Integrated Healthcare ASSOCIATION

Purchaser Business Group on Health

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Advancing Person-Centered Care Measurement

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SCOPE OF PROJECT

The delivery of person-centered care — defined as a holistic approach oriented around an individual's goals and preferences — is an important consideration for supporting health care system transformation. Prior research revealed that people whose preferences were not taken into account had fewer doctors' visits, were less likely to use home care, and were less likely to take prescription drugs; quality measurement and payment structure were suggested as health system and health policy levers that could help lead to more person-centered care.[1] For clinicians to deliver high quality, evidence-based care in an effective manner, where patients' and caregivers' individual preferences, needs, and values are reflected, payments need to enable this.

Supported by a grant from The SCAN Foundation, the Integrated Healthcare Association (IHA) and Purchaser Business Group on Health (PBGH) evaluated the relationship of provider organization (PO) performance on person-centered care measures for their Medicare Advantage population for 2020 with the payment model under which POs are paid – specifically the financial risk arrangement. This is consistent with the Health Care Payment Learning & Action Network framework push toward more risk through population-based payment.[2] The hypothesis for this study was that being paid under a flexible population-based method like capitation will allow innovation and customization to support more person-centered care, as demonstrated by better patient experience, higher quality, and lower total costs.

BACKGROUND: DEFINING PERSON-CENTERED CARE

Two decades ago, the Institute of Medicine (IOM) named patient-centered care as one of six aims for a 21st century health system. The IOM defined patient-centered care as "respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."[3] The American Geriatric Society also defined person-centered care as eliciting individual values and preferences to guide all aspects of health care and support realistic health and life goals.[4] We use patient-centered care synonymously with person-centered care.

A more recent New England Journal of Medicine Catalyst article summarizes the common elements of patient-centered care as follows:

- Care is **collaborative, coordinated, and accessible**. The right care is provided at the right time and the right place.
- Care focuses on **physical comfort** as well as **emotional well-being**.
- **Patient and family preferences**, values, cultural traditions, and socioeconomic conditions are respected.
- **Patients and their families** are an expected part of the care team and **play a role in decisions** at the patient and system level.
- **Information is shared fully and in a timely manner** so that patients and their family members can make **informed decisions**.[5]

The Picker Principles of Person-Centered Care reflect very similar themes:

- **Effective treatment** delivered by **trusted** professionals
- Clear **information**, communication, and support for self-care

- Continuity of care and smooth transitions (**coordination**)
- Involvement and support for **family** and caregivers
- **Involvement in decisions** and respect for preferences
- **Emotional support, empathy, and respect**[6]

METHODS

Selection of Measures to Assess Person-Centered Care

A set of patient experience, clinical quality, and total cost of care measures were selected with guidance from subject matter experts from PBGH and IHA's measurement committees.

Patient Experience

Patient experience measurement is an integral piece of person-centered care because it incorporates the patient's unique viewpoint of their care. Gathering information directly from patients manifests the person-centered concept that patients know best how well their care is meeting their own needs[7], including the extent to which care is respectful and responsive to their preferences and values.[8] The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is focused on assessing issues that are meaningful to health care consumers, and that guide their choice of provider.[9] The widely-endorsed, industry-standard nature of CAHPS allows benchmarking, trending, comparison, and use as a quality improvement tool, creating a critical pathway for system transformation that reflects patient values.[10] Importantly, we see the use of CAHPS data as practices transition to patient-centered medical homes.[11]

The patient experience measures are based on PBGH's annual statewide survey, the Patient Assessment Survey (PAS), which is based on the Clinician and Group CAHPS (CG-CAHPS) survey. Results are based on the commercial population responses since the Medicare Advantage population is not directly surveyed. Given that there are strong correlations for clinical performance between commercial HMO and Medicare Advantage, and between commercial clinical performance and patient experience, it is reasonable to use commercial patient experience for these Medicare Advantage analyses.

With stakeholder input from the PAS Steering Committee, the following PAS measures were selected to evaluate person-centered care in California.

- Overall Ratings (average of Rating of Doctor and Rating of Care)
- Access to Care
- Provider Communications
- Care Coordination
- Office Staff

Clinical Quality Measures

Receiving the right clinical care at the right time is also an essential part of person-centered care. The Picker Principles of effective treatment, as well as continuity of care and smooth transitions, can be assessed through clinical quality measures. To determine which measures to select, a core set of measures were sought that aligned with measures already in use for assessing care in California and nationally, specifically measures appropriate for Medicare from California's Advanced Primary Care

measure set and measures that were also included in CMS' Primary Care First program. Based on this process, the following measures produced through IHA's Align. Measure. Perform (AMP) program[12] were selected.

