NEW YORK STATE | Department of Health | Medicaid Redesign Team

Chronic Pulmonary, Chronic Heart, Diabetes and Primary Care VBP Clinical Advisory Group (CAG) Meeting #2

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September 14, 2017

Agenda

1. Opening Remarks and Objectives	5 min
2. Review of Quality Measure Set Development and Maintenance Process	30 min
3. 2018 Proposed Measure Set	15 min
4. Defining Priority Clinical and Care Delivery Goals	30 min
5. Additional Questions Identified by the Physical Health CAG	5 min
6. Closing Remarks and Next Steps	5 min

Opening Remarks and Objectives

September CAG Meeting Objectives:

1. Update on current status of the 2018 Value Based Payment Program (VBP) Measure Set.
2. Review feedback received for priority clinical and care delivery goals related to:
    1. General Primary and Secondary Prevention,
    2. Diabetes,
    3. Chronic Heart Disease, and
    4. Chronic Pulmonary Disease.

Section 2:

Review of Quality Measure Set Development and Maintenance Process

VBP Measure Set Development: *Crawl, Walk, Run!*

Status in VBP	• Several measures require final specifications and/or clinical or other data elements	• Work with measure stewards to develop and finalize specifications	• Fully developed VBP measures included in Measurement Years 2018 and 2019
Data Availability and Sources	• Assess data availability • Identify and investigate potential data sources • Survey technological capabilities	• Implement new data and reporting flows • Develop additional data sources	• Coordination established with Qualified Entities (QEs) for clinical data integration
Data Collection and Infrastructure	• Gather requirements for data collection • Begin developing infrastructure to support new data sources	• Initiate testing and evaluation of data collection methodologies • Work closely with technology vendors	• Data and reporting flows have been established • New data source infrastructure established

Note: Timelines will vary. The intent is to make substantive contributions within each phase to help realize NYS VBP Roadmap goals.

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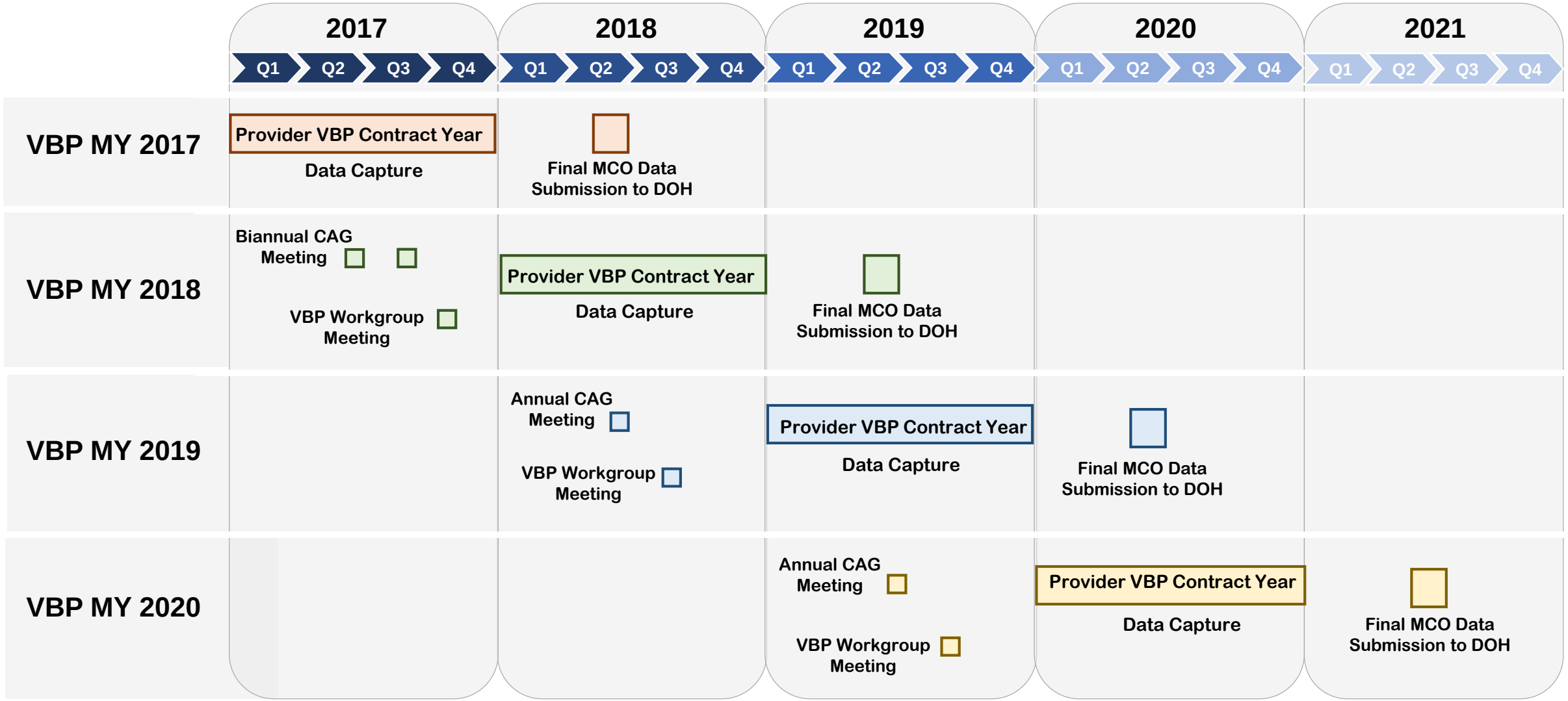
VBP Contracting, Measure Implementation and Reporting Timeline



