NH Accountable Care Project Advisory Board

November 19, 2012

CITIZENS HEALTH INITIATIVE

Agenda

- Welcome and Project Overview
- Project History
- NH Comprehensive Health Care Information System (NH CHIS)
- Development Partner
- Year 1Outputs
- Work in progress
- Questions and Discussion
- Next Steps

CITIZENS HEALTH INITIATIVE

The NH Citizens Health Initiative

- ***Leading New Hampshire to a better health future***
- ***Better health***
- ***Better care***
- ***Lower costs for everyone…***

CITIZENS HEALTH INITIATIVE

NH Citizens Health Initiative

- Current Pillar Projects
  - Medical Home Pilot
  - ACO/Payment Reform
  - Public Health and Clinical Care Integration
  - Roadmap for NH's Health
- Previous Pillar Projects
  - ePrescribing
  - Primary Care Workforce
  - Pay for Performance
  - Pound of Prevention

CITIZENS HEALTH INITIATIVE

Project Charter

- To select common measures and develop reports of cost, utilization and quality with a learning community focused on sharing quality and efficiency improvements, system transformation best practices and lessons learned amongst NH healthcare stakeholders.

CITIZENS HEALTH INITIATIVE

Project Goals

- Create and implement quality, cost and utilization reports across all payers to support health system transformation efforts in New Hampshire
- Provide systems undergoing transformation a capacity to compare performance on measures of quality, utilization and cost across systems and regions
- Maintain an environment of open sharing and discussion of results amongst project participants
- Create and sustain a payment reform/clinical/quality improvement learning network
- Define requirements and business model for ongoing operations of an independent data entity for reporting and system/regional benchmarking with the potential for expanded, aggregated data sets

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Who is Participating?

- Aetna
- Ammonoosuc Community Health Center
- Anthem
- Catholic Medical Center
- Center for Life Management
- Cheshire Medical Center
- Community Health Access Network (CHAN)
- Cigna
- Coos Family Health Services
- Cottage Hospital
- Dartmouth Hitchcock Health System
- First Choice PHO at St. Joseph Hospital
- Gateways Community Services
- Goodwin Community Health
- Harbor Homes
- Harvard Pilgrim Health Care
- Indian Stream Health Center
- Littleton Regional Hospital
- Mid-State Health Center
- NH Department of Health and Human Services
- NH Department of Insurance
- NH Medicaid
- NH Purchasers Group on Health
- Speare Hospital
- NH Service Links

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Project Structure

Measure Selection and Report Design Work Group (Frequent Meetings During Design Phase)

- Participants responsible for bringing the reporting interests of their organization. Knowledge of clinical or claims based
- Evaluate and recommend methodologies, measures and reports for the project.
- Required participation in Learning Network (Quarterly Webinars)

NH Accountable Care Project Committee (Bi-Monthly Meetings)

- Approve recommendations and make final decisions regarding methodology, measures and reports for the project.
- Responsible for providing input to advisory board on project sustainability.
- Required participation in Learning Network (Quarterly Webinars)

Advisory Committee (Quarterly Meetings)

- Stakeholders including providers, payers, patient and business representatives receiving updates and providing feedback to the Project Committee.
- Responsibility for defining a sustainability plan for the project.

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ALL PAYER CLAIMS DATA

All-payer claims databases

- Databases, created by state mandate, that typically include data derived from medical, pharmacy, and dental claims with eligibility and provider files from private and public payers:
- Insurance carriers (medical, dental, TPAs, PBMs)
- Public payers (Medicaid, Medicare)
- Augmenting (not replacing) hospital discharge, Medicaid, Medicare, registries, and other datasets

