Copley Hospital Community Health Needs Assessment Implementation Plan
Progress Report (as of May 2018)

Community Need: Reduce Preventable Hospital Visits (Reduce the Cost of Healthcare)

Objectives: Reduce service area's rate of 30-day all-cause readmissions; Reduce # of avoidable visits to the ER; All persons in HSA will have a primary care provider

Action Item/Specific Tactic	Outputs Performance Level Accountability	Results	Comments
Inpatient Readmissions	Follow up with PCP within 7 days from discharge	Achieved for all inpatients	Established process w/ Primary Care Practices
	Real time review of inpatient readmits	Established. In 2017, identified risk criteria of diagnosis of COPD or CHF, Lives Alone and Frailty as key risk factors. In 2018, refined to identify best risk criteria to be diagnosis of COPD or CHF and Lives Alone. Will continue to monitor.	Calendar Year 2016: Readmission rates ranged from 9.15%-26.11%; (all Vermont Critical Access Hospitals' range 12.74%-17.45%). Jan. – Sept. 2017: Copley's 30-day all-cause readmission rates ranged from 4.4%-16.98%; (all Vermont Critical Access Hospitals' range 8.73%-16.80%). [latest from claims data per VAHHS] 2018: 01/01/18 thru 04/30/18 Copley's readmission rate is 6.92% (source: MCG)
	Readmissions rate	Readmissions rate shows improvement, below or on par with rates of Vermont Critical Access Hospitals.	Team formed to implement the LACE tool for inpatients. (LACE is a risk assessment tool; LACE stands for length of stay, acuity of admission, Charlson comorbidity index, CCI, and number of emergency department visits in preceding 6 months). Use of LACE began as of July 1, 2017, to screen all inpatients prior to discharge, and establish baseline data and evaluate best risk criteria specific to our patient population. As of 2018, identified best risk criteria to be: diagnosis of COPD or CHF and Lives Alone.

ER Utilization Follow up w Frequent Users; modified to all ER patients identified with potential unmet needs	# of patients referred # of referrals made	January 2017-December 2017 837 unique patients in ER connected to social worker 1,106 total referrals made Referrals made, in order of most need, were for: securing a Primary Care Provider uninsured, financial assistance non-urgent referral for substance abuse non-urgent referral mental health lack of our unstable housing Home health referral dental services	Social Worker placed in the Emergency Department as of January 2017, in collaboration with Community Health Services of Lamoille Valley (CHSLV) Social Worker focused on working with "super users" of the ER. In a pilot program, we identified 29 "super users" and implemented a shared care plan. These super users accounted for 4% of the total ER viists in the initial 90-day period; they accounted for only 1% in the second 90-day period. That represents a potential $144,300 in cost savings to the system due to decrease in ED visits. The 3rd set of 90 days continued to see a decrease in the number of visits. Continued this pilot, with a narrower focus. Twenty-three patients identified as "super users, with 113 total visits in initial 90 day cycle. Number of visits reduced to 45 in the 2nd 90-day period. One success story from this collaborative pilot: Patient that struggles with substance abuse had 14 total ED visits since 2015. Twelve of those 14 visits were connected to substance abuse. Since the shared care coordination plan was put into place, zero ER visits. However, continue to see some High Utilizer visit increases even with shared care coordination put into place.
ED referral to Home Health	# of patients referred	January 2017-December 2017 38 patients referred	Process change as of Jan. 2017. Social Worker placed in the Emergency Department in collaboration with Community Health Services of Lamoille Valley (CHSLV).
Med Reconciliation via Home Health referral as part of Hospital Discharge, patients 65+	# of referrals		Home Health personnel participate in hospital discharge planning meeting. Referral is not captured electronically.

Assist ER patient in securing Primary Care Provider	# of patients referred	In FY2015, 176 patients referred to PCP In FY2016, 148 patients referred In January 2017, process change. Social Worker placed in Emergency Department. In 2017, 529 referred; 303 connected to PCP	Patients registering in the ER were asked if they had a PCP. If they did not, they were asked if they wanted assistance securing a PCP. If yes, their information was shared with a care coordinator at Community Health Services of Lamoille Valley (CHSLV) who would then contact them to help them get a PCP. Lag time and difficulty in confirming patient actually made an appointment. CHSLV/Copley Hospital collaboration. Social Worker was placed in the Emergency Department full time beginning mid-January 2017. In late 2017, Copley hired the ER social worker full time, and expanded the work to include inpatient population. In 2018, Copley is collaborating with CHSLV to place a referral resource person part-time to assist the social worker in handling the expanded case load. Position posted at the time of this report.
Learning Collaborative through Blueprint: Connecting Frequent Complex Patients with dedicated Care Coord.; Program run through Community Health Services of Lamoille County (CHSLV)	# of patients in program	Hospital's Social Worker uses shared care plan in collaboration with other providers and social service agencies to reduce avoidable use of the ER and readmissions.	May 2017: Process/Program being revamped by Blueprint for Health Care Coordination Team Facilitator due to difficulty in getting patient participation and measurable improvement. 2017: Copley Hospital's participation reflected in Social Worke in Emergency Department working with Blueprint initiative to integrate use of a shared care plan. Use of shared care plan continued into 2018 with hospital's social worker with inpatients and emergency room patients.
Advance Directives and Hospice Care included in Social Media information	Articles/content submitted and published	2 articles published re end of life/advanced directives 4 articles regarding Hospice	

