

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Agenda

Tuesday, March 11, 2014; 10:00 AM to 12 Noon

Calvin Coolidge Conference Room, National Life Building, 1 National Life Drive, Montpelier, VT

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 February Meeting	Yes
2	10:05-10:20	Co-Chairs' Report (e.g., Other VHCIP Work Group Activities, Core Team Update, Health Care Reform Update, Legislative Update) <i>Public Comment</i>		
3	10:20-10:30	Staff Report (update on webinars and inventory) <i>Public Comment</i>		
4	10:30-11:00	Presentation from Blueprint-VCCI-SASH-ACOs on Care Management Learning Collaborative <i>Public Comment</i>	Attachment 4 - Conceptual Proposal for Learning Community	
5	11:00-11:50	Prioritizing Activities: Results of Work Group Survey and Action Steps <i>Public Comment</i>	Attachment 5 - CMCM Priorities Survey Results	
6	11:50-12:00	Next Steps, Wrap-Up and Future Meeting Schedule	Attachment 6 - Meeting Schedule for CMCM (with Webinar dates)	

Attachment 1 - CMCM Work Group Minutes 02-11-2014



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

Date of meeting: February 11, 2014; 10am to 12 noon, DFR Conference Room, 3rd Floor 89 Main Street, Montpelier

Attendees: Bea Grause, Nancy Eldridge, Co-Chairs; Nancy Breiden, VT Legal Aid; Dana DeMartino, Central Vermont Medical Center; Pam Farnham, FAHC; Vicki Loner, One Care; Jackie Majoros, Long Term Care Ombudsman; Judy Morton, Mountain View Center; Laural Ruggles, NE Vermont Regional Hospital; Diane Leach, Northwestern Medical Center; Audrey-Ann Spence, Blue Cross Blue Shield of Vermont; Maura Crandall, Vermont Managed Care; Mary Moulton, Washington County Mental Health Services; Jessica Stadler, Sarah Narkewicz, Rutland Regional Medical Center; Toni Apgar, White River Family Practice; Patti Launer, Bi-State; Marge Houy, Bailit Health Purchasing; Patricia Clark, ; Dale Hackett, Consumer Representative; Michael Bailit, Bailit Health Purchasing; Susan Besio, Pacific Health Group; Erin Flynn, Beth Tanzman, Kelly Gordon, Dani DeLong and Jenney Samuelson, DVHA; Patricia Singer, DMH; Julie Wasserman, AHS; Allan Ramsay and Pat Jones, GMCB; Clare McFadden, DAIL; David Martini, DFR; Georgia Maheras, AoA; George Sales and Nelson LaMothe Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome	Kelly Gordon offered clarification on the Minutes of January 14; she suggested that Agenda item 6 (page 5), be edited to say “cross-agency and cross-professional collaboration is important to increase effectiveness in care delivery”. David Martini moved to accept January 14 Minutes as amended; Dale Hackett seconded the motion. Motion passed unanimously.	
2 Co-Chairs Report	VHCIP activity is starting to pick up and gain speed. Both the Medicaid and Commercial ACO programs are active and contracts/program agreements are nearing completion. The Medicaid and Commercial ACO Pilot extended the deadline for signing participation agreements with providers to the end of March. The 3 ACOs and VITL have submitted a proposal to the HIE Work Group, the CMCM work group may request that this group present to CMCM. We also plan to hear from a small group of ACOs, VCCI, SASH, and the Blueprint who have been meeting to discuss	

