Benchmarking Patient Experience and Quality to Improve Practice Performance

MGMA-ACMPE
Virtual Benchmarking Academy

June 27, 2013

David N. Gans, MSHA, FACMPE
Senior Fellow, Industry Affairs
MGMA-ACMPE
About MGMA-ACMPE

Since 1926, the Medical Group Management Association (MGMA-ACMPE) has elevated the performance of medical practice leaders and their organizations by connecting members, building partnerships, setting the standards for certification, advocating for physician practice and providing innovative solutions.

MGMA-ACMPE has

- 22,500 members…
- Who manage and lead 13,200 organizations
- With 280,000 physicians
- Providing more than 40% of U.S. physician services
Learning Objectives

1. Describe how proposed value based payment methodologies will include patient experience and quality components
2. Describe the patient satisfaction and quality metrics commonly used by CMS and other payers
3. Describe how a medical group can succeed in value-based payment
Learning Objective 1

How proposed value based payment methodologies will include patient experience and quality components
The Triple Aim

- The Triple Aim was developed by the Institute for Healthcare Improvement (IHI) in 2008 by its then president Don Berwick (who later served as the Director of CMS) along with Tom Nolan, and John Whittington.
- The concept behind the Triple Aim is to simultaneously:
  - improve the health of a population
  - improve the patient experience of care, and
  - reduce the per capita cost of healthcare.
The Triple Aim Describes Cost Effectiveness in the Context of Value-Based Payment

- Combining per capita cost for a population and the experience of care measures **efficiency**.
- Combining population health with the experience of care enables measurement of **effectiveness** of care, or **comparative effectiveness** when comparing alternative treatments.
- Combining all three dimensions of the Triple Aim — population health, experience of care, and per capita cost — enables measurement of **cost effectiveness**, or **overall value**.

Assessing Performance for Value-Based Payment Requires New Benchmarks

1. **Total cost of services** associated with the patient population
   - Patient co-payment amount
   - Billed services paid by the insurer
   - Costs paid by the insurer for inpatient services, referral specialists, imaging, laboratory, prescriptions, etc. associated with patients where the practice provides the plurality of primary care.

2. **Patient experience** measuring the perception of the quality of care patients received and their satisfaction with the care experience (scores on a CG-CAHPS patient survey)

3. **Quality metrics** assessing
   - Processes: activities that contribute to positive health outcomes (% of patients diagnosed with a heart attack who are given aspirin)
   - Outcomes: effects that care had on patients (% of patients whose diabetes is under control)
Sources of Benchmarking Information for Value-Based Payment

1. **Total cost of services:**
   - Must come from CMS or the insurance company

2. **Patient experience:**

2. **Quality metrics:**
   - CMS will post standards for the metrics used by the Pioneer and Shared Savings Accountable Care Organizations
   - Oregon Health Authority published benchmark standards on May 4, 2013 for Coordinated Care Organizations participating in the Oregon Medicaid Transformation Program
Learning Objective 2

Patient satisfaction and quality metrics commonly used by CMS and other payers
Quality Measurement Used by CMS for Accountable Care Organizations

Before an ACO can share in any savings generated, it must meet the quality performance standard using 33 measures in four key domains:

1. Patient/caregiver experience (7 measures)
2. Care coordination/patient safety (6 measures)
3. Preventive health (8 measures)
4. At-risk population:
   - Diabetes (6 measures)
   - Hypertension (1 measure)
   - Ischemic Vascular Disease (2 measures)
   - Heart Failure (1 measure)
   - Coronary Artery Disease (2 measures)

Of these 33 measures, 7 are collected via CG-CAHPS patient survey, 3 are calculated via claims, and 1 is calculated from the Medicare and Medicaid Electronic Health Record (EHR) Incentive.
Patient experience metrics from CG-CAHPS patient survey
1. Getting timely care, appointments, and information
2. How well providers communicate
3. Patients’ rating of provider
4. Access to specialists
5. Health promotion and education
6. Shared decision making
7. Patient health status/functional status

Percent of Respondents Answering “Always” on CG-CAHPS Key Questions

Percent of "Always" Responses for Key Questions on the CG-CAHPS Patient Experience Survey

- Got appointment for urgent care as soon as needed: 67%
- Got appointment for check-up or routine care as soon as needed: 70%
- Saw provider within 15 minutes of appointment time: 49%
- Got answer to phone questions during regular office hours on same day: 67%
- Someone from provider's office followed-up on laboratory or imaging test results: 70%
- Provider spent enough time: 81%
### Percent of "Always" Responses for Other Questions on the CG-CAHPS Patient Experience Survey

