OneCare Vermont
Community Health Results

Reducing Re-Admissions with a Transitions of Care Program at Rutland Regional Medical Center

There are significant quality and safety issues during transitions out of hospitals. People with chronic conditions receive fragmented care, with more clinicians, more meds, more risks and more expense. Patient lacking timely follow up run a significantly higher risk of being re-admitted. Medication errors harm an estimated 1.5 million people each year in the US, costing the nation at least $3.5 billion annually. SOURCE: Safe Passage Through Transitions of Care presentation, The Joint Commission, 2016.

Spotlight on Rutland Regional Medical Center Initiative

The Transitional Care Program was initiated in December 2015 with the goal of improving health and wellness of recently discharged patient thereby decreasing hospital re-admissions. The program is for adults with chronic health conditions and/or health risks. The Clinical Transitions Liaison (CTL) will visit patients during their hospital stay, attend follow up appointments, conduct home visits to confirm understanding of medications and how to manage symptoms, and make follow-up phone calls to answers questions and offer support. In the first year, the CTL has conducted 820 visits with patients in a variety of settings - inpatient, clinic, home and community.

RRMC's Outcomes

OUTCOME: Since the inception of the Transitional Care Program, the re-admission rate at RRMC has dropped from 14% to 10.9%. In addition to reduction of re-admission, there are many anecdotal stories of patients' successes:

- While making a home visit to a patient with COPD, noticing environmental irritants and placing a referral to Neighbor Works to have repairs done. Also by quitting smoking with the TCN's encouragement, the patient was able to afford the co-pay for a necessary medication.
- Having a patient initially decline a home visit post-discharge, but accept with reservations only to be found confused by all her new medications when the TCN arrived at her home shortly after discharge. Without that visit, the patient may have had high risk of medication errors.
- Provided necessary continued support to patient and spouse while transitioning to hospice care so that all paperwork was completed in a timely fashion.

For More Information on the RRMC Transitions of Care Program, please contact Kathy Boyd, Director of Case Management (kboyd@rrmc.org) or Samantha Helinksi, RN, Clinical Transitions Liaison (smhelinski@rrm.org).

Lessons Learned

- Medication reconciliation is a key need – many medication lists have been found to be inaccurate.
- Patients have a sense that everyone on their team is connected and talking. There needs to be one "source of truth" holder of information who connects with the patients regarding all care being provided.
- Key to a successful Transitions of Care Program – an RN in the CTL role with experience in the hospital and community settings who is skilled with motivational interviewing and providing patient education.
- The first 24/48 hours post-discharge are crucial in determining whether the patient will be re-admitted. Often community services cannot be put in place that quickly.

OneCare Vermont
Community Health Results

Decreasing Unplanned Transfers and 30 Day Readmission Rates in Skilled Nursing Facilities

In an analysis of data published in 2012, hospital readmission rates from skilled nursing facilities ranged from 14.3% to 16.4%. In 2014, the Centers for Medicare and Medicaid Services (CMS) recommended a measure to look at "all cause, unplanned hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) witin 30 days of discharge from a prior inpatient admission to a hospital, critical access hospital or a psychatric hospital". CMS July 2014

Spotlight on Southwestern Vermont Medical Center Initiative

Goal: To decrease avoidable transfers to the Emergency Department and to decrease the 30 Day readmission rates within 12 months (2015- 2016) from one skilled nursing facility the Centers for Living and Rehabilitation (CLR)

Key Drivers of the Problem

- SVMC readmission rates from CLR (all payer, all cause) were above national benchmark in 8 out of 12 months in 2015
- SNF transfers were noted to be the number one source of origin for readmissions.
- Lack of a standardized acute transfer process for all SNF's.
- Lack of a clear plan to decrease unplanned transfers and readmissions.

Actions Taken

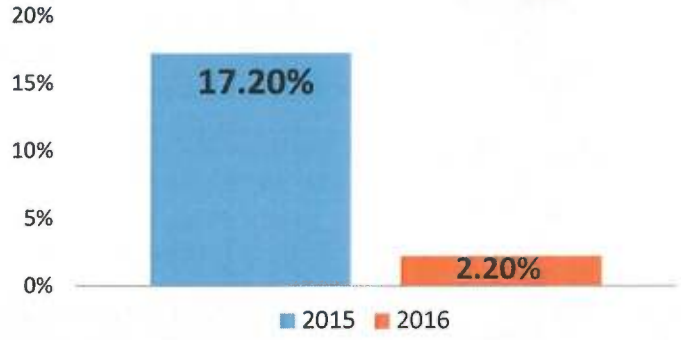
- In 2015, SVMC examined their readmission and ED transfer data to establish a baseline
- Identified an RN champion to educate and train staff on improved communication, decision support and advanced care planning
- Utilized Interact® tools (available online), focused on early intervention of changes in condition (Stop and Watch early warning tool)
- Reviewed documentation of orders for Clinician Order for Life Sustaining Treatment (COLST)

SVMC's Outcomes

SVMC Decreased Rates of All Payer, All Cause 30 day Readmission and Transfers to Hospital

- Improved COLST documentation from 39% to 65% (SVMC data from 5/16-10/16)
- Increased and improved quality of documentation surrounding change of condition.
- Improved teamwork LNA & nursing staff.
- Standardized SNF, ED and EMS transfer process.

