

MAKING HEALTH REFORM WORK
The Role of
Regional Health Improvement Collaboratives
in Achieving the Triple Aim

Purpose of Today's Discussion

- Share successes that Regional Health Improvement Collaboratives are having in improving the value of care
- Discuss Opportunities for National/Regional collaboration to increase our impact on the triple aim

Overview

- The Role of RHICs
- Successes and Lessons Learned in Three Regions
- Opportunities for National Regional Collaboration and the role of the NRI work group

Harold Miller

Chris Queram

Marc Bennett

Jim Chase

Discussion

National Goal: Better, More Affordable Care

TRIPLE AIM

- Improving Health
- Improving Quality of Care
- Reducing Costs

What's Needed to Make It Happen at the Local Level?

TRIPLE AIM

- Improving Health
- Improving Quality of Care
- Reducing Costs

People Need to Know Where The Opportunities To Improve Are

**Quality/Cost
Analysis &
Reporting**

TRIPLE AIM

- Improving Health
- Improving Quality of Care
- Reducing Costs

Providers Need to Change the Way They Deliver Care

**Quality/Cost
Analysis &
Reporting**

TRIPLE AIM

- Improving Health
- Improving Quality of Care
- Reducing Costs

**Value-Driven
Delivery Systems**

Payment & Benefit Systems Need to Support Higher-Value Care

**Quality/Cost
Analysis &
Reporting**

TRIPLE AIM

- Improving Health
- Improving Quality of Care
- Reducing Costs

**Value-Driven
Payment Systems
& Benefit Designs**

**Value-Driven
Delivery Systems**

And Patients Need to Be Educated and Engaged

**Patient
Education &
Engagement**

**Quality/Cost
Analysis &
Reporting**

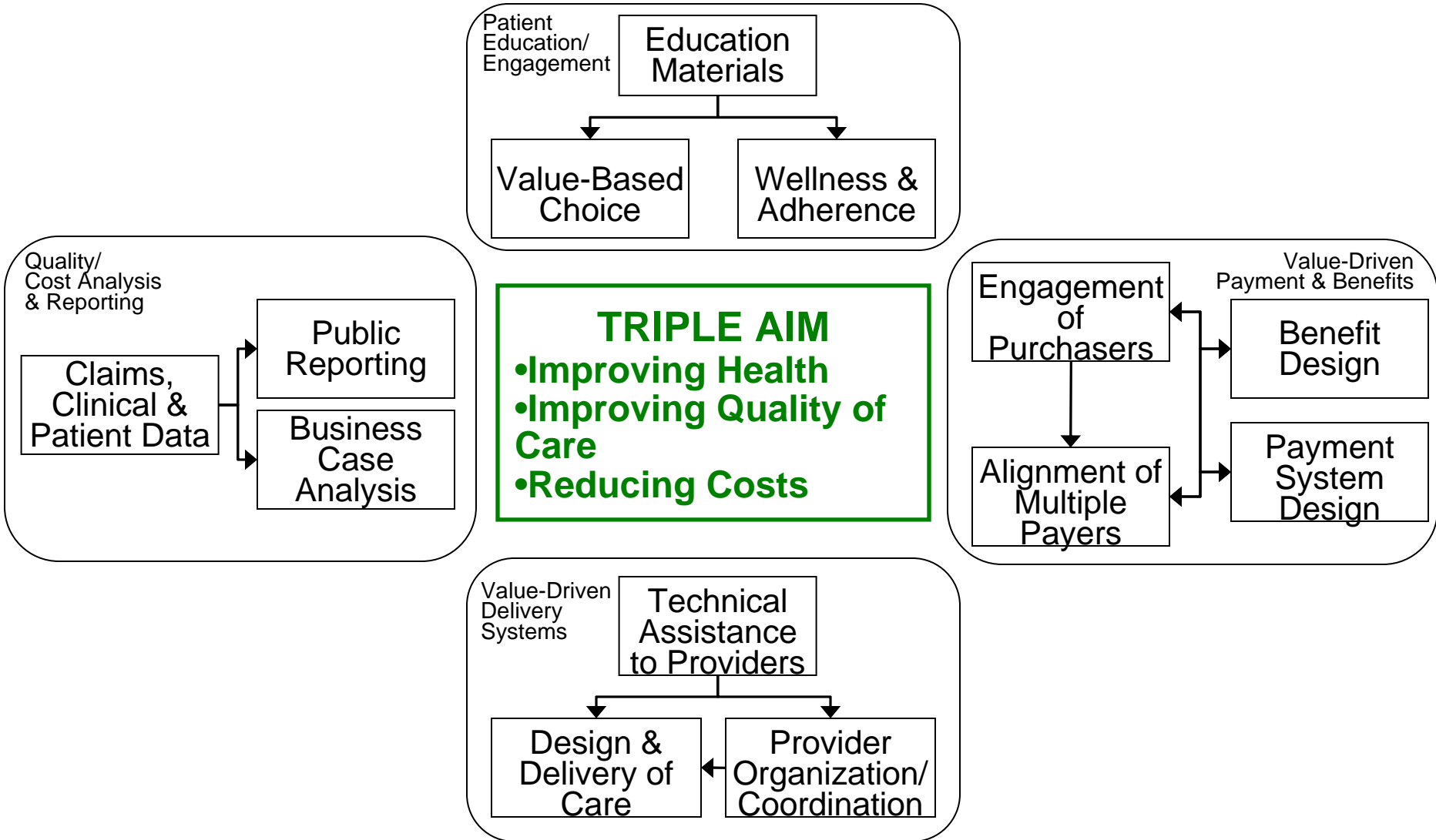
TRIPLE AIM

- Improving Health
- Improving Quality of Care
- Reducing Costs

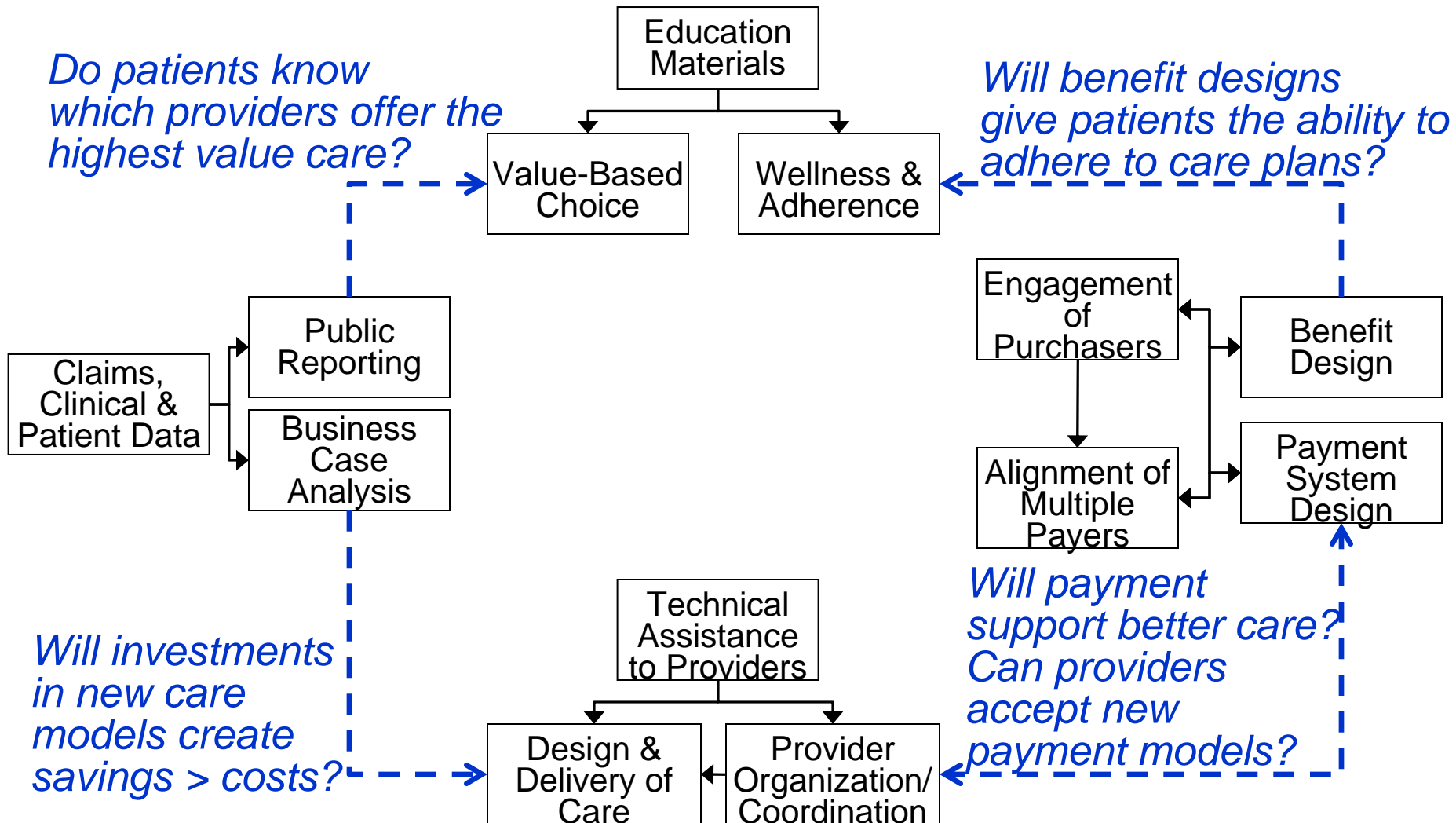
**Value-Driven
Payment Systems
& Benefit Designs**