<table>
<thead>
<tr>
<th>Staff communications and Courtesy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office staff showed courtesy and respect</td>
<td>86%</td>
</tr>
<tr>
<td>Office staff was helpful</td>
<td>76%</td>
</tr>
<tr>
<td>Got answers to phone question after hours as soon as needed</td>
<td>64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Communications</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider listened carefully</td>
<td>86%</td>
</tr>
<tr>
<td>Provider gave easy to understand instructions</td>
<td>84%</td>
</tr>
<tr>
<td>Provider explained things in a way that was easy to understand</td>
<td>85%</td>
</tr>
<tr>
<td>Provider knew important information about medical history</td>
<td>75%</td>
</tr>
<tr>
<td>Provider showed respect for what you had to say</td>
<td>89%</td>
</tr>
</tbody>
</table>

**Overall Rating of the Doctor**

(Percent of Responses >= 8 on 10 Point Scale)

| Patients' rating of the doctor                                       | 79%                 |
CMS ACO Quality Metrics

Care Coordination and Patient Safety

- Hospital readmission within 30 days following discharge
- Hospital admission for chronic obstructive pulmonary disease (COPD) or asthma in older adults
- Hospital admission for heart failure
- Percent of primary care physicians who successfully qualify for an EHR program incentive payment
- Medication reconciliation after discharge from an inpatient facility
- Falls and screening for future fall risk

CMS ACO Quality Metrics

Preventive health

- Influenza immunization percent
- Pneumococcal vaccination for patients 65 years and older
- Body mass index (BMI) screening and follow-up
- Tobacco use: screening and cessation
- Intervention screening for clinical depression and follow-up plan
- Colorectal cancer screening
- Breast cancer screening
- Proportion of adults 18+ who had their blood pressure measured within the preceding 2 years

At Risk Population— Diabetes

- Hemoglobin a1c control (< 8 percent)
- Low density lipoprotein control (<100)
- High blood pressure control (<140/90)
- Tobacco non-use
- Daily aspirin or antiplatelet medication use for patients with diabetes and ischemic vascular disease
- Hemoglobin a1c poor control (>9 percent)

CMS ACO Quality Metrics

At Risk Population—Hypertension
- Controlling high blood pressure (<140/90 mmhg)

At Risk Population—Ischemic Vascular Disease
- Complete lipid panel and LDL control (<100 mg/dl)
- Use of aspirin or another antithrombotic

At Risk Population—Heart Failure
- Beta-blocker therapy for left ventricular systolic dysfunction (LVSD)

At Risk Population—Coronary Artery Disease
- Lipid control
- Angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy - diabetes or left ventricular systolic dysfunction (LVEF 40)

Examples of the Specification of a Quality Metric

ACO 12: Medication Reconciliation
• Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

ACO 29: Ischemic Vascular Disease (IVD): Complete Lipid Profile and Low Density Lipoprotein (LDL-C) Control
• Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level was in control (less than 100 mg/dL)

Quality Benchmarks from the Oregon Health Authority

- Quarterly reports published by the Oregon Health Authority
- Measures selected through public process to represent the health care needs and challenges of a Medicaid population
- Focuses on services known to improve health and lower costs
- Goal is to reduce increase in Medicaid spending by two percentage points by the end of 2014
Examples of Oregon Health Authority Performance Metrics

**PERFORMANCE METRICS**

Statewide Metrics

**Improving primary care for children**

**Adolescent well-care visits**
Percentage of adolescents (ages 12-21) who had at least one well-care visit.
(CCO Incentive Measure)

- **Benchmark**
  - 2011 Baseline
  - n = 106,380
  - 53.2%

- **Data source:** Administrative (billing) claims
- **Benchmark source:** 2012 National Medicaid 75th percentile (administrative data only).
- **Pending Metrics and Scoring Committee review.**

**Childhood immunization status**
Percentage of children who got recommended vaccines before their 2nd birthday.

- **Benchmark**
  - 2011 Baseline
  - n = 15,864
  - 82.0%

- **Data source:** Administrative (billing) claims
- **Benchmark source:** 2012 National Medicaid 75th percentile

**Immunization for adolescents**
Percentage of adolescents who got recommended vaccines before their 13th birthday.

- **Benchmark**
  - 2011 Baseline
  - n = 16,889
  - 70.8%

- **Data source:** Administrative (billing) claims
- **Benchmark source:** 2012 National Medicaid 75th percentile

2011 baselines are pre-CCO and are based on data from the predecessor care organization.

