

SIM Health IT Council Meeting

March 18, 2016

Agenda Topics

- Introductions
- Public Comments
- Minutes approval
- HIT Relevant Updates
- Discuss HIT requirements
- Discuss next steps for Zato/BayState demonstration
- Q&A
- Next Steps

HIT Relevant Updates

- No Cost Extension / New Timeline
- Quality Measure Alignment for
 - Value Based Purchasing (VBP) and eCQMs
- Community and Clinical Integration Program
CCIP is an initiative of part of Practice Transformation Taskforce (PTTF)
- VBID Pilot using EHR Data

SIM: HIT Relevant Updates

- **No cost extension update**

SIM grant timeline if approved:



Health IT Operational Plan

- Hired Health Tech Solutions to write the Health IT Ops plan
- Process
 - Review of all SIM related documents
 - Develop a set of questions for identifying Health IT needs
 - Meetings with work streams (3 meetings with PMO and one meeting with MQISSP and VBID lead)
 - Challenge – Design is in process – How to gather Health IT requirements from SIM program participants
- Deliverable due date 6/1/2016
 - A high-level Health IT plan that is statewide and solves for care coordination and interoperability
 - Plan presented to Health IT Council at the June meeting
 - Plan submitted to CMMI 8/1/2016

SIM: HIT Relevant Updates: Quality Measure Alignment

- **Quality Measure Alignment:** Connecticut's SIM Quality Council has proposed a Provisional Core Measure Set for under 65 population
- Meanwhile, the **Core Quality Measure Collaborative** has been working to address the need for quality measure alignment at the national level
- The Core Quality Measure Collaborative is led by the America's Health Insurance Plans (AHIP) and its member plans' Chief Medical Officers, leaders from CMS and the National Quality Forum (NQF), as well as national physician organizations, employers and consumers
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>
- <http://www.ahipcoverage.com/2016/02/16/ahip-collaborative-partners-announce-core-set-of-quality-measures/>

Core Quality Measures Collaborative

- **Problem they are addressing:** The difficulty of having actionable and useful information because physicians and other clinicians must currently report multiple quality measures to different entities.
- Need to promote the use of accurate, useful information on health care quality that can inform the decisions of consumers, employers, physicians and other clinicians, and policymakers. Especially in the context of value-based reimbursement models.
- Designed to be meaningful to patients, consumers, and physicians, alignment will aid in:
 - promotion of measurement that is evidence-based and generates valuable information for quality improvement,
 - consumer decision-making,
 - value-based payment and purchasing,
 - reduction in the variability in measure selection, and
 - decreased provider's collection burden and cost.

Core Quality Measures Collaborative

- “Our goal is to promote a simplified and consistent process across public and private payers by reducing the total number of measures, refining the measures, and relating measures to patient health — known as the 3Rs (reduce, refine, and relate)”



Core Quality Measures Collaborative

- The Collaborative has reached consensus on **seven core measure sets** at the national level, as a step forward for alignment of quality measures between public and private payers:
 - Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH), and Primary Care
 - Cardiology
 - Gastroenterology
 - HIV and Hepatitis C
 - Medical Oncology
 - Obstetrics and Gynecology
 - Orthopedics

Core Quality Measures Collaborative ACO/PCMH Proposed Measures (1 of 2)

Measure Name	NQF #	Source	On SIM QC set?
Controlling High Blood Pressure	0018	EHR	✓
<i>or Controlling High Blood Pressure (HEDIS 2016)</i>	N/A	EHR	
Persistent Beta Blocker Treatment after a Heart Attack	0071	Claims*	
Ischemic Vascular Disease: Use of Aspirin	0068	Claims*	
Diabetes Care: HbA1c Poor Control (>9%)	0059	EHR	✓
Diabetes Care: Eye Exam	0055	Claims	✓
Diabetes Care: HbA1c testing	0057	Claims	✓
Diabetes Care: Foot Exam	0056	EHR	
Diabetes Care: Medical Attention for Nephropathy	0062	EHR	✓
Medication Reconciliation	0097	EHR	
Cervical Cancer Screening	0032	Claims	✓
Non-recommended Cervical Cancer Screening in Adolescent Females	N/a		

