DRAFT

Healthcare Innovation Steering Committee

Quality Council Update

March 12th, 2015

Participants

SIM Quality Council

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Quality Council

- Thirteen full council meetings to date
- Executive team
  - Dr. Mehul Dalal, DPH (co-chair)
  - Deborah Dauser Forrest, Connecticare
  - Meryl Price, consumer advocate
  - Dr. Steve Wolfson, physician (co-chair)
- See Appendix for design group participants

Process

Guiding Principles

1. Maximize alignment with the Medicare Shared Savings Program ACO measure set.

2. Recommend additional measure elements that address the most significant health needs of Connecticut residents, the needs of non-Medicare populations (e.g., pediatrics, reproductive health), and areas of special emphasis such as behavioral health, health equity, patient safety, and care experience.

3. Wherever possible, draw from established measures such as those already established by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, CMS Meaningful Use Clinical Quality Measures, NCQA measures, and the CMMI Core Measure Set.

*See appendix for complete set of Guiding Principles

Defining Council Outputs

- Recommend a Common Measure set that is actually a menu of measures
- No payer-provider contract would include all measures in all value-based contracts
- However, when payer focuses on a condition that is included in the measure set, they must use the measure and specifications as defined in the measure set

Defining Council Outputs

- Focus on Commercial/Medicaid measures
- Set aside measures for over 65
- Include all measures that are a high priority for <u>any</u> payer/population
- Include even those measures that may not be appropriate for some providers or populations

Defining Council Outputs

- If measure set is a menu, how we would we ensure achievement of SIM objectives?
  - Certain domains and measures could be deemed *essential* measures
  - Other measures would be *optional*
  - Status would be recommended by Council

Sample Measure Set Format

ACO #	Measure title	NQF #	Essential vs Optional	Data source	Pediatric/ Adult	Reporting vs. Payment		
						2016	2017	2018
Domain: patient/caregiver experience								
1	xxxxx	0123	E	Survey	P/A	P	P	P
2	xxxxx	0123	E	Survey	P/A	P	P	P
3	xxxxx	0123	E	Survey	P/A	P	P	P
4	xxxxx	0123	E	Survey	P/A	P	P	P
5	xxxxx	0123	E	Survey	P/A	P	P	P
6	xxxxx	0123	E	Survey	P/A	R	R	R
Domain: care coordination/patient safety								
9	xxxxx	0123	E	Claims	A	P	P	P
10	xxxxx	0123	E	Claims	A	R	P	P
11	xxxxx	0123	O	Claims	A	R	P	P
12	xxxxx	0123	E	Claims	P	P	P	P
13	xxxxx	0123	O	Claims	A	P	P	P
14	xxxxx	0123	O	Claims	P	P	P	P
Domain: preventive health								
15	xxxxx	0123	E	Claims	A	P	P	P
16	xxxxx	0123	E	EHR	A	P	P	P
17	xxxxx	0123	O	EHR	A	R	R	P
18	xxxxx	0123	E	Claims	A	P	P	P
19	xxxxx	0123	O	EHR	P	P	P	P
20	xxxxx	0123	O	EHR	P	P	P	P
Domain: at-risk population								
Asthma								
21	xxxxx	0123	E	EHR	P/A	R	R	P
22	xxxxx	0123	O	EHR	A	P	P	P

Resources

Technical assistance/consultation

- CMMI – NORC at the University of Chicago, SHADAC and Center for Healthcare Strategies
  - CT comparison to other SIM states, readmission, care experience
- Yale – CORE (Center for Outcomes Research and Evaluation)
  - Readmission, hospital admission, avoidable ED, cardiac
- NCQA
  - Readmission, admission, ED use, base rates,
- Leora Horwitz, MD, NYU
  - Readmission measures

Resources – Measure sets and summaries

- National Quality Forum (NQF) endorsed measures
- NCQA – HEDIS, ACO measure set
- RWJF – Buying Value Initiative – Most frequently used measures
- Physician Quality Reporting Systems (PQRS)
- eCQM – measures for production by ONC certified EHRs
- Pinnacle Registry – cardiac measures
- Medicaid Adult and CHIPRA Pediatric measures

