



SIM

Quality Metrics

Work Group

Monday, March 28, 2016

Agenda



- **Introductions**
- **District Objectives and Progress**
- **Overview of Other SIM States Quality Performance Reporting**
- **Priority Setting and Measure Selection Discussion**

Today's Objectives and Discussion

- Understand how other states have put together their quality
- Consensus on Priority Topic Areas
- Consensus on Selection Criteria for Measures
 - Besides being NQF-endorsed and most frequent use in the District, what other criterion should be used to select measures?
- Discuss Measures

Quality Metrics Work Group

Mandate

- The Quality Metrics Work Group will develop recommendations for the Advisory Committee to design a plan that would seek to streamline quality reporting across all District payers; promote agreement on a shared set of measures; identify quality report infrastructure needs; and strategies for quality improvement.

Key Questions for Work Group Recommendations

- How does the District promote more coordinated and streamlined quality reporting?
- What measures are needed to evaluate improved outcomes for specific target populations?
- What options are available to promote a quality reporting data infrastructure?
- What infrastructure do providers need to report quality measures?
- How does the District spread the reporting of existing quality measures to more practices?
- What are the specific metrics required to support the proposed payment model?

Work Group Progress

November &
December

- **Environmental Scan**

- Compile Inventory of Quality Performance Measures and Reporting Initiatives
- Understand CareFirst PCMH program and Quality Scorecard

January &
February

- **Health Home 2**

- Review CMS Health Home Core Measure Set
- Recommend adding three measures to the Health Home

February &
Beyond

- **Monitoring and Evaluating SIM and Future Initiatives**

- Identify Reporting Infrastructure Needs
- Identify Priority Areas and Align with District Initiatives
- Identify Measures to Assess Disparities and Care Integration

WASHINGTON



Legislative Language: ESHB 2572, Section 6

“There is created a performance measures committee, the purpose of which is to identify and recommend standard statewide measures of health performance to inform public and private health care purchasers and to propose benchmarks to track costs and improvements in health outcomes.”



The plan for a Healthier Washington

Build healthier communities through a collaborative regional approach

- Fund and support Accountable Communities of Health.
- Use data to drive community decisions and identify community health disparities.

Ensure health care focuses on the whole person

- Integrate physical and behavioral health care in regions as early as 2016, with statewide integration by 2020.
- Spread and sustain effective clinical models of integration.
- Make clinical and claims data available to securely share patient health information.

Improve how we pay for services

- Measure, improve and report common statewide performance measures.
- As purchaser for Apple Health and state employees, drive market toward value-based models.

Implementation tools: State Innovation Models grant, state funding, potential federal waiver, philanthropic support
Legislative support: HB 2572, SB 6312



History of Common Measure Set

1. The Health Care Authority partnered with the Washington Health Alliance to lead the development process.
2. Three technical work groups researched and recommended health and health care quality measures related to
 - Prevention
 - Chronic illness
 - Acute care
3. Public comments were collected and helped to shape the “starter set” of 52 measures, which was approved by the PMCC in December 2014 and designed to evolve over time.



What is the Purpose of the Measure Set?

- To standardize the way we measure performance as a state, reducing unnecessary burden on health systems
- Promote a voluntary alignment of measures across payers and purchasers
- Publicly share results to develop a common understanding of what needs to improve and where it needs to improve
- Ensure equal access to high-quality health care by reducing variation in care and improve health outcomes

Washington Core Principles

Required by Legislation:

1. The measure set is of manageable size.
2. Measures are based on readily available health care insurance claims and/or clinical data, and survey data.
3. Preference should be given to nationally-vetted measures (e.g., NQF-endorsed) and other measures currently used by public agencies.
4. Measures assess overall system performance, including outcomes and cost.
5. The measure set is aligned to the extent possible with the Governor's performance management system measures and common measures specific to the Medicaid program.
6. The measure set considers the needs of different stakeholders and populations served.
7. The measure set is useable by multiple parties (payers, providers, hospitals, health systems, public health and communities).

