

# Maine SIM Core Metrics Selection

## May 21, 2014

Over the past several months, the Maine SIM team has worked to develop a core set of targeted measures to monitor the effectiveness of the Maine SIM Innovations in achieving the Triple Aim goals of improved health outcomes, quality, patient experience, and lower costs. This document summarizes the work to date in selecting a set of core metrics for discussion and approval at the May 29 Steering Committee meeting.

### Process for Assessing Maine's SIM Metrics

The first step in developing a set of core metrics for the Maine SIM initiative was to compile measures that are currently tracked and reported across Maine's major SIM models (Health Homes, Behavioral Health Homes, Patient Centered Medical Homes, Commercial Accountable Care Implementation, and Accountable Communities). Stakeholders emphasized the importance of drawing on existing measurement efforts in the development of the core measure sets to minimize any additional reporting burdens on providers. A committee of representatives from the Maine SIM project management team, the Maine Health Management Coalition, Health InfoNet, MaineHealth, and Penobscot Community Health Care, with support from the NORC and RIT technical assistance teams, evaluated this broad set of metrics against the following criteria:

- Alignment across multiple model measure sets
- Alignment with SIM strategic pillars and Triple Aim goals
- Address priority domains of measurement recommended by Commissioner Mary Mayhew, including emergency department use, readmissions, imaging, and care coordination.
- Reflect a mix of process and outcomes and short and long term impacts
- Address populations prevalent in Medicaid (children, behavioral health, disabilities)
- Safeguard against restrictive patient/client selection practices (i.e., creaming, skimping, and premature discharge of patients)
- Address the Center for Medicare and Medicaid Innovation (CMMI's) core measurement areas related to population health (diabetes, obesity, and tobacco control).

### Measures Recommended by the Core Metrics Committee

Table 1 below shows the measures recommended by the Core Metrics Committee. The table provides information about which SIM initiatives are currently reporting on the measure, which of the triple aim outcomes and strategic pillars the measure maps to, and a brief description of the Committee's rationale for including the measure. Table 2 lists the measures that were initially considered for inclusion in the core set and provides information about why they were not selected by the Committee.

### Gaps

The core metric set was not intended to include all of the measures that will be used to evaluate the Maine SIM initiative, so some gaps inherently exist. Although the measures recommended for the core metric set (Table 1) collectively represent all of the Triple Aim outcomes and SIM strategic pillars, representation is weaker for several pillars and outcomes. Some of these gaps are due to data limitations and others are a result of selecting a limited number of core measures for the SIM dashboard.

**Table 1: Recommended Measures**

Measure	SIM Initiatives Using Measure	Strategic Pillars*	Triple Aim Outcomes**	Rationale
<b>ED Utilization</b>				
Non-emergent ED use: Based on Maine list of 14 diagnoses identified as preventable in A Maine ED study, including: sore throat; viral infection; anxiety; conjunctivitis; external and middle ear infections; upper respiratory infections; bronchitis; asthma; dermatitis and rash; joint pain; lower and unspecified back pain; muscle and soft tissue limb pain; fatigue; headache	ME Health Homes, ME Behavioral Health Homes, PCMH, Accountable Communities	1, 2, 3, 4, 6	2, 4	Commissioner recommendation and major cost driver
<b>Readmissions</b>				
All-cause readmissions	ME Health Homes, ME Behavioral Health Homes, PCMH, Accountable Communities	1, 2, 3, 4	2, 3, 4	Commissioner recommendation and major cost driver
<b>Imaging</b>				
Use of imaging studies for low back pain: The percentage of members with a primary diagnosis of low back pain who had an imaging study within 28 days of the diagnosis.	ME Health Homes, 1 of 4 ACI Commercial Payers, Accountable Communities	1	2, 4	Commissioner recommendation and important measure of potential overuse
<b>Fragmented Care</b>				
Percent of members with fragmented care: This measure uses Liu's fragmented care index (FCI) is based on Bice and Boserman's continuity of care index (CCI) that considers the number of different providers visited, the proportion of attended visits to each provider and the total number of visits.	ME Health Homes, ME Behavioral Health Homes	1, 2, 3, 4, 6	1, 4	Commissioner recommendation and key measure of overarching SIM goal to improve care coordination
<b>Total Cost of Care Index</b>				
Population based, case-mix (risk) adjusted, per capital total medical and pharmacy cost paid to providers with high cost claimants capped at 100K.	To be used across all SIM Initiatives	1, 4	2, 4	CMMI/CMS recommendation

