THE University of Vermont HEALTH NETWORK

To: The Honorable Kevin Mullin, Chair, Green Mountain Care Board
From: Rick Vincent, Chief Financial Officer, The University of Vermont Medical Center
Stephen Kenney, Chief Financial Officer, Central Vermont Medical Center
Jennifer Bertrand, Chief Financial Officer, Porter Medical Center
Date: April 30, 2019
Subject: Fiscal Year 2020 Non-Financial Reporting Requirements

---

I. Quality Improvement Initiatives

1. Vermont All-Payer Model Quality Measures by Hospital Service Area

Table 1a: Blueprint Profiles – Blueprint-Attributed Vermont Residents (CY 2017)

Measure	Statewide Rate *(All-Payer Model Target)*[1]	Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport	Randolph	Rutland	Springfield	St. Albans	St. Johnsbury	White River
Percentage of Medicaid adolescents with well-care visits[2]	71%	64%	73%	68%	76%	72%	66%	75%	66%	59%	72%	74%	73%	75%
Initiation of alcohol and other drug dependence treatment	41%	44%	38%	52%	42%	27%	45%	33%	40%	41%	42%	38%	37%	37%
Engagement of alcohol and other drug dependence treatment	34%	31%	29%	34%	38%	43%	43%	32%	42%	34%	27%	35%	27%	32%
30-day follow-up after discharge for mental health	69% *(60%)*	77%	76%	71%	65%	71%	67%	66%	60%	69%	66%	71%	63%	66%
30-day follow-up after discharge for alcohol or other drug dependence	23% *(40%)*	25%	23%	15%	23%	18%	32%	21%	N/A	19%	19%	32%	23%	26%
Diabetes HbA1c poor control (part of Medicare composite measure)[3,4]	11%	10%	8%	13%	11%	13%	9%	11%	N/A	14%	10%	14%	11%	10%
Controlling high blood pressure (part of Medicare composite measure)[5]	65%	71%	69%	68%	60%	62%	64%	67%	71%	62%	64%	66%	74%	60%
Appropriate asthma medication management (50% compliance)	77%	75%	75%	74%	76%	78%	76%	84%	75%	79%	82%	74%	79%	77%

Central Vermont Medical Center

- Primary care pediatricians use panel coordinators to call patients who are past due for an annual well child visit. Pediatricians receive a portion of their salary incentive pay tied to adolescent well child care.

- A Generalized Anxiety Disorder (GAD 7) screening is done on all patients in primary care to evaluate for possible substance use disorders (SUD). If positive, a Screening Brief Intervention and Referral to Treatment (SBIRT) clinician follows up with the patient via phone call for referral to treatment, if desired by the patient.

- Emergency department (ED) patients are similarly screened for SUD. Screening Brief Intervention and Navigation to Services (SBINS) clinicians and peer recovery workers are available 7 days a week for brief intervention and referral to treatment, if desired.

- Upon discharge from inpatient psychiatric admission, all patients are scheduled with a mental health provider and primary care provider within 7 to 14 days. All patients without a previous mental health provider are referred through the Access Program at Washington County Mental Health, who will schedule patients for follow up within 7 days.

- Primary care clinics use panel coordinators to track all patients with uncontrolled hypertension (blood pressure > 140/90) or diabetes (hemoglobin A1c > 9) on a spreadsheet that is run daily to ensure 6 month follow up. Primary care providers receive a portion of their incentive pay based on compliance with this measure.

Porter Hospital

- Diabetes hemoglobin A1c poor control: Porter Hospital is working on a quality improvement (QI) project in all primary care offices to connect patients with diabetes not in control to care managers who can then connect them to services in the health service area (HSA). Porter also is hosting a Diabetes Self-Management Program and connecting it to the new Pharmacy Program, which will give participants 12 weeks of a free community supported agriculture (CSA) share.

- Appropriate asthma medication management: The Porter pediatric practice is currently working on a QI project to increase the percentage of patients with asthma who have had an asthma action plan (AAP) in the last 12 months. Part of their well visit outreach is targeted towards asthma patients, and they have reworked their workflow to ensure patients due for an AAP come into the office and get one.

- Porter also is tracking 30 day follow up after discharge for mental health and for controlling high blood pressure, and may implement projects later this year.

University of Vermont Medical Center

- Development of a standardized ethyl alcohol (ETOH) treatment/detox pathway that includes more frequent and earlier referrals to ED Recovery Coaches (Turning Point Center) and also aims to standardize the medication assistance and follow up to programs like Day One for this patient population when appropriate. In April 2019, Day One put into place a standing next day program intake appointment for patients in the ED for ETOH use disorders.

