Health Care Innovation Challenge
Webinar 4: Measuring Success

December 19, 2011
Health Care Innovation Challenge Webinars

**November 17, 2011**
Webinar 1: Overview of the Innovation Challenge  
- Goals and objectives of the Innovation Challenge  
- Summary of FOA  
- Award Information

**December 6, 2011**
Webinar 2: Effective Project Design  
- Application Narrative  
- Awardee Selection Process & Criteria  
- Project Oversight and Support

**December 13, 2011**
Webinar 3: Achieving Lower Costs Through Improvement  
- Explaining Total Cost of Care  
- Demonstrating how applicants can achieve lower costs through improvement

**December 19, 2011**
Webinar 4: Measuring Success  
- Demonstrating measurable impact on Better Health and Better Care  
- Operational Planning

The Innovation Center

Mission Statement

“Be a constructive and trustworthy partner in identifying, testing, and spreading new models of care and payment that continuously improve health and health care for all Americans.”
Webinar 4 – Measuring Success

I. Introduction

II. Measuring for Better Care and Better Health

III. Operational Performance

IV. Summary and Q & A Session

V. Resources

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An open solicitation to identify a broad range of innovative service delivery/payment models in local communities across the nation.

- Looking for models that **accelerate system transformation** towards better care, better health and lower costs through improvement
- Looking for models that can be **rapidly deployed within six months** of award
- Specific focus on identifying models that will train and develop the **health care workforce of the future**
Health Delivery System Transformation

Acute Health Care System 1.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Coordinated Seamless Health Care System 2.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Community Integrated Health Care System 3.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Neal Halfon, M.D., M.P.H, Director, UCLA Center for Healthier Children, Families & Communities, nhalfon@ucla.edu
A successful **Operations Plan** will drive three-part aim outcomes

1. Better care
2. Better health
3. Lower costs through improvement
I. Measuring for Better Care and Better Health

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Illustrative Example

**Overarching Aim:** Improve the care and health of children with asthma in a target population

**Goals**
- Reduce asthma-related ER visits and preventable readmissions
- Improve quality of life for children

**Strategies**
- Individualize case management and care coordination
- Provide home visits and environmental interventions
- Educate providers and parents
- Improve access to primary care

*Better Care*

*Better Health*

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Measurement Readiness

Applicants should have data driven measurement processes for continuous quality improvement.

• Applicants should include their experience with self-evaluation and quality improvement in their narrative

• Applicants are expected to demonstrate data collection and analysis capabilities

• New data collection requirements should also be described

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Better Care – Key Domains

“The right care at the right place at the right time.”

Care Quality
- Evidence-based care
- Care coordination
- Patient safety
- Efficiency of service delivery

Care Experience
- Patient engagement
- Patient satisfaction
- Appropriateness of care

Utilization
- Appropriateness of care

Access
- To Services
- To Information
  - Culturally sensitive
  - Useful to target population
  - Accessible

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Better Care Measures

• Applicants should identify and define the target population in order to effectively evaluate the impact of their proposal.

• Applicants should select the care measures required to evaluate continuous performance improvement of their strategies.

• Data should be analyzed and measured on a continuous basis, enabled where appropriate by health IT.

• When available, applicants should use validated measures that are in the public domain, preferably CMS and HHS measures.
Better Health – Key Health Factors

Health Factor Examples

- Health Behaviors
  - Tobacco Use
  - Nutrition and Exercise
  - Substance Use

- Health Care
  - Quality of Care
  - Access to Care
  - Preventive Care

- Socioeconomic Factors
  - Education
  - Employment
  - Income
  - Family and Social Support
  - Community Safety

- Physical Environment
  - Environmental Quality
  - Built Environment


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A Measurably Healthier Population...

1. The County Health Rankings: Mobilizing Action Toward Community Health (MATCH).
   http://www.countyhealthrankings.org
• Applicants are expected to provide a rationale for measurement of population health outcomes in the target population defined for their project.

• Applicants are not expected to provide measures in all domains, only those applicable and feasible to their projects.

• Progress in care improvement can be demonstrated relatively quickly; however, improvements in population health are likely to take longer.

