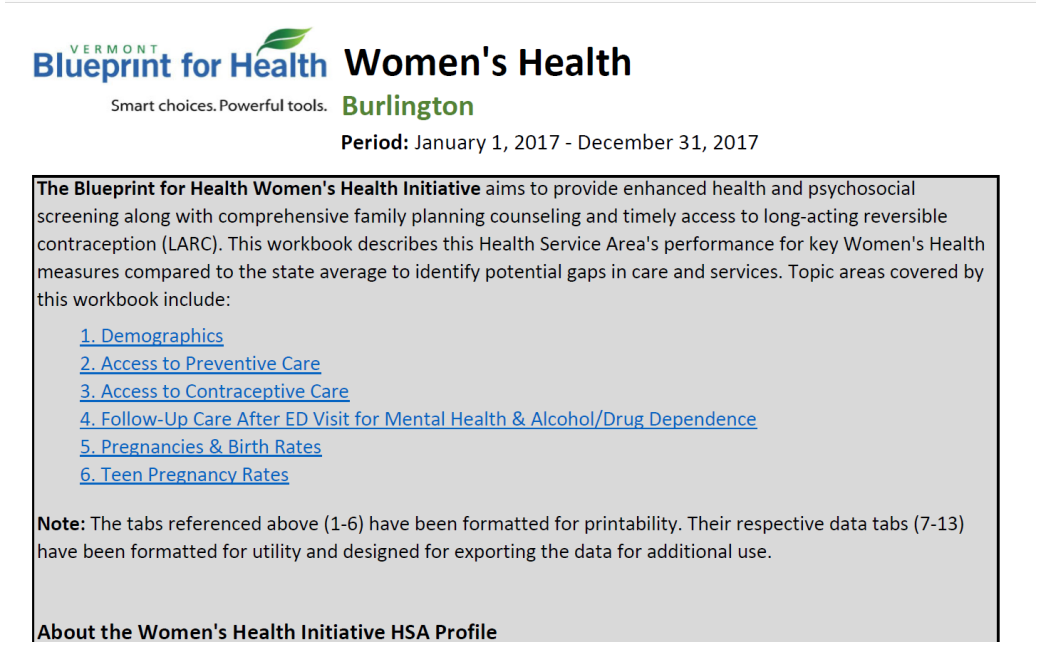
Women's Health Initiative Profiles

May 2019



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Women's Health

Burlington

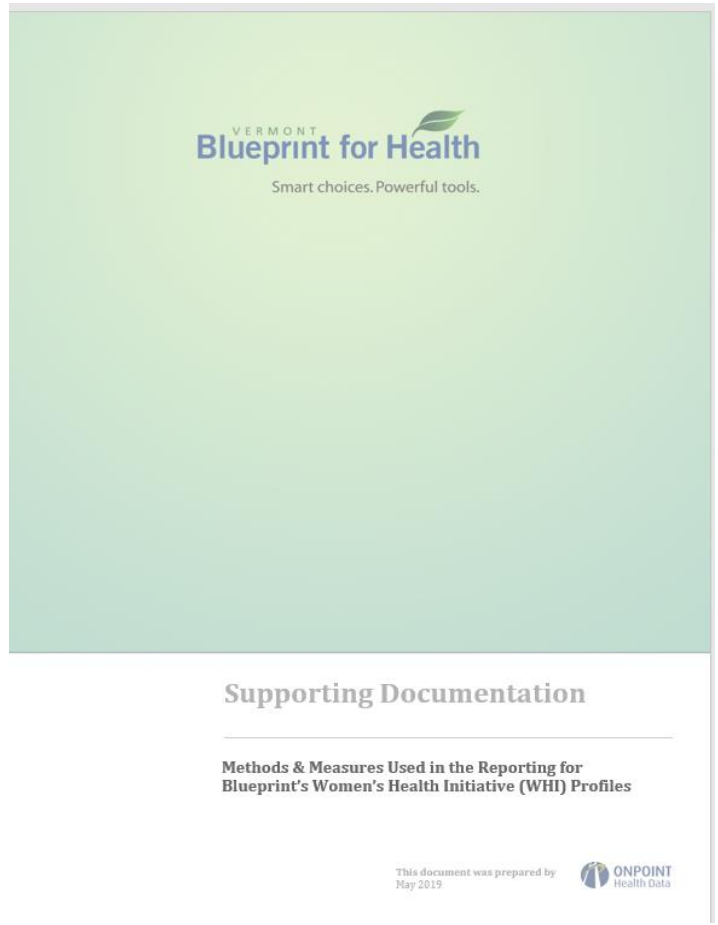
Period: January 1, 2017 - December 31, 2017

