VHCIP Provider Sub-grant
Fourth Quarter 2015
Quarterly Program Reports

CHAC Care Mgmt – 03410-1456-15
Bi-State Primary Care Association

Date: January 10, 2016

Reporting Period: October 1, 2015 through December 31, 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 improve the health outcomes for CHAC's "rising risk" population.
  - Objective: To develop and implement a care management model for CHAC designed to improve coordination and impact total cost of care for "rising risk" population.
  - Goal: Prepare ACO quality reporting submissions for the 2014 & 2015 Program Year for the:
    - Medicare Shared Savings Program
    - Medicaid Shared Savings Program
    - Commercial Shared Savings Program

Recent Accomplishments

- List the top five accomplishments for goals above since the previous reporting period.
  1. Providers are becoming more engaged due to further engagement campaigns and the tel-assurance program has been successfully integrated into health center work flows at some sites while still being worked on at others.
  2. The tel-assurance care coordinator has gained access to VITL Access and created letters to be sent out to patients in collaboration with care coordinators at individual organizations to increase enrollment in the tel-assurance program.
  3. Bi-State staff created training webinars and a slide set for all ACO participants conducting quality reporting in collaboration with OneCare Vermont and HealthFirst.
  4. Bi-State staff re-evaluated data abstraction tools due to new measures that were introduced.
  5. Bi-State staff worked in collaboration with OneCare Vermont and HealthFirst on a joint analytics proposal and vision.

Challenges and Opportunities

- Briefly discuss any major challenges encountered since the previous reporting period and responses to each.
  - While some health centers have been successful at implementing the tel-assurance program into their work flows and enrolling patients, others are still struggling. Some of the health centers have met with Pharos representatives to increase provider buy-in.
  - Working with a rural, elderly population is often difficult in that the patients tend to be skeptical of the tel-assurance program.
  - The number of ACO measures and patient charts that must be pulled in such a short time frame make quality reporting challenging. A data team of temporary staff members will be assembled.
  - Gaining VPN access was challenging due to the many, time-consuming steps involved.
- Briefly discuss any new opportunities available to support this project programmatically.
  - Bi-State submitted a grant proposal to the State for further funding to support staffing through the end of the contract period, analytics, and the telemonitoring program. In particular, the request for funding in the areas of telemonitoring and analytics would support project areas of this grant. Bi-State is awaiting this amendment for execution.

Activities Undertaken and Planned

- Ongoing Activities
  - Briefly describe any ongoing activities not previously mentioned above.
    - Analysis of quality results will guide future quality improvement efforts and clinical initiatives.
    - Patient identification for enrollment in the telemonitoring program is an ongoing activity.
    - Patients are in touch with CHAC through Pharos on a daily basis to record their vital information, and Central VT Home Health and Hospice will monitor and respond appropriately to patients whose data is flagged for follow up.
    - Patient education materials are distributed to Tel-Assurance patients on an ongoing basis by the Central Care Coordinator, and brochures and posters are used to promote the program in the health center offices
    - The CHAC Clinical Chair, Operations Chair, CEOs or delegates, and key staff from Bi-State and Pharos meet regularly as the Joint Oversight Committee to monitor success. There are weekly implementation meetings being held between Pharos and Bi-State.
    - Bi-State staff has weekly meeting with Pharos staff to discuss the program and next steps.
    - Bi-State staff continue to share aggregate and individual results of the Medicaid and Commercial ACO quality reporting with participating health centers.
    - Bi-State/CHAC continue to collaborate w/ OneCare Vermont and Healthfirst on ACO Measures.
    - Bi-State/CHAC continue to collaborate w/ OneCare Vermont and Healthfirst on analytics visioning.

Activities Undertaken and Planned

- New Activities
  - Briefly describe any new activities scheduled to take place before the next reporting period
    - Bistate Staff and representative from Pharos have planned meetings with two new organizations to begin the enrollment process for the tel-assurance program.
    - The tel-assurance care coordinator is working with care coordinators at individual health centers to get patient consents to increase the use of VITL Access.
    - Bi-state will be piloting Patient Ping, an event notification system with the tel-assurance population.
    - The chart abstraction process and quality reporting to all payers will occur within the next reporting period. This process also includes the assembly of a team of temporary staff members and gaining VPN access.
    - Due to the success of the first joint meeting of the Clinical and Operations Committees, it has been decided that these meetings will occur twice a year. The next one is scheduled for February 16, 2016 with topics of discussion to include gathering updates on current PDSA cycles and defining CHAC's clinical goals for 2016.

Activities Undertaken and Planned

- Long-Term Activities
  - Briefly describe any long-term activities currently being planned.
    - Efforts will be made to obtain feedback from the “rising risk” Medicare population that becomes enrolled in Pharos.
    - Work on improving care transitions will be a long term and ongoing process.
    - The results of the PY2014 quality reporting will be used for identification of areas for improvements.
    - The CHAC Clinical and Operations Committees will collaborate towards implementations of PDSA cycles and clinical recommendations.
    - Tracking the statuses of PDSA cycles will be a long term activity.

Providers and Beneficiaries Impacted

- Please provide the number of Providers participating in or otherwise impacted by your project.
  - Currently, 73 providers are directly impacted by the telemonitoring program. This number may increase as more patients enroll.
  - There are about ~1,600 providers attributing CHAC; these providers are all impacted by the ACO quality reporting activities.
- Please provide the number of beneficiaries of your project.
  - Currently 210 patients are enrolled and impacted by the telemonitoring program. This number may increase as more patients enroll.
  - There are ~35,300 attributed lives, which would count as beneficiaries and be impacted by the ACO quality reporting activities.

Evaluation Methodology

- Describe the target population for the initiative
  - The target population for the tel-assurance program consists of CHAC's Medicare rising-risk patients.
  - The target population for the ACO quality reporting includes CHAC's entire beneficiary population for all payers.
- 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 Developing a Care Management Model for Community Health Accountable Care is to compare project status to the project work plan.
  - The telemonitoring project will further be evaluated by:
    - Enrollment data
    - Patient Satisfaction
    - Analysis on Averted Hospital Admissions

Evaluation Methodology

- Data source/s for the metrics
  - MSSP claims data and patient satisfaction surveys
- Results to date (feel free to use additional slides, if necessary)
  - Bi-State is on track with our project work plan for Developing a Care Management Model for Community Health Accountable Care – see "Ongoing Activities"
  - To date, the tel-assurance program is showing promising results including 39% adverted admissions and patient satisfaction surveys show that 97% of enrolled patients would recommend the program to someone else.
- Timeline for final results
  - With further funding from the State, the tel-assurance program is funded through CY 2016.

Expenditures to Date & Revised Budget

- Please work from your approved revised budget to show any new expenditures.
  - See below
- Briefly discuss any potential changes to the budget going forward.
  - None at this time

03410-1456-15 (VX-15) Qtrly Reporting - DEC15					
	Approved Budget	Revised Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ -	$ 80,460.00	$ 47,654.83	$ 6,269.31	$ 53,924.14
Fringe	$ -	$ 18,506.00	$ 10,087.74	$ 1,299.31	$ 11,387.05
Travel	$ 704.00	$ 6,135.00	$ 81.75	$ 1,018.02	$ 1,099.77
Mileage	$ -	$ 1,536.00	$ 1,228.50	$ 21.57	$ 1,250.07
Meetings	$ 250.00	$ 250.00	$ 4.47	$ -	$ 4.47
Other IT	$ -	$ 14,636.00	$ 14,061.53	$ 277.26	$ 14,338.79
Supplies	$ 3,696.00	$ 6,069.00	$ 1,802.85	$ 171.49	$ 1,974.34
Compliance Expertise	$ -	$ 7,500.00	$ -	$ 3,132.50	$ 3,132.50
Professional Services	$ 16,750.00	$ 1,800.00	$ -	$ 3,102.50	$ 3,102.50
Contractrual - Pharos	$ 298,000.00	$ 328,000.00	$ 184,000.00	$ 32,000.00	$ 216,000.00
Contractual - Other IT, etc	$ 75,000.00	$ -	$ -	$ -	$ -
Contractual - Data Extraction	$ 14,000.00	$ 42,239.00	$ 8,526.02	$ -	$ 8,526.02
Contractual - Triage Care	$ 110,000.00	$ 174,000.00	$ 69,901.29	$ 29,552.93	$ 99,454.22
Support for Data Extraction	$ -	$ 5,000.00	$ -	$ -	$ -
Business Insurance	$ -	$ 7,000.00	$ 565.00	$ 1,080.00	$ 1,645.00
Facility Costs	$ 15,000.00	$ 25,372.00	$ 11,414.55	$ 3,284.46	$ 14,699.01
Indirect	$ -	$ 9,897.00	$ 5,702.70	$ 756.86	$ 6,459.56
Total	$ 533,400.00	$ 728,400.00	$ 355,031.23	$ 81,966.21	$ 436,997.44

Screening in the Medical home (SiMH)

University of Vermont Health Network-Central Vermont Medical Center

Date: January 6, 2016

Reporting Period: 2nd Year First 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

- Five 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, and UVMHC-CVMC Family Medicine- Berlin have screened over thirty nine hundred patients for substance use issues. An additional medical practice UVMHC-CVMC Granite City Primary Care- Barre, has screened over five hundred and fifty patients. One hundred and eighty patients have received Brief Interventions by our clinicians, and of those, one hundred and thirty have enrolled in Brief Treatment. Our clinicians are currently engaged with seventy six patients for either brief treatment or follow up on referral concerns.

- We have created an SBIRT project brochure and rack cards for the SBIRT clinicians. These items will increase both provider and patient understanding and access to our services.

- The Washington County Substance Abuse Regional Partnership Committee have met four times and appear to be making progress on building understanding of regional resources and needs. Through the work of the committee each partner submitted a program flow diagram, see **CVMC Medical Home SBIRT Process**.

- Together 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 a ***Successful Integration of Behavioral Health into Medical Practice: the SBIRT (Screening, Brief Intervention, & Referral to Treatment) Strategy Conference.*** Mark Depman MD will be the keynote speaker and we will explore lessons learned and avenues of sustainability.

Activities Undertaken and Planned

- Ongoing Activities
  - Regular meetings with each medical home to advance the implementation of the SBIRT screening model into their patient flow. Quality improvement of the screening process, feedback to providers about patient engagement in brief treatment services and problem solving barriers to screening.
  - Coordination of care efforts throughout CVMC's medical homes, the hospital system, and community partners.
  - Evaluation of our budget, working with Vermont Health Care Innovation Project Sr. Program Manager and Core Management Team to reallocate unused funds.
- New Activities
  - Pending the approval of our budget revisions, we will hire another clinician to increase our ability to effectively implement the SBIRT model into our medical homes.
  - Monthly meetings with each medical home to discuss data regarding utilization of SBIRT clinicians, referrals and screening proficiency
- 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. Build community alliances and a comprehensive clinical pathway for patients that are identified at moderate to high risk/dependent substance users.
  - Develop a strategy to sustain screening and intervention services initiated by this grant.

Challenges and Opportunities

- Delays continued to emerge in getting the SBIRT model established in one of our larger medical homes: Family Medicine Berlin. In the process of planning our SBIRT model roll out at Family Medicine Berlin, systematic issues regarding patient flow were uncovered and the practice assembled provider workgroups to resolve the issues. Although the SBIRT model integration is on hold, the practice does continue to utilize the SBIRT clinician through brief interventions, consultation, and patient referrals.

- Similar to our Family Medicine Berlin practice, our Family Medicine Waterbury practice has experienced barriers to integrating the SBIRT model. The initial screeners (AUDIT C and NIDA drug screen) were incorporated into the practice flow, however the engagement of nurses to provide scoring and administration of the secondary screens have been inconsistent. Additional training and supervision of the secondary screen administration is needed. Outside of the screening administration challenge is a larger issue, clinician availability. At this point, our SBIRT clinician is at the Waterbury practice only one day per week and has only one open slot in her schedule for a new patient referral. Until we are able to add at least one more day of SBIRT clinician coverage at Waterbury increasing the referrals through screening may not be appropriate.

- Our request to reallocate unused funds to hire an additional .6 FTE SBIRT clinician will provide the needed support to manage the intervention demand that comes with implementing a universal screening model in multiple medical homes throughout CVMC.

- As we enter our second year of this SiMH grant, we are beginning to see trends and patterns within practices that impact the effectiveness of the SBIRT model. A systematic review of varied levels of both practice and provider engagement in the SBIRT model will inform future direction and long term adoption of the SBIRT model in our medical home network.