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**Illustrative Example**

**Overarching Aim:** Improve the care and health of children with asthma in a target population

<table>
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</tr>
</thead>
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<tr>
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**Illustrative Example**

**Overarching Aim:** Improve the care and health of children with asthma in a target population

<table>
<thead>
<tr>
<th>Measures of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase % of children with asthma action plan</td>
</tr>
<tr>
<td>Decrease % of children with mold inside of home (in the past 30 days)</td>
</tr>
<tr>
<td>Increase % of children receiving flu shots (in the past 12 months)</td>
</tr>
<tr>
<td>Increase % of all pediatric asthma patients with mild, moderate, or severe persistent asthma who were prescribed preferred long-term control medication or acceptable alternative for long-term control</td>
</tr>
<tr>
<td>Decrease the rate of preventable hospitalizations</td>
</tr>
<tr>
<td>Reduce the rate of school days missed</td>
</tr>
<tr>
<td>Reduce the rate of days with limited physical activity</td>
</tr>
</tbody>
</table>

*Better Care

*Better Health


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Applicants are encouraged to submit care improvement plans as seen below...

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Regional Benchmark*</th>
<th>Current*</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care (HMPC) document</td>
<td>50%</td>
<td>55%</td>
<td>65%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Utilization/Appropriateness of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of all pediatric asthma patients with mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.</td>
<td>50%</td>
<td>56%</td>
<td>66%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>% of children with mold inside of home (in the past 30 days)</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of children receiving flu shots (in the past 12 months)</td>
<td>50%</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

If possible applicants should report on regional benchmarks and well-researched estimates of current baselines in their populations.


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Illustrative Example : Scorecard for Better Health

Applicants are encouraged to submit care improvement plans as seen below...

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Regional Benchmark</th>
<th>Current</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease and Injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of preventable hospitalizations (per 100,000)</td>
<td></td>
<td>2,000</td>
<td>1,800</td>
<td>1,500</td>
<td>1,400</td>
</tr>
<tr>
<td>Heath and Functional Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of days with limited physical activity (per 100,000) in the past 12 months</td>
<td></td>
<td>15,000</td>
<td>13,000</td>
<td>12,000</td>
<td>11,000</td>
</tr>
<tr>
<td>Rate of days missed from school during the past school year</td>
<td></td>
<td>9,000</td>
<td>8,000</td>
<td>7,000</td>
<td>6,000</td>
</tr>
</tbody>
</table>

*If possible applicants should report on regional benchmarks and well-researched estimates of current baselines in their populations.


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3. Operational Performance
An effective operational performance strategy will include:

- A strategy for measuring rapid cycle improvement of project operations
- Ongoing monitoring and evaluation of operational measures
- An ability to rapidly design a mitigation strategy and implement improvements
Operational Plan

Applicants are expected to provide a detailed operational plan demonstrating the ability for rapid, well-designed program execution.

The operational plan should include:

• Plans for implementation to start improving care within 6 months of funding
• Roles and responsibilities of key partners
• Major milestones and dates
• Organizational chart describing the governance structure and relationships with partners
• Key resources necessary for success

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Operational Plan Schedule Example

Examples might include:

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Short-term Action Steps</th>
<th>Lead Responsibility</th>
<th>Time Frame</th>
</tr>
</thead>
</table>
| Domain 1 Organizational goals, management, and governance | • Establish project charter  
• Approve operating budget |                     |             |
| Domain 2 Workforce                            | • Develop training plan and curriculum  
• Recruit and hire staff |                     |             |
| Domain 3 Self-Measurement for Quality Improvement | • Develop measurement plan  
• Secure data from partners  
• Design and administer patient survey |                     |             |

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5. Summary and Q & A
# Summary of HCIC Measures

