

EXECUTIVE SUMMARY

The *Change Packages* were originally created as part of Vermont's health system innovation work to reduce cost, to ensure quality of care, and to improve health outcomes. Increasingly, health care system partners are being pressed to shift from practices that focus on care for individuals to practices, systems, and structures that focus on the improvement of population health.

To be successful, this shift will require greater understanding of the determinants of health outcomes beyond health care: behaviors; social and economic factors; and the physical environment, and consideration of new ways of practicing that recognize the influence of these determinants.

How to Use The Prevention Change Packages

The *Change Packages* are intended to provide users with suggested evidence-based and best practices to address the social determinants of health and increase prevention. The *Change Packages* provide practical guidance and examples of strategies by which practitioners in different parts of the healthcare system can work in ways that recognize the influence of factors that determine health outcomes as well as the social determinants of health such as education, poverty, race and gender.

The primary audience for these *Change Packages* are members of Accountable Communities for Health and Regional Teams composed of ACO, Blueprint, health department and community partners working together to improve population health. The secondary audiences include organizations or other entities responsible for developing guidance and practice standards (e.g. state administrators, insurers).

The *Change Packages* are organized by health topic and the measures of accountability for Vermont's Accountable Care Organizations (ACOs) as these are an essential component in Vermont's health care system reforms supported by the Vermont Health Care Innovation Project (VHCIP). **(See Appendix X)**. The *Change Packages* recommend action across all partners in the health system, working toward the same goals, using best practices in three different domains to incorporate prevention activities and improve population health outcomes.

The *Change Packages* use the *Prevention Framework* developed by the Centers for Medicaid and Medicare Innovation and the Centers for Disease Control and Prevention¹. The Framework outlines three domains of action:

Traditional Clinical Approaches include increasing the use of prevention and screening activities routinely conducted by clinical providers. Examples include: annual influenza vaccination, use of aspirin for those at increased risk of a cardiovascular event, screening for tobacco use, screening for substance abuse, and screening for domestic or other violence.

Innovative Patient-Centered Care and/or Community Linkages include innovative, evidence-based strategies offered within the community that are not typically leveraged by health care systems under fee for service payment models. Examples include: community-based preventative services, health education to promote health literacy and patient self-management. In Vermont, this also includes actions to integrate care (physical, mental health, substance use) and connect individuals to necessary social services.

¹ Three Buckets of Prevention, J Auerbach, J Public Health Management Practice, 2016, 00(00), 1–4 Copyright C _ 2016 Wolters Kluwer Health, Inc. All rights reserved.

Community-Wide Strategies include specific system-wide action steps demonstrating an investment in total population health. Examples include: funding for worksite wellness, passing legislation that addresses public health issues (i.e., smoking bans in bars and restaurants), providing healthier food options at state-operated venues and public schools.

As Community Collaboratives and Accountable Communities for Health evolve, partners can use the Change Packages to identify actions in each of the three domains that can be carried out by appropriate partners, working simultaneously to improve population health in their own domain of influence.

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Clinical & Community Strategies to Improve Adolescent Well-Care Visits

The following table highlights evidence-based strategies to improve adolescent well-care visit rates in clinical and community settings.

ACO Measure: Core-2 (NCQA HEDIS): Adolescent Well-Care Visit (AWCV)

The percentage of attributed individuals 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Increase insurance access</p> <ul style="list-style-type: none"> Promote use of Vermont Health Connect resources including website, phone number, and local navigators, brokers, and certified application counselors Assist adolescents and families to understand insurance benefits and address perceived barriers to care (e.g., AWCV frequency, EOB descriptions, etc.) <p>Adopt current <i>Bright Futures</i> guidelines for health supervision</p> <ul style="list-style-type: none"> Adopt <i>Bright Futures</i> core tools (i.e. pre-visit questionnaires, documentation, education handouts) Educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits Adopt evidence-based screening tools Ensure all practice staff are aware of annual recommendations (including systems for scheduling and reminder-recall) <p>Provide adolescent-centered and informed care Ensure the physical space is welcoming and age-appropriate for adolescents</p> <ul style="list-style-type: none"> Provide training and tools to ensure all practitioners are adolescent-friendly 	<p>Use mobile devices, e-mail, and social networking sites to promote prevention education and services; new media vehicles offer low-cost avenues to develop and distribute tailored health care messages</p> <ul style="list-style-type: none"> Use social networking to reach adolescents and caregivers Use texting to reach adolescents and caregivers <p>Develop partnerships with key community stakeholders</p> <ul style="list-style-type: none"> Work with school-based and community health centers Work with partners to explore alternate funding sources Partner with Title V (maternal and child health) agencies Engage key community stakeholders Pediatric and Family practice providers can establish relationships to assist with transition of care from adolescence into young adulthood Partner with the Health Department/ Office of Local Health designees and leadership Review local <i>Youth Risk Behavior Survey</i> data to understand current risk behaviors. Partner with School Nurses to ensure all students are receiving AWCVs, and improve 	<p>Office of Local Health designees, Agency of Human Services departments, ACOs, and healthcare quality improvement focused organizations should make state-adopted periodicity schedules well known to all clinical and community providers (<i>Bright Futures</i> is Vermont’s EPSDT periodicity schedule)</p> <p>Providers and community partners (such as the Office of Local Health, schools, designated agencies, etc.) should educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits</p> <p>Providers and community partners should encourage their local schools to ask that sports physicals be completed during, or within a reasonable timeframe (as determined by the provider) of a recent AWCV</p> <p>Athletic directors and coaches can remind parents and caregivers that sports physicals should not replace recommended AWCVs</p>

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<ul style="list-style-type: none"> • Use or create adolescent-friendly materials; test materials with adolescents • Consider strategies to ensure continuity of provider care • Communicate the confidential nature of visits and EOB/billing to adolescents and parents/caregivers, and ensure private consultation time with patients • Expand or tailor office hours to fit adolescent lives (i.e. school, sports, and work) • Hold specific slots for AWCVs • Consider ways to evaluate satisfaction with care, privacy and confidentiality <p>Improve quality of adolescent care</p> <ul style="list-style-type: none"> • Ensure providers are well-trained to understand adolescent needs • Ensure providers and office staff adopt the <i>Bright Futures</i> guidelines • Adopt the use of a strengths-based approach as described in <i>Bright Futures</i> <p>Leverage missed opportunities to increase well-care visits</p> <ul style="list-style-type: none"> • Maximize other patient encounter opportunities to schedule AWCVs (e.g. episodic, acute care, sports physicals, sexual health services, immunizations) <p>Inform caregivers on the importance of AWCVs</p>	<p>communication between schools and provider offices</p> <ul style="list-style-type: none"> • Partner with supervisory union or school district's Whole School, Whole Community, Whole Child wellness teams 	

Resources

Bright Futures Guidelines: brightfutures.aap.org/Pages/default.aspx

Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits

[medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Paving-the-Road-to-Good-Health.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Paving-the-Road-to-Good-Health.pdf)

National Adolescent and Young Adult Health Information Center: <http://nahic.ucsf.edu/>

Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up

The following table highlights evidence-based strategies to improve adult BMI screening rates and follow up in clinical and community settings.

ACO Measure: Core-20: Adult Weight Screening and Follow-Up

Screen for obesity in adults 18 years or older. Patients with body mass index (BMI) of 30 or higher should be offered or referred to intensive, multicomponent behavioral interventions. Those with BMI of 25-30 should also be referred for nutrition and physical activity interventions.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Screen all adults for overweight or obesity.</p> <ul style="list-style-type: none"> • Calculate BMI using BMI calculator (available online) • Use motivational interviewing (http://motivationalinterviewing.org/) to discuss BMI findings with patient <p>For obese patients: Intensive, multicomponent behavioral interventions include the following:</p> <ul style="list-style-type: none"> • Behavioral management activities, such as setting weight-loss goals • Improving diet or nutrition and increasing physical activity • Addressing barriers to change • Self-monitoring • Strategizing about how to maintain a lifestyle change <p>For overweight patients: Learn about current diet and physical activity patterns and counsel on changes to encourage weight loss</p> <ul style="list-style-type: none"> • Offer nutrition counseling to increase the daily recommended servings of fruits and vegetables. • Screen for physical activity habits and offer 	<p>Use Motivational Interviewing: Providers should be trained in these techniques to best assist patients.</p> <p>Provide referrals to community-based YMCA Diabetes Prevention Programs or one of the other self-management programs: (http://myhealthyvt.org/)</p> <p>Adopt technology-supported multicomponent coaching or counseling interventions intended to reduce weight such as:</p> <ul style="list-style-type: none"> • apps to track food intake and physical activity • supportive texts • one-to-one counseling • tracking of food intake and physical activity. (http://www.thecommunityguide.org/obesity/TechnologicalCoaching.html) <p>Create or refer patients to social support interventions in community settings:</p> <ul style="list-style-type: none"> • Weight Watchers • Curves • TOPS (Taking off Pounds Sensibly) <p>Distribute fruit and vegetable prescriptions to encourage patients to eat more fruits and vegetables.</p>	<p>Support Healthy Community Design and food access projects that support physical activity and healthy eating.</p> <p>Promote increased healthy eating and physical activity option in worksites including:</p> <ul style="list-style-type: none"> • Use the Vermont Department of Health’s “Creating a Healthier Workplace” resource (http://www.healthvermont.gov/wellness/physical-activity-nutrition/worksites) to implement policies such as: • health insurance coverage with no or low out-of-pocket costs for medications • Healthy Food policies for meetings • Increased healthy eating and physical activity options at worksites • Worksite gardens • Flex time for physical activity • Paid time off for preventive screening • Healthy food incentives (Smoothie day, veggie platter) • Aim for at least 30% healthy items in vending machines • Include healthy choices at snack bars, cafeterias and events

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>counseling to maintain or improve habits</p> <p>For patients at a healthy weight: Learn about current diet and physical activity patterns and encourage continuation.</p>	<p>Provide park prescriptions encourage patients to be more physically active. For more information see http://vermontfitness.org/exercise-is-medicine/</p> <p>Offer gym memberships through the Ladies First program that provides funding for lifestyle programs and gym memberships to women meeting income thresholds http://ladiesfirst.vermont.gov/</p> <p>Arrange for health coaching that will continue the conversation with patients and encourage them to take the taking next steps to healthy eating and increasing physical activity.</p>	<p>Encourage increased availability of healthy foods and beverages at public service venues and in vending machines.</p> <p>Support primary prevention activities aimed at children and youth to build healthy habits in physical activity and food choices.</p>

Resources

- US Preventive Services Task Force: <http://www.uspreventiveservicestaskforce.org>
- The Community Guide to Preventive Services: <http://www.thecommunityguide.org/index.html>
- Vermont Department of Health: 3-4-50: <http://www.healthvermont.gov/3-4-50>

Clinical & Community Strategies to Improve Respiratory Care

The following table highlights evidence-based strategies to improve respiratory care in clinical and community settings.

