HOSPITAL NAME: Southwestern Vermont Medical Center

FY 2020 HOSPITAL BUDGET GUIDANCE AND REPORTING REQUIREMENTS

NON-FINANCIAL REPORTING REQUIREMENTS

Prepared by:

GREEN MOUNTAIN CARE BOARD
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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;
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:

SVMC supports a wide-range of innovative, community-facing programs that impact the health metrics indicated throughout this report (see attached grid).
Specific to Table 1a. Bennington is doing better than the state wide rate across several metrics because it sustains specific programs directed at addressing the issues monitored. Here we describe only a few examples;
• SVMC Pediatric Community Care team leverages more than 30 community agencies and organizations to review individual pediatric cases and implements approaches to enhance well-child visits for the most fragile youth (metric #1).
• Embedding diabetes educators in primary care practices has facilitated direct referrals and delivers more patients with HbA1C control (metric #6).
Bennington lags the state wide rate in several metrics, most notably in initiation of, and engagement in substance abuse treatment (metric #2 & #3). Historically, regional demand for behavioral health and addiction support services has overwhelmed capacity. SVMC has taken decisive action through the Opioid Task Force and has expanded several programs in collaboration with United Counselling Services (UCS), including;
• Establishing rapid access to Medication Assistive Treatment
• Peer Recovery Coaches from Turning Point Center servicing patients in the emergency department and inpatient units
• Launch of YSBIRT (Youth, Screening, Brief Intervention, Referral to Treatment) in SVMC Pediatrics
The attachment provides a more comprehensive description of the breadth and variety of SVMC's programs directed at the metrics in Table 1.

[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:

Bennington is doing better than the state wide rate for three of these four metrics. However, access to primary care is decreasing and the prevalence of chronic disease is still alarmingly high.
SVMC is considering launch of a Family Medicine Residency Program to address the primary care provider shortage.
Primary prevention strategies such as RiseVT are essential to reduce the prevalence of chronic disease. For example, SVMC's RiseVT chapter is coupling primary prevention activities with traditional pre-diabetes approaches such as hosting pre-diabetes education classes at local parks, where hiking or exercise is interwoven with more typical pre-diabetes teaching. Referrals of pre-diabetics from primary care to these innovative workshops ensures the most at risk pre-diabetics receive help and the prevalence of diabetes decreases. Similar programs are under development for patients at risk of COPD and Hypertension.
See the attached grid for the full complement of SVMC's innovative programs address primary prevention

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:

The demand for Medication Assisted Treatment (MAT) in Bennington is greater than capacity and SVMC is leading the Opioid Response Task Force striving to better meet community need. The task force has completed its comprehensive Opioid Response Plan and has begun implementation including;
• Expanding rapid access to MAT for individuals that present in SVMC's Emergency Department.
• Facilitating MAT referrals from the community care team that manages high-risk patients such as those that recently overdosed
• Expanding provider hub and spoke participation
• Launching YSBIRT screening in SVMC's pediatric office for swift referral to MAT as appropriate
The resources available to address the regional opioid epidemic up-stream of MAT are still too limited to stem the tide of individuals requiring MAT.

[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:

SVMC strives to have no deaths from drug overdose in Bennington and recognizes that achieving this goal requires a multifaceted approach extending across the community. SVMC is focusing on two areas to reduce the number of drug overdoses;
• Increasing the number of individuals that have chosen the path of recovery through efforts such as expanding MAT access increasing hub and spoke participation.
• Decreasing the number of individuals that succumb to substance abuse disorder and begin using dangerous drugs through efforts such as the community care teams, YSBIRT and RiseVT
Both areas of effort attempt to reduce the number of individuals using drugs and thereby reduces drug overdoses.

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:

SVMC is on par with the statewide rate for health system utilization for mental health and substance use-related care. However, SVMC believes additional opportunities exist. For example, SVMC in partnership with United Counseling Service (UCS) obtained a $165,000 grant from OneCare Vermont to establish a youth crisis area, where schools, pediatricians and community agencies can refer youth. The goal is to have youth engage with social workers and behavioral health counselors at this safe and welcoming site rather than advance to crisis an enter the emergency department or broader healthcare system. This s only one of the innovative ways SVMC is actively redirecting mental health and substance use issues to treatment deliver centers that are lower cost and more conducive to durable outcomes.

