

STATE OF CONNECTICUT
State Innovation Model
Quality Council

Conference Call Summary
April 15, 2015

Members Present: Rohit Bhalla; Aileen Broderick; Jessica DeFlumer-Trapp (for Karin Haberlin); Deb Dauser Forrest; Steve Frayne; Amy Gagliardi; Daniela Giordano; Elizabeth Krause; Steve Levine; Robert Nardino; Donna O'Shea; Jean Rexford; Andrew Selinger; Todd Varricchio; Steve Wolfson; Thomas Woodruff; Robert Zavoski

Members Absent: Mehul Dalal; Mark DeFrancesco; Kathleen Harding; Robert Hockmuth; Kathy Lavorgna; Arlene Murphy; Meryl Price; Rebecca Santiago

Other Participants: Sandra Czunas; Faina Dookh; Monica Farina; Alice Ferguson; Jane McNichol

Call to order

Steve Wolfson served as call chair. He called the meeting to order at 6:05 p.m. It was determined a quorum was present. Mark Schaefer introduced Alice Ferguson who will participate in the HIV measure discussion. Ms. Ferguson is chair of the City of Hartford HIV/AIDS Commission and a member of both the SIM Consumer Advisory Board and Equity and Access Council.

Public Comment

There was no public comment.

Recommendations of the Care Experience Design Group for consumer experience measurement

Dr. Schaefer presented the recommendations of the Care Experience Design Group ([see presentation here](#)). There was discussion regarding the volume of the sample and whether there would be issues achieving volume. Rohit Bhalla said that for hospitals, 300 surveys are needed to reach statistical significance. Aileen Broderick said that if done at the ACO level, volume should not be an issue. Dr. Schaefer said that Medicare is requiring ACOs to use one of two versions of the ACO CAHPS surveys. Those Connecticut-based ACOs would likely be among those who enter into commercial shared savings contracts and could enter into shared savings arrangements with Medicaid. Medicare, he noted, has not had issues with volume. The Medicaid population comprises 20 percent of the state's population.

The intent is to perform these surveys utilizing a methodology that would satisfy both payer and consumer interests. Ms. Broderick suggested using the CAHPS survey designed for patients on marketplace (insurance exchange) plans as it includes cultural competency and care coordination questions. She also suggested properly timing the survey so that it is not sent at the same time as the annual health plan survey schedule.

Dr. Schaefer noted that the Care Experience Design Group proposed the PCMH CAHPS as the best instrument with the intent to tweak the survey with input from the full council. Additionally, they recommend including measures regarding specialty access, but that differentiates behavioral health

and other specialty care. Steve Levine asked why behavioral health stood out. Dr. Schaefer noted that behavioral health providers are more likely to opt out of traditional commercial contracts. Daniela Giordano noted that behavioral health providers typically find it challenging to join a network and there are access issues with private insurance. Dr. Wolfson noted that there are also concerns about the information sharing required in return for payments. Dr. Schaefer noted that there is vagueness about what behavioral health treatment should look like. Question was asked how including it as a scorecard measure might change the behavior of the market. If Council does not press for improvement in this area, the problem will continue unresolved.

The Council discussed potential tweaks to the survey. Dr. Bhalla said that benchmarking will be important. He noted the Hospital CAHPS includes demographic variables in terms of disparities (race, ethnicity, language, education). That information provides information on opportunities for improvement and should be considered for inclusion in the SIM care experience survey.

Motion: to approve the goals as outlined on slide 7 of the presentation and to ensure the capture of demographic information to examine statewide performance – Andrew Selinger; seconded by Donna O’Shea.

There was no additional discussion.

Vote: all in favor.

Recommendations for HIV Measures

Alice Ferguson had asked whether HIV measures could be considered for the scorecard. HIV/AIDS affects 10,000 Connecticut residents who are nearly equally covered by Medicaid, Medicare and commercial insurance. It was noted that it may be difficult to include in the scorecard but could be considered as part of a special program. Dr. Levine asked how cervical cancer applied to HIV. Donna O’Shea said that those who are immuno-depressed are at higher risk for cervical cancer and they need yearly screenings.

There was discussion regarding the sensitivity around what information could be shared. Ms. Ferguson noted that anyone identified as having HIV is given an identifier that cannot be tracked to the individual. Dr. Schaefer noted that may create an audit issue as the data cannot be tracked back to the patient chart to validate performance reporting. Dr. O’Shea said that payers have claims data related to HIV/AIDS but they cannot share it. Robert Zavoski noted the law about sharing data is HIV specific and not payer specific and there is a great deal of concern about complying with the law. The group discussed the concerns about reporting at length. Additional research may be required as there is a great deal of sensitivity around this data. Steve Frayne said HIV/AIDS measures may be important from a reporting standpoint but not used for gain sharing.

A group met to discuss potential HIV/AIDS measures. There was discussion about whether the base rate was sufficient for accurate measurement. Dr. Schaefer said 150-180 is required in the denominator. There may be sufficient rates in Medicaid and commercial but it may not reach 150. It could be included as an optional measure. It was also noted that lead for such care has been infectious disease specialists. Ms. Ferguson noted that, increasingly, people with HIV/AIDS must have a primary care provider in addition to an infectious disease physician. She noted that her doctors all share information with one another and it was critical that they did so.

Council considered deferring action on the measures and working more closely with the Department of Public Health on the current state of data on HIV/AIDS management and data collection. Issues that would need to be addressed are whether to stand the three measures up as

reporting only, whether there were sufficient base rates, whether confidentiality would be a problem, and whether care was being provided by PCPS or specialists.

2016 Proof of Solution Definition Document

Due to the time, Dr. Schaefer asked if the payer representatives could remain on the call. Others could continue to participate as well at their option.

Jean Rexford asked for clarification of the term “proof of solution.” Dr. Schaefer said that proof of solution is also referred to as proof of concept. The process is intended to provide proof that the concept that edge server technology will meet the state’s data needs. The Health Information Technology Council will examine two measures to determine the limitations that need to be bridged going forward. Elizabeth Krause asked how health equity is phased in and also whether a two phase process would be beneficial. Dr. Schaefer said that using a two phase process would eliminate the ability to utilize an interactive portal or a tool that could perform sophisticated analytics. On the other hand, they could potentially stand up an outcomes measure that would otherwise not be feasible. If there is the ability to stratify the measures by race and ethnicity, the measures could be used to measure health equity gaps and reward improvement.

Thomas Woodruff asked for clarification with respect to the roles of each council. Dr. Schaefer said the Quality Council was responsible for defining policy and program requirements. The Health Information Technology Council will be responsible for determining what technology could most effectively enable implementation. There was a suggestion of blending Quality and HIT design groups so that there is more of a dialogue about what is possible.

Dr. Schaefer said there are issues with de-identified data. There is a need to be able to audit the data so the state may contract an audit process. He noted that employers also want to know the performance for their employee populations, which would require cutting data by both payer and employer. Because there is no audit trail, there is no way to respond to a provider’s appeal about the validity of a measure. These issues complicate matters. Dr. Schaefer suggested the health plans discuss how to best address some of these issues. Dr. O’Shea suggested pulling in the CT Association of Health Plans to facilitate the discussion.

Next Steps

Dr. Schaefer proposed setting a meeting time for those interested in discussing the proof of solution at a greater level of detail. Additional participants could be included in that discussion, such as payer experts.

The call adjourned at 7:30 p.m.