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# Participants

# SIM Quality Council

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*Anthem Blue Cross & Blue Shield*

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# SIM Quality Council

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*Cardiology Associates of New Haven PC*

Thomas Woodruff  
*Office of the State Comptroller*

# Quality Council

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- First meeting – 9/3/14, 13 full council meetings to date
- Executive team
  - Dr. Mehul Dalal, DPH (co-chair)
  - Deborah Dauser Forrest, Connecticare
  - Meryl Price, consumer advocate
  - Dr. Steve Wolfson, physician (co-chair)

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Process

# Guiding Principles

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1. Maximize alignment with the Medicare Shared Savings Program ACO measure set.
2. Recommend additional measure elements that address the most significant health needs of Connecticut residents, the needs of non-Medicare populations (e.g., pediatrics, reproductive health), and areas of special emphasis such as behavioral health, health equity, patient safety, and care experience.
3. Wherever possible, draw from established measures such as those already established by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, CMS Meaningful Use Clinical Quality Measures, NCQA measures, and the CMMI Core Measure Set.

\*See appendix for complete set of Guiding Principles

# Guiding Principles

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8. Recommend measures that are accessible with minimal burden to the clinical mission; should draw upon established data acquisition and analysis systems; should be both efficient and practicable with respect to what is required of payers, providers, and consumers; and should make use of improvements in data access and quality as technology evolves and become more refined and varied over time.



# Defining Council Outputs

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- Recommend a Common Measure set that is actually a menu of measures
- Do not expect that all payer-provider contracts would include all measures
- However, when payer focuses on a condition that is included in the measure set, they must use the measure and specifications as defined in the measure set
- Council has not deliberated on the question of a common scorecard format

# Defining Council Outputs

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- Focus on Commercial/Medicaid measures
- Will separately consider measures primarily for individuals over 65
- Include all measures that are a high priority for any payer/population
- Include even those measures that may not be appropriate for some providers or populations (e.g., pediatric measures not appropriate for provider with no pediatricians)

# Defining Council Outputs

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- If measure set is a menu, how would we ensure achievement of SIM objectives?
  - Certain domains and measures could be deemed *essential* measures
  - Other measures would be *optional*
  - Status would be recommended by Council

# Sample Measure Set Format

ACO #	Measure title	NQF #	Essential vs Optional	Data source	Pediatric/ Adult	Reporting vs. Payment		
						2016	2017	2018
Domain: patient/caregiver experience								
1	xxxxx	0123	E	Survey	P/A	P	P	P
2	xxxxx	0123	E	Survey	P/A	P	P	P
3	xxxxx	0123	E	Survey	P/A	P	P	P
4	xxxxx	0123	E	Survey	P/A	P	P	P
5	xxxxx	0123	E	Survey	P/A	P	P	P
6	xxxxx	0123	E	Survey	P/A	R	R	R
Domain: care coordination/patient safety								
9	xxxxx	0123	E	Claims	A	P	P	P
10	xxxxx	0123	E	Claims	A	R	P	P
11	xxxxx	0123	O	Claims	A	R	P	P
12	xxxxx	0123	E	Claims	P	P	P	P
13	xxxxx	0123	O	Claims	A	P	P	P
14	xxxxx	0123	O	Claims	P	P	P	P
Domain: preventive health								
15	xxxxx	0123	E	Claims	A	P	P	P
16	xxxxx	0123	E	EHR	A	P	P	P
17	xxxxx	0123	O	EHR	A	R	R	P
18	xxxxx	0123	E	Claims	A	P	P	P
19	xxxxx	0123	O	EHR	P	P	P	P
20	xxxxx	0123	O	EHR	P	P	P	P
Domain: at-risk population								
Asthma								
21	xxxxx	0123	E	EHR	P/A	R	R	P
22	xxxxx	0123	O	EHR	A	P	P	P

Pre-decisional – for discussion only

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# Technical Assistance Resources

