



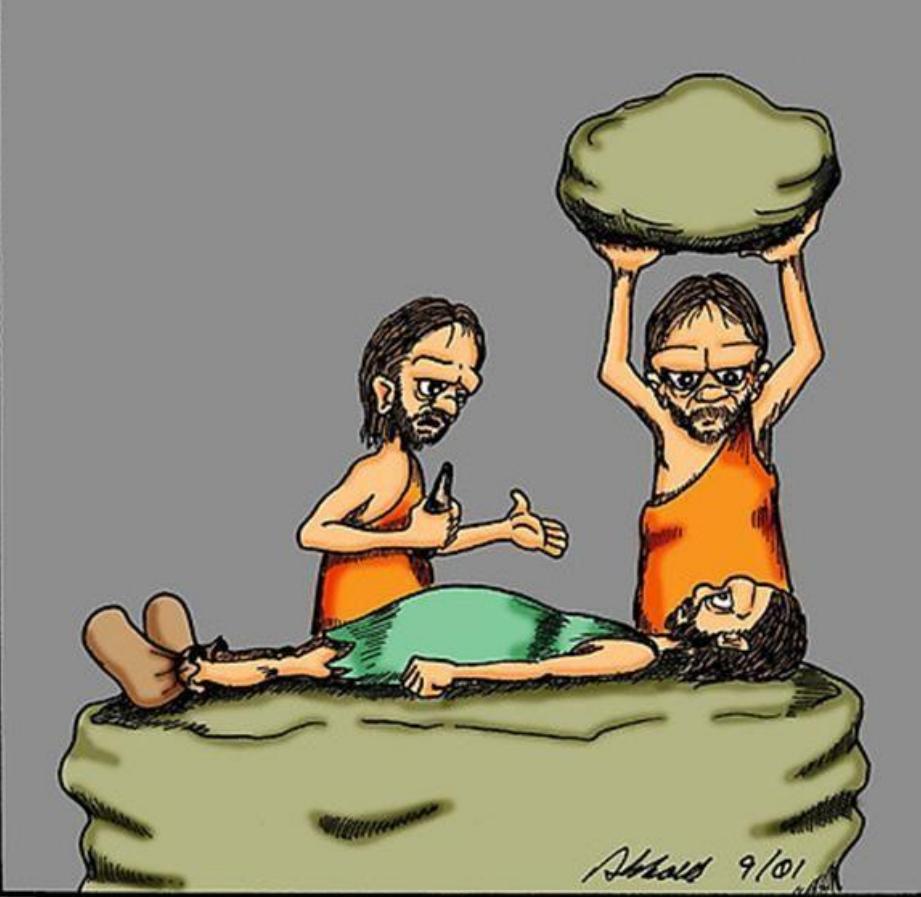
CONNECTICUT
Office of Health Strategy

SIM Quality Council

August 1, 2018



BILL ABBOTT



“...and this is Ralph, your anesthesiologist.”

Meeting Agenda

Item	Allotted Time
Introductions/Call to Order	5 min
Public Comment	5 min
Approval of Minutes	5 min
Purpose of Today's Meeting	5 min
Yale Health Equity Measure Update	30 min
Public Scorecard Comment Review	70 min
Next steps and Adjournment	5 min



Public
Comments



2 minutes
per
comment

Approval of the Minutes

Purpose of Today's Meeting

Yale Health Equity Measure Update

Measurement and Transparency Drive Improvement

- The Quality Council recommended the use of health equity quality measures as part of their core quality measure set recommendation.
- No quality measure scorecard or incentive models incorporate improving health disparities as a potential performance target.
- The Quality Council recommendation around health equity quality measures could not be implemented because no methodology existed.
- Connecticut State Innovation Model (SIM) Program Management Office (PMO) enlisted the Yale Center for Outcomes Research and Evaluation (CORE), with the help of a Connecticut Health Foundation grant, to advance this effort.