Long Term Care 30 Day All Cause Readmission Rate 2015 vs. 2016



Lessons Learned

- ✓ Monitoring small, incremental changes in a patient's condition and quickly applying appropriate clinical intervention decreased readmissions to the hospital from SNF
- ✓ Scheduling imaging and procedures was a useful strategy to reduce readmissions
- ✓ Skilled Nursing Facility readmission rates will be directly linked to the SNF star rating in the future and these proactive tools are helpful in achieving short and longer term goals

OneCare Vermont
Community Health Results

Implementing Evidence Based Developmental Screening Tools

Developmental screenings during the first three years of life foster a strong foundation of health and wellbeing for children, families and communities. The American Academy of Pediatrics (AAP) recommends developmental surveillance at all preventative care visits and standardized developmental screening of all children at ages 9, 18 and 30 months.[1]

The Blueprint for Health Pediatric Health Profile data for the Morrisville Health Service Area (Jan-Dec 2015) indicates that 10% of the continuously enrolled children in the Morrisville HSA received developmental screening in each of the first three years of life. Comparatively, the statewide screening rate was 60% for commercial patients and 47% for Medicaid patients.[2]

[1] CMMS: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html
[2] http://blueprintforhealth.vermont.gov/sites/blueprint/files/HSAProfiles

SPOLIGHT ON Morrisville Health Service Area

A group from the Lamoille Valley Unified Community Collaborative *(UCC) formed a subcommittee to address these rates with aim of increasing the number of children screened.

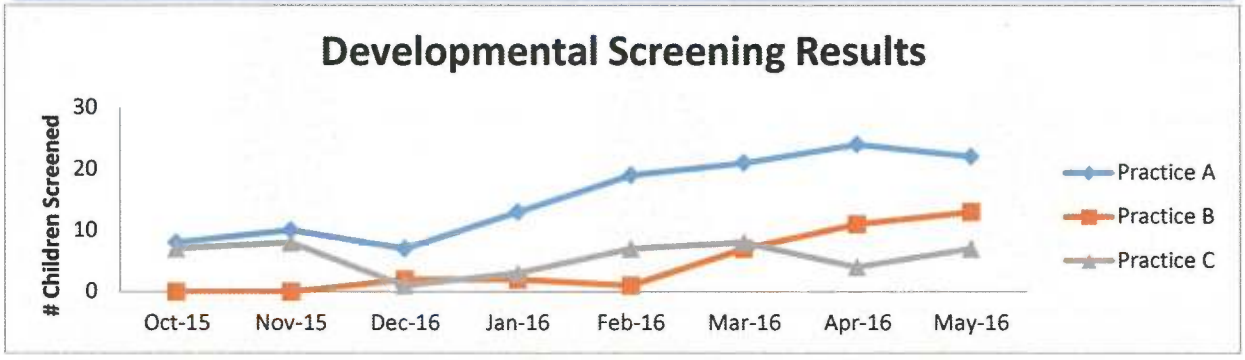
Key Drivers

- The need for clear and consistent information and communication across practices concerning the implementation and use of standardized developmental screening tools.
- The need for clear and consistent information about Coding/Billing Well-Child Visits.
- The need for office processes and workflows that effectively integrate developmental screenings.
- Community engagement and collaboration
- Selection of a structured, validated developmental screening tool – Ages and Stages Questionnaire (ASQ)

Actions Taken

1. A subcommittee of the UCC is participating in the VDH Developmental Screening registry pilot program in 2016-1017.
2. The subcommittee recruited three practices to expand use of structured developmental screening tools.
3. The following metrics were identified, implemented and tracked:
   - # of children seen for well-child care visit at age 9 months, 18 months and 36 months.
   - # of children seen for well-child care visit and screened with the ASQ tool.
   - # of children screened with ASQ tool who had billing for services coded with 96110.

OUTCOMES



Lessons Learned

- ✓ There is a community wide commitment to track and improve developmental screening rates throughout the HSA.
- ✓ The "N" was relatively small, but the improvement in screening rates was not! The aim is continuous improvement.
- ✓ The need to identify and implement standardized screening tools and coding for all annual well child visits across practices and organizations.

February 2017

OneCare Vermont
Community Health Results

Screening for Falls Risk in the Medicare Population

Falls are the leading cause of injuries in adults aged 65 and older. Data from 2012 indicated that in Vermont, a third of adults fell at least once during the past year.[1] In addition, those who fall once are two to three times more likely to fall again. By 2020, an estimated $54 billion nationally will be spent annually on medical costs associated with falls. Systemic reviews of fall intervention studies have established that prevention interventions can reduce falls, including early screening to detect risk factors as a critical first step to target care to a specific population that may need follow-up assessment and treatment.[2]

[1]Vermont Deparment of Health Behavioral Risk Factor Surveillance System Reports and Data Briefs; [2]A CDC Compendium of Effective Fall Interventions: What Works for Older Adults, 3rd Edition, 2015

SPOTLIGHT on the OneCare Vermont Network

Key Drivers

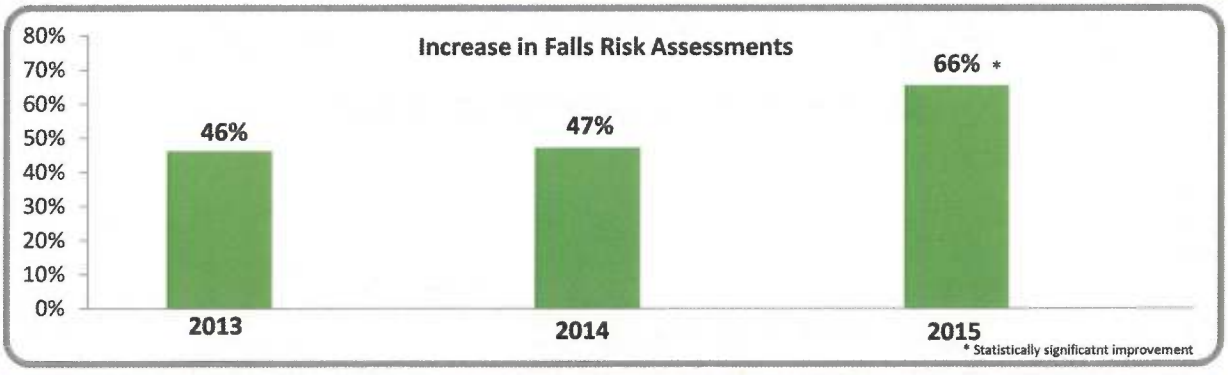
- Specific roles and responsibilities for fall prevention assessment and education are not well defined
- Lack of clear guidelines as to which patients should be screened
- Financial models (PQRS, MU, MAWV, ACO[3]) are relatively new and may not provide enough information to manage falls after risk is identified
- No discrete field in many electronic health records (EHRs) to document screening results
- Few published resources that target falls risk screening in the outpatient setting