# Technical assistance/consultation

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- CMMI – National Opinion Research Center (NORC) at the University of Chicago, State Health Data Assistance Center (SHADAC) Center for Healthcare Strategies
  - CT comparison to other SIM states, readmission, care experience
- Yale – CORE (Center for Outcomes Research and Evaluation)
  - Readmission, hospital admission, avoidable ED, cardiac
- National Committee for Quality Assurance
  - Readmission, admission, ED use, base rates
- Leora Horwitz, MD, NYU
  - Readmission measures

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Process

# Measure Comparison Table

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- 33 Medicare ACO measures (2012 – 2014)
- New Medicare ACO measures proposed and accepted for 2015
- All measures currently in use by Connecticut's largest commercial payers – claims based
- All measures currently in use by Connecticut Medicaid for the PCMH Program
- Supplemented with other measure sets as needed
- More than 100 measures reviewed



# Three Level Review

## Level 1

- Is the measure part of the Medicare ACO SSP set?
- Does the measure address a significant population health concern based on prevalence?
- Does the measure address a health disparity concern?
- Is there another compelling reason that the measure should be used for SSP, e.g., the measure represents a known patient safety, quality, or resource efficiency/cost concern?

## Level 2 (review all measures that pass level 1)

- Is the measure appropriate for VBP for Advanced network, FQHC, and/or ACO (e.g., eliminate measures recommended for individual clinicians, home health agencies, hospitals, etc.)
- Is the measure easily tied to QI efforts at the level of the Advanced Network/FQHC/ACO?
- If the measures within a performance domain or sub-domain (e.g., diabetes care) are in excess of what is necessary to demonstrate improved performance, retain those measures which serve as the best indicators of improvement.
- De-duplication
  - Is the measure the same or similar to another measure (e.g., “hospital admissions for asthma among older adults” is subsumed within “hospital admissions for COPD or asthma among older adults”)

# Three Level Review

## Level 3 (for all measures that pass level 2)

- Culling
  - Is the measure a process measure for which an available outcome measure would better serve?
  - Is there an opportunity for improvement or does the measure represent an area where the state is already performing well (consider for significant sub-populations if known)
  - Is there likely to be sufficient variation among provider organizations?
  - Does measure meet feasibility, usability, accuracy and reliability standards (e.g., can the measure be reliably produced with available or SIM proposed technology?, is the data sufficiently complete and accurate to be tied to payment?, will the measure be useful for quality improvement?, are base rates likely to be sufficient?)
  - Can performance on the measure be influenced by the Advanced Network/FQHC?
  - If the number of performance areas or measures (e.g., diabetes care, epilepsy care) is too high, such that organizational focus and improvement would be compromised, Council will rank and retain the highest ranked areas.
- Check for conflicts w guiding principles
- Reconsider previously rejected measures if necessary

*Action:* Accept those that remain.

# Break Out Groups

- Created three sub-groups in order to:
  - Provide the opportunity for in depth review outside of the full council meetings
  - Consolidate perspectives from 20+ individual members to 3 sub-group perspectives

**Consumer Advocates**

**Physicians**

**Payers**

# Design Groups & Care Management Committee

**Pediatric Design Group**



12 recommended measures

**Behavioral Health Design Group**

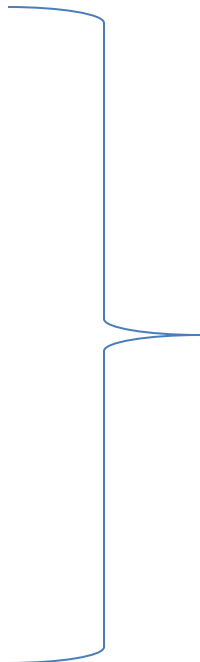


10 recommended measures

**Health Equity Design Group**

**Care Experience Design Group**

**MAPOC  
Care Management  
Committee**



Recommendations Pending

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# Provisional Measure Set

# Provisional Measure Set

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- Based on Level 1/2 review, measures have been recommended for provisional measure set
- Does not include readmission, admission, ED use, consumer experience measures
- Level 3 review and culling will be based on expanded stakeholder input and examination of base rate information and improvement opportunity
- Level 3 review will also consider HIT Council examination of feasibility, especially as it pertains to EHR based measures