ACO Measure: Core-10: Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults

ACO Measure: Core-12 Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<ul style="list-style-type: none"> Identify and utilize a reimbursement code(s) for clinic-based education visits delivered by the AE-C or another qualified provider Refer from the emergency room poorly managed, high utilizers to Vermont Chronic Care Initiative¹ for asthma case management; Rutland Regional Medical Center and Northwestern Medical Center among others do this using social worker referral system to VCCI Screen for tobacco use and provide referral and/or treatment for individuals with asthma using electronic health record for tracking tobacco status and clinical treatment, provide brief or intermediate cessation counseling² or fax/electronically refer to 802Quits³ which includes phone and local in-person group services Provide influenza and PCV-23 vaccines Identify a health care professional in medical home who is certified as an asthma educator (AE-C) Develop an asthma action plan⁴ in partnership with patient/family Assess asthma control to determine if therapy should be adjusted, assessing at each visit: asthma control, proper medication technique, written asthma action plan, patient adherence, patient concerns. Obtain lung function measures by spirometry at least every 1–2 years; more frequently for 	<p>Include AE-Cs as part of clinical and/or community health teams</p> <p>Seek reimbursement for providing asthma education in clinic including from a certified asthma educator (preventive counseling, health risk assessments, pulmonary diagnostic testing, spirometries)</p> <p>Deliver asthma education through a follow up phone call within three days following an Emergency Department discharge to reduce readmissions using the MAPLE Plan⁵</p> <p>Promote tobacco cessation resources targeted at people with asthma through community health teams, SASH case management, etc.</p> <p>Use the electronic referral system One Touch⁶ with home visiting programs to link individuals with energy, health, and other social programs.</p> <p>Follow Asthma Guidelines and adjust treatment to National Asthma Guidelines Expert Panel Review 3⁷.</p> <p>Follow and adjust therapies per national Guidelines- GOLD standards</p> <p>See Clinical & Community Strategies to Reduce Tobacco Use</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up to support community fitness and weight loss</p>	<p>See Clinical & Community Strategies to Reduce Tobacco Use by promoting tobacco free campuses, schools, hospitals, pharmacies, multi-unit housing, and worksites</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up for worksite wellness and physical activity recommendations</p> <p>Enforce anti-idling laws</p> <p>Promote worksite wellness and school indoor air quality (IAQ) through the Envision Program⁹ such as integrated pest management and ventilation inspection</p> <p>Use green cleaning products¹⁰ in daycares/schools</p> <p>Support Better Breather support groups through American Lung Association of Vermont</p> <p>Support and refer patients to Hospital Based Pulmonary Rehabilitation programs</p> <p>Transition Bus Fleets to Clean Diesel Technology¹¹:</p> <ul style="list-style-type: none"> Under these transition programs, fleets of diesel buses are retrofitted to operate using clean diesel technology. The body of scientific evidence demonstrates that these reductions have been associated with reduced adverse cardiovascular events, and have resulted in reduced respiratory conditions including asthma, and improved lung function among children.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>asthma that is not well controlled. Determine if therapy should be adjusted: Maintain treatment; step up, if needed; step down, if possible.</p> <ul style="list-style-type: none"> • Select medication and delivery devices that meet patient’s needs and circumstances. Use stepwise approach to identify treatment options • Review medications, technique, and adherence at each follow-up visit. • Recommend ways to control exposures to allergens, irritants, and pollutants that make asthma worse <p>Follow guideline based care for COPD patient</p>	<p>Motivational Interviewing: (http://motivationalinterviewing.org/)</p> <ul style="list-style-type: none"> • Providers should be trained in these techniques to best assist patients. <p>Home Improvement Loans and Grants⁸:</p> <ul style="list-style-type: none"> • These interventions provide funding to families to repair and improve their homes. For example, funds may cover weatherization to improve insulation, air quality, dampness, and energy conservation, as well as remove health or safety hazards from their homes. The evidence demonstrates that these interventions have been associated with improving resident’s general health and in reducing asthma symptoms and non-asthma related respiratory problems. 	

References:

State Asthma Action Plan: <http://www.healthvermont.gov/hv2020/ship.aspx>

¹ <http://dvha.vermont.gov/for-providers/vermont-chronic-care-initiative-vcci>

² <http://802quits.org/providers/webinars-2/>

³ http://802quits.org/wordpress/wp-content/uploads/2015/05/STVDH6381_TCP_NRT-Offerings.pdf

⁴ <http://healthvermont.gov/prevent/asthma/tools.aspx>

⁵ http://healthvermont.gov/prevent/asthma/documents/controlling_asthma_maple_plan.pdf

⁶ <http://onetouchhousing.com/locations/vermont/>

⁷ <http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines>

⁸ <http://www.countyhealthrankings.org/policies/housing-rehabilitation-loan-grant-programs>

⁹ <http://www.healthvermont.gov/enviro/envision.aspx>

¹⁰ http://healthvermont.gov/enviro/envision/documents/green_clean_basics.pdf

¹¹ <http://www.countyhealthrankings.org/policies/clean-diesel-technology-fleet-transition-programs>

Clinical & Community Strategies to Improve Outpatient Antibiotic Prescribing

The following table highlights evidence-based strategies and best practices to improve outpatient antibiotic prescribing in clinical and community settings.

ACO Measures:

Core-6: Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Core-13: Appropriate Testing for Children with Pharyngitis

The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Provider education & training</p> <ul style="list-style-type: none"> Offer clinician education (interactive educational meetings may be more effective than didactic lectures) Conduct audit and performance feedback¹ Arrange for peer group academic detailing to reinforce or change prescribing behavior² <p>Provider tools</p> <ul style="list-style-type: none"> Invest in clinical decision support tools to facilitate accurate diagnoses and treatment³ 	<p>Patient education & tools</p> <ul style="list-style-type: none"> Provide printed educational materials in the provider office Use prescription bag insert educational materials to enhance adherence Display appropriate antibiotic use posters in the clinical setting to educate patients, to reduce patient expectations for an antibiotic, and to demonstrate clinician commitment to judicious prescribing³ <p>Care planning⁵</p> <ul style="list-style-type: none"> Use delayed prescriptions when antibiotics are not immediately indicated Write post-dated prescription Re-contact patient after clinic visit Give verbal order to fill prescription after a predetermined length of time if symptoms do not improve Consider alternative management strategy if symptoms worsen after 48–72 hours of initial empiric antimicrobial therapy or fail to improve despite 3–5 days of initial empiric antimicrobial therapy 	<p>Public education</p> <ul style="list-style-type: none"> Educate the public through a variety of venues and formats, including social media, on the importance of appropriate antibiotic use <p>Improvements to the system of care</p> <ul style="list-style-type: none"> Integrate clinical decision support with electronic medical records⁶ <p>Establish retail clinics, which appear to provide care equal in quality to traditional clinics⁷</p>

Resources

CDC's Get Smart: Know When Antibiotics Work program: <http://www.cdc.gov/getsmart/community/improving-prescribing/interventions/index.html>

Agency for Healthcare Research and Quality's National Guideline Clearinghouse: <https://guideline.gov/>

County Health Rankings and Roadmaps: <http://www.countyhealthrankings.org/roadmaps/what-works-for-health>

¹ Gerber JS, et al. Effect of an outpatient antimicrobial stewardship intervention on broad-spectrum antibiotic prescribing by primary care pediatricians: A randomized trial. *JAMA*. 2013; 309(22): 2345-52.

² Vinnard C, et al. Effectiveness of interventions in reducing antibiotic use for upper respiratory infections in ambulatory care practices. *Popul Health Manag*, 2013; 16(1):22-7.

³ Gonzales R, et al. A cluster randomized trial of decision support strategies for reducing antibiotic use in acute bronchitis. *JAMA Intern Med*. 2013; 173(4):267-73.

⁴ Meeker D, et al. Nudging guideline-concordant antibiotic prescribing: A randomized clinical trial. *JAMA Intern Med*. 2014; 174(3):425-31.

⁵ Little P, et al. Delayed antibiotic prescribing strategies for respiratory tract infections in primary care: Pragmatic, factorial, randomised controlled trial. *BMJ*. 2014; 348:g1606.

⁶ McGinn TG, et al. Efficacy of an evidence-based clinical decision support in primary care practices: A randomized clinical trial. *JAMA Intern Med*. 2013; 173(17):1584-11.

⁷ Mehrotra A, et al. The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings. *Ann Intern Med*. 2009 September 1; 151(5): 321–328.

Clinical & Community Strategies to Improve Breast Cancer Screening Rates

The following table highlights evidence-based strategies and best practices to improve breast cancer screening rates in clinical and community settings.

