

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

Meeting Notes

CLIENT:	State of Idaho	MEETING DATE:	August 20, 2013
SUBJECT:	Clinical Quality Improvement (CQI) Work Group Meeting	LOCATION:	Blue Cross of Idaho, Boise, Idaho
Attendees:	Andy Baron, Angie Beauchaine, Bart Hill, Chris Hahn, Heather Healy, Yvonne Ketchum, Kelly McGraw, Bob Polk, Linda Rowe, John Rusche, Mary Sheridan, Miki Antonelli (Mercer), Shawna Kittridge (Mercer), and Marcia McDonell (Mercer)	DISTRIBUTION:	CQI Work Group

Decision Items

- The next meeting of the work group (WG) is scheduled for Thursday, September 12 from 8:30 am to 2:00 pm at Blue Cross of Idaho (BCI).

Follow-Up Items

- Marcia will send out an updated invitation for the next WG meeting.
- Chris will submit an alternative measure for childhood immunizations.
- Chris will talk with Elke Shaw-Tulloch to determine the preliminary feasibility of using Public Health as part of the network backbone.
- WG members to complete their review of the SHIP build out and submit comments to Mercer by Tuesday, August 27.

Notes

Andy kicked off the meeting by informing the WG members that we need to make decisions today regarding which performance measures to recommend to the Steering Committee (SC). We want to choose ones that are already being used. The use of opiates is the only new one added from the original list reviewed by the WG. Andy recommended that we start with several measures as a place to start in the first year and then add additional measures in subsequent years.

Angie said that whatever model/innovations the WG recommends, schools need to be involved. This may be the only venue for some children to receive care and learn about health/wellness

issues. However, John said that it would be difficult to get clinics into schools. The Legislature does not want to even allow social workers.

The WG members discussed the **regional structure** that the SC has recommended by reviewing documents titled *Healthy Idaho Network and Regional networks Governance* and *Healthy Idaho Network with Regional networks*. The group agreed that by using this type of structure, regions can have some flexibility to address their unique issues. Within this structure, Bart suggested that a team of IT experts consult across all regions, not be assigned to a single region. Kelly agreed that this resource should be shared.

Yvonne was concerned that the SC has not defined the scope and authority of the Network and the networks. Plus, it is heavy administratively. How will the funds be obtained? To inform the other members of the WG, she stated that the HIT WG is looking to the IHDE to provide analytic services, but their mission is a portal for an exchange of records, not quality analytics. There will also need to be legislative changes for these initiatives.

In response to **SC questions**, the group discussed:

- Are there tool kits that can be used for accreditation of PCMHs? We think there are.
- How can the existing collaborative be enhanced with new entrants? Kelly said that if we want more PCMHs, it needs to be a recipe/cookbook; each entity cannot write its own policies. The Network/networks need to have a core set of requirements. NCQA is an option, but it may not be the right one for Idaho. We may need an Idaho-specific certification process. There also should be a mentor relationship, so that practices that are further along in the certification continuum can assist those that are not.
- How can the model address workforce issues for practice transformation? Bart stated that professionals need to practice to the top of their license. John did not think there were too many legislative barriers. He said that the best practice model is an integrated one. Bart went on to state that medical assistants (MAs) should also be included. We need to identify if there are any barriers. Kelly explained their practice looked at MAs going to patients' homes, and were told that this is not possible. MAs can be licensed or certified (which is higher), per Heather. The Board of Nursing licenses MAs, but they operate under the physician. Nurses operate under the Board of Nursing. Per Angie, malpractice insurance may also be a problem. Practices have stressed staff career ladder improvements by offering richer employee benefits.

Several members of the WG agreed that MAs could drive the quality metrics. Reimbursement needs to be structured to fund services such as data review/analytics, telephone calls to patients, etc., per Angie. Yvonne said that BCI will pay for a blood draw even if it is done by an

MA, but telephone calls are more problematic. The group agreed that case management has to be paid on a global basis.