# Provisional Measure Set - Prevention

Prevention Measure	NQF	ACO Measure
Breast cancer screening	NQF 2372	ACO-20
Cervical cancer screening	NQF 0032	
Chlamydia screening in women	NQF 0033	
Colorectal cancer screening	NQF 0034	ACO-19
Preventive care and screening: influenza immunization	NQF 0041	ACO-14
Preventive care and screening: body mass index screening and follow-up	NQF 0421	ACO-16
Weight assessment and counseling for nutrition and physical activity for children/adolescents	NQF 0024	

# Provisional Measure Set - Prevention

Prevention Measure	NQF	ACO Measure
Developmental screening in the first three years of life	NQF 1448	Pediatric Prevention Composite
Well-child visits in the first 15 months of life	NQF 1392	Pediatric Prevention Composite
Well-child visits in the third, fourth, fifth and sixth years of life	NQF 1516	Pediatric Prevention Composite
Adolescent well-care visits		Pediatric Prevention Composite
Pediatric behavioral health screening	NQF 0722	
Preventive care and screening: tobacco use: screening and cessation intervention	NQF 0028	ACO-17
Preventive care and screening: screening for high blood pressure and follow-up documented		ACO-21



# Provisional Measure Set - Prevention

Prevention Measure	NQF	ACO Measure
Preventive care and screening: screening for clinical depression and follow-up plan	NQF 0418	ACO-18
Prenatal care & Postpartum care	NQF 1517	
Frequency of ongoing prenatal care	NQF 1391	
Maternal depression screening	NQF 1516	
Annual dental visit		

# Provisional Measure Set – Acute & Chronic care

Measure	NQF	ACO Measure
Medication management for people with asthma	NQF 1799	
Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis	NQF 0054	
DM: Hemoglobin A1c Poor Control (>9%)	NQF 0059	ACO-27
DM: Diabetes eye exam	NQF 0055	ACO-41
DM: Diabetes foot exam	NQF 0057	
DM: Diabetes: medical attention for nephropathy	NQF 0062	

# Provisional Measure Set – Acute & Chronic care

Measure	NQF #	ACO Measure
HTN: Controlling high blood pressure	NQF 0018	ACO-28
CHF: beta-blocker therapy for left ventricular systolic dysfunction	NQF 0083	ACO-31
COPD: Use of spirometry testing in the assessment and diagnosis of COPD	NQF 0577	
CAD: Persistence of Beta blocker therapy after a heart attack	NQF 0071	
CAD: Medication adherence	NQF 0543	
Use of imaging studies for low back pain	NQF 0052	
Avoidance of antibiotic treatment in adults with acute bronchitis	NQF 0058	
Appropriate treatment for children with upper respiratory infection	NQF 0069	

# Provisional Measure Set

<b>Behavioral Health Measures</b>	<b>NQF #</b>	<b>ACO Measure</b>
Follow-up care for children prescribed ADHD medication	NQF 0108	
Depression Remission at 12 Twelve Months	NQF 0710	
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	NQF 1365	
Preventive Care and Screening: Unhealthy Alcohol Use – Screening	PQRS 173	
<b>Obstetrics Measure</b>	<b>NQF #</b>	<b>ACO Measure</b>
Elective Delivery	NQF 0469	

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# Level 3 Considerations

# Opportunity for Improvement

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- Assess CT performance relative to national average where such data is available
  - Quality Compass
- Assess CT performance against national benchmark
  - E.g., AHRQ national benchmarks, Quality Compass
- Larger improvement opportunity – higher priority
- Consider provider variation where available

# Base Rate Analysis

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- Assess for base rate sufficiency:
  - Cases that meet the criteria for the numerator/5000 members/year
  - Cases that meeting the criteria for the denominator/5000 members/year
- Sufficiency for smallest Advanced Networks and FQHC population assuming minimum of 5,000 attributed lives
- Rule of thumb: denominator at least 150
- Based on overall commercial and Medicaid populations
  - actual rates may vary among individual Advanced Networks and FQHCs; hospital based may have a sicker population.

