OneCare Vermont
Network Success Story

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

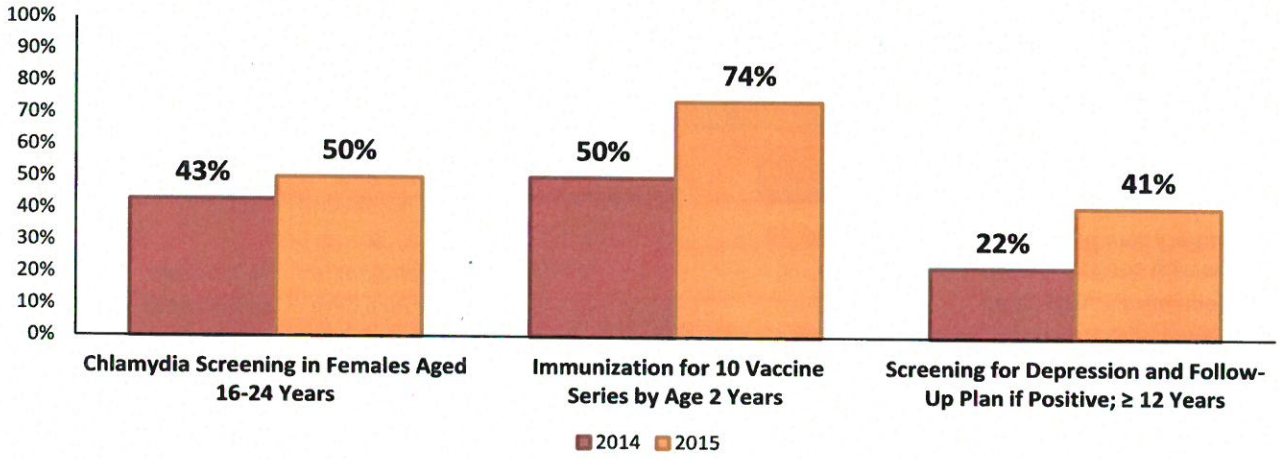
- ✓ Co-visits including patient, provider, family and patient navigators provided insight for all of the individuals involved; co-visits were very well received.
- ✓ Utilization of emergency department and inpatient admissions can be impacted by innovation in care management strategies.
- ✓ Testing changes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

OneCare Vermont Network Success Story

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

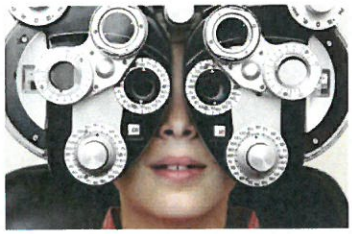
Primary Care Lessons Learned

- ✓ **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
Network Success Story

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 Center's 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

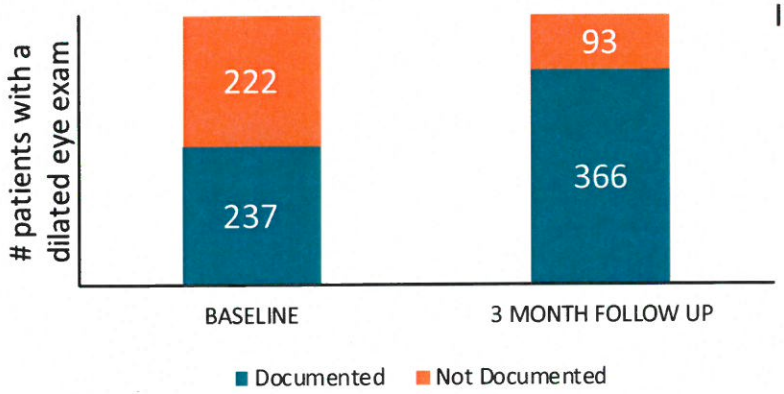
Goal: To increase the % of diabetic patients with a documented retinal exam by 5% over a period of three months

