



**Maryland Health Services Cost Review  
Commission: Measuring Consumer  
Engagement**

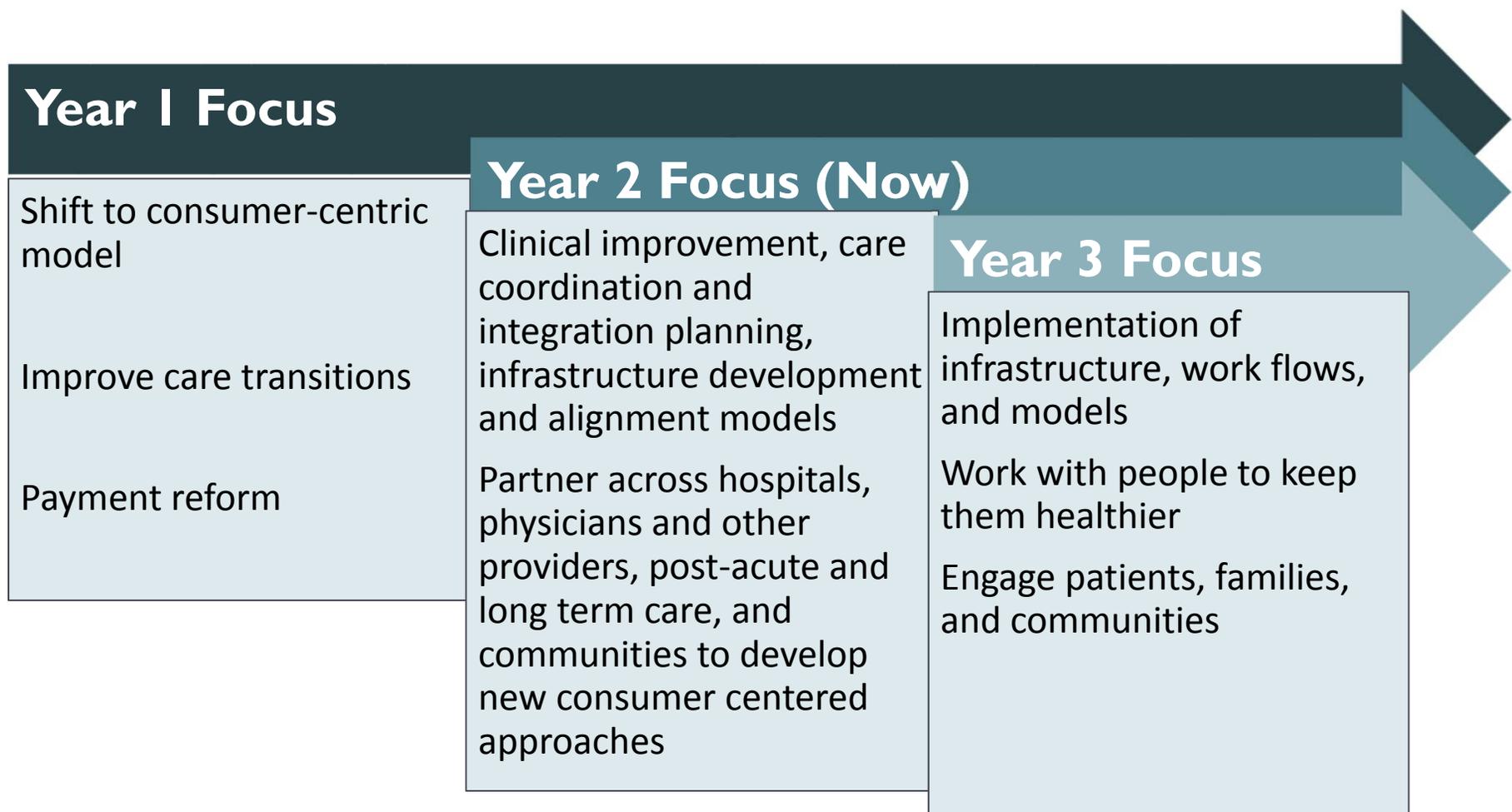
Consumer Engagement Task Force  
Meeting

June 30, 2015

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# Regional Partnerships Reporting

# Regional Partnerships: Progress Requires Goals, and Goals Need Measures.



# Regional Transformation Proposed Final Report Template

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## Regional Transformation Plan Template



### Goals, Strategies and Outcomes

Articulate the goals, strategies and outcomes that will be pursued and measured by the regional partnership.

Describe the target population that will be monitored and measured, including the number of people and geographical location.

