Vail Health Hospital Community Feedback Meeting

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Agenda

1. Hospital Community Benefit Accountability Program
   a. Review of community benefit activities during the previous year
   b. Review of community benefit implementation plan for upcoming year
   c. Open Discussion – Seeking feedback from participants on the above

2. Hospital Transformation Program (HTP)
   a. Review of the hospital's HTP interventions and milestone status
   b. Open Discussion – Seeking feedback from participants on the above

3. Vail Health's Commitment to Health Equity
   a. Review of hospital interventions to reduce health care disparities
   b. Review of community-wide interventions to reduce health care disparities
   c. Open Discussion – Seeking feedback from participants on the above

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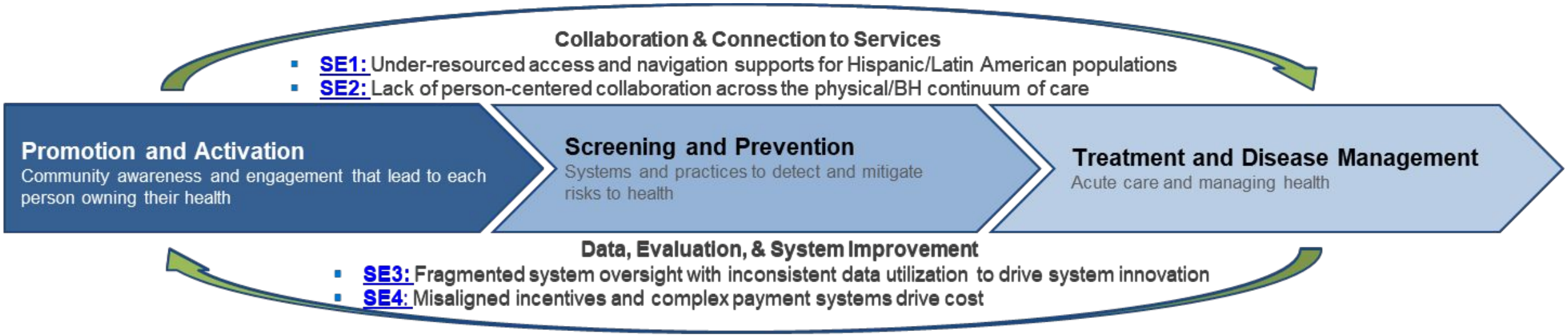
2021 Pop Health Gap Analysis



Promotion and Activation (PA)

- PA1: Lack of culturally-relevant messaging around individual health
- PA2: People are unaware of the available services they are eligible for and their value
- PA3: Inconsistent use of nutritious foods
- PA4: Recreation/daily movement is not a regular habit

Screening and Prevention (SP)

- SP1: Barriers to engaging in preventative care exacerbates conditions
- SP2: Inadequate and inequitable support for young children and families
- SP3: School-based supports are underutilized
- SP4: Inconsistent screening, immunization, & usage of labs to prevent and detect issues
- SP5: Underutilization of services in alternate settings (tele, in-home services, mobile, etc)

Treatment and Disease Management (TDM)

- TDM1: Lack of access to community providers across the full spectrum of services
- TDM2: Provider base and services do not reflect the community's diversity (ethnicity, age, etc)
- TDM3: High cost of long-term medication
- TDM4: Underutilization of lifestyle prescriptions

SE5: Care is unaffordable and uninsured rates are high

SE6: Workforce shortages make service delivery challenging

Partnering with the Community

2022-2024 CHNA Implementation Strategy

1. Engage, Enroll, and Connect People to Services that Improve Whole Person Health
2. Bring Care to the People
3. Focus Prevention and Early Intervention on Our Greatest Health Opportunities
4. Increase Utilization of Healthy Foods
5. Address Healthcare Staffing Shortages with a Focus on Increased Diversity
6. Increase Early Childhood and Family Supports
7. Improve System Interoperability and Integration
8. Advance Internal & External Policy & Incentives to Improve Population Health

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Engage, Enroll, and Connect People to Whole-Person Health

Prior 12 Months	Next 12 Months

• Launched a community-based Medicaid enrollment program for and public assistance programs (i.e. Medicaid, CHP+, etc.) +400 enrollments
• Expand Vail Health's Behavioral Health Service Line
  ○ 23 licensed providers
  ○ All accept commercial insurance and governmental programs
• Support and partner with Community Market (Eagle Valley Community Foundation) to improve access to health food
• Support and fund the Family and Intercultural Resource Center
• Continue funding community efforts with >$3M in grants across~ 12 local BH organizations
• Supported Mountain Family Health Center, providing 2 new locations - Avon and Gypsum
	• Enhance comprehensive care coordination and closed-loop referral system for social determinants of health
	• Implement "Find Help" system for social determinant of health service navigation and connection
	• Work with Eagle County Government to streamline and improve the Medicaid enrollment process
	• Expand community health worker programs, including billable services
	• Continue to funding community engagement and prevention and education efforts across community organizations

Bring Care to the People

Prior 12 Months	Next 12 Months
● Launched high acuity outpatient behavioral health services at Wiegers Mental Health Clinic ● Built out 12 additional outpatient offices for clinic engagement and case management. ● Began construction on the new Precourt Health Center (28 bed regional BH inpatient facility) ● Further expanded community Health Program on MIRA ● Continue to expand mental health, substance use, and physical health services in the community ● Integrated BH within primary care at CMM and MFHC ● Expand Telemedicine services in English and Spanish at CMM, MFHC, and support for private providers ● Olivia's Fund Scholarship Program-(Served over 3750 sessions in past 12 months) ● Added 3 Bilingual Case Managers	● Ensure funding and sustainability of Community Health Programs on MIRA ● Explore options to expand mobile at-home health services with community partners (Eagle County Community Paramedics) ○ create a pro forma and explore legal structure ● Engage with employers in programs to expand reach into the workplace

Focus Prevention & Early Intervention

Prior 12 Months	Next 12 Months
• CMM expanded Endocrinology, Internal Medicine Services, ENT & GI • CMM expanded pediatrics in both Eagle & Summit counties • CMM management of Urgent Care (UC) • CMM increased access with online scheduling • CMM added remote Triage Nurse program • Integrating Behavioral Health at CMM and Mountain Family Health Center (MFHC) • Expansion of telemedicine at CMM, Mountain Family Health Centers and with other providers • Funded multiple partners including (SURO, ECPs, VVMTA, Cycle Effect etc.)	• Expand Metabolic Screening, Education, Testing, and Access • Increase maternal health screening through Family Connects program • Develop easily accessible lactation supports in multiple languages • Expand Gender-specific Preventative Health Programs • Implement family-focused Screening and Treatment for ACES, MH, and SUD • CMM to add bilingual RN to remote Triage Program • CMM to add PHQ2 depression screening to all appointments