Actions Taken

- Assess drivers of change and resources for individual practices to tailor the approach and enhance measure adoption
- Use of fall prevention guidelines and tools including the AGS/BGS, USPSTF, and STEADI[4]
- Identify and assign appropriate practice personnel to conduct falls risk assessment and management tasks
- Across the network, trend towards adding a field in the EHR to improve captured rate of screening for risk of future falls

[3]Physician Quality Reporting System; Meaningful Use Incentive Program; Medicare Annual Wellness Visit; Accountable Care Organization Program
[4]American Geriatrics Society/British Geriatrics Society, The United States Preventive Services Task Force, Centers for Disease Control and Prevention's "Stopping Elderly Accidents, Deaths and Injuries (STEADI)"

NETWORK OUTCOME



LESSONS LEARNED

- ✓ Practice staff found that it was important to identify those who would conduct the falls risk assessment and to document the findings (screening, interventions) in a discrete location in the medical record
- ✓ Strategies to encourage standardized fall screening and referral are needed to improve practice
- ✓ Additional tools and guidance on implementation are needed, in particular, tools that are easy to use, stratify risk, triage and link interventions to risk factors, and include patient engagement factors

February 2017

OneCare Vermont
Community Health Results

CARE COORDINATION TOOLKIT TRAINING

Historically, it has been challenging to provide care coordination training in a manner that is collaborative, effective, and accessible to all those involved in a person's care. As a consequence, care has frequently been fragmented and lacking focus. Recently, the state of Vermont offered an interagency care coordination learning collaborative that introduced a number of patient-centered tools to improved shared care planning. To ensure common language and set of tools for care coordination in a community, the knowledge gained in the learning collaborative needs to be shared broadly with local partners. Rutland has developed a toolkit training to be used for this purpose.

SPOLIGHT ON Rutland's Blueprint Community Health Improvement Team (CHT) Initiative

KEY DRIVERS

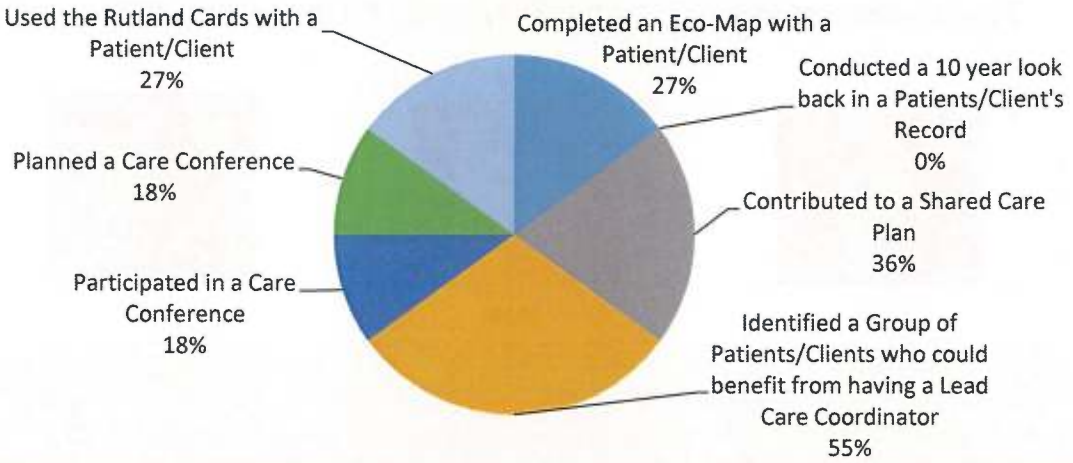
- Patients with high health and social needs have not been receiving coordinated care.
- Many clients within the local area are in need of a shared care plan.
- Staff in local agencies may not have knowledge of care coordination tools and how to use them.
- Turnover in agencies requires continued offering of toolkit training as new people orient to their positions.
- The only people aware of the tools and how to use them are those who participated in the statewide interagency learning collaborative.

ACTIONS TAKEN

- Since February 2016, four Care Coordination toolkit trainings have been offered to organizations involved in interagency shared care plans in the Rutland VT area.
- Information on the sessions and how to register is broadly shared with partners in the community. These are directed warm invitations to certain organizations inviting them to participate.
- The sessions are designed to include staff from various organizations to allow attendees to learn more about each other's roles in the community.
- Follow up surveys are sent to participants to obtain feedback for improving future sessions.

TRAINING OUTCOMES

As of the 3rd training in September 2016, 30 people had participated in trainings.
12 participants completed the follow-up survey (33% response rate).



LESSONS LEARNED

- ✓ It takes persistence to recruit participants but they find the training useful and recommend it to others.
- ✓ Smaller group trainings (12 or less) provide more opportunity for active participation of all attendees.
- ✓ When using case studies, adapt the backstory based on the roles of the staff attending the training.

