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# **VHCIP Provider Sub-grant Second Quarter 2016 Quarterly Program Reports**

**Vermont Health Care Innovation Project  
2016 Quarterly Report**

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

***Date July 10, 2016***

***Reporting Period:***

***2<sup>nd</sup> Year Second Quarter***

***(April – June)***

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

***Ginger Cloud, LCMHC, LADC***

# Grant Project Goals

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

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

# Scope of Work to be Performed: Update

- 1. Implement current SBIRT strategies within patient centered medical homes via the following activities:
  - a. Develop a Short Message Service (SMS) protocol to monitor substance use and engage and extend patient activation.

The SMS service was developed and implemented in the medical homes throughout CVMC, unfortunately this system was not well utilized by our patient population. Under ten patients accessed the SMS system, we did not renew our contract with Biostratica due to poor patient engagement/interest in the SMS system. We believe the service was under-utilized due to our average patient age being 52 and this demographic may not be interested in a texting program to assist with reducing their alcohol consumption. We hypothesize that a SMS system that patients could utilize post treatment to reinforce use of coping skills learned in therapy may be a better avenue to pursue in the future.

# Scope of Work to be Performed: Update

- b. Promote the SBIRT model statewide through presentations and targeted outreach to professional associations.

Our SBIRT team has engaged in presentation and targeted outreach to statewide professional organizations including: [Quarterly SBIRT Policy Steering Committee- Targeted Outreach/ presentations on progress/barriers](#); [Quarterly Mental Health & Substance Abuse Advisory Committee - Targeted Outreach](#); [Blueprint for Health Annual Meeting– Presentation](#); [Blueprint for Health/Department of Vermont Health Access – Targeted Outreach](#); [Washington County Youth Service Bureau – Targeted Outreach](#); [Maple Leaf Treatment Center – Targeted Outreach](#); [Central Vermont Addiction Medicine – Targeted Outreach](#); [Vermont Department of Health –Alcohol and Drug Abuse Programs- Targeted Outreach](#); [Blue Cross Blue Shield of Vermont – Targeted Outreach](#); [One Care -ACO- Targeted Outreach](#); [Community Alliance for Health Excellent Steering Committee- Targeted Outreach](#); [VHCIP Sub-grant Symposiums – Presentations](#); [Central Vermont Substance Abuse Services – Targeted Outreach](#); [Valley Vista – Targeted Outreach](#); [Washington County Mental Health Services- Targeted Outreach](#); [Act One/ Bridge Program – Targeted Outreach](#); [Serenity House – Targeted Outreach](#); [Tobacco Control Program – Targeted Outreach](#); [Turning Point – Targeted Outreach](#); [Brattleboro Retreat – Targeted Outreach](#); [Washington County Substance Abuse Regional Partnership- Targeted Outreach](#); [CVMC ‘s Medical Group Management Committee \(MRD\) – Presentations/ Targeted Outreach](#); [CVMC Medical Executive Committee \(MRD\) - Presentations/Targeted Outreach](#); [CVMC Quality Committee \(MRD\)-Targeted Outreach](#) ; [CVMC Board of Trustees \(MRD\)- Presentations/Targeted Outreach](#); [Vermont Emergency Department Directors Committee \(MRD\) Presentations/Targeted Outreach](#); [UVM Health Network Board of Trustees Population Health & Quality Committee \(MRD\)- Presentations/ Targeted Outreach](#).

# Scope of Work to be Performed: Update

- 2. Utilize SMHSA's Technical Assistance Systems-Level Implementation manual to develop a systemic training model to promote clinical skills learning, practice competency and fidelity in SBIRT.
- a. Trainings will be provided to provider health care teams, hospital management and other stakeholders through courses, webinars, onsite coaching and clinical toolbox resource.

Medical Home staff members were engaged in onsite SBIRT presentations, in-person and online trainings, and received a comprehensive SBIRT resource binder. Introductory SBIRT presentations were incorporated into multiple Medical Group Management meetings and specialty practices.

- 3. Conduct outreach to identify an SBIRT MGP Champion Team at each site to support SBIRT adoption and implementation.

Each participating Medical Home identified an SBIRT champion team consisting of a medical secretary, nurse, and medical provider. Regular PDSA meetings were held during initial implementation and continued support and training is available as needed.

# Scope of Work to be Performed: Update

- 4. Integrate the SBIRT measure set into eClinicalWorks (eCW) software, including: initial screening items (AUDIT C, 3 NIDA questions; secondary screening tools (AUDIT-10 and DAST-10); stratified risk scores; and clinical intervention tracking to improve care coordination and to expedite billing for reimbursement.

The integration of the SBIRT measures into eClinicalWorks software happened in January 2015. Routine tracking of clinical intervention rates are reviewed to improve care coordination. All services are captured in structured fields and track potential billing for reimbursement.

- 5. Increase and enhance current linkages to the ED and specialty behavioral health and addiction treatment providers in Central Vermont to facilitate the exchange of patient information, improve safety, care coordination and quality of health care.

We have been engaged in monthly meetings with ED SBIRT clinicians to assist coordination of care efforts for patients getting into specialty providers and ongoing care in the patient's medical home. We have brought together specialty behavioral health and addiction treatment providers in Central Vermont to facilitate exchange of patient information, improve safety, care coordination and quality of health care through the forming of Washington County Substance Abuse Regional Partnership Committee. This committee meets monthly and includes representatives from: CVMC SBIRT program, Central Vermont Substance Abuse Services, Turning Point, Alcohol and Substance Abuse Prevention Program regional director, Central Vermont Addiction Medicine, Washington County Mental Health Services, Washington County Youth Service Bureau, Valley Vista and other inpatient treatment programs as guests.

# Scope of Work to be Performed: Update

- 6. Explore the utility of the current SBIRT reimbursement practices across differing settings statewide and differing provider disciplines.

We have learned about different approaches to providing screening and behavioral health interventions in the medical settings in multiple sites throughout the state. From Bennington to St. Albans to Burlington, there appears to be varied approaches to integrating screening and behavioral health services. Federally Qualified Health Centers have a unique advantage to providing behavioral health services as they received a larger reimbursement rate for their services than non-FQHCs. For non-FQHC there appears to be a need to rely on the community behavioral health agency to provide behavioral interventions to patients.

The ability of a medical practice to be able to cover the cost of employing a behavioral health clinician to be available for brief interventions does not appear to be viable. Currently Medicaid and Blue Cross Blue Shield of VT are the only insurance providers that have their SBIRT codes active. There appears to be a high denial rate of submitted SBIRT codes to Medicaid and unclear guidelines on the documentation required for the code reimbursement, significantly complicating the reimbursement process.

For our site we believe that accessing funding opportunities through the community health team will be the best option. The patients that utilize SBIRT intervention services are a mix of Medicare (17%), Medicaid (32%), self pay (2%) and third party payers (49%). The brief intervention and brief treatment services appear to be well received by patients and providers as an immediately accessible and free service. Operating outside of the fee for service paradigm reduces barriers to accessing treatment and has shown significant patient engagement regardless of insurance coverage.



# Scope of Work to be Performed: Update

- 7. Collaborate with ADAP, DVHA, and commercial insurers via the Department of Financial Regulation, to develop a VT-SBIRT financial model to be adopted statewide and ultimately to ensure same-day billing for two services and that SBIRT codes are activated for an expanding workforce.

In the fall of 2015, ADAP expanded the workforce providers that are able to bill for SBIRT interventions to include licensed behavioral health clinicians. Blue Cross Blue Shield of Vermont opened their SBIRT codes and have a pilot program supporting the implementation of the SBIRT model into five primary care settings in the State of Vermont. We regularly participate in the state SBIRT Policy Steering Committee meetings connecting with ADAP, DVHA and commercial insurers (mainly BCBS) to explore the development of a state wide reimbursement model for SBIRT services. We have not found a viable solution at this point and we will continue to work on a sustainability strategy with the SBIRT Policy Steering Committee.

In the meanwhile, we continue to work on our internal strategy for sustaining the SBIRT model and interventions that have been developed at CVMC. Feedback from our medical providers is that they value the SBIRT services and they ultimately desire a long term plan that will allow for the service to remain non-billable, keeping the services equally accessible to all patients. We are exploring ways to wrap SBIRT services into our community health team umbrella, expanding the coverage for clinician availability for brief interventions, and keeping the services non-billable.

# Scope of Work to be Performed: Update

- 8. Educate and guide medical providers in substance abuse coding and billing.

We have explored various potential substance abuse codes and screening codes to utilize in the event the SBIRT interventions become a billable service or the clinicians get wrapped into the community health team and remain non-billable. At this point, it appears most likely that our program will get wrapped into the community health team and remain a non-billable service. Regardless, we do see an option to train medical staff on using the 99420 administration of a health screen code as a viable billing option for patients screened by nurses under the direction of the medical provider. Once we have final approval from our coding and finance departments we will proceed with appropriate education.

- A. Subrecipient shall work with VHCIP staff to coordinate several meetings with the State and third party payers to fully understand the potential billing mechanisms across differing care settings and provider types.

At the SBIRT Policy Steering Committee we work with the State and third party payers to understand the potential billing mechanisms across differing care settings and provider types. Our finance and coding departments have assisted the creation of a spreadsheet outlining the potential codes and reimbursement rates. These departments have been in contact with third party payers to understand limits or restrictions on the use of the associated codes. We are working with BCBS to verify the accuracy of these findings and contribute additional avenues of reimbursement. There appears to be greater opportunity for a fee for service model of SBIRT interventions at the FQHC sites due to increased reimbursement rates and the ability for the behavioral health interventions to generate significant revenue.

# 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
<b>Total Provider FTEs</b>	<b>5.01</b>	<b>5.69</b>	<b>7.45</b>	<b>4.73</b>	<b>1.6</b>	<b>2.3</b>
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
<b>Clinical FTEs</b>	<b>5.95</b>	<b>9.79</b>	<b>9.7</b>	<b>6</b>	<b>3</b>	<b>3.5</b>
Office Supervisor	1	1	1	1	0	1
Medical Secretary	5.27	6.06	7.18	5.72	1	2.5
<b>Front End/Other FTEs</b>	<b>6.27</b>	<b>7.06</b>	<b>8.18</b>	<b>6.72</b>	<b>1</b>	<b>3.5</b>
<b>Total FTE's Per Practice</b>	<b>17.23</b>	<b>22.53</b>	<b>25.33</b>	<b>17.45</b>	<b>5.6</b>	<b>9.3</b>
<b>Total Attributed Patients</b>	<b>3611</b>	<b>6816</b>	<b>8167</b>	<b>6655</b>	<b>957</b>	<b>4918</b>

# 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. The SBIRT model utilizes an initial alcohol screen the AUDIT C and an initial drug screen the NIDA three question drug screen. For patients that score positive on either initial screen the corresponding secondary screen is administered (AUDIT C- AUDIT 10; NIDA screen- DAST 10). When a patient is engaged in a brief intervention by the provider or SBIRT clinician this action is documented in our EMR, similarly if a patient is referred to brief treatment for intensive treatment these actions are documented in the EMR. Patients are routinely screened for tobacco and receive a brief intervention and as appropriate a referral for tobacco treatment.
- To collect data and evaluate the utilization of the SBIRT model in the medical home we are using the reporting functions through our EMR and patient self report. The demographic information, the number of screens complete, engagement in brief interventions, brief treatment and referral to treatment are tracked through the EMR. The reduction or elimination of use patterns among patients engaged in treatment with the SBIRT clinician is based on patient self-report.
- Please see results slide to review current screening and intervention data.
- We anticipate a summation of our implementation process and corresponding results by the end of our grant contract, November 30, 2016.

# Results

- 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 7,000\* patients have been screen for risky alcohol use and risky drug use. Of those patients screened 411 have received Brief Interventions by our clinicians, and of those. Regardless of if a brief intervention was performed, since April of 2015, 1,037 SBIRT referrals were made by providers, 625 patients have engaged in a Brief Treatment session with our clinicians and 156 patients are currently engaged in either brief treatment or follow up on referral concerns.

\*screens include women's health data (separate grant)

# Sustainability

- We have been working with the SBIRT Policy Steering Committee and national partners to identify codes and reimbursement rates per payer to gain insight into the sustainability of the SBIRT model throughout the state.
- Locally at CVCM we are discussing the option of having our SBIRT team absorbed by our Community Health Team, which would allow our services to remain available at no cost to patients. Moreover, we would be able to continue to offer patients individual tobacco treatment services which is currently not a billable service by licensed counselors.

# 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
<b>Salary</b>	\$ 357,017.07	\$ 195,099.47	\$ 45,128.99	\$ 240,228.46
<b>Fringe</b>	\$ 95,246.00	\$ 51,323.00	\$ 13,339.00	\$ 64,662.00
<b>Supplies/travel</b>	\$ 12,797.93	\$ 6,178.66	\$ 4,128.42	\$ 10,307.08
<b>Conferences</b>	\$ 4,000.00	\$ 413.42	\$ 1,021.34	\$ 1,434.76
<b>Equipment</b>	\$ 4,939.00			\$ -
<b>Contracts</b>	\$ 6,000.00	\$ 5,000.00		\$ 5,000.00
<b>Other Costs</b>	\$ 20,000.00	\$ 10,000.00		\$ 10,000.00
<b>Total</b>	\$ 500,000.00	\$ 268,014.55	\$ 63,617.75	\$ 331,632.30

- We submitted a budget reallocation to include a 10% indirect fee to assist with expenses associated with indirect costs (rent, heat, electricity etc).