The Blueprint for Health Women's Health Initiative aims to provide enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long-acting reversible contraception (LARC). This workbook describes this Health Service Area's performance for key Women's Health measures compared to the state average to identify potential gaps in care and services. Topic areas covered by this workbook include:

1. Demographics
2. Access to Preventive Care
3. Access to Contraceptive Care
4. Follow-Up Care After ED Visit for Mental Health & Alcohol/Drug Dependence
5. Pregnancies & Birth Rates
6. Teen Pregnancy Rates

Note: The tabs referenced above (1-6) have been formatted for printability. Their respective data tabs (7-13) have been formatted for utility and designed for exporting the data for additional use.

About the Women's Health Initiative HSA Profile



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Supporting Documentation

Methods & Measures Used in the Reporting for Blueprint's Women's Health Initiative (WHI) Profiles

This document was prepared by May 2019

ONPOINT Health Data

Objectives of WHI Profiles

- Knowing the Population Served
- Evaluation
- Quality Improvement
- Future Performance Based Payments

Types of Profiles

- **Community** – Assigns Vermont Female Residents, aged 15-44, with VHCURES data by region of residence

- **Practice** - Assigning female patients, aged 15-44, to participating practices sites (i.e., women's health clinics, OB/GYN practices, family practices, or other primary care practices)

- Supporting Documentation – Methods and Measures https://blueprintforhealth.vermont.gov/sites/bfh/files/Blueprint_WHI_Profiles_Methodology.pdf

Data Sources

- VHCURES – Vermont Health Care Uniform Reporting and Evaluation System (WHI only relevant to Medicaid population at this time)
  - Includes: All covered commercial, Medicaid, and Medicare members
  - Excludes: opt-out commercial self-funded (ERISA) plans, federal plans, military plans, non-insured
- BRFSS – Behavioral Risk Factor Surveillance System Measures
  - Annual phone interview of 6,000-7,000 Vermonters sponsored by the Vermont Department of Health

Why the Data Delay?

- Time period is 2017 calendar year
- VHCURES data – we calculate average and distinct members in a given year and use commonly accepted timelines for claims run out (timeline can range between 3-6 months); can experience delays in insurer record systems; time required for analytics vendor
- BRFSS - We use the latest available BRFSS data. The BRFSS is collected throughout each month in a given calendar year. At the end of the year, the data is processed and then made available for analysis. Data is usually released for use by June of the following year (e.g.2017 Vermont BRFSS data became available in June 2018).

Who is Being Reported?

- Attribution Methodology
  - Vermont residents with applicable insurances
  - 24 month look back

- Members are first attributed to participating women's health providers (e.g., OB/GYNs), then to participating primary care providers based on where a member received care, and finally to a Hospital Service Area (HSA) based on a member's location of residence. If a member visited both an OB/GYN and a PCP, **they could be attributed to both practices and would appear in the profiles for both practices**.

