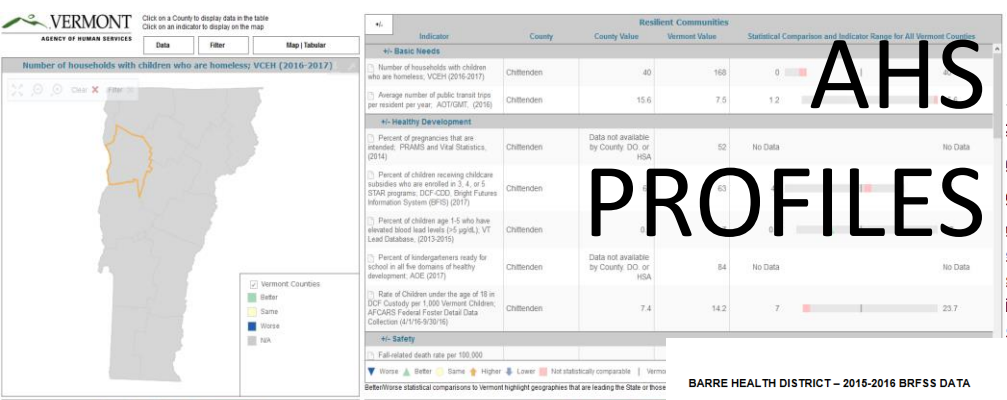
ACH DATA DASHBOARDS

ACH Learning Lab

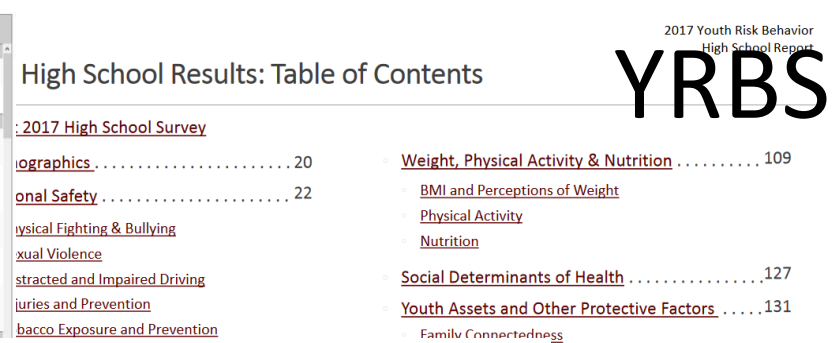
October 8, 2018

Why another dashboard?

