VHCIP Provider Sub-grant Symposium

AGENDA

May 27, 2015

8:00am – 12:30pm

Capitol Plaza Hotel and Conference Center
Montpelier, VT

- **8:00** **Arrival**

- **8:15** **Opening Remarks**
  Robin Lunge
  Director of Health Care Reform

- **8:30** **ACO Panel Discussion**
  - **MODERATOR: Steven Costantino,** Commissioner, Vermont Department of Health Access
  - **Amy Cooper,** Executive Director, Healthfirst, Inc
  - **Joyce Gallimore,** Director, Community Health Accountable Care, LLC
  - **Victoria Loner**, Vice President, Clinical and Network Operations, OneCare Vermont, University of Vermont Health Network

**break **

- **10:30** **Transitions of Care Panel Discussion**
  - **MODERATOR, Allan Ramsay,** Green Mountain Care Board
  - **Billie Lynn Allard,** Administrative Director of Outpatient Services and Transitions of Care, Southwestern Vermont Medical Center
  - **Pam Smart,** Care Integration Coordinator, NVRH Community Health Team, VT Blueprint for Health
  - **Toni Apgar,** Care Coordinator, White River Family Practice
  - **Sean Uiterwyk,** Physician, White River Family Practice
  - **Sara King,** Chief Financial Officer, Rutland Area Visiting Nurse Association & Hospice

- **12:15** **Debrief**
  Robin Lunge
  Director of Health Care Reform

Please join each other for lunch at one of the many restaurants in Montpelier!

Welcome to the VHCIP Sub-grant Symposium

Vermont's VHCIP sub-grant program is designed to directly support providers engaged in payment and delivery system transformation. By aligning with the three aims of health care reform – improving care, improving population health and reducing health care costs – these sub-grant projects will test alternative payment models, create innovative care models, and develop infrastructure to support a high-performing health care system in Vermont.

We extend our thanks to all of our participants for coming to our event today and hope to continue to foster cross-project sharing of ideas and best practices.

Vermont Health Care Innovation Project

VHCIP Provider Sub-grant Symposium

Moderator Biographies

Steven Costantino, Commissioner
Department of Vermont Health Access

Dr. Allan Ramsay, M.D.
Green Mountain Care Board

Steven M. Costantino
Biography

Steven M. Costantino's career in public service is distinguished by his dedication to propelling progressive, thoughtful and innovative reforms resulting in a greater accountability, effectiveness, and efficiency in government. Throughout his years in public service, he has demonstrated his abilities as a dynamic communicator and visionary leader capable of bringing diverse interests to the table and creating partnerships necessary to achieving sustainable change.

As of February, 2015, Steven joined the Department of Vermont Health Access (DVHA) as Commissioner. The Department is responsible for the oversight, implementation, and management of Vermont's publicly-funded health coverage programs. These programs include Medicaid and the Children's Health Insurance Program (Dr. Dynasaur), collectively branded Green Mountain Care (GMC), as well as the State's health insurance marketplace, Vermont Health Connect (VHC). DVHA also oversees and many of Vermont's expansive Health Care Reform initiatives, designed to increase access, improve quality, and contain the cost of health care for all Vermonters, including the federally funded Vermont Health Care Innovation Project (VHCIP), Vermont's Blueprint for Health, and health information technology strategic planning, coordination and oversight.

Prior to joining the Department of Vermont Health Access, Steven was the Secretary of the State of Rhode Island's Executive Office of Health and Human Services (EOHHS)—the umbrella agency that administers the state's Medicaid program—he also was in charge of overseeing the state's principal health and human services agencies: the Department of Children, Youth and Families, the Department of Human Services and its divisions of Elderly and Veterans Affairs, the Department of Health, and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

In this position, Secretary Costantino instituted objectives and established policies beneficial to transforming the way the state organizes, finances and delivers services across the health and human services spectrum. He was instrumental in building policy collaboratives consisting of public officials, providers, and business and community leaders that positively impact on how Rhode Island pays for and delivers primary care, housing and employment opportunities, and myriad additional programs assisting the state's most vulnerable residents.

