

VT Health Care Innovation Project
Quality and Performance Measures Work Group Meeting Minutes
Pending Work Group Approval

Date of meeting: May 18, 2015, DVHA Large Conference Room, 312 Hurricane Lane, Williston VT

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Catherine Fulton called the meeting to order at 9:01. A roll call was taken and a quorum was present.	
2. Approval of the April Minutes	Catherine Fulton called for a motion to approve the April 13 th minutes; Susan Aranoff moved to approve the minutes by exception and Heather Skeels seconded the motion. The minutes were approved by exception with one abstaining vote.	
3. Summary of Institute of Medicine Report	<p>Pat Jones summarized the IOM “Vital Signs” report (Attachment 2 from Bailit Health Purchasing). A link to the full report is provided in the meeting materials.</p> <p>Pat noted that Craig Jones was part of the group that created the report and asked if the group would like him to come to a future QPM Work Group meeting to describe the process that resulted in this report and the findings in more detail. The work group agreed that they would like to hear from Dr. Jones.</p> <p>A question was posed about which childhood immunization measure is recommended in the IOM report. Pat will check and provide the answer. Someone asked if the numbering of the measures indicated their relative importance. The answer is no. There were questions about some of the acronyms in the report. For some measures, the specifications and data sources may not yet be clear.</p>	
3. Vermont ACO Experience with Year 1 Clinical Data Collection	<p>The following team presented on the ACOs’ Year One experience with clinical data collection:</p> <p>Maura Crandall – OneCare Vermont Miriam Sheehey – OneCare Vermont Patricia Launer – CHAC; Bi-State Primary Care Heather Skeels - CHAC; Bi-State Primary Care Rick Dooley - Healthfirst</p> <p>The team stressed the unique collaboration that occurred between the three ACOs, and described the benefits,</p>	

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	<p>challenges and lessons learned from the process. They also described early indications of quality improvement and improved documentation, and showed examples of the data collection tools that they developed together. They presented several recommendations regarding increased measure alignment; improved timeliness and accuracy of the patient lists used to pull records for extraction; continuing to allow ACOs to develop template and collaborate on data collection; and more timely release of benchmarks.</p> <p>Miriam presented the OneCare Quality Measure Scorecard for Medicare measures; Heather Skeels reviewed the CHAC Scorecard. Sue Aranoff asked about the CHAC score for falls risk prevention – Heather Skeels noted that when the falls screening wasn't done, it was often a documentation issue versus a quality of care delivery issue. Most practices are doing some type of falls screening, but it may not meet the exact specifications of the measure.</p> <p>Work group members discussed the challenge facing practices in addressing all of the relevant measures in a 20 minute office visit. Some practices have begun to include questions to address some of the measures in pre-visit phone calls. Connie Colman noted that information for some measures can also be collected while the patient is in the waiting room. Practices are looking at different workflow adjustments to meet measure requirements.</p> <p>Rachel Seelig asked about when a patient receives both primary care and home health care, and the information (e.g., falls risk screening) is in the home health record, if it can be counted as meeting the measure. The response is yes, as long as the information appears in the primary care record.</p> <p>Cath Burns asked a question about improvement, and Rick Dooley noted that if an ACO improves its score due to improved documentation (rather than changes in care delivery), it won't translate into improved outcomes for patients because the recommended care was already being delivered.</p> <p>Rachel Seelig asked about significant improvement that OneCare has demonstrated in the Optimal Care for Diabetes composite measure for its Medicare population. Miriam noted that UVMHC practices used panel management for diabetic patients to ensure they received recommended follow up care, and referred diabetic patients to Blueprint self-management programs for ongoing management of their diabetes.</p> <p>Jenney Samuelson asked what types of supports are given to the practices after data collection – Patty and Heather noted that results are provided to CHAC practices via clinical director, quality director, and informatics meetings, as well as through Blueprint project managers.</p> <p>The work group applauded the ACOs efforts and presentation, and Cathy Fulton thanked everyone involved. The process has resulted in a number of takeaways, including the creation of a 'punch list' or work plan to ensure that ACOs have the information they need for a smooth data collection process.</p>	

