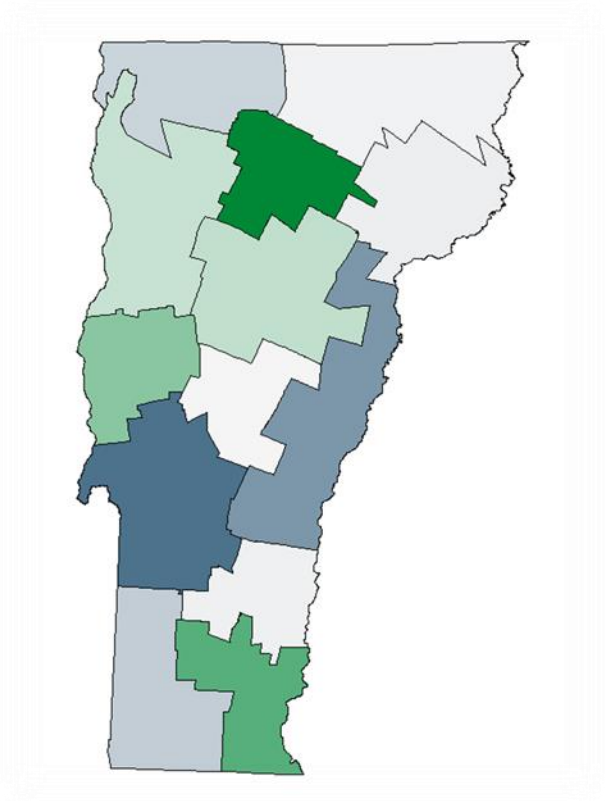

FY2020 Hospital Budgets Non-Financial Reporting

June 12, 2019

Agatha Kessler, Health Policy Director, GMCB
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Preliminary Results

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Overview

1. Non-Financial Reporting Requirements
2. Quality Improvement Initiatives
3. Community Health Needs Assessments
4. Patient Access/Wait Times
5. Staff Recommendations
6. Appendix

Non-Financial Reporting FY2020
Overview

FY2020 Budget Guidance

"For FY 2020, the Green Mountain Care Board will collect information on quality improvement initiatives, access to care, and community health needs in advance of the annual budget submission instead of at the same time (as was the case in most recent years). 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."

- Requirements reviewed by hospital CEO/CFOs, Health Care Advocate and Department of Health
- April 30th Submission Deadline
- Analysis in collaboration with GMCB policy team and Department of Health

Non-Financial Reporting FY2020
Overview

Considerations Sections

- Data as submitted by the hospital according to their own methodology
- June 12th presentation labeled "preliminary"
- Systemwide analysis is challenging without standard definitions
- Shortcomings of the data/analysis described in "Considerations" section of each topic
- Solicit feedback for FY2021

Results should be interpreted in context of the Considerations listed in each section

I. Quality Improvement Initiatives

Quality Improvement Initiatives
Overview

Methodology

- Tables included in the FY2020 budget *guidance document* pull from a variety of statewide sources (Blueprint for Health, BRFSS, VDH ADAP, VUHDDS).
- In the *guidance document*, indicators shaded in green and/or red showed statistically significant results.
- Many of these data update throughout the year, so as we get closer to budget hearings, some of these data may look different than their current state in the *guidance document*.
- Two versions of comparison (for applicable indicators) are outlined in this presentation: a comparison to All-Payer Model (APM) targets, and a comparison to last year's results.

Considerations

- Blueprint methodology changed between 2016 (included in FY 2019 guidance) and 2017 (included in the 2020 guidance); thus, no comparison to FY19 has been noted in today's presentation.
- For consistency in the FY19/FY20 comparison table, blue shaded cells note increases, purple cells show a decline, and yellow cells were unchanged from last year's data.

Comparison to APM Targets

Table 1a: Blueprint Profiles – Vermont Residents (CY 2017) [1]

Measure	Statewide Rate *(All-Payer Model Target)*	Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport	Randolph	Rutland	Springfield	St. Albans	St. Johnsbury	White River
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%

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%

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[2]	5% *(3%)*	19%	6%	-5%	-10%	5%	29%	4%	15%	7%	-12%	0%	5%	9%	6%

[1] Indicators shaded in green are meeting or exceeding the APM target; indicators shaded in orange show performance below the APM target.
[2] Shown as percent change from 2016-2017.

Comparison to FY19 Guidance Document

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

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%

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

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[3]	117 *(115)*	5	9	3	16	0	7	0	3	6	3	18	13	19	15

Table 3: Vermont Uniform Hospital Discharge Data Set (VUHDDS) - Vermont Residents and Non-Residents Utilizing Services[4]

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[5]	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[6]	17% *(N/A)*	4%	28%	7%	13%	2%	1%	4%	7%	14%	3%	32%	7%	20%	16%

[1] Indicators shaded in blue show improvement over 2016 results; indicators shaded in purple show a decline from 2016 results; indicators shaded in yellow show no change from 2016 to 2017 results.
[2] Indicators shaded in blue show improvement over 2016 results (i.e. Fewer deaths); indicators shaded in purple show a decline from 2016 rates; indicators shaded in yellow show no change from 2016 to 2017 results.
[3] Count of overdose deaths by county January through October 2018 – these numbers will continue to be updated as data become available.
[4] Indicators shaded in blue show improvement over 2016 results (i.e. Fewer ED visits); indicators shaded in purple show a decline from 2016 rates.
[5] Shown as percent change from 2016-2017.
[6] 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.

Quality Improvement Initiatives
Staff Analysis and Recommendations

Systemwide Staff Analysis

- Utilization of existing state programs for community benefit (e.g. VDH tobacco cessation & diabetes workshops)
- Designated staff to connect ED patients with primary care should they not have an existing provider
- Medication Assisted Treatment (MAT) initiation in the ED
- Specialized ED staffing for patients presenting with mental health and/or substance use conditions
- Transitioning existing ED space into safe and private areas for patients awaiting admission/transfer

FY2021 Recommendations:

- Moving into year 3 of quality measurement reporting, trending could be considered where appropriate.
- GMCB's first federal Statewide Health Outcomes and Quality of Care Targets report is due on September 30, 2019 – at which time we may consider a deeper dive into certain measures for the FY2021 guidance.
- Consistency within our regulatory processes is always a top priority – we also ask the ACO for quality measure results specific to both their payer contracts and the All-Payer Model – as programs continue to evolve, and reporting becomes more regular, hospital input may be of interest on specific topics and/or measures.

II. Community Health Needs Assessment

Community Health Needs Assessment
Purpose, Goal and Requirements

What is a Community Health Needs Assessment (CHNA)

Affordable Care Act added section 501(r) to the Internal Revenue Code requiring that non-profit hospitals conduct a CHNA and adopt an implementation strategy at least once every three years.

- Purpose & Goal
  - Identify healthcare and health-related (food, housing, etc.) needs of the community
  - Systematically assess unmet needs in order to develop strategies
  - Improve coordination of hospital community benefits with other initiatives

- Requirements:
  - Definition of community served
  - Process and methods used to conduct the CHNA
  - Community input received
  - Prioritize the needs
  - Description of resources to address needs
  - Standard methodology not set forth

- Application in Vermont:
  - Department of Health
  - GMCB
  - Hospitals

Community Health Needs Assessment
Common Methodology

Advisory Committee

- Review data, prioritize, recommendations
- Example Membership:
  - Hospital staff
  - Department of Health
  - United Way
  - Housing Authority
  - Law Enforcement
  - Visiting Nursing Association
  - Building Bright Futures

Quantitative Research

- Secondary Data (County Health Rankings, BRFSS, YRBS, Census, etc)
- Limitations: time periods, geography

Qualitative Research

- Surveys
- Focus Groups: state and local health departments, community members
- Interviews
- Limitations: sample population, self-report, anecdotal vs. scientific

BRFSS: Behavioral Risk Factor Surveillance System; YRBS: Youth Risk Behavior Survey

Community Health Needs Assessment Scheduled Updates (every 3 years)