OneCare Vermont
Community Health Results

Adult Pneumonia Vaccination Rates

Each year in the United States, pneumococcal disease kills thousands of adults, including 18,000 adults 65 years or older. Thousands more are hospitalized because of pneumococcal disease. The best way to prevent pneumococcal disease is by getting vaccinated. Pneumococcal disease is an infection caused by *Streptococcus pneumoniae* bacteria, also known as pneumococcus. Pneumococcal bacteria can cause many types of illnesses that range from mild to very severe. These illnesses can be life threatening, especially for adults 65 years or older, people with chronic health conditions, and people whose immune systems are weakened by disease or medicine. * https://www.cdc.gov/features/adult-

SPOTLIGHT ON OneCare Vermont Primary Care Network Clinics - Pneumococcal Disease

Clinical Recommendations:

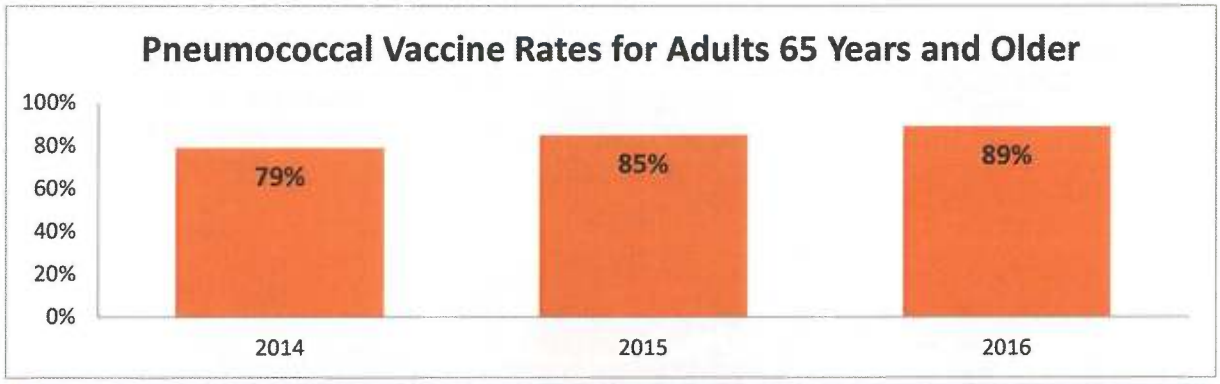
- CDC recommends 2 pneumococcal vaccines (PN) for all adults 65 years or older.
- ACIP* recommends that both PCV13 and PPSV23 be given in series to adults aged ≥65 years. A dose of PCV13 should be given first followed by a dose of PPSV23 at least 1 year later to immunocompetent adults aged ≥65 years. The two vaccines should not be co-administered.
- Adverse events occurring after administration of any vaccine should be reported to the Vaccine Adverse Events Reporting System (VAERS).

** Recommendations of the Advisory Committee on Immunization Practices (ACIP)*

Actions Taken:

- In 2013 OneCare began tracking pneumococcal vaccine compliance throughout the state.
- In February 2013, HL7, an electronic medical record interface platform, went live in VT. Such that by 2016, 59% of administered, recorded immunizations flowed from an EMR – to VITL – to the VT Immunization Registry.
- Training care teams to coordinate care for individual patients (a critical element for accreditation as a Primary Care Medical Home) ensures a higher likelihood that vaccine status is addressed prior to the scheduled patient visit.

Network Outcome



Lessons Learned

Primary Care Practices are responsible for most PN administered to 65+ in VT (75.7%) Hospitals account for 10.1% of PN administered to 65 and older adults. Pharmacies administered 13.3% of PN immunizations and 0.9% were attributed to 'other' sources.*

A survey sent from the Vermont Department of Health (VDH) to providers at medical practices, hospitals and pharmacies indicated that not all administration sites offered both PCV13 and PPSV23 vaccines leading to a variation in outcomes.*

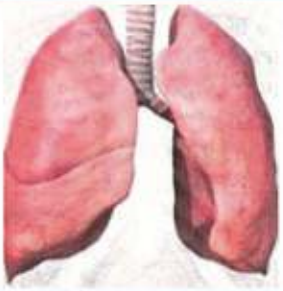
For smaller Family Practice sites, lack of a refrigerator for vaccine storage is an issue.*

**Bridget Ahrens MPH, Vermont Immunization Registry Manager*

March 2017

OneCare Vermont
Community Health Results

Reducing Admissions for Chronic Obstructive Pulmonary Disease (COPD) in Vermont



COPD is one of the most significant causes of mortality in the U.S.
Ranked as the third leading cause of death in 2014 among Americans, it is responsible for more than 135,000 deaths annually in the United States.

COPD is on the rise, with more than 15 million people in the US having been diagnosed with COPD. COPD is a serious lung disease that, over time, makes it hard to breathe. When COPD is severe, shortness of breath and other symptoms of COPD can impede sufferers' ability to perform basic tasks, such as taking a walk or performing personal care.

tiatives Across the Network

Key Drivers of COPD and Asthma-Related Admissions [1]:

- Evidence suggests that hospital admissions for COPD and asthma could be avoided through high quality outpatient care, and that COPD or asthma exacerbations would be less severe if treated early and appropriately.
- Appropriate outpatient treatment, physician adherence to practice guidelines, and patient compliance all influence the effectiveness of therapy and may reduce the rate of exacerbations of COPD and asthma and decline in lung function, and thus minimize hospital admissions for these conditions.

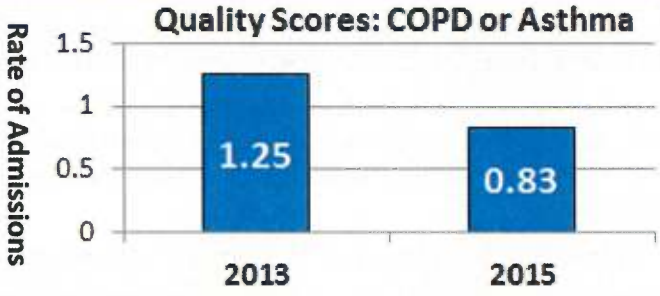
[1] Source: CMS, 2014 Quick Reference Guide for quality measure ACO-9

Actions Taken through Clinical Advisory Board recommendations:

- Identified and stratified patients at high risk for / with COPD.
- Promoted self-management skills, such as COPD education and support, nutritional therapy, and action plans with specific patient-selected goals for physical activity.
- Provided care to prevent complications of COPD, including controlling symptoms and providing regular assessments.
- Provided patient-centered COPD care, including considerations for special populations.

