TASK FORCE ON HEALTH CARE ANALYTICS
MEETING MINUTES

DECEMBER 7, 2016
10:00 AM TO 3:00 PM

630 DAVIS DRIVE
MORRISVILLE, NC 27560

Attendees:

- *Co-Chairs:* Warren Newton, Annette Dubard, Jim Hunter
- *Steering Committee:* Greg Randolph, James Spicka, Jeff Weegar, Kelly Crosbie
- *Task Force Members:* Evan Richardson, Melanie Phelps, SuEllen Fouse (stand-in for Alec Parker), Patti Forest, Tom Colletti, Andy McWilliams, Janet (Jan) Tillman, John Morrow, Sam Cykert, Nancy Henley, Brian Caveney, John Gambino, Heather McLean, Tammie Stanton, Rick Brajer, Anne Marie Robertson, Rhett Brown, Mary McCaskill, Sam Bowman-Fuhruman, Janice Gasaway, Joan Wynn, Sabrena Lea, Kelly Garrison, Susan Foosnes, Lydia Newman, Darren DeWalt, Virginia McClean, Trista Pfeiffenberger, Joe Pino, Blake Fagan, Craig Martin (phone-in for Brian Ingraham), Maida Avery (phone), Greg Burke (phone), Velma Taormina (phone), Becky Carter (phone), Richard Hudspeth (webinar), Sean McLean (webinar)
- *Interested Persons:* Susan Yang, Mark Massing
- *NCIOM Staff*: Adam Zolotor, Michelle Ries, Mari Moss, Anne Foglia, Lauren Benbow, Amber Bivins, Berkeley Yorkery, Chloe Louderback

Introductions and Welcome to the Task Force
Co-Chairs: Annette DuBard, Warren Newton, Jim Hunter

The meeting began with brief introductions of the task force co-chairs and steering committee members. Before the task force members introduced themselves, Adam Zolotor gave a brief discussion on conflict of interest. He explained that while each individual has a different background that shapes the way they think, the main priority of the task force should be to do what is best for the population of North Carolina. Next, each individual attending the meeting gave a brief introduction of themselves, including which organization they represent, in order to have full disclosure of potential conflicts of interest and explain what perspectives they bring to the table.

Task Force Charge from North Carolina Department of Health and Human Services
Rick Brajer, Secretary of Health and Human Services

Secretary Brajer thanked the co-chairs, steering committee members, and task force members for engaging in this important work. He emaphsized that metrics are able to transform the system when they are developed with two factors in mind: patient outcomes and system change. The task force should keep these criteria in mind when evaluating measures for North Carolina.

Secretary Brajer also explained that despite the election results on both the state and the national level, the work done by this task force will still be influential and will drive transformation of Medicaid and improvements in quality of care.

NCIOM Task Force Process, Overview, and Rules of Engagement
Adam Zolotor, President NCIOM

Adam gave a brief overview of the NCIOM and its work. He then talked more specifically about what this task force entails. There will be voting, potentially at each meeting, on various measures (task force members vote, while steering committee members, co-chairs, and interested persons do not. A voting member of the task force is allowed to send a designee in his/her place, who will vote on the task force member's behalf). Meetings are open to the public and guests are allowed. Constant Contact is the primary form of communication, with additional emails from NCIOM staff as needed. There was discussion of a potential website/domain/GoogleDoc where task force members will be able to communicate between meetings. Information should only be added to this document, not deleted. E-mails to NCIOM staff are always welcome- for questions contact Adam, Michelle Ries (project director), or Mari Moss (research assistant).

Zolotor presentation here.