- Coordination with the Howard Center, primary care, and the Addiction Treatment Program (ATP) to address the management of patients with significant behavior issues were the opioid agreement/protocol, Buprenorphine pathway (shared between the ATP and primary care providers), and self-management goals.

- Currently, UVM Medical Center has 50 waivered providers (greater Chittenden County has 99 waivered providers) across the ED, all adult and pediatric primary care, including medical homes, palliative care, OBGYN, addiction treatment, pain management, and urgent care. We continue to believe the treatment of opioid use disorders should be managed within the medical home. This assists in reducing the stigma associated with this population and begins to normalize care delivery. As such, maintaining an engaged and trained provider workforce is imperative. We have incorporated training each new primary care provider as they join our team to provide a

greater understanding of the disease of addiction and its treatment.

- Primary care pediatricians have established a quality improvement initiative to improve developmental screening in the first three years of life. The Accountable Care Organization (ACO) average for this effort is 36%. The target performance for our employed group is 75% by the end of FY 2019.

- Primary care pediatricians have established a quality improvement initiative to improve behavioral health screening in adolescents. The ACO average for this effort is 47%. The target performance for our employed group is 70% by the end of FY 2019.

- The adult primary care providers (family medicine and general internal medicine) have been working to improve their problem capture and self-management plans for depression, obesity, and opioid use disorder this year. They will add chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes beginning in FY 2020.

Table 1b: Behavioral Risk Factor Surveillance System Survey – Respondents to Survey of Random Sample of Vermont Residents (2017)

Measure	Statewide Rate *(All-Payer Model Target)*	Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport	Randolph	Rutland	Springfield	St. Albans	St. Johnsbury	White River
Percentage of adults reporting that they have a usual primary care provider	87% *(89%)*	88%	90%	89%	90%	85%	89%	91%	90%	88%	88%	89%	85%	85%
Prevalence of chronic disease: COPD	6% *(≤7%)*	6%	7%	7%	4%	6%	7%	10%	4%	9%	7%	7%	7%	8%
Prevalence of chronic disease: Hypertension	26% *(≤26%)*	29%	25%	24%	22%	24%	26%	27%	31%	29%	29%	29%	26%	25%
Prevalence of chronic disease: Diabetes	8% *(≤9%)*	9%	9%	9%	6%	9%	8%	10%	9%	11%	12%	10%	10%	9%

Central Vermont Medical Center

- We have several ways we are working to connect people with primary care providers. Our ED "super user group" is a multi-disciplinary and multi-organizational team that meets weekly to identify and provide suggestions for wrap-around services for individuals who present regularly to our ED. Part of that team's goal is to connect all patients with a primary care provider. Our Express Care service similarly refers people regularly to primary care. Our Provider Access Line (which serves to schedule people with primary care) receives 10 calls a day for people seeking a new primary care provider.

- As part of our community outreach initiatives, members of our team complete biometric screening which include blood pressure and glucose screenings, connect people to primary care, and encourage physical activity (Walk the Long Trail, Heritage Festival, Montpelier Alive, Home and Health Fair, Labor Day events in Northfield, and the National Life Do-Good Fest).

- We have a year-round robust employee wellness program that incentivizes employees to obtain biometric screening and to participate in wellness activities.

- Our Fitness for All program is offered to all patients in primary care who have an elevated body mass index (BMI), are a smoker, or have hypertension or diabetes. This is a 6 week wellness program that includes nutritional counseling, health coaches, and initiation of physical activities. Patients can return to the classes for a "refresher course" at any time.

Porter Hospital

- We are addressing some turnover in our primary care base with active recruitment, and we are working on schedule templates to maximize access. Additional appointment slots are being added. Additionally, we continually focus on identification of those without a primary care provider (PCP) and assignment of a PCP to all patients within each of our primary care practices.

- Our COPD prevalence is average. We underwent a local QI project headed by our outpatient pharmacist this past year to improve appropriate use of inhaled steroids for COPD patients, and believe this will help improve control and reduce ED visits for exacerbations.

- See comments under 1a above regarding hypertension and diabetes QI projects.