ACO Measure: ACO Measure: Core-11 (NCQA HEDIS): Breast Cancer Screening

Description: The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Educate provider, staff and billing on screening guidelines and methods.</p> <p>Adopt algorithms/critical pathways/prompts</p> <p>Provide access and coordination with appropriate specialists</p> <p>Use patient reminder systems:*</p> <ul style="list-style-type: none"> Written materials (e.g. letters, postcards, and emails) or telephone messages (including automated messages) advising people they are due for screening. Flowsheets, risk lists, tracking refused or lost to follow-up. <p>Provider assessment and feedback:*</p> <ul style="list-style-type: none"> Evaluate provider performance in delivering or offering screening. Supply providers with their performance information group/individual. Compare group or individual provider with a goal or standard i.e. HEDIS 90th percentile. Provide reminder and recall systems. Provide off-hours coverage. <p>Same-day or next-day access.</p> <ul style="list-style-type: none"> Appointments with a personal clinician. 	<p>Use Patient-Centered Personal Health Portal:</p> <ul style="list-style-type: none"> Information tailored to patient individual risk factors (e.g. age, gender, comorbidities, prior testing, family history, health behaviors) and presented in understandable language. <ul style="list-style-type: none"> Secure email with MDs Medical record access Appointments Discussion groups & health promotion info/factsheets Personalized prescription for health <p>Connect with <i>Ladies First</i> and community support programs to help patients receive breast cancer risk assessment, screening, diagnostics and treatment.</p> <p>Use social media and social networking sites to promote breast cancer screening services and education</p> <p>Use <i>Ladies First</i> member and provider websites to educate about breast cancer screening.</p> <p>Provide transportation to screenings for women with limited incomes</p>	<p>Establish policies that increase access to screening:</p> <ul style="list-style-type: none"> Education regarding full coverage of screening per ACA. Worksite policies that promote appropriate screening: <ul style="list-style-type: none"> Educate about need Onsite events Reminders – postcards, birthday cards, incentives Flex time for screening Supportive health benefits <p>Educate to increase awareness and screening uptake:</p> <ul style="list-style-type: none"> One-on-one education* Small media: <ul style="list-style-type: none"> Printed materials (e.g., pamphlets, fact sheets), social media or videos that provide information or motivational messages about screening. Information/motivational screening messages delivered in person/by text or telephone to individuals (by healthcare or trained lay people). Group education* <ul style="list-style-type: none"> Information or encouragement about screening delivered to a group (by health

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<ul style="list-style-type: none"> • Ability to have clinical questions answered by phone. • Electronic access to providers and services. • Helping vulnerable patients access care. • Child care services. • Interpreter services. <p>Establish and improve surveillance systems to track screening, diagnostics and referral to treatment.</p> <p>Use data to drive informed decision making about what works to improve and increase screening.</p>		<p>care professionals or trained lay people)</p> <p>Professional group standards and accreditation.</p> <p>See Clinical & Community Strategies to Reduce Tobacco Use.</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up.</p>

* Strategy recommended by *Guide to Community Preventive Services*

Resources:

Guide to Community Preventive Services: <http://www.thecommunityguide.org/cancer/screening/provider-oriented/index.html>

New Directions for Cancer Screening: www.cdc.gov/cancer/nbccedp/pdf/newdirections_screening.pdf

Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network with Evidence-based Tools): <http://cancercontrolplanet.cancer.gov/>

Research to Reality: <https://researchtoreality.cancer.gov/home>

The National Cancer Institute's Using What Works: http://cancercontrol.cancer.gov/use_what_works/start.htm

Community-Centered Health Homes: Bridging the Gap Between Health Services and Community Prevention: www.preventioninstitute.org/component/jlibrary/article/id-298/127.html

Clinical & Community Strategies to Improve Cervical Cancer Screening Rates

The following table highlights evidence-based strategies and best practices to improve cervical cancer screening rates in clinical and community settings.

ACO Measure: Core-30 (NCQA HEDIS): Cervical Cancer Screening

Description: The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/ HPV co-testing every 5 years.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Implement patient reminder systems: *</p> <ul style="list-style-type: none"> • Written materials (e.g. letters, postcards, and emails) or telephone messages (including automated messages) advising people they are due for screening. • Flowsheets, risk lists, tracking refused or lost to follow-up. <p>Provide provider assessment and feedback: *</p> <ul style="list-style-type: none"> • Evaluate provider performance in delivering or offering screening. • Supply providers with their performance information group/individual. • Compare group or individual provider with a goal or standard (i.e. HEDIS 90th percentile). <p>Use provider reminder and recall systems. *</p> <p>Establish and improve surveillance systems to track screening, diagnostics and referral to treatment.</p> <p>Educate provider, staff and billing on screening guidelines and methods.</p> <p>Adopt algorithms/critical pathways/prompts.</p> <p>Provide access and coordination with specialist.</p>	<p>Use Patient-Centered Personal Health Portal:</p> <ul style="list-style-type: none"> • Information tailored to their individual risk factors (e.g. age, gender, comorbidities, prior testing, family history, health behaviors) and presented in understandable language. <p>Secure email with MDs.</p> <p>Provide access to medical appointments.</p> <p>Offer discussion groups & health promotion information/factsheets.</p> <p>Provide personalized prescription for health.</p> <p>Connect with <i>Ladies First</i> and community support programs to help patients receive cervical cancer risk assessment, screening, diagnostics and treatment.</p> <p>Use social media and social networking sites to promote cervical cancer screening services, vaccines and education.</p> <p>Use <i>Ladies First</i> member and provider websites to educate about cervical cancer screening.</p> <p>Provide transportation to screenings for low income women.</p>	<p>Educate to increase awareness and screening uptake:</p> <ul style="list-style-type: none"> • Small media: * <ul style="list-style-type: none"> • Printed materials (e.g., pamphlets, fact sheets), social media or videos that provide information or motivational messages about screening. • One-on-one education: * <ul style="list-style-type: none"> • Information/motivational screening messages delivered in person/ by text, telephone to individuals (by healthcare or trained lay people). • Group education: * <ul style="list-style-type: none"> • Information or encouragement about screening delivered to a group (by health care professionals or trained lay people). <p>Professional group standards and accreditation.</p> <p>Establish policies that increase access to screening:</p> <ul style="list-style-type: none"> • Worksite policies that promote appropriate screening: <ul style="list-style-type: none"> o Onsite events o Reminders – postcards, birthday cards o Incentives o Flex time for appointments o Supportive Health Benefits

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Use data to drive informed decision making about what works to improve and increase screening.</p> <p>For prevention of cervical cancer, offer patient education by provider about the benefits of HPV vaccination.</p>		<p>For prevention of cervical cancer, create media campaigns for parents to explain benefits of HPV vaccination and promote uptake among preteen boys and girls ages 11 or 12.</p> <p>Offer free vaccines at local health departments, medical clinics, community colleges, outdoor festivals, stores, and businesses.</p> <p>See Clinical & Community Strategies to Reduce Tobacco Use.</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up.</p>

*Strategy recommended by *Guide to Community Preventive Services*

Resources

New Directions for Cancer Screening: www.cdc.gov/cancer/nbccedp/pdf/newdirections_screening.pdf

The Guide to Community Preventive Services: www.thecommunityguide.org/

Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network with Evidence-based Tools): <http://cancercontrolplanet.cancer.gov/>

Research to Reality: <https://researchtoreality.cancer.gov/home>

The National Cancer Institute's Using What Works: http://cancercontrol.cancer.gov/use_what_works/start.htm

Community-Centered Health Homes: Bridging the Gap Between Health Services and Community Prevention: www.preventioninstitute.org/component/jlibrary/article/id-298/127.htm

Clinical & Community Strategies to Improve Childhood Immunization Rates

The following table highlights evidence-based strategies and best practices to improve childhood immunization rates in clinical and community settings.

ACO Measure: Core-14 (NCQA HEDIS; NQF #0038):

Childhood Immunization Status (Combo 10) The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Ensure vaccine access</p> <ul style="list-style-type: none"> Enroll in the Health Department's Vaccines for Children (VFC) Program <p>Provide patient education & tools</p> <ul style="list-style-type: none"> Increase parental education on vaccine safety and efficacy Provide informational materials customized for specific audiences Direct patients/parents to reputable sources for information about vaccines <p>Protocols</p> <ul style="list-style-type: none"> Provide standing orders to authorize nurses, pharmacists, and other healthcare personnel allowed by state law to assess a patient's immunization status and administer vaccinations according to a protocol approved by an institution, physician, or other authorized provider without the need for examination or direct order from the attending provider at the time of the interaction. 	<p>Parent/Family resources</p> <ul style="list-style-type: none"> Reduce patient/parent out-of-pocket costs by enrolling in the Vermont VFC Program that provides all CDC-recommended vaccines at no cost for use in all patients. <p>Partnership building/referral resources</p> <ul style="list-style-type: none"> Assess client immunization status in WIC settings and refer to vaccination providers combined with: <ul style="list-style-type: none"> Provision of vaccinations on-site or in a collocated healthcare facility, or Additional interventions such as monthly voucher pickup requirements, manual tracking and outreach, or client reminder and recall systems. <p>Provide on-site vaccination programs in schools or child care centers. These programs include two or more of the following components:</p> <ul style="list-style-type: none"> Immunization education and promotion Assessment and tracking of vaccination status Referral of under-immunized school or child care center attendees to vaccination providers 	<p>Immunization requirements</p> <ul style="list-style-type: none"> Support immunization requirements requiring vaccinations or other documentation of immunity as a condition of child care, school, and college attendance. <p>Improvements to the system of care</p> <ul style="list-style-type: none"> Use aggregate data from the Immunization Registry in surveillance and program operations, and in guiding public health action with the goals of improving vaccination rates and reducing vaccine-preventable disease. <p>Immunization registry</p> <ul style="list-style-type: none"> Implement broad use of the Immunization Registry (e.g., medical homes, childcare, schools) Disseminate population-level registry reports to inform community-wide decision making Expand capacity to import data electronically into the registry <p>Health reform</p> <ul style="list-style-type: none"> Maintain universal vaccine purchase with health insurer funding as coordinated by the Immunization Funding Advisory Committee.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Documentation and tracking</p> <ul style="list-style-type: none"> • Use the Immunization Registry to document all vaccinations and to determine appropriate vaccinations. • Use patient/parent reminder recall systems to remind members of a target population that vaccinations are due (reminders) or late (recall). • Send provider reminders, such as alerts in electronic medical records, to inform those who administer vaccinations that individual patients are due for specific vaccinations. <p>Quality improvement</p> <ul style="list-style-type: none"> • Use AFIX to evaluate provider performance in delivering one or more vaccinations to a client population (assessment) and present providers with information about their performance (feedback). • Participate in quality improvement initiatives of the Health Department, VCHIP, AAP, AAFP, etc. 		<ul style="list-style-type: none"> • Provide new or expanded insurance coverage, or lower or eliminate patient/parent out-of-pocket expenses at the point-of-service (e.g., copayments, coinsurances, and deductibles).