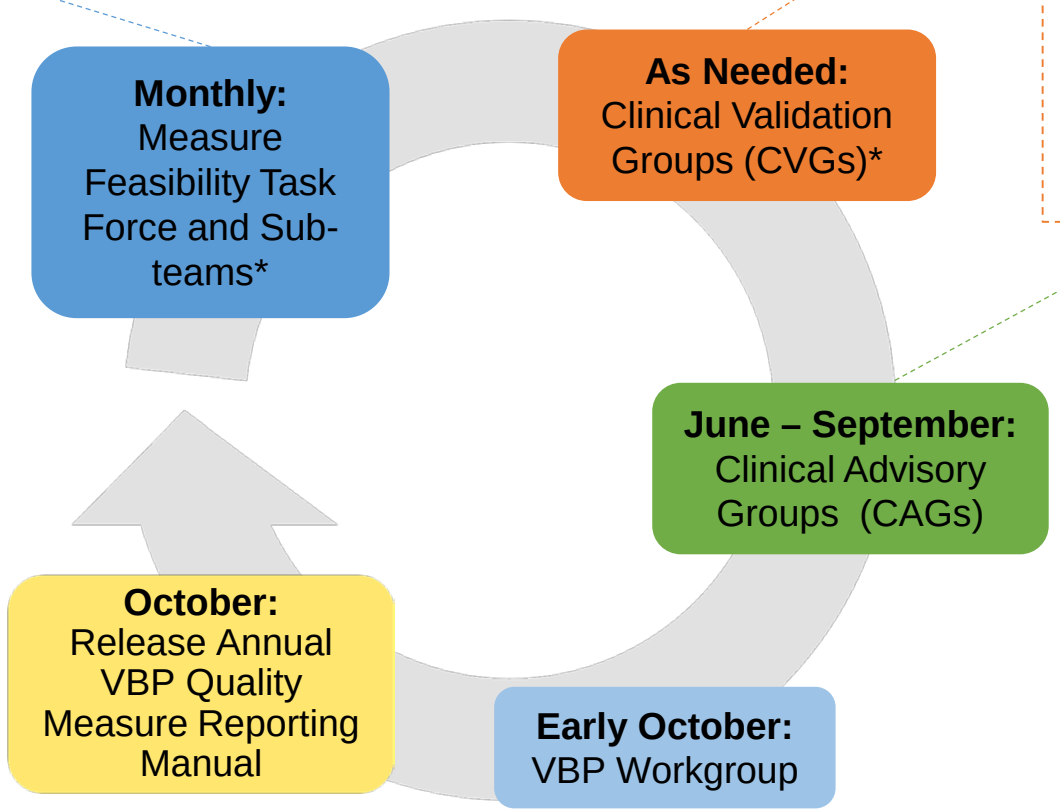
Quality Measurement Development and Maintenance

2017-2018 Measure Review Process

Purpose: Review feedback from VBP Pilot Contractors and Managed Care Organizations (MCOs) as it relates to feasibility of data collection and reporting at a VBP Contractor unit of analysis.

- **Cadence**: General Committee: Bi-monthly; Sub-teams: Monthly
- **Stakeholders**: Quality Measurement Professionals, VBP Pilots (Plans and Contractors)

Sub-teams:
- Behavioral Health (BH) / Health and Recovery Plan (HARP)
- Health Information Technology (HIT)-Enabled Quality Measurement
- HIV/AIDS
- Maternity
- Total Care for the General Population (TCGP) / Integrated Primary Care (IPC)



Purpose: Define and refine the episodes of care for each VBP Arrangement as well as for each Potentially Avoidable Complication (PAC) measure.

- **Cadence**: As necessary
- **Stakeholders**: New York State (NYS) Agencies** (OHIP, OQPS, OMH, OASAS, etc.) and Altarum

Purpose: Identify and fill critical gaps in the clinical and care delivery goals to strengthen Statewide quality measurement program.

- **Cadence**: Annual (or bi-annual) meeting
- **Stakeholders**: NYS Agencies, CAG Members (Clinicians/ Medical Professionals from across the State)

CAGs:
- BH/HARP
- Children's Health
- Chronic Conditions/ Primary Care
- HIV/AIDS
- Managed Long Term Care (MLTC)
- Maternity

** Initially for 2017-2018, the Measure Feasibility Task Force and CVGs require a more intensive effort. The workload for these groups is expected to taper off after the VBP Pilot program ends after 2018.*

*** OHIP: Office of Health Insurance Programs, OQPS: Office of Quality and Patient Safety, OMH: Office of Mental Health, OASAS: Office of Alcoholism and Substance Abuse Services.*

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Stakeholder Engagement Process for Measure Review

Department of Health Approach

Clinical Advisory Groups

The CAG activities focused on refining the priority clinical and care delivery goals for the VBP arrangement measure sets, providing recommendations for future measure development and inclusion within the measure sets to drive improvement and achieve results per VBP Roadmap.

Measure Feasibility Task Force

The Measure Feasibility Task Force reviewed the VBP arrangement measure sets to assist in building a clear picture of the current state and anticipated challenges regarding data capture, data flows, and the approaches taken by MCOs and provider organizations in the selection and utilization of measures within quality programs and VBP contracting.

Public Comment and Survey

In addition to the workgroups above, the state pursued additional outreach efforts including public engagement through request for comment on measurement specifications and a survey of the current state and challenges of measure implementation and reporting.

12 Week Intensive Stakeholder Review Process

50+
Represented Groups and Organizations

35+
Meeting Hours

200+
Stakeholders Engaged

Measure Calculation and Reporting Feasibility

Key Themes Identified by Stakeholders

1. **Significant Resource Requirements for Data Capture**
   Securing resources to program data capture workflows for hybrid and non-QARR* (Quality Assurance Reporting Requirements) measures is challenging. System modifications and the build of custom workflows are limited in many systems, further complicating the work required to address data capture and extraction requirements in support of non-standard measures.
2. **Disparate Electronic Record and Reporting Systems**
   Disparate systems and reporting processes present significant challenges for data capture and reporting. Providers must be able to extract and submit data consistent with the unique requirements from each plan contracted.
3. **Lack of Clarity Regarding Data Origin and Context**
   Each plan takes a unique approach to data collection for measure calculation, using data from many sources including commercial lab feeds, lab data from Qualified Entities (QEs), and abstracted data from providers.
4. **Challenges Associated with Medical Record Abstraction**
   Providers challenged to collect administrative data based on practice patterns, e.g. connecting previously run lab work with claims for patient visits when labs are run a week ahead of the visit.
5. **Attribution and Measure Alignment for Certain Populations**
   MCO-assigned PCP (Primary Care Provider) driven attribution may create misalignment between the assigned PCP and providers who are providing most of the care for a member.
6. **Transition from Sampling to Population Level Measurement and Reporting**
   Population sampling is used for a significant number of measures. Movement toward a population level reporting and measurement approach will be challenging and require that resource and workflow issues be addressed to support the reporting and calculation of a population-wide measure.