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<p>4. Year 3 ACO Shared Savings Program Measures</p>	<p>Pat reviewed Attachment 4a, which was presented to the work group at a previous meeting. It outlines national changes to measures currently in the Vermont commercial and Medicaid measure sets, and potential replacement measures. The most important changes include:</p> <ul style="list-style-type: none"> • The LDL Screening measure (Core-3a; Cholesterol Management for Patients with Cardiovascular Conditions) in the payment measure set is no longer considered a best practice, and was retired by MSSP and NCQA for 2015. NCQA has proposed statin measures to replace this measure, but they have not yet been finalized and there will be no benchmarks for some time. Another option, as discussed at the April meeting, is the MSSP Hypertension: Blood Pressure Control measure. • The Optimal Diabetes Care Composite measure (Core 16; “D5”) was retired by MSSP for 2015, probably because it includes the LDL Screening Measure (for people with diabetes). Minnesota Community Measurement, the measure steward, has replaced the LDL Screening sub-measure with a Statin Use sub-measure, but this version of the measure is not in widespread use. Other options are to continue to collect the D5 sub-measures that are not already in the Vermont measure set (except for the LDL Screening measure), to adopt the Hypertension: Blood Pressure Control measure specifically for people with Diabetes, or to adopt the Medicare Shared Savings Program (MSSP) replacement Diabetes Composite (known as “D2” – it includes Hemoglobin A1C poor control and Eye Exam sub-measures). <p>The work group discussed replacing these measures, not only for 2016 but also for 2015, because guidelines have changed. Under the Green Mountain Care Board’s recently adopted measures hiatus, there is the opportunity to replace measures if guidelines have changed. Unanimous votes would imply broad stakeholder support to the GMCB.</p> <p>A third measure change, this one in the monitoring and evaluation measure set for Year 3, was also discussed. Appropriate Medications for People with Asthma is being retired by NCQA in 2016. This measure is collected at the health plan level, not at the ACO level, in Vermont’s commercial and Medicaid shared savings programs. A potential replacement is Medication Management for People with Asthma, another NCQA HEDIS measure, which looks at whether people remain on their controller medication for a period of time.</p> <p>The co-chairs asked if the group was prepared to make a recommendation for replacement of the asthma measure for Year 3. Susan Aranoff made a motion by exception to replace Appropriate Medications for People with Asthma with Medication Management for People with Asthma in the Year 3 (2016) Monitoring and Evaluation measure set. Rick Dooley seconded the motion. There were no exceptions or abstentions; the motion carried unanimously.</p> <p>The discussion returned to the Hypertension measure. Pat referenced Attachment 4c, a memo from Health Commissioner Harry Chen regarding the Blood Pressure Control measure, and indicated that Nicole Lukas from</p>	

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	<p>VDH could answer questions about the memo. Dr. Virginia Hood from UVMHC joined the meeting to share her expertise on Hypertension. She presented Attachment 4e.</p> <p>Dr. Hood described why we should focus on hypertension; it is a pervasive and controllable risk factor for various serious chronic conditions. She said that despite some suggestions that higher blood pressure targets might be acceptable for older adults, a blood pressure of 140/90 for adults appears to be the best target. The systolic number is the most important. In terms of selecting a performance measure, she suggested:</p> <ul style="list-style-type: none"> • Percent at or below goal compared to a national or local benchmark • Percent at or below goal individualized for each patient • Percent with BP and other CV risk factors controlled <p>Pat noted that the measure under consideration is the same as the MSSP measure: the percentage of people diagnosed with hypertension whose blood pressure is in control. She noted that the description of the measure and its numerator in Attachment 4b is incorrect – the MSSP measure has a target of 140/90 for all ages.</p> <p>Diane Leach asked about measuring blood pressure when it may fluctuate. Dr. Hood noted that blood pressure naturally fluctuates based on our surroundings and circumstances. In an office setting, the lowest blood pressure should be recorded if there is more than one measurement. Risk from hypertension occurs over time (10-30 years), not from one measurement that falls into the high range. We can put patients on a medication treatment regimen and suggest they take steps to reduce their risk. Patients need to be involved, so that they can have control, understand how to improve blood pressure, and obtain support in doing so.</p> <p>Heather Skeels noted that there will always be a group of people for whom 150 is appropriate, and that this would be reflected in benchmarks -- having 100% of people at 140/90 is probably not achievable. Miriam noted that the ACOs are using the MSSP measure, which identifies the percentage of patients with a blood pressure measurement of 140/90 or lower. Dr. Hood noted that this measure shows results for the whole population, but would also allow ACOs to report back to providers regarding patients who need further follow up. It could support a team approach to improving management of chronic conditions.</p> <p>The work group expressed its appreciation for Dr. Hood’s presentation.</p> <p>Catherine asked if the group felt comfortable making a recommendation for replacement measures for Year 2 today. In terms of replacing LDL Screening with Blood Pressure Control, Rick Dooley asked if Blood Pressure Control would have to be a payment measure, given that the LDL screening measure is a payment measure. Nicole Lucas noted that Vermont does well with blood pressure control; the state is already showing 71% compliance for this measure, which is above the national benchmark. Catherine clarified that the vote would be</p>	

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	<p>to replace the payment measure with a payment measure.</p> <p>Heather Skeels made a motion for Year 2 (2015) of the Medicaid and Commercial Shared Savings Programs to eliminate the LDL Screening payment measure and replace it with the Medicare Shared Savings Program Blood Pressure Control measure as a payment measure; and to eliminate the Diabetes Care Composite (“D5”) reporting measure and replace it with the Medicare Shared Savings Program (“D2”) measure as a reporting measure. Sue Aranoff seconded the motion.</p> <p>Pat clarified that the Blood Pressure Control measure would align with the MSSP measure; it would have a target blood pressure of 140/90 or lower for all ages.</p> <p>A roll call vote was taken to ensure a quorum remained; the motion carried unanimously, with no abstentions or no votes.</p>	
<p>8. Next Steps, Wrap Up and Future Meeting Schedule</p>	<p>Next Meeting: Monday, June 22, 2015; 9:00 am – 11:00 am; EXE - 4th Floor Conf Room, Pavilion Building; 109 State Street, Montpelier. Please note that it is necessary for ALL visitors to have proper photo identification when signing in at the Kiosk Desk on the 1st floor.</p>	