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

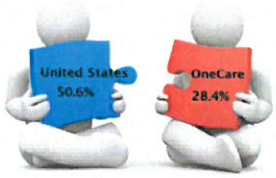
- ✓ **St. Albans Primary Care staff found patients were able to make and keep appointments for eye exams after the staff called them to encourage this and to offer assistance**
- ✓ **Care team members took on panel management activities and facilitated communication between patients and the practice 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

OneCare Vermont
Network Success Story

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

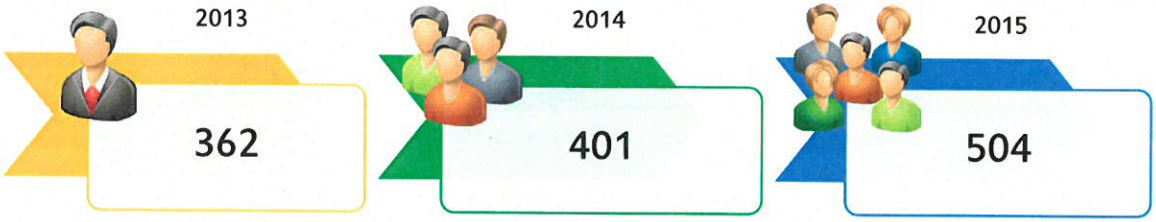
- Implemented inpatient flag on patients with CHF to cue provider to refer to hospice if appropriate
- Trained 48 outpatient PCPs on hospice referral
- Focused discussion with providers on referral for patients with end stage dementia
- Conducted an educational session with role play on end-of-life conversation
- 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

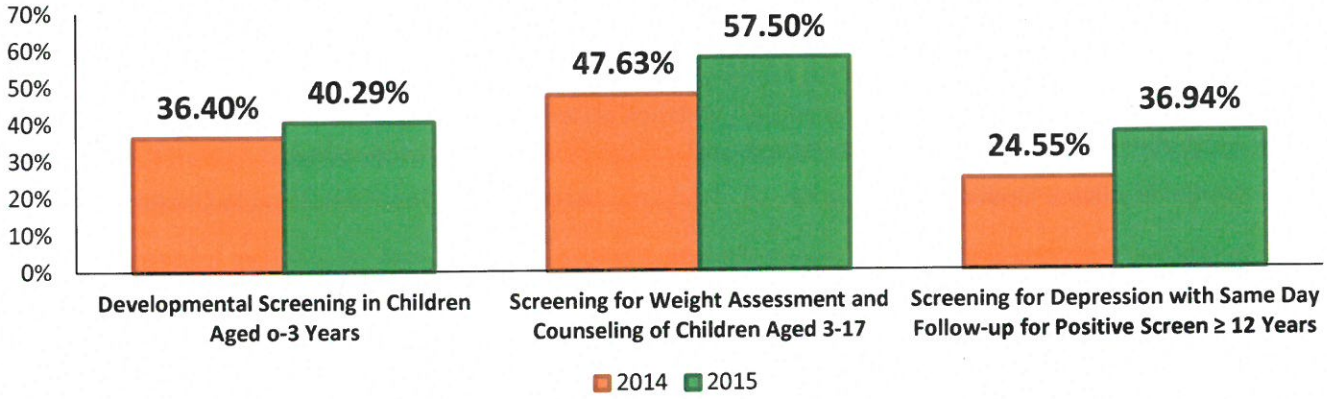
- ✓ Both consumers and providers lack clear information about the differences between palliative care and hospice services.
- ✓ Communication regarding end-of-life care is a learned skill.
- ✓ Focusing on a few discrete diagnoses allowed for clearer opportunities to start the improvement activities.

