VHCIP Provider Sub-grant
Third 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 October 10, 2016

Reporting Period:

2nd Year Third Quarter

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

Ginger Cloud, LCMHC, LADC

Grant Project Goals

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

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

Recent Accomplishments

- Changes have been made to the screening process at Family Medicine – Berlin and Family Medicine –Waterbury to increase screening effectiveness. Our new screening processes in these two practices utilize the Oregon Annual SBIRT screen. This evidenced based screen is briefer than our original initial screen and due to the format, now if a patient is positive on the initial screen the secondary screen will automatically populate in our electronic medical record. Nurse feedback has been positive and we anticipate increases in the administration of screenings at these two practices.
- We recently received data reports that will help identify patients screening in the risky, harmful or severe substance use categories and whether or not a particular patient received a secondary screen and intervention if appropriate. These data reports are more refined than what we have been able to access in the past. Now, we can track an individual patient's scores, if a secondary screen was given and if the patient received an intervention. Additionally, for those patients that scored in a risky, harmful or severe category and did not receive a secondary screen or intervention we can now flag that patient as at risk and make sure a secondary screen and intervention is done at their next visit. These new reports will also greatly increase our ability to identify site specific quality improvement projects.

Recent Accomplishments cont.

- SBIRT clinicians that are also Tobacco Treatment Specialists can now order free nicotine replace therapy (patches, gum lozenge) from the state tobacco control program and distribute these products to patients engaged in tobacco treatment counseling.
- We had our first consultation call with Scott Miller, PhD regarding implementing the use of Feedback Informed Treatment (FIT) into our brief intervention and brief treatment services. Dr. Miller's insight was helpful in guiding our integration of this evidenced based practice into our current model.
- Washington County Substance Abuse Regional Partnership (WCSARP) completed our first year of monthly meetings. Please see next slide for more information about WCSARP.

After a year of meeting, WCSARP has experienced the following successes and challenges:

Successes:

- We have worked together to identify the potential for two detox beds (currently there are none in Washington county) including support getting patients who detox directly into residential treatment. The details of this are being negotiated.
- We are also developing “safe harbor” bed capacity and 24/7 screener-navigator (mental health-substance abuse) capacity for the community and Emergency Department to meet acute crisis needs
- We have met monthly for a year now with consistent attendance and strengthened relationships between the hospital, outpatient, inpatient and community resources.
- As a group we identify service failures with specific patients as they move through the current treatment process and seek to improve process and communication to avoid future failures. We also track successful referrals and coordination of care for patients in the treatment process.
- We are learning about the different admission criteria, strengths and barriers for each treatment service organization and how we can work together more effectively
- We are sharing information with each other about different initiatives and programs being developed in the area, promoting understanding of resources and changes in the system of care
- We all signed a MOU together, developed a universal release, and referral follow up tracker form to use with the objective of increasing communication and coordination of care
- Overall agreement to keep focus on increasing patient care through discovery of system gaps, for the most part we have been able to avoid defensiveness, territorial and political responses to identified issues.

After a year of meeting, WCSARP has experienced the following successes and challenges:

Challenges:

- Creating changes to releases and administrative process inherent in each organization – although we created a universal release specific to SA population, most agencies were unable to incorporate it into their flow due to challenges (time, training staff, forms committees) in changing an established system.
- Communication amongst providers on case management remains limited but we may have an opportunity to pilot a shared management platform that would be a potential solution

Activities Undertaken and Planned

- Ongoing Activities
  - Regular meetings with each medical home to advance the implementation of the SBIRT screening model into their patient flow. Quality improvement of the screening process, feedback to providers about patient engagement in brief treatment services and problem solving barriers to screening.
  - Each practice site is receiving SBIRT model effectiveness feedback through practice reports detailing patients screened, rates of positive screens, secondary screening rates , and intervention rates.
  - Coordination of care efforts throughout CVMC's medical homes, the hospital system, and community partners.
  - Motivational interviewing trainings to increase screening and intervention effectiveness.

- New Activities
  - SBIRT clinicians will engage in a training at Blue Cross Blue Shield this month that will cover the implementation, interpretation, and application of information gathered by using the FIT tools. It will also cover a web application used to predict expected change and progress that a patient should be making, purpose of group consultation and next steps.

Activities Undertaken and Planned cont.

- Long-Term Activities
  - Engagement in comprehensive training of medical secretaries, nursing staff, and medical providers to enhance screening process in medical homes. Identification of areas of the screening and intervention process that are interrupting the efficacy of the SBIRT model. Build community alliances and a comprehensive clinical pathway for patients that are identified at moderate to high risk/dependent substance users.
  - Develop a strategy to sustain screening and intervention services initiated by this grant, with specific concern regarding ability to continue to support tobacco interventions, treatment and brief interventions for all substances.

Challenges and Opportunities

- One of our SBIRT clinicians accepted a new position at a different organization. Since we are in the final months of our SIM grant a decision has been made to not re-post that position. We will do our best to meet the needs of patients in our medical homes through the currently employed therapist and our project manager will increase direct patient care hours.

- Substance abuse counselor recruitment and retention appears to be a challenge throughout all treatment providers in the state, with the greatest challenges being felt at our designated agencies. Instituting a state alternative loan forgiveness program (similar to HRSA) for designated agencies in high need but that do not qualify for the federal HRSA program could drastically change the landscape of our workforce. Attached is the Vermont Care Partner's White Paper outlining the devastating impact low wages and high turnover are having on our workforce and community at large.

- Although the details are being worked out, we have received assurance that the SBIRT counselors and service will continue at CVMC after the SIM grant expires.

- Our data analyst has developed an excel file that we can now use to identify patients that score in a risky or harmful level of use and did not received an intervention. This information allows us to develop a patient panel of risky users to target future interventions and ideally reduce harm associated with their use level.

- This data file has also significantly increased our ability to target quality improvement efforts. As you will see on slides 13 and 14 our current rates of administering secondary screens are low. Prior to having access to this data we were relying on nurse self report and unidentified pulling of data regarding follow through for giving patients secondary screens.

Providers and Beneficiaries Impacted

FTE Category	BIM	MIFH	CVPC	WMA	GCPC	MRFP
MD FTE's	3.66	3	4.48	3.93	1	1.3
NP/PA FTE's	1.35	2.69	2.97	0.8	0.6	1
Total Provider FTEs	5.01	5.69	7.45	4.73	1.6	2.3
Clinical Coordinator	0.81	1.1	1	1	1	1
Office RN	4.2	4.1	4.58	4	1	2.5
Office LPN	0.83	0.97	4.12	0	0	0
MA/CCA	0.11	3.62	0	1	1	0
Clinical FTEs	**5.95**	**9.79**	**9.7**	**6**	**3**	**3.5**
Office Supervisor	1	1	1	1	0	1
Medical Secretary	5.27	6.06	7.18	5.72	1	2.5
Front End/Other FTEs	**6.27**	**7.06**	**8.18**	**6.72**	**1**	**3.5**
Total FTE's Per Practice	**17.23**	**22.53**	**25.33**	**17.45**	**5.6**	**9.3**
Total Attributed Patients	**4139**	**6903**	**7700**	**6554**	**1244**	**4065**

Evaluation Methodology

- The target population for our initiative is two fold. We aim to target medical home practices throughout CVMC network to engage in the SBIRT model of screening. Through the engagement of the SBIRT model we aim to identify people that use substances (alcohol and drugs) at a risky level, and people that are identified as addicted to tobacco and or other substances. Once identified we are able to offer appropriate services and continuity of care throughout the patient's change journey.
- We are measuring success by the number of practices engaged in screening patients using the SBIRT model, by the number of patients screened and intervened at each practice and the level of patient engagement in the available SBIRT services.
- To collect data and evaluate the utilization of the SBIRT model in the medical home we are using the reporting functions through our EMR and patient self report. The demographic information, the number of screens complete, engagement in brief interventions, brief treatment and referral to treatment are tracked through the EMR. The reduction or elimination of use patterns among patients engaged in treatment with the SBIRT clinician is based on patient self-report.
- We now have a new EMR report that gives us access to individualized screening results, making the process of identifying patients at risk easier. This new report also increases our ability to target model specific quality improvement efforts based on practice data.
- We anticipate that during the course of this grant we will develop a comprehensive service model for identification and intervention services for the people engaged substance use in Washington County.

Expenditures to Date & Revised Budget

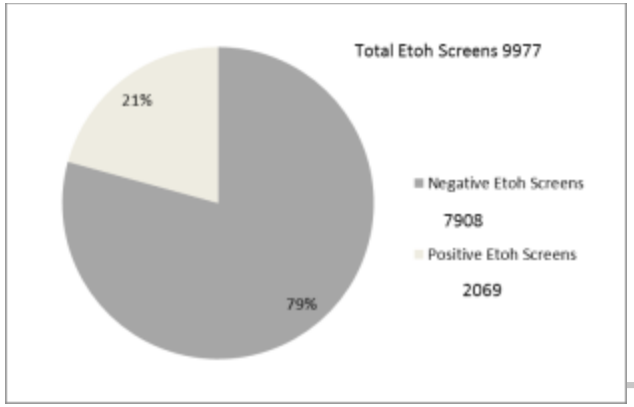
- Please work from your approved revised budget to show any new expenditures.

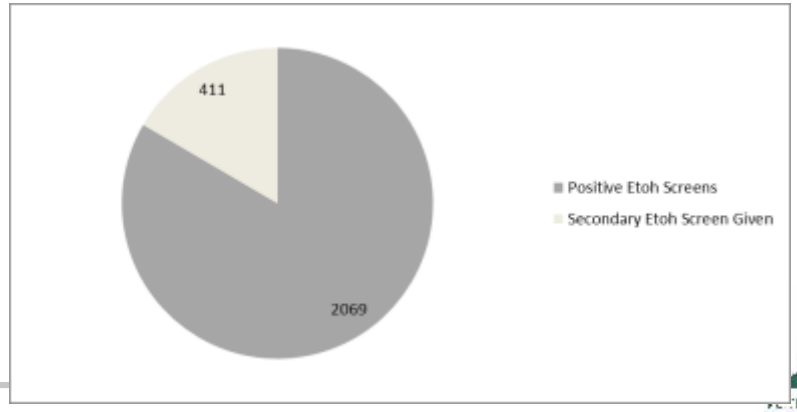
	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	$ 357,017.07	$ 240,228.46	$ 17,421.08	$ 257,649.54
Fringe	$ 95,246.00	$ 64,662.00	$ 5,226.33	$ 69,888.33
Travel*		$ 373.22		$ 373.22
Conferences*	$ 4,000.00	$ 1,434.76		$ 1,434.76
Equipment	$ 4,939.00	$ 2,519.00	$ -	$ 2,519.00
Contracts	$ 6,000.00	$ 5,000.00	$ -	$ 5,000.00
Other Costs	$ 20,000.00	$ 10,000.00		$ 10,000.00
Supplies	$ 12,797.93	$ 9,291.63	$ 113.12	$ 9,404.75

- * Tracked separately starting 8/1/15, in original budget Conferences were listed under Supplies
- Expenditures as of July 31 2016, awaiting a budget adjustment approval for 10% indirect rate and past approval for conferences prior to submitting budget as it will be inaccurate.

