

THINC RHIO, Inc.

Taconic Health Information Network and Community

Quality & Clinical Committee

November 20, 2008

A meeting of the Quality & Clinical Committee of the THINC RHIO, INC., a New York not-for-profit corporation (the “Corporation”), was held on November 20, 2008, beginning at 1:00 PM.

Committee members: Sanford Cohen, MD; Mary Donnelly; Luis Estevez; Lawrence Faltz, MD
Michael Freedman, MD; Renee Golderman; David Hassoun; Paul Kaye, MD; Lisa Kern, MD
Imtiaz Mallick, MD; Ravinder Mohini, MD; Cliff Omstrom; Paul Renner; Alec Rill; Jerry Salkowe, MD
Gregory Spencer, MD; Cliff Waldman, MD

Non-Committee members : John Blair, III, MD ; Susan Stuard ; Asha Upadhyay

I. APPROVAL OF OCTOBER 2008 MEETING MINUTES

A motion was made to approve the minutes of the October 2008 meeting. The motion was seconded and the minutes were unanimously approved.

II. P4P PROJECT UPDATE

Susan Stuard informed the committee that THINC received a 6% budget cut for the P4P project in the NY State legislature’s special summer session. She noted that we are waiting to see if proposed 2009 budget cuts will also impact grant budget. The grant is to complete by end of February 2009. NYSDOH is planning to apply for a no-cost extension on behalf of projects.

THINC is in the process of engaging Mass Pro to help with the Medical Home transformation work. The contracts with the six participating health plans are under review and three are almost near execution. THINC and MedAllies are working through the initial work orders with ViPS on the data specifications and evaluation issues. The physician recruiting for this project is going well and we are getting formal participation agreements from the physicians. We will have a firm list of physician participants in late Q1 2009. THINC will ask the Health Plans to identify who they have contracts with.

III. ATTRIBUTION LOGIC AND REPORTING LOGISTICS

THINC is starting to think through the reporting logistics and format. In the first phase, performance measures will be tracked at the physician level. THINC understands that there might be interest in tracking at the physician practice level, but noted that this might be too complex an issue to resolve in the first phase. So the first phase of the project track quality measures at the physician level. The physician practice level tracking could possibly be done in a future phase of the project. Lawrence Faltz asked if tracking can be done using a Tax ID number. Jerry Salkowe said that one group can have multiple tax IDs so it can be hard to sort out and track.

THINC and MedAllies will issue to the health plans an electronic file with the physicians’ aggregated performance measures data. The format of the file (ASCII, Excel, etc.) has not been determined. There will be one summary file with the physicians name and their aggregated performance measures data. Each

physician will be given their individual report card with a cover letter describing the project. Susan Stuard will ask the committee to review this letter before it is sent to the physicians. The format of the report card has not yet been determined (electronic vs. paper). Susan Stuard reviewed the P4P project high level data flow schematic diagram (a copy of which is attached).

Imitiaz Mallick asked if this reporting mechanism will be a part of the CMS. Recent AMA news mentioned that CMS did not send any information to physicians about their performance profile for one half of the physicians that are registered with them. A sample group of physicians who had reported for the PQRI incentive will be dis-enrolling from the project since it did not provide any meaning for them, and there was no real problem resolution coming to them from CMS. Would the THINC P4P be easier for them? Dr. Blair said that CMS will be announcing medical home pilots by end of 2008. We do not know if THINC-Hudson Valley project will be chosen. We will not be using PQRI for the payment mechanism. PQRI is not part of this project or anything that is anticipated for this project.

Sandy Cohen asked if there are any plans for external reporting for patients for full transparency. Dr. Blair said that the first phase will be for reporting back to the plans and to the physicians. After this phase it is up to the plans to decide what they would like to do in 2010.

Susan Stuard gave an update on the Committee's recommendations to date on attribution logic. Enrollment PCP selects when a provider ID exists on the enrollment record as of the last day of the reporting period. Imputed PCP selects when a provider has the greatest number of E&M visits during the 12 month period. The member must have at least one preventive care visit or two E&M visits with the selected provider in the twelve months measurement period to be the imputed provider. The PCP is family medicine, pediatrics, internal medicine. It will not include ob/gyn, cardiology, or mid-level providers. The Committee did not want to include prescriptions in the imputed methodology. Sandy Cohen asked if the imputed methodology is based on E&M visits and would it apply regardless of the type of product (ppo/hmo) the plans use? Susan Stuard said yes.

Susan Stuard said that previously it was discussed that the enrollment PCP is when the provider ID exists on the record on the last day of the reporting period. She asked the committee if they wanted an additional rule which specifies whether the physician had an encounter with the patient and if it has been recorded as a claim in the last 12 months. Jerry Salkowe said that we are focusing this project on the medical home concept. It could be that other providers in the practice may be providing care that is coordinated by that specific PCP. But the claim may not have come in that PCP's specific name. If we require that the physician actually have a claim for that member then we will lose data and contradict the concept of medical home. Lisa Kern agreed with Jerry Salkowe. But the rationale for requiring one visit in the last 12 months is that many health plans require the member to see a designated PCP or a partner PCP in 12 months, but many members do not do this. They seek care when they need it. The rationale is to avoid attributing patients who have no utilization with the PCP at all. Jerry Salkowe suggested that the report be run back to two years. Imtiaz Mallick said that ACP recommended that PCP should see a patient once a year. Patient needs to have a comprehensive exam to establish goals for the patient's health. This can be accomplished only if the patient has had contact with the PCP once a year. Susan Stuard proposed to the group that we will not apply the rule to the enrollment PCP since we do not have consensus. But when we are working with the initial cuts in data, we can see what the data tells us. We can look at how often there is an assigned PCP that has not seen a member in the last 12 or 24 months.

IV. BENCHMARKING POLICY RECOMMENDATIONS FOR MEDICAL HOME MANAGEMENT

Susan received a few requests to provide policy benchmarking information about the dollar amount being used in other parts of the country. This will be discussed at the next committee meeting.

V. OVERVIEW OF MEDICAL HOME TRANSFORMATION

Dr. John Blair reviewed the various components of the medical home transformation work. The objective is to create a quasi-integrated delivery network across the Hudson Valley. In order to do this, we need infrastructure in place, which includes EHRs in every provider's office and a health information exchange (HIE) that facilitates the movement of structured data between the various systems for easier coordination of care. On top of this infrastructure, we need transformation at the practice level starting with the primary care physicians. At a later stage, transformation at the community level will be needed, which will include specialists and inpatient to outpatient coordination. Other components are reimbursement design and transparency for a verifiable understanding of performance. The project will be evaluated by an independent third party to give legitimacy to the project. Current practices that have certified EMRs, will eventually be connected so that information can flow from primary care to primary care, and primary care to hospital.

THINC will be working with MassPro who has experience working with EMRs and practices. MassPro will work with each practice on its vision, goals, workflows, EHR utilization and functionalities for the medical home project. TransforMed will work with each practice to create a care team and do practice evaluation for medical home. They will do a formal report on the practice status and opportunities. THINC will ask MassPro and TransforMed to do a presentation at a future Quality Committee meeting.

VI. NEW BUSINESS

The next committee meeting is on January 22, 2009. There being no further business for discussion, the meeting was adjourned at 2:00 PM.

Reviewed and Approved:

Dr. Gregory Spencer, Committee Chair

THINC P4P Project High-Level Data Flow

