

Questions and Responses from Advisory Subcommittee Meeting
Presentation on Quality Measures
April 9, 2013

Core Measures

1. Depression Screening and Follow-up Care

Question [Dr. Martin]: Would follow up be done by the behavioral health provider or the primary care medical provider (PCMP)? If the latter, the PCMP seldom knows when a psychiatric hospitalization occurs.

QHI Response: Since the measure only counts follow-up care provided by a licensed mental health professional, PCMP follow-up visits would not be counted unless the PCMP is also a licensed mental health professional. Communication and collaboration will be needed among the hospital, the Behavioral Health Organization (BHO) and/or the Community Mental Health Center (CMHC), the PCMP, and the Regional Care Collaborative Organization (RCCO).

2. Care Transition Record Transmitted to Health Care Professional

Question [Dr. Martin]: How would this be measured? Do hospitals track this data? Would this also apply to nursing homes if they never send any discharge information?

QHI Response: The specifics are not yet known, but this is one measure included in the Adult Quality Measures Grant. The Department is currently working with the Center for Improving Value in Health Care (CIVHC) to develop a state-wide resource on transitions. The Department is also working to define "Care Transition Record" and is examining systems now being used.

3. Screening for Fall Risk

Question [Dr. Martin]: Will this be done by the RCCO or the PCMP? Since most PCMPs may not do this or document it systematically, it may make data gathering from chart reviews more difficult.

QHI Response: Again, the specifics are not yet known, but this information would be gathered from samples as part of a hybrid measure.

4. Initiation and Engagement of Alcohol and Other Drug Dependent (AOD) Treatment

Question [Dr. Martin]: Would the treatments and services be provided by the behavioral health provider, a substance abuse provider, or the PCMP? Would this

mean that anytime a PCMP used a diagnosis code indicating drug or alcohol abuse, the PCMP would be required to code three services to the individual within the next 30 days?

QHI Response: The Department submitted a budget request to the legislature to include substance abuse services in the community mental health services program. This service would most likely be provided through the BHO's network, which includes individual providers, CMHCs, Federally Qualified Health Centers (FQHCs), etc.

Possible State-Specific Demonstration Measures

- 1. Client Experience** [Data would be obtained on a sample through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.]

Question [Dr. Martin]: Are CAHPS surveys already being done? If not, who will do them or pay for them to be done?

QHI Response: The Department currently does health plan-related CAHPS surveys each year. A wide variety of CAHPS surveys target varied populations. CMS has indicated it will sponsor CAHPS for the Demonstration.

Question/Comment [Mary Kay Kisseberth]: This is a top priority for the second goal of the Demonstration, but it is fuzzy in its current description. We presume data will be pulled from the CAHPS survey. Which elements? Is the intent to focus on care coordination, person centeredness, and prevention? Should indicators and data be collected and measured on these three topics? It would be helpful to have more background on how CAHPS is administered, how reliable it is, and how timely the data is received.

QHI Response: Yes, questions added to the survey this year relate to care coordination, person centeredness, and prevention. More information about CAHPS will be provided at the Learning Lab on May 14, before the next Advisory Subcommittee meeting.

- 2. Flu Immunization** [This looks at the percentage of enrollees who received a flu immunization during flu season.]

Question [Dr. Martin]: These are often given at Walgreens and other locations. This is a good measure of population health, but it may not be a good indicator of RCCO or PCMP performance.

QHI Response: This is a valid point. These immunizations are given at many community locations. Data can be gathered through a hybrid measure or the immunization registry. The Colorado Health Regional Information Organization

(COHRIO) is also undertaking an effort to foster sharing data about flu immunization claims across payer sources. That effort may not become a reality until more providers are using electronic health records.

Question/Comment [Mary Kay Kisseberth]: Is Colorado's evidence of deaths each year from flu at the same level as national data? Is this data available or collected by another entity such as the Centers for Disease Control and Prevention (CDC)? If so, should it be a top priority for the Demonstration? It seems that we would want to concentrate on quality indicators that clearly focus on what we are testing in the Demonstration.

QHI Response: Data was not available last year. Immunization data goes from those in Colorado who provide immunizations to the Colorado Department of Public Health and Environment (CDPHE) to CDC. We welcome additional recommendations from the Advisory Subcommittee on this measure and the others.

- 3. Adult Weight Screening and Follow Up** [This relates to the percentage of enrollees whose body mass index (BMI) was measured in the past six months or during a current visit documented in the medical record. If the BMI is outside parameters, a follow-up plan is documented.]

Comment [Dr. Martin]: This is a meaningful use measure, so that's a nice alignment.

