Learning Objectives

• Recognize the context of quality measurement in health care
• Describe the connections between health plan, hospital, and physician measures of quality
• Identify key measures of ambulatory care quality in 2018
Questions to Think About

• Why do measures matter?
• How can I connect my work to measures of care and quality?
• How do I find out more about my practice’s measures and programs?
Why Measure?

• Demonstrate accountability
  – Compare care to recommended standards
  – Compare care across sites

• Improve performance
  – Identify what is working, and what is not
Triple Aim

CMS National Quality Strategy

- CMS National Quality Strategy
  1. Person and Caregiver-Centered Experience and Outcomes
  2. Patient Safety
  3. Communication and Care Coordination
  4. Community/Population Health
  5. Efficiency and Cost Reduction
  6. Effective Clinical Care

- Who is measured?
  - Health plans
  - Health systems
  - Physician practices
Types of Quality Measures

Donebedian Model

<table>
<thead>
<tr>
<th>TYPE</th>
<th>DESCRIPTION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td>Assesses the characteristics of a care setting, including facilities, personnel, and/or policies related to care delivery.</td>
<td>Does an intensive care unit (ICU) have a critical care specialist on staff at all times?</td>
</tr>
<tr>
<td>Process</td>
<td>Determines if the services provided to patients are consistent with routine clinical care.</td>
<td>Does a doctor ensure that his or her patients receive recommended cancer screenings?</td>
</tr>
<tr>
<td>Outcome</td>
<td>Evaluates patient health as a result of the care received.</td>
<td>What is the survival rate for patients who experience a heart attack?</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Provides feedback on patients' experiences of care.</td>
<td>Do patients report that their provider explains their treatment options in ways that are easy to understand?</td>
</tr>
</tbody>
</table>


Shifting to outcome measures for performance and payment
Calculating Value

Quality outcomes (+ Patient Experience)

Value = Cost to produce outcomes

Quality includes evidence based care, reduces adverse events
Cost is over time and includes tests, procedures, personnel, coordination, etc.

Definition adapted from Redefining Health Care by Michael Porter and Elizabeth Teisberg, 2006.
Connecting Quality to Value

Patients and Families

Health Plan

Pay for valuable coverage

Pay for valuable services

Providers and teams in PCMH

Providers and teams in Health Systems
Quality Overlap

Physician Practice Quality

Health Plan Quality

Health System Quality
## Interconnected Measurement

<table>
<thead>
<tr>
<th>Entity</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan</td>
<td>Assess services provided by the health plan and the overall performance of the network</td>
<td>Comprehensive Diabetes Care- HbA1c testing, HbA1c poor control ((&gt;9.0%)), HbA1c control ((&lt;8.0%)), Eye exam, Medical attention for nephropathy, BP control</td>
</tr>
</tbody>
</table>
| Health System        | Assess the quality of facilities and quality of care provided                | NQF 2362: Glycemic Control – Hyperglycemia  
NQF 2363: Glycemic Control – Severe Hypoglycemia                                                                     |
| Program              | Assess performance compared to targets                                       | ACO- Diabetes Control HbA1c <8%                                                                                   |
| Provider/Practice    | Assess the quality of care provided by individual (or group) health care professional | Diabetes Poor Control (A1c >9%)                                                                                  |
Common Quality Acronyms

• AHRQ- Agency for Health Research and Quality
  – https://www.ahrq.gov/
  – http://www.qualityindicators.ahrq.gov/,

• NCQA- National Committee for Quality Assurance
  – HEDIS- Healthcare Effectiveness Data and Information Set

• NQF- National Quality Forum
  – http://www.qualityforum.org/About_NQF/,
    https://www.qualityforum.org/Measures_Reports_Tools.aspx
Common Quality Acronyms

• CMS- Center for Medicare and Medicaid Services

• MIPS- Merit-based Incentive Payment System
  – assimilated the Physician Quality Reporting System (PQRS) into the Quality Payment Program (QPP)

• eCQM- electronic Clinical Quality Measures
  – https://ecqi.healthit.gov/ecqms

• Hospital Value-Based Purchasing Program (HVBP), Hospital Readmission Reduction Program (HRRP)
  – https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html
Michigan Quality

- Accountable Care Organizations (ACO)
- Organized Systems of Care (OSC)
- Accountable Systems of Care (ASC)
- Clinically Integrated Networks (CIN)
- Patient Centered Medical Home (PCMH)
- State Innovation Model
  - Community Health Innovation Regions (CHIR)
  - Patient Centered Medical Home
- Comprehensive Primary Care Plus (CPC+)
  - Track 1 or Track 2
Why so many Measures?

Which Apple to Use? Discover the 16 Varieties of Michigan Apples!