*Not recommended by QC due to low base rates in under 65 population

Core Quality Measures Collaborative ACO/PCMH Proposed Measures (2 of 2)

Measure Name	NQF #	Source	On SIM QC set?
Breast Cancer Screening	2372		✓
Colorectal Cancer Screening	0034	EHR	✓
Tobacco Use: Screening and Cessation	0028	EHR	✓
Body Mass Index (BMI) Screening and Follow-up	0421	EHR	✓
Use of Imaging Studies for Low Back Pain	0052	Claims	✓
CG CAHPS (Consumer Experience Survey)	0005	Survey*	✓
Depression Remission at 12 Months	0710	EHR	✓
Depression Remission at 12 Months – Progress Towards Remission	1885	EHR	
Medication Management for People with Asthma	1799	Claims	✓
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Claims	✓

*QC recommended CG CAHPS with PCMH supplement

QC Provisional Core Measure Set

Consumer Engagement
PCMH/CG - CAHPS care experience measure
Care Coordination
Plan all-cause readmission
Emergency Department Usage per 1000
Annual monitoring for persistent medications
Prevention
Breast cancer screening
Cervical cancer screening
Chlamydia screening in women
Colorectal cancer screening
Adolescent female immunizations HPV
Weight assessment and counseling for nutrition and physical activity for children/adolescents
BMI screening and follow up
Developmental screening in first 3 years of life
Well-child visits in the first 15 months of life
Adolescent well-care visits
Tobacco use screening and cessation intervention
Prenatal Care & Postpartum care
Screening for clinical depression and follow-up plan
Behavioral health screening (Medicaid only)

CQMC Recommended

Acute & Chronic Care
Medication management for people w/ asthma*
Asthma Medication Ratio*
DM: Hemoglobin A1c Poor Control (>9%)
DM: HbA1c Testing**
DM: Diabetes eye exam
DM: Diabetes: medical attention for nephropathy
HTN: Controlling high blood pressure
Use of imaging studies for low back pain
Avoidance of antibiotic treatment in adults with acute bronchitis
Appropriate treatment for children with upper respiratory infection
Behavioral Health
Follow-up for children prescribed ADHD medication
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid only, custom measure)
Depression Remission at 12 Twelve Months
Child & Adolescent Major Depressive Disorder: Suicide Risk Assessment
Unhealthy Alcohol Use – Screening

Adult measures NR by CQMC

CQMC recommended – QC no recommended

Consumer Engagement

Care Coordination

Medication Reconciliation (clinician measure)

Prevention

Non-recommended Cervical Cancer Screening in Adolescent Females

Acute & Chronic Care

Persistent Beta Blocker Treatment after a Heart Attack

Ischemic Vascular Disease: Use of Aspirin or Another Anti-thrombotic

Comprehensive Diabetes Care: Foot Exam

Behavioral Health

Depression Remission at 12 months – Progress Towards Remission

*Four measures in red will be re-considered by Quality Council

Key Takeaways from Comparison

- There is much overlap between the sets: 15 of CT's recommended measures are included in the 21 measure CQMC set
- It appears that only four of those not included in CT's set are appropriate for under 65
- CT recommended a number of additional measures **not yet considered** by the CQMC (e.g., pediatric and substance abuse)
- About half of the measures recommended by both sets require data from clinical systems (e.g., EHR)

• Next Steps

- Meet with CQMC representatives to better understand rationale for recommended measures
- Re-convene Quality Council to adjust Provisional Core Measure Set

HIT Implications

CMS:

- “The continued evolution, use, and expansion of electronic clinical quality measurement in CMS quality reporting and performance initiatives are important factors in the transition from volume-based reimbursement to value based reimbursement. Measures developed from electronic data sources draw from a rich set of clinical data contained within EHR systems and other clinical sources, such as clinical registries.

