Attachment 1a - DLTSS Work Group Meeting Agenda 5-22-14

VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, May 22 2014; 10:00 AM to 12:30 AM

DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Action
1	10:00 – 10:10	**Welcome; Introductions; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from April meeting	
2	10:10 – 12:15	**DLTSS Quality and Performance Measures Recommendations to the QPM Work Group** Deborah Lisi-Baker and Judy Peterson	• Attachment 2a: Shared Savings ACO Program All Measures-DLTSS Review • Attachment 2b: Performance Measures Reference Document for Discussion at DLTSS • Attachment 2c: Quality & Performance Measures (QPM) Work Group Selection Criteria dated 4/24/14.	
3	12:15 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson	Next Meeting: June 19th 10:00 am-12:30pm, Williston	

Attachment 1b - DLTSS Work Group Minutes 4-24-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Thursday April 24, 2014, 10 am – 12:30 pm, DVHA, 312 Hurricane Lane, Williston, VT

Attendees: Deborah Lisi-Baker and Judy Peterson, Co-Chairs; Georgia Maheras, AoA; Sam Liss, Statewide Independent Living Council; Dion LaShay, Consumer; Pat Jones, GMCB; Dale Hackett, Consumer; Ed Paquin, Disability Rights Vermont; Joy Chilton, CVHHH; Erin Flynn, Alicia Cooper, Amy Coonradt, Kara Suter, DVHA; Marlys Waller, Julie Tessler, VT Council of Developmental and Mental Health Services; Patrick Flood, Northern Counties Health Care; Brendan Hogan, Bailit Health Purchasing; Susan Besio, PHPG; Kirsten Murphy, VT Developmental Disabilities Council; Jeanne Hutchins, UVM Center on Aging; Trinka Kerr, HCA; Rachel Seelig, VT Legal Aid; Jason Williams, FAHC; Eileen Peltier, CVCLT; Jen Woodard, DAIL; Norm Ward, OneCare; Marie Zura, Howard Center; John Barbour, CVAAA; Nelson LaMothe, Jessica Mendizabal, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Judy Peterson called the meeting to order at 10:04 am. Judy asked for a motion to approve the minutes. Trinka Kerr moved to approve the minutes and Marybeth McCaffrey seconded. Dion LaShay noted his name was misspelled in the minutes. Pending the change, the motion passed unanimously.	**The minutes will be updated and reposted to the website.**
2. Approval of DLTSS Charter Discussion and approval of DLTSS work plan	Regarding final review of the work plan and charter (attachments 2a&b), there have not been any changes but the group did not vote at the last meeting due to a lack of membership attendance. Dale Hackett moved to approve the work plan as presented and Trinka Kerr seconded. There was no discussion and the motion passed unanimously. A participant list (attachment 1c) was distributed noting members, alternates and interested parties. Clarification was offered concerning the meaning of each of these classifications as follows: Members have voting rights and alternates are assigned to represent voting members	**Carol will email Georgia to make the correction to the participant list.** **If participants think he/she should be a member, email**

Agenda Item	Discussion	Next Steps
	when they are unable to attend a meeting; interested parties do not vote, but are encouraged to offer input on the agenda items. It is generally preferred for interested parties to wait until the public comment period, but may also offer comment during the meeting if it is pertinent. It was noted by phone participant Dion LaShay that he did not receive a copy of the membership list as it was not ready in advance of the meeting and that a copy would be mailed to him. Any corrections to the information on the membership list should be directed to Georgia or Work Group staff. On that note, Carol Maroni noted she is listed as interested party, but should be a member.	**Georgia and copy Judy and Deborah.** **Changes to name spellings, organization affiliation etc. should be directed to Georgia.**
3. DLTSS Medicaid Expenditure Overview	Susan Besio from Pacific Health Policy Group (PHPG) presented attachment 3 on behalf of Scott Whitman, who could not attend due to illness. PHPG is a Medicaid consulting firm based out of Chicago but they are involved in Medicaid programs around the country and are very familiar with the VT Medicaid program as they have been working in Vermont for many years. The following points were noted during the presentation: • The majority of expenditures for DLTSS are through Medicaid. • For the purposes of this presentation, PHPG focused on Medicaid claims data, but they would consider expanding their analysis if more data are available to them via VHCURES (i.e. – Medicare claims data). • The data are based on calendar year 2012 Medicaid claims. Global Commitment investment dollars (about $70 million) are not included in these analyses. • The Medicaid claims were analyzed using three different views: 1) expenditures related to “traditional” health services versus specialized programs and services (Slides 4 through 10); 2) expenditures on behalf of individuals receiving specialized services versus all other Medicaid program participants (Slides 11 & 12); and 3) expenditures for people enrolled in Medicaid due to disability-related eligibility versus all other enrollees (Slides 13 & 14). • Medicaid funds expenditures for both “traditional services” (such as hospital and physician visits) and “Specialized programs and services” (such as long-term care mental health and developmental services). • Category of service codes were used to divide services into “traditional services” and “specialized services and programs” (list of these categories are provided on slide 4). • Regarding slide 4: traditional services were categorized based on their primary function of	

Agenda Item	Discussion	Next Steps
	providing acute care. Susan responded that it was based on knowledge of what types of services are connected to the specialized services and programs. • If participants find data flaws, PHPG can re-run the analyses. • Specialized Services are not services you'd see in a traditional health plan however it is hard to determine how to distinguish and classify specialized services from a traditional provider (e.g., home health, nursing home). For example, Nursing Home care is listed as a specialized service- but now that Choices of Care has started is that still accurate? PHPG will clarify the rationale for how these kinds of services were categorized at the next Work Group meeting. • The analyses indicate that 55% of the Medicaid budget is spent on specialized services. • Ed Paquin stated a lot of the acute care "Traditional" services are covered by Medicare for the dually eligible population so these expenditures are not included in these analyses. Susan indicated that around $288 million is spent on dual eligible Medicare services- Susan will check on the exact dollar amount. • Slides 9 and 10 give the detail behind the pie charts on slides 4 through 8, and slide 12 gives the detail behind pie charts on Slide 11. • School Health is listed as specialized services because it is a program that's draws down a federal match to help fund it. It's a unique program Vermont has developed and is not offered through most health care plans. • Children's vision is under traditional services. • John Barbour noted that on slide 8 the majority of expenses for people 65 and over go to Choices for Care, but if nursing homes were considered traditional care, 2/3 of the expenses would be going to nursing home care. • Children's services are targeted services delivered through specific programs. Dale Hackett commented that it would be interesting to see what happens to these children's health care expenditures as they become adults. It was noted that it would be expensive to track this since it can't be done through claims analysis and needs to be more in depth such as case records, chart reviews etc. to see what happens over time. • Sam Liss commented that he would like to see the Medicaid Program for Working People with Disabilities (MWPD) included as a Specialized Program. Brendan Hogan commented that these individuals are included in the analyses, but you cannot distinguish them since the MWPD is not a specific category of service or eligibility code.	**Suggestions for revised analyses should be sent to Julie Wasserman and copy Susan and Scott.** **PHPG would like feedback from the group on the statement at the bottom of slide 11, if the group is comfortable using this framework. Deadline for this and other questions is May 2nd.**