**Value-Driven
Delivery Systems**

Many Specific, Complex Tasks Within Each Function



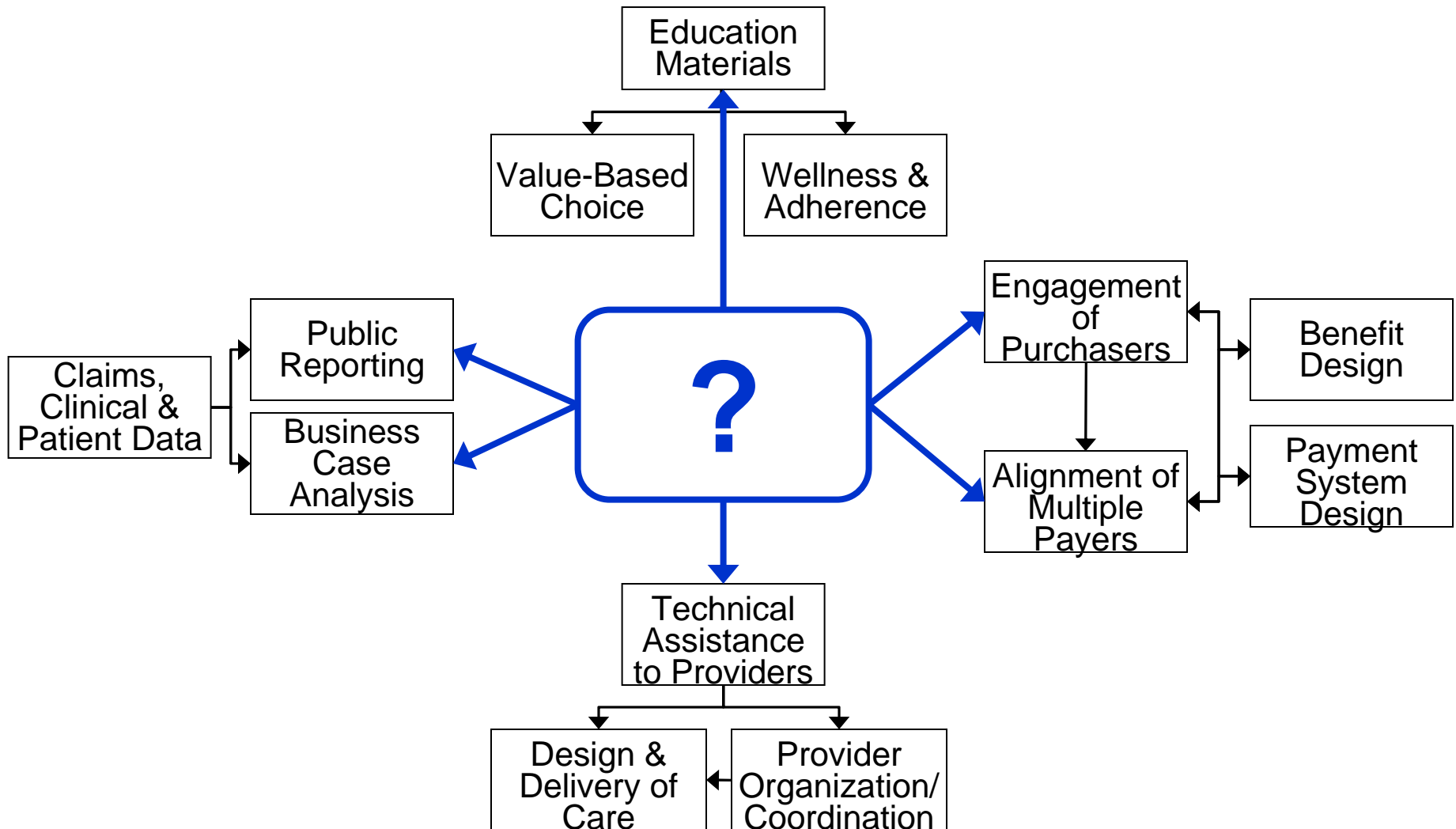
All Functions Need to Be Coordinated



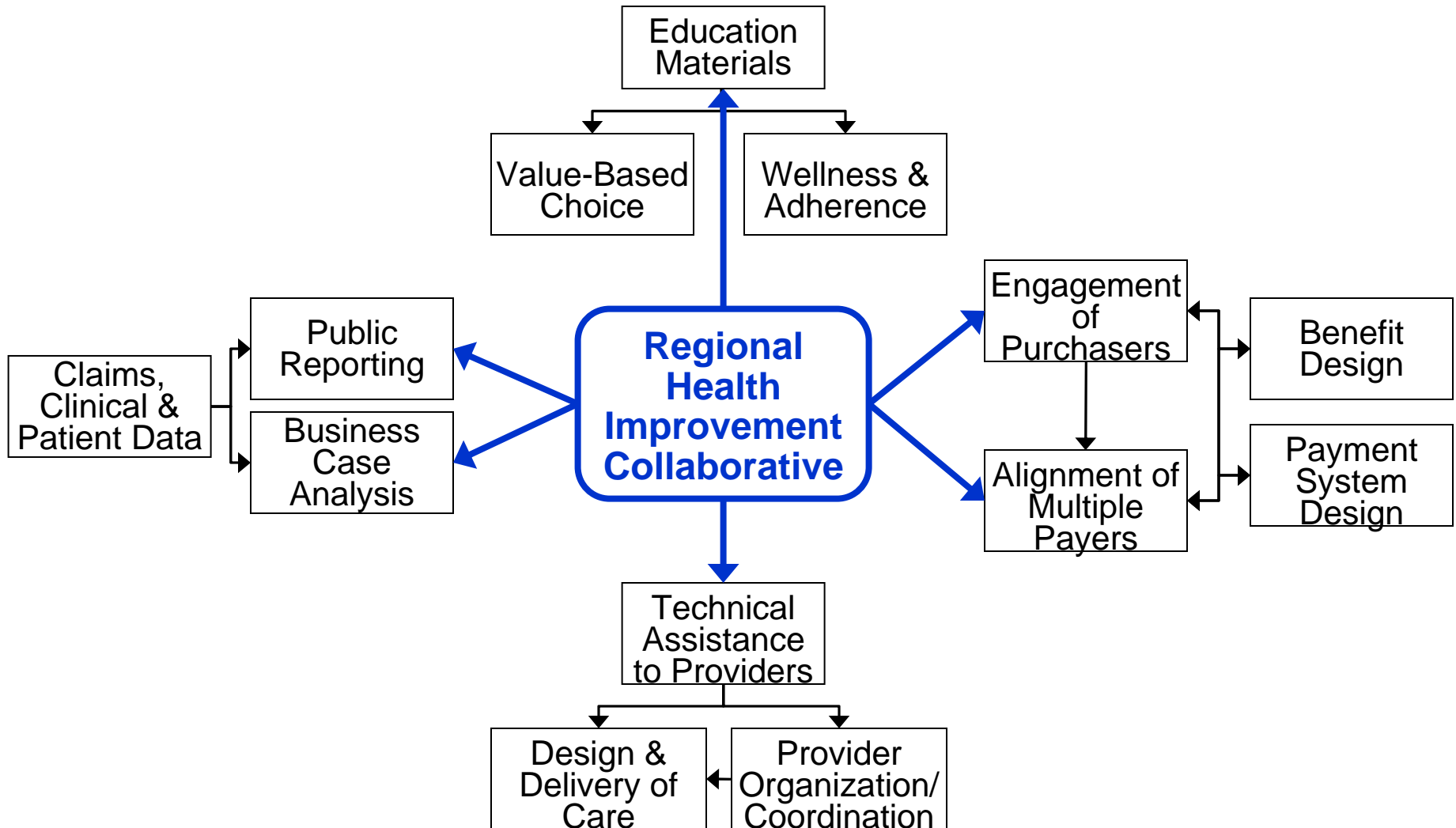
E.g., Comprehensive Approach to Readmission Reduction

- **Analyze data on readmissions to identify which types of patients are being readmitted at high volumes/rates**
- **Analyze and redesign current healthcare delivery system**
 - Which physician practices are caring for the patients, both in the hospital and in the community?
 - How can care processes in the hospital and in physician practices be redesigned to prevent ER visits & hospitalizations?
 - What is the most cost-effective way to provide care management support for patients – hospital? PCP? Home health?
- **Establish business case for improvement**
 - What reductions in readmission rates are needed to justify higher expenditures on care management and other services?
- **Change payment systems and benefit designs**
- **Provide coaching to providers**
- **Provide education and support for patients**
- **Analyze real-time data for continuous improvement**

How Can All These Functions Be Delivered in a Coordinated Way?

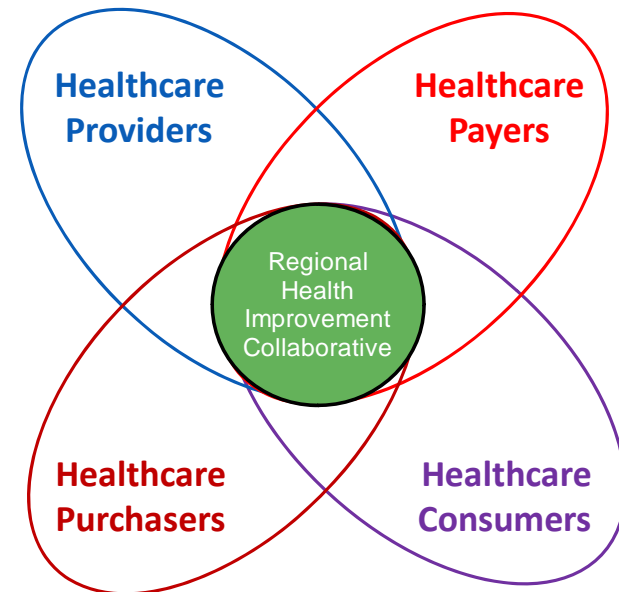


The Role of Regional Health Improvement Collaboratives

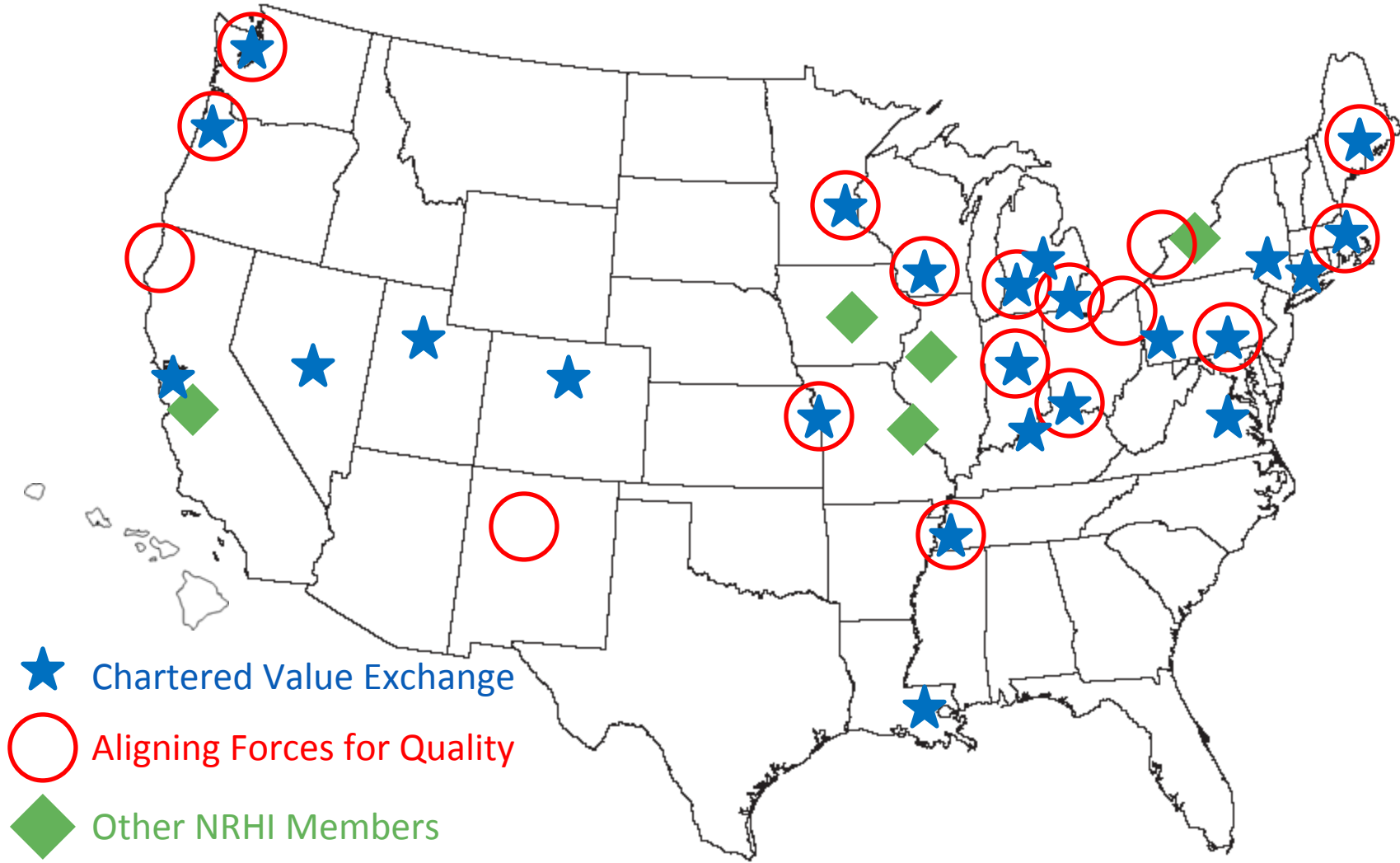


What is a "Regional Health Improvement Collaborative"?

