



## FORUM SESSION

# Patient-Centered Care, Payment, and Policy: The Leading Edge

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Putting patients at the center of care was heralded as one of six aims of a 21st-century health care system by the Institute of Medicine (IOM) in its *Crossing the Quality Chasm* in 2001. Now, more than a decade later, “patient-centeredness” is widely seen as integral to achieving other health system goals, including improved economic efficiency, clinical effectiveness, and care safety.

While there is consensus on the importance of the concept of patient-centered care, there is far less agreement on what “patient-centered” or its associated terms mean, and how the concept translates to actual practice—both for quality of care and for payment. Expectations for the patient’s role have undergone profound change since the beginning of the century. As concluded in a 2013 IOM meeting summary, “Prepared, engaged patients are a fundamental precursor to high-quality care, lower costs and better health.”<sup>1</sup> The particulars of which measures and goals become favored is now of pressing interest to stakeholders. Among providers, metrics related to patient-centeredness can directly affect compensation and reputation. Among policymakers, public and stakeholder support for reform may be inextricably linked to actions being seen as patient-centered.

In addition, patients face a changing economic landscape. In 2015, 81 percent of large employers will offer at least one high-deductible, consumer-directed health plan, according to a recent survey by the National Business Group on Health,<sup>2</sup> and that will be the only plan choice offered by one-third of those surveyed. Confronted with a median family deductible of \$3,000, consumers have a significant incentive to seek information on the necessity of a treatment and possible alternatives, the price of care, and the quality of care being offered. That same kind of quality-cost information on a more detailed level,

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including patient-centeredness as a quality metric, is also being sought by insurers and health plan sponsors who are narrowing their networks, introducing new payment incentives, and trying to survive and thrive in a world where value may become more important than volume.

Much is at stake in the effort to build a high-value health care system. As patient-centered care takes a more central role, a definition appropriate to the 21st century must be accompanied by reliable measurement and rules that encourage innovation rather than stifling it. Implementing strategies for change, such as those laid out in a recent multi-stakeholder “roadmap” for patient and family engagement,<sup>3</sup> will not be easy.

### PATIENT-CENTEREDNESS POST-ACA

The term patient-centeredness is used to describe three aspects of a provider’s relationship with a patient: an ethical responsibility, a clinical partnership, and an economic relationship.<sup>4</sup> Various sections of the Patient Protection and Affordable Care Act of 2010 (ACA) reference patient-centered care over 40 times, typically in a clinical or ethical context, in addition to other similar terms such as shared decision-making and patient engagement. The regulations that have been issued from the Centers for Medicare & Medicaid Services (CMS) give providers the task of turning each of these concepts into a measurable reality.

At present, implementing measurement of patient experience with health care is anchored firmly in a family of surveys known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Originally developed by NCQA (the National Committee for Quality Assurance) to assess consumer satisfaction with health plans, there are now CAHPS surveys for hospital care (HCAHPS), ambulatory care provided by clinicians and medical groups (CG-CAHPS), and many other aspects of care. Increasingly, an organization’s CAHPS scores are public, carrying reputational risk, or linked directly to reimbursement by Medicare and private payers. CAHPS data is incorporated into a variety of government quality reporting programs, among them Medicare’s Hospital Inpatient Quality Reporting Program and the Physician Quality Reporting System. Perhaps the most detailed measurement and management requirements of patient-centeredness anywhere are contained in the final rule for the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs). Under the MSSP rule,

actions are assessed as part of 33 different quality measures across four domains of care using CAHPS.

Private insurance and non-ACO Medicare programs are also focusing on measurement and management issues. Health plans and provider organizations are under pressure to meet the measures, but that pressure filters quickly to individual clinicians and others who have patient contact.

## APPLYING MEASURES TO PAYMENT

Deciding on measures of quality of care has always been contentious, with those being measured concerned that their patient populations may be sicker or that factors beyond their control are affecting how they are judged. Adding in patient-generated data to quality measurement and management efforts has raised concerns in many quarters. Some measures are well developed and validated, such as the Patient Activation Measure; others remain more conceptual than battle-tested. Evidence gathering on patient-centered measures is still at its early stages. Providers face increasing demands to document their professional conduct, yet measures are often inconsistent and/or defined or applied differently across payers. New measures may yet be defined: a 2012 study in *BMJ Quality and Safety*, for example, found that patient comments posted on Yelp are as useful as what is reported through meticulously validated HCAHPS.<sup>5</sup>

Despite widespread agreement that the health care system should move from “volume to value,” most reimbursement for most providers is still firmly anchored in a fee-for-service environment with some pay-for-performance reimbursement mixed in. While CAHPS is presented in academic and policy circles as an “experience of care” survey, not a “satisfaction” survey, some on the front lines feel that patient happiness is what health system managers are hoping for. Clinicians worry that they are being asked to eschew evidence-based medicine to boost their CAHPS evaluations; for instance, prescribing antibiotics for patients who clearly have a viral rather than bacterial infection, or providing opiates for moderate pain.<sup>6</sup>

Yet some providers are responding boldly to cultural and technological changes, such as the spread of web-enabled mobile devices that generate personalized clinical data (blood pressure, heart rate, glucose level). They are enabling clinician-patient relationships, recognizing both personal goals in seeking care and the

rights and responsibilities of individuals as responsible drivers of their own health.

