Clinical Practice Improvement Activities: What Consumers Want

Coalition for Better Care – Consumer Partnership for eHealth
MACRA Webinar Series
April 28, 2016
The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care, and policies that help women and men meet the dual demands of work and family.

Key health initiatives:
- **Coalition for Better Care:** A broad-based coalition of consumer organizations with a direct stake in improving health care quality for patients and family caregivers.
- **Consumer Partnership for eHealth:** Advancing health information technology in ways that benefit patients and families.

Agenda

- Welcome and Introductions
- Release of MACRA NPRM
- Request for Information: Assessing Interoperability for MACRA
  - CPeH Plans for Comment
- Clinical Practice Improvement Activities
  - Beneficiary Engagement w/ Christine Broderick, National Partnership
  - Patient Centered Health IT w/ Erin Mackay, National Partnership
  - Patient Decision Aids w/ Ben Moulton, Healthwise
- Next Steps
  - Consumer plans for comment
Yesterday, CMS released the MACRA Notice of Proposed Rule Making (NPRM)

- Comments are due on Monday, June 27

Note: We are still analyzing the rule and look forward to providing a more complete analysis soon. Stay tuned!
MACRA replaces the SGR and, starting in 2019, provides two separate payment pathways for Medicare providers:

- The Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APM)

Under MIPS, providers will be evaluated based on four performance categories:

- Quality
- Resource Use
- Meaningful Use of Electronic Health Records
- Clinical Practice Improvement Activities
  - New category for provider performance!
Assessing interoperability for MACRA

- In addition to changing the way Medicare pays physicians, MACRA also declares achieving widespread interoperability to be a national objective.

- On April 8, ONC published a Request for Information asking stakeholders for input on how to measure progress towards nationwide interoperability.

- Purpose: Establish metrics to evaluate interoperability for report to Congress, as required in MACRA. ONC requested information on:
  - (1) Scope of measurement: which population(s), components of interoperability to measure
  - (2) Current data sources for measurement; possible metrics
  - (3) Other data sources, metrics
  - (4) Overarching questions
Coming soon: CPeH comments

- **Comments on the RFI are due June 03**
  - HOWEVER! CPeH plans to submit comments in advance of the June deadline.
- **CPeH Comment Outline:**
  - Patients as health information exchange partners
  - Other exchange partners (long-term care facilities and community based organizations)
  - Support of proposed provider measures
  - Importance of implementing Stage 3 Meaningful Use on time and as finalized
  - Report to Congress on barriers to information exchange
- **Stay tuned for the comment letter...**
MACRA provides broad discretion for the HHS Secretary to define this category.

CPIA is an activity that stakeholders identify as improving clinical practice or care delivery and that the Secretary determines will likely result in improved outcomes.

CPIA will include **at least** the following subcategories:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an APM
Additional CPIA categories

- In the October Request for Information (RFI), CMS sought comment on additional potential categories for CPIA
  - And, the criteria that should be applicable for all clinical practice improvement activities
  - Not all categories potential categories in the RFI made it into the proposed rule
- In the proposed rule:
  - Achieving Health Equity
  - Emergency Preparedness
  - Integration of Behavioral and Mental Health
CPIA requirements

- CPIAs should include only those activities central to helping hospitals and provider practices provide more patient and family-centered care.

- In the proposed rule:
  - List of eligible activities for each subcategory of CPIA
  - Each activity is weighted as high or medium
    - High activity is worth 20 points
    - Medium activity is worth 10 points
    - Must achieve 60 points for the highest possible score

- Example of activity weighted as “high”: 24/7 practice access, with access to patient medical record; provision of same-day or next-day access to providers

- Example of activity weighted as “medium”: Engaging patients and family caregivers in developing a care plan and care priorities, documented in an EHR
How else to define CPIA: What consumers want

- **Meaningful beneficiary engagement**
- **Robust use of health IT across categories**
  - Exchange and share information among providers as well as with patients and families
- **Use of patient decision aids/shared decision making**
- **Other activities / priorities?**
Beneficiary engagement is critical to practice transformation

- Better quality health care
- More efficient care
- Improved population health

Context

- Shifting roles of patients and families in health care
- Growing body of evidence that supports patient engagement as a path to better outcomes, improvements in quality/safety and controlling costs
- US health care system: spending more money without better quality. Patients should be part of the solution.
What is meaningful beneficiary engagement?

