



# VHCIP Provider Sub-grant Symposium

## AGENDA

October 7, 2015

8:00am – 12:30pm

Capitol Plaza Hotel  
and Conference  
Center  
Montpelier, VT

- **8:00**     **Arrival**
  
- **8:15**     **Opening Remarks**  
**Lawrence Miller**  
Chief of Health Care Reform
  
- **8:30**     **Statewide Best Practices Panel Discussion**
  - **MODERATOR: Betty Rambur, Ph.D., R.N.**, Green Mountain Care Board
  - Jill Warrington, M.D., University of Vermont College of Medicine
  - Allen Repp, M.D., University of Vermont College of Medicine
  - Dorey Demers, R.N., Project Coordinator, RiseVT
  - Cathy Fulton, M.S., Executive Director, Vermont Program for Quality in Health Care
  - Linda Otero, M.S.N., Statewide Surgical Collaborative Program Coordinator, Vermont Program for Quality in Health Care
  
- \*\*break \*\*
  
- **10:30**    **Substance Abuse/Access to Care Panel Discussion**
  - **MODERATOR, Tom Simpatico, M.D.**, Chief Medical Officer, Department of Vermont Health Access
  - Mark Depman, M.D., University of Vermont Health Network, Central Vermont Medical Center
  - Ginger Cloud, M.S., L.C.M.H.C., L.A.D.C., SiMH Project Manager
  - Steve Dickens, M.A., Director, InvestEAP
  - Kirsten Murphy, Policy Director and Planner, Vermont Developmental Disabilities Council
  - Skye Peebles, Project Assistant, Program and Development Director, Green Mountain Self-Advocates
  - Nicole LeBlanc, Project Assistant, Advocacy Director, Green Mountain Self-Advocates
  
- **12:15**    **Debrief**  
**David Reynolds**  
Health Policy Consultant

*Please join each other for lunch at one of the many restaurants in Montpelier!*



## Welcome to the VHCIP Sub-grant Symposium

Vermont's VHCIP sub-grant program is designed to directly support providers engaged in payment and delivery system transformation. By aligning with the three aims of health care reform – improving care, improving population health and reducing health care costs – these sub-grant projects will test alternative payment models, create innovative care models, and develop infrastructure to support a high-performing health care system in Vermont.

We extend our thanks to all of our participants for coming to our event today and hope to continue to foster cross-project sharing of ideas and best practices.



## VHCIP Provider Sub-grant Symposium

# Speaker Biographies

Lawrence Miller  
*Chief of Health Care Reform*

David Reynolds  
*Health Policy Consultant*

Dr. Betty Rambur, M.D.  
*Green Mountain Care Board*

Tom Simpatico, M.D., Chief Medical Officer  
*Department of Vermont Health Access*

**Lawrence Miller**  
**Chief of Health Care Reform**

Lawrence Miller is a senior advisor to Governor Shumlin and Chief of Health Care Reform. Previously, Miller was the Secretary of the Agency of Commerce and Community Development.

Lawrence was the founder of Otter Creek Brewing, Inc. As owner, CEO, and Brewmaster Lawrence grew Otter Creek from a single-person, draft only brewery to a leading Regional Specialty brewer from 1990 through the successful sale of the company in 2002. During his time in the industry Lawrence also served on the Board and as Membership Chair of the Brewers Association of America; as President of the Vermont Brewers' Association; and as Technical Chair, District New England, Master Brewers Association of the Americas.

After selling Otter Creek, Lawrence developed an independent advisory practice focusing on manufacturers of consumer products including start-ups, high growth companies, and turnarounds. During this period Lawrence also served on the Committee of Operating Executives at Worth Mountain Capital Partners and as a Peer Advisor with the Vermont Peer-to-Peer Collaborative, now housed at the Vermont Sustainable Jobs Fund.

In 2007 he accepted the position of Chairman and CEO at client company Danforth Pewter where he led a migration strategy from wholesale to multi-channel consumer marketing, including acquisition of compatible pewter brands.

Lawrence had direct experience with the Agency of Commerce and Community Development as a client and volunteer. In 2010 he served on the Oversight Panel for the reform of State and Regional Economic Development and Planning services which was created as part of Challenges for Change. From 1997 to 2006 he served as a Board Member of the Vermont Economic Progress Council, the last two years as Chairman. VEPC was tasked with long range economic development planning and administering the state's tax incentive programs in support of a vision of "Vermont as an economically and environmentally healthy place to work and live." He was also the first Chairman of the Vermont Clean Energy Development Fund and served on the Advisory Committee to create the new VSJF Flexible Capital Fund. Until joining the Administration he had also been a member of the North Country Angels investment group.

Other past activities related to the Agency's mission have included service on the Board of the Addison County Chamber of Commerce; the Student Apprenticeship Council of Addison County; The Hannaford Career Center Regional Advisory Board; Employment Associates Business Advisory Council; the Middlebury Airport Commission; and as a Director and Treasurer of the Middlebury Area Land Trust.

Lawrence earned his undergraduate degree in psychology in 1987 from Reed College, in Portland, Oregon. From 1997- 1999 he completed the Birthing of Giants Entrepreneurial Leadership program at MIT, in Boston.

**David Reynolds, Dr.P.H.  
Health Policy Consultant**

David Reynolds has served as a senior health policy advisor to Senator Bernie Sanders (2007 – 2011), Governor Peter Shumlin (2011 – 2013), and Senator Patrick Leahy (2014). While with Senator Sanders, he drafted and negotiated key provisions of the Affordable Care Act, focusing on primary care and workforce issues.

David received his Master's (1972) and Doctorate (1999) degrees in Public Health from the University of Michigan, specializing in health care administration and policy.

In 1976, David founded, and led for 30 years, Northern Counties Health Care in the Northeast Kingdom, Vermont's first Federally Qualified Health Center network. He was also a founder of the Bi-State Primary Care Association in 1986. David was appointed to the position of Distinguished Visiting Faculty in Health Policy at George Washington University in 2005. In 2012, the New England College of Optometry awarded him an honorary doctorate of humane letters.

Previously, David was awarded several fellowships: Pew Foundation Fellowship in Health Policy (1984-1987), Kellogg Foundation International Leadership Fellowship (1995-1998) concentrating on southern Africa and Latin America, and the Department of State Congressional Fellowship (2012) during which he was part of a team that travelled to Kazakhstan.

**Dr. Betty Rambur, Ph.D., R.N.**  
**Green Mountain Care Board**

Dr. Betty Rambur is a professor of nursing and health policy at the University of Vermont (UVM). From 2000-2009 she served as an academic dean at UVM, where she led the merger of the School of Nursing and School of Health Sciences to establish the College of Nursing and Health Sciences. She was also Chair of the Department of Nursing at the University of Mary, in Bismarck, ND from 1993-2000. These experiences build on Dr. Rambur's substantive leadership history in health policy and finance. From 1991-1995 she led the statewide health financing reform effort in North Dakota.

A registered nurse, Dr. Rambur received her Ph.D. in nursing from Rush University in Chicago, IL. She maintains an active research program focused on health services, quality, workforce, and ethics. She has led or participated in research, education, and public service grants exceeding \$2 million and is author of about 40 published articles and numerous invited presentations on her research, health care economics and policy, and leadership development. In 2007, her research was honored by Sigma Theta Tau International. Dr. Rambur is also an accomplished teacher in both classroom and online venues. In May of 2013 she received the UVM Graduate Student Senate Excellence in Teaching Award and in November 2013 she received the prestigious Sloan Consortium Excellence in Online Teaching and Learning Award. Her teaching expertise includes the organization, finance, and policy of health care and evidence-based practice. Dr. Rambur has authored a textbook designed to explain health care finance, economics, and policy in an easy-to-understand, reader-friendly manner, published by Springer Publishing in April 2015.

Dr. Rambur was appointed to Vermont's Green Mountain Care Board in August 2013. The five member Green Mountain Care Board oversees Vermont's payment and delivery reform and holds broad regulatory, innovation, and evaluative authority.

**Dr. Thomas Simpatico, M.D.**  
**Chief Medical Officer, Department of Vermont Health Access**

Dr. Thomas Simpatico is a psychiatrist who trained at the University of Chicago and specializes in public health systems, serious mental illness, substance abuse services and public policy. He is Research Professor & Director of the Division for Integrated Health & Human Services at the UVM Center for Clinical & Translational Science and Professor of Psychiatry and Director of the Division of Public Psychiatry at the UVM College of Medicine. He receives over \$2 million in annual funding from the Veterans Administration for projects designed to connect veterans and their families with health care and human services.

Through UVM he serves as Chief Medical Officer for the Department of Vermont Health Access (DVHA, the Vermont Medicaid Authority), which oversees \$1.3 billion in health care funding annually. As DVHA CMO he is working to create and deploy a multi-payer system of health care. He also oversees several million dollars in funding for veteran's services for Vermont, parts of New York and New Hampshire.

He is a member of Governor Shumlin's Criminal Justice and Substance Abuse Cabinet and is part of the leadership team overseeing Vermont's "hub and spoke" system for opiate replacement therapy.



VHCIP Provider Sub-grant Symposium

# Project Summaries



**Healthfirst**  
**Capacity & Infrastructure Building and**  
**Clinical Quality Improvement Among Independent Physicians**

**What We Are Doing**

Healthfirst's work under our VHCIP grant has two main emphases, with a range of activities and initiatives to support these efforts. First, we are building infrastructure and capacity to support independent physicians as connected and engaged partners in Vermont's healthcare landscape. At the same time, Healthfirst is committed to supporting independent practices in delivering high-quality care by (1) introducing a collaborative care agreement among primary care and specialist physicians within our membership, (2) providing resources and support for implementing and managing data tracking and reporting, and (3) helping architect disease management programs by implementing and/or honing best practices for aiding patients through care transitions.