Added by the Committee:

1. Measures should be aligned with national measure sets and other measure sets commonly used in Washington, whenever possible.
2. Measures should have significant potential to improve health system performance in a way that will positively impact health outcomes (including morbidity, disability, mortality, health equity, and quality of life) and reduce costs.
3. Measures should be amenable to influence of health care providers.
4. There should be a sufficient numerator and denominator size for each measure to produce valid and reliable results.

Areas of Focus - Common Measure Set

PREVENTION	ACUTE CARE	CHRONIC ILLNESS
Adult Screening(s)	Avoidance of Overuse/ Potentially Avoidable Care	Appropriate Use of Medications
Childhood: early and adolescents	Behavioral Health	Asthma
Immunizations	Cardiac	Depression
Nutrition/ Physical Activity/ Obesity	Readmissions	Diabetes
Oral Health	Obstetrics	Hypertension and Cardiovascular Disease
Tobacco Cessation	Patient Safety	
Unintended Pregnancy	Stroke	
Cross Cutting: Patient Experience		

MAINE

Maine Payment Reform

The work group task is to:

- Develop multi-payer measure set aligned closely with CMS ACO and MaineCare measures supplemented with metrics to address specific populations.
- Minimize the reporting burden, initial phase will rely on claims-based measures and available uniform survey results.
- Identify outcomes measures for adoption as reporting capabilities grow.
- Establish protocol for identification of “pending” measures (outcomes, functional status, etc).
- Recommend selected measures to Pathways to Excellence (PTE) for consideration for public reporting.