Agenda Item	Discussion	Next Steps
	• Table 14 is based on aid codes. John Barbour asked how people's expenditures were classified if they change programs during the year (e.g., if people are on Medicaid and then qualify for Choices for Care are they switched from traditional to non-traditional services. Susan will discuss with Scott. • Susan and Deborah Lisi-Baker indicated that it would be helpful to choose one of these three analysis views to use in future documents that discuss DLTSS expenditures so there is consistency over time. The Work Group informally agreed that the analyses presented on Slide 11 should be used in all DLTSS documents when we talk about expenditures: "Individuals receiving specialized services represent approximately 25 percent of total Medicaid participants receiving services, but coverage of services to meet their DLTSS and traditional medical needs comprises more than 70 percent of the Medicaid budget." The group will formally vote on these criteria at the May 22nd mtg.	
4. DLTSS Quality and Performance Measures Recommendation to QPM Work Group	**Existing Core Payment Measures (attachment 4a):** • Dion LaShay asked about the specification of the measure "Avoidance of Antibiotic Treatment", and expressed concern that he doesn't support avoidance of treatment when treatment is necessary. Clarification was offered that this measure relates to unnecessary use or over use of antibiotics and that clinical guidelines take into consideration those specific cases in which antibiotics were necessary. • Marybeth McCaffrey reminded the group that the Medicaid ACO Shared Savings Program has several measures which may be relevant to the DLTSS population which are currently on the "pending" list and could be recommended for promotion to "payment" or "reporting" status. DLTSS programs in Vermont are quite strong based on national standards and she would like to know how the DLTSS population is faring for those measures that we already collect in order to learn what we're doing right and what we can improve on. • Chlamydia is not a concern specifically for this population. • A recommendation was made that the group should focus on preventative measures and practices as much as possible. • Regarding measuring hospital admissions (in addition to readmissions): Pat Jones explained there are some measures related to ambulatory care sensitive admissions which are not included in the payment measures. There are other measures around	**Pat Jones can provide more information about the detailed specifications of the measure if the group would like.**

Agenda Item	Discussion	Next Steps
	admission but it is challenging to use these measures in payment model programs as they need to be risk adjusted based on many factors, so a crude measure of hospitalizations won't provide a lot of information. Ambulatory care measures would tell us more but it can be difficult to produce measures that can be compared across different care settings. • As one component of its recommendations, this group is looking specifically at measures that are already being collected, and for which they would like information specific to the DLTSS population within the measures that are already being collected. The group can focus on exploring measures related to topics that are more prevalent for the DLTSS population when they recommend new measures as the next step. • Reporting measures is another category (as well as payment, pending and monitoring and evaluation) which means that ACOs are required to report these measures, but their performance on these measures will not impact their shared savings. Some of the measures touched on earlier are included in the reporting measure set. Jeanne Hutchins moved to approve the recommendation for analysis of the proposed Existing Core Payment Measures with the exception of Chlamydia and Julie Tessler seconded. Dion LaShay opposed and Dale Hackett abstained. The motion passed. **Pending Measures (attachment 4b):** • Of the 22 pending measures, there are 4 slightly related to DLTSS. • It is possible for measures to be promoted from pending to payment or reporting for the 2nd year of the shared savings program, 2015. • Marybeth noted the Influenza Immunization is worth measuring, the group agreed. • The measures do not specifically relate to DLTSS. Jason Williams doesn't wish to recommend measures that are challenging to collect if they are not related. • Rachel Seelig stated that Care Transition measures are important for this population. She acknowledged the administration burden associated with performance measures, but believes that measures of this type are important for this population. Marybeth moved to approve a recommendation for measure Core-35 Influenza Immunization and Julie Tessler seconded. Dale Hackett abstained and the motion passed.	

Agenda Item	Discussion	Next Steps
	Rachel Seelig moved to include Core- 37 Care Transition and Trinka Kerr seconded. Jason Williams, Julie Tessler and Joy Chilton (for Larry Goetschius) opposed the motion. The motion passed. **Potential Measures (attachment 4c):** • Should Ambulatory Care, Hospital Admissions, and Diabetes be promoted from reporting status? Joy Chilton stated that raw measure of hospitalization for the DLTSS population doesn't need to be risk adjusted because it's not tied to payment and the group can look at the difference as to what services were provided. Pat responded that they will be collecting the raw utilization measures. • The group can make the recommendation both if new measures should be added, and if they should be classified as reporting, monitoring or payment measures. Any recommendation could come with the type of measure it should be. • Jason Williams asked if any benchmarks exist for the payment measures already being used. Alicia responded that they are looking at national benchmarks to develop performance targets. There are a few measures for which national benchmarks do not exist (Medicaid only). In that case Medicaid data is used to set the benchmark, and data will be collected to determine whether or not the ACO has achieved statistically significant performance improvement over the internal benchmark from year to year. You won't know how an ACO is performing until you have the year one data. • Developmental Mental Health services don't usually use claims based data- is it possible to measure results based accountability? One of the categories in place for year one is a set of patient experience measures in conjunction with a survey from Blueprint for Health. Part of the ACTT proposal includes a project where non-claims based measures will be reviewed in the future of the ACO programs. • Non-medical outcomes should be part of the payment measures. There are multiple surveys that other agencies use to collect this information. This group can use the combined data from those surveys to make informed recommendations.	
5. Proposed DLTSS Model of Care	Susan Besio presented the Proposed DLTSS Model of Care (attachment 5): • The Model of Care (MOC) presentation was distributed by email to Work Group members prior to the meeting to get their feedback; the MOC was then edited based on this feedback, and a document summarizing the comments and changes was distributed the	**Dion will send his comments to Deb and Susan by the end of the week.**

