Health Care Quality Measurement and Monitoring Features to Consider

Supplement F to the Report:

Challenges and Alternatives for Employer Pay-or-Play Program Design: *An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2)*

For the
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and the
California Managed Risk Medical Insurance Board

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Supplement F:

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Background

The California Health Insurance Act of 2003 (also known as SB 2) adopted a "pay-or-play" mandate aimed at reducing the size of the state's uninsured population. This law required employers over a certain size to either: (a) "pay" a fee to the state so that their workers and, for employers with 200 or more workers, dependents could be covered through a State Health Purchasing Program established under the Act, or (b) "play" by directly providing health coverage for specified workers and dependents. Although SB 2 was overturned by a narrow margin in a November 2004 referendum, the passage of legislation intended to expand employment-based coverage provides a unique opportunity to assess and to evaluate the implementation issues and challenges presented by a "pay-or-play" program.

The Act directed California's Managed Risk Medical Insurance Board (MRMIB) to design and operate the program. This paper outlines key health care quality measurement and monitoring features that MRMIB may wish to consider in potential future efforts to develop such a program. Given that serious deficiencies in health care quality are known to exist throughout the United States, it is important that MRMIB build a quality monitoring component into its program [Schuster, 1998 #8;Institute of Medicine (IOM), 2001 #3;McGlynn, 2003 #159].

A Framework for Measuring the Quality Performance of the Health Care System

In 2001, the Institute of Medicine (IOM) published its landmark report "Crossing the Quality Chasm: A New Health System for the 21st Century" [Institute of Medicine (IOM), 2001 #3]. This report offered a detailed examination of the divide between what is known to be good health care and the health care that people actually receive. The IOM report defined a framework for the quality of the health care system, laying out six "aims for improvement." The IOM "STEEEP" framework (described below) is a useful blueprint that can help guide decisions about what aspects of care to measure.

- **Safe (S):** The system should be safe (i.e., free from accidental injury) for all patients, in all processes, all the time. For example, there should not be lower standards of safety on weekends or at night, patients should only need to tell their health care providers information once, and health information should not be misplaced or overlooked.

- **Timely (T):** The system should deliver care in a timely manner (i.e., without long waits that are wasteful and often anxiety-provoking). This domain addresses access issues.

- **Effective (E):** The system should provide care that is effective, based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcomes. This domain concentrates on the appropriateness of care (i.e., care that is indicated, given the clinical condition of the patient) and addresses the problems of over use and under use of health care services.

- **Efficient (E):** The system should be efficient (i.e., use resources to obtain the best value for the money spent). This domain addresses the underlying variation in resource utilization in the system and the associated costs.

- **Equitable (E):** The system should be equitable, meaning that care should be based on an individual's needs, not on personal characteristics (such as gender, race, or insurance status) that are unrelated to the patient's condition or to the reason for seeking care.

- **Patient-Centered (P):** The system should be patient-centered. This concept encompasses the following: respect for patients' values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support (i.e., relieving fear and anxiety); and involvement of family and friends.

In an ideal world, a comprehensive assessment of the quality-related performance of the health care system should seek to include measures that address all six of these IOM domains. However, currently there are measures that address only some of the domains (as discussed below); for others, there is either an absence of measures or the measures are only starting to emerge.

Beyond examining the quality-related performance features of the system, there are other dimensions of a health plan and its underlying network of health care providers that factor into consumer choice of health plan. Information on the dimensions known to be critically important to consumers should be provided to help them make informed choices. To start, the following information should be provided to consumers: comparative information on the specific benefits provided by each plan, the out-of-pocket costs to the consumer (i.e., co-payments, deductibles and whether those differ by tiered classification of provider), a listing of providers whom the patient can access, and the office locations of these providers [Farley, 2000 #163;Harris-Kojetin, 2001 #161;Braun, 2002 #162].