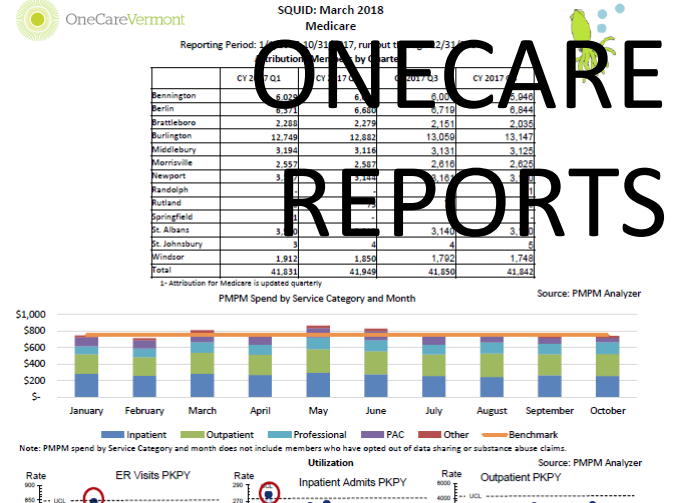
AHS PROFILES



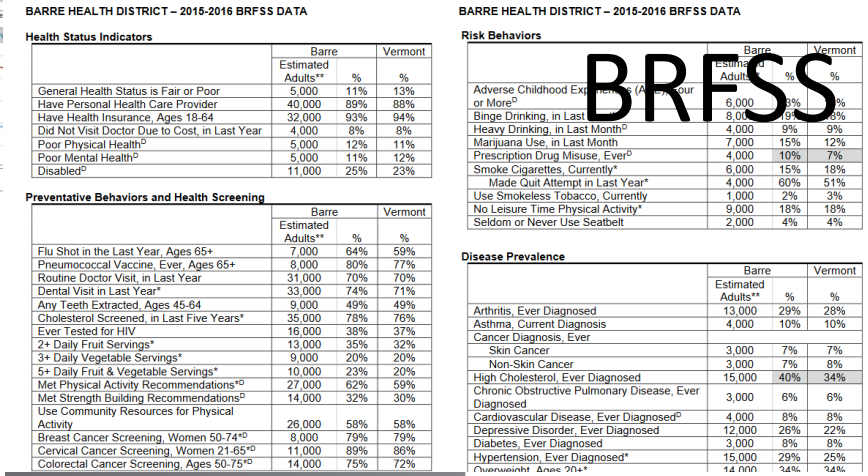
YRBS



ONECARE REPORTS

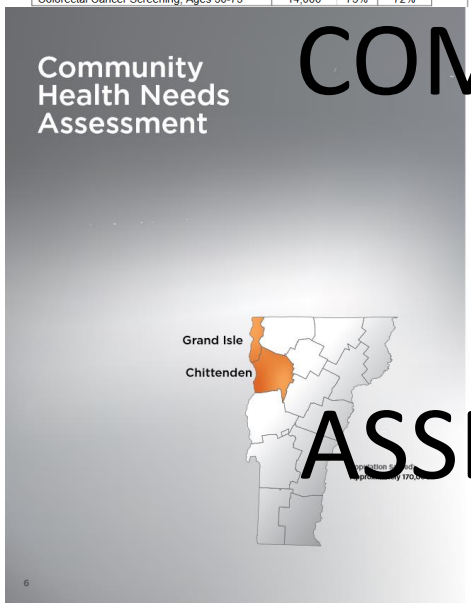


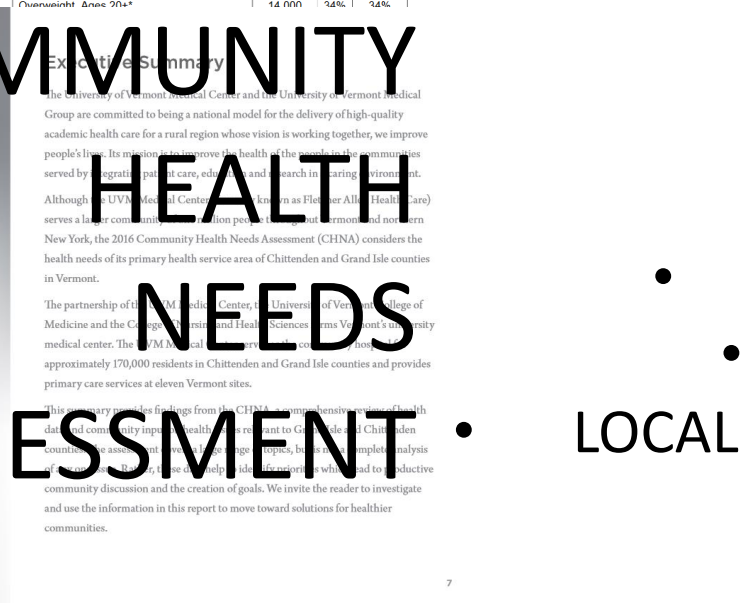
BRFSS



BLUEPRINT COMMUNITY PROFILES

COMMUNITY HEALTH NEEDS ASSESSMENT

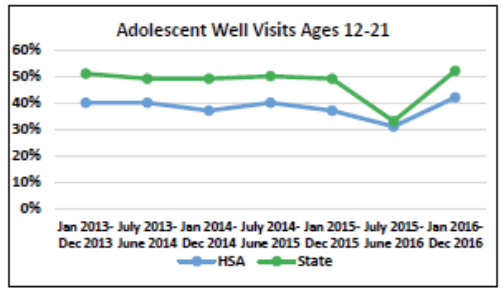




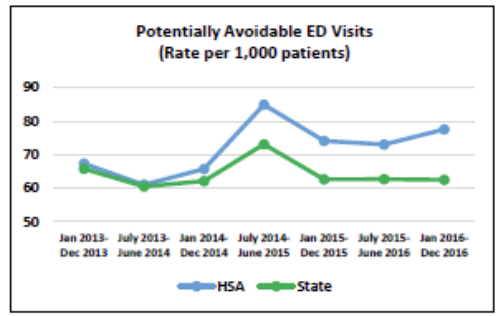
+ REPORTS FROM
- CENSUS
- ACH PARTICIPANT ORGS
- LOCAL HOSPITAL EHR
- LOCAL HOSPITAL QUALITY DEPT
- MORE

MORRISVILLE HSA DASHBOARD CY 2017 REPORT **JANUARY 24, 2018**

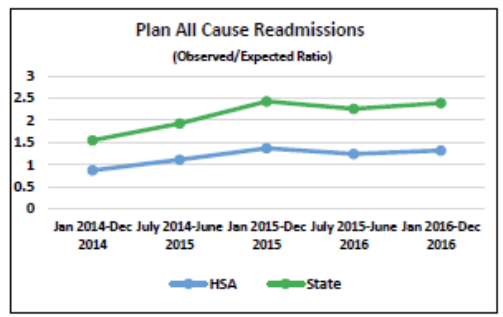
Organizations represented by the Morrisville UCC: Copley, Lamoille Home Health and Hospice, CHSLV, VDH, VCCI, The Manor, Agency of Human Services, Lamoille Housing/SASH, Hardwick Health, Medical homes, Lamoille County Mental Health, Lamoille Family Center, Recovery Center, Blueprint, OneCare Vermont, Health First, and Bi-State/Community Health Accountable Care.



Measure: Adolescent Well Visits
Population: Patients ages 12-21 years of age
Definition: The percentage of members ages 12-21 years, who had at least one well-care visit with a PCP or OB/GYN during the measurement year.
Data source: claims, Blueprint HSA profiles
Noteworthy: 100% of the medical homes are actively working on increasing adolescent well visits through panel management. This is also part of the Blueprint quality incentive PMPM payment.



