

# Quality Performance Measurement in California

*Findings and Recommendations*

**December 2008**

**Prepared for**

The Office of the Patient Advocate

**By**

University of California, Davis

Center for Healthcare Policy and Research



California's Health Plan Ratings

Excellent	★	★	★	★
Good	★	★	★	
Fair	★	★		
Poor	★			



**UCDAVIS**

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## **About The Center for Healthcare Policy and Research University of California, Davis**

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# I. Executive Summary

The Office of the Patient Advocate (OPA) contracted with the University of California, Davis Center for Healthcare Policy and Research (CHPR) to produce the *Quality Performance Measurement in California* report. This report sets forth recommendations to support the continued development of OPA's *Health Care Report Card* and *Health Care Quality Portal* website based on findings from a two-step process: 1) producing a detailed inventory of quality measures available to California; and 2) conducting interviews with key health care stakeholders about current and future quality measures, gaps in measurement, and OPA's role in quality measurement and reporting.

There is significant interest in planning a comprehensive strategy to improve the measurement of California's health care quality and publicly report the results. This is evident through a growing number of health care industry initiatives and recent state government actions. Both California's executive and legislative branches actively support the delivery of information about health care quality. Governor Schwarzenegger's Executive Order (EO) S-06-07 in March 2007 set forward goals of improving quality transparency and accountability. In response to government interest, OPA committed to conducting a strategic review of the quality performance measurement (QPM) field to assist with its future planning for publicly reporting quality of care in California.

## OPA BACKGROUND

OPA contributes significantly to the health care quality measurement field and plays an important role at the hub of California's QPM efforts. It is an independent office within the Business, Transportation & Housing Agency and works closely with the Department of Managed Health Care to help enrollees secure health care services to which they are entitled. It is statutorily mandated to develop consumer education materials and programs informing consumers on their rights and responsibilities as health plan enrollees and publish an annual report card on the quality of care. OPA strives to be a neutral, reliable source of health care quality information for consumers and the health care industry.

After seven years of producing the California *Health Care Quality Report* card, OPA further improved its public reporting efforts by launching the Health Care "Quality Portal" website. In addition to continued publication of the *Report Card*, the new Portal supports consumer education by providing links to an array of health care quality-related sites that span the continuum of health care.

## QPM PROJECT OBJECTIVES

The objectives of the QPM project are:

- To identify useful measures for reporting the quality of health care in California
- To assess health care stakeholders' use of current and future quality measures, their perceived gaps in health care measurement, and their perceived role of OPA in quality measurement and public reporting

- To assist OPA in developing strategies that contribute to the development of a coordinated and comprehensive set of publicly reported quality performance metrics for California

## **METHODS**

The QPM Inventory series is organized into five health care sectors to facilitate analysis and presentation (Appendix D).

- Health Plans
- Physician Organizations
- Hospitals
- Skilled Nursing Facilities
- “Other” Sources of Quality Measures

Each inventory includes:

- Name of Measure Set and Developer
- Title/Brief Description of Quality Measure (individual and composite measures)
- Organization Managing Quality Performance Data (by product line for health plan inventory)
- Measure Relevance to Institute of Medicine (IOM) Domains of Quality Care
- Measure Relevance to Life Cycle (pediatric, adult, geriatric)
- Measure Relevance to Type of Care (preventive, acute, chronic)
- Measure Relevance to Key Health Conditions

OPA invited a diverse group of 31 health care stakeholders, based on their interest and/or expertise in quality performance measurement or public reporting, to participate in an hour long interview that solicited feedback on:

- the comprehensiveness of the Inventories
- current quality measures sponsored or used by their organization or agency and any planned for the future
- perceived measurement gaps
- OPA’s role in quality measurement and reporting

CHPR staff completed 29 interviews by telephone or in person during Spring 2008. Prior to the interviews, the respondent was provided with relevant background materials, including the Inventories for Health Plans, Physician Organizations, Hospitals, and “Other” Sources of Quality Measures.

**LIMITATIONS:** This report reflects measures available through June 2008. Some limitations may affect the findings of this report due to the ongoing process of creating, refining and retiring metrics. Also, the assignments to IOM Quality Domains, Type of Care, and Life Cycle are subjective in nature, but we believe this approach provides insight into where measurement gaps may exist. Finally, the opinions summarized here are those of the individual respondent and may not necessarily reflect the formal views of the organizations or agencies they represent.

## FINDINGS AND RECOMMENDATIONS

There is a clear need for California to coordinate a statewide, common quality measurement system that reduces duplicative quality data collection efforts. OPA is well positioned to facilitate much of this work due to its positive reputation among a variety of stakeholders and its historic position in the hub of the California quality measurement and public reporting network, which includes stakeholders from both the private and public sectors.

**“Somebody needs to be delegated in California to help with this problem.”**

—Reporting organization

The recommendations in this report suggest ways to fill existing measurement gaps, refine public reporting, and improve OPA’s communication efforts. OPA may choose to use these suggestions individually or in combination with one another. The recommendations suggest both short-term activities and long-term projects that will yield a more accurate and comprehensive view of health care quality in California.

### Data Gaps Revealed in Inventories

The five QPM Inventories revealed gaps in the availability of measures related to some IOM domains and health conditions.

#### **Finding 1: Data Gaps**

Throughout the five Inventories, the IOM’s *Effectiveness* domain (evidence-based avoidance of overuse of inappropriate care and underuse of appropriate care) had the most relevant number of quality indicators and provided the richest amount of quality data. The *Patient-Centeredness* (care is respectful and responsive to patient needs, preferences, and values) domain also had a significant number of related quality measures. *Patient-centered* measures were related mostly to the CAHPS patient experience survey series. Any information gaps found within the CAHPS survey topics are consistent across all providers because the core questions are essentially the same regardless of provider type.

**“The measures aren’t the problem—it’s the implementation of measures based on ease of access to data.”**

—Reporting organization

The *Safety* and *Timeliness* domains (“avoidance of injury from care” and “wait times for care and harmful delays in care from patient or provider perspective,” respectively) had several quality measures sprinkled throughout each Inventory. The majority of *Safety*-related indicators reside in the Nursing Home and Hospital Inventories. The *Timeliness* indicators primarily related to administration of medications or patient perceptions of receiving timely care.

#### **Recommendation 1A**

To shore up the number of reportable *Safety* indicators, OPA should continue to collaborate with the California Department of Public Health (CDPH) to report hospital adverse events (medical errors) and hospital acquired infection rates as available.

Although data are not expected to be publicly available through CDPH until 2011, OPA may be able to assist CDPH by posting some data earlier on the existing OPA website. A link to the CDPH website should be maintained.

### Recommendation 1B

OPA should translate the surgeon-specific data from OSHPD’s CABG surgery reports into consumer-friendly terms and post findings on its Portal site. This will boost the number of patient safety indicators publicly reported while making these results more accessible to consumers.

### Recommendation 1C

New physician safety-related metrics may soon be available for public reporting, and OPA should evaluate their suitability. Although sources, such as Medicare’s Physician Quality Reporting Initiative and Integrated Healthcare Association’s (IHA) P4P, do not yet publicly report individual physician metrics, OPA should advocate for the public release of this information and be prepared to report it when available.

**“The rubber hits the road with reporting on [individual] doctor and hospital providers.”**  
—Government agency

### Finding 2: Data Gaps

Inventory analysis and stakeholder interviews confirmed that there is a dearth of indicators related to the IOM domains of *Efficiency* (avoidance of wasting resources) and *Equity* (care that does not vary based on population or individual characteristics). Although there are few *Efficiency* measures currently available, most quality reporting organizations reported a concerted effort to developing “efficiency of care” or “episodes of care” metrics. These metrics combine multiple interventions (e.g., pharmacy, lab, hospital and physician services) used to treat a health condition and capture the efficiency of care delivered. Theoretically, *Equity* can be measured using almost any quality indicator as long as sociodemographic data are collected and linked to the indicators.

**“You can drive quality of care with an ‘episodes of care’ approach. This is the future contracting strategy.”**  
—Reporting organization

### Recommendation 2A

To advance the development and implementation of *Efficiency* measures, OPA should advocate for the public use of reporting organizations’ proprietary “episodes of care” metrics that are under development (e.g., RAND or Thomson/MedStat) and track other emerging efficiency indicators (e.g., IHA and Hospital Value Initiative) to ensure their inclusion in the Portal once they are available.

### Recommendation 2B

OPA should work with its quality measurement and public reporting network (both public and private sectors) to construct a plan for collecting and reporting *Equity* measures at all levels of health care. For example, OPA should continue its effort to encourage the California Cooperative Healthcare Reporting Initiative (CCHRI) to

**“Equity is a derivative of the other five domains.”**  
—Reporting organization

use sociodemographic data already collected in the CAHPS survey. Also, if the results from an ongoing NCQA pilot project determine that (Medicare) plan data can be used to examine health disparities, OPA should advocate for matching *Equity* data with existing clinical quality measures and reporting health care disparities. Using pooled data may address concerns about appropriate sample sizes.

**“Measures that are heavily reported on generally aren’t ‘shoppable’ [elective] conditions.”**

—Reporting organization

### Finding 3: Data Gaps

Stakeholders agreed that there are a sufficient number of quality measures available (some of “better quality than others”) and that reporting entities need to selectively choose indicators that reduce the data collection burden on providers. Stakeholders encouraged OPA to report on indicators that:

- reflect variation in quality (significant differences)
- provide opportunities for improvement
- focus on elective interventions
- target clinically important conditions (high cost or prevalence)

### Recommendation 3A

Using this set of criteria, OPA should periodically review the indicators it publicly reports. Indicators with little variation or where opportunities for improvement are low or non-existent should be replaced with more informative indicators where provider or consumer actions will result in improvements. As a first step to determining the threshold for such decisions, OPA might consider convening a technical panel to review specific criteria.

### Finding 4: Data Gaps

Across the spectrum of health care stakeholders interviewed, most acknowledged or agreed that the more granular or discrete the reporting level the better. For example, most stakeholders believed that reporting at the individual physician level was crucial to consumer decision making and should be the next step in public reporting, and yet little information is publicly available by provider. There are many nationally-approved process and quality indicators measuring physician performance at the individual and organizational levels (see Physician Organizations Inventory in Appendix D for details).

**“No measurement would ever come about if we waited for 100% participation—mandatory or otherwise.”**

—Reporting organization

One state initiative, CCHRI’s California Physician Performance Initiative (CPPI), collects data at the individual physician level with results privately reported to participating physicians. However, this initiative is in a pilot phase and concerns remain about data reliability and whether results are accurate enough for public reporting.

### Recommendation 4A

Reporting quality data at the individual physician level will take patience and tenacity. To help bridge the political chasm and push forward with reporting California physician quality, OPA should continue to work with IHA in reporting

**“Using administrative data is OK even though it is not perfect.”**

—Reporting organization

quality by physician organization, and also should consider partnering with the California Association of Physician Groups (CAPG) to publicly report data from its proprietary *Standards of Excellence* survey (survey details on page 24). While the survey does not measure clinical quality, accepting CAPG's invitation to share its results can serve as a critical step for OPA to establish a positive relationship with physician organizations.

#### Recommendation 4B

OPA should consider supporting CCHRI in its effort to eventually publicly report individual physician performance data. As a neutral third-party, OPA can work with

**“It is too easy to confuse the failure of society with the failure of individual provider.”**

—Professional association

vested stakeholders and advocate for establishing acceptable physician data collection methods to improve Californian's access to useful, pertinent health care information. In addition, OPA's support for expanding CCHRI (and IHA) data collection to include Medicare and Medi-Cal data would help address the issue of small denominators (which is a significant barrier to physician performance measurement) and permit more detailed, product line analyses.

#### Recommendation 4C

In addition, participating in national initiatives, such as the Consumer-Purchaser Disclosure Project, (a national group of health care stakeholders that created a set of principles to guide measuring and reporting to consumers about doctors' performance: [http://healthcaredislosure.org/](http://healthcaredisclosure.org/)), or Charter Value Exchanges (CVE description on page 25), would support OPA's effort to bring individual physician performance results to the public. Participation in national initiatives also may allow California earlier access to national benchmark data to compare with California data.

#### Finding 5: Data Gaps

OPA chose to focus on nine key health conditions in the QPM Inventories. Of these, at least half had quality measures related to them. The most frequently measured conditions related to heart disease, cancer, asthma, and diabetes. Those health conditions less likely to have quality measures associated with them were mental health, COPD, reproductive health, hypertension, and musculoskeletal conditions.

In addition to the key conditions of interest, the Inventories also included metrics related to a handful of other health conditions and care methods including pneumonia (community-acquired), surgical infection prevention, stroke, gastroesophageal reflux disease, immunizations, and antibiotic timing. The vast majority of the conditions of interest to stakeholders were measured with hospital process or structure metrics rather than health outcomes metrics.

#### Recommendation 5A

OPA should work with its quality measurement and public reporting network (both public and private sectors) to

**“What unit is of most interest to the consumer?”**

—Government agency

periodically review the types of health conditions measured to ensure that the high cost or high prevalence conditions are included in public reporting (and replace those conditions not meeting the criteria). Specifically, OPA could collaborate with CDPH and OSPHD in 2009 on highlighting hospital-acquired infection rates.

### Recommendation 5B

OPA should report on its Portal site the progress of DMHC’s “Right Care Initiative,” which supports managed care plans efforts to meet the national 90<sup>th</sup> percentile goal for diabetes, heart disease, and hospital-acquired infection care. Information for consumers should include “Why this is important” information similar to the summaries offered in OPA’s Health Plan Report Card. As goals are met and new initiatives emerge, OPA’s focus should change to highlight other issues. Such an effort would demonstrate coordinated effort by California to improve quality of care.

## **OPA’s Role in Measurement and Public Reporting**

OPA enjoys a favorable reputation among the stakeholders interviewed due, in part, to its continued, inclusive efforts to solicit feedback from these organizations. Stakeholders believe OPA should continue to publicly report available quality measures, and it also should facilitate stakeholder discussions. However, stakeholders concluded that OPA should refrain from developing or mandating quality measures.

### Finding 6: OPA’s Role

Stakeholders from the public and private sectors perceived OPA as the appropriate, neutral organization for reporting health care quality data. Several stakeholders identified OPA as the appropriate entity to organize stakeholder discussions about publicly reporting information about quality.

**“How much do we really do to get people to understand what the report cards mean?”**

—Health plan

In general, the Portal concept was supported and considered to be the appropriate location for communicating California’s health care information.

Several stakeholders advised that OPA refrain from developing clinical quality measures because other organizations are more qualified to create those types of quality indicators. One stakeholder specifically cautioned OPA to avoid this type of “mission creep.” Instead, OPA should report those measures endorsed by respected organizations, such as NQF or AQA.

### Recommendation 6A

OPA should engage the Health and Human Services and Business, Transportation and Housing Agencies, and the Governor’s office to coordinate health care quality measurement and reporting in California. A centralized, coordinated effort to measure and report quality across the health care spectrum would reduce the burden on providers and would ensure a robust and efficient quality performance reporting system.

### Finding 7: OPA's Role

Stakeholders from all categories identified the need for OPA to clearly define the audience(s) or end-user(s) it serves. There are many groups with distinct interests that are interested in quality performance data (e.g., privately insured consumers, government agencies, policy makers, providers, etc.) and many stakeholders were confused as to which group(s) OPA serves.

**“Who are you  
[OPA]? What is your  
goal?”**

—Professional association

### Recommendation 7A

OPA should reaffirm and clearly identify its target audiences, which should include managed health care members (including PPO subscribers), policy makers, researchers, and publicly-insured beneficiaries. OPA should consider making a “Research and Policy” tab more prominent by moving it to first level (green) bar rather than its current position at the second level (blue) bar under “Quality Report Card.” This new format would be more dynamic and permit repackaging of valuable quality data that would provide public decision makers with critical information applicable to the macro level. Specific reports may include product line comparisons, trend information, or regional variation in care. National benchmark data, California Independent Medical Review data, and white papers addressing emerging issues could be housed in this location as well.

### Finding 8: OPA's Role

Government stakeholder comments about gaps in measures revealed that a tension exists between the increasing pressures on government entities to collect, analyze and publish quality data and the entities' traditional regulatory role. Most of the government organizations related to health care are regulating bodies charged with enforcing state laws and regulations. Publicly reporting the quality of health care is a new role for most entities and one that requires more technical and financial support. OSHPD, CDI, MRMIB and DHCS were amenable to OPA's assistance in public reporting.

**“Create a  
[government] Quality  
Council to do joint  
problem solving with  
QM departments.”**

—Government agency

### Recommendation 8A

OPA's first overtures for government collaboration were made at its April 2008 “Public Reporting on Health Care Quality for California State Agencies” meeting and should be followed up with the interested departments. Specifically, OPA should continue to work with OSHPD to translate some of OSHPD's valuable hospital quality data into lay terms for public reporting on OPA's website. Choosing to report “elective” treatments that OSHPD studied would yield the most benefit to consumers.

### Recommendation 8B

Continued collaboration with CDI to post new PPO quality data results on the OPA and CDI websites is another suggestion for OPA. From a consumer perspective, it would be more efficient to have all PPO and HMO plan results published on one site rather than forcing consumers to toggle between multiple sites. Assuming CDI also publishes the PPO

data on its own website, OPA should offer its Report Card template and reporting expertise to CDI to achieve a uniform presentation for consumers.