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

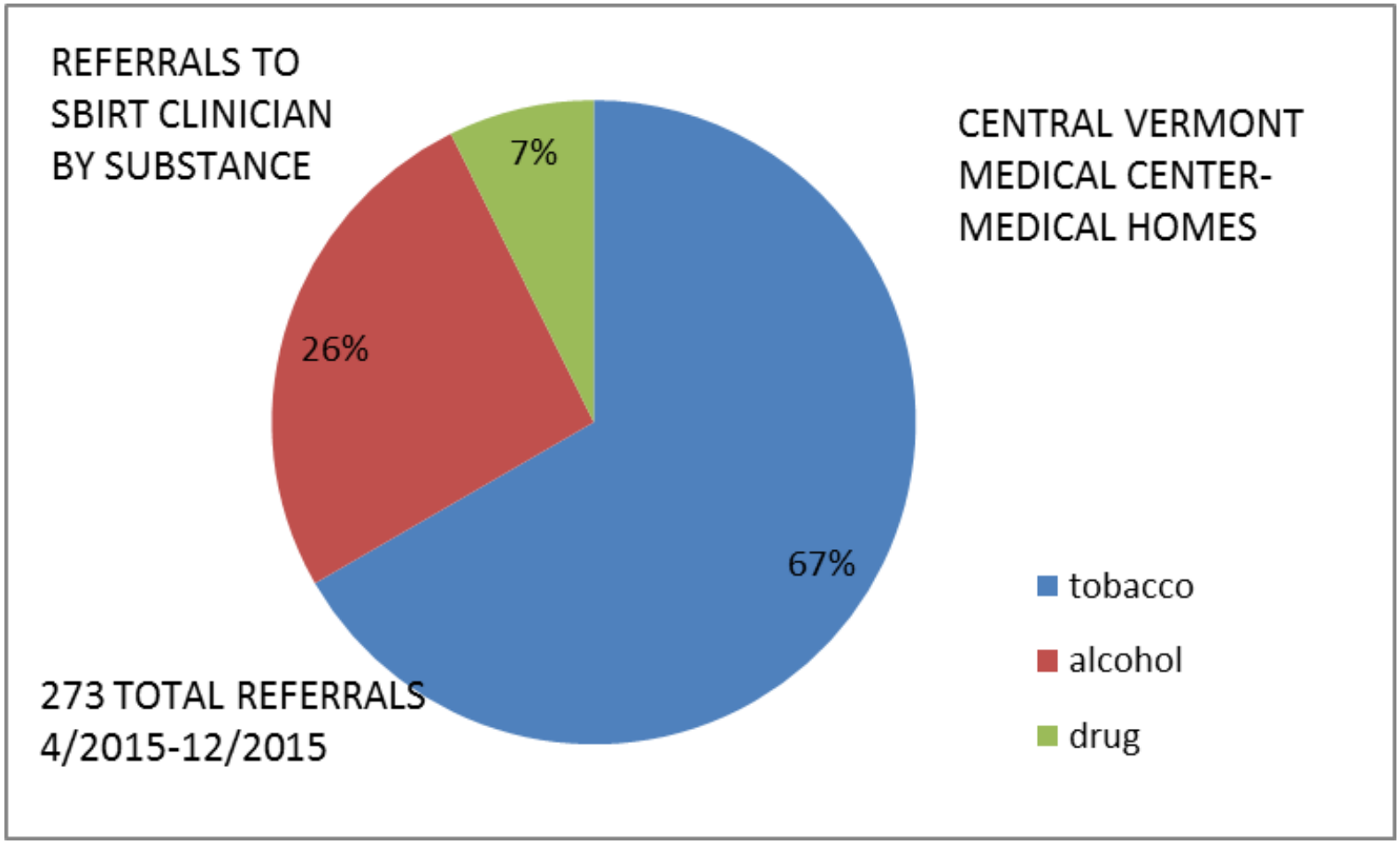
- The target population for our initiative is two fold. We aim to target medical home practices throughout CVMC network to engage in the SBIRT model of screening. Through the engagement of the SBIRT model we aim to identify people that use substances (alcohol and drugs) at a risky level, and people that 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

	BIM		CVPC		GCPC		MIFH		MRFP		WMA		TOTAL	
# OF PATIENTS SCREENED	649		189		567		1981		242		313		3941	
FEMALE	333		128		341		1189		128		190		2309	
AVERAGE AGE	55		50		61		51		54		54		54	
MALE	316		61		226		792		114		123		1632	
AVERAGE AGE	58		54		64		53		56		56		57	
# OF PATIENTS RECEIVED BI	77		37		2		52		6		7		181	
FEMALE	35		18		2		21		5		2		83	
AVERAGE AGE	51		47		40		55		46		43		47	
MALE	42		19		0		31		1		5		98	
AVERAGE AGE	53		44		0		56		63		47		44	
# OF BI PATIENTS ENROLL IN BT	59		33		1		22		5		11		131	
FEMALE	31		15		1		11		4		4		66	
AVERAGE AGE	58		50		40		51		48		51		50	
MALE	28		18		0		11		1		7		65	
AVERAGE AGE	55		41		0		49		63		53		44	
# OF REFERRALS TO SBIRT CLINICIAN	90		55		14		71		13		30		273	
tobacco	64	71%	38	69%	9	64%	50	70%	8	62%	13	43%	182	67%
alcohol	21	23%	12	22%	4	29%	16	23%	3	23%	15	50%	71	26%
drug	5	6%	5	9%	1	7%	5	7%	2	15%	2	7%	20	7%

BIM- ADULT MEDICINE BARRE
CVPC- FAMILY MEDICINE BERLIN
GCPC- GRANITE CITY PRIMARY CARE BARRE
MIFH- INTEGRATIVE FAMILY HEALTH MONTPELIER
MRFP- FAMILY MEDICINE MAD RIVER
WMA- FMAILY MEDICINE WATERBURY

Overall referrals to SBIRT clinicians



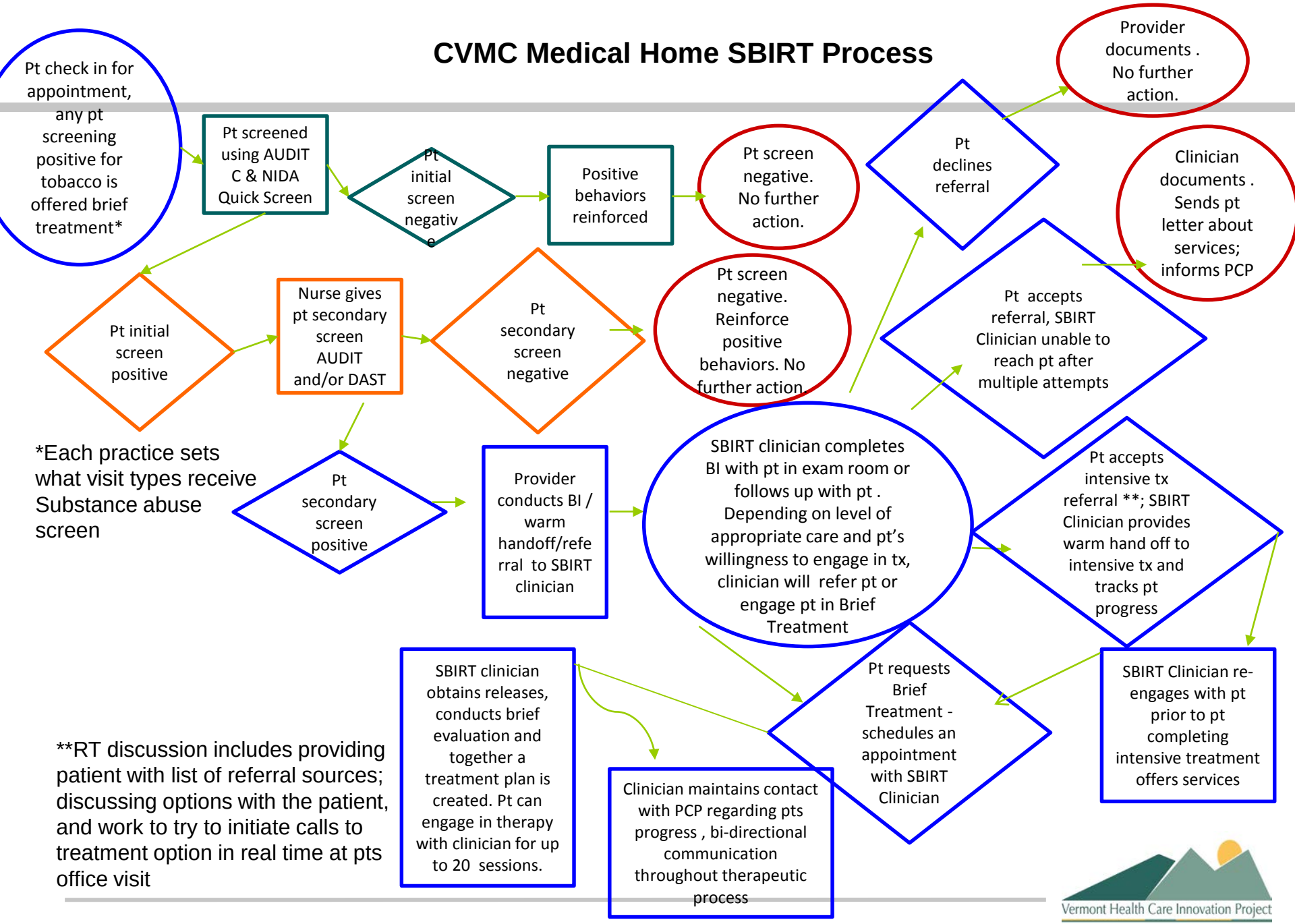
Expenditures to Date & Revised Budget

- 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	$ 85,149.00	$ 52,979.00	$ 138,128.84
Fringe	$ 98,400.00	$ 24,824.00	$ 11,102.00	$ 35,926.00
Travel*			$ 295.59	$ 259.59
Conferences*			$ 859.98	$ 859.98
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		$ 10,000.00	$ 10,000.00
Supplies	$ 10,670.00	$ 3,931.00	$ 594.96	$ 5,683.25

- * Tracked separately starting 8/1/15, in original budget Conferences were listed under Supplies
- Expenditures as of Nov 30 2015, from Aug- Nov
- We submitted of a reallocation 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.

CVMC Medical Home SBIRT Process



**RT discussion includes providing patient with list of referral sources; discussing options with the patient, and work to try to initiate calls to treatment option in real time at pts office visit

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

State Innovation Models: Funding for Model Design

Vermont Program For Quality in Health Care, Inc.

Date: January 8, 2016

Reporting Period: October 1, 2015- December 31, 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

- **Enrollments**

  Five of twelve hospitals are enrolled in ACS-NSQIP (41%)

  A 6th hospital has expressed interest

- **Data Collection Phase**

  Three of the five hospitals are collecting and entering data into ACS NSQIP workstation

  One hospital started collecting data, but is on hold due to hospital policy changes impacting the SCR.

  The fifth hospital will start SCR training in February

- **Presentations/Meetings**

  Held our first face to face meeting of collaborative members with good attendance; Presented topic of Surgical Care in Vermont at Quality Director's meeting 12/11/15

Challenges

- <u>EMR Challenges:</u> The rigorous nature of data abstraction coupled with the lack of a system wide hospital EMR adds additional strain to hospital resources and data collection process.
- ACS NSQIP provides SCR training with strict guidelines for registering SCR causing a delay in SCR training for 1 hospital
- Hospitals have declined participation in ACS-NSQIP at this time for various **reasons:** Resources, sustainability, lack of surgeon champion, low surgical case volumes; SCR's cannot be shared

<u>RESPONSES</u>: 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; VITL may be able to assist with EMR challenges.

Opportunity

- Raise awareness ACS NSQIP/Statewide Collaborative Efforts to improve surgical care
  - Dartmouth Hitchcock and UVMMC considering joining collaborative as participants as well as academic partners
  - Surgeons and insurers openly dialogue about surgical complications and methods to address public health problem.
  - Advance the concept of Surgical Home to decrease costs, increase patient safety, and decrease preventable surgical complications.

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.
- **Long term Activities:** Coordinate collaborative events for hospitals to share best practice statewide and nationally; Provide analytic support to hospitals and trend data

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:** COSTS 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 BEGAN OCTOBER and December 2015. SVMC, RRMC PORTER MEDICAL CENTER STARTED COLLECTING DATA OCTOBER 2015. MT. ASCUTNEY STARTED DECEMBER.	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

	Approved Budget	Prior Spending	Spent this Qtr. DEC 2015	Total Spent to Date DEC 2015
Salary	$ -	$ 58,309.93	$ 20,324.24	$ 78,634.17
Fringe	$ -	$ 17,493.37	$ 6,097.27	$ 23,590.64
Travel	$ -	$ 606.72	$ 117.30	$ 724.02
Conferences	$ -	$ 75.00	$ -	$ 75.00
Coord. Training	$ 900,000.00	$ 2,321.22	$ -	$ 2,321.22
Equipment	$ -	$ -	$ 1,000.00	$ 1,000.00
Contracts	$ -	$ 53,500.00	$ 10,000.00	$ 63,500.00
Indirect	$ -	$ 12,421.87	$ 3,524.89	$ 15,946.77
Total	**$ 900,000.00**	**$ 144,728.11**	**$ 41,063.70**	**$ 185,791.81**

- VPQHC is requesting repurposing of funds. Initial budget repurposing meeting was held 12/9/2015 with Core Team. Follow-up Core team meeting scheduled for 1/29/2016.

Caledonia & s. Essex Dual Eligibiles Project

Northeastern Vermont Regional Hospital

Date: January 6, 2016

Reporting Period: October – December 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

- Health Coach has started a walking group at the Mall.
- Completed handicapped accessible bathroom renovations in partnership with VCIL.
- Completed 3 handicapped ramps in partnership with Habitat for Humanity.
- Health Coach had 10 clients in smoking cessation.
- Provided custom circulation aids (not covered by Medicare or Medicaid) for a patient.

Challenges and Opportunities

- Challenges:
  - Difficult to engage people with anxiety disorders
  - Wait time (months of delays) to get Medicare and/or Medicaid approval or denials for services/supplies
  - Addressing clients in insecure housing
- Opportunities:
  - Recent successes partnering with embedded workers from Designated Agency
    - Including doing joint home visits
  - Increased referrals to the Choices for Care program
  - Referrals to the EMS Self-Management Fall Prevention

Activities Undertaken and Planned

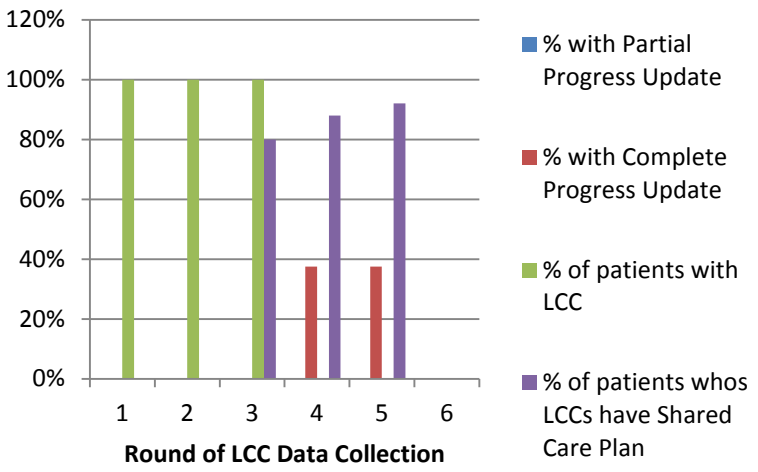
- Ongoing Activities
  - Health Coaching at maximum active case load of 20; 5 intermittent; 20 stable; 15 not active (total 65)
  - Tobacco cessation ongoing
- New Activities
  - DualsTeam presented at the local CHT meeting about Duals Project
  - Health Coach found resources for Thanksgiving dinner for clients
- Long-Term Activities
  - Health Coach and Team expanding lessons learned and care management tools (shared care plan, Camden Cards) to COPD population.