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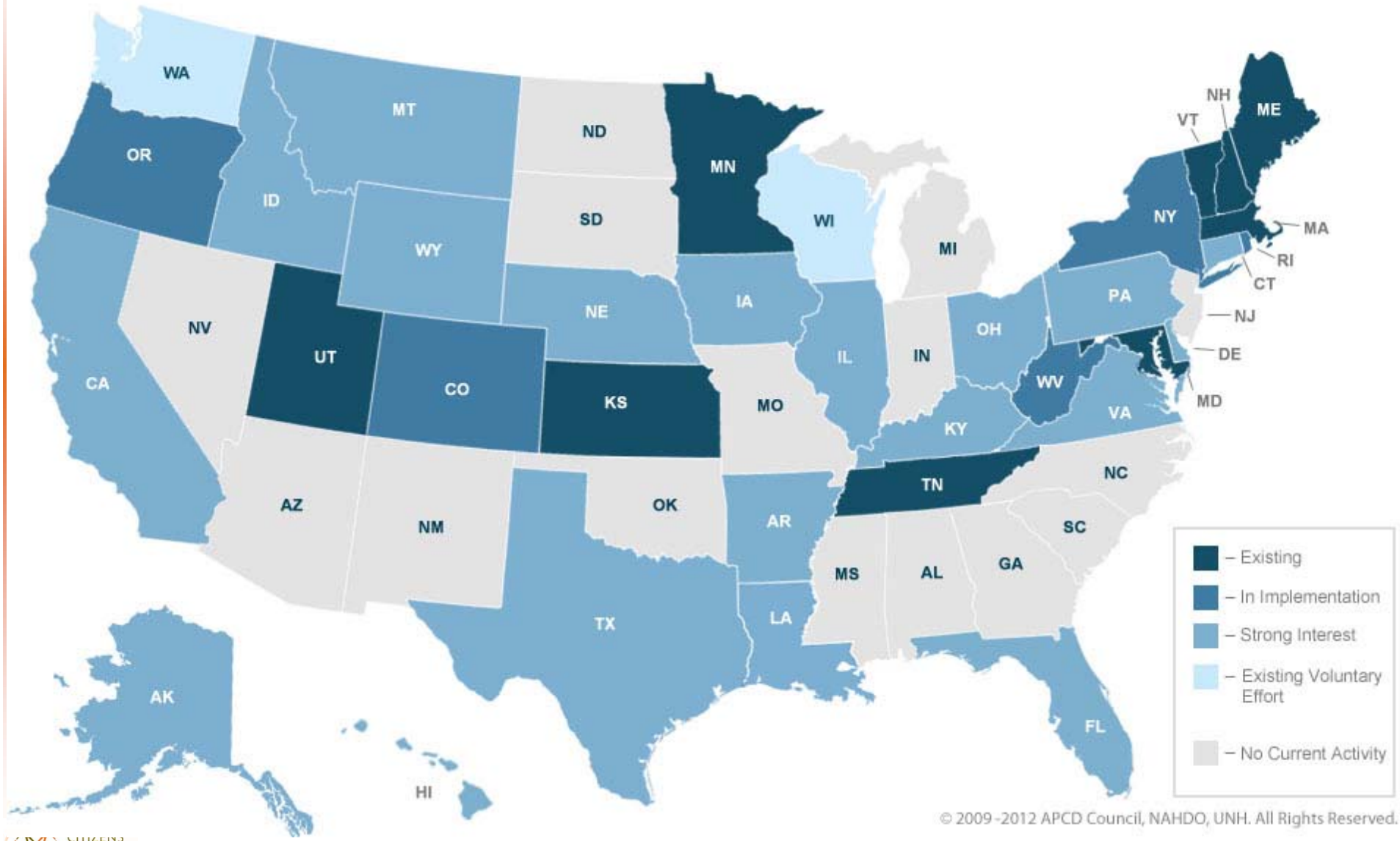
January 2012 State Progress Map



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NH Comprehensive Healthcare Information System (CHIS)

- Created by NH state statute to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices."

