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

TASK FORCE ON HEALTH CARE ANALYTICS

MEETING MINUTES

MAY 24, 2017
10:00 AM TO 3:00 PM

630 DAVIS DRIVE
MORRISVILLE, NC 27560

Goal for meeting: Consensus on draft measure set (following discussion of new measures and categories); list of suggested components for ongoing process; list of sub-populations to include in recommendations for stratification

Attendance

Task Force: Chris Egan, Tammie Stanton, Nancy Henley, Andy McWilliams, Chris DeRienzo, Evan Richardson, John Morrow, Kate Menard, John Byron, Sam Cykert, Sam Bowman-Fuhrmann, Edie Calamia (phone), Virginia McLean, Richard Hudspeth (phone), Chuck Rich, Susan Zhang, Anne Marie Robertson (phone), Tom Colletti, Anna Boone, Mary McCaskill, Allison Owen, Carol Burroughs, Trista Pfeiffenberger, Lydia Newman (phone), Darren Dewalt (phone)
Co-Chairs: Warren Newton, Annette DuBard
Steering Committee: Kelly Crosbie, Elizabeth Mizelle, Kate Berrien, Greg Randolph (phone)
Guests: Pam Shipman, Taylor Zublinka, Karen Luken, Catherine Tarkini, Eleanor Howell, Kushal Kadakia, Erica Cunill (phone)
NCIOM Staff: Mari Moss, Michelle Ries, Adam Zolotor, Berkeley Yorkery, Chip Haltermann

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

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

In her opening remarks, Annette DuBard reviewed Secretary Cohen's thoughts on the measure set thus far, highlighting domains in which the Secretary would like additional

measures, including additional measures population health to include opioids and social determinants of health.

Adam Zolotor concluded the opening remarks by stating that this measure set needs to respond to, and meet the needs of, DHHS.

SOCIAL DETERMINANTS OF HEALTH: DISCUSSION AND MEASURE PRIORITIZATION

Michelle Ries, MPH
Project Director
Institute of Medicine

Berkeley Yorkery, MPP
Associate Director
North Carolina Institute of Medicine

Yorkery presented three potential options for incorporating social determinants of health into the measure set:

1) % of Medicaid patients screened with a specific tool (eg, Health Leads)/ specific questions (eg, food insecurity, housing insecurity, transportation)
2) % of Medicaid patients that were screened for social determinants (tool or questions not specified)
3) Collection of population health data (census data, BRFSS)
   Adam Zolotor: With this option, the level of specificity we might want using this would be very hard to get. It would not be sorted by prepaid health plan.

The task force decided that no matter which option was chosen, social determinants would not be listed performance measure in the final set – i.e., these measures would be identified as ways to assess and drive improvements in the health of North Carolina's population, but we would not make recommendations on the operationalization of these measures at the provider/practice/system level.

There were many concerns and differing viewpoints on whether, and how, a screening tool would be implemented. Members were unsure what population the screening tool would be used for: the entire Medicaid population, or a subset, such as "high risk" beneficiaries. Members also discussed when this screening would take place, at the point of care, at the time of Medicaid enrollment, or ongoing at specific intervals. Task Force members also were unsure what providers' roles would be after the screening. Would providers be responsible for the social needs of patients? Could providers be liable for what happens to patients? The Task Force emphasized the need for resources to support any needs that may be identified by such screening.

Task Force members offered that DSS and other state agencies are already responsible for addressing the social needs of the Medicaid population. A suggestion was made to improve integration between agencies, so DSS employees would receive alerts in their workflows if Medicaid patients had social needs identified by health care providers.

Task Force members also were unsure where and how data collected through a screening tool would be stored. To coordinate care effectively, data would need to be merged with other statewide datasets and accessible across governmental departments and agencies. The data might also be used to build an analytic model.

Regarding compliance with screening, there was some discussion about incentives and/or penalties. However, it was determined to be beyond the scope of the Task Force to make a recommendation in this area.

Ultimately, it was decided that the task force will recommend a screening tool be developed for use across the entire Medicaid population, but a pilot program would only target a specific population. Michelle Ries ended the conversation, saying we would draft a summary of the discussion to be sent to Task Force members before the steering committee meeting, and then put specific areas of social determinants to the Task Force to a vote in order to identify top priorities.