Quality Measurement Considerations

Currently, there is an assortment of quality measures available that have been developed by various organizations throughout the country. Although they are limited in scope (i.e., the IOM domains and/or the clinical conditions covered), these measures are a good starting place.

In California, there are already several organized quality measurement efforts in play at the health plan, medical group, and hospital levels that could serve as a foundation for MRMIB's quality-related data collection and reporting efforts. Rather than "starting from scratch," MRMIB should begin by defining its priorities and determining whether and how these can be

achieved by working in collaboration with existing California quality measurement efforts. In doing so, MRMIB will promote the larger goals of standardizing measurement in the marketplace, minimizing conflict with existing measurement activities, and efficiently using resources so as to allow measurement of more areas of plan and provider quality-related competencies. To the extent that MRMIB can join and support current efforts already underway in California, it will be able to obtain a reasonable pool of measures in the near term that are comparable with those being compiled by the private sector.

The quality-related measures that MRMIB could consider, many of which are currently being used in California, are discussed below and presented in Table F-1. Both in the text and in the table, the measures are organized according to the IOM STEEEP domains in order to facilitate understanding of how well existing quality measurement efforts address these key dimensions.

- **Safe (S):** The area of patient safety measurement is still in its infancy. Currently there are only a handful of measures that can or are being applied that provide information on either the adoption of safe practices to reduce medical errors or adverse event errors themselves. The Leapfrog Group, a national consortium of more than 160 Fortune 500 corporations and other large public and private purchasers (representing more than 34 million enrollees), is collecting data from hospitals in the communities in which Leapfrog operates, including California. Fifty-nine percent of California's urban acute-care hospitals participated in the voluntary 2004 survey [The Leapfrog Group Data, 2004 #174].

The 2004 Leapfrog survey collected data on four safety practices:

1. Computerized Physician Order Entry (CPOE): When physicians use computers and specialty software to enter patient prescriptions and other orders, up to 80% of serious drug errors are prevented. Despite the significant investment needed to put CPOE into practice, 3% percent of responding hospitals have fully implemented the standard, and an additional 12% are making progress toward implementation.

2. ICU Physician Staffing (IPS): By staffing intensive care units with trained ICU specialists ("intensivists"), hospitals can reduce ICU mortality by 40%. In California, 19% of responding hospitals with ICUs had fully implemented the ICU physician-staffing standard.

3. Evidence-Based Hospital Referral: Hospitals with significant experience in performing a procedure and that adhere to certain patient care processes are more likely to produce good patient outcomes. Among responding hospitals that perform these procedures (e.g., coronary artery bypass graft, percutaneous coronary interventions, abdominal aortic aneurysm repair, and neonatal intensive care), fewer than one third met the standards that apply to them.

4. Leapfrog Quality Index: Leapfrog scores hospitals' progress on 27 National Quality Forum (NQF) Safe Practices; (the three practices listed above complete the set of 30 NQF standards). These practices include safe medication use, following specific care processes and improving the transfer of patient information. Twenty three percent of California hospitals scored in the top tier of the Quality Index.

The Leapfrog Group's initial efforts have been focused on the hospital setting, but future measurement efforts will focus on safety in the ambulatory care setting.

In addition to the work of Leapfrog, the federal Agency for Healthcare Research and Quality (AHRQ), through its patient safety portfolio of projects, continues to develop and refine a set of patient safety indicators (PSIs) that can be derived from administrative data [Agency for Healthcare Research and Quality, 2004 #172]. To date, AHRQ's PSIs have not been run on the California discharge data that is available through the California Office of Statewide Health Planning and Development (OSHPD); however, they could easily and inexpensively be run to flag hospitals with potential safety issues.

In the near term, we recommend that MRMIB make use of the Leapfrog data already being collected in California and work with that group to promote broader participation in the survey by California hospitals. Additionally, MRMIB may want to pursue the production of the AHRQ PSIs, either alone or in collaboration with other stakeholders in California.

