

# *VT Health Care Innovation Project*

## *Care Models and Care Management Work Group Meeting Agenda*

**Tuesday, February 11, 2014; 10:00 AM to 12 Noon**  
**Office of Professional Regulation - Large Conference Room, 3rd Floor, 89 Main Street, Montpelier**  
**Call-In Number: 1-877-273-4202; Passcode 2252454**

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00-10:05	Welcome; Introductions; Approval of Minutes	Attachment 1 - Minutes from January Meeting	Yes
2	10:05-10:15	Co-Chairs' Report (e.g., Other VHCIP Work Group Activities, Core Team Update, Health Care Reform Update, Legislative Update) <i>(ask for Public Comment)</i>		
3	10:15-10:20	Staff Report (update on consultant scope of work, webinars and inventory) <i>(ask for Public Comment)</i>	Attachments 3a & 3b - Consultant Scope of Work Attachment 3c – Ruggles Primary Care Specialist Interface References	
4	10:20-11:00	Presentation from Blueprint CHT Leaders <i>(ask for Public Comment)</i>	Attachment 4 - Power Point Presentation	
5	11:00-11:50	Prioritizing Activities (goals of activity; proposed process; review of Driver Diagram as it relates to improving care models and care management; identifying specific opportunities for improvement; next steps in prioritizing opportunities for focus) <i>(ask for Public Comment)</i>	Attachment 5a - Definitions Attachment 5b - Driver Diagram	
6	11:50-12:00	Next Steps, Wrap-Up and Future Meeting Schedule (including between-meeting webinars)	Attachment 6 - Meeting Schedule for CMCM (with Webinar dates)	

***VT Health Care Innovation Project  
Care Models and Care Management Work Group Meeting Minutes***

Date of meeting: Jan 14, 2014 10am to 12 noon; ACCD - Calvin Coolidge Conf Room 6<sup>th</sup> Floor; 1 National Life Drive, Montpelier

Attendees: Bea Grause, VAHHS and Nancy Eldridge, Cathedral Square Corporation, Co-Chairs; Anya Rader Wallack, Core Team Chair; Thomas Boyd, Dana DeMartino, Central VT Medical Ctr; Steve Dickens, Invest EAP; Laural Ruggles, NE VT Regional Hospital; Patty Launer, BiState; Marlys Waller, VT Council; Jane Catton, Northwestern Medical Center; Sarah Narkewicz, Rutland Blueprint (RRMC); Pam Farnham, Burlington Blueprint (FAHC); Judy Martin; Dale Hackett; Barbara Cimaglio, VDH; Diane Leach, Northwestern Medical Center; Dana Noble, Bennington Blueprint; Mary Moulton and Helen Oetjen, Washington County Mental Health; Ron Cioffi, Rutland Area Visiting Nurses; Lisa Viles, NEVAAA; Audrey Ann Spence, Blue Cross Blue Shield of VT; Jeanne McLaughlin, VNA of VT and NH; Julia Shaw and Nancy Breiden, VT Legal Aid; Jenney Samuelson, Blueprint; Melissa Bailey, AHS; Aaron French, Erin Flynn, and Kelly Gordon, DVHA; Suzanne Leavitt and Clare McFadden, DAIL; Trish Singer, DMH; Allan Ramsay, Pat Jones, and Betty Rambur, GMCB; Marge Houy and Christine Hughes, Bailit Health Purchasing; Nelson LaMothe and George Sales, Project Management Team

Agenda Item	Discussion	Next Steps
<b>1 Welcome and Introductions. Approval of Minutes</b>	Bea Grause called the meeting to order at 10:04 am Jenney Samuelson made a motion to approve the December 10, 2013 minutes; the motion was seconded by Nancy Breiden. Motion passed, no Nays, no Abstentions.	
<b>2 Co-Chair Report</b>	Co-Chair Bea Grause offered a report of current affairs as follows: The Legislature returned to business recently with Health Care reform and due diligence of public financing a top priority. There is no specific activity that would affect or change the CMCM Work Groups' direction at this time. The Administration decided not to pursue the Duals Demonstration project at this time. The State Fiscal Year budget will be announced tomorrow, again, no anticipated implications for the CMCM Work Group perceived at this time. Shared Savings Program contract negotiation with Medicaid ACOs and Commercial ACOs is nearing completion. The HIE Work Group was presented a collaborative proposal by the three ACOs and VITL to advance Health Information Exchange. The proposal is seeking funds from the	

Agenda Item	Discussion	Next Steps
	<p>VHCIP HIE budget. The three ACOs are also beginning to converse with the Blueprint, VCCI, SASH, hospitals and others regarding collaboration around Care Models and Care Management. Georgia Maheras will be the main point of contact for questions about the Provider Grant Program application process.</p> <p>Bea also reported on activities of other VHCIP Work Groups. The Payment Models WG is currently focused on the Episodes of Care (EOC) payment model, and is monitoring progress on the ACO pilots as contracts and agreements for the Medicaid and Commercial ACO Shared Savings Program pilots move forward. The Quality and Performance Measures (QPM) Work Group met yesterday, and approved standards for reviewing and modifying ACO measures in future years. As new payment models are developed, the QPM Work Group will address measures for those models.</p> <p>Renee Kilroy, former Co-Chair of CMCM, has accepted a wonderful job opportunity in Maryland, and Nancy Eldridge has graciously accepted and replaced Renee as the Co-Chair of CMCM.</p>	
<p><b>3 Staff Report</b></p>	<p>Pat Jones and Erin Flynn presented their Staff Report to the WG.</p> <p>Erin discussed the Provider Grant Program draft application process enclosed in today's meeting materials. The draft has yet to be approved by the Core Team and CMMI; however, it offers enough information to begin to develop potential proposals.</p> <p>A reminder to all participants, both Members and Interested Parties, to please read the Conflict of Interest (COI) policy, sign the Acknowledgement, scan and forward to George Sales. Contractors do not need to sign the COI Acknowledgement since there is adequate COI language in their standard Vermont contract.</p> <p>Pat discussed the scheduling of a number of webinars, the 1<sup>st</sup> of which is this week. The purpose is to ensure that organizations engaged in the implementation of various care models or care management activities have the opportunity to present to the larger group. Allan Ramsay, MD (care models for the seriously ill) and the Vermont Assembly of Home Health Agencies will present next week.</p>	

Agenda Item	Discussion	Next Steps
	<p>Bea expressed her appreciation that there is a clear emphasis on exchanging ideas and information. She asked that participants please try to attend webinars. Organizations interested in presenting should contact Pat to get on the schedule. The Webinar tool is “Go To Meeting” and the link will be provided. Meetings can be recorded and made available – staff is working on developing that capability now. Presentation guidelines include:</p> <ul style="list-style-type: none"> <li>- What are the successes?</li> <li>- What are the challenges?</li> <li>- Where are duplications?</li> <li>- Where are the gaps?</li> </ul> <p>The template for the Inventory of Care Models and Care Management Activities will be forwarded again to members in Word format. The hope is to obtain contractor support in compiling the complete inventory.</p>	
<p><b>4 Presentation form designated Agencies</b></p>	<p>Mary Moulton and Helen Oetjen of Washington County Mental Health Services (WCMHS) presented on their organization and their team delivery of care and services. WCMHS serves about 3000 consumers with severe and persistent mental illness in the Community Rehabilitation and Treatment (CRT) program (about 40,000 people are served by designated agencies statewide). The social determinants of health are the circumstances into which people are born, live, work, and age, as well as the systems put in place to deal with their illnesses. These social determinants are also shaped by local economics, social policies, and politics.</p> <p>WCMHS Case Managers deliver an array of services such as psychiatry, housing, transportation to medical appointments, outpatient services, vocational services, emergency services, community living, life coaching, pharmacy delivery, wellness services, crisis beds, peer supports, social networking, tax planning, and nursing care. The Case Manager is the connector for delivering all services to a consumer. An “Impact Team” is convened for very complex cases. The Impact Team customarily invites providers to collaborate and discuss complex cases when the consumer/client provides consent.</p> <p>WCMHS measured outcomes include: admissions, bed days, employment, average wait time for</p>	

