Health Care Innovation Awards

Round Two: Measuring for Success

June 26, 2013
Agenda

- Overview
- Introduction to Performance Measures
- Operational Plan
- Role of the Project Officer
- Next Steps
The CMS Innovation Center

Identify, Test, Evaluate, Scale

The purpose of the Center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid and CHIP...while preserving or enhancing the quality of care.

—The Affordable Care Act
Engage innovators from the field to:

- Identify new payment and service delivery models that result in better care and lower costs for Medicare, Medicaid and CHIP beneficiaries
- Test models in Four Innovation Categories
- Develop a clear pathway to new Medicare, Medicaid and Children’s Health Insurance Program (CHIP) payment models
Measuring Success

• BETTER CARE

• LOWER COSTS

• IMPROVED HEALTH STATUS
### Key Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 14, 2013</td>
<td>Application templates and user materials are available at</td>
</tr>
<tr>
<td>June 28, 2013</td>
<td>Letters of Intent due by 3:00 PM EDT</td>
</tr>
<tr>
<td>August 15, 2013</td>
<td>Application due electronically by 3:00 PM EDT</td>
</tr>
<tr>
<td>Early January, 2014</td>
<td>Anticipated award announcement dates</td>
</tr>
<tr>
<td>February 28, 2014</td>
<td>Anticipated Notice of Cooperative Agreement Award</td>
</tr>
<tr>
<td>April 1, 2014–March 31, 2017</td>
<td>3-year Cooperative Agreement Period</td>
</tr>
</tbody>
</table>
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Effective application of new ideas requires thoughtful, robust design...

- Who will participate in the service delivery model? Is there local demand?
- Who are the target beneficiaries?
- Is it easy to introduce? Complex?
- How will the model result in better health and lower costs for Medicare, Medicaid, CHIP enrollees?
- How long will it take to start work and see progress?
What is Your Theory of Change?

It is important to make explicit hypotheses about how change will happen...

- What is your aim – how much and by when?
- What are your primary strategies for achieving that aim and how will you know you that you are successfully implementing the strategy?
- What will it take to implement each of the primary strategies?
A Driver Diagram

Aim
What are you trying to accomplish?
What will be improved—by how much or how many and by when?

Primary Drivers
What do you predict it will take to accomplish this aim?

Secondary Drivers
What will be required for this to occur?
An Example of a Driver Diagram

**Aim and Outcome**

- Reduce preventable emergency department admissions by x% for y# of frail elderly within area z and reduce cost of care by a% by March 2017

**Primary Drivers**

- Deploy community health workers (CHWs)
- Support frail elderly through transitions in care
- Increase access to primary care

**Secondary Drivers**

- Recruit community members as CHWs
- Train for CHWs in core competencies
- Use protocols and scripts for high frequency scenarios
- Follow up visit post hospital discharge
- Medication reconciliation
- Provide same day access
- Provide care manager virtual visits...
- Use home tele-health monitoring
<table>
<thead>
<tr>
<th>Awardees are responsible for:</th>
<th>CMS will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Self-monitoring for continuous improvement</td>
<td>• Consider requests for Medicare</td>
</tr>
<tr>
<td>• Reporting to CMS on the progress and impact of</td>
<td>FFS data and provide on an as-</td>
</tr>
<tr>
<td>their model</td>
<td>needed basis</td>
</tr>
<tr>
<td>• Providing data and reports to CMS as specified</td>
<td>• Hire a contractor to conduct an</td>
</tr>
<tr>
<td>• Providing patient identifiable information to</td>
<td>independent evaluation</td>
</tr>
<tr>
<td>support independent evaluation</td>
<td>• Work with awardees to refine self-</td>
</tr>
<tr>
<td></td>
<td>monitoring metrics and strategies</td>
</tr>
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<td></td>
<td>to report progress</td>
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</tbody>
</table>
Self-Monitoring vs. Evaluation

**Awardees Self-Monitoring**

- **Goal:** Provide close to real time data for continuous quality improvement
- **Methods:** Repeated cross-sectional or longitudinal, ideally with pre-intervention comparison
- **Data:** Readily available from existing systems, with some further data collection

**CMS’ Independent Evaluation**

- **Goal:** Assess implementation and impact of awardees to inform decisions to scale
- **Methods:** Longitudinal with comparison group and pre-intervention period where possible
- **Data:** Primary and secondary data, including claims-based analyses
Measurement as a Partnership

- CMS will work collaboratively with awardees to develop and refine self-monitoring plans
- Self-monitoring data may inform independent evaluation
- Interim independent evaluation results may be shared with awardees
Two Broad Classes of Measures

• Programmatic and Operational Measures
  o Standard across all awardees
  o Examples: Full time equivalent (FTE) counts for hiring, unique participant counts

• Outcome Measures
  o Some standardization along with some customization by awardees
  o Examples: HbA1C control, proportion of patient with a care plan
Good self-monitoring plans should...