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	$ 40,327.83	$ 13,672.17	$ 54,000.00
Fringe	$ 18,900.00	$ 14,114.75	$ 4,785.25	$ 18,900.00
Travel	$ 2,000.00	$ 2,000.00		$ 2,000.00
Flex Funds	$ 100,000.00	$ 48,269.59	$ 22,485.98	$ 70,755.57
Equipment	$ 1,500.00	$ 1,536.55	$ -	$ 1,536.55
Contracts		$ -		$ -
Indirect		$ -		$ -
Total	$ 176,400.00	$ 64,321.54	$ 40,943.40	$ 147,192.12

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

Vermont Health Care Innovation Project
2015 Quarterly Report

Rutland Area Visiting Nurse Association and Hospice, Inc

and

Rutland Regional Medical Center

Supportive Care Program

Date: January 25, 2016

Reporting Period:

October 2015 - December 2015

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

- Continued collaboration with the hospital Case Management Team by holding monthly meetings with their manager as well as the manager of the Community Health Team.

- Seventeen referrals received and twelve patients admitted to the program

Recent Accomplishments

- To date, 30% of the patients admitted to the program have transitioned into either a Palliative care program or Hospice.

- Quality of life assessments are now consistently being completed on admission to the program and at discharge.

Challenges and Opportunities

- Rutland Regional Medical Center has implemented their Transitional Care Program, which has been beneficial by identifying patients that may benefit from the program.
- 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.
  - Collaborating with Case management and the Community Health Team
- New Activities
  - Communication and collaboration with the Transitional Care RN and the Community Health Team from Rutland Regional Medical Center
- Long-Term Activities
  - Enroll 10 patients to the supportive care program by March 1, 2016

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
      - 18 MDs (specialists – 4, PCP – 8, hospitalists – 6)
      - 2 NPs
- Please provide the number of beneficiaries of your project.
  - 37 with 3 pending admissions

Evaluation Methodology

- Collecting Missoula VITAS Quality of Life survey assessments on admission and discharge.
- Collecting Patient/Family Satisfaction Surveys and Provider Satisfaction Surveys, upon patient discharge from the program
- 30% of beneficiaries have transitioned to a Palliative Care Program or to Hospice

Expenditures to Date & Revised Budget

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

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ 82,174.74	$ 6,765.78	$ 3,592.77	$ 10,358.55
Fringe	$ 21,488.70	$ 1,769.25	$ 939.51	$ 2,708.76
Travel	$ 5,600.01	$ 367.36	$ 205.52	$ 572.88
Conferences	$ -	$ 264.32	$ -	$ 264.32
Equipment	$ 2,800.00	$ -	$ -	$ -
Contracts	$ -	$ -	$ -	$ -
Indirect	$ -	$ -	$ -	$ -
Total	$ 112,063.45	$ 9,166.71	$ 4,737.80	$ 13,904.51

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

RiseVT
Northwestern Medical Center

Date:
1.12.2015

Reporting Period:
October, November, December

Dorey Demers

RiseVT Coordinator

ddemers@nmcinc.org

Grant Project Goals

- Increasing the health of residents by decreasing rates of obesity and overweight
- Increasing the number of employers offering wellness programs with greater than 50% participation rate
- Expand resources for biking/walking
- Increasing fruit/vegetable consumption
- Decrease the number of people with no leisure time physical activity
- Increase the number of students walking/biking to school
- Increase smoke-free/tobacco-free environments

Recent Accomplishments

- Revamp of Business Scorecard
- Development of Childcare Scorecard
- Development of Classroom Scorecard
- Collaboration with agencies working with vulnerable populations including Agency of Human Services, Martha's Kitchen (Local Soup Kitchen) and CVOEO

Challenges and Opportunities

- A Major challenge was the individual scorecard which resulted in two completions during the first two quarters. We knew we had to figure out a better way to engage and developed a point in time scorecard that can be completed online. We had to create a systems online which was time-consuming. It officially launched in December. It has gotten great results and we continue to amplify. Through this we are able to refer people to primary care, and other local resources to help individuals embrace a healthy lifestyle.
- We are working collaboratively with a population health workgroup which was formed at NMC in October. This group consists of primary care, lifestyle medicine and comprehensive care management. It is a huge opportunity for RiseVT to integrate more with primary care.

Activities Undertaken and Planned

- Ongoing Activities
  - We are continuing to engage businesses schools and municipalities with a strong presence at local events and initiatives. Our advocates are actively participating in infrastructure meetings for municipalities and helped amplify a meeting on sidewalk infrastructure and bylaw which ended up with a packed room.
  - We attend and actively participate in collaborative meetings such as the Franklin Grand Isle Community Partnership and the Franklin Grand Isle Regional Prevention Collaborative. These involvements have led to many partnerships including Vermont Adult Learning, Foster Grandparent Program,

Activities Undertaken and Planned cont.

- New Activities
  - We are seeing a strong interest in our local schools. 4 schools will be engaged in school wide competitions and classroom engagement including 3 elementary schools and one high school.
- Long-Term Activities
  - We are actively engaging in sustainability conversations and have reached out to several successful initiatives including EPODE and Prevention Together to understand how they have created a sustainable and lasting initiative. We are investing in an formal evaluation(see evaluation slide)

Providers and Beneficiaries Impacted

- *RiseVT Numbers*
- 5337 People are Rising
  - **4058 people** have seen RiseVT at events across Franklin and Grand Isle
  - **814 people** have taken the RiseVT Pledge or taken the Health Assessment
  - **151 people** have completed the RiseVT Individual Scorecard and know their score – 9 have followed up with Health Coach
  - **314 people** are using the RiseVT Wellness Dashboard & Health Coaching
- 40 Businesses
- 15 Schools

Evaluation Methodology

- We are currently finalizing an agreement with the Center for Rural Studies at the University of Vermont to conduct a formal evaluation on RiseVT to be completed by October 2016. This will be reported on in more detail during the next quarter. This is guidance we have received from the Vermont Department of Health

Expenditures to Date & Revised Budget

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

Salary	$ 115,000.00		$ 45,025.00	$ 45,025.00
Fringe	$ 133,000.00	$ 10,769.87	$ 31,452.00	$ 42,221.87
Travel	$ 20,000.00	$ 1,848.68	$ 4,194.19	$ 6,042.87
				$ -
Equipment	$ 22,000.00	$ 509.00	$ 13,509.00	$ 14,018.00
Material/Supp	$ 19,500.00	$ 3,639.33	$ 16,650.33	$ 20,289.66
other Costs	$ 90,500.00	$ 13,008.23	$ 44,546.27	$ 57,554.50
Total	$ 400,000.00	$ 29,775.11	$ 155,376.79	$ 400,000.00
	$ 400,000.00			

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

An Innovative Adaptation of the TCM in a Rural Setting

Southwestern Vermont Health Care

Date:

January 10, 2016

Reporting Period:

October 2015 – December 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. INTERACT, a long term care program for early identification of condition changes and prompt implementation of clinical interventions, demonstrated to decrease ED visits and hospital admissions, was implemented at SVHC's Center for Living and Rehabilitation.
2. Both the Transitional Care Program and the Community Care Team were recognized by the Magnet Nurse Surveyor's during the summation conference as exemplary programs during SVMC's 4th Magnet Nurse Accreditation Survey in November, during which SVMC achieved its 4th Magnet accreditation.
3. Billie Allard MS RN presented to a group of 25 Case Managers, Medical Home staff, and Nursing Administration from Rutland Hospital as they look to develop a Transitions in Care Program. Information on SVMC's Transitions Nursing Program, Community Care Team and INTERACT program was reviewed.
4. Billie Allard MS RN and Jim Poole MD rounded at area Primary Care Practices, sharing information on the Transitions in Care Program, including the Community Care Team, INTERACT program and Transitional Care Nursing.
5. Meeting held with the Medical Home Team to do a comprehensive review of what is going well with the Transitional Care Program, identify challenges and plan future work to meet the needs of area patients.

Recent Accomplishments (continued)

7. Implemented Health Promotion Advocate EMR documentation.
8. Health Promotion Advocate implemented proactive meetings on four patients with key community resources/agencies to identify and implement support services prior to next Community Care Team meeting.
9. Health Promotion Advocate implemented an open dialogue meeting with a patient with chronic mental illness and a diagnosis of schizophrenia, and her treatment team to identify additional interventions to assist patient.
7. Billie Allard MS RN has been requested to present on Transitions in Care at the upcoming New England Hospital Association Conference.
8. Billie Allard MS RN was taped for a Podcast for the upcoming World Health Congress in April where she will participate as a panelist to discuss the Creation of an Integrated Care Delivery System.
9. A meeting was held with the Care Management Team of Dartmouth-Hitchcock Medical Center to review SVMC's Transitions in Care Program.
10. Billie Allard MS RN participated in a conference call with Karen Hirschman PhD MSW, NewCourtland Team Chair in Health Transitions Research at University of Pennsylvania's School of Nursing.

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.
   - Patients continue to be referred to Express Care (on site solution for urgent needs which bridges gaps for primary care)
2. Transportation has been a challenge for many patients to get to medical appointments and services, resulting in missed appointments.
   - The contract with Village Ambulance Service has been finalized, and service initiated to provide transportation services at a lower rate for patients with transportation challenges.
3. Our Health Promotion Advocate has been accepted into Nursing School and is unable to complete in her role full time.
   - Another employee has been hired to job share the Health Promotion Advocate Role and is now in orientation, working closely with Ashley Lincoln to continue the excellent care which has been provided to our community care patients.

Challenges and Opportunities (cont.)

Opportunities

1. Success of Transitions in Care Programs has stimulated new ideas and potential to expand services in our community.
   - With the positive outcomes and recognition of these programs, we are continuing to find ways to expand the impact of our programs, these include the expansion of social work services and pharmacist integration, the addition of respiratory therapy, and a pilot program of physical therapists in the ED, to support Transitions in Care.
2. 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 the New England Hospital Association meeting and World Health Conference.
   - Conference calls and meetings with other hospitals, schools and other locations to share information and provide support for development of Transitions in Care programs in other communities.
   - Guest lecture at Southern Vermont College on Heath Care Finance Reform and Transitions in Care.

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**
  - Meeting with SVMC Hospitalists to discuss additional ways to work to increase referrals to the Transitions in Care Program.
  - Meeting with the Veterans Home to discuss the INTERACT program.
  - Present the curriculum developed for area Nursing Programs.
  - Continue Planning of Regional Conference on Transitions in Care Program.
  - Expansion of direct referrals to the TCN Nurses from the ED.
- **Long-Term Activities**
  - Expand implement of INTERACT program to other area long term care settings
  - Plan and hold Regional Conference on Transitions in Care Program in Sept. 2016
  - Implement the Transitions in Care Curriculum for area Nursing Programs, first course scheduled for Summer 2016 semester.

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
  - Turning Point – drug treatment program
  - Washington Elms Community Care Home

Number of Beneficiaries participating in/or impacted

- Transitions of Care Program

	Q1	Q2	Q3	Q 4			Total YTD
# New patient encounters	224	117	127	65			533
Total # patient interactions	554	293	376	291			1514
Home	122	73	131	120			446
Hospital	290	144	141	101			676
Phone Call	100	57	71	58			286
PCP Office	18	8	26	12			64
Nursing Home	21	9	8				38
Emergency Department	3	2	1				6

Providers and Beneficiaries Impacted (Cont.)

- Community Care Team

	Q1	Q2	Q 3	Q 4			Total	
# New Participants	5	5	9	9			28	
# Referrals/Contacts:								
Shared Living Provider Program	2						2	
BPI Adult Day Service	2			2			4	
Employment Services	1						1	
Veterans Administration	2						2	
UCS / CRT (Community Rehab & Treat)	1			1			2	
Battelle House Crisis Center	2			1			3	
Chronic Pain Program	1	2					3	
Medicaid Case Manager	2	2	4	8			16	
Traumatic Brain Injury Program	1	1	1				3	
Blueprint Case Managers		3					3	

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q3	Q 4			Total	
# Referrals/Contacts CCT (cont.)								
Medical Provider	1			2			3	
United Counseling Services	2	4	8	10			24	
Developmental Services / UCS		3		4			7	
Housing Assistance	1	1	1				3	
Vocational Rehabilitation	1	2	1	1			5	
Economic Services		3					3	
Transitional Care Nurses SVMC		1					1	
Social Services SVMC		2		2			4	
Hawthorne Recovery Program		2					2	
Court Appointed Guardianship		1	1				2	
Memory Clinic		1					1	
Department of Corrections		1	1				2	

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q 3	Q 4			Total	
# Referrals/Contacts CCT (cont.)								
VT State Field Representative			1				1	
VNA			2				2	
Family Services DCF			1				1	
Food Assistance			1				1	
Pharmacist Services			1				1	
SASH (Support and Services at Home)			2				2	
Brattleboro Retreat			1				1	
Sunrise Family Services		1					1	
Turning Point (drug treatment)				1			1	
Washington Elms Community Care Home				1			1	
Case Management SVMC				1			1	
TOTAL	19	30	25	34			108	

Providers and Beneficiaries Impacted (Cont.)