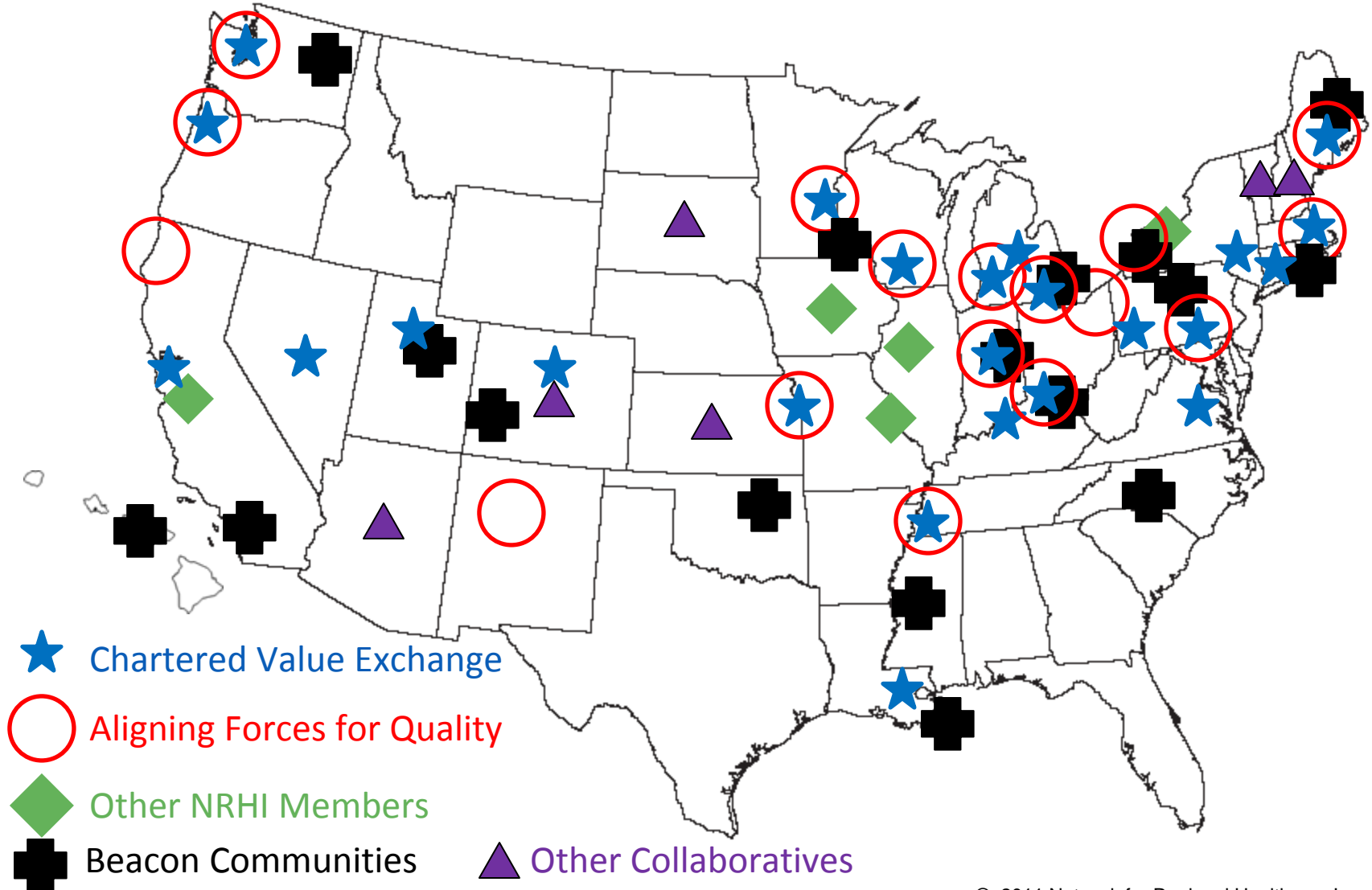
- A ***non-profit*** organization
- Working to ***improve healthcare quality and value***
- ***In a specific geographic region*** of the country (typically a metropolitan area or state)
- Through a ***collaborative effort of all healthcare stakeholders***
 - ***Providers***
 - ***Purchasers***
 - ***Payers***
 - ***Patients***



Growing Network of Regional Collaboratives in U.S.



With Opportunities to Expand Through Beacon & Others



Examples of Regional Collaborative Programs

Wide Range of Public Reporting Through Collaboratives

Process Measures

Quality Quest for Health of Illinois
Transforming Healthcare—Together.

Best Care Index for Colonoscopies (Q3 2009 - Q2 2010): [High to Low]

myCARE COMPARE.org
Southeast Michigan Health Care Performance Reports

| Hospital Name | City |
|--|--------|
| Eliathamby Kuganeswaran, MD Illinois Gastroenterology Institute (1001 Main St, Ste 500A) | Peoria |
| Victor Lawrinenko, MD OSF Gastroenterology (2805 N Knoxville Ave) | Peoria |
| Keremeth Camacho Illinois Gastroenterology Institute (1001 Main St, Ste 500A) | Peoria |
| Wasim Elahi, MD Illinois Gastroenterology Institute (1001 Main St, Ste 500A) | Peoria |
| Frank Adams, MD OSF Gastroenterology (2805 N Knoxville Ave) | Peoria |

Report on Hospital Performance
with Wayne County
Search: 1 | Select Hospital

| Name | Heart Attack | Children's Safety | Heart Failure | Pneumonia | Infection (UTI) | Stroke | Surgical Infection |
|---|--------------|-------------------|---------------|-----------|-----------------|--------|--------------------|
| Beaumont Hospital, Gross Pointe | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Children's Hospital of Michigan | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Detroit Receiving Hospital & Academic Health Center | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Steklen City Hospital, Okemos | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Henry Ford Health System | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Henry Ford Dearborn Hospital | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Henry Ford Westland Hospital | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Integrative Cancer Center | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Delaware Memorial Hospital | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Delaware Technical College | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Delaware Hospital & Medical Center | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

Outcome Measures

PSI 2
Patient Safety Indicator

Death in Low Mortality DRGs

This patient safety indicator measures the approximate death rate for patients with health problems that rarely result in death. Patients who are diagnosed with health problems that rarely result in death belong to "low-mortality (death) DRGs (Diagnosis-related Groups)" medical categories. Lower rates for this measure are better.

| City | Hospital Name |
|------------|----------------------------------|
| Albia | Monroe County Hospital |
| Algona | Kossuth Regional Health Center |
| Ames | Mary Greeley Medical Center |
| Anamosa | Jones Regional Medical Center |
| Atlantic | Cass County Memorial Hospital |
| Audubon | Audubon County Memorial Hospital |
| Belmond | Belmond Medical Center |
| Bettendorf | Trinity at Terrace Park |

WCHQ
Wisconsin Collaborative for Healthcare Quality

View Our Reports

Reporting Period: Q3 2009 - Q2 2010

| Organization | Rate |
|---|---------|
| Aurora Advanced Healthcare N-9736 | 19.36 % |
| Aurora Medical Group N-27577 | 23.87 % |
| Aurora UW Medical Group N-2074 | 17.60 % |
| Bellin Medical Group N-4429 | 25.38 % |
| Columbia St. Mary's Community Physicians N-7847 | 18.43 % |

Patient Experience

MHQP
MASSACHUSETTS HEALTH QUALITY PARTNERS
Invested information. Quality insights.

Celebrating 15 years of promoting quality health care

QUALITY INSIGHTS:
2009 PATIENT EXPERIENCES IN PRIMARY CARE

Doctors' Office Summary:
Care From Personal Doctors

click on the measure name to learn more information about the measure
click on the stars to learn about how patients answered each survey question

| Measure | Rating |
|--|--------|
| Doctors' Office | ★★★★★ |
| How Well Doctors Communicate with Patients | ★★★★★ |
| How Well Doctors Coordinate Care | ★★★★★ |
| How Well Doctors Know Their Patients | ★★★★★ |
| How Well Doctors Give Preventive Care and Advice | ★★★★★ |

423 Associates (Adult Survey), Partners Community Health Care (PCHI), Newton-Wellesley PHO, Inc.

Disparities

Better Health Greater Cleveland
An Alliance for Improved Health Care

How Are Our Practices Doing on Diabetes Standards?

Show Achievement by Insurance:
Medicaid [] update label

| Why isn't my practice listed? | Care Processes | Outcomes | # Patients |
|---|----------------|----------|------------|
| Regional Average | 34% | 29% | 2,348 |
| Electronic Medical Record (EMR) Systems Average | 43% | 29% | 1,749 |
| Deaconess Health Center | 38% | 25% | 181 |
| Brooklyn Medical Group | 31% | 18% | 65 |
| Deborah Health Center | 50% | 24% | 202 |
| Cleveland Clinic - Main Campus | 60% | 27% | 65 |
| Leo Harvard Health Center | 45% | 36% | 74 |

Cost of Care

MINNESOTA HealthScores
When Health Care Improves, Everyone Wins.

HOME OUR REPORTS

Endoscopy

Endoscopy to look at the upper part of the digestive system, with a biopsy of abnormal-looking areas

| Hospital | City | ZIP | Score | View Profile |
|------------------------|-----------|-------|----------|--------------|
| Gundersen Lutheran | La Crosse | 54601 | \$1090.0 | view profile |
| Mayo Clinic | Rochester | 55905 | \$969.0 | view profile |
| Mayo Health System | Rochester | 55905 | \$942.0 | view profile |
| Olmsted Medical Center | Rochester | 55904 | \$848.0 | view profile |
| Mankato Clinic, Ltd. | Mankato | 56002 | \$718.0 | view profile |

Collaboratives Overcome the Challenges to Public Reporting

- **Getting Access to Data**
 - Claims data from all payers
 - Clinical data from all providers
- **Ensuring Accuracy of Data**
 - Data cleaning
 - Provider review of data/draft measures
- **Building Provider Support for Reporting**
 - Engagement in choosing measures & presentation system
 - Ensuring validity/reliability of measures
- **Using Measures for Improvement**
 - Consumer friendly presentation of measures
 - Consistent use in payment systems
 - Assistance in performance improvement

Not Just “Measurement” But Use of Data for “Analysis”

- *Measurement* presumes we know what we’re looking for, that we know what’s desirable/achievable in all communities, and that we can legitimately rate/rank providers based on the measures
 - That’s a high standard, and it’s not surprising that we don’t have adequate measures in many important areas, particularly outcome measures
- *Analysis*, particularly *exploratory* analysis, presumes only that we believe there are opportunities to improve value, and that more work will be needed to determine what is achievable and cost-effective
 - Analysis needs to be done at the local level, with active engagement of providers and purchasers/payers

Example of Analysis to Support Improvement

PRHI Readmission Briefs

Brief I: Overview of Six Target Chronic Diseases

INTRODUCTION

As healthcare costs consume more and more of American resources, driven in large measure by the growing burden of chronic disease, both policy proposals and demonstration projects are exploring ways to improve care and to reduce costs. In many of these efforts, hospital readmission rates have become an important measure of both quality and costs. Not only are readmission rates extraordinarily high (in a recently-published estimate,¹ 17.6% of Medicare beneficiaries were readmitted within 30 days of discharge, resulting in \$15 billion in spending annually), but between 10% and 50% of readmissions are considered to be potentially avoidable.² Lastly, 30-day readmission rates have become important hospital financial metrics, as payers – most notably Medicare – are increasingly denying coverage without detailed medical justification for the readmission.

