
Vermont ACO Shared Savings Program Quality Measures: Recommendations for Year 2 Measures from the VHCIP Quality and Performance Measures Work Group

Presentation to VHCIP Steering Committee

August 6, 2014

Measure Use Terminology: Core

Payment

- Performance on these measures will be considered when calculating shared savings.

Reporting

- ACOs will be required to report on these measures. Performance on these measures will be not be considered when calculating shared savings.

Pending

- Measures that are included in the core measure set but are not presently required to be reported. Pending measures are considered of importance to the ACO model, but are not required for initial reporting for one of the following reasons: target population not presently included, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely accepted specifications, or overly burdensome to collect. These may be considered for inclusion in future years.

Measure Use Terminology: Monitoring & Evaluation

Monitoring

- These are measures that would provide benefit from tracking and reporting. They will have no bearing on shared savings; nonetheless, they are important to collect to inform programmatic evaluation and other activities. These measures will be reported at the plan or state-level. Data for these measures will be obtained from sources other than the ACO (e.g., health plans, state).

Utilization & Cost

- These measures reflect utilization and cost metrics to be monitored on a regular basis for each ACO. Data for these measures may be obtained from sources other than the ACO.

Year 1 Payment Measures – Claims Data

Commercial &
Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*

Medicaid-Only

- Developmental Screening in the First Three Years of Life

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Claims Data

Commercial
& Medicaid

- Ambulatory Care-Sensitive Conditions Admissions: COPD*
- Breast Cancer Screening*
- Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite
- Appropriate Testing for Children with Pharyngitis

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Clinical Data

Commercial
& Medicaid

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
 - *HbA1c control**
 - *LDL control**
 - *High blood pressure control**
 - *Tobacco non-use**
 - *Daily aspirin or anti-platelet medication**
- Diabetes HbA1c Poor Control*
- Childhood Immunization Status
- Pediatric Weight Assessment and Counseling

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Survey Data

Commercial
& Medicaid

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care

Year 1 Monitoring & Evaluation Measures

PLAN-LEVEL MONITORING

- Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Follow-up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management

STATE-LEVEL MONITORING

- Family Evaluation of Hospice Care Survey
- School Completion Rate
- Unemployment Rate

UTILIZATION & COST

- Total Cost of Care
- Resource Utilization Index
- Ambulatory surgery/1000
- Average # of prescriptions PMPM
- Avoidable ED visits- NYU algorithm
- Ambulatory Care (ED rate only)
- ED Utilization for Ambulatory Care-Sensitive Conditions
- Generic dispensing rate
- High-end imaging/1000
- Inpatient Utilization - General Hospital/Acute Care
- Primary care visits/1000
- SNF Days/1000
- Specialty visits/1000

- Annual Dental Visit

Year 1 Pending Measures

- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)*
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*
- Influenza Immunization*
- Tobacco Use Assessment and Tobacco Cessation Intervention*
- Coronary Artery Disease (CAD) Composite*
- Hypertension (HTN): Controlling High Blood Pressure*
- Screening for High Blood Pressure and Follow-up Plan*
- Cervical Cancer Screening
- Proportion not admitted to hospice (cancer patients)
- Elective delivery before 39 weeks
- Prenatal and Postpartum Care
- Care Transition-Transition Record Transmittal to Health Care Professional
- How's Your Health?
- Patient Activation Measure

- Frequency of Ongoing Prenatal Care
- Percentage of Patients with Self-Management Plans
- Screening, Brief Intervention, and Referral to Treatment
- Trauma Screen Measure
- Falls: Screening for Future Fall Risk*
- Pneumococcal Vaccination for Patients 65 Years and Older*
- Use of High Risk Medications in the Elderly
- Persistent Indicators of Dementia without a Diagnosis