- Health Promotion Advocate (documentation in this format implemented Q 2 Aug 14, 2015)

	Q 3	Q 4				Total YTD
# New patient encounters	19	9				28
Total # patient interactions						
Phone Contacts	14	1				15
Emergency Department	19	17				36
Inpatient Hospital	2	2				4
Visit In the Community	6	7				13
Consult w Community Resource	21	23				44
Screened for CCT	3					3
Meetings / CCT Team and Indiv Pt Planning		7				7

Providers and Beneficiaries Impacted (Cont.)

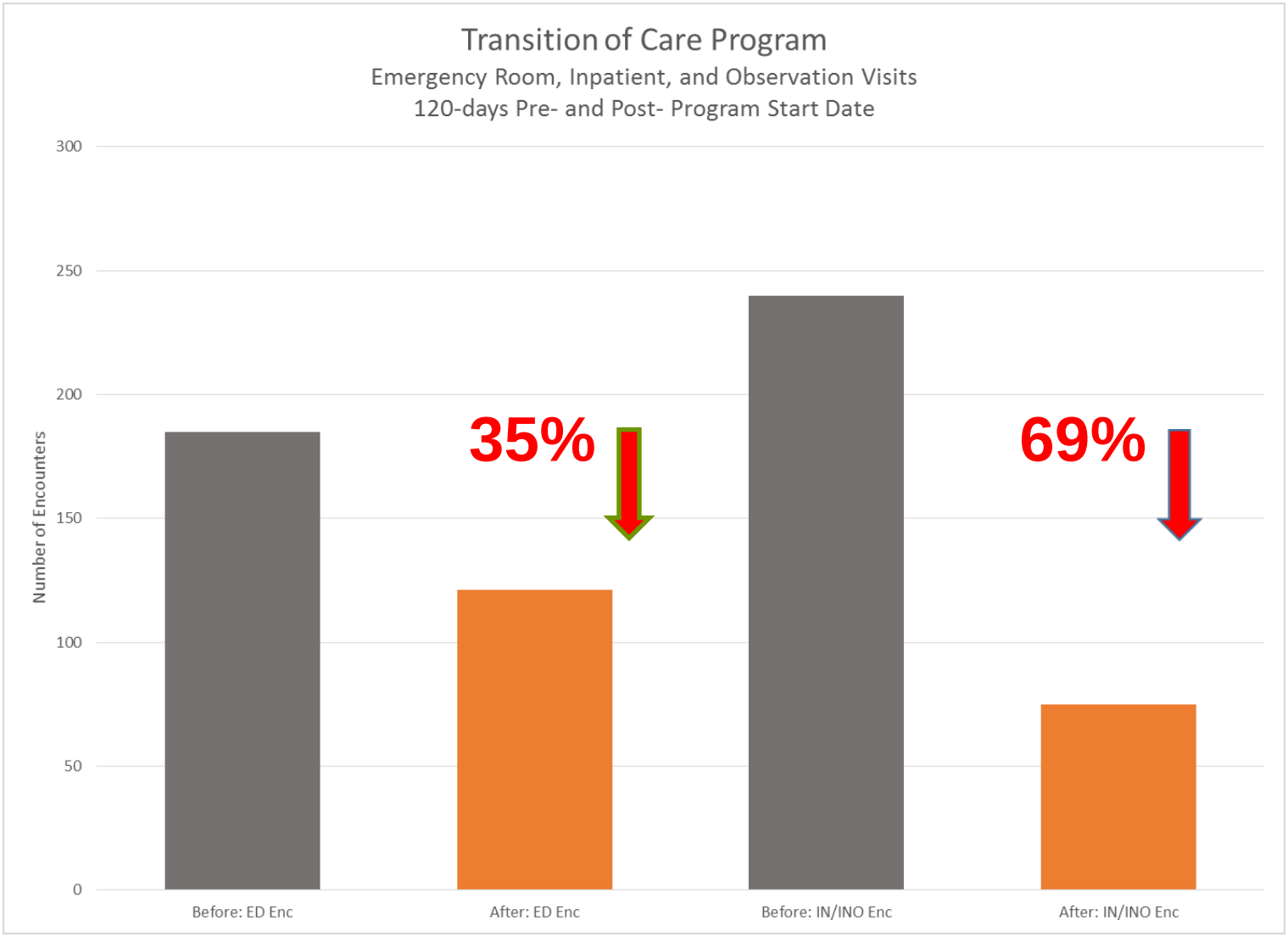
- INTERACT Program (program implemented November 11,2015)

	Sept 15	Oct 15	Nov 15	Dec 15		Total YTD
# Stop & Watches Initiated			30	22		55
# Progress Notes Written			224	159		383
# Sets of Vitals Obtained			222	158		380
% Compliance with Vitals			93.3%	94.0%		
% Compliance with Notes			88.5%	93.5%		
% Compliance with ECS Documentation			66.7%	72.7%		
% Compliance with Checklist			59.2%	90.9%		
# Transfers to ED from CLR	18	12	10	13		
# Hospital Admissions from CLR	12	10	6	9		

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.
- **INTERACT Program**
  - Number of transfers from Center for Living and Rehabilitation to ED.
  - Number of hospital admissions from Center for Living and Rehabilitation.
  - Quantitative measures – number of INTERACT interventions documented.

