

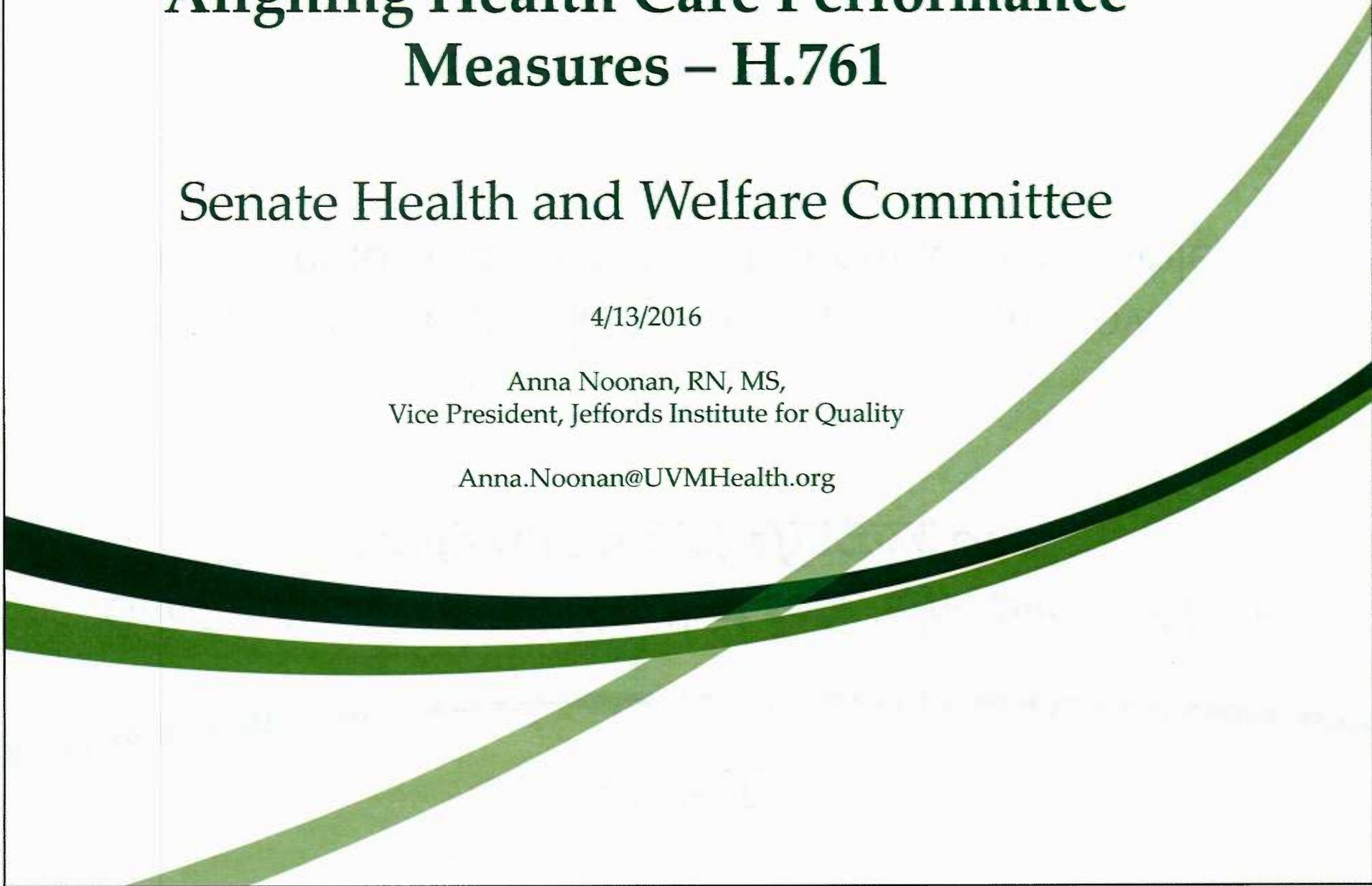
Aligning Health Care Performance Measures – H.761

Senate Health and Welfare Committee

4/13/2016

Anna Noonan, RN, MS,
Vice President, Jeffords Institute for Quality

Anna.Noonan@UVMHealth.org



Quality

Our fundamental belief is that *safe, effective and high quality care is cost-effective* care.

The right care, at the right time, by the right provider, in the right location with the best outcome possible.