The rich clinical information contained within the medical record contributes to the development of clinically meaningful measures; however, extracting this information retrospectively outside of the clinical workflow expends valuable time and resources of providers and care teams.”

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Draft-CMS-Quality-Measure-Development-Plan-MDP.pdf>

Core Quality Measures Collaborative

- **Several of the measures included in the core set require clinical data extracted from electronic health records (EHRs), are self-reported by providers, or rely on registries.**
- **CMS: “While some plans and providers may be able to collect certain clinical data, a robust infrastructure to collect data on all the measures in the core set does not exist currently. The implementation of some measures in the core set will depend on availability of such clinical data either from EHRs or registries. Providers and payers will need to work together to create a reporting infrastructure for such measures.”**
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-16.html>

HIT Implications

- Current quality measure reporting infrastructure is costly and burdensome.
- **US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures (Heath Affairs, March 2016)**
 - “Each year US physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.”

Community & Clinical Integration Program

- CCIP promotes care delivery transformation across an organization and its affiliated providers to deliver better care that results in better health outcomes at lower costs for Medicare, Medicaid, and commercial plan enrollees.
- CCIP establishes evidence-based care delivery standards in support of:
 - a) improving care for individuals with complex health needs,
 - b) introducing new quality improvement and care processes to reduce health equity gaps, and
 - c) improving behavioral health integration
- Participants will receive technical assistance and potential transformation awards to work towards or achieve the standards over a 15 month period

Community & Clinical Integration Program

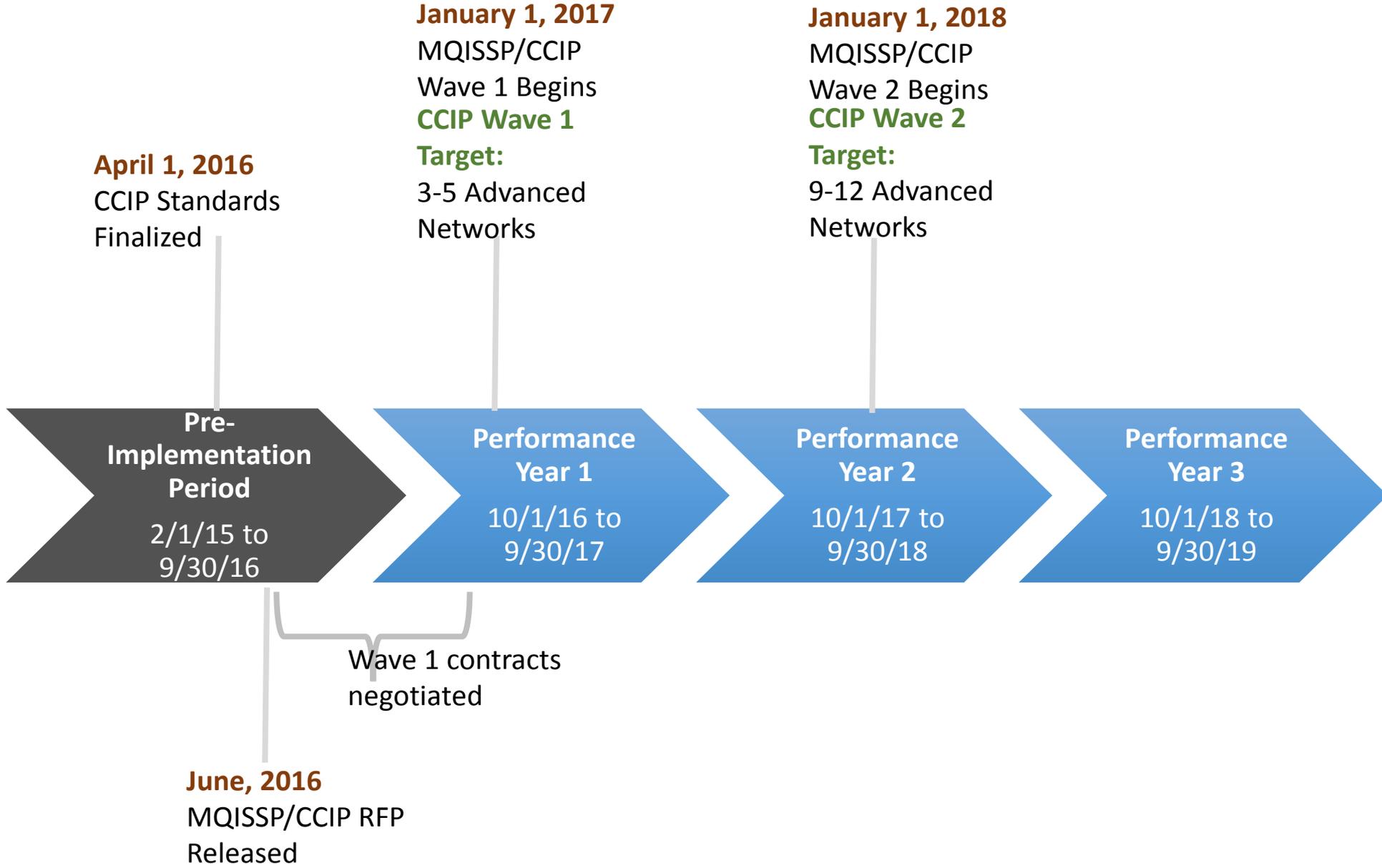
- Public comment closed March 2, 2016
- DSS and the PMO have prepared a response to concerns and a plan for coordinating the launch of MQISSP and CCIP
- The response and plan is summarized at:

