

**VT Health Care Innovation Project
 Episodes of Care Subgroup Meeting Agenda
 Friday, March 6, 2015 9:00 AM – 11:00 AM.
 109 State Street, Montpelier, EXE - 4th Floor Conf Room
 Call in option: 1-877-273-4202
 Conference Room: 2252454**

Cathy Fulton (VPHCQ), Andrew Garland (MVP), Pat Jones (GMCB), Kelly Lange (BCBSVT), Alicia Cooper (DVHA), Amy Coonradt (DVHA), Jim Westrich (DVHA), Mandy Ciecior (DVHA)

Topic	Notes	Follow up Items
Welcome and Introductions; Approval of 02/12/15 EOC Sub-Group Meeting Minutes	Alicia Cooper started the meeting at 9:15. A quorum was not present so the sub-group was unable to approve the minutes. Both the February 12th and March 6 th minutes will be approved at the next sub-group meeting.	
Arkansas Reports	<p>Alicia Cooper introduced two reports that the Arkansas SIM project is using to disseminate their Episodes of Care and PCMH analysis to providers and practices. The following were questions or comments on attachments 3a and 3b.</p> <ul style="list-style-type: none"> • For the Arkansas Episodes pilot, payments are still provided on a fee for service basis; however, they incorporate financial incentives (and penalties) based on retrospective comparison of providers to their peers. Providers can fall into the commendable, acceptable or unacceptable ranges – leading to additional payments or loses. Andrew Garland noted that Medicare is now using this approach as well for some of their episode-based initiatives. • Pat Jones asked for clarification around the term gain sharing. Gain sharing is the redistribution of any cost savings that is achieved by the commendable providers. In addition, Pat asked who provides this data to the practices. Alicia responded that it is presently a Medicaid and commercial initiative (Medicare has not yet agreed to participate). Both Medicaid and Commercial payers have agreed to use the same approach in their methodology and distribution but are not using the same vendor for analytics and report generation. Arkansas Blue Cross and Blue Shield has a strong analytics team so they are able to conduct this analysis internally. Arkansas Medicaid chose to contract with General Dynamics 	

Information Technology (GDIT) and reports coming from both payers are fairly comparable. So far, providers in Arkansas have not raised any issues with receiving two different reports.

- The group discussed the gain sharing concept, and how some practices will lose money if they perform poorly. Arkansas reported coming out fairly even in terms of payments as some practices received bonuses and others had a financial penalty for suboptimal performance relative to peers.
- Kelly provided some more insight into the Arkansas SIM project as some Federal funding went to support the Arkansas BCBS website and provider portal. As it is a multi-payer initiative, the call center put in place has been fairly well utilized. Additionally, in Arkansas there is a lot more variability in performance of providers, which allows for more low hanging fruit. She also commented on the difficulty of getting the often necessary patient level information to providers to drive change. As the Episodes initiative was established as a requirement for most of the providers in the State, Arkansas made it a priority to include providers in program planning to ensure buy-in.
- Andrew Garland asked how many episodes Arkansas is working with. Around 15 episodes now, with more planned for release in future. Episodes are being added in 'waves'.
- Andrew spoke about the difference between using provider specific information for educational purposes versus accountability. It is possible that Arkansas can be more hands-off in socializing their information with providers because there is accountability (i.e. payment or penalty) tied to the information contained in the reports. MVP only uses their reports to inform providers and therefore must socialize the information to ensure it is being consumed. Andrew went on to explain that if Vermont plans to use this information for payment purposes in the future, early socialization of this information will be helpful. By going this route, we are also allowing providers some time to see where they can start achieving a cost savings before being held accountable. Alicia added that Arkansas reported quick behavior change by some practices after seeing their first reports, while others have been less inclined to use the information and make practice-level changes. Pat clarified that there are some practices and procedures that are easier to change in the short term than others. She also said that if the financial penalty isn't large, some practices might chose to take that small loss in order to avoid making substantial operational changes.

	<ul style="list-style-type: none"> Arkansas chose to focus on acute episodes as these are more sensitive to changes occurring over a shorter period of time. They felt that it is the goal of the PCMH initiative to focus on chronic care as primary care has the ability to achieve longer term health maintenance and improvement. 	
<p>Approach for Sharing Reports</p>	<p>The sub-group went on to discuss what they would like to see in the RFP and shared their thoughts on dissemination of the Provider Reports</p> <ul style="list-style-type: none"> The vendor’s ability to produce reports after their analysis is a characteristic the sub-group would like to see in an application. Andrew believes it is fairly usual for a vendor to be able to create a final report for providers. The sub-group agreed that the selected vendor should be able to create the reports, rather than relying on a separate group or organization for report generation. The group went on to discuss how to best use the developed reports as an educational tool and how to approach the dissemination process. Pat suggested that primary care should not be a focus of this project; instead we need to start looking at specialty care. So far there is a lot of information available to primary care providers, and they are the focus of many payment reform initiatives. Thus far there has been little effort directed at helping to cut costs in specialty areas. Pat also supported the idea of not just sending the reports, but walking providers through the information in targeted education sessions. Kelly Lange discussed the importance of creating a synergy among payers and creating a powerful front for providers to drive change. She also suggested focusing efforts on providers that are the worst performing as well as those that are the best performing in order to create opportunities for practices to learn from one another. In the absence of financial incentives or penalties, we need to clearly identify the areas of opportunity and improvement. Another issue relates to acute episodes occurring at the hospital; for information to be used effectively it would be important to approach the physicians delivering care and not the hospital administration. The group went on to discuss the potential for a regionally focused discussions or collaboratives for education and information sharing, especially in Southern Vermont where there are two large hospitals in the same region. Pat suggested that each practice or hospital receives their own report, blinded, to see how they perform relative to peers. Andrew responded by saying MVP benchmarks regionally (and that for their network Vermont is considered a single region), to show how a practice is performing against their peers. For a multi-payer initiative he would suggest splitting Vermont into two regions, North and South, for 	

benchmarking purposes.

