Oregon Health Policy Board
Office for
Oregon Health Policy and Research

Health Incentives and Outcomes Committee Report and Recommendations

November 2010

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Incentives and Outcomes Committee
Background Materials & Recommendations to the Health Policy Board

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Executive Summary

The Health Incentives and Outcomes Committee ("Committee") was appointed by the Oregon Health Policy Board (OHPB) in March 2010 to develop recommendations for consideration by the OHPB and the Legislature on:

- Uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers, health care providers and consumers; and
- Transparent payment methodologies that provide incentives for cost-effective, patient-centered care and that reduce variations in cost and quality of care.

The initial stage of this work was completed by two subcommittees: the Quality & Efficiency Subcommittee, focusing on standards and metrics related to value; and the Payment Reform Subcommittee, focusing on recommendations for payment policy and standards. Strategies proposed by each subcommittee were compiled and further refined by the full Committee, resulting in the recommendations reported here. The Committee subsequently received input from the Health Equity Policy Review Committee, the Safety Net Advisory Council, and the Medicaid Advisory Committee; a proposal for integrating that input into the ongoing work of the committee and OHA staff accompanies this report.

The combined proposals of the two Incentives & Outcomes subcommittees would start Oregon on the path toward a transformed delivery system that:

- Fosters provider accountability through a mature measurement infrastructure that provides meaningful, accurate, and actionable data on performance at the provider, practice, and institutional levels;
- Measures health outcomes and cost metrics relative to historical performance, peer performance, and explicit benchmarks; and
- Pays for care in a way that initially rewards performance and ultimately is tied to a budgeted cost for efficient provision of necessary care.

As an initial step toward achieving the OHPB's Triple Aim, the Committee recommends six strategies designed to support the transformation to a sustainable health care system for Oregon:

1. Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services paid according to RBRVS. Standardization of payment methodologies is a vital foundation for aligning incentives and improving transparency in pricing and is also an important means of reducing administrative costs. While not perfect, using Medicare as the foundation to establish standardization would be the most expedient as Medicare's are the most widely used methods.

2. Move forward decisively to transform the primary care delivery system. A robust system of primary care is fundamental to achieving the triple aim. Widespread implementation of primary care homes as described in the Patient Centered Primary

Care Home (PCPCH) Standards Advisory Committee final report should begin as soon as possible.

3. Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest. In the first phase of system improvement, the primary emphasis should be eliminating the most significant defects in care and eradicating waste in the delivery system. The subcommittees have generated some initial proposals of targets that should be refined by immediate technical work and subsequently adopted as OHA's common focus areas.

4. Encourage the delivery system to become more patient- and family-centered. Responsibility for patient engagement should be clearly articulated and allocated in all reform proposals and among providers, patients, and plans. Common measures of patient experience and engagement should be used across the entire delivery system and the OHA should support technical assistance to help practices learn how to involve patients and families as advisors.

5. Initiate use of new payment incentives and methodologies, including pay-for performance, episode (bundled) payment, gain-sharing schemes, and the like. Building on the standardized payment base created via recommendation 1, the OHA and other payers should pilot new payment programs (or align with and expand existing ones) that reward desired structures, processes, and outcomes and that incent providers to coordinate care, eliminate care defects, and drive unnecessary costs out of the system.

6. Adopt a global health care spending target. To help the state stop spending an ever-greater share of public and private resources on health care, the Health Policy Board should set a spending target that limits growth of total health care spending to growth in a measure of overall consumption or income such as the consumer price index. Aggressive action should be taken to keep spending within the target.

As these recommendations are intended as a starting point for delivery system transformation, the Committee looks forward to continuing this body of work in collaboration with the Board and the OHA.

I. Background

A. The Challenge

Our health care delivery system is broken. Per capita health spending has risen faster than consumer prices and personal income for decades, and total health spending consumes an ever-growing percentage of our nation's gross domestic product. Health care is too often of poor quality—not safe, timely, effective, efficient, patient-centered, and equitably provided. It is estimated that about 30% of services provided to patients is unnecessary or inappropriate.[1]

But we have the delivery system we created, and we cannot correct flaws that cannot be identified or that providers lack the incentive to change. Many health care professionals and institutions lack the information and infrastructure they need to assess whether the services they provide and bill for actually improve the health of their patients. Moreover, the fee-for-service payment system fails to link payment to achievement of desired outcomes. It pays for units of service and procedures; it does not pay for improving health or delivering superior quality and efficiency. It rewards hospital admissions and expensive procedures; it does not reimburse for care coordination, discharge planning, and other activities that are critical to keeping people healthy.

The delivery system is in urgent need of change. Without fundamental reform, quality and access will continue to deteriorate because we cannot afford to maintain the system as it is. Key change strategies will include measuring quality and efficiency and deploying payment strategies that hold all participants in the system accountable for improvement.

B. Charge to the Committee

To assist with addressing the delivery system transformation challenge, the Health Policy Board established an Incentives and Outcomes Committee, charging it to make recommendations relating to quality improvement and payment strategies.

The committee's charter calls on it to:

- Make recommendations to the Board about and continually refine uniform, statewide health care quality standards in support of a high performing health system and the further development of value-based benefit design for use by all purchasers of health care, third-party payers, and health care providers;
- Adopt principles for payment; and
- Develop recommendations to the Board for transparent payment methodologies that provider incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care.

This report summarizes the committee's initial proposals in response to this charge. The recommendations are preceded by the committee's overall vision for delivery system

transformation (see below) and followed by suggested implementation steps developed by committee staff (see page 15).

C. An Oregon Strategy to Reach the Triple Aim

Delivery system transformation is urgently needed to reach the triple aim goals for all Oregonians: lifelong health; increased quality, reliability, and availability of care; and lower costs. Transformation of this scale requires collaborative efforts to continuously improve the quality of care for individuals and the performance of the system as a whole.

Oregon's transformed delivery system should function within a clear total system budget that reflects both the cost of providing care and the capacity and willingness of society to pay. That means health care must not continue to absorb an ever-greater share of private and public resources. Within the total system budget resources will shift. More resources will be directed to primary and preventive care and less to services that do not demonstrably contribute to good health outcomes.

Access to evidence-based care should not be differentially granted or denied based on factors unrelated to medical need. That means additional investment will be required in the form of general infrastructure support for transforming safety net practices and perhaps risk adjusted payments or payment incentives reflecting "health burden"—that is, the additional resources providers need to achieve good health outcomes for patients requiring additional services to overcome literacy, poverty, language, and culturally-related barriers to care.

The transformed delivery system should:

- Foster provider accountability through a mature measurement infrastructure that provides meaningful, accurate, and actionable data on performance at the provider, practice, and institutional levels;
- Measure health outcomes and cost metrics relative to historical performance, peer performance, and explicit benchmarks; and
- Be paid for through a system that initially rewards performance and ultimately is tied to a budgeted cost for efficient provision of necessary care.

Ultimately, providers should have the capability and responsibility to be wise stewards of limited health care dollars, working in partnership with patients who are empowered and supported to make health care decisions consistent with their values.

This transformation will not be instantaneous; it will be a process. Some provider organizations—particularly the integrated systems—should be able to respond very quickly to information on performance and changed incentives but others will require more support and time.

Transformation will not occur magically in response to payment incentives alone. New payment systems should help the delivery system make a course correction by establishing a guiding direction, but an array of other tools must be deployed to assist providers to progress in the new direction. A realistic transformation strategy must include six key elements:

- Payment incentives strong enough to overcome ingrained medical culture;
- Robust quality measurement and feedback;
- Strengthened physician and provider leadership for changed medical culture;
- Technical assistance and other support for change in medical practice and business strategy;
- Meaningful involvement of patients, families, and communities; and
- Time for adjustment.

In the short term, transformation efforts should focus on:

- Building provider capacity to lead, organize and restructure care processes, coordinate care, and use data to deliver care more effectively and efficiently;
- Increasing patient engagement; and
- Aligning improvement efforts across the system.

During this phase, the state should standardize and align payment systems and experiment with new payment methodologies. These strategies will also serve to build provider capacity to coordinate care and improve care processes.

In the mid-term, the system will should learn from payment experience, strengthen accountability, and improve tools for measuring efficiency and setting related targets.

In the long term, payers should adopt payment methods that place greater constraints on spending and more responsibility on providers to help allocate spending for greatest benefit to patients.

D. Delivery System Reform Cannot Wait

Change is hard, but it is also urgent. With the recommendations in this document, the Incentives & Outcomes Committee is asking providers and facilities to avoid events that—in today's payment environment—produce revenue: unnecessary office visits or procedures; duplicate tests procedures; preventable hospitalizations. Eliminating these events will mean reduced income for some providers. The Committee believes that, once providers and facilities learn to deliver care more efficiently, they can share in the resulting savings. However, the Committee members recognize that it is very difficult for providers to risk the fee-for-service income stream they have counted on to date.

But this is a unique moment. By 2015, an estimated 280,000 additional Oregonians will have insurance coverage due to passage of the federal Accountable Care Act. An increase in coverage will likely produce an increase in overall health service utilization. This will bring

more revenue to providers, cushioning the blow they might otherwise experience as unnecessary utilization declines. It is a triple win (Figure 1):

- Purchasers: Lower costs for purchasers through improvement of the quality and efficiency of care and reduction of the cost shift in which health insurance purchasers pay more for benefit plans in order to cover the costs of uncompensated care.
- Providers: Stable revenue for providers who will have new patients and the opportunity to be rewarded for providing good care efficiently.
- All Oregonians: The right care, at the right time, at the right price.

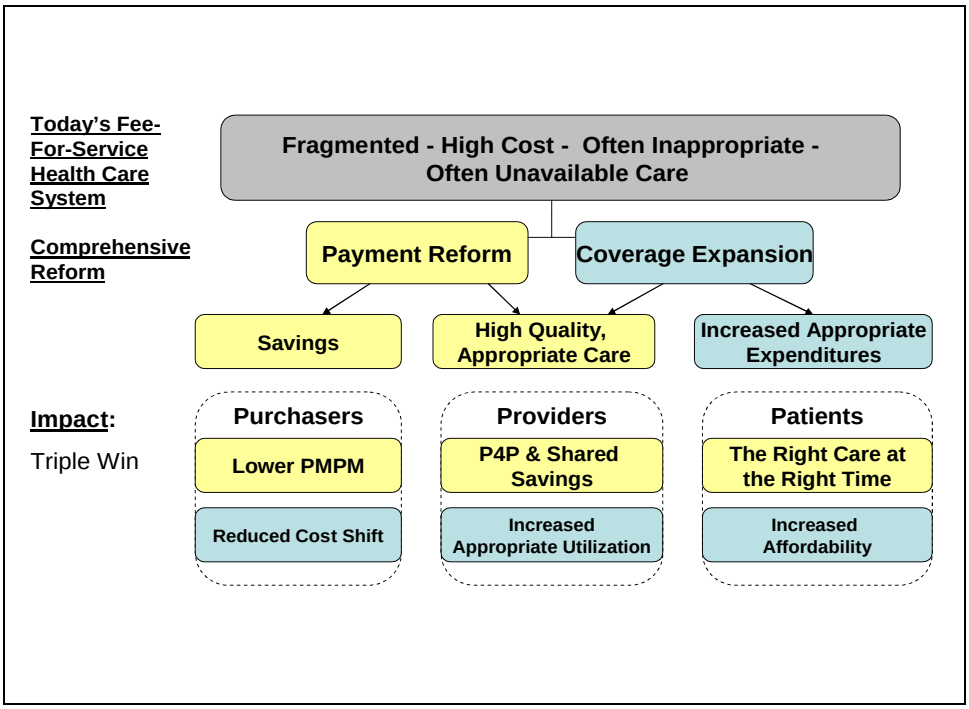

Figure 1. The Triple Win

II. Committee Recommendations

The transition from current payment mechanisms to those that will support a sustainable health care system must be grounded in transparent measurement of outcomes supportive of the Oregon Health Authority's Triple Aim goals and should be guided by the principles of equity, accountability, simplicity, transparency, affordability, and transformation.

The committee recommends six activities designed to support the transformation to a sustainable health care system for Oregon. For each activity, OHA should:

- Demonstrate the business case for the reform activity, outlining the expected health improvement and cost outcomes and why the reform makes financial sense for the OHA and the larger health system;
- Identify concrete implementation steps, processes, and timelines; and,

- Develop measurement capacity and evaluation strategies so that the Health Policy Board, policymakers, and others can see whether their reforms are producing the intended outcomes.

2. Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient services (except services in critical access hospitals and Type A & B rural hospitals), ASCs, and physician and professional services paid according to the Resource Based Relative Value System (RBRVS).

