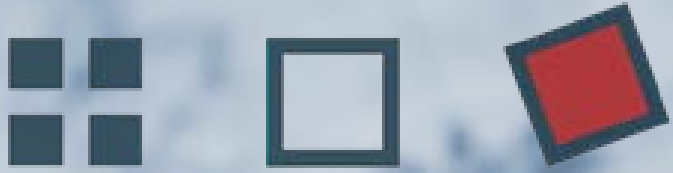**All Payer Hospital System Modernization**
Performance Measurement Workgroup Meeting

Meeting Agenda

May 28, 2014, 1 PM
HSCRC
4160 Patterson Ave
Baltimore, MD 21215
410-764-2605

1:00 PM   Efficiency measures report draft- brief status update

1:10 PM   Balanced scorecard measures mock up- discussion

Dianne Feeney, HSCRC

1:50 PM   Socio-economic status adjustments and linking cost and quality measures- update on NQF work

Tom Valuck, Discern

2:30 PM   Expansion to new measure areas including population based, patient centered measures- strategy and timeline discussion

Dianne Feeney, HSCRC

3:00 PM   Questions/Comments from the audience

3:15 PM   Adjourn

Supporting Schedule	DOMAIN/ MEASURE	Measurement Interval	Base Period Value	Target	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	March 15	April 15	May 15	June 15	Year to Date
	Hospital Name:																
	Rate Setting Methodology:																
	Revenue																
	Total Revenue	Monthly															
	Total Revenue Medicare Resident	Monthly															
	Total Revenue Non-Medicare Resident	Monthly															
	Volume																
	Total Inpatient Discharges	Monthly															
	Total Inpatient Discharges, Medicare Resident	Monthly															
	Total Inpatient Non-Medicare Resident	Monthly															
	Total ED Visits	Monthly															
	Data Sharing																
	Principle Provider Notification	Quarterly															
	BETTER CARE																
	Patient experience- HCAHPS Total Score	Annually															
	HCAHPS: Patient's rating of the hospital	Annually															
	HCAHPS: Communication with doctors	Annually															
	HCAHPS: Communication with nurses	Annually															
	Maryland Hospital Acquired Condition Rates	Monthly															
	All Cause Readmissin Rate (CMS Methodology with exclusions)	Monthly															
	Rates of Observation visits within 30 days post discharge	Monthly															
	Rates of ED Visits within 30 days post discharge	Monthly															
	Rates of ED to Inpatient Transfers	Monthly															
	Rates of Inpatient to Inpatient Transfers	Monthly															
	Increase data sharing through Health Information Exchange	Monthly															
	SHIP 2- Low Birth Weight Births	Annually															
	REDUCE COSTS																
	Potential Avoidable Utilization Costs																
	Inpatient- All Hospital, All Cause 30 Day Readmissions using (CMS with adjustment)	Monthly															
	ED – any visit within 30 days of an inpatient admission	Monthly															
	Observation- any observation within 30 days of an inpatient admission	Monthly															
	Potentially Avoidable Admissions/Visits	Monthly															
	Inpatient AHRQ PQIs	Monthly															
	Hospital Acquired Conditions as measured by Potentially Preventable Complications (PPCs)	Monthly															