[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	192		
Digestive Services	69		
Ear, Nose, Throat	N/A		
Endocrinology	N/A		
General Surgery	4		
Hematology/Oncology	7		
Hepatology	N/A		
Infectious Disease	6		
Internal Medicine	49		
Nephrology	N/A		
Neurology	N/A		
Obstetrics/Gynecology	12		
Ophthalmology	N/A		
Orthopedics	1		
Palliative Care	6		
Pediatrics	6		
Physiatry/Rehabilitation	6		
Podiatry	N/A		
Primary Care	17		
Pulmonology	7	7	
Rheumatology	17	17	
Sleep Medicine	31		
Urology	23		
Other (describe in comment)	7		Cardiology

Hospital Explanation (if necessary):

Numbers represent average performance Jan-Mar 2019. On the first Tuesday of the month, SVMC analyzes the third next available appointment for new patients for each provider. Performance for the practice is recorded as the number of days for the provider in the practice with the soonest availability. This method provides a estimate of the earliest access for a new patient. Performance is reviewed quarterly at by SVMC leadership. The Third next available appointment for Primary Care is an average across the primary care practices accepting new patients. Primary care practices not accepting new patients does not appear in this report. Internal Medicine, Ob/Gyn and Pediatrics are reported separately while also being rolled into the average for primary care.

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:
2a	3a	3b	2b	1		2 c														

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

The CHNA and implementation plan were updated in 2018 and are scheduled to be updates next in 2021. However, SVMC carefully reviews and adjusts the implementation plan based upon emerging opportunities to create impact. Based upon SVMC 2018 CHNA the priority health needs are;
1. Access to Preventative/Primary Care
2. Proximal social determinants of health
a. Physical Activity & Obesity
b. Access to Healthy Foods/Nutrition
c. Social & Economic: Support/Poverty/Stress
3. Mental Health and Substance Use Disorder/Counseling

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

https://svhealthcare.org/~/media/files/departments/planning-compliance/CHNA-2018-9-28.pdf?la=en

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

SVMC does not associate specific resources with a specific health need identified in the CHNA but rather SVMC resources projects and programs that span the underlying root causes of the several priority health needs simultaneously. For example, resourcing RiseVT improves primary prevention, increases physical activity thereby reducing obesity, increases social supports, reduces stress and builds resilience against mental health and substance abuse. Addressing the local transportation barriers that prevent patients from accessing primary care, preventive programs such a diabetes education, and mental health services addresses a root cause impacting multiple priority health needs.

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.

SVMC's community benefit indicated in Schedule H of the 990 includes items more medically related that the unreimbursed community impact items described above. Per standard accounting practices, SVMC includes unreimbursed charity as part of its community benefit reporting. In addition, SVMC accounts for some portion of the financial loses of primary care practices as part of its community benefit reporting. On its Schedule H, SVMC attempts to strike a balance between resources dedicated to medical initiatives and community facing efforts.

Programs Available at Southwestern Vermont Medical Center Transitional Care and Blueprint

Program	Target Population	Intervention	Results	Contact
Transitional Care Nursing	People with chronic diseases	Nurses partnering with people/families to review medication management, chronic disease education/symptom management/ referrals to resources	2014-2018 = TCN services assisted 1226 patients resulting in a ***51.5%*** reduction in hospitalizations 6 months before and after intervention 36% reduction in hospitalization one year before and after TCN involvement	transitionalcare@svhealthcare.org 802.447.5153 802.447.5072
Community Care Team	People with mental health and substance use disorders	Patient advocate in the ED navigates and connects people to community resources and support. Monthly meeting of community resources to create integrated care plan after consent obtained	2016-2018 = Community Care Team/patient advocate partnered with 189 patients. ED utilization has decreased by ***24.4%*** for this patient population with improved quality of life/access to appropriate help/housing/job training/ treatment for addictions	communitycareteam@svhealthcare.org 802.447.5145
Integrated Diabetes Education	People with pre-diabetes, type 1, 1.5, 2, or gestational diabetes	Diabetes educators embedded in primary care to facilitate patient centered goal identification to improve health, increase activity, and improve control of blood sugars	2016-2018 = 657 patients have worked with the Certified Diabetic Nurses. Resulting in a ***12.1%*** reduction in their A1C	diabetesed@svhealthcare.org 802.440.4025 802.447.4564