What: Adopting a standard payment methodology is the first step Oregon must take to restructure payment for value. Standardization of payment methodologies is a vital foundation for aligning incentives in payment methods such as episodes of care and is an important measure to reduce administrative cost and increase transparency. Medicare offers the most reasonable payment method to adopt for hospitals (except critical access hospitals and type A and B rural hospitals), ambulatory surgery centers, and physician and other professional services that are paid based on the resource based relative value scale. The methods are as good as any alternative available, have broader use, and can be expected to improve moving forward.

When all payers use the same basic payment methodology, it will be easier for

- Payers to offer consistent payment incentives on that base,
- Purchasers and patients to compare prices, and
- Providers to determine whether they have been paid according to their contractual arrangements.

In addition, the Medicare inpatient prospective payment system rewards efficiency in a way that the dominant alternative currently in use (percentage discounts off gross charges) does not.

How: A new statutory requirement should be enacted in 2011, effective in 2012 when Medicare's updated rules go into effect for the particular provider type (e.g. October 1 for hospitals). The standard payment method for Oregon would change as Medicare methods change. The statute should describe a process for determining which elements of Medicare's payment methodologies are adopted in Oregon and what deviations are permitted. Use of incentive and gain-sharing programs to modify the basic payment method and episode or global payment methods that increase provider accountability should be permitted.

1. Move forward decisively to transform the primary care delivery system.

What: Primary care homes, as described in the Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee final report, are fundamental to achieving the triple aim and should be rolled out as aggressively as possible. This will require the involvement of all payers and primary care providers.

How:

- The Health Policy Board should adopt the PCPCH standards and the Incentive & Outcomes Committee's proposed structure for aligning payment to the tiers within those standards as the model for primary care redesign in Oregon. This model provides for a system of base payments to pay for structure, process, and ultimately outcomes achievements separate from fee-for-service payments.
- The Oregon Health Authority (OHA) should sponsor development of the measurement, reporting, and feedback infrastructure necessary to implement the standards as a basis for payment.
- The Oregon Health Authority (OHA) and other payers should assist primary care practices to develop the capacity to measure and report in accordance with the standards.
- The OHA and other payers should immediately restructure primary care payment to align with the PCPCH standards framework. It is recognized that payers may pay different amounts for attainment of the same standards or performance levels and that practices will become robust primary care homes at varying speeds.

3. Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.

What: The primary emphasis of the first phase of work to improve quality and reduce cost should be eliminating the most significant defects in care and eliminating waste in the delivery system. 'Defects' is a broad term that includes over- and under-utilization, lack of safety, uncoordinated care, and other examples of poor quality, inefficiency or unreasonable cost. Eliminating common defects will improve patients' experience of care and should also jump start the process of driving costs out of the system.

How:

- Both subcommittees identified potential focuses. The Quality and Efficiency Subcommittee suggested readmissions, low back pain, cardiac care, health care acquired conditions, and care coordination, among others, and the Payment Reform Subcommittee identified cardiac conditions, orthopedic conditions, and cancer treatment. Other focuses also warrant consideration: A focus on care of people with multiple chronic conditions may also be a promising starting point, as these individuals account for a disproportionate share of total spending.[2] Likewise, the Health Equity Policy Review Committee has suggested that a focus on achieving health equity by eliminating disproportionate disease burden in communities of color may result in improved health system efficiency. Appendix 1 is a side-by-side comparison of potential targets identified by the subcommittees.
- Further technical work should begin immediately to finalize these initial proposals as OHA's common focus areas, identify measures appropriate for evaluation of progress in focus areas, and link them with payment. In selecting foci, primary emphasis should be

on the potential to reduce costs and improve quality, though the potential to reduce inequities and align with national and local initiatives should also be considered.
- Payers, purchasers, providers, and patients should adopt the recommended common focus areas for measurement and payment work to increase the impact of their efforts.

4. Patient and family engagement are critical. Encourage the delivery system to become more patient- and family-centered.

What: When patients and families participate as full partners with health care professionals to improve their health, system performance improves. A truly patient- and family-centered system will structure services and care to support the patient and family to be full members of the health care team on an ongoing basis. Responsibility for patient engagement should be clearly articulated and allocated among providers, patients, and plans.

How:
- Patient-centeredness is already an element of Oregon's PCPCH standards and should be extended to other parts of the system through the design of new payment systems and other mechanisms. All six dimensions of patient- and family-centeredness should be incorporated; this means exploring how best to involve patients and their families as advisors in practice design as well as partners in their own care (see Appendix 2).
- To accelerate patient engagement efforts, common measures of patient experience and engagement should be developed and deployed across the system.
- OHA should lead efforts to extend an existing learning network that provides technical assistance to organizations to help them learn how involve patients and families as advisors.

5. Initiate use of new payment incentives and methodologies, including pay-for-performance, episode (bundled) payment, gain-sharing schemes, and the like.

What: Migrate as rapidly as possible away from exclusively fee-for-service provider payment systems and toward systems that reward desired structures, processes, and outcomes and that incent providers to coordinate care, eliminate care defects, and drive unnecessary costs out of the system. To ensure successful transition to new payment methods, it will be necessary to build provider capacity to restructure their practices to respond effectively to new payment incentives. Projects should be initiated with a focus on specific diagnoses or care delivery processes where providers and payers can see opportunities for innovation and savings in order to increase the likelihood of their energetic participation.

How:
- The OHA and other payers should pilot new payment programs (or align with and expand existing ones), including pay-for-performance and episode payment,

cooperating to achieve the critical mass sufficient to support and incent delivery system change.

- Payment pilot programs should test the value of service agreements and patient engagement strategies and should address a range of clinical issues based on an assessment of potential for measurable delivery system improvement.
- To accelerate widespread adoption of common priorities, OHA should provide leadership by setting priorities and measures and using them in all of its programs.
- Pilots should be designed to facilitate rigorous evaluation of the payment innovation and to provide feedback to physicians and the public on provider performance.

6. Adopt a global health care spending target.

What: To help the state stop spending an ever-greater share of public and private resources on health care, the Health Policy Board should set a spending target that limits growth of total health care spending to growth in a measure of overall consumption or income such as the consumer price index. Aggressive action should be taken to keep spending within the target.

How:

- The Health Policy Board should set the spending target and monitor system performance relative to the target, recognizing that meeting those targets may involve increasing spending for priority activities including initiatives to eliminate complications, waste, and inequities, which will improve health and reduce cost in the long run.
- The OHA should develop improved measures of delivery system efficiency.
- The OHA should develop benchmarks, based on rigorous examination of the evidence, for the cost of delivering high quality care efficiently.
- Payers should use these benchmarks to set cost targets and payment levels.
- The business case (in terms of expected improvement in health outcomes and system cost) should be demonstrated for all programs, services and technologies, beginning with new proposals and eventually extending to existing practices.

III. Subcommittee Process and Recommendation Development

This section provides background on how the Incentives and Outcomes Committee developed the recommendations described in Section II. For further information on concepts developed in the subcommittees, not all of which were fully vetted and adopted by the full committee, see Appendices 2 and 3.

A. Quality Measurement in Support of Improvement

Performance measurement can highlight defects in care as well as exemplary performance and best practices. Measurement and feedback are critical first steps for broad-based quality improvement efforts.

In its initial body of work, the Quality & Efficiency Subcommittee concentrated on identifying measurement priorities and potential indicators to focus and inspire the work of its sister subcommittee and private sector groups by providing measureable targets for payment reforms. Measurement priorities and potential indicators were selected with the following considerations:

- A focus on measures that would be feasible to implement immediately and that would align with or build on the measurement efforts of local and national partners;
- A desire to balance the benefit of measurement against the burden it may create for providers and health care systems; and
- A strong appreciation for the value of having a mix of indicators: structural measures of the conditions under which care is provided; measures of the processes of care; and outcome measures focused on changes in health status or cost attributable to care provided. This categorization of measures is known as the Donabedian typology.

Measurement priorities and related indicators were identified both within and across settings of care. Two workgroups produced recommendations: one workgroup focused on patient- and family centeredness and the second on traditional quality, safety, and effectiveness topics. More detail is available in Appendix 2.

Patient- and family-centeredness

In a redesigned health care system that aligns payment with value, the degree to which patients and families are meaningfully engaged in their care will be a critical measure of success. When patients and families participate as full partners with health care professionals, both system performance and the patient experience of care improve significantly. The Quality & Efficiency Subcommittee recognized six distinct domains of patient- and family-centeredness:

- Patient and family engagement
- Self-management support
- Shared decision-making
- Respect for patient values, preferences, and expressed needs
- Care coordination; and
- Organizational attention to the patient experience of care

The Committee has made specific recommendations (see page 6) of steps OHA can take to improve patient and family-centeredness in Oregon's health care system. They include: establishing and Oregon standard for measures of patient experience of care and engagement and developing the capacity of provider organizations to involve patients and families as advisors in all aspects of care delivery. In addition, the Subcommittee recommended that measurement of patient engagement be incorporated in all payment reform initiatives, regardless of clinical focus or care delivery setting.

Hospital and specialty priorities

The Quality & Efficiency Subcommittee suggested the following as areas where payment reforms could help drive broader quality improvement in hospital settings:

- Skin injuries (pressure ulcers) and falls because of their frequency, the potential for synergy with national work and for partnerships with nursing leadership in the state, and the high cost of care related to these safety failures;
- Readmissions, because they are an indicative of shortcomings in care coordination within and outside the hospital;
- Health care acquired infections because of national and state momentum on this topic and the opportunity to advance quality in this area through NSQIP, the National Surgery Quality Improvement Program; and
- The areas of care covered by CMS's core process of care measures: heart failure, heart attack, pneumonia, and surgical safety.

In the area of specialty care, the Subcommittee recommended strengthening system and provider capacity to measure appropriate use of:

- Imaging
- Treatment for low back pain
- Maternity care (particularly cesarean sections)
- Joint replacement
- Cardiac diagnostics and percutaneous coronary interventions

These hospital and specialty suggestions will serve as starting points for implementation of Committee recommendations 3 and 5, although further technical work is needed to specify how measurement would occur and to link these topics to payment. Please see Appendix 2 for more details including specific metrics in each topical area listed above.

Primary care priorities

The Committee strongly supports the primary care home model as articulated by Oregon's Patient-centered Primary Care Home (PCPCH) Standards Advisory Committee in March 2010. The PCPCH Committee identified six core attributes of a primary care home and articulated number of standards that describe how care delivered by a primary care home would embody the core attributes. In addition, the Committee developed a detailed set of patient centered primary care home measures. The six core attributes, with patient-centered language explanations, are:

- Access to care (be there when I need you);
- Accountability (take responsibility for making sure I receive the best possible health care);
- Comprehensive whole person care (provide or help me get the health care and services I need);
- Continuity (be my partner over time in caring for my health);

- Coordination and integration (help me navigate the health care system to get the care I need in a safe and timely way); and
- Person and family centered care (recognize that I am the most important member of my care team and that I am ultimately responsible for my overall health and wellness).

For initial measurement and implementation, the Quality & Efficiency Subcommittee recommended prioritizing the following standards of each attribute:

- Access: in-person (appointment) and telephone access, followed by electronic access
- Accountability: tracking and reporting of clinical quality indicators, followed by improvements in medication management practices
- Comprehensiveness: provision of behavioral health care
- Continuity: linking patients with a personal clinician or care team
- Coordination: capacity for care planning, followed by evidence of the primary care home's connection to the larger medical neighborhood

Please see Appendix 2 for suggested methods of measuring each of these prioritized standards. Development of an operational measurement system and any other necessary infrastructure for primary care home implementation is one of the Committee recommendations for transforming primary care.

B. Transformation of Provider Payment

Principles for Provider Payment

The Committee believes getting payment incentives right is a critical element of system transformation. Its payment reform subcommittee developed detailed principles for a reformed payment system, which are attached as Appendix 3. In short, the guiding principles for the Committee's work are:

- Equity
- Accountability
- Transformation
- Cost Containment
- Simplicity
- Transparency.

The Transition Path

The Committee believes that for most providers, the path from fee-for-service payment to comprehensive payments will traverse some intermediate ground wherein providers are paid in a mix of ways. Each method is designed to reinforce incentives for improvements in

quality and efficiency and to support investment in transformation. Some providers may have the capacity to move more quickly along the transition path than others.