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NH Comprehensive Healthcare Information System (CHIS)

- Joint partnership between the Department of Health and Human Services and the Department of Insurance
- Commercial payers within thresholds submit
- Medicaid data also submitted (but not automatically integrated)
- Majority of data submitted by payers monthly
- Aggregated by third party vendor: Milliman (recent switch)

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Typically Included Information

- Encrypted social security
- Type of product (HMO, POS, Indemnity, etc.)
- Type of contract (single person, family, etc.)
- Patient demographics(date of birth, gender, residence, relationship to subscriber)
- Diagnosis codes (including E-codes)
- Procedure codes (ICD, CPT, HCPC, CDT)
- NDC code / generic indicator
- Revenue codes
- Service dates
- Service provider (name, tax id, payer id, specialty code, city, state, zip code)
- Prescribing physician
- Plan payments
- Member payment responsibility (co-pay, coinsurance, deductible)
- Date paid
- Type of bill
- Facility type

Typically Excluded Information

- Services provided to uninsured (few exceptions)
- Denied claims
- Workers 'compensation claims
- Referrals
- Test results from lab work, imaging, etc.
- Provider affiliation with group practice
- Provider networks
- Premium information
- Capitation fees
- Administrative fees
- Back end settlement amounts
- Back end P4P or PCMH payments

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ANALYSIS AND DEVELOPMENT PARTNER

UNH Center for Health Analytics

- Center for Health Analytics (CHA) a focus area of the Institute for Health Policy and Practice
- Conducts sponsored research and graduate education designed to:
  - Support practice-based and academic research projects with accurate and reliable healthcare data analysis with a focus on the use of all-payer claims databases
  - Foster interdisciplinary collaboration within and outside of UNH

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UNH CHIS Analysis

- Have an approved research application for NH CHIS data
- Updates generally made available to UNH quarterly
- Data available: **Paid claims 2005 – Q1 2012**
- Data available with reasonable QA results for analysis: **Paid claims 2007 – 2011**

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Example CHA APCD Projects

Funder	Project
NH Insurance Dept.	Quality Assurance and Analysis of NHCHIS
NH Insurance Dept.	Development of methodology to create “market rates” for common procedures
NH Department of Health and Human Services	Development of HealthWRQS – a community health web reporting and querying system http://nhhealthwrqs.org/
Tamworth Community Nurses Association	Data and cost analysis for a community-based organization
Various sources	Evaluation of medical home pilot sites in NH

CITIZENS HEALTH INITIATIVE

WHAT WE ARE WORKING ON…

Year 1 Project Outputs

- Succinct set of standardized measures across cost, utilization and quality
- Year over Year trending (post 2009)
- Regional benchmarks and system to system comparisons
- Multiple layers of reporting:
  - Region (Public Health Region, Hospital Referral Region, etc.)
  - System, Organization, ACO
  - Practice(s)

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Analytic Plan

- **Data Quality**
  - **Data update frequency and time periods**
  - **Payer inclusion**
  - Payer validation of CHIS
  - **Provider Data – Collection, review against the National NPI Registry and against NH CHIS**
- **Reporting Hierarchy – Defining our populations**
  - **Assignment of Patients to Providers (Attribution)**
  - Providers to Practices
  - Practices to Organizations, Systems or ACO's
  - Regions
- **Measure Selection and Specification**
- **Report Design**

CITIZENS HEALTH INITIATIVE

Draft Measures: Population Statistics

Category	Measure Name	Tech Owner	Data
Population Statistics	Attributable Patients by Payer	TBD	Claims
Population Statistics	Attributable Patients by Payer by Practice	TBD	Claims
Population Statistics	Gender prevalence (% male, % female)	TBD	Claims
Population Statistics	Chronic Disease Prevalence (Diabetes, COPD, HF, CAD, Asthma, Hypertension)	TBD	Claims
Population Statistics	% Patients w/ 2 or more chronic diseases	TBD	Claims

