VHCIP Provider Sub-grant
Third Quarter 2015
Quarterly Program Reports

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

Date: October 10, 2015

Reporting Period: July 1, 2015 through September 30, 2015

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

Kate Simmons, Director of Operations

Grant Project Goals

- 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

- List the top five accomplishments for goals above since the previous reporting period.

1. To comply with Medicaid requirements, CHAC completed the mailing of about 6,500 Beneficiary Notification Letters on September 29, 2015 for the months of May, June, and July. CHAC has been successfully reporting opt-outs for all Medicaid and Medicare participating organizations. CHAC submitted all annual reports including but not limited to the network model and payment alignment reports.
2. Dashboards for ACO measures were created and shared with the CHAC Clinical Committee. CHAC staff have started work on a recommendation for depression. The champion for this recommendation is from a designated agency and sits on the CHAC Clinical Committee.
3. CHAC is taking an active role in the Unified Community Collaboratives and in collaborations with other ACOs and the state. CHAC's Community Health Quality Manager presented at a UCC in September about our Diabetes recommendation. CHAC is helping to staff and support the continued work of the ACO Operations Committee and subcommittees.
4. Implementation of a new Consumer Advisory Panel with eight new consumer members was successful as evidenced by their first meeting held on August 20, 2015. CHAC staff have held successful focus groups with the consumer members of some the of the FQHC Boards.
5. CHAC generated 2014 savings under the VMSSP and MSSP programs. (CHAC's MSSP savings did not surpass the minimum savings ratio, so CHAC will not be receiving a share of those savings.

Challenges and Opportunities

- 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 CHAC is additionally exploring options to contract for temporary staffing.
  - The ongoing demand from the media for information about the outcome of the 2014 quality reporting has created extra burden to CHAC staff and participants.
- Briefly discuss any new opportunities available to support this project programmatically.
  - Bi-State anticipates receiving funding to further support staffing through the end of the contract period, analytics, and the telemonitoring program from the State. CHAC also anticipates investing some of its VMSSP 2014 savings into centralized initiatives and supports (in addition to distributing the majority of savings to participants for more localized investments).

Activities Undertaken and Planned

- Ongoing Activities
  - Briefly describe any ongoing activities not previously mentioned above.
    - Board Meetings are held monthly to keep moving business forward.
    - Each of the standing committees meets at least quarterly. This has been successful and is ongoing. Most of the committees have opted to meet more often.
    - A CHAC representative regularly attends all VHCIP work group meetings.
    - CHAC representatives take active parts in the Unified Community Collaboratives and Learning Collaboratives.
    - CHAC continues to implement new clinical guidelines in participating health centers.
    - CHAC tracks patients opting out of sharing information with the ACO.
    - CHAC's tel-assurance program enrolls and monitors "rising risk" patients.
    - The CHAC Network Update newsletter is sent out monthly.
    - Analysis of quality and financial results from 2014 will guide future quality improvement efforts and clinical initiatives.
    - Recruitment of consumer members and consumer outreach continues to be conducted with the help of the CHAC Board.

Activities Undertaken and Planned

- New Activities
  - Briefly describe any new activities scheduled to take place before the next reporting period.
    - The next Medicaid mailing is scheduled to occur by November 15, 2015. New Medicare templates for beneficiary notification will be sent out to the participating organizations.
    - A joint meeting of the Clinical Committee and Operations Committee is scheduled for October 20, 2015 to align implementation of quality improvement initiatives.
    - A subcommittee of the Clinical Committee will be working on completing the depression recommendation.

Activities Undertaken and Planned

- Long-Term Activities
  - Briefly describe any long-term activities currently being planned.
    - Collaboration with the State and VCCI to enroll more eligible patients. CHAC staff will be reaching out to individual member sites to gather more information on current use of VCCI and to create pilot sites.
    - Relationship building with practice managers at network sites to collect data for quality improvement dashboard to aid in implementation of clinical recommendations.
    - CHAC will continue quality improvement efforts focused on improving clinical measures and the implementation of the new care management standards.

Providers and Beneficiaries Impacted

- 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

- Describe the target population for the initiative
  - The target population for this initiative includes CHAC's designated employees, Governing Board, Standing Committees, participating organizations, providers, contractors, and beneficiaries.
- Describe the metrics being used to measure success (for example: # of activities by type, outcomes: clinical, financial, etc.)
  - 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

- Data source/s for the metrics
  - Quality and financial reports from all payer groups.
  - Clinical dashboards for recording progress of quality improvement initiatives.
- Results to date (feel free to use additional slides, if necessary)
  - Bi-State is on track with our project work plan for the Furthering Community Health Accountable Care project – see "Ongoing Activities"
  - CHAC has achieved savings, surpassing the MSR, under the VMSSP. CHAC's quality score entitles it to 85% of the shared savings and highlights several successes and several areas for future focus and improvement.
  - CHAC has achieved savings under the MSSP, but did not surpass the Medicare MSR.
  - CHAC, like the other two VT ACOs, did not achieve savings under the XSSP.
- Timeline for final results
  - With further funding from the State, CHAC will continue through the end of 2016 in all payer programs.

Expenditures to Date & Revised Budget

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

	Approved Budget	Revised Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ 257,700.00	$ 249,753.00	$ 126,539.66	$ 34,522.68	$ 161,062.34
Fringe	$ 59,271.00	$ 57,443.00	$ 26,521.25	$ 8,336.96	$ 34,858.21
Travel	$ 7,488.00	$ 16,653.00	$ 1,627.03	$ 3,004.09	$ 4,631.12
Meetings	$ 5,400.00	$ 4,800.00	$ 3,074.94	$ 994.05	$ 4,068.99
Professional Services	$ 12,750.00	$ 12,750.00	$ 337.50	$ -	$ 337.50
Facility Costs	$ 25,693.00	$ 10,000.00	$ 5,963.00	$ 1,344.50	$ 7,307.50
Other Beneficiary Engagement	$ -	$ 10,000.00	$ 3,728.83	$ 2,359.13	$ 6,087.96
Supplies	$ -	$ 7,882.00	$ 4,446.51	$ 194.93	$ 4,641.44
Indirect	$ 31,698.00	$ 30,720.00	$ 13,302.53	$ 3,685.93	$ 16,988.47
Total	$ 400,000.00	$ 400,000.00	$ 185,541.25	$ 54,442.27	$ 239,983.53

- Briefly discuss any potential changes to the budget going forward.
  - Bi-State submitted a rebudget request on 9/25/2015. The changes requested were minimal.

Insert Grant Project Title

Insert Name of Organization

Date: October 10, 2015

Reporting Period: Third Quarter

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

Ginger Cloud, LCMHC, LADC

Grant Project Goals

- To implement **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment (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

- Four medical homes: UVMHC-CVMC Integrative Family Medicine – Montpelier , UVMHC-CVMC Adult Primary Care- Barre , UVMHC-CVMC Family Medicine- Waterbury, and UVMHC-CVMC Family Medicine-Mad River have screened over twenty two hundred patients for substance use issues. An additional medical practice UVMHC-CVMC Granite City Primary Care- Barre, has joined the screening process and has screened over three hundred and fifty patients. One hundred and forty five patients have received Brief Interventions by our clinicians, and eighty six patients have been referred to Brief Treatment. Our clinicians are currently engaged with sixty six patients for either routine follow up on treatment goals or for brief treatment.

- We have enhanced our tobacco intervention and treatment efforts through the addition of CO monitors to use with patients, helping patients gain insight into the lingering effects of CO in the lungs post tobacco use.

- Our team has initiated an all-parties convocation to help establish a coherent and systematic flow of patient care throughout Washington Country.

- SBIRT screening at UVMHC-CVMC is extending to our Women's Health Clinic, and funding has been secured for a full time dually trained counselor to being this November.

- 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.

Activities Undertaken and Planned

- Ongoing Activities
  - Development of a brochure, blog post and SBIRT webpage at CVMC for patients and medical providers explaining SBIRT model in the medical home and services available.
  - Engaging medical providers in formal interviews to increase understanding of their perspective on an ideal patient visit and direct feedback about aspects of SBIRT/ integrative behavioral health that they are finding useful.
- New Activities
  - We anticipate building champion teams in the two pediatric practices, establishing the CRAFT screening tool into the EMR and access to an SBIRT clinician for adolescent population.
- Long-Term Activities
  - Engagement in comprehensive training of medical secretaries, nursing staff, and medical providers to enhance screening process in medical homes. Identification of areas of the screening and intervention process that are interrupting the efficacy of the SBIRT model. Building community alliances and a comprehensive clinical pathway for patients that are identified at moderate to high risk/dependent substance users.

Challenges and Opportunities

- Over the reporting period we have struggled to get screening established in one of our larger medical homes: Family Medicine Berlin. Complications with this practice have included competing practice requirements such as a roll out of a chronic pain management program, summer vacation schedules, and most recently the roll out of ICD 10. Through persistent efforts we have an implementation date of November 10th. We are hopeful that breaking trainings up into small groups and or offering trainings on an individual basis will alleviate the scheduling difficultly we have experienced thus far.

- The transition of one of our initial SBIRT clinicians into a different job has presented challenges and an opportunity to find a new clinician that is better equip to fulfill the level of responsibility inherent to the clinical position. Our Project Manager was able to provide clinical coverage for the practices until out new clinician was able to start. The Project Manager was able to gain valuable first hand experience of gaps in the screening and intervention process. Adjustments and additional training at several sites regarding these discoveries are now in progress.

- The new opportunity to strengthen coordination of care throughout stakeholders in Washington County is exciting. Initiating a workgroup and oversight committee to guide a new approach to providing substance abuse services to residents of Washington County has the potential to unify otherwise siloed efforts to meet the needs of our residents.

Providers and Beneficiaries Impacted

FTE Category	BIM	MIFH	CVPC	WMA	GCPC	MRFP
MD FTE's	3.66	3	4.48	3.93	1	1.3
NP/PA FTE's	1.35	2.69	2.97	0.8	0.6	1
Total Provider FTEs	5.01	5.69	7.45	4.73	1.6	2.3
Clinical Coordinator	0.81	1.1	1	1	1	1
Office RN	4.2	4.1	4.58	4	1	2.5
Office LPN	0.83	0.97	4.12	0	0	0
MA/CCA	0.11	3.62	0	1	1	0
Clinical FTEs	**5.95**	**9.79**	**9.7**	**6**	**3**	**3.5**
Office Supervisor	1	1	1	1	0	1
Medical Secretary	5.27	6.06	7.18	5.72	1	2.5
Front End/Other FTEs	**6.27**	**7.06**	**8.18**	**6.72**	**1**	**3.5**
Total FTE's Per Practice	**17.23**	**22.53**	**25.33**	**17.45**	**5.6**	**9.3**
Total Attributed Patients	**3611**	**6816**	**8167**	**6655**	**957**	**4918**

Evaluation Methodology

- The target population for our initiative is two fold. We aim to target medical home practices throughout CVMC network to engage in the SBIRT model of screening. Through the engagement of the SBIRT model we aim to identify people that use substances (alcohol and drugs) at a risky level, and people that are identified as addicted to tobacco and or other substances. Once identified we are able to offer appropriate services and continuity of care through out the patient's change journey.
- We are measuring success by the number of practices engaged in screening patients using the SBIRT model, by the number of patients screened and intervened at each practice and the level of patient engagement in the available SBIRT services.
- 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 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 see next slide for results.
- We anticipate that during the course of this grant we will develop a comprehensive service model for identification and intervention services for the people engaged substance use in Washington County.

Initial Utilization of Screening Implementation

	Medical Home/ Primary Care Practice						
	Integrative Family Health - Montpelier	Adult Medicine - Barre	Family Medicine - Waterbury	Family Medicine- Mad River	Granite City Primary Care- Barre	Family Medicine - Berlin*	Total
Total Patients Screened	1719	387	104	73	363		2646
Total Brief Interventions	65	54	4	6	5	11	145
Total Referrals to Brief Treatment	20	38	4	6	7	11	86
Total number of Patients engaged in SBIRT services (Brief Treatment or Follow up care)	15	23	6	4	7	11	66

* Family Medicine - Berlin has not started the screening process yet and there has been an SBIRT clinician available for referrals

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	$ 44,090.00	$ 41,059.00	$ 85,149.00
Fringe	$ 98,400.00	$ 12,106.00	$ 12,718.00	$ 24,824.00
Travel*			$ 171.00	$ 171.00
Conferences*			$ -	$ -
Equipment	$ 3,960.00	$ 2,519.00	$ -	$ 2,519.00
Contracts	$ 6,000.00	$ 5,000.00	$ -	$ 5,000.00
Other Costs	$ 20,000.00			
Supplies	$ 10,670.00	$ 2,910.00	$ 843.00	$ 3,753.00

- * Tracked separately starting 8/1/15, in original budget Conferences were listed under Supplies
- Expenditures as of 8/30/2015
- We anticipate submission of an addendum or revision of our budget contract to reallocate unused fund for this fiscal year. There are several unanticipated costs that have emerged and savings that occurred due to an unavoidable delay in hiring our initial SBIRT clinicians.

SIM Funding for Infrastructure Building

Health*first,* Inc.

Date: **October 10, 2015**

Reporting Period: **July 1 – September 30, 2015**

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

Amy Cooper, Executive Director, Health*first*

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) - completed/ongoing***
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)* - *ongoing***
13. Develop and distribute templates and educational materials to Health*first* 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:** With delivery of final quality measure results, HealthFirst has received feedback from many members that they are very confident in the data's integrity. This confidence is directly related to the office champions process we put in place with our VCP ACO practices, which ensured that data was captured accurately by practice staff who are familiar with their practices' data recording and could thoroughly review records. As we ready our member practices for the 2015 data collection and, with Susan Ridzon, our Quality and Care Coordination Manager now in place, we have been able to use feedback to refine the process. Ms. Ridzon and HF Clinical Director Rick Dooley have also been working to ensure that practices are being kept abreast of changes to the quality measures. Once again this year, HF will be working alongside OneCare and CHAC to develop guidance and training webinars to support practices across all ACOs in reporting for the 2015 collection.