Comment [Mary Kay Kisseberth]: This is good because it gets to a Colorado-specific issue. We have repeatedly been shown to be the "thinnest" state. We want to keep that award. We know we are slipping.

- 4. Care for Older Adults** [This relates to the percentage of enrollees who had advance directives and functional assessments during the measurement year.]

Comment [Dr. Martin]: The Department would need to make clear to providers which activities would qualify as advanced care planning and functional status assessment so that reviewers could make an accurate determination. Even with clarification, combing through charts to find where these are recorded could be a big challenge.

QHI Response: To clarify, the measure was previously presented incorrectly. The measure is, "*Care for older adults: percentage of adults 66 years and older who had each of the following during the measurement year: advance care planning, medication review, functional status assessment, and pain screening.*" Advanced care planning relates to issues of life support.

QHI Question: Is the Medical Orders for Scope of Treatment (MOST) form widely used by providers?

Question [Mary Kay Kisseberth]: What age is "older?" There are legal issues with advance directives. It would be a good idea to clarify this measure. What data would

support it, and where is that data? Individuals can change their minds at any time. It seems that this one needs more explanation.

QHI Response: “Older” for this measure is defined as 66 years and older. If this measure moves forward in the Demonstration, documentation issues would need to be addressed.

5. Pneumonia Immunization [This relates to the percentage of enrollees hospitalized during October-February who were vaccinated for pneumonia before discharge.]

Comment [Dr. Martin]: While pneumococcal vaccine is important and it should be, I believe it is generally given in primary care offices rather than during hospitalizations.

QHI Response: This measure intends to increase utilization of the vaccination in the inpatient setting, which is currently an underutilized delivery system. Sixty-five percent of individuals hospitalized for pneumonia were hospitalized at least once in the previous three to five years.

Question [Mary Kay Kisseberth]: Is this the same as the flu measure? Why would we collect this for the Demonstration if it’s already collected by others? Why would we collect it only in a hospital setting?

QHI Response: Please see the flu vaccine comments and the previous response to Dr. Martin’s question on this issue. CDC recommends all adults 65 years and older receive the pneumonia immunization.

6. Annual Monitoring for Individuals on Persistent Medications [This relates to the percentage of enrollees whose doctor or clinical pharmacist has reviewed, at least once a year, a list of everything the enrollee takes: prescription and non-prescription drugs, vitamins, herbal remedies, and other supplements.]

Question [Dr. Martin]: How would reviewers determine whether this was done? I think it will be a meaningful use measure. Eventually you could get it that way from some providers, but I think getting it from chart reviews would be very difficult.

QHI Response: To clarify, this is actually one element of the Care for Older Adults measure discussed above. If this measure moves forward in the Demonstration, details would need to be worked out since specifics are not yet known.

Question [Mary Kay Kisseberth]: Can this move up in priority? This is something where the Demonstration’s design and presence of the RCCOs provide a unique opportunity to assess effects of medication, both on efficacy and associated costs.

QHI Response: We look forward to the Advisory Subcommittee's additional recommendations on which measures to implement. Measures have been put in order for ease of discussion.

- 7. Controlling High Blood Pressure** [This relates to the percentage of enrollees who have a diagnosis of hypertension and whose blood pressure is adequately controlled, less than 140/90.]

Comment [Dr. Martin]: This is a meaningful use measure, which is good.

Comment [Mary Kay Kisseberth]: It seems that we would rather see a measure that shows how well the RCCO and case manager or care coordinator counseled enrollees with high blood pressure. While it is good to know those who are controlling high blood pressure, it is better to measure how well this Demonstration is identifying those with high blood pressure and counseling them.

- 8. Diabetes, Hemoglobin A1c Testing** [This relates to the percentage of enrollees who had the A1c test.]

Comment [Dr. Martin]: Just knowing whether a Hemoglobin A1c test was done is a fairly weak measure as far as being a proxy for good diabetes care. I think it can be obtained easily from billing data. Even then, since most testing is done in the doctor's office, I wonder if it shows up in billing to the Department, especially from the FQHCs. It seems like a better measure would be the percentage of enrollees whose Hemoglobin A1c test is less than 9. This information will not be easy to obtain from PCMPs without electronic health records.

QHI Response: Those are good observations. It is entirely possible to measure not only that it was tested but also that a percentage of results are less than 9, less than 8, etc. This would be a hybrid measure.

Comment [Mary Kay Kisseberth]: What is the percentage of the current Medicare-Medicaid population with diabetes? I think we should find those who are not controlling it rather than determining who is.