Using a readmission rate as a quality or cost measure, however, is not without shortcomings. There are numerous questions, for example, about the positive and negative impact on provider behavior of rewarding, penalizing and/or publishing readmission rates. The need for more information about the nature and characteristic of hospital readmissions is clear. The *PRHI Readmission Briefs* aim to add clarity to the debate by developing a series of reports that focus on the following questions:

1. What is the "right" time frame for defining a potentially avoidable readmission? For how many days past discharge is a readmission potentially preventable, and how does this vary by condition?
2. To what extent are readmissions likely to be related to an initial admission and to what extent does this vary across diagnoses?
3. To what extent are readmissions within the domain of hospital control?
4. Are there patterns of admissions and readmissions that can help clinicians flag, and then prevent, unnecessary hospitalizations?

Readmission Brief I begins with a comparative overview of admissions and readmissions to acute care hospitals in Southwestern Pennsylvania (SWPA) of patients with six key chronic conditions, between October 2007 and September 2008. Subsequent *Briefs* will focus in greater depth on specific chronic conditions, adding more detailed analyses about characteristics of both admissions and patients, including number of days between discharge and readmission, length of stay and hospital charges, as well as detailed analyses of diagnoses, patient demographics, severity of condition, presence and number of specific co-morbidities (including behavioral health co-morbidities), and patterns of patient admission, discharge and readmission over multiple hospitalizations.

METHODS

The report draws on hospital admissions data collected by the Pennsylvania Health Care Cost Containment Council (PHC4),³ an independent agency created by the Pennsylvania Legislature in 1986 with the mandate to collect a wide range of inpatient data, irrespective of payer or claims.⁴ PHC4 is one of the nation's more comprehensive sources of all-payer, inpatient data. The data for this study are drawn from a database of 408,925 all-cause admissions to 44 acute care facilities in the 11-counties of Southwestern Pennsylvania (SWPA).⁵

Admissions for patients with six target chronic conditions were identified using Medicare Severity Diagnostic Related Groups (MS-DRGs), which replaced DRGs on October 1, 2007. Like DRGs, MS-DRGs classify the reason for a hospitalization based on a series of principal and secondary diagnoses as well as procedure codes. In addition, unlike DRGs, MS-DRGs incorporate severity of the patient condition with codes that mark the presence of complications and comorbidities. This adjustment allows for enhanced payments to hospitals that care for sicker patients within the same MS-DRG. Hospitalizations for patients with the following chronic conditions will be the focus of this inquiry.



Spreading Quality,
Containing Costs.

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650 Smithfield St.
Suite 2400
Pittsburgh, PA 15222
Ph: 412-596-6700
Fax: 412-596-6701
www.nrhi.org

By:
Keith Kanel, MD
Susan Elster, PhD
Colleen Vrbic

Unlike the
Dartmouth Atlas,
the PHC4
database studied
all patients, not
just Medicare.

Pittsburgh Regional Health Initiative © June 2010

POTENTIALLY PREVENTABLE READMISSIONS

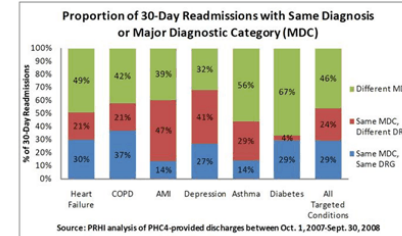
It is estimated that 10% of readmissions are "scheduled" – a figure we accept as plausible.⁹ Understanding what readmissions among the remaining 90% are potentially preventable requires, as an initial step, an assessment of which admissions are related to one another. Recognizing that there are complex methods for establishing such relationships,¹⁰ we, nevertheless, begin by identifying: (1) readmissions with the same MS-DRG as the index admission; and (2) readmissions for PHC4-defined complications or infections.

Reasons for Readmission

This section assumes that sequential admissions with the same diagnosis are more likely to be related to one another, and that some of these are likely to be unplanned and potentially preventable. For our purposes, a readmission was considered related to an index admission if any of the MS-DRG codes defining the condition were present on both. For example, COPD is defined using MS-DRG codes of 190-192; a readmission with MS-DRG 190 is considered related to an index admission with MS-DRG 191.

As shown in Figure 2, just over half of the 30-day readmissions for all targeted conditions are for the same major diagnostic category (MDC), although only 29% are for the same diagnosis. Specifically for asthma and diabetes, the majority of 30-day readmissions were for conditions *other than* the MDC registered on the index admission. Overall, more than 60% of 30-day readmissions for each condition are for a different diagnosis. Worthy of follow-up analysis is the fact that only 14% of 30-day readmission for patients who had asthma on the index admission were also for asthma. These findings suggest that patients with chronic disease are indeed complex and that readmission reduction efforts that ignore the complexity of chronic disease comorbidities are less likely to be effective. Future research efforts on the specific targeted conditions will provide more in-depth analysis on what other diagnoses these patients are returning with.

Figure 2



Readmissions for Complications or Infections

Admissions due to clearly preventable events – infections and complications – are of immense importance. The Centers for Medicare and Medicaid Services (CMS) has now been referring to some events in this category as "never events," meaning that they should never occur, and withholding payment accordingly. Using the Pennsylvania Health Care Cost Containment Council's definition of a complication or infection,¹¹ Figure 3 shows the proportion of 30-day readmissions (by diagnosis on the index admission) for complications or infections.

More than one in four readmissions of patients who were initially admitted for heart failure or COPD, and one in five readmissions for asthma and diabetes, were readmitted with PHC4-defined complications or

Over 70% of
30-day
readmissions
came back
with a
different
medical
diagnosis.

27% of 30-day
readmissions
were for
potentially
preventable
complications,
which more than
doubled the
charges for those
hospital stays.

Pittsburgh Regional Health Initiative © March 2010

Page 4

Need for Trusted Data for Pricing Under New Payment Models

- Provider needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount will cover its costs
- Purchaser needs to know what its current utilization rates, preventable complication rates, etc. are to know whether an episode or global payment amount is a better deal than they have today
- Both sets of data need to agree!

Examples of Collaborative Quality Improvement Initiatives

- **Improving Consistency and Effectiveness of Services**
 - E.g., Institute for Clinical Systems Improvement clinical guidelines
 - E.g., California Quality Collaborative workshops and collaboratives
- **Reducing Healthcare-Acquired Infections and Adverse Events**
 - E.g., Pittsburgh Regional Health Initiative HAI reduction projects
 - E.g., Iowa Healthcare Collaborative work to reduce infections
- **Creating Medical Homes**
 - E.g., Quality Counts Medical Home Initiative
 - E.g., Louisiana Health Care Quality Forum Medical Home initiative
- **Helping Providers Coordinate Services**
 - E.g., ICSI DIAMOND Initiative for depression care
 - E.g., PRHI Preventable Readmission Reduction project

Examples of Collaborative Work in Payment and Delivery Reform

- **Pay for Performance**
 - E.g., Integrated Healthcare Association measurement of quality and utilization to support multi-payer P4P
- **Building Consensus on More Fundamental Payment Reforms**
 - Payment Reform Summits in Maine, Memphis, Nevada, Washington, Wisconsin, and others
- **Coordinating Multi-Payer Payment Reforms**
 - E.g., ICSI High-Tech Diagnostic Imaging Initiative to reduce overutilization
 - E.g., ICSI DIAMOND Initiative to improve depression care
 - E.g., Puget Sound Health Alliance initiative to develop accountable medical homes
 - E.g., Maine Health Management Coalition initiative to implement global payment systems

Consumer Education and Engagement

Patient-Friendly Websites

Wisconsin Health Reports

Home : Helen's Story : Bob's Story : Learn Compare Act : About the Project : View the Reports

I found out the hard way that not all healthcare is equal.

For me, becoming more involved in my healthcare made all the difference.

Learn, Compare, Act
View practical suggestions for getting the most from your healthcare.

the **D5**

HOME ABOUT THE D5 VIEW CLINICS WHO WE ARE

THE FIVE GOALS FOR LIVING WELL WITH DIABETES

LIVING WITH DIABETES. SIMPLIFIED.

1 CONTROL BLOOD PRESSURE

2 LOWER BAD CHOLESTEROL

3 MAINTAIN BLOOD SUGAR

4 BE TOBACCO-FREE

5 TAKE ASPIRIN

The D5 represents the 5 goals you need to achieve to reduce your risk of heart attack or stroke when you have diabetes.

You achieve the D5 when you meet all five goals:

1. Your blood pressure is less than 140/90
2. Your bad cholesterol, LDL, is less than 100
3. Your blood sugar, A1C, is less than 8%
4. You are tobacco-free
5. You take an aspirin as appropriate (age 40 and older)

SEE HOW CLINICS IN YOUR AREA ARE DOING

In Minnesota, clinics are measured by how many of their patients achieve the D5.

Find a clinic in your area or see how your clinic measures up.

Patient-Oriented Education Materials

Making the most of your medical appointments

Partner for Quality Care
Information for a Healthy Oregon

We collaborate with patients, providers, health plans, and purchasers to measure and improve health care quality in Oregon.