Alcohol (ETOH) Screening Data CVMC

Central Vermont Medical Center					
		Total Screens Etoh	9977		
		Negative Etoh Screens	7908	79%	
Pts Screened Etoh	9977	Positive Etoh Screens	2069	21%	
Female	6652	Secondary Etoh Screen Given	411	20%	
Male	3325	Positive on Secondary Screen	136	33%	
Negative EtohScreens	7908				
Female	5303				
Male	2605				
				AUDIT C score greater than 8	286
Positive Etoh Screens	2069	Secondary Etoh Screen done	411	Positive on Secondary Etoh Screen (8 or greater)	163
Female	1349	Female	207	Female	38
Male	720	Male	204	Male	125
65+	600	Secondary Etoh Screen	27	Secondary Etoh Screen	7

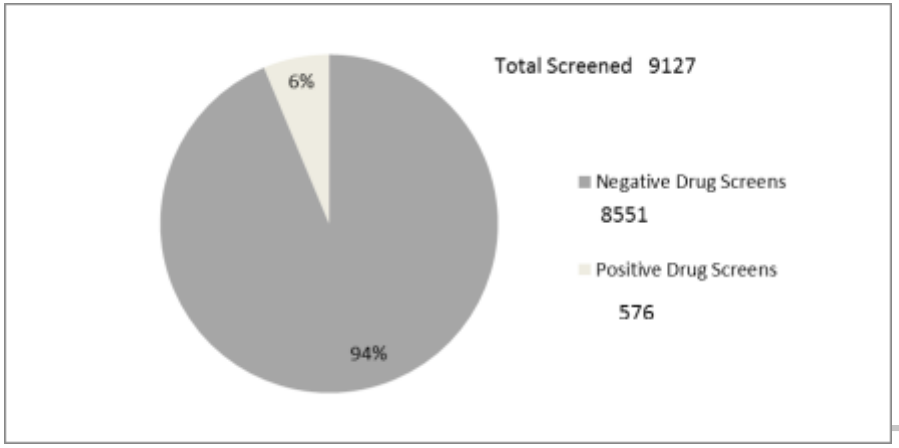


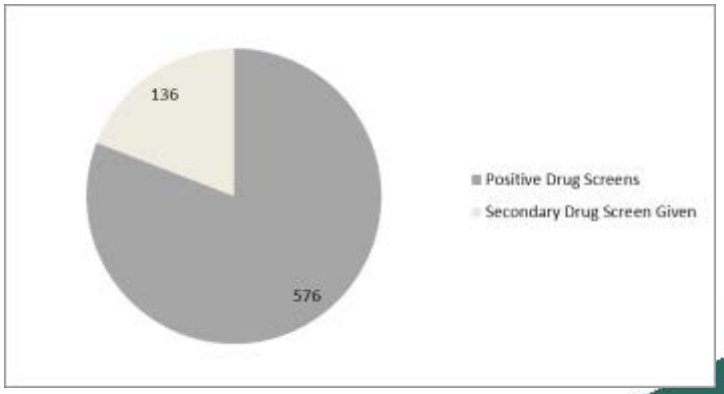


Drug Screening Data CVMC

Drug Screen Totals	9127						
Female	6183						
Male	2944						
Negative DrugScreens	8551						
Female	5907						
Male	2644						
Positive Drug Screens	576	Pos for Marijuana	Pos non legal drug use	Pos for Script misuse		Secondary Drug Screen done	136
Female	276	212	81	50		Female	72
Male	300	243	84	36		Male	64
65 +	62	42	17	8		65 +	4

Total Screens Drug	9127	
Negative Drug Screens	8551	94%
Positive Drug Screens	576	6%
Secondary Drug Screen Given	136	24%





SBIRT Resources

Ever Wonder What Happens to Your Body the Moment You Stop Smoking?

20 MINUTES
- Blood pressure drops to normal.
- Pulse rate drops to normal.
- Body temperature of hands and feet increases to normal.

8 HOURS
- Carbon monoxide level in blood drops to normal.
- Oxygen level in blood increases to normal.

24 HOURS
- Chance of heart attack decreases.

48 HOURS
- Nerve endings start regrowing.
- Ability to smell and taste is enhanced.

2 WEEKS TO 3 MONTHS
- Circulation improves.
- Walking becomes easier.
- Lung function increases up to 30%.

1 TO 9 MONTHS
- Coughing, sinus congestion, fatigue, and shortness of breath decrease.
- Cilia regrow in lungs, increasing ability to handle mucus, clean the lungs, and reduce infection.
- Body's overall energy increases.

1 YEAR
- Excess risk of coronary heart disease is half that of a smoker.

Ever Wonder What Happens to Your Body the Moment You Stop Smoking?

5 YEARS
- Lung cancer death rate for average smoker (one pack a day) decreases by almost half.
- Stroke risk is reduced to that of a nonsmoker 5-15 years after quitting.
- Risk of cancer of the mouth, throat and esophagus is half that of a smoker's.

10 YEARS
- Lung cancer death rate similar to that of nonsmokers.
- Precancerous cells are replaced.
- Risk of cancer of the mouth, throat, esophagus, bladder, kidney and pancreas decreases.

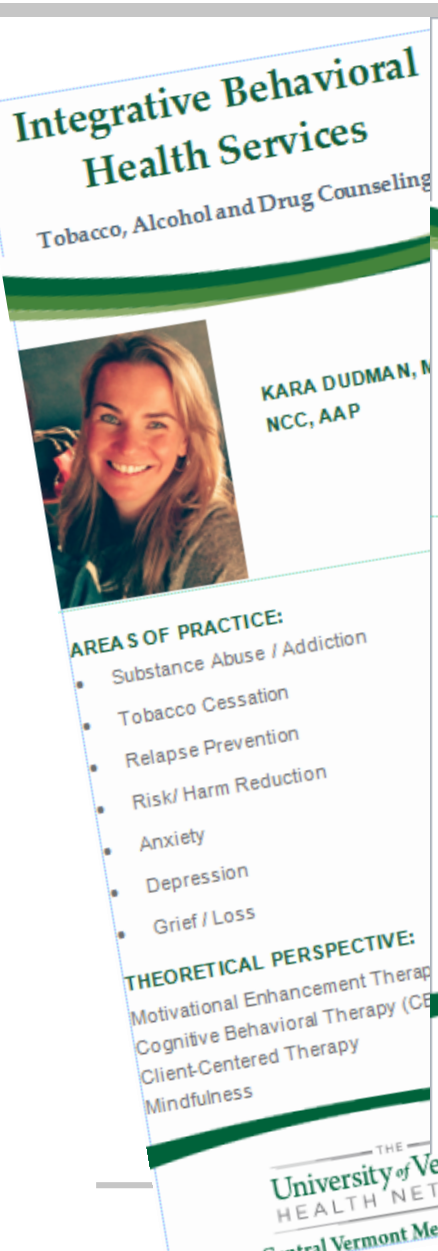
15 YEARS
- Risk of coronary heart disease is that of a nonsmoker.

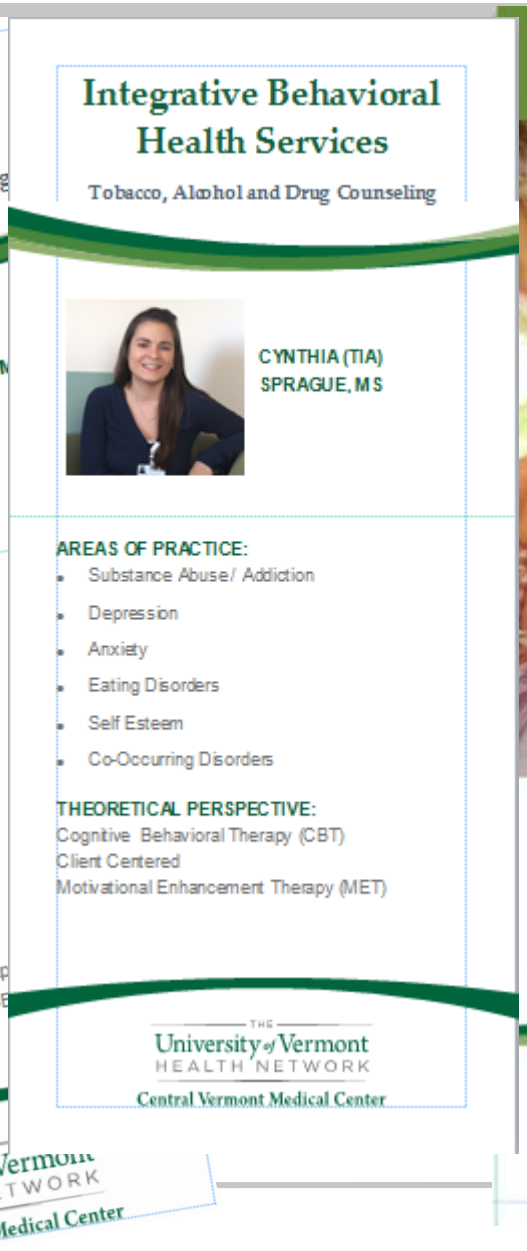
Maintain the changeUse the 5 Ds
- **Delay** the craving
- **Distract** yourself
- **Drink water** to beat the cravings
- **Deep breaths** help you relax
- **Discuss** your feelings

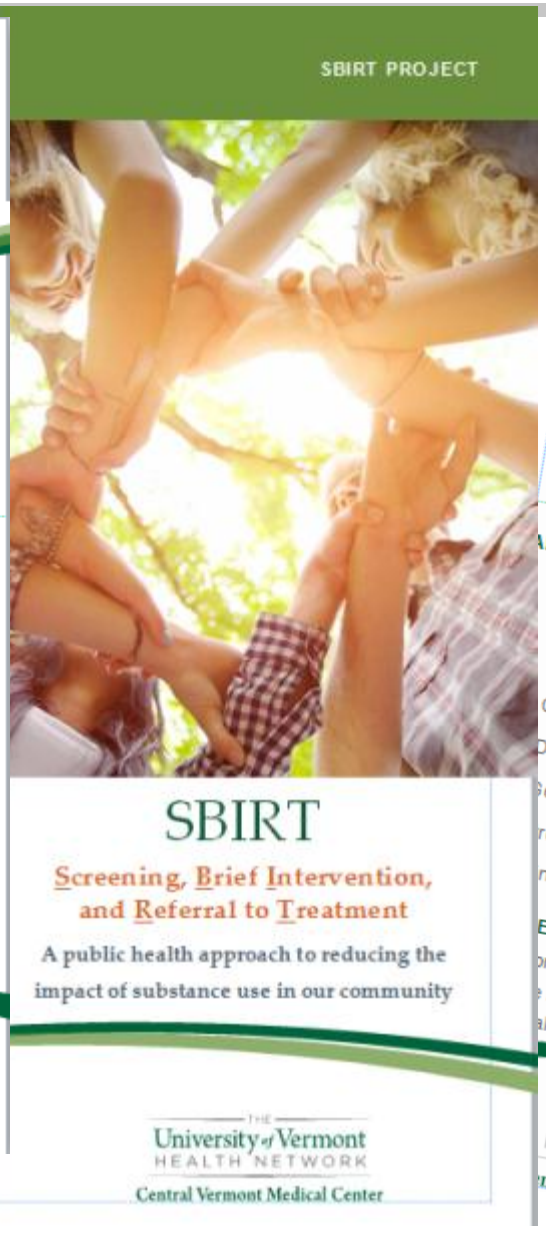
THE University of Vermont HEALTH NETWORK
Central Vermont Medical Center

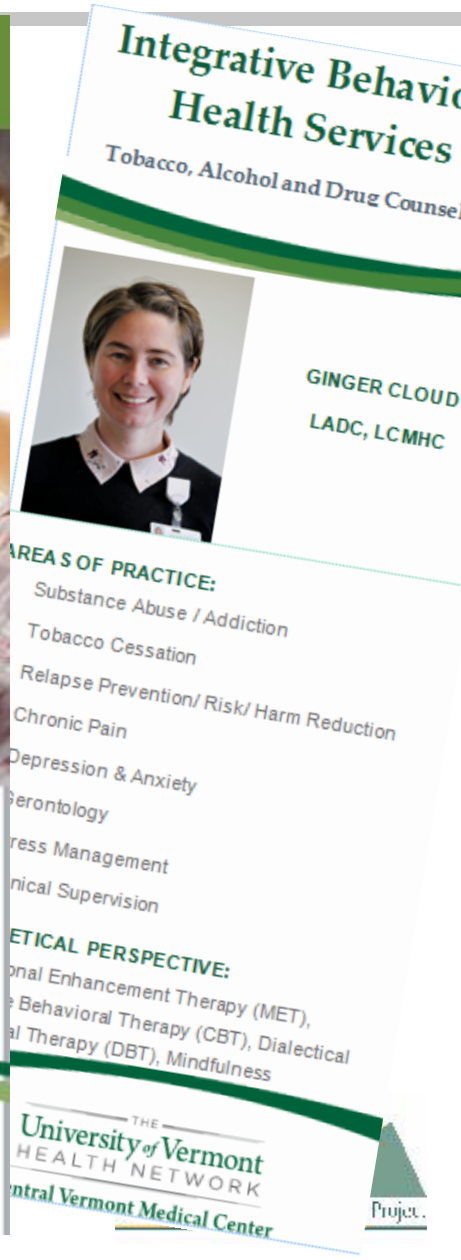
Works Cited "The Benefits of Quitting Smoking." Quit Smoking Support. Quit Smoking Support, n.d. Web. 24 Apr. 2016. www.quitsmokingsupport.com/benefits.htm

SBIRT Resources









RiseVT
Northwestern Medical Center

Date:10.10.2016

Reporting Period:
July August September

Dorey Demers

RiseVT Coordinator

ddemers@nmcinc.org

Grant Project Goals

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

Recent Accomplishments

- Interactive map: This map includes all parks, paths and playgrounds in Franking and Grand Isle and can be used as a resource for all residents. It gives directions, rules, information etc. for each of the entries. You can find it www.risevt.com
- Unique infrastructure installed in Saint Albans City- We have collaborated with Saint Albans Recreation to provide adult workout stations at a local playground to increase physical activity in the adult population while watching their kids play. They are being used all the time.