With the EOHHS serving as the Medicaid single state agency for Rhode Island, Secretary Costantino was involved in every phase of implementing Medicaid expansion and one of the nation's most successful health insurance marketplaces, HealthSource RI. He also employed his knowledge, expertise and strategic leadership to facilitate an array of ongoing initiatives that improve the integration and coordination of primary care and long-term services and supports; increase the use of home and community-based services; institute a multi-payer, patient-centered medical home; enhance program integrity; develop the state innovation model (SIM); and redesign the finance and delivery of services to encourage and reward quality, promote innovation and accountability, and assist providers and payers to adapt to changing concepts of healthcare.

Prior to being appointed to head the EOHHS, Secretary Costantino served eight consecutive terms in the Rhode Island House of Representatives. First appointed to the House Committee on Finance in 1999, he rose to the position of Chairman in 2004, retaining that leadership position for seven years, until assuming his duties as EOHHS Secretary.

Allan Ramsay, M.D.
Biography

Allan Ramsay, M.D. is a primary care physician who has practiced in Vermont for 30 years. Allan's signature work is in the area of palliative care, where he has been a leader in developing models for assuring that patients' wishes are followed at the end of their life. He is past Medical Director of Fletcher Allen Health Care's Palliative Care Service and the founder of the Rural Palliative Care Network.

In his long career in academic medicine, Allan served as Residency Director and Vice Chair in the Department of Family Medicine at UVM, where he is now Professor Emeritus. Allan is a past member of the board of the Visiting Nurse Association of Chittenden and Grand Isle Counties and the Board of the Community Health Center of Burlington.

While serving on the Green Mountain Care Board Allan has practiced family medicine at the People's Health and Wellness Clinic in Barre, Vermont.

VHCIP Provider Sub-grant Symposium

Project Summaries

Health*first*
Capacity & Infrastructure Building and
Clinical Quality Improvement Among Independent Physicians

What We Are Doing

Health*first*'s work under our VHCIP grant has two main emphases, with a range of activities and initiatives to support these efforts. First, we are building infrastructure and capacity to support independent physicians as connected and engaged partners in Vermont's healthcare landscape. At the same time, Health*first* is committed to supporting independent practices in delivering high-quality care by (1) introducing a collaborative care agreement between primary care and specialist physicians within our membership, (2) providing resources and support for implementing and managing data tracking and reporting, and (3) helping architect disease management programs and to implement and/or hone best practices for aiding patients through care transitions.

How Our Work Is Going

Since the award of our first round SIM grant, Health*first* has achieved many of its initial capacity and infrastructure goals, including hiring additional staff, securing office space, and convening several committees and subcommittees in support of our accountable care activities. Highlights of our initiatives to support quality improvement with second round funding include: (1) 100% of our practices signing our collaborative care agreement, for which we are now beginning to develop plans for successful implementation; (2) completion of our first data collection for our commercial ACO practices, with many take-away lessons to improve the process in future years; (3) beginning the process of hiring a Quality and Care Coordination Manager to provide direct support to practices for data tracking/reporting, coding compliance and more; and (4) engaging member physicians in meetings and discussions within and beyond H*f's* membership about healthcare around the state, including the evolution of unified community collaboratives and regional performance care communities, efforts that will help us identify local physicians who can serve as liaisons between H*f* member practices and the communities and stakeholders our members serve.

Lessons We Have Learned

Changing care patterns at the practice level is hard work. It requires constant, clear communication, regular feedback on progress, good quality data, and a high level of trust among H*f* network staff and individual physicians and practice managers.

Current financial incentives from ACO and Blueprint programs need to be upgraded so that practices are compensated appropriately for all the work required to implement and manage quality care initiatives. This is essential if the state and other stakeholders want to keep practitioners engaged in efforts to change care patterns.

Rutland Area Visiting Nurse Association and Hospice, Inc
and
Rutland Regional Medical Center
Supportive Care Program

What We Are Doing

The goal of the Supportive Care Program is to bridge the gap between inpatient palliative care and hospice, and expand beyond the existing palliative care program. Working with the primary care physicians, Rutland Regional Medical Center and the Rutland Community Health Team, this program will address the complex needs of seriously ill patients. The aim is to support patients and their caregivers in clearly identifying their goals and incorporating these goals into a suitable treatment plan in concert with their primary care providers earlier in the disease process. Higher quality communication will improve the likelihood of thoughtful planning and, therefore, the quality of care by aligning it with patient desires, promoting adherence with treatment and care plan(s) while lessening the physical emotional duress associated with serious illness.