Agenda Item	Discussion	Next Steps
	<p>service, prevented mental health hospitalizations (approx. 12,000), use of 24/7 help line, number of face to face sessions.</p> <p>Helen presented a case study: “Mary” has a complex history; entered Care Coordination and required a full range of services (care management, pharmacy management, emergency screens, payee services, day treatment, group home, transportation, housing, psychotherapy, and community living. The community partners that the Case Manager engaged ranged from the hospital to home health to adult protective services to law enforcement. An Impact Team assessed system gaps, and offered case consultations with providers.</p>	
<p><b>5 Outline concerns for adapting care models and care management in VT</b></p>	<p>Bea asked the thought provoking question: What keeps you awake at night about this work?</p> <p>Laural asked how the Blueprint fits into the future direction of care management, and asked if the goal was to move away from that important work. Anya responded that the Blueprint is still the key to the care management foundation. The intent is to build upon the Blueprint’s successes to achieve more comprehensive care. Acknowledging that there are gaps, the question is –“How do we create the best system to augment and supplement the Blueprint?” The Blueprint annual report will be coming out soon and will offer data that will provide opportunities to discuss next steps.</p> <p>Allan Ramsay suggested that as the first statewide innovative delivery system reform, the Blueprint is the foundation. The VHCIP opportunity is to coordinate a spectrum of services to complete what has already begun.</p> <p>Kelly Gordon shared that Blueprint is very complicated, and a presentation by the Blueprint would be very helpful.</p> <p>Bea asked how can we build on the Blueprint foundation with ACOs, and include patients who are currently not been a part of the Blueprint? Anya responded that through VHCIP, the plan is to meld Blueprint with specialty care, long term services and supports, and mental health and substance abuse services.</p>	

Agenda Item	Discussion	Next Steps
	<p>Mary suggested that embedding physicians in designated mental health agencies so that they could act as medical homes could be helpful for the people served by the designated agencies. The challenge is how to coordinate care at the community level. Many communities are struggling with these same problems, and progress has been made in different ways in different communities. Jenney Samuelson suggested that perhaps presentations from communities who have moved forward in developing coordination of care and case management would be helpful. The Blueprint Community Health Team leaders will present on 2/11/14 at the in-person meeting and a community network analysis conducted by the Vermont Child Health Improvement Program will be presented on 2/18/14 as a webinar. Melissa Bailey also asked for an opportunity to present on the services offered by Integrated Family Services.</p>	
<p><b>6 Discussion:</b></p>	<p>Bea segued the discussion to the Institute of Medicine paper entitled “Core Principles &amp; Values of Effective Team-Based Health Care.”</p> <p>Nancy Breiden commented that she didn’t see long term services and supports discussed very much in the article, but otherwise found it to be a thoughtful report. These are lifetime services and supports we are talking about, not episodic services.</p> <p>Trish Singer shared that the mental health sector might offer the best example of where team coordination and the characteristics of ideal care management are most needed. The need is tremendous, and the services are expensive. How do we better coordinate care for those in need of services while at the same time potentially yielding savings from more efficient care delivery?</p> <p>Pam Farnham offered that primary care practices often aren’t aware of other organizations’ involvement with their patients. As an example, pediatricians may not be aware that the Department of Children and Families is involved with their patients; that is important information that they should have.</p> <p>Kelly shared that DVHA offers cross-agency and cross-professional training to increase</p>	

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	<p>effectiveness in care delivery.</p> <p>Bea commented that these tools are necessary but won't work without communication.</p> <p>Anya referenced the Commonwealth Fund Power Point presentation entitled "Learning for High Performance Health Systems Around the Globe" and shared that the most effective systems integrate health care, social services, and financing. It is interesting to note what other countries do to effect that improvement.</p> <p>The CMCM Work Group has clear intersections with the Population Health and Health Information Exchange Work Groups.</p> <p>Marlys Waller shared that patients do not want their life viewed as a model, and wonders whether savings can be produced by shifting cost from inpatient and emergency departments through more creative care models.</p>	
<p><b>7 Business: Deliverables, Work Plan, Consulting Resources</b></p>	<p>The Work Group has funding to purchase consultant services to support the CMCM Work Group (Bailit Health Purchasing staff was asked leave the call for this discussion). Discussion followed concerning Bailit Health Purchasing's ability to provide these services. Bailit already has a contract in place that could be amended to allow for these services in the short term. A proposed scope of work was included in the meeting materials. Pat asked if there was consensus within the group about the scope shared in the meeting materials, and comfort with using Bailit over the short term.</p> <p>Laural Ruggles made a motion to accept proposed scope of work; the motion was amended to incorporate the following language changes in the scope of work: Under #3, add "integration of long term services and supports with other health care; integration of specialty care with other services;" to the list of areas of focus. Under #4, #5, #6, and #7, change the opening clause to read "Provide the Work Group with information to assist in..." Patty Launer seconded the motion. Motion passed, none opposed, no abstentions.</p>	

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	<p>Kelly Gordon made a motion to support an amendment to the Bailit Health Purchasing contract to support the Care Models and Care Management Work Group in accordance with the scope of work for up to one year. The motion was seconded by Tom Boyd. Motion passed, none opposed, 1 abstention by Nancy Breiden.</p> <p>Anya suggested that Brendan Hogan from Bailit Health Purchasing be considered as a resource for this work; he has worked with the Duals Work Group.</p>	
<p><b>8 Next steps, Wrap-up and future meetings</b></p>	<p>Next meeting: Tuesday February 11, 2014 at the DFR Conference Room, 3<sup>rd</sup> Floor; 89 Main Street, Montpelier.</p>	

## **Proposed Scope of Work for Consultants for VHCIP Care Models and Care Management Work Group**

**January 7As Approved at January 14, 2014 Work Group Meeting**

1. Collect information for Vermont Care Management Inventory, using template developed by work group and information previously provided by organizations engaging in care management activities in Vermont.
2. Summarize inventory information as accurately and concisely as possible, capturing key information (including information about service gaps and redundancies, and opportunities for improved coordination). Represent information using easily digestible tools; for example, tables, figures, maps or graphics.
3. Conduct research on best practices in care management in Vermont and elsewhere. Areas of particular focus could include integration of mental health and substance abuse care with other health care, social and community services; integration of long term services and supports with other health care; integration of specialty care with other services; care management for people living with disabilities; relationship between care management of social issues and resulting medical expenditures; or other priority areas identified by the work group.
4. ~~Assist~~Provide the Work Group with information to assist in identifying characteristics of ideal care management in Vermont.
5. ~~Assist~~Provide the Work Group with information to assist in developing a strategic plan that includes recommendations on how to invest resources to improve care management.
6. ~~Assist~~Provide the Work Group with information to assist in identifying implementation needs for new or improved care management activities.
7. Provide the work group with information to assist in ~~Develop recommendations for~~ coordinating and aligning Work Group activities with activities of other VHCIP Work Groups.



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7. Provide the work group with information to assist in coordinating and aligning Work Group activities with activities of other VHCIP Work Groups.

