Task Force on Health Care Analytics: An Overview

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Overview

NCIOM Staff:

- Adam Zolotor, MD, DrPH, President and CEO
- Berkeley Yorkery, MPP, Associate Director
- Michelle Ries, MPH, Project Director
- Mari Moss, Research Assistant
- Chip Haltermann, Graduate Research Assistant

Co-Chairs:

- Annette Dubard, MD, MPH, Director of Clinical Strategy, Aledade, Inc., Former Chief Health Information Officer, CCNC
- James Hunter, MD, CMO, Carolinas Health System
- Warren Newton, MD, MPH, Director, NC AHEC

Overview

Task Force members include broad cross-section of stakeholders, with focus on diverse geographic and professional representation and high level of engagement

- Medicaid and other DHHS representatives
- Health systems
- Quality improvement experts
- Data/HIT experts
- Providers (incl. pediatrics, OB, oral health, primary care, family medicine, nursing)
- Payers
- AHEC
- Professional organizations
- Beneficiary representatives

Overview

Charge of the Task Force:

To reach stakeholder consensus on a concise set of quality measures to be used by Medicaid to drive population health

Overview

6 Task Force meetings between December through May

- Focus on sets of measures already vetted at federal level, including whole system measures (DMA starter set, CMS Core Adult and Child, PCMH/ACO, CPC+, IHI 2.0, HEDIS); address how/whether measures meet elements of the Quadruple Aim (improving population health, patient experience of care, cost/utilization, and workforce wellbeing)
- NCIOM, co-chairs, and steering committee presented for consideration: a list of possible measures, review of evaluation criteria, considerations for prioritization, population-specific considerations, best practices from other states, and other contextual/background information (from outside speakers/experts)

Overview

- For each set of measures, Task Force members gave an initial non-binding rating, based on the evaluation criteria and additional background, to drive prioritization
- Task Force members voted online via Qualtrics survey using Likert scale
- Following presentations/discussion on methodological and procedural issues and comments from specific constituencies, we discussed in small groups and identified consensus measures to create a working draft set of measures

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Overview

- Presentations by content experts provided context and background information on quality measurement, use of measures by other states and health systems, demographic information on North Carolina Medicaid beneficiaries, and other topics as needed
- Prioritization of measures by Quadruple Aim, and by Medicaid population category (defined by the Steering Committee, generally, as child, adult, and maternity)
- Small group discussions on gaps in NC, what will drive improvement in population health, which measures best meet goals, followed by identification of consensus measures

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Evaluation Criteria

- Harmonization: Consistency with existing measures: measures have been federally endorsed and have existing performance benchmarks; align with measures for other settings and populations, and for other insurers/payers
- Importance/Relevance: Measures drive quality improvement in actual care settings; align with evidence-based or evidence-informed practices; focus on areas in which there is significant variation or less than optimal performance; and will make significant gains in health care quality (burden of suffering: morbidity/mortality/cost)
- Feasibility: Measures support future alignment across payers; will be supported by existing EHR or other reporting systems; data can be captured without undue burden
- Usability: Measure data can be used for accountability and performance improvement to achieve higher quality care

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Additional Principles

Additional principles

- Parsimony
- Balance
- Alignment
- Immediate Usefulness
- Consensus
- Adaptability

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Final Proposed Measure Set
Improving Population Health: Population Level Measures

Healthy Days	4-question patient survey capturing overall health status and number of days in past 30 when physical or mental health was not good or prevented usual activities.
Live Births Weighing Less than 2,500 grams (NQF 1382)	The percentage of births with birthweight <2,500 grams.
Obesity Screening and Follow-Up	1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Ages 3-17 years) (NQF 0024). 2. Body Mass Index (BMI) Screening and Follow-Up (Ages 18 years and older) (NQF 0421).
Infant Mortality	Rate per 1,000 births.
Chlamydia Screening in Women (NQF 0033)	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Social Determinants of Health	The Task Force selected the following domains for measurement, but did not identify specific screening tools or questions. 1. Food insecurity: limited or uncertain access to adequate and nutritious foods. 2. Housing instability: homelessness, unsafe housing, inability to pay mortgage/rent, frequent housing disruptions, eviction. 3. Transportation: difficulty accessing/affording transportation (medical or public).