Describe specific metrics that will be used to measure progress including patient satisfaction, quality, outcomes metrics, process metrics and cost metrics. Describe how the selected metrics draw from or relate to the State of Maryland's requirements under the new model.

Describe the regional partnership's current performance (target population) against the stated metrics.

# Performance Measurement

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Validated Measures

(Process, Cost, Quality, Patient Satisfaction  
Health)

Define Population

(Target Population, Region, Hospital level)

Adapt the measure to the plan

# Performance Measure Set

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## Core Set

- Uniform measures across all plans

## Plan Specific

- Validated measures based on plans
- New measures if needed

# Program Specific Measurement Potential Options

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- Maryland All Payer Model Contract Monitoring Measures
- GBR Infrastructure Reports
- HSCRC Total Cost Report (under development)
- CMS ACO Measure List
- Other validated quality measures
- Program specific unique measures

# HSCRC Total Cost of Care Report-Under Development

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## 1. Regulated:

- a. Hospital Inpatient:
  - i. Maryland Specialty Hospitals (Psych, Rehab, Children's Chronic)
  - ii. Maryland Acute Hospitals (Rehab, Oncology, Psych, Other)
- b. Hospital Outpatient:
  - i. Emergency Department
  - ii. Surgery
  - iii. Other Outpatient

## 2. Unregulated:

- a. Institutional:
  - i. SNF
  - ii. Long Term Care (LTC)
  - iii. Hospice
  - iv. Home Health
  - v. Other Institutional
- b. Professional:
  - i. ASC
  - ii. Urgent Care
  - iii. Primary Care
  - iv. Specialty
  - v. Therapies
  - vi. Other
- c. Other
  - i. Freestanding Lab
  - ii. Retail Pharmacy
  - iii. Freestanding Imaging

By  
Age,  
Zip Code,  
Payer Type

# ACO Measures

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- Set of measures that Medicare ACOs must report
- For purpose of demonstrating that care is being improved while savings are being realized
- Includes non-claims clinical data such as blood pressure readings
- Details can be accessed at:  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/R2015-Narrative-Specifications.pdf>
- Next slide shows a some measures that may be more applicable than others for this planning effort

# Some ACO Measures to Consider

Patient/Caregiver Exp	ACO #6	Shared Decision Making
Care coordination / Patient Safety	ACO #7	Health Status/Functional Status
	ACO #8	Risk Standardized, All Condition Readmissions
	ACO #9	ASC Admissions: COPD or Asthma in Older Adults
	ACO #10	ASC Admission: Heart Failure
	ACO #12	Medication Reconciliation
	ACO #13	Falls: Screening for Fall Risk
Preventive health	ACO #14	Influenza Immunization
	ACO #15	Pneumococcal Vaccination
	ACO #17	Tobacco Use Assessment and Cessation Intervention
	ACO #18	Depression Screening
At-Risk Population DM	ACO #27	Percent with diabetes whose HbA1c in poor control (>9 percent)
At-Risk Population IVD	ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic

# Example Difference Between ACO and PQI Measures: Uncontrolled Diabetes

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## ▶ ACO

- ▶ ACO # 27 = NQF 0059 (*NQF, National Quality Forum, is a place to find many more validated measures and links these to other sources*)
- ▶ Measure of poor control is percent of patients with an A1c > 9, so a clinical (non-claims) measure is needed
- ▶ Lens is physician panel of patients (or panels) but should be entire population as appropriate and possible

## ▶ PQI

- ▶ PQI # 14 = NQF 0638
- ▶ Measure of poor control is admissions for diabetes as a principle diagnosis (so claims data works and measure is an actual outcome of poor control)
- ▶ Lens is whole population in a geographic area

# Application of these Measures to Regional Partnerships

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- Selecting the Right Performance Measures
  - No need to reinvent the wheel or add new measures
  - Use Maryland measures, ACO measures or other NQF measures
  - Use evidence based or evidence-informed measures
- Some basic high level metrics are so fundamental to new All Payer Model and the goals of the Regional Partnerships, they should be included in all projects:
  - Recommended Core Outcome Measures
  - Recommended Core Process Measures
  - Recommended Core Savings Measures

