

Attachment 1 - Population Health Work Group Agenda 3-11-14

VT Health Care Innovation Project Population Health Work Group Meeting Agenda

Date: Tuesday, March 11, 2014 Time: 2:30-4:00 pm

Location ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Call-In Number: 1-877-273-4202; Passcode: 9883496

All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.

AGENDA					
Item #	Time	Topic	Presenter	Relevant Attachments	Action #
1	2:30	<p>Welcome, introduction, agenda review Goal: Make recommendations for ACO measures for year two</p> <ul style="list-style-type: none"> • Objective: Review and adopt criteria for recommendations • Objective: Review ACO measures The <p>The Measures Work Group is beginning to make recommendations for changes to the ACO measures for Year 2. We have an opportunity to recommend population health measures.</p>	Karen Hein	Attachment 1: Agenda	
2	2:40	Approval of minutes	Karen Hein	Attachment 2: Minutes	
3	2:45	<p>Review and adopt criteria for recommendations</p> <p><i>What criteria are important in recommending population health measures for ACO payment, reporting or measuring and evaluation?</i></p>	Heidi Klein	<p>Attachment 3a: ACO Criteria</p> <p>Attachment 3b: Draft Population Health criteria</p>	
4	3:15	<p>Review measure sets and begin to identify initial set of population health measures to recommend for ACO</p> <p><i>Given the criteria we have identified, which of the pending measures would the group recommend for inclusion in Year 2 for the ACOs? For another part of the VHCIP effort?</i></p>	Heidi Klein	<p>Attachment 4a: CMS Population Health Measures</p> <p>Attachment 4b: Pending ACO measures</p>	
5	3:50	<p>Public Comment and Next Steps</p> <p><i>What information do work group members need in order to continue our work together?</i></p>	Karen Hein		

OPEN ACTION ITEM LOG					
Date Added	Action Number	Assigned to:	Action /Status	Due Date	Date Closed
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Attachment 2 - Population Health Work Group Minutes 2-11-14



***VT Health Care Innovation Project
Population Health Work Group Meeting Minutes***

Date of meeting: February 11, 2014 - 2:30pm to 4pm; at ACCD Calvin Coolidge Conference Room 6th Floor, 1 National Life Drive - Montpelier. Call in : 877-273-4202 Passcode 9883496

Attendees: Karen Hein and Tracy Dolan, Co-Chairs; Georgia Maheras, AoA; Jill Berry-Bowen, Northwest Medical Center; Judy Cohen, UVM; Jim Hester; Laural Ruggles, Northeastern Vermont Regional Hospital; Deborah Shannon, Shannon Resources; Jesse Dellarosa, VT Wellness Educator; Penrose Jackson, VT Public Health Assn; Melanie Sheehan; Ted Mable, Northwest Counseling and Support Services; Bob Bick, Howard Center; JoEllen Tarallo-Faulk, Health and Learning; Melissa Miles, Bi-State; Wendy Davis, UVM; Geera Demers, Blue Cross Blue Shield; Heidi Klein, VDH; Daljit Clark, DVHA; Pat Jones and Annie Paumgarten, GMCB; Donna Burkis, Julia Shaw, VT Legal Aid; Nelson LaMothe and George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome, introductions, Agenda review	Karen called the meeting to order at 2:30pm and briefly reviewed today's Agenda.	
2 Approval of Minutes	Karen briefly reviewed the January 14 minutes. Judy Cohen moved to accept minutes; 2 nd by Jill Berry-Bowen. Passed unanimously.	
3 Framework for Population Health Measures	Heidi Klein presented: The Population Health Work Group has the same triple aim, as the SIM grant: to improve care; improve population health; and reduce health care costs. She shared a couple of diagrams that summarize the discussions of the work group to date. These diagrams are intended to serve as grounding frameworks for our future discussions and decisions. The 1 st diagram uses diabetes as an example, and the related measures reflect that successfully managing diabetes is highly dependent upon several socio-economic contributors. The diagram also illustrates the comparison for measures in clinical setting vs the view of population health measures. Measures can also be used to target activities and focus resource allocation. For example:	