** QARR is a component of the NY Medicaid Managed Care Quality Incentive Program.*

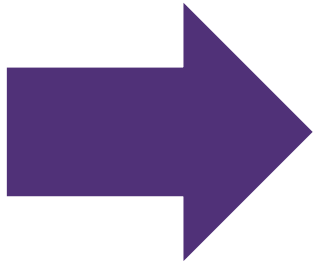
Section 3:

2018 Proposed Measure Set

The Role of the CAGs: Then and Now

Recommendations for the Initial Measure Sets

The **VBP CAGs** and subcommittees were created to address the larger VBP design questions. Their charge was to produce recommendations to the VBP Workgroup and to the State with their best design solutions. As a result, a number of VBP standards and guidelines were developed (included in the current version of the Roadmap) by the Subcommittees. The CAGs' scope of work included selecting Quality Measures for specific arrangements.



Identification of VBP Measurement Targets and Gaps

The CAG will focus its activities on refining the priority clinical and care delivery goals for the VBP Arrangements and providing recommendations, on an annual basis, to revise, strengthen, and improve the priority goals that will serve as the guide for long-term VBP Measure Set strategy, development and implementation.

The CAG will meet each year to review, identify, and fill critical gaps in the clinical and care delivery goals specific to the Medicaid population. The focus will be on **significant changes in the evidence base and clinical guidelines, along with opportunities for improvement** identified through experience in clinical practice and feedback from MCOs and VBP contractors.

TCGP/IPC VBP Arrangement – 2018 Proposed Measure Set

Measure Name	Description	Steward	VBP Category
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).	CMS	**Cat 1 P4P**
Antidepressant Medication Management - Effective Acute Phase Treatment & Effective Continuation Phase Treatment	The percentage of patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).	NCQA	**Cat 1 P4P**
Breast Cancer Screening	Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months	NCQA	**Cat 1 P4P**
Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	NCQA	**Cat 1 P4P**
Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NCQA	**Cat 1 P4P**

Acronyms: CMS – Centers for Medicare and Medicaid Services, NCQA – National Committee for Quality Assurance

TCGP/IPC VBP Arrangement – 2018 Proposed Measure Set

Measure Name	Description	Steward	VBP Category
Chlamydia Screening for Women	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period	NCQA	**Cat 1 P4P**
Colorectal Cancer Screening	Percentage of patients 50 - 75 years of age who had appropriate screening for colorectal cancer	NCQA	**Cat 1 P4P**
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period	NCQA	**Cat 1 P4P**
Comprehensive Diabetes Care: Foot Exam	Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period	NCQA	**Cat 1 P4R**
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.	NCQA	**Cat 1 P4R**
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	NCQA	**Cat 1 P4P**
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	NCQA	**Cat 1 P4P**

Acronyms: NCQA – National Committee for Quality Assurance

TCGP/IPC VBP Arrangement – 2018 Proposed Measure Set

Measure Name	Description	Steward	VBP Category
Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	NCQA	**Cat 1 P4P**
Comprehensive Diabetes Screening: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	NQF #s 0055, 0062, 0057 Number of people (18-75) who received at least one of each of the following tests: HbA1c test, , diabetes eye exam, and medical attention for nephropathy	AHRQ	**Cat 1 P4P**
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period	NCQA	**Cat 1 P4P**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	**Cat 1 P4P**
Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	NCQA	**Cat 1 P4P**
Initiation of Pharmacotherapy for Alcohol Dependence	The percentage of individuals who initiate pharmacotherapy with at least 1 prescription for alcohol treatment medication within 30 days following an index visit with a diagnosis of alcohol abuse or dependence.	OASAS	**Cat 1 P4R**

Acronyms: NCQA – National Committee for Quality Assurance, AHRQ – Agency for Healthcare Research and Quality, OASAS - Office of Alcoholism and Substance Abuse Services

TCGP/IPC VBP Arrangement – 2018 Proposed Measure Set

Measure Name	Description	Steward	VBP Category
Initiation of Pharmacotherapy for Opioid Use Disorder	The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid abuse or dependence.	OASAS	**Cat 1 P4P**
Medication management for patients with asthma	The percentage of patients 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 patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period. [A] ages 5-18 [B] ages 19-64	NCQA	**Cat 1 P4P**
Potentially Avoidable Complications (PAC) in routine sick care or chronic care	Percent of proxy-priced costs associated with Potentially Avoidable Complications (PACs) in the chronic bundle and in routine sick care. Expressed as the ratio of actual/expected costs. Costs is used as a proxy for the severity of the PAC.	Altarum	**Cat 1 P4R**
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.	CMS	**Cat 1 P4R**
Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	AMA PCPI	**Cat 1 P4R**
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	CMS	**Cat 1 P4R**

Acronyms: OASAS – Office of Alcoholism and Substance Abuse Services , NCQA – National Committee for Quality Assurance, CMS – Centers for Medicare and Medicaid Services, AMA – American Medical Association, PCPI – Physician Consortium for Performance Improvement

TCGP/IPC VBP Arrangement – 2018 Proposed Measure Set

Measure Name	Description	Steward	VBP Category
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	AMA PCPI	**Cat 1 P4R**
Statin Therapy for Patients with Cardiovascular Disease	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: (1) Received Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year. (2) Statin Adherence 80%. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.	NCQA	**Cat 1 P4R**
Statin Therapy for Patients with Diabetes	Percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have ASCVD who remained on a statin medication of any intensity for at least 80% of the treatment period.	NCQA	**Cat 1 P4R**
Use of spirometry testing in the assessment and diagnosis of COPD	The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis	NCQA	**Cat 1 P4R**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity	NCQA	**Cat 1 P4P**