Fundamental Healthcare Improvement Goals

- Measure current performance and identify variation in practice.
- Identify a “best practice” and implement a change that will drive improvement.
- Improve the “overall value” of the care provided and the care received.

$$\text{Value} = \frac{\text{Improved Outcomes}}{\text{Cost}}$$

Ideal Measures in Healthcare

- Applicable to a large population
- Limited administrative burden to collect and analyze the data. Best when data collection is built into clinical workflows
- Validated: Metric specifications have been tested as being reliable and replicable across a variety of care settings

Ideal Measures in Healthcare Are:

- **Actionable:** Information will be used to drive change
 - Data collected -> information that is actionable & drives improvement in care delivery and outcomes
- **Comparable:** Evidence based, nationally endorsed w/ baseline and validated benchmarks.
- **Replicable:** Measure is trended over a period of time so that performance can be monitored and changes can be tracked for effectiveness. Recommend that measures are kept stable for minimum of 3 years.
- **Meaningful & Informative:** Data will be used to assess the effectiveness of health care delivery in an identified population across care settings.

What We Should Know About Ideal Measures.....

- Measures provide “a lens” from which to evaluate performance of a system or an individual.
 - Measures are most effective when they are specific enough to drive change.
- Change is often best driven with a “*few good measures*” that target identified areas of improvement.
 - Measures are better when “a few” areas are identified for direct performance improvement.

The heart and science of medicine.

UVMHealth.org/MedCenter

Data

Information

Knowledge

Action

Results in Improvement Over Time

THE
University of Vermont
MEDICAL CENTER

Deciding what to measure...

- High risk, high volume, problem prone
- Evidence base exists from which to make actionable change
- Benchmarks are available to gauge performance

Measurement Tsunami

- National Committee for Quality Assurance (NCQA):
Healthcare Effectiveness Data Information Sets (HEDIS):
 - 83 measures across 5 domains
 - Preventative
 - Chronic
 - High Risk
- Meaningful Use
- ACO 33
- Regulatory measures:
 - The Joint Commission
 - Population based
- Process measures
- Others



Measures

Using data to drive change....