### Recommendation 8C

OPA should also continue to forge a reporting partnership with DHCS and MRMIB to provide quality data that are pertinent to their beneficiaries and are easily accessible

**“How do we best serve the public and the consumer?”**

—Professional association

through the OPA website. This approach not only provides important quality performance information, but also permits these beneficiaries to use other helpful information links provided only through the Quality Portal site. Furthermore, reporting the public insurance system’s information about quality on the same site as commercial plan information allows researchers and policy makers to compare product lines. Similar to the CDI approach, the same information could reside on the DHCS and MRMIB websites to increase the probability that consumers will access and use this information.

### Finding 9: OPA’s Role

Public reporting of quality data is increasing, but many stakeholders remarked that consumers are not considering the information in their health care decisions. Stakeholders speculated the reasons may be because:

- ultimately, consumers have very little control over provider choices (especially those enrolled in public insurance programs),
- the measures reported reflect conditions where patients have no choice in choosing care (heart attack care versus maternity care),
- the measures are not at a specific enough level (“how does *my* doctor rate?”), or
- the measures are not outcomes related. This observation relates to an aforementioned finding that choosing the “correct” (useful and “actionable”) indicators are critical to effective public reporting.

### Recommendation 9A

To encourage more consumer use of data, OPA should facilitate a roundtable discussion with public and private sector stakeholders in and beyond California’s quality measurement hub. The meeting goal should focus on the types and number of quality

**“What could be done to move forward with the large inventory of measures?”**

—Reporting organization

measures that California should be reporting. Possible agenda topics include culling non-informative metrics (due to no variation or standard met), choosing new metrics for conditions that are high cost/prevalence, identifying additional conditions for a public-private partnership to target for improvement (similar to DMHC’s “Right Care Initiative”), identifying funding needs and sources, increasing decision maker use of such quality data, and creating a single data warehouse that pools data (i.e., lab, pharmacy, hospital and physician data, etc.) from the private and public sectors.

## **Presentation and Dissemination of Report Card and Portal Information**

### **Finding 10: Presentation and Dissemination of Portal Information**

The vast majority of stakeholders agreed that displaying information in a uniform manner is critical to effective communication with OPA’s audience(s). They believe that a consistent format would enhance the users’ understanding of quality data across service providers or product lines.

Stakeholder opinions about the most appropriate and effective presentation style varied, but there was consensus on the need to identify OPA’s audience before measures are selected and the results are communicated (Recommendation 7A). Once the audience was defined, agreement on a presentation style would be more easily achieved.

#### **Recommendation 10A**

OPA should consider capitalizing on its current format to create “theme” tabs on its website. Tabs summarizing *all* quality measures (i.e., hospital, physician, and health plan) related to a particular population (e.g., children) or a health condition could be useful to consumers who would like to know more about the continuum of care.

#### **Recommendation 10B**

Using the same tabular website design, OPA should redesign the box format to make all sectors of the health care industry (i.e., hospital, nursing home, etc.) more prominent *and* expand the data presented. For example, OPA could propose adopting CHCF’s CalNursingHome reporting system and publishing the results on the Portal under a “Nursing Home” tab. Alternatively, OPA could simply summarize or highlight CHCF’s key nursing home findings on the Portal and offer a link to the CHCF site.

#### **Recommendation 10C**

Publishing on OPA’s website either specific or summary quality performance results from all health care sectors (rather than relying exclusively on website links to government departments) provides an opportunity for more consistent formatting and presentation. A uniform presentation can help the public understand complicated data and apply it comparatively.

### **Finding 11: Presentation and Dissemination of Portal Information**

Some of the stakeholders encouraged OPA to study social marketing strategies to continue refining its consumer communication efforts.

#### **Recommendation 11A**

OPA is in the process of exploring social marketing strategies and should share the QPM report findings with appropriate consultants to ensure consideration of issues such as determining OPA’s audience(s), and choosing appropriate reporting formats that accommodate multiple health care sectors (e.g., hospitals, health plans, physician organizations).

**Finding 12: Presentation and Dissemination of Portal Information**

Stakeholders from different health care sectors believed that OPA could and should improve consumer awareness about its service.

**Recommendation 12A**

Finding more opportunities throughout the year to promote the Report Card and Quality Portal website would benefit OPA, rather than relying on one annual press conference. For example, if a health plan is fined by DMHC, OPA could partner with DMHC to incorporate the Quality Portal website into the story. This would require designing a public relations campaign and encouraging OPA's sister departments to promote the Report Card and Quality Portal.

**“Do people know about the website? What has OPA done to promote the site to the public?”**

—Government agency

**Recommendation 12B**

OPA should consider collaborating with organized groups (i.e., legislators, health advocacy groups, consumer representatives, etc.) to sponsor “mini-town hall meetings” or “state of the state” presentations about health care quality (plans, physicians, hospitals, etc.) across California throughout the year.

**Recommendation 12C**

Asking health plans, hospitals, physician groups and other government departments (i.e., CDI, CDPH, OSHPD, etc.) to add prominent links on their websites to OPA's Quality Portal would also increase consumer awareness of OPA's services and facilitate consumer education. (Six of the eight health plans profiled on the OPA Report Card link to the OPA website, but it frequently required a minimum of four clicks into the website before a link was found.)

**“We would be happy to have OPA repackage our information to make it more ‘user friendly’ for consumers.”**

—Government organization

**Finding 13: Presentation and Dissemination of Portal Information**

Stakeholders' comfort and familiarity with quality performance measurement and public reporting methods vary markedly. There appears to be great opportunity for more education in these two areas to build a solid and even foundation for stakeholders.

**Recommendation 13A**

OPA should consider educating health care stakeholders in quality measurement and public reporting. OPA should continue sponsoring periodic seminars (i.e., “Lunch n' Learn”) about both topics.

**Finding 14: Presentation and Dissemination of Portal Information**

Many government colleagues mentioned that they could benefit from OPA's years of experience in reporting quality.

**Recommendation 14A**

When possible, OPA could act as an “internal quality reporting consultant” to other state departments that need help with quality reporting. OPA provides a strategic link for quality performance measurement and reporting in California and it possesses useful knowledge and contacts. Formally designating an OPA staff person as an “internal consultant” would be helpful to OPA’s colleagues and may help push forward other QPM Report recommendations that rely on cooperation from these departments.

**Recommendation 14B**

OPA may wish to act as a conduit between funding groups and state departments in need of enhancing quality reporting. OPA could monitor (through in-house staff or a contractor) possible sources of funding and communicate RFPs to a listserv of interested state departments.

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## II. Introduction

At the national, state and local levels, the quality performance measurement (QPM) field continues to grow in importance and influence with the increasing demand for health care quality information and the resulting creation of new metrics for all health care industry sectors. California's Office of the Patient Advocate (OPA) has played an important role in California's health care quality measurement and public reporting since 2000 and is one of the principal organizations at the hub of California's health care QPM efforts.

Interest in planning future measurement strategy for California is high. This is evident not only through the multitude of private industry initiatives, but also through government actions. Both the state's executive and legislative branches actively support the delivery of quality performance information. Governor Schwarzenegger issued Executive Order (EO) S-06-07 in March 2007, which acknowledged OPA's primary role in public reporting. Among many general mandates, the EO specifically requested that the State "collaborate with private and public entities to develop a quality reporting mechanism through the Office of the Patient Advocate" to provide relevant, reliable and useful quality health care information.

### OPA BACKGROUND

OPA is the primary state agency charged with publicly reporting managed health care quality-related information for consumer and industry use. In collaboration with various industry and consumer stakeholders, it annually publishes the *Health Care Quality Report Card*, which describes the quality of care delivered by commercial HMOs and PPOs (under Department of Managed Health Care jurisdiction), and medical groups in California. The report card is one way OPA fulfills its mission to inform consumers about their rights and responsibilities as HMO enrollees.

OPA's public reporting expanded in November 2007 to publishing a Health Care Quality "Portal" website. This new website supports consumer education through the original Report Card, and offers links to an array of health care quality-related sites that span the continuum of health care.

### QPM PROJECT PURPOSE

In tandem with the Governor and the state legislature's recent quality measurement initiatives, OPA determined that it was necessary to conduct a strategic review of current quality measures to assist with its future planning.

OPA contracted with the University of California, Davis Center for Healthcare Policy and Research (CHPR) to study the current status of quality measurement in California, identify gaps in quality measurement and assess OPA's role in quality performance reporting. The purpose of the *Quality*

*Performance Measurement in California* report is to provide OPA with recommendations for the continued development of its Report Card and Health Care Quality Portal.

The project objectives are:

- To identify useful measures for reporting the quality of health care in California
- To assess health care stakeholders' use of current and future quality measures, their perceived gaps in health care measurement, and their perceived role of OPA in quality measurement and public reporting
- To develop strategies for OPA that will result in publicly reporting a comprehensive set of quality performance metrics for California

## **PROJECT METHODS**

Two primary components inform the QPM report findings and recommendations: 1) an inventory of quality measures available for California's use; and 2) interviews with key health care stakeholders about current and future quality measures, gaps in measurement, and OPA's role in quality performance measurement and reporting.

### **Quality Performance Measurement Inventories**

The Inventory series is organized into five health care sectors to facilitate analysis and presentation (Appendix D).

- Health Plans
- Physician Organizations
- Hospitals
- Skilled Nursing Facilities
- "Other" Sources of Quality Measures

Each inventory includes:

- Name of Measure Set and Developer
- Title/Brief Description of Quality Measure (individual and composite measures)
- Organization Managing Quality Performance Data (by product line for health plan inventory)
- Measure Relevance to Institute of Medicine (IOM) Domains of Quality Care
- Measure Relevance to Life Cycle (pediatric, adult, geriatric)
- Measure Relevance to Type of Care (preventive, acute, chronic)
- Measure Relevance to Key Health Conditions

UC Davis CHPR identified eligible quality performance measure sets through extensive website searches, expert opinion and referral, and personal interviews with key stakeholders identified by OPA. Research took place between September 2007 and January 2008. Periodic updates to the Inventories, based on stakeholder interviews and current industry publications, occurred through June 2008 to ensure inclusion of the most recent information. Only measure sets with metrics approved by leading national organizations (e.g., National Committee on Quality Assurance, AQA, National Quality Forum, etc.) that provided clear documentation and an established reporting system

were included in the Inventories. Specific measure sets cited during interviews meeting the same criteria were also included.

**LIMITATIONS:** The measure sets in the QPM field change frequently and the Inventories included in this report are as complete as possible through June 2008. This report does not include measures for ancillary services (i.e., laboratory, pharmacy, etc.) or for other types of health care facilities licensed through the California Department of Public Health. The report does not include measure sets that use proprietary metrics or methodologies that are not readily transparent (e.g., HealthGrades). Another possible limitation relates to assigning IOM Quality Domains, Type of Care, and Life Cycle stage to each measure. The assignments are subjective in nature, but do, at minimum, provide a threshold of where measurement gaps may exist.

### Stakeholder Interviews

OPA identified and invited a diverse group of 31 health care stakeholder organizations to participate in an hour long interview that solicited feedback on the:

- comprehensiveness of the Inventories,
- current and future quality measures used by their organization or agency,
- perceived measurement gaps, and
- OPA's role in quality measurement and reporting.

OPA, in consultation with UC Davis CHPR, chose stakeholder organizations based on stakeholder interest and/or expertise in quality performance measurement or public reporting, with a particular focus on the California market (Appendix A). CHPR staff conducted 15 interviews in person and 14 interviews by telephone between February 2008 and April 2008. Each interview lasted between 20 and 75 minutes with one to seven representatives participating per stakeholder organization. Two organizations did not respond to the interview request.

**Table 1. Description of Key Stakeholder Groups**

Type of Organization Represented	Number of Organizations Interviewed
Government Organizations	10
Reporting Organizations	7
Professional Associations/Physician Organizations	5
Health Plans	3
Consumer Advocacy Groups	4

After identifying the stakeholders, OPA e-mailed letters that summarized the QPM project and invited the organization's quality performance metrics expert to participate in an interview. CHPR followed up by e-mail or telephone to schedule interviews and to ask stakeholder representatives to review background materials prior to their interview. CHPR e-mailed or mailed an interview packet to help each representative prepare for his or her interview. Each packet contained a project summary, the

interview protocol, inventories for Health Plans, Physician Organizations, Hospitals, and “Other” Sources of Quality Measures as well as a glossary (Appendix B). The Nursing Home Inventory was incomplete at the time of the interviews and was not included in the information packet.

**LIMITATIONS:** The opinions of the interviewees may not reflect the formal views of the organizations or agencies they represented. In most cases, stakeholders did not review the Inventories in detail prior to their interview.

## III. Quality Performance Measurement Inventory: Summaries and Findings

Surveying quality performance measures provides critical information for the continued development of OPA's quality measurement and public reporting efforts. To organize the available quality measures, the UC Davis CHPR divided the measures into five separate Inventories: Health Plans, Physician Organizations (i.e., medical groups), Hospitals, Nursing Homes, and Other Sources of Quality Measures (Section II). As a series, the Inventories present the quality of care performance metrics available to California (some of which are already reported by OPA) at the time of this report. The Inventories help identify gaps and opportunities in quality measurement.

In addition to itemizing measures, each Inventory identifies the:

- **Measure Set and Developer:** The developer creates and modifies, as needed, the quality measures. Some developers also collect and/or warehouse the data.
- **Individual Measures within the set:** This category describes each measure contained in the set. Some measures are composites of multiple individual measures and are noted as such.
- **Organization(s) Managing the Quality Data:** The organizations that collect, analyze and/or warehouse the performance measurement data frequently differ from the measure set developers.
- **Measure relevance to the IOM Domains of Quality:** The Institute of Medicine's (IOM) distinguished 2001 report, *Crossing the Quality Chasm*, identified six domains of quality care that are necessary to improving health: Safety, Effectiveness, Patient Centeredness, Timeliness, Efficiency, and Equity (defined in Table 2a). The Inventories' measures are assigned to the relevant domain(s) to assess gaps in quality measurement.
- **Stage(s) of the Human Life Cycle related to the measure:** The measures are assigned to the stage of the life cycle (pediatric, adult, geriatric) according to their denominator definitions. A measure can be relevant to more than one stage of the human life cycle.
- **Type of Care:** The quality performance measures are also categorized according to whether they address preventive, acute, and/or management health care. Some measures may be relevant to more than one type of care.
- **Key Health Conditions related to the measure:** OPA identified nine key health conditions to assess the gaps in the quality performance measures that are related to the following high prevalence and/or costly conditions: asthma, cancer, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, hypertension, mental health, musculoskeletal, and reproductive health.

Tables 2a and 2b summarize the findings from the Inventories regarding the number of quality measure sets available and the number of individual measures that are relevant to the categories defined above. A measure is counted once regardless of its appearance in more than one measure set. This accounting method precludes double counting of individual measures and misrepresenting the true number of measures available for use.

Table 2a. Relevance of Quality Measures to IOM Quality of Care Domains

Inventory Name	No. of Measure Sets	Number of Measures Relevant IOM Quality of Care Domains <sup>1</sup>					
		Safety	Effectiveness	Patient Centeredness <sup>2</sup>	Timeliness	Efficiency	Equity
Health Plan	3	12	38	43	19	12	2 <sup>3</sup>
Physician Organizations	8	31	212	31	37	7	0
Hospitals	8	32	92	15	19	5	4
Nursing Homes	6	19	23	20 <sup>4</sup>	0	0	0
Other Sources of Quality Measures	8	0	29	5	11	0	4

<sup>1</sup> Definitions of IOM Quality of Care Domains: **Safety** – avoidance of injury from care

**Effectiveness** – evidence-based avoidance of overuse of inappropriate care and underuse of appropriate care

**Patient-Centeredness** – care is respectful and responsive to patient needs, preferences, and values

**Timeliness** – specific to wait times for care and harmful delays in care (from patient or provider perspective)

**Efficiency** – avoidance of wasting resources

**Equity** – care that does not vary based on population or individual characteristics

<sup>2</sup> CAHPS measures populate the Patient Centeredness domain almost exclusively. The count represents individual and composite measures.

<sup>3</sup> CAHPS Children with Chronic Conditions Survey is counted as one equity measure. It allows for comparison between the chronic care and mainstream populations.

<sup>4</sup> Eleven of the 20 nursing home patient-centered indicators are currently under development through AHRQ's CAHPS series.

Table 2b. Relevance of Quality Measures to Stage of Life and Type of Care

Inventory Name	No. of Measure Sets	No. of Measures Relevant to Stage of Life Cycle			No. of Measures Relevant to Type of Care		
		Pediatric	Adult	Geriatric	Preventive	Acute	Management
Health Plan	3	15 HEDIS 20 CAHPS	31 HEDIS 31 CAHPS	19 HEDIS 22 CAHPS	19 HEDIS 3 CAHPS	11 HEDIS 10 CAHPS	13 HEDIS 2 CAHPS
Physician Organizations	8	23	58	222	78	89	80
Hospitals	8	39	110	55	32	53	6
Nursing Homes	6	0	48	48	16	15	5
Other Sources of Quality Measures	8	39	68	57	NA	NA	NA

## HEALTH PLAN INVENTORY SUMMARY

There are three QPM sets available for comparing and reporting the performance of health plans: one set captures clinical measures and two sets capture patient experience with health care using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

The National Committee for Quality Assurance (NCQA) developed and maintains the only quality tool that is used nationally to compare health plans' clinical quality of care. The two patient experience measure sets, NCQA's CAHPS 4.0H and the Agency for Healthcare Research and Quality (AHRQ) CAHPS 4.0, are closely related with the majority of indicators included in both sets.

