance. I also supported policy related studies in care personalization done by the KP Institute for Health Policy.

I have also served on the Board of Directors for 2 organizations focused on patient engagement in healthcare: the Center for Information Therapy and the Society of Participatory Medicine.

Finally, I have recently joined the Lewin Group, a health care consultancy, to contribute to efforts to evolve Comparative Effectiveness Research policy and practice. A personal interest is to make CER increasingly relevant and meaningful to patients and to those who support patient decision making. The Lewin Group is owned by Ingenix which is a part of the United Health Group.

The comments that follow are my own and not necessarily the positions of my current or past employers or the organizations I have served in governance and advisory roles. That said, in all of these roles, personal and professional, I have developed a growing appreciation for the importance of taking a disciplined approach to the engagement of multiple constituencies and perspectives in the measurement of health and health care associated benefit realization... or value..

I appreciate that the workgroup has sought input linked explicitly to perspectives beyond those immediately embedded in the delivery of health care services. I’ll focus my comments on what I have heard and am learning from these other perspectives – patients plus consumers and to some extent, payers including large employers - about their engagement and contribution to quality improvement.

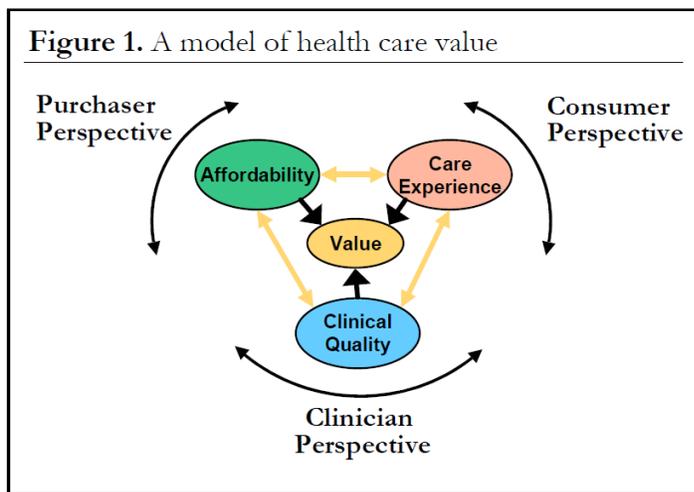
**The need to actively engage multiple perspectives of value...** To jump to my overall conclusion and suggestion, increased engagement of all of the stakeholders represented by these perspectives will be essential for improving health, but the steps needed and measures required to create impactful participation will vary by perspective. The MU quality measures program in its earliest phase has reasonably focused almost exclusively on responding to the supply side of health care focusing on the clinician and hospital perspective(s) of achieving value. Full involvement of this clinical perspective is essential but also, I believe ultimately insufficient. In particular, opportunity exists to bolster patient and consumer engagement, directly through involvement of the patient with their provider and delivery system and indirectly through influence exerted by their payer and when applicable, their employer and work environment. Building a portfolio that more fully reflects patient linkage and active engagement is a key opportunity for phases 2 and 3. I would not expect to have a balanced portfolio fully addressing all perspectives even by the end of phase 3, but major progress can be attained even with the concepts now being advanced.

### Investigation on Perspectives of Value

As the questions to the panel relate to how the constituencies assign value to aspects of the measurement portfolio, I'll preface my answers to those questions with description of a value model incorporating the varied perspectives of the clinician, the patient/consumer and the payer.

***“What will it take for the patient and payer to ‘get’ quality?”***

A few years ago at the KP Care Management Institute we systematically sought out, interviewed, and engaged through meetings, groups of health care providers, patients and payers – both public and private - to ascertain how they thought about and evaluated “value” in health care. Our initial framing was that we sought to understand what it would take for the consumer/patient and employer/purchaser to “get (understand...) quality”, as reflected by donabedian logic and nested measures of health care system structure, process and health outcomes. However, the more complex value model we eventually derived (Figure 1) reflected the quite different elements of perceived and desired aspects of the overall health care enterprise among the sampled perspectives.



(See Background Paper: Could a Quality Index Help us Navigate the Chasm by J. Bellows and MP Sullivan [http://xnet.kp.org/ihp/publications/docs/quality\\_background.pdf](http://xnet.kp.org/ihp/publications/docs/quality_background.pdf) )

Simply, clinicians and health system leaders did most frequently associate value with “traditional” metrics of clinical structure, process, and health outcomes. Patients however identified aspects of the care experience, including convenience, respectful providers and a trusting relationship with their clinician as most critical for them in terms of engagement and as meaningful attributes of value. Payers, including both health plans and major employers sponsoring self-funded coverage plans, not surprisingly identified financial metrics, and especially overall cost of health care services plus return on their health associated investments as their leading indicators of value. Importantly, no payer suggested reducing costs by relaxing clinical quality standards. Rather cost impact was generally identified as attainable through improved efficiency and reduction of waste. Each perspective recognized and granted importance, although lower priority, to the elements of the other perspectives. However, they assigned prime ‘value’ within their perspective to substantially different metrics. Each perspective did ‘get quality’, but in their own manner.

