# Quality Measurement: Perspectives from Primary Care to Policy

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# Objectives

- Understand the different levels of measurement, and how they impact practice change
- Review examples of common quality measures currently being utilized
- Discuss basic challenges with the current measurement system

# Roadmap

- Context for quality measurement
- Practice-based use of different measure sources
  - START Initiative
  - The Children's Clinic
- Challenges with the current measurement system
  - The Oregon Pediatric Improvement Partnership / CHIPRA demonstration grants
- How to choose the "right" measures
  - Oregon Health Authority Metrics & Scoring Committee
  - PCPCH Standards Advisory Committee

# QI Project Portfolio

- Immunizations
- Developmental Screening
- Autism Screening
- Promoting Healthy Development Survey implementation
- Maternal Depression Screening
- Asthma Registry Project
- ABCD III – EI / PCP Communication
- Medical Home Transformation
  - Identification of CYSHN
  - Care Coordination
- Early Social Emotional Development
- Mental Health Screening
- Adverse Childhood Experiences (ACEs)

# MEASUREMENT BASICS

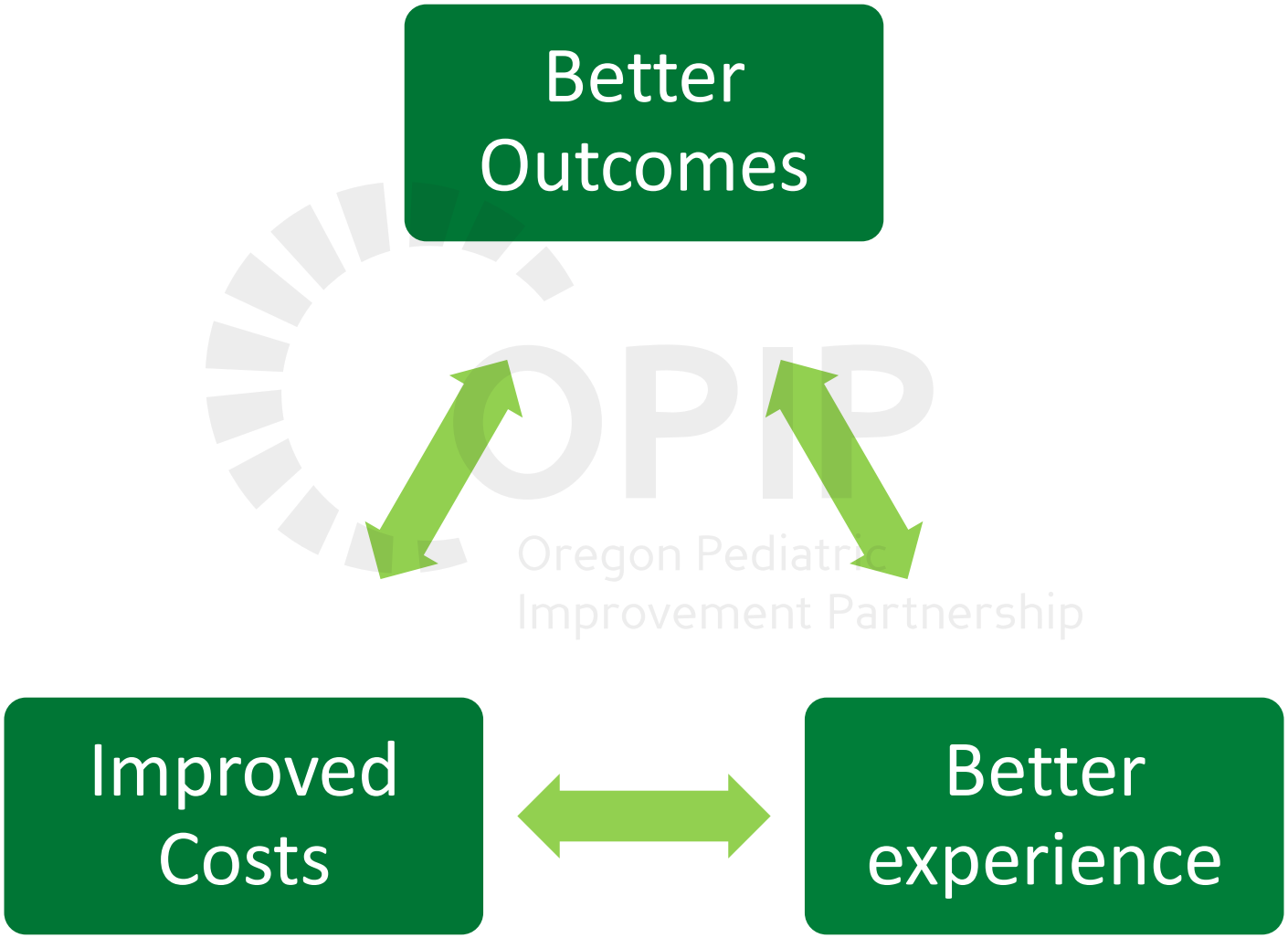
# In God we trust.
# All others bring data.

