

# Beyond HEDIS and CAHPS: Expanding Quality Performance Measurements

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# DEFINING QUALITY HEALTH CARE

- “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” ( Institute of Medicine)
- The right care at the right time



# DEFINING QUALITY HEALTH CARE\*

- **Safe** - avoiding injuries to patients from care that is intended to help them.
- **Effective** - providing services based on scientific knowledge and refraining from services not likely to benefit.
- **Patient centered** – providing care that is respectful or responsive to individuals' needs and values.
- **Timely** – reducing waits and potentially harmful delays
- **Efficient** – avoiding waste
- **Equitable** – providing care that does not vary regardless of personal characteristics

\* Institute of Medicine. 2001. Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century.




# HEDIS MEASURES

- Effectiveness of care
- Satisfaction with the experience of care
- Access/availability of care
- Use of services
- Health plan descriptive information
- Health plan stability



# HEDIS-EFFECTIVENESS OF CARE

- Childhood and adolescent immunizations
  - Appropriate treatment of children
    - URIs, pharyngitis
  - Colorectal, breast, and cervical cancer screening
  - Chlamydia screening
  - Appropriate medications for asthma
  - Hypertension
  - Beta blockers post-MI
  - Mental health, smoking cessation, and EtOH counseling
- 

# HEDIS-EFFECTIVENESS OF CARE: DIABETES

- Nephropathy screening
- HGB A1C testing
- HGB A1C outcomes
- LDL cholesterol screen
- LDL cholesterol outcomes
- Retinopathy



# HEDIS-EFFECTIVENESS OF CARE MEASURES

- Room to improve
  - Chlamydia screening
  - Colorectal screening
  - Diabetic retinopathy
  - Smoking cessation
  - Alcohol counseling
  - Management of depression



# HEDIS MEDICARE MEASURES

- Osteoporosis management in women after fractures
- Flu shots for older adults
- Pneumonia vaccination
- Health outcome survey
- Urinary incontinence



# HEDIS MEASURES 2005

- Reported in 2006
- Use of beta blockers 180 days after MI
- Imaging studies for low back pain
- Glaucoma screening in older adults



# NEW HEDIS MEASURES 2006

- Report in 2007
- Spirometry testing for COPD
- Pharmacotherapy management of COPD
- Care for children prescribed ADHD medication
- Appropriate treatment for adults with acute bronchitis
- Drugs to be avoided in the elderly
- Annual monitoring of patients on persistent medications



# PROPOSED NEW HEDIS MEASURES 2007

- **Relative Resource Use**
  - Diabetes, cardiac, asthma, COPD, HTN, and acute low back pain
- **Drug-Disease Interactions in the Elderly**
  - Developed with CMS
- **Comprehensive Diabetes Care**
  - BP control 135/85, and HbA1c <7%



# CAHPS

- Assesses:
  - Access to services
  - Member satisfaction
  - Demographic and health status information
- Can be customized
  - ECHO, Medicaid, Medicare, ACAHPS, HCAHPS
- Limited questions on chronic diseases
- Patient satisfaction on CAHPS not necessarily correlated with quality of care on clinical measures



# MEDICAL GROUP REPORTING

- Less governmental oversight
- Requires special audits to have adequate numbers for valid results
  - Cannot simply stratify health plan HEDIS data
- In California, medical group reporting conducted by Integrated Healthcare Association (IHA)
- Sponsors Patient Assessment Survey (PAS)
  - Analogous to CAHPS
  - Used to measure enrollee satisfaction with medical groups



# AMA PHYSICIAN CONSORTIUM FOR PERFORMANCE IMPROVEMENT

- Comprised of specialty societies, AHRQ, CMS
- Has developed 99 measures in 17 clinical areas
- Developing specialty guidelines
- Measures intended to facilitate individual physician quality improvement
- Not intended for physician comparison



# AMA PHYSICIAN CONSORTIUM FOR PERFORMANCE IMPROVEMENT

- Based on evidence based guidelines, but not intended to be used as clinical guidelines
- Settings and population delineated
  - No minimum sample size
- Prospective data collection flow sheets developed
- Relies on administrative and chart extraction data



# AMBULATORY CARE QUALITY ALLIANCE (AQA)

- Formed in 2004 with AAFP, ACIP, America's Health Insurance Plans, and AHRQ
- Includes 26 measures
- Drawn from existing measures developed by PCPI and NCQA
- Focus on prevention, chronic care, and overuse and misuse of certain treatments
- Concern that solo and small group practices not equipped to capture data or comply with measures



