# 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**



• 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

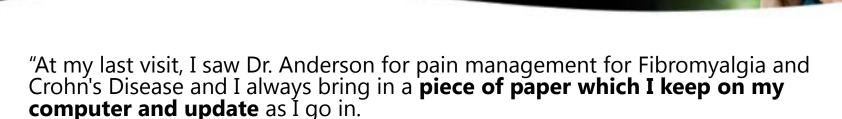
- Patient Activation (PAM)
- Decision quality/shared decision making
- Support for self management (tools, goals, etc.)

#### Ready Access

- Wait times
- Language services
- Cost of care measures
- Structural measures of access (after hours, online, etc.)

### **CAHPS**

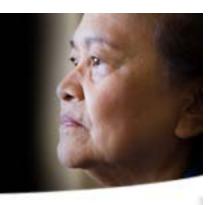
## Patient-Centered Feedback



**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: <a href="http://www.rand.org/news/press/2011/02/22/index1.html">http://www.rand.org/news/press/2011/02/22/index1.html</a>

## **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
- 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.)



- 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
- Measure performance at all levels (especially individual), reflecting shared accountability
- 10. Minimize burden; collect data efficiently

Consumer-Purchaser DISCLOSURE PROJECT

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# High Level Example of Breadth



#### The Patient-Centered Measure Dashboard

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

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

