Vital Signs:
The IOM’s 15 Core Metrics for Health & Health Care Progress

September 8, 2015
12PM – 1PM

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Leading the Movement for Patient-Centered Care
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• Webinars with national experts
• Discounted registration for QC 2016
QC Annual Meeting & Dinner

September 17th
Maple Hill Farm Inn
Hallowell, Maine

• Hear updates on QC's work.
• Learn about Franklin County's successful long-term public health intervention, with a presentation by JAMA study co-authors.
• Network with fellow QC Members.
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After Today’s Webinar

• You’ll receive links to the slides and recording of today’s session this afternoon

• All QC Lunch & Learn webinars are archived on our website: www.mainequalitycounts.org/lunchandlearn
Today’s Presenter

Elizabeth Mitchell serves as President & CEO of the Network for Regional Healthcare Improvement (NRHI), a national network of multi-stakeholder Regional Health Improvement Collaboratives with over 35 members across the US.

She is a Guiding Committee Member of the Health Care Payment Learning and Action Network (LAN), a member of the Institute of Medicine’s Consensus Committee on Core Metrics for Better Care and Lower Costs, and chairs this committee’s Implementation Task Force. Elizabeth serves on the Board of the National Quality Forum (NQF) and on the Coordinating Committee of NQF’s Measure Application Partnership, and she is Chair of the Health Insurance Exchange Quality Measure Task Force.
QC Lunch & Learn Webinar Series

September 15, 12:00PM – 1:00PM
The ABCs of ASPs: Antimicrobial Stewardship Programs

September 29, 12:00PM – 1:00PM
It’s That Time of Year Again: What You Need to Know About ACA Open Enrollment

October 13, 12:00PM – 1:00PM
Linking Clinic & Community to Improve Population Health

Find more information and register:
www.mainequalitycounts.org/lunchandlearn
Aligning Measures for Health

IOM Core Metrics for Health and Healthcare Progress

Tuesday, September 8, 2015
Noon – 1 p.m. EST
Who is the Network for Regional Healthcare Improvement (NRHI)?

NRHI is a network of more than 35 regional health improvement collaboratives (RHICs).

RHICs are non-profit, multi-stakeholder organizations working in and collaborating across regions to achieve better care at lower cost.

RHICs work together through NRHI to accelerate and spread regional innovation across the US.
Regional Health Improvement Collaboratives

- Are private, non-profit regional entities with multi-stakeholder governance.
- Convene physicians, provider organizations, commercial and governmental payers, employers, consumers, and other healthcare related organizations to improve care and payment.
- Exist in 25 states across the country.
- 21 RHICs are statewide, 14 are regional.
Public Reporting on All Aspects Of Care

Process Measures

Outcome Measures

Patient Experience

Disparities

Cost of Care
Facilitate Improvements in the Quality and Cost of Care

Perfecting Patient Care℠

Figure 11. Allegheny General Hospital: Central-Line Associated Bloodstream Infections Decreased in Two ICUs After Implementation of Perfecting Patient Care Process

CCU/MICU Aggregate Central Line Infection Data

Line Infections per 1,000 line days

Initiate PRHI/TPS Process

- NNIS
- CCU/MICU
- PRHI

CCU=coronary care unit. MICU=medical intensive care unit. NNIS>National Nosocomial Infection System. PRHI=Pittsburgh Regional Healthcare Initiative. TPS=Toyota Production System.

Source: Allegheny General Hospital.

ICSI Institute for Clinical Systems Improvement

DIAMOND Program (Depression Improvement Across Minnesota Offering a New Direction)

Outcomes Measures at 6 Months

Patients with PHQ-9>9 and Activated into DIAMOND-Intent to Treat (N=6410)

Patients Activated into DIAMOND who have PHQ-9 follow up at 6 months-Remeasured (N=3931)

Response Rate

Remission Rate

DIAMOND Measure Period: Sept 08-Oct 11
Support Multi-Stakeholder Payment Reform

- **Pay for Performance**
  - E.g., Integrated Healthcare Association measurement of quality and utilization to support multi-payer P4P

- **Building Consensus on More Fundamental Payment Reforms**
  - Payment Reform Summits in Maine, Memphis, Nevada, Washington, Wisconsin, and others