**How Our Work Is Going**

Healthfirst has achieved many of its capacity and infrastructure goals, including hiring additional staff, securing office space, developing policies and procedures, and convening committees and subcommittees in support of our accountable care activities. We are also making great progress on initiatives to support quality improvement, including: (1) 100% member practice participation in our collaborative care agreement; (2) completion of the 2014 data collection for our commercial ACO practices for which we piloted an "office champion" system for data collection from within the practices; (3) hiring a Quality and Care Coordination Manager to work directly with practices to support data tracking/reporting, coding compliance and more; and (4) engaging member physicians in meetings and discussions within and beyond HF's membership about healthcare around the state to ensure that independent physicians are informed and are represented as key stakeholders.

**Lessons We Have Learned**

1. Changing care patterns at the practice level can be very challenging. It requires constant, clear communication, regular feedback about progress, reliable quality data, and a high level of trust among HF network staff and individual physicians and practice managers.
2. Practices must be compensated appropriately for their work to implement and manage quality care initiatives required by ACO and Blueprint programs. Addressing necessary changes in funding is essential if the state and other stakeholders want to keep practitioners engaged in efforts to change care patterns.

**Rutland Area Visiting Nurse Association and Hospice, Inc  
and  
Rutland Regional Medical Center  
Supportive Care Program**

**What We Are Doing**

The goal of the Supportive Care Program is to bridge the gap between inpatient palliative care and hospice, and expand beyond the existing palliative care program. Working with the primary care physicians, Rutland Regional Medical Center and the Rutland Community Health Team, this program will address the complex needs of seriously ill patients. The aim is to support patients and their caregivers in clearly identifying their goals and incorporating these goals into a suitable treatment plan in concert with their primary care providers earlier in the disease process. Higher quality communication will improve the likelihood of thoughtful planning and, therefore, the quality of care by aligning it with patient desires, promoting adherence with treatment and care plan(s) while lessening the physical emotional duress associated with serious illness.

**How Our Work Is Going**

Initially there was difficulty getting non-Medicare patients who met the illness criteria to participate; therefore it was necessary to expand the criteria to include Medicare patients. In addition, collaborating with local nursing homes to integrate our services and theirs for CHF/COPD patients has allowed for an easier transition back home after rehabilitating in the facility has increased referrals into the program.

To date, RAVNAH has seen 25 patients under this program since expanding the payer criteria.

**Lessons We Have Learned**

In order to provide traditional home care services to Medicare patients, the patients are required to be home bound. Broadening the payer criteria to include the non-homebound Medicare patient population was critical to the success of this program.

One of the biggest hurdles that we continue to meet is the difficulty convincing referrals who are currently stable to utilize our services. Patients are resistant to discussing end of life planning when they are not immediately faced with that situation.

## **White River Family Practice High Risk Population Management in Advanced Primary Care Practices**

### **What We Are Doing**

We have identified a registry of patients within our practice comprised of patients who demonstrate one or more of the following characteristics: (a) frequent ER usage; (b) frequent hospital admissions or readmissions; (c) a diagnosis of asthma with treatment for this condition either in the ER or through hospital admission within the past 24 months; and (d) a diagnosis of poorly controlled diabetes with coexisting depression. These patients' self-reported confidence in managing their own health issues (Health Confidence, HC) is assessed at every visit. Employing increased and dedicated Care Coordination services, intensive pre-visit planning and post-visit communications, and our staff's newly acquired (and ongoing) motivational interviewing training, we are focusing on improving patients' HC and health understanding. To that end, we continue to meet with our motivational interviewing trainer, Caitlin Barthelmes, and our consultant, John Wasson, to refine our approach.

### **How Our Work Is Going**

Our initial patient registry is composed of about 76 patients, more than half of whom have responded with measures of HC (as of 8/15/15). Our recent evaluation of patients for whom we have serial HC measurements (N=33) shows that HC is improving. We have developed discreet "flow maps" defining office care processes for each of our four target patient populations, as well as templates within the electronic record to document pre-visit-planning, patient Care Plans, and post-visit patient contact including pathways to facilitate meeting with an on-site (part-time) Mental Health provider, if needed. Although we have requested insurance claims data from all payers regarding healthcare provided to WRFPP patients, to date only BCBSVT and DVHA have been willing to share claims data; of those two, only claims data from DVHA have been functionally integrated into our analytic software – and only within the last several weeks. The near-complete absence of insurance payer claims data has significantly compromised our ability to employ our population health management software in predictive analytics for risk stratification during the first year of the grant.

### **Lessons We Have Learned**

Preliminary data shows that we can make a significant difference in improving Health Confidence. We have just analyzed our data this week and hope to present more information to the SIMs group in subsequent updates.

Engaging our at-risk population continues to be a challenge. Social determinants of health play havoc with primary care practitioners' efforts to keep patients healthy; primary care is not equipped to deal with difficult socioeconomic factors such as homelessness, poverty, lack of transportation, and the complex and difficult family dynamics so often found to accompany poor health states.

Helping the entire office use motivational interviewing and work together with care planning requires a long-term commitment to the process.

Tools which would be helpful in the care of these patients have yet to be developed in an ideal way within our electronic medical record and appear to be lacking within the industry. The lack of infrastructure support makes implementation of care more difficult.

**Northeastern Vermont Regional Hospital**  
***Caledonia & s. Essex Dual Eligibles Project***

**What We Are Doing**

This project is providing a health coach for people dually covered by Medicare and Medicaid, and funding for goods and services not normally covered by insurance; thus enabling an integrated multi-disciplinary community care team to provide better care for clients who are at risk for poor outcomes and high costs of medical care.

**How Our Work Is Going**

The health coach continues to manage over 40 clients; he is working with numerous other organizations to coordinate care including mental health, home health, area agency on aging, and primary care. With the help of the VHCIP Integrated Community Care Management Learning Collaborative, the project is making great strides toward identifying a lead care coordinator for dually eligible clients, and also piloting a shared care plan.

**Lessons We Have Learned**

Lessons learned include:

- How do we share information across organizations
- Some agencies/organizations do not have capacity to provide timely services
- Lack of funding for preventative wellness
- Lack of funding for Dental Needs
- More dual eligible individuals in the community than the health coach has the capacity to serve

**Vermont Medical Society Education and Research Foundation and  
UVM Medical Center  
Optimizing Laboratory Testing Collaborative**

### **What We Are Doing**

Collaboratively, multi-disciplinary teams from eight regional hospitals are building a foundational improvement construct for retooling regional care processes. The Laboratory Collaborative represents change not forced from the outside in, but change led from the inside out; change based on professionalism and trust among leaders across multiple disciplines who work in the trenches every day. Our global aim is to reduce harm to patients and conserve system resources by optimizing the use of laboratory tests for patients cared for in our region's hospitals. Guided by a faculty of clinical, QI and analytic professionals, eight regional hospitals have uploaded a 1 year baseline of billing and laboratory data of all adult inpatients to a secure data enclave at University of Chicago (<http://www.norc.org/Research/Capabilities/Pages/data-enclave.aspx>); the baseline data base comprises more than 90% of hospital beds in the region. The goal for the reporting process is for each hospital to submit monthly updates; and for monthly all-collaborative and hospital specific performance reports to be sent to multi-disciplinary hospital improvement teams to support their investigations of problems and tests of changes targeting reducing harm and conserving resources - <http://www.vmsfoundation.org/simgrant> .

### **How Our Work Is Going**

One of the goals of this collaborative was to introduce quality improvement tools and models to interprofessional teams. The creation of an interprofessional team is critical to the success of any quality improvement efforts that cross the traditional professional and work unit boundaries. The interprofessional teams for our collaborative have consisted of Hospitalists, Pathologists, Medical Technologists, Nurses, IT Staff and Quality Improvement professionals. At one community hospital, analysis of their processes revealed that phlebotomists were often drawing extra tubes of blood – just in case a physician later requested “add-on” lab testing. On further investigation, the add-on testing turned out to be very rare occurrence, and the hospital was able to eliminate the practice of drawing extra tubes of blood – at an estimated savings of more than 12 liters of blood each year. Prior to this project, more than 90% of adult patients hospitalized on the Family Medicine and Internal Medicine services had recurring daily lab orders. Over the past months, we have seen this percentage drop to less than 50%.

### **Lessons We Have Learned**

1. Innovation and reform has to be arranged by leaders – they are not automatic;
2. Leaders have to be persistent, actively supportive and creative – resources are scarce for clinically driven improvement;
3. If improvement is to be actualized, all those involved in the everyday processes of care need to be involved;
4. The health care workforce is a generous creative resource for retooling the system of care; and
5. If the system is going to be changed in meaningful transparent ways, it has to be changed where the work is done with the input of the people that do the work;
6. Support for quality improvement varies across the region's hospitals;
7. Communication across departments varies across the region's hospitals; communication among clinical, analytic, and IT staff can be improved, especially around understanding key definitions.
8. Hospital data definitions, collection and storage processes vary enormously; and
9. There is a challenging trade-off between availability of clinical data and protection of patient privacy.

## **Invest EAP Resilient Vermont**

### **What We Are Doing**

Employee Assistance Programs (EAPs) have been demonstrated to reduce employee stress that may otherwise increase cortisol and epinephrine levels and lead to chronic disease. If such prevention and early intervention is effective in the workplace, what would be the impact on health outcomes and expenditures if we offered these same services to patients at a healthcare center?