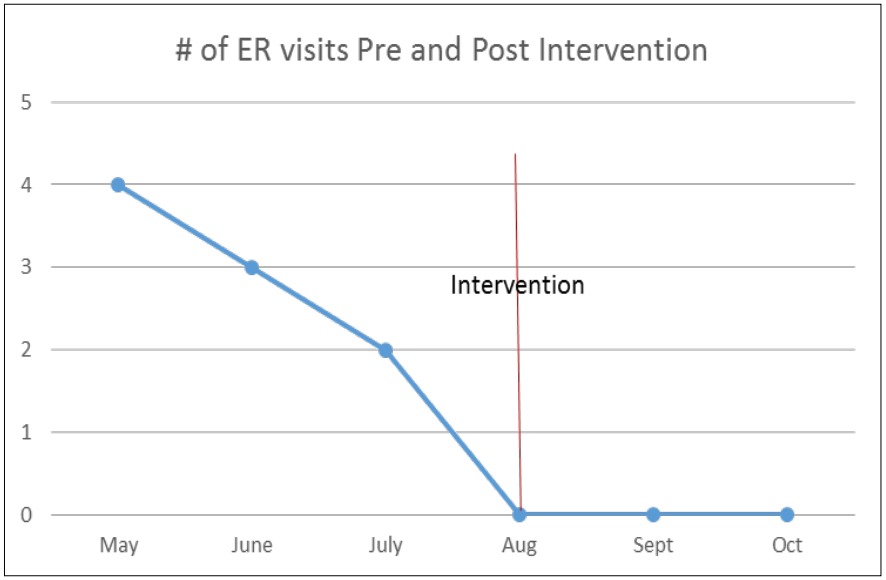
Transition of Care



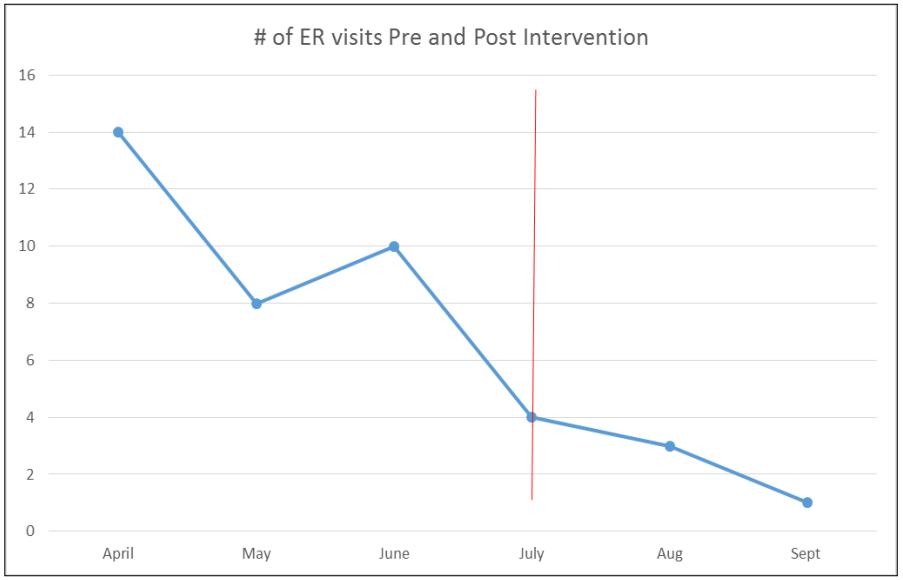
Vermont Health Care Innovation Project

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

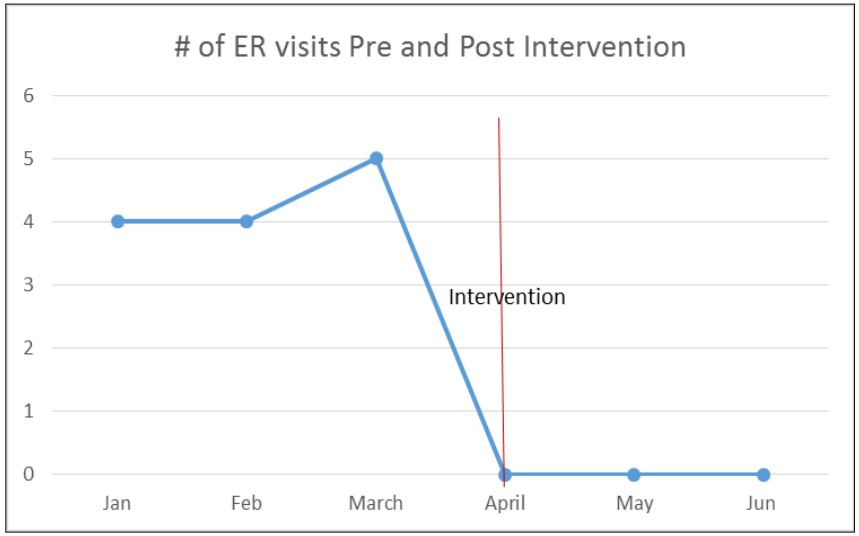


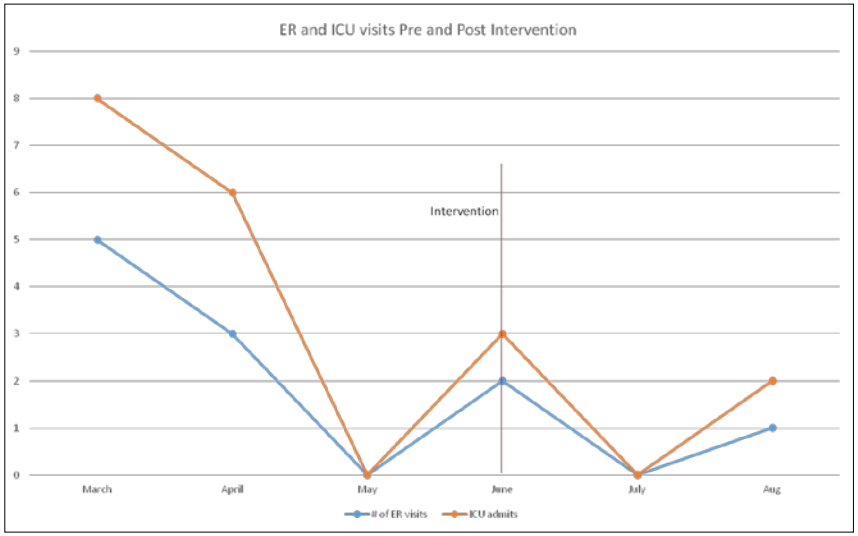
Vermont Health Care Innovation Project

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

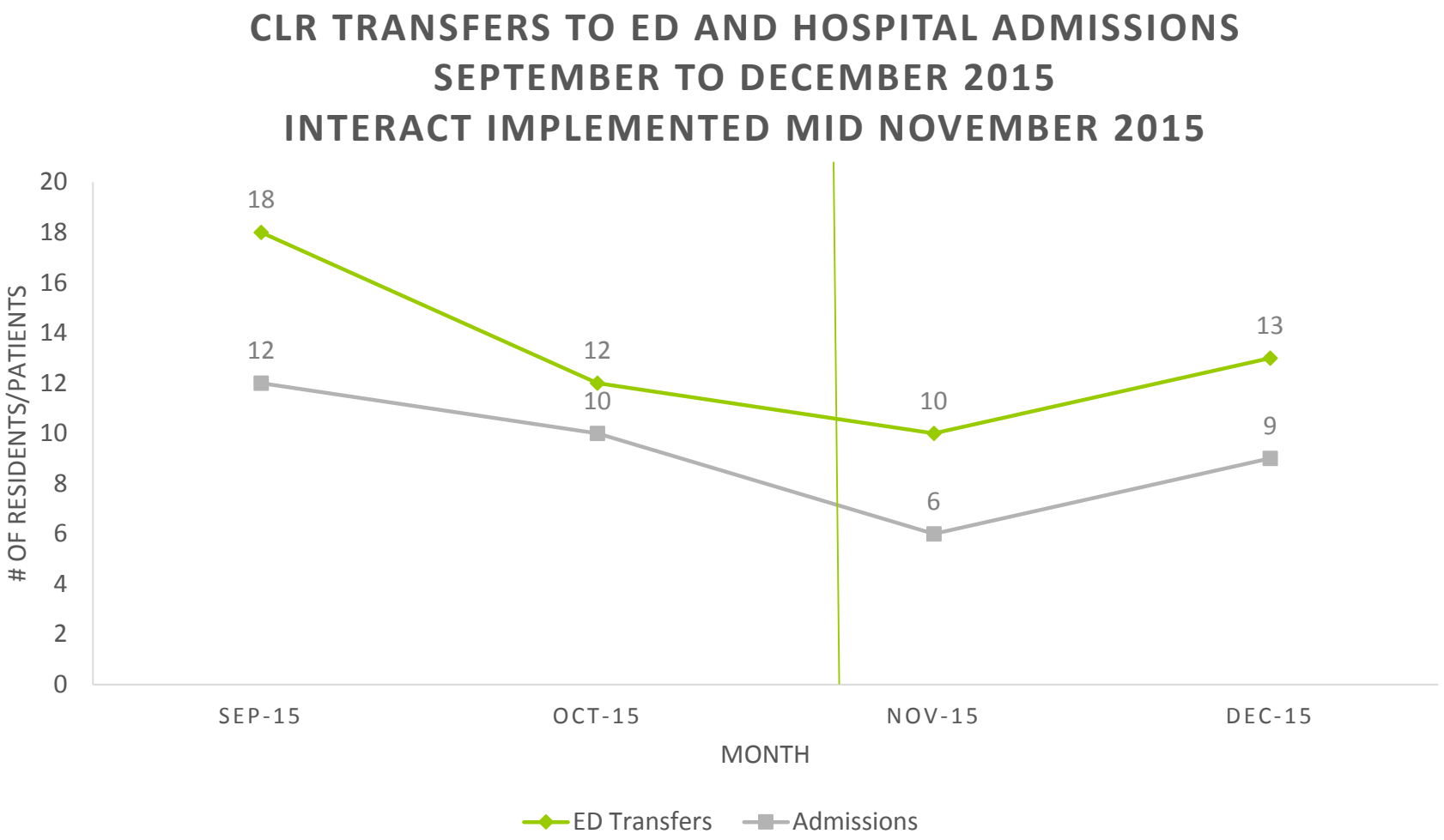




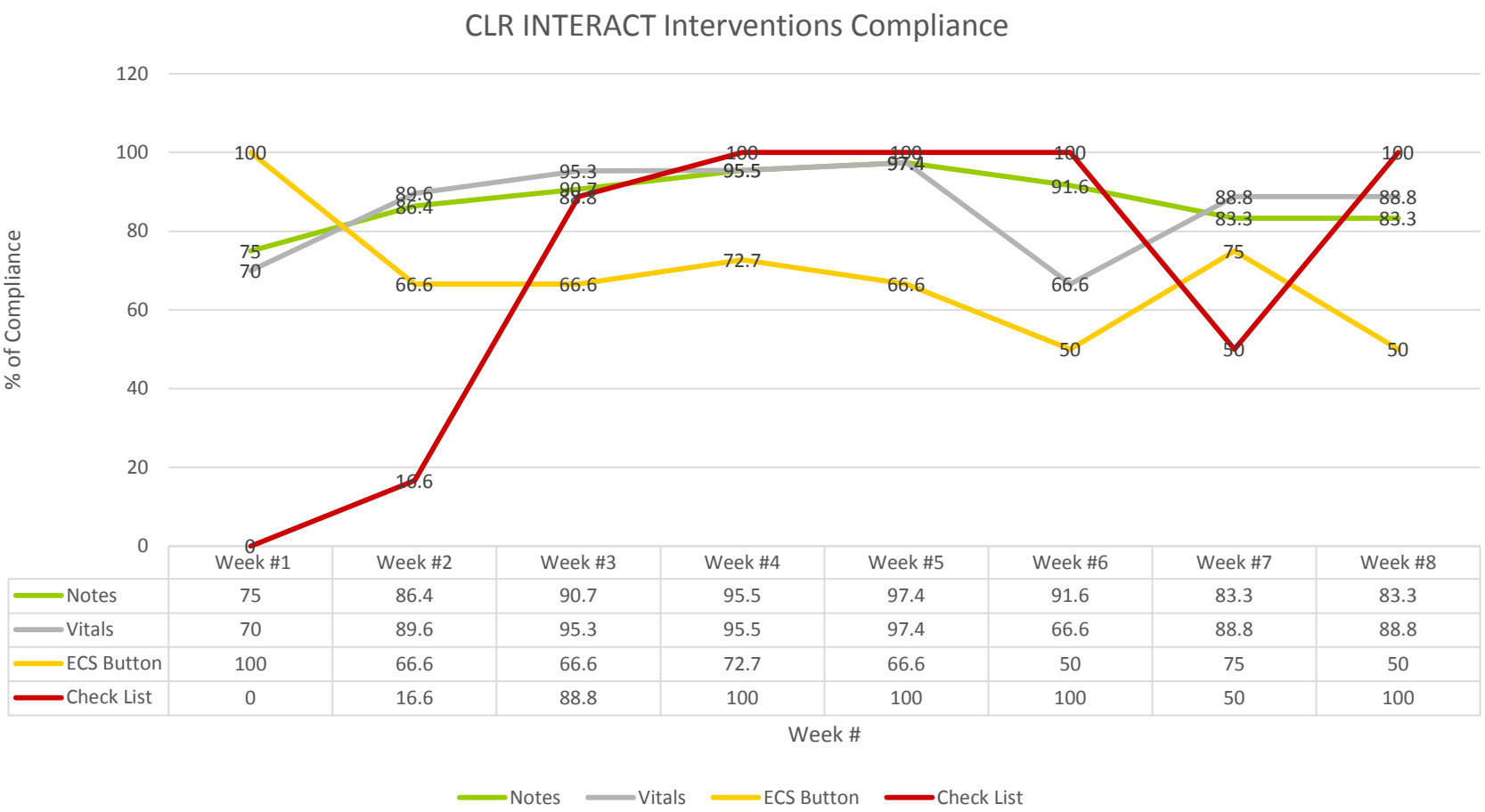
Mental Illness: A CCT Case Study

- **Background:** 2014: 23 ER visits 2015: Jan-Aug 17 visits
- **History:** Patient commonly presents to the ER for depression. Patient lives alone in an apartment in Bennington and receives services through the CRT program at United Counseling Services.
- **CCT Intervention:** In September of 2015 the patient agreed to sign consent for the Community Care Team after presenting to the ER six times in one month for suicidal ideations. When talking to the patient she expressed interest in going back to work. She said a job would give her a reason to get up every day. She missed seeing people and was sick of sitting in her apartment all alone. With the help of UCS and VocRehab the patient was able to apply for several different positions within the community. In October of 2015 the patient achieved a position at a local convenience store. On several occasions the HPA visited the patient at her job site; her smile gleams from ear to ear. Since employment the patient's ER visits have decreased to 1 visit.
- **Agencies essential to this cases success:**
- SVMC ED Health Promotion Advocate
- Vocational Rehab Program
- UCS (United Counseling Services) Job Developer
- UCS CRT(Community Rehab & Treatment)

INTERACT Program: ED visits and Hospital Admissions



INTERACT Program



	Week #1	Week #2	Week #3	Week #4	Week #5	Week #6	Week #7	Week #8
Notes	75	86.4	90.7	95.5	97.4	91.6	83.3	83.3
Vitals	70	89.6	95.3	95.5	97.4	66.6	88.8	88.8
ECS Button	100	66.6	66.6	72.7	66.6	50	75	50
Check List	0	16.6	88.8	100	100	100	50	100

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Quarter	Total Spent to Date
Salary	$ 287,310.00	$ 44,889.71	$ 51,437.06	$ 96,326.77
Fringe	$ 86,193.00	$ 13,101.06	$ 15,431.13	$ 28,532.19
Travel				
Conferences				
Equipment	$ 3,097.00	$ 1.192.16		$ 1,192.16
Contracts	$ 23,400.00			
Indirect				
Total	$ 400,000.00	$ 59,182.93	$ 66,868.19	$ 126,051.12

Briefly discuss any potential changes to the budget going forward.

No changes anticipated at this time.

Behavioral Screening and Intervention
Invest EAP

Date: January 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

- Preliminary evaluation results are showing statistically significant improvements on several health outcome measures
- Providing follow-up intervention services to employees.
- Patient Success Examples
  - Patient came to health coach looking to lose weight. She was exercising but still gaining weight. 3 months after finishing her sessions she had lost 15 pounds as a result of a different approach initiated with the health coach
  - Patient dealing with depression developed a plan to increase exercise, socialization , and healthy eating in conjunction with reframing beliefs and negative self talk . She has reported much less depressive symptoms and the ability to complete her daily tasks

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	$ 2,155.68	$ 2,215.68
Fringe	$ 8,431.00	$ 18.00	$ 1,436.77	$ 1,454.77
Travel	$ -	$ -		$ -
Conferences	$ -	$ -		$ -
Equipment	$ 5,400.00	$ 603.26	$ -	$ 603.26
Contracts	$ 21,000.00	$ 6,004.83	$ -	$ 6,004.83
Supplies	$ 370.00	$ -	$ -	$ -
Other	$ 1,680.00	$ 750.00		$ 750.00
Indirect	$ 5,467.70	$ 682.98	$ 312.18	$ 995.16
Total	$ 60,144.70	$ 8,119.07	$ 3,904.63	$ 12,023.70

Resilient Vermont
Invest EAP

Date: January 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

- Preliminary evaluation results are showing statistically significant improvements on multiple health outcome measures
- More than doubled the percentage of successful introductions of patient to health coach
- Patient Success Examples
  - Patient with health issues and long standing marital strife was able to quit a 45 year smoking habit, resolved relationship issues and gained enthusiasm for a new start with an expanded network of friends in a new environment.
  - Helped a middle aged mother utilize motivational interviewing (MI) to dramatically reduce daily drinking, develop healthy personal interests, and engage in rewarding volunteer work. She has not only lost weight but also gained friendships that enrich her life.
  - With MI a young woman was able to overcome heightened social anxiety and participate in structured activities outside of her home

Challenges and Opportunities

- The introductions between the nurses and health coach, although increasing, is still not at level to offer maximum benefit to those whom would benefit the most
  - There are reports that some nurses believe the program does not offer patient choice.
  - May simply be procedural or timing/availability issues
  - We have increased health coach on site availability by 25% to hope eradicate this
- Despite previous efforts to educate staff (nursing and administrative) more fully about project, more needs to be done.
- Continued to offer to bring Wisconsin researcher to clinic.

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 100-150 patients. We have had to significantly reduce this number due to the continued slower than projected referrals from the clinic staff.

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	$ 2,365.05	$ -	$ 2,365.05
Contracts	$ 196,260.00	$ 67,821.82	$23,036.00	$ 90,857.82
Supplies	$ 1,000.00		$40.45	$ 40.45
Other	$ 21,560.00	$ 750.00	$33.26	$ 783.26
Indirect	$ 22,722.00	$ 6,164.41	$ 2,008.23	$ 8,172.65
Total	$ 249,942.00	$ 77,101.28	$ 25,117.94	$ 102,219.23

Vermont Health Care Innovation Project
2015-2016 Quarterly Report

Pursuing High Value Care for Vermonters

VMS Foundation and UVM College of Medicine

Date: January 26th, 2016

Reporting Period: Sept 30th, 2015 – Jan 26th, 2016

Cyrus Jordan MD MPH

VHCIP Grant Cycle for this project ends June 30, 2016

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 – Oct, Nov, Dec 2015 and January 2016

- **Plenary interventions across all sites**
  - Quarterly face to face Learning Sessions
    - Oct 15, 2015 – Learning Session # 5 RRMC
    - Jan 14, 2016 – Learning Session #6 NVRH
  - Monthly Webinars for all teams and faculty
    - Nov 19, 2015 – webinar #10
    - Dec 17, 2015 – webinar #11
  - Regional comparative labs per day reports shared across all institutions
- **Hospital specific interventions**
  - UVM MC presented their educational intervention to DHMC and a community hospital
  - UVM MC CPOE templates further modified to encourage choosing orders on a daily as needed basis
  - NVRH changing monitoring tests for low dose heparin to best practice and reduced overall number of needle sticks and tests
  - NVRH CPOE alerts added to caution physicians of redundant or premature orders
  - RRMC clinical pathway for COPD refined and instituted
  - Brattleboro, NVRH posted reminders to physicians at all CPOE stations
  - CVMC reduced amounts of blood drawn per patient

Accomplishments – Oct, Nov & Dec 2015

- **Year 2 project expansion – Inpatient Management of COPD**
  - **Collection and analyses of existing institutional clinical pathways and order sets for inpatient management of acute exacerbations of COPD**
  - **Comparison of current state of care in Vermont with national consensus guideline, American Society of Hospital Medicine**
  - **Initial draft of regional consensus clinical guideline**
  - **Initial data queries of secure database focused on identifying target patient population and current state of lab ordering of patients**

The COPD expansion of the project will include consensus recommendations For ordering of all diagnostic testing, not just laboratory testing; as well as all Therapeutic interventions and discharge planning and coordination with Post discharge follow up.

