

## Health Systems Transformation Team

### AGENDA (REVISED)

Wednesday, February 23<sup>rd</sup>, 2011  
Webinar/Conference Call Meeting  
6:00 pm to 7:00 pm

Please note: The National Weather Service is forecasting snow this evening so we have decided to change the Transformation Team meeting to a combination webinar (for those who have access to a computer)/conference call. To log in to the Webinar, go to:

<https://www2.gotomeeting.com/register/212293882>

Public Audio Conference line: 1-877-455-8688, participant code 915042

#	Time	Item	Presenter
1	6:00	Welcome and agenda review	Bruce Goldberg Mike Bonetto
2	6:05	Review of last week's small group sessions	Diana Bianco
3	6:15	Developing the metrics (presentation) and Q&A	Lisa Angus
4	7:00	Closing remarks and notes on next week	Mike Bonetto, Bruce Goldberg

### Next Meeting:

Wednesday, March 2nd, 2011  
Willamette University  
Putnam University Center, Cafeteria  
6:00 pm to 9:00 pm

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# Health System Transformation Team

February 23, 2011

Indicators for Accountability

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font positioned above the word "Health". "Health" is written in a large, blue, serif font. Below "Health", the word "Authority" is written in a smaller, orange, serif font. A thin blue horizontal line is positioned just above the "Authority" text, extending from the left side of the "H" in "Health" to the right side of the "y" in "Authority".

Oregon  
Health  
Authority

## Purpose of the presentation

This presentation will offer some preliminary ideas about what we might want to measure in new world of person-centered health and services financing and delivery.

This is a work in progress; developing specific indicators will require a significant amount of work and attention, and we will be working closely in partnership with stakeholders over the next several months to develop those.

# Accountability in a transformed system

What do we need to know?

- Are care and services truly integrated?
- Are people getting the care and services they need, in the manner they want?
- Does the quality of care and services meet our benchmarks?
- Are care and services producing desired outcomes (health, independence, etc.)?
- Are care and services being provided efficiently?
- Are care and services provided of good value?

# Accountability in a transformed system

	Accountable Entity	Population level
Are care and services truly integrated?	Reporting requirements and performance benchmarks	Statewide scorecard and performance benchmarks
Are people getting the care and services they need, in the manner they want?		
Does the quality of care and services provided meet our benchmarks?		
Are care and services producing desired outcomes (health, independence, etc.)?		
Are care and services being provided efficiently?		
Are care and services provided of good value?		

# Assumptions

- Major topics measured should be the same for accountable entities and state-level measurement, but specific metrics might differ.
- At the accountable entity level, indicators should adequately evaluate and account for:
  - The range of care and services for which the entity is responsible
  - The range of people for which the entity is responsible
  - Performance with respect to all three elements of the triple aim
- Others?

# Guidelines

Goal is to maximize accountability with minimal administrative burden:

- We will build on previous and ongoing measurement work (e.g., OHPB's Incentives and Outcomes subcommittee work, Quality Corporation, other state and national groups).
- Anticipate upcoming changes and maximize alignment (e.g., meaningful use criteria, Medicare reporting requirements, other federal reporting requirements, etc.)
- May need new measures, to the extent that care is organized & delivered in new ways
- Parsimony in number of measures is highly desirable
- Use nationally-endorsed measures whenever possible
- Others?

# Implementation Considerations

- Measures may require a variety of data sources
- Expectation that measures will be reportable by race, ethnicity, primary language, age, disability and other relevant demographic factors to track and improve health disparities
- Identify other data that may be required to make measures useful (e.g. enrollment and utilization, data on covered population for risk-adjustment, etc.)
- Establish a meaningful approach to setting benchmarks
- Other?

