Quality and Performance Measures

Work Group Meeting

Agenda 5-18-15

VT Health Care Innovation Project
Quality and Performance Measures Work Group Meeting Agenda (Revised)

May 18, 2015; 9:00 AM to 11:00 AM
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202 Passcode: 420323867

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	9:00-9:05	Welcome and Introductions; Approval of Minutes	Attachment 1: April QPM Minutes	YES – Approval
2	9:05-9:20	Summary of Institute of Medicine Report: *Vital Signs: Core Metrics for Health and Health Care Progress* (Pat Jones) ***Public Comment***	Attachment 2: Bailit Health Purchasing Summary and Crosswalk with VT Measures Link to full report: http://www.iom.edu/Reports/2015/Vital-Signs-Core-Metrics.aspx	
3	9:20-10:00	Vermont ACO Experience with Year 1 Clinical Data Collection (Rick Dooley, Health*first;* Miriam Sheehey, OneCare Vermont; Heather Skeels, CHAC) ***Public Comment***	Attachment 3: Vermont ACO Experience with Data Collection 2015	
4	10:00-10:50	Year 3 ACO Shared Savings Program Measures (Work Group; Virginia Hood, MD, Nephrology Services, UVMMC joins at 10:30 to discuss hypertension measures) ***Public Comment***	Attachment 4a: Priority Changes and Options for Year 3 Measures Attachment 4b: Potential Replacement Measure Numerators and Denominators Attachment 4c: VDH Memo to QPM Attachment 4d: Recent documents promoting less than 140 and 90 Attachment 4e: Hypertension Control Considerations for Performance Measurement	YES – Measure changes
5	10:55-11:00	Wrap-Up and Next Steps ***Next Meeting:* June 22, 2015; 9:00 – 11:00 AM; 4th Floor Conference Room, Pavilion Building, Montpelier**		

Attachment 1

April Minutes

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

Date of meeting: April 13, 2015; 9:00 AM to 11:00 AM; 4th Floor EXE Conference Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome; Minutes Approval	Catherine Fulton called the meeting to order at 9:03. A roll call was taken and a quorum was established. A motion to approve the March minutes by exception was made by Rick Dooley; it was seconded by Lila Richardson. No exceptions were heard and the motion carried unanimously.	
2. Update: Gate and Ladder for Year 2 ACO Payment Measures	Alicia Cooper provided an update on the status of the proposed changes to the Medicaid Gate and Ladder Methodology. The proposal went to the Payment Models Work Group in January; they considered the proposal (including input from the QPM Work Group) for several meetings, and ultimately approved an updated methodology at their March 2015 meeting. Changes to the methodology included: 1) To use an absolute number of points earned rather than a percentage of points to determine where on the ladder an ACO falls 2) To adjust the minimum quality performance standard (the "Gate") to match the commercial standards 3) To introduce the ability to earn improvement points based on improvement over time On April 1, 2015, the VHCIP Steering Committee approved the proposed changes; on April 6, 2015, the VHCIP Core Team approved the proposed changes.	
3. Use of Performance Measures in Blueprint-ACO Unified Community Collaboratives	Jenney Samuelson, Assistant Director with the Blueprint for Health, presented the information in Attachment 3, linked here As ACOs and the Blueprint work toward developing community health systems (Unified Community Collaboratives, or UCCs), ACO Shared Savings Program (SSP) measures that came out of this work group are being incorporated into the Blueprint quality profiles. This "Unified Performance Reporting System" will help coordinate performance reporting, create a data utility, and support quality improvement. Each UCC is creating a Leadership Team, including representatives from each ACO, the Blueprint, Mental Health Agencies, Home Health Agencies, Pediatrics, Housing, Area Agencies on Aging and other membership reflecting the	

Agenda Item	Discussion	Next Steps
	community's make-up. The Team will identify community goals and convene stakeholders. The purpose is to form local work groups to review data and identify priority projects. For example, in St. Albans they are using ED utilization data to improve follow-up after ED visits and reduce admissions. Interventions include calling people the day after the ED visit and including primary care physicians in the follow up. The Blueprint provides comparative reports/dashboards/profiles that include both clinical and claims-based data (claims data from VHCURES and clinical data from the registry), including data for some of the ACO SSP measures. BRFSS data is also included. Health Service Area reports containing utilization, cost, and quality data (including clinical outcomes data) across ACOs and insurers are provided, as well as practice level reports. These comparative reports help identify outliers, and allow HSAs and practices that are doing well to share strategies. They also are exploring sources of clinical data that may reduce the need for chart reviews, but there is work to be done. Q: Is there a way to report trends over time? A: The Blueprint plans to publish the data twice per year so that practices can see their performance over time. Benchmarks are included when available. Jenney described proposed changes to the payment methodology that would increase medical home payments for practices, assuming that legislative approval can be secured. A) A base payment of $3.50 per member per month would be dependent on the practice achieving NCQA medical home standards AND participating in an improvement project via the UCC. B) An additional quality payment would be based on the HSA's performance on a quality composite (including ACO SSP measures). The goal is to have those measures collected centrally instead of relying on chart reviews. C) An additional utilization payment would be based on the HSA's performance on the Health Partners Total Utilization Index measure. Q: Would the HSAs receive payment? A: No, the practices receive payment, but part of that payment would be based on the HSA's performance. Q: How do partner organizations get funding if they're not in the SSP? A: The driving force is to increase support for primary care, which has been underfunded for some time. This is a transition phase (as depicted on Slide 2); the goal is to broaden support to other partners. Q: Doesn't the proposed payment methodology (quality and utilization components) tie payments to the work of others in the HSA over whom the provider has no control? A: Yes; this approach supports health care reform. Certain measures will not improve without community collaboration and integration. The goal is to achieve a community-based approach to health care and quality improvement.	

Agenda Item	Discussion	Next Steps
	Q: Will practices need to re-score within the NCQA medical home recognition program? A: The data shows that NCQA recognition makes a difference in quality. Instead of having different payments based on the numerical score, the base payment would be the same for all practices that meet NCQA's 'must-pass' elements and achieve recognition. This approach reduces overall administrative burden on practices. Practices that are currently recognized won't have to go through recognition in advance of their scheduled date to qualify for the base payment. Q: As you look toward more novel funding that includes ancillary partners, does this include those who cross HSAs? A: Howard Mental Health and one OBGYN practice are recognized under NCQA's specialty standards – some community providers don't have the resources to achieve NCQA recognition. Q: The service areas in the practice and HSA profiles don't exactly match the Blueprint service areas. A: The service areas in the profiles are based on hospital service areas; the only area in which the Blueprint service area differs significantly from the HSA service area is in the Eastern part of the State. Q: What are the preliminary thoughts about which quality measures will be chosen? A: We are trying to keep it limited to no more than five measures and align closely with the measures identified as highest priorities. Four have been identified and there is research being conducted on whether they have adequate benchmarks. All of the ACOs have been active participants as the measures are being selected. The Blueprint and ACOs plan to attend a future QPM Work Group to obtain feedback on the measures. Q: Is there a plan to open the UCCs to the public and to engage the public in some of the discussion? A: The UCC Communities are in very different places – each will have to identify how they want the UCC to form. The intent is to involve broader stakeholders (community at-large) via the leadership work groups.	
4. Green Mountain Care Board Vote on Hiatus for Year 3 Measures	The GMCB at a March meeting unanimously supported a hiatus for Year 3 ACO SSP measures. The language and the GMCB's rationale for the hiatus is in Attachment 4, and includes the following: *1) To allow ACOs to focus on enhancing data collection capability and improving quality of care and health outcomes, there will be a hiatus on changes to the measure set for Year 3, unless there are changes in measure specifications or in the evidence that serves as the basis for a particular measure.* *2) If a measure specification changes, the change would be incorporated into the measure set specifications, in accordance with "Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program.* *3) If a measure is no longer supported by evidence, the measure should be considered for elimination. If a measure is eliminated, the VHCIP Quality and Performance Measures work group could recommend replacing it with a measure that is supported by evidence, in accordance with "Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures*	

Agenda Item	Discussion	Next Steps
	Used in the Commercial and Medicaid ACO Pilot Program."	
5. Priority Changes and Options for Year 3 Measures	The group reviewed Attachment 5, a memo from Bailit Health Purchasing that outlined measure changes and options for replacing or updating those measures. **Payment Measures:** LDL Screening is no longer considered to be evidence-based practice; this measure should be retired. One option for replacing it is to use a statin therapy measure, but that measure has not yet been adopted by NCQA and benchmarks would not be available for a couple of years if it is adopted. Another option is to adopt one of the Medicare Shared Savings Program (MSSP) hypertension measures that were considered last year. Heather Skeels, Rick Dooley and others commented that inclusion of the Blood Pressure Control measure would allow the capture of blood pressure control for diabetics. They may not be captured otherwise if another measure, the Diabetes Composite Measure ("D5"), has to be dropped (that measure was dropped from the MSSP measure set, probably because it also contains the LDL screening measure). The new Diabetes Composite measure has 2 sub-measures instead of 5. The other MSSP hypertension measure (Blood Pressure Screening and Follow Up Plan) is a hard measure to collect; it requires manual chart extraction. Robin Edelman noted that hypertension isn't a disease, but it is the most modifiable risk factor for a number of chronic diseases. She noted that 60% of people over 60 are hypertensive. This is an important risk factor to monitor in an aging state. She noted that even though there has been discussion of a systolic rate of 150 for older adults, the guideline has remained 140/90. A systolic rate of 150 is not supported by any group, and could result in a decline in stroke prevention and other efforts. To discuss this in more detail, the group agreed to invite Dr. Hood, a state expert on hypertension, to come to the next meeting. **Reporting Measures:** Regarding the D-5 Diabetes Composite measure: Minnesota Community Health is the measure steward, and they have replaced the LDL Screening Measure with a Statin Use measure. An option for this measure is to use the 3 remaining individual components in the measure (Blood Pressure Control, discussed above; Tobacco Non-Use; and Aspirin Use) Other options are to use the MSSP D2 measure, or just the Blood Pressure Control measure. The D2 measure includes the Eye Exam sub-measure. Using it for Vermont's SSPs would reinforce ACO staff and practice staff training in collecting this measure. The more we can be consistent across payers, the better. Practices and ACOs do not provide care or participate in improvement projects based on payer. **Other measure changes include:** 1) Appropriate Medications for People with Asthma has been dropped by NCQA – a good option for replacing this monitoring and evaluation measure that is collected at the health plan level is Medication Management for	

