VT Health Care Innovation Project
Episodes of Care Subgroup Meeting Agenda
Thursday, February 12, 2015 9:00 AM – 11:00 AM.
Small Conference Rm, 312 Hurricane Lane, Williston, VT
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	9:00-9:10	Welcome and Introductions; Approval of 01/29/15 EOC Sub-Group Meeting Minutes	Alicia Cooper	Y- Minutes Approval	Attachment 1: 01/29/15 EOC Sub-Group Meeting Minutes
2	9:10-9:20	Updates & Follow-Up Items		N	Attachment 2: Sample Blueprint HSA Profile
3	9:20-10:20	Presentation on MVP Episodes of Care Analytics; Discussion	Andrew Garland	N	
4	10:20-10:50	Episode Prioritization; Flag "Wish List"	Discussion	N	Attachment 4: PPT
5	10:50-11:00	Public Comment and Next Steps		N	Next Meeting: March 6th, 9am-11am, EXE 4th Floor Conference Room, Montpelier, VT

Attachment 1

VT Health Care Innovation Project
Episodes of Care Subgroup Meeting Minutes
Thursday, January 29, 2015 10:00 PM – 12:00 PM.
289 Hurricane Lane, Williston VT
Call in option: 1-877-273-4202; Conference ID: 2252454
Attendees: Leah Fullem (OneCare Vermont), Cathy Fulton (VPQHC), Alicia Cooper (DVHA), Jim Westrich (DVHA), Amanda Ciecior (DVHA), Mike DelTrecco (VAHHS), Pat Jones (GMCB), Andrew Garland (MVP Health Care), Beth Tanzman (Blueprint for Health), Paul Harrington (VMS), Susan Aranoff (DAIL)

Item #	Notes	Next Steps
Introductions	Alicia Cooper started the meeting at 10:08am and thanked all who volunteered to serve on this sub-group. Members participating in person and by phone introduced themselves. For those unable to make this meeting, DVHA staff will make sure there is appropriate follow-up so that all members will be prepared for the next meeting.	
Episodes of Care Overview	Alicia Cooper laid out the format of this sub-group meeting and the plan for the next few months. The proposed timeline suggests 5-6 meetings over a course of 4 months, leading to the development of a funding request, and potentially an RFP for vendor support. Then, work will likely taper off and those involved with the sub-group will become more of an advisory team. Alicia reviewed the sub-group charter; the following were comments or questions regarding the timeline and charter: • Mike DelTrecco asked how Episodes of Care initiatives would align with the ongoing work of the ACOs and the All Payer Waiver efforts currently underway in Vermont. He also asked if this Episode sub-group was going to look at all payers, or just for a subset of payers. Finally, he asked how any measures and standards to be used for Episodes work would relate to those already in place for other programs, wondering whether we would be able to build upon the existing foundation. Leah Fullem agreed that these were important questions to address. Alicia stated that the key role of the sub-group is to work through some of these bigger questions, drawing upon empirical evidence and the expertise and experience of the sub-group members. She believes it makes sense to draw on the standards and measures that are already in place to the extent possible as we go forward, and it makes sense to have members of this sub-group participating in other innovation activities across the state so we can work to align efforts. • Paul Harrington referenced CMS' recent commitment to moving 30% of Medicare FFS payments to alternative, value based, payment models by end of 2016. EOC is specifically highlighted as a mechanism of interest in the press release, and he feels it is noteworthy that they are taking such	Ensure Press Release is

	an ambitious stance. He suggests that we should watch what they are doing at the Federal level and emulate it in order to keep in alignment with CMS. By observing and replicating, we will do less original work, learn more from CMS, and apply as we see fit. Suggests looking to the initial press release for more information. Pat Jones asked if CMS will be identifying particular episodes. Paul said that was his understanding. Right now most things are aspirational, but there will be a lot of work done this year. There is also a clear movement from process to outcome measures.	circulated among sub-group members
	• Andrew Garland marked the distinction between using Episodes of Care analytics to inform care delivery and using Episodes of Care as the basis for an alternative payment model. Paying based on Episodes is a significant effort, and requires a substantial investment of overhead and time for both administrators and providers. Most of the time, payment programs are structured to roll out one episode at a time because of all the work that goes into it. Conversely, EOC-based analytics is very powerful and can be done quickly and cheaply. It allows us to compare treatment patterns, and different clinical approaches. Alicia agreed that the focus of the sub-group at this time would be to determine how best to use EOC analytics to support delivery system transformation, and noted that there were no immediate plans to implement an episodic, bundled payment program. Andrew agreed that this approach is the one to take. For MVP, the process took around 2-3 years to disseminate all the data to those who needed it, yet only 2-3 months to actually produce findings. Those representing hospitals, ACOs and FQHCs have the opportunity to benefit greatly from this data.	
	• Leah Fullem inquired if any of the project's current contractors was already using an Episode Grouper. Alicia responded that a contractor had been doing related work previously, but that work has concluded. Now we need to figure out where to go next, if we want to expand on the episodes they provided, or look into other issue areas. Leah found Andrew's distinction of payment versus analytic very helpful – believes it will be helpful to identify treatment variation across the state. Once we start discussing how to pay providers based on Episodes, the issues become much more complex.	
	• Andrew noted that defining episodes (included and excluded services, start and end points, etc.) for analytic purposes and for payment purposes can vary. The definitions can become more contentious as we move toward payment.	
	• Andrew shared that MVP attempted to make a business case to develop payments based on Episodes, and discovered that every episode roll out is extremely expensive – a significant amount of time is necessary to see any return on investment. However, using the information to disseminate information has been very beneficial. They are able to look at a certain episodes and practices, which allows them to dig deeper and identify best practices from one location to another. This also encourages providers to use peer-to-peer learning. Providers have a natural desire to do	

	better, all it takes is the information. Mike commented that VT might be too small to do an analysis that way. Andrew assured the group that even the data on Vermont's relatively small MVP population has been beneficial. • Beth Tanzman asked about risk grouping, and if it could be helpful to identify a part of the population that needs more attention. Andrew responded that they have not sought information on individual risk retrospectively. However, going to the provider with names of the high risk individuals might allow them to identify additional patient needs. • Mike asked about attribution for Episodes and how a future methodology could work to complement the ACOs' current activity. Andrew noted that, while attribution to a particular provider is challenging when developing a payment model around Episodes, multiple providers can be considered "responsible" for an episode when using Episode-based analytics to understand practice patterns. For example, a physician might be linked to a patient's episode if they account for 25% or more of the nonhospital care spending. Paul supported a focus on analytics and distribution of results as CMS moves forward with their initiative, and to evaluate episode based payment models in future when more information was available. Andrew commented that, relative to others, this is a modest payment reform model, and suggests not spending a lot of money on it when providers in VT are ready to do something even more innovative. Leah responded that analysis will be beneficial to ACOs, and could impact the distribution of global payments in future.	
Future of Episodes in Vermont	Group sees value in EOC analytics in State. Future meetings will iron out what that looks like. Discussion occurred around which state entity would hold the contract with a future vendor. That information is unknown at present. • Paul commented that a lot of this work has been done by Brandeis and HCi3, and has a sense that a lot of organizations in Vermont have occupied this space. Feels that we might what to identify who has done what to date in the state before creating an RFP for additional work. Finally, he asked if an educational tool is provided should it be working through existing efforts or should we create something new. Beth asked if this is supposed to be an ongoing information stream, how do we create this capacity or utility that can be shared amongst those across the State over a longer period of time. • Alicia responded that there is an opportunity to on the work that has already been done by HCi3. The previous analyses have had both strengths and limitations. HCi3 provided the preliminary analysis by looking at a limited period of time, using de-identified VHCURES data, and examined 25 episodes. It would be good to build off this work by doing things such as identifying a subset of episodes for additional, ongoing analysis, and developing a tool that is available to multiple parties for future usage, and creating practice- or HSA-level reports. Beth commented that the power in	Determine who in state has started EOC work

	this is to do it over time, not just one time. Andrew emphasized that it needs to be actionable, and we must provide information from which people can learn and change behavior.	
	• Mike suggested engaging the GMCB to ensure alignment with other ongoing state initiatives. Mike also noted that MVP has benefited in that they (the insurance company) are paying the providers with whom they are sharing information. He noted that there might be a future hurdle with providers receiving data and not believing that it is accurate. Andrew commented that there needs to be investment in teaching providers how the analytics work, but that they have had relatively few providers doubt the information that had been shared. The sub-group felt it will be important to have future work supported by existing programs to support the credibility of data; Pat Jones suggested sharing data at the ACO level could help to achieve this.	
	• Andrew suggested that the group may not want to narrowly limit the episodes selected for future consideration. MVP did analysis on 500+ episodes and it was not significantly more difficult to produce data on 500 episodes than 20 episodes. A large analysis like this can be seen as being more democratic as it does not focus only on certain specialties or areas of care. Some members expressed concern that that many episodes would overwhelm providers, and make it harder to focus on organizational or statewide priorities. Organizations may want to choose certain episodes of focus, but MVP has had no pushback on producing 500+ episode reports. Andrew will provide an example of what is given to providers at next meeting.	
Review	A review of the HCi3 EOC analytic work that has been shared thus far took place, the following are comments or questions regarding this portion of the presentation: • Leah asked for confirmation that no current contracts already included funding for Episodes-based analytics. She recalled having seen a presentation from Lewin of a Tableau-based EOC dashboard. Pat and Alicia responded that EOC analytics were not in Lewin's current scope of work, but that they do have an episode grouper in their tool-kit. • Andrew noted that vendor selection impacts the methodology being used. Some focus on potentially avoidable complications and high cost patients; others focus on routine care where there is less variation. Most spending and opportunities for improvement are in routine care.	
Next Steps	Next Steps discussion around future meetings: • Homework was assigned: send priority episodes, or support of unlimited episodes, to Amanda.ciecior@state.vt.us by Feb 10 • Andrew to present on MVP work; he will provide a sample report • Beth will share HSA level Blueprint profiles	

| | | • Mike suggested additional discussion about attribution flags for various programs. They do not yet exist in VHCURES for all programs of interest, but conversation around how to do this has been occurring. Pat would like more help identifying what flags would be useful to build into VHCURES.

• Please communicate good days and times for scheduling future meetings to Amanda.ciecior@state.vt.us | |

Attachment 2

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HSA Profile: Barre
Period: 01/2013 - 12/2013   **Profile Type:** Adults (18+ Years)

Welcome to the *2014 Blueprint Hospital Service Area (HSA) Profile* from the Blueprint for Health, a state-led initiative transforming the way that health care and comprehensive health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services.

Blueprint HSA Profiles are based on data from Vermont's all-payer claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members attributed to Blueprint practices that began participating by December 31, 2013.

Blueprint HSA Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years. Practices have been rolled up to the HSA level.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

For the first time ever, these profiles use three key sources of data: VHCURES, the DocSite clinical database, and the Behavioral Risk Factor Surveillance Study (BRFSS), a telephone survey conducted annually by the Vermont Department of Health.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the year prior. Rates for HSAs reporting fewer than 30 members for a measure are not presented in alignment with NCQA HEDIS guidelines.

Demographics & Health Status

	HSA	Statewide
Average Members	29,937	244,958
Average Age	49.9	50.0
% Female	54.6	55.0
% Medicaid	13.9	16.5
% Medicare	24.6	25.5
% Maternity	1.8	1.9
% with Selected Chronic Conditions	41.7	40.8
Health Status (CRG)		
% Healthy	38.9	40.6
% Acute or Minor Chronic	20.0	19.2
% Moderate Chronic	25.5	24.9
% Significant Chronic	14.4	14.1
% Cancer or Catastrophic	1.2	1.3

Table 1: This table provides comparative information on the demographics and health status of the specified HSA and of the state as a whole. Included measures reflect the types of information used to generate adjusted rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial lengths of enrollment during the year. In addition, special attention has been given to adjusting for Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's HSA's percentage of membership that is Medicaid or Medicare, Medicare disability or end-stage renal disease status, and the degree to which the member required special Medicaid services that are not found in commercial populations (e.g. day treatment, residential treatment, case management, school-based services, and transportation).

