

ABSTRACT

The Dirigo Health Agency's Maine Quality, with support from Aligning Forces for Quality, Quality Counts, and MHMC, plans to conduct a statewide CG-CAHPS survey of as many primary care and specialty physicians as possible in 2011, to inform consumers and support payment reform efforts. We believe that without this avenue for input from consumers, new delivery models will be less likely to succeed.

This project is aligned with elements of the State Health Plan in its emphasis on payment reforms which promote a patient-centered approach and the intent of the State to protect the public interest. The ACA emphasizes the importance of patient experience measurement in sections dealing with Medicare value-based purchasing, quality measures for the care of Medicaid-eligible adults, bundled payment initiatives, and measurement development.

We propose to administer CG-CAHPS surveys statewide to patients in as large a number of primary care and specialty care practices as possible. Success of the project will be determined on recruitment of an adequate number of practices surveyed, on reporting the results in a comprehensible manner on the DHA/MQF website, and on feedback on the usefulness of this information to consumers, purchasers, and providers.

We also propose to oversample MaineCare members to ensure that the experience of this vulnerable population is assessed and benchmarked against the entire Maine population.

We are specifically seeking support for project planning and implementation and for the cost of additional surveys to allow sufficient MaineCare membership sampling.

Question 1)

Proposal

The Dirigo Health Agency's Maine Quality Forum (MQF) plans to use the National Quality Forum-endorsed Clinician and Group Consumer Assessment of Healthcare Providers and System survey (CG-CAHPS) to assess and report patient experience of care at the level of the individual physician.

Rationale

We suggest that measurement of patient experience of care is foundational to any and all payment reform models; and that measurement and public reporting of patient experience metrics is critical for consumers, providers, and purchasers, and will be instrumental and necessary to the success of payment reform.

For providers designing new systems of care such as the accountable care organization (ACO) or patient centered medical home (PCMH), omitting or failing to monitor patient experience as changes are made would jeopardize the success of the model. In *Charting a Path to Healthcare Reform: Recommendations for the Field* (Robert Wood Johnson Foundation June 17, 2010), the authors state, "Reform efforts that are not informed by consumers' perspectives are not likely to achieve the desired perspective of high value care for consumers. That point is particularly true if consumers feel they will lose flexibility or autonomy in where and from whom they seek care. In addition to payment changes, consumer benefit design must be adjusted to improve the alignment of consumer and payment incentives." Citing the difficulties of providing effective care in an environment of mistrust, Mirabito and Berry conclude, "The hard truth is that PCMHs will not realize their potential unless they offer a better total experience to patients and to the caregivers who serve them—without overutilizing resources—than alternative models of care. For this to happen, a genuine sense of partnership between patients and providers must prevail." (Mirabito AM, Berry LL. Lessons That Patient-Centered Medical Homes Can Learn From the Mistakes of HMOs. *Ann Intern Med* 2010; 152:182-185.) In short, patient experience metrics will help designers and implementers of new payment (and care) models avoid predictable pitfalls by ensuring that the patient voice is helping to drive these efforts.

For clinicians, structured inquiries into patient care experience allow for practice quality improvement. In a discussion of new care models and the impediments to their success, Harold Miller writes, "Physicians and other providers are willing to accept accountability for outcomes in general but do not want to accept responsibility for poor outcomes due to lack of adherence to recommendations. Patients are either unwilling to follow recommendations or are more likely unable to do so." (Harold Miller. *Making Reform a Reality: Ways to Facilitate Better Healthcare Payment and Delivery Systems and Lower Healthcare Costs*. Robert Wood Johnson Foundation. January 17, 2010). An understanding of the care experience as perceived by the patient may facilitate necessary

changes in the local delivery system that would help patients adhere to recommendations. Fisher et al note “Without persuasive measures, patients will not have confidence that new alternatives to volume- and intensity-based payment are really giving them greater value, rather than just providing new pressures to withhold potentially valuable care” (Fisher ES, McClellan MB, Bertko J, Lieberman SM, Lee JJ, Lewis JL, and Skinner JS. *Fostering Accountable Health Care: Moving Forward In Medicare*. Health Affairs, March/April 2009; 28(2): w219-w231).