Local Multi-Stakeholder Forums Will Be More Important in Future

TODAY

Fee for Service

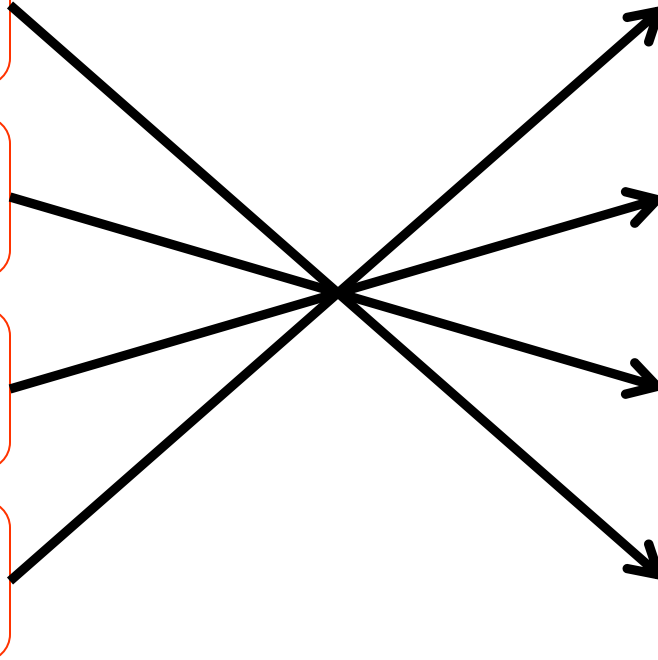
Fragmented Care

Health Plans

Hospitals/
Specialists

PCPs

Consumers



Consumers

PCPs

Hospitals/
Specialists

Health Plans

THE FUTURE

Episode & Comprehensive Care Payment

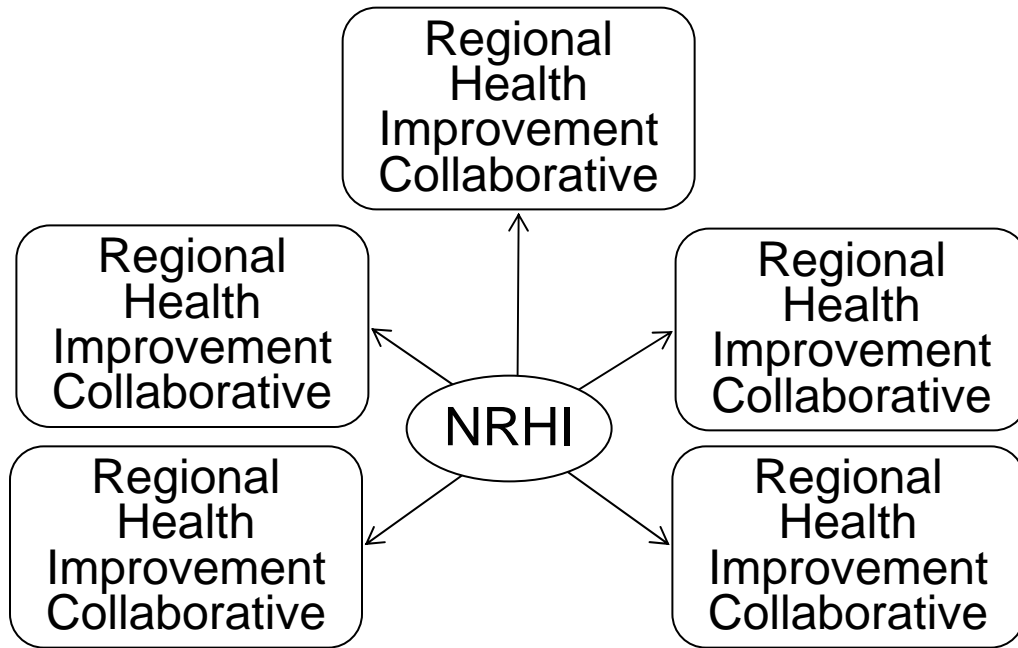
Accountable Care Organizations



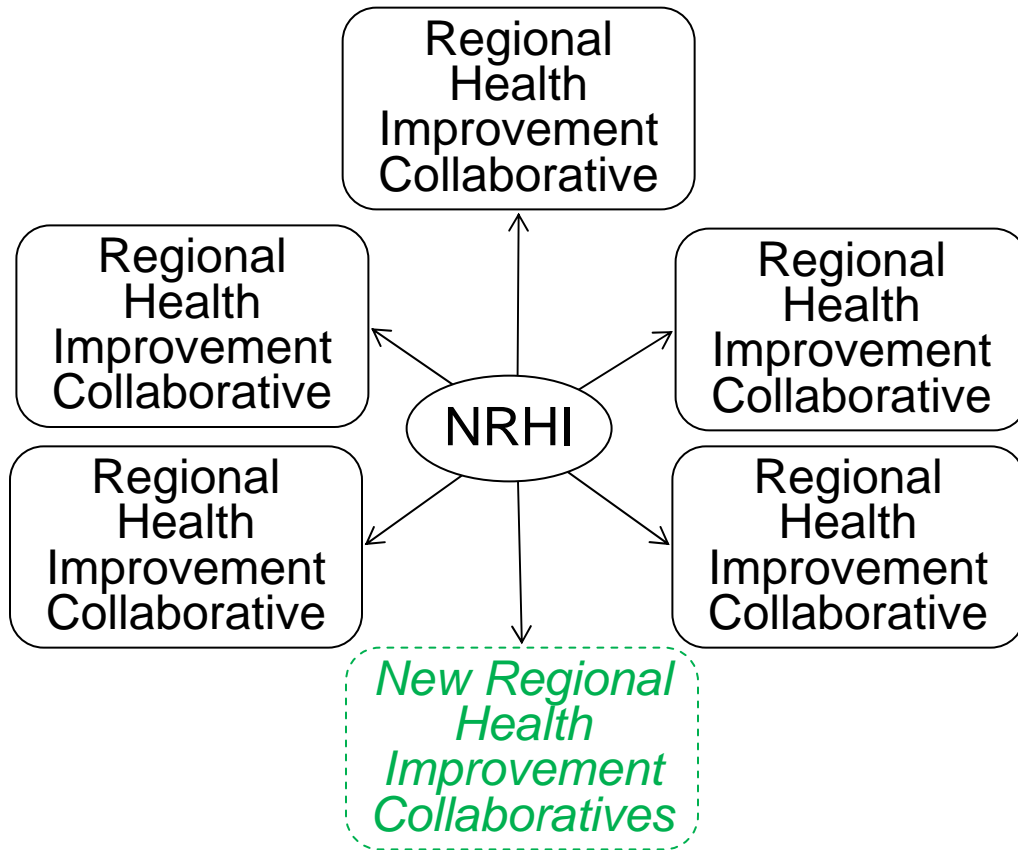
Evolving Roles of Regional Health Improvement Collaboratives

| ROLES | PAST FOCUS | FUTURE FOCUS |
|--|---|--|
| 1. Performance Measurement | <ul style="list-style-type: none">• Quality Measurement & Reporting | <ul style="list-style-type: none">• Quality & Cost M&R• Exploratory Analysis to Find Imp. Opportunities |
| 2. Payment and Delivery Reform | <ul style="list-style-type: none">• Common Measures to Support P4P• Payment Reform Summits | <ul style="list-style-type: none">• Business Case Analysis• Payment Design & Multi-Payer Alignment• Facilitating Multi-Provider Collaborations |
| 3. Training/Assistance in Perf. Improvement | <ul style="list-style-type: none">• Single-Provider Quality Improvement Initiatives | <ul style="list-style-type: none">• Business Case Analysis• Redesign of Multi-Provider Care Processes |
| 4. Patient Education and Engagement | <ul style="list-style-type: none">• Choosing providers based on quality measures• Health promotion education | <ul style="list-style-type: none">• Choosing providers and services based on value• Supporting efforts to coordinate care |
| 5. Strategic Planning and Coordination | <ul style="list-style-type: none">• Facilitating applications for foundation & federal funds | <ul style="list-style-type: none">• Consensus on priorities• Coordinating initiatives• Filling gaps |

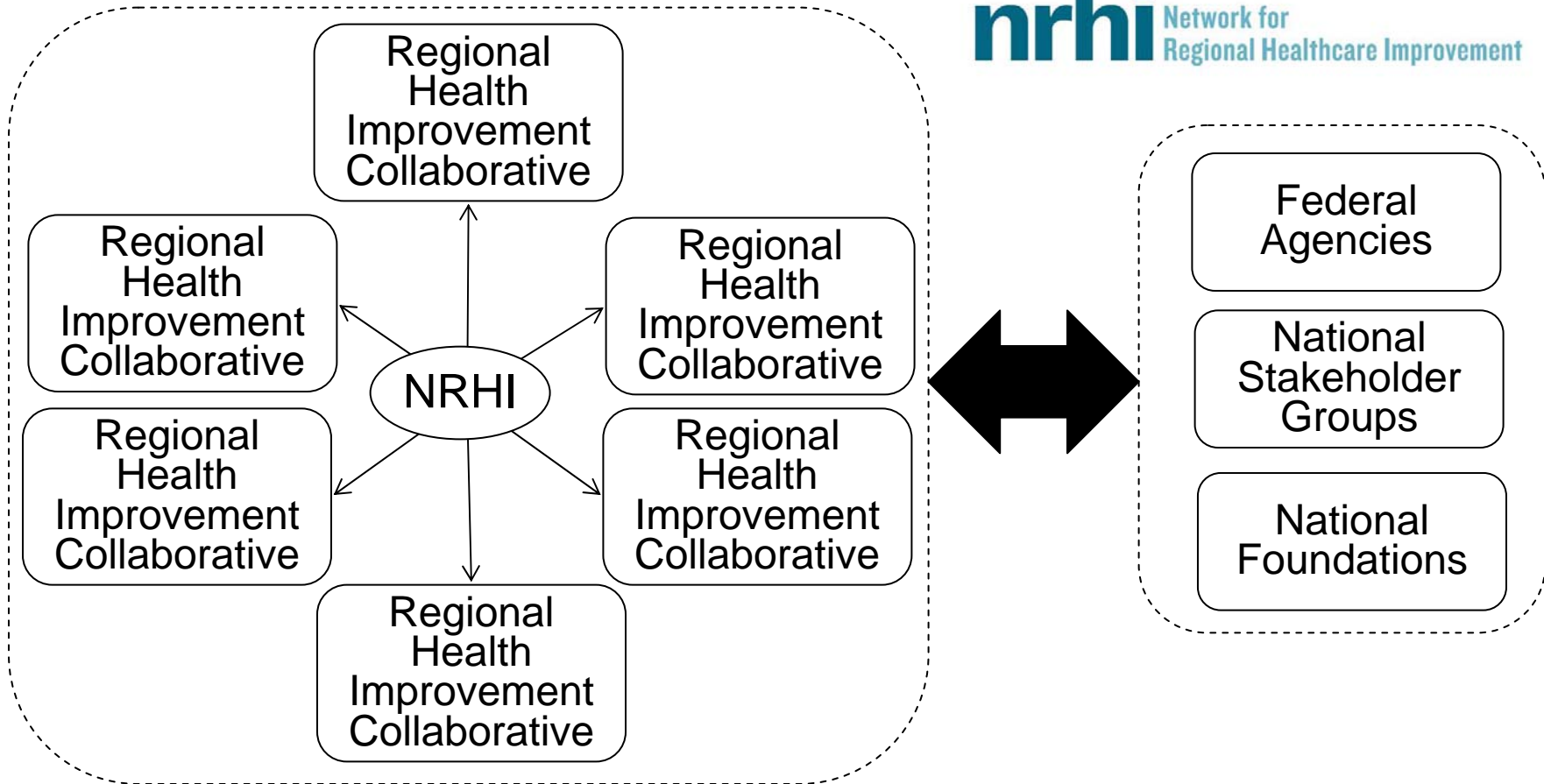
NRHI: Helping Collaboratives Share Best Practices...



...Helping New Collaboratives To Form...



...and Work Collaboratively With Federal/National Organizations



Does Public Reporting Impact Quality of Care in Wisconsin?

Christopher Queram

President/CEO

Wisconsin Collaborative for Healthcare Quality



Vision

WCHQ dramatically impacts the health and increases the value of healthcare for the people of Wisconsin.

Mission

WCHQ publicly reports and brings meaning to performance measurement information that improves the quality and affordability of healthcare in Wisconsin, in turn improving the health of individuals and communities.