- **Coordinating Multi-Payer Payment Reforms**
  - E.g., ICSI High-Tech Diagnostic Imaging Initiative to reduce overutilization
  - E.g., ICSI DIAMOND Initiative to improve depression care
  - E.g., Puget Sound Health Alliance initiative to develop accountable medical homes
  - E.g., Maine Health Management Coalition initiative to implement global payment systems
Educate and Engage Consumers

Patient-Friendly Websites

Patient-Oriented Education Materials

Making the most of your medical appointments
NRHI Members

-Albuquerque Coalition for Healthcare Quality
-Aligning Forces for Quality – South Central PA
-Alliance for Health
-Better Health Greater Cleveland
-California Quality Collaborative
-Center for Improving Value in Health Care (Colorado)
-Finger Lakes Health Systems Agency
-Greater Detroit Area Health Council
-The Health Collaborative (Greater Cincinnati)
-HealtheConnections
-Healthy Memphis Common Table
-Institute for Clinical Systems Improvement
-Integrated Healthcare Association
-Iowa Healthcare Collaborative
-Kansas City Quality Improvement Consortium
-Louisiana Health Care Quality Forum
-Maine Health Management Coalition
-Massachusetts Health Quality Partners
-Midwest Health Initiative
-Minnesota Community Measurement
-Nevada Partnership for Value-Driven Healthcare (HealthInsight)
-North Texas Accountable Healthcare Partnership
-Oregon Health Care Quality Corporation
-P² Collaborative of Western New York
-Pittsburgh Regional Health Initiative
-Quality Counts (Maine)
-Utah Partnership for Value-Driven Healthcare (HealthInsight)
-Washington Health Alliance
-Wisconsin Collaborative for Healthcare Quality
-Wisconsin Health Information Organization

-MyHealth Access Network
-North Coast Health Information Network
-Mountain Pacific Quality Health Foundation
We have a problem.

Health Spending as a Share of GDP
United States, 1962 to 2022
We know the reason(s).

- Lack of Access
- Wrong Incentives
- Medical Error Rates
- Poor Health Outcomes
- Fragmented Delivery System
- Lack of Cost Transparency
We have a force for change...

Secretary Burwell Announces HHS Quality Payment Goals, Introduces Timeline For Shifting Medicare Reimbursements From Volume to Value

Payment Reform Taxonomy

1. Fee for Service
   - No link to quality

2. Fee for Service
   - Link to quality

3. Alternate Payment Models
   - Built on Fee for Service

4. Population-Based Payment
an opportunity to change care for the better

Practice Transformation
Interoperability Roadmap

...consensus on a starting point...

Transparency
The Significant Lack of Alignment Across State and Regional Health Measure Sets:
An Analysis of 48 State and Regional Measure Sets, Presentation

Kate Reinhalter Bazinsky
Michael Bailit
September 10, 2013
Finding #1: Many state/regional performance measures for providers are in use today

- In total, we identified 1367 measures across the 48 measure sets
  - This is counting the measures as NQF counts them, or if the measure was not NQF-endorsed, as the program counts them

- We identified 509 distinct measures
  - If a measure showed up in multiple measure sets, we only counted it once
  - If a program used a measure multiple times (i.e., variations on a theme) we also only counted it once

- We excluded 53 additional hospital measures from the analysis.
Programs use measures across all of the domains

- **Treatment and secondary prevention**: 28%
- **Health and well-being**: 14%
- **Safety**: 19%
- **Person-centered**: 11%
- **Infrastructure**: 4%
- **Comm & care coordination**: 5%
- **Access, affordability & inappropriate care**: 11%
- **Utilization**: 8%

Distinct measures by domain, \( n = 509 \)
Finding #2: Little alignment across the measure sets

- Programs have very few measures in common or “sharing” across the measure sets
- Of the 1367 measures, 509 were “distinct” measures
- Only 20% of these distinct measures were used by more than one program

Number of distinct measures shared by multiple measure sets

\[ n = 509 \]

* By “shared,” we mean that the programs have measures in common with one another, and not that programs are working together.
Finding #3: Non-alignment persists despite preference for standard measures

Measures by measure type

\[ n = 1367 \]

**Defining Terms**

**Standard:** measures from a known source (e.g., NCQA, AHRQ)

**Modified:** standard measures with a change to the traditional specifications

**Homegrown:** measures that were indicated on the source document as having been created by the developer of the measure set

**Undetermined:** measures that were not indicated as “homegrown”, but for which the source could not be identified

**Other:** a measure bundle or composite
Finding #5: Even shared measures aren’t always the same - the problem of modification!