Acronyms: AMA – American Medical Association, PCPI – Physician Consortium for Performance Improvement, NCQA – National Committee for Quality Assurance

Review: Types of Clinical Quality Measures

	CLINICAL QUALITY MEASURES			
	Administrative/ Claims-Based	**Hybrid**	**Proxy**	**eCQM**
Numerator	Derived from Claims	Derived from Claims & Medical Record Review	Derived from EHR or CDR	Derived from EHR or CDR
Denominator	Derived from Claims	Derived from Claims	Derived from EHR or CDR	Derived from EHR or CDR
Additional Information	Supplemental data may also be used to identify numerator events & denominator exclusions	A sample of the population is targeted chart review	Approximates specification using available electronic data. May "loosen" the spec. to account for data gaps	Specification is used to build a query of the clinical data source; specs have known limitations
Uses/ Example	Health plans HEDIS reporting/ APC/ VBP	Health plans HEDIS reporting/ APC/ VBP	QEs generating measures to drive pop. Health management	MU Attestation

Source: NYSTEC, June 2017
Acronyms: EHR: Electronic Health Records; CDR: Clinical Data Repository; HEDIS: Healthcare Effectiveness Data and Information Set; APC: Advanced Primary Care; QE: Qualified Entities; MU: Meaningful Use; eCQM: Electronic Clinical Quality Measures

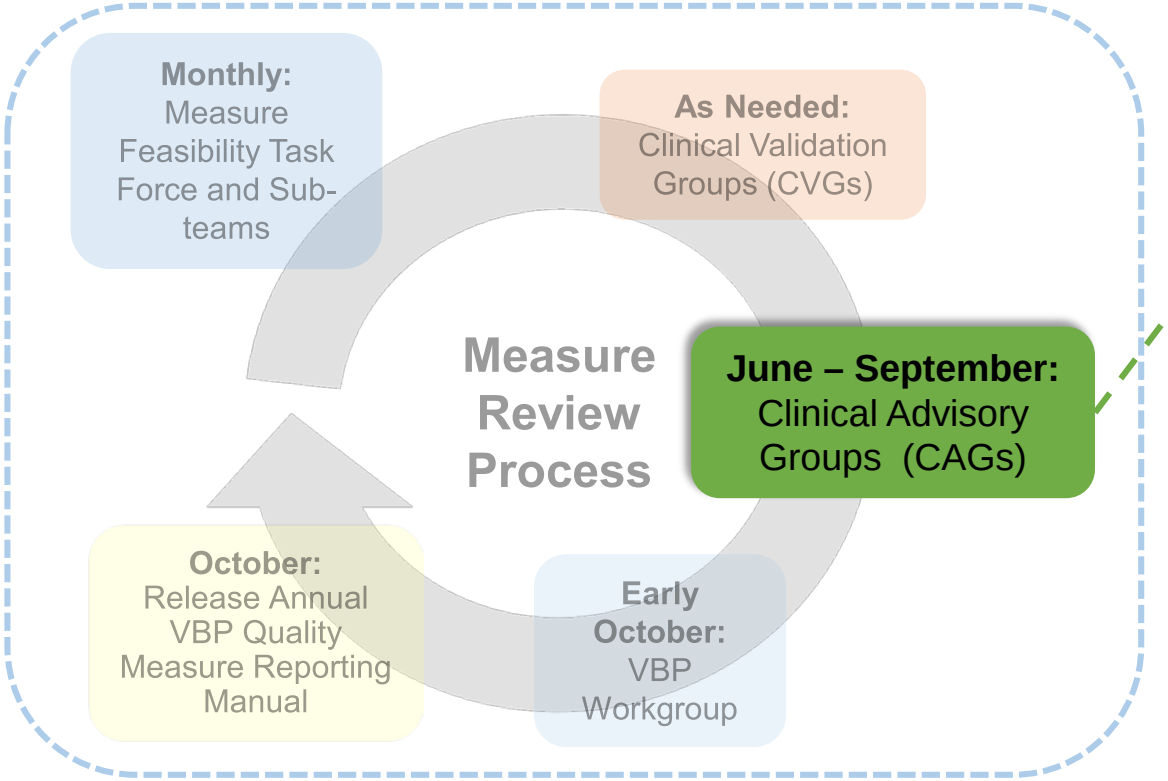
Section 4:

Defining Priority Clinical and Care Delivery Goals

Recommendations for Development of Future VBP Quality Measurement

Priority Clinical and Care Delivery Goal Setting Strategy

Clinical care delivery goal setting, facilitated by the CAGs, will establish clear targets and provide **strategic direction** for the State to consider in the development of a multi-year VBP quality measurement strategy. This process will drive the development and implementation of a high-value and responsive measure set for the VBP Arrangements.



Purpose: **Identify and fill critical gaps in the clinical and care delivery goals to strengthen Statewide quality measurement program.**

- **Cadence**: Annual (or bi-annual) meeting
- **Stakeholders**: NYS Agencies, CAG Members (Clinicians/ Medical Professionals from across the State)

CAGs:

- BH/HARP
- Children's Health
- Chronic Conditions/ Primary Care
- HIV/AIDS
- Managed Long Term Care (MLTC)
- Maternity