WCHQ Member Organizations

Wisconsin health systems, physician groups, hospitals and health plans

Representing approximately 70% of Wisconsin primary care physicians and 50% of all Wisconsin physicians

- Aurora Advanced Healthcare
- Aurora Healthcare
- Aurora UW Medical Group
- Bellin Health
- Columbia St. Mary's
- Dean Clinic
- Fort HealthCare
- Franciscan Skemp Healthcare – Mayo Health System
- Froedtert Health
- Gundersen Lutheran Health System
- Luther Midelfort – Mayo Health System
- Marshfield Clinic
- Medical College of Wisconsin
- Mercy Health System
- Meriter Health Services
- Monroe Clinic
- Prevea Health
- ProHealth Care
- QuadMed
- Sacred Heart Hospital
- Saint Joseph's Hospital (Marshfield)
- St. Mary's Hospital (Madison)
- ThedaCare
- UW Hospital and Clinics
- UW Medical Foundation
- West Bend Clinic – Froedtert Health
- Wheaton Franciscan Healthcare

Our Core Competencies

What We Do:

- Develop, prioritize and implement performance measures for assessing the quality of healthcare services.
- Guide the collection, validation, application and analysis of both administrative and clinical data.
- Publicly report comparative performance measurement results for healthcare providers, purchasers and consumers.
- Share the best practices of healthcare organizations that demonstrate high quality service, enabling all providers to adopt successful methods.

Building a Better Measure

Our “All patients, All payers” Methodology:

We endeavor to build and maintain a set of ambulatory care measures that **enable medical groups and / or health systems to collect and report quality of care data using data on all patients regardless of payer.**

WCHQ Primary Care Measures

Preventive Care

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Pneumococcal Vaccinations
- Osteoporosis Screening
- Adult Tobacco Use
 - Screening for Tobacco Use
 - Tobacco User Receiving Cessation Advice

Chronic Care

- Diabetes Care
 - A1c Screening
 - A1c Control
 - LDL-C Screening
 - LDL-C Control
 - Nephropathy Monitoring
 - Blood Pressure Control
 - Diabetes All-or-None Measures:
 - Optimal Testing (process)
 - Optimal Results (outcome)
- Uncomplicated Hypertension
 - Blood Pressure Control

Chronic Care (Continued)

● Cholesterol Management of Patients with Cardiovascular Conditions

- LDL-C Screening
- LDL-C Control
- Daily Aspirin Therapy

● Screening for Chronic Kidney Disease (CKD)

- Annual eGFR Test

● CKD Care in Stages I, II and III

- Annual eGFR Test
- LDL-C Screening
- LDL-C Control
- Blood Pressure Control

● CKD Care in Stages IV and V

- Calcium Level
- Phosphorus Level
- Intact Parathyroid Hormone (iPTH)
- Lipid Profile
- Annual eGFR
- Hemoglobin test annually
- Blood Pressure Control
- Referral or evidence of a visit to a nephrologist

New in
Fall 2011

Access

● Time to Third Next Available Appt.

- Family Practice
- Pediatrics
- Internal Medicine
- OB / GYN

WCHQ Hospital Measures

Value Metrics

- Length of Stay and Quality Comparison
(Heart Attack, Heart Failure, and Pneumonia)
- Charges and Quality Comparison
(Heart Attack, Heart Failure, and Pneumonia)
- Hospital Charges
(Knee Replacement and Normal Vaginal Delivery)
- Length of Stay
(Knee Replacement and Normal Vaginal Delivery)

Readmission Rate Measure

- All Cause In Development
- Acute Myocardial Infarction
- Asthma
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Pneumonia
- Stroke

Phase II:
Reporting by
Diagnosis Type

Clinical Measures Reflecting Specialist (Non-Primary Care) Physicians:

- Society of Thoracic Surgeons (STS)
- Chronic Kidney Disease (CKD) New in 2011
- CAHPS Pilot New in 2011

Repository Based Data Submission (RBS)

RBS: Innovative Tool for Submitting Data

- WCHQ members submit a global file of patient demographic, encounter, and clinical data.
- The RBS tool's centrally programmed measure specifications calculate performance results for reporting.

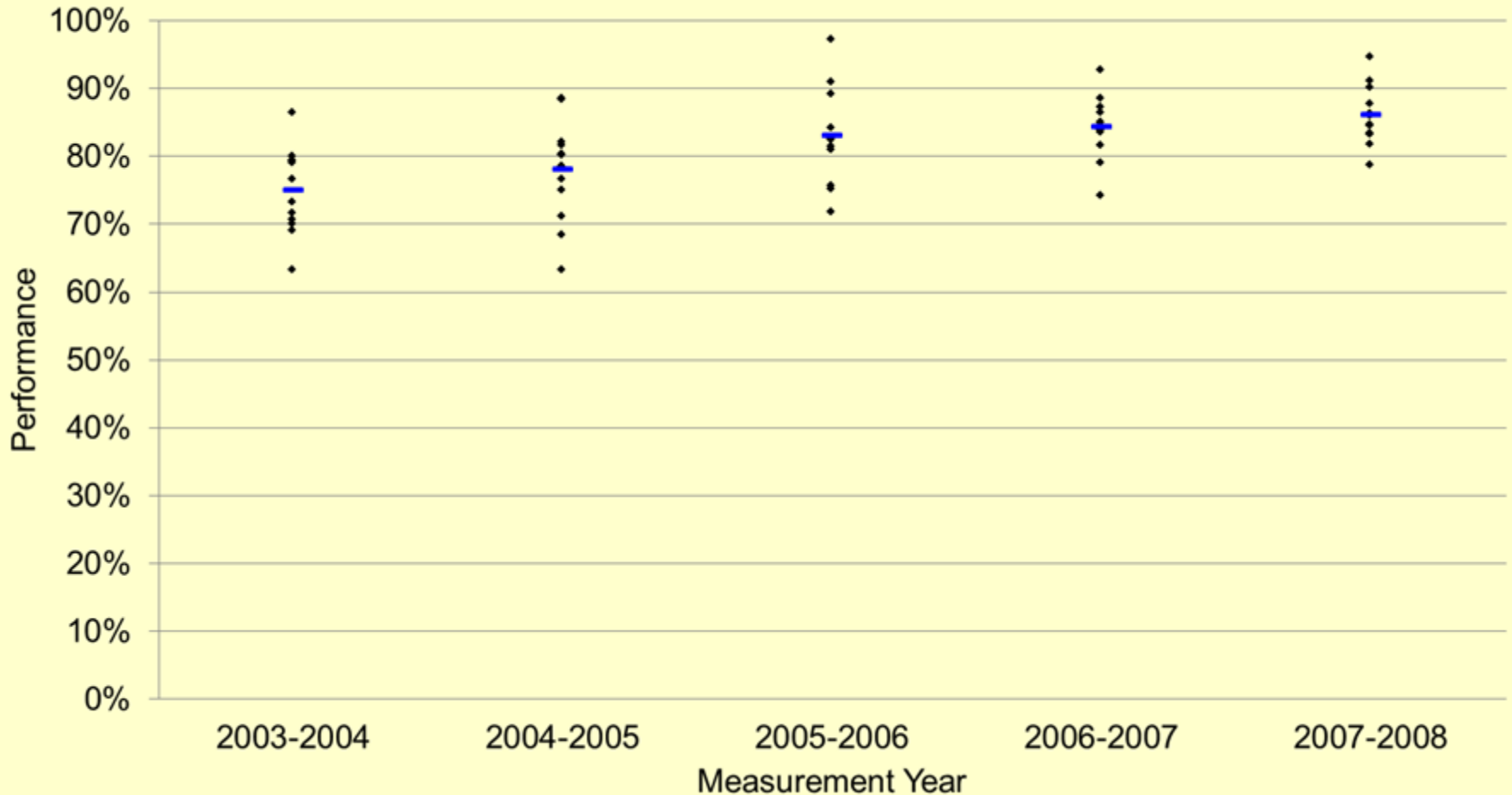
Benefits for WCHQ Members:

- Time savings when querying and aggregating data
- Increased efficiency during data validation
- Reduced programming burden
- Ready access to patient-level data for internal testing and reporting
- CMS approved registry for Physician Quality Reporting Initiative

- Has there been any improvement in performance on WCHQ reported measures?

