APPENDIX

A

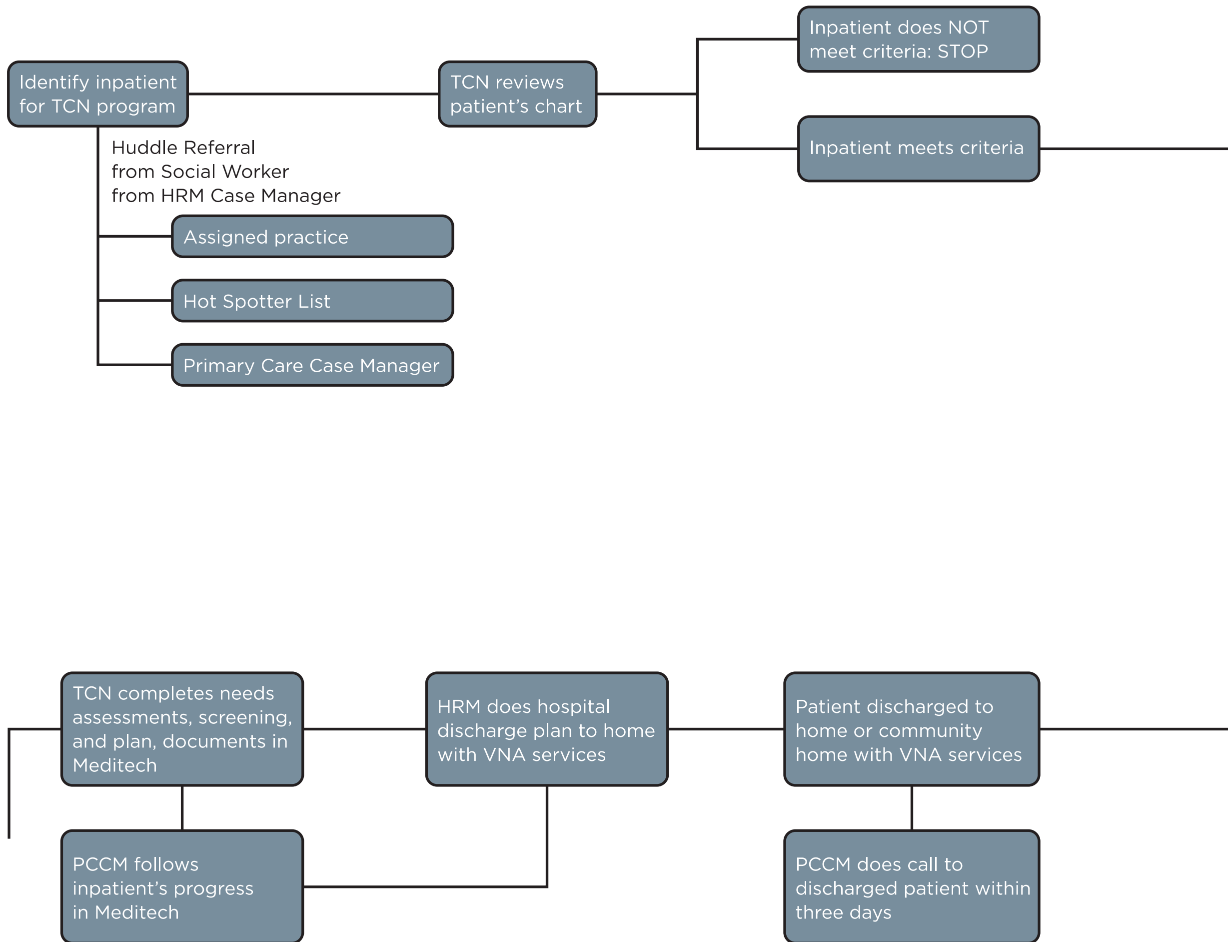
MAPPING OUT WORKFLOWS WITH COMMUNITY PARTNERS: STRATEGY TO BUILD TEAMWORK, TRUST, AND ACCOUNTABILITY WITH BLUEPRINT FOR HEALTH

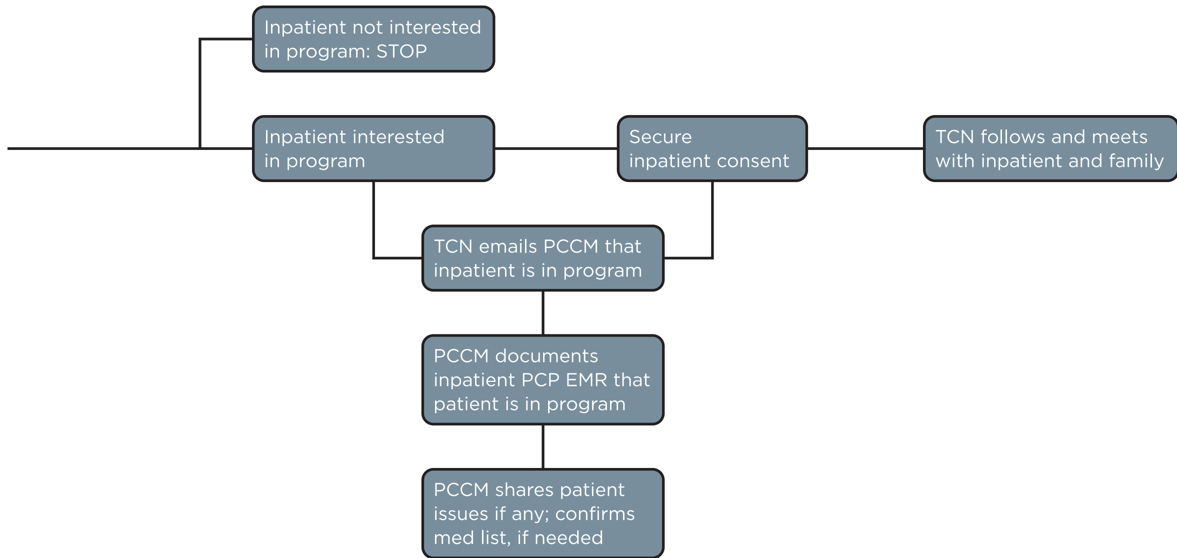
A1: Transitional Care for Inpatients Discharged With VNA Services

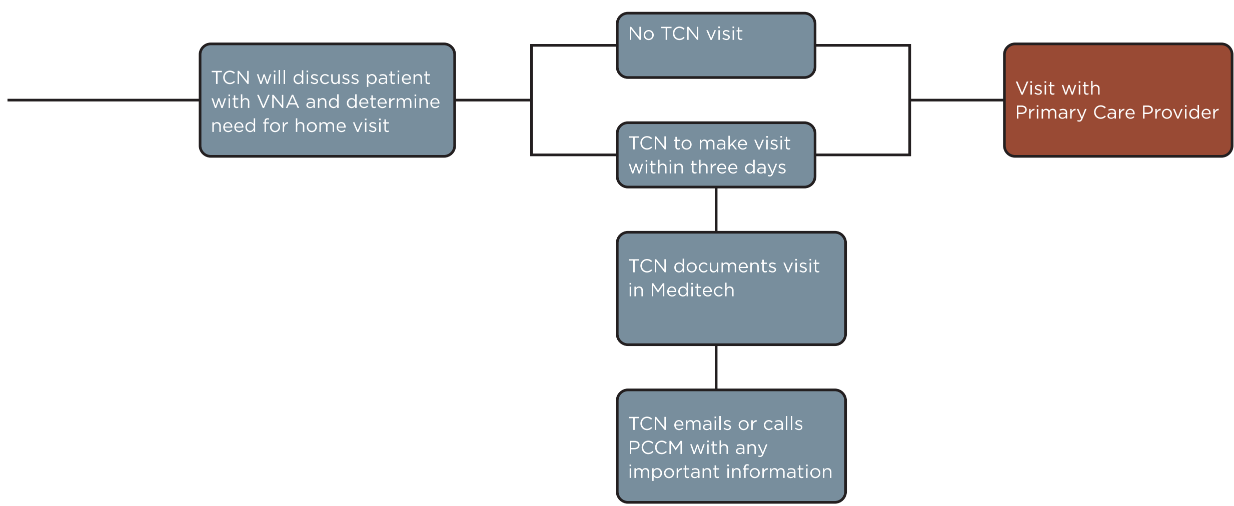
A2: Transitional Care for Inpatients Discharged to Subacute Unit

Vermont Blueprint
Integration with Transitional Care Nurse Program

Workflow for integration with TCN for inpatients who are DISCHARGED HOME WITH VNA SERVICES

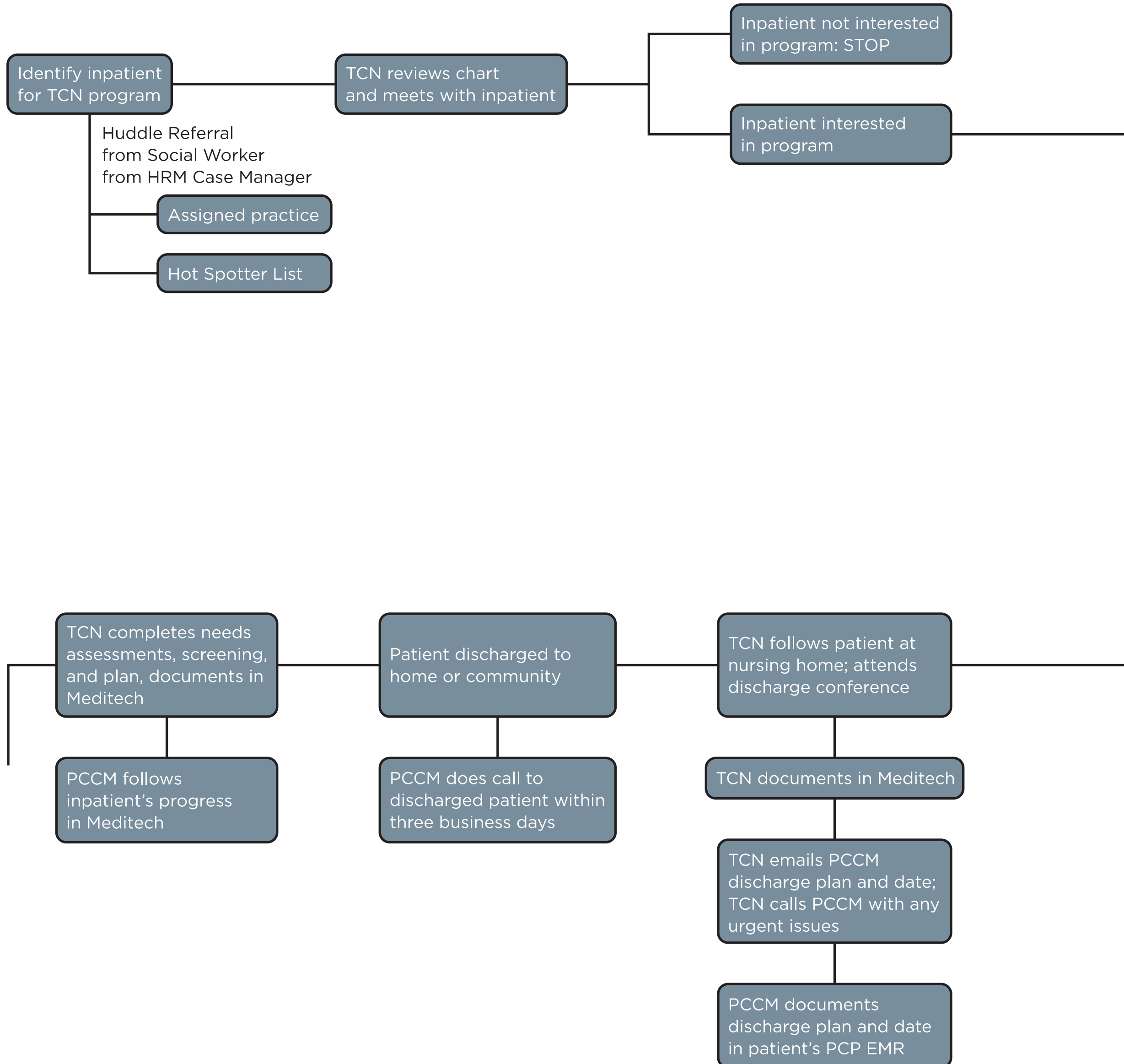


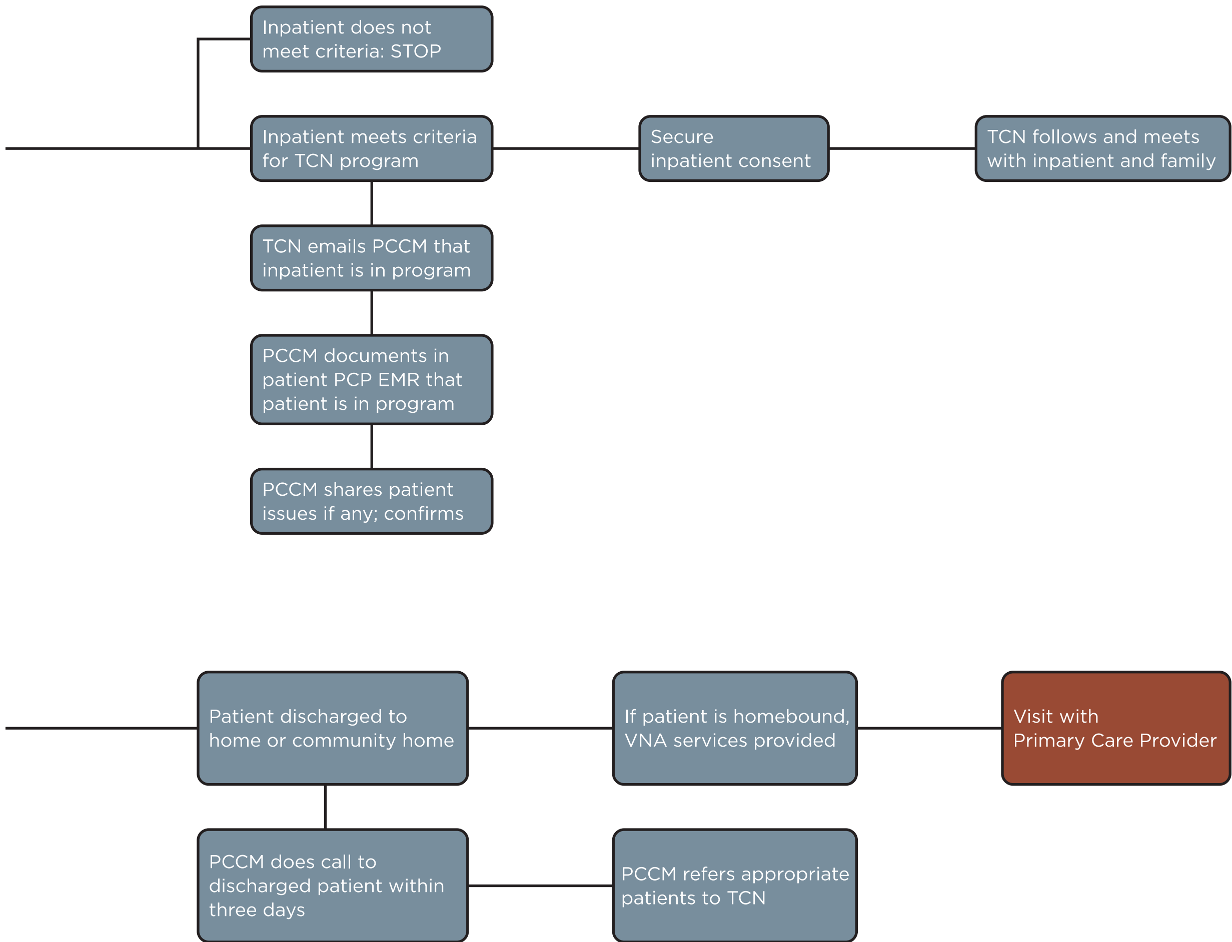

Inpatient not interested in program: STOP
Inpatient interested in program
Secure inpatient consent
TCN follows and meets with inpatient and family
TCN emails PCCM that inpatient is in program
PCCM documents inpatient PCP EMR that patient is in program
PCCM shares patient issues if any; confirms med list, if needed


TCN will discuss patient with VNA and determine need for home visit
No TCN visit
TCN to make visit within three days
Visit with Primary Care Provider
TCN documents visit in Meditech
TCN emails or calls PCCM with any important information

Vermont Blueprint
Integration with Transitional Care Nurse Program

Workflow for integration with TCN for inpatients who are DISCHARGED TO SUB-ACUTE UNIT




Inpatient does not meet criteria: STOP
Inpatient meets criteria for TCN program
Secure inpatient consent
TCN follows and meets with inpatient and family
TCN emails PCCM that inpatient is in program
PCCM documents in patient PCP EMR that patient is in program
PCCM shares patient issues if any; confirms
Patient discharged to home or community home
If patient is homebound, VNA services provided
Visit with Primary Care Provider
PCCM does call to discharged patient within three days
PCCM refers appropriate patients to TCN

APPENDIX

B

TRANSITIONAL CARE NURSING

B1: Job Description

Transitional Care Nurse (TCN) Job Description

Job Purpose:

The TCN is responsible for the oversight and management of a panel of high-risk patients/residents across care settings using evidence-based protocols and best practices. The TCN works in collaboration with a primary care practice, the SVHC care team, healthcare facilities and services, and home health agencies to support optimal patient/resident clinical outcomes and satisfaction based on patient shared decisionmaking.

