SIM Quality Council Recommendations Review

Consumer Advisory Board

Webinar

July 28, 2016

10 am – 11 am

Meeting Objectives

- Review SIM Quality Council Measure Recommendations
- Promote **public comment** on Quality Council Report – **DEADLINE August 5, 2016**

Meeting Format

- Focus on recommended health and behavioral health measures
- Opportunity for questions
- Additional questions can be emailed to Deanna.Chaparro@ct.gov

How Will Recommended Quality Measures Be Used?

- SIM Quality Council recommended measures for use in Value Based Payment (VBP)
  - Value Based Payment's goal is to shift from pure volume-based payments (such as fee-for-service) to payments that are more closely related to outcomes and to slow the increase in the total cost of care (such as pay-for-performance, bundled payments, shared savings, global payments)
  - Accountable Care Organizations (ACO) are relatively new health care delivery structures of health care providers working together to manage individuals' full continuum of care, being responsible for the overall cost and quality of care of a defined population.
- SIM Quality Council recommended additional reporting only measures

Types of Measures and Types of Measure Sets Recommended

- Types of Measures
  - Claims Based
  - Clinical/ Electronic Health Records (EHR)

- Measure Sets Recommended
  - Core Measure Set - Highly Recommended for Value Based Payment
  - Reporting Set– Measures for Reporting only by insurance carriers or the State/Medicaid
  - Developmental Set – Measures that are considered important but require significant development for implementation

Consumer Priorities for Quality Measures

- Care Experience
- Health Equity
- Care Coordination
- Behavioral Health
- Prevention, Acute and Chronic Care Management
- Alignment with Medicare, National and State Measures
- Outcome vs Process Measures

Design Groups & Care Management Committee

Pediatric Design Group

Health Equity Design Group

Behavioral Health Design Group

Care Experience Design Group

Obstetrics Design Group

MAPOC
Care Management Committee

Behavioral Health Design Group - Process

Charge: to identify *specific validated quality measures* that can be used within the primary care setting

- Specific (first iteration/phase) measures included in subsequent slides

Broader discussion focused on ***process of integrating*** mental health and substance use into primary care setting

- Universal screenings (mental health, substance use, trauma, well being)
- Follow-up assessment and care
- Access to care
- Coordination of care

Overall recommendation

- Identifying ***educational opportunities*** for community at large and Health care providers

Health Equity Design Group (HEDG)

Members:

- Ignatius Bau, JD, Health Policy Consultant
- Aileen Broderick, Anthem Blue Cross Blue Shield
- Dora Hughes, MD, MPH, Health Policy Consultant, Sidley Austin
- Kathleen Lavorgna, MD, Connecticut State Medical Society
- Elizabeth Krause, ScM, Connecticut Health Foundation, HEDG Leader
- Theanvy Kuoch, MA, Khmer Health Advocates, SIM Consumer Advisory Board
- Wayne Rawlins, MD, MBA, ConnectiCare (formerly Aetna)

Charge:

The HEDG was charged with providing measure recommendations for race/ethnicity stratification to the Quality Council to ensure that health equity is advanced in the implementation of Connecticut's State Innovation Model's (SIM) quality improvement and value based payment program.

Measure Selection and Prioritization Criteria Used:

- From the universe of the EHR and claims based measures in the SIM Quality Council's provisional measure set
- Evidence of racial/ethnic gaps for each measure
- Clinically important from multiple vantage points, but especially to consumers and populations that bear disproportionate inequities
- Aligned with other national and state improvement efforts for leverage and efficiency
- Likely to have adequate base rates (to be determined down the line)