<table>
<thead>
<tr>
<th>Performance Goal</th>
<th>Performance Metrics</th>
<th>Application Section</th>
<th>Deliverable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on Better Care</td>
<td>Better Care Quality Measures - Care Quality - Care Experience - Utilization - Access</td>
<td>- Section IV.2.iv: 2.2 Operational Plan 4.1: Reporting and Evaluation of quality measures and elsewhere in narrative</td>
<td>- Application narrative - Scorecard with metrics (suggested)</td>
</tr>
<tr>
<td>Impact on Better Health</td>
<td>Population Health Outcomes - Disease and Injury - Unhealthy Behaviors - Health/Functional Status Assessment - Life Expectancy</td>
<td>- Section IV.2.iv: 2.2 Operational Plan Section 4.1: Reporting and Evaluation of quality measures and elsewhere in narrative</td>
<td>- Application narrative - Scorecard with metrics (suggested)</td>
</tr>
<tr>
<td>Impact on Lower Cost (Webinar 3)</td>
<td>Financial Measures - Program-level net savings over the duration of each awards - Projected medical cost trend reduction</td>
<td>- Section IV.2.v: 5.1-3: Funding and Sustainability and elsewhere in Narrative</td>
<td>- SF242A - Financial plan - Supporting narrative and schedules</td>
</tr>
<tr>
<td>Operational Performance</td>
<td>- As defined by the Operational Plan</td>
<td>- Section IV.2.iv: 2.1-2.3:Organizational capacity</td>
<td>- Operational plan schedule - Organizational chart - Staffing plan</td>
</tr>
</tbody>
</table>

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Award Information

Funds will be awarded through **cooperative agreements**
- Funding Opportunity Announcement (FOA) released on November 14, 2011
- 2 planned award cycles (March 2012, August 2012)
- Awards expected to range from $1 million - $30 million

### Key Dates: 1st Cycle Award Process

<table>
<thead>
<tr>
<th>Date</th>
<th>Award Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 19, 2011</td>
<td>Letter of Intent by 11:59 pm EST</td>
</tr>
<tr>
<td>January 27, 2012</td>
<td>Application Due Electronically by 11:59 pm EST</td>
</tr>
<tr>
<td>March 30, 2012</td>
<td>Awards Granted to Selected Applicants</td>
</tr>
<tr>
<td>3-years from Award</td>
<td>End of Period of Performance</td>
</tr>
<tr>
<td>date</td>
<td></td>
</tr>
</tbody>
</table>
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)** number which can be obtained at [http://www.dunandbradstreet.com](http://www.dunandbradstreet.com)

- Register in the **Central Contractor Registration (CCR)** database. More information at [http://www.ccr.gov](http://www.ccr.gov)
Questions & Answers

Please use the webinar feature to submit any questions you have for the speaker.

Contact us at: InnovationChallenge@cms.hhs.gov

FAQs are now online at http://innovations.cms.gov
6. Resources

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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**  
- **Medicare Health Outcomes Survey**  
  [http://www.hosonline.org/Content/SurveyInstruments.aspx](http://www.hosonline.org/Content/SurveyInstruments.aspx)
- **Accountable Care Organizations – Measures used in the Shared Savings Program**  
- **Health Indicators Warehouse**  
- **Healthy People 2020**  

### 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)
- **National Quality Forum**  
  [http://www.qualityforum.org/Home.aspx](http://www.qualityforum.org/Home.aspx)
- **NCQA**  

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**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</td>
<td>• Electronic medical records</td>
</tr>
<tr>
<td>disease and injury</td>
<td>• Claims data</td>
</tr>
<tr>
<td>• Preventable events</td>
<td>• Health records</td>
</tr>
<tr>
<td>• Adverse outcomes</td>
<td>• Surveys</td>
</tr>
<tr>
<td>• Reduction in iatrogenic events</td>
<td>• Health Risk Assessments (HRAs)</td>
</tr>
<tr>
<td></td>
<td>• Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td></td>
<td>• MATCH County Health Rankings</td>
</tr>
</tbody>
</table>

**Unhealthy Behaviors**
- Tobacco Use
- Nutrition and Exercise
- Substance Abuse

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### Better Health: Examples of Measures and Sources

#### Population Health Outcomes (Examples)

**Health and Functional Status**
- Multi-domain Health/Functional Status
- Utility-based Health/Functional Status

**Life Expectancy**
- Healthy Life Expectancy (HLE)
- Years of Potential Life Lost

#### Suggested Source for Data/Measures

- Behavioral Risk Factor Surveillance System
- CDC Health Related Quality of Life (HRQOL-14)
  - SF-12 or SF-36
  - Patient Reported Outcomes Measurement Information System (PROMIS)
- HHS Community Health Status Indicators

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