**February 5, 2014**

**TO: Care Models and Care Management Work Group Members**

**RE: References from Laural Ruggles on interface between primary care and specialists (she may be able to provide pdf versions):**

1. Forrest CB, Nutting PA, von Schrader S, Rohde C, Starfield B. Primary care physician specialty referral decision making: patient, physician, and health care system determinants. *Medical decision making* 2006;26:76-85.
2. Bodenheimer T. Coordinating care-a perilous journey through the health care system. *New England Journal of Medicine* 2008;358:1064.
3. Chen AH, Yee Jr HF. Improving the primary care-specialty care interface: getting from here to there. *Archives of internal medicine* 2009;169:1024.
4. Shih A, Fund C. Organizing the US health care delivery system for high performance: Commonwealth Fund; 2008.
5. Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *Journal of General Internal Medicine* 2000;15:626-31.
6. Forrest CB, Glade GB, Baker AE, Bocian AB, Kang M, Starfield B. The pediatric primary-specialty care interface: How pediatricians refer children and adolescents to specialty care. *Archives of Pediatrics & Adolescent Medicine* 1999;153:705-14.
7. Jarve RK, Dool DW. Simple Tools to Increase Patient Satisfaction With the Referral Process. *Family Practice Management* 2011;18:9-14.
8. Fisher ES, Staiger DO, Bynum JPW, Gottlieb DJ. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. *Health Affairs* 2007;26:w44-w57.
9. Faulkner A, Mills N, Bainton D, et al. A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care. *The British Journal of General Practice* 2003;53:878.
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11. The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia, PA: American College of Physicians; 2010.
12. Yee JHF. The Patient-Centered Medical Home Neighbor: A Subspecialty Physician's View. *Annals of Internal Medicine* 2011;154:63-4.
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16. Quality Improvement and Utilization Management Program Evaluation, San Francisco Health Plan Annual Report. San Francisco,CA: San Francisco Health Plan; 2012.
17. Forrest CB, Glade GB, Baker AE, Bocian A, von Schrader S, Starfield B. COordination of specialty referrals and physician satisfaction with referral care. *Archives of Pediatrics & Adolescent Medicine* 2000;154:499-506.
18. Centralized Orthopedic Center and Streamlined Referral and Triage Processes Enhance Access to Appropriate Treatment. Agency for Healthcare Quality and Research, 2013. (Accessed September 9, 2013, at [http://www.innovations.ahrq.gov/innovations\\_qualitytools.aspx?search=Centralized%20Orthopedic%20Center](http://www.innovations.ahrq.gov/innovations_qualitytools.aspx?search=Centralized%20Orthopedic%20Center).)
19. D. McCarthy KM, J. Wrenn. Mayo Clinic: Multidisciplinary Teamwork, Physician-Led Governance, and Patient-Centered Culture Drive World-Class Health Care: The Commonwealth Fund August 2009.
20. NCQA. Patient-Centered Specialty Practice Standards and Guidelines. In. Washington,DC; 2013.





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# Community Health Team Models of Care across Vermont

*Pam Farnham RN, Manager Community Health Team -Burlington*

*Dana DeMartino, MA Community Health Coordinator-Central Vermont*

*2/11/14*

# Medical Home Model- Burlington HSA

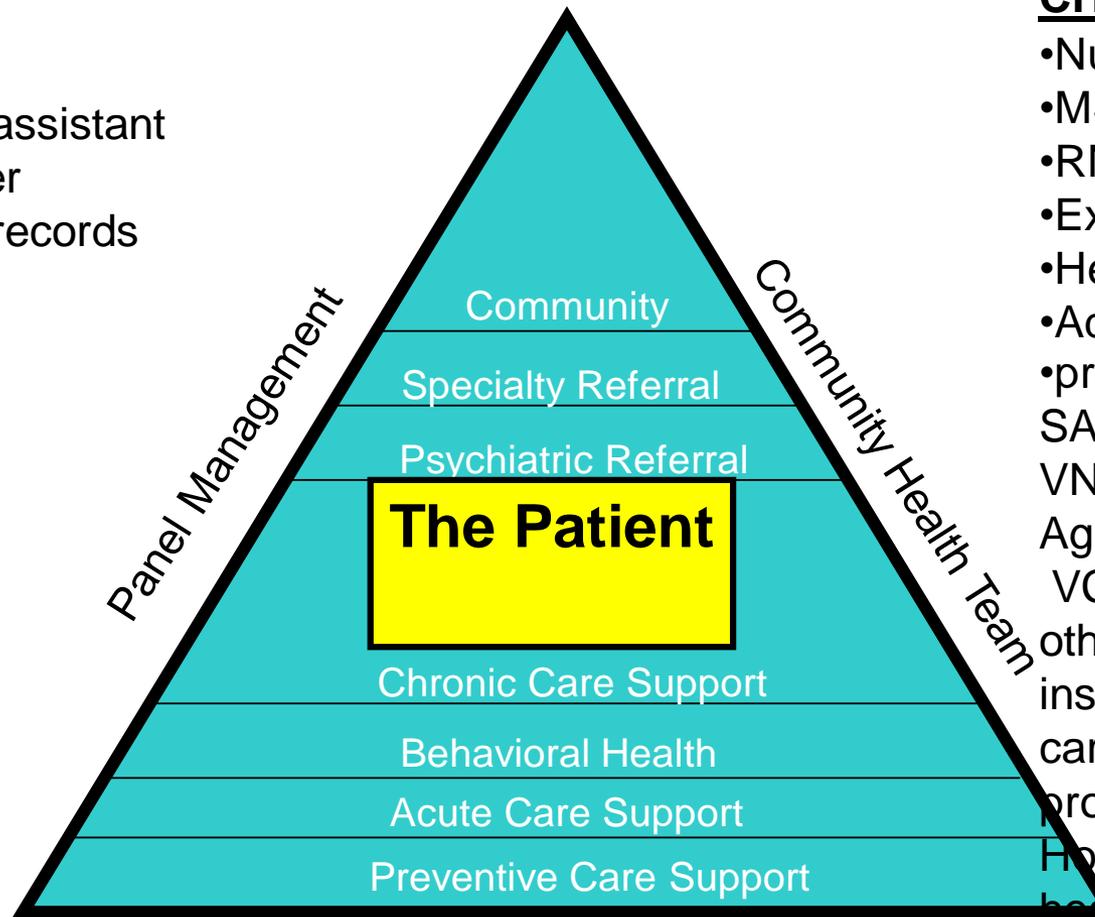
Primary Care Provider

## Clinic

- RN
- Medical assistant
- Scheduler
- Medical records

## CHT

- Nutrition/CDE
- MSW
- RN
- Exercise/Fitness
- Health Educator
- Admin
- practice extenders
- SASH,
- VNA, Agency on Aging
- VCCI, VMC and other
- insurance/hospital care management programs
- Howard Mental health

