

**Vermont Health Care Innovation Project**  
**Quality and Performance Measures Work Group Meeting Minutes**

**Pending Work Group Approval**

**Date of meeting:** Monday, February 23, 2015, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Introductions</b> <b>Approval of December minutes</b>	<p>Laura Pelosi called the meeting to order at 9:00 am. A roll call attendance was taken and a quorum was present.</p> <p>Joyce Galimore moved to approve the minutes; the motion was seconded by Sue Aranoff. The motion passed with two abstentions.</p>	
<b>2. Gate and Ladders</b>	<p>Alicia Cooper provided an update on the proposed Gate and Ladder methodology changes from the Payment Models work group – the Payment Models work group has met to hear about the G&amp;L proposal – the group has not voted yet but hope to vote today as the work group is meeting on 2-23-15 at 1PM. They hope to report outcome at next meeting.</p>	
<b>2. Workplan Update</b>	<p>Update – all workplans for every VHCIP work group are reaching final form. The work group staff have done extensive work this year to line up cross workgroup links.</p>	
<b>3. Status of Yr 1 SSP data collection</b>	<p>Update Alicia Cooper and Pat Jones-</p> <p>Claims based measures – working Lewin Group to generate preliminary reports – 1<sup>st</sup> performance year. Working to streamline the results. Learning about the data and measure specification to ensure that components are set prior to a review of the year one performance. Many are payment measures – one item of note is that commercial data in particular is revealing small numbers due to the fact that claims based measures have a 12 month look back period and the fact that many people didn't sign up as of January so the eligible number of people is lower. Going forward this will be less of an issue as the timeframe will include more enrollees.</p>	

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	<p>Medicaid has historical data so low numbers aren't an issue.</p> <p>With respect to the clinical reporting measures, the data collection is complicated (Kudos to the three ACOs and practices who are working tirelessly to gather this data.)</p> <p>Discussion of potential hiatus in new commercial SSP measures – update is that Green Mountain Care Board (GMCB) will be discussing this at a meeting in the near future. Unsure if that will result in a vote, but it is up for discussion. More to come on this.</p> <p>Patient Experience survey is going well – State is sponsoring – it is occurring at the practice level to allow them to use it for NCQA purposes; includes attribution for the ACOs. 90 practices have taken advantage of this.</p> <p>When will we see data? Won't have 12 months of data for a couple more months; we won't use 6 or 9 month data as it won't be useful. Timeline indicates summer – August for results as we have a 6-month run out for the claims based measures.</p>	
<p><b>4. Incorporation of ACO SSP Measures into Practice and Health Service Area Quality Profiles - Dr. Craig Jones</b></p>	<ul style="list-style-type: none"> <li>- Update on bringing the measures into play as part of a learning health system.</li> <li>- To integrate with ACOs and emphasize the community health system</li> <li>- Dr. Jones reviewed the slides that are included in the meeting materials (<a href="#">Linked here</a>)</li> <li>- Following are discussion highlights to accompany slides:</li> <li>- ACO structures and participation is strengthening the community health models.</li> <li>- The 'ground game' is to get all the community partners working together using the standard measures – that's the infrastructure for going into 2017.</li> <li>- Key is to form one unified community collaborative – to use the results of the measures. Can we take advantage of centralized state data systems to combine performance reporting to fuel the use of unified community collaboratives around the reporting measures?</li> <li>- UCC proposed a variety of participants on the Leadership Team (to include pediatrics, AAA, DAs and others). But to act as Leadership and work with larger groups of participants; leadership group envisioned to be 11 or 12 members.</li> <li>- It would be aspirational to have such a state that after the SIM, clinical data and claims data and CAPHS survey data is all collected centrally so that all of the man-hours and effort to collect such data (chart reviews) is no longer necessary; SIM provides that opportunity.</li> <li>- Once the data is centralized, we can then move to a centralized measurement environment. The key is the data quality effort on the front end process, which must occur at the practices. The challenge is to do this in an automated way as opposed to the manual effort being undertaken now. This includes hands-on assistance to get the practices to a place where quality data can be systematically or in an automated way, collected and submitted.</li> </ul>	