Local and peer-reviewed research indicates a gap between perceptions of care by providers and by patients. Olson and Windish (Olson DP, Windish DM; *Communication Discrepancies between Physicians and Hospitalized Patients*. Arch Int Med 2010; 170 (15): 1302-1307) documented this gap in an inpatient setting, using CAHPS patient experience surveys. A Hanley Leadership Development Course group found similar gaps through focus group discussions with ambulatory patients and surveys of clinicians, particularly in the area of communications and care coordination. In this study, consumers frequently reported gaps in support for care coordination and in communication, while providers were largely unaware of these gaps. (*Building Consumer Engagement in the Sustainability of Primary Care: “What Does an Effective Medical Home Look Like to Consumers?”* Institute for Civic Leadership, Daniel Hanley Center for Health Leadership. Health Leadership Development Course II Practicum. May 1, 2009). In *Improving the Health of Maine People: Getting Down to Basics* (Maine Health Access Foundation, January 2010), MeHAF communicated problems with the health care system as viewed through the consumers’ eyes. In addition to administrative issues with MaineCare and problems with ready access to care, confusion and lack of understanding of health information and illness issues was found to be a problem in consumers’ ability to be active participants in their care and a barrier to health improvement. This underscores the importance of patient feedback as operational information to providers to help them uncover opportunities to improve the patient experience through a variety of ways.

In summary, because of the demonstrated ability of patient experience surveys, specifically CG-CAHPS, to reveal gaps in system performance, to enhance loyalty to practices, increase member satisfaction, and to correlate with better performance on effective care processes and outcomes, creating a system to measure patient experience is foundational to the success of any new payment reform model.

Methodology

While there are increasing numbers of sources of information on patient impressions and satisfaction with encounters with the health care system, CG-CAHPS is the only standardized instrument for surveying and analyzing patients’ experience with specific aspects of care. Developed by the Agency for Healthcare Research and Quality (AHRQ), CG-CAHPS is part of a suite of patient experience surveys which also includes H-CAHPS, used by all Maine hospitals to assess inpatient care experience. Its questions have been validated through psychometric testing to provide insight into the ambulatory patient experience. Its sampling methods are scientifically sound, and its results are

statistically valid. This scientific basis differentiates it from other satisfaction surveys and unfiltered patient opinion information published on the internet. The survey can be modified to look at specific issues of the outpatient care process as perceived by patients, such as racial and ethnic disparities, specialty care, or care coordination. The CG-CAHPS survey tools are in the public domain, and technical assistance is available from AHRQ for analysis and reporting of results as well as for using the survey results to improve the experience of ambulatory care.

We are also proposing and are seeking funding to ensure adequate sampling of practices for MaineCare members, in order to make certain that patient experience in this population is measured. Targeted sampling is needed because using a standard sampling approach of 40 patients per provider would likely result in surveying only 2-8 MaineCare members (the average primary care practice population consists of approximately 5-20% MaineCare enrollees and uninsured). Such a small number of MaineCare members surveyed per practice may not be enough to specifically measure their experience, depending on the level (population, health system, practice, etc.) of analysis. Ensuring that sufficient numbers of MaineCare members are surveyed will help ensure that quality is improved for these vulnerable populations, and may require oversampling of MaineCare members.

We intend to publicly report the results of this survey data. Currently, two states (California and Massachusetts) report CG-CAHPS survey results on public websites (http://opa.ca.gov/report_card/medicalgroupcounty.aspx and <http://www.mhqp.org/quality/pes/pesMASumm.asp?nav=031600>). Part of the funding for this project will support planning activities focused on identifying ways to conduct the survey that are most useful to consumers and fair to providers. Consumers need information on the experience of patients in a practice in order to decide whether to select that practice. We have been told by consumer organizations that this is the information that is most important to consumers. From a provider perspective, the issue of public reporting of this information could be perceived as threatening. However, experience in other states with patient experience in the practices participating in the Maine Patient Centered Medical Home Pilot, and early experience with the Robert Wood Johnson Foundation-funded CG-CAHPS demonstration (see section 2 below) suggests that there is enthusiasm in practices for discovering this information. As part of this funding opportunity, MQF plans to convene a statewide Learning Collaborative on CG-CAHPS in ambulatory practices to educate providers on the validity and utility of these surveys in improving patient-centeredness.