W.E. Deming

# Why collect quality measures?

- How do patients know if their healthcare is good?
- How do providers pinpoint the steps that need to be improved for better patient outcomes?
- How do insurers and employers determine whether they are paying for the best care that science, skill and compassion can provide?
- How do policymakers know that health care system transformation is achieving its intended goals?

# IHI "Triple Aim"



***The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society on the other hand needs these three aims optimized (given appropriate weightings on the components) simultaneously.***

***--- Tom Nolan, PhD***

# What patients want

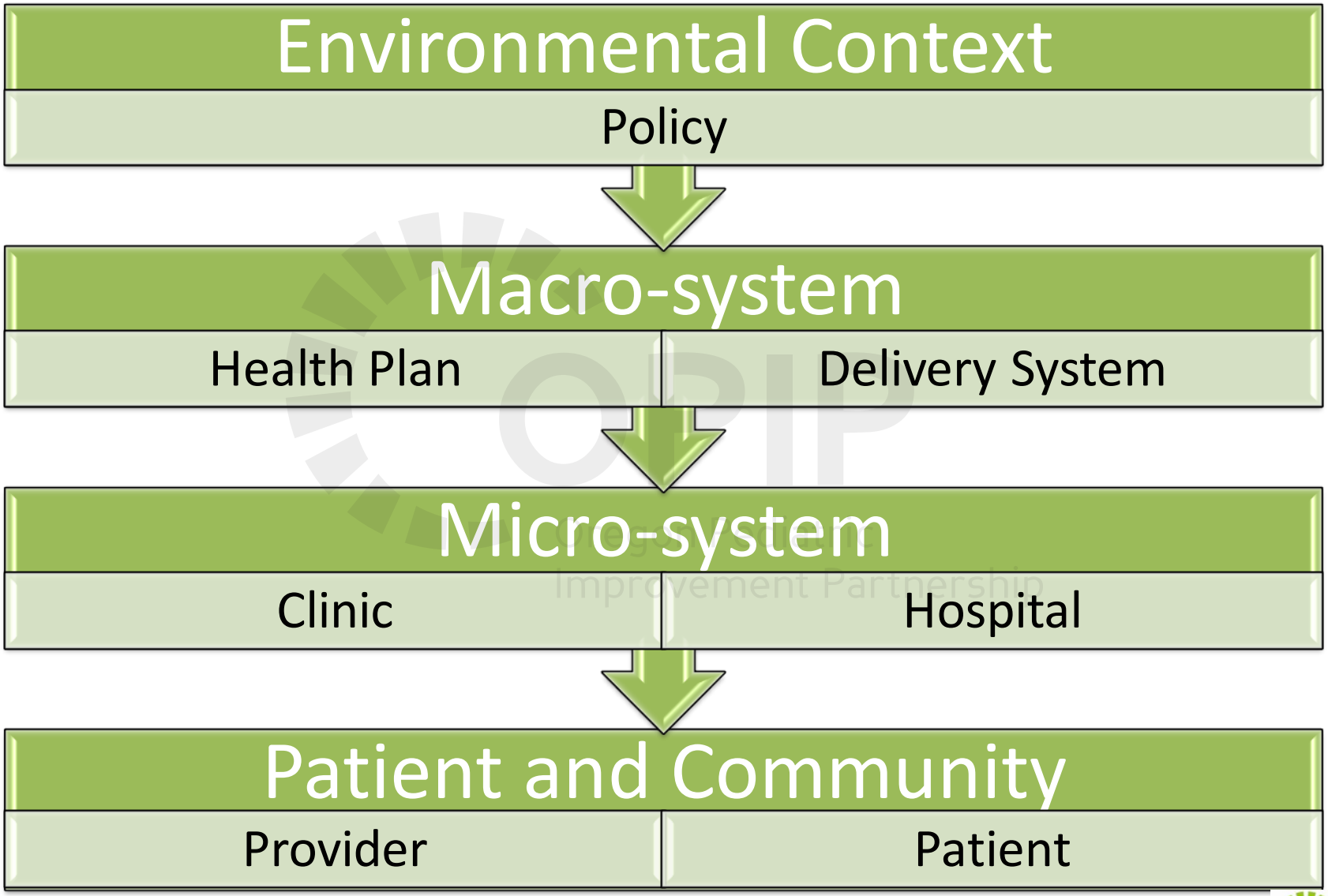
- Most consumers are satisfied with care but want better service and improved value
- Significant gap between service expected and what they receive
- Consumers believe quality varies between hospital
- Consumers value ability to choose, self-direct care
- Consumers want convenient access to care