Recent Accomplishments cont.

- Our collaboration with LocalMotion BikeSmart Curriculum in 10 schools resulted in almost ***2000 children receiving a combined 7300 hours in the BikeSmart Curriculum. 1853 kids trained were low income students.*** This is a great collaboration to continue, with that said we need to identify new schools to whom we can bring this training. The following schools received this curriculum: Isle La Motte, Saint Albans City, Saint Albans Town, Berkshire, Highgate, Enosburg, Richford, Richford After School, LEAP Program, Bakersfield.

Recent Accomplishments cont.

- Small Business Umbrella has taken off and will have its first meeting on October 20th. This is an opportunity for our businesses with less than 15 people to come together and network on worksite wellness and use each other as resources.
- Classroom Scorecard revamp- Each classroom grades K-9 now have their own scorecard which challenges them to adopt healthy behaviors as a class to improve their wellness. So far over 50 classes are participating in the challenge.
- 3 Active communities participating in RiseVT Show Up events- (free physical activity events in the center of the community) We saw over 300 participants.

Challenges and Opportunities

- RiseVT capacity is running low. With the number of towns and communities that want to be collaborating with RiseVT in Franklin and Grand Isle, our team is being stretched fairly thin. With that said, this is a great time for us to plan accordingly and make plans for our next few years.
- Northwestern medical Center has included RiseVT in their operating budget for FY17
- Learning from others around us in neighboring states and countries will be a key point in the next year. A group from NMC will be attending the EPODE Conference in Canada in October and Internationally in Amsterdam in November.

Activities Undertaken and Planned

- Ongoing Activities
  - We are continuing to engage businesses schools and municipalities with a strong presence at local events and initiatives. Our advocates are actively participating in infrastructure meetings, sidewalk committees and recreation committees.
  - We attend and actively participate in collaborative meetings such as the Franklin Grand Isle Community Partnership and the Franklin Grand Isle Regional Prevention Collaborative. These involvements have led to many partnerships including Vermont Adult Learning, Foster Grandparent Program, and Samaritan House.

Activities Undertaken and Planned

New Activities

- None at this time as we are trying to implement our activities from our last report that includes small business umbrella, classroom scorecard, etc.

Providers and Beneficiaries Impacted

- *RiseVT Numbers*
- 16488 People are Rising
  - **12637 people** have seen RiseVT at events across Franklin and Grand Isle
  - **2214 people** have taken the RiseVT Pledge or taken the Health Assessment
  - **1130 people** have completed the RiseVT Individual Scorecard and know their score – 149 referrals to health coaching, 21 referrals to primary care, 9 referrals to tobacco cessation, and 20 referrals to dental care providers
  - **506 people** are using the RiseVT Wellness Dashboard & Health Coaching

Providers and Beneficiaries Impacted

- *RiseVT Numbers Continued*
- Facebook Likes: 9015

- 46 Businesses engaged
- 15 Schools
- 9 Municipalities

Evaluation Methodology

- 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	
$ 115,000.00	$ 115,000.00		$ 115,000.00	
$ 133,000.00	$ 53,272.88	$ 13,721.97	$ 70,532.03	
$ 20,000.00	$ 4,111.21	$ -	$ 4,111.21	
	$ -		$ -	
$ 22,000.00	$ 17,841.03	$ 3,944.33	$ 21,785.36	
$ 19,500.00	$ 19,455.72		$ 19,455.72	
$ 90,500.00	$ 107,075.49	$ 30,007.49	$ 137,082.98	
$ 400,000.00	$ 316,756.33	$ 47,673.79	$ 367,967.30	

An Innovative Adaptation of the TCM in a Rural Setting

Southwestern Vermont Health Care

Date:

October 7, 2016

Reporting Period:

July 2016 – September 2016

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

Billie Lynn Allard MS,RN

Grant Project Goals

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

Recent Accomplishments

1. SVMC, with the support of the Vermont Health Care innovation Project held the "Leading Health Care Reform by Building Accountable Communities" Regional Conference on September 20th. Additional sponsorships included the Dartmouth-Hitchcock, Organization of Nurse Leaders, Rutland Regional Medical Center, Southern Vermont College and Vermont Tech. Close to 150 attendees heard keynote speaker Mary Naylor PhD, FAAN, RN, of the Univ. of Penn School of Nursing, Kevin Stone, BA, MBA and Heidi Klein MSPH present on relevant topics as "The Relationship of Transitional Care to Population Health & System Redesign", "Financial Implications of Accountable Care Organizations" and "Integrating Population Health and Prevention in Health Care Reform, Vermont's Exploration of Accountable Communities'.
2. Posters were accepted and displayed at the Leading Healthcare Reform Conference on topics such as Nine Elements of an Accountable Community from Northeastern Vermont Regional Hospital, Caring for Opioid Dependent Mothers and Families, Home Health Care, as well as SVMC's Transitional Care Program, INTERACT and the Community Care Team.
3. 20 Table Discussions were part of the Conference. Participants were able to attend two table discussions on topics such as SASH a community service agency, Substance Abuse Programs, Food Sustainability, a Falls Community Program, VT Blueprint, Housing Programs and financial models as well as the TCN Nursing and Pharmacy programs, INTERACT and the Community Care Team. We received very positive feedback on this opportunity for attendees to sit and discuss these topics in more depth.
4. At the Regional Conference, the Transitions in Care Toolkit was distributed to all attendees. This toolkit included information from all poster presentations, table discussions, Mary Naylar PhD, FAAN, RN's presentation, and a white paper on the Bennington Blueprint.

Recent Accomplishments (continued)

5. An INTERACT Training program was held and the Director of Nursing, Subacute Nurse Manager and Long Term Care Nurse Manager of Centers for Living and Rehabilitation and the Director of Nursing for the Centers for Nursing and Rehabilitation all received Certification in the INTERACT program.
6. Katharine Murphy RN, developed a standardized program through her INTERACT work, and now four of five skilled nursing facilities in the Bennington area are now using this standardized red transfer folder and transfer forms for unplanned transfers the Emergency Department, providing the information needed for a successful transfer and treatment of these patients.
7. Katharine Murphy RN has been asked to present on the INTERACT Program and successful implementation outcomes at SVMC's Clinical Communication Rounds, The Organization of Nurse Leaders Fall Conference, and the 8th Annual Nursing Research and Evidence Based Practice Symposium in November.
8. The Community Care Team has added a component the monthly agenda to include presentations from participating agencies on the scope of services provided. This has expanded the knowledge of programs in the area and has increased referrals between agencies to support clients. Through the presentation done by Bennington Project Independence, informing the team of their direct referral process, SVMC ED has already increase referrals to the agency to support at risk patients.

Recent Accomplishments (continued)

9. Barbara Richardson, MSN RN-BC, CCRN, one of our Transitional Care Nurses will be receiving the Magnet Nurse of the Year Award for Structural Empowerment. This award will be presented at the Annual National Magnet Conference in October. ANCC Magnet is viewed around the world as the ultimate seal of quality and confidence in nursing excellence.
10. The Transitional Care Program Nurses will be presenting “Creating an Accountable Community” at the Magnet Nursing Conference. 9000 nurses from across the country and the world will be attending this conference on nursing excellence.
11. The Transitional Care Nurses continue to work to implement a research program on High Flow Oxygen project. They are currently in the process with the Director of Research at Dartmouth-Hitchcock and are completing the IRB process.

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.
   - Late approval of the SVMC operational budget has been a challenge. Financial analysis has been completed and commitment is strong to continue the Transitional Care Program.
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.
   - Continue to work with Information Systems to improve data collection and analysis.
3. Full implementation of the INTERACT program at all facilities due to changes in administration, nursing leadership, education directors and clinical staff.
   - With the demonstration of the positive outcomes of this program, plan is to continue to advocate for this program and monitor implementation. Education program provided this quarter will allow continuation of this program through nursing leadership oversight in each nursing home.
4. One of SVMC's Health Promotion Advocates (20 hours) left to attend graduate school, resulting in a decrease in HPA hours to 20 per week through August. By mid September a replacement was hired and is completing orientation.

Challenges and Opportunities (cont.)

- **Opportunities**

1. The success of the Leading Health Care Reform by Building Accountable Communities Conference at Mount Snow has expanded the number of requests for information and raised additional potential opportunities for additional programs and collaboration with others interested in Transitional 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 continued to both challenge 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. Through the success of the INTERACT program, nursing home administrators are seeing quality improvement results and monitoring these quality measures in their facilities more closely.
4. SVMC has received the SBIRT (Screening, Brief Intervention and Referral) Grant through the VT Department of Health to implement services to help identify and reduce substance misuse in VT adults. This program will also support the work with the Health Promotion Advocate in the ED and more patients can be reached.

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 – through end of contract**
  - Transition program over to hospital operations.
  - 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**
  - Continue the programs supported by the Vermont Health Care Innovation Project.

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)
  - BROC 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
  - Renselear County Department of Aging
  - PAVE – Project Against Violent Encounters

Number of Beneficiaries participating in/or impacted INTERACT Program

INTERACT® in the Community

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 & Rehabilitation	✓	✓	✓	✓	✓	✓
Center for Nursing & Rehabilitation	✓	✓	✓	✓	✓	✓
Vermont Veterans' Home	✓	✓	✓	✓	✓	✓
Bennington Health & Rehabilitation	✓	✓	✓			
Crescent Manor Rehabilitation	✓		✓			

✓ = INTERACT® Tool implemented at the facility October 2015 – January 2016

✓ = INTERACT® Tool implemented at the facility February 2016 – May 2016

✓ = INTERACT® Tool implemented at the facility June 2016 – September 2016

Number of Beneficiaries participating in/or impacted

- Transitions of Care Program

	Q1	Q2	Q3	Q 4	Q5 Jan-Mar 2016	Q 6 Apr-Jun 2016	Q 7 Jul-Sept 2016	Total YTD
Total # patient interactions	741	471	527	568	704	602	418	3429
Home	173	140	203	274	344	283	198	1332
Hospital	337	166	163	148	160	158	103	1077
Phone Call	166	120	110	109	149	134	99	753
PCP Office	37	22	36	29	35	13	13	172
Nursing Home	23	19	12	8	11	0	1	74
Emergency Department	3	13	1	0	3	1	0	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	Q 7 Jul-Sept 2016	Total YTD
# New patient encounters	19	9	18	3	5	56
Total # patient interactions						
Phone Contacts	14	1	26	31	17	89
Emergency Department	19	17	29	25	20	110
Inpatient Hospital	2	2		2	5	11
Visit In the Community	6	7	28	33	35	109
Consult w Community Resource	21	23	70	138	22	274
Consult with SVHC Resource			2	4		6
Screened for CCT	3		2		4	9
Meetings / CCT Team and Indiv Pt Planning		7	5	8	5	25

Providers and Beneficiaries Impacted (Cont.)

