QPM Work Group Agenda
11-24-14

VT Health Care Innovation Project
Quality and Performance Measures Work Group Meeting Agenda
November 24, 2014; 10:00 AM to 12 Noon
Pavilion Building 4th Floor Conference Room, Montpelier, VT
Call-In Number: 1-877-273-4202 Passcode: 420323867

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00-10:05	Welcome and Introductions; Approval of Minutes	Attachment 1 – October QPM Minutes	YES – Minutes Approval
2	10:05-10:20	Updates • Year 2 ACO Shared Savings Program Measures Review Process • CMS Decision on Sample Size for Clinical Measures (reduced from 411 to 248 records) ***Public Comment***		
3	10:20-10:50	ACO Improvement Efforts Related to Medicare and Vermont Commercial/Medicaid Shared Savings Program Measures (OneCare Vermont) ***Public Comment***	Attachment 3 – OneCare Quality Measurement and Improvement	
4	10:50-11:20	VITL Gap Analysis & Remediation Plan ***Public Comment***	Attachment 4 – VITL Gap Analysis & Remediation Plan	
5	11:20-11:55	Targets & Benchmarks for Year 2 ACO Payment Measures ***Public Comment***	Attachment 5a – Memo from Payment Models Work Group to Quality & Performance Measures Work Group Re: Year 2 Targets and Benchmarks Attachment 5b – Year 2 Targets and Benchmarks Presentation ear 2 Payment Measure National Benchmarks – Medicaid Attachment 5d – Year 2 Payment	YES – Recommendation about Year 2 Commercial and Medicaid Targets & Benchmarks (for PMWG)

			Measure National Benchmarks -- Commercial	
6	11:55-12:00	Next Steps, Wrap-Up and Future Meetings ***Next Meeting: December 22***		

Attachment 1 - QPM Minutes 10-27-14

VT Health Care Innovation Project
Quality & Performance Measures Work Group Meeting Minutes

Date of meeting: October 27, 2014, 10:00 am-12 pm, 4th Floor Conf. Room, Pavilion Building, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approval of Minutes	Cathy Fulton Called the meeting to order at 10:00 am. Georgia Maheras took a roll call of attendees. Cathy announced Frances Keeler's retirement and thanked her for her contributions to the QPM work group. Suzanne Levitt will join the work group as a member for DAIL. The group reviewed minutes from August and September 2014. Joyce Gallimore moved to approve the August and September minutes. Vicki Loner seconded. There was no discussion and a roll call vote was taken. The motion passed unanimously.	
2. Updates	Year 2 ACO Shared Savings Program Measures Review Process: - The Core Team and the GMCB reviewed the recommendations of the QPM Work Group. They voted to promote the two outcome measures Diabetes HbA1c Poor Control and Ambulatory Care Sensitive Conditions Readmissions (composite) from reporting to payment. They also voted to promote Cervical Cancer Screening and Tobacco Use Screening and Cessation Intervention from Pending to Reporting; to move Breast Cancer Screening from Reporting to Monitoring and Evaluation (M&E); to move SBIRT from Pending to M&E; and to use Developmental Screening as a Reporting measure for the commercial SSP. They also voted to add the Custom DLTSS Patient Experience Survey questions to Reporting, and LTSS Rebalancing to M&E. - They did not support the following: Promotion of Pediatric Weight Assessment and Counseling from Reporting to Payment; promotion of Avoidable ED Visits from M&E to Reporting. - GMCB wants to discuss a hiatus for shared savings program measure changes for year 3. To be discussed and voted on at the next Board meeting, Thursday, November 6th. - The Healthcare Advocate has asked for an extension for public comments on the proposal for a	

Agenda Item	Discussion	Next Steps
	hiatus in measure changes (original deadline for public comment was Monday, October 27th, 2014; deadline subsequently changed to Tuesday, November 4th). • The processes for reviewing targets, benchmarks, and the gate and ladder methodology will be discussed further at the November meeting. The Payment Models Work Group will begin the discussion, and will solicit specific points for QPM input.	
3. ACO Improvement Efforts Related to Medicare and Vermont Commercial/Medicaid Shared Savings Program Measures (Health*first* and CHAC)	Amy Cooper from Health*first* gave a presentation on their ACO quality improvement efforts to date (Attachment 3a). Follow up discussion: - Will focus on quality improvement help ACOs earn shared savings in future? Effort around wellness visits, helping people self-manage and take care of themselves; reducing costly hospitalizations and lowering costs. - Develop initiatives that relate to the specific measures (e.g. CHF program). Change in performance on measures indicates programs are working, but may not see results in short time period. Impact will be over a longer term. - Downside risk has been an ongoing discussion at the leadership level but no decisions have been made. - 2013 template is oriented toward Medicare SSP measures and is now being modified to incorporate commercial SSP measures. They are trying to look at workflow and add into the EHR without adding extra work for practitioners. - PHQ2 is an initial screen for depression. Are there instructions and resources for the practice when screens are positive? If positive screen indicates that a patient may be experiencing depression, there needs to be a follow up plan. - Sharing data and addressing gaps: providers will be given the data and Health*first* will work with providers to perform better in those areas where they are underperforming compared to other practitioners. - Provider response to measurement check lists: check lists are simplified for presentation to clinicians. Detailed versions with specifications and exclusion criteria are used with practice managers. - Reporting tools: they are developing a new tool where providers will be able to access data electronically but historically it's been regularly reported in hard copy. Providers are named on the reports- the individual physicians are named and they can see how they compare to other providers. - ACOs are working on a joint data collection tool.	

Agenda Item	Discussion	Next Steps
	- The data is risk adjusted but it's not 100% accurate because providers have not had to code all conditions before. Joyce Gallimore and Patty Launer gave a presentation on CHAC's ACO quality improvement efforts to date (Attachment 3b). Follow up discussion: - How were QI initiatives identified? Medicare data and Blueprint data show opportunities for improving care OR improving data capture. For example, fall risk is not being captured in the EHR. - Effort is being made to get patients into care management programs if necessary, as the attributed lives are being reported. - Primary care standards and integration with non-primary care: working with VDH, Behavioral Health Network and VNAs. FQHCs have been leaders in promoting a holistic vision of care. Integration of care is sometimes addressed with co-location models- which result in non-primary care providers (e.g., mental health practitioners) being located at primary care practices. - Currently addressing issues for FQHCs that are on different EHR platforms. Working on identifying elements that are necessary to extract data in an easy and automated way. Provider concern about capture and extraction of data; adding FTEs and increasing budgets to accommodate tracking new measures. OneCare will give its presentation next month. Vicki Loner provided a preview of that presentation.	
4. Revised QPM Work Plan	Pat Jones reviewed the changes in the QPM work group work plan (Attachment 4). - VITL will present the gap analysis at the November work group meeting. - Lewin, the GMCB analytics contractor, may be able to report preliminary claims based measures in November for the Year 1 Medicaid and commercial SSPs. Work group members should email any additional suggestions on the work plan to Pat and Alicia; the work group will vote on the revised work plan during the November or December meetings so that the new work plan will be in effect for January.	
5. Year 1 Measure Reporting	Work group members were asked to think about what they might like to see in the SSP measure reporting templates, and how the data should be presented for various audiences. The staff and Co-Chairs will present the group with mock-up templates from the Analytics Contractor for discussion at an upcoming meeting.	