Final Proposed Measure Set
Improving Population Health: Preventive Care

Immunizations	1. Childhood Immunization Status (NQF 0038): Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. 2. Immunizations for Adolescents (NQF 1407) (current HEDIS measure includes Human Papillomavirus Vaccine in this measure): The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) vaccine and three doses of human papillomavirus (HPV) vaccine by their 13th birthday.
Well Child Visits	1. Well-Child Visits in the First 15 Months of Life (NQF 1392): The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life 2. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (NQF 1516): The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. 3. Adolescent Well Care Visits: The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Percentage of Eligibles Who Received Preventive Dental Services (CMS)	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.
Tobacco Use: Screening and Cessation Intervention (NQF 0028)	Assesses different facets of providing medical assistance with smoking and tobacco use cessation.
Screening for Clinical Depression and Follow Up Plan (NQF 0418)	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Cervical Cancer Screening (NQF 0032)	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

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Final Proposed Measure Set
Improving Population Health: Preventive Care (cont.)

Contraceptive Care – Postpartum Women Ages 15-44 (NQF 2902)	Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care."
Behavioral Health Risk Screening for Pregnant Women (CMS)	Proportion of women who had at least one prenatal visit who received behavioral health risk screening assessment (for depression, tobacco use, drug use, alcohol use, intimate partner violence). Suggested tool: Community Care of North Carolina Pregnancy Medical Home Risk Screening Form.
Prenatal and Postpartum Care (NQF 1517)	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery

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Final Proposed Measure Set
Improving Population Health: Care of Acute and Chronic Conditions

Medication Management for People with Asthma (NQF 1799)	The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed appropriate medication that they remained on during the treatment period. Two rates are reported: 1) Percent of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2) Percent of patients who remained on an asthma controller medication for at least 75% of their treatment period.
Comprehensive Diabetes Care: HbA1c poor control (NQF 0059)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
Controlling High Blood Pressure (NQF 0018)	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
Hospital-Acquired Conditions	The rates of acute care hospitals of the following conditions: 1) Foreign object retained after surgery; 2) Air embolism; 3) Blood incompatability; 4) Falls and traumas; 5) Manifestations of poor glycemic control; 6) Catheter- associated urinary tract infection; 7) Vascular catheter- associated infection; 8) Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG); 9) Surgical site infection following certain orthopedic procedures; 10) Surgical site infection following cardiac implantable electronic device; 11) Deep vein thrombosis/pulmonary embolism following certain orthopedic procedures; 12) Latrogenic pneumothorax with venous catherization
Use of Opioids at High Dosage (NQF 2940)	The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.
Follow Up After Hospitalization for Mental Illness (NQF 0576)	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: 1) The percentage of discharges for which the patient received follow-up within 30 days of discharge. 2) The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Final Proposed Measure Set
Improving Population Health: Patient Experience of Care and Cost and Utilization

Consumer Assessment of Healthcare Providers and Systems (Selected Key Indicators) (NQF 0005)	1. Getting timely care, appointments and information: Percentage of patients who answer "Always" or "Usually" to CG-CAHPS questions on their ability to get urgent care, routine care, or needed information from a physician's office. 2. How well providers communicate with patients: Percentage of patients who report the highest level of satisfaction (Always or Usually) with their provider's communication 3. Access to specialists: The percentage of patients who report the highest level of satisfaction (Always or usually) to the question "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?"
Total Cost of Care Population-based PMPM index (risk-adjusted index) (NQF 1604)	Total Cost of Care reflects a mix of complicated factors such as patient illness burden, service utilization and negotiated prices. Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. A Total Cost Index when viewed together with the Total Resource Use measure (NQF-endorsed #1598) provides a more complete picture of population based drivers of health care costs.
Inpatient Admission Rate (risk-adjusted index)	Inpatient admissions per 1,000 member months.
Emergency Department Utilization (risk-adjusted index)	This measure is used to assess the risk-adjusted ratio of observed to expected emergency department (ED) visits, for members 18 years of age and older.
Use of Imaging for Low Back Pain (NQF 0052)	The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis. Assesses low value care.
NTSV Cesarean Delivery (NQF 0471)	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.

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Final Proposed Measure Set: Workforce Wellbeing

Job Satisfaction	Percentage of clinicians who respond 'agree' to select indicators of job satisfaction.
Measurement of Burnout	Suggested RAND question or Maslach scale.
Overall satisfaction with the prepaid health plan	Providers reporting by, "Extremely satisfied, Satisfied, Dissatisfied, Extremely Dissatisfied."