- Most state programs modify measures
- 23% of the identifiable standardized measures were modified (237/1051)
- 40 of the 48 measure sets modified at least one measure
- Two programs modified every single measure
  1. RI PCMH
  2. UT Department of Health
- Six programs modified at least 50% of their measures
  1. CA Medi-Cal Managed Care Specialty Plans (67%)
  2. WA PCMH (67%)
  3. MA PCMH (56%)
  4. PA Chronic Care Initiative (56%)
  5. OR Coordinated Care Organizations (53%)
  6. WI Regional Collaborative (51%)
Conclusions

- **Bottom line:** Measures sets appear to be developed independently without an eye towards alignment with other sets.

- The diversity in measures allows states and regions interested in creating measure sets to select measures that they believe best meet their local needs. Even the few who seek to create alignment struggle due to a paucity of tools to facilitate such alignment.

- The result is “measure chaos” for providers subject to multiple measure sets and related accountability expectations and performance incentives. Mixed signals make it difficult for providers to focus their quality improvement efforts.
Vital Signs:
Core Metrics for Health and Health Care Progress

An IOM Consensus Study
Topics

• Committee
• Study motivations
• Committee charge
• Core metrics benefits
• Core metrics characteristics
• Challenges
• 15 recommended core measures
• Stakeholder roles
Committee on Core Metrics for Better Health at Lower Cost

DAVID BLUMENTHAL (Chair), The Commonwealth Fund
JULIE BYNUM, The Dartmouth Institute
LORI COYNER, Oregon Health Authority
DIANA DOOLEY, California Health and Human Services
TIMOTHY FERRIS, Partners HealthCare
SHERRY GLIED, New York University
LARRY GREEN, University of Colorado at Denver
GEORGE ISHAM, HealthPartners
CRAIG JONES, Vermont Blueprint for Health
ROBERT KOCHER, Venrock
KEVIN LARSEN, Office of the National Coordinator for HIT
ELIZABETH McGLYNN, Kaiser Permanente
ELIZABETH MITCHELL, Network for Regional Health Improvement
SALLY OKUN, PatientsLikeMe
LYN PAGET, Health Policy Partners
KYU RHEE, IBM Corporation
DANA GELB SAFRAN, Blue Cross Blue Shield of Massachusetts
LEWIS SANDY, UnitedHealth Group
DAVID STEVENS, National Association of Community Health Centers
PAUL TANG, Palo Alto Medical Foundation
STEVEN TEUTSCH, Los Angeles County Department of Public Health
Study motivations

• Measure proliferation is independent of priority
• Requirements are often inconsistent
• Measures themselves are often inconsistent
• Data collected inconsistently have limited usefulness
• Clinician burden (time/$) is growing rapidly
• Process focus tends to fragment actions
• Fragmented measures obscure system performance
Committee Charge

An ad hoc committee will conduct a study and prepare a report directed at exploring measurement of individual and population health outcomes and costs, identifying fragilities and gaps in available systems, and considering approaches and priorities for developing the measures necessary for a continuously learning and improving health system. The Committee will:

- consider candidate measures suggested as reliable and representative reflections of health status, care quality, people’s engagement and experience, and care costs for individuals and populations;
- identify current reporting requirements related to progress in health status, health care access and quality, people’s engagement and experience, costs of health care, and public health;
- identify data systems currently used to monitor progress on these parameters at national, state, local, organizational, and individual levels;
- establish criteria to guide the development and selection of the measures most important to guide current and future-oriented action;
- propose a basic, minimum slate of core metrics for use as sentinel indices of performance at various levels with respect to the key elements of health and health care progress: people’s engagement and experience, quality, cost, and health;
- indicate how these core indices should relate to, inform, and enhance the development, use, and reporting on more detailed measures tailored to various specific conditions and circumstances;
- identify needs, opportunities, and priorities for developing and maintaining the measurement capacity necessary for optimal use of the proposed core metrics; and

recommend an approach and governance options for continuously refining and improving the relevance and utility of the metrics over time and at all levels.
Core metrics benefits