Question 2)

The Dirigo Health Agency's Maine Quality Forum is demonstrably qualified to pursue this work. The MQF has a long record of measuring and reporting provider performance.

MQF was created in 2003 as part of the Dirigo Health Agency. Its enabling legislation calls for MQF to identify, coordinate, collect, and report performance measures on individual providers. MQF has been reporting on hospital quality for several years. These reports include measures on cardiac care, pneumonia care, healthcare associated infection prevention, surgical care, and nursing sensitive care indicators including care transition measures. In addition, MQF has evaluated and displayed variations in regional utilization using the hospital discharge data base. MQF, in collaboration with Health Dialog Analytic Solutions, has done two major analyses of Maine's all-payer claims database. The first was a pilot project demonstrating the capability of the information in the data base to show variation in utilization and quality and included a study of regional variation in the use of advanced imaging across healthcare service areas in the state. The second project, *Healthcare Variation in Maine: and All-Payer Analysis* (April 2009), was a study of cost drivers in ambulatory and inpatient care.

In addition, MQF

- Is a convener, along with *Quality Counts* and the Maine Health Management Coalition and through that effort has actively supported keeping patients at the center of reform efforts.
- Supports the Pathways to Excellence initiative on physician and hospital performance measurement and reporting of the Maine Health Management Coalition.
- Convened and supports the Maine Infection Prevention Collaborative, among whose projects are measurements of performance on hand hygiene measures and determination of the structural measures of adequate infection control programs.
- Serves on the Steering Committee of the Robert Wood Johnson – funded Aligning Forces for Quality project which has an area of focus the coordination of healthcare quality reporting.
- Participates in and serves as a board member of Quality Counts, a broad stakeholder group with experience in public engagement and discussion of care issues and

MQF operates on a public platform with broad stakeholder input. Its Advisory Council includes consumers, purchasers, payers, and providers. Its projects are approved by the Advisory Council and ultimately endorsed by the Dirigo Health Agency Board of Trustees before they are initiated.

MQF has access to national experts on measuring and publicly reporting patient experience. Preliminary discussions have been held with Dale Shaller, a national authority on the CAHPS suite of survey tools and director of the National CAHPS Benchmarking Database. Through Aligning Forces for Quality we have discussed consumer accessibility of our public website with national experts on health information website design. The Maine Quality Forum, along with collaborating organization Maine HealthInfoNet, Maine Health Management Coalition, and Quality Counts, is a convener and member of the Maine Chartered Value Exchange Alliance sponsored by the Agency

for Healthcare Research and Quality. This status gives MQF preferred access to resources at AHRQ, developer of the CAHPS tools.

In addition, MQF is a convener of the Robert Wood Johnson Foundation-funded Aligning Forces for Quality project, along with Quality Counts (the grantee) and the Maine Health Management Coalition. Support from this project includes access to national experts on public reporting of performance data in a consumer-accessible manner. Moreover, assessment and reporting of patient experience is a priority of the AF4Q project. In fact, Quality Counts also holds a subsidiary grant from RWJF for a pilot project on measurement and public reporting of patient experience with ambulatory care at six practice sites. This project, supported by national experts, is currently ongoing, with the involvement of MQF.

Question 3)

Healthcare payment reform is discussed and emphasized in the 2010-2012 State Health Plan in its Chapter VI, “Pay for What Matters.” The Plan articulates several underlying principles of payment reform initiatives and describes several possible models of payment reform, including ACOs, bundled payments, global payment systems, care coordination payments, and pay-for-performance. In each, quality measurement is implicit for the measurement of the effect of the reform as well as for protection of the patient against potential disincentives for good care.

The importance and relevance of patient experience measurement to the ACO model has been discussed above. To an equally important extent, measurement of patient experience will be critical to measuring – and assuring – the success of the other four models enumerated in the Plan.

Most important is the role of patient experience measures in performance-based incentive programs. Although the highest role for patient experience measurement is arguably quality improvement for providers, there is no question that performance in measures of patient experience could be used for “tiering and steering” of providers and patients as well.