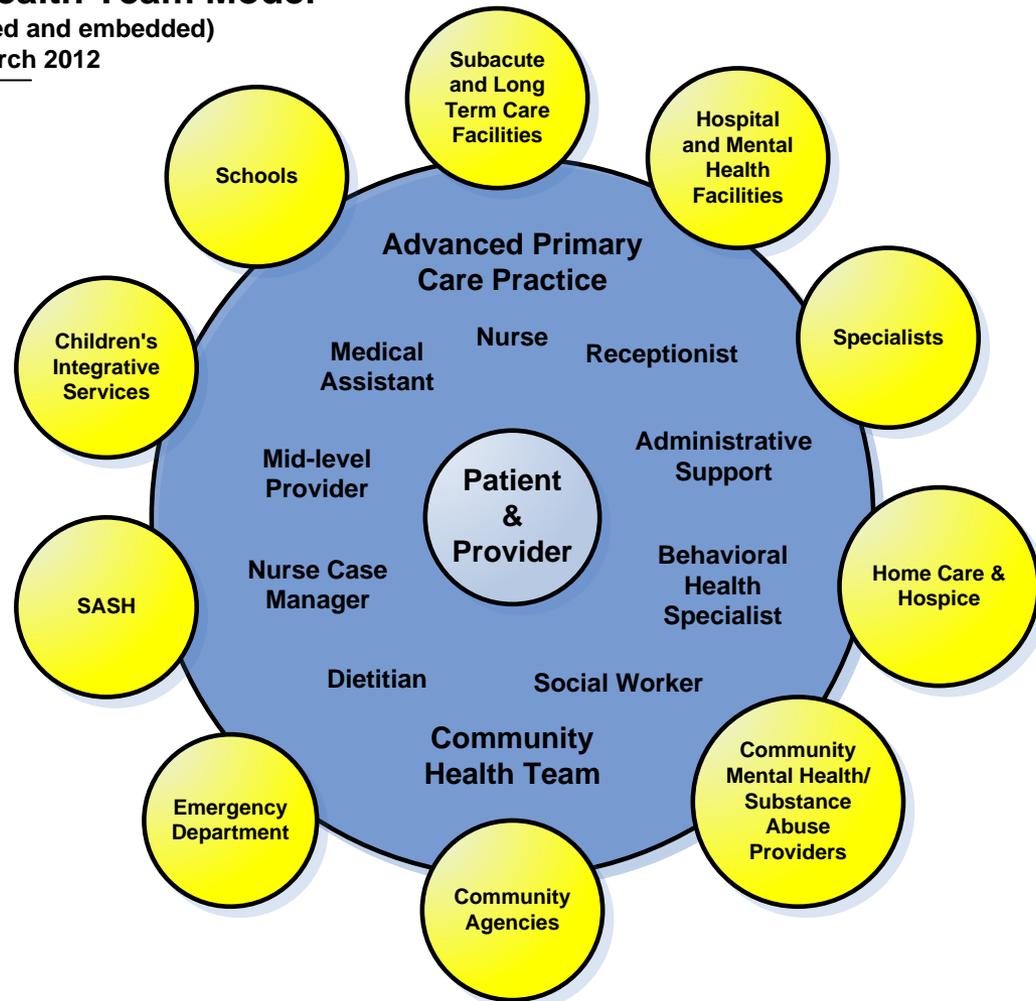


Panel Manager

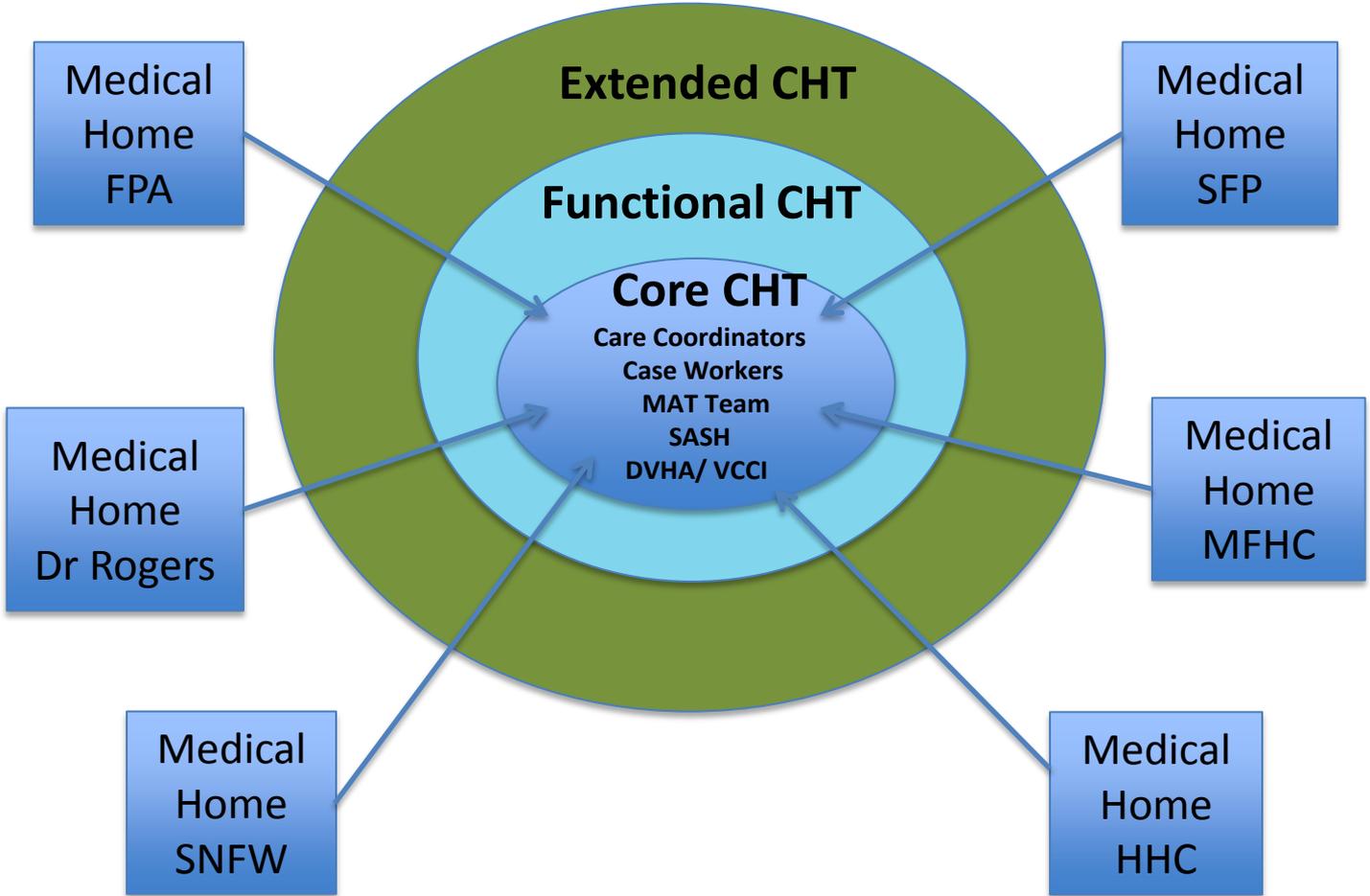
EMR/DocSite

CHT

**Bennington Blueprint**  
**Community Health Team Model**  
(decentralized and embedded)  
March 2012



# Morrisville HSA Community Health Team



# Our Team – Middlebury HSA

## Care Coordinator Roles:

- Care Coordination is extended care offered by the primary provider to the chronically ill and high risk patients.
- Panel management and patient outreach.
- Collaborates with the practice for recertification for the PCMH (patient centered medical home).
- Meets one on one with patients that have barriers to healthcare:
  - Transportation, Medications, Insurance, Advance directives, Missed appointments
- Refer patients and help promote Healthy Living Workshops.
- Manage transition of cares from hospital to home.
- Trained as a Certified Application Counselor by the state to assist in insurance enrollments for the practices.

## BEHAVIORAL HEALTH ROLE:

Brief mental health, psychosocial, and substance abuse screenings and assessments

- Short term, brief and/ or intermittent mental health interventions.
- Psycho-education
- Referrals for mental health and substance abuse treatment
- Short term care management
- Crisis intervention with provider and team
- Consultation with primary care provider and other team members
- Assist patients to help manage and cope with their chronic health conditions
- Assist patient with issues related to:
  - Anxiety/Depression, Stress Management, Lifestyle issues, Family Issues, Grief and bereavement, Chronic Pain, Insomnia, Tobacco Cessation
- Assist patients with connection to community and financial resources.
- Support and assistance to caregivers of patients with dementia or other difficult chronic conditions.
- Utilize motivational interviewing with patients to help create readiness for change.

## NUTRITION ROLES:

Nutrition education and Counseling for:

- Healthy eating and cooking for infancy, childhood, adolescence, and adulthood
- Pre-pregnancy
- Breastfeeding and Lactation Support
- Chronic disease including diabetes, heart disease, hypertension, chronic kidney disease, gastrointestinal issues, food intolerances, celiac disease.
- Eating Disorders
- Healthy Weight gain or loss
- Sports Nutrition
- Program facilitator for Health Living Workshop with Diabetes
- Special projects such as Healthy Choices for Healthy Kids (a nutrition and physical activity class for overweight children)

## Navigator work

- Our goal is to provide our patients with support and accurate information about the exchange so they can transition their health insurance with as little inconvenience as possible.
- Through outreach events and one-on-one meeting we have reached 450 Middlebury Health Service Area residents and patients
  - Outreach materials (i.e. navigator rack cards) and media (i.e. radio PSA and Addison Independent interview) have reached over 1000 residents and patients
- We held outreach events and enrollment sessions in Brandon, Middlebury, Vergennes, and Bristol.

## Chronic Disease Self-management Programs

- The Middlebury HSA has held Tobacco Cessation, Healthier Living with Diabetes, Healthier Living with Chronic Diseases, WRAP, and the YMCA's Diabetes prevention programs.
- Our workshops are held in Middlebury, Brandon, Bristol, and Vergennes.
- We work with our community partners and practices and their providers to refer their patients to the appropriate programs.

