Performance Measurement Work Group Report to the Commission:

Strategy for Population Based, Patient Centered

Performance Measurement

Health Services Cost Review Commission

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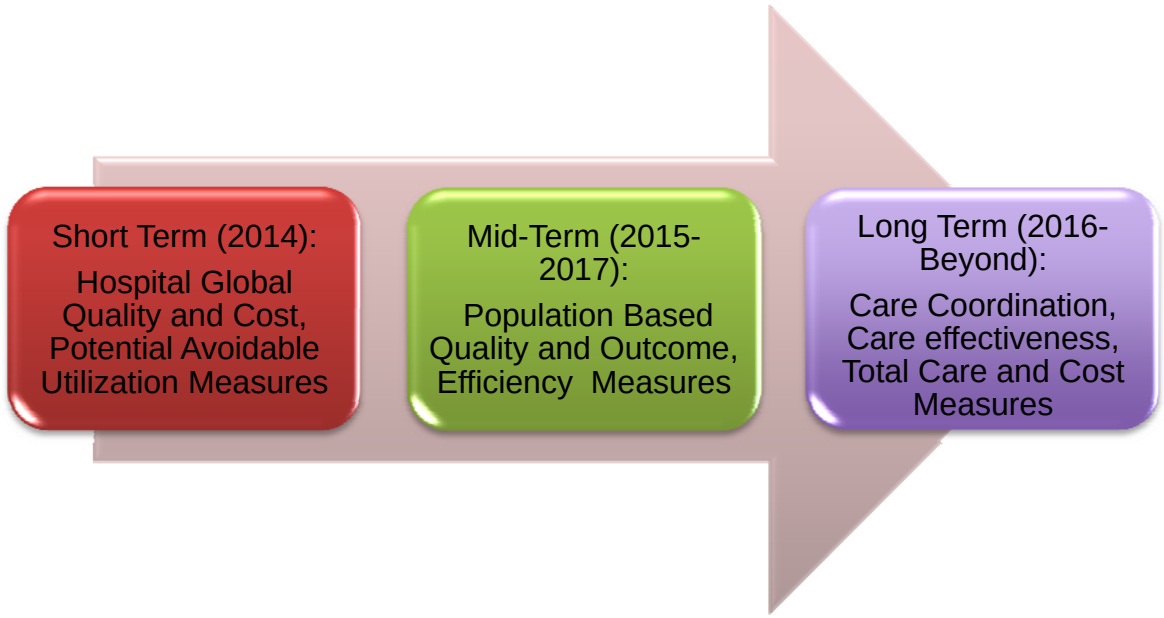
This document summarizes the deliberations of the Performance Work Group on aligning performance measurement with the new All-Payer Model. This report is intended for the purpose of discussion related to a strategy and direction for performance measurement, and does not require formal action by the Commission.

INTRODUCTION

The charge of the Performance Measurement Workgroup is to provide input on what specific measures of cost, care and health should be considered for adoption, retention or development in order to evaluate and incentivize performance improvements under the population-based All-Payer Model. A comprehensive measurement strategy must first be developed to support achievement of the Model goals; this strategy must align with the All-payer Model development and implementation timeline as well as recognize and support the priorities at each phase of the process. In beginning to address this charge, the Workgroup acknowledged that the performance measurement strategy must first focus on measurement of global hospital-based services and care that support immediate success in achieving the new All-payer Model targets, then expand to measurement of population-based quality and efficiency, and ultimately measurement that supports patient-centered, coordinated, cost-effective care that achieves better outcomes (Figure 1).

Figure 1: Performance Measurement Strategy Priorities Over Time



The Performance Measurement Workgroup discussed the context for developing an overall measurement strategy, and presentations on specific measures in some relevant categories of measures in which we need to expand over time. The Workgroup also discussed the need to monitor performance in "real time" to the extent possible, and to this end vetted draft dashboards at the hospital/system- and statewide-level to be finalized and put into place in the short term.

This report summarizes the Workgroup's efforts to date as well as other important proposed considerations toward fleshing out a robust performance measurement strategy.

PPERFORMANCE MEASUREMENT STRATEGY CONSIDERATIONS

Regarding the potential array of purposes or uses of measures, Figure 2 illustrates the key principles and stakeholders that must be considered in the overall performance measurement strategy for each of the domains and measures identified to support the All-payer Model. Although the HSCRC has traditionally been focused on payment related measures, the workgroup acknowledged a need for coordinated effort in addressing emerging needs of performance measurement related to public reporting and monitoring in the context of All-payer Model.