How Our Work Is Going

Initially there was difficulty getting non-Medicare patients who met the illness criteria to participate; therefore it was necessary to expand the criteria to include Medicare patients. In addition, collaborating with local nursing homes to integrate our services and theirs for CHF/COPD patients has allowed for an easier transition back home after rehabilitating in the facility has increased referrals into the program.

To date, RAVNAH has seen 25 patients under this program since expanding the payer criteria.

Lessons We Have Learned

In order to provide traditional home care services to Medicare patients, the patients are required to be home bound. By broadening the payer criteria to include the non-homebound Medicare patient was critical to the success of this program.

One of the biggest hurdles that we continue to meet is the difficulty convincing referrals who are currently stable to utilize our services. Patients are resistant to discussing end of life planning when they are not immediately faced with that situation.

White River Family Practice
High Risk Population Management in Advanced Primary Care Practices

What We Are Doing

We have identified a registry of patients within our practice comprised of patients who demonstrate one or more of the following characteristics: (a) frequent ER usage; (b) frequent hospital admissions or readmissions; (c) a diagnosis of asthma with treatment for this condition either in the ER or through hospital admission within the past 24 months; and (d) a diagnosis of poorly controlled diabetes with coexisting depression. These patients' self-reported confidence in managing their own health issues (Health Confidence, HC) is assessed at every visit. Employing increased and dedicated Care Coordination services, intensive pre-visit planning and post-visit communications, and our staff's newly acquired (and ongoing) motivational interviewing training, we are focusing on improving patients' HC and health understanding.

How Our Work Is Going

Our initial patient registry is composed of 76 patients, about half of whom have responded with measures of HC (as of 3/29/15). We have developed discreet "flow maps" defining office care processes for each of our four target patient populations, as well as templates within the electronic record to document pre-visit-planning, patient Care Plans, and post-visit patient contact including pathways to facilitate meeting with Mental Health provider, if needed. Although we have requested insurance claims data from all payers regarding healthcare provided to WRFP patients, to date only BCBSVT and DVHA have been willing to share claims data, compromising our ability to employ our population health management software in predictive analytics for risk stratification.

Lessons We Have Learned

Patients are not as engaged in their healthcare as we might assume. At least half of the patients in our panel don't necessarily welcome intense case management or RN involvement in helping them get better. They don't return our calls; they frequently don't show up for office visits. Negotiating the paradigm shift within the entire office to attend to "What matters to the patient" and address deficiencies in patients' self-reported Health Confidence is a challenge. Social determinants of health play havoc with primary care practitioners' efforts to keep patients healthy; primary care is not equipped to deal with difficult socioeconomic factors such as homelessness, poverty, lack of transportation, and the complex and difficult family dynamics so often found to accompany poor health states.

Northeastern Vermont Regional Hospital
Caledonia & S. Essex Dual Eligible Project

What We Are Doing

This project is providing a health coach for people dually covered by Medicare and Medicaid, and funding for goods and services not normally covered by insurance; thus enabling an integrated multi-disciplinary community care team to provide better care for clients who are at risk for poor outcomes and high costs of medical care.

How Our Work Is Going

The health coach currently has over 40 active clients and is working with numerous other organizations to coordinate care including mental health, home health, area agency on aging, and primary care. With the help of the Care Models Care Management Workgroup Learning Collaborative, the project is making great strides toward identifying a lead care coordinator for dually eligible clients, and also piloting a shared care plan.

Lessons We Have Learned

Many dually eligible clients do not currently have case/care management services; therefore, the case load for the health coach filled up quickly. We need to be flexible and adaptable as patient's/client's needs are met and consequently change. Creating a system to allocate flexible funds is harder than it sounds!

Vermont Medical Society Education and Research Foundation and
UVM Medical Center
Optimizing Laboratory Testing Collaborative

What We Are Doing

Our global aim is to reduce harm to patients and conserve system resources by optimizing the use of laboratory tests for patients cared for in our region's hospitals. We are using a collaborative approach considering the best medical evidence and quality improvement science. We began with an evaluation of current test ordering profiles and patterns followed by an organized plan to optimize testing; our effort ends with a plan to sustain these practices.