# Provider Perspective

- Health outcomes tend to be major focus
- Office workflow inefficiencies negatively impact providers
  - Providers are only productive 50% of the time because of systemic barriers
- Autonomy
- Freedom from risk

# Value to health plans

- Cost containment / business bottom line
- Competitiveness in free market
- Attractiveness to purchasers
- Avoiding medical waste / unnecessary expenses



# Types of Measures

- Process measures include measures of the health care performance (e.g., periodic blood and urine tests for diabetic patients)
- Outcome measures (e.g., 60-day survival rate for cardiac bypass patients)
- Balancing measures (unexpected ways that QI "mess up" the existing system)
- Patient based measures (e.g., experience with patient–provider communication)

# Measure Sources

- Medical chart review
  - Considered by some to be the "source" about whether a given service happened during an encounter. Can also glean information not available in other sources (What if a service is offered, but declined by the patient? What if there is a contraindication to a service being measured?)
  - Documentation-dependent, not all data is retrievable in EMR systems without manual review…time and resource intensive
- Claims / billing data
  - Can be impacted positively or negatively by policy
  - Diagnosis codes may not accurately reflect services being done
  - Subject to provider billing consistency, negatively impacted by bundled payments
- Patient report / patient experience
  - Can examine not only satisfaction, but whether informational needs were met
  - Can be impacted by patient / family understanding of terms
- Hybrid measures
  - Compares what is captured in billing to what is documented in the medical record

# Measure synergy

- Stories told by claims, patient surveys, and med chart reviews are often quite different
- Measuring the same thing across multiple levels of the system doesn't help identify why gaps in services are happening
- Is it important to keep the same measure specifications at different levels, or keep the measure topic the same to better identify where improvement can be done?



# EXAMPLES OF MEASURES USED IN PRACTICE

# Data sources and their utility

- Developmental screening:  comparing stories told by different data sources
- Maternal depression screening:  creating QI based on patient surveys, tracking a measure of clinical interest
- Immunizations:  conducting a gap analysis between claims and medical record
- Well-child visits:  using health plan data for exclusion lists of those missing essential services

# Example: Developmental Screening

- Concept: children who are screened for developmental disabilities early and referred into services have better outcomes.
- AAP recommends screening at 9, 18, and 24-30 months for all children.
- CHIPRA core measure: screening done by 1, 2 and 3 years. State rate: ~19%
- Practice based measure (chart review): percentage of relevant visits where a screening tool is completed. TCC rate: ~90%
- Patient based measure: parents asked if a developmental screen was completed during the visit: TCC rate: ~85%
- We know that over 1000 providers have been trained to do developmental screening in the last 5 years in the state, and all have implemented in a similar way to TCC, so…
    - Why is there a gap?
    - How do you reduce the gap?