We are working to ensure health equity is incorporated into healthcare value based payment model incentive systems

Health Equity Quality Measures Project

- Connecticut State Innovation Model (SIM) Program Management Office (PMO)
- Yale Center for Outcomes Research and Evaluation (CORE)
- Department of Social Services, Medicaid (DSS)
- SIM Quality Council

Goal: Use data to propose a disparity measure methodology that can be incorporated into alternative payment models, in order to promote racial and ethnic health equity in healthcare delivery and outcomes

Prior Quality Council Discussion

1. Preliminary evaluation of the data

- Known issues with previous collection of race and ethnicity, now improving with new data collection approach
- We found 2015 data adequate for disparity measure methodology development based on comparability with other sources of information about race/ethnicity

2. Measure selection

- Identified potential measures for initial use based on:
 - Sample size by racial and ethnic categories for provider group
 - Current disparities in measure rates for CT Medicaid patients
 - Variation among provider groups (initially grouped by TIN)

3. Developing equity measure methodology

Three Methods for Disparities Measurement

Method 1 – Absolute Disparity

- Compares each provider's measure performance between two groups (e.g. Black compared with White or Hispanic compared with White)
 - Direct assessment of the difference in performance between groups
 - Easy to interpret, e.g. 2% difference in performance favoring white patients

Method 2 – Distance to a Benchmark

- Compares provider's measure performance for selected group to a chosen benchmark (e.g. 90th percentile)
 - Reports the difference in performance scores from the assigned benchmark
 - Focuses achieving high performance for all, but does not directly measure disparities

Method 3 – Between Group Variance

- Calculates how much variation in measure performance among racial groups
 - Provides a single metric of equity in care across all patient groups
 - Can be difficult to interpret, does not directly provide information about performance with individual racial and ethnic groups

Recommendations

- 1. Propose the use of 1 - 4 disparities measures for incorporation into the current PCMH+ program as reporting measures**
 - Request for Proposals alerted providers to the potential for incorporation of such measures
 - Using these measures will familiarize providers with disparities measurement, but as reporting measures these will initially not be used to influence payment
- 2. Report providers' percentile ranking on absolute disparity score**
 - Absolute disparities is straightforward to interpret and directly measures the disparity
 - Using more recent data will allow opportunity to confirm the adequacy of race and ethnicity data (recognizing that some beneficiaries will elect not to report) and variation among providers
 - Providers will be scored only if they have adequate numbers of patients in both
- 3. Give healthcare providers detailed underlying information to support quality improvement**
 - Provide information such as number of patients in each subgroup, measure performance for each subgroup, and the performance on the other methodologies for further illumination of disparities
 - Consider stratifying disparities results by patient volume (within racial or ethnic groups) to support comparisons and quality improvement

Next Steps to Expand Measurement Initiatives

We also recommend further investigation of the following to support ongoing expansion of these efforts in the state of Connecticut:

Within PCMH+ Program:

- In updated data source, further confirm the appropriate provider groups to align with programmatic structure (TIN vs. PCMH+ grouping)
- Examine options for more granular race groups and other social risk factors, including assessing adequacy of sample size as race data improves
- Test options for composite measures of disparities that combine results across quality measures
- Test approaches to measuring disparities improvement

For expansion of work to other programs:

- Test methods in all-payer data set
 - This may require alternative methods for determining patient race/ethnicity, such as using birth registry data
- Test methods for clinical measures and risk-adjusted outcomes measures (will require modification in methods)