How Our Work Is Going

Guided by a faculty of clinical, QI and analytic professionals, eight regional hospitals (University of Vermont Medical Center, Dartmouth Hitchcock Medical Center, Rutland Regional Medical Center, Central Vermont Medical Center, Porter Medical Center, Northeastern Vermont Region Hospital, Brattleboro Memorial Hospital, Southwestern Vermont Health Care) have uploaded a 2 year baseline of billing and laboratory data of all adult inpatients to a secure data enclave at University of Chicago; the baseline data base comprises more than 90% of hospital beds in the region. The data set is updated monthly; monthly all-collaborative and hospital specific performance reports are sent to hospital teams to support their investigations of problems and tests of changes targeting reducing harm and conserving resources - **http://www.vmsfoundation.org/simgrant** .

Lessons We Have Learned

The Laboratory Collaborative effort represents change not forced from the outside in, but change led from the inside out; change based on professionalism and trust among leaders who work in the trenches every day. Acceleration of innovation and reform require: 1) the will to improve; 2) ideas about alternatives to the status quo; and 3) actualization through execution; all three have to be arranged by leaders – they are not automatic. This rigorous improvement project is a model for retooling the regional delivery system in a meaningful and transparent process closing the gap between practice and policy, reducing harm and conserving resources.

Invest EAP
Resilient Vermont

What We Are Doing

Employee Assistance Programs (EAPs) have been demonstrated to reduce employee stress that may otherwise increase cortisol and epinephrine levels that can lead to chronic stress and disease. If such prevention and early intervention is effective in the workplace, what would be the impact on health outcomes and expenditures if we offered these same services to all patients at a healthcare center? We are investigating the combined effects of EAP and behavioral health screenings and interventions at the St. Johnsbury Healthcare Center.

How Our Work Is Going

We have seen many patients to-date. We have provided them with short-term solution-focused counseling and resources to enable them successfully resolve a number of life challenges. The health center has been screening patients for key behavioral risk factors and those who screen positive are referred to our on-site health coach. This is working well.

Lessons We Have Learned

Individuals who are not working are proving easier to engage for repeated visits.
Individuals almost always benefit from simply sharing their story and receiving support.

Community Health Accountable Care, LLC.
Furthering Community Health Accountable Care, Collaborations and Analytics

What We Are Doing

The VHCIP Provider Grant funding is truly the backbone of Community Health Accountable Care (CHAC) as it has funded basic infrastructure including core staffing, facility costs, meeting costs, professional services, and IT support. Accomplishments of the last year include implementation of CHAC's four standing committees; development, adoption of, and implementation of clinical recommendations for COPD, CHF, Falls Risk Assessment, and Diabetes; implementation of a telemonitoring pilot; and operationally supporting all ACO requirements (i.e. beneficiary notification mailings and report submission including quality reporting).

How Our Work Is Going

CHAC officially became an ACO as of January 1, 2014 so we are just beginning to receive the results of the required ACO reporting for our first year, but CHAC is very proud of the many accomplishments thus far and looks forward to even more in the upcoming terms. The progress of our clinical committee has been remarkable as they have invested substantial time to develop through a consensus driven process best practice clinical recommendations that have been shared within our network, with community partners, and throughout the state. The telemonitoring program, especially the care coordination aspect, has received rave reviews from providers and patients, and demonstrates CHAC's commitment to being the integrator for primary care with community partners and other support services.

Lessons We Have Learned

Adoption and implementation of new processes can be challenging to disseminate across a statewide network of individual organizations and requires a champion at each location to advocate for the changes. Our clinical committee members, who are deeply invested in the clinical recommendations the developed and agreed to adopt have taken on the role of champions in an effort to unite our provider network and establish the expectation for ongoing quality improvements. CHAC is still in the early stages of learning from the results of our data reporting, but what was evident from the data collection process was that collaborations between the three ACOs was valuable in making the process as seamless as possible. There will be more lessons to share in the near future and CHAC will be sharing them individually with our health centers, network wide, and with the QPM Work Group.