Resources – State Measure Sets

- Massachusetts – CHIA, Standard Quality Measure Set (SQMS)
- Main – Accountable Communities
- Oregon – Coordinated Care Organizations
- Minnesota - Integrated Health Partnership
- New Jersey – Medicaid ACO Demonstration Project
- Vermont – Medicaid ACO Shared Savings Program

Resources

- Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs – CHCS

  http://www.chcs.org/media/QM_Medicaid-ACOs_matrix_0924142.pdf
- Achieving the Potential of Health Care Performance Measures

  http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/quality/2014-09-03/rwjf_406195_performance_measures_brief.pdf
- Medicare publications – proposed and final rules

Process

Measure Comparison Table

- 33 Medicare ACO measures (2012 – 2014)
- New Medicare ACO measures proposed and accepted for 2015
- All measures currently in use by Connecticut's largest commercial payers – claims based
- All measures currently in use by Connecticut Medicaid for the PCMH Program
- More than 100 measures reviewed

Three Level Review

Level 1

- Is the measure part of the Medicare ACO SSP set?
- Does the measure address a significant population health concern based on prevalence?
- Does the measure address a health disparity concern?
- Is there another compelling reason that the measure should be used for SSP, e.g., the measure represents a known patient safety, quality, or resource efficiency/cost concern?

Action: Provisionally accept if [one, two three???] of the above is true.

Level 2 (review all measures that pass level 1)

- Is the measure appropriate for VBP for Advanced network, FQHC, and/or ACO (e.g., eliminate measures recommended for individual clinicians, home health agencies, hospitals, etc.)
- Does measure meet feasibility, usability, accuracy and reliability standards?
- Is the measure easily tied to QI efforts at the level of the Advanced Network/FQHC/ACO?

Action: Provisionally accept if one of the above is true.

Three Level Review

Level 3 (for all measures that pass level 2)

- De-duplication
  - Is the measure the same or similar to another measure (e.g., “hospital admissions for asthma among older adults” is subsumed within “hospital admissions for COPD or asthma among older adults”)
- Culling
  - E.g,. Is the measure a process measure for which an available outcome measure will suffice?
  - Does the measure represent an area where the state is already performing well, including for significant sub-populations (if known)
  - If the measures within a performance domain or sub-domain (e.g., diabetes care) are in excess of what is necessary to demonstrate improved performance, retain those measures which serve as the best indicators of improvement.
  - If the number of performance areas (e.g., diabetes care, epilepsy care) is too high, such that organizational focus and improvement would be compromised, Council will rank and retain the highest ranked areas.
- Check for conflicts w guiding principles
- Reconsider previously rejected measures if necessary

Action: Accept those that remain.

Break Out Groups

- Created three sub-groups in order to:
  - Provide the opportunity for in depth review outside of the full council meetings
  - Consolidate perspectives from 20+ individual members to 3 sub-group perspectives

Consumer Advocates

Physicians

Payers

Design Groups & Care Management Committee

Pediatric Design Group → 12 recommended measures

Behavioral Health Design Group → 10 recommended measures

Health Equity Design Group

Care Experience Design Group

MAPOC Care Management Committee

Recommendations Pending

Opportunity for Improvement

- Assess CT performance relative to national average where such data is available
  - Quality Compass
- Assess CT performance against national benchmark
  - E.g., AHRQ national benchmarks
- Larger improvement opportunity – higher priority
- Consider provider variation where available

Base Rate Analysis

- Assess for base rate sufficiency:
  - Cases that meet the criteria for the numerator/5000 members/year
  - Cases that meeting the criteria for the denominator/5000 members/year
- Sufficiency for smallest Advanced Networks and FQHC population assuming minimum of 5,000 attributed lives
- Rule of thumb: denominator at least 150
- Based on overall commercial and Medicaid populations - actual rates may vary among individual Advanced Networks and FQHCs; hospital based may have a sicker population.

