



# **Maryland Health Services Cost Review Commission**

Technical Assistance  
Goals and Measures  
Webinar

June 25, 2015

# Agenda

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- Regional Partnerships' requirement to define performance measures related to goals
- Overview of HSCRC performance measurement
- Aligned ACO measures
- Recommended Core Measures for Regional Partnerships (Goals, Outcomes, Process, Savings)
- Next steps
  - FAQs – Webinar follow-up and RP requests
  - July Webinars and utilizing CRISP data and tools

# Why are we here?

## Year 1 Focus

Shift to consumer-centric model

Improve care transitions

Payment reform

## Year 2 Focus (Now)

Clinical improvement, care coordination and integration planning, infrastructure development and alignment models

Partner across hospitals, physicians and other providers, post-acute and long term care, and communities to develop new consumer centered approaches

## Year 3 Focus

Implementation of infrastructure, work flows, and models

Work with people to keep them healthier

Engage patients, families, and communities

*Progress requires goals. Goals need measures.*

# Regional Transformation 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.

# HSCRC Performance Measurement

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Director of Population Based Methodologies

# 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
- Draft at the end

## 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 Performance Measures

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Process  
of Care

Patient  
Satisfaction

Outcomes

# Clinical Care Measures

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- These measures show how often hospitals provide care that research shows gets the best results for patients with certain conditions.
- National Hospital Inpatient/Outpatient Quality Measure Specifications- based on medical chart abstractions
  - Examples
    - Heart attack patients who got drugs to break up blood clots within 30 minutes of arrival
    - Heart attack patients given aspirin at discharge
    - Giving the recommended antibiotics at the right time before surgery
    - Stopping the antibiotics within the right timeframe after surgery
  - Reference:  
[http://www.jointcommission.org/assets/1/18/ACCOUNTABILITYMEASURESList\\_2014\\_May2015.pdf](http://www.jointcommission.org/assets/1/18/ACCOUNTABILITYMEASURESList_2014_May2015.pdf)

# Patient Experience of Care

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- HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay.
- The survey asks a random sample of recently discharged adult patients to give feedback about topics such as:
  - how well nurses and doctors communicated,
  - how responsive hospital staff were to patient needs,
  - how well the hospital managed patients' pain,
  - the cleanliness and quietness of the hospital environment.

# Outcomes

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- Mortality:
  - HSCRC- All Payer Inpatient Mortality Rates
  - CMS- Medicare Condition Specific 30-Day Mortality Rates
    - Heart Attack
    - Heart Failure
    - Stroke
    - Pneumonia
    - COPD
- Complications
  - HSCRC-Potentially Preventable Complications (PPC)
  - CDC-Health Care Associated Infections
- Patient Safety Indicators
  - AHRQ- Patient Safety Composite Measure

# Inpatient Readmissions

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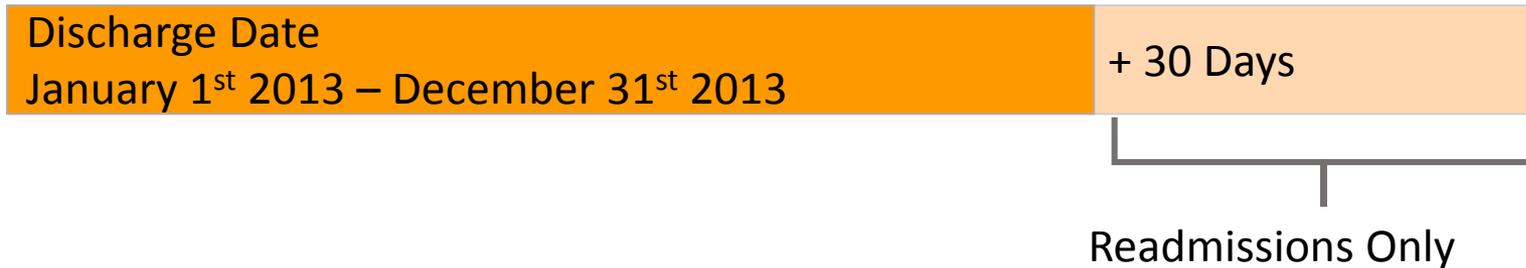
- Inpatient 30 Day Readmission Rates
  - 30-Day Follow up
  - All-Payer
  - All-Cause
  - All-Hospital (both same and other hospital)
- Exclusions:
  - Planned readmissions (CMS Planned Admission + all deliveries)
  - Deaths
  - Same-day transfers
  - Newborns

# Readmissions Data Source and Timeframe

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- Inpatient abstract/case mix data with CRISP Unique Identifier (EID).
- Measurement Timeframe:

## Example CY2013 Base Period:



- Readmission costs= Total charges for readmission
- Readmission charges assigned to index admission/hospital