- Concurrent Use of Opioids and Benzodiazepines
- HbA1c Poor Control >9%
- All-Cause Readmissions
- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Osteoporosis Management for Women Who Had a Fracture

Total Cost of Care

The amount someone needs to pay for healthcare services is also a part of person-centered care, as it can affect how accessible care is. Since copayments are often a fixed percentage of the allowed amount, higher total cost of care is generally associated with higher patient cost sharing. With this in mind, the following measure was also included in the analysis.

- Geography- and Risk-Adjusted Total Cost of Care

Determination of Financial Risk Arrangements

Provider organizations (POs) are groups of health care providers organized to contract with health plans. In California, POs participating in a capitated, delegated model of care assume responsibility and financial risk for managing the care of their assigned patients. One hundred fifty-one (151) POs were categorized by level of financial risk/risk arrangement at the Plan-PO contract level (n = 378).

The description of the financial risk categories are listed below.

Financial Risk Category	Description
No risk	all services paid fee-for-service
Facility risk only	capitation paid for facility services, but fee-for-service for professional services
Professional risk only	capitation paid for professional services, but fee-for-service for facility services
Full risk	capitation paid for both professional services and facility services

Assessing Correlations between Person-Centered Care and Financial Risk Arrangement

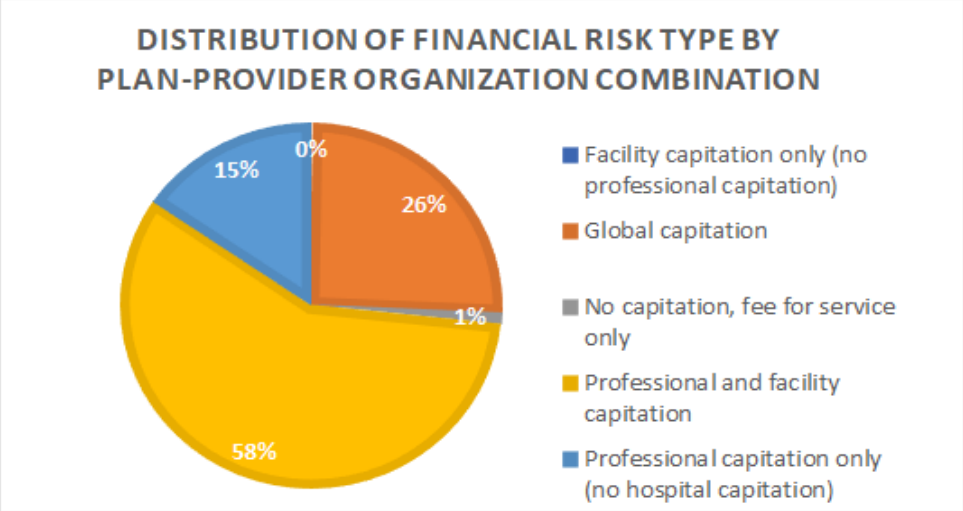
To assess whether financial risk arrangements were associated with the delivery of person-centered care, data from IHA's AMP program were used. The first step was to examine sample size and univariate descriptions of the outcomes by risk arrangement, payer, and PO size to inform the approach for a regression analysis.

A multivariate regression analysis was then run to assess correlation between financial risk and performance on person-centered measures. The regression included risk arrangement and PO size since the distribution of PO size was different by risk arrangement, with professional risk contracts more often with smaller POs compared to full risk arrangements with large POs. By adjusting for PO size, these results show to what degree the performance of the measure for a Plan-PO in a full risk arrangement is better or worse compared to those in a professional only risk arrangement.

RESULTS

Plan-PO Risk Arrangements, Medicare Advantage, MY 2020

Almost all Medicare Advantage Plan-PO contracts in California are risk-based.



- 99% of Plan-PO contracts for Medicare Advantage in 2020 included some type of risk
    - 84% of contracts were full risk, which includes global capitation (26%) and dual capitation (58%, with separate contracts for professional capitation and facility capitation)
    - 15% of contracts were professional risk only
- No risk (FFS) and facility capitation only represented 1% of contracts (5 Plan-PO contracts) and were excluded from the analysis because this was not enough to get an accurate signal.

When layering in PO size, based on Medicare Advantage member enrollment, the distribution of Plan-POs is shown below. Small POs are the 25th percentile or below of member enrollment size across all observed Plan-POs; medium POs were between the 25th and 75th percentiles; and large POs are the 75th percentile and above.