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	People with Asthma, which is a HEDIS 2012 measure. LaRae Francis confirmed that BCBSVT collects this measure. 2) ED Utilization Measure is being dropped by AHRQ – there are other measures related to ED utilization in the measure set. 3) Pending measures: LDL measure was retired by MSSP, so this group may need to consider retiring the LDL measures from the pending group as well. Q: Can replacement Pending Measures be added? A: Yes. Note that data is not collected for the Pending Measures. Q: The Board's decision regarding a hiatus on adding new measures applies to Commercial SSP measures; what's happening at DVHA regarding changes to the measures used in the Medicaid SSP? A: AHS and DVHA leadership is discussing what to do now – no decision has been made and the timeframe for that decision is not known at this time. Continued discussion of changes in measures and potential replacements for Year 3 will be on the May agenda. An updated grid with potential replacement measures will be sent out prior to the next meeting, with descriptions of numerators and denominators.	
6. Next Steps, Wrap Up, Future Meetings	**Next Meeting:** Monday, May 18, 2015; 9:00 am – 11:00 am; DVHA Large Conference Room; 312 Hurricane Lane, Williston. The ACOs will share more about their Year 1 clinical data collection efforts.	

VHCIP QPM Work Group Member List

Roll Call: 4/13/2015

Rick Dooley 1°
Lila Richardson 2°

Motion to approve March Minutes by exception
– Motion Carried Unanimously

Member			Member Alternate		Minutes		
First Name	Last Name		First Name	Last Name			Organization
Susan	Aranoff	✓	Patricia	Cummings			AHS - DAIL
Jaskanwar	Batra	✓	Kathleen	Hentcy			AHS - DMH
Catherine	Burns	✓	Kim	McClellan			DA - HowardCenter for Mental Health
Connie	Colman	✓	Peter	Cobb			Central Vermont Home Health and Hospice
Yvonne	DePalma						Planned Parenthood of Northern New England
Rick	Dooley	✓					HealthFirst
Judith	Franz						VITL
Aaron	French	✓	Cynthia	Thomas			AHS - DVHA
Catherine	Fulton	✓					Vermont Program for Quality in Health Care
Paul	Harrington						Vermont Medical Society
Pat	Jones	✓	Richard	Slusky			GMCB
Heidi	Klein	✓	Robin	Edelman			AHS - VDH
Patricia	Launer	✓	Kate	Simmons			CHAC
Diane	Leach						Northwestern Medical Center
Vicki	Loner	✓	Miriam	Sheehey			OneCare Vermont
Mike	Nix	✓					Jeffords Institute for Quality, FAHC
Laura	Pelosi	✓					Vermont Health Care Association
Paul	Reiss		Amy	Cooper			Accountable Care Coalition of the Green Mountains
Lila	Richardson	✓	Julia	Shaw			VLA/Health Care Advocate Project
Rachel	Seelig	✓	Julia	Shaw			VLA/Senior Citizens Law Project
Lily	Sojourner	✓	Shawn	Skaflestad			AHS - Central Office
Heather	Skeels	✓	Patricia	Launer			Bi-State Primary Care
Jennifer	Stratton						Lamoille County Mental Health Services
Monica	Weeber						AHS - DOC
Robert	Wheeler		Teresa	Voci			Blue Cross Blue Shield of Vermont
	25			14			

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VHCIP QPM Work Group Participant List

Attendance: 4/13/2015

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

First Name	Last Name		Organization	QPM
Peter	Albert		Blue Cross Blue Shield of Vermont	X
Susan	Aranoff	here	AHS - DAIL	S/M
Bill	Ashe		Upper Valley Services	X
Ena	Backus		GMCB	X
Melissa	Bailey		Vermont Care Partners	X
Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Jaskanwar	Batra ✓	here	AHS - DMH	M
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
Catherine	Burns ✓	here	DA - HowardCenter for Mental Health	M
Joshua	Cheney		VITL	A
Amanda	Ciecior ✓	here	AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	MA
Connie	Colman		Central Vermont Home Health and Hospice	M
Amy	Coonradt ✓	here	AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA

Alicia	Cooper ✓	here	AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Patricia	Cummings		AHS - DAIL	MA
Jude	Daye		Blue Cross Blue Shield of Vermont	A
Yvonne	DePalma		Planned Parenthood of Northern New England	M
Rick	Dooley ✓	here	HealthFirst	M
Robin	Edelman ✓	here	AHS - VDH	MA
Erin	Flynn		AHS - DVHA	S
Judith	Franz		VITL	M
Aaron	French ✓	Phone	AHS - DVHA	M
Catherine	Fulton ✓	here	Vermont Program for Quality in Health Care	C/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Bryan	Hallett		GMCB	S
Paul	Harrington		Vermont Medical Society	M
Kathleen	Hentcy		AHS - DMH	MA
Bard	Hill		AHS - DAIL	MA
Craig	Jones		AHS - DVHA - Blueprint	X
Pat	Jones ✓	here	GMCB	S/M
Joelle	Judge ✓	here	UMASS	S
Sarah	Kinsler ✓	here	AHS - DVHA	S
Heidi	Klein ✓	here	AHS - VDH	S/M
Peter	Kriff		PDI - Creative Consulting	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer ✓	here	CHAC	M
Diane	Leach		Northwestern Medical Center	M
Deborah	Lisi-Baker		SOV - Consultant	X
Vicki	Loner		OneCare Vermont	M
Nicole	Lukas ✓	here	AHS - VDH	X
Georgia	Maheras		AOA	S
Mike	Maslack			X
Kim	McClellan		DA - Northwest Counseling and Support Services	MA
Darcy	McPherson		AHS - DVHA	X
Jessica	Mendizabal		AHS - DVHA	S

Robin	Miller		AHS - VDH	X
Mike	Nix ✓	Phone	Jeffords Institute for Quality, FAHC	M
Annie	Paumgarten ✓	here	GMCB	S
Laura	Pelosi ✓	here	Vermont Health Care Association	C/M
Luann	Poirer		AHS - DVHA	S
Sherry	Pontbriand		NMC	X
Betty	Rambur		GMCB	X
Allan	Ramsay		GMCB	X
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Lila	Richardson ✓	here	VLA/Health Care Advocate Project	M
Jenney	Samuelson ✓	here	AHS - DVHA - Blueprint	X
Rachel	Seelig		VLA/Senior Citizens Law Project	M
Julia	Shaw ✓	Phone	VLA/Health Care Advocate Project	MA
Miriam	Sheehey ✓	Phone	OneCare Vermont	MA
Kate	Simmons		Bi-State Primary Care/CHAC	MA
Colleen	Sinon		Northeastern Vermont Regional Hospital	X
Shawn	Skaflestad ✓ ✓	here	AHS - Central Office	M
Heather	Skeels ✓	here	Bi-State Primary Care	M
Richard	Slusky		GMCB	S/MA
Jennifer	Stratton		Lamoille County Mental Health Services	M
Kara	Suter		AHS - DVHA	S
Julie	Tessler		DA - Vermont Council of Developmental and Mental Health Serv	X
Cynthia	Thomas		AHS - DVHA	MA
Win	Turner		✓	X
Teresa	Voci	Lakae Francis ✓	Blue Cross Blue Shield of Vermont	MA
Nathaniel	Waite		VDH	X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Julie	Wasserman ✓	here	AHS - Central Office	S
Monica	Weeber		AHS - DOC	M
Kendall	West		Bi-State	X
James	Westrich		AHS - DVHA	S
Robert	Wheeler		Blue Cross Blue Shield of Vermont	M
Bradley	Wilhelm		AHS - DVHA	S
Cecelia	Wu		AHS - DVHA	S
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MaryKate Mohlman here

Attachment 2

Bailit Summary and Crosswalk with Vermont Measures

On April 28, 2015, the Institute of Medicine (IOM) released a draft report titled "Vital Signs: Core Metrics for Health and Health Progress." The report was written to address the question "What are the core measures that will yield the clearest understanding and focus on better health and well-being for Americans?"[1] Whereas the measures contained in the ACO measure set were selected to evaluate the performance of ACOs in improving health care and reducing cost, the IOM sought measures to assess the health of the nation.

The report concluded that for many of the IOM's "core measure foci, significant research and development are needed to build measures and data streams that are true reflections of the most critical facets of American health."[2] Nonetheless, the report did identify 15 core measures (really, measurement topics), and a "best current measure" for each of the 15 (see Table A below). In addition, it identified 39 additional "additional priority measures" that can be used as surrogates for the core measures as they are being refined.

The IOM report identifies provisional data sources for the 15 core measures. The vast majority of the measures use federal data sources, including many measures using population surveys. In contrast, most of the ACO measures utilize health plan and provider-reported data.

As a result, while some of the IOM "core measures" can be found in the ACO measure set, their specifications and data sources differ with those found in the tool (see Table B).