Figure 2. Measurement Strategy Principles and Stakeholders

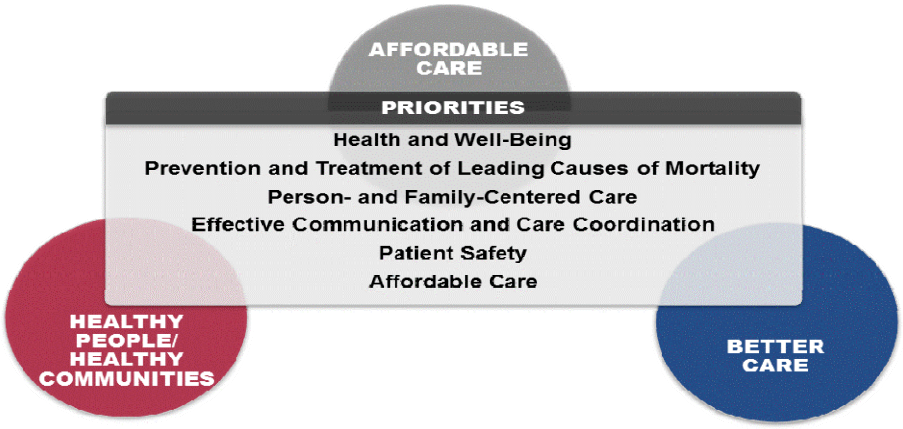
Principles/criteria to guide measure domains to be implemented:
❖ Accountability
➢ Payment
➢ Public reporting
➢ Program monitoring and evaluation
❖ Improvement
❖ Alignment with Model targets and monitoring commitments
Stakeholders
❖ Policymakers – CMS, HSCRC (commission, staff), MHCC, DHMH
❖ Providers – hospitals, physicians, others
❖ Payers/purchasers – health plans, employers
❖ Patients – consumers

Achieving the Three-Part Aim of Better Care, Better Health and Lower Cost

The National Quality Strategy (NQS) first published in March 2011 and led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS) articulated the three-part aim. Maryland's All-payer Model has directly aligned its aims with those of the NQS's three-part aim. So too, Maryland's performance measurement strategy needs to address the NQS priorities and use the available levers as identified by the NQS, either directly through policy implementation or indirectly in working with partners, to maximize success in achieving the aims.

To advance the aims, the NQS focuses on six priorities, as illustrated in Figure 3.

Figure 3. National Quality Strategy Priorities.



Each of the nine NQS levers, listed below, represents a core business function, resource, or action that Maryland can use to align to the NQS and maximize our opportunity for improvement and success under the new Model. HSCRC already uses several of the levers in its performance measurement programs.

- Measurement and Feedback: Provide performance feedback to plans and providers to improve care
- Public Reporting: Compare treatment results, costs and patient experience for consumers
- Learning and Technical Assistance: Foster learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals
- Certification, Accreditation, and Regulation: Adopt or adhere to approaches to meet safety and quality standards
- Consumer Incentives and Benefit Designs: Help consumers adopt healthy behaviors and make informed decisions
- Payment: Reward and incentivize providers to deliver high-quality, patient-centered care
- Health Information Technology: Improve communication, transparency, and efficiency for better coordinated health and health care
- Innovation and Diffusion: Foster innovation in health care quality improvement, and facilitate rapid adoption within and across organizations and communities
- Workforce Development: Investing in people to prepare the next generation of health care professionals and support lifelong learning for providers

MEASUREMENT UPDATES AND NEW DOMAINS

The Workgroup vetted near term measurement updates for the Maryland Hospital Acquired Conditions (MHAC) and Readmission Reduction Policies, and provided important input on efficiency measurement, a topic that is addressed in a separate report.