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***SIM Funding for Infrastructure Building***

**HealthFirst, Inc.**

***Date: July 10, 2016***

***Reporting Period: April 1 – June 30, 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) - ongoing**

# Grant Project Goals

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

# Recent Accomplishments

- **Goal 8. Clinical quality measures data collection process:** With 2015 data quality finalized and submitted to the state, our Quality and Care Coordination Manager (QCCM) and Clinical Quality Director have turned attention to evaluating the 2015 ACO quality data against 2014 quality performance, health service area data, and statewide quality performance data. They are creating “score cards” to help member practices compare their performance under Blueprint and ACO quality data and identify areas of strength and in need of improvement. Our QCCM continues to work directly with practices to provide assistance for ACO data tracking in preparation for the 2016 data collection and to help connect lower performing practices with high-performing practice “mentors.”

# Recent Accomplishments

- **Goal 11. Architecting disease management programs:** ACO quality data from 2014 and 2015 suggests that a number of our network's diabetic patients had not received annual dilated retinal exams, a key screening for diabetic care management. Further investigation shows that this may result not from a lack of care, but from poor communication between patients' eye care providers and their primary care doctors. HealthFirst has prepared a letter to eye care professionals across the state who may serve patients under our member physicians' care asking them to commit to alerting primary care practices when their diabetic patients have had this eye exam. Ensuring that patient care is being reported accurately enables our practices to make timely, effective changes to procedures and protocols to improve patient care and outcomes.

# Recent Accomplishments

- **Goals 13 & 15. Education opportunities and materials to guide practices in the delivery of high-quality care and data tracking:** At the April Clinical Implementation Committee meeting, Jennifer Gordon of Qualidigm's QIN-QUO program presented a slide show outlining changes to PQRS and the value-based modifier (VBM) for 2016. She stressed that 2016 is a pivotal year for practices to complete the PQRS process and provided context to highlight the importance of the VBM and how it affects physicians' offices. Beyond the presentation, Ms. Gordon encouraged practice managers to contact her with questions or if they needed support for the PQRS process. Committee members asked insightful questions related to the program as a whole and how it relates to their specific practices. Following Ms. Gordon's talk, our Clinical Quality Director, Rick Dooley, gave a brief overview of upcoming changes to Medicare coding and how those changes could affect practices. Following the meeting, he sent additional guidance about the changes to practices.

# Recent Accomplishments

- **Overarching Goal. Capacity and Infrastructure Building:** This grant has helped transform HealthFirst over the past two years by enabling us to hire personnel, establish an office, create an identity with a new logo and website, and expand our outreach and support to our members. To capture our members' perspectives about HealthFirst's efforts, in June, we developed a member benefit survey. Our goal is to find out what members value most about HealthFirst and to invite them to share feedback and ideas for strengthening the organization further. About one-third of our members have responded to the survey thus far and the survey will remain open throughout the summer. Preliminary results show us that our members especially appreciate HF's efforts to keep them informed about the intricacies of healthcare reform in the state, technical assistance for data tracking and reporting, and efforts to clinically integrate our network of independent providers. The survey also elicited feedback around how HealthFirst can sustain programs and services once the grant ends in October.

# Challenges

- **Quality Data:** HealthFirst is very pleased with the “office champion” model we implemented for the ACO data collection starting in 2014, and we are confident that the data collected for the past two years is far more accurate than data we had been seeing when outside contractors were performing the data abstractions. Despite this positive outcome, this methodology highlights the tremendous amount of staff time and resources it can take for practices to manage value-based programs. It also underscores the need for more concerted efforts to ensure that providers and payers are aligned with base groups, time lines, and shared benchmarks to reduce the burdens on practices while supporting meaningful evaluation of performance quality.



# Opportunities

- **The VHCIP Symposium** in mid-June was a welcome opportunity for HealthFirst to talk about some of the ways in which we have been successful in using the capacity we have built under the grant, namely personnel capacity to provide direct support to practices. It was gratifying to learn about other subgrantees' projects, too, as it provided some perspective on the broader implications of the SIM program for the state's healthcare reform efforts.
- **CPC+:** Another exciting opportunity that came up last quarter is the CPC+ program. We are hoping that Vermont will be selected as a CPC+ region; several of our member practices are interested in applying for the program. CPC+ is evidence that the voices of primary care physicians are being heard not only in Vermont, but also across the country as communities and regions grapple with provider shortages for preventive and acute primary care.
- **Data Integration:** HF Executive Director Amy Cooper and HF Board Treasurer Dr. Bruce Bullock, who also sits on VITL's board of directors, have met with some vendors to discuss possible ACO-level data integration solutions so we can standardize data across several EMRs to ensure that our data efforts align with VITL's work on a data gateway and the state's data integration plan.

# Planned Activities

- **Annual Meeting:** Planning is underway for our annual meeting, which will be held in late October. HF staff and board members are thinking about a change from our usual format. Instead of having three speakers and a speaker Q & A panel, we are considering one or two speakers, a Q & A panel focused on health reform in the state, and networking time for member guests to meet and talk with other physicians in the network, which will strengthen ties for collaborative care and clinical integration.

# 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 shows that Vermont's independent physicians are providing excellent care to their patients. Data for 2015 was finalized and submitted to the state before the July 1 deadline. Performance in 2015 improved on two-thirds of the quality measures when compared against HSA and statewide performance. Cross-year analysis comparing 2014 data to 2015 data shows that our practices continue to maintain and/or improve already high performance across the majority of benchmarks.

# 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.

# Sustainability Planning

## Current Planning

- HealthFirst's sustainability planning is well underway, and we are grateful that we have been awarded a grant extension to help us make the smoothest financial transition possible once the grant period ends. Our board's finance committee has been meeting regularly to examine possible options and revenue streams, including a member dues increase and participation in the all-payer waiver model, a process in which HealthFirst has been highly engaged for the past 18 months.
- Part of the reason we undertook the member survey was to understand how our members are prepared to contribute to maintaining our infrastructure after our grant funding ends. After doing an initial review of the results, we are contemplating changing our dues and fee structures in order to more fully support the services we provide to independent practices.
- Additionally we are engaging in serious conversations with other groups about expanding our network in some creative ways that will best position independent doctors to succeed in value-based payment initiatives.

# Sustainability Planning

## Continuing SIM Activities Beyond the Grant

- Because our grant focuses specifically on capacity and infrastructure building, work started under the grant will continue intrinsically. Personnel compensation is a top priority in our financial planning. We have built an excellent team and wish to retain staff in every position to harness the expertise gained during the grant period so we can provide the most effective and efficient support to practices, particularly around data tracking and reporting; clinical integration, collaborative care and care transitions; and best practice sharing. As noted, we are also working to identify solutions for network-wide data integration with goals of (1) streamlining data collection to reduce administrative burdens on our practices participating in value-based quality programs and (2) enabling more efficient and accurate data analysis.



# Expenditures to Date: January to March 2016

HealthFirst, Inc. - SIM Grant #03410-1305-15					
Financial Report: April 2016-June 2016					
	Approved Budget	Spent Prior Quarter Jan-Mar 2016	Spent Current Quarter Apr-June 2016	Spent to Date	Balance
<b>Staff Compensation</b>					
Executive Director	\$172,066.52	\$19,980.12	\$19,980.12	\$146,999.98	\$25,066.54
Administrative Assistant	\$55,166.84	\$6,437.52	\$6,437.52	\$46,583.38	\$8,583.46
Operations Director	\$122,092.66	\$9,321.45	\$32,653.45	\$86,332.06	\$35,760.60
Clinical Lead, Other MD	\$24,325.00	\$0.00	\$0.00	\$24,325.00	\$0.00
Quality & Care Coord. Mgr.	\$93,333.28	\$16,249.98	\$19,583.34	\$68,333.28	\$25,000.00
Fringes	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>Total Wages</b>	<b>\$466,984.30</b>	<b>\$51,989.07</b>	<b>\$78,654.43</b>	<b>\$372,573.70</b>	<b>\$94,410.60</b>
<b>Consultants</b>					
Local Physician Liaison Team	\$26,561.25	\$0.00	\$0.00	\$26,561.25	\$0.00
Legal services, HR, IT, other contracts	\$52,039.15	\$0.00	\$0.00	\$52,039.16	(\$0.01)
<b>Total Consultants</b>	<b>\$78,600.40</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$78,600.41</b>	<b>(\$0.01)</b>
<b>Office</b>					
Rent	\$22,657.76	\$2,378.48	\$0.00	\$22,657.76	\$0.00
Utilities	\$3,013.90	\$270.54	\$0.00	\$3,013.90	\$0.00
Supplies (incl computers, communication)	\$14,983.32	\$1,423.89	\$0.00	\$14,983.32	\$0.00
Meetings and travel	\$8,086.90	\$0.00	\$0.00	\$8,086.90	\$0.00
Bi-annual meeting	\$3,236.24	\$0.00	\$0.00	\$3,236.24	\$0.00
Outreach	\$2,437.18	\$0.00	\$0.00	\$2,437.18	\$0.00
<b>Total Office</b>	<b>\$54,415.30</b>	<b>\$4,072.91</b>	<b>\$0.00</b>	<b>\$54,415.30</b>	<b>\$0.00</b>
<b>TOTALS</b>	<b>\$600,000.00</b>	<b>\$56,061.98</b>	<b>\$78,654.43</b>	<b>\$505,589.41</b>	<b>\$94,410.59</b>

# Budget Notes

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## Notes

We have no notes for this budget report, but encourage you to contact us if you have questions.

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

**State Innovation Models: Funding for  
Model Design**

**Vermont Program For Quality in Health Care, Inc.**

*Date: July 8, 2016*

*Reporting Period: April 1, 2016- June 30, 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

## Ongoing Data Collection

- Four hospitals are collecting and entering data into ACS NSQIP workstation
- A fifth hospital is discussing NSQIP internally
- Preliminary collaborative NSQIP Outcomes shared with collaborative members (October-June)

## SCRS

- Two of the SCRS' are now certified in ACS NSQIP data collection

## Surgeon Champion

- Enlistment of a new surgeon champion

# 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.
- ❑ Human Resources: Two SCRS' resigned their positions forcing hospitals to place data collection on hold.
- ❑ 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 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; Q-Centrix may be able to help with SCR needs and data abstraction.

# Opportunity

- Raise awareness ACS NSQIP/Statewide Collaborative Efforts to improve surgical care
  - Dartmouth Hitchcock and UVMHC 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.

# PRE-OP RISK FACTORS

## **1269 CASES**

778 adults (61%) 1 or more risk factors

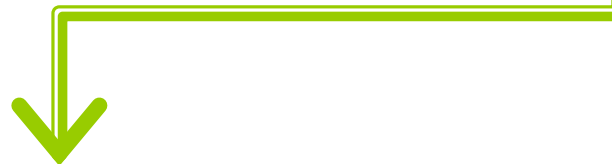
491 adults (39%) no risk factors

**11.9%** adults with diabetes

**21.5%** smokers within past year

**92.2%** functionally independent

**38.2%** require medication HTN



**Concept: Surgical Home**



# Activities Undertaken and Planned

- **Ongoing Activities:** Facilitating meetings of collaborative members and SCRS'; Reviewing AND trending data entered into NSQIP workstation; Coordinating face to face collaborative meetings; Providing clinical and technical support to hospitals, Quality Directors, and surgical clinical reviewers (SCRs') for clinical abstraction; Communicating NSQIP to hospital leadership.
- **Planned Activities:** Anticipate enrolling more hospitals in NSQIP; Continue to schedule collaborative members 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

# VSSS Collaborative Data: Outcomes and Costs

- **1269 Cases** entered into work station
- **94.2%** 30 day follow up
- **76 adults (6%)** had a surgical complication
  
- **Complications:** wound, respiratory, urinary, cardiac, central nervous system
  
- **Costs: 76 X \$11,000(AVG added cost) = \$836,000 additional direct health care cost**

# EVALUATION METHODOLOGY

TARGET POPULATION	QUANTITATIVE METRICS TO MEASURE SUCCESS	DATA SOURCE FOR METRICS	RESULTS TO DATE	TIMELINE FOR FINAL RESULTS
<p>INPATIENT OR OUTPATIENT SURGICAL PATIENTS at 18 YEARS OF AGE OR OLDER</p> <p>NO TRAUMA CASES</p>	<p><b><u>CLINICALLY:</u></b> RATES OF POSTOPERATIVE COMPLICATIONS INCLUDING MORTALITY</p> <p><b><u>FINANCIAL:</u></b> COSTS FOR POSTOPERATIVE COMPLICATIONS EXCLUDING MORTALITY</p>	<p>VUHDDS <b><u>AND</u></b> ACS NSQIP RAW OUTCOMES DATA</p> <p>PATIENT DATA ENTERED INTO ACS NSQIP WORKSTATION PRODUCES HOSPITAL LEVEL CLINICAL OUTCOME, RISK ADJUSTED REPORTS USING ODDS RATIOS</p>	<p>RAW DATA: AS OF 6/2016 1269 CASES ENTERED INTO NSQIP 76 PEOPLE (<b>6%</b>) EXPERIENCED POST-OPERATIVE OCCURANCE WITHIN 30 DAYS</p> <p>TRANSLATES TO APPROXIMATELY <b>\$836,000</b> <b>Average added direct health care costs.</b></p>	<p>THE SMALL SURGICAL VOLUMES FOR CRITICAL ACCESS HOSPITALS MAY REQUIRE AT LEAST 1 TO 2 YEARS (2017) BEFORE DATA IS RELIABLE. MID-SIZE HOSPITALS <b>MAY</b> HAVE RELIABLE DATA AS EARLY AS FALL 2016.</p>

# Sustainability

To date, we have had meetings with 4 insurance groups and requested a meeting with a 5<sup>th</sup> insurance group with no response. We will continue to look for opportunities to find additional funding.

One insurance group (MVP) has agreed to support our efforts..... and we are hopeful more people will recognize the value NSQIP brings to improving public health

Hospitals currently enrolled in NSQIP will continue collecting data into 2017 and beyond with a commitment from hospital administration.

# Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Qtr. JUN 2016	Total Spent to Date JUN 2016
Statewide SC Project Coordinator	136,267.00	77,872.90	9,151.15	87,024.05
Surgical Case Reviewers (Salaries)	275,000.00	48,056.53	23,587.92	71,644.45
Sr. Program Mgr./Epidemiologist	22,661.00	3,678.70	180.87	3,859.57
Executive Director	9,914.00	5,588.16	562.33	6,150.49
Administrative Assistant	10,622.00	3,125.70	188.97	3,314.66
Business Office	11,278.00	5,640.31	1,655.62	7,295.93
IT Manager	4,993.00	520.00	-	520.00
<b>Total Salary</b>	<b>470,735.00</b>	<b>144,482.31</b>	<b>35,326.87</b>	<b>179,809.15</b>
Surgical Case Reviewers (Fringe)		11,312.27	6,355.86	17,668.13
Fringe (30% year 1, 32% year 2)		29,283.96	3,756.46	33,040.43
<b>Total Fringe</b>	<b>143,350.00</b>	<b>40,596.23</b>	<b>10,112.32</b>	<b>50,708.55</b>
<b>Total Salary &amp; Fringes</b>	<b>614,085.00</b>	<b>185,078.53</b>	<b>45,439.19</b>	<b>230,517.72</b>
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	1,022.04		1,022.04
Computer Equipment -12 computers for SCRs	12,000.00	3,000.00		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	23,942.51	4,266.74	28,209.25
<b>Totals :</b>	<b>900,000.00</b>	<b>278,939.28</b>	<b>49,705.93</b>	<b>328,645.21</b>

Approved Budget column does not reflect amended budget amount

**Vermont Health Care Innovation Project  
2016 Quarterly Report**

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

***Date: July 15, 2016***

***Reporting Period: April 1 – June 30, 2016***

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

***Laural Ruggles***

# Grant Project Goals

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



# Recent Accomplishments

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- Flexible funds used for:
  - Eye glasses
  - Home care
  - Lift chair
  - Rent

# Challenges and Opportunities

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- Challenges
  - Long wait lists for people with special needs for housing
- Opportunities
  - Continued cohesion of care team

# Activities Undertaken and Planned

- Ongoing Activities
  - Health Coach has served 80 clients during this grant period
- New Activities
  - This is the final report; however, we have successfully applied lessons learned to populations of people beyond Duals.
- Long-Term Activities
  - Spread of lessons learned to additional at risk/high risk people.

# 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 110 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 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.

# Sustainability

- Many of the tools and processes learned from this project have already been hardwired into our care coordination work. We have spread the work to a new population of people – those with COPD. Lew, the Health Coach, has been hired permanently by NVRH as a community health worker in the Community Connections program. Lew will continue to work with “duals” and with people in need of his services regardless of insurance.
- We hope new funding mechanisms in Vermont health reform will make our work a financial “no brainer”, meaning there will be money to support staff and interventions that improve quality of life and health; and prevent, reduce or eliminate the need for people to access high cost health care.

# 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
<b>Salary</b>	\$ 54,000.00	\$ 54,000.00		\$ 54,000.00
<b>Fringe</b>	\$ 18,900.00	\$ 18,900.00		\$ 18,900.00
<b>Travel</b>	\$ 2,000.00	\$ 2,000.00		\$ 2,000.00
<b>Non-covered</b>	\$ 100,000.00	\$ 89,000.50	\$ 5,581.08	\$ 94,581.58
<b>Equipment</b>	\$ 1,500.00	\$ 1,536.55		\$ 1,536.55
<b>Contracts</b>				\$ -
<b>Indirect</b>				\$ -
<b>Total</b>	\$ 176,400.00	\$ 165,437.05	\$ 5,581.08	\$ 171,018.13

**Vermont Health Care Innovation Project  
2016 Quarterly Report**

*Supportive Care Grant*

Rutland Area Visiting Nurse Association  
and Hospice

***Date: July 8, 2016***

***Reporting Period:***

***April 2016 – June 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 with complex conditions and needs
- Improve symptom management and quality of life for the patient and caregivers
- Promote earlier referrals to hospice
- Support the Blueprint for Health goals for improving care for patients with chronic illness

# Recent Accomplishments

- Continued collaboration with the hospital Case Management Team by holding monthly meetings with their manager.
- Collaborated with the new Transitional Care Nurses from both Rutland Regional Medical Center (RRMC) and the Community Health Centers of Rutland Region (CHCRR).
- Five referrals received and seven patients admitted to the program.

# Recent Accomplishments

- To date, 35% of the patients admitted to the program have transitioned into either a Palliative care program or Hospice.
- Quality of life assessments continue to be completed on admission to the program and at discharge, when applicable.

# Challenges and Opportunities

- Receiving referrals near or at the end of the program.
- Continuing to receive referrals for patients who do not know they have been referred and/or are not interested in the services provided.
- Continued internal misunderstanding of the program among different disciplines.

# Activities Undertaken and Planned

- Ongoing Activities
  - Collaborating with Case management and the Community Health Team
  - Consistent communication with the Transitional Care Nurses both from RRMC and CHCRR
  - Collaboration within the Supportive Care Grant Team (Nursing and Social Work)
- New Activities – N/A
- Long-Term Activities – N/A

# 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)
      - 4 NPs
- Please provide the number of beneficiaries of your project.
  - 48

# 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
- 35% 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
<b>Salary</b>	\$ 82,174.74	\$ 22,723.75	\$ 4,071.60	\$ 26,795.35
<b>Fringe</b>	\$ 21,488.70	\$ 5,942.25	\$ 1,064.72	\$ 7,006.97
<b>Travel</b>	\$ 5,600.01	\$ 3,176.63	\$ 2,544.95	\$ 5,721.58
<b>Conferences</b>	\$ -		\$ -	\$ -
<b>Equipment</b>	\$ 2,800.00	\$ -	\$ -	\$ -
<b>Contracts</b>	\$ -	\$ -	\$ -	\$ -
<b>Indirect</b>	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	\$ 112,063.45	\$ 31,842.63	\$ 7,681.27	\$ 39,523.90

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



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

***RiseVT***  
**Northwestern Medical Center**

***Date:7.10.2016***

***Reporting Period:  
April May June***

***Dorey Demers***

***RiseVT Coordinator***

***[ddemers@nmcinc.org](mailto: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

- Swanton school will have walking Wednesday every Wednesday next year, up from one time per month
- Year end health coaching at Swanton village which resulted a 30% shift from moderate risk to low risk with 25 employees.
- Alburgh extended their school day starting next year by 15 minutes to meet the requirements to provide recess to all students K-8!
- City Pool removed candy and soda from their concessions stands

# Recent Accomplishments continued

- EPODE Visit- team ranked in the top 10 throughout the road for initiatives (46 programs in 30 countries)
- Increase in Alburgh walk to schools participants from 10%- 32%
- Swanton, Sheldon, Highgate, Saint Albans City, Saint Albans Town participation and completion in classroom scorecard challenge. Added brain breaks, policies on healthy eating and more.
- Collaboration with Abenaki Tribe and adding community gardens to their community gathering facility.

# Challenges and Opportunities

- RiseVT has really taken off and with that, many other communities have contacted us wanting to be involved. This includes communities outside our area that are ready to join RiseVT. Although the enthusiasm is there, our committee is still working out details and logistics on how this could be replicated. Communities are ready and it is challenging to tell them to hold tight.
- EPODE is a huge opportunity for us,. As the largest obesity prevention network in the world, RiseVT can learn from their methodology and get results faster and stronger through their process. Our committee has currently moved forward with bringing them back to meet with our group and will be bringing a team of people to their conference in Toronto in September.

# 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, Samaritan House

# Activities Undertaken and Planned

- Small Business Umbrella
  - We have created a small business umbrella which will serve as a committee for our micro businesses (under 15 employees). This will act as a clearing house for our small businesses to meet as a group, establish business to business challenges and more.
- Interactive Map creation for online website (to be released in September)

# 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:* 12529 People are Rising
  - **9513 people** have seen RiseVT at events across Franklin and Grand Isle
  - **1542 people** have taken the RiseVT Pledge or taken the Health Assessment
  - **996 people** have completed the RiseVT Individual Scorecard and know their score – 86 referrals to health coaching, 7 referrals to primary care, 8 referrals to tobacco cessation, and 11 referrals to dental care providers
  - **478 people** are using the RiseVT Wellness Dashboard & Health Coaching
- Facebook Likes: 7282
- 46 Businesses engaged; 15 Schools; 9 Municipalities

# Evaluation Methodology

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- UVM Rural Studies is currently evaluating program. Full report will be available in October

# 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
<b>Salary</b>	\$ 115,000.00	\$ 73,923.58	\$ 41,076.42	\$ 115,000.00
<b>Fringe</b>	\$ 133,000.00	\$ 39,550.91	\$ 13,721.97	\$ 53,272.88
<b>Travel</b>	\$ 20,000.00	\$ 4,111.21	\$ -	\$ 4,111.21
				\$ -
<b>Equipment</b>	\$ 22,000.00	\$ 16,281.03	\$ 1,560.00	\$ 17,841.03
<b>Material/Supp</b>	\$ 19,500.00	\$ 18,520.22	\$ 935.50	\$ 19,455.72
<b>other Costs</b>	\$ 90,500.00	\$ 69,744.43	\$ 37,331.06	\$ 107,075.49
<b>Total</b>	\$ 400,000.00	\$ 222,131.38	\$ 94,624.95	\$ 316,756.33

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

**Southwestern Vermont Health Care**

***Date:***

***July 8, 2016***

***Reporting Period:***

***April 2016 – June 2016***

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

**Billie Lynn Allard MS,RN**

# Grant Project Goals

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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. Karen Coppin MS RN and Sandra Driscoll MS RN, Transitional Care Nurses presented at the NICHE conference on Transitional Care Nursing.
2. Karen Coppin MS RN and Katharine Murphy RN presented at the Vermont Health Care Innovation Project Meeting to review the Transitional Care Nursing Program and INTERACT Program which are supported by this grant.
3. Planning has continued for our regional conference, “Leading Health Care Reform by Building Accountable Communities” which will be held September 20, 2016. Mary Naylor PhD, FAAN, RN, of the Univ. of Penn School of Nursing has accepted our invitation to be the keynote speaker, Kevin Stone, BA, MBA and Heidi Klein MSPH will also be presenting.
4. 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, has further expanded to now include five Bennington area long term care facilities.
5. Katharine Murphy RN presented on the INTERACT program at the Centers for Living Medical Director Meeting, at the Southwestern Vermont Medical Executive Committee Meeting and at the RCPC Meeting for the Blueprint Program.
6. The INTERACT Program has been closely involved in our organization wide goal of reducing readmissions. Root Cause Analysis were completed on CLR’s readmissions to the hospital with data reviewed with the Nursing Home Administrator, Director of Nursing and Education Director for CLR as well as the Medical Director and CLR’s Nurse Practitioner, and the Director of Hospitalist Services at SVMC.

# Recent Accomplishments (continued)

7. The INTERACT RN completed improvements in the documentation system which provides triggers to staff and has improved efficiency and compliance.
8. The Transitional Care Program will be presenting “Creating an Accountable Community” at the Magnet Nursing Conference in October.
9. The Transitional Care Nurses have been finalizing the curriculum for the fall Transitional Care Course at Southwestern Vermont College, and will become adjunct faculty at both local colleges.
10. The TCNs have received support from the SVMC Care Team to move forward with the High Flow Oxygen project. They will be working with the Director of Research at Dartmouth-Hitchcock and are moving forward with this as a research project at SVMC.
11. The Health Promotion Advocate participated in a Housing Review Team meeting, which was successful in getting a patient emergency assistance housing.
12. The HPA is assisting with the implementation of the SBIRT Program at SVMC.
13. Community Care Team leadership met with UCS Administration to discuss lack of access and prompt referral and space in key programs for CCT clients. As a result, our HPA and Social Services have forged a stronger relationship with UCS and implemented a new liaison to help streamline timely referrals for these high risk clients.
14. The TCNs now participate in the SVMC Interdisciplinary daily rounds led by nursing which now include the SVMC Hospitalists.

# Recent Accomplishments (continued)

15. Billie Allard MS RN attended the Accountable Care Community Meeting in Waterbury VT and has since connected with multiple health systems interested in learning more about the Transitional Care Program. A Site visit is scheduled with Northwestern Hospital.
16. SVMC submitted an application to the Hillman Grant for \$ 600,000 to expand the Transitional Care Nursing Program to Maternal Newborn patients.



# Challenges and Opportunities

## ■ Challenges and Response Activities:

1. As the VHCIP Grant comes to a close at the end of 2016, and the SVMC FY '17 budget process is well underway, continuation of the Transitional Care Program and grant supported positions continues as a challenge. See Sustainability.
  - Billie Allard MS RN has completed a financial analysis and met 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.
2. 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.
3. We identified that our volume data for the TCN Program, including number of visits was not being fully reported through our Midas Reports, and as a result not being fully reported on previous Quarterly Reports submitted. It was not capturing patient interactions on patients carried over from the previous quarter.
  - Midas reports were revised, and volume data corrected YTD in this report.
4. Full implementation of the INTERACT program at all facilities due to changes in administration, nursing leadership and education staff.
  - With the demonstration of the positive outcomes of this program, plan is to continue to share this data with area LTC administration.

# 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 and INTERACT program.

## ■ New Activities - next reporting period

- Continue Implementation of additional clinical components of the INTERACT program in area nursing homes.
- Our Regional Conference, “Leading Health Care Reform by Building Accountable Communities”, is being held on September 20<sup>th</sup> with a reception on September 19<sup>th</sup>.
- Finalize Transition in Care Tool Kit to assist other facilities in implementation.
- Implement the Transitions in Care Curriculum for area Nursing Programs, first course scheduled for Fall 2016 semester.
- Continue work with DH for approval of the High Flow Oxygen research program through the IRB and plan for implementation.

