Developing a Core Measure Set to Assess Quality and Value of Primary Care in New York State
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Supported by the New York State Department of Health (M. Friedrich, F. Gestion, L. Kicinski, E. McNamara, H. Plavin)

Background
- Through a State Innovation Model (SIM) grant, New York State Department of Health (NYSDOH) is scaling the Advanced Primary Care (APC) model (enhanced PCMH) linked to value-based payment policies.
- The goal is for 80% of New Yorkers to receive primary care under a value-based payment model by 2020.
- UHF Quality Institute was tasked with helping the state develop a Core Measure Set which will measure performance at a practice-level and be critical to quality improvement and value-based payment.

Core Principles for a Measure Set
UHF used the IOM Vital Signs1 and the national Core Measures Collaborative2 to identify a set of core principles to inform the APC set:
1. National endorsement and standard specifications
2. Relevance to population and care needs
3. Addresses performance gaps and New York health priorities
4. Balance of structure, process, outcome, and utilization
5. Feasible to collect and report
6. Utility at multiple levels (person, provider, system, state)
7. Parsimony
8. Alignment with major state and national value-based programs.

Sources:

- Set core principles
- Identify New York health care priorities (e.g., Prevention Agenda)
- Choose standardized measures. Align with public and private programs
- Scan the measure environment
- Check for parsimony, balance, feasibility, utility
- Vet with stakeholders
- Keep the set current and relevant

APC Core Measure Set

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>DATA SOURCE</th>
<th>MEASURE (NQF#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENTION</td>
<td>Claims/EHR</td>
<td>Cervical Cancer Screening (#3)</td>
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<tr>
<td></td>
<td>Claims/EHR</td>
<td>Breast Cancer Screening (#2374)</td>
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<tr>
<td></td>
<td>Claims/EHR</td>
<td>Colorectal Cancer Screening (#74)</td>
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<tr>
<td></td>
<td>Claims/EHR</td>
<td>Chlamydia Screening (#85)</td>
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<tr>
<td></td>
<td>Claims/EHR/Survey</td>
<td>Influenza Immunization - all ages (#45)</td>
</tr>
<tr>
<td></td>
<td>Claims</td>
<td>Fluoride Varnish Application (#45)</td>
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<tr>
<td></td>
<td>Claims</td>
<td>Tobacco Use Screening and Intervention (#28)</td>
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<td></td>
<td>Claims</td>
<td>Controlling High Blood Pressure (#18)</td>
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<tr>
<td></td>
<td>Claims/EHR</td>
<td>Comprehensive Diabetes Care: HbA1c Poor Control (#95)</td>
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<tr>
<td></td>
<td>Claims</td>
<td>Comprehensive Diabetes Care: HbA1c Testing (#97)</td>
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<tr>
<td></td>
<td>Claims</td>
<td>Comprehensive Diabetes Care: Eye Exam (#85)</td>
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<td>Claims</td>
<td>Comprehensive Diabetes Care: Foot Exam (#85)</td>
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<tr>
<td></td>
<td>Claims</td>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy (#6a)</td>
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<tr>
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<td>Claims/EHR</td>
<td>Persistent Beta Blocker Treatment after Heart Attack (#7a)</td>
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<tr>
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<td>Claims/EHR</td>
<td>Medication Management for People With Asthma (#799)</td>
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<tr>
<td></td>
<td>Claims/EHR</td>
<td>(Combined obesity measure) Weight Assessment and Counseling for nutrition and physical activity for children and adolescents (#74)</td>
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<td>Claims/EHR</td>
<td>Screening for Clinical Depression and Follow-up Plan (#4)</td>
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<td>Claims</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#4)</td>
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<td>Claims/EHR</td>
<td>Advance Care Plan (#7)</td>
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<tr>
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<td>Survey</td>
<td>CAHPS Access to Care, Getting Care Quickly (#6)</td>
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<tr>
<td></td>
<td>Claims</td>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (#58)</td>
</tr>
<tr>
<td></td>
<td>Claims</td>
<td>Inpatient Hospital Utilization (HEDIS)</td>
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<td>Claims</td>
<td>All-Cause Readmissions (#76)</td>
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<td>Claims</td>
<td>Emergency Department Utilization</td>
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<tr>
<td></td>
<td>Claims</td>
<td>Total Cost Per Member Per Month</td>
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FAST FACTS
- 28 Measures
- 16 measures can be collected using claims
- All NOF-endorsed
- Mostly HEDIS
- Process: ≤5, Patient-reported: 2, Resource Utilization: 6
- Five domains: prevention, chronic disease, behavioral health, patient-reported, appropriate use, cost
- Populations: Children, Adolescents, Adults, Elderly

Ongoing Challenges
- Aligning specifications of utilization metrics (e.g., ED use, Readmissions, Total Cost of Care) across payers – not consistently collected
- Attributing at primary care practice level
- Ensuring validity given payer variability
- Poor measure validity for small denominators
- Facilitating reporting of practice-level clinical measures in absence of:
  - An active all-payer database
  - Robust electronic medical record measure specifications and extraction processes
- Data aggregation across payers to create a meaningful, innovative all-payer scorecard

Highlights of Process
- UHF and NYSDOH received regular input from the Integrated Care Work Group, a multi-stakeholder group of payers, providers, TA organizations, consumers, research, and government entities, and the Northeast Business Group on Health.
- Aligned set with key natl. and state initiatives in NY: DSRIP, TCPI, CPC, CPC+, MACRA
- Reviewed over 60 measures of primary care performance:
  - Some not adopted due to changing clinical guidelines (e.g., Asthma Medication Ratio)
  - Some fiercely debated, yet adopted (e.g., Fluoride Varnish)
- Set then modified to align with the CMS/AHIP Primary Care Set, released in March 2016.

Learnings
- The process used to develop the APC Core Measure Set can inform other statewide, multi-payer practice transformation efforts.
  - Be flexible about process. New developments (e.g., release of a federal guideline) may change your original plan but open other opportunities.
  - Use regular convening to solicit input. It may take time for certain issues to surface.
  - Stick with nationally-endorsed guidelines when working on a multi-stakeholder initiative.
  - Listen to stakeholders as well as external content experts. Try to find a middle ground.
  - Combine idealism (e.g., more outcome measures) with pragmatism (e.g., what practices can realistically do).
  - Align with what is already in play. Avoid “death by measures.”
  - Develop a process for updating measures in response to a dynamic healthcare environment.

Notes:
1. Five domains: chronic disease, preventive care, behavioral health, substance use, patient-reported
2. Sixty-six primary care measures
3. Five domains of the state’s APC Core Measure Set
4. Five domains of the state’s APC Core Measure Set