# Community Health Team Components- Rutland

## Stakeholders

- Represent community health and human service agencies
- Meets quarterly

## Referral Committee

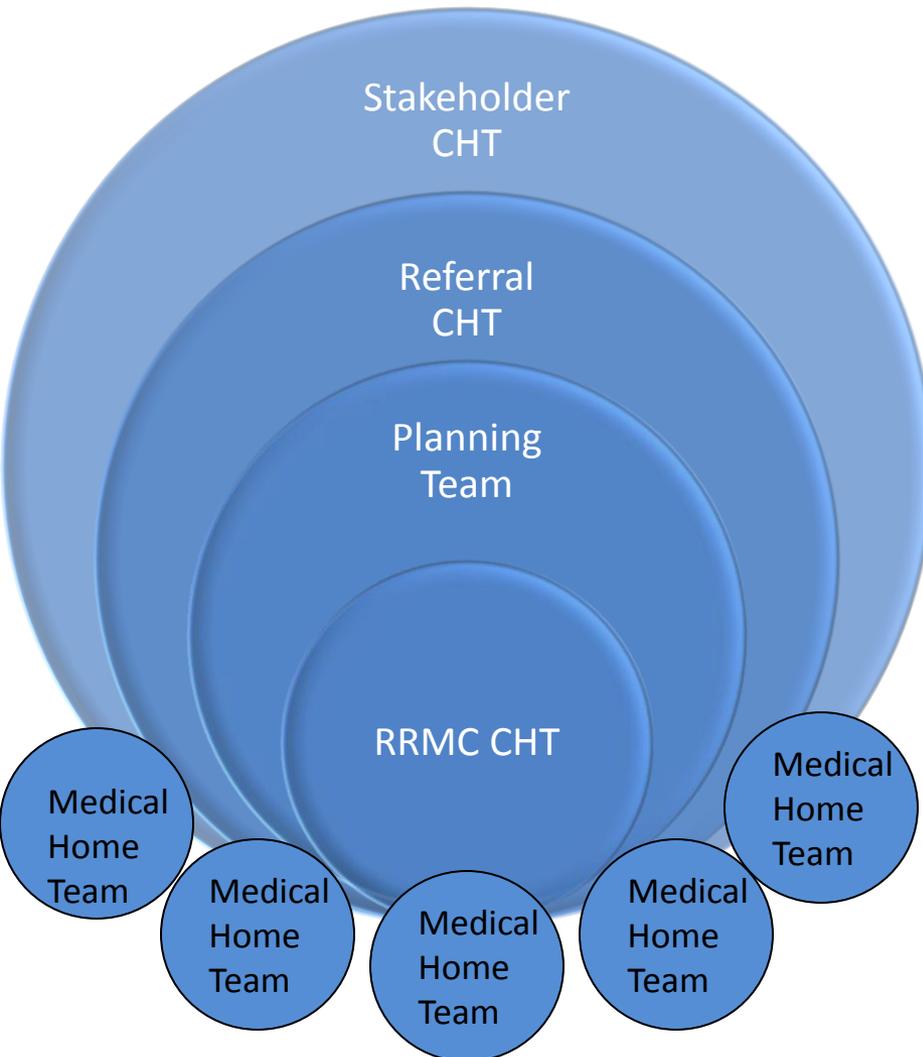
- Case managers
- Meets monthly
- Discusses systems and specific patient needs.

## Planning Team

- Meets monthly
- Plans CHT activities

## RRMC Community Health Team Practice Based Teams – Medical Homes

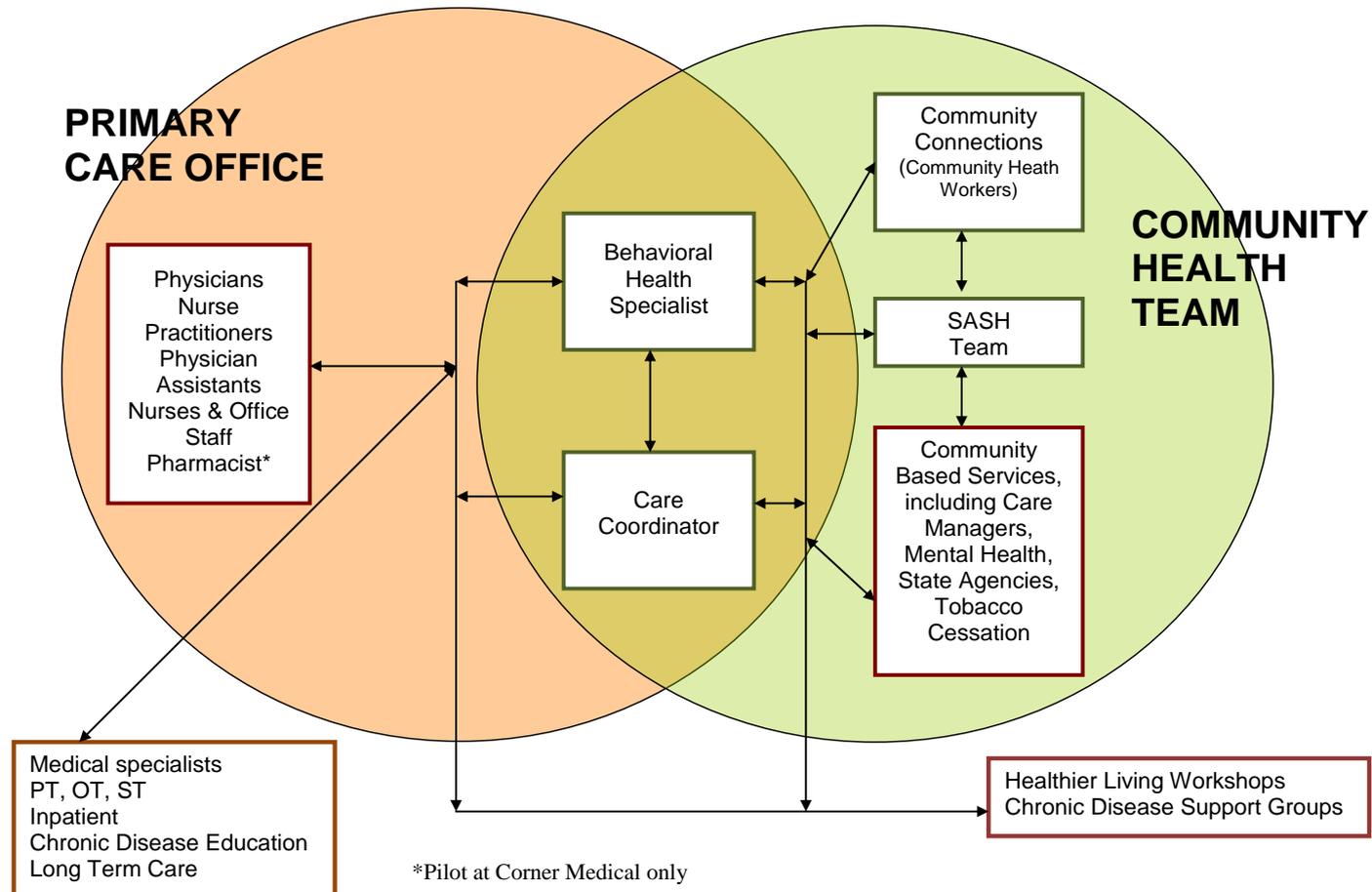
- care coordinators
- panel managers



# St. Johnsbury HSA

## St Johnsbury Community Health Team

### Referral and Communication Flow Chart





# One Blueprint Core CHT/Care Coordinator, Blueprint \$ used for practice extenders, and an active functional CHT

**CHT lead, Care Coordinator,**  
embedded at White River  
Family Practice  
Toni Apgar, BA,RN

**Practice Extenders:** Weekly Fresh Start meetings, Weekly Diabetes Prevention Program, Clara Martin Center social worker/MH counselor in the practice 4 hours a week

**Functional CHT:** Clara Martin Center~ Good Neighbor Health Clinic~ DVA Women's Veterans Program~ WISE~Habit OPCO~ UV Oral Health Coalition~ Health Connections~ Advance Transit~ Bayada~ Thetford Elder Network~ HCRS~ VDH~ Bugbee Senior Center~ Hartford School nurses~ Child & Family Services~ V T 211~ White River Family Practice~ The Stern Center~ VCCI~ The Family Place~ Southern Vermont Health Ed Center~ Ottauquechee Health Center~ Apria Healthcare~ Comfort Zone~ Upper Valley Haven~ Upper Valley Turning Point/Second Wind~ Hartford Parks & Rec~ TLC Nursing.