University of Vermont Medical Center

- Implementation of innovative wellness programs are critical components of Population Health Management that impact the prevention and management of chronic disease:
    - Healthy hearts
    - Diabetes management
    - BMI
    - Health coaching for behavior change and healthier lifestyle
    - Annual incentive platform – focus on resilience
    - Campaigns and programs that promote health awareness and prevention

- Development and implementation of Medical Home RN and Social Work Care Management Program. This program is focused on assessing the need for registered nurse (RN) care management and/or social work support for well, risking risk, and our high and very high risk patient populations, outreaching to providers and patients, and engaging patients in the program to prevent and support management of chronic disease. Approximately 3,000 patients have been reviewed, outreach has occurred to over 500 patients, and 150 patients have engaged in the program. The model will be spread to all 10 UVM Medical Center primary care clinics in 2019.

- Healthy Planet, an application within Epic, has been implemented which provides risk identification, risk stratification, care management documentation tools, functionality to support patient outreach, care team quantification, and tools to organize data for provider and staff awareness and review. Further development is occurring to support access and utilization of Healthy Planet by community partners and practices, providing a common platform for coordination and communication. Healthy Planet also includes chronic disease registries to track patient blood pressure, diabetes, and COPD.

- Development and implementation of the Healthy Planet module within the electronic medical record. This functionality will allow for members of a patient's multidisciplinary care team to be populated within the record, allowing for coordination of care to be improved and improve

proactive management of patients to mitigate/reduce the prevalence of chronic disease including COPD, hypertension, and diabetes.

- Working with the Vermont Child Health Improvement Plan (VCHIP) Quality Improvement Facilitators in all Chittenden County Community and Medical Group practices to support QI projects focused on the All-Payer Model waiver goal to manage and prevent chronic disease.

- The UVM Medical Center has three new primary care physicians coming on board this fall as we begin FY 2020 (one each in family medicine, general internal medicine, and geriatrics). Additional recruitments are currently underway to continue to grow our primary care workforce.

- The UVM Medical Center has four Tobacco Treatment Specialists who work with patients who are inpatient at the hospital, as well as in the general surgery clinic and OB/GYN clinic at the hospital, to support smoking cessation efforts. Additionally, they are available to support patients throughout Chittenden County and run ongoing support groups.

- Our Self-Management Programs are designed to help patients meet their own health goals and two programs in particular, Healthier Living with Diabetes and Healthier Living with Chronic Conditions, are available to support patients living with COPD, hypertension, and diabetes.

- Our Registered Dietitians and Certified Health Coaches are available to patients through their primary care offices to support health goals around the above conditions. We are supporting a pilot program to support patients with hypertension at one of our community primary care clinics by having a Health Coach available for a shared medical appointment.

- Through the primary care clinics we offer a one month free membership to a gym and two visits with a personal trainer to support patients' health and wellness goals.

- RiseVT is expanding to reach an even greater segment of the Chittenden County population to support preventative efforts and hopefully avoid chronic conditions.

2. Vermont All-Payer Model Quality Measures by County

Table 2a: Blueprint for Health Hub and Spoke Profiles – All Vermont Residents Utilizing Services (2016)

Measure	Statewide (Rate/10,000) *(All-Payer Model Target)*	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
# per 10,000 population ages 18-64 receiving Medication Assisted Treatment for opioid dependence[8]	2,076 (162) *150*	77	108	158	127	116	208	135	106	125	213	202	163	161	177

Central Vermont Medical Center

- CVMC currently has 12 providers engaged in medication assisted treatment (MAT). Support for the providers and their patients is through the Blueprint MAT teams and coordinator. We

currently have no waiting period for MAT in our primary care clinics or through our local HUB, the BAART Clinic.

- The CVMC ED was the first in the state to provide rapid access to MAT (RAM). For patients who meet criteria, a health screening is done and patients are initiated on suboxone in our ED. If the patient tolerates the treatment well, after an observation period they are discharged on a three day supply of suboxone with a follow up appointment at either the HUB or an outpatient MAT clinic, if appropriate. Similarly, if patients are admitted to the hospital and identified as having an untreated opioid use disorder, they are initiated on suboxone with follow up care arranged upon discharge. Support for ED and inpatients are provided by our recovery coaches who staff the ED full time, by peer recovery coaches from the Turning Point Center, and by our outpatient MAT team.