• Sharpen focus on the actionable issues most broadly important to improving people’s health
• Counter the natural tendency to focus on separate pieces at the expense of system performance
• Drive relationships and integration across levels and activities
• Provide key standardized reference points for tailored measurement activities of specialized interest
Core metrics characteristics

- Reliably reflect health, care quality, and cost
- Parsimonious
- Standardized—simplify and facilitate comparison
- Multi-level: national, state, local, institutional
- Multi-stakeholder: shared accountability for health
- Publicly led
- Cooperatively stewarded
Challenges

• Finding the most important measures
• Relating core performance to the rest
• Buffering special interests, tendency to expand
• Reflecting the whole, in a way that captures the parts
• Agreement on standardization
• Stakeholder uptake and use
• Leadership and stewardship that is sustained
VITAL SIGNS
Core Metrics for Health and Health Care Progress
<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Element</th>
<th>Core Measure Focus</th>
<th>Best Current Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy people</td>
<td>Length of life</td>
<td>Life expectancy</td>
<td>Life expectancy at birth</td>
</tr>
<tr>
<td></td>
<td>Quality of life</td>
<td>Wellbeing</td>
<td>Self-reported health</td>
</tr>
<tr>
<td>Healthy behaviors</td>
<td>Overweight and obesity</td>
<td>Body mass index</td>
<td></td>
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<tr>
<td></td>
<td>Addictive behavior</td>
<td>Addiction death rate</td>
<td></td>
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<tr>
<td></td>
<td>Unintended pregnancy</td>
<td>Teen pregnancy rate</td>
<td></td>
</tr>
<tr>
<td>Healthy social circumstances</td>
<td>Healthy communities</td>
<td>High school graduation rate</td>
<td></td>
</tr>
<tr>
<td>Care quality</td>
<td>Prevention</td>
<td>Preventive services</td>
<td>Childhood immunization rate</td>
</tr>
<tr>
<td></td>
<td>Access to care</td>
<td>Care access</td>
<td>Unmet care need</td>
</tr>
<tr>
<td></td>
<td>Safe care</td>
<td>Patient safety</td>
<td>Hospital acquired infection rate</td>
</tr>
<tr>
<td></td>
<td>Appropriate treatment</td>
<td>Evidence-based care</td>
<td>Preventable hospitalization rate</td>
</tr>
<tr>
<td></td>
<td>Person-centered care</td>
<td>Care match with patient goals</td>
<td>Patient-clinician communication satisfaction</td>
</tr>
<tr>
<td>Care cost</td>
<td>Affordability</td>
<td>Personal spending burden</td>
<td>High spending relative to income</td>
</tr>
<tr>
<td></td>
<td>Sustainability</td>
<td>Population spending burden</td>
<td>Per capita expenditures on healthcare</td>
</tr>
<tr>
<td>Engaged people</td>
<td>Individual engagement</td>
<td>Individual engagement</td>
<td>Health literacy rate</td>
</tr>
<tr>
<td></td>
<td>Community engagement</td>
<td>Community engagement</td>
<td>Social support</td>
</tr>
</tbody>
</table>
**MEASURE CATEGORIES**

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>Resp: asthma management composite, Resp: COPD evaluation protocol</td>
</tr>
<tr>
<td>Diabetes</td>
<td>DM: HbA1c, DM: LDL</td>
</tr>
<tr>
<td>Diabetes</td>
<td>DM: diabetes composite, DM: hyperglycemia, DM: antipsychotic med use, DM: care at discharge</td>
</tr>
<tr>
<td>ID: HIV viral load suppression, ID: antibiotic use, Surg: volume (by procedure)</td>
<td></td>
</tr>
<tr>
<td>OG: EHR functionality, OG: ED throughout time, OG: smoking cessation protocol, OG: pain management protocol</td>
<td></td>
</tr>
<tr>
<td>MCH: prenatal care, MCH: Cesarean sections, MCH: post-partum care, Prev: USPSTF recommended services, Prev: physical activity fitness coaching</td>
<td></td>
</tr>
<tr>
<td>Other: ...</td>
<td></td>
</tr>
</tbody>
</table>