Agenda Item	Discussion	Next Steps
6. Next Steps, Wrap up, and Future Meeting Schedule	**Next meeting:** Monday, November 24, 2014, 10 am-12 pm, 4th Floor Conf. Room, Pavilion Building, Montpelier. **Members should notify Pat and Co-Chairs if they think they will not attend the next meeting, given that it takes place during the week of Thanksgiving.**	

(26)

VHCIP QPM Work Group Attendance List ~~8-25-14~~ 10.27.14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

First Name	Last Name		Title	Organization	QPM
Peter	Albert			Blue Cross Blue Shield of Vermont	MA
April	Allen		Director of Policy and Planning	AHS - DCF	X
Bill	Ashe		Executive Director	Upper Valley Services	X
Ena	Backus			GMCB	X
Michael	Baillt			Baillt-Health Purchasing	X
Susan	Barrett		Executive Director	GMCB	X
Jaskanwar	Batra			DMH	M
Kate	Bazinsky			Baillt-Health Purchasing	X
Charlie	Biss			AHS - Central Office - IFS	X
Catherine	Burns		Director of Quality for Mental Health	HowardCenter for Mental Health	M
Deb	Chambers			MVP Health Care	M
Amanda	Clecior		Health Policy Analyst	AHS - DVHA	S
Peter	Cobb		Executive Director	VNAs of Vermont	X
Connie	Colman		Quality Improvement Director	Central Vermont Home Health and Hospi	M
Amy	Coonradt		Health Policy Analyst	AHS - DVHA	X
Amy	Cooper		Executive Director	Accountable Care Coalition of the Green	M
Alicia	Cooper		Quality Oversight Analyst	AHS - DVHA	S
Jude	Daye			Blue Cross Blue Shield of Vermont	A
Yvonne	DePalma		Senior Director of Centralized Suppor	Planned Parenthood of Northern New En	M
Robin	Edelman		Health Systems Program Administrat	AHS - VDH	X
Audrey	Fargo		Administrative Assistant	Vermont Program for Quality in Health C	A
Aaron	French		Deputy Commissioner	AHS - DVHA	M
Catherine	Fulton		Executive Director	Vermont Program for Quality in Health C	C/M
Joyce	Gallimore		Director, Community Health Paymen	BI State Primary Care/CHAC	M
Lucie	Garand		Senior Government Relations Special	Downs Rachlin Martin PLLC	X
Christine	Geiler		Grant Manager & Stakeholder Coord	GMCB	S
Bryan	Hallett				X
Paul	Harrington		President	Vermont Medical Society	M
Kathleen	Hentcy		Health Care Integration Liaison	DMH	X

Bard	Hill		Director - Policy, Planning & Data Uni	AHS - DAIL	X
Craig	Jones		Director	AHS - DVHA - Blueprint	X
Pat	Jones			GMCB	S/M
Frances	Keeler		Director	AHS - DAIL	M
Heidi	Klein		Heidi Klein	AHS - VDH	M
Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
Patricia	Launer		Clinical Quality Improvement Facilitat	Bi-State Primary Care	MA
Diane	Leach		VP Quality	Northwestern Medical Center	M
Diane	Lewis			AOA - DFR	A
Deborah	Lisi-Baker		Disability Policy Expert	Unknown	X
Vicki	Loner		Director of Quality and Care Manage	OneCare Vermont	M
Nicole	Lukas		Cancer & Cardiovascular Disease Pre	AHS - VDH	X
Georgia	Maheras			AOA	S
David	Martini			AOA - DFR	M
Marybeth	McCaffrey		Principal Health Reform Administrato	AHS - DAIL	X
Kim	McClellan		Director of Quality Improvement	Northwest Counseling and Support Servic	X
Richard	McCoy			AHS - VDH	X
Kate	McIntosh		Medical Director	Vermont Information Technology Leader	M
Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
Darcy	McPherson		Program Technician	AHS - DVHA	X
Jessica	Mendizabal			AHS - DVHA	S
Robin	Miller			AHS - VDH	MA
Anna	Noonan		Vice President	Jeffords Institute for Quality, FAHC	M
Susan	Onderwyzer		Quality & Care Management Director	AHS - DMH	M
Annie	Paumgarten		Eveluation Director	GMCB	X
Laura	Pelosi		Executive Director	Vermont Health Care Association	C/M
Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
Betty	Rambur		Board Member	GMCB	X
Allan	Ramsay		Board Member	GMCB	X
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green	M
Lila	Richardson		Attorney	VLA/Health Care Advocate Project	M
Jenney	Samuelson		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
Rachel	Seelig		Attorney	VLA/Senior Citizens Law Project	M
Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	MA
Kate	Simmons		Director, VT Operations	Bi-State Primary Care/CHAC	MA
Colleen	Sinon		VP of Quality Programs	Northeastern Vermont Regional Hospital	X
Shawn	Skaflestad		Quality Improvement Manager	AHS - Central Office	M

Heather	Skeels		Project Manager	Bi-State Primary Care	M
Richard	Slusky		Payment Reform Director	GMCB	MA
Joe	Smith			MVP Health Care	MA
Jennifer	Stratton			Lamoille County Mental Health Services	M
Kara	Suter		Reimbursement Director	AHS - DVHA	X
Julie	Tessler		Executive Director	Vermont Council of Developmental and M	X
Cynthia	Thomas			AHS - DVHA	MA
Win	Turner				X
Teresa	Vocl				X
Nathaniel	Waite			VDH	X
Anya	Wallack		Chair	SIM Core Team Chair	X
Marlys	Waller			Vermont Council of Developmental and M	X
Norm	Ward		Medical Director	OneCare Vermont	MA
Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	X
Monica	Weeber			AHS - DOC	M
Robert	Wheeler		Vice President & CMO	Blue Cross Blue Shield of Vermont	M
Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
Jennifer	Woodard		Long-Term Services and Supports He	AHS - DAIL	X
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
Dave	Yacovone		Commissioner	AHS - DCF	X
Mike	Maslack				X
[illegible]	[illegible]	CA	Pub'l Hlth Advisor	VDH/[illegible]	
Rick	Dooley		ACCGM		
Jim	Westrich				

QPM Roll call 10.27.14

1° Joyce 8/25/14
2° Vicki

9/22/14

Kathleen Hentey	DMH	✓	
Catherine Burns	Howard Center	✓	
Amy Cooper	ACCGM	✓	
Joyce Gallimore	CHAC	✓	
Cathy Fulton	UPQHC	✓	
Paul Harrington	UMS	✓	
Fran Keeler	DAIL	✓	
Heidi Klein	VDH	✓	
~~Kathy Carr~~ Pat Jones	CMCB	✓	
Vicki Loner	OCV	✓	
Lila Richardson	HCA / VLA	✓	
Rachel Seelig	HCA /	✓	
Shawn Skaflestad	AHS-CO	✓	
Heather Steels	Bi state	✓	
Cynthia Thomas	DUHA	✓	
Bob Wheeler	BCBS	A	

Attachment 3 - OneCare Quality Measurement and Improvement

Quality Measurement and Improvement

November 24, 2014

OneCare Vermont Clinical Advisory Board
Vicki Loner MHCDS, RN.C
Director, OneCare Vermont Clinical Operations