# Potentially Avoidable Utilization (PAU)

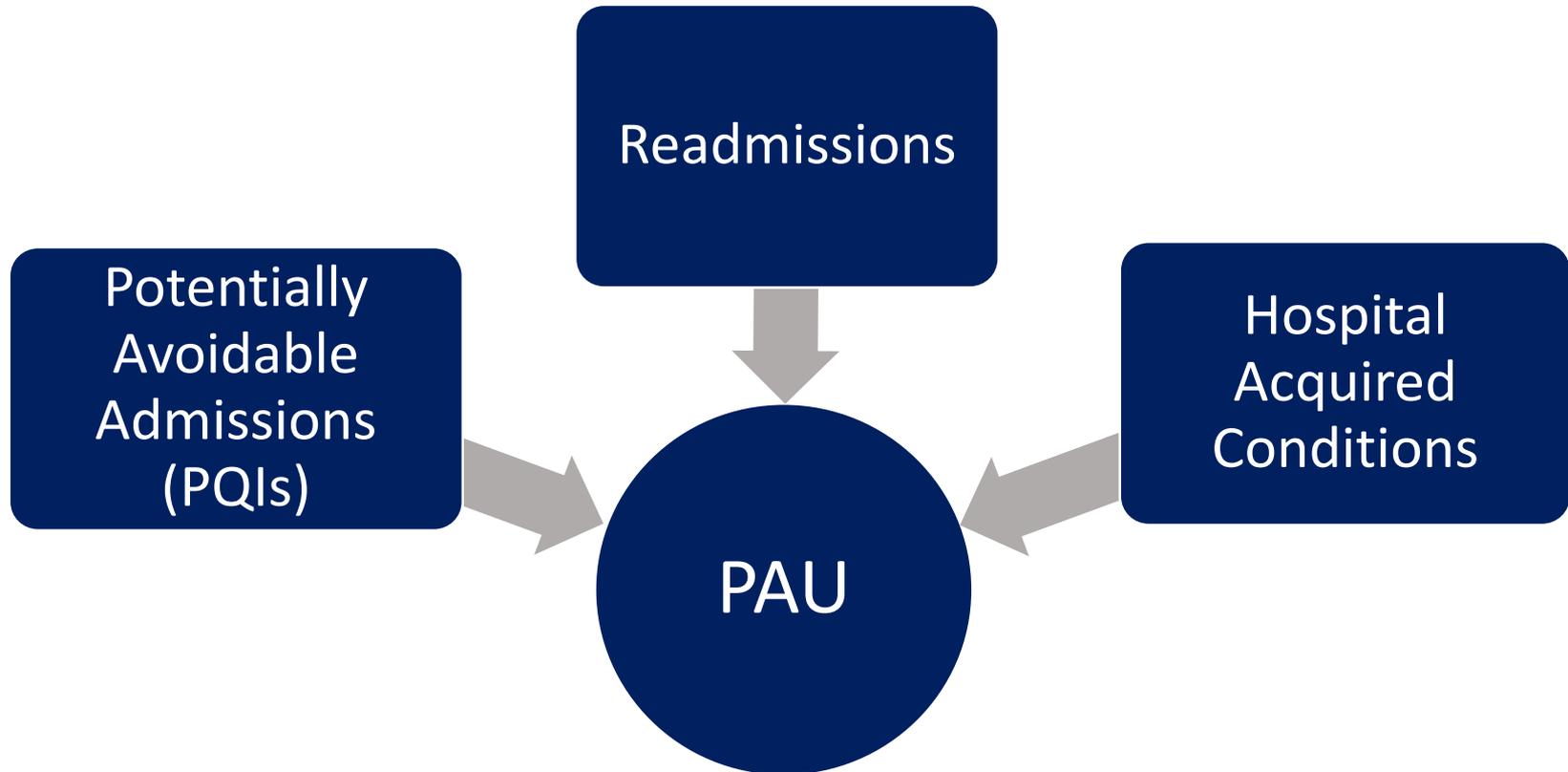
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**Definition:** “Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health.”

HSCRC Calculates Costs Attributable to PAUs as  
a Percent of Total Hospital Revenue

# Current PAU Data Components

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# Other PAUs Under Consideration

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- High-need patients
- Admissions from Nursing Homes
- Sepsis
- Avoidable ED visits
- Choosing Wisely Recommendations

# PAU Measure Definitions

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- Includes inpatient and 24 hr+ Observation Cases
- 30-day Readmissions
- Potentially Avoidable Admissions
  - AHRQ Prevention Quality Indicators
  - Ambulatory Care Sensitive Admissions

# PQI Measure Specifications

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- The measures include acute and chronic PQIs.
- Currently using AHRQ Software Version 4.5a.
- • PQI #1 Diabetes Short-Term Complications
  - PQI #3 Diabetes Long-Term Complications
  - PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults
    - PQI #7 Hypertension
    - PQI #8 Heart Failure
    - PQI #10 Dehydration
    - PQI #11 Bacterial Pneumonia
    - PQI #12 Urinary Tract Infection
    - PQI #13 Angina Without Procedure
    - PQI #14 Uncontrolled Diabetes
    - PQI #15 Asthma in Younger Adults Admission Rate
    - PQI #16 Lower-Extremity Amputation among Patients with Diabetes

# 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/Ry2015-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<br>≥ 3 IP Admits | High Cost<br>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

# Questions/Discussions

# Next Steps

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- Frequently Asked Questions
  - Specific to this webinar
  - Overall list on Basecamp
- Memo from HSCRC and DHMH
- 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