Recent Accomplishments

- **2 - Goal 9. Website redesign:** The new HealthFirst website has been launched at www.vermonthealthfirst.org! Our overarching goal for the redesign was to create a more user-friendly site for our members and their patients. The site incorporates our newly designed logo and color scheme, supporting our objective of continuing to establish a brand identity for public awareness about HealthFirst, the VCP ACO, and the important role independent practices play in the state's healthcare landscape.

  Along with an improved provider directory that allows users to sort and search across several variables and to print their results, the site includes reorganized and expanded ACO resources and member resources and information. A patient resources page has been set up and we are continuing to develop content for this feature with input from our members and supporters; we will also seek ideas from the Consumer Advisory Board at the October meeting and beyond. Member practices are enthusiastic about the site, particularly a homepage scrolling banner that showcases practice logos that link to practice websites (if available). A press release about the launch was distributed to print and broadcast media around the state.

Recent Accomplishments

- **3 - Goal 11. Architect Disease Management Programs:** Continuing the work started in January 2015 with participation in Qualidigm's quality improvement support team, HealthFirst leadership has met several times with Qualidigm to coordinate practice-level education around clinical disease management resources and best practices for Medicare quality reporting programs. HF is also using data from Qualidigm to track population health metrics in the Medicare population, which allows us to continue the important work started under ACCGM, through this Medicare ACO closed in January 2015.
- **4 - Goal 12. Local Physician Liaison Team:** We have had solid success in getting member physicians involved in various state-level healthcare reform initiatives. Currently, we have members (both members of our board of directors and non-board provider members) participating in VITL's HIE workgroup, the state's alternative payment workgroup and subcommittees, the Blueprint executive committee, and the community health team planning committee, among others. This has enabled HF to stay current on an array of important issues, while ensuring that the perspective of independent practitioners is represented.

Recent Accomplishments

- **5 - Goal 13. Education Materials and Resources:** On October 13, HealthFirst is hosting a free risk management seminar for member practices presented by Coverys, the medical malpractice insurance carrier we work with for our group purchasing benefit. The seminar will cover two topics. The first, Managing Difficult Patients and Situations, will focus on how practices can handle challenging patients, such as drug seekers, successfully, and how to assess when termination from a practice is appropriate and the steps a practice should take prior to termination. Next, participants will learn strategies for navigating social media and texting in the HIPAA environment; specifically, the session will focus on the differences between medical and general social networking sites, appropriate times, places and uses of social media, breach potential, negative impacts of using mobile devices during patient encounters, and strategies to address appropriate use in the work setting. Currently, about a quarter of our member practices have signed up staff members for the event.

Challenges

- Blueprint planning for 2016 and beyond continues to be a great area of uncertainty. In an effort to further help ensure that health reform programs are responsive to the needs of Vermont's primary care physician work-force, HealthFirst members from our physician liaison team and HealthFirst executive staff have offered to collaborate with the Blueprint on a survey that measures primary care provider satisfaction with the program. This survey was identified as a key initiative for the Blueprint program to undertake in legislation from 2008 and from 2010 that established the Blueprint program; however, the resources have not yet been dedicated to complete it. Using capabilities and funding provided to HF under the SIM grant, we hope we can play a productive role in the execution of such a survey that will be helpful in identifying best practices to be used in future iterations of value-based payment programs.

- Though we are engaged in the process to develop UCCs around the state, we continue to seek greater clarity about their role in Blueprint and ACO initiatives.

Opportunities

- HealthFirst has been approached by the international consultancy group GesaWorld to pilot its clinical integration assessment tools and process. An initial meeting with Ailene Thiele, a project director with the group, led to a meeting with a full team from GesaWorld and HealthFirst's full staff. The GesaWorld team guided us through a targeted evaluation to consider the degree to which our member network is clinically integrated currently, where there is room for improvement, and the role that HealthFirst can play in strengthening the network's clinical integration going forward. The process is focused on patient outcomes and quality of care delivery and will be invaluable as we consider strategies for fully implementing our collaborative care agreement among our member practices.

Activities Undertaken and Planned

New Activities

- We are excited to have the opportunity for some technical assistance from the state to work with Wakely Actuarial. Wakely consultants are helping review claims history on our population so we can make informed decisions about what portions of costs of care our members may want to assume risk for and the parameters HealthFirst would need to put into place to ensure our members could do so successfully.

Activities Undertaken and Planned

Ongoing

- HealthFirst continues to meet with several groups in support of VCP as well as of our overall mission. These groups meet regularly and we keep each group apprised of the others' activities as appropriate. At the beginning of the year, the ACO Management Team welcomed a consumer representative to the group. David Sterrett, a healthcare attorney and advocate, is also generously volunteering his time to sit on the Consumer Advisory Board, which itself welcomed two new members over the summer: (1) Lindsay DesLauriers is the state director of the nonprofit Main Street Alliance Vermontas well as president of a Burlington-based government relations group, and (2) Carol Moore is a licensed radiologic technologist with a specialty in breast imaging and is also a product owner at IDX and GE Healthcare. Our Clinical Implementation Subcommittee, comprising practice managers from our largest member practices, continues to be an essential sounding board for data tracking and reporting and the feedback from this group is helping to shape planning for the upcoming 2015 data collection. The Clinical Quality Board, now run by HF Clinical Director Rick Dooley and Quality and Care Coordination Manager Susan Ridzon, also continues to meet to discuss quality reporting issues, policies and procedures.

Activities Undertaken and Planned

Activities Planned

- HF will be holding its annual member meeting and speaker panel on Saturday, November 14, at the Catamount Country Club in Williston. We are very excited to have engaged three diverse and dynamic speakers for the afternoon following the members-only morning meeting.
  - Dr. H. Gilbert Welch, a general internist at the VA in White River Junction, Vermont, and a professor of Community and Family Medicine at the Dartmouth Institute for Health Policy and Clinical Research and at Dartmouth Medical School will be speaking about his research focused on overdiagnosis and overtreatment, particularly as he covered them in his recently published book *Less Medicine, More Health: 7 Assumptions That Drive Too Much Medical Care*.
  - Ailene Thiel, a principal with GesaWorld, will address the topic of clinical integration and its necessity and value in quality patient care.
  - Finally, Vermont Senator Tim Ashe will give an overview of healthcare issues that are anticipated to be addressed in the upcoming legislative session.

Providers and Beneficiaries Impacted

- **Number of Providers:** Healthfirst counts more than 160 independent physicians among its members and we estimate that, collectively, our member practices at least 90 physician assistants and nurse practitioners. We do not formally track the number of RNs and LPNs employed by our member practices, but know that our smallest practices often do without nursing staff while our largest member practices may employ 10 or more nurses to assist with patient care.

- **Number of Beneficiaries:** Based on Blueprint practice attributions and estimates for our smaller, non-Blueprint practices, and taking care not to double count patients seen by both PCP and specialists in our membership, we estimate that our member physicians care for between 70,000 and 120,000 patients at their practices.

Evaluation Methodology

- **Target population:** HealthFirst's target population are the patients under the care of our 160+ independent physician members, both PCP and specialist, at 70+ practices around the state.

- **Metrics:** Several of HealthFirst's goals under this grant are focused on building organizational infrastructure and capacity so that we can support our member practices in achieving clinical quality goals, both national (e.g, based on HEDIS) and local (i.e., specifically developed for Vermont), that have been established and are tracked through Blueprint, the commercial ACO program, and the Medicare ACO program; though we no longer formally participate in the Medicare ACO program, we continue to support our practices in meeting benchmarks established for the Medicare population.

Evaluation Methodology

- **Metrics (cont.):**

  Regarding capacity and infrastructure building, to date, we have achieved many of our discrete goals, such as hiring staff, securing office space, and convening and managing several ongoing committees in support of our initiatives. We achieved our target of 100% participation for our collaborative care agreement, which has enabled us to move forward with objectives that will support clinical integration among our member practices. While we set no specific target number for participation, we have made great strides in enlisting HF member physicians to serve as local liaisons for several state-level initiatives and will continue to seek members to represent us when additional opportunities arise in the future.

Evaluation Methodology

- **Data sources:** Our member practices, commercial payers (e.g., BCBSVT and MVP), and Medicare/Medicaid programs are the sources of the data we use to assess progress against our goals of supporting our members in the delivery of quality care. The metrics for these goals, as noted, include HEDIS national benchmarks along with state-specific metrics established for the commercial and Medicare ACO programs and Blueprint. Our decision to support our member practices that are participating in the commercial ACO in reporting their own data through self-selected office champions has greatly improved the quality of our data reporting and our members report high levels of confidence in the integrity of the data and the collection process.

Evaluation Methodology

- **Results to date:** Across all measures, data have shown that Vermont's independent physicians are providing excellent care to their patients usually at costs significantly lower than those paid out to hospital-owned practices. For HF practices participating in the commercial ACO, between half and two-thirds of practices performed in the 90th percentile for national benchmarks. On three of the four state-specific measures, between 60% and 77% of VCP practices were shown to be engaging fully in best practices. The one area in which improvement is indicated, Depression Screening, has long been an area of concern and HF is addressing the measure by meeting with participating practices to engage them in making changes that will positively increase outcomes for the standard, including use of formal screening tools.

  Though not part of this grant specifically, results of quality reporting on an array of benchmarks established by commercial payer MVP, with which HF has negotiated a contract for our members, showed that member practices were performing well enough not only to achieve the standards, but also to receive close to the highest percentage of bonuses made available by the payer. Many of these quality measures align with those used in the commercial ACO program with BCBSVT and in Blueprint.

Evaluation Methodology

- **Results to date (cont.):**

  With the exception of access to specialists – a widely recognized statewide challenge in Vermont – HF practices that were engaged in the HF's Medicare ACO from 2012-2014, were praised publicly by OneCare's Todd Moore as showing the lowest cost/highest value of care delivery, even in a national context.

- **Timeline for final results:** The organizational capacity and infrastructure goals we established for this grant have largely been completed and are serving as the basis for planning far beyond the end of the grant period.

  There is no end date for the goals related to supporting our members in meeting clinical quality goals; this work is inherently ongoing. That said, we are confident that the processes and procedures we have carefully developed, and are continuing to develop, under this grant are responsive and flexible enough to evolve over time in response to continuing healthcare reform efforts.

Expenditures to Date: July to September 2015

HealthFirst, Inc. - SIM Grant #03410-1305-15					
Financial Report: Jul 2015-Sept 2015					
	Approved Budget	Spent Prior Quarter	Spent Current Quarter	Spent to Date	Balance
Staff Wages					
Executive Director	$147,000.00	$17,499.00	$19,980.12	$87,059.62	$59,940.38
Administrative Assistant	$50,750.00	$6,250.02	$6,437.52	$27,270.82	$23,479.18
Operations Director	$63,000.00	$8,571.42	$9,321.45	$35,035.71	$27,964.29
Clinical Lead, Other MD	$60,900.00	$7,500.00	$7,725.00	$31,475.00	$29,425.00
Quality & Care Coord. Mgr.	$65,000.00	$0.00	$16,249.98	$16,249.98	$48,750.02
Fringes	$0.00	$0.00	$0.00	$0.00	$0.00
Total Wages	**$386,650.00**	**$39,820.44**	**$59,714.07**	**$197,091.13**	**$189,558.87**
Consultants					
Local Physician Liaison Team	$52,000.00	$8,242.50	$12,887.50	$24,130.00	$40,757.50
Legal services, HR, IT, other contracts	$100,864.00	$16,875.00	$14,455.41	$41,410.41	$73,909.00
Total Consultants	**$152,864.00**	**$25,117.50**	**$27,342.91**	**$65,540.41**	**$114,666.50**
Office					
Rent	$28,400.00	$3,287.31	$3,474.25	$16,711.56	$15,162.69
Utilities	$4,200.00	$650.98	$449.16	$2,278.60	$2,370.56
Supplies (incld computers, communication)	$14,000.00	$1,646.59	$3,632.64	$11,603.53	$6,029.11
Meetings and travel	$8,250.00	$2,500.35	$614.10	$7,151.95	$1,712.15
Bi-annual meeting	$3,236.00	$0.00	$500.00	$1,736.24	$1,999.76
Outreach	$2,400.00	$0.00	$0.00	$0.00	$2,400.00
Total Office	**$60,486.00**	**$8,085.23**	**$8,670.15**	**$39,481.88**	**$29,674.27**
TOTALS	**$600,000.00**	**$73,023.17**	**$95,727.13**	**$302,113.42**	**$297,886.58**

Budget Notes

Potential Budget Changes

- We will be requesting an extension of our grant period to October 31, 2016. Toward the end of the fourth quarter of CY2015, we anticipate that we will request some budget revisions to align our funding with initiatives and activities we anticipate for the final portion of the grant.

Caledonia & s. Essex Dual Eligibiles Project

Northeastern Vermont Regional Hospital

Date: October 2, 2015

Reporting Period: July – September 2015

Key Contact: Laural Ruggles, MPH, MBA

Grant Project Goals

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

Recent Accomplishments

- Addition of Brain Injury Association of Vermont to the team.
- Reconnected an isolated person to the community e.g. safe housing, access to medical care, food security.
- Health Coach had 2 clients quit smoking.
- Health Coach focusing on Advanced Directives with clients.
- Connecting food insecure clients to Meals on Wheels. MOW is now referring people to team.