The State Health Plan also articulates six core principles for use in design, implementation, and evaluation of payment reform efforts:

- Support integrated, efficient and effective systems of care delivery and payment
- Promote a patient-centered approach to service delivery and payment
- Encourage and reward the prevention and management of disease
- Promote the value of care over volume to measurably lower costs
- Support payment and processes that are transparent, easy to understand, and simple to administer for patients, providers, purchasers and other stakeholders
- Balance the interests of patients, payers, and providers while pursuing necessary change

The second core principle describes promotion of a patient-centered approach to service delivery and payment. The antecedent document to this payment reform chapter in the State Health Plan, the Advisory Council for Health Systems Development's Report to the Legislature to Advance Health Care Payment Reform in Maine (January 22, 2010; accessible at <http://www.maine.gov/tools/whatsnew/attach.php?id=91516&an=1>) specifically requires improving the effectiveness and efficiency of care *from a consumer perspective* (italics added). There are no other valid measures for evaluating performance of a program in this area other than CG-CAHPS patient experience of care measures. The Report also specifies the promotion of shared decision making where appropriate that "recognizes patient values and preferences." Again, there is no other way of evaluating the performance of a program in this area. The success of a program in incorporating linguistic and cultural awareness, another characteristic of patient-centeredness cited in the Report, would also require patient experience measurement.

Finally, in its discussion of the role of state government in supporting and shaping payment reform, the Plan notes that government protects the public interest when weighing the merits of policy and statutory changes proposed to facilitate certain reform initiatives, "especially as they impact vulnerable populations." Monitoring valid measures of patient experience would be an important way of preserving the voice of the consumer in the shaping and evaluation of payment reforms from this perspective and assuring that an avenue for input on the impact of policy changes remains available.

It is clear from an examination of the quality measurement foundations of many of the provisions of the ACA that patient-centered outcomes will become increasingly important in the assessment of payment reform initiatives. Some specific examples follow.

- Section 3001 requires the implementation of value-based purchasing programs in Medicare, in which a percentage of payment will be tied to performance measured, among other things, by H-CAHPS (patient experience of hospital care).
- Section 2701 requires the development of care quality measures for Medicaid-eligible adults which are similar to measures required under CHIPRA. CHIPRA measures include patient experience of care measures; presumably these adult care measures will as well.
- Section 3013 requires AHRQ to identify gaps where measures are lacking. Among the priority areas for further measure development is the area of "patient experience and satisfaction."
- Section 3023 requires development of episode bundled payment pilots, in which one quality metric to be monitored includes patient experience of care.

It is clear that the value of patient experience measurement is woven into many of the initiatives required by ACA. The fact that Medicare now requires and reports on inpatient experience measurement suggests that ambulatory experience will become valuable in the future for programs aiming to avail themselves of advantages in the ACA. A program which measures patient experience would give Maine providers a head start in administering, analyzing, and reporting on performance in this area.

Patient experience of care measurement has been sustainable in the states which have engaged in it. The Massachusetts Health Quality Partners recently released a second round of reporting on patient experience at the primary care practice level. The first was reported in 2006. In Massachusetts, funding is provided by commercial health plans. In Maine, the sustainability of a publicly funded program is by no means assured. However, given the central importance of this type of quality measurement, its support from purchasers, and its central positioning in the State Health Plan and the Affordable Care Act, and given that patient surveys other than CAHPS are done by many practices now, the value of CG-CAHPS should become evident as its use becomes routine through this project. The first round of surveys will be the most difficult. With lessons learned by MQF, providers, and consumers, making patient experience surveys routine in quality measurement will be more widely accepted and easier in subsequent rounds. We foresee subsequent rounds of surveys and reports at approximately three-year intervals. This interval, at least in the Massachusetts experience, has been found necessary for practices to effect the changes necessary for improvement.

Question 4)

Quality Counts: As a strong supporter of the Care Model for chronic disease management (whose success is partly dependent of patient experience), a proponent of consumer engagement, and a convener of stakeholders from all aspects of the healthcare system, *Quality Counts* will be an instrumental participant. In May, 2010, after a discussion of the intention of MQF to measure and report on patient experience, *Quality Counts'* board endorsed MQF's efforts to conduct a statewide patient experience of care survey. Importantly, *Quality Counts* holds a grant from the Robert Wood Johnson Foundation to pilot the use of CG-CAHPS with six practice sites in Maine. The experience of this project in planning, contracting for, administering, analyzing, and publicly reporting results in a consumer-accessible format will be extremely important in informing this larger scale initiative. As the primary grantee for the Robert Wood Johnson Aligning Forces for Quality initiative (discussed separately below), *Quality Counts'* role fits well with this project.

