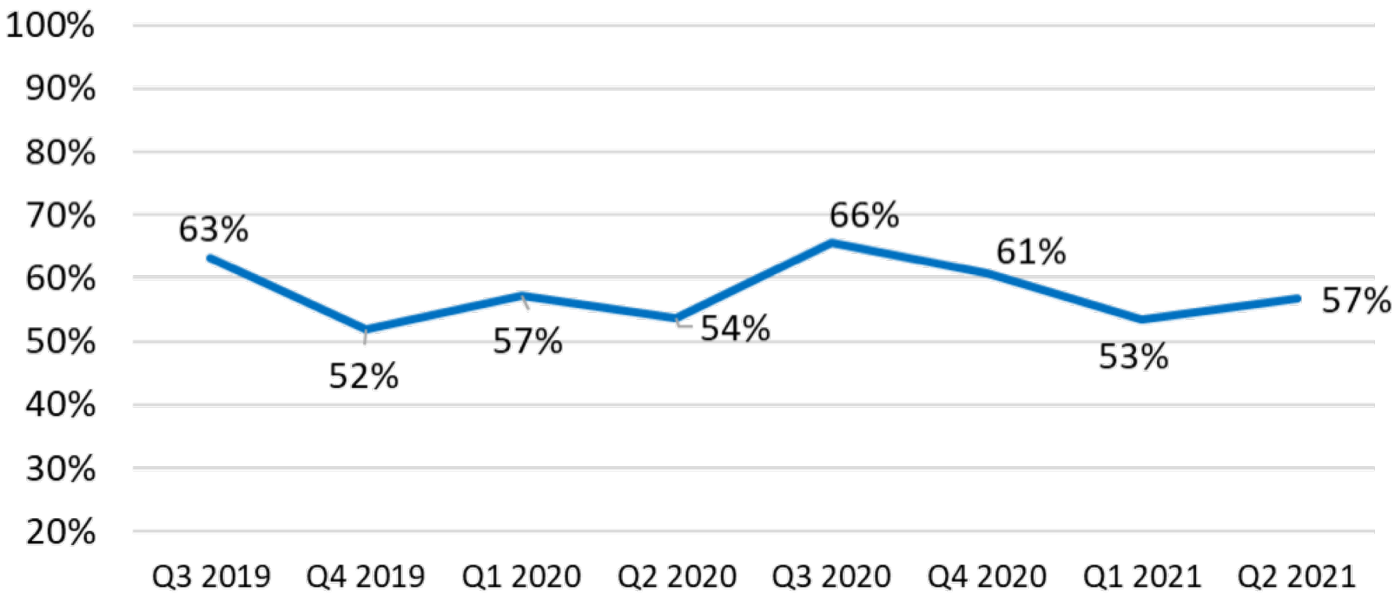


# Hypertension Care

**Blood pressure (BP) in control:  
% of Mt. Ascutney patients with hypertension whose last  
BP measurement was in control**



**Measure Definition** The percentage of patients 18 to 85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90) at their last measurement. No measurement within twelve months is considered not in control. Measure is NQF 0018 (definition [here](#)). Note the NQF specs changed slightly from 2018 – 2019.