Challenges to success

- **Major challenges encountered**
  - **Teams being provided the time to complete their improvement activities in their institutions**
  - **Teams being able to attend as a group to face to face Learning Sessions**
  - **Delays for project analysists getting access to uploaded data in HIPAA compliant data warehouse**
  - **Unexpected difficulties exporting data out of data warehouse**

Opportunities for programmatic support

- **Collaborative to be highlighted in a discussion with key private and public sector executives on March 4th, 2016 at Gifford Medical Center**
  - **An example of the potential for "change led from the inside out" opposed to "change forced from the outside in"**
  - **Goal for the day is to seek continued support for the Collaborative after the end of the VHCIP grant cycle in June 2016**
- **Conversations begun with alternative instate and out of state data warehouse vendors with the goal of better match between security and ease of access to protected health information**

Remaining Activities Planned

Lab Collaborative Continuation

- Learning Sessions 8:30 AM to 3:30 PM
  - Thursday, April 14th, 2016- DHMC
  - Thursday, June 9th, 2016- UVM MC

- Webinars- 2:00 PM – 3:00 PM
  - Thursday, February 18th, 2016
  - Thursday, March 24th, 2016
  - Thursday, May 12th, 2016
- Full faculty meetings 4 weeks prior to each LS
- Operational weekly faculty meetings every Monday

VHCIP Grant Cycle for this project ends June 30, 2016

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 Nov 30, 2015

	Approved Budget	Total Spent to Date	% Spend	% Grant Cycle
VMS Foundation	$ 153,912	$ 93,743	61%	71%
UVM Pathology	$ 98,401	$ 61,111	62%	71%
UVM Medicine	$ 273,301	$ 188,682	69%	71%
Hospital support	$ 23,214	$ 16,030	69%	71%
Total	$ 548,828	$ 359,566	66%	71%

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

VHCIP Grant Cycle for this project ends June 30, 2016

State Innovation Model Grant
White River Family Practice

Date: January 2016

Reporting Period: July 2015 through January 2016

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
  - Reduction in hospital use (DHMC) among targeted at-risk group.
- Continued efforts to engage the entire office
  - Intra-office newsletter (continues, sent monthly to SIM team)
  - Office-wide report of health confidence data

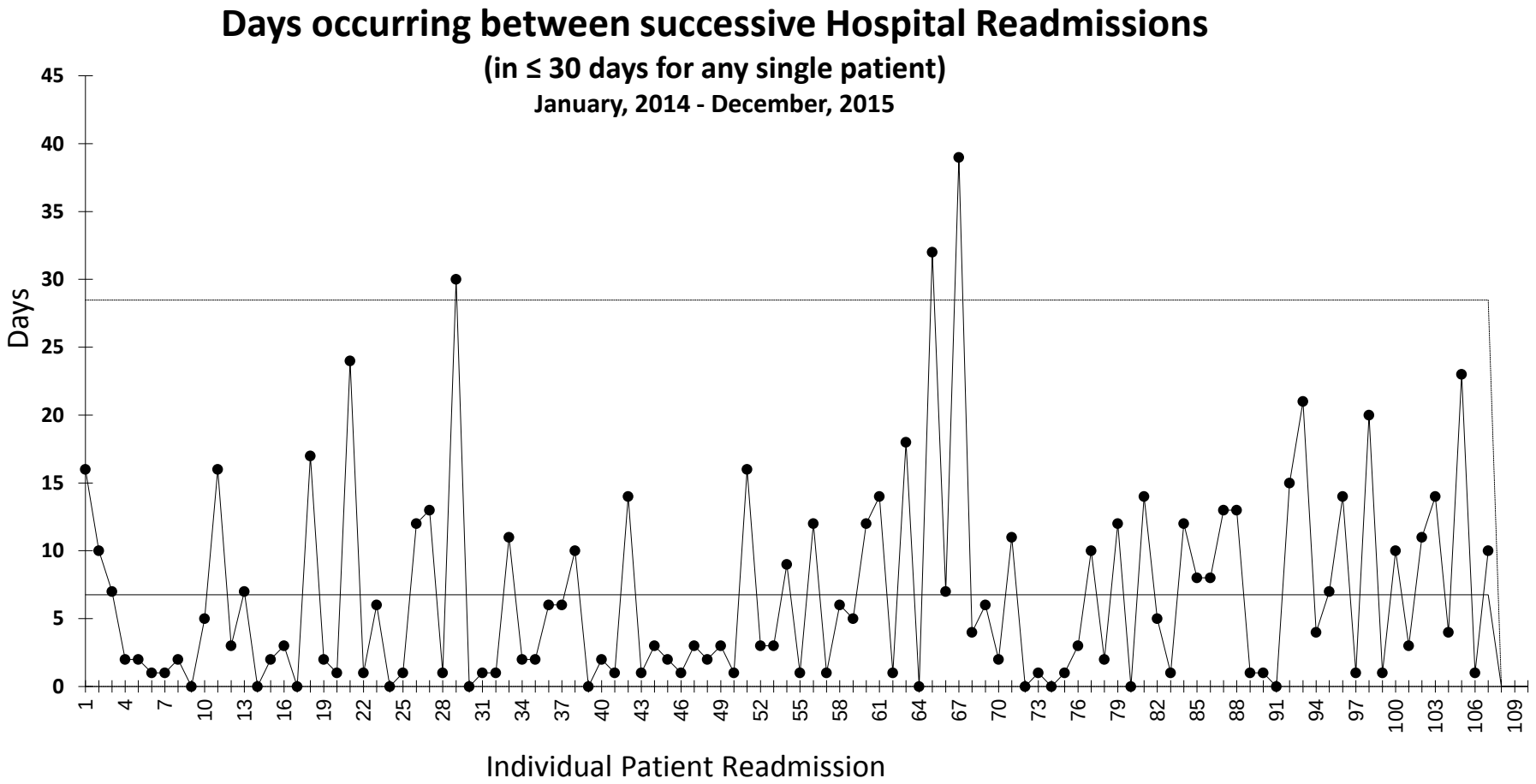
Recent Accomplishments

- Presentation of findings to date to groups who may help facilitate in the future
  - CMMI ONC
  - Dartmouth Hitchcock Medical Center
  - BCBSVT
  - Mount Ascutney Hospital – HSA Coordinated Care Committee

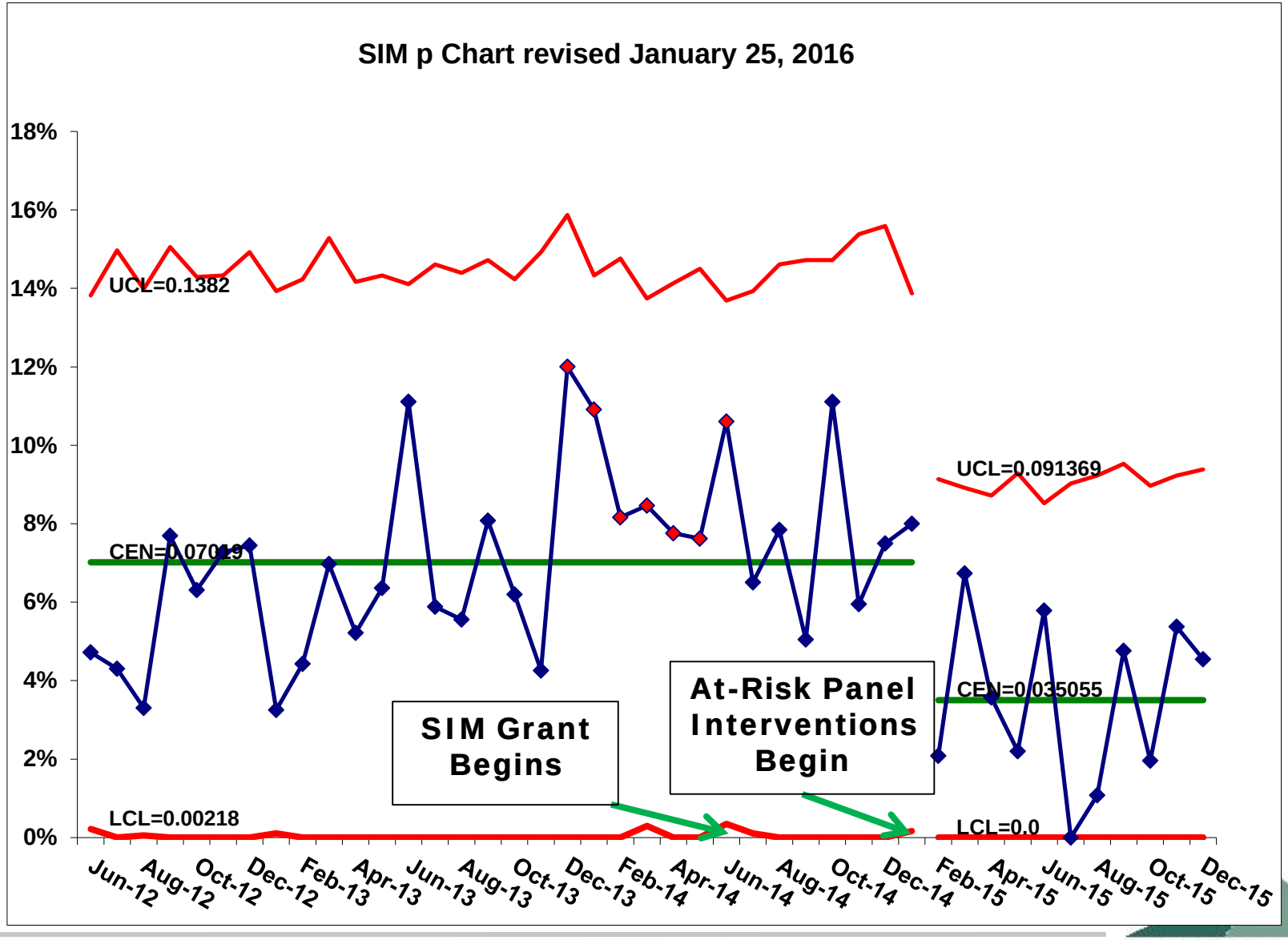
Evaluation Methodology

- 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 at-risk cohort
- We have used our internal data gathered with respect to patient-reported confidence to manage their health issues.
- See following slides

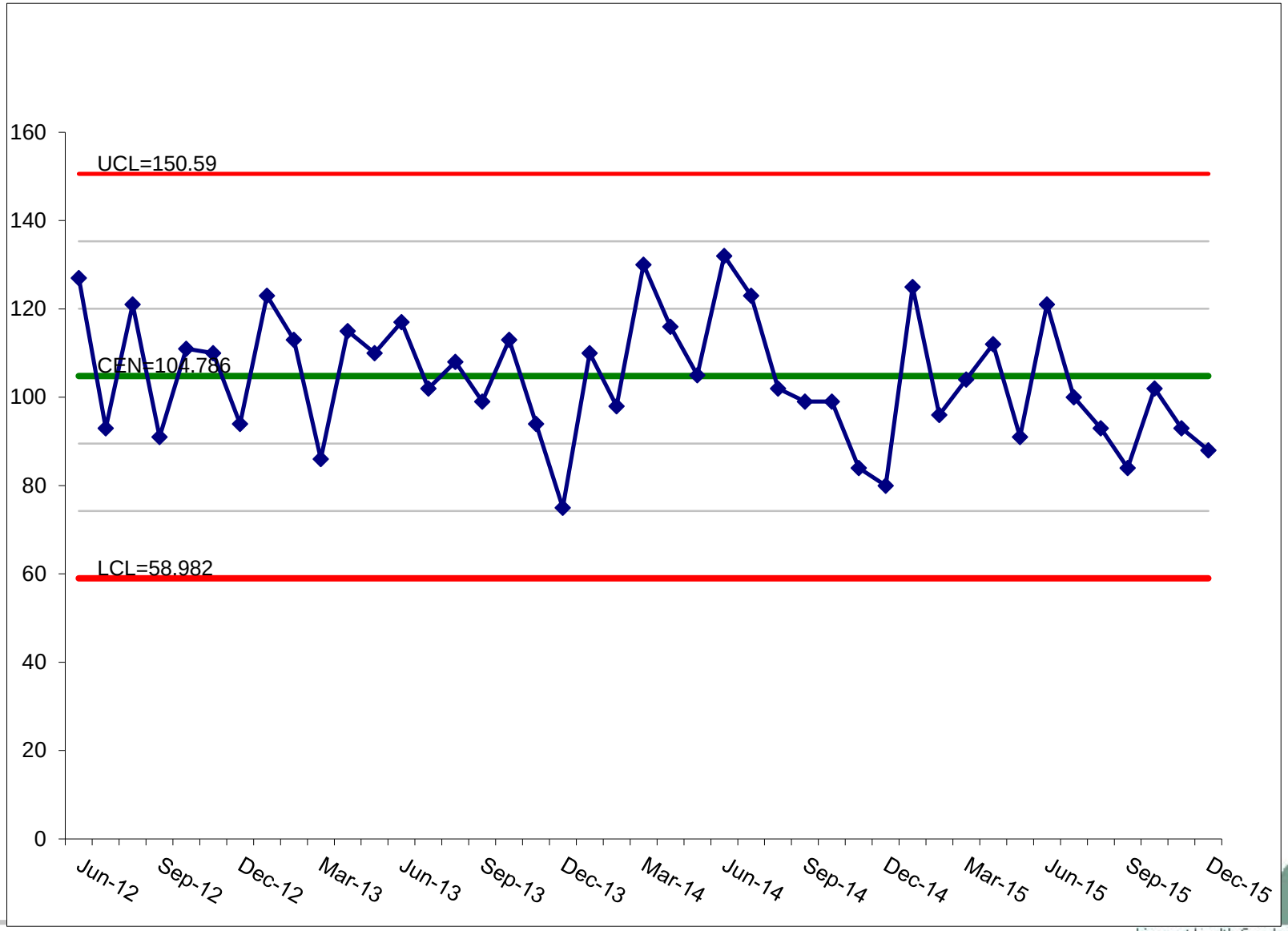
Using Statistical Process Control analyses…