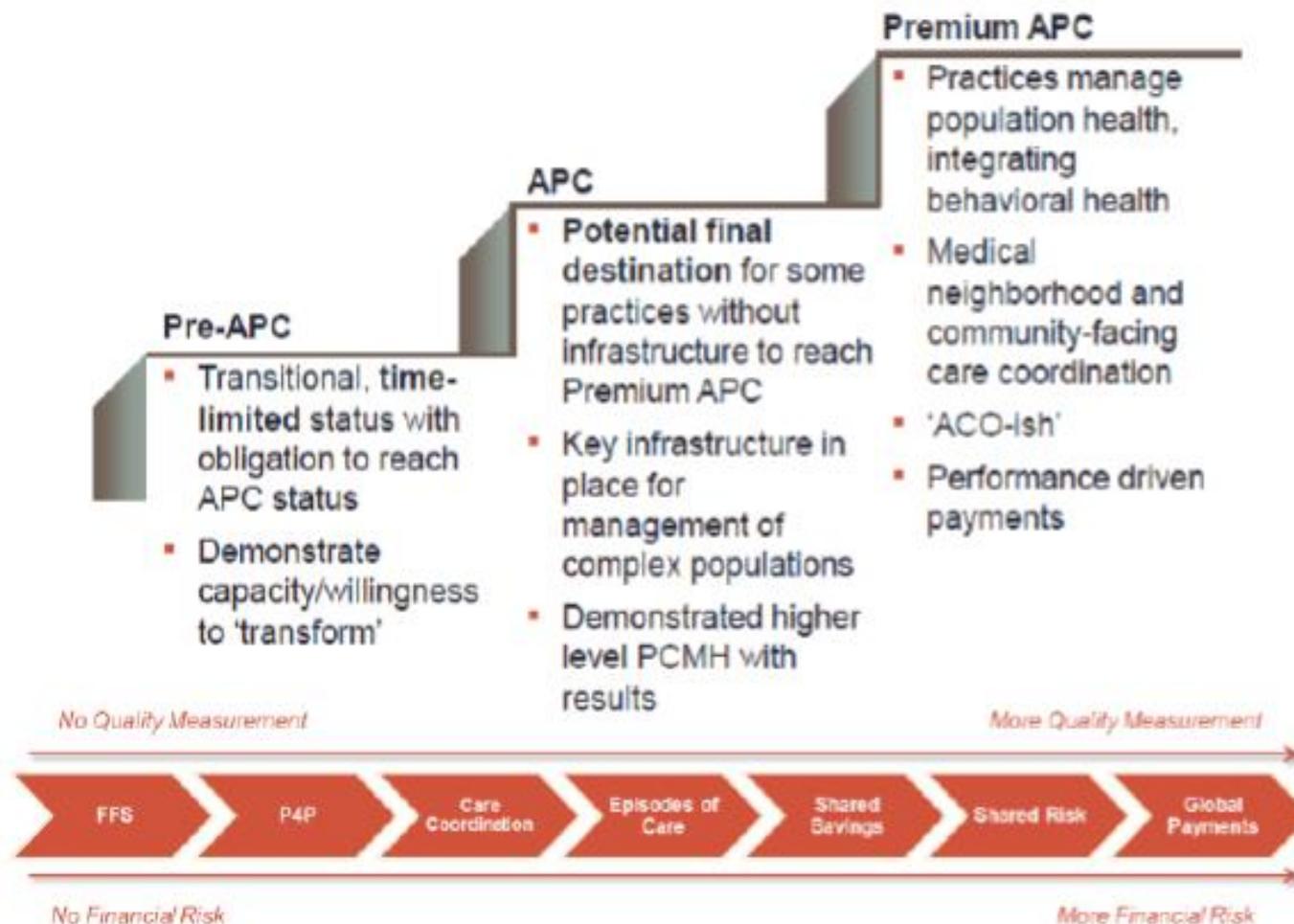
Maine's Criteria for Selecting System

Measures

- **Current Feasibility (NQF)** - Reasonable cost, extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.
- **Scientific Acceptability (NQF)** – Extent to which measure as specified produces consistent (reliable) and credible (valid) results about the quality of care when implemented.
- **“Setting Free”**- Useable across multiple settings and for different populations likely to find them useful for decision-making.
- **Usability/Adaptability (NQF)** – Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision-making.
- **Patient Experience** – Patient’s perspective on their care, family perspective, customer perspective.
- **Existing state, regional, and/or national benchmarks** – Allows comparison to similar organizations.
- **Financial/Incentivization** – includes payment systems, P4P (hospital and physician based), rewards and penalties.
- **Improving this measure will translate into significant changes in *value*** – Value is defined as outcomes relative to costs and encompasses efficiency. Value depends on results and is measured in healthcare by the outcomes achieved, not the volume of services delivered.
- **Durability** – Longevity of measure.
- **Multi-Payer Alignment** – Maximize overlap of measures with CMS, MaineCare and commercial payers. While there may be measures selected to address a targeted population (e.g., children, elderly, etc.), effort should be sustained to align measures with public payers and commercial health plans.

NEW YORK

SHIP ADVANCED PRIMARY CARE (APC) MODEL



A critical goal of design and implementation is for multi-payer alignment on this multi-tiered model coupled with payment support for transformation, care management AND value-based payment.

New York APC

- The target interventions address the most significant health challenges faced by NY:
 - Tobacco,
 - Obesity,
 - Diabetes,
 - HIV,
 - Poor maternal and health outcomes and
 - Mental health.
- New York’s rigorous first draft of a proposed ‘standard scorecard’ is based on industry standards and includes:
 - 5 measurement categories,
 - 18 primary domains,
 - 8 composite scores, and
 - 207 individual measures.
- NYS APC program creates a new environment where “trust but verify” is possible:
 - APC identifies a core set of milestones, gates, and measures common across payers and providers
 - NYS involvement sets the stage for aligned incentives for providers, payers and consumers

NY Core Set Principles

- Measures need to fit the purpose of the APC model.
- Measures used in APC should strive toward alignment and parsimony.
- Measures should be valid, reliable, tested and used, and endorsed by the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), or other endorsing organizations.
- Measures need to be meaningful to patients, payers, and providers.
- Measures need to provide opportunity to improve health and measures that will influence the health care delivery system.
- Measures need to be balanced.