http://healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_response_to_concerns_summary_03152016_final.pdf

http://healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_response_to_concerns_03152016_final.pdf

- Plan is under discussion with:
 - Medical Assistance Program Oversight Council, Care Management Committee
 - Practice Transformation Task Force
 - Healthcare Innovation Steering Committee
- Finalize CCIP standards by end of March 2016

CCIP Timeline



CCIP – Potential HIT Implications

- The planning process for CCIP capabilities has revealed potential gaps across health systems including the need to:
 - **share health information efficiently across clinical and community partners**
 - **use e-referral, tracking and follow-up to effect clinical and non-clinical linkages to services and supports**
 - **receive timely information re: ADTs**
 - **effectively coordinate and communicate with inter-disciplinary team including patient, patient supports, clinical and non-clinical community partners**
 - **care teams have access to a comprehensive view of the patient and care plan**
 - **analytic tools enable use of clinical systems to identify high risk populations and sub-population analyses (e.g., race, neighborhood, social factors) to support targeted continuous quality improvement**

CCIP & HIT - Discussion

- How can the State Innovation Model HIT investments promote care delivery transformation and address the gaps that exist in the above areas?

DISCUSS

- Discuss next steps for demonstration Zato/BayState pilot
 - a. Capabilities council would like to see (gathered input by calling and subsequently emailing council members)
 - b. Criteria for evaluation
 - c. Logistics

What do members of the HIT Council want to see in the BayState / Zato demo?

FUNCTIONAL REQUIREMENTS	
Overarching Capabilities	
That the technology has been successfully deployed in a healthcare setting	4
How the technology works	1
Data Source Interface	
How does Zato create the ability to access data, create and manage on-going contact with each database to retrieve data at will?	2
What are the specs for data interfaces/connections to data sources, what is involved?	2
What is the mapping effort involved aggregating across systems? Across corporate entities?	2