Medicaid and Quality Measures Background
Nancy Henley, CMO, Division of Medical Assistance, DHHS

Nancy provided an overview of Medicaid, and some aspects of Medicare, in the state of North Carolina. She explained the demographics of Medicaid beneficiaries and the elegibility requirements to enroll. Nancy then explained some specifics about the 1115 waiver, submitted to CMS by the state of North Carolina, including populations excluded from the waiver. She then discussed the current quality measurement and reporting being done across the state in North Carolina. This includes CMS Core Measures, HEDIS, CCNC, CAHPS, and Access. Some of the sets'measures overlap. Nancy then discussed national benchmarks to North Carolina for various measures. Next, the outlined the work that DMA has done on the ACO Common Measures. Finally, she explained the CMS guidelines for measure development, including mandatory reporting, measures that cover access, quality and satisfaction, have key goals that they can be linked to, are coupled with a proposed quality reporting system, and have some public engagement process.

Questions/Comments:
- How good is benchmark reporting? For example, if the benchmark is 50% and we're meeting the benchmark, that doesn't necessarily mean that we're doing a good job. (Sam Cykert)
- There was discussion about a way to measure quality not based on the benchmarks- overlapping Medicaid, Medicare, and commercial populations to help see where thresholds differ (Brian Caveney)
- We need to focus on choosing measures where we are expecting achievement, not just measures that seem important (Sam Cykert)

Henley presentation here.

Evaluation Criteria: Discussion
C. Annette DuBard, CCNC

Annette outlined the criteria by which the measures for this task force will be evaluated. This included importance, usability, feasibility, and harmonization. Within these criteria come wider principles, including balance, parsimony, aligment, immediate usefulness, consensus, and adaptability. Additional considerations include overall cost, safety and quality, patient experience and sonsumer engagement, provider engagement, and health outcomes/population health. These additional considerations were what was specifically written in the contract between DHB and the NCIOM. Annette then explained that these were being presented to the task force because it is important for task force members to have a shared vocabulary for discussion of specific measure criteria and broader evaluation principles.

Questions/Comments
- The IDI set of principles (what was refered to as "wider principles" are good ones to worl with. However, it will be a challenge to address the quadruple aim in terms of provider satisfaction, when one thing that causes unsatisfaction is constant reporting and reporting systems.
- What do we know about how measures have transformed the system already? What do we mean by the quadruple aim? There is a 5-E framework fo experience design. This task force is an opportunity to come up with a long-lasting product. (Evan Richardson)
- Timeliness should be added to the list. This refers to data availability- will it be a quarterly lag time, an annual lag time, etc. (Jim Hunter)
- Perspective should be added to the list. Providers and MCO's can't necessarily have the same measures. We have to look at the population these are supposed to serve. Talk of the patient literacy tool- this should be part of the system (Sam Cykert)
- Outcomes measures have to be something that we look at long term. Have to be able to evaluate what are healthy or non-healthy costs and have to be willing to get rid of things that are not working (Janice Gasaway)
- Are these metrics for reporting Medicaid specific? We want things that are both reportable and usable in ongoing quality improvement; measure ethat might cascade other effects for patients.
- Have to make sure that the concept of feasibility is considered for rural communities, independent health practices
- Need to consider un-intended consequences of the metrics we choose (Andy McWilliams)
- Motion to change the wording of the definition of "importance"- should be significant gains in the quadruple aim, rather than the other wording

DuBard presentation here.

Overview of Medicaid Reform and Task Force Goals
Warren Newton, DHHS and AHEC

Warren showed a comparison of health outcomes between the U.S. and other developed countries; the U.S. is behind in many measures. In addition, North Carolina is ranked in the low 30's out of 50 states for health care. He then explained the primary groups covered by Medicaid: children, pregnant women, the disabled, and elderly. He also explained that these groups are different than the average population, with lower incomes and poorer health among adults. Warren then explained recent change in the NC health care system and proposed reforms to Medicaid. The 1115 waiver was submitted to CMS in June 2016; this waiver will allow innovations within NC's Medicaid program. He then explained why the NCIOM was selected to guide the work of the Task Force and re-stated the charge: to evaluate quality measures and specification (measures should focus on Medicaid but align as much as possible with measures for the entire population), prioritize these measures for North Carolina, and provide guidance on implementation and ongoing vetting processes. Some potential discussions include where this data will actually come from. However, the task force will not focus on financing/incentive, implementation details, and the evaluation process for the selected measures. Warren emphasized that the task force is committed to transparency. Measure evaluation will begin with previously defined sets, including those from DMA, CMS, PCMH/ACO, CPC+, and IHI 2.0.