*We meet once a month in a hands-on, working session where we discuss progress toward our goals*



# Burlington Service Area

- **Challenges/Gaps**: Access to Mental Health Services, affordable housing, food and fuel assistance, the size of Chittenden county and the large number of practices our HSA supports: 32 clinics/160,000 attributed lives
- **Successes**: much improved coordination of care and improved clinical and psychosocial outcomes for patients within a medical home
- **Duplication of services**: Chittenden County is rich in services/resources. That in itself brings on a challenge to really work on avoiding duplication. We are always working creatively as a large group of providers to reduce duplication.

- Biggest Gaps in Care - Services for ages three to four between Early Intervention and Essential Early Education services, adult dental care, transportation, affordable behavioral health services especially for seniors on fixed incomes and who are homebound, accessible Gerontology services.
- Recent Collaboration Successes - The Housing Review Team - A panel of community services collaborating on patient housing crises or threat of homelessness. It includes members from our CHT, Central Vermont Community Action Council, Washington County Mental Health Services, Housing Authorities, Reach Up, Circle, Building Bright Futures, Good Samaritan, and the Youth Service Bureau. Working with Council on Aging, and SASH. Collaboration with Central Vermont Home Health and Hospice on a pilot program for diabetic patients.

# White River Family Practice CHT

- **Gaps:** So much need for MH services... Transitional Care Management for CMS billing is time-consuming (We are using a platform called ACT.md to help)... Managing “gaps in care” data from payers.
- **Successes in 2013:** 3 in-house Fresh Start programs (12 patients), Diabetes Prevention Program (15 patients), 60 patients seen by embedded SW, Care coordination for EVERY hospital discharge.
- **Challenges:** Prioritizing! Single-patient needs (*tyranny of the urgent*) vs. getting entire panels of patients to adopt healthier habits.

How do you juggle: Transitional Care Management **PLUS** Care Coordination (“Can you get this patient help with food stamps... Lifeline... heat.....a better life” **PLUS** Panel management—self-management & education of smokers, diabetics, asthma patients... **PLUS** Reduce ER visits and hospital admissions (prepare for ACO?) **PLUS** Work with multiple payers on reducing # of high-risk patients...



# Success Stories- Burlington HSA (colors are examples of community collaboration)

- The CHT Social Worker received a referral for a patient with a dx of bipolar disorder and ADHD to help with obtaining housing, case management and mental health services. The patient was on the verge of becoming homeless and desperately needed psychiatric follow up for better management of her major mental health issues. MSW provided assessment of patients mental health status. Then provided brief counseling to help her cope with symptoms of depression, anxiety and suicidal thoughts until long term services could be obtained. MSW assisted her with completing an application to the **Seneca Center** and advocated for her admission in to that program. Meanwhile, MSW also assisted patient with contacting **Howard Community Services** to advocate for admission to their CRT program for ongoing case management, psychiatric follow up and therapy. This involved helping patient gather documentation from her previous mental health providers to demonstrate a need for such services. This was a challenging process and required multiple contacts with multiple out of state providers to make this happen. After several months of regular meetings with patient, she has been admitted to the CRT program and now has safe housing that also provides support services to help her cope with her mental health issues. She is also seeing a therapist weekly. MSW also helped patient apply for **Social Security Disability**, food stamps and other public benefits that she would be eligible for. The MSW also empowered the patient to use the **CCTA vouchers** local bus to get to and from her day treatment program at the Seneca Center.

# Middlebury HSA CHT Success Stories!

- I've been working with this gentleman for seven months that had problems adhering to a regular medication regime. He brings all of his medications to the office every two weeks and I dispense them in a daily container. His diabetes numbers have improved. This was written by the provider, "HbA1c down to 7.7 from 9.2 with increase in glipizide and assistance with medication compliance (kudos to CHT Care coordinator). "
- I was managing the care of an elderly patient with dementia. She would come in bi-weekly for her PT/INR finger sticks and I would dispense her medication. She was moving into the Lodge and was placed in the wrong unit. I only noticed due to tracking her hospital discharge. I continued to manage her medications via phone with the **Lodge staff and home health** until she could be moved into the assisted living unit. This was over a two week period.
- Forty Five yr. old man with hx of bipolar disorder and alcoholism, is referred to CHT by primary care physician for assessment of depressed mood. The patient also reports he has had difficulty organizing himself , following through on projects at work and home, and procrastination. He also reports not managing diabetes well, gaining weight and not adhering to diabetic diet. Phq-9 screen is positive for depression . Screening for A.D.D. is positive. A consultation with an **A.D.D. specialist** is arranged . He is started on medication for A.D.D. He is also oriented to basic principles of CBT (cognitive disputation) and relaxation exercises (mindfulness breathing, etc.) and he meets with dietician to get a better handle on managing his diabetes. At ten months his PCP reports diabetes numbers improved and stable, he is employed and enjoying his work , and he is enjoying life.
- 13 year old female, presenting with poor weight gain and complaining of abdominal discomfort at mealtime, was found to be struggling with anorexia related to an anxiety disorder. The pediatrician and the dietitian collaborated efforts and provided weekly piggy-backed appointments to support the family in a modified Maudsley approach to treating the eating disorder. She was also referred to a therapist and over the next few months, successfully regained and maintained a safe weight.

# Rutland CHT

## Successes:

Systems work – as an example for us...developing a mechanism that works for the PCMH's and the community for them to refer “healthy” folks to the CHT to assist in completion of Advance Directives. Helping clients understand and then assisting with getting all of the copies made and distributed along with getting the documents into the registry.

Looking at Population health at the provider, practice and community level – panel managers at practice sites contribute greatly to this effort. Increasing preventive health measures being completed and then chronic disease management such as what you folks do with diabetes

# Success Story:

## St. Johnsbury- colored words are examples of community collaboration

19 year old female w/ chronic back pain new to our clinic. Previous thorough work up for back pain without solid diagnosis/injury. Patient met with provider and was referred to **Physical therapy** and the Chronic Care Coordinator. CCC discussed lifestyle changes/behaviors to help w/ pain management and provided information about the **Healthier Living and Chronic Pain Workshops**. It was explained that until a diagnosis could be found that these workshops could assist in helping her to find alternative ways to manage her pain. It was also identified that patients stress level correlates with her pain level. Lengthy discussion regarding this. Offered referral to **Behavioral Health** as well as to **Community Connections** health coach, Shauna. Patient stated that her mother told her to ask about applying for **disability** for her back pain. It was evident in our discussion that patient has dreams of attending college and eventually getting a job in technology. Area resources such as **Vocational Rehab** were discussed. Patient agreed to meet with Shauna.

Since meeting with her at Corner Medical, patient has met with Shauna, attended Physical Therapy sessions and plans to attend upcoming Vocational Rehab orientation. She has also registered for the upcoming Chronic Pain Workshop.

Shauna was able to identify further needs including limited food in the home and concern for a lack of finances for the holiday season. Shauna not only provided this patient with information about **local food shelves** but also gave her a voucher for **HOPE** so that she was able to “purchase” new clothes. Shauna also coordinated with other **local resources** so that the patient as well as her mother and younger brother will be provided with Christmas gifts this year.

- Top Challenges - Communication, Releases, HIPAA Barriers, Motivating people who have been in “the system” for a few years to realize it is possible that they can gain control of their lives and future, Identifying additional ways to quantify our team’s efforts.
- Duplicated Efforts—Strong communication avoids many duplicated efforts, but it can sometimes be challenging to obtain certain information without proper releases in place.

### **Recent Patient Successes**

75 year old professional male with increasing dementia, lives alone, only family is in Sweden, Medicare and Medicaid: It is difficult for the family in Sweden to support the patient and manage patient's finances from a distance. **Central Vermont Community Action Council** conducted a "Choices for Care" assessment so that patient can remain at home until a **Montpelier Housing Authority** apartment is available. We worked with the patient in developing his support team of friends and helpers for everyday needs and most importantly, a safety net. We also helped develop the patient's surgery and recovery team of surgeon, SDS staff, friends and family so that the patient can have successful hernia surgery and return home safely. The patient will need the same team in 3 months after a scheduled hip replacement surgery.