During the intermediate phases, we expect payers to use the following types of payment:

- "Pay-for-performance" incentive payments: These payments are built on a fee-for-service base to reward structure, process, or health outcome achievements. Incentive payments are often calculated as a percentage of the underlying fee-for-service payment. They may result in increased total provider payments. But a payer's total cost may be kept neutral by reducing base fee-for-service payments and using the difference to create a pool from which incentive payments can be made to top performers.
- "Shared savings" payments: Shared savings are also built on a fee-for-service base. If a provider or group of providers keeps costs of care below a target while maintaining or improving quality standards, an insurer or other payer may allow the provider to keep a portion of the savings—thereby encouraging coordination of care and efficiency.
- "Bundled" or "episode" payments: A bundled or episode payment is a single payment for all services connected to an episode of care such as a hospital admission for a surgery and post-acute care or a year's care for a diabetic patient. The payment covers services performed by multiple providers in multiple settings, thereby encouraging coordination of care and avoidance of unnecessary re-admissions.
- "Primary care base payments": Payments to support primary care practices' infrastructure development, care coordination, patient engagement, and other activities that the current fee-for-service system does not reimburse. The base payment can also include reimbursement for provision of a bundle of primary care services.

The Committee's vision for the transition from fee-for-service to more comprehensive, outcomes-oriented payment models is illustrated below for three major categories of providers: primary care practices, specialty practices, and hospitals. In each illustration, fee-for-service payments decline over time as a share of all payments, while other payment methods grow. The Committee also anticipates that total spending for primary care will increase as responsibilities of that sector expand, whereas total spending for specialty care and hospital services will probably decline as the system becomes more efficient. The illustrations are not intended to suggest the Committee is recommending an ideal mix of different payment methods within a given sector of care. Likewise, they should not be interpreted to say we currently spend equally for primary, specialty and hospital services. In fact, hospital spending now accounts for a larger share of the health care dollar than primary or specialty physician services combined[3] and spending for specialty physician services outstrips spending for primary care.

Carrying out the transition process is further complicated by the reality that Oregon providers function in relation to an array of payers of which the Oregon Health Authority is

only one. They therefore respond to incentives created by multiple payment systems. Our goal is for all payers to re-configure their payment policies in accordance with the framework discussed below.

Primary care

Primary care practices need to take on greater responsibility for care coordination and management, prevention, and support for patient engagement. To take on these new roles practices will incur new expenses such as salaries for nurse case managers and costs of implementing electronic medical records systems, which cannot be recovered by billing traditional codes. The payment system will need to support those changes through a system of "patient-centered primary care base payments" that could take the form of enhanced rates for billed services or, more likely, risk-adjusted per member per month health plan payments. The Committee envisions that base payments will grow over time to replace fee-for-service payment for preventive and routine care services in addition to continuing to support the primary care home infrastructure and non-billable services.

In addition to the base payment, primary care practices will receive some of their payment in the form of "pay-for-performance" incentive payments that reward achievements not covered under the base payment; "bundled payments;" and "shared savings" payments. Until the fee-for-service model is entirely replaced by something else, primary care practices would also be paid fee-for-service payments for procedural services to encourage providers to practice to the "top of their license".

The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 2.

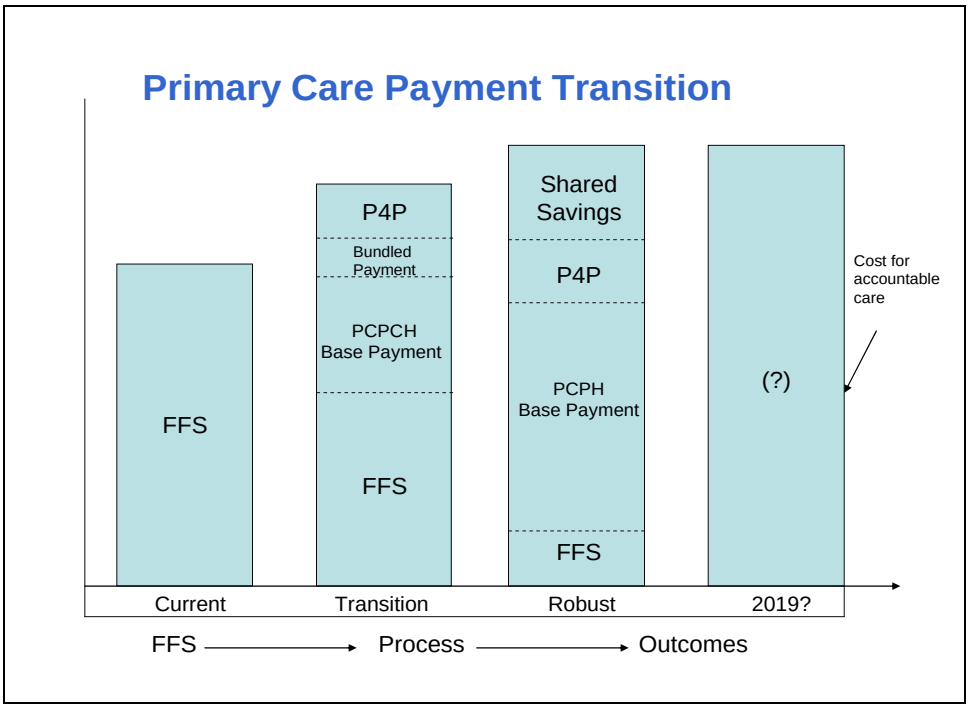

Figure 2. Primary Care Payment Transition

Specialty care

Specialty provider practices will also need to change. In a reformed delivery system, they will coordinate more closely with both primary care practices and hospitals and other care facilities. They will be asked to provide greater support to primary care practices to manage chronic conditions. This will reduce unnecessary referrals and hospital admissions. They will be asked to work with hospitals to avoid preventable admissions and reduce costs of hospital care. They will be asked to involve patients more in decision-making about their care, which we expect to reduce variation in utilization of procedures such as back surgery that are over-utilized in Oregon relative to the rest of the country. Provider revenue will gradually move away from the fee-for-service bucket to pay-for-performance, shared savings, and bundled payment buckets. Payers using bundled payment methods may wish to support increased coordination by paying specialists on a fee-for-service basis for advising primary care physicians and other work that is not currently reimbursed.

The committee expects there to be a decline in payments to specialists, as a percentage of total health care spending. This reduction in revenue to specialists will be mitigated by increases in utilization as more Oregonians enroll in health plans with the support of federal assistance. The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 3.

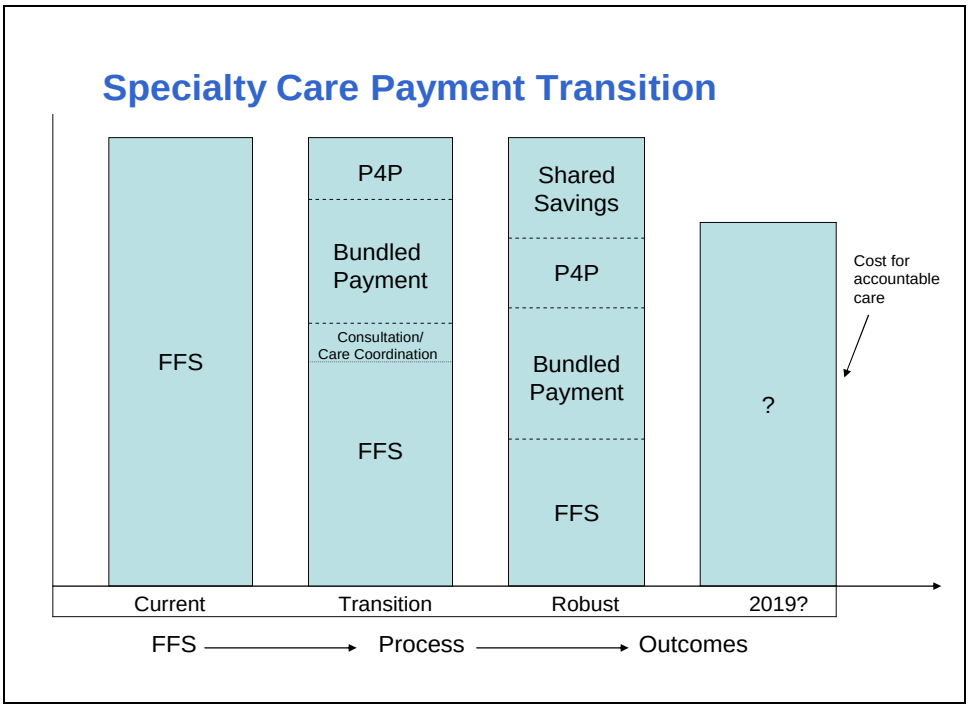

Figure 3. Specialty Care Payment Transition

Hospital care

Hospitals, like specialty care practices, will need to coordinate more closely with providers in other settings to improve quality and efficiency. Whereas the bulk of hospital payments are currently paid on a fee-for-service basis, as a percentage of charges, hospitals should eventually be paid primarily on a bundled basis. Bundles should be constructed so that hospitals no longer make money from readmissions but rather must "guarantee" their work for a period following a patient's discharge.

The committee expects there to be a decline in payments to hospitals as a percentage of total health care spending as transitions of care improve, unnecessary hospitalizations are avoided, and services are provided in the least intensive setting consistent with good health outcomes. The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 4.

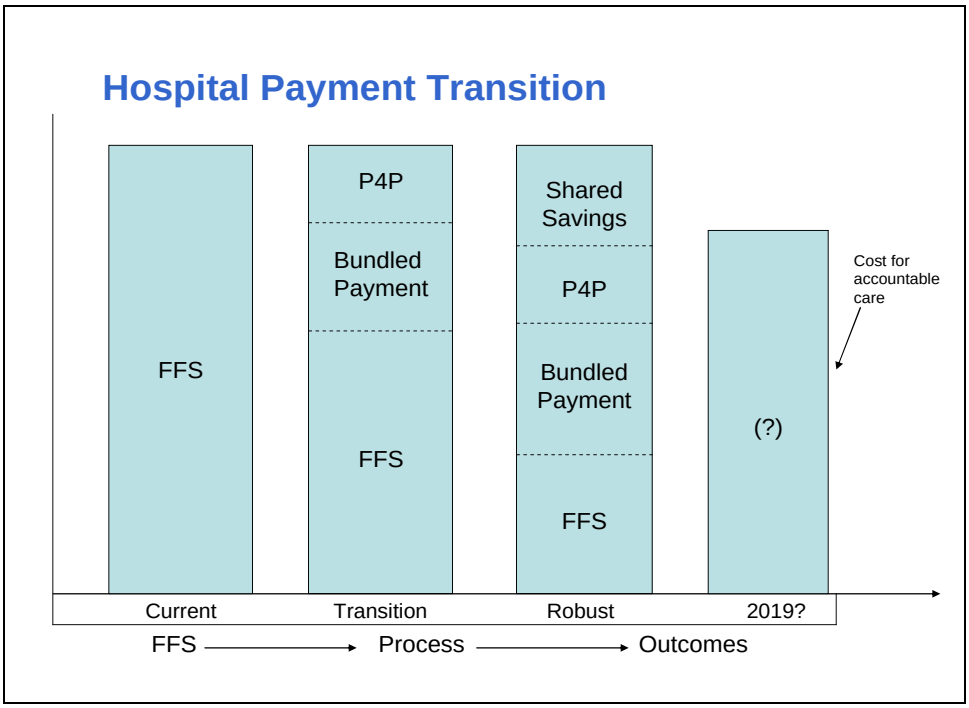

Figure 4. Hospital Payment Transition

Paying for Truly Accountable Care

The Committee has not identified the ideal type or mix of payment methods that should be in place after the interim payment methods initiate and drive toward system transformation. What is clear, however, is that the payment system that emerges must ensure that providers partner with patients to improve outcomes and with state and community leaders to contain total health care spending. Only then will Oregon experience a system of truly accountable care.

IV. Next Steps in Quality and Efficiency Measurement and Payment Reform

Staff Recommendations for Action by the Oregon Health Authority (not reviewed by the committee)

1. Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services paid for on an RBRVS basis.

<u>Short-term</u>

2010

- Convene work group to flesh out details, including exceptions that allow room for episode payment and other more comprehensive payment methods

2011

- Introduce legislative measure

- Develop method to predict cost/benefit and measure actual administrative savings from standardization

2012

- Changes should take effect in 2012 when Medicare's updated rules go into effect for the particular provider type (e.g. October 1 for hospitals).

Medium-term

- Evaluate the program (2014)
- Make recommendations on the value likely to come from standardizing additional provider payments to Medicare (2015)

2. Move forward decisively to transform the primary care delivery system.

Short-term

2010

- Adopt Patient Centered Primary Care Home (PCPCH) standards and proposed structure to align payments to the tiers
- OHA (Medicaid, PEBB, OEBB, OMIP) participates in Health Leadership Council multi-payer pilot
- Initiate design of regional expansion of primary care homes across OHA populations and care settings (e.g. private practice and community health centers) building in appropriate methods for compensating providers

2011

- Sponsor development of measurement, reporting and evaluation systems and infrastructure for implementing new bases of payment
- Develop learning collaborative for OHA providers to prepare for primary care redesign
- Begin PCPCH implementation in regions with high percentage of OHA lives and where OHA can leverage enhanced Medicaid payments authorized by the ACA

2013

- Evaluate medical home pilots, including ROI, patient and provider satisfaction, improvement in health outcomes; refine PCPCH program as necessary
- Require all OHA plans and providers to implement PCPCH and develop strategy to ensure statewide adoption of PCPCH

3. Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.