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	Work Group via email two days before this meeting. • These slides will be presented to the CMCM Work Group pending the approval of the DLTSS Work Group. • Kara Suter clarified that Medical Health Home collaborations (slide 16) can be virtual. • Marie Zura suggested using the bullets on slide 18 as performance measures. • The entire model of care is about getting services that are coordinated, making sure people can access care when they need it (physical and mental health parity is part of this). Dale Hackett asked that the slides make the focus on parity more explicitly stated. • Dion LaShay asked if people are going to receive help with navigation. Susan responded that patients will get a single point of contact they will be able to choose. In some cases patients are already working with someone they'll want to keep. Marybeth McCaffrey moved to approve the proposed DLTSS Model of Care and John Barbour seconded. He asked if Susan could move individual and quality of life to slide 1. There will be time to adjust the details of the model in the future but the group was encouraged to vote if they were comfortable with the general concept going to the CMCM Work Group as a recommendation for consideration in the work considering models of care. Marybeth suggested Susan should have more time to present at the Care Models meeting. The group voted and the motion to recommend that the model of care presentation go to the CMCM Work Group passed unanimously.	**Change last bullet on slide 20 to say Health Care Advocate.**
6. Public Comment/Updates/ Next Steps	There were no public comments offered. Next meeting: Friday, May 2nd, 2014 10:00 AM – 12:00 PM, 4th Floor Pavilion, Montpelier.	

Attachment 2a - Shared Savings ACO Program All Measures-DLTSS Review

Current Status of ACO All Measures and Proposed DLTSS Work Group Recommendations for Changes - 5/22/14

VT Measure ID	MSSP Measure ID	MEASURE *Note: Measures in BOLD have a DLTSS WG recommendation*	Measure Domain	Nationally Recognized /Endorsed	Impact on Current Measure Collection Infrastructure	Linked to Payment, Monitoring, or Program Evaluation (ACO Year 1)	DLTSS WG Recommendations (based on expectation that the impact may be more significant for the DLTSS population) Black = DLTSS WG recommendation on 4/24/14 Red = New proposed DLTSS WG recommendation Green = New proposed DLTSS endorsement of others' recommendation Blue = New proposed DLTSS sub-population analysis	See specific section in "Performance Measures Discussion Reference Document for DLTSS Work Group"	Other WG Recommendations
Core-1		**All-Cause Readmission**	Care Coordination/ Patient Safety	NQF #1768, HEDIS measure	Administrative Claims	Payment	Recommended DLTSS sub-population analysis to QPM WG on 4/28	8.C.	
Core-2		Adolescent Well-Care Visit	Children/Adolescents	HEDIS measure	Administrative Claims	Payment			
Core-3	MSSP-29	**Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)**	Chronic Conditions: Cardiovascular	NQF #0075, NCQA	Administrative Claims	Payment	Recommended DLTSS sub-population analysis to QPM WG on 4/28		
Core-4		**Follow-up after Hospitalization for Mental Illness, 7 day**	Care Coordination/ Patient Safety	NQF #0576, HEDIS measure	Administrative Claims	Payment	Recommended DLTSS sub-population analysis to QPM WG on 4/28		
Core-5		**Initiation & Engagement of Alcohol and Other Drug Dependence Treatment a) Initiation, b) Engagement**	Effectiveness of Care	NQF #0004, HEDIS measure	Administrative Claims	Payment	Recommended DLTSS sub-population analysis to QPM WG on 4/28		
Core-6		**Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis**	Overuse	NQF #0058, HEDIS measure	Administrative Claims	Payment	Recommended DLTSS sub-population analysis to QPM WG on 4/28		
Core-7		Chlamydia Screening in Women	Preventive Health: Screening	NQF #0033, HEDIS measure	Administrative Claims	Payment			
Core-8		**Developmental Screening in the First Three Years of Life**	Children/Adolescents	NQF #1448	Administrative Claims	Payment	Endorse Pop Health WG recommendation; include DLTSS sub-population analysis	8.A.	Pop Health WG recommended inclusion for Commercial ACOs to QPM WG on 4/28
Core-10	MSSP-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	Care Coordination/ Patient Safety	NQF #0275, AHRQ (Prevention Quality Indicator (PQI) #5)	Administrative Claims	Reporting			DVHA recommended change to Payment for Year 2 (due to CMS memo) to QPM WG on 4/28
Core-11	MSSP-20	Mammography/ Breast Cancer Screening	Preventive Health: Screening	NQF #0031, HEDIS measure	Administrative Claims	Reporting			
Core-12		**Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Composite**	Care Coordination/ Patient Safety	NQF #0275, AHRQ (Prevention Quality Indicator (PQI) Composite)	Administrative Claims	Reporting	Endorse DVHA recommendation; include DLTSS sub-population analysis	8.B.	DVHA recommended change to Payment for Year 2 (due to CMS comments) to QPM WG on 4/28
Core-13		Appropriate Testing for Children with Pharyngitis	Children/Adolescents	NQF #0002	Administrative Claims	Reporting			
Core-14		Childhood Immunization Status (Combo 10)	Children/Adolescents	NQF # 0038, HEDIS measure	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Reporting			
Core-15		**Pediatric Weight Assessment and Counseling**	Children/Adolescents	NQF #0024	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Reporting	Proposed new recommendation: Promote to Payment for Years 2 and 3; include DLTSS sub-population analysis	6, 8.F.	
Core-16	MSSP-22-26	**Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use**	Chronic Conditions: Diabetes	NQF #0729 (Composite)	Administrative Claims, Electronic Clinical Data (Laboratory), Paper Medical Records	Reporting	Proposed new recommendation: Promote to Payment for Years 2 and 3; include DLTSS sub-population analysis	6, 8.G.	
Core-17	MSSP-27	**Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)**	Chronic Conditions: Diabetes	NQF #0059, NCQA	Administrative Claims, Electronic Clinical Data(Laboratory), Paper Medical Records	Reporting	Proposed new recommendation: Promote to Payment for Years 2 and 3; include DLTSS sub-population analysis	6	
Core-18	MSSP-19	Colorectal Cancer Screening	Preventive Health: Screening	NQF #0034, NCQA HEDIS Measure	Administrative Claims, Electronic Clinical Data: (Imaging/Diagnostic Study, Laboratory), Paper Medical Records	Reporting			
Core-19	MSSP-18	**Depression Screening and Follow-Up**	Preventive Health (Mental Health): Screening	NQF #0418 , CMS	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Reporting	Proposed new recommendation: Promote to Payment for Years 2 and 3; include DLTSS sub-population analysis	6	
Core-20	MSSP-16	**Adult Weight Screening and Follow-Up**	Preventive Health: Obesity	NQF #0421, CMS	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Reporting	Proposed new recommendation: Promote to Payment for Years 2 and 3; include DLTSS sub-population analysis	6, 8.F.	
Core-21		Access to Care Composite	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	Reporting	Include DLTSS sub-population analysis	9	

