VHCIP Provider Sub-grant
First Quarter 2016
Quarterly Program Reports

Screening in the Medical home (SiMH)

University of Vermont Health Network-Central Vermont Medical Center

Date April 10, 2016

Reporting Period:

2nd Year Second 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

- We have integrated the SBIRT model into five medical homes, Granite City Primary Care, and Women's Health Clinic here at UVMHN-CVMC. All together over 6,192* patients have been screen for risky alcohol use and 5,488 have been screened for risky drug use. Of those patients screened 332 have received Brief Interventions by our clinicians, and of those, 228 were referred to Brief Treatment. Regardless of if a brief intervention was performed, since April of 2015, 742 SBIRT referrals were made by providers, 383 patients have engaged in a Brief Treatment session with our clinicians and 191 patients are currently engaged in either brief treatment or follow up on referral concerns.
- The tobacco intervention and treatment services offered through this grant have been highly utilized. The medical homes and Granite City Primary Care have screened over 21,565 patients for tobacco use with 4,874 of patients screening positive as current tobacco users. Of those tobacco users, 344 were referred to our SBIRT clinicians, 206 received a brief intervention, and 68 engaged in brief treatment. To date, 24 brief treatment patients report being smoke free, 30 patients report reducing tobacco intake by an average of 50%, 1 patient reports no change, and 14 patients are enrolled to start brief treatment sessions.
- Nurses at several medical homes have expressed interest in motivational interviewing training to increase their screening effectiveness. Four nurses have completed a series of motivational interviewing trainings and several more are scheduled to engage in the motivational interviewing trainings later this month.
- We are working on our strategic plan for sustaining SBIRT services in the medical homes once the grant expires. At this point we anticipate continuation of the alcohol and drug SBIRT screening model through the current infrastructure and will be transitioning our SBIRT clinicians into psychotherapist positions based on a fee for service model. However this approach will impact the availability of the clinician to do the brief interventions, a key component of the SBIRT model. We hope to train our Community Health Team members to be able to perform brief interventions so they will be able to fill the anticipated gap in the SBIRT model

*Screening data includes women's Health Clinic site

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.
  - Motivational interviewing trainings to increase screening and intervention effectiveness.
- New Activities
  - Kara Dudman, one of our full time clinicians accepted the .6 hospital/medical home hybrid position so we are now looking to fill a full time position in the medical homes. In the meanwhile, Project Manager Ginger Cloud, LCMHC, LADC will be covering the vacant position in the practices. Once we have our vacant clinician position filled, we will have an increased presence in the two pediatric practices at CVMC.
  - CRAFFT adolescent screening cards for providers, drinking limits cards and brief intervention cards for providers – see SBIRT Resources slides.
- 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, with specific concern regarding ability to continue to support tobacco interventions, treatment and brief interventions for all substances.

Challenges and Opportunities

- Two medical homes (Family Medicine Berlin and Family Medicine Waterbury) continue to experience systematic barriers to the implementation of the screening model and remain in a semi-integrated state. At each practice the SBIRT clinician is utilized and more often than not has a full schedule of brief treatment patient visits.

- As we move forward on sustainability planning we are struggling to find a solution to transitioning the tobacco intervention and treatment component of our SBIRT project. Currently tobacco cessation counseling is not reimbursed at a comparable rate to substance abuse or mental health counseling and therefore sustaining a master's level clinician for these session appears grim. The tobacco intervention and treatment component of this SBIRT model has been huge. Tobacco users have been high utilizers of the services and are the most common referral from providers. Moreover receiving skilled counseling services for tobacco cessation appears to be making a significant impact on successful quit attempts among our patient population.

- Later this month our SBIRT team will meet with Vermont Department of Health Tobacco Control representatives to ascertain how we can work together to continue to our tobacco intervention and treatment process in the medical homes.

- Our data analyst is out on medical leave and consequently our data report is presented this quarter in overall screen instead of practice by practice.

Providers and Beneficiaries Impacted

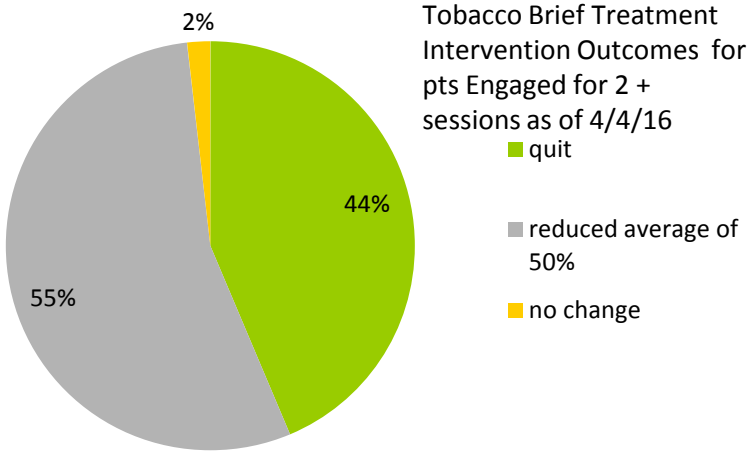
FTE Category	BIM	MIFH	CVPC	WMA	GCPC	MRFP
MD FTE's	3.66	3	4.48	3.93	1	1.3
NP/PA FTE's	1.35	2.69	2.97	0.8	0.6	1
Total Provider FTEs	5.01	5.69	7.45	4.73	1.6	2.3
Clinical Coordinator	0.81	1.1	1	1	1	1
Office RN	4.2	4.1	4.58	4	1	2.5
Office LPN	0.83	0.97	4.12	0	0	0
MA/CCA	0.11	3.62	0	1	1	0
Clinical FTEs	**5.95**	**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 throughout 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.
- 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.

Identified Tobacco Users by Site, Interventions, Brief Treatment and Referrals

Practice	Pt Screened	Positive	Brief Intervention	Referrals
BIM	3420	949	64	105
CVPC	5635	1495	31	76
CGPC	1024	175	14	31
WMA	4622	974	7	25
MRFP	2488	458	11	27
MIFH	4376	823	79	80
Tobacco totals	21565	4874	206	344



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

Total Tobacco smokers Engaged in Brief Treatment 2 + sessions			55
quit	24	44%	
reduced average of 50%	30	55%	
no change	1	2%	
new engagement	14		

Vermont Health Care Innovation Project

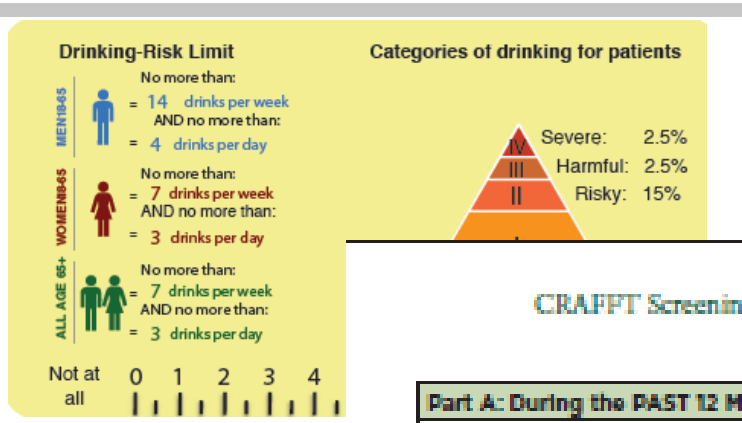
Expenditures to Date & Revised Budget

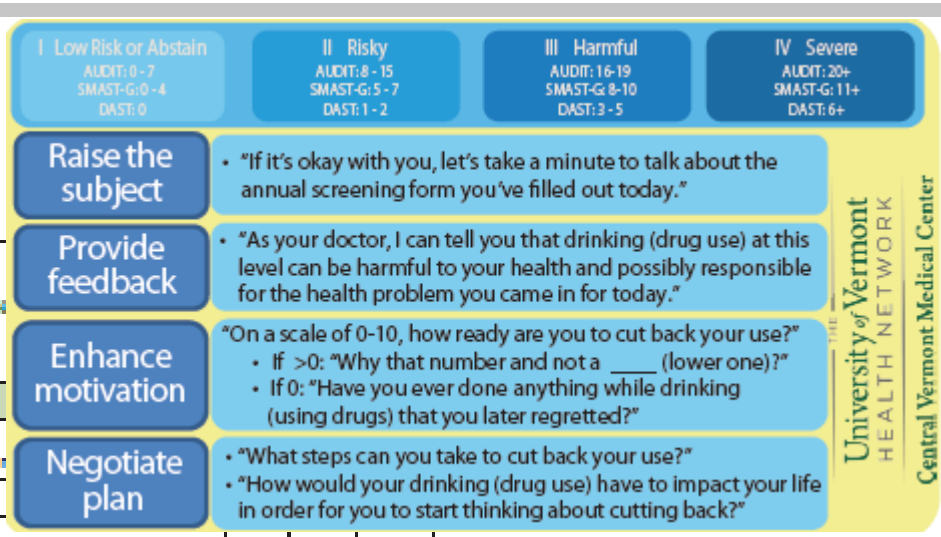
- Please work from your approved revised budget to show any new expenditures.

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ 360,970.00	$ 152,302.98	$ 28,098.14	$ 180,401.12
Fringe	$ 98,400.00	$ 39,757.00	$ 7,594.00	$ 47,351.00
Travel*		$ 267.38	$ 105.84	$ 373.22
Conferences*		$ 275.00	$ 448.41	$ 723.41
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	$ 5,695.25	$ 39.99	$ 5,735.24

- * Tracked separately starting 8/1/15, in original budget Conferences were listed under Supplies
- Expenditures as of February 2016

SBIRT Resources





CRAFFT Screening Tool for Adoles

Part A: During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? Do not count sips of alcohol taken during family or r		
2. Smoke any marijuana or hashish?		
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter prescription drugs, and things that you sniff or "huff")		
Part B: CRAFFT	**No**	**Yes**
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
lcohol or drugs to RELAX, feel better about yourself, or		
lcohol or drugs while you are by yourself, or ALONE?		
ET things you did while using alcohol or drugs?		
r FRIENDS ever tell you that you should cut down on rug use?		
tten into TROUBLE while you were using alcohol or		

Vermont Health Care Innovation Project

SBIRT Resources

SIM Funding for Infrastructure Building

HealthFirst, Inc.

Date: **April 10, 2016**

Reporting Period: **January 1 – March 31, 2016**

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:** We are pleased to report that 100% of our VCP practices have completed the chart review data collection and our Quality and Care Coordination Manager (QCCM) and Clinical Quality Director are now analyzing the data for the state's July 1 submission deadline. A preliminary data review suggests that VCP practices showed improvement or maintained high performance on several measures. This year's data collection went very smoothly using the process we piloted for 2014, which placed chart review and data extraction in the hands of the practices versus outside consultants. With our QCCM in place and practices' experience and familiarity with the process, we were able to complete the collection phase of the process more efficiently and for a lower cost.
- **2 – Goal 6. Collaborative care agreement:** The Quality Improvement Implementation Committee (QICC) is developing a monitoring process for effective protocols in and around practice communications to ensure smooth care transitions. Once implemented, the process will support our goal of clinical integration among our member practices.

Recent Accomplishments

- **3 – Goal 12. Physician liaison activity:** A number of our members continue to represent HealthFirst/VCP at a variety of health reform meetings, among them, the all-payer waiver workgroup and some of its subcommittees; Blueprint's value-based advisory committee; and as experts providing requested testimony to several legislative committees to ensure lawmakers understand the ACO structure and its benefits and challenges for independent physicians. Our members' willingness to step up is invaluable; there is no way our small staff would be able to represent HealthFirst in so many key health reform initiatives without their assistance.
- **4 – Goal 11. Architecting disease management programs:** Over the last several months, our QCCM has been working closely with lower performing practices to help them implement best practices that higher performing practices have already integrated successfully. She is also connecting some practices to have direct conversations about quality measure tracking and reporting. We will be updating the members of our clinical implementation committee, practice managers from some of our member practices, about this at their next meeting to see if they have feedback on how to make these efforts even more effective.

Recent Accomplishments

- **5 – Goal. Overarching goal to build infrastructure and capacity:** Over the past several months, HealthFirst has been interfacing with VITL about the development of an ACO data gateway. Our goal is to ensure that the gateway will be responsive to current data collection and reporting needs while still remaining flexible to allow for modifications as HealthFirst continues to evolve. The opportunity to have a customized, ready-to-launch data gateway is an extremely valuable step in HealthFirst's efforts to build capacity and connectivity with other ACOs in Vermont.

Challenges

- **Time demands:** As we come into the final stretch of our SIM grant, we are looking even more carefully at how personnel and member volunteers are spending their time and evaluating the value of some activities against our list of priorities. One of our biggest concerns has become that of time. Our staff is small, with the equivalent of 3.5 FTEs combined; only two of whom are contracted to work full-time hours. The all-payer waiver process in particular has become increasingly demanding, with additional responsibilities arising frequently for subcommittees, which are being pushed to meet challenging, possibly impossible, scheduling goals. The project development committee, for example, has become very active recently and now requires an additional six to 10 hours of meeting time and committee work every week. Our executive director and operations director have been shouldering the brunt of this committee's increased demands, but their time and attention are also needed for other priority activities for and outside of the SIM grant. We simply cannot stretch our resources any more than we already have.

Challenges

- **Loss of independent practices:** This challenge goes well beyond HealthFirst; in fact, this is a problem for all of Vermont. We are losing high-quality low cost practices to hospital consolidation at an alarming rate. The recent loss of pediatricians in Franklin County and the loss of the state's two remaining orthopaedic practices just last week undermine every healthcare reform goal, from improving the quality of care to improving the affordability of and access to care. Among all physicians in the state, Vermont's independent practices score consistently at the top percentages for quality performance. When independent practices are absorbed into hospitals, undeniably, patients' out-of-pocket costs rise. Families in Franklin County have been left with few local choices for their children's care because remaining pediatric practices in the area are full. Providers outside of the community become the only option, leaving families struggling to figure out the logistical challenges of both time (travel time to offices outside of their community, loss of work time, loss of school time, how much time you want a sick child in transit) and money (costs over and above insurance premiums and co-pays, transportation costs, loss of work time, etc.). Orthopaedic care may now be billed at 200% more than before those practices were bought by the University of Vermont Health Network, even if patients do not change doctors. Additionally, patients now have very limited choices for this care and will likely be facing higher out-of-pocket costs.

Activities: New, Undertaken, Planned, Ongoing

New Opportunities

- **New members:** HealthFirst just welcomed a new primary care practice to our membership and will welcome another over the summer. Both of these practices are also joining our ACO, Vermont Collaborative Physicians.

Planned

- **Annual meeting planning:** We have just started the long process of planning for our annual meeting next fall, starting with brainstorming possible speakers.