# Example: Patient survey data

- One of our early initiatives was to implement a patient survey that assessed the clinical content of well child visits.
- Network of providers helped to pilot the online Promoting Healthy Development Survey developed by the CAHMI.
- Previous data we were getting only spoke to frequency of service, but didn't help us understand the content of visits.
  - HEDIS Measures: did well child care occur on schedule?
- The PHDS, which looks at the content of well child visits, provided us ideas for areas of improvement.

# An Opportunity for Improvement: Peripartum Depression

- PHDS can stratify results by demographics and by some risk factors.
- 12% of parents of children under a year of age were experiencing depression.
  - Only 24% of these parents were asked about the presence of symptoms.
  - Without patient-centered data, we never would have known this information.
- Supported the need for universal postpartum depression screening.

Source: Promoting Health Development Survey, CAHMI, 2008-9.

# Maternal Depression Screening – Our First few PDSA Cycles

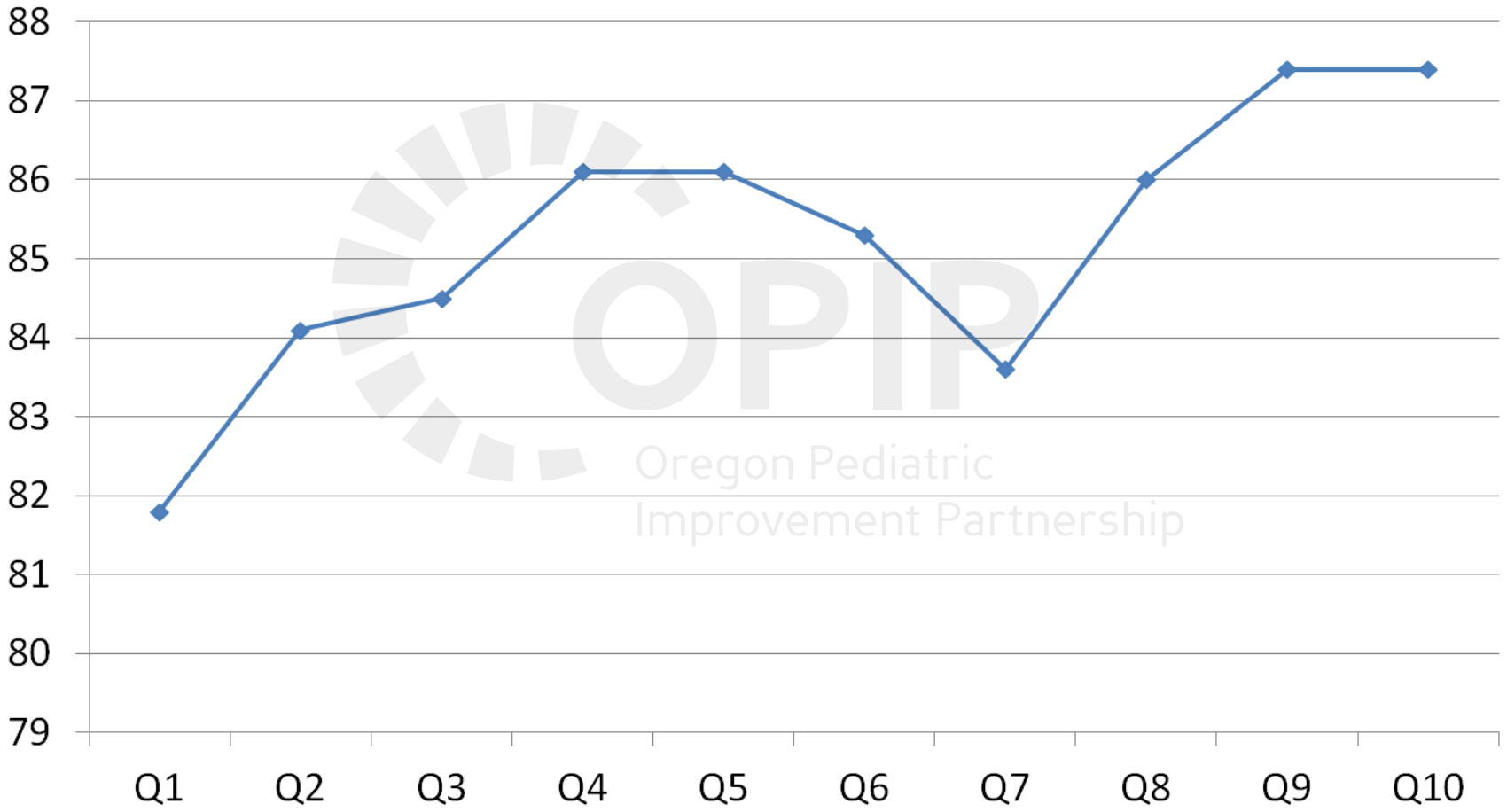
| Interval | Number of visits | Percentage Screened | Prevalence of positive screens | Percentage referred out |
|---|---|---|---|---|
| 2 week visit | 625 | 79.0% | 8.7% | 65% |
| 2 month visit | 588 | 78.9% | 5.4% | 48% |