Draft Measures: Cost

Category	Measure Name	Tech Owner	Data
Cost	**Total and average PMPM Costs (Raw)** - Costs using claims based allowed amount. - Cost for population (cross payer) and cost by payer and cost by service category		**Claims**
Cost	**Total Cost of Care Population based PMPM Index (Risk Adjusted)** Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. A Total Cost of Care Index when viewed together with a Resource Use measure provides a more complete picture of population based drivers of health care costs.	**Health Partners NQF #1604**	**Claims**
RRU	**Relative Resource Use Index** The Resource Use Index (RUI) is a risk adjusted measure of the frequency and intensity of services utilized to manage a provider group's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	**Health Partners NQF #1598**	**Claims**

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Draft Measures: Cost

Category	Measure Name	Tech Owner	Data
Cost	Top 20 Diagnoses by Cost and Count	TBD	
Cost	Costs by Facility Name	TBD	Claims
Cost	Cost by Episodes (Optum Insight ETGs)	Optum Insight Episode Treatment Grouper (ETG)	Claims

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Draft Measures: Utilization

Category	Measure Name	Tech Owner	Data
Inpatient	**Total Hospital Admissions for Any Condition Age 0-64 per 1000** Inpatient Utilization - General Hospital/Acute Care (IPU) is the number of patients age 0-64 with an inpatient hospital admission for any health related condition excluding newborns (Numerator), over the total number of patients age 0-64 (Denominator).	**TBD**	**Claims**
Admissions	**Ambulatory Care Sensitive Conditions Admissions – Composite Measure** The Prevention Quality Indicators represent hospital admission rates for the following ambulatory care-sensitive conditions in adult populations. "Ambulatory care-sensitive conditions" are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. They are: • Bacterial pneumonia • Chronic obstructive pulmonary disease • Dehydration • Uncontrolled diabetes • Urinary tract infections • Diabetes, short-term complications • Perforated appendix • Diabetes, long-term complications • Low birth weight • Adult asthma • Angina without procedure • Congestive heart failure • Hypertension • Lower extremity amputations among patients with diabetes	**AHRQ – Patient Quality Indicators (PQI)**	**Claims**

Draft Measures: Utilization

Category	Measure Name	Tech Owner	Data
ED Utilization	**ED Visits/1000**		**Claims**
ED Utilization	**ED Visits that Lead to Hospitalizations / 1000**		**Claims**
ED Utilization	**ED Visits, no hospitalization / 1000**		
ED Utilization	**ED Visits Categorized by…** - Non-Emergent - Emergent/Primary Care Treatable - Emergent - ED Care Needed - Preventable/Avoidable - Emergent - ED Care Needed - Not Preventable/Avoidable - Injury - Psych - Alcohol (maybe) - Drug (maybe) - Unclassified	**the NYU Center for Health and Public Service Research** http://wagner.nyu.edu/chpsr/index.html?p=62	**Claims**

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Draft Measures: Utilization

Category	Measure Name	Tech Owner	Data
Visits	Primary Care Service Visits / 1000	TBD	Claims
Visits	Specialist Visits / 1000	TBD	Claims
Imaging	CT Events / 1000	CMS	Claims
Imaging	MRI Events / 1000	CMS	Claims
Readmissions	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	CMS NQF # 1789	Claims
Care Coordination	30-Day Post-Discharge Provider Visits per 1,000 Discharges	CMS	Claims

Draft Measures: Quality- Adults (Claims)

Category	Measure Name	Tech Owner	Data
Quality – Adult	**Mammogram Screening** The number of women age 42 – 64 who had a screening mammogram during measurement year or year prior (Numerator) over the total number of same-aged women (Denominator).	**NCQA NQF #31**	**Claims**
Quality – Adult	**Cervical Cancer Screening** Cervical Cancer Screening (CCS) rate is the number of women age 21 to 64 who had cervical cancer screening during measurement year or 2 years prior (Numerator), over the total number of same-aged women (Denominator).	**NCQA, HEDIS, NQF #32**	**Claims**
Quality – Adult	**Percent of Women (16 to 24 years) Receiving Chlamydia Screening** Chlamydia Screening (CHL) rate is the number of women with at least one test for chlamydia screening during measurement year (Numerator), over the total number of same-aged women (Denominator).	**NCQA, HEDIS, NQF #33**	**Claims**