Risk Type	PO Size	Number of Plan-POs
Professional Risk	Small/Medium PO	62
Full Risk	Small/Medium PO	238
Full Risk	Large PO	96

Multivariate and Univariate Regression Analyses, Medicare Advantage, MY 2020

Risk arrangement matters: Full risk POs performed slightly better than professional risk POs on all but two measures.

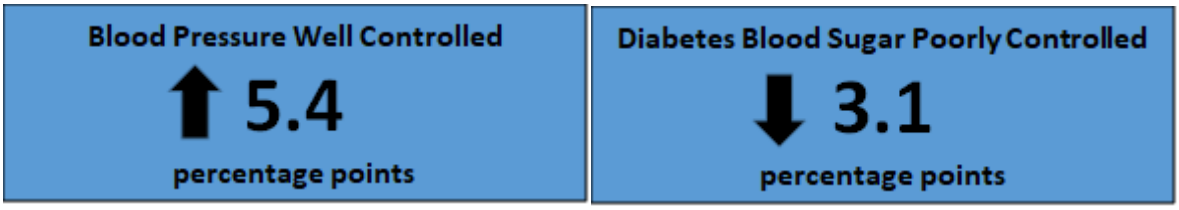
Full risk POs slightly outperformed professional risk POs on most measures, with the differences being statistically significant for three of the seven clinical quality measures, as well as two of the five patient experience measures. Access to Care and Total Cost of Care were exceptions where full-risk POs performed slightly worse than those with professional risk.

Size also matters: Large POs outperformed small/medium POs on all but two measures.

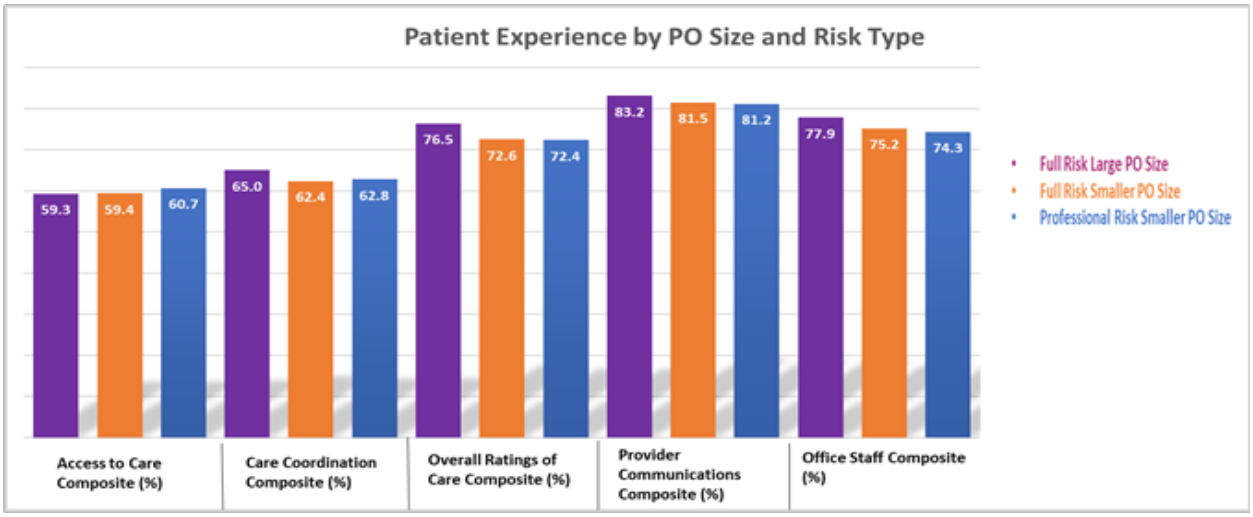
Large POs outperformed small/medium POs – sometimes by a wide margin – across all measures except Access to Care and Total Cost of Care. For all seven clinical quality measures and four of five patient experience measures, the differences were statistically significant. While all twenty-eight Kaiser Permanente POs were large POs, this is not just a Kaiser phenomenon; large POs excluding Kaiser Permanente POs still outperformed small/medium POs, but by a smaller differential.

