OneCare Vermont

**OneCare Vermont 2020 Clinical Focus Areas**

The OneCare Vermont 2020 Clinical Focus Areas were approved at the February 18, 2020 meeting of the Board of Managers. The process leading to this decision involved extensive outreach to our participant network in the form of an open ended survey solicitation of ideas and vetting of these ideas by the Office of the CMO, the OneCare Analytic Department, OneCare Management, the Clinical and Quality Advisory Committee, and the Board Population Health Strategy Committee. While OneCare Vermont remains committed to maximizing network performance on an array of payer determined quality measures for Medicare, Vermont Medicaid, and our commercial payer partners, the Board wished to focus special attention on a short list of clinical focus areas. The chosen topics met the criteria of clinical relevance, evidence based care, sufficient variation between hospital service areas to reasonably expect likelihood of success, that success would be dependent on improved performance by a wide variety of network care roles and organizations, applicability to multiple payer programs, and adequate data sources. All areas are linked to OneCare Vermont's Complex Care Coordination model intervention to achieve success. OneCare Vermont also reports to the network on a wide variety of cost and utilization metrics that are in addition to our quality measures and these clinical focus areas.

1. **Reducing 30-Day All Cause Inpatient Readmissions –** The rationale for reductions in 30-day readmissions includes improved patient experience of care, improved coordination of care with hospital discharge transitions, and total cost of care reductions. Strategies include improving the timing, quality, and communication of hospital discharge plans, timely post discharge follow-up care by both primary and specialty care, improving care continuity and supports in skilled nursing facilities and home health to reduce needs for emergency department evaluations of clinical deterioration in those settings, improved engagement with mental health services and other supportive community services, and possible root cause analysis of a sample of readmissions at each hospital. A reduction target of 5% was set for the network for each payer and each health service area.
2. **Reducing Emergency Department Utilization –** While emergency department utilization per se is not included for any payer in our quality measure reporting, successful reductions in emergency department use is likely to reduce hospital admissions for so called ambulatory sensitive conditions (asthma, COPD, heart failure), encourage growth of primary care access, reduce costs, and improve coordination of care for high emergency department utilizing patients. The OneCare Complex Care Coordination model targets high and very high risk patients to reduce the likelihood that such patients will seek emergency department services for unmet clinical, mental health and social needs. Emergency departments will be encouraged to establish treatment plans for their frequent visit patients in concert with ambulatory medical and community support services. A 5% reduction target was established for the network by payer and by health service area.

The third and fourth clinical focus areas reflect a desire to promote the ability of our participant network to query their respective electronic medical records for clinical values in a real time payer agnostic manner. Historically, quality measures based on clinical measurements (blood pressure) or laboratory values (hemoglobin A1C) have been dependent on manual chart abstraction typically after the performance year and for a small statistical sample of payer provided patients. While Vermont's health information exchange is making progress on having sufficient data feeds from hospitals and practices to accomplish such queries, the OneCare network will be asked to allocate IT resources to report on these measures quarterly beginning at the end of Q2. Practitioners around the state report that the care of attributed ACO patients is accomplished in

the same manner as unattributed patients and also not dependent on payer source so the performance on these two measures will be irrespective of attribution or payer. Since the values will be of a mixed payer nature, HEDIS or other benchmarking standards will not apply. Quarterly trended results will allow each practice to determine if they are improving their performance and whether the aggregate network trends are favorable. Over time, nationally, as many organizations are having their financial payments linked to quality measurement, a successful ACO must continually improve performance to even maintain their percentile rankings against benchmarks. The OneCare Vermont clinical and analytic team will work with practices and their Blueprint practice facilitators to assist with EMR queries and sharing of best practices by top performers. Additionally, since OneCare Vermont's current Value Based Incentive Fund policy is dependent on quality measure performance, these two measures represent a way to improve our overall quality score and maximize the return of these dollars to the network.

3. **Blood Pressure in Control (NQF 0018) -** OneCare Vermont's 2018 historical performance on this measure was in the 50$^{th}$ percentile range for multiple payers. While there are mitigating factors in the measure definition that make performance challenging (ex. inability to include in-control home blood pressure readings, variation in national guidelines as to control parameters for different age groups) there is little doubt of the importance of blood pressure control for reducing morbidity and mortality from stroke, cardiovascular disease, and chronic kidney disease and impact on the total cost of care. It is felt that regular measurement of blood pressure in control will enhance practice efforts to focus attention on behavioral, dietary, and medication interventions.

4. **Diabetes Hemoglobin A1C Poor Control (NQF 0059) –** While OneCare Vermont's 2018 performance on this measure by payer was variable (50$^{th}$ to 90$^{th}$ percentile) diabetes represents such an important chronic disease with multiple comorbid complications that selection of this area was logical. Improved care of diabetes will rely on OneCare Vermont's complex care coordination model, primary and secondary prevention initiatives by Rise Vermont, and self-care programs such as the CDC Diabetes Prevention Program. Improved referral communication and coordination of care between primary care and endocrinology, diabetes educators, home health and skilled nursing facilities will be enhanced as improvement strategies.

- **Please Note: The COVID19 pandemic has occurred since the Board endorsed these clinical focus areas. Stresses on the delivery system and drastic changes in the historical ways in which care has been delivered (face to face visits evolving to telemedicine/telephone care, reduced access to laboratory monitoring testing, reliance on home vital signs, distortions in benchmarking data owing to pandemic driven delays of deferrable care, etc.) will make our efforts more difficult. OneCare is committed to continuing our attention to quality improvement while continuing to focus first on the needs of helping the providers on the front lines dealing with the pandemic.**