# AQA

- AQA Clinical performance measures for ambulatory care
  - Prevention measures include breast, colorectal, and cervical cancer screening
  - Screening tobacco use, and advising smokers to quit
  - Influenza, pneumococcal vaccinations
- Coronary artery disease
  - Drug therapy for LDL cholesterol
  - Beta blocker after MI at 7 days and 6 months



# AQA CLINICAL PERFORMANCE MEASURES FOR AMBULATORY CARE

- Similar to HEDIS measures plus;
- Heart Failure
  - ACE/ARB therapy
  - Left ventricular function assessment
- Prenatal care
  - Screening for HIV
  - Rhogam



# NATIONAL QUALITY FORUM

- Evolved from 1998 recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry
- Established in 1999 as a public benefit corporation
- Public-private collaborative venture
- National voluntary consensus standards
- Generated with physician input



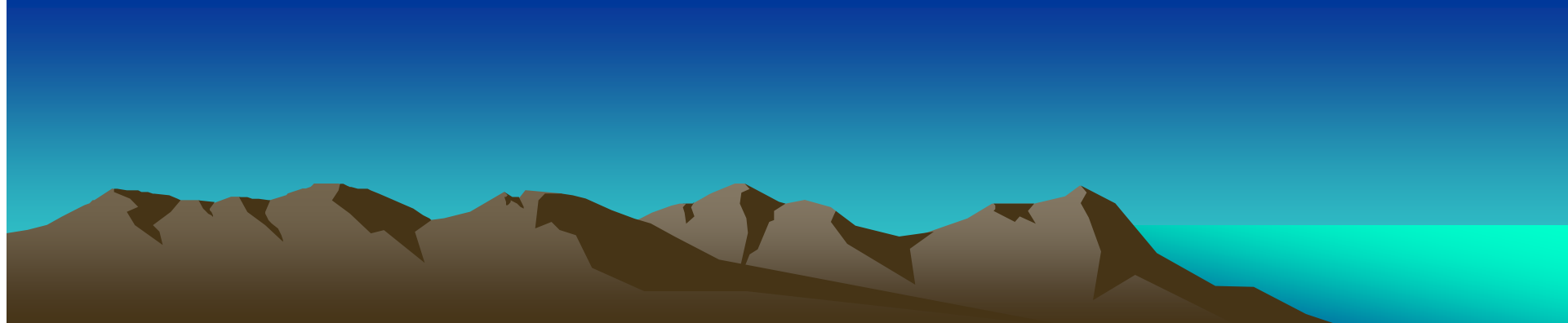
# NQF Ambulatory Care Standards

- Measures drawn from PCPI, NCQA and others
- Focus on primary care, not subspecialty care
- May 2006 endorsed 37 measures in 5 areas
  - Asthma/respiratory illness
  - Hypertension
  - Medication management
  - Obesity
  - Prevention/immunization/screening



# NQF Additional Proposed Ambulatory Measures

- 49 more measures
  - Bone and Joint Disease
  - Diabetes
  - Heart Disease
  - Mental Health and Substance Use
  - Prenatal care



# CMS Physician Voluntary Reporting Program (PVRP)

- 36 measures identified from AQA and NQF
- Represent range of specialties
  - Emphasis on geriatrics/Medicare conditions
- CMS will provide confidential reports to participants



# Enrolling in PVRP

- Inform CMS of intent to participate via:  
[www.qualitynet.org/pvrpintent](http://www.qualitynet.org/pvrpintent)
- Takes less than 5 minutes to complete
- Tax ID and UPIN required
- Questions?- **PVRP@cms.hhs.gov.**



# CMS 16 PVRP CORE STARTER SET MEASURES

- Aspirin at arrival for acute myocardial infarction
- Beta blocker at time of arrival for acute myocardial infarction
- Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus
- Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus
- High blood pressure control in patient with Type I or Type II diabetes mellitus
- Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction
- Beta-blocker therapy for patient with prior myocardial infarction
- Assessment of elderly patients for falls