**NCQA HEDIS 4.0:** The NCQA developed the Healthcare Effectiveness Data and Information Set (HEDIS) to measure performance on important dimensions of care and service. The HEDIS consists of 71 measures across eight domains of care (a few measures are unrelated to quality and, therefore, are not included in this inventory). Because more than 90 percent of plans voluntarily collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples to apples" basis, which supports NCQA's accreditation process. Health plans collect data from their administrative records, medical record reviews, and patient surveys. NCQA's Quality Compass is a database in which HEDIS data are warehoused and made available for public use. Plans voluntarily submit data annually (<http://www.ncqa.org/tabid/177/Default.aspx>).

**NCQA CAHPS 4.0H:** This patient health care experience survey, technically a subset within NCQA's HEDIS, is commonly referred to as a stand-alone measure set. The CAHPS 4.0H core questions are mostly duplicative of the AHRQ CAHPS (see below for AHRQ explanation), but add different questions that serve other NCQA measurement needs (such as smoking cessation counseling and

influenza vaccination). This survey is administered annually to a sample of members by each commercial health plan. NCQA warehouses and makes public the survey results voluntarily submitted by health plans. Data are updated annually (<http://www.ncqa.org/tabid/536/Default.aspx>).

**AHRQ CAHPS 4.0:** The AHRQ CAHPS 4.0 is the original patient health care experience survey. Its *core* measure set consists of fewer questions than the NCQA version, however AHRQ permits numerous *supplemental* measures (related to chronic conditions, people with mobility impairments, and quality improvement) to be added at an individual health plan's discretion. The National CAHPS Benchmark Database (NCBD), sponsored by AHRQ, warehouses all CAHPS data voluntarily submitted by plans. Data can be updated annually at the discretion of the participating plans. No plan-specific data are publicly available ([https://www.cahps.ahrq.gov/content/products/PROD\\_AmbCareSurveys.asp?p=102&s=21](https://www.cahps.ahrq.gov/content/products/PROD_AmbCareSurveys.asp?p=102&s=21)).

## HEALTH PLAN INVENTORY FINDINGS

### Measure Developers and Data Managers

- The organizations that develop and modify the quality performance measure sets for health plans frequently differ from those that collect, warehouse, and report the data. For example, NCQA develops and maintains the HEDIS measure set, but the California Cooperative Healthcare Reporting Initiative (CCHRI) manages the data collection and analysis for its member health plans. CCHRI works closely with OPA to publicly report the results (see inset box below). The same data are also submitted to NCQA by plans applying for NCQA accreditation.

### Duplication of Measures

- The HEDIS clinical indicators are unique and not duplicated elsewhere in the Health Plan Inventory. However, NCQA's core CAHPS 4.0H indicators repeat those indicators appearing in the AHRQ CAHPS 4.0 set. In addition to the core set, the AHRQ CAHPS offers a substantial number of supplemental indicators that are left to the health plan's discretion for inclusion.

### California Level

The California Cooperative Healthcare Reporting Initiative (CCHRI) supports HEDIS (including CAHPS) data collection and data analysis for its membership, the largest health plans in California. This collaborative of health plans, employers, and other stakeholders ensures comparable performance measurement methodologies and rigorous quality data collection for plans within California. Although HEDIS measures are determined by and data are submitted to NCQA, CCHRI is the organization, rather than NCQA, that collaborates with OPA to publicly report California health plan results.

### National Level

HMOs, PPOs, Medicare Advantage, and Medicaid managed care plans report HEDIS data to NCQA's Quality Compass database to gain coveted accreditation. The HEDIS measure set permits fair comparison between plans nationwide.

CAHPS 4.0 (AHRQ) results can be obtained for commercial health plans, Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) managed care plans through AHRQ's NCBD, a repository for data submitted voluntarily by health plans. Beginning in 2007, the NCBD also obtained commercial health plan CAHPS data submitted to NCQA. The NCBD will continue to receive Medicaid data from States and other plans that may or may not submit data to the NCQA. By arrangement, the NCQA generates Medicaid and SCHIP "sponsor reports" that are case-mix adjusted (unlike NCQA's own reports). Requests for CAHPS results for Medi-Cal and Healthy Families health plans must be directed to their respective state regulatory agencies. The NCBD does not permit public access to plan-specific data.

## Levels of Reporting

- Because NCQA requires health plans to submit HEDIS 4.0 (including CAHPS 4.0H) quality data for NCQA accreditation, the vast majority of HMOs in California and nationwide participate in this process. Recently PPO participation increased markedly. This permits valid and reliable comparisons of health plan performance in various combinations:
  - California (state aggregate) to national benchmark
  - California plan to California state or national benchmark
  - Among California plans
- HEDIS health plan data are not currently organized or reported at the county (except Medi-Cal) or regional levels.
- In addition to different reporting cycles, which make comparisons between public sector and private sector health plans challenging, the different geographic areas captured in the data provide challenges. For example, Medi-Cal plans report HEDIS results by county, whereas Healthy Families plans and commercial plans cover a much wider geographic area.

## **Data Collection**

- Both the CCHRI (state level) and NCQA and AHRQ/NCBD (national levels) collect and warehouse CAHPS core measures. However, the AHRQ CAHPS survey is voluntary and unrelated to accreditation, unlike the NCQA-based CAHPS. Because AHRQ offers no incentives or penalties to encourage participation, health plan participation is variable, greatly reducing comparability for public reporting purposes. This is especially true with regard to the CAHPS supplemental items that are inconsistently administered and reported.
- There is a great deal of overlap in CAHPS measures that different HMO product lines use (e.g., commercial HMO, Medicare managed care, Healthy Families and Medi-Cal Managed Care product lines). However, product line comparisons are challenging due to the inconsistency of where plans submit data (NCQA or AHRQ), the measures used (core or supplemental) and the frequency of administering the survey.

## **Relevance to IOM Domains**

- The Effectiveness and Patient-Centered domains contain the most quality related measures.
- The Timeliness, Efficiency, and Safety domains have far fewer related measures.
- There are essentially no equity-related measures. HEDIS 4.0 does not capture demographic information, thus limiting its use for measuring equity between various populations. NCQA is considering the addition of such information in a future HEDIS version.

## **Product Line Comparisons**

- Private sector commercial health plans (HMOs and PPOs) and Medicare managed care plans report the most HEDIS and CAHPS measures of any group. California's MRMIB reports 12 HEDIS clinical indicators and the core CAHPS indicators for the Healthy Families program. Other MRMIB programs (AIM and MRMIP) do not track quality of care indicators. Medi-Cal typically requires their contracted plans to report 12 HEDIS clinical indicators and the core CAHPS indicators.
- Product line comparisons may be possible on a limited basis provided that data are collected for the same time period. For example, CalPERS, Medi-Cal and Healthy Families include the following HEDIS measures: Immunization Combo 2 and Combo 3, appropriate upper respiratory infection treatment, appropriate medicine for asthma, and chlamydia screening. However, the public programs have difficulty collecting data annually due to budget

constraints. This can make comparisons difficult because measurement can occur during different time periods.

### **Life Cycle**

- The human life cycle (pediatric, adult and geriatric) is another useful tool for assessing the breadth of quality performance measures available to a population. HEDIS and CAHPS measures focus much more frequently on adults than on the pediatric or geriatric populations.

### **Type of Care**

- The quality performance measures are also categorized according to whether they address preventive, acute, and/or management health care.
  - 19 HEDIS and 3 CAHPS measures are related to preventive care
  - 11 HEDIS and 10 CAHPS measures are related to acute care
  - 13 HEDIS and 2 CAHPS measures are related to disease/condition management care

### **Key Health Conditions**

- The HEDIS measures in the Health Plan Inventory are fairly well distributed among the nine key health conditions. Heart disease (6), mental health (4), cancer (4), musculoskeletal (4) and COPD (4) have the most measures while reproductive health (3) and asthma (1 measure with three age groupings) have fewer measures. Diabetes has one large composite measure composed of nine individual indicators that are reported separately and rolled into a composite. Other conditions with quality measures include immunizations, dental health, and well-child visits.

### **Gaps in Health Plan Measures or Reporting**

- There is a large gap in measuring the IOM domains of *Equity* and *Efficiency*. Although CAHPS surveys collect limited demographic data, these data are not commonly used in quality care reports because member-level data are retained by the participating plans. HEDIS does not collect these data and some health plans incorrectly believe that it is illegal to collect such data from plan members. There are very few *Efficiency* measures, although efforts to create such measures are ongoing.
- PPOs regulated by the California Department of Insurance (CDI) do not publicly report HEDIS or CAHPS measures leaving a portion of the insured California population with no quality performance information upon which to make informed decisions. CDI plans to introduce a report card in 2009 that includes HEDIS and CAHPS indicators.

## PHYSICIAN ORGANIZATION INVENTORY SUMMARY

Table 3 summarizes the eight QPM measure sets available for assessing physician quality performance. The national measure sets generally report at the physician organization (medical group) level rather than the individual level. California offers one of the few coordinated efforts in the U.S. to report on physician quality of care from both the clinical and patient experience perspectives.

**Table 3. Physician Organization Measure Sets**

Measure Set*	Reporting Level	Type of Measure Set	Data Publicly Available for...	
			Phys. Org.	Individual Physician
IHA/NCQA P4P MY 2007	California specific	Clinical and patient experience measures	Yes	No
CCHRI/CMS CPPI	California specific	Pilot program – clinical measures	No	No
CCHRI PAS Group Survey	California specific	Patient experience	Yes	No
AHRQ Clinician and Group CAHPS Survey 4.0	National	Patient experience measures	No	No
CMS Physician Quality Reporting Initiative (P4P Program)	National	Clinical measures	No	No
CMS DOQ-IT	National	Pilot program – clinical measures	No	No
NCQA Physician Recognition Program (PRP)	National	Clinical measures	No	Yes
California OSHPD	California specific	CABG mortality rates	No	Yes

\*The California Association of Physician Organizations (CAPG) created an information technology *Standards of Excellence* survey to assess physician groups' infrastructure and tools in three domains: Care Management Practices; Health Information Technology; and Accountability and Transparency. The survey tool is available at <http://www.capg.org/home/index.asp?page=229> and CAPG anticipates publicly releasing results in the near future. This measure set could be considered as another a resource for performance measurement of physician organizations once it becomes publicly available.

**IHA/NCQA P4P:** California health plans, Physician Organizations (PO), hospital systems, purchaser and consumer representatives, and academic and pharmaceutical representatives comprise the Integrated Healthcare Association (IHA) membership. IHA collaborates with NCQA to use HEDIS-based clinical measures to evaluate the performance of California's POs in a pay-for-performance (P4P-MY 2007) program. IHA's P4P program uses a data subset of the PAS to measure patient experience. Data are available annually in early fall (<http://www.ih.org/p4py5.htm>).

**CCHRI CPPI:** The California Cooperative Healthcare Reporting Initiative (CCHRI), operated by the Pacific Business Group on Health, received approval from the Centers for Medicare and Medicaid Services (CMS) to participate in the federal *Better Quality Initiative* pilot program, which tests various methods of aggregating and reporting data on physician performance. The California Physician Performance Initiative (CPPI) pilot project aggregated claims data from Medicare fee-for-service and

three commercial PPOs in California as part of a national effort to establish physician performance standards. Results from 15 clinical quality measures are privately reported to physicians ([http://www.cchri.org/programs/programs\\_CPPI.html](http://www.cchri.org/programs/programs_CPPI.html)).

#### **Chartered Value Exchanges: Future Data Source**

CCHRI and OPA are part of the recently formed California Chartered Value Exchange. A Chartered Value Exchange (CVE) is a local multi-stakeholder collaborative. Composed of purchasers, health plans, providers, and consumers, the CVEs work to improve care and make provider quality and pricing data widely available as part of the federal Value-Driven Health Care initiative. The CVEs have access to a Learning Network sponsored by AHRQ, which features decision tools, access to experts, and a private Web-based knowledge management system.

Specially designated CVEs have access to a summary Medicare provider performance dataset, which can be combined with commercial sector data to produce and publish all-payer performance results. (This CMS data set differs from another data set that CMS provided to the Better Quality Initiative groups, which are also involved in physician measurement.)

**CCHRI PAS Group Survey:** The CCHRI also sponsors the Patient Assessment Survey (PAS) Group Survey. This cooperative of California health plans, POs, and purchasers assists physician organizations with measuring their patients' health care experience. Closely aligned with AHRQ's Clinician and Group CAHPS survey, the PAS focuses on areas of particular interest to California and topics that support IHA's P4P program. There are separate, but similar, PAS surveys for primary care physicians, specialists, and pediatricians. Data for California POs and individual physicians are collected and managed by CCHRI and reported annually ([http://www.cchri.org/programs/programs\\_pas.html](http://www.cchri.org/programs/programs_pas.html)).

**AHRQ Clinician and Group CAHPS Survey 4.0:** The Agency for Healthcare Research and Quality (AHRQ) Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey 4.0 data are collected at the PO level by the physician organization and submitted to the National CAHPS Benchmarking Database (NCBD) annually. Data are submitted voluntarily from POs across the U.S and can be accessed only by those contributing data. Data are not available to the public ([https://www.cahps.ahrq.gov/content/products/CG/PROD\\_CG\\_CG40Products.asp](https://www.cahps.ahrq.gov/content/products/CG/PROD_CG_CG40Products.asp)).

**CMS Physician Quality Reporting Initiative--P4P Program:** The voluntary PQRI-P4P program is sponsored by the Centers for Medicare and Medicaid Services (CMS) and pays individual physicians annually for reporting specified clinical quality measures related to fee-for-service Medicare patients. Measurement results are derived from administrative/billing data. The data are not publicly available at this time (<http://www.cms.hhs.gov/pqri/>).

**CMS DOQ-IT:** The Centers for Medicare and Medicaid Services created the Doctors' Office Quality–Information Technology (DOQ-IT) pilot program. Similar in purpose to the CMS P4P Program, these data are pulled exclusively from electronic health records of Medicare beneficiaries rather

than administrative or billing records. Data submission by physicians is voluntary with no financial incentive to participate. Data are not publicly available at this time (<http://providers.ipro.org/index/doqit>).

**NCQA Physician Recognition Program (PRP):** NCQA developed and manages a program to publicly recognize physicians meeting clinical requirements for appropriate care in these areas: Back Pain, Heart/Stroke, Diabetes, and Primary Care Medical Home. Physicians who seek official recognition from NCQA submit appropriate data voluntarily (<http://www.ncqa.org/tabid/58/Default.aspx>).

**California OSHPD:** Every two years, OSHPD reports on surgeon-specific, risk-adjusted CABG surgery outcomes. Hospitals submit data to OSHPD annually ([http://www.oshpd.ca.gov/HID/Products/Clinical\\_Data/CABG/03-04Breakdown.html](http://www.oshpd.ca.gov/HID/Products/Clinical_Data/CABG/03-04Breakdown.html)). (Of note: There is precedent for limited public reporting about some surgeon outcomes in a few other states including New York and Pennsylvania.)

## PHYSICIAN ORGANIZATION INVENTORY FINDINGS

### Measure Developers and Data Managers

- Unlike the measure sets in the Health Plan Inventory, the PO measure set developers are the same organizations that warehouse the resulting data.
- Of the eight measure sets, two sets publicly report individual physician scores (OSHPD-CABG Mortality Rates by Surgeon and NCQA PRP).
- The measure sets developed by AHRQ CG CAHPS 4.0, PQRI-P4P Program, and DOQ-IT collect data nationwide at the physician group level and at the individual physician level, however data are typically used for internal quality improvement efforts and are not publicly reported.
- The NCBD warehouses data collected from POs nationwide and includes CAHPS survey data from multiple product lines.
- CMS collects and warehouses PO data (specific to its Medicare fee-for-service population) from the CMS P4P Program and the CMS DOQ-IT pilot program.
- There are two California-specific resources for publicly reporting individual physician performance:
  - 1) CCHRI and IHA assist California physician organizations with the collection and analysis of their clinical measures and patient experience survey data. Both organizations work closely with OPA to publicly report the results at the PO level; and
  - 2) OSHPD reports on surgeons' risk-adjusted CABG surgery outcomes.

### **Levels of Reporting**

- Clinical and/or patient experience indicators are reported (publicly or privately) at the state level for four measure sets and at the national level for four measure sets. Comparisons among California POs can be made using the IHA P4P and CCHRI PAS measure sets, but no national benchmark data are available from those sets and public reporting is limited to the PO level. National benchmarks may become available through the CPPI or CVE initiatives in the future.
- Currently, the clinical measures used nationally are substantially different from the measures used at the state (California) level and therefore cannot be used as benchmarks for California. Again, the CVE or CPPI programs may permit future reports about individual physician performance.
- National and state patient experience data are difficult to compare due to the difference in PO participation and the difference in survey questions used.

### **Duplication of Measures**

- There is virtually no overlap of clinical quality indicators in the physician organization inventory, however patient experience measures from the AHRQ CAHPS, CCHRI, and IHA measure sets frequently overlap.

### **IOM Domains of Quality Care**

- There is a wealth of effectiveness-related measures in this inventory. There are substantially fewer timeliness, patient-centeredness and safety-related measures and only a handful of efficiency-related measures. There are no equity-related measures directly represented in any of the eight sets.