Increase Utilization of Healthy Foods

Prior 12 Months	Next 12 Months
● Nutritional education & free meals on MIRA ● Expanded SafeFit program for certain employer groups ● Continue to work with Community Market to improve food bank space at Edwards Community Health Campus	● Increase The Community Market's ability to source and provide nutritious foods ● Maximize Utilization and Quality of Federal Nutrition Programs ● Ensure successful implementation of Proposition FF to provide free school meals for all public school students

Address Healthcare Staffing Shortage with Focus on Diversity

Prior 12 Months	Next 12 Months

• Community Paramedics Partnership:
  ○ Social Determinant of Health (SDoH) screener
  ○ BH assessments & bilingual BH Community Navigator referrals
• Executed contract to build 87 new staffing units in Edwards
• Enrich employee benefits based on staff feedback
  ○ $1000 wellness credit
  ○ Providing four weeks of paid parental leave for healthcare staff
  ○ Increase minimum wage to $20 for all positions
  ○ implemented a housing subsidy
• Created Patient Care Tech and Clinical Assistant 12 month training program for local workforce
• Expanded Mountain Strong EAP to 13 businesses, and added 50 providers
	• Recruit to Optimize the Mix of Providers and Staff Across qualifications
	• Retain and Grow Healthcare Providers and Workforce
	• Accelerate Growth of Diverse Healthcare Leaders as a Part of Broader DEI Efforts
	  ○ implement system wide approach at Vail Health
	• Implement Bilingual Pay Policies to Attract and Grow Language Acquisition for Health Care Workforce
	• Working on multiple housing projects to expand housing options for healthcare staff
	• Expansion of Patient Care Tech and Clinical Assistant training program
	• Adding more employers and providers to Mountain Strong

Increase Early Childhood & Family Supports

Prior 12 Months	Next 12 Months
• Expand home visitation through implementation of Family Connects program • Eagle Valley Behavioral Health (EVBH) funding for Early Childhood Partners • Launch of family/child peer support groups	• Addition of 2 new child/adolescent psychiatrists • Addition of 2 more family therapists • Expand Parent/Family Peer Support • Further expand Family Connects program and partner with Valley View and Aspen Valley

Improve System Interoperability & Integration

Prior 12 Months	Next 12 Months
• Aligning Population Health work across Vail Health system, Mountain Family, Eagle County Paramedics and community partner organizations • Development of Vail Health Outpatient Behavioral Health Cerner Electronic Medical Record • Shaw Cancer Center added to Cerner • Sharing data with Medicaid care coordinators to improve care transition and health outcomes	• Improve alignment of back office operations across healthcare organizations in the community • Launch outpatient behavioral health electronic health record (EMR) system • Develop EMR for inpatient facility (inpatient behavioral health facility to open in 2025) • Invest in health record interoperability, releases of information, etc., to enable seamless case management across various systems of care and human service organizations • Develop a data and evaluation system and rhythm to measure the system's performance and drive continuous improvement

Advance Policy to Improve Community Health

Prior 12 Months	Next 12 Months
• Increased Vail Health's Financial Aid policy eligibility to 550% Federal Poverty Level (FPL) • Aligned Vail Health Financial Assistance Policy with Olivia's Fund • Case Managers crossed train to support clients to apply for the VH Financial Assistance Program	• Explore availability of primary care for all residents at an affordable price • Implement Common Front Door Access for Patient Care at VH/ CMM • Ensure Financial Sustainability via Appropriate Contracted Reimbursement Rates for outpatient behavioral health

Q&A, Discussion & Community Feedback related to Community Benefit Efforts

Hospital Transformation Program (HTP) Overview

Hospital Transformation Program

Statewide initiative to drive improved patient outcomes and reduce costs for the Medicaid population through community health neighborhood engagement (CHNE) and key quality initiatives

CHNE requirements – public engagement, key stakeholder consultation, community advisory meetings

VHH Implementation Plans look to achieve 7 interventions and in turn impact performance for 10 measures – focused on improving health outcomes & cost of care through care coordination, d/c planning & follow up, opioid stewardship, & a focus on BH

HTP – 7 Interventions to Improve in 10 Measures

Interventions:

- Expand SDoH screening and f/u
- Improve behavioral health care & f/u
- Improve hospital utilization PI efforts r/t readmissions, LOS
- Improve community partner/Regional Accountable Entity care coordination
- Decrease opioid prescriptions through pain mgt committee efforts and increase alternate therapies
- Use Hospital Index data to focus PI efforts in order to improve clinical outcomes and reduce cost/utilization
- Improve primary care provider capture on admission in order to improve sharing of electronic transmission of records

Measures:

- # of hospital readmissions
- # of pts with f/u appt prior to discharge & notification to the regional accountable entity
- # of social needs screenings and notification to the regional accountable entity (RAE)
- # of pts screened & referred for perinatal depression/anxiety and notification to the RAE
- # of behavioral health patients with a collaborative discharge plan with the RAE
- # of opioid Rx's vs # of ALTO Rx's
- # of successful record transmissions to PCP upon discharge
- Average length of stay
- Hospital Index score (avoidable complications/cost of care)
- # of pts who received f/u within 30 days of ED visit

Vail Health Hospital's HTP Progress – CHNE

Ongoing Community Health Neighborhood Engagement

- Population Health Strategy meetings
- Community Referral Coordination Meetings
- Continuous coordination with key stakeholders to streamline referral processes
  - Regional Accountable Entity – Rocky Mountain Health Plans
  - Quality Health Network – Health Information Exchange
  - CMM Care Coordinators (physical health)
  - Vail Health Behavioral Health Care Coordinator and Clinical Leadership
  - Hope Center Clinical Leadership
  - Behavioral Health Case Managers
  - Community Paramedics
  - Mountain Family Health Center