Challenges and Opportunities

- Challenges:
  - Identified more complex cases
    - partner agencies' capacity is limited
    - difficult to coordinate the large number of team partners needed to meet client needs
- Opportunities:
  - Strengthening relationships with new partners
    - Including PCP's more and more in care team meetings
    - USDA
    - Habitat for Humanity

Activities Undertaken and Planned

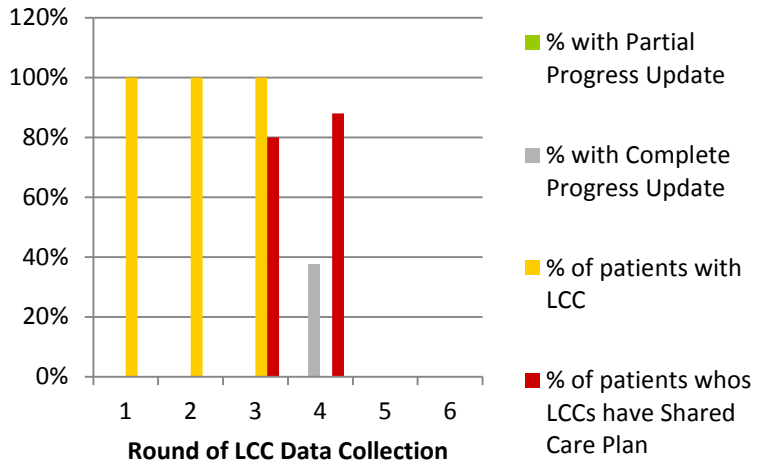
- Ongoing Activities
  - Health Coaching active case load of 20; 5 intermittent; 20 stable; 15 not active (total 65)
  - Tobacco cessation ongoing
- New Activities
  - Partnership with Lyndon State College exercise science program: offering free personal training for duals
  - Health Coach helped chronic pain client start a Chronic Pain Support Group
- Long-Term Activities
  - Working with Vermont Food Bank to implement a mobile food pantry at hospital

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 = 65

Evaluation Methodology

- We have asked for technical assistance for the evaluation of this process. Evaluation vendor has only recently been selected.
- Separate from this project is the CMCM Learning Collaborative. Below is one of the data charts for that subgroup of duals,



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	$ 31,327.83	$ 9,000.00	$ 40,327.83
Fringe	$ 18,900.00	$ 10,964.75	$ 3,150.00	$ 14,114.75
Travel	$ 2,000.00	$ 2,000.00		$ 2,000.00
Flex Funds	$ 100,000.00	$ 19,232.41	$ 29,037.18	$ 48,269.59
Equipment	$ 1,500.00	$ 796.55	$ 740.00	$ 1,536.55
Contracts		$ -		$ -
Indirect		$ -		$ -
Total	$ 176,400.00	$ 64,321.54	$ 41,927.18	$ 106,248.72

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

State Innovation Model Grant
White River Family Practice

Date: October 2015

Reporting Period: July 2015 through October 2015

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

Toni Apgar RN, Jill Blumberg, MD and Mark Nunlist, MD

Grant Project Goals

- Measure and reduce emergency room utilization and hospital readmission among WRFP patients (at DHMC)
- Follow patient reported measure of health confidence over time
- Utilize self-confidence measure to stratify patients with chronic disease and target appropriate interventions
- Deploy team-based care protocols to identify patients at risk and to try to increase health confidence

Recent Accomplishments

- Developed and Deployed Motivational Interviewing Curriculum
  - We have completed phase one of our motivational interviewing training for all staff members.
  - We are working on how to best use these new skills within the office and will be planning a last meeting with our coach after implementation.
- 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 WRFP patients.

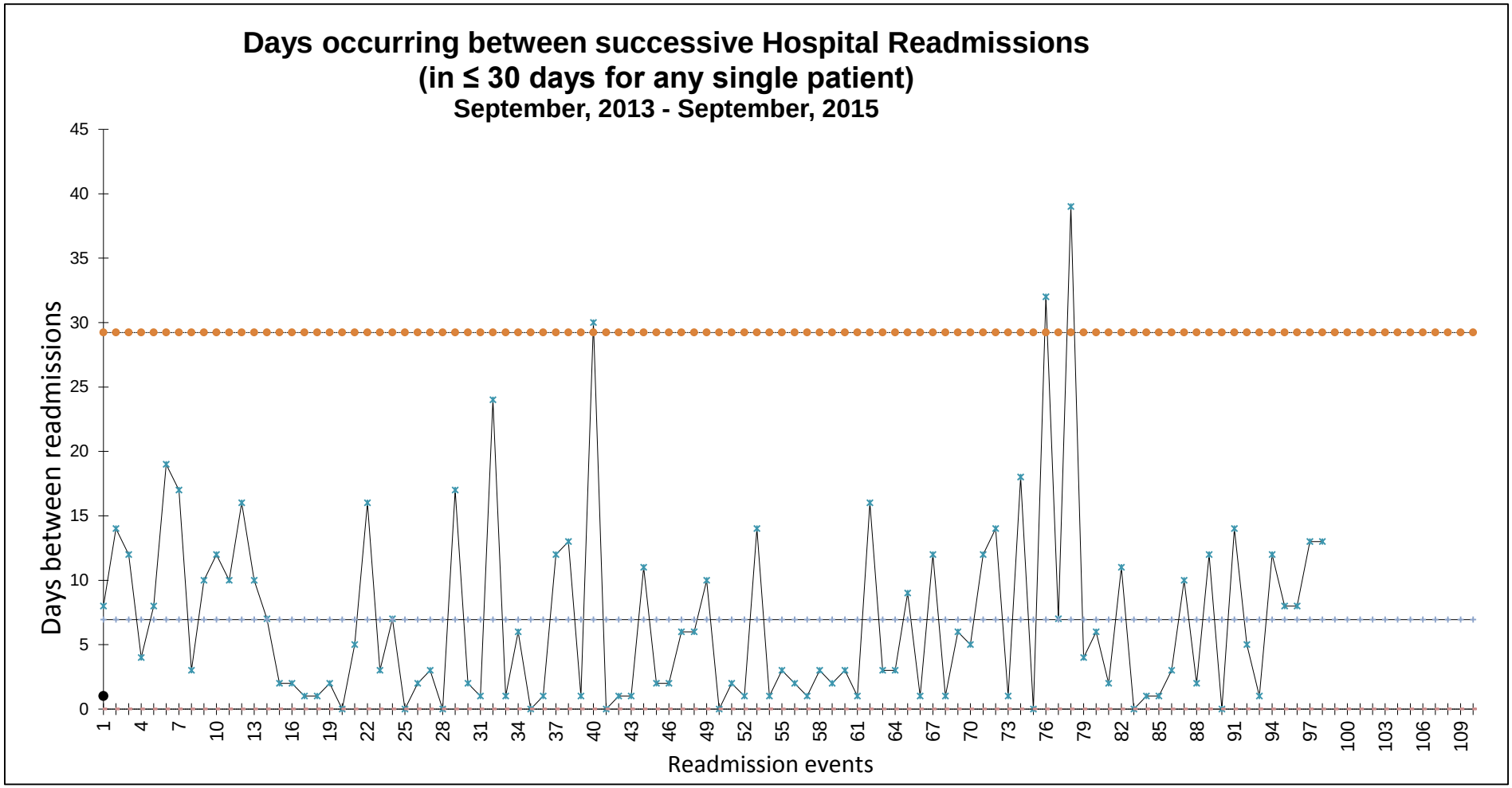
Recent Accomplishments

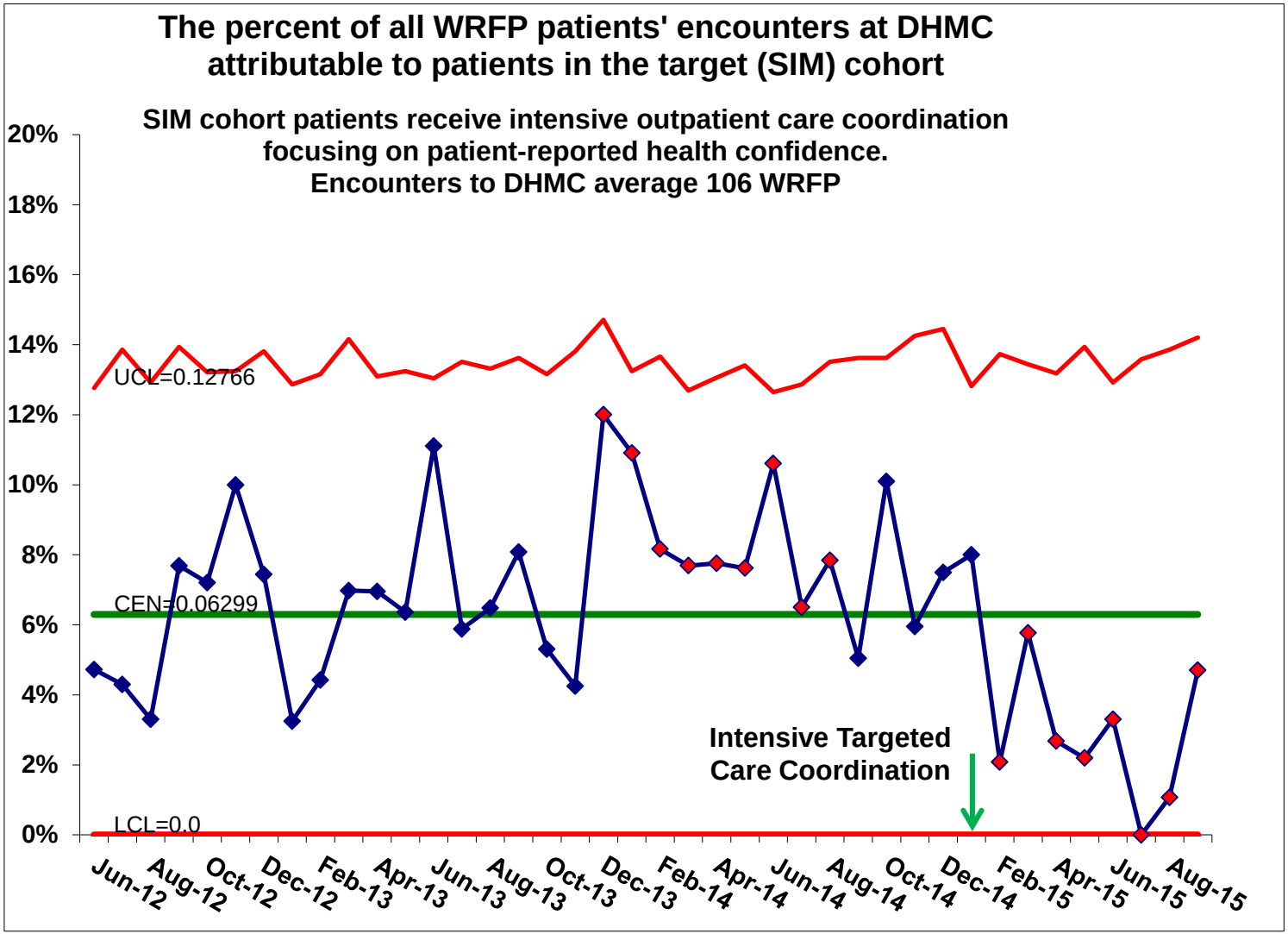
- Health Confidence
  - Please see attached graphs regarding increasing health confidence in our intervention group. We are cautiously optimistic and would like to continue to follow this trend to determine if our interventions are making a lasting change.
- High Utilization Group
  - Ongoing intensive management by our care coordination team with clear identification of our intervention population
- Continued efforts to engage the entire office
  - Intra-office newsletter (continues, sent monthly to SIM team)
  - Office-wide report of health confidence data

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 WRFP population as well as our targeted SIM cohort
- We have used our internal data gathered with respect to patient reported confidence to manage their health issues.
- See following slides