- Community Care Team

	Q1	Q2	Q 3	Q 4	Q5	Q 6 Apr – Jun 2016	Q 7 Jul-Sept 2016	Total
# New Participants	5	5	9	9	18	3	5	56
# Referrals/Contacts:								
Shared Living Provider Program	2				8	3	5	18
BPI Adult Day Service	2			2	2	2	2	10
Employment Services	1							1
Veterans Administration	2						2	4
UCS / CRT (Community Rehab & Treat)	1			1		3	5	10
Battelle House Crisis Center	2			1		6	9	18
Chronic Pain Program	1	2						3
Medicaid Case Manager	2	2	4	8	6	2	4	28
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	Q 7 Jul-Sept 2016	Total
# Referrals/Contacts CCT (cont.)								
Medical Provider	1			2	3	13	4	23
United Counseling Services	2	4	8	10	10	10	10	54
Developmental Services / UCS		3		4	5	17	9	38
Housing Assistance	1	1	1			9	3	15
Vocational Rehabilitation	1	2	1	1	5	5	2	17
Economic Services		3			8	9	5	25
Transitional Care Nurses SVMC		1			1	1	2	5
Social Services SVMC		2		2			4	8
Hawthorne Recovery Program		2					1	3
Court Appointed Guardianship		1	1			5	1	8
Memory Clinic		1						1
Department of Corrections		1	1		1		3	6

Providers and Beneficiaries Impacted (Cont.)

	Q1	Q2	Q 3	Q 4	Q 5	Q 6 Apr – Jun 2016	Q 7 Jul-Sept 2016	Total
# Referrals/Contacts CCT (cont.)								
VT State Field Representative			1		1	5		7
VNA			2		9	3	3	17
Family Services DCF			1		1			5
Food Assistance			1				2	3
Pharmacist Services			1					1
SASH (Support and Services at Home)			2			1	1	4
Brattleboro Retreat			1					1
Sunrise Family Services		1						1
Turning Point (drug treatment)				1		1	2	4
Washington Elms Community Care Home				1	1	1	4	8
Case Management SVMC				1	1	1	4	7
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	Q 7 Jul-Sept 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	Q 3	Q 4	Q5	Q 6 Apr-Jun 2016	Q 7 Jul-Sept 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
TOTAL	19	30	25	34	102	131	87	428

Providers and Beneficiaries Impacted (Cont.)

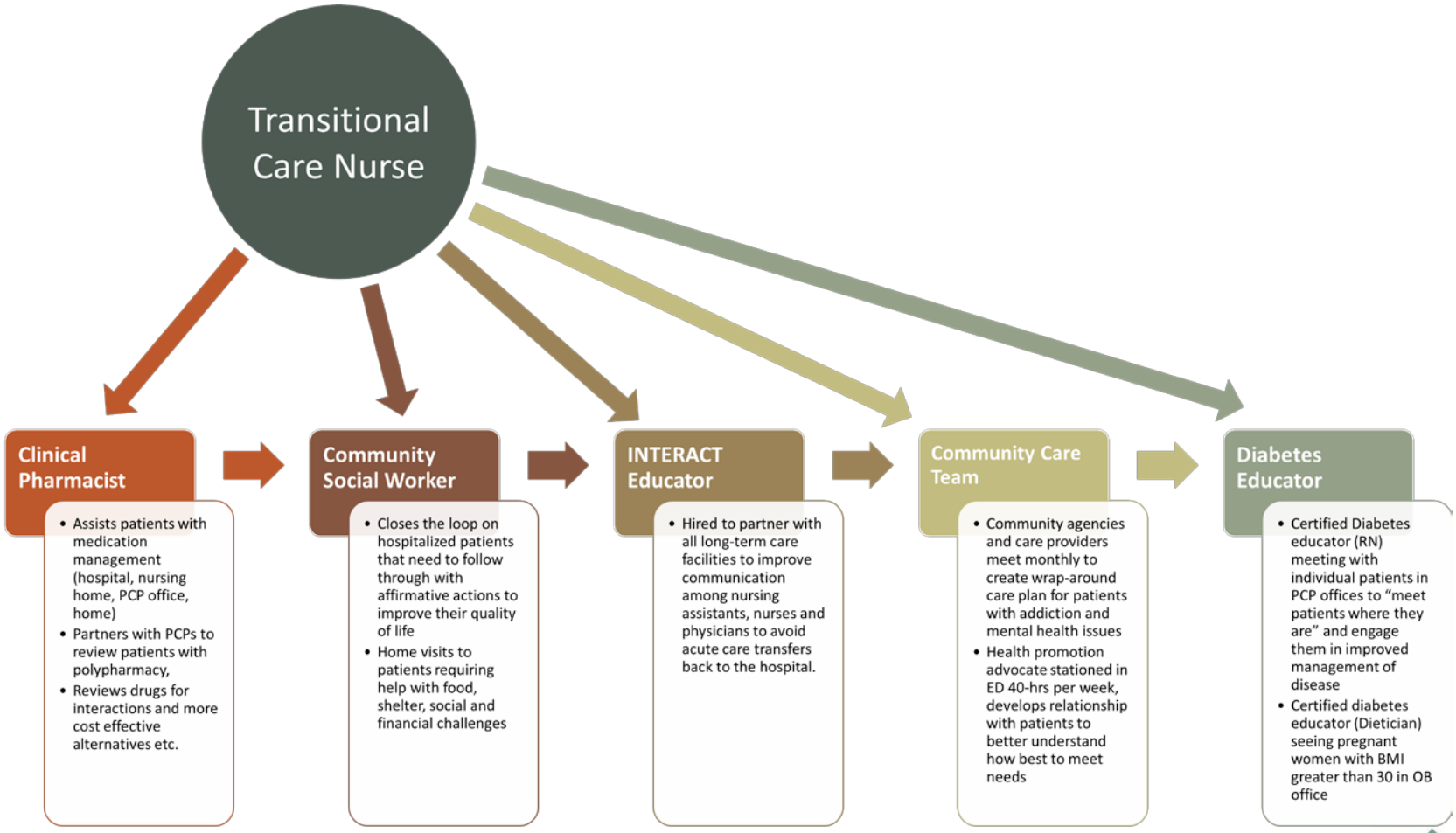
- INTERACT Program (program implemented November 11,2015)

INTERACT	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Totals	Year to Date
# of Stop & Watches Initiated	30	22	14	23	33	32	37	50	41	28	308	Stop & Watches
# of Progress Notes Written	224	159	70	148	196	225	314	367	338	219	2260	Notes
#f Sets of Vitals Obtained	222	158	78	141	211	242	304	336	200	295	2207	Vitals
% of Compliance with Vitals	93%	94%	88%	92%	92%	93%	95%	88%	94%	93%	92%	% Vitals Compliance
% of Compliance with Notes	89%	94%	76%	85%	77%	81%	91%	94%	93%	91%	87%	% Note Compliance
% of Compliance with ECS documentation	67%	73%	75%	74%	100%	88%	90%	96%	100%	100%	86%	% ECS Compliance
% of Compliance with Checklist	59%	91%	83%	100%	100%	100%	100%	100%	100%	100%	93%	% Checklist Compliance
# of Transfers to the ED from CLR	10	15	21	20	16	14	16	16	11	10	149	# of Transfers to ED from CLR
# of Hospital Admissions from CLR (INPT & OBS)	7	9	12	15	10	8	5	10	4	5	85	# of Inpatient/Observation Admissions
# of 30-Day Readmissions	4	7	6	8	3	2	2	5	1	6	44	# of 30-Day Readmissions

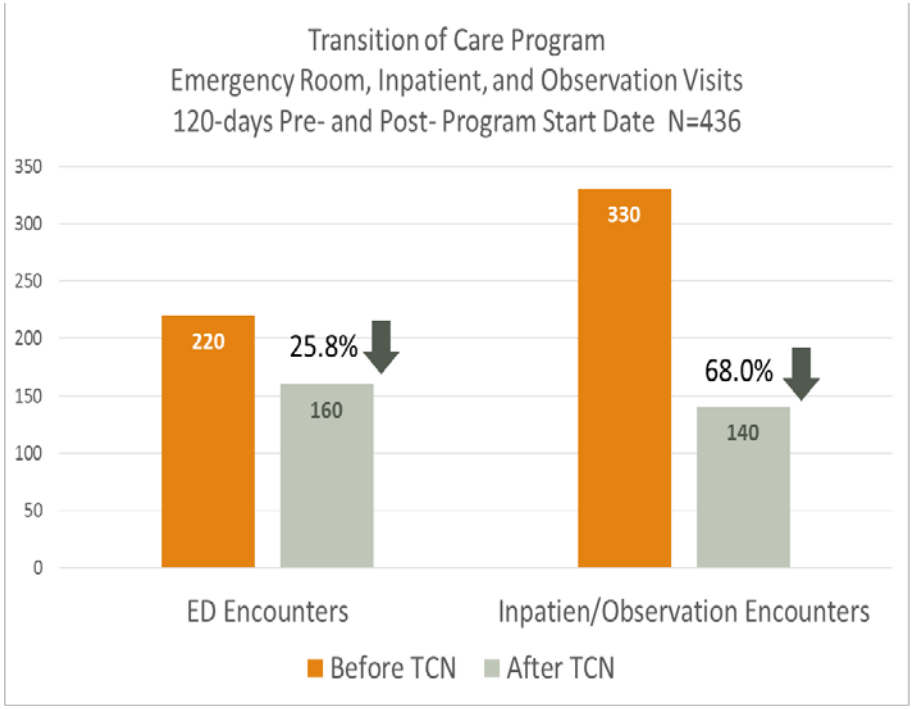
Evaluation Methodology

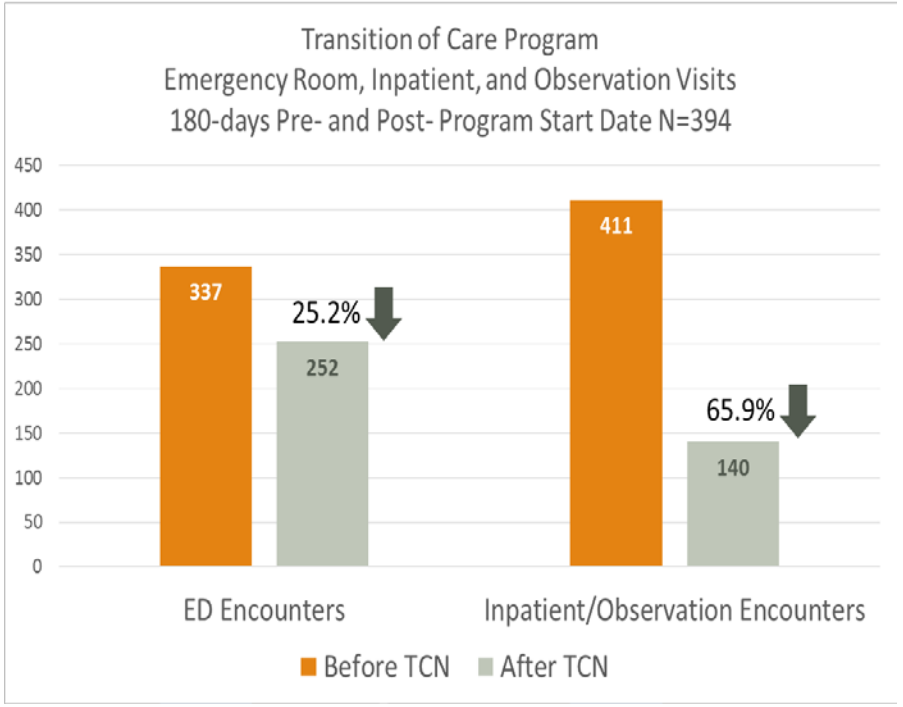
- **Transitions of Care Program**
  - Number of inpatient admissions to the hospital 120 days prior to TCN Program and 120 days post TCN Program.
  - Number of inpatient admissions to the hospital 180 days prior to TCN Program and 180 days post TCN Program.
  - Number of ED Visits 120 days prior to TCN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