Ongoing Activities

- **GesaWorld/Clinically Integrated Network:** GesaWorld will be presenting HealthFirst with two proposals to continue the work we started with the group last fall to support our efforts to become a fully clinically integrated network.
- **Wakely Actuarial:** Based on our work with Wakely Actuarial to date, we continue to refine our recommendations for benchmarking and quality measures for the third year of the commercial shared savings program. Wakely's analysis of our data has been extremely beneficial and we are grateful that the funding was available for us to receive this technical assistance at no cost.

Providers and Beneficiaries Impacted

- **Number of Providers:** HealthFirst counts more than 140 independent physicians among its members, and we estimate that our member practices employ at least 75 physician assistants and nurse practitioners collectively. We do not formally track the number of RNs and LPNs employed by our member practices, but know that our smallest practices often go 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:** Our target population is the patients 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.,* 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. (Although we no longer formally participate in the Medicare ACO program, we continue to support our practices in meeting benchmarks established for this population.) Regarding capacity and infrastructure building, to date, we have achieved many of our discrete goals, such as contracting with personnel, securing office space, and convening and managing several ongoing committees in support of our initiatives. We have 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 and needs arise in the future.

Evaluation Methodology

- **Data sources:** Our member practices, commercial payers (e.g., BCBSVT and MVP), and Medicare/Medicaid programs are the data sources 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.
- **Results to date:** Across all measures, data have shown that Vermont's independent physicians are providing excellent care to their patients. A review of the raw data collected for 2015 shows some promise in the results. Data is now being verified and analyzed for submission to the state on July 1. We are looking forward to seeing final results and comparing them against 2014 results, which showed such high performance across most measures that, for most of this year's data, we are looking more for maintenance as well as incremental improvements.

Evaluation Methodology

- **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 our continuing involvement in healthcare reform efforts.

Expenditures to Date: January to March 2016

HealthFirst, Inc. - SIM Grant #03410-1305-15					
Financial Report: January 2016-March 2016					
	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	$127,019.86	$19,980.14
Administrative Assistant	$50,750.00	$6,437.52	$6,437.52	$40,145.86	$10,604.14
Operations Director	$63,000.00	$9,321.45	$9,321.45	$53,678.61	$9,321.39
Clinical Lead, Other MD	$60,900.00	$8,725.00	$3,575.00	$43,775.00	$17,125.00
Quality & Care Coord. Mgr.	$65,000.00	$16,249.98	$16,249.98	$48,749.94	$16,250.06
Fringes	$0.00	$0.00	$0.00	$0.00	$0.00
Total Wages	**$386,650.00**	**$60,714.07**	**$55,564.07**	**$313,369.27**	**$73,280.73**
Consultants					
Local Physician Liaison Team	$52,000.00	$11,056.25	$0.00	$35,186.25	$16,813.75
Legal services, HR, IT, other contracts	$100,864.00	$10,628.75	$0.00	$52,039.16	$48,824.84
Total Consultants	**$152,864.00**	**$21,685.00**	**$0.00**	**$87,225.41**	**$65,638.59**
Office					
Rent	$28,400.00	$3,567.72	$2,378.48	$22,657.76	$5,742.24
Utilities	$4,200.00	$464.76	$270.54	$3,013.90	$1,186.10
Supplies (incld computers, communication)	$14,000.00	$1,955.90	$1,423.89	$14,983.32	($983.32)
Meetings and travel	$8,250.00	$755.55	$0.00	$7,907.50	$342.50
Bi-annual meeting	$3,236.00	$1,500.00	$0.00	$3,236.24	($0.24)
Outreach	$2,400.00	$2,437.18	$0.00	$2,437.18	($37.18)
Total Office	**$60,486.00**	**$10,681.11**	**$4,072.91**	**$54,235.90**	**$6,250.10**
TOTALS	**$600,000.00**	**$93,080.18**	**$59,636.98**	**$454,830.58**	**$145,169.42**

See Budget Notes on next slide for explanation of highlighted fields

Budget Notes

Notes

- Yellow highlighted figures include funds invoiced but not paid by the state; we have included them in this report to match the current reconciliation based on monthly invoices to date:
  - Of the $8,725 invoiced for Oct-Dec 2015 for Clinical Lead/Other MD, only $2,575 was paid
  - None of the $3,575 for Jan-Mar 2016 for Clinical Lead/Other MD was paid
  - Of the $11,056.25 invoiced for Oct-Dec 2015 for Liaisons, only $6,743.75 was paid

Potential Budget Changes

- We are awaiting final approval from CMMI for our revised grant revision request we submitted in February – and which the Core Team approved at its March meeting – but now anticipate that our budget will apply to the balance of our grant without further revisions. The grant is being submitted for retroactive coverage back to March 1, so we will be working with DVHA to ensure that we handle invoicing correctly once the approval is finalized.

Caledonia & S. Essex Dual Eligibles Project

Northeastern Vermont Regional Hospital

Date: April 4, 2016

Reporting Period: Jan – March 2016

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

- Funded several projects to allow people to stay in their homes.
  - Purchased emergency monitoring system
  - Modified bathroom
  - Pumped a septic system
  - Purchased a lift chair
  - Subsidized rent
- Hardwired the team based care approach – all clients supported by a team

Challenges and Opportunities

- Challenges:
  - Addressing mobility issues (not just transportation)
  - Home visits with families with young children – distractions when kids are present
  - Addressing memory issues with people with TBI's
  - Interruption of Medicaid services causes delays in services
- Opportunities:
  - Successes with new and different partners: Foodbank, pharmacies
  - Increased referrals to the Choices for Care program

Activities Undertaken and Planned

- Ongoing Activities
  - Health Coaching at maximum active case load of 20
  - Tobacco cessation ongoing
  - Walking group at the mall
- New Activities
  - Partnership with Vermont Foodbank - VeggieVanGo
  - Health Coach partnering with RuralEdge on financial literacy
  - Health Coach working closely with independent landlords to keep people in their homes
- Long-Term Activities
  - Health Coach and Team piloting the CDC Health Related Quality of Life HRQoL indicators.

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 = 80 (for the entire project)
  - Flexible Funds distributed to 107 individuals

Evaluation Methodology

- We have asked for technical assistance for the evaluation of this process. VHCIP directed us to an evaluator at DHVA.
  - A pre and post intervention Medicaid claims review has been completed and will be submitted with the final grant report.
  - Case studies with qualitative outcomes are being collected.
- Separate from this project is the CMCM Learning Collaborative; a subset of the Duals was chosen for this project and Learning Collaborative goals and results will also be submitted with the final grant report.

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	$ 54,000.00	$ -	$ 54,000.00
Fringe	$ 18,900.00	$ 18,900.00	$ -	$ 18,900.00
Travel	$ 2,000.00	$ 2,000.00	$ -	$ 2,000.00
Flex Funds	$ 100,000.00	$ 70,755.57	$ 17,641.90	$ 88,397.47
Equipment	$ 1,500.00	$ 1,536.55	$ -	$ 1,536.55
Contracts		$ -		$ -
Indirect		$ -		$ -
Total	$ 176,400.00	$ 147,192.12	$ 17,641.90	$ 164,834.02

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

Vermont Health Care Innovation Project
2016 Quarterly Report

Supportive Care Grant
Insert Name of Organization

Date: April 7, 2016

Reporting Period:

January 2016 – March 2016

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

Nicole Moran, RN, MSN

Grant Project Goals

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

Recent Accomplishments

- 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.

- Nine referrals received and seven patients admitted to the program.

Recent Accomplishments

- To date, 40% of the patients admitted to the program have transitioned into either a Palliative care program or Hospice.

- Quality of life assessments are 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 five more patients before our cut off date of June 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.
  - 45 with two pending referrals

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
- 40% 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	$ 10,358.55	$ 3,828.35	$ 14,186.90
Fringe	$ 21,488.70	$ 2,708.76	$ 1,001.11	$ 3,709.87
Travel	$ 5,600.01	$ 631.68	$ -	$ 631.68
Conferences	$ -		$ -	$ -
Equipment	$ 2,800.00	$ -	$ -	$ -
Contracts	$ -	$ -	$ -	$ -
Indirect	$ -	$ -	$ -	$ -
Total	$ 112,063.45	$ 13,698.99	$ 4,829.46	$ 18,528.45

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

RiseVT
Northwestern Medical Center

Date: 4.11.2016

Reporting Period:
January, February, March

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

- Saint Albans Town bylaw change to require sidewalks in new developments
- New Individual Scorecard Launch
- Facebook hit 5000 likes with a successful Healthy New You challenge that reached over 60000 users during the month of January.

Recent Accomplishments

- Walking Challenge at Northwest Technical Center High school with over 100 participants grades 9-12
- RiseTV collaboration with local access channel bringing a 15 minute show every week on health and wellness. Partnership with Vermont Department of Health to be a WIC Certified Activity
- Vermont Adult Learning collaboration with a RiseVT Led Walk, Yoga class, health assessment completion and more for students working on their GED.

Challenges and Opportunities

- An interesting challenge that has yielded great opportunity is our collaboration with schools. We recently developed the Classroom scorecard to engage students that the classroom level while also working with their administration to change policies. What we have found is that classrooms absolutely love it and they want more. Kids are getting really excited about adopting brain breaks and movement into their daily routines. The challenge has been that our classroom scorecard really only works for a few grades because of the educational level and activities. We are going to revamp this process in the summer to offer better engagement for certain grades.

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, sidewalk committees and recreation committees.
  - 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, and Samaritan House.

Activities Undertaken and Planned

- New Activities:
  - Table Talks at vulnerable locations have been going well and we have decided to increase our engagement by co-tabling with organizations. We have so far reached over 200 people at our Table Talk events with 7 individuals following up with a tobacco cessation specialist and 151 receiving a free blood pressure check.
  - Table talks are currently happening at Champlain Valley Office of Economic Opportunity, Community College of Vermont, Martha's Kitchen and the Agency of Human Services.

Activities Undertaken and Planned

- Long-Term Activities:
  - Our largest long term activity is sustainability. RiseVT has had great momentum and success in the first year, we are looking to continue this effort long term to change the health and wellbeing our residents.
  - We are bringing in experts including EPODE to have conversations about sustainability and how we can align better with best practice approaches to ensure a sustainable future.

Providers and Beneficiaries Impacted

- *RiseVT Numbers*
- 8836 People are Rising
  - **6254 people** have seen RiseVT at events across Franklin and Grand Isle
  - **1351 people** have taken the RiseVT Pledge or taken the Health Assessment
  - **770 people** have completed the RiseVT Individual Scorecard and know their score – 9 have followed up with Health Coach
  - **461 people** are using the RiseVT Wellness Dashboard & Health Coaching

Providers and Beneficiaries Impacted

- *RiseVT Numbers*
  - Facebook Likes: 5300
  - 43 Businesses engaged
  - 15 Schools
  - 8 Municipalities

Evaluation Methodology

- Finalized agreement with Rural Studies at the University of Vermont. The project has begun and will be finished in October.
- EPODE will be coming for a site visit on April 13 and 14th. This will include conversations about sustainability, evaluations and current interventions.

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ 115,000.00	$ 45,000.25	$ 28,923.33	$ 73,923.58
Fringe	$ 133,000.00	$ 31,452.38	$ 8,098.53	$ 39,550.91
Travel	$ 20,000.00	$ 4,111.21	$ -	$ 4,111.21
				$ -
Equipment	$ 22,000.00	$ 13,627.90	$ 2,653.13	$ 16,281.03
Material/Supp	$ 19,500.00	$ 16,805.57	$ 1,714.65	$ 18,520.22
other Costs	$ 90,500.00	$ 44,546.27	$ 25,198.16	$ 69,744.43
Total	$ 400,000.00	$ 155,543.58	$ 66,587.80	$ 400,000.00

*Please see next slides for reallocated budget information

Expenditures to Date & Revised Budget

- On 3/14/2016, the VHCIP Core team approved a reallocation of $60,000 from Travel and Fringe benefits to Other costs. Here is the budget change request that was approved:

- **Reallocate Travel line and reinvest in Other Budget Line**
  - Due to recent regulation changes in federal reimbursement for travel, we are requesting that Northwestern Medical Center takes over travel reimbursement for staff. This would allow us to not have to account for a difference in reimbursement from the hospital and reduce the need for multiple forms with different amounts to be accounted for. We are requesting that the $10,000 budgeted for CY 2016 for RiseVT Travel be moved to the "Other" budget line.

Expenditures to Date & Revised Budget

- **Reallocate Benefits and reinvest in Other Budget Line**
  - Benefits for our staff were over projected, resulting in about a $50,000 over-budget for benefits. We are requesting to move these funds to the "Other" Budget line. This would allow us to move even further in our efforts to improve the health and wellness or our residents in Franklin and Grand Isle.

  - RISE VT will reinvest these funds and provide technical assistance based on evidence-based practices along with mini-grants to targeted communities. Examples may include: promote creation of smoke-free environments; create or enhance access to locations for physical activity and healthy eating; promote increase physical activity and healthy eating options at worksites; encourage increased availability of healthier food and beverage choices at public service venues; support parent and family education programs that promote healthy eating and physical activity; and support municipal ordinances that promote mixed use development including increased walkability or bike-ability.

An Innovative Adaptation of the TCM in a Rural Setting

Southwestern Vermont Health Care

Date:

April 8, 2016

Reporting Period:

January 2016– March 2016

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. The SVMC Transitional Care Program was highlighted on NBC's Albany Channel 13 Benita Zhan's Health Report. The report included an interview with Carol Conroy DNP, MS, RN SVMC's Chief Nursing Officer, Billie Allard MS RN, Karen Coppin, MS RN Transitional Care Nurse and one of our transitional care patients in his home.
2. Karen Coppin MS RN and Sandra Driscoll MS RN, Transitional Care Nurses are scheduled to present at the NICHE conference on Transitional Care Nursing.
3. Billie Allard MS RN and Barbara Richardson MS RN did a poster presentation at the Organization of Nurse Leaders for MA, RI, NH and CT Meeting on the Transitional Care Program.
4. Planning has begun for our regional conference on Transitional Care which is scheduled for September 20, 2016. Mary Naylor MS RN has accepted our invitation to be the keynote speaker.
5. INTERACT, the long term care program for early identification of condition changes and prompt implementation of clinical interventions, which was implemented at SVHC's Center for Living and Rehabilitation last quarter, is now being integrated with area long term care facilities by the INTERACT Nurse.
6. The INTERACT Program has demonstrated a 7.7% decrease in the 30-day readmission rate from February 2016 vs February 2015.
7. SVMC 's Transitional Care Program has been invited to be part of MIT's Pop Up Lab Nurse Design Kit for innovations in nursing, through the Hillman Foundation.
8. SVMC Respiratory Therapists are now participating in daily interdisciplinary rounds and available one day each week to make home visits through the Transitional Care Program.