**Medicare Shared Savings Program measure*

QPM WG Year 2 Measure Review Process

- **Goals were to adhere to transparent process and obtain ongoing input from WG members and other interested parties**
- **March-June**
 - Interested parties and other VHCIP Work Groups presented Year 2 measure changes for consideration
 - WG reviewed and finalized criteria to be used in evaluating overall measure set and payment measures
 - WG reviewed and discussed proposed measure changes
- **June-July**
 - Co-Chairs/Staff/Consultant scored each recommended measure against approved criteria on 0-1-2 point scale and developed proposals for Year 2 measure changes for the WG's consideration
 - WG reviewed and discussed proposals
- **July**
 - WG voted on measures during July 29th meeting

QPM Criteria for Evaluating All Measures

- ✓ Valid and reliable
- ✓ Representative of array of services provided and beneficiaries served by ACOs
- ✓ Uninfluenced by differences in patient case mix or appropriately adjusted for such differences
- ✓ Not prone to effects of random variation (measure type and denominator size)
- ✓ Consistent with state's objectives and goals for improved health systems performance
- ✓ Not administratively burdensome
- ✓ Aligned with national and state measure sets and federal and state initiatives whenever possible
- ✓ Includes a mix of measure types
- ✓ Has a relevant benchmark whenever possible
- ✓ Focused on outcomes
- ✓ Focused on prevention, wellness and/or risk and protective factors
- ✓ Limited in number and including measures necessary to achieve state's goals (e.g., opportunity for improvement)
- ✓ Population-based

QPM Criteria for Evaluating Payment Measures

- ✓ Presents an opportunity for improvement
- ✓ Representative of the array of services provided and beneficiaries served
- ✓ Relevant benchmark available
- ✓ Focused on outcomes
- ✓ Focused on prevention and wellness
- ✓ Focused on risk and protective factors
- ✓ Selected from the Commercial or Medicaid Core Measure Set

Summary of Year 2 Recommended Changes

- QPM Work Group voted to:
 - Re-classify **9 existing** measures
 - 3 to Payment
 - 5 to Reporting
 - 1 to M&E
 - Add **2 new** measures
 - 1 to Reporting (Patient Experience Survey)
 - 1 to M&E

Recommended Year 2 Payment Measures

– Claims Data

Commercial &
Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*
- **Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite** (10-5 vote of QPM WG; move from Reporting)

Medicaid-Only

- Developmental Screening in the First Three Years of Life

**Medicare Shared Savings Program measure*

Recommended Year 2 Payment Measures

– Clinical Data

Commercial
& Medicaid

- **Diabetes Care: HbA1c Poor Control (>9.0%)*** (10-5 vote of QPM WG; move from Reporting)
- **Pediatric Weight Assessment and Counseling** (10-5 vote of QPM WG; move from Reporting)

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Claims Data

Commercial
& Medicaid

- Ambulatory Care-Sensitive Conditions Admissions: COPD*
- ~~Breast Cancer Screening*~~
- ~~Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: Composite~~
- Appropriate Testing for Children with Pharyngitis
- **Avoidable ED Visits** *(9-6 vote of QPM WG; move from M&E)*

Commercial-
Only

- **Developmental Screening in the First Three Years of Life** *(10-4 vote of QPM WG; already in Y1 Payment Measure Set for Medicaid SSP)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Clinical Data

Commercial &
Medicaid

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
 - *HbA1c control**
 - *LDL control**
 - *High blood pressure control**
 - *Tobacco non-use**
 - *Daily aspirin or anti-platelet medication**
- ~~Diabetes HbA1c Poor Control*~~
- Childhood Immunization Status
- ~~Pediatric Weight Assessment and Counseling~~
- **Cervical Cancer Screening** (*Unanimous vote of QPM WG, move from Pending*)
- **Tobacco Use: Screening & Cessation Intervention*** (*Unanimous vote of QPM WG, move from Pending*)

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures

– Patient Experience Survey Data

Commercial
& Medicaid

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care
- **Provider Knowledge of DLTSS Services and Help from Case Manager/Service Coordinator**
(11-3 vote of QPM WG; NEW)

