
VHCIP Provider Sub-grant Second Quarter 2015 Quarterly Program Reports

VHCIP Sub-grant Program Summary

Round One Grantees

- *Healthfirst* – ACO Management
- Rutland Area VNA and Associates – Supportive Care for Seriously Ill Patients
- Northeastern Vermont Regional Hospital – Flexible Funding for Community Care Program
- White River Family Practice – Innovative Care Management
- InvestEAP – Resilient Vermont (Stress Reduction)
- VMS Foundation – Pursuing High Value Care (Pre-Operative Testing, Inpatient Lab testing)
- Bi-State – Community Health ACO

VHCIP Sub-grant Program Summary

Round Two Grantees

- CVMC – Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Medical Home
- Developmental Disabilities Council – Inclusive Partnership Project
- Vermont Program for Quality in Health Care (VPQHC) – Statewide Surgical Collaborative
- Northwestern Medical Center – RiseVT Project
- Southwestern Vermont Health Care – Transitions of Care
- InvestEAP – King Arthur Flour

SIM Funding for Infrastructure Building
Healthfirst, Inc.

Date: July 10, 2015

Reporting Period: April 1 – June 30, 2015

Name of Presenter(s) and/or Key Contact:
Amy Cooper, Executive Director, Healthfirst

Grant Project Goals

1. Hire an executive director (**Q3 2014**) - **completed**
2. Hire a staff assistant (**Q3 2014**) - **completed**
3. Hire a clinical quality director (**Q4 2014**) - **completed**
4. Form the following with membership from VCP:
 - a. ACO Governance Board (**Q3 2014**) - **completed**
 - b. Consumer Advisory Board (**Q3 2014**) - **completed**
 - c. Clinical Quality Board (**Q3 2014**) - **completed**
 - d. Primary Care Physician and Specialist Subcommittee to create a network collaboration agreement outlining communication protocols and enable specialists to benefit financially from shared savings (**Q2 2014**) - **completed**
5. Secure office space for ACO and board meetings (**Q4 2014**) - **completed**

Grant Project Goals

6. Obtain board and membership approvals for Collaborative Care Agreement **(Q4 2014-Q1 2015) - completed**
7. Create a stipend policy for physicians representing subrecipient in the state healthcare reform meetings to encourage broad participation **(Q3 2014) - completed**
8. Develop processes for collection of clinical quality measures from member physicians' electronic medical records in collaboration with payers and other entities **(Q3 2014-Q3 2015) - completed**
9. Redesign subrecipient's website to increase member physician use and public outreach **(Beginning Q1 2015) - underway**
10. Hire a Quality and Care Coordination Manager **(Q1 2015) - completed**
11. Architect disease management programs for independent practices **(Ongoing, beginning Q2 2015) - planned**

Grant Project Goals

12. Recruit local physician liaison team (*beginning mid-Q2 2015*) - *underway*
13. Develop and distribute templates and educational materials to Healthfirst members to guide delivery of high-quality care and related data tracking (*beginning Q4-2014*) - *ongoing*
14. Monitor hospital admission/discharge records - *ongoing*
15. Monitor hospital admission/discharge records - *ongoing*
16. Continue to support the shared learning clinical implementation committee (*meeting quarterly since Q3-2013*) - *ongoing*

Recent Accomplishments

- **1 - Goal 8. Clinical quality measures data collection process:** HF's clinical quality director, Rick Dooley, submitted results of the 2014 quality measures data collection for the Vermont Collaborative Physicians ACO to the state for the July 1 deadline. Results show that the majority of VCP practices exceeded benchmarks for the three national measures evaluated, significantly for two of the three. Practices also showed excellent performance on three of the four benchmarks that do not have national comparisons. Performance for the fourth benchmark, rates of depression screening during well visits, showed the widest wide margin for improvement. The finding is not a surprise; HF is well aware of the challenges that exist for PCPs in identifying reliable mental health providers for referrals. We also showed low penetration of depression screening in our Medicare ACO data. Using a standard tool to screen for depression was a new protocol for practices to implement when we began our ACO work a couple of years ago, and we are making progress toward improving scores on this measure. Our desire to support VCP practices in addressing this challenge was the basis of our request for technical assistance from the state about this specific issue. HF had the opportunity to work with Bailit Health Purchasing regarding the availability and quality of online state- and national-level mental health provider databases. The current status of that work is outlined under Planned Activities.

Recent Accomplishments

- **2 – Goal 10. Quality and Care Coordination Manager (QCCM):** After a slow start, we finally received materials from several strong candidates. HF's chief medical officer, Dr. Paul Reiss, and our clinical quality director, Rick Dooley, interviewed four candidates, ultimately selecting Susan Ridzon, M.S., R.D., for the position. Ms. Ridzon began working for HealthFirst on June 29. Ms. Ridzon brings not only many years of clinical research experience in population health management, but also, more recently, specific experience with clinical quality improvement as a leader for BCBSVT's projects related to HEDIS and other quality measures. She is skilled at building cross-functional teams that analyze and overcome barriers to quality health care. Ms. Ridzon will work closely with Dr. Reiss and Mr. Dooley to support VCP practices with clinical quality data tracking and reporting. She started officially in June and already is well on her way getting up to speed. Her experience will be a true asset to HealthFirst's team.

Recent Accomplishments

- **3 – Goal 9. Website redesign:** We are excited to report that our web redesign project is underway. Initially, we envisioned engaging a designer to develop both a new website and a logo, but, in the end, we chose separate designers for these elements. After researching local design firms, we issued an RFP to several firms and selected two finalists. StudioJ Creative is working with us on the website redesign. We were impressed with the clean lines, clear organization, and functionality we saw in their website designs for other clients. While we are updating some content from our exiting website, the new site will also feature some new content. Most significantly, we are developing consumer resources pages with two primary goals: (1) helping consumers understand independent practices' role in Vermont's healthcare landscape and (2) providing resources to further consumer understanding of key elements of healthcare reform in the state, such as accountable care organizations, quality assessments, pricing transparency, and cost comparison tools. The design is nearly finalized, and we are working with the creative team to develop and place content and graphics to keep us on track for a fall site launch.

Based on an impressive their client logo portfolio and the broad stroke design ideas for our branding, we chose Proportion Design for our logo development. Proportion created three compelling options, and we selected a design choice at the end of June. The graphic incorporates two images. The first is of a bird flying across the sun, which represents our mission to support independent practices in aiming high and delivering the highest quality care. The image can also be “read” as a rising sun couched by two mountains, which evokes a sense of place. The logo and its colors are incorporated into the web design to create continuity as we begin developing an identity beyond our membership.

Recent Accomplishments

- **4 – Goal 13. Education and Outreach:** To support practices in making a smooth transition to the ICD-10 medical coding system in October, HealthFirst contracted with medical coding and compliance expert, Betsy Nicoletti, to run a series of six webinars for member practices. The hour-long sessions ran throughout June, with the final session running in the first week of July. Ms. Nicoletti tailored the presentations based on feedback from member practices, with topics ranging from a broad overview of the new coding standards to specific coding related to primary care and several specialties. A recording of each session is posted on HF's YouTube channel (https://www.youtube.com/channel/UCF1x9ENUWPzpcleIFWm-_XQ) and handouts of Ms. Nicoletti's presentation slides were distributed to all member practices. We heard from several practices that they were grateful for the training opportunity and pleased that the information will continue to be available. We estimate that close to 100 clinicians and practice staff members participated in the live trainings and, to date, about 175 people have viewed the posted recordings. We anticipate that the number of views will increase as the October changeover to the ICD-10 system nears.

Recent Accomplishments

- **5 – Goal 15. Care transitions:** Though the ACCGM ACO closed in March, HF has continued meeting with clinical care coordinators at several of our member practices to actively look at the care transition best practices they are using and how we can help both disseminate these strategies and support development of additional strategies among our practices. Susan Ridzon's arrival at HF will elevate this initiative by providing member practices with greater continuity and more opportunities for face-to-face support across a broader array of topics. Our work toward this goal has also been boosted by HF leadership's participation in Qualidigm's quality improvement support team, which convened in January 2105 to offer practices free resources to assist with population health management for the Medicare population.

Challenges and Opportunities

This quarter provided both a challenge and opportunity through a single process. Along with other healthcare stakeholders, HF was invited to participate in a workgroup convened to help the state, through the GMCB, determine the feasibility and logistics of pursuing an all-payer waiver for Vermont. HF's chief medical officer, Dr. Paul Reiss, and long-time board member, Dr. Joseph Haddock, have been representing HF and the interests of independent providers in the workgroup.

The challenges the state's efforts present go beyond those that may be most relevant to independent practices; by all reports, all stakeholders are working to balance compromise with advocacy for their constituents' key priorities. There is round agreement among workgroup members that the task is, by itself, extremely daunting and that it is only made more so by the tight time line the state has set for completing the work necessary to develop a strong proposal. The biggest challenge is the most fundamental: how to structure governance, including budget and fund disbursement processes, to ensure that all stakeholders can be fairly represented and will participate going forward if the waiver is granted. Despite the challenges, however, HF views the process as an opportunity to work closely with the array of stakeholders toward a common goal focused on improving healthcare for all Vermonters.

Activities Undertaken and Planned

Activities Completed

- 2014 VCP quality data submitted to the state
- QCCM hired
- ICD-10 training webinars completed
- Logo design completed
- Web design firm selected, process underway for a fall site launch

Activities Undertaken and Planned

Activities Planned

- As noted, HF received technical assistance from Bailit Health Purchasing to help us evaluate mental health care delivery needs and available resources for primary care providers. The Bailit report outlines the thorough process used to evaluate existing state-specific and national online mental health provider databases. The process included website reviews for accuracy and completeness of information, as well as interviews with a range of healthcare stakeholders in the state, a handful of clinicians from HF PCP member practices, and several mental health providers. One key question HF was seeking to answer related to the feasibility of assuming responsibility of one of several Vermont-specific online databases either as the sole manager of the resource or in partnership with other healthcare stakeholders in the state. Based on the research, Bailit has recommended that HF not pursue this path and instead focus on (1) selecting and promoting an existing national database among members, (2) offering training opportunities to support primary care providers in developing expertise in the use of the database to assist patients in identifying, accessing, and engaging in mental health services, (3) reaching out to key mental health provider professional organizations and individual providers to encourage enrollment in a selected database, and (4) providing ongoing reminders and support to mental health providers to encourage them to keep their listings up to date. We anticipate convening a workgroup this fall to determine feasibility and a time line for implementing recommended strategies.

Activities Undertaken and Planned

Activities Planned

- HF will be holding its annual member meeting and speaker panel on Saturday, November 14. We have secured a venue and are now in the process of engaging speakers for the event.

Expenditures to Date: April to June 2015

	Approved Budget	Spent Prior Quarter	Spent Current Quarter	Spent to Date	Balance
Staff Wages					
Executive Director	\$147,000.00	\$17,499.00	\$17,499.00	\$67,079.50	\$79,920.50
Administrative Assistant	\$50,750.00	\$6,250.02	\$6,250.02	\$20,833.30	\$29,916.70
Operations Director	\$63,000.00	\$8,571.42	\$8,571.42	\$25,714.26	\$37,285.74
Clinical Lead, Other MD	\$60,900.00	\$7,500.00	\$7,500.00	\$23,750.00	\$37,150.00
Quality & Care Coordination Manager	\$65,000.00	\$0.00	\$0.00	\$0.00	\$65,000.00
Fringes	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total Wages	\$386,650.00	\$39,820.44	\$39,820.44	\$137,377.06	\$249,272.94
Consultants					
Local Physician Liaison Team	\$52,000.00	\$3,000.00	\$8,242.50	\$11,242.50	\$40,757.50
Legal services, HR, IT, other contracts	\$100,864.00	\$1,180.00	\$16,875.00	\$26,955.00	\$73,909.00
Total Consultants	\$152,864.00	\$4,180.00	\$25,117.50	\$38,197.50	\$114,666.50
Office					
Rent	\$28,400.00	\$3,300.00	\$3,287.31	\$13,237.31	\$15,162.69
Utilities	\$4,200.00	\$716.56	\$650.98	\$1,829.44	\$2,370.56
Supplies (incl computers, communication)	\$14,000.00	\$1,246.72	\$1,646.59	\$7,970.89	\$6,029.11
Meetings and travel	\$8,250.00	\$2,137.50	\$2,500.35	\$6,537.85	\$1,712.15
Bi-annual meeting	\$3,236.00	\$0.00	\$0.00	\$1,236.24	\$1,999.76
Outreach	\$2,400.00	\$0.00	\$0.00	\$0.00	\$2,400.00
Total Office	\$60,486.00	\$7,400.78	\$8,085.23	\$30,811.73	\$29,674.27
TOTALS	\$600,000.00	\$51,401.22	\$73,023.17	\$206,386.29	\$393,613.71

Budget Notes

Potential Budget Changes

- We have not identified any potential changes to the budget for second year spending at this time.

Supportive Care Program
**Rutland Area Visiting Nurse Association
& Hospice, Inc.**

July 10, 2015
Reporting Period:

Nicole Moran

Grant Project Goals

- Integrate supportive care and end-of-life decision making earlier in the disease process
- Expand upon collaborative approaches with primary care, RRMC and the Rutland Community Health Team to facilitate patient care decisions based upon patients' own values
- Avoid unnecessary hospitalization and/or re-hospitalization for patients with complex conditions and needs
- Improve symptom management and quality of life for the patient and caregivers
- Promote earlier referrals to hospice
- Support the Blueprint for Health goals for improving care for patients with chronic illness

Recent Accomplishments

- Presented the program at the Hospitalist Section of Medicine meeting.
- Worked with Customer Relations and Marketing to create a patient brochure to distribute to local physician offices, nursing homes and the hospital.
- Admitted 7 patients to the program, with one pending referral
- Providing consultation to potential patients

Challenges and Opportunities

- Continued difficulty in convincing referrals who are currently stable to utilize our services.
- Collaborating with local nursing homes to integrate our services and theirs for CHF/COPD patients to help transition to home after rehabilitating.