# Drafting the major domains within the triple aim

## Triple Aim element: Population Health

- **Staying healthy** - getting help to maximize health and wellness, avoid illness and remain well
- **Getting better** - getting help to recover from an illness or injury
- **Living with illness or disability** - getting help with managing an ongoing, chronic condition or dealing with a disability that affects function
- **Living well at the end of life** - getting help to deal with a terminal condition
- **Population Health Equity** – population health does not differ according to personal characteristics other than clinical condition or preferences for care

# Drafting the major domains within the triple aim

## Triple Aim element: Experience of care

- **Access** – timely access to needed services
- **Safety** - relates to actual or potential bodily harm
- **Timeliness** – obtaining needed services & minimizing delays
- **Effectiveness** - providing care processes and achieving outcomes as supported by scientific evidence (including care coordination)
- **Person-centeredness** – treating individuals as equal partners in their own care, meeting their needs and preferences, providing education and support
- **Integration** – services are truly integrated
- **Equity in experience of care** – experience of care does not differ according to personal characteristics other than clinical condition or preferences for care

# Drafting the major domains within the triple aim

Triple Aim element: Cost

- **Per-capita costs**
- **Appropriate care & waste** – addressing over- and under-utilization of services and evidence-based care
- **Efficiency** – maximizing health value as compared to resources used

# Example – readmissions

- Readmissions often used as indicator of the effectiveness of care coordination across settings
- Can apply to a range of populations, e.g.:
  - Persons with acute medical need: hospital all-cause readmission rates
  - Persons with mental illness: rates of readmission to acute psychiatric facility
  - Persons with long-term care needs: rates of hospital readmission from skilled nursing facility setting, or rates of readmission to skilled nursing from home- or community-based setting
- Can be used in performance-based contracting (e.g. forthcoming Medicare penalties for hospitals with high rates of readmissions)
- Can be examined by race and ethnicity to identify and address health disparities, e.g.:
  - Joynt et al. JAMA, 16 February 2011

# Discussion

- Are the assumptions (slide 5) and guidelines (slide 6) the right ones? Any others?
- Are the categories/domains proposed the right ones? Are there categories/domains that are missing?
- Do people have ideas about how to prioritize among categories /domains, or whether we need to do so?
- Do people have ideas about how to keep the total number of measures small while still covering the range of care types, populations, and important topics?

**EXAMPLE candidate measures, by category/domain**  
*Work in progress, for discussion purposes only*

Triple Aim & Domain	EXAMPLES ONLY		Applicable settings/care types	Relevance to major chronic conditions?	Alignment	
	For accountable entities	For statewide scorecard				
<b>Population Health (improve the lifelong health of Oregonians)</b>						
<b>Staying healthy</b>	1	BMI screening and follow-up	Obesity rate	Outpatient, Behavioral, LTC	✓	Meaningful use, Medicaid adult & child, HEDIS, QCorp
	2					
<b>Getting better</b>	1	Proportion of service recipients with decreased mental health symptomatology	Average number of days in past month when mental health was not good	Behavioral outpatient & inpatient	✓	SAMHSA national outcome measure
	2					
<b>Living with illness or disability</b>	1	Appropriate monitoring for people with diabetes (e.g. HbA1C & lipid testing, eye exam)	Proportion of diabetics with appropriate screening in last year	Outpatient, Behavioral, LTC	✓	Meaningful use, Medicaid adult HEDIS, QCorp
	2	Percent of home health or nursing home service recipients who get better at walking or moving around	Population-level functional health status	Long-term care		CMS Nursing home quality measure
<b>Living well at the end of life</b>	1	Proportion of clients who receive palliative care at the end of life	Average hospital days in last 6 months of life	Long-term care, acute		PACE, others
	2					
<b>Population Health Equity</b>	1	Proportion of individuals who receive recommended preventive care by race, ethnicity, primary language, disability, and other factors	Premature death by race, ethnicity, primary language, disability, and other factors	Outpatient	✓	
	2					