Recommended Year 2 Monitoring & Evaluation Measures

PLAN-LEVEL MONITORING

- Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Follow-up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- **Breast Cancer Screening** (*Unanimous vote of QPM WG; moved from Reporting*)

STATE-LEVEL MONITORING

- Family Evaluation of Hospice Care Survey
- School Completion Rate
- Unemployment Rate
- **LTSS Rebalancing** (*Medicaid-only; state and county level; unanimous vote of QPM WG; NEW*)
- **SBIRT** (*for pilot sites; unanimous vote of QPM WG; move from Pending*)

UTILIZATION & COST

- Total Cost of Care
 - Resource Utilization Index
 - Ambulatory surgery/1000
 - Average # of prescriptions PMPM
 - Avoidable ED visits- NYU algorithm
 - Ambulatory Care (ED rate only)
 - ED Utilization for Ambulatory Care-Sensitive Conditions
 - Generic dispensing rate
 - High-end imaging/1000
 - Inpatient Utilization - General Hospital/Acute Care
 - Primary care visits/1000
 - SNF Days/1000
 - Specialty visits/1000
- Annual Dental Visit

Recommended Year 2 Pending Measures

- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)*
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*
- Influenza Immunization*
- ~~Tobacco Use Assessment and Tobacco Cessation Intervention*~~
- Coronary Artery Disease (CAD) Composite*
- Hypertension (HTN): Controlling High Blood Pressure*
- Screening for High Blood Pressure and Follow-up Plan*
- ~~Cervical Cancer Screening~~
- Care Transition-Transition Record Transmittal to Health Care Professional
- Percentage of Patients with Self-Management Plans

- How's Your Health?
- Patient Activation Measure
- Elective delivery before 39 weeks
- Prenatal and Postpartum Care
- Frequency of Ongoing Prenatal Care
- ~~Screening, Brief Intervention, and Referral to Treatment~~
- Trauma Screen Measure
- Falls: Screening for Future Fall Risk*
- Pneumococcal Vaccination for Patients 65 Years and Older*
- Use of High Risk Medications in the Elderly
- Persistent Indicators of Dementia without a Diagnosis
- Proportion not admitted to hospice (cancer patients)

**Medicare Shared Savings Program measure*

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant recommended considering these measures for promotion
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Reporting	Prenatal and Postpartum Care (Clinical Data)	5 in favor of promotion 9 opposed to promotion
Pending	Reporting	Influenza Immunization (Clinical Data)	7 in favor of promotion 7 opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering this measure for promotion
- Work group members requested additional consideration for use as Reporting in Year 2
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Pending	Screening for High Blood Pressure and Follow-Up Plan Documented (Clinical Data)	2 in favor of promotion to Reporting 11 opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering these measures for promotion
- QPM work group members chose not to vote on these measures

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure
Reporting	Reporting	Optimal Diabetes Care (D5 – Composite)
Reporting	Reporting	Rate of Hospitalization for ACSCs (COPD/Asthma in Older Adults)
Reporting	Reporting	Screening for Clinical Depression & Follow-Up
Reporting	Reporting	Adult BMI Assessment
Pending	Pending	Controlling High Blood Pressure
Pending	Pending	Care Transition Record Transmitted to Health Care Professional
Pending	Pending	Transition Record with Specified Elements Received by Discharged Patients
Pending	Pending	Percentage of Patients with Self-Management Plans

Attachment 5b - Year 2
Proposed Measures Overview
with Benchmarks

VT Quality and Performance Measures Work Group
Review of Changes in Measures Proposed for Year 2 Reporting and Payment
June 20, 2014