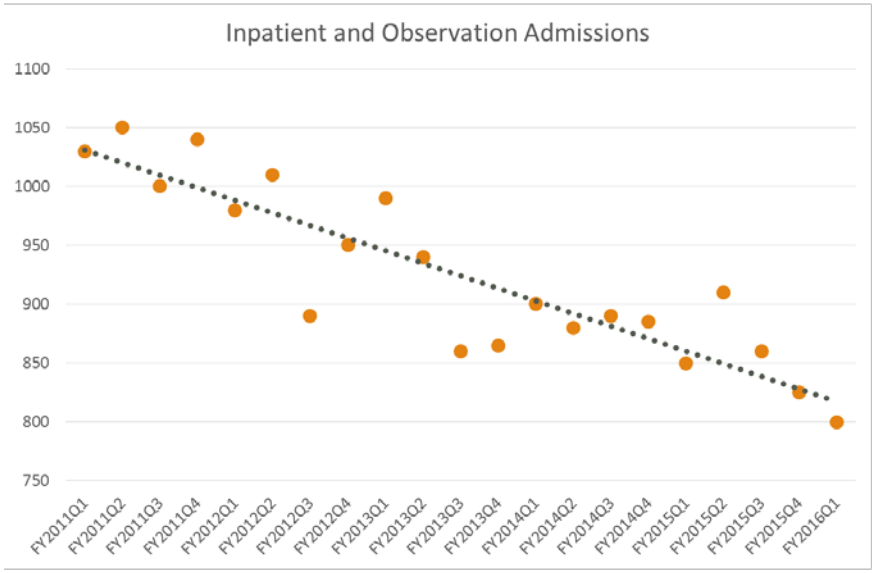


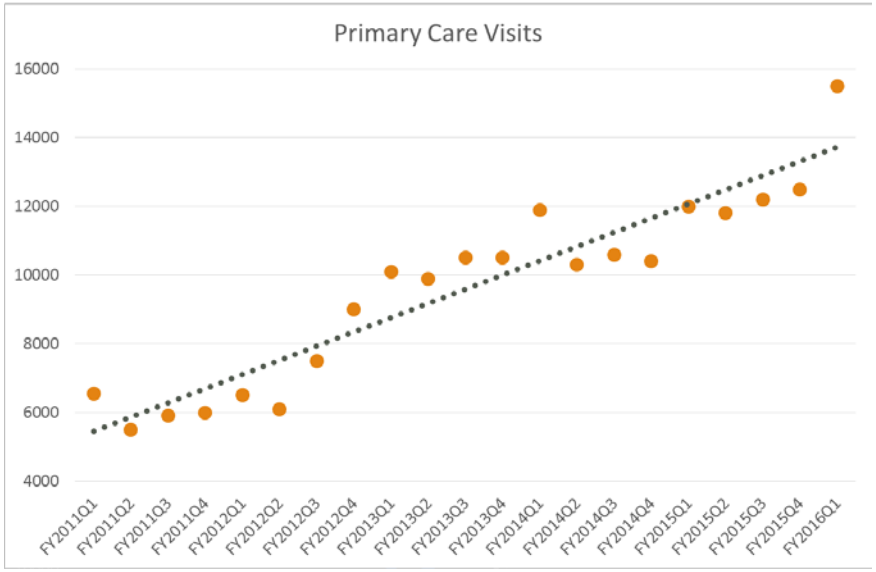
Transition Care Program
IMPROVES POPULATION HEALTH



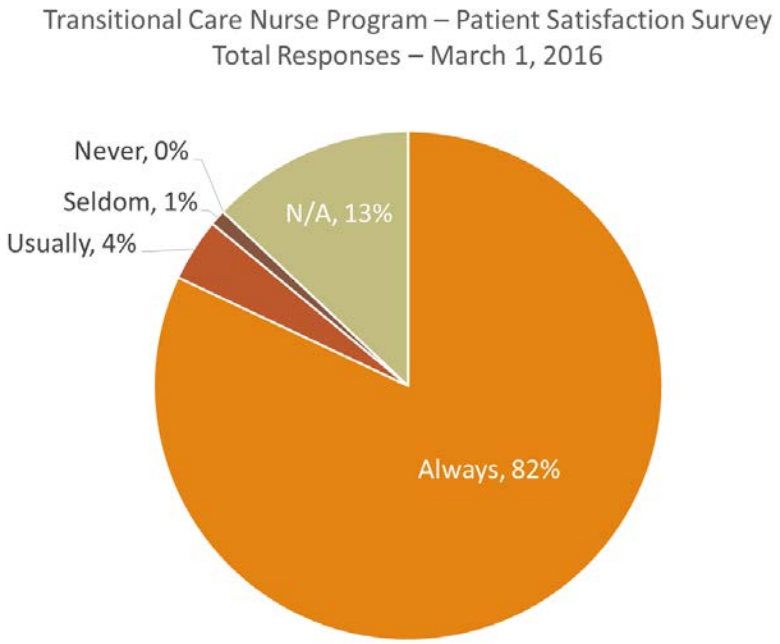


Transition Care Program Demonstrates Decreased Healthcare Costs





SVMC's Transitional Care Program IMPROVES the PATIENT EXPERIENCE

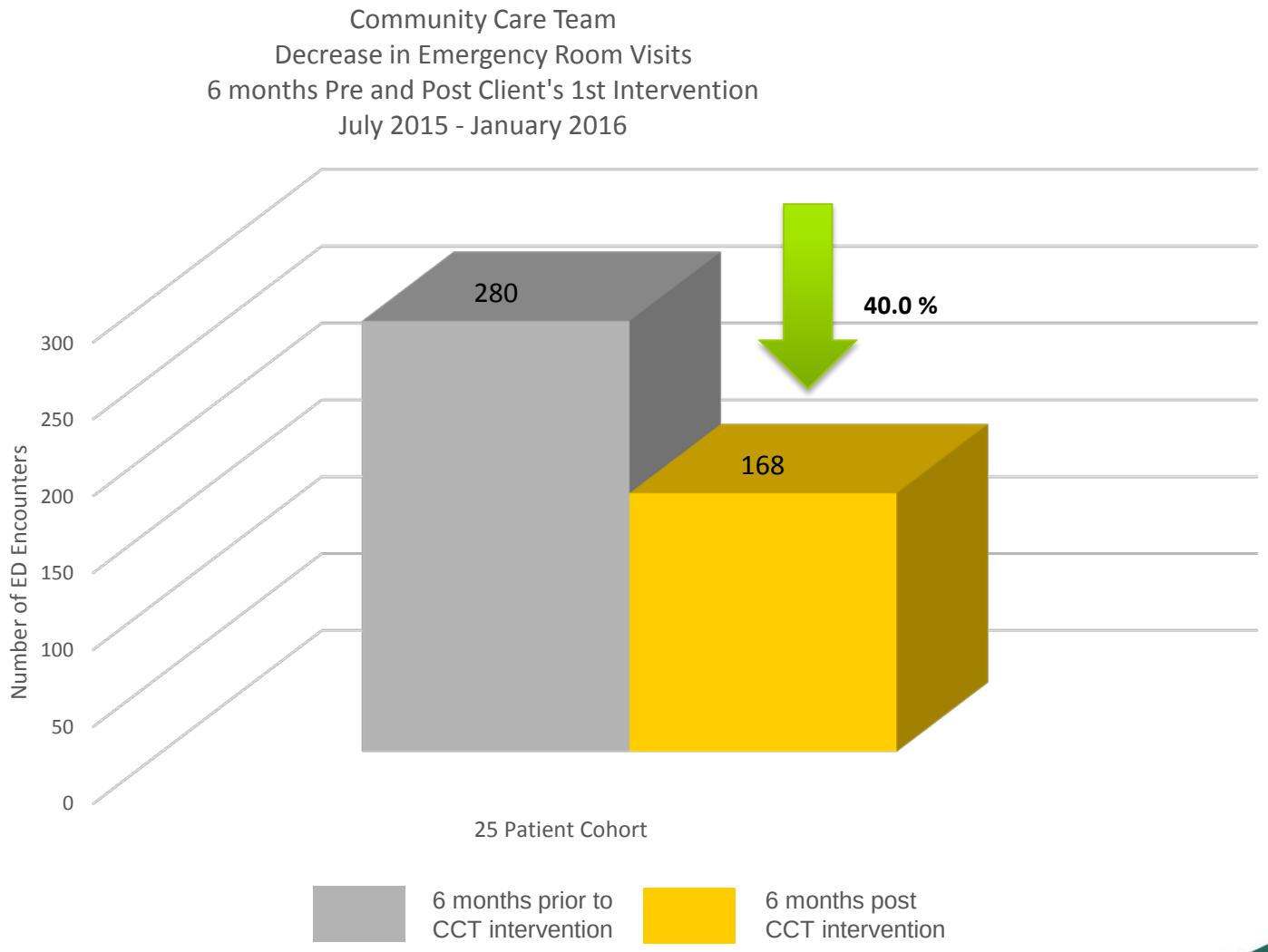


This graph illustrates the total Likert scale responses to the following questions.

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: A Hospital-Community Partnership to Serve the At-Risk Behavioral Health Population of Bennington County, VT

Ashley Lincoln BS, SVMC Health Promotion Advocate

BACKGROUND

- Increasing numbers of behavioral health patients in the ED that:
  - ✓ have no primary care connections,
  - ✓ lack adequate social networks,
  - ✓ have poor post-discharge treatment adherence,
  - ✓ rarely obtain follow-up services.
- Because they ultimately use the ED as their "home," these patients:
  - ✓ overwhelm the ED's capacity to care for all patients,
  - ✓ lead to ED overcrowding,
  - ✓ decrease safety and lead to poor care coordination,
  - ✓ lead to financial losses.
- Psycho-social problems are community problems. No one entity alone can effectively improve outcomes for this population.
- There is a need for someone to work closely with ED providers, nursing, and community agencies to coordinate services for these patients.

SOLUTION

- Hire a Health Promotion Advocate to lead a Community Care Team
- Program will reduce unnecessary utilization of Emergency Department and Inpatient Services by behavioral health patients with non-emergent, medical, behavioral and/or social needs
- This program will also develop patient-centered care and improve outcomes by developing wrap-around services through multi-agency partnerships and care planning

HEALTH PROMOTION ADVOCATE

- One year grant-funded position (VHCIP)
- 40-hour position (ED is the Home Base)
- Care coordination and case management
- Direct and indirect referrals
- Works closely with ED providers and nurses
- Resource to connect with community agencies
- Coordinating the Monthly Community Care Team Meeting

PROGRAM DEVELOPMENT

- Assemble Team
- Implement a Health Promotion Advocate
- Identify patients
- Develop a release of information
- Schedule monthly meetings to present patients to community agencies
- Share pertinent information/updates
- Implement plan of care

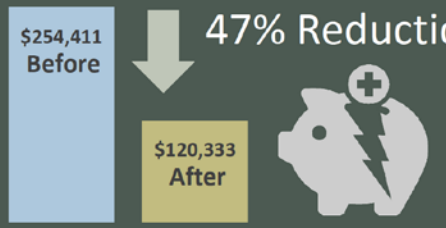
COMMUNITY PARTNERSHIPS

- Community Housing Services
- Addiction and Behavioral Health Resources
- Family Support Services
- Vocational Training
- State Human Services Departments
- State Health Departments
- Outpatient Hospital Services
- Emergency Transport Services

ANALYSIS AND RESULTS

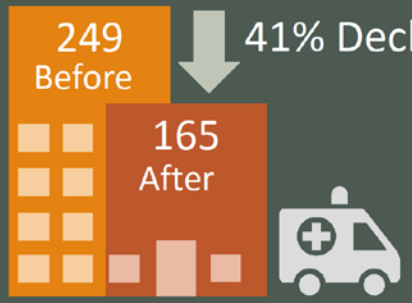
Decreasing Healthcare Cost

- For 23 patients, we tracked their total visit cost for 6 months pre and post first intervention.



