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

TASK FORCE ON HEALTH CARE ANALYTICS
MEETING MINUTES

JANUARY 18, 2017
10:00 AM TO 3:00 PM

630 DAVIS DRIVE
MORRISVILLE, NC 27560

Purpose of meeting: To use results of pre-meeting survey to narrow child-specific 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 children
- Shared understanding of how Whole System Measures relates to our process, particularly around the population health domain and the measure selection process used
- Shared understanding of Task Force goals, next steps, and revised plan for subsequent meetings

Attendance: Edith Calamia, Chris Egan, Tom Colleti, Kate Menard, Virginia McClean, Sam Cykert, Anne Marie Robertson, Ken Lewis, Susan Foosness, Daryn Dewalt, Terri Pennington, Alec Parker, Evan Richardson, Chris DeRienzo, Joan Wynn, Chuck Rich, Heather McLean, Tammie Stanton, Anna Boone, Rhett Brown, Patti Forest, Darryl Meeks, Velma Taormina, Mary McCaskill, Nancy Henley, Sandy Montilius, Blake Fagan

Steering Committee: Kelly Crosbie, Jeff Weegar, James Spicka, Kate Berrien, Greg Randolph

Co-Chairs: Warren Newton, Annette DuBard, Jim Hunter

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

Guests: Mark Massing, Taylor Zublina, Robin Huffman

Phone: Greg Burke, Brian Caveney, Richard Hudspeth, Chris Collins, Lydia Newman, Sam Bowman Fuhrman, Jan Tillman

INTRODUCTIONS AND WELCOME TO THE TASK FORCE

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

James C. Hunter, MD

Chief Medical Officer
Carolinas Health System

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

REVIEW OF TASK FORCE GOALS AND PROCEDURES

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

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

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

Warren began by explaining the goal of the task force using the pyramid analogy: the very bottom of the pyramid consists of system measures (including HEDIS, CMS, ACO Consensus Sets, etc.), the middle tier consists of outcomes measures and at the top are system transformation measures. This task force is trying to pick out the middle tier: outcomes measures from the various sets of system measures. He then gave the task force some additional things to consider when picking the outcomes measures. First, burden of suffering caused by the disease that the measure pertains to. To what extent does the disease decrease quality of life and for how many people in the population? Second, cost as well as quality of the measure. Third, gaps in North Carolina. In what areas does North Carolina fall behind nationally? Fourth, does the measure simply monitor the problem or can it be used for actual quality improvement?

These measures should be evaluated with the Medicaid population in mind, but we also want to be able to align with other insurers as much as possible.

Task Force Comments:

Darren DeWalt- Who is the ultimate customer? Are we focused on Medicaid or the entire population?

*These are metrics for Medicaid reform. However, we have tried to bring in other payers because we do ultimately want to align these measures.

Darren DeWalt- What measures are at the bottom?

*The measures at the bottom of the pyramid are already vetted, accepted measures that most health systems are currently reporting. Our job is to select the things that are most important for Medicaid in NC to measure quality improvement.

Chris DeRienzo- During this process we need to really think about the Medicaid population. This gets difficult as we start thinking about the beneficiaries that are on/off each year.

Sandy Montillus- Time is of the essence. It's good to have measures, but appointment time limits are too short; it is hard to address everything at the time of the appointment. Providers don't want to just stare at a computer, nor do their patients, so must keep this in mind – will affect both provider burden and patient engagement. These measures should drive patient satisfaction.

Heathe McLeanr: how are we going to balance the set across the quadruple aim?

* We are aiming for 3-5 measures per aim, with the exception of "quality". The quality category will be separated out by Medicaid population (child, maternity, adult) with the goal of 3-5 measures per population (or 1-2 per domain). TBD is approach for special populations.

DuBard: Today is not the final answer on the child measure set

Darryl Meeks- need to be able to collect Medicaid data as clinical data in order to connect with the HIE.

Sam Cykert- we need to pick the measures that are most impactful (in terms of measure outcomes)

DeRienzo: when picking measures we need to be thinking about the system we're trying to create. System integration measures are important; we want mental health, and oral health, and those systems to work collaboratively

Nancy Henley- CMS has new managed care regulations with completely separate sections on access and quality

Blake Fagan- how do we narrow the measures down? Are we ranking them them? So that we can have them when we drop off?

**Yes, that is what today's process is all about.

Evan Richardson: Will be be talking about operationalization of the measures?