Transforming Primary Care

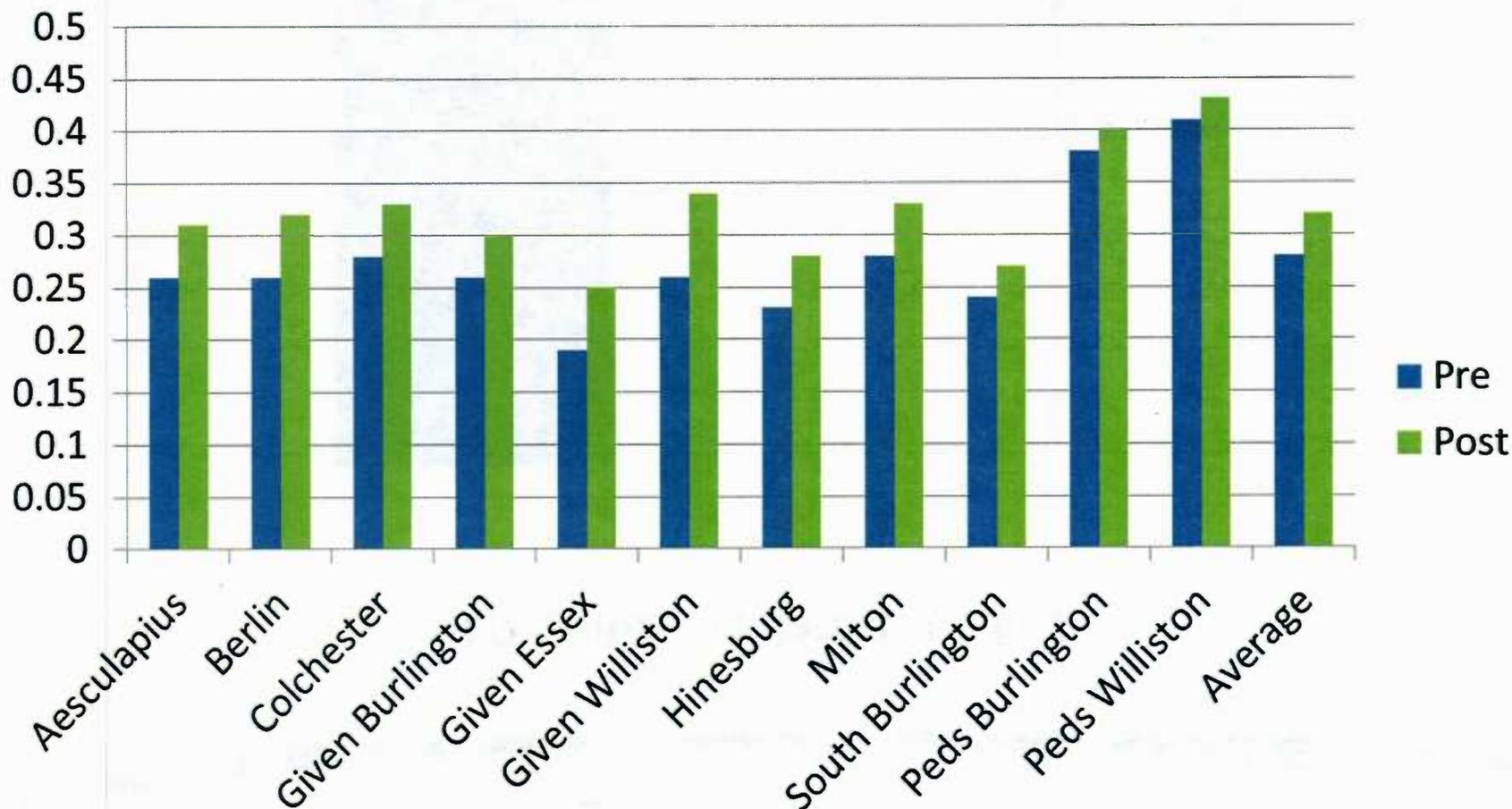
■ **Project Goals:**

- Optimize an integrated network of patient centered medical homes providing a highly reliable primary care foundation to support primary care practices that will effectively connect patients with community health resources and our specialty care colleagues.
- A new care delivery process founded on the principles of standardization, reliability and customization to the patient.