Porter Hospital

- Porter has been building our MAT program over the last two years. The majority of our MAT patients have been seen at our Bristol Primary Care office, which closed on 4/12/19 due to the departure of two providers over a short period of time. We had reached a zero waiting list as of last year. Our primary MAT provider, Dr. Will Porter, will be moving his practice to the Mt. Health Federally Qualified Health Center (FQHC) practice in Bristol, along with the Blueprint support team. Most, if not all, of his MAT patients are going to continue with Dr. Porter at that location. Other MAT patients will be able to transfer to one of several other MAT providers at Mt. Health. We expect and will encourage other MAT patients to transfer to our Vergennes Primary Care site, where three Porter providers offer MAT. We are encouraging Porter providers to seek waivers and incorporate MAT into all primary care patient panels at the primary care sites.

University of Vermont Medical Center

- The DOST, formerly the Day One Suboxone Transition, is now called the Addiction Treatment Program (ATP). There were 159 total patients in ATP between 3/1/18 through 2/28/19 (41 current patients, 118 previous patients). 83 patients transitioned from ATP to PCPs. The average length of stay at ATP was 9 weeks. There is currently no waitlist. There are 0 patients cleared, but waiting to go to ATP.

- As of 2/28/19, the Burlington HSA has 99 waivered suboxone providers (50 are UVM Medical Center providers) trained largely in part by UVM Medical Center's Dr. Sanchit Maruti. Additionally, many of the non-Medical Center waivered providers are part of the Medical Center MAT spoke system by having the UVM Medical Center MAT staff team with them to work directly with their patients.

- The number of waivered providers has increased largely due to word of mouth between providers and support from various departments' leadership to waiver providers and all new residents, as well as a strong UVM Medical Center presence in community MAT meetings, partnerships, and the local Chittenden County Opioid Alliance (CCOA).

- Recently, the UVM Medical Center MAT supervisor has begun meeting one-on-one with newly waivered providers, and will do so with others, as part of ongoing efforts to encourage them to increase their panel to operate at the maximum of their waivers.

Table 2b: Vermont Department of Health Vital Statistics Data – Vermont deaths by county of residence (released 1/2019)

Measure	Statewide Count *(All-Payer Model Target)*	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Deaths related to drug overdose[9]	117 *(115)*	5	9	3	16	0	7	0	3	6	3	18	13	19	15

Central Vermont Medical Center

- CVMC is providing MAT services in our ED (rapid access to MAT described above), our outpatient clinics, and in the inpatient setting. We currently do not have a waitlist for either outpatient suboxone or for methadone or suboxone at our HUB.

- Our opioid stewardship program is focused on inpatient (hospital, peri-surgical, and ED) acute opioid prescribing, including following best practices for prescribing, patient consent, and Narcan prescribing. The focus for outpatient chronic opioid prescribing includes best practices for chronic opioid use, patient consent, and monitoring and compassionate tapering.

- Narcan is prescribed to appropriate patients (on high dose opioids and patients on opioids in combination with benzodiazepines) and is available free at several facilities.

- Sharps boxes have been distributed throughout Washington County, including in the hospital lobby, for safe disposal of used needles.

- Through a grant with the Turning Point Center, we provide peer recovery workers in our ED who are also available to do consults in the hospital for inpatients.

- Washington County Substance Abuse Regional Partnership (WCSARP) is a multi-organization group that meets monthly to discuss and develop initiatives around the care of people with substance use disorders.

Porter Hospital

- Deaths related to drug overdose have decreased by approximately 50% in Addison County over the last three years. We think there is likely a relationship between this decrease and the growth of the HSA's MAT programs. The Porter Medical Group's efforts to control and decrease the prescribing of narcotics has no doubt also contributed.

- Providing care management and support through our Blueprint Community Health Teams is another factor that we believe is contributing to patients getting wrap-around services and help within the medical home primary care offices.

University of Vermont Medical Center

- UVM Medical Center invests in the Chittenden County Opioid Alliance for a coordinated approach to children and families affected by substance abuse to reduce deaths.

- Currently, UVM Medical Center has 50 waivered providers (greater Chittenden County has 99 waivered providers) across the ED, all adult and pediatric primary care, including medical homes, palliative care, OBGYN, addiction treatment, pain management, and urgent care. We continue to believe the treatment of opioid use disorders should be managed within the medical home. This assists in reducing the stigma associated with this population and begins to normalize care delivery. As such, maintaining an engaged and trained provider workforce is imperative. We have incorporated training for each new primary care provider as they join our team to provide a greater understanding of the disease of addiction and its treatment.

- The Comprehensive Pain Program launched in fall 2018 and is focused on treating patients with chronic pain, with the goal of minimizing/eliminating dependence on opioids. The program offers alternative approaches to managing chronic pain including yoga, nutrition, massage, acupuncture, and a new cohort program.

