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

**Section 5**

**Attachment B**

| **Measure** | **Current ACO Activities Underway** | **Planned ACO Activities Underway** |
| --- | --- | --- |
| **Goal #1: Increase Access to Primary Care** |
| Percentage of adults with usual primary care provider | * Ensuring that all VMNG beneficiaries attributed to the program through specialists have a primary care provider identified. For beneficiaries with a PCP outside the VMNG network, we are working with local communities on workflows to ensure there is a community-based point of contact to facilitate connection to primary care
 | * Finalize community workflows and document expectations for quality measurement and care coordination through VMNG communities
* Plan for similar experiences as we expand to more risk-based contracts with specialist attribution in 2018
* Planning phase for primary care payment reform (i.e. AIPBP) that could enhance recruitment of primary care providers with more favorable/reliable reimbursement
 |
| Medicare ACO composite of 5 questions on Getting Timely Care, Appointments and Information | * Disseminate 2016 quality results (ACO and HSA-level) once they become available in late Summer 2017
* Plan and conduct at OCV Grand Rounds in June 2017 on the Medicare Wellness Visit, specifically new models such as use of RN
 | * Identify positive outliers and cull for best practices; disseminate to OCV network
* Ongoing quality improvement (QI) work in local HSAs and with specific practices to improve access and timeliness of care
 |
| Percentage of Medicaid adolescents with well-care visits | * Identified as a 2017 OCV clinical priority area under the category of preventive care
* Assessing best practices in communities through partnership between OCV and BP staff in local HSAs
* Actively partnering with VCHIP CHAMP team on a QI project to improve this pediatric measure; 22 OCV pediatric-serving practices actively participating in the monthly QI project including education/training and monthly measurement
* Regular discussion and report out at OCV Pediatrics Subcommittee on lessons learned from VCHIP’s national technical assistance work in this domain
 | * Preparing to run data reports for 22 practices in VCHIP CHAMP QI project (July 2017); developing a dissemination and wrap up plan with VCHIP
* Scheduled meeting with VDH MCH leadership and staff to discuss new innovations to improve on this measure (i.e. What are we learning nationally? Community-based strategies? Practice-based strategies?)
* Consider the impact of future primary care payment reform on improving well-child visit rates
 |
| Percentage of Medicaid enrollees aligned with ACO | * Developing payment models that are attractive to primary and specialty care providers that serve Medicaid beneficiaries
 | * Examining current attribution methodology and working collaboratively with DVHA to identify ways to improve the quality of the data and corresponding accuracy of attribution
 |
| **Goal #2: Reduce Deaths Related to Suicide and Drug Overdose** |
| Deaths related to suicide | * A number of HSAs (e.g. Burlington, Berlin, St. Albans) are exploring embedded behavioral health in primary care
* UVMMC is investigating new team-based care models that consider the unique provider availability, beneficiary risks, etc.
* OCV is working with State SBIRT team on next steps to recruit primary care practices to learn this model and deploy it in their sites
* OCV provided sponsorship to the June 5, 2017 5th Annual Suicide Prevention Conference
* Collaborating with DMH on two SAMHSA grant opportunities to increase resources and technical assistance in Vermont
 | * Explore opportunities for data sharing with DMH, DAs, and other community providers to improve identification of high-risk/high-needs individuals that could benefit from community-based care coordination
* Continue discussions with State SBIRT leadership on dissemination strategies
* OCV is planning a December Grand Rounds on mental health/suicide prevention available to anyone in our network
 |
| Deaths related to drug overdose | * Provider support for ongoing MAT efforts
 | * Same as above
* Educate network providers on new legislation and VPMS requirements
 |
| Multi-Payer ACO initiation of alcohol and other drug dependence treatment | * OCV working with Compliance Office on an information sharing/consent process for Care Navigator that will facilitate appropriate communication and coordination to support patient initiation and engagement