Short term

2011

- Conduct technical work necessary to support selection of common focus areas and measures and to link those with payment. Criteria for targeting to include impact on cost or quality, feasibility, potential to address disparities, and opportunity to create synergy with local or national efforts.
- Actively foster multi-payer alignment on common focus areas for measurement and payment. (2011-12)

2013

- Incorporate metrics into OHA contractual programs for performance improvement, pay-for-performance, and bundled payment (see #5).

Medium term

- Continually assess, revise, and expand priorities for efforts (2014-ongoing).

4. Patient and family engagement are critical. Encourage the delivery system to become more patient- and family-centered.

Short-term

2011

- Develop recommendations for statewide standardization of patient experience of care and engagement measures, including measuring perceptions of bias and cultural competency

2012

- Lead efforts to extend an existing learning network to increase provider capacity in patient- and family-centered care and to assist organizations to learn how to involve patients and families as advisors and how to use organizations that serve underserved populations as a resource for improving quality of care and engagement of patients and families.

2013

- Require measurement of patient experience of care/engagement across OHA contracted providers, including stratification of results by race, ethnicity, gender and other demographic factors
- Extend focus on patient and family engagement beyond primary care to other parts of the system through the design of new payment systems and other mechanisms

Medium term

- Develop web-based mechanism to assist smaller organizations in collection of patient experience of care/engagement data (2014)
- Evaluate effectiveness of patient and family engagement efforts (2015)

5. Initiate use of new payment incentives and methodologies, including pay-for-performance, episode (bundled) payment, gain-sharing schemes, and the like.

Short-term

2011

- Establish P4P metrics and benchmarks to be used across OHA; aligning with Medicaid and Medicare P4P metrics where possible and ensure performance measurement includes measuring performance by patient demographics
- Define 5-10 bundles for services where there is high opportunity for improvement in quality/cost/equity/learning and identifies services required to deliver the bundle without defects (2011-2013)
- Determine how risk adjustment systems can be developed for use in episode payment. Consider developing a system for adjusting or enhancing payment to providers based on social disparities when the evidence shows that they increase costs for care in ways that standard risk adjustment methods do not address.
- Determine whether there is a business case for aligning with Medicare by discontinuing payment to hospitals for hospital acquired conditions ("never events")
- Develop payment rules that mean physicians as well as hospitals are not paid for hospital acquired conditions (2011-2012)

2012

- Develop contractual language and administrative rules to discontinue payment to hospitals for hospital acquired conditions
- Align and expand P4P programs within and across the OHA
- Actively foster multi-payer alignment on metrics used in OHA for P4P programs.
- Develop a payment reform pilot evaluation protocol, including a system for sharing findings broadly
- Establish a method for aggregating and disseminating data on provider performance, including a trusted party to do the work and ensuring neutrality, inclusivity and transparency in data collection and analysis

2013

- Pilot episode payments, to include service agreements, in areas with high percentage of OHA lives and/or where alignment can be achieved with other payers

Medium term

- Evaluate experimental programs (2014-2015)
- Consider standardizing P4P metrics and episode bundles that may be used in payment in Oregon (2015)
- Develop benchmarks for efficiency and the total cost of care across all settings (2015)

6. Adopt a global health care spending target.

Short term

2011-13

- Develop improved measures of system efficiency hospital, specialty, and primary care
- Develop benchmarks for the cost of delivering high quality care efficiently that are based on rigorous examination of the evidence

Medium term

- Evaluate ROI, patient and provider satisfaction, improvement in health outcomes and refine performance measurement systems as necessary (2015)
- Use benchmarks to set cost targets and payment levels. (2015-17)

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[1] IOM, National Academy of Engineering, *Building a Better Delivery System: A New Engineering/Health Care Partnership*, Washington, DC: National Academies Press; 2005.

[2] Friedman, B et al, "Hospital Inpatient Costs for Adults with Multiple Chronic Conditions," *Medical Care Research and Review* 63, no. 3, 2006.

[3] Truffer, CJ et al, "Health Spending Projections Through 2019: The Recession's Impact Continues," *Health Affairs* 29, no. 3, 2010.

Appendix 1

Potential focus areas for Incentives & Outcomes Committee Proposals

The Incentives and Outcomes Committee believes that the health care system must do better in delivering care that is patient- and family-centered, effective, efficient, safe, timely, and equitable. Subcommittee work and staff research have generated a large number of clinical conditions or procedures that might serve as concrete starting points for pilot testing or initial roll-out of reforms designed to achieve those goals. This document outlines some of the similarities and differences between potential targets and is intended as an informational tool to assist in the identification of a small number of focus areas for reform proposals emerging from the full Committee.

The **Quality & Efficiency Subcommittee** has recommended targets that align with those identified by the National Priorities Partnership as having "the most potential to result in substantial improvements in health and health care, and thus accelerate fundamental change in our healthcare delivery system".

The **Payment Reform Subcommittee** has identified the following as principles for payment system design: equity; accountability; transformative; cost containment; simplicity; and transparency. Its specialty workgroup has recommended targets based on evidence of variation, high cost, and potential for savings.

OHPR staff has recommended targets that rank high on at least 2 of the following dimensions:

- Potential to improve quality and efficiency where resource use is high or number of people affected is large (impact);
- Feasible to start addressing in the short-term (feasibility);
- Of differential importance to marginalized populations (health equity); and
- Potential for synergy with local or national partner efforts (synergy)

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
Heart attack, heart failure (hospital setting – from CMS core measures) Rationale: National alignment; existing reporting infrastructure	**Cardiac conditions** Rationale: Key cost driver in commercial coverage	**Congestive Heart Failure, Coronary Artery Disease** Rationale: Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; OR commercial inpatient costs are highly variable Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; high-value services are underutilized; Equity - disparities exist in receipt of recommended tx;

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
		Synergy - synergy with local or national partners; prevalent chronic diseases
Low back pain / spine surgery appropriateness Rationale: NPP and local priority; high cost for PEBB; potential for useful physician profiling and intervention; good area for consumer education and shared decision-making.		**Low back pain/surgery** Rationale: Impact - High cost for PEBB; OR Medicare utilization high and variability within Oregon is high Feasibility - bundle models for episode payment exist; good patient decision-making tools exist Synergy - synergy with local and national partners
Joint replacement Rationale: NPP priority	**Musculoskeletal conditions, particularly joint disease and joint replacement surgery** Rationale: Key cost driver in commercial coverage	**Osteoarthritis and arthopathies/joint disorders and joint replacement** Rationale: Impact: preventable complications are high % of commercial claims; cost driver in Medicare FFS and Oregon Medicare FFS cost is high; represents large share of hospital costs for commercial pop; Oregon Medicare utilization is high; commercial cost highly variable; Feasibility: bundle models for episode payment exist; high-value services are underutilized; Synergy - synergy with local and national partners
	Oncology Rationale: Key cost driver in commercial coverage	**Colon cancer** Rationale: Impact: preventable complications are high % of commercial claims; Oregon Medicare FFS cost is high Feasibility: bundle models for episode payment exist; good patient decision-making tools exist Equity: racial disparities exist in screening and mortality
Imaging appropriateness Rationale: NPP priority; national and local momentum; potential to address in inpatient and ED settings **Cardiac diagnostics** Rationale: NPP priority	**Duplicate or inappropriate diagnostic tests**	

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
Skin injuries and falls (hospital setting) Rationale: NPP priority		
Readmissions (hospital setting) Rationale: measure of defects in coordination of care; cross-setting issue	**Readmissions** (hospital setting)	
Healthcare acquired infections Rationale: NPP priority; national and state momentum; opportunity to further NSQIP; existing state reporting infrastructure	**Healthcare acquired infections**	
		COPD Rationale: Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; Synergy - synergy with local or national partners; prevalent chronic disease
Maternity care (c-sections) Rationale: Difficult issue but huge area for Medicaid; good area for patient-centered and shared-decision making approaches; NPP priority	**Maternity care**	**Pregnancy, delivery, newborns** Rationale: Impact - High cost for OHP, PEBB; Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; high-value services are under-utilized; Equity - disparities exist by insurance status
Pneumonia (hospital setting – from CMS core measures) Rationale: National alignment; existing reporting infrastructure		**Pneumonia** Rationale: Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; high cost for OHP; OR inpatient costs are highly variable; Feasibility - high-value services are under-utilized; bundle models for episode payment exist Equity - disparities exist by income and insurance status Synergy - Synergy with national partners

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
Heart attack, heart failure (hospital setting – from CMS core measures) Rationale: National alignment; existing reporting infrastructure		
Children's asthma care (hospital setting – from CMS core measures) Rationale: National alignment; existing reporting infrastructure		**Asthma** Rationale: Impact - preventable complications are high % of commercial claims Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available Disparities - income-based disparities exist Synergy - synergy with local or national partners; prevalent chronic disease
		Diabetes Rationale: Impact - preventable complications are high % of commercial claims; high rate of readmissions; Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available Equity - disparities exist particularly in complication rates Synergy - prevalent chronic disease
		Mental disorders (undifferentiated) Rationale: Impact - cost driver for Medicare; high cost for OHP, PEBB Disparities - OR suicide rate is high compared to nat'l average

Appendix 2

Quality & Efficiency Subcommittee Workgroup Products

The Quality & Efficiency Subcommittee formed topical workgroups to generate recommendations of measurement priorities and potential indicators for use in payment reform initiatives. The first workgroup focused on patient- and family centeredness and the second on traditional quality, safety, and effectiveness topics. Both workgroups' suggestions are reflected throughout the full Committee's recommendations, particularly recommendations 3 and 4. This appendix provides more detail on the Quality & Efficiency workgroup thinking including suggested metrics for use in payment reform work and valuable provider resources for measurement or quality improvement, by topic.

Patient- and Family Centeredness

The workgroup identified six key domains of patient activation and engagement:

- Patient- and family-centered practices - patients and families are involved in practice design and improvement.
- Self-management support - patients have the resources and support they need to take an active role in managing their diseases and improving their health.
- Shared decision-making - patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- Respect for patient values, preferences, and expressed needs - patient and family knowledge, values, beliefs and cultural backgrounds are respected in the planning and delivery of care.
- Care coordination - patient information, needs, and preferences are shared between providers and settings to reduce the potential for harm and waste.
- Patient experience of care - providers and organizations assess and make efforts to improve the overall patient experience of care.

The workgroup suggested two broad strategies for using payment reform as a vehicle to make health care delivery in Oregon more patient-centered:

1. Require tracking of each key domain of patient activation and engagement in every payment reform initiative, regardless of clinical focus or care delivery setting.
2. Consider an incentive for the entire "bucket" of patient-centered care, e.g. grant preferred provider status in public contracting to providers and practices that can demonstrate achievement of at least one structural measure in each domain of patient activation and engagement.

The workgroup also compiled over 60 measures of patient-centeredness that can be used in conjunction with payment reforms or experiments (as standards for participation, reward criteria, evaluation metrics) and a variety of patient and provider resources that can be used in the design or implementation of a payment reform initiative.

