NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

TASK FORCE ON HEALTH CARE ANALYTICS

MARCH 15, 2017
10:00 AM TO 3:00 PM

630 DAVIS DRIVE
MORRISVILLE, NC 27560

MEETING MINUTES

Purpose of meeting: To use results of pre-meeting survey to narrow adult quality measures and cost/utilization measures and land on a workable first draft of these measures
By the end of the meeting, we will have:

- First draft of selected measures for adult measures and cost/utilization measures

ATTENDANCE: Sam Cykert, Mary McCaskill, Vivek Nanda, Leslie McKinley, Trista Pheiffenberger, Allison Owen, Chris Egan, Chuck Rich, Chris DeRienzo, Carol Burroughs, Joe Pino, Rhett Brown, Sam Bowman-Fuhurmann, Tammie Stanton, Anne Marie Robertson, Kate Menard, Lydia Newman, Jan Tillman, Anna Boone, Heather Mclean, Ken Lewis, Joan Wynn

Guests: Taylor Zublina, Peter Freeman, Connor Randolph

Phone: Evan Richardson, Velma Taormina

NCIOM Staff: Michelle Ries, Berkeley Yorkery, Adam Zolotor, Mari Moss

Steering Committee: Kate Berrien, Greg Randolph, Kelly Crosbie, Elizabeth Mizelle

Co-Chairs: Warren Newton, Jim Hunter

INTRODUCTIONS AND WELCOME TO THE TASK FORCE

James C. Hunter, MD
Chief Medical Officer
Carolinas Health System

Warren P. Newton, MD, MPH
Director, North Carolina AHEC

The co-chairs explained that when evaluating cost and utilization measures, the task force needs to consider whether they will drive the improvement of care and/or if they will drive the improvement of health. Use "if/then logic": if we choose this as a metric, then will it drive improvement in health? Additional issues to be discussed by this Task Force include attribution and risk adjustment.

2 things the task force has to think about:
**attribution- we have to have an opinion about this as a task force.
**risk adjustment- what is our strategy for dealing with this?

PAYER AND HEALTH SYSTEM PERSPECTIVES ON COST AND UTILIZATION: DISCUSSION

Facilitator:
Elizabeth Mizelle, MPH
Director of Measurement
North Carolina Hospital Association

***How will these measures drive the quadruple aim?

1) Vivek Nanda: BCBS and Leslie McKinney; the infrastructure we will need is a large lift
- affordability is as a crisis, no matter what; what measures might address the buckets?
- Bucket 1- inpatient costs 16% (readmissions, avoidable and not; right place right time; length of stay)
- Bucket 2- outpatient costs (site of service); emergency medicine use. Metrics as linked to primary care
- Bucket 3- pharmacy 22%- growing by greatest percent year after year; give physicians information that is actionable- have to address these costs in some way. Where are medications being given?
- Bucket 4- professionals/specialists- are we overusing this group? (orthopedics, cardiology, two top uses)
**You have to be very selective in measures, need to look at ones that really drive outcomes
** We need a primary-care centric model to drive improvements
Vivek: attributon- there are too many perspectives. And along with this comes the risk adjustment. Not a one-size fit all model. We need to be able to come up with a ratio of cost- that takes into account access issues. Cost is the number one item for employers- bringing Medicaid costs down can drive change/ build the foundation for a larger population.

2) Ken Lewis: Association of Health Plans
- not all physicians are on the same level- urban v. rural= a world apart. Technology that those two sides face is something you have to consider. Keep simple, then build upon it (in terms of measures, like leslie said). Wants care to be driven by physicians, not by health plans- don't want to get in between the patient and the physician. ACO establishment is an opportunity for physicians to drive care
- health plans look at total cost of care- important to push this discussion back to physicians, but this is difficult- we want to make it simple for the provider, hospital, and system.
- new access points (telehealth)- rural nc is very different than urban nc
- Pharmacy- highest piece of the premium. There are good reasons for this, but it's not necessarily cost-effective. On average 25% of the premium.
- 20 years ago- how do we get to the physicians? Medicare- move them to generics, split pills; physicians do have to worry about pharmacy costs