Essential Functions:

1. Identifies high-risk individuals for care transitions
2. Communicates to the care team patient risk factors and gaps in care
3. Works collaboratively to develop action plans that mitigate risk for hospital admission, re-admission, or use of the emergency department
4. Facilitates patient/resident transitions across the continuum of care
5. Refers high-risk patients to appropriate resources
6. Conducts in-person, telephone, or electronic communication with patient or caregivers within two to three business days of any facility discharge
7. Conducts home visits or skilled nursing facility rounds with complex patients after a facility discharge
8. May accompany patient at first post-discharge office visit and will modify plan of care accordingly or provide hand-off communication to PCP day of appointment
9. Educates patient, residents, and families with primary focus on disease self-management, symptom identification/management, and medication safety
10. Establishes patient-centered goals using motivational interviewing and develops realistic strategies to meet the goals

11. Disseminates knowledge of evidence-based practice for chronic diseases, such as heart failure, COPD, asthma, and diabetes, to other members of the care team across the continuum using magnets, journals, and personalized care plans
12. Develops and implements clinical protocols across the continuum of care in collaboration with community partners
13. Identifies and works to resolve gaps and barriers in processes that interfere with access to effective transitions
14. Identifies and works to resolve gaps/barriers in systems that interfere with transfer of information from one care setting to another
15. Identifies and works to decrease cost of care delivery within the models of care-delivery healthcare reforms, such as accountable care organizations, bundled payments, and value-based payment
16. Participates in and conducts research
17. Participates in and leads quality improvement efforts
18. Provides education across the care continuum related to population health, value-based payment, and care coordination
19. Serves on nursing school advisory boards to provide assistance in curriculum development related to new care delivery models
20. Disseminates education training on evolution of ambulatory care management and value-based payment by publication of articles, podium presentations, and guest lectures

Minimum Education:

Graduation from an accredited school of nursing and a bachelor’s degree required (master’s degree preferred).

Three to five years of clinical experience in acute care setting required; some home care and long-term experience preferred. Current Vermont RN license.

APPENDIX

ROLE CLARIFICATION FOR: HOSPITAL-BASED CASE MANAGER, BLUEPRINT FOR HEALTH MEDICAL HOME NURSE CASE MANAGER, TRANSITIONAL CARE NURSE

C1: Comparison Grid

COMPARISON GRID

Health Resource Management (HRM): Hospital-based discharge planning and case management

Medical Home Case Manager (MHCM): Medical office–based case management

Transitional Care Nurse (TCN): Hospital, skilled nursing facility, rehabilitation unit, homeless shelter, home

FOCUS		
HRM	**MHCM**	**TCN**
Episodic care management; discharge from medical center; short-term planning	Health promotion and illness management; primary care setting; short- and long-term care planning	Transition of care across continuum; patient and systems; short- and long-term planning by navigating with patient across settings
PURPOSE		
HRM	**MHCM**	**TCN**
This position is responsible for providing case management services for SVMC patients	This position is responsible for providing case management services for patients in a primary care practice	This position is responsible for care coordination across the continuum by maximizing, integrating, and developing resources
ESSENTIAL FUNCTIONS		
HRM	**MHCM**	**TCN**
Assesses patient clinical condition, including but not limited to presenting symptoms, cause for referral/admission, plan of care, etc.	Case manages high-risk and/or complex patients including patients discharged from the hospital and selected patients with emergency department visits	Facilitates patient/resident transitions across the continuum of care, including home visits to assess SDOH-onsite medication management
Assists physicians in determining patient's status or level of care in accordance with InterQual criteria; updates patient record to reflect clinical decision-making and care determinations	Identifies patients at risk for proactive intervention	Communicates with care team patient risk factors, gaps in care, and action plans to mitigate clinical risk factors and support patient shared decision- making

Develops patient discharge plan and provides patient/caregiver education in coordination with patient, family, physician, other members of the healthcare team, payers, and other agencies; plan is entered into Meditech to facilitate communication with involved parties	Performs a comprehensive assessment of the patient's needs including health status and behaviors, level of function, psychosocial situation, and available support systems and determines potential needs from primary care office setting	Identifies high-risk individuals for care transitions; meets them in hospital, medical office, or home
Serves as liaison with third party payers to assure ongoing coverage of hospital benefits; negotiates with third party payers for a post-hospital patient plan of care; communicates and documents outcomes to patient, family, physicians, billing department, and other team members to maximize the effectiveness of a discharge plan	Establishes a plan of care with the primary care physician including the community health team, referrals, and self-management support	Refers high-risk patients to appropriate resources; following home visit coordinates care with PCP and other specialty offices and clinical teams
Issues hospital notices of insurance non-coverage in accordance with CMS and SVMC policies and procedures	Serves as a resource for self-management support	Education of patients, residents, and families in their homes using patient-centered approach
Coordinates patient referrals to outside agencies, including but not limited to home health, nursing homes, other hospitals, etc.	Coordinates patient referrals to outside agencies including but not limited to home health, hospice, long-term care facilities, and behavioral health services	Education of other members of the healthcare team regarding assessment in home setting

Refers patients to a variety of in- house resources including but not limited to nutrition, social work, rehabilitation, diabetes Education, etc.	Refers patients to a variety of resources including but not limited to healthier living workshops, nutrition, social work, rehabilitation, or diabetes education	Development and implementation of clinical protocols across the continuum of care
Identifies and reports actual or potential quality of care issues to SVMC Quality and Patient Safety personnel	Coordinates care with patients transitioning between primary care and home health, nursing care facilities, hospice, and other providers	Education of nursing staff and students across all care settings regarding opportunities for improved care coordination
Actively participates in a variety of organizational development processes including but not limited to Six Sigma, quality improvement, audits, etc. as requested	Provides panel management for selected chronic diseases and health maintenance using the DocSite registry or the physician office's electronic medical record	Direct, telephone, or electronic communication with patients or caregivers after any facility discharge including home visits
Maintains up-to-date and accurate documentation of assessment and planning provided to ensure the effective integration of information for use by the healthcare team to ensure ongoing and continued quality of care, in accordance with evidence-based practice, Vermont State Board of Nursing, and SVMC policies and regulations	Works with the practice staff to assure outreach to patients identified through panel management	Conducts face-to-face visits with complex patients or caregivers after a facility discharge
Analyzes patient care trends and actively seeks out and collaborates with physicians and other providers to improve overall quality and efficiency of care	Works collaboratively with and participates in/ leads the community health team	Participates in and conducts research to advance nursing practice

Continuously seeks opportunities and leads efforts for improving department productivity, efficiency, and quality improvements including but not limited to process improvements, procedure improvements, workflow improvements, equipment advancements, feedback received through staff input, etc.	Maintains timely and accurate documentation of patient assessment, planning, and care provided in the practice's electronic medical record or the medical record to ensure effective integration of information within the practice's care team	Participates and leads quality improvement efforts across the care continuum including development of programs targeting gaps in care coordination
Demonstrates critical thinking for problem-solving, prioritization, etc.	Maintains patient confidentiality and privacy according to state and federal regulations; obtains patient consents as required	Obtains patient consent prior to visiting patient in home setting
Actively participates in multidisciplinary rounds and leads patient care conferences	Maintains timely and accurate documentation in the DocSite Care Coordination log so that daily case management tasks are recorded; runs reports as requested	Participates in the integration of informatics into clinical practice
Pro-actively advocates for patient care issues to ensure that overall quality and type of care are sensitive to each specific patient's/family's needs	Participates in process improvement, NCQA Medical Home recognition survey preparation and compliance, and clinical outcomes improvement. Is a resource on clinical microsystems	Serves on committees/councils/boards as patient advocates across the continuum

Performs other duties as required	Analyzes patient care trends and actively seeks out and collaborates with the practice care team and/or community health team to improve overall quality and efficiency of care	Performs other duties as required
	Demonstrates critical thinking for problem and prioritization	

Actively leads and/or participates in patient care conferences
Serves as a patient advocate for patients and their families
Participates in orientation of new case managers and serves as a role model and mentor
Performs other duties as required

APPENDIX

TRANSITIONAL CARE NURSE ORIENTATION

D1: CNS/TCN Orientation Plan

CLINICAL NURSE SPECIALIST/TRANSITIONAL CARE NURSE ORIENTATION PLAN

CONTINUUM OF CARE

Observation in Medical Practice specific to diagnosis-related role (ex.) COPD CNS would spend time in pulmonary office, Family Practice and Internal Medicine, Heart Failure CNS would be assigned to Cardiology office, Family Practice and Internal Medicine, Diabetes CNS would spend time in Endocrinologist practice, Family Medicine and Internal Medicine. (40 hours)

Plan would include sitting in on MD exams and discussions, meeting and observing office staff roles and interactions with patients and families, meeting held to discuss challenges and opportunities for future collaboration. CNS will review documentation, medication reconciliation practices, and payment structure for reimbursement based on insurance/government payment requirements as well as quality measures and performance. CNS would be looking for learning needs of staff and ideas for future collaboration and teamwork.

(Part of rotation would include time in medical home setting, attending meetings, case reviews, and conferences)

Observation at Center of Living and Rehabilitation specific to diagnosis -related role. Plan would include rounding on all patients with Nurse Practitioner, attending "stand up meeting," family meetings, rounding with social worker, observing admissions and discharges, and assessing potential educational/clinical opportunities for staff. CNS will review documentation system and become familiar with long-term care regulations and payment structure as well as quality measures and performance. Plan includes spending time on subacute unit as well as long term care. Meeting scheduled for CNS group to meet with Director of Nursing, Educator and managers to discuss challenges and potential opportunities for the future by collaboration and teamwork. (40 hours)

Observation at VNA/Hospice specific to diagnosis-related role. Plan would include observations of scheduling of patients, intake, admission and discharge, home visits with variety of caregivers including LNA, RN, hospice team, physical therapist, occupational therapist, and social worker. CNS will review documentation and billing practices and review reimbursement model and home care regulations and payment

structure as well as quality measures and performance. Will also investigate transitions of care following discharge from the hospital and evaluate educational needs of patient, families, and clinical staff in setting. Meeting scheduled with Executive Director, Director of Nursing, and Educator to discuss challenges and opportunities for future collaboration and teamwork. (40 hours)

Observation of Case Manager/Documentation Specialist Role specific to diagnosis-related role. Follow case manager throughout the work day including discharge planning, morning meeting, collaboration with physicians and rest of care team, documentation, queries, review of payment and denial management and chart reviews for documentation.

Review case manager role in quality improvement and assess opportunities for increased collaboration and teamwork. Meeting scheduled with Director, Clinical Leader to discuss challenges and strategies in the future to improve care coordination. (40 hours)

Attend and participate in the Improving Transitions of Care Team Meeting monthly (review literature shared file)

Review the Guide To Measuring the Triple Aim, Population Health, Experience of Care, PerCapita Cost (defined population, data over time, outcome and process measures, benchmark and comparison data.)

Patient Experience—explore the perspectives of individuals interacting with the healthcare system by interviewing re-admissions, frequent ED users, non-compliant patients, high-cost users

Attend Utilization Management meeting and gain understanding of challenges and opportunities

Attend and participate in Blueprint Community Care Team meeting monthly to better understand how it works and possibilities for future collaboration without overlap of service

Research and investigate best practices for care of chronic disease management (Dartmouth Hitchcock or other ACO sites)

Meeting scheduled with Revenue Cycle Manager and Coding supervisor to better understand challenges we face with documentation, reimbursement, denials and write offs; gain clearer understanding of how we are reimbursed now and how it will change in the future

Seek internship with established Care Coordinator to observe role and responsibilities and lessons learned, develop relationships for future collaboration, peer support, and encouragement

Complete learning needs assessment identifying opportunities for development in leadership, collaboration, project management, and teamwork

Identify 33 core measures and consider strategies for implementation, training, and education for staff on population management and safe patient transition

APPENDIX

E

TRANSITIONAL CARE LAUNCH

E1: Initial Transitional Care Nurse Proposal Approved by SVMC

Date: July 31, 2013

To: Strategic Planning Team
From: Billie Lynn Allard, MS, RN
Re: Proposal for Transitional Care Nurse

SUMMARY

Patients with chronic conditions who are unable to adhere to their medical care plan are likely to use hospital and emergency department resources with high frequency. While there are many reasons patients do not cooperate with medical advice, the Transitional Care Nurse program is designed to address that critical period of time right after facility discharge. In this way, the TCN serves as an "extender" of hospital or nursing home services until your patient gets re-established at your primary care office and/or other community-based services.

OBJECTIVES

1. Our primary objective is to ensure that patients follow their plan(s) of care. The period of time following discharge from a health facility can be overwhelming. There may be different medications, modifications to their living space, new routines to daily life, and a psychological adjustment to the illness itself. Any/all of these things challenge the patient's ability to adhere to their care plan. The TCN provides support and assistance during this vulnerable period. In addition, the TCN can provide a "human hand-off' between the personnel at the facility and the medical home—information and insights that might not be readily available in the formal record.

2. A second objective it to reduce the rate of hospital re-admissions. One measure that CMS uses to keep track of "successful" facility discharges is the rate in which patients return to the facility in their first month home. About 10% of Bennington area patients are re-admitted to the hospital within 30 days of discharge. Although this rate is lower than the national average, we believe that a goal of 4% is attainable in our service area. A recent study funded by the Commonwealth Fund outlines six strategies for lowering 30-day re-admission rates (Bradley, et al 2013). They indicate that the strategy most closely associated with reduced admission rates is a strong partnership between the hospital and local healthcare providers. We hope to build that partnership through the Transitional Care Nurse program.

Further, the TCN program is consistent with the goals of the OneCare ACO, which creates the financial incentive to maintain/improve health outcomes while also reducing the costs that are incurred with repeat hospital admissions and emergency room visits (Silow-Carroll and Edwards, 2013).

PROJECT DESCRIPTION

SVMC will make a Transitional Care Nurse (SVMC employee) available to your office practice, should you request this service. The TCN will meet your patient while they are at the hospital or nursing facility and assist with their transition to home. Because this can be a complex and potentially overwhelming transition, your patients benefit by having the skills of an advanced practice nurse there for support during this process. The work of the TCN is focused on navigating the transition, carefully coordinating services with the PCP office staff and other community resources.

Each newly discharged patient will receive, at a minimum, one home visit from a Transitional Care Nurse to ensure that medications are reconciled and other aspects of their care plan are securely in place. Others may stay in contact with that nurse for a longer period of time because their needs are more challenging. The work of the TCN focuses on helping patients gain the skills, knowledge, and confidence in managing their health condition(s).

Primary Care Physician/ Office Case Manager will:

- Identify those patients with chronic disease who you feel are at high-risk for repeat hospital admissions.
- Review key program metrics at specified intervals to ensure that the program is performing as expected and to troubleshoot aspects of the program that are not.
- Provide the professional expertise of the office Case Manager to share information and provide context that will enable the TCN to more effectively guide the patient's care transitions.

The Transitional Care Nurse will:

- Monitor your list of high-risk patients and meet with any patients who are admitted to a nursing home or hospital.