## ■ Long-Term Activities

- Present the Transitions in Care Program at the national Magnet Conference.

# 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
  - ❖ INTERACT Program:
    - 1 INTERACT RN
    - 4 Long Term Care Facilities:
      - Center for Living and Rehabilitation
      - Center for Nursing and Rehabilitation
      - Vermont Veterans Home
      - Bennington Health and Rehabilitation
      - Crescent Manor Rehabilitation

# Providers and Beneficiaries Impacted (cont.)

## ❖ Community Care Team

- 3 Physicians
- 1 ED Case Manager
- 4 SVMC Administrative RNs
- 1 SVMC Social Work Coordinator
- 1 SVMC Health Promotion Advocate
- 1 SVMC Practice Manager
- 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

# Providers and Beneficiaries Impacted (Cont.)

## ❖ Community Care Team (Continued)

### • Agencies / Community Partners

- 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
- Interfaith Council Service
- Sunrise Family Services
- Vermont Department of Health
- Turning Point Center of Bennington County – drug treatment program
- SVMC Blueprint CHT Leader
- Interfaith Council Service
- Washington Elms Community Care Home

# Providers and Beneficiaries Impacted (Cont.)

## ❖ Community Care Team (Continued)

- BROCC Community Action Program
- Southern Vermont AIDS Project
- Vermont 211
- Samaritan Hospital, Troy NY
- Green Mountain Express
- Adult Protective Services
- Battenkill Health Center
- Choices for Care DIAL
- Serenity House, Rutland
- Emergency Medical / Rescue Squads
- Fidelis, NY Medicaid
- Simply the Best Home Care
- Rensselaer County Department of Aging
- PAVE – Project Against Violent Encounters

# Number of Beneficiaries participating in/or impacted INTERACT Program

Facility	Stop & Watch Early Warning Tool	Care Paths & Change of Condition File Cards	Nursing Home to Hospital Transfer Form, Document Checklist, SBAR	INTERACT Workbook 30-Day Readmission Data Collection	Root Cause Analysis & Quality Improvement Tools	Advanced Care Planning Tools
Center for Living & Rehab	✓	✓	✓	✓	✓	✓
Center for Nursing & Rehab	✓	✓	✓	✓		
Vermont Veteran's Home	✓	✓	✓	✓		✓
Bennington Health & Rehab	✓	✓	✓			
Crescent Manor Rehab	✓		✓			

✓ = INTERACT® Tool implemented at the facility



# Number of Beneficiaries participating in/or impacted

## ■ Transitions of Care Program

\* Data revised from prior report to capture all interactions

	Q1	Q2	Q3	Q 4	Q5 Jan-Mar 2016	Q 6 Apr-Jun 2016	Total YTD
# New patient encounters							
Total # patient interactions	741	471	527	568	704	602	3011
Home	173	140	203	274	344	283	1134
Hospital	337	166	163	148	160	158	974
Phone Call	166	120	110	109	149	134	654
PCP Office	37	22	36	29	35	13	159
Nursing Home	23	19	12	8	11	0	73
Emergency Department	3	13	1	0	3	1	10

# Providers and Beneficiaries Impacted (Cont.)

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

	Q 3	Q 4	Q 5	Q 6 Apr – Jun 2016	Total YTD
# New patient encounters	19	9	18	3	51
Total # patient interactions					
Phone Contacts	14	1	26	31	72
Emergency Department	19	17	29	25	90
Inpatient Hospital	2	2		2	6
Visit In the Community	6	7	28	33	74
Consult w Community Resource	21	23	70	138	252
Consult with SVHC Resource			2	4	6
Screened for CCT	3		2		5
Meetings / CCT Team and Indiv Pt Planning		7	5	8	20

# Providers and Beneficiaries Impacted (Cont.)

## ■ Community Care Team

	Q1	Q2	Q3	Q4	Q5	Q6 Apr – Jun 2016	Total	
# New Participants	5	5	9	9	18	3	51	
# Referrals/Contacts:								
Shared Living Provider Program	2				8	3	13	
BPI Adult Day Service	2			2	2	2	8	
Employment Services	1						1	
Veterans Administration	2						2	
UCS / CRT (Community Rehab & Treat)	1			1		3	5	
Battelle House Crisis Center	2			1		6	9	
Chronic Pain Program	1	2					3	
Medicaid Case Manager	2	2	4	8	6	2	24	
Traumatic Brain Injury Program	1	1	1		1		4	
Blueprint Case Managers		3			11	12	26	

# Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q3	Q 4	Q5	Q 6 Apr – Jun 2016	Total	
# Referrals/Contacts CCT (cont.)								
Medical Provider	1			2	3	13	19	
United Counseling Services	2	4	8	10	10	10	44	
Developmental Services / UCS		3		4	5	17	29	
Housing Assistance	1	1	1			9	12	
Vocational Rehabilitation	1	2	1	1	5	5	15	
Economic Services		3			8	9	20	
Transitional Care Nurses SVMC		1			1	1	3	
Social Services SVMC		2		2			4	
Hawthorne Recovery Program		2					2	
Court Appointed Guardianship		1	1			5	7	
Memory Clinic		1					1	
Department of Corrections		1	1		1		3	

# Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q3	Q4	Q5	Q6 Apr – Jun 2016	Total
# Referrals/Contacts CCT (cont.)							
VT State Field Representative			1		1	5	7
VNA			2		9	3	14
Family Services DCF			1		1		5
Food Assistance			1				1
Pharmacist Services			1				1
SASH (Support and Services at Home)			2			1	3
Brattleboro Retreat			1				1
Sunrise Family Services		1					1
Turning Point (drug treatment)				1		1	2
Washington Elms Community Care Home				1	1	1	3
Case Management SVMC				1	1	1	3
Vermont 211					1		1
BROC Community Action					4	7	11
Southern Vermont AIDS Project					1		1
Coalition for the Homeless					4	4	8

# Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q 3	Q 4	Q5	Q 6 Apr-Jun 2016	Total
# Referrals/Contacts CCT (cont.)							
VT State Hospital					1		1
Council on Aging					1		1
SVMC Patient Advocate					1	2	3
Danforth Center					1		1
Renselear Department of Mental Health					3		3
Smoking Cessation					1		1
Bennington Health & Rehabilitation					1	2	3
Unity House of Troy					4		4
Renselear ARC					2		2
Managed Medicaid Long Term Care					3		3
EMS / Rescue Squads						2	2
Adult Protective Services						4	4
Green Mountain Express						1	1

# Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q3	Q4	Q5	Q6 Apr-Jun 2016	Total	
# Referrals/Contacts CCT (cont.)								
Bennington Interfaith Food and Fuel Fund						1	1	
Battenkill Health Center						2	2	
Village Primary Care						1	1	
Choices for Care DIAL						1	1	
Serenity House, Rutland VT						1	1	
Samaritan Hospital, Case Management						2	2	
Private Therapist						1	1	
PAVE						3	3	
Simply the Best Home Care						8	8	
Renselear Cty Dept on Aging						5	5	
Fidelis, NY (Medicaid Services)						3	3	
<b>TOTAL</b>	<b>19</b>	<b>30</b>	<b>25</b>	<b>34</b>	<b>102</b>	<b>131</b>	<b>341</b>	

# Providers and Beneficiaries Impacted (Cont.)

## ■ INTERACT Program (program implemented November 11,2015)

<b>INTERACT</b>	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Totals	Year to Date
# of Stop & Watches Initiated	30	22	14	23	33	32	41	195	Stop & Watches
# of Progress Notes Written	224	159	70	148	196	225	307	1329	Notes
#f Sets of Vitals Obtained	222	158	78	141	211	242	299	1351	Vitals
% of Compliance with Vitals	93%	94%	88%	92%	92%	93%	95%	92%	% Vitals Compliance
% of Compliance with Notes	89%	94%	76%	85%	77%	81%	91%	85%	% Note Compliance
% of Compliance with ECS documentation	67%	73%	75%	74%	100%	88%	95%	82%	% ECS Compliance
% of Compliance with Checklist	59%	91%	83%	100%	100%	100%	100%	90%	% Checklist Compliance
# of Transfers to the ED from CLR	10	15	21	20	16	14	16	110	# of Transfers to ED from CLR
# of Hospital Admissions from CLR (INPT & OBS)	7	9	12	15	10	8	5	63	# of Inpatient/Observation Admissions
# of 30-Day Readmissions	4	7	6	8	3	2	2	32	# of 30-Day Readmissions



# 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.

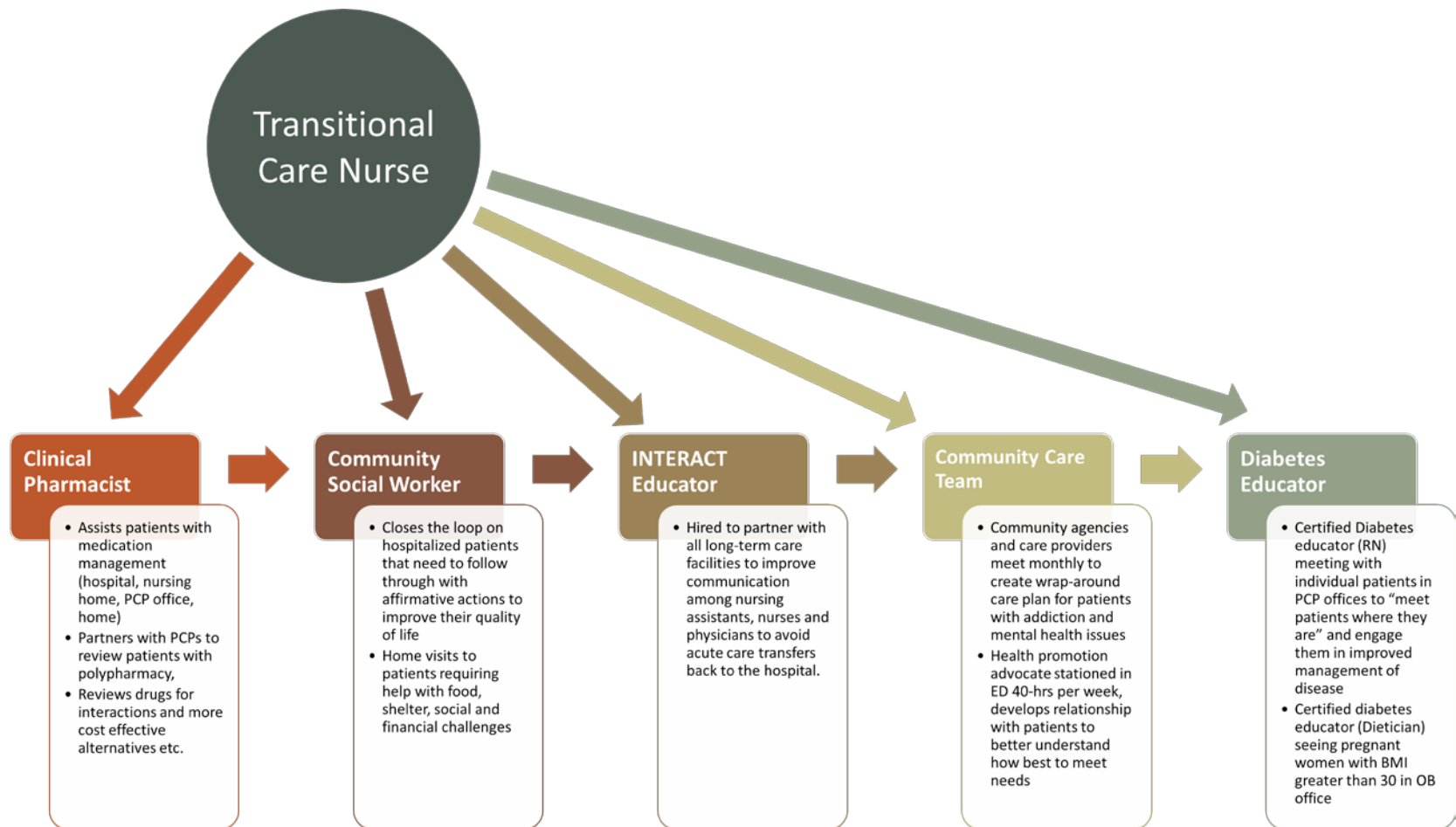
## ■ Community Care Team

- 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.