Screening, Brief Intervention, Referral and Treatment (SBIRT) programs have been shown to effectively screen for and enable clinicians to address substance abuse problems. Behavioral Screening and Intervention (BSI) programs have effectively expanded such screening to include depression and smoking. What if we combined SBIRT, BSI and a screen for the most common issues helped by EAP?

We are investigating the combined effects of such a combined program of EAP and behavioral health screenings and interventions at the St. Johnsbury Healthcare Center. Our staff has undergone intensive Motivational Interviewing training by staff from the University of Wisconsin School of Medicine and Public Health. The training included a full week in person, weekly and then monthly follow-up debriefing calls with the trainer for one year and staff submitting session tapes for evaluation and feedback throughout the year.

### **How Our Work Is Going**

Hundreds of patients have been screened to date; many of them have screened positive. Working out the logistics of getting those in to see the trained clinician has been a challenge for a number of reasons: (1) when the patients are free the clinician may be tied up with another patient; (2) some clinic staff have not been proactive with introductions and instead ask patients if they want to work with someone on their “drinking problem.” Our clinician has seen a number of patients and has a number of success stories. We are working on improved referral mechanisms.

### **Lessons We Have Learned**

- Individuals who are not working are proving easier to engage for repeated visits.
- Patients are grateful for the service
- Changing the culture and traditional practice of medical providers can be challenging.

**Community Health Accountable Care, LLC.**  
**Furthering Community Health Accountable Care, Collaborations and Analytics**

**What We Are Doing**

The VHCIP Provider Grant funding is truly the backbone of Community Health Accountable Care (CHAC) as it has funded basic infrastructure including core staffing, facility costs, meeting costs, professional services, and IT support. Accomplishments of the last year include implementation of CHAC's standing committees; development, adoption of, and implementation of clinical recommendations for COPD, CHF, Falls Risk Assessment, and Diabetes; implementation of a telemonitoring pilot; and operationally supporting all ACO requirements (i.e. beneficiary notification mailings and report submission including quality reporting).

**How Our Work Is Going**

CHAC is excited to be welcoming new organizations into our network for the 2016 program year including Northeastern Vermont Regional Hospital and Grace Cottage Hospital for all payers and others for Medicare. We successfully completed quality reporting for Program Year 1, and were delighted to be notified that we achieved savings from the Medicaid program, a large portion of which we will be able to distribute to our participants for investment at the local level. We are sharing data at each of the individual health centers and working on improvements. The progress of our clinical committee has been remarkable as they have invested substantial time to develop through a consensus driven process best practice clinical recommendations that have been shared within our network, with community partners, and throughout the state. The telemonitoring program, especially the care coordination aspect, has received rave reviews from providers and patients, and as of September 2015 initial results demonstrate a significant reduction in hospitalizations attributable to that program.

**Lessons We Have Learned**

Adoption and implementation of new processes can be challenging to disseminate across a statewide network of individual organizations and requires a champion at each location to advocate for the changes. Our clinical committee members, who are deeply invested in the clinical recommendations they developed and agreed to adopt have taken on the role of champions in an effort to unite our provider network and establish the expectation for ongoing quality improvements. It is important for the clinical and operations to be integrated and we will be holding our first joint meeting of our Clinical and Operations committees in October through which we hope to initiate a process for implementation and follow-up of quality improvement recommendations. Accurate alignment of the ACO measures takes time as the national recommendations for best practice often change before the measures are updated.

**Northwestern Medical Center  
RiseVT**

**What We Are Doing**

RiseVT is a community initiative to embrace healthy lifestyles. RiseVT motivates, inspires and works with individuals and families to help them make small changes in their lives that will have a big impact on their health. In addition, RiseVT has strategically placed Health Advocates around Franklin and Grand Isle to work with schools, businesses and municipalities to wrap around our residents to create an environment where the healthy choice is the easiest choice.

**How Our Work Is Going**

RiseVT launched on June 1, 2015 and has been rising ever since. Currently RiseVT is working with five municipalities, 27 businesses, six schools and has engaged with over 3,000 Franklin and Grand Isle residents.

**Lessons We Have Learned**

Piloting has been key as we have learned from our different entities how to engage and make a meaningful impact on their environment. Developing relationships with community members, leaders, schools, etc., will be an ongoing process and the importance of making these connections has been and will continue to be a vital component of our success.



**Vermont Developmental Disabilities Council, in partnership with Green Mountain Self  
Advocates  
The Inclusive Health Care Partnership Project**

### **What We Are Doing**

People with intellectual and developmental disabilities (I/DD) now enjoy a life expectancy almost equal to that of the general population. However, as a group, people with disabilities fare far worse than their nondisabled counterparts across a broad range of health indicators and social determinants of health. In fact, there is a building national conversation aimed at changing the way we think of people with disabilities in the healthcare system: Far from the rare but costly “high utilizers” that some policy makers fear, people with disabilities in general – and specifically, people with developmental disabilities – are not only an increasingly common part of the patient mix, they are as a group a classic example of a medically underserved population, deserving of the same benefits and considerations afforded other such groups. The goal of the Inclusive Healthcare Partnership Project (IHPP) is to identify and recommend a set of innovative best practices in the delivery of health services to adult Vermonters with I/DD that will improve their care experience and their health while reducing cost. Data from Medicaid claims, a one-on-one survey, and health screenings at Special Olympics events confirm that Vermont adults with I/DD have a lower health status, receive less preventative care, and experience more stressful encounters with health providers than do their peers without developmental disabilities. The inappropriate use of emergency room care is a particularly concerning example. At the same time, extensive interviews with both national experts and key Vermont stakeholders indicate both a strong willingness to make improvements and numerous opportunities to put emerging best practices to use in this effort.

### **How Our Work Is Going**

The IHPP Planning Team, which meets monthly, has organized its work around four themes: (1) The transition of care from pediatrics to adult health services; (2) Tools to improve provider-patient communication; (3) Integration of disability awareness into all levels of provider training; and (4) Policy initiatives that will support alternative models of care and an inclusive approach in public health initiatives. The IHPP Team plans to release its findings and recommendations as scheduled in mid-November. More importantly, the lead organizations in this grant have begun laying the groundwork for initiatives to move many of these recommendations forward in 2016.

### **Lessons We Have Learned**

IHPP is unique within VCHIP’s portfolio of community grants in the degree to which health care consumers, specifically those with disability-related long term support and service needs (DLTSS), provide leadership and expertise. The Lesson Learned that we would most like to share with the group is that while it takes some additional time and planning to involve self-advocates in meaningful conversations about the health care that they want to receive, it can be done. The result has been an unusually rich set of actionable ideas that we look forward to sharing with the Vermont Health Care Innovation Project.

**University of Vermont Health Network at Central Vermont Medical Center  
SBIRT in the Medical Home (SiMH)**

**What We Are Doing**

University of Vermont Health Network at Central Vermont Medical Center (UVMHN-CVMC) aims to implement screening and behavioral interventions for patients that present with risky levels of tobacco, alcohol and drug use. Our approach is to utilize the **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment (SBIRT) model in medical homes throughout CVMC with the goal of reducing and preventing health related consequences, disease, accidents and injuries that are associated with substance misuse. Additionally we have initiated the use of a SMS text messaging intervention, Caring TXT VT, for patients engaged in binge drinking behaviors.

**How Our Work Is Going**

We have established universal screening templates in the medical home's electronic medical records system. Coordination of care and information exchange between CVMC's Emergency Department SBIRT interventionists and the medical home interventionists has been established. To date six medical homes are in the process of utilizing the SBIRT model and have access to an onsite SBIRT counselor. Enrollment into Caring TXT VT is encouraged at these practices through face to face engagement and flyers. We anticipate the two pediatric medical homes at CVMC will start incorporating SBIRT into their patient care by January 2016.

Over the past year concern has surfaced at our CVMC Women's Health Clinic regarding substance abuse among pregnant women and an increase of post-partum depression. Interest in integrating the SBIRT model into prenatal and post-partum care as well as universal screening for all patients receiving gynecological services at Women's Health Clinic has prompted expansion of SBIRT. Outside funding has been secured to hire an additional SBIRT Clinician that will be available to offer substance abuse and mental health interventions for patients at our Women's Health Clinic.

A concern that has surfaced throughout the CVMC community is the path that a patient experiences when traveling through Central Vermont's systems of substance abuse care. In response to this concern we initiated an all-parties convocation on September 28, 2015 to help establish a coherent and systematic flow of patient care throughout Washington County. This meeting is an initial step toward Central Vermont's approach to providing the best care path possible for our community members struggling with substance misuse issues.

**Lessons We Have Learned**

There appears to be a concrete need for SBIRT services in the medical homes. The process of adding screenings to a workforce that is already burdened with numerous health screening tasks presents a unique challenge. Discomfort with the expanding expectations placed on routine patient visits combined with the cultural stigmas associated with substance misuse/dependence creates staff hesitancy in engagement of a comprehensive adherence to the SBIRT model.