Resources

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/vaccines/index.html>

CDC Vaccines for Children (VFC) Program: <http://www.cdc.gov/vaccines/programs/vfc/index.html>

Vermont Department of Health Immunization Program: <http://www.healthvermont.gov/disease-control/immunization>

It's OK to Ask <http://oktoaskvt.org/>

Vermont Child Health Improvement Program: <https://www.uvm.edu/medicine/vchip/>

Clinical & Community Strategies to Improve Chlamydia Screening in Women

The following table highlights evidence-based strategies to improve chlamydia screening in women.

ACO Measure: Core-7 (NCQA HEDIS; NQF #0033)

The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Provider education and training</p> <ul style="list-style-type: none"> • Conduct provider training on clinical practice guidelines on chlamydia testing and treatment • Use provider tools and toolkits to facilitate discussion with patients about chlamydia testing in routine examinations • Use provider tools for sexual risk assessment • Conduct provider training in partner treatment for chlamydia <p>Validated screening tool and protocol</p> <ul style="list-style-type: none"> • Promote Expedited Partner Therapy (EPT) for Chlamydia and Gonorrhea among clinical providers • Promote re-screening for Chlamydia 90-120 days after treatment among woman 16-24 with clinical providers <p>Patient education</p> <ul style="list-style-type: none"> • Use patient reminders on preventive screenings (i.e. mailings and calls) • Use or create adolescent/young adult friendly materials • VDH Disease Intervention Specialist (DIS) will attempt to contact women 16-24 years of age who have been diagnosed and treated for Chlamydia 80 days after treatment to encourage them to be rescreened at the 90- 	<p>Patient and parent education materials</p> <ul style="list-style-type: none"> • Increase parental education on chlamydia infection and the importance of testing • Provide educational materials to patients on chlamydia infection and the importance of testing (i.e. Chlamydia: The Facts, CDC; Chlamydia at a Glance, Planned Parenthood; Partner Services brochure, VDH) • Use patient reminders about preventive screenings <p>Partnerships and referral resources</p> <ul style="list-style-type: none"> • Promote educational materials with providers and partners • Train community level providers to promote chlamydia testing in target communities <p>Provider education and training</p> <ul style="list-style-type: none"> • Collaborate across state agencies and with community partners <ul style="list-style-type: none"> • AOE (Agency of Education) • Student Health Centers • PPNNE (Planned Parenthood of Northern New England) 	<p>VDH staff will develop community wide messages to promote screening as endorsed by CDC and distribute these messages widely in community settings including healthcare settings, schools and other youth-serving settings.</p> <p>Implement a pilot project with Vermont Title X providers to ensure that at least 20% of their patients diagnosed and treated for Chlamydia are rescreened 90-120 days after treatment.</p>

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>120-day mark. These calls will happen exclusively through Title X site providers. DIS will monitor the results of how many women are rescreened and the positivity trend.</p> <p>Provide adolescent and young adult centered care</p> <ul style="list-style-type: none"> All women between the ages of 16-24 who have two infections within a 12-month period will be assigned to a VDH Disease Intervention Specialist (DIS) for interview <p>Data collection</p> <ul style="list-style-type: none"> Monitor trend positivity data on chlamydia incidence among women 16-24 years of age Collect screening data from Medicaid on portion of women on Medicaid 16-24 that are screened at least annually for CT Monitor percentage of women who have tested positive for Chlamydia that are rescreened 90-120 days after treatment <p>Quality Improvement</p> <ul style="list-style-type: none"> Conduct assessment to identify barriers to chlamydia testing in clinic setting 		

Resources

Centers for Disease Control and Prevention (CDC), Chlamydia: <http://www.cdc.gov/std/chlamydia/default.htm>

National Chlamydia Coalition: <http://www.ncc.prevent.org>

[Why Screen for Chlamydia? An implementation Guide for Healthcare Providers](#)

[Tips for Developing Chlamydia Screening Messages and Materials for Young Women](#)

Clinical & Community Strategies to Improve Colorectal Cancer Screening Rates

The following table highlights evidence-based strategies and best practices to improve colorectal cancer screening rates in clinical and community settings.

ACO Measure: Core-18 (NCQA HEDIS): Colorectal Cancer Screening

Description: The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

USPSTF Screening Guidelines (2016):

The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. Multiple effective screening strategies are available to choose from: **(a)** Guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) annually, **(b)** FIT-DNA test every 1 or 3 years, **(c)** Colonoscopy every 10 years, **(d)** CT colonography or flexible sigmoidoscopy every 5 years or **(e)** Flexible sigmoidoscopy every 10 years plus FIT every year.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Screening:</p> <ul style="list-style-type: none"> Implement a practice-level cancer screening policy and/or protocol using evidence-based approaches such as the National Colorectal Cancer Roundtable toolkit at: http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/. <p>Screen all adults age 50-75 for colorectal cancer. To increase screening uptake:</p> <ul style="list-style-type: none"> Educate patients on all screening test options for colorectal cancer as this is a proven way to increase screening uptake. Utilize tools such as the 2013 CDC Vital Signs documents: https://www.cdc.gov/vitalsigns/pdf/2013-11-vitalsigns.pdf. Use patient reminders for due/overdue patients such as by mail, email or phone.* Sample letter and phone script examples from the American Cancer Society: http://www.cancer.org/healthy/informationforhealthcareprofessionals/colonmdcliniciansinfo 	<p>Motivational Interviewing: Train in these techniques to best assist patients. (http://motivationalinterviewing.org)</p> <p>Implement a Flu-Fit Clinic, an innovative way to incorporate influenza vaccination and colorectal cancer screening. Visit http://flufit.org/ for more details.</p> <p>Facilitate a strong relationship & coordination with local gastroenterologists/ colonoscopy centers to understand their scheduling and intake process for performing colonoscopies and to improve the referral of patients for CRC screening.</p> <p>Use one-on-one or group education* to communicate screening messages in person/by phone to individuals or groups by healthcare professionals or trained lay people.</p> <p>Facilitate actions to reduce barriers to screening, such as providing flexible clinic hours, working in non-clinical settings, and providing patient navigators.*</p>	<p>Public Education:</p> <ul style="list-style-type: none"> Make Department of Health Cancer Screening Guideline provider and public documents well known to all clinical and community providers. http://www.healthvermont.gov/wellness/cancer/early-detection-and-screening Promote and distribute videos and printed materials in clinics, businesses and community locations to educate and motivate people to get screened. * Make it Your Own (Miyo: http://www.miyoworks.org/) provides a sampling of customizable templates to create professional grade health information to promote colorectal cancer screening. <p>Worksite Wellness: encourage employers to promote work site policies that promote CRC screening by using the Vermont Department of Health Worksite Wellness Resource http://www.healthvermont.gov/wellness/physical-activity-nutrition/worksite to implement policies such as:</p> <ul style="list-style-type: none"> Paid time off for CRC screening.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>mationsource/foryourclinicalpractice/colonm d-sample-reminder-letters.</p> <ul style="list-style-type: none"> • Use provider reminder/recall systems to inform providers before or during a visit that a patient is due or overdue for screening. * • Implement QI processes to support provider assessment and feedback* such as by evaluating provider screening rate, comparing group or individual provider with goal/standard. * • Support provider and staff education on screening guidelines and methods. The CDC offers free education (CME eligible) with providers guidance and tools for clinicians to optimally implement screening: http://www.cdc.gov/cancer/colorectal/quality/. • Use a patient-centered personal health portal to support increased screening with reminders, medical record access, and ability to make appointments. 	<p>Vermont’s Community Health Teams (CHTs): Promote the Vermont Blueprint for Health’s CHTs as a resource for health coaching, care coordination, and other team-based care approaches that continue the conversation with patients around screening and preventive care.</p> <p>Coordinate with health insurers to promote patient reminders and sending gap-in-care patient reports to provider practices.*</p> <p>Coordinate with Community Health Centers and local hospitals to host screening days and other screening events where patients can receive guidance and support, and make screening appointments.</p>	<ul style="list-style-type: none"> • Employee education promoting cancer screening. • Colorectal cancer screening reminders (pay stubs, posters, etc.) <p>Provider Education:</p> <ul style="list-style-type: none"> • Coordinate with colleges and universities to enhance medical student (including physician assistants, nurses/nurse practitioners) education around cancer screening. <p>Policy</p> <ul style="list-style-type: none"> • Support legislation and other policies that eliminate cost sharing associated with diagnostic testing • Support legislation and other policy initiatives to pay for transportation and other cost barriers associated with screening.

*Strategy recommended by *Guide to Community Preventive Services*

Resources:

The US Preventive Services Task Force: Colorectal cancer screening guidelines:

<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening>

The Guide to Community Preventive Services helps you choose evidence-based programs and policies to improve health and prevent disease in your community:

<http://www.thecommunityguide.org/about/What-Works-Cancer-Screening-factsheet-and-insert.pdf>

Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers: http://ncrt.org/wp-content/uploads/0305.60-Colorectal-Cancer-Manual_FULFILL.pdf

Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network with Evidence-based Tools)—includes Research Tested Intervention Programs that are evidence-based.

<http://cancercontrolplanet.cancer.gov/>

Clinical & Community Strategies to Improve Developmental Screening Rates

The following table highlights evidence-based strategies and best practices to improve developmental screening rates in clinical and community settings.