Using Statistical Process Control analyses…




The percent of all WRFP patients' encounters at DHMC attributable to patients in the target (SIM) cohort
SIM cohort patients receive intensive outpatient care coordination focusing on patient-reported health confidence.
Encounters to DHMC average 106 WRFP
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
UCL=0.12766
CEN=0.06299
LCL=0.0
Intensive Targeted Care Coordination
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
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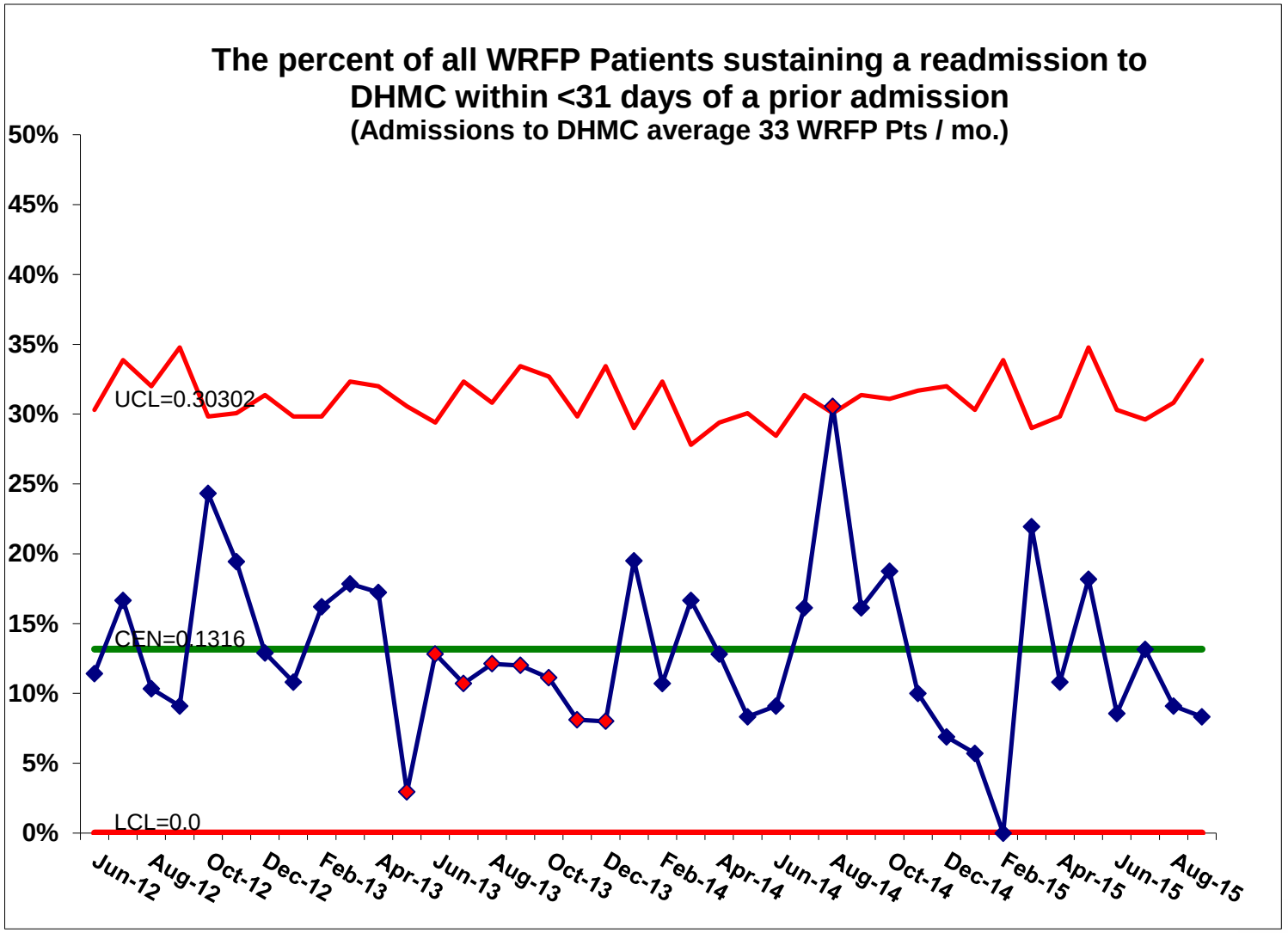
The percent of all WRFP Patients sustaining a readmission to DHMC within <31 days of a prior admission
(Admissions to DHMC average 33 WRFP Pts / mo.)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
UCL=0.30302
CEN=0.1316
LCL=0.0
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
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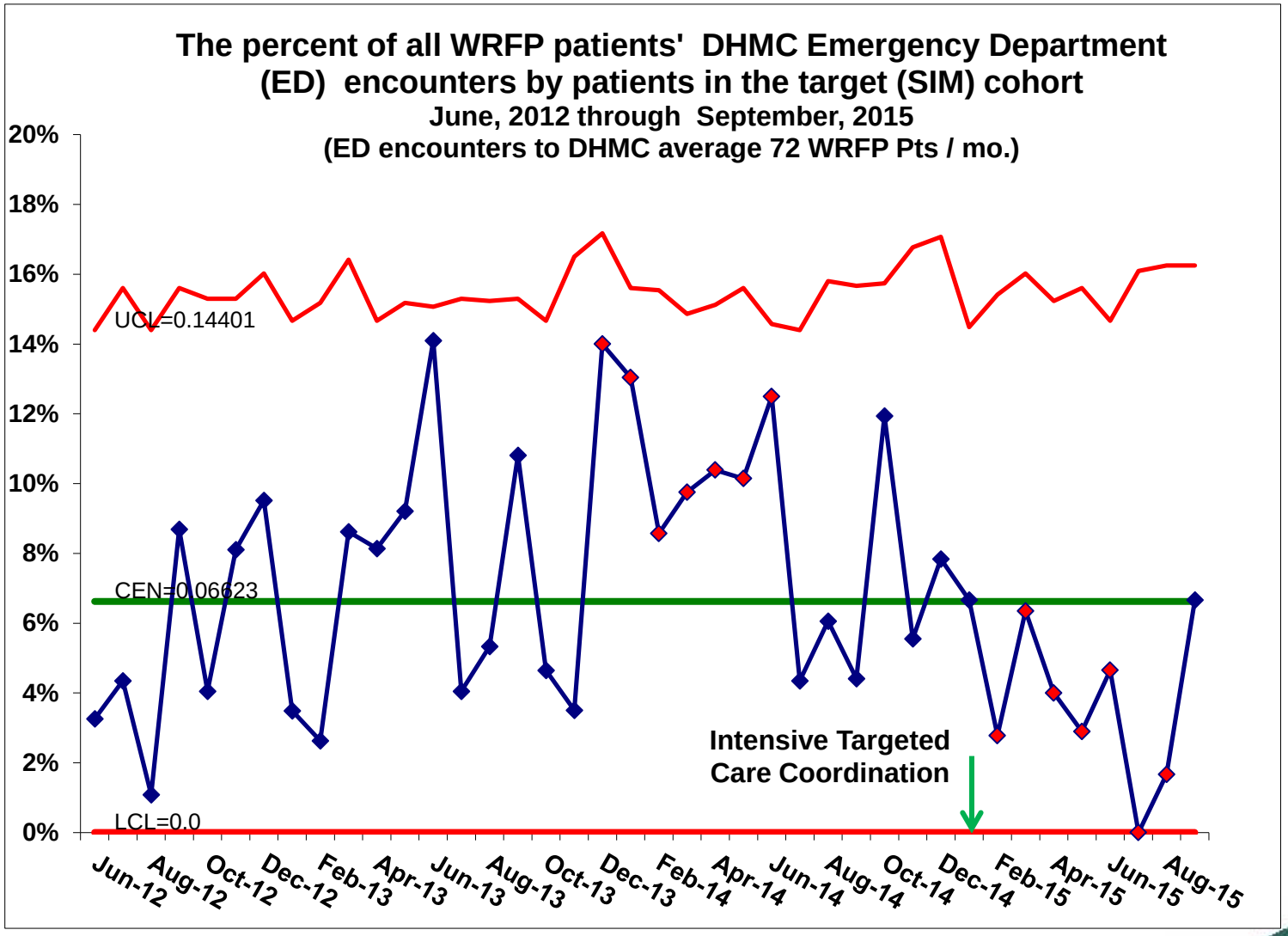
The percent of all WRFP patients' DHMC Emergency Department (ED) encounters by patients in the target (SIM) cohort
June, 2012 through September, 2015
(ED encounters to DHMC average 72 WRFP Pts / mo.)
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
UCL=0.14401
CEN=0.06623
LCL=0.0
Intensive Targeted Care Coordination
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
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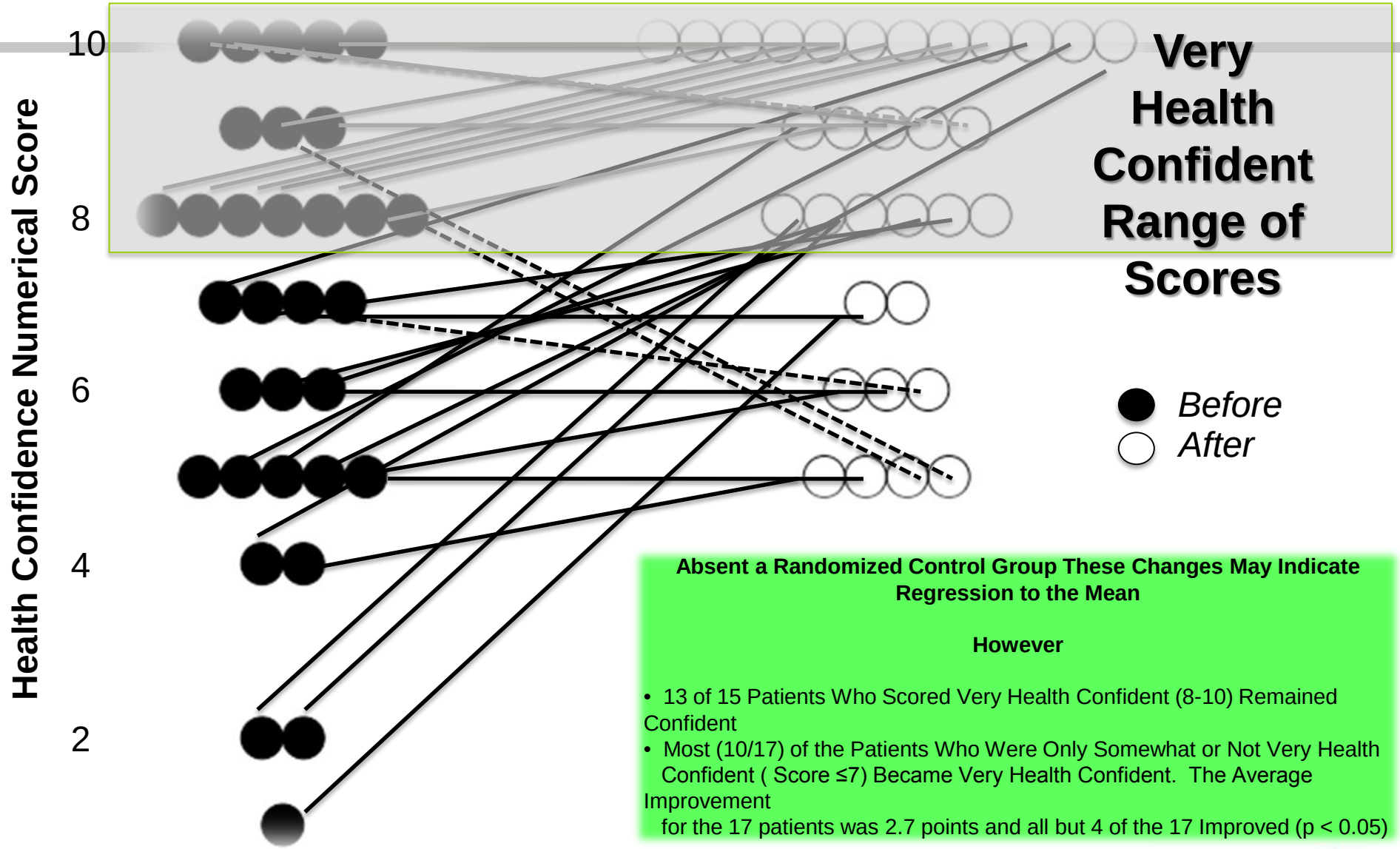
Feb-15
Apr-15
Jun-15
Aug-15

Details for Intensive Intervention Patients



Absent a Randomized Control Group These Changes May Indicate Regression to the Mean

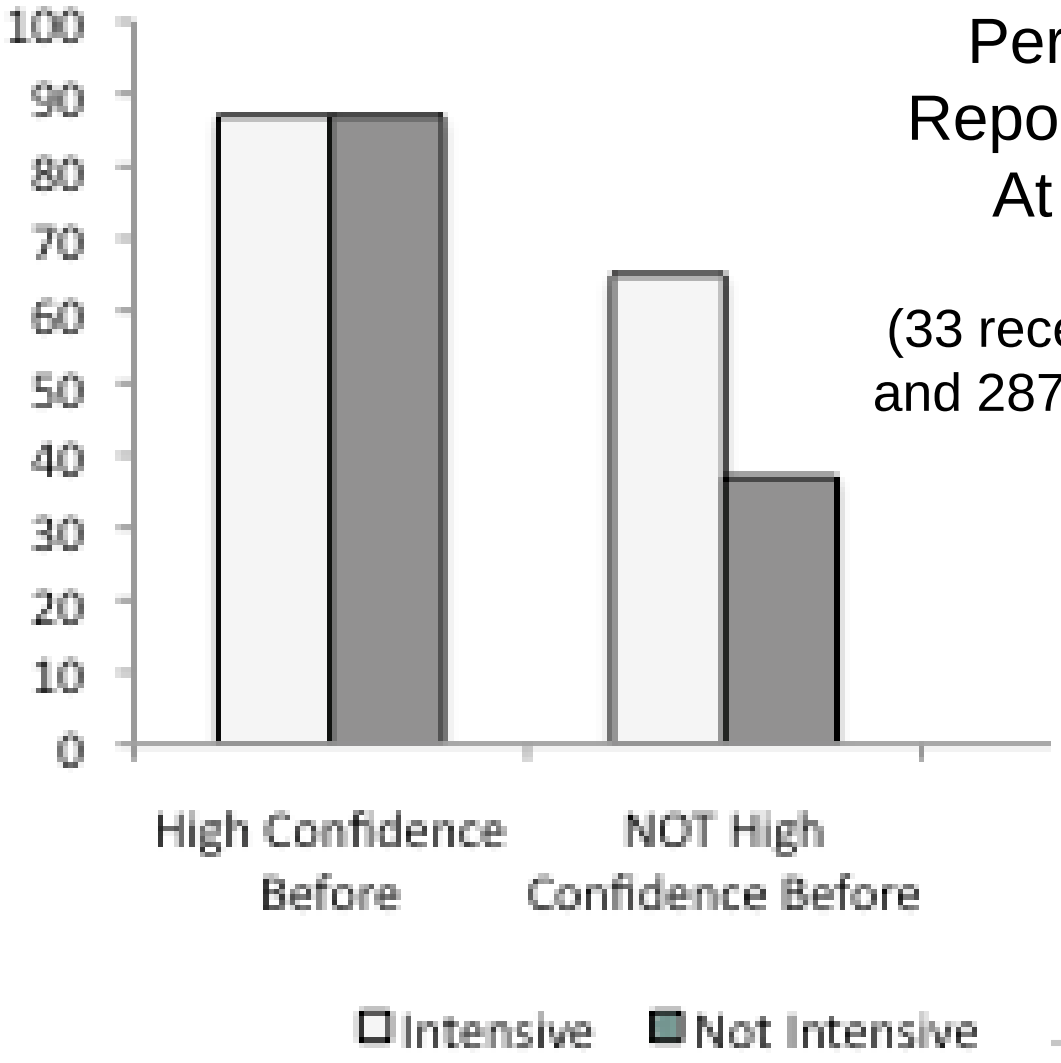
However

- 13 of 15 Patients Who Scored Very Health Confident (8-10) Remained Confident
- Most (10/17) of the Patients Who Were Only Somewhat or Not Very Health Confident (Score ≤7) Became Very Health Confident. The Average Improvement for the 17 patients was 2.7 points and all but 4 of the 17 Improved ($p < 0.05$)

Data analysis by John Wasson, MD

Vermont Health Care Innovation Project

Comparison of HC reported numbers for patients divided based on confidence at baseline and intensity of intervention

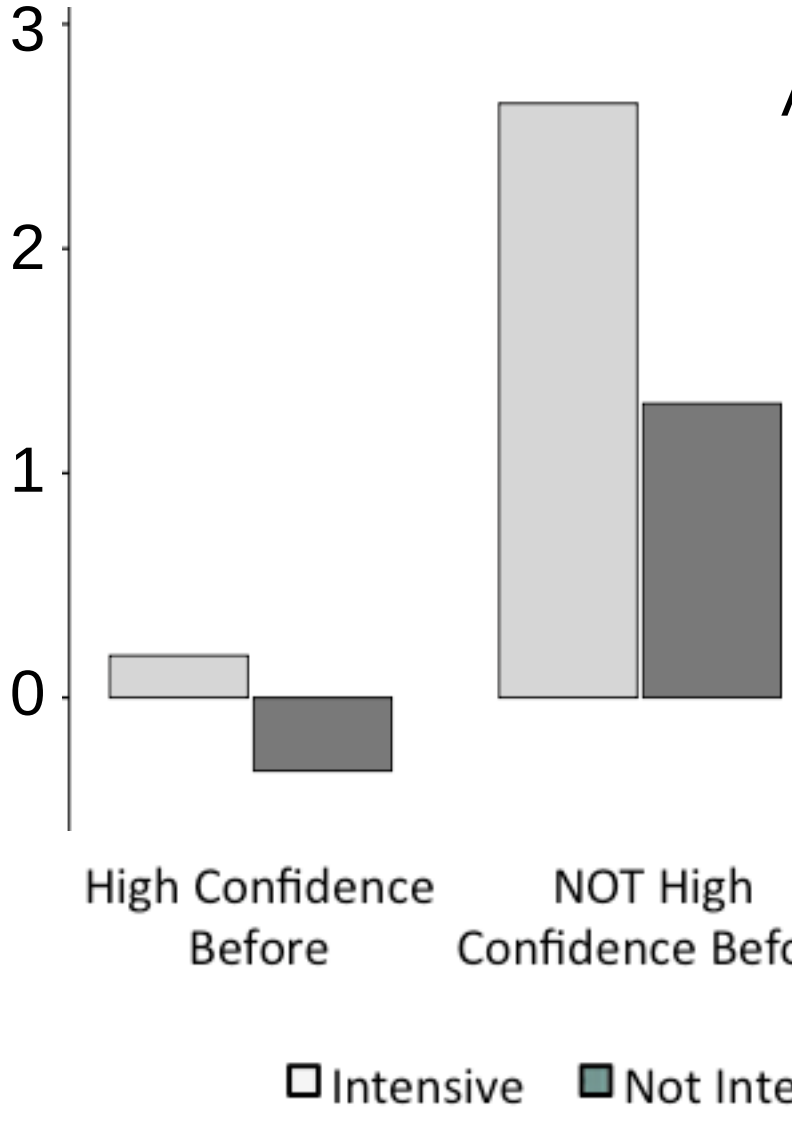


Percentage of Patients Reporting High Confidence At A Later Office Visit

(33 received intensive intervention and 287 less intensive intervention)

Data analysis by John Wasson, MD

Comparison of HC change for high confidence and not high confidence patients at baseline when grouped by intensity of intervention.