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Agenda Objectives

I. Understand OneCare Vermont's Provider Governance Structure

II. Review Quality Measurement Findings and Priorities
   - Medicare Yr. 1 Findings
   - Mid-year analysis of Clinical Priorities

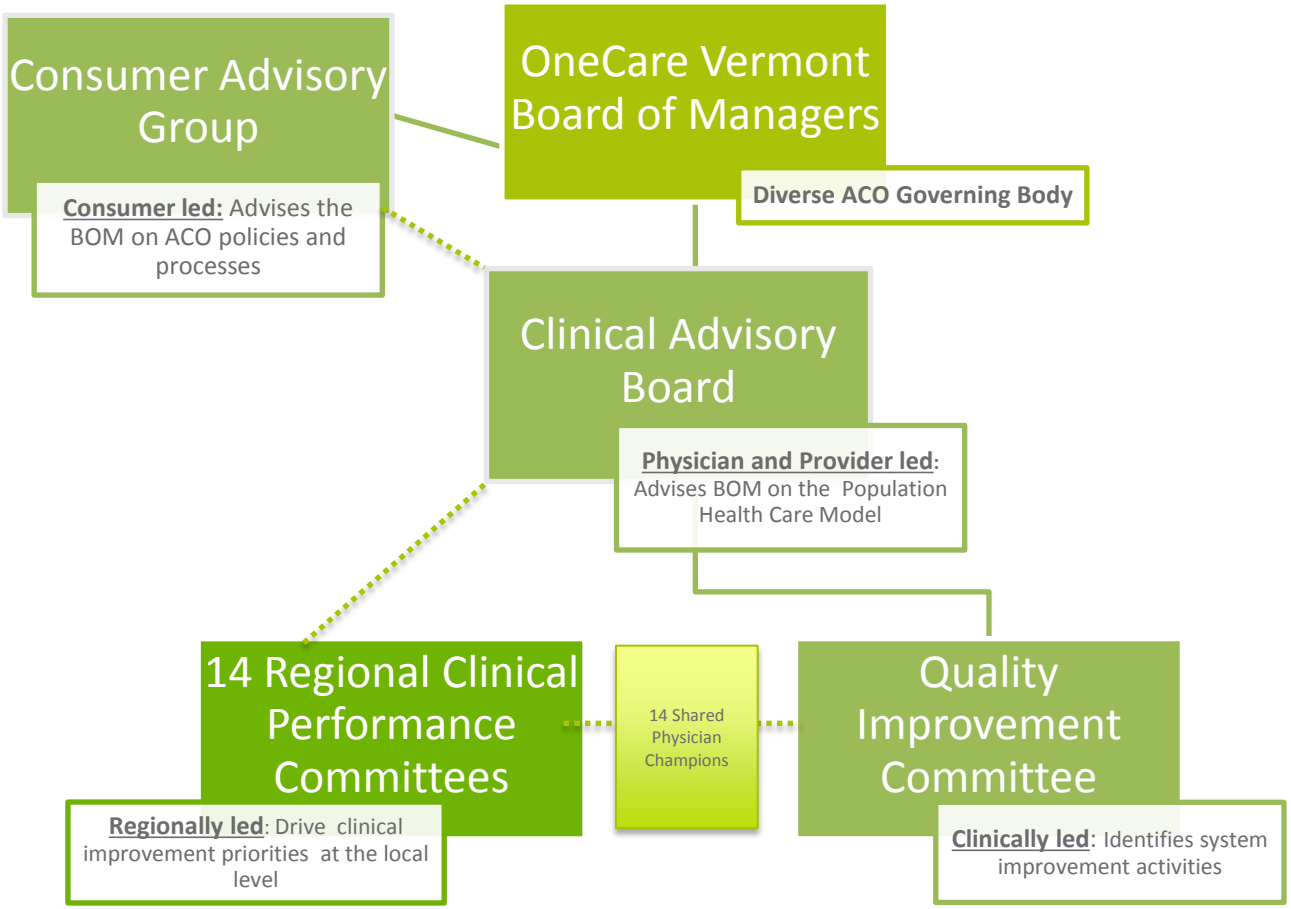
III. Review of how Regional Clinical Performance Committees are leading the way
   - Case Examples

IV. Review of ACO Collaboration Efforts

Governance Structure

Engaged Multi-disciplinary Boards and Committees

Governance that focuses on improvements with health outcomes, costs, and consumer experience



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019

Consumer Advisory Board

Composition:

- Currently 13 person Consumer Advisory Group
- Facilitated by OneCare Medical Director Leadership
- OneCare Board Member representation: including Physicians and Consumers

Charge:

- Provide consumer input into ACO policies in order to improve consumer access, quality of care and satisfaction

Connection Points:

- Board of Managers (BOM): OneCare Physician Board Manager attends the Consumer Advisory Group and reports up via the Board
- Clinical Advisory Board (CAB): OneCare Medical Director facilitates the Consumer Advisory Group and reports to the CAB
- Quality Improvement Committee (QIC):OneCare Chief Medical Officer for Medicaid/Commercial attends the Consumer Advisory Group

020

Clinical Advisory Board

Composition:

- Co-Chaired by Founding organizations Physician Executives
- Providers appointed by OneCare Vermont (OCV) Accountable Care Organization participants and approved by the Board of Managers

Charge:

- Developing and implementing a population health care model designed to achieve high quality, coordinated, and efficient health care delivery

Connection Points:

- Consumer Advisory Group (CAG): OCV CMO who co-chairs CAB and QIC attends the CAG
- Regional Clinical Performance Committee (RCPC): Contracted Physician Reps attend and report up via CAB
- Quality Improvement(QI): RCPC Contracted Physicians voting members of the QIC

021

Quality Improvement Committee

Composition:

- Co-Chaired by Founding organizations Physician Executives
- Founders VPs of Quality and Clinical Integration/Population Health (4)
- Founders Directors of Quality and Clinical Operations (2)
- Contracted Regional Physician Representatives (14)

Charge: Identify and recommend clinical quality priorities to the CAB and support the RCPCs in carrying out the priorities

Connection Points:

- Clinical Advisory Board (CAB): Contracted Physician Reps attend and report up through the CAB and/ or are members of the CAB
- Regional Clinical Performance Committee (RCPC): Contracted Physician Reps are members if the QIC

022

Regional Clinical Performance Committees

Proposed Composition:

- OneCare contracted physician representatives, other ACO's, BP, and HSAs
- Participants/Affiliates of the ACO's
- Participants of the CHT
- State employees directly involved in care coordination activities
- Community providers

Charge: Lead identified performance improvement activities

Connection Points:

- Clinical Advisory Board (CAB): Contracted Physician Reps attend and report up through the CAB and/ or are members of the CAB
- Quality Improvement Committee (QIC): Contracted Physician Reps are members if the QIC