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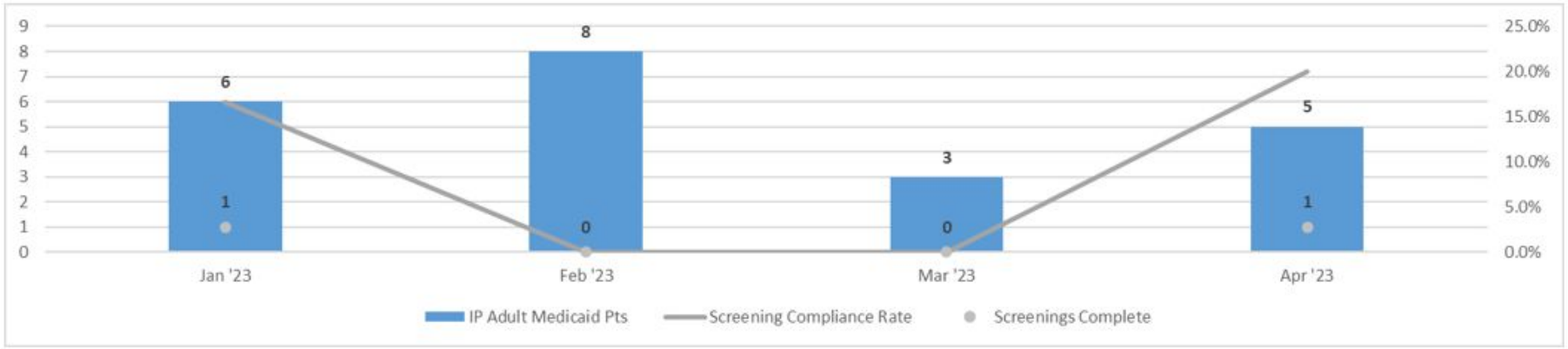
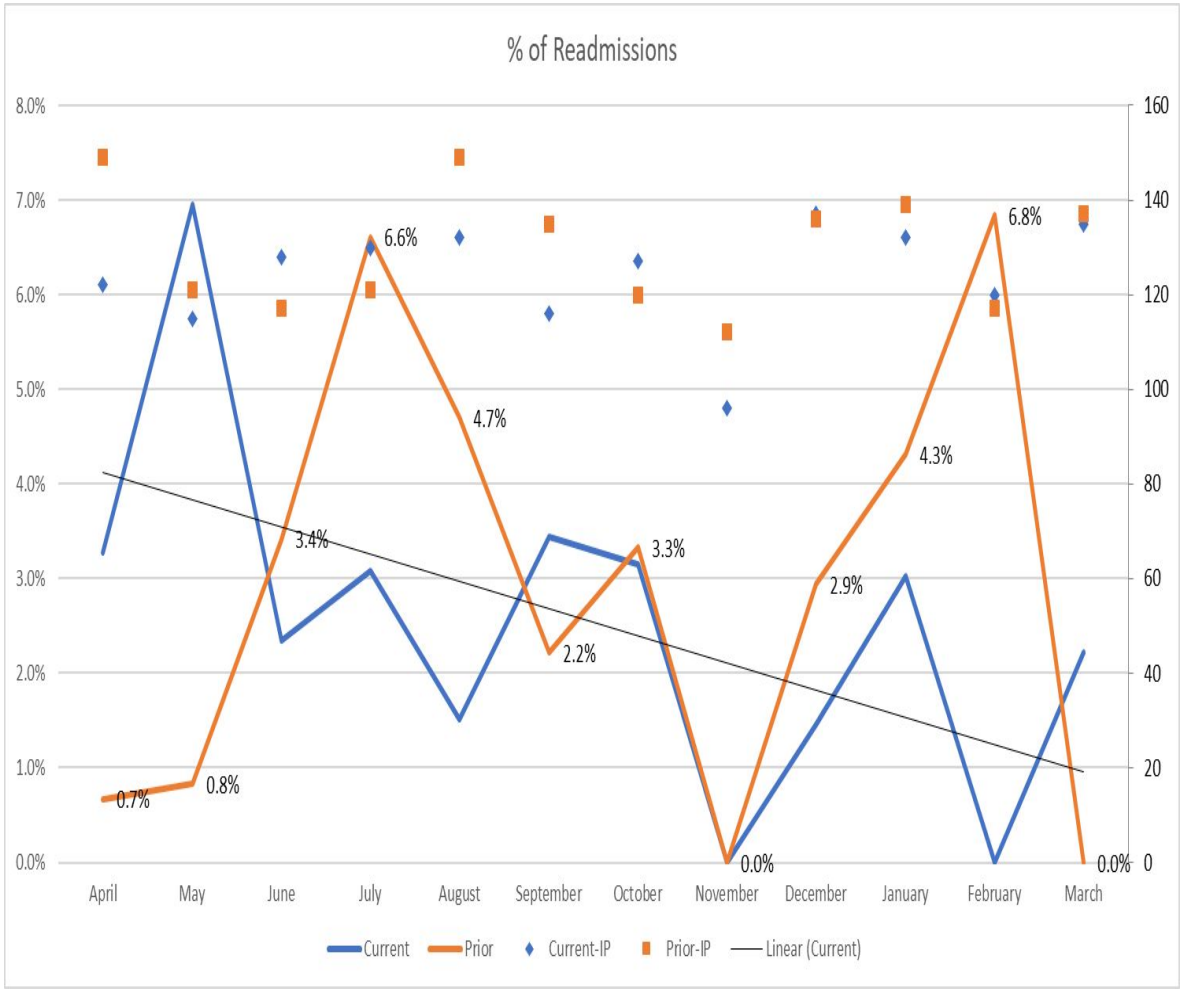
HTP Progress – Expand Social Driver of Health Screening and Follow Up