# Base Rate Analysis – Target Measures

- Readmission
- Ambulatory care sensitive conditions composite (all-cause PQI or new NCQA spec)
- COPD (numerator, hospital admissions for COPD)/(denominator, pts with COPD)
- CHF (numerator, all-cause hospital admissions)/(denominator, patients with CHF)
- DM (numerator, all-cause hospital admissions)/(denominator, patients with DM)
- MCC (numerator, all-cause hospital admissions)/(denominator, patients with MCC as defined below\*)
- Asthma, adult (numerator, all-cause hospital admissions)/(denominator, adult patients with asthma)
- Asthma, pediatric (numerator, all-cause hospital admissions)/(denominator, pediatric patients with asthma)
- Rheumatoid arthritis
- Cardiac conditions in the semi-final measures under consideration



# Feasibility

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- Identify data source and methodology
  - Survey
  - Claims
  - Electronic Health Record (EHR)
- Consider feasibility of building claims based measures:
  - By payers or by means of APCD
- Consider feasibility of building EHR based measures
  - Quality Council memo to HIT Council requesting “proof of concept”
  - Examine full cycle solution for production of EHR based measures using A1C poor control and hypertension control as demonstration measures

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Measures  
Under Review

# Under Review – Consumer Experience

Domain: consumer experience		NQF	Steward
ACO-1-7, 34	ACO-CAHPS	0005 (adapted)	CMS
	PCMH CAHPS	0005 (adapted)	NCQA

Note: Design group is recommending some version of CAHPS; Council has not yet recommended use of CAHPS

# Under Review – Consumer Experience

	ACO CAHPS	PCMH CAHPS
Pros	<ul style="list-style-type: none"><li>• Medicare SSP aligned</li></ul>	<ul style="list-style-type: none"><li>• National benchmark data</li><li>• Aligned with CT Medicaid</li></ul>
Cons	<ul style="list-style-type: none"><li>• No national benchmark data</li></ul>	<ul style="list-style-type: none"><li>• Not aligned w/Medicare</li><li>• Focus on practice team rather than neighborhood team</li></ul>

# Under Review - Readmission

Domain: care coordination/patient safety		NQF	Steward
ACO-8	Risk standardized all condition readmission	1789 (adapted)	CMS
	Plan All-cause Readmissions	1768	NCQA

# Under Review - Readmission

	CMS readmission NQF 1789	NCQA readmission NQF 1768
Pros	Medicare SSP aligned Risk standardization can apply to commercial and Medicaid	Harmonized with CMS measure on index admission and planned exclusions Includes BH admissions National benchmark data
Cons	Excludes BH admissions No national benchmark	No risk adjustment for Medicaid Excludes births

## Options:

- Use NCQA measure and exclude readmission from Medicaid scorecard
- CT (w/ other SIM states?) stewards risk standardization for NCQA/Medicaid
- CT stewards addition of BH component to CMS measure

# Under Review – Ambulatory Care Sensitive Condition Admissions

Domain: care coordination/patient safety		NQF	Steward
ACO-35	Skilled Nursing Facility 30-day All-Cause Readmission Measure (SNFRM)	TBD	CMS
ACO-36	All-cause unplanned admissions for patients with DM	TBD	CMS
ACO-37	All-cause unplanned admissions for patients with heart failure	TBD	CMS
ACO-38	All-cause unplanned admission for multiple chronic conditions (MCC)	TBD	CMS
ACO-9	Ambulatory Sensitive conditions admissions: chronic obstructive pulmonary disease (COPD) or asthma in older adults	0275	AHRQ, PQI-5
ACO-10	Ambulatory sensitive conditions admissions: heart failure (HF)	0277	AHRQ, PQI-8
	Hospital admissions for asthma (adults)	0283	AHRQ, PQI-15
	Hospital admissions for asthma (child)	0728	AHRQ