Activities Undertaken and Planned

- Ongoing Activities
 - Collaborating with a local company to provide respiratory therapy consultation to the supportive care program.
- New Activities
 - Exploring the possibility of consultation in the hospital for potential referrals.
- Long-Term Activities
 - Enroll 15 patients to the supportive care programs by September 1, 2015

Providers and Beneficiaries Impacted

- Please provide the number of Providers participating in or otherwise impacted by your project.
 - The working definition for ‘Provider’ is *ANY provider of care – not limited to the clinical setting.*
 - If possible, please break down providers into classes (MD, RN, NP, Home Health Provider, etc...)
- Please provide the number of beneficiaries of your project.
 - The working definition for ‘Beneficiary’ is *ANY consumer of services provided within the scope of the project.*

Evaluation Methodology

- To date, the Missoula-VITAS Quality of Life Index, Version – 15R has been completed upon admission to the program. Follow up measurement not completed to date.
- Opportunities:
 - Implement the Missoula-VITAS Quality of Life Index upon discharge from program
 - Measure patient satisfaction
 - Measure provider satisfaction

Expenditures to Date & Revised Budget

- Please work from your approved revised budget to show any new expenditures.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	\$ 82,174.74	\$ -	\$ -	\$ -
Fringe	\$ 21,488.70	\$ -	\$ -	\$ -
Travel	\$ 5,600.01	\$ -	\$ -	\$ -
Conferences		\$ -	\$ -	\$ -
Equipment	\$ 2,800.00	\$ -	\$ -	\$ -
Contracts		\$ -	\$ -	\$ -
Indirect		\$ -	\$ -	\$ -
Total	\$ 112,063.45	\$ -	\$ -	\$ 112,063.45

- RAVNAH anticipates spending the approved amount by the end of the grant. We will be submitting our first invoice by the end of April 2015.

**Vermont Health Care Innovation Project
2015 Quarterly Report**

***Caledonia & s. Essex Dual Eligibles
Project***

Northeastern Vermont Regional Hospital

Date: July 6, 2015

Reporting Period: April – June 2015

Name of Presenter(s) and/or Key Contact:

Laural Ruggles

Grant Project Goals

- Reduction in overall healthcare costs
- More efficient use of Medicaid special services
- Improved well-being of clients

Recent Accomplishments

- Identification of lead care coordinator for subset of the duals population.
- Testing shared care plans on a subset of the duals population.
- Transitioned person receiving complementary medicine treatment from flex funds to self-pay.
- Partnered with VCIL and Choices for Care to install a chair lift in home, allowed person to remain at home.
- Person receiving personal trainer services now confident to go to a local fitness center (she has lost 125 pounds)

Challenges and Opportunities

- Continued delays working with VCIL. We have the money, they don't have the available contractors to do the work.
- Now partnering the Vermont Traumatic Brain Injury Association on several clients.

Activities Undertaken and Planned

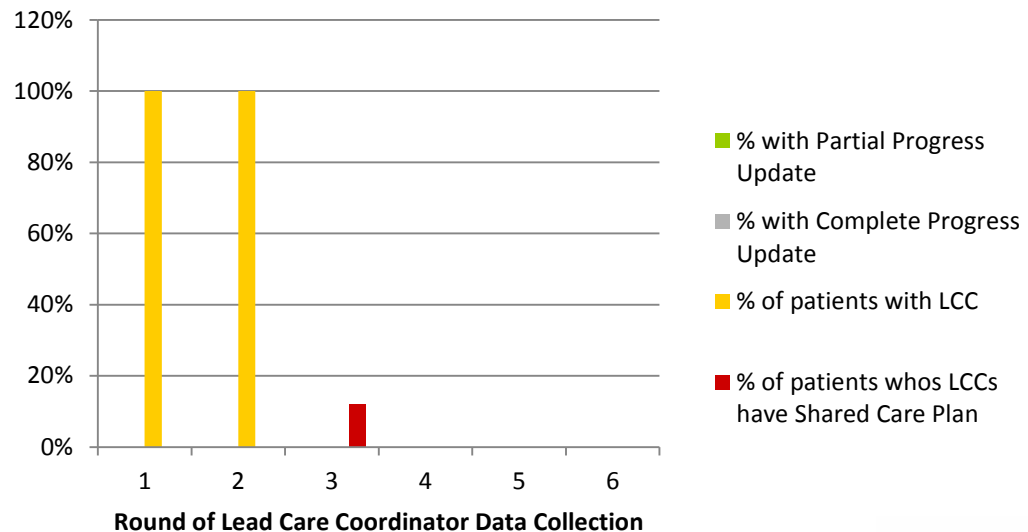
- Ongoing Activities
 - Home visits by health coach.
 - Smoking cessation services provided by health coach.
- New Activities
 - Health Coach trained in assisting clients with Advance Directives.
 - Health Coach trained in Motivational Interviewing.
- Long-Term Activities
 - Continued partnering with SASH

Providers and Beneficiaries Impacted

- 20 MD PCPs; 11 NP/PA PCPs; 2 Palliative Care MD's; 4 Nurse Care Coordinators; 2 Ophthalmologists; Numerous Home Health and Hospice Nurses and Area Agency on Aging Case Managers; 2 SASH Coordinators; 2 Voc Rehab Case Managers; 1 Tobacco Cessation Counselor; 4 hospital Care Managers
- Please provide the number of beneficiaries of your project.
 - Health Coach clients = 60

Evaluation Methodology

- We have asked for technical assistance for the evaluation of this process. Discussions are ongoing.
- Separate from this project is the CMCM Learning Collaborative. Below is one of the data charts for that subgroup of duals with an assigned Lead Care Coordinator (LCC)



Expenditures to Date & Revised Budget

- Please work from your approved revised budget to show any new expenditures.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	\$ 54,000.00	\$ 25,847.18	\$ 5,480.65	\$ 31,327.83
Fringe	\$ 18,900.00	\$ 9,046.52	\$ 1,918.23	\$ 10,964.75
Travel	\$ 2,000.00	\$ 2,000.00		\$ 2,000.00
Non-Covered	\$ 100,000.00	\$ 9,458.44	\$ 9,773.97	\$ 19,232.41
Equipment	\$ 1,500.00	\$ 796.55		\$ 796.55
				\$ -
				\$ -
Total	\$ 176,400.00	\$ 47,148.69	\$ 17,172.85	\$ 64,321.54

- No potential changes to the budget going forward.

State Innovation Model Grant White River Family Practice

Date: July 15 2015

***Reporting Period: April 1 2015 to June 30
2015***

Name of Presenter(s) and/or Key Contact:

Sean Uiterwyk, MD

Grant Project Goals

- Measure and reduce emergency room utilization and hospital readmission among WRFPP patients (at DHMC)
- Measure patient self-confidence
- Utilize self-confidence measure to stratify patients with chronic disease and target appropriate interventions
- Deploy team-based care protocols to address chronic disease

Recent Accomplishments

- Developed and Deployed Motivational Interviewing Curriculum
 - We continue our work with motivational interviewing training for the entire office
 - This will serve to enhance skills of team to further team-based care for chronic diseases
- eCW CCMR Analytics Implementation
 - We continue to work on CCMR configuration as well as working to incorporate claims data from BCBSVT and DVHA
 - We met with Qualidigm, the CMMI sub-contractor in Vermont, and shared our work and interest in obtaining claims data from CMS for care provided to WRFPP patients.

Recent Accomplishments

- Health Confidence
 - Ongoing collection of health confidence
- High Utilization Group
 - Ongoing intensive management by our care coordination team
- Collaboration with DHMC ER High Utilizer Project
 - Met with Dr. Kevin Curtis who is developing high ER utilizer intervention at DHMC
 - Reviewed shared patients as well as possible future collaborations
- Intra-office newsletter (continues, sent monthly to SIM team)

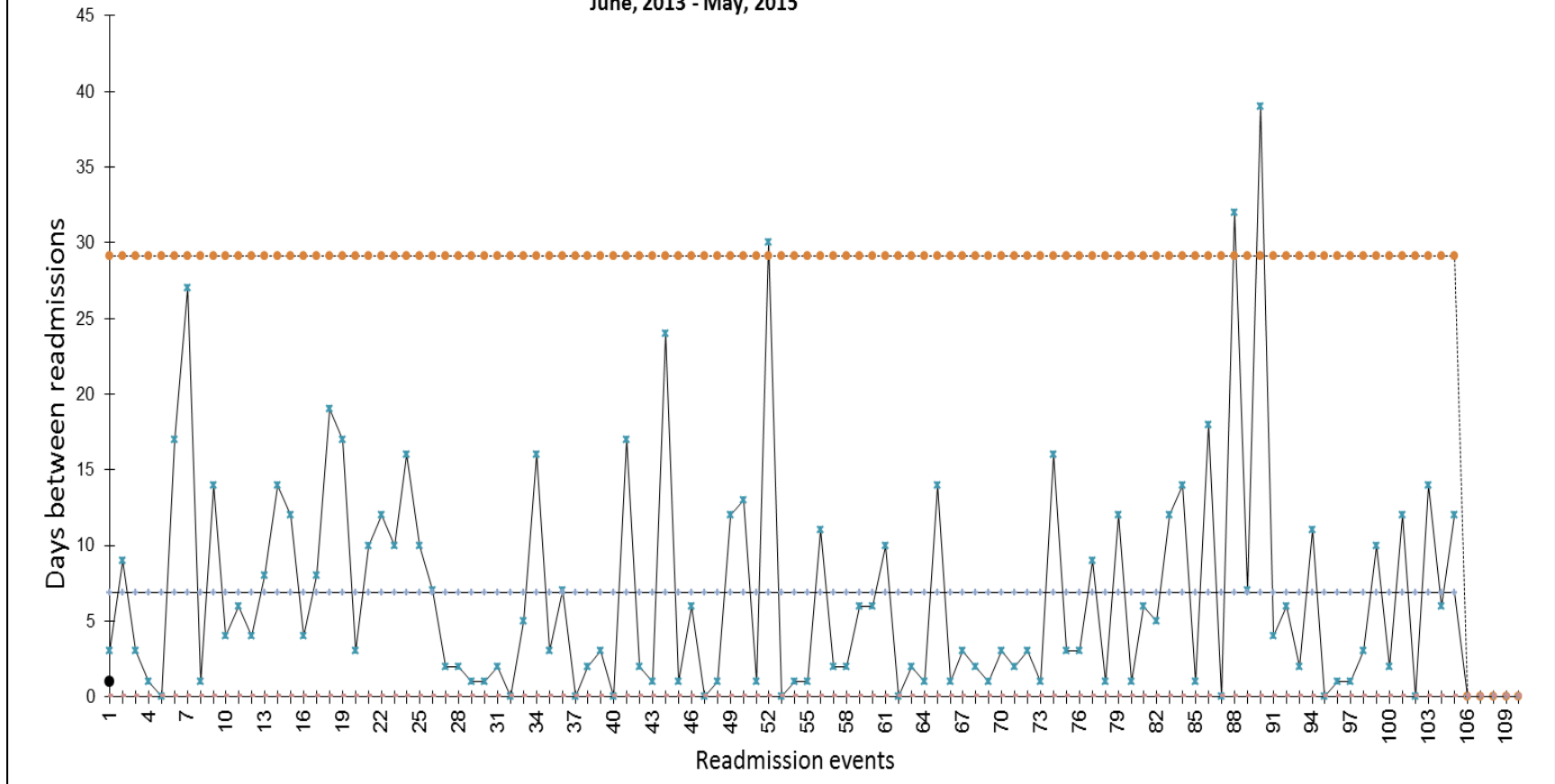
Evaluation Methodology

- We are currently using monthly data reports from DHMC to track Emergency Room and Inpatient utilization to develop SPC charts to monitor for any change in both our overall WRFPP population as well as our targeted SIM cohort
- See following slides

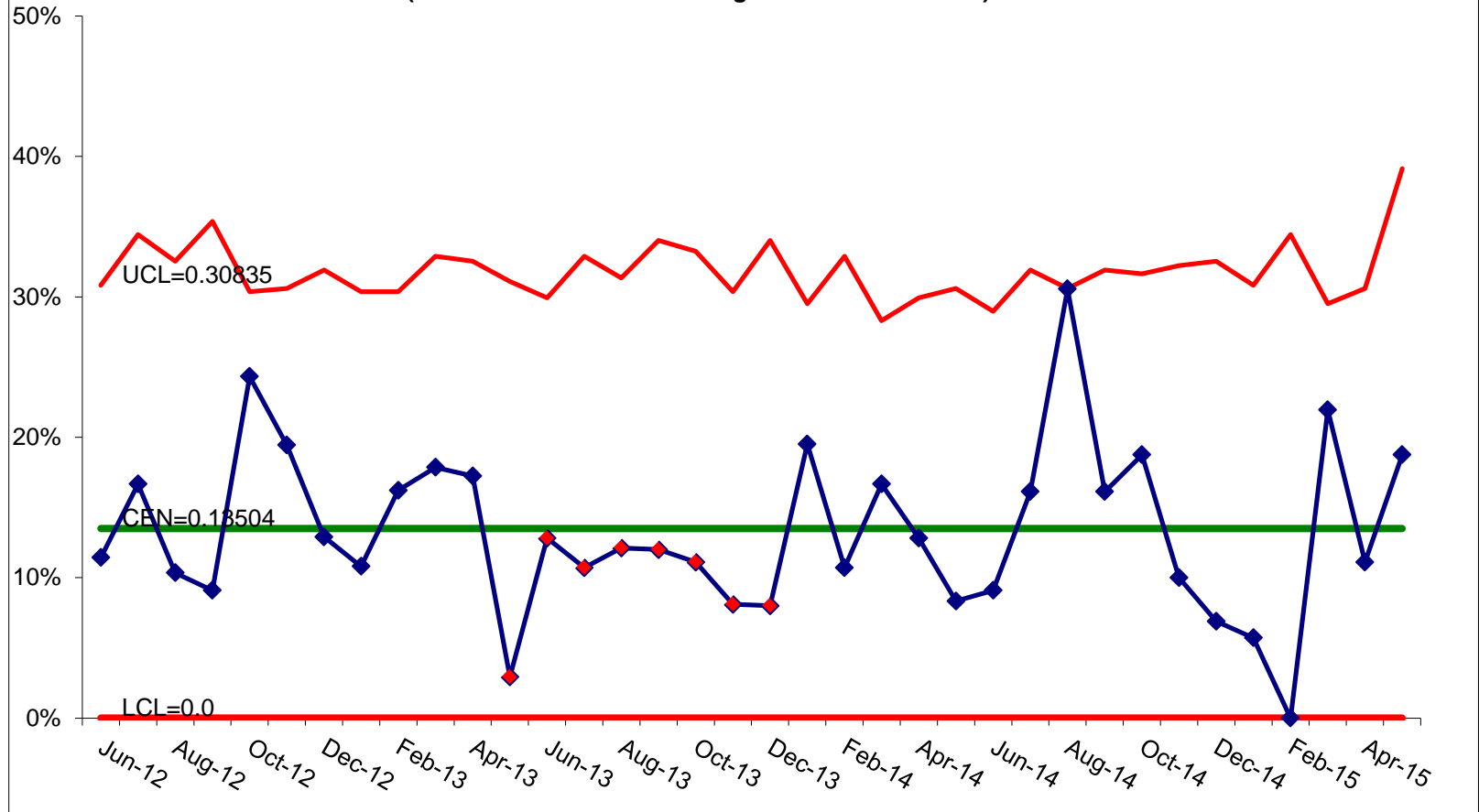
Using SPC...