2019	2020	2021	2022
• CVMC • Springfield		• Brattleboro • Copley • Gifford • Grace • Mt Ascutney • North Country • Northeastern • Porter • Rutland • Southwestern	• Northwestern • UVMMC

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Community Health Needs Assessment
GMCB Methodology & Considerations

GMCB Methodology

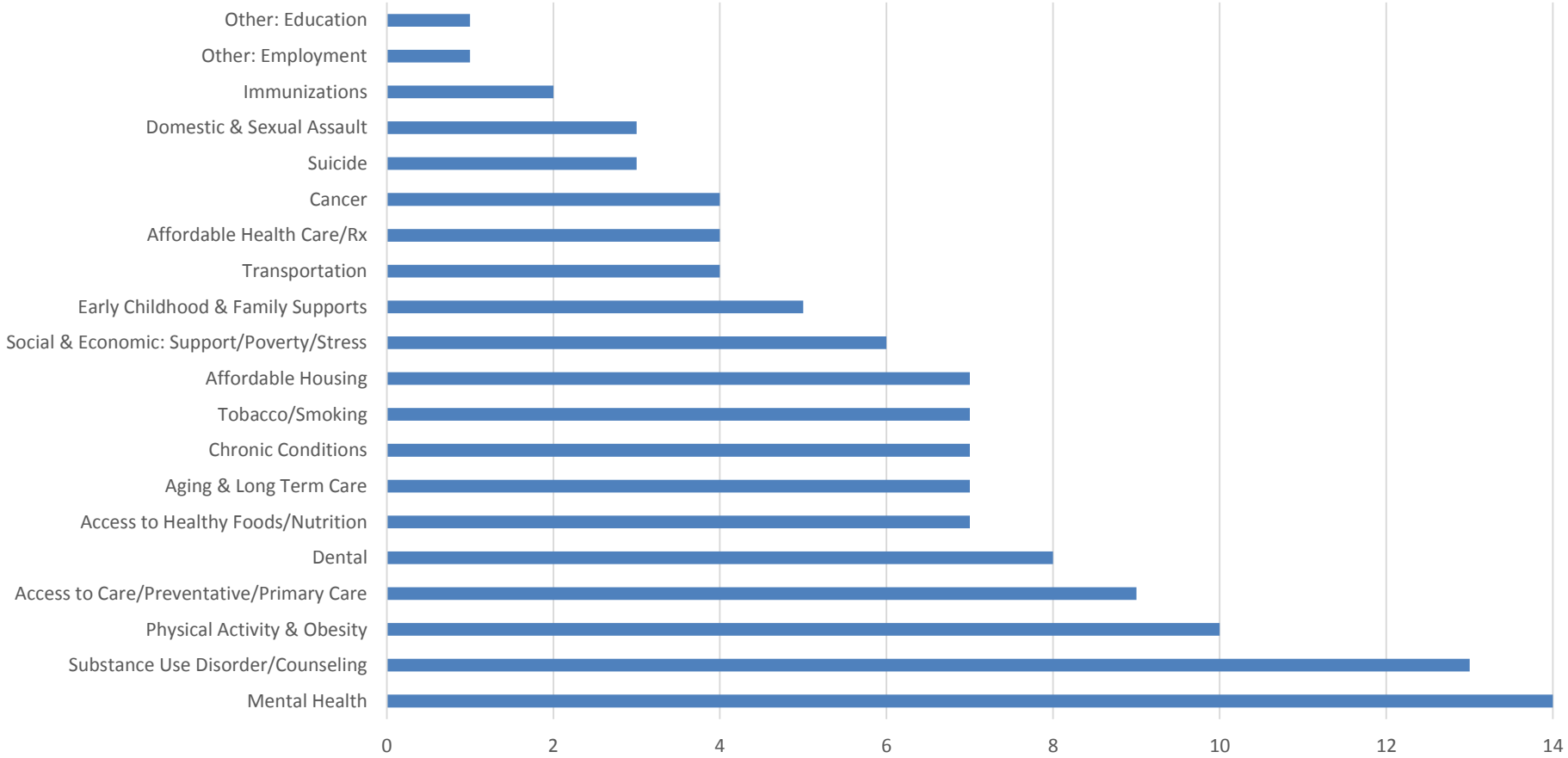
- Hospitals were asked to prioritize community needs numerically, with one (1) representing the highest priority
- No limit to number of responses
- Categories based on previous CHNAs with option to add
- Financial Resources assessed based on:
  - Implementation Plan
  - Schedule H of IRS form 990

Considerations

- Interpretation of "need": is the identified need an UNMET need or the MOST CRITICAL
- Number of needs identified: range of identified needs 4-18, potential to skew aggregate results
- Category definitions: overlapping/predefined categories may skew results
- Category rankings: some hospitals ranked only one need per numerical value, others selected several needs per numerical value

Community Health Needs Assessment Results

Mental Health and Substance Abuse Disorder/Counseling are the most widespread community need



Number of hospitals identifying need in their CHNA

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Community Health Needs Assessment
Community Need & "Underlying Need"

In addition to identifying healthcare and/or health-related needs, some hospitals report on the underlying needs that present barriers to accessing services. This type of information would be useful for a systemwide analysis.

Chart 10: Most Significant Barriers to Accessing Services
Perspectives of Key Stakeholders

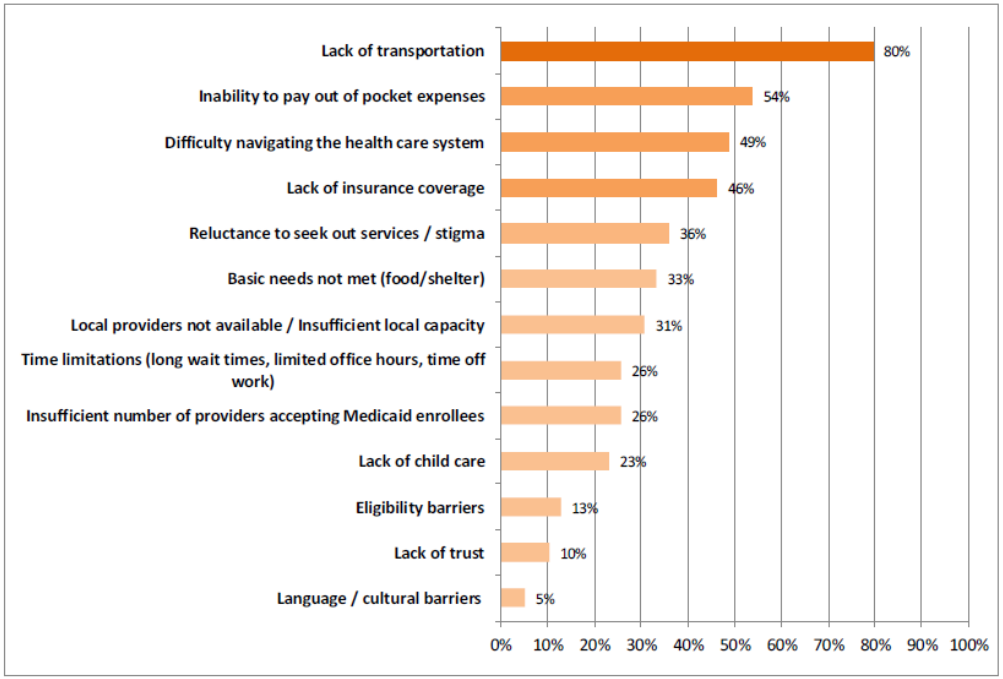
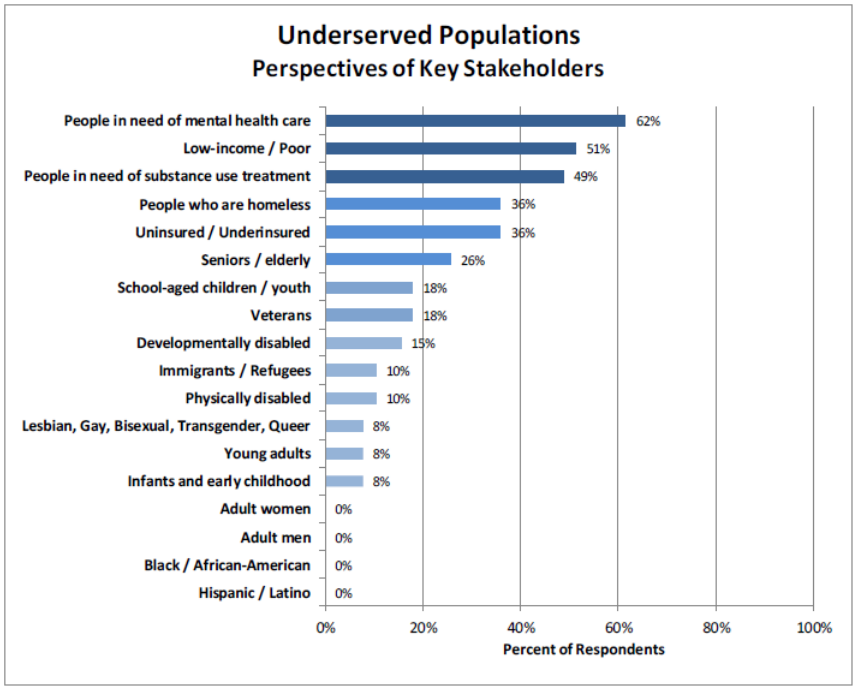