| Interval | Number of visits | Percentage Screened | Prevalence of positive screens | Percentage referred out |
|---|---|---|---|---|
| 2 month visit | 705 | 78.6% | 5.1% | 71% |
| 6 month visit | 711 | 68.5% | 4.7% | >100% |

Next cycle is to add the question: Do you look happier on the outside than you feel on the inside?

Source: Independent chart review, The Children's Clinic, Portland, OR. 2011-12.

# Example:  2 year old Immunization Rates



# Reasons for Missing 2-year-old Immunizations

| Reason not up to date | Percent of total | Cumulative percent |
|---|---|---|
| Missing well child exam | 29 | 29 |
| Parent requested modified schedule | 19 | 48 |
| No appointment for 12 mo. | 15 | 63 |
| Parental refusal | 12 | 75 |
| Missed opportunity | 10 | 85 |
| Vaccine shortages | 5 | 90 |
| Deferred due to illness | 4 | 94 |
| Other (minimum spacing error, vaccine contraindication) | 6 | 100 |

# Example: Well child visits

- Currently three well visit measures meant to assess access to preventive services:
  - 0-15 months
  - 3-6 years
  - 12+ years
- What's more useful? An overall rate of completion or an exclusion list? Where should this exclusion list come from?
- TCC provided a list of patients attributed to us who were missing well visits
- Clinic was able to "work the list" to ensure patients made appointments
- Due to errors in attribution, moved to a recall system based on data in our practice management system.

# Practice-level Tips for Effective Measures

- Plot data over time
- Seek usefulness, not perfection
- Use sampling
- Integrate measurement into the daily routine
- Use qualitative and quantitative data

# CHALLENGES WITH THE CURRENT MEASUREMENT SYSTEM

# The plot thickens…

Do the current pediatric measures accurately reflect the scope and scale of pediatric medicine?

How does one measure complex systems change?

What data source is most appropriate for such a measurement?

# Example: Medical Home

- An enormous effort is being put into medical home "transformation" in the country and the state
  - CHIPRA demonstration grants
  - PCPCH Standards
  - Medical Home Learning Collaboratives (ECHO and PCPCI)

# CHIPRA – Demonstration Grant

- Goal: Establish and evaluate a national quality system for children's health care.
- Five areas funded:

TCHIC

Category A: Experiment With, and Evaluate use of Newly Developed and Evidence-Based **Measures of the Quality** of Children's Healthcare