Looking beyond the point of care

- MACRA RFI focuses primarily on engagement at point of care (participation in shared care planning and decision-making.)
- Engagement should occur at all levels of care: care redesign, governance, and in the community
- Aim for partnership with beneficiaries across all six CPIA subcategories

Striving for partnership over involvement

- Engagement at multiple levels
- Shared power and responsibility: patients are stakeholders with an investment in transformation and improvement
- Patients are active partners in defining agendas and making decisions
Examples of engagement

- **Practices can partner with patients and families to:**
  - Choose a patient portal
  - Enhance support for care transitions
  - Identify community-based supports

- **Patient and Family Advisory Councils (PFACs)**
  - A strong way to establish meaningful engagement at the governance level.
  - Similarly, including beneficiary/family caregiver representatives on key governance and decision-making bodies.
Our recommendations

- **Specific “functions and capabilities” can support assessment**
  - Look for systems and processes in place that ensure beneficiary engagement with care planning, EHRs, transitions, etc.

- **Weighting categories**
  - Use a weighting structure that reflects beneficiary engagement as a strategy for care improvement and transformation

- **Providers begin with a self-assessment**
  - A self-assessment can identify needs and gaps, and inform improvement goals
  - This assessment should go beyond clinical care level
Our recommendations

- **Ask beneficiaries how well they are being engaged**
  - Agendas set by consumers
  - Consumer-identified priorities
  - What information and support are needed to participate effectively?
  - Do consumers feel that they are making an impact?

- **Consumers can identify gaps in engagement**
Beneficiary Engagement CPIAs include:

- Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms.
- Engage patients and families to guide improvement in the system of care.
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.

Expanded Practice Access CPIAs include:

- Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.
Patient engagement and improved health outcomes are enabled by patients’ electronic access to and use of their health information.

Of those who are offered online access, 86% use it, and 55% use it 3 or more times per year.

Online access to one’s health information has a positive impact on:

- Knowledge of their health
- Ability to communicate with their doctors

Notably, those who access their health information more frequently report a significantly greater positive impact:

- 71% of frequent users report that access improves their desire to do something about their health (vs. 31% of infrequent users)
Because of the positive impacts of patients’ online access to their health information, CPIAs that leverage this access are particularly important for the categories of beneficiary engagement and care coordination.

In the RFI, the National Partnership suggested these specific activities:

- Information reconciliation
- Shared care planning
- Connecting with social services and community supports
Accuracy and completeness of health records vital to providing high-quality care and improving outcomes

**Recommendation:** Include patients and family caregivers in confirming/reconciling information that is likely to change between health care encounters

Use online access to offer individuals a way to submit corrections or updates to their health record

Activities of information reconciliation can include discussion and electronic documentation of:

- Medications actually taken (including over-the-counter drugs and herbal supplements)
- Caregiver name, contact information, and role
- Additional care team members (e.g. primary care, specialists, ER, retail clinic, etc.)
- Health problems/complaints
- Advance directive status and content
- Others?
Beneficiary Engagement CPIAs include:

- Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.
Care Plans 2.0: How Do We Get to Healthy?

- What Consumers Want: Care Plans 2.0
  - A multidimensional, person-centered health & care planning process facilitated by a dynamic, electronic platform that connects individuals, their family and other personal caregivers, paid caregivers (such as direct care workers and home health aides), and health care and social service providers, as appropriate.
  - The care plan supports all members with actionable information to identify and achieve the individual’s health and wellness goals.
Consumer Principles for Health & Care Planning

1) Health & care plans should be goal-oriented, dynamic tools.

2) Tools that facilitate health & care planning should enable all members of the care team to securely access and contribute information, according to their roles.

3) Health & care plans should identify and reflect the ability and readiness of an individual to successfully meet their goals, as well as potential barriers.

4) Health & care planning and tools should facilitate decision-making and specify accountability.