Supporting Schedule	State/County/Region:	Measurement Interval	Base Period Value	Target	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	March 15	April 15	May 15	June 15	Year to Date
	Revenue																
	Total Revenue	Monthly															
	Total Revenue Medicare Resident	Monthly															
	Total Revenue Non-Medicare Resident	Monthly															
	Volume																
	Total Inpatient Discharges	Monthly															
	Total Inpatient Discharges, Medicare Resident	Monthly															
	Total Inpatient Non-Medicare Resident	Monthly															
	Total ED Visits	Monthly															
	Data Sharing																
	Principle Provider Notification	Quarterly															
	BETTER HEALTH																
	Rates of Acute Composite AHRQ Prevention Quality Indicators	Quarterly															
	Rates of Chronic Composite AHRQ Prevention Quality Indicators	Quarterly															
	Maryland State Health Imrpovement Process																
	SHIP 33- Diabetes-related ED visits	Annually															
	SHIP 34- Hypertension-related ED visits	Annually															
	SHIP 36- ED visits for mental health conditions	Annually															
	SHIP 37- ED visits for addictions-related conditions	Annually															
	SHIP 41- ED visits for asthma	Annually															
	BETTER CARE																
	Patient experience- HCAHPS Total Score	Annually															
	HCAHPS: Patient's rating of the hospital	Annually															
	HCAHPS: Communication with doctors	Annually															
	HCAHPS: Communication with nurses	Annually															
	Maryland Hospital Acquired Condition Rates	Monthly															
	All Cause Readmissin Rate (CMS Methodology with exclusions)	Monthly															
	Rates of Observation visits within 30 days post discharge	Monthly															
	Rates of ED Visits within 30 days post discharge	Monthly															
	Rates of ED to Inpatient Transfers	Monthly															
	Rates of Inpatient to Inpatient Transfers	Monthly															
	Increase data sharing through Health Information Exchange	Monthly															
	SHIP 2- Low Birth Weight Births	Annually															
	REDUCE COSTS																
	Potential Avoidable Utilization Costs																
	Inpatient- All Hospital, All Cause 30 Day Readmissions using (CMS with adjustment)	Monthly															
	ED – any visit within 30 days of an inpatient admission	Monthly															
	Observation- any observation within 30 days of an inpatient admission	Monthly															
	Potentially Avoidable Admissions/Visits	Monthly															
	Inpatient AHRQ PQIs	Monthly															
	Hospital Acquired Conditions as measured by Potentially Preventable Complications (PPCs)	Monthly															

Risk Adjustment for Socioeconomic Status; Linking Cost and Quality Measures

**HSCRC
Performance Measurement
Workgroup**

May 28, 2014

Tom Valuck, MD, JD

Discern Health
1120 North Charles Street
Suite 200
Baltimore, MD 21201
(410) 542-4470
www.discernhealth.com

Presentation Overview

- Update the Performance Measurement Workgroup on NQF activities related to two measurement issues raised in previous workgroup deliberations

  - **Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors**

    - Public comment draft published March 2014; final report in development

  - **Linking Quality and Cost Indicators to Measure Efficiency in Healthcare**

    - Public comment draft published April 2014

Risk Adjustment for Socioeconomic Status and Other Sociodemographic Factors

Clinical vs. Socioeconomic Risk

- Current NQF policy:
    - Recommends the adjustment of outcome measures for clinical factors, such as severity of illness and co-morbidities, recognizing that patients who are sicker and have multiple conditions have a higher likelihood of worse outcomes, regardless of the quality of care provided
    - Does not allow adjustment for sociodemographic factors to make disparities visible; rather, recommends that measures be stratified by the relevant factors

Clinical vs. Sociodemographic Risk

- Adjustment for sociodemographic factors may be appropriate to avoid undesirable unintended effects

  - Adverse selection—providers avoiding disadvantaged populations

  - Shifting performance-based payments and market share away from providers that serve disadvantaged populations, resulting in fewer resources to treat those populations

Draft Recommendation

- Appropriate adjustment depends on the purpose of measurement

    - For purposes of **accountability** (e.g., public reporting, performance-based payment), sociodemographic factors should be included in risk adjustment of the performance score

    - For purposes of identifying and reducing **disparities**, performance measures should be stratified on the basis of relevant sociodemographic factors

Risk Factors

- Socioeconomic Status
  - Income (or proxy based on residence)
  - Education
  - Occupation/employment
  - Community-level variables, such as:
    - Distance to healthcare providers and pharmacies
    - Access to food outlets and parks
    - Transportation
    - Neighbors, social support infrastructure
    - Crime rates

Risk Factors

- Demographic factors related to socioeconomic status and/or clinical outcomes:
  - Insurance status
  - Race and ethnicity
  - English language proficiency
  - Homelessness
  - Marital status
  - Literacy/health literacy