- **Timely (T):** See "patient-centered" below. Timeliness of services is addressed in the CAHPS survey, which covers a range of access items.

- **Effective (E):** The effectiveness of health care is usually assessed through evidence-based process and/or outcomes measures. Process refers to what occurs during the patient-provider interaction (e.g., the provision of care, such as administering an immunization), and consists of both technical excellence (i.e., the appropriateness of the intervention) and interpersonal excellence (i.e., the humane and responsive nature of the care provided to the patient) [Donabedian, 1988 #19]. Outcome refers to the effect of the care on the health status of both patients and populations (i.e., what happens as a result of delivering the service, such as reduced mortality or increased functional status); it includes the results of efforts to prevent, diagnose, and treat health problems, and is often viewed as the "bottom-line" of health care quality assessment [Donabedian, 1988 #19;McGlynn, 2001 #4]. Process data are thought to be more sensitive measures of quality than outcome data because a poor outcome does not necessarily occur every time the provision of care is substandard and/or may not be captured because the outcome (e.g., increased longevity) may not occur for many years [Brook, 1996 #34]. Process measures may also be viewed as proxies for outcomes if a link has been demonstrated. For example, the process measure of an adult receiving an immunization against measles, mumps, and rubella is a proxy for the desired outcome, preventing these diseases and the associated morbidity and mortality.

Presently in California as elsewhere in the country, the reporting of outcome measures is not as common as the reporting of process measures; there are several reasons why outcomes are not routinely collected and reported. First, outcome data are not typically entered into administrative data systems (i.e., encounter data), and must therefore be derived from medical chart review which is a costly and time-consuming endeavor. Second, important outcomes (e.g., mortality) often require significant amounts of time to detect. Third, outcome measures frequently require case mix adjustment to account for the differential mix of patients across health plans, medical groups, and hospitals. As the case mix adjustment variables are often only available in medical charts, considerable energy and resources are required to collect this information. Fourth, with

outcome measures, hard-to-measure patient compliance (e.g., diet, exercise) may be a more significant factor than it is with process measures.

As a start, MRMIB should consider including the measures that NCQA requires for accreditation: HEDIS clinical measures (approximately one dozen measures) and CAHPS patient experience survey measures. Whether MRMIB can use the data already collected through the California Cooperative Healthcare Reporting Initiative (CCHRI)-- a collaborative of purchasers, plans and provider organizations that collects HEDIS and CAHPS data annually for California commercial HMO plans-- will depend on the type of plan offerings the program makes available and whether those mimic what is offered in the private commercial market. As the existing CCHRI effort does not capture HEDIS or CAHPS information for PPO plans, the program would need to collect new information for this plan type. Concerning hospital quality, OSHPD tracks outcomes relating to coronary artery bypass surgery (CABG) surgery as well as care provided for pneumonia and acute myocardial infarction (AMI). As these data are publicly available, MRMIB could track them for the hospitals involved in the program. MRMIB could also consider AHRQ's Quality Indicators (QIs) that assess hospital quality using readily available administrative data [AHRQ Quality Indicators, 2004 #175].

Over time, as more comprehensive and less labor-intensive measurement systems are developed, MRMIB-- in conjunction with other large purchasers in the state-- should consider moving to these newer systems, given that they are likely to result in broader measurement of quality of care across a multitude of dimensions at lower cost. For example, RAND is currently developing a version of its comprehensive Quality Assessment Tools ("QATools") measurement system that can be run using claims data to produce clinical scores; this system contains some hospital measures, but mainly focuses on ambulatory care and can be applied at the plan, group, practice site, or physician level. Another emerging measurement effort is the California Hospital Assessment & Reporting Task Force-Phase I (CHART-1) Project. The CHART-1 project is a collaborative planning effort (funded by the California HealthCare Foundation, CHCF) involving a variety of stakeholders (e.g., purchasers, health plans, consumers, and hospitals) that is working to define the contents of a hospital report card for California as well as a business model for implementing the plan. If implemented, phase II of CHART would constitute a voluntary reporting initiative to produce public performance information pertaining to safety, access, and clinical measures at the hospital level. This measurement effort represents a significant opportunity for MRMIB to gain access to comparative hospital performance information to share with consumers; MRMIB could also participate in the development process to ensure that issues germane to program enrollees are reflected in the quality measures reported under CHART.