TCHIC

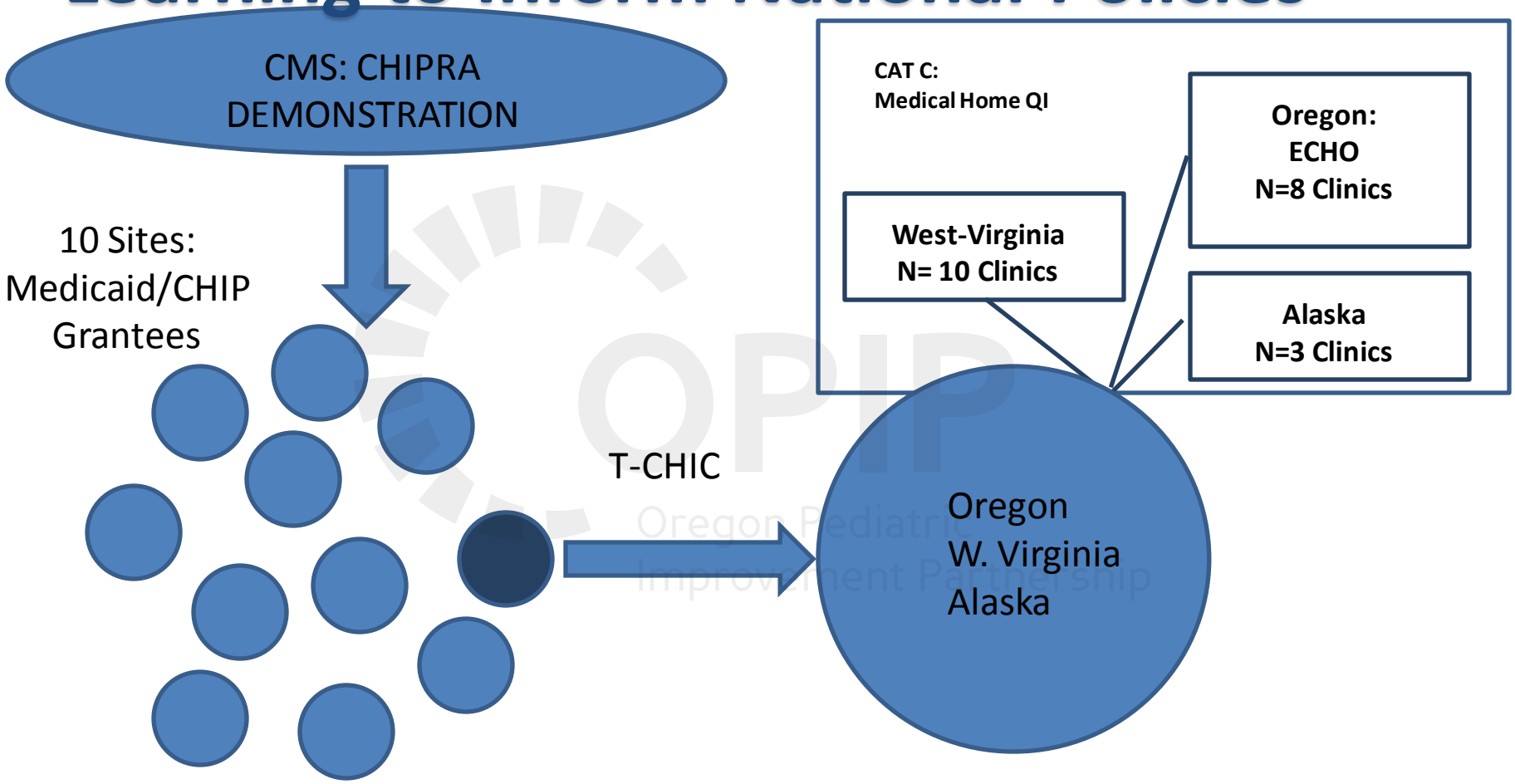
Grant Category B: Promote The Use of **Health Information Technology (HIT)** in Children's Healthcare Delivery

TCHIC

Grant Category C: Evaluate **Provider-Based Models** Which Improve the Delivery of Children's Healthcare.

- Grant Category D: Demonstrate the Impact of the **Model Pediatric Electronic Health Record** Format
- Grant Category E: Create a **State or Multi-State Model** Targeting an Issue Related to Healthcare Delivery, Coordination, Quality, or Access

# Across CHIPRA DEMONSTRATION SITE Learning to Inform National Policies



# Medical Home – AAP definition

**Accessible**

**Family-Centered**

**Continuous**

**Comprehensive**

**Coordinated**

**Compassionate**

**Culturally Effective**

So how does one measure all this? How do you know it worked?

