

2016 Community Health Needs Assessment Implementation Strategy (2017-2019)

WORK-TO-DATE: CALENDAR YEAR 2017



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Senior Leaders approved and ranked tactics for each need area in early 2017. Progress for each of the tactics has been reported to the Community Benefit/CHNA Council over FY17; enclosed is a compendium of all work to date.

Over the fall of 2017, Executive Sponsors and Accountable Persons for the need areas either attended an in-person Results-Based Accountability (RBA) training session or received relevant materials for review from Jason Minor, Director, Continuous Systems Improvement.

Over the next two calendar years, Accountable Persons will apply the RBA framework when providing updates for their tactics.

The University of Vermont Medical Center's Community Benefit/CHNA Council selected nine needs for inclusion in the 2016 CHNA Implementation Strategy

(in alphabetical order):

- **Access to Healthy Food**
- **Affordable Housing**
- **Chronic Conditions**
- **Early Childhood & Family Supports**
- **Healthy Aging**
- **Mental Health**
- **Oral Health**
- **Removing Barriers to Care**
- **Substance Use Disorder**

Program Accountability:

Performance Measurement Using Results-Based Accountability

PROGRAM PERFORMANCE MEASURES	1. Who do we serve?
	2. What do we do?
	3. How good of a job is the program doing? (How well is this strategy performing?)
	3A. How much do we do?
	3B. How well did we do it?
	3C. Is anyone better off? (Who? How so?)
4. Story Behind the Numbers? (Measures of program effectiveness.)	
5. Improvement Plan: What work needs improving?	

DESCRIPTION & TIPS

1. Give a brief statement to describe who the program serves/helps. Who is meant to benefit from this program. Examples:
 - Low income families with young children
 - Young adults without a HS education
 - Homebound seniors
2. This is the classic **program description**. In our outcomes we answer the question what to we help with? This is not a long narrative – just hit the high points of what the program does.
3. Three basic, essential types of Performance Measures. Answer all three clearly and simply and track over time. Each can be answered many ways. Pick the top level highlight measures. Explore the background in the Story Behind the Numbers/Results.
 - 3A. How Much?** These are “outputs” – quantity of work accomplished. How much = measure of program’s effort. Examples:
 - # of people served
 - # of trainings
 - # of service hoursHow many things can be counted; focus on those that do the best job documenting scope. Track over time and explain changes, (i.e. serving fewer people but more casework hours provided).
 - 3B. How Well?** This is another measure of program effort. How can you demonstrate the quality of activities/how well service is provided. Examples:
 - Licensing
 - Oversight
 - External evaluations (CARF, State audit)
 - Use of best practices
 - Adherence to standards
 - Staff Training
 - Client Satisfaction
 - 3C. Is anyone better off?** = measure of effect or effectiveness. Intended outcomes for participants in a program. Examples:
 - Improved Knowledge/skills
 - Change in behavior
 - Change in status/situation
 - Clinical improvement
4. The Story behind the Numbers is where you explain data quality concerns, other influences on the data, how the Outcome may not be a total indicator of improvement toward a goal, etc.
5. The improvement plan involves your program planning. What will you do to improve/strength/sustain? What do you need to do that? What works? Draw on best practice, research/theory understanding of program participants. Gather ideas based on experience to maximize the program’s performance.

Mark Friedman’s Results Based Accountability (RBA) Model

For more information, visit: www.resultsaccountability.com

Access to Healthy Foods

GLOBAL AIM:

To improve nutrition, culinary literacy and access to affordable healthy foods to reduce food insecurity and/or prevent obesity.

TACTIC #1

Develop a work plan for the expansion of culinary medicine.

WORK-TO-DATE:

The 2017 Culinary Medicine Work Plan was approximately 80% complete; the 2018 Culinary Medicine Work Plan is being finalized.