The Workgroup also considered options for implementing hospital- and regional-level dashboards that present of a mixture of key financial and non-financial measures that would be monitored closely (mostly monthly) and consistently across hospitals and for the state or other defined regions, and provide a "snapshot" of trends over time. The dashboard is intended as a

tool to articulate the links between leading inputs, processes, and lagging outcomes and focuses on the importance of managing these components to achieve the strategic priorities. The Workgroup noted the dashboard is not meant to replace traditional financial or operational reports but is intended to provide a succinct summary to help users with situational awareness. In vetting the hospital/system- and regional-level draft dashboard templates, there was agreement among the Workgroup members to begin by including the domains and measures for monitoring listed in Appendix A. As the All-Payer model includes reducing racial/ethnic disparities as part of the quality improvement strategy in achieving three-part aim, the dashboard will also be adapted to look at racial/ethnic disparities at the state-wide level. HSCRC staff will coordinate with the DHMH Office of Minority Health in determining the most appropriate measurement strategy to effectively monitor the racial and ethnic disparities in quality of care and patient outcomes.

In addition, the Workgroup discussed measurement domains/areas where there is great added potential for success in reaching the three-part aim, but which are still the most aspirational in terms of achieving robust valid and reliable measurement**.** These "new frontiers" of measures include Population Health and Patient Centered Care measures.

Population Health Measures

According to the World Health Organization, health is defined as "A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Population health entails improving overall health status and health outcomes of interest to individuals, the clinical care system, the government public health system, and stakeholder organizations. It is influenced by physical, biological, social and economic factors in the environment, by personal health behavior, and by access to and effectiveness of healthcare services.Sub-domains of population health measures with specific measure examples are listed below.

- Health Outcomes- high-level indicators
  Measure examples: mortality, longevity, Infant mortality/ low birth weight/ preterm birth, Injuries/ accidents/homicide, suicide rate

- Access- availability and use of services
  Health insurance status; primary care access; access to needed services; condition specific hospital admissions; Measure examples:
  (NQF#1337) Children with Inconsistent Health Insurance Coverage in the Past 12 Months,
  (NQF #718) Children Who Had Problems Obtaining Referrals When Needed,
  (NQF #277) Heart Failure Admission Rate (PQI 8)

- Healthy Behaviors- choices by individuals and communities
  Addictive substances assessment and counseling; weight assessment and physical activity counseling; Measure examples:
  (NQF #2152) Preventive Care and Screening and Counseling: Unhealthy Alcohol Use
  (NQF #1656) Tobacco Use Treatment Offered at Discharge

(NQF #1406) Risky Behavior Assessment or Counseling by Age 13 Years
(NQF #421) Body Mass Index (BMI) Screening and Follow-Up

- Prevention- screening and early intervention
  Disease and condition screening; immunizations; maternity care; newborn and child development; Measure examples:
  (NQF #34) Colorectal Cancer Screening
  (NQF #1659) Influenza Immunization
  (NQF #278) Low Birth Weight Rate (PQI 9)
  (NQF #1385) Developmental screening using a parent completed screening tool
  (NQF #104) Adult Major Depressive Disorder: Suicide Risk Assessment

- Social Environment- health literacy and attention to disparities
  Health literacy; education (e.g., graduation rate); community safety; poverty level; disparities-sensitive measures; Measure example:
  (NQF #720) Children Who Live in Communities Perceived as Safe

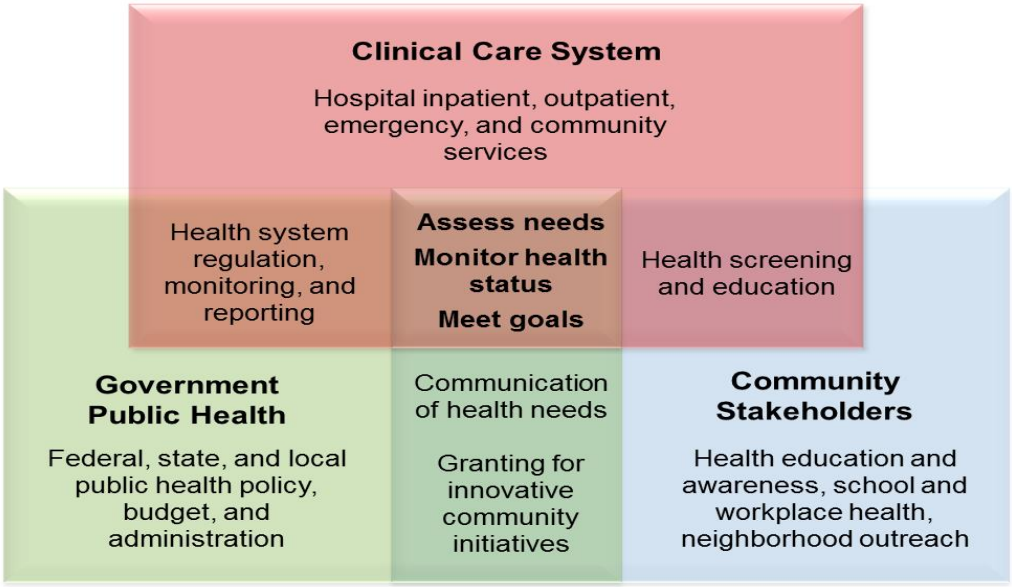
- Physical Environment- built infrastructure and natural resources
  Healthy food options, neighborhood walkability, air quality; Measure example:
  (NQF 1346) Children Who Are Exposed To Secondhand Smoke Inside Home