OneCare Vermont
Accountable Care Organization Operations

What We Are Doing

OneCare Vermont's work through the contract complements other successful Vermont health reform efforts, such as the Vermont Blueprint for Health, by bringing together Vermont's provider continuum (e.g., primary care, academic centers, community hospitals, specialists, rehab and nursing facilities, home health and hospice agencies, mental health and substance abuse providers, housing supports and those who provide for Vermonters with special needs). OneCare Vermont is using the grant to further innovative, highly reliable, evidenced based population health management strategies by providing support to:

- Collect, analyze and disseminate data for targeted performance improvement priorities.
- Fund local medical leadership, clinical facilitation, analytic support, and performance improvement training.
- Design and disseminate tools, best practices, and trainings to guide and support performance improvement targets.
- Facilitate performance improvement work through 14 Regional Clinical Performance Committees (RCPCs) serving every Vermont community.

How Our Work Is Going

- Successful completion of quality measurement training and collection process (winter 2015) between Vermont's three (3) ACOs.
- Alignment with the Blueprint for Health on quality measures linked to medical home payments.
- Selection of clinical priorities that align with and complement other statewide reform initiatives.
- Regional Clinical Performance Committees started in collaboration with the continuum of care providers, the Blueprint for Health, and the other ACO's throughout the state.
- Launch of a statewide learning collaborative forum to support performance improvement work on OneCare Vermont's emergency room and readmission/admission clinical priorities.

Lessons We Have Learned

- Creating, identifying and adopting better ways to keep individuals and communities well is a goal everyone can agree on. The work is hard and it takes longer than you would like but the cooperative effort by Vermont's provider continuum brings greater value than would be possible if the initiatives proceeded independently.
- Designing and acquiring the necessary sophisticated information technology resources, skilled analytics capabilities and dedicated clinical leadership is foundational.

Northwestern Medical Center
RiseVT

What We Are Doing

RiseVT is a community initiative to embrace healthy lifestyles. RiseVT motivates, inspires and works with individuals and families to help them make small changes in their lives that will have a big impact on their health. In addition, RiseVT has strategically placed Health Advocates around Franklin and Grand Isle to work with schools, businesses and municipalities to wrap around our residents to create an environment where the healthy choice is the easiest choice.

How Our Work Is Going

We are currently in our Pilot Phase of the project with a launch of June 1. So far we have worked with eight businesses, two schools, one municipality, and 250 individuals have actively signed the pledge to embrace healthy lifestyles. We have successfully certified four businesses in Breast Feeding Friendly state certification, reestablished a Wellness Committee in a local business, brought Safe Routes to School to a rural school setting and are working collaboratively with three non-profits to provide health coaching and biometric screenings. Our media presence has been widespread including actively engaging with our community in social media to help spread the mission of RiseVT to embrace healthy lifestyles.

Lessons We Have Learned

Piloting has been key as we have learned from our different entities how to engage and make a meaningful impact on their environment. Developing relationships with community members, leaders, schools, etc., will be an ongoing process and the importance of making these connections has been and will continue to be a vital component of our success.

Vermont Developmental Disabilities Council, in partnership with Green Mountain Self Advocates
The Inclusive Health Care Partnership Project

What We Are Doing

People with intellectual and developmental disabilities (I/DD) now enjoy a life expectancy almost equal to that of the general population. However, as a group, people with disabilities fare far worse than their nondisabled counterparts across a broad range of health indicators and social determinants of health. The goal of the Inclusive Healthcare Partnership Project (IHPP) is to identify and recommend a set of innovative best practices in the delivery of health services to adult Vermonters with I/DD that will improve their care experience and their health while reducing cost.

How Our Work Is Going

During the first five months of this one-year planning grant, IHPP has established a strong staff team, which includes a self-advocate, and recruited an eight member Planning Team composed of three other self-advocates, a family care-giver, three physicians, and a nurse from the developmental services system. All Planning Team members have received an orientation to the project, and IHPP will have hosted the first of its seven planning meetings by the end of May.

In preparation for these meetings, the Project coordinator has collected considerable information through stakeholder interviews, conversations with national leaders in the emerging field of developmental medicine, surveys and the first of five scheduled focus groups with self-advocates, families, and providers. With technical support from VHCIP, project staff have been able to use Medicaid claims data to quantify the health status and utilization patterns of Vermonters with I/DD. IHPP is on schedule to complete its research and share its recommendations by the end of 2015.

