TASK FORCE ON HEALTH CARE ANALYTICS

MEETING MINUTES

APRIL 12, 2017
10:00 AM TO 3:00 PM

630 DAVIS DRIVE
MORRISVILLE, NC 27560

By the end of the meeting, we will have: Set of draft quality measures; list of suggested measures for data development; recommendations on additional considerations for Medicaid

INTRODUCTIONS AND WELCOME TO THE TASK FORCE

C. Annette DuBard, MD, MPH
Community Care of North Carolina

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

BENEFICIARIES WITH COMPLEX HEALTH NEEDS: CONTEXT SETTING AND DISCUSSION

Melinda K. Abrams, MA
Vice President, Health System Delivery Reform
The Commonwealth Fund

Ms. Abrams' presentation (available here) highlighted some of the key issues that most commonly affect high cost, high need patients. The issue was framed in terms of chronic health needs need to be considerations for both patients and people. Goal oriented care is key in helping treat and motivate these patients, with comfort and daily function being a driving goal. Behavioral health issues are a key cost driver for these patients. These patients often have functional limitations, which makes it difficult to provide for themselves through work. One key area that should have a quality focus is home health care. Programs will be most effective when there is a focus on the different kinds of needs. Programs must also account for social risk factors.

In terms of quality measurement for these individuals, disease specific measures have limited value (because they have multiple conditions). Comfort and coping are just as important forms of treatment, coordination between the medical and social side (esp. the care giver);

Notes: high need high cost patients= the focus for the Commonwealth Fund initiative. Mostly work with adults, but in reality the presenter does understand that these conditions do cross across many populations.

Goal oriented care= key to the process. (i.e. I want to go to my daughter's wedding)

Behavioral health issues are a significant cost driver.

High needs adults are generally older and have low socioeconomic status.
**these individuals have functional limitations

Home health quality care= key for this population. Hard to get quality data from these cites, but important to see and try to look at.
They use more services, but there are increased needs even with this use.

High need patients with Medicaid often don't have any other resources to tap into. They are really sick, disadvantaged in the work force, even harder to make ends meet. Social isolation is greater for these individuals as well.

How are needs operationalized? Care teams, effective matching to services.
We also need to address how to assess quality in other areas of care – should we reduce focus on primary care?

Potential recommendations: DHB should consider developing additional measures for these groups. DHB should develop additional types of analysis of existing data.

How can a provider be considered responsible for outcomes? Are we sending a signal flare on need? Using a process to identify need?

Discussion:
Warren: to what extent should we look at individuals' high cost conditions?

Melinda: starting with high cost patients, looking at clinical complexity, but not individual disease. Come up with a meaningful subgroup with common needs. Ended up w/ 5 or 6 groups (i.e. major complex chronic, older with dementia, older without dementia, etc.). It's important to look at the high need population separately, but are trying to lump individuals together with multiple chronic conditions. It is important to not divide narrowly – i.e. 3 or more chronic conditions.

Annette: There is a lack of measures that capture outcomes for this population. Does the healthy days measure work in this population?

Melinda: compelling idea. It is subjective, but it is also goal oriented for the individual. Preventable readmissions and such as still relevant for this population.

Karen: can be cost prohibitive to provide teams in person. Are we looking at this on a virtual/telehealth realm?

Melinda: Yes! Emerging studies that show this is effective and cost effective. But would call it emerging and promising, need increased unbiased literature. Also have to think about individuals having access to that technology (i.e. having a cell phone versus having a smart phone).

Joan Wynn: home health and star ratings can be helpful for the data gap in that area. Process v. outcome measures- if our systems are doing a good job of treating these patients, then social and environmental factors will be understood by those already giving them care.

Melinda: sometimes these measures can send something to the providers. You can measure outcomes and look to see if the process helps meet those outcomes.

Joan: for additional sites of care, can we use Medicare data for quality measurement? Process vs. outcome measures – must address social needs, we need to address care management and health outcomes. What message does this send to providers?

Adam: variables that are sorted for risk adjustment and others that are sorted for outcomes. Take for example behavioral health needs outcomes. We don't need to only focus solely on high cost high need patients

Melinda: risk adjustment v. outcomes is a good questions. On the risk adjustment side there is functional status and behavioral health. Doesn't need to be done on the outcomes side if it's done on the risk adjustment side.

Brian Caveney: customer- employers want a dollar value (that's the threshold for considering high cost). But, this person could just have an expensive medication and be completely fine, while others might use increased services. We are changing the way we look at this and segment people. Self-reported status= high correlation to total amount of spend over the next 24 months. It could be a social or family need, not a provider need. Intervening early can help you find high need before finding cost. We need a more detailed analysis of cost and need – who needs outreach, not just who is higher cost. Also, fragmentation of care has implications for quality and outcomes.