# Recommended Core Outcome Measures for Regional Partnerships

Measure	Definition	Source	Population(s) expected
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
Total hospital admits per capita	Admits per thousand person	HSCRC Casemix Data	
Total health care cost per person	Aggregate payments/person	HSCRC Total Cost Report	
ED visits per capita	Encounters per thousand	HSCRC Casemix Data	
Readmissions	All Cause 30-day Inpatient Readmits (see HSCRC specs)	Regional Readmission Reports (CRISP)	
Potentially avoidable utilization	Total PAU Charges/Total Charges	PAU Patient Level Reports	
Patient experience	TBD		
Composite quality measure	TBD		

# Recommended Core Process Measures for Regional Partnerships

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Measure	Definition	Source	Population(s) expected
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
Completion of health risk assessments	% High utilizers with <u>completed</u> Health Risk Assessments	Partnership	High utilization set, target population if different
Established longitudinal care plan	% of High Utilizers Patients with completed care	Partnership	High utilization set, target population if different
Shared Care Profile	% of patients with care plans with data shared through HIE in Care Profile	CRISP	High utilization set, target population if different
Portion of target pop. with contact from assigned care manager	% of High Utilizers Patients with contact with an assigned care manger	Partnership	High utilization set, target population if different

# Recommended Core Cost/Savings Measures for Regional Partnerships

- $ROI = G \text{ (variable savings)} \div D \text{ (annual intervention)}$
- ROI should be greater than 1 at steady state operations (and get there early)

Illustration	High Utilizers ≥ 3 IP Admits	High Cost Top 10%
A. Number of Patients	40,601	136,601
B. Number of Medicare and Dual Eligible	27,000	79,000
C. Annual Intervention Cost/Patient	\$3,500	\$3,500
D. Annual Intervention Cost (B X C)	\$95M	\$277M
E. Annual Charges (Baseline)	\$1.9B	\$3.8B
F. Annual Gross Savings (15% X E)	\$280M	\$570M
G. Variable Savings (F X 50%)	\$140M	\$285M
H. Annual Net Savings (G-D)	\$45M	\$8M

# Data Resources Available to Regional Partnerships

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- Regional Partnerships are expected to use a combination of data resources to monitor the performance of their programs
- Some data will need to be developed and produced by the Regional Partnership
- There are data resources available through DHMH, HSCRC and CRISP that can serve as a resource
  - An Inventory of data resources will be the subject of the July 9<sup>th</sup> Webinar
  - A Data Resources link is available on the Regional Partnership website that describes these resources

# Regional Partnerships Next Steps

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- Next webinars are:
  - July 9 – Data Resources (DHMH, HSCRC, CRISP and other)
  - July 23 – CRISP, activities list, tools to support transformation, e.g., care profiles and health risk assessments
- Report Inventory – in progress, to be posted on Basecamp

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# HSCRC Potential Consumer Engagement Measures

Prepared By:



NQF #	AHRQ #	Measure Title	Measure Description	Gap Area	Part of Cluster?	Program Alignment	Designated Care Setting	Designated Level of Analysis	Designated Data Sources	Stage II?	Stage III?
1919		Cultural Competency Implementation Measure	The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations.	Shared Decision-Making		MU2 Core: 80% all unique patients have demographics recorded (including language, gender, race, ethnicity...)	ASC; Ambulatory Care; Clinician Office/Clinic, Urgent Care, Emergency Medical Services/Ambulance; Home Health; Hospice; Hospital/Acute Care Facility, Specialty Hospitals	Facility; Health Plan; Integrated Delivery System	Healthcare Provider Survey		X
1641		Hospice and Palliative Care: Treatment Preferences	Percentage of patients with chart documentation of preferences for life sustaining treatments.	Shared Decision-Making/End of Life	Yes		Hospice, Hospital/Acute Care Facility	Clinician: Group, Facility	Electronic Clinical Data, EHR	X	
1898		Health literacy measure derived from the health literacy domain of the C-CAT	0-100 measure of health literacy related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit	Patient Nav/Self-Management	Yes		Ambulatory Care: Clinician Office/Clinic, Urgent Care, Hospital/Acute Care Facility	Facility	Healthcare Provider Survey		X
1892		Individual engagement measure derived from the individual engagement domain of the C-CAT	0-100 measure of individual engagement related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit	Patient Nav/Self-Management	Yes		Ambulatory Care: Clinician Office/Clinic, Urgent Care, Hospital/Acute Care Facility	Facility	Healthcare Provider Survey		X
1896		Language services measure derived from language services domain of the C-CAT	0-100 measure of language services related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit (C-CAT)	Patient Nav/Self-Management	Yes		Ambulatory Care: Clinician Office/Clinic, Urgent Care, Hospital/Acute Care Facility	Facility	Healthcare Provider Survey		X