The IOM's 39 "additional priority measures" identified in the report are defined by name only. Again, some of them appear be reflected in the ACO measure set (e.g., colorectal cancer screening), while others (e.g., air quality index) are not (see Table C). No data sources or measures specifications are identified in the IOM report for the "additional priority measures."

[1] "Vital Signs: Core Metrics for Health and Health Care Progress" Institute of Medicine Report Brief, April 2015.
[2] "Vital Signs: Core Metrics for Health and Health Care Progress" Institute of Medicine Report, April 2015.

Table A **IOM Core Measure**	**Best current measure identified by IOM Report**	**Source**
1. Life expectancy	Life expectancy at birth	CDC VSS
2. Well-being	Self-reported health	CDC NHIS
3. Overweight and obesity	**Body mass index***	CDC NHANES
4. Addictive behavior	Addiction death rate	Surgeon General report and CDC VSS
5. Unintended pregnancy	Teen pregnancy rate	CD VSS
6. Healthy communities	**High school graduation rates**	DOEd NCES
7. Preventive services	**Childhood immunization rate**	CDC NIS
8. Care access	**Unmet care need reported**	CDC NHIS
9. Patient safety	Hospital-acquired infections (HAI)	CC HAI and AHRQ HCUP
10. Evidence-based care	**Preventable hospitalization rate**	AHRQ HCUP
11. Care match with patient goals	**Patient-clinician communication**	CAHPS
12. Personal spending burden	High spending relative to income	Commonwealth Fund
13. Population spending burden	Per capita expenditures on health care	CMS
14. Individual engagement	Health literacy rate	DOEd NCES
15. Community engagement	Social support	CDC BRFSS

* **Bold font** indicates the measure has similar measures in the Vermont ACO measure set and will appear in Table B.

Table B **Best Current Measure Identified by IOM Report**	**Similar Measures Within the Vermont ACO Measure Set**
Body Mass Index	Core-15 (NCQA HEDIS; NQF #0024): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Core-20 (CMS; NQF #0421; MSSP-16): Body Mass Index (BMI) Screening and Follow-up
High school graduation rates	M&E-8: School Completion Rate
Childhood Immunization Rate	Core-14 (NCQA HEDIS; NQF #0038): Childhood Immunization Status (Combo 10)
Preventable hospitalization rate	Core-10 (NQF #0275; AHRQ PQI #05; MSSP-9): Ambulatory Care-Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate Core-12 (PQI #92): Prevention Quality Chronic Composite (Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite)
Patient-clinician communication	Core-22 (NQCA HEDIS CAHPS PCMH Survey): Communications Composite Core-23 (NQCA HEDIS CAHPS PCMH Survey): Shared Decision-making Composite

Table C **39 Priority Surrogate Measures for each IOM Core Measure**	**Similar Measures Within the ACO Measure Set**
Life expectancy 1. Infant mortality 2. Maternal mortality 3. Violence and injury mortality	None
Well-being 4. Multiple chronic conditions	None
5. Depression	• Core-19 (CMS; NQF #0418; MSSP-18): Screening for Clinical Depression and Follow-up Plan • Core-25 (NQCA HEDIS CAHPS PCMH Survey): Comprehensiveness Composite • M&E-6 (NCQA HEDIS; NQF# 0105): Antidepressant Medication Management
Overweight and obesity 6. Activity levels	• Core-15 (NCQA HEDIS; NQF #0024): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
7. Healthy eating patterns	• Core-15 (NCQA HEDIS; NQF #0024): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Addictive behavior 8. Tobacco use	• Core-36 (NQF#0028 MSSP-17): Tobacco Use Assessment and Tobacco Cessation Intervention
9. Drug dependence/illicit use 10. Alcohol dependence/ misuse	• Core-5 (NCQA HEDIS; NQF #0004): Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement • Core-25 (NQCA HEDIS CAHPS PCMH Survey): Comprehensiveness Composite • M&E-26: Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Unintended pregnancy 11. Contraceptive use	None
Healthy communities 12. Childhood poverty rate	None
13. Childhood asthma	• M&E-1 (NCQA HEDIS; NQF# 0036): Appropriate Medications for People with Asthma
14. Air quality index	None
15. Drinking water quality index	None

Table C **39 Priority Surrogate Measures for each IOM Core Measure**	**Similar Measures Within the ACO Measure Set**
Preventive services 16. Influenza immunization	• Core-14 (NCQA HEDIS; NQF #0038): Childhood Immunization Status (Combo 10) • *(Core-35/ MSSP-14) Influenza Immunization*
17. Colorectal cancer screening	• Core-18 (NCQA HEDIS; NQF #0034; MSSP-19): Colorectal Cancer Screening
18. Breast cancer screening	• M&E-25 (NCQA HEDIS; NQF #2372; MSSP-20): Preventive Care and Screening: Breast Cancer Screening
Care access 19. Usual source of care	None
20. Delay of needed care	• Core-21 (NQCA HEDIS CAHPS PCMH Survey): Access to Care Composite
Patient safety 21. Wrong-site surgery	None
22. Pressure ulcers	None
23. Medication reconciliation	• *(Core-49) Use of High Risk Medications in the Elderly (Medicaid-only, duals-specific measure)*
Evidence-based care 24. Cardiovascular risk reduction	• Core-3a (NCQA HEDIS Retired as of 2015): Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only) • *(Core-38) Coronary Artery Disease (CAD) Composite* •
25. Hypertension control	• *(Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure* • *(Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented* •
26. Diabetes control composite	• Core-16 (MN Community Measurement; NQF #0024; MSSP 22-26): Optimal Diabetes Care (Diabetes Composite (D4D5)) • Core-17 (NCQA HEDIS; NQF #0059; MSSP-27): Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)
27. Heart attack therapy protocol	None
28. Stroke therapy protocol	None
29. Unnecessary care composite	None
Care match with patient goals 30. Patient experience	• Core-24 (NQCA HEDIS CAHPS PCMH Survey): Self-Management Support Composite
31. Shared decision making	• Core-23 (NQCA HEDIS CAHPS PCMH Survey): Shared Decision-making Composite

Table C **39 Priority Surrogate Measures for each IOM Core Measure**	**Similar Measures Within the ACO Measure Set**
	• *(Core-44) Percentage of Patients with Self-Management Plans (Medicaid only)*
32. End-of-life/advanced care planning	• *(Core-32) Proportion Not Admitted to Hospice (cancer patients)* • M&E-7: Family Evaluation of Hospice Care Survey Questions
Personal spending burden 33. Health care–related bankruptcies	None
Population spending burden 34. Total cost of care	• M&E-10: Health Partners TCOC: Total Cost Index (TCI; NQF #1604) • M&E-11: Health Partners TCOC: Resource Use Index (RUI; NQF#1598) • All Cost Measures
35. Health care spending growth	• All Cost Measures over time
Individual engagement 36. Involvement in health initiatives	• *(Core-42) Patient Activation Measure*
Community engagement 37. Availability of healthy food	None
38. Walkability	None
39. Community health benefit agenda	None

Note: Pending measures are indicated in *italic.*

Attachment 3

Vermont ACO Experience

Data Collection 2015

Vermont ACO Experience with Data Collection 2015

Goal

- To share our experience: the positive, the challenging, and recommendations.

The Benefits of ACO Collaboration: We cannot say enough…

- **Team atmosphere:** Grateful to have each other as sounding board and resource
- **Streamlining:** Able to develop shared tools, training, and methods of reporting common throughout the state, regardless of ACO specific participation
- **Relationships and skill sets built:** Shared expertise that will outlast any individual organization and specific initiative
- **Common language developed:** Allowed for more uniform data collection regardless of ACO affiliation.
- **Platform for common initiatives:** Supports apples to apples comparisons and creation of HSA level initiatives