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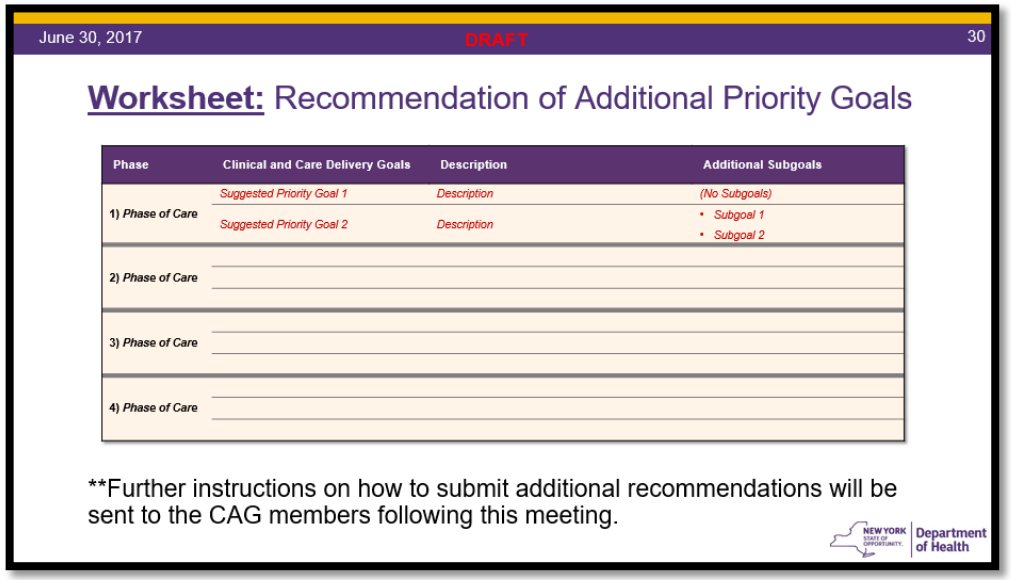
2017 Clinical Advisory Group Feedback Process

Work to Date

- The initial set of Priority Clinical and Care Delivery Goals presented to the CAGs in July was based on a review of the CAG and Integrated Care Workgroup (ICWG) Measure Set recommendations.
- Following the July CAG meetings, members were asked to submit their feedback on the priority clinical and care delivery goals and sub-goals for each arrangement's measure set.
- Responses were aggregated and used to update the goals and sub-goals targeted by each arrangement.



June 30, 2017 DRAFT 30

Worksheet: Recommendation of Additional Priority Goals

Phase	Clinical and Care Delivery Goals	Description	Additional Subgoals
1) *Phase of Care*	*Suggested Priority Goal 1*	*Description*	*(No Subgoals)*
	Suggested Priority Goal 2	*Description*	• *Subgoal 1* • *Subgoal 2*
2) *Phase of Care*			
3) *Phase of Care*			
4) *Phase of Care*			

**Further instructions on how to submit additional recommendations will be sent to the CAG members following this meeting.

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Summary of Feedback

Clinical and Care Delivery Goals

Recommendations for updates and modification of the four Clinical and Care Delivery Goal tables have been extracted from both the July CAG meeting member discussion and the worksheets subsequently submitted to the Department of Health (DOH).

Feedback has been analyzed to create a summary of key themes and incorporate recommendations into the updated Clinical and Care Delivery Goal tables that follow.

Key Themes

1	General Primary and Secondary Prevention	Recommendations fell into two core themes related to the addition of clinical and care delivery goals addressing control of modifiable risk factors to prevent the occurrence of chronic disease and the addition of goals focused on screening and early detection of disease.
2	Diabetes	Feedback included emphasis on the importance of goals for patient self-management, optimal health behaviors, and psychosocial health, including depression and stress management, supporting optimal diabetes management and prevention of diabetes-related complications
3	Chronic Heart Disease	Recommendations for additional goals related to psychosocial health and optimal lifestyle/health behaviors supporting self-management of chronic heart disease, slow disease progression, and prevent acute cardiovascular events.
4	Chronic Pulmonary Disease	Recommendations supporting the addition of goals related to assessment of environmental exposures, self-management of asthma, and obesity screening/weight management for patients with chronic pulmonary disease.

Clinical and Care Delivery Goals

General Primary and Secondary Prevention

Based on feedback received, the Clinical and Care Delivery Goals table for General Primary and Secondary Prevention has been modified to include:

- Goals focusing on prevention and early detection of chronic diseases including diabetes, cardiovascular disease, and obesity.
- Additional goals for optimal health behaviors and psychosocial health including goals related to physical activity and stress management.
- Additional reproductive and sexual health goals related to HIV risk assessment and screening based on recommendations from the HIV/AIDS CAG.

Care Focus	Priority Clinical and Care Delivery Goals	
1) Immunizations/ Vaccinations	**Childhood Immunizations**	**Prevention and Control of Seasonal Influenza with Vaccinations**
2) Optimal Health Behaviors/ Lifestyle	**Active Living / Regular Physical Activity** **Healthy Weight** **Nutrition**	**Screening and Prevention of Drug Abuse and Excessive Alcohol Use** **Tobacco Avoidance and Cessation**
3) Prevention and Early Detection of Disease	**Cancer Screening** − *Breast Cancer* − *Cervical Cancer* − *Colorectal Cancer* **Chronic Disease Screening** − *Pre-Diabetes* − *Cardiovascular Risk Assessment* − *Hypertension* − *Dyslipidemia* − *Obesity*	**Medication Management** − *Daily Aspirin use as cardiovascular prophylaxis for those at elevated risk for cardiovascular disease/events ^*
4) Psychosocial Health	**Depression Screening** − Early Identification, Initiation of Treatment, and Management	**Psychosocial Stress Management**
5) Reproductive and Sexual Health	**Sexually Transmitted Infection Prevention** − *HIV Risk Assessment (Identification of at-risk patients)* − *HIV Pre-Exposure Prophylaxis (PrEP)*	**Sexually Transmitted Infection Early Detection** − *Hep B Screening* − *Chlamydia Screening* − *HIV Screening* − *HIV Re-screening for at-risk patients (high-risk negatives)*

Red text indicates goals that were added based on feedback

^ *Source:* https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer

Clinical and Care Delivery Goals

Diabetes

Based on feedback received, the Clinical and Care Delivery Goals table for Diabetes has been modified to include:

- Incorporation of diabetes self-management.
- Inclusion of regular physical activity and exercise for diabetes management and prevention of cardiovascular comorbidities.
- Assessment and management of depression and psychosocial stressors in patients with diabetes.