Days occurring between successive Hospital Readmissions (in ≤ 30 days for any single patient)

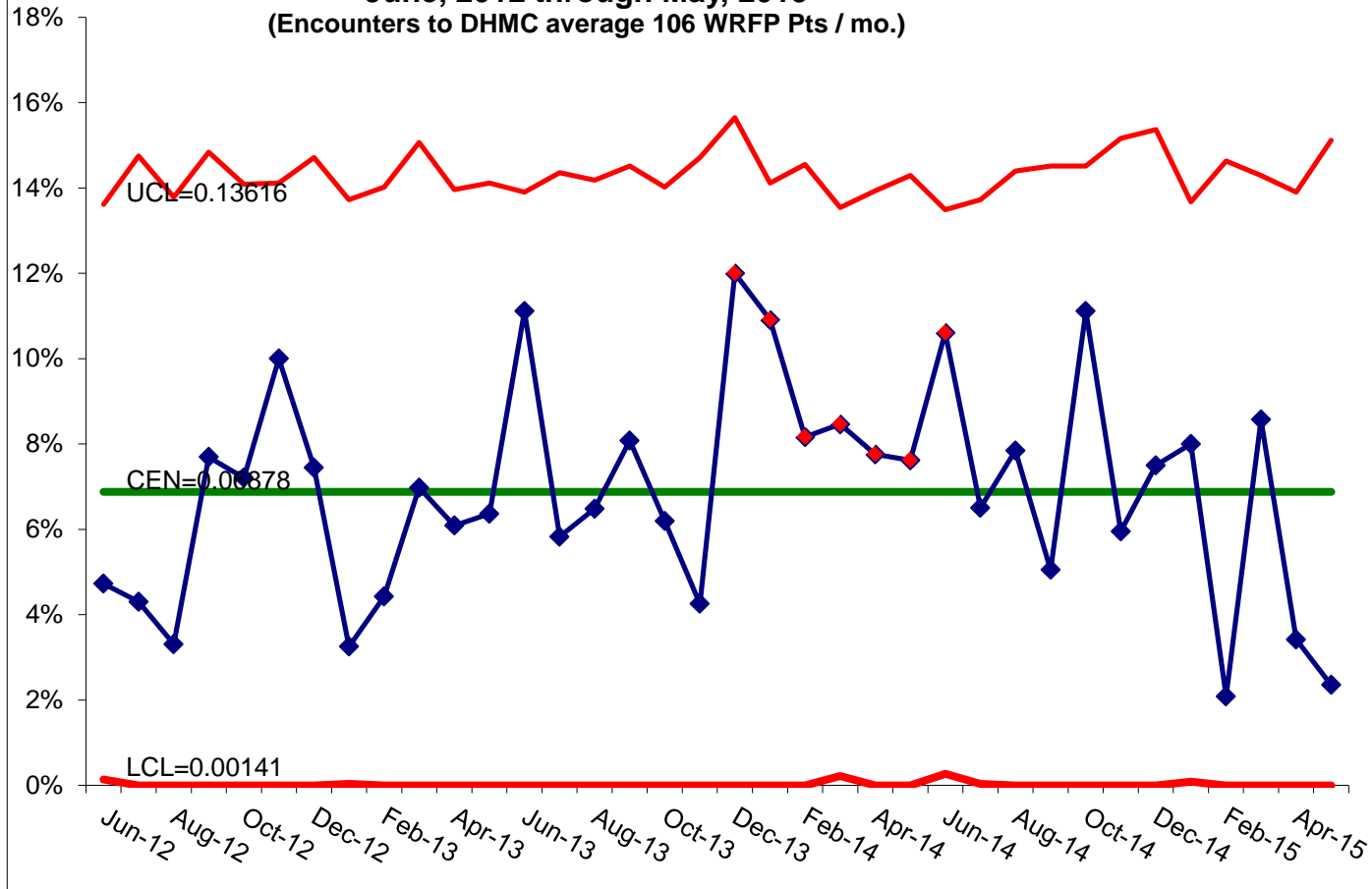
June, 2013 - May, 2015



The percent of all WRFP Patients sustaining a readmission to DHMC within <31 days of a prior admission
(Admissions to DHMC average 33 WRFP Pts / mo.)

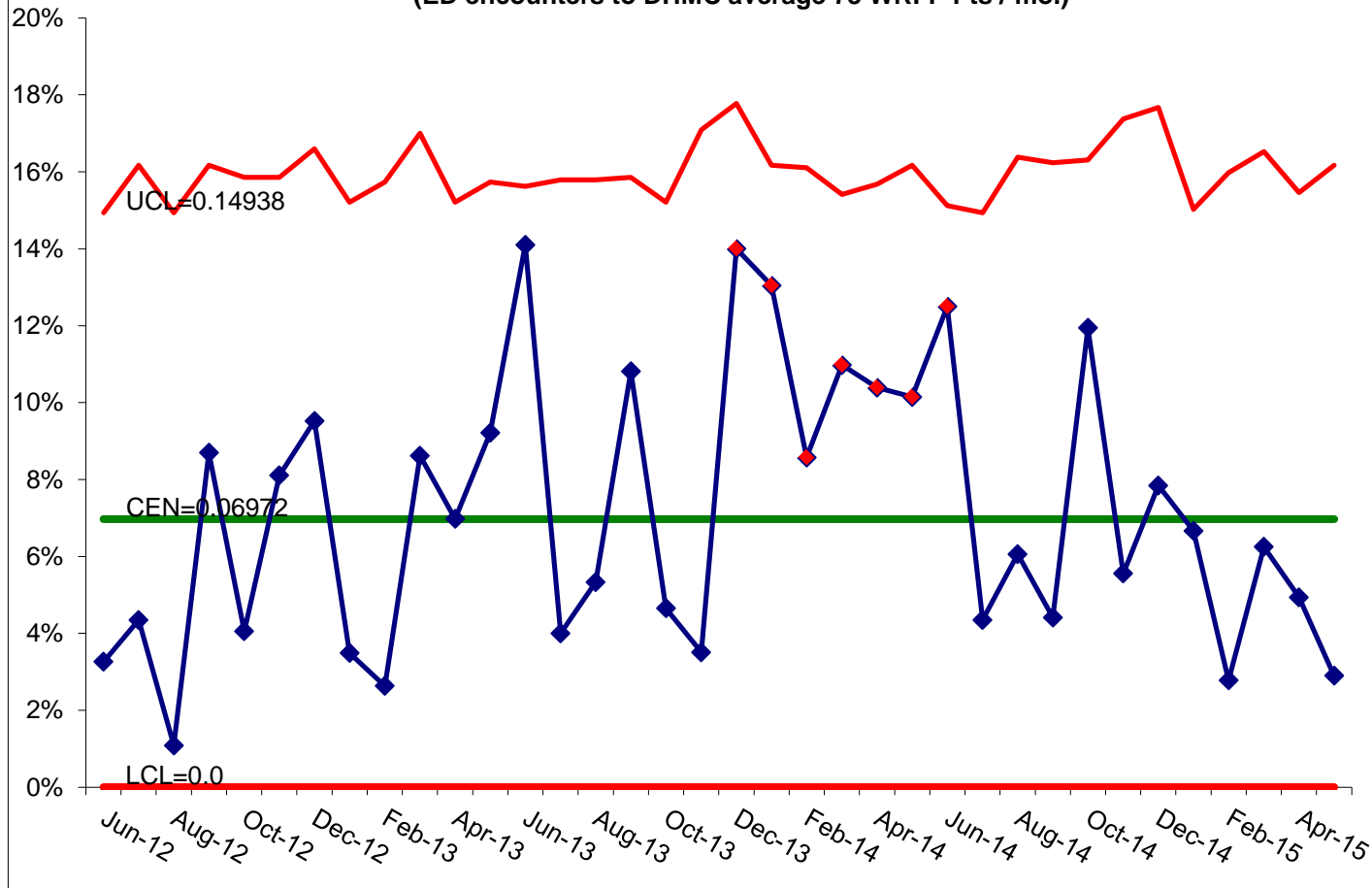


**The percent of all WRFP patients' encounters at DHMC attributable to patients in the target (SIM) cohort
June, 2012 through May, 2015
(Encounters to DHMC average 106 WRFP Pts / mo.)**



The percent of all WRFPP patients' Emergency Department (ED) encounters at DHMC attributable to patients in the target (SIM) cohort, June, 2012 through May, 2015

(ED encounters to DHMC average 73 WRFPP Pts / mo.)



Opportunities

- Expand our use of health confidence to better refine the use of our clinical resources towards patients who are at higher risk of poor health outcomes
- Further build the motivational interviewing skills of our team
- Consider re-evaluating the data to see if we can detect subtle, significant changes that may be occurring due to our interventions.

Challenges

- We continue to be challenged in obtaining claims data –BCBSVT and DVHA are currently only payors actively working with us. This remains a problem as it has been in all of the other quarterly reports.
- Data from CMS remains a significant hurdle. We have had a meeting with Qualidigm and hope this bears “data” fruit
- We would like to expand our work to include a more robust collaboration with the DHMC ER high utilizer project, but we are limited by the lack of resources to support this.

Challenges

- Sean Uiterwyk, MD will be leaving WRFPP in September 2015. While any change in grant personnel is a challenge, it also presents an opportunity for others to provide a new perspective on this project. Jill Blumberg, MD has been working with the grant team since the initiation of the grant. She is an incredibly talented physician and most capable to work on this pilot. She will assume some of Dr. Uiterwyk's work during this transition.

Activities Undertaken and Planned

- Ongoing Activities
 - Grant team meetings
 - Regular meetings with DHMC to refine monthly data feed
 - Ongoing weekly work with eCW to refine CCMR
- New Activities
 - No new activities to report
- Long-Term Activities
 - Development of interventions targeted at patients with low self-confidence and/or high utilization
- *as well as activities in previous slides

Providers and Beneficiaries Impacted

- Please provide the number of Providers participating in or otherwise impacted by your project.
 - WRFP Staff 25
 - 6 MDs, 3 NPs, 3 RN, 5 MA
 - 4 front desk staff, 1 billers, 2 medical records ,1 office manager
 - Mark Nunlist, MD – consultant
 - Caitlin Barthelmes, MPH – MI trainer
 - James Jasie – DHMC Health IT
 - Swathi Iruvanti, eCW, CCMR configuration
 - Lexi Burroughs – Mental Health Counselor

Providers and Beneficiaries Impacted

- Please provide the number of beneficiaries of your project.
 - 3,474 patients seen at WRFPP April 1 2015 – June 30 2015
 - WRFPP averages 33 admissions per month to DHMC
 - WRFPP averages 73 ER visits per month to DHMC

Expenditures to Date & Revised Budget

- June 2015 Invoice

	Start 7/1/14 24 Month	(Awardee to complete) Current Month	Reconciliation: Cumulative	Award
White River Family Practice	<u>Award \$:</u>	<u>Spending</u>	<u>Spend to date:</u>	<u>Balance</u>
Toni Apgar	99,008.00	\$3,370	43,718.30	55,289.70
Lexi Burroughs	20,000.00	869.50	9,564.50	10,435.50
Sean Uiterwyk	23,100.00	\$1,004.34	11,047.74	12,052.26
	-		-	-
Total Salary	142,108.00	5,243.92	64,330.54	77,777.46
Fringe	17,168.00	\$750	8,198.43	8,969.57
Conference Travel	3,000.00		3,138.00	(138.00)
Supplies	500.00		897.39	(397.39)
Equipment	36,818.00	\$1,350.00	14,921.13	21,896.87
Mark Nunlist, MD	115,200.00	\$2,762.50	69,310.00	45,890.00
Symquest	7,500.00		3,756.96	3,743.04
Cert Diabetes Educator	270.00		-	270.00
Dev't of Health Coach Curriculum	7,500.00	\$3,250	6,651.54	848.46
Indirect	33,006.00	\$1,435.04	14,350.40	18,655.60
Total :	\$ 363,070.00	14,791.46	185,554.39	177,515.61
Less: unspent Advances				
Net Invoice :		14,791.46		

Expenditures to Date & Revised Budget

- At this time, we do not have any significant budget variances to report

Additional Information

- See newsletter

**Vermont Health Care Innovation Project
2015 Quarterly Report**

Resilient Vermont
Invest EAP

Date: July 1, 2015

Reporting Period: April – June 2015

Steven P. Dickens

Grant Project Goals

- Evaluate effectiveness of providing EAP prevention/early intervention services to FQHC patients to mitigate life stressors that would otherwise lead to chronic disease.
- Demonstrate effectiveness of conducting systematic behavioral health screening of FQHC patients and providing short-term evidence-based treatment for identified problems to improve health outcomes and reduce future healthcare expenditures.

Recent Accomplishments

- Provided intensive in-person training to Health Coach to hone MI skills
- Completed development and testing of online evaluation database.
- New hardware and software provided to Health Coach to ensure treatment fidelity and improve patient experience.
- Patient Success Examples
 - Prevented father of 3 on medical leave from losing apartment.
 - Helped victim of domestic violence gain required self esteem to enable her to establish a new life for her self and children.

Challenges and Opportunities

- Problems persisted with vendor software for some time. Although it appears that this is now resolved, it forced us to work with our evaluator to create an alternate means of data collection that is actually proving to be a much more efficient means of data entry. The vendor software will still be employed for clinical purposes and to ensure treatment approaches maintain fidelity to the evidence-based protocols.