Recent Accomplishments (continued)

7. To improve Nursing Home to Hospital transfers, meetings were held with the INTERACT Nurse and ED Team as well as with Bennington Rescue (EMT) to identify concerns and develop plans to implement improvements. The process included a survey of ED staff and EMT staff to gather feedback. The Nursing Home to Hospital Transfer Form has been implemented successfully and is being expanded to additional long term care facilities.
8. The Transitional Care Nurses returned from their conference with a new evidence based treatment for COPD, patients with frequent hospitalizations due to pneumonia, which involved high flow oxygen therapy. They have invited the speaker to present to the SVMC Respiratory Therapy Team including the Medical Director and plan to start a pilot program to assist these high risk patients.
9. The Clinical Pharmacists are now providing medication education to patients in our long term care facility prior to discharge, and scheduling additional home visits as necessary to assure proper medication management.
10. Billie Allard MS RN participated in a poster session at Dartmouth-Hitchcock, as well as SVMC as part of their Patient Safety Week activities.
11. Billie Allard MS RN Participated in a Conference Call with Lynn Chase, of Dartmouth-Hitchcock's Knowledge Map for Population Health on the Transitional Care Program.
12. Billie Allard MS RN has accepted an invitation to participate in One Care ACO's Task Force Post Hospitalization Visits.
13. The Transitional Care Program was recently accepted to present at the Magnet Nursing Conference in October.

Challenges and Opportunities

- **Challenges and Response Activities:**

1. SVMC plans to hold a regional conference on Transitional Care. Funding for conference was initially included in SVMC's VHCIP application, but needed to be cut due to budget constraints.
   - SVMC has been running below budget YTD in grant expenses due to decreased personnel expenses. Requested reallocation of funding to cover a portion of regional conference costs and conference attendance. Reallocation was approved by the *VT Health Care Innovation Project Core Team*.
2. As the VHCIP Grant comes to a close at the end of 2016, and the SVMC FY '17 budget process begins, continuation of the Transitional Care Program and grant supported positions becomes a challenge.
   - Billie Allard MS RN is completing a financial analysis and meeting with SVMC CFO to review grant funded positions and the related decreases in emergency department and hospital admissions as we prepare for healthcare reimbursement changes.
3. Data Management of multiple programs and the activities of each has been a challenge as we continue to expand the Transitions in Care Program with multiple components and an increased number of healthcare professionals.
   - Meeting with Information Technology Team to review additional options for managing data.

Challenges and Opportunities (cont.)

- **Opportunities**

1. Success of Transitions in Care Programs continues to stimulate 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 number of referrals to the programs, including the Transitional Care Nursing Program, the Community Care Team program and the INTERACT Program have both challenged the staff as well as provide additional opportunities to help patients manage independently at home or in their homecare settings, and decrease hospital and emergency department admissions in our community.
3. Administration of all aspects of this program become a challenge as the program continues to grow. Finding both the time and resources to manage the program with multiple requests from other communities and healthcare programs as the grant comes to an end in December 2016 challenges us to find an effective way to continue these proven effective programs in our community.

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**
  - Billie Allard MS RN to present on the Transitional Care Program at the World Health Congress.
  - Implement additional clinical components of the INTERACT program in area nursing homes.
  - Continue Planning of Regional Conference on Transitions in Care Program.
  - Provide education and plan for implementation of a pilot program for high flow oxygen with our patients in the community.
- **Long-Term Activities**
  - Expand implementation 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
    - Clinical Pharmacists
    - Respiratory Therapists
    - Social Workers
  - 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
    - Bennington-Rutland Opportunity Council and Substance Abuse Services
    - Bennington County Coalition for the Homeless

Providers and Beneficiaries Impacted (Cont.)

- Community Care Team (Continued)
  - 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
  - BROC Community Action Program
  - Southern Vermont AIDS Project
  - Vermont 211

Number of Beneficiaries participating in/or impacted

- Transitions of Care Program

	Q1	Q2	Q3	Q 4	Q5 Jan-Mar 2016		Total YTD
# New patient encounters	224	117	127	65	123		646
Total # patient interactions	554	293	376	291	402		1916
Home	122	73	131	120	171		617
Hospital	290	144	141	101	126		802
Phone Call	100	57	71	58	84		370
PCP Office	18	8	26	12	14		78
Nursing Home	21	9	8		3		41
Emergency Department	3	2	1		2		8

Providers and Beneficiaries Impacted (Cont.)

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

	Q 3	Q 4	Q5 Jan-Mar 2016			Total YTD
# New patient encounters	19	9	18			48
Total # patient interactions						
Phone Contacts	14	1	26			41
Emergency Department	19	17	29			65
Inpatient Hospital	2	2				4
Visit In the Community	6	7	28			41
Consult w Community Resource	21	23	70			114
Consult with SVHC Resource			2			2
Screened for CCT	3		2			5
Meetings / CCT Team and Indiv Pt Planning		7	5			12

Providers and Beneficiaries Impacted (Cont.)

- Community Care Team

	Q1	Q2	Q 3	Q 4	Q5 Jan-Mar 2016		Total	
# New Participants	5	5	9	9	18		46	
# Referrals/Contacts:								
Shared Living Provider Program	2				8		10	
BPI Adult Day Service	2			2	2		6	
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	6		22	
Traumatic Brain Injury Program	1	1	1		1		4	
Blueprint Case Managers		3			11		14	

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q3	Q 4	Q5 Jan-Mar 2016		Total	
# Referrals/Contacts CCT (cont.)								
Medical Provider	1			2	3		6	
United Counseling Services	2	4	8	10	10		34	
Developmental Services / UCS		3		4	5		12	
Housing Assistance	1	1	1				3	
Vocational Rehabilitation	1	2	1	1	5		10	
Economic Services		3			8		11	
Transitional Care Nurses SVMC		1			1		2	
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		1		3	

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q 3	Q 4	Q 5 Jan-Mar 2016		Total	
# Referrals/Contacts CCT (cont.)								
VT State Field Representative			1		1		2	
VNA			2		9		11	
Family Services DCF			1		1		5	
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		2	
Case Management SVMC				1	1		2	
Vermont 211					1		1	
BROC Community Action					4		4	
Southern Vermont AIDS Project					1		1	
Coalition for the Homeless					4		4	

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q 3	Q 4	Q5 Jan-Mar 2016		Total	
# Referrals/Contacts CCT (cont.)								
VT State Hospital					1		1	
Council on Aging					1		1	
SVMC Patient Advocate					1		1	
Danforth Center					1		1	
Renselear Department of Mental Health					3		3	
Smoking Cessation					1		1	
Bennington Health & Rehabilitation					1		1	
Unity House of Troy					4		4	
Renselear ARC					2		2	
Managed Medicaid Long Term Care					3		3	
TOTAL	19	30	25	34	102		210	

Providers and Beneficiaries Impacted (Cont.)

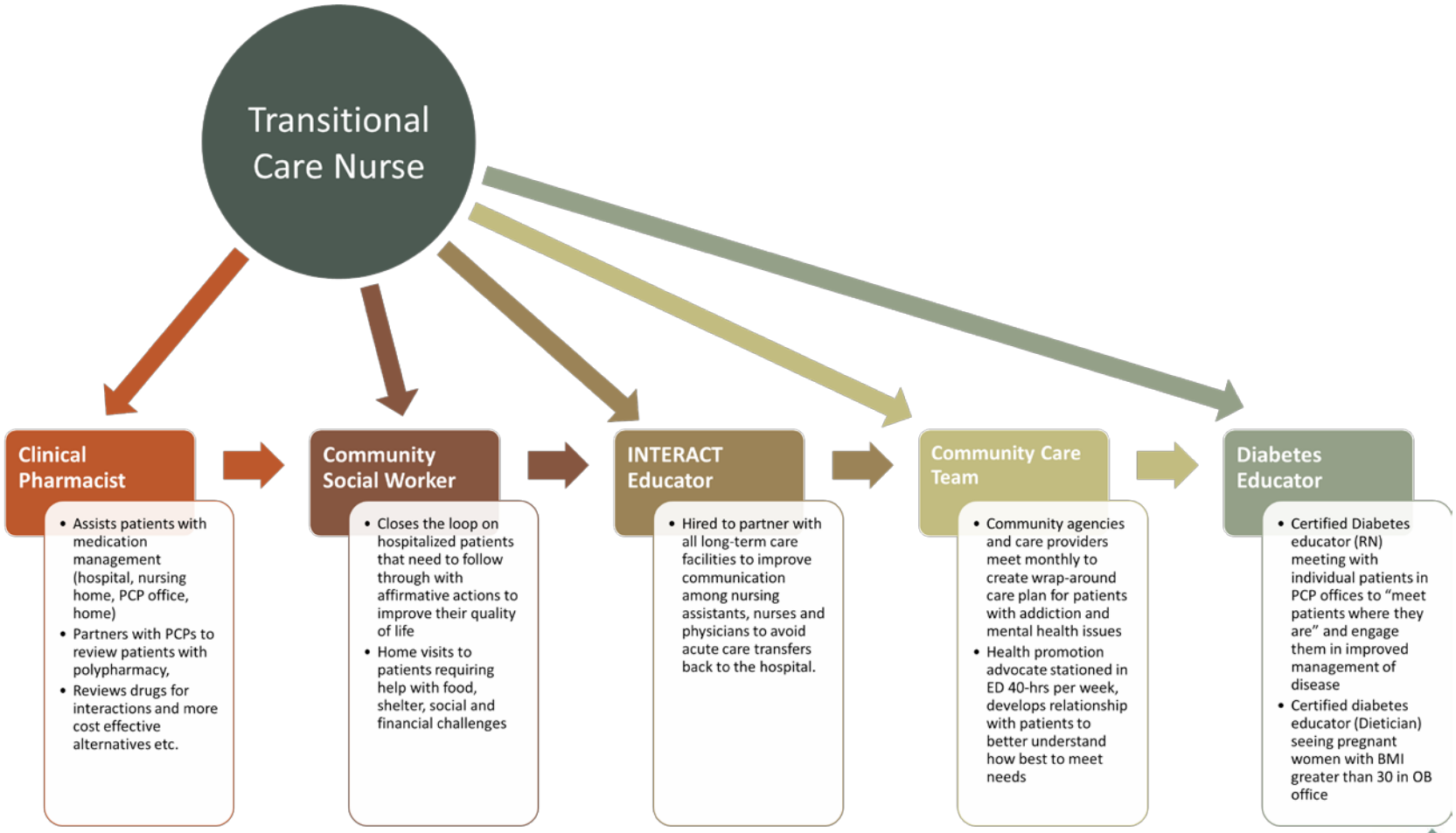
- INTERACT Program (program implemented November 11,2015)

	Nov '15	Dec '15	Jan '15	Feb '15	Mar '15	Improvement Intervention	Total YTD
# Stop & Watches Initiated	30	22	14	23	33	Staff on Subacute units encouraged to start Stop & Watches for abnormal vital signs and weight gains – these were identified as common transferred diagnosis through RCA	120
# Progress Notes Written	224	159	70	148	196	Formatting changes in ECS improved flow f the notes – pulled information to 24 hour report, allowing managers to review changes of conditions easily	797
# Sets of Vitals Obtained	222	158	78	141	211	Stop & Watch checklist assists staff to easily trend/track vitals in the moment	380
% Compliance with Vitals	93%	94%	88%	92%	92%	Durable report covers supplied on each unit to keep current Stop & Watches in – improve shift handoff communications for both LNA & Nursing staff	92%
% Compliance with Notes	88%	93%	76%	85%	77%	*AD-PIE* (Assessment, Diagnosis, Problem, Intervention, Evaluation) Formatting added to note content requirements to meet Skilled Charting Standards for CMS	84%
% Compliance with ECS Documentation	66%	72%	75%	74%	100%	Formatting changes made in ECS to add note headings for the 24 hour reports: INITIAL STOP & WATCH & UPDATE STOP & WATCH	78%
% Compliance with Checklist	59%	91%	83%	100%	100%	LNA's helped to create checklist and had ownership in the process. Holds staff accountable shift to shift for documentation expectations	87%
# Transfers to ED from CLR	10	13	21	20	16		
# Hospital Admissions from CLR	6	9	12	15	10		

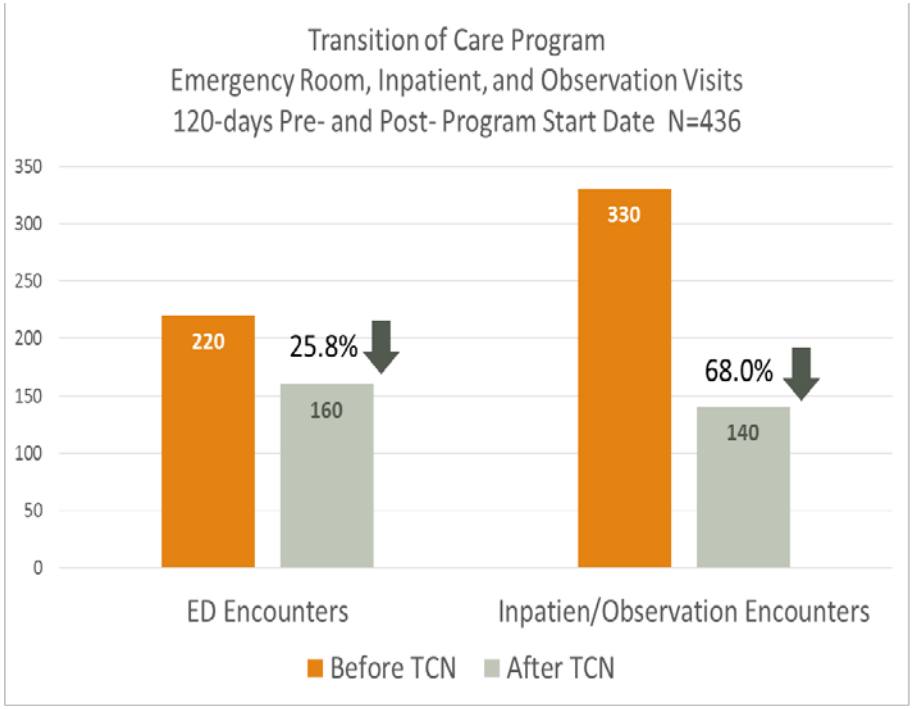
Evaluation Methodology

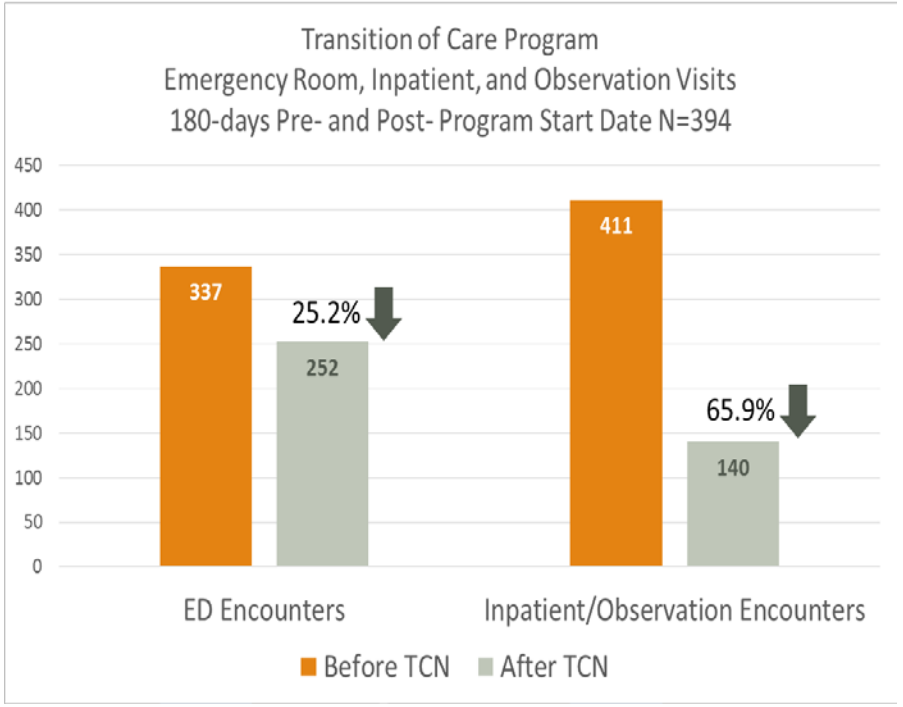
- **Transitions of Care Program**
  - Number of inpatient admissions to the hospital 120 days prior to TCN Program and 120 days post TCN Program.
  - Number of inpatient admissions to the hospital 180 days prior to TCN Program and 180 days post TCN Program.
  - Number of ED Visits 120 days prior to TCN Program and 120 days post TCN Program.
  - Patient Satisfaction Survey.
  - Number of ED Visits 180 days prior to TCN Program and 180 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.