- Results <11 not reported

Included Measures - Demographics

- Behavioral and Socioeconomic Risk Factors
  - Household Income
  - Physical Activity Level
  - Fruit and Vegetable Consumption
  - Cigarette use
  - Educational Level
- Age
- Insurance Type
- Health Status*
- Condition Prevalence
  - Depression, Asthma, Hypertension, Diabetes, Mental Health, Substance Use (Tobacco, Opioid Use, Non-Opioid Substance Use)

Health Status - 3M Clinical Risk Groups

#	CRG Major Health Status Categories	Examples	Aggregation for Regression Model
1	Healthy	N/A	Reference Group (Healthy)
2	History of significant acute disease	Acute ear, nose, or throat illness	Acute or Minor Chronic
3	Single minor chronic disease	Minor chronic joint	Acute or Minor Chronic
4	Minor chronic disease in multiple organ systems	Minor chronic joint and migraine	Moderate Chronic
5	Single dominant or moderate chronic disease	Diabetes	Moderate Chronic
6	Significant chronic disease in multiple organ systems	Diabetes and hypertension	Significant Chronic
7	Dominant chronic disease in 3 or more organ systems	CHF, diabetes, and COPD	Significant Chronic
8	Dominant, metastatic, and complicated malignancies	Malignant breast cancer	Cancer or Catastrophic
9	Catastrophic conditions	HIV, cystic fibrosis, muscular dystrophy, quadriplegia	Cancer or Catastrophic

Included Measures – Access to Preventative Care

- Primary care visit within the last two years
- Cervical cancer screening
- Chlamydia screening

Ties to Overall WHI Program aim of helping women be well.

Ties to Practice's WHI Participation Agreement to:

- Ensuring protocol for patients who are without a primary care provider.

Included Measures – Access to Contraceptive Care

- Choice of LARC or Most or Moderately Effective Contraception
  - All Women 15-44
  - Postpartum
- Choice of LARC

Ties to Overall WHI Program aim of avoiding unintended pregnancies.

Ties to Practice's WHI Participation Agreement to:

- Stock the full spectrum of LARC at adequate level for practice size
- Implement One Key Question (R)
- See patient within 1 week of referral for comprehensive family planning services
- Provide same day LARC insertion

Included Measures – Follow up After ED Visit

- ED Visit Rates for Mental Illness or Alcohol and Other Drug Dependence (male and female)
- Follow-Up after ED Visit for Mental Illness
  - 7 day
  - 30 day
- Follow-Up after ED Visit for Alcohol and Other Drug Dependence
  - 7 day
  - 30 day

Ties to Overall WHI Program Aim of helping women be well and building thriving families.

Ties to Practice's WHI Participation Agreement to:

- Implement screening, brief intervention, and navigation to services for depression, substance use disorder, and interpersonal violence.
- Execute formal referral protocols with community –based organizations

Included Measures – Pregnancies and Birth Rates

- Live Births
- Miscarriages
- Abortions
- Teen Pregnancy Rates

Ties to Overall WHI Program aim of supporting healthy pregnancies.

Ties to Practice's WHI Participation Agreement to:

- Implement screening, brief intervention, and navigation to services for depression, substance use disorder, and interpersonal violence.
- Execute formal referral protocols with community –based organizations

Observations and Opportunities

- Denominator of approx. 87,143 for WHI - approximately 34% of attributed Vermont females have moderate chronic, significant chronic, or cancer/catastrophic conditions

- High proportion of individuals with diagnosed **depression (13%) and MH conditions (33%)**

- While the majority had a visit with a primary care provider over the last two years, there is opportunity to improve **preventative screening rates (especially Chlamydia Screening)**

- Drastic increase in the percentage of females choosing LARC over the last 9 years

Observations and Opportunities for Improvement

- In absence of a standardized measure that we can effectively collect about screening and intervention for mental health and substance use, we have considerable **opportunities for follow up after ED visits for mental health and substance use**

- Overall rate of births, miscarriages, and abortions has remained relatively consistent over time; **teenage pregnancy rates have been steadily decreasing over time** (but still present an opportunity for intervention)

Questions and Supports

Interpretation and use for Quality Improvement

Program Manager / QI Facilitators

https://blueprintforhealth.vermont.gov/contact-us

Profile distribution/data source questions

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Community WHI Profiles and Methods Document

https://blueprintforhealth.vermont.gov/womens-health-initiative-profiles