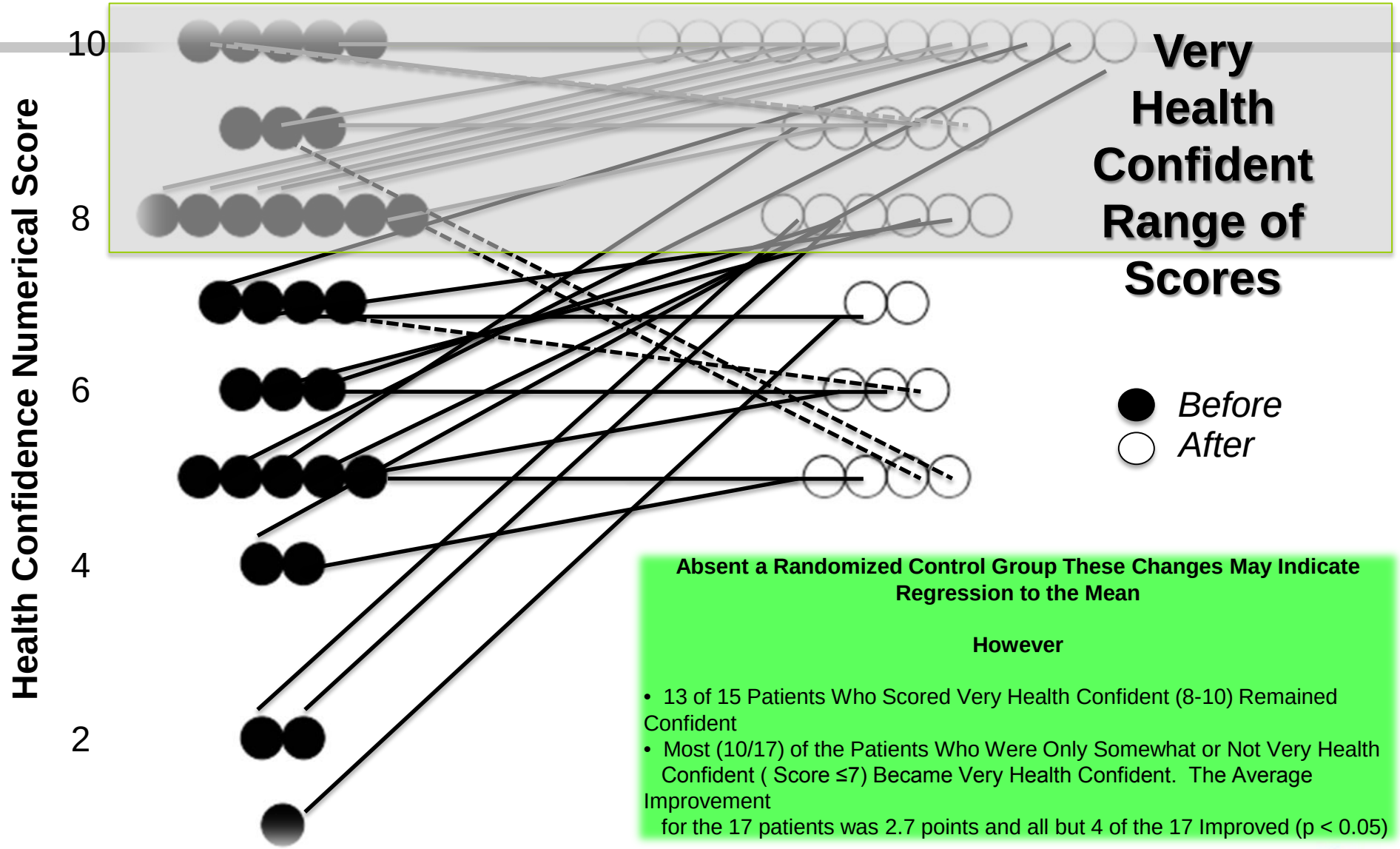
The % of all WRFP patients' encounters at DHMC attributable to patients in the At-Risk cohort



Number of WRFP Patients receiving care at DHMC (Admissions and ED visits) each month



Details for Intensive Intervention Patients



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

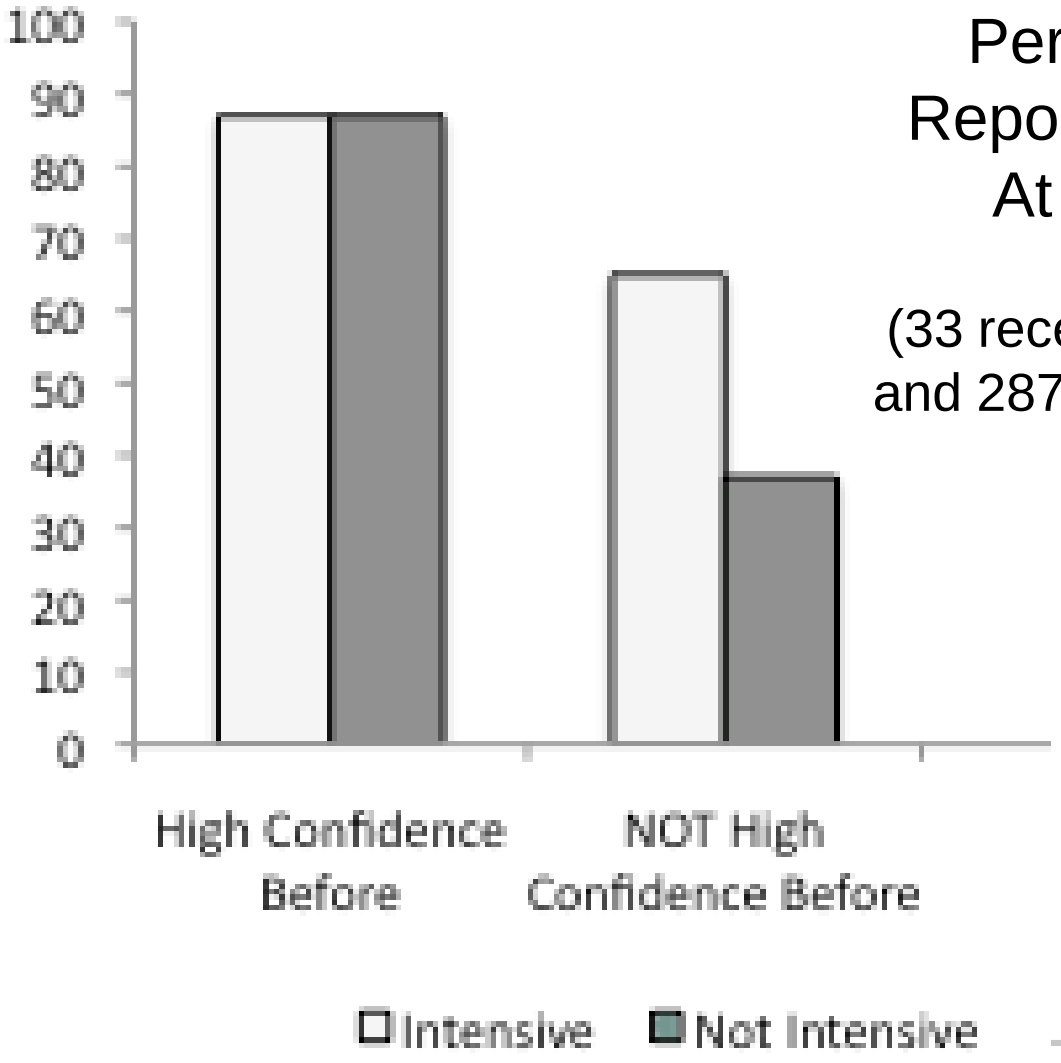
However

- 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

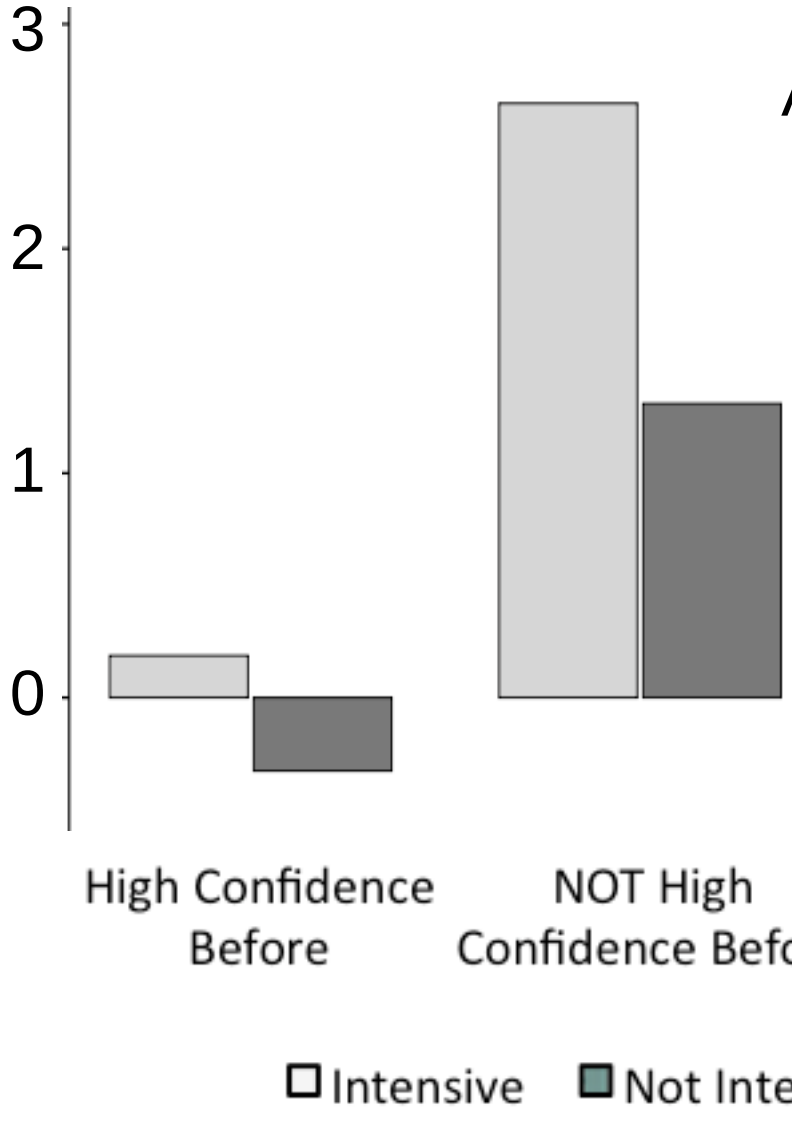


Percentage of Patients Reporting High Confidence At A Later Office Visit

(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.

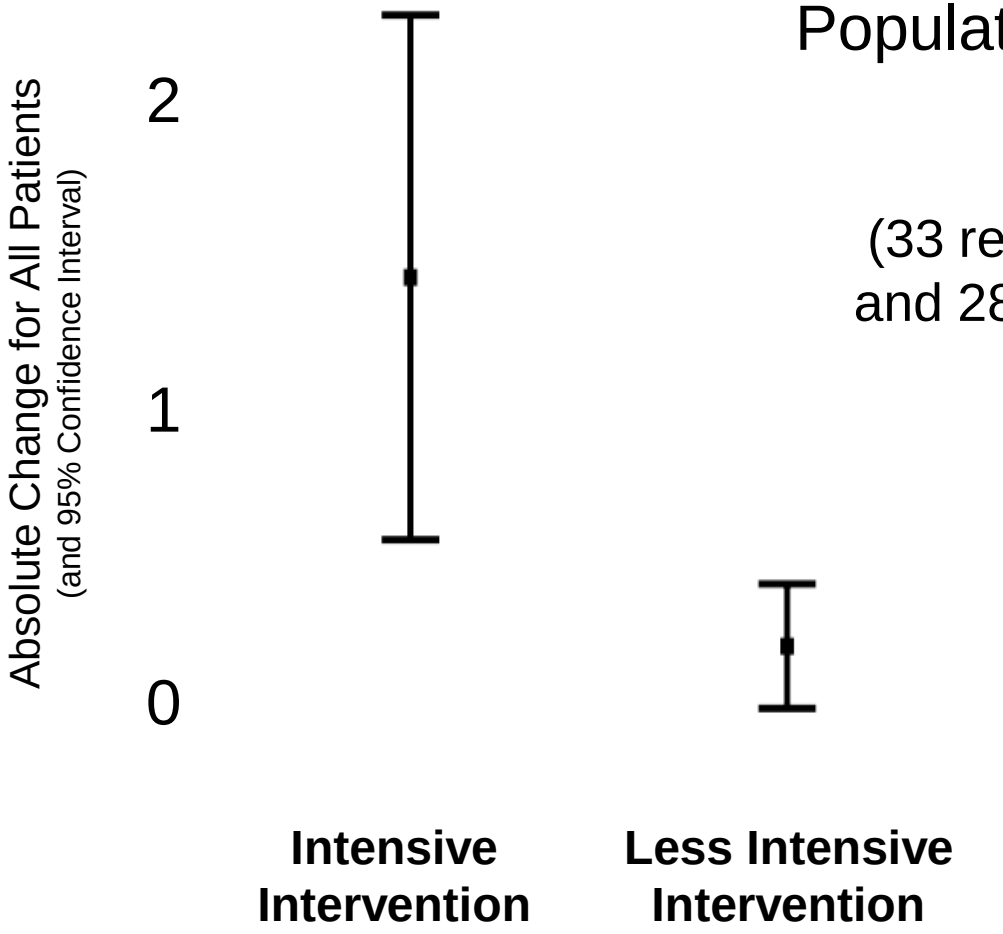


Average Change in Confidence On a 0-10 Scale for Patients At A Later Office Visit

(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 use of Health Confidence to better refine the use of our clinical resources towards patients who are at higher risk of poor health outcomes
- Optimally utilize 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 observed trends reflect a long-term and sustainable increase in Health Confidence and concomitant decrease in health care cost through decreased ER and hospital admissions.

Challenges

- In the past 18 months, no payers other than BCBSVT and DVHA have provided claims data, significantly handicapping our risk-stratification.
- Claims data from CMS likewise is unavailable, despite Medicare patients being disproportionately represented among older patients with multiple chronic diseases.
- Limited resources at both WRFP & DHMC have precluded more robust collaboration with the DHMC ER high-utilizer project.

