Consumer Health First

*Access • Quality • Equity*

**Health Services Cost Review Commission**
**Performance Measures Comments**
**Submitted 20 July 2016**

## Introduction

Consumer Health First (CHF) appreciates the opportunity to submit its perspective on the Health Services Cost Review Commission's (HSCRC) "strategic development of its future performance measurement activities." CHF[1] is a statewide nonprofit whose mission is to advance health equity through access to high-quality, comprehensive and affordable health care for all Marylanders. Our focus in this work is to ensure that the voices of consumers are raised and their needs met as Maryland implements its health care reform initiatives, including the All-Payer Model.

The following recommendations reflect the input of a number of our colleagues, who have served in various capacities with the design and implementation of the All-Payer Model. That includes our President, who currently serves on the HSCRC Advisory Council and former chair of the Consumer Engagement Task Force, Vice-President, Madeleine Shea, who served on the first performance measures workgroup, and Ben Turner, Program Director at our member organization, Primary Care Coalition of Montgomery County, who also serves on the current performance measures workgroup. The majority of these recommendations are general in nature rather than specific to the categories identified in the call for white papers. However, we hope that they will prove useful to HSCRC continues to refine the process of gathering data to inform its work.

## Recommendations

At the outset we would note our **emphasis on the core principle of health equity**. We believe this should define the All-Payer Model's patient-centered care approach. In that regard, we would underscore that there is a true value to the collection of data that reveals health disparities and that effective analysis and transparency in

[1] Formerly the Maryland Women's Coalition for Health Care Reform

reporting can and should inform policies that promote health equity. This is an area that has historically not been within the purview of hospitals. However, with the transformation of the delivery system this becomes an imperative that must be addressed across all stakeholder groups.

Therefore, we believe that **performance measures, including those for clinical quality, must:**

- be stratified based, as appropriate, upon the following factors: race, ethnicity, preferred language, disability status, sexual orientation, gender identity, income, wealth, years of education, other socioeconomic status and social, psychological and behavioral health factors. And, that not only should the quality of care for those served by the system be examined, but data should be collected for those who are not being served.
- be stratified based on proxy indicators until all of the data elements listed above are consistently collected. This may include Area Deprivation Index, payer category, or other methods to capture socioeconomic and social disparities.
- incorporate measures that can promote an understanding of any under-utilization of services in hospital settings.
- consider tracking outcomes "upstream" in areas such as school-days missed, patient experiences with the system (not solely patient satisfaction); and outcomes for specific health issues.

Current quality measures should be analyzed to determine their **sufficiency with particular attention paid to the most common conditions and those related to behavioral health** (mental health and substance use disorder). This is a challenging area due to the history of previous carve outs for these services. However, we commend the strategy of creating the new HSCRC Behavioral Health Sub-Group. This is an important step in addressing the lack of national and state metrics.

The following includes measures that could address **patient-centered and/or population health measures** goals:

- measurements for end/quality of life conversations that could include billing rates.

- the length of time between a request for services and an actual appointment with a provider.
- measures that illustrate the retention of health care-related information retained by consumers from PSAs, print and/or web-based materials, etc.
- the percent of residents within a community who are satisfied with the health care system.
- the availability of both health and social service support systems within communities.
- the percent of individuals with a consistent source of care.
- for population health specifically, we would suggest that the State Health Improvement Process (SHIP) measures should be considered. The measures were developed through a thoughtful process and, while some areas such as Behavioral Health are slim, they can provide a substantive starting point. And, the creation of the Local Health Improvement Coalitions to establish County-specific priorities should also be considered.
- when considering population health measures we suggest that Turning Point's Guidebook for Performance Measurement could be a useful resource. Another useful resource is the Commonwealth Fund's Data Brief on core PCMH measures.

Given the importance of addressing the **opioid epidemic** we would anticipate that prescribing practices for chronic pain will be a priority in 2017. The CDC has released new guidelines for this. HSCRC should consider new measures that will show compliance with CDC guidelines and ensure that these are stratified - particularly for minorities and persons with disabilities, who are more likely to be under prescribed for pain than whites.

One **litmus test for the inclusion of specific measures**, which would be consistent with MIPS, is the response to the question - will this measure help to improve practice? To be effective the periodicity of feedback will be important. We would suggest that a quarterly timeframe would be a good goal so that clinicians can actually use the feedback to improve care.

We recognize that some of our recommendations may go beyond what the HSCRC has projected particularly as regards the social determinants of health. However, we would suggest that, with the All-Payer Model and the movement to phase two, there is a unique opportunity and an obligation to be pro-active in the design of performance measures. This would be consistent with the path that HSCRC has taken in the design and implementation to date and we would encourage its continued efforts in this regard.

We welcome the opportunity to provide these comments and look forward to continuing to work with the HSCRC as it determines the appropriate performance measures to ensure the success of the All-Payer Model and its goal of addressing the Triple Aim. In that regard, we have included below several resources that we have found helpful in preparing these comments.

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