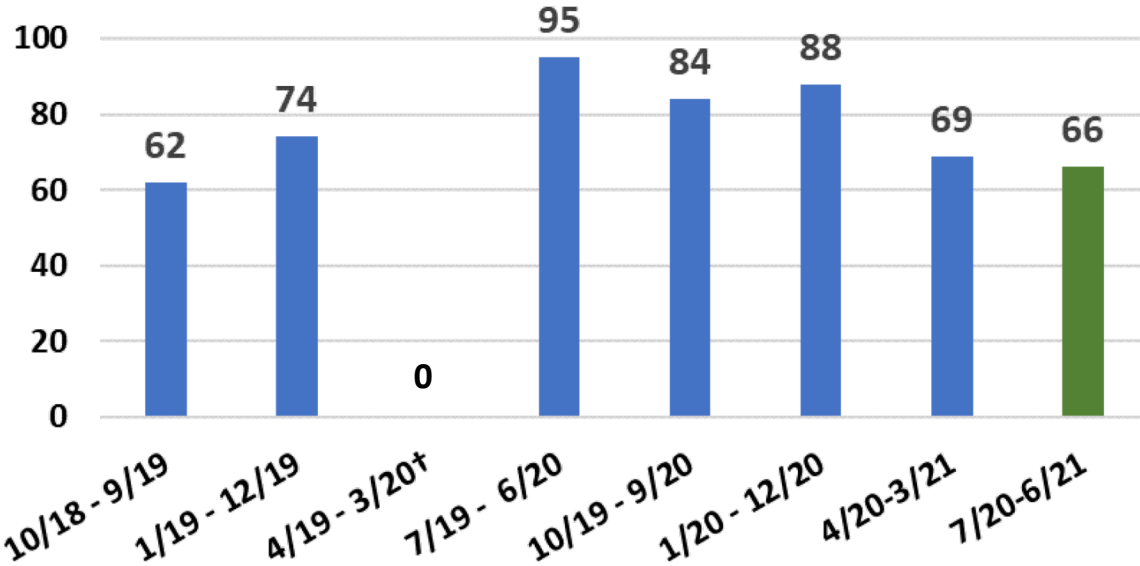
**Source** Local clinical data from Mt. Ascutney Hospital and Health Center

## Improvement Work

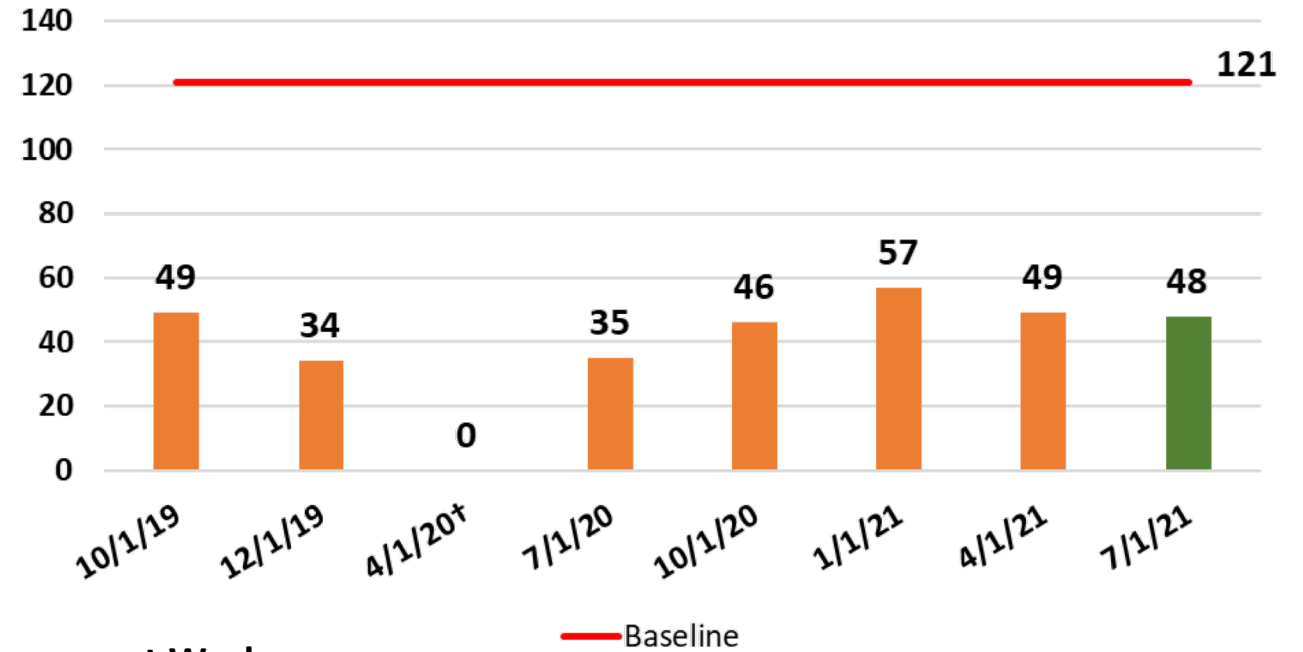
- Pandemic-related diet and activity changes have impacted chronic disease management.
- CCNs report success in helping most patients be within hypertension goal "within one to two visits"!
- PCPs documenting real-time values from patients' trusted home monitors with a 'home BP' comment; do not count for this measure.
- Monthly data shows improvement of 11 percentage points, from January to June
- Still an opportunity for improvement in use of BpTRU™ and documentation of second BP value before encounter note is closed.