Activities Undertaken and Planned

- Ongoing Activities
 - Continued training of clinical staff in evidence-based behavioral treatment protocols: weekly telephone conferences and evaluation of session recordings
 - Refining fidelity/reporting/database software
 - Continue service delivery
 - Conduct assessments and enter data
- New Activities
 - Outreach to additional physicians at health center
- Long-Term Activities
 - Initial data assessment with project evaluator.

Providers and Beneficiaries Impacted

- Please provide the number of Providers participating in or otherwise impacted by your project.
 - *The project will impact approximately 2 physicians, 6 nurses and 2 behavioral health counselors.*
- Please provide the number of beneficiaries of your project.
 - The project will benefit approximately 300 patients.

Evaluation Methodology

- Behavioral health related assessment data is collected from program participants at these times:
 - At the start of treatment
 - At the end of treatment
 - 3-months post treatment
 - 6-months post treatment
- An independent evaluator will conduct a statistical analysis of this data to assess program impacts.
- The evaluator will correlate any improvements in health outcomes with extant studies linking these same improvements with cost reductions and model predicted cost savings accordingly

Expenditures to Date & Revised Budget

- Please work from your approved revised budget to show any new expenditures.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	in-kind			\$ -
Fringe	in-kind			\$ -
Travel	\$ 6,500.00	\$ -		\$ -
Conferences	\$ -	\$ -		\$ -
Equipment	\$ 1,900.00	\$ 1,729.16	\$ 635.89	\$ 2,365.05
Contracts	\$ 196,260.00	\$ 67,821.82		\$ 67,821.82
Supplies	\$ 1,000.00			\$ -
Other	\$ 21,560.00	\$ 750.00		\$ 750.00
Indirect	\$ 22,722.00	\$ 6,116.19		\$ 6,116.19
Total	\$ 249,942.00	\$ 76,417.17	\$ 635.89	\$ 77,053.06

**Vermont Health Care Innovation Project
2015 Quarterly Report**

Pursuing High Value Care for Vermonters
VMS Foundation and UVM College of Medicine

Date: July 10th, 2015

***Reporting Period: April 16th, 2015 – June
30th, 2015***

Cyrus Jordan MD MPH

Grant Project Goals

■ Global Aim

- We aim 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.
- We will use a collaborative approach considering the best medical evidence and quality improvement science.
- It begins with an evaluation of current test ordering profiles and patterns followed by an organized plan to optimize testing and ends with a plan to sustain these practices.
- By doing this we expect to reduce cost and improve satisfaction and quality of care for patients and the health system.
- It is important to work on this now because as health care professionals we can play an important role in health care reform by designing more patient-centered, efficient and high value inpatient care.

Accomplishments in April, May and June 2015

■ Plenary interventions across all sites

- HIPPA Business Associate Agreements covering the project activities at all 8 sites
- Data uploading processes to the data enclave and IS staffing in place at 6 sites; uploading process being finalized for sites 7 and 8

■ Hospital specific interventions

- Changing computerized physician order entry (CPOE) templates to exclude repetitive order defaults and options; and support customized patient centered ordering;
- CME sessions with staff and trainees (UVM includes Residents in their QI team and are addressing this as part of their education)
- Posters and reminders in clinical areas
- Concentrating QI resources on high volume patient populations, e.g. COPD
- Current collaborative QI team includes broader representation of hospital staff; e.g. IS, billing, lab IS, phlebotomy, nursing, QI department, pathology

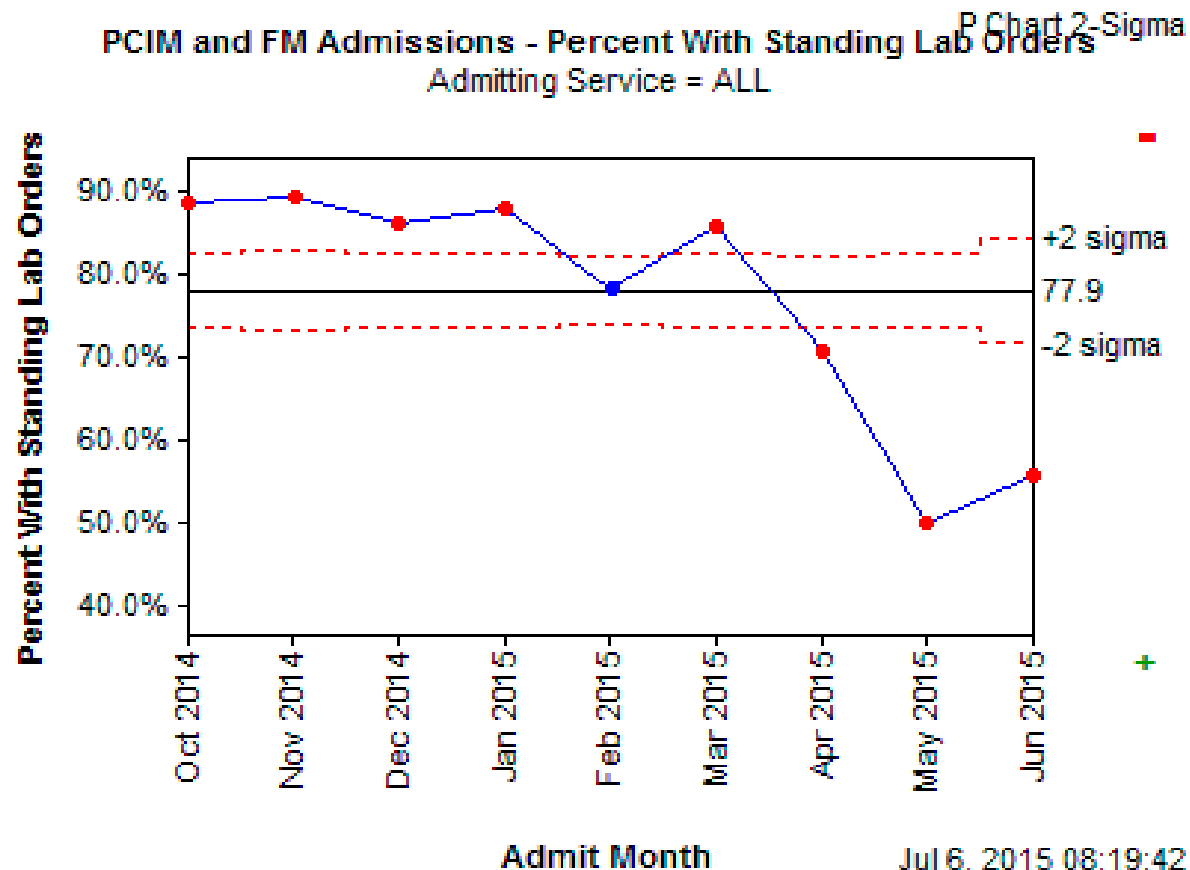
Accomplishments in April, May and June 2015

■ Behavioral Changes

- Discontinuing drawing extra tubes of blood in case of subsequent “add-on” physician orders – Laboratory staffing
- Decreasing frequency and number of tests to monitor for heparin side effects in patients receiving prophylactic heparin – nursing, physician, laboratory and pharmacy staff
- Awareness to consider if the test results will change diagnosis or treatment – nursing, pharmacy, lab and physician staff
- Awareness that serial and or daily tests may not be necessary in a stable patient – nursing, pharmacy, lab and physicians staff
- Sense of security in ordering fewer tests as colleagues are doing the same – nursing, physician, lab and pharmacy staff
- Awareness of the total induced blood loss from frequent phlebotomies (hospital induced anemia) – nursing, lab, pharmacy and physician staff

Accomplishments in April, May and June 2015

- Behavioral change as a result of CME education at an academic medical center



Accomplishments in April, May and June 2015

- Educational intervention on part of Laboratory staff at a community hospital
 - Estimated unnecessary blood loss as a result of drawing extra tubes of blood in case of add-on tests

Average blood waste in a 12 month period

- ▶ 36 cans of soda (12 ounces)



Challenges to success

- **Major challenges encountered**
 - **Establishing a standard definition for an inpatient admission and corresponding time stamp for admission time across all organizations**
 - **No standard across the region's hospitals for start time of an admission**
 - **Some include ER visits and observations stays; some do not**
 - **Difficult to compare numbers of tests per admission across institutions, e.g. some include ER testing, some do not**
 - **Teams being provided the time to complete their improvement activities in their institutions**

Opportunities for programmatic support

- **Creating a structure that brings together multidisciplinary representatives (MDs, laboratory professionals, nursing, pharmacy, IS, measurement experts, statisticians) from a variety of institutions from critical access hospitals to academic medical centers to work collaboratively to enhance the value of care delivered to our patients across the region**
- **Building QI / high value care experience and expertise among the represented teams – to bring back to their own hospitals**
- **Creating a technical infrastructure and support that allows data from this broad spectrum of hospitals with highly variable levels of expertise and resources to allow comparative reporting of metrics needed to guide QI changes**
- **Educating our learners – resident physicians, medical students, nursing students – about high value care, and positively impacting their thinking and decisions about test ordering – so that they consider the utility of the tests, the potential harms to the patients as well as costs to the system.**

Activities Undertaken and Planned

Summer Activities for teams

- Continue with your current improvement efforts
- Continue to send data to NORC data enclave
- Review Process and Outcomes data- Local and NORC data
- Consider new change ideas, develop PDSA and Measurement plans
- Set up a time to meet with data analysts
- Attend Webinars

Summer activities for faculty

- Refine hospital reports
- Reach out to 5 non participating CAHs in region
- Develop second year curriculum expanding scope and scale of lab testing targeted for optimization across the region
 - High cost labs, e.g. hypercoagulability testing, out dated cardiac enzyme testing
 - Increase scale to include other clinical services, e.g. ICU, surgery services

Activities Planned – Collaborative Year 2

Lab Collaborative Continuation

- Kick off Webinar for Phase 2 of the Collaborative
 - Thursday September, 10th, 2015 - 2:00 PM to 3:00 PM

- Learning Sessions 8:30 AM to 3:30 PM
 - 1. Thursday, October 15, 2015- location TBD
 - 2. Thursday, January 14th, 2016- location TBD
 - 3. Thursday, April 14th, 2016- location TBD
 - 4. Thursday, June 9th, 2016- location TBD

- Webinars- 2:00 PM – 3:00 PM
 - 1. Thursday, July 16th, 2015
 - 2. Thursday, August 13th, 2015
 - 3. Thursday, November 19th, 2015
 - 4. Thursday, December 17th, 2015
 - 5. Thursday, February 18th, 2016
 - 6. Thursday, March 24th, 2016
 - 7. Thursday, May 12th, 2016

Providers Impacted

- **Faculty – 10 members**
 - Physicians, lab techs, quality, statisticians, database experts and IS
- **8 hospital teams – 45 individuals**
 - Team size ranging from 4 to 8 members
 - Hospitalists, intensivists, CIOs, lab techs, IS, Lab IS, Quality, Nursing
- **Learners impacted**
 - UVMHC alone approximately 60 residents and at least as many medical students
- **Potential impact**
 - All physician, nursing, IS, pharmacy, laboratory and quality staff at all regional hospitals

Beneficiaries Impacted

- **An estimated number of individuals currently captured in the Collaborative data set is in excess of 30,000 per year; a more precise estimate will be available in next report**
 - **This estimate is based on an analysis of the 2013 VT Discharge Data Set which results in 30,000 discharges from Vermont hospitals that met the Collaborative's inclusion criteria**
 - **The Collaborative data set captures a larger number of individuals because it includes all DHMC discharges**
 - **DHMC discharge number included in the Collaborative data set will be available in the next quarterly report**
 - **Small number of beds represented by 6 non-participating CAH hospitals**
 - **Collaborative inclusion criteria are all discharges of individuals older than 18 years and no principal discharge diagnosis of maternity, newborn or psychiatry**

Ongoing Evaluation Methodology

- **Monthly reports display metrics by hospital and by aggregated population**
- **Current measures include -**
 - 15 most frequent DRGs
 - Number of patient stays and LOS
 - Patient sex and age
 - Lab test rates per patient day (CDC definition) by month beginning Jan 2014
- **Reports display metrics over time and compared to all other hospitals**
- **Laboratory tests being followed for all institutions for the full grant cycle include routine hematology, electrolytes, renal and hepatic function as well as cardiac enzymes**
- **Additional high cost labs will be added for institutions ready for expansion starting Sept 2015**
- **End of grant evaluation will include qualitative inquiry from faculty and all hospital teams about project value**
- **Peer review publications of process and outcomes are planned**

Expenditures July 1, 2014 to May 31, 2015

	Approved Budget	Total Spent to Date	% Spend	% Grant Cycle
VMS Foundation	\$ 150,912	\$ 69,694	46%	46%
UVM Pathology	\$ 98,401	\$ 39,591	40%	46%
UVM Medicine	\$ 273,301	\$ 95,726	35%	46%
Hospital support	\$ 26,214	\$ 1,530	6%	46%
Total	\$ 548,828	\$ 206,541	38%	46%

- **Redirected \$4,000 from hospital support to original \$3,000 allocated to website support (approved contract amendment)**
- **VMS Foundation project management budget line overspend in previous quarters resolving as a result of decreasing personnel reimbursement rate**
- **No invoices from UVM Pathology for Pre Op Lab Project to date; Pathology invoices only cover Pathology support to Lab Collaborative**
- **Budget does not reflect cost of support from Policy Integrity, LLC which provides database and analytic expertise**

Vermont Health Care Innovation Project
2015 Quarterly Report

**Furthering Community Health
Accountable Care – 03410-1295-15
Bi-State Primary Care Association**

Date: July 10, 2015

Reporting Period: April 1, 2015 through
June 30, 2015

Name of Presenter(s) and/or Key Contact:

Kate Simmons, Director of Operations

Grant Project Goals – 03410-1295-15

- List overall grant goals and how they are aligned with the mission of the VHCIP SIM project.
 - Goal: To increase provider collaboration across the continuum of care in local communities.
 - Objective: To grow and strengthen Community Health Accountable Care, LLC (CHAC), a Shared Savings Accountable Care Organization

Recent Accomplishments – 03410-1295-15

- List the top five accomplishments for goals above since the previous reporting period.
 1. Clinical recommendations for CHF and Diabetes were completed and approved by the board. CHAC committees are working to implement these recommendations in their respective health centers. Webinars were held for CHAC network providers which introduced them to the best practice recommendations approved by the Board and provided them with suggestions on implementation of these recommendations in their practices. The first webinar on COPD and Falls Risk was held during the previous reporting period. The second webinar on CHF and Diabetes was held on April 28, 2015. All webinars, recommendations, and education materials have been uploaded to CHAC's website for provider and patient reference.
 2. To comply with Medicaid requirements, CHAC completed the fourth mailing of 2,407 Beneficiary Notification Letters on May 15, 2015 for the months of February, March, and April. CHAC has been successfully reporting opt-outs for all Medicaid and Medicare participating organizations.
 3. Quality reporting for Medicaid and Commercial was successfully completed and submitted. The unofficial data has been shared with the CHAC Board and a webinar was held on June 25, 2015 for health center representatives.
 4. CHAC is taking an active role in the Unified Community Collaboratives and in collaborations with other ACOs and the state.
 5. CHAC staff participated in three separate evaluations.

