

# **Health Care Homes Outcomes Measurement Work Group Recommendation Process**

The Health Care Homes (HCH) Outcomes Measurement Advisory Work Group began meeting in August 2009. The purpose of this work group is to recommend a decision-making process for measuring health care home improvement in the areas of patient health, patient experience and cost-effectiveness and to recommend measures to the Commissioners of Health and Human Services for HCH. The Advisory Work Group formulated recommendations for the decision making structure based on the health care home rule. A technical group was formed to review the recommendations and address identified issues raised in the work group.

This document focuses on the following areas of the HCH rule: population measurement, risk adjustment for outcomes measures and measurement over time. For each area there is a short description of the topic, recommendations from the Advisory Work Group and additional recommendations if needed from the technical group.

## **I. Population-Based Measurement (4764.0040 Subp. 3 A; Subp. 11 B)**

Population health is the measurement of the state of health of a group of persons defined by geographic location, organizational affiliation or non-clinical characteristics (NCQA). The health care home is responsible for the management of the certified HCH patient population.

### **Work Group Recommendations:**

1. Measurement of the HCH outcomes should be based on the **entire patient population of a certified HCH**. The data should be stratified by payer mix, patient need for care coordination and/or patient participation in care coordination.

- a) Certified health care homes should identify patients by stratified data using the payment methodology risk tiers:

- Panel management: Risk Tier 0
- Care coordination accepted: Risk Tiers 1-4
- Care coordination declined: Risk Tiers 1-4

- b) Additional data stratification will be collected for HCH recertification

At HCH recertification for the 2<sup>nd</sup> year, the certified HCH patient population should be stratified not only by health insurance status, but also, gender, age, race/ethnicity, primary language, and socio economic status (SES) to address patient-centeredness and meet the requirement of the HCH rule (4764.0040 Subp 11 A) and HCH legislation (256B.0751 Subd. 6 and 256B.0752 Subd 2) thus evaluating the impact of HCH on health care quality and outcomes. Although some of the data will need to be collected only once (e.g. race/ethnicity, gender, birth date) some of the information will need to be collected annually (e.g., SES, insurance status).

## **II. Outcome Measurement System (4764.0040 Subp. 10 A)**

The health care home outcome data collection system is the operational structure in which the outcome measures are identified, tracked, analyzed and reported. The health care homes certification program strives to achieve the goals of the Institute for Healthcare Improvement's Triple Aim: 1) improvement in patient health; 2) quality of patient experience; and 3) measures related to cost-effectiveness of services (4764.0040 Subp. 10 B).

### **Work Group Recommendations:**

**1. The process of HCH measurement should seek to minimize the administrative burden on clinics by prioritizing measures, using MNMCM data collection methodologies, allowing measures to be retired (dropped) when benchmarks are achieved and sustained, and keeping brand new measures to a minimum.**

- a. The initial HCH measures recommended are a "starter set" that is to be continually refined as new evidence emerges on health care homes. Process and structural measures (i.e. ICSI HCH Outcomes Report measures) need to be considered.
- b. To the extent possible, the HCH measurement should be integrated and aligned with other clinic outcome reporting requirements, such as MN Statewide Quality Reporting and Measurement System, Provider Peer Grouping, others.
- c. The data collection and audit process for the recommended measures should be simple (e.g., submission to one location) and straight forward.
- d. The HCH outcome measures that have been fully achieved and sustained by a majority of certified HCH clinicians or clinics should be retired with the ability to conduct subsequent periodic auditing of those measures. For example, if 95% of the certified HCHs have met an immunization measure, this measure would not be reported to the HCH data collection system. The HCH certification team would have the ability to conduct periodic auditing of this measure. The Technical Group will be charged to recommend an achievement threshold.
- e. In order to measure the success of HCH, new measures will be needed. Care coordination plays a pivotal role in the quality of a HCH and thus provides the clinic a point of veracity to measure the HCH's success. An example of a new system's measurement would be "Care Coordination" where the quality of care coordination is based on identified factors.