The Benefits of the Process

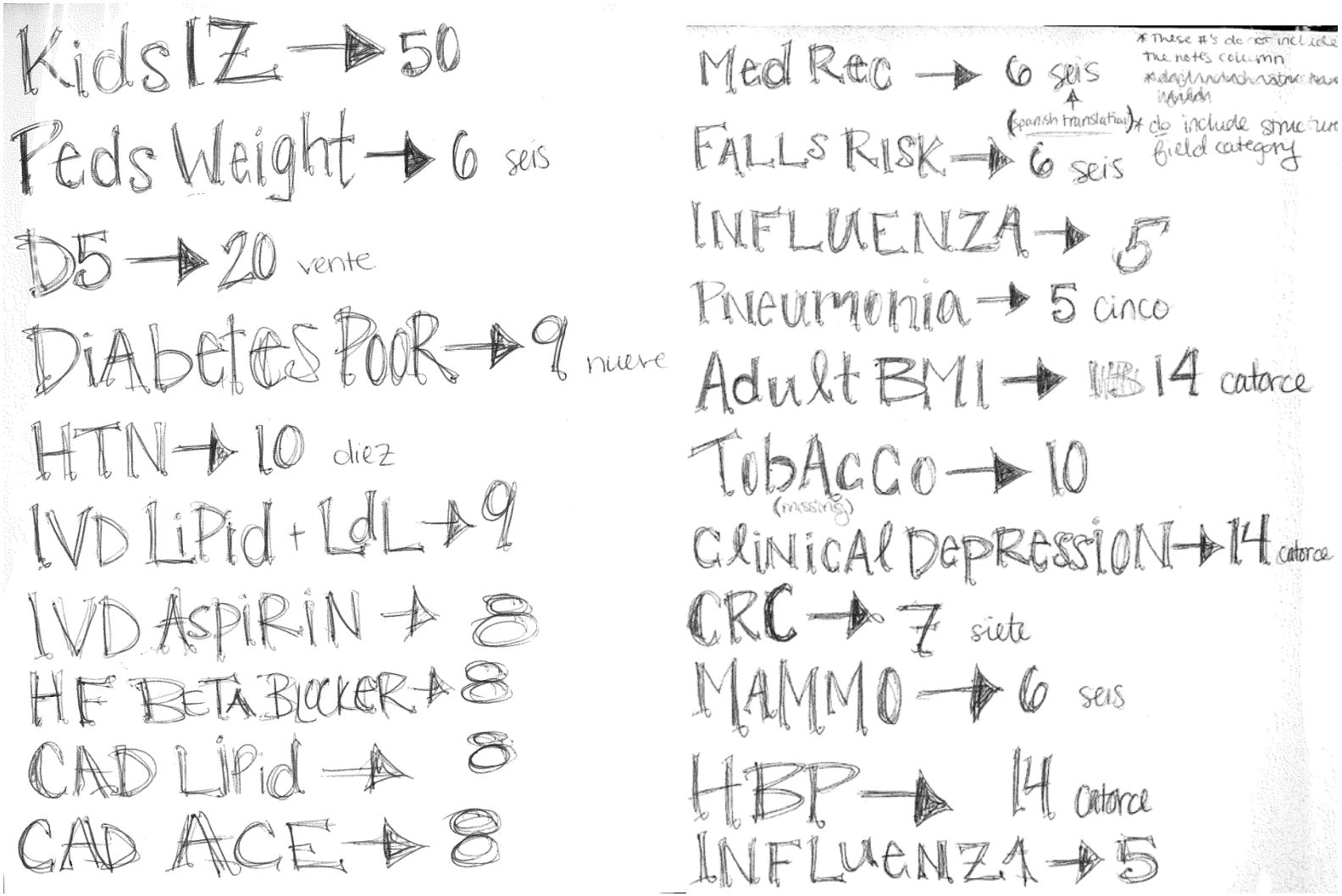
- **Quality Data:** Have organization level data on which to base quality improvement initiatives, based on common measures, that are trusted and consistent network-wide
- **Relationships Built:** Worked closely with practice staff and developed good working relationships with network organizations
- **Identified Opportunities for Improvement:** Opportunities range from documentation improvements to workflow development and implementation
- **Excellent Liaison:** Working with Pat Jones was a huge benefit to the ACOs, always responsive and available.

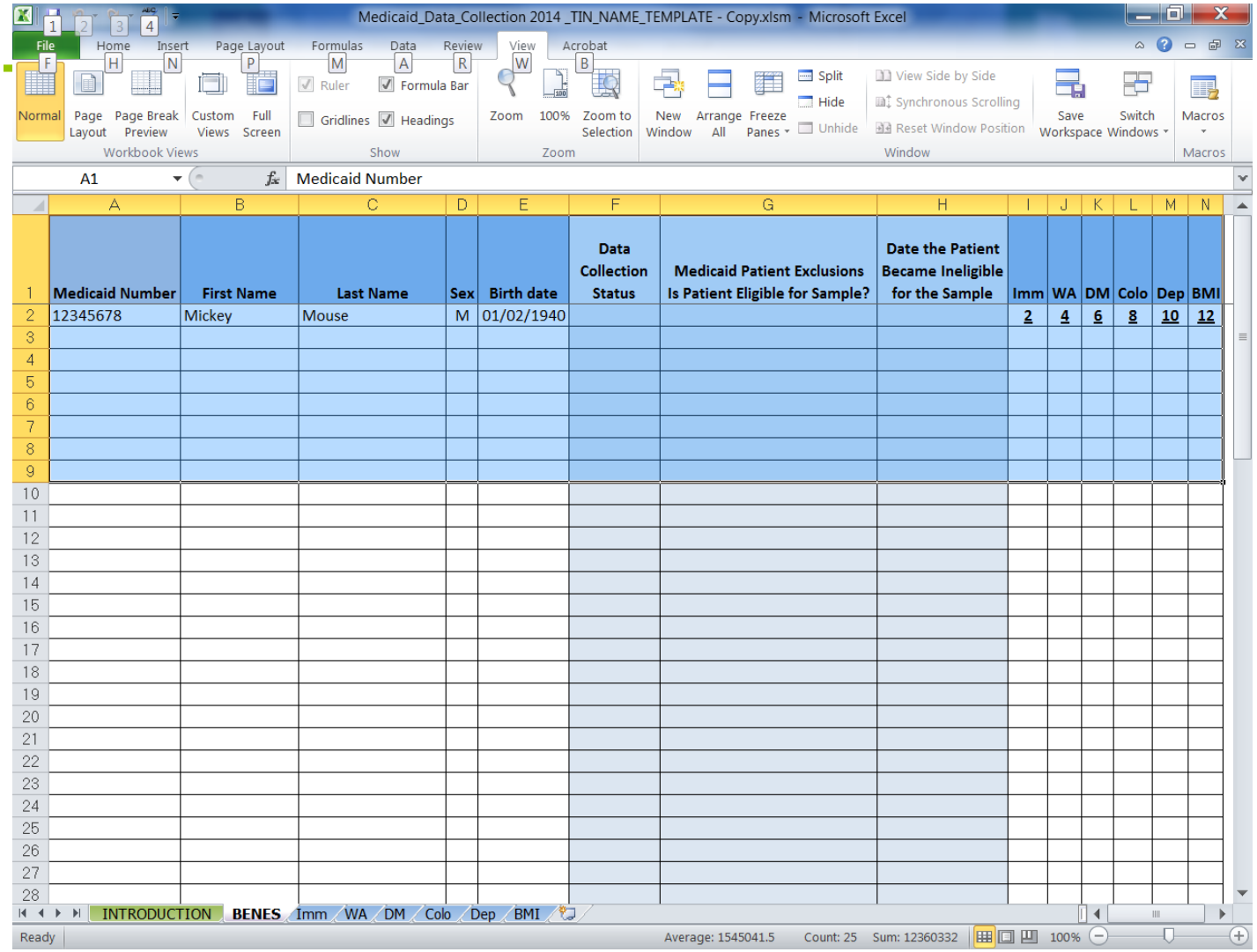
The Challenges of the Process

- **Patient Ranking:** The lateness, reliability, and multiple versions of payer ranking lists caused many issues from timeliness of setting up abstractions to producing extra burden on practices
- **Specificity of Narrative Lists:** Reliance on Medicare guidance for all payer reporting

Data Abstraction

- Planning began late summer 2014
- Combined training December 2014 and January 2015 via WebEx
- Data points extracted :
  - MSSP: 616 X 22 = 13,552
  - VMSSP: 372 X 10 = 3,720
  - XSSP: 372 X 10 = 3,720
  - total abstracted: 20,992


Kids IZ → 50
Peds Weight → 6 seis
D5 → 20 vente
Diabetes Poor → 9 nueve
HTN → 10 diez
IVD Lipid + LdL → 9
IVD Aspirin → 8
HF Beta Blocker → 8
CAD Lipid → 8
CAD ACE → 8
Med Rec → 6 seis
(spanish translation)
FALLS RISK → 6 seis
INFLUENZA → 5
Pneumonia → 5 cinco
Adult BMI → 14 catorce
TobAcco → 10
(missing)
Clinical Depression → 14 catorce
CRC → 7 siete
MAMMO → 6 seis
HBP → 14 catorce
INFLUENZA → 5


Medicaid_Data_Collection 2014 _TIN_NAME_TEMPLATE - Copy.xlsm - Microsoft Excel
File
Home
Insert
Page Layout
Formulas
Data
Review
View
Acrobat
Normal
Page Layout
Page Break Preview
Custom Views
Full Screen
Workbook Views
Ruler
Formula Bar
Gridlines
Headings
Show
Zoom
100%
Zoom to Selection
Zoom
New Window
Arrange All
Freeze Panes
Split
Hide
Unhide
View Side by Side
Synchronous Scrolling
Reset Window Position
Window
Save Workspace
Switch Windows
Macros
A1
Medicaid Number
Medicaid Number
First Name
Last Name
Sex
Birth date
Data Collection Status
Medicaid Patient Exclusions Is Patient Eligible for Sample?
Date the Patient Became Ineligible for the Sample
Imm
WA
DM
Colo
Dep
BMI
12345678
Mickey
Mouse
M
01/02/1940
2
4
6
8
10
12
INTRODUCTION
BENES
Imm
WA
DM
Colo
Dep
BMI
Ready
Average: 1545041.5
Count: 25
Sum: 12360332
100%

CHAC tool

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1	SiteID	Site Name	OrgID	Medicare Rank	HICN/Patient ID	First	Last	Gender	DOB	IVD Rank	Discharge History in previous 12	AMI	CABG	PCI	OR	Active Dx of IVD	Date of complete lipid profile	Result of LDL-C	Did data appear in a structured Field	PCP	Notes	Abstractor Initials
2	Populated	Populated	Populated	Populated	Populated	Populated	Populated	1=M 2=F	Populated	Populated	y,n	Y	Y	Y		Y	xx/xx/xx	##	y,n	Name of l	y Notes H	XXX
3																						
4																						
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Recommendations

- **Measure Alignment:** Align measures across payers reducing "measure fatigue" and increasing consistency of data abstraction and the subsequent development of quality initiatives
- **Patient Ranking Lists:** Have structured, reliable, and complete patient ranking lists available from all payers on the Medicare schedule (this year January 6th); these need to be well developed and free of errors.
- **Scheduling:** Keep data abstraction and reporting in the same time frame as the Medicare reporting "season". Mid to late April for Vermont programs works well.
- **Templates:** Continue to let ACO teams develop the template for data collection and reporting
- **ACO Collaboration:** Continue to encourage cross ACO collaboration
- **Benchmarks:** Have preset percentile rankings to evaluate performance