# Diabetes Care

**A. Number of patients with diabetes whose recent A1c >9.0% across MAHHC**



**B. Number of patients with diabetes, with no A1c test in one year, across MAHHC**



**Definitions** In chart A, “patients with diabetes” means patients with most recent A1c  $\geq 6.5\%$  at any time within reported 12 months.  
In chart B, “patients with diabetes” are identified through an active diagnosis code in the Cerner EHR.

**Source** Local clinical data from MAHHC Patients

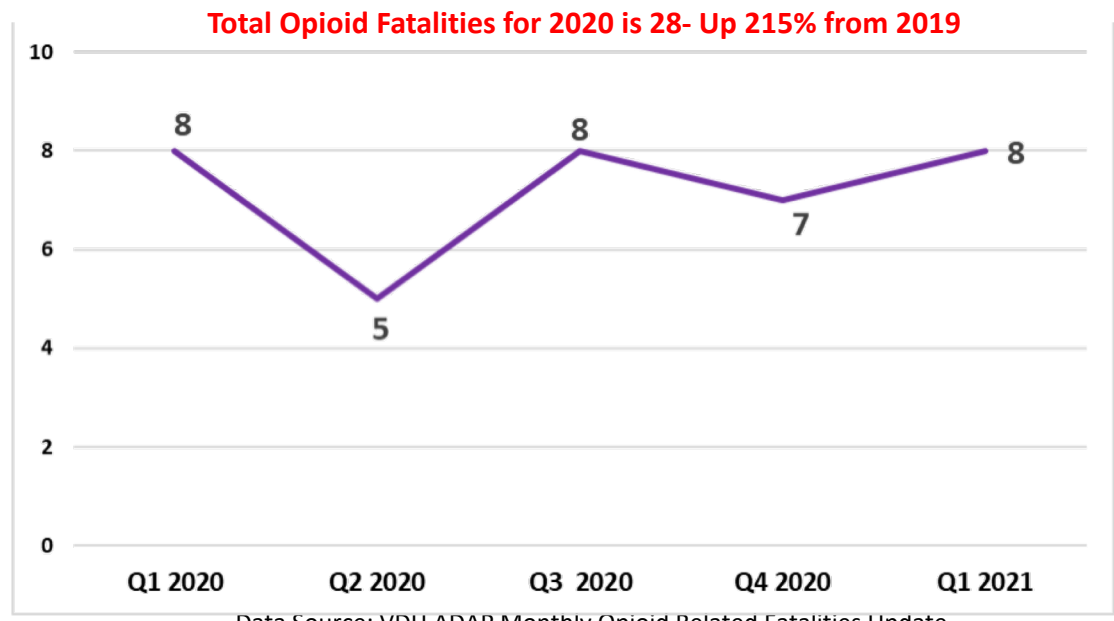
† Reflects lack of reported data due to COVID-19