ACO Measure: Core-8 (NCQA HEDIS): Developmental Screening in the First Three Years of Life

The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life, that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Patient education & tools</p> <ul style="list-style-type: none"> • Adopt Bright Futures (i.e. pre-visit questionnaires, documentation, education handouts) • Educate families on developmental milestones • Establish a multidisciplinary team within a practice to implement universal developmental screening <p>Validated screening tool and protocol</p> <ul style="list-style-type: none"> • Review and identify a primary structured, validated developmental screening tool • Implement structured developmental screening using a validated tool at the 9, 18 and 30 month well visits • Implement developmental screening at other visits <p>Training and roles</p> <ul style="list-style-type: none"> • Ensure practitioners and staff are trained on accurate administration of screening tool • Identify and assign roles/responsibilities across the practice • Consider strategies to ensure continuity of practitioner care (i.e. children seeing the same practitioner for well care) 	<p>Parent/Family resources</p> <ul style="list-style-type: none"> • Increase parental education on early child development • Provide parents/caregivers with 2-1-1- phone number and encourage outreach to Help Me Grow (HMG) • Provide informational materials customized for specific audiences to increase knowledge of HMG resources • Provide information on community-based resources and education in support of early childhood development (e.g. parenting classes, library services) <p>Partnership building/referral resources</p> <ul style="list-style-type: none"> • Promote educational resources and materials with providers and partners (e.g. Bright Futures, Learn the Signs Act Early) • Outreach to community stakeholders (e.g. early care and education providers, CIS, schools) • Identify appropriate referral resources and capacity • Maintain an up-to-date list of referral resources • Track referrals, timeliness, and outcomes 	<p><i>Help Me Grow</i></p> <ul style="list-style-type: none"> • Enhance use of <i>Help Me Grow</i> (HMG) http://helpmegrowvt.org/ by providers, families, and community resources • Collect feedback from HMG community stakeholders and families to improve service delivery <p>Quality improvement</p> <ul style="list-style-type: none"> • Integrate QI activities in support of universal developmental screening (i.e. medical home, early care and education, Unified Community Collaboratives) • Connect providers (medical home and early care and education) to VCHIP-supported quality improvement activities • Spread VCHIP’s early care and education learning collaboratives by adding new regions each year <p>Improvements to the system of care</p> <ul style="list-style-type: none"> • Strengthen referral and evaluation systems at the community level • Build relationships to improve communication and collaboration around referrals

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Documentation and tracking</p> <ul style="list-style-type: none"> • Determine where screening results will be documented • Identify all children eligible for screening • Track current developmental screening rates • Develop recall/reminder systems to ensure timely screening • Use a tool (e.g. EHR report, paper log) to track children in need of screening <p>Referrals</p> <ul style="list-style-type: none"> • Identify children in need of evaluation and/or referral • Initiate referrals and track progress until completion • Ensure receipt of evaluation/referral reports <p>Quality improvement</p> <ul style="list-style-type: none"> • Create a process flow map to identify barriers to screening 	<p>Care planning</p> <ul style="list-style-type: none"> • Develop and/or contribute to patient's individual care plan • Ensure individual care plans are routinely implemented and updated 	<ul style="list-style-type: none"> • Conduct a community level gap analysis and needs assessment to identify levers to enhance the system of care • Convene stakeholders as needed to ensure consistency of services and plan for future innovations <p>Provider education and training</p> <ul style="list-style-type: none"> • Continue collaboration among AHS (VDH, AOE), VCHIP, VB5, LAUNCH to support provider education and training <p>Developmental screening registry</p> <ul style="list-style-type: none"> • Implement broad use of developmental screening registry (i.e. medical homes, early care and education, CIS) • Identify a training plan and roll-out for the implementation of the registry • Mitigate barriers to use of the registry • Disseminate population-level registry reports to inform community-wide decision making • Develop processes to import data from EHRs electronically into the registry • Revise and refine population-level data reports to maximize relevance for specific audiences <p>Health reform</p> <ul style="list-style-type: none"> • Coordinate Universal Developmental Screening activities with Vermont's ACOs and the Blueprint to leverage health reform and enhanced payment opportunities • Engage health reform stakeholders in use of registry data and in planning enhancements

Resources

Bright Futures Guidelines: brightfutures.aap.org/Pages/default.aspx

Vermont's System for Universal Developmental Screening (Birth – 8 Years): uvm.edu/medicine/vchip/documents/UDSLinks_000.pdf

Help Me Grow: helpmegrownational.org/ and cdn.buildingbrightfutures.org/wp-content/uploads/2015/01/Final-Fast-Facts-Help-Me-Grow4.pdf

Clinical & Community Strategies to Improve Adult Type 2 Diabetes Control

The following table highlights evidence-based strategies to reduce poor A1C control in clinical and community settings.

ACO Measure: Core-17: Diabetes Mellitus: Hemoglobin A1C Poor Control >9%

A1C testing is recommended quarterly for adults who do not meet treatment goals. Performance measures apply to adults 18 – 75 years of age. Patients with an A1C greater than 9 percent should be offered multicomponent interventions to improve blood glucose control.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Implement a standardized diabetes treatment protocol using evidence-based clinical practice recommendations—Diabetes Care Clinical Practice Recommendations:</p> <ul style="list-style-type: none"> • Diabetes self-management education/support (DSME/S) • Medical nutrition therapy (MNT) • Education on physical activity • Guidance on routine immunizations • Psychosocial care is a critical component of diabetes management <p>Tobacco Cessation:</p> <p>See Clinical & Community Strategies to Reduce Tobacco Use. Use motivational interviewing techniques to discuss behavior change goals and action plans</p> <p>For patients with A1C greater than 9 percent, offer multicomponent behavioral interventions to include the following:</p> <ul style="list-style-type: none"> • Achieving a realistic body weight • Improving nutrition and increasing physical activity • Achieving blood pressure control • Scoring diabetes distress and reducing it • Treating depression 	<p>Use Motivational Interviewing: (http://motivationalinterviewing.org/) Train providers in these techniques to best assist patients.</p> <p>Provide referrals to self-management programs: (http://myhealthyvt.org/)</p> <ul style="list-style-type: none"> • Healthier Living Workshop – Diabetes for problem solving and action planning; healthy eating; exercise; monitoring blood sugar; managing stress; using good foot care; and handling sick days <p>Use of Diabetes Self-Management Education (DSME) Programs provided by Certified Diabetes Educators in all local health service areas</p> <ul style="list-style-type: none"> • http://myhealthyvt.org/ <p>Use of Registered Dietitians who provide medical nutrition therapy (MNT) available through the local Vermont Blueprint for Health Community Health Teams (CHTs) and ambulatory services at all Vermont Hospitals (http://blueprintforhealth.vermont.gov/)</p> <ul style="list-style-type: none"> • See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up. • See Clinical & Community Strategies to Reduce Tobacco Use. 	<p>Community-based YMCA’s Diabetes Prevention Program to reduce diabetes risk</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up.</p> <p>Policy and Regulatory Approaches</p> <ul style="list-style-type: none"> • Advocate lowering of sugar content in processed foods and beverages • Use new Nutrition Facts labels starting in July 2018 to note “added sugars” • Promote population level oral health by supporting community water fluoridation

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<ul style="list-style-type: none"> Establishing realistic priorities for lifestyle improvement Adjusting diabetes medications Adjusting plans for self-monitoring of blood glucose <p>For self-management support:</p> <ul style="list-style-type: none"> Encourage use of patient portals Community-based programs and services Consumer support group <p>Provide patients with information and resources available in the local health service areas and statewide including:</p> <ul style="list-style-type: none"> Learning to Live Well with Diabetes (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP_Diabetes_Learning%20to%20Live%20Well%20with%20Diabetes.pdf) Single Page Guide For Diabetes Care (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP_Diabetes_guide_for_diabetes_care.pdf) DASH Eating Plan (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP-Diabetes_dash%20eating%20plan.pdf) A1C...what's Your Number? (http://www.healthvermont.gov/sites/default/files/documents/2016/12/HPDP_Diabetes_A1C_whats_your_number.pdf) 	<p>Oral Health</p> <p>Having diabetes increases a person's risk for having oral disease; untreated oral disease makes it more difficult to control A1C levels.ⁱⁱ</p> <p>Integrate messages about the importance of oral health to overall health using the Qualis Guide for Implementing Oral Health Integration and refer patients to a local source for dental care as you would make a referral to any other specialist.</p>	

Additional Resources:Centers for Disease Control and Prevention, Diabetes: <http://www.cdc.gov/diabetes/home/>NIH Diabetes Health Sense: <http://ndep.nih.gov/resources/diabetes-healthsense/>American Diabetes Association: <http://www.diabetes.org/>Vermont Department of Health Diabetes Prevention and Control: <http://www.healthvermont.gov/prevent/diabetes/diabetes.aspx>Vermont Department of Health: 3-4-50: <http://healthvermont.gov/prevent/3-4-50/index.aspx>

Clinical & Community Strategies to Improve Adult Hypertension Control

The following table highlights evidence-based strategies to improve adult hypertension control rates in clinical and community settings.

ACO Measure: Core-39: Controlling High Blood Pressure

Screen for hypertension (HTN) in adults 18 years or older. Patients with a blood pressure reading of 140/90 or higher should be offered multicomponent education, behavioral interventions, and take-home resources to reduce and maintain blood pressure control.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Implement a standardized hypertension (HTN) treatment protocol using an evidence-based protocol. See examples and templates at Million Hearts¹</p> <p>Screen all adults for blood pressure (USPSTF Grade A recommendation)²</p> <ul style="list-style-type: none"> • Calculate Blood Pressure using accurate blood pressure measurement technique such as the technique recommended by the American Heart Association³ • Create a blood pressure measurement station where all patients can rest quietly for 5 minutes before measurement and that is designed to support proper measurement techniques (e.g., feet on floor, proper arm position, multiple cuff sizes conveniently located). • Support patients with blood pressure >140/90 by offering multicomponent behavioral interventions that include: <ul style="list-style-type: none"> • Setting weight-loss goals • Improving diet or nutrition • Increasing physical activity (See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up) • Blood Pressure Self-monitoring (SM) 	<p>Motivational Interviewing: Train providers in these techniques to best assist patients (http://motivationalinterviewing.org/).</p> <p>Community-based Self-management programs: YMCA’s Diabetes Prevention Program assists patients with supported weight loss and physical activity (http://www.ncbi.nlm.nih.gov/pubmed/22812594).</p> <p>Promote engagement with community pharmacists and partnerships with community pharmacies for:</p> <ul style="list-style-type: none"> • Free self-measured blood pressure machines • pharmacists to provide patient support <p>Use the Community Health Worker Toolkit to provide culturally and socially relevant support and clinical referrals to community members https://www.ruralhealthinfo.org/community-health/community-health-workers/1/roles</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up.</p> <p>See Clinical & Community Strategies to Reduce Tobacco Use.</p>	<p>Promote placement of Blood Pressure Monitors in community locations such as libraries, schools, grocery stores, fire stations, etc.</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up.</p>