Agenda Item	Discussion	Next Steps
	<p>a potential proposal for a learning collaborative focusing on care coordination, collaboration, and integration. Core Team has determined a method to review and score Provider Grant applications, and will ultimately be responsible for selecting proposals and awarding grants. The first round of applications is due on Friday 2/14.</p>	
<p>3 Staff Report</p>	<p>Pat Jones reviewed the Scope of Work for Consultants in Attachments 3a and 3b and indicated that recommended edits have been integrated.</p> <p>Pat also apologized for the recent webinar’s technical difficulties. The next scheduled webinar will include presentations on the Blueprint Network Analysis by Craig Jones and, MD from the Blueprint and Maurine Gilbert from VCHIP. Barbara Cimaglio, Beth Tanzman, Aaron French and Eileen Girling will also present on the Care Alliance for Opioid Addiction (“Hub & Spoke”) program. The inventory work is still being refined with the help of Marge Houy and Christine Hughes from Bailit Health Purchasing. Thanks to Laural Ruggles for sharing the list of references on primary care and specialty care integration.</p> <p>Bea asked Laural to identify her top 3 references.</p> <p>Public comment was requested; none offered.</p>	
<p>4 Presentation from Blueprint CHT Leaders</p>	<p>Pam Farnham and Dana DeMartino presented on “Community Health Team Models of Care across Vermont” (Att 4). Pam collected diagrams of Community Health Team Models from her partners in Burlington, Bennington, Morrisville, Middlebury, Rutland, White River, St. Johnsbury, and Springfield to share with the Work Group. Each Community Health Team is organized differently based upon the unique needs of their community. Pat Jones noted that the Blueprint for Health and VCHIP will be presenting a network analysis of the community health teams which will offer some more information about each CHT. Typically, CHTs meet weekly and focus on coordination of care for patients; core CHTs include a range of professionals, such as registered dietitians, licensed social workers, RNs, and health coaches. The broader functional CHTs include partners from other organizations such as SASH, VCCI, and other provider or payer-led health care organizations. This functional team often extends to other social services organizations, such as local police, housing, social services, fuel assistance, transportation, specialty care and aging services – groups of 50-60 organizations in some communities are meeting quarterly to share about their activities, review case studies, and discuss areas for improvement.</p>	

Agenda Item	Discussion	Next Steps
	<p>Bea asked presenters to describe the best attribute of Community Health Teams, and what is the one thing they wish they could improve. Discussion followed, including:</p> <ul style="list-style-type: none"> - CHT's are a work in process and are in learning mode all the time. Pam commented that her wish for improvement has to do with barriers to sharing information, particularly HIE. She sees a need to avoid the duplication that comes from working with multiple EHRs and DocSite. Streamlining the exchange of information, and avoiding double documentation are key items to improve. When asked a similar question, LaRae Francis from Randolph commented that she sees a need for both panel managers and care coordinators, as they have different functions which are both important. - Laural Ruggles pointed out that the St. Johnsbury Referral and Communication Flow Chart helps medical staff understand how the CHT works. She also pointed out that there isn't just one point of entry to the CHT. You can connect with any point in the organization and they will refer you to the right point of contact. - Bea commented that the models seem to have variations across the different communities and asked if this is intentional. Pam responded that the goal is to find a model that fits well with that particular community. There are similarities between the models, i.e. – staffing often covers similar professions such as nurse case managers, LMH/LSWs, dieticians, health coaches, etc. but the structure really depends on the community's structure, communication channels, shared goals, etc. - It is a challenge to find a balance between individual patient needs and general population management. The functional community health team includes an incredibly diverse array of providers (not just from the health and human services field). - Bea mentioned that a CDC call to action is encouraging people to develop population health plans in partnership with providers. Michael Bailit echoed this sentiment; he said that he is observing this conversation on a national level, and that everyone is experiencing similar challenges to integrating public health with health care. 	
<p>5 Prioritizing Activities, review of Driver Diagram</p>	<p>Pat Jones introduced the next agenda item; the goal is to obtain input and share ideas about where the CMCM Work Group should focus its activities. To accomplish this goal, Michael Bailit will engage the group in a brainstorming activity to solicit ideas for focus, and then will follow up with a Survey Monkey survey tool in which group members will be asked to rank their top areas of focus for work group activities. The results of this survey will be presented at the next work group</p>	<p>Survey Monkey. Blueprint report read b4 Webinar.</p>

