

STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
February 18, 2015

Meeting Location: CT State Medical Society, 127 Washington Avenue, North Haven

Members Present: Rohit Bhalla; Aileen Broderick; Mehul Dalal; Jessica DeFlumer-Trapp (for Karin Haberlin); Mark DeFrancesco; Steve Frayne; Amy Gagliardi; Daniela Giordano; Elizabeth Krause; Kathy Lavorgna; Arlene Murphy; Robert Nardino; Donna O'Shea; Meryl Price; Andrew Selinger; Todd Varricchio; Steve Wolfson

Members Absent: Deb Dauser Forrest; Kathleen Harding; Gigi Hunt; Steve Levine; Jean Rexford; Rebecca Santiago; Thomas Woodruff; Robert Zavoski

Other Participants: Deb Amato; Mary Boudreau; Mark Schaefer

Call to Order

The meeting was called to order at 6:06 p.m. Mehul Dalal served as meeting chairman. Participants introduced themselves. Mark Schaefer proposed adding the obstetrics proposal after item 6 to the agenda.

Public Comment

Mary Boudreau offered public comment regarding oral health measures ([see public comment here](#)). She noted there are very high rates of tooth decay among young impoverished children. She recommended including oral assessments in primary care. She noted that the Practice Transformation Task Force included oral health screening in its core areas of emphasis and recommended inclusion of oral health quality measures. Andrew Selinger asked whether commercial would reimburse. Ms. Boudreau said she would share additional information and provide background on fluoride varnish. Steve Wolfson said he was in favor of the measures.

Update – base rates/opportunity for improvement

Arlene Murphy asked who was on the work group to discuss improvement opportunities. Dr. Schaefer said there was no work group and that he would compile information to bring back to the group. There may be measures where the population is only large enough if Medicare is included. Dr. Schaefer referenced payer agnostic measures and the implications for moving in that direction. Dr. Wolfson asked if the group had discussed the fifth item on the agenda – measures primarily for individuals over 65. Dr. Schaefer said that the discussions have focused on under age 65 measures to keep the discussion focused.

Target date for provisional measure set

Dr. Schaefer rolled out the process for developing the measure set. Once the measure set is drafted, it will be presented to the Healthcare Innovation Steering Committee and then be put forth for public input. He said he would like to aim for April so that the set can be implemented for 2016. He asked how they should go about getting payer support: should the group wait to receive support from the payers before moving forward or should they release a set that the payers can cull from and take into their own structure. Dr. Schaefer proposed getting presenting a provisional set to the

Steering Committee on March 12. There is currently a Council meeting set for March 11. He suggested scheduling a conference call before the March 11th meeting. Members proposed seeing where they land at the end of the meeting and then scheduling a brief call if needed. The Council will prepare a presentation for the March 12 Steering Committee meeting.

Measures primarily for individuals over 65

This was discussed under the previous item. The Council will focus on measures targeted to the under 65 population.

Quality Measure Comparison Table Review

The Council continued its measure review ([see table here](#)).

- Diabetes (lines 81, 94, and 98 of the table)
Council members expressed concern about weighing diabetes too heavily. Other diabetes measures covered topics already addressed in other measures (blood pressure, tobacco usage). Foot exams are already part of the Physician Quality Reporting System.
 - Foot exam: include in provisional set.
 - LDL: do not include.
 - Medication adherence: do not include.

- Cardiac and other chronic conditions (lines 100-146 of the table)
 - Epilepsy (lines 100-104): Consensus is not to include.
 - Hypertension (lines 106-109):
 - Controlling high blood pressure has been referred to the Health Information Technology Council for a proof of solution.
 - Hypertension Serum Testing: Consensus is not to include.
 - Diuretics persistent use and medication adherence: Consensus is not to include.
 - Ischemic Stroke/Warfarin Monitoring (line 111): Consensus is not to include.
 - Ischemic vascular disease
 - IVD Complete Lipid panel and LDL control: consensus is not to include.
 - IVD Use of Aspirin: needs further review as to how it is captured
 - Lines 115-117: consensus is not to include.
 - Heart Failure (lines 119-121)
 - Heart failure: beta-blocker therapy for left ventricular systolic dysfunction: consensus is to include
 - Heart failure: beta-blocker therapy: consensus is not to include
 - Digoxin: Persistent use with lab monitoring: consensus is to include
 - COPD
 - Pharmacotherapy management of COPD exacerbation: consensus is not to include
 - Use of spirometry testing in the assessment and diagnosis of COPD: consensus is to include
 - Coronary Artery Disease
 - Coronary artery disease all-or-nothing composite: Lipid Control – redlined
 - Angiotensin-converting enzyme inhibitor or angiotensin receptor blocker (ACE-I/ARB) therapy - diabetes or left ventricular systolic dysfunction – consensus is not to include
 - Persistence of Beta blocker therapy after a heart attack – consensus is to include
 - Lipid lowering drug for LDL>30 – consensus is to not include
 - ACE-I/ARB: Persistent use with lab monitoring – consensus is to not include
 - Post-MI use of ACE-I/ARB w/ h/o, HTN, DM, or HF – consensus is to not include

- Medication adherence – consensus is to include
 - Drug-eluting stent: antiplatelet therapy – consensus is not to include
 - Low Back Pain: Use of imaging studies for low back pain – consensus is to include
 - Migraines: Frequent use of acute meds/ receiving prophylactic meds – consensus is to not include
 - Osteoporosis management in women who had a fracture – consensus is to leave as Medicare only.
 - Otitis Media with Effusion: Tympanostomy tube insertion: pediatric hearing test – redlined. Group to revisit to make sure it is covered.
 - Any Diagnosis: Medication Adherence among members 81 years and older – consensus is to leave as Medicare only
- Acute Care
 - Avoidance of antibiotic treatment in adults with acute bronchitis – consensus is to include
 - Appropriate testing for children with pharyngitis – consensus is to not include
 - Appropriate treatment for children with upper respiratory infection – consensus is to include

The Council will review behavioral health measures at its next meeting. They reviewed obstetrical measures. Mark DeFrancesco reviewed the reasoning behind the obstetrical recommendations ([see recommendations here](#)). He said that ultimately, if the patient's needs are not being met, the primary care practice can recommend the patient go to a different OB/GYN. Dr. Schaefer said this area is not traditionally within the focus of an ACO but noted that ACOs do have influence with the medical neighbors. He said the recommendations do push the boundary on ACO expectations and ties into the Robert Wood Johnson Foundation's Buying Value initiative. He noted the measures could be deemed optional. Aileen Broderick said that the commercial side does well with prenatal care. Ms. Murphy asked whether, for health equity analysis, there will be enough data if it is Medicaid only. Dr. Schaefer said they can work on the gap within Medicaid. Steve Frayne said that they should have the data for the entire population so that they can compare Medicaid to commercial. Dr. Schaefer said the group can recommend inclusion and potentially build off of the All Payer Claims Database. The Council eliminated the surgery measures and included elective delivery and prenatal for Medicaid only and reporting only for commercial.

Next Steps

The Council will complete a new review of behavioral health measures and clean up the list. The last item for review is ambulatory care sensitive conditions which is a complicated measure. Dr. Schaefer proposed scheduling a one hour conference call to review behavioral health and reserving March 11 to review care coordination measures. The call was scheduled for March 4 at 7 p.m.

The meeting adjourned at 8:29 p.m.