Measure: Potentially Avoidable Emergency Department Visits
Population: Patients ages 18 years older
Definition: The number of ED visits by members per 1,000 patients that had a qualifying ICD code as a primary diagnosis.
Data source: claims, Blueprint HSA profiles
Noteworthy: This has been recognized as a problem in Morrisville HSA. The medical homes have attempted to tackle this problem for years, however, the recent addition of a Social worker in the ED is the most promising intervention.



Measure: Plan All Cause Readmission
Population: Patients ages 18 years older
Definition: Comparison of the rate of members who had an inpatient stay followed by an acute readmission for any diagnosis within 30 days during the measurement year to the expected rate of readmissions given risk factors of the pat
Data source: claims, Blueprint HSA profiles
Noteworthy: The UCC focused on this measure for the past few years. Most recently, Copley hospital has been piloting a new screening tool to help identify patients at risk for readmission.

Getting Started

What kind of dashboard will this be?

Operational * Leadership * Analytic

Who is Your Audience / What Do They Need?

Ask them

What would you like to know?

What would you do if you knew this information?

Finding the Right Data

Your priorities / locally meaningful

Standardized if possible

Accessible

Understandable

Actionable

Design

“It’s beautiful if it optimizes the user’s ability to take in the information.”

Case Study: Randolph

Randolph Area Community Health Dashboard

2nd Quarter 2018 — Dashboard developed by the Randolph Executive Community Council

About the Randolph Executive Community Council

Randolph Executive Community Council Members: South Royalton Health Center, Gifford, Central Vermont Council on Aging, Capstone Community Action, Clara Martin, Community Health Accountable Care/Bi-State, Stagecoach, RACDC/SASH, VT Food Bank, Visiting Nurse and Hospice of VT and NH, Bayada, VDH, Randolph Area Opioid Response Team, DVHA – VCCI, Vermont Blueprint for Health, Green Mountain United Way, Orange Co. Parent/Child Center

Population & Health Coverage

	Local	Vermont
Blueprint Members, Randolph Hospital Service Area	6,167 adults; 1,1715 ages 1-17	223,498 adults; 67,430 ages 1-17
% Medicaid, Blueprint Members	25.1%	21.9%
% Medicare, Blueprint Members	31.9%	27.8%
Residents, Orange Co.	28,974	623,657
W/out health coverage, 18-64, WRJ	6%	6%

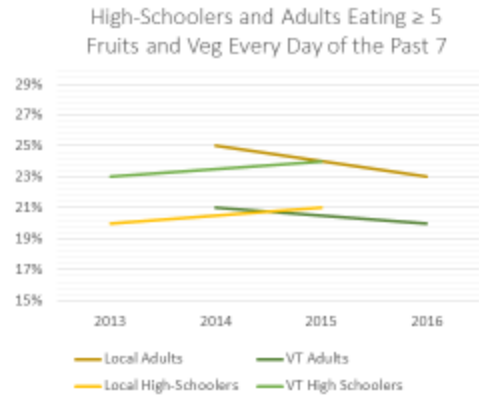
RECC Team Functionality

Team Principle	Average Randolph Agreement 2015/2017 *scored 1-5; 1 = strongly disagree, 5 = strongly agree*
Shared Goals	3.8
Mutual Trust	3.7
Clear Roles	3.2
Effective Communication	3.7
Measuring Work and Outcomes	3.1

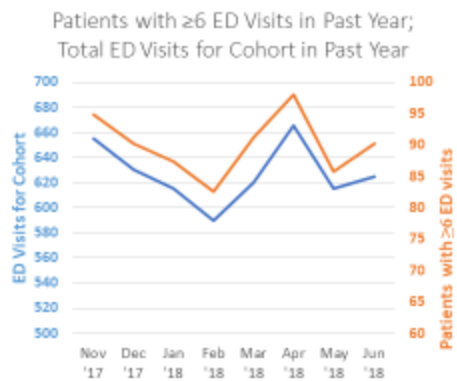
About the Local Population

For more census data, see the end of this document

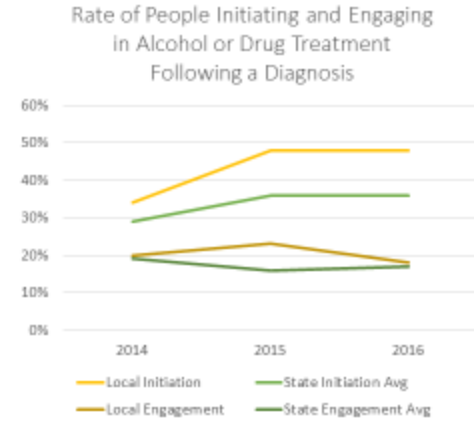
Measure	**FRUIT AND VEGETABLE CONSUMPTION**
Data Source	VDH: 2014 and 2015-2016 BRFSS, 2013 and 2015 YRBS
Population	Adults in the WRJ Health District; High-Schoolers in Orange County
Measure Definition	Self-reported eating of 5 or more fruits and vegetables every day for the last 7 days
Measure Leads	Emerging RECC Nutrition Workgroup
Community Goal	TBD in 2018
Improvement Strategy	TBD in 2018
Process Measures	TBD in 2018