Challenges & Opportunities – 03410-1295

- Briefly discuss any major challenges encountered since the previous reporting period and responses to each.
 - Bi-State continues to have staff vacancies that would be in support of ACO work. The amount of work required to implement the ACO continues to grow. It is an ongoing challenge to continue to operate as leanly as possible while aligning other work with the work for the ACO. Recruitment for the vacant positions is ongoing, and a temporary staff position was filled to help conduct some ACO work.
 - The number of quality performance measures expected to be reported on and reacted to are causing provider team fatigue. Bi-State staff members are participating in State/VHCIP committees to align measurements where possible.

- Briefly discuss any new opportunities available to support this project programmatically.
 - Bi-State submitted a grant proposal to the State for further funding to support staffing through the end of the contract period, analytics, and the telemonitoring program.

Activities Undertaken & Planned – 03410-1295

■ Ongoing Activities

- Briefly describe any ongoing activities not previously mentioned above.
 - Board Meetings are held monthly in an effort for coordination and to keep moving business forward.
 - Each of the four standing committees must meet at least quarterly. This has been successful and is ongoing. Most of the committees have opted to meet more often.
 - A CHAC representative attends all VHCIP work group meetings.
 - CHAC representatives take active parts in the Unified Community Collaboratives.
 - Roll out and implementation of new clinical guidelines in participating health centers.
 - Tracking of the patients opting out of sharing information with the ACO.
 - Monitoring of the tel-assurance program and enrollment of “rising risk” patients.
 - The CHAC Network Update newsletter is sent out monthly.
 - Bi-State staff members serve on the statewide planning and implementation committee for care management.

Activities Undertaken & Planned – 03410-1295

■ New Activities

— Briefly describe any new activities scheduled to take place before the next reporting period.

- CHAC's data and quality team will be visiting individual health centers to explain their quality performance measures to them and discuss improvement areas.
- CHAC will be expanding the Beneficiary Engagement Committee in an effort to engage more consumers.
- Next Medicaid and Medicare Beneficiary Notification mailings will be sent out by August 15, 2015.
- The Beneficiary Engagement Committee will be reaching out the boards of the FQHCs in our network for suggestions on improvements. They will conduct analysis on these responses and provide a report of suggestions to CHAC's Governing Board in September or October.
- The Clinical Committee will be developing a depression protocol and creating a process to collect measurement data for dashboards to be reported quarterly to the Governing Board.
- A joint meeting of the Clinical Committee and the Operations Committee is planned for the fall to align implementation initiatives.

Activities Undertaken & Planned – 03410-1295

■ Long-Term Activities

- Briefly describe any long-term activities currently being planned.
 - Enrollment of the ACO's Medicare patient population into the tele-monitoring program will be a continuous process.
 - Collaboration with the other ACOs and health care agencies on clinical priorities will be an ongoing effort to create more integrated care delivery while improving quality and lowering costs.
 - CHAC will continue quality improvement efforts focused on improving clinical measures and the implementation of the new care management standards.
 - The monitoring and coordination of all four standing committees of the Board will be ongoing to ensure that all of the committees are collaboratively working towards the same goals.

Providers & Beneficiaries Impacted – 03410-1295

- Please provide the number of Providers participating in or otherwise impacted by your project.
 - There are about ~1,600 providers attributing CHAC and are consequently directly impacted by the VHCIP Sub-grant program.
- Please provide the number of beneficiaries of your project.
 - There are ~35,300 attributed lives, which would count as beneficiaries.

Evaluation Methodology – 03410-1295-15

- Please briefly describe the evaluation methodology and metrics you are using to evaluate your project.
 - The evaluation methodology to be used for the Furthering Community Health Accountable Care Project is to compare project status to the project work plan.
 - CHAC will further be evaluated by:
 - whether it achieved savings in any of its three product lines and whether those savings surprised the MSRs
 - whether the ACO has improved quality of care:
 - utilizing ACO quality measures
 - through successful implementation of CHAC Clinical Recommendations

Evaluation Methodology – 03410-1295-15

- Please share any evaluation results you have to date
 - Bi-State is on track with our project work plan for the Furthering Community Health Accountable Care project – see “Ongoing Activities”
 - CHAC shared preliminary ACO quality reporting findings at the VHCIP QPM Meeting in May 2015.

Expenditures to Date & Revised Budget – 03410-1295

- Please work from your approved revised budget to show any new expenditures.
 - * Bi-State is completing its fiscal year end close. This information will be reported by July 31, 2015.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary				\$ -
Fringe				\$ -
Travel				\$ -
Conferences				\$ -
Equipment				\$ -
Contracts				\$ -
Indirect				\$ -
Total	\$ -	\$ -	\$ -	\$ -

- Briefly discuss any potential changes to the budget going forward.

**Vermont Health Care Innovation Project
2015 Quarterly Report**

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

Date: July 10, 2015

Reporting Period: Second Quarter

Name of Presenter(s) and/or Key Contact:

Ginger Cloud, LCMHC, LADC

Grant Project Goals

- To implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) into the medical homes at Central Vermont Medical Center (CVMC). For the purpose of this grant SBIRT will focus on tobacco, alcohol and drug misuse.
- To develop and extend a Short Message Service (SMS) for patient engagement to monitor binge drinking behavior: Caring Txt VT.
- Integrate SBIRT measure set into eClinical Works (EMR) calculating stratified risk scores and clinical intervention tracking to improve care coordination and expedite billing for reimbursement.
- Explore utility of current SBIRT reimbursement practices.
- Educate and guide medical providers in substance abuse coding and billing.
- Promote SBIRT model statewide.

The implementation of SBIRT into the patient centered medical home model aligns with the mission of VHCIP to support health care payment and delivery system reforms. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services. Screening in the Medical Homes (SiMH) aims to prevent and reduce substance misuse, reduce healthcare costs, increase care coordination, and implement a novel strategy to enhance patient participation.

Recent Accomplishments

- Two medical homes: UVMHC-CVMC Integrative Family Medicine – Montpelier and UVMHC-CVMC Adult Primary Care- Barre have screened nearly twelve hundred patients. Of those patients screened one hundred and fifteen accepted a brief intervention and twenty three percent of those patients entered into Brief Treatment. Currently sixty five percent of the patients that have engaged in Brief Treatment report making reduction in use or maintaining sobriety.
- The SMS text messaging system Caring Txt VT is now available and accessible for patients in the UVMHC-CVMC Integrative Family Medicine – Montpelier, UVMHC-CVMC Adult Primary Care- Barre, UVMHC-CVMC Adult Primary Care – Berlin, and UVMHC-CVMC Family Medicine – Waterbury.
- The Emergency Department SBIRT Clinicians are now logging Brief Treatment notes and referrals in E Clinical Works increasing communication regarding SBIRT work being done in the Emergency Department and Primary Care setting.
- Engagement with the Vermont SBIRT Policy Steering Committee, Department of Vermont Health Access Blueprint for Health, and Vermont Department of Health Alcohol and Drug Abuse Program is ongoing. Outreach by SBIRT clinicians to Vermont recovery resources continues to enhance coordination of care.

Challenges and Opportunities

- SMS texting system age demographic- Caring Txt Vt is a Texting program aimed at reducing weekend binge drinking and specifically targets younger adults. The mean age of our patient population thus far is 52 years of age. Consequently the utilization of the texting program is low for multiple reasons (comfort with texting, lack of weekend binge drinking) .
- Universal physical screens verse universal visit screens – Our Montpelier Medical Home chosen to incorporate Alcohol and Drug screenings universally on every patient visit, whereas our Barre Medical Home is screening universally on all new visits, physicals and annual visits. This creates both challenges and opportunities.
- Being available for BIs –As SBIRT clinician services are expanded to multiple Medical Homes the availability of the SBIRT clinician for the onsite brief interventions during a patient visit with PCP is becoming a challenge. Each clinician will be in a practice on specific weekdays but not every day due to two clinicians covering ultimately seven practices.
- Access to NRT in practices – The medical home patients have been utilizing access to individual therapy for tobacco treatment. Although best practice indicates access to both behavioral health and NRT creates best outcome the SBIRT clinicians do not have direct access to (free) NRT for those patients engaging in tobacco treatment. The clinicians refer patients to the 802 Quits options, follow through to those resources appears to be limited.
- Clinicians focus being on Substance Abuse only - For the purpose of this grant the clinicians main focus with patients is substance use interventions. Given that we have two clinicians extending services to several practices a substance use focus is appropriate. Sustainability conversations will likely focus on having a clinician providing integrated mental health and substance use services verses a division of these services.
- **Opportunities**
- Revise texting program to better meet needs of patients – see above challenge
- Utilization of the SBIRT model in the Medical Homes at CVMC is fueling a larger conversation on substance abuse resources and pathways to treatment here in central Vermont.

Activities Undertaken and Planned

■ Ongoing Activities

- Increased engagement and coordination of care between the Emergency Department's SBIRT project and the Medical Home SBIRT Project.
- Data collection and tracking of SBIRT model utilization.

■ New Activities

- Implementing screening into additional practices – We are currently in the process of adding on five additional sites (Associates in Pediatrics- Berlin; Barre Pediatrics; Central Vermont Adult Primary Care- Berlin; Granite City Primary Care; Waterbury Medical Center;). Arrangement of meetings, champion identification, and implementation process has been challenging due to summer vacation schedules. We hope to have these five sites engaged in SBIRT model by next reporting cycle.
- After multiple requests from patients the SBIRT clinicians are piloting an open group for patients thinking about changing substance use patterns. This group is therapeutic in nature and incorporates evidenced based practices. The aim of the group is to help at risk substance users reduce use through gaining insight into use patterns and the impact their use has on their life/relationships.
- A federally funded SBIRT grant is scheduled for CVMC's Women's Health Clinic. This will add another SBIRT clinician position to the CVMC network. Although this is a separate project it will add another SBIRT resource to the CVMC network and continue to enhance the substance use interventions happening at CVMC.

■ Long-Term Activities

- Engagement with State and local resources to increase awareness of SBIRT project at CVMC is ongoing. Strategic planning to understand the sustainability of the SBIRT project after the end of the grant cycle.

Providers and Beneficiaries Impacted

FTE Category	BIM	MIFH	CVPC	WMA
MD FTE's	3.66	3	4.48	3.93
NP/PA FTE's	1.35	2.69	2.97	0.8
Total Provider FTEs	5.01	5.69	7.45	4.73
 				
Clinical Coordinator	0.81	1.1	1	1
Office RN	4.2	4.1	4.58	4
Office LPN	0.83	0.97	4.12	0
MA/CCA	0.11	3.62	0	1
Clinical FTEs	5.95	9.79	9.7	6
 				
Office Supervisor	1	1	1	1
Medical Secretary	5.27	6.06	7.18	5.72
Front End/Other FTEs	6.27	7.06	8.18	6.72
 				
Total FTE's Per Practice	17.23	22.53	25.33	17.45
 				
Total Attributed Patients	4410	6182	7146	5494

Evaluation Methodology

- To collect data and evaluate the utilization of the SBIRT model in the medical home we are using the reporting functions through our EMR and patient self report. The demographic information, the number of screens complete, engagement in brief interventions, brief treatment and referral to treatment are easily tracked through the EMR. The reduction or elimination of use patterns among patients engaged in treatment with the SBIRT clinician is based on patient self-report.
- Please note that practice sites vary in the number of screen collected due to different implementation strategy and timeline. For example the Montpelier practice has a goal of screening all non-acute patient visits. The Barre practice is screening all new patients, annual visits, and physicals. The Montpelier practice started screening in April and the Barre practice started in May 2015. The benefits of employing different implementation approaches are twofold. First the practice incorporates the SBIRT model in a way that promotes the most “buy in” from staff. Secondly, we are able to compare and contrast different outcomes based on implementation approach.

Evaluation Methodology

	Montpelier	Barre	Totals
Total Patients Screened	983	200	1183
Total Brief Interventions	86	29	115
Females	36	11	47
Males	50	17	67
Transgender		1	1
Average Patient Age	52	53	52.5
Engaged for at least 1 Brief Treatment Session	10	13	23
Active Patients (new appointments scheduled/ referral pending) as of 7/8/15	17	20	37
Number of patients that have reduced use or maintained sobriety	7	8	15
Referral to Intensive Treatment	3	2	5
% of Brief interventions converted to Brief Treatment (engaged)	12%	45%	20%
Enrolment in Caring Txt VT	1	0	1

Expenditures to Date & Revised Budget

- Please work from your approved revised budget to show any new expenditures.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	\$ 360,970.00	\$ 19,906.00	\$ 24,184.00	\$ 44,090.00
Fringe	\$ 98,400.00	\$ 6,251.00	\$ 5,855.00	\$ 12,106.00
Travel				\$ -
Supplies	\$ 10,670.00	\$ 340.00	\$ 2,570.00	\$ 2,910.00
Equipment	\$ 3,960.00	\$ 2,519.00	\$ -	\$ 2,519.00
Contracts	\$ 6,000.00	\$ 5,000.00	\$ -	\$ 5,000.00
Indirect	\$ 20,000.00			\$ -
Total	\$ 500,000.00	\$ 34,016.00	\$ 32,609.00	\$ 66,625.00

As of 6/1/15

**Vermont Health Care Innovation Project
2015 Quarterly Report**

The Inclusive Healthcare Partnership Project
The VT Developmental Disabilities Council

Date: July 15, 2015

Reporting Period: Quarter 2

Name of Presenter(s) and/or Key Contact:
Kirsten Murphy

Grant Project Goals

Overview and Relation to VHCIP Goals

IHPP 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.