5) Every individual would benefit from health & care planning and tools.
Recommendation: Providers should engage patients (and their family caregivers, as appropriate) in developing shared care plans and tracking longitudinal improvements in health outcomes.

- Part of beneficiary engagement and/or care coordination category

At a minimum, criteria could include:

- Electronic documentation of both patient and provider (clinical) goals
  - Entered directly by patient via certified EHR technology
- Electronic sending of care plans to patients and family caregivers, as well as to other members of the care team
- Recording family caregiver status and roles
Ted’s Care Plan: Knee Replacement

About Ted
Ted is a 72 year-old man who suffers from chronic knee pain. He has always been active and is an avid tennis player, but his arthritis has become so painful that he now has trouble walking up the stairs. Medicine, including prescription medicine and steroid injections, no longer works to manage his pain, so he has consulted with his doctor about knee replacement surgery. Ted’s doctor supports surgery as an effective treatment option, and Ted’s family agrees that now is an appropriate time for the procedure.

About the Care Team
After his surgery, Ted will follow-up with his surgeon, who will monitor how the wound is healing. Ted will work with a physical therapist to strengthen his knee muscles and improve his mobility to return to performing his normal household activities. His daughter has invited Ted to live at her house for the first few weeks after his surgery. Her house has a bedroom on the first floor, which is crucial because Ted won’t be able to climb stairs for many weeks. When he does return home, Ted worries about his wife being able to help him around. The family has discussed hiring a home health aide for a few weeks.

Clinical Goals
• Preventing infection. While Ted is recovering in the hospital, a big concern is preventing infection, which can threaten Ted’s health. The removal of the artificial joint, and increase his length of stay in the hospital.
• Avoid falls. Once Ted is out of the hospital, it is important to avoid falls, which could damage the artificial knee and cause the need for further surgery.
• Prevent wear and tear. Over the long-term, his surgeon wants to prevent Ted from wearing out the artificial joint because doing so can cause pain and the loosening or dislocation of the joint, which would necessitate further surgery. She recommends that Ted refrain from engaging in high-impact activity, and suggests low-impact activities like walking, swimming, or golfing instead.

Personal Goals
• Regain normal activity levels ASAP. Ted takes a family vacation every summer at their lake house, and he is determined to be able to get around without a walker or cane.
• Exercise with his wife. Ted would really like to play tennis again because it is an activity that he and his wife do together. He is struggling with the reality that he can no longer do high-impact activities.
• Continue driving. Ted does not want to be a burden to his family, and he also hopes to maintain his independence. His surgeon mentioned that he might be able drive in four to six weeks, depending on his range of motion.

Action Steps to Achieve Goals
• Ted and his surgeon choose to implant a type of artificial joint that does not wear with activity as easily as a typical prosthesis so Ted can be more active. His surgeon also prescribes antibiotics to prevent infection while Ted is in the hospital.
• His physical therapist develops an exercise plan that gradually increases Ted’s activity level, beginning with chair exercises and short walks around the house and progressing into normal household activities. Ted keeps a daily log of his activity and his resulting fatigue and pain.
• The local Red Cross provides free transportation service, so Ted’s family plans to use this service to take him to his physical therapy appointments (until Ted is driving again).
• Ted’s daughter organizes the installation of appropriate safety features in Ted’s home, including handrails on the stairs and a shower bench for bathing, to help Ted avoid falls when he moves back home.
• Ted and his wife register for ballroom dancing classes, a low-impact activity that they can do together rather than tennis.
NPRM sneak peak:
Care planning

Care Coordination CPIAs Include:

- Implementation of practices/processes to develop **regularly updated individual care plans** for at-risk patients that are shared with the beneficiary or caregiver(s).
- Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).

Beneficiary Engagement CPIAs include:

- Engage patients, family and caregivers in developing a plan of care and **prioritizing their goals for action**, documented in the certified EHR technology.
- Participation in a QCDR, that promotes implementation of patient self-action plans.
- Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.
- Incorporate evidence-based techniques to promote self-management into usual care, using techniques **such as goal setting with structured follow-up**, teach back, action planning or motivational interviewing.
- Provide coaching between visits with follow-up on care plan and goals.
Medical care delivery determines only an estimated 10-15 percent of health.