Base Rate Analysis – Target Measures

- Readmission
- Ambulatory care sensitive conditions composite (all-cause PQI or new NCQA spec)
- COPD (numerator, hospital admissions for COPD)/(denominator, pts with COPD)
- CHF (numerator, all-cause hospital admissions)/(denominator, patients with CHF)
- DM (numerator, all-cause hospital admissions)/(denominator, patients with DM)
- MCC (numerator, all-cause hospital admissions)/(denominator, patients with MCC as defined below*)
- Asthma, adult (numerator, all-cause hospital admissions)/(denominator, adult patients with asthma)
- Asthma, pediatric (numerator, all-cause hospital admissions)/(denominator, pediatric patients with asthma)
- Rheumatoid arthritis
- Cardiac conditions in the semi-final measures under consideration

Feasibility

- Identify data source and methodology
  - Survey
  - Claims
  - Electronic Health Record (EHR)
- Consider feasibility of building claims based measures:
  - By payers or by means of APCD
- Consider feasibility of building EHR based measures
  - Quality Council memo to HIT Council requesting "proof of concept"
  - Examine full cycle solution for production of EHR based measures using A1C poor control and hypertension control as demonstration measures

Provisional Measure Set

Provisional Measure Set

- Based on Level I/II review, measures have been recommended for provisional measure set
- Does not include readmission, admission, ED use, consumer experience measures
- Final review and culling will be based on expanded stakeholder input and examination of base rate information and improvement opportunity
- Final review will also consider HIT Council examination of feasibility, especially as it pertains to EHR based measures

Provisional Measure Set - Prevention

Prevention Measure	NQF
Breast cancer screening	NQF 2372
Cervical cancer screening	NQF 0032
Chlamydia screening in women	NQF 0033
Colorectal cancer screening	NQF 0034
Preventive care and screening: influenza immunization	NQF 0041
Preventive care and screening: body mass index screening and follow-up	NQF 0421
Weight assessment and counseling for nutrition and physical activity for children/adolescents	NQF 0024

Provisional Measure Set - Prevention

Prevention Measure	NQF
Developmental screening in the first three years of life	NQF 1448
Well-child visits in the first 15 months of life	NQF 1392
Well-child visits in the third, fourth, fifth and sixth years of life	NQF 1516
Adolescent well-care visits	
Pediatric behavioral health screening	NQF 0722
Preventive care and screening: tobacco use: screening and cessation intervention	NQF 0028
Preventive care and screening: screening for high blood pressure and follow-up documented	

Provisional Measure Set - Prevention

Prevention Measure	NQF
Preventive care and screening: screening for clinical depression and follow-up plan	NQF 0418
Prenatal care & Postpartum care	NQF 1517
Frequency of ongoing prenatal care	NQF 1391
Maternal depression screening	NQF 1516
Annual dental visit	

Provisional Measure Set – Acute & Chronic care

Measure	NQF
Medication management for people with asthma	NQF 1799
Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis	NQF 0054
DM: Hemoglobin Alc Poor Control (>9%)	NQF 0059
DM: Diabetes eye exam	NQF 0055
DM: Diabetes foot exam	NQF 0057
DM: Diabetes: medical attention for nephropathy	NQF 0062

Provisional Measure Set – Acute & Chronic care

Measure	NQF #
HTN: Controlling high blood pressure	NQF 0018
CHF: beta-blocker therapy for left ventricular systolic dysfunction	NQF 0083
COPD: Use of spirometry testing in the assessment and diagnosis of COPD	NQF 0577
CAD: Persistence of Beta blocker therapy after a heart attack	NQF 0071
CAD: Medication adherence	NQF 0543
Use of imaging studies for low back pain	NQF 0052
Avoidance of antibiotic treatment in adults with acute bronchitis	NQF 0058
Appropriate treatment for children with upper respiratory infection	NQF 0069

Provisional Measure Set

Behavioral Health Measures	NQF #
Follow-up care for children prescribed ADHD medication	NQF 0108
Depression Remission at 12 Twelve Months	NQF 0710
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	NQF 1365
Preventive Care and Screening: Unhealthy Alcohol Use – Screening	PQRS 173