Triple Aim & Domain	EXAMPLES ONLY		Applicable settings/care types	Relevance to major chronic conditions?	Alignment	
	For accountable entities	For statewide scorecard				
<b>Experience of care (increase the quality, reliability, and availability of care for all Oregonians)</b>						
<b>Access</b>	1	Avg. number of days to 3 <sup>rd</sup> next available appointment	Proportion of individuals with a relationship with a patient-centered primary care home	Outpatient		OR patient-centered primary care standards
	2	Initiation & engagement with alcohol & drug treatment	Substance abuse rates	Outpatient	✓	Medicaid adult, HEDIS
<b>Safety</b>	1	Stage 3 or 4 pressure ulcers acquired after admission to a health care facility	Rate of central-line associated blood stream infections (CLABSI)	Hospital, long-term care institution, other		Never events, PACE, OR Patient Safety Comm., others
	2					
<b>Timeliness</b>	1	(Surgeries) Prophylactic antibiotic received within 1 hour prior to surgical incision	Proportion of patients who received appropriate prophylactic care prior to surgery	Hospitals, ASCs		SCIP (Surgical care improvement project) measure
	2					
<b>Effectiveness</b>	1	Readmissions (to hospital, acute psychiatric facility, short-stay skilled nursing, etc.)	Readmissions (to hospital, acute psychiatric facility, short-stay skilled nursing, etc.)	Various inpatient (hospital, acute psychiatric, LTC facility)	✓	
	2					
<b>Person-centeredness</b>	1	Number of people eligible for long-term care who have a personalized care plan within X days of enrollment	Proportion of people served in home and community-based settings (vs. institutionalization)	Long-term care		

Triple Aim & Domain		EXAMPLES ONLY		Applicable settings/care types	Relevance to major chronic conditions?	Alignment
		For accountable entities	For statewide scorecard			
	2	Experience of care, patient activation surveys	Proportion of clients who rate quality and experience of care and services highly	All		Many relevant survey instruments (CAHPS, ECHO, NRC+Picker, etc.)
<b>Integration</b>	1	Care Transition: Hospital patients report that they have a good understanding of their responsibilities upon discharge	Care Transition: Proportion of hospital patients who understand their responsibilities upon discharge from hospital	Hospitals	✓	CMS care transitions measure (CTM-3)
	2	Entity can exchange key clinical information (e.g. problem list, diagnostic test results) electronically with external providers	Oregon HIE participation rate	Primarily hospitals and outpatient	✓	Meaningful use
<b>Equity in experience of care</b>	1	Proportion of encounters where service was provided in individual's preferred language (directly or via qualified interpreter)	Proportion of individuals who report (via experience of care survey) that care was provided in a culturally competent manner	All		Many relevant survey instruments (CAHPS, ECHO, NRC+Picker, etc.)

Triple Aim & Domain		EXAMPLES ONLY		Applicable settings/care types	Relevance to major chronic conditions?	Alignment
		For accountable entities	For statewide scorecard			
<b>Cost (lower or contain the cost of care so it is affordable to everyone)</b>						
<b>Costs</b>	1	Per-capita cost for various service categories (inpatient, outpatient, Rx, home-and community based services, etc.)	Per-capita cost for various service categories (inpatient, outpatient, Rx, home-and community based services, etc.)	All		
	2					
<b>Appropriate care &amp; waste</b>	1	Proportion of clients with up-to-date lists of diagnoses, medications, and medication allergies	Rate of preventable hospital admissions	Primarily outpatient, but widely applicable	✓	Meaningful use, Medicaid adult, others
	2					
<b>Efficiency</b>	1	Generic drug fill rate	Generic drug fill rate	All	✓	
	2					

## Identifying Metrics for Health System Transformation

Indicators for accountability and statewide performance

**DRAFT FOR REVIEW, COMMENT AND DISCUSSION AT 2-23-11 HST Team meeting**

### Assumptions:

- Performance metrics will be established to assess performance of the accountable entity. In addition, a statewide scorecard will be developed to monitor the state's progress toward improving health, health care, and reducing costs.
- At the accountable entity level, indicators should adequately evaluate:
  - The range of care and services the entity is responsible for (primary, behavioral, acute, long-term, oral)
  - The population for which the entity is responsible (e.g. children, elderly, adults with chronic diseases, healthy people with physical or mental disabilities, etc.)
  - Performance with respect to all three elements of the triple aim (e.g., health outcomes, quality of care and services, financial accountability)
- Other?