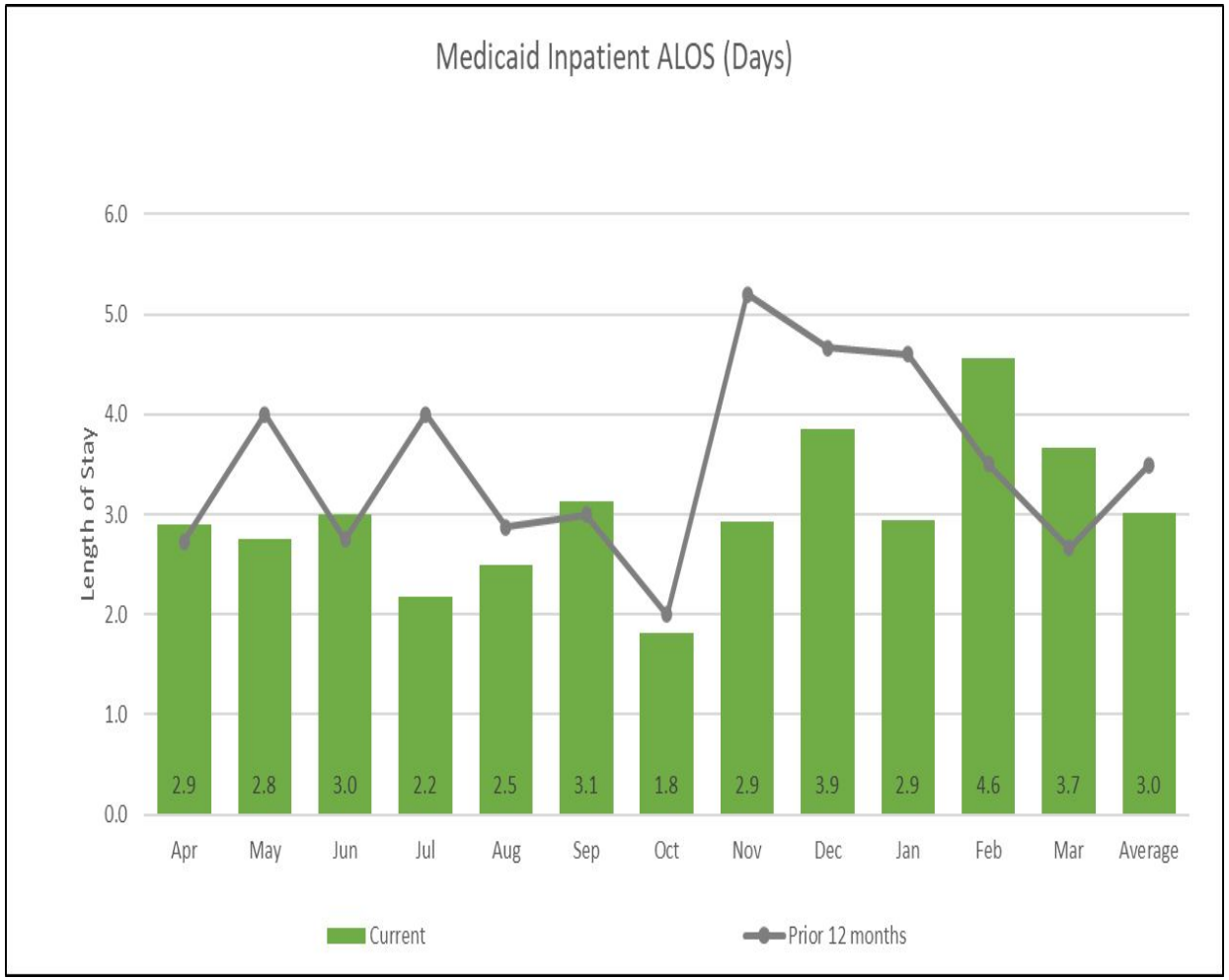
- PREPARE Social Determinants of Health Screener embedded into Electronic Medical Record
- Admission questions to guide consult to Social Work for screener
- Social Work team performs screener and provides follow up/resources
- Find Help Social HIE (Healthcare Information Exchange)
- Use data to fill gaps in services

Social Determinates Of Health Screening Compliance (IP Adult Medicaid Patients Only)		20%	↑	20%	↓ 70.91% (Avg = 9.09%)		At or better than benchmark	≥ 80% HTP



HTP Progress – Focus on QI Efforts r/t Hospital Utilization – Length of Stay and Readmissions





HTP Progress – Opioid Stewardship

SW-BH3/ED ALTO: Hospital and Total Rates

***The Rate Numerator is counting number of VISITS where an ALTO or opioid was administered

c|h|a Colorado Hospital Association

ALTO Rate per 1,000 ED Visits: Selected Hospital(s) and Total

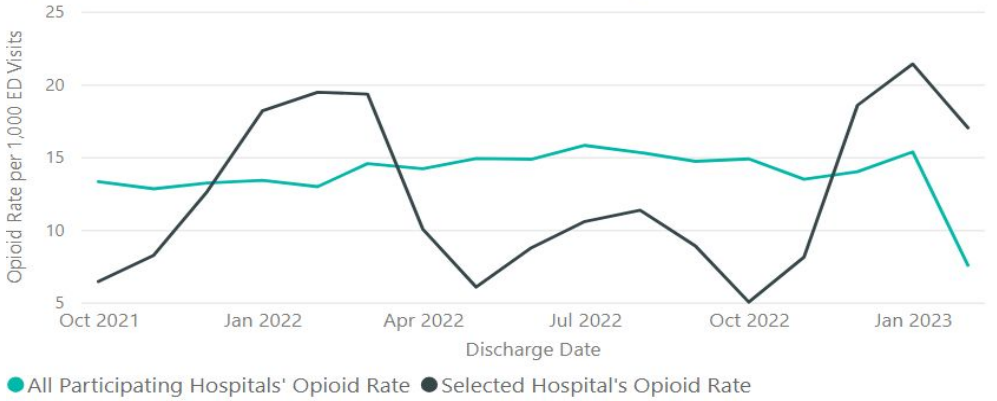
Hospitals Participating with CHA (data in dashboard)

49

ALTO Rate: Selected Hospital(s) and Total

Performance Year	Selected Hospital's ALTO Rate	All Participating Hospitals' ALTO Rate
PY-1	331	393
PY-2	191	149

Opioid Rate per 1,000 ED Visits: Selected Hospital(s) and Total



Opioid Rate: Selected Hospital(s) and Total

Performance Year	Selected Hospital's Opioid Rate	All Participating Hospitals' Opioid Rate
PY-1	140	170
PY-2	70	62

Interventions to reduce Opioids and increase ALTOs in the ED:

- Multidisciplinary Pain Management Committee
- Diagnosis-specific ALTO Powerplans (guides provider practice)
- More real time data collection and sharing (CHA uses claims data)
- Stratify data by diagnosis and provider
- Provide feedback and education