3) Chris DeRienzo: Carolinas
- cost is challenging because everything we do is interconnected; an easy fix is just do less- provide less care. But this in reality isn't great. We want to re-direct from "do less" to "do different things"
- Three buckets:
    1) overutilization: i.e. image studies for low back pain
    2) underutilization: if we improve metrics for asprin use, we will save money via mortality (if we are driving the right quality measures)
    3) business model of health care; to get at something like preventative admissions, we need to change the way we charge for health care and we are going to have to invest in new ways to pay and charge and recommend care (i.e. asthma in the home)

**things to be cautious about:
- conversations we have with patients (and parents) around provision of care and unnecessary treatments/tests; need to have conversations about evidenced base care
- need to talk about risk adjustment; need to make sure we are incentivizing the right things for providers to work on; you have to be mindful of where you are starting
- articulate a level of achievement and a level of improvement- be measured on how much better you are now than you were 2-5 years ago.

4) Tammie Stanton, Rex - post acute world
- when you're sick you want to be home!
- 35 years ago we started talking about readmissions- it brought home health to the table; this is also when you started seeing good medication reconcilliation because of the readmission penalty
- ED admission rate penalty is also important as well- drives care at home
- preventable hospitalizations- also important, making sure they have a PCP visit annually- patient care goals have not been happening.
- Need to talk about future planning, link to patient engagement- address the social determinants- this measure is important because it helps get to these needs- also drive behavioral health; total cost of care= changing patterns

5) Jim Hunter: Carolinas Health System
- good quality metrics are good because they can save long-term costs. It used to be hard to talk about cost- but now it is a natural part of the discussion. Everyone knows we need to drive down the cost of care. Has allowed us to bring new players to the table.
- new Medicaid population- protective quality metrics might come into play with this Medicaid population.
- readmissions used to be a hospital thing- but you have to go somewhere to be readmitted. Has helped with coordination.
- we should intersect cost while providing better care. Don't' want to decrease cost by increasing the amount of care. Readmissions seems natural; there are limitations in terms of risk adjustment, but hospitalization and ED utilization rates + pharmacy.

Discussion:

**McKinney: for quality, consider a threshold- you need everyone to be at 50% at least, don't need everyone at 90 right now. But there should be minimum quality thresholds. Underutilization can happen and it can't. even need the threshold for participation.

**Chris DeRienzo: how long does it take to see decreases in cost? When do you see changes in utilization? When you see improvement in quality, how long from there before you see changes in cost?

** McKinney: it depends on the measure in terms of how quickly you see the cost return. Readmission can be pretty fast
**Nanda: population health changes can be a wrong time (preventative health, for example)
**Lewis: balance is key for payers.
** McKinney: churn is also an issue. How do you keep patients? But, if no one likes the doctor and they leave, then that's an issue.
**Nanda: dual eligible will be an interesting population to tackle.

**Newton: capitation and pay per day in the 80's. this started care going into outpatient settings. Can Medicaid combine /align with what the commercials are doing?

** McKinney: commercial plans look at how to align with Medicare and Medicaid. You lose efficiency if everyone picks a flavor.
**Ken: you follow the lead of CMS because they have the most impact. Value-based care.

**Evan Richardson: driving short-term v. long-term gains. Savings that can be re-invested. How can we drive investing in behavioral health now? And patient self-management support?
**DiRienzo: need to be mindful about the long-term, fundamentally changing delivery systems. There will be winners and losers in CGR. If we are talking about measures that might change long-term delivery strategies then we need to be mindful of providers not falling off the road.
**Cykert: risk-stratification- can get immediate benefits from controlling chronic conditions; wants to discuss primary care offices that are barley succeeding to have a margin- minimum spend or % spent on primary care and chronic care management? How does primary care do outreach? What is the supportive structure for primary care? i.e. community health worker. There are a lot of cost savings in that population and primary care is fundamental. Maybe we need to look at a primary care utilization/cost measure and primary care management – Michelle to send the one from Health Partners.

**Kate Menard: the patient's role in controlling cost- is there a way?
**Jim Hunter: appropriate chosen metrics will get to that point. Patient activation is a tactic for driving down costs. A good metric will make the hospital want to get there, and patient engagement is a huge part of this.
**Ken Lewis: long-term is patient recognition; patient engagement is how you get there. We shield the patient from all the cost- so there isn't as much incentive to care. All the questions a care manager might ask starts the discussion and starts people taking charge of their own healthcare.