Specific discussion:

Evan Richardson: Any tool we recommend must be evidence-based. For everyone receiving care management through CCNC, they received screening on these items. Should we specify the denominator to only high risk patients?

John Morrow: In terms of option A, are we talking about recommended a proprietary tool? (Potentially, or specific questions for targeted areas).

John Byron: Collecting/using option A gives us the opportunity to get both B and C. Option A would give providers worthwhile information.

Virginia McLean: How are providers going to combat the social determinant problems that they screen for?

Adam Zolotor: It should be entirely up to the provider to combat these issues. The Medicaid plan has to come up with ways to help alleviate those factors.

Anna Boone: If a provider is using a tool to screen (ie, Health Leads), there is no way for the MCO to get that individual question by question data out of the EHR. Does the MCO just want to know if the provider is screening? Or, do we want population level data on these via CAHPS? Too many feasibility issues.

Sam Cykert: If we are going to screen, whether it's a web based system that goes to the MCO or not, then measure has to be % of folks that had something actionable done (related to social determinants). We have to give the MCO permission to do something.

Kate Berrien: Burden does not need to be 80/20 provider/system, it needs to be the other way around. Having data at the plan level helps the plan see what they need to address.

Option B causes the burden stay with the provider without much benefit. The goal of a screening is to have big picture data that shows what is affecting the population, it shouldn't just be a box that a provider has to check off.

Evan Richardson: Providers need actionable information, they need a care management system. Longer term vision is good. What about incentives? PCMH is required to do this.

Berkeley Yorkery: The Secretary has the goal of collecting this data, then deciding what to do with it.

Pam Shipman: From a logistical point of view, it makes sense for CCNC to screen populations that are at risk and then a physician who is concerned about a patient can refer to the care coordinator for action. If the practice identified a problem, they can refer to the care coordinator. Expand the CCNC infrastructure?

Newton: Maybe use a combo – screen high risk, use pop. Level data. There are practical issues – this is a very long tool to ask providers to use.

Robert Chuck Rich: Many providers have been screening for social determinants for years. Will the MCOs really be tasked with getting us the resources/assistance?

Kelly: If we choose a specific tool, then we should use the tool in its entirety, not just pick one or two questions. You don't always know what question on the tool matters. Plans should start by collecting all the data from a tool, find out which of the questions help cut costs, then shorten the survey to reflect these areas.

Carol Burroughs: What if the patient doesn't present what's true in the survey? There might be a blend in data, targeted questions in order to dig a little deeper and get help for an individual who might not admit there is a larger problem going on.

Chris DeRienzo: There is a validated tool for food security for children that Mission Health is using. We have to ensure that the MCOs help/are incentivized to help in the area of social determinants.

What are opportunities that are broader than just Medicaid? Can we coordinate care across agencies? It's hard to think about social determinants in isolation.

Adam Zolotor: These are the opportunities that the secretary are working for.

Warren Newton: Right now, local/community organizations are doing things that they have tools for- for example, they can work with food insecurity, but they can't work with transportation or housing insecurity. The tools vary from place to place in terms of what individuals can impact.

Evan Richardson: There is a 5 question survey/screening tool out of LA that relates to

social determinants of health. Focusing on one area, like food insecurity, isn't enough. We also need disaggregation by zip code.

Adam Zolotor: What are care managers doing (through CCNC and CC4C) and is there a mechanism for billing for it? Is there IT infrastructure in place?

Evan Richardson: CCNC and CC4C do have a risk assessment tool, CMIS (care management data system for CCNC), that includes social determinants. It is a structured risk assessment and it is a statewide web based tool. The payment is under CCNC capitated PMPM costs.
*sidenote: this assessment is only being done on 1.5% of Medicaid patients.

Kelly Crosbie: what are the questions like for this tool?

Evan Richardson: There are more than 10 questions

Chuck Rich: Care managers not only screen, but they are trained to access the available resources in any given area.

Pam Shipman: Individuals are more honest filling out a form online than asking face to face. This can be done on an iPad, and can be given to a patient before the appointment.