Bart said that the issues are providers operating at the top of their licenses, paying for alternate means of care (telephone, group visits), and provider availability (BH providers, care managers, etc.). Miki said that the Network WG has not assumed that access will be much improved in the first year.

What functions can be attractive to small practices to increase the number of PCMHs? Shared resources such as care managers, after hours' triage, IT support, QI, pharmacy management/consultation, diabetes education, health coaching, and behavioral health providers were identified.

The WG members reviewed the **payment structure** document. Yvonne said that this approach has not been approved by the Multi-payer WG. Kelly thought that the model was to touch 80% of Idahoans, but this document does not reflect/facilitate this approach. Heather said that being seen by a PCP may be an issue because there are not enough in the State. Andy thought we could get to the 80% goal in three years, but a tool box needs to be available to practices. Angie thought that 24 months is tight. Angie thought that with every document, we need to consider whether we must use a physician or whether providers can be used for certain tasks because extenders are more available.

Yvonne said that BCI pays providers a higher reimbursement if they offer 46 or more hours of access in a week. The model could incentivize with payments, mentorship, tool kits, etc.

The group discussed how to engage patients in their health care improvement. Incentives and wellness education during school years should be provided. Chris wondered if we needed to educate patients on the PCMH. Yvonne said we should only educate if we can deliver changes. Bart said that care and education must be convenient, and we must define what the benefits are for the patient. Andy said that in a recent survey, 40% of urgent care patients felt no need for a medical home.

Mary asked if an abbreviated certification for PCMH is on the table, because it is not with the Idaho MHC. Miki said that it was.

Andy said that an EHR is key to a medical home and that it may be the medical home.

Miki and Shawna discussed the **results/highlights of the focus groups** in Boise and Coeur d'Alene. The participants agreed that there needs to be an innovation to improve the EHR process. A uniform instrument that allows data sharing and ease of use is necessary. A group in Idaho could and should work with EHR vendors to improve the process.

During the focus groups, providers wanted to be evaluated only on what they prescribed, not what the patient did. The WG members vehemently disagreed with this approach. This “not my responsibility” mindset is the culture that needs to be changed. Kelly said that their parent company bases payment on seeing patients. You must show that you have seen the patient to receive a payment.

The WG members discussed the **innovations** document. Yvonne questioned if we recommended a website to report data results; the group said that we did. As part of the SHIP, the group suggested that the use of HealthWise patient engagement tools be proposed.

Miki said the Network WG recommended a regional advisory board that would assess the community health and needs and develop a plan for improving population health specific to the locale. John suggested that the regions be the same as the Exchange underwriting regions. There needs to be a health authority (governance level) that can determine needs and then obtain the necessary resources. Chris thought the public health infrastructure be utilized.

Bob shared some concern that the regions may be too autonomous/variable. He thought the model must ensure that there is oversight of all regions for consistency and economics.

In response to **SC questions related to the CQI WG innovations**, the WG members discussed:

- Are there a specific set of recommendations from PCMHs that may add to the measures already identified in the Patient-Centered Medical Home Collaborative? The WG agreed that they had addressed this issue through the initial set of measures identified for inclusion in the SHIP.
- Are there any measures currently collected by payers that might be valuable if they could see how their enrollees measured against the entire state? The WG identified that cost of care and HEDIS measures are available in the payer data to augment CQI measures identified. However the WG noted that different payers have differing patient populations and that would need to be considered in any across-State comparison or peer analyses.
- The IHDE was not mentioned by the CQI WG as the entity that is positioned currently to be such a repository. Is there a reason why it couldn't be the entity? The WG discussed that the IHDE was built as a switchboard and there would need to be more understanding of its capabilities before it was identified as 'the' entity to support CQI activities. The WG supported the idea of avoiding redundancy within the State; however the WG recommends that a RFP be issued to clearly identify the capabilities of IHDE, the vital statistics agency, or another potential entity (Angie identified the Utah repository as an example to explore) to take on this role for the State.