Domain: Patient- and family-centered care
Suggested metric options:

Patient- and family-centered care measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
Organization has method to recruit, mentor and utilize advisors [patients/families] in meaningful ways to help design, provide input to health care services	X			X			
Patient/Family Advisors provide ongoing input on quality improvement efforts		X		X			
% and/or number of advisors involved in providing ongoing input/participation on committees and/or improvement teams			X	X			

Resources:

- Institute for Patient and Family Centered Care, see: http://www.ipfcc.org/
- Consumers Advancing Patient Safety, see: www.patientsafety.org
- Oregon Healthcare Quality Corporation has contracted with PeaceHealth to develop a statewide learning network on this topic
- The Joint Commission's 2010 report: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*

Domain: Self-management support
Suggested metric options:

Self-management support measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From OR PC^2 Standards Advisory Committee							
PCPCH documents patient/family education and self management efforts (OR PC^2)	X				X		
PCPCH meets benchmark of patients receiving relevant self-management materials (OR PC2)			X		X		
From NRC+Picker patient experience survey							
Did the provider explain what to do if problems or symptoms continued, got		X		X			

Self-management support measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
worse, or came back?							
Did someone explain the purpose of any prescribed medicines in a way that you could understand?			X	X			
Did someone tell you about side effects the medicines might have?		X		X			
Did you get as much information about your condition and treatment as you wanted from your heath care provider?		X		X			
Did your provider explain why you needed tests in a way that you could understand?			X	X			
Did someone tell you how you would find out the results of your tests?		X		X			
Did someone tell you when you would find out the results of your tests?		X		X			
After the tests were done, did someone explain the results in a way that you could understand?			X	X			
Did you know who to call if you needed help or had more questions after you left your appointment?		X			X	X	
From CMS Care Transition Measures (CTM-3)							
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.			X				X
When I left the hospital, I clearly understood the purpose for taking each of my medications.			X				X
From AHRQ CAHPS tools							
Percentage of adult inpatients who reported whether they were provided specific discharge information (H-CAPHS)		X					X

Self-management support measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
Note: New CG-CAHPS items currently being tested lifestyle and the role of the care team in supporting the patient in making changes and accessing community resources. A chronic condition version survey is similar but much more targeted on patient understanding of their condition, medication use and lifestyle changes and the role/helpfulness of the care team to provide support to them.							
Additional measures							
Patient Activation Measure (PAM) – 13 item scale developed by Judy Hibbard of U of O.			X	X			
Organization measures patient activation using standardized survey to provide appropriate interventions/support to patient		X		X			
Organization measures and improves the activation levels of patients over time			X	X			

Resources:
Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey
- Care Transition Measure (CTM-3 used by CMS or longer version: CTM-15)

Tools for providers or patients:

- Living Well with Chronic Conditions – Oregon Public Health Division chronic disease self-management program includes leader training and patient workshops, see: http://www.oregon.gov/DHS/ph/livingwell/index.shtml
- Coaching for Activation website (Insignia Health, Portland) has several resources, see: http://www.insigniahealth.com/products/coaching.html
- Motivational interviewing and related techniques can improve patient self-management skills. Resources in this area include:
  - Foundation for Medical Excellence has a number of trainings on physician-patient communication, see: http://www.tfme.org/ (Contact: Barry Egener)
  - Oregon project to incorporate screening for alcohol and drug misuse into primary care is using a very brief variant of M.I. called the "brief negotiated interview," see their curriculum at: http://www.sbirtoregon.org/

Domain: Shared decision-making
Suggested metric options:

Shared decision-making	Measure level	Setting

	Structure	Process	Outcome	All	PC	Specialty	Hospital
From NRC+Picker patient experience survey							
Were you involved in decisions about your care as much as you wanted?			X	X			
Did the provider ask you about how your family or living situation might affect your health?		X		X			
From Press-Ganey patient experience survey							
Degree to which you and your family were able to participate in decisions about your care			X	X			
From OR PC^2 Standards Advisory Committee							
Organization provides materials to patients that outlines their role as member of care team		X					
Organization meets benchmarks of % patients receiving educational materials on PCH and patient roles and responsibilities			X				
Note: New CG-CAHPS items being tested include items about the quality of the interaction patient and provider have about treatment choices, pro/cons, both medication and treatment choices. Some emphasis on why patient might not want to do each of the treatments and if provider asked what patient's opinion was.							
Additional measures							
Organization/provider provides and discusses information on alternative treatment choices prior to scheduled surgery or procedure		X		X			
Organization uses/provides evidence based shared decision making programs to patients/families as part of its delivery of care	X			X			
Organization/provider is able to include information about the cost of services in the process of obtaining informed consent	X			X			
Organization tracks use of preference sensitive care	X			X			
Use of preference-sensitive care is neither significantly			X	X			

Shared decision-making measures	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
above or below standards for patient demographics							

Resources:
Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey

Tools for providers or patients:

- Foundation for Informed Decision-making has a series of preference sensitive aids/programs, see: http://www.informedmedicaldecisions.org
- Ottawa Health Decision Centre has an inventory of many decision aides for physical health care and a certification program see: http://decisionaid.ohri.ca
- Dartmouth-Hitchcock Medical Center Decision Support Center has established an on-site decision-support center for patients and also provides limited on-line resources, see: http://www.dhmc.org
- SAMSHA shared decision-making resources for mental health, see: http://mentalhealth.samhsa.gov/consumersurvivor/shared.asp
- Health Dialogue is a vendor for shared decision-making programs and also source of information and evidence on motivational interviewing and other techniques, see: http://www.healthdialog.com/Main/default

Domain: Respect for patient values, preference, expressed needs
Suggested metric options:

Measures of Respect for Values, Preference, Expressed Needs	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From Press-Ganey patient experience survey							
Degree to which your choices were respected to have family members/friends with you during your care		X		X			
Degree to which staff respected your family's cultural and spiritual needs		X		X			
From OR PC^2 Standards Advisory Committee							
Organization identifies the patient's preferred language and has resources to respond to needs	X				X		
From NRC+Picker patient experience survey							

Measures of Respect for Values, Preference, Expressed Needs	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
Did your health care provider treat you with respect and dignity?			X	X			
From CMS Care Transition Measures (CTM-3)							
The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.			X				X
From AHRQ CAHPS tools							
Percentage of patients who report that their doctors communicated well (CG-CAHPS)			X		X	X	

Resources:
Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey
- Care Transition Measure (CTM-3 used by CMS or longer version: CTM-15)

Tools for providers or patients:

- Navigating Patient- and Family-Centered Care Rounds: A Guide to Achieving Success (Medical College of Georgia, Center for Patient- and Family-Centered Care), see: http://www.mcg.edu/centers/cpfcc/PFCCRoundsGuidebook.html

Domain: Care Coordination
Suggested metric options:

Measures of Care Coordination	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From Press-Ganey patient experience survey							
Staff explained role in care		X		X			
From OR PC^2 Standards Advisory Committee							
PCH assigns individual responsibility for care coordination and tells each patient the name of the team member responsible for coordinating care	X				X		

Measures of Care Coordination	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
PCH demonstrates that people acting as care coordinators have received specific training in care coordination functions	X				X		
From NRC+Picker patient experience survey							
If you needed another visit with another health care provider, did the staff do everything they could to make the necessary arrangements?		X		X			
From NQF consensus standards on care coordination							
Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)		X					X
Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)		X					X
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care])		X				X	
From AHRQ CAHPS tools							
Percentage of patients who reported how often their doctor's office followed up on results for blood tests, x-rays or any other tests ordered (CG-CAHPS)		X			X	X	
Percentage of inpatients who reported whether they were provided specific discharge information (H-CAHPS)		X					X
Note: New CG-CAHPS items currently being tested include:							

Measures of Care Coordination	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
▪ Questions indirectly query the role of this provider in helping patient access care outside their office. ▪ Questions identify the patient's perception of the provider's knowledge of care received from specialists ▪ Focus on role of provider in helping patient get counseling for mental health or substance abuse issues. ▪ Questions about the ability of provider to follow-up on tests, diagnoses and referrals outside their office							
From Client perceptions of coordination questionnaire (Australia)							
How often were [are] you confused about the roles of different service [health care] providers [you see]?		X		X			
How often did [do] you seem to get conflicting advice from service [health care] providers?		X		X			
How often did [does] your GP [primary care provider] seem to be communicating with your other providers		X			X		
From CMS Care Transition Measures (CTM-3)							
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.			X				X
When I left the hospital, I clearly understood the purpose for taking each of my medications.			X				X

Resources:
Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey
- Care Transition Measure (CTM-3 used by CMS or longer version: CTM-15)
- CPCQ - Client perceptions of coordination questionnaire (Australia), see: www.ncbi.nlm.nih.gov//pubmed/12930046
- Forthcoming NQF consensus standards on care coordination, see: http://www.qualityforum.org/projects/care_coordination.aspx#t=2&s=&p=8%7C5%7C

Tools for providers or patients:

- Care Management Plus (OHSU & David Dorr) - care managers and information systems to improve the quality of care for seniors and patients with chronic illnesses, see: http://caremanagementplus.org/
- National Transitions of Care Coalition, see: http://www.ntocc.org/
- Care Transitions Program (Dr. Eric Coleman) at the University of Colorado has an intervention program, some patient and provider tools, and details on the 3- and 15-item version of the Care Transition Measure, see: http://www.caretransitions.org/

Domain: Patient Experience of Care
Suggested metric options:

Measures of Patient Experience of Care	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
From Press-Ganey patient experience survey							
Degree to which the staff supported your family throughout your health care experience		X		X			
Degree to which staff respected your family's cultural and spiritual needs		X		X			
From OR PC^2 Standards Advisory Committee							
Entity conducts a patient experience survey	X				X		
Entity uses results of patient experience survey to improve care		X			X		
Entity uses standardized patient experience survey and can compare performance to benchmarks			X		X		
From NRC+Picker patient experience survey							
During your clinic visit, was your family or someone close to you involved in your care as much as you wanted?			X	X			
When you saw your health care provider, did he or she give you a chance to explain the reasons for your visit?		X		X			
Did the provider listen to what you had to say?		X		X			
Did you have questions about your care or treatment that you		X		X			

Measures of Patient Experience of Care	Measure level			Setting			
	Structure	Process	Outcome	All	PC	Specialty	Hospital
wanted to discuss but did not?							
If you and your provider didn't talk about your questions, was it because... (mark all that apply) embarrassed, forgot, I didn't have time, provider didn't have time, too many interruptions/no privacy, no questions		X		X			
From AHRQ CAHPS tools							
Percentage of patients who reported that their provided communicated well (H-CAHPS or CG-CAHPS)			X	X			
Note: New CG-CAHPS items currently being tested have strong emphasis on whether efforts were made to check for patient understanding and provider's knowledge of patient values, beliefs about health							
Additional measures							
Organization has way to identify who patient identifies as family and the degree they want them involved in care decisions	X			X			

Resources:
Sources of validated metrics include:

- AHRQ CAHPS surveys (CG-CAHPS, H-CAHPS, etc.)
- Press-Ganey patient experience survey
- NRC+Picker patient experience survey

Quality, Safety, Efficiency

This workgroup made suggestions of measurement priorities, quality improvement approaches, and potential metrics for use in payment reform work in three different settings: hospital, specialty, and primary care. Suggestions are presented by setting because most existing measures are specific to one or another type of care; the presentation is not intended to reinforce existing silos that the workgroup acknowledges contribute to defects in quality and efficiency.

Hospital recommendations

- **Skin injuries (e.g. pressure ulcers) and falls**

Rationale: NPP priorities; federal priorities (both are CMS no-pay events); events are high total cost to hospitals (even if reimbursement impact of CMS no-pay policy is sometimes low because of filters and exclusions); Events are frequent enough that small numbers aren't usually a problem

Approach: Work with nursing leadership in the state; use participation in National Database of Nursing Quality Indicators (NDNQI) as first step/structural measure (CMS now asks about participation in a systematic clinical database registry for nursing-sensitive care as part of annual quality reporting for hospital payment updates – RHQDAPU).

Measures:

	Skin injuries	Falls
Structure	– Existence of rules or protocols for the prevention of pressure ulcers	– Existence of rules or protocols for identifying patients at risk of falls
Process	– Percentage of patients with documented assessment of skin for breakdown (AMDA)[i]	– Percentage of eligible patients documented as having a fall risk, using an accepted risk assessment tool
Outcome	– Stage 3 or 4 pressure ulcers acquired after admission to a health care facility (OR PSC/CMS)[ii]	– Patient death or serious physical injury associated with a fall while being cared for in a healthcare facility (OR PSC/CMS)[ii] – Rate of inpatient falls with injury per 1,000 patient days (ICSI)[iii]

- **Readmissions**

  Rationale: Are a measure of defects in coordination of care; cross-setting issue.

  Approach: Measures should be global because the quality defects in this area aren't specific to a given condition, but will then need some case-mix adjustment; align with emerging national consensus on how best to measure this – 30 days seems to be most common timeframe.

  Measures: Align with 3M algorithms for potentially preventable readmissions, as state will be using 3M software.

- **Healthcare acquired conditions (infections specifically)**

  Rationale: NPP priority; national and state momentum; opportunity to further NSQIP (National Surgery Quality Improvement Program).

  Approach: Take lead from state program - use CDC's National Health and Safety Network (NHSN) for reporting.

  Measures: Follow state program – see pages 106 and 107 of this document: http://www.oregon.gov/OHPPR/docs/HCAIAC/Report_HAI_Final.pdf for current and proposed future measures

- **CMS Core measures**

  Rationale: National alignment.

  Approach: Give hospitals flexibility – have them choose focus areas and measures that meet their improvement needs or the needs of their patient populations. Use participation in relevant quality improvement program, collaborative, or reporting

initiative either as minimum qualification/floor for participation (as in Michigan BCBS example) or as bonus; use CMS measures as outcomes.