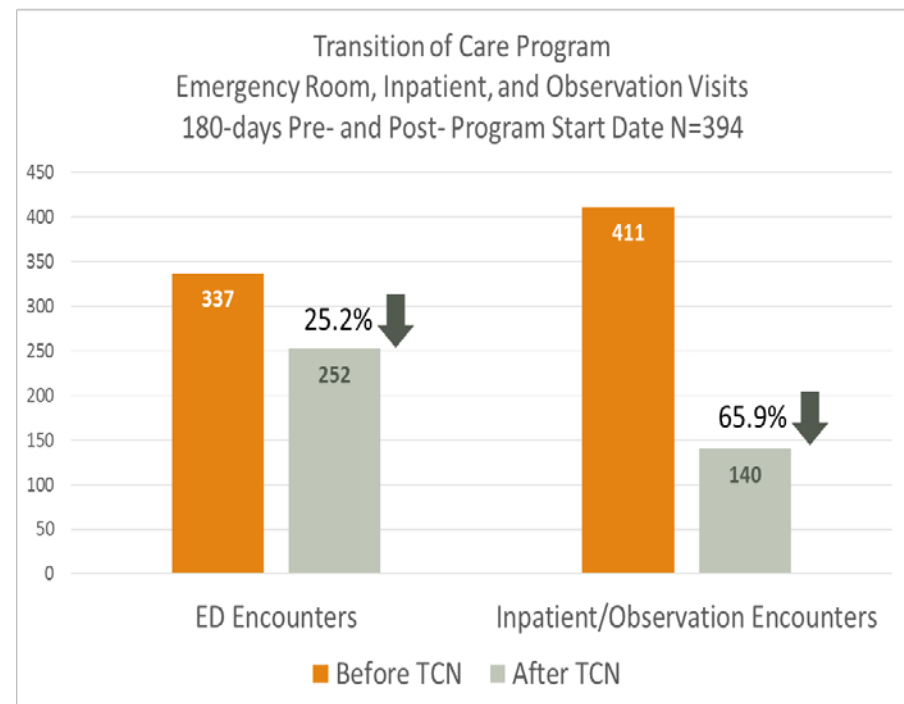
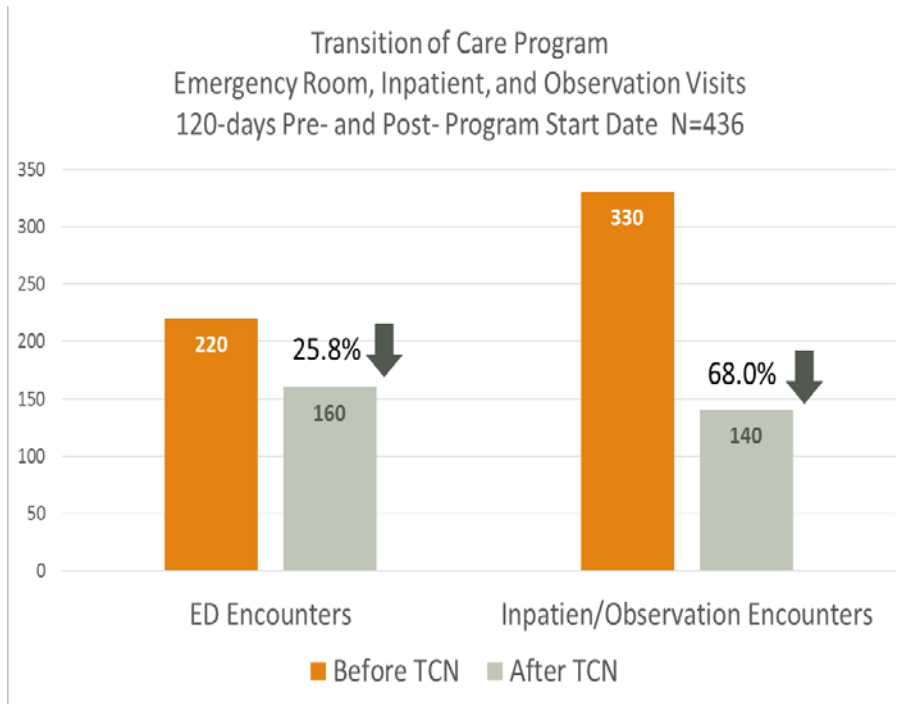
## ■ INTERACT Program

- Number of transfers from Center for Living and Rehabilitation to ED.
- Number of hospital admissions from Center for Living and Rehabilitation.
- Number of 30 day readmissions
- Quantitative measures – number of INTERACT interventions documented.

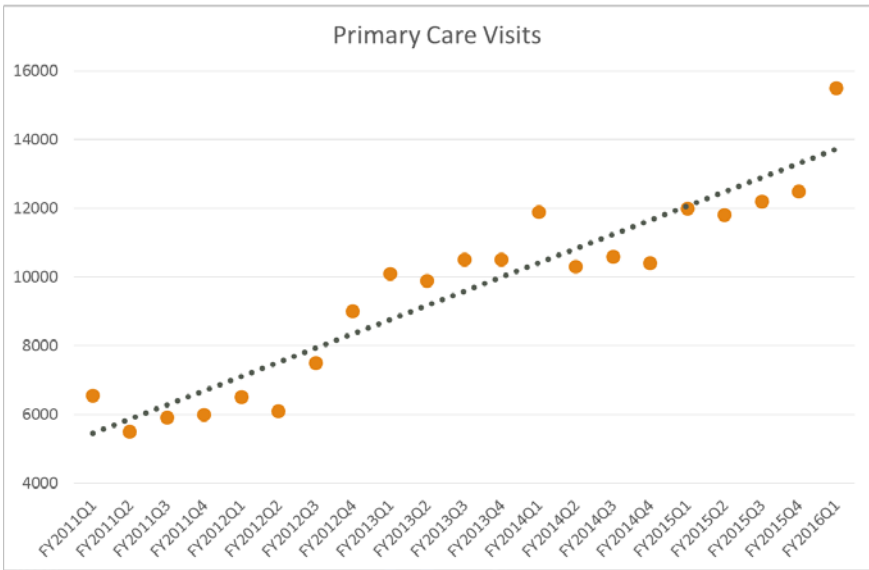
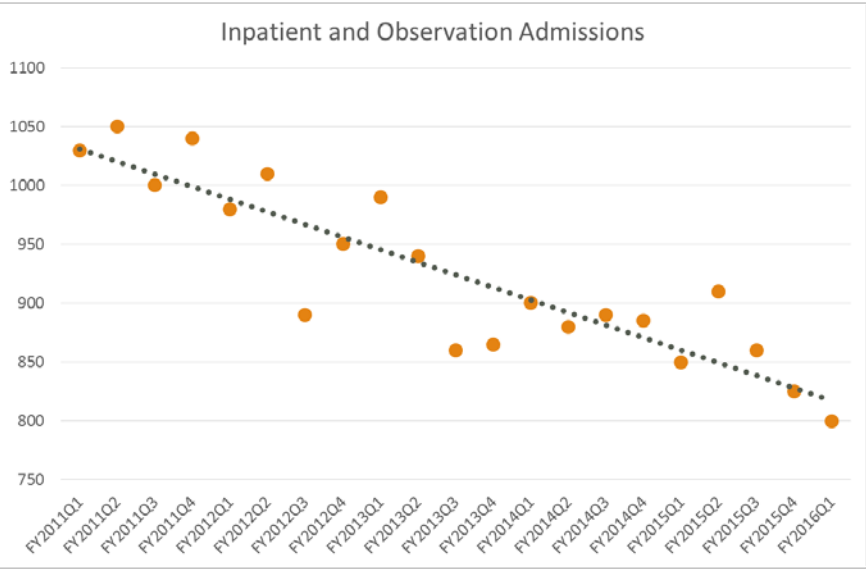
# INTEGRATED CARE DELIVERY TEAM



# Transition Care Program IMPROVES POPULATION HEALTH

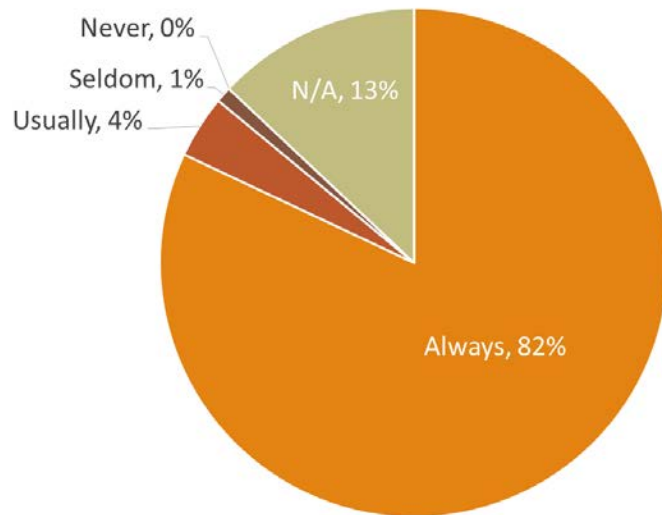


# Transition Care Program Demonstrates Decreased Healthcare Costs



# SVMC's Transitional Care Program IMPROVES the PATIENT EXPERIENCE

Transitional Care Nurse Program – Patient Satisfaction Survey  
Total Responses – March 1, 2016



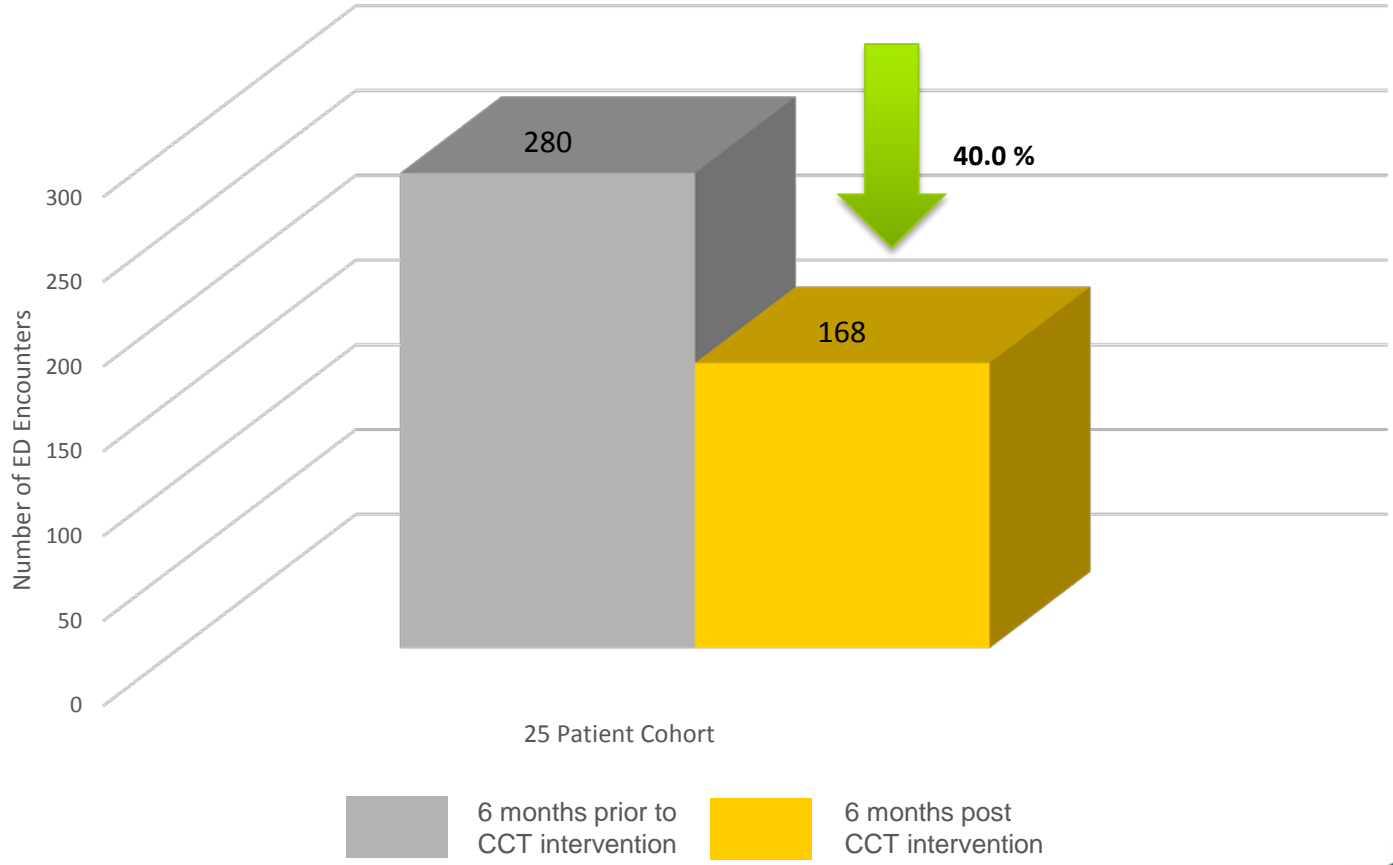
This graph illustrates the total Likert scale responses to the following questions.

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

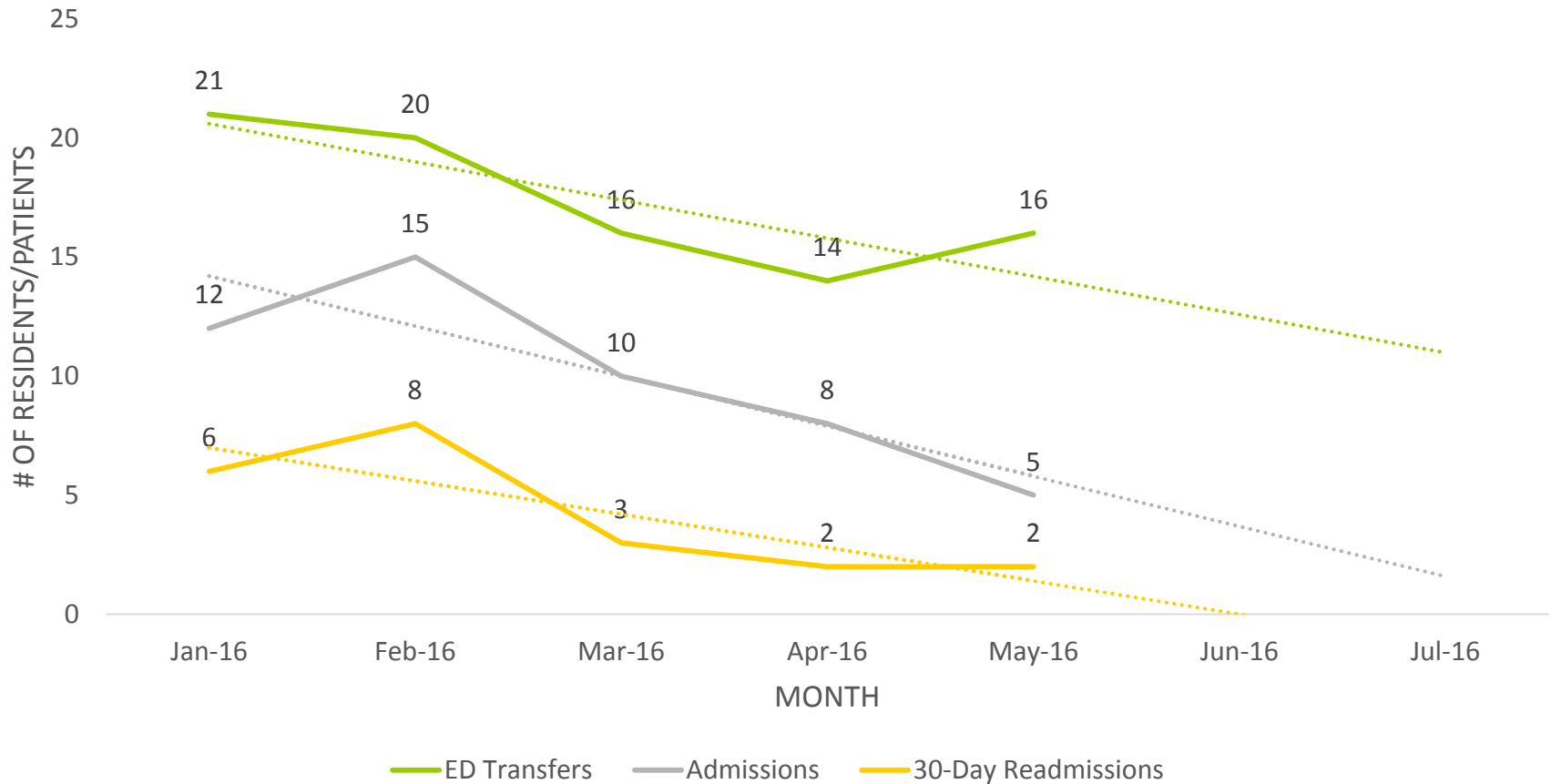
# Community Care Team Demonstrates decreased ED Visits over 6 months