**No, this is not part of theTF conversation – but may be able to make some recommendations about ongoing process

WHOLE SYSTEM MEASURES 2.0

Lindsay A. Martin, MSPH
Executive Director and Improvement Advisor
Institute for Healthcare Improvement

Martin explained the rationale behind the IHI measure set, highlighting that they wanted to make a small set of measures that affect overall performance, were simple to understand, and helped connect health systems to the communities in which they serve. Some criteria they used to assess measures were balance (across the triple aim), immediate usefulness, and adaptability (for different health systems and providers). She also spoke of some of the process challenges, noting that parsimony was especially difficult. Presentation here.

http://riversdeveloper.com/wp-content/uploads/2016/11/Martin_North-Carolina-Institute-of-Medicine.pdf

Discussion:

Chris DeRienzo- health systems have same problem- how are we doing at what? what interventions can we do in order to drive change like high school graduation rate while also being fiscally responsible for doing more interventions? cost will go down for health systems, but we also want to be able to keep helping

Adam Zolotor- we tend to have a reluctance to talk about cost- but when you get into things like high school graduation rate, how do you incentavize turning the system on its head?

Darren DeWalt- it is sometimes necessary

Patti Forest- we are going from volume to value. As helath systems take on more risk it should align those goals. We have to recognize that the concept of cost does impact patient care and access.

Sandy- are we looking at a culture of health in these kids' lives or are we looking at them being sick when they come into the office? Lots of kids in Medicaid don't have good diets- do we look at that at all?

**BCBS is sponsoring school gardens in the community. Educating kids about healthy eating can also educate parents. Studies have shows that kids in the Medicaid population who participated in schools with community gardens have increased math scores/testing scores. However, this method is unsustainable unless everyone buys into it.

Lindsay Martin- in one case a great health system in a community was un-aware of the high infant mortality rate. Health systems are often unaware of what is going on in the community so they can't help fix it.

Edith Calamia- payers are starting to look at things differently. We are looking at social determinants and searching for how to partner with other places and people. There is a lot of medical data, but everyone is looking at things outside of hedis. The pyramid concept explained by Warren is interesting, because this is how national payers are looking at things.

Adam Zolotor- when incentives change, we will have to talk about different factors. There are elements of social determinants that will evetually be looked at.

Annette DuBard/Lindsay Martin: We need to have the data for the community; it's hard to have the conversations about these issues without the data. When you start a conversation you want to have the actual data available. It is also important to acknowledge that time and space is necessary for improvement- people are more willing to change when they have time to digest it and think about it.

Warren- (to Lindsay)- these measures were developed for the health system, how did you all think about independent providers? Or at the state level?
** Lindsay- almost all of the measures are applicable at each of the levels- public health is thinking about a lot of these measures. all of the measures already exist in some format for small providers- many are publicly available. They are very appropriate at the state level.

CHILDREN ON MEDICAID: OVERVIEW

Marian F. Earls, MD, MTS, FAAP
Director of Pediatric Programs
Community Care of North Carolina

Dr. Earls reviewed pediatric measure collection and performance in North Carolina, noting the areas that we are doing well in (developmental screening and autism). Presentation here.

http://riversdeveloper.com/wp-content/uploads/2016/11/Earls-_-Pediatric-Quality-Metrics-for-NCIOM-Jan-2017.pdf

Discussion:

How is CAHPS information obtained?
**Paper survey, then phone calls (for CCNC). For Medicaid, the paper surveys come back in, with phone follow ups. CMS has very specific rules for surveys. There are also different kinds of CAHPS surveys.

Measures do not have all the same usefulness. For example, a measure might look good on paper but might not be very useful for quality improvement at the practice level i.e. "ADHD measure (initiation of medication)"- this takes two years to show the effects, so it is not good for quality improvement initiatives.

Adam Zolotor- most measures presented are screening and process measures; not many are reflective of health. It would be better to do screening and appropriate referal, because screening isn't exactly interesting

Some EHR measures stalling at feasibility

Sandy- is vitamin deficiency part of any guidelines at the moment?
*No

Virginia McLean: how do I look at measures to judge them if its not feasable to obtain them from our EHR
**Warren- in this case, perfect is the enemy of the good

There are not many mental health measures endorsed for a pediatric population. In this case, we might have to choose process measures until outcome measures are developed.