### **Recent Patient Successes (continued)**

Mary\* is a 57 year-old woman whom I met in November of 2012. She was referred to CHT for support with weight loss and hypertension. At that time she weighed 270 pounds and her blood pressure was 144/98. She did not engage in any regular physical activity and as a recent 'empty nester' she spent most of her time engaged in sedentary activities around the house. Her eating habits were sporadic as she didn't have any real structure to her day and she often found herself eating out of boredom. She consumed significant amounts of fat, sugar and sodium. Over the past year we have worked together on her goals of losing weight and improving her blood pressure. Over the past year she has worked incredibly hard to implement healthy eating behaviors, improve the quality of her food choices and has incorporated regular physical activity into her life. At her most recent physical her weight was down 30 lbs and her blood pressure had come down to 132/88. She is ecstatic about her clinical results but also about her increased energy and overall improved sense of well-being.

# Community Partners Burlington HSA (not complete list)

- Visiting Nurses Association
- Other Home Health Providers
- Vt Chronic Care Initiative
- Private Insurance Care Managers
- SASH
- Howard Center Programs
- FAHC Case Management
- ACO Nurses (ONE Care, Health First)
- Fitness Centers
- NCQA Clinic Leadership & Care Coordinators
- Agency of Aging

# Outcomes Data Burlington HSA

- Referred for Diabetes Related Issues (n=144)
- **Weight loss:** For those patients with a recorded weight loss (n=58) the average amount of weight lost = 14.05 pounds. Collectively the 58 patients lost 815.35 pounds.
- **Change in BMI:** For those patients with a recorded BMI (on initial intake and on six-month follow-up (n=57)), 61.4% had an improvement in their BMI.
- **Change in HbA1c:** For those patients with a recorded decrease in their HbA1c (n=63) the average decrease was 1.09. For those patients with a recorded A1c (on initial intake and on six-month follow-up (n=97)), 65% had an improvement in their A1c.
- **Change in LDL:** For those patients with a recorded decrease in their LDL (n=37) the average decrease was 26.86. For those patients with a recorded LDL (on initial intake and on six-month follow-up (n=94)), 39.36% had an improvement in their LDL.

# Outcomes Data, Burlington HSA continued

- Referred for Exercise/Nutrition Related Issues (n=265)
- **Weight loss:** For those patients with a recorded weight loss (n=123) the average amount of weight lost = 10.9 pounds. Collectively the 123 patients lost 1,345 pounds.
- **Change in BMI:** For those patients with a recorded BMI (on initial intake and on six-month follow-up (n=149)) 53.0% had an improvement in their BMI. Average decrease was 1.9
- **Change in LDL:** For those patients with a recorded decrease in their LDL (n=46) the average decrease was 25.3. For those patients with a recorded LDL (on initial intake and on six-month follow-up (n=136)), 33.8% had an improvement in their LDL

Data results for Phase 1 of a project which focused on finding patients seen in the Emergency Room (ED) a Primary Care Provider

Our entire PCMH CHT worked on this.

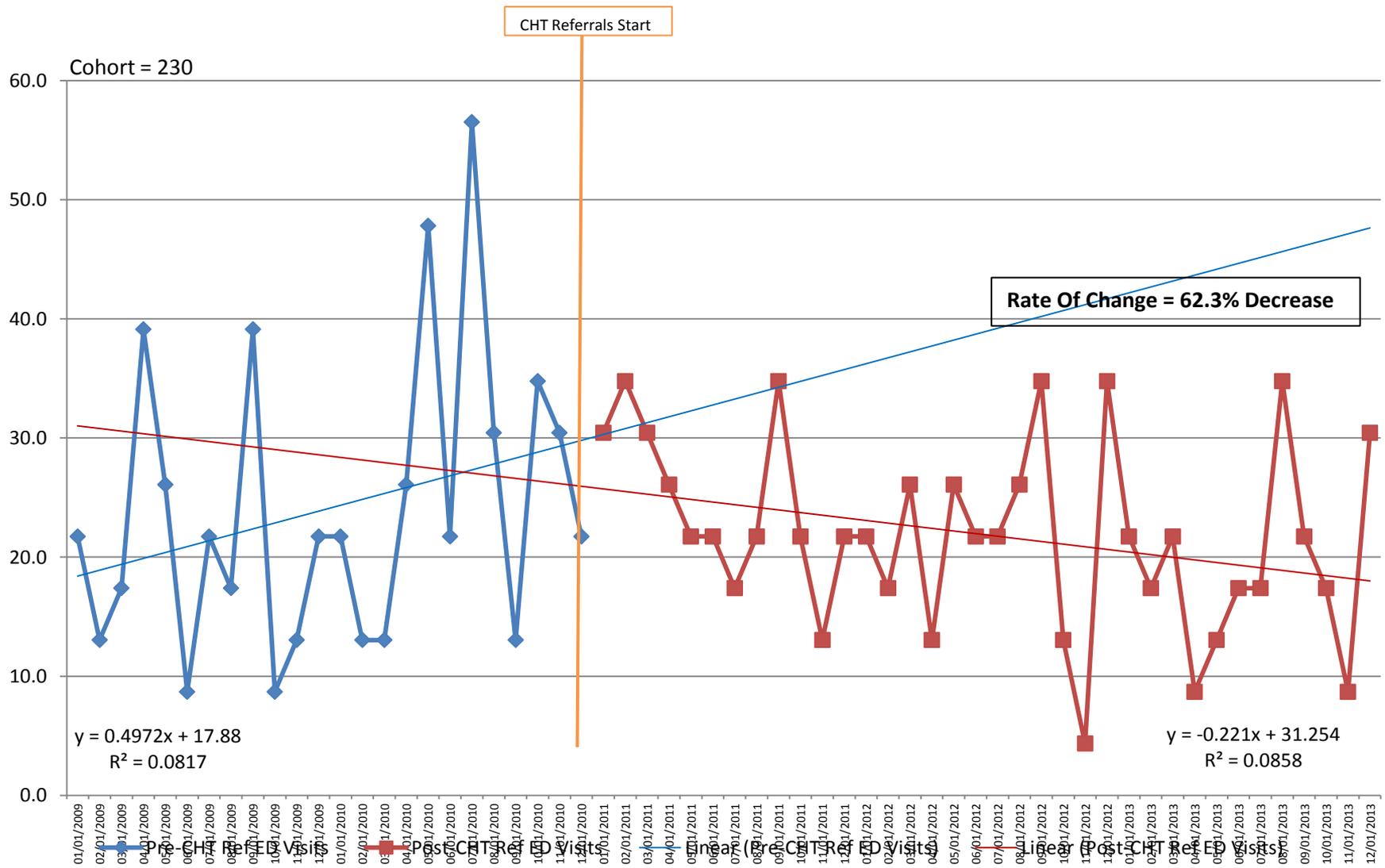
- Cambridge
- Johnson
- Stowe
- Morrisville
- Hardwick

All patients who came into Copley Hospital ED without a PCP filled out a consent form which allowed the CHT staff to contact them at a later date. They were provided with a list of primary care providers who were currently accepting new pts. They then called the office of their choice to request a PCP

## Initiative to find patients seen in the Emergency Department a PCP-Morrisville HSA

	12-Aug	12-Sep	12-Oct	12-Nov	12-Dec	13-Jan	13-Feb	13-Mar	13-Apr	13-May	13-Jun	13-Jul	13-Aug	TOTAL
# of Pts who requested a PCP in the ED and then made an appointment with a PCP in our Health Service Area	2	18	9	16	9	11	13	9	14	12	18	8	10	149
Total number of Pts seen in the ED who requested a PCP	4	22	13	20	13	13	17	10	18	22	26	13	17	208
Total # of ED Patients who requested a PCP from Aug 2012-Aug 2013 and who scheduled an appointment with a PCP in our Health Service Area	149		72%		<p>*Total number of referrals received from the ED between Aug 2012-August 2013 was 230. 22 of those PCP request forms from the ED did not have a signature, were out of our HSA, didn't have the appropriate box checked giving us permission to follow up, or the patient refused follow up. These were not included in the final denominator because permission was not granted to take any further action.</p> <p>59 of the patients who requested assistance finding a PCP were contacted 3 times by phone and a letter was sent to them. These 59 patients never responded to these outreach attempts.</p>									
Total ED Patients who Requested PCP from Aug 2012-Aug 2013	*208													