Agenda Item	Discussion	Next Steps
	<p>influencers of a ‘health outcome’ are key to understanding the strategy of prevention. The 2nd diagram, the Freiden Pyramid, is another way to think about implementing a population health program obtaining largest impact with limited resources. Investing at the lower level, e.g. in Socio Economic factors, has a much broader impact on ‘health outcomes’ vs investing in clinical interventions; while investing in counseling and education has least impact on population health outcomes.</p> <p>Our Work Group will make recommendations of Population Health measures to:</p> <ul style="list-style-type: none"> • incentivize changes in payment methods and care models that will improve population health • target strategies and resources of VHCIP; and • evaluate the impact of the changes. <p>We will collaborate with the HIE Work Group to assess the burden to collect and track these recommended measures.</p> <p>Tracy Dolan advised that Anya Rader Wallack suggested a “mixed portfolio of measures” some of which are short term in nature, and some have the long term nature more consistent to evaluating impact on Population Health. Discussion followed.</p>	
<p>4 Framework for an Integrated Community Health</p>	<p>Jim Hester presented his recent talk at the Institute of Medicine Roundtable on Population Health and the meeting attachment “How Can We Pay for A Healthy Population”, published by the Prevention Institute.</p> <p>The two primary challenges are</p> <ul style="list-style-type: none"> - How to pay for Population Health? - How to develop a Community Health System infrastructure that supports a Population Health strategy? <p>The transition from paying for volume to paying for value is to design a funding stream that could pay for Population Health. The evolution of health care delivery could be explained this way:</p> <p>Health Care version</p> <ul style="list-style-type: none"> - 1.0 = Acute Care - 2.0 = Coordinated Seamless health care - 3.0 = Community Integrated health care where the organization is responsible for community’s entire population. 	

Agenda Item	Discussion	Next Steps
	<p>The role of the community is to integrate clinical health, public health, and community services. There is a growing inventory of financing vehicles to help the community accomplish this, e.g.</p> <ul style="list-style-type: none"> - Payment for clinical services with capitated budgets, global budgets, shared savings programs - Multi-sector programs that blend funding - Non-traditional sources; e.g. social impact bonds; community development; financial institutions (banks) that are required to demonstrate that they serve the community, <p>The best financial models match the investor with the desired intervention and community, and have a balanced portfolio of investments that reinvests in the community,</p>	
5 Contractual Support Population Health Work Group	<p>Karen expressed a need to continue funding for Jim Hester’s contract. Jim has substantive expertise, has been a liaison between CDC, CMS and CMMI, and also supports Karen and Tracy’s. Laurel Ruggles moved to approve a sole source contract for Jim Hester 2nd by Penrose Jackson. Motion passed unanimously.</p>	
6 Public Comment, Next Steps	<p>Karen requested public comment. Melanie Sheehan: Noted that the financial model could look beyond the current systems of payment and include using funds collected through the legalization of substances for initiatives aimed at decreasing substance abuse.</p>	

Attachment 3a - ACO Criteria

Proposed Objectives of the Vermont ACO Measures Work Group:

March 29, 2013 Draft

To identify standardized measures that will be used to:

1. evaluate the performance of Vermont's Accountable Care Organizations (ACOs) relative to state objectives for ACOs,
2. qualify and modify shared savings payments, and
3. guide improvements in health care delivery.

The measures selected will:

1. be representative of the array of services provided and beneficiaries served by the ACOs;
2. be valid and reliable;
3. be selected from NQF endorsed measures that have relevant benchmarks whenever possible;
4. align with national and state measure sets and federal and state initiatives whenever possible;
5. be focused on outcomes to the extent possible;
6. be uninfluenced by differences in patient case mix or be appropriately adjusted for such differences;
7. not be prone to the effects of random variation (measure type and denominator size);
8. not be administratively burdensome;
9. be limited in number and include only those measures that are necessary to achieve the state's goals;
10. be population-based; and
11. be consistent with the state's objectives and goals for improved health systems performance (e.g., present an opportunity for improved quality and/or cost effectiveness).