### **Life Cycle**

- At the national level, the AHRQ CG-CAHPS covers all three populations; however the two CMS measure sets focus exclusively on the Medicare-eligible population. This explains the imbalance between the few pediatric-related measures and the numerous geriatric-related measures.

## **Type of Care**

- The IHA measure set contains more preventive care indicators than management or acute care. Each of the CMS measure sets emphasizes different types of care. The CMS PQRI-P4P measures more acute care conditions, followed by management care and some preventive care conditions. In contrast, most of the CMS DOQ-IT measure set relates to care management and preventive care while there are few acute care-related measures. The NCQA PRP includes all three areas of care.
- The PO measures sets, taken as a whole, cover the three types of care almost equally.

## **Key Health Conditions**

- The IHA/NCQA P4P program has a handful of measures that are related to diabetes, cancer, asthma, and heart disease.
- The CMS PQRI-P4P program continually adds new indicators to its measure set, but as of June 2008, the program had 19 measures related to cancer or heart disease followed by a handful of measures related to diabetes, COPD and cancer.
- Most of the indicators in the CMS DOQ-IT measure set relate to heart disease followed in frequency by diabetes. The set also includes a few measures related to cancer, COPD, hypertension and mental health.
- NCQA's PRP indicators cover musculoskeletal (back pain), heart disease, hypertension and diabetes.
- The CCHRI PAS Survey and the AHRQ CG-CAHPS measures are not applicable to this category.
- There are 38 other measures in the PO inventory that are unrelated to the key health conditions specified by OPA. Additional conditions measured in one or more of the eight measure sets include: eye conditions (macular degeneration, cataracts, and glaucoma), perioperative care (related to antibiotic administration), urinary tract infections, GERD, stroke, and end stage renal disease.

## **Gaps in PO Measures or Reporting**

- The most glaring gap in the PO Inventory relates to the lack of quality data and public reporting at the PO level (nationally) and at the individual physician level (nationally and in California). PO group level performance data are available to a limited extent for the larger California POs, but no national benchmarks are available. Gaps in the *Equity* and *Efficiency* domains at the PO level also exist.

## HOSPITAL INVENTORY SUMMARY

Table 4 summarizes the Hospital Inventory’s eight overlapping quality measure sets. California has several efforts underway to publicly report certain aspects of hospital quality of care.

**Table 4. Summary of Hospital Measure Sets**

Measure Set	Reporting Level	Type of Measure Set	Data Publicly Available
CMS HospitalCompare	National	Clinical measures	Yes
Hospital CAHPS	National	Clinical measures	Some
Quality Check	National	Clinical measures	Yes
Leapfrog Hospital Quality and Safety Survey	National	Process measures and Patient Safety measures	Yes
California Hospitals Assessment and Reporting Taskforce (CHART)	California-specific	Clinical measures	Yes
California Office of Statewide Health Planning and Development (OSHPD)	California-specific	Clinical measures Outcomes measures	Yes
California Perinatal Quality Care Collaborative (CPQCC)	California-specific	Clinical measures	No (except for specific measures through CHART)
California Nursing Outcomes Coalition (CalNOC)	California-specific	Clinical measures	No

**CMS HospitalCompare:** This voluntary, pay-for-participation program offers hospitals a financial incentive (“Reporting Hospital Quality Data for Annual Payment Update”) to submit Medicare and non-Medicare data extracted from medical records and administrative records on a quarterly basis. This set includes both clinical and CAHPS patient experience measures. Individual hospital results are publicly available on the CMS HospitalCompare website: (<http://www.hospitalcompare.hhs.gov>).

**Hospital CAHPS:** CMS and AHRQ developed the H-CAHPS to assess patients’ perspectives on quality of care delivered during their hospital stay. Individual hospital comparisons of 10 composite measures are available at the CMS HospitalCompare website. Medicare requires hospitals to participate annually to receive their full payment update from Medicare. Hospitals submit data to the CMS QualityNet Exchange database for CMS analysis and reporting and are publicly updated through HospitalCompare. Data also can be voluntarily submitted to the AHRQ National CAPHS Benchmarking Database <http://www.hospitalcompare.hhs.gov> and <http://www.hcahponline.org/>.

**Quality Check:** The Joint Commission’s Quality Check program includes some measures that are shared with the CMS HospitalCompare website, but it also includes additional Core Measures that are not collected by CMS. In order to earn the Joint Commission’s well-respected accreditation, the Commission requires hospitals to submit data and meet certain standards. Quarterly updates are posted on its website (<http://www.qualitycheck.org/consumer/searchQCR.aspx>).

**Leapfrog Hospital Quality and Safety Survey:** This survey, administered by Thomson Healthcare, assesses hospital performance based on four quality and safety practices that are believed to reduce preventable medical mistakes. Hospitals voluntarily report computerized physician order entry, intensive-care unit physician staffing and evidence-based hospital referral, and NQF-endorsed safe practices to Leapfrog. The fourth indicator, a unique measure developed by Leapfrog, calculates resource efficiency for five conditions. All results are publicly reported and updated annually on its website (<http://www.leapfroggroup.org>).

**California Hospitals Assessment and Reporting Taskforce (CHART):** A collaboration of California groups representing health care stakeholders developed a statewide hospital performance reporting system in 2004. The quality of care delivered by hospitals for eleven health conditions is publicly reported annually. CHART developed its own risk-adjusted intensive care mortality measure, but relies on other measures developed by the Joint Commission, OSHPD, Leapfrog, H-CAHPS, CPQCC and Cal-NOC. CHART is actively expanding its family of indicators (<http://www.calhospitalcompare.org>).

**California Office of Statewide Health Planning and Development (OSHPD):** This state office provides quality of care reports on potentially preventable hospitalizations for 15 health conditions. It also reports on the Agency for Healthcare Research and Quality's Inpatient Quality Indicators of hospital volume and utilization. In addition, OSHPD provides reports on risk-adjusted mortality related to pneumonia, heart attack, and CABG mortality. Reports are issued on an ad hoc basis and are available for public review (<http://oshpd.ca.gov/HID/DataFlow/HospQuality.html>).

**California Perinatal Quality Care Collaborative (CPQCC):** Professional and government stakeholders collaborate with 60 hospitals on the development of perinatal and neonatal outcomes and information. This collaborative requires the coordination of existing California databases such as birth and death files, rehospitalizations, hospital chart information, and maternal/newborn discharges. Data are submitted annually and available for member use only (<http://cpqcc.org/>).

**California Nursing Outcomes Coalition (CalNOC):** In collaboration with the American Nurses Association and the National Database of Nursing Quality Indicators project, CalNOC coordinates the submission of structure, process and outcome data to evaluate nursing quality at the unit level. California hospitals voluntarily submit data quarterly (except for an annual RN survey) and a rolling average of eight consecutive quarters (with national comparisons) is reported to participating hospitals quarterly (<https://www.calnoc.org/globalPages/mainpage.aspx>).

### Future Data Sources

California Department of Public Health: CDPH formed two quality-related groups in 2008: the Center for Healthcare Quality and the Office of Patient Safety. The groups plan to inventory public health measures related to the national Healthy People 2010 goals and quality indicators derived from CDPH's enforcement and certification data sets to choose appropriate metrics for public reporting. Data from "27 Never Events" (in-patient safety indicators as required by state law), medication safety and medical error reports, and health care acquired infection reports are under consideration.

Hospital Value Initiative: PBGH and CalPERS created the HVI to build consensus among California stakeholders and produce scientifically-sound efficiency measures to assess hospital resource use and total cost of hospital care to payers. The goal is to use these measures with CHART's quality measures to create reward programs for hospitals. Using publicly available financial data from OSHPD, a report on hospital cost efficiency was released in October 2007.

## HOSPITAL INVENTORY FINDINGS

### Measure Developers and Data Managers

- There are eight developer organizations in the Hospital Inventory of which seven also manage the quality data submissions from hospitals and report the results. These sets provide one of the richest collections of performance indicators in health care.
- Public reports on performance are issued by five of the eight organizations managing the data. Three organizations report results exclusively to their participants.

### Levels of Reporting

- Results are available at the individual hospital level for all measure sets (although not always publicly). State and national averages are available for comparative purposes on four sites.

### Duplication of Measures

- The HospitalCompare and Joint Commission measure sets overlap on most indicators although each has its own set of unique indicators as well.
- Leapfrog, OSHPD, CPQCC and CalNOC developed unique indicators within their respective organizations.
- HospitalCompare (at the national level) and CHART (at the California state level) duplicate the AHRQ H-CAHPS indicators.

- CHART mostly reports on indicators from the aforementioned sources, but also includes a unique indicator regarding respirator complication prevention.

### **IOM Domains of Quality Care**

- Similar to the other inventories, the Hospital Inventory is most robust in *Effectiveness* indicators followed by *Safety* and *Timeliness* indicators. *Patient-centeredness* indicators are primarily captured through the H-CAHPS set. CHART added six unique measures to the core H-CAHPS survey as well as Leapfrog's patient-centered measure of "Adherence to 'Never-Events' Policy".

### **Life Cycle**

- Adult-related measures outnumber, by far, the geriatric- and pediatric-related indicators.

### **Type of Care**

- Acute care has the largest number of measures represented. Preventive care indicators are second in frequency and mostly relate to preventing complications such as surgical infections and death after heart attack. Measures related to management care are much less likely to be found throughout the Hospital Inventory.

### **Key Health Conditions**

- Of the health conditions specified by OPA, heart disease has the most hospital quality measures. Asthma, COPD, and reproductive health conditions have only a handful of related measures.
- Other conditions considered important to hospital measure set developers include pneumonia, surgical care, NICU care, and nosocomial infections.

### **Gaps in Measures or Reporting**

- There are several areas in the Hospital Inventory where gaps exist. As is consistent with the rest of the health care sectors profiled in the Inventories, the IOM *Equity* and *Efficiency* domains lack measures. There are no hospital quality measures in the inventory that are related to cancer, mental health and musculoskeletal conditions. Also, indicators for elective treatments, such as orthopaedic or gastric bypass surgeries, are lacking.

## NURSING HOME INVENTORY SUMMARY

Table 5 summarizes the six measure sets related to nursing home quality of care. The indicators contained in these sets are largely duplicative. The California-specific measure set duplicates the CMS Nursing Home Compare measure set, although it offers some cost and financial data not readily available on the CMS site.

**Table 5. Summary of Nursing Home Measure Sets**

Measure Set	Reporting Level	Type of Measure Set	Data Publicly Available
Nursing Home Compare Quality of Care (CMS)	National	Clinical, quality of life, facility, and staffing measures	Yes
California Nursing Home Search (CHCF)	State	Clinical, quality of life, facility, staffing measures, and financing/cost data	Yes
QualityCheck (Joint Commission)	National	Clinical, quality of life, facility, and staffing measures	Yes
CAHPS Nursing Home Survey	National	Patient experience	No
Advancing Excellence in America's Nursing Homes	National	Clinical, quality of life, facility, and staffing measures	No
Nursing Home STAR	National	Clinical and quality of life measures	Yes

**Nursing Home Compare Quality of Care:** The Centers for Medicare and Medicaid Services (CMS) developed this measure set and maintains the Minimum Data Set (MDS) repository for the quality data submitted by nursing homes nationwide. An Online Survey Certification and Reporting database (OSCAR) captures nursing home characteristics and health deficiencies issued during the three most recent state inspections and recent complaint investigations. Nursing homes must submit data to be eligible for CMS reimbursement. Public reports on the quality of care provided by nursing homes nationwide are updated quarterly. National and state averages are available for comparison with individual facilities (<http://www.medicare.gov/NHCompare/>).

**California Nursing Home Search:** The California HealthCare Foundation (CHCF) compiles California-only nursing home quality data using data from CMS and the California Department of Public Health Division of Licensing and Certification. CHCF publicly reports the results on its website and updates reports quarterly. There are no unique measures within this measure set, except for the average expenditures per resident per day for direct care. This measure allows each facility's spending on care to be compared to other nursing facilities. A California state average offers a benchmark for comparison with individual facilities (<http://www.calnhs.org/nursinghomes/index.cfm?itemID=107169>).

**Quality Check:** The Joint Commission developed patient safety standards as part of its accreditation process for nursing homes. In order to be eligible for accreditation, nursing homes must submit quality data quarterly to the Joint Commission and meet its standards. Public reports about nursing home performance nationwide are available through the Joint Commission's QualityCheck website (<http://www.qualitycheck.org/consumer/searchQCR.aspx>).

**CAHPS Nursing Home Survey (NH-CAHPS):** The nursing home survey, one of the series of patient experience survey tools developed by AHRQ, is under development. Three similar surveys (for short-term and long-term residents and family members) will assess the environment, care, communication, autonomy, and activities provided in a nursing home facility. The data collection process and reporting cycle have yet to be determined. Public availability of the data has yet to be determined. ([http://www.cahps.ahrq.gov/content/products/NH/PROD\\_NH\\_Intro.asp](http://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Intro.asp)).

**Advancing Excellence in America's Nursing Homes:** This two-year, coalition-based campaign, composed of long-term care providers, medical and quality improvement experts, government agencies and health care providers, monitors key indicators of nursing home quality of care. Twenty-five percent of California's nursing homes voluntarily submit data on three or more goals on a quarterly (Goals 1-5) or annual (Goals 6-8) basis. No public reporting occurs, but participating nursing homes receive reports with national benchmarks to use for comparison and internal quality improvement (<http://www.nhqualitycampaign.org>).

**Nursing Home STAR:** Sponsored by the Nursing Home Quality Initiative (organized by Quality Improvement Organizations), the STAR program has 9,600 participating nursing homes nationwide that voluntarily submit quality data on six key measures. CMS developed and maintains the measures. STAR provides software for nursing homes to set improvement targets and track performance goals for the key measures. The STAR Program reports compare individual facility data with state and national averages trended over a four-year period. Results are updated quarterly and publicly available on the STAR Program website (<http://www.nhqi-star.org>). The six key indicators are also available through the CMS NursingHomeCompare website.

## **NURSING HOME INVENTORY FINDINGS**

### **Measure Developers and Data Managers**

- There is one primary clinical measure set (NursingHomeCompare) and one primary patient experience measure set (NH-CAHPS under development) included in the Nursing Home Inventory. The third measure set (QualityCheck) includes a unique set of patient safety standards.
- Three of the six measure sets duplicate quality measures found in other sets.
- All 19 unique clinical quality indicators are publicly available.

**Levels of Reporting**

- Five measure set developers warehouse and report the data collected from state survey agency nursing home inspectors. Individual nursing home quality data from across the nation are available on each of the five sites. Only one measure set, reported by CHCF at CalNursingHome.org, focuses on nursing home quality at the state (California-specific) level.

**IOM Domains of Quality Care**

- The *Effectiveness*, *Safety* and *Patient-centeredness* domains have the most indicators. Currently, there are a few comparative indicators that relate to activities of daily living, mobility and use of restraints. However, there are no direct measures of patient experience with nursing home care at this time.
- The Nursing Home inventory recorded no indicators related to the IOM *Timeliness*, *Efficiency* or *Equity* domains.

**Life Cycle**

- All the quality measures in the Nursing Home Inventory are related to the Medicare-eligible population, which is predominantly over age 65 (geriatric).

**Type of Care**

- The preventive and acute care-related quality measures are more prevalent than management-related measures.

**Key Health Conditions**

- Pneumonia and influenza vaccination measures are the only quality indicators related to the Inventory-specific health conditions.

**Gaps in Measures or Reporting**

- There are several data gaps in the Nursing Home indicators including the lack of comparable patient experience information. Although the NH-CAHPS will fill this void at some point, it is unknown when these data will be publicly available. Only one measure set (QualityCheck) includes an indicator related to tracking safety of medication administration. Also, no quality indicator measures management of chronic conditions affecting nursing home patients, or the *Timeliness* or *Efficiency* of care provided.

## “OTHER SOURCES” OF QUALITY MEASURES INVENTORY SUMMARY

Numerous health care surveys and registries focus on issues such as cost and utilization of health services, health behaviors, and tracking health status, but only rarely do they directly measure quality of care. The purpose of the “Other Sources” Inventory is to list alternative measures or data collection activities that may supplement or enhance more traditional clinical or patient experience quality of care measures. The sponsoring organizations sometimes publish summary reports, but these reports do not present the data at the level of individual practitioner, facility or plan levels. Typically, data sets must be purchased and researchers must conduct their own analyses to ascertain the quality of care at the provider level.

The eight sources summarized in Table 6 are either linked directly to the California population or have some aspect that allows for grouping and analyzing data at a more granular level (hospital, physician, health plan, demographic grouping, etc.).

**Table 6. Summary of “Other Sources” of Quality Measures**

Measure Set	Reporting Level	Data Publicly Available <sup>1</sup>
Behavioral Risk Factor Surveillance System (BRFSS)	National, State, MSA	Yes
California Health Interview Survey (CHIS)	California-specific (state/ regional/county)	Yes
Medical Expenditure Panel Survey (MEPS)	National (Census regions)	Yes
Medicare Health Outcomes Survey (MHOS)	National	Yes
California Cancer Registry (CCR)	California-specific	Yes
California Adult Tobacco Survey (CATS)	California-specific	Yes
Young Adult Health Care Survey (YAHCS)	National	Yes
California Women's Health Survey (CWHS)	California-specific	Yes

<sup>1</sup>These data are publicly available for a fee.