- Our Addiction Treatment Program continues to provide suboxone therapy along with counseling in a bridge to primary care approach, which has been highly successful.

- We maintain a commitment to adding to our waivered prescriber group by offering in-house waiver trainings twice a year and making efforts to have all residents waivered. Also, we have begun initiating MAT in our ED.

3. Vermont All-Payer Model Quality Measures by Hospital

Table 3: Vermont Uniform Hospital Discharge Data Set (VUHDDS) – Vermont Residents and Non-Residents Utilizing Services

Measure	Statewide Rate *(All-Payer Model Target)*	BMH	CVMC	CH	GMC	GCH	MAHHC	NCH	NMC	NVRH	PMC	RRMC	SVMC	SH	UVMMC
Rate of Growth in number of mental health and substance use-related ED visits[10]	**5%** *(3%)*	19%	6%	-5%	-10%	5%	29%	4%	15%	7%	-12%	0%	5%	9%	6%
Percent of mental health and substance use-related ED visits resulting in admission[11]	**17%** *(N/A)*	4%	28%	7%	13%	2%	1%	4%	7%	14%	3%	32%	7%	20%	16%

Central Vermont Medical Center

- CVMC has seen an increase in the number of individuals with substance use and mental health disorders seeking care. In our ED and in our primary clinics we screen for both mental health and substance use disorders. We have SBIRT clinicians embedded in primary care clinics and SBINS clinicians and peer recovery workers embedded in our ED who can provide brief interventions and referrals to treatment.

- In alignment with the UVM Health Network, we are developing an embedded mental health provider model within our medical homes.

- Like our partners at UVM Medical Center and Porter Hospital, we are seeing an increase in the number of mental health "boarders" in our ED, awaiting placement at an inpatient mental health facility.

Porter Hospital

- Our rate of growth in the number of mental health and substance use-related ED visits declined in 2018.

- The percent of mental health and substance use-related ED visits resulting in admission at Porter for this time period is significantly lower than the statewide rate.

- We have worked hard to grow our MAT program, resulting in a waiting list of zero at the end of 2018. It is our assumption that with both the MAT program provision and the increase in care management in our practices, as well as a focus on primary care access, we have been able to move the needle on providing better care for our patients with these conditions.

University of Vermont Medical Center

- UVM Medical Center provides significant funding to Howard Center for programs around embedded clinicians in the ED, Act/1 Bridge, and to support community outreach.

- We are developing a standardized monthly patient level report on ED utilization to identify high ED utilizers and to work with care coordination teams for follow up. This work is inclusive of an ED care plan template developed in order to document drivers of utilization, Lead Care Coordinator contact info, and recommended next steps upon ED visits for high utilizing patients.

- A standardized ED care plan template has been developed that includes identified drivers of utilization, Lead Care Coordinator and contact information, social/community resources in place, and recommended next steps for when the patient presents to the ED, among other info. In the next few weeks, our goal is to bring together project team members who are most familiar with the ED high utilizer population to complete these ED care plans in Epic for the identified highest utilizers, then monitor ED utilization moving forward to assess impact/benefit.

- Through individual chart reviews, our team identified that substance use was the most common characteristic in the highest ED utilizers, and of the possible substances, ETOH was by far the most commonly present. In light of this information, a smaller team has been working on a standardized ETOH treatment/detox pathway that includes more frequent and earlier referrals to ED Recovery Coaches (Turning Point Center) and also aims to standardize the medication assistance and follow up to programs like Day One for this patient population when appropriate. In April 2019, Day One put into place a standing next day program intake appointment for patients in the ED for ETOH use disorders.

- The UVM Medical Center is developing an embedded mental health provider model within our medical homes, working with Intermountain Health. We hope to have our first primary care site fully functional later this year.

Table 4: Health Service Area/Hospital Crosswalk

Health Service Area	Hospital(s) located in HSA
Barre	Central Vermont Medical Center
Bennington	Southwestern Vermont Medical Center
Brattleboro	Brattleboro Memorial Hospital; Grace Cottage Hospital
Burlington	University of Vermont Medical Center
Middlebury	Porter Medical Center
Morrisville	Copley Hospital
Newport	North Country Hospital
Randolph	Gifford Medical Center
Springfield	Springfield Medical Center
St. Albans	Northwestern Medical Center
St. Johnsbury	Northeastern Vermont Regional Hospital
White River Junction	Mount Ascutney Hospital and Health Center

