RUTLAND REGIONAL MEDICAL CENTER

FY 2020 HOSPITAL BUDGET GUIDANCE AND REPORTING REQUIREMENTS

NON-FINANCIAL REPORTING REQUIREMENTS

Prepared by:

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Introduction

For FY 2020, the Green Mountain Care Board will collect the following non-financial information in advance of the annual budget submission:

I. Quality Improvement Initiatives
II. Access to Care/Wait Times
III. Community Health Needs Assessment (CHNA)

This change streamlines the budget submission to focus mainly on financial matters, while ensuring that the Board has the necessary quality, access, and community needs information available to inform the hospital's budget review. The Board also has substantial information about each hospital's participation in delivery system reform through the accountable care organization budget process and will use that information in the review to determine how and to what extent a hospital is committed to health care reform. In addition, enhanced financial reporting is required this year due to challenges facing community hospitals; bifurcating the reporting will assist hospitals in meeting these reporting requirements.

Submissions

Using the provided templates, hospitals are required to submit by April 30, 2019.

Email submissions to:
Agatha Kessler Agatha.Kessler@vermont.gov;
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I. Quality Improvement Initiatives

Using the space labeled "Hospital Response," please describe hospital initiatives addressing the quality measures results that are listed by health service area, county or hospital.

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%

[1] Measures with no target listed are those measures that have targets based on national percentiles rather than rates.
[2] Rates shown are for Medicaid only.
[3] Lower scores indicate better performance.
[4] Rates shown are for Medicare only.
[5] Rates shown are for Medicare (ages 18-85) only.

Hospital Response:

Understanding these data and creating community-wide initiatives in Rutland is uniquely challenging in the Rutland area insofar as RRMC provides no primary care services directly. Much of the data used to create quality metrics reported through the Blueprint for Health are derived from primary care based clinical and claims data. Additionally, more than seventy percent of primary care in the Rutland HSA is provided by a single organization that does not participate in the submission of clinical measures related to high blood pressure, asthma, and diabetes. We are working closely with our primary care partners to share their internal data more widely through so meaningful community-wide initiatives can be undertaken.

RRMC works very closely with primary care providers through our shared Care Management System and the Rutland Community Collaborative (RCC. The intent of the Care Management System is to create a single, integrated, seamless care management system across the community that aligns care management from primary care, home health, mental health, supported housing, aging services, housing services and the hospital. Toward that goal, RRMC has developed a Shared Care Plan that can be accessed by all participating providers to coordinate care of patients with complex health needs, regardless of payor source. We have worked with One Care Vermont to send data to them from the RRMC Shared Care Plan related to any ACO attributable lives. This committee has begun work on mapping of clinical pathways for COPD, CHF, Diabetes, and Sepsis.

The Rutland Community Collaborative represents a broader group of stakeholders working together on initiatives that improve the quality, efficiency and effectiveness of our local system of care. There are over 20 health and human service agencies or programs which participate actively in the RCC or one of its six subcommittees. Related to the data above, the RCC has specific projects in place to improve access to mental health and substance abuse services following an inpatient or emergency department visit. Additionally, the group was instrumental in efforts to create "Open Access" models at Rutland Regional Behavioral Health and the West Ridge Center which has resulted in the elimination of waiting lists at both programs. This model has also been adopted by Rutland Mental Health Substance Abuse Services.

Table 1b: Behavioral Risk Factor Surveillance System Survey – Respondents to Survey of Random Sample of Vermont Residents (2017)[6]

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%

Hospital Response:

Through our Community Health Improvement department, we offer multiple self-management and educational workshops that are open to the community related to COPD, Hypertension, Diabetes and Tobacco Cessation. We also work closely with primary care partners to ensure that patients are being screened for chronic disease risk factors and are provided individualized coaching and education to prevent disease progression.