Phase of Care	Priority Clinical and Care Delivery Goals		
1) Evaluation and Ongoing Management	**Access to Care** **Care Coordination** **Glycemic Control** **Cardiovascular Disease** **Diabetes Self-Management** **Eye Care** **Foot Care** **Kidney Disease** **Medication Management**	**Optimal Health Behaviors/Lifestyle**	– *Weight Management** – *Nutrition** – *Active Living/Regular Physical Activity** – *Tobacco Avoidance and Cessation**
		Psychosocial Health	– *Depression Screening and Management** – *Psychosocial Stress Management**
2) Exacerbation and Complex Treatment	**Access to Care** **Care Coordination**	**Clinical Outcomes**	

Red text indicates goals that were added based on feedback.
** Goals also included in General Primary and Secondary Prevention tables.*

Clinical and Care Delivery Goals

Chronic Heart Disease

Based on feedback received, the Clinical and Care Delivery Goals table for Chronic Heart Disease has been modified to include:

- Assessment and management of depression and psychosocial stress in patients with chronic heart disease.
- Inclusion of regular physical activity and exercise as part of the chronic heart disease management plan.

Care Focus	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	**Access to Care** **Blood Pressure Control** **Cardiovascular Function (Ejection Fraction)** **Care Coordination** **Functional Status Assessment** **Lipid Control** **Medication Management** **Stroke Risk Assessment**	**Optimal Health Behaviours/ Lifestyle** – *Weight Management** – *Nutrition** – *Active Living/Regular Physical Activity** – *Tobacco Avoidance and Cessation** **Psychosocial Health** – *Depression Screen and Management** – *Psychosocial Stress Management**
2) Acute / Hospitalization	**Care Coordination** **Mortality**	**Outcomes**
3) Post Acute / Rehab	**Access to Care**	**Care Coordination**
4) Cardiac Procedures	**Cardiac Catheterization**	

Red text indicates goals that were added based on feedback.
** Goals also included in General Primary and Secondary Prevention tables.*

Clinical and Care Delivery Goals

Chronic Pulmonary Disease

Based on feedback received, the Clinical and Care Delivery Goals table for Chronic Pulmonary Disease has been modified to include:

- Assessment of environmental exposures including indoor allergens and outdoor air pollution.
- Influenza and Pneumococcal vaccinations for chronic pulmonary disease patients at increased risk.
- Tobacco use assessment and cessation for patients with chronic pulmonary disease.
- Screening/management of obesity and weight management to support improvements in levels of pulmonary function and asthma control.

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	**Access to Care** **Asthma Severity Assessment and Monitoring** **Asthma Self-Management** – *Management of Asthma Triggers* **Care Coordination** **Environmental Exposure** – *Assessment of Environmental Exposures: Air Quality (indoor allergens; outdoor air pollution)*	**Immunizations/ Vaccinations** – *Influenza*, – *Pneumococcal* **Medication Management** **Optimal Health Behaviors/ Lifestyle** – *Weight Management** , – *Tobacco Avoidance and Cessation** **Obesity- Screening and Management** **Pulmonary Function**
2) Acute / Hospitalization	**Asthma Self-Management** **Mortality**	**Outcomes** – *Utilization of Controller Medications*
3) Post Acute / Rehab	**Functional Status Assessment**	**Health Related Quality of Life**

Red text indicates goals that were added based on feedback.
** Goals also included in General Primary and Secondary Prevention tables.*

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Children's Health CAG

Priority Clinical and Care Delivery Goals - ***Physical Health***

The Children's Health CAG met between October 2016 and July 2017. During deliberations the committee discussed care for the general pediatric population within the TCGP arrangement. As a result, additional child-focused clinical and care delivery goals have been recommended for consideration to ensure that providers are striving to improve and achieve high performance for children under the TCGP VBP Arrangement.

Question: Do you agree that these clinical and care delivery goals recommended in the following slides should be included in Total Care for the General Population arrangements?

Clinical and Care Delivery Goals

General Primary and Secondary Prevention

The following clinical and care delivery goals have been highlighted for consideration as they apply to the **pediatric population.**

- Goals listed in black text are currently included in the Primary and Secondary Prevention tables, but are included here to emphasize inclusion of the pediatric population as evolve in VBP program ahead.
- Goals listed in red are not currently included in the Primary and Secondary Prevention table and would be a new addition.

Care Focus	Priority Clinical and Care Delivery Goals	
1) Immunizations/ Vaccinations	**Childhood Immunizations** − *Emphasis placed on recommended immunizations/vaccinations received by 2 and 13 years of age*	
2) Optimal Health Behaviors/ Lifestyle	**Active Living / Regular Physical Activity** **Healthy Weight** **Nutrition**	**Screening and Prevention of Drug Abuse and Excessive Alcohol Use** **Tobacco Avoidance and Cessation**
3) Prevention and Early Detection of Disease	**Oral Health** − *Access to Dental Care* − *Risk assessment and prevention for caries*	**Eye Health** − *Reduced Visual Acuity*
4) Psychosocial Health	**Depression Screening** − Early Identification, Initiation of Treatment, and Management	**Recommended developmental screenings for children age ≤36 months**
5) Reproductive and Sexual Health	**Sexually Transmitted Infection Prevention** − *Screening and counseling to reduce risky sexual behavior*	**Sexually Transmitted Infection Early Detection** − *Chlamydia Screening*

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Clinical and Care Delivery Goals

Chronic Pulmonary Disease

The following clinical and care delivery goals have been highlighted for consideration as they apply to the **pediatric population.**

- Goals listed in black text are currently included in the Primary and Secondary Prevention tables, but are included here to emphasize inclusion of the pediatric population as evolve in VBP program ahead.
- Goals listed in red are not currently included in the Primary and Secondary Prevention table and would be a new addition.