Pediatric Community Care Team	At risk children in needs of medical, emotional, and social supports	Family advocate available in Pediatric office, engage with families to identify needs, utilize community resources, and facilitate appropriate referrals. Monthly meeting with community partners to create integrated care plan after consent obtained.	Since inception in June 2018 the family advocate has engaged with ***75*** families and engaged in ***142*** care coordination encounters.	Melissa.Delmolino@svhealthcare.org 802.447.3930 802.447.5404
Palliative Care	People with pending end of life challenges who could benefit from improved symptom management/emotional support	Transitional care palliative care nurse partnering with MDs, attending daily interdisciplinary rounds, PCP practices and SNFs to increase appropriate referrals/ access to services	Since inception in January 2018, tripled palliative care referrals, decreasing hospitalizations and ED visits and increasing patient/family satisfaction	Jani.Albans@svhealthcare.org 802.447.5642
Clinical Pharmacist	Pilot project in Primary Care office partnering with patients with polypharmacy, unstable health issues	Comprehensive review/consultation with Primary Care Physician to discuss medications. Goal= decrease interactions, educate patient to increase compliance, De-prescribe (reduce total # of medications)	2018=Medication therapy management services provided to 341 patients Anticoagulation support services to 117 patients Total of 645 patient encounters	Billielynn.Allard@svhealthcare.org 802.447.5318 Robert.Sherman@svhealthcare.org 802.447.5595
Pulmonary Rehab w/ maintenance	People with chronic lung disease	Improve quality of life, maintain functionality, and utilize self-management techniques through exercise and behavior changes	***75%*** of patients reported significantly improved quality of life per St. George's Respiratory Questionnaire ***85%*** of patients reported significantly improved endurance per Six Minute Walk Test.	pulmonaryrehab@svhealthcare.org 802.447.5140 802.440.4272

Physical Therapist in Emergency Department	Patients in ED with musculoskeletal/ orthopedic issues	Prompt evaluation by Physical Therapist to enhance assessment and prompt access to specialized treatment	Referrals expanding to include patients with balance issues, evaluations for safe discharge	Kathryn.Sleeman@svhealthcare.org 802.447.5131
Financial Counselor	People with financial needs, concerns, or questions	Financial Counseling	Improved satisfaction with access to assistance for patients without insurance, financial struggles	Susan.Daugherty@svhealthcare.org 802.440.4083
Chronic Disease Self-Management	People living with chronic diseases and their caregivers	Program that focuses on pain, nutrition, exercise, medical use, emotions, and communicating with health care providers for individuals with chronic diseases and their caregivers	Need to increase appropriate referrals to increase attendance to valuable education programs	Kathy.Dockum@svhealthcare.org 802.440.4098
INTERACT ®	Skilled Nursing Facility residents	Implementation of Interact **(I**nteraction to **R**educe **A**cute **C**are **T**ransfers) empowers nursing assistants to speak up about changes in patient conditions, prompting evaluation by RN/Provider	Decreased SNF ED visits and hospital admissions/readmissions	Katharine.Green@svhealthcare.org 802.447.5073
RiseVT	Entire Community	Access to education and support for healthy eating, increase physical activity to improve health	Since inception Fall 2018, programs with 1500 participants across community, 12 Amplify grants provided to increase community involvement/engagement	Andrea.Malinowski@svhealthcare.org 802.447.5507
Health Care Share (food insecurity strategy)	Patients in Cardiac and Pulmonary Rehab	Provides fresh produce, recipes and cooking classes to increase healthy eating habits	Monthly distribution to 20-30 participants	Tiffany.Tobin@svhealthcare.org 802.447.5163

Grateful Hearts	People in shelters, low income housing, food pantries	Meals prepared from fresh produce gleaned from farm and delivered to high risk families.	51,340 pre-packaged soups stews and casseroles distributed from July 2016-present	Tiffany.Tobin@svhealthcare.org 802.447.5163
Harvest House	Families with food insecurity in Bennington	Distribution of unused food from SVMC to families in need	3,134 meals distributed since July 2016	Tiffany.Tobin@svhealthcare.org 802.447.5163
Vermont Food Bank Drop	Needy families in Bennington	Access to free vegetables, fruit and healthy food. (RiseVT activities on site, cooking demonstration with taste tests/ recipes distributed)	300 families pick up food, distributed to other families unable to pick up their own	Tiffany.Tobin@svhealthcare.org 802.447.5163
Chronic Pain Self-Management	People living with chronic pain and their caregivers	Program that focuses on problem solving, appropriate usage of medication, exercise, nutrition, emotions, and communicating with health care providers for both people with chronic pain and their caregivers	Education of providers underway to increase referrals	Kathy.Dockum@svhealthcare.org 802.440.4098
Tobacco Cessation	People living with tobacco addiction	Helping people quit or reduce tobacco use. Workshops are on a weekly bases for 4 weeks or can be ongoing. Participants may join at any time. Offered on individual bases or group session in a designated location or the work setting upon request	Increased referrals after partnership with pulmonary rehab and respiratory therapy	Kathy.Dockum@svhealthcare.org 802.440.4098

Diabetes Prevention Program	People that have the potential of developing diabetes	Focus on people who have the potential of becoming diabetic if they were not to take the necessary preventative precautions. By participating in this program they are taught proper nutrition, exercise, and dealing with stress	Three cohorts of pre-diabetes classes in 2018, 2 more scheduled for 2019 to date	Kathy.Dockum@svhealthcare.org 802.440.4098
Other Resources not listed				CommunityResources@svhealthcare.org