The % with Selected Chronic Conditions measure indicates the proportion of members identified through the claims data as having one or more of seven selected chronic conditions: asthma, chronic obstructive pulmonary disease, congestive heart failure (CHF), coronary heart disease, hypertension, diabetes, and depression.

The Health Status (CRG) measure aggregates 3M™ Clinical Risk Grouper (CRG) classifications for the year for the purpose of generating adjusted rates. Aggregated risk classification groups include: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (e.g., minor chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (e.g., diabetes and CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (e.g., HIV, muscular dystrophy, cystic fibrosis).

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Total Expenditures per Capita
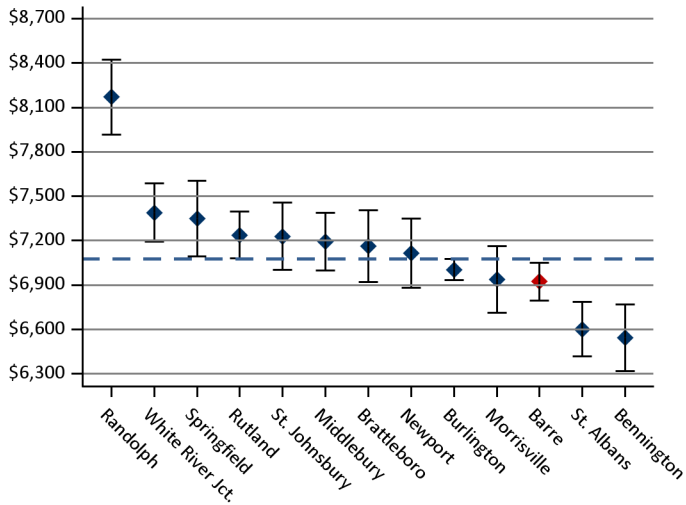
Figure 1: *Presents annual risk-adjusted rates, including 95% confidence intervals, with expenditures capped statewide for outlier patients. Expenditures include both plan payments and member out-of-pocket payments (i.e., copay, coinsurance, and deductible). The blue dashed line indicates the statewide average.*

Total Expenditures by Major Category
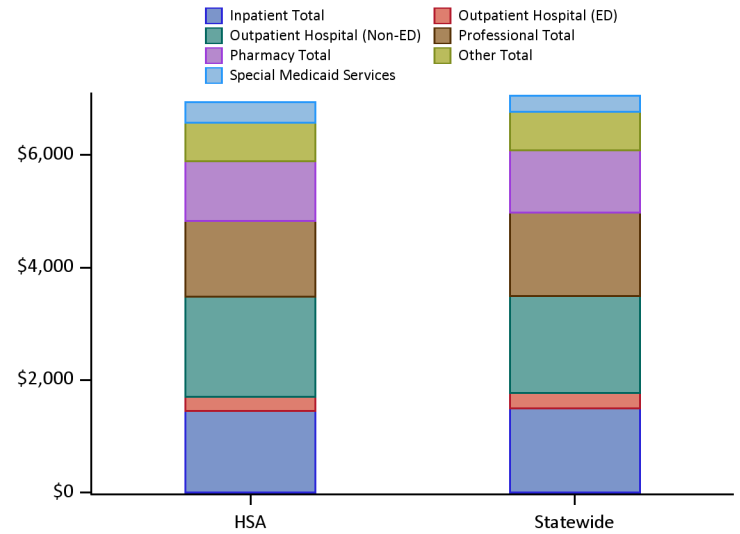
Figure 2: *Presents annual risk-adjusted rates for the major components of cost (as shown in **Figure 1**) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS).*

Total Expenditures (Excluding SMS)
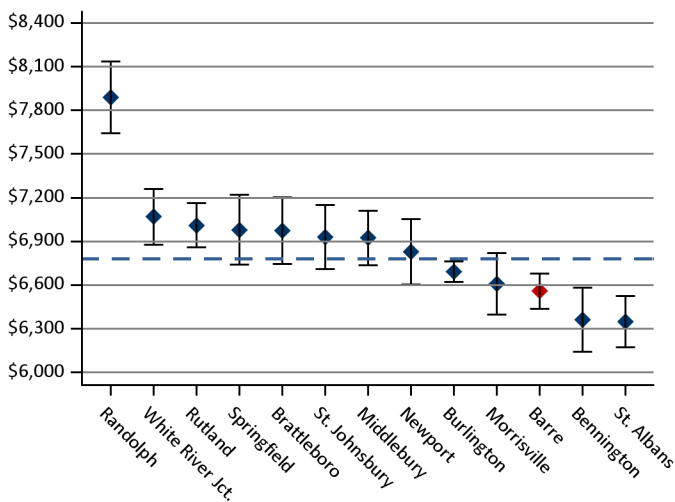
Figure 3: *Presents annual risk-adjusted rates, including 95% confidence intervals, with expenditures capped statewide for outlier patients. Expenditures include both plan payments and member out-of-pocket payments (i.e., copay, coinsurance, and deductible) and exclude Special Medicaid Services. The blue dashed line indicates the statewide average.*

Total Resource Use Index (RUI) (Excluding SMS)
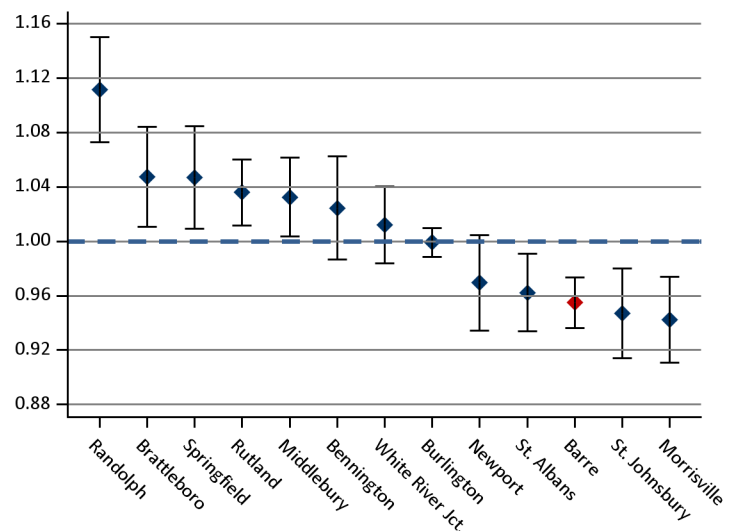
Figure 4: *Presents annual risk-adjusted rates, including 95% confidence intervals. Since price per service varies widely, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects an aggregated capped cost based on utilization and intensity of services across major components of care and excludes Special Medicaid Services. The HSAs are indexed to the statewide average (1.00), which is indicated by the blue dashed line.*

| Demographics / Health | Cost of Care | Utilization | Preventive Care / ACO | BRFSS | Data Detail |

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Annual Total Expenditures per Capita (Excluding SMS) vs. Resource Use Index (RUI)
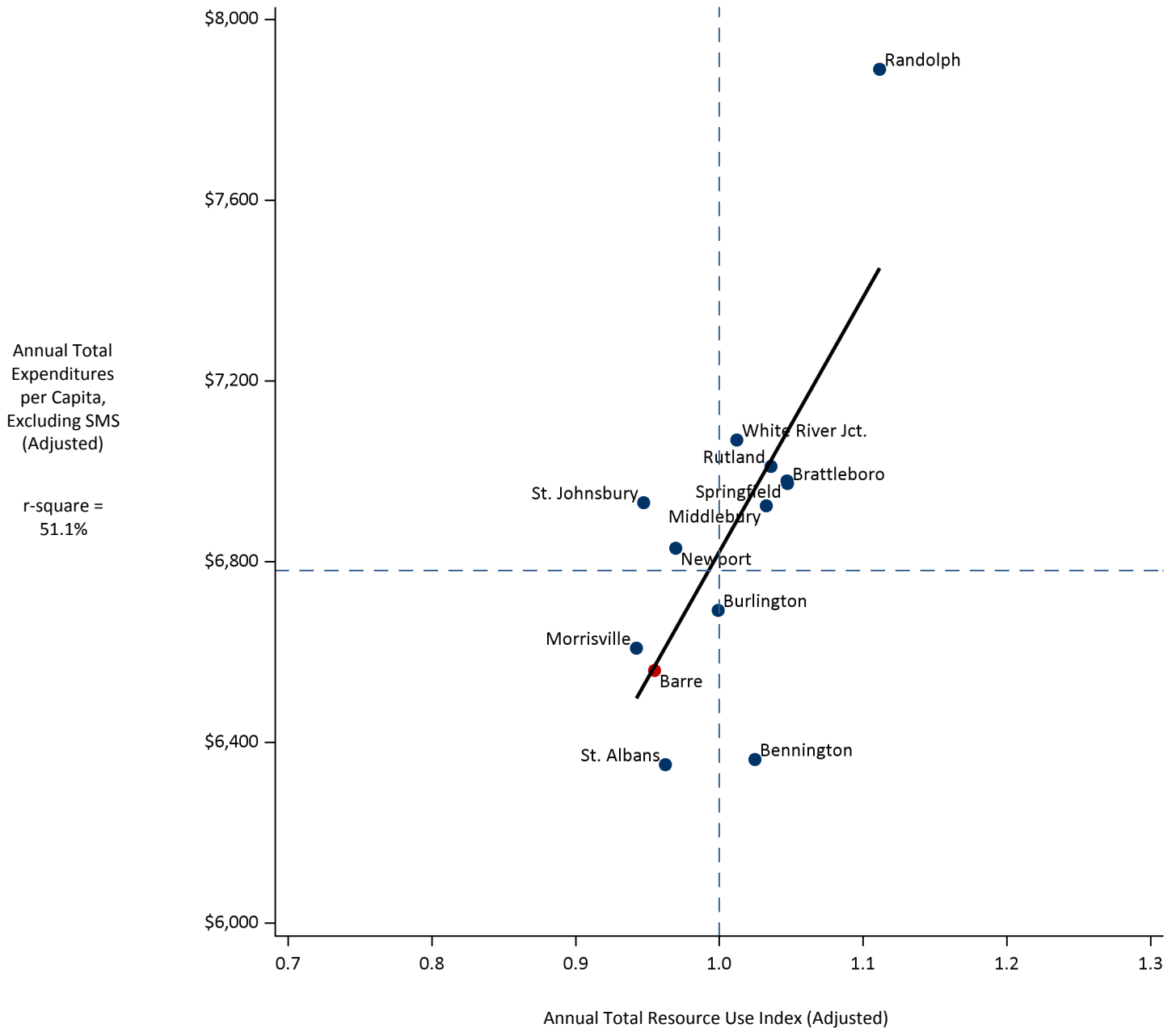
Figure 5: *This graphic demonstrates the relationship between risk-adjusted expenditures, excluding SMS, and risk-adjusted utilization for each of the HSAs in Vermont. This graphic illustrates the specified HSA's risk-adjusted rates (i.e., the red dot) compared to those of all other HSAs statewide (i.e., the blue dots). The dashed lines show the average Expenditures per Capita and average Resource Use Index statewide (i.e., 1.00). HSAs with higher expenditures and utilization are in the upper right-hand quadrant, while HSAs with lower expenditures and utilization are in the lower left-hand quadrant. An RUI value greater than 1.00 indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than average utilization. A trend line has been included in the graphic, which demonstrates that, in general, HSAs with higher risk-adjusted utilization had higher risk-adjusted expenditures.*

Legend

🔴 *Barre*

🔵 *All other Blueprint HSAs statewide*

| Demographics / Health | Cost of Care | Utilization | Preventive Care / ACO | BRFSS | Data Detail |