INTEGRATED CARE DELIVERY TEAM

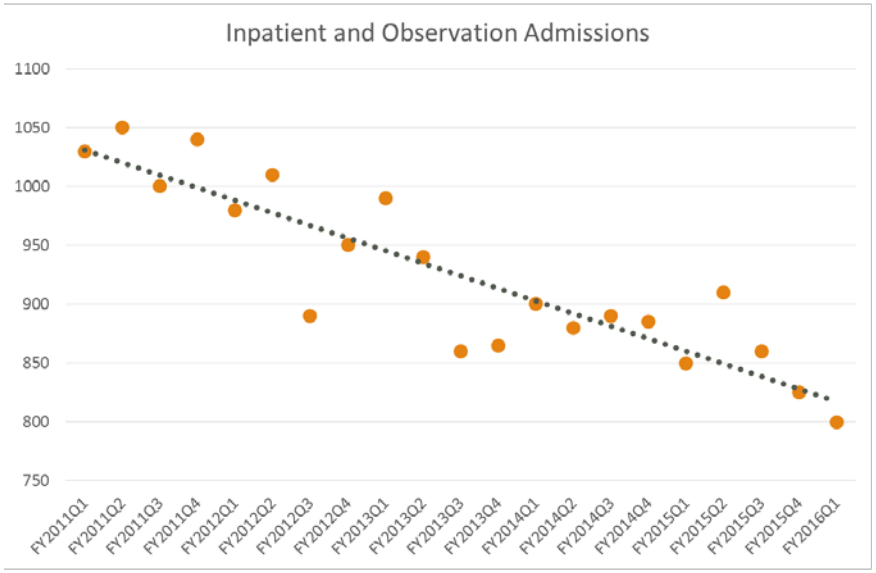


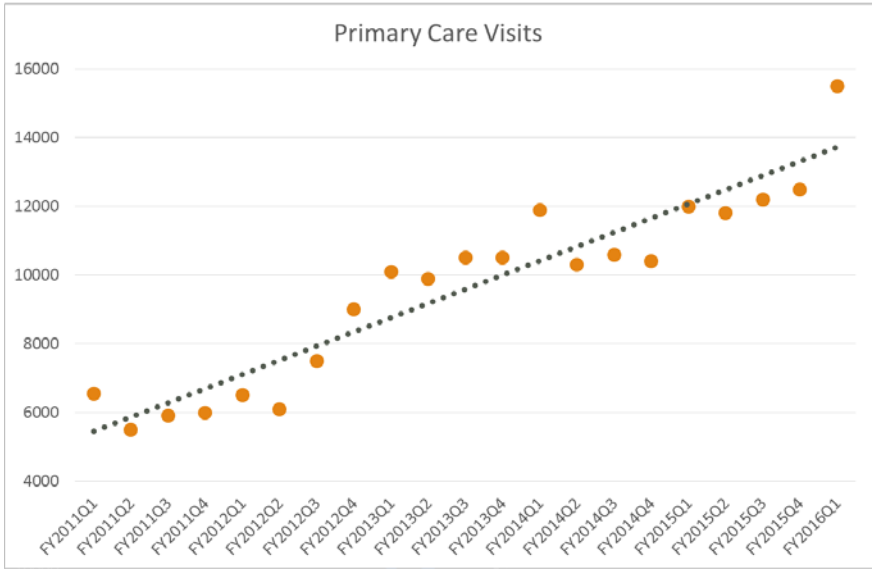
Transition Care Program
IMPROVES POPULATION HEALTH



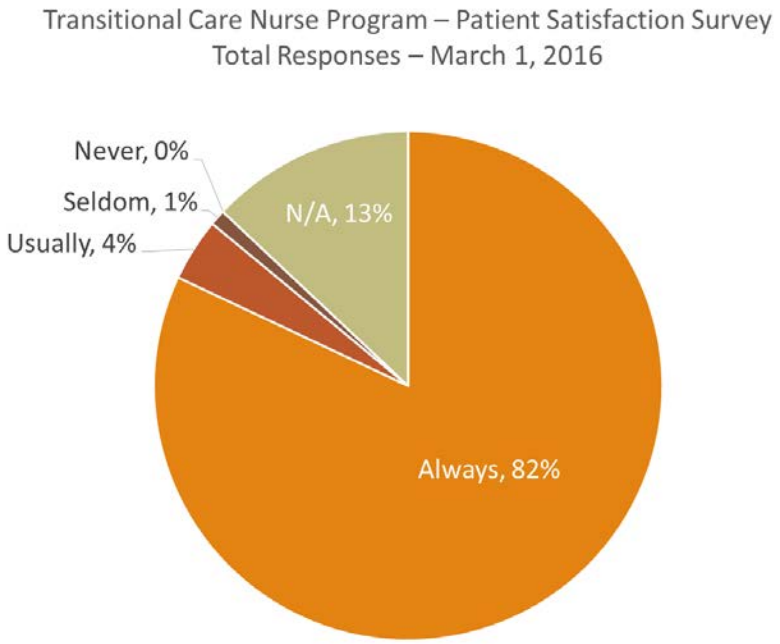


Transition Care Program Demonstrates Decreased Healthcare Costs





SVMC's Transitional Care Program IMPROVES the PATIENT EXPERIENCE



This graph illustrates the total Likert scale responses to the following questions.

My Transitional Care Nurse helped me:

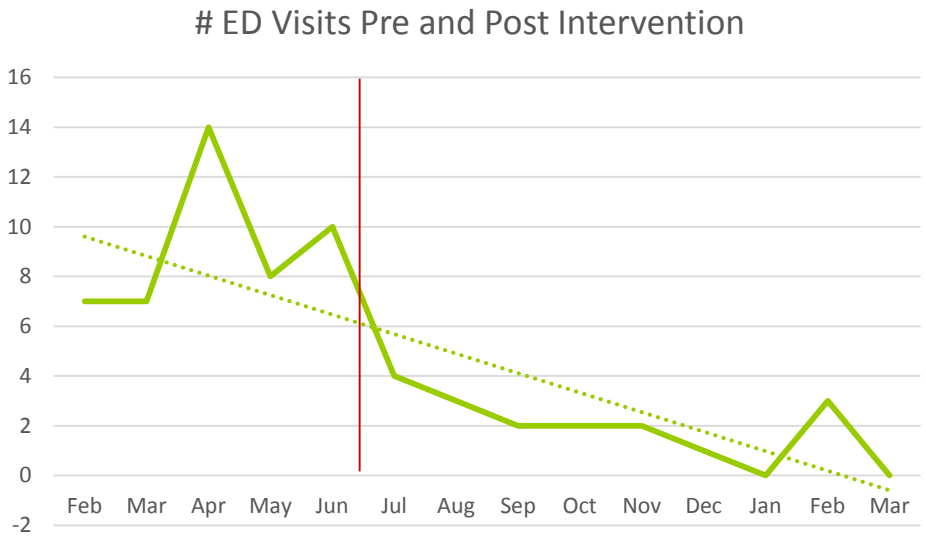
- feel more confident that I can manage my medications
- feel more confident that I can follow my discharge plan
- learn when to call the doctor, go to the emergency room or call 911
- learn about my illness and how to manage it better
- develop goals that matter to me
- connect with services that I needed
- connect with a hospital pharmacist who explained things so that I could understand

Community Care Team Demonstrates decreased ED Visits & Admissions

CCT Case Study # 7

Hx 51 ED Visits Jan-Jun 2015
Intervention July 2015:
8 ED visits last 6 months

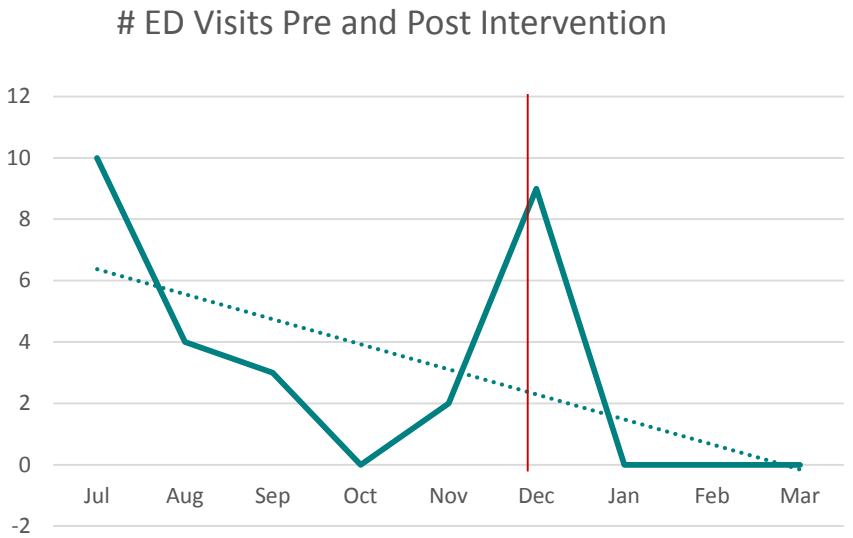
CCT Interventions:
Community Based referral, Shared living provider, Health Promotion Advocate visits and phone support



CCT Case Study # 8

Hx 28 ED Visits July-Dec 2015
Intervention Dec 2015
0 Visits last 3 months

CCT Interventions:
Facilitated move from homelessness to appropriate State Hospital for treatment.



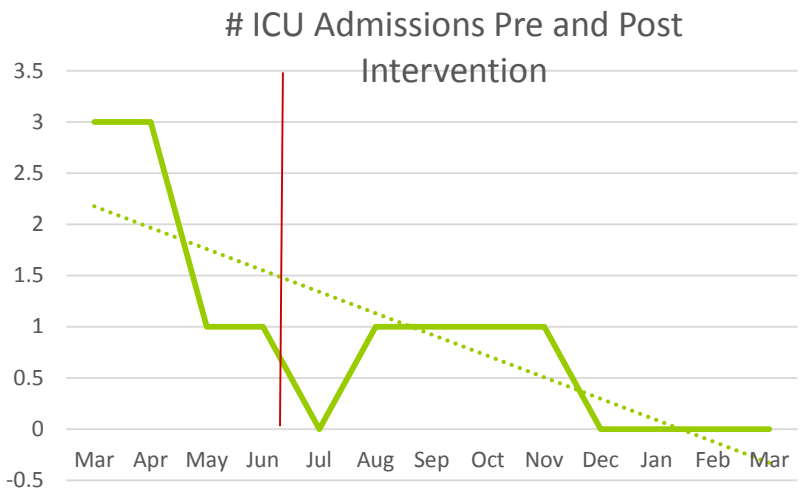
Community Care Team Demonstrates decreased ED Visits & Admissions

