morganhealth

An Employer's Perspective on Health Care Quality Improvement

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JPMorganChase

Introduction

Morgan Health, in collaboration with the JPMorganChase benefits team, developed and is implementing a data-driven and measurable approach to quality improvement.

We identify, prioritize and integrate measures into contracts that aim to improve four domains: better health outcomes, increased access to care, effective chronic condition management and reduced disparities. This document breaks down our approach to quality improvement[1] with a goal of helping other employers understand how they can incorporate quality improvement into their benefits offering.

An Approach for Self-Insured Employers

Foundational Questions to Answer Before Getting Started:

- How high should the bar be set?
- Do you want the measures of success to be stretch goals or more achievable?
- How should goals be incentivized or penalized if they are not met?

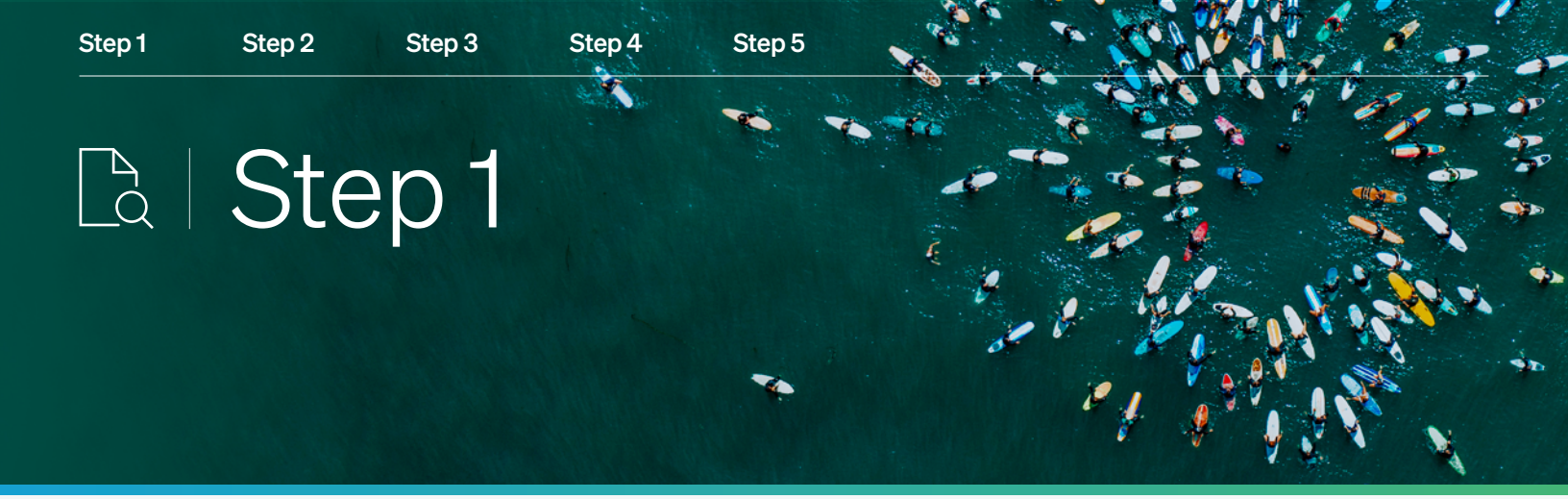
Step 1
Identify today's improvement opportunities to set tomorrow's quality goals

Step 2
Select measures based on your quality goals

Step 3
Determine measure baselines and set targets

Step 4
Set performance payments that incentivize quality improvement

Step 5
Establish a timeline and process for calculating quality measures in contracts



Step 1

Identify today's improvement opportunities to set tomorrow's quality goals

Understanding the current health status of the member population will help employers identify gaps in health care quality and prioritize areas for improvement. For example, high levels of A1c (average amount of glucose) of a member population or sub-populations might lead to a goal of reducing diabetes prevalence.

Identify opportunities for quality improvement: Review available data (e.g., medical claims, biometric, employee survey, etc.) to understand the current health status of employees. Review data by specific geographic locations and/or demographic factors, such as race and ethnicity, to understand health disparities in certain populations or areas. Review nonmedical factors that affects health outcomes, such as social drivers of health (SDOH).[2]

Establish a quality improvement strategy that aligns with the overall benefits strategy to help determine which measures to prioritize: Document the short- and long-term quality improvement[3] goals you want to achieve, and select health outcomes that map to those goals and are measurable over time.

"When payments are tied to performance, employers can feel more confident that covered health care providers will focus on improving clinical outcomes and employee health."