Obstetrics Measure	NQF #
Elective Delivery	NQF 0469

Measures Under Review

Under Review – Consumer Experience

Domain: consumer experience		NQF	Steward
ACO-1-7, 34	ACO-CAHPS	0005 (adapted)	CMS
	PCMH CAHPS	0005 (adapted)	NCQA

Note: Design group is recommending some version of CAHPS; Council has not yet recommended use of CAHPS

Under Review – Consumer Experience

	ACO CAHPS	PCMH CAHPS
Pros	• Medicare SSP aligned	• National benchmark data • Aligned with CT Medicaid
Cons	• No national benchmark data	• Not aligned w/Medicare • Focus on practice team rather than neighborhood team

Under Review - Readmission

Domain: care coordination/patient safety		NQF	Steward
ACO-8	Risk standardized all condition readmission	1789 (adapted)	CMS
	Plan All-cause Readmissions	1768	NCQA

Under Review - Readmission

	CMS readmission NQF 1789	NCQA readmission NQF 1768
Pros	Medicare SSP aligned Risk standardization can apply to commercial and Medicaid	Harmonized with CMS measure on index admission and planned exclusions Includes BH admissions National benchmark data
Cons	Excludes BH admissions No national benchmark	No risk adjustment for Medicaid Excludes births

Options:

- Use NCQA measure and exclude readmission from Medicaid scorecard
- CT (w/ other SIM states?) stewards risk standardization for NCQA/Medicaid
- CT stewards addition of BH component to CMS measure

Under Review – Ambulatory Care Sensitive Condition Admissions

Domain: care coordination/patient safety		NQF	Steward
ACO-35	Skilled Nursing Facility 30-day All-Cause Readmission Measure (SNFRM)	TBD	CMS
ACO-36	All-cause unplanned admissions for patients with DM	TBD	CMS
ACO-37	All-cause unplanned admissions for patients with heart failure	TBD	CMS
ACO-38	All-cause unplanned admission for multiple chronic conditions	TBD	CMS
ACO-9	Ambulatory Sensitive conditions admissions: chronic obstructive pulmonary disease (COPD) or asthma in older adults	0275	AHRQ, PQI-5
ACO-10	Ambulatory sensitive conditions admissions: heart failure (HF)	0277	AHRQ, PQI-8
	Hospital admissions for asthma (adults)	0283	AHRQ, PQI-15
	Hospital admissions for asthma (child)	0728	AHRQ

Under Review – Ambulatory Care Sensitive Condition Admissions

- Currently assessing base rate sufficiency
- Base rates likely to be an issue for all conditions other than asthma
- Options:
  - Use APCD to calculate commercial payer agnostic performance
  - Use APCD to calculate commercial/Medicare payer agnostic performance*
  - Use Ambulatory Care Sensitive Condition (ASC) composite (see next slide)

*Medicaid could be included though SDS risk issues might be problematic

Under Review – Ambulatory Care Sensitive Condition Composite

Domain: care coordination/patient safety		NQF	Steward	
	Ambulatory Sensitive Condition (ASC) Admissions		Anthem/ AHRQ	Claims
	Pediatric Ambulatory Care Sensitive Admissions		Anthem/ AHRQ	Claims
	Ambulatory Sensitive Condition Admissions		NCQA	Claims

- **Options:**
  - Use Anthem adaptation of AHRQ/PQI ambulatory care sensitive condition composite
  - CT (w/ other SIM states?) stewards risk standardization of NQCA ambulatory care sensitive condition composite (currently Medicare only)

Under Review – Emergency Department Measures

Domain: care coordination/patient safety		NQF	Steward	
	Annual % of asthma patients (ages 2-20) with one or more asthma-related emergency department visits	d/c	Alabama	Claims
	Potentially avoidable ER rate		Anthem	

Under Review – Emergency Department Measures

- Comment on asthma ED measure:
  - Asthma ED possible strong indicator of effective asthma management; however, NQF endorsement removed
  - NCQA recommends CT consider using risk-standardized asthma ED observed/expected ratio that is one component of their relative resource utilization measure
- Comment on avoidable ED measure:
  - Avoidable ED use is difficulty to measure accurately
  - Yale CORE advises not a clear dichotomcy
  - VT reports effort to use NYU algorithm (Anthem also uses adaptation of NYU algorithm); providers concerned about lack of national benchmarks, difficulty categorizing visits reliably/accurately…some admissions are part avoidable/part un-avoidable, and measure does not give clear guidance as to which cases should have different follow-up; neither payment nor reporting – monitoring only