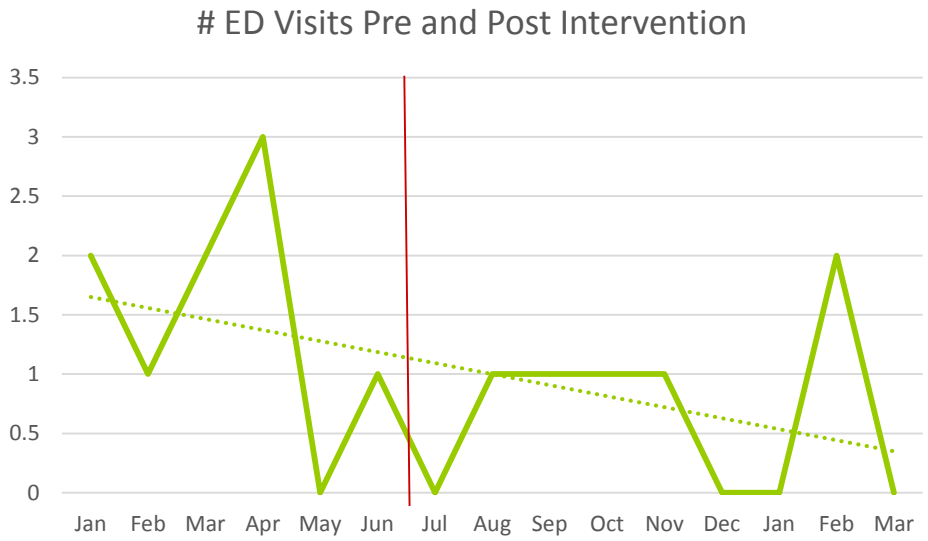
CCT Case Study # 9

8 ICU Admissions Mar – Jun 2015
6 ED Visits Mar – June 2015
Intervention July 2015

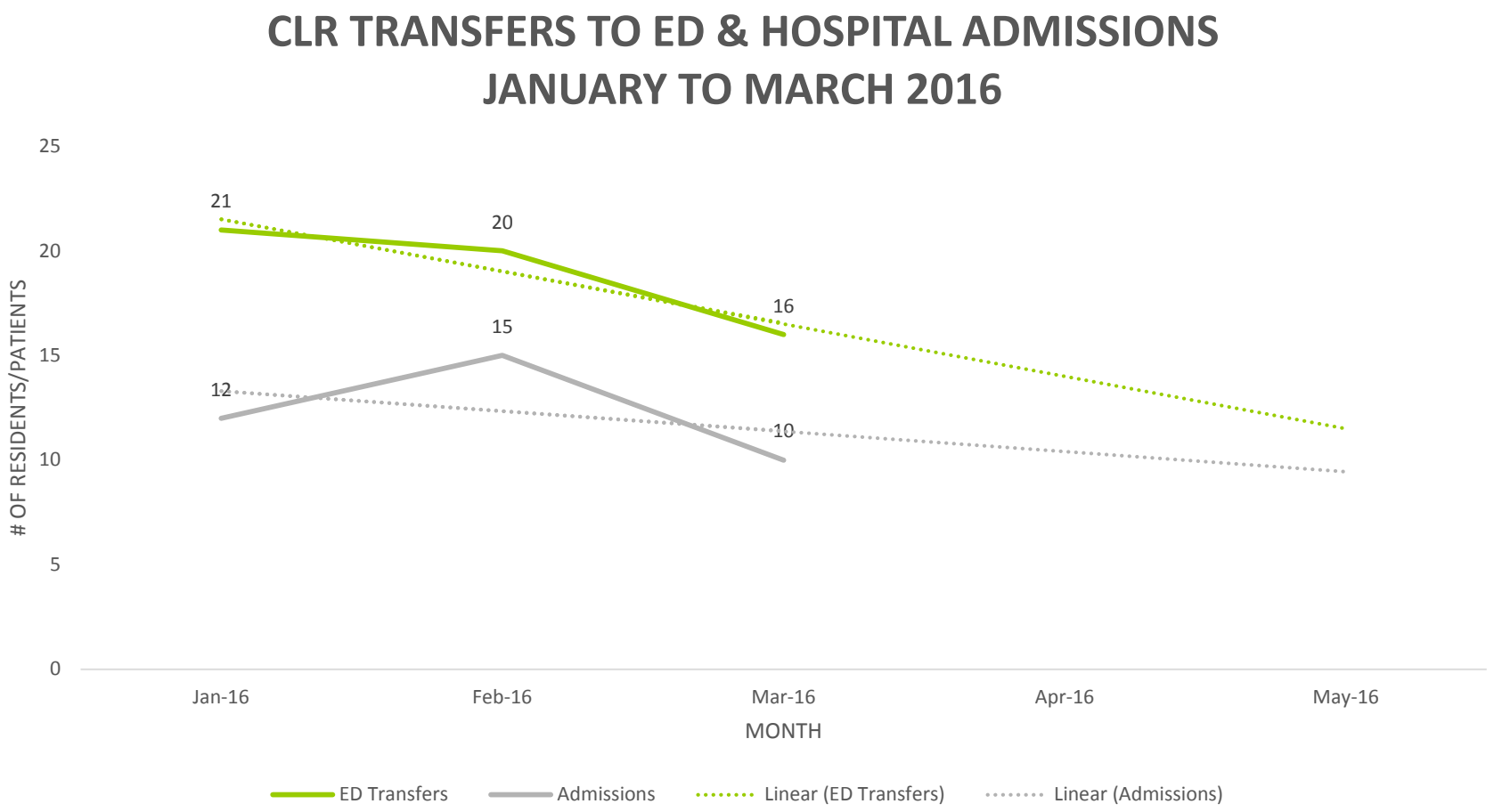
4 ED ICU Admissions past 9 months
6 ED Visits past 9 months

CCT Interventions:
Vermont Chronic Care Initiative Field Nurse, referral to PCP, Endocrinology, Dentistry, Housing, Health Promotion Advocate biweekly visits and phone support





INTERACT Program demonstrates decreased ED transfers and Hospital Admissions



Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Quarter	Total Spent to Date
Salary	$ 287,310.00	$ 96,326.77	$ 52,867.21	$ 149,193.98
Fringe	$ 86,193.00	$ 28,532.19	$ 15,860.16	$ 44,392.35
Travel				
Conferences				
Equipment	$ 3,097.00	$ 1.192.16		$ 1,192.16
Contracts	$ 23,400.00		$ 4,133.60	$ 4,133.60
Indirect				
Total	$ 400,000.00	$ 126,051.12	$ 72,860.97	$ 198,912.09

Briefly discuss any potential changes to the budget going forward.

No changes anticipated at this time.

Behavioral Screening and Intervention
Invest EAP

Date: April 8, 2016

Reporting Period: January – March 2016

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

- Employees continue to be screened.
- Providing follow-up intervention services to employees.
- Patient Success Examples
  - Patient completed a 3 month follow up survey and reported that she has been able to make progress on her own since meeting with the Health Coach.
  - Patient reported that the experience was great and that she was able to build upon the steps provided by the Health Coach to keep the changes manageable and ongoing.

Challenges and Opportunities

- Most employees seeking help at this time are looking to improve their diet and/or increase their exercise levels.

- Some employees who took a break from meeting with the health coach over the busy seasonal holiday work schedule have been able to re-engage.

Activities Undertaken and Planned

Ongoing Activities

- Continued peer supervision training of clinical staff in evidence-based behavioral treatment protocols.

New Activities

- Outreach plan for April 2016 to increase visibility of project to employees to increase participation.

Long-term Activities

- Coordination of follow up survey data collection.

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	$ 3,028.52	$ 3,612.16	$ 6,640.68
Fringe	$ 8,431.00	$ 1,990.86	$ 2,513.07	$ 4,503.93
Travel	$ -	$ -		$ -
Conferences	$ -	$ -		$ -
Equipment	$ 5,400.00	$ 603.26	$0.00	$ 603.26
Contracts	$ 21,000.00	$ 6,004.83	$ -	$ 6,004.83
Supplies	$ 370.00	$ -	$ -	$ -
Other	$ 1,680.00	$ 860.00	$ 555.00	$ 1,415.00
Indirect	$ 5,467.70	$ 1,248.75	$ 668.02	$ 1,916.77
Total	$ 60,144.70	$ 13,736.22	$ 7,348.25	$ 21,084.47

Resilient Vermont
Invest EAP

Date: April 8, 2016

Reporting Period: January – March 2016

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

- 84% increase in the number of introductions made by staff to the Health Coach
- 26% increase in number of participants enrolled
- Patient Success Example
  - Patient presenting with multiple issues began working with Health Coach to focus on tobacco use and exercise/nutrition. Through motivational interviewing patient was able to identify other areas of concern. The MI process helped patient to gain clarity and develop behavioral strategies. The results were a reduction in depressive symptoms, decreased social anxiety, and incorporation of a healthy lifestyle of better nutrition and exercise. She has lost 13 lbs. in three weeks and feels emotionally stronger.

Challenges and Opportunities

- Nurse referrals to health coach continue to remain lower than projected goals
  - Could be procedural issue – some patients may have recently completed a BSI and do not want to fill out again
  - Some patients already seeing another behavioral specialist so don't want to engage
- We have met with clinic management and developed new procedures to facilitate increased referrals
  - Identifying returning patients to meet him/her at current medical appointments for ease of services

Activities Undertaken and Planned

- Ongoing Activities
  - Continue service delivery
  - Conduct assessments and enter data
- New Activities
  - Initiated incentive program (March 2016) for staff at FQHC to encourage group effort in getting screens completed and proper flow for project
- Long-Term Activities
  - Initial data assessment with project evaluator.
  - Collecting data for follow up surveys

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 150 patients.

Evaluation Methodology

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

Expenditures to Date & Revised Budget

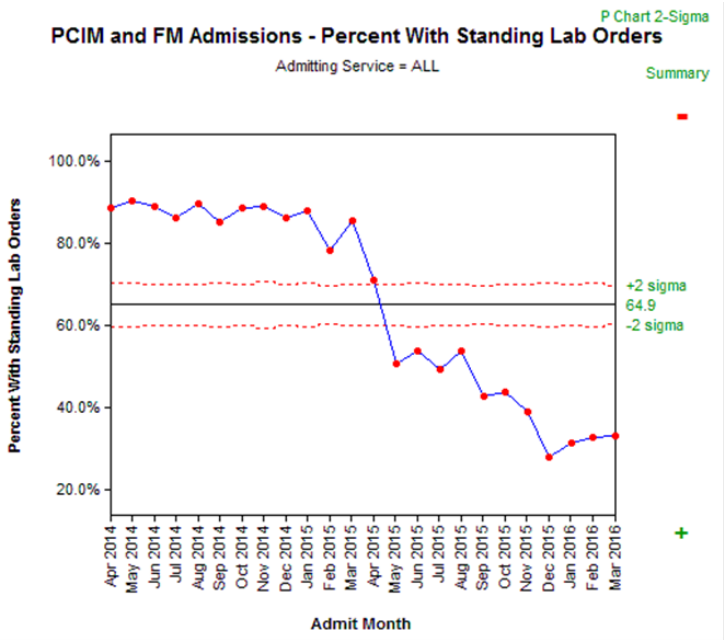
- Please work from your approved revised budget to show any new expenditures.

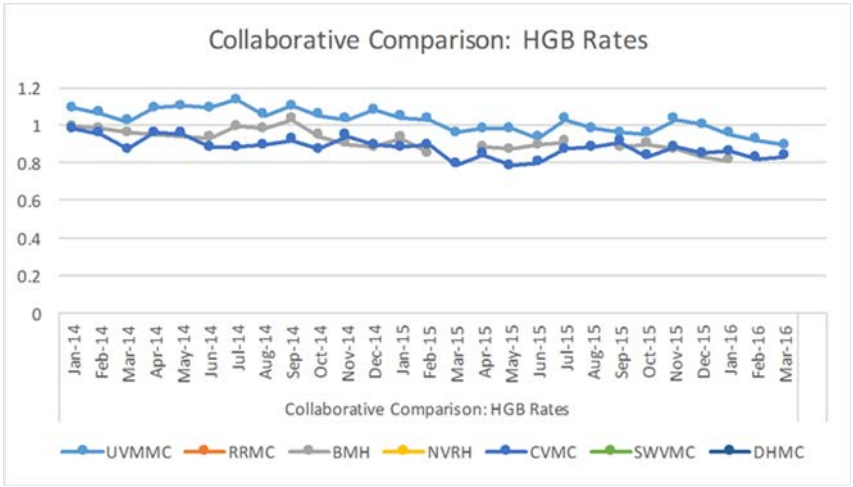
	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	in-kind			$ -
Fringe	in-kind			$ -
Travel	$ 6,500.00	$ 4,330.00		$ 4,330.00
Conferences	$ -			$ -
Equipment	$ 1,900.00	$ 2,329.00	$ -	$ 2,329.00
Contracts	$ 196,260.00	$ 71,073.82	$28,524.84	$ 99,598.66
Supplies	$ 1,000.00	$ -	$0.00	$ -
Other	$ 21,560.00	$ 750.00	$0.00	$ 750.00
Indirect	$ 22,722.00	$ 7,848.00	$ 2,852.00	$ 10,700.00
Total	$ 249,942.00	$ 86,330.82	$ 31,376.84	$ 117,707.66

Vermont Health Care Innovation Project
1st Quarter 2016 Report

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

February 1st, - April 27th, 2016 Cyrus Jordan MD MPH



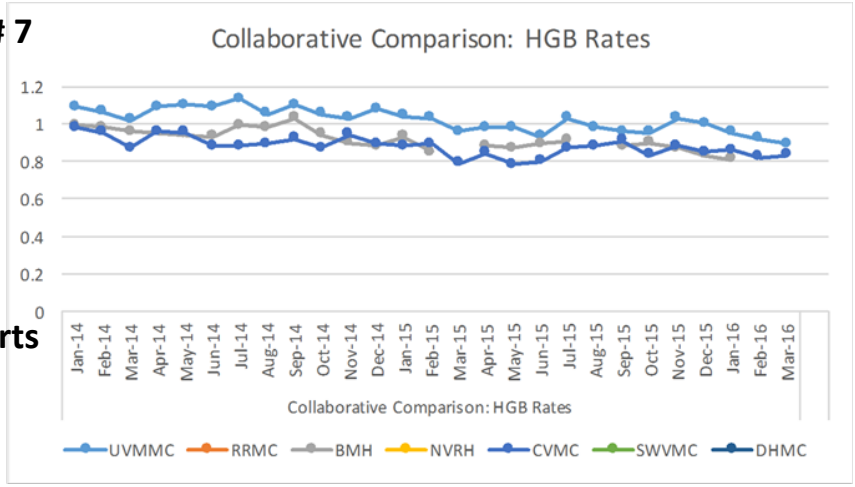


Grant Project Goals

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

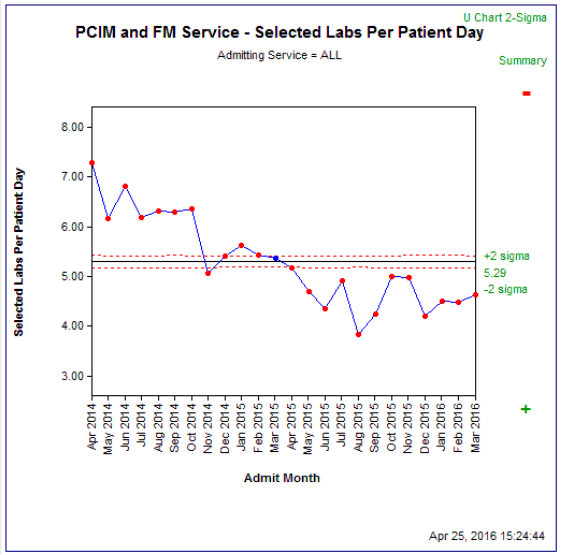
Accomplishments – Feb, March and April 2016