# Federal Government's "idea"

- Use changes in the CHIPRA core measure set to measure change…
- Total of 24 measures

- Adolescent Well-Care Visits
- Ambulatory Care: ED Visits
- Appropriate Testing for Children with Pharyngitis
- Child and Adolescent Access to Primary Care Practitioners
- Childhood Immunization Status
- Chlamydia Screening in Women
- Developmental Screening in the First 3 Years of Life (NCQA and CAHMI)
- Follow-Up after Hospitalization for Mental Illness
- Follow-Up Care for Children Prescribed ADHD Medication
- Frequency of Ongoing Prenatal Care
- HEDIS CAHPS/Chronic Conditions
- Immunizations for Adolescents
- Prenatal and Postpartum Care: Timeliness of Prenatal Care
- Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents
- Well Child Visits in the First 15 months of Life
- Well Child Visits/Third, Fourth, Fifth, Sixth Years of Life

# State Government's "idea"

- Practice-based attestation about the services offered within a clinic – Patient-Centered Primary Care Home (PCPCH) Standards
  - Clinics may be subjected to an audit to ensure services are being conducted
- Similar to NCQA's Medical Home attestation process
- Is there a gap between attestation and actual delivery of services for all patients in need of said services?

# Why Primary Care Homes?

*Goals of HB 2009*

- Improve individual and population health outcomes
- Reduce inappropriate utilization
- Reduce health system costs
- Strengthen primary care
- Encourage prevention and chronic disease management over acute, episodic care
- Stimulate delivery system change

***"Right care at the right time and in the right place"***

# Oregon's Transformation Journey

- HB 2009 mandated the formation of the PCPCH Standards Advisory Committee
- Goal: *to improve the availability and affordability of high quality patient centered primary care to all Oregonians*
- Convened in Fall, 2009. Work completed in Spring, 2010.
- Considered previous medical home models and definitions
  - NCQA – 2007 Standards
  - AAP definition
  - Other state, federal, and private efforts

# Oregon's Transformation Journey

- PCPCH Pediatric Standards Advisory Committee convened Fall, 2010

- Mission: *to further refine the standards to ensure the unique needs of children and adolescents were captured*

- Revised the work of the previous committee to create a combined report

# Adaptive Reserve

- What's predictive of medical home transformation is the characteristics of the practice themselves…specifically adaptive reserve
- The ability of a practice to be resilient, to bend, and thrive survive under force. Facilitates adaptation during times of dramatic change.
- So how do you measure Adaptive Reserve? What are the most critical components associated with practices' ability to change?

# Medical Home Learning Collaboratives

- OPIP is currently conducting two:
  - Enhancing Child Health in Oregon (ECHO)
    - 2 ½ year project, five face-to-face learning sessions
  - PCPCI Pediatric Learning Collaborative
    - 10 month project, three face-to-face learning sessions

# Structure of the Learning Collaborative

- Collaboration with Oregon Rural Practice-based Research Network (ORPRN)
- Technical assistance and in-kind support from OCCYSHN
- Total of eight practices (77 providers) recruited representing various practice characteristics
    - Pediatrics (5), Family Medicine (3)
    - Rural and Urban settings
    - Ranging in size from 5 to 25 providers
    - EHR (7) and paper based charting (1)
- Practices participate in 5 face-to-face learning sessions, with monthly calls between sessions

# Goals of the ECHO Learning Collaborative

- Assist practices in implementing components of a medical home for children and youth as articulated in the standards of the Oregon Patient Centered Primary Care Home (PCPCH).
- Identify and support meaningful systems and changes processes that primary care homes can implement to achieve the standards in the PCPCH for children and youth. Identify and categorize the challenges and barriers at the practice level in achieving the goals of the PCPCH Standards, and evaluate the practice's experience of care and of implementation of the PCPCH Standards.
- Identify specific measures that achieve the goals articulated in the PCPCH standards.

# Goals of the ECHO Learning Collaborative

- Develop a community and targeted process by which primary care homes can learn from each other about innovative care systems.
- Create technical assistance resources for Pediatric and Family Medicine practices, across a diverse range of clinic settings, who are interested in achieving the PCPCH standards.
- Assess the impacts of Medical Home / PCPCH designation on patient outcomes, including patient experience of care.

