

STATE OF CONNECTICUT
State Innovation Model
Quality Council

Conference Call Summary
Wednesday, March 4, 2015

Members Present: Rohit Bhalla; Aileen Broderick; Sandra Czunas (for Thomas Woodruff); Mehul Dalal; Deb Dauser Forrest; Jessica DeFlumer-Trapp (for Karin Haberlin); Steve Frayne; Daniela Giordano; Kathy Lavorgna; Arlene Murphy; Donna O'Shea; Meryl Price; Andrew Selinger; Todd Varricchio; Steve Wolfson

Members Absent: Mark DeFrancesco; Amy Gagliardi; Kathleen Harding; Gigi Hunt; Elizabeth Krause; Steve Levine; Robert Nardino; Jean Rexford; Rebecca Santiago; Robert Zavoski

Other Participants: Deb Amato, Faina Dookh, Lisa Honigfeld; Mark Schaefer

Call to Order

The call was called to order at 7:01 p.m. Steve Wolfson served as call chairman. Participants introduced themselves. It was noted that alternates can participate in the discussion but cannot vote.

Inter-Council Memo – Proof of Solution

The Council reviewed the memo to the Health Information Technology Council regarding a request for a proof of solution ([see memo here](#)). Deb Dauser Forrest asked about the inclusion of a readmission measure. Mark Schaefer said they suspended a request for a proof for a claims based measure until they were certain which measure they planned to use. The goal is to test the limits of the proposed technology. They may find there are certain things they cannot do.

Mehul Dalal suggested the memo be updated to ask for race, ethnicity, and primary language so that it comports with the Department of Public Health's data collection policy. Dr. Schaefer said he would make the change. Dr. Dalal said gender should also be included. Donna O'Shea asked whether line of business would be included as an analytic option. Dr. Schaefer said the idea is to make no assumptions at this time regarding the ability to support pooled performance data. He said flexibility is needed. Daniela Giordano asked for clarification of the term geocode. Dr. Schaefer said it is used to loosely identify neighborhoods. They are trying to get a sense of the limits of the technology. Race, ethnicity, language, and gender are likely to be captured in an EHR but there may be other demographics they would want to capture, if possible. Aileen Broderick asked if they would test the solution by accessing different electronic medical record systems. Dr. Schaefer said the goal is to develop a proof of solution for the entire pathway that includes data integrity. He recommended the Council review the latest HIT Council presentation.

Quality Measure Comparison Table Review

Dr. Schaefer asked Lisa Honigfeld to provide background on her public comment ([see public comment here](#)). She urged the group to strongly consider using the broad behavioral health screening measure, at least as a placeholder. She said no other measure has been validated. Arlene Murphy said there were few things as important in pediatric healthcare as screening for those issues. Dr. Wolfson said he was intimidated by the size of the tool but happy to include it as a placeholder as part of the level 3 discussion.

Ms. Giordano provided an overview of the Behavioral health Design Group's review process. She said they strongly agree that there needs to be something in place for behavioral health in a children's setting. She said they documented recommendations that focused on standards of care. There should be screenings, assessments, and follow up care, care coordination, and hospital based measures. She noted there were not many measures that focused on behavioral health specifically ([see BHDG recommendations here](#)). She reviewed the five measures they recommend for inclusion:

- Preventative Care and Screening: Unhealthy Alcohol Use – Screening
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Co-morbid Conditions
- Depression Remission at Twelve Months
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Dr. Wolfson noted that the BHDG recognizes that many behavioral health clinicians do not have electronic health record systems. He noted an inconsistency in terms of how to solve this issue. He said it appears as though primary care is being asked to solve a behavioral health clinician problem. Ms. Giordano said there needs to be communication from both sides. Dr. Wolfson said that the practice in behavioral health has been not to share their information with others. He was not sure how primary care could break through that. Dr. Schaefer noted that the design group did debate that issue. In those discussions, it was noted that Medicare uses primary care to influence those who are not part of the ACO. Andrew Selinger said that BH care is in short supply. Behavioral health clinicians would need to sign compacts with ACOs that would commit them to exchange information. He was not sure the incentives were there to convince them to take on the extra work. Dr. Schaefer noted that large clinics have EHRs in place. He asked how to best capture the data. Dr. Selinger said they are expected to document the follow up of a referral. The administrative staff would receive a fax or report and check off in the order queue that it has been completed. Dr. Schaefer said it is important that behavioral health serve as an active collaborator. Steve Frayne said that in the Medicare ACO, patients have the ability to prohibit their information from being shared. He asked why they would hold clinicians responsible for something that they cannot influence. Dr. Schaefer said more research could be done. He noted that it was clear this is outside of the direct control of primary care. There could be patient education about the value of communicating this information. It was suggested that Adult MDD measure be tabled further additional research.