- **Efficient (E):** Efficiency measures that combine into a single metric the clinical services offered at a particular price have not been used to assess the overall value of the care provided. Researchers have shown that there is significant variation in the efficiency with which health care services are provided within episodes of care [Thomas, 2004 #176][Thomas, 2004 #177]; both public (e.g., the Center for Medicare and Medicaid Services/CMS, and the Medicare Payment Advisory Commission/MedPAC) and private purchasers as well as their health plan agents are increasingly paying attention to this area, wanting to monitor this information, and use it to help guide consumers' choices of providers. MRMIB should follow the development of efficiency

measures, and as measures become available, MRMIB should review and consider including them.

- **Equitable (E):** At present, the assessment of equity is largely limited to a handful of research studies and is not part of the routine measurement of the health care system. There is a dearth of measures in this area for "ready implementation." In the absence of "off the shelf" measures, MRMIB could require that the plans and providers participating in the program track basic demographic characteristics of enrollees to understand whether services are delivered in an equitable manner. As better equity measures become available, MRMIB should review them and consider requiring them.

- **Patient-centered (P):** With respect to consumer satisfaction/experience at the health plan level, the standard tool is the Consumer Assessment of Health Plans Survey (CAHPS). In California, CAHPS data are collected for both the commercially-insured HMO population as well as the Medicare-plus-choice population. This survey is a widely recognized, reliable, and valid measurement tool that the major health plans in California use for meeting external accreditation requirements through NCQA. The commercial HMO plans in California have six years of experience collecting and reporting the CAHPS data. As such, MRMIB should support CAHPS. If MRMIB identifies unique needs associated with its program, it could consider adding "trailer questions" to existing CAHPS data collection efforts.

At the medical group level, CCHRI annually fields the group-level CAHPS survey (i.e., the Consumer Assessment Survey or "CAS"). For the 2004 measurement year, 155 medical group reporting units participated in the survey effort, and for 2005, 180 groups have signed up to participate. These data are made available to consumers at two websites: 1) the Pacific Business Group on Health's (PBGH) California Consumer Healthscope website [HealthScope, 2004 #171] and 2) the Office of the Patient Advocate (OPA) website [California Office of the Patient Advocate, 2004 #170]. PBGH has been working for the past three years with approximately 20 medical groups in California to implement physician level surveying; these data are not yet publicly reported to consumers. Given that consumers are very interested in physician level information, MRMIB should consider working with other purchasers in California to push for increased accountability of physician level performance information, starting with a consumer experience survey.

Nationally, the AHRQ sponsored-CAHPS team is developing a patient experience with care survey (i.e., Ambulatory CAHPS OR "A-CAHPS") that can be applied at the medical group, practice site, or individual doctor level [CAHPS, 2004 #165]. Over time, it is likely that market pressure in California will push for the implementation of A-CAHPS data collection and public reporting at the individual doctor level. MRMIB may want to consider working in concert with other purchasers in the market place to require that these data be collected and reported.