**Recommendation:** Integrate social determinants of individuals’ health and promote social and community involvement by linking the EHR to community and social services.

**Potential activities:**
- Collect and integrate information on patients’ social determinants of health
- Link to community resources and supports
  - Develop and maintain directory of community supports
- Exchange information with non-clinical settings of care
Care Coordination CPIAs include:

- Establish standard operations to manage transitions of care that could include one or more of the following:
  - Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or
  - Partner with community or hospital-based transitional care services.
- Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following:
  - Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or
  - Provide a guide to available community resources.

Achieving Health Equity CPIAs include:

- Participation in QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health; use of supporting tools that can be incorporated into CEHRT is also suggested.
Shared Decision Making / Patient Engagement

- Goals for today
- Quick overview of SDM
- Its link to patient engagement & safety
- Shared decision making and quality PtDAs are “perfected informed consent”
- What I see as what is going on at the state and federal level
MACRA: Shared Decision Making- PDA’s: Medical Discussion guides

- MACRA Accelerating the movement away from fee for volume to fee for value.
- Shared Decision Making is key for both Merit Based Payment System (MIPS) and Alternative Payment Models (APM).
- For the MIPS pathway under the new category Clinical practice improvement activities- shared decision making is the keystone to patient/beneficiary/family engagement and patient safety. It is the heart of shared care planning.
- For Alternative Payment Models such as CMMI grants and Medicare shared savings programs SDM is key to achieving higher quality, patient satisfaction and reducing unwarranted care.
SDM in the Affordable Care Act

- Section 3506 creates a new shared decision-making program and calls for:
  - Establishing a process to certify decision aids
  - Awarding funding to produce and update aids
  - Creating Shared Decision Making Resource Centers
  - Providing grants to healthcare providers for development, use and assessment of shared decision making using certified decision aids
Section 3021 CMS Innovation Center

• Test innovative payment models to reduce costs and enhance quality. To design, implement and evaluate 18 different models.

• 9) “Assisting applicable individuals in making informed health care choices by paying providers for using patient decision support tools that improve individual understanding of medical options.”

Authorized and Appropriated 10 Billion FY 2011-2019
Making Health Care Decisions

The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship

Volume One: Report
Shared Decision Making (SDM) is a Process

“The process of **interacting** with patients who **wish** to be involved in arriving at an **informed, values-based** choice among two or more medically reasonable alternatives”¹

¹A.M. O’Connor et al, “Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids”  
*Health Affairs, 7 October, 2004*
Patient Decision Aids Can Help!

• Tools designed to help people participate in decision-making
• Provide information on the options
• Help patients clarify and communicate the values they associate with different features of the options
### EXHIBIT 1

**Group Health Patient Satisfaction Survey Results On Decision Aids**

<table>
<thead>
<tr>
<th>Please rate how well the decision aid:</th>
<th>Excellent/very good</th>
<th>Good</th>
<th>Fair/poor</th>
<th>Total responses per question (out of 2,223)</th>
<th>% positive ratings out of total responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helped you understand your health condition</td>
<td>1,428</td>
<td>613</td>
<td>112</td>
<td>2,153</td>
<td>94.8</td>
</tr>
<tr>
<td>Helped you understand the treatment choices for your health condition</td>
<td>1,573</td>
<td>499</td>
<td>84</td>
<td>2,156</td>
<td>96.1</td>
</tr>
<tr>
<td>Helped you understand what is most important to you when thinking about treatment choices for your health condition</td>
<td>1,500</td>
<td>536</td>
<td>112</td>
<td>2,148</td>
<td>94.8</td>
</tr>
<tr>
<td>Helped you prepare to talk with your health care provider about treatment choices for your health condition</td>
<td>1,528</td>
<td>508</td>
<td>103</td>
<td>2,139</td>
<td>95.2</td>
</tr>
</tbody>
</table>

**SOURCE** Group Health Research Institute. **NOTES** Raw data from 2,223 survey participants, out of 12,263 surveys mailed with decision aids from January 2009 to April 2011. Data provided by Group Health Research Institute and on file with authors. *Positive rating means excellent, very good, or good.*
“Many doctors aspire to excellence in diagnosing disease. Far fewer, unfortunately, aspire to the same standards of excellence in diagnosing what patients want.”