Melinda: I agree with both comments. Not just about high cost, also about high need. Cost alone is not sufficient, but neither is counting chronic conditions.

Warren: coordination of care for high cost high need patients- should we include experimental or developmental measures? In order to get providers and caregivers thinking about an issue from a different perspective?

Melinda: Sarah Singer, HSPH- measure about patient integration of care. Believer in experimental measurement, as long as there is flexibility for implementation. With outcomes only we don't know where the link in the chain is broken. Information on care coordination is very hard to extract from provider data.

Nancy: CAHPS surveys have a question on perception of health. How do you translate social determinants into population measures? Because we want consistent measures.

REVIEW OF DRAFT MEASURE SETS – DISCUSSION AND VOTING

Adam Zolotor, MD, DrPH
President and CEO
North Carolina Institute of Medicine

Michelle Ries, MPH
Project Director
North Carolina Institute of Medicine

Notes:

Are these measures the ones that will help providers change systems of care?

Maternity measures:
Annette (2): what is this talking about?
Kate: we have used this process as a way to report. We want to make the point that we want to keep this structure, not the CMS one.
John: this assessment has all of the social determinants.
Warren: we want to protect the things that are innovative for North Carolina. We don't want to use it.

Eliminate 1! Because there is tobacco use everywhere else.

Provider satisfaction discussion - should we look at more? Expand? Will look at that in May.
Satisfaction re: Medicaid care and reimbursement

Patient Experience:
Annette: coordination of care measures put on by Melinda- bring back and have a May conversation?

Cost/Utilization:
Cost of care v. cost paid? Something else is more useful because we are going to look at 3 regardless.

Inpatient admission rate: we need a clear definition for this. 2, 4, 5 are very interrelated. Can we find one that gets at the other?
Andy- is there strong evidence to define preventable?
Annette- not a fan of the 2 and 5 measures (the PQI measures)
2 and 4 are good statewide, but not for small hospitals.
Potential CCNC measure of readmissions for one year? Is that worth it to add?

Adult
2- extremely blunt. Only capturing a sliver of the problem. Opioid as needing more measure development.
HEDIS has a new measure, but there are additional components.
Could potentially be 2-3 providers, 4 is more.

1- How do you measure a follow up plan? This could change care. And this could be measured.

Following this discussion, the Task Force members voted on the draft list, on order to narrow it down to ~20 measures.

DISCUSSION OF ADDITIONAL CONSIDERATIONS

C. Annette DuBard, MD, MPH
Community Care of North Carolina

Presentation available here. Dr. DuBard presented context and additional considerations for the Task Force to discuss in developing recommendations to DHB on quality measurement. Included: risk adjustment, attribution, social context, performance targets, and levels of measurement.

Risk adjustment:

Current risk adjustment does a good job on clinical measures, but not always with other areas – something is missing.

CCNC only looks at health care, costs, diagnoses, age…nothing goes into this currently in terms of social risk factors or functional limitations

How much do you have to risk adjust? By what factors? CCNC isn't drilling down too deep…can you put people in categories by income to risk adjust for Medicaid beneficiaries? At the plan level?

CCNC- education was easier to look at than income level (for pregnancy). But it's very different in pregnancy than in other areas of the population.

Trista: CCNC community pharmacies. Observed that the CCNC measures are great at adjusting for medical complexity. But, they are referring someone who takes 15 chronic medications. Within that, there is some component that risk adjustment isn't correcting. Vast sense is that there is something missing.

Attribution:

One touch vs. plural touch vs. assignment to medical home.
What are multiple levels of influence and shared accountability
Enrollment vs. retrospective attribution vs. prospective attribution

CCNC patient medical home= clean linkage by which to base performance measurement.
Explanation of the three levels- dramatic savings impact varied across categories.
You don't want retrospective attribution.
The community, patient, public health, home health- multiple entities have a role in achieving the outcomes we aspire to. Beneficiaries are attributed to various care staff in the system.
Vermont- blurring the lines between your population and broader population health.

Discussion:
Warren: practice is the real unit- you need to be able to capture the practice- they determine access and quality. It's hard to get insurers to come together with attribution because they have different approaches- how do you think of this problem?

Edie: should be more transparent about what the attribution looks like. MCOs could have a common approach to this. Has been done in other states- followup to figure out – Arizona, New Mexico. Attribution needs to be transparent.

Darren: CMS is trying to move away from retrospective and giving patients voluntary choice. White paper- shared approaches to attribution. No reason why Medicaid plans can't. Look at Health Care Learning Action Network.

Brian Caveney: HIPPA regulations/issues The entities should be a common and universal attribution methodology. Want the same rules for everyone. Providers usually want to steer attribution.