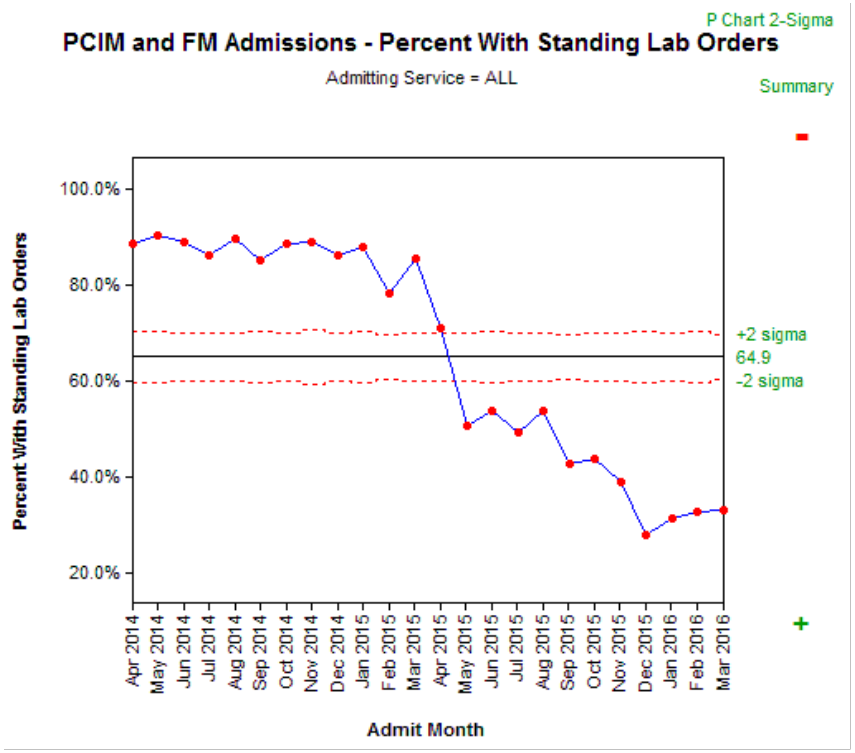
- **Plenary interventions across all sites**
  - Quarterly face to face Learning Sessions
    - April 14, 2016 – Learning Session # 7 Dartmouth Hitchcock
  - Monthly Webinars for all teams and faculty
    - February 18, 2016 – webinar #12
    - March 24, 2016 – webinar #13
  - Regional comparative labs per day reports shared across all institutions
  - All uploaded data sets validated by project analyst with each hospital team setting the stage for trusted benchmark comparisons across all institutions
- **Suggested 20% decrease in labs order across selected hospitals**



Accomplishments – Feb, March and April 2016

- **Hospital specific interventions**
  - DHMC team leader attending UVM MC team meetings
  - UVM MC CPOE templates continue to be modified to encourage choosing orders on a daily as needed basis
  - UVM MC educational sessions for staff physicians and trainees continue





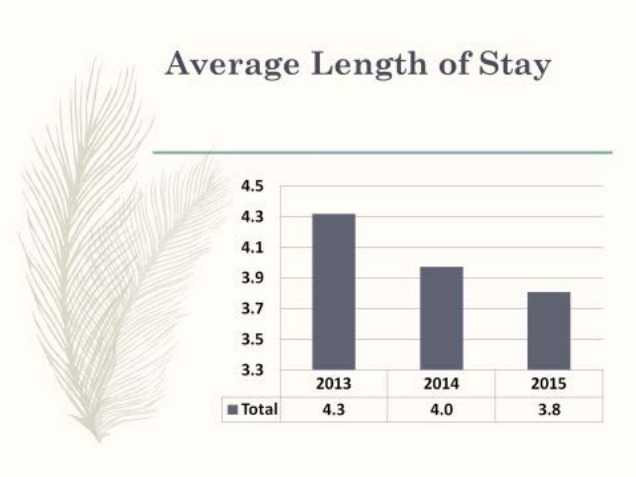
Accomplishments – Feb, March and April 2016

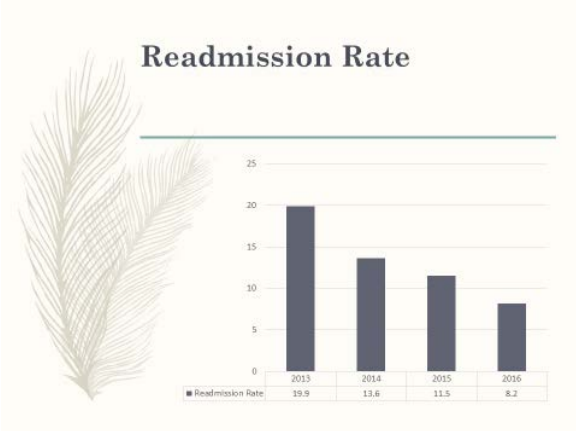
- **Year 2 project expansion – Inpatient Management of COPD**
  - **Northwestern Medical Center hospitalist staff has joined the Collaborative; was the key presentation during the March webinar**
  - **RRMC has moved their inpatient effort into post acute care settings and coordinating with community efforts to manage COPD**
  - **RRMC readmissions for COPD have decreased significantly; remaining readmissions are principally "hospital dependent" patients not choosing palliative care approaches to their terminal illnesses**

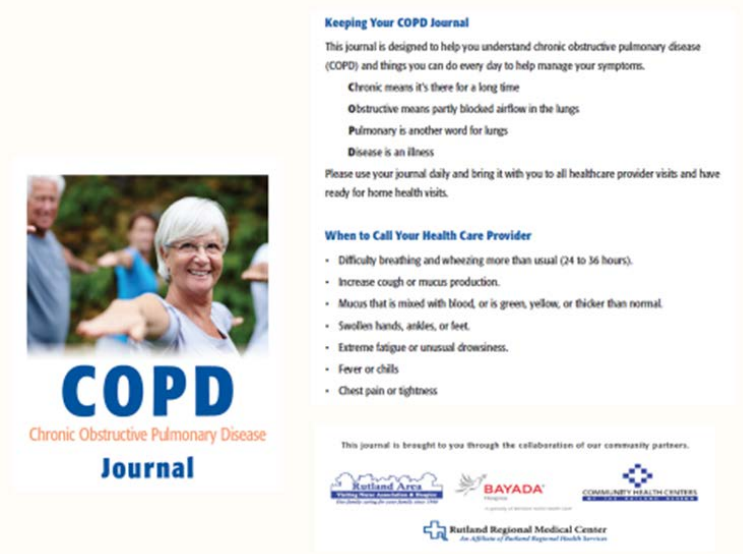
The COPD expansion of the project will include consensus recommendations for ordering of all diagnostic testing, not just laboratory testing; as well as all therapeutic interventions and discharge planning and coordination with post discharge follow up.

Accomplishments – Feb, March and April 2016

- **Hospital specific interventions**
  - **RRMC clinical pathway for COPD continues to be refined and coordinated with post acute care and chronic management**
  - **Nursing staff at CVMC has begun to champion effort and question physicians about orders**
  - **Porter Hospital team disbanded by administration**







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**
  - **Need for validation of each uploaded hospital data set**

Opportunities for programmatic support

- March 4th, 2016 session at Gifford Medical Center was canceled due to conflicts for key attendees
  - An example of the potential for "change led from the inside out" opposed to "change forced from the outside in"
  - Goal for the day was to seek continued support for the Collaborative after the end of the VHCIP grant cycle in June 2016
- Meetings scheduled for May with key private sector leaders proposing ongoing support post SIM grant
- Two choices for future siting of database
  - VAHHS interested in housing the database at their Iowa Hospital Association site
  - Data ware house barriers easing at current University of Chicago NORC site

Remaining Activities Planned

Lab Collaborative Continuation

- Outcomes Congress 8:30 AM to 3:30 PM
  - Thursday, June 9th, 2016- UVM MC

- Final Webinar- 2:00 PM – 3:00 PM
  - Thursday, May 12th, 2016
- Final full faculty meetings May 9th UVM COM
- 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 Feb 29, 2016

	Approved Budget	Total Spent to Date	% Spend	% Grant Cycle
VMS Foundation	$ 153,912	$ 108,915	71%	83%
UVM Pathology	$ 98,401	$ 71,864	73%	83%
UVM Medicine	$ 273,301	$ 209,691	77%	83%
Hospital support	$ 23,214	$ 16,030	69%	83%
Total	$ 548,828	$ 406,500	74%	83%

- **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

Vermont Health Care Innovation Project
Grant # 03410-1461-15
2016 Quarter One Report

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

Date: April 8, 2016

Reporting Period: January 1, 2016- March 31, 2016

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

- **#1 Sustainability**: To date, one insurance group has agreed to support our efforts…… and we are hopeful more people will recognize the value NSQIP brings to improving public health.

- **#2 Ongoing Data Collection**
  - Four hospitals are collecting and entering data into ACS NSQIP workstation
  - Preliminary collaborative NSQIP Outcomes shared with collaborative members (October-March)

Challenges

- EMR Challenges: 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.
- Financial 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

RESPONSES: Open invitation to all surgeon champions to attend monthly meetings and advocate for program at their hospitals; strategizing and acting on sustainable options with insurers; VITL may be able to assist with EMR challenges; communicate with hospital leadership the availability of additional funding to support NSQIP integration in their hospitals.

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 and the risk calculator to decrease costs, increase patient safety, and decrease preventable surgical complications.

Activities Undertaken and Planned

- **Ongoing Activities:** Facilitating monthly meetings of collaborative members and SCRS'; Reviewing AND trending data entered into NSQIP workstation; Coordinating face to face collaborative meetings; Scheduling insurer meetings with collaborative group. Providing clinical and technical support to hospitals, Quality Directors, and surgical clinical reviewers (SCRs') for clinical abstraction; Communicating NSQIP to hospital leadership.
- **Planned Activities:** Attend Vermont ACS Chapter meeting in May to share collaborative news; Anticipate enrolling more hospitals in NSQIP; Continue to schedule collaborative and insurer meetings.
- **Long term Activities:** Coordinate collaborative events for hospitals to share best practice statewide and nationally; Provide analytic support to hospitals through data analysis and comparative performance monitoring.

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**: RATES OF POSTOPERATIVE COMPLICATIONS INCLUDING MORTALITY **FINANCIAL:** COSTS FOR POSTOPERATIVE COMPLICATIONS EXCLUDING MORTALITY	VUHDDS **AND** ACS NSQIP RAW OUTCOMES DATA PATIENT DATA ENTERED INTO ACS NSQIP WORKSTATION PRODUCES HOSPITAL LEVEL CLINICAL OUTCOME, RISK ADJUSTED REPORTS USING ODDS RATIOS	RAW DATA: AS OF 4/3/2016 752 CASES ENTERED INTO NSQIP 50 PEOPLE **(6.6%)** EXPERIENCED POST-OPERATIVE OCCURANCE WITHIN 30 DAYS TRANSLATES TO APPROXIMATELY **$792,000 TOTAL** COSTS	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 AS EARLY AS FALL 2016.

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr. MAR 2016	Total Spent to Date MAR 2016
Statewide SC Project Coordinator	136,267.00	65,810.02	12,062.88	77,872.90
Surgical Case Reviewers (Salaries)	275,000.00	-	48,056.53	48,056.53
Sr. Program Mgr./Epidemiologist	22,661.00	2,613.61	1,065.10	3,678.70
Executive Director	9,914.00	4,222.51	1,365.65	5,588.16
Administrative Assistant	10,622.00	2,601.58	524.11	3,125.70
Business Office	11,278.00	2,866.46	2,773.85	5,640.31
IT Manager	4,993.00	520.00	-	520.00
Total Salary	470,735.00	78,634.18	65,848.13	144,482.31
Surgical Case Reviewers (Fringe)		-	11,312.27	11,312.27
Fringe (30% year 1, 32% year 2)	143,350.00	23,590.65	5,693.31	29,283.96
Total Salary & Fringes	614,085.00	102,224.83	82,853.70	185,078.53
Training fee for Coordinator	2,500.00	2,321.22	-	2,321.22
Travel to hospitals by Coordinator - Avg. 4				
Trips per month @.$575 per mile	11,559.00	952.65	69.39	1,022.04
Computer Equipment -12 computers for SCRs	12,000.00	1,000.00	2,000.00	3,000.00
Vermont Statewide Collaborative Meetings	2,600.00	75.00	-	75.00
Hospital Enrollment fees –annual	180,000.00	63,500.00	-	63,500.00
Indirect Costs	77,256.00	15,968.23	7,974.28	23,942.51
Totals :	900,000.00	186,041.91	92,897.37	278,939.28

- VPQHC REQUEST TO REPURPOSE FUNDS APPROVED. AWAITING ADJUSTED BUDGET.

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

Date: April 10, 2016

Reporting Period:

January 1, 2016 – March 31, 2016

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

Kate Simmons, Director of Operations

Organization / DUNS

Bi-State Primary Care Association / 939836698

Grant Project Goals

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

Recent Accomplishments

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

1. To comply with Medicaid requirements, CHAC completed the mailing of 2,538 Beneficiary Notification Letters on February 29, 2016 for the months of October, November and December 2015. CHAC has been successfully reporting opt-outs for all Medicaid and Medicare participating organizations.
2. The CHAC Board approved the Depression Screening and Follow-up protocols developed by the Clinical Committee at the February 17, 2016 CHAC Board meeting. This has been implemented at the practice level although some providers are still finding efficient ways to incorporate it into their systems.
3. CHAC has been collaborating with two other ACOs to work towards a unified organization. This joint effort has been a significant part of CHACs recent workload and will continue to be a primary focus moving forward.
4. To comply with ACO reporting requirements, CHAC submitted its ACO quality reporting to Medicare in March 2016 by deadline. CHAC is on track to submit quality reporting on Medicaid and Commercial patients by deadline.
5. CHAC has successfully completed the distribution of the dollars received from the Vermont Medicaid Shared Savings earned in 2014 to participating organizations. A portion of the distribution in each community was intended for local investment, as determined by the local participants.

Challenges and Opportunities

- Briefly discuss any major challenges encountered since the previous reporting period and responses to each.
  - CHAC has begun collaborating with two other ACOs. This has proven challenging due to having to balance CHAC projects, as well as the ongoing and increasing workload from the collaboration. CHAC has rearranged duties and delegated some projects to its administrative assistant and to other Bi-State employees to provide relief to CHAC staff. This enables the staff to focus more on the unified organization.
- Briefly discuss any new opportunities available to support this project programmatically.
  - No new opportunities at this time.

Activities Undertaken and Planned

- Ongoing Activities
  - Briefly describe any ongoing activities not previously mentioned above.
    - Board Meetings are held monthly to keep moving business forward.
    - Each of the standing committees meets at least quarterly. This has been successful and is ongoing. Most of the committees have opted to meet more often.
    - A CHAC representative regularly attends all VHCIP work group meetings.
    - CHAC continues to implement new clinical guidelines in participating health centers.
    - CHAC tracks patients opting out of sharing information with the ACO.
    - CHAC's tel-assurance program enrolls and monitors "rising risk" patients.
    - Analysis of quality and financial results from 2015 will guide future quality improvement efforts and clinical initiatives.
    - Recruitment of consumer members and consumer outreach continues to be conducted with the help of the CHAC Board.
    - CHAC is helping to staff and support the continued work of the ACO Operations Committee and subcommittees.

Activities Undertaken and Planned

- New Activities
  - Briefly describe any new activities scheduled to take place before the next reporting period.
    - The next Medicaid mailing is scheduled to occur by May 15, 2016. New Medicare templates for beneficiary notification were sent out to the participating organizations.
    - Due to the success of the first joint meeting of the Clinical and Operations Committees, it has been decided that these meetings will occur at least twice a year. The next one is scheduled for June 21, 2016 with topics of discussion to include the results from the chart abstraction.
    - Bi-State is now generating claims-based summary reports of Medicaid claims data for attributed patients. These reports are provided individually to health centers when our Program Manager of Health Care Informatics meets with them one-on-one.