Outcomes

- Between 2013 and 2015, 34% reduction in the number of hospital admissions for COPD or asthma in older adults
- The OneCare Network improved its quality score from the 40th to the 60th percentile compared to other ACOs nationwide



Admissions Rate: Observed to Expected Ratio

Note: A rate <=1.0 indicates higher quality with a lower rate of admissions for the ACO than expected

Lessons Learned

⇒ Emphasize pre-emptive action plans for "sick days" to support patients' self-monitoring
⇒ Review COPD re-admissions monthly to identify root causes and successful strategies to improve care
⇒ Focus on post-ED discharge follow up calls and prioritize office access for these patients

April 2017

OneCare Vermont
Community Health Results

Vermont ACO Medicaid and Commercial Quality Measures

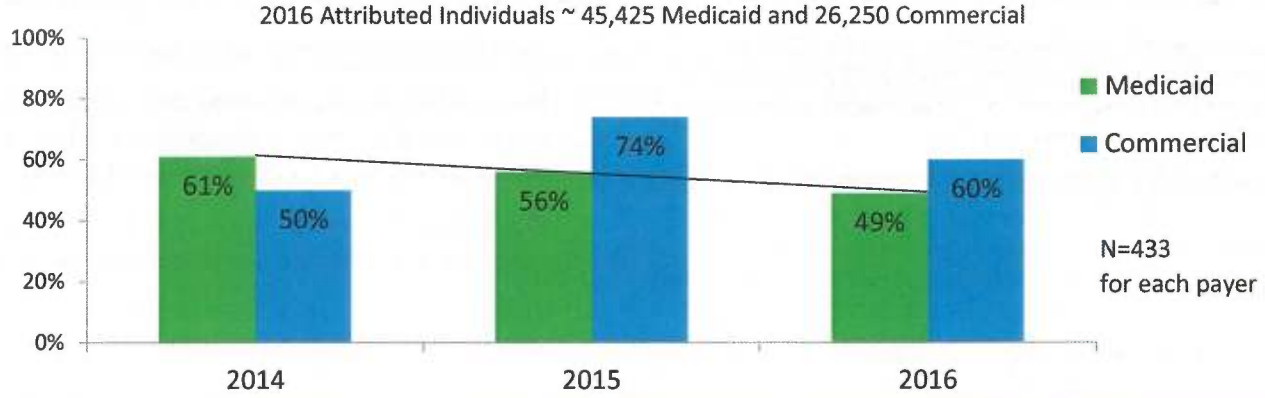
Recommend Vaccines by 24 months of age			
3	HepB	1	MMR
4	DTaP	1	VZV
3	HiB	1	HepA
3	IPV	2	Flu
4	PCV	2	Rotavirus

Childhood coverage rates for ten vaccines were evaluated as one of the Vermont ACO quality measures. This is the first year that data was obtained from the Vermont Immunization Registry. 81% of the data was found to be complete from the registry. When the measure was not met the medical record was also reviewed. Additional data was available in the medical record on 19% of individuals, including more vaccines (12%) and declined status (7%). The network's use of the registry is a success, however, compared to last year there has been a decline in this measure.

2016 Childhood Immunization Status (CIS)

One Care Network Vaccine Coverage Rates

2016 Attributed Individuals ~ 45,425 Medicaid and 26,250 Commercial



OUTCOMES

- Vaccines with the lowest coverage rate varied by payer. Influenza vaccine was 65% for those with Medicaid and Hepatitis A was 75% for those with commercial insurance.
- Rotavirus, hepatitis A, and influenza vaccines had the lowest coverage for both payers. This continues the trend found in the National Immunization Survey data for 2014 and 2015 in which Vermont had lower rates than the national average for both hepatitis A and rotavirus.
- Completion of the DTaP series is also a factor in the decreased coverage rates.

Lessons Learned

- ✓ Reminder/recall activities for children behind on vaccinations at 8 and 20 months of age provide time to get children in for well-child visits and completion of vaccines. The VDH Immunization program sends letters to parents/ guardians of children who are not up to date on all recommended vaccines (except flu) at 8 and 20 months of age.
- ✓ Practices can use the VDH Immunization registry to obtain a list of children behind one or more immunizations at any age. Some practices find texting to be the best way to contact parents/guardians.
- ✓ A provider's recommendation of vaccines has been found to be the most important factor in the decision to vaccinate. The anti-vaccination movement is strong in Vermont. When parents hear conflicting information regarding vaccine safety, they become hesitant to vaccinate. The majority of those that are hesitant to vaccinate, can be moved to acceptance of vaccination once their concerns are addressed by a provider.

Vermont Department of Health Immunization Program (802) 863-7638 Health Vermont .gov

May 2017

OneCare Vermont
Community Health Results

Hospice Utilization Rates in Vermont | Activities & Improvements

In 2012 the "Dartmouth Atlas of Health" placed Vermont 44th among states with Medicare Beneficiaries who took advantage of the Medicare hospice benefits available to them.

The 2013 OneCare Vermont data revealed a rate of **28.4%** compared to United States average of **50.6%**.

