Measuring High Performers and Assessing Readiness to Change
Looking Beyond the Lamppost

Mathematica Policy Research
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Moderator

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About CHCE

The Center on Health Care Effectiveness (CHCE) conducts and disseminates research and policy analyses that support better decisions at the point of care. Our focus is on the delivery systems and policy environments that help clinicians and patients make more informed decisions, using information on outcomes and effectiveness.

For more information about CHCE, please visit http://chce.mathematica-mpr.com/
Introduction to Today’s Topic

• Key attributes of health care organizations necessary for practice transformation and better care
• Existing measures of organizations’ readiness for change
• Use of measures to support transformation and delivery of better care
• Needed improvements to the current state of measurement
Today’s Speakers

Catherine DesRoches, Mathematica

Eric Gertner, Lehigh Valley Health Network

Craig Schneider, Mathematica

Michael S. Barr, National Committee for Quality Assurance
Assessing Organizational Readiness for Change

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Catherine M. DesRoches
Research Questions

• What types of constructs have been assessed (for example, culture, leadership)?

• Where are the gaps in measures of organizational characteristics?
Factors Affecting Organizational Readiness and Successful Change

• Individual characteristics

• Organizational Characteristics
  – Structural characteristics
  – Leadership
  – Organizational culture
  – Focus on quality

• Market Characteristics
Successful organizational change

Improved outcomes

Individual factors
- Professional training
- Readiness for change
- Motivation to change

Market factors
- Pressures to change

Organizational factors

Culture
- Organizational Climate
- Shared values
- Emphasis on learning and development
- Organizational goals
- Training programs
- Participation in external collaboratives
- Employee incentive programs

Structural factors
- Institutional resources
- Size
- Ownership
- Network membership

Leadership
- Alignment
- Effective training and learning
- Engaged leadership

Focus on value
- Reporting systems and feedback loops
- Quality improvement strategies
- Measuring clinical performance and patient satisfaction
- Financial performance
- Empanelment
- Care coordination
- Enhanced access
- Evidence-based care
- Patient-centered interactions

Improved outcomes
Methods

• Ovid Medline search for published literature and data collection instruments focused on characteristics associated with organizational performance

• Key terms: organizational culture, climate, survey, business of health, organization of care, delivery of care, innovation, decision making, leadership, questionnaire

• Search was restricted to 2004–2014

• We only included a survey if we had access to the instrument and data/information on questionnaire development and testing
Findings: Number of Instruments

- 18 validated instruments met our criteria
- 15 of the 18 provided information on internal consistency
- 3 provided other measurement information
## Findings: Survey Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Individual constructs</th>
<th>Number of surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readiness for change</td>
<td>Motivation</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Readiness</td>
<td>7</td>
</tr>
<tr>
<td>Leadership</td>
<td>Alignment</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Effective training</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Engaged leadership</td>
<td>12</td>
</tr>
<tr>
<td>Culture</td>
<td>Organizational climate</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Shared values</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Culture of learning and development</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Organizational goals</td>
<td>6</td>
</tr>
<tr>
<td>Focus on quality/value</td>
<td>Constructs include use of reporting systems, participation in QI activities</td>
<td>12</td>
</tr>
<tr>
<td>Structural factors</td>
<td>Constructs include size, ownership</td>
<td>10</td>
</tr>
<tr>
<td>Market factors</td>
<td>Constructs include competition, pressure to change</td>
<td>1</td>
</tr>
</tbody>
</table>
A Closer Look at “Focus on Quality and Value”

• 12 individual constructs within the focus on quality and value domain
  – These can be loosely grouped into four categories
    • Patient-centered care
    • Use of quality data and reporting
    • Participation in quality improvement activities
    • Care coordination

• One survey includes items covering all of these constructs

• Most covered between one and seven of the constructs
Specific Gaps

- Lack of consistent definitions
- Lack of replicability
- Lack of predictive value and alignment with performance indicators
- Need to reconcile the value of the domain with the ability to operationalize the domain
- Lack of consistency in the measurement of external or contextual factors
Overview of Findings

• The review highlighted the significant methodological challenges associated with measuring organizations’ readiness for change

• Soft attributes are extremely difficult to accurately measure

• The large number of potential factors that could affect readiness for change makes it difficult to include measures of all domains in a single survey

• Rapidly changing health care market requires new tools for measurement
Purpose of the meeting

1. Assess the completeness and merits of the survey measures
2. Learn from the general experiences of those involved with the Center for Medicare and Medicaid Innovation evaluations and the Medicare Shared Savings Program
   - How relevant are these measures to their own evaluations?
   - What are they learning about ways to collect and use these metrics?
   - Could a standard set of organizational characteristics and contextual factors be used across evaluations?”