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>information from the American Medical Association on self-measured blood pressure⁴</p> <ul style="list-style-type: none"> • See the NYC Adult Hypertension Clinical Practice Guidelines for patient tools and self-management goals⁵ <p>Use medication adherence strategies to support patients taking hypertension medications:</p> <ul style="list-style-type: none"> • The American Association of Colleges of Pharmacy's Medication Adherence Educators Toolkit provides information on non-adherence assessment and medication adherence tools such as pillboxes and mobile apps to increase medication compliance⁶ <p>Provide patients with information, resources, and tools to increase patient engagement. Patient tools available at Million Hearts include:⁷</p> <ul style="list-style-type: none"> • Blood pressure journal • Blood pressure wallet card • Medication infographic • Factsheet for HTN control goals • Links to self-monitored BP technique • HTN prevalence estimator tool • Heart Attack risk calculator 		

Resources:

US Preventive Services Task Force: <http://www.uspreventiveservicestaskforce.org>; The Community Guide to Preventive Services: <http://www.thecommunityguide.org/index.html>

Million Hearts Initiative: <http://millionhearts.hhs.gov/>

¹ <http://millionhearts.hhs.gov/tools-protocols/protocols.html>;

² [United States Preventive Taskforce: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/blood-pressure-in-adults-hypertension-screening](http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/blood-pressure-in-adults-hypertension-screening)

³ <http://hyper.ahajournals.org/content/45/1/142.full>

⁴ <http://www.ama-assn.org/ama/ama-wire/post/need-self-measured-blood-pressure-monitoring>

⁵ https://millionhearts.hhs.gov/files/NYC_HHC_Hypertension_Protocol.pdf

⁶ http://millionhearts.hhs.gov/files/TipSheet_HCP_MedAdherence.pdf and

<http://www.aacp.org/resources/education/Documents/AACP%20NCPA%20Medication%20Adherence%20Educators%20Toolkit.pdf>

⁷ <http://millionhearts.hhs.gov/tools-protocols/tools.html>

⁸ <http://eatbettermovemore.org/sa/policies/>

Clinical & Community Strategies to Improve Screening and Follow Up for High Blood Pressure

The following table highlights evidence-based strategies to increase screening and documented follow-up plan for adult hypertension.

ACO Measure: Core-40: Screening for High Blood Pressure and Follow-up Documented

Screen for hypertension (HTN) in adults 18 years or older. Patients with a blood pressure reading of 140/90 or higher should be offered multicomponent education, behavioral interventions, and take-home resources to reduce and maintain blood pressure control.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Implement a standardized hypertension (HTN) treatment protocol using an evidence-based protocol. See examples and templates at Million Hearts¹</p> <ul style="list-style-type: none"> • Screen all adults for blood pressure (USPSTF Grade A recommendation)² • Calculate BP using accurate BP measurement technique such as that recommended by American Heart Association³ • Create a BP measurement station where patients can rest quietly for 5 minutes before measurement and that is designed to support proper measurement techniques (e.g., feet on floor, proper arm position, multiple cuff sizes conveniently located). <p>Support patients with BP >140/90 by offering multicomponent behavioral interventions encouraging a self-management plan</p> <p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up for suggestions for healthy weight.</p> <p>For tobacco cessation, see Clinical & Community Strategies to Reduce Tobacco Use.</p> <p>Provide patients with information, resources, and tools to increase patient engagement. Patient tools</p>	<p>Motivational Interviewing: Providers should be trained in these techniques to best assist patients (http://motivationalinterviewing.org/).</p> <p>Promote placement of Blood Pressure Monitors placed in community locations like libraries, schools, grocery stores, fire stations, etc.</p> <p>Promote engagement with community pharmacists and partnerships with community pharmacies for:</p> <ul style="list-style-type: none"> • free self-measured blood pressure machines • pharmacists to provide patient support • Assistance with Medication Reconciliation <p>Use the Community Health Worker Toolkit to provide culturally and socially relevant support and clinical referrals to community members https://www.ruralhealthinfo.org/community-health/community-health-workers/1/roles</p> <p>Oral Health: The American Dental Association recommends that dental care providers screen patients for hypertension; additionally, oral health care providers can reinforce the importance of oral health as an important part of overall health (5).</p>	<p>See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up for suggestions for community-wide action create or enhance access to healthy eating and physical activity by engaging with municipal, regional and state planning agencies</p> <p>Worksite Wellness: encourage employers to promote employer-supported worksite wellness interventions that design and sustain a wellness program that fits the scale and culture of the organization. See Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up for relevant strategies regarding worksite wellness, and add:</p> <ul style="list-style-type: none"> • Onsite blood pressure monitor stations <p>Support policies which reduce cost sharing / out of pocket costs for patients with hypertension for services including:</p> <ul style="list-style-type: none"> • Medication therapy management • Behavioral counseling • Behavioral support (community-based weight management programs, gym membership <p>Visit The Community Guide for more information): http://www.thecommunityguide.org/cvd/ROPC.html</p>

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>available at Million Hearts include⁶ a blood pressure journal, blood pressure wallet card, medication infographic, factsheet for HTN control goals, and links to self-monitored BP technique.</p> <p>Work with your EHR and/or clinical registry vendor to develop or refine systems and prompts that can:</p> <ul style="list-style-type: none"> • identify patients for screening/follow up and who do not have a self-management plan • support shared care plans or team-based care approaches • provide follow up reminders and check in prompts for patients with self-management plans • auto-feed lab result into the registry or EHR • provide alert when hospital or ER visits take place • provide alert when medication regimens are altered 	<p>Integrate messages about the importance of oral health to overall health using the Qualis Guide for Implementing Oral Health Integration and refer patients to a local source for dental care as you would make a referral to any other specialist.</p> <p>Healthy eating and physical activity: see Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up</p>	

Resources: US Preventive Services Task Force: <http://www.uspreventiveservicestaskforce.org>; The Community Guide to Preventive Services: <http://www.thecommunityguide.org/index.html>
Million Hearts Initiative: <http://millionhearts.hhs.gov/>

¹ <http://millionhearts.hhs.gov/tools-protocols/protocols.html> and http://www.healthvermont.gov/sites/default/files/documents/pdf/HPDP%20Hypertension-Management-Toolkit_v1.0.pdf

² United States Preventive Taskforce: <http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/blood-pressure-in-adults-hypertension-screening>

³ <http://hyper.ahajournals.org/content/45/1/142.full>

⁴ <http://www.ama-assn.org/ama/ama-wire/post/need-self-measured-blood-pressure-monitoring>

⁵ https://millionhearts.hhs.gov/files/NYC_HHC_Hypertension_Protocol.pdf

⁶ <http://millionhearts.hhs.gov/tools-protocols/tools.html>

⁷ <http://eatbettermovemore.org/sa/policies/>

Clinical & Community Strategies to Improve Pediatric Weight Assessment and Counseling

ACO Measure: Core-15 (NCQA HEDIS; NQF #0024): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The percentage of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, counseling for nutrition, and counseling for physical activity

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Provider Tools</p> <ul style="list-style-type: none"> • Use Promoting Healthier Weight in Pediatrics Toolkit • Adopt <i>Bright Futures</i> Guidelines (i.e. pre-visit questionnaires, documentation, education handouts) <p>Validated screening tool and protocol</p> <ul style="list-style-type: none"> • Assess all children for obesity at well-care visits 2-18 years. • Annually assess behaviors and attitudes, diet and physical activity behaviors, and medical risks through physical exam and family history • Use Body Mass Index (BMI) to screen for obesity, record the BMI percentile and make a corresponding weight category diagnosis • Use motivational interviewing to discuss BMI findings with patient and family • Integrate oral health risk assessments, and fluoride varnish applications as part of well-care visits using Vermont's From the First Tooth Program. 	<p>Parent/Family resources</p> <ul style="list-style-type: none"> • Provide resources to parent/caregivers regarding healthy eating and physical activity practices for appropriate age level • Provide VDH resource on screen time • Provide parents/caregivers with 2-1-1- phone number and encourage outreach to <i>Help Me Grow</i> • Provide information on community-based resources and education for physical activity and healthy nutrition (Parks and Recreation, Cooking for Life, etc.) • Provide information to 802Quits for information on smoking cessation • Integrate messages about the importance of oral health to overall health using the Qualis Guide for Implementing Oral Health Integration, and refer patients to a local source for dental care <p>Partnership building/referral resources</p> <ul style="list-style-type: none"> • Promote educational resources and materials with providers and partners (e.g. <i>Promoting Healthier Weight</i> toolkit, <i>Bright Futures</i>). • Outreach to community stakeholders (e.g. schools, early education providers, children, etc.) • Connect with local Parent Child Center 	<p>School strategies</p> <ul style="list-style-type: none"> • Educate families, children and adolescents on the benefits of having a well-care visit each year, as outlined by <i>Bright Futures</i> • Promote activities aimed at children and youth to build healthy habits including: <ul style="list-style-type: none"> • Participating in the Whole School, Whole Community, Whole Child Framework • Implementing local wellness policies for both early childhood education programs and K-12 schools that include adherence to the federal school nutrition standards, physical activity during the school day, and nutrition education in each grade. • Supporting schools and municipalities for Safe Routes to School, so that students can walk or ride their bike to school • Integrating and supporting Farm to School activities <p>Community Leaders including VDH staff, local business, regional councils, health care providers</p> <ul style="list-style-type: none"> • Create or enhance access to healthy eating and physical activity by increasing sidewalks, bike paths, farmers' markets, community gardens