The Chittenden Community Collaborative Hospice Subcommittee

Aim: Improve Rates of Hospice Utilization in Chittenden County
(VNA, Bayada, SASH, CHI, CVAA)

ACTIONS

- Implemented inpatient flag on patients with CHF to cue provider to refer to hospice if appropriate
- Trained 48 outpatient PCPs on hospice referral
- Focused discussion with providers on referral for patients with end stage dementia
- Conducted an educational session with role play on end-of-life conversation
- Reviewed charts to understand more about barriers to referral and acceptance of hospice services
- Produced easy to use referral card for providers to reinforce how to refer to hospice services

Increase in Hospice Utilization by Specific Diagnosis

	# Individuals Baseline*	% Increase	# Individuals Current
CHF	31	66%	47
Dementia	16	156%	41
Cancer	56	23%	69

* Baseline: 2/15-9/15; current 10/15-9/16.
Numbers represent individuals without overlap in time period and without overlap in diagnosis.

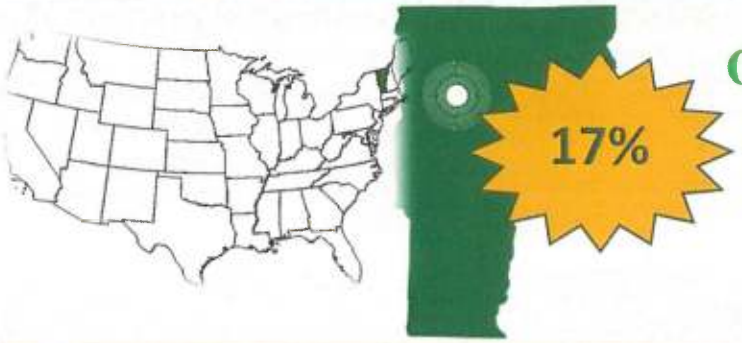
Chittenden County Hospice Utilization Increased!

Lessons Learned

- ✓ Both consumers and providers lack clear information about the differences between palliative care and hospice services.
- ✓ Communication regarding end-of-life care is a learned skill.
- ✓ Focusing on a few discrete diagnoses allowed for clearer opportunities to start the improvement activities.

OneCare Vermont
Community Health Results

Our Network Demonstrates High Quality, Low Cost Care for Vermonters

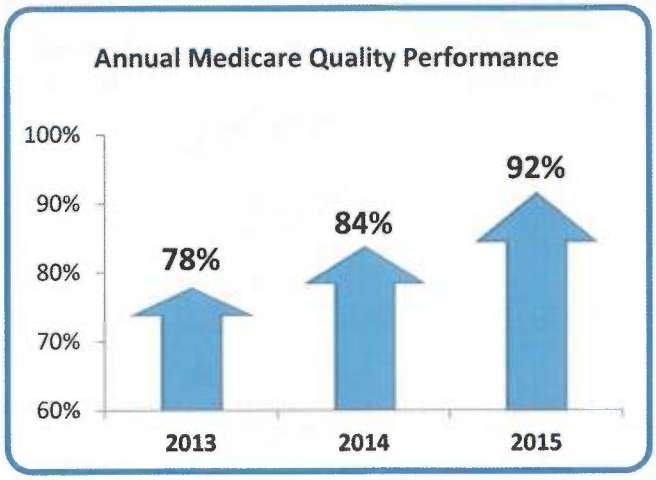


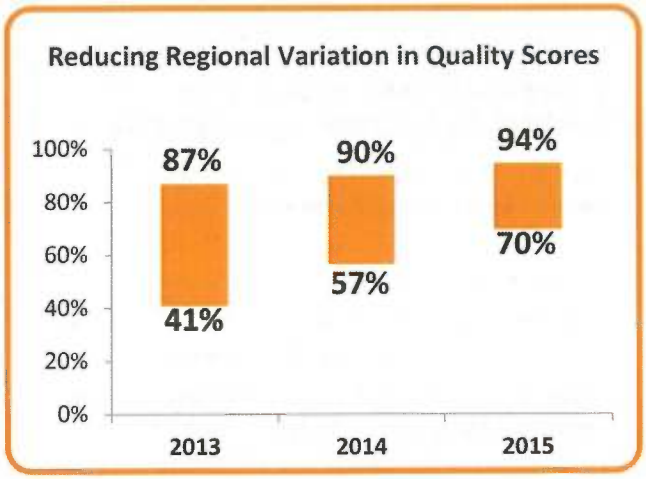
OneCare Vermont ranked in the top 17% (66th out of 392*) of Medicare Shared Savings Program in 2015.

*MSSP ACO's with publically available data from CMS

OneCare Vermont Achieves Consistent Improvements in Quality Across the Network

Focused work across the network resulted in steadily improving Medicare quality scores and less variation across the communities





Measure Spotlight: Decreasing Admissions for Patients with Heart Failure

OneCare Vermont improved the quality of the care for patients with congestive heart failure (CHF) as measured by admissions to the hospital for that diagnosis. We were able to decrease our Ambulatory Sensitive Conditions (ASC) admissions for heart failure and improve our benchmark scores. We started out at less than the 30th percentile for all the MSSP programs and improved to the 60Th percentile by 2015 which increased our quality points for this measure. Our goal is to keep improving this measure every year.

Lessons Learned

- Breaking performance goals down into small, actionable steps creates opportunities for meaningful improvement
- Appealing to provider's desire to provide the right care, at the right time, to the right patients is a good starting place to motivate change and improvement
- Sharing data across the Network generates positive competition and sparks action
- Testing a variety of interventions as pilots across the Network and spreading successes results in faster improvement in quality measure scores

OneCare Vermont
Community Health Results

Improving Care for Patients with Congestive Heart Failure (CHF) in Vermont

CHF is one of the most significant causes of morbidity and mortality in the US, accounting for more than 1,000,000 hospitalizations annually. Patients experiencing transitions of care from hospital to outpatient are particularly vulnerable for readmission to the hospital.

August 2016 data from OCV showed a CHF admission rate of 10.28 per thousand.