## Improvement Work

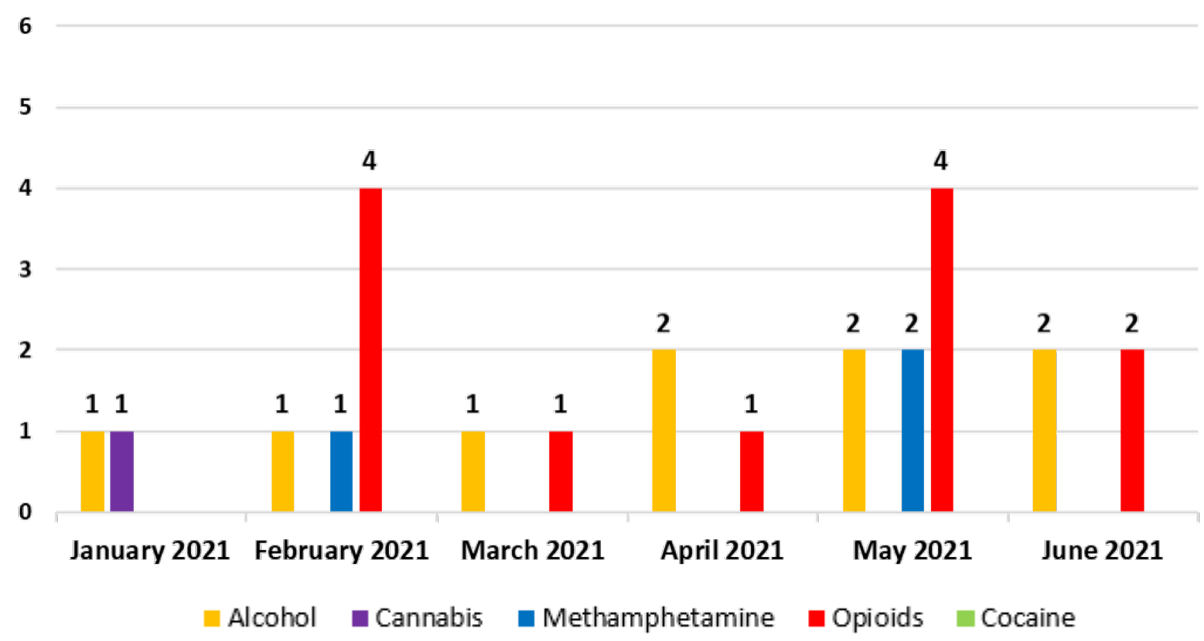
- Dr. Levin is leading this quality improvement process and working with clinic providers to implement it.
- CCNs have best practice order sets for labs, patient education, and follow-up.
- We continue to see the positive changes in both groups of interest.
- We have implemented the new *Diabetic Medications Refill Policy* with the goal to have every patient with diabetes be seen in the clinic at least twice a year.
- We are working to allow our providers at OHC to check A1c level before a patient’s encounter.

# Substance Use Disorder Statistics

## A. Quarterly Opioid Related Fatalities for Windsor County Residents



## B. Monthly Recovery Coach Visits by Substance



### Vermont Key Points

- The number of opioid-overdose fatalities increased 115% between 2019 and 2020.
- Compared to 2019:
  - A higher percentage of fatalities were female.
  - A higher percentage involved fentanyl.
  - A lower percentage of deaths involved cocaine.