Questions/Comments:
- Should also look at international measure sets, since the US ranks worse on the national scale than most developed countries

Newton presentation here.

Community Health Priorities
Eleanor Howell, State Center for Health Statistics, DHHS

Eleanor gave an explanation of the community health assessment process both at the local and state level, as well as provided a brief history of community assesments in North Carolina. At the county level, the assessments are a product of resident work and document the health needs and concerns of the county. State level community health assesments help assess the needs of the entire state by establishing health priorities based on the most common problems across the state. Eleanor concluded with an explanation of the top NC priorities for the state as identified by Healthy NC 2020.

Questions/Comments:
- Can we use the data from each county to comprise a list of the needs for the proposed 6 regions? (Warren). Yes.
- How do you compare these measures to one another when they are on different playing fields? In some cases, like comparing apples to oranges. (Warren).
- How intentional is the the community health assessment system? It is just giving out guidelines? (Sam Cykert). It gives counties a plan for what they can do to improve one thing at a time.

Howell presentation here.

Suggested Timeline: Discussion
Michelle Ries, NCIOM

Michelle concluded with some final discussion on the potential timeline for the task force. She re-affirmed that the task force will focus on measures that have already been created. She also noted that the measure sets will be broken up into domains for consideration, with an emphasis on population-specific discussion according to the selected evaluation criteria. There is a possibility to look at what other states are doing for some measures, as well as bring in outside experts. Materials will be sent out for feedback/comment throughout the process. It is our expectation that task force members will read and engage with the materials that we send.

Questions/Comments
- Want to be on the same page- we are looking at measures that improve health, not just health care

Ries presentation here.

Background Materials:
(Task Force members received these materials via email. Please contact Michelle Ries or Mari Moss if you need any of the files)

Evaluation Criteria – we have drafted this using several sources and suggested criteria and will be using this as a jumping off point for discussion.

"Running the Numbers" - NCMJ article with overview of NC Medicaid program

"Driving Improvement in Health and Health Care: A Strategy for Setting Metrics for Medicaid Outcomes" NCMJ article with overview of Medicaid reform and goals for NCIOM Task Force on Health Care Analytics. This paper describes the general approach of the Department of Health and Human Services in setting metrics, including goals, assumptions and starting principles.

"Medicaid Moving Forward" - This issue brief from Kaiser provides a current profile of Medicaid and highlights developments in the program unfolding at the federal and state level. (not NC specific): http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

"Institute for Healthcare Improvement White Paper: Whole System Measures 2.0: A Compass for Health System Leaders." The Institute for Healthcare Improvement (IHI) developed Whole System Measures 2.0 (WSM 2.0) to provide specific guidance to health care system leaders and boards on how to measure current overall system performance and use this data to inform organizational strategy. WSM 2.0 is a set of 15 measures that help leaders better understand their organization's current (and desired) state across three domains: health, experience of care, and per capita cost. http://www.ihi.org/resources/Pages/IHIWhitePapers/Whole-System-Measures-Compass-for-Health-System-Leaders.aspx

Measures for discussion. These measures will provide a starting point for our discussions around selection of measures and evaluation criteria.

- DMA 2015 measure set for waiver proposal
- CMS Medicaid Adult Core Measures
- CMS Medicaid Child Core Measures
- CMS/AHIP Consensus Core Measures—(there are 7 consensus core sets: ACO/PCMH, Cardiovascular, Gastroenterology, HIV/Hep C, Medical Oncology, OB/GYN, Orthopedic)
- IHI Whole System Measures 2.0