Aligning Forces for Quality (AF4Q): Maine's Robert Wood Johnson funded AF4Q project is jointly convened and managed by MQF, *Quality Counts*, and the Maine Health Management Coalition. *Quality Counts* is the grantee. Maine's AF4Q has provided the Maine measurement and reporting community with considerable resources on consumer engagement (including orientation and coaching of involved consumers) and effective methods of public reporting including website design.

The Maine Health Management Coalition (MHMC): Through its Pathways to Excellence program, MHMC has experience in convening physicians and practice managers, as well as hospitals, engaging them in measurement and reporting. Some of the reported hospital metrics are derived from data collected by MQF and the Maine Health Data Organization. MHMC has identified the importance of patient experience of care in ambulatory practice and has made a commitment to including patient experience in its public reporting of provider performance in its “Pathways to Excellence.” The ability of this organization to convene interested providers, help generate interest, and provide input into public reporting will be important to this project.

Consumers for Affordable Health Care (CAHC): Patients value experience of care and use this information to select providers. Presence of consumers in the management and governance of this project will be important for making certain that any messaging and reporting is done in a way that is also useful and intelligible to consumers. Several discussions of this project with CAHC have already occurred. Public Law Chapter 350 requires MQF to “make provider-specific information regarding quality of services available on its publicly accessible website.” Because of its advocacy of this legislation, CAHC and MQF have discussed various choices of provider-specific information whose reporting would discharge this obligation. MQF’s decision to measure and report on patient experience of care is a direct result of those discussions.

MaineCare: Maine’s Medicaid program has experience in surveying its members on patient experience and MQF’s project will avail itself of insights gained through that process. Additionally, MaineCare’s CMS CHIPRA grant to improve pediatric care involves the use of CAHPS surveys for measuring and reporting patient experience to CMS. With MaineCare, we will look at ways to coordinate with and contribute to the CHIPRA grant project, including benchmarking experience of MaineCare members against the wider population surveyed in this project. As mentioned above, that may include the oversampling of MaineCare members in order to discern any disparities in this aspect of care quality.

Maine Medical Association (MMA) and Maine Osteopathic Association (MOA): Although patient experience of care measurement is well-established in Maine’s hospital community, and some physician practices survey patient satisfaction, the use of patient experience measures as a valuable improvement tool is not widely known or accepted in Maine’s physician community. The MMA and MOA, as well as the specialty societies that are supported by the MMA, will have critical convening functions as conversations with physicians progress and expand.

The Maine Primary Care Association (MPCA): Representing Federally Qualified Health Centers, community health centers, and Indian health centers in Maine, MPCA will be an important link to these safety net practices and will help assure their participation in this survey process. In addition, MPCA’s experience and success in quality improvement programs based on observable data will help inform the quality improvement processes that must follow patient experience measurement.

Question 5

Ultimately, success for this project will be defined as (1) acceptance and use of patient experience data by consumers and purchasers as important quality measures when selecting or compensating providers, particularly as the information will support the success and acceptance of new models of care organization and reimbursement, and (2) recognition of patient experience data by physicians and clinicians as a valuable metric of care useful for quality improvement. In the shorter term, the following milestones expressed in the project plan will define success:

- Development of a broad based steering committee, with representation by consumers, providers, and purchasers; by November, 2010.
- Project manager selected, by March, 2011.
- Survey vendor chosen and survey plan developed (including substitution of proprietary surveys by non-chosen vendors), by June, 2011.
- Administration of the survey to an adequate sample of the patient panels of physicians/clinicians representing primary and specialty care, by December, 2011.
- Publication of a report, by physician, of the survey results in a form that is acceptable to consumers and providers, on the MQF website; by June, 2012.

For purposes of payment reform support, which is the focus of patient experience measurement of the funds applied for in this application, a report will be issued by the end of 2012 which will document:

- The use of patient experience measures by consumers, measured by website visit numbers and by focus groups
- The inclusion of patient experience in benefit design by purchasers and health plans.
- The extent to which measurement of patient experience has been taken into account in the evaluation of structural payment reform models such as bundled payment models or ACOs.