Fatema Salam
Vice President and Quality Lead, Morgan Health

Snapshot of quality measure concepts in the JPMorganChase benefits ecosystem

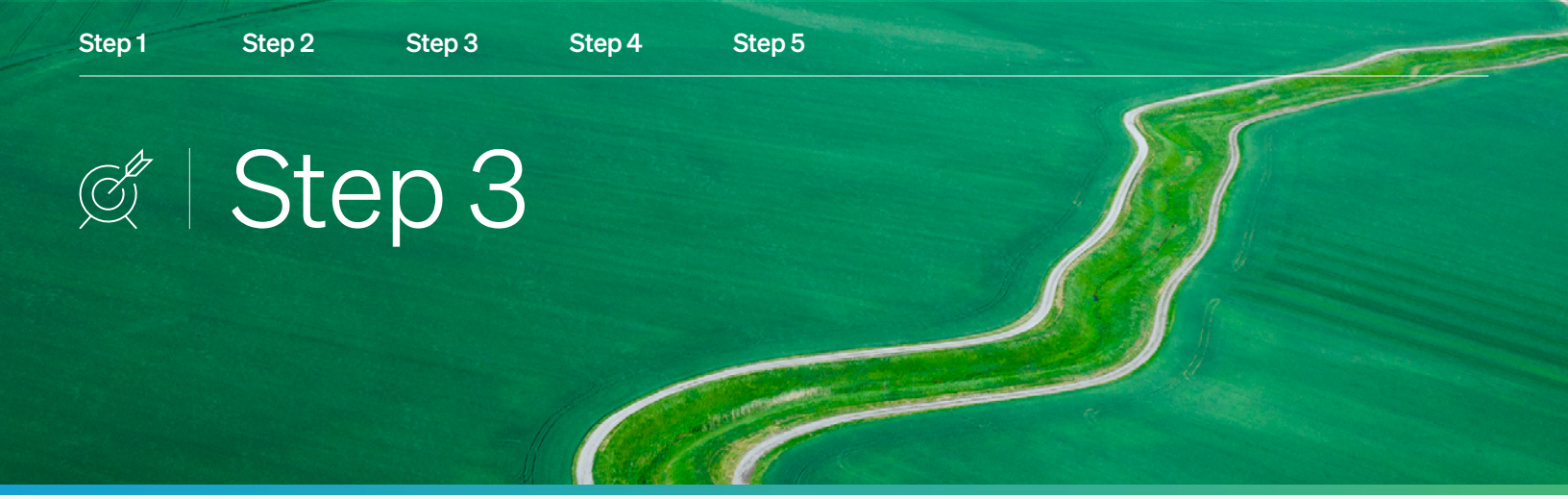
Morgan Health and JPMorganChase Benefits identified quality priorities across three measure categories for its three organizational goals: quality, health equity and affordability. The table below lays out specific measures selected by category.

	Health outcome and improvement measures	Innovative and Engagement Measures	Program success and evaluation measures
Quality: Is the program or intervention improving quality outcomes in areas identified for improvement?	– Breast cancer screening – Colon cancer screening – Screening for depression and follow-up – Blood pressure control – Depression screening and follow-up	– Percentage of members with undiagnosed diabetes being managed by a provider – Percentage of members with hypertension being managed by a provider – Percentage of members with hypertension with a health coaching encounter to manage hypertension	– Closed loop primary care referrals to specialists – Same day accessible appointments for acute care – Patient reported outcomes
Affordability: Is the program or intervention lowering overall cost of care for the employer and employee?	– Avoidable emergency department (ED) utilization		
Equity: Is the program or intervention ensuring all members have access to high quality health care, regardless of race, ethnicity and income level?	– Screening for SDOH and follow-up with resources or support for positive screens – All subpopulations reach the national Healthcare Effectiveness Data and Information Set (HEDIS) 50th percentile for select populations	– Percentage of members with self-reported race and/or ethnicity data in electronic medical record (EMR) – Stratifying a subset of quality measures by race and/or ethnicity to identify gaps - cervical cancer screening, blood pressure control, diabetes control, depression screening and follow-up, prenatal and postpartum care	– Percentage of members that agree to participate in a program to address social and economic needs that affect their ability to maintain their health and well-being.