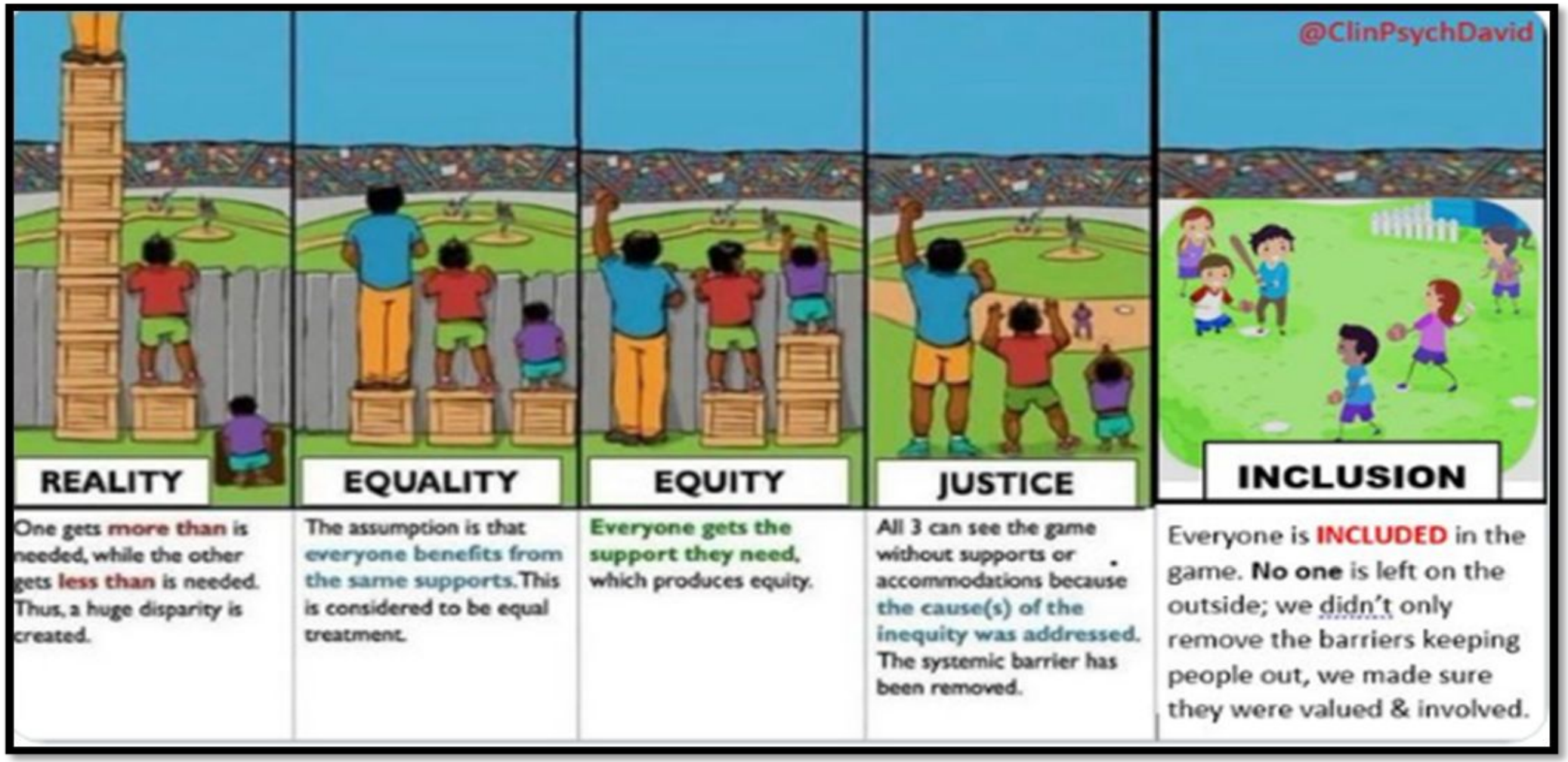
Q&A, Discussion & Community Feedback related to HTP Efforts/Status