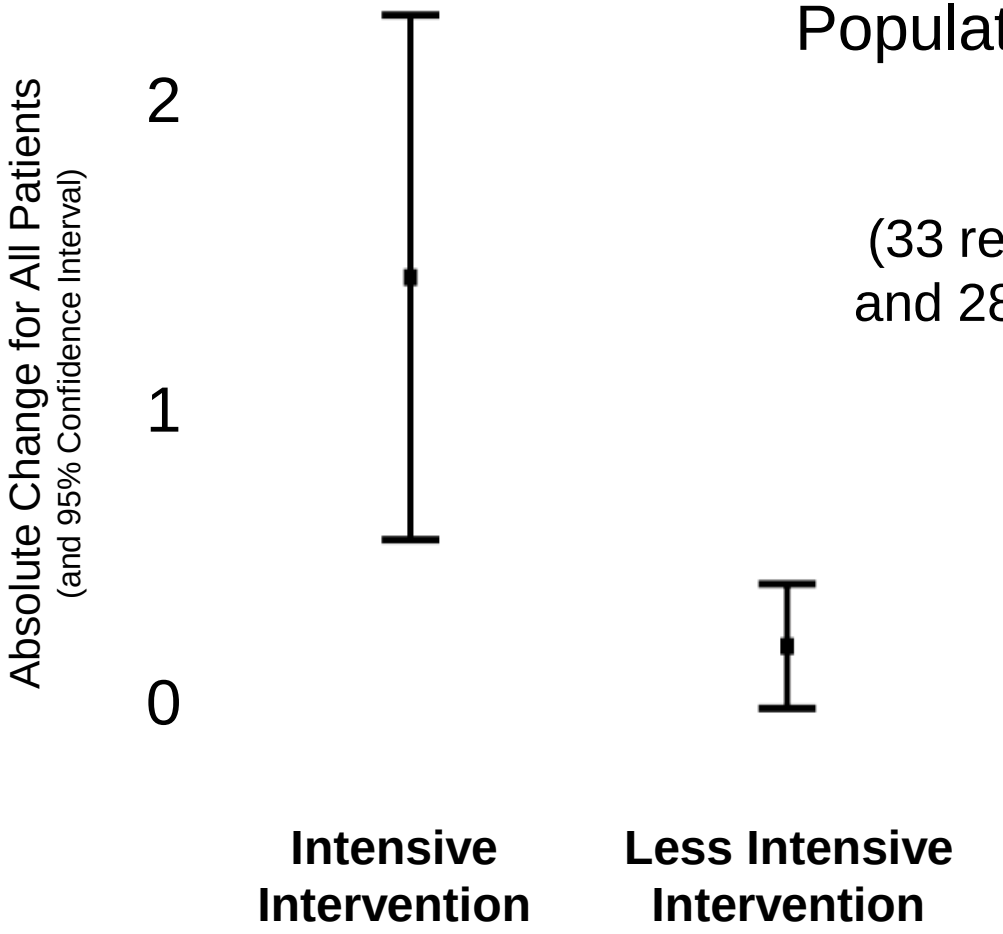


Average Change in Confidence On a 0-10 Scale for Patients At A Later Office Visit

(33 received intensive intervention and 287 less intensive intervention)

Data analysis by John Wasson, MD

Change in HC for those patients who were not confident at baseline based on the intensity of intervention



Population Change in Confidence On a 0-10 Scale

(33 received intensive intervention and 287 less intensive intervention)

Data analysis by John Wasson, MD

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
- Utilizer further the motivational interviewing skills of our team and to use all staff members to help with health confidence and self care plans.
- Continue to monitor our data to determine if the trends we are seeing reflect a long-term and sustainable increase in health confidence and decrease in health care cost through decreased ER and hospital admissions.

Challenges

- We continue to be challenged in obtaining claims data – BCBSVT and DVHA are currently the only payors actively working with us. This remains a problem as it has been in all prior quarterly reports.
- Claims data from CMS remains unavailable. 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 WRFP is limited by the lack of resources to support this.

Challenges

- We continue to adjust to our new roles in the project with the departure of Dr. Sean Uiterwyk.
- We continue to reach out to partners in our community to help us explore additional ways to communicate with our patients.

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
  - Analysis of health confidence data collected serially (contained here)
- Long-Term Activities
  - Development of interventions targeted at patients with low self-confidence and/or high utilization, particularly self care plans.

- *as well as activities in previous slides

Providers and Beneficiaries Impacted

- Providers participating in or otherwise impacted by our project include
  - 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
  - Aditi Malvankar, eCW, CCMR configuration
  - Lexi Burroughs – Mental Health Counselor

Providers and Beneficiaries Impacted

- Number of beneficiaries of our project.
  - 6,250 patients seen at WRFP between 1/1/15 – 10/21/15
  - WRFP averages 33 admissions per month to DHMC
  - WRFP averages 73 ER visits per month to DHMC

Expenditures to Date & Revised Budget

Invoice #9 **Date:** **10/5/2015**
Agreement # 03410-1280-15

	Start 7/1/14 **24 Month**	(Awardee to complete) **Current Month**	**Reconciliation: Cumulative**	Award
White River Family Practice	**Award $:**	**Spending**	**Spend to date:**	Balance
Toni Apgar	99,008.00	$3,934	56,324.68	42,683.32
Lexi Burroughs	20,000.00	869.50	12,173.00	7,827.00
Sean Uiterwyk, M.D.	23,100.00	$1,004.34	14,060.76	
Jill Blumberg, M.D.	-		-	9,039.24
Total Salary	142,108.00	5,807.98	82,558.44	59,549.56
Fringe	17,168.00	$750	10,448.43	6,719.57
Conference Travel	3,000.00		3,138.00	(138.00)
Supplies	500.00		897.39	(397.39)
Equipment	36,818.00		15,014.88	21,803.12
Mark Nunlist, MD	115,200.00	$2,925.00	76,362.50	38,837.50
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		6,651.54	848.46
Indirect	33,006.00	$1,435.04	18,655.52	14,350.48
Total :	$ 363,070.00	**10,918.02**	**217,483.66**	145,586.34
Less: unspent Advances				
Net Invoice :		**10,918.02**		

Expenditures to Date & Revised Budget

- We do not have any significant budget variance to report at this time.
  - We have realized that our equipment needs have shifted.
  - Monies which we expected to be used towards hardware will be best used for computer training and building IT expertise within our office.
  - This training will be around the use of tablets to collect patient reported measures and surveys which will then be captured in our electronic medical record.
- We do not have any forecasted travel plans

Vermont Health Care Innovation Project
2015 Quarterly Report

Insert Grant Project Title

Insert Name of Organization

Date: October 9, 2015

Reporting Period:

June 2015 - September 2015

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

Nicole Moran, RN, MSN

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 will 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

- Increased collaboration with the hospital Case Management Team by holding monthly meetings with their manager as well as the manager of the Community Health Team.
- Patient brochure completed and distributed to local clinics, hospital case managers and to the Community Health Team.
- Eighteen referrals received, nine patients admitted to the program and four pending admission
- Created and distributed Patient/Family Satisfaction surveys and Provider Satisfaction surveys

Recent Accomplishments

- Created and implemented a Provider Communication tool to assist in keeping providers informed about the status of their patients.
- Created and implemented a follow-up letter to patients who were not successfully reached by telephone to schedule an initial visit.
- Trained a new RN.

Challenges and Opportunities

- Rutland Regional Medical Center is implementing a Transitional Care Program, which may impact referrals.
- Medicare Care Choices Model will begin January 1, 2016, which may impact referrals.
- 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
  - Collaborating with Case management and the Community Health Team
  - Ongoing provider communication
- Long-Term Activities
  - Enroll 15 patients to the supportive care program by December 1, 2015

Providers and Beneficiaries Impacted

- Please provide the number of Providers participating in or otherwise impacted by your project.
  - Total time of program
    - Twenty referring providers
      - 17 MDs (specialists – 4, PCP – 7, hospitalists – 6)
      - 2 NPs
- Please provide the number of beneficiaries of your project.
  - 24 with 4 pending admissions

Evaluation Methodology

- Currently collecting Missoula VITAS Quality of Life survey assessment on admission and discharge.
- At the end of September began sending out Patient/Family Satisfaction Surveys and Provider Satisfaction Surveys, upon patient discharge from the program
- Currently no data to report

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ 82,174.74	$ 3,446.47	$ 3,319.31	$ 6,765.78
Fringe	$ 21,488.70	$ 901.25	$ 868.00	$ 1,769.25
Travel	$ 5,600.01	$ -	$ 367.36	$ 367.36
Conferences	$ -	$ 264.32	$ -	$ 264.32
Equipment	$ 2,800.00	$ -	$ -	$ -
Contracts	$ -	$ -	$ -	$ -
Indirect	$ -	$ -	$ -	$ -
Total	$ 112,063.45	$ 4,612.04	$ 4,554.67	$ 9,166.71

RiseVT
Northwestern Medical Center

Date:
October 10, 2015

Reporting Period:
July-September 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

- Individual-
  - Over the past 3 months, RiseVT has attended over 35 community events reaching over 3800 people. We are engaging community members in a variety of ways to spark interest in RiseVT with our Smoothie Bikes, #RiseVTShowUp Events, Life-size Jenga Game, and more. Our #RiseVTShowUp events started in July and have continued every Wednesday where individuals can just "show-up" and be physically active with our Health Coach. We are averaging 15-20 participants each week.
  - We are currently health coaching 60 individuals who have collectively lost over 100 pounds. In addition, we are seeing some early results in reducing blood pressure and cholesterol numbers.
  - Over 160 individuals are utilizing our online software to track their health and engage with RiseVT.
- Schools/Businesses-
  - RiseVT is collaborating with 6 local schools including post-secondary education. We have connected schools to Safe Routes to School Partnerships, created challenges for students, discussed sugary sweetened beverages, created wellness teams and more. Recently we have seen a big ask from our childcare providers asking for a "Childcare RiseVT Scorecard" which is now in production. Our hope is to engage with our 0-6 population beginning in January 2016.
  - RiseVT is currently collaborating with 30 businesses with 25 being certified in RiseVT. We have established over 20 policies ranging from breastfeeding friendly employer initiatives to healthy eating guidelines for meetings to smoke free policy development. Our policy development is impacting over 1000 employees. We are also seeing businesses competing against each other to see who can reach RiseVT Gold Status the fastest. This external competition is resulting in higher and faster change for our businesses and a demand for more certifications across our region.
- Municipality
  - RiseVT is collaborating with 5 municipalities across the region. Our advocates are engaging with key leaders in their communities to adopt policies and systems to create a healthy environment. Some highlights from our Municipalities have been creating a trail plan for building and expanding trails in a region, providing free access to fresh water in a recreational facility, creating a bike/pedestrian friendly environment including adding bike racks and signage, adopting policies relating to healthy eating and town/village events.
- Community Campaign/Branding
  - RiseVT has been extremely successful on social media and print material. Our collaboration with the community newspaper has yielded a full page spread weekly on RiseVT. In addition we have collaborated with the Vermont Health Department to create quick how-to cooking videos highlighting fresh local food and our local public health nutritionist.
- Vulnerable Populations:
  - RiseVT is currently collaborating with our local mental health agency, Vermont Adult Learning, Franklin County Home Health Agency, The Agency of Human Services and more. Recently a huge success has come from our Collaboration with the Agency of Human Services to table monthly in the state office building. This building has over 500 visitors each week and RiseVT is setting up a booth to offer a free blood pressure check and connect clients back to RiseVT.

Challenges and Opportunities

- *How to evaluate a program that has population health measures that are only reported on every 2 and data is behind a year? (please see our Evaluation Slide)*

Another challenge that we have created an opportunity in is capacity. For example, we are seeing a huge interest in RiseVT from schools in our area and wanting us to engage with them and their classes. Unfortunately with 5 Staff members, we are unable to provide every class with this want. To remedy this and to not lose momentum, RiseVT is creating a "Classroom Scorecard," which allows a class to implement their own policies to impact the health of their students. This way when RiseVT is working with administrators in a school on policy and systems changes, we also are working on the ground level with classes to identify and champion current practices that relate to health and wellness from a classroom standpoint.