Hospitals have an interest in population health management for many reasons, including:

- Caregivers are passionate about promoting health.
- Length of stay, readmissions, and complications are linked to health and wellness of patients before and after hospital stay.
- Increased policy efforts can improve care coordination between hospitals, primary care, pharmacy, and the entire medical neighborhood.
- Hospital data can be used to assess community health.
- Community health initiatives build goodwill and reinforce non-profit status.
- Hospitals are themselves parts of the communities in which they are located.

Hospitals' expanded interest and work to improve population health overlaps significantly with their own quality measurement and performance, as illustrated in Figure 4 below.

Figure 4. Hospital Measurement Overlap with Population Health Measurement



Maryland state health agencies must continue to collaborate in both measurement and improvement of quality in our broader community. Hospitals, for example, engage in community needs assessments and link these assessment findings in their community benefit activities summarized in their Community Benefits Reports updated each year. In terms of phasing of implementation and use of population health measures for potential use in hospital payment incentive programs, the Workgroup discussed first measuring healthy behaviors and preventive services for hospital patients, then expanding to assessing community health needs and developing a measurement strategy around improvement, and finally collaborating with public health officials and community services on measuring progress in addressing community needs. Some of the population health measures could directly be applicable for measuring hospital performance; however; existing measurement definitions often times capture a geography or group of people and would require further methodological development to adapt to hospital specific performance measurement in this phasing approach.

Person (Patient and Family) Centered Care Measures

NQF conducted a Person-Centered Care Measure Gaps Project that defined Patient and Family Centered Care as "an approach to the planning and delivery of care across settings and time that is centered on collaborative partnerships among individuals, their defined family, and providers of care." This care also "supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values." Key principles for these measures include:

- They are meaningful to consumers and built with the involvement of consumers
- They are focused on their entire care experience, rather than a single setting or program

- They are measured from the person's perspective and experience (i.e., generally patient-reported unless the patient/consumer is not the best source of the information)

Person centered care measure sub-domains with examples of measures are listed below.

- Experience of Care
  Measure examples:
  (NQF #166) HCAHPS- Survey for Hospital Inpatients on Communication with doctors, Communication with nurses, Responsiveness of hospital staff, Pain control, Communication about medicines, Cleanliness and quiet of the hospital environment, Discharge information.
  Communication Climate Assessment Toolkit (C-CAT)- American Medical Association Survey Tool Measure domains: Health literacy, Cross-cultural communication, Individual engagement, Language services Provider leadership commitment, Performance evaluation.

- Health-Related Quality of Life
  Functional Status; mental health assessment; "whole person" well-being; Measure examples:
  (NQF #260)Assessment of Health-Related Quality of Life (Physical and Mental Functioning) Using KDQOL-36
  (NQF #'s 0422-0428)Functional States Change for Patients with Orthopedic Impairments
  (NQF #0418) Screening for Clinical Depression and Follow-Up Plan

- Burden of Illness
  Symptom management (pain, fatigue); treatment burden (patients, family, community); Measure examples:
  (NQF #0050)Osteoarthritis: Function and Pain Assessment
  (NQF #0420)Pain Assessment and Follow-up
  (NQF #0101)Falls: Screening, Risk Assessment and Plan of Care to Prevent Future Falls

- Shared Decision-Making
  Communication with patient and family; advance care planning; establishing goals; care concordant with individual preferences; Measure examples:
  (NQF #326)Advance Care Plan
  (NQF #0310)Back Pain: Shared Decision-Making
  (NQF #557)Psychiatric Post-discharge Continuing Care Plan Created
  (NQF #1919)Cultural Competency Implementation Measure

