VPQHC

Vermont Program for Quality in Health Care, Inc.

Catherine E. Fulton, Executive Director
Vermont Program for Quality in Health Care, Inc.
VPQHC Testimony to the House Committee on Health Care on H.761
Wednesday, February 10, 2016 3:30 pm

VPQHC **supports H.761** and a plan to catalogue and align health care performance measures for primary care providers.

VPQHC has supported this activity through my previous role as Co-Chair of the Quality and Performance Measures Workgroup of the VHCIP award. This support continues in my current role as Co-Chair of the Payment Models Design Implementation Workgroup.

The following activities were undertaken to provide protections against undue burden in consideration of primary care practices:

1. **Measures Criteria** (see attached document) - 14 items designed to ensure:
    i. **Technical integrity**
        a. Valid, reliable
        b. Uninfluenced by case mix
        c. Not prone to random variation
    ii. **Common sense implementation**
        a. Aligned with state's goals for health systems performance and improvement
        b. NOT administratively burdensome to collect – prioritized administrative claims measures
        c. Aligned with other measure sets (federal and state sets) and data being collected (i.e. PQRS, MSSP)
    iii. **Aspirational vision**
        a. Focused on outcomes
        b. Wellness and prevention
        c. Population-based
        d. Considers upstream causative factors and risk

2. **Technological Solutions** – integration of HIT Workgroup efforts to develop capacity to capture specific data elements electronically; this effort relieves the burden of manual abstraction for clinical data
    a. **Gap Remediation Plan** – included assessment of clinical quality measures and related data elements for the Payment and Reporting Measure Sets
    b. **Update/Current Status** – at present, 17 out of 33 ACO measures are able to be collected electronically

3. **Data Collection Process Solution** – the quality leaders of the three ACOs organized ***themselves*** to create a data collection process that was minimally disruptive to the practices:
    a. Unified data collection form
    b. Collaborated on data collection – timing and scheduling
    c. Shared efforts and information as appropriate

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***NOTE:** this effort is no small feat; these individuals represent three distinctly unique care delivery organizations with separate business models who came together to reduce the impact of data collection on practice operations; it is a testament to the professionalism of these 3 quality staff that this efficiency was achieved:

Rick Dooley – Healthfirst
Patty Launer – CHAC
Miriam Sheehy – OneCare

4. **Utilizing Existing Mechanisms – where feasible**
    a. Patient Experience Surveys currently administered by Blueprint were utilized in lieu of creating yet another survey process – this benefits BOTH providers and patients
    b. Reporting output for ACO measures were incorporated into the Blueprint Practice Profiles – this provides the opportunity to present a relevant and comprehensive view of practice performance

H.761 provides a vehicle within the GMCB structure to memorialize and preserve the efforts that have already been undertaken to assure minimal impact of performance measurement. VPQHC supports the continuing effort of the Legislature and GMCB to minimize impacts to primary care practices as healthcare payment reform efforts create value rather than volume, improved outcomes and healthier Vermonters.

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VHCIP Quality and Performance Measures Work Group
Adopted Criteria for ACO Shared Savings Programs – Year 2 Overall Measure Selection
As of July 2, 2014

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

The following criteria from the Population Health Work Group were adopted by the QPM Work Group at its June 2014 meeting:

Focus on prevention and wellness by patient, physician and system	Focus on prevention, self-care and maintaining wellness. The measure would include actions taken to maintain wellness rather than solely on identifying and treating disease and illness.
Focus upstream to include risk and protective factors	The measure would capture personal health behaviors such as tobacco, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.