**Behavioral Risk Factor Surveillance System (BRFSS):** (California 2007) – The Centers for Disease Control and Prevention (CDC) collaborates with all states (including California’s Department of Public Health) to track health conditions and behavioral risk factors through an annual telephone survey. The survey is composed of CDC Core Measures, CDC Optional Modules, and state-added questions. Data are embargoed for one year following the collection year for sponsor-only use and then released in April of the following year. Each state is responsible for surveying its own population. Data can be analyzed at national, state, and Metropolitan Statistical Areas (MSA) levels. Demographic

data are collected and data are comparable by product line (e.g., Medicare, Medicaid, commercial managed care, other government plans). Sample size: Approximately 5,000 Californians (<http://www.cdc.gov/brfss/>).

**California Health Interview Survey (CHIS):** (California 2005) - The California Departments of Health Care Services and Public Health, the Public Health Institute, and the UCLA Center for Health Policy Research collaborate on the design, administration and analysis of a statewide telephone survey of California children, adolescents, and adults regarding health behaviors and health status. The survey consists of established core questions and new questions rotated in to address emerging health issues. Data are collected biennially and released during the subsequent data collection process two years later (e.g., 2005 data become publicly available in 2007). Data can be analyzed at the state level, state-regional, and county levels. Demographic information is collected and data are comparable by product line. Sample size: Approximately 42,000 Californians (<http://www.chis.ucla.edu/>).

**Medical Expenditure Panel Survey (MEPS):** AHRQ developed and manages the MEPS tool and database, which gathers health information about families and individuals and their medical providers nationwide. Data collection occurs through rounds of interviewing over a two-year period to determine how changes in respondents' health status, use of services, eligibility for coverage, etc. are related. Data are available at the national and census region levels and data are comparable by insurance product line (<http://www.meps.ahrq.gov/mepsweb/>).

**Medicare Health Outcomes Survey (MHOS):** CMS, in collaboration with NCQA, developed this survey, which relies on self-reported health outcomes by Medicare Advantage (MA) beneficiaries to assess their health plans' ability to maintain or improve physical and mental health function. CMS provides each MA plan with a "plan performance measurement report" that describes changes in beneficiaries' health status over a two-year period. Plan reports are not available for public review. The survey is based on the Veterans' RAND 12-Item Health Survey and four HEDIS measures. Demographic data are collected. The survey is conducted every spring. Sample size: Approximately 100,000 beneficiaries from plans nationwide (<http://www.hosonline.org/>).

**California Cancer Registry (CCR):** The California Department of Public Health collaborates with the Public Health Institute, ten regional registries, hospitals and cancer researchers to maintain the cancer registry, which adds approximately 140,000 cancer cases annually. The registry includes information on demographics, cancer type, extent of disease at diagnosis, treatments, and survival rates. Data are publicly available. Hospitals and physicians are required by law to submit data. Registry size: 2.5 million cancer cases (<http://www.crcal.org/abouttheccr.html>).

**California Adult Tobacco Survey (CATS):** The California Department of Public Health's Tobacco Control Section oversees an ongoing, monthly telephone survey that collects information on a wide variety of tobacco-related behaviors, attitudes and beliefs from a random sample of adult Californians. Data are publicly available. A biennial children's survey is also conducted. Sample size: 4,200 adults (<http://www.dhs.ca.gov/tobacco/>).

**Young Adult Health Care Survey (YAHCS):** The Child and Adolescent Health Measurement Initiative (CAHMI), in collaboration with NCQA and the now defunct FAACT, developed YAHCS. This annual survey targets adolescents ages 14-18 years to assess how well the health care system provides recommended preventive care. CAHMI has collected and analyzed more than 3,000 surveys to date. The survey tool and some data are publicly available; however no benchmark data are available. MRMIB used this survey in 2007 to help assess its adolescent population. CAHMI houses the data at the Oregon Health and Science University (<http://www.cahmi.org>).

**California Women's Health Survey (CWHs):** The California Departments of Health Services, Mental Health, Alcohol and Drug Programs, and Social Services, and the Public Health Institute (PHI) collaborate on this statewide, annual telephone survey. The survey collects information from randomly selected adult women ages 18 years or older on a wide variety of health indicators and health-related knowledge, behaviors and attitudes. The PHI Survey Research Group administers the survey. Reports on the data are available for public review. Sample size: 4,000 (<http://www.dhcs.ca.gov/dataandstats/reports/Pages/DataPoints.aspx>).

## **"OTHER SOURCES" OF QUALITY MEASURES INVENTORY FINDINGS**

### **Measure Developers and Data Managers**

- In addition to creating the survey tools, the developers are responsible for overseeing the data collection, analysis and public reporting of summary results.

### **Levels of Reporting**

- Five of the eight sources of registries and survey tools provide data limited to the California population and one offers comparative data between California and the nation. The remaining two sources (MEPS and MHOS) are limited to comparisons at the national level only.

### **Duplication of Measures**

- Very few measures are duplicated between the sources listed in the Inventory. BRFSS and CHIS both address many of the same health topics, but CHIS frequently offers more detail.

### **IOM Domains of Quality Care**

- Because these sources are not direct indicators of quality of care, there are very few measures related to the IOM domains. The *Effectiveness* and *Timeliness* domains contain the most related survey questions. (The *Timeliness* questions are usually related to access to care.)

**Life Cycle**

- The Inventory covers all stages of the life cycle. BRFSS, CHIS and MEPS include all three stages in their surveys, while MHOS captures only the geriatric stage and the YACHS captures only the pediatric stage.

**Key Health Conditions**

- The surveys and registries not only cover the health conditions identified by OPA, but expand into other areas such as physical disabilities and HIV/STDs.

**Gaps in Measures or Reporting**

- These surveys and registries primarily assess population health rather than individual health. This makes the application of the data more challenging and complicated than other Inventory measure sets, which were designed specifically to measure the quality of care. Those who use these data for quality performance measurement may also face a challenge with the timeliness of some survey data. For example, BRFSS and CHIS use two-year data cycles and much of the data are outdated in comparison with other measure sets (e.g., HEDIS, HospitalCompare, etc.). Another limitation to using these data for quality measurement relates to the small sample size in some surveys.



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## IV. Stakeholder Interviews

The voluntary participation of health care providers in quality performance measurement has been essential to establishing and improving California's public reports on quality of care. OPA recognizes the pivotal role these providers play in promoting transparency and accountability in health care. Therefore, as part of the QPM project, it was important to OPA to consider the opinions, perceptions, and suggestions of these stakeholders in the development of its plan for QPM and public reporting.

Twenty-nine of the 31 stakeholders invited by OPA agreed to be interviewed about the state of quality measurement and public reporting in California. In general, stakeholder comments are not attributed to a specific organization to assure a frank and enlightening discussion.

The interview summaries are organized into three primary topics: current and future measures; gaps in measurement and OPA's role in quality measurement and public reporting. Within each topic, responses are grouped into one of five stakeholder groups to identify possible variation in stakeholder perspectives. The contributing organizations are:

### **Government Organizations**

1. Business, Transportation and Housing Agency (BTH)
2. CalPERS
3. Department of Health Care Services (DHCS)
4. Department of Insurance (CDI)
5. Department of Managed Health Care (DMHC)
6. Department of Public Health (DPH)
7. Health and Human Services Agency (HHS)
8. Managed Risk Medical Insurance Board (MRMIB)
9. Office of Governor Schwarzenegger
10. Office of Statewide Health Planning and Development (OSHPD)

### **Health Plans**

1. Aetna
2. Anthem Blue Cross of California
3. Kaiser Permanente

### **Consumer Advocacy Groups**

1. AARP
2. Center for Health Improvement
3. Consumers Union
4. Health Access

### **Quality Reporting Organizations**

1. California Healthcare Foundation (CHCF)
2. California Hospital Assessment and Reporting Taskforce (CHART)
3. Integrated Healthcare Association (IHA)
4. National Committee for Quality Assurance (NCQA)
5. Pacific Business Group on Health (PBGH)
6. RAND
7. Thomson Healthcare

### **Professional Associations/Physician Organizations**

1. California Association of Health Plans
2. California Association of Physician Groups (CAPG)
3. California Hospital Association
4. California Medical Association
5. Humboldt-Del Norte Foundation for Medical Care

## **CURRENT AND FUTURE MEASURES**

The interview questions in this domain focused on whether the Inventories were complete and whether the interviewee was aware of any current or potential future measures that were not included in the Inventories, but could be useful to the public.

### **Current Quality Measures**

#### **Government Organizations**

- Six of the ten government stakeholders did not identify measure gaps in the Inventories. Two stakeholders suggested adding the following quality measures/sources:
  - Young Adult Health Care Survey (YAHCS)
  - CAHPS Dental Survey
  - Hospital utilization rates
  - More structure measures related to hospitals (e.g., staffing ratios, procedure volume, accreditation.)
- Five government entities have some experience collecting and publicly reporting quality measures (CalPERS, MRMIB, DHCS, CDPH, and OSHPD) and CDI anticipates publicly reporting HEDIS/CAHPS results in 2009 for the first time. CDPH anticipates reporting “events and investigated outcomes to consumers” in 2009.
- All government stakeholders collect HEDIS measures annually and all but two entities collect CAHPS measures biennially, (assuming budget resources are available). However, the specific HEDIS/CAHPS measures collected by CalPERS, MRMIB, and DHCS differ somewhat as does the frequency of their data collection.

- All government stakeholders using HEDIS/CAHPS measures are satisfied with the breadth and depth of the clinical and patient satisfaction survey measures and found no reason to expand beyond those, nor to create their own measures of patient experiences with care.
- Some stakeholders suggested using other quality sources, including HMO-specific Quality Improvement Plans, HMO Annual Reports (both regulatory in nature and obtained through DMHC), California Women’s Health Survey (tracking health indicators and behaviors), and “California Perspectives” published by OSHPD (an overview of healthcare facilities and services). These sources are not intended for the public’s use in decision making, but rather to motivate health plans or providers to improve their quality of care or for public health research purposes.
- OSHPD highlighted the outcomes data they produce for CABG surgeries at the individual surgeon and hospital levels of care.
- CalPERS created two unique composites from the HEDIS measures: a medical composite and a mental health composite. Each composite reports the average rating for *all* of the clinical measures and for *all* of the mental health measures that CalPERS studies. CalPERS publicly reports the composites to members annually.

**“Outcomes are the gold standard.”**  
—Government agency

## Health Plans

- None of the plan representatives stated that any specific measures were missing from the Inventories. However, one representative mentioned that it tracks “NCQA-blessed” IT infrastructure measures (Physician Practice Connection, internal communication, E-prescribing) that could be useful for quality reports.
- All plans reported using at least some of the health plan-related measures included in the Inventories (HEDIS/CAHPS).
- One plan stated that the measures their plan uses are already endorsed at the national level.
- Two plans mentioned that they use their national offices to help determine which quality measures should be used.
- The plans observed that measures are developed through a scientific process that is not immune to political considerations.

**“There are challenges with operationalizing [quality] measures.”**  
—Health plan

## Consumer Advocates

- No consumer advocacy group identified any missing measures from the Inventories. One group stated that, in general, California’s quality measurement movement should focus on outcomes measures and patient safety measures.
- One advocacy group described the Agency for Healthcare Research and Quality’s free Patient Safety Indicators (PSI) software that tracks 15-20 PSI and 20-25 Inpatient Quality Indicators.

The group stated that more than 20 states track and report these indicators and they would like to see California take part in this initiative. (CDPH began PSI data collection in 2007.)

- Consumers Union is the only advocacy group involved with quality reporting. It publishes “Best Buy Drugs” which offers “value-based” reviews of various drug categories. Consumers Union needs help disseminating this information to the public and would welcome the opportunity to link their website with OPA’s Quality Portal.
- Two consumer groups advocated for publicly reporting efficiency measures related to the “value received for the health care dollar spent.”

### Quality Reporting Organizations

- No quality reporting organizations suggested specific, publicly available quality measures to add to the Inventories.
- One organization suggested adding Information Technology (IT) type measures.
- Several organizations identified some of the leading quality metric systems used for assessing performance. These systems, developed by RAND QA, Resolution Health, Thomson Healthcare (MedStat), and Ingenix, are proprietary and not publicly available.
- One organization cited the National Surgical Quality Improvement Program (NSQIP) as an important resource for quality indicators. The program was developed by the Department of Veterans Affairs and is now used by private hospitals through the American College of Surgeons. The data describe risk-adjusted surgical outcomes (rather than survival rates only) and are not publicly reported.

### Professional Associations/Physician Organizations

- One stakeholder reported that the Inventories missed a quality measure set. CAPG created a quality measurement tool for California “physician groups” in delegated managed care groups that focuses on a physician group’s infrastructure rather than clinical indicators. CAPG introduced the *Standards of Excellence* quality survey instrument in 2007. CAPG collects, analyzes, and reports the data in aggregate. It will eventually contract with a third party to oversee future data collection and analysis. The survey assesses three domains:
  - care management
  - health information technology
  - accountability and transparency

CAPG shares the physician group-specific results with each participating physician group but does not release the results publicly. (However, the survey instrument can be shared publicly.) CAPG anticipates public reports by group name will be available in the near future once the survey tool is validated and finalized.

**“We’re in a situation where nobody has more influence on quality than individual doctors.”**  
—Reporting organization

- All stakeholders acknowledged the need for or trend toward reporting at the provider level whether it is at the hospital level, physician group, or individual physician level. Enthusiasm for reporting at this more granular level varied by stakeholder.
- Four stakeholders mentioned that they personally contributed feedback to OPA about the quality measures reported on the *Health Care Quality Report Card*. They also mentioned having the opportunity to respond to the Report Card's results. These unsolicited comments were presented in an appreciative tone indicating that OPA's collaborative effort was important to them.
- Each stakeholder in this category represents a different part of the health care service industry and expressed different needs and concerns that were unique to their organization.

## Future Quality Measures

### Government Organizations

- Most government stakeholders plan to maintain their current quality performance measurement programs with slight adjustments. Specifically, efficiency measures will receive more attention in the future as they become available. CalPERS (through the CHART initiative) and OSHPD both mentioned a need for developing efficiency measures.
- OSHPD's Health Information Resource Center will focus on developing and reporting currently undetermined population-based measures. A team will take two to three years to design and implement this new measure set.
- OSHPD is expanding its custom outcomes reports and developing a new report style that does not require intensive data validation. OSHPD is confident in the validity of its dataset and is comfortable using those data in the custom reports. OSHPD staff will develop the entire methodology based on an AHRQ design, but they will include additional variables such as "conditions present upon admission" that OSHPD considers important. The conditions OSHPD chooses for the custom reports depend on the prevalence of condition, contribution to mortality rates, cost, and whether the care is elective (e.g., CABG, maternity care). Currently, two conditions are in queue with two more under consideration:
  - Maternal birth outcomes (perineal lacerations)
  - Mortality following hip fracture
  - Mortality following abdominal aortic aneurysm surgery (under consideration)
  - Heart failure mortality (under consideration)
- OSHPD plans to fully develop data collection efforts for in-patient hospitalizations, Emergency Departments, and ambulatory surgery centers in the near future.

**“Who should pay for the cost of data flow?”**

—Reporting organization

- CDI will report HEDIS/CAHPS measures on California's six largest PPOs within the next two years. This effort will cover about 85 percent of the PPO insured market. This is a cooperative effort on behalf of the PPOs as CDI has no statutory authority to require PPOs to contribute data or publicly report results. Eventually, CDI would like "to move further down the chain of the insurers" to include more of the smaller PPOs.
- CDPH formed two new quality-related groups in 2008: Center for Healthcare Quality and the Office of Patient Safety. Both groups plan to inventory public health measures related to the national *Healthy People 2010* goals and quality measures. The new Center will look at "tracking and identifying issues, creating robust reports and sharing best practices." The director hopes to fund these efforts through grants. Examples of pertinent data collection include "27 Never Events" (as required by state law), medication safety and medical error reports, and health care acquired infections. Most of these data points are designed and collected for enforcement purposes rather than quality measurement, but CDPH feels that there are valuable quality data available for analysis and reporting. CDPH would like to issue public reports and information in 2008-2009 using quality indicators derived from its enforcement and certification data sets.

**"The real goal is to go as far as needed to capture a majority of the physicians serving the PPO population."**

—Government agency

### **Health Plans**

- Two plans mentioned that they provide continuing medical education and training modules for their physicians to maintain their licensing/certification and suggested that something similar could be used as part of a quality performance measure for physicians. Both plans thought that including the scores from quality and practice improvement modules in a physician report card would be useful for physicians and consumers.
- One plan drew a parallel between the Centers for Medicare and Medicaid Services' *Bridges to Excellence* program and its own internal program.

### **Consumer Advocates**

- Consumers Union is working on a public education effort to inform consumers that "more care is not always better." A new website (<http://www.consumerreports.org/health/doctors-and-hospitals/hospital-home.htm>), introduced in June 2008, provides hospital intensity measures (defined as time in hospital and number of doctor visits) for nine conditions at 3,000 facilities nationwide. Based upon 2008 Dartmouth Atlas hospital data, Dr. John Santa of Consumers Union, translated "hospital intensity measures" into lay language to educate consumers that more interventions can sometimes be dangerous and more expensive without improving health outcomes. The measures are based on the medical care received by patients during their last two years of life.

### **Quality Reporting Organizations**

- Regarding the future need for more measures, one organization specifically stated that there are many measures that are not yet fully implemented at the proper health care levels, and therefore, there is no need to add more measures. "The measures implemented today are done

so in a patchwork—no PPOs report, little for HMOs, hospitals have some measures, but no group is comprehensive in its use or reporting of currently available measures.”