At the hospital level, momentum is gaining for the adoption and implementation of a national standardized tool for measuring patient experience with care. Historically, hospitals have used a variety of proprietary survey tools that have not allowed for comparisons of patient-reported care experiences across hospitals. AHRQ and CMS are funding the CAHPS teams to developed "H-CAHPS," a survey of patients who have been admitted to hospitals that asks them to report on

their care experiences. In California, CHCF in conjunction with California Institute for Health Systems Performance (CIHSP) have been fielding the Patients' Evaluation of Performance in California (PEP-C) survey annually for the past three years. The 2004 survey (PEP-C III) embeds the H-CAHPS survey items in a larger survey covering more domains of the patient care experience than is captured alone by the H-CAHPS tool [CAHPS, 2004 #165]. The PEP-C III survey is being conducted in 200 hospitals in California. It is anticipated that if the CHART process moves forward, a significant share of California hospitals will participate in a standardized consumer assessment survey (i.e., either H-CAHPS or a modified version of H-CAHPS that may incorporate domains covered in the PEP-C survey). MRMIB's program or its plan partners should consider making such information available to consumers to guide their choice of where to receive hospital care.

As noted earlier, Table F-1 below presents measures that MRMIB could consider. As revealed in this table, current quality measurement efforts are largely focused on clinical effectiveness (evidence-based), timeliness, patient centeredness, and (to a limited extent) safety. Most of these efforts are at the plan level, but increasingly measures are drilling down to the medical group and hospital levels as well. To date, the same level of attention has not been directed towards efficiency and equity measures; although some valid metrics exist, additional work is needed in these areas to create standardized measures.

Table F-1: California Quality Measurement Activities Organized by IOM Six Quality Aims

Quality Measures	Organization Collecting Information	IOM Six Quality Aims					
		Safe	Timely	Effective	Efficient	Equitable	Patient-centered
HEDIS clinical measures (health plan level)	CCHRI			X			
CAHPS (health plan level)	CCHRI		X				X
Consumer Assessment Survey (medical group level)	CCHRI		X				X
IHA Pay for Performance HEDIS clinical measures	IHA and participating plans			X			
Leapfrog Measures*	Leapfrog Group in partnership with PBGH in CA	X					
AHRQ Patient Safety Indicators (PSIs)	Not being collected	X					
AHRQ Quality Indicators	Not being collected			X		X	
CHART-1 Hospital Measures	CHART stakeholders (planning stage)	X	X	X			X
California Hospital Outcomes Program (hospital level)	OSHPD			X			
Efficiency Measures	Under development (PBGH, health plans, CMS)				X**		

* Currently hospital only; will include ambulatory in future.
** Currently under development

In terms of the level of measurement, the initial focus for quality assessment within MRMIB's program should center on plan level indicators of quality, piggybacking on the efforts already in play in the California market. Significant work is already occurring in California to shift measurement down to the hospital, medical group, and physician levels, and these efforts offer important opportunities for MRMIB to capture information that is more useful to consumers in making decisions about where to receive care. For example, the Integrated Healthcare Association (IHA)-- a California leadership group of health plans, physician groups, health systems, and other industry representatives-- is tracking clinical performance and patient experience scores of capitated medical groups in the state, and the participating health plans are providing financial rewards for better performance [Integrated Healthcare Association, 2004 #164]. In California, OPA and PBGH are already reporting measures publicly to consumers at the plan and medical groups levels.

Significant challenges are associated with moving measurement down to the provider level— including who will pay for measurement for a large number of providers, ensuring sufficient denominators to provide stable estimates of an individual provider's performance, pooling data across public and private payers to facilitate measurement, and the lack of electronic information systems to support cost-effective measurement. MRMIB can serve as another important voice in the marketplace to push for accountability/transparency at this level and encourage the development of solutions to these measurement challenges.

It is assumed that MRMIB's program would offer a variety of plans, potentially including health maintenance organizations (HMOs), point of service (POS), preferred provider organizations (PPOs), and possibly fee-for-service (FFS) plans. These different plan types have different implications for measurement and for discussing the other dimensions of choice. Certain measures that may be available in managed care delivery models (e.g., HMOs and POS plans and providers) tend not to be available in more open types of plan (e.g., PPO and FFS), primarily due to issues associated with accountability, which is less clear-cut in PPO and FFS models of delivery. Additionally, an individual's eligibility for and enrollment in MRMIB's program as well as self-selection into different plan types must be taken into account to the extent that comparisons across plan types are going to be made. If differences are significant, it is preferable to display within-plan-type comparisons only. Plan type differences may necessitate separate surveys (as NCQA does) and/or separate report cards.