Community Care Team  
Decrease in Emergency Room Visits  
6 months Pre and Post Client's 1st Intervention  
July 2015 - January 2016



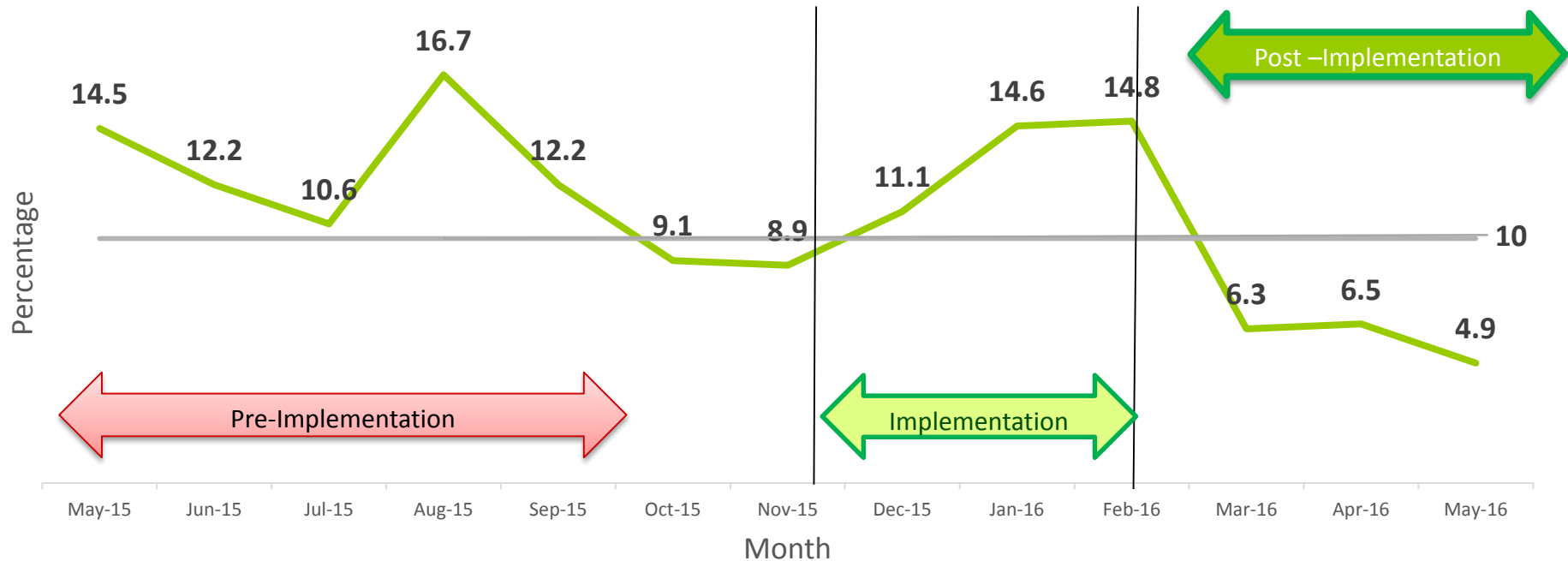
# INTERACT Program demonstrates decreased ED transfers Hospital Admissions and 30 day Readmissions

CLR Transfers to ED & Hospital Admissions  
January to May 2016



# INTERACT Program demonstrates decreased CLR 30 day Readmission Rates

*All Payer, All Cause – 12-Month Look Back*



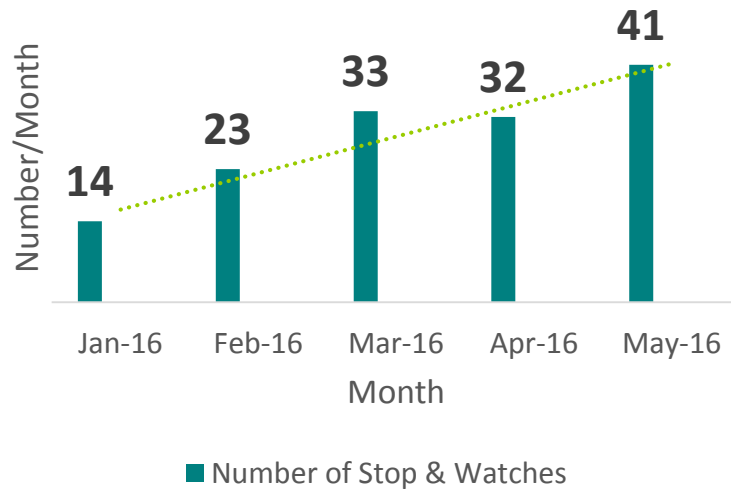
— 30-Day Readmission Rate    — SNF National Goal



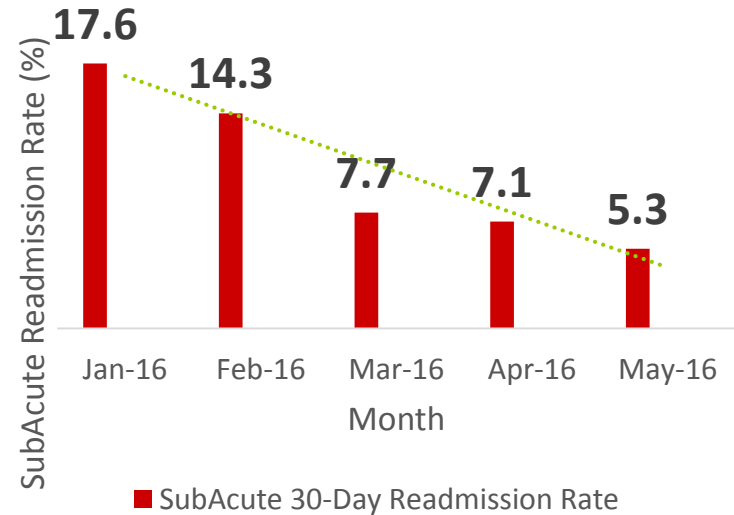
# INTERACT Program demonstrates decreased 30-Day Readmission Rates



Stop and Watch Usage at CLR  
per Month



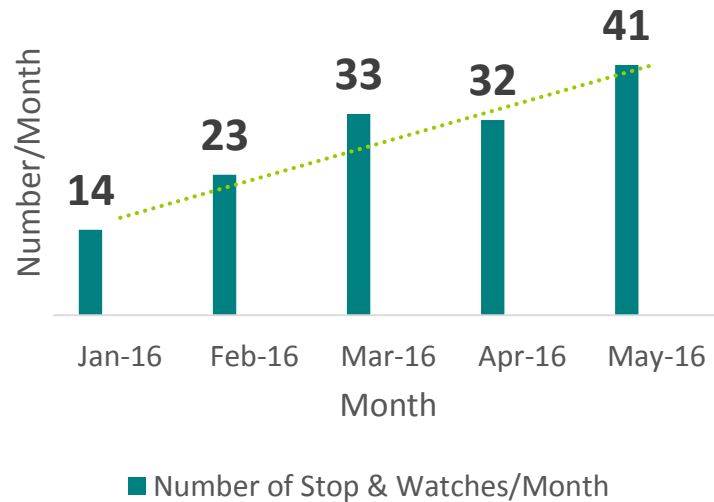
SubAcute 30-Day Readmission  
Rates



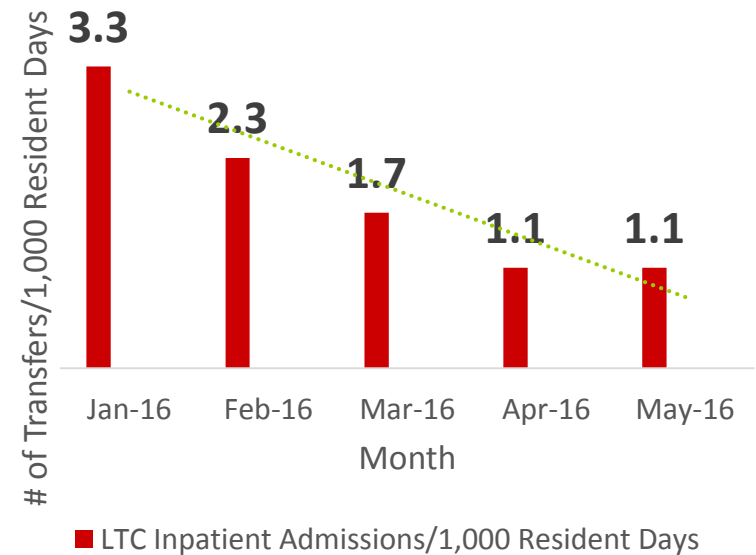
# INTERACT Program demonstrates decreased LTC Transfers resulting in Inpatient Admission



### Stop and Watches per Month at CLR



### LTC Transfers resulting in Inpatient Admission



# Sustainability

- Please describe any sustainability planning that is currently underway and the status of that work.
  - SVMC has contracted with Polaris to do a financial analysis of the Transitional Care Nursing Program. Preliminary information is positive to support the continuation of this program within the SVMC Operational Budget.
  - The 4<sup>th</sup> Transitional Care Nurse was added through this grant to increase coverage to all primary care practices in the area, which has been achieved. Three TCN positions have been included in the operational budget throughout this time.
- Please describe any efforts to transfer or continue project work beyond the SIM project.
  - The INTERACT Program was funded for one year for implementation into area nursing homes. We plan to have INTERACT come onsite to train super users for each nursing home to sustain this program moving forward.
  - Polaris has also been contracted to review the Health Promotion Advocate / Community Care Team work. It is felt that the positive outcomes of this program, with the decrease in ED visits and admissions will fully justify this 1 FTE, and has been included in the proposed FY 17 SVMC Operational Budget.
  - Review of the results of the financial analysis and meetings with the CFO continue until the FY SVMC budget is finalized.

# Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Quarter	Total Spent to Date
<b>Salary</b>	\$ 287,310.00	\$ 149,193.98	\$ 51,499.78	\$ 200,693.76
<b>Fringe</b>	\$ 86,193.00	\$ 44,392.35	\$ 15,449.94	\$ 59,842.29
<b>Travel</b>				
<b>Conferences</b>				
<b>Equipment</b>	\$ 3,097.00	\$ 1,192.16		\$ 1,192.16
<b>Contracts</b>	\$ 23,400.00	\$ 4,133.60	\$ 2,833.15	\$ 6,966.75
<b>Indirect</b>				
<b>Total</b>	\$ 400,000.00	\$ 198,912.09	\$ 69,782.87	\$ 268,694.96

Briefly discuss any potential changes to the budget going forward:  
 Approved reallocated expenses to be included once contract signed.

**Vermont Health Care Innovation Project  
2016 Quarterly Report**

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

***Date: July 8, 2016***

***Reporting Period: April – June 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

- Increased participant enrollment for project by 66%
- Continued follow-up intervention services to employees.
- Very strong preliminary data
  - Statistically significant improvements on numerous key outcome variables pre- and post-treatment.
  - Indication of sustained improvements at follow-up. Awaiting additional follow-up data.

# Challenges and Opportunities

- Most employees seeking help at this time are looking to improve their diet and/or increase their exercise levels.
- New enrollment had tapered off so we participated in company wide meeting to increase visibility and remind employees of opportunity.



# Activities Undertaken and Planned

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## Ongoing Activities

- Continue service delivery

## New Activities

- Presentation to employees to increase visibility of project 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 not impact any providers
- Please provide the number of beneficiaries of your project.
  - The project will benefit approximately 30 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	\$ 6,640.68	\$ 3,181.75	\$ 9,822.43
Fringe	\$ 8,431.00	\$ 4,503.93	\$ 2,147.85	\$ 6,651.78
Travel	\$ -	\$ -		\$ -
Conferences	\$ -	\$ -		\$ -
Equipment	\$ 5,400.00	\$ 603.26	\$0.00	\$ 603.26
Contracts	\$ 20,000.00	\$ 6,004.83	\$ -	\$ 6,004.83
Supplies	\$ 370.00	\$ -	\$ -	\$ -
Other	\$ 2,680.00	\$ 1,665.00	\$ 325.00	\$ 1,990.00
Indirect	\$ 5,467.70	\$ 1,941.77	\$ 565.46	\$ 2,507.23
Total	\$ 60,144.70	\$ 21,359.47	\$ 6,220.06	\$ 27,579.53

**Vermont Health Care Innovation Project  
2016 Quarterly Report**

***Resilient Vermont***  
**Invest EAP**

***Date: July 8, 2016***

***Reporting Period: April – June 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

- 12% increase in the number of introductions made by staff to the Health Coach
- 14% increase in number of participants enrolled
- Very strong preliminary data
  - Statistically significant improvements on almost every outcome variable.
  - Significant improvements on comorbid outcome measures
  - Indication of sustained improvements at follow-up. Awaiting additional follow-up data.