- Another organization stated that there are many proprietary measures generated by different groups that possibly could be used by California, if there was interest. For example, “episode groupers” link related claims together based on a diagnosis. Stakeholders reported that this approach measures an outcome for a particular condition with risk-adjustment.
- Two stakeholders reported that they are working together on developing efficiency measures (episodes of care) related to physician performance to see what drives practice variation. Only participating physician groups will receive the pilot project results in 2008. These efficiency indicators may become publicly available in the future.
- It was reported that, in the near future, NQF should be adopting efficiency metrics created by Leapfrog, PacifiCare and United Health. Once approved by NQF, CHART will consider adopting these indicators for public reporting.

### **Professional Associations/Physician Organizations**

- Of the five association stakeholder groups, none have future plans to create, administer or report quality measures with the exception of CAPG, which will continue to refine its *Standards of Excellence* survey (described in Chapter III).

## **GAPS IN QUALITY MEASUREMENT**

Another area of critical importance to mapping a future measurement and reporting plan in California is assessing where gaps in quality measurement currently exist. All stakeholders were queried about their perceived gaps in quality measurement.

**“Quality measurement is nothing but gaps—there are a few islands in the ocean.”**

—Government agency

### **Government Organizations**

- Of the stakeholder groups interviewed, the government organizations overlapped the most in their identification of gaps in quality performance measures. Several of the government organizations mentioned that they have not seen OPA’s Report Card or Quality Portal site and felt somewhat unprepared to comment on gaps specific to the Report Card.

#### Gaps in Types of Measures

- Two stakeholders felt outcomes measurement, rather than process measurement, should be promoted. Three stakeholders said they have no feel for where the clinical or quality gaps may be in measure sets. One stakeholder stated that, “data at the individual physician level is the biggest missing piece.”

- Two stakeholders said that, when choosing which gaps to fill, it was important to emphasize data that lead to “actionable” steps. They wanted indicators chosen that providers can control or change. There was sensitivity to the number of measures already required and the reporting burden on providers.
- Two stakeholders volunteered that the ability to compare a plan’s product lines (such as Medi-Cal, commercial, PPOs, etc.) is very important as is the geography of reporting: regional reporting is very important to some, but frequently is not available. Also, fee-for-service plans are not included in quality measurement, but one entity specifically mentioned the value in capturing that product line.

**“Data at the individual physician level is the biggest missing piece.”**

—Reporting organization

#### Gaps in IOM Domains

- Four government stakeholders reported that measures related to the Efficiency domain need to be expanded. Two stakeholders mentioned the need for more Equity measures to identify possible racial, ethnic, or socioeconomic disparities. Two stakeholders identified the need for more patient safety measures.

#### Gaps in Health Conditions Measured

- Two stakeholders reported that there are not enough mental health quality measures and two more reported that hospital acquired infections need more focus. Also, government stakeholders mentioned preventable hospitalizations, chronic care management, obesity, dental care, and elective surgery as other key areas of interest.

#### Structural Gaps in Reporting

- Several government stakeholders discussed the need to identify a designated quality reporting authority. In a related comment, one raised the question about “beefing up [OPA’s authority] if they go any further” in reporting clinical quality metrics. “Right now, it’s all voluntary and the real question is will people be willing to [continue] doing this?” Another observed that “there is a gap between DMHC and OPA. Some people think they are linked, but there’s potential value in having OPA be a much more independent organization. For OPA to be truly a patient advocate organization, it has to assume an independent role. Right now OPA’s budget is tied to DMHC, so by nature it’s not as independent as it should be.”

**“...there’s potential value in having OPA be a much more independent organization.”**

—Government agency

In contrast, a few government stakeholders did not want a central authority responsible for reporting all measures, but rather wanted “to be told where the gaps are, so we can make [reporting] adjustments.”

- A few government stakeholders said that quality reporting is a new and very different responsibility for most government organizations. Most stakeholders focus on policy, consultation and/or enforcement and said they needed support in reporting.

## Health Plans

Overall, health plans were satisfied with the selection of clinical quality measures with a few exceptions.

### Gaps in Measures

- There was some overlap in the gaps identified by health plans. Stakeholders from one plan said reporting on individual physician performance is important, but they believe the physician specialty measures adopted by CMS are “very weak and not solid evidence-based.” They said that CMS accepted lists of AMA-recommended measures that were not “vetted with scientific rigor” that is common to NCQA-approved measures. Also, the plans won’t use any measure unless it is endorsed by AQA, NQF or NCQA.
- Stakeholders noted that there is a need to report on PPO quality and a need for more outcomes data.

### Gaps in IOM Domains

- Areas that need more attention include racial/ethnic disparities and efficiency, but “how do you capture that and report it?” The plans expressed concern over the ability of any reporting entity to properly risk-adjust for population differences, but cautioned that it was “not OPA’s role to create the risk-adjustment models.”

### Structural Gaps in Reporting

- The stakeholders also mentioned their concern over reporting “old data.” They said improvements in programs and services may have occurred since the last measurement cycle, but those improvements would not be recognized because of the time lag in the reporting cycle.
- Finally, one plan encouraged OPA to change its approach from highlighting the worst performers to highlighting the best performers. They felt the biggest gap in public reporting is not sharing the successful, best practices amongst providers. By highlighting the best performers, it was thought that providers would be encouraged to adopt best practices across each sector of the health care industry.

## Consumer Advocates

The consumer advocates had very distinct opinions about gaps in quality performance measures.

### Gaps in Measures

- One stakeholder said that more hospital quality performance information is needed, specifically information related to patient safety (such as AHRQ’s Patient Safety Indicators). The stakeholder believes OSHPD “is doing some data analysis on this topic, but I don’t see the numbers publicly reported.” Another stakeholder mentioned the need for public reporting on readmission rates and timely access. For example, it is more

**“People use this [hospital quality] information as ‘just in time’ information.”**  
—Reporting organization

useful to know who provides the timeliest access and care (“within 7 days”) rather than “as soon as you thought was needed.” He believes using a specific time standard is more helpful to consumers.

- Another stakeholder reported that no CAHPS survey measures capture the “inadequate interpretation/translation services” in California. The stakeholder felt that integrating the CAHPS language/interpretation measures into the core CAHPS survey (rather than supplemental) is important to measuring health plan compliance with the new California language assistance regulations.
- Finally, the impact of cost of care on patients and medical debt suffered by patients was of utmost importance to one advocacy group. They wanted to know, “Does that [cost or medical debt] impact future care sought by a patient, and thus [his] future health outcomes?”

## **Quality Reporting Organizations**

The reporting organizations overlapped in their identification of gaps more than most of the stakeholder groups interviewed.

### Gaps in Measures

- Most reporting organizations observed that there is a plethora of quality indicators available, but that reporting entities should choose their required indicators carefully. The groups publicly reporting such data should be sure that the indicators measure conditions for which there are: 1) high rates of variation; 2) opportunities for improvement; and 3) clinically important questions to be answered. Another stakeholder included “shoppable” or elective measures as another criterion for choosing the most appropriate indicators for reporting.
- A related comment focused on the need for thorough data collection. For example, accurately measuring physician beta-blocker treatment rates would require pharmacy data, but it is very difficult to link those data because pharmacy data are reported to the plan and not to the physician.
- Three reporting organizations said that physician measures lack both chronic and acute care quality indicators (prevention is “pretty well covered”) and that there are no measures available for specialists—the few that are available focus on the primary care level.
- Several reporting organizations identified the need for more patient safety indicators at the physician level and the hospital level for ER and ambulatory care. One stakeholder mentioned nursing homes as having very few quality measures available to the public. Home health care providers also have no quality measures to which they are held accountable.

### Structural Gaps in Reporting

- Concerns regarding gaps in the structure or process of reporting data related to ensuring that physicians see their individual measures, the challenges of data warehouse management, and concern over all hospitals reporting CAHPS measures for public review.

Gaps in Health Conditions

- At least two quality reporting organizations said that “comfort care” measures would be worthy indicators once there is agreement on the definition and measure design. This area should include measuring palliative care (quality, type, process) delivered in hospitals.
- It was noted by one stakeholder that cancer care is a high cost and high impact condition, but it is too complex to measure. Others noted that obesity and outcomes and readmission rates for an array of conditions are all areas that need attention.
- Future measures should assess “longitudinal care” which is more comprehensive than readmit rates or episodes of care. This stakeholder believed that payment reform would fundamentally change how measures are used in the long run.

Gaps in IOM Domains

- There was much agreement between reporting organizations with regard to gaps in the IOM domains of care. Six stakeholders said that Efficiency measures are sorely lacking. Using somewhat varied terminology, they agreed that there is a great need for “episodes of care” or “relative resource use/cost” measures. They noted that timeliness and accessibility of data are the hurdles to overcome in establishing these measures. Calculating the cost per episode of care should be done at both the physician group and individual physician level too.
- Two stakeholders mentioned the lack of comparability of the efficiency of treatment patterns. For example, Consumer Reports produces an efficiency report on pharmaceuticals, but no organization produces the equivalent report for other medical interventions. Efforts need to be made to assess treatment options as related to health outcomes and cost to the patient.
- Two stakeholders noted that while health care disparities are difficult to measure, creating a hospital unit of analysis that linked the demographic statistics from the hospitals’ catchment area would be very worthwhile. Another stakeholder from a reporting organization encouraged a regional approach to measuring quality reasoning that it may not be as specific as a report about an individual provider, but it offers more detail than a statewide report.
- One stakeholder observed, “Equity is a derivative of the other five IOM domains.” In other words, the potential to measure equity exists in virtually all quality indicators as long as sociodemographic data are collected along with the quality indicators. The stakeholder mentioned that geocoding may help solve this problem.
- There is also a void in the number of Timeliness measures for physicians, hospitals (other than door-to-needle measures), and specific treatment options.

**“Equity is a derivative of the other five IOM Domains.”**

—Reporting organization

## Professional Associations/Physician Organizations

Professional Associations/Physician Organizations mentioned very different gaps in quality measurement with virtually no overlap within their group. However, this group shares concern about burdening providers with too many measures.

### Structural Gaps in Reporting

- Several stakeholders stated that there are “no resources available to help physicians to collect, analyze, or report data” and that this is a big challenge for primary care physicians. In a related comment, some expressed concern about too much transparency driving physicians away from cooperating with measurement or even continuing to practice. The stakeholders suggested that those requiring quality reports be judicious in choosing what to measure.
- One stakeholder from the association/physician organization group noted that political interests are working their way into measure sets. For example, he considered the new cultural competency indicators for physicians offensive and unquantifiable, and therefore ineffective in identifying health disparities.
- Another structural gap in quality measurement relates to quantifying “dropped hand-offs” between providers. A stakeholder asked, “How do we make sure instructions are followed and information is forwarded to the PCP?” He noted that readmission is a big and expensive problem and that “quality, safety, and economic issues are tied up in these dropped hand-offs.”
- One stakeholder identified a gap in the availability of national comparisons to California results and felt that “private payers may find it useful to see CMS physician indicator results compared to California results.”
- Publicly reporting results at the physician group level with private reporting at the individual physician level was considered the most optimal for improving outcomes. Respondents observed that care is a “team sport” and mid-level practitioners deliver 30 percent of care, so reporting individual physician scores may not be accurate.

**“[Physicians are] being forced to participate in reporting quality, but are not yet properly prepared.”**

— Professional association

### Gaps in IOM Domains

- There were several suggestions for measuring efficiency. One stakeholder mentioned the gap in capturing Emergency Department use and “how to cut down on preventable trips to the ER.” Another mentioned that episodes of care — “a systematic approach to care for conditions, such as diabetes” — is more important to measure than individual services or processes.

### Gaps in Health Conditions

- One stakeholder reported gaps in measuring hospital-acquired infections, surgical outcomes, and service-related measures (although it was noted that the PAS survey helps capture the service topic somewhat).

## SUMMARY OF OPA’S ROLE IN PUBLICLY REPORTING QUALITY PERFORMANCE INFORMATION

During the interviews, the CHPR staff asked two questions regarding OPA’s role in publicly reporting health care quality information: “What do you think OPA might do to encourage the collection of necessary data for additional quality measurement and public reporting?” and “What might OPA do to increase coordination between government and private sector stakeholders around quality measurement and public reporting?”

**“OPA is doing a good job in reporting information about quality.”**

— Government agency

### Government Organizations

The vast majority of government stakeholders volunteered that OPA is “doing a good job in reporting information about quality.”

#### Statutory/Regulatory Authority

- Three government stakeholders pointed out issues surrounding OPA’s limited authority to require data collection and reporting. Two felt OPA’s role is supported enough at the agency level to continue its momentum with moving the quality reporting process forward. The other stakeholder felt that OPA needs more (formal) authority in order to improve reporting participation.

#### Collaborative Efforts

- Five of the 10 stakeholders mentioned the need for collaboration among the government departments and offices. A few commented on being “expected to work with each other” as related to the Governor’s Executive Order.
- Four stakeholders mentioned the need to meet together more often to discuss the quality performance reporting issue. Comments ranged from the need to create a “Quality Council of government interests to problem solve” to expressing appreciation for OPA’s April 2, 2008 “Public Reporting on Health Care Quality for California State Agencies” meeting and expressing interest in continuing such meetings.
- One stakeholder suggested that OPA, CDPH and OSHPD should collaborate to go beyond process measures (the “low-hanging fruit”) to drive the field of reporting toward outcomes measures.
- Several stakeholders wanted to utilize OPA’s expertise in public reporting, including learning more about social marketing and data presentation. One stakeholder mentioned that OPA could collaborate with sister departments to apply for quality reporting funding. The stakeholder cited a Commonwealth quality reporting RFP that contained considerable funding, but went un-bid by California because there was no lead agency to execute the RFP.

### Centralized Quality Performance Portal Site vs. Multiple Reporting Sites

- Six government stakeholders recognized OPA’s expertise and experience in publicly reporting quality data and would consider linking to or reporting data through OPA’s Quality Portal site. Some were open to having their quality data reported on OPA’s Report Card while most were more interested in OPA acting only as a portal to connect to their home sites.
- Those government stakeholders only interested in using OPA’s Quality Portal to connect to their site agreed that the information should be reported to the consumer in a uniform manner. One specifically mentioned the importance of a “seamless view” for the consumer.
- One suggestion focused on creating a summary comparison of all product lines on OPA’s Report Card, but also creating website links to the “drill-down detail” that would be located independently in each government organization’s site.

**“Not many people know about OPA and its Health Care Report Card.”**  
— Government agency

### Marketing OPA

- Two government stakeholders thought OPA should put more effort into marketing itself. “Not many people [consumers and other decision makers] know about OPA and its Health Care Report Card.”

### Communication

- Stakeholders representing three different government organizations discussed the need for OPA to define its end-users of the Report Card and Quality Portal (i.e., consumers, policy makers, purchasers, etc.). They suggested talking with end-users to learn how to present information in the most useful way.
- One stakeholder finds OPA’s website “user-friendly.”
- Another stakeholder expressed interest in using OPA’s experience with consumers and public reporting to help it “translate” its data and reports into a consumer-friendly format.

### Concerns

- Two stakeholders raised the issue of “clinical authority.” OPA “should not reinvent the wheel” with regard to clinical quality measures, partly because it does not have the clinical expertise to do so. One stakeholder asked whether OPA should strive to gain more expertise in this area.
- A stakeholder expressed concern for the financial and staff resources needed to maintain the system for collecting, analyzing, and reporting quality data.
- Also, some concern was expressed about data “freshness” and how to report data in a timely manner.

## Health Plans

The health plans felt that OPA greatly improved its quality reporting over the years.

### Collaborative Efforts

- Two health plan stakeholders were supportive of OPA taking the lead in collaboration among various stakeholders in reporting quality measures. They thought that OPA's mission ("serving the interest of the people") helps maintain the integrity and neutrality of quality reporting.
- One stakeholder appreciated OPA's efforts to collaborate with the organizations that do the "heavy lifting" (data collection), and also appreciated that OPA participates in industry meetings around quality measurement.

### Measurement

- Two stakeholders advised OPA to focus on the consumer education aspect rather than measure development. They stated that OPA should not require more measurement or data collection, but instead it should simplify the information it already reports to consumers.
- Two stakeholders reported that data collection is a burdensome task and becomes more so when multiple groups ask for similar data in different formats.

**"Explain the information you already have to consumers in a useful and simple manner."**

— Health plan

### Centralized Quality Performance Portal Site vs. Multiple Reporting Sites

- One of the three health plan stakeholders suggested producing a central site where consumers can compare the quality of care of all health care provider types.

### Communication

- All plan stakeholders said that communication is very important, but their emphasis differed somewhat. Two said that OPA and other report card sponsors need to do more to understand whether the end users find the information helpful and understandable. One stakeholder also would like to know more about who uses the Report Card.
- Another stakeholder urged OPA to focus on translating the information and educating the public to understand the results published on its Report Card.
- Two health plan stakeholders said that the rating format chosen to communicate health plan performance is critical. The differences between many rates are insignificant or, in some cases, are due to documentation issues rather than actual performance issues. They advised OPA not to differentiate each plan, but perhaps simply aggregate indices (e.g., what are the best organizations? Or, "Males 50 yrs. + receive the best heart disease care at the following organizations..."). They felt this reporting method would be more meaningful to consumers.

- One stakeholder mentioned that state benchmarks should be included in physician organization performance reports so readers know how groups perform comparatively. It was noted that while consumers can't choose between doctors who are located in L.A. and Sacramento, the pressure to improve a medical group's overall rating compared to a state average probably would be motivating to physician organizations.