The results ……

OCV Quality Measure Scorecard 2014 vs 2013

Domain	Measure		30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	OCV Score 2013	OCV Score 2014	n 2014	Quality Points 2014
Patient/Caregiver Experience	1	Getting Timely Care, Appointments, and Information	30.00	40.00	50.00	60.00	70.00	80.00	90.00	83.81			
	2	How Well Your Doctors Communicate	30.00	40.00	50.00	60.00	70.00	80.00	90.00	92.54			
	3	Patients' Rating of Doctor	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.84			
	4	Access to Specialists	30.00	40.00	50.00	60.00	70.00	80.00	90.00	82.21			
	5	Health Promotion and Education	54.71	55.59	56.45	57.63	58.22	59.09	60.71	59.46			
	6	Shared Decision Making	72.87	73.37	73.91	74.51	75.25	75.82	76.71	75.98			
	7	Health Status/Functional Status	N/A	N/A	N/A	N/A	N/A	N/A	N/A	73.70			
Care Coordination/ Patient Safety	8	Risk Standardized, All Condition Readmissions	16.62	16.41	16.24	16.08	15.91	15.72	15.45	14.75			
	9	ASC Admissions: COPD or Asthma in Older Adults	1.75	1.46	1.23	1.00	0.75	0.56	0.27	1.25			
	10	ASC Admission: Heart Failure	1.33	1.17	1.04	0.90	0.76	0.56	0.27	1.22			
	11	Percent of PCPs who Qualified for EHR Incentive Payment	51.35	59.70	65.38	70.20	76.15	84.85	90.91	57.55			
	12	Medication Reconciliation	30.00	40.00	50.00	60.00	70.00	80.00	90.00	73.81	93.41	683	2.00
	13	Falls: Screening for Fall Risk	17.12	22.35	27.86	35.55	42.32	51.87	73.38	46.30	47.31	594	1.70
Preventive Health	14	Influenza Immunization	29.41	39.04	48.29	58.60	75.93	97.30	100.00	71.36	63.81	572	1.55
	15	Pneumococcal Vaccination	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.73	77.80	599	1.55
	16	Adult Weight Screening and Follow-up	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.94	70.81	418	1.55
	17	Tobacco Use Assessment and Cessation Intervention	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.37	96.67	600	2.00
	18	Depression Screening	5.31	10.26	16.84	23.08	31.43	39.97	51.81	24.71	28.07	456	1.55
	19	Colorectal Cancer Screening	19.81	33.93	48.49	63.29	78.13	94.73	100.00	65.33	70.27	592	1.55
	20	Mammography Screening	28.59	42.86	54.64	65.66	76.43	88.31	99.56	68.04	71.12	599	1.55
	21	Proportion of Adults who had blood pressure screened in past 2 years	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.66	66.43	414	1.55
At-Risk Population Diabetes	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	17.39	21.20	23.48	25.78	28.17	31.37	36.50	23.08	28.67	600	1.70
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	70.00	60.00	50.00	40.00	30.00	20.00	10.00	22.12	13.10	603	1.85
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	60.00	63.16	65.69	68.03	70.89	74.07	79.65	67.04	70.57	581	1.55
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	35.00	42.86	51.41	57.14	61.60	67.29	78.81	60.92	58.81	471	1.55
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	45.44	56.88	68.25	78.77	85.00	91.48	97.91	86.65	90.02	471	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	30.00	40.00	50.00	60.00	70.00	80.00	90.00	81.78	84.12	170	1.85
At-Risk Population CAD	CAD Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	54.08	61.44	66.11	69.96	72.32	76.40	79.84	58.95	66.67	438	1.40

2014 scores not available at this time for survey-based measures and CMS-calculated claims based measures.

Note: Measures 8, 9, 10, and 27 are 'reverse scored'.

n = number of beneficiaries included in the CMS GPRO submission for each quality measure. For measure 12, n is the number of discharge dates selected for medication reconciliation.

The benchmarks are the performance rates the ACO must achieve to earn the corresponding quality points for each measure. Shown are the benchmarks for each percentile, starting with the 30th percentile (corresponding to the minimum attainment level) and ending with the 90th percentile (corresponding to the maximum attainment level). For 9 measures, benchmarks are set using flat percentages when the 60th percentile was equal to or greater than 80.00 percent, as required by the program regulations. Note that measures 8, 9, 10, and 27 are reverse-scored (lower scores indicate better performance).

2014 Percentile
2013 Percentile
2013 & 2014 Percentile (No Change)

OneCareVermont

The results ……

CHAC

2014 Medicare Percentile Benchmarking Results

Domain	Measure	Short Description	P4P Phase Yr 1	30th Perc.	40th Perc.	50th Perc.	60th Perc.	70th Perc.	80th Perc.	90th Perc.	CHAC Score	CHAC Quality Points
Patient/Caregiver Experience (25%)	1		R	30.00	40.00	50.00	60.00	70.00	80.00	90.00		
	2		R	30.00	40.00	50.00	60.00	70.00	80.00	90.00		
	3		R	30.00	40.00	50.00	60.00	70.00	80.00	90.00		
	4		R	30.00	40.00	50.00	60.00	70.00	80.00	90.00		
	5		R	54.71	55.59	56.45	57.63	58.22	59.09	60.71		
	6		R	72.87	73.37	73.91	74.51	75.25	75.82	76.71		
	7		R	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Care Coord./Patient Safety (25%)	8		R	16.62	16.41	16.24	16.08	15.91	15.72	15.45		
	9		R	1.24	1.02	0.84	0.66	0.52	0.36	0.00		
	10		R	1.25	1.03	0.88	0.72	0.55	0.40	0.18		
	11		R	51.35	59.70	65.38	70.20	76.15	84.85	90.91		
	12	Medication Reconciliation	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	**98.12**	2.00
	13	Falls Risk	R	17.12	22.35	27.86	35.55	42.32	51.87	73.38	**8.72**	0.00
Preventive Health (25%)	14	Flu Shot	R	29.41	39.04	48.29	**58.60**	75.93	97.30	100.00	**67.98**	1.55
	15	Pneumonia Shot	R	23.78	39.94	54.62	**70.66**	84.55	96.64	100.00	**83.97**	1.55
	16	BMI with Follow Up	R	40.79	44.73	**49.93**	66.35	91.34	99.09	100.00	**63.47**	1.40
	17	Tobacco Screen w/Follow Up	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	**76.84**	1.70
	18	Depression Screening	R	5.31	10.26	16.84	23.08	31.43	**39.97**	51.81	**51.49**	1.85
	19	Colorectal Cancer Screen	R	19.81	33.93	48.49	**63.29**	78.13	94.93	100.00	**64.71**	1.55
	20	Mammogram	R	28.59	42.86	54.64	**65.66**	76.43	88.31	99.56	**65.71**	1.55
	21	BP Screen with follow up	R	**30.00**	40.00	50.00	60.00	70.00	80.00	90.00	**37.93**	1.10
At Risk Populations (25%)	22-26	DM Diabetes Composite	R	17.39	21.20	23.48	25.78	28.17	31.37	36.50	**15.63**	0.00
	27	DM Diabetes Poor Control	R	70.00	60.00	50.00	40.00	**30.00**	20.00	10.00	**27.34**	1.70
	28	HTN Control	R	60.00	63.16	65.69	68.03	**70.89**	74.07	79.65	**73.39**	1.70
	29	IVD - Dx and Lipid Test	R	35.00	**42.86**	51.41	57.14	61.60	67.29	78.81	**51.38**	1.25
	30	IVD - Dx and Aspirin	R	45.44	56.88	68.25	78.77	**85.00**	91.48	97.91	**86.24**	1.70
	31	HF - Dx w/ Beta Blocker Rx	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	**100.00**	2.00
	32-33	CAD - CAD Composite	R	**54.08**	61.44	66.11	69.96	72.32	76.40	79.84	**60.00**	1.10

Attachment 4a

Priority Changes and Options for Year 3 Measures

bailit health PURCHASING

56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

TO: Pat Jones and Alicia Cooper
FROM: Michael Bailit and Michael Joseph
DATE: April 7, 2015
RE: Changes to ACO Measures

In our memo dated 3-10-15 we identified changes in national measure sets that are relevant to the Vermont ACO measure set. Last week you asked that we provide you with options for measures that could replace measures that have been retired, or have been proposed for retirement, from national measure sets. This memo responds to that request.

I. Payment Measures

Measure	Reason	Options for Replacement
Core-3a: Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)	Removed from HEDIS 2015 due to a change in the national guideline	1. Statin Therapy for Patients with Cardiovascular Disease *This is a newly proposed HEDIS 2016 measure, effectively replacing LDL screening. CMS is likely to adopt the measure, but has not yet done so. NCQA will not publish benchmarks for 2016, but is likely to do so for 2017. Final specifications will be released with in July.* 2. (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure, or (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented *These currently pending measures assess high blood pressure, a significant population health risk. They align with the MSSP and benchmarks exist, but they require clinical data.*

II. Reporting Measures

Measure	Reason for Retirement	Options for Replacement
Core-16 (MN Community Measurement's Optimal Diabetes Care)	CMS has retired this measure (MSSP-22-25) from the MSSP measure set. This may be because MSSP-23 (Core-16b) is an LDL control measure.	1. The revised MN Community Measurement Optimal Diabetes Care for 2015 *MN Community Measurement has replaced the LDL measure with a statin use measure. Maine has adopted this measure.* 2. The three remaining individual measure components of Core-16 not already in the measure set, i.e., Core-16c: Blood Pressure <140/90, Core-16d: Tobacco Non-Use, and Core-16e: Aspirin Use *All of these are evidence-based measures of effective diabetes management. Benchmarks are available for the blood pressure control measure.* 3. Blood pressure control *This is an important outcome measure for management of diabetes. Benchmarks are available for the diabetes blood pressure control measure.*

III. Monitoring and Evaluation Measures

Measure	Reason for Retirement	Options for Replacement
M&E-1: Appropriate Medications for People with Asthma	NCQA is proposing retiring this measure for 2016 due to consistently high HEDIS performance rates and little variation in plan performance for both commercial and Medicaid plans.	1. Medication Management for People with Asthma *This measure was first introduced in HEDIS 2012. NCQA views it as a more effective way of assessing asthma medication management. National benchmarks are available, and the measure can be calculated with claims.*
M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions	AHRQ has retired this measure for unidentified reasons.	AHRQ is working on ED-specific PQI measures, and conducted a beta test for the draft ED-PQI SAS software from March – May 2014. The beta test was conducted to test how well the software calculates the measures using data from different users and to see how reliable the program is. The measure has not yet been finalized. In the meantime, the measure set still contains M&E-14: Avoidable ED visits-NYU algorithm. This measure is available only at the end of the year, but captures related content to the retired measure.