# Challenges and Opportunities

- Overall number of screens decreased this quarter
  - Could be procedural issue – at this point in project, a substantial number of patients may be “repeat clients” (returning for quick follow up or regular tests with his/her provider) and may have already previously completed a BSI and do not want to fill out again
- We have met with clinic staff and developed new procedures to facilitate increased referrals
  - Identified returning patients to meet him/her at current medical appointments for ease of services
  - Hired a staff person to help facilitate introductions, of these returning patients, to the Health Coach



# Activities Undertaken and Planned

- Ongoing Activities
  - Continue service delivery
  - Conduct assessments and enter data
- New Activities
  - Brought on additional staff member to facilitate introductions and help manage data entry
- Long-Term Activities
  - Additional outreach to clients for follow up data collection
    - Letters/phone calls

# 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
<b>Salary</b>	in-kind			\$ -
<b>Fringe</b>	in-kind			\$ -
<b>Travel</b>	\$ 6,500.00	\$ 4,330.00		\$ 4,330.00
<b>Conferences</b>	\$ -			\$ -
<b>Equipment</b>	\$ 1,900.00	\$ 2,329.00	\$ -	\$ 2,329.00
<b>Contracts</b>	\$ 191,260.00	\$ 113,886.00	\$31,978.36	\$ 145,864.36
<b>Supplies</b>	\$ 1,000.00	\$ -	\$935.45	\$ 935.45
<b>Other</b>	\$ 26,560.00	\$ 1,750.00	\$3,050.00	\$ 4,800.00
<b>Indirect</b>	\$ 22,722.00	\$ 10,700.00	\$ 3,291.00	\$ 10,700.00
<b>Total</b>	\$ 249,942.00	\$ 132,995.00	\$ 39,254.81	\$ 172,249.81

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# ***State Innovation Model Grant White River Family Practice***

***Date: July 2016***

***Reporting Period: April 2016 through  
June 2016***

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

Jill Blumberg, MD and Mark Nunlist, MD

# Grant Project Goals

- Measure & reduce ER utilization and hospital readmission among WRFPP 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
- Obtain feedback from patients to help improve the interventions
- Provide information for other practices on identifying and intervening with high risk patients

# Recent Accomplishments

- Acceptance of paper to Family Practice Management with information learned to date regarding the project.
- Ongoing development of patient interviewing strategy and focus group with help from the Dartmouth Co-op
- Started reallocation of care coordination work to new nurse within the practice
- Continued monitoring of health confidence with patients.
- Continued monitoring of utilization of patients at DHMC

# Challenges and Opportunities

- As a challenge, we continue to struggle with uncertainties around grant funding and expenditures that a small practice can absorb without guaranteed reimbursement. This has led us to seek out other connections in our medical community which can provide similar support for our interviews and focus groups without charge.



# Activities Undertaken and Planned

- Ongoing Activities
  - Analysis of health confidence data collected serially
  - Support of study patients with entire office engagement (care coordination outreach, motivational interviewing, etc.)
  - Continued monitoring of utilization
  - 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

# Activities Undertaken and Planned (cont.)

- New Activities
  - Telephone interviews and focus group feedback to obtain information from our patients and families
  - Working with our patients and with community partners to develop further interventions targeted at patients with low self-confidence and/or high utilization
- Long-term Activities
  - Presentation of some aspects of our work at the eClinicalWorks conference in Florida

# 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
  - Dartmouth Cooperative Network

# Providers and Beneficiaries Impacted

- Number of beneficiaries of our project.
  - 7,465 unique patients seen at WRFP between 7/1/15 – 6/30/16
  - WRFP averages 36 patient admissions per month to DHMC
  - WRFP averages 82 patient ED visits per month to DHMC

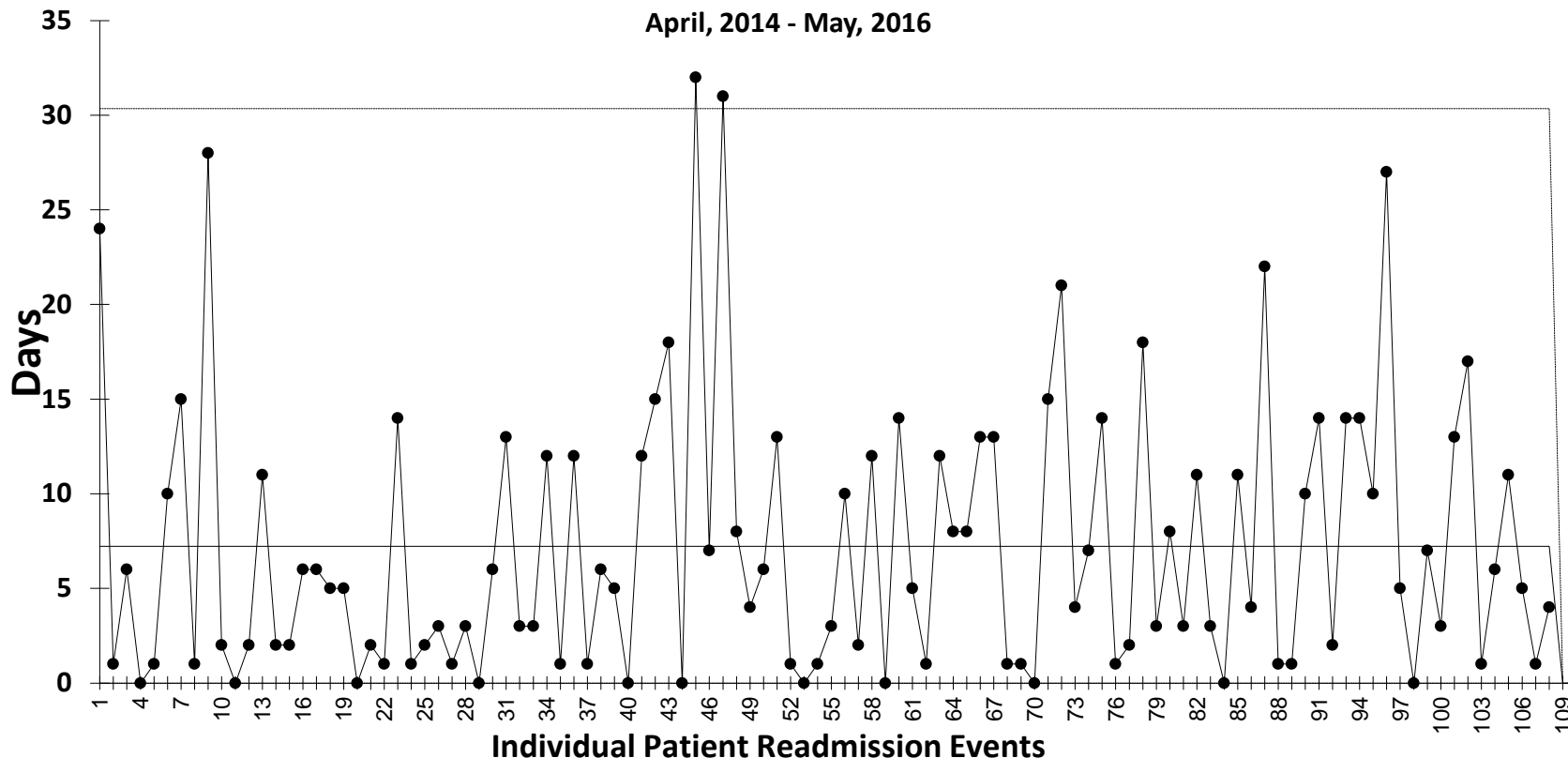
# Evaluation Methodology

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

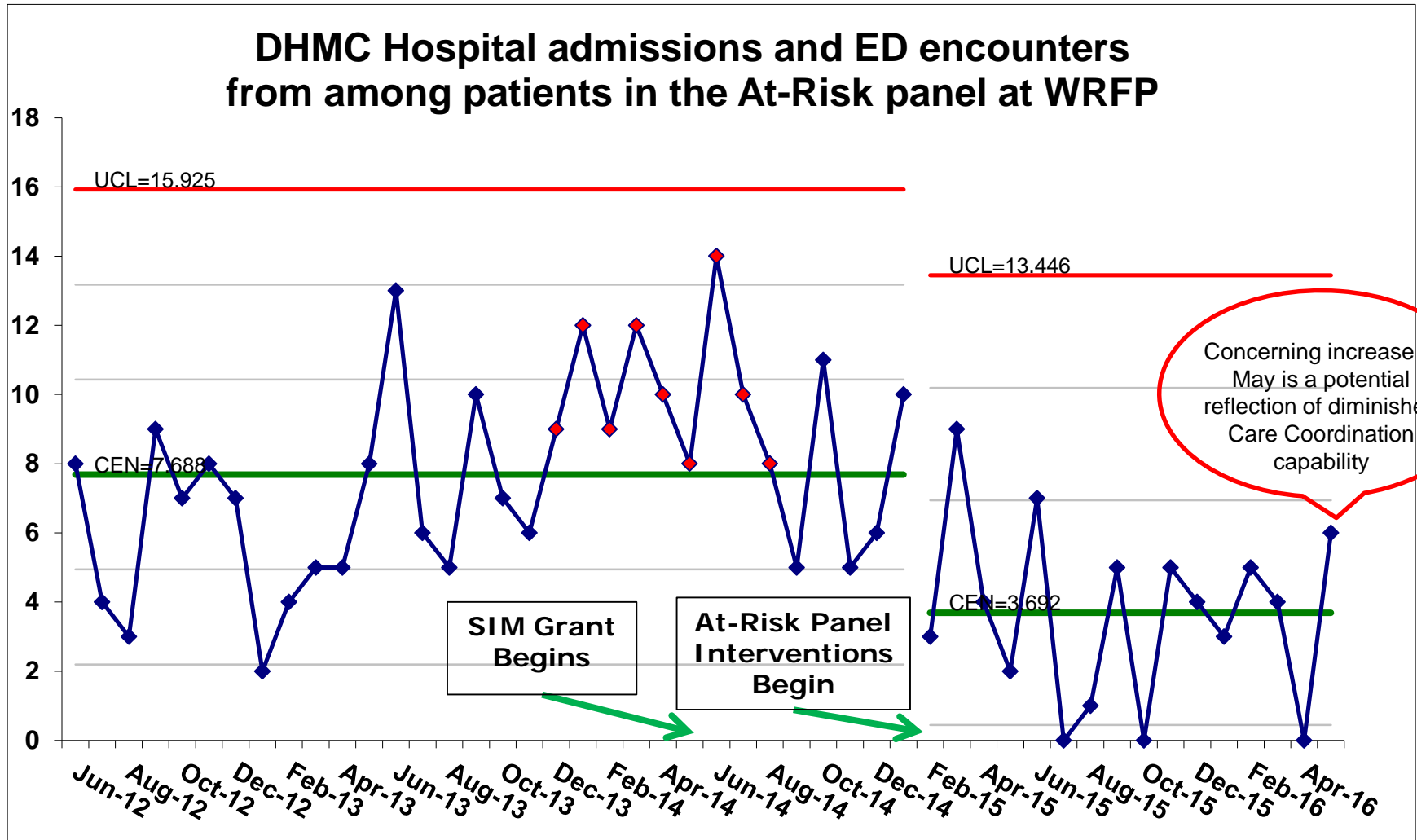
# Using statistical process control analyses...