As mentioned above, Rutland has a very active and engaged Rutland Community Collaborative through which collective initiatives are planned and implemented. The RCC has focused on establishing clinical pathways that improve the care coordination for patients with chronic disease.

2. Vermont All-Payer Model Quality Measures by County

Table 2a: Blueprint for Health Hub and Spoke Profiles - All Vermont Residents Utilizing Services (2016)[7]

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

Hospital Response:

We are very fortunate in Rutland to have a well-developed Hub and Spoke model in our community. Through the West Ridge Center (Hub) we serve an average of 400 patients at a time with no waiting list for access to treatment. Within the spoke part of the system, the Community Health Centers of the Rutland Region, which provides more than 70% of adult primary care in Rutland County, has very significantly increased the number of primary care providers who now provide Medication Assisted Treatment to patients on their primary care panel as part of the spoke. Additionally, there are independent spoke practices that are not full and able to accept appropriate new referrals.

[6] Indicators shaded in green are statistically better than the statewide rate; indicators shaded in red are statistically worse than the statewide rate.
[7] Indicators shaded in green are statistically higher than the state average; indicators shaded in red are statistically lower than the state average.
[8] The State reports these rates for Hubs & Spokes per 100,000. For consistency with the APM, rates shown have been calculated per 10,000.

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

Hospital Response:

Deaths related to overdose and suicide remain one of our largest health concerns in Rutland County. Through the Project Vision Health Committee which is chaired by RRMC staff, we are actively engaged with non-traditional health care partners to create community-wide responses to these alarming trends. With respect to overdose, the community has developed an Opiate Response Team that responds with a team visit to the home of any known overdose in the county within 48 hours. The team consists of a police officer, a mental health clinician and a peer recovery specialist who offer support, education, and referrals to the patient, their families and other interested people at the home. We also provide free Narcan and training to anyone that calls the West Ridge Center seeking services.

RRMC has also formed a partnership with Rutland Mental Health Services, and the Community Health Centers of the Rutland Region to implement the evidence-based Zero Suicide model across our community. With a three-year grant from RRMC through the Bowse Health Trust, the team has contracted with the Center for Health and Learning to implement a community engagement plan to train both professional health care providers as well as lay people in how to recognize suicidal ideation and what to do if they have concerns about someone they encounter.

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%

[9] Count of overdose deaths by county January through October 2018 – these numbers will continue to be updated as data become available.

[10] Shown as percent change from 2016-2017.

[11] This is not an All-Payer Model measure. Information provided to give context and help frame narrative response; shown as percent of mental health and substance use-related ED visits resulting in an admission in 2017.

Hospital Response:

RRMC is working closely with Rutland Mental Health Services directly and through the Community Collaborative to establish a robust mobile crisis and outreach service that will be able to prevent unnecessary ED visits, as well as support patients in the community that might otherwise be hospitalized. RRMC has hired four Social Workers dedicated to the ED in order to reduce the amount of time for RMHS crisis to provide mobile crisis and outreach services. We are tracking the volume of mobile services through the Community Collaborative.

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

As of March 1, 2019, provide wait times for all employed provider practices. Wait times should be measured based on the third next available appointment, as defined by the Institute for Healthcare Improvement (IHI). Hospitals that are unable to report using the IHI measure should explain why they are unable use the measure and describe the alternative measure in detail. Please mark "NA" if the specialty is not offered by the hospital.

	Third next available appointment (in Days)	Alternative Measure	Comment, if applicable
Dermatology	NA		
Digestive Services	53		Actively recruiting physician over the past 2 years.
Ear, Nose, Throat	27		Actively recruiting physician over the past 3 years.
Endocrinology	36.5		Actively recruiting physician over the past 6 months.
General Surgery	21		