Inpatient Discharges
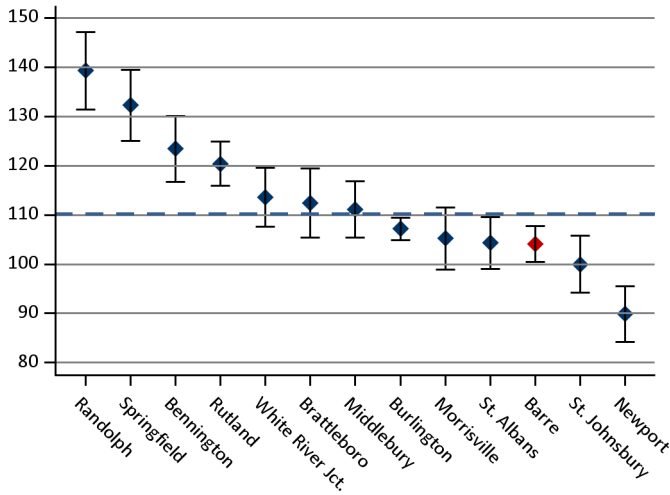
Figure 6: *Presents annual risk-adjusted rates, including 95% confidence intervals, of inpatient discharges per 1,000 members. Additional detail measures for inpatient utilization —* Inpatient Days, Inpatient Readmissions within 30 Days, *and* Inpatient Discharges for Ambulatory Care Sensitive (ACS) Conditions — *can be found in* **Table 5.**

Outpatient ED Visits
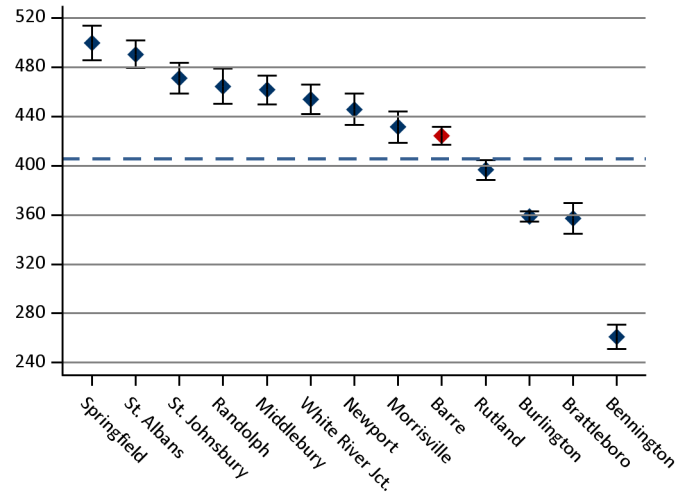
Figure 7: *Presents annual risk-adjusted rates, including 95% confidence intervals, of outpatient emergency department (ED) visits per 1,000 members. An additional detail measure —* Outpatient Potentially Avoidable ED Visits — *can be found in* **Table 5.**

Advanced Imaging (MRIs, CT Scans)
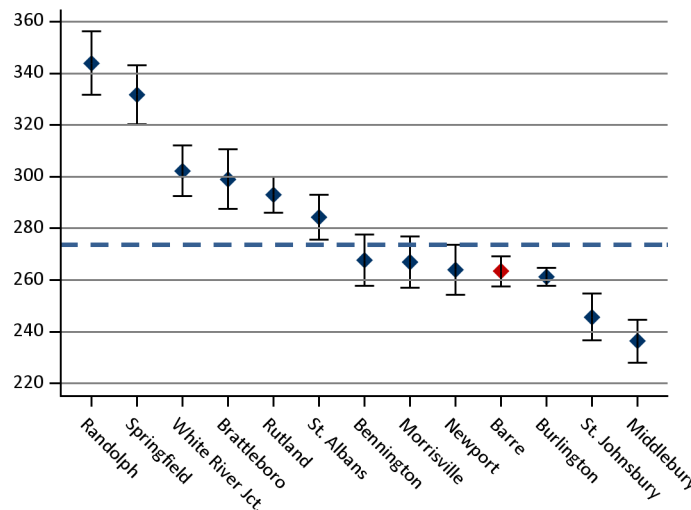
Figure 8: *Presents annual risk-adjusted rates, including 95% confidence intervals, for advanced imaging diagnostic tests (i.e., MRIs, CT scans) per 1,000 members.*

| Demographics / Health | Cost of Care | Utilization | Preventive Care / ACO | BRFSS | Data Detail |

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Diabetes: HbA1c Testing

Figure 9: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, that received a hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

Diabetes: LDL-C Screening
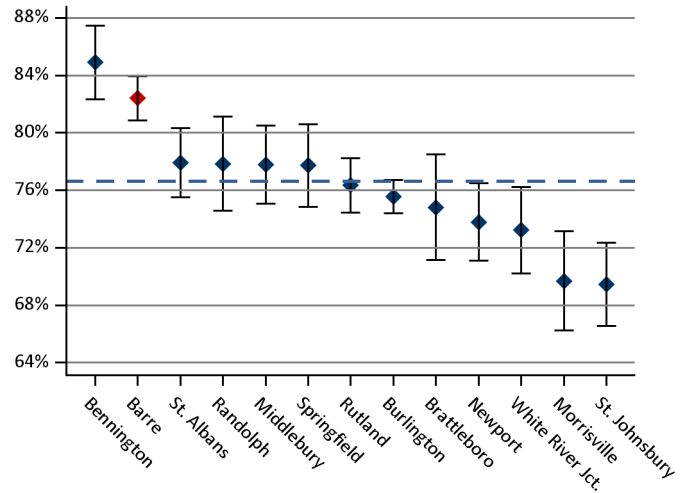
Figure 10: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, that received an LDL-C screening during the measurement year. The blue dashed line indicates the statewide average.

Diabetes: Eye Exam
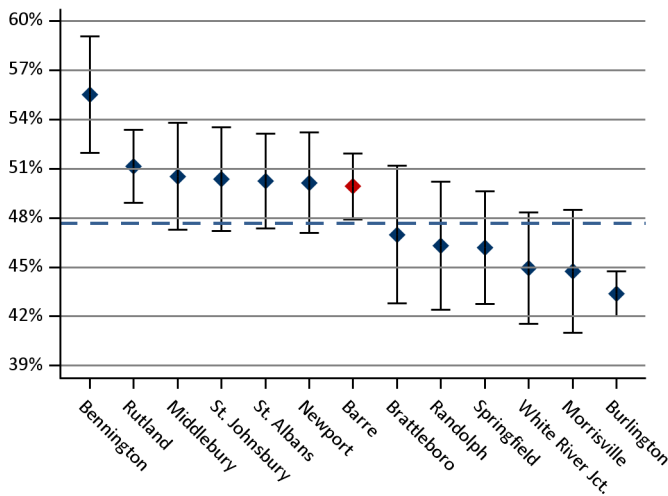
Figure 11: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, that received an eye screening for diabetic retinal disease during the measurement year. The blue dashed line indicates the statewide average.

Diabetes: Nephropathy Screening

Figure 12: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, that had a nephropathy screening test or evidence of nephropathy documented in the claims data. The blue dashed line indicates the statewide average.

| Demographics / Health | Cost of Care | Utilization | Preventive Care / ACO | BRFSS | Data Detail |

![Vermont Blueprint for Health logo] Smart choices. Powerful tools.

HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Imaging Studies for Low Back Pain

Figure 13: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18–50 years, that received a primary diagnosis of low back pain but appropriately did not have an imaging study (e.g., plain X-Ray, CT scan, MRI) within 28 days of the diagnosis. This is an inverted measure for which a higher score indicates appropriate treatment (i.e., imaging did not occur). The blue dashed line indicates the statewide average.

Cervical Cancer Screening (Core-30)

Figure 14: Presents the proportion, including 95% confidence intervals, of continuously enrolled female members, ages 21–64 years, that received one or more PAP tests to screen for cervical cancer during the measurement year or the two years prior to the measurement year. The blue dashed line indicates the statewide average.

Chlamydia Screening (Core-7)

Figure 15: Presents the proportion, including 95% confidence intervals, of continuously enrolled women, ages 16–24 years, identified as sexually active during the measurement year and with at least one test for chlamydia during the measurement year or the year prior to the measurement year. (Note that, due to the age ranges for this ACO measure, women below the age of 18 years, not typically represented in adult profiles, have been included in these rates.) The blue dashed line indicates the statewide average.
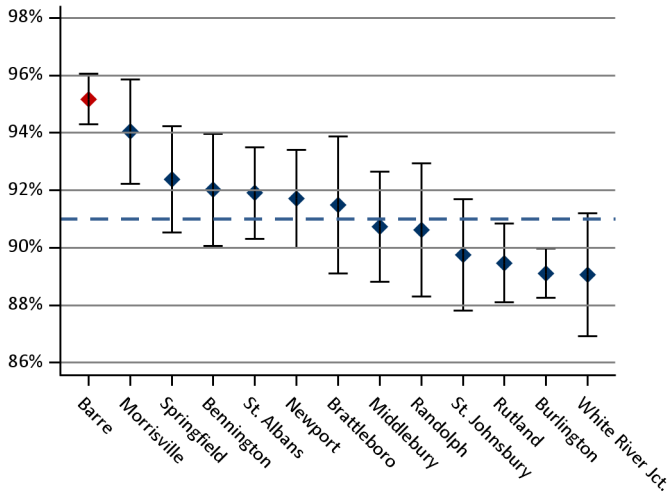
Breast Cancer Screening (Core-11, MSSP-20)

Figure 16: Presents the proportion, including 95% confidence intervals, of continuously enrolled women, ages 52–64 years, that had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year. The blue dashed line indicates the statewide average.

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Plan All-Cause Readmissions (Core-1)
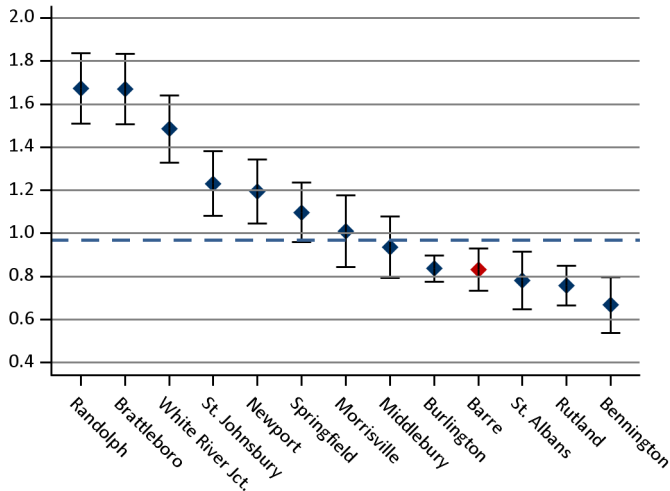
Figure 17: Presents the relative rate, including 95% confidence intervals, of continuously enrolled members, ages 18 years and older, that had an inpatient stay that was followed by an acute readmission for any diagnosis within 30 days during the measurement year. The rate is expressed as a ratio of observed to expected readmissions where the expected number of readmissions has been risk adjusted. The blue dashed line indicates the statewide average.