IV. Pending Measures

Measure	Reason for Retirement	Options for Replacement
Core-3b: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Removed from HEDIS 2015 due to a change in the national guideline	See option 1 for Core-3a on page 1.
Core-38: Coronary Artery Disease (CAD) Composite <100 mg/dL)	CMS has retired this measure (MSSP-32) from the MSSP measure set, in all likelihood because it is an LDL control measure.	See option 1 for Core-3a on page 1.

Attachment 4b

Potential Replacement Measure Numerators and Denominators

Vermont Quality and Performance Measures Work Group
Potential Replacement Measure Numerators and Denominators
May 18, 2015

#	Measure Name	Use by Other Programs	Description	Numerator	Denominator
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. ***Note:*** *Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.*	The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg. • Members 60–85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg. To determine if the member's BP is adequately controlled, the representative BP must be identified.	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP	Percentage of patients aged 18 years and older seen during the measurement period who were screened for high blood pressure (BP) AND a recommended follow-up plan is documented based on the current BP reading as indicated	Patients who were screened for high blood pressure and a recommended follow-up plan is documented as indicated if the blood pressure is pre-hypertensive or hypertensive.	All patients aged 18 years and older at the beginning of the measurement period

#	Measure Name	Use by Other Programs	Description	Numerator	Denominator
Core-16 MSSP-22-26	Diabetes Composite (D5): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco non-use, Aspirin use (note LDL removed for 2014)	NQF #0729; MSSP; Year 1 Vermont SSP Reporting Measure	Please note that this measure is in a transition phase due to changes in national guidelines for cholesterol management. For the 2014 reporting year, dates of service between 1/1/2013 – 12/31/2013 the measure was: the percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. For the 2015 reporting year, dates of service 1/1/2014 – 12/31/2014 the cholesterol component (LCL<100) is removed from the numerator. For the 2016 reporting year, dates of service 1/1/2015 – 12/31/2015, MN Community Measurement has replaced the LDL measure with a statin use and renamed the measure D5. The new D5 includes the following • HbA1c <8.0, Blood Pressure Control <140/90, patient is on a statin medication unless contraindication or valid exception is documented, patient is currently a non-tobacco user, if the patient has a comorbidity of Ischemic Vascular Disease, the patient is on daily aspirin or an accepted contraindication or valid exemption is documented	Patients ages 18 to 75 with diabetes who meet all of the following targets from the most recent visit during the measurement year: HbA1c less than 8.0, blood pressure less than 140/90, tobacco non-user, and daily aspirin for patients with diagnosis of ischemic vascular disease use unless contraindicated, and is on a statin medication unless contraindication or valid exception is documented.	Patients ages 18 to 75 with diabetes who have at least two visits for this diagnosis in the last two years (established patient) with at least one visit in the last 12 months.

#	Measure Name	Use by Other Programs	Description	Numerator	Denominator
N/A	Statin Use Measures: • Statin Therapy for Patients with Cardiovascular Disease • Statin Therapy for Patients with Diabetes	HEDIS	These are proposed new HEDIS measures for 2016. *At this time it is unknown if they were adopted, but we think it likely.* Benchmarks would not be available at least until HEDIS 2017: 1. Statin Therapy for Patients With Cardiovascular Disease: NCQA proposes to assess the number of males 21–75 years of age and females 40–75 years of age with clinical atherosclerotic cardiovascular disease to improve the use and adherence of statin therapy for secondary prevention of cardiovascular disease. Two rates are reported for this measure: 1) Patients who were dispensed at least moderate intensity statin therapy at least once during the measurement year and 2) Patients who were dispensed at least moderate intensity statin therapy that they remained on for at least 80% of their treatment period. The proposed measure aligns with new blood cholesterol guidelines from the American College of Cardiology and American Heart Association (ACC/AHA). 2. Statin Therapy for Patients With Diabetes: NCQA proposes to assess the number of adults 40–75 with diabetes to improve the use and adherence of statin therapy for primary prevention of cardiovascular disease. Two rates are reported for this measure: 1) Patients who were dispensed any intensity statin therapy at least once during the measurement year and 2) Patients who were dispensed a statin of any intensity that they remained on for at least 80% of their treatment period. The proposed measure is based on recommendations from the ACC and AHA and the American Diabetes Association.	1. Statin Therapy for Patients With Cardiovascular Disease: Two rates are reported for this measure: 1) Patients who were dispensed at least moderate intensity statin therapy at least once during the measurement year and 2) Patients who were dispensed at least moderate intensity statin therapy that they remained on for at least 80% of their treatment period. 2. Statin Therapy for Patients With Diabetes: Two rates: 1) Patients who were dispensed any intensity statin therapy at least once during the measurement year and 2) Patients who were dispensed a statin of any intensity that they remained on for at least 80% of their treatment period.	1. Statin Therapy for Patients With Cardiovascular Disease: males 21–75 years of age and females 40–75 years of age with clinical atherosclerotic cardiovascular disease. 2. Statin Therapy for Patients With Diabetes: Adults 40–75 with diabetes

#	Measure Name	Use by Other Programs	Description	Numerator	Denominator
N/A	Eye Exams for Diabetics	MSSP (part of 2015 Diabetes Composite measure that also includes Diabetes HbA1c Poor Control); HEDIS NQF# 0055	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.	An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: – A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
N/A	Medication Management for People with Asthma	HEDIS, NQF# 1799	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	The number of members who achieved a PDC of at least 50% for their asthma controller medications (Table ASM-D) during the measurement year. The number of members who achieved a PDC of at least 75% for their asthma controller medications (Table	Members age 5 – 64 years of age who were identified using the following steps: Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. – At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set). – At least one acute inpatient

#	Measure Name	Use by Other Programs	Description	Numerator	Denominator
				ASM-D) during the measurement year. Follow the steps below to identify numerator compliance.	encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set). – At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set) on different dates of service, with any diagnosis of asthma (Asthma Value Set) and at least two asthma medication dispensing events (Table ASM-C). Visit type need not be the same for the four visits. – At least four asthma medication dispensing events (Table ASM-C). Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year). Step 3: Required exclusions. Exclude members who met any of the following criteria: • Members who had any diagnosis from any of the following value sets, any time during the member's history through Dec. 31 of the measurement year:

#	Measure Name	Use by Other Programs	Description	Numerator	Denominator
					– Emphysema Value Set. – Other Emphysema Value Set. – COPD Value Set. – Obstructive Chronic Bronchitis Value Set. – Chronic Respiratory Conditions Due to Fumes/Vapors Value Set. – Cystic Fibrosis Value Set. – Acute Respiratory Failure Value Set. – Members who had no asthma controller medications (Table ASM-D) dispensed during the measurement year.

Attachment 4c

VDH Memo to QPM

VERMONT

Department of Health

To: Quality and Performance Measures Work Group, VHCIP

From: Harry Chen, MD
Commissioner of Health, Vermont Department of Health

Date: May 11, 2015

Re: Proposed changes to ACO measures for year three, and rationale for maintaining systolic blood pressure target at less than 140 mm Hg

The Vermont Department of Health would like to provide comments in response to the memo from Bailit and Joseph dated April 7, 2015 (attachment five in the April 13, 2015 Work Group packet). The Health Department staff members working on programs for diabetes and cardiovascular disease prevention and control and health surveillance have reviewed recent performance measures and issues related to these conditions discussed by the Quality and Performance Measures Work Group (QPM WG). We also reviewed the published literature, discussed these issues with CDC science advisors, and conferred with a Vermont clinical expert who is planning to attend the QPM WG on May 18th, 2015 to answer questions related to hypertension management. Following careful consideration of the issues, we strongly support replacing the measure being removed with a hypertension control measure, and that the systolic blood pressure control target remains less than 140 until further guidelines are issued in 2016. (See the attached annotated articles that advocate keeping blood pressure target at less than 140/90 mm Hg).

Regarding options for replacing the payment measure, Core-3A (cholesterol management), we support Core-39/MSSP-28 Controlling High Blood Pressure because it is an existing NQF measure already being widely collected and reported. It is a priority measure for the CDC and for other organizations funding Million Hearts (blood pressure control) projects nationwide. Prevalence of hypertension in Vermont is high: 29% for adults overall and 65% for those aged 60 and older. As a state with an aging population this measure will impact the majority of Vermonters. Hypertension is the most modifiable risk factor for reducing stroke and preventing the progression of heart and kidney disease.