Health Equity Design Group Recommended Measures Summary

Measure	Measure Type	Health Equity background data
Diabetes mellitus: HbA1c poor control (>9%)	Clinical (EHR)	• CT adult prevalence: White 5.7%, Black 14.9%, Hispanic 10.5%, low income 12.3% • CT premature mortality rate from diabetes (males): White 119/100KP, Black 261/100KP, Hispanic 178/100K • CT premature mortality rate from diabetes (females): White 60/100K, Black 175/100K, Hispanic 102/100K • CT lower extremity amputation rate: White 17.4/100K, Black 75.5/100K, Hispanic 47.0/100K
Hypertension: Controlling high blood pressure	Clinical (EHR)	• CT adult prevalence: White 32.5%, Black 35.7%, Hispanic 25.8%, low income 39%
Colorectal cancer screening	Clinical (EHR)	• CT screening prevalence age 50+ with colonoscopy/sigmoidoscopy: White 75.9%, Black 66.1%, Hispanic 69.5%, low income 65%
Screening for clinical depression and follow-up	Clinical (EHR)	• Data needed. Behavioral health is part of whole person centered care; screening already required for PCMH racial disparities in depression screening, SIM Plan p.30
Diabetes mellitus: HbA1c screening	Claims	• See diabetes data above
Plan all-cause readmission	Claims	• Data needed; documented national and state racial/ethnic readmission disparities for conditions including diabetes, heart failure, maternity care, etc.
Asthma medication management	Claims	• CT adult asthma prevalence: White 8.1%, Black 15.5%, Hispanic 11.7%, low income 14% • CT hospitalization rate adults w/ asthma primary dx: White 8/10K, Black 39/10K, Hispanic 43/10K • CT child asthma prevalence: White 10%, Black 18%, Hispanic 12%, low income 18% • CT hospitalization rate children asthma primary dx: White 11/10K, Black: 46/10K, Hispanic 31/10K
Consumer Assessment of Healthcare Providers & Systems (CAHPS)	Survey	• Stratified consumer experience data needed

Considerations for Measure Selection

Robert Wood Johnson Foundation “Buying Value Tool” used to rank measures based on criteria:

- National Quality Rate (NQF) endorsement
- Base rate sufficiency
- Availability of an appropriate benchmark
- Opportunity for improvement
- Outcome vs. process measure
- Health Equity value

QC Provisional Core Measure Set

Consumer Engagement
PCMH - CAHPS care experience measure
Care Coordination
Plan all-cause readmission
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)

Acute & Chronic Care
Medication management for people w/ asthma
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)
Depression Remission at 12 Twelve Months
Progress towards depression remission
Child & Adolescent Major Depressive Disorder: Suicide Risk Assessment
Unhealthy Alcohol Use – Screening

Provisional Core Measure Set

#	Provisional Core Measure Set	NQF	ACO	Steward	Source*	Equity	MQISSP
	Consumer Engagement						
1	PCMH – CAHPS measure**	0005		NCQA		✓	✓
	Care Coordination						
2	Plan all-cause readmission	1768		NCQA	Claims	✓	
3	Annual monitoring for persistent medications (roll-up)	2371		NCQA	Claims		
	Prevention						
4	Breast cancer screening	2372	20	NCQA	Claims		
5	Cervical cancer screening	0032		NCQA	Claims		
6	Chlamydia screening in women	0033		NCQA	Claims		
7	Colorectal cancer screening	0034	19	NCQA	EHR	✓	
8	Adolescent female immunizations HPV	1959		NCQA	Claims		
9	Weight assessment and counseling for nutrition and physical activity for children/adolescents	0024		NCQA	EHR		
10	Preventative care and screening: BMI screening and follow up	0421	16	CMMC	EHR		
11	Developmental screening in the first three years of life	1448		OHSU	EHR		✓
12	Well-child visits in the first 15 months of life	1392		NCQA	Claims		✓
13	Adolescent well-care visits			NCQA	Claims		✓
14	Tobacco use screening and cessation intervention	0028	17	AMA/ PCPI	EHR		
15	Prenatal Care & Postpartum care***	1517		NCQA	EHR		✓
16	Screening for clinical depression and follow-up plan	418	18	CMS	EHR	✓	
17	Behavioral health screening (pediatric, Medicaid only, custom measure)			Custom	Claims		✓

Provisional Core Measure Set

#	Provisional Core Measure Set	NQF	ACO	Steward	Source*	Equity	MQISSP
	Acute & Chronic Care						
18	Medication management for people w/ asthma	1799		NCQA	Claims	✓	✓
19	DM: Hemoglobin A1c Poor Control (>9%)	0059	27	NCQA	EHR	✓	
20	DM: HbA1c Screening****	0057		NCQA	Claims		✓
21	DM: Diabetes eye exam	0055	41	NCQA	EHR		
22	DM: Diabetes: medical attention for nephropathy	0062		NCQA	Claims		
23	HTN: Controlling high blood pressure	0018	28	NCQA	EHR	✓	
24	Use of imaging studies for low back pain	0052		NCQA	Claims		
25	Avoidance of antibiotic treatment in adults with acute bronchitis	0058		NCQA	Claims		✓
26	Appr. treatment for children with upper respiratory infection	0069		NCQA	Claims		
	Behavioral Health						
27	Follow-up care for children prescribed ADHD medication	0108		NCQA	Claims		
28	Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only)	2800		NCQA	Claims		✓
29	Depression Remission at 12 Twelve Months	0710	40	MNCM	EHR		
30	Depression Remission at 12 months – Progress Towards Remission	1885		MNCM	EHR		
31	Child & Adlscnt MDD: Suicide Risk Assessment	1365		AMA/ PCPI	EHR		
32	Unhealthy Alcohol Use – Screening			AMA/ PCPI	EHR		