Year 1 Medicare Findings

OneCare Results

2013 Medicare Results

Domain	Measure		PY1	PY2	PY3	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	OCV Score	n	Quality Points
Patient/Caregiver Experience	1	Getting Timely Care, Appointments, and Information	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	83.81	476	1.85
	2	How Well Your Doctors Communicate	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	92.54		2.00
	3	Patients' Rating of Doctor	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.84		2.00
	4	Access to Specialists	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	82.21		1.85
	5	Health Promotion and Education	R	P	P	54.71	55.59	56.45	57.63	58.22	59.09	60.71	59.46		1.85
	6	Shared Decision Making	R	P	P	72.87	73.37	73.91	74.51	75.25	75.82	76.71	75.98		1.85
	7	Health Status/Functional Status	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	73.70		2.00
Care Coordination/ Patient Safety	8	Risk Standardized, All Condition Readmissions	R	R	P	16.62	16.41	16.24	16.08	15.91	15.72	15.45	14.75	-	2.00
	9	ASC Admissions: COPD or Asthma in Older Adults	R	P	P	1.24	1.02	0.84	0.66	0.52	0.36	0.00	1.25		0.00
	10	ASC Admission: Heart Failure	R	P	P	1.22	1.03	0.88	0.72	0.55	0.40	0.18	1.22		1.10
	11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	P	51.35	59.70	65.38	70.20	76.15	84.85	90.91	57.55	629	2.20
	12	Medication Reconciliation	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	73.81	547	1.70
	13	Falls: Screening for Fall Risk	R	P	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	46.30	432	1.70
Preventive Health	14	Influenza Immunization	R	P	P	29.41	39.04	48.29	58.60	75.93	97.30	100.00	71.36	398	1.55
	15	Pneumococcal Vaccination	R	P	P	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.73	440	1.55
	16	Adult Weight Screening and Follow-up	R	P	P	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.94	413	1.55
	17	Tobacco Use Assessment and Cessation Intervention	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.37	417	2.00
	18	Depression Screening	R	P	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	24.71	344	1.55
	19	Colorectal Cancer Screening	R	R	P	19.81	33.93	48.49	63.29	78.13	94.73	100.00	65.33	424	1.55
	20	Mammography Screening	R	R	P	28.59	42.86	54.64	65.66	76.43	88.31	99.56	68.04	413	1.55
	21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.66	351	1.55
At-Risk Population Diabetes	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	P	P	17.39	21.20	23.48	25.78	28.17	31.37	36.50	23.08	416	1.25
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00	22.12	416	1.70
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	67.04	443	1.40
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	P	P	35.00	42.86	51.41	57.14	61.60	67.29	78.81	60.92	412	1.55
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P	45.44	56.88	68.25	78.77	85.00	91.48	97.91	86.65	412	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	81.78	236	1.85
At-Risk Population CAD	CAD Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P	54.08	61.44	66.11	69.96	72.32	76.40	79.84	58.95	458	1.10

This score is subject to change depending on the outcome of the discussions with CMS about OCV's score on measure 11.

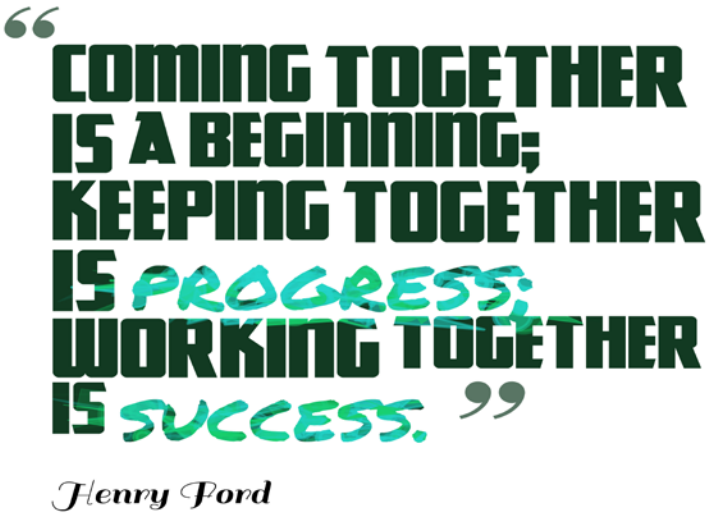
2013 was a reporting-only year for OCV. Since OCV successfully reported on all quality measures our score is **100%.** However, had 2013 been a performance year for OCV, our score would have been:

78.4%

Clinical Priorities: Success stories from around the State

The Majority of Health Service Areas and select practices completed a deeper dive on the 4 Clinical Priorities for 2014:

- Diabetes Composite
- Coronary Composite
- Readmissions
- Frequent ER user



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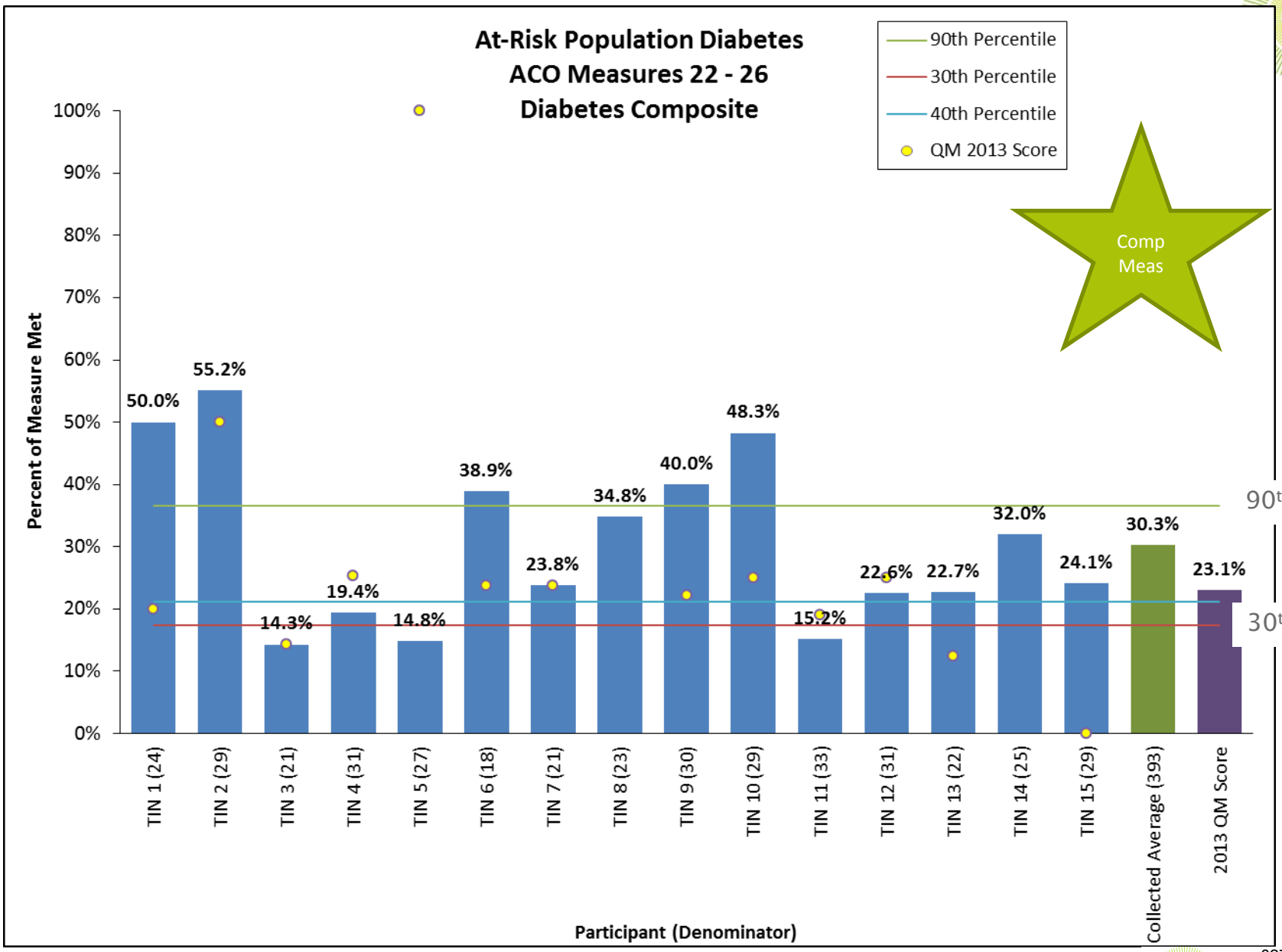