OneCare Vermont
Network Success Story

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

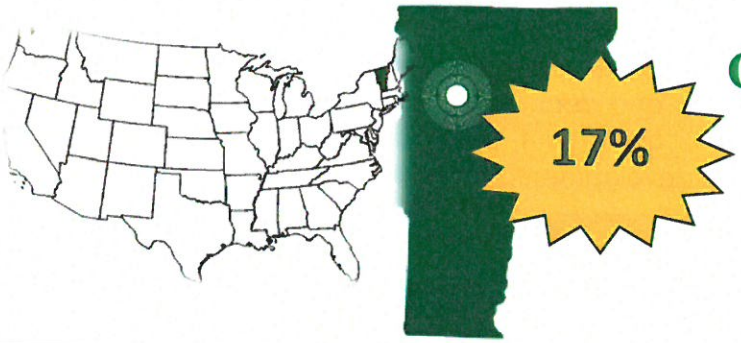
Lessons Learned

- ✓ **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
Network Success Story

Our Network Demonstrates High Quality, Low Cost Care for Vermonters

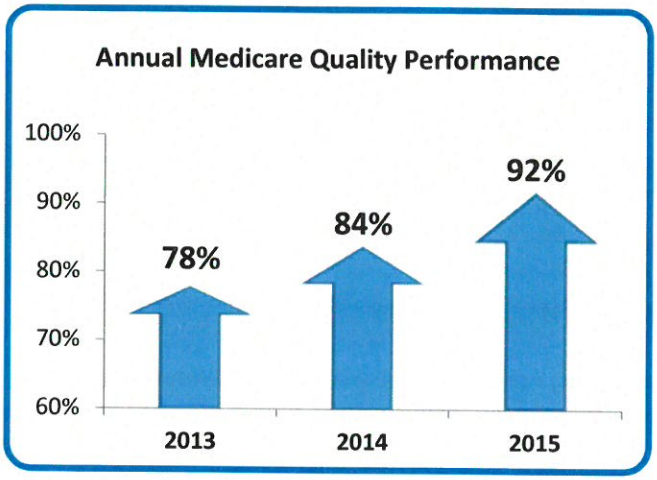


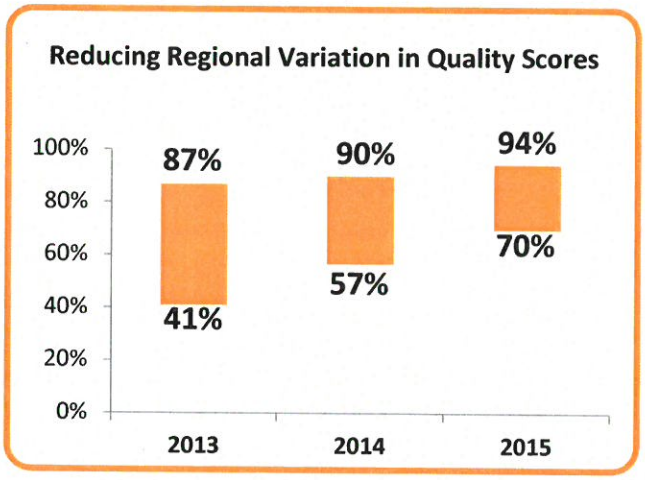
OneCare Vermont ranked in the top 17% (66th out of 392*) of Medicare Shared Savings Program in 2015.

*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 Network Success Story

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

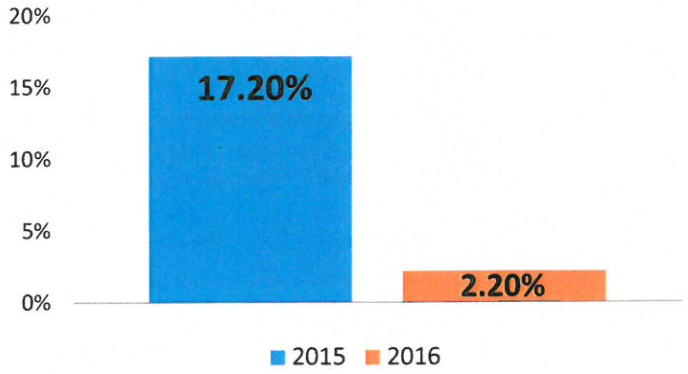
- In 2015, SVMC examined their readmission and ED transfer data to establish a baseline
- Identified an RN champion to educate and train staff on improved communication, decision support and advanced care planning
- Utilized tools focused on early intervention of changes in condition (Stop and Watch 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

January 2017