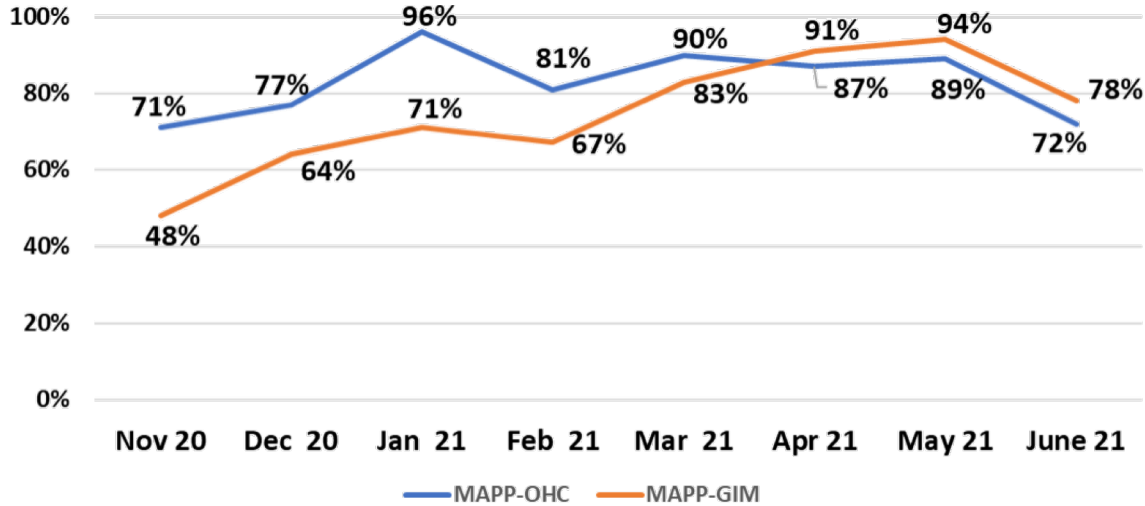


### Recovery Coaches

Results by Referrals Made		92%	Results by extended Quarterly Follow Up	
	Grand Total			Grand Total
Referrals Made	26	92%	Quarterly Follow Up Responses	4
Agreed to meet with a Recovery Coach	24		88%	Identified as still being in Recovery
Agreed to receive follow up calls	23	100%		Still engaged with Turning Point
Were called by Coaches	23		100%	
Agreed to a referral for additional support	24			

# Substance Use Disorder Treatment

**A. Percentage of Patients (New Patients, Annual Exams, Well Visits) Who Received SBIRT Screening**



### Narcan Education

### Rapid Administration of Medication (RAM) Through the Emergency Department

- “Overdose Happens; Make A Plan” Narcan education booklet completed and widely distributed in the county.
- 10 doses of Narcan were distributed from the ED in the first two quarters of 2021, with an annual goal of 18.

- 5 doses were initiated in FY2020.
- 7 doses were initiated in FY2021 to date.

# Windsor County Efforts to Prevent Opioid Fatalities

## PREVENTION

- Community-level grants (\$253,000)
- Environmental strategies/Town Policy efforts
- Increase drug disposal efforts (Drug Take Back, Envelopes)
- Health/wellness/prevention messaging
- Collaborative Problem Solving for School district
- Data Dashboard planning, grants and evaluation
- Health Disparities Needs Assessment and report
- Prevention digest and “For Your Health” TV shows

## INTERVENTION & TREATMENT

- Data monitoring, dissemination, outcomes reporting
- Systematic SBIRT training
- Creation of Narcan Education booklet & distribution of CPR Masks
- Outreach After Overdose (Police, Fire, EMS, HCRS, Recovery)
- Hartford, Windsor & Springfield
- Hartford Overdose Awareness Vigil
- Rapid Access to MAT in ED – Springfield, Windsor, VA
- “We are Worthwhile” anti-self stigma campaign
- Mobile Syringe Services Programs
- Chronic Pain Consult Team (Windsor) and Workshops

## RECOVERY

- Recovery Coaches in ED – Springfield, Windsor
- Recovery Ready Workforce initiatives
- Rides to Recovery, Springfield
- NA, AA, & Family Groups – Springfield, Hartford areas
- Turning Point Recovery Centers – drop in/safe haven
- Youth Based Recovery Services, Springfield
- Recovery Inclusive community events, outreach at food sites
- Point of access for “We Are Worthwhile” campaign

**Across all segments there has been an intentional building of infrastructure/network of community partners**

### COVID-19 FACTS – MAHHC

- MAHHC has administered a total of **12,122** doses of COVID vaccine between December 16, 2020 – June 18, 2021.
- Vaccine administration for the community vaccine clinics as of June 18, 2021 – **9,137**
- Vaccine administration for the 1a population of health care workers and essential personnel – **2,985**
- Female 53.63%, Male 46.34%, Other 0.03%
- MAHHC has been serving as a State of Vermont mass COVID-19 vaccination site and will be transitioning to administering COVID-19 vaccinations in the Primary Care clinic and is open to the community.

**12,122!**