**MEASURES IN USE**

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>PC: insurance coverage, PC: out of pocket med payments, RR: total cost of care index, RR: prescription of generic drugs, UI: condition-specific imaging use, UI: others</td>
</tr>
<tr>
<td>Engagement</td>
<td>Ind: health literacy, Ind: children reading at grade level, Ind: collaborative decision-making, Ind: patient activation, Com: community-wide benefit strategy, Com: others</td>
</tr>
<tr>
<td>Env: air particulate matter, Env: others</td>
<td></td>
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</tbody>
</table>

**SAFETY MEASURES CURRENTLY IN USE**

- Perioperative care: discontinuation of prophylactic parenteral antibiotics (non-cardiac procedures)
- Perioperative care: venous thromboembolism prophylaxis (when indicated in ALL patients)
- Discontinuation of prophylactic parenteral antibiotics (cardiac procedures)
- Medication reconciliation prevention of catheter-related bloodstream infections from central venous catheter insertion protocols
- Documentation of current medications in the medical record
- Radiology: exposure time reported for procedures using fluoroscopy
- Falls risk assessment
- Oncology radiation dose limits to normal tissues
- Thoracic surgery: recording of clinical stage prior to lung cancer or esophageal cancer resection
- Carcinoembryonic antigens (CEA) determinations within 30 days following cardiac surgery requiring additional surgical procedures
- Perioperative temperature monitoring
- Thoracic surgery: pulmonary function tests before major anatomic lung resection
- Use of high-risk medications in the elderly: image confirmation of successful excision of image-localized breast lesion
- Falls screening for future fall risk
- Atrial fibrillation and anticoagulation therapy
- Maternal care: elective delivery or early induction without medical indication at greater than or equal to 37 weeks and less than 39 weeks
- And many more...

**IMPACT ASSESSMENT**

- Quality-sensitive outcomes
- System-impact protocols

**STANDARDIZED MEASURES**

- Life expectancy at birth
- Infant mortality
- Maternal mortality
- Violence and injury mortality
- Co-occurring chronic conditions
- Self-reported health
- Health-related quality of life
- Body mass index
- Activity levels
- Healthy eating patterns
- Tobacco use
- Drug dependence/illicit use
- Alcohol dependence/misuse
- Addiction deaths
- Adolescent pregnancy
- Contraceptive use
- Unmet need or delayed care
- Patient experience
- Patient-clinician communication
- High blood pressure therapy protocol
- Acute heart attack therapy protocol
- Stroke therapy protocol
- Diabetes therapy protocol
- Breast cancer therapy protocol
- Pain management protocol
- Childhood immunization
- Influenza immunization
- USPSTF recommended services
- Depression screening and treatment
- Colorectal cancer screening
- Breast cancer screening
- Preventive care services
- Care access
- Care access: Patient safety
- Evidence-based care
- Care match with patient goals
- Personal spending burden
- Population spending burden
- Individual engagement
- Community engagement

**CORE MEASURES**

- Life expectancy
- Wellbeing
- Overweight and obesity
- Addictive behavior
- Unintended pregnancy
- Healthy communities
- Preventive services
- Care access

**PROONENT GROUPS**

- Standards organizations
- Professional societies
- Payers and employers
- Care institutions
- Federal, state, and local government

**CORE MEASURES**

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**Impact Assessment**

- Quality-sensitive outcomes
- System-impact protocols

**Safety Measures Currently in Use**

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**Impact Assessment**

- Quality-sensitive outcomes
- System-impact protocols

**Standardized Measures**

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**Core Measures**

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- UI: others

**Engagement**

- Ind: health literacy
- Ind: children reading at grade level
- Ind: collaborative decision-making
- Ind: patient activation
- Com: community-wide benefit strategy
- Com: others

**Population Health**

- HS: life expectancy
- HS: perceived health
- HS: days with physical or mental illness
- Beh: fruit/vegetable consumption
- Beh: activity levels
- Soc: income/child poverty
- Soc: neighborhood crime
- Soc: others
- Env: air particulate matter
- Env: others
Stakeholder roles

- **Clinicians**: reduced burden through streamlined and standardized measures that register results and performance that matter most.

- **Payers and employers**: ability to anchor reporting requirements on results most important to the health of a covered population, and compare provider performance in a standardized, meaningful way.