Challenges

- Key WRFP personnel have been stressed to lead WRFP's successful grant work while also responding to requests for additional grant-related documentation.
- Uncertainty regarding CMMI repayments has compromised WRFP's ability to deploy grant resources in the few remaining months to achieve SIM Grant goals.
- *The biggest challenge to our work in the SIM grant has become the grant itself.*

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
  - Intensive Care Coordination among at-risk patients
  - Analysis of health confidence data collected serially (contained here)
- New Activities
  - Preparation and submission of scholarly paper to Family Practice Management
  - Presentation to the Feb., 2016 Dartmouth Primary Care Co-op meeting
- Long-Term & Continuing Activities
  - Development of interventions targeted at patients with low self-confidence and/or high utilization, particularly self care plans.
  - Working with community partners to identify additional ways to communicate with our patients.

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.
  - 7,557 patients seen at WRFP between 1/1/15 – 12/31/15
  - WRFP averages 33 admissions per month to DHMC
  - WRFP averages 72 ER visits per month to DHMC

Expenditures to Date & Revised Budget

Invoice#10 **Date:** **1/12/2016**

Agreement # 03410-1280-15

White River Family Practice	Start 7/1/14 **24 Month** **Award $:**	(Awardee to complete) **Current Month** **Spending**		**Reconciliation: Cumulative** **Spend to date:**	Award Balance
Toni Apgar	99,008.00		$6,433	70,655.00	28,353.00
Lexi Burroughs	20,000.00	869.50		14,781.50	5,218.50
Sean Uiterwyk, M.D.	23,100.00			17,073.78	
Jill Blumberg, M.D.	-		$1,004.34	-	9,039.24
Total Salary	142,108.00	8,307.32		102,510.28	39,597.72
Fringe	17,168.00		$750	12,698.43	4,469.57
Conference Travel	3,000.00			3,138.00	(138.00)
Supplies	500.00			897.39	(397.39)
Equipment	36,818.00			16,364.88	20,453.12
Mark Nunlist, MD	115,200.00		$5,005.00	87,867.40	27,332.60
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	24,395.68	8,610.32
Total :	$ 363,070.00	**15,497.36**		**258,280.56**	104,789.44
Less: unspent Advances					
Net Invoice :		**15,497.36**			

Expenditures to Date & Revised Budget

- We will submit our budget change requests in a separate document.
- We do not have any forecasted travel plans.

SIM Funding for Infrastructure Building

Health*first,* Inc.

Date: **October January 8, 2016**

Reporting Period: **October 1 – December 31, 2015**

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

Amy Cooper, Executive Director, HealthFirst

Grant Project Goals

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

Grant Project Goals

6. Obtain board and membership approvals for Collaborative Care Agreement ***(Q4 2014-Q1 2015) - completed***
7. Create a stipend policy for physicians representing subrecipient in the state healthcare reform meetings to encourage broad participation ***(Q3 2014) - completed***
8. Develop processes for collection of clinical quality measures from member physicians' electronic medical records in collaboration with payers and other entities ***(Q3 2014-Q3 2015) - completed***
9. Redesign subrecipient's website to increase member physician use and public outreach ***(Beginning Q1 2015) - 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:** The 2015 data collection kicked off with the first of six chart abstraction webinar sessions in mid-December. HealthFirst, OneCare, and CHAC collaborated to create materials for the sessions, each of which cover the same basic material. With our network of "office champions" already established and our Quality and Care Coordination Manager in place, we anticipate that the 2015 data collection will run smoothly and look forward to comparing 2014 results with those in 2015, which will help us support our commercial ACO practices in continuous improvement and reform efforts.
- **2** - **Goal 9. Website redesign:** After a "soft launch" of the new website in September and "full launch" in early October, we called on our Consumer Advisory Board members to serve as a focus group for user feedback for the site at their October meeting. Discussion covered everything from the overall presentation to navigability, with several excellent suggestions for making our member directory more user friendly and for reimagining the presentation of our ACO quality data. Some of the more simple changes inspired by the feedback have already been made, and we are working with our web designer to make some of the more significant changes. We know that a website is never really "done," but we are confident that the current changes will strengthen the usability and usefulness of this resource.

Recent Accomplishments

- **3 - Goals 10 and 11. Quality and Care Coordination Manager and architecting disease management programs:** The addition of Susan Ridzon as QCCM to HealthFirst's staff has been a boon. Recently, Ms. Ridzon undertook an analysis of Blueprint Practice Profiles for HealthFirst practices, comparing HF practices' performances to one another as well as to local and statewide performance results. In addition, she started matching lower and higher performing practices, with an immediate goal of creating best practice mentoring for the implementation of quality measures. Looking ahead, these activities are essential first steps in developing new, and improving existing, chronic disease management strategies across our member practices, which in turn will support our efforts to establish a fully clinically integrated network.

Recent Accomplishments

- **4 - Goal 13. Education materials and resources:** HealthFirst was busy with outreach during the past quarter. In October, we hosted a free **risk management seminar** for member practices presented by Coverys, the medical malpractice insurance carrier we work with for our group purchasing benefit. About a quarter of our member practices sent staff to the event, and we received very positive feedback. In early November, we created a **one-page quality results fact sheet using 2014 data**. The sheet was developed for a patient audience and, at our annual meeting, members were encouraged to take one or more laminated copies for their waiting rooms. Also at our annual meeting, we distributed **free copies of event speaker Gilbert Welch's recent book, *Less Medicine, More Health: 7 Assumptions That Drive Too Much Medical Care***, which focuses on consumer education about informed decision making in healthcare. As noted above, in December, we also reached out to commercial ACO practices with **webinar opportunitie**s for the upcoming quality data collection. Finally, perhaps our most significant outreach efforts of the past quarter have been keeping our membership apprised of the **all-payer waiver workgroup**, its purpose, goals, process, and progress. HF has been very fortunate to have PCPs Dr. Paul Reiss and Dr. Joe Haddock serve on the main workgroup as well as several subcommittees and to also have a few of our specialist members participate in relevant subcommittees. Their participation is essential in helping our members understand this highly complex process and its possible outcomes for providers.

Recent Accomplishments

- **5 - Goal 16. Support the shared learning clinical implementation committee:** This committee continues to meet quarterly and the feedback from committee members – practice managers from several practices and HF clinical quality staff – provides invaluable insight into the "on-the-ground" impacts of healthcare reform initiatives and programs. At its last quarterly meeting in November 2015, the group discussed the possibility of convening an annual or bi-annual meeting for managers from all HF practices to come together to share best practices and find support for some of the challenges independent practices face in the state's ever-changing healthcare environment.

Challenges

- **Physician liaison stipend funding:** As noted in our October 2015 report, we have successfully recruited several member physicians to be our liaisons for various state-level healthcare reform initiatives. One of the biggest challenges related to this initiative this past quarter has been CMMI's unexpected scrutiny of funding for stipends for these efforts. While we appreciate the imperative of accountability for federal funding, we are frustrated that the state has been obligated to withhold this funding, even temporarily, as it was specifically granted under the second round of SIM grants to ensure that, along with OneCare and CHAC, HF can participate fully in the many state-level innovation initiatives being funded through the grant program. The withhold compels HF to delay stipends promised to our liaisons, who, unlike hospital- or FQHC-employed practitioners, are compensated only when they see patients. Though modest, the stipends we offer help offset liaisons' loss of patient care time and income, making it possible for them to support their independent colleagues around the state through this work. We are hopeful that the documentation HF has provided will be reviewed quickly and favorably, resolving federal concerns about "double dipping" by our independent physicians.

Activities Undertaken and Planned

Undertaken

- **Blueprint survey:** Prompted by program feedback from our participating member practices, a small committee of HF staff and HF Blueprint physicians developed a brief Survey Monkey survey for distribution to physicians and practice managers at both HF and non-HF Blueprint practices. The survey included three sections – demographics, program feedback, and an open response – and was open from mid-October until the end of November. We received 80 completed surveys, with 64% coming from independent practices, 21% from hospital-owned practices and the remaining 15% from FQHCs. Just over half of respondents' practices are part of the Burlington HSA and more than 60% are family medicine practices. Across provider types, programmatic impacts on patient care were consistently rated positively. In contrast, the majority of respondents indicated that administrative burdens (e.g., staff time, documentation, reporting) increased or significantly increased under the program, and there was agreement that the level of financial support for practices to implement the model is inadequate.

(continued on next slide)

Activities Undertaken and Planned

- **Blueprint survey (cont.):** A significant number of respondents reported that they do not feel that they have any meaningful influence over the design, evaluation, and implementation of the program, but an even higher percentage of respondents indicated that they would like to have more opportunities to participate in these activities. Overall, the survey results were consistent with informal feedback about the program's challenges for practitioners and benefits for patients, but we were interested to see the high level of interest by practitioners to work with the program to improve the practice experience, particularly around financial and administrative structures. We are happy to share our full report of final survey results.

Activities Undertaken and Planned

Undertaken

- **Annual meeting:** HF held its annual member meeting and speaker panel on Saturday, November 14, at the Catamount Country Club in Williston. About 50 HF members attended the morning member meeting, and they were joined by 15-20 additional guests for lunch and the afternoon program of speakers and a culminating speaker panel. In the member meeting, HF announced results of board member elections, which resulted in a changeover of five seats, two to former board members rejoining the group and three to new members to the board. The afternoon opened with a dynamic and highly engaging talk by 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, who spoke about strategies practitioners can use when talking with patients about the costs (financial and practical) of unnecessary medical tests. Dr. Welch was very well-received

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Activities Undertaken and Planned

Undertaken

- **Annual meeting (cont.):** and many attendees seemed eager to implement his suggestions for improving patient outcomes. Our second speaker, Ailene Thiel, a principal with GesaWorld, presented the preliminary results of HealthFirst's clinical integration assessment. Her talk helped guests understand not only the complexities involved in developing a fully clinically integrated a network, but also showed that HealthFirst is on track to achieve clinical integration with our member network. Finally, Vermont Senator Tim Ashe talked about healthcare reform and how he anticipates it will be handled in the upcoming legislative session. Many guests appreciated the opportunity to hear about the legislative process as it pertains to HealthFirst's legislative goals and expressed interest in having a similar presentation at next year's meeting.

Activities Undertaken and Planned

Ongoing Activities

- **GesaWorld/Clinically Integrated Network:** In early November, HealthFirst completed an initial evaluation of where we fall on the continuum in our efforts to clinically integrate our network of member practices. In the coming months, our board of directors will review those results more closely to determine our best next steps for working with the consultants and for using the evaluation to inform strategic planning around our collaborative care agreement and clinical integration.

- **Wakely Actuarial:** We are pleased with the work we have done with Wakely Actuarial, whose services we are accessing through technical assistance under the grant. Wakely reviewed VHCURES data for VCP and BCBSVT commercial claims for our attributed lives. The resulting analysis will be instrumental in helping us assess which lines of business VCP practices may be able to assume risk for in the future, which supports our efforts to become a more sophisticated network that can be more accountable for the total cost of care.

Providers and Beneficiaries Impacted

- **Number of Providers:** Healthfirst counts more than 140 independent physicians among its members and we estimate that, collectively, our member practices at least 75 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 140+ independent physician members, both PCP and specialist, at 65+ 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. *(continued on next slide)*

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.

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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: October to December 2015

HealthFirst, Inc. - SIM Grant #03410-1305-15					
Financial Report: Oct 2015-Dec 2015					
	Approved Budget	Spent Prior Quarter	Spent Current Quarter	Spent to Date	Balance
Staff Wages					
Executive Director	$147,000.00	$19,980.12	$19,980.12	$107,039.74	$39,960.26
Administrative Assistant	$50,750.00	$6,437.52	$6,437.52	$33,708.34	$17,041.66
Operations Director	$63,000.00	$9,321.45	$9,321.45	$44,357.16	$18,642.84
Clinical Lead, Other MD	$60,900.00	$7,725.00	$8,725.00	$40,200.00	$20,700.00
Quality & Care Coord. Mgr.	$65,000.00	$16,249.98	$16,249.98	$32,499.96	$32,500.04
Fringes	$0.00	$0.00	$0.00	$0.00	$0.00
Total Wages	**$386,650.00**	**$59,714.07**	**$60,714.07**	**$257,805.20**	**$128,844.80**
Consultants					
Local Physician Liaison Team	$52,000.00	$12,887.50	$11,056.25	$35,186.25	$16,813.75
Legal services, HR, IT, other contracts	$100,864.00	$14,455.41	$10,628.75	$52,039.16	$48,824.84
Total Consultants	**$152,864.00**	**$27,342.91**	**$21,685.00**	**$87,225.41**	**$65,638.59**
Office					
Rent	$28,400.00	$3,474.25	$3,567.72	$20,279.28	$8,120.72
Utilities	$4,200.00	$449.16	$464.76	$2,743.36	$1,456.64
Supplies (incld computers, communication)	$14,000.00	$3,632.64	$1,955.90	$13,559.43	$440.57
Meetings and travel	$8,250.00	$614.10	$755.55	$7,907.50	$342.50
Bi-annual meeting	$3,236.00	$500.00	$1,500.00	$3,236.24	($0.24)
Outreach	$2,400.00	$0.00	$2,437.18	$2,437.18	($37.18)
Total Office	**$60,486.00**	**$8,670.15**	**$10,681.11**	**$50,162.99**	**$10,323.01**
TOTALS	**$600,000.00**	**$95,727.13**	**$93,080.18**	**$395,193.60**	**$204,806.40**

Budget Notes

Potential Budget Changes

- In December, HealthFirst submitted a request for (1) an extension of our SIM grant until October 31, 2016, (2) permission to use surplus funding from year 1 of the grant to support work in the period of the grant extension, and (3) approval of budget revisions to reallocate funding based on projected needs for the remainder of the grant.