II. Access to Care/Wait Times

UVM Health Network leadership recognizes the need for focused efforts to improve access across the Network. The Patient Access & Service Task Force was convened in FY 2018 to provide oversight and guidance to UVM Health Network leaders who are in the process of developing a multi-year strategic plan to improve patient access to care. For FY 2018, the focus was regarding optimizing patient access to ambulatory care. That focus will be expanded in FY 2019 and beyond. The Task Force will be utilizing the following more specific tactics in the near term to help support this work:

- Improving the referral experience, including identifying expectations for referral processing and implementing steps to improve both patient and referring provider experiences;
- Defining a methodology to predict demand for patient care and implementing steps to prepare for that demand;
- Creating dashboards to track progress on key performance metrics related to patient access;
- Implementing steps to reduce backlog in key specialties; and
- Prioritizing the Epic upgrade, including the rollout of Epic scheduling. Having all UVM Health Network hospitals on the same scheduling system will allow us to monitor metrics across our ambulatory network. Executing the Epic rollout will have a great impact on how we are able to implement our UVM Health Network access strategies.

Central Vermont Medical Center

In alignment with the UVM Health Network, CVMC's access measure is now the percentage of new patients seen within 10 days of the initial call to schedule an appointment.

Clinic	seen within 10 days of scheduling an appointment (February 2019)
CVMC Adult Primary Care - Barre	50.00%
CVMC Adult Primary Care Hematology & Oncology - Berlin	89.66%
CVMC Cardiology	72.73%
CVMC Dermatology	36.00%
CVMC Endocrinology	3.03%
CVMC Family Medicine -Berlin	64.71%
CVMC Family Medicine -Waterbury	40.48%
CVMC Family Psychiatry	59.09%
CVMC Integrative Family Medicine - Montpelier	25.93%
CVMC Neurology	19.05%
CVMC Occupational Medicine	71.43%
CVMC Orthopedics & Podiatry	53.33%
CVMC Orthopedics & Spine Medicine	88.24%
CVMC Orthopedics & Sports Medicine	47.75%
CVMC Pediatrics Primary Care - Berlin	76.92%
CVMC Rheumatology	30.00%
CVMC Urology	36.59%
CVMC Women's Health	38.16%
CVMC Granite City Primary Care	100.00%
CVMC Green Mountain Family Practice	77.38%

Porter Hospital

Porter Hospital continues to measure patient access by the third next available appointment.

Department	Third next available appointment (in days)	Alternative measure	Comment, if applicable
Ear, Nose, Throat	5 days		
General Surgery	30 days		
Obstetrics/Gynecology	Same day/1 day		
Orthopedics	4-6 days		
Pediatrics	0-1 days		
Podiatry	11 days		
Primary Care	Same day for established patient/19 days for new patient		
Other (describe in comment)	0-5 days		Cardiology

University of Vermont Medical Center

In FY 2018, the UVM Medical Center adopted a new metric for measuring patient access. Rather than measuring the wait time for the "third next available appointment," the Medical Center now measures the percentage of new patients seen within 10 days of scheduling a new appointment. This metric, adopted by Vizient to assess academic medical centers throughout the country, allows us to benchmark the Medical Center against its peers.

Clinic	% New patients seen within 10 days of scheduling an appointment (February 2019)
Acute Care Surgery	100.00%
Adult & Child Psychiatry	20.45%
Adult Primary Care - Burlington	9.52%
Adult Primary Care - Essex	50.00%
Adult Primary Care - South Burlington	7.69%
Adult Primary Care - Williston	0.00%
Bariatric Surgery	28.40%
Berlin ENT	21.88%
Berlin Family Medicine	82.45%
Berlin General Surgery	69.49%
Berlin Ophthalmology	45.00%
Cardiology	28.52%
Cardiothoracic Surgery	46.15%

Children's Specialty Center	30.24%
CNL	46.02%
Comprehensive Pain	45.45%
Continence Center	19.67%
Day One/Addiction Treatment Program	94.55%
Dermatology	43.52%
Endocrinology	44.32%
ENT	21.60%
Family Medicine - Colchester	66.67%
Family Medicine - Hinesburg	72.50%
Family Medicine - Milton	89.56%
Gastroenterology	21.31%
General Surgery	27.37%
Hematology/Oncology	45.86%
Infectious Disease	28.95%
Interventional Pain Medicine	69.49%
IR Clinic	64.71%
Medical Psychology	66.67%
Middlebury Urology	26.92%
Nephrology	62.82%
Neurological Associates of Vermont	26.92%
Neurology/Memory/EP5	27.92%
Neurosurgery	30.32%
Ophthalmology - ACC	43.17%
Ophthalmology - Shelburne Rd	42.67%
Ortho - San Remo	41.10%
Ortho - Tilley Drive	39.18%
Osteoporosis	11.36%
Pediatric Neurology	32.91%
Pediatric Primary Care - Burlington	93.65%
Pediatric Primary Care - Williston	98.31%
Plastic, Reconstructive & Cosmetic Surgery	39.77%
Pulmonary	49.62%
Radiation Oncology	67.74%
Rheumatology	24.64%
Seneca	40.00%
Sleep	12.82%
South Burlington Family Medicine	96.37%
Surgical Oncology	56.19%
Transplant	39.13%
Urgent Care	100.00%