### Selecting measures:

- Build on previous measurement work (e.g., OHPB's Incentives and Outcomes subcommittee work, Quality Corporation, other state and national groups) and align with federal reporting requirements
- Anticipate upcoming changes and maximize alignment (e.g., meaningful use criteria, Medicare reporting requirements, etc.)
- Emphasize parsimony in number of measures is highly desirable
- Use nationally-endorsed measures whenever possible
- Other?

### Implementation considerations

- May need new measures, to the extent that care is organized & delivered in new ways
- Measures may require a variety of data sources (claims, clinical data or EHRs, client experience surveys, population-level surveys or monitoring systems)
- Expectation that measures will be reportable by race, ethnicity, primary language, age, disability and other relevant demographic factors to track and improve health disparities
- Identify other data that may be required to make measures useful (e.g. enrollment and utilization, structural information about accountable entity, data on covered population for risk-adjustment, etc.)
- Establish a meaningful approach to setting benchmarks
- Other?

**For your review and comment, potential categories or domains for measurement are listed by triple aim category on the next three pages.**

## Key categories or domains for measurement, by triple aim category

### 1. Triple Aim element: Population Health (improve the lifelong health of Oregonians)

#### Metrics should assess:

- **Staying healthy** - getting help to maximize health and wellness, avoid illness and remain well
- **Getting better** - getting help to recover from an illness or injury
- **Living with illness or disability** - getting help with managing an ongoing, chronic condition or dealing with a disability that affects function
- **Living well at the end of life** - getting help to deal with a terminal condition
- **Population Health Equity** – population health does not differ according to personal characteristics other than clinical condition or preferences for care

#### Comments:

Are these the correct categories? Are there categories that are missing?

2. Triple Aim Element: Experience of care (increase the quality, reliability, and availability of care for all Oregonians)

**Metrics should assess:**

- **Access** – timely access to needed services
- **Safety** - relates to actual or potential bodily harm
- **Timeliness** – obtaining needed services & minimizing delays
- **Effectiveness** - providing care processes and achieving outcomes as supported by scientific evidence (including care coordination)
- **Person-centeredness** – treating individuals as equal partners in their own care, meeting their needs and preferences, providing education and support
- **Integration** – services are truly integrated
- **Equity in experience of care** – experience of care does not differ according to personal characteristics other than clinical condition or preferences for care

**Comments:**

Are these the correct categories? Are there categories that are missing?

FOR REVIEW AND COMMENT

3. Triple Aim Element: Cost (lower or contain the cost of care so it is affordable to everyone)

**Metrics should assess:**

- **Costs** – total and per capita for various components
- **Appropriate care & waste** – addressing over- and under-utilization of services and evidence-based care
- **Efficiency** – maximizing health value as compared to resources used

**Comments:**

Are these the correct categories? Are there categories that are missing?

FOR REVIEW AND COMMENT

Public Input for the Oregon Health Policy Board and  
Health System Transformation Team  
February 16, 2011 to February 22, 2011

Doc #	Summary	Comment Type	Writer
1	Long waiting processes, bogged down by a paper process, can have adverse effects on the patient as well as the providers who are trying to do their job. It would make sense to approach the process electronically.	Email Submitted: 2/15/2011	Mina Dickson
2	What happens to those of us who fall through the cracks? Some people do not meet any of the multiple criteria that would allow them to be covered by OHP. Please address this issue as you work through this healthcare system transformation.	Email Submitted: 2/17/2011	Peggy Burnett
3	The Transformation Team should consider tribally run clinics and tribal clinics run by the Indian Health Service as integrated health and services organizations?	Email Submitted: 2/17/2011	Sonciray Bonnell
4	Reducing unintended pregnancies in Oregon may be one of the most cost effective ways to address the Triple Aim. The One Key Question initiative proposes that the question, "do you plan to become pregnant in the next year?" become a routine preventive screening question in all primary care offices that serve reproductive age women.	Email Submitted: 2/18/2011	Helen Bellanca
5	There is a program under consideration in New Zealand that pays family doctors to counsel injured workers about how the abilities that they still have could allow them to return to work. A similar approach could be useful here for this and other lifestyle issues.	Email Submitted: 2/18/2011	David Gilmour