Adam Zolotor: A proposed plan for a recommendation. 1) Figure out the common elements of the CCNC tool. As care management develops, we should make sure these are more alike then different with included core elements that are all validated. 2) Continue to operationalize that in a common data system that prepaid plans can use. 3) Work on a pilot process where in a primary care setting everyone is assessed. Can be a 5 item screen.

John Morrow: We don't want to leave social services out of this process. We have to hold local governments accountable/responsible and keep them involved in this network. A provider should be calling DSS if there.

John Byron: We want more than 5 questions in the pilot.

Berkeley Yorkery: The time of screening could be at the point of Medicaid enrollment. This would be a way to incorporate DSS.

Michelle Ries: To clarify, we want to put Option A in the measure set, with recommendations around the development of a specific tool. Does this fit into a performance metric?

Annette DuBard: Not right now. We are endorsing that a screening needs to take place, as a developmental quality measure.

John Byron: If there is no consequence for not screening, then people won't.

Berkeley Yorkery: Any development on a screening tool will be added to the population health domain, but we can't develop the measures yet until the tool is developed.

Richard Hudspeth: People who are already doing this should be rewarded/reimbursed.

Trista Pfeiffenberger: If we don't have social determinants data over the population, then we can't put it into case mix and risk adjustment. We want to move this screening upstream, but also if we have others screening for it downstream they can act on it in some ways as well.

Sam Cykert: Screening at enrollment does not work because people's situations change over time. We should endorse screening at a set interval (doesn't have to be done in a specific place). DHHS/DSS could map recommended resources in response to the screen.

Carol Burroughs: Once the HIE is up and running, hopefully everyone can have access to the data. We could build analytic monitoring and see who has access to it.

Mary McCaskill: how do you get this data from an EHR?

Pam Shipman: Health Vie? Tracks referrals from providers (DSS, a church group, behavioral health, etc.). It isn't a data repository, but it tracks referrals so it knows problems by looking at where people are being referred to. Initial screening done on an iPad. There are neat tools like this.

Kate Menard: What is the difference in making this a developmental measures over a performance metric? The more often these determinants can be assessed, the better.

Adam Zolotor: Right now we are not talking about incentives and penalties. We are a long way away from using social determinant metrics themselves as an incentive or penalty for a health system. Population measures help us report on the characteristics/wellbeing of the population (which ideally would go to the prepaid health plan). A performance metric is how a health plan is keeping people well. A developmental measure might not be ready to be rolled out to an entire population, but this is where pilot comes in. We think that measuring social determinants is important, and there are a variety of places that this can be measured. DHHS can and should figure this out.

Michelle Ries: For the report we will write up a summary of this conversation, try to make sure all components are included, then have an up down vote (survey) on what types of areas/questions should be included in a screening. These will be sent out to the task force for consideration.

Sam Cykert: If DSS has the resources to act on insecurities, then there should be a work outflow to address the warning signs.

Evan Richardson: Public health should also work on this. Consideration of reimbursement.

Carol Burroughs: agencies outside DHHS (i.e., DHI) should have access to this data too

Adam: We are recommending that this be developed for the whole Medicaid population

PROVIDER SATISFACTION: DISCUSSION AND MEASURE PRIORITIZATION

Adam Zolotor, MD, DrPH

Michelle Ries, MPH

Michelle Ries explained that there is a lack of validated measures in the area of workforce wellbeing. She asked the Task Force if they want to recommend additional measures of provider/workforce satisfaction. She presented some potential questions from the LME/MCO provider satisfaction survey and a survey of physicians and other health care staff developed by the RAND Corporation.

Discussion centered around clinician burnout and resilience, with Task Force members agreeing that burnout is an issue. Burnout is important to address because the state has an interest to keep providers practicing, particularly in rural and underserved areas of the state. If survey findings identified clinicians who had issues, there was no consensus on a single organization or agency that would be responsible for dealing with those issues. However, state plans should be doing QI, provider trainings, and interventions.

The task force brought up the idea that burnout in nurses, medical office assistants, and other health care workers should be considered in addition to physician burnout.

Although no vote was held, there seemed to be a consensus that 2 questions regarding provider satisfaction should be included in the Task Force recommendations. The title for this section will be called "Workforce Wellbeing." Generic health care worker terminology will be used in the questions i.e. to include beyond physicians. Multiple types of providers and staffing agencies will be assessed.