VT ACO Measures Work Group

Proposed Selection Criteria for Commercial Measures Used for Payment

July 9, 2013

To identify the measures from the commercial measure set that will be used to qualify and modify shared savings payments.

The measures selected will:

12. be selected from the commercial measure set;
13. have relevant benchmarks;
14. present an opportunity for improvement;
15. be focused on outcomes to the extent possible, and
16. be representative of the array of services provided and patients served by pilot ACOs.

Attachment 3b - Draft Population Health Criteria

Criteria for Recommending Population Health Measures

Uses of Measures:

- Identify problems and populations at risk
- Target interventions
- Evaluate outcomes and impact
- Determine payment

CMS Criteria for Population Health Measures

- High population burden, societal costs
- Amenable to interventions with potential improvement in health, quality of care and decreased costs within the next three to five years
- Data for the measure are available for major segments of the population at the state and/or sub-state level.

Additional Potential Criteria for Measures for ACO Measures

- Ease of collection
- Reflects a driver of health outcomes – if changed it will lead to both to cost saving and health improvement
- Focus is on upstream determinants of health and/or preventive contributors to positive health outcomes
- Opportunity to link data on attributed and geographic populations

Other Ideas to Consider

- Measures subjective component of patients' self-reported impact on quality of life and ability to cope with illness
- Accountability for geographic population within a community instead of attributed population
- Measures that do not need to be measured at the ACO level (at the statewide or county or HSA level) that could be considered for addition to the Monitoring and Evaluation measures list
- Measures of the health of the system to improve health overall beyond clinically related measures

Attachment 4a - CMS Population Health Measures

CMS Population Health Measures

The measures were selected based on the following three criteria:

- High population burden, societal costs
- Amenable to interventions with potential improvement in health, quality of care and decreased costs within the next three to five years
- Data for the measure are available for major segments of the population at the state and/or substate level.

Topic	Population Health Measure	Population Data Source/ Link	Related NQF # / Measure
Core Measures			
Tobacco - Adult	Four Level Smoking Status	BRFSS – 2011 http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=TU&yr=2011&qkey=8171&state=US	NQF 0028 Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B)Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
Tobacco	Percent of adult smokers who have made a quit attempt in the past year	BRFSS 2011 To Be Provided	NQF 0028 Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B)Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
Obesity - Adult	Weight Classification by BMI	BRFSS – 2011 http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=OB&yr=2011&qkey=8261&state=All	NQF 0024 NQF 0421 Adult Weight Screening and Follow-Up Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented
Obesity - Youth	Obese: Students who were >=95 th Percentile for BMI (based on 2000 CDC Growth Charts)	YRBS – 2011	No relevant NQF measure identified Body Mass Index (BMI) 2 through 18 Years of Age Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender
Physical Activity	Participated in enough Aerobic and Muscle Strengthening exercises to meet guidelines	BRFSS - 2011 http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=PA&yr=2011&qkey=8291&state=All	No relevant NQF measure identified