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	**Medication Management**	**Asthma Control** – *Reduction in non-planned (emergency) admissions*

Children's Health CAG

Priority Clinical and Care Delivery Goals - ***Incorporation of Maternal Health***

The Children's Health CAG also discussed the need to incorporate additional clinical and care delivery goals for maternal health within the Maternity and TCGP VBP Arrangements.

The CAG noted the following:

- Maternal health has a major impact on child health, especially during pre- and post-natal periods and during the first year of a child's life. Under the VBP Roadmap, maternity services could be provided either through the Maternity Care episodic VBP arrangement or through a TCGP VBP arrangement (maternity costs are specifically excluded from the IPC model).
- The Maternity Care Measure Set, however, only applies to births covered under a Maternity Care episodic VBP arrangement. Given the dual impact on child and maternal health, and the reality that many births will take place in TCGP arrangements, there is interest from the Children's' Health CAG that this Primary Care/ Chronic Conditions CAG consider some maternity measures in its deliberations next year.

In the draft Final Report, the CAG recommended that "*at least some Maternity Care Measure Set metrics should be included in the TCGP measure set (subject to additional deliberation and recommendation by the Maternity CAG).*"

The Maternity CAG will discuss the identified maternal health clinical and care delivery goals and will make recommendations to the Physical Health CAGs in the future.

Section 5:

Additional Questions Identified by the Physical Health CAG

Additional Questions Identified by the Physical Health CAG

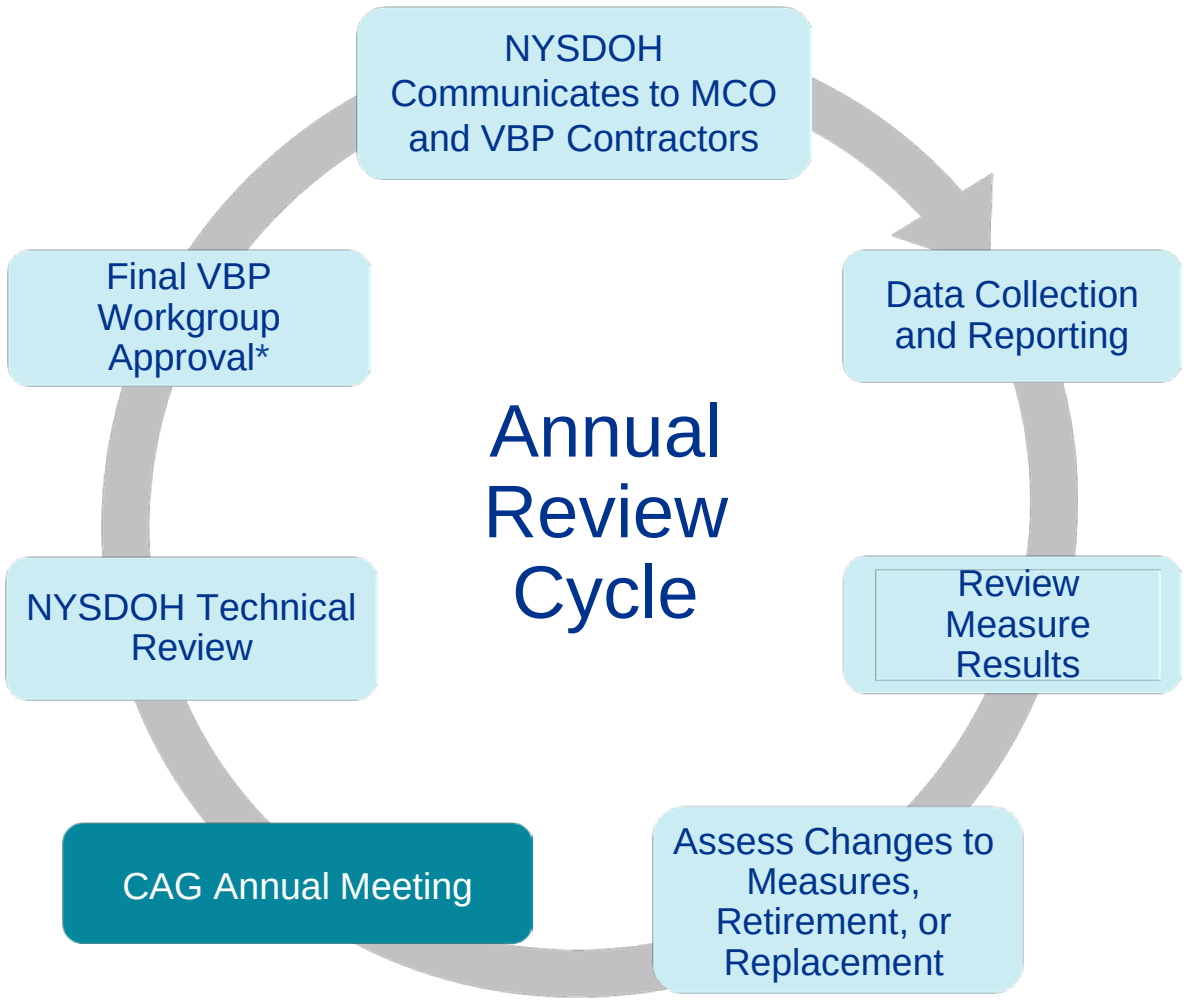
1. **Low Dose Aspirin measure consideration, related clinical goal/ subgoals, and potential for inclusion in measure set.**
   - The Cardiovascular CAG report shows that the CAG originally placed the aspirin measure into Category 3 for the following reason: "Collecting the data necessary for this measure takes a lot of effort because it requires data from both clinical records and surveys. Given the other measures in this set, the CAG recommends not to use this measure."
2. **More information requested by CAG: Asthma Medication Ratio[1] (National Committee for Quality Assurance):**
   - Description: The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
   - Numerator: The number of members who have a medication ratio of 0.50 or greater during the measurement year.
   - Denominator: Members 5 to 64 years of age by December 31 of the measurement year with persistent asthma.
3. **More information requested by CAG: Hepatitis C Screening[2] (Health Resources and Services Administration):**
   - Description: Percentage of patients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV.
   - Numerator: Number of patients with a diagnosis of HIV who have documented HCV status in chart.
   - Denominator: Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year.