Urology - ACC	31.58%
Urology - MOB	18.00%
Vascular Surgery	14.29%
Women's Health	45.39%

III. Community Health Needs Assessment (CHNA)

1. Identify community needs from the hospital's most recent CHNA. Prioritize the needs numerically, with one (1) representing the highest priority.
2. When are the CHNA and implementation plan scheduled to be updated?
3. Please provide a link to the most recent CHNA and implementation plan.
4. What budget/resources are allocated to the implementation plan to support community health needs identified in the CHNA? For which needs? Please describe.
5. The GMCB recognizes that hospitals use Schedule H of their 990 (question 7e-k) to record "community benefits," and that expenses recorded in this section may not be comprehensive of total community investments. To better understand the connection between Schedule H and CHNA, if any, please describe how program funding identified in question 7e-k of Schedule H relates to your CHNA and implementation plan.

Central Vermont Medical Center

- The most recent CHNA was completed in 2016. The needs identified in that survey are as follows: 1) Drug and alcohol use; 2) Mental health support; 3) Tobacco use; 4) Healthy diets; and 5) Youth participation in physical activities.

- CVMC's 2019 CHNA is currently underway. We have finished our community surveys, focus groups, and analysis of demographic and health data of our service area. Our report on this year's findings will be finalized by June 2019 and reported on our website by the end of September. At this point we have not yet finalized what our priority areas will be for an implementation strategy, but the areas that are being identified as high priorities are: financial stability; mental health care; substance use disorders; healthy lifestyles (including the treatment of chronic conditions, food security, and physical activity); and housing.

- For the 2016 CHNA and implementation plan, please visit: https://www.cvmc.org/sites/default/files/documents/Community-Needs-Assessment-2016.pdf

- CVMC has strong community partnerships established as part of two community collaboratives: THRIVE (our accountable community for health) and WCSARP (Washington County Substance Abuse Regional Partnership). It is through these partnerships that much of our needs identified in our community are addressed.

    - Drug and alcohol use: We have strong community partners that we rely on for comprehensive identification of patients with SUD, referral to treatment, and maintenance of sobriety. WCSARP is our main vehicle for the identification of the needs in our community and a way to address these needs. Out of WCSARP a "detox bed" was identified in the community that would allow individuals withdrawing from substances a clean and safe place to spend a night. This is paid for by Washington County Mental Health. Our Rapid Access to MAT (RAM) was also born out of WCSARP; the hospital

supported ED clinicians obtaining waivers to prescribe buprenorphine, SBIRT clinicians who work full-time in the ED were initially funded through a HRSA grant and have since been operationalized into the hospital budget, and peer recovery coaches are also present in our ED currently through a grant through the Turning Point Center. The sharps boxes in our lobby were an initiative from the Barre Police Department. Our MAT teams that follow all of our patients prescribed buprenorphine are funded through the Blueprint for Health. The opioid steering committee and work that has come out of that group for acute and chronic opioid prescribing best practices and tapering has been funded by hospital operations.

- Mental health support: Screening for depression (and substance use) has been incorporated into our primary care clinics and the ED. We also have strong collaboratives with Washington County Mental Health, our Designated Agency, for counseling and psychiatric services. In conjunction with UVM Health Network we are currently in the planning phases for a new inpatient psychiatric facility, which will be built on the CVMC campus. We also provide a Wellness Recovery Action Plan that any patient can be referred to for mental health treatment and stabilization.

- Tobacco use is also a multi-organization and multi-prong initiative. Individuals presenting for care in all care settings are screened for tobacco use. The Vermont 802Quits program is highly publicized, and patients are referred to this program. We have a team member who is funded by CVMC to manage this program. We also offer monthly classes through our self-management program for individuals desiring to quit. Central Vermont Home Health & Hospice is a key partner for evaluating tobacco use in post-partum women and their children.