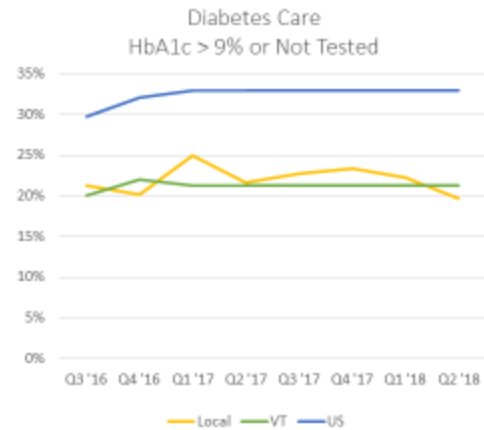
Measure	**EMERGENCY DEPARTMENT UTILIZATION**
Data Source	Gifford Workgroup
Measure Definition	Patients with 6 or more visits to Gifford ED in past 12 months; total ED visits for this cohort of patients over past 12 months
Measure Leads	Care Coordination / ED Utilization Workgroup
Community Goal	TDB in 2018
Improvement Strategy	Gifford-Clara Martin team looking at who on list of ED high utilizers uses both organizations' services, then planning coordinated care management for cohort with aim of connecting them to preventative care that keeps them out of crisis.
Notes	Potentially Avoidable Outpatient ED Visits measure in Blueprint Profiles shows Randolph HSA at 69 per 1000 in 2016, vs. 63 VT average.



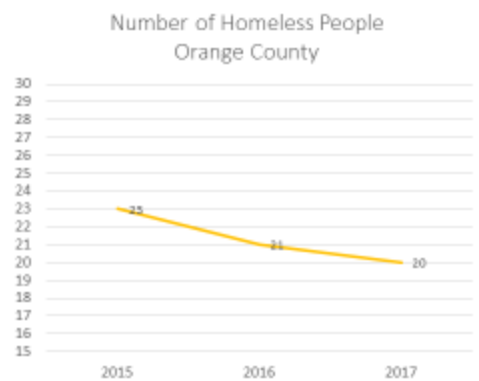
Measure	**INITIATION AND ENGAGEMENT IN DRUG AND ALCOHOL TREATMENT**
Data Source	Blueprint HSA Profiles
Measure Definition	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: initiation of AOD treatment through an admission, encounter, or visit within 14 days; engagement of AOD treatment including 2 or more addl' services within 30 days of the initiation visit. Measure is NQF #0004 defined here
Measure Leads	RECC will ask RAORT
Community Goal	TBD in 2018
Improvement Strategy	TBD in 2018
Process Measures	TBD in 2018



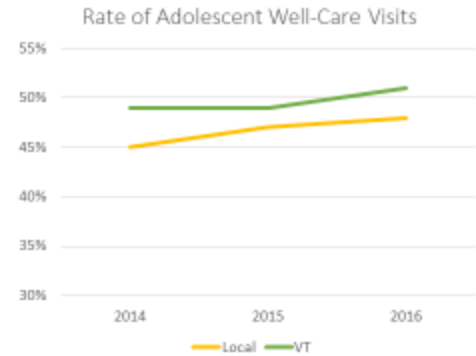
Measure	**DIABETES: HBA1C IN POOR CONTROL**
Data Source	Gifford Quality Department
Population	Gifford patients with diabetes, n 428 - 527
Measure Definition	Percentage of diabetic patients age 18-75 who were seen at least once in the quarter and whose most recent HbA1c level was greater than 9% or not tested (within the past year). Excludes gestational diabetes and steroid-induced diabetes. See NQF #0059. Comparison groups are from UDS dataset of FQHC patients (2017 data).
Measure Leads	RECC Clinical QI Workgroup
Community Goal	TBD in 2018 – current Gifford goal is <21%, Healthy People 2020 goal is 16.1%
Improvement Strategy	QI Team at Gifford underway
Process Measures	TBD in 2018



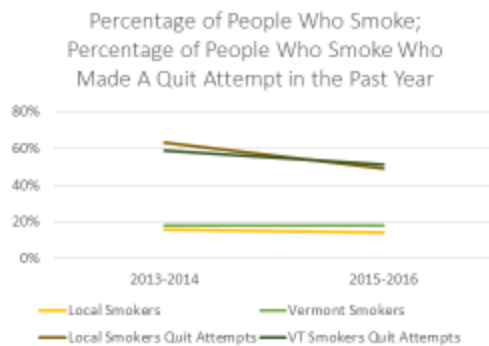
Measure	**HOMELESSNESS**
Data Source	Vermont Statewide Point-in-Time Count
Improvement Strategy	RECC monitoring only for now
Process Measures	Consider including Capstone Housing Opportunity Program clients stabilized; clients who remained stabilized after 90 days



Measure	**ADOLESCENT WELL-CARE**
Data Source	Blueprint HSA Pediatric Profile
Population	Randolph Health Service Area pediatric population
Measure Definition	Proportion of members, ages 12–21 years, who received one or more well-care visits with a primary care practitioner or OB/GYN during the measurement year.
Community Goal	
Improvement Strategy	
Process Measures	
Notes	Working to incorporate So. Royalton data into the measure, Bi-State QI project in 2016



