STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
January 21, 2015

Meeting Location: CT State Medical Society, 127 Washington Avenue, North Haven

Members Present: Rohit Bhalla; Aileen Broderick; Mehul Dalal; Mark DeFrancesco; Deb Dauser Forrest; Daniela Giordano; Gigi Hunt; Elizabeth Krause; Arlene Murphy; Robert Nardino; Donna O'Shea; Jean Rexford; Andrew Selinger; Todd Varricchio; Thomas Woodruff; Robert Zavoski

Members Absent: Karin Haberlin; Kathleen Harding; Kathy Lavorgna; Steve Levine; Meryl Price; Rebecca Santiago; Steve Wolfson

Other Participants: Sandra Czunas; Monica Farina; Lisa Honigfeld; Mark Schaefer

1. Call to order
The meeting was called to order at 6:12 p.m. Mehul Dalal served as meeting chair.

2. Public Comment
The Connecticut Hospital Association submitted written public comment (see public comment here). Mary Reich Cooper has offered to participate at the next meeting and Council members can pose questions to her there.

3. Referral to Health Information Technology Council
Mark Schaefer reviewed his proposal to have the Health Information Technology Council deliberate on a measure production strategy for measures that might not be produced by individual payers. The recommendation is for the HIT Council to map out a technological solution to provide a pathway to produce both claims based and electronic health record based measures. The proposed measures include the ACO-8 readmission measure, the ACO-27 A1C control measure, and the ACO-28 hypertension control measure. Dr. Dalal said the recommendation was a good one as the sooner they get feedback, the better position the Council will be in. Dr. Schaefer said that one question for consideration is whether there is value in the state measuring on behalf of all payers.

Arlene Murphy asked what the process is once the HIT Council concludes its deliberations. Dr. Schaefer said it is an iterative process. If the HIT Council determines the data cannot be readily compiled and is too big a burden then the Council would likely favor measures that are electronic health record reported. Thomas Woodruff asked the payer representatives what their A1C data looks like. Deb Dauser Forrest said that ConnectiCare's lab data is not great. Values will be reported in a text field and it is messy. Aileen Broderick said that Anthem uses a hybrid method for HEDIS reviews. Dr. Forrest said that data needs to be validated with medical record reviews. Donna O'Shea said United spends a great deal of time on chart review which is expensive and time consuming. Dr. O'Shea said that for hypertension data, they use CPT codes which the doctor submits for the procedure but that it is not ideal.

Rohit Bhalla said that the All Payer Claims Database (APCD) factors into the solution. Dr. Schaefer said they are represented on the HIT Council. They could build in an analytic overlay but his understanding was that edge server technology could be used to tap into claims data directly. The roadmap of activities for the APCD is based on claims data and they do not have the authority to obtain clinical data. There are obstacles to overcome.

Dr. Schaefer noted that Chartis is working on a formal approach to govern interactions between councils.

4. Meeting process
The Executive Team considered the most efficient way to proceed with the Council's review. Their recommendation is to gauge consensus informally with minimal discussion when all three groups recommend "no" or "yes" and recording that consensus. The Council would then formally vote on the slate of "yes" measures and formally vote on the slate of "no measures." The Council would follow the three step review process, first making decisions on measures where general agreement can be reached. Measures that would require further review or discussion could be tabled and the issues worked through at a later date. It was also recommended that discussion of measures for a particular area (for example, obstetrics) be tabled if one of the Council's physician experts cannot attend. Todd Varricchio asked whether they would cull at the same time. Dr. Schaefer said they are not culling at this time and there may be duplication.

5. Quality Measure Comparison Table Review
Dr. Dalal proposed they review obstetrics measures as Mark DeFrancesco is on the call and skip cardiology and asthma measures until the next meeting. Dr. Schaefer noted that Monica Farina has done research on diabetes measures and can assist with the discussion on those measures.

Prenatal care (NQF 1517) and Frequency of ongoing prenatal care (NQF 1391)
Dr. DeFrancesco said he was concerned with retrospective measures as it makes it difficult to take prenatal care into account. He said he would be surprised if most practices aren't seeing patients within six weeks. Dr. Schaefer noted that some measures can be used for reporting only. There is a question as to whether there is an opportunity for improvement for commercial payers. Ms. Broderick said that they have high rates for those measures but Medicaid could be a different story. Dr. O'Shea said that maternal mortality is low but has been increasing over the last 10 years. From a population health perspective, early care matters. Jean Rexford proposed leaving the measure in and revisiting it later.
Recommendation: Yes, leaning towards Medicaid only. The Council will revisit this measure.