Draft Measures: Quality- Adults (Claims)

Category	Measure Name	Tech Owner	Data Collection
Quality – Adult	**Diabetes: Annual Eye Exam** The number of patients age 18 – 64 with a diagnosis of diabetes mellitus who received diabetic retinal exam during measurement year (Numerator), over the total number of same-aged enrolled adults with a diagnosis of diabetes mellitus (Denominator).	**NCQA, HEDIS, NQF #55**	**Claims**
Quality – Adult	**Diabetes: Annual Low-density Lipoproteins (LDL) Testing** The number of enrolled adults who had been diagnosed with diabetes mellitus (type 1 and type 2) and had low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year (Numerator), over the total number of same-aged adults with a diagnosis of diabetes mellitus (Denominator).	**NCQA, HEDIS,**	**Claims**
Quality – Adult	**Diabetes : Glycosylated Hemoglobin (HbA1c) Testing** The number of adults with a diagnosis of diabetes mellitus who had one or more glycosylated hemoglobin (HbA1c) testing performed during measurement year (Numerator), over the total number of same-aged adults with a diagnosis of diabetes mellitus (Denominator).	**NCQA, HEDIS, NQF #57**	**Claims**

Draft Measures: Quality (EHR/EMR)

Category	Measure Name	Tech Owner	Data
Quality – Diabetes	% of patients with diabetes with most recent HbA1c less than 8%	**NCQA NQF 0575 MU**	**EHR/EMR**
Quality – Diabetes	% of patients with diabetes with most recent HbA1C greater than 9%	**NCQA NQF 0059 MU**	**EHR/EMR**
Quality – Diabetes	Percentage of patients aged > 18 years with diagnosed hypertension who had visits where blood pressure measurement was recorded. Blood Pressure is <140/90 mmHg during the measurement year.	**NCQA NQF 0061 MU**	**EHR/EMR**
Quality – Diabetes	Percentage of adult patients with diabetes aged 18-75 years with most recent (LDL-C) <130 mg/dL B: Percentage of patients 18-75 years of age with diabetes whose most recent LDL-C test result during the measurement year was <100 mg/dL	**NCQA NQF 0064 MU**	**EHR/EMR**

Draft Measures: Quality (EHR/EMR)

Category	Measure Name	Tech Owner	Data
Quality – Flu	% of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization	**AMA-PCPI NQF 0041 MU**	**EHR/EMR**
Quality - Pneumonia	% of patients age 65 years and older with at least one pneumococcal immunization in their lifetime	**NCQA NQF 0043 MU**	**EHR/EMR**

Draft Measures: Quality (EHR/EMR)

Category	Measure Name	Tech Owner	Data
Quality – Colon Cancer	% of patients 50–75 years of age who had appropriate screening for colorectal cancer.	**NCQA NQF 0034 MU**	**EHR/EMR**
Quality – BMI	% Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow up plan is documented. Parameters: age 65 and older BMI > or = 30 or < 22; age 18-64 BMI > or = 25 or< 18.5	**CMS NQF 0421 MU **No follow up plan**	**EHR/EMR**
Quality – Tobacco	% of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months	**AMA-PCPI NQF 0028a MU **No follow up plan**	**EHR/EMR**
Quality – Depression	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	**PQRS 134 **No follow up plan**	

Web Based Reporting Tool (currently EMR only)

Megan Spencer
Update my information

Home | Logout
Admin | Enter Data | Upload Data | View Upload History | Median Rates Report | View Data Summary | View Member Summary |

Practice Measure By Reporting Period [redacted]