Data Retrieval & Aggregation Capabilities	
Data retrieval and aggregation across clinical systems and platforms; what data is being aggregated and what are the data sources?	6
Data accuracy	4
Unstructured data retrieval, accuracy, and accuracy of NLP	4
How the technology reaches in, tags data, brings it into a user interface - quickly, accurately	2
How are alerts of updates/changes to tagged data handled?	1
How does the data extraction, tagging, reporting deal with duplication of patients?	1
How is the site of service information collected and how is it being categorized and cataloged in the system?	1
Taxonomy is important and not just the listing but how the system collapses this information for data aggregation and collection.	1
How complex are the data sets, underlying data currently being used?	1
Where/how are indexes stored?	1
What does the UI look like?	1
How are the ICD codes aggregated up and down tied to HCPCS codes?	1
What are the Bay State algorithms tuned to do? What effort would be involved to develop the algorithms for SIM?	1
What is the architecture? Is data taken directly out of the clinical system or is there a repository involved. Where does the indexing occur?	1

Reporting Capabilities	
Report samples developed from the tool - end products, reports, dashboards, etc.	4
Production of computed measures; quality measures; is there a list of measures currently reported on and what is the criteria/specs for those measures? Using NCQF measures?	4
Report generator - how much coding is required to customize or build new reports?	2
If there is no database, what is the process for storing results of queries and verifying reports?	2
Proof of concept; someone is using and relying on the reports/data.	2
Quality Measurement	
Functionality that aligns with the functionality needed to compute/report eQMs	2
What data elements and variables are they working with (e.g. race, ethnicity, co-morbidities, pediatric, behavioral health)?	2
Level of stratification of computed measures (e.g. by health disparities factors)	2
How they are pulling or capturing the information for analysis and how the report functionality works and the query in general- how real time information is incorporated into previous reports and how the system is filtering information so there is consistency and commonality of information/data that is fed through to reports.	1
How reports that are being created over time are changing or being updated - is there consistency in report generation by timing (monthly pull etc).	1
Who gets the reports? For SIM will the reports be subject to FOIA?	1
Demonstrate an algorithm for measuring outcomes, e.g. for diabetes or HBP	1
Show the integration of claims and clinical data	1

NON-FUNCTIONAL REQUIREMENTS	
Data Security	
What are the roles of the data source operator vs. Zato/data aggregator, esp. in terms of access and maintenance to UI, security, technical operations?	3
The data security model; how do they deal with obtaining authority to get access to the data, e.g. IRB, patient consent? Who has access to the data?	2
Have any privacy or security breaches occurred?	1
Operations	
What is Zato doing with BayState - does the scope, scale, # of clinical systems/platforms, # of patient records, who are the end users align with what CT SIM would need to do? What is the end-to-end use case?	3
BayState staff- testing for accuracy - process, effort, what are they doing with the data?	3
What are the costs and requirements of the data owner at the source? Who pays for the servers, NLP tuning, mapping, maintenance?	2
Talk to BayState staff -- level of effort involved for reporting to get up and running (e.g. IT staff, cost, challenges, security)	2
Who does the data extraction and who does the analysis?	1
How is the information being translated into something actionable i.e., what are they doing with it?	1
How are they validating the accuracy of the product? What is their quality control process?	1
How are the providers using this information and what do they think of the accuracy of the information?	1
What is the time required to setup the software?	1
What are the hardware, software or other requirements to use the software?	1

Customization & Requirements for SIM Pilot

What is the level of customization that would be required to fulfill CT SIM requirements versus the BayState requirements? How replicable is the solution to handle SIM requirements?	2
What is the time requirement for participation in the pilot?	1
Will there be a cost to the payer for participating?	1
What data is needed by the payer for the pilot?	1
What is the value to the payer for using the Zato technology?	1
Is the data only available for one patient/record at a time?	1
Is there any opportunity to review multiple patients/records at once?	1
Is historical data for a patient/record also available?	1
Is the technology able to be used to view patients/members that meet certain criteria, i.e, all Anthem members/patients that have diabetes, etc?	1
What are the security requirements/processes for protecting the data and use of the software?	1

b. Criteria for evaluation

- ▶ How would we know the demonstration is successful?

c. Logistics

- How many members?
- Travel
- Signing non-disclosure agreement
- Dates – April or May

Next Steps