District of Columbia State Innovation Model
Quality Metrics Work Group: Meeting Summary

December 14, 2015
3:00 p.m. – 4:30 p.m.

Participants: Mark Weissman, Jennifer Zutz, DaShawn Groves, Derdire Coleman, Constance Yancy, Jane Hooker, Dayne Maust, Jennifer Du Mond, Earl Jackson, Cathy Anderton, Donald Miller, Jonathan Perry, Gwen Young, Pat Thompson, Melanie Sage, Melissa Mayer, Kandis Driscoll, Karin Werner, Luis Pazmino, Emily Eelman, An-Tsun Huang, Jasmine Shih, Remy Szykier, Shelly Ten Napel. Joe Weissfeld, Bruce Points, Johnathan Blum, Victor Freeman

TOPIC	DISCUSSION
Brief SIM Overview	• **DaShawn Groves provided a brief overview of the SIM Initiative, highlights include**: ➢ The aim of SIM is to improve health outcomes, the experience of care, and value in health care spending for high-cost, high-need patients in D.C. ➢ The primary drivers include: supporting value-based payment models; investing in capacity building infrastructure and supports; strengthening data exchange infrastructure; and improving and integrating the coordination of health and social services. ➢ The Quality Metrics Work Group will work to develop recommendations for the SIM Advisory Committee to streamline quality reporting across all District payers; promote agreement on a shared measure set; and identify quality report infrastructure needs and strategies for quality improvement.
CareFirst Presentation on Quality Scorecard	• **Jonathan Blum presented on the quality scorecard used by CareFirst, key takeaways include:**

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	➢ Of the 4,000 primary care providers (PCPs) in the CareFirst network, 85 percent participate in the PCMH program. The membership includes 400 panels that average about 3,000 patients each. ➢ PCPs are incentivized to lower the total cost of care for their panel of patients through an Outcome Incentive Award (OIA), which takes the form of shared-savings. The savings are then transferred to the provider through higher reimbursement rates the following year. All PCPs must meet quality thresholds in order to be eligible for the OIA. o In 2014, 80 percent of PCPs in the PCMH program qualified for the OIA; however, only 60 percent met the quality measures required to receive the shared-savings payment. ➢ There are 5 domains which include PCP engagement (top priority), appropriate use of services, effectiveness of care, patient access (e.g. extended weekend hours or telemedicine), and structural capabilities. o PCP Engagement is the highest priority for CareFirst. In this measure, PCPs must demonstrate their commitment to transforming care. In performance year 2015, a PCP had to have at least 22 out of 35 engagement points in order to be eligible for an OIA. ➢ Providers have critiqued the scorecard for being not tailored to pediatric populations and for being misaligned with core measures used by CMS. Moving forward, CareFirst plans to develop two scorecards, one for adults and one for children. Each will focus on clinical measures from the CMS core set and PCP engagement. ➢ CareFirst has a provider portal of their assigned patients which are risk stratified. Providers can look at their Top 50: costly patients, Rx users, frequent ED users. However the providers cannot stratify by demographics. ➢ Quality measures show a 20 percent decrease in the rate of hospital inpatient care, as well as a reduction in hospital readmissions and ED use, lower total cost of care, and decreased outpatient

TOPIC	DISCUSSION
	care.
<u>Open Forum:</u> Stakeholder Reactions to CareFirst Scorecard	• **Participants reacted to John Blum's presentation with questions and comments, including:** ➢ *Are there any common factors among successful providers?* Providers with high levels of engagement perform well. This includes emphasizing effective care planning and working with CareFirst to better understand patient data. o CareFirst reimburses $200 for care plan development and $100 for care plan maintenance. o Of the 1.1 million patients in the PCMHH program, 50,000 have a care plan. ➢ *Who tracts PCP engagement?* The regional care director and a program consultant work together to tract this information on a quarterly basis, utilizing a combination of qualitative and quantitative data collection methods. ➢ *How are specialists considered in the quality measures?* The PCMH model is designed to empower the PCP. The PCP acts as the "quarterback" of care, ensuring that patients see specialists when necessary. As a result, specialists do not received shared-savings. ➢ *Are patients with behavioral health conditions included in provider panels?* Yes, CareFirst also contracts with an outside provider if patients need more intense behavioral health services. ➢ *How should D.C. think about aligning with these types of quality reporting measures*? 1. Share the quality framework used by CareFirst with other stakeholders; 2. Identify Medicaid providers who are also CareFirst PCPs; 3. Think about metrics that target performance at the practice-level; and

TOPIC	DISCUSSION
	4. Determine if DHCF can commit to the investment and incentive required of this type of program.
Next Steps	• **Next Steps:** 1. The next meeting is scheduled for **Wednesday, January 20th from 3:00PM to 4:30PM**—the meeting will be in collaboration with the Care Delivery Work Group.