# ***PVRP 16 Core Starter Set Measures***

- Dialysis dose in end stage renal disease patient
- Hematocrit level in end stage renal disease patient
- Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis
- Antidepressant medication during acute phase for patient diagnosed with new episode of major depression
- Antibiotic prophylaxis in surgical patient
- Thromboembolism prophylaxis in surgical patient
- Use of internal mammary artery in coronary artery bypass graft surgery
- Pre-operative beta-blocker for patient with isolated coronary artery bypass graft



# Medicare PVRP Physician's Data-Collection Sheet

Date: \_\_\_\_\_

Physician: \_\_\_\_\_ Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ MR#: \_\_\_\_\_

## For patient with diabetes Report quarterly (last reported: \_\_\_\_\_)

- Hemoglobin A1c (Check only one.)**
- ☐ Patient in this practice < 12 months ..... G8018
  - ☐ Patient documented as not eligible for the A1c measure ..... G8017
  - ☐ No A1c documented ..... --
  - ☐ Most recent A1c documented as  $\leq 9\%$  ..... G8016
  - ☐ Most recent A1c documented as  $> 9\%$  ..... G8015

- Low Density Lipoprotein (Check only one.)**
- ☐ Patient in this practice < 12 months ..... G8022
  - ☐ Patient documented as not eligible for the LDL measure ..... G8021
  - ☐ No LDL documented ..... --
  - ☐ Most recent LDL within the last 12 months documented as  $< 100$  mg/dl ..... G8020
  - ☐ Most recent LDL within the last 12 months documented as  $\geq 100$  mg/dl ..... G8019

- Blood Pressure Control (Check only one.)**
- ☐ Patient in this practice < 12 months ..... G8026
  - ☐ Patient documented as not eligible for the blood pressure measure ..... G8025
  - ☐ No blood pressure documented ..... --
  - ☐ Most recent blood pressure within the last 12 months documented  $< 140$  systolic and  $< 80$  diastolic ..... G8024
  - ☐ Most recent blood pressure within the last 12 months documented as  $\geq 140$  systolic or  $\geq 80$  diastolic ..... G8023

## For patient with heart failure Report quarterly (last reported: \_\_\_\_\_)

- ACE-I or ARB Therapy for LVSD (Check only one.)**
- ☐ LVEF  $\geq 40\%$  or Patient documented as not being a candidate for ACE-I or ARB ..... G8029
  - ☐ Patient documented to be on either ACE-I or ARB ..... G8027
  - ☐ Patient not documented to be on either ACE-I or ARB ..... G8028

## For patient with coronary artery disease Report quarterly (last reported: \_\_\_\_\_)

- Beta-blocker Therapy for Patient with Prior Myocardial Infarction (Check only one.)**
- ☐ Patient documented as not eligible for beta-blocker or has no prior myocardial infarction ..... G8035
  - ☐ Patient documented to be on beta-blocker ..... G8033
  - ☐ Patient not documented to be on beta-blocker ..... G8034

## For patient age 75 or older Report annually (last reported: \_\_\_\_\_)

- Assessment for Falls (Check only one.)**
- ☐ Patient documented as not eligible for falls assessment within last 12 months ..... G8056
  - ☐ Falls assessment documented within last 12 months ..... G8055
  - ☐ Falls assessment not documented within last 12 months ..... G8054

## For patient age 18 or older, with new episode of major depression (Check only one.) Report quarterly (last reported: \_\_\_\_\_)

- ☐ Patient documented as not eligible for antidepressants for all 12 weeks or not treated with antidepressants ..... G8128
- ☐ 12 weeks of antidepressant medication prescribed; treatment just beginning or ongoing ..... G8126
- ☐ Patient documented as treated with antidepressant medication for entire 12 weeks ..... G8126
- ☐ Patient not documented as treated with antidepressant medication for entire 12 weeks ..... G8127

Physician signature \_\_\_\_\_

# MEDI-CAL PROVIDER ACCESS STANDARDS 2005

- 90% compliance required:
  - Preventive care exam with PCP within 30 days
  - Urgent care visit with any physician with 24 hours
  - Routine (non urgent) with PCP within 4 days
- Well child visit with PCP within 7 days
- Initial prenatal visit to OB/GYN within 7 days
- After hours instructions for accessing emergency care
- After hours ability to contact a physician



# NATIONAL HEALTHCARE QUALITY REPORT

- The most extensive healthcare quality report in US or any industrialized country
- Includes measure specifications from varying sources
  - Healthy People 2010, SEER, BRFSS, CMS
- Includes both national and state databases
- Ambulatory, inpatient, and nursing home measures
- Often expressed in rates for a population
  - Process and outcome measures



