APPENDIX IV

All-Payer Model Quality Measures: Regional Performance Results

1. Vermont All-Payer Model Quality Measures by Hospital Service Area

Table 1a: Blueprint Profiles – Blueprint-Attributed Vermont Residents (2016)

Measure	Statewide Rate *(All-Payer Model Target)*[1]	Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport	Randolph	Rutland	Springfield	St. Albans	St. Johnsbury	White River
Percentage of Medicaid adolescents with well-care visits	**50%**	49%	51%	41%	53%	52%	45%	56%	48%	44%	49%	47%	60%	49%
Response: The Gifford Community Health Team in conjunction with our Primary Care clinics reach out to our adolescent population, ages 12-21, to schedule them for annual well visits. Recent QI initiatives focused on well-child visits, including education to staff and providers on the importance of annual wellness visits. Gifford uses proactive scheduling when patients leave their appointments to ensure their next visit is scheduled prior to them leaving the office. Additionally, our new EMR system includes a panel management module that enhances our ability to track patients who are overdue for an annual physical and contact them.														
Initiation of alcohol and other drug dependence treatment	**36%**	40%	45%	43%	33%	39%	30%	25%	49%	37%	31%	36%	33%	41%
Response: Screening for alcohol and drug dependence is embedded in the practice workflow for Gifford's Primary Care practices.														
Engagement of alcohol and other drug dependence treatment	**17%**	15%	22%	20%	17%	17%	16%	11%	18%	19%	13%	20%	20%	20%
Response: Screening for alcohol and drug dependence is embedded in the practice workflow for our Primary Care practices. Gifford has increased capacity of our substance use and Addiction Medicine program as well as staff and continuing medical education (CME) on opioid and substance use disorders. Our medication-assisted treatment (MAT) program is embedded with our Primary Care teams with a focus on expediting the initial assessment so that patients can be seen quickly. The Addiction Medicine team will see Emergency Department referrals the same day if their schedule allows.														
30-day follow-up after discharge for mental health	**68%** *(60%)*	73%	78%	75%	58%	58%	75%	68%	69%	74%	68%	67%	58%	70%
Response: We monitor provider schedules to ensure timely access for acute illness.														
30-day follow-up after discharge for alcohol or other drug dependence	**27%** *(40%)*	38%			26%		26%			28%		38%		
Response: We monitor provider schedules to ensure timely access for acute illness.														
Diabetes HbA1c poor control (part of Medicare composite measure)[2]	**10%**	8%	9%	10%	9%		11%	10%			9%	11%	12%	

[1] Measures with no target listed are those measures that have targets based on national percentiles rather than rates.

[2] Lower scores indicate better performance.

Response: Gifford actively participates in the statewide learning collaborative on Diabetes Prevention and Management. We have a multidisciplinary QI team analyzing workflows and looking for opportunities to improve. Interventions already in place include point-of-care hemoglobin A1c analyzers in each of our Primary Care clinics, and standing orders that allow nurses to order labs when due/overdue. We use a proactive scheduling approach with patients to schedule their next appointment before they leave the office. We are currently working to improve our referral process to the Diabetes Educator. We measure performance on this measure on our division dashboard, which is updated quarterly.														
Controlling high blood pressure (part of Medicare composite measure)	**67%**	73%	64%	69%	64%	72%	63%	64%	70%	67%	67%	67%	75%	71%
Response: We utilize tools within our EMR to guide providers in the delivery of national clinical guidelines.														
Appropriate asthma medication management (75% compliance)	**52%**	50%	56%	49%	49%	48%	52%	50%	60%	58%	57%	51%	56%	48%
Response: Asthma Action Plans are completed for patients with diagnosis of asthma (and include revisiting the plan at least annually, or more often if there is a change in condition or treatment plan). We utilize tools within our EMR and our Community Health Team to follow up with patients who are due for their six-month follow-up appointment and/or who are due for an updated Asthma Action Plan.														

Table 1b: Behavioral Risk Factor Surveillance System Survey – Respondents to Survey of Random Sample of Vermont Residents (2016)