Lessons We Have Learned

IHIP is unique within VCHIP's portfolio of community grants in the degree to which health care consumers, specifically those with disability-related long term support and service needs (DLTSS), provide leadership and expertise. The Lesson Learned that we would most like to share with the group is that while it takes some additional time and planning to involve self-advocates in meaningful conversations about the health care that they want to receive, it can be done. In fact, many of the tools we use to support self-advocate participation are also best practices that we anticipate recommending to improve the communication between health providers and individuals with I/DD during medical appointments – for example, visual supports and cognitively accessible materials.

University of Vermont Health Network at Central Vermont Medical Center
Screening in the Medical Home (SiMH)

What We Are Doing

University of Vermont Health Network at Central Vermont Medical Center (UVMHN-CVMC) aims to implement screening and behavioral interventions for patients that present with risky levels of tobacco, alcohol and drug use. Our approach is to utilize the **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment (SBIRT) model in medical homes throughout CVMC with the goal of reducing and preventing health related consequences, disease, accidents and injuries that are associated with substance misuse. Additionally we have initiated the use of a SMS text messaging intervention for patients engaging in binge drinking behaviors.

How Our Work Is Going

We have established universal screening templates in the medical home's electronic medical records system. Two medical homes now have incorporated the SBIRT model into their practice and have full time SBIRT counselors on staff. Outreach for enrollment into the SMS texting intervention is happening in these practices through face to face engagement and flyers. The remaining five medical homes have expressed interest in adopting the SBIRT model and accessing counselors for their practice.

Lessons We Have Learned

Adoption of the screening in the medical home by the medical providers and nursing staff requires an ongoing investment of time and training. An enthusiastic SBIRT champion team from each practice is essential. There appears to be a concrete need for SBIRT services in the medical homes. The process of adding screenings to a workforce that is already burdened with numerous health screening tasks presents a unique challenge. Discomfort with the expanding expectations placed on routine patient visits combine with the cultural stigmas associated with substance misuse/dependence creates staff hesitancy in a comprehensive adherence to the SBIRT model.

Southwestern Vermont Medical Center
Transitional Care Program

What We Are Doing

SVHC, in close cooperation with the Bennington Blueprint and community partners across the service area, is creating an integrated care delivery system to better serve our population in preparation for the global budget anticipated in 2017. We have re-deployed acute care resources (Clinical Nurse Specialists, Pharmacists, Social Worker) to partner with high risk, chronic care patients in primary care practices and are successfully navigating them from one setting to another and decreasing resources utilization (ED visits and inpatient hospitalizations.) Through this process, we have identified gaps in care delivery and developed solutions to bridge these gaps including:

- Development of a Community Care Team meeting monthly to provide wrap around care planning for high ED use behavioral health and clients with addictions
- Hiring of a nurse educator to assist with implementation of Interact program in all area nursing homes (Evidence based program with interventions to reduce transfers to the hospital) to decrease unnecessary readmissions from this setting
- Standardization of care for CHF and COPD patients across the care continuum (primary care, hospital, long term care, home care)
- Use of clinical pharmacist for patient education and MD consultation in primary care and long term care setting to increase medication adherence and decrease polypharmacy

How Our Work Is Going

Since the inception of the Transitional Care Nurse program in the fall of 2013, we have demonstrated consistent decreases in inpatient hospitalization ranging from 63-68% measured at 120 and 180 day intervals for patients using this program. ED utilization has also decreased but not as consistently during the same time frames ranging from 28-44% for 120 days and 0-30% for 180 days. We are forging a strong partnership with Primary Care Practices, Medical Home Case Managers and all community care partners to identify opportunities to better coordinate care and maximize use of appropriate resources. Each of the new programs being implemented will target other identified opportunities to decrease cost, improve quality and the patient experience.

Lessons We Have Learned

- Partner with all care providers and community agencies and maximize appropriate referral and usage of what exists in your service area.
- Find opportunities to meet the patient /family where they are and bring appropriate resources to them whenever possible.
- Transitional Care nurses “partnering over time” and developing relationships with patients in the hospital, office, nursing home and home care setting can bridge the gaps from one care setting and provider to the next and assist with development of a realistic, patient centered plan of care.
- Seldom are there opportunities for meaningful education for patients in the hospital setting due to short length of stay, acuity of illness and anxiety and discomfort of the patient. Realistic plans for follow-up are essential to improve chronic disease management and patient engagement in the plan.
- Medication reconciliation, management and education are key drivers in decreasing the cost of healthcare

Vermont Program for Quality in Health Care
American College of Surgeons National Surgical Quality Improvement Program

What We Are Doing

The Vermont Program for Quality in Health Care, Inc. (VPQHC) is coordinating the implementation of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) in 12 hospitals across the state of Vermont. Participation in the ACS NSQIP assists hospitals in identifying and reducing preventable surgical complications by extracting relevant clinical data. Other hospitals that have participated in ACS NSQIP have seen improvements in quality of care, patient safety, and patient satisfaction, in addition to reduced costs.