WCHQ as a whole

Diabetes: LDL Testing



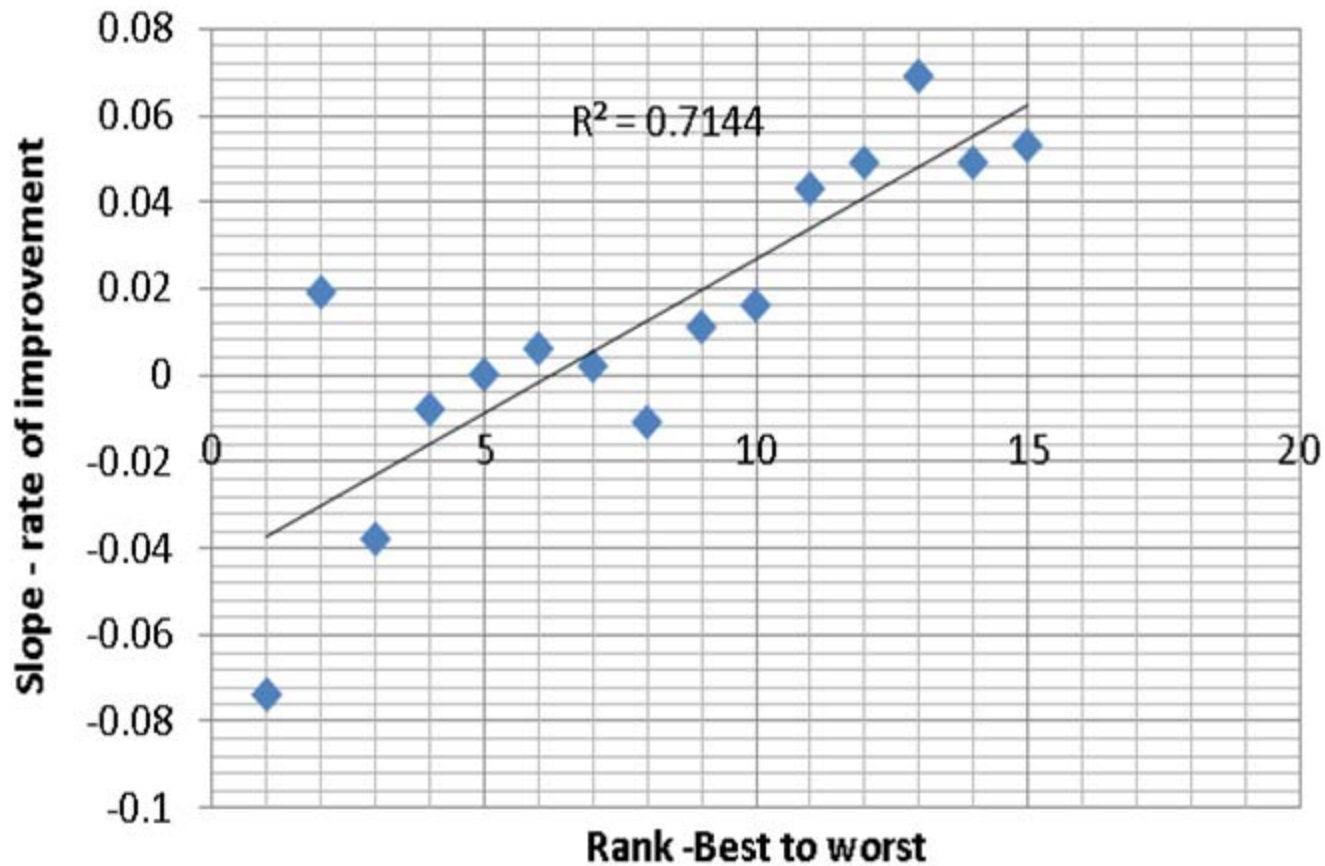
By Measure

| WCHQ Measure | First Year of Measurement | Significant Improvement (through 2008) | Number of Years to Improve | Percentage Improvement Since First Year |
|---|---------------------------|--|----------------------------|---|
| <i>Diabetes</i> | | | | |
| HbA1c Control (<7.0%) | 2003-2004 | Yes | 4 | 8.9 |
| HbA1c Testing | 2005-2006 | No | | 2.0 |
| Kidney Function Monitored | 2003-2004 | Yes | 2 | 17.3 |
| LDL Control (<100 mg/dL) | 2003-2004 | Yes | 2 | 14.9 |
| LDL Testing | 2003-2004 | Yes | 2 | 11.0 |
| Blood Pressure Control (<130/80 mmHg) | 2006-2007 | No | | 2.0 |
| <i>Coronary Artery Disease</i> | | | | |
| LDL Control (<100 mg/dL) | 2007 | No | | 1.2 |
| LDL Testing | 2007 | No | | 1.9 |
| <i>Uncomplicated Hypertension</i> | | | | |
| Blood Pressure Control (<140/90 mmHg) | 2004-2005 | Yes | 2 | 9.1 |
| <i>Screening Measures</i> | | | | |
| Screening for Pneumococcal Vaccinations | 2007 | No | | 4.3 |
| Breast Cancer Screening* | 2004-2005 | Yes | 4 | 4.0 |
| Cervical Cancer Screening* ^Δ | 2003-2005 | No | | 4.3 |
| Colorectal Cancer Screening* | 2005 | Yes | 3 | 6.7 |

Group Level Analysis

- Correlations with rate of improvement:
 - No correlation with size
 - Variable correlation with decision to focus
 - Strong correlation with initial rank

HgbA1c testing

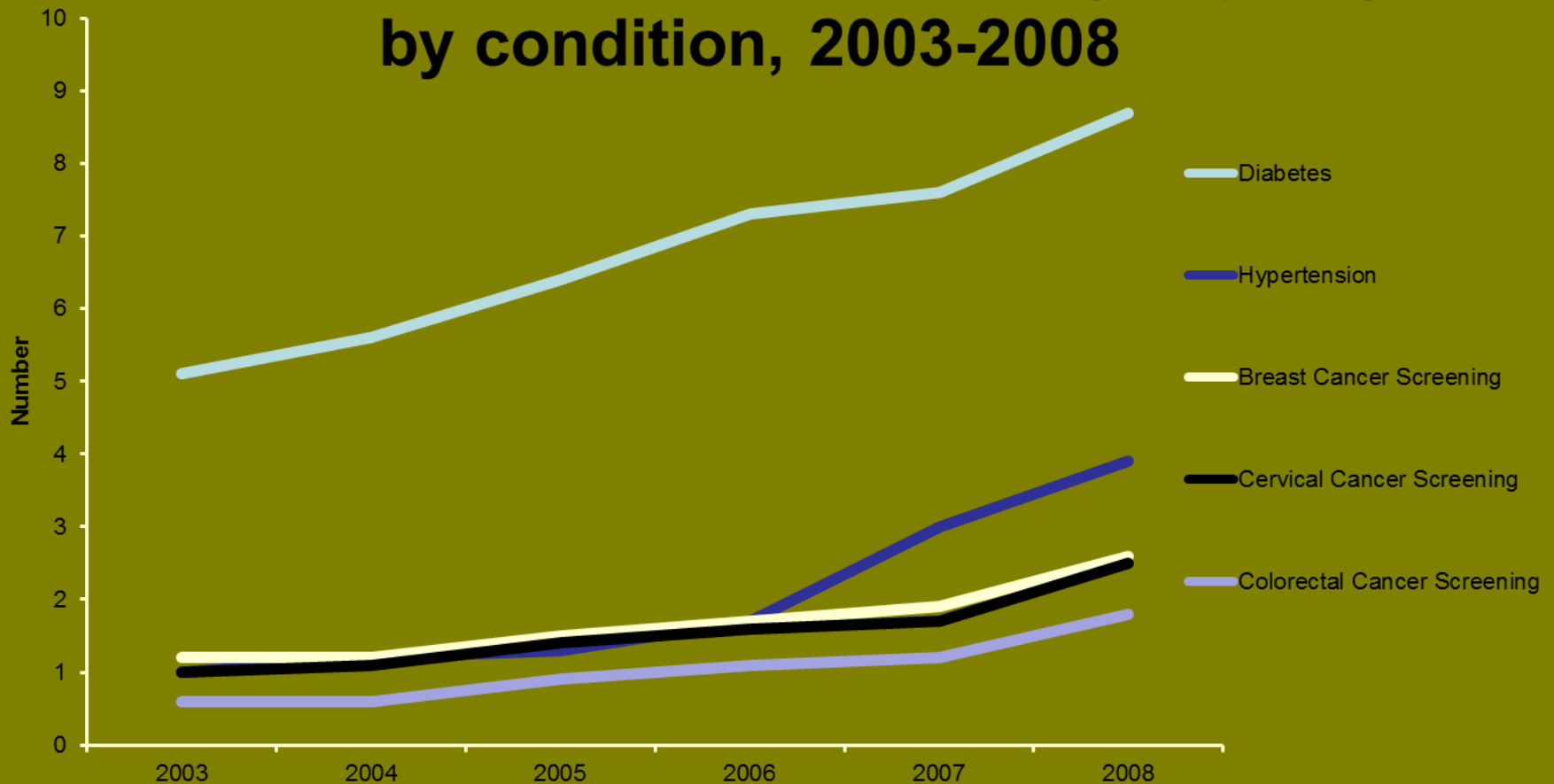


Response to Public Reporting

How did participants respond to public reporting of measures?

Mean Number of Interventions (all types) by condition, 2003-2008

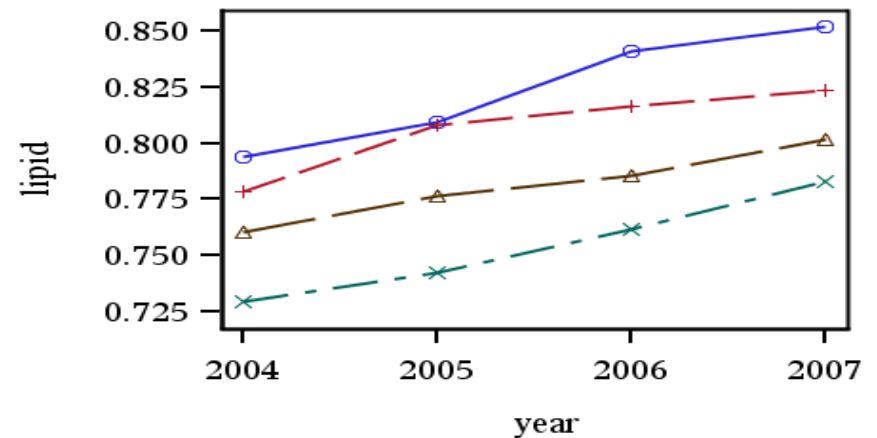
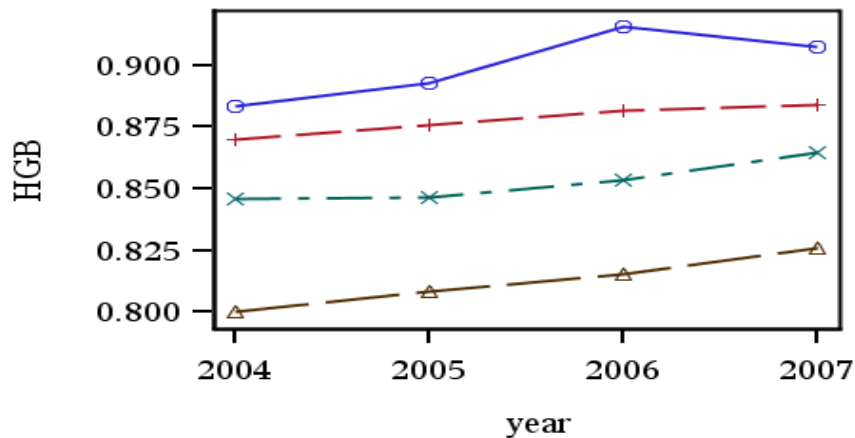
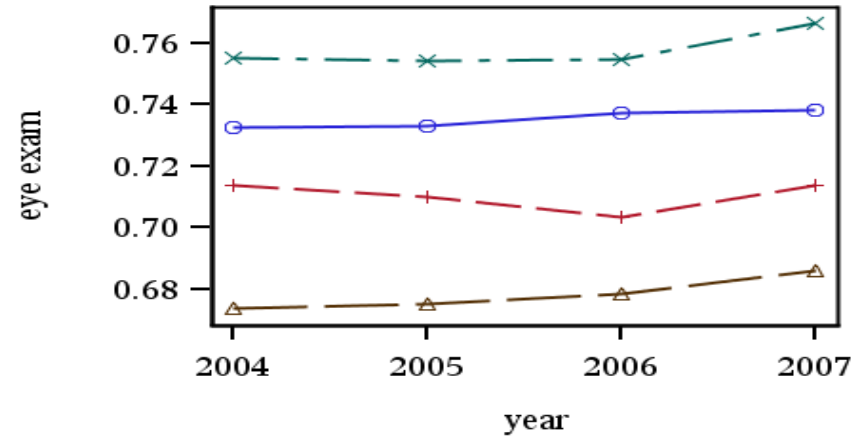
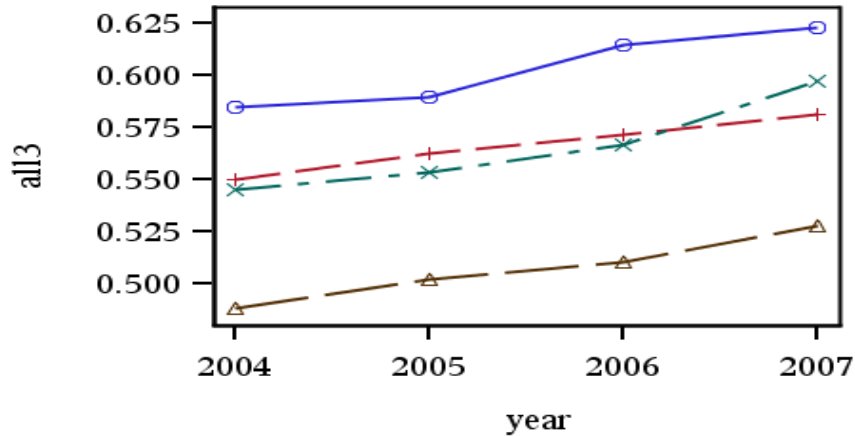
Mean number of interventions (all types) by condition, 2003-2008



- Is there any difference in improvement when WCHQ involvement is compared to noninvolvement?