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Core-22		Communication Composite	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**	**Include DLTSS sub-population analysis**	**9**	
Core-23		Shared Decision-Making Composite	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**	**Include DLTSS sub-population analysis**	**9**	
Core-24		Self-Management Support Composite	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**	**Include DLTSS sub-population analysis**	**9**	
Core-25		Comprehensiveness Composite	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**	**Include DLTSS sub-population analysis**	**9**	
Core-26		Office Staff Composite	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**	**Include DLTSS sub-population analysis**	**9**	
Core-27		Information Composite	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**			
Core-28		**Coordination of Care Composite**	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**	**Proposed new recommendations: 1) Add question regarding case manager assistance with individual's needs; 2) Add question regarding provider knowledge of individual's DLTSS use; include DLTSS sub-population analysis**	**9**	
Core-29		**Specialist Composite**	Patient/Caregiver Experience	NCQA	PCMH CAHPS Survey	**Reporting**	**Proposed new recommendation: Add question regarding specialist knowledge of individual's DLTSS use; include DLTSS sub-population analysis**	**9**	
NEW		**LTSS Rebalancing: Ratio of HCBS utilization to institutional utilization (number of people and expenditures) in DLTSS sub-population**	Effectiveness of Care		Administrative Claims		**Proposed new recommendation: Include as Reporting for Year 2 and Payment for Year 3; based on DLTSS sub-population**	**7**	
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Chronic Conditions: Cardiovascular	NQF #0075, NCQA	Administrative Claims, Electronic Clinical Data(Laboratory), Paper Medical Records	**Pending**			
Core-30		Cervical Cancer Screening	Preventive Health: Screening	NQF #0032, HEDIS measure	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			Pop Health WG recommended promotion to Reporting to QPM WG on 4/28
Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Chronic Conditions: Cardiovascular	NQF #0068, NCQA	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			
Core-32		Proportion not Admitted to Hospice (cancer patients)	End-of-Life Care	NQF #0215	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			
Core-33		Elective Delivery before 39 Weeks	Pregnant Women	NQF #0469	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			
Core-34		Prenatal and Postpartum Care Timeliness	Pregnant Women	NQF #1517	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			Pop Health WG recommended promotion to Reporting to QPM WG on 4/28
Core-35	MSSP-14	**Influenza Immunization**	Preventive Health: Immunizations	NQF #0041, AMA-PCPI	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**	**Made same recommendation as Pop Health WG to QPM WG on 4/28 plus promotion to Payment in Year 3; include DLTSS sub-population analysis**	**4, 5**	Pop Health WG recommended promotion to Reporting to QPM WG on 4/28
Core-36	MSSP-17	**Tobacco Use Assessment and Tobacco Cessation Intervention**	Preventive Health: Tobacco	NQF #0028, AMA-PCPI	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**	**Endorse Pop Health WG recommendation; include DLTSS sub-population analysis**	**5**	Pop Health WG recommended promotion to Reporting to QPM WG on 4/26
Core-37		**Care Transition-Transition Record Transmittal to Health Care Professional**	Care Coordination/ Patient Safety	NQF #0648	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**	**Recommended promotion to Reporting for Year 2 and Payment for Year 3 to QPM WG on 4/28; include DLTSS sub-population analysis**	**4**	

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Core-38	MSSP-32-33	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-C	Chronic Conditions: Cardiovascular	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	Administrative Claims, Electronic Clinical Data (Laboratory), Pharmacy, Paper Medical Records	**Pending**			
Core-39	MSSP-28	**Hypertension (HTN): Controlling High Blood Pressure**	At Risk Population: Hypertension	NQF #0018, NCQA HEDIS measure	Administrative Claims, Electronic Clinical Data(Laboratory), Paper Medical Records	**Pending**	**Endorse Pop Health WG recommendation; include DLTSS sub-population analysis**	**5, 8.G.**	Pop Health WG recommended promotion to Reporting to QPM WG on 4/28
Core-40	MSSP-21	**Screening for High Blood Pressure and Follow-Up Plan Documented**	At Risk Population: Hypertension	CMS	Administrative Claims, Electronic Clinical Data(Laboratory), Paper Medical Records	**Pending**	**Endorse Pop Health WG recommendation; include DLTSS sub-population analysis**	**5, 8.G.**	Pop Health WG recommended promotion to Reporting to QPM WG on 4/28
Core-41		How's Your Health? **	Patient Engagement		*TBD*	**Pending**			
Core-42		Patient Activation Measure	Patient Engagement		Ongoing Blueprint Survey	**Pending**			
Core-43		Frequency of Ongoing Prenatal Care	Effectiveness of Care	NQF # 1391, HEDIS Measure	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			
Core-44		**Percentage of Patients with Self-Management Plans --> Transition Record with Specified Elements Received by Discharged Patients**	Care Coordination/ Patient Safety	**Suggest using specifications for NQF #2036 (paired with Core 37)**	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**	**Made same recommendation as Pop Health WG to QPM WG on 4/28 plus promotion to Payment in Year 3; include DLTSS sub-population analysis**	**4**	Pop Health WG recommended promotion to Reporting to QPM WG on 4/28
Core-45		**Screening, Brief Intervention, and Referral to Treatment**	Mental Health/ Substance Abuse	AHRQ Measure	*TBD*	**Pending**	**Endorse Pop Health WG recommendation; include DLTSS sub-population analysis**	**5**	Pop Health WG recommended promotion to Reporting to QPM WG on 4/28
Core-46		Trauma Screen Measure	Children/Adolescents		*TBD*	**Pending**			
Core-47	MSSP-13	Falls: Screening for Future Fall Risk	Elderly	NQF #0101	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			
Core-48	MSSP-15	Pneumococcal Vaccination for Patients 65 Years and Older	Elderly	NQF #0043	Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			
Core-49		Use of High-Risk Medications in the Elderly	Elderly	NQF #0022, HEDIS Measure	Administrative Claims, Pharmacy	**Pending**			
Core-50		Persistent Indicators of Dementia without a Diagnosis	Elderly		Administrative Claims, Electronic Clinical Data, Paper Medical Records	**Pending**			
M&E-1		Appropriate Medications for People With Asthma	Overuse	NQF #0036, HEDIS measure	Administrative Claims, Pharmacy	**Monitoring & Evaluation**			
M&E-2		Comprehensive Diabetes Care: Eye Exams for Diabetics	Chronic Conditions: Diabetes	NQF #0055, HEDIS measure	Administrative Claims	**Monitoring & Evaluation**			
M&E-3		Comprehensive Diabetes Care: Medical Attention for Nephropathy	Chronic Conditions: Diabetes	NQF #0062, HEDIS measure	Administrative Claims	**Monitoring & Evaluation**			
M&E-4		Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Chronic Conditions: COPD	NQF #0577, HEDIS measure	Administrative Claims	**Monitoring & Evaluation**			
M&E-5		Follow-Up Care for Children Prescribed ADHD Medication	Children/Adolescents	NQF #0108, HEDIS measure	Administrative Claims, Pharmacy	**Monitoring & Evaluation**			
M&E-6		Antidepressant Medication Management	Effectiveness of Care	NQF #0105, HEDIS measure	Administrative Claims, Pharmacy	**Monitoring & Evaluation**			
M&E-7		Family Evaluation of Hospice Care Survey	End-of-Life Care	NQF #0215	Hospice Survey (Statewide)	**Monitoring & Evaluation**			
M&E-8		School Completion Rate	Social Determinants		State Data	**Monitoring & Evaluation**			
M&E-9		Unemployment Rate	Social Determinants		State Data	**Monitoring & Evaluation**			
M&E-10		Total Cost of Care: Total Cost Index	Utilization	NQF #1604	Administrative Claims	**Monitoring & Evaluation**			
M&E-11		Total Cost of Care: Resource Use Index	Utilization	NQF #1598	Administrative Claims	**Monitoring & Evaluation**			
M&E-12		Ambulatory Surgery/1000	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-13		Average # of Prescriptions PMPM	Utilization		Administrative Claims	**Monitoring & Evaluation**			