May 2013 Oregon Health System Transformation
Examples of Oregon Health Authority Performance Metrics

**PERFORMANCE METRICS**
Statewide Metrics

**Improving primary care for adults**

**Colorectal cancer screening**
Percentage of adult patients (ages 50-75) who had appropriate screenings for colorectal cancer.
(CCO Incentive Measure)

- **Benchmark**
  - 2011 Baseline: 54.6%
  - 2011 Baseline n = 19,142

- **Data source:** Administrative (billing) claims
  - Benchmark source: 2012 National Commercial 75th percentile (administrative data only, with adjustment). Pending Metrics and Scoring Committee review.

**Chlamydia screening**
Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection.

- **Benchmark**
  - 2011 Baseline: 63.0%
  - 2011 Baseline n = 22,221

- **Data source:** Administrative (billing) claims
  - Benchmark source: 2012 National Medicaid 75th percentile

**Cervical cancer screening**
Percentage of women patients (ages 21 to 64) who got one or more Pap tests for cervical cancer during a recent three-year period.

- **Benchmark**
  - 2011 Baseline: 74%
  - 2011 Baseline n = 85,062

- **Data source:** Administrative (billing) claims
  - Benchmark source: 2012 National Medicaid 75th percentile

2011 baselines are pre-CCO and are based on data from the predecessor care organization.
Examples of Oregon Health Authority Performance Metrics

Patient experience

Access to care (CAHPS)*
Percentage of patients (adults and children) who thought they received appointments and care when they needed them.
(CCO Incentive Measure)

Satisfaction with care (CAHPS)*
Percentage of patients (adults and children) who received needed information or help and thought they were treated with courtesy and respect by customer service staff.
(CCO Incentive Measure)

*From Consumer Assessment of Health Care Providers and Systems Survey Composite
2011 baselines are pre-CCO and are based on data from the predecessor care organization.
Examples of Oregon Health Authority Performance Metrics

Ambulatory care: Emergency department utilization
Rate of patient visits to an emergency department.
(CCO Incentive Measure)

State Benchmark 44.4/1,000 member months
2011 State Baseline 61.0/1,000 member months
(A lower score is better.)

Data source: Administrative (billing) claims
Benchmark source: 2011 National Medicaid 90th percentile

Visits per 1,000 members

2011 baselines are pre-CCO and are based on data from the predecessor care organization.
Learning Objective 3

How to succeed in value-based payment
The Successful Practice Must Balance Value and Costs

- Both financial and non-financial metrics are needed
- Payment and quality incentives should be the basis for quantifiable metrics
- The practice’s information system will need to aggregate data from multiple sources and time periods
Medical Groups with the “Right Stuff” Will Succeed Regardless of the Payment System

The new payment mechanisms of shared savings, bundled and global payment reward practices who have:

• Lower utilization
• Better quality
• Better patient satisfaction
• Better patient outcomes
• Lower cost to the insurer

These are the same factors that will enable a practice to thrive in Fee-for-Service payment

Good management will make the difference
References on Value-Based Payment


• CMS Innovation Center payment and service delivery models: http://innovation.cms.gov/initiatives/index.html#_Expand


• CAHPS Clinician & Group Surveys https://www.cahps.ahrq.gov clinician_group/
Are There Any Questions?

David N. Gans, MSHA, FACMPE
Senior Fellow Industry Affairs
MGMA-ACMPE
dgans@mgma.com
303. 799.1111 X 1270
Biographical Summary

David N. Gans, MSHA, FACMPE
Senior Fellow Industry Affairs
MGMA-ACMPE

Mr. Gans is a national authority on medical practice operations and health systems for MGMA-ACMPE (formally known as the Medical Group Management Association). He is an educational speaker for the Association, authors a monthly column in the Association journal and serves MGMA-ACMPE members as a resource on all areas of medical group practice management. His current work includes many issues of importance to medical practice executives including:

- Patient safety and quality
- Administrative simplification, cost efficiency, and the dissemination of best practices
- Information technology
- Preparing for health care reform and a transformed health delivery system.

Mr. Gans received his Bachelor of Arts degree in Government from the University of Notre Dame, a Masters of Science degree in Education from the University of Southern California, and a Master of Science in Health Administration degree from the University of Colorado. Mr. Gans retired from the United States Army Medical Service Corps in the grade of Colonel, U.S. Army Reserve. He is a Certified Medical Practice Executive and a Fellow in the American College of Medical Practice Executives.

Address: MGMA-ACMPE, 104 Inverness Terrace East, Englewood, CO 80112
Phone: (303) 799-1111, ext. 1270  E-mail: dgans@mgma.com