# Under Review – Ambulatory Care Sensitive Condition Admissions

- Currently assessing base rate sufficiency
- Base rates likely to be an issue for all conditions other than asthma
- Options:
  - Use APCD to calculate commercial payer agnostic performance
  - Use APCD to calculate commercial/Medicare payer agnostic performance\*
  - Use Ambulatory Care Sensitive Condition (ASC) composite (see next slide)

\*Medicaid could be included though socio-demographic status (SDS) risk issues might be problematic



# Under Review – Ambulatory Care Sensitive Condition Composite

Domain: care coordination/patient safety		NQF	Steward	
	Ambulatory Sensitive Condition (ASC) Admissions		Anthem/AHRQ	Claims
	Pediatric Ambulatory Care Sensitive Admissions		Anthem/AHRQ	Claims
	Ambulatory Sensitive Condition Admissions		NCQA	Claims

- **Options:**

- Use Anthem adaptation of AHRQ/PQI ambulatory care sensitive condition composite
- CT (w/ other SIM states?) stewards risk standardization of NCQA ambulatory care sensitive condition composite (currently Medicare only)

# Under Review – Emergency Department Measures

Domain: care coordination/patient safety		NQF	Steward	
	Annual % of asthma patients (ages 2-20) with one or more asthma-related emergency department visits	d/c	Alabama	Claims
	Potentially avoidable ER rate		Anthem	

# Under Review – Emergency Department Measures

- Comment on asthma ED measure:
  - Asthma ED possible strong indicator of effective asthma management; however, NQF endorsement removed
  - NCQA recommends CT consider using risk-standardized asthma ED observed/expected ratio that is one component of their relative resource utilization measure
- Comment on avoidable ED measure:
  - Avoidable ED use is difficult to measure accurately
  - Yale CORE advises not a clear dichotomy
  - VT reports effort to use NYU algorithm (Anthem also uses adaptation of NYU algorithm); providers concerned about lack of national benchmarks, difficulty categorizing visits reliably/accurately...some admissions are part avoidable/part un-avoidable, and measure does not give clear guidance as to which cases should have different follow-up; neither payment nor reporting – monitoring only

# Other Measures Under Review

Domain: care coordination/patient safety		NQF	Steward
	Post-Admission Follow-up: Percentage of adults w/ inpatient “medicine” admissions with post-admission follow-up within 7 days of discharge	?	DSS
ACO-11	Percent of primary care physicians who successfully meet meaningful use requirements	N/A	CMS
Domain: Behavioral Health		NQF	Steward
	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Co-morbid Conditions	N/A	CMS

# Under Review – Oral Health Measures

Domain: care coordination/patient safety		NQF	Steward
Annual dental visit	The 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.	None	CMS
Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers	The measure will a) track the extent to which the PCMP or clinic (determined by the provider number used for billing) applies FV as part of the EPSDT examination and b) track the degree to which each billing entity's use of the EPSDT with FV codes increases from year to year (more children varnished and more children receiving FV four times a year according to ADA recommendations for high-risk children.	1419	University of Minnesota
Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	Percentage of enrolled children aged 1-21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.	2528	American Dental Association on behalf of the Dental Quality Alliance

# Key Questions

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- What data source is most appropriate – claims vs. EHR
- Who is responsible for producing new measures?
- How do we handle base rate limitations?
- Some measures may not be ready for implementation in 2016, even for reporting purposes
  - Such measures could be included in the measure set, or as a supplemental set, but projected for implementation at a later time
- Consider value of claims based interim measures until EHR based measures can be produced and tested
- Common scorecard?

