

Quality Performance Measurement in California

Findings and Recommendations

Prepared for

The Office of the Patient Advocate

By

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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 90th 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.