# NATIONAL HEALTHCARE QUALITY REPORT

- Produced by AHRQ
- Produces annual reports since 2003
- Based on detailed analyses of 179 measures
- Allows comparisons nationwide
- Found quality is improving but gaps exist, and improvement is possible



# NATIONAL HEALTHCARE QUALITY REPORT

- Standardizes national measures
- Allows comparisons by state or health plan
- Measures healthcare quality across four dimensions
  - Effectiveness
  - Safety
  - Timeliness
  - Patient centeredness



# NATIONAL HEALTHCARE QUALITY REPORT: EFFECTIVENESS MEASURES

- Cancer
  - Death rates/100,000 population
- Diabetes
- End stage renal disease
- Heart disease
- HIV/AIDS
- Maternal child health
- Mental health
- Respiratory diseases
- Nursing home and home health care



# Behavioral Risk Factor Surveillance System (BRFSS)

- Sponsored by CDC and states
- Telephone survey of 2,000-6,000 adults/state
- Core questions: states can customize
- Targets alcohol and drug use, health status, prevention, utilization, and access
- Collects gender, age, educational attainment, race/ethnicity, household income, employment status, and marital status



# 2004 Oregon Health Risk Health Status Survey Report

- Personal doctor
  - White 71%, African American 64%, Hispanic 65%
- Needed care, did not get
  - White 18%, African American 27%, Hispanic 23%
- Little racial/ethnic variability for some measures
  - Getting appointments as soon as wanted
  - Physical, and mental composite summary scores



# California Health Interview Survey CHIS

- Provides information on health and access to health care services

Telephone survey of 40-50,000 California adults, adolescents, and children

- Conducted every two years since 2001

CHIS is the largest state health survey in the United States

- Oversamples racial and ethnic minorities with multi-language interviews
- Collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute
- Funding from state and federal agencies and private foundations

The California Health Interview Survey is based at the UCLA Center for Health Policy Research in Los Angeles, California



# CHIS and Mental Health

- CHIS 2001 data
- 16% of Californians, and 20% of Latinos and African Americans reported needing mental health services
- 42% of Californians reporting needing mental health received mental health services
- Minorities 30% less likely to receive mental health services
- LEP 80% less likely to receive mental health services after controlling other variables
- Lack of insurance reduced services by 50%

– Sentell P. California Program on Access to Care Findings. February 10, 2005



# Hospital Quality Incentives

- Medicare sponsoring demonstration project
  - Premier Hospital Quality Incentive
  - Based on 33 indicators including joint replacement, CAPG, MI, CHF, and pneumonia
  - Rewards programs in top decile with 2% bonus
    - 1% in 2<sup>nd</sup> decile
  - Planning reduced payments for poor performance



# Hospital Safety Measures

- “Read back” key information
- Communicating with patients and families re adverse events
- Accurate labeling of reports
- Communicate medication list through continuum of care
- Computerized order entry system
- Handwashing



# California Hospitals Assessment and Reporting Task Force (CHART)

- Based on NQF, CMS and JCAHO standards
- Over 200 hospitals
  - All hospitals with >250 beds
- Planned launch including public reporting in 2006



# CHART Measures

- JCAHO-
  - CABG, Pneumonia, CHF, MI
- Patient surveys- HCAHPS
- ICU mortality and length of stay
- Pregnancy/childbirth



# CHART Safety Measures

- Leapfrog
  - ICU intensivists
  - Electronic ordering
- Patient falls
- Central line infections
- Nosocomial infections
- Decubitus ulcers



# Potential End of Life Measures

- Family perceptions of care
- Comfort care
- Intensity of services
  - Admissions
  - ICU
  - Chemotherapy



# California Healthcare Foundation

## Home Health Quality Measures

- **Quality of Facility**
- Total number of deficiencies
- **Quality of Care**
- ***Quality of Life***
- Getting better at walking or moving around
- Getting better at getting in and out of bed
- Have less pain when moving around
- Getting better at bathing
- Confused less often
- ***Clinical Care***
- Getting better at taking medications correctly
- Received urgent, unplanned medical care
- Admitted to the hospital



# CHALLENGES IN MEASURING HEALTHCARE QUALITY

- Lack of information and information systems
- Coordinating collection and analysis
- Appropriate risk adjustment
- Institutional resistance, limited incentives
- Cost