- Assist with discharge planning and then a post-discharge follow-up meeting with your patient.
- Visit patient 24–48 hours post facility discharge to assist with medication reconciliation and offer resources to increase your patient's ability to manage the medication regimen. (medication box, list, instructions for when to call MD)
- Review all discharge instructions with your patient and other key family members and evaluate patient understanding using teachback methods.
- Assure that the patient plans to keep their appointment scheduled follow-up at your office.
- Assure that necessary medical equipment and supplies are delivered and community support resources are in place (e.g., Meals on Wheels, oxygen)
- Arrange for continued contact with your patient, as necessary, to monitor for risk of re admission (phone calls, email, home visits).
- Assess safety of your patients home care setting and provide suggestions for resources that may be helpful, which may include a home visit by physical or occupational therapist.
- For patients who you feel are at high-risk of repeat hospital admissions, but do not have a recent admission, the TCN can conduct a home visit to review the treatment plan and reinforce those things most important to optimize the patient's health and keep them at home.
- Encourage the patient to identify personal goals that may serve as motivation to follow care plan (motivational interviewing)
- Review key program metrics at specified intervals to ensure that the program is performing as expected and to troubleshoot aspects of the program that are not.
- Facilitate care coordination through the sharing of physician care plan with other relevant care-givers, consistent with patient's permission
- Conduct focused nursing assessments, as needed.

OTHER WAYS THE TCNS WILL IMPROVE CARE COORDINATION

Because the TCNs will be guiding care coordination at multiple facilities, and ultimately with the patient's Medical Home, it will be important to standardize forms and materials so that everyone is working with the same basic information. It may become important for the TCNs to engage with other community caregivers in educational activities. Certainly as our participation in the ACO expands, it will be paramount that patient care transitions occur with a minimum of duplicated effort and maximum efficiency.

BUDGET

Southwestern Vermont Health Care currently employs a group of hospital-based Clinical Nurse Specialists. With the advent of payment reforms through the ACO, SVHC wishes to redirect the work of those nurses to a more strategic role. Research has shown that when advanced practice nurses serve as "extenders" of hospital or nursing home care through the transition back to home, there are fewer re-admissions, better overall clinical outcomes and lower costs. In addition, patients and their families report greater satisfaction with their encounter with the healthcare system. TCN "extenders" also reduce some of the burden of managing facility transitions on busy primary care practices (CMS July 2013)

DOCUMENTATION

Transitional Care Nurses document in Meditech. These reports can be viewed through Clinical Review or PCI. Following each TCN encounter, you will automatically receive a printed or faxed copy of the report. Where capability exists, you can receive documentation to your office EMR.

We look forward to hearing from you regarding this proposal and are prepared to begin working with you as soon as the details are arranged.

APPENDIX

F

EXAMPLES OF PATIENT EDUCATION TOOLS CREATED BY INTERDISCIPLINARY TEAM FOCUSED ON CARE COORDINATION FOR COPD

F1: Magnets for Refrigerator (used in hospital, PCP offices, SNF, and home care)

COPD ACTION PLAN

GREEN ZONE

I am doing well today.	ACTIONS
• Usual activity and exercise level • Usual amounts of cough and mucus • Sleep well at night • Appetite is good	• Take daily medications • Use oxygen as prescribed • Continue regular exercise/diet • Avoid cigarette smoke, irritants

YELLOW ZONE

I am having a bad day or a COPD flare.	ACTIONS
• More breathless/coughing than usual • Less energy for daily activities • Increased or thicker mucus • Using quick relief inhaler more often • Ankles more swollen than usual • Feel like have a "chest cold" • Poor sleep • Appetite is not good • Medicine is not helping	• Continue daily medication • Use quick relief inhaler as prescribed • Use oxygen as prescribed • Get plenty of rest • Use pursed lip breathing • Avoid cigarette smoke, irritants • Call your doctor if symptoms don't improve in 48 hours

RED ZONE

I need urgent medical care.	ACTIONS
• Severe shortness of breath even at rest • Not able to do any activity because of shortness of breath • Fever or shaking chills • Feeling confused or very drowsy • Chest pains • Coughing up blood	• Call 911 or seek medical care immediately

Southwestern Vermont Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-367-9559 (TTY: 1-866-237-0174, option 1 then client code 05201).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-367-9559 (TTY: 1-866-237-0174, option 1 then client code 05201).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-9559 (ATS : 1-866-237-0174, option 1 then client code 05201).

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Southwestern Vermont MEDICAL CENTER

APPENDIX

STRUCTURE TO MAXIMIZE EFFICIENCY FOR ID ROUNDS HELD DAILY AT 9 A.M. TO REVIEW ALL INPATIENTS IN MED SURG, ICU

G1: Interdisciplinary Rounds Script

Clinical Coordinator

Name

Room #

Code Status

Level of Care (ICU Pts Only)

MD

DX

TX Plan

D/C Date

RN

Pt/Family/RN Concern

Interventions Needing MD Order

D/C Barriers

CM

Status

Post D/C Plan

Pharmacy

# of Days on Antibiotic Therapy

# of Days Anticipated Duration for Antibiotic Rx

Clinical Coordinator

A P P E N D I X

BROCHURES FOR TRANSITIONAL CARE PROGRAM

H1: Transitional Care Nursing Team

H2: Clinical Pharmacy Team

Transitional Care Team

Barbara Richardson, MS, RN-BC, CCRN
Clinical Nurse Specialist
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Karen Coppin, MSN, RN, CCRN
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Transitional Care Social Worker
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A transitional care program helps adults with chronic conditions safely return home from a hospital or nursing home.

SVMC's Transitional Care Program

Helping adults with chronic illness return home safely

Southwestern Vermont Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Rev. 020518

SOUTHWESTERN VERMONT MEDICAL CENTER

What is a transitional care program?

This program is for adults with chronic illnesses or health risks. It helps them safely return home from a hospital or nursing home by:

- Helping patients, their families, and caregivers learn how to manage chronic disease at home.
- Helping patients safely move from one care setting to another, such as hospital to home.
- Checking in to monitor the patient's health.
- Assisting with communication between one care provider and another.

Your Primary Care Provider leads and directs your care. He or she works with a team of health care professionals that includes pharmacists, social workers, case managers, respiratory therapists, and specialist physicians.

The team also includes Transitional Care Nurses. These nurses have special training to care for adults with chronic illness. They help you take charge of your chronic disease and medication plan.

How does the program work?

The Transitional Care Program lasts up to three months. It is free. It will not interfere with other services you receive. A transitional care nurse will:

- Visit you in the hospital or nursing home to help you get ready to go home.
- May meet you at a physician's or specialist's office visit after your discharge.
- Visit you at home to help you understand your medicines and learn more about managing your chronic disease.
- Phone you periodically to find out how you are doing and answer questions or concerns.

What can you expect?

The transitional care nurse may:

- Help you set goals for your health and work with you and the rest of the team to find ways to meet those goals.
- Help you and your family understand your chronic illness, how to manage it, and when to call for help.
- Review discharge instructions you receive after being in the hospital.
- Review your medication list for any changes and help you understand why you are taking the medicines and what side effects to watch for.
- Listen to your heart and lungs and examine your legs for swelling.

How can you help?

- Work with the transitional care nurse to make the changes you need to better manage your disease.
- Learn to recognize what your symptoms mean and what to do when they occur.
- Keep appointments with your doctor.
- Take your medicines as directed.

Patient and Family Benefits:

- The transitional care nurse will work with you no matter what setting you are in.
- The transitional care nurse will help you and your family develop a realistic plan of care.
- The transitional care nurse can help make sure you and your doctor understand each other.
- Transitional care can help you avoid needing hospital care for a chronic disease.
- Transitional care can connect you with a social worker, who will help you meet your social and economic needs.

What Patients Say

"I live alone and felt relieved knowing that a professional person was checking in on me regularly."

"Outstanding service was a needed and appreciated blessing…"

"Transitional Care has empowered me to deal with this new and serious illness…"

"Wonderful service at no cost to patients."

Transitional Care Clinical Pharmacist Team

Frank Rickus, RPh
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Frank.Rickus@svhealthcare.org

Joanne Race, RPh
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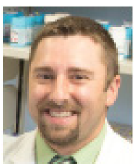
Michelle Lester, RPh
Phone: 802-447-5159
Michelle.Lester@svhealthcare.org



Jeffrey Post, RPh
Phone: 802-447-5159
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SVMC's Transitional Care Program

Clinical Pharmacists: Helping adults understand and manage their medications

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APPENDIX

TRANSITIONS OF CARE ANNUAL REPORTS

Share with team to celebrate successes and expand program

Share with providers to expand referrals

Share with executive team to demonstrate success

I1: 2017 Annual Report

I2: 2018 Annual Report

Transitional Care Nursing (TCN)

Calendar Year 2017 Annual Report

Target Population: Patients with chronic diseases who express an interest in self-management.

Primary Goal: Improve chronic disease management, increase independence, and reduce hospitalizations.

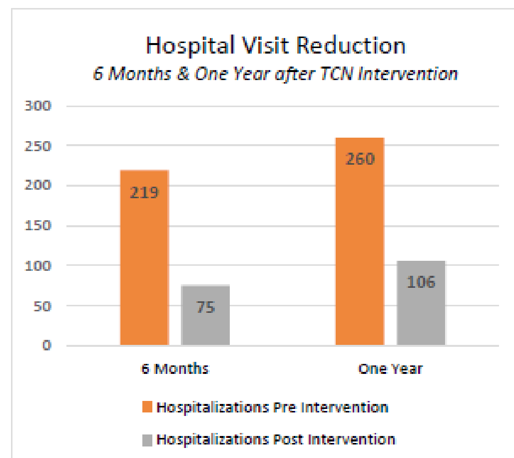
Team Members: Barb Richardson, CNS RN; Karen Coppin, CNS RN; & Kathy Brandi, CNS RN

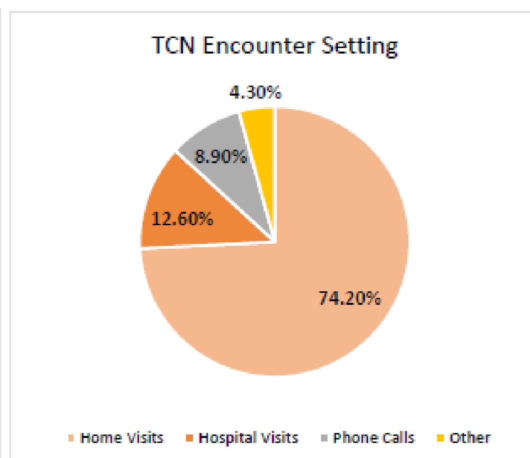
Summary: The Transitional Care Nursing (TCN) program is founded on partnership with the patient and the primary care provider. This triad seeks to foster a collaborative method to chronic disease management utilizing a multifaceted approach. Home visits coupled with the expert knowledge of the TCNs allows for a holistic and complete picture of the patient situation to be painted. The TCNs then create individualized care plans, communicate directly with primary care providers, and partner with patients to set realistic and attainable health goals.

Patients Served	*Number of Encounters*	*Number of Discharges*	*% patients with 3+ risk factors*	*Gender Mix*	
231	1,478	179	68.8%	Male 47.2%	Female 52.8%

Payer Mix					*% of Patients who met Criteria for TCN Services*	*States Served*		
BCBS 5.6%	Champus 0.9%	Medicaid 7.8%	Medicare 80.5%	Other 10%	93.3%	MA 1.7%	VT 77.1%	NY 21.2%

Average Visit Time (mins)	*Median Travel Time (mins)*	*Median Mileage*	*Primary Referral Source*	*Top 3 Referral Reasons*		
59	20	11.1	Interdisciplinary Rounds 52.9% of referrals	Chronic Disease Education	Discharge Follow up	Medication Concern





65.8% Reduction in INPT/OBS Visits at 6 months & 59.2% reduction in INPT/OBS Visits at 1 year

Transitional Care Nursing (TCN)

Calendar Year 2018 Annual Report

Target Population: Patients with chronic diseases who express an interest in self-management.

Primary Goal: Improve chronic disease management, increase independence, and reduce hospitalizations.

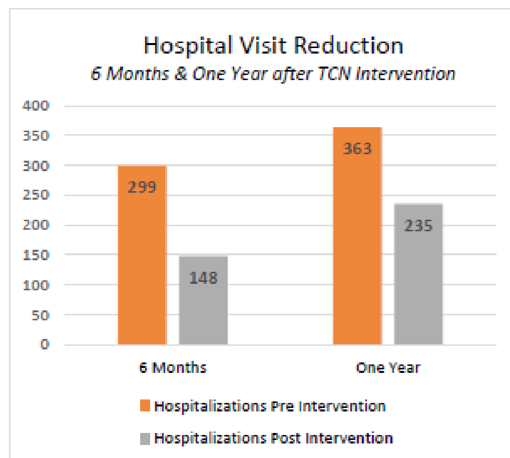
Team Members: Barb Richardson, CNS RN; Karen Coppin, CNS RN; & Kathy Brandi, CNS RN

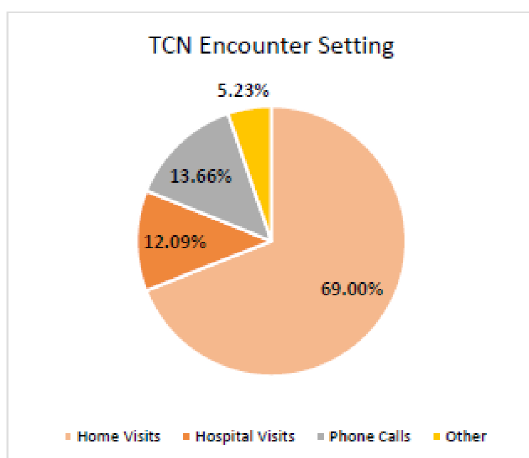
Summary: The Transitional Care Nursing (TCN) program is founded on partnership with the patient and the primary care provider. This triad seeks to foster a collaborative method to chronic disease management utilizing a multifaceted approach. Home visits coupled with the expert knowledge of the TCNs allows for a holistic and complete picture of the patient situation to be painted. The TCNs then create individualized care plans, communicate directly with primary care providers, and partner with patients to set realistic and attainable health goals.

Patients Served	*Number of Encounters*	*Number of Discharges*	*% patients with 3+ risk factors*	*Gender Mix*	
335	1910	258	66.9 %	Male 41.2%	Female 58.8%

Payer Mix					*% of Patients who met Criteria for TCN Services*	*States Served*		
BCBS 6.9%	Champus 2%	Medicaid 7.8%	Medicare 79.1%	Other 7.5%	99.5%	MA 2.7%	VT 70.7%	NY 26.2%

Average Visit Time (mins)	*Median Travel Time (mins)*	*Median Mileage*	*Primary Referral Source*	*Top 3 Referral Reasons*		
56	29	9.9	Interdisciplinary Rounds 55.3% of Referrals	Discharge Follow Up	Chronic Disease Education	Medication Concern





50.5% Reduction in INPT/OBS Visits at 6 months & 35.27% reduction in INPT/OBS Visits at 1 year

APPENDIX

COMMUNITY CARE TEAM ANNUAL REPORTS

Share with team to celebrate successes and expand program

Share with providers to expand referrals

Share with executive team to demonstrate success

J1: 2017 Annual Report

J2: 2018 Annual Report

Community Care Team (CCT)

Calendar Year 2017 Annual Report

Target Population: Clients aged 18+ with substance use and mental health disorders.

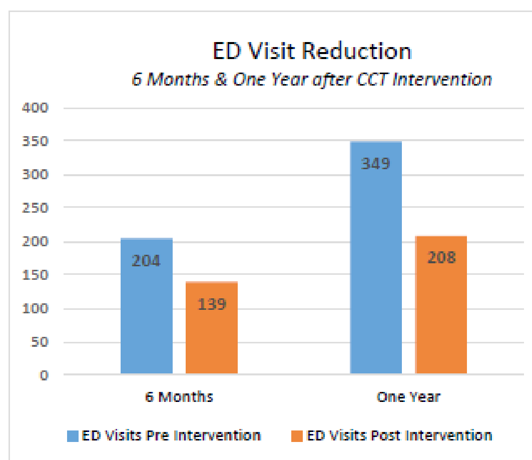
Primary Goal: Reduce Emergency Department utilization, improve access to primary care and increase community resource referrals.