Activities Undertaken and Planned

- Long-Term Activities
  - Briefly describe any long-term activities currently being planned.
    - CHAC is collaborating with the State and VCCI to enroll more eligible patients by increasing provider awareness and facilitating warm handoffs. Representatives of VCCI presented to the CHAC Clinical Committee in December. CHAC staff, along with staff from Northern Tier Center for Health, presented on collaborative work with VCCI at the January meeting of the RCPC in St.Albans. Meetings regarding this work were put on hold during the busy chart abstraction period. Additionally, lists of eligible patients were unavailable during this time period related to VCCI's "go-live" with their new health record. CHAC staff have been in close communication with VCCI staff throughout this process and met on April 1, 2016 to begin an intensive period of piloting improved workflow and communication at three of the FQHCs. Springfield, CHSLV, and THC have all agreed to be part of this pilot work.
    - CHAC is continuing relationship building with practice managers at network sites to collect data for quality improvement dashboard to aid in implementation of clinical recommendations.
    - CHAC will continue quality improvement efforts focused on improving clinical measures and the implementation of the new care management standards.

Providers and Beneficiaries Impacted

- Please provide the number of Providers participating in or otherwise impacted by your project.
  - There are about ~340 providers attributing to CHAC and are consequently directly impacted by the VHCIP Sub-grant program.
- Please provide the number of beneficiaries of your project.
  - There are ~55,000 attributed lives, which would count as beneficiaries.

Evaluation Methodology

- Describe the target population for the initiative
  - The target population for this initiative includes CHAC's designated employees, Governing Board, Standing Committees, participating organizations, providers, contractors, and beneficiaries.
- Describe the metrics being used to measure success (for example: # of activities by type, outcomes: clinical, financial, etc.)
  - The evaluation methodology to be used for the Furthering Community Health Accountable Care Project is to compare project status to the project work plan.
  - CHAC will further be evaluated by:
    - whether it achieved savings in any of its three product lines and whether those savings surpassed the MSRs
    - whether the ACO has improved quality of care:
      - utilizing ACO quality measures
      - through successful implementation of CHAC Clinical Recommendations

Evaluation Methodology

- Data source/s for the metrics
  - Quality and financial reports from all payer groups.
  - Clinical dashboards for recording progress of quality improvement initiatives.
- Results to date (feel free to use additional slides, if necessary)
  - Bi-State is on track with our project work plan for the Furthering Community Health Accountable Care project – see "Ongoing Activities"
  - As noted previously, CHAC achieved 2014 savings, surpassing the MSR, under the VMSSP. CHAC's quality score entitles it to 85% of the shared savings and highlights several successes and several areas for future focus and improvement. CHAC achieved 2014 savings under the MSSP, but did not surpass the Medicare MSR. CHAC, like the other two VT ACOs, did not achieve 2014 savings under the XSSP.
- Timeline for final results
  - CHAC will continue through the end of 2016 in all payer programs.

Expenditures to Date & Revised Budget

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

03410-1295-15 (VV-15) Qtrly Reporting - MAR16						
	Approved Budget	Revised Budget	2nd Revised Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ 257,700.00	$ 249,753.00	$ 251,711.00	$ 202,969.02	$ 31,231.51	$ 234,200.53
Fringe	$ 59,271.00	$ 57,443.00	$ 57,894.00	$ 43,232.54	$ 7,262.22	$ 50,494.76
Travel	$ 7,488.00	$ 16,653.00	$ 8,876.00	$ 6,844.40	$ 448.41	$ 7,292.81
Contract - Admin Support	$ -	$ -	$ 6,888.00	$ 4,546.58	$ 2,825.79	$ 7,372.37
Meetings	$ 5,400.00	$ 4,800.00	$ 7,000.00	$ 4,849.29	$ 704.54	$ 5,553.83
Professional Services	$ 12,750.00	$ 12,750.00	$ 8,790.00	$ 337.50	$ 2,227.50	$ 2,565.00
Facility Costs	$ 25,693.00	$ 10,000.00	$ 10,000.00	$ 9,751.20	$ 1,666.30	$ 11,417.50
Other Beneficiary Engagement	$ -	$ 10,000.00	$ 10,000.00	$ 7,305.70	$ 1,121.91	$ 8,427.61
Supplies	$ -	$ 7,882.00	$ 7,882.00	$ 5,755.50	$ 556.60	$ 6,312.10
Indirect	$ 31,698.00	$ 30,720.00	$ 30,960.00	$ 21,312.63	$ 3,310.46	$ 24,623.09
Total	$ 400,000.00	$ 400,000.00	$ 400,000.00	$ 306,904.36	$ 51,355.24	$ 358,259.60

State Innovation Model Grant
White River Family Practice

Date: April 2016

Reporting Period: July 2015 through April 2016

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

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

- Successful Reallocation of Grant Funds to help answer additional questions regarding Health Confidence.
- Redefining work strategies and personnel use within the office after loss of Care Coordinator
- Working with DHMC following their discovery of additional WRFP patient encounters previously not defined within their system. Updated report enclosed.
- Re-submission of paper to Family Practice Management addressing their comments to our first draft.

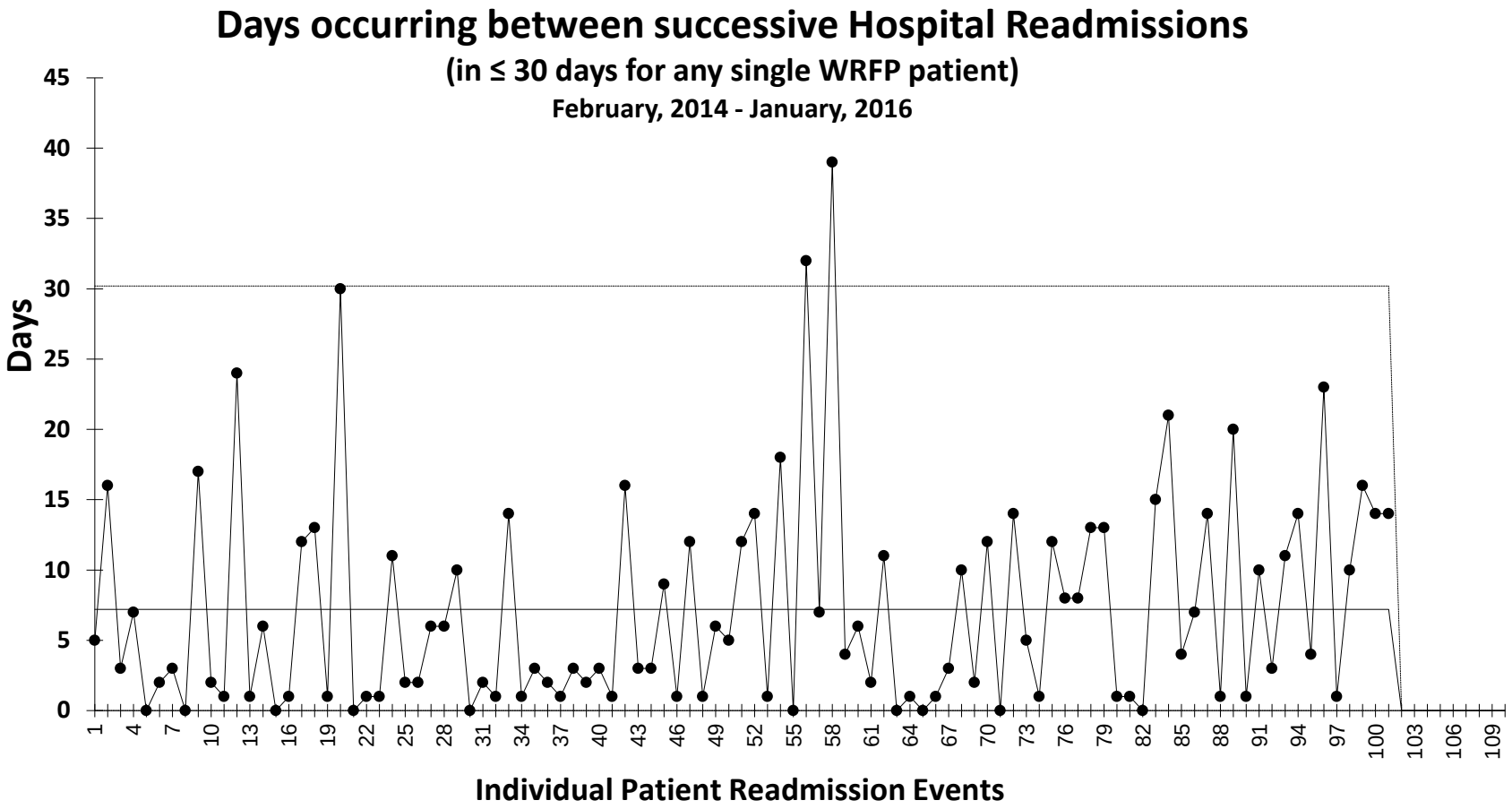
Recent Accomplishments

- 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
  - Dartmouth Primary Care CO-OP

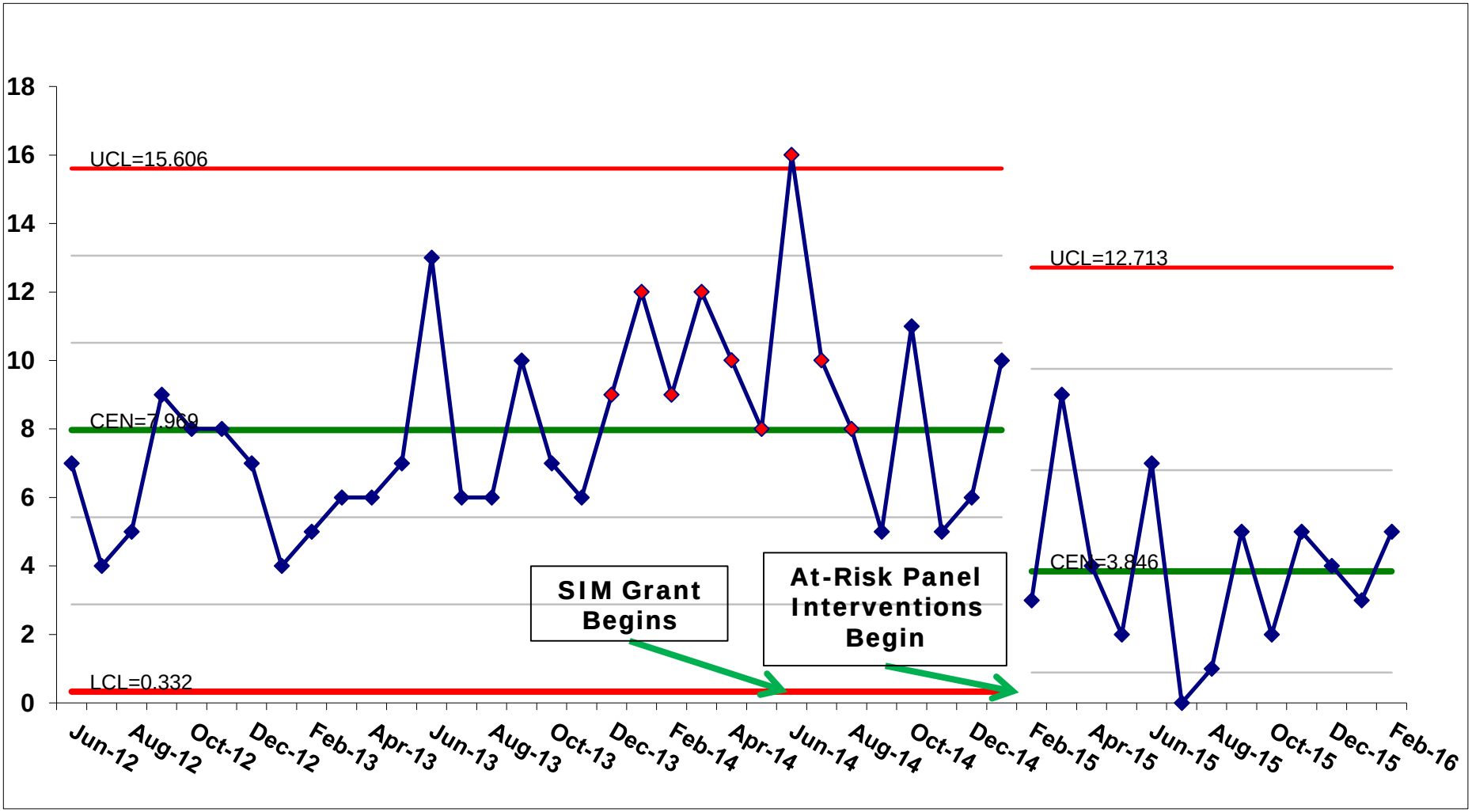
Evaluation Methodology

- 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.
- We are preparing to add focus groups and patient interviews to our process.