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Additional Considerations and Recommendations

Rec. 5.1: Risk Adjustment

- State stakeholders (including DHHS/DHB, payers, and health systems) should develop/implement standard risk adjustment methodology
- Methodology applied across care settings and locations, pre- and post-Medicaid reform
- Used to address use of both adjusted and non-adjusted data to meet data needs and incorporate socioeconomic factors/other data on social determinants of health

Rec 5.2: Attribution

- DHHS should develop/implement common/universal model of patient attribution across Medicaid managed care organizations
- Model must acknowledge multiple levels of influence on patients' care and outcomes, account for data sharing when possible, and encourage transparency/patient choice

Additional Considerations and Recommendations (continued)

Rec. 5.3: Performance Targets and Language of Measurement

- North Carolina Medicaid should identify specific performance targets and consistent measurement language/definitions to inform quality improvement at provider, practice, system, and population levels
- Targets may be informed by mean performance on the indicator or by percentiles (the Task Force recommends the 90th percentile) at the local, state, or federal level
- Target setting may be informed by current/recent benchmarks and statewide variation in performance
- Performance targets should align with those of commercial insurers, where possible, to increase sustainability of data collection and long-term improvement in population health

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Additional Considerations and Recommendations (continued)

Data Collection and Data Sharing:

Rec. 5.4: Ongoing investment in the development of NC Health Connex in order to allow state agencies, public and private payers, and health care providers shared access to quality improvement and performance data. The infrastructure should:

- maintain integration and alignment across electronic health record systems
- be aligned as much as possible across payers
- allow for flexibility in reporting methods
- meet federal meaningful use standards for interoperability.

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Additional Considerations and Recommendations (continued)

Data Collection and Data Sharing:

Rec. 5.5: Division of Health Benefits should develop a consistent methodology for identifying appropriate sub-populations and stratifying data on selected measures by one or more of these sub-populations

- All measurement data should be stratified by race and ethnicity, and all measures should be considered for data stratification by one or more of several additional sub-populations
- Sub-populations include (but not limited to):
  - Age
  - Sex
  - Pregnancy status
  - Geographic region
  - Urban/rural classification
  - Prepaid health plan membership
  - Provider
  - Individuals with multiple chronic conditions and/or functional limitations and individuals with chronic mental health conditions
  - Individuals with intellectual/developmental disabilities
  - Individuals dually eligible for Medicaid and Medicare
  - Children in foster care system

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Ongoing Process

Task Force identified several areas for additional research and exploration of measure development (in some cases, measures may be under development or are being used by some health systems or payers)

- Screening for children for trauma and adverse childhood experiences
- Cost of pharmaceuticals
- Screening for severe and persistent mental illness
- Behavioral health and integrated care
- Care coordination
- Pregnancy intendedness
- Family planning
- Care transitions for children with intellectual/developmental disabilities (pediatric care to adult care)
- Individuals with intellectual/developmental disabilities;
- Individuals dually eligible from Medicaid and Medicare;
- Children in foster care system

Ongoing Process

Rec. 5.6: Division of Health Benefits, as part of its development of a Medicaid quality strategy, should establish and coordinate a statewide coalition to review the measures selected by this Task Force and relevant additional information:

- Coalition should be a multi-stakeholder group, consisting of quality improvement experts, researchers, clinicians and other providers, Medicaid beneficiaries, health professional organizations, and payers

The coalition should be charged with:

- Reviewing all measures selected by the Task Force, through annual in-depth review of measures and data, with quarterly reviews, as needed, of new measures or revisions (by National Quality Forum or other quality agencies) to those included in selected set
- Reviewing data on selected measures collected by Medicaid, identifying progress on benchmarks/performance targets, examining relevance of new technological innovations that may impact data collection and reporting, and reviewing new evidence and federal data on measures and federal performance

Ongoing Process

- Producing annual report for NC General Assembly, outlining Medicaid performance on all measures, suggestions for revisions to measure set, and recommendations to Medicaid on any changes to use of measures
- Providing guidance for the selection of additional measures, or review and implementation of existing measures, according to changes to the Medicaid program (measures may include those appropriate for measuring improvement within integrated care settings, specialty settings, and/or enhanced care management settings for patients with high needs)
- Serving in an advisory capacity to the North Carolina Department of Health and Human Services Division of Health Benefits and Division of Medical Assistance to support additional recommendations on operationalization of quality measurement and its use to improve population health

Current Status

- Report published in October 2017
- Measure set referenced in DHHS proposed Medicaid managed care plan:

"Key quality priorities and initiatives will be derived from existing performance on quality measures and outcomes in North Carolina and build on the work of the North Carolina Institute of Medicine (NCIOM)…DHHS will draw upon the work of the NCIOM to identify specific measures; the work conducted by CCNC to measure outcomes, support provider practices, and inform care management efforts; and existing quality reporting priorities and measurement efforts within DHHS."

For More Information

- Websites: www.nciom.org

  www.ncmedicaljournal.com

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