Chart 11



*Source: Mount Ascutney's FY2018 CHNA

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Community Health Needs Assessment Results

Community Needs identified as a top priority*

- Mental Health
- Substance Use Disorder/Counseling
- Physical Activity & Obesity
- Access to Care/Preventative/Primary
- Access to Health Foods/Nutrition
- Aging and Long Term Care
- Social & Economic Support/Poverty/Stress
- Early Childhood & Family Supports

*These community needs were assigned #1 as a numerical value. Some hospitals assigned more than one need as #1.

Community Health Needs Assessment
Financial Support for Community Needs

Implementation Plan

- Not all hospitals include financial resources allocated to support community needs
  - One project may address several community needs. For example, RiseVT improves primary prevention, physical activity, and social supports which build resilience against mental health and substance abuse.

Schedule H of 990*

Required for tax-exempt hospitals

- Hospitals asked to describe how program funding identified in 7e-k relates to CHNA and implementation plan
- Community investments are baked-in, difficult to extrapolate (hiring psychiatrist to address mental health needs, not included in Schedule H)
- Examples of use:
  - Medical projects
  - Unreimbursed charity

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50192T **Schedule H (Form 990) 2018**

* https://www.irs.gov/pub/irs-pdf/f990sh.pdf

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Community Health Needs Assessment
Staff Analysis and Recommendations

Systemwide Staff Analysis

- Mental Health and Substance Abuse Disorder/Counseling continue to be the most widespread community need statewide.
- Reducing deaths due to suicide and drug overdose is an APM Agreement priority area. Hospitals are working to address this gap in care in various ways, including:
  - ED and PCP office staffing
  - Referral to appropriate services and treatments
  - Extending offerings for family support
  - Exploring ways to offer Narcan free of charge
  - Initiating medication assisted treatment in the ED
- Resource Allocation:
  - As hospitals move towards population health, addressing the underlying causes of medical disorders, and continuing to integrate with the community, financial assessment of "community benefits" becomes more difficult to evaluate.
  - Implementation Plan and Schedule H of Form 990 are not reliable references to assess total community investments and resource allocation
    - ACO fees and withholds, not included in schedule H, though intended for community benefit

FY2020 Budget Submission, GMCB staff recommend:

- Potential questions for hospital:
  - How does the hospital share results of the CHNA internally and integrate with hospital operations
  - How does the hospital assess whether its level of community investment is adequate
- Staff to monitor
  - Risks/opportunities related to community needs
  - Provider transfers/acquisitions related to community needs
  - Certificate of Need related to community needs

Community Health Needs Assessment
FY2021 Non-Financial Reporting

Looking Forward

- Review list of considerations
- Feedback and collaboration with hospital community
- Collaboration with Department of Health
- Integration with GMCB initiatives (HRAP, CONs, APM)

III. Patient Access/Wait Times

Patient Access/Wait Times
Overview and Considerations

Methodology

- Wait times for all employed provider practices, as of March 1, 2019
- Third next available appointment, as defined by the Institute for Healthcare Improvement (IHI)*
  - IHI Goal: 0 days for Primary Care; 2 days for Specialty Care
- UVMMC and CVMC alternate metric: % of new patients seen within 10 days of the initial call

Considerations

- Service types are not categorized (emergency, preventative, diagnostic, palliative, etc.)
- Hospitals added 5 additional service types. It is possible that additional hospitals provide these services but did not report on the wait times.
- Hospitals should be assessed in context of their type- Prospective Payment System (PPS) or Critical Access Hospitals (CAH)
  - PPS hospitals are indicated by an asterisk (*)
- System Average was not calculated
  - Several categories have limited participants, especially when considering hospitals by type
  - Wait times can be fact-specific
  - Inconsistent use of subcategories

*Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.
The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability. http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx

Patient Access/Wait Times
Third next available appointment

This table is a summary and excludes comments and additional information provided by the hospital. Please review in context of the considerations list on the preceding slide and refer to each hospital's individual report for further detail.

Service Type	Copley	Gifford	Grace Cottage	Mount Ascutney	North Country	Northeastern	Porter	Springfield	Brattleboro*	Northwestern*	Rutland Regional*	Southwestern*
Dermatology												192
Digestive Services				3							53	69
Ear, Nose, Throat						28	5	10		34	27	
Endocrinology											37	
General Surgery	1	3		15	22	6	30	7	5 (OV); 7 (NP)	26	21	4
Hematology and Oncology	0			15							1	7
Infectious Disease											5	6
Internal Medicine		3		43				28	12 (OV & NP); 33 (PE)			49
Nephrology	0								12 (OV & NP)		52	
Neurology		7			16	35				35	116	
Obstetrics Gynecology	69	4			17	3	0-1	3*	42 (OV & NP); 96 (PE)	15	90	12
Ophthalmology				16				24		6	68	
Orthopedics	66	0			9	21	4-6	1	16 (OV & NP)	1	22	1
Palliative Care	0	0				8			0			6
Pediatrics		0		24	46	17	0-1	3	1 (OV); 19 (NP); 17 (PE)	18		6
Physiatry Rehabilitation	5 (PT/MO); 8 (PT/CH); 4 (OT)	12		41				7	21 (NP)	1	33	6
Podiatry		3		6			11			14		
Primary Care		3	10.6 (20 min. visit) 15 (40 min. visits)	43	32	3	0-19	21	33 (OV); 62 (NP); 36 (PE)	18		17
Pulmonology	0	0								15	42	7
Rheumatology	0	0		75								17
Sleep Medicine		0			7						49	31
***Urology		3			68	24		3	19 (OV); 47 (NP)	28	71	23
***Addiction Center										12	7	
***Cardiology	117					101	0-5			117		7
***Psychiatry Mental Health					63	45					5	
***Plastic Surgery								3				

*Prospective Payment System (PPS) hospital
**Springfield only provides gynecological services
***Service types added by the hospitals
OV- Routine office visit; PE-Physical exam or wellness visit; NP-New patient appointment;
MO- Mansfield Orthopedic, CO- Copley Hospital

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Patient Access/Wait Times
Alternate Metric: % of patients seen within 10 days