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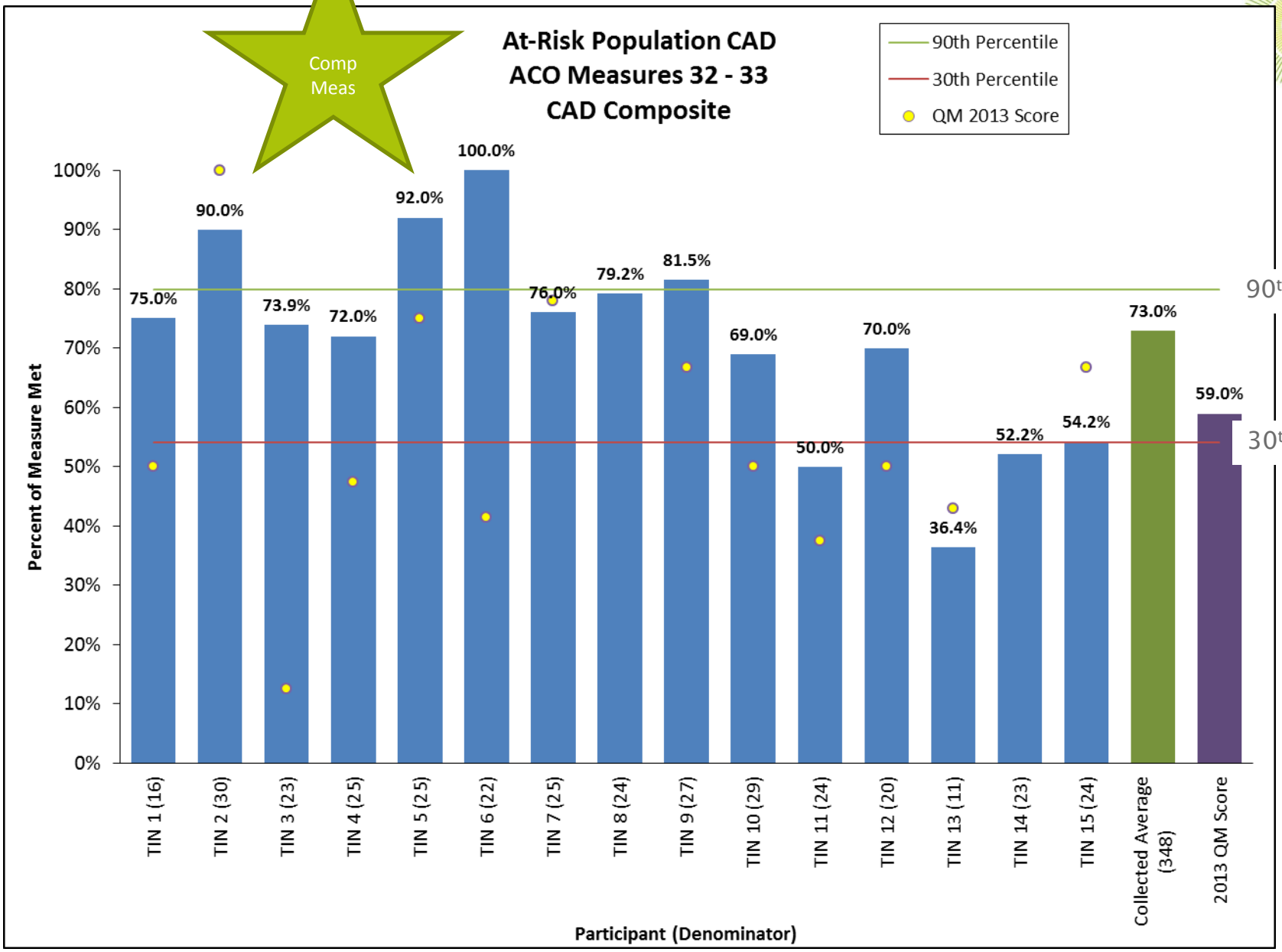

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Inpatient Readmission Case Findings Reveal Opportunities for Newly Dx and Complex Populations

Practices & Health Services Participated in a deep dive case analysis on at least 3 patients who had been readmitted within 30 days of a hospital discharge

- Top reasons for readmission were: new dx/ and or a complex pt. with challenges adhering to treatment regimen
  - > 50% noted that their planned/ actual Interventions included developing a dx specific plan of care
  - >25% noted that their planned/ actual intervention involved improved communication and/or transitions with the community at large

Frequent ER User Findings Reveal Opportunities for Chronic and at Risk Populations

Practices & Health Services Participated in a deep dive case analysis on at least 5patients who had been to the ER 3 or more times in a calendar year

- Top reasons for ER visits: Chronic and Complex pt. with challenges adhering to treatment regimen
  - > 50% noted that their planned/ actual Interventions included developing a dx specific plan of care
  - >25% noted that their planned/ actual intervention involved improved communication and/or transitions with the community at large

030

Regional Clinical Performance Committees

Leading the Change

Amazing Team Work Happening Around the State

- 71% of the Health Service Areas have either started a regional clinical performance committee or are in progress of developing a committee to address the clinical priorities

- 100% of the Health Service Areas are engaged in clinical performance improvement work

Bennington Regional Clinical Performance Committee Working Together as a Community to Understand ER Admissions… ***"It's not about the diagnosis… it's about the patient"***

- Meeting for years as Regional Communications Group
  - Subgroup working on ED utilization
- Reviewed data from January through May 2014
  - Population: 732 patients with 5+ visits to the ED- Extensive drill down by PCP, day of week, time of day, discharge disposition, financial class, type of visit, referral to Medicaid CM, Care plans in place

Next Steps… *Community Based Partners meet weekly to review specific patients*

- Continuum of care providers: Designated Mental Health Provider, Home health
- Transitional care nurses from SVMC
- Blueprint, SASH, SPOKE Services
- Local Department of Health & HHS
- Council on Aging, Housing, VCIL

033

Berlin Regional Clinical Performance Committee Beginnings and Evolution

- Beginning: Internal CVMC group (Med Director, CAB members, BluePrint members) to implement OneCare VT initiatives within CVMC
- Evolution: After a few meetings, realized they needed to involve community members. Invited CV Home Health and Hospice and Washington County Mental Health. Further expanding to include SNF and merge with BluePrint community

Berlin RCPC Pilot Program for Care Management of Complex Chronic Care Population

Targeting Criteria:

- CHF, COPD, DM as primary dx
- At least one inpt admission AND one ER visit to CVMC, FAHC or DHMC
- Claims from Home Health OR Wash Co Mental Health
- Meet all above and are NNEACC moderate financial risk (85%-94%)

Interventions:

- Aggressive management of care transitions
- Close interaction and sharing of information between care coordinators (main care manager, CVHHHA, WCMH) and PCPs
- At least one in-person contact/month by main care manager
- PCP aware of patient's risk and program
- Self-management including intense education on medication adherence; evidence-based education on behavior change
- Depression screening

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Collaboration

Training and Aligning Measurement

Solid ACO Collaboration on Quality Measurement, Materials, Training, and Collection

Training Materials

- Standardized presentations and "pearls" completed for Medicare, Medicaid, and Commercial – same for all ACO's

Participant Training

- Training to start in December and January via web-ex –jointly hosted by all 3 ACO's
- Individualized training being performed by the ACOs

Collection

- Collection "menu options" between OneCare and CHAC are the same when participating providers are in both ACO's
- Spreadsheet tools being developed by OneCare that will be jointly utilized by all ACOs for Medicaid and Commercial measures
  - For those practices that can extract the information from their EMR another type of spreadsheet is being developed by OneCare that will allow electronic abstraction
- All ACO's jointly coordinating collection dates so that the office practice desires are priority #1

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Thank you and Questions

Attachment 4 – VITL Gap Analysis & Remediation Plan

Gap Remediation Proposal

Proposal to the VHCIP HIE/HIT Work Group

November 19, 2014

Accountable Care Coalition of the Green Mountains
Established by Healthfirst, Inc.

OneCareVermont

Community Health Accountable Care LLC
Transitioning Our Communities for Better Health