CMS Population Health Measures

Fruit and Vegetable Consumption	Median intake of fruits and vegetables (times per day)	Behavioral Risk Factor Surveillance System. See report: http://www.cdc.gov/nutrition/downloads/State-Indicator-Report-Fruits-Vegetables-2013.pdf	No relevant NQF measure identified
Food Desert/ Food Availability	Percentage of the population living in census tracts designated as food deserts	USDA: http://www.ers.usda.gov/data-products/food-access-research-atlas http://assessment.communitycommons.org/DataReport/SelectArea.aspx?reporttype=FOOD	No relevant NQF measure identified
Diabetes	Percentage of Adults(aged 18 years or older) with Diabetes Having Two or More A1c Tests in the Last Year	BRFSS 2012 2012 Data Forthcoming	NQF 0729 Optimal Diabetes Care The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.
Diabetes	Percentage of Adults (aged 18 years or older) with Diabetes Receiving a Foot Exam in the Last Year	BRFSS 2012 2012 Data Forthcoming	NQF 0056 Foot Exam Percentage of adult patients with diabetes aged 18-75 years who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)
Diabetes	Percentage of Adults (aged 18 years or older) with Diabetes Receiving a Dilated Eye Exam in the Last Year	BRFSS 2012 2012 Data Forthcoming	NQF 0055 Eye Exam Percentage of adult patients with diabetes aged 18-75 years who received an eye screening for diabetic retinal disease during the measurement year
Additional Measures for Consideration			
Community Characteristics			
Health Care Access	Do you have any type of health care coverage?	BRFSS 2011 http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=HC&yr=2011&qkey=8021&state=All	No relevant NQF measure identified
Tobacco	Legislation – Smokefree Indoor Air	CDC OSH State Tobacco Activities Tracking and Evaluation (STATE) System – 2013	No relevant NQF measure identified

CMS Population Health Measures

		http://apps.nccd.cdc.gov/statesystem/DetailedReport/Detail edReports.aspx	
Tobacco - Youth	Smoked cigarettes on at least one day in the last 30 days	YRBS – 2011 http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?TT=&OUT=&SID=HS&QID=H31&LID=&YID=&LID2=&YID2=&COL=&ROW1=&ROW2=&HT=&LCT=&FS=&FR=&FG=&FSL=&FRL=&FGL=&PV=&TST=&C1=&C2=&QP=G&DP=&VA=CI&CS=Y&SYID=&EYID=&SC=&SO=	HP2020 LHI Objective NQF 0028 Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B) Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
Key Health Behaviors			
Motor vehicle injury prevention	Driving after drinking in the past 30 days	BRFSS 2012 (not asked annually) During the past 30 days, how many times have you driven when you've had perhaps too much to drink? http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=IN&yr=2010&key=7315&state=All	No relevant NQF measure identified
Health Care Quality and Outcomes			
Colorectal Cancer	Percentage of respondents aged 50-75 years who reported colorectal test use, by test type: <ul style="list-style-type: none"> Up-to-date with CRC screening FOBT within 1 year Sigmoidoscopy within 5 years with FOBT within 3 years Colonoscopy within 10 years 	BRFSS 2012 2012 Data Forthcoming	NQF – 0034 Colorectal Cancer Screening Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer
Healthcare associated infections	Patient Safety- Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	To Be Provided	NQF 1717 Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure - Standardized infection ratio (SIR) of hospital-onset CDI Laboratory-identified nursing units, nurseries and neonatal intensive care units (NICUs)
Immunization Rate – Adult	Adults aged 65+ who have had a flu shot within the past year	BRFSS - 2011	NQF 0041 Influenza Vaccination

CMS Population Health Measures

		http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=IM&yr=2011&qkey=8341&state=US	Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization
Immunization Rate – Child	Estimated Vaccination Coverage* with Individual Vaccines and Selected Vaccination Series	US National Immunization Survey, 2011 http://www2a.cdc.gov/nip/coverage/nis/CountNIS.asp?fmt=v&rpt=tab03_antigen_state_2011.xlsx&qtr=Q1/2011-Q4/2011	NQF 0038 Childhood Immunization Status Measure calculates a rate for each recommended vaccines and nine separate combination rates.
Blood Pressure / Hypertension	Taking medicine for high blood pressure control among adults aged >= 18 years	BRFSS – 2011 To Be Provided	NQF 0018 HTN: Controlling High Blood Pressure Percentage of patients > 18 years of age with a diagnosis of hypertension in the first six months of the measurement year or any time prior with last BP < 140/90 mm Hg
Cholesterol		NQF 0074 To Be Provided	Lipid Control Percentage of patients aged 18 years and older with a diagnosis of CAD seen within a 12 month period who have a LDL-C result <100 mg/dL OR patients who have a LDL-C result >=100 mg/dL and have a documented plan of care to achieve LDL-C <100mg/dL, including at a minimum the prescription of a statin
HIV	Stage 3 (AIDS) at the time of diagnosis of HIV infection, among persons aged 13 years and older	http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_17_no_3.pdf#page=15	NQF 1999 Percentage of persons 13 years and older diagnosed with Stage 3 HIV infection (AIDS) within 3 months of a diagnosed HIV infection.
	HIV viral suppression at most recent viral load test, among persons aged 13 years and older with HIV infection	http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_18_no_2.pdf#page=20 (limited state set)	NQF 2082 Percentage of patient, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.
Measures of Health			
Health Related Quality of Life	Health Related Quality of Life— physically and mentally unhealthy days In the past month.	BRFSS 2011 Unique data run. DPH may need provide as it is not regularly reported by BRFSS Also here on CDI site from 2010 http://apps.nccd.cdc.gov/cdi/SearchResults.aspx?IndicatorIds=36,50,44,136,135,55,16,122,123,124&StateIds=46&StateNames=United%20States&FromPage=HomePage	No relevant NQF measure identified
Low Birth Weight	Percent of live births <2500 g.	http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=5425	No relevant NQF measure identified