* OCV is forming a Primary Care Subcommittee that can serve as a vehicle to identify evidence-based best practices, test them, and spread them across the network
 | * OCV actively exploring partnership with DVHA, VDH, and BP on an IEP QI project
* OCV is planning a December Grand Rounds on mental health/suicide prevention available to anyone in our network
 |
| Multi-Payer ACO engagement of alcohol and other drug dependence treatment | * Same as above
 | * Same as above
 |
| Multi-Payer ACO 30-day follow-up after discharge from ED for mental health | * Same as above
* Initiated conversations in clinical governance committees about how to monitor this measure on a regular basis
 | * Same as above
 |
| Multi-Payer ACO 30-day follow-up after discharge for alcohol or other drug dependence | * Same as above
 | * Same as above
 |
| Number of mental health and substance abuse-related ED visits | * A number of HSAs (e.g. Burlington, Berlin, St. Albans) are exploring embedded behavioral health in primary care
 | * Promote SBIRT and embedded mental health in primary care models using a team-based approach to care delivery
 |
| % of Vermont providers checking prescription drug monitoring program before prescribing opioids | * Discussing Opioid Prescribing Project with Blueprint and VDH staff; disseminating toolkit in two HSAs
* Sharing best practices at All Field Team staff meetings to facilitate uptake in local HSAs
 | * Explore data sharing and tracking with VDH to provide timely performance monitoring data
* Plan educational sessions for providers in the OCV network around the change in law
 |
| Multi-Payer ACO screening and follow-up for clinical depression and follow-up plan | * Current ACO quality measure
* Disseminate results from 2016 quality measures scorecards; identify lessons learned and best practices
 | * Create and disseminate at Network Success Story if clear actions are identified that related to measurable improvements in care delivery.
 |
| #per 10,000 population ages 18-64 receiving medication assisted treatment (MAT) | * Educate providers on MAT resources
* Promote trainings for PCPs to become prescribers
 | * Explore a possible waiver with payers to support improved payment models for PCP prescribers
 |
| **Goal #3: Reduce Prevalence and Morbidity of Chronic Disease (COPD, Hypertension, Diabetes)** |
| Statewide prevalence of chronic disease: COPD | * Partner with VDH to support 3-4-50 campaign in local communities with emphasis on Vermont Quits resources and tools
 | * Educate care coordinators to run patient panels by disease state in Care Navigator to look for gaps in care and identify and prioritize outreach to specific populations with complex health needs
 |
| Statewide prevalence of chronic disease: Hypertension | * OCV is currently co-leading a formal QI Learning Collaborative to improve the NQF measure on controlling hypertension. LS1 is June 14, 2017. Ten practices and one home health and hospice agency are actively engaged in the project
* Researching evidence-based tools and resources for patients to build out a patient resource library on hypertension in Care Navigator
 | * Obtain community buy-in and agreement on common HTN patient education tools and resources
* Build HTN patient resource library in Care Navigator
* Explore future education and QI initiatives on pre-hypertension as part of our overall population health management strategy
 |
| Statewide prevalence of chronic disease: Diabetes | * Provider referrals to CHT self-management workshops and related resources
* Quality measurement data on BMI screening and follow-up
* Support the design of a RiseVT expansion plan to additional communities
 | * Explore future education and QI initiatives on pre-diabetes as part of our overall population health management strategy
 |
| Medicare ACO chronic disease composite: Diabetes HbA1c poor control; controlling high blood pressure; and all-cause unplanned admissions for patients with multiple chronic conditions | * See above
 | * See above
 |
| Percentage of VT residents receiving appropriate asthma medication management | * Providers are building protocols into their EMRs
 | * Dissemination of best practices and evidence-based protocols for asthma medication management
 |
| Multi-Payer ACO tobacco use assessment and cessation intervention | * Provider referrals to CHTs for counseling and support around tobacco cessation
* Partner with VDH to support 3-4-50 campaign in local communities with emphasis on Vermont Quits resources and tools
 | * Explore focused QI activities through OCV’s newly forming Primary Care Subcommittee
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