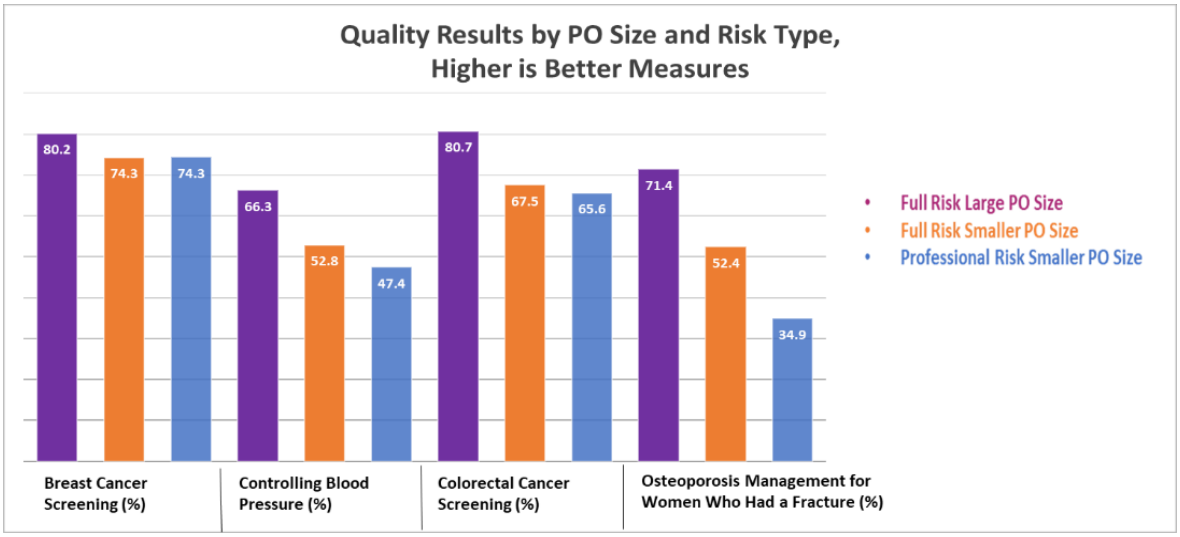
Bringing risk arrangement and size together: Large, full risk POs outperformed small/medium POs that are full risk or professional risk on almost all measures.

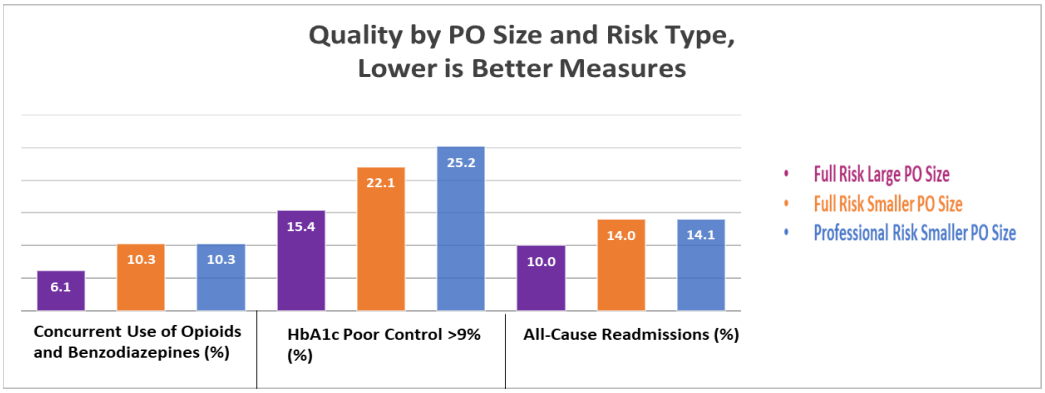
The multivariate regression analysis – assessing the association between risk type and performance on person-centered care measures after adjusting for PO size – found statistically significant results for two measures. After adjusting for PO size, compared to professional only risk arrangements, performance for Plan-POs in full risk arrangements show:

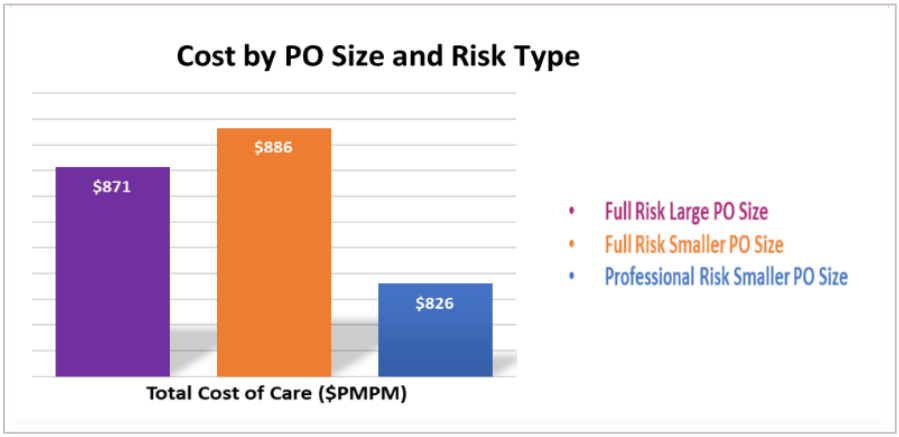


For all other measures, the relationship between risk type and person-centered care performance, after accounting for PO size, was not statistically significant. However, the graphs below still show a clear pattern that large, full risk Plan-POs (purple bars) generally outperform other categories of Plan-POs.