## **Southwestern Vermont Medical Center Transitional Care Program**

### **What We Are Doing**

SVHC, in close cooperation with the Bennington Blueprint and community partners across the service area, is creating an integrated care delivery system to better serve our population in preparation for the global budget anticipated in 2017. We have re-deployed acute care resources (Clinical Nurse Specialists, Pharmacists, Social Worker) to partner with high risk, chronic care patients in primary care practices and are successfully navigating them from one setting to another and decreasing resources utilization (ED visits and inpatient hospitalizations.) Through this process, we have identified gaps in care delivery and developed solutions to bridge these gaps including:

- Development of a Community Care Team meeting monthly to provide wrap-around care planning for high ED use behavioral health and clients with addictions. (Integrated plan created for 18 patients with 5 success stories to date. Consistently 25 community partners attend weekly meeting. Recent survey = enthusiastic support for the benefits of the process and partnership.)
- Hiring of a nurse educator to assist with implementation of Interact program in all area nursing homes (Evidence based program with interventions to reduce transfers to the hospital) to decrease unnecessary readmissions from this setting (Interact nurse educator partnered with first long term center.)
- Standardization of care for CHF and COPD patients across the care continuum (primary care, hospital, long term care, home care.)
- Use of clinical pharmacist for patient education and M.D. consultation in primary care and long term care setting to increase medication adherence and decrease polypharmacy (working on research project to decrease unnecessary PPI use.)

### **How Our Work Is Going**

Since the inception of the Transitional Care Nurse program in the fall of 2013, we have demonstrated consistent decreases in inpatient hospitalization. (Data collected from partnering with 267 patients demonstrates 1 69% decrease in hospitalizations and a 35% decrease in ED visits measured 120 days before and after TCN involvement.) We are forging a strong partnership with Primary Care Practices, Medical Home Case Managers and all community care partners to identify opportunities to better coordinate care and maximize use of appropriate resources. Each of the new programs being implemented will target other identified opportunities to decrease cost, improve quality and the patient experience.

### **Lessons We Have Learned**

Partner with all care providers and community agencies and maximize appropriate referral and usage of what exists in your service area.

Find opportunities to meet the patient /family where they are and bring appropriate resources to them whenever possible.

Transitional Care nurses “partnering over time” and developing relationships with patients in the hospital, office, nursing home and home care setting can bridge the gaps from one care setting and provider to the next and assist with development of a realistic, patient centered plan of care.

Seldom are there opportunities for meaningful education for patients in the hospital setting due to short length of stay, acuity of illness and anxiety and discomfort of the patient. Realistic plans for follow-up are essential to improve chronic disease management and patient engagement in the plan. (Recent meeting with home care agencies identified need to partner some patients with both TCN and home care to maximize benefit.)

Medication reconciliation, management and education are key drivers in decreasing the cost of healthcare. (Providers in our region are open to pharmacists assisting with evaluation of patients with polypharmacy and suggesting changes to maximize benefit, decrease cost and avoid interactions.)

**Vermont Program for Quality in Health Care  
American College of Surgeons National Surgical Quality Improvement Program**

**What We Are Doing**

The Vermont Program for Quality in Health Care, Inc. (VPQHC) is coordinating the implementation of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) in Vermont hospitals. Twelve hospitals across the state of Vermont were afforded an opportunity to join ACS NSQIP and be participants in a statewide surgical service collaborative. Participation in the ACS NSQIP assists hospitals in identifying and reducing preventable surgical complications by extracting relevant clinical patient data from the time of surgery to 30 days post procedure. Other hospitals that have participated in ACS NSQIP have seen improvements in quality of care, patient safety, and patient satisfaction, in addition to reduced costs.

**How Our Work Is Going**

Over the past eight months, we have made great progress. VPQHC has hired the Statewide Surgical Collaborative Program Coordinator, facilitated monthly statewide meetings of our collaborative members, and provided ongoing outreach and education to Vermont hospitals. Six of the twelve hospitals are enrolled in one of the NSQIP program options and have joined the statewide surgical services collaborative. Hospitals have hired or are in the process of hiring surgical case reviewers (SCRs') to abstract the clinical data. Several SCRs' began training October 5, 2015.

**Lessons We Have Learned**

The success of a complex project requires a strategic plan that is structured but has flexibility to allow for changes necessary to move the process forward.

If the project has several stakeholders or is large in scope, establishing a collaborative will help engage, educate, and motivate participants toward a shared and sustainable goal.

## **InvestEAP and King Arthur Flour Behavioral Screening and Intervention**

### **What We Are Doing**

Employee Assistance Programs (EAPs) serve a number of employees with a wide range of presenting issues each year. However, most employees who come to EAP, do so on their own usually in response to some acute issue in their lives. While this produces many positive outcomes, a more active behavioral screening process could identify key risk factors for adverse health outcomes that may otherwise go undetected. Providing such screening in person would enable EAP counselors to apply evidence based Motivational Interviewing techniques to specifically address these behaviors, beginning at the time of the screening. Traditional Health Risk Assessments (HRAs) have attempted to screen employees for a range of behavioral issues. Unfortunately, follow-up is typically poor when health coaches call employees in the evening to engage them.

Our project enables the EAP counselor to provide short *in-person* behavioral assessment. When the employee meets a counselor and rapport is developed, employees are much more likely to engage in behavioral change work. This is especially true when the counselor has advanced training (lasting one year or more) in Motivational Interviewing.

### **How Our Work Is Going**

We have screened and treated more than a dozen employees thus far. There are a number of success stories already. Many employees have come in interested in improving their diet or exercise. Fewer have thus far screened positive for substance issues.

### **Lessons We Have Learned**

- Working closely with the employer's HR department is key to an effective rollout and adoption of the project.
- Offering employees the choice of meeting with us at their worksite *and* at our offices is important as individuals have divergent preferences related to time, ease of access and confidentiality.
- An extensive roll-out and packaging of the program engenders employee interest in participating.



VHCIP Provider Sub-grant Symposium

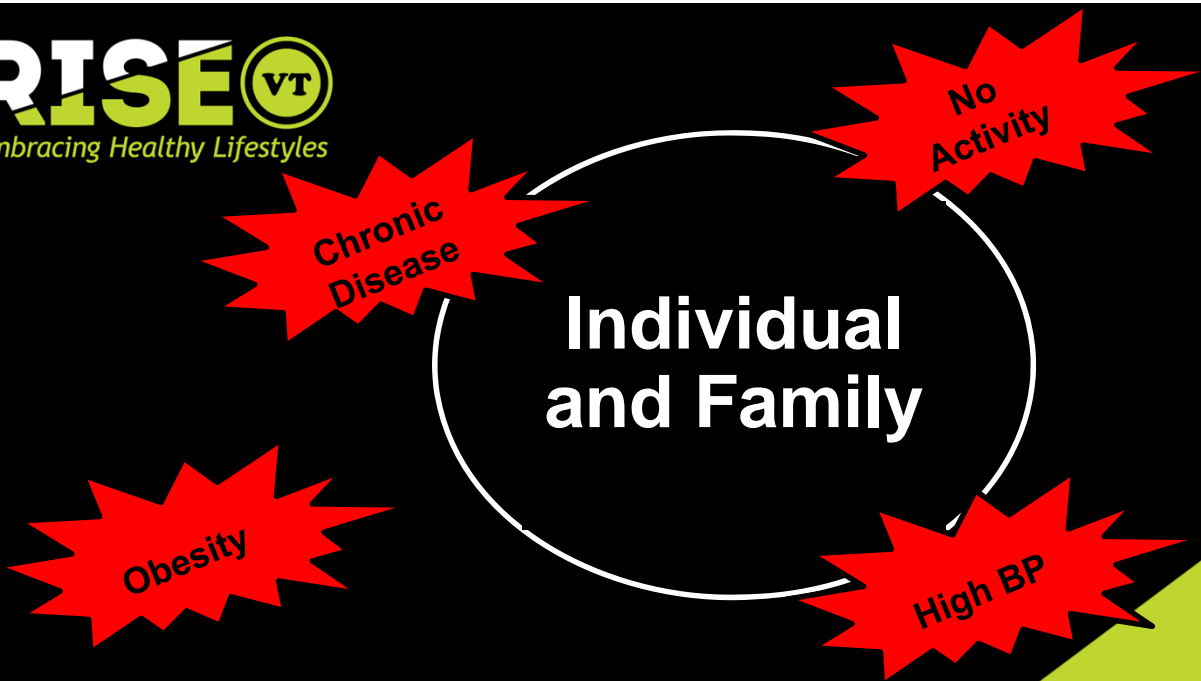
Materials from Statewide  
Best Practices Panel  
Discussion

# RISE<sup>VT</sup>



*Embracing Healthy Lifestyles*

## RISE<sup>VT</sup>

*Embracing Healthy Lifestyles*

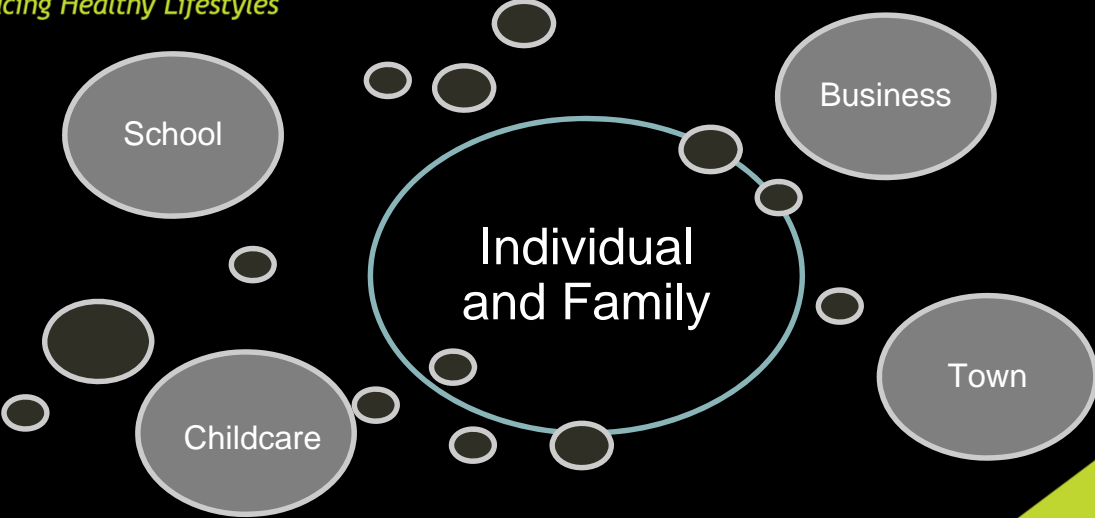
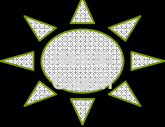