Performance Diabetes 2004 - 2007

diabetic measures



group —○— WCHQ, mainly WI —+— WI, not WCHQ —x— IA/SD —△— Rest US

Other Outcomes

| | WCHQ | Non WCHQ, WI | Iowa and South Dakota | The rest of the US |
|--|-------------|-----------------------------|--------------------------------------|-------------------------------|
| Ambulatory sensitive conditions (%) | 6.0 | 6.6 | 7.0 | 6.7 |
| Long-term diabetic adm rate (%) | 1.9 | 2.0 | 1.9 | 3.1 |
| Short-term diabetic adm rate (%) | 0.14 | 0.16 | 0.13 | 0.29 |
| Mammography (%) | 76.8 | 73.8 | 71.0 | 67.4 |
| Fundoscopy in diabetics (%) | 73.8 | 71.4 | 76.6 | 68.6 |
| Lipid testing in diabetics (%) | 85.2 | 82.4 | 78.3 | 80.2 |
| Hemoglobin A1c testing (%) | 90.7 | 88.4 | 86.5 | 82.6 |
| Diabetes composite (%) | 62.3 | 58.1 | 59.7 | 52.8 |
| Colonoscopy rate (%) | 6.8 | 6.5 | 6.6 | 7.1 |

Lessons Learned

- Multiple stakeholder involvement and buy-in.
- Importance of “sweat equity”.
- Physician leadership helps foster physician engagement.
- Credible, reliable data.

Pondering the Imponderable

- Dynamic Federalism (ARRA, ACA) - - Opportunity or Threat?
- Sustainable business model.
- Increasingly crowded transparency landscape.
- Data are “Necessary but not sufficient”.

Beyond Measurement: Supporting Redesign at the Community Level

- Building Vision & Tension for Change
- Convening to Improve Alignment & Coordination
- Skill Development & Facilitated Learning Programs
- One-on-one Learning & Consultative Support

About *HealthInsight*:

Coordinating Across Programs

- Focus on Utah, Nevada, and New Mexico (local multi-stakeholder governance)
- CMS QIO contractor in all three states
- Office of the National Coordinator: REC, HIE, & Beacon Community leader
- RHIC (NRHI member)—also CVE, AF4Q site



Building Vision & Tension

- Board & Leadership Training
- Transparency & Award Programs
- White Papers: e.g., Transformational Change, The Employer Role in Health Reform
- Health Quality Forums



Convening for Alignment: Getting All the Players at the Table

- Multi-payer Payment Reform Efforts
- HIE, Beacon
- Standing up ACOs: e.g., data analysis support, connections, shared services
- Projects: e.g., Readmissions, Pressure Ulcers Projects



Skill Development & Facilitation

- Human Factors Training
- Patient Safety & QI Training Programs: RCA, Event Trees, FMEA, PDSA, Lean, etc.
- Learning Collaboratives: e.g., Surgical Care, Diabetes Management
- HIT Vendor Fairs

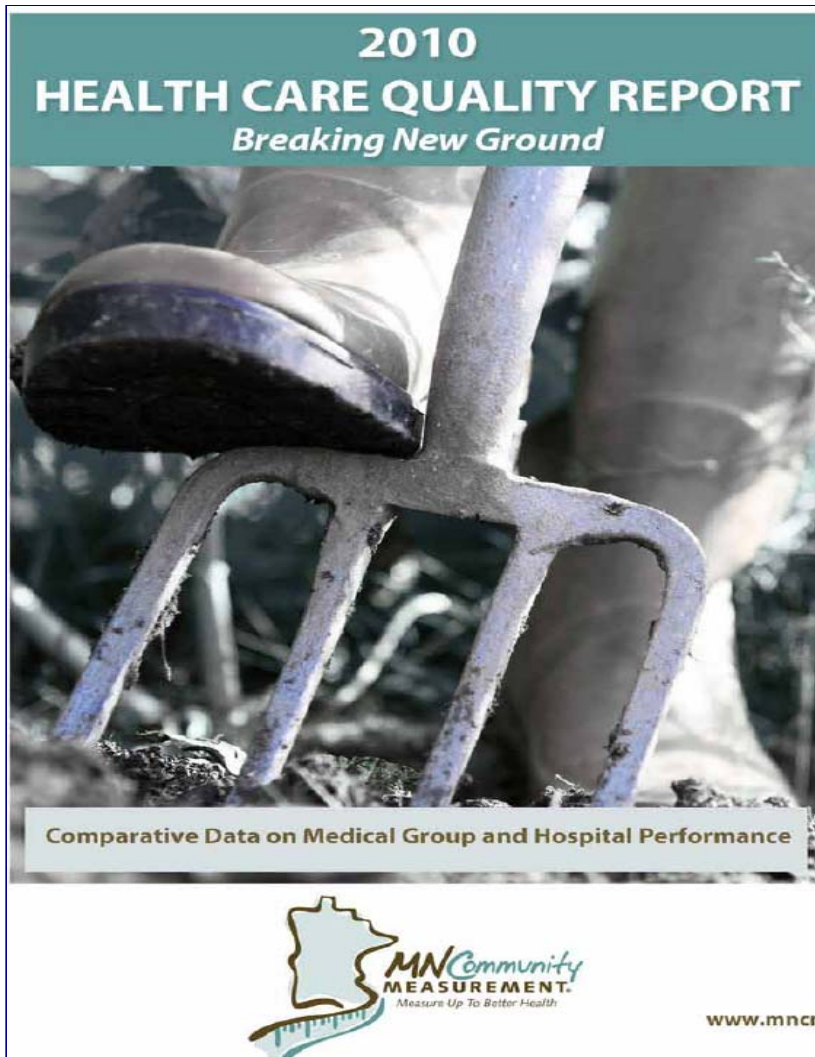


One-on-One Consultation

- HIT REC Workflow Redesign Support, Using EMRs for quality
- Process Mapping, Supported PDSA (small change) experiments
- Small, Under-resourced Provider focus: RECs, Home Health Agency Support, FQHCs
- Low Performers focus: QIAs, Data-driven TA Support



MN Community Measurement Health Care Quality Report



- Reports on 18 clinical quality measures, Health Information Technology, patient experience, cost of care, and hospital measures
- Reports results on 315 medical groups and 550 clinics
- Results from health plan and medical group data
- Results remain steady for most measures

Depression Care Measure

- Use of PHQ-9 Assessment Tool
- Six and Twelve Month Remission Rate
- Six and Twelve Month Response Rate

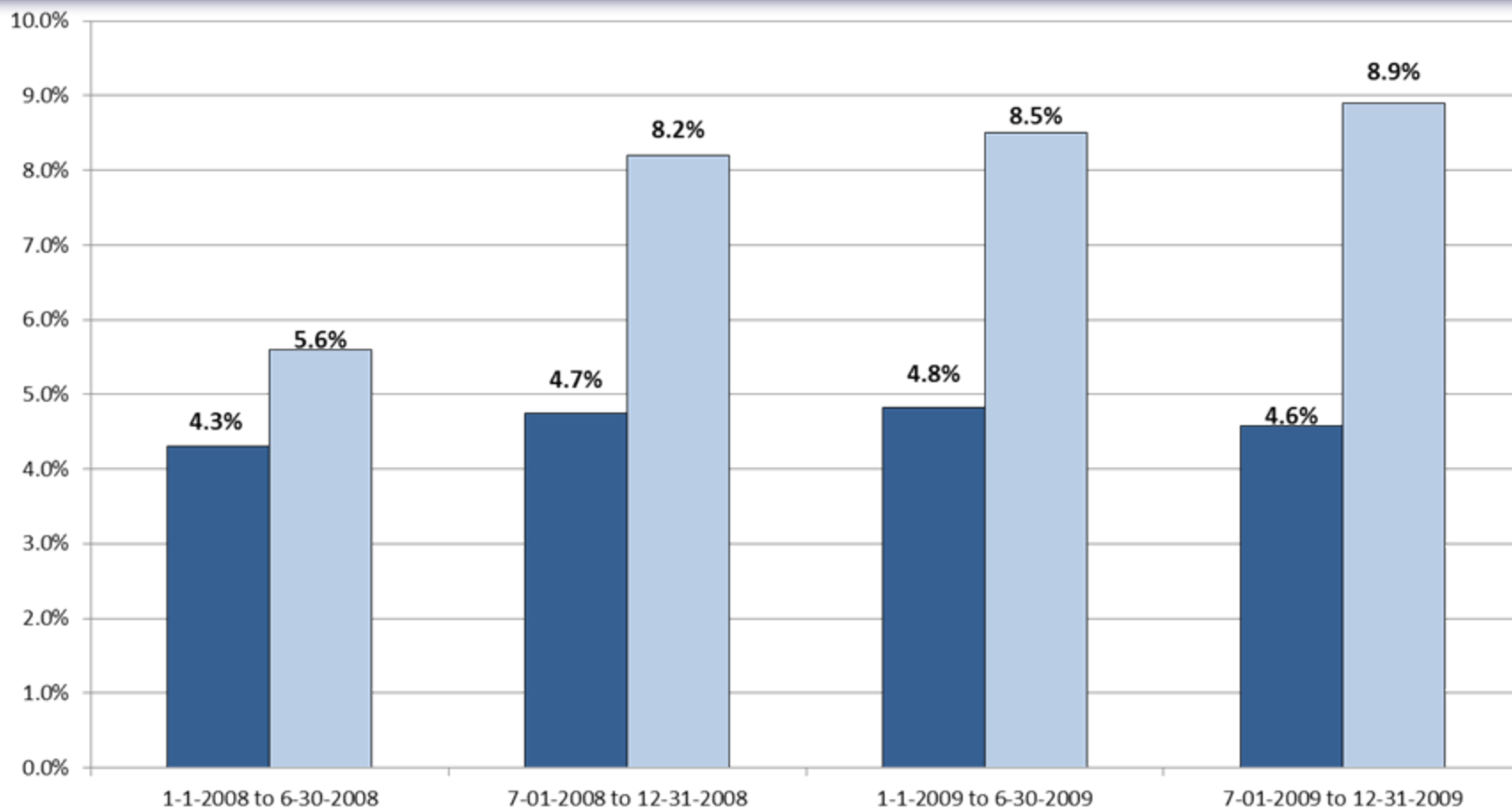
(patient must be in treatment for numerator score)

National Quality Forum Endorsed

Six Month Depression Remission Rates

Clinics That Have Implemented DIAMOND
versus Clinics Not in DIAMOND

■ Non-DIAMOND Clinics
□ DIAMOND Clinics



These rates represent the full population of patients with depression at a clinic site; not just the DIAMOND patients who have opted in to the program

Lessons Learned

- Measures tied to improvement and care redesign
- Alignment across payers
- Prioritization for the community
- Trusted source and local buy-in
- Local implementation advantages (e.g. provider directories)

Opportunities for Collaboration

- “More Fewer” Measures
- Path to Standardization
- Impact on Cost of Care
- Multi-payer Support for Local Improvement
- Long Term Business Model
- Share Resources/Tools Across Communities
- Methods for Spread

Discussion and Next Steps