Measure	2008	2009	2010				2011				Pilot Goal	ME Median	NH Median	Run Chart
	Q4	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
1. % of patients with at least one HbA1c test within previous 12 months	96.3%	97.6%	97.9%	98.5%	98.8%	100%	100%	100%	100%	100%	> 85%	90.7	84.5	Run Chart
2. % of patients with diabetes with most recent HbA1c level less than 7%	63%	59%	55.8%	54.5%	54%	58%	52.1%	51.9%	51.7%	55%	> 40%	46.6	46.1	Run Chart
3. % of patients with diabetes with most recent HbA1c less than 8%	78.2%	79.6%	77.5%	76.5%	79%	81.2%	77.1%	78%	75%	80%	> 60%	66.4	64.95	Run Chart
4. % of patients with diabetes with most recent HbA1C greater than 9%	10.9%	9.8%	10.7%	10%	9.9%	7.6%	10.3%	10.4%	10.8%	7.9%	< 15%	17.3	15.85	Run Chart
5. % of patients with diabetes BP recorded within previous 12 months	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	> 85%	96.85	97.1	Run Chart
6. % of patients with diabetes with most recent BP 140/90 or greater	22.3%	23.5%	27.5%	23%	23.5%	20.9%	24.5%	19.3%	18.4%	18.3%	< 35%	27.35	21.3	Run Chart
7. % of patients with diabetes with most recent BP less than 130/80	46.1%	48.4%	48.7%	46.8%	47.5%	54.6%	47.7%	53.3%	55.9%	59%	> 25%	48	46.1	Run Chart
8. % of patients with diabetes with most recent BP less than 140/80	58.2%	60.3%	57.1%	59.3%	61.4%	65.5%	59%	63.2%	68.4%	69.8%	TBD	62.4	57.5	Run Chart

CITIZENS HEALTH INITIATIVE

Report Design

PATIENT CENTERED MEDICAL HOME

Home | Logout

Admin | Enter Data | Upload Data | View Upload History | Median Rates Report | View Data Summary | View Member Summary |