Activities Undertaken and Planned

- Ongoing Activities
  - Continuing to engage and outreach to potential partners with extra consideration to vulnerable populations. RiseVT is involved in ACO Learning Collaborative to increase engagement with primary care.
- New Activities
  - Our recently developed childcare scorecard will be running through the "pilot" phase during the next reporting period. This will allow us to look at how we can implement the Vermont Prevention Model in the 0-6 age group.
- Long-Term Activities
  - The Community Committee on Healthy Lifestyles (where RiseVT was created) has sub-divided into 3 different

Providers and Beneficiaries Impacted

- *Beneficiaries:*
  - *3800+ engaged through events, pledging, health coaching and online wellness. This*
  - *30 businesses are collaborating with 25 certified in RiseVT Status. This includes 16 non-profit organizations including Vermont Adult Learning, NCSS, and the Agency of Human Services.*
  - *5 Municipalities are engaged in RiseVT*
  - *6 Schools are engaged in RiseVT.*

Evaluation Methodology

- The target population is all residents in Franklin and Grand Isle.
- To measure success-
  - # of entities certified and if they have moved up in certification since working with RiseVT.
  - Physical markers for behavior changes with our health coaching clients including weight, BMI, cholesterol and blood sugar.
  - Number of children walking and biking to school
  - Number of individuals impacted by policy or system change
  - Number of trails/paths highlighted

Evaluation (cont)

- RiseVT has collaborated with VDH Surveillance and is looking to identify potential partners to establish a robust evaluation plan for our program. Since RiseVT is measured in population health, which does not change in a short time frame, our team has identified the need to have a formal evaluation plan with short term measures. In addition, we have created a logic model to help guide us along the way. We are looking to identify an evaluator within the next 3 months. This would increase our sustainability and identify what we are doing, how well we are doing it and if anyone is better off.

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	$ 45,000.00	42,892.25	$ 2,108.00	$ 45,000.25
Fringe	$ 63,000.00	$ 12,072.03	$ 8,610.48	$ 20,682.51
Travel	$ 10,000.00	$ 1,339.96	$ 1,005.55	$ 2,345.51
Materials/Sup	$ 19,500.00	$ 1,161.00	$ 11,850.00	$ 13,011.00
Equipment	$ 16,000.00	$ 13,000.00		$ 13,000.00
Other	$ 46,500.00	$ 23,673.64	$ 7,864.40	$ 31,538.04
Indirect				$ -
Total	$ 200,000.00	$ 94,138.88	$ 31,438.43	$ 94,138.93

An Innovative Adaptation of the TCM in a Rural Setting

Southwestern Vermont Health Care

Date:

October 7, 2015

Reporting Period:

July 2015 – September 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 provided phone and computer access resulting in improved communication with patients and community agencies.
2. Community Care Team has demonstrated success with 4 patients, with decreased number of visits to the ED following intervention.
3. Implemented Community Care Team pre-planning meetings, including the Field Director from the Vermont Agency of Human Services, to improve community leadership.
4. Implemented a survey of the Community Care Team to evaluate Community Care Team meetings and implemented suggestions for improvement.
5. Documentation tools implemented for the Health Promotion Advocate. Meetings held with Director of Information Systems and the Director of Health Information Systems, to implement documentation in the EMR, expected completion Oct 15th.
6. 4th Transitional Care Nurse has completed orientation, now working independently with a patient case load.

Recent Accomplishments (continued)

7. Data from 120 days pre- and post- using Transitional Care Program, demonstrates a 35% decrease in Emergency Department Visits and 69% decrease in Inpatient and Observation Hospital stays for 267 patients enrolled in the program.
8. INTERACT Nurse has been hired and begun orientation in her role
9. Billie Allard, MS RN has been requested to be a panelist for the World Health Congress in April to discuss Creation of an Integrated Care Delivery System.
10. Transitional Care Nurses participate in new Interdisciplinary Care Rounds daily with inpatient units, improving coordination of care.
11. Implemented biweekly meetings to plan for Transitional Care Nursing Conference in Fall 2016.

Challenges and Opportunities

- **Challenges and Response Activities:**

1. Transitional Care Nurses continue to work with patients to find Primary Care Physicians to allow them access to additional services.
   - Discussed this concern at Bennington Regional Clinical Performance Committee to identify community solution.
   - Patients referred to Express Care (on site solution for urgent needs and bridge gaps for primary care)
2. Transportation has been a challenge for many patients to get to medical appointments and services, resulting in missed appointments.
   - Finalizing contract with Village Ambulance service to provide a driver for new transportation service for the TCN program, anticipate November implementation.

Challenges and Opportunities (cont.)

- **Opportunities**

1. Southwestern Vermont Health Care is opening a new physician practice in Pownal, Vermont on October 19, 2015.
   - New Transitional Care Nurse has obtained MA license and will be part of the team
2. Potential ability to expand services further with Transitional Care Program being highlighted in multiple publications and marketing efforts.
   - New Transitional Care Team brochure developed, which highlights the many components of the program.
   - Health Matters column in local newspaper highlighting components of the program
   - Presentation of program planned for Magnet Nursing survey in November
3. Increased interest in this Transitional Care Program from many other healthcare facilities and communities, and requests to assist in planning discussions, and speak with interested individuals and groups.
   - Information being provided to assist other communities, within time constraints.
   - Speaking engagements at NEHA Conference and World Health Conference.
   - Planning session and panel presentation for Rutland Regional Hospital

Activities Undertaken and Planned

- **Ongoing Activities**
  - Weekly strategy Transitional Care Nursing Team sessions.
  - Data analysis / data summary reports.
  - Community Care Team monthly meetings.
  - Continued expansion of Transitional Care Program.
- **New Activities - next reporting period**
  - Implementation of INTERACT program at Center for Living and Rehabilitation
  - Expansion of TCN Program to an additional Medical Practice, continue to expand services.
  - Implement Health Promotion Advocate EMR documentation October 2015
  - Implement transportation service November 2015
- **Long-Term Activities**
  - Expand implement of INTERACT program to other area long term care settings
  - Plan and hold Regional Conference on Transitional Care Nursing.
  - Develop and implement the Curriculum for area Nursing Programs.
  - 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, Substance Abuse Counselor and Developmental Services
    - CRT Community Rehab & Treatment Service
    - Vermont Division of Vocational Rehabilitation

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
  - SVMC Blueprint CHT Leader

Number of Beneficiaries participating in/or impacted

- Transitions of Care Program

	Q1	Q2	Jul 15	Aug 15	Sept 15	Q3 total	Total YTD
# New patient encounters	224	117	31	39	57	127	468
Total # patient interactions	554	293	118	132	126	376	1,223
Home	122	73	38	42	51	131	326
Hospital	290	144	45	53	43	141	575
Phone Call	100	57	23	24	24	71	228
PCP Office	18	8	9	10	7	26	52
Nursing Home	21	9	3	1	4	8	38
Emergency Department	3	2	0	1	0	1	6

Providers and Beneficiaries Impacted (Cont.)

- Community Care Team

	Q1	Q2	July 15	Aug 15	Sep 15	Q3 Total	Total	
# New Participants	5	5	5	4	NO Meeting		19	
# 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	2					3	
Medicaid Case Manager	2	2	1	3		4	8	
Traumatic Brain Injury Program	1	1		1			3	
Blueprint Case Managers		3					3	

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	July 15	Aug 15	Sept 15	Q3 Total	Total	
# Referrals/Contacts CCT (cont.)								
Medical Provider	1						1	
United Counseling Services	2	4	3	5		8	14	
Developmental Services / UCS		3					3	
Housing Assistance	1	1		1		1	3	
Vocational Rehabilitation	1	2		1		1	4	
Economic Services		3					3	
Transitional Care Nurses SVMC		1					1	
Social Services SVMC		2					2	
Hawthorne Recovery Program		2					2	
Court Appointed Guardianship		1		1		1	1	
Memory Clinic		1					1	
Department of Corrections		1	1				2	

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	July 15	Aug 15	Sept 15	Q3 Total	Total	
# Referrals/Contacts CCT (cont.)								
VT State Field Representative				1			1	
VNA			1	1			2	
Family Services DCF				1			1	
Food Assistance				1			1	
Pharmacist Services				1			1	
SASH (Support and services at Home			1	1			2	
Brattleboro Retreat				1			1	
Sunrise Family Services		1					1	
TOTAL	19	30				25	74	

Providers and Beneficiaries Impacted (Cont.)

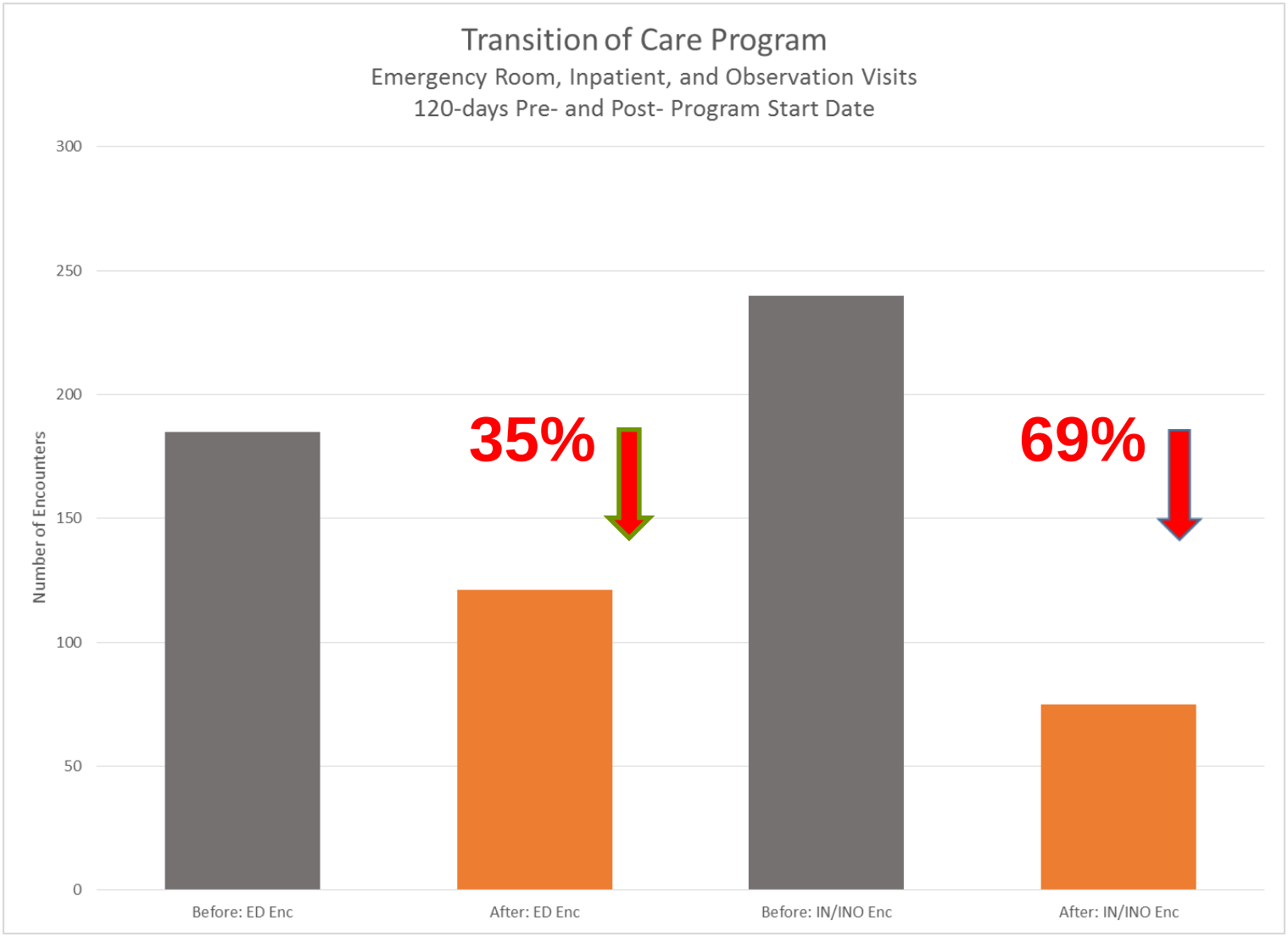
- Health Promotion Advocate (documentation in this format implemented Aug 14, 2015)

	Aug 15	Sept 15				Total YTD
# New patient encounters	4					19
Total # patient interactions						
Phone Contacts	4	10				14
Emergency Department	11	8				19
Inpatient Hospital		2				2
Visit In the Community	2	4				6
Consult w Community Resource	6	15				21
Screened for CCT	1	2				3

Evaluation Methodology

- Transitions of Care Program
  - Number of inpatient admissions to the hospital 120 days prior to TCN Program and 120 days post TCN Program.
  - Number of ED Visits 120 days prior to TCN Program and 120 days post TCN 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.