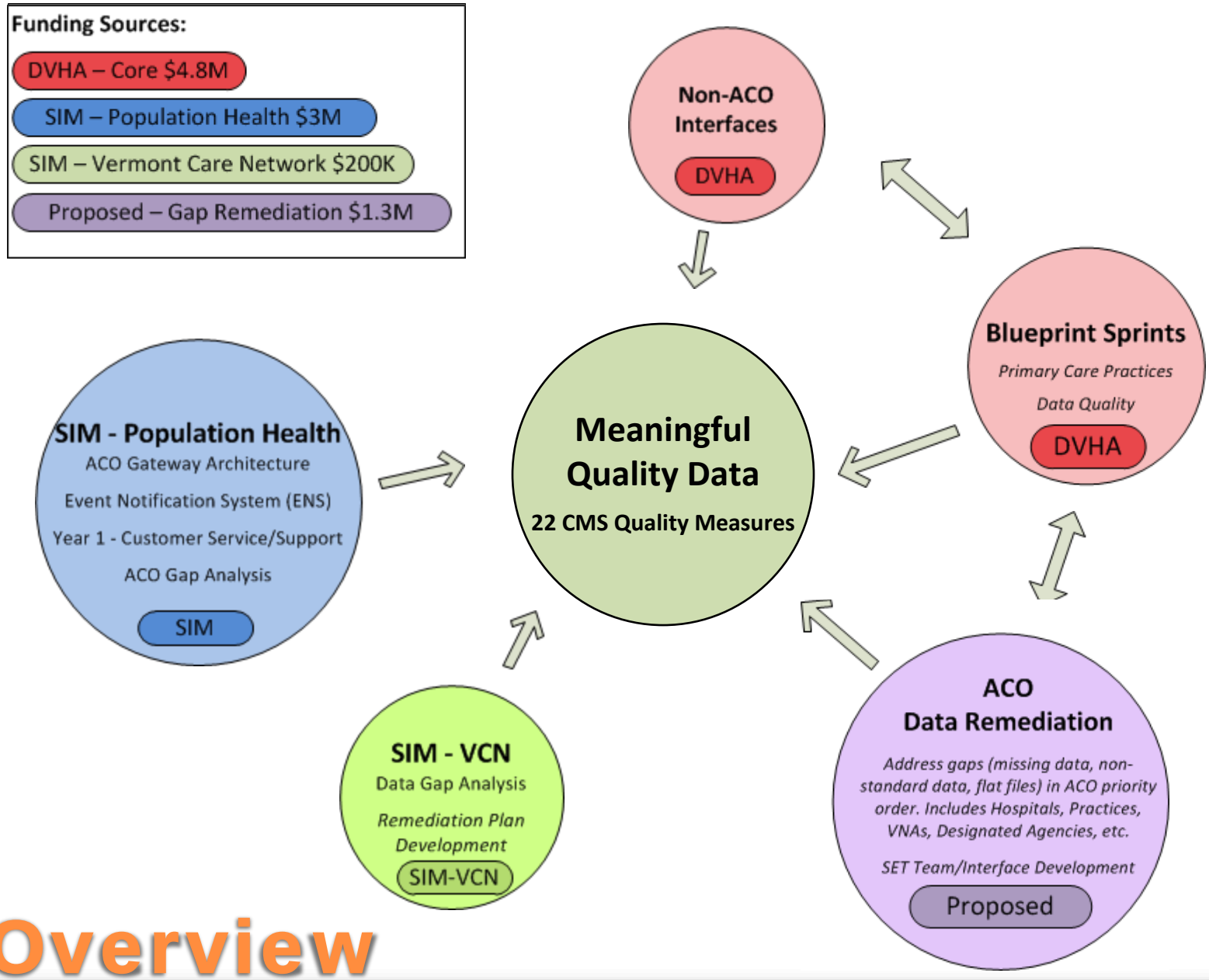
VITL

Vermont Health Care Innovation Project

Key Components of Remediation

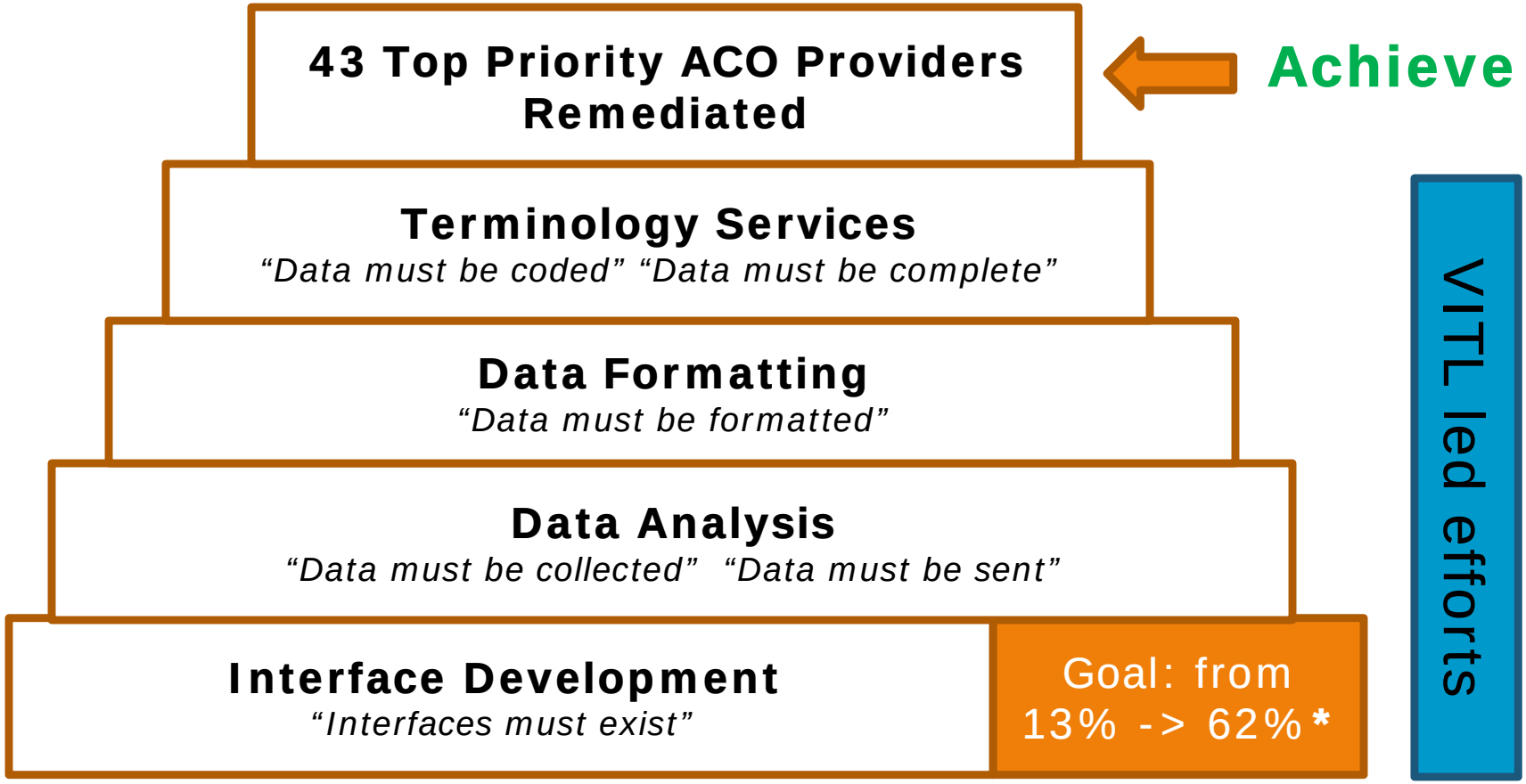
Achieve accurate, comprehensive performance data utilizing electronic health records (EHRs) and the Vermont Health Information Exchange (VHIE)

- ✓Interfaces
- ✓Data Analysis and Formatting
- ✓Terminology Services


Funding Sources:
DVHA – Core $4.8M
SIM – Population Health $3M
SIM – Vermont Care Network $200K
Proposed – Gap Remediation $1.3M
Non-ACO Interfaces
DVHA
Blueprint Sprints
Primary Care Practices
Data Quality
DVHA
SIM - Population Health
ACO Gateway Architecture
Event Notification System (ENS)
Year 1 - Customer Service/Support
ACO Gap Analysis
SIM
Meaningful Quality Data
22 CMS Quality Measures
SIM - VCN
Data Gap Analysis
Remediation Plan Development
SIM-VCN
ACO Data Remediation
Address gaps (missing data, non-standard data, flat files) in ACO priority order. Includes Hospitals, Practices, VNAs, Designated Agencies, etc.
SET Team/Interface Development
Proposed

Overview

State of Remediation for ACO Providers Based on Beneficiary Population Size



*All ACOs have identified interface priorities. Expectation is to achieve 62% of beneficiary data for ACCGM and OCV top priority practices.
CHAC beneficiary totals TBD.

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SET Team –

- Medicity resources dedicated to VT-only interface development for a six month period.
- Approved as part of previous SIM funding to accelerate interface development
- Purposely delayed by VITL because Medicity was not done with previous work on VITLAccess

SET Team approval *required* as a prerequisite to other remediation work

Set Team

ACO and VITL Recommendation

Type of Cost	*Cost*
SET Team/New Interface Development (6 months) ***Prerequisite***	$650,000
Gap Remediation (1 Year)	$367,500
Terminology Service (2 years)	$284,000
Remediation Proposal Total	**$1,301,500**

Budget

- Quarterly gap analysis reviews
- Monthly status reports regarding remediation progress
- Develop progress metrics
- Just in Time communication of roadblocks, obstacles, issues, etc.

Progress Management

SET Team / New Interface Development

- ☑ Accelerates interface development. This is a Prerequisite for full data remediation.

Data Analysis and Formatting

- ☑ Increases the percentage of data that can meet the ACO quality measures in an electronic reportable way and reduce the need for chart abstracts (aka chart “pulls”).

Terminology Services

- ☑ Enhances clinical data quality

Summary

Questions?

Attachment 5a – Memo from Payment Models Work Group to Quality & Performance Measures Work Group Re: Year 2 Targets and Benchmarks

MEMO

DATE: November 17, 2014
TO: VHCIP Quality & Performance Measures Work Group
FROM: VHCIP Payment Models Work Group
RE: Request for Input – Year 2 ACO Measure Targets & Benchmarks; Year 2 Medicaid SSP Gate & Ladder

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The VHCIP Payment Models Work Group (PMWG) will be making formal recommendations to the VHCIP Steering Committee and Core Team regarding Year 2 ACO measure targets and benchmarks for both the Medicaid and Commercial Shared Savings Programs (SSPs), as well as the Year 2 Gate & Ladder for the Medicaid Shared Savings Program. The PMWG has opened a period of public comment on these topics through the close of business on Friday November 28, 2014.

To aid in the development of these recommendations, the PMWG is soliciting input from the Quality and Performance Measures Work Group (QPM) on the following:

1. The selection of benchmarks for the Commercial and Medicaid Shared Savings Programs for Year 2 ACO Payment Measures.
2. The setting of performance targets for the Commercial and Medicaid Shared Savings Programs for Year 2 ACO Payment Measures.

Although the PMWG is not seeking specific recommendations from QPM regarding changes in Year 2 to the Gate & Ladder methodology, QPM members are invited to submit any comments they may have on this topic to PMWG for consideration. Comments may be directed to Mandy Ciecior (Amanda.Ciecior@state.vt.us) before the deadline above.

The PMWG will review recommendations from QPM, as well as any public comment received, during their December 1, 2014 meeting.

Attachment 5b – Year 2 Targets and Benchmarks Presentation

Year 2
Benchmarks & Performance Targets: Commercial & Medicaid Shared Savings Programs

Quality & Performance Measures Work Group Meeting

November 24, 2014

Overview

- Review
  - Year 1 Payment Measures
  - Year 1 Benchmarks & Targets
- Changes to Year 2 Payment Measures
- Options for Updating Performance Benchmarks & Targets in Year 2

Year 1 Payment Measures

Year 1 Payment Measure		Medicaid SSP	Commercial SSP
Core-1	Plan All-Cause Readmissions	X	X
Core-2	Adolescent Well-Care Visits	X	X
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	X	X
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	X	X
Core -5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	X	X
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	X	X
Core-7	Chlamydia Screening in Women	X	X
Core-8	Developmental Screening in the First Three Years of Life	X	

Year 1 Benchmarks

	Medicaid SSP	Commercial SSP
Approach: Use national HEDIS benchmarks for all measures for which they are available; use improvement targets when national benchmarks are unavailable	Core 2-7: National Medicaid HEDIS benchmarks Core 1 & 8: Improvement targets based on 2012 VT Medicaid performance	Core 1-7: National commercial HEDIS benchmarks