Investing in Quality Measures

• Ensure optimal care for patients
• Demonstrate interconnectedness of care team
• Demonstrate value of services to patients, payers, employers
• Achieve or retain accreditation
  – Earn incentives or other recognition for performance
Measuring

• Determine what “counts”
  – Who, what, and how
  – Numerators and denominators

• Learn about exclusions

• Understand performance
  – Is higher better?
Key Measures Across Settings

• Comprehensive Diabetes Care
  – Eye exam
  – ACE/ARB and use of statins
  – Foot care
  – \textit{A1c testing and control}
  – \textit{Blood pressure control}

• Cardiovascular Health
  – Healthy weight: activity and nutrition
  – Smoking cessation
  – Medications if needed
  – \textit{Blood pressure control}
Key Measures Across Settings

• **Respiratory Care**
  – Appropriate testing for infections and appropriate use of antibiotics
  – Immunizations
  – *Asthma and COPD control*

• **Utilization** — monitoring follow-up and readmission
  – Emergency room
  – Hospitalizations
    • Particularly for diabetes*, heart failure, asthma*/COPD, pneumonia**
    • Timely Follow up after discharge (<7 days)

*Ambulatory Care Sensitive Conditions, **Inpatient Prospective Payment System; Hospital Readmission Reduction Program
Practical Quality in Daily Work

• Framework
  – Today: urgent needs, transitions of care support
  – Daily: self-management support, chronic condition education
  – This year: monitoring and prevention services
Examples of Care for Youth

• Transitions and Appropriate Use
  – All-cause readmission
  – Testing for children with pharyngitis
  – Appropriate treatment for children with upper respiratory infection

• Chronic conditions
  – Asthma, diabetes, hypertension, obesity
  – Measures of testing, control, and evidence-based care for these conditions, such as A1c testing for diabetes, control of blood pressure <140/90 for hypertension, and completed eye exam for diabetes

• Prevention
  – Weight assessment and counseling for nutrition and physical activity
  – Cervical cancer screening, chlamydia
  – Immunization status Lead screening in children
  – Well-child visit in first 15 months and in 3rd, 4th, 5th, and 6th years
  – Adolescent well care visits
Examples of Care for Adults

• Transitions and Appropriate Use
  – All-cause readmission
  – Avoidable emergency department use
  – Ambulatory care sensitive hospitalizations

• Chronic conditions
  – Asthma, diabetes, hypertension, obesity
  – Testing, control, and recommended care

• Prevention
  – BMI
  – Cancer screenings
  – Depression screening
  – Influenza immunization
Who’s on Your Team?

- Care Manager
- Quality Manager
- Licensed Professional Counselor
- Registered Nurse
- Masters of Social Work
- Care Coordinator
- Masters of Social Work
- Community Health Worker
- Nurse Practitioner
- Dietician
- EMR Specialist
- Data Analyst
- Certified Asthma Educator
- Physician Assistant
- Certified Medical Assistant
- PCMH Coach
- Lay Health Coach
- Office Manager
- Pharmacy
- Practice Transformation Specialist
- Certified Diabetes Educator
- Registry Technician
- Social Services Technician
Examples of Team Care Managers

• Social work expertise
  – Advanced care planning, depression screening, dementia, alcohol screening and use, functional status

• Dietician expertise
  – BMI, support for healthy lifestyles, obesity, diabetes, hypertension

• Pharmacist expertise
  – Medication adherence, monitoring medications, avoiding high risk medications in elderly

• Others
Children and Adolescents

• Compare what you would do to support high quality care management for a patient using the emergency room for asthma compared to emergency use for influenza (no wheezing).
CPC+ 2018

• Required:

<table>
<thead>
<tr>
<th>CMS ID#</th>
<th>NQF #</th>
<th>Measure Title</th>
<th>Measure Type/Data Source</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS165v6</td>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>Outcome/eCQM</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>CMS122v6</td>
<td>0059</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td>Outcome/eCQM</td>
<td>Effective Clinical Care</td>
</tr>
</tbody>
</table>

• And 7 of the following:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>Screening for depression and follow-up plan</td>
<td>Screening for future fall risk</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>Depression: Use of PHQ-9</td>
<td>Influenza immunization</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Dementia: cognitive assessment</td>
<td>Pneumococcal vaccination status</td>
</tr>
<tr>
<td>Diabetes eye exam</td>
<td>Tobacco use: screening and cessation</td>
<td>Ischemic vascular disease use of aspirin or other antiplatelet</td>
</tr>
<tr>
<td>Diabetes medical attention for nephropathy</td>
<td>Initiation and engagement of alcohol and other drug dependence treatment</td>
<td>Statin for prevention and treatment of cardiovascular disease</td>
</tr>
<tr>
<td>Receipt of specialist report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(closing loop)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reflecting

• Why do measures matter?
• How can I connect my work to measures of care and quality?
• How do I find out more about my practice’s measures and programs?
### New to Care Management?

#### Care Manager Measure Map

<table>
<thead>
<tr>
<th>My programs</th>
<th>CPC+, ACO, PDCM, SIM, duals</th>
</tr>
</thead>
<tbody>
<tr>
<td>My target conditions</td>
<td>Diabetes and heart failure</td>
</tr>
<tr>
<td>My practice population</td>
<td>geriatric, adult</td>
</tr>
<tr>
<td>My population focus/high risk</td>
<td>DM and/or CHF + any transition</td>
</tr>
<tr>
<td>Important quality measures for me</td>
<td>readmission, ACSC admission, ED, A1c control, eye exam,</td>
</tr>
<tr>
<td>Documentation tips for my quality measures</td>
<td>be sure to get copy of eye consult</td>
</tr>
<tr>
<td>My important reports</td>
<td>ADTs, A1c</td>
</tr>
</tbody>
</table>
Questions