Follow-Up After Hospitalization for Mental Illness (Core-4)
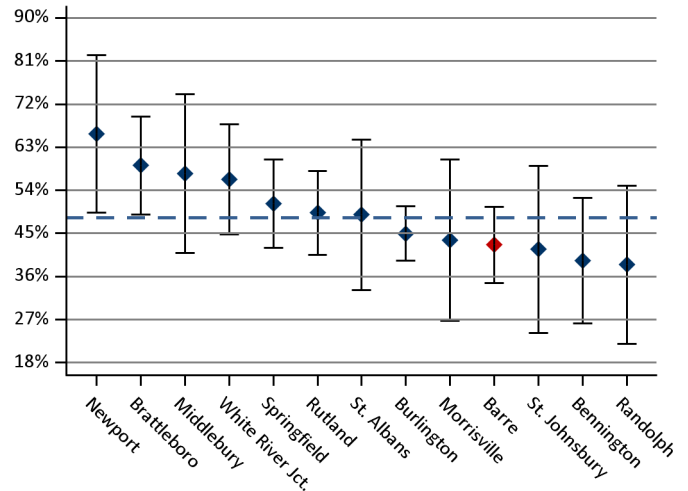
Figure 18: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 6 years and older, hospitalized for mental illness with an intensive outpatient encounter or partial hospitalization with a mental health practitioner and a follow-up visit within seven days of discharge. The blue dashed line indicates the statewide average.
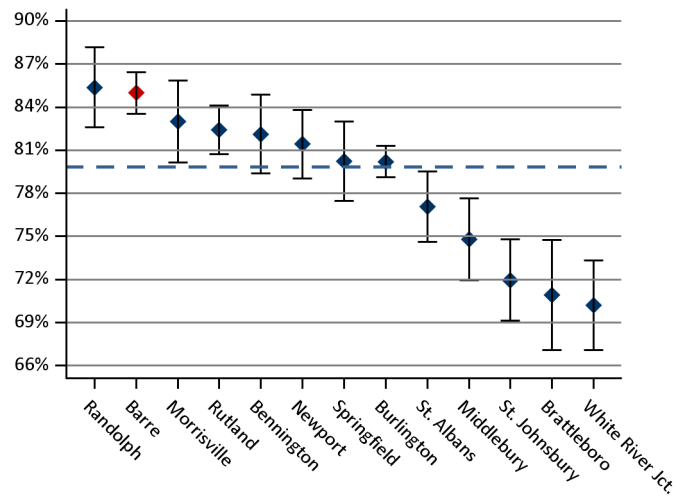
Initiation of Alcohol/Drug Treatment (Core-5a)
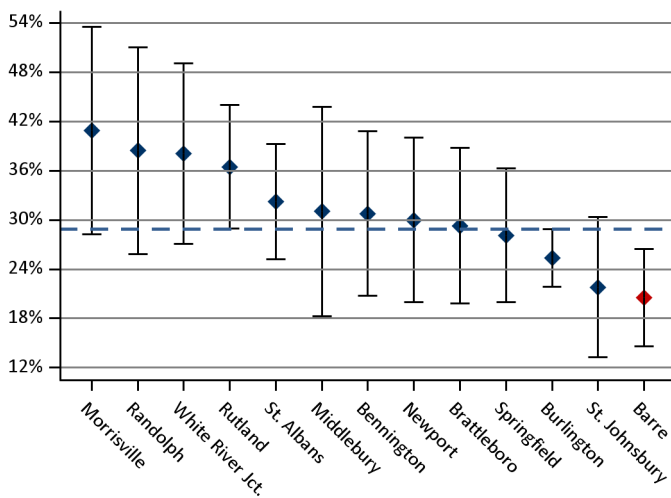
Figure 19: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18 years and older, that initiated treatment through an inpatient alcohol or other drug (AOD) admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. The blue dashed line indicates the statewide average.

Engagement of Alcohol/Drug Treatment (Core-5b)
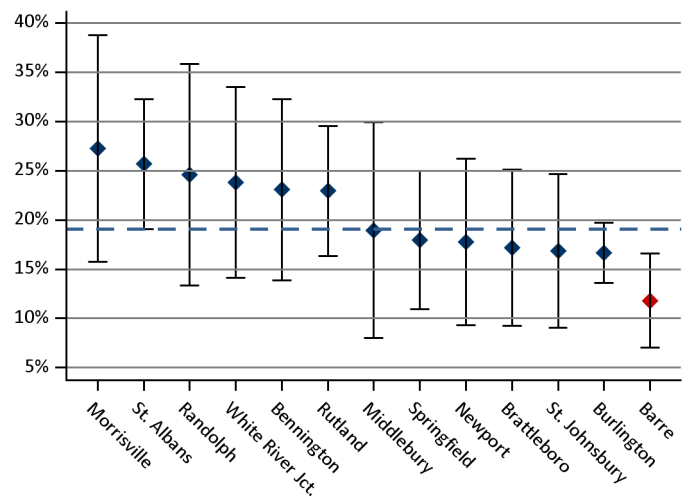
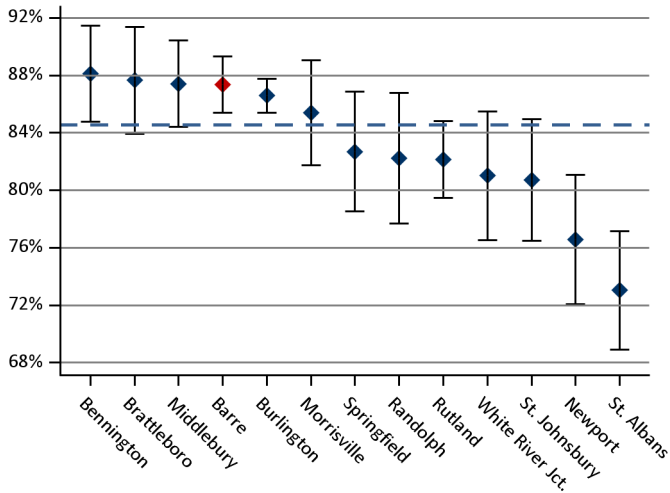*Figure 20:* Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18 years and older, that initiated treatment and that had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The blue dashed line indicates the statewide average.

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Cholesterol Management, Cardiac (Core-3, MSSP-29)

Figure 21: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18–75 years, discharged alive for acute myocardial infarction (AMI), coronary artery bypass grafting (CABG), or percutaneous coronary intervention (PCI) in the year prior to the measurement year or with a diagnosis of ischemic vascular disease (IVD) during the measurement year and year prior and with an LDL-C screening during the measurement year. The blue dashed line indicates the statewide average.

Avoidance of Antibiotic Treatment, Acute Bronchitis (Core-6)
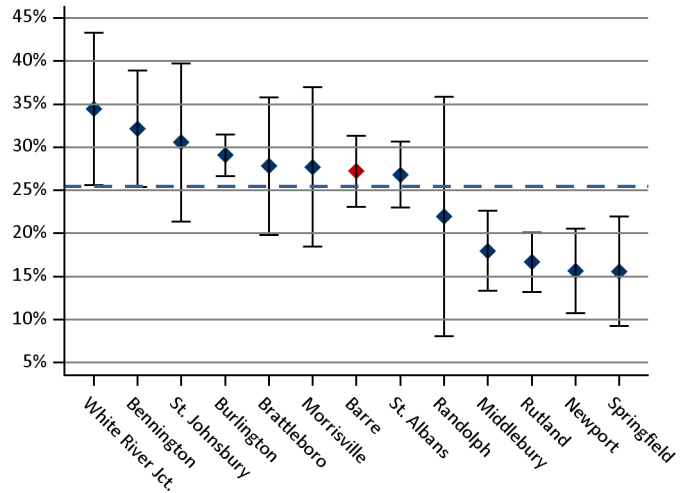
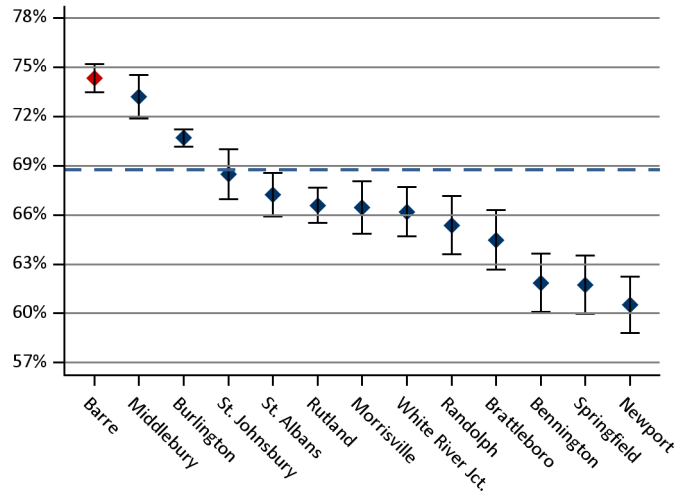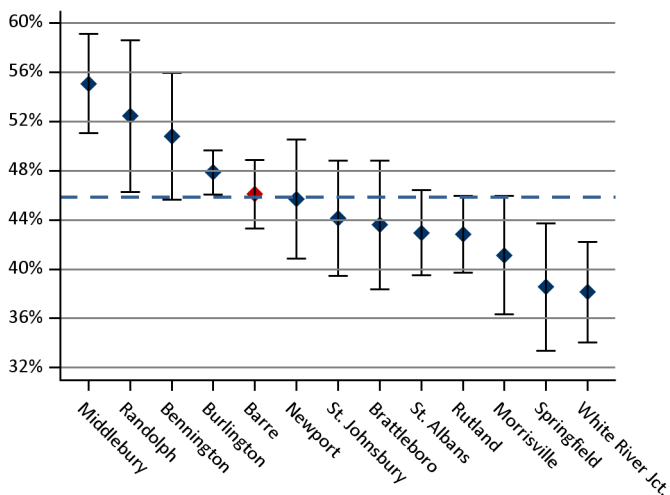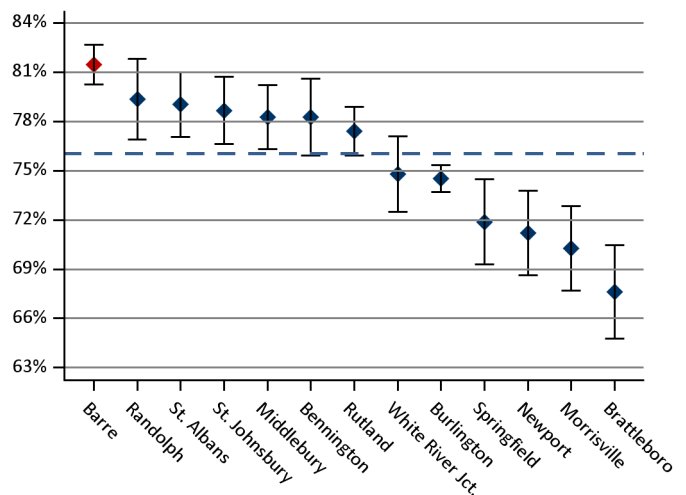*Figure 22: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18–64 years, that received a diagnosis of acute bronchitis but was not dispensed an antibiotic prescription. The blue dashed line indicates the statewide average.*

Influenza Vaccination (MSSP-14)
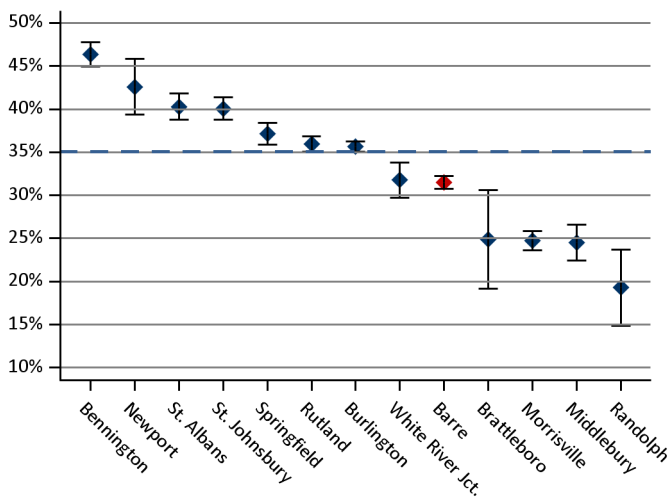
Figure 23: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages six months and older, that received an influenza immunization from October 1 of the prior year through March 31 of the measurement year. Immunizations were identified in the medical claims or, if available, in the DocSite clinical registry. The blue dashed line indicates the statewide average.

Pneumonia Vaccination (MSSP-15)

Figure 24: Presents the proportion, including 95% confidence intervals, of Vermont residents, ages 65 years and older, that reported ever receiving a pneumonia vaccine as measured by the Behavioral Risk Factor Surveillance System (BRFSS). The blue dashed line indicates the statewide average.