[www.risevt.com](http://www.risevt.com) | #RiseVT



**Individual and Family**

[www.risevt.com](http://www.risevt.com) | #RiseVT



**Individual and Family**

School

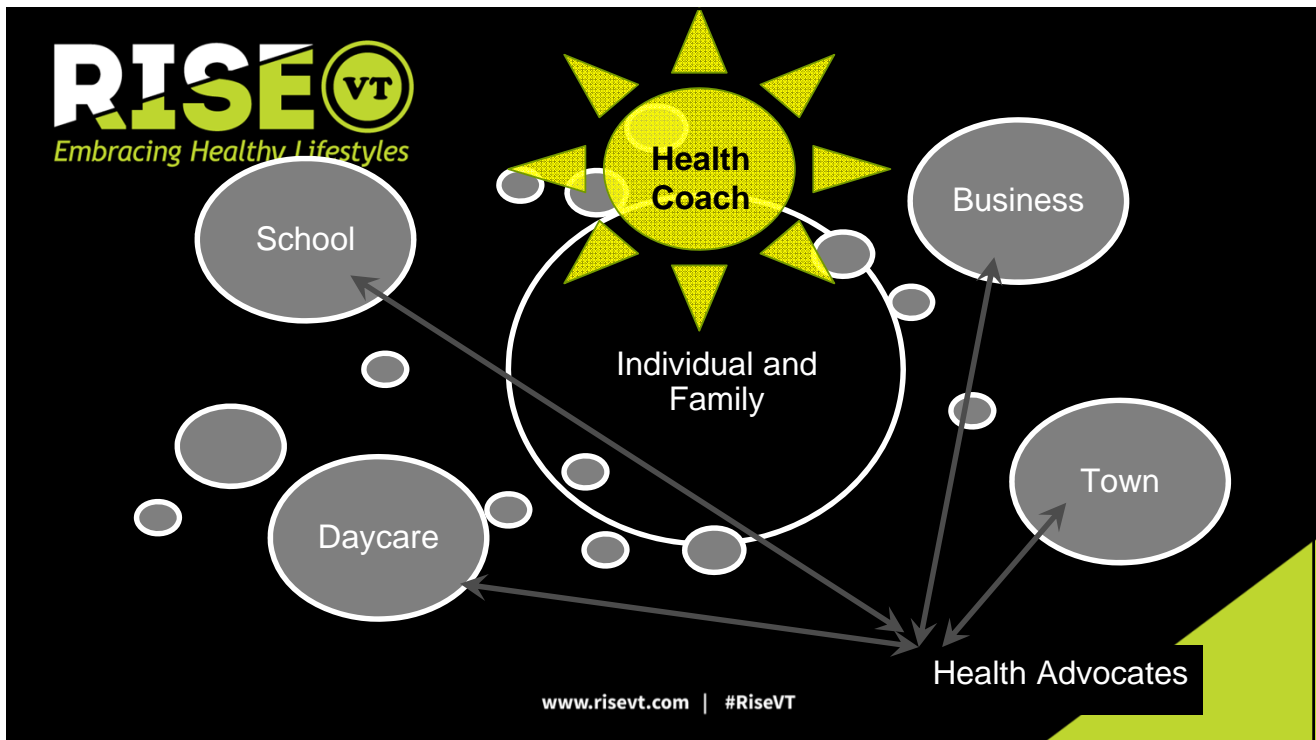
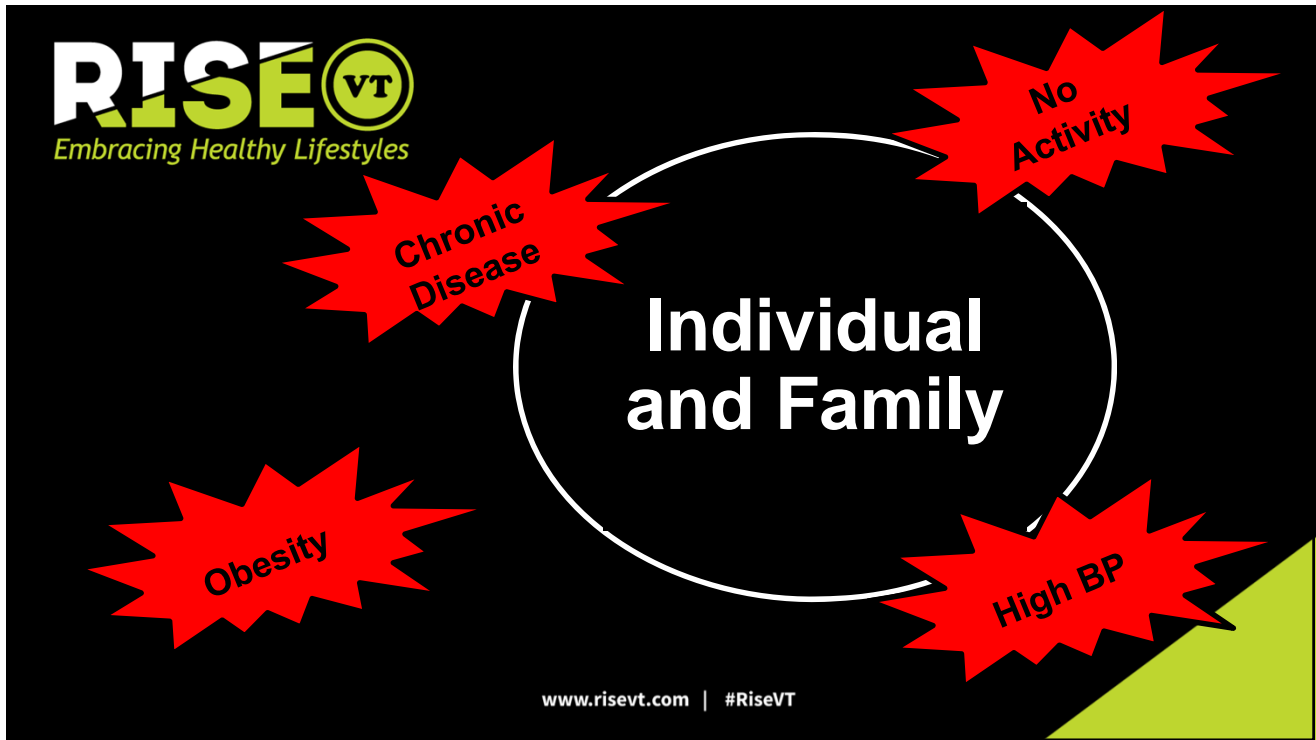
Childcare

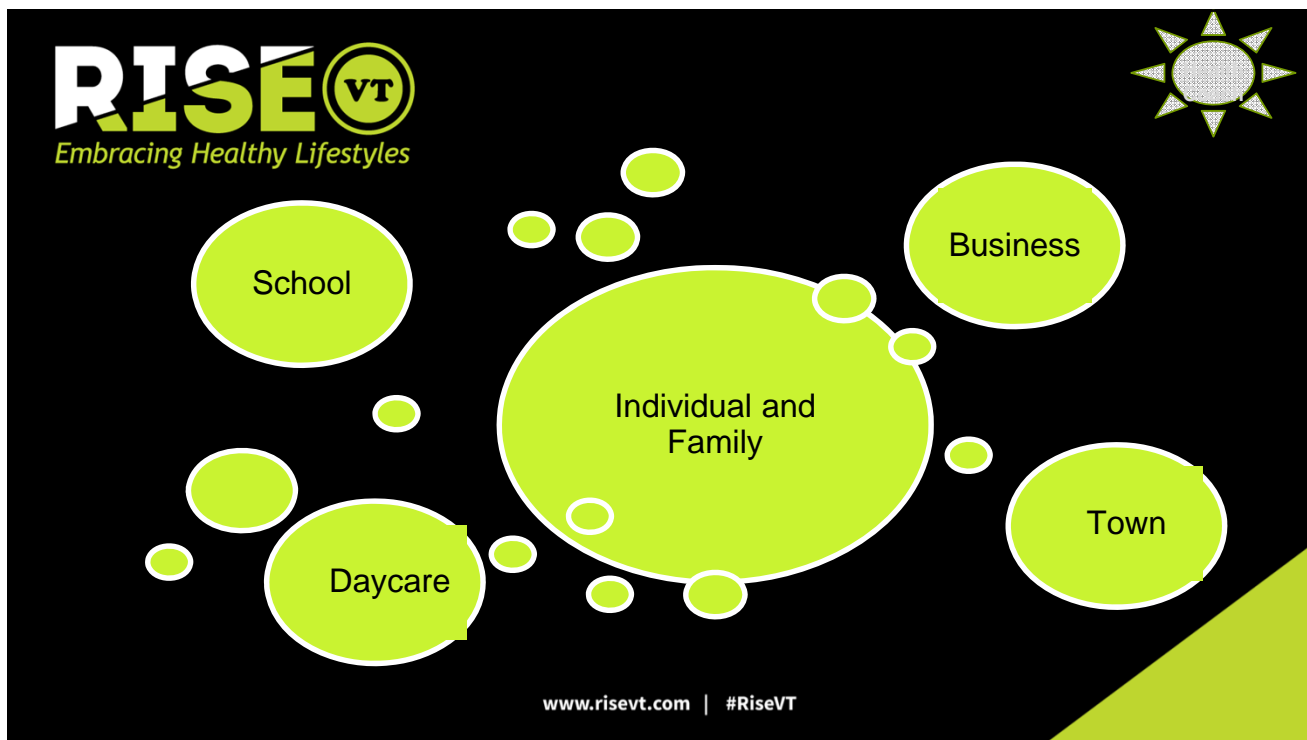
Business

Town

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**RISE** VT  
Embracing Healthy Lifestyles