Measure	2008	2009	2010				2011				Pilot Goal	ME Median	NH Median	
	Q4	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
1. % of patients with at least one HbA1c test within previous 12 months	96.3%	97.6%	97.9%	98.5%	98.8%	100%	100%	100%	100%	100%	> 85%	90.7	84.5	
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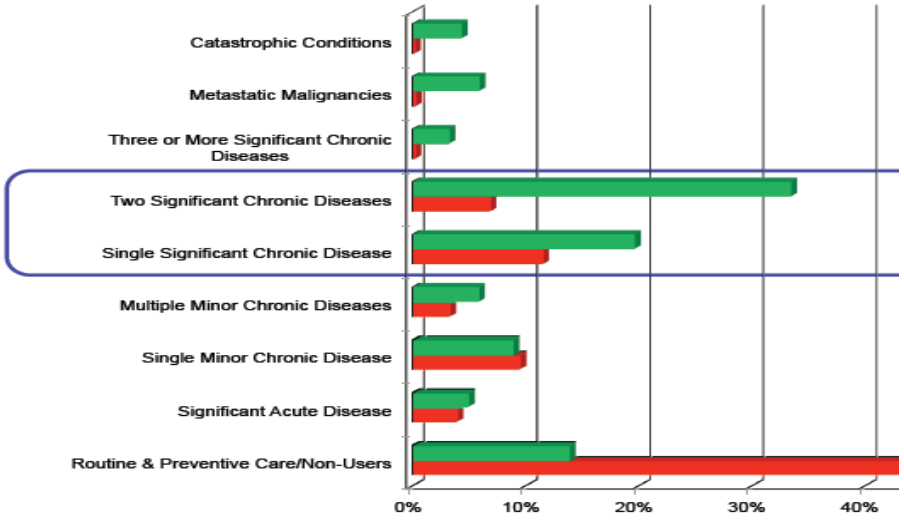
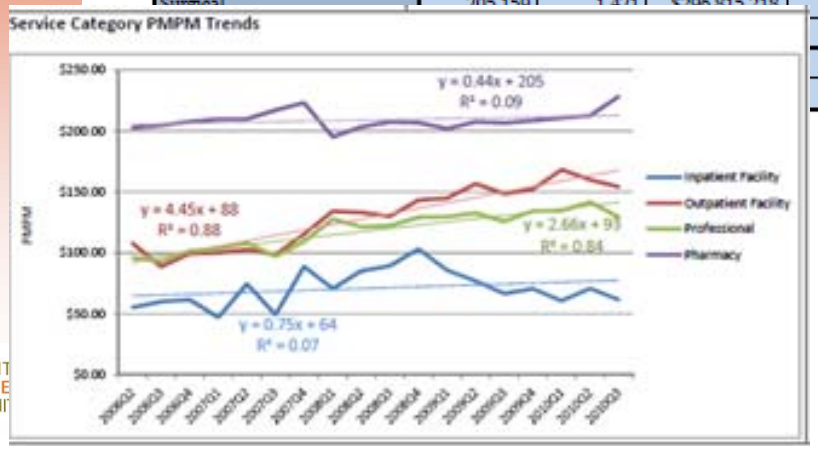
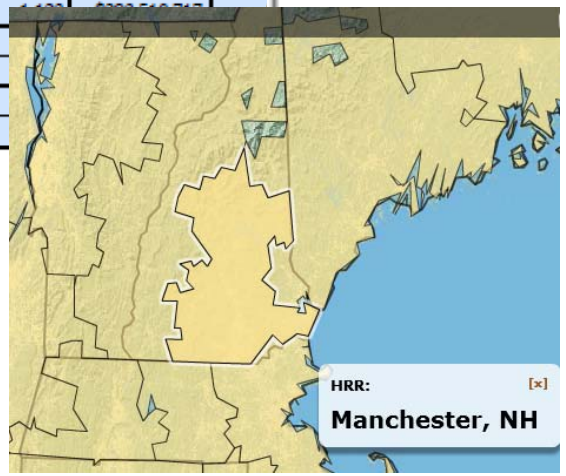
7. % of patients with diabetes with most recent BP l														
8. % of patients with diabetes with most recent BP l														



	Practice	Peer Benchmark
Patients	683	839
Average Age	46	45
% Male	42	43
% Chronic	21.2	16.4
% Asthma	10.0	6.8
% CAD	2.3	2.1
% COPD	0.08	1.1
% Diabetes	11.5	9.8
% Heart Failure	0.5	0.9
% Hypertension	30.4	28.3
%Obesity	28.6	26.6
Average Health Risk	1.06	1.02

Service Type	01/01/2009 - 12/31/2009				01/01/2010 - 12/31/2010			
	Total Encounters	Rate per 1,000	Cost	PMPM	Total Encounters	Rate per 1,000	Cost	PMP
Drugs Administered	217,561	454	$111,789,389	$19	340,658	554	$142,497,363	
Emergency	118,969	248	$57,371,733	$10	155,947	254	$69,149,192	
Evaluation & Management	1,998,928	4,171	$255,070,955	$44	2,731,082	4,442	$327,031,686	
Laboratory	993,117	2,072	$147,190,814	$26	1,257,369	2,045	$188,148,151	
Medical	1,680,732	3,507	$216,224,236	$38	2,259,539	3,675	$289,090,557	
Mental Health/Substance Abuse	427,853	893	$36,223,153	$6	527,877	859	$43,786,622	
Radiology	503,367	1,050	$237,893,884	$41	690,504			
Surgical	705,159	1,471	$296,815,218	$52	1,016,582			
				$66	44,416			
				$33	N/A			
				$335	N/A			





Questions and Next Steps

CITIZENS HEALTH INITIATIVE