- **Communities**: raise awareness of priorities and develop collaborative multisectoral strategies for tracking and improving health.

- **Public health**: forge population health partnerships with health care organizations and shared accountability for outcomes.

- **Voluntaries**: pilot the use of core metrics by integrating measurement activities and developing performance dashboards.

- **Measure developers**: produce and pilot composite measures through multistakeholder collaboration, and work with HHS on implementation.
What Would Regional Implementation Look Like?

Data Access?
Measure Availability?
Local Priorities?
Attribution?
Actionability?
Relevance for Different Stakeholders?
Readiness?
Transformation Must be Founded on Reliable Data and Information

- Patient Education & Engagement
- Quality/Cost Analysis & Reporting
- Value-Driven Delivery Systems
- Value-Driven Payment Systems & Benefit Designs

Data, Analytics and Effective Use
Employer and Community Common Dashboard Priorities

**Employer and Community Leader Common Measure Priorities:** Triple Aim Dashboard

- Total Cost of Care
- Patient Experience
- Patient Reported Outcomes
- Preventive Screening Composite
- Preventable Admissions
- Patient Safety Composite
- Chronic Care Management (i.e., Optimal Diabetes Care Composite)

**Employers & Federal Purchasers Additional Measure Priorities**

- Management of Chronic Care (i.e., Optimal Diabetes Care; High Blood Pressure; Depression)
- Episodes of Care
- Longitudinal Care (Chronic conditions)
- Readmissions
- Shared Decision-making
- Access to Care in Network
- Specialty Measures

**Community Leaders Additional Measure Priorities**

- Life expectancy
- High School graduation rate
- Self-reported Health
- Addiction death rate
- BMI for population
- Teen pregnancy rate
- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to health care services

**Multiple Data Sources:**

- Polling
- Diverse Databases

**Provider and Payer Data Submission; Clinical Data Warehouse**
## Top Ten Priorities: CHT User Advisory Council

<table>
<thead>
<tr>
<th><strong>Provider</strong></th>
<th><strong>Patient</strong></th>
<th><strong>Purchaser</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Allowed episode cost, by patient chronic condition group</td>
<td>• Facility complication and mortality rate</td>
<td>• Patient experience score</td>
</tr>
<tr>
<td>• Procedure complication rate (physician or overall)</td>
<td>• Copayment for common procedures with weighted site of care</td>
<td>• Patient-reported functional outcome status</td>
</tr>
<tr>
<td>• Resource use per episode</td>
<td>• Patient experience score</td>
<td>• Procedure complication rate (physician or overall)</td>
</tr>
<tr>
<td>• Allowed episode cost, overall</td>
<td>• Copayment for E&amp;M and common procedures</td>
<td>• Allowed TCOC, overall</td>
</tr>
<tr>
<td>• Chronic management composite (e.g., Optimal Diabetes Care/Optimal Vascular Care)</td>
<td>• Procedure complication rate (physician or overall)</td>
<td>• Facility complication and mortality rate</td>
</tr>
<tr>
<td>• Cost per unit for E&amp;M and common procedures</td>
<td>• Access to care</td>
<td>• Allowed episode cost, by patient chronic condition group</td>
</tr>
<tr>
<td>• Facility complication and mortality rate</td>
<td>• Average cost share for E&amp;M and common procedures</td>
<td>• Allowed episode cost, overall</td>
</tr>
<tr>
<td>• In/out network, physician and facility</td>
<td>• In/out network, physician and facility</td>
<td>• Resource use per episode</td>
</tr>
<tr>
<td>• Patient experience score</td>
<td>• Procedure volume</td>
<td>• Resource use, by chronic condition group</td>
</tr>
<tr>
<td>• Patient-reported functional outcome status</td>
<td>• Patient-centeredness score</td>
<td>• Total resource use</td>
</tr>
</tbody>
</table>
# Triple Aim Dashboard Draft: Care Cost