## Outcomes

Increasing the health of residents by decreasing rates of obesity and overweight (*long term*)

### Strategies to Achieve Long-Term Goal

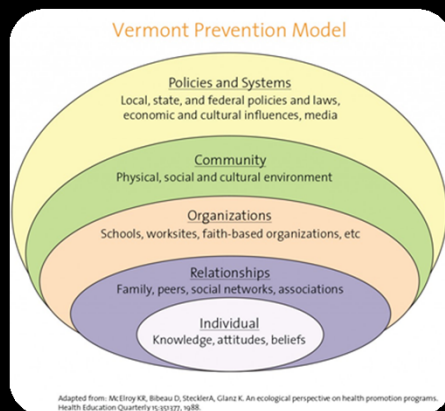
1. Increasing the number of employers offering wellness programs with greater than 50% participation rate (*short and medium term*)
1. Expand resources for biking/walking (*short and medium term*)
2. Increasing fruit/vegetable consumption (*medium term*)
3. Decrease the number of people with no leisure time physical activity (*medium term*)
4. Increase the number of students walking/biking to school (*short and medium term*)
5. Increase smoke-free/tobacco-free environments (*medium term*)

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# Strategy

RiseVT utilizes a US Preventive Services Task Force recommended strategy in obesity control, a **“community-wide campaign”** to increase motivation and demand for additional recommended obesity prevention strategies such as: worksite wellness, increased access to walkable/bikeable communities, policy/environmental/systems changes which support sustained healthy behaviors



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## WHO'S ALREADY RISING?

  
**3889**  
PEOPLE  
[VIEW ALL](#)

  
**25**  
BUSINESSES  
[VIEW ALL](#)

  
**5**  
SCHOOLS  
[VIEW ALL](#)

  
**5**  
COMMUNITIES  
[VIEW ALL](#)

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# Partnerships

*Individual, Relationship and Organizational Strategy*

Success Story

### Social Media June Launch Contest

Goal: to build momentum and increase awareness of local resources in our community.

RiseVT Highlighted Lets Grow Kids, NCCS, VDH, Franklin Grand Isle Tobacco Prevention Coalition, Healthy Roots

26 Posts yielded 1,428 Likes, 437 Comments, 501 Shares and had a reach of 49,904 residents.

- Northwest Counseling and Support Services
- Learning Together
- Local Gyms
- Recreation Departments
- Messenger Newspaper
- LocalMotion
- Fox44 and Fox22
- Hall Communication
- Messenger Print and Design
- Courier Newspaper
- Island Health and Wellness Committee
- Watershed Mentoring
- Vermont Department of Health Substance Abuse Prevention Consultant
- Franklin County Caring Communities Day Camps
- Vermont National Guard and Family Programs
- Safe Routes to School
- Vermont State Parks
- Vermont Department of Health
- Lions Club
- Police Department
- Hunger Free Vermont
- Healthy Roots
- FGI Regional Prevention Collaborative
- Local Farms- Green Heron Farm
- Libraries
- NOTCH
- Vermont City of Leagues and Towns
- Trail Finder
- Let's Grow Kids
- Local Motion
- Building Bright Futures
- Childcare Centers
- Franklin County Chamber of Commerce
- Agency of Human Services
- Voices Against Violence

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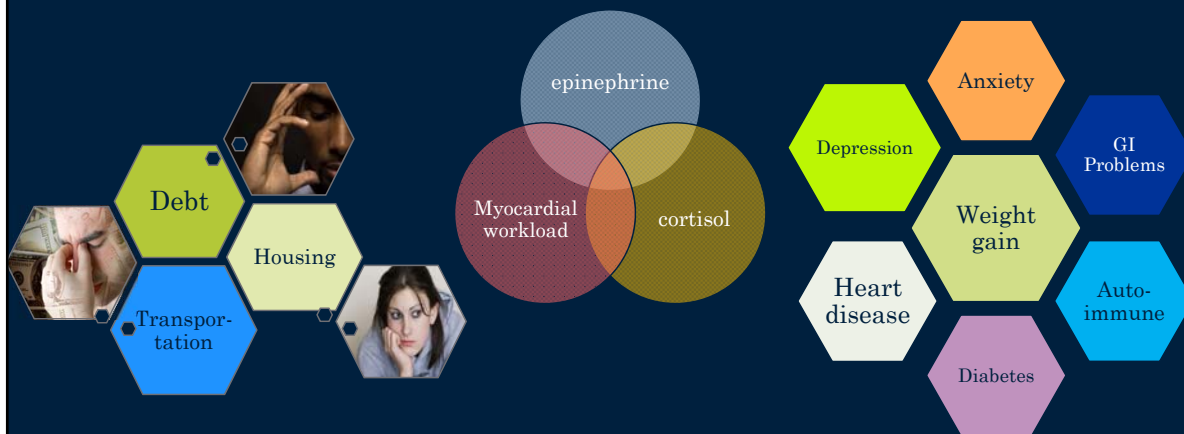
VHCIP Provider Sub-grant Symposium