- Veggie Rx program pilot is complete; evaluation of the program is due to be complete by the end of December 2017
- Pay It Forward launched in August, 2017
 - In April, 2017, a Hannaford Charitable Foundation grant provided \$25,000 in seed money
 - As of December, 2017:
 - Received 11,800 donations, totaling \$11,461
 - 3315 coupons redeemed, approximately \$15,000
- Ongoing Culinary Medicine programs:
 - Teaching Kitchen Collaborative (2016-Present)
 - Food Matters Series (2012-Present)
 - Health Care Shares (2012-Present)
 - The Fanny Allen Pantry (launched in early 2017)

TACTIC #2

Increase community awareness of food insecurity through a “Food is Healthcare” campaign by the end of FY 2017.

WORK-TO-DATE:

Health Care Shares Video:

- Produced in November, 2016
- Screened at Community Leaders Breakfast on November 18, 2016
- Third most popular story in Highlights Annual Report

The UVM Medical Center Blogs:

- Recipients of Community Health Investment Fund grants contributed blog posts about their programs:
 - Salvation Farms: April 5, 2017
 - Chittenden Emergency Food Shelf's Good Food Truck: April 3, 2017

Food Is Medicine Video:

- Collaboratively produced in May, 2016 with the Vermont Association of Hospitals & Health Systems (VAHHS)
- Features the Vermont Workgroup- food service directors collaborating to bring healthy, local food to patients
- Video will be shared by VAHHS and other organizations

TACTIC #2 CONTD.

NEWS MEDIA COVERAGE:

- August 25, 2017, The Buffalo News: [Hospital food that's fresh from the farm](#)
Readership: 463,580 / Social Media Shares: 378
- September 13, 2017, WCAX: [New program helps doctors help you to eat your veggies](#)
Readership: 123,224 / Social Media Shares: 181
- September 17, 2017, The Washington Post:
[After single payer failed, Vermont embarks on a big health care experiment](#)
Includes several paragraphs about the UVM Medical Center Family Medicine – Colchester Health Care Shares pickup.
Readership: 35,993,869 / Social Media Shares: 3141

TACTIC #3

The UVM Medical Center will test a systematic screening tool to identify food insecurity, provide appropriate referrals to resources when results of the screening are positive, and take the learning from a pilot program to a broader population.

WORK-TO-DATE:

- Multidisciplinary team has been formed
- The screening tool, Hunger Vital Sign, for inpatient and outpatient clinics has been identified and implemented across multiple provider domains
- Workflows and communication tools for screening have been developed
- Added Best Practice Advisory to nursing navigator
- Social Determinant of Health screener has been built in PRISM and is live in all primary care sites
- Developed paper screening tool and introduced to nursing staff
- Provided food insecurity education to nursing staff
- Developed daily nursing report to identify positive screens and missed screens

GOALS:

- Screen 90% of children admitted to inpatient pediatrics for food insecurity using the Hunger Vital Sign by February 2, 2018
- Provide referrals to UVMHC Case Management for 100% of families that screen positive for food insecurity by February 2, 2018
- Notify 100% of primary care providers when their patient has a positive screen for food insecurity by February 2, 2018

TACTIC #3 CONTD**2016 (DIRECT ASK BY MEDICAL TEAM)**

MONTH	POSITIVE SCREENS	COMPLETED SCREENS	FOOD INSECURITY RATE (POSITIVE SCREENS / COMPLETED SCREENS)	HOSPITAL ADMISSIONS	SCREENING RATE (COMPLETED SCREENS / ADMISSIONS)
AUGUST	1	32	3%	135	23.7%
SEPTEMBER	1	39	2.5%	139	28%
OCTOBER	0	34	0%	123	27.6%
NOVEMBER	0	11	0%	51	21.5%

2017 (PAPER QUESTIONNAIRE WITH EXPLANATION)

MONTH	POSITIVE SCREENS	COMPLETED SCREENS	FOOD INSECURITY RATE (POSITIVE SCREENS / COMPLETED SCREENS)	HOSPITAL ADMISSIONS	SCREENING RATE (COMPLETED SCREENS / ADMISSIONS)
AUGUST	11	64	17%	126	50.8%
SEPTEMBER	16	72	22%	116	62.1%
OCTOBER	5	56	9%	128	43.8%
NOVEMBER	3	21	14%	48	43.8%

LESSONS LEARNED:

- Initially, this project involved directly asking families about food insecurity. This methodology produced a rate of food insecure families that was about 9%, consistently below the expected 14% Vermont prevalence
- Screening method now involves a paper screening too; rate of positive screens for food insecurity has increased dramatically

NEXT STEPS:

- Address PRISM barriers
- Display process flow map of screening process
- Implement daily charge nurse report for Food Insecurity
- Formalize Food Insecurity screening into Case Management Rounds with pediatric resident team
- Develop communication tools in discharge summary to convey results of Food Insecurity screening to PCP

TACTIC #4

Integrate food insecurity screening into current Employee Wellness and Employee Family Assistance Work Life programs and broaden the distribution of information on community resources that provide access to healthy foods.

WORK-TO-DATE:

- The Hunger Vital Sign screening questions have been integrated into the LeRoyer Emergency Assistance Fund application:
 1. Within the past 12 months we worried whether our food would run out before we got money to buy more
True or False
 2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more
True or False
- Community Health Team dieticians have improved a rack card that depicts food resources available in the community. Applicants for the LeRoyer Emergency Assistance Fund will receive this rack card, and a flyer with the same resources will be distributed to eight departments within the Medical Center
- The Working Bridges newsletter is now distributed to several departments within the hospital
- Employees enrolled in Working Bridges receive help with applying for 3 Squares
- The Pay It Forward Program was launched in August, 2017; see more information under Access to Healthy Foods, Tactic #1
- Employees in need can access gift cards for grocery stores from the Employee Family Assistance Program

Affordable Housing

GLOBAL AIM:

To improve housing retention, temporary emergency shelter and permanent supportive housing for the members of our community.

TACTIC #1

Continue to provide support for transitional and supportive housing opportunities as defined in the plan, “Housing and Health Care; The University of Vermont Medical Center’s Role in Local Housing.”

WORK-TO-DATE:

The UVM Medical Center has invested in the following initiatives to help meet the housing needs of its patients and community:

- **Harbor Place** is a motel in Shelburne established for people experiencing homelessness and provides case management and other services to individuals and families who stay there. UVM Medical Center provided some funding to assist with startup costs, and now pays to have patients stay there if they are medically ready for discharge but have nowhere safe to go. This program has been in place since November, 2013.
- **Beacon Apartments** is a former motel which provides permanent housing to chronically homeless individuals who have significant medical needs. Providing people in these circumstances with housing has been shown to decrease their need for intensive medical services. Beacon Apartments started taking residents in January, 2016.
- The former **Bel-Aire Motel** is used to house patients who cannot be discharged because they lack housing or for those who have experienced chronic homelessness. Residents of the one-bedroom apartments began moving-in in August 2017. Medical respite placements are anticipated to begin in January 2018.
- **Memory Care at Allen Brook**, operated by the Cathedral Square Corporation, will provide residential care for Medicaid patients with dementia. It is expected to begin taking residents in January, 2018.

These projects are being evaluated with strong results. Data will help identify other opportunities for the UVM Medical Center to address housing needs within the communities it serves.

TACTIC #2

Explore expansion of Working Bridges, the LeRoyer Fund and NEFCU’s Pay Day Advance Loans for employees.

WORK-TO-DATE:

These programs are currently available and utilized by Medical Center employees, and due to resource capacity constraints there is no expectation of movement prior to the next Implementation Strategy.

TACTIC #3

Continue to participate on the Chittenden County Homeless Alliance and use this partnership to develop a business plan to explore including community health workers in the Community Health Team.

WORK-TO-DATE:

To gauge how easily people experiencing homelessness can navigate community resources the Accountable Persons hosted a facilitated discussion on September 22, 2017, among community partners whose organizations have a street outreach component. People with lived experience also participated. Highlights from the discussion, which were shared with the Chittenden County Homeless Alliance at their December, 2017 meeting:

- Thirty-two individuals from sixteen partner agencies, as well as two individuals with lived experience attended the half-day session
- Each community partner explained their outreach work as it relates to supporting individuals experiencing homelessness; those with lived experience shared their stories and perspectives on services
- Facilitators utilized the STEEP (Safe, Timely, Efficient, Effective, Equitable, Person & Family Centered tool) to highlight existing services
- There are five basic areas in which current outreach services are supporting individuals experiencing homelessness
 1. Shelter
 2. Healthcare
 3. Outreach relationship building
 4. Response lines (211 and 911)
 5. Data Collection
- Strengths identified among outreach services:
 - Safety is a priority
 - Everyone deserves housing; Housing First is a recognized practice
 - Our community is committed to social justice and is small enough to find solutions for effective practices
- Recommended actions:
 - Develop shared data systems and acquire funding for resource gaps
 - Build upon Coordinated Entry process, identify physical spaces for increased access, and establish a budget, protocol, and procedures
 - Pilot a Coordinated Funding System that utilizes funding from multiple sources
 - Agree upon a Universal Release Form for every agency to use with clients; create mechanism for mobile access to shared database
 - Create a Consumer Advisory Board for 211 to improve access to outreach services with individual profile options

TACTIC #4

Continue to participate as a member of the Building Homes Together collaborative which aims to develop 3,500 new units of housing in Chittenden County by 2020, with a focus on vulnerable populations.

WORK-TO-DATE:

- 916 new homes built in 2016; however, only 69 new affordable homes were added
- 2017: 360 new rentals added to the market in 2017 with 52 of them affordable
- 2018: nonprofit organizations described willingness to build over 300 homes
- As of July, 2017, current vacancy rate is 2.5%
- Rent continues to rise 4% each year

Chronic Conditions

GLOBAL AIM:

Enable positive behaviors in order to reduce the incidence and impact of chronic conditions for patients within our communities.

TACTIC #1

Explore a care-team model design for delivering high-value primary care that will support care coordination for our patient community.

WORK-TO-DATE:

- The Accountable Person for this tactic is overseeing a Telemedicine Pilot to understand the feasibility of Tele-Health as a solution to remove transportation as a barrier for vulnerable patients to see their primary care provider. This program could possibly increase access to preventive and chronic care before conditions require an emergency department visit.
- Start date: January 2017
- During the first half of 2017, the effort tested and evaluated technology and procedures
- Estimated 4-5 patient visits per provider
- Telemedicine staff trained
- New scope solution tested
- Clinicians trained on Avizia scopes
- CAB approval
- Tasks coordinated for Go Live
- System is live and working between SASH and Primary Care
- October 2017: one successful visit with Dr. John Miller
- The Network Director of Tele-Health Services is working with OneCare and SASH to leverage the Medicare waiver

TACTIC #2

Develop a work plan for the expansion of culinary medicine.

THIS TACTIC IS NOW UNDER ACCESS TO HEALTHY FOODS

Early Childhood and Family Supports

GLOBAL AIM:

Improve the health of children and families by incorporating culturally sensitive strategies that involve two generations and increase awareness and inclusion of Adverse Childhood Experiences (ACEs).

TACTIC #1

Create an inventory of the UVM Medical Center's current investments in Early Childhood and Family Supports and assess their alignment with Social Determinants of Health.

WORK-TO-DATE:

- The Accountable Persons will meet in January 2018 to begin the inventory process

NOTE:

The original tactic for Early Childhood & Family Supports was, "The UVM Medical Center will create two business plans. The UVM Medical Center will continue to develop and implement a pilot program aimed at preventing ACEs. The program will use a family-centered curriculum which will include a home visiting service. The UVM Medical Center will research and develop a second business plan for how the Medical Center will address the community-identified need regarding Early Childhood and Family Support. When meeting about this need area, the Accountable Persons and Quality Improvement Partner refined the language of this tactic.

Healthy Aging

GLOBAL AIM:

To enable the aging population to optimize health and to live a high quality of life.

TACTIC #1

Collaborate with community partners in order to provide improved access to, and better coordination among, existing community resources for the aging.

Concepts of this tactic are being carried out through the following project pilot: TeleConsult for Specialty Palliative Care Continuity among People at High Risk for Goal-Discordant Hospital Re-admission.