Postpartum depression screening (not NQF endorsed)
The payers do not recommend the measure while all others say it should be included. Dr. Schaefer asked how postpartum depression screening is billed in a pediatric office. Robert Zavoski said that for the most part, there is no rule that says they can't bill for an adult and it may be a CHIPRA measure. It would be billed under the mother's name. Dr. O'Shea said that the pediatrician would need a chart for that person under her name. That would require a change in operations. Dr. DeFrancesco said that it could be in the child's chart as the screening is being conducted in relation to the safety and protection of the child. The group discussed how data for the measure would be collected, either through claims or the electronic health record. Daniela Giordano said the Behavioral Health Design Group reviewed the measure and thought it should come from the electronic health record. She noted that mothers may not go to a primary care physician or an OB/GYN but may go to the pediatric office. Dr. Zavoski noted that there is not an established tool for this. Ms. Broderick recommended using it as a monitoring measure initially.
Recommendation: Yes, but needs additional data.

Cesarean section rate in singleton low risk deliveries (NQF 0471)
Dr. DeFrancesco provided background on the measure. It excludes breech births, multiple births, VBACs. He said the average cesarean section rate is between 32 and 33 percent but that is for all conditions. Mr. Varricchio said that Aetna uses the measure and seeks incremental improvement along the curve as opposed to an absolute target. Once they hit 10%, practices are asked to maintain that rate. He said no one will be 100%. Dr. DeFrancesco said he was unsure if there was an ideal number. While numbers were decreasing, there are still a lot of providers who think it is okay. The Council discussed how to best apply the measure and how it would impact an Accountable Care Organization. Dr. Schaefer said there may be measures that are best dealt with in an ACO and others that are best dealt with in episode based care.
Recommendation: postpone for further review.

Episiotomy in vaginal deliveries (NQF 0470)
Dr. DeFrancesco said that there may be other things that are more important for measurement and reward. Dr. Bhalla said they post the episiotomy rate by provider and work to reduce it. He noted that it is one of the

few safety measures but had reservations about thinking what is more important to measure. Mr. Varricchio said that while the measure is valuable, it may not be appropriate for primary care.
Recommendation: yes, pending further review.

Breast cancer screening (NQF 2372) – all three recommend inclusion.

Cervical cancer screening (NQF 0032) – all three recommend inclusion.

Chlamydia screening (0033)
Dr. DeFrancesco said that there are a lot of positive results in asymptomatic people. Dr. Zavoski said Medicaid has reported this for a number of years and try to do it for males but they don't pay based on it. Ms. Broderick said it was not part of the current scorecard. Elizabeth Krause said that the consumers said no but that if others were willing to include it, they were open to changing. Dr. Schaefer said they can further review the measure during the culling process.
Recommendation: provisional yes.

Lead screening in children (not NQF endorsed)
All said no except for Medicaid. Dr. Zavoski noted there was little room for improvement.
Recommendation: no.

Glaucoma screening – all three recommended exclusion

Colorectal screening (NQF 0034)
It was noted this measure has a data capture issue. Dr. Woodruff said that they can make the ACOs capture the data and report out. Dr. Schaefer said that they have had to do this for Medicare. The data is self reported and not reliably done through claims. Dr. Bhalla noted that this was the only screening that included a therapeutic intervention.
Recommendation: provisional yes.

Childhood immunizations DTaP and IPV – all three recommended exclusion

Childhood immunizations MMR – all three recommended exclusion

Childhood immunizations VZV – all three recommended exclusion

Childhood immunizations status combo 2, 3, 4 (NQF 0038)
All said no except for Medicaid. It is incentivized under PCMH but may not see much improvement.
Recommendation: no.

Adolescent immunizations TDaP/TD and meningococcal – recommended for exclusion

Adolescent female immunizations HPV
The physicians recommended updating the measure to include males. Dr. Dalal said it could provide a significant improvement opportunity. The payers said they had some concerns about the measure.
Recommendation: yes.

ACO-14 Preventive care and screening: influenza immunization (NQF 0041)
The payers had concerns about the engineering of data collection as it can happen in multiple locations. Dr. Schaefer said the PCP has to ask if it has happened and capture the data. Andrew Selinger said most pharmacies forward the data that it has been performed. He said it can be reliably captured and is clinically important.
Recommendation: yes, with the need to solve the production problem.

ACO-15 Pneumonia vaccination status for older adults (NQF 0043)

The health plans said no based on the age. Dr. Schaefer said they will have to assess how far they want to go into that space. No recommendation was made.

ACO-16 Preventive care and screening: body mass index screening and follow-up (NQF 0421)
The measure may have an issue of EHR data capture. Dr. Schaefer said that if they can engineer the production of the measure, it can be an important clinical process. Ms. Broderick said the follow up is not part of HEDIS reporting and that it is more of a process measure that did not imply any follow up action. Dr. Selinger said there is no metric for follow up plans and there is nothing in their EHR that allows them to capture the follow up other than an open note.
Recommendation: revisit once Dr. Selinger provides additional information.

6. Next Steps
The Council will work to resolve identified issues and will continue with measure review at a brisk pace. Dr. Schaefer said he will see if he can bring additional expertise to the table. The Council can revisit asthma and cardiology measures. Dr. Schaefer said he will forward information on diabetes.

The meeting adjourned at 8:30 p.m.