**Materials from Substance  
Abuse and Access to Care  
Panel Discussion**

# vthealthEngage

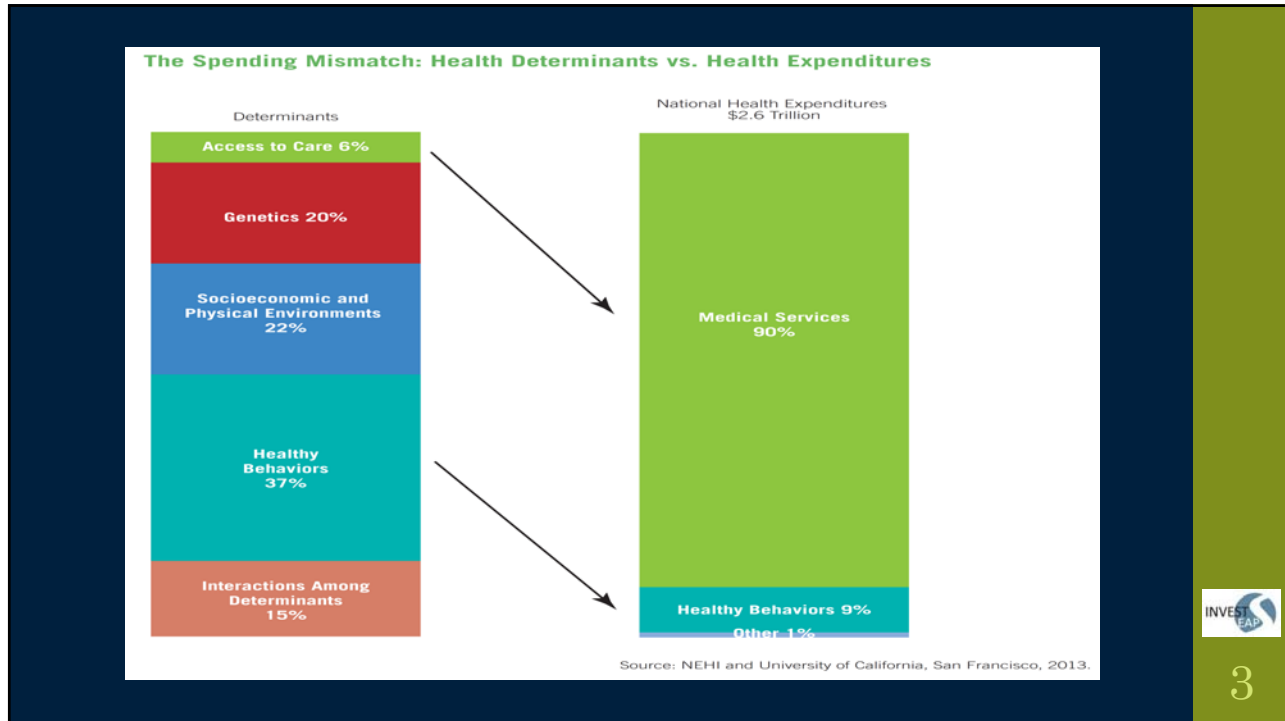
Engaging Vermonters in Wellbeing

## Chronic Stress Leads to Disease

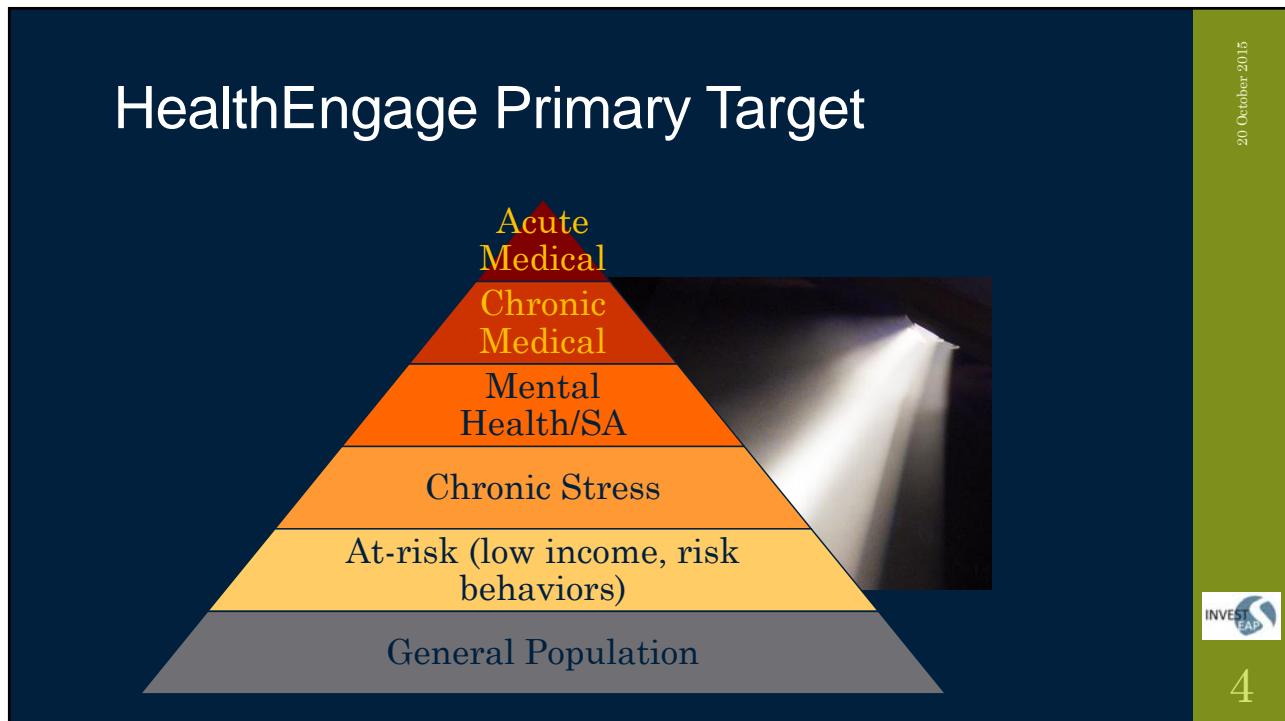


Daily Stressors → Chronic Stress → Disease





3

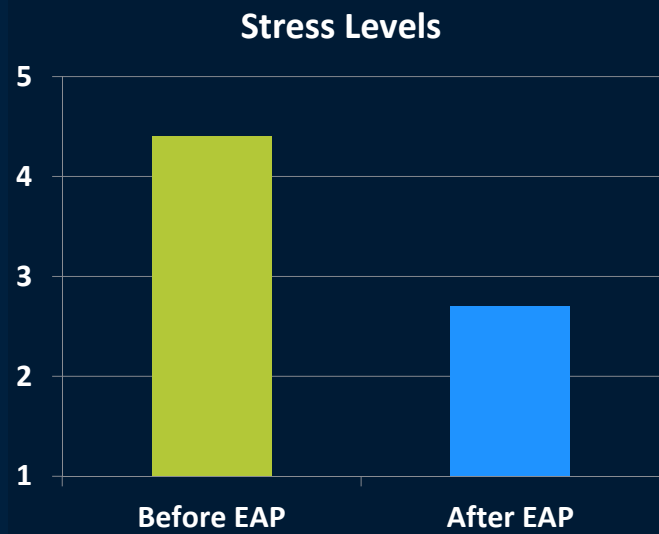


20 October 2015



4

## Outcome Data



20 October 2015



5

## Wisconsin Initiative to Promote Healthy Lifestyles

- \$13 Million in funding, 3 federal grants
- 50 primary care clinics (incl FQHCs)
- BSI+MI
- Nutrition, exercise, smoking, depression, drug/alcohol use
- 7,367 Medicaid patients
- \$680 reduction in healthcare costs over 2 years



20 October 2015



6



# Screening

- 1. Nutrition
- 2. Exercise
- 3. Smoking
- 4. Depression
- 5. Substance
- 6. Family
- 7. Legal
- 8. Financial
- 9. Stress
- 10. Housing
- 11. Childcare
- 12. Eldercare



20 October 2015



7

## Two Settings



Northern Counties Healthcare (FQHC)



King Arthur Flour

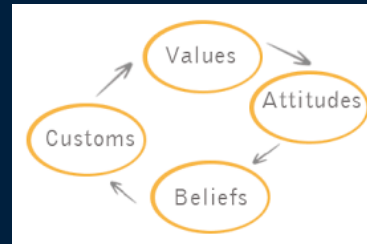
20 October 2015



8

## What we've learned: NCHC

- Perspective and culture key
- Buy-in critical all parties
- Asking permission vs prescribing



20 October 2015



9

## What we've learned: KAF

- PR, presentation, outreach is key!



Town meeting



20 October 2015



10

## Success Stories: NCHC

- Liver disease
  - Screening
- ↓
- MI
  - 3 months sober



20 October 2015



11

## Success Stories: NCHC

- Depression and Weight Gain
- ↓
- Weight loss group
  - Workshops/activities  
Community Ctr.



20 October 2015



12

## Success Stories: NCHC Housing/Legal

- Injured father of 3 children
- Awaiting worker's comp
- Landlord: home to be sold
  - Move within month in middle of January
  - Unable to work



- Referred to legal aid
- Due to hardship, family allowed to remain in home until suitable time to move



20 October 2015



13

## Success Stories: KAF

- Depression, heavy napping
- Sleep hygiene



- Improved sleep
- Increased exercise
- Increased social life
- Improved mood



20 October 2015



14

## Success Stories: KAF

- Quit smoking




- MI: list of reasons to quit. Etc.
- Developed plan to join smoking cessation group
- Obtain medication
- Specific changed in home routine to ensure success
- Cut back to 6/day; then quit





*Inclusive  
Healthcare  
Partnership  
Project*

**VHCIP Summit**  
October 7, 2015



*Of all the forms of  
inequality, injustice in  
healthcare is the most  
shocking and inhuman.*

*-- Martin Luther King, Jr.*

## The Inclusive Healthcare Partnership Project will...



...identify and recommend a set of innovative best practices in the delivery of health services to adult Vermonters with intellectual and developmental disabilities (I/DD) that will support the triple aims of healthcare reform – improving the experience of care and population health while reducing the cost of high quality, effective health services.

**Partners:** Vermont Developmental Disabilities Council (VTDDC) & Green Mountain Self Advocates (GMSA)

**Amount:** Under \$200,000

**Time:** Calendar 2015

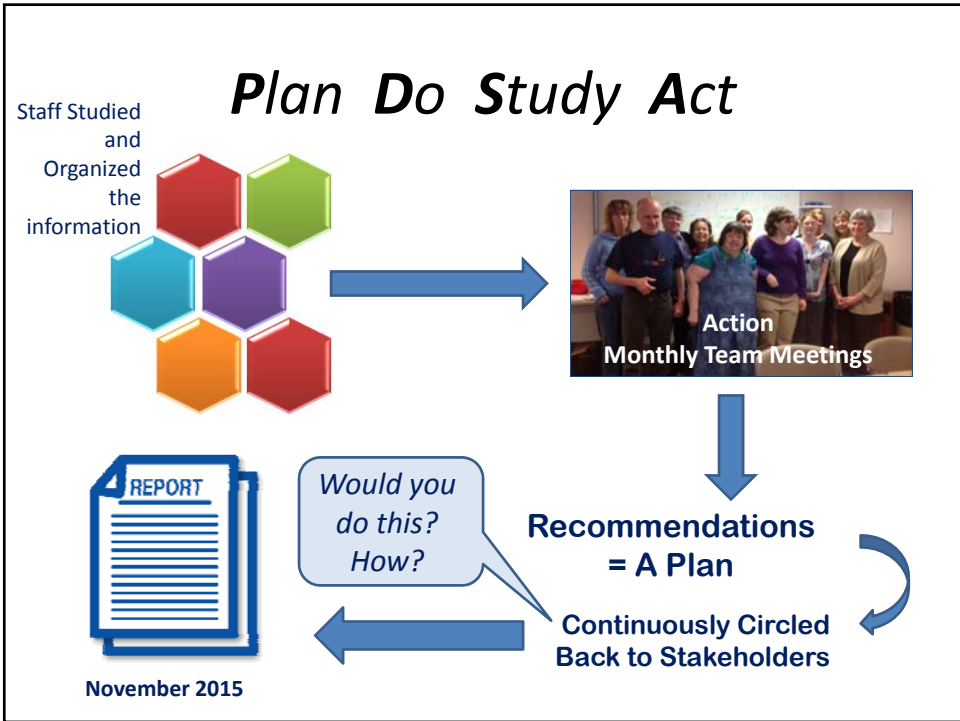
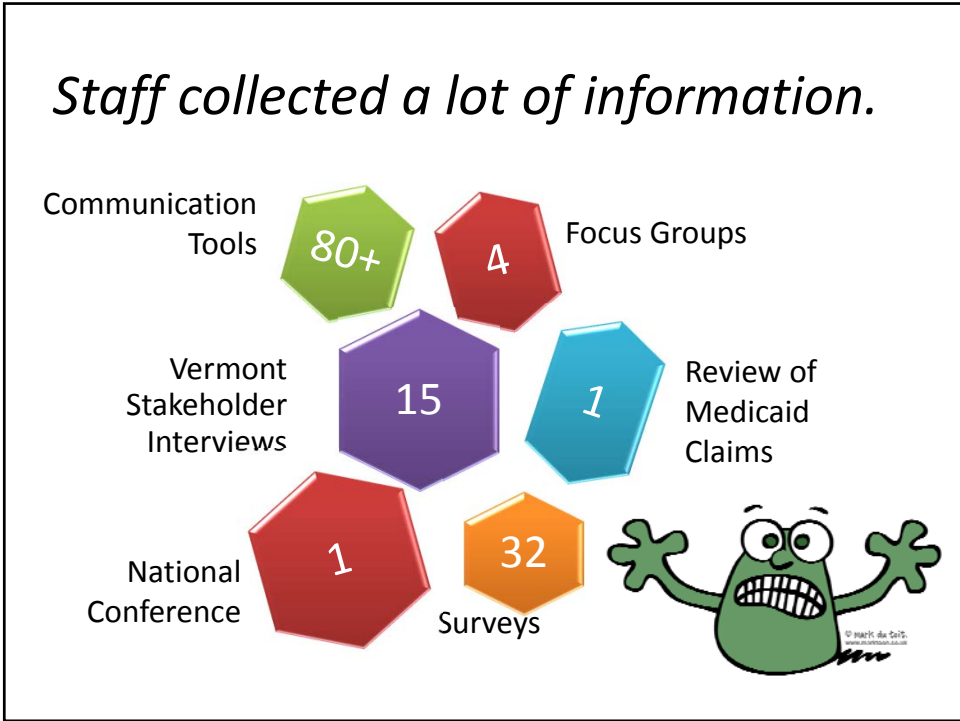