Measure	Statewide Rate *(All-Payer Model Target)*	Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport	Randolph	Rutland	Springfield	St. Albans	St. Johnsbury	White River
Percentage of adults reporting that they have a usual primary care provider	**88%** *(89%)*	89%	93%	88%	90%	86%	90%	91%	93%	88%	87%	89%	86%	86%
Response: We currently perform above target. Community Health Team members monitor the list of patients discharged from the Emergency Department who do not have a primary care provider. They conduct outreach to these patients and let them know that they can establish care with a Gifford provider.														
Prevalence of chronic disease: COPD	**6%** *(≤7%)*	7%	8%	6%	4%	5%	6%	10%	4%	9%	7%	6%	6%	7%
Response: We currently perform above target.														
Prevalence of chronic disease: Hypertension	**25%** *(≤26%)*	28%	27%	25%	24%	26%	27%	27%	27%	28%	31%	28%	27%	28%
Response: We utilize tools within our EMR to guide providers in the delivery of national clinical guidelines. And we develop education and self-management resources for patients.														
Prevalence of chronic disease: Diabetes	**8%** *(≤9%)*	8%	9%	8%	6%	10%	7%	13%	9%	10%	11%	10%	9%	11%
Response: Gifford offers two free, evidence-based, self-management programs—one focused on diabetes prevention and one on diabetes management. The Prevent T2 program is a lifestyle-change program that can help prevent or delay Type 2 diabetes and improve overall health. We offer medical nutrition therapy for all (non-diabetic) patients who can benefit from education on a healthy diet. And we routinely incorporate counseling on exercise and healthy diet at office visits.														

2. Vermont All-Payer Model Quality Measures by County

Table 2a: Blueprint for Health Hub and Spoke Profiles - All Vermont Residents Utilizing Services (2016)

Measure	Statewide (Rate/10,000) *(All-Payer Model Target)*	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
# per 10,000 population ages 18-64 receiving Medication Assisted Treatment for opioid dependence[3]	**6,110 (155.4)** *150*	183 (77.1)	362 (170.5)	291 (157.6)	1,387 (126.6)	41 (115.8)	635 (207.8)	58 (135.2)	256 (160.3)	224 (125.2)	337 (212.8)	732 (202.1)	596 (163.3)	422 (160.9)	584 (176.8)
Response: The appropriate screening and education is provided in Primary Care with referrals to our Addiction Medicine program and/or other treatment, as appropriate. We have capacity to accept more people seeking medication-assisted treatment (MAT) for opioid use disorder. Our access spans from Berlin to Randolph, to White River Junction. We actively market and try to reach those in the community seeking treatment to dispel any misconceptions that there are wait lists or many hurdles to overcome to obtain treatment.															

Table 2b: Vermont Department of Health Vital Statistics Data - Vermont deaths by county of residence (2017 – released 3/16/18)

Measure	Statewide (Rate/10,000) *(All-Payer Model Target)*	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Deaths related to drug overdose[4]	**122 (2.2)** *(115)*	1 (0.3)	4 (1.2)	8 (3.0)	34 (2.4)	0 (0.0)	12 (2.9)	1 (1.7)	3 (1.4)	7 (2.8)	2 (0.8)	11 (2.1)	12 (2.3)	17 (4.4)	10 (2.0)
Response: Gifford has enhanced its community outreach efforts to raise awareness in the last six months. We hosted a five-part Dose of Reality series at Chandler Center for the Arts and supported the LEAD program in area schools as well as the HELP program at Randolph Union High School. Screening and education are completed in Primary Care with referrals to Addiction Medicine and/or other treatment as appropriate. We are in the process of becoming a Narcan distribution site with support from the State of Vermont. We have capacity to accept more people seeking MAT for opioid use disorder.															

3. Vermont All-Payer Model Quality Measures by Hospital

Table 3: Vermont Uniform Hospital Discharge Data Set (VUHDDS) - Vermont Residents and Non-Residents Utilizing Services

Measure	Statewide Rate *(All-Payer Model Target)*	BMH	CVMC	CH	GMC	GCH	MAHHC	NCH	NMC	NVRH	PMC	RRMC	SVMC	SH	UVMMC
Rate of Growth in number of mental health and substance use-related ED visits[5]	**6%** *(3%)*	13%	0%	13%	-8%	-4%	-5%	-11%	14%	8%	-13%	9%	-11%	11%	10%

[3] The State of Vermont reports these rates for Hub and Spoke per 100,000. For consistency with the APM, counts and rates have been calculated per 10,000 using 2016 population estimates (ages 18-64).
[4] Rates calculated using 2016 population estimates (ages 14+).
[5] Shown as percent change from 2015-2016.

Table 4: Health Service Area/Hospital Crosswalk

Health Service Area	Hospital(s) located in HSA
Barre	Central Vermont Medical Center
Bennington	Southwestern Vermont Medical Center
Brattleboro	Brattleboro Memorial Hospital; Grace Cottage Hospital
Burlington	University of Vermont Medical Center
Middlebury	Porter Medical Center
Morrisville	Copley Hospital
Newport	North Country Hospital
Randolph	Gifford Medical Center
Springfield	Springfield Medical Center
St. Albans	Northwestern Medical Center
St. Johnsbury	Northeastern Vermont Regional Hospital
White River Junction	Mt. Ascutney Hospital and Health Center