Measurable long term outcomes

% 30 day all-cause readmissions for Copley for all payers (Copley)

Measurable long term outcomes (population level accountability)

Outpatient Potentially Avoidable ED Visits (per 1,000**) :** 77.5 (calendar year 2016 per Blueprint for Health HSA profile)

89% of residents with PCP 92% of residents with insurance (age 18-64)

Source: 2015-2016 BRFSS data, Morrisville Health District

Community Need: Chronic Conditions: Obesity

Objectives: Reduce the rate of obesity in the Copley Hospital Service Area

Action Item/Specific Tactic	Outputs Performance Level Accountability	Results	Comments
Copley Employee Wellness Program; Facilitate healthier lifestyle/choices w/ largest year round employer in area	# of employees participating # of events/programs/screenings	2017: 1,764 employee participation interactions 132 events/programs/screenings 2018 (as of April 2018) 524 employee participation interactions 2017 highlights: 15 employees participated in Employee Wellness program "Go Figure." 7 employees participated in 12-week Lunchtime Boot Camp Increased employee participation in Corporate Cup 5K from 13 to 40 to 62 participants from 2016 to 2017 to 2018.	Working in tandem with our insurance company. Set aggregate baseline data; impact results will take several years. As of 2017: 1.6% Copley employees using Copley health insurance are obese 6.7% Copley employees using Copley health insurance have hypertension 3.2% Copley employees using Copley health insurance have diabetes In 2017, 80 employees (15%) participated in the hospital's insurance company's Personal Health Assessment program.
Copley Workplace Wellness Programs; Help area employers develop healthier living programs for their employees	# of participants #of employers participating # of events/programs/screenings	2017: 292 employees participating 15 employers participating 20 events/programs/screenings 2018 (as of April 2018) 150 employees participating 6 employers participating 6 events/programs/screenings	Seeing positive behavior changes in some, but nothing tangible in the numbers.
Wellness Programs offered in community	# of events # of participants	2017 1,254 participants, 75 events total 2018 (as of April 2018) 234 participants, 25 events	Offered in 2017 and 2018 (as of April 2018) Diabetes Support Group Public CPR Class First Aid Training Type 1 Diabetes 101 Nutrition w/ Cardiac Rehab

			Nutrition Fair /Health Talks Public Health Screenings "Baby Shower Party" w/ VDH Childbirth Education Classes (series). Bike Safety, Stroke Awareness Classes AARP Drivers Class , Medquest – Student Shadow, Hemlich Training
Copley 5k Run/Walk for the Heart	5K Run/Walk established	90 runners and walkers participated in 2016 and 2017. Race planning underway for 2018, with race to be a citizen race within Peoples Academy Invitational. Event is held in conjunction with Rocktoberfest.	In 2016 and 2017, promotes use of the Lamoille Valley Rail Trail for exercise and recreation. 2018 race will be moved to Peoples Academy to integrate into existing running event; continues to be a part of Morristown's Rocktoberfest.
Bike Share/Bike Racks in Morristown	Grant made to Morristown Bike Share program	$1,000 donation to Morristown Bike Share in 2016 and 2017.	Supports recreation and transportation
Targeted Social Media Marketing Campaign re Healthy Living Choices, Preventive Screenings, Healthy Activities in Area	Blog LiveWellLamoille.com created	Launched April 19, 2016, Averaging one post every 2 weeks.	Blog is funded and hosted by Copley Hospital and features Bloggers from social service organizations, healthcare providers, community leaders and community members. Topic Areas: Health Behaviors, Clinical Care, Social & Economic Factors, Physical, Preventive Screenings; Healthy Activities in the Area; Healthy Living Choices; Substance Abuse Prevention; Hospice/Advance Directives
Advocate for town policies that support healthy lifestyle choices (sidewalks, green space, etc.)		Copley representatives participated in People in Partnership meetings, Lamoille Hunger Council of Lamoille Valley and Town Planning Commission as needed. Donated $1,000 to Hunger Free VT Lamoille Hunger Council in 2017.	Copley spoke in support of proposed renovation of school sports facility to include community recreational use. Spoke in support of zoning and environmental policies that encourage healthy lifestyle choices including sidewalks, bike lane on roads, green space.