Year 1 Performance Targets

- *When using National HEDIS Benchmarks:*
  Compare each payment measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

- *When using Improvement Targets (Medicaid only in Year 1):*
  Compare each payment measure to VT Medicaid benchmark, and assign 0, 2 or 3 points based on whether the ACO declines, stays the same, or improves relative to the benchmark.
  - Statistical significance; targets associated with each point value are set according to ACO-specific attribution estimates

HEDIS Benchmarks		Change Relative to Historic Performance	
25th Percentile	1 Point	Statistically significant decline	0 Points
50th Percentile	2 Points	Statistically same	2 Points
75th Percentile	3 Points	Statistically significant improvement	3 Points

Year 2 Payment Measures

Year 2 Payment Measure		Medicaid SSP	Commercial SSP
Core-1	Plan All-Cause Readmissions	X	X
Core-2	Adolescent Well-Care Visits	X	X
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	X	X
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	X	X
Core -5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	X	X
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	X	X
Core-7	Chlamydia Screening in Women	X	X
Core-8	Developmental Screening in the First Three Years of Life	X	
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	X	X
Core-17	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	X	X

Suggested QPM Recommendations to PMWG

- Year 2 Benchmarks
  - Use national HEDIS benchmarks where available, and use improvement targets when national benchmarks are unavailable

	Medicaid SSP	Commercial SSP
Use national HEDIS benchmarks for all measures for which they are available; use improvement targets when national benchmarks are unavailable	Core 2-7, 17: National Medicaid HEDIS benchmarks Core 1, 8, 12: Improvement targets based on ACO-specific Year 1 Medicaid performance	Core 1-7, 17: National commercial HEDIS benchmarks Core 12: Improvement targets based on ACO-specific Year 1 commercial performance

Suggested QPM Recommendations to PMWG

- Year 2 Performance Targets
  - Use Year 1 system for assigning points for performance

HEDIS Benchmarks		Change Relative to Historic Performance	
25th Percentile	1 Point	Statistically significant decline	0 Points
50th Percentile	2 Points	Statistically same	2 Points
75th Percentile	3 Points	Statistically significant improvement	3 Points

Additional Comments?

- Additional comments regarding the Year 2 Gate & Ladder methodology can be directed to PMWG.

- Send to Mandy Ciecior (Amanda.Ciecior@state.vt.us) by close of business on Friday November 28, 2014.

Attachment 5c – Year 2 Payment Measure National Benchmarks – Medicaid

#	Measure	2012 National Medicaid HEDIS Benchmarks	2012 Vermont Medicaid Performance	2013 National Medicaid HEDIS Benchmarks	2013 Vermont Medicaid Performance
Core-1	Plan All-Cause Readmissions	National benchmark not available.	16.60	National benchmark not available.	16.62
Core-2	Adolescent Well-Care Visits	HEDIS National Medicaid CY2012 Nat. 75th: 57.07 Nat. 50th: 47.24 Nat. 25th: 41.72	46.27	HEDIS National Medicaid CY2013 Nat. 75th: 59.06 Nat. 50th: 48.42 Nat. 25th: 41.74	46.97
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	HEDIS National Medicaid CY2012 Nat. 75th: 85.20 Nat. 50th: 82.36 Nat. 25th: 78.44	45.67	HEDIS National Medicaid CY2013 Nat. 75th: 84.91 Nat. 50th: 81.44 Nat. 25th: 78.29	47.87
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	HEDIS National Medicaid CY2012 Nat. 75th: 54.64 Nat. 50th: 43.95 Nat. 25th: 30.91	42.01	HEDIS National Medicaid CY2013 Nat. 75th: 54.45 Nat. 50th: 41.94 Nat. 25th: 31.69	41.61
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	HEDIS National Medicaid CY2012 Nat. 75th: 29.64 Nat. 50th: 24.75 Nat. 25th: 20.59	33.22	HEDIS National Medicaid CY2013 Nat. 75th: 29.23 Nat. 50th: 24.08 Nat. 25th: 19.52	32.16

#	Measure	2012 National Medicaid HEDIS Benchmarks	2012 Vermont Medicaid Performance	2013 National Medicaid HEDIS Benchmarks	2013 Vermont Medicaid Performance
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	HEDIS National Medicaid CY2012 Nat. 75th: 28.07 Nat. 50th: 22.14 Nat. 25th: 17.93	28.62	HEDIS National Medicaid CY2013 Nat. 75th: 30.45 Nat. 50th: 24.31 Nat. 25th: 20.20	32.86
Core-7	Chlamydia Screening in Women	HEDIS National Medicaid CY2012 Nat. 75th: 63.72 Nat. 50th: 57.15 Nat. 25th: 50.97	51.18	HEDIS National Medicaid CY2013 Nat. 75th: 62.75 Nat. 50th: 54.97 Nat. 25th: 48.87	50.55
Core-8	Developmental Screening in the First Three Years of Life (Medicaid-only Payment measure)	National benchmark not available.	30.17	National benchmark not available.	40.47
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	National benchmark not available.	Not Reported	National benchmark not available.	Not Reported
Core-17	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	HEDIS National Medicaid CY2012 *(lower rate is better)* Nat. 75th: 36.53 Nat. 50th: 44.89 Nat. 25th: 53.77	Not Reported	HEDIS National Medicaid CY2013 *(lower rate is better)* Nat. 75th: 36.53 Nat. 50th: 44.89 Nat. 25th: 53.77	Not Reported

Attachment 5d – Year 2 Payment Measure National Benchmarks - Commercial

#	Measure	2012 National Commercial HEDIS Benchmarks (PPO)	2013 National Commercial HEDIS Benchmarks (PPO)
Core-1	Plan All-Cause Readmissions (lower rate is better)	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 0.73 Nat. 50th: 0.78 Nat. 25th: 0.83	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 0.72 Nat. 50th: 0.76 Nat. 25th: 0.81
Core-2	Adolescent Well-Care Visits	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 46.38 Nat. 50th: 38.64 Nat. 25th: 32.79
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 87.94 Nat. 50th: 84.67 Nat. 25th: 81.27	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 86.02 Nat. 50th: 83.76 Nat. 25th: 79.89
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 57.12 Nat. 50th: 50.09 Nat. 25th: 42.69
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 32.25 Nat. 50th: 26.55 Nat. 25th: 22.58

#	Measure	2012 National Commercial HEDIS Benchmarks (PPO)	2013 National Commercial HEDIS Benchmarks (PPO)
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 26.70 Nat. 50th: 22.78 Nat. 25th: 19.68
Core-7	Chlamydia Screening in Women	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 46.29 Nat. 50th: 40.93 Nat. 25th: 36.03
Core-8	Developmental Screening in the First Three Years of Life (Medicaid-only Payment measure)	National benchmark not available.	National benchmark not available.
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	National benchmark not available.	National benchmark not available.
Core-17	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	HEDIS National Commercial (PPO) CY2012 Nat. 75th: 27.10 Nat. 50th: 33.81 Nat. 25th: 39.86	HEDIS National Commercial (PPO) CY2013 Nat. 75th: 30.57 Nat. 50th: 35.28 Nat. 25th: 39.62