How Our Work Is Going

Over the past four months, VPQHC has hired the Statewide Surgical Collaborative Program Coordinator, facilitated statewide meetings of our surgeon champions, and provided ongoing outreach and education to Vermont hospitals. Seven of the twelve hospitals will be submitting hospital participation agreements and enrolling in one of the program options within the next few weeks, three hospitals are discussing ACS NSQIP internally with no decision yet, and one hospital is uncommitted, but may enroll if other hospitals join. Only one hospital has reported they will not be enrolling in ACS NSQIP at this time. After enrollment, the next step is for hospitals to hire a surgical case reviewer to extract the clinical data.

Lessons We Have Learned

The success of a complex project requires a strategic plan that is structured but has flexibility to allow for changes necessary to move the process forward.
If the project has several stakeholders or is large in scope, establishing a collaborative will help engage, educate, and motivate participants toward a shared and sustainable goal.

InvestEAP and King Arthur Flour
Behavioral Screening and Intervention

What We Are Doing

Employee Assistance Programs (EAPs) serve a number of employees with a wide range of presenting issues each year. However, most employees who come to EAP do so on their own usually in response to some acute issue in their lives. While this produces many positive outcomes, a more active behavioral screening process could identify key risk factors for adverse health outcomes that may otherwise go undetected. Providing such screening in person would enable EAP counselors to apply evidence based Motivational Interviewing techniques to specifically address these behaviors beginning at the time of the screening.

How Our Work Is Going

This project only recently began. We have screened and treated a few employees thus far. We will be integrating a new software program into our approach to ensure fidelity to key aspects of Motivational Interviewing and to enable us to provide detailed action plan printouts to clients.

Lessons We Have Learned

Working closely with the employer's HR department is key to an effective rollout and adoption of the project.
Offering employees the choice of meeting with us at their worksite or at our offices is important as individuals have divergent preferences related to time, ease of access and confidentiality.

VHCIP Provider Sub-grant Symposium

Transitions of Care

Panel Discussion Materials

VHCIP Provider Sub-grant Symposium
Transitions of Care Panel
Dr. Allan Ramsay, M.D.
May 27, 2015

Transitions in Care Panel

VHCIP Provider Sub-grant Symposium
May 27, 2015
Moderator: Allan Ramsay, MD

Panelists:
Billie Lynn Allard, SVMC
Pam Smart, NVRH
Sara King, RAVNAH
Toni Apgar, White River Family Practice
Sean Uiterwyk, MD, White River Family Practice

VERMONT
GREEN MOUNTAIN CARE BOARD

Objectives

1. Identify barriers that have existed to the effective transition of care and review successful transition models that have led to improved patient care and possibly reduced the total cost of care.
2. Discuss opportunities to improve care transitions that may not yet have been implemented (thinking outside the box).

VERMONT
GREEN MOUNTAIN CARE BOARD

VHCIP Provider Sub-grant Symposium
Transitions of Care Panel
Dr. Allan Ramsay, M.D.
May 27, 2015

Projected population growth in one Vermont hospital service area

	Actual 2012	Projected 2022
Total population 0-19 yrs	262,130	247,647
Total population 20-64 yrs	632,913	642,907
Total population 65-84 yrs	**141,574**	**212,528**
Total population 85+ yrs	22,001	23,702
Total	1,058,618	1,126,784

