Doctors Community Hospital
**Attachment D: HSCRC Outcomes and Processes Measures**
CY 2016

| | HSCRC Core Outcomes Measures | | | |
|---|---|---|---|---|
| | **Measure** | **Definition** | **Source** | **Population(s) expected** |
| A | Total hospital cost per capita | Hospital charges per person | HSCRC Casemix Data | All population for covered zips, high utilization set, target population if different, each by race/ethnicity |
| B | Total hospital admits per capita | Admits per thousand | HSCRC Casemix Data | All population for covered zips, high utilization set, target population if different, each by race/ethnicity |
| C | Total health care cost per person | Aggregate payments/person | HSCRC Total Cost Report | All population for covered zips, high utilization set, target population if different, , each by race/ethnicity |
| D | ED visits per capita | Encounters per thousand | HSCRC Casemix Data | All population for covered zips, high utilization set, target population if different, , each by race/ethnicity |
| E | Readmissions | All Cause 30-day Readmits (see HSCRC specs) | CRISP | High utilization set, target population if different, each by race/ethnicity |
| F | Potentially avoidable utilization | (see HSCRC specifications) | PAU Patient Level Reports | High utilization set, target population if different, each by race/ethnicity |
| G | Patient experience | % rating 9 or 10 | HCAPHS | High utilization set, target population if different, each by race/ethnicity |
| H | Composite quality measure | TBD | | High utilization set, target population if different, each by race/ethnicity |

| | HSCRC Core Process Measures | | | |
|---|---|---|---|---|
| | **Measure** | **Definition** | **Source** | **Population(s) expected** |
| I | Use of Encounter Notification Alerts | % of inpatient discharges that result in an Encounter Notification System alert going to a physician | CRISP | All population for covered zips, high utilization set, target population if different |
| J | Completion of health risk assessments | % High utilizers with completed Health Risk Assessments | Hospital, Partnership, Collaboration | High utilization set, target population if different |
| K | Established longitudinal care plan | % of High Utilizers Patients with completed care | Hospital, Partnership, Collaboration | High utilization set, target population if different |
| L | Shared Care Profile | % of patients with care plans with data shared through HIE in Care Profile | CRISP | High utilization set, target population if different |
| M | Portion of target pop. with contact from assigned care manager | % of High Utilizers Patients with contact with an assigned care manger | Hospital, Partnership, Collaboration | High utilization set, target population if different |
| N | Variable savings to expense (ROI) on intervention | See next slide | Multiple sources needed | Intervention population |