VT Measure ID	MSSP Measure ID	MEASURE *Note: Measures in BOLD have a DLTSS WG recommendation*	Measure Domain	Nationally Recognized /Endorsed	Impact on Current Measure Collection Infrastructure	Linked to Payment, Monitoring, or Program Evaluation (ACO Year 1)	**DLTSS WG Recommendations** (based on expectation that the impact may be more significant for the DLTSS population) Black = DLTSS WG recommendation on 4/24/14 Red = New proposed DLTSS WG recommendation Green = New proposed DLTSS endorsement of others' recommendation Blue = New proposed DLTSS sub-population analysis	See specific section in "Performance Measures Discussion Reference Document for DLTSS Work Group"	Other WG Recommendations
M&E-14		**Avoidable ED Visits (NYU algorithm)**	Utilization		Administrative Claims	**Monitoring & Evaluation**	**Proposed new recommendation: Promote to Payment for Years 2 and 3; include DLTSS sub population analysis**	**8.D.**	
M&E-15		Ambulatory Care (ED rate only)	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-16		ED Utilization for Ambulatory Care Sensitive Conditions	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-17		Generic Dispensing Rate	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-18		High-End Imaging/1000	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-19		Inpatient Utilization: General Hospital/Acute Care	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-20		Primary Care Visits/1000	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-21		SNF Days/1000	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-22		Specialty Visits/1000	Utilization		Administrative Claims	**Monitoring & Evaluation**			
M&E-23		Annual Dental Visit	Utilization		Administrative Claims	**Monitoring & Evaluation**			

Attachment 2b - Performance Measures Reference Document for Discussion at DLTSS

Performance Measures Reference Document for Discussion at the DLTSS Work Group

May 22, 2014

The DLTSS Work Group staff and chairs developed this document the support the Work Group's discussion on quality and performance measures that would be recommended to the VHCIP Quality and Performance Measures Work Group. This proposal provides background on the quality and performance measurement structure and suggests measures that could be promoted to a new status or newly included in the measure set for the Commercial and Medicaid Shared Savings ACO Programs.

1. Background on the quality and performance measurement structure

There are four types of measures in the measurement structure:

- Payment: considered when calculating shared savings (8 measures in Year 1)
- Reporting: required but no penalty for not reporting, and not considered when calculating shared savings (20 measures in Year 1); *typically are included as a Reporting measure rather than a Payment measure in Year 1 because there are no baseline data available and/or it may be difficult to accurately collect the required data in Year 1*
- Pending: not currently being used; *included as Pending measures in Year 1 for one of the following reasons: target population not included in Medicaid/commercial SSPs, lack of availability of clinical or other required data, lack of clear or widely accepted specifications, or overly burdensome to collect.*
- Monitoring and Evaluation (M&E): reported at the plan or state level, not obtained from ACO; are not considered when calculating shared savings; *important to collect to inform programmatic evaluation and policy/planning decisions.*

2. Process for identifying measures for DLTSS Work Group discussion.

The staff and chairs reviewed data and definitions as part of their process for identifying recommended measures for DLTSS Work Group discussion. Specifically, the staff and chairs used the following lenses with which to screen measures for DLTSS Work Group recommendations:

- ***It is expected that the impact of the item being measured will be more significant for individuals with DLTSS needs as compared to the broader population being measured.***
    - VHCIP should perform data analyses on the DLTSS sub-population for any measures recommended by the DLTSS Work Group.

- ***Proposed new measures need to meet the criteria used by the Quality and Performance Measures Work Group to select Shared Savings ACO Program measures. ("QPM Measure Selection Criteria")***

Staff and chairs also reviewed the possible definitions of the DLTSS sub-population, the recommendations previously made by the DLTSS Work Group to the Quality and Performance Measures Work Group, reviewed those measures suggested by other entities such as Howard Center, and reviewed discussion materials from previous DLTSS meetings including survey and measure information. Staff and chairs developed a series of proposals for the DLTSS Work Group and these are found in sections 3-9 below.

3. Proposal regarding selection of the definition of "DLTSS sub-population"[i] to be used when conducting DLTSS sub-population analyses for these measures.