Additional Measures Proposed for 2015 Reporting:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-8	Developmental Screening in the First Three Years of Life (<i>currently in Medicaid measure set; proposed for commercial measure set</i>)	NQF #1448; NCQA (not HEDIS); and CHIPRA	Yes		Medicaid can use claims data, but provider coding for commercial payers is not currently reliable, so the commercial measure could require data from clinical records.	CMS has analyzed data from five states (AL, IL, NC, OR, TN) that reported the measure for FFY12 consistently using prescribed specifications. CMS reports that 12 states reported in FFY13, and 18 intend to do so in FFY14. Best practice is in IL, which reported rates of 77%, 81%, 65% in Years 1-3; the five-state median was 33%, 40%, 28%.	<ul style="list-style-type: none"> Vermont Legal Aid Population Health WG DLTSS Work Group
Core-30	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS)	Yes	<u>Changes in HEDIS specifications for 2014:</u> <ul style="list-style-type: none"> Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21-64 years of age and cervical cytology/HPV co-testing performed every five years in women 30-64 years of age. 	For HEDIS purposes in 2014, both commercial and Medicaid plans could use the hybrid method which requires data from clinical records.	<p>HEDIS benchmark available (for HEDIS 2015; no benchmark for 2014).</p> <p>Historical Performance HEDIS 2013 (PPO)</p> <ul style="list-style-type: none"> BCBSVT: 72%; CIGNA: 71%; MVP: 71% National 90th percentile: 78%; Regional 90th percentile: 82% National Average: 74%; Regional Average: 78% 	<ul style="list-style-type: none"> Population Health WG
Core-34	Prenatal and Postpartum Care	NQF #1517; NCQA (HEDIS)			HEDIS rates are collected using the hybrid method, using claims data and clinical records.	<p>Timeliness of Prenatal Care Historical Performance HEDIS 2013 (PPO):</p> <ul style="list-style-type: none"> BCBSVT: 94%; CIGNA: 74%; MVP: 95% National 90th percentile: 96%; Regional 90th percentile: 96% National Average: 81%; Regional 	<ul style="list-style-type: none"> Population Health WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						<p>Average: 82%</p> <p>Postpartum Care Historical Performance (PPO):</p> <ul style="list-style-type: none"> • BCBSVT: 83%; CIGNA: N/A; MVP: 84% • National 90th percentile: 86%; Regional 90th percentile: 90% • National Average: 70%; Regional Average: 70% 	
Core-35/ MSSP-14	Influenza Immunization	NQF #0041; MSSP	Yes		Requires clinical data or patient survey to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events)	Medicare MSSP benchmarks available from CMS.	<ul style="list-style-type: none"> • Population Health WG • DTLSS WG
Core-36/ MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #0028; MSSP	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50 th percentile is 50%, and the 90 th percentile is 90%. This measure is in use in other states and HRSA and CDC publish benchmarks, so additional benchmarking feasible if there is interest in adoption.	<ul style="list-style-type: none"> • Population Health WG • DLTSS WG
Core 37	Transition Record Transmittal to Health Care Professional	NQF #0648/#2036 (paired measure - see below)	Yes		Clinical records	None identified	<ul style="list-style-type: none"> • DTLSS WG
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP	Yes	<u>Guideline change:</u> In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of	Clinical records	HEDIS benchmark currently available, but with measure likely to change, there is a possibility that there won't be a benchmark for 2015.	<ul style="list-style-type: none"> • Population Health WG • DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
				<p>hypertension:</p> <ul style="list-style-type: none"> Set the BP treatment goal for patients 60 and older to <150/90 mm Hg. Keep the BP treatment goal for patients 18-59 at <140/90 mm Hg. <p><u>Changes in HEDIS Specifications for 2015:</u> Proposed changes to HEDIS specifications in 2015 to align with the JNC 8 guidelines. The measure will be based on one sample for a total rate reflecting age-related BP thresholds. The total rate will be used for reporting and comparison across organizations.</p>		<p>Historical Performance HEDIS 2013 (PPO)</p> <ul style="list-style-type: none"> BCBSVT: 61%; CIGNA PPO: 62%; MVP PPO: 67% National 90th percentile: 65%; Regional 90th percentile: 78% National Average: 57%; Regional Average: 63% 	
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP			Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50 th percentile is 50%, and the 90 th percentile is 90%. However, this measure is in use by other states so it may be possible to identify benchmarks.	<ul style="list-style-type: none"> Population Health WG DLTSS WG
Core-44	Percentage of Patients with Self-Management Plans	Not NQF-endorsed	No. Need to develop measure specs based on the NCQA standard, or borrow from a state that uses this measure.		Clinical records	This measure is used by some PCMH programs in other states. Benchmarks could be obtained from those states.	<ul style="list-style-type: none"> Population Health WG DLTSS WG (see Core-44 ALT)