- The capability to harness information and understand our performance in terms of outcomes, cost, and satisfaction to thrive in a health care reform and population landscape
- Optimize provider and facility resources

Key Changes

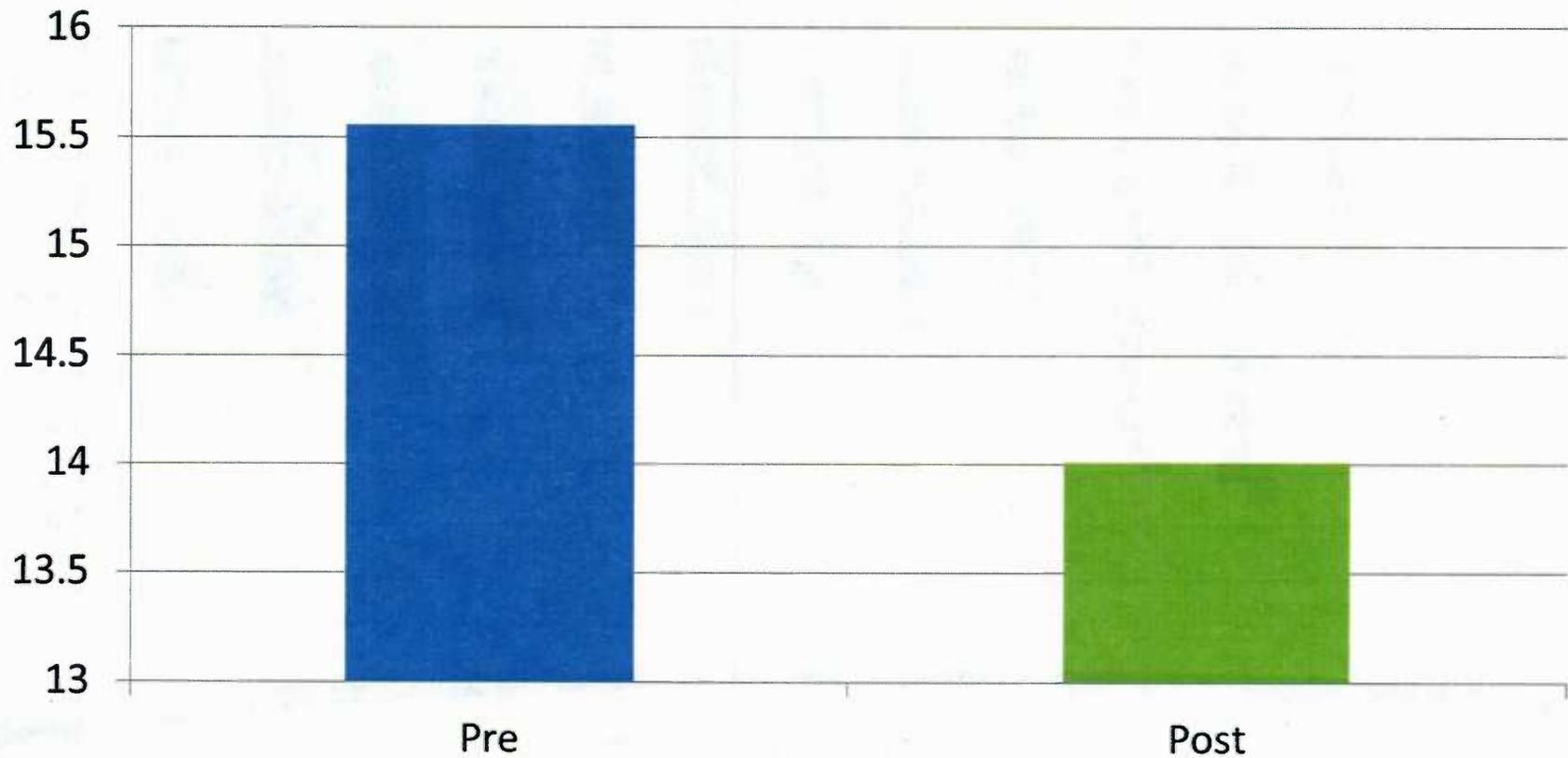
- Ideal Primary Care Encounter (NCQA standards linked)
- Pre-Visit Planning
- Daily Huddles for each Care Team
- Weekly Care Team Coordination Meetings
- Implementation of registry functionality in EPIC
- New Staffing Model with centralized training support
 - Continuity in the staff interactions w/ patients and their families