Mulley A, Trimble C, Elwyn G. Patients' preferences matter: stop the silent misdiagnosis.
Top Three Goals and Concerns for Breast Cancer Decisions

- Keep your breast: 71% Provider, 7% Patient
- Live as long as possible: 96% Provider, 59% Patient
- Look natural without clothes: 40% Provider, 24% Patient
- Avoid using a prosthesis: 0% Provider, 33% Patient

Lee et al. Health Expec. 2010 Sept. 13(3)258-72.
“Perfected Informed Consent”

Traditional Informed Consent
- Risks
- Benefits
- Alternatives
- Severity
- Probability

Shared Decision Making
- Values
- Preferences
- Risks
- Benefits
- Alternatives
- Subjective
Introducing Decision Aids At Group Health Was Linked To Sharply Lower Hip And Knee Surgery Rates And Costs

ABSTRACT Decision aids are evidence-based sources of health information that can help patients make informed treatment decisions. However, little is known about how decision aids affect health care use when they are implemented outside of randomized controlled clinical trials. We conducted an observational study to examine the associations between introducing decision aids for hip and knee osteoarthritis and rates of joint replacement surgery and costs in a large health system in

introduction of decision aids was associated with 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements, and 12–21 percent lower costs over six months. These findings support the concept that patient decision aids for some health conditions, for which treatment decisions are highly sensitive to both patients’ and physicians’ preferences, may reduce rates of elective surgery and lower costs.
Considerable Evidence of Impact

• In 130 trials addressing 23 different screening or treatment decisions, use has led to:
  • Greater knowledge
  • More accurate risk perceptions
  • Greater comfort with decisions
  • Greater participation in decision-making
  • Fewer people remaining undecided
  • Fewer patients choosing major surgery

WA State Passed Three Bills

• Passed legislation in 2007
• Explicitly recognizes SDM is an enhanced informed consent for Preference-Sensitive Conditions if provider uses a “certified aid”
• Led to Group Health demonstration project
• 2009 Passed Bree Collaborative—SDM promoted
• 2012 Passed legislation allowing CMO of HCA to “certify aids” moving forward with criteria
• Payment of providers for SDM being considered
What is the Medicare Lung Cancer Screening Reimbursement?

- In eligible high-risk, long-term smokers, Medicare will reimburse for
  - A counseling/SDM visit
  - Annual low-dose CT scans (LDCT)

- Reimbursement requires
  - SDM conversation, supported by decision aids
  - Discuss key facts about the pros and cons of screening
  - Smoking cessation counseling
Certification of Decision aids/Medical Discussion guides

• WA HCA certification criteria Live as of April 28: http://www.hca.wa.gov/hw/Pages/pda_applications.aspx

• NQF will host and external meeting to work on consensus standards for a national certification schema

• CMS can use its regulatory authority to promote
Certification of Decision aids/Medical Discussion guides

What needs to happen to advance SDM

• SDM needs to be clearly defined
• SDM needs to be measured- NQF has patient reported measures that are being assessed- PROM’s
• CMS Payors and Patients need the attestation of “Certified” Patient Decision Aids
• Providers need to be trained in SDM conversation techniques
Did the patient know a decision was being made?
Did the patient know the pros and cons of the treatment options?
Did the provider elicit the patient’s preferences?

Did the decision reflect the patient’s goals and concerns?

Did the patient know what he or she needed to know?
Beneficiary Engagement CPIAs include:

- Participation in a Qualified Clinical Data Registry (QCDR), demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.
- Use of evidence-based decision aids to support shared decision-making.
Questions, comments, reactions?

Comments on the NPRM are due on June 27

- Additional webinars to analyze rule, gather reactions and feedback

Plans for comment:

- National Partnership for Women & Families
- Coalition for Better Care
- Consumer Partnership for eHealth
For more information

Contact us:
Stephanie Glover
sglover@nationalpartnership.org

Erin Mackay
emackay@nationalpartnership.org

Christine Broderick
cbroderick@nationalpartnership.org

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