Memorandum

To: Greg Moody, Office of Health Transformation
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McKinsey consulting team
From: John Arnold, Project Director, Value Advocacy Project
Marie Curry, Primary Care Medical Home Design Workgroup Chair
Ohio Consumers for Health Coverage Value Advocacy Project Leadership Team
Date: February 26, 2016
Re: Input into PCMH Metrics and Measures

The PCMH Design Workgroup reviewed the metrics described in two documents: (1) the *State Innovation Models Round 2 Model Test: Ohio Operational Plan* (updated December 16, 2015) and (2) the *Ohio PCMH Patients and Advocates Focus Group* (Strawman updated December 9, 2015). In addition, the PCMH Workgroup researched metrics described by National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), CMS Comprehensive Primary Care Initiative (CPCi), Healthcare Effectiveness Data and Information Set (HEDIS), and Health Policy Institute of Ohio Dashboard (HPIO Dashboard). We recognize that for simplicity in the initial roll out of PCMH, according to the *Ohio Operational Plan*, only metrics that can be measured through claims data will be used (i.e., prioritize claims-based measures) (*Ohio Operational Plan, p.28).* We urge reconsideration of this approach and describe below the particular areas in which we find significant gaps in the contemplated requirements and metrics.

Please find below three tables:

- Table 1 Clinical Quality Requirements (CQR) (from *State Innovation Models Round 2 Model Test: Ohio Operational Plan*, updated December 16, 2015);
- Table 2 Standard Processes Requirements (SPR) (from *Ohio PCMH Patients and Advocates Focus Group* Strawman updated December 9, 2015); and
- Table 3 Activity Requirements (AR) (from *Ohio PCMH Patients and Advocates Focus Group* Strawman updated December 9, 2015).

Note that the information regarding Behavioral Health measures in the *Ohio Operational Plan* is different than what was stated in the December 9, 2015 Strawman measures. The Strawman had two measures for Behavior Health:

1. Screening for Clinical depression and follow up plan; and
2. Preventative care and screening: tobacco use: screening and cessation intervention.

The *Ohio Operational Plan* still includes the "Preventative care and screening: tobacco use: screening and cessation intervention" measure but not the "Screening for Clinical depression and Follow up plan" measure. The Ohio Operational Plan added two additional BH measures:

1. Anti-depression medication management
2. "Follow up after hospitalization for mental illness"

According to the *Ohio Operational Plan,* "Antidepressant medication management" measure was chosen in favor of "Screening for Clinical Depression and Follow-up Plan" because it can be measured using claims data. (*Ohio Operational Plan, 41).* Similarly, *Ohio Operational Plan* decided against adding the "Preventative care and screening: BMI screening and follow up measure" and chose instead "Adult BMI" because the model prioritizes claim based measures (*Ohio Operational Plan, 41)*. The PCMH Design workgroup urges Ohio Office of Health Transformation to include "Screening for Clinical depression and follow up plan" (NQF 0418) in the initial PCMH model metrics, as unmet mental health needs and lack of meaningful integration of behavioral and physical health care are two significant gaps in our current delivery system.

The PCMH Design workgroup selected the following eleven (11) metrics/measures **(*incorporated in the tables using bold italics*)** for integration into the existing CQR, SPR, and AQ information:

<u>Clinical Quality Requirements</u> (CQR)

Under Preventative care:

1. "Trauma Toxic Stress/Violence: adverse childhood experiences/violent crimes"
2. "Screening for Fall Risk"

Under Appropriate Care:

3. "Provide Comprehensive Medication management"

Under Behavioral Health:

4. "Screening and Brief Counseling: Unhealthy Alcohol Use"
5. "Screening for Clinical Depression and Follow up plan" (add back in from OHT December 9, 2015 document)

<u>Standard Processes Requirements</u> (SPR)

6. "Integration of Community Support"

<u>Activity Requirements</u> (AR)

7. Patient Engagement and Self-Management: "Access Health Literacy"
8. Promote Active Patient Engagement: "Support Self-Care and Shared Decision Making"
9. CLAS-"Track Additional Patient Information" (sex, race, ethnicity, and preferred language),
10. CLAS-"Track Additional Patient Information" (sexual orientation, gender identity, religion, and disabilities),
11. CLAS-"Survey Patient Engagement/Experience: Cultural Competence"

Within each table, the PCMH workgroup has incorporated metrics it urges OHT to include at the initial roll-out of the PCMH model. As already noted, these additional metrics are identified by ***boldface italics*** type. We have provided information on the population health priority served by the metric, the type of data than would need to be collected, and the authoritative source of the metric. We appreciate the opportunity to provide input. As always, we would be glad to meet to clarify or discuss in greater detail.

TABLE 1. CLINICAL QUALITY REQUIREMENTS

Document: State Innovation Models Round 2 Model Test: Ohio Operational Plan (updated December 16, 2015)

Category	Measure Name	Population	Pop Health Priority	Data Type	NQF#
Preventative Care	Adult BMI	Adults	Obesity	Claims/Hybrid	1690
	Well-child Visits in 1st 15 months of life	Pediatrics		Claims/Hybrid	1392
	Well-child Visits in 3rd, 4th, 5th, 6th years of life	Pediatrics		Claims/Hybrid	1516
	Adolescent Well-care visit	Pediatrics		Claims/Hybrid	N/A
	Breast Cancer Screening	Adults	Cancer	Claims/Hybrid	2372
	Weight assessment and counseling for nutrition and physical activity for children/adolescents; BMI assessment for children/adolescents	Pediatrics	Obesity, physical activity, nutrition	Claims/Hybrid	0024
	Timeliness of prenatal care	Adults	Infant Mortality	Claims/Hybrid	1517
	Postpartum Care	Adults	Infant Mortality	Claims/Hybrid	1517
	Live Births Weighing Less than 2,5000 grams	Pediatrics	Infant Mortality	State Records	N/A
	Screening for Fall Risk	***Adults***	***Managing Fall Risk***	***EHR***	***101/CMS CPCi Measure***
	Trauma Toxic Stress/Violence	***All Patients***	***Social and Economic Environment: Adverse Childhood Experiences/Crime***	***National Survey of Children's Health***	***Health Policy Institute of Ohio (Health Value Dashboard)***