### ***Linking Value Models and Quality Strategy...***

This value model is a close cousin of the triple aims proposed by the Institute for Quality Improvement with 3 overarching goals to be addressed *simultaneously* in pursuit of improved health system value. The IHI specific aims are

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

<http://www.ihq.org/IHI/Programs/StrategicInitiatives/IHITripleAim.htm>

Very similar concepts – *Better Care, Affordable Care, and Healthy People/Healthy Communities* - now form the framework for the National Quality Strategy.

Beyond performance monitoring and management, strategic use and communication of measurement topics and priorities is a critical step for engaging needed stakeholders. It is also reasonable to expect that how diverse stakeholders weigh the relative importance of each aim in these national strategies will be closely linked to the differing perspectives of these same interested parties in health quality. A balanced approach to quality will ideally engage all of the perspective as key beneficiaries as well as gaining wider participation as the required enablers of the overall strategy.

### ***Measuring across the spectrum of the Care Experience***

Clearly, the interaction of a patient with the health system has multiple dimensions that vary with patient circumstance as well as available services. While patient-centeredness has been positioned securely as a basic element of Quality since the IOM quality reports of the last decade, measurement frameworks to capture the patient’s quality experience have been problematic, with most progress coming from standardized patient surveys such as the CAHPS family of instruments. While the capability for doing such surveys will be an appropriate goal for meaningful use, we were also interested in additional complementary approaches to better

bridge other forms of quality measurement to the patient experience, especially in the context of health reform.

In the fall of 2008 the KP Institute for Health Policy convened a roundtable discussion among several California and National Health Care leaders including providers, payers, regulators and policy 'wonks' about opportunities for elevating the concept of patient-centeredness in the health reform debate. A key and I believe durable take away from that discussion was the need to move beyond an exclusive focus on what can be done to and for patients by providers and a health system. Successful patient engagement was seen as enabling patients to understand, participate in and direct their own care. Examples that were cited included shared decision making, use of PHRs by patients and their clinicians, plus programs for palliative and end-of life care that require care decisions highly customized for and dependent on the patient and their family. ([http://xnet.kp.org/ihp/publications/docs/quality\\_background.pdf](http://xnet.kp.org/ihp/publications/docs/quality_background.pdf) )

The added element relevant to this discussion of quality measurement in meaningful use is that a measurement framework that is informative across the patient experience should ideally include metrics that reflect:

- Care delivered **for the patient** (e.g. key prevention testing, case management, and much chronic condition management)
- Care delivered **with the patient**, (e.g. shared decision making, and care coordination)
- Care 'delivered' **by the patient** and their family, ideally with health system support (e.g. traditional self-care, health behavior change, and much end-of-life support)

*The focus in my responses to the following questions is on how actively considering non-provider perspectives, and especially those of the patient and consumer, complement and extend the scope of provider directed measurement topics plus offer opportunity for expanding direct patient engagement and contribution to desired health outcomes...*

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### **Questions to Panel 3: Consumers/Patients/Payers**

- **Which of the Stage 1 quality measures are most valuable to consumers and patients?**
  - *While the measure topics in stage 1 feature multiple important areas for clinicians to address in pursuit of specific health outcomes, this measure set provides little direct insight to the consumer patient about their often dominant value concerns relating to the care experience. For example, using the "bridging" framework discussed above,*
  - *the only Stage 1 quality measure **not** best classified as being done for patients would be Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies*
  - *With this exclusive focus on what the provider does for the patient, the Stage 1 measures also don't communicate to clinicians and their associated delivery systems the importance of patient engagement or create robust accountabilities for support of self-care*

*This is not just a matter of “the (quality measures) glass being 90% full...” with a few tweaks needed to bring the patient into compliance; the challenge is more fundamental in building a portfolio relevant across perspectives of value and the spectrum of the patient experience; fortunately, as noted below, stages 2 and 3 do begin to more fully address the more complete patient perspective*

*An area of comparable need in building out the full “value based” portfolio of measures is to more fully address affordability as the key issue of the payer and employer perspectives, as a component of the triple aim, and as a topic increasingly entering the patient consumer perspective. Beyond identifying as a critical element of the overall measurement portfolio I will defer specific suggestions about affordability to others on the panel.*

*I’d be remiss if I didn’t note that Stage 1 overall did substantially impact aspects of the care process that are highly relevant to and valued by the consumer/patient. Providing reliable and timely access to care information plus the combined enhancements focused on information sharing among providers while protecting confidentiality are highly consistent with an enhanced care experience. .Also, the support for the Use of certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate requirement is an important message for both providers and patients about opportunities for meaningful use.*

**Which of the proposed Stage 2 e-specified measures and new measure concepts are most valuable to consumers and patients – (noting that the data may not be made public)?**

*Opportunity, as noted above, from the patient perspective, is to move towards building an increasingly **balanced** portfolio that reflects:*

*What is being **done for patients***

*What is being **done with patients** including both collection of patient generated data (e.g. HRA, and self-identified QOL and PS) plus active collaboration with patients(e.g. Aspects of Care coordination, Shared decision making)*