Non-Emergent Hospital Visits

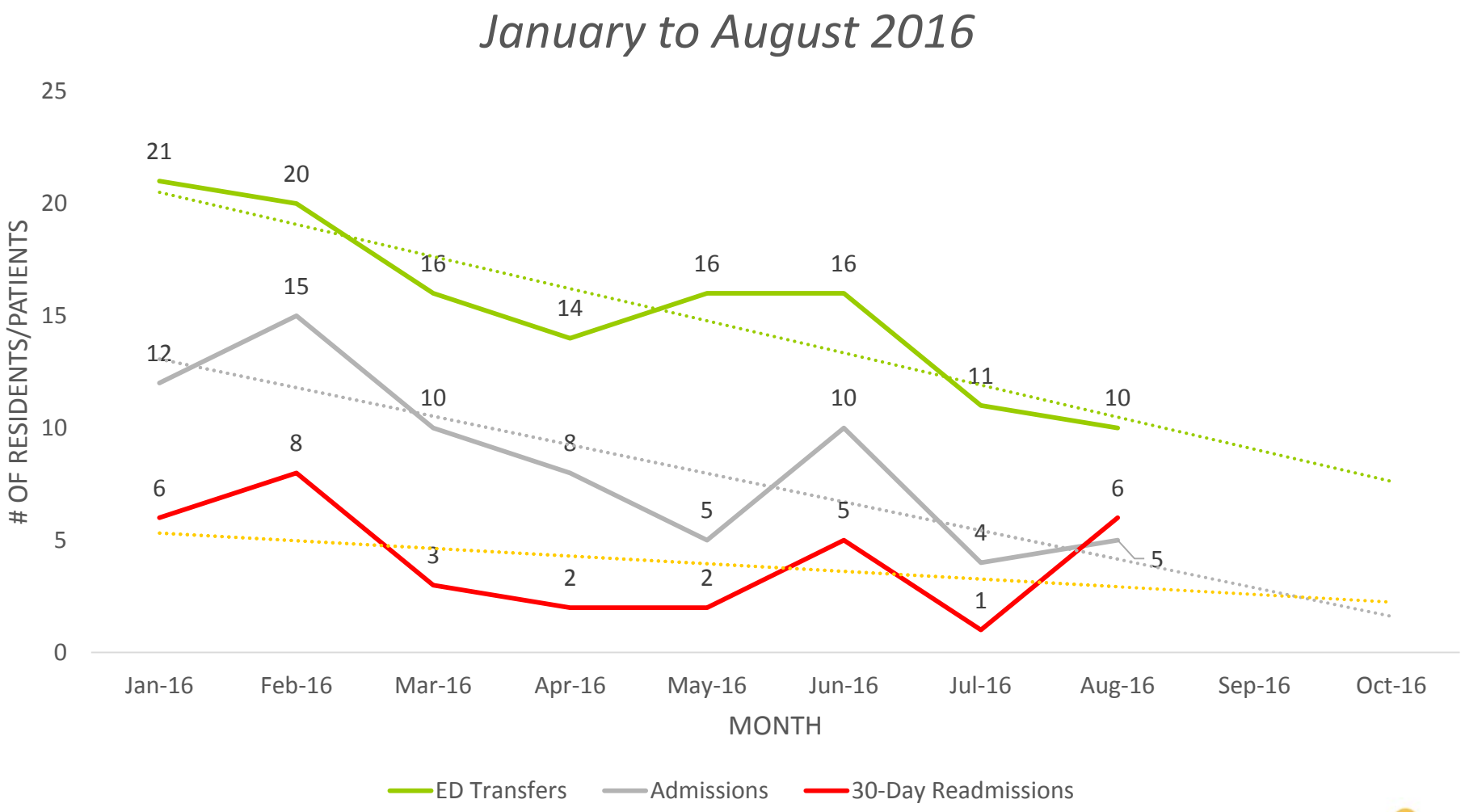
- For 23 patients, we tracked their total visits to the Emergency Department, for 6 months pre and post client's first intervention.
- We tracked a 41% decline in visits 6 Months after the Community Care Team Intervention



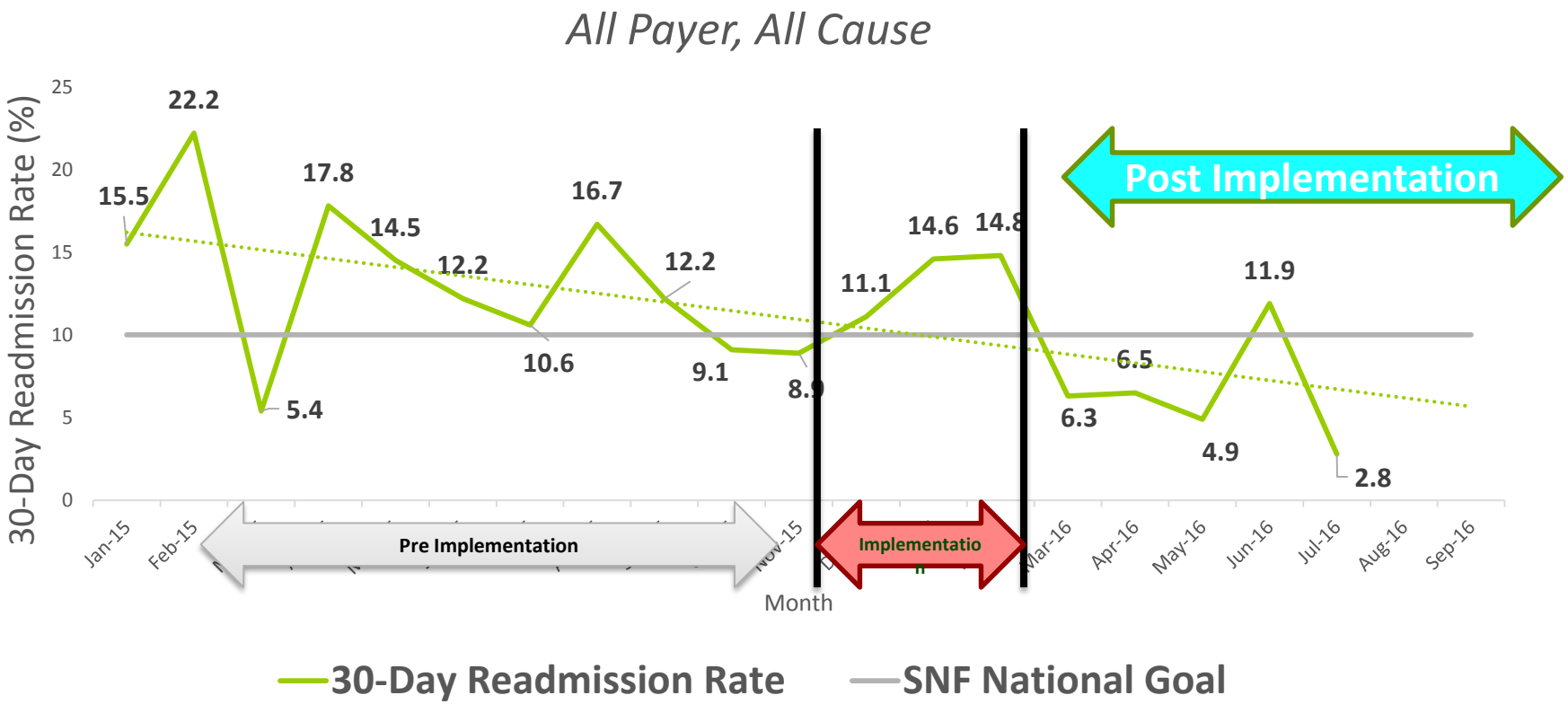
MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

Southwestern Vermont MEDICAL CENTER

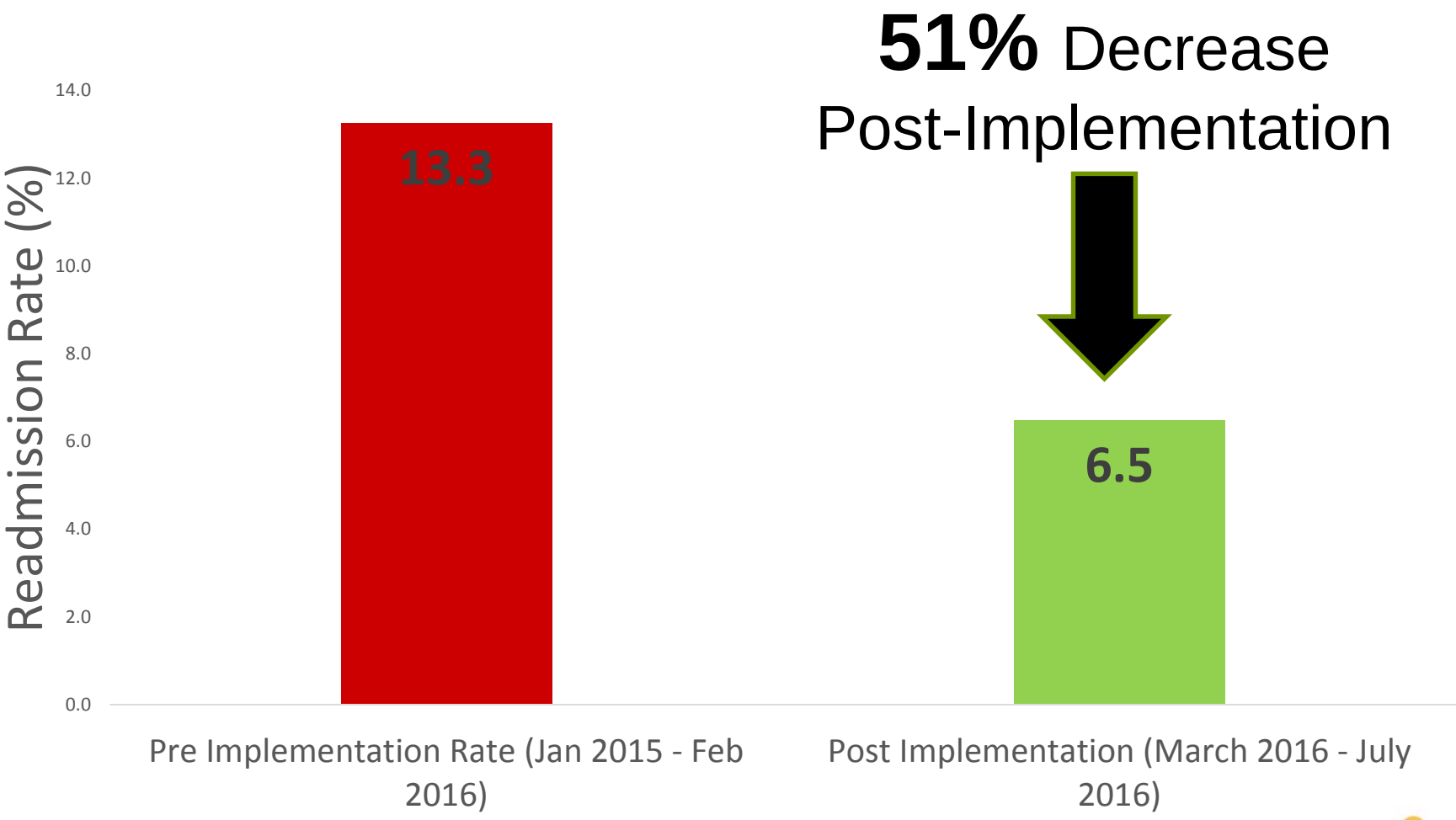
INTERACT Program demonstrates decreased ED transfers Hospital Admissions and 30 day Readmissions