• Align with driver diagram, with at least one measure per aim and primary driver

• Strive to use validated measures, where appropriate

• Cover 3 equally important areas:
  o Health and care quality
  o Total cost of care
  o Operational performance
Three Measurement Areas:

1. Health and Care Quality

• Type: Outcome and intermediate outcome
• Measures of improved care quality:
  o Reducing inappropriate utilization, e.g. rate of low-acuity ED visits
  o Increasing recommended or evidence-based services, e.g. proportion of patients with weight screening and follow up
  o Patient satisfaction, e.g. CAHPS survey
  o Patient access, e.g. proportion of urgent-visit patients seen same day
• Measures of better health:
  o Clinical outcomes, e.g. HbA1C level
  o Health behaviors, e.g. proportion of patients who use tobacco
  o Health-related quality of life, e.g. SF-12
Three Measurement Areas:

2. Total Cost of Care

- Type: Outcome
- Measure of all medical expenditures
  - Typically reported on per beneficiary per month basis
- May also be broken down by cost category, e.g. inpatient expenditures
- May require proxy measures, e.g. measures of utilization
Three Measurement Areas: 3. Operational Performance

- Type: Process and structure
- Measures progress and fidelity in implementing intervention(s)
- Examples:
  - Proportion of recruited patients who agree to participate
  - Proportion of patients with an assigned care manager
  - Number of lay educators trained
Example: Diabetes Prevention

Aim and Outcome

Reduce incidence of diabetes by 10% and reduce cost of care by 5% within a geographic region by March 2017

Primary Drivers

- Decrease proportion of patients who are overweight and obese by 25%
- Improve health status of persons with diabetes

Secondary Drivers

- Educate and recruit patients at risk for diabetes
- Provide classroom-based weight management class
- Recruit and train diabetes educators
<table>
<thead>
<tr>
<th>Aim/Driver</th>
<th>Measure</th>
<th>Data Source</th>
<th>Frequency of Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce incident cases of diabetes</td>
<td>Proportion of patients who developed diabetes in the past 12 months</td>
<td>Survey of participants</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Decrease proportion of patients who are overweight and obese</td>
<td>Proportion of patients who are obese (BMI≥30)</td>
<td>Weight data gathered from classes</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of patients who are overweight (BMI 25-29.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce total cost of care</td>
<td>Total Medicare Part A and B spending per beneficiary per month</td>
<td>Claims</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Aim/Driver</td>
<td>Measure</td>
<td>Data Source</td>
<td>Frequency of Measurement</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Educate and recruit patients at risk for diabetes</td>
<td>Number of health fairs held in the past quarter</td>
<td>Program records</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of people given blood test who were pre-diabetic</td>
<td>Clinical records from event</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of pre-diabetic patients recruited for program</td>
<td>Program records</td>
<td>Monthly</td>
</tr>
<tr>
<td>Recruit and train diabetes educators</td>
<td>Proportion of diabetes educator positions filled</td>
<td>Program records</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of diabetes educators trained</td>
<td>Program records</td>
<td>Monthly</td>
</tr>
<tr>
<td>Provide classroom-based weight management class</td>
<td>Proportion of participants completing course</td>
<td>Program records</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Number of classes held in the past quarter</td>
<td>Program records</td>
<td>Quarterly</td>
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Operational Plan

- One of the Supplemental Application Materials required in the Funding Opportunity Announcement.

- Please note updated version posted on June 20, 2013. Please make sure to use the latest version in your submission.

- Awarded applicants will be required to update their operational plan at the beginning of the performance period.

- The operational plan will also be updated each quarter to make additions and refinements for the next six month period.
Operational Plan, cont.