**Warren Newton: we've gone too far with copays and coinsurance. Co-pays make people not

want to go. How do you decide what is too much? We've priced out primary care and disease meds. How do you create a cost measure that doesn't nickel and dime patients to death?
**Kate Menard: we shield people from things that are covered in terms of genetic screening- forgoe the test based on cost. Co-pays- it costs more to see my on the plan than a general obgyn or midwife- but the professional fee is the same- co-pays push people in directions that do not make sense. Primary care also isn't the best way to take care of complex patients. It's a lot more complex then it seems. What if we just showed people what care is going to cost?
**Sam Bowman Fuhrmann: families want to know what their options are in terms of care and cost. Why doesn't my primary care doctor tell me this? It hits a point where a test can tell us information, but it will not make a difference in what our actions will be. Patients should share in responsibility of cost.
**Joan Wynn: we're not as transparent as we could be about cost.
**Bowman Fuhrmann: pharmacy is the same! Need to know they don't have to take it. Less is sometimes better.
**DiRienzo: health care is different than buying a car (I'm not scared when buying a car). We're not at a place where cost and quality are not the same in terms of transparency- you very rarely have a chance to make choices in healthcare. As patients, we are not pentalized for some of the things we control. Patients have accountability, but we have never asked that of patients. Is America ready for this conversation?
**Bowman Fuhrmann: well we're going to have to be! If people realized the impact…
**DiRienzo: how intimate into my private life are we going to let healthcare go?
**Brown: those conversations are going to go back to primary care. We need Mental health in primary care. We need to challenge Medicaid barriers; we need to extend what we mean by primary care. Coaches, mental health professionals.
**Richardson: we need to make sure providers are getting paid or incentivized for doing these services. Going back to patient engagement- not thinking about what we bring up is going to be the right intervention to engage the patient. Quality and metrics might not help people get it.

SMALL GROUP DISCUSSION: COST AND UTILIZATION MEASURES

Participants divided into four small groups and discussed the pre-meeting survey of the cost/utilization measures, and whether the top-scoring measures accurately capture the groups' priorities for inclusion in our draft set.

REPORT BACK TO GROUP AND LARGE GROUP DISCUSSION

Discussion of groups' selected priority measures.

CCNC QUALITY MEASURES: OVERVIEW

Anna Boone, RN, BSN, MSPH
Director of Quality Management
Community Care of North Carolina, Inc.

Ms. Boone's presentation available here.

***all claims data
***measures are not meant to capture every form of clinical care
**population health v. quality improvement- do we want o enable providers to take control over what they have control over in orderto drive improvement?

Anna provided an overview of the adult Medicaid population, including the breakdown of type and amount of chronic conditions. She also outlined measure considerations (feasibility, actionable information, alignment, moving the needle). She provided a table showing who measures what. Went through how CCNC is performing on various measured compared to the benchmark.

HEDIS MCO Medicaid mean (as opposed to CMS Medicaid) was the benchmark

**Wynn: is average the benchmark you want to use? Would it be better to use top 25%?
**Boone: If you use mean and there are still performance gaps, then that is a logical priority

* *Cykert: setting a benchmark for a certain measure should reflect its importance and influence

**Newton: risk stratification in groups for cervical cancer
** Boone: we use the HEDIS measure there- important to align the measure with what providers really need to be doing

**Boone: asthma measures- medication management for people with asthma- was picked on the draft list for the child measures

**Newton: have you experimented with bundled measures?
**Boone: diabetes care bundled measure, don't necessarily represent the actual care that is being given

**McKinney: something with information exchange is challenging

SMALL GROUP DISCUSSION: ADULT QUALITY MEASURES
Participants divided into four small groups and discussed the pre-meeting survey of the adult quality measures, and whether the top-scoring measures accurately capture the groups' priorities for inclusion in our draft set.

REPORT BACK TO GROUP AND LARGE GROUP DISCUSSION
Discussion of groups' selected priority measures.

REVIEW OF PROCESS AND NEXT STEPS
Adam Zolotor
Michelle Ries