There are two definitions that could be used for these analyses:

i. Individuals receiving specialized services, or
ii. Individuals enrolled in Medicaid based on disability aide codes

- ***Proposal: Recommend that the DLTSS sub-population analyses be calculated using the following definition: Individuals enrolled in Medicaid based on disability aid categories.*** *The rationale is that this definition is broader and will provide a more comprehensive set of analyses. This definition includes individuals with disabilities who are not eligible for specialized programs.*

4. Measures previously recommended by the DLTSS Work Group to the QPM Work Group:

The DLTSS recommended, on April 24th, that the following three measures be promoted from 'Pending' status to 'Reporting' status.[ii] The rationale for this is that there will need to be baseline data collected in Year 2 of the Shared Savings ACO Programs in order for these measures to be considered for payment in Year 3:

Core-35	Influenza Immunization
Core 37	Transition Record Transmittal to Health Care Professional
Core-44	Transition Record with Specified Elements Received by Discharged Patients *(proposed replacement for "Percentage of Patients with Self-Management Plans" since no specifications were available for the latter and the proposed measure includes self-management plans)*

5. Proposal to support recommendations made by the Population Health Work Group, the Howard Center and Vermont Legal Aid to the QPM Work Group.

The Population Health Work Group, Howard Center and Vermont Legal Aid all made recommendations to the Quality and Performance Measures Work Group to promote measures from pending to reporting in Year 2.[iii]

- ***Proposal: Endorse the following Population Health Work Group recommendations regarding promotion of the following measures from Pending to Reporting measures in Year 2.*** *The rationale is that it is expected that the impact will be more significant for individuals with DLTSS needs as compared to the broader population being measured:*

		Proposed DLTSS Endorsement
Core-30	Cervical Cancer Screening	
Core-34	Prenatal and Postpartum Care	
Core-35	Influenza Immunization	**Yes**
Core-36	Tobacco Use Assessment and Tobacco Cessation Intervention	**Yes**
Core-39	Hypertension (HTN): Controlling High Blood Pressure	**Yes**
Core-40	Screening for High Blood Pressure and Follow-Up Plan Documented	**Yes**
Core-44	Percentage of Patients with Self-Management Plans	**Yes**
Core-45	Screening, Brief Intervention, and Referral to Treatment	**Yes**

- ***Proposal: Endorse Vermont Legal Aid's recommendation***

Vermont Legal Aid recommended inclusion of the Developmental Screening Measure (Core 8) in the Commercial Shared Savings ACO Program measures. It is currently in the Medicaid measure set. *The rationale is that the impact will be more significant for individuals with DLTSS needs.*

		Proposed DLTSS Endorsement
Core-8	Developmental Screening Measure	**Yes**

6. Proposal to promote Reporting measures to Payment measures.

These measures are currently Reporting measures for Year 1 and would be used for Payment in Year 2.

- ***Proposal: Recommend that the following measures be promoted from Reporting to Payment measures in Year 2.*** *The rationale is that it is expected that the impact will be more significant for individuals with DLTSS needs as compared to the broader population being measured:*

Core-15	Pediatric Weight Assessment and Counseling
Core-16	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use
Core-17	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)
Core-19	Depression Screening and Follow-Up
Core-20	Adult Weight Screening and Follow-Up

7. Proposal regarding potential new measures that would be added to the measure set.

These measures are not yet in the measure set and would be added as new measures.[iv]

- ***Proposal: Recommend that the following actions be taken:***
  - ***Recommend that the following measure be added as a new Reporting measure for Year 2 and Payment measure for Year 3:***
    - LTSS Rebalancing: Ratio of Home and Community Based Services (HCBS) utilization to institutional utilization (number of people and expenditures) in identified LTSS sub-populations. *The rationale is that this measure is claims-based measures and is already being used by the State.*
  - ***Recommend that measurement strategies be explored by the ACTT Partners for the following****. The rationale is that valid and reliable measurement for these is complex and/or challenging and requires further study and discussion:*

Percent of new Medicaid LTSS users first receiving services in the community	Proportion of Medicaid LTSS beneficiaries in measurement year who did not receive any LTSS in the previous year who in the first calendar month of receiving LTSS received HCBS only and not institutional services.
Percent of home health patients with a hospital admission	Percent of home health care patients who were hospitalized for an acute condition.

Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities	Proportion of Medicaid LTSS and home health spending for older people and adults with physical disabilities (defined as nursing homes, personal care, aged/disabled waivers, home health, and other programs used primarily by older people and adults with physical disabilities) going to HCBS, including Medicaid and state-funded services.
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community	The number of participant-months (divided by 12) of Medicaid LTSS for adults age 65+ or age 21+ with a physical disability divided per 100 persons age 21+ with a self-care difficultly at or below 250% of the poverty threshold, or of any age living in a nursing home. 250% of poverty was chosen in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300% of SSI.
Percent of long-stay nursing home residents with a hospital admission	Percent of long-stay residents (residing in a nursing home relatively continuously for 100 days prior to the second quarter of the calendar year) who were ever hospitalized within six months of baseline assessment.
Percent of high-risk nursing home residents with pressure sores	Percent of long-stay nursing home residents impaired in bed mobility or transfer, comatose, or suffering malnutrition who have pressure sores (stage 1–4) on target assessment.
Percent of long-stay nursing home residents who were physically restrained	Percent of long-stay nursing home residents who were physically restrained daily on target assessment.
Percent of Enrollees stratified to medium or high risk with a completed initial assessment within 90 days of enrollment	Proportion of beneficiaries receiving an initial assessment within 90 days of enrollment who were classified as being either medium or high risk.
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.
Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients	Percent of home health episodes of care in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care for patients assessed to be at risk for pressure ulcers.