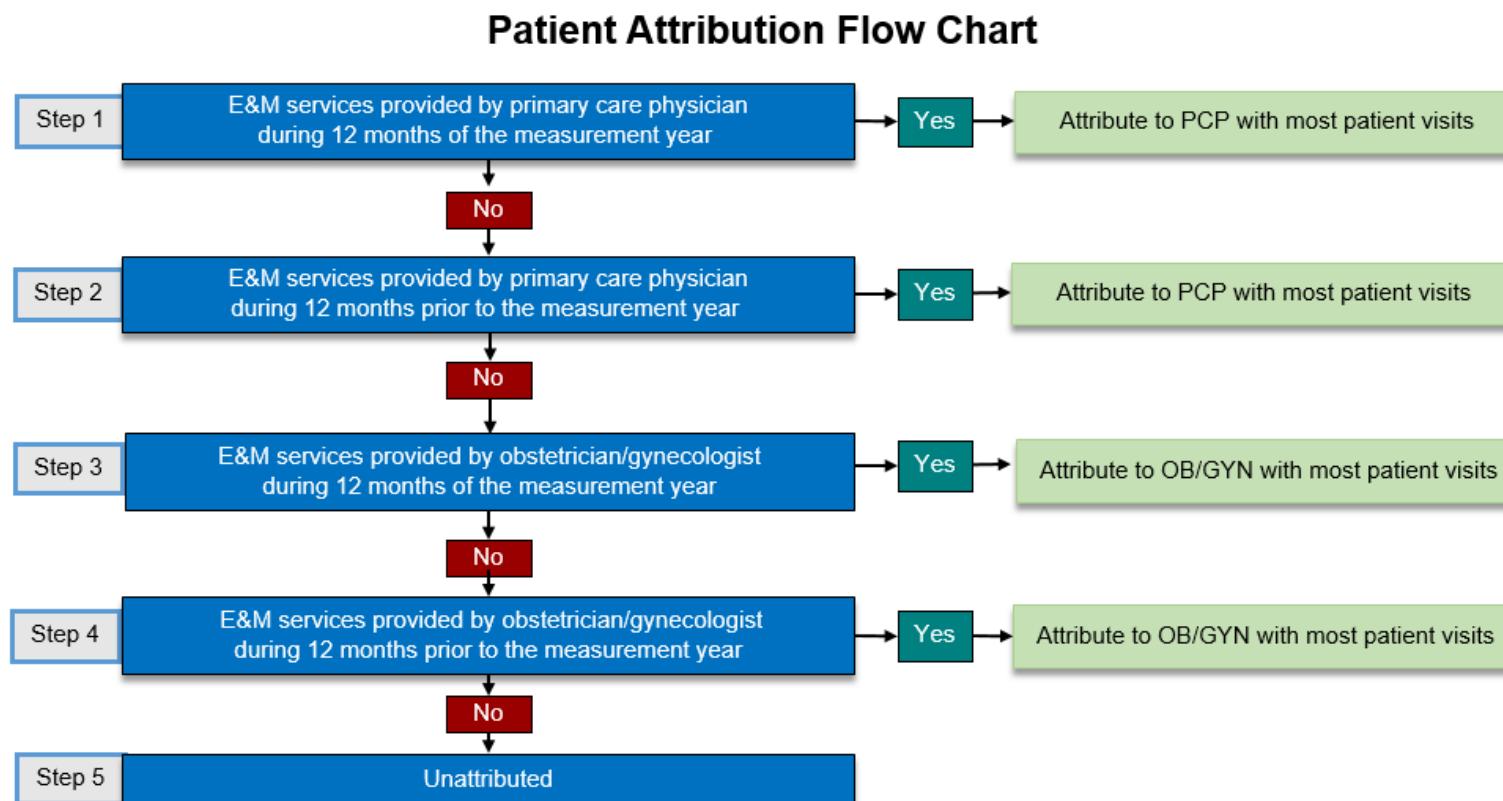
Public Scorecard Comments

Public Comments Overview

- Public comments were solicited on three summary documents related to HealthQualityCT:
 - Public Scorecard Project Overview
 - Public Scorecard Attribution Methodology
 - Public Scorecard Benchmark, Rating, and Risk Adjustment
- Four organizations submitted responses to the public comment documents:
 - Northeast Medical Group
 - Cornell-Scott Hill Health Center
 - Community Medical Group
 - Connecticut Voices for Children
- After review and discussion with the Quality Council of these comments, we will publish a single public response document, incorporating all feedback, our responses, and action steps.

Comments on the Attribution Process

- **Comment:** When there is no PCP or OB/GYN listed within the previous 12 months, patient is attributed to a specialist, which will lead to inaccurate attribution.
 - Response: A 24 month look-back has been instituted to capture payer/ population differences in longer than 12 month visits for PCP scheduling



Comments on the Attribution Process

- **Comment:** How will APRN and PAs be determined to be PCPs?
 - *Response:* They will be determined to be PCPs based on the services they provide, the exact details of which are under investigation.
- **Comment:** Will Certified Nurse Midwives be classified as PCPs? Will they be attributed to OB/GYNs?
 - *Response:* No, they will not be classified as PCPs, nor will they be attributed to OB/GYNs.

Comments on the Attribution Process

- **Comment:** How will multispecialty clinics or group practices be defined?
 - *Response:* We are not defining a multispecialty group or clinic, as they are not a target of scoring in the HealthQualityCT.