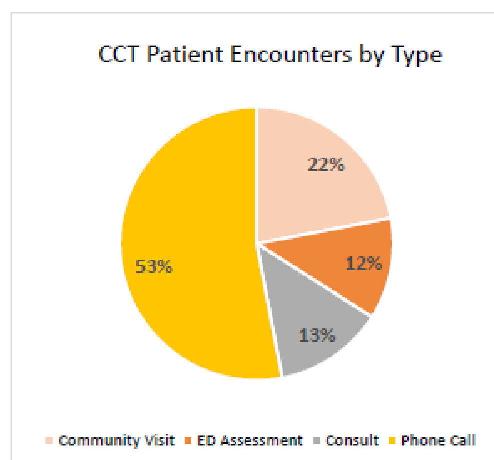
Team Members: Kim Warren, Health Care Advocate

Summary: The Community Care Team (CCT) is an interdisciplinary team of agencies and individuals from within the organization and throughout the community. Their aim is to collaboratively create care plans for patients with substance use and mental health disorders that facilitate growth, independence, and stability while reducing unnecessary utilization of the Emergency Department. Monthly team meetings in conjunction with one on one support from the Health Care Advocate (HCA), who is embedded in ED forty hours per week, fosters shared success and improved client outcomes.

Patients Served	*Number of Encounters*	*Average Age of Patient*	*Gender Mix*		*States Served*	
76	696	43	Male 37.5%	Female 62.5%	MA: 2.2%	VT: 97.8%
Payer Mix						
Blue Cross 2.2%	Champus 2.2%	Medicaid 30.4%	Medicare 32.6%		Other 32.6%	

Age Range	*19 - 30*	*31 - 40*	*41 - 50*	*51 - 60*	*61+*
# of Patients	19	17	16	10	14





31.9% reduction in ED visits at 6 months & **39.8%** reduction in ED visits at one year

Community Care Team (CCT)

Calendar Year 2018 Annual Report

Target Population: Clients aged 18+ with substance use and mental health disorders.

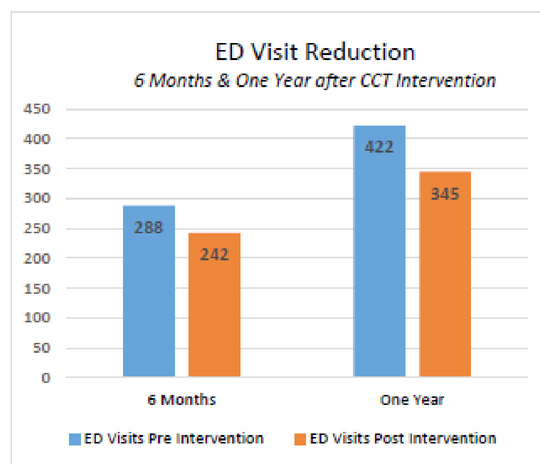
Primary Goal: Reduce Emergency Department utilization, improve access to primary care and increase community resource referrals.

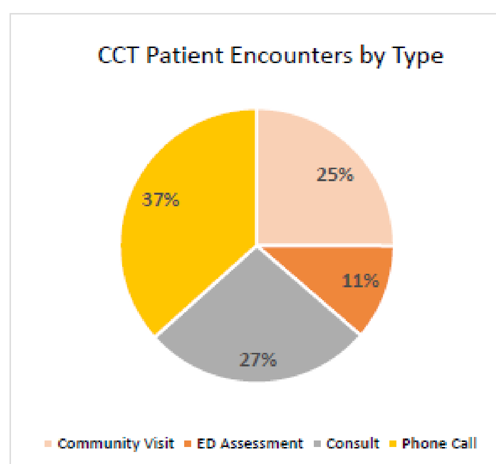
Team Members: Kim Warren, Health Care Advocate

Summary: The Community Care Team (CCT) is an interdisciplinary team of agencies and individuals from within the organization and throughout the community. Their aim is to collaboratively create care plans for patients with substance use and mental health disorders that facilitate growth, independence, and stability while reducing unnecessary utilization of the Emergency Department. Monthly team meetings in conjunction with one on one support from the Health Care Advocate (HCA), who is embedded in ED forty hours per week, fosters shared success and improved client outcomes.

Patients Served	*Number of Encounters*	*Average Age of Patient*	*Gender Mix*		*States Served*		
134	1102	42	Male 46.5%	Female 53.5%	NY: 2%	MA: 1%	VT: 97%
Payer Mix							
Blue Cross 5.1%	Champus 1.0%	Medicaid 37.4%	Medicare 29.3%		Other 27.3%		

Age Range	*10 - 30*	*31 - 40*	*41 - 50*	*51 - 60*	*61+*
# of Patients	35	33	28	16	22





16.0% reduction in ED visits at 6 months & 18.2 % reduction in ED visits at one year

APPENDIX

K

COMMUNITY CARE TEAM

K1: Poster Presentation

Community Care Team: A Hospital-Community Partnership to Serve the At-Risk Behavioral Health Population of Bennington County, VT

BACKGROUND

- Increasing numbers of behavioral health patients in the ED that:
  - ✓ have no primary care connections,
  - ✓ lack adequate social networks,
  - ✓ have poor post-discharge treatment adherence,
  - ✓ rarely obtain follow-up services.
- Because they ultimately use the ED as their "home," these patients:
  - ✓ overwhelm the ED's capacity to care for all patients,
  - ✓ lead to ED overcrowding,
  - ✓ decrease safety and lead to poor care coordination,
  - ✓ lead to financial losses.
- Psycho-social problems are community problems. No one entity alone can effectively improve outcome for this population.
- There is a need for someone to work closely with ED providers, nursing and community agencies to coordinate services for these patients.

SOLUTION

- Hire a Health Promotion Advocate to lead a Community Care Team
- Program will reduce unnecessary utilization of Emergency Department and Inpatient Services by behavioral health patients with non-emergent, medical, behavioral and/or social needs
- This program will also develop patient-centered care and improve outcomes by developing wrap-around services through multi-agency partnerships and care planning

HEALTH PROMOTION ADVOCATE

- One year grant-funded position (VHCIP)
- 40-hour position (ED is the Home Base)
- Care coordination and case management
- Direct and indirect referrals
- Works closely with ED providers and nurses
- Resource to connect with community agencies
- Coordinating the Monthly Community Care Team Meeting

PROGRAM DEVELOPMENT

- Assemble Team
- Implement a Health Promotion Advocate
- Identify patients
- Develop a release of information
- Schedule monthly meetings to present patients to community agencies
- Share pertinent information/updates
- Implement plan of care

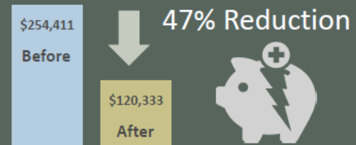
COMMUNITY PARTNERSHIPS

- Community Housing Services
- Addiction and Behavioral Health Resources
- Family Support Services
- Vocational Training
- State Human Services Departments
- State Health Departments
- Outpatient Hospital Services
- Emergency Transport Services

ANALYSIS AND RESULTS

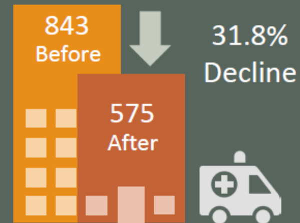
Decreasing Healthcare Cost

- For 23 patients, we tracked their total visit cost for 6 months pre and post intervention



Non-Emergent Hospital Visits

- 167 patients have engaged with CCT from 2016 – 2018. We track their ED utilization pre and post CCT intervention.
- Looking 6 months before the intervention CCT clients had 843 ED visits and in the 6 months after CCT intervention 575 visits.
- Pre-intervention clients averaged 5 visits to the ED and after CCT intervention they averaged 3.4 visits to the ED



APPENDIX

PEDIATRIC COMMUNITY CARE TEAM ANNUAL REPORT

L1: 2018–2019 Annual Report

Pediatric Community Care Team (PCCT)

Calendar Years 2018 & 2019 Annual Report

Target Population: Clients age 0+ with complex care coordination needs due to medical diagnoses, social determinants of health, or parents and guardians with substance use and mental health disorders.

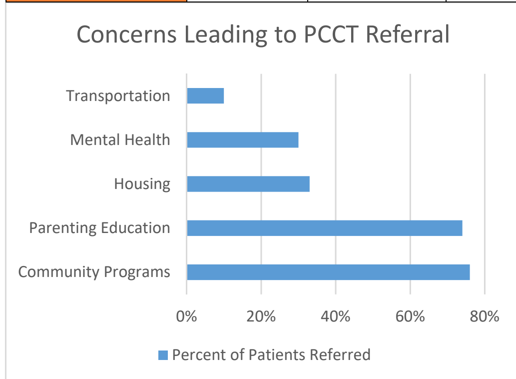
Primary Goal: To improve care coordination, strengthen relationships with primary care teams, and increase community resource referrals.

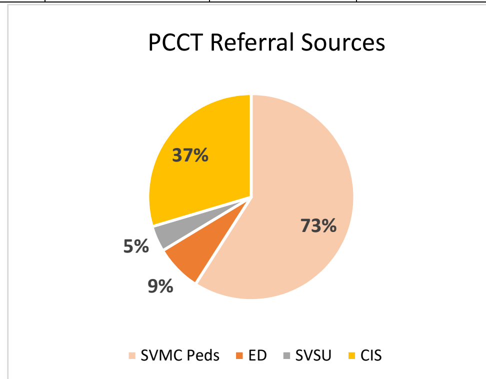
Team Members: Melissa Delmolino, Social Worker

Summary: The Pediatric Community Care Team (PCCT) is an interdisciplinary team of agencies and individuals from within the organization and throughout the community. Their aim is to collaboratively create care plans for pediatric patients with complex care coordination needs due to medical diagnoses, social determinants of health, or parents and guardians with substance use and mental health disorders. This program facilitates growth, independence, and stability while reducing utilization of health care services. Monthly team meetings in conjunction with one on one support from the Health Care Advocate (HCA) provide partnership to attain shared success and improve client outcomes.

Patients Served	*Number of Encounters*	*Average Age of Patient*	*Gender Mix*		*States Served*	
92	619	7	Male 48.7%	Female 51.3%	NY: 6.67%	VT: 93.3%
Average Visit Length	**Average # of Services at Program Start**	**Average # of Service After Program Involvement**	**Percentage of Patients Connected with Services After Program Involvement**		**Parental Involvement**	
45 minutes	3	4	87%		Single: 57%	Dual: 43%

Age Range	*< 1*	*1 - 3*	*4 -10*	*11 - 18*	*19 - 25*	*26+*
# of Patients	15	45	49	30	8	3





(Data run 5/1/18 – 12/4/19)

APPENDIX

PULMONARY REHABILITATION ANNUAL REPORTS

Share with team to celebrate successes and expand program

Share with providers to expand referrals

Share with executive team to demonstrate success

M1: 2017 Annual Report

M2: 2018 Annual Report

Pulmonary Rehabilitation

Calendar Year 2017 Annual Report

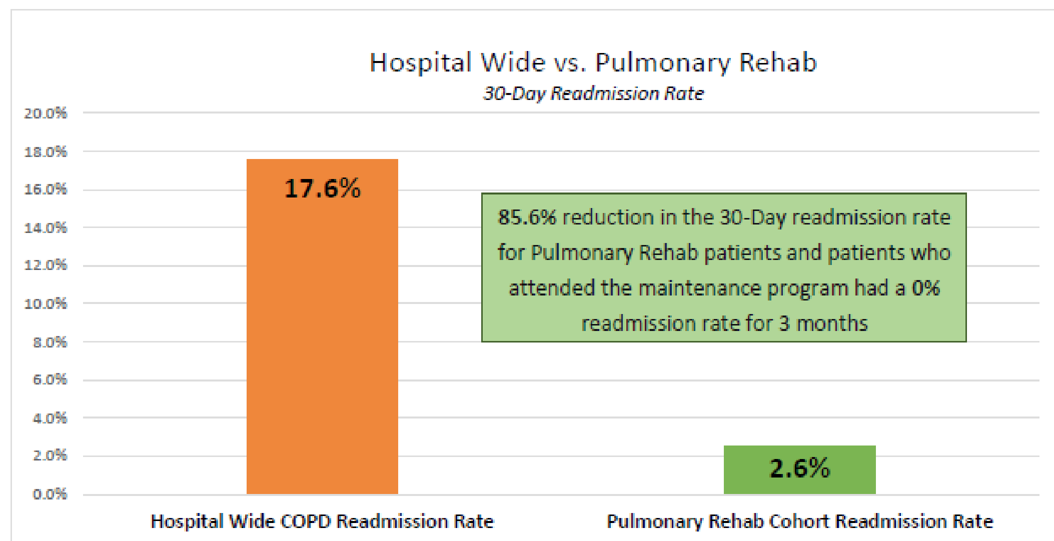
Target Population: Patients with breathing issues that are impacting their daily life. COPD is the primary diagnosis but any lung disease can apply (lung cancer, cystic fibrosis, asthma, pulmonary fibrosis, bronchiectasis, etc.) as long as the lung condition is impacting their function.

Primary Goal: Improve quality of life, maintain functionality, and utilize self-management techniques.

Team Members: Caitlyn Boyd, DPT & John Gottung, RT

Summary: Pulmonary Rehab is the Gold Standard in treatment along with medications for moderate to very severe COPD. Patients with lung disease most commonly experience shortness of breath with walking, stairs, or basic ADL's like dressing. Patients who are currently smoking and unwilling to quit cannot participate. If they are smoking but willing to establish a quit plan, or have already started the process, they can attend. Patients engage in exercise and behavior change during the program and can attend a maintenance group once they graduate the program.

Patients Served	*Improved Functionality & Quality of Life*
33	85% of patients reported significantly improved endurance per *Six Minute Walk Test*
Program Completion Rate	75% of patients reported significantly improved quality of life per *St. George's Respiratory Questionnaire*
60%	45% of patients reported significantly improved shortness of breath per *UCSD Shortness of Breath Questionnaire*



Pulmonary Rehabilitation

Calendar Year 2018 Annual Report

Target Population: Patients with breathing issues that are impacting their daily life. COPD is the primary diagnosis but any lung disease can apply (lung cancer, cystic fibrosis, asthma, pulmonary fibrosis, bronchiectasis, etc.) as long as the lung condition is impacting their function.

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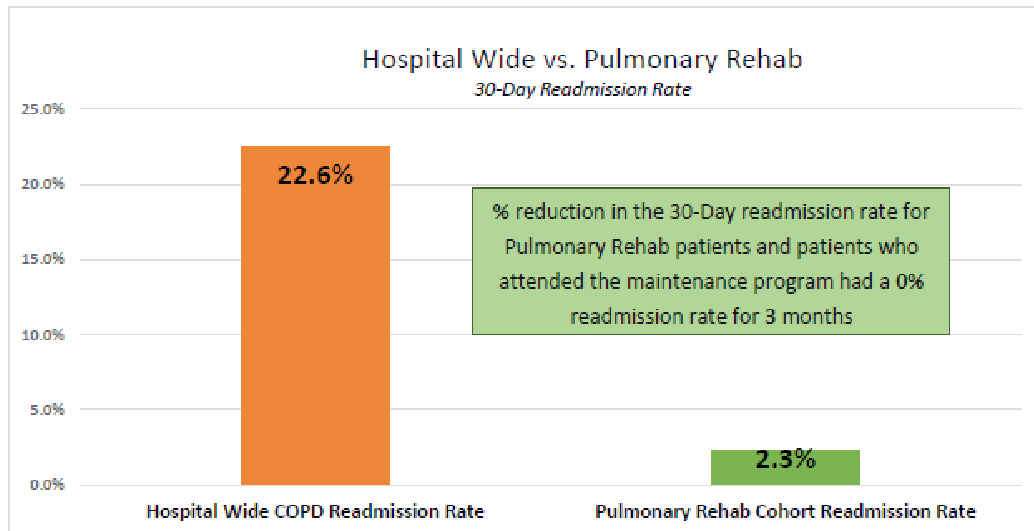
Patients Served	*Improved Functionality & Quality of Life*
48	**58.62%** of patients reported significantly improved endurance per *Six Minute Walk Test*
Program Completion Rate	**55.17%** of patients reported significantly improved quality of life per *St. George's Respiratory Questionnaire*
60.42%	**48.28%** of patients reported significantly improved shortness of breath per *UCSD Shortness of Breath Questionnaire*



APPENDIX

N

DIABETES EDUCATION ANNUAL REPORTS

Share with team to celebrate successes and expand program

Share with providers to expand referrals

Share with executive team to demonstrate success

Useful for posters, podium presentations, and article publications

N1: 2017 Annual Report

N2: 2018 Annual Report

Integrated Diabetes Education (IDE)

Calendar Year 2017 Annual Report

Target Population: Patients with pre-diabetes, type 1, type 1.5, type 2, and gestational diabetes.