CMS Population Health Measures

		and can be computed at: http://wonder.cdc.gov/	
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Attachment 4b - Pending ACO Measures

VT Measure ID	MSSP Measure ID	MEASURE	Measure Domain	National Recognized /Endorsed	Aligns with CMS/HHS Requirements, Programs Measure Sets	Aligns with State Requirements, Programs or Measure Sets	Linked to Payment, Monitoring, or Program Evaluation (ACO Year 1)	VT Medicaid SSP	VT Commercial SSP	Medicare SSP	Can we measure	Data Source	Is it a health dept priority? (SHIP/HV2020)
Core-9		Depression Screening by 18 Years of Age	Children/Adolescents	NQF #1515		Healthy Vermonters 2020 (thoguh no data source available)	Pending	x			No-though it is a HV2020 goal there is no baseline data and there has not been a data source identified for future measurement	***	HV2020 goal
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Chronic Conditions: Cardiovascular	NQF #0075, NCQA		Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	No- while we can measure some information related to stroke we do not measure for this clinical test	***	No
Core-30		Cervical Cancer Screening	Preventive Health: Screening	NQF #0032, HEDIS measure	Meaningful Use, Adult Core	Blueprint Recommendation, Healthy vermonters 2020	Pending	x	x		Yes-We have been measuring this for several years and we can adjust our estimates to match how the guidelines have changed over the past several years	BRFSS	HV2020 goal among women age 21 and older
Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Chronic Conditions: Cardiovascular	NQF #0068, NCQA	Meaningful Use	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	No- while we can measure some information related to stroke we do not measure this level of detail	***	No
Core-32		Proportion not Admitted to Hospice (cancer patients)	End-of-Life Care	NQF #0215			Pending	x	x		No	***	No
Core-33		Elective Delivery before 39 Weeks	Pregnant Women	NQF #0469			Pending	x	x		Maybe- this could be collected by looking at birth certificate data. Though the data we obtain and classify as elective may be more robust than GMCB expected for this measure	Vital Records	No
Core-34		Prenatal and Postpartem Care Timeliness	Pregnant Women	NQF #1517	Child Core		Pending	x	x		Maybe- there is a measure of adequate prenatal care that we can obtain on the birth certificate. However, I am not sure this will align with the NQF measure. I am not sure what postpartem care timeliness means or how we could measure this.	Adequate prenatal care, and time entered prenatal care are collected on the brith certificate	No
Core-35	MSSP-14	Influenza Immunization	Preventive Health: Immunizations	NQF #0041, AMA-PCPI	Meaningful Use, Adult Core	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	Yes-we can measure this. We can measure this as self reported data or we can try to use to use the immunization registry. I would recommend the BRFSS self report since immunizations can be administered at various locations (including work based wellness clinics, drug/grocery stores, dr office, etc.)	BRFSS (Immunization registry is also possible but may not be best choice at this point)	HV2020 goal among adults ≥65 years
Core-36	MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	Preventive Health: Tobacco	NQF #0028, AMA-PCPI	Meaningful Use	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	Yes- we can measure information about smoking prevalence, quit attempts, cessation methods, and other information about smoking perceptions	BRFSS or the ATS	There are HV202 goals related to smoking prevalence in adults and adolescents as well as quit attempts in adults, these are also mentioned in the SHIP