8. Proposals for specific measures

Members of the DLTSS Work Group have proposed several measures or types of measures for inclusion in the measure set. Proposals regarding these measures are listed below.[v]

A. Preventable or unnecessary hospital admissions
"Rate of Hospitalization for Ambulatory Care Sensitive Conditions" is an existing Reporting measure (Core 12), and has been recommended by DVHA to be promoted to Payment status

- ***Proposal: The above measure is sufficient with the addition of DLTSS Sub-population analysis***

B. Preventable or unnecessary hospital readmissions
"All Cause Re-admission" is an existing Payment measure (Core 1)

- ***Proposal: The above measure is sufficient with the addition of DLTSS Sub-population analysis***

C. Preventable or unnecessary ER visits
"Avoidable ED visits - NYU algorithm" (M&E-14) is an existing Year 1 M&E measure

- ***Proposal: Recommend that this measure be promoted to Payment for Years 2 and 3**. The rationale is that this is a key indicator of how well the health care system is functioning overall.*

D. Preventable or unnecessary nursing home stays
- ***Proposal for DLTSS Work Group Consideration: None.** The rationale is that measurement would be very complex and burdensome.*

E. Obesity
Year 1 Reporting measures include "Adult BMI Screening and Follow-Up" (Core 20) and "Pediatric Weight Assessment and Counseling" (Core 15)
- ***Proposal: Recommend that these measures be promoted to Payment for Years 2 and 3 with the addition of DLTSS Sub-population analysis.** The rationale is that it has been incorporated under #6 above.*

F. High Blood Pressure
- Year 1 Pending Measures include "Hypertension (HTN): Controlling High Blood Pressure" (Core 39) and "Screening for High Blood Pressure and Follow-up Plan" (Core 40)
- Year 1 Reporting Measures include "High Blood Pressure Control" in the Diabetes Composite (Core 16)
- ***Proposal: Recommend that the Pending Measures (Core 39 and 40) be promoted to Reporting in Year 2 with the addition of DLTSS Sub-population analysis.** The rationale is that it has been incorporated in #5 above, **and the Reporting measure (Core 16) be promoted to Payment for Years 2 and 3 with the addition of DLTSS Sub-population analysis.** The rationale is that it has been incorporated in #6 above.*

G. Shingles
- ***Proposal: None.** The rationale is that there currently are no National Quality Forum endorsed measures related to shingles).*

9. Proposal related to DLTSS sub-population analyses.[vi]

- ***Proposal: Recommend that DLTSS subpopulation analyses be conducted in Year 2 for the Year 1 Patient Experience Reporting measures identified in the following Table (i.e., Core Measures 21-26, 28, 29).** The rationale is that these core measures contain elements that are aligned with the DLTSS key principles (see below); these core measures already exist as valid and reliable* Reporting *measures for Year 1 via the CAHPS PCMH survey; it is too late to recommend that a DLTSS sub-population analysis be conducted in Year 1). The CAHPS PCMH survey is and existing survey that is fielded in Vermont and we have access to the results of that survey for analyses.*

  Note: This survey is distributed to patients of primary care providers (PCPs); as such, responses by people who primarily rely on specialists or other providers instead of a PCP will not be included.

CAHPS PCMH Survey Patient Experience Composites and Questions in Year 1 ACO Reporting Measures
Core 21 - Access
In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?

In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?
In the last 12 months, how often were you able to get the care you needed from this provider's office during evenings, weekends and holidays?
In the last 12 months, when you phoned this provider's office during regular office hours, how often did you get an answer to your medical question that same day?
In the last 12 months, when you phoned this provider's office after regular office hours, how often did you get an answer to your medical question as soon as you needed?
Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this provider within 15 minutes of your appointment time?
Core 22 - Communication
In the last 12 months, how often did this provider explain things in a way that was easy to understand?
In the last 12 months, how often did this provider listen carefully to you?
In the last 12 months, how often did this provider give you easy to understand information about these health questions or concerns?
In the last 12 months, how often did this provider seem to know the important information about your medical history?
In the last 12 months, how often did this provider show respect for what you had to say?
In the last 12 months, how often did this provider spend enough time with you?
Core 23 - Shared Decision Making
When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might want to take a medicine?
When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might not want to take a medicine?
When you talked about starting or stopping a prescription medicine, did this provider ask you what you thought was best for you?
Core 24 - Self-Management Support
In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health?
In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?
Core 25 – Comprehensiveness - Adult Behavioral
In the last 12 months, did anyone in this provider's office ask you if there was a period of time when you felt sad, empty or depressed?
In the last 12 months, did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?
In the last 12 months, did you and anyone in this provider's office talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?
Core 26 - Office Staff
In the last 12 months, how often were the clerks and receptionists at this provider's office as helpful as you thought they should be?
In the last 12 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?
Core 27 - Information
Did this provider's office give you information about what to do if you needed care during evenings, weekends, and holidays?
Some offices remind patients between visits about tests, treatment and appointments. In the last 12 months, did you get any reminders from this provider's office between visits?
Core 28 – Coordination of Care
In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?
In the last 12 months, how often did the provider seem informed and up-to-date about the care you got from specialists?
In the last 12 months, did you and anyone in the provider's office talk at each visit about all the prescription medicines you were taking?
Core 29 – Specialist Care
In the last 12 months, did you try to make any appointment with specialists?
In the last 12 months, how often was it easy to get appointments with specialists?

In the last 12 months, how often did the specialist you saw most seem to know the important information about your medical history?

DLTSS Person-Centered and Person-Directed Services and Supports Key Principles	Year 1 ACO Core Measure
Individuals feel welcome and heard and their choices are supported	22, 23, 24, 25, 26, 28*
Individuals have access to independent supports for informed decision-making and rights protection	None applicable
Availability of stable well-trained workforce and contractor network, including access to alternative providers and peer run services	None applicable
Commitment & capacity to promote self- help and person-directed services for individuals with diverse and multiple disabilities, over time, and across service settings	None applicable
"One size does not fit all": organizational/systemic capacity to effectively respond to a range of preferences regarding service information & assistance and service coordination	None applicable
Individuals have access to services and supports when needed	21, 28*
Assessment, planning, coordination and service delivery practices are shaped by the interests, needs and preferences of individuals rather than agencies	24, 28*
Written, verbal and/or other form of communication about treatment and services is provided in a manner that is accessible and understandable for the individual	22
Services are coordinated across all the individual's needs	28, 29
Supports are provided, as needed, to assist individuals to participate in all aspects of society and have a high quality of life	None applicable

* *Core 28 Measure applicable to Key Principle only if the following recommendation is proposed by the DLTSS Work Group to the Quality and Performance Measures Work Group, and it is adopted.*

- ***Proposal: Recommend adding the following new question to Core 28 in the CAHPS PCMH survey as a Reporting measure for Year 2:***

Performance Measure	Source	Notes
If you ask for something, does your case manager / service coordinator help you get what you need? *Yes* ☐ 1 *Sometimes* ☐ 2 No ☐ 3 Not applicable ☐ 4	*National Core Indicators (NCI)* • *Question in Systems Performance Indicators, Service Coordination Sub-domain (NCI 2009/10: CS-39)*	National Core Indicators (NCI) is a collaborative data collection effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS), state agencies, and the Human Services Research Institute (HSRI). The purpose of the survey, which began in 1997, is to create and monitor performance outcomes on a number of domains that can be used to track performance over time, to compare results across states, and to establish national benchmarks. It is administered in 39 states (but not Vermont). This measure was identified through the National Quality Forum Measurement Application Partnership (NQF-MAP) recommendations for DLTSS populations.