Measure	**SMOKING AND QUIT ATTEMPTS**
Data Source	VDH BRFSS 2013-2014; 2015-2016
Population	White River Junction Health District
Measure Definition	Percentage of people who currently smoke and percentage of people who smoke who made a quit attempt in the past year
Measure Leads	Self-Management Programs Workgroup
Community Goal	TBD in 2018
Improvement Strategy	TBD in 2018
Process Measures	TBD in 2018

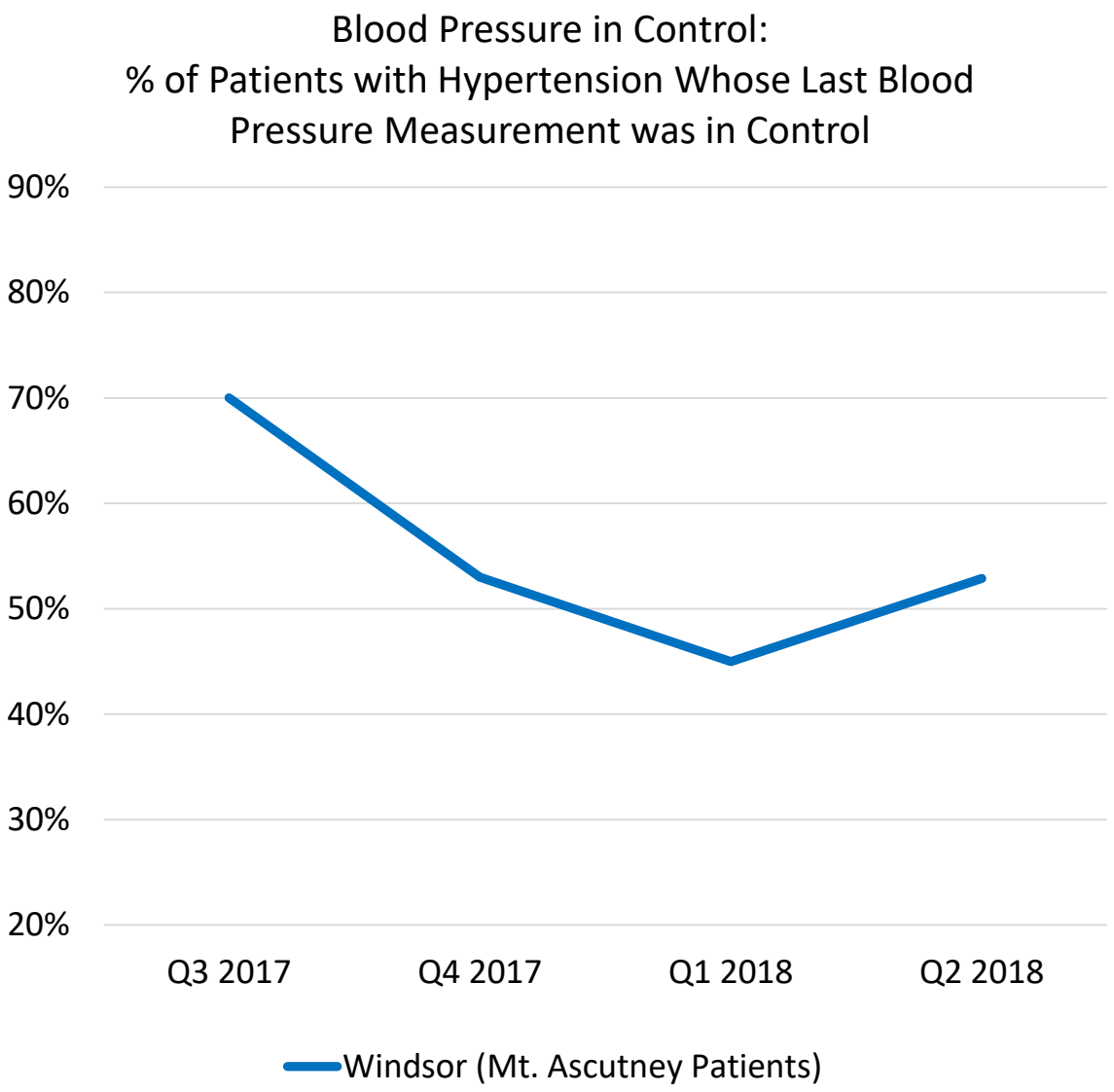


About the Population: Census Data for Orange County with Vermont Comparison Data

Measure	Time	Vermont	Orange County
Population estimate	7/1/17	623,657	28,974
Persons under 5 years, %	Accessed 6/14/18	4.9%	4.8%
Persons under 18 years, %	Accessed 6/14/18	19.0%	18.8%
Persons 65 years and over, %	Accessed 6/14/18	18.1%	19.2%
Female persons, %	Accessed 6/14/18	50.6%	50.0%
Race: white alone, %	Accessed 6/14/18	94.6%	96.8%
Veterans	2012-2016	42,848	2,326
High school graduate or higher, % of persons 25+	2012-2016	91.9%	91.7%
Bachelor's degree or higher, % of persons 25+	2012-2016	36.2%	30.2%
Persons with a disability, under age 65, %	2012-2016	10.3%	12.9%
Persons without health insurance (do not compare VT to county)	2016/2015	4.5%	4.8%
Median household income (in 2016 dollars)	2012-2016	$56,104	$54,263
Per capita income in past 12 months (in 2016 dollars)	2012-2016	$30,663	$28,691
Persons in poverty, % (do not compare VT to county)	2016/2015	11.9%	10.6%