LIMITATIONS & FUTURE OPPORTUNITIES

These results are for MY 2020, which was far from a normal year with the COVID-19 pandemic. The results indicate that POs that enter into full risk contracts and serve a larger number of Medicare Advantage members were better able to continue providing needed care even in the midst of a pandemic. Analyses for other years would be needed to confirm that these findings hold true under more normal circumstances.

This research indicated that there is a positive relationship between delivering person-centered care and being paid under a more flexible, population-based payment model with greater financial risk. However, the analysis could not compare performance of POs with no financial risk since only 1% of Medicare Advantage PO contracts were categorized as no risk or facility risk only. Previous work by IHA showed that populations cared for by providers with any financial risk sharing received better quality care at a lower total cost than populations cared for by providers with no financial risk sharing.[13] Assuming that finding would apply to this study, performance on person-centered care measures would be weaker for providers with no financial risk. This should be confirmed in future analysis by including traditional Medicare, where many providers are still paid fee-for-service.

Using a subset of measures already being collected to produce baseline measurement of person-centered care in California, and assessing its relationship to provider financial risk arrangement, is an important foundation. There is opportunity to continue to expand measurement to other areas important to person-centered care. Some examples of this could be shared decision making through use of the collaboRATE tool[14] or CAHPS supplemental questions,[15] CAHPS Patient-Centered Medical Home (PCMH) item set,[16] functional outcomes using PROMIS,[17] patient preferences via use of POLST,[18] the new Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure,[19] and person-driven outcome measurement being tested by National Committee for Quality Assurance.[20] Any expanded person-centered measurement efforts should be incorporated into existing measurement initiatives to avoid increasing burden on providers.

Determining the type(s) of payment model(s) that can support the trust and relationship building necessary for person-centered care is a worthwhile endeavor, and this study suggests that financial risk arrangements such as population-based payment may allow the flexibility and innovation needed. In California, there is limited opportunity for further increasing risk-based contracting in Medicare Advantage because providers already nearly universally take risk through professional, facility, or global capitation in their Medicare Advantage contracts. Increased risk-based contracting could be pursued in other scenarios.

As the health care industry strives to increase equity and decrease disparities, person-centered care should be a focal point. The use of provider financial risk arrangements through population-based payments is a key consideration in advancing person-centered care.

AUTHOR INFORMATION

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APPENDIX

Measuring Person-centered Care in California Today

There are many areas of alignment between performance measurement currently being done in California and the common elements of person-centered care, detailed in the table below.

Performance Area	Description	PCC Alignment Area
Access to Care	Timely appointment for routine care and acute care, same day response for contact during office hours	Access, timeliness
Provider Communication	Doctor easy to understand, listens carefully, shows respect, spends enough time	Respect, empathy, collaboration
Care Coordination	Doctor knows important medical history, followed up on test results, discussed all medications, is informed about other care	Coordination, communication, information sharing
Office Staff	Clerks and receptionists helpful, courteous, and respectful	Respect
Ratings Composite	Overall rating of doctor	Trust, Respect, Empathy, Collaborative
	Overall rating of care	Access, Timeliness, Coordination, Effective Treatment
Clinical Quality	Preventive care, chronic care, patient safety	Effective treatment, continuity of care and smooth transitions
Cost	Total cost of care	Access

[1] https://www.healthinnovation.org/resources/publications/body/Person-Centered-Care-Infographic_Jan-2021.pdf
[2] Alternative Payment Model (APM) Framework (hcp-lan.org)
[3] https://pubmed.ncbi.nlm.nih.gov/25057539/
[4] Person-Centered Care: A Definition and Essential Elements. JAGS, 64:15-18, 2016.
[5] https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559
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[13] https://cost-atlas-iha.s3-us-west-2.amazonaws.com/downloads/1.+Atlas+Risk+Story+2018+ry2019.pdf
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[20] https://www.ncqa.org/blog/person-driven-outcomes-opportunities-for-your-quality-measurement/