Nancy Henley: attribution will be done centrally- will be one process for the state. They will pick the PCP they want to be attributed to.

Adam: Providers need to know who is attributed to them

Performance targets:

Risk-reward based on improvement or attainment of a threshold? Something we need to think about. Do we want internal or external benchmarks?

Warren: you want a combination of external benchmarks and improvement

Small numbers vs. random variation

Darren: what CMS is trying to do makes sense- but it is complicated. Resource allocation- no perfect way to set that target. Taking into account progress made from year to year makes sense. Meeting a benchmark is not setting you up for ongoing improvement. Conceptually this makes more sense to the delivery system. How do we incentivize ongoing improvement?

Brian: BCBS does both, but depends more on denominators

Measurement domains:

Need to be clean with the language. Do we want to differentiate between population health outcomes/indicators and performance measures, which tell us if programs/providers/agencies are working well. Look at Vermont.

Brian: was there doctor backlash in Vermont when payments were tied to the community?

Darren: CMS is not interested in population health outcomes that are attributed to a particular hospital or individual doctor. It’s bold, but it’s forcing people to become accountable for their community, but this is new. We should consider/chime in on this in the report. Shared accountability and incentives to community partners

Data requirements:

Issues of provider reporting burden, esp. for rural health providers.
Centralized functions supported by the state.

Reimbursement, standardization, etc.

Data sharing. When you get to improvement, you need much more granular data. Transparency in sharing data with practice or health system?

Annette- CMS is more progressive with data systems in terms of sharing with providers.

Edie: want to make sure it is not too burdensome- MCOs have to explore how this has been done in other spaces. The foundation is the back and forth sharing.

Darren: you have to push for data sharing between the payer and the provider.

Edie: how do we push out the data from payers? Should it be the same way? I think it should. Right now everything is different in terms of systems. We should make it look as seamless to the provider as possible. The ask is type of data is very actionable and have the back and forth conversation. It makes our job easier too.

Brian: have been sharing info with doctors, but can’t get any clicks. But it gets lost in some IT or analytics and never gets to the physician.

Chuck Rich: in the waiver for the purpose of data collection, will it be sent to the state or to the individual MCOs and reported back to the state? Want to make sure that the data received is full.

Nancy: these go to the insurers then to the state, who sends it to CMS.

Warren: this is part of the set of solutions relating to provider experience. We don't want 11 different insurers with 11 different rules.

Edie: Knowing that there is a level playing field for providers goes a long way.

Velma: you need the data to know where you are starting – at provider/county/state level. Also for population health.

Adam: is there a way to integrate data into the EHR? From the insurers?

Edie: looking into the EHR. Will change in the next 1 to 2 years. Insurers see they have to invest in this.

Warren: standards for operability for EHRs- is this something we should get into?

Edie: to some extent it is helpful, but it's not pushing out the data necessarily in the way you want it.

Adam: bi-directional access to data- can write a generic recommendation presenting that.

Sam Cykert: EHRs are not designed to give you the measures you need for quality improvement. Recommendation to make is that rural area providers, through the HIE, we provide that kind of service to process data into actionable information. All-payer administrative data would be great so I can know what happens to the patient outside of my practice. We don't know what's going on in the community.

Anne Marie Robertson: you can get into the weeds. Physician cost is significant. Sometimes when you go to share documents 75% of the information gets pushed off.

Can we integrate data collection and align across EHRs, using standards for interoperability? What is the downside? Hard for small practices. How to connect this conversation to provider satisfaction? Reducing data collection burden – streamline across all payers.

REVIEW OF VOTING RESULTS AND SUGGESTED DATA DEVELOPMENT

Adam Zolotor and Michelle Ries facilitated the discussion with the group – are we comfortable with this measure set as is stands? What are we missing? Any duplicates or decisions we need to discuss?

Patient Engagement: we might add another measure, and then get feedback from the patient population: good as is
Cost and Utilization: good as is
Maternity: CMS behavioral risk too, and we report using the CCNC system (note to change); the high cost high risk are the ones who don't go to the doctor; the pre-natal care measure can be a driver of other process/put pressure on everyone to get things done.

Annette: don't we need an outcome measure for this group?
We can put infant mortality or something in population health.

Adult

**add weight or low birth weight as measure of population health

Child

Members re-voted on priorities

Others/to add
We need an opiate measure
We should consider healthy days
Something related to STIs
Transition- nothing in transition from youth to adult. Vulnerable in transition from pediatrician to older doctor. Integration of care measure that Melinda mentioned?

How do we move forward with risk adjustment and attribution?

REVIEW OF PROCESS AND NEXT STEPS

We will hold our next and final task force meeting on May 24. Task Force members will receive the draft report about a week in advance for review and comments prior to the meeting.