# STRATEGIES FOR IMPROVING HEALTH CARE QUALITY\*

- Implement quality improvement and measurement systems
- Adopt evidence based standards
- Embrace tracking and public reporting
- Reward those who deliver excellent care

\*Hansen D. Health Care Quality in California. Cal. HealthCare Foundation. Jan. 2000



# Public Reporting



# WEBSITE MAIN PAGE (TOP)

## 2006 Healthcare Quality Report Card

Welcome to **California**



### 2006 Healthcare Quality Report Card

Rating California's HMOs and Medical Groups

[Glossary](#) [Directory](#) [English](#) [Español](#) [中文](#) [A](#) [A](#)



#### California HMOs' Ratings

	★★★★★ Excellent	★★★★ Good	★★★ Fair	★★ Poor
<b>Providing Quality Care</b> How HMOs scored on meeting national standards of care				
<b>Members Rate HMO</b> How HMOs scored on a member survey of care and service				

Aetna Health of California Inc.	★★	★		
Blue Cross HMO - CaliforniaCare	★★	★★		
Blue Shield of California HMO	★★	★★		
CIGNA HealthCare of CA	★★	★		
Health Net of California, Inc.	★★★★	★★		
Kaiser Permanente - Northern California	★★★★	★★★★		
Kaiser Permanente - Southern California	★★★★	★★★★		
PacificCare of California	★★★★	★★		
Western Health Advantage	★★	★★★★		

#### 1 HMO Ratings

An HMO is the health insurance plan that pays for your care | [More](#)

This report card rates HMOs on the quality of the care its members receive, what its members say about their care, and its services for members who do not speak English. Compare HMOs by choosing a topic below.

<b>Providing Quality Care</b>	<b>Members Rate HMO</b>
Asthma Care	Helping Smokers Quit
Checking for Cancer	HMO Customer Service
Diabetes Care	Member Complaints
Heart Care	Members Rate HMO Doctors and Care
Maternity Care	
Mental Health Care	<b>Language Services</b>
Sexually Transmitted Infections	Language services for members who do not speak English
Testing for Cause of Back Pain	Servicios en otros idiomas para afiliados que no hablan inglés
Treating Children: Infections and Immunizations	為母語不是英語的會員提供語言協助服務

#### 2 Medical Group Ratings

A medical group is the group of doctors that provide your care | [More](#)

This report card rates medical groups on what its patients say about their care and service. Compare how patients rate these groups of doctors by choosing a county below.

Choose a county

# Why Public Reporting?\*

- Promote accountability
- Promote competition
- Aid consumers in decision making
- Promulgate standards

\*Performance Measurement: Accelerating Improvement. Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs, Board on Health Care Services. Institute of Medicine. The National Academies Press. Washington, DC. 2006



# Public Reporting On Quality In The United States And The United Kingdom\*

- Few published studies
  - No published data from randomized controlled trials on the effect of public reporting specifically on quality
- Strongest existing evidence from observational studies of short-term mortality and morbidity following cardiac surgery
  - Indicate that states with public reporting systems have experienced declines in cardiac surgery mortality more rapid than without public reporting

\*Marshall et al. *Health Aff (Millwood)* 2003;22:134-148



# Public Report Cards--Cardiac Surgery and Beyond\*

- Thirty-seven states have mandatory health care reporting systems for inpatient hospital data
  - 10 have voluntary systems
- In general, more information available from individual states than from any national source.
- Evidence that the public disclosure of death rates associated with surgery in New York and other states has contributed to reductions in operative mortality

\*Steinbrook *NEJM* 2006;355:1847-1849



# Does making hospital performance public increase quality improvement efforts?\*

- Study conducted in Wisconsin
- Public report significantly changed consumer views about quality differences among hospitals
- Those seeing the report more likely to indicate they would recommend or choose top tier hospitals than those not seeing the report
- Providing an evaluable report appears to have affected consumer views about which are the better and worse hospitals

\*Hibbard JH, Stockard J, Tusler M. 2002. Presented at Acad. Health Serv. Res. Health Policy. Annu. Res. Meet., Washington, DC



