HOSPITAL NAME: Brattleboro Memorial Hospital

FY 2020 HOSPITAL BUDGET GUIDANCE AND REPORTING REQUIREMENTS

NON-FINANCIAL REPORTING REQUIREMENTS

Prepared by:

GREEN MOUNTAIN CARE BOARD
144 State Street
Montpelier, Vermont 05602

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;
Harriet Johnson Harriet.Johnson@vermont.gov

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%

Hospital Response:

Medicaid Adolescents with well care visits: BMH went live with Cerner on June 5th, 2017. The implementation of a new EMR posed challenges with the previous channels of running reports on which patients were overdue with adolescent well visits. BMH turned to OCV's 'Workbench One' tool to aid in this process moving forward, as well as creating and utilizing internal tracking reports. Lastly, BMH employed Care Coordinators in each of their Practices in January of 2018 to track and reach out to patients overdue for a wellness visit.

Diabetes HbA1c poor control: BMH implemtned a qualty committee, specific to BMH's outpatient practices. The focus for CY2018 and CY2019 for Family Practice and Internal Medicine was working to lower A1C rates for DM patients. BMH is proud to announce that our group average is now at 9%.

BMH will continue to focus on population health metrics to make necessary improvements. BMH has the structural components necessary to sustain the quality successes their patients have enjoyed, as well as enable them to focus on areas of improvements. These committees and group, include, BMH's ACO Steering Committee; Quality, Patient Safety Committee; BMH Medical Group Quality Committee and BMH's Patient Centered Medical Home Committee.

BMH has hired a Nurse Practitioner to work in our ED specifically with our Mental Health and Substance Abuse patients. His work includes creating increasingly rigorous aftercare plans which includes referrals to alcohol and drug treatment progmas. In addition we are starting a program to initiate treatment with MAT from our ED.

---

[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.

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:

BMH has a department dedicated to connecting patients without a PCP to a PCP. This department assists with release of records, scheduling intial and acute appointments for new patients and ensuring that paper records are entered into BMH's electronic medical record. BMH scheduled their 7,000th new patient on March 19th, since the inception of this department in 2014.

Dedicated RN Care Coordinators follow patients with chronic conditions closely, provide outreach to patients outside of scheduled visits and create care plans that involve community members as necessary and appropriate.

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:

Brattleboro Memorial Hospital continues to be the Administrative Entity for the Blueprint for Health Hub and Spoke program in the Brattleboro Health Service Area. Putney Family Health, part of the BMH Medical Group, is a Spoke site for the program. Currently, there are approximately 136 patients receiving Medication Assisted Treatment in the Hub and Spoke Program with no wait time. BMH partners with the Brattleboro Retreat (Hub) to deliver these services.

[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:

Brattleboro Memorial Hospital is doing the following to support patients with Substance Use Disorder in our community:
- Continue to support the Hub and Spoke program by serving as the administrative entity through the Blueprint for Health.
- Continue working with the Brattleboro Retreat (our Hub) to provide Medication Assisted Treatment (MAT) for patients in recovery from an opioid addiction as a spoke site.
- Exploring Rapid Access to Medication Assisted Treatment in the Emergency Department with a warm hand-off to the Retreat HUB.
- Exploring embedding Recovery Coaches in the Emergency Department
- Exploring prescribing practices of clinicians through the Opioid Task Force
- Continue to be a member of the Consortium on Substance Use (COSU) to explore the opioid use in Windham County as part of a HRSA planning grant.
- Continue support efforts and participation in Project CARE
- Continue to support the Care Coordinators in the BMH Medical Group practices, Inpatient Care Managers and Emergency Department Care Manager.
- Exploring Stigma Awareness Training and focus on providing Trauma Informed Care at BMH for all staff.

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%

Hospital Response:

BMH has an increasingly large share of mental health patients with acute issues presenting to our ED, though we have no acute mental health inpatient resources. After evaluating several models of care, this year BMH elected to hire a Nurse Practitioner with Psychiatric experience for our ED to focus specifically on this population. This NP has worked to provide resources and increasingly rigorous acute and aftercare plans for these patients. Daily psychiatric care huddles now occur in the ED, a Psychiatric Care Committee has been formed to review and improve our approach to care, including providing scrutiny of the use of restrains and seclusion. We are in the early stages of providing naloxone for free from our ED, and of a program to initiate MAT directly from our ED.
BMH has also started an Opioid Resource Team of clinicians who are reviewing high dose prescriptions of opiates and providing assistance to clinicans for tapering patients to lower and safer doses of opioids.

[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.

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	N/A		
Digestive Services	N/A		
Ear, Nose, Throat	N/A		
Endocrinology	N/A		
General Surgery	5 days for OV; 7 for NP		
Hematology/Oncology	N/A		
Hepatology	N/A		
Infectious Disease	N/A		
Internal Medicine	12 days for OV, 12 days for NP; 33 days for PE		
Nephrology	12 days for OV; 12 days for NP		
Neurology	N/A		
Obstetrics/Gynecology	42 days for OV; 42 days for NP; 96 for PE		
Ophthalmology	N/A		
Orthopedics	16 days for OV; 16 days for NP		
Palliative Care	0 days for all appointment types		
Pediatrics	1 day for OV, 19 days for NP; 17 days for PE		
Physiatry/Rehabilitation	21 days for NP		
Podiatry	N/A		
Primary Care	33 days for OV; 62 days for NP; 36 for PE		
Pulmonology	N/A	N/A	
Rheumatology	N/A	N/A	
Sleep Medicine	N/A		
Urology	19 days for OV; 47 days for NP		
Other (describe in comment)	N/A		

Hospital Explanation (if necessary):

OV- Routine office visit
PE-Physical exam or wellness visit
NP-New patient appointment

Primary Care-1 clinician is out on FMLA and 2 recently resigned. This is an average of 4 Family Medicine Practices

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:
5	1	2		4	3															

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

The 2018 CHNA has been updated and is posted on the BMH website. The implementation plan is finished and pending approval by the Senior Leadership Team at BMH and the BMH Board of Directors in May.

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

https://3ohond29fxl43b8tjw115y91-wpengine.netdna-ssl.com/wp-content/uploads/2018-BMH-CHNA-report-FINAL.doc.pdf

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

Accessing and Navigating Healthcare	1,699,935
Obesity	476,678
Dental Needs	116,300
Substance misuse	294,750
Mental health	334,188
	2,921,851

* Most of these dollars support multiple CHNA sections

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.

Question 7 e is largely the core costs and offsetting revenue of the Community Health Team.
Question 7 f represents cost of training programs for Medical Assistants, as well as ongoing training, education and tuition for employees.
Question 7 i represents various community contribution made by BMH.