Measurable long term outcomes (population level accountability)

11% of residents without PCP 8% of residents without insurance 29% of adults with hypertension
26% of adults who are obese 61% of adults meeting the physical activity guidelines 7% of adults with diabetes (VDH)
source: (2015-2016 BRFSS/Morrisville Health District

Copley specific

1.6% Copley employees using Copley health insurance who are obese 6.7% Copley employees using Copley health insurance with hypertension
3.2% Copley employees using Copley health insurance with diabetes

Community Need: Routine Preventive Care: Screenings

Objectives: Targeted Population(s) will receive screening for tobacco, alcohol and depression annually/as appropriate; with appropriate referrals made

Action Item/Specific Tactic	Outputs Performance Level Accountability	Results	Comments
Healthy Lamoille Valley / Partnership for Success Advocacy	Grant made to Healthy Lamoille Valley in support of advocacy for green space, healthy town planning and prevention.	$2,500 donation to Healthy Lamoille Valley in 2016; $1,000 for sustainability project in 2017.	2018: researching federal regulations regarding placement of prescription drug drop box on Copley's campus.
Women receiving "Well Woman" exams and/or Pre-Natal Intake at TWC will be screened for Tobacco, Alcohol and Depression; Referrals will be made as needed	# of patients receiving screening Screening tool will be part of electronic health record with mineable data fields for aggregate data collection. Screening expanded to add electronic collection re substance abuse, food security, housing security, personal safety	100% of women receiving "Well Women" exams and/or Pre-Natal Intake at The Women's Center screened for Tobacco, Alcohol and Depression: 2017: 23% of the women screened indicated they smoked. Of patients screened, 20% received smoking cessation support or education. Of patients screened, 8% indicated they were ready to quit. Expanded screening tool built into Electronic Health Record, late 2017. With electronic screening, we see trend in Oct/Nov/Dec of 2017 that 44-70% of women offered screening participated in the screening. Of those that participated, following referrals were made: 4 referrals for food insecurity 3 referrals for housing insecurity 3 referrals re concerns for their personal and/or child's safety. In 2018 (as of March 2018), 35-83% of women offered screening participated in the screening. Of	Training in how to offer screenings to patients offered late 2017. Uptick in participation seen from 2017 to 2018, in part due to additional training and practice in asking screening questions. Participation is typically lower for the questions about personal safety; i.e. Are you scared that your partner or someone else will try to hurt you or your child? Do you always feel safe in your home.

		those that participated: 7 received referrals for food insecurity; no responses indicated housing or personal safety concerns. Social Worker added to The Women's Center practice as part of Women's Health Initiative as of January 2017.	Many patients' needs are handled directly by social worker without additional referral. For those requiring outside referrals, needs are (in order of frequency): Housing Needs, Substance Use & Mental Health Counseling; Health Insurance; Food Insecurity; Intimate Partner Violence; Family/Parenting Support; Smoking Cessation.
Expand tobacco/alcohol /depression screening to additional Outpatient Clinic: Cardiology	Screening tool will be part of electronic health record with mineable data fields for aggregate data collection.	Tobacco/alcohol/depression screening not implemented due to focus on piloting Shared Decision Making program in outpatient cardiology clinic.	Shared Decision Making initiative took three years to complete, longer than anticipated. Copley Hospital was able to successfully implement a decision aid on anticoagulant medication into clinical workflow. The results of this study suggest that use of the decision aid improved decision quality in the patient population, specifically patients were able to correctly answer knowledge questions and rated the decision making process as more collaborative and balanced. These results are important because knowledge of anticoagulants has been shown to improve medication adherence.
ER Referrals to Blueprint for Health Opiate Neighborhood Program (MAT)	# of patients referred	2017: Of 1106 referrals by the social worker in the ER, 51 were referred for non-urgent substance abuse issue.	Note we are tracking referrals for non-urgent substance abuse issues. Patients treated for overdose are connected to Lamoille County Mental Health Crisis Team. Referral to MAT program is made by the LCMH team as appropriate.

Consider Screening Readiness in Emergency Department		Screening is occurring via referrals to hospital social worker.	
Inclusion in targeted Social Media Marketing Campaign re Healthy Living Choices, Preventive Screenings, Healthy Activities in Area	Blog LiveWellLamoille.com created Marketing Campaign promoting Healthy Choices Healthy Choices, tips and prevention information shared via FB, Twitter daily	Launched April 19, 2016, Averaging one post every 2 weeks. Print/Radio campaign ran Jan/Feb; June-Sept. 2017. Ongoing.	Blog is funded and hosted by Copley Hospital and features Bloggers from social service organizations, healthcare providers, community leaders and community members. Topic Areas: Health Behaviors, Clinical Care, Social & Economic Factors, Physical, Preventive Screenings; Healthy Activities in the Area; Healthy Living Choices; Substance Abuse Prevention; Hospice/Advance Directives

Measurable long term outcomes (population level accountability)

15% of Adult Excessive/Binge Drinking (VDH) 16 % of Youth Excessive/Binge Drinking (VDH)
18% of Adults who smoke cigarettes (VDH) 10 % of Adults with 1+ days mental health "not good" (VDH)
12% of Youth (grades 9-12) who smoked cigarettes in last 30 days (VDH)
23% of Youth (grades 9-12) who used marijuana in last 30 days (VDH)
Source: VDH Public Health Explorer; BRFSS (2015-2016)