BREAKOUT SESSION: CHILD MEASURES

Discussion Guide Here

LARGE GROUP REPORT-BACK AND DISCUSSION

Access to Care:
- Group 1 (Michelle): 56 or 62 as measure from this category
*Reasoning: Both of these measures represent an unmet need. 56 looks at care that is delayed due to cost, but were unsure if this is applicable to Medicaid. Perhaps 62 is more operationalizeable.
- Group 2 (Mari): 14, 62, 69
*Reasoning: 56 did not make the top three because the group did not believe it was feasible. 66 was also a contender, but unsure how to measure it. Could possibly be captured from a CAPS survey.

Discussion/Questions:
*Are these measures for the health system or measures for the health plan?
* Do we want to create new measures ourselved? Or should be make a recommendation saying that a new measure needs to be created?

* Number 22 is important, however additional data is needed in order to be able to make a clear decision. This data can be extracted from the EHR and is one element of PCMH certification.

Behavioral Health:
- Group 1 (Michelle): 4, and 2 (currently under preventative care)
*Reasoning: 2 refers to patients with no existing diagnosis of clinical depression

- Group 2 (Mari): 70, 2 (currently under preventative care), 7
*Reasoning: Number 7 addresses a common problem that is currently a CMS initiative

- Group 4 (Adam): Measure that addresses a general screening for tobacco and illicit drug use (not simply exposure; does not exist currently), 4

Discussion/Questions:
*Is there currently a measure that addresses sexual abuse or trauma? No, or at least there is not one that is currently calidated.

Chronic Conditions:
- Group 1 (Michelle): 8, 65 (this measure could potentially be moved up to the behavioral health category)
*Notes: Measure 65 is currently being used in another state- Nancy Henly to follow up.

- Group 2 (Mari): 5, 20, 8

-Group 3 (Berkeley): 5, 31

-Group 4 (Adam): 8, 5

Discussion/Questions:
*Motion to move measure 8 to the "population health" domain
*Unsure whether measure 5 was the right measure to address this issue

Oral Health:
- Group 1 (Michelle): 12
*Reasoning: UDS measure

-Group 2 (Mari): 11, 12

- Group 3 (Berkeley): 11

- Group 4 (Adam): 11, add a measure about untreated tooth decay at age 5

Discussion/Comments:
* Dental services are not covered under the waiver, but health systems should have some accountability for dental issues

* Does measure 11 come from claims data? (yes)
* There should be two oral health measures: one on the PCP side and the other on the oral health side. A potential for a PCP measure is one dealing with varnish.

Population Health:
- Group 2 (Mari): None
*Reasoning: wondered whether there were more measures to consider in this category. Brought up infant mortality as a potential measure.

- Group 3 (Berkeley): None
*Reasoning: what effect does a physician really have on nutrition and physical activity? Might want to add something relating to BMI.

- Group 4 (Adam): None
*Reasoning: these measures will be hard to hold the health system accountable for

Discussion/Comments:
*Potential for obesity and tobacco rate measures
*It might be worth looking at self reported outcomes. Studies show that these are linked to better overall health. And, if the purpose of Medicaid is to improve the health of children we need a way to easily know the health of children.

Preventative Care:
- Group 2 (Mari): 10, 15, 17, 16
*Reasoning: argued for more than three preventative care measures because this is an extremely important category

- Group 3 (Berkeley): 10, 15, 17

- Group 4 (Adam): 15, 10, 17 (amended to say 0-24 months instead of 0-15).
*Reasoning: additional years will help capture an autism screening

Discussion/Comments:
*There is more room for improvement on measure number 17. However, neither number 16 or 17 was perfect- might have to modify.
* Important to remember that we already do well on developmental screening in NC

Cost and Utilization:
- Group 4 (Adam): measure of emergency department utilization

Discussion/Comments:
*Unsure of how to measure ED rates. Some ideas: Raw Rate v. Ambulatory sensitive; emergency department utilization – admission. In order to decide this the task force needs more information on which performs the best.
*Most ED visits are ambulatory sensitive. However, admission are rare in pediatrics. We need more raw data.

*Is readmissions a measure of quality for pediatrics? High rates might be sign of medical complexity not poor quality care
*IHI has an optimal life metric and infant mortality metric under their community well-being domain. They list these as outcomes measures.

REVIEW OF PROCESS AND NEXT STEPS

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

Michelle Ries, MPH
Project Director
North Carolina Institute of Medicine

Overall, today was productive. However, there are some things that can be done better for next meeting, including providing specifications for the measures prior to sending out the survey and spending more time on small group discussions rather than listening to presentations.