Spotlight on the Berlin Community Collaborative Team

Aim: Improve outpatient primary care management of patients with CHF to reduce ED and inpatient utilization

Team: Jeremiah Eckhaus, MD, Kari Little, LICSW, Colleen Donegan, RN, Walter Ziske CHT Panel Coordinator, Monika Morse RN

ACTIONS

One primary care practice redesigned care for 18 patients with congestive heart failure (CHF):

- Implemented a "CHF Clinic"
- Enhanced health record template to support workflow
- Instituted a team huddle to review scheduled patients, including home health agency when appropriate
- Established one hour patient visits
- Instituted co-visits between patient, provider and patient navigator
- Implemented group patient visits and provided information on pathophysiology, nutrition, advanced directives and mindfulness activities
- Aligned primary care educational materials with those provided by hospital and home health agency to ensure consistent messages for patients with CHF

Decrease in Utilization / Improvement in Documentation of CHF

	# Individuals Before Care Redesign*	% Increase or Decrease	# Individuals After Care Redesign
ED Visits for Diagnosis of CHF	4	50% ↓	2
Inpatient Admissions for Diagnosis of CHF	4	75% ↓	1
Advanced Directive in Health Record	8	44% ↑	18

*Baseline data: 5/4/15-11/4/15 | Follow-up data: 11/5/15-5/5/16

Adding Patient Navigators to the Care Team

Patient Navigators are clinical advocates who support patients, families, and caregivers during and between office visits by coordinating care, communicating among various health professionals and agencies, and assisting with meeting patient goals.

Lessons Learned

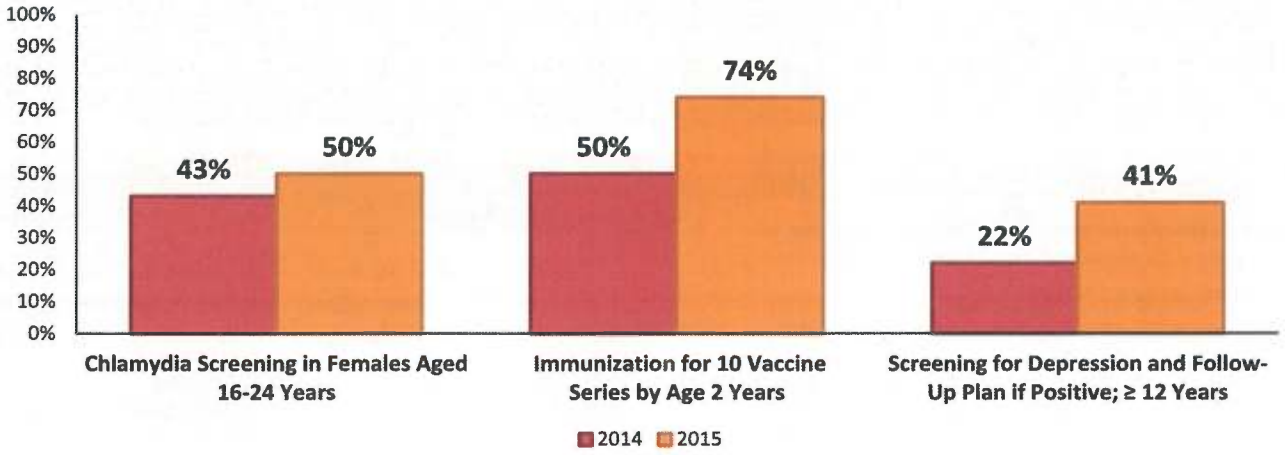
- ✓ Co-visits including patient, provider, family and patient navigators provided insight for all of the individuals involved; co-visits were very well received.
- ✓ Utilization of emergency department and inpatient admissions can be impacted by innovation in care management strategies.
- ✓ Testing changes in care processes with one provider in one practice offered a path to start small and learn from the improvement activities.

OneCare Vermont
Community Health Results

Commercial Quality Measures

OneCare Vermont's commercial contract covers beneficiaries that purchased their insurance through the Vermont Health Exchange and were attributed to our Network participants. From 2014 to 2015, the total number of attributed beneficiaries rose by 14% from 24,355 to 27,764.

OCV Network: A Snapshot of Selected Commercial Quality Measure Areas of Improvement



Measure Spotlight: Vermont Data on Immunizations for Young Children

- From 2014 to 2015, Vermont rates for vaccination of young children increased for every vaccine except for Hepatitis A vaccine.
- Vermont provides universal access to childhood vaccines, but has lower rates than other northeastern states with universal access.
- Vermont had lower rates than the national average for three vaccines: Varicella, Hepatitis A and Rotavirus vaccines.

Centers for Disease Control and Prevention 2016

Primary Care Lessons Learned

- ✓ **Sharing data with patients using waiting room posters displaying the practice's vaccine coverage rates for the 10 vaccine combination's improved the practice's overall immunization rates as well as served to share messages with patients to promote protecting personal and public health.**
- ✓ **Creating a standard "script" with key talking points for providers to engage parents/caregivers in immunization discussions, dispel immunization myths, and recommend vaccination led to increase comfort by providers in facilitating these discussions and led to increased vaccine coverage rates.**
- ✓ **Systems to recall/remind patients combined with nurse-only scheduled visits improved vaccine coverage rates for children 18 to 24 months of age.**

