TASK FORCE ON HEALTH CARE ANALYTICS

FEBRUARY 22, 2017
10:00 AM TO 3:00 PM

630 DAVIS DRIVE
MORRISVILLE, NC 27560

MEETING MINUTES

Purpose of meeting: To use results of pre-meeting survey to narrow patient engagement and maternity measures and land on a workable first draft of these measures

By the end of the meeting, we will have:
- First draft of selected measures for patient engagement and maternity measures

Attendance: Tom Colletti, Edie Calamia, Sabrena Lea, Anna Boone, John Byron, Robin King-Thiele, Maida Avery, Sam Bowman-Fuhrmann, Darryl Meeks, Darren DeWalt, Kate Menard, Joe Pino, Rhett Brown, Vivek Nanda, Jenna McCauley, Mary McCaskill, Lydia Newman, Chris DeRienzo, Andy McWilliams, Sam Cykert, Susan Foosness, Terri Pennington, Nancy Henley,

Steering Committee: Elizabeth Mizelle, Kate Berrien

Co-chairs: Warren Newton, Annette DuBard, Jim Hunter

NCIOM Staff: Adam Zolotor, Berkeley Yorkery, Michelle Ries, Mari Moss

Guests: Taylor Zublina, Brenda Allen, Robin Huffman, Eleanor Howell, Karen Luken

Phone: Evan Richardson, Velma Taormina

10:15 – 10:45 **PATIENT PERSPECTIVES: DISCUSSION**
Facilitator: Adam Zolotor

Sam Bowman Fuhrmann
Maida Avery

The patient/beneficiary representatives on the Task Force participated in a short informal discussion about what patients want from their experiences with their care. Adam Zolotor facilitated the discussion.

Panelists discussed the following:

Thinking about your experience with the health care system (and also the experiences of families you've worked with, etc.):

- What is important TO YOU that your doctor know about your experience?

- What do you want your doctor (or hospital, or practice) to be good at?

- What could your doctor (or hospital) measure and make information available on that would help you make decisions about your health care?

- What kinds of questions could they ask that would help you manage your health and also help the doctor in treating you? What kind of feedback would be most important for you to give?

- What format would that feedback be in? (paper survey, phone survey, etc.) What kind of feedback would be too much of a burden?

Question 1: what is important for providers and staff to know before you walk in the door?

- Ms. Bowman Fuhrmann: Parents want the staff to know (reception, etc.) the background of the patient who is coming through the office door. Small elements like the waiting room or the check-in can make or break a visit for a child. Also, there may be a lot of errors in the child's chart. Mistakes in a chart makes it easy to lose confidence in providers. Lots of families don't know how to speak up or are scared to speak up during an appointment, they feel intimidated and don't realize that they might have choices.

- Ms. Avery: Everything Sam mentioned does make a difference. These elements can really help a child feel safe. With negative experiences, parents can become reluctant to take their child to the doctor and that can't and shouldn't happen.

2) How do you prefer to get information after appointments?

Ms. Avery: Electronically. But some of the Medicaid population does struggle with electronic communication.

Ms. Bowman Fuhrmann: People have a preferred way of communication. Now, people like that doctors can share information. Overall, electronic seems to be the choice of the majority. Ideally, case managers would be able to help disseminate this information. They are great in terms of communication.

3) How are health care providers and systems doing with communication? What about families with limited English proficiency?

Ms. Bowman Fuhrmann: This is very difficult, especially in terms of translator support. You see a gap in the Asian population. We need to keep it simple. Sometimes, this might just be telling someone in plain terms exactly that is going on, say, in their bloodstream. Say exactly what it is doing to their liver.

Ms. Avery: lots of limited English. I struggle with trying to understand in English, so when I try to translate in Spanish it is even more difficult. The explanation of diagnoses, procedures, and complications needs to be simpler.

4) What information do you want/need when choosing a doctor or practice?

Ms. Bowman Fuhrmann: Most families look at internet ratings. They want to know that other people have had a good experience. Many people get this by word of mouth from people in the community. Outside that circle, it gets more difficult. There are family support networks who can give recommendations, but if you aren't sure where to go for those then you are at the mercy of your doctor.