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	<ul style="list-style-type: none"> <li>- Query how many practices aren't in an ACO? Small number – most are in one or more. And, there is an incentive to improve based on the quality measures even if not participating because the proposed Medical Home payment model includes incentives based on the outcomes for those measures across the service area.</li> <li>- Query whether BP is collecting 'Lessons Learned' throughout this process? Not yet, but all of the data is now collected and it's a great idea to create those LL.</li> <li>- Review of individual measures – discussion of the challenges in improving these measures and linking it to the power of the UCC model. It will take a community effort to address all of the factors that impact the measures.</li> <li>- Discussion of who is being measured – the attribution is based on where people get their primary care and attributed to the hospital service area.</li> <li>- If a location does not appear in the graphics within the presentation, then it means that the location is not submitting all its clinical data.</li> <li>- Point – the numbers breakdown reveals areas of opportunity to allow outreach to impact populations based the measures and the data. E.g. Diabetes: The data now shows that approximately 500 Vermonters whose A1C levels are not well controlled have increased costs compared to those whose A1C levels are under control. This is a perfect opportunity for direct outreach to those individuals for more coordinated and targeted care.</li> <li>- CMS recently released a report on the demonstration states – that report is <a href="#">linked here</a>.</li> <li>- IOM is working to produce a set of core measures for the entire country – they will represent the spectrum of the human condition. Very soon...by Spring/Summer.</li> <li>- Query: Is the data available by ACO? Yes, it is.</li> <li>- Final thought: The measures can come alive!</li> </ul>	
<p><b>5. Year 3 ACO Shared Savings Program Measures Update</b></p>	<p>Update on Yr 3 ACO SSP Measures (Michael Bailit, Alicia and Pat)</p> <p>With some lingering uncertainty of Yr 3 measures, there are still activities in which to engage:</p> <ol style="list-style-type: none"> <li>1) Look at recent and proposed changes to measures in the measure set – i.e. proposed changes to the HEDIS measures.</li> <li>2) Consider any recent change in clinical guidelines that impact the measures in our measure set.</li> <li>3) Medicare SSP also changes; we have been trying to align with these where appropriate as we have dual populations being served, in many cases.</li> </ol> <p>As we forecast, there are some measures where the ACO numbers in the denominator are small, so we need to be mindful if that is going to continue in the future.</p> <p>If the GMCB moratorium is only on the Commercial measures – maybe we don't want to lump the Medicaid and Commercial together. We likely wish to align them as much as possible unless there is a measure that impacts</p>	

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	<p>one population over the other. Medicaid has been waiting for the discussion at the Board before making any decisions.</p> <p>Query: What if Total Cost of Care expands to include items not currently covered in our measure set? Research is underway related to what types of measures would go along with that expansion. Thus far, it's an internal discussion within Medicaid as the topic develops.</p> <p>Comment – the delay in discussing the topic has been frustrating to the work of this group. This week, it was noted that the Board will revisit the discussion 'in the near future.' It is unclear what exactly that means – as soon as timing is known it will be distributed to the group.</p>	
<p><b>6. Episodes of Care</b></p>	<p>Alicia Cooper presented; her comments were accompanied by slides that are included in the materials for this meeting.</p> <p>There will be touchpoints between the groups, and where appropriate, input from other groups will be sought. The plan is to develop recommendations around episodes of care that will be of interest to providers in the area; going forward the group will request support for analytics and to develop an RFP for vendor support.</p> <p>While episodes of care will not be used directly to propose a new payment model, this work will support and provide conversation and analytics to inform the review and consideration of new models.</p>	
<p><b>7. Next Steps, Wrap Up and Future Meeting Schedule</b></p>	<p><b>Next Meeting:</b>  <b>March 16, 2015 – 9:00 to 11:00 AM</b>  <b>DVHA Large Conference Room, 312 Hurricane Lane, Williston</b></p>	