UVMMC
% patients seen within 10 days of scheduling an appointment

Adult Primary Care - Williston	0.00%	Ophthalmology - Shelburne Rd	42.67%
Adult Primary Care - South Burlington	7.69%	Ophthalmology - ACC	43.17%
Adult Primary Care - Burlington	9.52%	Dermatology	43.52%
Osteoporosis	11.36%	Endocrinology	44.32%
Sleep	12.82%	Berlin Ophthalmology	45.00%
Vascular Surgery	14.29%	Women's Health	45.39%
Urology - MOB	18.00%	Comprehensive Pain	45.45%
Continence Center	19.67%	Hematology/Oncology	45.86%
Adult & Child Psychiatry	20.45%	CNL	46.02%
Gastroenterology	21.31%	Cardiothoracic Surgery	46.15%
ENT	21.60%	Pulmonary	49.62%
Berlin ENT	21.88%	Adult Primary Care - Essex	50.00%
Rheumatology	24.64%	Surgical Oncology	56.19%
Middlebury Urology	26.92%	Nephrology	62.82%
Neurological Associates of Vermont	26.92%	IR Clinic	64.71%
General Surgery	27.37%	Family Medicine - Colchester	66.67%
Neurology/Memory/EP5	27.92%	Medical Psychology	66.67%
Bariatric Surgery	28.40%	Radiation Oncology	67.74%
Cardiology	28.52%	Berlin General Surgery	69.49%
Infectious Disease	28.95%	Interventional Pain Medicine	69.49%
Children's Specialty Center	30.24%	Family Medicine - Hinesburg	72.50%
Neurosurgery	30.32%	Berlin Family Medicine	82.45%
Urology - ACC	31.58%	Family Medicine - Milton	89.56%
Pediatric Neurology	32.91%	Pediatric Primary Care - Burlington	93.65%
Transplant	39.13%	Day One/Addiction Treatment Program	94.55%
Ortho - Tilley Drive	39.18%	South Burlington Family Medicine	96.37%
Plastic, Reconstructive & Cosmetic Surgery	39.77%	Pediatric Primary Care - Williston	98.31%
Seneca (mental health)	40.00%	Acute Care Surgery	100.00%
Ortho - San Remo	41.10%	Urgent Care	100.00%

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Patient Access/Wait Times
Alternate Metric: % of patients seen within 10 days

CVMC 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%

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Patient Access/Wait Times

High Wait Times

- Specialty Care, such as
  - Neurology
  - Urology
  - Ear, Nose and Throat (ENT)

	Neurology	Urology	ENT
CAH average	19 days	25 days	14 days
PPS average	76 days	35 days	31 days
UVMMC	26.92% - 30.32% within 10 days	18% - 31.58% within 10 days	21% within 10 days
CVMC	19.05% within 10 days	36.59% within 10 days	NA

CHNA Priorities

- Primary Care
  - Above IHI goal of 0 days
- Psychiatry/Mental Health
- Addiction Treatment

	Mental Health	Addiction Treatment
CAH average	54 days	NA
PPS average	5 days	10 days
UVMMC	Seneca: 40% within 10 days	Day One: 95% within 10 days
CVMC	59% within 10 days	Integrated in Primary Care

Analysis based on information submitted by the hospitals as of March 1, 2019.
Does not account for fact-specific considerations such as practice size, referral patterns, recruitment efforts, range of services provided or provider FMLA.

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Patient Access/Wait Times
Staff Analysis and Recommendations

Systemwide Staff Analysis

- Workforce issues contribute substantially to higher wait times
- Specialty Care experiences higher wait times, including Ear, Nose and Throat, Neurology and Urology
- CHNA Priorities
    - Mental Health: Potential lack of reporting in this category. Patient access is limited by relatively high wait times.
    - Addiction Treatment: Potential lack of reporting in this category. Patient access is improved by the relatively low wait times and access to same day service.
    - Primary care: above the IHI goal of 0 days to third next available appointment
        - Primary care is difficult to assess given the range of services provided in this setting

- Strategies for reducing wait times:
    - Improve referrals and contracting services with other health care organizations
    - Methodology for anticipating demand
    - On-call physicians to accommodate urgent needs

FY2020 Budget Submission GMCB Staff Recommend:

Potential questions for hospitals:

- What are effective strategies for reducing wait times
- What are the hospital's internal benchmarks
- How does the hospital determine the right balance of access based on service type

- Staff to monitor:
    - Risks/opportunities related to patient access/wait times
    - Provider transfers/acquisitions related to access/wait times
    - Certificate of Need related to access/wait times

Analysis based on information submitted by the hospitals as of March 1, 2019.
Does not account for fact-specific considerations such as practice size, referral patterns, recruitment efforts or range of services provided.

Patient Access/Wait Times
FY2021 Non-Financial Reporting

Looking Forward

- Review list of considerations, specifically data quality issues
- Feedback from hospital community
- Internal Benchmarks by hospital
  - Fact-specific nature of wait times makes comparisons difficult. Comparisons on an individual basis to internal benchmarks would be more relevant
- Count of ALL services offered at the hospital
  - The prepopulated list of services may have unintentionally omitted services that are provided by the hospital. With a complete list, we can more adequately assess resource allocation (coordinate with HRAP project team)
- Comparisons by hospital from year-to-year instead of systemwide analysis
- Impact of referrals

FY2020 Non-Financial Reporting
Staff Recommendations

Staff will monitor CON, provider transfer/acquisitions and budget requests related to:

- Mental Health and Substance Use Disorder, for example
  - Transitioning existing ED space into safe and private areas for patients awaiting admission/transfer
  - Allocation of additional resources to initiate MAT treatment in the ED; provide specialized staffing in the ED
- Primary Care

Potential Questions for hospitals:

- CHNA
  - How does the hospital share results of the CHNA internally and integrate with hospital operations
  - How does the hospital assess whether its level of community investment is adequate

- Patient Access/Wait Time
  - What are effective strategies for reducing wait times
  - What are the hospital's internal benchmarks
  - How does the hospital determine the right balance of access based on service type

Moving Forward

- Review considerations in each section
- CHNA collaboration

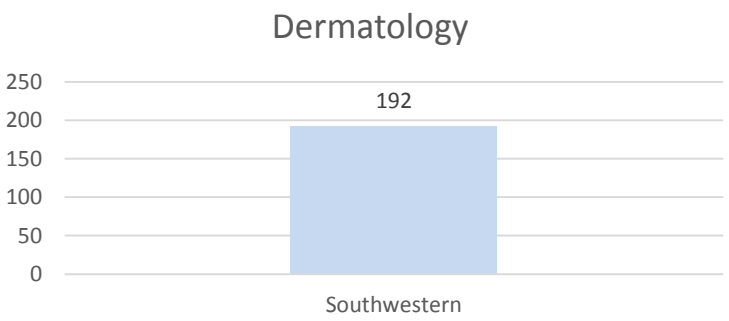
Appendix

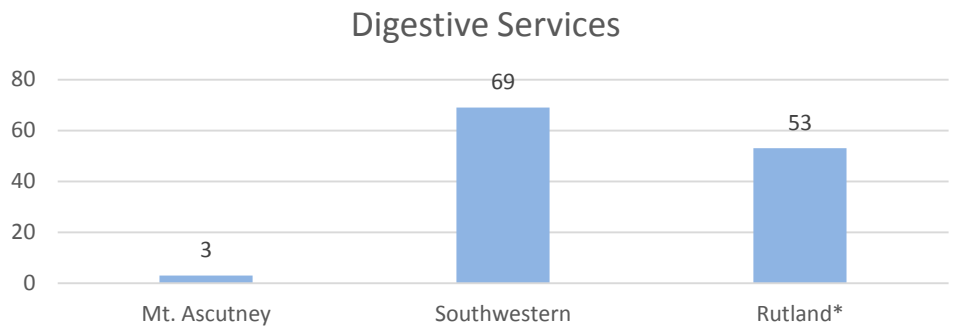
Appendix A
Individual Non-Financial Reports

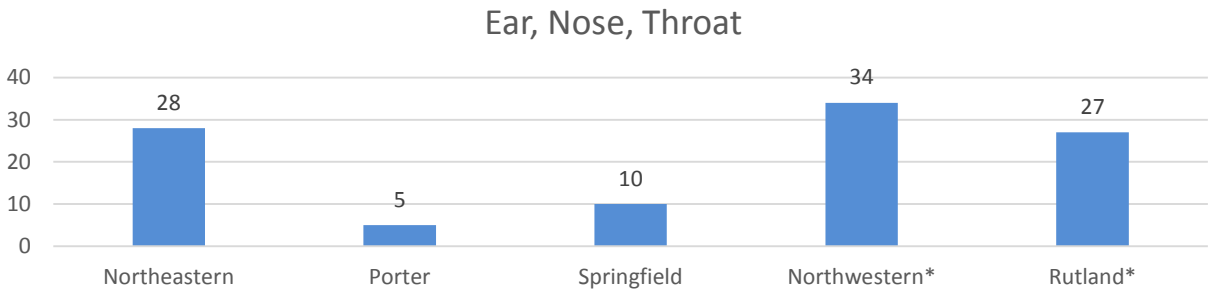
The individual non-financial reports submitted by each hospital is available on the Green Mountain Care Board website:

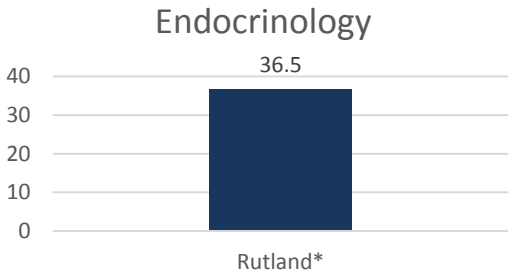
https://gmcboard.vermont.gov/content/FY2020-Budget

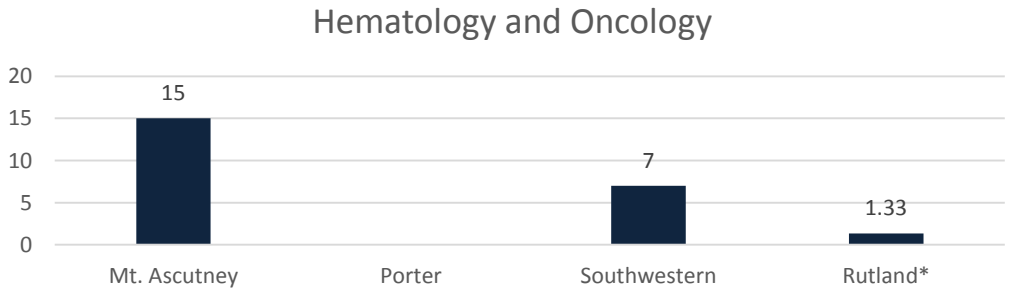
Appendix B
Wait Times- Third next available appointment

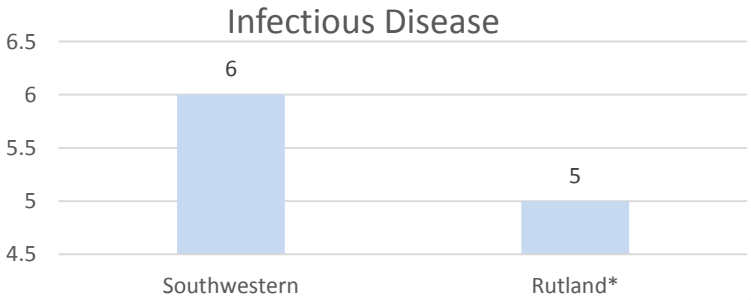












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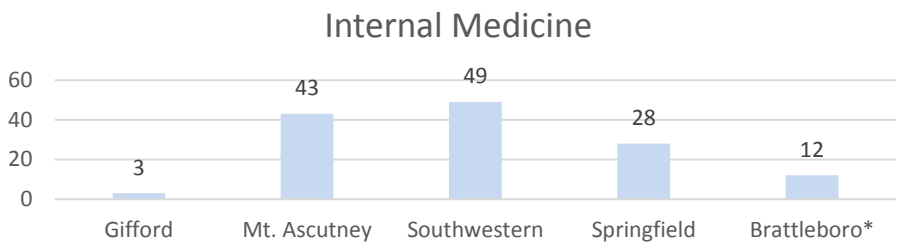
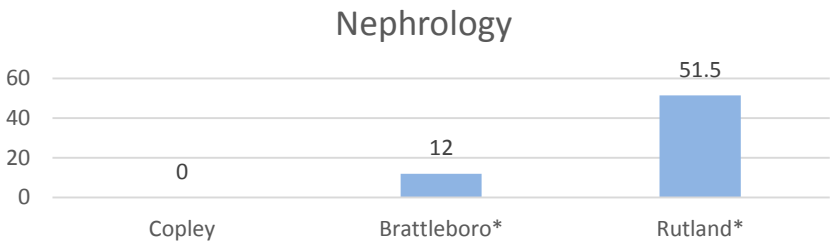
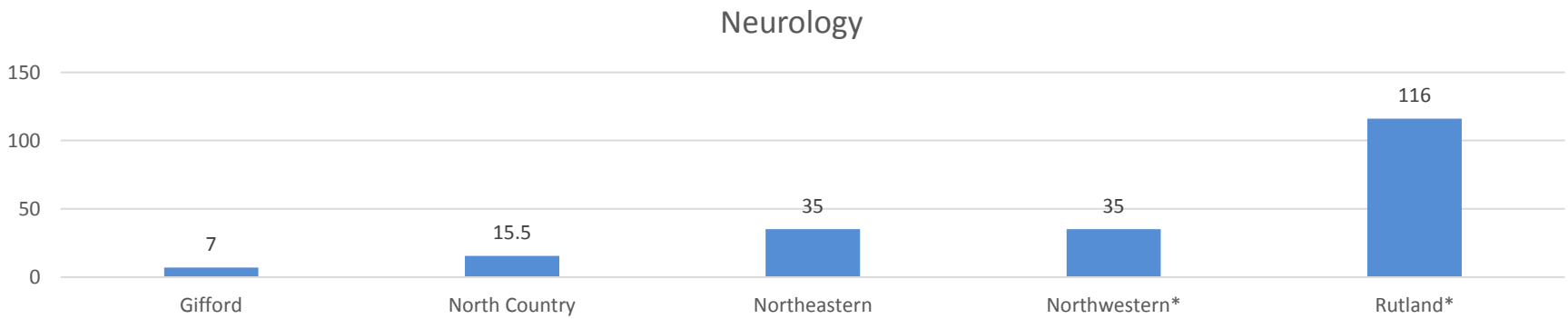
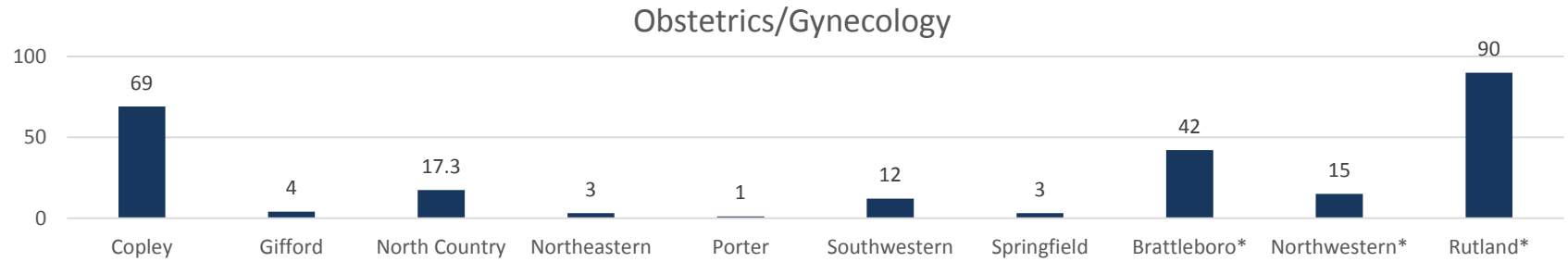
VERMONT
GREEN MOUNTAIN CARE BOARD

Appendix B
Wait Times- Third next available appointment









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GREEN MOUNTAIN CARE BOARD

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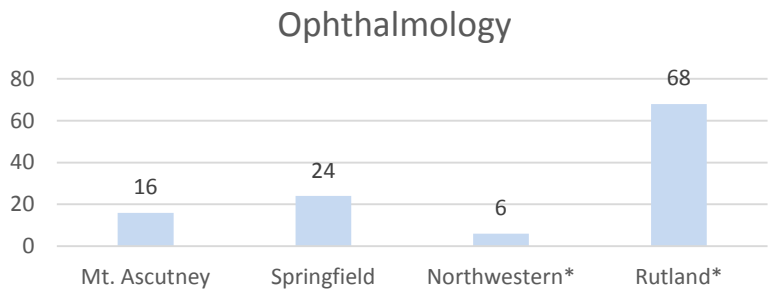

