Maine and New Hampshire Healthcare Transformation Learning Symposium

Wednesday March 14, 2012

Thank you to our sponsor:
Consumer Engagement in Maine

03/14/12

Nancy R. Morris
Director of Communications
Maine
Dashboard on Health Care Quality Compared to All States

Overall Health Care Quality

Average
Weak
Strong
Very Weak
Very Strong

Performance Meter:
All Measures

= Most Recent Data Year
= Baseline Year
MHMC’s 2011-2012 Switch Strategy
Showing the Community Brighter Spots

- Statewide book club Nov. 2011
- 10 appearances by T.R. Reid including the Maine Health Management Coalition’s annual meeting
- Widespread media coverage
- Corresponding PBS program just broadcast
Book Club Results-

16,000+ Participants
  • Local events
  • Business Events
  • AARP Town Hall

1,000,000 Media Impressions
  • Print
  • Television
  • Radio and Social Media
Script the Critical Moves

An 8 module program covering:
Quality, Best Practices
EB Wellness, Data,
Actuarial Basics, VBID,
and Behavior
Modification Principles
Pointing to the Destination

Open Invitation | Healthcare Cost Workgroup

The Maine Health Management Coalition Board approved the creation of the Health Care Cost Workgroup to identify regional cost drivers and variations and spotlight savings opportunities through priority interventions by sector such as employer, provider etc.

Michael DeLorenzo, PhD, MHMC’s Director of Health Analytics, will be the lead staff for this workgroup. Harold Miller, CEO of the Network for Regional Health Improvement will provide consulting support and we will contract for actuarial services as needed.

If you wish to join this multi-stakeholder workgroup of Maine Health Management Coalition members please commit to working with us on the dates listed below:

March 30th    April 26th    May 31st    June 27th

All meetings will run from 9am-12:30pm and will be held at University of Maine in Augusta campus.

Additional meetings may be scheduled if necessary. Please contact Tricia’s replacement, Lindsey Hartford, or call 899-1971 if you or a designee would like to participate.
‘I am part of labor representing about 360 members. My members cannot afford a healthcare plan that does not give them the best possible outcome or quality of care. The classes have taught me the buying power of our group. We should not pay for bad results or poor quality of service. As consumers, we need to be more pro-active in our healthcare.’

- City of Portland Employee

‘Before I learned about the work of the Coalition, I thought the only thing I could do about healthcare was complain.’

- Prof. Arthur Hill, UMaine Employee
Shrinking the Change
Growing Your People

MHMC is currently seeking grant funding to seek this $100,000 prize for the City.
Shaping the Path

Health Insurance Policy
The City of Portland Still In Process

Likely to consider the first true value based insurance program that will include:

- Tiering
- “Guided Care” services
- Shared Decision Making
- Payments that vary according to evidence and actual performance
- An evidence-based wellness program
Build Habits

Health Insurance Policy
Rallying the Herd

City of Portland

Hannaford
National Semi

Unum
University of NE

USM
Tools and Resources

• Video on how to use the website: https://stateofmaine.adobeconnect.com/_a827390218/getbettermaine/

• Book Club: http://www.getbettermaine.org/bookclub
Contact Information

- Nancy Morris: nmorris@mehmc.org
- Trevor Putnokky: tputnokky@mehmc.org
- Amy Deschaines: adeschaines@mehmc.org
Consumer Engagement: The Healthy UNH Example

Kimberly Persson, MSW
Project Director
Healthy UNH
NH Institute for Health Policy & Practice
What is Healthy UNH?

Healthy UNH is a campus-wide initiative at the University of New Hampshire that encourages faculty, staff, and students to improve their health while simultaneously decreasing health care costs.
Goal

To be the healthiest campus community in the country by 2020
Inclusive Approach

Action Committee

• Faculty, staff, and students representatives from academic, business, and service departments across campus

• Defined key elements of the effort
Values

1. Transforming health care delivery
2. Advancing mental and physical well-being
3. Creating value for the money we invest in medical care
4. Sustaining health and health care
5. Ensuring that the care we purchase is the right care at the right time
6. Following medical care practices that are evidence-based
7. Improving the health of our entire community, spanning multiple locations and audiences
8. Collaborating across our community
9. Engaging and educating our community
10. Promoting work/life balance
Brown Bag Series

A presentation featuring an introductory video followed by a facilitated discussion about concepts introduced in the video.

- The video introduces a series of concepts about health, health care, health cost, and wellness.
- Represents all four work areas
- Includes members of campus population including faculty, staff, and students and reflects diversity of age, gender, and race
- Campus leadership explains importance of the issues
Video
Sample Discussion Questions

1. A number of concepts were introduced in this video. What new or surprising things did you learn about:
   - Fitness/being active?
   - Nutrition/healthy eating?
   - Resources available to you?

2. What new or surprising things did you learn about health care costs relating to:
   - Total cost of health care for UNH?
   - Cost variation?
   - Generic drugs?
   - Duplicate testing?
   - Emergency room use?

3. What do you do to help make UNH the healthiest campus community in the country 2020?
Lessons Learned

- Health care is a common ground. Everyone has a story.
- Awareness of existing resources was low.
- The information about the costs health care often generated the most discussion.
- We saw a shift in receptivity of the information in the midst of changes in benefits.
- Leadership involvement is key (and possibly rare).
- “Safe” environments generated the best discussion.
Questions?

For more information about Healthy UNH, visit www.unh.edu/healthyunh.

kimberly.persson@unh.edu
(603) 862-2493
Pioneer ACO
Wherever we engage with patients and families…

EMHS: Hospitals
Credentials - A few of our success’s

- **PCMH** - 31 practices have achieved some level of NCQA certification.
- **Bangor Beacon** - 12 partners, $12.75 million from the Office of the National Coordinator for Health Information Technology.
- **Cigna** - Collaborative Accountable Care Program - EMMC and Blue Hill Memorial Hospital launched the effort in 2010, all other affiliates followed during 2011.
- **In System Rewards** - Offering Care Coordination to EMHS and Affiliate employees and their families, effective 1/1/2012.
- **Pioneer ACO** - TAMC, Inland and EMMC, with 9500 aligned members amongst the three hospital systems.
- **Practices with Common EMR (Centricity)** - 45
Population Health Management: EMHS
Bangor Beacon

The twelve Bangor Beacon Community partners: Bangor is fortunate to have a rich depth of healthcare resources that are working together to provide leadership and guidance for the program. Catherine Bruno, FACHE, of Eastern Maine Healthcare Systems (EMHS), is the executive sponsor.
High Risk/High Cost Patients

Control Group
Total Enrolled
215

Intervention Group
Total Enrolled
1,172

Completed 6 months visit
468 (40%)

Withdrawn
101

Pending 6 months visit
603
Clinical outcomes
A1C comparison for High Risk/High Cost diabetes care managed patients

Total No. of patients completing Visit 2: 486
Total number of DM: 293
HbA1c>9: 100
HbA1c>9 at visit 2: 34

Visit 1 - Baseline: A1C>9
Visit 2 - 6 months: 66%
34
Clinical outcomes
BP comparison for High Risk/High Cost diabetes care managed patients

Total No. of patients completing Visit 2
486

BP > 140/90 on visit 1
61 (12.5%)

BP > 140/90 on visit 2
36

Clinical outcomes
BP comparison for High Risk/High Cost diabetes care managed patients

Visit 1 - Baseline
Visit 2 - Six months
Healthcare utilization (Financial outcomes)

Visit 1 - Baseline: 53
Visit 2 - 6 months: 33

N=137
Healthcare utilization (Financial outcomes)

N=137

Visit 1 - Baseline
Visit 2 - 6 months

ED visits
### Care Manager XYZ Organization

#### DM Metrics

<table>
<thead>
<tr>
<th>November 2011 Care Manager</th>
<th>November 2011 Practice</th>
<th>November 2011 Organization</th>
<th>NCQA GOALS</th>
<th>BBC GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1C tested within 12 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Num</td>
<td>Den</td>
<td>Pct</td>
<td>Num</td>
<td>Den</td>
</tr>
<tr>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>698</td>
<td>724</td>
</tr>
<tr>
<td><strong>HbA1C &lt;7</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>66</td>
<td>38%</td>
<td>407</td>
<td>724</td>
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<tr>
<td><strong>HbA1C &lt;8</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>66</td>
<td>56%</td>
<td>575</td>
<td>724</td>
</tr>
<tr>
<td><strong>HbA1C &gt;9</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>66</td>
<td>18%</td>
<td>78</td>
<td>724</td>
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<tr>
<td><em>(new) HbA1C &gt;9 who had an A1C tested within 365</em></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>66</td>
<td>18%</td>
<td>52</td>
<td>724</td>
</tr>
<tr>
<td><strong>LDL ≥130</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>66</td>
<td>20%</td>
<td>171</td>
<td>724</td>
</tr>
<tr>
<td><strong>LDL &lt;100</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>47</td>
<td>66</td>
<td>71%</td>
<td>511</td>
<td>724</td>
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<tr>
<td><strong>BP recorded prev 365 days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>724</td>
<td>724</td>
</tr>
<tr>
<td><strong>BP ≥140/90</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>66</td>
<td>21%</td>
<td>127</td>
<td>724</td>
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<tr>
<td><strong>BP &lt;130/80</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>66</td>
<td>85%</td>
<td>627</td>
<td>724</td>
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<tr>
<td><strong>Foot examination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>57</td>
<td>95%</td>
<td>578</td>
<td>626</td>
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<tr>
<td><strong>Retinal eye exam</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>66</td>
<td>94%</td>
<td>622</td>
<td>724</td>
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<tr>
<td><strong>Smoking status documented</strong></td>
<td></td>
<td></td>
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<tr>
<td>34</td>
<td>34</td>
<td>100%</td>
<td>393</td>
<td>393</td>
</tr>
<tr>
<td><strong>Tobacco free</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>66</td>
<td>82%</td>
<td>543</td>
<td>724</td>
</tr>
<tr>
<td><strong>Tobacco free OR smoking cessation advice given</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>644</td>
<td>724</td>
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<tr>
<td><strong>BMI Assessed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>66</td>
<td>94%</td>
<td>689</td>
<td>724</td>
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<tr>
<td><strong>Depression screening (PHQ-2) within last 365 days</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>37</td>
<td>38</td>
<td>97%</td>
<td>475</td>
<td>547</td>
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<tr>
<td><strong>DM Minnesota Bundle (BBC Modified)</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>11</td>
<td>66</td>
<td>17%</td>
<td>125</td>
<td>724</td>
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<tr>
<td><strong>Flu vaccine (≥ 18 yo) within 365 days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>66</td>
<td>70%</td>
<td>391</td>
<td>724</td>
</tr>
<tr>
<td><strong>(new) 2011-2012 Flu vaccine (≥18 years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>38</td>
<td>66</td>
<td>58%</td>
<td>337</td>
<td>724</td>
</tr>
<tr>
<td><strong>Pneumovax (≥ 18 yo)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>712</td>
<td>724</td>
</tr>
</tbody>
</table>