The APCscorecard aspires to include 20 common measures

Categories	Measures	Measure steward	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	HEDIS	✓	✓	
	2 Chlamydia Screening	HEDIS	✓	✓	
	3 Influenza Immunization - all ages	AMA (all ages) or HEDIS (18+)	✓	✓	✓
	4 Childhood Immunization (status)	HEDIS	✓	✓	
	5 Fluoride Varnish Application	CMS (steward), NQF, MU	✓		
Chronic disease	6 Tobacco Use Screening and Intervention	CMS (steward), NQF, MU	✓	✓	
	7 Controlling High Blood Pressure	HEDIS	✓	✓	
	8 Diabetes A1C Poor Control	HEDIS	✓	✓	
	9 Medication Management for People with Asthma	HEDIS	✓	✓	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	Children: HEDIS Adults: CMS	✓	✓	
BH/Substance abuse	11 Depression screening and management	CMS	✓	✓	
	12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	✓		
Patient reported	13 Record Advance Directives for 65 and older	HEDIS	✓	✓	✓
	14 CAHPS Access to Care, Getting Care Quickly	HEDIS			✓
Appropriate use	15 Use of Imaging Studies for Low Back Pain	HEDIS	✓		
	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	HEDIS	✓		
	17 Hospitalization	HEDIS	✓		
	18 Readmission	HEDIS	✓		
	19 Emergency Dept. Utilization	HEDIS	✓		
Cost	20 Total Cost Per Member Per Month		✓		

Aligning APC to CMS Measure Set Summary: Measures in **green** (found in CMS set only) would be added and the measures in **red** (found in APC only) would be removed.

Domains	NQF #/HEDIS	Measures
Prevention	32	Cervical Cancer Screening
	--/HEDIS	Non-recommended Cervical Cancer Screening in Adolescent Females
	2372/HEDIS	Breast Cancer Screening
	34/HEDIS	Colorectal Cancer Screening
	33/HEDIS	Chlamydia Screening
	41/AMA	Influenza Immunization - all ages
	38/HEDIS	Childhood Immunization (status)
	2528/ADA	Fluoride Varnish Application
Chronic Disease	28/AMA	Tobacco Use Screening and Intervention
	18/HEDIS	Controlling High Blood Pressure
	59/HEDIS	Comprehensive Diabetes Care: HbA1C Poor Control
	57/HEDIS	Comprehensive Diabetes Care: HbA1C Testing (currently proposed for version 1 of APC only)
	55/HEDIS	Comprehensive Diabetes Care: Eye Exam
	56/HEDIS	Comprehensive Diabetes Care: Foot Exam (currently proposed for version 1 of APC only)
	62/HEDIS	Comprehensive Diabetes Care: Medical Attention for Nephropathy (currently proposed for version 1 of APC only)
	71/HEDIS	Persistent Beta Blocker Treatment after Heart Attack
	1799/HEDIS	Medication Management for People With Asthma
	24/HEDIS	[Combined obesity measure] Weight Assessment and Counseling for nutrition and physical activity for children and adolescents
	421/CMS	[Combined obesity measure] Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
Behavioral Health/ Substance Use	418/CMS	Screening for Clinical Depression and Follow-up Plan
	4/HEDIS	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	105/HEDIS	Antidepressant Medication Management (currently proposed for version 1 of APC only)
	710/MCM	Depression Remission at 12 months
Patient-Reported	1885/MCM	Depression Response at 12 months – Progress towards Remission
	326/HEDIS	Advance Care Plan
Appropriate Use	5/AHRQ	CAHPS Access to Care, Getting Care Quickly
	52/HEDIS	Use of Imaging Studies for Low Back Pain
	58/HEDIS	Avoidance of Antibiotic Treatment in adults with acute bronchitis
	--/HEDIS	Inpatient Hospital Utilization (HEDIS)
	1768/HEDIS	All-Cause Readmissions
Cost	--/HEDIS	Emergency Department Utilization
	--	Total Cost Per Member Per Month

DISTRICT OF COLUMBIA

AIM

What are you trying to improve, by how much, and by when?