Attendees

- CMMI and Medicare Shared Saving Program evaluators
- CMMI/Centers for Medicare and Medicaid
- Assistant Secretary for Planning and Evaluation
- Outside experts
Critical Constructs Identified by the TEP (1)

• Key organizational constructs
  – Practice autonomy
  – Consistent leadership
  – Practice revenue
  – “Grit”
  – “Slack”
• Key individual constructs
  – “Trickle-down” motivation
  – Sustaining momentum
  – Satisfaction
  – Burnout
Critical Constructs Identified by the TEP (3)

• Key contextual factors
  – Perceptions of market competitiveness
  – Other initiatives occurring in the community
  – Quality and consistency of information received from insurers
  – Scope of practice regulations
  – Insurance churning
Next Steps

• Meeting participants noted the need for standardized domains and measures relating to organizational change
  – These measures could be used in addition to customized measures and other types of data collection methods
  – Limited number of domains with a few key measures within each

• Meeting participants discussed the potential for a public/private partnership to move the discussion forward.
Measuring the Performance of Medicare ACOs

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Craig Schneider
Medicare ACOs

• Launched January 2012

• Three models
  – Pioneer
  – ESRD Seamless Care Organization (ESCO)
  – Shared Savings Program (SSP)

• Other models coming in near future?
Where the ACOs Are
Launching an ACO

• Year 1: Start-up priorities
  – Analyze data to understand patient populations
  – Engage providers
  – Hire staff
  – Identify priority areas for care improvement
  – Understand program requirements and processes

• Year 2: Implementation priorities
  – Implement scale-specific care management strategies
  – Focus on PAC, HRHC
  – Engage patients, doctors, and community more deeply in improvement efforts
  – Address pt turnover (30 percent?)
Learning System Model

- Pioneer
- ESCO
- SSP/AP

Core competencies

Identify and prioritize learning needs

Develop curriculum

Modalities

- Online
  - Webinars
  - Innovation pods
  - Tech. assistance

- In-person
  - IPLCs
  - Conference

- Written
  - Case studies
  - Change package

Self-evaluation

Participant feedback

Input from CMS

Input from SMEs

Analysis of dashboard, L&M reports, and other sources

ESCOPioneerSSP/AP

Learning Systems for Accountable Care Organizations

Identify and prioritize learning needs

Develop curriculum

Modalities

Online

In-person

Written

Self-evaluation

Participant feedback

Input from CMS

Input from SMEs

Analysis of dashboard, L&M reports, and other sources
Curriculum Topics (1)

• Care coordination
  – Primary care, improving transitions, avoiding readmissions, reducing disparities, behavioral health

• Provider engagement
  – Payment incentives, data feedback, contracting, supporting transformation

• Quality improvement
  – Understanding measures, responding to quality data, patient safety, PDSA cycles

• Patient-centered care
  – Patient engagement, information follows patient, chronic care management, improving beneficiary experience of care
Curriculum Topics (2)

• Health information technology (HIT)
  – HIT infrastructure for accountable care, clinical decision support, data analytics

• Managing population health
  – Risk stratification, evidence-based medicine, working with community on population health

• Leadership
  – Measuring costs of care, manage risk, partner with payers, role of board and executive leadership, practice transformation, clinical/financial integration
Quality Measures for Pioneer, SSP

• Patient/Caregiver Experience
  – Timely care, appointments, other info
  – How well doctor communicates
  – How patient rates doctor
  – Access to specialists
  – Health promotion, education
  – Shared decision-making
  – Health status/functional status

• Care Coordination/Patient Safety
  – Risk standardized, all conditions readmissions
  – ASC admissions: COPD, asthma, heart failure
  – % PCPs who got EHR incentive payments
  – Medication reconciliation
  – Screening for fall risk
Quality Measures (2)

• Preventive Health
  – Flu, pneumonia immunization
  – Adult weight screening and follow-up
  – Tobacco use, cessation intervention
  – Depression screening
  – Colorectal cancer screening, mammography
  – Proportion who had blood pressure screened

• At-Risk Populations
  – Diabetes: composite measure for HbA1c, LDL, BP, smoking, aspirin; % HBA1c controlled
  – Hypertension: % pts w/ high blood pressure
  – Ischemic vascular disease: Lipid profile, LDL control, take aspirin
  – Heart failure: Beta-blocker therapy
  – Coronary artery disease: Rx to lower LDL, ACE inhibitor
Project Dashboard