Primary Goal: Improve management of diabetes, decrease A1C levels, and foster self-management techniques.

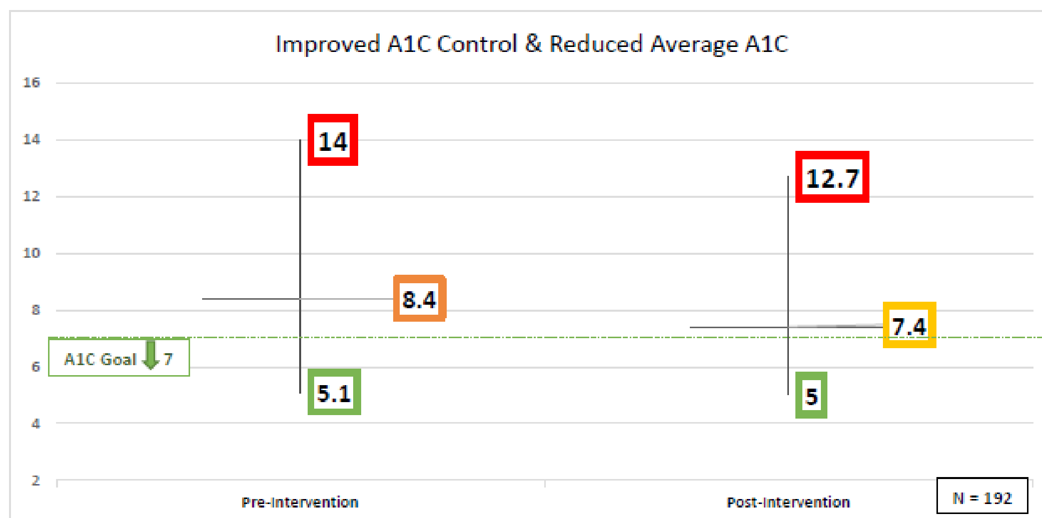
Team Members: Paula Haytko, CDE RN

Summary: The Integrated Diabetes Education (IDE) program allows the Certified Diabetes Educator (CDE) to partner with patients over time to either prevent or manage diabetes. The CDE is able to meet newly diagnosed diabetics in the hospital, has one-on-one schedule appointments in their office, and meets patients within primary care practices as well. This three pronged approach to the prevention and management of diabetes increases access for patient and demonstrates that they are able to better manage their diabetes, make informed food choices, and feel successful.

Patients Served	*Number of Encounters*	*Average Visits per Patient*	*Average Visit Time (mins)*	*Average Pre A1C*	*Average Post A1C*
300	628	2.3	57.4	8.3	7.5

Payer Mix				*Gender Mix*		*States Served*		
BCBS	Medicaid	Medicare	Other	Male	Female	MA	VT	NY
16.5%	14.7%	40.1%	28.7%	41.2%	58.8%	7%	68.4%	24.6%

Diabetes by Type					*Visits by Location*				
GDM	Pre-Diabetic	Type 1	Type 1.5	Type 2	Phone Consult	Inpatient	Nursing Home	Primary Care	Diabetes Office
4.2%	14.9%	8%	2.8%	70.2%	0.4%	10.2%	5.8%	30.1%	53.5%



11.9% Reduction in average A1C post Integrated Diabetes Education intervention

Integrated Diabetes Education (IDE)

Calendar Year 2018 Annual Report

Target Population: Patients with pre-diabetes, type 1, type 1.5, type 2, and gestational diabetes.

Primary Goal: Improve management of diabetes, decrease A1C levels, and foster self-management techniques.

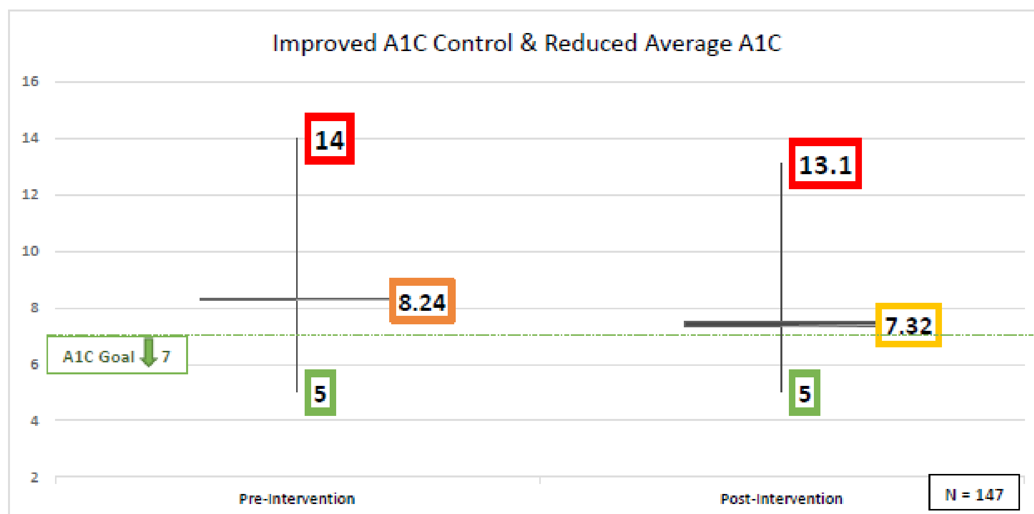
Team Members: Paula Haytko, CDE RN

Summary: The Integrated Diabetes Education (IDE) program allows the Certified Diabetes Educator (CDE) to partner with patients over time to either prevent or manage diabetes. The CDE is able to meet newly diagnosed diabetics in the hospital, has one-on-one schedule appointments in their office, and meets patients within primary care practices as well. This three pronged approach to the prevention and management of diabetes increases access for patient and demonstrates that they are able to better manage their diabetes, make informed food choices, and feel successful.

Patients Served	*Number of Encounters*	*Average Visits per Patient*	*Average Visit Time (mins)*	*Average Pre A1C*	*Average Post A1C*
503	1179	2.3	135.11	8.42	7.19

Payer Mix				*Gender Mix*		*States Served*		
BCBS	Medicaid	Medicare	Other	Male	Female	MA	VT	NY
19.1%	18%	30.9%	28.7%	44.4%	55.6%	4.56%	66.8%	27.8%

Diabetes by Type					*Visits by Location*				
GDM	Pre-Diabetic	Type 1	Type 1.5	Type 2	Phone Consult	Inpatient	Nursing Home	Primary Care	Diabetes Office
6.88%	11.19%	6.70%	.73%	74.5%	3.9%	8.13%	.51%	48%	38.7%



13.18% Reduction in average A1C post Integrated Diabetes Education intervention

APPENDIX

MEDICATION THERAPY MANAGEMENT ANNUAL REPORT

Share with team to celebrate successes and expand program

Advocacy for increased funding

Share with executive team to demonstrate success

Useful for posters, podium presentations, and article publications

O1: 2017 Annual Report

Medication Therapy Management (MTM)

Calendar Year 2017 Annual Report

Target Population: Patients with polypharmacy and complex medication regimes in both the inpatient and primary care practice setting.

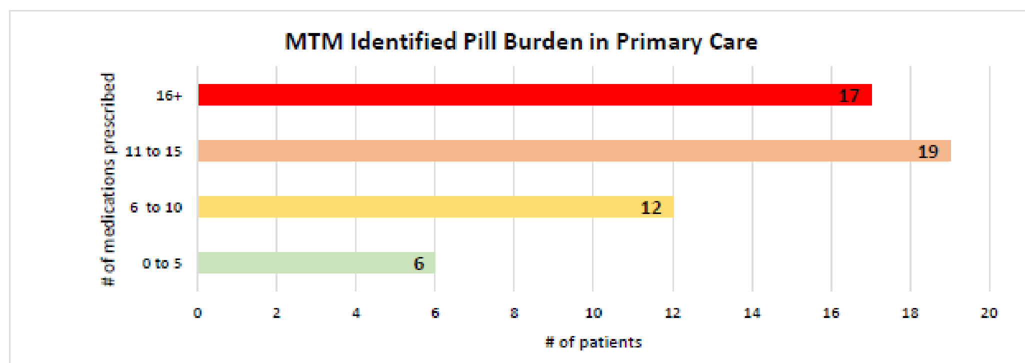
Primary Goal: Decrease pill burden, improve medication adherence, and increase patient knowledge and medication self-management skills.

Team Members: Frank Rickus, RPh; Michelle Lester, RPh, Joanne Race, RPh; & Jeff Post, RPh

Summary: The Medication Therapy Management (MTM) program is designed to empower patients to better manage their medications. The MTM program is comprised of medication therapy review (MTR), completion of a personal medication record (PMR), and creation of a medication-related action plan (MAP). The MTM pharmacists then present their interventions to providers for review. The program has recently expanded into a primary care practice with an MTM pharmacists embedded throughout the week completing comprehensive medication reviews.

Inpatient MTM Data						
Inpatients Served	*Number of Encounters*	*Face to Face Encounters*	*Average length of Face to Face visit*	*Inpatient Visit Types*		
1, 415	1,930	267	16 minutes	Antibiotic Review 73%	Clinical Care 23%	Other 4%

Primary Care MTM Pilot Spring 2018 Data						
Average Number of Chronic Conditions		*Average Number of Medications*	*Average Age*	*% of Patients with Medication Related Problem*		*Average Visit Time (mins)*
3		13	70	66.1%		18
Gender Mix		*# of Encounters*	*Medication Related Problem Types*			
Male 47%	Female 43%	185	Therapy Change Required 78.6%	Dose/Drug Error 12.5%	Nonadherence 8.9%	



APPENDIX

P

YOUTH SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT (YSBIRT) AGE 12–24 YEARS

P1: Data for First Three Months

P2: Data for First Six Months

AMONG YOUTH UNDER 18

		No	Low	Mod	Severe	Total
CRAFFT	YTD	109	21	9	4	143
	Aug	33	8	1	0	42
Nicotine	YTD	111	18	3	10	142
	Aug	38	3	1	0	42
Alcohol	YTD	115	24	3	0	142
	Aug	36	6	0	0	42
Marijuana	YTD	115	9	3	15	142
	Aug	37	2	1	2	42
Other drugs	YTD	138	0	0	4	142
	Aug	42	0	0	0	42

		No	Yes	No %	Yes %	Total
ANY AOD Risk	YTD	92	50	65%	35%	142
	Aug	28	14	67%	33%	42

***6 of those with AOD Risk were Nicotine ONLY.**

Of those with AOD Risk, Interventions delivered:	
Brief Intervention	19
Brief Treatment	1
Referral to Treatment	0

Of those with Nicotine Risk, Interventions delivered:	
Brief Intervention	21
Monitor by Provider	3
Other	6

		No to Minimal	Low	Mod	Severe	Total
Depression	YTD	109	9	12	12	142
	Aug	37	1	2	2	42
Anxiety	YTD	106	9	12	10	137
	Aug	34	1	4	3	42

Note: 22 of 142 (15%) youth screened endorsed suicidal thinking.

Of those with Depression Risk, Interventions delivered:	
Brief Intervention	37
Referral to Treatment	2
On Site Medication	6
Monitor by Provider	26
Other	21

Of those with Anxiety Risk, Interventions delivered:	
Brief Intervention	25
Referral to Treatment	2
On Site Medication	4
Monitor by Provider	23
Other	17

ID Questions that need to be resolved					
clientid	**site**	**Screen Date**	**DOB Month**	**DOB Year**	**age**
g05000000000091	symc	2019/07/	10	2003	15

AMONG YOUNG ADULTS AGES 18 TO 24

		No	Low	Mod	Severe	Total
Alcohol	YTD	42	11	1	0	54
	Aug	16	3	0	0	19
Marijuana	YTD	26	12	0	16	54
	Aug	10	7	0	2	19
Other drugs	YTD	38	11	4	1	54
	Aug	17	2	0	0	19

***Marijuana is positive if frequency is weekly or greater; no CIS used. Low is less than weekly use, Moderate is weekly use, Severe is near daily or daily use.**

		No	Yes	No %	Yes %	Total
ANY AOD Risk	YTD	31	23	57%	43%	54
	Aug	14	5	74%	26%	19

Of those with AOD Risk, Interventions delivered:	
Brief Intervention	16
Brief Treatment	0
Referral to Treatment	0

Of those with Nicotine Risk, Interventions delivered:	
Brief Intervention	13
Monitor by Provider	0
Other	5

		No to Minimal	Low	Mod	Severe	Total
Depression	YTD	39	3	5	7	54
	Aug	14	0	2	3	19
Anxiety	YTD	31	7	10	6	54
	Aug	12	1	6	0	19

Note: 6 of 54 (11%) screened endorsed suicidal thinking. All in August.

Of those with Depression Risk, Interventions delivered:	
Brief Intervention	17
Referral to Treatment	2
On Site Medication	2
Monitor by Provider	16
Other	12

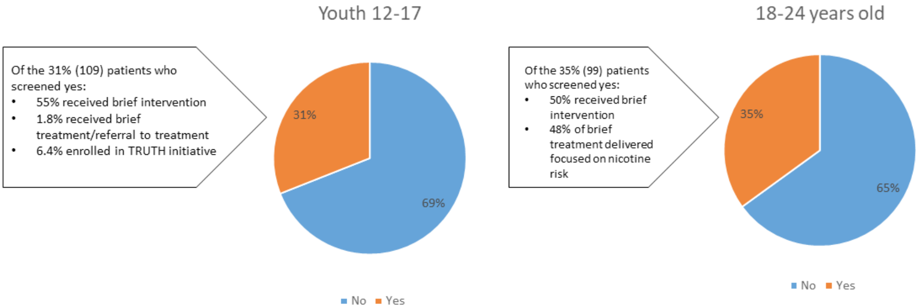
Of those with Anxiety Risk, Interventions delivered:	
Brief Intervention	13
Referral to Treatment	2
On Site Medication	0
Monitor by Provider	14
Other	12

YSBIRT- May 2019 to November 2019 results

- 454 individuals screened
- High rate of depression/anxiety
- 14% suicidal thinking (some to ED for evaluation)
- Few homicidal thoughts
- Providers appreciative of support in office

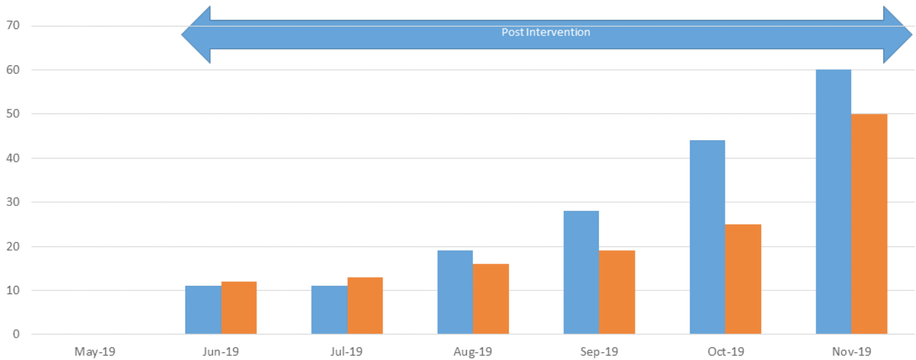
Screening for Alcohol and Other Drug Use

May 2019- November 2019



YSBIRT- Brief Interventions for Alcohol and Other Drug Risk

May 2019 – November 2019

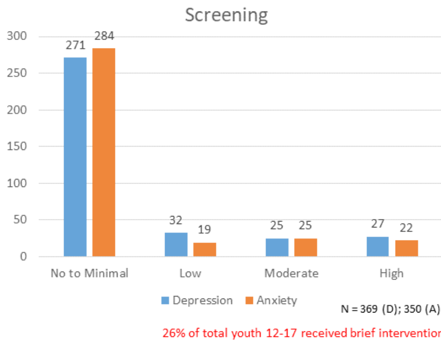


Screening for Anxiety and Depression

May 2019 - November 2019

Approximately 14% of patients between 12-24 endorsed suicidal ideation at least several days over the past 2 weeks

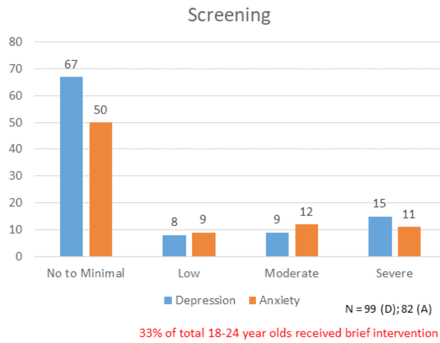
Youth 12-17



N = 369 (D); 350 (A)

26% of total youth 12-17 received brief intervention

18-24 year olds

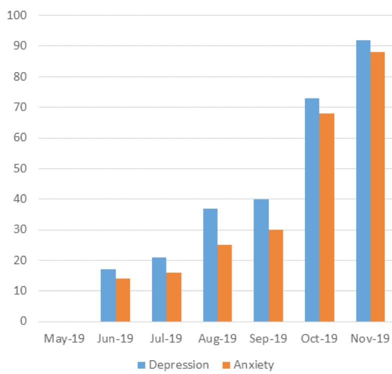


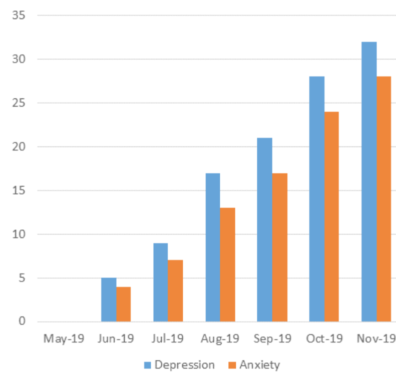
N = 99 (D); 82 (A)

33% of total 18-24 year olds received brief intervention

YSBIRT- Brief Interventions for Depression and Anxiety

May 2019 – November 2019





APPENDIX

PEDIATRIC COMMUNITY CARE TEAM

Strategy for success in creation of innovative projects requiring buy-in from administration, providers, clinical team, staff, and patients

Q1: Pediatric Community Care Team Charter

CHARTER FOR PEDIATRIC COMMUNITY CARE TEAM

PROBLEM/OPPORTUNITY STATEMENT

An interdisciplinary team is being formed to review high-risk children in the Bennington service area, sharing pertinent information with other team members and strategizing how we can best help and support them. An integrated care plan will be developed by the interdisciplinary team and will be documented in Care Navigator viewable by all members of the care team.