To this end, activities are tracked under four sub-goals

GOAL 1: The Project Team will be prepared to engage individuals with I/DD and their family caregivers in a fully inclusive planning process that bridges gaps in understanding between stakeholders from traditional medical services and those who either provide or receive Disability Long Term Services and Supports (DLTSS).

Begun	Progress Made	Finished
✓	✓	✓

All project start-up work has been completed and an inclusive process has been established.

Grant Project Goals, *continued*

GOAL 2: Identify and recommend a set of best practices that will improve the healthcare experience of adults with I/DD and reduce the disproportionate burden of illness experienced by this population.

Begun	Progress Made	Finished
✓	✓	

The IHPP Planning Team has reviewed: (1) tools designed to improved patient-provider communication; (2) curricula designed to increase health literacy and healthy choices for adults with I/DD; and (3) best practices to support the transition from pediatric to adult healthcare.

GOAL 3: Collect and analyze qualitative and quantitative data that describes the health status and care experience of adults with I/DD in Vermont..

Begun	Progress Made	Finished
✓	✓	almost

Qualitative data collection and analysis is complete.
Review of Medicaid claims data is ongoing.

Grant Project Goals, *continued*

GOAL 4: By sharing information and soliciting input, the Project Team builds relationships with other collaborative healthcare groups, including the Blueprint and the VHCIP Regional Learning Collaboratives that are currently working toward better integrating traditional medical care and DLTSS.

Begun	Progress Made	Finished
✓	✓	

Outreach will be a primary area of emphasis during the third quarter, including vetting potential recommendations with key stakeholders

Five Recent Accomplishments

- 1. Existing Tools Reviewed:** Using a standard scoring system, GMSA completed a review of more than 80 tools currently available to improve healthcare for adults with I/DD. The IHPP Planning Team identified the “Best of the Best” to recommend to Vermont, as well as some critical gaps. Examples include:



- ❖ Forms and a phone application that store critical information about an individual’s accommodations.
- ❖ Cognitively accessible print and online materials about specific health conditions, procedures, and medications.
- ❖ Curricula to support wellness education for people with I/DD, including a peer-to-peer model.

Five Recent Accomplishments, *continued*

2. Qualitative Data Collection Completed: IHPP staff conducted 4 focus groups and 2 one-on-one interviews, arranged to accommodate individuals who agreed to share especially sensitive personal stories. A written summary of findings is available.

Focus group topics:

- Health services for people with HCBS waivers
- Women's health issues
- The family caregiver perspective
- Health services for people with I/DD who do not receive HCBS.

Five Recent Accomplishments, *continued*

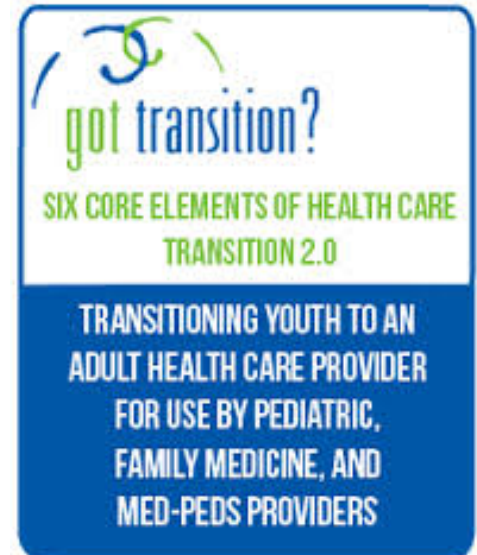
- 3. Initial Review of Medicaid Claims Data Conducted:** IHPP staff reviewed the health status and care utilization of adults with I/DD across 25 measures.

For Vermonters with I/DD...

- Overuse of emergency room care presents a significant opportunity to improve practice and lower cost.
- Those who do not receive HCBS (Medicaid waiver) spend more on traditional medical care (state plan Medicaid), than those who *do* receive HCBS.
- Because of coding practices that may be particular to this population, some measures do not provide accurate information about the population health of this group. Secondary conditions like obesity are rarely noted .

Five Recent Accomplishments, *continued*

4. **Planning Team consults national champion for the medical home model.** Dr. Carl Cooley met with the IHPP Planning Team at their June meeting to discuss *Got Transition*, a new resource promoting best practices for transitioning youth with special healthcare needs from a pediatric to an adult healthcare model.



www.gottransition.org

The Six Core Elements of Healthcare Transition, 2.0

This tool was subsequently shared with VHCIP consultant(s) working with the DLTSS Group in developing guidelines for Care Coordinators.

Five Recent Accomplishments, *continued*

- 5. IHPP staff identify physicians interested in specialty care for adults with I/DD at UVM Medical Center: *Please see opportunities for details.***

Challenges...

Goal 1:

A fully inclusive planning process

Meaningful inclusion requires good planning and careful preparation.

Steps Taken

- IHPP staff draft meeting materials 2 weeks in advance to allow time for GMSA to develop cognitively accessible handouts for self-advocates.
- GMSA meets with self-advocates on the Planning Team to preview the agenda and core concepts.
- Planning Team meetings include 2-3 small group discussions, which are preferred by self-advocates.

...and Opportunities

Goal 4: Outreach to UVM Medical Center

IHPP staff spoke with physicians who oversee UVM's "Comfort Zone," a specialty clinic for children who require sedation for some routine procedures like dental fillings and MRI scans.

Some adults with I/DD also seek care at the Comfort Zone; but as a pediatric service, the Comfort Zone is not necessarily prepared to see adults, according to staff.

Next Step

- IHPP staff are sharing information with UVM about the potential need for an adult service similar to the Comfort Zone.
- IHPP Staff will meet with UVM in September.

Activities Undertaken and Planned

Ongoing Activities

- GMSA crafting cognitively accessible materials for 2 remaining Planning Team meetings.
- IHPP Staff are refining their review of Medicaid claims data through ongoing conversation with assigned technical assistance.
- Stakeholder Interviews: Although formal interviews have been completed, IHPP staff are conducting additional interviews for information as other important contacts are identified. Key areas previously overlooked include dental care providers.

Activities Undertaken and Planned, *Cont.*

New Activities, Quarter #3

- Two additional Planning Team meeting:
 - AUGUST: *Medical Education and Provider Training*
 - SEPTEMBER: *Policy Initiatives to Improve Care*
- Project Director will attend the annual conference of the American Academy of Developmental Medicine and Dentistry [AADMD], July 27-29.
- IHPP staff will begin vetting draft recommendations with potential partner organizations for implementation.



Activities Undertaken and Planned

Long-Term Activities, Quarter #4

- The primary focus of Quarter #4 is completing the IHPP's final White Paper, *Findings and Recommendations Regarding the Health and Healthcare of Vermonters with Intellectual and Developmental Disabilities*.
 - OCTOBER: Draft reviewed by IHPP Planning Team
 - NOVEMBER 18, 2015: Final paper to be adopted by IHPP
- Next Steps planning meeting schedule for August 5, 2015 with key partners in the disability/DLTSS community to discuss a training initiative for care coordinators

Providers & Beneficiaries Impacted

- Providers participating or potentially impacted

Providers	Planning team	Consulted by IHPP	See ≥ 20 w/ I/DD in 4 yrs	Statewide estimate
Physicians (MD's)	3	8	184	2122*
Nurses and Physician Assistants	1	3	70	8695*
Dentists	0	0	Not known	374*
Other health care providers	1	3	Not known	Not known
Developmental Services staff	3	5	n/a	1700

* From Kaiser State Health Facts: <http://kff.org/state-category/providers-service-use/?state=VT>

Providers & Beneficiaries Impacted, *Cont.*

- If recommendations from this planning project are implemented, IHPP could potentially impact 2 groups of beneficiaries:
 - *Cohort 1: Defined as adult Vermonters with I/DD who receive Medicaid-funded Home and Community Based Services (HCBS). Total = 2521, FY 14*
 - *Cohort 2: Defined as adult Vermonters with I/DD who are covered by Medicaid, but do not qualify for HCBS. Several factors make this sub-group difficult to identify. Estimated Total = 12,308, FY 14.*

NOTE: Cohort 2 is estimated base on a prevalence rate for I/DD. We anticipate that the total for cohort 2 will be refined by comparison with Medicaid claims data.

Evaluation Methodology, RBA Framework

■ *How much did we do?*

- IHPP is a planning grant with specific deliverables due periodically throughout the planning process. The Project Director reviews written summaries of each phase of data collection. To date all deliverables have been completed within required timelines.

■ *How well did we do it?*

- IHPP is dedicated to an inclusive planning process. To this end, every planning team meeting ends with a review of participants' evaluation of their contribution to the group.
- Written summaries of Stakeholder Interviews and Focus Groups have been shared widely with participants to assess fidelity to the information shared; and with other stakeholders to assess the relevance of our analysis. To date we have received only one concern from a participant regarding our Stakeholder Interviews.

Evaluation Methodology, *Continued*

- The important question, *Are Vermonters better off because of this project?*, depends upon the future implementation of IHPP recommendations and the ongoing evaluation of the implementation process.



IHPP Staff and Self-Advocates at Orientation, April 2015

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	\$ 19,400.00	\$3,655.00	\$ 3,862.00	\$ 7,517.00
Fringe	\$ 6,402.00	\$ 1,337.00	\$ 3,593.00	\$ 4,930.00
Travel	\$ 2,500.00	-	\$ -	\$ -
Conferences	\$ 2,500.00	-	\$ 1,500.00	\$ 1,500.00
Equipment	\$ 6,890.00	\$1,759.00	\$ 2,113.46	\$ 3,872.46
Contracts	\$ 151,408.00	\$0.00	2,460.00	\$ 2,460.00
Indirect	\$ 3,900.00	\$ 75.00	\$ -	\$ 75.00
Total	\$ 193,000.00	\$ 6,826.00	\$ 13,528.46	\$ 20,354.46

NOTES: Reflects all spending recorded by the AHS business office through June 30, 2015.

**Vermont Health Care Innovation Project
Grant # 03410-1461-15
2015 Quarter Two Report**

**State Innovation Models: Funding for
Model Design
Vermont Program For Quality in Health Care,
Inc.**

Date: July 10, 2015

Reporting Period: April 1, 2015- June 30, 2015

Prepared by: Linda Otero MSN/ED RN

Vermont Program for Quality in Health Care, Inc.

Statewide Surgical Collaborative

Project Coordinator (SSCPC)

Grant Project Goals

- To collect and submit surgical clinical data to the American College of Surgeons National Quality Improvement Program (ACS- NSQIP) database for the purpose of improving surgical outcomes and performance through data analysis and comparative performance monitoring.
- Develop infrastructure for the implementation of a clinical management systems designed to improve quality, patient safety and reduce costs of surgical care across State of Vermont.

Recent Accomplishments

- **Established a Vermont Statewide Surgical Services Collaborative**
- **Six of 12** hospitals will be enrolling in ACS-NSQIP (50%)
 - Three hospitals currently enrolled in ACS-NSQIP program (2 CAH & 1 Community hospital)
 - Three hospitals enrolling Fall 2015 (2 Community & 1 CAH)
- Coordinated monthly Steering Committee meetings
- Created opportunity for UVMHC Surgeons to learn about ACS NSQIP curriculum for medical students/residents
- Provided ongoing NSQIP education to Quality Directors
 - Quality Director's meeting 6/12

Challenges and Opportunities

❑ Six hospitals have declined participation in ACS-NSQIP at this time for various **reasons**:

- Resources, sustainability, or lack of surgeon champion (2 hospitals)

Responses: Keep enrollment period open until after hospital budget review process; ongoing education of NSQIP benefits; open invitation to surgeon champions to attend monthly meetings and advocate for program; Invitation extended Dr. Allan Ramsay (GMCB) collaborative meeting July 1, 2015.

❑ Opportunity to work with GMCB on potential funding sources and next steps to sustain project

❑ Potential opportunity to establish a **Surgical Medical Home**

Activities Undertaken and Planned

- **Ongoing Activities:** Coordinating hospital enrollments into ACS NSQIP; Reviewing and discussing best metrics and evaluation methodologies (VHCURES vs. VUHDDS); Facilitating monthly communication of collaborative members; Encouraging attendance national ACS conference or statewide meetings/conferences
- **Planned Activities:** Preparing hospitals and surgical case reviewers (SCRs') for Clinical abstraction and program implementation; ACS-NSQIP training of SSPCS and SCR's'; SSPCS to attend National ACS Conference 7/2015
- **Long term Activities:** Coordinating collaborative events for hospitals to share best practice statewide and nationally; Facilitating hospital QI efforts with QIO-QIN as resource.

Providers and Beneficiaries Impacted

- Providers: Approximately **65** Surgeons performing general, orthopedic, gynecological, and urologic inpatient and outpatient surgeries on adults in 6 enrolled hospitals
- Potential Beneficiaries:
Patients/Hospitals/Insurers/State of Vermont
 - According to 2012 VUHDDS, 57,753 surgical procedures performed on adults 18 or older statewide.