**2. The HCH measures should be based on the following criteria:**

- **Relevance and meaningfulness to health care home goals:** Does the measure evaluate or capture meaningful features of health care homes (e.g. care coordination, patient-centered decision-making, etc.)? Is the measure easily interpreted, will the measure stimulate internal efforts toward quality improvement?
- **Scientifically acceptable and usable:** What is the strength of the evidence supporting the measure? Is the measure reliable, valid, and accurate?
- **Feasibility:** Does the measure have clear specifications for data sources and methods for data collection and reporting? Is the data available? Is the measure susceptible to manipulation or "gaming" that would be undetectable in an audit?

3. A HCH outcomes technical team should be established to recommend the specific HCH measures.
- Two patient health quality measures are recommended: optimal asthma care and optimal vascular care.
  - The use of the CG-CAHPS survey tool is recommended. HCHs should recommend to AHRQ-CAHPS suggestions for modifications that will measure HCH standards.
  - Cost effectiveness measures should focus on population-based health measures (e.g., avoidable re-admissions, ER visits, and hospitalizations). In future years population measures will be considered such as functional measures that would capture preventing disease, ability to improve optimal well being, etc.

**Measures (4764.0040 Subp. 10 B 1-3)**

The Health Care Homes Outcomes Measurement Technical Team considered a number of issues related to the overall quality component of Minnesota’s Health Care Homes Certification Program. The Health Care Homes legislation requires the HCH standards to incorporate measures of 1) improvement in patient health; 2) quality of patient experience; and 3) measures related to cost-effectiveness of services.

**Selection of patient health measures (clinical):**

The technical group has recommended two clinical quality measures: asthma care and vascular care. Family practice clinicians or clinics serve both adults and pediatrics and must report on the two measures. Pediatric clinics will most likely select and measure asthma care and internal medicine clinics will most likely select and measure vascular care. Both of these measures are required for direct data submission to MN Community Measurement via the MN Statewide Quality Reporting and Measurement System. Both measures are an “optimal care” measure and are a “composite all-or-none” measure in which *all* components of the measure must be met for the patient to be considered optimally managed.

**Recommendation for Patient Health Measures (4764.0040 Subp. 10 B.2):**

**Optimal Asthma Care (OAC)**

A composite measure of the percentage of patients who have asthma. Optimal Asthma Care is defined as:

1. Asthma is well controlled
2. Patient is not at increased risk of exacerbations
3. Patient has a current written asthma action/management plan

**Optimal Vascular Care (OVC)**

A composite measure of the percentage of adult patients with vascular disease. Optimal vascular care is defined as patients who reached all four treatment goals to reduce modifiable risk factors. These include:

1. Low-Density Lipoprotein (LDL) cholesterol (less than 100 mg/dl)
2. Blood pressure control (less than 130/80 mm Hg)
3. Daily aspirin use as appropriate
4. Documented tobacco free

The technical group underwent an expedited process for choosing these measures for the certified HCH applicants. The team reviewed a summary document of the current and potential measures that MN medical groups report. These standardized measures have been vetted through national organizations. They are suitable for accountability, are derived from all data sources, are fully developed and precisely specified, and are fully open sources.

Overall the recommended conditions were selected because they impact a cross section of patient and payer populations, they have high prevalence rates, they require a level of care coordination and a care plan, they have high variability in cost among providers and they are either identical or similar to other measures that the clinics report. The following is a summary of the discussion of the criteria:

- Condition represents a significant public health issue or a high impact clinical condition.
- Potential of savings through a reduction in avoidable ER visits and hospitalizations.
- Care will be supported by partnerships among various members of the health care team (e.g., primary care clinician [MD, NP, PA], RN, care coordinator, medical assistant, specialists).
- There is an opportunity for greater coordination of care by diverse health care disciplines (e.g., pharmacy, home care, mental health, cardiac rehabilitation, nurse educators, health educators, dieticians).
- There is an opportunity for community partnerships for care coordination and resources (e.g., specific sites [schools, home schools, center-based child care, family day care, and summer camps], WIC, food stamps and community-based organization services [health care navigation with a CHW, counseling, health education workshops, case management, and fitness], etc).