BUSINESS CASE

On January 1st, 2018, SVMC and other members of the OneCare ACO entered into an agreement with Medicaid where funds will be available for care of Medicaid patients based on prior year's data. If care of this population costs more than the allocated funds, SVMC will be responsible with a cap of maximum $500,000 loss before the hospital would have to pay out more. The hospital, primary care providers, council on aging, home care agencies and united counseling will receive funds (see attachment) and authorized lead care coordinators will receive funds monthly based on pre-arranged agreements. In order to receive payment, services must be rendered that improve the patient experience, meet or exceed quality outcomes and at or equal to previous costs. Teams are encouraged to consider share resources and increase communication and collaboration.

PROJECT SCOPE

Of the 3,716 Medicaid patients that we are responsible for, 54% are under age 20. Our plan is to create two teams, one for 0–6 year olds and one for 7–19 year olds. Our focus will be on the high and very high-risk cases identified by the Johns Hopkins scale deployed by One Care ACO. Level s can be adjusted based on updated information and knowledge by care providers. Our goal will be to review all 89 children in the high and very high category, create an integrated care plan and document it in Care Navigator. A "lead care coordinator" will be identified and will be responsible to periodically update the plan.

GOAL/METRIC

To review each high and very high-risk Medicaid child's case at the pediatric community care team composed of representatives across the spectrum of care providers that could assist this patient/family unit over the next three to six months.

Over the 12-month period, all high and very high-risk patients will have a care plan documented and updated in care navigator.

MEASURE DESCRIPTION

After each meeting, assign responsibilities to team members and need for further outreach to other sources of support/care.

Report to Bennington Community Collaborative a summary of monthly data and share any barriers to success or lack of available resources.

MAJOR MILESTONES

Milestone	Date
Create pediatric community care team for 0–6 years old and finalize charter	March 2017
Create pediatric community care team for age 7–19 years old and finalize charter	March 2017
Find solution to share information at meeting (consent, governor decree)	April 2017
Recruit and Hire pediatric health promotion advocate	April 2017
Convene monthly meeting with stakeholders (first meeting is orientation)	May/June 2017
Assess need for more training on care navigator	Ongoing
Begin data collection/ report to BCC/EMT	July 2017
Assess gaps in resources, care coordination, plan for improvement	July/August

TEAM LEADERSHIP

Project Lead: Billie Lynn Allard, MS, RN

Project C0-lead: Pediatric Health Promotion Advocate (Melissa Delmolino)

Team Members: Children's integrated Services team, Local interagency Team

(Steering team: Billie Lynn Allard, MS (PMG Clinical services), RN, Kelly Belville (CIS supervisor), Jennie Moon (Early Intervention Coordinator), Robin Stromgren (Bright Futures Coordinator), Keili Trottier (UCS Supervisor), Julie Paglicia (UCS supervisor), Debbie Dutcher, RN (Vermont Department of Health), Bridget Bromirski (SVMC Women and Childrens')

TIMELINE

Start Date February 2017

End Date February 2018

APPENDIX

R

TRANSITIONS OF CARE PROGRAM CONSENT FORMS

Involved compliance officer, hospital attorney, and safety officer

R1: Transitional Care Nursing Consent

R2: Community Care Team Consent

R3: Pediatric Community Care Team Consent

Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

Transitional Care Program
Consent and Authorization to Release Information

Patient's Name: ______________________ **Date of Birth:** ______________

Address: ______________________ **Telephone Number:** (   ) __________

____

Consent to participate in the Transitional Care Program

- I am the patient, or the Legal Guardian of the patient (authorized to extend this consent and authorization). I understand and consent to receive services provided by a Transitional Care Nurse as part of the Transitional Care Program in order to support my care and treatment.

Authorization to receive Transitional Care Services

- I understand that the Transitional Care Nurse will be a part of my care team in any health care setting (e.g. physician office, hospital, nursing home, home, etc.)
- I understand that the Transitional Care Nurse will have access to my health care record and other protected health information in order to support my care and treatment. The information authorized for disclosure includes full access to my complete health care record and may include information related to my mental health, alcohol or drug abuse treatment, and/or HIV related illness.
- I authorize the Transitional Care Nurse to provide access to and to disclose protected health information to Southwestern Vermont Medical Center and appropriate health care facilities, home care agencies, medical staff and my primary care or specialist physician's office in order to support my care and treatment.
- I understand that the Transitional Care Nurse will work with me to manage my chronic disease and medication plan. I assume responsibility to partner with the Transitional Care Nurse to identify things that I can do to help me better manage my chronic disease.
- I understand that the average duration of this program is 2-3 months but the length may vary depending on a number of factors and no promises are made about the duration of my care.
- I understand that the Transitional Care Nurse will visit me in my home or contact me by phone during the time of this program.
- I understand that unsecured firearms and aggressive animals are potential hazards that may jeopardize the safety of the Transitional Care Nurse and impede the delivery of care. I agree to secure any firearms and aggressive animals from the area of care while receiving services from the Transitional Care Nurse or services will be discontinued.
- I understand that I will not be billed for this program.
- I understand that I can withdraw from this program at any time without consequences.
- A photocopy of this Authorization is as effective and valid as the original.

______________________________ __________ __________
Signature of patient or patient's representative   Date   Time

EXPIRATION DATE: This authorization will expire at such time as I am no longer receiving Transitional Care Services or upon my withdrawal.

COPY PROVIDED: Transitional Care Nurse shall provide a copy of this authorization, when signed, to the parent/guardian.

transitional_care_consent_auth   ell
created: 12/16/13

Form #: S6144

Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Community Care Team
Authorization for Release of Information

Patient Name: ________________________________ Date of Birth: __/__/____
Address:_ _
Phone:_ _

Below is the list of Departments and agencies that will be participating in the Community Care Team. Each of these individuals will sign a confidentiality agreement and receive education to protect your personal and health information that may be discussed at the meeting.

I give my permission for the Community Care Team and the following health and service providers:

Housing Services:

Bennington County Coalition for Homeless
Shires Housing
Bennington-Rutland Opportunity Council
Bennington Housing Authority
THM Housing
Other___ _ ______________

Mental Health/Substance Abuse:

United Counseling Services
Addiction Services
Other _______ ____________________
Turning Point
Savida Health

Visiting Nurses/Home Health Agencies:

Bayada Home Health Agency
The VNA of Southwestern Region

Family Resources:

Sunrise Family Resource Center
Greater Bennington interfaith Council Services
Department of Children and Families Economic Services
Vermont DAIL Vocational Rehabilitation Services
Vermont Center for Independent Living (VCIL)
Vermont Association of Business Industry and Rehabilitation
Council on Aging (COA)
Other_____________________________________

Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Health Care Agencies

Southwestern Vermont Medical Center
Vermont Agency of Human Services
Other _ _ _ _ _ _ _ _ _ _ _ _ _
Vermont Department of Health
Vermont Chronic Care Initiative (VCCI)

To communicate with and disclose to one another the following information:

Mental health records
Physical health records
Substance abuse treatment records
Intake, screening, assessment and/or CCT evaluation records

The purpose of disclosing the information includes:

Determining services necessary for you, coordinating services with all Community Team Members, and consulting with professionals associated with the Community Care Team in my region when needed.

By signing this form, I understand:

- The purpose of the disclosure is to allow the Community Care Team (CCT) to discuss my health history to provide a comprehensive care plan for me
- I authorize Community Care Team (CCT) to have access to all my medical records as needed for this purpose
- I am giving permission for the Community Care Team members to enter information into my medical records for the purpose of communication among other providers
- I understand that staff at SVHC will create a summary of my pertinent medical history and information which will be shared with Community Care Team/Community Partners
- I understand that this authorization is voluntary and I may revoke this authorization at any time

Signature of Individual or Legal Representative	Date:	Time:
Name of Person Explaining Authorization Process	**Date:**	**Time:**

Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Pediatric Community Care Team
Authorization for Release of Information

Name of Individual Served:_ **DOB:_ _ _ _ _**

Parent/Legal Representative:_ _

The Pediatric Community Care Team is a group of dedicated individuals who represent Southwestern Vermont Medical Center (SVMC), SVMC Pediatrics, and community agencies with the goal of providing each individual served with assistance.

This team meets two hours, once per month, to assess each individual served, ages birth to nineteen years of age, in order to create a plan to best meet their needs. A team member will contact you to coordinate this process.

Team Members

The following organizations, agencies, entities, and providers may be a part of the team:

Primary Healthcare Provider; Children's Integrated Services (CIS); OB/GYN Provider; VDH-Children with Special Health Needs; Child Development Clinic; Childcare Provider; Childcare Community Support Agency Staff; Mental Health Provider; Substance Abuse Counselor; Food/Nutrition Services; Housing Assistance Provider; Employment Assistance Provider; Economic Assistance Provider; Professional Consultants to Assist the Team with its Provision of Services; Strong Families; Vermont Home Visiting; Sunrise Family Resource Center; Department for Children and Families; Early Intervention; Center for Restorative Justice; Child Advocacy Center; Vermont Department of Health; Vermont Agency of Human Services; Southwestern Vermont Medical Center; SVSU; schools; other area schools including private and charter schools.
Other: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Communication

.1 provide consent for the team to communicate with and disclose to one another the following Information:

> Mental Health Records

> Medical Records

> Substance Abuse treatment records, if applicable

> Other Records (pertaining to services checked above)

Purpose of Disclosure

The purpose(s) of the disclosures authorized is:

> To determine services necessary for me, my child, or the individual who I have been appointed to care for as Legal Guardian

> To coordinate services across all maternal and early childhood providers

> To consult with professionals associated with the CIS and Pediatric Community Care Team in my region when needed

> Other: _

Signature

By signing this form, I understand:

> The reason(s) I am being asked to release information.

> That the Pediatric Community Care Team and CIS members may enter the above information into the medical records of the individual served for the purpose of communication among other providers.

> I will be provided a copy of this form.

> Other agencies may join the Community Care Team and I consent to participating in providing services unless other wise notified in writing.

> This authorization is valid for one year unless otherwise specified.

Signature of Individual or Parent/Legal Representative	Relationship to Client	Date	Time
Name of Person Explaining Authorization Process	**Organization/Position**	**Date**	**Time**

A P P E N D I X

TRANSITIONAL CARE PATIENT SATISFACTION TOOL

TCN gives to patient upon discharge from the program

S1: Sample Survey

S2: Satisfaction Tool With Results

S3: Patient Comments

TRANSITIONAL CARE NURSE PROGRAM PATIENT SATISFACTION SURVEY

WE VALUE YOUR OPINION

Please complete the survey below. Once completed, place in the self-addressed envelope we provided and mail.

I am: ❏ ***A patient*** ❏ ***A caregiver***

1. My Transitional Care Nurse explained things so that I could understand.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

2. My hospital pharmacist explained things so that I could understand.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

3. My Transitional Care Nurse connected me with services that I needed.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

4. My Transitional Care Nurse helped me feel more confident that I can manage my medications.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

5. My Transitional Care Nurse helped me feel more confident that I can follow my discharge plan.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

6. My Transitional Care Nurse helped me learn about my illness and how to manage it better.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

7. My Transitional Care Nurse helped me develop goals that matter to me.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

8. My Transitional Care Nurse helped me learn when to call the doctor, go to the emergency department, or call 911.

Always ❏ Usually ❏ Seldom ❏ Never ❏ Does not apply to me ❏

Comments about the services you received:

Please use the space below for any other comments or suggestions you would like to share with us about your experience with the Southwestern Vermont Medical Healthcare Transitional Care Program.

Other Comments:

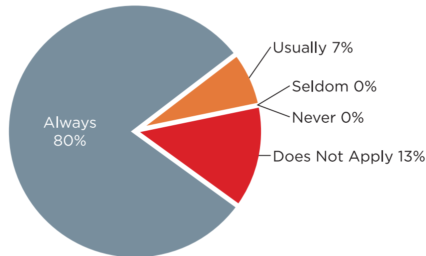
Thank you for taking the time to complete our survey.

Transitional Care Nurse Program Patient Satisfaction Survey

Patient Responses

	Always	Usually	Seldom	Never	Does Not Apply	N/A
My Transitional Care nurse explained things so that I could understand:	17	1	0	0	0	0
My hospital Pharmacist explained things so that I could understand:	8	1	0	0	8	1
My Transitional Care nurse connected me with services that I needed:	11	2	0	0	5	0
My Transitional Care nurse helped me feel more confident that I can manage my medications:	16	1	0	0	1	0
My Transitional Care nurse helped me feel more confident that I can follow my discharge plan:	16	1	0	0	1	0
My Transitional Care nurse helped me learn when to call the doctor, go to the emergency room or call 911.	14	2	0	0	2	0
My Transitional Care nurse helped me learn about my illness and how to manage it better:	16	1	0	0	1	0
My Transitional Care nurse helped me develop goals that matter to me:	16	1	0	0	1	0
TOTAL	114	10	0	0	19	1

Program Overall—Percentage Totals



NOTE: N/A means the attendee didn't select a number or selected more than one.

TRANSITIONAL CARE NURSING: SURVEY RESULTS-PATIENT COMMENTS

Karen has been very good at helping us with some difficulties that my dad has been having. When she didn't know the answers, she would consult with those who did. She is a good listener and truly understands the needs of her patients and their caregivers.

Sandra Driscoll went above and beyond my expectations. She was very knowledgeable and conveyed information easily. Very helpful and caring. It was a pleasure to have been able to receive these services. I never once felt pressured and found Sandi to be very accommodating. I am glad this service is available. Thank you.