- Healthy diets: In conjunction with Vermont Youth Conservation Corps, CVMC provides funding for fruits and vegetables at no charge to qualifying patients at "farmers markets" that occur in our lobby monthly throughout the growing season. Through our Community Health Team, CVMC employs four dieticians. Patients can be referred to the dieticians either individually or through the Fitness for Wellness Program.

- All items listed in schedule H of form 990 are listed above.

Porter Hospital

- The most recent CHNA was completed during FY 2018. The needs identified in that survey are as follows: 1) Substance use disorder/counseling; 2) Mental health; 3) Affordable housing; 4) Physical activity & obesity; 5) Social & economic: support/poverty/stress; 6) Chronic conditions; 7) Access to preventative/primary care; 8) Early childhood & family supports; 9) Dental; 10) Transportation; and 11) Aging & long-term care.

- The CHNA for the Porter HSA was recently completed during FY 2018. The implementation plan was also completed during that time.

- For the most recent CHNA and implementation plan, please visit:
  http://www.portermedical.org/2018%20CHNA%20draft%203.pdf
  http://www.portermedical.org/2018ImplementationReport.pdf

- Please reference the chart below, which provides the resource allocation and description of the support Porter Hospital is providing, as part of the implementation plan in our community.

	Identified Need	*Description*	*Budget / Resource Allocation*
1	Substance Use Disorder/Counseling	Expansion of MAT Program	$100,000
2	Mental Health	Expansion of Mental Health Support Services in the ED	$270,000
3	Physical Activity & Obesity	Rise Vermont Participation	$22,750
4	Social & Economic: Support/Poverty/Stress	Open Door Clinic Support Food Shares VT Futures Medication Assistance Program	$392,500
5	Chronic Conditions	Smoking Cessation Diabetes Classes	$1,000
6	Access to Preventative/Primary Care	Provide Free EPI Pens	$285,000
7	Early Childhood & Family Supports	Provide Free Pediatric Inhalers Child Birth Education Classes	$7,000
8	Aging & Long Term Care	Palliative Care Program	$135,000

- The program funding identified in Schedule H includes support for the following community benefits:

  - Open Door Clinic support in which the hospital provides free care vouchers to be used toward healthcare expenses incurred at the hospital;
  - Open Door Clinic support for rental space;
  - Community education courses, such as diabetes education and tobacco cessation courses; and
  - Healthcare professional education.

Each of the above initiatives supports several needs identified in our CHNA, including chronic conditions, access to primary care, and social and economic support. Furthermore, as referenced in the chart above, schedule H does not include the full complement of initiatives and community benefits provided to our HSA.

University of Vermont Medical Center

- The most recent CHNA for the UVM Medical Center was completed in 2019. The needs identified in that survey are as follows: 1) Mental health; 2) Substance use disorder; 3) Affordable housing; 4) Childhood and family health; 5) Disease prevention; and 6) Cancer. The next step over the next few months is to create an implementation strategy to track progress and

programming specifically on mental health and childhood and family health.

- The 2019 CHNA for the UVM Medical Center was approved in March 2019. The accompanying implementation plan will be approved in December 2019.

- For the most recent CHNA and implementation plan, please visit:
  https://www.uvmhealth.org/medcenter/Documents/CHNA-March2019-web-approved.pdf
  https://www.uvmhealth.org/medcenter/Documents/2018%20Compendium%20Web.pdf

- Approximately $850,000 is allocated each year for grants to community organizations to address the identified needs from the most recent CHNA.

- Our CHNA and the resources and investments we put into place to address those needs are embedded within each subsection of section 7 on our Schedule H.

    - Subsections a, b, c, f, and g all address the need to create and maintain access to services that support the mental health, substance use disorder, childhood and family health, disease prevention and cancer needs from our 2019 CHNA. We have a robust patient assistance program (a) to ensure that patients who can't afford to pay are still able to access these services. We have services that that operate at a loss (b, c, g), many of these CHNA-related, so that patients have access to those services. We subsidize our resident and fellow education programs (f) since these future physicians are key to maintaining access to CHNA-needed services.

    - Subsection e includes the cost of our Community Health Improvement team, which provides key coordination services between patients and the resources available within UVM Medical Center and the community aimed at addressing the CHNA.

    - Subsection i includes investments we make to support the affordable housing need in our CHNA, as well as the grants we distribute each year to community-based programs that are aligned with our CHNA.