VERMONT GREEN MOUNTAIN CARE BOARD

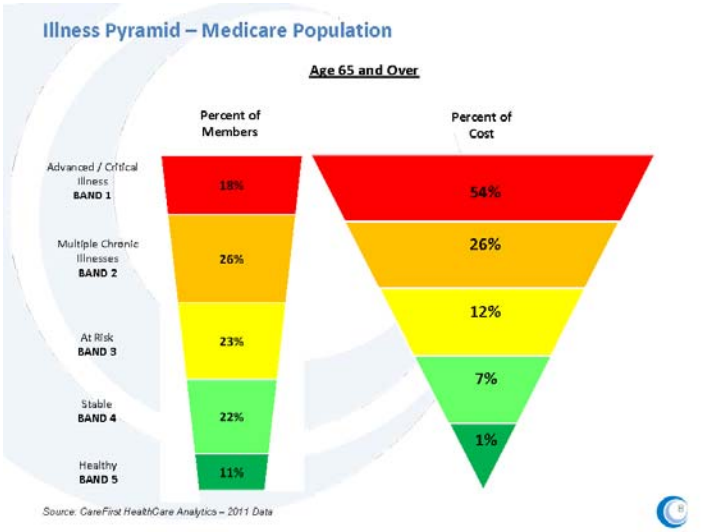
The Pareto Principle

- The Pareto principle is also known as the 80–20 rule
- Named after Italian economist Vilfredo Pareto in 1896
- For many events, roughly 80% of the effects come from 20% of the causes
- We can "roughly" apply the Pareto Principle to the target population in health care transitions

VERMONT GREEN MOUNTAIN CARE BOARD

VHCIP Provider Sub-grant Symposium
Transitions of Care Panel
Dr. Allan Ramsay, M.D.
May 27, 2015

The Pareto Principle and Health Care Transitions: Where the savings will be



VERMONT GREEN MOUNTAIN CARE BOARD

Defining the seriously ill (Vermonters who don't get good health care)

(Meier: communication, 2012).

Diagnosis	Health care utilization	Patient/family issues
Cancer: metastatic, locally advanced head neck, pancreas, CNS	> 1 hosp in 3 months unrelated to disease modifying therapy	Poor func status, > 2 symp rated moderate or severe, cog impair, caregiver stress, unavailability, MH
CHF or COPD	> 3 hosp/ED visits in past 6 months, ICU adm unrelated to a procedure, home inotrope, VAD	Poor func status, dyspnea or > 2 symp mod or severe, cog ,impair; caregiver stress, unavailability, MH
ALS	Complex homecare requirements	Dysphagia, dyspnea or > 2 symp rated mod/sev; caregiver stress, unavail
Dementias	Mult MD visits in 3 mon; pneumonia, hip fx, sepsis, dehyd in past 6 mon	Poor func status, dysphagia; caregiver stress, unavailability, MH
Advanced cirrhosis	MELD >30	Caregiver stress/unavailability, MH
* HIV+ cirrhosis, cachexia, cancer * Developmental disabilities (Ped PC)		

VERMONT GREEN MOUNTAIN CARE BOARD

VHCIP Provider Sub-grant Symposium
Transitions of Care Panel
Dr. Allan Ramsay, M.D.
May 27, 2015

What are the continuing issues related to transitions of care?

1) **Sadly…the Money**
   - The payment models are outdated (FFS)
   - ??
2) **Structural**
   - Lack of coordination of care among the many health care entities and providers (HIE)
   - The slow implementation of truly team-based care
   - ??
3) **Attitudinal**
   - Trust in the delegation of responsibilities
   - Misunderstanding of the principles of shared decision making
   - ??

VERMONT GREEN MOUNTAIN CARE BOARD

The Vermont Health Care Expenditure Analysis

(all spending on Vermont residents- the first barrier)

- Total health care expenditures in 2012 were $5.1 billion
- *Home health* care was 1.9% of that total
  - Hospital expenditures were 38.7%
- In 2013 total expenditures increased $272 million and again only 1.9% of the increase was attributed to *home health* ($102,000)
- Average annual increase in *home health* expenditures 2007-2012 was 0.0%
  - Overall expenditures grew an average of 4.5%

VERMONT GREEN MOUNTAIN CARE BOARD

VHCIP Provider Sub-grant Symposium
Transitions of Care Panel
Dr. Allan Ramsay, M.D.
May 27, 2015

Opportunities to improve care transitions

(*there is hope for a better future)*

Money

- ACOs, Value based payment, shared risk
- ??

Structural

- PCMH/CHT
- Hospice/palliative care programs
- ??

Attitudinal

- Community wide coalitions
- ??

VERMONT
GREEN MOUNTAIN CARE BOARD