Our overall vision for this project is that patient experience measurement through CG-CAHPS will become routine in assessing and reporting on care quality in Maine and that further rounds of measurement will show improvement of patient's experience of care in physician practices across the state, particularly in the vulnerable populations.

Objective	Activity / Timeframe	Responsible Party	Benchmarks and measures
Develop Project Steering Committee	<ol style="list-style-type: none"> 1. Present this project to MQF-AC for approval and identification of potential partners to collaborate on this project. 2. Present project plan to potential partners and request commitment to the project. 3. Create Project Steering Committee 4. Project Steering Committee holds its first planning meeting <p>Timeframe: September – November 2010</p>	DHA-MQF	By end of November Project Steering Committee has formed and met.
Recruit Project Staff	<ol style="list-style-type: none"> 1. Develop RFP 2. Contract with Project Manager (PM) <p>Timeframe: September 2010 – January 2011</p>	DHA-MQF	A Project manager will commence work no later than March , 2011
Develop Survey Questions	Determine questions for primary care, specialty care, and surgical care	<ul style="list-style-type: none"> • DHA-MQF • Steering 	Establish survey questions by April 2011.

	<p>surveys.</p> <p>Timeframe: January – April 2011</p>	<p>Committee</p> <ul style="list-style-type: none"> • PM 	
Recruit Survey Contractor	<ol style="list-style-type: none"> 1. Develop and publish a RFP for a contractor to administer the survey 2. Select a contractor for administering the patient experience of care survey. <p>Timeframe: May– June 2011</p>	<ul style="list-style-type: none"> • DHA-MQF • PM 	By June 2011 a contractor will have been selected to administer the survey
Distribution and Administration of Survey	<ol style="list-style-type: none"> 1. Work with providers to include the survey instrument in the vendor patient customer satisfaction module. 2. Obtain statewide lists of primary care physicians from MaineCare, Maine Health Management Coalition and Maine Medical Association. 3. Obtain statewide list of medical specialists from the medical specialties professional organizations with attention to high use specialty areas 	<ul style="list-style-type: none"> • PM • DHA-MQF • Contractor 	<p>Reach agreement with providers to include survey instrument by April 2011.</p> <p>Completed lists of primary care and specialists by end of July 2011.</p> <p>Confirm participating providers and sample sizes by August 2011.</p> <p>Distribute and administer surveys by December 2011.</p>

	<p>(cardiology, pulmonology, gastroenterology, orthopedic surgery).</p> <p>4. Solicit the participation of primary care physicians and specialists to be surveyed and the sample to be selected from each physician patient base.</p> <p>5. Distribute and administer the survey.</p> <p>Timeframe: June – December 2011</p>		
Raise Consumer Awareness	<p>Develop collateral for distribution through providers regarding survey.</p> <p>Hold educational sessions with consumer and MaineCare advocacy groups, DHHS, and other interested parties to provide information on the survey.</p> <p>Timeframe: August – September 2011</p>	<ul style="list-style-type: none"> • DHA-MQF • PM 	<p>Have developed collateral for distribution by August 2011.</p> <p>Complete series of educational sessions by September 2011.</p>
Convene Learning Collaborative	<p>Hold a statewide learning collaborative for providers on ambulatory CAHPS</p>	<ul style="list-style-type: none"> • DHA-MQF • PM 	<p>Ambulatory CAHPS Collaborative convened by end of April, 2011</p>

	Timeframe: April 2011		
Analyze the Data	<ol style="list-style-type: none"> 1. Analyze the data collected and charts developed to communicate the results. 2. Interpret the survey results and develop system recommendations and next steps. 	Contractor	Report to the Steering Committee on the results of the survey and the recommendations arising from this study by March 2012.
	January – March 2012		
Interpret and Communicate the Results	<ol style="list-style-type: none"> 1. Establish reporting methodology. 2. Communicate survey results and recommendations to MQF advisory council, DHA Board, and public. 	<ul style="list-style-type: none"> • Steering Committee • DHA- MQF • PM 	Final report to MQF Advisory Council, the DHA Board of Trustees and the public on the survey results and recommendations by June 2012.
	Timeframe: April – June 2012		