Case Study: Windsor

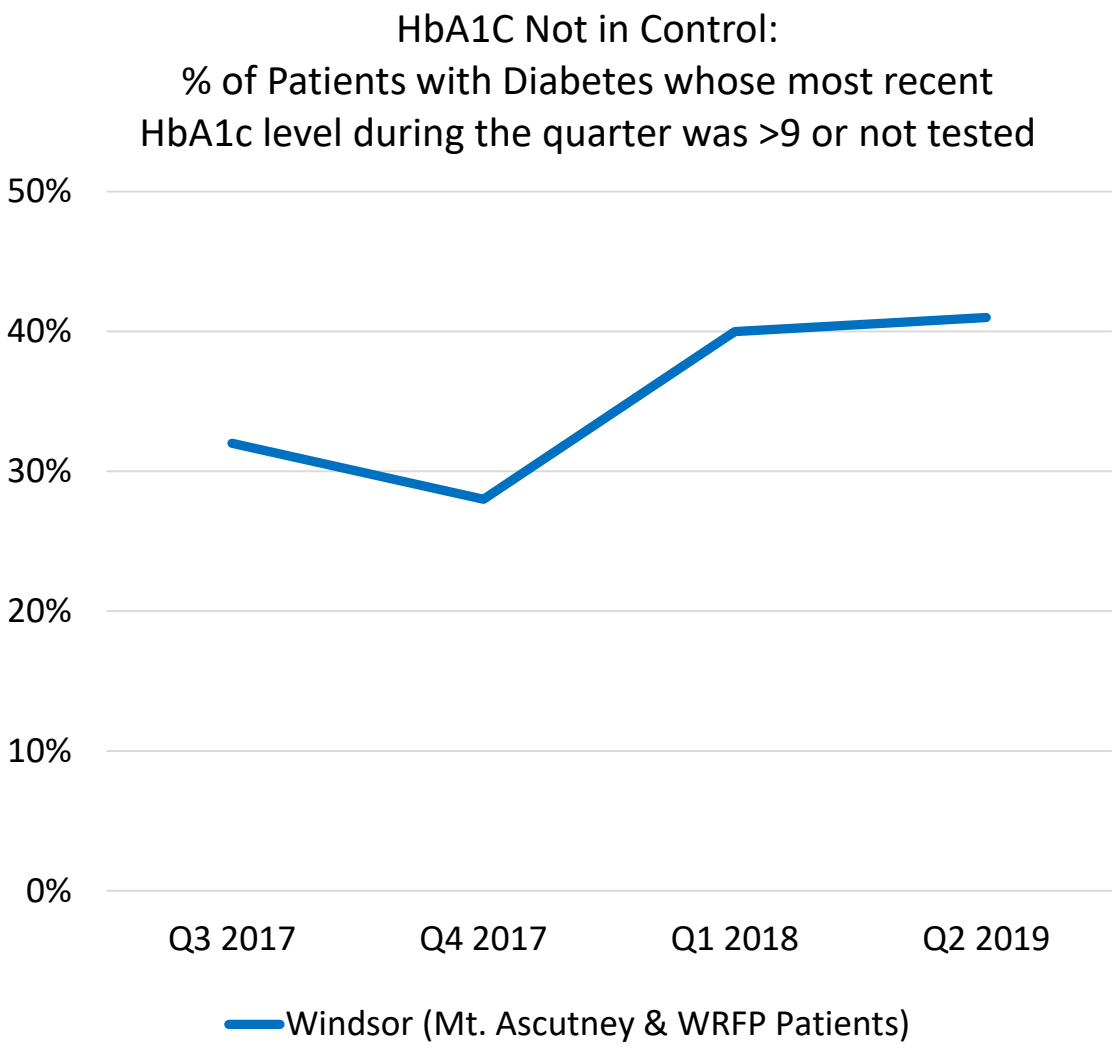
Hypertension Care



HYPERTENSION CARE: BLOOD-PRESSURE IN CONTROL

Measure Definition	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement quarter. Measure adapts NQF #0018 (definition here), using quarter instead of year.
Source	Local clinical data from Mt. Ascutney
Benchmark	The VT Blueprint aggregate blood pressure in control rate is 71% (using a year timeframe).
Community Goal or Process Measure	TBD
Notes	See the Vermont Hypertension Management Toolkit for Hypertension QI tools