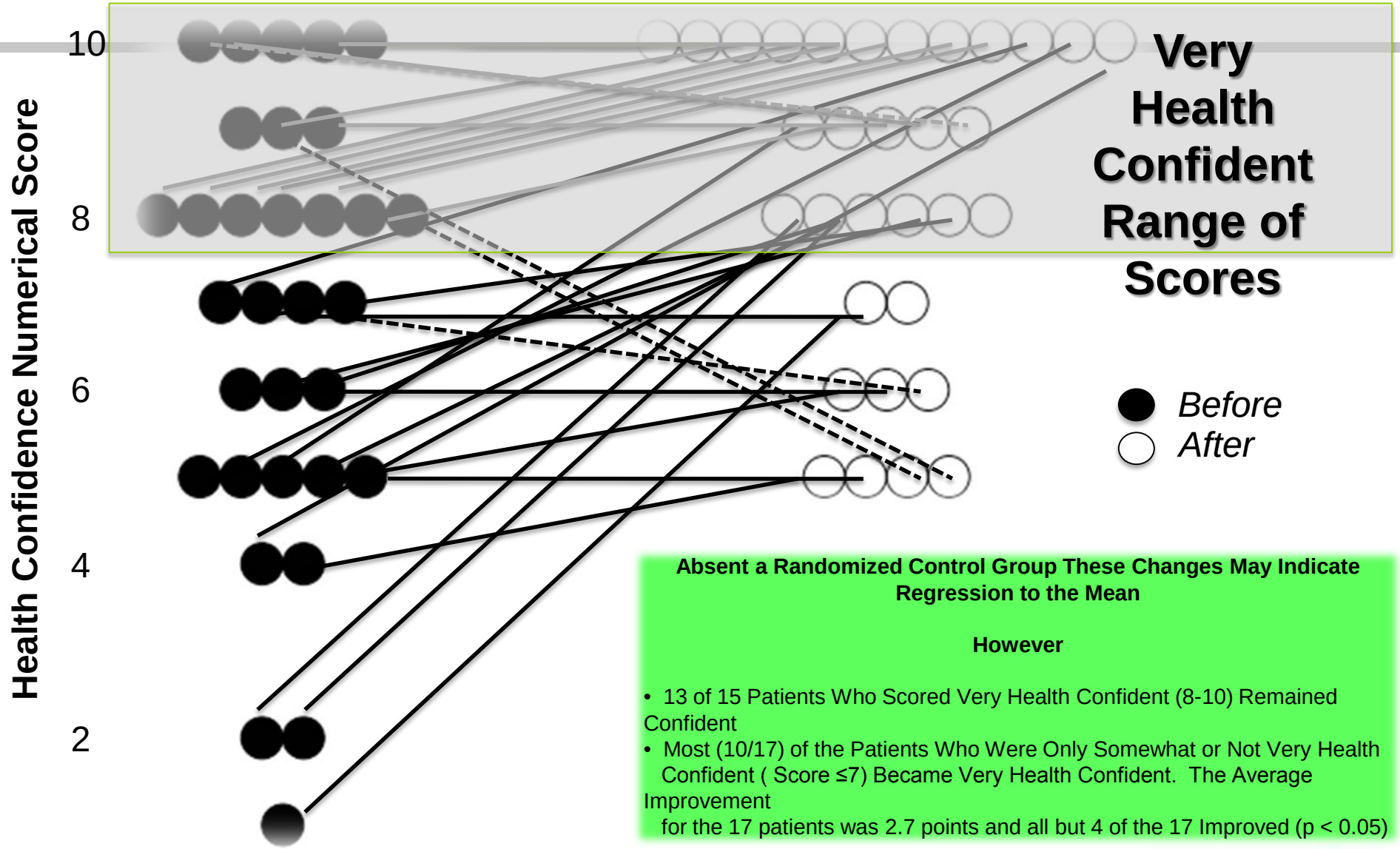
Using statistical process control analyses…



DHMC Hospital Admissions & ED Encounters from among patients in the At-Risk panel at WRFP



Details for Intensive Intervention Patients



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

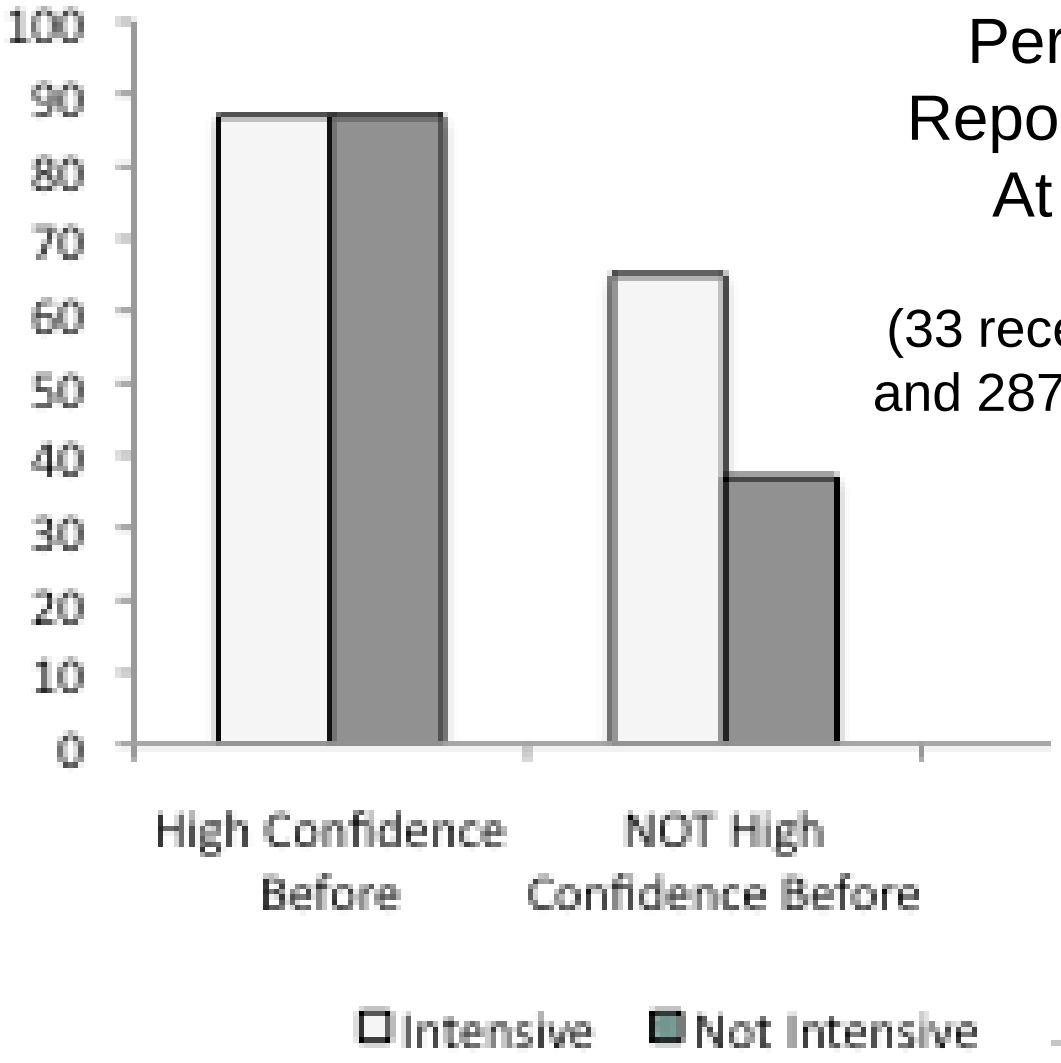
However

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

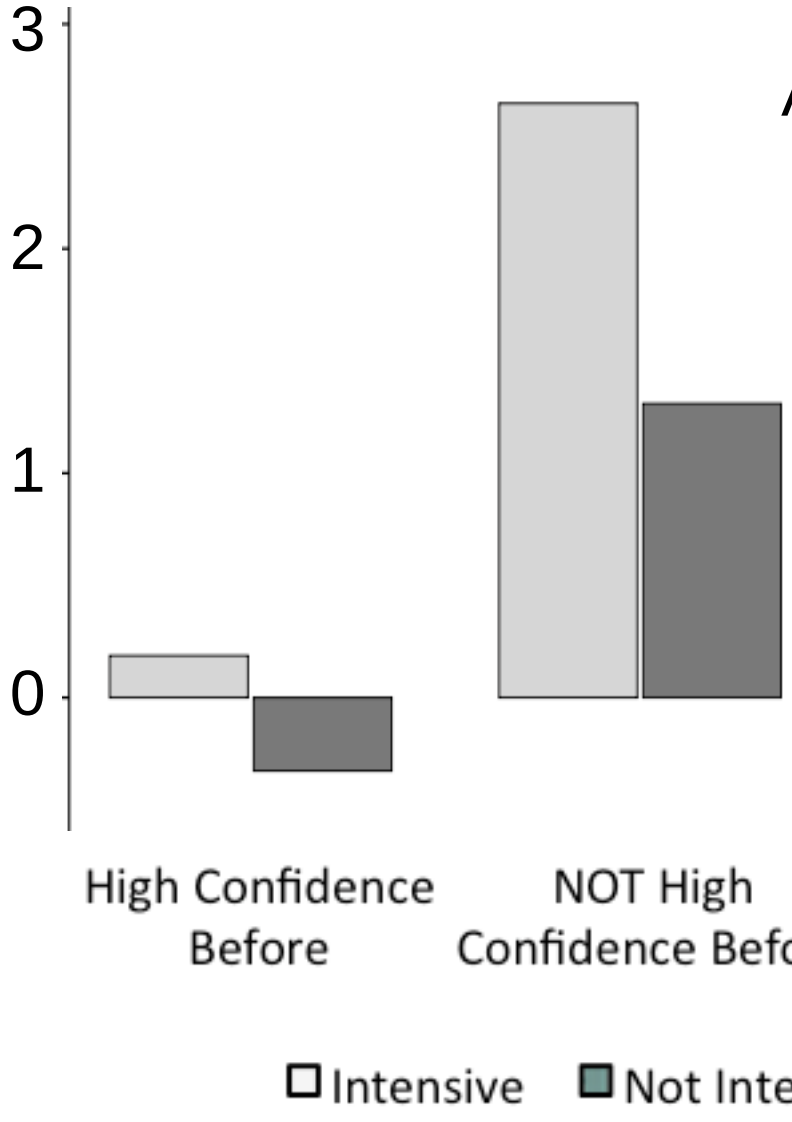


Percentage of Patients Reporting High Confidence At A Later Office Visit

(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.

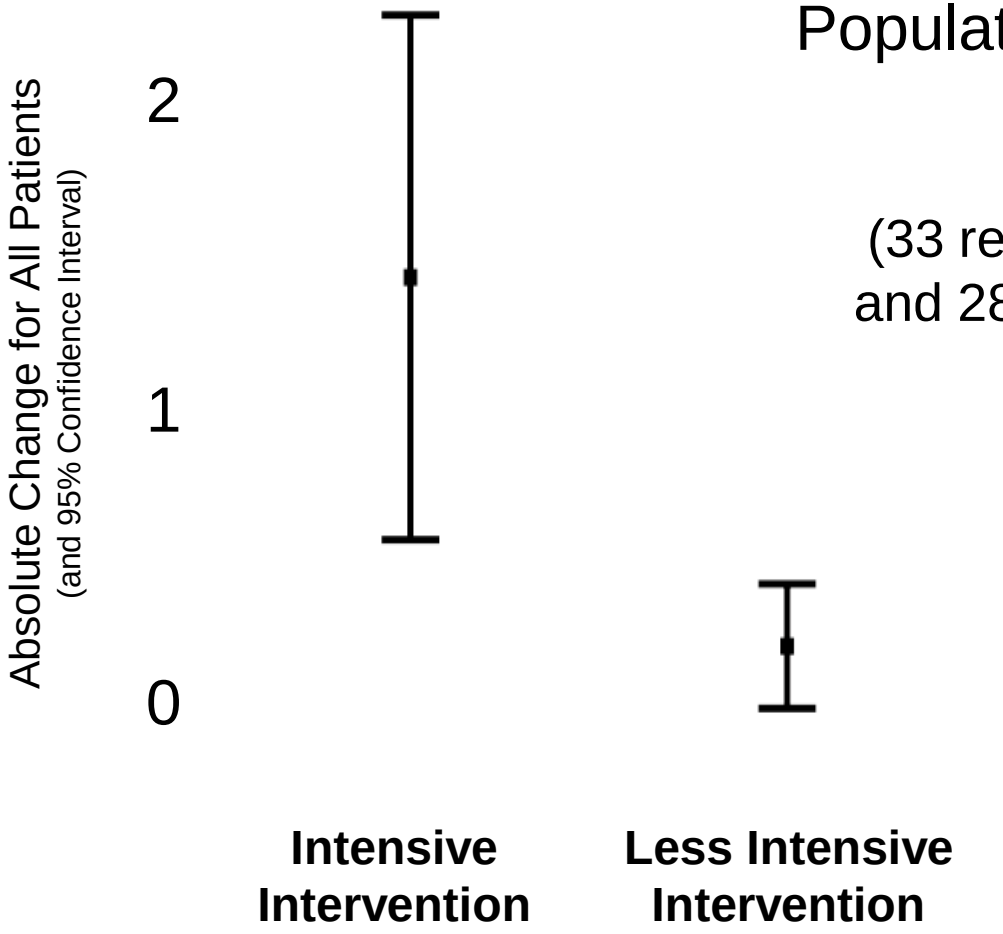


Average Change in Confidence On a 0-10 Scale for Patients At A Later Office Visit

(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 refine allocation of clinical resources towards patients at higher risk of poor health outcomes or avoidable hospital use.
- Optimally utilize the Motivational Interviewing skills of our team including all staff members to help with patients' 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.

Opportunities, continued

- Patient Focus groups and patient interviews to determine which interventions were most meaningful to our patients, what additional interventions would be helpful, and what health confidence means to our patients.
- Re-instituting Care Coordinating Services and Mental Health services over the summer.
- Use of eClinicalWorks Kiosk function to increase the ways in which our patients are able to update their own records and provide more patient reported measures (PRMs).

Challenges

- Our biggest challenge has been re-invigorating our project and reconstituting our team after the cessation of payment in late 2015 and the subsequent loss of our Care Coordinator.
- Other than BCBSVT & Vermont's DVHA, claims data remains unavailable.
- Limited resources at both WRFP & DHMC have precluded more robust collaboration with the DHMC ER high-utilizer project.

Activities Undertaken and Planned

- Ongoing Activities
  - Grant team meetings
  - Regular meetings with DHMC to refine monthly data feed
  - Ongoing work with eCW to refine CCMR and its use within the office
  - Sharing our work with colleagues through a submission of scholarly paper to Family Practice Management and a presentation at the Feb 2016 Dartmouth Primary Care CO-OP meeting.
  - Analysis of health confidence data collected serially (contained here)
- New Activities
  - Improvements in Care Management plans within the office.
  - Preparation for focus groups and patient interviews.
- Long-Term & Continuing Activities
  - Working with our patients and with community partners to develop further interventions targeted at patients with low self-confidence and/or high utilization

Providers and Beneficiaries Impacted

- Providers participating in or otherwise impacted by our project include
  - WRFP Staff 25
    - 5 MDs, 3 NPs,1 PA, 2 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.
  - 7,528 patients seen at WRFP between 4/1/15 – 4/1/16
  - WRFP averages 38 patient admissions per month to DHMC
  - WRFP averages 89 patient ED visits per month to DHMC

Expenditures to Date & Revised Budget

- I N V O I C E & RECONCILIATION -

Invoice # 18 Date: 4/4/2016

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		79,338.25	19,669.75
Lexi Burroughs	20,000.00		16,520.50	3,479.50
Sean Uiterwyk, M.D.	23,100.00		19,082.46	
Jill Blumberg, M.D.	-	$1,004.34	-	9,039.24
Total Salary	142,108.00	$1,004.34	114,941.21	27,166.79
Fringe	17,168.00		14,198.43	2,969.57
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	$3,055.00	97,942.50	17,257.50
Symquest	7,500.00		3,756.96	3,743.04
Cert Diabetes Educator	270.00		-	270.00
Dev't of Health Coach Curriculum	7,500.00		6,651.54	848.46
Indirect	33,006.00	$1,435.04	27,265.76	5,740.24
Total :	$ 363,070.00	5,494.38	285,156.67	77,913.33
Less: unspent Advances				
Net Invoice :		5,494.38		

Instructions to report spending (above):

The Awardee must prepare a detailed expenditures report identifying monthly spending and cumulative spending vs budget. Please use this Excel spreadsheet.

To begin, please first complete the "Spend trend" tab.

"Cumulative Spend to Date" and "Unspent Award Balance" values on this " Invoice & Reconciliation" sheet will auto-calculate.

Then, please copy the current month spending from the Spend Trend Tab to this schedule in column "E" titled: "Current Month Spending"

Please deduct any unspent advances from the current month to calculate the new invoice value