Days occurring between successive Hospital Readmissions  
(in  $\leq 30$  days for any single patient)

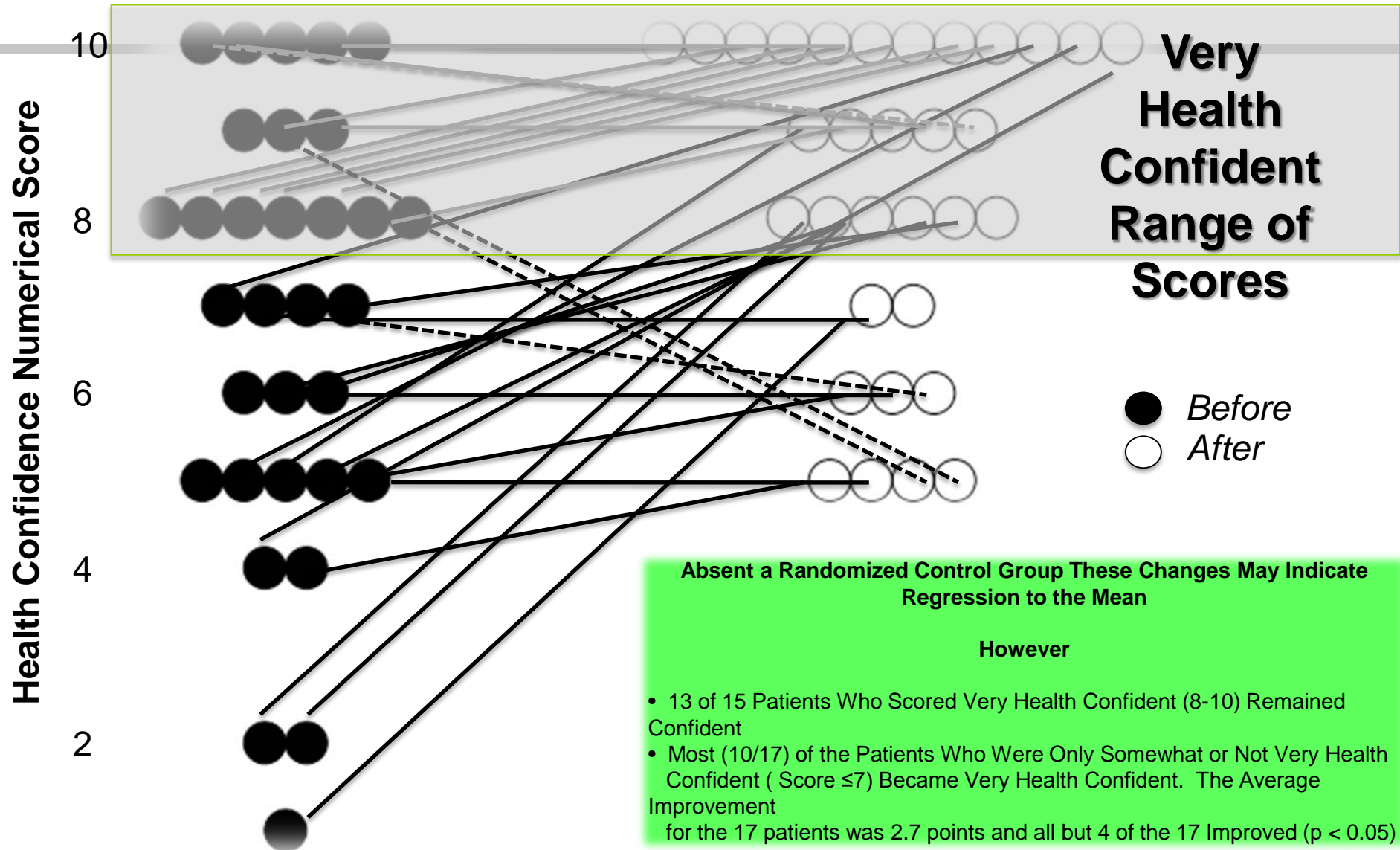
April, 2014 - May, 2016



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



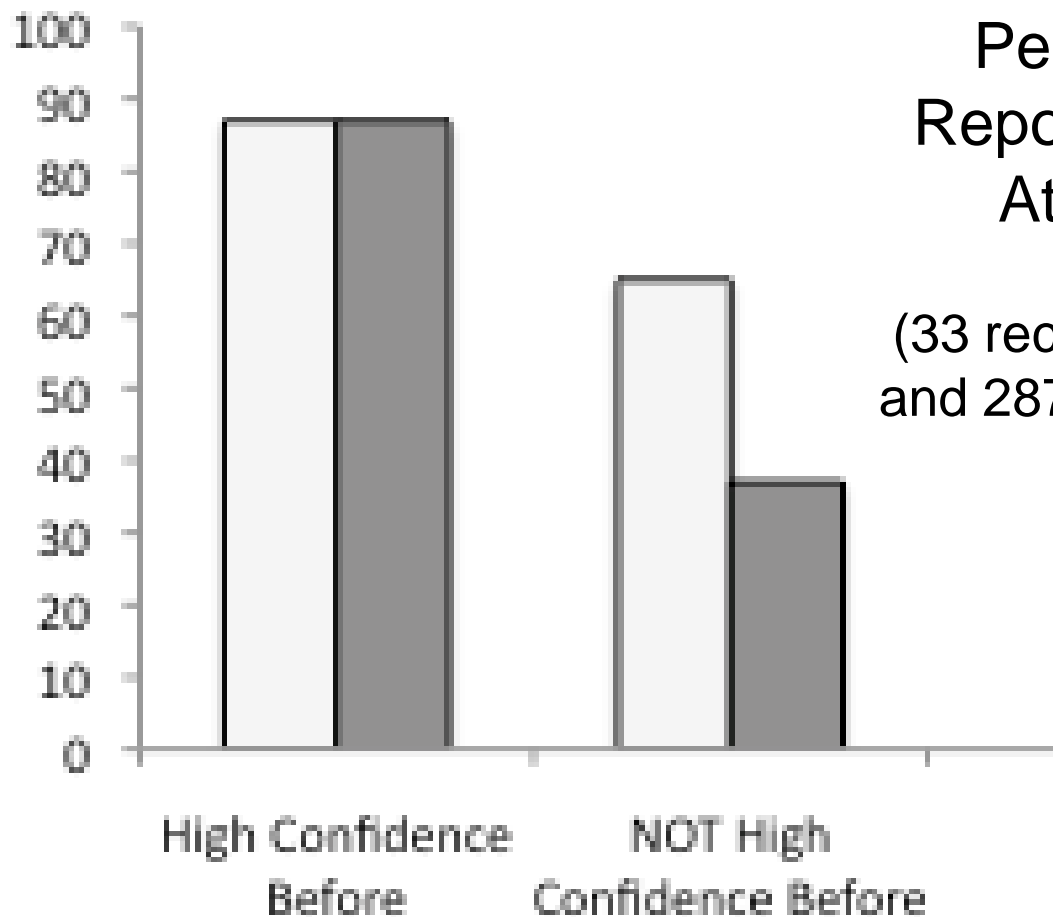
# Details for Intensive Intervention Patients



Data analysis by John Wasson, MD



# 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

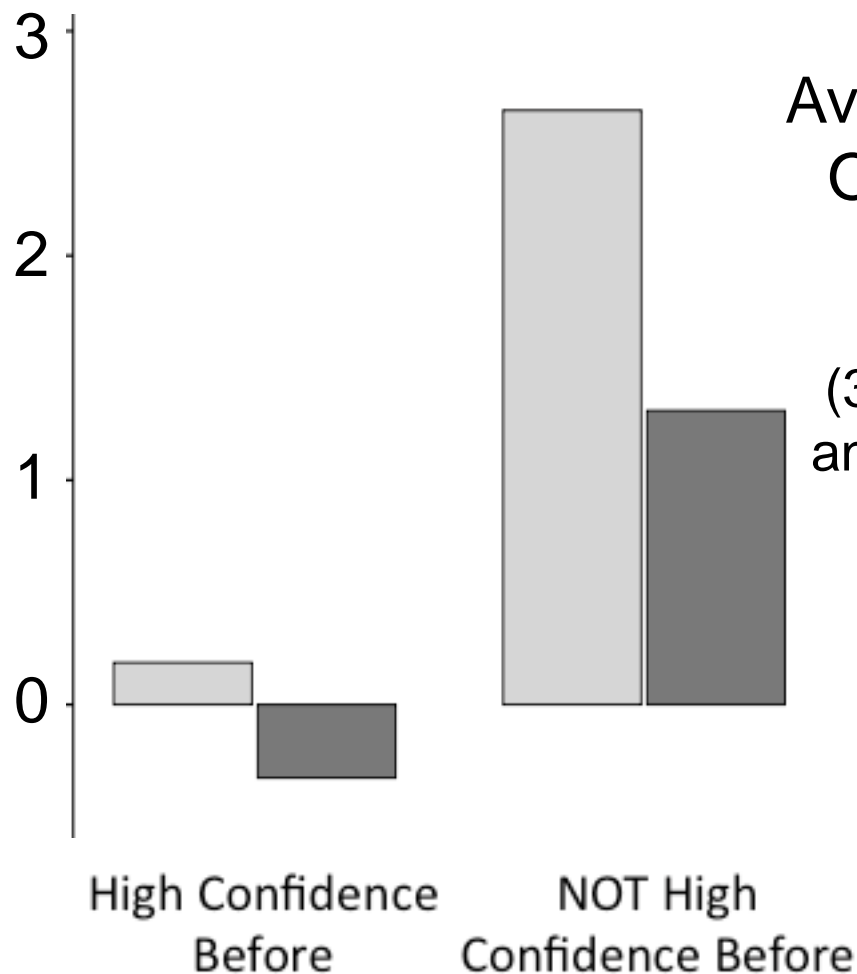
(33 received intensive intervention and 287 less intensive intervention)

□ Intensive    ■ Not Intensive

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

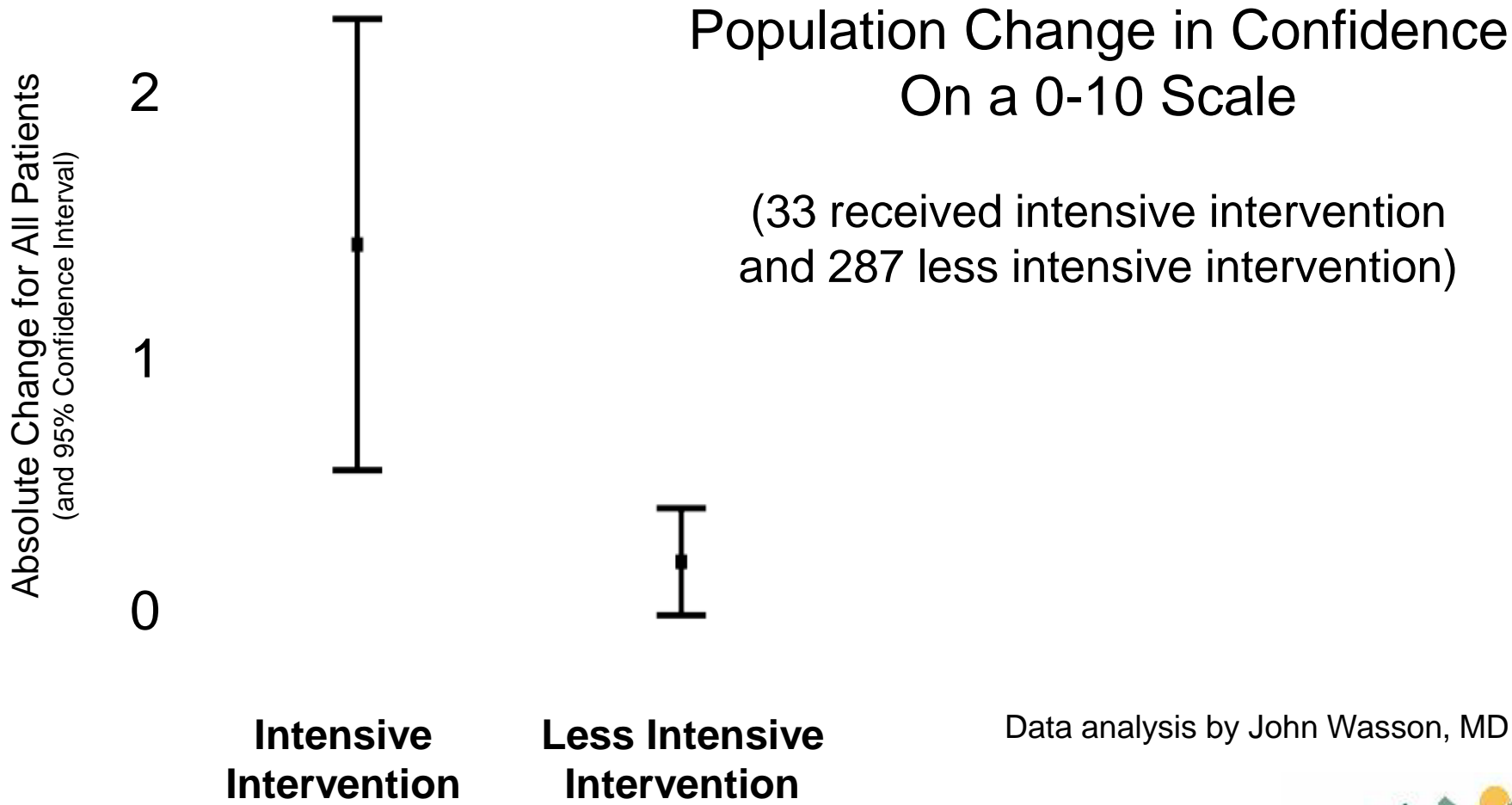
(33 received intensive intervention  
and 287 less intensive intervention)

□ Intensive    ■ Not Intensive

Data analysis by John Wasson, MD



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



Data analysis by John Wasson, MD



# Sustainability

- We have had multiple conversations with area third party payers regarding the mutual advantages (better patient care, decreased utilization) in supporting our work. To date, we have not received any commitments.
- Without significant changes to the current funding structure, we do not see an ongoing path forward to support this work.
- We are considering a new grant to work with John Wasson, MD and DHMC utilizing health confidence and other measures to risk stratify patients and design appropriate interventions.

# Expenditures to Date & Revised Budget

- INVOICE & RECONCILIATION -				
Invoice #21			Date:	6/30/2016
Agreement # 03410-1280-15				
	Start 7/1/14	(Awardee to complete)	Reconciliation:	
	24 Month	Current Month	Cumulative	Award
White River Family Practice	<u>Award \$ :</u>	<u>Spending</u>	<u>Spend to date:</u>	<u>Balance</u>
Lisa Paquette	99,008.00	\$772	81,109.29	17,898.71
Lexi Burroughs	20,000.00		16,520.50	3,479.50
Sean Uiterwyk, M.D.	23,100.00		22,095.48	
Jill Blumberg, M.D.	-	\$1,004.34	-	<u>9,039.24</u>
Total Salary	142,108.00	\$1,776.34	119,725.27	22,382.73
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	\$942.50	104,670.00	10,530.00
Symquest	7,500.00		3,756.96	3,743.04
Cert Diabetes Educator	270.00		-	270.00
Dev't of Health Coach Curriculum	7,500.00		6,651.54	848.46
Indirect	33,006.00	\$1,435.04	31,570.88	1,435.12
Total :	\$ 363,070.00	4,153.88	300,973.35	62,096.65
Less: unspent Advances				
Net Invoice :		4,153.88		