# CY2011 CHT referrals(graduated)- ED visit rate per thousand- Burlington HSA



# Questions

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- [pam.farnham@vtmednet.org](mailto:pam.farnham@vtmednet.org)
- 802-847-2394
- Dana Demartino, MA
- Community Health Coordinator
- Central Vermont Health Service Area
- 802-225-5682
- [Dana.Demartino@cvmc.org](mailto:Dana.Demartino@cvmc.org)

**VHCIP Care Models and Care Management Work Group**  
**Proposed Definitions of Care Coordination, Care Management,**  
**Care Models and Case Management**  
**February 4, 2014**

**Care Coordination:** Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.<sup>i</sup>

**Care Management:** This term is often used interchangeably with care coordination. In a background paper, Mechanic states “care management programs apply systems, science, incentives, and information to improve medical practice and help patients manage medical conditions more effectively. The goal of care management is to improve patient health status and reduce the need for expensive medical services. The principal challenge is finding effective ways to change physician and patient behavior.”<sup>ii</sup>

**Care Models:** Care models are operational descriptions of roles and responsibilities, including relationships among clinicians and non-clinicians with respect the manner in which they work together to deliver health care and/or support services. Care models can describe care delivery at different levels of specificity, but are often expressed in terms of protocols or care pathways. Care models may target patient populations of varying illness burden and care needs. Examples of care models include a description of team-based care processes being implemented in a PCMH practice and protocols for integrating co-located mental health providers into the delivery of primary care services.

**Case Management:** The Case Management Society of America defines case management as “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.” According to a Mathematica report that included case management in its definition of care coordination, “case management implicitly enhances care coordination through the designation of a case manager whose specific responsibility is to oversee and coordinate care delivery [targeted to] high-risk patients [with a] diverse combinations of health, functional, and social problems.”<sup>iii</sup>

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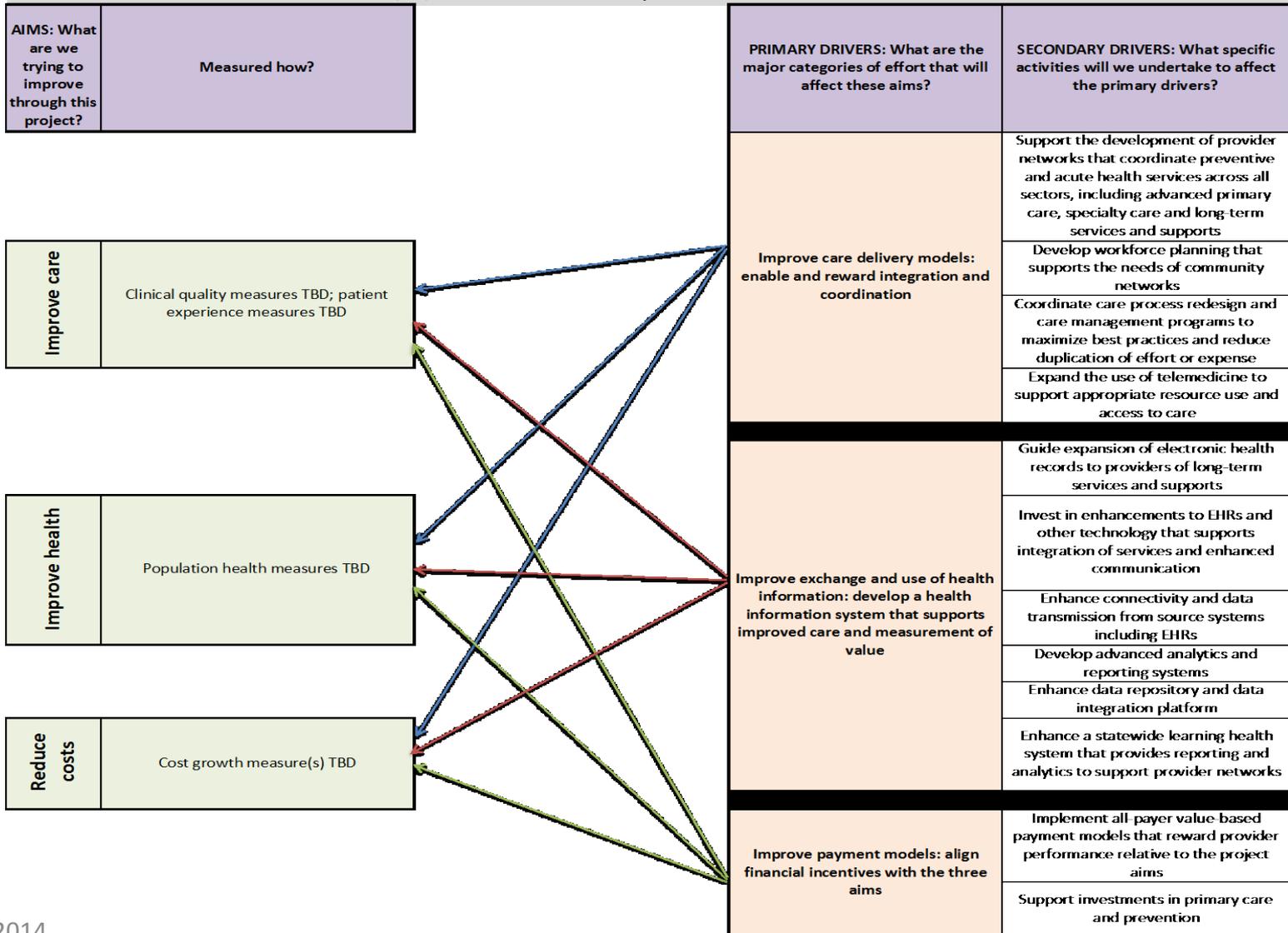
<sup>i</sup> Chapter 2. What is Care Coordination?: Care Coordination Measures Atlas. January 2011. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/systems/long-termcare/resources/coordination/atlas/chapter2.html>.

<sup>ii</sup> McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun.

<sup>iii</sup> McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun.

# DRAFT-Vermont driver diagram

SIM DRIVER DIAGRAM -- DRAFT 7/30/13 -- WORK IN PROGRESS, TO BE DEVELOPED FURTHER BY THE SIM STEERING COMMITTEE



## ***Vermont Health Care Innovation Project***

### **2014 Meeting Schedule for Care Models and Care Management Work Group**

In-Person Meetings: Second Tuesday of Each Month from 10:00 AM to 12:00 Noon

Webinars: Third Tuesday of Each Month from 10:00 AM to 12:00 Noon

- **January 14, 2014** (In-Person; presentation from Designated Agencies)
- **January 21, 2014** (Webinar; presentations by Allan Ramsay, MD on Care Models for Supportive Care of the Seriously Ill and from the Vermont Assembly of Home Health Agencies)
- **February 11** (In-Person; presentation from Blueprint CHT Leaders)
- **February 18** (Webinar; presentation from VCHIP on Blueprint Network Analysis and Hub and Spoke)
- **March 11, 2014** (In-Person)
- **March 18, 2014** (Webinar; presentation from Melissa Bailey, IFS)
- **April 8, 2014** (In-Person; presentation from Dual Eligible work group)
- **April 15, 2014** (Webinar)
- **May 13, 2014** (In-Person; presentation from Vermont Council of Developmental and Mental Health Services)
- **May 20, 2014** (Webinar)
- **June 10, 2014** (In-Person)
- **June 25, 2014** (Webinar)
- **July 8, 2014** (In-Person)
- **July 15, 2014** (Webinar)
- **August 12, 2014** (In-Person)
- **August 19, 2014** (Webinar)
- **September 9, 2014** (In-Person)
- **September 16, 2014** (Webinar)
- **October 14, 2014** (In-Person)
- **October 21, 2014** (Webinar)
- **November 18, 2014** (In-Person)
- **November 25, 2014** (Webinar)