The Council discussed the process for the tabled measures. Dr. Schaefer said they will be indicated as being part of the provisional set pending further review, with information included regarding the reasoning for including the measure and what barriers exist that require further examination.

The Council further reviewed additional behavioral health measures. With regard to "Initiation and Engagement of Alcohol and Other Drug Dependence Treatment" the measure is widely used nationwide, mostly for health plan performance. Dr. Wolfson said he anticipated there was lots of room for improvement as resources are lacking. Rohit Bhalla asked if it was appropriate to put the measure on a provider if there was a dearth of resources. Dr. Wolfson said it would highlight an existing problem. Ms. Giordano said that will happen with nearly all of the measures as there is a shortage when it comes to access. Dr. Bhalla asked whether it was fair to differentiate payment if there is no place to refer patients. Dr. Schaefer said there was no disagreement on the clinical importance but that capacity was an important issue for consideration. He said the Council could

provisionally endorse the measure and further determine full endorsement in the next phase. It could also be instituted as reporting only to obtain more information.

The Council discussed depression remission. This is both a behavioral health and primary care measure. There is a concern about a reporting burden. Medicare retained the measure as reporting only for three years. It may be tied to payment at some point. Dr. Selinger said the measure is commonly used and not too burdensome. Dr. Dalal asked how effective treatment was. Dr. Selinger said that when the disorder is identified, they are obligated to treat it. He said it was helpful to have a tool to document it. He did not think there was a risk of overtreatment. PCPs would need to document whether treatment is beneficial to the patient. The downfall is the follow up, which would force more rigor in outcome assessment. He noted that the next measure, "Depression Utilization of the PHQ-9 Tool" would be superfluous. The Council agreed to drop that measure in favor of "Depression Remission."

The Council had already recommended "Maternal Depression Screening" as a provisional measure. Dr. Schaefer said the design group supported the measure and any ambivalence should be resolved. The Council agreed to add it to the measure set. The Council also agreed to add MDD Suicide Risk Assessment.

Ms. Giordano asked if the hospitalization and readmission measures would be tabled. Dr. Schaefer said that was accurate.

Next Steps

Dr. Schaefer said he would prepare a brief summary with a note regarding the disposition. At the March 11th meeting, the Council will review ambulatory and emergency department measures. They can also review the measures on the under review list. Pediatric behavioral health screening and postpartum depression screen have been reviewed. Documentation of current medications in the medical record is a Medicare ACO measure and does not appear to be redundant so it makes sense to include it. Chlamydia screening in women is used widely nationwide. Adolescent screening is also widely in use. With regard to asthma, Dr. Schaefer spoke to Steve Levine and he is okay with using asthma as a measure of system health improvement but indicated that "use of appropriate medication for people with asthma" and "medication management for people with asthma" were not feasible. Dr. Schaefer consulted with Robert McLean regarding drug therapy and that consultation supported inclusion. There will be sufficient base rates but Anthem and Medicaid are further looking at base rates. Dr. Wolfson said that pending the outcome of the base rate questions, there is no opposition to any of the measures.

The Council discussed having an in depth discussion on value based payment to serve as a level set. Due to timing, that would not be feasible for the March 11 meeting. There are also requests to consider an HIV/AIDS measure, one or two coronary artery disease measures, and an oral health measure. Mr. Varricchio said that, in light of timing, they should focus on completing the review of the provisional list before delving into payment models. Dr. Wolfson suggested deferring discussion of the cardiology measures until he was able to participate. Dr. Dalal suggested having the Pediatric Design Group weigh in on the oral health measure. The Behavioral Health Design Group was thanked for their work on the behavioral health measures.

The meeting adjourned at 8:10 p.m.