Healthcare Innovation Steering Committee

April 9th, 2015

Practice Transformation Task Force Composition

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Suggested Considerations from March 17th Meeting

Primary care provider	Cultural health organization
Practice manager	Rural health
Hospital that is part of an accountable system	Educational institution
Housing	Home Health
Employment	ACO in different part of the state
Food security organization	Disease focused group
Faith based organization	

Personnel Subcommittee

Personnel Subcommittee recommended adding no more than 3 new members and would like to select those members from nominees who fall into any of ***five categories***. They further recommended that we ***solicit nominees from members of our current SIM Governance Structure and also by contacting the head of CSMS, CHA, and CT Association for Healthcare at Home.*** The goal was to obtain nominations by ***NOON, Wednesday, April 8th***, to support Personnel Subcommittee review Wednesday evening. The slate of nominees would then be presented to the HISC for approval on ***Thursday, April 9***.

6. Revised Membership

	Category	Description
1	Practice Manager	Practical understanding of the challenges of workflow management as it relates to incorporating PCMH capabilities in the primary care office and the challenges of coordinating with outside partners
2	Hospital	An individual from a hospital that is part of an ACO/Advanced Network; familiarity with process engineering, ED and inpatient transitions, and case management/care coordination/discharge planning interface
3	Housing	Individual with experience with housing and the process of coordinating an array of community supports for complex and/or vulnerable populations
4	Cultural Health Organization	Community organization with a health/health disparity focus and applied experience with community health worker services
5	Home Health	Actively coordinating with systems but not owned/operated; independent may deal with multiple systems

Practice Transformation Task Force Recommendations

The PTTF considered the Personnel Subcommittee's recommendations and supported the proposed five categories. However, they further recommended the following:

- five member appointments, one representing each of the five categories
- on the ground "hands on" people
- appointment of two of the positions by the Consumer Advisory Board (#3 and 4 as highlighted in previous slide)
- extension of the timeframe for solicitation of nominees, but with the aim of obtaining Steer Co approval of appointments prior to the next meeting of the PTTF on April 28th
- recommendation that DSS fill its vacancy

Practice Transformation Task Force – Considerations

Although not formal recommendations, the following considerations were recommended by various members

- that appointments favor applicants with recent or current applied experience in the field and can understand the "frontline" rather than individuals representing trade associations or in primarily policy positions
- That practice manager has applied experience with integrating new standards of practice such as medical home standards and integrating behavioral and/or oral health
- that hospital representative has direct and recent or current "hands on" experience
- that hospital representative has familiarity with the process of developing care measures
- that hospital representative has post-acute care strategy and planning experience, *possibly* as manager or director of care management or care management staff but not far removed from the work

Practice Transformation Task Force – Considerations

Although not formal recommendations, the following considerations were recommended by various members

- That housing be broadened to allow "*a consumer representative from a community based organization with experience meeting the non-medical needs of consumers that effect their well-being, e.g., housing, food"* (recommended by HISC member)
- That housing or cultural health organization representative might include leadership if they are close enough to the day-to-day work
- that DSS vacancy by filled by expert in long term services and support (LTSS) and have the ability to liaise with LTSS stakeholders as necessary to support CCIP design

Quality Council Update

Opportunity for Improvement

- Assess CT performance relative to national average where such data is available
  - Provided by DSS and Anthem
- Assess CT performance against national benchmark
  - SIM PMO will obtain license to access this data from NCQA with permission to share with Quality Council
- Larger improvement opportunity – higher priority
- Consider provider variation where available

Base Rate Analysis

- 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

- Identify data source and methodology
  - Survey
  - Claims
  - Electronic Health Record (EHR)
- Consider feasibility of building claims based measures:
  - Produced by each payer 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

Questions

Appendix

Guiding Principles

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

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

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.

Resources

Resources – Measure sets and summaries

- 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

- 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

- Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs – CHCS

  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

- 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