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Procedure and Counseling For patients with healthy weight:</p> <ul style="list-style-type: none"> Reinforce healthy habits of patient and family and re-evaluate at next visit <p>For overweight and obese patients:</p> <ul style="list-style-type: none"> Order appropriate laboratory tests Review signs and symptoms associated with obesity Learn about current diet and physical activity patterns and counsel on changes Assess readiness to change Work with patient/family to set achievable goals for nutrition and activity Promote self-management skill development Make appropriate referrals & schedule follow-up visits as indicated <p>Referrals</p> <ul style="list-style-type: none"> Identify children in need of referral to appropriate care (Registered Dietician, Nutritionist, Endocrinology, etc.) Initiate referrals and track progress until completion and ensure receipt of referral report <p>Training and roles</p> <ul style="list-style-type: none"> Ensure practitioners and staff are trained on accurate administration of BMI screening tool Train practitioners and staff in strength-based communication strategies with children, youth, and families 	<ul style="list-style-type: none"> Participate in Community Coalitions or Partnerships to Address Obesity <p>Provide fruit and vegetable prescriptions to encourage patients to eat more fruits and vegetables.</p> <p>Provide park prescriptions encourage patients to be more physically active. For more information see http://vermontfitness.org/exercise-is-medicine/</p>	<ul style="list-style-type: none"> Provide incentives to food retailers to locate in underserved areas and to offer healthier food and beverage choices Promote population-level oral health by supporting community water fluoridation <p>Promote increased healthy eating and physical activity options at worksites:</p> <ul style="list-style-type: none"> Worksite gardens Flex time for physical activity Healthy food incentives Engage municipal governments, employers, schools, and health care providers to develop community-wide strategies to address physical activity and nutrition

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Documentation and tracking</p> <ul style="list-style-type: none"> • Determine a consistent location where screening results will be documented • Track current overweight and obese screening rates • Develop recall/reminder systems to ensure follow-up visits and referrals happen <p>Quality improvement</p> <ul style="list-style-type: none"> • Create a process flow map to identify barriers to BMI screening and follow up counseling 		

Resources:

The First Tooth Program: <http://www.fromthefirsttooth.org/healthcare-providers/state-pages/vermont/>

Qualis Guide for Implementing Oral Health Integration: <http://www.qualishealth.org/about-us/newsroom/press-releases/qualis-health-publishes-comprehensive-guide-for-implementing-oral-health-integration>

Community Water Fluoridation: <https://www.cdc.gov/fluoridation/index.html>

The Community Guide to Preventive Services: <http://www.thecommunityguide.org/index.html>

Promoting Healthier Weight in Pediatrics: <http://www.med.uvm.edu/vchip/promotinghealthierweight>

Clinical & Community Strategies to Improve Adult Immunization Rates

The following table highlights evidence-based strategies and best practices to improve adult immunization rates in clinical and community settings.

ACO Measure:

Core-35: Influenza Immunization

Core-48: Pneumococcal Vaccination for Patients 65 Years and Older

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Strategies
<p>Ensure vaccine access</p> <ul style="list-style-type: none"> Encourage primary care providers to purchase these vaccines, so they can offer them during patient visits. Provide clear communication regarding Medicare coverage for vaccines in those 65+ Collaborate with pharmacies to ensure influenza vaccine is offered for those 18+ years and pneumococcal vaccine is offered for those 65+ years. <p>Patient education & tools</p> <ul style="list-style-type: none"> Increase patient awareness of what vaccines are needed. Increase patient education on vaccine safety and efficacy. Provide informational materials customized for specific audiences. Direct patients to reputable sources for information about vaccines. <p>Protocols</p> <ul style="list-style-type: none"> Create standing orders to authorize nurses, pharmacists, and other healthcare personnel allowed by state law to assess a patient's immunization status and administer vaccinations according to a protocol approved by an institution, physician, or other 	<p>Patient resources</p> <ul style="list-style-type: none"> Create rewards in exchange for keeping an appointment, receiving a vaccination, returning for a vaccination series, or producing documentation of vaccination status. <p>Partnership building/referral resources</p> <ul style="list-style-type: none"> Provide seasonal influenza vaccination programs at work sites. These programs should be: <ul style="list-style-type: none"> On-site Free Actively promoted Promote flu clinics offered by VAHHA on Health Department website. <p>Quality Improvement</p> <ul style="list-style-type: none"> Participate in quality improvement initiatives of the Health Department, AAFP, etc. Use the EHR to identify those with risk factors (for example COPD) for whom providers should ensure timely vaccination. 	<p>Immunization requirements</p> <ul style="list-style-type: none"> Support immunization requirements for vaccinations or other documentation of immunity as a condition of college attendance. Encourage health care institutions to adhere to CDC recommendations for immunization of health care workers. <p>Improvements to the system of care</p> <ul style="list-style-type: none"> Use aggregate data from the Immunization Registry in surveillance and program operations, and in guiding public health action with the goals of improving vaccination rates and reducing vaccine-preventable disease. Collaborate with and promote community vaccinators, such as primary care, specialty practices, home health agencies, and pharmacies. Consult with CMS (Medicare) to identify any options for its participation in the Vermont Vaccine Purchasing Program. <p>Immunization registry</p> <ul style="list-style-type: none"> Implement broad use of the Immunization Registry, for example by medical homes, correctional settings, long-term care facilities, and pharmacies.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Strategies
<p>authorized provider without the need for examination or direct order from the attending provider at the time of the interaction.</p> <p>Documentation and tracking</p> <ul style="list-style-type: none"> • Use the Immunization Registry to document all vaccinations and to determine appropriate vaccinations. • Use patient reminder recall systems to remind members of a target population that vaccinations are due (reminders) or late (recall). • Provider reminders, such as alerts in electronic medical records, to inform those who administer vaccinations that individual patients are due for specific vaccinations. <p>Quality improvement</p> <ul style="list-style-type: none"> • Use AFIX to evaluate provider performance in delivering one or more vaccinations to a client population (assessment) and present providers with information about their performance (feedback). • Participate in quality improvement initiatives of the Health Department, AAFP, etc. 		<ul style="list-style-type: none"> • Disseminate population-level registry reports to inform community-wide decision making. • Expand capacity to import data electronically into the registry. <p>Patient education</p> <ul style="list-style-type: none"> • Engage community leaders in reaching the public with information about the importance of adult vaccination. • Conduct outreach to DAIL, AARP-VT, AAA to identify opportunities to provide education. • Increase awareness among adults of vaccines needed; consider use of press releases for BRFSS data. • Encourage the development of adult immunization champions across all sectors.

Resources

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/vaccines/index.html>

The Guide to Community Preventive Services: <http://www.thecommunityguide.org/worksites/index.html>

CDC Adult Immunization Schedule: <http://www.cdc.gov/vaccines/schedules/hcp/adult.html>

Vermont Department of Health Immunization Program: <http://healthvermont.gov/hc/imm/index.aspx>

National Adult Immunization Plan: <http://www.hhs.gov/sites/default/files/nvpo/national-adult-immunization-plan/naip.pdf>

Clinical & Community Strategies to Improve Initiation and Engagement of Alcohol and Other Drug Treatment Rates

The following table highlights evidence-based strategies and best practices to improve initiation and engagement of alcohol and other drug treatment in clinical and community settings.

ACO Measure: Core-5 (NCQA HEDIS) Initiation and Engagement in Alcohol and Other Drug Treatment (IET)

The percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) dependence who received the following:

- Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
- Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Patient education & tools</p> <ul style="list-style-type: none"> • Provide educational handouts about substance abuse conditions • Educate families on signs for potential issues with AOD • Establish a multidisciplinary team within your practice to implement universal AOD screening <p>Validated screening and assessment tools and protocols</p> <ul style="list-style-type: none"> • Review and identify a primary structured, validated AOD screening tool • Implement structured AOD screening • Implement SBIRT model¹ • Continue to support use of evidence-based screening and assessment tools (such as AUDIT for adults and CAGE for screening^{2,3} and the ASI for assessment⁴) based on stage of change, age, and cultural identification <p>Training</p> <ul style="list-style-type: none"> • Ensure PCPs and staff are trained on accurate administration of an AOD screening tool 	<p>Parent/Family resources</p> <ul style="list-style-type: none"> • Increase family-based treatment⁵ • Provide parents/caregivers with 2-1-1 phone number and encourage outreach to private LADCs and ADAP preferred providers • Provide information on community- based resources (e.g. recovery centers) <p>Partnership building/referral resources</p> <ul style="list-style-type: none"> • Promote educational resources and materials with providers and partners (e.g. list of practicing LADCs) • Reach out to community stakeholders (e.g. PCPs, private clinicians, ADAP preferred providers) • Identify appropriate referral resources and capacity • Maintain an up-to-date list of referral resources • Track referrals, timeliness, and outcomes <p>Engage in intensive case management for individuals involved with DCF</p>	<p>Quality improvement</p> <ul style="list-style-type: none"> • Integrate QI activities in support of universal substance abuse screening (i.e. medical home) • Connect providers (medical home) to ADAP-preferred provider quality improvement activities <p>Improvements to the system of care</p> <ul style="list-style-type: none"> • Strengthen referral and evaluation systems at the community level • Build relationships to improve communication and collaboration around referrals • Strengthen peer support services and build connections for individuals to access those services • Conduct a community level gap analysis and needs assessment to identify levers to enhance the system of care • Provide clarity around billing structure and codes to medical providers