Evaluation Methodology: Administrative Claims

- Administrative Claims (VUHDDS) for statewide baseline and semi-annual reports
 - Surgical Outcome Measures
 - Length of Stay (LOS)
 - Postoperative Readmission/ER Visit
 - Insurance Charges
 - Insurance provider Case Mix
- Possible comparative analysis control group (hospitals not enrolled in NSQIP)

Evaluation Methodology : HOSPITAL CLINICAL DATA ABSTRACTION 30 DAY POSTOPERATIVE (ACS NSQIP)

Clinical data on outcome measures



Raw, risk and case mix-adjusted semiannual and annual data reports

Data Collection to **start Fall 2015**

Comparative Analysis to Other Hospitals Enrolled in ACS NSQIP

Surgical Site Infections/ Wound Dehiscence	Cardiac Arrest/MI
Pneumonia	Hemorrhage
Pulmonary Embolism	Deep Vein Thrombosis
Unplanned Intubation/Respiratory Failure	Sepsis
Ventilator > 48 Hours	Septic Shock
Urinary Tract Infection	Mortality
Acute Renal Failure	Foreign Object Left in Body
Stroke/CVA	Readmission Rate r/t surgical complications

Expenditures to Date & Revised Budget

- Please work from your approved revised budget to show any new expenditures.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	\$ 470,735.00	\$ 17,989.85	\$ 20,718.12	\$ 38,707.97
Fringe	\$ 143,350.00	\$ 5,397.35	\$ 6,215.43	\$ 11,612.78
Travel	\$ 11,559.00	\$ 547.72	\$ -	\$ 547.72
Coord. Training	\$ 2,500.00	\$ -	\$ 2,321.22	\$ 2,321.22
Conferences	\$ 2,600.00	\$ 75.00		\$ 75.00
Equipment	\$ 12,000.00	\$ -		\$ -
Contracts	\$ 180,000.00	\$ -	\$ 10,000.00	\$ 10,000.00
Indirect	\$ 77,256.00	\$ 2,196.06	\$ 3,742.81	\$ 5,938.87
Total	\$ 900,000.00	\$ 26,205.98	\$ 42,997.58	\$ 69,203.56

**Vermont Health Care Innovation Project
2015 Quarterly Report**

RiseVT
Northwestern Medical Center

Date:

July 1, 2015

Reporting Period:

April-June 30 2015

Name of Presenter(s) and/or Key Contact:

Dorey Demers, RiseVT Coordinator

ddemers@nmcinc.org

524-8825

Grant Project Goals

- Increase the overall health of residents by decreasing the percentage of overweight and obese individuals,
- Increase the number of employers offering a wellness program in which greater than 50% of the employees participate
- Expand resources for biking and walking.
- *All three indicators are in line with the Vermont Department of Health's State Improvement Plan (2013-2017) and to reduce the prevalence of chronic diseases such as cardiovascular disease, cancer, chronic obstructive pulmonary disease, diabetes, and asthma, it is necessary to address modifiable risk factors.*

Recent Accomplishments

- Much of the beginning of the quarter was prepping for our Launch and continuing to pilot with our families, individuals, schools, businesses and municipalities.
- We officially launched on June 1
- Collaboration with Saint Albans City School where over 900 kids and staff came together to celebrate their wellness and wrote out “RiseVT” on their soccer fields.
- Health Coaching in small non-profits has been incredibly successful with one location having lost 31.4 pounds in one month of working with our RiseVT Health Coach.
- Policy and environmental changes are begin to occur during our RiseVT Certifications with Businesses, municipalities and schools. Currently we have adopted 5 breastfeeding friendly certifications from the State of Vermont Breastfeeding Employer Initiative. Working with local businesses to go smoke free and connecting them to our community resources has worked well.
- Social Media and Website current numbers:
 - Facebook- 1569 Likes Post Reach: 216,943
 - Twitter Impressions- 2,062
 - Pinterest Viewers- 1,076
 - Website Clicks- 3,748

Challenges and Opportunities

- Articulating and educating the community about RiseVT has been challenging as the program is very broad. Our presence at local events and collaborations with organizations has proven to be a good tactic. In addition, we have utilized social media to help with this and we are working on videos, blogs, newspaper articles to talk about RiseVT. People are starting to recognize RiseVT, now we have to get them to understand it.
- Prevention Institute from California visited RiseVT and is currently creating a snapshot of the work we are doing for an Accountable Communities for Health Opportunities and Recommendation report

Activities Undertaken and Planned

■ Ongoing Activities

- Continuing to establish partnerships with local organizations. RiseVT is an active participant in the Franklin Grand Isle Community Partnership. RiseVT has presented to Franklin County Chamber of Commerce and has another scheduled presentation in July.

■ New Activities

- Piloting #RiseVTShowUp Events to encourage safe, free and community centered classes. These events happen on Wednesdays at 6:00 am and 8:00 am. We are averaging 20 attendees and other communities are requesting that we have these events in their areas.
- “What’s In Your CSA?” Cooking Collaboration with Northwest Access Television and VDH Saint Albans short video clips to be utilized on social media, website, Cerner to provide a short 2 minute how to recipe with local, fresh, food.

■ Long-Term Activities

- Once fully established with a strong infrastructure we will be working with providers and collaborating with the Lifestyle Medicine Clinic.

Providers and Beneficiaries Impacted

- Collaboration with VDH Clinical Staff to discuss RiseVT opportunities for WIC families.
- *Collaboration with NOTCH to bring RiseVT initiative to NOTCH Day Camps for families*
- *Engaging with Lifestyle Medicine Clinic which is currently being piloted for Northwestern Medical Center Employees.*
- *Beneficiaries:*
 - 605 Pledges, Health Coaching and Cerner users (122), 19 businesses are currently working with RiseVT with 11 Certified, 4 Schools , 4 Municipalities

Evaluation Methodology

- RiseVT has established a data committee with VDH, NMC and RiseVT representation. The committee is utilizing the Youth Risk Behavior Survey, BRFSS Survey, Cerner and RiseVT Scorecards to evaluate the effectiveness of the grant. Most of these data sets are long term, and data can only be obtained every two years. The data committee has also identified benchmarks for number of business, municipalities, schools, trails etc. that RiseVT is working towards. The data committee meets quarterly or more if needed.
- In addition RiseVT is identifying number of people effected by policy and environmental changes.

Evaluation Results

Outcome	Current	Notes
Increase the overall health of residents by decreasing the percent of overweight and obese individuals	27% in FC 37% In GC	Goal: FC & GC – 15%
Increase the numbers of employers offering a wellness program in which 50% of employees participate- Baseline (0)	7 employers all at 50% or more	To have 10 by end of 2015
Expand resources for walking and biking	See below	
Increase the number of FGI residents who report no secondhand smoke exposure from 43% to 60%	43%	Long-term
Increase fruit and vegetable consumption from 18% to 28%	18%	Long-term
Decrease the number of people with no leisure time physical activity from 26% to 19%	26%	Long-term

Strategies to Achieve Outcomes

Strategy	Starting	Current	2015 Goal	2016 Goal	2017 Goal
# of Paths Available or Improved	29	29*	31		
# of Safe Routes to Schools	4	11	6	8	10
# of Employers with Employee Wellness Programs	0	8	10	20	30

Evaluation Results

Overall Engagement

Rise VT Memberships			
Group	Pursing	Achieved	Total
Individuals/Families	395	n/a	605
Businesses	8	11	19
Schools	4	4	4
Municipalities	3	2	5

Online/ Social Media		
	Quarter to Date	Total
Facebook Likes	1000	1569 (as of 8/10)
Facebook Post Reach	191,687	216,943
Pinterest Monthly Viewers	1,076	1,076
Twitter Impressions	2,062	2,225
Website Clicks	3748	3748

Rise VT Outreach Efforts		
	Quarter to Date	Total
Face to Face encounters	447*	662*
# of Rise Certified Events	n/a	n/a

*The outreach efforts are capturing pledges at events, #RiseVTShowUp, and presentations.

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	\$ 45,000.00	\$ 13,676.00	\$ 29,216.30	\$ 42,892.30
Fringe	\$ 63,000.00	\$ 3,892.00	\$ 8,180.03	\$ 12,072.03
Travel	\$ 10,000.00	\$ 286.00	\$ 1,053.96	\$ 1,339.96
Materials/Suppli	\$ 19,500.00	\$ -	\$ -	\$ -
Equipment	\$ 16,000.00	\$ 13,000.00	\$ 1,161.00	\$ 14,161.00
Other	\$ 46,500.00	\$ 3,405.00	\$ 20,268.64	\$ 23,673.64
Indirect				\$ -
Total	\$ 200,000.00	\$ 34,259.00	\$ 59,879.93	\$ 94,138.93

- No changes to budget

**Vermont Health Care Innovation Project
2015 Quarterly Report**

***An Innovative Adaptation of the TCM
in a Rural Setting***

Southwestern Vermont Health Care

Date:

July 8, 2015

Reporting Period:

April 2015 – June 2015

Name of Presenter(s) and/or Key Contact:

Billie Lynn Allard MS,RN

Grant Project Goals

1. Design and share plans of care and identify gaps as we deliver integrated healthcare in the Bennington Service Area.
2. Create an interdisciplinary team to better meet the needs of behavioral health/drug and alcohol addicted patients that frequent the Emergency Department at SVMC.
3. Decrease the number of hospital admissions and ED visits of high risk chronic care patients in our Bennington Service Area.
4. Create required reports and disseminate information on project progress and lessons learned through toolkit and regional conference.

Recent Accomplishments

1. Health Promotion Advocate completed orientation, actively working with patients for inclusion in Community Care Team Meetings, implementing action plans.
 - Obtained 15 Release of Information forms from high risk ED patients for review at Community Care Team Meetings.
 - 9 new patients reviewed at Community Care Team MeetingAdditional Transitional Care Nurse currently completing orientation, has obtained MA nursing license to expand service area. Assigned to 2 new practices and one existing practice.
2. Team attended the VHCIP Provider Sub-Grant Symposium. Billie Allard MS,RN participated in panel discussion, and has responded to information requests through conference calls and emails from audience participants since the presentation.
3. Presented Transitional Care Program at Quarterly Medical Staff Meeting to encourage patient referrals from additional medical practices.
4. Interviewed 2 excellent candidates for Interact Educator position, anticipate hiring decision next week.

Challenges and Opportunities

- Challenges and Response Actions:
 1. Identified need for increased community agency leadership in the Community Care Team meetings.
 - Invited Field Director from the Vermont Agency of Human Services to pre-planning sessions for the Community Care Team meetings.
 2. Identified need for documentation tool in Medical Record for patients identified and discussed by Community Care Team to document activities occurring between ED visits and assure information is available to the health care team.
 - Meeting scheduled with Director of Information Systems and Director of Health Information Systems to identify and implement documentation tool.
 3. Identified need to capture interventions of the Health Promotion Advocate.
 - Review of activities of HPA and tool developed to capture list

Challenges and Opportunities (cont.)

3. Identified need for patient and agencies to have direct access to Health Promotion Advocate.
 - Request for phone and laptop for Health Promotion Advocate approved and ordered
4. Transitional Care Nurses receiving requests for assistance with patients without Primary Care Physicians.
 - Discussed this concern at Bennington Regional Clinical Performance Committee for further input.
 - Continue to connect patients with Primary Care Physicians
5. Transportation remains a challenge for patients unable to get to medical appointments and services
 - New Chair Car Service now available through local Village Ambulance service to provide transportation.
 - A SUV been donated to SVHC will be outfitted to provide transportation for patients who do not require the level of care of a chair care service, but need transportation to appointments. (Expect implementation in next quarter)

Challenges and Opportunities (cont.)

■ Opportunities

1. Southwestern Vermont Health Care opening a new physician practice in Pownal Vermont on October 1, 2015.
 - New Transitional Care Nurse has obtained MA license and will cover this office.
2. Potential ability to expand services with Transitional Care Program being highlighted in multiple publications and marketing efforts.
 - TCN Program highlighted in SVHC's Annual Report – "Partnership is Powerful Medicine"
 - TCN program highlighted in Community Outreach program through SVHC Marketing Department.
 - Updated Transitional Care Team brochure in development, highlighting new components of the program.

Activities Undertaken and Planned

■ Ongoing Activities

- Weekly strategy Transitional Care Nursing Team sessions.
- Data analysis / data summary reports.
- Community Care Team monthly meetings.
- Continued implementation of Transitional Care Program.

■ New Activities - next reporting period

- Hire and train new INTERACT position to work with local Nursing Homes.
- Planning meeting with nursing team from first identified nursing home setting
- Expansion of TCN Program to additional Medical Practice
- Participation in new Interdisciplinary Daily Rounding program.
- Implement documentation system to communicate HPA care in the Medical Record and accurately capture HPA patient interactions.
- Implement biweekly meetings to plan Regional Conference.
- Implement Interact program in first nursing home setting

■ Long-Term Activities

- Implement INTERACT program in all area nursing homes
- Plan and hold Regional Conference on Transitional Care Nursing.
- Data review & program modifications as necessary.

Providers and Beneficiaries Impacted

- **Number of Providers participating in or otherwise impacted:**
 - ❖ TCN Program:
 - 18 Physicians
 - 4 Physician Assistants
 - 7 Nurse Practitioners
 - 4 Transitional Care Nurses

 - ❖ Community Care Team
 - 3 Physicians
 - 1 ED Case Manager
 - 4 SVMC Administrative RNs
 - 1 SVMC Social Work Coordinator
 - 1 SVMC HPA
 - 1 SVMC Practice Manager

Providers and Beneficiaries Impacted (Cont.)

❖ Community Care Team (Continued)

- Agencies / Community Partners

- Vermont Center for Independent Living
- RAVNA Visiting Nurse Association
- BAYADA Visiting Nurse Association
- Bennington Housing Authority
- Council on Aging Case Manager and Options Counselor
- SASH (Support and Services at Home)
- Vermont Agency of Human Services
- Department of Vermont Healthcare Access
- United Counseling Services – Substance Abuse Counselor, Mental Health and Substance Abuse Counselor
- CRT Community Rehab & Treatment Service
- Vermont Division of Vocational Rehabilitation
- SVMC Blueprint CHT Leader

Providers and Beneficiaries Impacted (Cont.)

❖ Community Care Team (Continued)

- Bennington-Rutland Opportunity Council and Substance Abuse Services
- Bennington County Coalition for the Homeless
- Interfaith Council Service
- Sunrise Family Services
- Vermont Department of Health
- Turning Point Center of Bennington County

Number of Beneficiaries participating in/or impacted

- Transitional Care Program

	Dec 14- Mar 15 Q1 Total	Apr 15	May 15	Jun 15	Q2 Total	Total YTD
# New patient encounters	224	33	47	37	117	341
Total # patient interactions	554	72	126	95	293	847
Home	122	21	23	29	73	195
Hospital	290	31	67	46	144	434
Phone Call	100	15	24	18	57	157
PCP Office	18	3	5	0	8	26
Nursing Home	21	0	7	2	9	30
Emergency Department	3	2	0	0	2	5

Providers and Beneficiaries Impacted (Cont.)

- Community Care Team

	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Total
# New Participants	-	-	-	5	2	1	2	9
# Patient Care Plan reviews	-	-	-	6	7	8	9	
# Referrals/Contacts								
Shared Living Provider Program				2				2
BPI Adult Day Service				2				2
Employment Services				1				1
Veterans Administration				2				2
CRT (Community Rehab & Treat)				1				1
Battelle House Crisis Center				2				2
Chronic Pain Program				1		1	1	3
Medicaid Case Manager				2			2	4
Traumatic Brain Injury Program				1	1		1	3
Blueprint Case Managers							3	3
Sunrise Family Services							1	1

Providers and Beneficiaries Impacted (Cont.)