Measures:

- CMS core measures meeting Chassin's accountability criteria are listed on page 3 of: http://www.nejm.org/doi/suppl/10.1056/NEJMsb1002320/suppl_file/nejmsb1002320_appendix.pdf
- Suggestions for quality improvement program, collaborative, or reporting initiative participation include:
  - Oregon NSQIP Consortium
  - Oregon Hospital Collaborative to reduce healthcare acquired infections
  - National Database of Nursing Quality Indicators

Specialty recommendations

- **Imaging appropriateness**

  Rationale: NPP priority; national and state momentum.

  Approach: Developmental – build measurement and reporting capacity first. This issue is especially difficult in inpatient and ED settings

  Measures:

Structure	– TBD
Process	– NQF has six imaging efficiency standards currently out for member voting, see: http://www.qualityforum.org/projects/imaging_efficiency.aspx#t=2&s=&p=6%7C . Most are process measures, i.e.: ▪ Appropriate Pulmonary CT Imaging for Pulmonary Embolism ▪ Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury ▪ Preoperative Evaluation for Low-Risk Non-Cardiac Surgery Risk Assessment ▪ Cardiac stress imaging not meeting appropriate use criteria (3 measures) – [*Placeholder for shared decision making or other patient-centered metrics*]
Outcome	– Placeholder for OHLC measure on high-end imaging for radiculopathy – see also low back pain – *Emergency cardiac imaging?* – *Head CTs in ERs (developmental)*

- **Low back pain tx / spine surgery appropriateness**

  Rationale: NPP and local priority; high cost for PEBB; potential for useful physician profiling and intervention; good area for consumer education and shared decision-making.

  Approach: Incent appropriate early intervention and conservative tx prior to imaging; improve alignment between provider payment and consumer co-pays and benefits.

  Measures:

Structure	– Evidence-based guidelines for tx of low back pain are in place – Participation in relevant quality improvement program – [*Placeholder for shared decision making or other patient-centered metrics*]
Process	– Measures of appropriate work-up and advice for low pain patients (NQF)[iv] – Use of Imaging Studies for Low Back Pain (HEDIS / QCorp 2011)[v]

	– [*Placeholder for forthcoming OHLC measure on high-end imaging for radiculopathy* – see also imaging appropriateness] – Appropriate use of epidural steroid injections (NCQA)[vi] – [*Placeholder for shared decision making or other patient-centered metrics*]
Outcome	– Relative Resource Use for People With Acute Low Back Pain (HEDIS) – Back surgery rates (plan level measure) – Functional status post surgery (ICSI)[vii] – [*Placeholder for shared decision making or other patient-centered metrics*]

- **Maternity care/c-sections**

  Rationale: Difficult issue but huge area for Medicaid; good area for patient-centered and shared-decision making approaches; NPP priority.

  Approach: Take transparency and shared decision-making approach rather than specifying target rate; report cesarean rates by hospital; separate hospitals with and without high-risk programs (peri- or neonatology)

  Measures:

Structure	– Existence of evidence-based protocol for c-section use, with respect for patient decision-making – Participation in relevant quality improvement program
Process	– [*Placeholder for shared decision making or other patient-centered metrics*]
Outcome	– Primary cesarean delivery rate (AHRQ IQI)[viii]

- **Joint replacement**

  Rationale: NPP priority

  Approach: Developmental – build measurement and reporting capacity first.

  Measures:

Structure	– TBD
Process	– [*Placeholder for shared decision making or other patient-centered metrics*]
Outcome	– HEDIS measures of utilization of: ▪ Total hip replacement ▪ Total knee replacement

- **Cardiac diagnostic studies and PCIs**

  Rationale: NPP priority

  Approach: Developmental – build measurement and reporting capacity first.

  Measures:

Structure	– TBD
Process	- NQF has six imaging efficiency standards currently out for member voting, 3 of which are about appropriate use of cardiac stress imaging, see: http://www.qualityforum.org/projects/imaging_efficiency.aspx#t=2&s=&p=6%7C . – TBD
Outcome	– HEDIS measures of utilization of: ▪ Percutaneous transluminal coronary angioplasty (PTCA) rate ▪ Coronary artery bypass graft (CABG) rate

Primary care recommendations

The group suggests the following as priorities among the standards and measures already identified by the Oregon Patient centered Primary Care Home Standards Advisory Committee:

Priorities for **Access**

1. In-person and telephone access measures should be foundational/part of base payment
2. Electronic access is the next level

Measures:

	In-person and telephone access	Electronic access
Structure	– PCH provides continuous access to clinical advice by telephone (OR PC^2) – PCH offers appointments at least 4 hours weekly outside traditional business hours (OR PC^2)	– Individual physicians provide patients with clinical summary of each office visit / hospitals provide electronic copy of discharge instructions upon request (CMS MU)[ix] – Provide patients with timely electronic access to their health information (CMS MU)[x] – Send reminders to patients (per patient preference) for preventive and follow-up care (CMS MU)[xi] – On request, provide patients with an electronic copy of their health information (CMS MU)[xii] – PCH provides at least one option for electronic access, such as secure email or a secure web portal (OR PC^2)
Process	– PCH tracks and reports a standard measures of appointment access (OR PC^2)	–
Outcome	– Standardized appointment access measure (e.g. days to 3rd next available appointment) – Patient experience access measure (e.g. were you able to get an appointment as soon as you wanted one?)	–

Priorities for **Accountability**

1. Tracking and reporting of clinical quality indicators (measures 1-3 under this standard); align with CMS meaningful use measures.
2. Medication management should be a second focus; use HEDIS and CMS meaningful use measures.

Measures:

	Track and report clinical quality indicators	Medication management
Structure	– Report clinical quality measures to CMS or states [if state has the option, align specific measures with Q-Corp reporting] (CMS MU)[xiii] – Generate list of patients by specific	– Enable functionality for drug-drug and drug-allergy interaction checks (CMS MU)[xv]

	conditions to use for quality improvement, reduction of disparities, research, or outreach (CMS MU)[xiv]	
Process	–	– Annual monitoring for patients on persistent medication (4 HEDIS measures)[xvi] – Use of high-risk medications in the elderly (HEDIS)[xvi]
Outcome	–	– Percentage of members 65 and older whose medications were reconciled within 60 days of discharge (HEDIS)

Priorities for **Comprehensive, Whole-Person Care**

1. Offering mental health services (measure 3 under this standard) should be prioritized, although all are important.

Measures:

	Provision of behavioral health services
Structure	– PCH documents (OR PC^2): ▪ Screening strategy for mental health (e.g. with PHQ-9 tool) and substance abuse conditions (e.g. using Oregon SBIRT protocol for substance abuse) ▪ Onsite and local referral resources ▪ Actual or virtual co-location with specialty mental health or substance abuse providers – PCH conducts analysis of the Health and Behavior Assessment and Intervention codes related to a physical health diagnosis – Use of registry for care management of MH/SU conditions
Process	For mild or moderate depression: – PCH documents referral to cognitive behavioral therapy (a value-based service) For major depression: – Anti-depression medication management – acute and continuous phase (2 HEDIS measures)[xvii] – PCH demonstrates improvement in the number of active patients screened for mental health issues (OR PC^2)
Outcome	– % screened annually for mental health and substance abuse issues – % of patients w/ top five disease conditions screened for depression and substance abuse – % patients with new episode of clinically significant depression or diagnosis of substance abuse disorder showing improvement on clinically valid tool in given time period

(Additional measures might be found in Cascades Community Engagement Behavioral Health Integration Measurement/Evaluation Strategy document from January 2010)

Priorities for **Continuity**

1. Association of patient with a personal clinician or team should be first priority.

Measures:

	Association with personal clinician[xviii] or team
Structure	– TBD
Process	– PCH tracks and reports the percentage of active patients assigned to a clinician or team (OR PC^2)
Outcome	– PCH meets a benchmark or demonstrates improvement in proportion of visits where patient sees assigned clinician or (OR PC^2)

Priorities for **Coordination & Integration**

1. Prioritize care planning items (measure 6) as a practical first step.
2. Second priority should be the medical neighborhood items (measures 4 and 5); further measure development is needed in this area.

Measures:

	Association with personal clinician[xix] or team	Medical neighborhood
Structure	– Generate list of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach (CMS MU)[xx] – Maintain up-to-date problem list of current and active diagnoses (CMS MU)[xxi] – Maintain active medication list (CMS MU)[xxi] – Report clinical quality measures to CMS or states (CMS MU) [if state has the option, align with Q-Corp collection & reporting plans for 2011 and beyond][xiii]	– Implement capability to electronically exchange key clinical information among providers and patient-authorized entities (CMS MU)[xxii]
Process	– TBD	– TBD
Outcome	– TBD	– TBD

Priorities for **Patient and Family-Centered Care** not addressed here – see material from small workgroup on patient-centeredness.

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[i] American Medical Directors Association (AMDA). Percentage of patients with a pressure ulcer or pressure ulcer risk with documented periodic assessment for specific risk factors.

[ii] Oregon Patient Safety Commission; CMS no-pay/never event

[iii] ICSI – Institute for clinical systems improvement

[iv] Process measures include documentation of initial assessment including specific items, advice against bed rest, advice to maintain normal activity, and patient education, see: http://www.qualityforum.org/Measures_List.aspx#k=low%2520back%2520pain&e=1&st=&sd=&s=&p=1

[v] NCQA HEDIS use of imaging studies for low back pain: percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis

[vi] Percentage of patients with back pain who have received an epidural steroid injection in the absence of radicular pain AND those patients with radicular pain who received an epidural steroid injection without image guidance (overuse measure, lower performance is better).

[vii] Percent of patients with a previous visual analog scale (VAS) pain scale rating of 4 or higher and an Oswestry score of 20 or higher that had a reduction of the Oswestry score by at least 30 percent at six weeks

[viii] AHRQ Inpatient Quality Indicator: cesarean delivery rate excluding presentation, preterm delivery, fetal death, multiple gestation diagnosis codes

[ix] Core item – standard for office visits is 50% of patients receive summary within 3 days; standard for hospitals is 50% of patients who request electronic discharge info receive it

[x] Menu item - standard is more than 10% of patients get access within 4 days of EHR update

[xi] Menu item - standard is more than 20% of patients over 64 or under 6 are sent appropriate reminders

[xii] Core item – standard is more than 50% of requesting patients electronic copy within 3 business days

[xiii] Core item – standard is attestation of aggregate numerator and denominator data for 2011 and electronic submission of measures for 2012

[xiv] Menu item – standard is demonstrating generation of at least one list

[xv] Core item – standard is that functionality is enabled
[xvi] See: http://qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?orgid=8&objid=14912
[xvii] Acute: Percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (12 weeks); Continuous: percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).
[xviii] Note: clinician as used here does not imply a particular profession or level of training
[xix] Note: clinician as used here does not imply a particular profession or level of training
[xx] Menu item – standard is demonstrating generation of at least one list
[xxi] Core item – standard is that more than 80% of patients have at least one item recorded as structured data
[xxii] Core item – standard is performing at least one test of this capability

Appendix 3

Guiding Principles for Payment Reform

Preamble

Oregon's health care system is unsustainable. Current financing and payment mechanisms (such as fee for service) contribute to the problems of the system by failing to link payment for health care goods and services to achieving desired outcomes. The transition from current payment mechanisms to those that will support a sustainable health care system must be grounded in transparent measurement of outcomes supportive of the Oregon Health Authority's Triple Aim goals[1] and guided by the following principles.

Payment Reform Principles

1. Improve the lifelong health of all Oregonians.

   Equity **-** Payment for health care should provide incentives for delivering evidence-based care (where known) to all people, not creating advantages or disadvantages for certain individuals or populations based on factors unrelated to medical need.

   > *Consumer perspective – I expect to be offered the same services as others with similar health needs.*

2. Increase the quality, reliability, and availability of care for all Oregonians.

   Accountability **-** Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals.

   > *Consumer perspective – I expect my providers to deliver high quality care and supportive services that meet my needs.*

   Transformative **-** Payment for health care should encourage innovation by aligning incentives across all payers and encouraging providers and consumers to coordinate care across the care continuum.

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[1] The Triple Aim goals are:

- Improving the lifelong health of Oregonians
- Increasing the quality, reliability, and availability of care for all Oregonians
- Lowering or containing the cost of care so it's affordable to everyone.

Consumer perspective – I expect to buy health care based on value, not volume – I want the right care delivered at the right time in the right way.

3. Lower or contain the cost of care so it is affordable to everyone.

Cost Containment **-** Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency.