**Selection of patient experience measure:**

Patient experience with care is a patient-centered survey measure that obtains information from patients about the process of obtaining care from a specific clinician. Patient experience measures obtain information about specific and clinically relevant aspects of the care process.

**Recommendation for Patient Experience Measure (4764.0040 Subp. 10 B.2):**

- 1. Implement one survey (e.g. CG-CAHPS) tool statewide to measure patient experience.**
- 2. Recommend to national organizations such as NCQA and AHRQ-CAHPS additional domains/questions that will both enhance the quality of the survey and measure MN HCH domains.**

## **CG-CAHPS Survey**

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician and Group Survey is a relatively new instrument developed to capture patient experience with care at the provider level. The instrument was developed by AHRQ through a process that included extensive cognitive and field testing.

### **Benefits**

More and more clinics are utilizing the CG-CAHPS survey instrument nationwide. In addition, the Minnesota Statewide Reporting System (MN Statute § 62U.02, Subd. 2) has recommended this survey instrument and the Patient Experience Evaluation Committee for the national PC-PCC demonstration group. CG-CAHPS provides comparative survey results and national benchmarking. Clinics are also able to do internal benchmarking.

The CG-CAHPS survey builds on more than 10 years of extensive and application of the CAHPS Health Plan survey. The questions have been extensively field tested and are valid and reliable measures of patients' experience with care.

### **Limitations**

The work group reviewed the CG-CAHPS survey questions and recommended supplemental medical home questions that may lend its use to measuring health care home domains and the underlying principle of patient and family centered care. The following gaps were identified which are integral in the HCH standards of Access and Communication, Care Coordination and Care Plan: a focus on patient and family centered care in the CG-CAHPS domains of whole person orientation, care coordination, shared decision making and chronic disease management/self management. The MN Shared Decision Making Collaborative Measurement Committee is studying and testing a set of Shared Decision Making questions that would supplement the CG- CAHPS survey.

Another limitation is the CG-CAHPS survey questions are asked about "your doctor" which may be confusing to those who receive care from an NP or PA. Efforts are underway at MNCM and at national organizations such as AHRQ to amend CAHPS language to make it more provider inclusive.

### **Selection of cost-effectiveness measure:**

Cost effectiveness of care is another outcome that is to be measured for Health Care Homes. There are other elements of the State's health reform initiative that address cost of care performance of physician practices that may serve this purpose as well.

#### **Recommendation for Cost - Effectiveness Measure (4764.0040 Subp. 10 B.2):**

- 1. Cost-effectiveness measures should focus on population-based health measures (e.g., ER visits and unscheduled hospitalizations)**
- 2. Cost-effectiveness of care measures should be aligned to the greatest extent possible with other elements of the State's health reform initiatives that measure cost of care (i.e. Peer Grouping).**

The most relevant such initiative is the Peer Grouping initiative which will be begin publically reporting quality and cross-payer (Medicaid, commercial, and Medicare) cost of care performance for every physician practice in the state beginning in 2010 (possibly 2011)..

There will be two types of cost-of-care measures used in the peer grouping initiative. One is a risk adjusted total annual cost of care measure for each patient that can be attributed to the physician practice based on the volume of primary care provided using a post hoc attribution method. The second cost of care measure will be episodes of care costs for approximately four chronic conditions yet to be determined in which the costs are for the treatment of the identified condition only. While the total cost of care measure is more useful as an HCH outcome measure, the condition-specific measures may have utility as well.

The peer grouping data set will include flags that identify which practices are health care homes and patients. This flag may allow for the cost analyses to be aggregated to the HCH with much less ambiguity about both the unit of cost performance (e.g. clinic site) and the attribution of patients to the clinic sight than for non-HCHs. This opportunity will need to be further explored.

Minnesota Community Measurement is working on developing a hospital readmission measure and the measure specifications for it that may be used as a cost effectiveness measure for HCH.

**Selection of additional health care home measures (4764.0040 Subp. 10 C; Subp. 11 A):**

The HCH measurement system should include measures that evaluate the comprehensiveness of a health care home.