Stratification for Identifying Disparities

- Patient populations are grouped (stratified) by sociodemographic indicators and their measured outcomes are evaluated for each group
  - Upside- Makes demographic disparities evident, and results in groups of patients that can be compared across providers
  - Downside- Does not lead to an obvious "overall score" for financial incentives; groups across providers may have different sample sizes, making comparisons questionable

Using Peer Groups as an Alternative

- Make comparisons within peer groups of providers with similar resources and similar populations

    - Upside- Performance scores would not need to be adjusted to compare quality outcomes

    - Downside- Disparities not identified; hard to evaluate across peer groups

Public Comments on Draft Report

- Providers
  - Sociodemographic risk adjustment is essential for fairness
  - Necessary to avoid undesirable unintended effects for vulnerable populations and the providers that care for them

- Consumers and Purchasers
  - Sociodemographic adjustment might mask quality problems or disparities; could promote using different clinical standards for different patients
  - Unclear if there is enough evidence that, without risk adjustment, there is the potential of harm for patients

Other Notes Regarding Adjustment for Socioeconomic Status

- No absolutes- Each measure should be considered for the appropriateness of risk adjustment

  - For example, central line infections or wrong site surgery should not be adjusted

- Access to good sociodemographic data a barrier

- Stratification, risk adjustment, and peer grouping are not mutually exclusive methods- consider hybrid approaches

Linking Quality and Cost Indicators to Measure Efficiency

Linking Quality and Cost Indicators

- Commissioned paper authors performed an environmental scan to identify methods that combine quality and cost measures to assess efficiency
- Identified 7 proposed or currently-used approaches
- No definitive approach in use

What Is Efficiency?

- Relationship between inputs and outputs

- Efficiency = quality / costs

- Can increase efficiency by increasing quality, decreasing costs, or both; but cheaper is not necessarily more efficient

- To measure efficiency, need both the quality and cost components

Approaches to Assessing Efficiency

Conditional Model

1. Quality assessed with a single measure or a composite measure
2. Cost assessed, typically with a measure of total cost
3. Quality and cost domains classified into performance groups, frequently low, medium, and high
4. Classifications combined to assess efficiency (e.g., high quality, medium cost; low quality, high cost)

Variations of the Conditional Model

Hurdle Model

□ Minimum quality standard must be met before cost is assessed, or vice versa

Unconditional Model

□ Quality and cost are assessed independently, and then quality and cost domains are assigned different weights and combined into a single measure

Side-by-Side Comparison Model

□ Quality and cost are evaluated but not combined, leaving the standalone values for comparison

Other Approaches to Assessing Efficiency

Regression Model

- Uses regression analysis to account for within-provider correlation between quality and cost outcomes

Cost-Effectiveness Model

- Assigns dollar amounts to quality outcomes (like increased survival) so that outcomes may be compared in financial terms

Data Envelopment Analysis Model

- Develops a continuous "efficiency frontier" against which all quality and cost results are compared

Use of Efficiency Assessment Models

Method	Current Use
Conditional	Wide use among private payers to tier providers based on efficiency
Hurdle	Used in shared savings programs
Unconditional	Used in Hospital Value-Based Purchasing and Leapfrog Recognition Program
Side-by-Side	Used in Medicare Star Ratings and NCQA Relative Resource Use
Regression	Health services research
Cost-Effectiveness	Health services research
Data Envelopment	Health services research

Approaches to Assessing Efficiency

- Considerations
  - Conditional, Unconditional, Side-by Side, and Hurdle models are easier to understand and more transparent, but they depend on measure weighting mechanisms that may undermine validity
  - In all models, if relationship to outcomes and actual patient health is not well defined, then promoting measure compliance might not actually yield efficiency gains
  - Cost and quality measures are often not harmonized across timeframes, patient populations/denominators, or price
  - Virtually no assessment of the reliability and validity of these models

Thank You

Draft Strategy for Population Based, Patient Centered

Performance Measurement

The HSCRC measurement strategy must align with the All-payer Model development and implementation timeline.