• Focuses on implementation realities and demonstrates the applicant’s ability to effectively launch the project’s service delivery within the first six months, if awarded

• Gauges operational capacity and project readiness

• Defines the path to implement proposed strategies and achieve project goals

• Serves as a mutual road map between the Innovation Center and the Awardee
## Operational Plan Sections

<table>
<thead>
<tr>
<th>Section</th>
<th>Over-Arching Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Strategies, Aims, and Drivers</strong></td>
<td>What are the key drivers in your plan to achieve these measurable results? What are the collective goals of the project especially for cost savings?</td>
</tr>
<tr>
<td><strong>B. Project Set-Up Needs, Risks, and Key Personnel</strong></td>
<td>What are the specific considerations in being able to implement your project within the first six months after award?</td>
</tr>
<tr>
<td></td>
<td>How are you addressing project set-up needs and potential risks or barriers?</td>
</tr>
<tr>
<td><strong>C. Implementation Milestones and Work Plan</strong></td>
<td>What are the milestones, timelines, and accountabilities for your major work streams, especially during the 6 month ramp-up?</td>
</tr>
<tr>
<td><strong>D. Self-Measurement Plan</strong></td>
<td>What is your approach for self-measurement for your own quality improvement?</td>
</tr>
<tr>
<td></td>
<td>1) Your progress against project health, quality and cost goals?</td>
</tr>
<tr>
<td></td>
<td>2) The successful operations of your program?</td>
</tr>
</tbody>
</table>
An effective operational performance strategy will include:

- Identification of the critical enablers and potential barriers to project success
- Ability to rapidly design a mitigation strategy for risks
- Plan for rapid cycle improvement of project operations and outcomes using self-monitoring
- Focus on milestone planning and execution
Section A. Strategies, Aims, and Drivers

• Insert a driver diagram into this section

• For more information on creating driver diagrams visit our user guide on the HCIA 2 Web site:
Defining and Using Aims and Drivers for Improvement: A How-to Guide

http://innovation.cms.gov/Files/x/HCIATwoAimsDrvrs.pdf
Several Project Set-up needs are requested across domains essential to success.
Section C. Implementation Milestones and Work Plan

<table>
<thead>
<tr>
<th>Quarter (Q1 or Q2)</th>
<th>Key Milestone</th>
<th>Aim / Driver</th>
<th>Project Set-Up Needs</th>
<th>Start Date</th>
<th>End Date</th>
<th>Lead Organization or Staff Member</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 - 04/01/14 - 06/30/14</td>
<td>Describe key task or milestone (e.g. patient recruitment, intervention dev.) (Driver diagram)</td>
<td>Note how this task relates to Aim or Driver(s)</td>
<td>Relate task to Set-up Needs from Section B above by listing the specific need (driver diagram, leadership etc.)</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>List responsible party for task</td>
<td>List key partners that will participate in the task</td>
</tr>
<tr>
<td>Q2 - 07/01/14 - 09/30/14</td>
<td>Example: Reach 200 patients enrolled by end of first month</td>
<td>Example: patient recruitment will relate to our Aim to Enroll 5000 patients by end of award</td>
<td>Patient Recruitment</td>
<td>04/01/14</td>
<td>04/30/14</td>
<td>Project Director</td>
<td>Vendor for Recruitment Materials</td>
</tr>
<tr>
<td>Example: Q1</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Example: Reach 200 patients enrolled by end of first month

Example: patient recruitment will relate to our Aim to Enroll 5000 patients by end of award

Patient Recruitment

04/01/14 | 04/30/14 | Project Director | Vendor for Recruitment Materials
Section D. Measurement and Self-Monitoring

- Intended use of self-monitoring results
- Data collection capabilities for beneficiary information required for independent evaluation
- Operational measures (patient counts, encounters, etc.)
- Process and outcome measures for self-monitoring
Section D. Measurement and Self-Monitoring

• In order to consider standard measures we have provided a CMS measures list for Section D.4 Process and Outcome Measures.

• For your own unique measures, Section D.5 on custom measures can be used.

• For each measure the operational plan asks for the related aim, frequency, data sources and other pertinent information.
Operational Plan Hints

• Additional tables may be added in similar formats.
  o Application Narrative can be used to integrate additional information
• Please keep similar margins, font to the template.
• Be mindful of page length. There is a 50 page limit to supplemental materials, including the operational plan.
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These awards are Cooperative Agreements that require significant involvement from CMS Project Officers (POs).

- PO meets regularly with awardee:
  - Approval process on operational plans
  - Progress reporting
  - Escalation of any issues

- PO connects awardees with CMS contractors as needed
  - All awardees are expected to cooperate with CMS independent evaluation and monitoring

- PO makes recommendation on project continuation

- The Grants Specialist manages formal business functions, including all budget and payment issues
Awardees will be supported through Learning and Diffusion Activities organized by the Innovation Center.