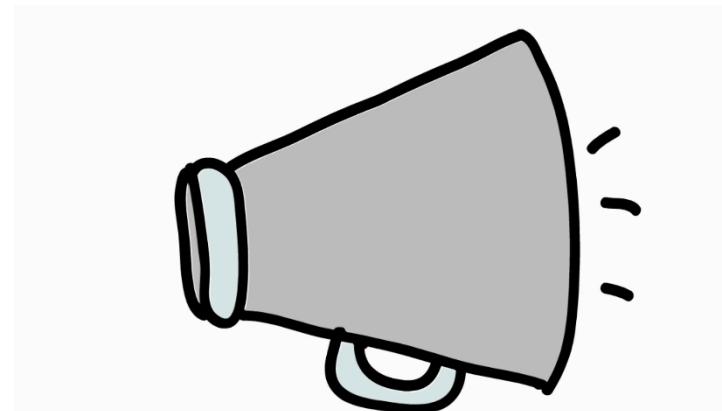


Comments on Data Sources

- **Comment:** Access to ongoing data and measure results throughout the year would be helpful for quality improvement initiatives related to the measures.
 - *Response:* The Scorecard will be published annually, and the results will be available throughout the year. All data comes from the APCD and is available to organizations via request.

Comments on Data Sources

- **Comment**: All measure definitions and formulas should be made publicly available.
 - *Response*: Measure analysis follows HEDIS standards, via NCQA, which are public and available at a cost.
- **Issue**: Will OHS be obtaining claims data from all commercial payers?
 - *Response*: Yes, HealthQualityCT will use all commercial claims contributed to the APCD, and will also include claims from Medicare (by Fall) and Medicaid (by end of the year.)



Comments on Scoring Calculations

- **Comment:** Are there minimum volume thresholds for the reporting and rating of each measure?
 - *Response:* The thresholds have not yet been determined, but will be made public when available
- **Comment:** Risk stratification is an important component for the production of quality and actionable measures. Without it, we will create a selection bias and an artificial snapshot of organizational quality.
 - *Response:* We are using the risk adjustment that has been incorporated into the endorsed measures, with an added layer of reporting separately for Medicaid, Medicare, and Commercial populations.

Comments on Scoring Calculations

- **Comment:** How are we determining measure benchmarks, given that some of the measures were designed for different data types than ours?
 - *Response:* The benchmark used as the primary visual reference and in scoring performance is the State average, which will be calculated using the same methods and data as is used to calculate healthcare organization performance. National benchmarks will be offered in advanced views as an additional informational reference only. Benchmark methodology will be made public when available.

Comments on the Measures

- **Comment:** What is the difference between the Core Measures and Reporting Measures?
 - *Response:*
 - Core Measures: Recommended for performance monitoring and inclusion in value based payment
 - Reporting Measures: Recommended for performance monitoring, but not recommended for incentives or value based payment
- **Comment:** Measuring all-cause readmissions assumes all organizations have access to hospitalization data, when they often don't, making measurement and amelioration of this metric difficult.
 - Response: This is an important metric for all stakeholders in the healthcare system, and a metric that organizations should be looking to incorporate into their own quality initiatives. Additionally, the state's HIT plan includes provisions to solve for the ability to access to comprehensive data including hospitalization admissions.

Comments on the Measures

- **Issue:** The scorecard measures do not evaluate racial health disparities per se, and race/ethnicity variables should be included wherever possible.
 - *Response:* While we agree with this assessment, those data are not currently available, and we are working to incorporate race/ethnicity into the APCD. The CT SIM is one of the only states that is focused on promoting health equity by closing the health disparity gap between the highest and lowest achieving populations for key quality measures.
- **Comment:** SIM emphasizes integrating traditional health services with community-based supports, but the scorecard measures do not assess this integration (e.g. housing, environmental, nutritional, and/or community supports)
 - *Response:* These measures are currently beyond the scope of HealthQualityCT. However, there are other SIM initiatives such as the Health Enhancement Communities and Primary Care Modernization efforts. (provide website)

Comments on the Measures

- **Comment:** Why are costs absent from the list of measures?
 - *Response:* Cost measures were not chosen, although they are an important component of the SIM initiative.
- **Comment:** More indicators of child wellbeing are needed, like tracking treatment for preventable illness and follow-ups after positive screenings.
 - *Response:* Some additional measures of child wellbeing are found in the quality measures et, but we are unable to include them in this first iteration of HealthQualityCT, given the data availability. Those measures could become feasible at a later date if EHR data are made available through the State HIT initiative and/or if the APCD is able to release those dates fields.



Upcoming Meetings

September 26th: Regular Meeting

Adjourn