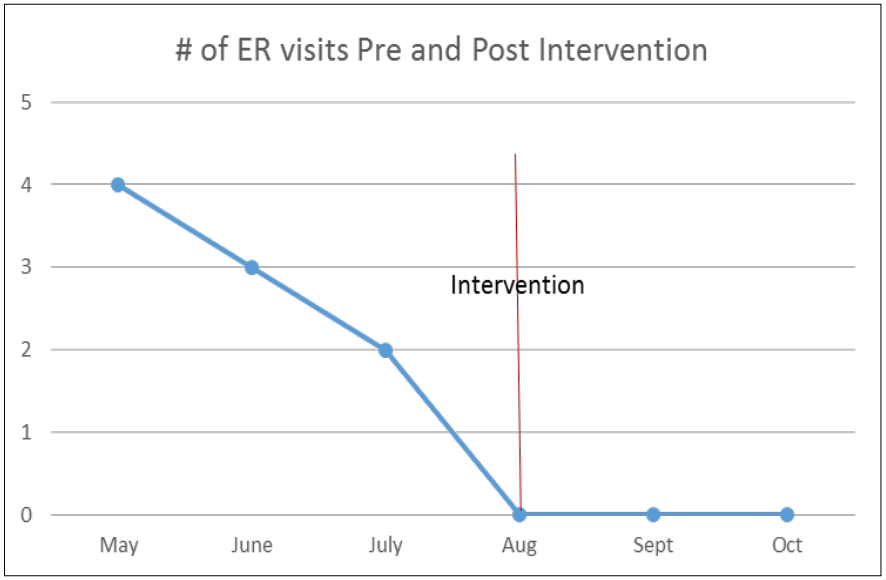
Transition of Care



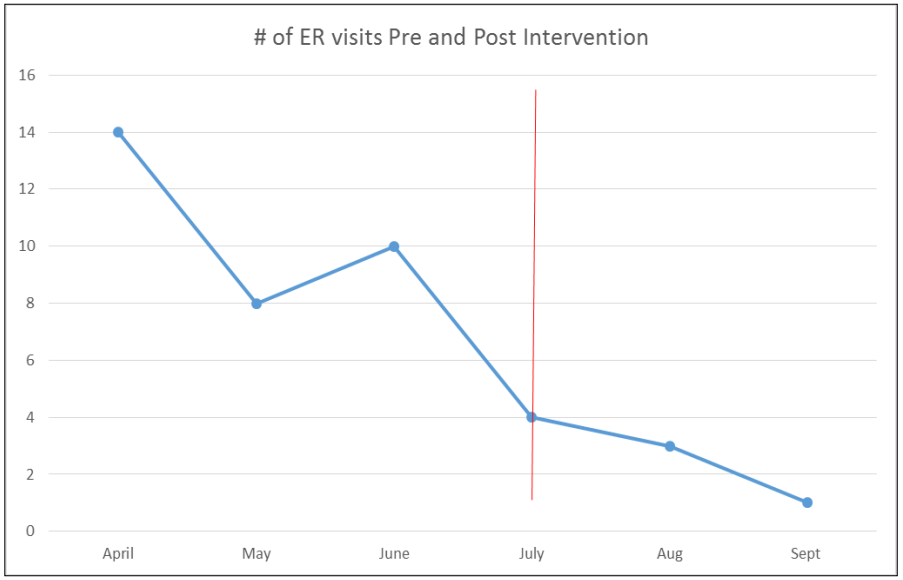
Vermont Health Care Innovation Project

Community Care Team Case Studies

CCT Case Study #1: Alcohol Abuse:
Hx ED visits since 2010
2013 15 ED visits / 7 inpatient admits
2014 40 ED visits / 8 inpatient admits
2015 Jan-June 10 ED visits



CCT Case Study #2: Developmental Disability: Hx ED visits since 1995
2014 68 ED visits
2015 Jan-June 59 ED visits

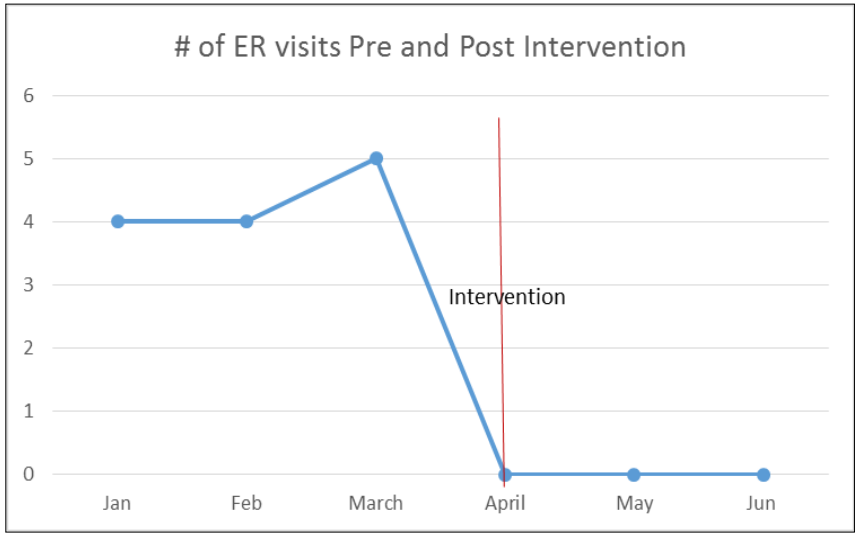


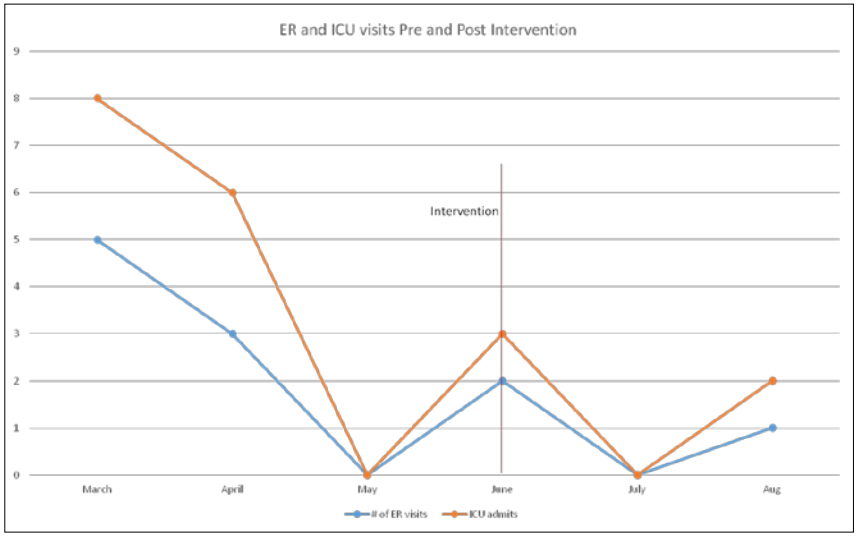
Vermont Health Care Innovation Project

Community Care Team Case Studies

CCT Case Study #3: Chronic Mental Illness
Hx ED visits since 2013
2014 35 ED visits
2015 Jan-April 14ED visits

CCT Case Study #4: PolySubstance Drug Abuse
2013 8 ED visits
2014 7 ED visits / 3 inpatient ICU admits
2015 Jan-July 15 ED visits / 11 ICU admits





Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr	Total Spent to Date
Salary	$ 287,310.00	$ 12,359.23	$ 32,530.48	$ 44,889.71
Fringe	$ 86,193.00	$ 3,707.77	$ 9,393.29	$ 13,101.06
Travel				
Conferences				
Equipment	$ 3,097.00		$ 1,192.16	$ 1,192.16
Contracts	$ 23,400.00			
Indirect				
Total	$ 400,000.00	$ 16,067.00	$ 43,115.93	$ 59,182.93

Briefly discuss any potential changes to the budget going forward.

No changes anticipated at this time.

Insert Grant Project Title

Insert Name of Organization

Date: October 12, 2015

Reporting Period: Period 3

Name of Presenter(s) and/or Key Contact:
Kirsten M. 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
✓	✓	almost

The IHPP Planning Team has reviewed a fourth topic, care models and policy implications. A draft final paper is under review.

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
✓	✓	✓

Qualitative data collection and analysis is complete. Additional data has been identified from Vermont Special Olympics. Medicaid claims data has been refreshed and undergone a final review with IHPP's technical support provider.

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
✓	✓	almost

Outreach has been the primary area of emphasis during the third quarter, including vetting potential recommendations with key stakeholders

Five Recent Accomplishments

1. **Draft Final Report :** IHPP's Project consultant Susan Covert has submitted a draft report for Planning Team review, ahead of schedule. We anticipate the Planning Team formally adopting the report at our October 21, 2015 meeting.

2. **First Formal Presentation**: IHPP staff participated in the second VHCIP Community Grant Summit, sharing selected findings and recommendations, October 7, 2015.

Five Recent Accomplishments

3. **Additional Data Set Identified**: IHPP staff have struggled to find reliable data regarding secondary conditions like obesity for adults with I/DD. Physicians often do not code for these diagnoses in claims data, because then do not trigger additional payment.

Special Olympics Vermont

The Healthy Athletes Program is a screening and health education initiative by Special Olympics. The Vermont chapter has provided IHPP with their screening data, an excellent supplement to Medicaid claims information.

Five Recent Accomplishments

4. **Response to VHCIP request for bids**: IHPP staff "fast-tracked" a proposal to create training materials for care coordinators and other health providers based on VHCIP's "Disability Awareness Briefs." [See notes slides 11 and 18].

5. **Cultivating Opportunities:** Period 3 has focused on assessing the viability of potential recommendations by seeking "buy in" from key stakeholders. Each section of IHPP's report will not only include findings and recommendations, but opportunities where the Team describes next steps toward implementation. [See Slide 9 for specific examples]

Challenges…

Goal 2:
Identify a set of best practices

The scope of this project is potentially very wide, making it difficult to "get our arms around it."

Steps Taken

- IHPP staff set strict parameters based on early discussions with key stakeholders. These include:
  - Narrowing inquiry to 4 themes
  - Narrowing recommendations to those assessed to have a reasonable chance of stakeholder support.
  - Deliberately setting aside some large issues (e.g. dental services)

NOTE: For an additional challenge, see Accomplishment 3, slide 6.

…and Opportunities

Goal 2 & 4:

Each section of IHPP's final report will include opportunities planned or in process for implementing recommendations

Examples of Opportunities

- Northern Counties Health Care had expressed interested in piloting home visits by nurses to conduct a health screening prior to a primary care visit.
- VTDDC and GMSA have been invited to present on disability competencies at the Vermont's annual Family Medicine Conference, Spring 2016 (pending approval of proposal).
- Burlington area pediatric practices have begun a pilot project in developing a best practice model for transitioning youth with special health care needs to adult practices.

Activities Undertaken and Planned

Ongoing Activities, Project Goal 2

- IHPP has completed all information gathering activities within the project's scope of work.
- Ongoing work is focused on finalizing the group's report, tentatively titled, *Removing the Barriers: Improving Health Care for Adult Vermonters with Intellectual and Developmental Disabilities*

Sometimes we got to celebrate!

Dr. Mark Levine joined us for our July meeting about provider training

Activities Undertaken and Planned, *cont.*

New Activities, *if selected for funding…*

VTDDC took the lead in organizing a cross disability coalition of organizations that crafted a proposal to the VHCIP for the development of training curricula. This is a critical next step for implementing IHPP's recommendations for provider training.

- Ten training modules covering key disability and related competencies, including communication, disability etiquette, ADA compliance and universal design, cultural competency, trauma informed care, and the social determinants of health.
- Materials to be piloted in live presentations to regional learning collaboratives and translated into on-line training available through AHS's new Learning Management System.
- Succinct, self-paced units supplemented with video illustrations based on the lived experience of Vermonters with disabilities.

Activities Undertaken and Planned, *cont.*

On-going Activities, Project Goal 4

IHPP staff have shifted from gathering input to vetting draft recommendations. IHPP is seeking allies for implementation through meetings and presentations, including outreach to:

- Leadership at the Vermont Department of Health: Commissioner Harry Chen, MD; Deputy Commissioner Tracy Dolan; and Maternal and Child Health Director Breena Holmes.
- Directors of developmental services for Vermont's designated and specialty agencies.
- Vermont Council of Special Education Administrators, Executive Board.
- Interested leaders at both the Geisel School of Medicine and the UVM Medical School through physician members of the IHPP Planning Team.

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.*

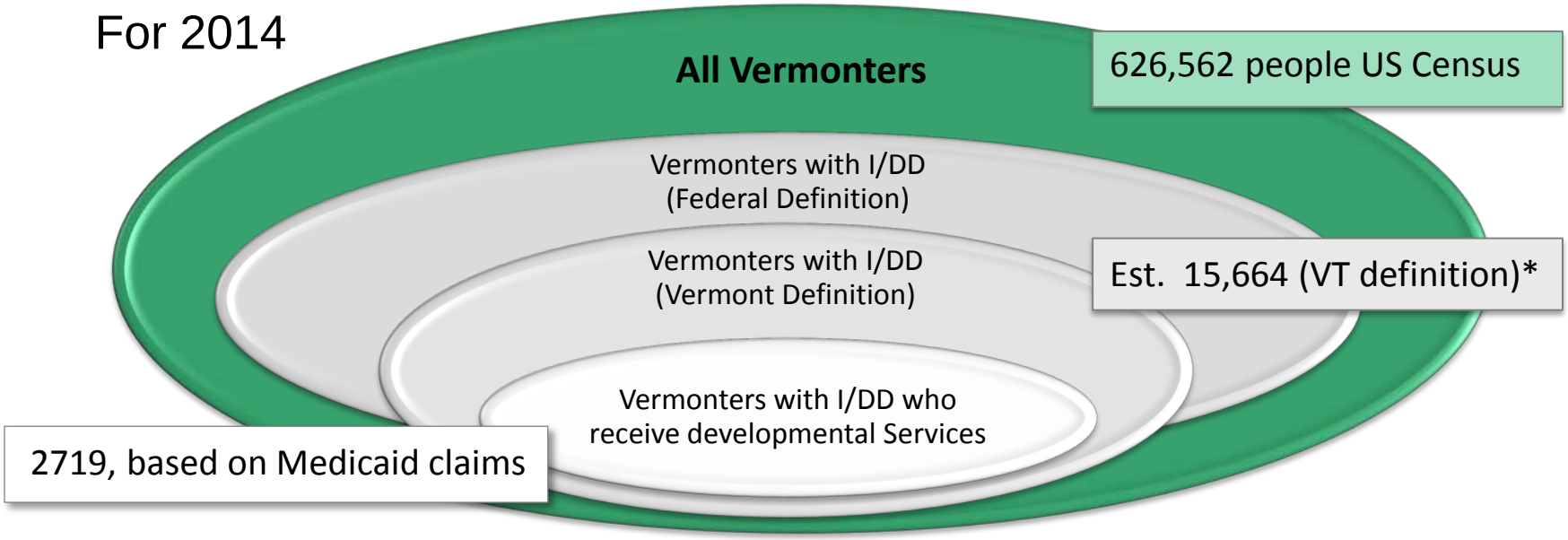
- If recommendations from this planning project are implemented, IHPP would impact 2 groups of beneficiaries:
  - *Cohort 1: Defined as adult Vermonters with I/DD who receive Medicaid-funded Home and Community Based Services (HCBS). 2014 Total = 2719**
  - *Cohort 2: Defined as adult Vermonters with I/DD who are covered by Medicaid, but do not qualify for HCBS. Several factors make this sub-group difficult to identify. Estimated 2014 Total = 15,664**

NOTES: (1) Cohort 1 was reported by Developmental Services to be 2770 in State Fiscal Year 2013; the variation in time frame accounts for the difference. (2) Cohort 2 is estimated base on a prevalence rate for I/DD. IHPP's technical assistant has been able to identify 1906 subjects within cohort 2 for 2014 based on diagnosis codes (12.1%). Noted that these numbers have been revised since the Period 2 Report.