Outcomes – Immunization Rates 2011 vs 2014

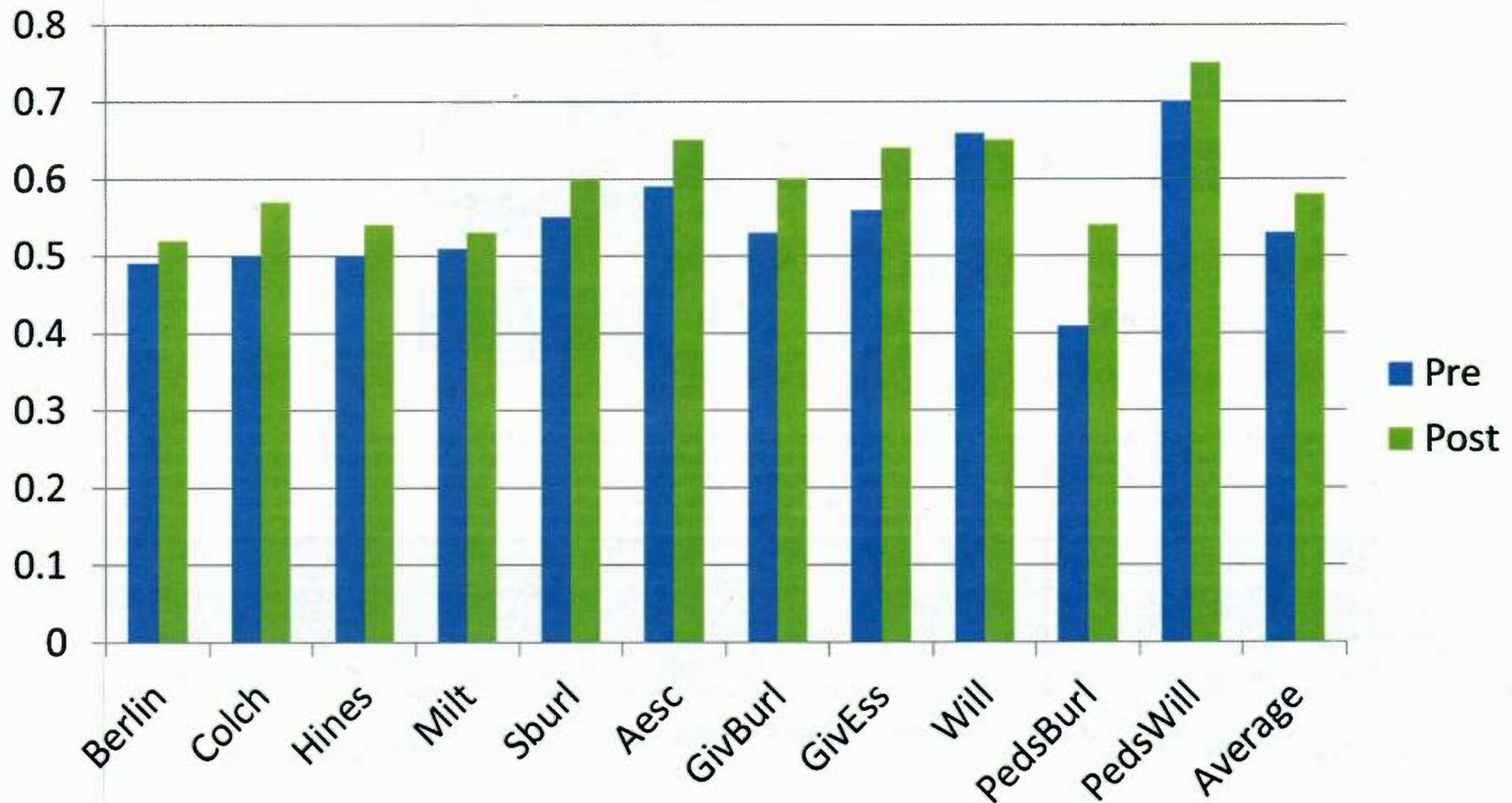


Outcomes – ED Utilization 2011 vs 2014

ED Utilization Rate per 1,000



Outcomes – Patient Satisfaction (% 5's) 2011-2015



Comparative Data



2015 Ambulatory Care Quality and Accountability (AQA) Performance Scorecard



The University of Vermont Medical Center, University of Vermont Medical Group

This document presents the measures evaluated in the 2015 UHC Ambulatory Care Quality and Accountability ranking. This scorecard provides a comparison of your organization's performance with that of other academic medical centers. The data were obtained from existing UHC data resources, including the Faculty Practice Solutions Center (Q2 2014 – Q1 2015), the Access Initiative (Q2 2014 – Q1 2015), Core Measures Data Base (Q2 2014 – Q4 2014), and the Operational Data Base (Q2 2014 – Q1 2015). Data from the most recent CMS Quality Resource Use Report (Mid-Year QRUR) was also used. The goal of the Ambulatory Care Quality and Accountability ranking is to assess organizational performance across a broad spectrum of high-priority dimensions using measures developed by UHC, national organizations or the federal government. The 2015 scoring and ranking cover the domains of access to care, quality and efficiency, equity, continuum of care and capacity management and throughput. Refer to the methodology white paper (available at www.uhc.edu) for specifics regarding the metrics, scoring, and data sources used.

Overall Composite Performance	Rank (*denotes ties)	Overall	Your Weighted Score	AQA Top Score	AQA Median Score
Overall (Based on Domain Performance)	8	60.9%	60.9%	65.0%	56.6%
Domain (Weight)	Rank (*denotes ties)	Your Score	Your Weighted Score	AQA Top Score	AQA Median Score
Access to Care (30%)	23*	55.5%	16.7%	20.0%	16.7%
Includes performance on new patient visits, new patient visit schedule lag and provider-initiated bump rates for various medical and surgical subspecialties.					
Continuum of Care (10%)	19*	57.5%	5.8%	7.4%	5.8%
Includes performance on Joint Commission Hospital Core Measures ED-1b and ED-OP-18b (median time); ED patients that are low acuity and ED frequent fliers.					
Quality & Efficiency (25%)	3	66.8%	16.7%	18.4%	14.1%
Includes select CMS Value-Based Payment Modifier Quality and Cost measures at the medical group-level and CT-scan utilization for specific ED patient populations.					
Capacity Management & Throughput (30%)	21	56.0%	16.8%	20.5%	16.6%
Includes encounters per physician per session and utilization of existing capacity for select medical and surgical subspecialties and high cost imaging throughput. Also includes an information-only metric on encounters per room per hour for select medical and surgical subspecialties.					
Equity (5%)	1*	100.0%	5.0%	5.0%	5.0%
Includes access to care measures on appointment schedule lag by payer class (Medicaid and Medicare) for select medical and surgical subspecialties and ED length of stay (ED-1b) by gender and race.					

You can't improve what you don't
measure.....



Summary

- The most important reason to measure is to drive improvement.
- Use measures that have limited administrative burden:
 - Easily validated and do not require extensive chart review.
- Select a number that is manageable:
 - “A few good measures that are aligned to optimize improvement.”
- Monitor the selected measures over time:
 - Don't change the measures or add new ones for at least 36 months so that performance may be tracked over time
- The process takes time and resources and when done well the results can be profound.

The heart and science of medicine.

UVMHealth.org/MedCenter

Thank you for your time....

Questions?

— THE —
University of Vermont
MEDICAL CENTER