**DM BUNDLE**

- HbA1C tested within 12 months
- HbA1C <8
- LDL <100
- BP recorded prev 365 days
- Tobacco free OR smoking cessation advice given
- BP <130/80
- Smoking status documented
- Pneumovax vaccine
- Flu vaccine

Meets BBC Criteria
Meets NCQA Criteria. Where no NCQA criteria exists, interim goal is 10% below
Does not meet any criteria
Today….

• What are employers and purchasers asking us to do?

• Approaches to population health management: How some organizations are enhancing value

• *Pioneer ACO Program Highlights and EMHS’s approach*
Bringing Value through Population Health Management

Beneficiaries of Employers’ Health Plans (whether fully insured or self-insured), MaineCare, Medicare, the uninsured….the problem is the same

EMHS Care Systems

- Patient Retention, Wellness & Preventive Care
- Chronic Disease Management Programs & Shared Decision Making
- Complex Case Management & Shared Decision Making

TOGETHER We’re Stronger
Pioneer ACO: Program Highlights

- Improve the patients’ experience of care
- Increased accountability for population health
- Increase accountability for costs
Pioneer ACO: Program Highlights

• *Improve the patients’ experience of care*
  – Expansion of Patient Centered Medical Home
  – Care Coordination
  – Improved utilization of extended care facilities and home care
  – Pharmacy management
  – Shared learning collaborative with Dartmouth-Hitchcock and Maine Health

• Monitor Primary Care patient experience of care through the Consumer Assessment of Healthcare Providers Survey Patient Centered Medical Home (CAHPS PCMH)
Pioneer ACO: Program Highlights

- **Increased accountability for population health**
  - Wellness and preventive care
  - Chronic disease management care coordination and shared decision making
  - Complex case management care coordination and shared decision making

- Approximately 9,000 Medicare beneficiaries attributed to Beacon Health LLC. Across three PPS hospitals will expand to 15,000 with the addition of EMHS Critical Access Hospitals in January 2013
Pioneer ACO: Program Highlights

- Annual expenditures for 9,000 beneficiaries: ~ $ 90 million
- *Increase accountability for costs*
  - **YEAR 1**
    - 50% share of savings (varies with quality score) up to a cap of 5% of total part A and part B expenditures ($4.5 million)
    - Must achieve a Minimum Savings Rate of approximately 2.5%
  - **YEAR 2**
    - 70% share of savings or losses (varies with quality score) up to a cap of 15% of total part A and part B expenditures (~ $14 million)
    - 1% Minimum Savings Rate
  - **YEAR 3**
    - Migrate to capitation models, *and*
    - Have > 50% of revenue from risk share contracts
### Yearly Preliminary Baseline/Benchmark Report for Pioneer ACOs
Pioneer ACO P040 - Beacon Health LLC

**Worksheet 1: Preliminary Prospective Baseline/Benchmark**
**Performance Year 1: Jan 1, 2012 to Dec 31, 2012**

<table>
<thead>
<tr>
<th>Capped baseline / benchmark calculations</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>3-year baseline</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td><strong>Aligned population</strong></td>
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<td></td>
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</tr>
<tr>
<td>45. 3-year baseline expenditure</td>
<td></td>
<td></td>
<td></td>
<td>$9,231</td>
<td></td>
</tr>
<tr>
<td><strong>Reference population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. 3-year baseline expenditure</td>
<td></td>
<td></td>
<td></td>
<td>$9,715</td>
<td></td>
</tr>
<tr>
<td>47. Performance year expenditure</td>
<td></td>
<td></td>
<td></td>
<td>$10,729</td>
<td></td>
</tr>
<tr>
<td><strong>Benchmark calculation</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>48. Reference population trend (%)</td>
<td></td>
<td></td>
<td></td>
<td>10.4%</td>
<td></td>
</tr>
<tr>
<td>49. Trend applied to aligned pop. baseline</td>
<td></td>
<td></td>
<td></td>
<td>$963</td>
<td></td>
</tr>
<tr>
<td>50. Change in reference population exp. ($)</td>
<td></td>
<td></td>
<td></td>
<td>$1,014</td>
<td></td>
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<tr>
<td>51. Increment to aligned pop. baseline</td>
<td></td>
<td></td>
<td></td>
<td>$988</td>
<td></td>
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<tr>
<td>52. Benchmark</td>
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</tr>
</tbody>
</table>

**How do we impact this number?**

$10,220
Pioneer ACO Program Highlights: Quality Indicators

- 7 measures dedicated to Patient Experience of Care, timeliness of care, doctor communication, access to specialists, health promotion and education, shared decision making, health/functional status, Consumer Assessment of Healthcare Providers Survey Patient Centered Medical Home (CAHPS PCMH)

- 6 measures for Care Coordination and Patient Safety: Ambulatory Sensitive Conditions, EMR use, medication reconciliation, falls screening

- 8 measures of preventive health: Immunizations, Screenings, Weight, and Tobacco

- 12 measures for at risk populations: patients with diabetes, hypertension, coronary artery disease, ischemic vascular disease

Table 1. Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings

<table>
<thead>
<tr>
<th>ACO #</th>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure #</th>
<th>Method of Data Submission</th>
<th>P4P Phase-in PY1</th>
<th>P4P Phase-in PY2</th>
<th>P4P Phase-in PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient/Caregiver Experience</td>
<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
<td>R</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>2.</td>
<td>Patient/Caregiver Experience</td>
<td>CAHPS: How Well Your Doctors Communicate</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>3.</td>
<td>Patient/Caregiver Experience</td>
<td>CAHPS: Patients' Rating of Doctor</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>4.</td>
<td>Patient/Caregiver Experience</td>
<td>CAHPS: Access to Specialists</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
<td>P</td>
<td>P</td>
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<tr>
<td>5.</td>
<td>Patient/Caregiver Experience</td>
<td>CAHPS: Health Promotion and Education</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
<td>P</td>
<td>P</td>
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<tr>
<td>6.</td>
<td>Patient/Caregiver Experience</td>
<td>CAHPS: Shared Decision Making</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
<td>P</td>
<td>P</td>
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<tr>
<td>7.</td>
<td>Patient/Caregiver Experience</td>
<td>CAHPS: Health Status/Functional Status</td>
<td>NQF #6 AHRQ</td>
<td>Survey</td>
<td>R</td>
<td>R</td>
<td>R</td>
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<td>8.</td>
<td>Care Coordination/ Patient Safety</td>
<td>Risk-Standardized, All Condition Readmission(^1)</td>
<td>CMS</td>
<td>Claims</td>
<td>R</td>
<td>R</td>
<td>P</td>
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<tr>
<td>9.</td>
<td>Care Coordination/ Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)</td>
<td>NQF #275 AHRQ</td>
<td>Claims</td>
<td>R</td>
<td>P</td>
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<td>10.</td>
<td>Care Coordination/ Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)</td>
<td>NQF #277 AHRQ</td>
<td>Claims</td>
<td>R</td>
<td>P</td>
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<tr>
<td>11.</td>
<td>Care Coordination/ Patient Safety</td>
<td>Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment</td>
<td>CMS</td>
<td>EHR Incentive Program Reporting</td>
<td>R</td>
<td>P</td>
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</tbody>
</table>

\(^1\) We note that this measure has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012.
Table 1. Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings (cont.)

<table>
<thead>
<tr>
<th>ACO #</th>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure #/ Measure Steward</th>
<th>Method of Data Submission</th>
<th>P4P Phase-in PY1</th>
<th>P4P Phase-in PY2</th>
<th>P4P Phase-in PY3</th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>Care Coordination/ Patient Safety</td>
<td>Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility</td>
<td>NQF #97 AMA-PCPI/NCQA</td>
<td>GPRO Web Interface</td>
<td>R</td>
<td>P</td>
<td>P</td>
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<tr>
<td>13</td>
<td>Care Coordination/ Patient Safety</td>
<td>Falls: Screening for Fall Risk</td>
<td>NQF #101 NCQA</td>
<td>GPRO Web Interface</td>
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<td>14</td>
<td>Preventive Health</td>
<td>Influenza Immunization</td>
<td>NQF #41 AMA-PCPI</td>
<td>GPRO Web Interface</td>
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<td>Preventive Health</td>
<td>Pneumococcal Vaccination</td>
<td>NQF #43 NCQA</td>
<td>GPRO Web Interface</td>
<td>R</td>
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<tr>
<td>16</td>
<td>Preventive Health</td>
<td>Adult Weight Screening and Follow-up</td>
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<td>Tobacco Use Assessment and Tobacco Cessation Intervention</td>
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<td>21</td>
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<td>Screening for High Blood Pressure</td>
<td>CMS</td>
<td>GPRO Web Interface</td>
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<tr>
<td>22</td>
<td>At Risk Population - Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (&lt;8 percent)</td>
<td>NQF #729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
<td>R</td>
<td>P</td>
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<tr>
<td>23</td>
<td>At Risk Population - Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (&lt;100)</td>
<td>NQF #729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
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<tr>
<td>24</td>
<td>At Risk Population - Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Blood Pressure &lt;140/90</td>
<td>NQF #729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
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AIM: Better Health for Populations

(continued)
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<thead>
<tr>
<th>ACO #</th>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure # Measure Steward</th>
<th>Method of Data Submission</th>
<th>P4P Phase-in PY1</th>
<th>P4P Phase-in PY2</th>
<th>P4P Phase-in PY3</th>
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<tr>
<td>25.</td>
<td>At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Tobacco Non Use</td>
<td>NQF #729 MN Community Measurement</td>
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<td>At Risk Population – Diabetes</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control (&gt;9 percent)</td>
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<td>At Risk Population – Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (&lt;100 mg/dL)</td>
<td>NQF #75 NCQA</td>
<td>GPRO Web Interface</td>
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<td>30.</td>
<td>At Risk Population – Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>NQF #68 NCQA</td>
<td>GPRO Web Interface</td>
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<td>31.</td>
<td>At Risk Population – Heart Failure</td>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>NQF #83 AMA-PCPI</td>
<td>GPRO Web Interface</td>
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<td>32.</td>
<td>At Risk Population – Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol</td>
<td>NQF #74 CMS (composite) / AMA-PCPI (individual component)</td>
<td>GPRO Web Interface</td>
<td>R</td>
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<td>33.</td>
<td>At Risk Population – Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>NQF #66 CMS (composite) / AMA-PCPI (individual component)</td>
<td>GPRO Web Interface</td>
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**NOTE:** ACO = accountable care organization; NQF = National Quality Forum; P4P = pay for performance; P = performance; R = reporting
Pioneer ACO EMHS’s Next Steps

- Develop *systematic* population health management capabilities
- Engage patients – phase 1: opt in vs. opt out for data purposes
- Engage patients – phase 2: screen “at risk” and enroll for care coordination
Pioneer ACO: Next Steps

- Establish population health management capabilities
  - Health plan administration (ACO administration)
  - Medical management/care coordination
  - Network (“Beacon”)
Beacon Health LLC: Accountable Care at EMHS

The Purpose of the Accountable Care Organization ("ACO") Executive Steering Committee is to ensure that EMHS and all its Affiliate Members have the functional capabilities to deliver the optimum experience of care for our patients under financially sustainable models of risk sharing and accountability.

Formed Beacon Health LLC, a company to accept shared savings and to repay shared losses, and to bring non-EMHS hospitals and other providers offices into partnership with EMHS for population health management.
Pioneer ACO: Next Steps

- Engagement of patients and families as partners: Phase 1
Patients’ role

• Providers choose to participate, not patients

• Patients have the option of allowing Medicare to share their claims data with Beacon Health LLC
  – Option is “Opt-Out” for general data
  – Option is “Opt-In” for Substance Abuse data
Opt-Out/In Process

- Patient will receive a letter from their provider describing our ACO and claims data sharing option.

- A Medicare phone number will be provided and reference that the patient may want to discuss this with their provider.

- EMHS has set up a phone number for questions you can’t answer, 973-5788.
Pioneer ACO: Next Steps

- Engage Patients - Phase 2: Enroll high risk persons into case management strategies at our PCMH
Primary Care – Care Coordination Model

- Plan Design
- Treatment Model
- Components of collaborative care
- Scope/Role of the RN care manager
- Enrollment Criteria
Care Coordination Model

Plan Design:

– A standard consensus care coordination model across the EMHS System’s Entities (including risk stratification and decision support systems, as well as core competency development)

– Standard Performance Measures

– Pilot innovative models in alignment with local market-based needs

– Ensuring access of Health Plan members to chronic disease and wellness promotion services, and to coordination of transitions of care in consultation with primary care teams, consulting physicians, and patients and their families
Care Coordination Program Overview

Care Coordination Concept

Care coordination is a function that fosters information sharing across levels of care to ensure patients’ needs and preferences are met. The goal is to provide efficient, high quality and cost effective care through collaboration and coordination of services in the management of medical cases. Care coordination engages patients and families in the development of their care plan and links them to health and other services that address the full range of needs and/or concerns related to their health care.

Benefits of effective care coordination include

- Reduced hospital admissions
- Reduced length of hospital stays
- Reduced emergency department visits
- Improved patient satisfaction
- Enhanced opportunities for clinical improvement

TOGETHER We’re Stronger

EMHS
Access to Quality Healthcare
Care Coordination Capabilities

1. Triage and risk stratification of different populations
2. Enrollment of patients for care coordination
3. Assessment, care plan development, care plan management
4. Outcomes measurement (functional status, patient perception)
5. Care managing in context of benefits and plan design
6. Disease management protocols and collaborative practice models
7. Case conferences and feedback to teams
8. Patient self-management education
9. Collaboration with TPA’s and health plans
10. Interfaces and roles of care coordinators across the continuum
Sample Enrollment Criteria

CHF

Open Criteria

Referrals for the primary practice care manager may be made when a patient meets one or more of the following criteria:

- Patient has had hospital discharge for a CHF exacerbation
- Patient has had an ER/WIC visit for a CHF exacerbation
- Patient with CHF and 3 or more co-morbidities
- Provider referral:
  - Newly diagnosed CHF patient.
  - Patients screened to be at increased risk for exacerbation or complication of CHF
  - Patient has had an office visit for exacerbation of CHF.
  - Patient’s disease state is such that the patient would benefit from ongoing RN nursing assessment.
  - Patient would benefit from CHF education and care coordination as part of their self-management plan
Pioneer ACO Goals
March-June 2012

- Education of Pioneer Patients
- Analyze CMS cost detail on non opt-out attributed Pioneer Patients
- Develop/Implement work plan to focus on high spend and high utilization areas
- Compare monthly CMS data information to progress in focus areas
- Evolve Care Coordination tools based on work plan progress
Relational Coordination and the Transformation of Healthcare

Jody Hoffer Gittell
Professor, Heller School, Brandeis University
Director, Relational Coordination Research Collaborative

Maine & New Hampshire Healthcare Transformation Learning Symposium
University of New Hampshire
March 14, 2012
Challenges we face

- Pressure to deliver better outcomes at lower cost
- Learning to do *more with less*
- Are these goals possible to achieve?
- Can relational coordination help healthcare organizations to achieve these goals?
Today we discuss...

- Relational coordination and its performance effects
- Organizational structures that support relational coordination
- Getting from here to there: A relational model of organizational change
Flight departure process:
A coordination challenge
“Here you don’t communicate. And sometimes you end up not knowing things…On the gates I can’t tell you the number of times you get the wrong information from operations…The hardest thing at the gate when flights are delayed is to get information.”
“Here there’s constant communication between customer service and the ramp. When planes have to be switched and bags must be moved, customer service will advise the ramp directly or through operations…Operations keeps everyone informed. It happens smoothly.”
“If you ask anyone here, what’s the last thing you think of when there’s a problem, I bet your bottom dollar it’s the customer. And these are guys who work hard everyday. But they’re thinking, how do I stay out of trouble?”
“We figure out the cause of the delay. We don’t necessarily chastise, though sometimes that comes into play. It’s a matter of working together. Figuring out what we can learn. Not finger-pointing.”
“Ninety percent of the ramp employees don’t care what happens. Even if the walls fall down, as long as they get their check.”
“I’ve never seen so many people work so hard to do one thing. You see people checking their watches to get the on-time departure. People work real hard. Then it’s over and you’re back on time.”
Employees revealed little awareness of the overall process. They typically explained their own set of tasks without reference to the overall process of flight departures.
Employees had relatively clear mental models of the overall process -- an understanding of the links between their own jobs and the jobs of their counterparts in other functions. Rather than just knowing what to do, they knew why, based on shared knowledge of how the process worked.
“There are employees working here who think they’re better than other employees. Gate and ticket agents think they’re better than the ramp. The ramp think they’re better than cabin cleaners -- think it’s a sissy, woman’s job. Then the cabin cleaners look down on the building cleaners. The mechanics think the ramp are a bunch of luggage handlers.”
“No one takes the job of another person for granted. The skycap is just as critical as the pilot. You can always count on the next guy standing there. No one department is any more important than another.”
Relationships shape the communication through which coordination occurs ...
For better...

Shared goals
Shared knowledge
Mutual respect

Frequent communication
Timely communication
Problem-solving communication
... Or worse

Functional goals
Specialized knowledge
Lack of respect

Infrequent communication
Delayed communication
“Finger-pointing”
This process is called

**relational coordination**

“Communicating and relating for the purpose of task integration”
Investigated performance effects of relational coordination

- Nine site study of flight departures over 12 months of operation at Southwest, American, Continental and United
- Measured relational coordination among pilots, flight attendants, gate agents, ticket agents, baggage agents, ramp agents, freight agents, mechanics, cabin cleaners, fuelers, caterers and operations agents
- Measured quality and efficiency performance, adjusting for product differences
Relational coordination and flight departure performance

<table>
<thead>
<tr>
<th></th>
<th>Efficiency</th>
<th>Quality</th>
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<tr>
<td></td>
<td>Gate time/flight</td>
<td>Staff time/passenger</td>
<td>Customer complaints</td>
<td>Lost bags</td>
<td>Late arrivals</td>
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<td>Relational coordination</td>
<td>-0.21***</td>
<td>-0.42***</td>
<td>-0.64***</td>
<td>-0.31*</td>
<td>-0.50**</td>
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<tr>
<td>Flights/day</td>
<td>-0.19****</td>
<td>-0.37***</td>
<td>-0.30***</td>
<td>0.13</td>
<td>-0.22+</td>
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<td>Flight length, passengers, cargo</td>
<td>0.79***</td>
<td>0.45***</td>
<td>0.13</td>
<td>0.12</td>
<td>-0.54**</td>
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<td>Passenger connections</td>
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<td>0.19**</td>
<td>0.09</td>
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<td>R squared</td>
<td>0.94</td>
<td>0.81</td>
<td>0.69</td>
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Relational coordination and flight departure performance

Quality/efficiency performance index

Relational coordination
Does relational coordination matter in other industries?
Patient care: A coordination challenge

- Case Managers
- Attending Physicians
- Physical Therapists
- Administrators
- Referring Physicians
- Technicians
- Social Workers
- Nursing Assistants
- Nurses
- Patients
“The current system shows too little cooperation and teamwork. Instead, each discipline and type of organization tends to defend its authority at the expense of the total system’s function.” (2003)
Physicians recognize the problem

“The communication line just wasn’t there. We thought it was, but it wasn’t. We talk to nurses every day but we aren’t really communicating.”
Nurses observe the same problem

“Miscommunication between the physician and the nurse is common because so many things are happening so quickly. But because patients are in and out so quickly, it’s even more important to communicate well.”
Same study conducted in hospital setting

- Nine hospital study of 893 surgical patients
- Measured relational coordination among doctors, nurses, physical therapists, social workers and case managers
- Measured quality and efficiency performance, adjusting for patient differences
### Relational coordination and surgical performance

<table>
<thead>
<tr>
<th></th>
<th>Length of stay</th>
<th>Patient satisfaction</th>
<th>Freedom from pain</th>
<th>Mobility</th>
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<td>Relational coordination</td>
<td>-.33***</td>
<td>.26***</td>
<td>.08*</td>
<td>.06+</td>
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<td>Patient age</td>
<td>.02</td>
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<td>.01</td>
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<td>Pre-op status</td>
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<td>.01</td>
<td>.20***</td>
<td>.28***</td>
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<td>Surgical volume</td>
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<td>.10*</td>
<td>.06+</td>
<td>.03</td>
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<td>R Squared</td>
<td>.82</td>
<td>.63</td>
<td>.50</td>
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Observations are patients (n=878) in hospitals (n=9). Model also included gender, marital status, psychological well-being and race. Standardized coefficients are shown.
Relational coordination and surgical performance

Quality/efficiency performance index

Relational coordination
Findings extended to other healthcare settings

- Medical care units in Boston suburban hospital
- Medical, surgical and intensive care units in Pennsylvania rural hospitals
- Nursing homes in Massachusetts
- Chronic care in California multi-specialty group
- Chronic care in Netherlands
- Hospital/early intervention handoffs in Mass
Relational coordination also improves worker outcomes

- Increases job satisfaction
- Increases career satisfaction
- Increases professional efficacy
- Reduces burnout, emotional exhaustion
Fundamental process improvements *push out* the quality/efficiency frontier – to achieve more with less
There are other useful responses to coordination challenges...

- Reengineering
- Total quality management
- “Lean” strategies
- Redesigning work flows
Addressing technical issues is necessary but not sufficient

“We’ve been doing process improvement for several years, and we think we’re on the right track. But we’ve tried a number of tools for process improvement, and they just don’t address the relationship issues that are holding us back.”

-- CMO, Tenet Healthcare Systems
Why does relational coordination matter?

Relationships of shared goals, shared knowledge and mutual respect provide an organizational culture that supports process improvement.
Why does relational coordination matter?

Relationships of shared goals, shared knowledge and mutual respect help workers to connect *around* the customer.
Relational coordination: Connecting around the patient

- Case Managers
- Attending Physicians
- Physical Therapists
- Technicians
- Administrators
- Referring Physicians
- Social Workers
- Nursing Assistants
- Nurses

Patient and family
How do organizations support relational coordination?
Invest in frontline leadership
Resolve conflicts proactively
Reward team performance
Select for teamwork
Measure team performance
Make job boundaries flexible
Create boundary spanners
Develop shared protocols
Broaden participation in team meetings
Develop shared info systems
Partner with suppliers

Organizational structures that support relational coordination

Quality Performance
Efficiency Performance
Worker Well-Being

Relational Coordination
Shared goals
Shared knowledge
Mutual respect
Frequent
Timely
Accurate
Problem-solving
Communication

Worker Well-Being
“Here technical expertise exceeds teamwork ability as a criterion; doctors expect teamwork of others simply by virtue of the fact that they are doctors, after all.”
“You’ve got to be a nice person to work here... We pick it up through their references. The doctors here are also sure to know someone who knows that doctor... Nurses like it here because physicians respect their input.”
“The quality assurance (QA) committee is strictly departmental and it’s strictly reactive. Everybody is giving reports to QA but nobody is listening or learning. The QA committee satisfies hospital-wide reporting requirements. But it’s not effective. We have board members on that committee, but we still can’t get it to work. People have a bad attitude when they go. It’s a lengthy, cumbersome meeting.”
“Quality assurance used to be completely reactive here, with incident reports. There would be a review to determine injury or no injury. QA is more real-time now, not so reactive.”

“But we don’t have a full system in place. It’s evolving… It’s not cross-functional yet. Usually I take the nurses and the chief of the service takes the physicians. There is finger-pointing.”
“We have a Bone Team which includes the service line director, the case management supervisor, the head of rehab, the VP for nursing, the nurse manager, the clinical specialist, three social workers and three case managers. We generally look at system problems.”
“I would say that for any non-physician to challenge a physician has the whole episode laced with pitfalls. For a nurse, a therapist, a pharmacist, a social worker, a nutritionist, an occupational therapist to challenge a physician is up there with losing a job or getting a divorce—very stressful. And I can say personally as a nurse that in my more formative years that was something that you would try to avoid at all costs.”
“The kinds of conflicts we often have are disagreements about the patient’s treatment plan: what it should be. It can go across all of the groups. The other big thing is getting a physician to come up to the unit, to be available. . . . We have a formal grievance process if you’re fired, but not for conflicts among clinicians. . . . There are no particular processes. We just hope people use common sense and talk to each other.”
“We implemented training classes for all employees that teach employees how to deal with conflict resolution, including adopting appropriate behaviors. There is a Pledge to My Peers, which is a structured format for resolving conflicts in a peer-to-peer fashion. Aggrieved employees are encouraged to approach the coworker or supervisor or whoever and say, ‘I would like to speak with you regarding the pledge.’”
Make job boundaries flexible

“There are customs – like the fact that a physical therapist will never deal with bedpans and such – that go above and beyond licensing. These customs have a negative effect, like when a physical therapist will go get a nurse just to deal with the bedpan, making things difficult.”
“[Here] physical therapists definitely do the bedpans. You see, length of stay is so compressed and time is so valuable. You’ll only delay yourself if you try to hunt down the nurse’s aide.”
“The case manager does the discharge planning, utilization review and social work all rolled into one. The case manager discusses the patient with physical therapy and nursing and with the physician. He or she keeps everyone on track. The case manager has a key pivotal role – he or she coordinates the whole case.”
"Case managers have to be very very very good communicators and negotiators and very assertive but also have a good sense of timing .... Willing to be a patient advocate but also be able to balance the financial parameters and think ‘out of the box’ and have a system perspective.”
"I have about 30 patients – with that number I pretty much just go down the list and see who is ready for discharge."
“You can’t track down all of the physicians here because some of the physicians have their own system. That’s a problem – they don’t talk. Independent physicians have their own independent systems, and they only talk to themselves. I mean, so there’s a big problem. Some of them are on the email system, and some of them aren’t.”
"Information systems are important for coordination, I think, but right now they are more a hope than a reality. Our chief information officer is building a clinical and administrative information system allowing patients to receive care anywhere across the continuum... But for automation to work, it’s important to get a format that’s understood across all specialists."
Organizational structures that support relational coordination

- Select for teamwork
- Measure team performance
- Reward team performance
- Resolve conflicts proactively
- Invest in frontline leadership
- Make job boundaries flexible
- Create boundary spanners
- Develop shared protocols
- Broaden participation in team meetings
- Develop shared info systems
- Partner with suppliers

Relational Coordination
- Shared goals
- Shared knowledge
- Mutual respect
- Frequent
- Timely
- Accurate
- Problem-solving
- Communication

Quality Performance
Efficiency Performance
Worker Well-Being

RELATIONAL COORDINATION RESEARCH COLLABORATIVE
HIGH PERFORMANCE HEALTHCARE

Using the Power of Relationships to Achieve Quality, Efficiency and Resilience

JODY HOFER GITTELL

Award-winning author of *The Southwest Airlines Way*
Measuring, mapping and improving relational coordination
Measuring relational coordination

<table>
<thead>
<tr>
<th>RC dimensions</th>
<th>Survey questions</th>
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<tr>
<td>1. Frequent communication</td>
<td>How <em>frequently</em> do people in each of these groups communicate with you about [focal work process]?</td>
</tr>
<tr>
<td>2. Timely communication</td>
<td>How <em>timely</em> is their communication with you about [focal work process]?</td>
</tr>
<tr>
<td>3. Accurate communication</td>
<td>How <em>accurate</em> is their communication with you about [focal work process]?</td>
</tr>
<tr>
<td>4. Problem solving communication</td>
<td>When there is a problem in [focal work process], do people in these groups blame others or try to <em>solve the problem</em>?</td>
</tr>
<tr>
<td>5. Shared goals</td>
<td>How much do people in these groups <em>share your goals</em> for [focal work process]?</td>
</tr>
<tr>
<td>6. Shared knowledge</td>
<td>How much do people in these groups <em>know</em> about the work you do with [focal work process]?</td>
</tr>
<tr>
<td>7. Mutual respect</td>
<td>How much do people in these groups <em>respect</em> the work you do with [focal work process]?</td>
</tr>
</tbody>
</table>
Mapping relational coordination

Work Group 1

Work Group 2

Work Group 3

Work Group 4

Work Group 5

Customer
Mapping relational coordination before intervention

- Physicians: 3.70
- Day nurses: 4.42
- Night nurses: 4.43
- Secretaries: 4.57
- Nurse mgrs: 4.57
Consultant was asked to help

- Physicians considered to be a “problem”
- Uncivil behaviors among themselves and with other groups
- Consultant focused on physicians, using
  - Appreciative inquiry
  - New physician group leader
  - Coaching and goal-setting
  - Accountability for relational behaviors
  - Weekly meetings to check in, make group decisions
Mapping relational coordination after six month intervention

Shaded numbers indicate significant positive change
Partial success

- Relational coordination improved
  - Among physicians
  - Between physicians and nurse managers
  - Between nurse managers and secretaries

- But RC stayed the same or got worse
  - Between other groups

- “Shared knowledge” did not improve for anyone, even physicians

- Lessons learned?
Lessons learned

- **Relational intervention**
  - Build relational coordination more broadly, not just among physicians but with other work groups as well

- **Work process intervention**
  - Improve relational coordination *in the context* of the work by doing process improvement – create shared knowledge

- **Structural intervention**
  - Set up new structures -- forms of accountability, roles, meetings, conflict resolution -- not just for physicians but for other work groups as well
A Relational Model of Organizational Change

**Structural Intervention**
- Selection
- Training
- Conflict resolution
- Performance measures
- Rewards
- Meetings
- Boundary spanners
- Protocols
- Information systems

**Relational Coordination**
- Shared goals
- Shared knowledge
- Mutual respect
- Frequent communication
- Timely communication
- Accurate communication
- Problem-solving comm

**Performance Outcomes**
- Quality
- Efficiency
- Worker well-being

**Relational Intervention**
- Relationship mapping
- Coaching/role modeling
- Perspective taking

**Work Process Intervention**
- Process mapping
- Goal and role clarification
- Structured problem solving
Beyond relational coordination

- Need relational coordination
  - Connecting workers with each other

- But also relational *coproduction*
  - Connecting workers with the *patient and family*

- And relational *leadership* as well
  - Connecting workers and *managers*
Three kinds of reciprocal relationships

- Relational leadership
- Relational coordination
- Relational coproduction
All benefit from...

• Shared goals
  – Identifying with and embracing the goals of the whole

• Shared knowledge
  – Understanding the whole, how each role contributes

• Mutual respect
  – Respecting each participant, role that he/she plays
Relational Model of Organizational Change

**Structural Intervention**
- Selection
- Training
- Conflict resolution
- Performance measures
- Rewards
- Meetings
- Boundary spanners
- Protocols
- Information systems

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- Problem-solving communication

**Relational Leadership**

**Work Process Intervention**
- Process mapping
- Goal and role clarification
- Structured problem solving

**Performance Outcomes**
- Quality
- Efficiency
- Worker well-being

**Relational Intervention**
- Relationship mapping
- Coaching/role modeling
- Perspective taking
Relational Coordination Research Collaborative
RCRC Vision
Making relational coordination the norm for how human beings work together

RCRC Mission
Building the knowledge, evidence and tools to enable the transformation of relationships for high performance
Building a global learning community for practitioners and researchers

- U.S. (East Coast, West Coast, Southwest, Midwest)
- Canada
- Denmark, Norway, Sweden
- Netherlands, Belgium
- Spain, Italy
- Ireland, Scotland, England
- Australia
- Japan
Resources for RCRC Partners

- Online RC survey, reports and benchmarking
- Intervention data base
- Monthly webinars
- Annual roundtable, other gatherings
- Partner webpages to share efforts, visions
- Referrals to RC consultants
- Training and certification to become RC consultant
NH Accountable Care Organization Project

Sharon Beaty
CEO
Mid-State Health Center
Plymouth, NH
NH Health Payment Reform: The Challenge

New Hampshire has some of the highest medical costs in the nation.

- Significant variation in prices of individual services, as well as for a market basket of services across providers of health care
- Health spending that amounts to more than 18% of GSP and is expected to reach 22% by 2017
- An average family health insurance premium that is one of the highest average family premium in the United States. In 2006, NH’s $12,686 premium far exceeded the national average of $11,381
- Personal annual per capita health care spending of $6,456 in 2007, with a projection of reaching $11,043 by 2017
A Call to Action

In an effort to remedy the health care value challenges faced in New Hampshire, in late 2009,

Governor John Lynch charged the health care leaders in the state to implement strategies that would bend the cost curve by 2014 and enable the state as a whole to achieve the level of cost and quality performance of the top five “low cost, high quality” states.
NH ACO Project Inception

- Facilitated through the NH Citizens Health Initiative (NH CHI)
- Intended to support NH based health systems during a time of transformation and ultimately impact the unsustainable growth in health care costs
- Create a common table for provider organizations, health plans, the states and other stakeholders to explore the concepts of Accountable Care
Participating Organizations

- 5 delivery systems represent more than 300 clinicians and a total population served of more than 400,000 NH residents (out 1.3 million total)

<table>
<thead>
<tr>
<th>Delivery Systems</th>
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<tbody>
<tr>
<td>1. Chesire Medical Center/ Dartmouth-Hitchcock Keene</td>
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<tr>
<td>2. Southern NH Health System</td>
</tr>
<tr>
<td>3. Exeter Health Resources</td>
</tr>
<tr>
<td>4. Central NH Health Partnership:</td>
</tr>
<tr>
<td>Speare Hospital</td>
</tr>
<tr>
<td>Mid-State Health Center</td>
</tr>
<tr>
<td>Pemi-Baker Home Health &amp; Hospice</td>
</tr>
<tr>
<td>Newfound Area Nursing Assoc.</td>
</tr>
<tr>
<td>Genesis Community Mental Health Center</td>
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<tr>
<td>5. North Country ACO:</td>
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<tr>
<td>Ammonoosuc Community Health Services</td>
</tr>
<tr>
<td>Littleton Regional Hospital</td>
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<tr>
<td>Cottage Hospital</td>
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<tr>
<td>North Country Home Health &amp; Hospice</td>
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<table>
<thead>
<tr>
<th>Health Plans</th>
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<tr>
<td>- Anthem Blue Cross Blue Shield of NH</td>
</tr>
<tr>
<td>- CIGNA</td>
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<tr>
<td>- Harvard Pilgrim Healthcare</td>
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<td>- MVP Health Care</td>
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<table>
<thead>
<tr>
<th>State and Other Organizations</th>
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<tbody>
<tr>
<td>- N.H. Department of Health and Human Services</td>
</tr>
<tr>
<td>- N.H. Department of Insurance</td>
</tr>
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</table>
Original NH ACO Pilot Goals

- Identify agreed ACO Model across pilots systems
  - Primary care focused ACO model
- Define a common financial framework across health plans and ACO systems
- Implement a common financial framework across health plans and ACO systems
  - Implement independent data entity for operational and performance reporting
  - Create and sustain clinical and administrative learning networks
  - Evaluation and Assessment
Updated Project Goals

- Create and implement *quality, cost and utilization reports* 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
- Create and sustain a 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
Mid-State Health Center

- How did we benefit?
- Where do we go from here?
- What we have learned from the process.
Designing a Financial Model to Address ACO Challenges
New Hampshire Citizens Health Initiative

James Highland, PhD, MHSA
Compass Health Analytics, Inc.
March 14, 2012
Key Design Dimensions

• Patient Attribution – Without lock-in, who is in which ACO?
• Baseline Budget Formulation
• Outlier Removal
• Budget Target Calculation
• Risk Sharing Structure
Overview of Challenges in NH ACO Development

- Turnover in patient attribution from year to year is large
- Numbers of persons attributed to an ACO/Carrier intersection tends to be too small for actuarial credibility
- Historical trend rates can be unstable
- Hard to set mutually satisfactory risk-sharing
- Leakage (out of ACO service use) is large
Challenge #1: Turnover in Attribution is High

Of those who attribute to an ACO prospectively....

- Attribute retrospectively also: 19%
- Eligible but do not attribute to a provider: 55%
- Eligible and attribute to another provider: 15%
- No longer eligible: 11%
Design Feature #1: Using a Modified Retrospective Attribution to Balance Fairness and Responsibility

• Include those who attribute retrospectively in the contract period based on a plurality of E&M claim counts and have at least six months of eligibility.

• Consider those who attribute prospectively based on historical claim data using a 24-month look-back and a plurality of E&M claim counts, but retain only those who are still eligible in the contract period and did not attribute to another provider but did not have E&M claims.

• The combination of these two populations is the “modified” retrospectively attributed population.
Baseline Budget Development

• Determine the “Modified” Retrospectively Attributed population for the year prior to the contract period

• Find the PMPM allowed claim amount for this population, capping claims at $75,000 per person
Challenge #2: “N” for budgets tends to be too small for actuarial credibility

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<tbody>
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<tr>
<td>Carrier #3</td>
<td>9,061</td>
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<td>Carrier #4</td>
<td>1,137</td>
</tr>
<tr>
<td>All ACO sites combined</td>
<td>75,243</td>
</tr>
</tbody>
</table>
Design Feature #2: Parallel arrangements and risk pooling

• Using parallel risk arrangements across carriers creates effective risk pooling
• As if budget pools and “N” were sum of all carriers
• This method is fair for carriers if primary management effects stem from provider action
• Getting agreement on one model an issue
Challenge #3: Trend Rates Are Unstable

• Trend from 2008-2009: 8.9%
• Trend from 2009-2010: -0.3%
• Assumed budget trend from 2010-2011: ?
• NH commercial trend 2008-2009: 10.6%
• NH commercial trend 2009-2010: 1.0%
Design Feature #3: Cohort-Based Budget Target

- Compare growth rate experienced by ACO in the contract period to the overall growth rate for the state of NH
- Accounts for system-wide changes in health care spending
- Demonstrates savings of ACO systems versus non-ACO population
- Variability in trends from year to year makes individual ACO trend projections difficult
Challenge #4: Risk sharing common ground?

• If provider upside gain is too low, won’t offset lost fee-for-service income
• Some carriers willing to share sufficient upside if comparable downside risk is assumed
• Providers wary of downside risk
• Risk assumption is the “product” for which carrier’s receive most of their profits, reluctance to give away source of income
Design Feature 4a: Risk Shares Set to Balance Considerations

• Two-sided arrangement with 60% sharing for providers and 40% for carriers, optionally phased in over 3-4 years
• Sharing percentage adjusted by Quality Score, i.e. 60% x Quality Score
• If Quality Score is less than Quality Threshold then Sharing percentage is 0%
• In loss situations, the provider’s share is the lesser of 60% or 1-(60% x Quality Score)
Design Feature 4b: Outlier Removal Reduces Risk for Providers

- Recommend capping allowed amount per person to $75,000 per year in budget development and contract period reconciliation
- Less than 1% of individuals are affected by this
- Results in the removal of less than 10% of claim dollars on average
- Keeps high risks out of provider budget pool
Challenge #5: Leakage is Large

- Leakage can be upwards of 80% for primary-care oriented systems
- Professional E&M and outpatient services tend to have less leakage, but can still be 50%-60%
- Specialty services tend to have higher leakage (70%-90%)
- Depends on composition of ACOs provider systems
Design Feature #5: Measurement

• Data on leakage was not available prior to project completion, however.
• Leakage only a problem if rate of growth for leaked services is higher than average reflected in cohort.
• Data available to measure leakage during phase-in period could be used to identify high growth “leakees”.
• Direct care to philosophically similar networks.
Recommended Arrangement

• Potential Savings Pool defined by financial performance relative to Spending Target
• Spending Target is growth rate of cohort population
• One percent aggregate financial threshold with application to full range once threshold is exceeded
• Access to Potential Savings Pool determined by Quality Score and limited by minimum Quality threshold
Conclusion

• Product design with network lock-in would be easier, would it sell?
• Low-population state with about 300,000 fully insured persons adds to challenges
• Features to address challenges can be developed
• Infrastructure & resource requirements compel commitment to population-based future
• Agreeing to a common vision and committing to the vision with tactical adjustment is the key
The MHMC is a purchaser-led partnership among multiple stakeholders working collaboratively to maximize improvement in the value of healthcare services delivered to MHMC members’ employees and dependents.

The Maine Health Management Coalition Foundation is a public charity whose mission is to bring the purchaser, consumer and provider communities together in a partnership to measure and report to the people of Maine on the value of healthcare services and to educate the public to use information on cost and quality to make informed decisions.
4 Steps to Improving Health Care Value

1) Performance Measurement and Public Reporting
2) Consumer Engagement
3) Value Based Purchasing
4) Reformed Payment/Effective Incentives
Meaningful system performance measurement and public reporting is necessary for accountability to purchasers, patients and community.

- Transparency of cost, resource use and appropriateness
- Transparency of utilization rates and patterns
- Transparency of patient outcomes and experience
- Transparency of quality and safety
### Compare Hospital Ratings

#### See how your selected Hospitals compare for Quality ratings:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine Medical Center</td>
<td>22 Bramhall Street, Portland, ME 04102</td>
<td>Good</td>
</tr>
<tr>
<td>Mercy Hospital</td>
<td>144 State Street, Portland, ME 04101</td>
<td>Good</td>
</tr>
<tr>
<td>Southern Maine Medical Center</td>
<td>One Medical Center Drive, Biddieford, ME 04005</td>
<td>Best</td>
</tr>
<tr>
<td>Mid Coast Hospital</td>
<td>123 Medical Center Drive, Brunswick, ME 04011</td>
<td>Best</td>
</tr>
</tbody>
</table>

#### Hospitals ratings for your selected hospitals:

**Effective**

- **Heart Attack Care**
  - Ratings explained
  - Rating: Better
- **Heart Failure Care**
  - Ratings explained
  - Rating: Good
- **Pneumonia**
  - Ratings explained
  - Rating: Good

**Safe**

- **Preventing Surgical Infection**
  - Ratings explained
  - Rating: Better
- **Medication Safety**
  - Ratings explained
  - Rating: Best
- **National Safe Practice Score**
  - Ratings explained
  - Rating: Better

**Patient Satisfaction**

- **Overall Experience**
  - Ratings explained
  - Rating: Better
- **Would Recommend to Others**
  - Ratings explained
  - Rating: Better
Employer Use

• State of Maine Tiered Networks
  – Hospital based on PTE Metrics - 2006
    • Added cost of care w/ quality Aug 2011
  – PCPs based on PTE Metrics - July 2007
• Other Employers/Plan Sponsors
  – Jackson Lab and Barber Foods – January 2011
  – U Maine System – January 2012
  – MMEHT – January 2012
Employer Use

- Employer members choose if/how to use performance measures
- Consistency across employers preferred by providers
- Gradual ‘raising of the bar’ on performance
- Transparent, multi-stakeholder process important to employees and providers
- Threshold: Achieving minimum of ‘Good’ in every category (only quality/safety for 5 years)
Cost Variation

Figure 2. Large Maine Hospitals (Level 2). Mix-Adjusted Average Payment Variance for Inpatient & Outpatient Level 1 and Level 2 Services. 2010 Commercial Claims Data.

Onpoint Health Data • Hospital Cost Comparison for Hospital Tiered Benefit, January 2012
What is MAP?

- The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum.

- MAP was created to provide input to the Department of Health and Human Services on the selection of performance measures for use in public reporting, performance-based payment, and other programs.
More than 60 major stakeholder organizations, 40 individual experts, and 9 federal agencies are represented on the MAP.
Purpose of MAP

- Provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs
- Identify gaps for measure development, testing, and endorsement
- Encourage alignment of public and private sector programs
- Harmonize measurement across levels of analysis and settings to:
  - Promote coordination of care delivery
  - Reduce data collection burden
Pre-Rulemaking Input – General Themes

• The National Quality Strategy (NQS) provides the guiding framework for MAP decision making and is reflected as a key component of the MAP Measure Selection Criteria

• MAP adopted a person-centered approach to measure selection, encouraging broader use of patient-reported measures such as the Clinician Group-Consumer Assessment of Healthcare Providers (CG-CAHPS)

• Many high priority measurement gaps were identified, including measures of patient experience, functional status, shared decision making, care coordination, cost, appropriateness of care, and mental health

• Measures used in federal programs should promote team-based care and shared accountability through population-level measurement, as exemplified by the Medicare Shared Savings Program

  • Final report submitted February 1, 2012
  • Report available at www.qualityforum.org
Example: Maine’s Transition to Global Payments & ACOs

PURCHASERS

State Employees Health Commission and UMS

FACILITATOR

Maine Health Management Coalition

PROVIDERS

Maine General Health

MidCoast Health System

Data

Technical Assistance

Bath Iron Works

MidCoast Health System

Maine Health Management Coalition

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Maine Health Management Coalition

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Technical Assistance

Bath Iron Works

Maine General Health

MidCoast Health System

Maine Health Management Coalition

Data

Technical Assistance

Bath Iron Works
Multistakeholder group to identify care improvement strategies and address barriers to implementing system redesign and payment changes

1. Review the Data
2. Set Baselines and Targets
3. Identify Barriers: Needed Benefit, Payment and Clinical Changes
4. Measure and Compare Progress
5. Share Learnings/Best Practice
6. Scale Successes
Payment Reforms Needed that Support Care Changes

• It’s not about “risk” or “incentives,” It’s about giving healthcare providers the ability/flexibility to improve outcomes and reduce costs in a way that is financially feasible

• Desired changes in care should drive payment reforms that support them, not the other way around
Committees: What

Health Care Cost Workgroup

Targets and Goals:
Identify cost drivers and variations in care and costs. Through comparative data identify savings opportunities and spending targets through priority interventions by sector.

Implementation:
Multistakeholder group to identify care improvement strategies and address barriers to implementing system redesign and payment changes to meet cost and quality targets.

Accountable Care Implementation Group

Incentives:
Identify key patient and provider benefit and reimbursement incentives to facilitate appropriate utilization.

Value Based Benefit Design Workgroup

Accountability:
Public reporting of subset of common cost and quality system performance measures to monitor progress, reward quality and inform public.

EASC/CE

Consumer Engagement
Engage employees and communities in their role in system and care improvement including personal responsibility for health, choosing quality and appropriate utilization of services.

MHMC Data and Analytics

www.getbettermaine.org & www.mehmc.org
# ME-NH PCMH Clinical Metrics

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<th>NCQA·BTE/PTE</th>
<th>CMS·PQRI</th>
<th>Maine·Care·PIP</th>
<th>Anthem·Quality·Insights</th>
<th>CMS·Grp·Prec·Demo</th>
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</tr>
<tr>
<td>4. HbA1c·&gt;9%</td>
<td></td>
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</tr>
<tr>
<td>5. BP·recorded·(prev·12·mos)</td>
<td></td>
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</tr>
<tr>
<td>6. BP·&gt;140/90 (140/90)</td>
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</tr>
<tr>
<td>7. BP·&lt;130/80</td>
<td></td>
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</tr>
<tr>
<td>8. BP·&lt;140/80</td>
<td></td>
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</tr>
<tr>
<td>9. LDL·testing·(prev·12·mos)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Diabetes
- CVD
- Hypertension
- Preventive Care
- Behavioral Health
Lessons Learned
Maine PCMH Pilot

• Change starts with effective physician leadership
  – Primary selection criteria for Pilot
  – Don’t assume physician leadership skills - need ongoing support

• Change happens through effective teams

• NCQA PPC-PCMH ≠ “medical home”

• It’s all about relationships – with patients AND within teams
Maine PCMH Pilot – Payment Model

• Medicare contributing $7 pmpm
• Anthem, Aetna, HPHC & MaineCare participating
• Common 3-component payment model:
  1. Prospective (pmpm) care management payment (approx $3 pmpm)
  2. Ongoing FFS payments
  3. Use existing payer P4P programs
• Practices expected to make changes across all populations
## Compare Practice Ratings

See how your selected Practices compare for Quality ratings:

- **Good**
- **Better**
- **Best**

*Practices can only receive a "Best" rating in the Safe category*

### Where do these ratings come from?

Adult Care ratings for your selected practices

(Last updated on Sun, 12/04/2011 - 22:06)

<table>
<thead>
<tr>
<th>Practice Details</th>
<th>Ratings</th>
<th>Effective</th>
<th>Safe</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Care</strong></td>
<td><strong>Good</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Download a diabetes checklist for your doctor</td>
<td>Ratings explained</td>
<td>Did Not Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Heart Disease Care</strong></td>
<td><strong>Better</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Download a heart disease checklist for your doctor</td>
<td>Ratings explained</td>
<td>Did Not Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td><strong>Best</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What patients say about this practice</td>
<td>Ratings explained</td>
<td>Did Not Report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Areas of Consumer Interest

Taking new patients, office hours, health benefit discounts, and other useful information

- **Accepting New Patients**
  - Yes
  - Yes
  - Yes
  - Yes
Pathways to Excellence – Physicians
Steering Committee

Practice Leaders:
- Mike Albaum MD: Primecare
- Bob Allen MD: PCHC
- Marcus Deck MD: Bowdoin Med Group
- Tom Claffey MD: Intermed
- Rich Engel MD: Greater Portland MG
- Louis Hanson DO: Cumberland
- Ralph Harder MD: St. Mary’s
- David Howes MD: Martin’s Point
- Don Krause MD: St. Joseph’s
- Lisa Letourneau MD: Quality Counts
- Frank Bragg MD: EMMC
- John Yindra MD: MMC PHO

Health Plans Med. Directors:
- Aetna
- Anthem
- CIGNA
- Harvard Pilgrim
- MaineCare

Employers/Plan Sponsors:
- Christine Burke: MEA Benefits Trust
- Frank Johnson: State Employee Health Plan
- Tom Hopkins: Univ. Maine System
- Chris McCarthy: Bath Iron Works
- Steve Gove: ME Municipal Health Trust
- Joanne Abate: Hannaford Bros.
PTE Physicians 2012

All BTE Outcomes Measures
- Diabetes
- CAD
- CHF
- COPD
- Hypertension
- Asthma
- Depression
- Spine

Claims Based Preventive Health
## Compare Hospital Ratings

See how your selected hospitals compare for Quality ratings:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Effective</th>
<th>Safe</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heart Attack Care</strong></td>
<td>Ratings explained</td>
<td><strong>Preventing Surgical Infection</strong></td>
<td>Ratings explained</td>
</tr>
<tr>
<td><strong>Heart Failure Care</strong></td>
<td>Better</td>
<td><strong>Medication Safety</strong></td>
<td>Best</td>
</tr>
<tr>
<td><strong>Pneumonia</strong></td>
<td>Better</td>
<td><strong>National Safe Practice Score</strong></td>
<td>Best</td>
</tr>
</tbody>
</table>

### Effective
- Provides the care that experts recommend

<table>
<thead>
<tr>
<th>Heart Attack Care</th>
<th>Ratings explained</th>
<th>Better</th>
<th>Good</th>
<th>Good</th>
<th>Unable to Determine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure Care</td>
<td>Ratings explained</td>
<td>Better</td>
<td>Better</td>
<td>Good</td>
<td>Best</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Ratings explained</td>
<td>Better</td>
<td>Good</td>
<td>Better</td>
<td>Better</td>
</tr>
</tbody>
</table>

### Safe
- Has systems to prevent medical errors

<table>
<thead>
<tr>
<th>Preventing Surgical Infection</th>
<th>Ratings explained</th>
<th>Better</th>
<th>Better</th>
<th>Better</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Safety</td>
<td>Ratings explained</td>
<td>Best</td>
<td>Best</td>
<td>Best</td>
<td>Best</td>
</tr>
<tr>
<td>National Safe Practice Score</td>
<td>Ratings explained</td>
<td>Best</td>
<td>Better</td>
<td>Better</td>
<td>Best</td>
</tr>
</tbody>
</table>

### Patient Experience
- What patients say about this hospital

<table>
<thead>
<tr>
<th>Overall Patient Experience</th>
<th>Ratings explained</th>
<th>Good</th>
<th>Good</th>
<th>Low</th>
<th>Good</th>
</tr>
</thead>
</table>

Would you like us to ask your doctor or hospital to report?
Pathways to Excellence – Hospitals
Steering Committee

Hospital VPMA:
- Scott Rusk, MD: Mercy Hospital
- Doug Salvador, MD: Maine Med. Center
- Mark Souders: Maine General Med. Center
- Larry Losey, MD: Parkview Adventist Med. Center
- Frank Lavoie, MD: So. Maine Med. Center
- Peter Watco: St. Mary’s Regional Hospital
- Roger Renfrew, MD: Redington Fairview General Hospital
- Patty Roy, RN: Central Maine Medical Center
- Scott Mills, MD: Midcoast Hospital
- Erik Steele, DO: Eastern Maine Healthcare
- James Razcek, MD: EMMC
- Vance Brown, MD: MaineHealth
- Mike Swann: Franklin Memorial Hospital

Health Plans:
- Aetna
- Anthem
- CIGNA
- Harvard Pilgrim
- MaineCare

Employers:
- Christine Burke: MEA Benefit Trust
- Frank Johnson: State Employees Hlth Comm
- Tom Hopkins: University of Maine System
- Chris McCarthy: Bath Iron Works
- Peter Hayes: Hannaford Bros.
- Steve Gove: ME Mun. Employee Health Trust

Organizations:
- Alex Dragatsi: Maine Quality Forum
- Sandra Parker: Maine Hospital Assn.
- Art Blank: ME Hosp. Assn, Mt. Desert Isl Hosp
- Marie Vienneau: MHA / Millinocket Hospital
Good-Better-Best

- Standardize definitions so are equitable across programs and consumers can understand type of care they can expect:
  - Good: About 50th % / national average
  - Better: About 75th % nationally
  - Best: About 90th % nationally

- How does that feel to you?
### PCP Physician Practices

<table>
<thead>
<tr>
<th>Practices</th>
<th>2007</th>
<th>2008</th>
<th>% Ch</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Blue Ribbon</td>
<td>131</td>
<td>171</td>
<td>+ 31%</td>
</tr>
<tr>
<td>2 Blue Ribbon</td>
<td>59</td>
<td>71</td>
<td>+ 20%</td>
</tr>
<tr>
<td>1 Blue Ribbon</td>
<td>70</td>
<td>69</td>
<td>-1%</td>
</tr>
<tr>
<td>0 Blue Ribbon</td>
<td>169</td>
<td>125</td>
<td>-26%</td>
</tr>
</tbody>
</table>
Maine

Dashboard on Health Care Quality Compared to All States

Overall Health Care Quality

Average

Weak

Very Weak

Strong

Very Strong

Performance Meter:
All Measures

= Most Recent Data Year

= Baseline Year

www.getbettermaine.org & www.mehmc.org
<table>
<thead>
<tr>
<th></th>
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<td>Bridgton Hospital</td>
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<td>MaineGeneral Medical Center</td>
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<td>The Aroostook Medical Center</td>
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<td>St. Mary's R.M.C.</td>
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<td>Calais Regional Hospital</td>
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<td>Millinocket Hospital</td>
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<td>Houlton Regional</td>
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<td>CA Dean</td>
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<td>Waldo County General Hospital</td>
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<td>43</td>
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</tbody>
</table>
PTE Systems

Employers/Health Plan Sponsors:
- Christine Burke – MEABT
- Joanne Abate – Delhaize America
- Wayne Gregersen – Jackson Lab
- Thomas Hopkins – U Maine System
- Frank Johnson – State Employee Health and Benefits
- Chris McCarthy, Manager – BIW

Consumers:
- David White, MHMC Foundation Board
- SEHC member

Providers:
- Jeff Aalberg, MD – MMC PHO
- Barbara Crowley, MD – MaineGeneral Health
- David Howes, MD – Martins Point Healthcare
- Jim Kane – CWM PHO
- Donald Krause MD – St. Joseph Hospital
- Jim Raczek, MD - EMMC

Health Plans:
- Bob Downs, Vice President - Aetna

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Proposed ACO Quality & Cost Measures

- Dartmouth I - Claims
- Dartmouth II – Claims with Clinical
- Dartmouth III - Patient Reported Measures
  - CAHPs +
  - Risk Assessment (i.e. identified BRFSS)
  - Functional Assessment based on PROMIS
- Per Capita (PMPM) Cost Measure
### PTE Systems: Schedule as of Feb 1

<table>
<thead>
<tr>
<th>Status</th>
<th>Measure</th>
<th>Scheduled Web Updates</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results</td>
<td>Care Transition</td>
<td>2011, 2012, 2013, 2014</td>
<td>D</td>
</tr>
</tbody>
</table>

**Key:**
- △ Post on public website

**Potential Overall Process Duration (Months):**
- **Cat.**
- **Specs**
- **Value Assign/Rpts**
- **Results**
- **Go Public**

**Durations can be shortened with PTE recommendation and FB approval**

- 2 min* 3 min* 6 min* 3 min* 12 max*
# System (‘ACO’) Performance

<table>
<thead>
<tr>
<th>Focus</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping People Well</td>
<td>Population Health</td>
</tr>
<tr>
<td></td>
<td>- Imunizations</td>
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<tr>
<td></td>
<td>- BMI</td>
</tr>
<tr>
<td></td>
<td>- Tobacco Use</td>
</tr>
<tr>
<td></td>
<td>- Preventive Screenings</td>
</tr>
<tr>
<td>Improving Quality of Life</td>
<td>VR-12</td>
</tr>
<tr>
<td>Keeping People at Home and Happy</td>
<td>System Coordination</td>
</tr>
<tr>
<td></td>
<td>- All cause readmissions</td>
</tr>
<tr>
<td></td>
<td>- Hospital days (per 1000)</td>
</tr>
<tr>
<td></td>
<td>- Hospital admissions for ASCs</td>
</tr>
<tr>
<td></td>
<td>- Care Transitions</td>
</tr>
<tr>
<td></td>
<td>- ER visits (per 1000)</td>
</tr>
<tr>
<td>Managing Resources Wisely</td>
<td>Resource Use</td>
</tr>
<tr>
<td></td>
<td>- PMPM</td>
</tr>
<tr>
<td></td>
<td>- Imaging Rates</td>
</tr>
<tr>
<td></td>
<td>- Use of Generics</td>
</tr>
</tbody>
</table>
Maine PCMH Pilot Practices
Ownership Types

Legend

Ownership Type
- FQHC
- Private
- H-O

County lines

Hosp. Service Areas w. Pilot Practices

- Augusta
- Bangor
- Bar Harbor
- Belfast
- Biddeford
- Blue Hill
- Bridgton
- Damariscotta
- Dover-Foxcroft
- Farmington
- Lewiston
- Pittsfield
- Portland
- Rumford
- Waterville

0 10 20 Miles
Other Medical Homes in Maine

~ 540 Maine Primary Care Practices

82 NCQA PCMH Recognized Practices

~100 MaineCare HH Practices

14 FQHCs CMS APC Demo

26 Maine PCMH Pilot Practices

20 Pilot Phase 2 Practices

Payers:
- Medicare
- Medicaid
- Commercials (Anthem, Aetna, HPHC)

Payer: Medicaid

Payer: Medicare

www.getbettermaine.org & www.mehmc.org
## PTE to PCMH

### Current 2012-13

<table>
<thead>
<tr>
<th>SAMPLE</th>
<th>NCQA PCMH Office Survey</th>
<th>Outcomes BTE</th>
<th>Patient Experience per CAHPS</th>
<th>Depression</th>
<th>Access per CAHPS</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>PCMH Level 1 or BTE</td>
<td>2 Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Best</td>
<td>Best</td>
<td>2 Best</td>
<td>Best</td>
<td>Best</td>
<td>Best</td>
<td>Best</td>
</tr>
</tbody>
</table>

Or some combination of good-better-best for different levels, e.g.
- **Good**: all goods
- **Better**: 2 goods, 3 betters, 2 bests
- **Best**: all bests, or maybe 4 bests and 3 betters

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HealthPartners Cost of Care

Total Cost of Care: price, service utilization, market-specific variation

Total Resource Use: resource consumption across inpatient, outpatient, professional, and pharmacy

Reliability Tested: consistent results
Validity Tested: performs as intended
NQF approved: adoption, benchmarking
## Prometheus

<table>
<thead>
<tr>
<th>Category</th>
<th>Conditions</th>
<th>NQF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Medical</td>
<td>Asthma, COPD CAD, CHF, HTN Diabetes GERD</td>
<td>NQF Outcomes Endorsed</td>
</tr>
<tr>
<td>Acute Medical</td>
<td>AMI, Stroke Pneumonia</td>
<td>NQF Outcomes Endorsed</td>
</tr>
<tr>
<td>Inpatient Procedural</td>
<td>CABG Bariatric Hip, Knee replace Colon resection</td>
<td>Used by BXNC for tiered benefits for DelHaize</td>
</tr>
<tr>
<td>Outpatient Procedural</td>
<td>Colonoscopy, Gall Bladder, Angioplasty, Hysterectomy, Knee Arthroscopy, Pregnancy/Delivery</td>
<td>Used by BXNC for tiered benefits for DelHaize</td>
</tr>
</tbody>
</table>
PCHM Link Up to ACOs

**Amb**
- **Advanced Primary Care/PCMH** (New workforce: Practice RN Care Managers)

**Comm**
- **Community Care Teams for High-Cost/High-Risk Patients** (New workforce: CCT staff)
- **Enhanced Care Transitions** (New workforce: Hospital + Community-based Care Transition Coaches)

- **Bundled Payments**
- **Partial Capitation**
- **Global Capitation**

Healthcare Delivery System Change + Payment Reform = System Transformation

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NH ACO Clinical Transformation Workgroup

Physician members
  Provider organizations
  Health plan
  NH Public Health

All members agreed on a shared philosophy/aim
Philosophy

• Identify a set of nationally recognized, standardized measures that are clinically significant and have maximum ability for impact by the ACO
• Select a mixture of process, outcomes and utilizations measures
ACO Clinical Workgroup

Began with 265 measures including:
- NCQA metrics
- CMS Pay-for Performance Metrics
- CMS ACO measure sets
- US Preventive Services Task Force recommendations
ACO Clinical Work Group

Philosophical principles were applied to the metrics

We standardized specification for most measures

Claims based measures were coded and run against the APCD using draft attribution methodology for financial framework
Core Measures

- Performance
- Tracking
## CORE Measures (Total = 19)

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure Name</th>
<th>Data Collection</th>
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<tbody>
<tr>
<td>Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Follow Up Visit within 7 Days of Discharge</td>
<td>Claims</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility</td>
<td>EMR</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Diabetes Composite* (HbA1c, LDL Screen, Blood Pressure Check, Nephropathy Screen, Eye Exam, Foot Exam)</td>
<td>EMR</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Heart Failure Composite* (LVF Screen, Patient Education, LVF &lt; 40 with Beta Blocker, LVF &lt; 40 with ACE/ARB, Afib on Warfarin)</td>
<td>EMR</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>CAD Composite* (Antiplatelet, Lipid-lowering, Beta-Blocker following MI, LDL Screening, LVF &lt; 40 with ACE/ARB)</td>
<td>EMR</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>COPD* Composite (Spirometry, Smoking Cessation Counseling, Bronchodilator Therapy)</td>
<td>EMR</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>Hypertension* (Blood Pressure Check, Document Plan of Care)</td>
<td>EMR</td>
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<tr>
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<tr>
<td>ER Utilization</td>
<td>Ambulatory Sensitive Care ER Visits / 1000</td>
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## Tracking Measures (Total = 11)

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Benchmarks

- Work to date is on going.
  - National norms
  - Best practice - external
  - Best practice - internal
Thank you

Questions?????