INTERACT Program demonstrates decreased CLR 30 day Readmission Rates

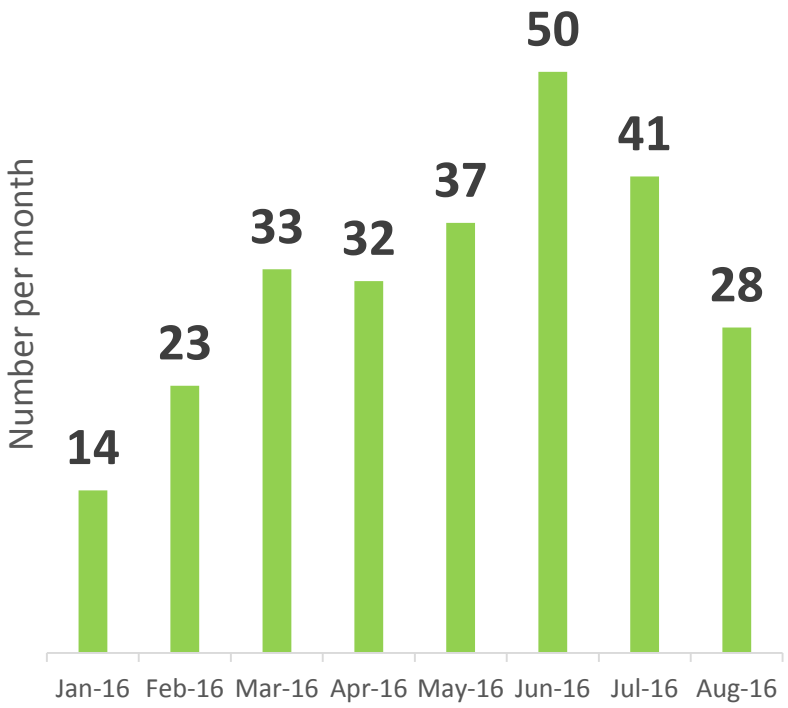


INTERACT Program demonstrates decreased 30-Day Readmission Rates All Payer, All Cause

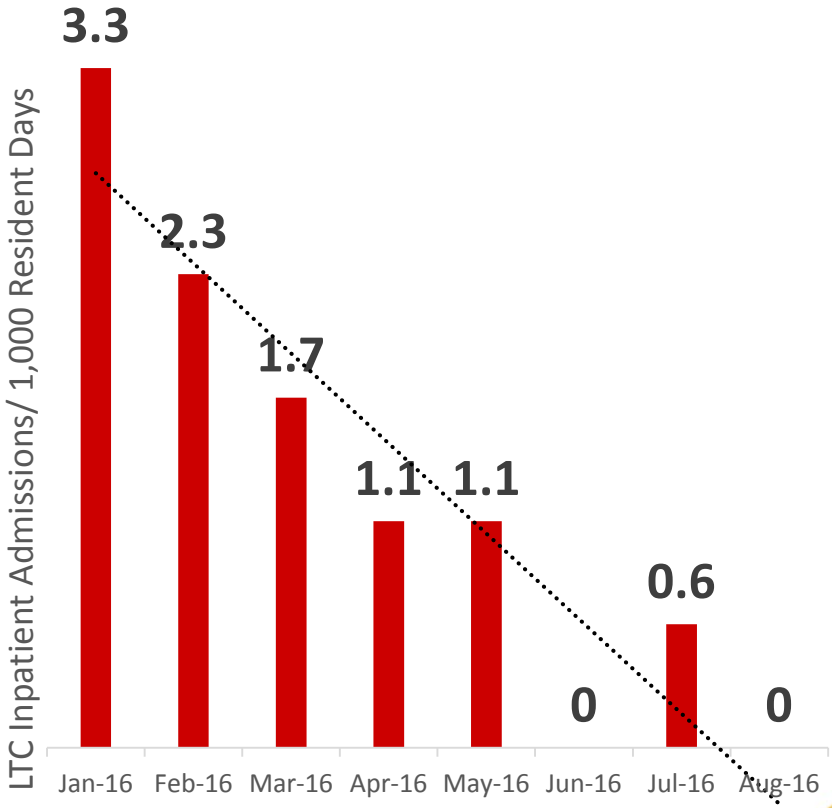


INTERACT Program demonstrates decreased LTC Transfers resulting in Inpatient Admission

Number of Stop & Watches/Month



LTC Inpatient Admissions per 1,000 Resident Days



Vermont Health Care Innovation Project

Sustainability

- Please describe any sustainability planning that is currently underway and the status of that work.
  - SVMC has conducted a financial analysis of the Transitional Care Nursing Program. Information is positive to support the continuation of this program within the SVMC operational budget.
  - Operational planning is underway to continue the Transitional Care Nursing Program through the SVMC Operational Budget.
  - Pharmacist, Respiratory Therapist and Social Work expansions of the Transitional Care Program are already funded through the SVMC operational budget.
- 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. Education was provided this quarter to train super users for each nursing home to sustain this program moving forward.
  - SVMC has received a SBIRT grant which will also continue to support our substance abuse patients and those at risk for substance abuse. A Social Worker position is funded in the ED to screen for risk and implement immediate intervention including referrals to many of the community agencies included in our Community Care Team.
  - Review of the results of the financial analysis and meetings with the CFO continue on an ongoing basis.

Expenditures to Date & Revised Budget

	Approved Budget	Prior Spending	Spent this Quarter	Total Spent to Date
Salary	$ 258,813.00	$ 200,693.76	$ 44,392.57	$ 245.086.33
Fringe	$ 86,193.00	$ 59,842.29	$ 13,316.66	$ 73,158.95
Travel	$ 6,497.30		$ 1,112.04	$ 1,112.04
Conferences	$ 22,000.00		$ 19,743.07	$ 19,734.07
Equipment/Supplies	$ 3,097.00	$ 1,192.16	$ 1,528.99	$ 2,721.15
Contracts	$ 23,399.00	$ 6,966.75	$	$ 6,966.75
Indirect				
Total	$ 400,000.00	268,694.96	$ 80,084.33	$ 348,779.29

Briefly discuss any potential changes to the budget going forward:

Approved budget updated to include reallocated approved budget.

Behavioral Screening and Intervention
Invest EAP

Date: October 7, 2016

Reporting Period: July – Sept 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

- Very strong preliminary data showing statistically significant improvements on numerous key outcome variables pre- and post-treatment.

- Success Story

  Female given BSI and scored for depression. She met with Health Coach to deal with symptoms of grief, loss of family connections and better nutrition and exercise. Developed behavioral strategies for journaling, engaging in crafts, mindfulness around eating, and exercising. These interventions reduced her depressive symptoms and her weight, greatly increasing her overall health and wellbeing.

Challenges and Opportunities

- Over half of participants completed 6-month follow-up surveys.
- Newer participants had the ability to benefit from enrollment but the time period to collect follow-up surveys at the 3-month and 6-month time frame is limited.

Activities Undertaken and Planned

Ongoing Activities

- Continuation of survey collection and distribution of incentives.

New Activities

- Additional supplemental outreach to participants to collect data.

Long-term Activities

- Formal data analysis to begin.

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

Sustainability

- We are currently presenting interim findings to several large insurance trusts, insurance companies and our larger self-insured employer accounts at EAP.
- There is considerable interest given the initial findings for paying of these services ongoing through fees-for-service and potentially other mechanisms.

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	$ 9,822.43	$ 2,371.80	$ 12,194.23
Fringe	$ 8,431.00	$ 6,651.78	$ 1,548.55	$ 8,200.33
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	$ 2,430.00	$ 455.00	$ 2,885.00
Indirect	$ 5,467.70	$ 2,551.23	$ 437.54	$ 2,988.77
Total	$ 60,144.70	$ 28,063.53	$ 4,812.89	$ 32,876.42

Resilient Vermont
Invest EAP

Date: October 7, 2016

Reporting Period: July – Sept 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

- Health Coach completed follow up sessions with participants.
- Survey request via mailing was successful in getting follow up data collected for a good number of participants
- 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

- Data collection surveys still need to be collected.
  - Some patients have moved out of area, may not readily have access to the on-line survey, may have literacy challenges in reading surveys. These challenges increased our need for additional outreach via phone and/or coordinating to meet participant when he/she showed up at Heath Center for a medical appointment.
  - There are patients who seemed to benefit by having variable time between sessions (rather than meeting once a week) with Health Coach. When patient returned on his/her time schedule, interventions seemed well timed to match participants initiative level. Variable timing made it harder to close out participants on regular schedule.

Activities Undertaken and Planned

- Ongoing Activities
  - Conduct assessments and enter data
- New Activities
  - Mailing outreach completed
- Long-Term Activities
  - Additional outreach to clients for follow up data collection
    - Letters/phone calls
  - Data analysis

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

Sustainability

- We are currently presenting interim findings to several large insurance trusts, insurance companies and our larger self-insured employer accounts at EAP.
- There is considerable interest given the initial findings for paying of these services ongoing through fees-for-service and potentially other mechanisms.

Expenditures to Date & Revised Budget

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

	Approved Budget	Prior Spending	Spent this Qtr.	Total Spent to Date
Salary	in-kind			$ -
Fringe	in-kind			$ -
Travel	$ 6,500.00	$ 4,330.00	$ -	$ 4,330.00
Conferences	$ -		$ -	$ -
Equipment	$ 1,900.00	$ 2,329.00	$ -	$ 2,329.00
Contracts	$ 191,260.00	$ 145,864.36	$21,838.76	$ 167,703.12
Supplies	$ 1,000.00	$ 935.45	$0.00	$ 935.45
Other	$ 26,560.00	$ 4,800.00	$5,965.80	$ 10,765.80
Indirect	$ 22,722.00	$ 15,825.88	$ 2,780.46	$ 18,606.34
Total	$ 249,942.00	$ 174,084.69	$ 30,585.02	$ 204,669.71

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

State Innovation Models: Funding for Model Design

Vermont Program For Quality in Health Care, Inc.

Date: October 6, 2016

Reporting Period: July 1, 2016- September 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

NSQIP Participation

- 3 hospitals renewed for a 2nd year of NSQIP with potential for 4th hospital to renew
- Porter Medical Center rejoined NSQIP
- Copley Hospital renewed interest in NSQIP

- Face to face collaborative meeting with surgeon champions and SCRS'

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
  - 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.
  - Develop a surgical project surrounding opioid use post-surgery

PRE-OP RISK FACTORS

2037 CASES

1234 adults (60.6%) 1 or more risk factors

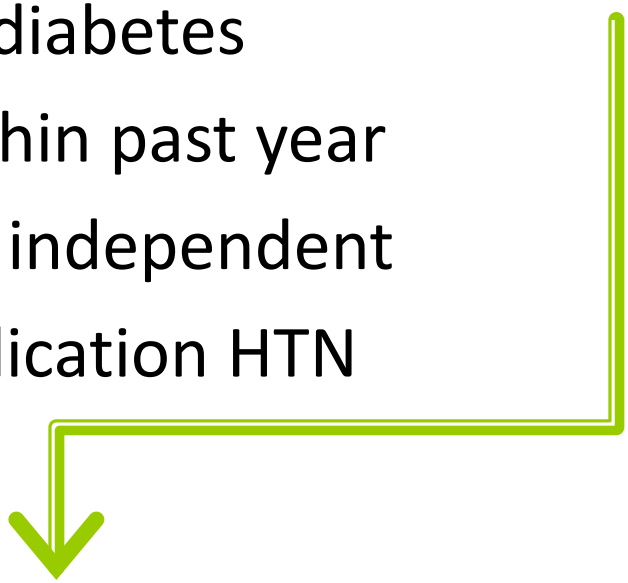
803 adults (39.4%) no risk factors

11.9% adults with diabetes

20.7% smokers within past year

97.2% functionally independent

37.7% 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:** Continue to schedule collaborative members and insurer meetings. Facilitate communication ACS NSQIP and hospitals regarding enrollment.
- **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

- **2037 Cases** entered into work station
- **93.9%** 30 day follow up
- **119 adults (5.8%)** had a preventable surgical complication

- **Complications:** wound, respiratory, urinary, cardiac, central nervous system

- **Costs:** 119 X $11,000(AVG added cost) = **$1,309,000 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
INPATIENT OR OUTPATIENT SURGICAL PATIENTS at 18 YEARS OF AGE OR OLDER NO TRAUMA CASES	**CLINICALLY**: RATES OF POSTOPERATIVE COMPLICATIONS INCLUDING MORTALITY **FINANCIAL:** COSTS FOR POSTOPERATIVE COMPLICATIONS EXCLUDING MORTALITY	VUHDDS **AND** ACS NSQIP RAW OUTCOMES DATA PATIENT DATA ENTERED INTO ACS NSQIP WORKSTATION PRODUCES HOSPITAL LEVEL CLINICAL OUTCOME, RISK ADJUSTED REPORTS USING ODDS RATIOS	RAW DATA: AS OF 9/2016 2037 CASES ENTERED INTO NSQIP 119 PEOPLE **(5.8%)** EXPERIENCED POST-OPERATIVE OCCURANCE WITHIN 30 DAYS TRANSLATES TO APPROXIMATELY **$1.3 Million Average added direct health care costs.**	THE SMALL SURGICAL VOLUMES FOR CRITICAL ACCESS HOSPITALS MAY REQUIRE AT LEAST 1 TO 2 YEARS (2017) BEFORE DATA IS RELIABLE. MID-SIZE HOSPITALS **MAY** HAVE RELIABLE DATA AS EARLY AS FALL 2016.