As noted, much of the performance information currently is being collected in California by CCHRI. The provision of such information is also in keeping with what MRMIB already provides to enrollees in some of its other programs (e.g., Healthy Families). This significant measurement work and infrastructure for collecting quality data in California offers an important opportunity for MRMIB to dovetail its quality assessment efforts with CCHRI, so as to ensure standardization and to improve the efficient use of resources.

Finally and importantly in terms of measurement, in addition to the six areas outlined above, MRMIB should track the structural characteristics of the health care organizations involved in its program. Structure refers to the relatively stable elements of a health care delivery system that may impact several components of quality (e.g., access, provision of services) [McGlynn, 2001 #4]. It includes community characteristics (e.g., disease prevalence, distance to health service

areas), organizational characteristics (e.g., number of hospital beds per capita, staffing patterns), provider characteristics (e.g. specialty mix, board certification status), and population characteristics (e.g., sociodemographics, insurance status) [McGlynn, 2001 #4]. In California and nationally, structural quality is most commonly assessed through organizational accreditation (i.e., programs that evaluate whether organizations, such as hospitals and health plans, have systems in place that support the delivery of high quality care). The primary players for accreditation are the National Committee for Quality Assurance (NCQA) which accredits managed care plans, URAC which accredits PPOs, and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) which accredits hospitals. (Of note, for NCQA accreditation, managed care plans must submit and report data on clinical and patient experience with care measures.) MRMIB should track and report the accreditation status of the hospitals and health plans involved in its program.

Reporting Considerations

Given that both the state and enrollees will need information about the program in order to assess it and/or make informed choices, it is assumed that MRMIB—a government agency accountable to the public-- will report the data it collects publicly. Report cards are the most obvious and familiar way to provide information on quality to consumers, typically at the time consumers are asked to choose a health plan. In California and nationally, plans, employers, purchasing coalitions, and others increasingly use this method of communication with consumers (e.g., PBGH, OPA, NCQA). However, despite the fact that report cards on health care quality are becoming increasingly common, there are many pitfalls and caveats, as MRMIB is likely already aware from its previous experiences producing report cards for some of its other programs (e.g., Healthy Families). In this section, we offer MRMIB some areas for consideration for reporting quality information to program participants.

First, as noted earlier, MRMIB should identify the set of measures it wants to collect and report, the purpose or goals of tracking these measures (e.g., accountability, quality improvement, etc), and the strategy by which it will collect the data (including partnering with other organizations that are already collecting data so as to avoid redundancies and minimize the burden of data collection on plans and other providers). Once MRMIB has established its measurement goals and data collection strategy, it should follow the report planning and design principles below when reporting health care quality information to consumers or other audiences [Kanouse, 2004 #168]:

Report Planning Principles:

- Know the audience of the report; clearly identify who they are, what they care about, and what actions they can take.
- Identify resource and other (e.g., political) constraints that may limit what is feasible in terms of reporting. Here, MRMIB should identify other players in the marketplace that it can partner with to achieve its objectives in a cost effective manner.
- Consider barriers (e.g., norms) and facilitators (e.g., champions) to achieving objectives and/or how to overcome them and/or turn them to into an advantage.
- Define objectives (i.e., the behaviors of the intended audience that you want to change and the outcomes you want to effect), and set priorities.

Report Design Principles:

- Design a report that specifically incorporates the results of the priority-setting and trade-off process.
- Develop a plan for promotion and dissemination at the project's outset.
- Build in on-going testing and evaluation—both formative work to shape the reporting effort, and "after-the-fact" evaluation to identify successes and areas needing improvement.