# Performance Improvement Specialist Support

- Monthly site visits with practice sites, as well as continuous phone / email access
- Assesses progress on practices' stated goals and PDSA cycles
- Offers or coordinates technical assistance in implementing project components
- Documents findings across practices, including successes, barriers to implementation

# Factors that Contribute to Ability to Change

- EMR “Maturity”
- Size – relates to staff support
- Previous QI experience, particularly participation in learning collaboratives

So how does one measure all this? How do you know it worked?

# HOW DO YOU KNOW YOU HAVE THE RIGHT MEASURES?

# Metrics & Scoring

- Committee convened to decide what quality measures would be associated with the emerging CCO development
- Based work off of the Quality, Outcomes & Efficiency Metrics workgroup appointed by the Governor
- Lists of measures selected for an incentive pool, as well as an overall quality pool
- Plan is to continue working on an overall measurement framework once incentive pool metrics are settled
- Does not relieve state of its obligations to report other measure sets (such as the CHIPRA core set)

# Measures selected

- Total of 16 measures selected
- Need to include measures that touch on quality, utilization, medical home implementation, patient survey, and EHR utilization
- The plan for the measures, including improvement targets, performance targets, and specifications due to CMS November 5.
  - Also needed to include the plan for disbursement of incentive funds

# The way the committee left it…

- Each of the incentive measures was attributed with a improvement target and a benchmark target
- Benchmarks based on available data from HEDIS, National Medicaid 75th or 90th percentile
- Improvement targets mostly associated with methodology used by Minnesota Department of Health's Quality Incentive Payment System
  - CCO calculates a gap between their own baseline and performance target
  - Must move the metric 10% (minimum of 3% for most measures) in order to get the incentive
- Some targets were not set by the committee (such as PCPCH)
- Incentive could be awarded for either performance improvement or meeting benchmark

# Developing a Measure Framework

- When creating a measure set, consider:
  - Does the set of measures capture all relevant settings of care?
  - Are all age groups and subpopulations considered?
  - Is there representation of types of care: prevention, health promotion, screening / diagnosis, and treatment?
  - What are the data sources? Claims, chart review, population health measures, patient surveys?

# Quality framework example

| Consumer Perspectives on Healthcare Needs | Components of Healthcare Quality: Effectiveness | Safety | Patient Centeredness | Timeliness |
|---|---|---|---|---|
| Staying healthy | | | | |
| Getting better | | | | |
| Living with illness or disability | | | | |
| Coping with the end of life | | | | |



- To thoroughly consider a quality framework, need additional dimensions:
  - Age groups (neonate, infant, child, adolescent, early middle and late adulthood)
  - Data source (claims, chart review, patient survey)
  - Special conditions that aren't illness or disability (such as preconception and pregnancy care)
  - Locations of care (ambulatory settings, emergency care, hospital care)

# What makes a good measure?

- Relevant to physician, patient, health plan
- Actionable
- Definitions agreeable
- Easy to measure

# What makes a good measure set?

| Principle | Selection criteria |
|---|---|
| Transformative potential | Measure helps drive system change |
| Consumer engagement | Measure successfully communicates to consumers what is expected of the CCO |
| Relevance | Condition or practice being measured has impact on issues of concern or focus; aligns with evidence-based practices |
| Consistency | Measure is nationally validated, with existing benchmarks |
| Attainability | It is reasonable to expect improved performance on this measure |
| Accuracy | Changes in CCO performance will be visible in the measure |
| Feasibility | Measure allows CCO / OHA to use existing data flows |
| Reasonable accountability | CCO has a degree of control over the practice / outcome |
| Range / diversity of measures | CCO performance measures cover the range of topics, services, operations, populations of interest |

# Final Thoughts

- Quality measurement has the potential to drive change within the health care system but…
  - Measures need to be an accurate reflection of the scope and scale of health care
  - Measures need to be actionable at a state, health plan and provider / practice level
  - When considering measure synergy, think about synergy of concept, not using the same measure at different system levels

# How to Cite this Presentation:

- Gillespie, R.J. (2013). *Quality Measurement: Perspectives from Primary Care to Policy* [PowerPoint Slides]. Retrieved from the Oregon Pediatric Improvement Partnership website: http://www.oregon-pip.org/resources/presentations.html