Sustainability

To date, we have had meetings with 4 insurance groups and requested a meeting with a 5th 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. SEP 2016	Total Spent to Date SEP 2016
Statewide SC Project Coordinator	101,772.56	87,024.05	10,121.73	97,145.79
Surgical Case Reviewers (Salaries)	160,417.00	71,644.45	2,683.66	74,328.11
Sr. Program Mgr./Epidemiologist	22,660.82	3,859.57	4,340.77	8,200.34
Executive Director	9,914.11	6,150.49	1,901.20	8,051.69
Administrative Assistant	10,622.37	3,314.66	1,037.53	4,352.19
Business Office	11,278.08	7,295.93	7,794.69	15,090.62
IT Manager	4,992.06	520.00	1,713.60	2,233.60
Total Salary	**321,657.00**	**179,809.15**	**29,593.18**	**209,402.34**
Surgical Case Reviewers (Fringe)		17,668.13	805.10	18,473.23
Fringe (30% year 1, 32% year 2)	101,358.00	33,040.43	8,611.05	41,651.47
Total Fringe	**101,358.00**	**50,708.56**	**9,416.15**	**60,124.70**
Total Salary & Fringes	423,015.00	230,517.71	39,009.33	269,527.04
Training fee for Coordinator	2,321.00	2,321.22	-	2,321.22
Travel to hospitals by Coordinator - Avg. 4				
Trips per month @.$575/.54 per mile	1,724.00	1,022.04	43.20	1,065.24
Computer Equipment -12 computers for SCRs	4,000.00	3,000.00		3,000.00
Vermont Statewide Collaborative Meetings	10,298.00	75.00	-	75.00
Conference Sponsorship - Nat'l NSQIP Conf	3,000.00			
Hospital Enrollment fees –annual	97,000.00	63,500.00	-	63,500.00
Indirect Costs	50,832.00	28,209.25	3,667.03	31,876.28
Totals :	592,190.00	328,645.22	42,719.56	371,364.78

SIM Funding for Infrastructure Building

HealthFirst, Inc.

Date: **October 10, 2016**

Reporting Period: **July 1 – September 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 Health*first* members to guide delivery of high-quality care and related data tracking ***(beginning Q4-2014)* - *ongoing***
14. Monitor hospital admission/discharge records ***- ongoing***
15. Monitor hospital admission/discharge records ***- ongoing***
16. Continue to support the shared learning clinical implementation committee ***(meeting quarterly since Q3-2013)* - *ongoing***

Recent Accomplishments

- **Goal 8. Clinical quality measures data collection process:** One of the most significant impacts HealthFirst has had under the SIM grant is empowering practices to manage and report their own data. Not only has this increased confidence in the data, it has also allowed HealthFirst to provide targeted technical support and to disseminate best practices among our members. In 2015, VCP practices again had the highest quality scores among the three Vermont commercial ACOs as measured against national and state benchmarks. In five of the seven nationally benchmarked measures, VCP practices ranked in the 75 percentile or higher. One area in which VCP practices showed significant improvement is depression screening, which is not nationally benchmarked. When 2014 data showed a performance gap for this benchmark, our clinical quality team set about working with all VCP practices to help them improve procedures and ensure this essential screening was taking place. Clearly, that technical assistance paid off, and we saw the percentage of practices performing this screening jump from 19% in 2014 to 34% in 2015. There was a slight decline (not statistically significant) in the rate of childhood immunizations – though the 2015 rate was at 75% – but we believe this is attributable to small sample size and some overly strict criteria, namely cutoff dates, within the benchmark. HealthFirst's voice is among those providing feedback about the benchmark's problematic configuration.

Recent Accomplishments

- **Goal 11. Architecting disease management programs:** In our last quarterly report, we noted that many of our primary care practices were reporting that numerous diabetic patients were not receiving dilated retinal exams. With a closer look, practices discovered that, in many cases, it was not that patients were not getting this important exam, but that the primary care practices were not receiving reports from patients' ophthalmologists or optometrists alerting them to exam results. To help rectify this, in September, HealthFirst sent a letter to 45 eye care practices that serve the same geographic areas as our primary care providers. We asked practitioners to sign an agreement to report exam results (a simple yes or no to the presence of diabetic retinopathy) to primary care practices within one week. Thus far, 24 practices (53%) have signed an agreement. Our next step will be compiling a list of collaborating eye care practices to distribute to our member primary care providers to help practices close the loop in their diabetic patient care protocols.

Recent Accomplishments

- **Goals 13. Education opportunities and materials to guide practices in the delivery of high-quality care and data tracking:** As noted, our clinical quality staff continue to work closely with member practices to help them refine their data tracking protocols and procedures. The ability to compile and analyze data by practice helps us target practices that need the most support. Seeing their results in the context of their peers' has proven to be highly motivating for practices, which can receive technical assistance from HealthFirst clinical quality staff as well as from collegial practices.

Recent Accomplishments

- **Goal 15. Continue to support the shared learning clinical implementation committee and other committees convened under the grant:** As part of our SIM grant, HealthFirst convened several committees to further support practice education and evolution. The Clinical Implementation Committee, comprising practice managers from several of our largest practices, continues to be an excellent source of constructive feedback about how value-based programs affect practices' operations and care delivery. This committee was started under HealthFirst's Medicare ACO (ACCGM) and continued into the commercial ACO program. We plan for this committee to go on meeting after the SIM grant ends because the group has been so valuable in helping HealthFirst determine how it can best support member practices. We also plan to continue the Consumer Advisory Board and the Clinical Quality Board beyond the grant to ensure that we are knowledgeable about a variety of stakeholder perspectives.

Challenges

- **Funding:** Outside of the grant, HealthFirst's primary income is from member dues, with sponsorships and contract administration fees HealthFirst adding to our revenue. In essence, we are a small business working to support a network of small businesses and we share some of the same concerns about funding. HealthFirst is continuously seeking and advocating for economic opportunities for our member practices to help support their operations and their commitment to delivering the highest quality care to their patients. To this end, HealthFirst has been actively involved in the all-payer waiver process, advocated strongly for the CPC+ program, has advised members about Next Gen and other payment models in which practices could engage, and has been very vocal in our advocacy for increases in Medicaid reimbursements. One of the biggest challenges in our sustainability planning has been the constantly shifting time lines and details for several potentially promising programs, such as the all-payer waiver. It is difficult to plan for stability and sustainability in funding when available programs have not stabilized. This uncertainty is especially hard on small practices, which generally do not have large reserves and cannot cost shift to make up for reimbursement shortfalls.

Opportunities

- **Population Health Alliance:** HealthFirst's alliance with Community Health Centers of Burlington to form the Population Health Alliance (PHA) is designed to address not only some of the economic challenges independent practices are facing, but also to support practices in getting back to their primary focus: delivering the best quality care efficiently for patient populations as well as for individuals. The initial goal of PHA is to work with payers to develop new models for cost-effective care delivery based on population-level intervention and care management.

Planned Activities

- **Annual Meeting:** Our annual meeting is just a few weeks away and we are looking forward to bringing our members together to connect with one another and to look ahead to 2017 and the future of Vermont's independent practices. This meeting is also an opportunity for HealthFirst to reflect about the progress made under the SIM grant and how our work under the grant has helped position independent practices as a strong and important voice in Vermont's healthcare landscape. Members will have the opportunity to hear from the executive director of the national Association of Independent Doctors, an organization working on a national level to help strengthen the viability of independent practices. Senator Tim Ashe will also be speaking and will talk about the positive impacts of HealthFirst's efforts to educate legislators about the role of independent practices in ensuring that all Vermonters have access to high-quality personalized care. He will also look ahead to the upcoming legislative session and some of the healthcare issues he believes will be on the docket.

Providers and Beneficiaries Impacted

- **Number of Providers:** HealthFirst counts more than 130 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 130+ 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), Blueprint 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 continues to show that Vermont's independent physicians are providing excellent care to their patients. Data for 2015, which included an expanded slate of quality benchmarks, supports this trend. 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

- Since the fall of 2015, HealthFirst has been engaged in sustainability planning, with this effort becoming an increasing priority over the past few months. The infrastructure and capacity building the SIM grant afforded HealthFirst has made it possible for individual independent practices to become coordinated as a unit that can now effectively execute on a population health level. This accomplishment helped set the stage for the creation of the Population Health Alliance, HealthFirst's alliance with Community Health Centers of Burlington. Autonomously, HealthFirst will continue in its role as an advisor to support independent practices in making sense of and succeeding in emerging value-based payment initiatives.

Sustainability Planning

Continuing SIM Activities Beyond the Grant

- Because our grant has focused specifically on capacity and infrastructure building, work started under the grant will continue intrinsically, though the scope of our work will change when the current commercial ACO program ends in December. We are continuing to evaluate our staffing and program needs and refining our plans as needed as external programs and initiatives evolve.

Expenditures to Date: July 1 to September 30, 2016

HealthFirst, Inc. - SIM Grant #03410-1305-15					
Financial Report: July 2016-September 2016					
	Approved Budget	Spent Prior Quarter - Apr-June 2016	Spent Current Quarter - July-Sept 2016	Spent to Date	Balance
Staff Compensation					
Executive Director	$172,066.52	$19,980.12	$19,980.12	$166,980.10	$5,086.42
Administrative Assistant	$55,166.84	$6,437.52	$6,437.52	$53,020.90	$2,145.94
Operations Director	$122,092.66	$32,653.45	$32,653.45	$113,152.51	$8,940.15
Clinical Lead, Other MD	$24,325.00	$0.00	$0.00	$24,325.00	$0.00
Quality & Care Coord. Mgr.	$93,333.28	$19,583.34	$19,583.34	$87,083.28	$6,250.00
Fringes	$0.00	$0.00		$0.00	$0.00
Total Wages	**$466,984.30**	**$78,654.43**	**$78,654.43**	**$444,561.79**	**$22,422.51**
Consultants					
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)
Total Consultants	**$78,600.40**	**$0.00**	**$0.00**	**$78,600.41**	**($0.01)**
Office					
Rent	$22,657.76	$0.00	$0.00	$22,657.76	$0.00
Utilities	$3,013.90	$0.00	$0.00	$3,013.90	$0.00
Supplies (incld computers, communication)	$14,983.32	$0.00	$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
Total Office	**$54,415.30**	**$0.00**	**$0.00**	**$54,415.30**	**$0.00**
TOTALS	**$600,000.00**	**$78,654.43**	**$78,654.43**	**$577,577.50**	**$22,422.50**

Budget Notes

Notes

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