These shared learning activities will:

• bring organizations together to learn from one another
  o to participate in learning collaboratives
  o to organize peer networks of innovators
• actively measure success
• share breakthrough ideas to accelerate progress
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Submitting an Application

Access application electronically at:

- [http://www.grants.gov](http://www.grants.gov)

In order to apply all applicants must

- Obtain a [Dun and Bradstreet Data Universal Numbering System (DUNS)](http://www.dunandbradstreet.com) number which can be obtained at [www.dunandbradstreet.com](http://www.dunandbradstreet.com)

- Register in the System for Award Management (SAM) at: [https://www.sam.gov/portal/public/SAM/](https://www.sam.gov/portal/public/SAM/)
Upcoming Webinars

Webinar 6: Payment Models
- What is a Payment Model?
- What makes a Payment Model “Fully Developed”?
- What is a sustainable Payment Model?

Webinar 7: Application Narrative and Road Map
- Application Narrative
- Awardee Selection Process & Criteria
- Helpful Hints

Webinar 8: Technical Assistance for Submitting an Application

Slides, transcripts and audio will be posted at http://innovation.cms.gov
Next Steps

- Additional information regarding the Innovation Awards will be posted on [http://innovation.cms.gov](http://innovation.cms.gov)

- More Questions? Please Email [InnovationAwards@cms.hhs.gov](mailto:InnovationAwards@cms.hhs.gov)
Thank You!

Please use the webinar chat feature to submit questions
Better Care: Examples of Sources

Public Sources for CMS or HHS Approved Quality Measures

- HHS Measures Inventory
- Medicaid and CHIP Programs;
  CHIPRA Core Set Technical Specifications Manual
  Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults
- Accountable Care Organizations – Measures used in the Shared Savings Program

Other Measure Sources

- IOM Health Services Geographic Variation Data Sets
  [http://www.iom.edu/Activities/HealthServices/GeographicVariation/Data-Resources.aspx](http://www.iom.edu/Activities/HealthServices/GeographicVariation/Data-Resources.aspx)
### Better Health: Examples of Measures and Sources

<table>
<thead>
<tr>
<th>Population Health Outcomes (Examples)</th>
<th>Suggested Source for Data/Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disease and Injury</strong></td>
<td>• Disease management registries</td>
</tr>
<tr>
<td>• Incidence and/or prevalence of disease and injury</td>
<td>• Electronic medical records</td>
</tr>
<tr>
<td>• Preventable events</td>
<td>• Claims data</td>
</tr>
<tr>
<td>• Adverse outcomes</td>
<td>• Health records</td>
</tr>
<tr>
<td>• Reduction in iatrogenic events</td>
<td>• Surveys</td>
</tr>
<tr>
<td><strong>Unhealthy Behaviors</strong></td>
<td>• Health Risk Assessments (HRAs)</td>
</tr>
<tr>
<td>• Tobacco Use</td>
<td>• Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>• Nutrition and Exercise</td>
<td>• MATCH County Health Rankings</td>
</tr>
<tr>
<td>• Substance Abuse</td>
<td><a href="http://www.countyhealthrankings.org/">http://www.countyhealthrankings.org/</a></td>
</tr>
</tbody>
</table>
## Better Health: Examples of Measures and Sources

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<tr>
<th>Population Health Outcomes (Examples)</th>
<th>Suggested Source for Data/Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and Functional Status</strong></td>
<td><strong>Behavioral Risk Factor Surveillance System</strong></td>
</tr>
<tr>
<td>• Multi-domain Health/Functional Status</td>
<td><strong>CDC Health Related Quality of Life (HRQOL-14)</strong></td>
</tr>
<tr>
<td>• Utility-based Health/Functional Status</td>
<td><strong>SF-12 or SF-36</strong></td>
</tr>
<tr>
<td><strong>Life Expectancy</strong></td>
<td><strong>Patient Reported Outcomes Measurement Information System (PROMIS)</strong></td>
</tr>
<tr>
<td>• Healthy Life Expectancy (HLE)</td>
<td><strong>HHS Community Health Status Indicators</strong></td>
</tr>
<tr>
<td>• Years of Potential Life Lost</td>
<td><strong>MATCH County Level Health Rankings</strong></td>
</tr>
</tbody>
</table>