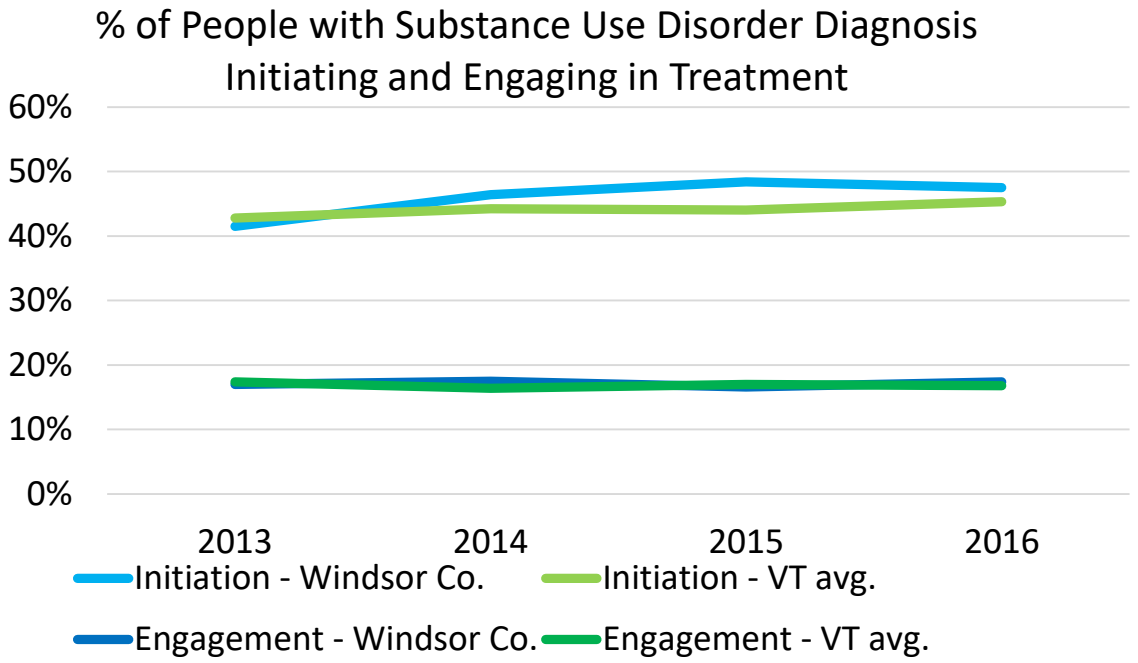
Diabetes Care



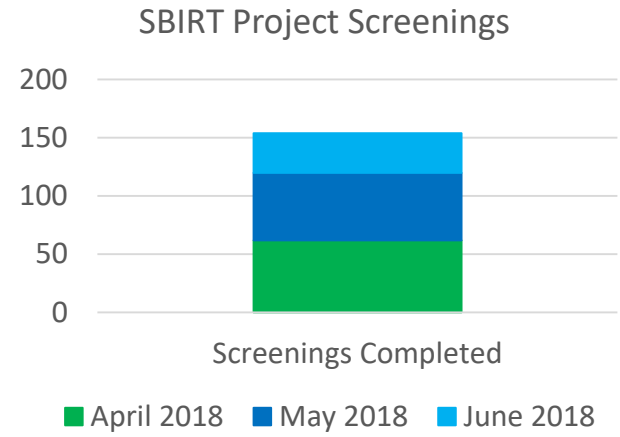
DIABETES CARE: DIABETES IN POOR CONTROL

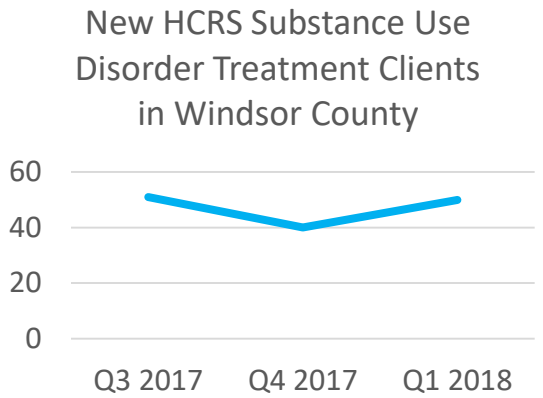
Measure Definition	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement quarter was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement quarter. Measure adapts NQF #0059 (definition here) using quarter instead of year.
Source	Local clinical data from Mt. Ascutney and White River Family Practice
Benchmark	The VT Blueprint aggregate A1c in poor control rate was 12% in 2016 (using a year timeframe).
Community Goal or Process Measure	TBD
Notes	Dr. Levin is leading a quality improvement project at Mt. Ascutney, aiming to help patients with Diabetes improve their health.

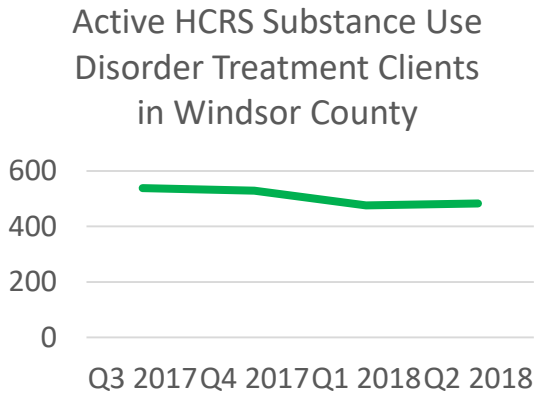
Substance Use Disorder Treatment



Measure Definition	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: initiation of AOD treatment through an admission, encounter, or visit within 14 days; engagement of AOD treatment including 2 or more addl' services within 30 days of the initiation visit. Measure is NQF #0004 defined here. Rates have been adjusted for Medication Assisted Treatment and Behavioral Health Residential Treatment.
Source	Vermont Department of Health data
Notes	Project underway building SBIRT into Emergency Department workflow through CHT staff, making referrals to treatment as needed.