**Table 1: Recommended Measures (cont.)**

Measure	SIM Initiatives Using Measure	Strategic Pillars*	Triple Aim Outcomes**	Rationale
<b>Pediatric/Adolescent Care</b>				
Well-child Visits (ages 3-6 and 7-11)	ME Health Homes; ME Behavioral Health Homes; 2 of 4 ACI Commercial Payers; Accountable Communities	1	2, 3	Well visits in younger ages strong impact on preventable diseases
Developmental Screenings in the First 3 Years of Life	ME Health Homes; Accountable Communities	1	2, 3	Key measure of early childhood
<b>Mental Health</b>				
Follow-Up After Hospitalization for Mental Illness	ME Health Homes; ME Behavioral Health Homes; Accountable Communities	1, 2, 5, 6	2, 3	Important mental health measure
Screening for Clinical Depression and Follow-up Plan	ME Health Homes; ME Behavioral Health Homes	1, 2, 5, 6	2, 3	Important mental health measure
<b>Patient Experience/Engagement</b>				
Providers support you in taking care of your own health, CAHPS PCMH		1, 6	1	Captures patient experience & engagement
Willingness to Recommend Provider (Definitely Yes/Somewhat Yes/No), CAHPS	Accountable Communities	1, 6	1	Captures patient experience
<b>Obesity</b>				
Adult BMI Assessment	ME Health Homes; ME Behavioral Health Homes	1	2, 3	Addresses CMMI core population health priorities
Weight Assessment and BMI Classification (ages 3-17)	ME Behavioral Health Homes	1,2	2, 3	Addresses CMMI core population health priorities
Adults Meeting Physical Activity Guidelines: ≥150 minutes per week of moderate-intensity aerobic activity, or ≥75 minutes of vigorous-intensity aerobic activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity [where vigorous-intensity minutes are multiplied by 2] totaling ≥150 minutes per week).	None, available from BRFSS	1,2	2, 3	Addresses CMMI core population health priorities

Diabetes Care				
Diabetic Care HbA1c (ages 18-75)	All Models, 2 of 4 ACI Commercial Payers	1, 2, 5	2, 3	Addresses CMMI core population health priorities

\* **Strategic Pillars:** 1 – Strengthen Primary Care; 2 – Integrate Physical and Behavioral Health; 3 – Develop New Workforce Models; 4 – Develop New Payment Models; 5 – Centralize Data & Analysis; 6 – Engage People & Communities

\*\* **Triple Aim Outcomes:** 1 – Improved Patient Experience; 2 – Improved Quality of Care; 3 – Improved Population Health; 4 – Reduced Health Care Costs

**Table 2. Measures NOT Selected for Inclusion by Core Metric Committee**

Measure	SIM Initiatives Using Measure	Strategic Pillars*	Triple Aim Outcomes**	Rationale / Notes
<b>ED Utilization</b>				
ED utilization: Number of ED visits per 1000 member months	ME Health Homes, ME Behavioral Health Homes, PCMH	1, 2, 3, 4	2, 4	Avoidable ER use stronger measure of SIM goals
<b>Readmissions/Preventable Hospitalizations</b>				
ACSC admissions Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.	ME Health Homes, ME Behavioral Health Homes, PCMH, Accountable Communities, 1 of 4 ACI Commercial Payers	1, 3, 4, 6	2, 3, 4	Readmissions stronger measure of SIM goals
All readmissions for behavioral health diagnoses, including IMD	ME Behavioral Health Homes	1, 2, 3, 4	2, 3, 4	Specifications for this measure still under development
<b>Pediatric/Adolescent Care</b>				
Adolescent well-care visits (ages 12-20)	ME Health Homes; ME Behavioral Health Homes; 2 of 4 ACI Commercial Payers; Accountable Communities	1	2, 3	Measure for younger children represents goals of early intervention
Pediatric ACSC Admissions	All models currently track ACSC admissions (composite)	1, 3, 4, 6	2, 3, 4	Rare events

Obesity				
Adult Obesity	None, available from BRFSS	1, 2	2, 3	Physical activity metric better targets goals around patient engagement in health
Diabetes Care				
Diabetic Care HbA1c (ages 5-17)	All Models except PCMH, 2/4 ACI Payers	1, 2, 5	2, 3	Pediatric diabetes more likely to be Type 1, less of a link to population health
Diabetic Eye Care Exam	All Models, 3/ 4 ACI Payers	1, 2	2, 3	HbA1C measure better link to overall diabetes care
Diabetic LDL measured within previous 12 months	All Models, 3/4 ACI Payers	1, 2	2, 3	HbA1C measure better link to overall diabetes care
Diabetic Nephropathy Screening	All Models, 1/4 ACI Payers	1, 2	2, 3	HbA1C measure better link to overall diabetes care

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