The "2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC8)" caused controversy about raising the target systolic blood pressure from 140 to 150 mm Hg. The majority of published opinions about blood pressure targets since this report continue to advocate for targets of less than 140/90 in everyone but the frail or elderly (over age 80). Groups that support keeping the target at 140/90 include CDC, American Heart Association (AHA), HRSA, American College of Cardiology (ACC), International Hypertension Society and the American

Society of Hypertension. ACC and AHA are among those working on hypertension treatment guidelines slated for release sometime in 2016.

Target guidelines for group performance measures are not meant to supersede healthcare providers' clinical judgment about individualized treatment goals. The Vermont Department of Health echoes the majority of authorities advocating to keep the blood pressure target at less than 140/90 mm Hg. In light of the current scientific controversy we feel it is premature to change the blood pressure target to 150/90 for those at age 60 plus and risk losing the gains we made in decreasing hypertension-related deaths and co-morbidities.

Virginia Hood, MD, MPH, from Nephrology Services at the University of Vermont Medical Center, and past President of the American College of Physicians, will answer QPM WG members' questions on May 18th.

Attachment 4d

Recent Articles Related to Blood Pressure Targets

Recent Annotated Articles Promoting BP targets of < 140/90 mm Hg

William B. Borden, MD, et al., Impact of the 2014 Expert Panel Recommendations for Management of High Blood Pressure on Contemporary Cardiovascular Practice: Insights from the NCDR PINNACLE Registry. *Journal of the American College of Cardiology* 2014; 64: 2196–2203.

1. Study used the National Cardiovascular Data Registry PINNACLE Registry to assess the proportion of patients who met the 2003 and 2014 panel recommendations and highlighted the populations of patients for whom the blood pressure goals changed.
    a. Of 1,185,253 patients in the study cohort, 706,859 (59.6%) achieved the 2003 JNC-7 goals. Using the 2014 recommendations, 880,378 (74.3%) patients were at goal.
    b. Among the 173,519 (14.6%) for whom goal achievement changed, 40,323 (23.2%) had a prior stroke or transient ischemic attack, and 112,174 (64.6%) had coronary artery disease. In addition, the average Framingham risk score in this group was 8.5 ± 3.2%, and the 10-year ASCVD risk score was 28.0 ± 19.5%.
2. Among U.S. ambulatory cardiology patients with hypertension, nearly 1 in 7 who did not meet JNC-7 recommendations would now meet the 2014 treatment goals. If the new recommendations are implemented in clinical practice, blood pressure target achievement and cardiovascular events will need careful monitoring, because many patients for whom the target blood pressure is now more permissive are at high cardiovascular risk.

Krakoff LA, et al. 2014 Hypertension recommendations from the eighth Joint National Committee panel members raise concerns for elderly black and female populations. *J Am College of Cardiol* 2014; 64:394-402.

1. Opinions expressed in this article are about the detrimental impact to select populations if treatment goals were increased from < 140 to < 150 mm Hg in populations ≥ 60 years of age.
    a. The Association of Black Cardiologists (ABC) and clinical specialists treating hypertension in Blacks believe that a treatment goal of 150 mm Hg for those ≥ 60 could potentially result in a major health threat for Blacks with hypertension.
    b. A Working Group on Women's Cardiovascular health suggests that the new hypertension recommendation disproportionately negatively impacts women, since there are so many more women in the > 60 age demographic with hypertension.
    c. Several studies are cited in which elderly patients received benefits from lower BP targets without harm or excessive adverse effects.
2. CDC, AHA, and American College of Cardiology (ACC) reiterate a systolic treatment goal of < 140 mm Hg.
    a. International Hypertension Society and American Society of Hypertension concur.
3. The recommendations of what would have become the Joint National Committee (JNC) 8 to raise the treatment goal to < 150 for those ≥ 60 were never endorsed.
    a. The minority portion of the panel preferred to retain the < 140 threshold and treatment goal in the general hypertensive population without diabetes or chronic kidney disease, except for those older than age 80 years who are frail. Some of their main points are highlighted in the article referenced further below.

Wright JT et al. Evidence supporting a systolic blood pressure goal of less than 150 mm Hg in patients aged 60 years or older: the minority view. *Annals of Internal Medicine* 2014; 160:499-503.

1. Increasing the target from < 140 to < 150 will probably reduce the intensity of antihypertensive treatment in large populations at high risk for CVD: African Americans, hypertensive patients with multiple CVD risk factors other than diabetes and chronic kidney disease, and those with clinical CVD.
2. The evidence supporting the higher systolic blood pressure in people aged 60 and older was insufficient and inconsistent with the evidence supporting < 140 mm Hg.
3. The higher target may reverse the decades-long decline in CVD, especially stroke mortality.

4. Observational studies and random control trial data that the JNC panel did NOT review more strongly supports < 140, and other recent groups examining guidelines have recommended a goal of less than 140 mm Hg, particularly in people aged 80 years or younger.
5. A target systolic BP of less than 140 mm Hg for patients younger than 80 years would also be in line with the guidelines from Europe, Canada, the American College of Cardiology Foundation, and the American Heart Association, the United Kingdom, and the American Society of Hypertension and the International Society of Hypertension.

Many state and national organizations are recommending no change to blood pressure guidelines at this time.

Three professional organizations have issued a joint statement on treating high blood pressure in people who have been diagnosed with coronary heart disease, stroke or other forms of heart disease. (American Heart Association, American College of Cardiology, and American Society of Hypertension)

- The statement reinforces the goal of reducing blood pressure to under 140/90 in order to reduce the risk of heart attack and stroke.
- Patients should know their blood pressure, make lifestyle changes to reduce their risk of heart attack and stroke, and work with a physician to safely lower their blood pressure.

MN Community Measurement: http://mncm.org/updated-blood-pressure-guidelines-mean-no-change-to-mncm-measures/ (accessed 4/29/15) released a statement that MNCM does not expect changes to the blood pressure components for our Optimal Diabetes Care and Optimal Vascular Care measures in the near future. The Optimal Diabetes Care and Optimal Vascular Care all-or-nothing composite measures both include blood pressure components with targets of less than 140/90 mm Hg.