<table>
<thead>
<tr>
<th>IOM Domain</th>
<th>IOM Core Measure Focus</th>
<th>IOM Candidate Measures</th>
<th>NRHI Phase 3 Measures End of 2018</th>
<th>NRHI Phase 2 Measures End of 2017</th>
<th>NRHI Phase 1 Measures End of 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Cost</td>
<td>Personal Spending Burden</td>
<td>High spending relative to income*; Healthcare-related bankruptcies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population Spending Burden</td>
<td>Per capita expenses on health care*; Total Cost of Care; Health care spending growth</td>
<td>Total Cost of Care Population-Based PMPM</td>
<td>Total Resource utilization Population-Based PMPM</td>
<td>Total Resource utilization Population-Based PMPM</td>
<td></td>
</tr>
</tbody>
</table>

*IOM designated Best Current Measure
## Triple Aim Dashboard Draft: Care Quality

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Care Quality</td>
<td>Preventive Services</td>
<td>Childhood immunization rate*; Influenza immunization; Colorectal screening; Breast cancer screening</td>
<td>Prevention Services Composite**</td>
<td>Selected existing measures TBD</td>
<td>Selected existing measures TBD</td>
</tr>
<tr>
<td>Care Access</td>
<td>Unmet care need*; Usual source of care; Delay of needed care</td>
<td>Primary Care Composite**</td>
<td>Selected existing measures TBD</td>
<td>Selected existing measures TBD</td>
<td>Selected existing measures TBD</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Hospital-acquired infection rate*; Wrong site surgery; Pressure ulcers; Medication reconciliation</td>
<td>Patient Safety Composite**</td>
<td>Hospital-acquired infection rate and other selected existing measures</td>
<td>Hospital-acquired infection rate and other selected existing measures</td>
<td>Hospital-acquired infection rate and other selected existing measures</td>
</tr>
<tr>
<td>Evidence-based care</td>
<td>Preventable hospitalization rate*; Hypertension control; Diabetes control composite; Heart attach therapy protocol; Stroke therapy protocol; Unnecessary care composite</td>
<td>Prevention Quality Overall Composite PQI 90*** (Preventable Admissions)</td>
<td>Prevention Quality Overall Composite PQI 90*** (Preventable Admissions)</td>
<td>Selected sub measures of PQI 90 TBD (Preventable Admissions)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Optimal Diabetes Care (Composite) Outcome</td>
<td>Optimal Diabetes Care (Composite) Process/Outcome</td>
<td>Optimal Diabetes Care (Composite) Process</td>
<td></td>
</tr>
<tr>
<td>Care Match with Patient Goals</td>
<td>Patient-clinician communication satisfaction</td>
<td>CG-CAHPs***/PCMH CAHPs - evolved**</td>
<td>CG-CAHPs***/PCMH-CAHPs - selected measures</td>
<td>CG-CAHPs***</td>
<td></td>
</tr>
</tbody>
</table>

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**For composite methodology development; sub-measures to come from existing measures  
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<th>NRHI Track 3 Measures End of 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People</td>
<td>Life expectancy</td>
<td>Life expectancy at birth*; Infant mortality; maternal mortality; violence and injury mortality</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Wellbeing</td>
<td>Self-reported health*; Multiple chronic conditions; Depression</td>
<td>PHQ-9 (Depression remission)</td>
<td>PHQ-9 (Use)</td>
<td>PHQ-9 (Use)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Patient Reported Outcome Measure/PROMIS</td>
<td></td>
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<td></td>
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<tr>
<td>Overweight and Obesity</td>
<td>Body mass index*; Activity levels; Health eating patterns</td>
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<tr>
<td>Addictive Behavior</td>
<td>Addiction death rate*; Tobacco use; Drug dependence/illicit use; Alcohol dependence/misuse</td>
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<td></td>
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<td></td>
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<tr>
<td>Unintended Pregnancy</td>
<td>Teen pregnancy rate*; Contraceptive use</td>
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<tr>
<td>Healthy Communities</td>
<td>High school graduation rate*; Childhood poverty rate; Childhood asthma; Air quality index; Drinking water quality index</td>
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</tbody>
</table>

*IOM designated Best Current Measure*
## Triple Aim Dashboard Draft: Public and Personal Engagement

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<tr>
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<th>NRHI Phase 1 Measures End of 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public and Personal Engagement</td>
<td>Individual Engagement</td>
<td>Health literacy rate*; involvement in health initiatives</td>
<td>CollaboRATE Quality-adjusted Life Years (QALYs)</td>
<td></td>
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</tr>
<tr>
<td>Community Engagement</td>
<td>Social support*; Availability of healthy food; walkability; Community health benefit agenda</td>
<td></td>
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</tr>
</tbody>
</table>

*IOM designated Best Current Measure
How Do We Get to Better Measures?