- ***Proposal: Recommend adding the following new question to Core 28 in the CAHPS PCMH survey- Coordination of Care as a Reporting measure for Year 2:***
  - In the last 12 months, how often did the provider seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.?

- ***Proposal: Recommend adding the following new question to Core 29 in the CAHPS PCMH survey- Specialist Care as a Reporting measure for Year 2:***

- In the last 12 months, how often did the specialist you saw seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.?

The rationale for both recommendations is that coordination between traditional medical services and DLTSS is a significant issue that affects the health outcomes, service effectiveness and cost of care for people with DLTSS needs.

10. Proposal regarding use of existing survey data to inform work undertaken at the DLTSS Work Group.

Among the surveys at AHS, there are 6 that provide information that can inform DLTSS Work Group activities.

Program	Survey	Description
DMH: Community Rehabilitation and Treatment (CRT)	CRT client satisfaction survey	Surveys consumers served by CRT programs in Vermont, part of a larger effort to monitor CRT program performance from the perspective of service recipients.
DAIL	Vermont Long Term Care (LTC) Consumer Survey	Surveys consumers receiving the following long-term care programs/services regarding their satisfaction with services and quality of life: • Choices for Care (CFC) Case Management • Personal Care Services • Homemaker Services • Adult Day Services • Attendant Services Program • Traumatic Brain Injury Program • Home-Delivered Meals Program
DAIL: Choices for Care (CFC)	CFC HCBS Consumer Survey *(part of Vermont LTC Consumer Survey)*	Surveys consumers of the long-term services system regarding specific CFC services. Several specific questions are included to more fully measure outcomes around choice, personal goals and maintaining health.
	'MyInnerView' Nursing Facility and RCH Resident Satisfaction Survey *(part of Vermont Health Care Association resident satisfaction survey)*	Surveys residents in nursing facilities, assisted living facilities, and ERCs to evaluate information dissemination, access, experience with care and quality of life. *(results are used in the CFC Independent Evaluation)*
DAIL: Developmental Disability Services	DDS client satisfaction survey	Surveys consumers served by DDS to identify what people feel is important to their quality of life and how the program can provide the best support possible.
DVHA	CAHPS Managed Care Survey	Surveys enrollees covered by the Global Commitment to Health 1115 Demonstration Waiver to assess satisfaction with areas such as access to information about benefits and rights, and access to providers.

- ***Proposal: Recommend having the results of each of these surveys presented in a common format to the DLTSS Work Group over the coming year so that this information is more transparent and can be used as a baseline for DLTSS Work Group monitoring over time.*** *The rationale for this is that the results of these surveys are currently shared with small audiences and DLTSS Work group review may lead to shared understanding of the survey elements and findings. This information can inform DLTSS Work Group decisions.*

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[i] Background information on this issue is found in the April 24, 2014 DLTSS meeting materials found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/4.24.14.DLTSS_.Merged.Meeting.Materials.v2.pdf

[ii] Additional information can be found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/4.24.14.DLTSS_.Merged.Meeting.Materials.v2.pdf

[iii] Additional information can be found in the QPM Work Group meeting materials found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/QPM.4.28.14.Merged.Meeting.Materials.v2pdf.pdf

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[iv] Additional information about these measures can be found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/3.20.14.DLTSS_.Merged.Meeting.Materials.v2.pdf

[v] Additional information can be found in the meeting minutes from the April 24th DLTSS Work Group meeting, which is included in the May 22, 2014 meeting materials.

[vi] More information can be found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/3.20.14.DLTSS_.Merged.Meeting.Materials.v2.pdf

Attachment 2c - Quality & Performance Measures (QPM) Work Group Selection Criteria dated 4/24/14.

Quality and Performance Measures Work Group
Overall Measure Selection Criteria Survey Results
April 25, 2014

Criterion	Description	Percent Recommending "Include"
1. Valid and reliable	The measure will produce consistent (reliable) and credible (valid) results.	100.00%
10. Representative of the array of services provided and beneficiaries served	The overall measures set will be representative of the array of services provided, and of the diversity of patients served.	100.00%
3. Uninfluenced by differences in patient case mix	Providers serving more complex or ill patients will not be disadvantaged by comparative measurement. Measures will be either uninfluenced by differences in patient case mix or will be appropriately adjusted for such differences.	94.44%
8. Not prone to random variation, i.e., sufficient denominator size	In order to ensure that the measure is not prone to the effects of random variation, the measure type will be considered so as to ensure a sufficient denominator in the context of the program.	94.44%
4. Consistent with state's goals for improved health systems performance	The measure corresponds to a state objective for improved health systems performance (e.g., presents an opportunity for improved quality and/or cost effectiveness).	88.89%
5. Not administratively burdensome, i.e., feasible to collect	The measure can be implemented and data can be collected without undue administrative burden.	88.89%
6. Aligned with other measure sets	The measure aligns with national and state measure sets and federal and state initiatives whenever possible.	88.89%
13. Includes a mix of measure types	Includes process, outcome and patient experience (e.g., self-management, perceptions, PCMH CAHPS®) measures, including measures of care transitions and changes in a person's functional status.	88.89%
2. Relevant benchmark available	The measure has been selected from NQF endorsed measures that have relevant benchmarks whenever possible.	88.24%
7. Focused on outcomes	To extent feasible, the measure should focus on outcomes, i.e., improving this measure will translate into significant changes in outcomes relative to costs, with consideration for efficiency.	83.33%
11. Limited in number	The overall measure set should be limited in number and include only those measures that are necessary to achieve the state's goals.	83.33%
12. Population-based/focused	The overall measure set should be population-based so that it may be used not only for comparative purposes, but also to identify and prioritize state efforts. Recognizes population demographics; gives priority to aging population and other ages; considers geographic community and not just patient population; consistent with State Health Improvement Plan.	82.35%