My call nurse did an excellent job helping me understand everything pertinent to me. Everyone that works at Southwestern Vermont Medical does a really nice job. It is one of the best hospitals I have been to. Would not go anywhere else.
I appreciated the care, patience, and gentleness of the nurses. They were knowledgeable and always ready to help. Would easily recommend the hospital in all respects to a future patient. I have praise for all who work there.
After my short stay in the hospital, it was very comforting to know that the nurse would be checking up on me. She made me feel much more comfortable after being discharged from the hospital. She was very comforting and took the time to explain things and she made me feel much better. I feel she did a great job.
Caring, professional, not rushed, smiling. Reassuring, safe, willing, warm, sensitive, thoroughly pleasant surroundings with welcoming attempts towards my feeling safe and secure. She went well beyond her duty to assure me appropriate (and good) care. Much gratitude for her help. Thank you.
Since my hospital stay in October 2014, my care nurse has taught me what I need to do to live with my diabetes and heart conditions. Your services have helped me change my life choices. I now know what I need to do to improve my life. Thank you for the services. I hope you can continue this program to help others.
The expertise of my TCN and education, medical care, and outstanding service were a needed and appreciated blessing. She stayed in close contact with my doctor and my case as things progressed from November through early March. She closely monitored my oxygen situation and made a doctor's appointment for me when she felt that I needed an unscheduled visit. I believe her vigilance, familiarity, and interest in my condition prevented further hospitalizations. I cannot suggest any improvements and hope others take advantage of this hidden service offered by SVMC.
Pharmacy and nurse worked together to enforce the importance of taking the medication and how to stay healthy. I was also educated on the signs to watch for before this situation could go bad. Thank you to pharmacy, TCN, and the hospital discharge nurse. Transitional care is very helpful and informative. In the packet you receive when admitted there is a medical information record. It would be nice to have it filled out by the staff prior to discharge. An extra one would also be nice to share with a spouse, family member, or caregiver. Elderly people forget, handwritten records might not be legible, and some people just don't want to take the time. Thank the staff at SVMC for their help in treating our loved ones.

TCN was a great help. Upon coming home I realized I had another problem. She called my NP and I went in for a visit. Found out I had shingles. She was always there for me and she also checked on how I was progressing as long as I needed her. It made a great deal of difference for me. If I had it when I was discharged the first time I might not have have had to return for another stay the second time.

I am an RN. This transitional care nurse was well versed and gave me helpful hints and tips that I hadn't even thought of! She also empowered me to deal with this new and serious illness—a definite need for those going home from the hospital! I feel that this is an incredible and important program. Helpful to follow the patient at home. Due to shortened lengths of stay, this is a vital part of the whole hospital experience. I do believe it saves on re-admissions for the same problem, too.

When I had questions, it was so helpful to have the nurse answer them! I could make a plan for my own future care. She was terrific—a real confidence builder!

Transitional care nurses always listened and explained everything I needed for my patient's care. I feel a lot more confident I will manage to follow his discharge plan and he can achieve goals that matter to his health. She gave us detailed explanations about all his illnesses and gave us some very useful recommendations about his diet and activities of daily living. We discussed his medication list as she explained and answered each question. We are thankful for her care. [Caregiver]

Very helpful. Questions were always answered. Solutions to issues were given. Nurse was always friendly and professional. This was a great experience. It made the transition from hospital to home easier and less stressful. Keep this program going—good job!

Thank you for this new service. I live alone and felt much more relieved knowing that a professional person was checking in on me regularly and answering my questions and encouraging me. My family (they live quite a distance away) also was very pleased that I was receiving your service. Thank you. P.S. I also think it is wonderful that the service comes at no cost to the patient!

Barbara was our transitional nurse. She was kind and knowledgeable and was able to help us feel relieved about our situation. Because of her professional and relaxed way, we then relaxed and were able to understand the information that was necessary for me to heal and when to go back to the hospital for help. I am diabetic and have difficulty healing at times. Barbara showed me how to care for an open area on my leg and, thanks to her, it healed. We are grateful for the transitional care program. Thank you!

APPENDIX

STRATEGY FOR FOOD INSECURITY

T1: Prescription for food provided to patients by physician/associate provider

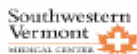
NAME

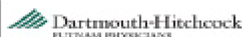
FOR GOOD HEALTH:

Three to five servings daily of FRESH VEGGIES!

GET YOUR FREE VEGGIES!

It's always prime time for fresh, delicious veggies! And you can use this slip to get **FREE VEGGIES** every month from VeggieVanGo™, the Vermont Foodbank's mobile nutrition program. Just come to **Southwestern Vermont Medical Center Monument Avenue Parking Lot-11am-12p Every 4th Wednesday of each month** to get your free, fresh produce. Look for the VeggieVanGo signs!





PARTNERSHIP IS POWERFUL MEDICINE℠

Vermont Foodbank

NOTE: *You do not need this form to pick up your produce, simply stop by on:*
The 4th Wednesday of every month

SIGNATURE

DATE

A P P E N D I X

SAMPLE ANCC ABSTRACT

U1: Abstract Submitted to ANCC Magnet and Accepted for Podium Presentation

ABSTRACT

Southwestern Vermont Health Care (SVHC), an affiliate of Dartmouth Hitchcock, joined OneCare, an ACO demonstration project in Vermont, on Jan 1st, 2013. We have embarked on transforming our acute care Clinical Nurse Specialist team into Transition Care Nurses. Bridging the gap from hospital-based, inpatient care delivery to a focus on high-risk populations in nursing homes, elderly housing, and medical practices is our role. We are participating in a TCM training program at UPENN to expand our knowledge base and learn to manage high-risk patients across the continuum. Patient navigation across multiple, complex settings is out of our comfort zone and requires orientation to medical practices, nursing homes, and home-care settings. Our goals include improving clinical outcomes for heart failure, respiratory disease, and diabetes, as well as improving core measures and HCAPS scores. Key elements of cost reduction require decreasing ED visits, hospital admissions, and re-admissions while improving the patient resident experience and satisfaction. Outside of the hospital walls where we had control, we are now in unfamiliar settings where patient self-management and shared decision-making are essential to success. This journey began 12 months ago during a visioning exercise at a CNS retreat as we embraced the challenges of healthcare reform and contemplated meeting the IOM mandate to function at the highest level of our license. We are coming to realize that improving population health requires coordinated, expert nursing knowledge and expertise across the continuum to truly impact outcomes and patient safety. It is time for CNSs to get "out of the hospital." Advance practice nurses have a unique skill set and opportunity to become leaders in healthcare reform and to really make lasting, meaningful, positive change for our patients.

A P P E N D I X

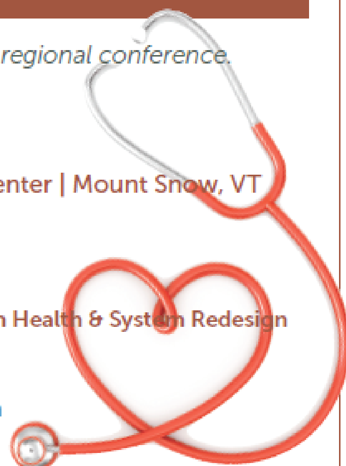
STRATEGY TO DISSEMINATE NURSING AND CLINICAL INNOVATION SUPPORTED BY GRANT FUNDS

V1: Leading Healthcare Reform Conference Save the Date
V2: Table Discussions
V3: Example Table Discussion Summary

SAVE THE DATES – Sept. 19 and 20

Leading Health Care Reform
BY BUILDING ACCOUNTABLE COMMUNITIES

Please join your peers across many disciplines for this important regional conference.

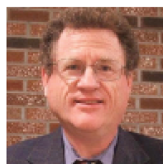


RECEPTION Evening, Monday, September 19, 2016

CONFERENCE All day, Tuesday, September 20, 2016
Grand Summit Resort and Conference Center | Mount Snow, VT

SESSIONS:

KEYNOTE PRESENTATION:
The Relationship of Transitional Care to Population Health & System Redesign
MARY NAYLOR, PhD, FAAN, RN
Marian S. Ware Professor in Gerontology
Director, New Courtland Center for Transitions & Health
University of Pennsylvania School of Nursing



Financial Implications of Accountable Care Organizations
KEVIN STONE, BA, MBA
Senior Consultant and Principal, Helms & Company
Project Specialist for Accountable Care Organization Development and Regional Services, Dartmouth-Hitchcock

Integrating Population Health and Prevention in Health Care Reform: Vermont's Exploration of Accountable Communities for Health
HEIDI KLEIN, BA, MBA
Director, Division of Health Surveillance
Vermont Department of Health

Panel discussion moderated by Gay Landstrom, PhD, RN, NEA-BC, Executive Vice President and Chief Nursing Officer, Dartmouth-Hitchcock

Round table discussions led by pharmacists, nurses, and specialists in public health, addiction, and behavioral health

Program support from VHCIP

CALL FOR ABSTRACTS

POSTER PRESENTATIONS Abstracts will be accepted.

For submission information, to receive a full registration packet, and/or to join the mailing list, contact Beth Dillard at
beth.dillard@svhealthcare.org

Organized by Southwestern Vermont Health Care
100 Hospital Drive, Bennington, VT 05201
802-442-6361 | svhealthcare.org

Leading Health Care Reform by Building Accountable Communities

Interest Table Discussions

Session 1: 10:30 - 11:00
Session 2: 11:00 – 11:30
All Tables Available for Both Sessions

Raponda South

- **TABLE 1: Leading a Community Collaborative**
  Jennifer Fels, RN, MS - Bennington Blueprint - Southwestern Vermont Health Care
- **TABLE 2: Vermont Blueprint for Health**
  Teresa Reinertson, RN, BSN - Bennington Blueprint - Southwestern Vermont Health Care
- **TABLE 3: New England Quality Innovation Network / Quality Improvement Organization**
  Gail Colgan - Vermont Care Transitions NE QIN-QUO
- **TABLE 4: Value-Based Reimbursement**
  Steven Majetich – Corporate Finance - Southwestern Vermont Health Care

Raponda Central

- **TABLE 5: Food Insecurity Within The Bennington Area Community**
  Tiffany Tobin - Hospitality Services - Southwestern Vermont Medical Center
- **TABLE 6: Housing: The Foundation for Health**
  Stephanie Lane - Shires Housing
- **TABLE 7: RiseVT: Community Wide Engagement**
  Dorey Demers - RiseVT
- **TABLE 8: Fallscape™: Community Fall Prevention**
  Elaina Noblet, MS, AEMT - Bennington Rescue Squad
- **TABLE 9: SASH - Support and Services at Home**
  Cathy Cardiff – SASH of Bennington County

Raponda West

- **TABLE 10: Inpatient Post-Operative Pain Management: Safe Opioid Prescribing**
  Kelly Filippi, RN – Intensive Care Services – Southwestern Vermont Medical Center
- **TABLE 11: The Substantial Public Health Impact of Adolescent Substance Use**
  Nissa L Walke, PhD - Vermont Department of Health
- **TABLE 12: Safe Arms: Support for Opiate Addicted Mothers and Their Withdrawing Newborns**
  Shiela Boni, MSN, RN - Inpatient & Emergency Services - Southwestern Vermont Medical Center

Leading Health Care Reform by Building Accountable Communities

Interest Table Discussions

Session 1: 10:30 - 11:00
Session 2: 11:00 – 11:30
All Tables Available for Both Sessions

Deerfield North

- **TABLE 13: Emergency Department Physical Therapy Services**
  Kathryn Sleeman & Michael Fredette - Rehabilitation and Physical Therapy - Southwestern Vermont Medical Center
- **TABLE 14: SVMC Diabetes Education**
  Paula Haytko MS, RN, CDE – Diabetes Education – Southwestern Vermont Medical Center
- **TABLE 15: Pulmonary Rehabilitation Program**
  John Gottung & Caitlyn Boyd - Rehabilitation and Physical Therapy - Southwestern Vermont Medical Center
- **TABLE 16: Inpatient Redesign**
  James Poole MD - Southwestern Vermont Medical Center
- **TABLE 17: Decreasing 30-Day Readmission Rates in Skilled Nursing Facilities**
  Katharine Murphy – Centers for Living and Rehabilitation - Southwestern Vermont Health Care

Deerfield South

- **TABLE 18: Transitional Care: Transforming the Role of the Clinical Nurse Specialist (CNS)**
  Karen Coppin, MSN, RN, CCRN & Barbara Richardson, MS, RN-BC, CCRN - Transitional Care Services - Southwestern Vermont Medical Center
- **TABLE 19: Transitional Care Social Worker**
  Katherine Nicole Sparks - Transitional Care Services - Southwestern Vermont Medical Center
- **TABLE 20: Pharmacist Medication Therapy Management**
  Frank Rickus RPh & Michelle Lester RPh - Pharmacy Services - Southwestern Vermont Medical Center
- **TABLE 21: Community Care Team: A Hospital-Community Partnership to Serve the At-Risk Behavioral Health Population of Bennington County VT**
  Ashley Lincoln, BS & Jill Maynard, RN - Emergency Services - Southwestern Vermont Medical Center
- **TABLE 22: Home Health Partnerships**
  Bea Wells & Mary Driscoll - VNA & Hospice of the Southwest Region

Leading Health Care Reform – Interest Table Discussions

Community Care Team: A Hospital-Community Partnership to Serve the At-Risk Behavioral Health Population of Bennington County VT

The Bennington County Community Care Team (CCT) is comprised of a number of community agencies that specialize in the care of patients struggling with substance abuse and/or mental health disorders. The goal of the team is provide patient centered care and improve health outcomes by developing and implementing a safety-net of alternative services through multi-agency intervention and care planning. Currently over 20 community agencies participate in monthly meetings held at Southwestern Vermont Medical Center. The target population are high risk individuals who are experiencing acute and chronic mental health issues and or substance abuse with high emergency department utilization.

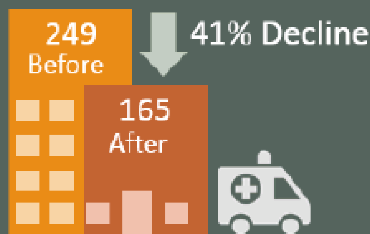
Patients with mental health and addiction diagnoses who seek care in the emergency department often do not get their needs met. Instead, they are exposed to unnecessary radiation, costly work ups and at times invasive procedures that do not have a positive impact on their health. This is a source of concern and frustration for providers who feel unsuccessful when caring for this population, leading to increased provider burnout and job dissatisfaction.

The Community Care Team was designed as a multi-agency, multi-disciplinary team aimed to provide compassionate supportive care to patients and their families while facilitating access to services. This is accomplished by bringing together representatives from mental health, addiction, workforce development, Medicaid, Economic Services, social work, case management and primary care providers. A grant through the Vermont Health Care Innovation Project helped support the hiring of a Health Promotion Advocate, stationed full time in the ED, providing telephone support, care planning and referral services to participating clients.

While the number of patients with mental health and addictive diagnoses continue to grow, the number of patients who have been helped by this program is encouraging. To date the team has discussed over 65 individual cases. According to our preliminary data, which looked at a cohort of 23 patients there was a 41% decrease in emergency department visits 6 months post community care team intervention, and a 47% reduction in total healthcare cost. Through this integrative approach, the Community Care Team is meeting the triple aim; improving the patient experience of care, improving the health of populations; and reducing the per capita cost of health care.

Non-Emergent Hospital Visits

- For 23 patients, we tracked their total visits to the Emergency Department, for 6 months pre and post client's first intervention.
- We tracked a 41% decline in visits 6 Months after the Community Care Team Intervention



Contact Information

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A P P E N D I X

PALLIATIVE CARE ANNUAL REPORT

W1: Palliative Care Nursing Calendar Year 2018 Annual Report

Palliative Care Nursing

Calendar Year 2018 Annual Report

Target Population: Patients with serious illness seeking symptom management to improve their quality of life.

Primary Goal: Improve patient discomfort related to chronic disease processes through a patient and family centered approach; decrease hospitalization related to uncontrolled symptomology.

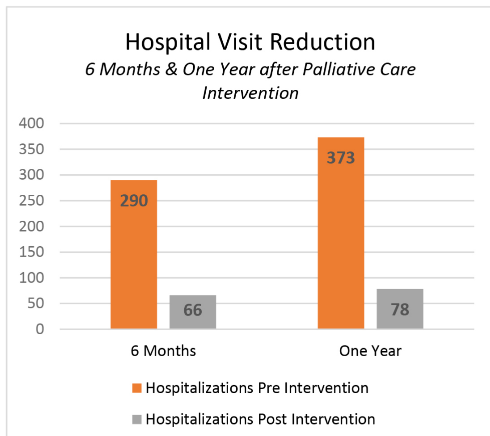
Team Members: Jani Albans, RN, CHPN

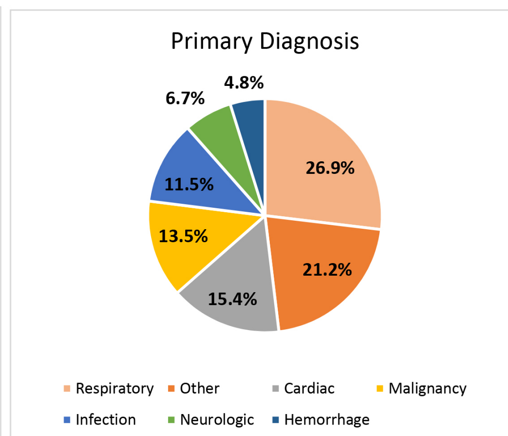
Summary: The Palliative Care Nursing program is founded with the goal in mind to improve quality of life for patients with chronic illnesses. With the guidance of the Palliative Care Nurse, patients and their families are supported in creating a patient-centered care plan that allows for a holistic approach to disease management. The program is focused on managing patients in the home setting, opposed to repeated hospital visits for uncontrolled symptoms associated with their disease process. The palliative care nurse works collaboratively within an interdisciplinary team and acts as an advocate for the patient and their family while they navigate treatment options and ensure appropriate referral to needed community resources.