Hematology/Oncology	1.33		
Hepatology	NA		
Infectious Disease	5		
Internal Medicine	NA		
Nephrology	51.5		Contracted service with UVMC.
Neurology	116		New physician starting in 2019.
Obstetrics/Gynecology	90		New physician starting in 2019.
Ophthalmology	68		
Orthopedics	22.13		
Palliative Care	NA		
Pediatrics	NA		
Physiatry/Rehabilitation	32.75		
Podiatry	NA		
Primary Care	NA		
Pulmonology	41.5		Actively recruiting physician over the past 4 months.
Rheumatology	NA		
Sleep Medicine	49		Actively recruiting physician over the past 4 months.
Urology	71		Actively recruiting physician over the past 5 years.
Other (describe in comment)	55		Cardiology
Other (describe in comment)	5		Behavioral Health
Other (describe in comment)	7		West Ridge Center Opiate Addiction Center

Hospital Explanation (if necessary):

The West Ridge Center and Rutland Regional Behavioral Health have both adopted Open Access models in which patients are not required to schedule an appointment or pre-register before entering services. Both programs offer times each week in which any patient can present for an intake appointment.

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.

Physical Activity & Obesity	Mental Health	Substance Use Disorder/Counseling	Access to Healthy Foods/Nutrition	Access to Preventative/Primary Care	Dental	Social & Economic: Support/Poverty/Stress	Aging & Long-Term Care	Chronic Conditions	Tobacco/Smoking	Transportation	Affordable Healthcare/Rx	Cancer	Affordable Housing	Early Childhood & Family Supports	Suicide	Domestic & Sexual Assault	Immunizations	Other:	Other:	Other:
	X						X						X	X						

2. When are the CHNA and implementation plan scheduled to be updated?

The most recent RRMC CHNA was completed in October of 2018 and the Implementation Strategy was adopted in February of 2019. The comprehensive assessment process did not result in rank ordering of the top four priority areas. The next update to the CHNA will be done in 2021.

3. Please provide a link to the most recent CHNA and implementation plan.

https://www.rrmc.org/about/community-health-needs-assessment/

4. What budget/resources are allocated to the implementation plan to support community health needs identified in the CHNA? For which needs? Please describe.

For more than 20 years RRMC has offered grants to local non-profit agencies that are working to meet the health needs of our community through the Bowse Health Trust (link here). The funding priorities for the Bowse Health Trust (BHT) are re-established in each three-year cycle of the Community Health Needs Assessment. The RRMC Board has approved a policy that sets the minimum annual funding for the BHT at $300,000. In addition to the base amount dedicated to supporting the CHNA, RRMC has also created targeted investments in housing of $30,000 per year in an initiative called Healthy Homes (link here) which enables Neighborworks of Western Vermont to assess and remediate housing conditions that contribute to a patient's health conditions and health care utilization.

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 relate to your CHNA and implementation plan.

Our most recent 990 filing reports two different community benefit costs that can be attributed to our CHNA, specifically they are community health improvement initiatives and cash and in-kind funding.

Community health improvement initiatives (Schedule H, line 7.e) totals $600,904. The four largest items in this category relate to:

- Bridges and Beyond program which serves to support patients with their transportation needs to/from medical appointments.
- Funding of the community health team managed through the BluePrint.
- A variety of educational programs that are open to the community related to Asthma, COPD, Hypertension, Diabetes and Tobacco Cessation.
- Partnership with primary care partners to provide screenings for chronic disease risk factors along with individualized coaching and education to prevent disease progression

RRMC aligns its donations and in-kind contributions to activities that support the health and wellness of our community and that are linked to needs identified in the Community Health Needs Assessment. This funding is reported in the 990 on Schedule H, line 7i and totals $634,632. The largest donations include:

- IT support for the Community Health Centers of Rutland Region to support the management of their EMR and the exchange of clinical, quality and utilization data
- Bowse Community Health Grants, as described in question 4 above
- Come Alive Outside –A 501c3 nonprofit founded in 2014 that works closely with partners in healthcare, public health, outdoor recreation and the landscape profession with a goal to promote healthy and active lifestyles