PARTNERS:

- The UVM Medical Center Division of Palliative Medicine
- VNA Home Health & Hospice
- UVM Computer Science/Complex Systems
- UVM Engineering
- Graduate Students from UVM Complex Systems and Champlain College Emergent Media Center

PROJECT OBJECTIVES:

- Conduct 25 specialty palliative care follow-up tele-consult home visits with a VNA Home Health & Hospice staff member physically in the home to facilitate technology interface and navigate post-conversation resource mobilization
- Evaluate the feasibility and quality of tele-consult communication

WORK-TO-DATE:

- Grant proposal has been submitted for full project funding
- Training for collaborating VNA nurses and palliative physicians has begun
- Process for identifying and scheduling tele-consult home visits has been developed
- Project leaders expect to complete one tele-consult visit by the end of 2017
- 1-2 tele-consult visits per month are anticipated beginning in Spring 2018

NOTE:

The original tactic for healthy aging was, “Collaborate with community partners in order to provide improved access to, and better coordination among, existing community resources for the aging. Specifically, the concept of a principal case worker to coordinate services for elders will be explored. If endorsed, UVM Medical Center will lead or collaborate in the creation of a business plan as agreed by the collaborators. Additionally, UVM Medical Center will also explore the capacity of Community Health Improvement’s existing programs to meet the needs of vulnerable adults.” When meeting about this need area, the Executive Sponsor and Project Leader refined the language of the tactic.

Mental Health

GLOBAL AIM:

To increase awareness regarding mental health services and support for all ages.

TACTIC #1

Create a business plan to explore providing Inpatient child psychiatry and extended residential services in northwestern Vermont through a partnership with existing suppliers of these services.

TACTIC #2

Create a business plan to explore expansion of integrated mental health services in all primary care offices in Grand Isle and Chittenden Counties.

TACTIC #3

Create a business plan to explore joining the Rise VT collaborative, and become a backbone for the initiative in Grand Isle and Chittenden counties.

WORK-TO-DATE:

The University of Vermont Health Network Leadership Council, which consists of the leaders of the Network, its affiliate hospitals, and its physician group, has recognized mental health care delivery reform as one of the Network's top strategic priorities for 2018. Over the next year, the Network will develop a comprehensive strategic plan to improve the delivery of mental health care across our service region in Vermont and New York. When completed, that plan will include tactics to address access to inpatient and outpatient mental health services, integrating mental health services in primary care office through a medical home model, and collaborations with existing public and private providers of these services. As a result, progress on these tactics will now be monitored through the Network strategic planning process, and the results will be included in future CHNA reports.

2017 INITIATIVES:

- The Child Psychiatry unit at Champlain Valley Physicians Hospital is at nearly full capacity and the UVM Health Network is working closely with both the Vermont Department of Mental Health and the New York Office of Mental Health to make this resource available to children and their families from both states.
- The Medical Center's Child Psychiatry Fellowship has been doubled (from two to four fellows per year) to provide specialized support to inpatient pediatrics at the UVM Medical Center, and to pediatric patients in the Emergency Department. This fellowship has become a major pipeline for child psychiatrists in Vermont and New York. This will be effective in July, 2018, due to the recruitment cycle of fellowship programs.
- The UVM Medical Center made a significant investment with its partners at the Howard Center in mental health services for our region. Following that decision, the two organizations worked together to determine how best to financially support increased behavioral and mental health supports and agreed upon the following:
 - ACT 1: to partially support the operations of the program, which provides 24/7/365 information, referral, screening and assessment for individuals of all ages who are suspected to be incapacity due to alcohol or other drugs
 - Safe Recovery Program: to support the program's needle exchange and Narcan distribution program
 - Dedicated Crisis Clinician Deployed to the Medical Center's Emergency Department: to hire a dedicated crisis clinician to be deployed to the Department during identified peak times
 - Howard Center Social Workers for Primary Care Clinic Needs: to deploy social workers to primary care. In early 2018 a clinician will begin work with New American patients served by Adult Primary Care Burlington, and another with pediatric patients and their families who are served by UVM Children's Hospital Primary Care

Oral Health

GLOBAL AIM:

To improve the oral health of our community.

TACTIC #1

Develop a white paper on dental and oral health needs in Chittenden and Grand Isle counties by the end of 2017.