Core-37		Care Transition-Transition Record Transmittal to Health Care Professional	Care Coordination/ Patient Safety	NQF #0648	Adult Core, Home Health Core	Duals Demonstration	Pending	x	x		No	***	No
Core-38	MSSP-32-33	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-C	Chronic Conditions: Cardiovascular	NQF #0074 CMS (composite) / AMA-PCPI (individual component)		Duals Demonstration	Pending	x	x	x	No	***	No
Core-39	MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	At Risk Population: Hypertension	NQF #0018, NCOA HEDIS measure	Meaningful Use, Adult Core, Home Health Core	Duals Demonstration, Healthy Vermonters 2020	Pending	x	x	x	maybe- we can measure some prevalence information related to hypertension and high blood pressure but it may not be specific enough to match this measure	BRFSS	HV2020 measure of % adults with HTN
Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented	At Risk Population: Hypertension	CMS	Meaningful Use	Duals Demonstration	Pending	x	x	x	yes to the screening of high blood pressure, but 'no' to the documentation of a follow-up plan by a provider	High blood pressure screening information collected on BRFSS	No
Core-41		How's Your Health? **	Patient Engagement				Pending	x	x		yes-we do measure self reported response to general health status	BRFSS	No, but I am also not clear what this is
Core-42		Patient Activation Measure	Patient Engagement			Blueprint Recommendation	Pending	x	x		maybe- I think this is a composite of a few different components and we may collect information on the various components	BRFSS	No, but I am also not clear what this is
Core-43		Frequency of Ongoing Prenatal Care	Effectiveness of Care	NQF # 1391, HEDIS Measure	Child Core	Healthy Vermonters 2020	Pending	x	x		Maybe...what does this mean? Number of prenatal visits-that the number of prenatal visits in each trimester is on the birth certificate	Vital Records??	No
Core-44		Percentage of Patients with Self-Management Plans	Care Coordination/ Patient Safety	NCOA			Pending	x	x		yes we measure the presence of an asthma action plan	BRFSS/ACBS	HV2020 measure for both adults and children
Core-45		Screening, Brief Intervention, and Referral to Treatment	Mental Health/ Substance Abuse	AHRQ Measure		VT SBIRT Grant	Pending	x	x		yes we have measured this for alcohol in 2011	BRFSS	No
Core-46		Trauma Screen Measure	Children/Adolescents				Pending	x	x		no	***	No
Core-47	MSSP-13	Falls: Screening for Future Fall Risk	Elderly	NQF #0101	Meaningful Use	Duals Demonstration	Pending	x	x	x	maybe- we have been measuring self reported falls and injuries due to falls, but I am not sure what the components to future fall risk means or how it is measured	BRFSS	Fall related deaths are the only fall related HV2020 measure
Core-48	MSSP-15	Pneumococcal Vaccination for Patients 65 Years and Older	Elderly	NQF #0043	Meaningful Use	Duals Demonstration	Pending	x	x	x	yes, we measure this in BRFSS and it may also be collected with the immunization registry. However, we face some of the same issues stated with flu vaccines, imr may miss some vaccines depending on where they were delivered	BRFSS (possibly IMR)	HV2020 measure
Core-49		Use of High-Risk Medications in the Elderly	Elderly	NQF #0022, HEDIS Measure	Meaningful Use	Duals Demonstration	Pending	x			No	***	No
Core-50		Persistent Indicators of Dementia without a Diagnosis	Elderly				Pending	x			maybe- in 2013 we did the alzheimers module (also have some information in 2012 on alz./dementia)	BRFSS	No