Evaluation Methodology

- **Target Population**: Vermont adults who have an intellectual or other developmental disability as defined by federal statute. [See U.S. Code 15002 § 102(8)].

  Note that the federal definition of "developmental disability" is broader than the definition used by Vermont and includes individuals who may be served by Choices for Care, rather than developmental services.



* Estimated as .025% of total population, as per Vermont State System of Care Plan, pg. 7. It is not clear how this would differ from the number of Vermonters who would meet the federal definition.

Evaluation Methodology, *Cont.*

Part I. Project Evaluation

- **Metrics:** IHPP is a planning grant with specific deliverables due periodically throughout the planning process.
- **Data sources:** Written summaries are provided for each phase of research
- **Results to date**: To date all deliverables have been completed within required timelines or earlier.
- **Timeline for final results**:
  - 10/21/15. Final Report to be adopted by Planning Team
  - 11/18/15. Final Report to be released.

Evaluation Methodology, *Cont.*

Part II. Evaluation Conducted within this Project

IHPP used both qualitative and quantitative sources to assess the following research questions:

Q1. *What is the health status of adult Vermonters with I/DD?*

Q2. How do Vermonters with I/DD or their family members describe their experiences with the healthcare system?

- **Data sources**

  2014 Medicaid claims data

  VT Special Olympics health screenings

  4 focus groups

  2 one-on-on interviews

  Statements, 4 Planning Team members

- **Metrics / Results:** These are beyond the scope of this update. They will be part of the final report, due November 18, 2015.

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$19,400.00	$ 7,517.00	$ 2,970.00	$ 10,487.00
Fringe	$6,402			$ 2,739.00
Travel	$2,500	$ -	$ 152.00	$ 152.00
Conferences	$2,500	$ 1,500.00	$ -	$ 1,500.00
Equipment	$ 6,890.00	$ 3,872.46		$ 3,872.46
Contracts	$151,408	$ 2,460.00	$ 32,325.00	$ 34,785.00
Other	$ 3,900.00	$ 75.00	$ 51.00	$ 126.00
Total	$ 193,000.00	$ 15,424.46	$ 35,498.00	$ 53,661.46

- Current to Vision Interim Report 8/30/15.
- Correction was needed to fringe, revises Period 2 Report.
- Additional conference expense pending VHCIP approval.
- NOTE: Although reported as an "accomplishment," development of VTDDC's proposal for curriculum development exceeds the scope of work for this grant; staff time for proposal was covered by VTDDC's federal allotment (Account #37650), not SIM.

Behavioral Screening and Intervention
Invest EAP

Date: October 1, 2015

Reporting Period: Oct – Dec 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 submitted session tapes for review by MI trainer and received positive feedback.
- Implemented new outreach plan to employees.
- Numerous employees have called and been screened in response to outreach seeking services.
- Providing follow-up intervention services to numerous employees.

Challenges and Opportunities

- Most employees seeking help at this time are looking to improve their diet and/or increase their exercise levels.
  - These are the issues for which MI interventions in the Wisconsin NIH research showed are most likely to produce lasting change
  - We are cautiously optimistic that our interventions will be more impactful because they are provided by a licensed clinician; most providers in the Wisconsin study were not licensed clinicians.

Activities Undertaken and Planned

- Ongoing Activities
  - Continued training of clinical staff in evidence-based behavioral treatment protocols: periodic telephone conferences and evaluation of session recordings
- New Activities
  - Completion of revised outreach plan
  - Scheduled new meetings with 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	$ 2,968.52	$ 3,028.52
Fringe	$ 8,431.00	$ 18.00	$ 1,972.86	$ 1,990.86
Travel	$ -	$ -		$ -
Conferences	$ -	$ -		$ -
Equipment	$ 5,400.00	$ 603.26	$0.00	$ 603.26
Contracts	$ 21,000.00	$ 6,004.83	$ -	$ 6,004.83
Supplies	$ 370.00	$ -	$ -	$ -
Other	$ 1,680.00	$ 750.00	$ 110.00	$ 860.00
Indirect	$ 5,467.70	$ 743.61	$ 505.14	$ 1,248.75
Total	$ 60,144.70	$ 8,179.70	$ 5,556.52	$ 13,736.22

Resilient Vermont
Invest EAP

Date: October 1, 2015

Reporting Period: Oct – Dec 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

- Trainer reviewed tapes of client sessions to evaluate adherence to MI model. Counselor received high scores.
- Trained new PhD contractor to provide closer oversight and ensure compliance with research protocols
- Patient Success Examples
  - Patient with liver disease now 3 months sober.
  - Helped depressed patient join weight loss group, attend workshops and activities at local community center.
  - Helped young adult forced to leave family home after filing DCF report on her mother (on behalf of younger brother) finish high school and obtain job.

Challenges and Opportunities

- Nurses have greatly slowed referrals to health coach.
  - There are reports that some nurses believe the program does not offer patient choice.
  - May simply be procedural issues
- Despite previous efforts to educate staff more fully about project, more needs to be done. We have offered to bring Wisconsin researcher to clinic.
- We have met with clinic management and developed new procedures to facilitate increased referrals.

Activities Undertaken and Planned

- Ongoing Activities
  - Continued training of clinical staff in evidence-based behavioral treatment protocols: telephone conferences and evaluation of session recordings
  - Continue service delivery
  - Conduct assessments and enter data
- New Activities
  - Possible visit of Wisconsin researcher to clinic
- 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	$ 1,500.47	$ 299.90	$ 1,800.37
Contracts	$ 196,260.00	$ 53,869.32	$17,204.50	$ 71,073.82
Supplies	$ 1,000.00	$ -	$0.00	$ -
Other	$ 21,560.00	$ 750.00	$0.00	$ 750.00
Indirect	$ 22,722.00	$ 6,116.19	$ 1,575.40	$ 7,691.59
Total	$ 249,942.00	$ 62,235.98	$ 19,079.80	$ 81,315.78

Vermont Health Care Innovation Project
2015 Quarterly Report

Pursuing High Value Care for Vermonters

VMS Foundation and UVM College of Medicine

Date: October 13th, 2015

Reporting Period: July 1st, 2015 – Sept 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 - July, Aug & Sept 2015

- **Plenary interventions across all sites**
  - **Monthly Webinars for all teams and faculty**
  - **Merged individual hospital data uploads into a single multi-facility database on the secure data enclave server to facilitate analysis and reporting**
- **Hospital specific interventions**
  - **9th hospital to join – North Country Hospital in Newport, VT**
  - **Variable team activity across institutions due to summer schedules**
  - **2 hospitals have invited UVM MC team leader to present their educational intervention**
- **Decision to expand clinical focus to the subset of patients with structural lung disease**
  - **Consensus regional clinical pathway for inpatient management of COPD**

Challenges to success

- **Major challenges encountered**
  - **Teams being provided the time to complete their improvement activities in their institutions**
  - **Summer work and vacation schedules interfering with regular team meetings at all but one institution**
  - **Requests for hospital specific reports competing with resources needed for collaborative-wide reports**
  - **Identification to revise data transfer protocols and fire wall permissions at off site data enclave**

Opportunities for programmatic support

- **Expanding professional leadership at hospitals beyond hospitalist and laboratory physicians to include laboratory managers**
- **Scheduled Fall presentation to the New England Clinical Laboratory Managers (NECLA) to recruit broader participation among regional hospitals**
- **Scheduled presentation at the Vermont Medical Society Annual Meeting in November including membership of the GMCB to discuss potential sustaining and expanding support post SIM Grant Cycle end in June 2016**
- **Assignment of a faculty member to each hospital team to facilitate understanding of opportunities and barriers**

Activities Planned – Collaborative Year 2

Lab Collaborative Continuation

- Learning Sessions 8:30 AM to 3:30 PM
  - 1. Thursday, October 15, 2015- location RRMC
  - 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
- Full faculty meetings 4 weeks prior to each LS
- Operational weekly faculty meetings every Monday
- Expansion of clinical focus to include special attention to patients with structural lung disease

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**

Providers Impacted

- **Faculty – 10 members**
  - **Physicians, lab techs, quality, statisticians, database experts and IS**
- **9 hospital teams – 47 individuals**
  - **Team size ranging from 4 to 8 members**
  - **Hospitalists, intensivists, CIOs, lab techs, IS, Lab IS, Quality, Nursing and Pathologists**
- **Learners impacted**
  - **UVMMC 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**

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
- 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 August 30, 2015

	Approved Budget	Total Spent to Date	% Spend	% Grant Cycle
VMS Foundation	$ 153,912	$ 80,816	53%	58%
UVM Pathology	$ 98,401	$ 50,358	51%	58%
UVM Medicine	$ 273,301	$ 127,550	47%	58%
Hospital support	$ 23,214	$ 1,530	7%	58%
Total	$ 548,828	$ 260,254	47%	58%

- **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**
- **Budget does not reflect cost of support from Policy Integrity, LLC which provides database and analytic expertise**

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

State Innovation Models: Funding for Model Design

Vermont Program For Quality in Health Care, Inc.

Date: October 10, 2015

Reporting Period: July 1, 2015- September 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 Surgical 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

HOSPITAL ENROLLMENTS IN NSQIP PROGRAM UP 50%

- **Five of twelve** hospitals are enrolled in ACS-NSQIP (41%)
  - Five hospitals currently enrolled in ACS-NSQIP program (2 CAH & 3 mid sized Community hospitals)
- Coordinated monthly Collaborative meetings with membership expanding to include surgeons, surgical clinical reviewers and quality directors from VT hospitals and surgeon champion mentors and SCRS' from UVMMC and DHMC.
- Prepared presentation for SCR and IT departments in preparation for training and success in NSQIP
- SSPCC completed SCR training
- Provided ongoing NSQIP education to Quality Directors

  Quality Director's meeting 9/3/15

Challenges and Opportunities

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

  Resources, sustainability, lack of surgeon champion, low surgical case volumes

  SSCPC cannot fill in as temporary SCR; One enrolled hospital is having difficulty finding SCR

- **RESPONSES**: Ongoing education of NSQIP benefits; open invitation to all surgeon champions to attend monthly meetings and advocate for program at their hospitals; strategizing sustainable options; VPQHC posted SCR job

- **Potential opportunity to present VT collaborative at ACS NSQIP National Conference 2016.**

Activities Undertaken and Planned

- **Ongoing Activities:** Coordinating hospital enrollments into ACS NSQIP; Facilitating monthly meetings of collaborative members; Encouraging hospitals enrolled in NSQIP to perform patient safety surgical culture survey prior to program implementation and annually.
- **Planned Activities:** Provide clinical and technical support to hospitals, Quality Directors, and surgical clinical reviewers (SCRs') for Clinical abstraction and program implementation; Review AND trend data entered into NSQIP workstation; coordinate face to face collaborative meeting. Pursue opportunity to present collaborative success at National Conference 2016.
- **Long term Activities:** Coordinate collaborative events for hospitals to share best practice statewide and nationally; Provide analytic support to hospitals

Providers and Beneficiaries Impacted

- Providers: Approximately **60** Surgeons performing general, orthopedic, gynecological, and urologic inpatient and outpatient surgeries on adults in 5 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.
  - ACS NSQIP is a guide path to transform surgical care from fee for service to pay for performance

EVALUATION METHODOLOGY

TARGET POPULATION	QUANTITATIVE METRICS TO MEASURE SUCCESS	DATA SOURCE FOR METRICS	RESULTS TO DATE	TIMELINE FOR FINAL RESULTS
INPATIENT OR OUTPATIENT SURGICAL PATIENTS at 18 YEARS OF AGE OR OLDER NO TRAUMA CASES	**CLINICALLY**: 1).LENGTH OF STAY 2).RATES OF POSTOPERATIVE READMISSIONS OR ER VISITS 3). RATES OF POSTOPERATIVE COMPLICATIONS INCLUDING MORTALITY **FINANCIAL:** CHARGES TO INSURERS FOR POSTOPERATIVE COMPLICATIONS, READMISSIONS, AND LOS	VUHDDS **AND** ACS NSQIP OUTCOMES DATA PATIENT DATA ENTERED INTO ACS NSQIP WORKSTATION PRODUCES HOSPITAL LEVEL CLINICAL OUTCOME, RISK ADJUSTED REPORTS USING ODDS RATIOS	PATIENT DATA COLLECTION BEGINS IN OCTOBER, OR DECEMBER 2015. SVMC, RRMC PORTER MEDICAL CENTER START COLLECTING DATA OCTOBER 2015.	THE SMALL SURGICAL VOLUMES FOR CRITICAL ACCESS HOSPITALS MAY REQUIRE AT LEAST 1 TO 2 YEARS (2017) BEFORE DATA IS RELIABLE. MID-SIZE HOSPITALS **MAY** HAVE RELIABLE DATA SPRING OR FALL 2016.

Expenditures to Date & Revised Budget

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

	Approved Budget	Prior Spending	Spent this Qtr. SEP 2015	Total Spent to Date SEP 2015
Salary	$ 470,735.00	$38,707.97	$ 19,601.96	$ 58,309.93
Fringe	$ 143,350.00	$11,612.78	$ 5,880.59	$ 17,493.37
Travel	$ 11,559.00	$547.72	$ 59.00	$ 606.72
Conferences	$ 2,600.00	$75.00	$ -	$ 75.00
Coord. Training	$2,500.00	$ 2,321.22	$ -	$ 2,321.22
Equipment	$ 12,000.00	$ -	$ -	$ -
Contracts	$ 180,000.00	$10,000.00	$ 43,500.00	$ 53,500.00
Indirect	$ 77,256.00	$5,938.87	$ 6,483.00	$ 12,421.87
Total	**$ 900,000.00**	**$ 69,203.56**	**$ 75,524.55**	**$ 144,728.11**

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