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

ACS Admissions: COPD and Asthma (Core-10, MSSP-9)
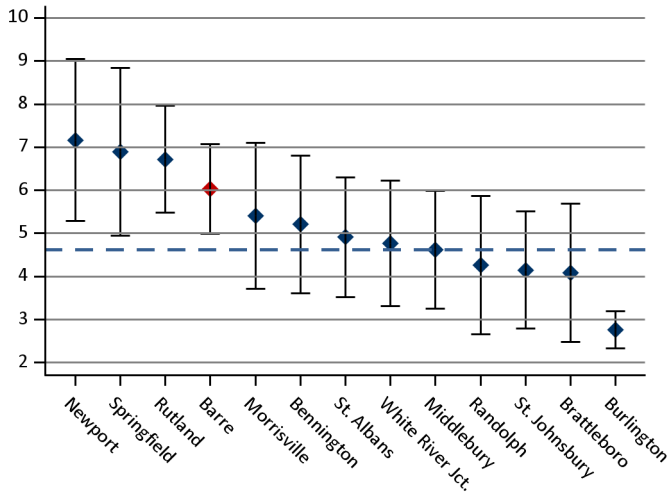
Figure 25: *This Prevention Quality Indicator (PQI) presents the rate of ambulatory care sensitive (ACS) admissions with a principal diagnosis of chronic obstructive pulmonary disorder (COPD) or asthma per 1,000 members, ages 40 years and older. The blue dashed line indicates the statewide average.*

ACS Admissions: Heart Failure (MSSP-10)
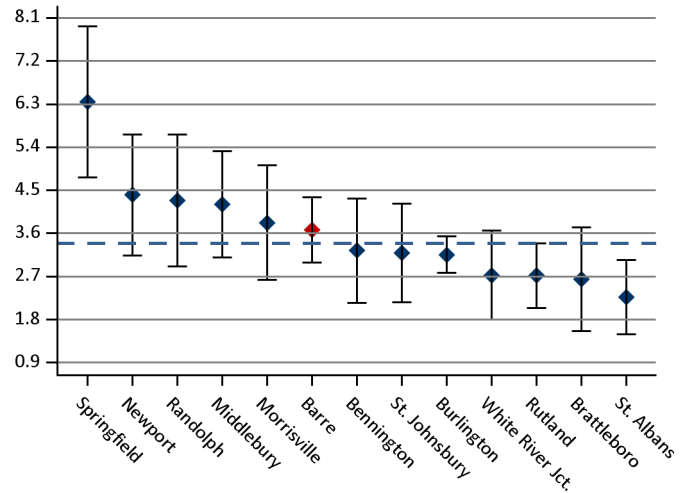
Figure 26: *This Prevention Quality Indicator (PQI) presents the rate of admissions with a principal diagnosis of heart failure per 1,000 members, ages 18 years and older. The blue dashed line indicates the statewide average.*

PQI Composite (Chronic): Rate of Hospitalization for ACS Conditions (Core-12)
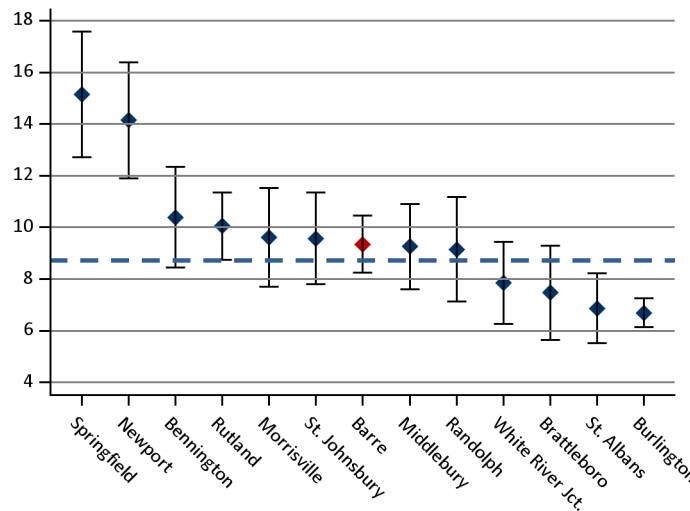
Figure 27: *This Prevention Quality Indicator (PQI) presents a composite of chronic conditions per 1,000 members, ages 18 years and older. This measure includes admissions for at least one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The blue dashed line indicates the statewide average.*

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Diabetes: HbA1c in Control (MSSP-22)

Figure 28: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the DocSite clinical database was in control (<8%). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

Diabetes: LDL-C in Control (MSSP-23)
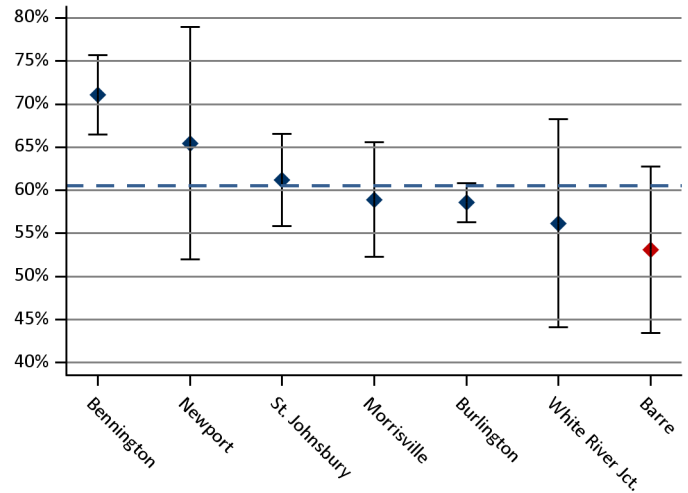
Figure 29: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded LDL-C screening test in the DocSite clinical database was in control (<100 mg/dL). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one LDL-C screening test during the measurement year. The blue dashed line indicates the statewide average.
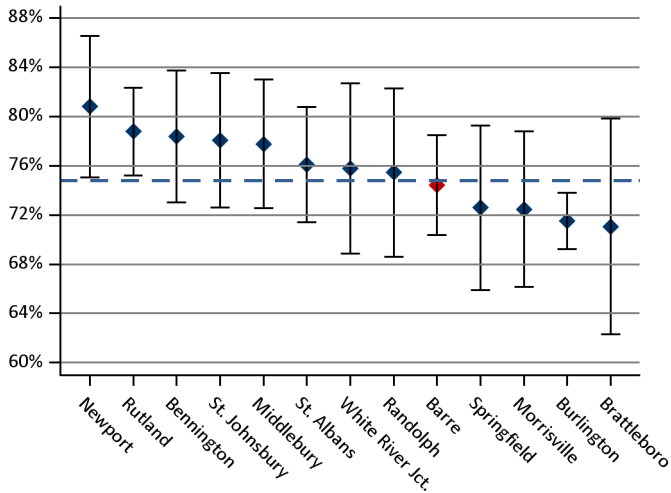
Diabetes: Blood Pressure in Control (MSSP-24)
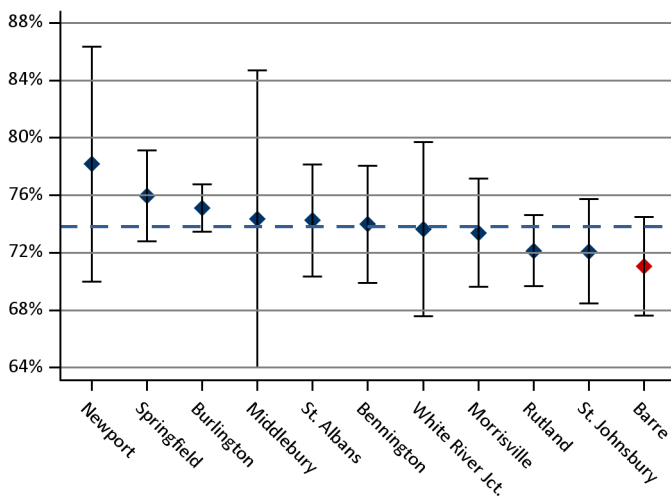
Figure 30: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded blood pressure measurement in the DocSite clinical database was in control (<140/90 mmHg). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one blood pressure test during the measurement year. The blue dashed line indicates the statewide average.

Diabetes: Tobacco Non-Use (MSSP-25)
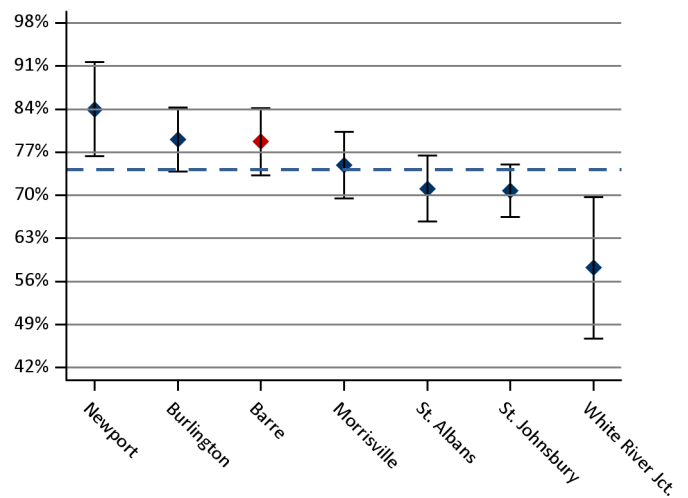
Figure 31: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, documented as tobacco non-users in the DocSite clinical database. Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for tobacco non-use during the measurement year. The blue dashed line indicates the statewide average.

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Diabetes: Composite (Core-16, MSSP 22-25)
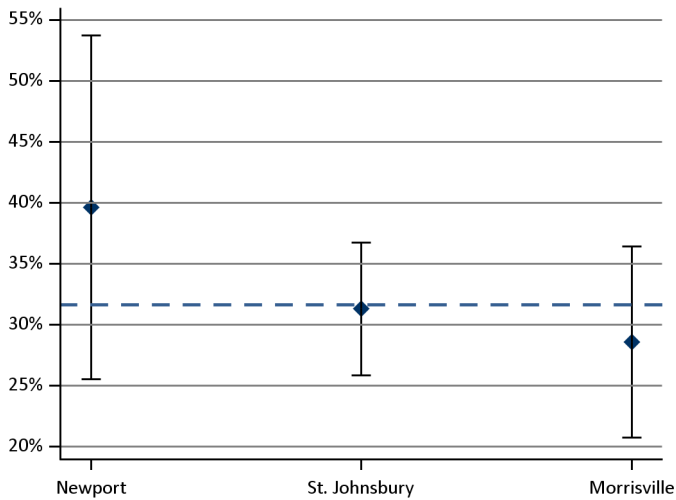
Figure 32: *Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, in control for hemoglobin A1c (<8%), LDL-C (<100 mg/dL), blood pressure (<140/90 mmHg), and tobacco non-use during the measurement year. Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for all four components of this measure within the measurement year. The blue dashed line indicates the statewide average.*

Diabetes: Poor Control (Core-17, MSSP-27)
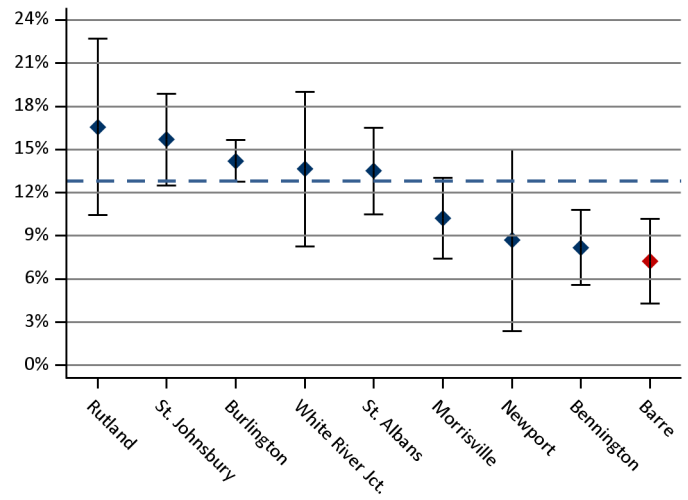
Figure 33: *Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the DocSite clinical database was in poor control (>9%). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.*

Comparison of Patients by HbA1c Control Status, Statewide

Metric	Diabetes A1c in Control	Diabetes A1c not in Control (>9%)
Members	4,220	568
Annual expenditures per capita	$12,507 ($12,059, $12,954)	$15,267 ($13,867, $16,667)
Inpatient hospitalizations per 1,000 members	181.7 (168.7, 194.7)	275.0 (231.1, 318.8)
Inpatient days per 1,000 members	877.8 (849.2, 906.4)	1,524.0 (1,421.8, 1,627.2)
Outpatient ED visits per 1,000 members	532.1 (509.8, 554.4)	752.2 (654.0, 796.4)

Note: Risk-adjusted rates with 95% confidence intervals are provided in parentheses. Outliers beyond the 99th percentile have been excluded.