## An inclusive planning process



Staff	IHPP Planning Team
Project Director	3 Self-Advocates
Project Coordinator	1 parent
2 GMSA Assistants	3 physicians/ARN
Support provider(s)	1 agency nurse







## A solution-focused approach

### Four Themes:

- Transition from Pediatric Care to Adult-Focused Medicine
- Medical Education & Provider Training
- Care Models
- Health & Wellness

### Report:

- Findings
- Recommendations
- **Opportunities !**



Inclusive Healthcare Partnership Project

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## **SELECTED FINDINGS**

Special Olympics<sup>8</sup>

## On a Team of 10 Athletes



6 are obese or overweight



4 have obvious tooth decay and 1 needs and urgent referral to a dentist



3 fail a hearing test



4 need glasses and 2 have an eye disease



5 have a significant problem with flexibility; 4 with balance.

## Vermont Special Olympics

	All USA	Vermont
Mouth Pain	14.4%	8.2%
Untreated Tooth Decay	36.6%	22.2%
Eye Disease	16.0%	32.3%
Failed Hearing Screening	26.4%	35.7%
Obese (youth)	14.8%	18.8%
Obese (adults)	31.8%	45.7%
Use Tobacco Products	6.5%	5.7%



**Special  
Olympics**  
Vermont



## Emergency Room Use

- In a small survey of self-advocates attending GMSA's annual conference 40% said that they had been seen in an emergency room in the past year. N=35.



## Medicaid Claims for ED visits, 2014

VT HSA	Cohort 1	Cohort 2	Total
Barre	.57	1.80	.99
Bennington	1.95	1.22	1.52
Brattleboro	.53	1.00	.79
Burlington	.60	.78	.66
Middlebury	.39	2.29	1.26
Morrisville	.67	.62	.65
Newport	.38	1.45	.79
Out of State	.62	.96	.76
Randolph	.56	.56	.56
Rutland	.77	1.51	1.10
Springfield	.87	1.54	1.21
St. Albans	1.13	1.41	1.26
St. Johnsbury	.81	.92	.86
White River Jct.	.61	1.11	.84
<b>Total</b>	<b>.74</b>	<b>1.27</b>	<b>.96</b>

**Cohort 1**  
People with HCBS  
N= 2719

**Cohort 2**  
People w/out HCBS  
N= 1906

Average  
Vermonters used  
ED .48 x/year

## *Deeper dive....*



- ED use by Cohort 1, 38.8% non-emergent  
ED use by Cohort 2, 44.0% non-emergent
- Mean cost of ED visit, Cohort 1: \$ 40.27  
Mean cost of ED visit, Cohort 2: \$279.01  
Almost 7x more for adults

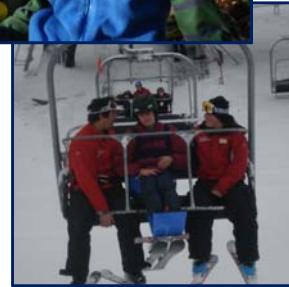
## *Deeper dive....*

- Frequent Fliers – top ten users of ED in 2014
  - Cohort 1 – 734
  - Cohort 2 - 715
- High cost individuals, top 24 in 2014, Cohort 2
  - Average age 29.5, range is 22- 50 years
  - Total cost is \$3,283,086



## Qualitative Data

*P's Story....*



Inclusive Healthcare Partnership Project

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## **SELECTED RECOMMENDATIONS & OPPORTUNITIES**

## Recommendation:

*Vermont's healthcare system will provide annual pre-appointment nursing checks to certain adults with I/DD.*



- ❖ Evidence-based strategy
  - Randomized Control Trial (2014)<sup>5</sup>.
  - Literature Review (2014)<sup>6</sup>
- ❖ 3-5 health issues identified per visit
- ❖ Impact does not diminish over time (2008)<sup>7</sup>
- ❖ Cost effective (2009)<sup>9</sup>



**HeALTH**  
**CHeCKS**

*What would this look like?*

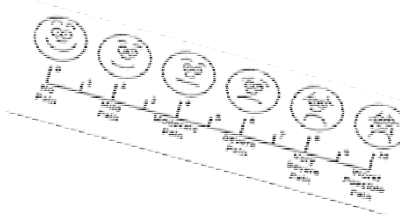
- Home visit by a nurse prior to an individual's annual visit to the Primary Care Provider (PCP).
- Standardized set of screenings, questions, etc., including anticipating accommodations for upcoming visit.
- Time with PCP can be better targeted to address health issues identified earlier.

*Northern Counties Health Care is interested in piloting this approach.*



## Recommendation:

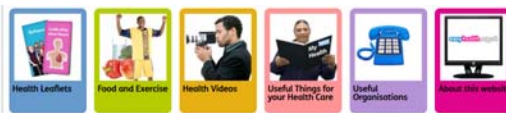
*The Vermont Health Department will assess accessibility of health care settings, including accessibility of medical equipment in diagnostic and treatment settings, and promote **physical and cognitive accommodations** for adults with intellectual and developmental disabilities.*



**ADA 25**  
AMERICANS WITH  
DISABILITIES ACT 1990-2015

*What would this look like?*

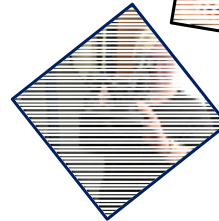
- Compliance with US Access Board standards per the Affordable Care Act
- Improves patient & provider safety
- Increase access to preventative care
- Empowers adults with I/DD to be more independent in managing their health.



*GMSA can help create cognitively accessible health information!*

## Recommendation:

*Provide opportunities throughout the training continuum, from pre-clinical curricula to continuing medical education, to work directly with and learn from individuals with I/DD and their family members who may serve as mentors, standardized patients, presenters, panel participants, or other types of trainers.*



## *What would this look like?*

- Build on existing curricula focused on medically underserved populations.
- Draw from Vermont's wealth of self-advocates
- Place people with I/DD in simulations that do *not* focus on I/DD.

*Both UVM Medical School and Geisel Medical School have expressed strong interest.*

*An expanded coalition of disability groups has applied to provide in-person and on-line training.*



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1. "The Case for Designating People with Intellectual and Developmental Disabilities as a Medically Underserved Population," Kornblau, Barbara L. The Autistic Self Advocacy Network, Policy Brief (April, 2014), [http://autisticadvocacy.org/wp-content/uploads/2014/04/MUP\\_ASAN\\_PolicyBrief\\_20140329.pdf](http://autisticadvocacy.org/wp-content/uploads/2014/04/MUP_ASAN_PolicyBrief_20140329.pdf).
2. "People with ND/ID should be formally recognized as constituting a 'medically underserved population' by the HRSA and other appropriate Federal agencies and receive the consideration, benefits, opportunities and assistance provided to populations with that designation." Adopted by the American Academy of Developmental Medicine and Dentistry (2004). See: <https://aadmd.org/articles/health-disparities-consensus-statement>
3. "...that the AMA support a simplified process across appropriate government agencies to designate individuals with developmental disabilities as a medically underserved population." Resolution 805-1-10. Council on Medical Service review, 3-1-11.
4. "Resolved, that the American Dental Association support a simplified process across appropriate governmental agencies to designate individuals with intellectual disabilities as a medically underserved population, and be it further Resolved, that the ADA seek to collaborate with the American Medical Association and the American Academy of Developmental Medicine and Dentistry to promote this process to appropriate governmental agencies.." Resolution 96, 2014.
5. "Practice nurse health checks for adults with intellectual disabilities: a cluster-design, randomised controlled trial." Cooper, Sally-Ann *et al.* *The Lancet Psychiatry*, Volume 1, Issue 7, 511 – 521.
6. "The impact of health checks for people with intellectual disabilities: An updated systematic review of evidence." Robertson, Janet, *et al.* *Research in Developmental Disabilities*, Volume 35 (2014), 2450-2462.
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9. "Cost estimation of a health-check intervention for adults with intellectual disabilities in the UK." Romeo, R., *et al.* *Journal of Intellectual Disability Research*, Volume 53, Part 5 (May, 2009), 426-439.