Alicia asked the sub-group their thoughts on how frequently these reports should be provided. Arkansas provides them quarterly, Blueprint provides them bi-annually, while MVP provides reports annually. The limited availability of the SIM funding will also have to be taken into account.

- Andrew noted that when involving financial incentives or penalties, reports need to be more frequent. However, when they are just there to serve as an educational tool for providers, they can be more infrequent. Kelly agreed with this, and felt annually would be sufficient for this initiative at its onset.
- Cathy asked if there is a possibility of leveraging the provider portal through VITL. It could be beneficial to have a resource page for specialists with an option to see performance reports whenever they would like. The possibility of offering a learning session in addition to online reports would be a good complement. For those performing poorly, it would also make sense to have a 'friendly' visit, especially in the first round to facilitate learning. Kelly reported that it would be difficult to provide this online portal option with sufficiently data drill-down capabilities, and it would likely require a large change in the basic functions of VITL. This idea, and functionality of VITL should be further evaluated for future work.
- Pat felt there will likely be a significant requirement of time to create the impact we want to see using these reports. Alicia responded that Arkansas uses the approach of focusing on poorly performing practices and spending most of their time there. However, the group also saw a potential benefit in targeting the highest performing practices in order to spread best practices.
- Pat offered the idea of using multiple communication techniques while focusing on fewer specialties or episodes in order to test out a variety of dissemination and communication methods.
- Andrew reported that providers are not very likely to look at this information through an online portal. However, if the ACOs agree to participate there is a greater chance of them utilizing this information through an online portal and then discussing it with the providers delivering care.
- Andrew stated that there are four to six specialty types that account for the majority of episode-specific spending, making it easy to focus on a select number of episodes if that is what the group decides to do. He estimated that each

specialty has anywhere from 12-15 individual practices in the state, which would lead to ~60 practice visits per year if focusing on the most expensive six episodes. This number could be reduced by focusing on the most poorly performing practices. Alicia pointed out that we will need to identify the people who can do this level of dissemination work. It will be important research if there are already existing systems in place to utilize, and/or obvious candidates to do this work. Andrew described the MVP detailing team, it consist of 5 to 6 clinically trained people, with strong backgrounds in informatics as they bring the most credibility when speaking with providers.

- Kelly said that BCBSVT does not have dedicated people for this work like MVP, but together, the quality and provider relations folks do this type of outreach.
- Pat suggested the staff look into SIM funding for specific practice facilitation dollars that could potentially be leveraged.
- Alicia asked the group if we need to look into funding practice facilitation or if it would be feasible to use the payers, ACOs (and potentially Blueprint) to help disseminate this information. Andrew will discuss this issue with his Director of Detailing – although he also thinks it will be important to include someone from Medicaid as they know the program intricacies. Pat suggests asking the DVHA medical directors for more insight into this issue. Kelly will also bring this to the BCBS Director for further discussion.
- Alicia summarized the decisions of the group, the list is more inclusive than will likely be possible:
 - the sub-group will propose vendor support for analytics and report generation,
 - initial Episodes analytics work will focus on a subset of provider specialties with the most potential for cost-savings
 - will advise face to face meetings at least for the lowest performing practices (and potentially all practices), using a detailing team comprised of ACO and payer representatives
 - propose a variety of strategies for information dissemination such as supplemental materials, online tools, ad hoc analyses (by request) and the establishment of regional meetings where higher performing practices will help to share their best practices.

<p>Quality Measures</p>	<ul style="list-style-type: none"> • Discussion took place around whether the sub-group will request input on quality measures identified by the vendor. The goal of seeking input and allowing for alternative measures would be to achieve alignment with ongoing State initiatives. Pat suggests looking at existing measure sets related to the specialties which are selected, this would lead to a broader alignment with what is occurring in healthcare, not necessarily just in Vermont. • Andrew noted that if we go outside the vendor scope, we will need a lot more clinical expertise involved in developing additional measures. In addition, he also reported that the specialty providers he works with rarely look at the quality measures (as the majority of measures being used by state and federal programs focus on primary care). • As there is no payment component in this initial run, it makes sense to use the measures that are available through the vendor. The subgroup can then adjust the measures after the first year if needed. • There will be opportunity for the Quality and Performance Measures work group to review the proposed measures for each episode once a vendor has been selected. 	
<p>Public Comment and Next Steps</p>	<ul style="list-style-type: none"> • Staff needs to be sure the funding request incorporates the new Steering Committee priorities. • The next meeting will be used to nail down the details of the funding request while the final meeting in April will focus on the RFP. • Cathy suggests revisiting the HCl3 RFP to ensure we get the correct outcomes with the new RFP. • Andrew suggests creating a 5 year roadmap to ensure what we are doing in the short term aligns with the ultimate goals of this project. 	<p>Next Meeting: March 26th, 9am-11am, AHS Training Room, 298 Hurricane Lane, Williston</p>