Table 2: *Presents a comparison of health care expenditures and utilization in the measurement year for continuously enrolled members, ages 18-75 years, whose diabetes hemoglobin A1c was in control (<8%) compared to those with poor control (>9%). Rates have been adjusted for age, gender, and health status. The rates in this table are presented at the state level only. Members with poor control had statistically significant higher total expenditures, inpatient hospitalizations, inpatient days, and outpatient ED visits.*

Hypertension: Blood Pressure in Control (Core-39, MSSP-28)
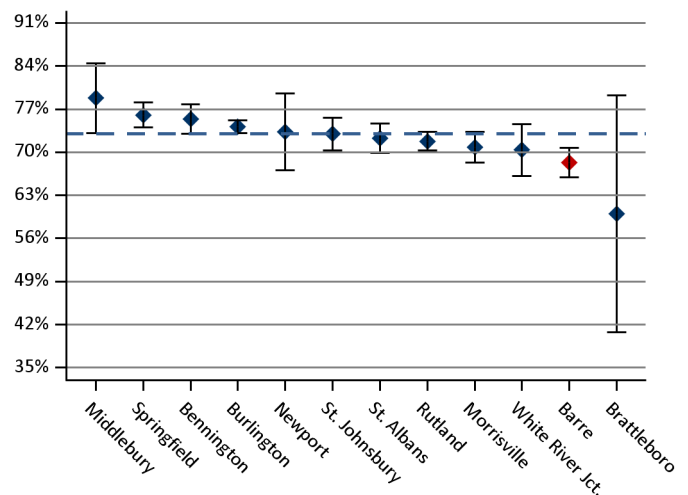
Figure 34: *Presents the proportion, including 95% confidence intervals, of continuously enrolled members with hypertension, ages 18–85 years, whose last recorded blood pressure measurement in the DocSite clinical database was in control (<140/90 mmHg). Members with hypertension were identified using claims data. The denominator was then restricted to those with DocSite results for a blood pressure reading during the measurement year. The blue dashed line indicates the statewide average.*
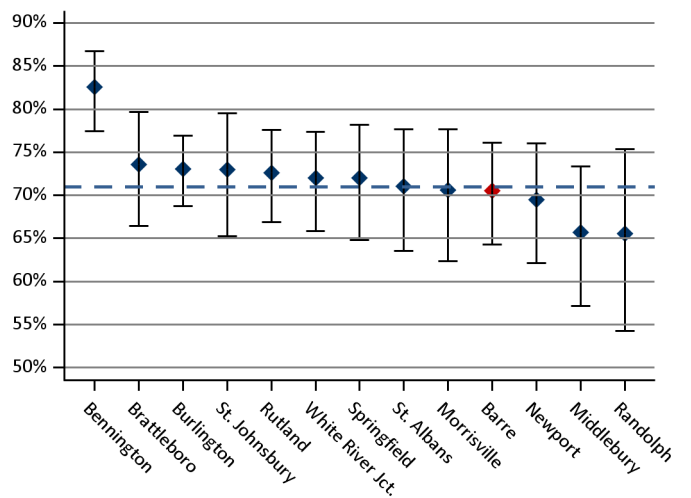
BRFSS: Households with Income <$25,000
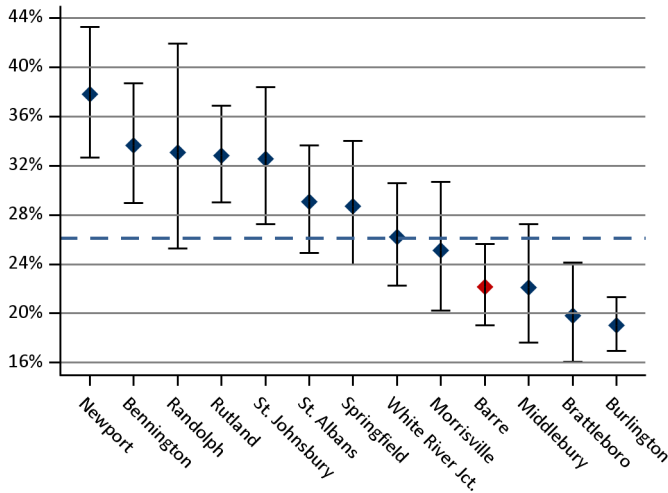
Figure 35: Presents the proportion, including 95% confidence intervals, of Vermont residents, ages 18 years and older, that reported a household income of less than $25,000 per year. This data was collected through the Behavioral Risk Factor Surveillance System (BRFSS). The blue dashed line indicates the statewide average.
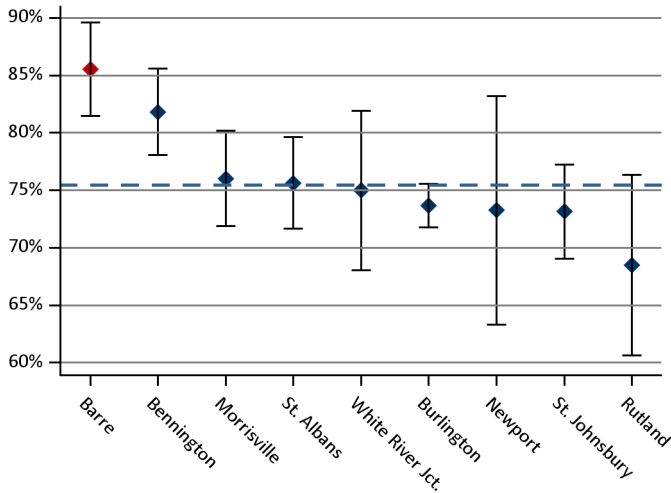
BRFSS: Cigarette Smoking
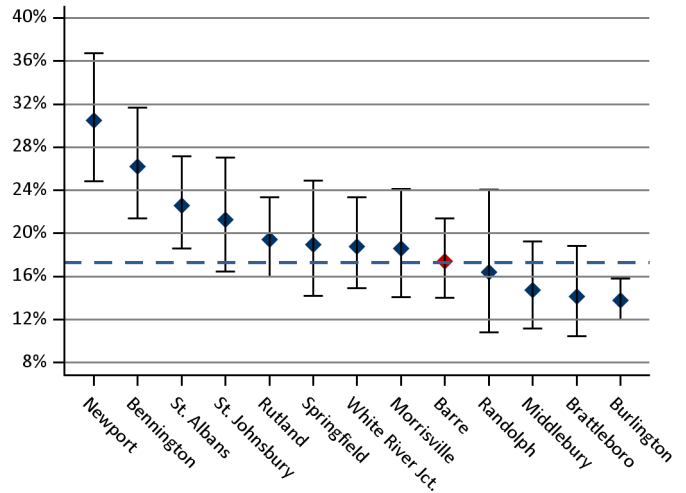
Figure 36: Presents the proportion, including 95% confidence intervals, of Vermont residents, ages 18 years and older, that reported being cigarette smokers. This data was collected through the Behavioral Risk Factor Surveillance System (BRFSS). The blue dashed line indicates the statewide average.

BRFSS: No Leisure-Time Physical Activity/Exercise
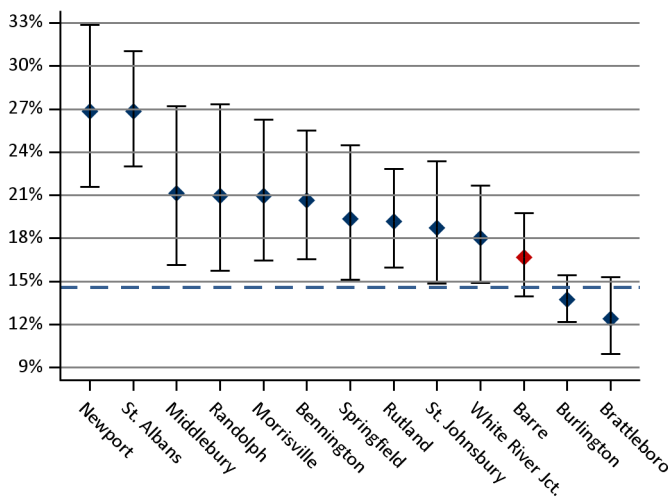
Figure 37: Presents the proportion, including 95% confidence intervals, of Vermont residents, ages 18 years and older, that said they did not participate in any physical activity or exercise during the previous month. This data was collected through the Behavioral Risk Factor Surveillance System(BRFSS). The blue dashed line indicates the statewide average.

BRFSS: Meets Fruit/Vegetable Recommendations
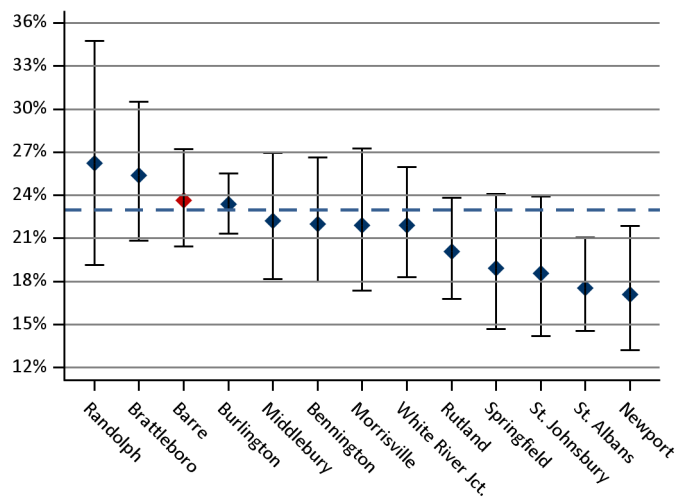
Figure 38: Presents the proportion, including 95% confidence intervals, of Vermont residents, ages 18 years and older, that said they did not meet fruit and vegetable consumption recommendations. This data was collected through the Behavioral risk Factor Surveillance System (BRFSS). The blue dashed line indicates the statewide average.

| Demographics / Health | Cost of Care | Utilization | Preventive Care / ACO | BRFSS | Data Detail |

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

The following tables provide greater detail on the annual risk-adjusted rates presented in the preceding figures.

Table 3. Expenditure Measures (Adjusted)

Measure	HSA			Statewide		
	Rate Per 1,000	95% LCL	95% UCL	Rate Per 1,000	95% LCL	95% UCL
Total	$6,923	$6,795	$7,051	$7,075	$7,030	$7,120
Inpatient Total	$1,447	$1,361	$1,533	$1,497	$1,467	$1,528
Inpatient Mental Health	$72	$57	$86	$78	$72	$84
Inpatient Maternity	$97	$88	$106	$86	$83	$89
Inpatient Surgical	$703	$633	$774	$736	$712	$760
Inpatient Medical	$596	$548	$644	$614	$598	$631
Outpatient Total	$2,034	$1,992	$2,076	$2,000	$1,985	$2,014
Outpatient Hospital Mental Health	$24	$21	$26	$23	$22	$24
Outpatient Hospital ED	$260	$251	$270	$271	$268	$274
Outpatient Hospital Surgery	$479	$456	$502	$476	$469	$484
Outpatient Hospital Radiology	$423	$397	$449	$479	$469	$489
Outpatient Hospital Laboratory	$342	$335	$349	$307	$305	$309
Outpatient Hospital Pharmacy	$90	$82	$99	$79	$76	$82
Outpatient Hospital Other	$909	$882	$935	$856	$847	$865
Professional Non-Mental Health Total	$1,184	$1,166	$1,202	$1,317	$1,310	$1,323
Professional Physician Total	$926	$910	$943	$974	$968	$980
Professional Physician Inpatient	$165	$154	$177	$173	$169	$177
Professional Physician Outpatient Facility	$309	$301	$318	$305	$302	$308
Professional Physician Office Visit	$390	$384	$397	$434	$432	$436
Professional Non-Physician	$241	$235	$246	$324	$322	$326
Professional Mental Health Provider	$156	$150	$162	$162	$159	$164
Pharmacy Total	$1,064	$1,037	$1,091	$1,102	$1,093	$1,112
Pharmacy Psych Medication	$194	$184	$204	$190	$187	$193
Other Total	$686	$651	$721	$685	$672	$697
Special Medicaid Services	$367	$324	$410	$290	$277	$303
Mental Health Substance Combined*	$428	$412	$445	$430	$424	$436

* The *Mental Health Substance Combined* measure is the sum of all expenditures associated with medical and pharmacy services for mental health / substance abuse.