Step 2

Select measures based on your quality goals

Measure Types	Example Measures
Leading indicators: Track progress throughout the year to gain preliminary insights into how a program is performing	Develop a set of leading indicators using available data sources that are reported frequently (i.e., quarterly) and provide an early signal of how pilots and programs are tracking toward goals. Leading indicators can be easier to operationalize in the short-term. Examples: – Behavioral health (BH) care utilization of engaged members – Post visit survey satisfaction or Net Promoter Score (NPS) – Percentage of members with chronic disease management plans in advanced primary care settings – SDOH Screening and follow-up
Clinical quality measures: Opportunities to improve quality, affordability and equity	Morgan Health calculated measures, including breast and cervical cancer screening rates in specific geographic areas and compared them to other geographic areas, to determine if quality improvement opportunities existed. When the data revealed an opportunity to improve breast cancer screening rates, targeted outreach could be deployed to increase mammogram rates.
Measures of success: Evaluate program/pilot success and efficacy	JPMorganChase included an Avoidable ED utilization measure in two direct contracts for advanced primary care, as a key measure of success for those clinical models.
Engagement measures: Accommodate the challenges employers face compiling medical claims across multiple data sources	Blood pressure readings are not typically available in medical claims without EMR data joined to the patient's record. An employer could leverage biometric data, if available, to identify members whose reading indicated stage 1 hypertension. Health coaches can confirm and offer health coaching specific to managing hypertension. In another example, an employer could identify members with elevated A1cs using biometric data without a diabetes diagnosis in their medical claims. They could use that data to direct their disease management vendor or other programs to engage these members and connect them to care.



Step 3

Determine measure baselines and set targets

Morgan Health used a data-driven process to set baselines, agree on targets, and assess quality improvement. Data limitations may present challenges: for example employers typically do not have longitudinal data on their members due to employee turnover. However, employers can leverage HIPAA-compliant national patient data sets (e.g. Health Verity) to supplement when member data is not available to use for baselining.

Morgan Health leverages multiple data sources to establish measure baselines. Use national benchmarks (e.g., NCQA Quality Compass - Employers can use a tool for examining HEDIS benchmarks for industry standard quality measures) or evidence-based research studies as a proxy for current performance on a measure concept if member medical claims are not stable enough to set a baseline.

Approaches to setting targets for Advanced Primary Care Pilots and Programs

As the foundation of the health care system, the following examples illustrate setting targets around tenets of advanced primary care (e.g., behavioral health integration and increased access to primary care as a strategy for a conduit for reducing avoidable ED visits).

Type of target	Example	Considerations
Year-over-year improvement	**Screening for depression and follow-up** **Target:** 15% improvement in screening rates over the prior measurement year	This measure is an indicator of program efficacy. Set a target to determine whether the program is delivering its intended result (i.e., integration of behavioral health into primary care).
Improvement in a specific geography	**Potentially avoidable ED visits per 1,000 members** **Target:** 5% lower avoidable ED rate in the geographic area where the program is implemented versus not implemented	This measure is an indicator of program success. Set a target tied to improvement over a specific geographic area to determine impact.
Anchored to a longer-term goal (i.e. reducing chronic disease prevalence and health disparities)	**Percentage of members with race and ethnicity data in the EMR** **Target:** 85% or more members have race and/or ethnicity in their EMR record	This is a process measure. However, the target aims to capture critical data to set the stage for identifying, and ultimately, implementing programs to reduce health disparities.

Step 4

Set performance payments that incentivize quality improvement

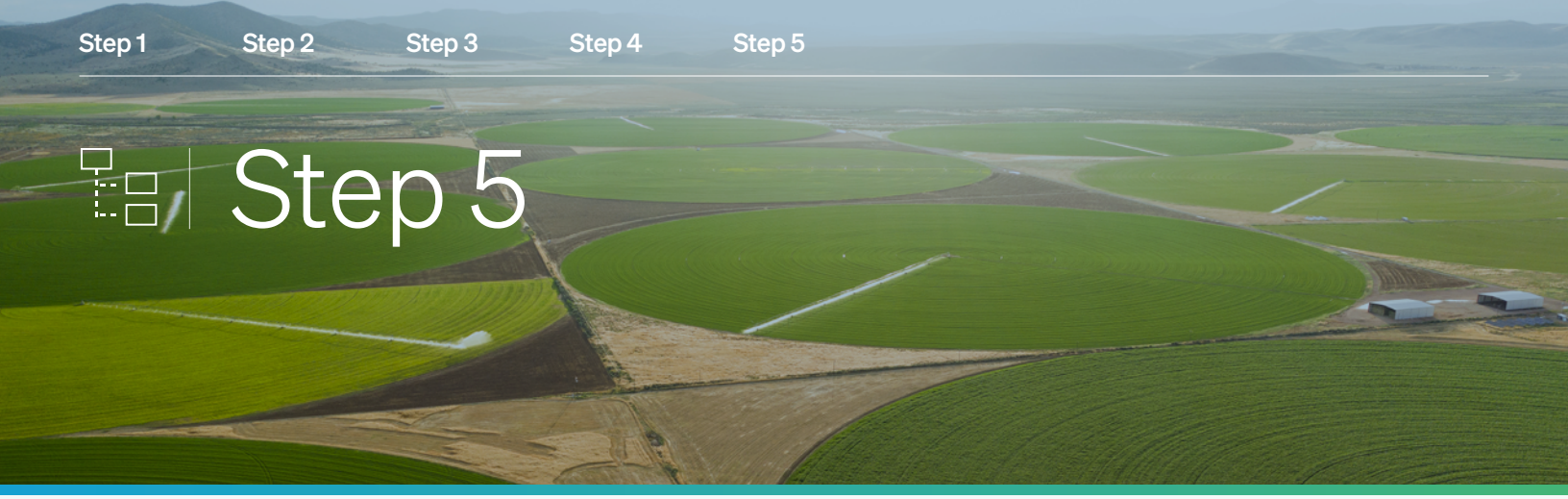
Setting payment incentives or agreeing on fees-at-risk for performance is critical to establishing accountability for quality. Employers and vendors should discuss the best approach for the first year and align around the longer-term goals for the payment incentives and risk arrangement at the onset of contract negotiations. There are multiple considerations and trade-offs when tying quality improvement to financial incentives and putting fees-at-risk, for example:

Start with up-side only payments. New vendors may be hesitant to enter into downside risk arrangements at the outset, especially early-stage companies. Upside-only payments incentivize vendors to prioritize an employer's quality goals and collect data on the program's performance.

Ramp up fees-at-risk over time. Increase accountability for outcomes by transitioning from upside-only to downside risk arrangements. As employers and vendors begin working together and more information and data are collected about program implementation, they will better understand the right balance of risk arrangements to improve vendor performance, without putting the company at too much risk. For example, if a target is aggressive, but achievable, consider tiering the payment incentive structure so that the vendor receives an incentive for making significant progress towards the goal.

Increase accountability for outcomes by transitioning from upside-only to downside risk arrangements.

Establish payment incentives with intention. Performance payments are a means to an end. For example, if a vendor is new, in year one, the focus is on member engagement. The goal is to encourage adoption by employees and performance incentives for member engagement to ensure adequate participation in the first year rather than quality improvement. In year two, introduce payment incentives for quality improvement in known areas with gaps in care.



Step 5

Establish a timeline and process for calculating quality measures in contracts

As a final step, it is important to document how baselines were set and how results are calculated. This ensures all parties involved in the contract are aligned on measure methodologies and avoids results being contested. Documenting methodologies can also be useful in the event of an audit, especially when quality measures in contracts are tied to financial incentives and accountability. While this process may be commonplace for many large employers, below are key considerations:

Agree on which party will calculate results and establish data-sharing arrangements. Most employers will not want results to be calculated by the vendor, however data limitations may hamstring an employer's ability to measure or require a different methodology. In some cases, employers may choose a third-party vendor.

Set a timeline for when quality measures are calculated and results shared with the vendor. Document quality measure calculation steps and coding (baseline and results) along with screenshots of the output to memorialize the results.

Leverage leading indicators to continually (e.g., quarterly or monthly) monitor progress towards outcome-based performance guarantees through the contract year across pilots and programs. Leading indicators provide early signals whether a performance guarantee is at risk or underperforming and provides an opportunity for intervention to improve performance.

Identify a person accountable for producing digestible dashboards on a regular cadence to quickly identify progress towards quality goals and report to leadership.

"With 285,000 lives covered through our benefits plan, we're dedicated to sharing our learnings to help our industry peers drive greater value from their benefit offerings."

Dotan Ziv
Head of U.S. Benefits Design and Strategy, JPMorganChase

Contract for Quality

Employers should codify an internal approach to integrating quality measures into the benefits ecosystem to drive accountability for health outcome improvements based on the quality improvement goals they want to achieve. Leveraging a data-driven approach to quality integration during contracting in the form of health outcome-based performance guarantees sends a strong signal to external vendors and in direct contracts that employers demand value.

Start by embedding one to three outcomes-based performance guarantees into your next vendor contract to start building your internal capacity to contract for quality to ensure investments in benefits improve the health of your employees and their families.

We learned from a recently conducted **series of interviews with self-insured employers** that employers want to learn from other employers through open access to best practices that provide details around what worked or did not work when integrating accountability for health outcomes into the benefits ecosystem. As we continue to share our experience, we invite other employers to participate and share best practices across the sector.

Small and mid-sized employers and/or younger vendors may have more limited ability to establish quality improvement goals tied to financial accountability. As a starting point, these employers can obtain mutual agreement towards measures of success provides a framework to integrate quality measures in future contract years.

To learn more, please visit **www.morganhealth.com/health-care-quality**

1 This information was compiled based on multiple sources, of which JPMC benefits is one. However, inclusion of examples or guidelines does not necessarily mean JPMC benefits has implemented or plans to implement such programs.

2 Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

3 Quality improvement is the framework used to systematically (continuous and on-going) improve care.