Vail Health's Commitment to Health Equity

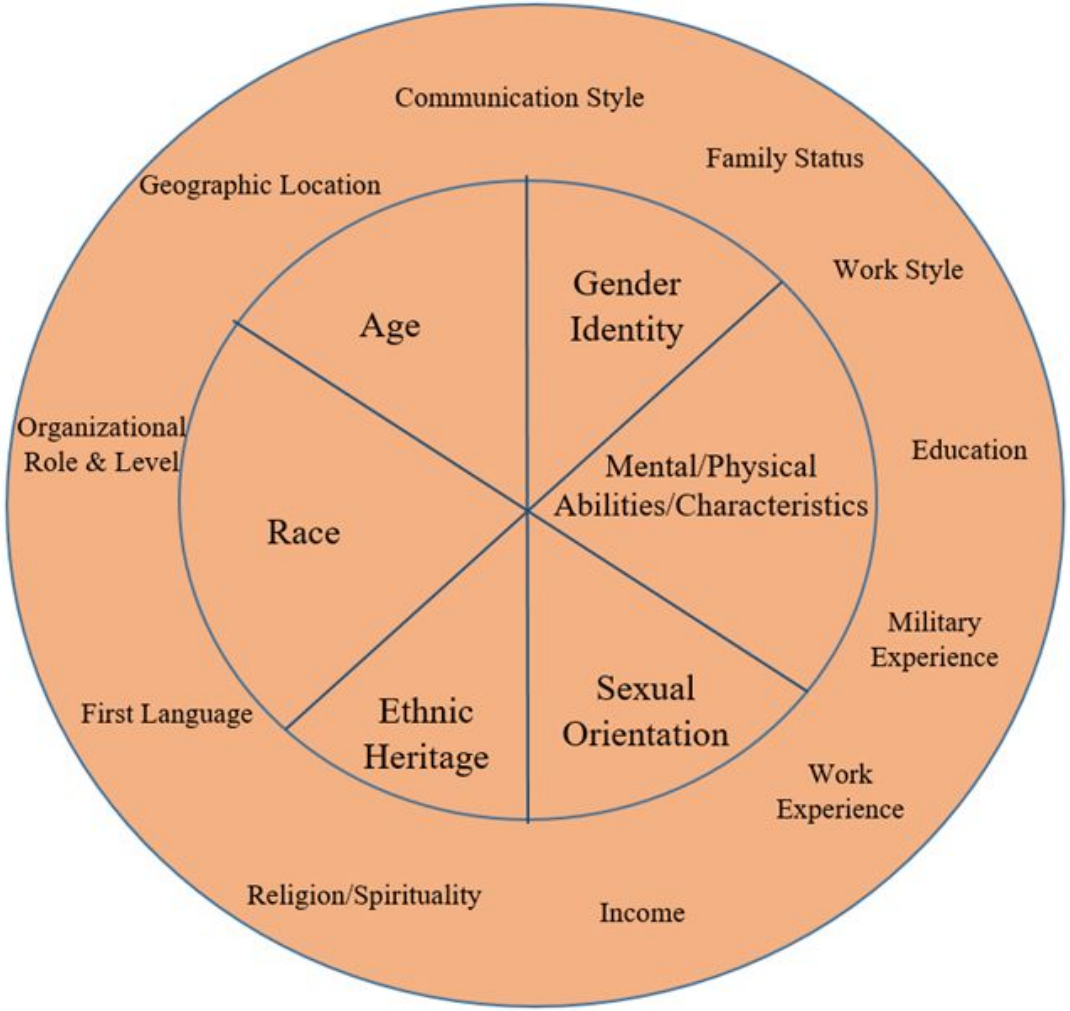
Health Equity

Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

Health Equality vs Equity



Patient Characteristics Affecting Health



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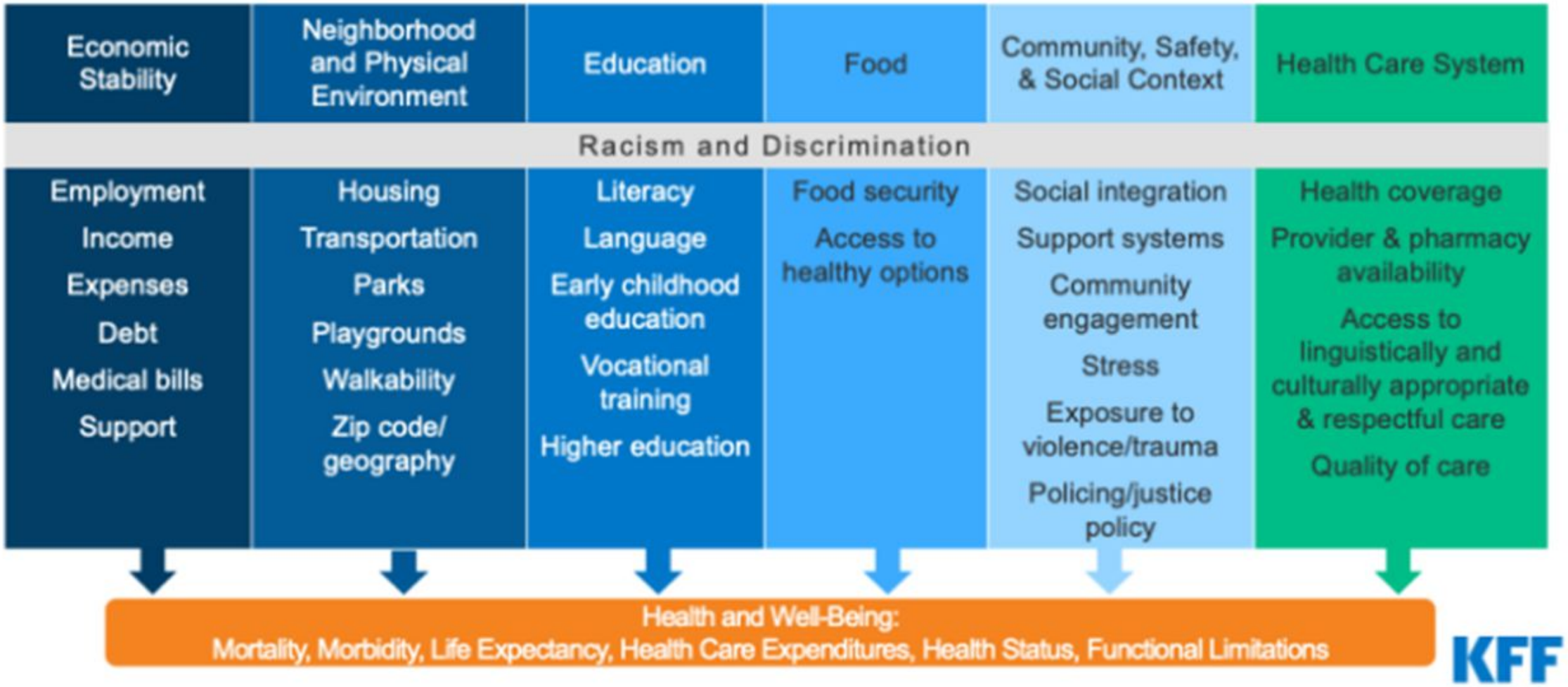
How Health Social/Economic Inequities Drive Health Disparities

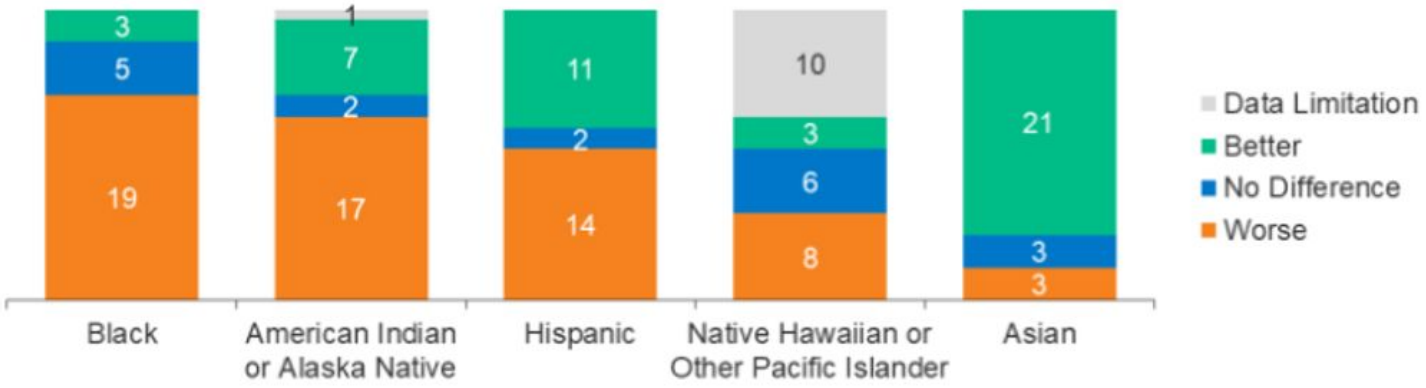


Disparities in the U.S.