Table 4. Total Resource Use Index (RUI) (Adjusted)

Measure	HSA			Statewide		
	Rate Per 1,000	95% LCL	95% UCL	Rate Per 1,000	95% LCL	95% UCL
Total	0.95	0.94	0.97	1.00	0.99	1.01
Inpatient	0.95	0.89	1.00	1.00	0.98	1.02
Outpatient Facility	1.00	0.97	1.02	1.00	0.99	1.01
Professional	0.93	0.91	0.94	1.00	1.00	1.00
Pharmacy	0.97	0.95	0.99	1.00	0.99	1.01

Table 5. Utilization Measures (Adjusted)

Measure	HSA			Statewide		
	Rate Per 1,000	95% LCL	95% UCL	Rate Per 1,000	95% LCL	95% UCL
Inpatient Discharges	104.1	100.4	107.7	110.2	108.9	111.6
Inpatient Discharges for Ambulatory Care Sensitive Conditions	18.9	17.4	20.5	17.6	17.0	18.1
Inpatient Days	516.0	507.8	524.1	512.5	509.6	515.3
Inpatient Readmissions within 30 Days	15.3	13.9	16.7	15.6	15.1	16.1
Outpatient ED Visits	424.4	417.0	431.8	405.6	403.1	408.2
Outpatient Potentially Avoidable ED Visits	72.8	69.7	75.9	65.8	64.8	66.8
Outpatient ED Ambulatory Care Sensitive Conditions	51.4	48.8	53.9	51.1	50.2	52.0
Non-Hospital Outpatient Visits	6,396.9	6,368.2	6,425.5	6,746.4	6,736.1	6,756.7
Primary Care Encounters	3,750.5	3,728.6	3,772.5	3,840.6	3,832.9	3,848.4
Medical Specialist Encounters	978.4	967.2	989.7	980.4	976.5	984.3
Surgical Specialist Encounters	1,185.9	1,173.6	1,198.3	1,187.2	1,182.8	1,191.5
Standard Imaging	977.5	966.3	988.7	979.9	976.0	983.8
Advanced Imaging	263.4	257.6	269.2	273.6	271.5	275.6
Echography	322.0	315.6	328.5	345.6	343.2	347.9
Colonoscopy	55.6	52.9	58.2	57.6	56.7	58.6

Table 6. Effective & Preventive Care Measures

Measure	HSA				Statewide			
	N	Rate %	95% LCL	95% UCL	N	Rate %	95% LCL	95% UCL
Comprehensive Diabetes Care (CDC)								
HbA1c Testing	2,406	95%	94%	96%	18,188	91%	91%	91%
LDL-C Screening	2,406	82%	81%	84%	18,188	77%	76%	77%
Eye Exam	2,406	50%	48%	52%	18,188	48%	47%	48%
Nephropathy Screening	2,406	85%	84%	86%	18,188	80%	79%	80%
Imaging Studies for Low Back Pain	1,148	87%	85%	89%	8,962	85%	84%	85%

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Table 7a. ACO Measures Detail

Measure		HSA				Statewide			
		N	Rate %	95% LCL	95% UCL	N	Rate %	95% LCL	95% UCL
Cervical Cancer Screening	Core-30	10,209	74%	73%	75%	81,392	69%	68%	69%
CCS–Commercial	Core-30	8,557	76%	75%	77%	65,173	71%	70%	71%
CCS–Medicaid	Core-30	1,652	67%	65%	69%	16,219	60%	60%	61%
Chlamydia Screening (Ages 16–24 Years)	Core-7	1,271	46%	43%	49%	10,033	46%	45%	47%
CHL–Commercial	Core-7	944	45%	42%	48%	7,001	45%	43%	46%
CHL–Medicaid	Core-7	327	50%	44%	55%	3,032	49%	47%	50%
Breast Cancer Screening (Ages 52–64 Years)	Core-11	4,019	81%	80%	83%	31,647	76%	76%	77%
BCS–Commercial (Ages 52–64 Years)	Core-11	3,336	85%	84%	86%	25,427	80%	80%	81%
BCS–Medicaid (Ages 52–64 Years)	Core-11	320	62%	56%	67%	3,335	59%	57%	61%
BCS–Medicare (Ages 52–64 Years)	Core-11	363	66%	61%	71%	2,885	59%	58%	61%
BCS (Ages 52–74 Years)	Core-11	5,472	80%	79%	81%	44,732	75%	75%	76%
BCS (Ages 65–74 Years)	Core-11	1,453	77%	75%	79%	13,085	73%	72%	74%
Follow-up After Hospitalization for Mental Illness (7 day)	Core-4	162	43%	35%	51%	1,208	48%	45%	51%
FUH–Commercial	Core-4	37	59%	42%	77%	281	56%	50%	62%
FUH–Medicaid	Core-4	91	38%	28%	49%	706	48%	44%	52%
FUH–Medicare	Core-4	34	35%	18%	53%	221	39%	33%	46%
Initiation of Alcohol/Drug Treatment	Core-5a	195	21%	15%	26%	1,937	29%	27%	31%
IET (INI)–Medicaid	Core-5a	194	20%	14%	26%	1,927	29%	27%	31%
Engagement of Alcohol/Drug Treatment	Core-5b	195	12%	7%	17%	1,937	19%	17%	21%
IET (ENG)–Medicaid	Core-5b	194	12%	7%	17%	1,927	19%	17%	21%
Cholesterol Management for Patients with CVD	Core-3	469	74%	70%	78%	4,651	75%	74%	76%
CMC–Commercial	Core-3	192	73%	66%	79%	1,581	70%	68%	72%
CMC–Medicaid	Core-3	38	74%	58%	89%	362	68%	63%	73%
CMC–Medicare	Core-3	239	76%	70%	81%	2,708	79%	77%	80%
Avoidance of Antibiotic Treatment for Acute Bronchitis	Core-6	474	27%	23%	31%	4,246	25%	24%	27%
AAB–Commercial	Core-6	303	29%	24%	35%	2,650	27%	25%	28%
AAB–Medicaid	Core-6	113	20%	12%	28%	1,127	24%	21%	26%
AAB–Medicare	Core-6	58	29%	17%	42%	469	23%	19%	26%
Influenza Vaccination	MSSP-14	15,155	32%	31%	32%	81,497	35%	35%	35%
INF–Commercial	MSSP-14	7,829	30%	29%	31%	38,390	31%	30%	31%
INF–Medicaid	MSSP-14	2,037	28%	26%	30%	12,805	31%	30%	31%
INF–Medicare	MSSP-14	5,289	35%	33%	36%	30,302	42%	42%	43%

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Table 7a. ACO Measures Detail, Continued

Measure		HSA				Statewide			
		N	Rate %	95% LCL	95% UCL	N	Rate %	95% LCL	95% UCL
Diabetes HbA1c in Control (<8%)	MSSP-22	311	86%	81%	90%	4,771	75%	74%	77%
Diab–Commercial (HbA1c in Control)	MSSP-22	135	84%	78%	91%	1,847	74%	72%	76%
Diab–Medicaid (HbA1c in Control)	MSSP-22	40	78%	63%	92%	563	67%	63%	71%
Diab–Medicare (HbA1c in Control)	MSSP-22	136	89%	83%	95%	2,361	79%	77%	81%
Diabetes LDL in Control (<100 mg/dL)	MSSP-23	113	53%	43%	63%	3,129	60%	59%	62%
Diab–Commercial (LDL)	MSSP-23	54	52%	38%	66%	1,293	57%	54%	59%
Diab–Medicare (LDL)	MSSP-23	47	57%	42%	73%	1,523	66%	63%	68%
Diabetes Blood Pressure in Control (<140/90 mmHg)	MSSP-24	705	71%	68%	74%	7,980	74%	73%	75%
Diab–Commercial (BP)	MSSP-24	298	72%	67%	78%	3,003	75%	74%	77%
Diab–Medicaid (BP)	MSSP-24	80	69%	58%	80%	1,033	72%	69%	74%
Diab–Medicare (BP)	MSSP-24	327	70%	65%	75%	3,944	73%	72%	75%
Diabetes Tobacco Use in Control	MSSP-25	235	79%	73%	84%	1,750	74%	72%	76%
Diab–Commercial (Tob)	MSSP-25	95	88%	81%	95%	522	84%	80%	87%
Diab–Medicaid (Tob)	MSSP-25	39	54%	37%	71%	288	56%	50%	61%
Diab–Medicare (Tob)	MSSP-25	101	79%	71%	88%	940	75%	72%	78%
Diabetes HbA1c Not in Control (>9%)	Core-17	331	7%	4%	10%	5,129	13%	12%	14%
Diab–Commercial (HbA1c Not in Control)	Core-17	135	4%	1%	8%	1,847	13%	11%	14%
Diab–Medicaid (HbA1c Not in Control)	Core-17	60	22%	10%	33%	904	22%	19%	25%
Diab–Medicare (HbA1c Not in Control)	Core-17	136	4%	0%	7%	2,378	9%	8%	11%
Hypertension with BP in Control (<140/90 mmHg)	MSSP-28	1,530	68%	66%	71%	20,136	73%	72%	74%
HYP–Commercial (Ages 18–85 Years)	MSSP-28	627	67%	64%	71%	7,259	72%	71%	73%
HYP–Medicaid (Ages 18–85 Years)	MSSP-28	112	60%	50%	69%	1,607	68%	66%	70%
HYP–Medicare (Ages 18–85 Years)	MSSP-28	791	70%	67%	73%	11,270	75%	74%	75%
HYP (Ages 18–64 Years)	MSSP-28	879	65%	62%	68%	10,349	71%	70%	72%
HYP (Ages 65–85 Years)	MSSP-28	651	73%	69%	76%	9,787	75%	74%	76%

Table 7b. ACO Measures Detail

Measure		HSA				Statewide			
		N	Observed / Expected Ratio	LCL	UCL	N	Observed / Expected Ratio	LCL	UCL
Plan All-Cause Readmissions	Core-1	2,024	0.83	0.73	0.93	18,692	0.97	0.94	1.00
PCR–Commercial	Core-1	524	0.72	0.54	0.91	4,085	0.78	0.72	0.85
PCR–Medicaid	Core-1	264	1.29	1.04	1.55	2,608	0.99	0.91	1.07
PCR–Medicare	Core-1	1,236	0.77	0.64	0.90	11,999	1.02	0.98	1.06

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Table 7c. ACO Measures Detail

Measure		HSA				Statewide			
		N	Rate Per 1,000	95% LCL	95% UCL	N	Rate Per 1,000	95% LCL	95% UCL
ACS Admissions for COPD and Asthma	Core-10	21,393	6.0	5.0	7.1	174,259	4.6	4.3	4.9
PQI–Commercial (COPD and Asthma)	Core-10	12,227	1.1	0.5	1.7	92,962	0.7	0.5	0.9
PQI–Medicaid (COPD and Asthma)	Core-10	1,747	5.2	1.8	8.5	17,130	5.0	4.0	6.1
PQI–Medicare (COPD and Asthma)	Core-10	7,419	14.3	11.6	17.0	64,167	10.2	9.4	11.0
ACS Admissions for Congestive Heart Failure	MSSP-10	29,937	3.7	3.0	4.4	244,958	3.4	3.2	3.6
PQI–Commercial (CHF)	MSSP-10	18,307	0.3	0.0	0.5	140,833	0.2	0.2	0.3
PQI–Medicaid (CHF)	MSSP-10	3,889	1.0	0.0	2.0	37,667	1.0	0.6	1.3
PQI–Medicare (CHF)	MSSP-10	7,741	13.0	10.5	15.6	66,459	11.5	10.7	12.3
PQI Composite (Chronic)	Core-12	29,937	9.4	8.3	10.4	244,958	8.7	8.4	9.1
PQI–Commercial (Comp)	Core-12	18,307	1.5	0.9	2.0	140,833	1.3	1.1	1.5
PQI–Medicaid (Comp)	Core-12	3,889	8.5	5.6	11.4	37,667	7.0	6.2	7.9
PQI–Medicare (Comp)	Core-12	7,741	28.4	24.7	32.2	66,459	25.5	24.3	26.7