Improve health outcomes, experience of care, and value in health care spending for high-cost, high-need patients in D.C.

By 2020:

- 1) Significantly improve performance on selected health and wellness outcome quality measures and reduce disparities;
- 2) Reduce inappropriate utilization of inpatient and emergency department by 10% or meet DC Healthy People 2020 benchmark goal;
- 3) Reduce preventable readmission rates by 10% or meet DC Healthy People 2020 benchmark goal;
- 4) Better align overall health spending and re-invest savings towards prevention and addressing housing and other social determinants of health; and
- 5) Develop a continuous learning health system that supports more timely, efficient, and higher-value health care throughout the care continuum.

Primary Driver

What are the major categories of effort that will help achieve the aim(s)?
(Note: may impact multiple aims)

Support value-based payment models that reward quality, improved health and efficiency

Invest in capacity building infrastructure and supports to assist providers as they change their business model and workflows

Strengthen data exchange infrastructure to inform clinical and social services, measure performance, and engage patients

Improve and integrate coordination of health care and social services with an enhanced focus on high-need patients

Secondary Driver

What specific activities will be done to help achieve the primary driver? (Note: may impact multiple aims)

Develop personalized and integrated interventions for high-need patients that address social determinants of health

Identify or develop, monitor, and align health and wellness quality measures

Establish alternative payment model(s) that incentivize and improve provider accountability and outcomes

Provide an upfront investment to transform organizational structures

Recruit, retain, and continuously develop a workforce that meets the needs of all District residents and accelerates the integration of evidence-based knowledge in their practice

Incentivize providers to invest in EHR/HIE/data analytic tools and effectively utilize data for population health and quality improvements

Integrate data across Agencies in order to incorporate data into clinical workflow and for analysis by gov't agencies

Link PCPs, specialists, community-based providers, and social service providers to reduce avoidable hospital and ER use

Reward coordination of health and social services within payment model(s)

What are our Priority Areas?

- Work group suggested
 - Leverage CMS/AHIP Collaborative Core Set with a focus on:
 - Prevention
 - End Stage Renal Disease
 - Autoimmune – Sickle Anemia
- Align with other District-wide initiatives

Priority Topic Areas

AHIP/CMS Collaborative Seven Core Sets

1. **ACO and PCMH / Primary Care Measures (22)**
 - Cardiovascular Care (4)
 - Diabetes (5)
 - Care Coordination / Patient Safety (1)
 - Prevention and Wellness (6)
 - Utilization & Cost / Overuse (1)
 - Patient Experience (1)
 - Behavioral Health (2)
 - Pulmonary (2)
2. **Cardiovascular Measures (31)**
 - Chronic Cardiovascular Condition (15)*
 - Congestive Heart Failure (4)
 - Hypertension (2)
 - Ischemic Heart Disease / Coronary Heart Disease (7)
 - Atrial fibrillation (1)
 - Prevention (1)
 - Acute Cardiovascular Condition (16)*
 - Acute Myocardial Infarction (6)
 - Angioplasty and Stents (2)
 - Implantable Cardiac Defibrillators (1)
 - Cardiac Catheterization (1)
 - Pediatric Heart Surgery (6)
3. **Gastroenterology Measures (8)**
 - Endoscopy & Polyp Surveillance Measures (4)
 - Inflammatory Bowel Disease (4)
4. **HIV / Hep C Core Measures (8)**
 - HIV (6)
 - Hep C (2)
5. **Medical Oncology Measures (14)**
 - Breast Cancer (3)
 - Colorectal Cancer (3)
 - Prostate Cancer (2)
 - Hospice/End of Life (6)
6. **OB/GYN Measures (11)**
 - Ambulatory Care setting (6)
 - Hospital/Acute Care setting (5)
7. **Orthopedic Measures (3)**