Ms. Avery: My pediatrician or primary care doctor would be ideal. I want to know that whoever I am going to is going to be willing to communicate with the other doctors my son is seeing.

5) How do you know when a doctor really cares about you?

Ms. Bowman Fuhrmann: There are certain questions that you can ask: Did that help me? Did you meet my need? There should be a way to measure this. Did we find an answer to the problem? And is there is not an answer" Did that provider communicate the concern, did they admit they don't know the answer but tell me that we would work together to find it? Did they give me options?

Ms. Avery: When staff have accurate information and are prepared to meet a child's need. Doctors who follow up after a visit to the ER to see if there was anything that the family didn't understand

Themes:

Accessibility of resources – re: language, literacy, format of materials. Families need additional support in navigating resources and interpreting information

How can we measure whether a health team CARES? It's important to feel safe and cared for. What would success look like by this measure?

Did that help me? Did that meet my need? And – anticipation of needs, thorough follow up and coordination of resources. Were you given options for your care?

10:45 – 11:15 PATIENT ENGAGEMENT MEASURES IN PRACTICE

Kevin A. Schulman, MD
Professor of Medicine
Gregory Mario and Jeremy Mario Professor of Business Administration
Associate Director, Duke Clinical Research Institute
Visiting Scholar, Harvard Business School
Duke University

Dr. Schulman's presentation (here) explained how we currently measure physician performance as it relates to patient engagement and how these methods are flawed.

Four ways to improve performance results of physicians:

1) reward top performers

2) remove bottom performers

3) improve area under the curve

4) motivate everyone to do better – statistically, this achieves the biggest possible improvement

He then explained how benchmarking in the traditional sense does not drive improvement because those who rank worse don't necessarily know how to improve. Additionally, when the scores for providers are within .5 of each other, the bottom 10% is not necessarily doing a bad job. They just happen to be the "bottom" of an amazing group of performers. Rankings compare doctors to their peers rather as opposed to doctors across the country.

There is the issue of how to communicate with the patient population. While electronic communication might do "worse" with certain demographic groups, there is evidence that this is getting better. CG-CAHPS is never designed to evaluate individual physicians. And, if you want to break results into low, medium, and high performers then how do you determine the cutoff? 9.365/10 should not be a low performance score.

Physician performance can be driven by two types of motivation: intrinsic and extrinsic. Right now, performance measurement is based on extrinsic motivation. However, most physicians are motivated intrinsically because each day they are driven by wanting to take care of patients. Why are we experiencing burnout? Part of it is how we're measuring performance and giving feedback.

The power to transform patient experience needs real-time feedback (smarter surveys). Using smart surveys that are short and to the point can uncover things that the hospital system never noticed before. For example, there was a woman whose husband waited 7 hours to receive his dialysis medicine. She detailed this in the survey, and the system discovered that there was a problem with information and orders getting to the pharmacy. Small things like this, changes to performance overtime, are how you get constant quality improvement. You also have to give deliverable action data to physicians. Feedback about how they are doing against their peers in specific areas can help providers know what specifically to improve on and drive collaboration between providers. They are able to learn from other providers and share what they do best.

12:15 – 12:45 REPORT BACK TO GROUP AND LARGE GROUP DISCUSSION

Group 1: Michelle
1 and 3 combined; 2 and 6 are tied for third place
Michelle's group decided to table the PAM measures because of lack of understanding of how they would be used individually (as opposed to as a whole in the current survey format). Did not choose 14 because the group thought that it should address more than just cost. Are we in the business of re-writing measures? We recognized that measure 7 has value when talking about risk adjustment. We also wondered whether 9 and the PAM survey was captured by 2 with the CAHPS survey.

Adam: PAM would pose a feasibility challenge. And what is the validity of it? What is it designed for? We might need more information on this. Measure number 14 (Unmet Healthcare Need) is from IHI, and not all of those are together as validated measures. For me, the title of the measure is more helpful than the measure itself.

Group 2: Warren
1, 2, (14, 9, 6) third
Warren's group had the same discussion about 14 as other groups. 6 and 9 offer two different sides, one from the provider and one from the patient. They also discussed the idea of having one aspirational measure.