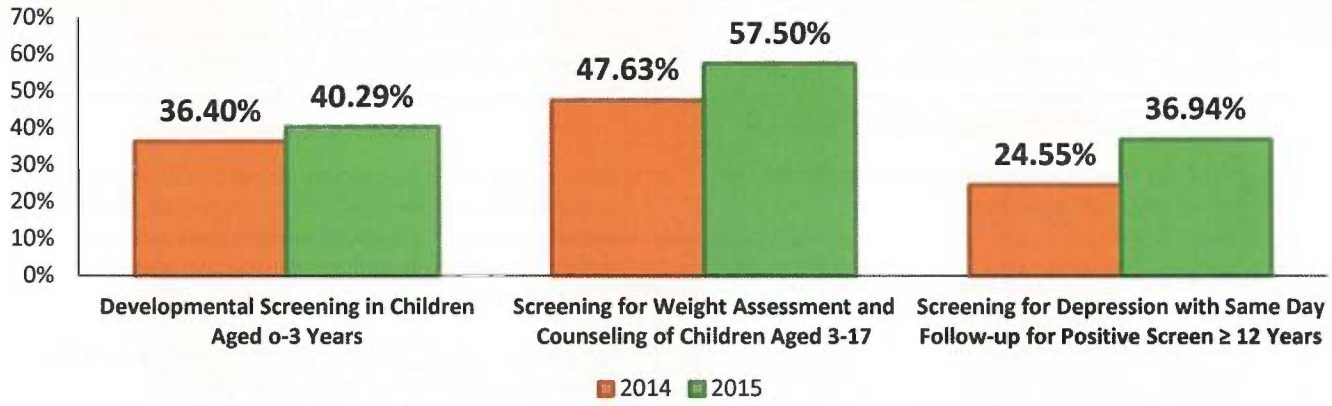
November 2016

OneCare Vermont
Community Health Results

Medicaid Quality Measures

Although we don't have national data to compare on the Medicaid Shared Savings Programs measures, we want to highlight areas where the Network changed clinical workflow and documentation procedures to increase rates of screening for depression, assessment of weight and counselling for physical activity and nutrition and developmental screening.

OCV Network: A Snapshot of Selected Medicaid Quality Measure Areas of Improvement



Measure Spotlight: Depression Screening

1. 22 practices associated with Central Vermont Medical Center, Primary Care Health Partners, Windsor Hospital and UVM Medical Center improved their depression screening follow-up rates by ≥ 10% between 2014 and 2015.
2. OneCare Vermont's Network improved screening for depression and follow-up by 50% between 2014 and 2015 (Table 1).
3. Females were five times more likely to screen positive for depression in the 2015 measurement sample.

Table 1: > 10% Improvement for Depression Screening

- Berlin Health Center
- Barre Health Center
- Adult Primary Care – Barre
- Adult Primary Care – Berlin
- Granite City Primary Care
- Family Medicine – Berlin
- Family Medicine – Mad River & Waterbury
- Green Mountain Family Practice
- Integrative Family Medicine – Montpelier
- UVM MC Primary Care Burlington, Essex, South Burlington, Williston, Colchester, Hinesburg, Milton, and UVM MC Pediatrics
- Brattleboro Primary Care
- Mt. Anthony Primary Care
- St. Albans Primary Care
- Timber Lane Pediatrics
- Mt. Ascutney Physicians Practices

Lessons Learned

- ✓ Primary Care practices selected and implemented standardized depression screening tools (PHQ-2 and PHQ-9)
- ✓ Patients reacted positively to being screened for depression in a familiar setting (i.e. primary care office) with trusted team members
- ✓ Clarifying roles and responsibilities among care team members facilitated increased screening and follow-up.

November 2016

OneCare Vermont
Community Health Results

Diabetic Retinal Eye Exams

Diabetic retinopathy is a highly specific vascular complication of both type 1 and type 2 diabetes. A recent study conducted by the Centers for Disease Control and Prevention identified the prevalence as one in three adults over age 40 years with diabetes, and more than one-third of African- Americans and Mexican- Americans with a diagnosis of diabetes. Male sex, higher A1C level, longer duration of diabetes, insulin use and higher systolic blood pressure were independently associated with the presence of diabetic retinopathy.

Info retrieved from CDC.gov/visionhealth/factsheet on 12/16

St. Albans Primary Care: A Snapshot of Quality Measure Improvement

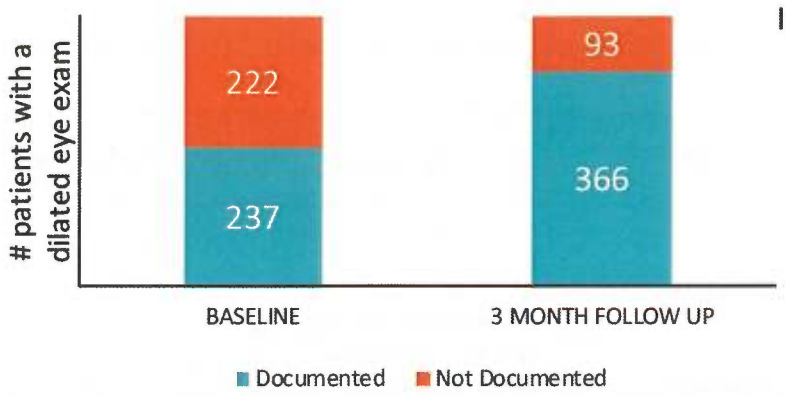
Goal: To increase the % of diabetic patients with a documented retinal exam by 5% over a period of three months

Key Drivers of the Problem

- Gaps in communication between specialists and primary care providers
- Gaps in patient understanding and knowledge about the importance of this exam and early detection of retinopathy
- Workflow and electronic medical record did not support the documentation of results of the exam

Actions Taken

- Panel management activities included identifying patients with diabetes, reviewing records for documentation of a retinal eye exam in the last 12 months, and conducting patient outreach to facilitate making appointments for patients to have a dilated eye exam.
- Flow sheets in medical record were created that contained a discrete, reportable field for this eye exam
- Letters to ophthalmology/optometry were created to encourage regular communication between specialty care and primary care practices on shared patients



Improvement

Goal 5%

Actual 28%

Lessons Learned

- ✓ St. Albans Primary Care staff found patients were able to make and keep appointments for eye exams after the staff called them to encourage this and to offer assistance
- ✓ Care team members took on panel management activities and facilitated communication between patients and the practice about this initiative
- ✓ Creating flow sheet in electronic health record containing discrete, reportable field eased the burden of documentation by all providers and staff.

December 2016