Consumer perspective – I expect my health care providers to engage me as an active partner in improving my own health. As an active partner, I have a responsibility to keep myself healthy to the extent that my environment allows and to use only the care I need in the most appropriate setting.

Simplicity **-** Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse.

Consumer perspective – I should be able to understand how my health care is paid for.

Transparency **-** Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers.

Consumer perspective – I expect to know how much treatment options will cost and what value I am receiving so I can make informed decisions about my health care.

Appendix 4

Payment Reform Work Group Products

The Payment Reform Subcommittee completed some of its more detailed work in three small work groups. One work group focused on primary care physician practices, another on specialty physician practices, and another on hospitals. In doing so, the subcommittee recognized that one of the key delivery system improvement objectives is improved coordination across provider types. Each group sought to identify delivery system improvement objectives, barriers to improvement, and payment reform strategies for incenting improvement. The subcommittee discussed the recommendations coming out of the work groups and incorporated them into recommendations that went on to the full Incentives and Outcomes Committee. The subcommittee expanded on the hospital work group's standardization recommendation—suggesting that base ASC and physician as well as hospital payment methods be standardized.

Summary of Thinking as of 8/27/10
Specialty Physician Payment Staff Advisory Work Group

Objective #1: Improved decisions regarding choice of treatment.

- Physicians follow evidence-based practice guidelines
- For preference-sensitive conditions, physicians use high quality tools for shared decision-making to help patients make choices that reflect their values
- Appropriate technologies are used (in view of comparative effectiveness and cost)
- Variation in utilization is reduced

Objective #2: Improved coordination to prevent hospital admissions and readmissions.

- Reduce admissions for ambulatory sensitive conditions
- Reduce readmissions

Objective #3: More cost-effective care for an acute episode.

- Reduce total costs for an episode
- Increase use of lower cost alternatives for high cost implants, cancer drugs and other technologies where good evidence does not support selection of higher cost alternatives

Objective #4: Improved decisions about when to refer patients to specialists and back to primary care.

Detail on recommendations:

1. Statewide: Provide payment incentives for specialty care physicians to enter into and follow primary care/specialty care service agreements.

- Service agreements are non-financial agreements that spell out responsibilities of the primary care and specialty practices in providing coordinated care. Agreements should be developed by adapting standard template agreements as necessary by primary care and specialty practices to fit the kinds of conditions they are jointly managing, the capacities of the particular practices, and the like. The agreements should result in more

consultations and fewer or more appropriate referrals as well as more continuity of care and improved resource utilization.[1]

- Participation in service agreements might be a condition to participating in episode payment pilots or gain-sharing programs or accepting referrals from patient-centered primary care homes.
- To support implementation of these agreements, specialty physicians participating in these collaborations should be paid for consultations on a fee for service basis (using newly developed codes). [The work group is split on this recommendation: Some argue that specialists should be providing consultation to primary care physicians now, knowing that they will eventually be paid adequately for the referrals they receive; they say they cannot support paying specialists more to do this. Other members of the group argue that we are asking specialists, like primary care providers, to take on new tasks and change practice patterns to help create a system of more efficient, coordinated care. We expect the new system to reduce utilization of specialty services. At least as we transition to more global forms of payment, payment should be made for the new activities.]
- It will be important to develop metrics to measure the effectiveness of the incentives in improving the efficiency and quality of care. It may be wise to pilot and evaluate each of the two approaches to compensating specialty providers for non-office visit activity.

2. Pilots: Make bundled payments for acute episodes.

- Provider groups (either formal organizations or ad hoc groups--generally including hospitals or other facilities) will be paid for an episode of care rather than individual services.
- Pilots should be initiated that bundle payment for both episodes involving hospital admissions and episodes triggered by an event that is not a hospital admission, such as pregnancy or an acute episode of back pain. They might also include episodes of chronic care defined by a calendar period.
    - Episodes that commence with a hospital admission would continue for 90 days post-discharge with payment to include professional services, hospital stay, and facilities delivering post-acute care. These episodes would include any readmissions during the 90-day period. (Geisinger and Prometheus have developed such bundles.)
    - Episodes that do <u>not</u> commence with a hospital admission would require a different bundle design. (Both Prometheus and the State of Minnesota have developed such bundles for an acute episode of low back pain, prenatal care, and care for a calendar period of care for diabetes, COPD, and asthma.)
- Pilots should be initiated that pay for bundles using each of these methods:
    - Episode case rates: Payers make a single payment to a group of professionals and facilities who have developed the internal structures to accept and divide the payment among themselves. (Such structures might be embryonic ACOs.)

- [1] An experiment conducted by UCSF referral network that included independent practices showed that a protocol involving a pre-referral consult resulted in a median decline in actual referrals of 25% with neurology referrals declining very little and liver referrals declining 53%. In addition, there was a more than 50% decline in the number of visits to specialists where the reason for the referral/visit was difficult to identify. (California Improvement Network powerpoint June 23, 2010.)

    - Fee for service rates with risk-sharing: Payers continue to make FFS payments to individual professionals and facilities; but the cost of the episode is measured against a benchmark and, at the conclusion, payments are adjusted depending on how the actual cost of care compared with a benchmark rate. (This approach could be used where the level of provider organization is less well-developed.)
- Criteria for selecting conditions to pilot might include conditions with high potential for improvement in care quality or efficiency such as conditions with high cost variation, readmission variation, involvement of preference sensitive conditions (maybe some heart conditions, total hips), or use of implants or injectables.
- Episodes should also be selected that require coordination of different components of the delivery system—eg, primary and specialty physician coordination to manage low back pain versus physician/hospital/post-acute care to manage an acute MI and post-hospital care.

3. Pilots: Provide incentives for use of shared decision-making tools for preference-sensitive conditions, where there is high variability in utilization, conditions where there are risks of treatment or value choices to be made.

[Note: This approach has not been well-developed in the group. The group discussed using payment tools including denial of payment if decision-making is not done properly and payment for the decision-making process (rather than simply for the procedure). Service agreements should define responsibility for the shared decision-making process; it may be that shared decision-making will often be a primary care responsibility, for which the practice is compensated, if decision-making occurs there.]

4. Physicians should not be paid for treatment required due to hospital-acquired conditions for which the Medicare payment methodology would deny payment to the hospital.

5. Consideration should be given to standardizing ASC payment to the Medicare methodology (APCs).

Other projects flagged by the group for further discussion—now or later:

- How to pay and make use of community workers to help address prevention, public health, and social issues.
- Payment reform approach to end of life care issues
- Payment reform approach to oncology treatment issues (propose convening a group of oncologists to discuss)
- How to establish price targets for gainsharing programs, case rates, etc.
- Hospital practice of refusing to admit patient from primary care without ED workup
- Payment and other mechanisms for addressing duplicate or inappropriate diagnostic tests

Summary of Thinking as of 8/17/10
Hospital Payment Staff Advisory Work Group

Some desired delivery system changes to be incented via hospital payment reform:

> Objective #1: Reduce hospital costs/increase hospital efficiency by lowering cost relative to historical cost or trend or relative to benchmarks
> Objective #2: Reduce hospital acquired conditions, medical errors, and preventable readmissions by improving processes within the hospital and coordinating care more effectively across sites of care.
> Objective #3: Improve discharge planning and coordination of post-acute care.

Detail on recommendations:

1. Standardize payment by tying payment for all hospital care for PPS hospitals to the Medicare methodology.

- Standardization should apply to PPS hospitals (also known as DRG hospitals) but not to hospitals that are paid by Medicare on a cost basis. This will cover about 95% of all payment.
- Standardization of payment should occur for both inpatient and outpatient services.
- Inpatient standardization to Medicare means adopting the entire Medicare inpatient prospective payment system—including the rules governing nonpayment for hospital acquired conditions but not the rate. It means using the CMS list, not the OAHHS list. [There is difference of opinion in the group about whether outlier rules should be adopted from Medicare or left to negotiation.]
- Outpatient standardization to Medicare means using Medicare's APC payment methodology. Apparently APC's are fairly widely used in the private sector in Washington where they are also used by the Medicaid program. In Oregon, however, adoption has been slower and the Medicaid program is paying a % of charges tied to the hospital's cost to charge ratio.
- The standardization rules need to leave room for exceptions and innovation. Some examples: (1) Pregnancy/childbirth DRG weights may need to be different in Medicaid and commercial populations than in Medicare. (2) Episode payments and case rates that bundle hospital and physician services should be permissible. (3) Global payments should be permissible. Law should specifically allow certain kinds of payments that vary from the Medicare payment structure and/or allow approval of exceptions for innovative systems.

2. Pay hospitals for performance improvement on specific quality and efficiency metrics.

- Payers should use common metrics for their pay for performance programs.
- Indicators might include medication errors, hospital acquired infections, readmissions, and HCAHPS. They should include measures of efficiency, quality, and outcomes.
- All hospitals should be required to report metrics that allow the state to publish comparisons on measures of efficiency.

3. Pilots: Make fixed payments for acute episodes involving a hospital admission.

- Areas for potential savings through a bundled payment system (based on the collective knowledge of work group participants) include
    - Pregnancy and childbirth where programs such as that at GroupHealth drop c-section rates
    - Mental health
- All hospitals should be required to participate in at least one bundled payment pilot so that they begin learning how to transform care systems and think about reducing their costs.
- Consider experimenting with two bundled payment methodologies:
  a. Case rate model: Pay providers a bundled case rate for acute episodes involving a hospital admission. The case rate would cover a period extending 90 days beyond discharge, including readmissions. Providers divide the rate among themselves as they choose. Providers would retain the full benefit of any improved efficiency they achieve. However, case rates might be adjusted in the future to reflect improved efficiency.
  b. Shared savings model: Pay providers traditional fee for service rates. However, establish acuity adjusted case rates based on historic costs. If costs for a case come in below the case rate, split savings among the payer and the providers. Providers might or might not be put at risk for costs in excess of the case rate.

Next steps:

- Centers of Excellence: The state should have designated centers of excellence for procedures that can be done at lower cost and higher quality in a few rather than many hospitals. This might be done via a state-led process for consolidating services or by establishing benchmarks for quality and volume and cost that must be met to continue to provide the service.
- Achieving large improvements in hospital efficiency: Hospitals should figure out how to operate their entire facilities within a Medicare rate level of reimbursement.
- Mental Health: Payment needs to be transformed to improve investment in the mental health delivery system.

Observations:

- If Oregon payers do not pay hospitals for hospital acquired conditions per the Medicare methodology, the physician also should not be paid for care required to address those conditions.
- Focus of payment reform for primary and specialty care should be on getting utilization right (that is, correcting both under and over-utilization problems); focus of payment reform for hospitals should be increasing efficiency, improving discharge planning, reducing hospital acquired conditions.

Other projects flagged by the group for further discussion—now or later (carried over from earlier report):

- How to set payment[2]
- Reference-based pricing or other techniques for incenting evidence-based decisions about choice high cost/ high variability technologies like implants and cancer drugs.
- Develop good efficiency metrics.

[2] Federal alignment note: Federal reform opens the door for exploring all-payer hospital payment systems where payment levels are the same for Medicare, commercial, and other payers.

Summary of Thinking as of 09/08/10
Primary Care Payment Staff Advisory Workgroup

Objective:

Develop a payment strategy feasible for immediate implementation which:

1) Incents providers to transform into robust primary care homes,
2) Is risk-adjusted to reflect the health of a provider's patient population,
3) Is sensitive to the value that some services have over others depending on the patient population, and
4) Remains flexible enough to be augmented, if necessary, based on lessons learned during implementation.

Recommendations

1. **Pilot a transitional payment strategy for Patient-Centered Primary Care Homes (PCPCH) with reimbursement tied to base payment, pay-for-performance, and fee-for-service components.**

   <u>PCPCH Base Payment</u>:

   - Includes risk-adjusted reimbursement for providing a set bundle of primary care services as well as entry level primary care home standards.
   - A subset of the standards would be contractually required through provider network contracts with the remainder reported to a designated entity responsible for data analysis and reporting functions
   - Could be distributed in the form of a per-member per month (PMPM) fee or on an enhanced fee-for-service (FFS) basis
   - See Page 8 of this attachment for entry level primary care home standards that could be used for immediate implementation (Phase I)
   - See Page 9 of this attachment for the complete list of PCPCH Standards developed by the PCPCH Standards Advisory Committee.