Susan Foosness: PAM is new, but aspirational and has been promising so far.

Anna Boone: with PAM you are coaching patients to move along. This is not necessarily an appropriate measure of performance, but could be good one-on-one using to understand where your patient is

Evan Richardson: PAM is a validation tool that helps providers understand which interventions to apply. PAM is a predictor of utilization.

Group 3: Adam
1, 2, 3
Adam's group believed that shared decision between a provider and a patient was important, but thought that could possibly be captured under measure 2. They had a similar discussion [to Michelle's group] about measure 14. They also did not feel that PAM was quite ready to be used in this way.

Terri Pennington said we are doing CAHPS this year with Adults.

Group 4: Berkeley
1, 3 (with the concern about just asking patients, also want to ask providers); concerns about 6; interested in 9, but the group didn't know if it was proven

We need something actionable that comes from these measures.

Are we asking the plans to ask the survey questions or is the state asking the questions? Each year, consumers and providers are both required to both complete on survey/year as a federal regulation from the state. The mechanism for this survey is up in the air, as are the questions. The contents of the survey are up to us.

NCIOM staff compiling selected measures.

1:15– 1:40 **MATERNITY QUALITY MEASURES: OVERVIEW**

Kate Berrien, RN, BSN, MS
Director, Maternal Health Programs
Community Care of North Carolina

Kate provided an overview of the current maternal measures that are in place for groups including. She described how some measures would not necessarily drive system change and improve overall outcomes, while highlighting how others hold great promise and importance. Berrien presentation here.

Infant mortality is a good indicator of population health. But, what is more actionable than infant mortality that can really drive change? In general, infant mortality is hard to move, but it does reflect the health of the community

Question: Is addiction (opioid dependent) driving up infant mortality? No data yet to determine this 100%

Considerations to think about when discussing measures:

- We need measures that address both maternal and infant health
- Ambulatory measures and inpatient measures
- Who are we trying to influence with these measures? There are many levels to think about.
- Racial/Ethnic disparities. Should we be putting more eggs in these baskets?

Medicaid statistics:
First trimester prenatal care is one of the worst gaps between the commercial population and the Medicaid population.
Tobacco use and cessation counseling indicates racial disparity racial disparity
**** offered through CCNC is a Medical risk screening form, which is more real-time than administrative data. This is a very strong screening.**
Unintended pregnancy shows a huge racial disparity
Post-partum contraception does not have a large racial disparity.
Early- elective delivery might not able to be moved anymore

Data Sources:
Strong sourced are birth certificates
*Medicaid- makes a match file of the birth certificate
PRAMS: one of the only places you can get data, and this is done in several months post-delivery. The CCNC screening is great, but is only for the Medicaid population.

2:30 – 2:55 Report Back to Group and Large Group Discussion

Group 1: Michelle:
1) comprehensive post-partum visit; 2) 17 and by race; 3) 34- BH risk assessment- but with addition of CCNC questions (want to make sure that it includes a depression screening and follow-up planning) 4) referral; 5) timeliness of pre-natal care; 6) 30 post-partum contraception
One thing to consider is having a question that asks "do you intend to be pregnant in the next year?" Because depending on an individual's answer, they should be receiving different care. The group also said that there needed to be a way to look at racial disparities across all of these measures;

Group 3: Adam
4 measures; 2 process, 2 outcome
1) CCNC pregnancy risk assessment tool in the first trimester (combining w/ 14 week visit); 2) comprehensive post-partum visit; 3) pre-maturity;

Group 4: Berkeley
1) CCNC screen + depression screnning; 2) intendness; 3) C-section rate
All of these should measure disparities. Measure child-bearing age women's health is important, but not sure how to do this.

Group 2: Warren
pregnant population comes on and off; pre-term labor as overarching element (need one "kitchen sink" measure in the set); 1 and 2) comprehensive post-partum and pre-partum screening; 3) anto-natal steroids (because it can save lives)
Timeliness of prenatal care and exclusive breastfeeding are very aspirational, but because of that we pushed away from both of these

NCIOM staff compiling selected measures.

Additional NCIOM background work:

Task Force requested additional research/information on:

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