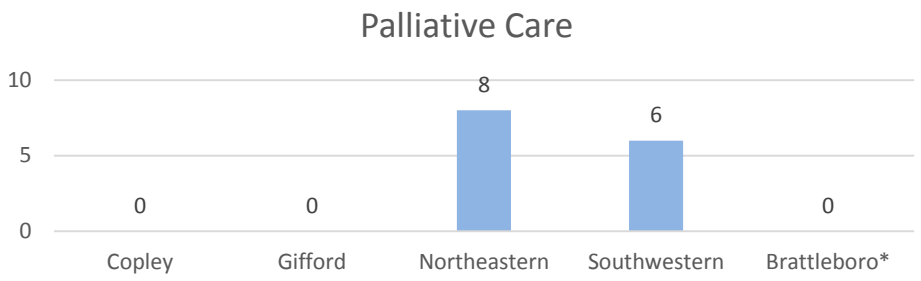

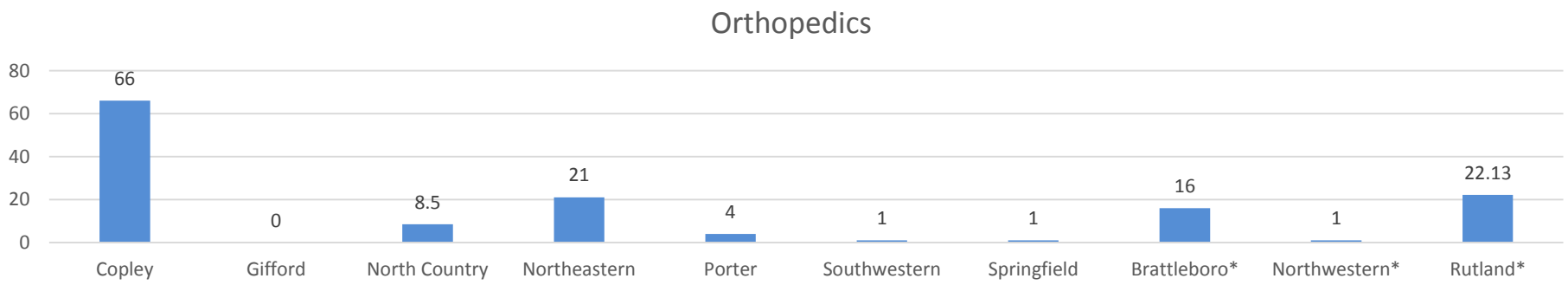

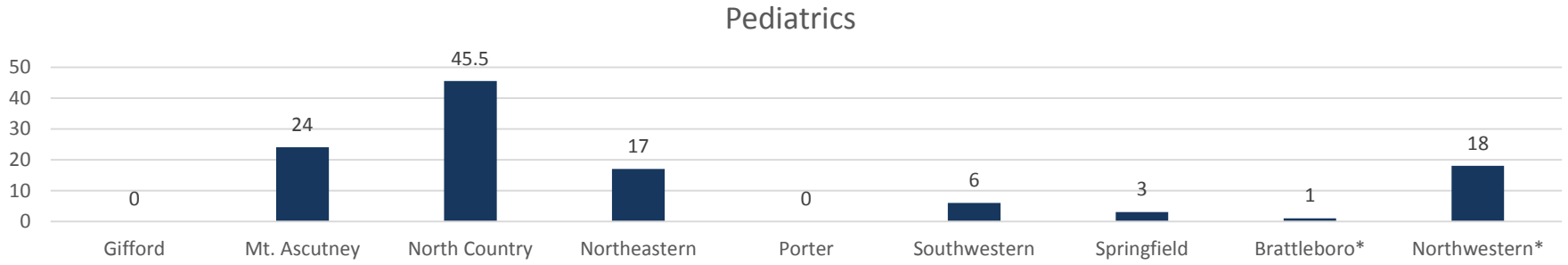

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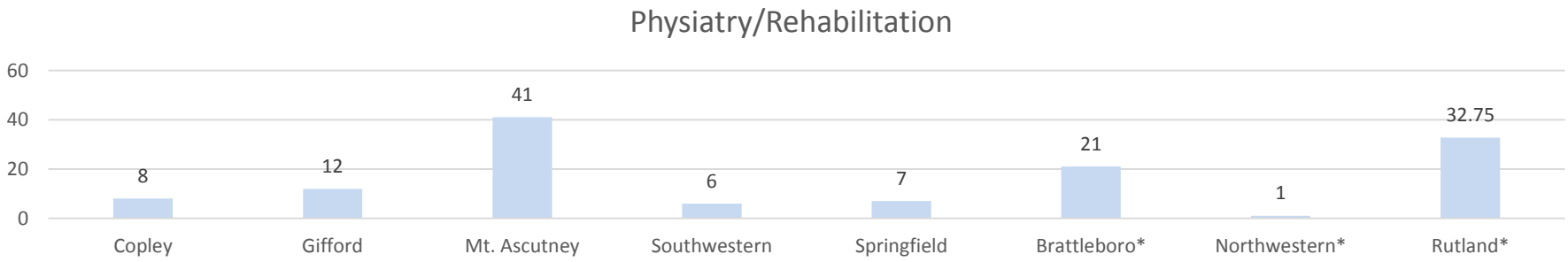