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-44 (ALT*)	Transition Record with Specified Elements Received by Discharged Patients	NQF #0647/#2036 (paired measure - see above)	Yes		Clinical records	None identified	<ul style="list-style-type: none"> DTLSS WG
Core-45	Screening, Brief Intervention, and Referral to Treatment	Not NQF-endorsed	No, but a form of the measure is in use by Oregon Medicaid		Could potentially use claims or data from clinical records. If claims-based, could involve provider adoption of new codes.	None available, but a form of the measure is in by Oregon Medicaid, so benchmark rates could be available if the same measure was adopted.	<ul style="list-style-type: none"> Population Health WG DLTSS WG Howard Center
New Measure	LTSS Rebalancing (<i>proposed for Medicaid measure set</i>)	Not NQF-endorsed	DAIL has proposed specifications		DAIL collects statewide and county data from claims; potential to collect at ACO level.	None available	<ul style="list-style-type: none"> DLTSS WG
New Measures	3 to 5 custom questions for Patient Experience Survey regarding DLTS services and case management	Not NQF-endorsed	Questions have been developed; may require NCQA approval to add to PCMH CAHPS Survey		Could add to PCMH CAHPS Patient Experience Survey; might increase expense of survey.	None available	<ul style="list-style-type: none"> DLTSS WG

Additional Measures Proposed for 2015 Payment:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-10 MSSP-9	Ambulatory Care-Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF# 0275; AHRQ PQI #05; Year 1 Vermont SSP Reporting Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	<ul style="list-style-type: none"> • CMS • DVHA
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Not NQF-endorsed; AHRQ PQI #92; Year 1 Vermont SSP Reporting Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	<ul style="list-style-type: none"> • CMS • DVHA • DLSS WG
Core-15	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	<p>HEDIS benchmarks available from NCQA. This measure has three components:</p> <ul style="list-style-type: none"> • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity <p>BMI Percentile Historical Performance HEDIS 2012 (PPO)</p> <ul style="list-style-type: none"> • CIGNA PPO: 63% • National 90th percentile: 65%; Regional 90th percentile: 87% <p>National Average: 25%; Regional Average: 42%</p> <p>Counseling for Nutrition Historical Performance HEDIS 2012 (PPO)</p> <ul style="list-style-type: none"> • CIGNA PPO: 73% • National 90th percentile: 69%; Regional 90th percentile: 90% <p>National Average: 28%; Regional Average: 45%</p>	<ul style="list-style-type: none"> • DLSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						Counseling for Physical Activity Historical Performance HEDIS 2012 (PPO) <ul style="list-style-type: none"> CIGNA PPO:72% National 90th percentile: 65%; Regional 90th percentile: 86% National Avg.: 26%; Regional Avg.: 42%	
Core-16 MSSP-22- 26	Diabetes Composite (D5): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco non-use, Aspirin use	NQF #0729; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u>	Yes. Measure steward (MCM) changed specs for 2014 and 2015.	Change to national LDL control guideline impacted this measure.	Clinical records	Available from Minnesota Community Measurement for Minnesota provider performance	<ul style="list-style-type: none"> DLTSS WG
Core-17 MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u>	Yes		Clinical records	HEDIS benchmarks available from NCQA. Historical Performance HEDIS 2012 (PPO): (Lower rate is better) <ul style="list-style-type: none"> BCBSVT: 41% National 90th percentile: 22%; Regional 90th percentile: 18% National Average: 28%; Regional Average: 34%	<ul style="list-style-type: none"> DLTSS WG
Core-19 MSSP-18	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u>	Yes		Clinical records	Measure in use in some other states; we would have to review how implemented to see if benchmarks are available	<ul style="list-style-type: none"> DLTSS WG
Core-20 MSSP-16	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u>	Yes		Clinical records	In use by HRSA so benchmark data may be available	<ul style="list-style-type: none"> DLTSS WG
M&E-14	Avoidable ED Visits (NYU Algorithm)	Not NQF-endorsed; Year 1 Vermont SSP <u>Monitoring and Evaluation Measure</u>	Yes		Claims	Measure used in other states and in research, so it may be possible to identify benchmarks	<ul style="list-style-type: none"> DLTSS WG

