**Appendix D – ACO Initiatives to Address All-Payer ACO Model Quality Measures**

| **Measure** | **Current ACO Activities Underway** | **Planned ACO Activities Underway** |
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| **Goal #1: Increase Access to Primary Care** | | |
| Percentage of adults with usual primary care provider | All of CHAC's FQHC participants are NQCA PCMH recognized. NCQA's PCMH 2014 standards require FQHCs to have practices in place to ensure that patients are assigned a PCP (see Standard 2A: The practice provides continuity of care for patients/families by: Assisting patients/families to select a personal clinician and documenting the selection in practice records; and monitoring the percentage of patient visits with selected clinician or team.) CHAC has also required that other participants (VNAs, and CMHCs) should have practices in places to ensure patients are assigned a PCP. | Plan outreach activities to connect with "attributed but not seen" patients. FQHCs will continue with activities that fulfill PCMH requirements related to PCP assignment. Promote best practices of VNAs, CMHCs, and Designated Agencies to ensure patients are properly assigned. |
| Medicare ACO composite of 5 questions on Getting Timely Care, Appointments and Information | Annually, CHAC completes the CAHPS survey as a condition of its contract with Medicare. The data from the survey are reviewed across the CHAC governance entities (Clinical Committee, Board, and the Consumer Advisory Panel) to identify set ACO-level goals and best practices. | Same activities planned for next year |
| Percentage of Medicaid adolescents with well-care visits | Not applicable. | Not applicable. |
| Percentage of Medicaid enrollees aligned with ACO | Not applicable. | Not applicable. |
| **Goal #2: Reduce Deaths Related to Suicide and Drug Overdose** | | |
| Deaths related to suicide | CHAC has implemented ACO-wide efforts that focus on depression screening that include questions related to suicide risk. Many of the CHAC participants are engaged in regional/local efforts as well including expanded use of the PHQ2/PHQ9 screenings. At least one CHAC participant is engaged in a Zero Suicide pilot. CHAC monitors these regional efforts and best practices and learnings are shared widely across the ACO. | Same activities planned for next year |
| Deaths related to drug overdose | None |  |
| Multi-Payer ACO initiation of alcohol and other drug dependence treatment | No data is available to conduct these activities. |  |
| Multi-Payer ACO engagement of alcohol and other drug dependence treatment | No data is available to conduct these activities. |  |
| Multi-Payer ACO 30-day follow-up after discharge from ED for mental health | No data is available to conduct these activities. |  |
| Multi-Payer ACO 30-day follow-up after discharge for alcohol or other drug dependence | No data is available to conduct these activities. |  |
| Number of mental health and substance abuse-related ED visits | No data is available to conduct these activities. |  |
| % of Vermont providers checking prescription drug monitoring program before prescribing opioids | CHAC complies with state law and facilitates the sharing of best practices at Clinical Committee | Same activities as previous year. |
| Multi-Payer ACO screening and follow-up for clinical depression and follow-up plan | CHAC institutes ACO-wide depression screening. Best practice clinical guidelines were developed and approved by the CHAC Clinical Committee. These practices have been deployed across the CHAC network, and beyond to the network of OneCare and HealthFirst providers. | Same activities as previous year. |
| #per 10,000 population ages 18-64 receiving medication assisted treatment (MAT) | None, activities here done at the practice level and linked with Blueprint activities. |  |
| **Goal #3: Reduce Prevalence and Morbidity of Chronic Disease (COPD, Hypertension, Diabetes)** | | |
| Statewide prevalence of chronic disease: COPD | CHAC has established standard clinical guidelines around Diabetes, Congestive Heart Failure, COPD, and Falls Prevention. In addition, CHAC practices support the integration of preventative screening (including annual HgA1c, B/P, and BMI screenings; and biannual screening for tobacco use). These screenings support the early identification of (and in some cases prevention of) hypertension, diabetes, and COPD. | Expand training and QI support. |
| Statewide prevalence of chronic disease: hypertension | See above | Expand training and QI support. |
| Statewide prevalence of chronic disease: diabetes | See above | Expand training and QI support. |
| Medicare ACO chronic disease composite: Diabetes HbA1c poor control; controlling high blood pressure; and all-cause unplanned admissions for patients with multiple chronic conditions | CHAC QI staff have encouraged the incorporation of best practice clinical guidelines, developed and approved by the CHAC Clinical Committee, into provider workflows. This effort has targeted all provider participants not just PCPs. CHAC worked with its participants to ensure they had incorporated at least one guideline into daily patient care. | No data is available to conduct these activities. |
| Percentage of VT residents receiving appropriate asthma medication management | No activities planned or in place |  |
| Multi-Payer ACO tobacco use assessment and cessation intervention | This is a CHAC ACO measure that is reviewed consistently. | Same activities as previous year. |