**Recommendation for additional health care home measures (4764.0040 Subp. 10 C; Subp. 11 A):**

- 1. Develop a new Health Care Home composite measure which includes cross cutting measures (e.g., care coordination) that support the Health Care Homes standards.**
- 2. Identify or create a Health Care Home survey that measures certified health care homes systems and care processes.**

These measures would be used to evaluate the success of the clinician or clinic in meeting the HCH standards and criteria for re-certification. The standards include: 1) Access; 2) Patient Registry and Tracking; 3) Care Coordination; 4) Care Plans; 5) Performance Reporting and Quality Improvement.

### **III. Measurement over time (4764.0030 Subp. 6. Benchmarks)**

The purpose of benchmarking is to identify areas where improvements are required in performance and then monitor whether changes are effective. Benchmarking must be a team process because the outcome will involve changing current processes and practices.

The HCH rules state that the commissioner must announce benchmarks for patient health, patient experience, and cost-effectiveness annually. The benchmarks must be based on one or more of the following factors: A) an improvement over time as reflected by a comparison of data measuring quality submitted by the health care home in the current year to data submitted in prior years; B) a comparison of data measuring quality submitted by the health care home to data submitted by other health care homes; C) standards established by state or federal law; D) best practices recommended by a scientifically based outcomes development organization; E) measures established by a national accrediting body or professional association; F) additional measures that improve the quality or enhance the use of data currently being collected.

#### **Work Group Recommendations:**

1. A HCH outcomes technical team should advise the work group on benchmarks utilizing the HCH rule on benchmarking.
  - a. The benchmark will be a percentage improvement by comparing the data submitted measuring the patient outcomes and patient experience from Year 1 to Year 2 of certification.
2. The measures should be trended over time based on a recommended threshold instead of a set number of years of data collection.
3. The measure results should be evaluated annually on a recommended target or the percent of progress gained within components of the composite measure.

### **IV. Variance for Superior Outcome Improvement (4764.0050 Subp. 3)**

According to the HCH rules, the commissioner must annually announce the benchmarks for superior achievement. To receive a variance, the certified clinician or clinic must demonstrate that they have met or surpassed the benchmarks for superior achievement in outcomes related to patient health, patient experience, and cost-effectiveness, as reflected in the data submitted to the HCH quality reporting system.

#### **Work Group Recommendations:**

1. The clinician or applicant must show a statistically significant improvement in the health quality measure and in either the patient experience or cost-effectiveness measures (show improvement in 2 of the 3 measurement categories). Additionally, there should be no decrease in the 3<sup>rd</sup> outcome area.
2. The clinician or clinic's data results must show:
  - a defined (to be recommended by the Technical Group) percentage of change from baseline.
  - positive trending annual measurement results over time.
  - announced benchmarks are consistently being met

## **V. Assessing low performance on triple aim measures (4764.0050 Subp. 5):**

According to the HCH rules, the commissioner may grant a variance to a health care home seeking recertification that fails to show measureable improvement, if the clinician or clinic demonstrates the following: A) reasonable justification for the applicant's inability to show required measureable improvement; and B) a plan to achieve measurable improvement in the following year or a shorter time period.

### **Work Group Recommendation:**

The following process is recommended:

1. MDH assesses applicant's justification:
  - Applicant needs to justify population-based reasons for not showing improvement. To justify the reason, the applicant will complete a risk assessment that examines institutional disparities (e.g., special causes such as adaptive reserve or type of patients, low literacy, etc).
  - Data validation is conducted through an audit (e.g. chart audit, ED visits, costs of care, patient experience, coordination of efforts, etc).
2. The applicant develops a remediation plan based on assessment results. The plan could focus on improving technology, building capacity and resources, or developing leadership.
3. A remediation plan timeline is developed that has been mutually agreed upon between applicant and MDH.

## **VI. Other**

### **Title for this Work Group:**

While outcomes are the most important, it may be essential to include process and structural measures, e.g. number of calls to patients, presence of adequate care plans, etc. We need to have markers of clinic efforts to take coordination seriously. Prior recommendations have suggested we include process and structural measures, not just outcome measures.

### **Recommendation:**

MDH should change the name of the HCH Outcomes Measurement Work Group to the HCH Performance Measurement Work Group.