Specific discussion:

Kelly Crosbie: The mechanism for evaluating this must exist, the department will be screening in some way.

Warren: We should look deeper than the question "are you happy with your plan?"

Evan Richardson: Provider resilience is a powerful thing

Anna Boone: CCNC does a provider satisfaction survey, along the lines of the LME/MCO survey. But we should go deeper with burnout and resilience.

Chris DeRienzo: These are hot topics right now. There is evidence showing that short periods of provider/workforce stress can be masked by teamwork without outcomes being impacted. But, we don't want to have this all the time. We want to ask questions that get at outcomes. It's not satisfaction or experience...it's things that tie us to the Medicaid program.

Annette DuBard: The fourth aim is an aim within itself. The state needs to care about the wellbeing of the workforce.

Pam Shipman: Some questions to think about are "Are you paid timely? Is this burdensome? etc. There might be questions that have to do with Medicaid plan operations.

Kate Berrien: It is important to capture both plan satisfaction and job satisfaction. Let's say a plan incorporated a good managed care team that can address social determinants, this should make providers happier and help providers.

Nancy Henley: who is going to do something about workforce distress? Where will this data go?

Chris DeRienzo: There is an opportunity to connect these results to intervention.

Kelly Crosbie: In addition to the questions you want to add to the screening tool, the plans are supposed to do trainings and interventions. Can we intervene at the provider level if 80% have burnout?

Adam Zolotor: Medicaid can drive changes in care and potentially intervene. But who is supposed to intervene? DMA? We don't know the answer, but we can at least identify some of the problems.

Pam Shipman: Other things to consider include, "does Medicaid require more paperwork than commercial insurance? Are you planning to stay in the Medicaid network next year?" This helps us see how managed care is changing provider perspective and contributing to burnout.

Warren: Burnout is much broader than just clinicians. There is national convergence at how to look at a burnout percent.

Erica Cunill (phone): Since you "get what you measure" you need to be sure that you are measuring the "amount of burden" that this new structure is creating or relieving from providers. Also, turnover increases cost of care. Steady, happy providers will decrease cost of care.

Michelle Ries: Should we prioritize 2-3 additional metrics to include in the measure set? We can send options out to the task force via a survey. We can call this section workforce wellbeing.

DISCUSSION OF ADDITIONAL MEASURES

Adam Zolotor, MD, DrPH

Michelle Ries, MPH

Michelle Ries explained that since the last meeting, there are measures that have come up for additional consideration. Some of these were from Secretary Cohen, while others were brought up by task force members and outside organizations.

1. Opiate Measure. This was a call from the secretary and is a priority for the state.

   Specific discussion:

   Andy McWilliams: This could work as a population health measure

   Chuck Rich: we need a measure that looks more at the escalation getting to this point. How do we keep this patient from becoming a chronic patient?

   Nancy Henley: We could look at the new patients on opioids who are not being taken off (Minnesota measure- addressed people coming into chronic use)

   Adam: We should have something that we are able to look at over time. We are looking for the highest level measures that are the public face of how we are improving opiates over time.

   Warren Newton: What about death rates from opioids?

   Berkeley Yorkery: You can't measure death rates of Medicaid only, the data is stratified by county.

   Adam Zolotor: We also won't be able to get the death rate for each MCO.

   Eleanor: Opioid deaths are moving from prescription drugs to heroin and fentanyl. Opioid deaths are small numbers to see in each county (there only will be about 1,000/year). Some counties will have none at all.

   Andy: We need to look a little further upstream (i.e., admission to the hospital because of opioids)

   Michelle: Lets's make a choice between the following two measures:
   Opiates at high dosage and a population level measure of opiate-related deaths.

Vote:
A: Opiates at high dosage: 11
B: Population measure (deaths): 5

In the report, we will comment on other opioid measures that are currently in development.

2. Unintended pregnancy- CMS core adult set postpartum contraceptive

   Michelle Ries: We talked about this measure during our February meeting, but have decided to bring it back for further discussion by presenting two options. The first is using PRAMS level data to measure pregnancy intendedness. The second is a measure on postpartum contraception that was recently added to the 2017 CMS core adult set.