- Patient Navigation and Self-Management
  Patient activation; health literacy; caregiver support; Measure examples:
  (NQF #1340)Children with Special Health Care Needs (CSHCN) Who Receive Services Needed for Transition to Adult Health Care
  (NQF #0603)Adults Taking Insulin with Evidence of Self-Management

A phased approach for person centered care measurement and its potential use in payment incentive models may begin by measuring experience of care (HCAHPS) which HSCRC has measured for Quality Based Reimbursement since 2009. The next phase could expand to measuring burden of illness (pain), cultural competency, and shared decision-making (care plans/procedures) measures, and finally advance to measuring improvement in functional status and patient self-management. Performance in this domain is important not only for policymakers and providers but would have particular significance for consumers.

Collaboration is Essential to Improving Population-Based, Patient Centered Care

Some of the most important potential gains in patient centered care and improving hospital efficiency and population health require community-wide interventions, outside hospital walls. Global budgets alone are unlikely to lead most GBR hospitals to collaborate around community initiatives in this area. An approach recommended by the Maryland Citizens Health Care Initiative Education Fund, Inc. in their white paper submission to HSCRC on Hospital Collaboration would directly incentivize such collaboration by rewarding a hospital, not just for its own efficiency, population health and patient centered care improvement gains, but also for those throughout its service area (link to the white paper: http://hscrc.maryland.gov/documents/md-maphs/wp-sub/HCFA-White-Paper-2-Multi-Hospital-Collaboration-060914.pdf). The white paper further suggests that DHMH should further encourage collaboration by sponsoring forums at which hospitals and other local stakeholders can develop arrangements, including gain-sharing and shared savings agreements, to reduce unnecessary costs by improving community-based care, including through investing in care coordination, perhaps starting with chronically ill Medicare patients. If successful, this approach will further integrate Maryland's new hospital financing system with the delivery system and financing reforms that are taking place outside the state's hospitals, synergistically strengthening innovations in both realms to help accomplish the Triple Aim.

NEXT STEPS: PERFORMANCE MEASUREMENT PLANNING STRUCTURE

Many factors come to bear in implementing a robust and successful performance measurement strategy that is population based and patient centered. Priorities and levers for achieving the three-part aim, performance measurement principles/criteria, and stakeholders that must have a voice will require collaboration among agencies, workgroups and stakeholders. Going forward, an updated Performance Improvement and Measurement Workgroup, for example, may work with multi-agency and multi- stakeholder groups such as those focused on consumer engagement and care coordination and infrastructure, and potential ad hoc subgroups focused on, for example, efficiency, ongoing monitoring activities, and total cost of care. Much work will need to focus on developing and implementing measures where there are gaps in important measurement areas/domains. To this end, staff will work with all the identified stakeholders through the various workgroups and ad-hoc groups to review inventories of currently available measures for each targeted domain where measurement must occur, and to identify where new measures will be required. For each of the domains and measures proposed, the Workgroup will again need to consider the purpose(s) for use of the measures—accountability (payment, public

reporting, program monitoring and evaluation), improvement, and alignment with Model targets and monitoring— as well as the stakeholders for whom these data are intended—policymakers (CMS, HSCRC, MHCC, DHMH), providers (hospitals, physicians, etc.), payers/purchasers, health plans, employers, patients, consumers.

The Performance Measurement Workgroup has reviewed a proposal of the staff as a part of the strategy for moving performance measurement work forward; Appendix B illustrates a draft plan that sketches out performance measurement expansion over time, including potential purposes, domains and potential audiences of measures/domains.