Patients Served	*Number of In-Person Encounters*	*% patients with 2+ visits*	*Gender Mix*	
104	260	83.5 %	Male 51 %	Female 49 %

Payer Mix					*% of Referred Patients Accepting Palliative Services*	*States Served*		
BCBS 5.8%	Champus 1%	Medicaid 2.9%	Medicare 79.8%	Other 10.6%	98%	MA 6%	VT 79%	NY 15%

Average Visit Time (mins)	*Primary Referral Source*	*Top 3 Symptoms Alleviated by Palliative Care Referral*		
55	Interdisciplinary Rounds/Hospitalist 68%	Shortness of Breath	Pain	Feeling Tired





77.2% Reduction in total hospital visits at 6 months & **79.1 %** reduction in total hospital visits at 1 year

APPENDIX

RISEVT STATEWIDE WELLNESS INITIATIVE

X1: Power of Produce Club Flier
X2: RiseVT November 2019 Newsletter
X3: RiseVT Small Business Scorecard

POP Club!

10:00 AM - 1:00 PM

At the Bennington Farmers Market

First Baptist Church, 601 Main St.

Bennington, VT 05201

FREE activities for kids ages 4-12!

December 7th
January 4th
February 1st
March 7th
April 4th

FARMERS MARKET COALITION

RiseVT Bennington County
Andrea Malinowski, Program Manager

www.bennington.risevt.org
andrea.malinowski@svhealthcare.org
802.379.5468

RiseVT in the Community…

NOVEMBER 2019

Students of The Village School of North Bennington display signs which say "Thank You RiseVT" for the Amplify Grant funding to hold their after-school bicycle club

International Walk to School Day at Bennington Elementary

AMPLIFY GRANT SPOTLIGHT: BENNINGTON COUNTY CHILD ADVOCACY CENTER

33 elementary school students took to the streets this fall under the guidance of school staff to embrace the fun and joy of riding safely on their two-wheelers. Joy Kitchell, Executive Director of the Bennington County Child Advocacy Center, worked with Jamie Poulen and Pattie Dewey from Bennington Elementary School, and Leslie Koelker and Marlene Driscoll, from the Village School of North Bennington, to create afterschool bike riding clubs. This pilot project was a huge success. With one day of registration, Jamie cut off the signups at 16 students. Likewise, Leslie had a steady following of 17 students appear for bike club (even on the rainy days!).

The groups each ran for 4-5 weeks one afternoon a week. The key take-aways? Wear bright colors, hand signals, put lights on your bike, and ride single file. Something we'll include in the next round of biking will be simple bike maintenance to keep yourself safe on the road. Jamie, Pattie, Leslie and 15 of the bike club students also participated in the Just Bike! justice for kids 5-mile family ride. It was a perfect day!

~ Projects ~

- **SVSU School Wellness Policy work presently underway!**
- **"Risercise" - FREE aqua classes (Bennington Rec Center Mon. 7:30 pm, Fri. 9:30 am), daycare classes, adaptive fitness, walking groups**
- **Bennington Bike Around - Inaugural ride on October 5 was a big hit; more rides coming in Spring 2020**
- **Come Alive Outside—Spring/Summer Passport Series**
- **BCBSVT - Snow Day at Prospect Mountain, Wellness Revolution (Women's Bicycle Club) & Mountain Day on Mount Anthony!**

The Power of Produce (PoP) Club is debuting at the December Farmer's Market at the Baptist Church, Main Street. PoP Club is a farmers market incentive program for children that originated in OR in 2011. Each week children, ages 4-12 receive a $2 token to spend on fresh fruits and vegetables when participating in activities.

Next Stakeholders Meeting: Wed., 11/20 4:30 pm, Vermont Dept of Health Community Room

Fallapalooza Fun with the spin art bike!

SMALL BUSINESS
Scorecard
50 Employees or Fewer

Business Name: ____

Contact Name: ____

Contact Email: ____

Phone Number: ____

Business Address: ____

Number of Employees: ____

Insurance Provider: ____

BRONZE

Employer must complete all 5 core activities and 2 optional activities to qualify for Bronze Certified Organization.

CORE REQUIREMENTS:

☐ Promotion of Tobacco Free Education.

Examples: Included, but not limited to 802 Quits, handouts readily available, Human Resource referrals to local and statewide tobacco cessation opportunities.

☐ Vermont Department of Health Bronze Level Breastfeeding Friendly Employer.

- Are you willing to be a Breastfeeding Friendly Place for the community?

Resource: http://www.healthvermont.gov/sites/default/files/documents/2016/11/HPDP_PA%26N%20Worksite%20BF_employer_application.pdf

☐ Daily encouragement of physical activity or walking.

Examples: This may include stair point-of-decision prompts for increasing stair use where elevators exist, allowing employees to utilize scheduled breaks for physical activity, timer built into worksite email prompting movement.

APPENDIX

HEALTHY HOME PROGRAM

Y1: Housing Crisis Navigation Tool
Y2: Housing and Other Resources

Housing Crisis Navigation Tool

Trying to get help with housing needs in Vermont is complicated. This tool is meant to make it easier. Here are the basic steps you can take if you're in a housing crisis in Vermont:

1. First, do a Coordinated Entry Screening and have all adult members of the household sign a *Release of Information* to allow your local housing team to discuss your housing situation and try to find solutions. This can be found at: http://helpingtohousevt.org/wp-content/uploads/2017/01/VCEH-Housing-Crisis-Referral-Form-1.20.18.pdf

2. If your household is in need of immediate shelter, you can find a complete listing of all Vermont shelters and information about how to contact staff to see if there's room at: https://vtlawhelp.org/homeless-shelters-and-help-homeless-people

3. If you can't stay at a shelter for medical or mental health reasons, you can apply for an emergency hotel stay through the General Assistance program in your local Economic Services office. Everything you need to know about GA can be found at: https://dcf.vermont.gov/benefits/EA-GA

4. If you have found housing that you can afford but need help with move-in fees like a security deposit and first and last month's rent you can work with a housing team in your area that has funds to help with this. The person in charge of the "Continuum of Care" in your county will know how to put you in touch with the housing team. Go to http://helpingtohousevt.org/ and click on the "local continua of care tab" to get this information.

5. If you're already working with a case manager or housing team and they are not able to find solutions for your situation, you can reach out to a Field Services Director in the Vermont Agency of Human Services to help. You can see who the Field Services Director is in your county, and how to reach them by visiting: http://humanservices.vermont.gov/departments/ahs-fs-folder/ahs-field-directors-map-4-2-19.

6. If you will need ongoing help paying rent you'll want to apply for subsidized housing and/or "affordable housing. A listing of all subsidized and affordable housing options in Vermont can be found at: https://www.housingdata.org/

7. If you don't have enough income from work or benefits to pay rent, and you can't find a subsidized apartment, you might want to apply for a voucher to help pay rent.
   The most common voucher programs are:

Family Unification Voucher: https://dcf.vermont.gov/oeo/fup
Vermont Rental Subsidy: https://dcf.vermont.gov/sites/dcf/files/ESD/proc/P2600/P2695.pdf
Section 8: https://www.vsha.org/vsha-programs/rental-assistance-program/
Shelter Plus Care: http://www.vtaffordablehousing.org/news/wp-content/uploads/2014/08/VSHA-S+C-Program-Guide-82614.pdf
Rapid Rehousing: https://www.usich.gov/solutions/housing/rapid-re-housing/
VASH: https://www.va.gov/homeless/hud-vash_eligibility.asp

TDO - Bennington District Office — **Updates/changes? Let us know! (click here)** Include which tab/DO you are reporting on

200 Veteran's Memorial Drive, Suite 6, Bennington, VT 05201-1918

Arlington | Bennington | Dorset | Glastenbury | Landgrove | Manchester | Peru | Pownal | Readsboro | Rupert | Sandgate | Searsburg | Shaftsbury | Stamford | Sunderland | Winhall | Woodford

Resource	Name	phone	address	notes
General Resources				
Domestic Violence	Project Against Violent Encounters (PAVE)	802-442-2370		EMERGENCY: 802-442-2111
Social Security	Rutland Social Security Offices	866-690-1944	88 Merchants row, Rutland VT 05701	TTY: 802-773-3202
Community Action	Bennington Rutland Opportunity Council (BROC)	802-447-7515	45 Union St., Rutland VT 05701	1-800-717-BROC, FAX: 802-447-7516
Senior Support	Southwestern VT COA	802-442-5436		800-642-5119
	Southeastern COA	800-642-5119		
Family Support	Bennington Senior Center	802-442-1052		
	Sunrise Family Resource Center	802 442-6934	244 Union St. Bennington	
Community Support	Greater Bennington Interfaith Community Service			
WIC				
Food Resources				
Food Shelves	Bennington Food Pantries			
	Arlington Food Shelf	802-375-6328 802-375-9075	165 Old Mill Rd. Arlington, VT	
	Bible Baptist Church Food Basket	802-447-3618	Harwood Hill Bennington, VT 05201	
	BROC Food Shelf	802-447-7515	Orchard Rd. Bennington, VT	
	Green Mountain Christian Center	802-447-7224	440 Main St. Bennington, VT	See Site for Schedule
	Sacred Heart St. Francis	802-442-3141	238 Main St. Bennington, VT	Wednesdays: 1-4pm Fridays 10am-12pm
	Kitchen Cupboard/GBCIS	802-379-0149	121 Depot St. Bennington, VT	Tues: 5:30pm -8:30pm Sat: 2-5pm
	Manchester Community Cupboard	802-362-0057	6039 Main St (Town Offices) Manchester, VT	
	North Bennington Baptist Church	802-442-2711	19 Church St. North Bennington, VT	
	St. John the Baptist Food Shelf	802-447-7504	5 Houghton St. North Bennington, VT	
Community Meals	Meals on Wheels	802-442-8012	124 Plesant St. Bennington, VT	Mon-Fri 11am-1pm **Fees may Apply**
	Congregation Beth El	802-442-9645	225 North St. Bennington, VT	Sept-May: 4th Monday of the Month at 5pm
	Second Congregational Church	802-442-2559	Hillside St. Bennington, VT	Sundays at 5pm
	Harvest House Soup Kitchen	802-447-0869	Corner of River St and Benomont Ave, Bennington, VT	Mon-Fri 8-10am & 11:15-1pm, Sat 8-9:30, Sun 8:30-9:45
Housing Resources				
Shelters	Thatcher House	802-445-5677	212 Pleasant St, Bennington	Homeless Shelter 802-753-7205
	Bennington Coalition for the Homeless	802-442-2424	966 Main St Bennington VT	FAX: 802-681-7777
	Good Shephard Drop in Center	802-442-2424	250 North St. Bennington	M-F 9am-5pm S&S: 9am-2pm
	Good Shephard Emergency Overnight Shelter	802-442-2424		
	Vermont Veterans Home	802-442-6353	325 North St, Bennington	
Heating Assistance	Bennington Rutland Opportunity Council (BROC)			
Housing Resources	Bennington Housing Authority	802-442-8000	22 Willow Brook Dr. Bennington	fax: 442-7301
	Willowbrook Apartments	802-442-8000		
Utility	Green Mountain Power	800-649-2877		Electric Co.
Local Agencies & Misc.				
Clothing & Home Goods	The Salvation Army Thrift Store	802-442-2774	511 South St, Bennington	
	Goodwill Thrift Store	802-442-4285	215 North St, Bennington	
Education Facilities	Bennington Tutorial Center	802-447-0111	208 Pleasant St, Bennington	
Family Resources	Sunrise Family Resource Center	802-447-6937		Child care subsidy
	Benn County Child Care	802-447-3778		Child care referral
Financial Supports	SEVCA Money management program			
Transportation	Green Mtn. Community Network	802-447-0477		Bennington County Bus Routes
	VTRANS			
	Transit Provider Rte. and Service Areas			Download of Map
Health Care Support				
Clinics	Bennington Free Clinic	802-447-3700		+VHC Navigators
	Southern Vermont Medical Cntr. SVMC Express Care	802-440-4077	140 Hospital Dr, Bennington	
	VA Bennington Outpatient Clinic	802-4403300	186 North St, Bennington	
Dentists				
Mental Health	United Counseling Service (UCS)	802-442-5491		
Addiction Resources				
Misc	Bennington Lions (eyeglasses)	802-442-2090	Bennington	
	Red Cross	802-442-9458		
	Maplewood Recovery Residence	802-770-5003	195 Stratton Rd, Rutland	VT Residential Care Type III
	SVMC	802-442-6361		
	North Shire UCS	1-866-720-3784	Manchester Center	Toll Free Assessment
Legal				
	District Court	802-447-2727		
	Family Court	802-447-2729		
	Probation & Parole	802-447-2777		
	Vermont Legal Aid	802-775-0021		Rutland Office
State of Vermont				
AHS	Department for Children and Families			
	Office of Child Support	802-447-2717		
	Family Services	802-442-8138		
	Vocational Rehab	802-447-2780		
	Social Security Specialist			
	Department of Vermont Health Access (DVHA)			
	Long Term Care			
	Department of Labor	802-442-6376		
	Department of Health (DoH)	802-447-3531		
	WIC (link to wichealth.org)	802-447-6408		
	Department of Mental Health			
	Department of Disabilities, Aging and Independent Living			
	Office of the State Treasurer			
	Department of Motor Vehicles	802-447-2756		
	States' Attorney	802-442-8116		

APPENDIX

Z

HEALTHCARE REGULATIONS

Z1: Summary Table of Relevant Federal Healthcare Regulations

RELEVANT FEDERAL HEALTHCARE REGULATIONS		
Anti-Kickback Statute, Section 1128B(b)	42 U.S.C. 1320a-7b(b)	The AKS is a criminal law that prohibits the knowing and willful payment of remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by the federal healthcare programs (e.g., drugs, supplies, or healthcare services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash. The statute covers the payers of kickbacks—those who offer or pay remuneration—as well as the recipients of kickbacks—those who solicit or receive remuneration. Though it is a criminal statute, it provides both criminal and civil penalties.
Beneficiary Inducements Civil Monetary Penalty Statute (CMP)	42 U.S.C. 1320a-7a(a)(5)	CMP defines *remuneration* to include items or services at anything other than fair market value. It prohibits remuneration intended to influence the selection of a particular healthcare provider.
Anti-Kickback Statute "Safe Harbors"	42 CFR 1001.952	Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution. To be protected by a safe harbor, an arrangement must fit squarely in the safe harbor and satisfy all its requirements. Some safe harbors address personal services and rental agreements, investments in ambulatory surgical centers, and payments to bona fide employees.
Health Insurance Portability and Accountability Act (HIPAA)	5 CFR Part 160, 162, and 164	HIPAA rules were designed to both protect patient privacy and promote the exchange of information to promote patient care.

Patient Protection and Affordable Care Act (PPACA)	76 Fed. Reg. 67803 (November 2, 2011), codified at 42 CFR Part 425	Goals of the Affordable Care Act were to improve access to health insurance, lower healthcare costs, and improve system efficiency.
Physician Self-Referral Law (Stark Law)	42 USC 12395n(n)	The Stark Law prohibits physicians from referring patients for “designated health services” to entities from which the physician or an immediate family member has a financial relationship.
Substance Abuse and Confidentiality (42 CFR Part 2)	42 CFR Part 2, including 42 USC § 290dd–2; 42 CFR 2.11, et. seq.	42 CFR Part 2 was enacted in 1975 to encourage individuals to seek treatment for substance use disorders by protecting the confidentiality of patient records related to such treatment.

Definitions provided by Office of Inspector General, HHS where possible.