TABLE 1. CLINICAL QUALITY REQUIREMENTS - continued Document: State Innovation Models Round 2 Model Test: Ohio Operational Plan (updated December 16, 2015)					
Category	**Measure Name**	**Population**	**Pop Health Priority**	**Data Type**	**NQF#**
Appropriate Care	Controlling high blood pressure	Adults	Heart Disease	Hybrid	0018
	Med Management for people with Asthma	Both		Claims	1799
	Comprehensive Diabetes Care: HgA1c poor control >9.0%	Adults	Diabetes	Claims/Hybrid	0059
	Statin Therapy for patients with cardiovascular Disease	Adults	Heart Disease	Claims	HEDIS SPC
	Provide comprehensive medication management	***All patients***	***Care Coordination***	***EHR***	***NCQA 4C***
Behavioral Health	Antidepressant med management	Adults	Mental Health	Claims	0105
	Follow up after hospitalization for mental illness	Both	Mental Health	Claims	0576
	Preventative care and screening: tobacco use: screening and cessation intervention	Both	Substance Abuse	Claims/Hybrid	0028
	Screen and Brief Counseling: Unhealthy Alcohol Use	***Adults***	***Substance Abuse***	***EHR***	***2152***
	Screening for Clinical Depression and Follow up plan	***Adults***	***Mental Health***	***Hybrid***	***0418***

TABLE 2. STANDARD PROCESSES REQUIREMENTS

Ohio PCMH Patients and Advocates Focus Group (December 9, 2015)

Category	**Requirements**	**Source**
Risk Stratification	The practice uses a methodology to assign a risk status in accordance with criteria aligned across payers	CPCi
Same day appointments	The practice provides same-day access to a practitioner connected to the PCMH who can diagnose and treat	NCQA
24/7 access to care	The practice provides and attests to 24 hour, 7 days a week patient access to a practitioner connected to the PCMH who can diagnoses and treat	CPCi
Practice uses a team	The practice uses a team to provide a range of patient care services by: • Defining roles for clinical and nonclinical team members • Designating a lead for quality improvement efforts • Holding scheduled patient care team meetings or a structured communication process focused on individual patients care	NCQA
Care management	The practice indicates who provides care management services for high priority members	CPCi
Care Management and Support	***Integration of Community Support: The practice connects patients to community resources of importance to patient population***	***NCQA 4E***
Relationship Continuity	The practice has a process to orient all patients to the PCMH	NCQA

TABLE 3. ACTIVITY REQUIREMENTS

Ohio PCMH Patients and Advocates Focus Group (December 9, 2015)

Category	Requirements	Source
Risk Stratification	Percentage of a practice's at risk beneficiaries-defined in accordance with criteria aligned across payers-who are seen by attributed PCP at least twice in past 12 months	Other state
Population Management	At least annually, the practice proactively identifies patients not recently seen by the practice and reminds them, or their families/caregivers, of needed care based on personal treatment plan	NCQA
Care plans	At least 80% of high priority beneficiaries have a treatment plan in the medical record defined with accordance with a set of key elements aligned across payers.[1] Care plan must be updated at lease 2x/year and with significant changes in conditions	Other state
Follow up after hospital discharge	Percentage of high priority beneficiaries who had an acute inpatient hospital stay and had follow up contact within 1 week	NCQA
Tracking of follow up tests and specialist referrals (we have)	The practice has a documented process for and demonstrates that it: Asks for self-referrals and requests reports from clinicians; Tracks lab tests and imaging tests until results are available, flagging and following up on overdue results; Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports; Tracks fulfillment of pharmacy Rx(s)	NCQA + new

[1] E.g., documentation of a beneficiary's current problem that includes barriers to care. Plan of care integrating contributions from health care team (including BH). Modifications of treatment goals in conjunction with patient and family priorities. Instructions for follow up. Assessment of progress to date.

TABLE 3. ACTIVITY REQUIREMENTS - continued Ohio PCMH Patients and Advocates Focus Group (December 9, 2015)		
Category	**Requirements**	**Source**
Patient Experience	The practice assess their approach to patient centeredness and cultural competence to improve overall patient experience and reduce disparities in patient experience (e.g., by creating a patient/family advisory council, by administering and assessing CAHPS survey	CPCi
Patient Engagement and Self-Management: Assess Health Literacy	***Comprehensive health assessment***	***NCQA/PAM, CAHPS, other validating tool***
Promote Active Patient Engagement: Support Self-Care and Shared Decision Making	***Promote self-care, enhance patient confidence, provide knowledge and education***	***NCQA 4E***
Cultural and Linguistically Appropriate Services: Track additional patient information	***Sex, race, ethnicity, preferred language***	***NCQA 2C***
Cultural and Linguistically Appropriate Services: Track additional patient information	***Sexual Orientation, Gender Identity, Religion, Disabilities***	***Health Policy Commission of Massachusetts***
Cultural and Linguistically Appropriate Services: Survey Patient Engagement/Experience	***Patient Reported Data/Survey & Clinician's Cultural Competence based on CAHPS Cultural Competence Item set***	***NQF 1904***