The points made in the last two bullets (regarding dissemination and evaluation) are often over looked when organizations are designing reports. To increase the odds of creating a report that is actually used, it is critically important for report designers to map out how the report will be disseminated (e.g., in open enrollment packets, in public locations like libraries, etc) and promoted (e.g., via a press conference, in open enrollment materials, etc). It is also critical to evaluate the report to obtain feedback that can be incorporated into subsequent reports.

In terms of report design specifics, key areas that MRMIB should consider include (but are not limited to):

- Medium of report (e.g., paper vs. web-based)
- Language(s) in which report(s) offered
- Reading level of report(s)
- Length of report(s)
- Graphical displays
- Presentation of different types of data together in one report (e.g. HEDIS, CAHPS)
- Explanation of methods/statistical analyses
- Ease of navigation
- Special considerations of MRMIB program population

Cost Considerations

The costs associated with quality measurement potentially may include data collection, data analysis, reporting of the results, dissemination of the results, and evaluation of the measurement and reporting efforts. The costs to MRMIB of assessing quality for its program will depend on the extent to which the program can make use of existing data collection efforts or whether new data collection efforts are required. For HMO data produced by existing collaboratives, MRMIB would be expected to pay a share of the costs of the data collection, which will be lower than if MRMIB were collecting the data itself. For PPO data, it is likely that MRMIB will need to expend resources, as this portion of the market has not already been measured. MRMIB should keep in mind the data collection and reporting requirements of other organizations, such as CCHRI and other state reporting entities, and aim to work collaboratively with them to minimize the burden on reporting entities and the associated costs.

If MRMIB does elect to require public reporting and especially if measures are added that many plans are not currently collecting, it should consider instituting a pre-public report phase during which plans have a chance to get used to the measures before they are made public. Such a pre-release phase may require resources from MRMIB to host meetings where concerns about the measures can be discussed.

Finally, given that costs are an important consideration to consumers in selecting a health plan, MRMIB should consider providing consumers with a way to calculate the direct costs to them for their health insurance. Such tools are very helpful and are becoming more common. For example, several large employers in California embed PBGH's cost calculator into their customized websites to assist their employees in comparing both the quality and costs of care in available plans [Pacific Business Group on Health, 2004 #173]. PBGH also offers the cost calculators in its PacAdvantage small group purchasing pool. MRMIB should consider providing such a feature on its web site for this program.

Other Monitoring Components to Consider

Distinct from the quality-related information MRMIB collects, it should consider obtaining feedback from employers, plans, and program participants themselves about the administration of the program. Feedback could be obtained via add-on trailer questions to an existing survey, a separate short survey, focus groups, and/or telephone interviews of a representative sample. Such information would likely provide useful information to MRMIB that would help in maintaining and improving the program.

Conclusion

In summary, we recommend that MRMIB consider doing the following:

1. Embark on a planning process to identify the "units" of accountability and the areas for which MRMIB wants to hold these units accountable. Then, MRMIB should determine whether its goals overlap with existing quality measurement work in California.

2. Link to existing measurement efforts to obtain data that is already routinely collected in California. At the plan level this includes: NCQA accreditation status, HEDIS, and CAHPS. At the medical group level, this includes: IHA clinical measures and the CCHRI patient experience survey. At the hospital level, this should include the OSHPD outcomes measures, the PEP-C or H-CAHPS patient experience measures, the larger CHART set of measures (should it be implemented), and AHRQ's PSIs and QIs. As less cumbersome and less expensive measurement alternatives become available (e.g., claims-derived measures), MRMIB should consider their adoption.

3. Adhere to national standards of measurement, and avoid developing "local" or "homegrown" measures unless there are no national and/or California standardized measures available to address the unique needs of the program.

4. Reflect upon what is unique to the program (e.g., multiple plan types) and implications of these factors for measurement and cost.

5. Link with public reporting efforts already underway in California (e.g., PBGH and OPA).

6. Require the public reporting of measures to promote transparency, which has been shown to motivate quality improvement. Design reports that are geared to the intended audience and make them available at the point of decision.

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