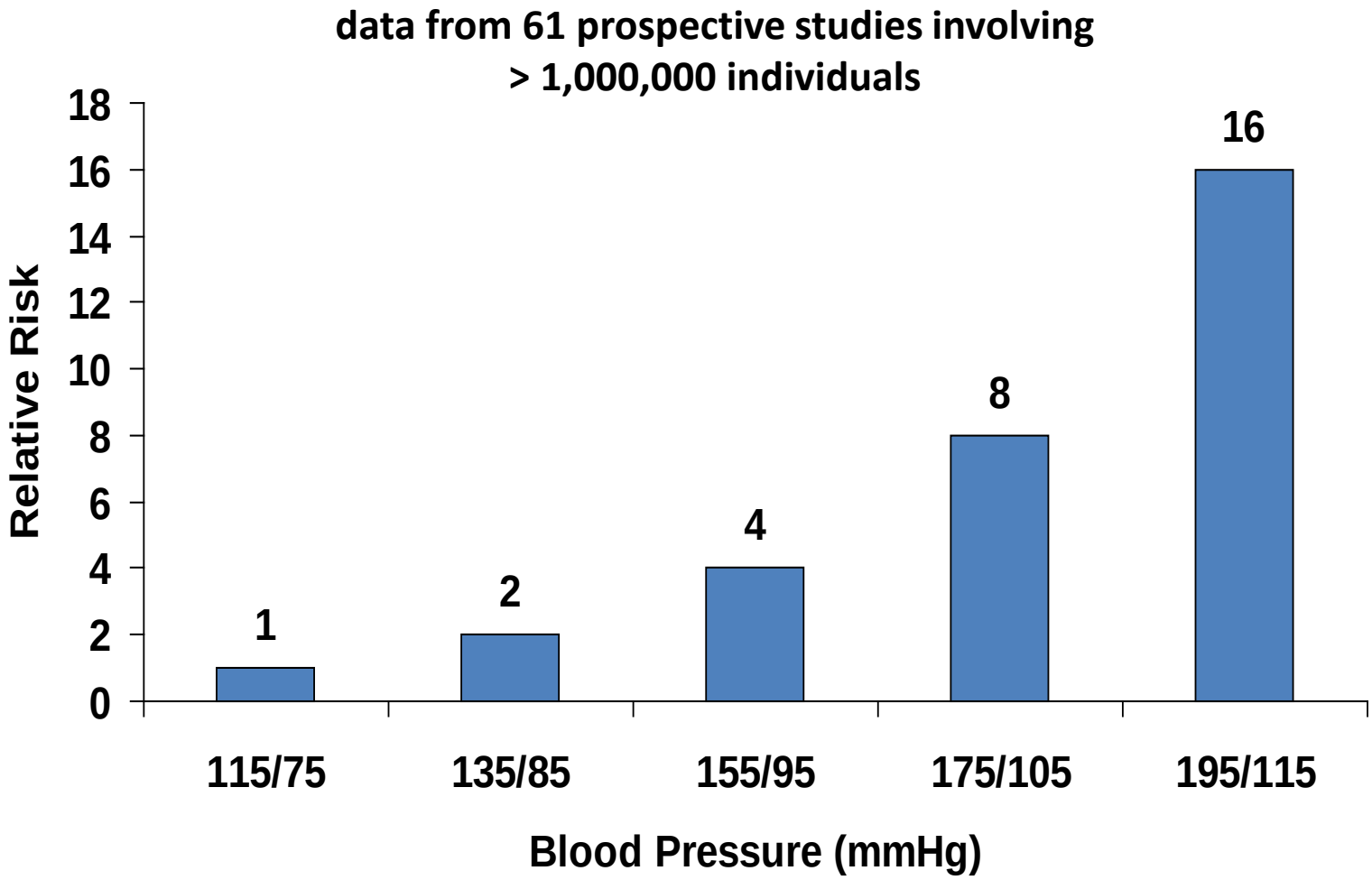
Attachment 4e

Hypertension Control Considerations for Performance Measurement

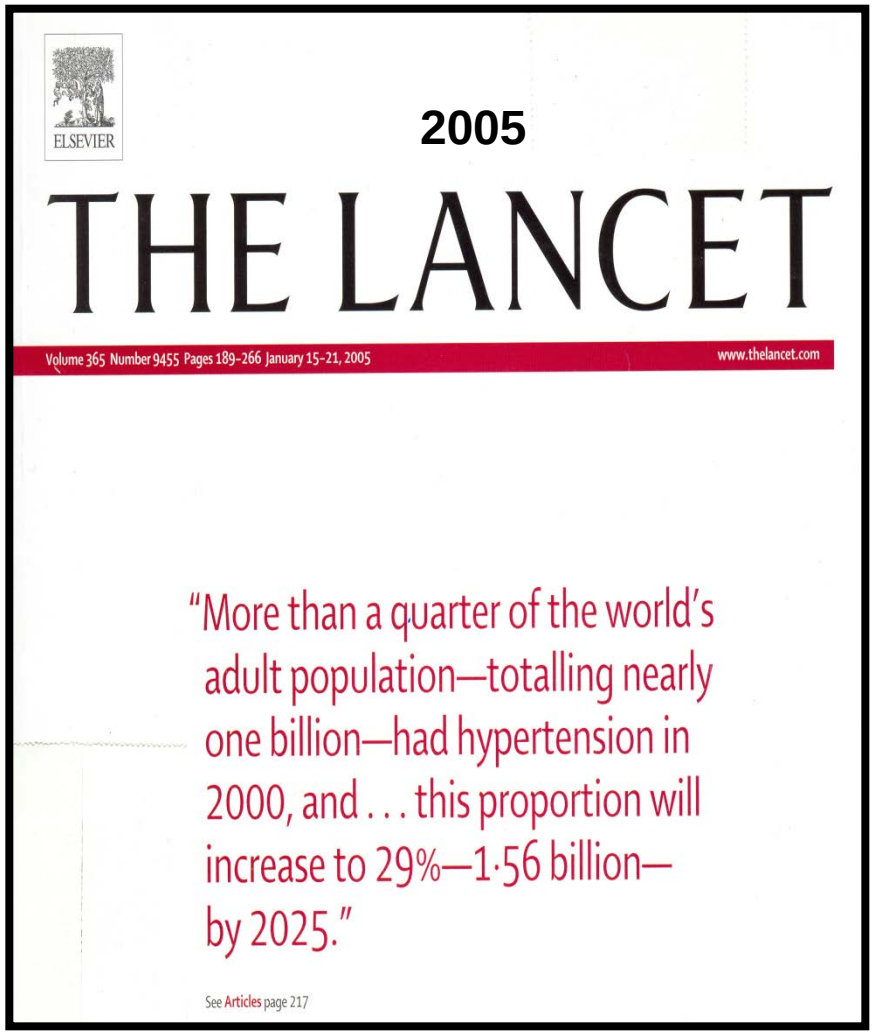
Hypertension Control Considerations for Performance Measurement

Virginia L. Hood, MBBS, MPH
Nephrologist, Professor of Medicine
University of Vermont College of Medicine

Relative Risk of Cardiovascular Mortality



Lewington et al, Lancet 2002



- **14% of deaths**
- **54% strokes**
- **47% IHD (heart disease)**
- **80% low and middle income people**
- **8 million aged 45-69 die prematurely**

Lancet 371:1480-2 and 1513-18, 2008

- **High blood pressure is the foremost modifiable risk factor for stroke, progression of renal disease and cardiovascular disease (CVD)**

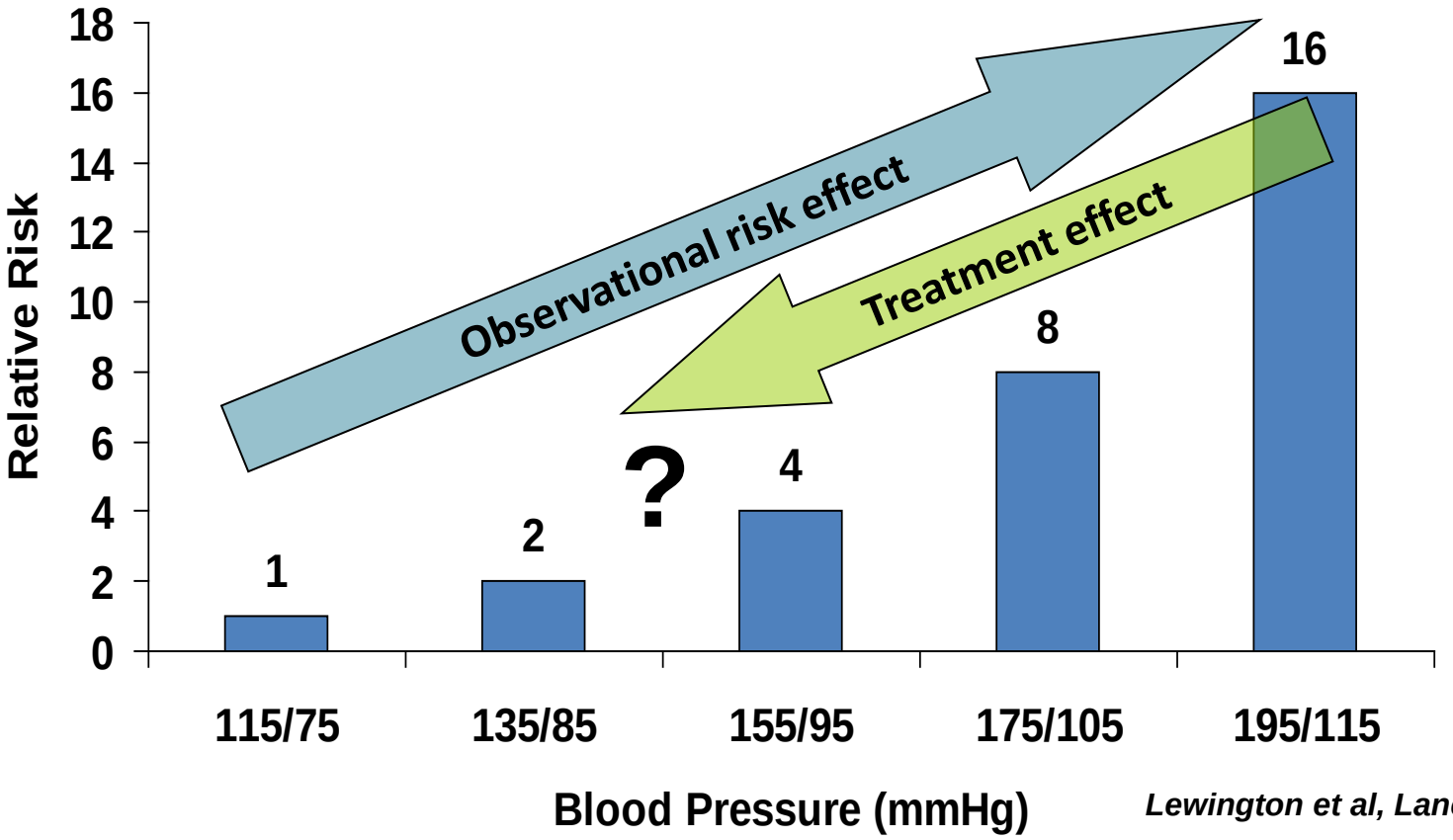
Hypertension in US– “a neglected disease”

Institute of Medicine (IOM) February 2010

- **1/3 adults have it; 1/2 > 60y, 3/4 >70y**
- **1/6 die as a consequence**
- **1/2 have it controlled**
  1/3 of uncontrolled are unaware or untreated

  JAMA 2014;312:1973-74
- **1/4 at high risk for CVD (diabetes, CKD, increased lipids) have it controlled (NHANES III)**
- **easy to prevent,**
  simple to diagnose,
  inexpensive to treat

Hypertension treatment effect mirrors observational risk effect



Lewington et al, Lancet 2002

High blood pressure is the most modifiable risk factor for reducing stroke and preventing progression of kidney & cardiovascular disease

What constitutes an “optimal” blood pressure goal

- for treated or untreated
- for systolic or diastolic
- by measurement: office, home, ambulatory
- by outcome: risk reduction for CVD, CKD, stroke, all cause mortality
- with other CV risk factors: age, albuminuria, diabetes, hyperlipidemia
- for individual or group

Current evidence based treatment goals for office BP ≥140/90 to reduce CVD and CKD progression

- **<140/90 mmHg for all adults**
- **<150/90 if >80y (KDIGO, NICE) or > 60y (JNC8)**
- **<140/90 for DM, CKD, CVD**
  ? < 130/80 for CKD with much albuminuria
- **focus on systolic (top) BP i.e. SBP < 140**

Blood Pressure Lowering Treatment Trialists' Collaboration. BMJ 2008;336;1121-1123

- **individual patient targets may need to be adjusted for co-existing conditions**

KDIGO 2012 KI Sup2:343-369; NICE Aug 2012 nice.org.uk; JAMA Feb 5 2014 JNC 8

What constitutes an “optimal” blood pressure goal for a performance measure

- **Percent at or below “goal” compared to national or local benchmark for a group**
  - **patients in the State (with or without HTN and or treatment)**
  - **patients in a practice group (with HTN or not)**
  - **patients managed by an individual health care professional**
- **Percent at or below goal individualized for each patient**
- **Percent with BP and other CV risk factors controlled**