## Consumer Advocates

The stakeholders gave positive reviews of OPA's quality reporting efforts, but would like to see more health care quality information.

### Statutory/Regulatory Authority

- The consumer advocate stakeholders agreed that OPA lacks the "political heft" to mandate data collection or reporting. Because reporting is voluntary, gaps exist in the data. There was a difference of opinion as to whether OPA should have statutory power to mandate data collection and reporting.
- One stakeholder thought that there was no big role for OPA in determining health care quality measures or public reporting.

**"[OPA is] in a strange and contested space in government."**

— Consumer advocate

### Centralized Quality Performance Portal Site vs. Multiple Reporting Sites

- One stakeholder commented on the various quality reporting formats between different government websites. It was recommended that OPA work to centralize the reported data on one site with a uniform format for all government organizations.

**"Most consumers don't know about the Report Card. A one shot effort is made annually and then it's forgotten. You have done good work, but you're not reaching consumers."**

—Consumer advocate

### Marketing OPA

- All the consumer advocate stakeholders agreed that OPA should focus more effort on marketing its Report Card to consumers.
- Another stakeholder thought that the OPA budget for advertising the Report Card was \$50,000-\$100,000 which is "not to California's scale." OPA needs to advocate for increased funding to improve its consumer outreach.

**"There is much information available about how to effectively communicate with consumers, but it's not been taken to the next level yet."**

— Consumer advocate

### Communication and Presentation

- One stakeholder advised OPA to take advantage of the research and investment already made in social marketing. "There is much information available about how to communicate effectively with consumers, but it's not been taken to the next level yet."

- One stakeholder commented that OPA draws no conclusions about the data reported (i.e., “Health Plan A improved on all measures in 2006”). This type of summary would be very helpful to consumers.
- Another stakeholder noted that trend information about health plan performance over a specific time period is more important for decision makers (especially purchasers) than snapshot data.
- One consumer group (Health Access) is open to linking its website to OPA’s Quality Portal site.

## Quality Reporting Organizations

### Collaborative Efforts

- Three of the seven quality reporting organization stakeholders encouraged the pooling of quality data. Specifically, two recommended that OPA encourage health plans to pool their databases to increase denominator sizes for physician reporting on efficiency and effectiveness. Another suggested that the state create a data warehouse where all health care entities would be required to report quality performance data (i.e., OSHPD cost data, and claims data from Medicare, commercial, Medi-Cal, FFS, etc.) to “give power to the numbers.” Maine was cited as a good example for pooling data. (It publicly released its pooled data in Spring 2008.)
- One stakeholder mentioned some concern over whether OPA had the statutory power to oversee the collection and pooling of data.
- Another collaborative idea from a stakeholder was to encourage OPA and OSHPD to work closely together.

### Measurement

- A quality reporting organization recommended that OPA encourage reporting data that can be “rolled up and down” by levels: individual physicians, physician groups and health plans. Offering a variety of data presentations from summary aggregate measures to detailed granular measures would be very helpful to stakeholders with different interests.
- One stakeholder suggested that OPA foster pressure in California to encourage more PPO participation in HEDIS/CAHPS reporting.

## Professional Associations/Physician Organizations

These stakeholders reported their continued interest in collaborating with OPA on publicly reporting health care quality performance in California.

### Communication

- One stakeholder mentioned that OPA should provide simpler information and less of it by focusing on the most meaningful measures. Obtaining feedback from OPA’s audience (providers

**“More does  
not translate  
to better.”**

—Professional association

and “choice makers”) about the types of information they use in their decision making would be very helpful. Another stakeholder held a similar opinion. “How do you put together the metrics so that stakeholders (hospitals, consumers, purchasers, etc.) can look at a simplified report and draw valid conclusions about the comparative quality of hospitals? It doesn’t take 150 metrics to do this—maybe 15 or 22.”

- One stakeholder recommended that OPA study social marketing and consumer usability testing as ways to improve the usefulness of the Report Card.
- One stakeholder considered educating the general population about the benefits and pitfalls of data measurement as critical to fulfilling OPA’s mission.

### Measurement

- One association/physician organization stakeholder mentioned that OPA or its affiliates review the utility of measures periodically, especially if there is little to no difference in high ratings between groups.
- Another association/physician organization stakeholder mentioned that any focus on health disparities/equity needs to be well defined. CHIS data could be used to identify disparities between groups and focus public attention at the societal level rather than criticizing a clinical group practicing in an underfunded clinic. This stakeholder felt that underfunded clinics and underequipped facilities cannot be held responsible for health disparities.

**“If the health issue  
has become less  
relevant, then retire  
the measure.”**

**—Professional association**

### Collaborative Efforts

- One stakeholder mentioned that OPA should be involved with the California Regional Health Information Organization (CalRHIO) Board and another mentioned that OPA should advocate for adequate Health Information Technology resources for physicians and medical groups.
- Two stakeholders recommended that OPA reach out to practicing physicians and draw them into the discussion about measures under consideration for public reporting.

## V. Findings and Recommendations

These report findings demonstrate the need for California to coordinate a statewide, common quality measurement system that reduces duplicative quality data collection efforts. OPA is well positioned to facilitate much of this work due to its positive reputation among a variety of stakeholders and its historic position within the hub of California's quality measurement and public reporting network. The report recommendations provide methods to fill in existing measurement gaps, refine public reporting, and improve OPA's communication efforts. OPA may use these suggestions individually or in combination with one another.

**“Somebody needs to be delegated in California to help with this problem.”**

—Reporting organization

### Data Gaps Revealed in Inventories

The five QPM Inventories revealed gaps in the availability of measures related to some IOM domains and health conditions.

#### Finding 1: Data Gaps

The IOM's *Effectiveness* domain (evidence-based avoidance of overuse of inappropriate care and underuse of appropriate care) had the most relevant number of quality indicators and provided the richest amount of quality data. The *Patient-Centeredness* (care is respectful and responsive to patient needs, preferences, and values) domain also had a significant number of related quality measures. *Patient-centered* measures were related mostly to the CAHPS patient experience survey series. Any information gaps found within the CAHPS survey topics are consistent across all providers because the core questions are essentially the same regardless of provider type.

**“There's a whole universe of stuff that isn't looked at. What we're measuring isn't quality overall, but just pieces of quality.”**

—Government agency

The *Safety* and *Timeliness* domains (“avoidance of injury from care” and “wait times for care and harmful delays in care from patient or provider perspective,” respectively) had several quality measures sprinkled throughout each Inventory. The majority of *Safety*-related indicators reside in the Nursing Home and Hospital Inventories. The *Timeliness* indicators primarily related to administration of medications or patient perceptions of receiving timely care.

#### Recommendation 1A

To shore up the number of reportable *Safety* indicators, OPA should continue to collaborate with the California Department of Public Health (CDPH) to report hospital adverse events (medical errors) and hospital acquired infection rates as available. Although data are not expected to be publicly available through CDPH until 2011, OPA may be able to assist CDPH by posting some data earlier on the existing OPA website. A link to the CDPH website should be maintained.

### Recommendation 1B

OPA should translate the surgeon-specific data from OSHPD's CABG surgery reports into consumer-friendly terms and post findings on its Portal site. This will boost the number of patient safety indicators publicly reported while making these results more accessible to consumers.

**“The rubber hits the road with reporting on [individual] doctor and hospital providers.”**

—Government agency

### Recommendation 1C

New physician safety-related metrics may soon be available for public reporting, and OPA should evaluate their suitability. Although sources, such as Medicare's Physician Quality Reporting Initiative and Integrated Healthcare Association's (IHA) P4P, do not yet publicly report individual physician metrics, OPA should advocate for the public release of this information and be prepared to report it when available.

### Finding 2: Data Gaps

Inventory analysis and stakeholder interviews confirmed that there is a dearth of indicators related to the IOM domains of *Efficiency* (avoidance of wasting resources) and *Equity* (care that does not vary based on population or individual characteristics). Although there are few *Efficiency* measures

**“There is still a struggle with how to capture or measure efficiency.”**

—Reporting organization

currently available, most quality reporting organizations reported a concerted effort to developing “efficiency of care” or “episodes of care” metrics. These metrics combine multiple interventions (e.g., pharmacy, lab, hospital and physician services) used to treat a health condition and capture the efficiency of care delivered. Theoretically, *Equity* can be measured using almost any quality indicator as long as sociodemographic data are collected and linked to the indicators.

More could be done to examine disparities in care using equity-related measures. (For example, a researcher recently presented Medi-Cal plan performance data by race, ethnicity, and language [Rodriguez, 2008]).

### Recommendation 2A

To advance the development and implementation of *Efficiency* measures, OPA should advocate for the public use of reporting organizations' proprietary “episodes of care” metrics that are under development (e.g., RAND or Thomson/MedStat) and track other emerging efficiency indicators (e.g., IHA and Hospital Value Initiative) to ensure their inclusion in the Portal once they are available.

### Recommendation 2B

OPA should work with its quality measurement and public reporting network (both public and private sectors) to construct a plan for collecting and reporting *Equity* measures at all levels of health care. For example, OPA should continue its effort to encourage CCHRI to use sociodemographic data already collected in the CAHPS survey. Also, if the results

from an ongoing NCQA pilot project determine that (Medicare) plan data can be used to examine health disparities, OPA should advocate for matching *Equity* data with existing clinical quality measures and reporting health care disparities. Using pooled data may address concerns about appropriate sample sizes.

### Finding 3: Data Gaps

Stakeholders agreed that there are a sufficient number of quality measures available (some of “better quality than others”) and that reporting entities need to selectively choose indicators that reduce the data collection burden on providers. Stakeholders encouraged OPA to report on indicators that:

- reflect variation in quality (significant differences)
- provide opportunities for improvement
- focus on elective interventions
- target clinically important conditions (high cost or prevalence)

### Recommendation 3A

Using this set of criteria, OPA should periodically review the indicators it publicly reports. Indicators with little variation or where opportunities for improvement are low or non-existent should be replaced with more informative indicators where provider or consumer actions will result in improvements. As a first step to determining the threshold for such decisions, OPA might consider convening a technical panel to review specific criteria.

### Finding 4: Data Gaps

Across the spectrum of health care stakeholders interviewed, most acknowledged or agreed that the more granular or discrete the reporting level the better. For example, most stakeholders believed that reporting at the individual physician level was crucial to consumer decision making and should be the next step in public reporting, and yet little information is publicly available by provider. There are many nationally-approved process and quality indicators measuring physician performance at the individual and organizational levels (see Physician Organization Inventory in Appendix D for details).

One state initiative, CCHRI’s California Physician Performance Initiative (CPPI), collects data at the individual physician level with results privately reported to participating physicians. However, this initiative is in a pilot phase and concerns remain about data reliability and whether results are accurate enough for public reporting.

### Recommendation 4A

Reporting quality data at the individual physician level will take patience and tenacity. To help bridge the political chasm and push forward with reporting California physician quality, OPA should continue to work with IHA in reporting quality by physician organization, and also should consider partnering with CAPG to publicly report data from its proprietary *Standards of Excellence* survey (survey details on page 46). While the survey does not measure clinical quality, accepting CAPG’s invitation to share its Information Technology survey results can serve as a critical step for OPA to establish a positive relationship with physician organizations.

**“There is more value at discrete levels of reporting.”**

—Reporting organization

### Recommendation 4B

OPA should consider supporting CCHRI in its effort to eventually publicly report individual physician performance data. As a neutral third-party, OPA can work with vested stakeholders and advocate for establishing acceptable physician data collection methods to improve Californian's access to useful, pertinent health care information. In addition, OPA's support for expanding CCHRI (and IHA) data collection to include Medicare and Medi-Cal data would help address the issue of small denominators (which is a significant barrier to physician performance measurement) and permit more detailed, product line analyses.

**“The unit of analysis should be more granular—especially from the consumers’ perspective.”**  
—Reporting organization

### Recommendation 4C

In addition, participating in national initiatives, such as the Consumer-Purchaser Disclosure Project or Charter Value Exchanges (project descriptions on page 27), would support OPA's effort to bring individual physician performance results to the public. Participation in national initiatives also may allow California earlier access to national benchmark data to compare with California data.

**“Reporting at the physician and hospital levels is the most useful to stakeholders. Reporting at the plan level is only a necessary to stop to getting the system to move toward full reporting at the practitioner level.”**  
—Professional association

### Finding 5: Data Gaps

OPA highlighted nine key health conditions in the QPM Inventories. Of these, at least half had quality measures related to them. The most frequently measured conditions related to heart disease, cancer, asthma, and diabetes. Those health conditions less likely to have quality measures associated with them were mental health, COPD, reproductive health, hypertension, and musculoskeletal conditions.

In addition to the key conditions of interest, the Inventories also included metrics related to a handful of other health conditions and care methods including pneumonia (community-acquired), surgical infection prevention, stroke, gastroesophageal reflux disease, immunizations, and antibiotic timing. The vast majority of the conditions of interest to stakeholders were measured with hospital process or structure metrics rather than health outcomes metrics.

### Recommendation 5A

OPA should work with its quality measurement and public reporting network (both public and private sectors) to periodically review the types of health conditions measured to ensure that the high cost or high prevalence conditions are included in public reporting (and replace those conditions not meeting the criteria). Specifically, OPA could collaborate with CDPH and OSPHD in 2009 on highlighting hospital-acquired infection rates.

**Recommendation 5B**

OPA should report on its Portal site the progress of DMHC’s “Right Care Initiative,” which supports managed care plans efforts to meet the national 90<sup>th</sup> percentile goal for diabetes, heart disease, and hospital-acquired infection care. Information for consumers should include “Why this is important” information similar to the summaries offered in OPA’s Health Plan Report Card. As goals are met and new initiatives emerge, OPA’s focus should change to highlight other issues. Such an effort would demonstrate coordinated effort by California to improve quality of care.

**OPA’s Role in Measurement and Public Reporting**

**“OPA has done a valuable service.”**

—Professional association

OPA enjoys a favorable reputation among the stakeholders interviewed due, in part, to its continued, inclusive efforts to solicit feedback from these organizations. Stakeholders believe OPA should continue to publicly report available quality measures, and it also should facilitate stakeholder discussions. However, stakeholders concluded that OPA should refrain from developing or mandating quality measures.

**Finding 6: OPA’s Role**

Stakeholders from the public and private sectors perceived OPA as the appropriate, neutral organization for reporting health care quality data. Several stakeholders identified OPA as the appropriate entity to organize stakeholder discussions about publicly reporting information about quality.

In general, the Portal concept was supported and considered to be the appropriate location for communicating California’s health care information.

Several stakeholders advised that OPA refrain from developing clinical quality measures because other organizations are more qualified to create those types of quality indicators. One stakeholder specifically cautioned OPA to avoid this type of “mission creep.” Instead, OPA should report those measures endorsed by respected organizations, such as NQF or AQA.

**“[OPA should] beware of mission creep—don’t go beyond public reporting.”**

—Reporting organization

**Recommendation 6A**

OPA should engage the Health and Human Services and Business, Transportation and Housing Agencies, and the Governor’s office to coordinate health care quality measurement and reporting in California. A centralized, coordinated effort to measure and report quality across the health care spectrum would reduce the burden on providers and would ensure a robust and efficient quality performance reporting system.

### Finding 7: OPA's Role

Stakeholders from all categories identified the need for OPA to clearly define the audience(s) or end-user(s) it serves. There are many groups with distinct interests that are interested in quality performance data (e.g., privately insured consumers, government agencies, policy makers, providers, etc.) and many stakeholders were confused as to which group(s) OPA serves.

#### Recommendation 7A

OPA should reaffirm and clearly identify its target audiences, which should include managed health care members (including PPO subscribers), policy makers, researchers, and publicly-insured beneficiaries. OPA should consider making a “Research and Policy” tab more prominent by moving it to first level (green) bar rather than its current position at the second level (blue) bar under “Quality Report Card.” This new format would be more dynamic and permit repackaging of valuable quality data that would provide public decision makers with critical information applicable to the macro level. Specific reports may include product line comparisons, trend information, or regional variation in care. National benchmark data, California IMR data, and white papers addressing emerging issues could be housed in this location as well.

### Finding 8: OPA's Role

Government stakeholder comments about gaps in measures revealed that a tension exists between the increasing pressures on government entities to collect, analyze and publish quality data and the entities' traditional regulatory role. Most of the government organizations related to health care are regulating bodies charged with enforcing state laws and regulations. Publicly reporting the quality of health care is a new role for most entities and one that requires more technical and financial support. OSHPD, CDI, MRMIB and DHCS were amenable to OPA's assistance in public reporting.

**“OPA, OSHPD, and CDPH could work together to change the focus from just process measures to outcomes measures.”**

—Government agency

#### Recommendation 8A

OPA's first overtures for government collaboration were made at its April 2008 “Public Reporting on Health Care Quality for California State Agencies” meeting and should be followed up with the interested departments. Specifically, OPA should continue to work with OSHPD to translate some of OSHPD's valuable hospital quality data into lay terms for public reporting on OPA's website. Choosing to report “elective” treatments that OSHPD studied would yield the most benefit to consumers.

**“We are willing to share any information to improve the report card because we know there is value there for the beneficiaries.”**

—Government agency

#### Recommendation 8B

Continued collaboration with CDI to post new PPO quality data results on the OPA and CDI websites is another suggestion for OPA. From a consumer perspective, it would be more efficient to have all PPO and HMO plan results published on one site rather than

forcing consumers to toggle between multiple sites. Assuming CDI also publishes the PPO data on its own website, OPA should offer its Report Card template and reporting expertise to CDI to achieve a uniform presentation for consumers.

