ACH DATA DASHBOARDS

ACH Learning Lab
October 8, 2018
Why another dashboard?
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 CHW/DTY during the measurement year.
Data source: claims, Blueprint HSA profiles
Noteworthy: 100% of medical homes are actively working on increasing adolescent well visits through panel management. This is also part of the Blueprint quality incentives/PPM payment.

Measure: Potentially Avoidable ED 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 Morristown 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 Readmissions
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 patient.
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 Rivers Health Center, Gifford Central Primary Care (COMPASS), Burlington Community Health Center, Burlington Area Health Care, Avera Health/Ames, Sanford Health, and Avera Memorial Hospital.

Population & Health Coverage:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Fruit and Vegetable Consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>砻FDR 2015 and 2017; RERCS 2013 and 2015 WHO</td>
</tr>
<tr>
<td>Foundation</td>
<td>Adults in the VRI Health District, High-Schoolers in Orange County</td>
</tr>
<tr>
<td>Measure Definition</td>
<td>Self-reported eating of 5 or more Fruits and Vegetables every day for the last 7 days</td>
</tr>
<tr>
<td>Measure Leads</td>
<td>Emerging PCG Nutrition Workgroup</td>
</tr>
<tr>
<td>Community Goal</td>
<td>TBD in 2018</td>
</tr>
<tr>
<td>Improvement Strategy</td>
<td>TBD in 2018</td>
</tr>
<tr>
<td>Process Measures</td>
<td>TBD in 2018</td>
</tr>
</tbody>
</table>

About the Local Population

High Schoolers and Adults Eating ≥5 Fruits and Veg Every Day of the Past 7 Days

Patients with ≥6 ED Visits in Past Year

Total ED Visits for Cohort in Past Year

Potential Unavailable: Unmet ED Visits measure in Blueprint昊拓 in Avera Health, SFHA at 95 per 1,000 in 2016, vs. 63 in 2017.
Measure: Adolescent Well-Care
Data Source: BHSR assessed through the ARMS-CAIS Population
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 Measure:
Notes: Working to incorporate Six Sigma data into the measure. Staged GYPS in 2018.

Measure: SWIMMING AND QUIT ATTEMPTS
Data Source: VDH DPSS 2011-2014: 2015-2018
Population: White River Junction Health District
Definition: Percentage of people who currently smoke and percentage of people who smoke who made a quit attempt in the past year.

Measure Leads:
Community Goal: TBD in 2018
Improvement Strategy: TBD in 2018
Process Measure: TBD in 2018

Percentage of People Who Smoke; Percentage of People Who Smoke Who Made A Quit Attempt in the Past Year

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total</th>
<th>Vermont</th>
<th>Orange County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population estimate</td>
<td>791/97</td>
<td>428,657</td>
<td>70,473</td>
</tr>
<tr>
<td>Persons under 18 years, %</td>
<td>Accessed 6/3/14</td>
<td>9.4%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Persons 18 years and older, %</td>
<td>Accessed 6/3/14</td>
<td>19.1%</td>
<td>19.8%</td>
</tr>
<tr>
<td>Persons 65 years and older, %</td>
<td>Accessed 6/3/14</td>
<td>18.1%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Female persons, %</td>
<td>Accessed 6/3/14</td>
<td>51.0%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Maternal, white, %</td>
<td>Accessed 6/3/14</td>
<td>54.8%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Veterans</td>
<td>2012-2016</td>
<td>42,848</td>
<td>2,120</td>
</tr>
<tr>
<td>High school graduate or higher, % of persons</td>
<td>2012-2016</td>
<td>59.5%</td>
<td>59.7%</td>
</tr>
<tr>
<td>Bachelor’s degree or higher, % of persons</td>
<td>2012-2016</td>
<td>36.2%</td>
<td>31.2%</td>
</tr>
<tr>
<td>Persons with activity, age 65+, %</td>
<td>2012-2016</td>
<td>10.3%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Persons without health insurance (do not compare VT to county)</td>
<td>2012-2015</td>
<td>4.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Median household income (in 2014 dollars)</td>
<td>2011-2016</td>
<td>$56,504</td>
<td>$54,263</td>
</tr>
<tr>
<td>Per capita income in 2015 (in 2016 dollars)</td>
<td>2011-2016</td>
<td>$30,663</td>
<td>$38,691</td>
</tr>
<tr>
<td>Persons in poverty, % (do not compare VT to county)</td>
<td>2012-2015</td>
<td>11.0%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>
Case Study: Windsor
Hypertension Care

Blood Pressure in Control:
% of Patients with Hypertension Whose Last Blood Pressure Measurement was in Control

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.
**HbA1C Not in Control:**

% of Patients with Diabetes whose most recent HbA1c level during the quarter was >9 or not tested

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**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

% of People with Substance Use Disorder Diagnosis
Initiating and Engaging in 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.

**SBIRT Project Screenings**

Screenings Completed

- April 2018
- May 2018
- June 2018

**New HCRS Substance Use Disorder Treatment Clients in Windsor County**

- Q3 2017
- Q4 2017
- Q1 2018

**Active HCRS Substance Use Disorder Treatment Clients in Windsor County**

- Q3 2017
- Q4 2017
- Q1 2018
- Q2 2018

**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

% of People Who Ate Vegetables 3 or More Times per Day, Past 7 Days

Local Adults  VT Adults  Local High Schoolers  VT High Schoolers

2013  2014  2015  2016  2017

15%  17%  19%  21%  23%  25%

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.

Cumulative Number of People Engaged by 3-4-50 Outreach

Q1 2017  Q2 2017  Q3 2017  Q4 2017  Q1 2018  Q2 2018

Engagement