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<ul style="list-style-type: none"> • Provide therapeutic techniques to both medical and behavioral health providers (e.g. motivational interviewing, contingency management) ^{5,6,7,9} • Encourage providers to reflect on current and evolving attitudes, perceptions and biases, and values and beliefs when working with clients at risk for, or experiencing, a substance use disorder ¹⁰ • Develop champions who specialize in assessment and management of substance use and its related issues who have had specialized training in substances, screening, assessment and interventions, who integrate best practices, and who act as a resource for staff in specific practice settings – within organizations to support best practices uptake and implementation ¹⁰ • Provide access to self-directed learning opportunities, including web-based learning and videos ¹⁰ • Open access and encourage participation to current learning collaboratives around medication-assisted treatment <p>Documentation and tracking</p> <ul style="list-style-type: none"> • Determine where screening results will be documented and communicate instructions to staff • Use a tool (e.g. EHR report, paper log) to track people in need of AOD screening <p>Referrals</p> <ul style="list-style-type: none"> • Identify people in need of AOD evaluation and/or referral • Initiate referrals and track progress until completion • Ensure receipt of evaluation/referral reports 	<ul style="list-style-type: none"> • Ensure that: 1) pharmacotherapy options are considered in management planning; 2) clients have access to appropriate pharmacotherapy; and 3) pharmacotherapy is administered safely ¹⁰ • Develop universal release to continue collaboration between medical and behavioral health professionals <p>Care planning</p> <ul style="list-style-type: none"> • Approach the individual care plan as a document that is reviewed and updated routinely and the individual receiving services agrees with and signs • Ensure individual care plans are routinely implemented and updated • Discuss relapse in individual care plans Develop and use counselor-friendly manuals to help guide sessions on special topics⁸ 	<p>Development of workforce with training in AOD through partnerships with local colleges and universities</p> <ul style="list-style-type: none"> • Establish policies and procedures to assess and treat all clients at risk for or experiencing a substance use disorder that incorporate principles of harm reduction and the social determinants of health ¹⁰ • Establish and integrate principles of harm reduction and the social determinants of health into all new and existing programs that address substance use across the system (e.g., needle exchange programs, naloxone overdose prevention programs) ¹⁰ <p>Restructuring of the professional regulations</p> <ul style="list-style-type: none"> • Convene stakeholders as needed to ensure consistency of services and plan for future innovations • Establish equity in reimbursement for licensed alcohol and drug abuse counselors <p>Provider education and training</p> <ul style="list-style-type: none"> • Continue collaboration among AHS (VDH, DVHA, SBIRT), preferred providers, and private providers to support provider education and training <p>Health reform</p> <ul style="list-style-type: none"> • Coordinate screening and referral activities with Vermont’s ACOs and the Blueprint to leverage health reform and enhanced payment opportunities Provide more intensive case management services ⁹

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Quality improvement <ul style="list-style-type: none"> • Create a process flow map to identify barriers to referral • Collect data to determine effective referral flows for the community and providers 		

Resources

¹ SBIRT: Screening, Brief Intervention, and Referral to Treatment <http://www.integration.samhsa.gov/clinical-practice/SBIRT>

² National Institute on Drug Abuse Chart of Evidence-Based Screening Tools for Adults and Adolescents <https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults>

³ U.S Preventive Services Taskforce Final Recommendation Statement Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care, May 2013 <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>

⁴ Substance Abuse Treatment: Addressing the Specific Needs of Women. <http://www.ncbi.nlm.nih.gov/books/NBK83253/>

⁵ Community Reinforcement and Family Training (CRAFT) <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=378>

⁶ Motivational Interviewing (MI) To Improve Treatment Engagement and Outcome in Subjects Seeking Treatment for Substance Abuse <https://www.drugabuse.gov/about-nida/organization/cctn/ctn/research-studies/motivational-interviewing-mi-to-improve-treatment-engagement-outcome-in-sub>

⁷ Motivational Interviewing to enhance treatment engagement <http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/497/Motivational-Interviewing-to-enhance-treatment-engagement>

⁸ Patient Engagement and Duration of Treatment <http://www.ncjrs.gov/ondcppubs/treat/consensus/simpson.pdf>

⁹ Intensive Case Management Improves Welfare Clients Rates of Entry and Retention in Substance Abuse Treatment <https://aspe.hhs.gov/basic-report/intensive-case-management-improves-welfare-clients-rates-entry-and-retention-substance-abuse-treatment>

¹⁰ Engaging clients who use substances <https://guideline.gov/summaries/summary/49419/engaging-clients-who-use-substances>



Clinical & Community Strategies to Reduce Tobacco Use

The following table highlights evidence-based strategies to improve respiratory care in clinical and community settings.

ACO Measure: Core-36: Tobacco Use: Screening and Cessation Intervention

ACO Measure: Core-1: All Cause Readmission (since tobacco use contributes to higher readmission)

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>Perform 2As and a R¹-brief intervention (reimbursable through Medicare and Medicaid), three to ten minutes up to sixteen sessions per patient per year</p> <ul style="list-style-type: none"> • Ask: Ask all patients on every visit if they use tobacco and document regularly. Evidence shows that reminders (chart stickers, computer prompt, tobacco use in vital signs) built into clinic screening systems are shown to work.² • Advise: All physicians advise every patient who smokes to quit. Evidence shows that physician advice increases quitting.² Medicaid reimburses for counselling, including when provided by a tobacco treatment specialist using 99406, 99407 under provider care. Group is an option. • Refer: Tailored fax referral and/or e-referral support is available through the www.802Quits.org website or by emailing tobaccovt@vermont.gov. 802Quits provides free cessation support on the phone, in person in all hospital service areas, on the web and via text-with dual therapy NRT at no cost. <p>Perform 5 A's: Ask, Advise, Assess, Assist, & Arrange³-Intermediate intervention (reimbursable)</p>	<p>State resources are available to assist providers and care teams based on the Treating Tobacco Use and Dependence, 2008 Update. Evidence based interventions including the quitline (1-800-Quit-Now) and Quit Partners (listing found at www.802Quits.org) are designed to support cessation and increase quit attempts.</p> <ul style="list-style-type: none"> • Tobacco treatment specialists can be integrated into community health teams, clinics, home visiting programs, SASH case management, and Screening, Brief Intervention, and Referral to Treatment. Provided by University of Massachusetts Center for Tobacco and the state, free tobacco treatment specialist training is available for staff who work at treatment centers, clinics, and care teams. • Use an electronic referral system called One Touch with home visiting programs to increase links to cessation supports available through www.802Quits.org. Email the Asthma Program at vdhco@state.vt.us. • Promote directly to beneficiaries and providers to increase tobacco preventative service delivery in-clinic or through state quitline/quit online services. Examples include the state's Medicaid Tobacco Benefit and Promotion 	<p>Healthy communities with fewer tobacco users are created through smoke- and tobacco-free work and recreational places and limiting exposure to promotion and products. Examples include:</p> <ul style="list-style-type: none"> • Promote tobacco-free public spaces, campuses, schools, hospitals, pharmacies, multi-unit housing, parks, playgrounds and worksites. Tobacco-free and smoke-free work and public places are shown to reduce youth from starting to smoke, to reduce tobacco use, and to prevent exposure to secondhand smoke. • Partners and community coalitions around the state participate in media campaigns implemented by the Vermont Tobacco Control Program. State and community collaboration on media campaigns and smoke- and tobacco-free places are effective at reducing tobacco's impact. • Evidence-based interventions shown to reduce adult tobacco use and prevent youth initiation: increase excise taxes or price of tobacco products; reduce promotion of and access to tobacco by youth; use mass reach health communications to drive awareness and cessation activity, and put state funding toward tobacco control & prevention.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
<p>through Medicaid and Medicare), more than ten minutes, can be performed by clinic support team.</p> <p>Quitting success for smoking and other tobacco products more than doubles when patients receive counselling and FDA-approved cessation medications including:</p> <ul style="list-style-type: none"> • Over-the-counter nicotine replacement therapies such as the patch, gum, and lozenge⁴ • Prescription nicotine replacement therapies such as an inhaler and nasal spray • Prescription Zyban and Chantix • FDA has approved dual and extended NRT therapy. Over the counter therapy can be used by people who are still using tobacco⁵ <p><u>E-cigarettes and other vaping devices</u> are not shown to be effective at helping tobacco users to quit⁶. Use FDA approved NRT. See Public Health Advisory for Providers: E-Cigarettes available at www.healthvermont.gov.</p> <p>Continuing Clinical Education: Find available trainings & webinars³ related to emerging research, promising best practices and 802Quits resources to support a more informed and up-to-date support for tobacco users. Email tobaccovt@vermont.gov for more information.</p>	<p>Initiative, and broadcasting of CDC Quit Tips from former sSmokers. If interested for your health system, email tobaccovt@vermont.gov.</p> <ul style="list-style-type: none"> • Promote online cessation resources available through www.802Quits.org. There are mobile phone-based cessation interventions that are shown to be effective. One is called SmokefreeTXT and is designed for teens and young adults. Go to www.smokefree.gov. <p>Motivational Interviewing: (http://motivationalinterviewing.org/)</p> <ul style="list-style-type: none"> • Train providers in these techniques to best assist patients. <p>Community Fitness and Weight loss</p> <ul style="list-style-type: none"> • <i>Ladies First</i> provides funding for lifestyle programs and gym memberships to women meeting income thresholds http://ladiesfirst.vermont.gov/ • Promote community-based resources like Weight Watchers, Curves Complete, and community fitness centers • Promote walking paths 	<ul style="list-style-type: none"> • Limit the access, advertising, promotion, and placement of cigarettes, cigars, e-cigarettes, and other tobacco products in tobacco retail outlets. Implement retailer education and youth sales enforcement checks.. For more information about point-of-sale and the impact of tobacco on youth in Vermont, visit www.counterbalancevt.com. • Hospitals and clinics can advance tobacco control and prevention in their communities by using reinvestment funds for tobacco treatment and prevention. Northwestern Medical Center is investing a portion of its annual hospital budget in tobacco treatment and integration into care. The state offers free training to certify specialists for in-patient hospital and outpatient clinical care for tobacco treatment. Examples include: <ul style="list-style-type: none"> • cross training staff to become certified tobacco treatment specialists, which are eligible for reimbursement in Medicaid • using electronic health patient registries for referral to 802Quits (UVM Health) • funding for clinical/community team members to provide cessation (RRMC)

References

- ¹ [Health and Human Services for ACA Implementation 20 14](#) (FAQ XIX, Q5)
- ² <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html>
- ³ <http://802quits.org/>
- ⁴ <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm345087.html>
- ⁵ http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/pharmacologic-guide.pdf
- ⁶ <http://www.lung.org/stop-smoking/smoking-facts/e-cigarettes-and-lung-health.html>

ⁱ <http://care.diabetesjournals.org/site/misc/2016-Standards-of-Care.pdf>

ⁱⁱ <http://bjgp.org/content/64/619/103.short>