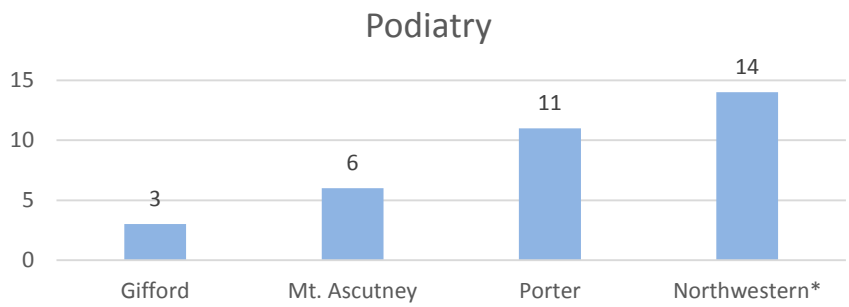

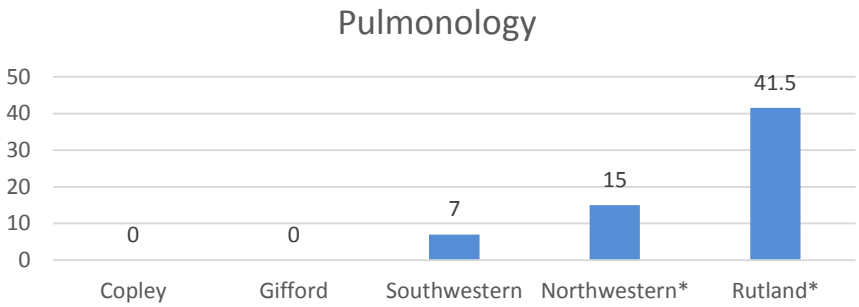

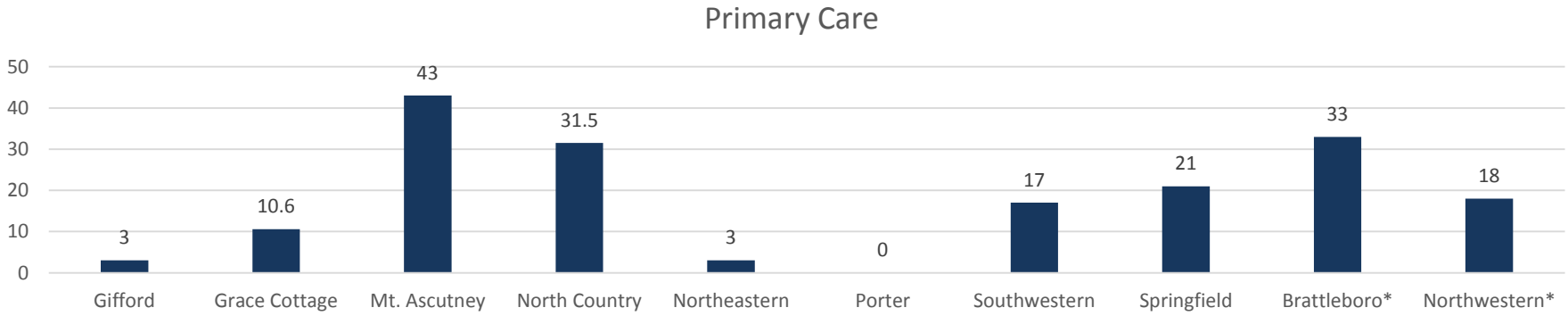

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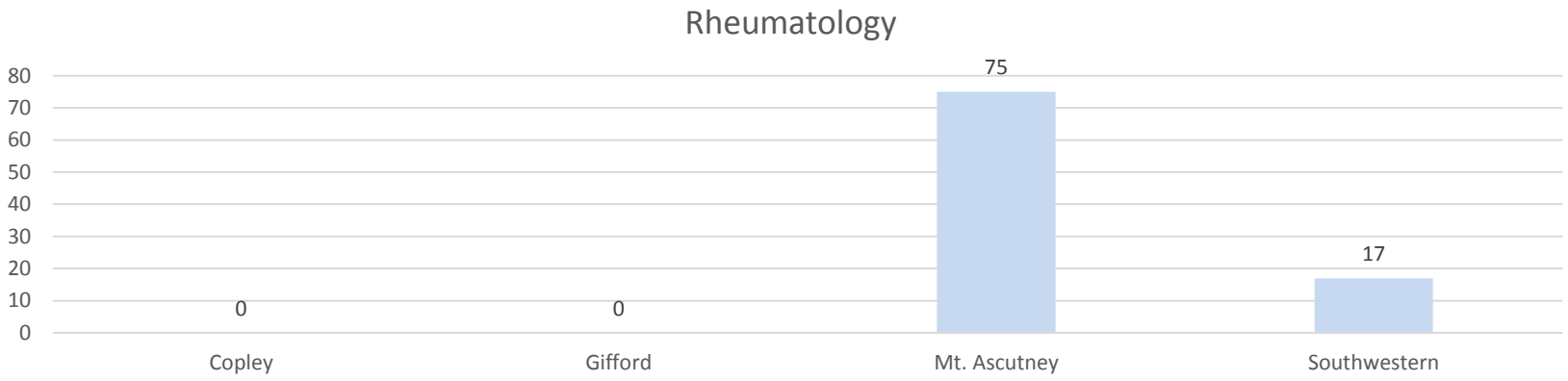

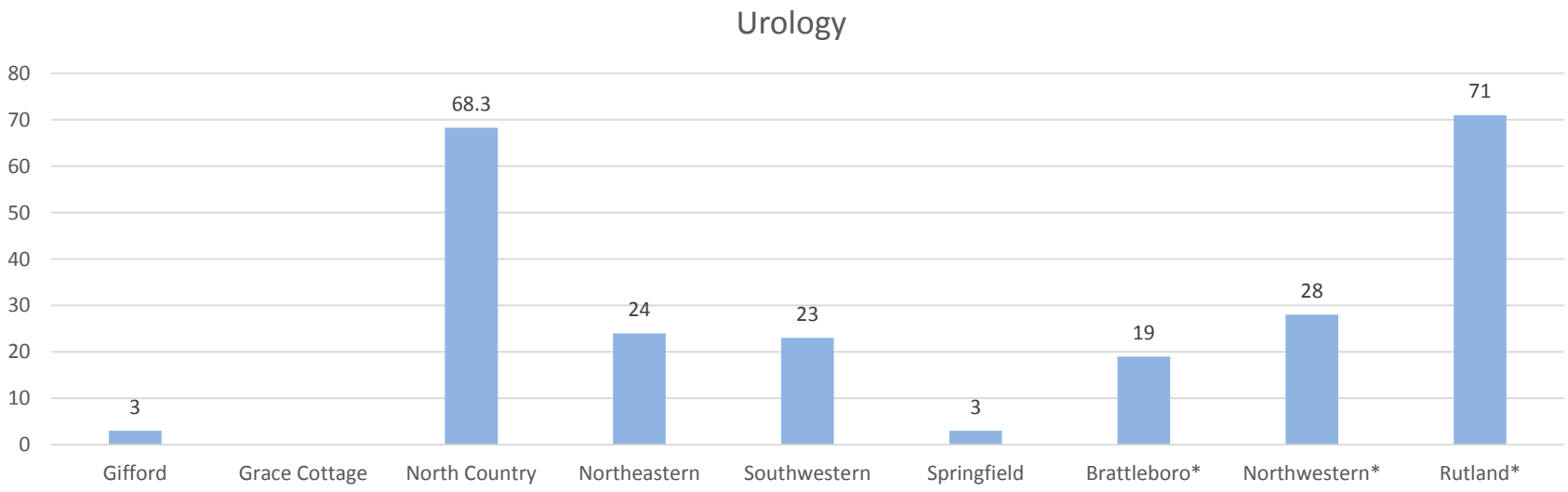

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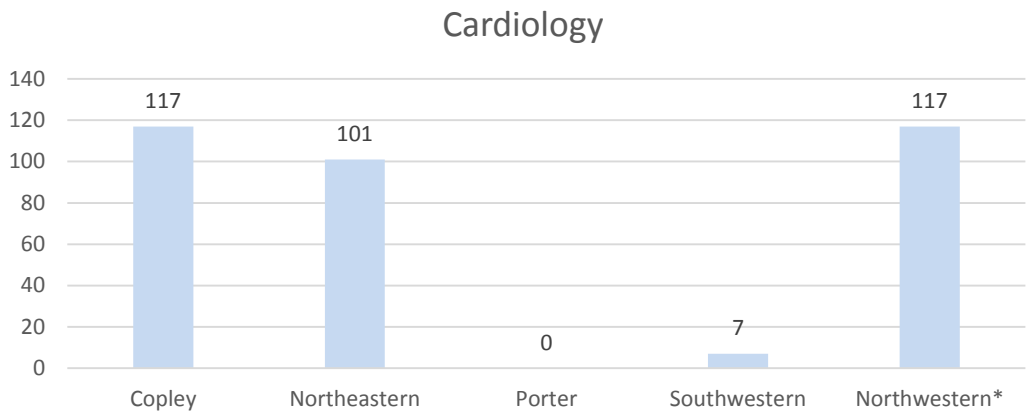
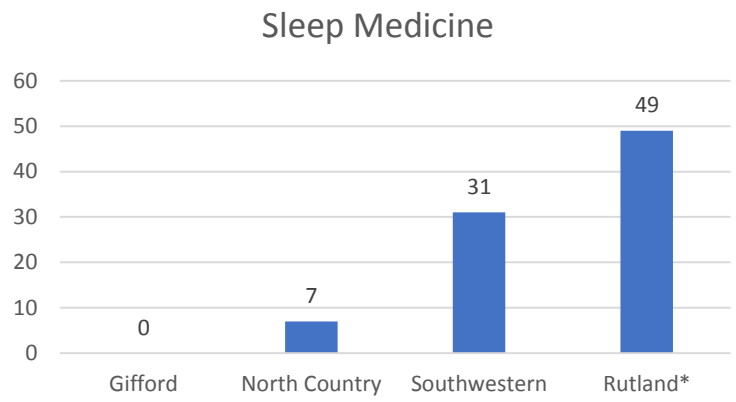
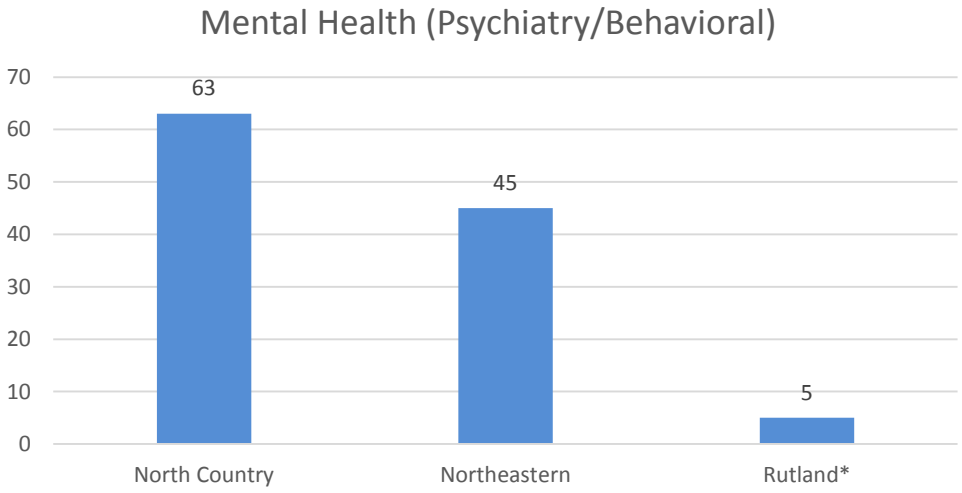
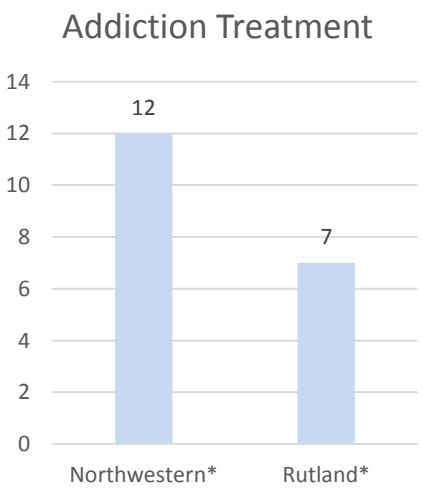
Wait Times- Third next available appointment