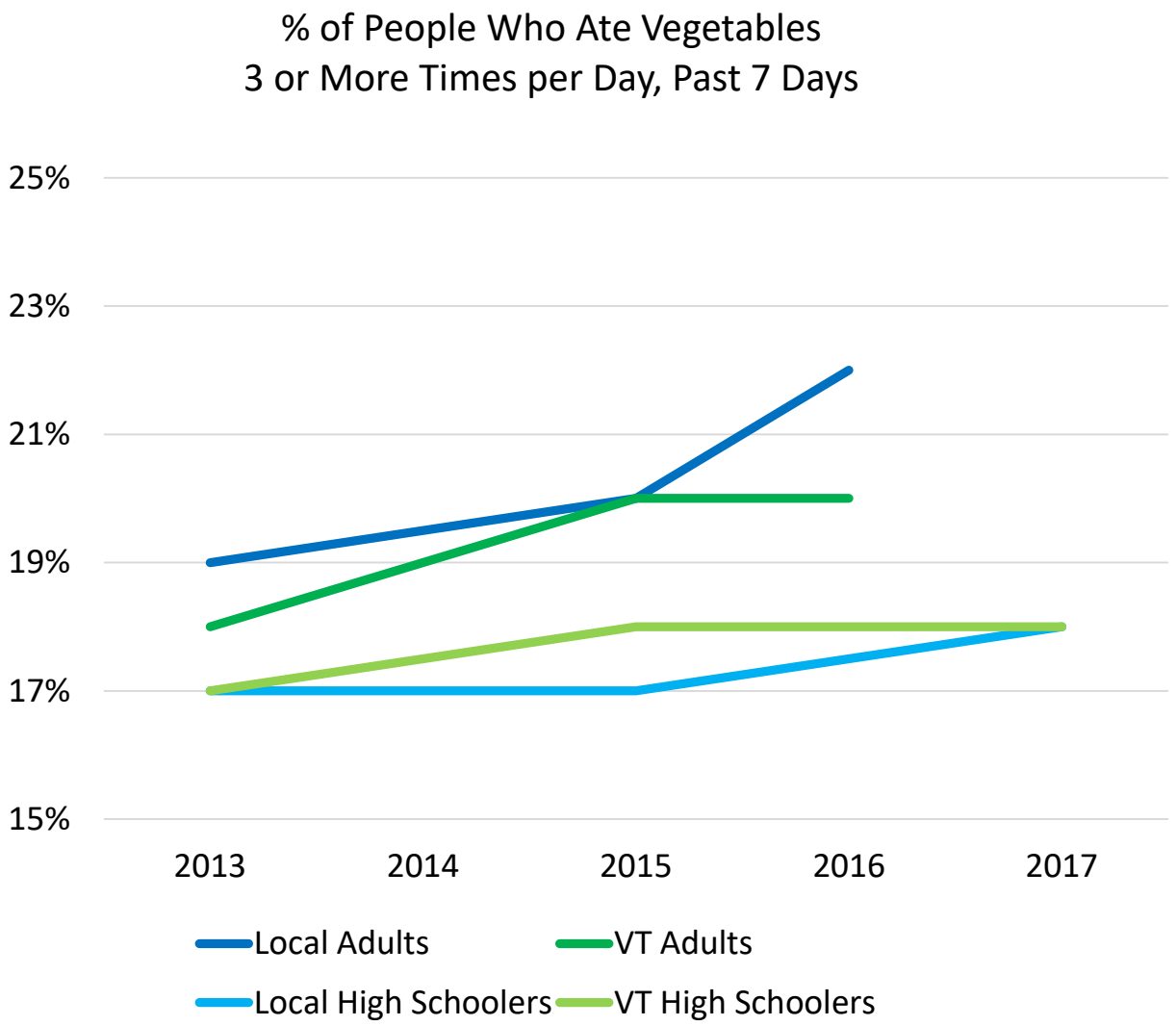






Spoke Medication Assisted Treatment Resources, May 2018	
MDs prescribing	11
MDs prescribing to ≥ 10 patients	5
Staff FTE Hired	3
Medicaid Beneficiaries	224

3-4-50 Prevention Work



3-4-50 Prevention

Measure Definition	Percentage of adults and high schoolers who report eating 3 or more vegetables each day of the last 7. Interaction with local prevention and healthy living initiatives will also be reported.
Source	VDH's YRBS for Windsor Co., BRFSS for White River Jct.
Notes	Shifted from fruit and vegetable consumption to vegetable consumption based on available YRBS calculations.