Table 8. ACO Measures Reference Table

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-1		Plan All-Cause Readmissions	NQF #1768, HEDIS measure	Adult	For members 18 years and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.
Core-2		Adolescent Well-Care Visit	HEDIS measure	Pediatric	The percentage of members 12-21 years who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)	NQF #0075, NCQA	Adult	The percentage of members 18-75 years who were discharged alive for acute myocardial infarction, coronary artery bypass grafting, or percutaneous coronary intervention in the year prior to the measurement year or who had a diagnosis of Ischemic Vascular Disease during the measurement year and one year prior, who had LDL-C screening.
Core-4		Follow-up after Hospitalization for Mental Illness, 7 Day	NQF #0576, HEDIS measure	Adult	The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Core-5		Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement	NQF #0004, HEDIS measure	Adult	(a) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment within 14 days. (b) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and had two additional services with a diagnosis of AOD within 30 days of the initiation visit.
Core-6		Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	NQF #0058, HEDIS measure	Adult	The percentage of adults 18-64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic.
Core-7		Chlamydia Screening in Women	NQF #0033, HEDIS measure	Adult and Pediatric	The percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period.
Core-8		Developmental Screening in the First Three Years of Life	NQF #1448	Pediatric	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.
Core-10	MSSP-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF, AHRQ (Prevention Quality Indicator (PQI) #5)	Adult	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.
Core-11	MSSP-20	Mammography / Breast Cancer Screening	NQF #0031, HEDIS measure	Adult	The percentage of women 50-74 years who had a mammogram to screen for breast cancer in the last two years.
Core-12		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite	NQF, AHRQ (Prevention Quality Indicator (PQI) Chronic Composite)	Adult	Prevention Quality Indicators' (PQI) overall composite per 100,000 population, ages 18 years and older; includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Table 8. ACO Measures Reference Table, Continued

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-13		Appropriate Testing for Children with Pharyngitis	NQF #0002	Pediatric	Percentage of children 2-18 years who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode.
Core-14		Childhood Immunization Status (Combo 10)	NQF #0038, HEDIS measure	No	The percentage of children 2 years of age who had each of nine key vaccinations (e.g., MMR, HiB, HepB, etc.).
Core-15		Pediatric Weight Assessment and Counseling	NQF #0024	No	The percentage of members 3-17 years who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
Core-16	MSSP-22,-23,-24,-25,-26	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	NQF #0729 (composite)	Adult	(a) MSSP-22: Percentage of patients 18-75 years with diabetes who had HbA1c <8% at most recent visit; (b) MSSP-23: Percentage of patients 18-75 years with diabetes who had LDL <100 mg/dL at most recent visit; (c) MSSP-24: Percentage of patients 18-75 years with diabetes who had blood pressure <140/90 at most recent visit; (d) MSSP-25: Percentage of patients 18-75 years with diabetes who were identified as a non-user of tobacco in measurement year; (e) MSSP-26: Percentage of patients 18-75 years with diabetes and IVF who used aspirin daily -- Aspirin use was not included as part of the profile composite.
Core-17	MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059, NCQA	Adult	Percentage of patients 18-75 years with diabetes whose HbA1c was in poor control >9%.
Core-18	MSSP-19	Colorectal Cancer Screening	NQF #0034, NCQA HEDIS measure	No	The percentage of members 50-75 years who had appropriate screening for colorectal cancer.
Core-19	MSSP-18	Depression Screening and Follow-Up	NQF #0418, CMS	No	Patients 12 years and older who had negative screening or positive screening for depression completed in the measurement year with an age-appropriate standardized tool. Follow-up for positive screening must be documented same day as screening.
Core-20	MSSP-16	Adult Weight Screening and Follow-Up	NQF #0421, CMS	No	Patients 18 years and older who had BMI calculated during the last visit in the measurement year or within the prior 6 months. In cases where the BMI is abnormal, a follow-up plan must be documented during the visit the BMI was calculated or within the prior 6 months.
Core-21		Access to Care Composite	NCQA	No	NCQA Survey - percentage of patients who could get appointments or answers to questions from providers when needed.
Core-22		Communication Composite	NCQA	No	NCQA Survey - percentage of patients who felt they received good communication from providers.
Core-23		Shared Decision-Making Composite	NCQA	No	NCQA Survey - percentage of patients whose provider helped them make decisions about prescription medications.
Core-24		Self-Management Support Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about specific health goals and barriers.
Core-25		Comprehensiveness Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about depression, stress, and other mental health issues.
Core-26		Office Staff Composite	NCQA	No	NCQA Survey - percentage of patients who found the clerks and receptionists at their provider's office to be helpful and courteous.

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HSA Profile: Barre

Period: 01/2013 - 12/2013 **Profile Type:** Adults (18+ Years)

Table 8. ACO Measures Reference Table, Continued

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-27		Information Composite	NCQA	No	NCQA Survey - percentage of patients who received information from their provider about what to do if care was needed in the off hours and reminders between visits.
Core-28		Coordination of Care Composite	NCQA	No	NCQA Survey - percentage of patients whose providers followed-up about test results, seemed informed about specialty care, and talked at each visit about prescription medication.
Core-29		Specialist Composite	NCQA	No	NCQA Survey - percentage of patients who found it easy to get appointments with specialists and who found that their specialist seemed to know important information about their medical history.
Core-30		Cervical Cancer Screening	NQF #0032, HEDIS measure	Adult	The percentage of females 21-64 years who received one or more PAP tests to screen for cervical cancer in the measurement year or two years prior to the measurement year.
Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #0068, NCQA	No	Percentage of patients 18 years and older with IVD who had documentation of using aspirin or another antithrombotic during the measurement year.
Core-35	MSSP-14	Influenza Vaccination	NQF #0041, AMA-PCPI	Adult	Patients 6 months and older with an outpatient visit between October and March who received an influenza vaccine.
Core-36	MSSP-17	Tobacco Use Assessment and Cessation Intervention	NQF #0028, AMA-PCPI	No	Percentage of patients 18 years and older who had a negative tobacco screen or positive tobacco screen with cessation intervention in the two years prior to the measurement year.
Core-38	MSSP-32	Drug Therapy for Lowering LDL Cholesterol	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and an outpatient visit in the measurement year whose LDL-C <100 mg/dL or LDL-C >=100 mg/dL and who received a prescription of a statin in the measurement year.
Core-38	MSSP-33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and a LVEF < 40% or diagnosis of CAD and diabetes who received a prescription of ACE/ARB medication in the measurement year.
Core-39	MSSP-28	Percent of Beneficiaries With Hypertension Whose BP < 140/90 mmHg	NQF #0018, NCQA HEDIS measure	Adult	Percentage of patients 18-85 years with hypertension whose BP was in control <140/90 mmHg.
Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented	Not NQF-endorsed; MSSP	No	Percentage of patients 18 years and older seen during the measurement period who were screened for high blood pressure and a recommended follow-up plan is documented based on the current blood pressure reading as indicated.
Core-47	MSSP-13	Falls: Screening for Fall Risk	NQF #0101	No	Percentage of patients 65 years and older who had any type of falls screening in the measurement year.
Core-48	MSSP-15	Pneumonia Vaccination (Ever Received)	NQF #0043	Adult	Patients 65 years and older who had documentation of ever receiving a pneumonia vaccine.

Table 8. ACO Measures Reference Table, Continued

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
	MSSP-1	CG CAHPS: Getting Timely Care, Appointments, and Information	NQF #0005, AHRQ	No	CMS Survey - Getting Timely Care, Appointments, and Information
	MSSP-2	CG CAHPS: How Well Your Doctors Communicate	NQF #0005, AHRQ	No	CMS Survey - How Well Your Doctors Communicate
	MSSP-3	CG CAHPS: Patients' Rating of Doctor	NQF #0005, AHRQ	No	CMS Survey - Patients' Rating of Doctor
	MSSP-4	CG CAHPS: Access to Specialists	NQF #0005, AHRQ	No	CMS Survey - Access to Specialists
	MSSP-5	CG CAHPS: Health Promotion and Education	NQF #0005, AHRQ	No	CMS Survey - Health Promotion and Education
	MSSP-6	CG CAHPS: Shared Decision Making	NQF #0005, AHRQ	No	CMS Survey - Shared Decision Making
	MSSP-7	CG CAHPS: Health Status / Functional Status	NQF #0006 , AHRQ	No	CMS Survey - Health Status/Functional Status
	MSSP-8	Risk-Standardized, All Condition Readmission	CMS, not submitted to NQF (adapted from NQF #1789)	No	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.
	MSSP-10	Ambulatory Sensitive Condition Admissions: Congestive Heart Failure	NQF #0277, AHRQ (Prevention Quality Indicator (PQI) #8)	Adult	All discharges with an ICD-9-CM principal diagnosis code for CHF in adults ages 18 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with CHF. This is an observed rate of discharges per 1,000 members.
	MSSP-11	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CMS EHR Incentive Program Reporting	No	Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Program incentive payment.
	MSSP-12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #0554	No	Percentage of patients 65 years and older who were discharged from any inpatient facility in the measurement year and had an outpatient visit within 30 days of the discharge who had documentation in the outpatient medical record of reconciliation of discharge medications with current outpatient medications during a visit within 30 days of discharge.
	MSSP-31	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #0083	No	Percentage of patients 18 years and older with a diagnosis of heart failure who also had LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
M&E-2		Comprehensive Diabetes Care: Eye Exams for Diabetics	NQF #0055, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received an eye exam for diabetic retinal disease during the measurement year.
M&E-3		Comprehensive Diabetes Care: Medical Attention for Nephropathy	NQF #0062, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received a nephropathy screening test during the measurement year.

Attachment 4

Episodes of Care Sub-Group

February 12, 2015

Meeting 2

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Meeting 2: Objectives

- MVP Episodes of Care Analytics presentation

- Review PMWG EOC selection criteria

- Identify 'Priority' Episodes, and determine scope of analytics request

- Prepare for methodology discussion on March 6th

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PMWG's EOC Selection Criteria

1. EOC is of interest to providers
2. EOC is consistent with state-wide clinical priorities and/or other health reform efforts
3. EOC has adequate sample size across payers and providers
4. EOC has high potentially avoidable complication (PAC) rate or other defined opportunities for improvement
5. EOC has high resource variation
6. EOC represents opportunities to improve coordination of care among primary care, specialists and other specialized service providers (e.g., MH, SA, DTLSS)
7. EOC has evidence-based guidelines or clinical pathways that could improve care delivery system or quality of care

Sub-Group Decision Points

- How many episodes should we target for future analytics?
  - Limited sub-set?
  - "Universe" of episodes (vendor dependent)?

- If we prioritizing particular episodes, which episodes of interest would we like to highlight in future analytics?
  - Sub-group staff will prepare more detailed, episode-specific reports for review and discussion at next meeting.

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Brainstorming: Sub-set vs. All Episodes

	PRO	CON
Episode Sub-Set	• Potential to encourage shared focus across providers and stakeholders on episodes of mutual interest • • •	• Limited to certain specialties and/or provider types • • • • •
Universe of Episodes	• Inclusive of many specialties and/or provider types • Analytics on large number of episodes possible at little added cost • •	• Potential to overwhelm providers and/or diminish focus on episodes of mutual interest • • •

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Brainstorming: Episodes of Interest

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Brainstorming: VHCURES Flag "Wish List"

- ACO attribution

- Blueprint attribution

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Meeting 3: Objectives

- Focused discussion about key methodological consideration for selected episodes of interest
  - Levels of variation (HSA, provider, payer)
  - Minimum sample size
  - Provider attribution
  - Risk adjustment

March 6th from 9-11am in Montpelier (EXE 4th floor conference room)

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