Measure Gaps?
Testing Methods?
Data Availability?
Cost?
Burden?
Implementation and Use?
NHRI RHICs Measuring, Reporting and Working with Clinicians to Improve Patient Experience

Diverse Markets & Approaches → Common Results

<table>
<thead>
<tr>
<th>State</th>
<th>Commercial</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Pediatric</th>
<th>Years Public Reporting</th>
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</thead>
<tbody>
<tr>
<td>California</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td>13</td>
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<tr>
<td>Detroit</td>
<td>Yes (2015)</td>
<td></td>
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<tr>
<td>Maine</td>
<td>Yes</td>
<td>Yes</td>
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<td>Massachusetts</td>
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<td>Minnesota</td>
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<tr>
<td>Washington</td>
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<tr>
<td>Wisconsin</td>
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</tr>
</tbody>
</table>
The imperatives

The consensus of leading experts and regional collaboratives that implement ambulatory patient experience measures (November 2014 MHQP Patient Experience Summit)

Advancing Ambulatory Patient Experience Measurement, Public Reporting, Quality Improvement and Innovation

Improve data collection methods to improve value and reduce costs

Better align existing survey programs

Improve survey relevance
1. Report CG-CAHPS in regions that cover more than 50% of the US
   - Broad implementation requires more nimble and dramatically more cost effective administration & survey options

2. Pilot “Next Generation” forms of capturing, measuring & publicly reporting reliable patient experience information that can quickly be rolled out across the country to meet User needs

Will take private, public and foundation support.
How Do We Align Measure Use?

Standard Implementation?
Barriers to Alignment?
Choosing a Measure Set?
Measuring Total Cost of Care across Communities
Alignment & Standardization

- Common vision and aligned mission
- Commitment to early and often multi-stakeholder engagement
- Locally tailored to market
- Neutral forum, trusted data
- Private sharing before public release
Pilot Goals Achieved

• Each region produced attributed practice level reports in their respective communities.

• A benchmarking approach across five regions was developed and tested.

• Each Regional Collaborative shared reports with community stakeholders.

• Participating physicians were supported to lead change both locally and nationally with a reporting framework, strategy and practical approaches to affect change.
Through a national network of locally governed regional entities, the Center for Healthcare Transparency plans to make information on the relative cost and quality – including the patient experience - of healthcare services available to 50 percent of the U.S. population by 2020.
CHT network participants expect to publicly report diverse types of high value measures

### Proposed Measure Dashboard
**Phased in from 2017-2020**

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Data Source</th>
<th>Expected Dashboard Measures</th>
</tr>
</thead>
</table>
| **Patient Generated**         | Patient reported outcomes, patient experience surveys and narratives, etc.  | • Depression Remission at 6 Months  
                                 | (May also be captured in EMRs)                                                          | • Knee Replacement Functional Status  
                                 |                                                                              | • PROMIS – Overall Well Being/Physical Health  
                                 |                                                                              | • CG-CAHPS  
                                 |                                                                              | • CollaboRATE Shared Decision-Making Tool  
                                 |                                                                              | • Next Generation Patient Experience measure (to be developed in 2016)        |
| **Clinical**                  | Electronic medical records, lab and pharmacy records, registries, etc.      | • Optimal Diabetes Care Composite  
                                 |                                                                              | • Controlling High Blood Pressure                                                   |
| **Cost & Utilization**        | Payer enrollment, medical and pharmacy claims files                        | • Total Cost of Care  
                                 |                                                                              | • Total Resource Use  
                                 |                                                                              | • Procedure Episode Cost  
                                 |                                                                              | • Plan All Cause Re-admissions  
                                 |                                                                              | • Procedure Volume  
                                 |                                                                              | • Cancer Prevention Composite                                                   |
Building *Accountable Health Communities* for Accountable Care

Community Reinforcing Loop

ACO: Accountable Care Organization

Portion of shared savings and/or other dollars

ACO with improved health outcomes at lower costs

AHCo for improved population health

Investments in determinants of health

AHCo: Accountable Health Community