QHI Response: More than 27% of current full benefit Medicare-Medicaid beneficiaries in Colorado have a diagnosis of diabetes.

- 9. Adherence to Antipsychotics for Individuals with Schizophrenia** [This relates to the percentage of enrollees with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication and who take that medication regularly enough for it to be effective.]

Question [Dr. Martin]: Why would this not come from pharmacy data to see if prescriptions are filled on time?

QHI Response: It is assumed that a prescription refilled each month is taken. The source of data for this measure is a combination of clinical and pharmacy claims. This measure looks at the percentage of individuals in a population who take the medication regularly. From there, it can be determined who is not taking the medication regularly.

Comment [Mary Kay Kisseberth]: Shouldn't this be at least one of our top three? Is this the best behavioral health measure? Which behavioral health measure(s) would test the Demonstration's ability to coordinate care, improve outcomes, and enhance client experience?

QHI Response: The small number of the population this measure would represent is one concern. On the other hand, this issue contributes to poor health and high costs. One way to improve health and reduce costs is to make sure enrollees take their medications. Also, the Adult Quality Measures Grant will focus on depression and diabetes and represent a state-wide effort to address behavioral health issues. Also, the Behavioral Health Organizations (BHOs) have a mature set of quality measures already in place. More information about those may be found on the Department's website.

10. Medication Reconciliation [This relates to the percentage of enrollees discharged from any inpatient facility and seen within 60 days following discharge by the physician who is providing ongoing care and who reconciled discharge medications with the current list in the individual's medical record.]

Question/Comment [Dr. Martin]: How would the reviewer determine whether the medication reconciliation was done? I think it is variable whether or where this would be documented. I think medication reconciliation is vitally important, but it should be done within the first few days after discharge, not six or seven weeks later.

QHI Response: It is appropriate for medication reconciliation to be done shortly after discharge, particularly since unreconciled medications are a high driver of readmissions within 30 days of discharge. If this measure moves forward in the Demonstration, these details would need to be worked out.

Comment [Mary Kay Kisseberth]: This is clearly a measure that would test the effectiveness of the RCCOs and coordination. It should be a higher priority. Maybe it could be combined with item #6.

General Questions and Comments

1. Mary Kay Kisseberth: How were the three fundamental aims of the Demonstration (improving health outcomes, improving client experience, and decreasing unnecessary and duplicative services) considered in prioritizing the state-specific measures?

QHI Response: The Demonstration's goals, which are also part of the Triple Aim, are always informing and guiding decisions. Other issues, such as obtaining the data, having a large enough sample, finding measures that align with other measurement efforts, or identifying measures whose results are meaningful for the project, are also important to consider.

2. Mary Kay Kisseberth: The Medicare-Medicaid enrollees consist of those who are younger and have disabilities and those who are elderly. Are we selecting measures that address both groups? Is data collected such that those 65 years and older and those under 65 are separately measured?

QHI Response: Results from CAHPS are shown by age groups; other measures are not. The largest segment of the Demonstration population is 65 years and older. Several of the quality measures target that population specifically. It is important when selecting quality measures to ensure that a large enough population is considered.

3. Mary Kay Kisseberth: The big difference to enrollees in the Demonstration is the presence of the RCCO and a care coordinator. Therefore, it seems our state-specific measures should focus on how RCCOs and their staff affect the three aims. In selecting measures, we should consider what is clearly representative of health care delivery in Colorado through the Demonstration. Some of the measures don't seem particularly tied to the Demonstration's population or to its design. They seem to be more "health care at large" items such as the examples for flu and pneumonia.
4. Gary Montrose: I wanted to comment on medication reconciliation versus prescription adherence as a proxy for care coordination, perhaps in connecting acute (medical) and home care (social) providers in a shared function or protocol.

Is there potential value of medication adherence as a proxy for care coordination between medical and long-term services and supports providers? Could we track prescription adherence at home, possibly with unskilled home care workers, who report observations about medication adherence to a provider's office? Perhaps that's a way of getting these two aspects of acute care and long-term services and supports to work together on an important issue.

Prescription adherence at home would be different from prescription reconciliation. Prescription reconciliation is an important chronic care function at the provider's office and in care transitions. But could we identify what actually happens at home, weeks after an office visit or hospital discharge, for chronic condition management for persons with disabilities, but especially for seniors? We would need to check with subject matter experts to see which changes to scopes of practice might be involved. We would also need to understand the field-based data collection and reporting challenges. This might be one way to better coordinate between home-based care and service agency management and medical management within the RCCO environment.