Figure 1. Expansion of Model Focus over Time
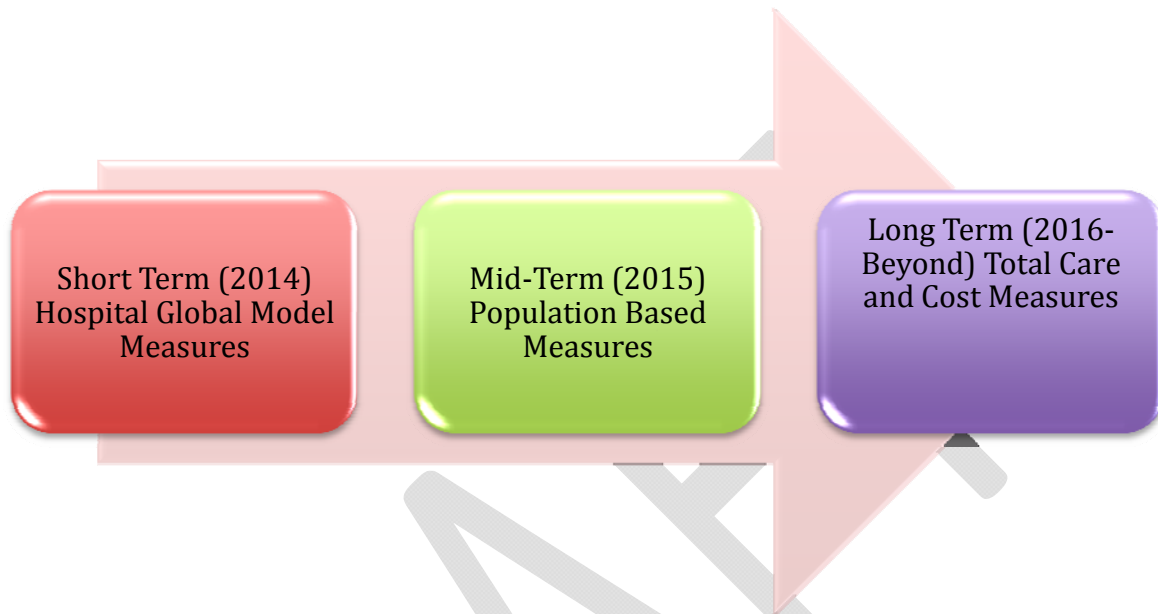
The strategy must address principles, stakeholders and targeted domains of measures going forward over time.

- o 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
- o Stakeholders
  - Policymakers – CMS, HSCRC (commission, staff), MHCC, DHMH
  - Providers – hospitals, physicians, others
  - Payers/purchasers – health plans, employers?
  - Patients – consumers
- o List the potential measures by domain, timing-
  Table 2 below is a draft that sketches out performance measurement expansion over time, including purposes, domains and potential audiences of measurement domains.

Draft Strategy for Population Based, Patient Centered

Performance Measurement

Consider for candidate measures:

- o Reliable data/source
- o Timely availability
- o Risk adjusted as appropriate
- o Aligned with achieving All-payer Model targets
- o Aligned with national priorities and measures

The continued work that relates to performance measurement will include collaboration with other workgroups and ad hoc subgroups that will be convened.

Draft Strategy for Population Based, Patient Centered

Performance Measurement

Table 1. Measure Domains, Potential Uses and Target Audiences

Measure Domains	Purposes/Uses					Target Audiences			
	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		

3

Draft Strategy for Population Based, Patient Centered

Performance Measurement

Measure Domains	Purposes/Uses					Target Audiences			
	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		

Draft Strategy for Population Based, Patient Centered

Performance Measurement

Measure Domains	Purposes/Uses					Target Audiences			
	Improve-ment	Account-ability	Pay-ment	Public Reporting/ Trans-perancy	Program Monitoring/ Evaluation	Policy Makers	Providers	Payers	Patients
Care Coordi-nation	X				X	X	X		
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

Draft Strategy for Population Based, Patient Centered

Performance Measurement

Measure Domains	Purposes/Uses					Target Audiences			
	Improve-ment	Account-ability	Pay-ment	Public Reporting/ Trans-perancy	Program Monitoring/ Evaluation	Policy Makers	Providers	Payers	Patients
Risk Adjusted Readmis-sions	X	X	X	X	X	X	X	X	X
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