- Were any candidates to actually develop the data standards, monitor, and track reporting back to payers, providers, etc. identified? The WG addressed this in the CQI model build out discussion and multi-year plan.
- Could operating costs associated with medical home measures be built into the medical home payment mechanism (similar to the amounts identified in the current Collaborative pilot)? Yes – the WG agreed that utilizing the Collaborative model would be appropriate.
- Are there any thoughts on measures that would be appropriate for the medical home model (behavioral health and obesity clearly are already identified)? The WG has drafted specific quality performance measures that address this question.

The WG reviewed the **clinical quality metrics** document. Measures related to diabetes, BMI, and tobacco cessation are required by the SIM grant. Miki reviewed the dashboard document. Angie thought that depression screening should start at age 12, not 10, and that the smoking metric include individuals at age 12 and above. Bart thought that any screening measure must lead to treatment and outcomes. In addition to depression/suicide, the WG might also want to consider a measure that assesses depression/disability outcomes.

At the beginning of the initiative, metrics must be obtained based on claims data because other analytics will not be available. Yvonne did not think this would be a valuable comparison because of population differences. She also said that the IHDE was built as a switchboard, not a repository. WG members suggested that Vital Statistics or the hospital association could be the repository. Kelly said that redundancy must be avoided. The group thought that our model could describe the qualities of the data warehouse/repository, but not assign responsibility. Perhaps IHDE could manage a contract with a vendor, or participation in the IHDE could be required via State legislation.

Regarding other metrics, the group thought that instead of acute care admissions, readmissions for the top five prevalent medical conditions be assessed. In addition, low birth weight and pre-term delivery should also be included. Kelly wondered how results for deliveries that occur out of State could be measured. Bart thought it could be reviewed when the report made it back to the physician. Kelly said that all complicated deliveries north of McCall go out of state. The group agreed to eliminate the hip fracture measure and broaden medication adherence for behavioral health diagnoses in general. Access to care could be measured using Behavioral Risk Factor Surveillance System (BRFSS) data.

The WG members agreed that the first year would determine the performance measure baseline and then in second and subsequent years, measures could be expanded. Education of

communities and providers must come first, followed by establishment of the baseline, performance measurement, reporting of results, and measure revision/enhancement.

A provider's readiness for reporting measures could be assessed as part of the community assessment. Providers may need to be stratified and placed on separate timelines. Providers without EHRs may have to do chart reviews manually. The following suggestion was made regarding the reporting process:

- 1st year – Collect baseline data
- 2nd year – Set regional target based on baseline data
- 3rd year – Report regional-level results, with information at provider level. If not meeting standard providers, must develop a corrective action plan for approval by the Network
- 4th year – Report PCMH-level results

In the first year, Bart thought that the networks could start reviewing the data and determine who the frontrunners are. Then they could be asked what they are doing right and a toolkit of best practices could be developed. The toolkit could be refined along the way as experiences are gathered. Results could be reported globally on a consumer website in the second year.

Heather said that networks should have some flexibility to focus on certain measures and design their own innovations. However, Angie thought that the networks should have to collect and report on required measures first. Bart said that the model should start with baseline results, and then set targets for each region. The Network could determine goals for required measures and use toolkits for improvements. National benchmarks could also be considered.

John wondered if the **Health Quality Planning Commission** (HQPC) could set the standards. Yes, thought Bart, but the baseline must be known first. John thinks this should be an innovation. The HQPC could develop the overall targets and determine how to collect and report the data. With additional resources, the HQPC could collect the data and do the analytics. Bart was not sure if this should be their mission. There may need to be legislative changes. The Network could make suggestions to the Commission. John said the HQPC has two missions – overseeing the IHDE and making recommendations to improve health care quality in the State. Perhaps a member of the Commission should be on the Network.

Options for completing the **SHIP evaluation** include Boise State University Center for Health Policy, Qualis Health, Idaho State University Rural Health Institute, or the University of Washington's WWAMI program.