Other Measures Under Review

Domain: care coordination/patient safety		NQF	Steward
	Post-Admission Follow-up: Percentage of adults w/ inpatient "medicine" admissions with post-admission follow-up within 7 days of discharge	?	DSS
ACO-11	Percent of primary care physicians who successfully meet meaningful use requirements	N/A	CMS
Domain: Behavioral Health		**NQF**	**Steward**
	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	N/A	CMS

Under Review – Oral Health Measures

Domain: care coordination/patient safety		NQF	Steward
Annual dental visit	The percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.	None	CMS
Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers	The measure will a) track the extent to which the PCMP or clinic (determined by the provider number used for billing) applies FV as part of the EPSDT examination and b) track the degree to which each billing entity's use of the EPSDT with FV codes increases from year to year (more children varnished and more children receiving FV four times a year according to ADA recommendations for high-risk children.	1419	University of Minnesota
Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	Percentage of enrolled children aged 1-21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.	2528	American Dental Association on behalf of the Dental Quality Alliance

Key Questions

- What data source is most appropriate – claims vs. EHR
- Who is responsible for producing new measures?
- How do we handle base rate limitations?
- Some measures may not be ready for implementation in 2016, even for reporting purposes
  - Such measures could be included in the measure set, or as a supplemental set, but projected for implementation at a later time
- Consider value of claims based interim measures until EHR based measures can be produced and tested
- Common scorecard?

Questions

Appendix

Guiding Principles

Guiding Principles

1. Maximize alignment with the Medicare Shared Savings Program ACO measure set.

2. Recommend additional measure elements that address the most significant health needs of Connecticut residents, the needs of non-Medicare populations (e.g., pediatrics, reproductive health), and areas of special emphasis such as behavioral health, health equity, patient safety, and care experience.

3. Wherever possible, draw from established measures such as those already established by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, CMS Meaningful Use Clinical Quality Measures, NCQA measures, and the CMMI Core Measure Set.

Guiding Principles

4. Balance comprehensiveness and breadth with the need to prioritize and focus for the purpose of enabling effective and continuous quality improvement.

5. Promote measures and methods with the aim of maximizing impact, accuracy, validity, fairness and data integrity.

6. Promote credibility and transparency in order to maximize patient, employer, payer, and provider engagement.

7. Assess the impact of race, ethnicity, language, economic status, and other important demographic and cultural characteristics important to health equity. Leverage the output of this analysis to identify potential reportable metrics for inclusion in the scorecard. (Draft…referred to Health Equity Design Group)

Guiding Principles

8. Recommend measures that are accessible with minimal burden to the clinical mission; should draw upon established data acquisition and analysis systems; should be both efficient and practicable with respect to what is required of payers, providers, and consumers; and should make use of improvements in data access and quality as technology evolves and become more refined and varied over time.
9. Maximize the use of clinical outcome measures and patient reported outcomes, over process measures, and measure quality at the level of the organization.
10. Use measurement to promote the concept of the Rapidly Learning Health System.

Design Group Participants

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Acronyms

Acronyms

Acronym	
ACO	Accountable care organization
AHCT	Access Health Connecticut
AMH	Advanced Medical Home
BEST	Bureau of Enterprise Systems and Technology
CID	Connecticut Insurance Department
DAS	Department of Administrative Services
DCF	Department of Children and Families
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DSS	Department of Social Services
HEC	Health Enhancement Community
HIT	Health Information Technology

Acronyms

Acronym	
HIT	Health Information Technology
MOA	Memorandum of Agreement (contract between state agencies)
MQISSP	Medicaid Quality Improvement & Shared Savings Program
OSC	Office of the State Comptroller
OHA	Office of the Healthcare Advocate
PCMH	Patient Centered Medical Home
PMO	Program Management Office
RFP	Request for Proposals