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# Questions

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# Appendix



# Guiding Principles

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1. Maximize alignment with the Medicare Shared Savings Program ACO measure set.
2. Recommend additional measure elements that address the most significant health needs of Connecticut residents, the needs of non-Medicare populations (e.g., pediatrics, reproductive health), and areas of special emphasis such as behavioral health, health equity, patient safety, and care experience.
3. Wherever possible, draw from established measures such as those already established by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, CMS Meaningful Use Clinical Quality Measures, NCQA measures, and the CMMI Core Measure Set.

# Guiding Principles

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4. Balance comprehensiveness and breadth with the need to prioritize and focus for the purpose of enabling effective and continuous quality improvement.
5. Promote measures and methods with the aim of maximizing impact, accuracy, validity, fairness and data integrity.
6. Promote credibility and transparency in order to maximize patient, employer, payer, and provider engagement.
7. Assess the impact of race, ethnicity, language, economic status, and other important demographic and cultural characteristics important to health equity. Leverage the output of this analysis to identify potential reportable metrics for inclusion in the scorecard. (Draft...referred to Health Equity Design Group)

# Guiding Principles

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8. Recommend measures that are accessible with minimal burden to the clinical mission; should draw upon established data acquisition and analysis systems; should be both efficient and practicable with respect to what is required of payers, providers, and consumers; and should make use of improvements in data access and quality as technology evolves and become more refined and varied over time.
9. Maximize the use of clinical outcome measures and patient reported outcomes, over process measures, and measure quality at the level of the organization.
10. Use measurement to promote the concept of the Rapidly Learning Health System.

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# Resources

# Resources – Measure sets and summaries

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- National Quality Forum (NQF) endorsed measures
- NCQA – HEDIS, ACO measure set
- RWJF – Buying Value Initiative – Most frequently used measures
- Physician Quality Reporting Systems (PQRS)
- eCQM – measures for production by ONC certified EHRs
- Pinnacle Registry – cardiac measures
- Medicaid Adult and CHIPRA Pediatric measures

# Resources – State Measure Sets

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- Massachusetts – CHIA, Standard Quality Measure Set (SQMS)
- Main – Accountable Communities
- Oregon – Coordinated Care Organizations
- Minnesota - Integrated Health Partnership
- New Jersey – Medicaid ACO Demonstration Project
- Vermont – Medicaid ACO Shared Savings Program

# Resources

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- Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs – CHCS  
[http://www.chcs.org/media/QM\\_Medicaid-ACOs\\_matrix\\_0924142.pdf](http://www.chcs.org/media/QM_Medicaid-ACOs_matrix_0924142.pdf)
- Achieving the Potential of Health Care Performance Measures  
[http://www.healthreform.ct.gov/ohri/lib/ohri/work\\_groups/quality/2014-09-03/rwjf\\_406195\\_performance\\_measures\\_brief.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/quality/2014-09-03/rwjf_406195_performance_measures_brief.pdf)
- Medicare publications – proposed and final rules

# Acronyms

Acronym	
ACO	Accountable care organization
AHCT	Access Health Connecticut
AMH	Advanced Medical Home
ASC	Ambulatory Care Sensitive Conditons
BEST	Bureau of Enterprise Systems and Technology
CID	Connecticut Insurance Department
DAS	Department of Administrative Services
DCF	Department of Children and Families
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DSS	Department of Social Services
HEC	Health Enhancement Community
HIT	Health Information Technology



# Acronyms

Acronym	
HIT	Health Information Technology
MCC	Multiple Chronic Conditions
MOA	Memorandum of Agreement (contract between state agencies)
MQISSP	Medicaid Quality Improvement & Shared Savings Program
OSC	Office of the State Comptroller
OHA	Office of the Healthcare Advocate
PCMH	Patient Centered Medical Home
PMO	Program Management Office
RFP	Request for Proposals