Figure 2

People of Color Fare Worse than their White Counterparts Across Many Measures of Health Status

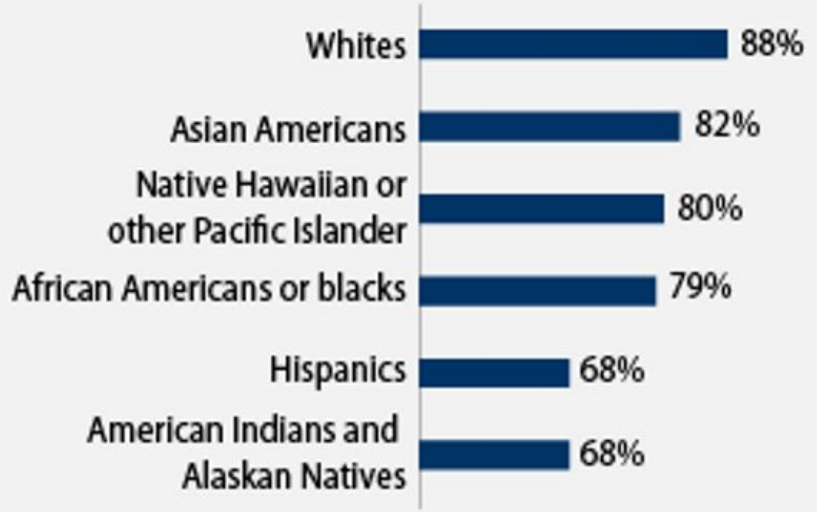
Number of health status measures for which group fared better, the same, or worse compared to White counterparts:



REPORTED NOT DISCLOSING THEIR SEXUAL ORIENTATION TO ANY MEDICAL PROVIDER

Who has health coverage?

Percent of Americans with health coverage, by race



Note: Percentages for Native Hawaiian or other Pacific Islander and American Indian and Alaskan Natives is based on 2005–2007 data, all other percentages based on 2009 data.

Reducing Health Disparities in Acute Care

Health Outcomes Related to Acute Conditions

Looking at VH Data

Sepsis Data Stratification

Sex

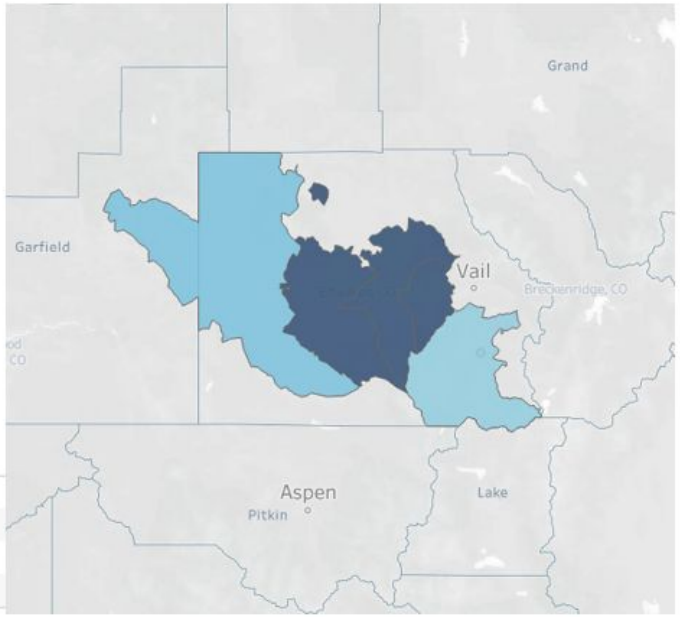
Female	21
Male	50

Payment Source

Medicare	31
Non-Medicare	40

Discharge Disposition

Acute Care Facilitly	2
Expired	2
HOME	21
Hospice - Health Care Facility	1
Left Against Medical Adcive..	1
Other Health Care Facility	3



Race

White	
Black or African American	
Asian	
UTD: Unable to determine the patient's ra..	

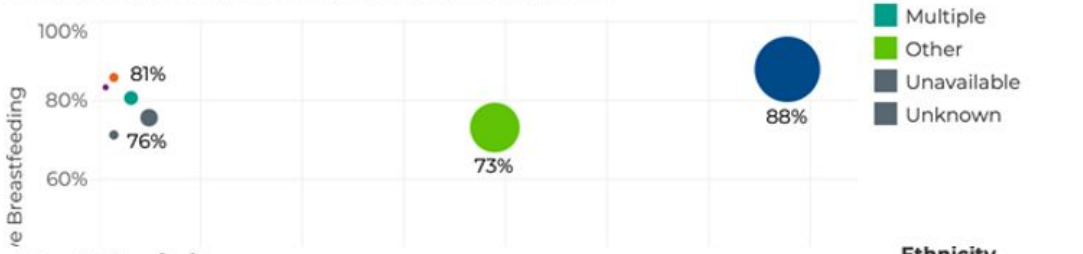
Ethnicity

N - Non-Hispanic	55
Y - Hispanic	16

% Breastfeeding Rates by Race & Ethnicity

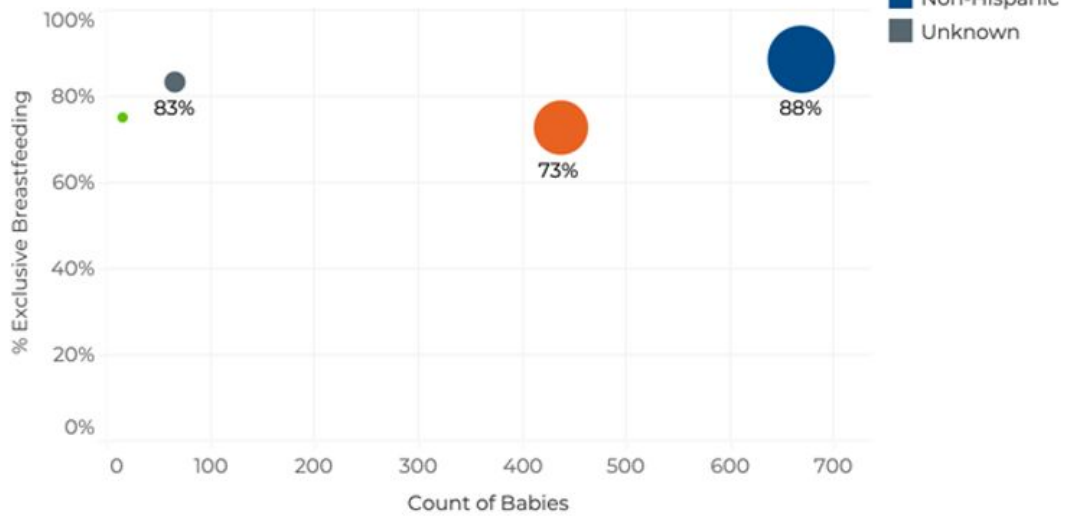
By Race

% Breastfeeding rates by race
Size of dot represents amount of babies in each racial category
Categories with less than 5 total encounters are excluded