*What is best **done by patients** themselves, although often with health system support (e.g. “selfcare”, behavior change, ...)*

*Examples of new measures reflecting care done with patients:*

*HRA(2)*

*Functional status collection(2) and change over time (3)*

*Experience with care survey*

*Use of Shared decision materials (3)*

*Decision Quality (3)*

*The care transitions subdomain (2 and 3)*

*Examples of new measures ideally reflecting both care done with patients and by patients*

*Patient activation and self management (3)*

*The effective care planning subdomain (2 and 3)*

*Further enhanced “Value” in Stages 2 and 3, as it relates to EPs and Hospitals is the signaling by these measures to providers of the importance of addressing the care experience , and ideally more fully engaging the provider to become more actively contemplative of the importance of addressing directly the patient perspective*

**How do the Stage 1 and proposed Stage 2 quality measures correspond to or add value to existing payer efforts to use quality information?**

*I’ll limit my comments to a higher level view of where there is an intersection of payer/employer interests and initiatives with the expanded patient perspective of value, plus where associated quality measures can provide important signals to the patient plus offer reinforcement to efforts to address and improve aspects of the care experience.*

*As others will discuss the payer perspective primarily needs more robust measures that relate directly to affordability*

*However, at least some payer leverage is being applied to improve quality and address value more globally by also providing support of improving patient engagement via benefit design and program implementations such as health and wellness coaching. Over time, the evolution of payer initiated, patient focused efforts related to aspects of value (including affordability) can be stratified as follows:*

*Efforts to reinforce and clarify the “Rules of the game”- examples include close attention to benefit coverage, the choice of plans offered, and implementation of case management for selected patients*

*Efforts to engage patients and consumers to have “Skin in the game”, designed to enhance engagement through personal financial risk – examples include expanded cost sharing and “value based benefit designs”*

*Efforts to get the patient’s “Mind in the game”, through programs to promote engagement to address personal health risk. Examples include employee/patient engagement and behavior change; incentives linked to health related behaviors and outcomes; and health and wellness coaching*

*These payer/employer interventions map well to the full spectrum of the patient perspective:*

*Rules of the game ↔ Largely done for the patient*

*Skin in the game ↔ Largely done with the patient*

*Brain in the game ↔ Largely done by the patient with system supports*

*These latter interventions have increasingly relied on expanding overall patient engagement – consequently, measures that reflect increased patient engagement plus overall improvement in the care experience are at least theoretically very much aligned with aspects of the payer and employer perspectives.*

**• How are patients/consumers becoming aware of the collection and reporting of quality measures?**

- At Kaiser Permanente, a highly structured internal approval and implementation process is followed to create online availability for consumers and patients to “third

party” quality and other performance measures. A partial list of measures reflective of overall organizational performance is made available through the KP patient portal, [kp.org](http://kp.org) includes:

- Health plan accreditation status from the National Committee for Quality Assurance (NCQA )
- Clinical effectiveness of care measures of performance from the Healthcare Effectiveness Data and Information Set (HEDIS )<sup>1</sup>
- Health plan member satisfaction from the Consumer Assessment of Healthcare Providers and Systems (CAHPS ) Survey<sup>2</sup>
- Hospital accreditation status and national quality improvement goals from The Joint Commission (TJC )
- Hospital patient safety from The Leapfrog Group
- Collaborative statewide hospital report card (CalHospitalCompare.org) from the California Hospital Assessment and Reporting Taskforce (CHART )
- Health plan clinical quality and efficiency from the National Business Coalition on Health's eValue8™ (NBCH eValue8 )
- Physician group clinical care ratings from the Integrated Healthcare Ass'n (IHA ), the State of California Office of the Patient Advocate (OPA ), and the California Cooperative Healthcare Reporting Initiative (CCHRI )
- Initiated in the Northern California KP region and now implemented more widely, physicians have individual personalized home pages directed to current and potential patients that focus on professional credentials plus aspects of the care experience within that physicians practice (<http://permanente.net/homepage/index.html> )
- In addition to this “Public reporting” of performance as overseen by payers, health systems and provider organizations, aspects of physician performance, largely related to the patient experience can also be obtained directly from the “reporting public” at sites such as:
  - Yelp (<http://www.yelp.com/c/sf/physicians>)
  - HealthGrades (<http://www.healthgrades.com/> )

## In Conclusion

The MU quality measures program in its initial phase has reasonably focused almost exclusively on responding and engaging to the supply side of health care, focusing on the clinician and hospital perspective(s) of achieving value. Full involvement of this clinical perspective is essential but also, I believe ultimately insufficient. In particular, opportunity exists to bolster patient and consumer engagement, both directly through using measurement to promote involvement of the patient with their provider and delivery system and indirectly through influence exerted by their payer and when applicable, their employer and work environment. Building a portfolio that more fully reflects patient linkage and active engagement across the continuum of the patient experience is a key opportunity for phases 2 and 3 and is occurring to a modest but significant degree. I would not expect to have a fully balanced portfolio even by the end of phase 3, but major progress can be attained even with the concepts now being advanced.

Thank you.