Attachment 6 - Financial Proposal PowerPoint

Financial Proposal

August 6th, 2014

Georgia Maheras, JD

Project Director

AGENDA

1. Integrated Community Care Management Learning Collaborative

CMCM Work Group Proposal for Integrated Community Care Management Learning Collaborative

- **Request from Care Models and Care Management Work Group:** Funding to support a year-long learning collaborative that will improve integration of care management activities for at-risk people and provide learning opportunities for best practices for care management in at least 3 pilot communities (Burlington, Rutland and St. Johnsbury).
- **Project Summary:** Learning collaborative aims to:
 - Identify existing care management services and resources and gaps in services in the pilot communities
 - Implement and test best practices for integrating care management, such as shared care planning, and care management protocols for referrals and transitions in care
 - Develop care management tools and training resources to support implementation and testing
 - Develop and collect measures of success and accountability
 - Provide shared learning opportunities for participating organizations

Proposed Budget

- **Project estimated cost:** Not-to-exceed amount of \$300,000 would support:
 - Two full-time contracted facilitators at a cost of \$95,000/year each (includes travel and training).
 - Expenses estimated at \$60,000 for multiple Learning Sessions during the year, including expert faculty and travel expenses, rental of meeting space, and materials.
- **Project Timeline:** Proposed for October 1, 2014 – October 31, 2015
- **Budget Line-Item:** Type 2 Learning Collaboratives

Intent of Request/Relationship to VHCIP Goals

- By grounding its work in the Plan-Study-Do-Act model for quality improvement, the Integrated Community Care Management Learning Collaborative will demonstrate that integrated care management services based on best practices can:
 - Improve quality of care, person and family experience, health outcomes, and wellness, and
 - Reduce unnecessary utilization and cost.
- These goals align with the CMCM work group's charge to develop an integrated delivery system that leads to coordination, collaboration, and improved care for Vermonters; and also with the overarching goals of the VHCIP to improve care, improve population health, and reduce health care costs.

Scope of Work

Using skilled facilitators, this Learning Collaborative will support organizations that provide care management services in creating Integrated Communities; implementing best practices, tools, and training resources; and measuring results.

Facilitators will have expertise in quality improvement methods, transformation, team facilitation, group dynamics and project management.

1. **Facilitator A** will coordinate collaborative design, learning session design and logistics, team member outreach, communications, and learning collaborative implementation in the pilot communities.
2. **Facilitator B** will work closely with team members in the pilot communities on data resource identification, data analysis, panel management and measurement activities.

Deliverables

- Multi-organization teams in pilot communities will identify existing and needed care management resources; implement selected best practices in care management integration; adopt tools and training resources to support those best practices; measure results; and engage in learning opportunities.
- Facilitators will promote an environment of collaborative learning within and between the pilot communities and across the health system, through mechanisms that include multiple learning sessions with expert faculty.
- Facilitators will meet with teams in pilot communities on a regular basis to provide the following services:
 - Change Management Support
 - Technical Assistance and Training
 - Data Analysis, Measurement and IT Support
 - Creation of a Learning Health System
 - Development of Connections Within and Between Pilot Communities