# Public Views on Healthcare Performance Indicators and Patient Choice\*

- Little evidence that Americans use this information to make choices
- Possible explanations:
  - Consumers are not aware of variations in quality so do not seek information about 'the best' providers
  - Consumers do not believe they have a choice or prefer to leave it to their employer to choose a plan
  - Relevant information is not available at the time it is needed
  - Healthcare report cards are badly designed and consumers find them hard to understand
  - Consumers do not trust the information or its source
- British public likewise ambivalent about value of performance indicators
- Strong sense that some form of public monitoring is necessary and desirable

\*Magee et al. *J. R. Soc. Med.* 2003;96:338-342



# Supporting Informed Consumer Health Care Decisions\*

- To make informed choices and navigate within a complex health care system, consumers must have easily available, accurate, and timely information
  - Then they must use it.
- Abundance of information may not mean it is used to inform choices
  - Need to present and target that information so it is used in decision-making.
- Departure from how most health care information producers see their role
  - Not enough to provide complete, objective, and accurate information
  - Places additional responsibility on public reporting
  - supporting decisions will require more strategic and sophisticated efforts

\*Hibbard J. Peters E. Annual Review of Public Health, Vol. 24: 413-433



# Impact of Public Reporting\*

- Consumers and purchasers rarely search out the information and do not understand or trust it
- Small, although increasing, impact on their decision making
- Physicians are skeptical about such data and only a small proportion makes use of it.
- Hospitals appear to be most responsive to the data.
- In a limited number of studies, the publication of performance data has been associated with an improvement in health outcomes.

**\*The Public Release of Performance Data What Do We Expect to Gain? A Review of the Evidence**  
Martin N. Marshall, MSc, MD, FRCGP; Paul G. Shekelle, MD, PhD; Sheila Leatherman, MSW; Robert H. Brook, MD, ScD *JAMA*. 2000;283:1866-1874.



# How Do We Maximize the Impact of the Public Reporting of Quality of Care?\*

- Understand the environment within which public reporting takes place
- Actively address unintended consequences
- Incentivize response to data and of engaging the public and media

\*Martin N. Marshall, Patrick S. Romano, and Huw T. O. Davies Int J Qual Health Care 2004 16: i57-i63; doi:10.1093/intqhc/mzh013



# It's the Economy Stupid

- When all is said and done:
  - Enrollees say they value quality but...
  - Other factors appear more important
    - Physician or office loyalty
    - Cost, cost, cost



# Unintended Consequences of Public Reporting\*

- Ability to improve health remains undemonstrated
- May inadvertently reduce, rather than improve, quality
  - Physicians avoiding sick patients to improve quality ranking
  - Encouraging physicians to achieve "target rates" for health care interventions even when it may be inappropriate
  - Discounting patient preferences and clinical judgment
- "Teaching to the test"

\*The Unintended Consequences of Publicly Reporting Quality Information [Rachel M. Werner, MD, PhD; David A. Asch, MD, MBA](#) JAMA. 2005;293:1239-1244



# CHALLENGES OF MEASURING HEALTHCARE QUALITY

- Cost of collecting data
  - Promise of EHRs
- Scope of measures
  - Skewed toward objective, quantifiable indicators
  - Limited to “evidence based” measures
    - ?Obesity
  - ?Too narrow; vs overwhelming for providers or consumers
- Unintended consequences
  - Sophisticated understanding of populations served



# CHALLENGES OF MEASURING HEALTHCARE QUALITY

- **What's missing?**
  - IOM six domains of quality
  - Equity/health disparities
    - Race and ethnicity data
  - Efficiency
  - Safety
- “Systemness”
- Patient counseling
  - Healthy lifestyles
- Access
  - Limited english proficiency
  - Mental health, disability, special populations

# THE FUTURE OF PUBLIC REPORTING OF HEALTHCARE QUALITY MEASURES

- What level of service do we report?
  - Health plans
  - Medical groups
  - Physicians
    - Caution: Beware of unintended consequences!!
  - Integration



# THE FUTURE OF PUBLIC REPORTING OF HEALTHCARE QUALITY MEASURES

- Improve quality by identifying disparities
  - Plan to plan comparisons
- Other sources of disparities
  - Geographic
  - Demographic
  - Product line



# THE FUTURE OF PUBLIC REPORTING OF HEALTHCARE QUALITY MEASURES

- Better demographic/denominator data
- Address all 6 domains of quality
- Assess spectrum of health care delivery settings
  - Primary care/specialty care
  - Ambulatory care/inpatient care/nursing & home health care
- Stakeholder engagement
  - Providers
  - Purchasers
  - Consumers

