

STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
Wednesday, October 8, 2014

Members Present: Gregory Barbiero; Rohit Bhalla; Aileen Broderick; Mehul Dalal; Deb Dauser Forrest; Daniela Giordano; Karin Haberlin; Elizabeth Krause; Steve Levine; Arlene Murphy; Robert Nardino; Meryl Price;

Members Absent: Mark DeFrancesco; Kathleen Harding; Gigi Hunt; Kathy Lavorgna; Donna O'Shea; Jean Rexford; Rebecca Santiago; Andrew Selinger; Todd Varricchio; Steve Wolfson; Thomas Woodruff

Meeting was called to order at 6:05 p.m.

1. Introductions/public comment

Mehul Dalal chaired the meeting. Participants introduced themselves.

Michaela Fissel provided public comment. Ms. Fissel is a member of the Consumer Advisory Board spoke regarding the guiding principles. She suggested principle #7 be revised to include sexual orientation and gender identity as the LGBT community can be underserved and marginalized.

2. Approval of minutes

Motion: to approve the minutes of the September 3, 2014 meeting – Rohit Bhalla; seconded by Steve Levine.

Discussion: none.

Vote: all in favor, Daniela Giordano abstained.

3. Roadmap

Council members reviewed the roadmap of activities ([page 6 of the meeting presentation](#)). There is the potential to schedule additional meetings before the end of the year if needed. Mark Schaefer asked members would be interested in serving on a care experience design team. Deb Dauser Forrest, Arlene Murphy, Karin Haberlin, and Daniela Giordano volunteered.

Ms. Haberlin and Ms. Giordano are overseeing the behavioral health design group. They are looking for help in terms of potential meeting locations and they are looking for expertise. Elizabeth Krause is overseeing the health equity design group and has begun to schedule meetings.

Ms. Giordano asked if there was a roadmap beyond December. Dr. Schaefer said the group would need to deliberate on changes to subsequent measure sets, continue to align on primary care measures, and then look at specialty care and hospital measures. The preliminary focus will be to focus on aligning to a common measurement set.

4. Guiding principles

The Council revisited the guiding principles ([see Draft 5 tracked changes version here](#) and [Draft 5 accepted changes version here](#)). The discussion focused on Principle #7, taking Ms. Fissel's earlier recommendation into account. There was some agreement that it made sense to collect data related

to sexual orientation and gender identity but that it would need to be reported by patient to ensure it is accurate. Ms. Haberlin said that DMHAS is beginning to collect this information from its clients and that the agency's Office of Multicultural Health is working on appropriate phrasing. There was also discussion as to whether the data should be collected by the provider or the insurer. Dr. Forrest said patients may not trust insurers to collect this information, as they may fear their answers will lead to higher rates. Ms. Murphy suggested having the Health Equity Design Group develop a recommendation. Dr. Forrest suggested including disabilities as well.

Motion: to refer guiding principle #7 to the Health Equity Design group and include socio-demographic information – Arlene Murphy; seconded by Steve Levine.

Discussion: Ms. Krause asked for a clarification of the task. Ms. Murphy said they are looking for a refinement on the language and whether to include sexual orientation, gender identity and disability as part of the principle.

Vote: all in favor.

The Council also discussed principle #8. There were concerns the principle covered too much ground. Rohit Bhalla said this was the only principle that addressed the practicality of the measures. Dr. Schaefer said he would prefer it say they aim to "maximize existing capabilities." Ms. Giordano suggested adding "where possible" to that. She also suggested switching the working around so that similar concepts are paired. The revised principle read:

Recommend measures that are accessible with minimal burden to the clinical mission and are efficient and practicable with respect to what is required of payers, providers, and consumers. Wherever possible the measures will draw upon established data acquisition and analysis systems and make use of improvements in data access and quality as technology evolves and becomes more refined and varied over time.

Motion: to approve the revised language – Meryl Price; seconded by Deb Dauser Forrest.

Discussion: none.

Vote: all in favor.

5. Selection of core measures

The Council began to review an ACO measure comparison chart ([found here](#)). The chart is based off of the Medicare ACO measurement set and includes information as to whether Medicaid or commercial payers use similar measures. There was discussion as to whether measurement was happening at the individual practitioner level. Dr. Bhalla said the measures tie to provider types. For instance, he said, readmission measures would tie to hospitals while diabetes-related A1C measures would tie to primary care. Dr. Schaefer said the payers would be able to measure at the organizational level for the purpose of value-based payment and that perhaps it is up to each organization to look at data at a more granular level and determine where change is needed.

Members discussed ACO Measure #8 – Risk standardized all condition readmission. Medicare released an updated version in spring of 2014. That included a rigorous review process and public comment. Medicaid has a measure that is close to Medicare's. Greg Barbiero said he would share it with the group. Ms. Murphy asked whether it would be possible to have further discussions on risk standardization so that the concept is more easily understood. Dr. Forrest highlighted an article from NCQA on risk adjustment that may be a helpful starting point. Dr. Schaefer said the PMO was open to a number of options to help educate on the concept. ***The Council agreed via consensus to include this measure as a preliminary recommendation.***

The Council discussed ACO Measure #9 – Ambulatory Sensitive conditions admissions: chronic pulmonary disease (COPD) or asthma in older adults. Medicaid is looking to expand this area out into multiple chronic conditions but details are not yet available. There was discussion as to which chronic conditions the state could include in a scorecard. Ms. Price suggested including a limited set of measures for the scorecard with a larger set of performance data that would be fed back. Dr. Forrest said that ConnectiCare uses simpler, HEDIS-based measures that allows for some comparison. They are working to move to risk adjusted measures. Dr. Bhalla noted that health systems need data on how they compare to the rest of the state. Dr. Schaefer noted that this is an area that could be flagged for consideration by the Health Information Technology Council.

The group discussed whether the state's measure should be expanded to other age groups. Medicaid measures asthma under PCMH for those between the ages 2 and 20. There is not an adult asthma measure. Dr. Levine said that they are different issues based on age in which children with asthma are acute reactive and older adults being persistent leading to COPD.

Dr. Dalal asked the group whether they were in favor of including the four measures, noting that three of them do not have detail. The group agreed via consensus to include them based on principle with the goal of following up once more detail becomes available.

Dr. Dalal offered to discuss population health indicators at the state level at a future meeting. Council members said that would be helpful.

6. Next steps

The Council will next meet on October 29th at 6 p.m. at the CT Behavioral Health Partnership.

Meeting adjourned at 8:21 p.m.