By Ethnicity

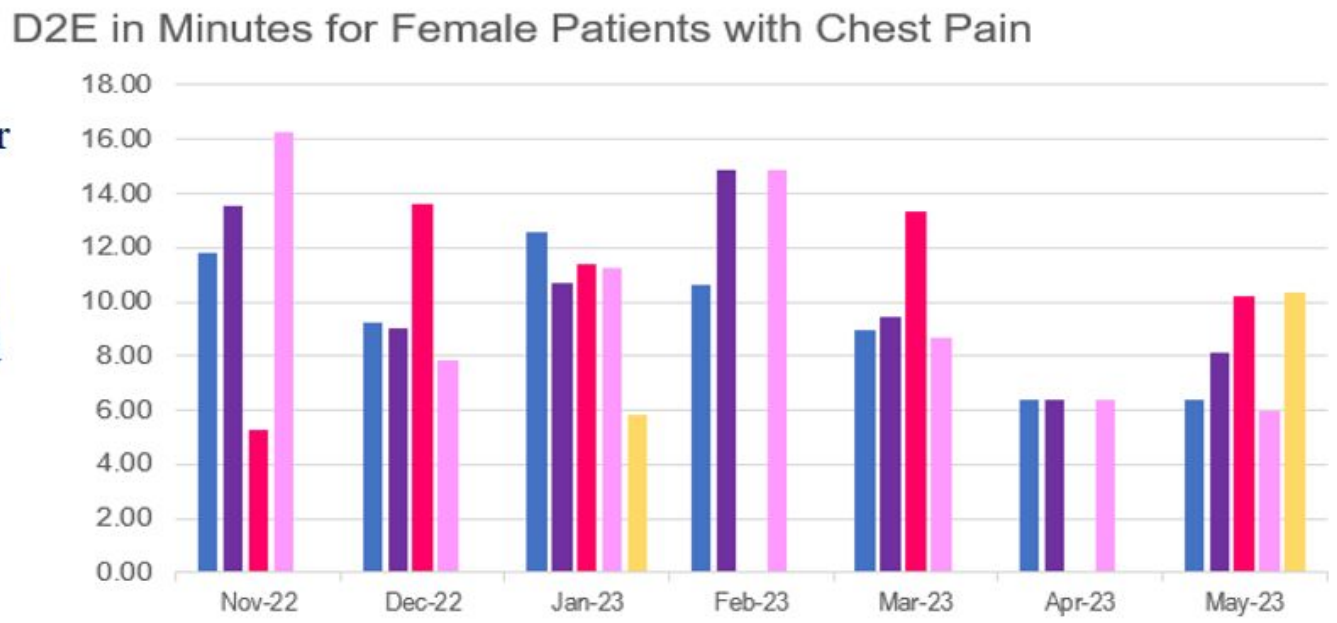
% Breastfeeding rates by ethnicity
Size of dot represents amount of babies in each ethnic category



Looking at VH Data

Door-to-EKG: Female Patients with Chest Pain

Deliberate efforts to reduce gender and ethnic disparities: additional tech available, earlier differential diagnosis in triage, awareness and emphasis (cultural awareness) and additional translation tools



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
AVG D2E	11.81	9.21	12.55	10.61	8.96	6.42	6.36
AVG FEMALE	13.52	9.03	10.72	14.86	9.44	6.39	8.12
AVG HISPANIC FEMALE	5.25	13.60	11.39	0.00	13.33	0.00	10.23
AVG NON-HISPANIC FEMALE	16.28	7.88	11.28	14.86	8.66	6.39	5.97
AVG OTHER FEMALE ("UNKNOWN")	0.00	0.00	5.82	0.00	0.00	0.00	10.33

Reducing Health Disparities through Community Efforts

Health Outcomes related to Chronic Conditions

Community Health Program Model

Novel approaches:

- Providing health care & preventative health screenings in the community
- Healthcare navigation services
- Health insurance navigation & Medicaid enrollment assistance
- Care coordination
- Integrated Behavioral Health
- Informal counseling & social support (SDoH)
- Culturally appropriate health education

What are community health workers?

- Trusted members of the community, with shared life experience- ethnicity, language, geography, socioeconomic factors
- Can provide health education, counseling, health care navigation, care coordination, connection to resources, and social support

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Community Health Patient Experience

MIRA Bus & Community Referral

The MIRA bus is a trusted resource in the community. Through relationship building, MIRA identifies uninsured or underinsured clients and refers them to Community Health Program at Vail Health.

Community Health Worker Intake

Community Health Workers meet with clients on the MIRA bus or in the community to provide intake screenings & services:

- Medicaid Eligibility & Insurance Navigation
- Social Determinants of Health Needs Assessment
- General inquiry into the patients reported needs

Preventative Health Screenings

Patient presents for an appointment with a nurse practitioner for general medical evaluation and behavioral health screenings.

Community Health Programs

Clients are referred to various programs based on need and interest:

- Preventative Health Screenings follow-up, patient education, care coordination, and medical referrals as appropriate
- Integrated Behavioral Health Supports
- Referral for additional resources based on identified needs

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Community Health Program Impact

Medicaid Enrollment:

- Total number of lives approved in 2022: 301
- Number of lives approved in 2023: 118

OmniSalud Enrollment (only available during Open Enrollment):

- Total number of lives approved in 2022: 86

Community Health Program - Preventative Health Screenings:

- Total number of patients seen in 2022: 226
- Number of patients seen in 2023: 98

Future State

"We can achieve health equity in America, **but first, we all must care enough, know enough, do enough, and persist long enough.**"

David Satcher, MD, PhD
Former United States Surgeon General

Diversity is a fact.
Equity is a choice.
Inclusion is an action.
Belonging is an outcome.
Arthur Chan

Q&A, Discussion & Community Feedback Related to Health Equity Efforts

Plan for Future Community Feedback Meetings

- Engagement of key stakeholders **and** community members
- In-person versus virtual
- Translation services
- 1 large meeting versus smaller focus groups
- Cadence – annual versus more frequent – time of year
- If in-person
  - Offer food and childcare
  - “Booths” for community organizations – “health fair” feel
- Required topics plus any additional topics

Contact Information

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Community Health Needs Assessment and additional information can be found at:
https://www.vailhealth.org/about/community-health-needs

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