Re-engineering care will not be easy. It will change the traditional flow of information and raise questions about information control, information reliability, privacy, and legal liability. As patients take more responsibility for decisions, roles and relationships will need to be renegotiated. Government actions as an informed payer or, if necessary, regulator could encourage rapid development and deployment of validated tools and measures that are patient-centered, go beyond current CAHPS measures, and let consumers and others make better choices.

### KEY QUESTIONS

- What are the varied goals of providers in collecting information on patient satisfaction, experience of care, and engagement? Is some of what is learned more relevant to building or preserving market share, as opposed to efforts at re-engineering care delivery?
- How are private plans and government payers using this kind of information to define network participation, set payment rates, etc.?
- What methods are most effective at collecting and assessing patient experience? What are the biggest concerns? For instance, are some patients more likely to respond to surveys than others, potentially skewing data toward the very satisfied or the disgruntled?
- To what extent are patient experience metrics standardized? What is the role of CMS or other organizations such as NQF (National Quality Forum) in determining when changes to such measures are needed and/or developing them?

### SESSION

This Forum session featured presentations from two thought leaders who are also deeply immersed in implementation. Reflecting on how patient experience information has been used, the discussion explored the goals and concerns of Congress and others in promoting patient-centered care. Some of the challenges in measuring, risk adjusting, and reporting such information were noted.

**Donna Cryer** of the health care consultancy CryerHealth, **Dr. Leana Wen** of George Washington University Medicine, and **Dr. Kate Goodrich** from CMS joined the question-and-answer portion of the

session from the audience. We look forward to offering a second session on this topic, in which they will more fully explore the viewpoints of patients, providers, and government.

A background paper on this issue is also forthcoming.

## SPEAKERS

**Arnold Milstein, MD, MPH**, is professor of medicine at Stanford and directs the Stanford Clinical Excellence Research Center. He will review efforts among leading-edge providers and payers to measure and reward quality based on assessments of patient experience, patient-reported outcomes, and patient engagement, while also clarifying some common misconceptions about those terms. Drawing on his experience as a consultant to the Pacific Business Group on Health and his work at Mercer with purchaser and provider clients, Dr. Milstein offered perspectives on quality improvement and issues that policymakers may expect to address as the field continues to mature.

**Joe Boyce, MD, MS**, is the chief information officer and chief medical information officer at Heartland Health, a non-profit health care system that received the prestigious Malcolm Baldrige National Quality Award. He described the unusual strategic path taken by Heartland Health/Mosaic Life Care of St. Joseph, Missouri, in implementing process changes designed to include patients as full participants in their health and health care. Seen as a bellwether of change, the organization has restructured its delivery capacity to focus on patient-generated information, including engaging with patients through shared notes and making diagnostic tools available on its website. Previously, Dr. Boyce worked at Intermountain Healthcare, another leading-edge organization.

## ENDNOTES

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3. K.L. Carman *et al.*, "A Roadmap for Patient + Family Engagement in Healthcare: Practice and Research," prepared for the American Institutes for Research under a grant from the Gordon and Betty Moore Foundation, September 2014, <http://patientfamilyengagement.org/>.
4. Michael L. Millenson, "New Roles and Rules for Patient-Centered Care," *Journal of General Internal Medicine*, published online February 12, 2014, <http://link.springer.com/article/10.1007%2Fs11606-014-2788-y>.
5. Naomi S. Bardach *et al.*, "The relationship between commercial website ratings and traditional hospital performance measures in the USA," *BMJ Quality & Safety*, 22, no. 3 (2013): pp. 194-202, <http://qualitysafety.bmj.com/content/22/3/194.full>.
6. See, for example, Jennifer Thew, "Patient Satisfaction: Who's Paying the Price for Happy Patients?" *HL7 Standards*, [www.hl7standards.com/blog/2014/06/10/happy-patients/](http://www.hl7standards.com/blog/2014/06/10/happy-patients/); William Sonnenberg, "Patient Satisfaction is Overrated," *Medscape Multispecialty*, March 6, 2014, [www.medscape.com/viewarticle/821288](http://www.medscape.com/viewarticle/821288).