   Kate Berrien: Pregnancy medical home does get data on pregnancy intendedness during the screening (during prenatal care, as opposed to 3-6 weeks after having the baby)
   Adam: how are we doing with entering data from the pregnancy medical home? This measure becomes dependent on keeping the CCNC screening.
   Kate Menard: screening 70-75% of the Medicaid population (but not through the EHR)
   A: Postpartum contraception: 10
   B: CCNC screening tool: 5

3. Early prenatal care measure (bundled with postpartum)

   Michelle Ries: We discovered that there is a bundled measure for timely prenatal care and a postpartum visit. Should we include this measure in the set, as opposed to just the postpartum care measure?

   The Task Force voted, almost unanimously, to include a measure that includes both prenatal and postpartum care, although it is no longer endorsed by NQF or CMS.

   Vote:
   Yes: 18
   No: 0

4. Well child visits and Immunizations

   Michelle Ries: The following measures on well child visits and immunizations were proposed for additional consideration. Would we like to include well child visits for children 0-15 months, adolescent well care visits, and child immunizations?

The Task Force voted to include 3 additional measures regarding well-child visits and child immunization, well-child visits in the first 15 months of life, adolescent well care visits, and child immunization status. All 3 measures are included in CMS's 2017 child core set, but adolescent well care visits are not endorsed by the NQF.

Well child visits, 0-15 months:
Yes: 14
No: 4

Child immunizations
Yes: 8
No: 3

Adolescent well care visits
Yes: 10
No: 2

5. Low value care measure

Michelle Ries: Adding a low value care measure is important to the Secretary. It shows that the department recognizes the importance of acknowledging low value care/services and developing strategies to address overutilization of these services.

There was broad task force conversation relating to the potential for an overuse measure relating to prescribing antibiotics for a upper respiratory infection, but it was expressed generally that this is not as accurate a measure for assessing low value care or overutilization.

Low value care -screening for lower back pain:
Yes (include): 15
No: 2

6. STI's

Michelle Ries: This is also an area that the Secretary is interested in highlighting.

The Task Force reached a general consensus that it would recommend a measure of chlamydia screening, although no vote was held. The proposed measure only screens women ages 16 to 24, however the Task Force wants to include a comment that 14- and 15-year-old women should be screened, as well.

There was a concern that the screening should begin at age 14, as opposed to age 16.

7. Total Cost of Care

   The Task Force voted to recommend a measure of the total cost of care, endorsed by the NQF. However, the Task Force wants to include a paragraph in the report stating the importance of assessing the total cost of care, but highlighting concerns that this type of assessment could limit services, lead to selection bias, and have a negative effect on quality of care.

   Specific discussion:

   Michelle Ries: This is another request from the Secretary.

   Warren Newton: Is there a way to align this with Medicare? The more alignment we make, it will drive everyone to create the data systems that we need to collect this information.

   Evan Richardson: A PMPM number doesn't help providers.

   Chris DeRienzo: We agree that this needs to be looked at, but we're unsure how we're driving it through plans to providers.

   Evan Richardson: We want to incentivize those who can take great care of people with a lower cost.

   Annette DuBard: Everyone in the system needs to know where the health care dollar goes. It is one of the aims.

   Vote
   Yes (include): wins
   No:

8. Medication management for people with asthma v. asthma medication ratio.

   The Task Force voted to tentatively recommend a measure of medication management for people with asthma, which is included in CMS's 2017 child core set. Members of the Task Force did not think either of the two proposed measures was best. They voted to include one measure in the draft of the report, but they thought NCIOM should look into a composite asthma measure, asthma action plans, or another measure.

   Specific Discussion:

   Michelle Ries: These two measures came up for discussion about which one is best.

   Virginia Mclean: The asthma ratio measure isn't as accurate as the medication

management measure because providers patients a dose of medication in order to demonstrate how to administer it. My preference would be for provider follow up at certain intervals with the patient rather than the 50 and 75% ratios.

Anna Boone: Medication management is part of MIPS, if we're talking about alignment.