[1] *National Quality Forum: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69923*
[2] *Health Resources and Services Administration (HRSA): https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/adolescentadultmeasures.pdf*

Section 6:

Closing Remarks and Next Steps

VBP Quality Measure Set Annual Review



Annual Review

Clinical Advisory Groups will convene to evaluate the following:

- Feedback from VBP Contractors, MCOs, and stakeholders
- Any significant changes in evidence base of underlying measures and/or conceptual gaps in the measurement program

State Review Panel

- Review data, technical specification changes or other factors that influence measure inclusion/exclusion*
- Review measures under development to test reliability and validity
- Review measure categorizations from CAG and make recommendations where appropriate [Cat. 1 vs. Cat. 2; P4P (pay for performance) vs. P4R (pay for reporting)]

** Final Workgroup approval will occur annually in September/ October*

Next Steps for CAGs

Immediate:

- The DOH and other agencies will be meeting internally on 9/21 to finalize the 2018 Measure Set in preparation for the VBP Workgroup meeting in early October.
  - Any outstanding comments regarding the proposed measure set must be submitted to DOH by 9/19.

Long-Term:

- The CAGs will reconvene next year (date to be determined) to continue to review, identify, and fill critical gaps in the clinical and care delivery goals for measure set development.
- The CAGs will review feedback from the VBP Pilots and Contractors regarding their experiences with VBP quality measurement.

Thank you!

Please send questions and feedback to:

vbp@health.nygov

Appendix

TCGP/IPC VBP Arrangement – 2018 Measure Set

Category 2

Measure Name	Description	Steward	VBP Category
Asthma: Assessment of Asthma Control – Ambulatory Care Setting	Percentage of patients aged 5 years and older with a diagnosis of asthma who were evaluated for asthma control (comprising asthma impairment and asthma risk) at least once during the measurement period	AAAAI	**Cat 2**
Avoidance of Antibiotic Treatment in adults with acute bronchitis	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA	**Cat 2**
Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence	New Measure: Percentage of individuals undergoing initiation and engagement of alcohol and other drug dependence treatment (IET) who have three (3) or more same- or lower-level SUD service visits/claims between 45 days post the IET Index Episode Start Date (IESD) and 180 days post the IESD.	OASAS	**Cat 2**
Continuity of Care (CoC) within 14 days of discharge from any level of SUD inpatient care	1. Continuity of Care from Inpatient Detox to Lower Level of Care. The percentage of inpatient detox discharges for members 13 years of age and older with a diagnosis of alcohol and other drug (AOD) dependence, who had a follow-up lower level visit for AOD within 14 days of the discharge date. 2. Continuity of Care from Inpatient Rehabilitation to Lower Level of Care. The percentage of inpatient discharges for members 13 years of age and older for alcohol and other drug abuse or dependence treatment (AOD), who had a follow-up lower level AOD visit within 14 days of the discharge date.	OASAS	**Cat 2**
Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver (process)	An assessment that there is documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric (age of 2 through 17 years) asthma patient/caregiver	TJC	**Cat 2**
Lung Function/Spirometry Evaluation (asthma)	Percentage of patients aged 5 years and older with asthma and documentation of a spirometry evaluation, in the medical record within the last 24 months	AAAAI	**Cat 2**
Patient Self-Management and Action Plan	Percentage of patients aged 5 years and older with asthma and documentation of an asthma self management plan	AAAAI	**Cat 2**

Acronyms: AAAAI – The American Academy of Allergy, Asthma & Immunology, NCQA – National Committee for Quality Assurance, OASAS – Office of Alcoholism and Substance Abuse Services , TCJ – The Joint Commission, CMS – Centers for Medicare and Medicaid Services, AHRQ – Agency for Healthcare Research and Quality

TCGP/IPC VBP Arrangement – 2018 Measure Set

Category 2

Measure Name	Description	Steward	VBP Category
Topical Fluoride for Children at Elevated Caries Risk, Dental Services	Percentage of enrolled children aged 1-21 years who are at “elevated” risk (i.e., “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year.	ADA	**Cat 2**
Use of Imaging Studies for Low Back Pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).	NCQA	**Cat 2**
Utilization of Pharmacotherapy for Alcohol Dependence	The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.	OASAS	**Cat 2**
Utilization of Pharmacotherapy for Opioid Use Disorder	The percentage of individuals with any encounter associated with opioid dependence, with at least 1 prescription or visit for appropriate pharmacotherapy at any time during the measurement year.	OASAS	**Cat 2**

Acronyms: ADA – American Dental Association, NCQA – National Committee for Quality Assurance, OASAS – Office of Alcoholism and Substance Abuse Services

Definitions Measures: Medication (3/4)

#	Measure	Measure Steward	Data Source	Description	Numerator	Denominator
27	CAD: Angiotensin-Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy - diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	American College of Cardiology	Claims Data and Clinical Records	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	Patients who were prescribed ACE inhibitor or ARB therapy.	All patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who also have diabetes or a current or prior LVEF <40%.
28	Chronic Stable CAD: antiplatelet therapy (aspirin)	American College of Cardiology	Claims Data and Clinical Records	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were prescribed aspirin or clopidogrel.	Patients who were prescribed aspirin or clopidogrel within a 12 month period.	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period.
29	CAD: beta-blocker therapy—prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	AMA-convened Physician Consortium for Performance Improvement	Claims Data and Clinical Records	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.	Patients who were prescribed beta-blocker therapy.	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40%.

Definitions Measures: Medication (4/4)

#	Measure	Measure Steward	Data Source	Description	Numerator	Denominator
30	Proportion of Days Covered (PDC): 3 rates by therapeutic category (% of patients who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for RAS antagonists, diabetes medication or statins)	Pharmacy Quality Alliance (PQA, Inc.)	Claims Data	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins.	The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.	Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year. For the Diabetes rate only: Exclude any patient with one or more prescriptions for insulin in the measurement period.