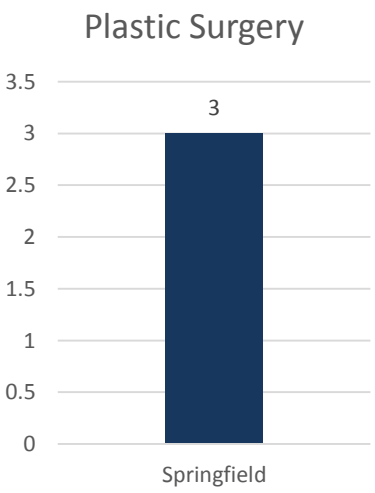
The following categories were not required and were added by the hospitals. As such, it is possible that additional hospitals provide these services, but did not report on the wait times.











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Appendix C
Department of Health Draft Summary
CHNA Priority Areas for Vermont Hospitals

Hospital	CHNA	1	2	3	4	5	6
Brattleboro Memorial Hospital	2018	Access to health care including physical, mental and oral health services	Access to illness prevention	Adequate nutrition	Safe and healthy housing	Social supports	Environmental factors (clean air, eater, access to recreation, etc.)
Central Vermont Medical Center	2016	Drug abuse – barriers to treatment, collaborating with community partners	Mental health – toll on overall health, deaths, prenatal/postpartum support	Tobacco use – cause of preventive death, chronic diseases	Healthy diets – lack of availability and affordability of healthy foods leads to obesity, which make up several of leading causes of death	Youth participation in physical activities - Participation in regular physical activity among the youth population results in many positive health and well-being outcomes	
Copley Hospital	2018	Preventive care – screening at CH for substance abuse, mental health, adverse childhood events, smoking, food insecurity, housing, BP and BMI; transportation, falls, etc.	Mental health – access for care and mental health resources in ED; screening	Chronic health conditions – screening; healthy lifestyle promotion; follow-up care plan	Substance use/abuse – mobile crisis team; referrals;	Reducing the cost of healthcare – assist patients with enrolling for insurance; focus on “super-users”;	Housing insecurity – screening; laundry services at shelter
Gifford Health Care	2018	Preventative healthcare/ access to healthcare	Substance abuse counseling	Obesity	Dental care		

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Department of Health Draft Summary
CHNA Priority Areas for Vermont Hospitals

Hospital	CHNA	1	2	3	4	5	6
Grace Cottage Hospital	2015	Diabetes/obesity/weight management	Mental health issues (stress, anxiety, depression)	Substance use			
Mt. Ascutney Hospital	2018	Alcohol and drug abuse prevention, treatment, and recovery	Access to mental health care – access for care including youths	Access to affordable health insurance, service and RX -	Family strengthening, including poverty, and childhood trauma – effects of parent stress and poverty on health and welfare of child; abuse/neglect;	Availability of primary care services	Healthcare for seniors – limited resources for seniors; future challenges of caring for frail elders
North Country Hospital	2018	Supporting substance free lifestyle and mental wellness -	Supporting older Vermonters aging in place	Supporting tobacco free life styles	Supporting healthy eating and physical activity	Supporting access to medical and oral health resources	
Northeastern	2018	"financially secure community" - gap in transportation services by low income residents and public transportation providers; employee advancement and access to childcare; screening for financial security	"physically healthy community" – recruit and retain primary care providers; chronic disease self-management; community paramedic program; transportation to appointments, other essential trips; promote physical activities	"mentally healthy community" – access to mental health services including in ED; community involvement; substance abuse support & treatment; suicide prevention	"well-nourished community" – availability of healthy foods; screening of food insecurity	"Well housed community" – homelessness; recovering housing; housing insecurity screening	

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Department of Health Draft Summary
CHNA Priority Areas for Vermont Hospitals

Hospital	CHNA	1	2	3	4	5	6
Northwestern Medical Center	2019	Mental health – high death rates; meeting demands at ED	Substance abuse – high opioid-related deaths; expand services & treatments	Obesity – chronic disease death rates; promotion of healthy lifestyles	Suicide – Adverse Childhood Experiences; schools;	Domestic and sexual abuse – expand screening in ED, obgyn, primary, pediatrics;	Food Insecurities – support healthy eating; food insecurity screening
Porter Hospital	2018	Access to primary care	Chronic Health Conditions	Substance Abuse/Addiction			
Rutland Regional Medical Center	2018-2020	Supporting an aging community – lack of geriatricians, social isolation & falls, food security & housing	Mental health - demand for mental health services heavily outweighs the available resources; need to look within our community for peer supports and community involvement	Housing - stable, healthy, and safe housing	Parenting and childcare - significant gap between the amount of childcare provider slots and those who need childcare		
Southwestern Vermont Health Care	2018	Access to care – increase primary and urgent care access, improve access to behavioral health services	Obesity and healthy behaviors – enhance health and wellness programs; foster links between good health, nutrition, exercise, and education and economic development	Behavioral health and substance abuse – expand substance abuse prevention and treatment options, develop youth stress management and coping programs			

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Department of Health Draft Summary
CHNA Priority Areas for Vermont Hospitals

Hospital	CHNA	1	2	3	4	5	6
Springfield Hospital	2016	Substance Abuse/ Mental Health - additional psychiatric resources needed for youths, geriatrics. Provide timely access to treatment/recovery services.	Obesity – increase in chronic diseases	Oral Health – limited access to care, esp. for those without insurance or limited coverage			
UVMC	2019	Mental health – avail. of providers, comorbidities, death rates, depression & stress, LGBTQ & services, stigma, suicide deaths	Substance abuse disorder – avail. of providers, binge drinking, comorbidities, drug-induced & opioid deaths, DUI-related deaths, opiate & narcotic controls, stigma	Affordable housing – availability, home ownership vs. rentals, homelessness, housing stock age, housing cost burden, livable wages	Childhood & family health – childcare services, social engagement, integrated health & support services, parenting education, smoking during pregnancy, substance use disorder, teen births	Disease prevention – aging population, diet & exercise habits, delayed care, preventive care & education, healthy food access, obesity on rise, premature deaths	Cancer – high need for access to cancer screenings and resources, financial assistance, access to affordable prescription/medication coverage, access to timely specialty care, stress/anxiety resources & treatment