Reporting Set

#	Reporting Only	NQF	ACO	Steward	Source	Equity
	Coordination of Care					
1	30 day readmission			MMDLN	Claims	
2	% PCPs that meet Meaningful Use		11	CMS	EHR	
	Prevention					
3	Non-recommended Cervical Cancer Screening in Adolescent Female			NCQA	Claims	
4	Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)	1516		NCQA	Claims	
5	Frequency of Ongoing Prenatal Care (FPC)	1391		NCQA	EHR	
6	Oral Evaluation, Dental Services (Medicaid only)	2517		ADA	Claims	✓
	Acute and Chronic Care					
7	Cardiac strss img: Testing in asymptomatic low risk patients	0672		ACC	EHR	
	Behavioral Health					
8	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions			APA	EHR	
9	Anti-Depressant Medication Management	0105		NCQA	Claims	
10	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004		NCQA	Claims	
11	Follow up after hospitalization for mental illness, 7 & 30 days			NCQA	Claims	

Development Set

#	Development Set	NQF	ACO	Steward	Source
	Care Coordination				
1	ASC admissions: chronic obstructive pulmonary disease (COPD) or asthma in older adults	0275	9	AHRQ	Claims
2	ASC: heart failure (HF)	0277	10	AHRQ	Claims
3	All-cause unplanned admission for MCC		38	CMS	Claims
4	All-cause unplanned admissions for patients with heart failure		37	CMS	Claims
5	All-cause unplanned admissions for patients with DM		36	CMS	Claims
6	Asthma in younger adults admission rate	0283		AHRQ	Claims
7	Preventable hospitalization composite (NCQA)/Ambulatory Care Sensitive Condition composite (AHRQ)			NCQA/ AHRQ	Claims
8	Asthma admission rate (child)	0728			Claims
9	Pediatric ambulatory care sensitive condition admission composite			Anthem	Claims
10	ED Use (observed to expected) – New			NCQA	Claims
11	Annual % asthma patients (2-20) with 1 or more asthma-related ED visits				Claims
	Prevention				
12	Oral health: Primary Caries Prevention	~~1419~~		None	Claims
	Acute and Chronic Care				
13	*Gap in HIV medical visits*	2080		HRSA	EHR
14	*HIV/AIDS: Screening for Chlamydia, Gonorrhea, and Syphilis*	0409		NCQA	EHR
15	*HIV viral load suppression*	2082		HRSA	EHR

Implementation phase

- The State is encouraging public and private insurance to consider adopting recommended measures in one of two ways:
  - as part of a standard measure set for all value-based payment contracts or
  - as part of a suite of measures that are included in value-based payment contracts when there is an opportunity for performance improvement. The State recognizes that there are measures in the core set that may not be applicable to all plans or all providers.
- Encourage public and private insurance to use measure set as a reference when negotiating or re-negotiating value-based payment contracts
- Care experience and Claims-based measures will be the initial focus of alignment. Measures that require collection of clinical data will require additional lead time
- Monitor the pace of quality measure alignment

Special issues

- Care coordination measures
- OB/GYN measures
- HIV measures
- Oral health measures
- Cardiology measures
- Core Quality Measures Collaborative

Continuing Challenges

- Health Equity – quality measures must be implemented in ways that identify and address health disparities
- Pediatric and Prenatal measures
- Behavioral Health Measures
- Oral Health Measures
- HIV Measures
- Implementation of (EHR) Electronic Health Records/Clinical Measures

How to Submit Public Comment

- Public Comments on the SIM Quality Council recommendations need to be sent to SIM@ ct.gov by the end of public comment period which is 5pm of August 5, 2016. Please note “SIM Quality Measures” in the comments line.

- Quality Council Report can be found at link below: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=336272