WORK-TO-DATE:

After reviewing recommendations of the Green Mountain Care Board, the data in UVM Medical Center's service area, and the priorities of the Vermont Oral Health Coalition, a white paper proposed that one of the original tactics be retained (with a slight rewording) and that two additional tactics be added. In order for any of the tactics to occur, a provider champion as well as appropriate colleagues are essential. Continued involvement and input from community partners, such as CHCB, VSDS and the Office of Oral Health will be critical to the success of any of these tactics.

Original tactic #1:

Pilot and Implement an oral health screening tool at UVMMC which will include the creation of an associated algorithm for generating appropriate follow-up referrals based on the results of screening.

Recommended tactic #1:

Working with community partners, such as the Vermont Department of Health and Community Health Centers of Vermont, explore the potential development of an oral health screening tool at a primary care site family medicine at UVMMC, which would include appropriate referrals based on the results of the screening.

New tactic #2:

Explore with the UVMMC Dental Residency program the feasibility of providing operative restorative care for adult patients with special needs in 2018.

New tactic #3:

Ensure the UVM Medical Center' Dental Clinic is represented on the Vermont Oral Health Coalition.

Removing Barriers to Care

GLOBAL AIM:

To ensure all individuals have access to resources to receive the care and support they need to live healthy lives.

TACTIC #1

Develop a business plan to quantify the need for community health workers and create the structure to connect currently unconnected services.

WORK-TO-DATE:

The need for community health workers is currently under evaluation. The implementation of those positions will be considered in 2019.

TACTIC #2

Continue to advocate for “Transportation is Healthcare” through membership on the Environmental Community Opportunity Sustainability (ECOS) group.

WORK-TO-DATE:

The UVM Medical Center continues to be a part of the ECOS group, which coordinates its plans with the Vermont Agency of Transportation. The 2013 ECOS Plan includes the strategy to “Increase opportunity for every person in our community to achieve optimal health and personal safety,” in its Transportation section.

The UVM Medical Center also has representation on the Neighbor Rides Advisory Team, a program that connects volunteer drivers with the Special Services Transportation Agency.

Substance Use Disorder¹

GLOBAL AIM:

To improve the lives of people affected by substance use disorder.

TACTIC #1

Develop a business plan to assess return-on investment related to the expansion of existing support services available in the Medication Assisted Treatment program and increase wrap-around supports to patients within the Medical Center.

Concepts of this tactic have been included in the following Mental Health tactic: submit a proposal to leadership for a business plan to explore the expansion of integrated mental health services in all primary care offices in Grand Isle and Chittenden counties.

TACTIC #2

Train and support UVM Medical Center's primary care teams on treating patients affected by substance use disorder.

WORK-TO-DATE:

- Learning Collaborative: The UVM Medical Center's Addiction Treatment Program (ATP) received a grant from the State to deploy an educational program to provide training to all interested MD's, Nurse Practitioners, and Physician Assistants in Vermont on addiction and medication assisted treatment
- Their first program was delivered successfully; there will be more opportunities throughout the year
- ATP has developed a training program for APPs at the hospital
- Internal Medicine and Family Medicine residents have a rotation in the ATP
- Licensed Alcohol and Drug Counselors provide consultations for patients on medical and surgical inpatient units

TACTIC #3

Support the Emergency Department and the Inpatient Units by creating guidelines to help individuals with substance use disorder needs and offering treatment during longer stays.

CURRENT RESOURCES:

- Nasal spray kits for patients who have presented to the ED with opiate overdose
- Referrals to Howard Center's Safe Recovery
- Referrals to the ACT-1/Bridge Program for acute detoxification services related to alcohol & opioid addiction

FUTURE INITIATIVES:

- Initiate a short bridging course of buprenorphine in the ED with an agreement from the The UVM Medical Center's Addiction Treatment Program to see patients for a full screening and treatment plan within 72 hours

¹ At the suggestion of Accountable Persons, the name of this need area has changed from Substance Abuse to Substance Use Disorder. This name change is also consistent with the DSM-5, which no longer uses the term Substance Abuse.



Notes

QUESTIONS ABOUT THE IMPLEMENTATION STRATEGY?

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