• Provide opportunities to assess trends

• Compare ACO performance on key cost metrics to benchmarks, and to peers
  – Total costs, costs by line of service (also reported as percentages)
  – Cost data to be aggregated at ACO level
  – Blinded data for peers
  – Drill-downs of cost metrics

• Compare performance on 33 GPRO/PQRS quality measures

• For Pioneers and ESCOs

• ACOs will see their own data compared to benchmarks; CMS to have program-wide view
Mockup of Dashboard View—Cost Data
Mockup of Dashboard View—Quality Data
Challenges for ACOs to Meet (1)

• Patient attribution: who are my patients?
• Integrating multiple EHRs, interoperability
• Limited funding for infrastructure
• Aligning incentives (much of care still fee-for-service)
• Behavioral health
• Patient leakage (“keepage”), opting out of data sharing, turnover
• Lack of timely and complete data
• Collaboration in a competitive marketplace
Challenges for ACOs to Meet (2)

• Building provider network in rural areas
• Engaging patients
• Transforming organizations
• Leveraging private contracts, Medicaid
• Addressing changing (Pioneer) or inflexible (SSP) program rules
• Integrating newly acquired organizations
• Optimizing use of care managers in care team
Needs Assessment

• CMS and Mathematica developed a needs assessment tool for ESCOs

• Four Domains
  – Clinical care model (implementation, care coordination, vulnerable populations)
  – Financial plan and experience
  – Patient centeredness
  – Organizational structure, leadership/management, and governance
Preparing for PCMH Transformation: Lessons from Lehigh Valley Health Network

Eric Gertner, MD, MPH, FACP
Medical Director, PCMH and Practice Transformation
Who We Are

- 4 Hospital Campuses
- 1 Children’s Hospital
- 136 Physician Practices
- 17 Community Clinics
- 11 Health Centers
- 9 ExpressCARE Locations
- 34 Testing and Imaging Locations
- 13,100 Employees
- 1,340 Physicians
- 582 Advanced Practice Clinicians
- 3,700 Registered Nurses
- 60,585 Admissions
- 208,700 ED visits
- 1,161 Acute Care Beds
Primary Care Initiative: Brief Timeline

January 2008
Chairs meet and create PCDTF

August 2008
Survey to all primary care practices

Nov 2008 - Feb 2009
PCDTF Strategic Planning; SCPA Rollout and 7 LVHN practices

March 2009
Strategy Endorsed by Management

June 09 – June 2010
CPO rollout; Reporting infrastructure; practice selection

Oct 2010
LHN Primary Care Learning Collaborative begins

Oct 2012
Repeat survey to all primary care practices

Network Priority

Transitions of Care

PHO Grant
Primary Care Assessment 2012

Practice survey results: one of several factors used in the practice selection for next PCMH initiative:

- CCT
- NCQA recognition
- Learning Collaborative participation
- Practice coaches

Other selection factors include, but not limited to:

- Practice agreement on initiatives
- Number of patients with high-cost hospitalizations

Compiled by the Department of Community Health and Health Studies, 2013
Primary Care Assessment 2012

Survey Components:

1. Practice Survey
   - Structural Core: financials, visits (N=50/87)
   - Clinician Staff Questionnaire: Adaptive Reserve (N=84/87)
   - Adapted Kotter: Perceived readiness to change (N=84/87)

2. TransforMed’s MHIQ:
   - PCMH: overall and by components (66/87)
Lessons Learned

- **Time, Trust, and Teamwork**

  - Create collaborative learning environments; group accountability can catalyze change.
  - Develop relationships through communication and trust, basic tenets of relational coordination; attention to change management, and recognition of the change effect.
  - Work together to review, reflect, and innovate without fear of lost revenue or job loss.
Lessons Learned

- “Quality” vs. Transformation
  - Practices need data for their transformation
  - Initial focus on chronic disease metrics may be helpful, but insufficient for transformative change.
  - Nationally recognized PCMH recognition programs can offer roadmap, but don't provide the destination for transformed care. If they get you too far off from your destination, they can be more harmful than helpful.
Lessons Learned

▪ Established Care Management Resources

  • Dedicated care managers can facilitate improved patient care, especially those with chronic and complex management.

  • Care management is both central and local.
    – Care managers from several practices in a geographic region should share resources
    – Within every practice, some individuals must focus on care management needs of individual patients and the needs of sub-populations within the practice
Lessons Learned

▪ Multidisciplinary Approach to Care and Care Management
  • Everyone in the practice is valuable.
  • Care management is a team sport. Optimal care management occurs when it is multidisciplinary. Sharing resources among multiple practices can increase service reach.
Questions?

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NCQA Presentation

Michael S. Barr
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Audience Q&A

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