A: Asthma medication ratio: 0
B: Medication management for people with asthma: 18

SUB-POPULATIONS AND STRATIFICATION

Adam Zolotor, MD, DrPH

Michelle Ries, MPH

Michelle Ries presented various subpopulations that might be mentioned in the report in terms of measure stratification. She asked the task force if there were any populations missing from this list.

There was agreement that the Task Force will recommend all the subpopulations Michelle presented. However, they also want to include additional subpopulations: age, sex, and (possibly) pregnancy status. A discussion was also held about stratifying by social determinants of health, housing transportation, food insecurity, and physical activity.

Specific discussion:

Is it possilbe to add social determinants to this list? Or broaden what this encompasses, such as physical activity/access to green spaces?

Substance use disorders?

Kelly Crosbie: Some of the groups we've identified in this list might get their own plan.

Berkeley Yorkery: in that case, the department can determine which to include.

Want to be able to pull data by age, sex, and gender

Warren Newton: There may be a privacy issue with HIPPA, when looking at the state's population by specific subpopulations.

Eleanor Howell: HIPPA won't cause limitations for all measures, but it will on clinical data

Andy McWilliams: What operable definition are we using for multiple chronic conditions?

Michelle Ries: 3 or more or 5 or more- we can specify that (but we don't want to start specifying conditions)

Trista Pfeiffenberger: The pregnant population? This might always be self-obvious, but not PMPM necessarily.

ONGOING PROCESS – WHAT COMPONENTS DO WE RECOMMEND?

Kelly Crosbie, MSW, LCSW
Senior Program Manager
Division of Health Benefits
North Carolina Department of Health and Human Services

Kelly Crosbie presented various actions that can be part of the ongoing process of measure selection. This included how to report measures, how to hold PHPs accountable, and how to assess compliance with implementing the use of measures and reporting measures. Task Force members proposed this new group should include consumers, advocacy organizations, and insurers, but not members of General Assembly.

Members did not agree on a specific timeframe for reevaluating measures, but thought it could be either annually or biannually.

Specific discussion:

Warren Newton: What is a reasonable amount of time for revisiting measures? 2 years?

Sam Cykert: 2 years is a reasonable number, but there has to be a contingency that if a measure comes up then there should be a process for reconsideration

Evan Richardson: CMS has an annual review of measures. There is value in having a yearly small review

Kelly Crosbie: This should be an external process

Adam Zolotor: Who should be part of this process?

John Byron: For pregnancy medical home, we look at data monthly and change continuously, 2 years isn't helpful when you're trying to change quickly

Warren: We're talking about performance indicators here, not how they are going to be used

Kelly Crosbie: We're concerned about making sure we have the right folks at the table

for specialized measures

Sam Bowman-Fuhrmann: This is why you need to have beneficiaries at the table too

Warren Newton: The process needs to be transparent

Evan Richardson: Assisted living homes and residential facilities should be at the table too, in addition to patients and families

Adam Zolotor: Providers, consumers, advocacy organizations

Warren Newton: Can we recommend a structure that that incorporates legislative accountability? Maps by regions/legislative district. We haven't talked about it, but the Senate is driving all of this

Adam: I'm not sure that members of the senate should be on the committee, but whoever is responsible should report to the joint legislative oversight committee on a bi-annual basis

Adam (to Kelly): What is the process for reviewing the measures?

Kelly: One of the things we have to operationalize is how the original quality strategy gets reviewed. There is potential for this group to be key in that process

Warren: how do we define what we're giving up under Medicaid reform?

Adam: If we propose an ongoing process, should it live within DHHS? Should NCIOM be the group? Or another organization? CCNC?

Chris DeRienzo: Convening this group has precedent

John Byron: With this group, we have all the right components

Warren: We need to align with other insurers (commercials and Medicare)- whatever we do depends on how we can align the insurers

Evan Richardson: We need an evidence-based approach to revisitation, which this group gave

Warren Newton: There is something powerful about communicating face to face

Adam Zolotor: I just want to note that anyone who is part of this task force is under no obligation to continue to be on a committee for ongoing vetting. This was the only commitment we asked for.

REVIEW OF PROCESS AND NEXT STEPS

Michelle Ries, MPH

A draft report will be sent to DHB on 5/31. A public comment period will follow. Task Force members will have another opportunity to review the draft report and make comments.