Appendix A. DRAFT Hospital and Regional Dashboard Domains and Measures

Hospital and Regional (State, County, etc.) Measures	Measurement Interval	Applicability
Revenue		
Total Inpatient Revenue	Monthly	Hospital and Regional
Total Outpatient Revenue	Monthly	Hospital and Regional
Total Revenue	Monthly	Hospital and Regional
Total Revenue Resident	Monthly	Hospital and Regional
Total Revenue Medicare Resident	Monthly	Hospital and Regional
Total Resident Revenue per Capita	Monthly	Hospital and Regional
Total Medicare Resident Revenue per beneficiary	Monthly	Hospital and Regional
Volume		
Total Inpatient Discharges	Monthly	Hospital and Regional
Total Inpatient Discharges- Resident	Monthly	Hospital and Regional
Total Inpatient Discharges, Medicare Resident	Monthly	Hospital and Regional
Total ED Visits	Monthly	Hospital and Regional
Total ED Visit - Resident	Monthly	Hospital and Regional
Total ED Visits- Medicare Resident	Monthly	Hospital and Regional
Total Equivalent Case Mix Adjusted Discharges (ECMAD)	Monthly	Hospital and Regional
Total ECMAD - Resident	Monthly	Hospital and Regional
Data Sharing		
Principle Provider Notification	Quarterly	Hospital and Regional
BETTER HEALTH		
Rates of Acute Composite AHRQ Prevention Quality Indicators	Monthy	Regional Only
Rates of Chronic Composite AHRQ Prevention Quality Indicators	Monthy	Regional Only
Maryland State Health Improvement Process		
SHIP 33- Diabetes-related ED visits	Monthly	Hospital and Regional
SHIP 34- Hypertension-related ED visits	Monthly	Hospital and Regional
SHIP 36- ED visits for mental health conditions	Monthly	Hospital and Regional
SHIP 37- ED visits for addictions-related conditions	Monthly	Hospital and Regional
SHIP 41- ED visits for asthma	Monthly	Hospital and Regional
SHIP 2- Low Birth Weight Births	Monthly	Hospital and Regional
BETTER CARE		
HCAHPS: Patient's rating of the hospital	Quarterly	Hospital and Regional

Hospital and Regional (State, County, etc.) Measures	Measurement Interval	Applicability
HCAHPS: Communication with doctors	Quarterly	Hospital and Regional
HCAHPS: Communication with nurses	Quarterly	Hospital and Regional
Maryland Hospital Acquired Condition Rates	Monthly	Hospital and Regional
All Cause Readmission Rate (CMS Methodology with exclusions)	Monthly	Hospital and Regional
Rates of ED/Observation visits within 30 days post discharge	Monthly	Hospital and Regional
Numbers/Percent of ED to Inpatient Transfers	Monthly	Hospital and Regional
Numbers/Percent of Inpatient to Inpatient Transfers	Monthly	Hospital and Regional
REDUCE COSTS		
Potentially Avoidable Utilization Costs		
Inpatient- All Hospital, All Cause 30 Day Readmissions using (CMS with adjustment)	Monthly	Hospital and Regional
ED/Observation – any visit within 30 days of an inpatient admission	Monthly	Hospital and Regional
Potentially Avoidable Admissions (as measured by AHRQ PQIs)	Monthly	Hospital and Regional
Hospital Acquired Conditions as measured by Potentially Preventable Complications (PPCs)	Monthly	Hospital and Regional

Appendix B

Measure Domains, Potential Uses and Target Audiences

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
SHORT TERM									
QBR	X	X	X	X	X	X	X	X	X
MHAC	X	X	X	X		X	X		
PAU	X				X	X	X		
PQI	X (statewide / regional)				X (statewide/ regional)	X	X		
FALL 2014 UPDATES									
QBR	X	X	X	X	X	X	X	X	X
MHAC	X	X	X	X	X	X	X		
PAU	X	X	X	X	X	X	X		
PQI	X (statewide				X (statewide/	X	X		

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
	/ regional				regional)				
Cost Efficiency Measures	X	X	X	X	X	X	‘X	X	X
JULY 2014- JUNE 2015 DEVELOPMENT									
Risk Adjusted Readmis-sions	X	X	X	X	X	X	X	X	X
Care Improve-ment	X				X	X	X		
Patient-Centered Care	X				X	X	X		
EHR Measures	X				X	X	X		
Care Coordi-	X				X	X	X		

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
nation									
Total Cost of Care	X				X	X	X		
LONG TERM									
QBR	X	X	X	X	X	X	X	X	X
MHAC	X	X	X	X	X	X	X		
PAU	X	X	X	X	X	X	X		
PQI	X (statewide / regional				X (statewide/ regional)	X	X		
Cost Efficiency Measures	X	X	X	X	X	X	X	X	X
Risk Adjusted Readmis-sions	X	X	X	X	X	X	X	X	X

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
Care Improve-ment	X	X	X	X	X	X	X	X	X
Patient-Centered Care	X	X	X	X	X	X	X	X	X
EHR Measures	X	X	X	X	X	X	X	X	X
Care Coordi-nation	X	X	X	X	X	X	X	X	X
Total Cost of Care	X	X	X	X	X	X	X	X	X