   <u>Pay-for-Performance</u>:

   - Program designed using the PCPCH Standards that are not included in the Base Payment
   - Each standard is assigned a point value, reflective of the advanced degree of the primary care home characteristic, and the clinic's P4P program reimbursement is based on the number of points earned, directly reflecting how robust the primary care home has become and the needs of that primary care homes' patient population
   - Upon evaluation of the initial implementation phase, select PCPCH standards would move from P4P reimbursement to the PCPCH base payment and vice versa, if necessary (Phase II)

   <u>Fee-for-service</u>:

   - A selection of procedural services will continue to be reimbursed on a fee-for-service (FFS) basis to encourage providers to practice to the "top of their

license" by doing appropriate procedures and management of acute conditions while also discouraging overutilization of specialty referral

2. **Evaluate "Phase I" pilot projects and refine base payment and P4P programs as necessary.**

    - Given the transformative nature of this initiative, both the measures used to track the robustness of a medical home as well as the payment strategy tied to those measures should be continually evaluated and refined.

PCPCH Base Payment Potential Phase I Standards

Standards reported to designated entity by provider:

1. Tracks and reports a standard measure of appointment access
2. Provides continuous access to clinical advice by telephone
3. Tracks at least three performance indicators and reports goals for improvement
4. Reports, using a checklist, that provider offers a certain percentage of recommended preventive services
5. Reports the percentage of active patients assigned a personal clinician R
6. Reports patients' usual provider continuity with their assigned personal clinician or team member
7. Demonstrates the ability to reliably identify, track and proactively manage the care needs of a sub-population of its patients
8. Documents the use of either providers who speak a patient's language or real time face-to-face or telephonic interpreters to communicate in their language of choice
9. Surveys a sample of its patients at least annually on their experience of care; survey must include certain questions (detail in PCPCH Standards Advisory Committee report)
10. Publically reports practice-level clinical quality indicators to an external entity
11. Collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics

Standards contained in provider contractual agreements:

12. Reports that provider offers certain categories of services (detail in PCPCH Standards Advisory Committee report)
13. Maintains a health record for each patient that contains certain criteria (detail in PCPCH Standards Advisory Committee report) and updates this record at each visit
14. Has written agreement with its usual hospital providers or directly provides routine hospital care
15. Assigns individual responsibility for care coordination and tells each patient the name of the team member responsible for coordinating his or her care
16. Has written document or other educational materials that outline PCH and patient roles and responsibilities and documents that this information has been communicated to each patient or a family member/caregiver

Patient-Centered Primary Care Home Standards[3,4]

Attribute #1: Access to Care
Patient Centered Language: "Be there when I need you."
Standard: In-Person Access
Measure 1 - Appointment Access: PCH tracks and improves access to appointments in the clinic and patient satisfaction with appointment access.
Tier 1: PCH tracks and reports a standard measure of appointment access.
Tier 2: PCH sets a specific goal for improving an appointment access measure and demonstrates improvement.
Tier 3: PCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to appointments on a patient experience survey.
Measure 2 - After Hours Appointments: PCH offers appointments outside of traditional business hours.
Tier 1: PCH offers appointments at least 4 hours weekly outside traditional business hours.
Additional measure: PCH offers appointments 8 or more hours weekly outside traditional business hours.
Standard: Telephone and Electronic Access
Measure 3 - PCH provides telephone access to a clinician for advice 24 hours a day and tracks and improves telephone care.
Tier 1: PCH provides continuous access to clinical advice by telephone.
Additional Measure: Telephone encounters (including after hours encounters) are documented in the patient's medical record.
Additional Measure: PCH tracks and improves the time required to resolve telephone requests for clinical advice.
Measure 4 - Electronic Access: PCH provides an option for patients to access care, clinical advice and test results in an electronic format.
Additional Measure: PCH provides at least one option for electronic access, such as secure e-mail or a secure "web portal" (See also Continuity Measure #4)
Standard: Administrative Access
Measure 5 - Prescription Refills: PCH responds promptly to patient requests for prescription refills.
Additional Measure: PCH tracks the percentage of prescription refill requests completed within 48 hours and meets a benchmark or demonstrates improvement in this percentage over time.

Attribute #2: Accountability
Patient Centered Language: "Take responsibility for making sure I receive the best possible health care."
Standard: Performance Improvement
Measure 1 - Performance Improvement: PCH measures its own performance, sets goals and improves its care over time.
Tier 1: PCH tracks at least three performance indicators and reports goals for improvement.
Tier 2: PCH demonstrates improvement towards its reported goals on at least three performance indicators.
Measure 2 - Clinical Quality Improvement: PCH improves clinical quality indicators in its patient population
Tier 3: PCH demonstrates improvement in a certain number of clinical quality indicators.
Measure 3 - Public Reporting: PCH participates in a program of voluntary public reporting.
Tier 2: PCH publically reports practice-level clinical quality indicators to an external entity.
Standard: Cost and Utilization
Measure 4 - Ambulatory Sensitive Utilization: PCH manages patient care effectively, thereby reducing unnecessary or preventable utilization of specific services that increase costs without improving health.
Additional Measure: PCH demonstrates risk-adjusted reductions in utilization measures or excellent performance across its patient population according to prior performance or a risk-adjusted community standard.

Attribute #3: Comprehensive Whole Person Care
Patient Centered Language: "Provide or help me get the health care and services I need."
Standard: Scope of Services
Measure 1 - Preventive Services: PCH offers most age and gender appropriate preventive services.
Tier 1: PCH reports, using a checklist, that it offers a certain percentage of recommended preventive services.
Measure 2 - Medical Services: PCH offers a broad range of medical services to meet the care needs of its patient population within the PCH as often as possible.
Tier 1: PCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases; Office-based procedures and diagnostic tests; Patient education and self-management

[3] For the full report developed by the Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee, see http://www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/docs/FinalReport_PCPCH.pdf.

[4] These standards do not reflect the work of the PCPCH Pediatric Standards Advisory Committee. An updated matrix will be available December 2010.

	Measure 3 - Mental Health and Substance Abuse Services: PCH routinely offers care for mental health and substance use disorders.	
		Tier 1: PCH documents its screening strategy for mental health and substance use conditions and documents on-site and local referral resources.
		Tier 2: PCH documents direct collaboration or co-management of patients with specialty mental health and substance abuse providers.
		Tier 3: PCH documents actual or virtual co-location with specialty mental health and substance abuse providers.
	Measure 4 - Health Risk Behavior Assessment and Intervention: The PCH routinely assesses common health risk behaviors in its population and offers interventions to support behavior change.	
		Tier 1: PCH documents routine assessment and intervention for at least three health risk behaviors.
		Additional Measure: PCH documents improvement in its rates of intervention for a given health risk behavior.
		Additional Measure: PCH documents reduction of the percentage of its patients with a given health risk behavior over time.

Attribute #4: Continuity		
Patient Centered Language: "Be my partner over time in caring for my health."		
Standard: Provider Continuity		
	Measure 1 - Personal Clinician Assignment: The PCH assigns individuals to a personal clinician and primary care team using individual and family choice as the primary guiding principle.	
		Tier 1: PCH reports the percentage of active patients assigned a personal clinician and team.
		Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team.
	Measure 2 - Personal Clinician Continuity: The PCH tracks and seeks to improve patients' continuity with their chosen personal clinician and primary care team.	
		Tier 1: PCH reports patients' usual provider continuity with their assigned personal clinician or a team member.
		Tier 2: PCH meets a benchmark or demonstrates improvement in patients' usual provider continuity with their assigned personal clinician and team.
Standard: Information Continuity		
	Measure 3 - Organization of Clinical Information: PCH maintains up-to-date and accurate records and organizes clinical information in a way that is easily shared with and understandable by health care professionals inside and outside the PCH.	
		Tier 1: PCH maintains a health record for each patient that contains at least the following elements (problem list, medication list, allergies, basic demographic information and preferred language) and updates this record as needed at each visit.
	Measure 4 - Clinical Information Exchange: PCH demonstrates timely and confidential exchange of important clinical information with hospitals and consultants and provides patients with electronic access to their health information.	
		Tier 3: PCH shares clinical information electronically in real time with other health care providers (electronic health information exchange).
		Additional Measure: PCH demonstrates that it transmits data to patients' electronic personal health records or provides an electronic means for patients to access their personal health information in real time (See also Access Measure #4).
Standard: Geographic Continuity		
	Measure 5 - Specialized Care Settings: PCH tracks when its patients are cared for in specialized care settings and is actively involved during and after care in these settings	
		Tier 1: PCH has a written agreement with its usual hospital providers or directly provides routine hospital care.
		Tier 2: PCH meets benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge.
		Additional Measure: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department.

Attribute #5: Coordination and Integration		
Patient Centered Language: "Help me navigate the health care system to get the care I need in a safe and timely way."		
Standard: Data Management		
	Measure 1 - Population Data Management: PCH uses a system to organize, track and improve the care of sub-populations of its patients with specific care needs	
		Tier 1: PCH demonstrates the ability to reliably identify, track and proactively manage the care needs of a sub-population of its patients.
		Additional Measure: PCH demonstrates the use of its population data management system to improve a specific care indicator within a sub-population of its patients.
	Measure 2 - Electronic Health Record: PCH has an electronic health record (EHR) and uses this tool to improve patient care.	
		Tier 3: PCH has an electronic health record and demonstrates "meaningful use" of the electronic record, according to CMS rules.

Standard: Care Coordination		
	Measure 3 - Care Coordination: PCH assigns individual responsibility for care coordination for each patient to a member of the health care team.	
		Tier 1: PCH assigns individual responsibility for care coordination and tells each patient the name of the team member responsible for coordinating his or her care.
		Tier 2: PCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.
		Additional Measure: PCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions.
	Measure 4 - Test and Result Tracking: PCH tracks laboratory and imaging tests and follows up on results.	
		Tier 1: PCH demonstrates tracking tests ordered by its clinicians and ensures timely notification of results to patients and clinicians.
		Additional Measure: PCH demonstrates tracking planned or indicated tests and generating reminders for patients and clinicians.
	Measure 5 - Referral and Specialty Care Coordination: PCH tracks and coordinates the care its patients receive outside the PCH.	
		Tier 1: PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians.
		Tier 1: PCH either manages hospital and skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings.
		Additional Measure: PCH demonstrates collaborative care planning with other health care professionals and patients and their families when patients receive ongoing specialty care outside the PCH.
Standard: Care Planning		
	Measure 6 - Comprehensive Care Planning: PCH plans and coordinates care for its patients at the level of intensity indicated by each individual's needs.	
		Tier 1: PCH demonstrates that it can provide all patients with a written care summary that includes the following: current problem list, medication list and allergies, indicated preventive care, goals of preventive and chronic illness care.
		Tier 2: PCH demonstrates the ability to identify high-risk individuals who need and will benefit from additional care planning.
		Tier 3: PCH measures and demonstrates improvement in the percentage of high-risk individuals who have a written care plan that has been reviewed with the patient and/or caregivers in the past year.
	Measure 7 - End of Life Planning: The PCH offers end of life planning or counseling to patients who may benefit from these services.	
		Tier 1: PCH documents offering patients the opportunity to complete a POLST form or advanced directive (when appropriate) and attests to submitting completed POLST forms to the Oregon POLST registry (unless patients opt out).
		Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of patients age 65 or older who are offered the opportunity to complete a POLST.

Attribute #6: Person and Family Centered Care		
Patient Centered Language: "Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness."		
Standard: Communication		
	Measure 1 - Communication of Roles and Responsibilities: PCH communicates with its patients about the roles and responsibilities of the PCH and patients.	
		Tier 1: PCH has a written document or other educational materials that outline PCH and patient roles and responsibilities and documents (e.g. through a patient signature) that this information has been communicated to each patient or a family member/caregiver
		Tier 2: PCH meets a benchmark of the percentage of active patients who have received educational materials on PCH and patient roles and responsibilities.
	Measure 2 - Interpreter Services: PCH communicates with patients in their language of choice.	
		Tier 1: PCH documents the use of either providers who speak a patient's language or real time face-to-face or telephonic interpreters to communicate with patients in their language of choice.
Standard: Education and Self-Management Support		
	Measure 3 - Education and Self-Management Support: PCH offers education and self-management support to patients and their families and caregivers who would benefit from such services.	
		Tier 1: PCH documents patient and family education and self-management support efforts, including available community resources.
		Additional Measure: PCH assesses patients' activation or readiness to change (as appropriate) and uses this information to improve patient education and self-management.

		Additional Measure: PCH tracks and improves the percentage of patients with a particular chronic condition (e.g. diabetes) who have been offered education or self management support, including referral to community programs outside the PCH.
		Additional Measure: PCH demonstrates active follow up with patients regarding their self-management goals.
Standard: Experience of Care		
	Measure 4 - Patient Experience Survey: PCH regularly surveys its patients on their experience of care and uses this information to improve care.	
		Tier 1: PCH surveys a sample of its patients at least annually on their experience of care. The patient survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family center
		Tier 2: PCH demonstrates using the results of its patient experience survey to improve care.
		Tier 3: PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics