

## Health Care Homes Outcomes Measurement Workgroup

### *Summary of Meeting Minutes*

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Topic	Recommendation Discussion	Action
<b>Population-based Measurement</b>	<p>The Workgroup broke into 4 groups answering one or more of the following questions:</p> <ul style="list-style-type: none"> <li>❖ What does clinic population-based measurement mean?</li> <li>❖ What about population-based measurement and those patients who do not have a payment source for health care home services?</li> <li>❖ How do you define clinic population-based measurement on patients who receive their care intermittently or leave the practice?</li> <li>❖ How does this work when only individual clinicians or departments are certified?</li> </ul> <p>Responses from the groups:</p> <p>Group #1</p> <ol style="list-style-type: none"> <li>1. Population-based measurement is an ideal; define it as broadly as possible and stratify the data by collecting information on a defined population.</li> <li>2. Peer grouping, a method for comparing health care providers based on a combination of risk-adjusted cost and quality was discussed.</li> <li>3. Big systems use attribution to primary care provider. Attribution right now is a passive process. We need to make it an active process. Patients need to take an active role and choose to participate in a health care home.</li> <li>4. Creating a health care home may be difficult for a single practitioner.</li> <li>5. There may be a measure needed for patient experience.</li> </ol> <p>Group #2</p> <ol style="list-style-type: none"> <li>1. There were different opinions in the group about what the denominator should be, with some people believing that population based measurement should be health care home patients only and others believing that is should be the total clinic population.</li> <li>2. There is concern about excluding patient populations; what about people who do not have a clinical condition?</li> <li>3. The group discussed whether the services of HCH would be offered irrespective of a payment source.</li> <li>4. Clinics are going to need to alter the way they offer services.</li> </ol> <p>Group #3</p> <ol style="list-style-type: none"> <li>1. The whole clinic population needs to be measured. If we only measure those who are eligible for</li> </ol>	

	<p>HCH and opt in, we risk bias to the data.</p> <ol style="list-style-type: none"> <li>2. Systems will change due to HCH.</li> <li>3. Look at risk adjustment and how that fits in.</li> <li>4. The group urged caution when setting up the criteria for the denominator so not to exclude people who are mobile or diverse.</li> <li>5. It will be very difficult for an individual clinician to do this because of the systems that are needed.</li> </ol> <p>Group #4</p> <ol style="list-style-type: none"> <li>1. Is the population everyone in clinic or just health care home? Those getting care coordination vs everyone getting care from provider. As with group #1, this group discussed the total population and the stratification of data.</li> <li>2. What can we learn about those patients who decline or accept and are “non-compliant”, how can we learn about them? How is “family-centered” care measured in the population? How do we integrate family?</li> <li>3. How about patients without enough money or a payment source? This is sometimes intermittent and it makes it difficult to care for them. The poor and other groups may be over represented in this category.</li> </ol>	
<p><b>HCH Outcome Measurement System</b></p>	<p>The Workgroup broke into 3 groups answering one or more of the following questions:</p> <ol style="list-style-type: none"> <li>1. Cycle of ANNOUNCING and reporting for outcomes measurement. We need to announce outcomes measures at least annually. When do we announce our first measures? How many measures per year. How do measures trend over the years? Do we sunset measures? How many measures in year one, year two? How do new certified clinics get started with outcomes measures?</li> <li>2. How are we going to make outcomes measures decisions? Do we use current measures, national measures, develop measures? How will we use the work of ICSI related to cost, quality and patient experience? Where do process / system measures fit in? How does the work of the quality measurement system fit in with HCH?</li> <li>3. What type of risk adjustment methodology will we use for outcomes? The same as the payment methodology? Data element examples: what they would be, how are they currently collected, how would they be reported?</li> </ol> <p>Responses from the groups:</p> <p>Group #1</p> <ol style="list-style-type: none"> <li>1. The group recommended announcing first set of measures in January 2010.</li> <li>2. How many measures for Year 1? The group had 2 ideas: 1) choose one pediatric and one adult measure for each of the triple aims for all clinics; 2) Offer 2 measures (2 for peds and 2 for adults) for each of the 3 aims and let the clinic choose 1 for each aim. How many measures for Year 2? The group would encourage tracking Year 1 items and adding an additional measure for each aim in Year 2.</li> <li>3. How do measures trend over years? The group recommends basing the trending on some type of threshold measures (90%, 95%?) vs. a set number of years.</li> <li>4. Measures that have reached a threshold by majority of cohort could be sunset; but we recommend</li> </ol>	

	<p>spot-checking so clinics do not slide backwards on important outcomes. We could apply the sunset principle across the entire population of HCH.</p> <ol style="list-style-type: none"> <li>5. Clinics need some idea of quality measures as they begin to design HCH processes. The clinics will be at different phases of HCH certification and have different timelines.</li> </ol> <p>Group #2</p> <ol style="list-style-type: none"> <li>5. The recommended criteria for making outcomes measures decisions: feasibility, reliability, validity, cannot be over burdensome, patient engagement, and “medical homeness”.</li> <li>6. The group recommended that all measures need to be considered. We should not stay with the status quo and recognize that it may take at least a year to report.</li> <li>7. The group reported that the process and system measures should be measured and be concrete.</li> </ol> <p>Group #3</p> <ol style="list-style-type: none"> <li>6. The group suggested we look at multiple audiences for the type of risk adjustment- outcomes and payment. We need to look at the implications for outcomes by taking into account institutional disparity and whether or not a clinic has the ability to report data.</li> <li>7. In determining the data elements, we should consider: a limit in number, administration feasibility; credible/face validity, follow the 80-20 rule.</li> <li>8. The diagnosis data element should have a diagnosis mix, assuming the focus is on improving consistency of reporting including mental health and social support.</li> <li>9. Additional data elements include: communication access and language and readiness to change.</li> <li>10. The Opt In or Opt Out feature may be affected by the readiness to change.</li> </ol>	
<p><b>Measurement over time</b></p>	<p>The Workgroup broke into 3 groups to discuss the following topics:</p> <ol style="list-style-type: none"> <li>1. Measures and Benchmarking</li> <li>2. Variance for superior outcome improvement</li> <li>3. Assessing low performance on triple aim</li> </ol> <p>Responses from the groups:</p> <p><b>#1 Measures and Benchmarking</b></p> <p>Principles:</p> <ul style="list-style-type: none"> <li>• Set realistic and achievable targets that clinics can attain so that clinics will know there is progress</li> <li>• Bring along clinics that are not at the target so that clinics do not feel too defeated</li> <li>• Small improvement on an outcome –based composite measure is more impressive than a huge improvement on really make a difference, for more than a large increase on a process measure.</li> <li>• Educate stakeholders (i.e. legislature)</li> </ul> <p>Recommendations:</p> <p>Add additional pediatric measures, i.e. immunizations, URI, asthma</p> <ul style="list-style-type: none"> <li>• Identify measures that are already being collected</li> <li>• Ensure that the measures support health care home activity</li> <li>• Submission is to one location and easy</li> <li>• Quality reporting data is for all clinics</li> <li>• Technical team to determine benchmarks; Clinics must meet the target or some %</li> </ul> <p>❖ Year 1: function as health care homes track and report on current quality measures</p>	

- ❖ Quality team reports on their own measures
- ❖ Year 2: did they meet the % of progress, each measure has a body of knowledge that needs to be addressed by the technical team

## #2 Variance for Superior Outcome Improvement

Principle:

- Only do something innovative if quality measures are at a certain level.
- Add overuse as example such as pap smear or antibiotic use

Recommendations:

- An improvement in 2 out of 3 areas of triple aim; one must be a health quality measure and no decrease in the 3<sup>rd</sup> triple aim goal.
  1. Peak % based on baseline
    - Peak increase in % based on percentage point improvement without a decline (some stability in peak/tolerance)
  2. Consistently meeting benchmarks on a schedule of increments over a defined time period.
  3. Evaluation of systems, process measures need consideration
  4. Consideration of innovative work/measures outside of the announced outcomes, i.e. advance directive %; work of the quality team
  5. Patient experience is key into priority area for outcome; establish a goal point, such as measures around shared decision making
  6. Cost effectiveness, such as readmissions, ER visits, high tech imaging, use same indicators

## #3 Assessing low performance on triple aim

1. Find out what is wrong:

- Complete a risk assessment, assess for special causes- adaptive reserve or type of patients- low literacy, etc  
We might find a consistent percentage of those patients that are not engaged and we need to acknowledge. Error on the side to try to acknowledge, we work it out for patients.
- Conduct data validation through a chart review audit- challenge the data

2. Develop a remediation plan

- Technology problem
- Capacity - resources
- Adaptive capacity- do they have the right leadership?

3. Timeline

### Re-certification:

12 months - data collection and review only

18 months – data evaluation; mandatory participation

### Provisional Certification:

24 months - formal assessment process; 6 month remediation, repeat one time

36 months – council review and if no improvement, would lose certification

**Brainstorm on Public Reporting**

We need to present HCH outcomes to the public:

- Internal in clinic
- Local level
- Community-wide
- State-wide
- Get info to providers

One stop shop that everyone uses, like the health reform website  
For both consumers and providers, multiple languages, literacy level

What is the purpose in having consumers review this knowing that consumer engagement is a long term education process

- Same point for legislatures & decision makers
- Understandable
- Challenge to train people
- Listen to consumer panels

Patients would care about the pt experience and focus in on what is important to patients.  
What you can expect in a health care home, explain things in a way I can understand

- We need educate on why consumers should look at this info
- Patients trust the clinician
- We would like a fully engaged patient population in there health care