### Recommendation 8C

OPA should also continue to forge a reporting partnership with DHCS and MRMIB to provide quality data that are pertinent to their beneficiaries and are easily accessible through the OPA website. This approach not only provides important quality performance information, but also permits these beneficiaries to use other helpful information links provided only through the Quality Portal site. Furthermore, reporting the public insurance system's information about quality on the same site as commercial plan information allows researchers and policy makers to compare product lines. Similar to the CDI approach, the same information could reside on the DHCS and MRMIB websites to increase the probability that consumers will access and use this information.

### Finding 9: OPA's Role

Public reporting of quality data is increasing, but many stakeholders remarked that consumers are not considering the information in their health care decisions. Stakeholders speculated the reasons may be because:

- ultimately, consumers have very little control over provider choices (especially those enrolled in public insurance programs),
- the measures reported reflect conditions where patients have no choice in choosing care (heart attack care versus maternity care),
- the measures are not at a specific enough level (“how does *my* doctor rate?”), or
- the measures are not outcomes related. This observation relates to an aforementioned finding that choosing the “correct” (useful and “actionable”) indicators are critical to effective public reporting.

### Recommendation 9A

To encourage more consumer use of data, OPA should facilitate a roundtable discussion with public and private sector stakeholders in and beyond California's quality measurement hub. The meeting goal should focus on the types and number of quality measures that California should be reporting. Possible agenda topics include culling non-informative metrics (due to no variation or standard met), choosing new metrics for conditions that are high cost/prevalence, identifying additional conditions for a public-private partnership to target for improvement (similar to DMHC's “Right Care Initiative”), identifying funding needs and sources, increasing decision maker use of such quality data, and creating a single data warehouse that pools data (i.e., lab, pharmacy, hospital and physician data, etc.) from the private and public sectors.

**“Push one reporting system that is not duplicative.”**

—Professional association

## Presentation and Dissemination of Report Card and Portal Information

Both information access and data presentation are important to stakeholders.

### Finding 10: Presentation and Dissemination of Portal Information

The vast majority of stakeholders agreed that displaying information in a uniform manner is critical to effective communication with OPA's audience(s). They believe that a consistent format would enhance the users' understanding of quality data across service providers or product lines.

Stakeholder opinions about the most appropriate and effective presentation style varied, but there was consensus on the need to identify OPA's audience before measures are selected and the results are communicated (Recommendation 7A). Once the audience was defined, agreement on a presentation style would be more easily achieved.

**“There has been much investment in studying social marketing, but no one’s taken it on the way it needs to be taken on.”**

—Consumer advocate

### Recommendation 10A

OPA should consider capitalizing on its current format to create “theme” tabs on its website. Tabs summarizing *all* quality measures (i.e., hospital, physician, and health plan) related to a particular population (e.g., children) or a health condition could be useful to consumers who would like to know more about the continuum of care.

### Recommendation 10B

Using the same tabular website design, OPA should redesign the box format to make all sectors of the health care industry (i.e., hospital, nursing home, etc.) more prominent *and* expand the data presented. For example, OPA could propose adopting CHCF's CalNursingHome reporting system and publishing the results on the Portal under a “Nursing Home” tab. Alternatively, OPA could simply summarize or highlight CHCF's key nursing home findings on the Portal and offer a link to the CHCF site.

### Recommendation 10C

Publishing on OPA's website either specific or summary quality performance results from all health care sectors (rather than relying exclusively on website links to government departments) provides an opportunity for more consistent formatting and presentation. A uniform presentation can help the public understand complicated data and apply it comparatively.

**Finding 11: Presentation and Dissemination of Portal Information**

Some of the stakeholders encouraged OPA to study social marketing strategies to continue refining its consumer communication efforts.

**Recommendation 11A**

OPA is in the process of exploring social marketing strategies and should share the QPM report findings with appropriate consultants to ensure consideration of issues such as determining OPA's audience(s), and choosing appropriate reporting formats that accommodate multiple health care sectors (hospitals, health plans, physician organizations, etc.).

**Finding 12: Presentation and Dissemination of Portal Information**

Stakeholders from different health care sectors believed that OPA could and should improve consumer awareness about its service.

**Recommendation 12A**

Finding more opportunities throughout the year to promote the Report Card and Quality Portal website would benefit OPA, rather than relying on one annual press conference. For example, if a health plan is fined by DMHC, OPA could partner with DMHC to incorporate the Quality Portal website into the story. This would require designing a public relations campaign and encouraging OPA's sister departments to promote the Report Card and Quality Portal.

**“Do people know about the website? What has OPA done to promote the site to the public?”**

—Government agency

**Recommendation 12B**

OPA should consider collaborating with organized groups (i.e., legislators, health advocacy groups, consumer representatives, etc.) to sponsor “mini-town hall meetings” or “state of the state” presentations about health care quality (plans, physicians, hospitals, etc.) across California throughout the year.

**Recommendation 12C**

Asking health plans, hospitals, physician groups and other government departments (i.e., CDI, CDPH, OSHPD, etc.) to add prominent links on their websites to OPA's Quality Portal would also increase consumer awareness of OPA's services and facilitate consumer education. (Six of the eight health plans profiled on the OPA Report Card link to the OPA website, but it frequently required a minimum of four clicks into the website before a link was found.)

**Finding 13: Presentation and Dissemination of Portal Information**

Stakeholders' comfort and familiarity with quality performance measurement and public reporting methods vary markedly. There appears to be great opportunity for more education in these two areas to build a solid and even foundation for stakeholders.

**Recommendation 13A**

OPA should consider educating health care stakeholders in quality measurement and public reporting. OPA should continue sponsoring periodic seminars (i.e., “Lunch n’ Learn”) about both topics.

**Finding 14: Presentation and Dissemination of Portal Information**

Many government colleagues mentioned that they could benefit from OPA’s years of experience in reporting quality.

**Recommendation 14A**

When possible, OPA could act as an “internal quality reporting consultant” to other state departments that need help with quality reporting. OPA provides a strategic link to quality performance measurement and reporting in California and possesses useful knowledge and contacts. Formally designating an OPA staff person as an “internal consultant” would be helpful to OPA’s colleagues and may help push forward other QPM Report recommendations that rely on cooperation from these departments.

**Recommendation 14B**

OPA may wish to act as a conduit between funding groups and state departments in need of enhancing quality reporting. OPA could monitor (through in-house staff or a contractor) possible sources of funding and communicate RFPs to a listserv of interested state departments.

# **Appendix A**

## **List of Stakeholders Interviewed**



## Stakeholders Interviewed

### California Government Organizations

Kathryn Lowell, Undersecretary  
Business, Transportation and Housing Agency

Mary Wieg, RN, Nurse Consultant II  
CalPERS Office of Health Policy Research

Sandra Shewry, Director  
Department of Health Care Services  
(Delegated to Ellie Birnbaum: Ellie Birnbaum interviewed in person 3/3/08 with Rene Mollow, Dean Skertis, Larry Dickey, MD, Don Fields, Ellen Badley and Vanessa Baird)

David Link, Deputy Commissioner, Legislative Director  
Department of Insurance

Hattie Hanley, Health Policy Advisor, Office of the Director  
Department of Managed Health Care

Kathleen Billingsley, Deputy Director  
Department of Public Health

Ruth Liu, Associate Secretary for Health Policy Development  
Health and Human Services Agency

Shelley Rouillard, Deputy Director Benefits and Quality Monitoring  
Major Risk Medical Insurance Board

Herb Schultz, Senior Health Policy Advisor  
Office of the Governor

David Carlisle, MD, Director  
Office of Statewide Health Planning and Development

### Health Plan Representatives

Melissa Welch, MD, Medical Director  
Terri Schroeder, West Region Director, Quality Management  
Aetna, West Region

Mike Belman, MD, Vice President & Medical Director  
Anthem Blue Cross of California

Joel Hyatt, MD, Assistant Regional Medical Director  
Kaiser Permanente Southern California

Andy Amster, Director, Integrated Analytics Care Management Institute  
Kaiser Permanente

## **Consumer Advocacy Groups**

Casey Young, Advocacy Manager  
AARP

Patricia Powers, President & CEO  
Center for Health Improvement

Betsy Imholz, Director of Special Projects  
Consumers Union-West Coast

Anthony Wright, Executive Director  
Elizabeth Abbott, Project Director  
Health Access California

## **Quality Reporting Organizations**

Maribeth Shannon, Director, Market & Policy Monitor  
California HealthCare Foundation

Bruce Spurlock, MD, Chairman CHART Steering Committee  
California Hospital Assessment and Reporting Taskforce (CHART)

Tom Williams, Executive Director  
Integrated Healthcare Association

Greg Pawlson, MD, Executive Vice President  
National Committee for Quality Assurance

Arnold Milstein, MD, Medical Director  
Pacific Business Group on Health

Cheryl Damberg, Public Policy and Health Services Research  
RAND Health

Mahil Senathirajah, Senior Research Manager  
Thomson Healthcare

## **Professional Associations/Physician Organizations**

Chris Ohman, President & CEO  
California Association of Health Plans

Wells Shoemaker, MD, Medical Director  
California Association of Physician Groups

Duane Dauner, President & CEO  
California Hospital Association

Richard Frankenstein, MD, President  
California Medical Association

Alan Glasseroff, MD, Chief Medical Officer  
Humboldt-Del Norte Foundation for Medical Care

## **Contacted**

Foundation for Taxpayer and Consumer Rights

Hill Physicians Medical Group, Inc.



## **Appendix B**

### **Background Information for Interviews**

- Letter of Invitation
- Interview Protocol
- Data Dictionary



# Background Information for Interviews

January 2008

Dear,

Sandra Perez, Director of the Office of Patient Advocate (OPA), recently invited you [and your colleague(s)] to participate in a project which will improve public reporting of health care quality data for California consumers. This project will use critical input from public and private health care stakeholders to assess California's public reporting capacity of health care performance and provide OPA with recommendations to plan and prioritize future reportable measures.

This letter serves to confirm your interview logistics as well as provide preparatory material for the interview. Your interview, which will be conducted [by telephone/in person] by our staff from the UC Davis Center for Healthcare Policy and Research (CHPR), is scheduled for . [Cite location if necessary]. As you may recall, the purpose of the interview is to learn more about your organization's use of and opinions about the current quality performance measures available to California as well as future needs for quality performance measurement.

We recognize that quality measurement is a complex topic and therefore prepared this packet for your review prior to our meeting. We suggest familiarizing yourself with the enclosed materials in order to expedite the interview.

The materials include three inventories that focus quality measurements for health plans, physician organizations and "Other Sources of Data", as well as a data dictionary. In addition, we included the interview guide for your preparation.

OPA considers your organization's involvement in quality performance measurement as critical to improving the quality and transparency of health care measurement in California. We greatly appreciate your participation in this project. If you have any questions, please contact Dominique Ritley (UC Davis CHPR) at 916-734-2681.

Sincerely,

Patrick Romano  
Principal Investigator

Julie Rainwater  
Project Manager

Dominique Ritley  
Research Analyst

# Quality Performance Measurement in California

## Background Materials for Interviews

Sponsored by Office of the Patient Advocate

The Office of the Patient Advocate (OPA) is sponsoring a report on health care quality performance measurement in California with the goal of promoting quality and transparency by publicly reporting reliable and useful health care quality data. The report's first phase solicits input from stakeholders on inventories of health care quality performance measures (QPM) available to California. The attached materials provide background material for stakeholders to review in preparation for their interviews about necessary quality performance measurements.

The following materials include: the interview protocol to be administered to stakeholders; three QPM inventories which are organized by health care sector (Health Plans, Physician Organizations, and "Other Sources of Data"); and a data dictionary defining terms and categories in each inventory.

Each inventory summarizes information about the measurement set and its developer, the geographic level at which data collection occurs, and identifies the organization that collects and manages the data. The inventories link pertinent IOM quality domains to individual measures. Finally, to identify where measurement gaps exist for various populations, the inventory assigns the stage(s) in the human life cycle (age-related), the type of care (preventive, acute, management), and key health conditions that pertain to each measure.

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**Tab 1:** QPM Interview Protocol

**Tab 2:** Health Plan QPM Inventory

**Tab 3:** Physician Organization QPM Inventory

**Tab 4:** "Other Sources of Data" QPM Inventory

**Tab 5:** Data Dictionary

## **QPM Interview Protocol**

### **Current Quality Performance Measures**

1. What measurement sets or individual measures do you feel should be added to this inventory?
  - a. What is the name and developer of the measurement(s) or set(s)?
  - b. Why do you believe that this measurement or measure set should be included in the inventory?
  - c. What do you perceive as the “value-added” aspects of the measurement (set)?
2. What other quality measures does your organization currently use that are not included in this inventory, but potentially could be released to the public (or “useful to the public”)? (IF ANY: What would be the mechanism for publicly reporting these data?)

### **Future Quality Performance Measures**

3. What are the quality measures you plan to use in the near future? Please describe the name and developer of the measure or measure set, its objective(s), and its implementation timetable.
4. What group(s) does your organization partner with to collect data for these future measures? Does this partner assist with data analysis and dissemination?
5. What are your organization’s parameters for sharing the data for public reporting?
6. In what way might OPA help your organization disseminate these data for public use?
7. Many quality measurement experts acknowledge that there are gaps in the quality performance data currently available. A preliminary analysis of the inventory suggests there are gaps in measures of equity (disparities), efficiency and our ability to compare product lines. What measures would you suggest to fill these gaps?
  - a. What data sources might be available or should be explored to address these gaps?
  - b. What other gaps in quality measures do you see?
  - c. How might the gaps be filled?

### **OPA's Role in Publicly Reporting Quality Health Care Information**

8. We've talked about what your organization and other organizations do to collect publicly reportable quality information. OPA's mission is to promote health care quality and transparency for California as whole. What you think OPA might do to encourage the collection of necessary data for additional quality measurement and public reporting?
9. What might OPA do to increase coordination between government and private sector stakeholders around quality measurement and public reporting?

## Data Dictionary for the QPM Inventories

This dictionary defines the inventory categories and provides details about information recorded in the spreadsheet.

Inventory Categories	Definition
<p><b>Measurement Set and Developer</b></p>           <p>Data Availability:</p>           <p>Data Collection at Geographic Levels:</p>           <p>Reporting Cycle:</p>	<p><u>Purpose:</u> To provide a basic description and background on the measurement set developer, to establish common names of measurement sets and to identify the developer to refer to for questions of methodology.</p> <p>This column names each measurement set and organization that is responsible for developing and maintaining the measurement set. Individual measures within a set may be developed by other entities, but as a set, the named developer is responsible for the whole.</p> <p>It also summarizes the following points of information that are important to reporting consistent, comparable data.</p> <p>Assesses ease of obtaining measurement data for public reporting</p> <p>Assesses availability of data at the national, state (California) or state’s regional levels</p> <p>States how often new data becomes available for reporting (annually, quarterly, etc.)</p>
<p><b>Title/Brief Description of Quality Measure</b></p>	<p><u>Purpose:</u> To identify specific measures and learn where gaps in measurement may occur.</p> <p>Each measure within the measurement set is individually defined. Numerous measures comprise the measurement set.</p>
<p><b>Data Collection Occurs At...</b></p>	<p><u>Purpose:</u> To assess whether California data may be compared with national data and to learn where California may be leading or lagging in data measurement.</p> <p>Measures may be available for the California population and/or for the national population.</p>

<p><b>Organizations Managing Quality Performance Data by Product Line</b></p>	<p><u>Purpose:</u> To identify where the data can be found.</p> <p>The national organizations that develop the measurement sets are frequently different than the state or regional organizations that warehouse and manage the data.</p>
<p><b>Measure Relevance to IOM Six Domains of Quality Care</b></p>	<p><u>Purpose:</u> To place measurement in context of nationally accepted health care quality goals.</p> <p>This field assigns individual measures to one or more of the IOM’s six quality domains, if applicable.</p> <p><b>Safety</b>—avoidance of injury from care_  <b>Effectiveness</b>—evidence-based avoidance of overuse of inappropriate care and underuse of appropriate care_  <b>Patient Centeredness</b>—care is respectful and responsive to patient needs, preferences, and values_  <b>Timeliness</b>—Specific to wait times for care and harmful delays in care (from patient or provider perspective)  <b>Efficiency</b>—Avoidance of wasting resources  <b>Equity</b>—Care that does not vary based on population or individual characteristics</p>
<p><b>Life Cycle</b></p>	<p><u>Purpose:</u> To identify which age (and gender) populations are being measured.</p> <p>Measures are categorized according to their denominator definitions, by age and gender where appropriate. Both genders are included unless otherwise specified.</p> <p>Pediatric: 0-17 years  Adult: 18-64 years  Geriatric: 65+ years</p>
<p><b>Type of Care</b></p>	<p><u>Purpose:</u> To identify the types of care being measured and whether gaps are present.</p> <p>Measures are categorized according to whether they address Preventive, Acute, and/or disease Management care. Some measures may be assigned to more than one type of care.</p>
<p><b>Key Health Conditions Related to Measures</b></p>	<p><u>Purpose:</u> To identify whether key health conditions are being measured sufficiently.</p> <p>Pertinent measures are assigned to one of nine health conditions OPA identified based on high prevalence or high treatment costs.</p>

# **Appendix C**

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