Transparency Advisory Group Meeting
April 18, 2017

Attendees:

Brantley Scott, OHCS
Bri Marshall, HealthInsight
Charles Hawley, OHCS
Jeff Black, HealthInsight
Jesse Liddell, SelectHealth
Jennifer Thiros, OHCS
Lynette Hansen, Molina
Norm Thurston, OHCS
Sarah Woolsey, HealthInsight
Sterling Petersen, OHCS
Tim Johnson, Intermountain
Wu Xu, OHCS

Please see slides for more detailed information

Clinic Identification and Attribution Feedback from Medical Provider Subcommittee

Question/Comment	Action
• We've been taking comments on attribution Goal #1 One thing important is site of service – where care is delivered for acute care. For example, Granger identified as primary care clinic but they also provide InstaCare services so it looks like patient is getting primary care but they really aren't. Or if a patient goes into another site of service & gets imaging, that goes back to primary care instead of urgent care We've got to make sure it washes out and is consistent for all providers Inclusion of Urgent Care is important	• OHCS to mitigate inclusion of urgent care and communicate back to providers that it's been addressed • Figure out how to address 20 and 22 and then share back with the group
• In Price conversation showed Medicare OpenData site. In general listing of prices didn't adapt to use cases, wasn't clear where that's super useful to them. Also express concern about putting NPI not sure if it's useful, may allow for track back to contract price. Bundled maternity model is something providers understand a bit better than one-off CPT codes Providers aren't our only audience, other places price data may be useful Big pool of episodes like maternity or knee/hip that we've heard interest in building but with the necessary resources we have are a constraint Charles interested in rather than building a house, he wants to try and put out bricks. Raw data useful to some and there are people who could compile bricks and make meaningful information out of them MPS had big concerns about NPIs. Unless we have a compelling reason, Sarah doesn't see how that will bring value to provider community Charles heard that and thinks there are lots of approaches we could explore, could be even broader in terms of procedure price transparency Want to move conversation forward to get data crunched out	• MPS advises no NPI in the price data sets that are published

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Changes were made for 2017 reporting – how we identify Primacy care clinics. Look for office visits then simultaneously looking for certain places of services. Feedback was to include 20 & 22 for urgent care visits For acute care measures are we going to include Emergency department? Yes that's how they are tabulated If person goes to ER and gets imaging, that goes back to doctor who diagnosed with lower back pain so it's really who gives diagnosis Following HEDIS plan measures – for HEDIS physician measure they follow same specification. Designed for system level view of care, not individual care – your patients are getting x-rays – larger responsibility of medial home or system Research suggests these rates wouldn't look much different if we honed that in more Make sure to communicate that back to MPS group If someone had specific concern, OHCS happy to dig in further	

Preliminary Data Results for the New Measures

Question/Comment	Action
OHCS finishing up have some initial work. Have done MMA measures, mediation adherence for asthma, diabetes, and breast cancer – chronic or ongoing care measures have attributed to actual clinics. Weren't able to get 20 & 22 in – but gives sense of where we are. Tim thinks denominator seems small, especially for IHC. Also noted that KidsCare clinics are Urgent Care, not primary care pediatrics he would not expect to see well child checks OHCS cannot dig into specs as 3M processed this data Norm thinks this raises larger question – we've been committed to using national standards like HEDIS & we don't have to worry about criticism but raises question – is HEDIS good to do? Tim's opinion is it is good to stick to HEDIS, might not be perfect but that's what we're looked at as a state and as individual organizations Lynette agrees with Tim, need to stick with HEDIS. It's nationally accepted, utilized by CMS for star ratings and is less confusing. If health plans are collecting data for HEDIS, provider offices don't always understand HEDIS but the more they see HEDIS the less we have to educate. Sarah said if everyone has same direction it helps This year is lots bigger than last year – bigger N Will have final data back from 3M by end of month and can give more definitive recommendation for HDC then	• May MPS will be important meeting – watch for that invite, we will debut data there • If you have questions about the preliminary data for the new measures, please feel free to reach out to Charles Hawley or Sterling Peterson

Goal 4 Community Input from Intermountain Healthcare

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Last meeting we talked about useful way TAG can contribute to opioid. Charles got lead from Jan and Sarah talked to opiate collaborative. Work they've started can inform things for us. Haven't calculated MME's – maybe we can do that. Opioid community collaborative strong and well supported initiative by Intermountain, led by Lisa Nichols. They are looking at how to get information to prescribing providers, understand what's happening and also use that data feedback from clinical claims to have people compare themselves and see best practices. They will move into development of best practices for different specialties to roll out and impact inappropriate prescribing and ensure prescribing that is done is safe. They've been pulling data, doing educational sessions like grand rounds with provider groups. They have already marched into giving this info out. Looked at primary care setting, ER settings, surgical settings and several others and they are picking providers. They've gone to them and asked what are proxy clinical codes & conditions you prescribe pain meds for that are important in your field. Then showed them their pill counts they prescribe for those sets. Showing them data in peer sets by region. Not looking at MME – looking at number of pills and type of pills. Sarah learned they are figuring this out and they have learned a lot about how to affect clinical behavior. They picked clinical conditions we could pull from We should learn from work they've done and APCD – how does it fit in public side? Norm – thought about APCD – those are obvious but one thing is to look at APCD – see someone getting lots of MME's – go back & look but might find other things – could trace back to tooth pain or something. But APCD could inform this discussion. Also identified things that are root causes that triggered this. We have longer history over diff providers Tim- Agrees there is work to be done. Some already been done, don't need to reinvent wheel Sarah – from provider POV – to compare to peers is useful, looking at conditions, red flags is good – if we had across payer/system – for providers who don't have this thing Intermountain is doing. Here is event, someone having appendectomy what are we doing for them? They get certain number of pills – is that really necessary – did they fill prescription and get more or are they done? Sarah – we know kids getting pills from left overs in the cabinet – if we see variation in prescribing habits we could narrow. We don't know best number of pills you get for something – very influenced by culture, not evidence – could narrow and potentially have less pills on street. Depends on field – done a lot with clinical settings we could learn from Michael Ngyuen is data expert – Sarah to connect with Charles – would be interested	• Charles and team will be ready for a decision on the Transparency use cases for Opioid Data by the next meeting

in talking to OHCS Charles – met with Bridgette Shears – had conversation about what they are looking to do – specifically using pill counts as unit of analysis – hearing that as useful measure in addition to aside from quality measures was useful information to hear. Otherwise sounds like doing lot of provider level reporting – need to give thought to how we'd leverage that type of reporting for transparency. Where can we provide something of value thru transparency the CSD isn't doing. Helpful to her what they are doing – they offered to keep OHCS in the loop. Sarah would be super interesting or see where it complements Pill count – MME important marker for OD – in terms of Rx – what you write on script - #10 or #15 – don't put MME on scripts	

Optional-Quality Data Composite Index for future reporting

Question/Comment	Action
Quality index – takes all measures for clinics that gives composite of care – should be aspiration for us in the future.	• Will hold topic for next meeting

Next TAG Meeting:

TAG April Meeting
May 16, 2017
Cannon Health Building
288 North 1460 West, Room 125, Salt Lake City, Utah 84116

Medical Provider Subcommittee (MPS) Meeting
May 4, 2017
HealthInsight
756 East Winchester Street, Suite 200, Salt Lake City, Utah 84107