	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Total
# Referrals/Contacts CCT (cont.)								
Medical Provider				1				1
United Counseling Services				2	2		2	6
Developmental Services / UCS					1	1	1	3
Housing Assistance				1	1			2
Vocational Rehabilitation				1	1		1	3
Economic Services					1		2	3
Transitional Care Nurses SVMC					1			1
Social Services SVMC					1	1		2
Hawthorne Recovery Program					1		1	2
Court Appointed Guardianship							1	1
Memory Clinic							1	1
Department of Corrections							1	1

Evaluation Methodology

■ Transitional Care Program

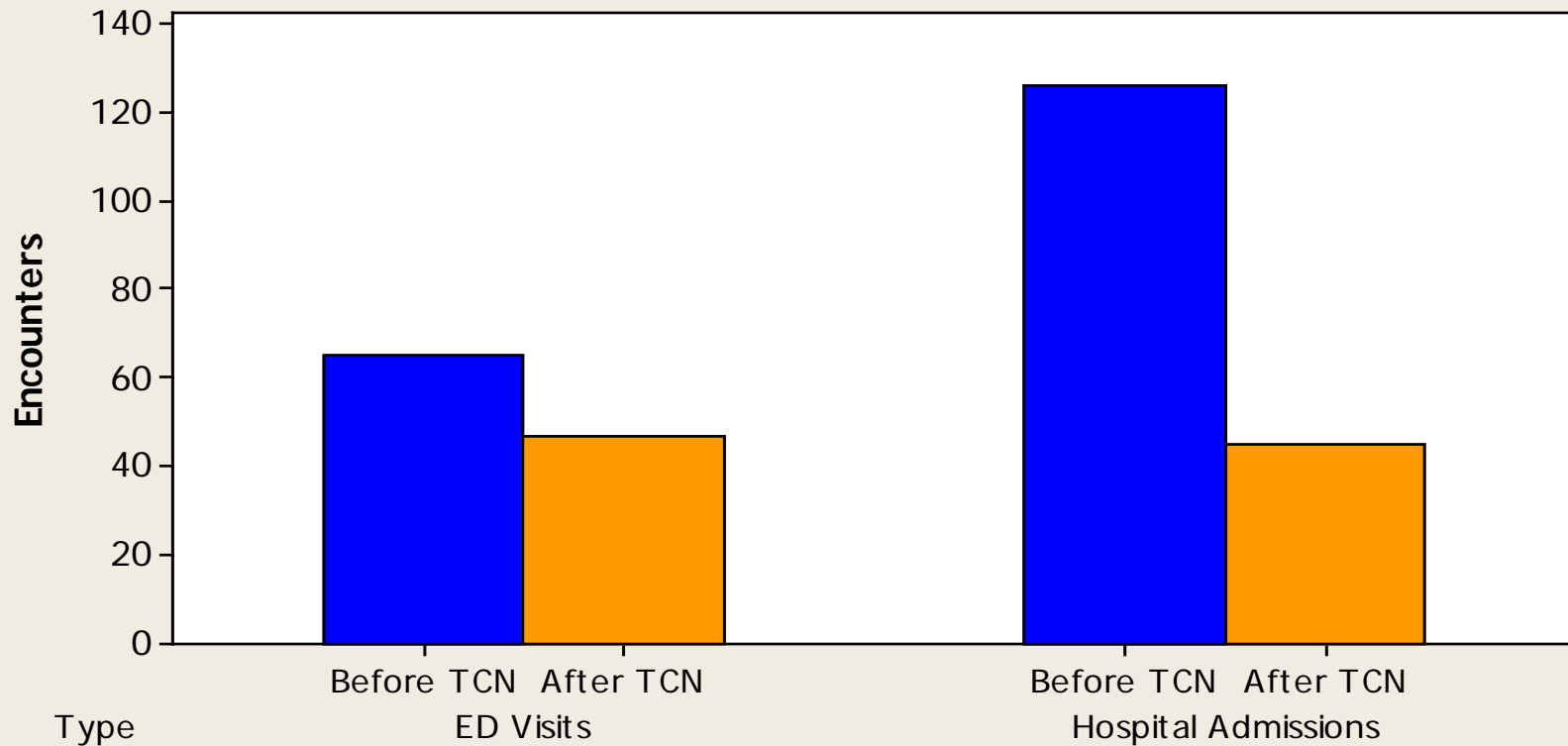
- Number of inpatient admissions to the hospital 120 and 180 days prior to TCN Program and 120 and 180 days post TCN Program.
- Number of ED Visits 120 and 180 days prior to TCN Program and 120 and 180 days post TCN Program.
- Comparison of above data points to a control group of patients who opted out of the program.
- Patient Satisfaction Survey.
- Quantitative measures – number of patient interactions, services provided etc.

■ Community Care Team

- Number of ED Visits 90 and 180 days prior to Community Care Team involvement and 90 and 180 days post CCT involvement.
- Quantitative measures – number of patient interactions, number of referrals for additional services, etc.

Transitional Care Nursing -- Bennington, Vermont

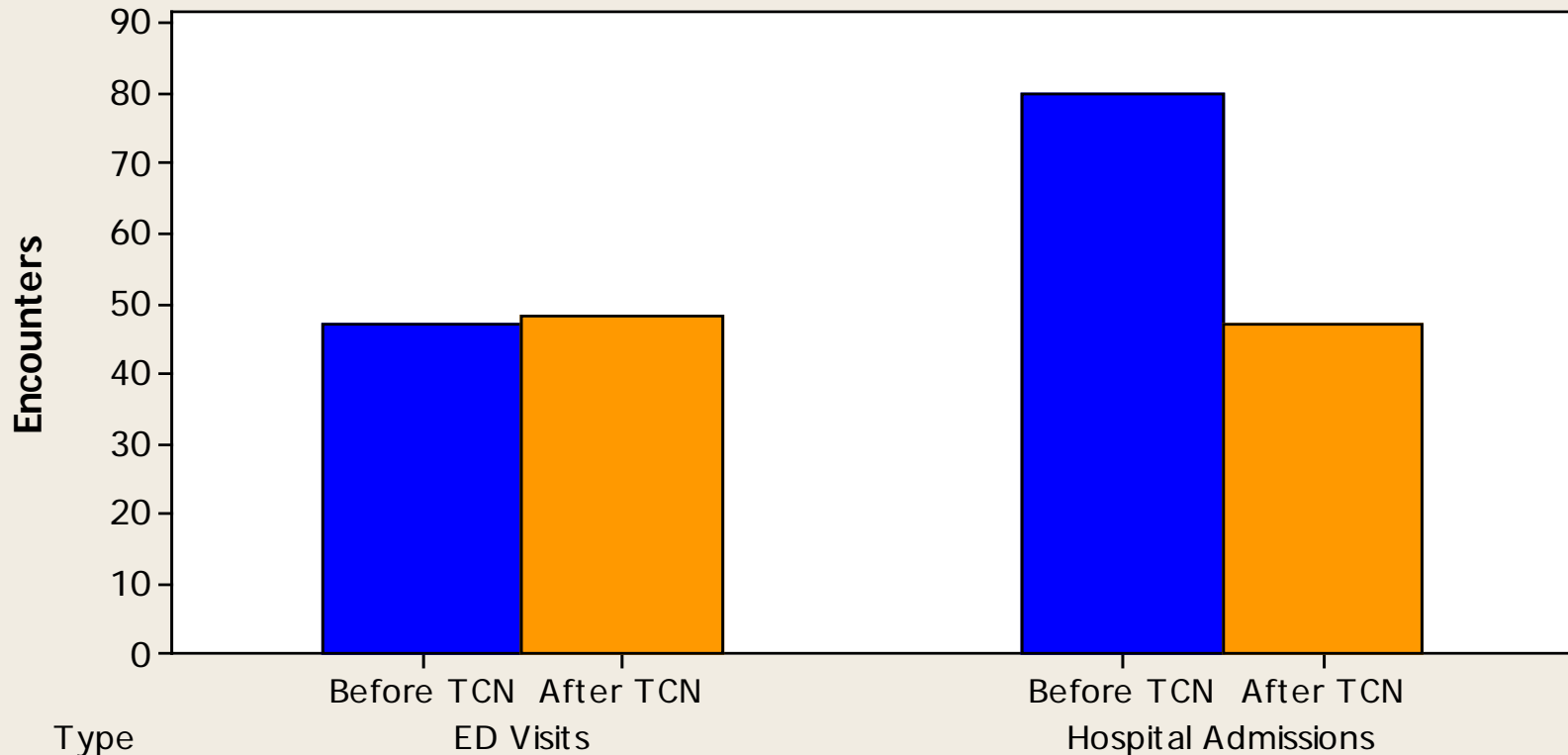
Comparison of ED Visits and Hospital Admissions Before/After TCN
(n=114 patients on TCN 120 Days)



Data Source: SVMC ED Visits May 2014-Dec 2014

Transitional Care Nursing -- Bennington, Vermont

Comparison of ED Visits and Hospital Admissions Before/After TCN
(n=65 patients on TCN 180 Days)

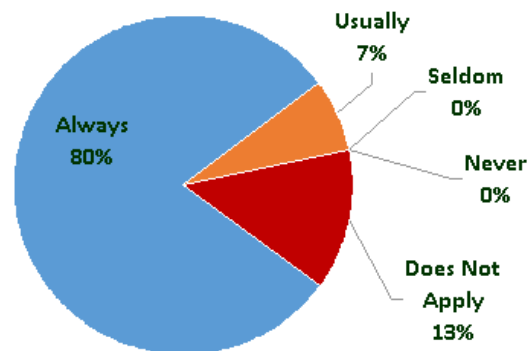


Data Source: SVMC ED Visits Jan 2014-Dec 2014

Transitional Care Nurse Program Patient Satisfaction Survey

	Always	Usually	Seldom	Never	Does Not Apply	N/A
<i>My Transitional Care nurse explained things so that I could understand:</i>	17	1	0	0	0	0
<i>My hospital Pharmacist explained things so that I could understand:</i>	8	1	0	0	8	1
<i>My Transitional Care nurse connected me with services that I needed:</i>	11	2	0	0	5	0
<i>My Transitional Care nurse helped me feel more confident that I can manage my medications:</i>	16	1	0	0	1	0
<i>My Transitional Care nurse helped me feel more confident that I can follow my discharge plan:</i>	16	1	0	0	1	0
<i>My Transitional Care nurse helped me learn when to call the doctor, go to the emergency room or call 911.</i>	14	2	0	0	2	0
<i>My Transitional Care nurse helped me learn about my illness and how to manage it better :</i>	16	1	0	0	1	0
<i>My Transitional Care nurse helped me develop goals that matter to me:</i>	16	1	0	0	1	0
TOTAL	114	10	0	0	19	1

Program Overall - Percentage Totals



Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr	Total Spent to Date
Salary	\$ 287,310.00	\$ 1,313.01	\$ 11,046.22	\$ 12,359.23
Fringe	\$ 86,193.00	\$ 393.91	\$ 3,313.86	\$ 3,707.77
Travel				
Conferences				
Equipment	\$ 3,097.00			
Contracts	\$ 23,400.00			
Indirect				
Total	\$ 400,000.00	\$ 1,706.92	\$ 14,360.08	\$ 16,067.00

Briefly discuss any potential changes to the budget going forward.
No changes anticipated at this time.

**Vermont Health Care Innovation Project
2015 Quarterly Report**

***Behavioral Screening and Intervention
Invest EAP***

Date: July 1, 2015

Reporting Period: April – June 2015

Steven P. Dickens

Grant Project Goals

- Evaluate impact of behavioral health screening and intervention at a private place of employment on health outcomes.
- Screen employees for poor nutrition, lack of exercise, depression, substance use and smoking.
- Provide short-term evidence-based treatments for employees who screen positive to improve their overall health and wellbeing and thus reduce future healthcare expenditures.

Recent Accomplishments

- Health Coach has met regularly with MI expert as extension of intensive week-long in person training to continue to hone treatment skills.
- Completed development and testing of online evaluation database.
- New hardware and updated software provided to Health Coach to ensure treatment fidelity and improve patient experience.
- Developed and began implementation of employee outreach plan.
- Program posters on display in workplace.

Challenges and Opportunities

- Initial program outreach has significantly increased EAP referrals since the project's inception; however, employees have so far been slow to volunteer for screenings. We have begun to implement a revised and more intensive outreach plan with the employer.
- King Arthur employees have participated in numerous wellness initiatives over the past year and there may be some participation fatigue. We are speaking with a few other employers in the area should we need to broaden program participation beyond King Arthur Flour.

Activities Undertaken and Planned

- Ongoing Activities
 - Continued training of clinical staff in evidence-based behavioral treatment protocols: weekly telephone conferences and evaluation of session recordings
 - Refining fidelity/reporting/database software
 - Outreach to employees
- New Activities
 - Implementation of revised outreach plan
 - Scheduled new meetings with employer and employees
- Long-term Activities
 - Coordination of evaluation plan with project evaluator.

Providers and Beneficiaries Impacted

- Please provide the number of Providers participating in or otherwise impacted by your project.
 - *The project will indirectly impact approximately 2 physicians, 4 nurses and 2 behavioral health counselors.*
- Please provide the number of beneficiaries of your project.
 - The project will benefit approximately 50 employees.

Evaluation Methodology

- Behavioral health related assessment data is collected from program participants at these times:
 - At the start of treatment
 - At the end of treatment
 - 3-months post treatment
 - 6-months post treatment
- An independent evaluator will conduct a statistical analysis of this data to assess program impacts.
- The evaluator will correlate any improvements in health outcomes with extant studies linking these same improvements with cost reductions and model predicted cost savings accordingly

Expenditures to Date & Revised Budget

- Please work from your approved revised budget to show any new expenditures.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	\$ 17,796.00		\$ 60.00	\$ 60.00
Fringe	\$ 8,431.00		\$ 18.00	\$ 18.00
Travel	\$ -	\$ -		\$ -
Conferences	\$ -	\$ -		\$ -
Equipment	\$ 5,400.00	\$ 74.99	\$528.27	\$ 603.26
Contracts	\$ 21,000.00	\$ 6,004.83	\$ -	\$ 6,004.83
Supplies	\$ 370.00	\$ -	\$ -	\$ -
Other	\$ 1,680.00	\$ 750.00	\$ -	\$ 750.00
Indirect	\$ 5,467.70	\$ 682.98	\$ 60.63	\$ 743.61
Total	\$ 60,144.70	\$ 7,512.80	\$ 666.90	\$ 8,179.70