CMS Primary Care Key Takeaways

Four key takeaways:

1. Age range: CMS does not include measures that address children and adolescents
2. Prevention: Does not include chlamydia screening, influenza immunization, childhood immunization and fluoride varnish. Notably, chlamydia screening is in the CMS OB/GYN set.
3. Cancer screening includes breast cancer, cervical cancer, and non-recommended cervical cancer screening in adolescents females.
4. Behavioral health:
 - Does not include a measure of alcohol and substance use
 - Two outcome measures : depression remission and response at 12 months

Align With Other Initiatives:

DC Healthy People 2020 Leading Health Indicators

- 1. Mental Health and Mental Disorders**
- 2. Substance Use**
- 3. Maternal, Infant and Child Health**
 - Infant mortality
 - Preterm Births
- 4. Tobacco Use**
- 5. Access to Health Services**
 - Increase preventive care
- 6. Nutrition, Weight Status and Physical Activity**
 - Reduce child and adolescent obesity
- 7. Clinical Preventive Services**
 - Cancer screening
 - Diabetes
 - Controlled Hypertension
 - Childhood Immunization
- 8. Oral Health: Preventive Dental Care**
- 9. Older Adults**
- 10. HIV**
- 11. Social Determinants of Health**
 1. Education
 2. Poverty

Community Needs Assessment

- FY 2014-2016 DC Healthy Community Collaborative Community Health Improvement Plan
 - Sexual Health
 - Routine Screenings for Sexually Transmitted Diseases
 - HIV
 - Maternal and Infant Health
 - Mental Health and Substance Abuse
 - Screenings
 - Obesity/overweight
 - Asthma
- Other CHNA
 - Heart disease and stroke
 - Cancer
 - Diabetes
 - Obesity
 - Affordable housing
 - Food insecurity/access to healthy food
 - Transportation

Other Initiatives

- **CMMI**
 - **Strong Start for Mothers**
 - Reducing early elective deliveries
 - Reducing preterm births
 - **PREVENTION AT HOME**
 - *Sexual health and HIV*
 - *ER and hospitalization*
 - **Capital Clinical Integrated Network**
 - *Emergency Room Visits*
 - *Costs*
 - *Asthma*
 - *Hypertension*
 - *Behavioral Health*
 - *Diabetes*
 - **Joslin Diabetes Center, Inc**
 - *Diabetes*
 - *Costs*
 - *Avoidable Hospitalizations*
 - *Co-morbidities*
- **CDC Racial and Ethnic Approaches to Community Health (REACH)**
 - *Healthy Ties that Bind* intended to strengthen linkages among the existing health care resources and community/faith-based organizations in the medically underserved communities with high prevalence of **diabetes, CVD, stroke, poverty, lower education achievement, and lack of access to preventive health services.**

Discussion

- Are there other we should consider?
- Common themes:
 - Sexual Health
 - Asthma
 - Cancer
 - Cardiovascular Disease
 - Diabetes
 - Behavioral Health
 - Oral Health
 - Maternal and Infant Health

Exercise: DC Area of Focus

Prevention	Acute Care	Chronic Illness
	Potentially Avoidable Care - Emergency Department & Inpatient	
	Readmissions	

Common Measure Set Discussion

- ❖ What criteria should we use to select measures?
 - ✓ 1) NQF-Endorsed
 - ✓ 2) Aligns with DC Priorities and Opportunity for Improvement
 - ✓ 3) Reduces Reporting Burden: Transition from Claims → eCQM as Technology Progresses
 - ✓ Other Criteria

Criteria Selection Common Themes

- Current Feasibility
- Evidence-based and Scientifically Acceptable
- Setting Free
- Usability / Adaptability
- Patient Experience
- Has a Relevant Benchmark
- Financial / Incentives
- Improving this Measure will Translate into Significant Changes in Value
- Durability
- Aligned with Other Measure Sets

MEASURE SELECTION EXERCISE