Agenda Item	Discussion	Next Steps
	<p>meeting, and decisions will be made on where the group will begin to focus its work. In order to refresh work group members on the overarching goals of the project, and to ground these suggestions in the general work of the VHCIP, Pat asked the Work Group members to review the Driver Diagram included in meeting materials, including the 3 aims: improve care (enable and reward collaboration), improve health of population (improve the exchange and use of health care information), and reduce growth in cost. The Work Group’s goal is to support improvement of care coordination and care management to maximize best practices and reduce costs. Michael Bailit led a brainstorming exercise to invite and generate ideas. Where are the greatest opportunities for care coordination?</p> <p>He offered examples of helpful suggestions that have already come out of the work group’s discussions:</p> <ul style="list-style-type: none"> - Making designated agencies the medical home for patients with severe mental health needs. - Integrating medical services with social services - Improving communication and avoiding duplication of effort - Improving access to mental health providers - Facilitating communication between PCPs and mental health providers - Supporting PCPs to be better able to treat and understand mental health - Identifying communication needs and gaps in services; it is sometimes unclear what services are offered by what providers. <p>Work Group identification of opportunities:</p> <ul style="list-style-type: none"> • flexible funding streams • inclusion of organizations focused on poverty and economic services to address impacts on health (food, heat, housing) • How does childhood trauma impact mental health and substance abuse • SASH has developed a model to organize and share information and includes non-health care providers (schools, etc.). They also have MOUs governing how organizations share information (SASH is HIPAA compliant) • Improve care transitions • Improve access to dental care • Identify people in DAs who haven’t seen a PCP, cross-reference that list with Medicaid enrollment lists and see if they have a self or auto-assigned PCP. Data can help us 	

Agenda Item	Discussion	Next Steps
	<p>understand populations. This might help us understand the relationship between PCP visits and outcomes.</p> <ul style="list-style-type: none"> • Locate the care where people go most. • Look at the possibility of a home hospitalization program for the seriously ill. Johns Hopkins has a home hospitalization program that greatly improves the quality of life. Could be built on the services of the CHT/VNA, etc. • Map the interface between community health teams, ACOs, VCCI, SASH. Start with clinical mapping. • School based health clinics • Transportation • Guardianship education, support to older guardians who themselves may be seeking multiple services • CHTs can focus on preventative population based measures <p>Staff and consultants will work together to aggregate this list and distribute a survey to the work group to identify top areas of focus.</p>	
<p>6 Next Steps, Wrap-Up</p>	<p>Next meeting: Webinar scheduled for next Tuesday, February 18, 10am – noon; Next in-person Work Group meeting is Tuesday, March 11, 2014, at the ACCD Calvin Coolidge Conference Room, National Life (6th Floor), Montpelier.</p>	

Attachment 4 - Conceptual Proposal for Learning Community

Conceptual Proposal for Care Management Learning Community



**VHCIP CARE MODELS AND CARE MANAGEMENT
WORK GROUP**

MARCH 11, 2014

**PATTY LAUNER, BI-STATE PRIMARY CARE ASSOCIATION
JENNEY SAMUELSON, VERMONT BLUEPRINT FOR HEALTH
VICKI LONER, ONECARE VERMONT**

Approach and Participants

(Patty)

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- Initial discussions have taken place about the idea of a Care Management Learning Collaborative.
- The proposal is to create a Learning Collaborative that incorporates the community of organizations serving Vermonters, including (but not limited to) ACOs, health care and community service providers, the Blueprint for Health, VCCI, SASH, and payers.

Approach and Participants (continued)

(Patty)

3

- The Learning Collaborative would seek to build on and coordinate current care management activities, test potential improvements in care management, identify gaps in care, and create a “no wrong door” approach to serving the people of Vermont.
- We are in the process of identifying Pilot Health Service Areas.



What is a Learning Collaborative?

(Patty)

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- A Learning Collaborative combines subject matter experts in specific clinical areas with application experts who can help organizations select, test and implement changes. (IHI, 2003)
- In this case, the Learning Collaborative is an opportunity to both build on and inform the purpose of this Work Group.

Learning Collaborative Aim

(Jenney)

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- Aim is to create a supportive environment that fosters change to improve health outcomes, cost containment, and patient and provider experience
- Supportive environment promotes innovation:
 - Participating teams share their deficits
 - Peers provide constructive feedback
 - Sense of comradeship
 - Non-judgmental (no “should” or “must”)

Key Characteristics of Learning Collaboratives

(Jenney)

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- Informed by evidence base
- Include common measurement
- Focus on actionable knowledge
- Strive toward behavior change by:
 - Identifying clear actionable standards
 - Providing tools for systems changes
 - Measuring: what we measure is what we change

Participant-Centered Learning Collaboratives

(Jenney)

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- Participation is voluntary and based on the interests of the participants
- Participants help design the Learning Collaborative
- Common aim to improve
- Improvements and areas of focus may differ across participants, which promotes innovation and shared learning

Vermont's Proposed Design Pilot

(Jenney)

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- Proposal is to start with 3 or 4 Health Service Areas in a Design Pilot
- Pilot participants will review evidence and identify best practices in care management
- Pilot will convene experts to help:
 - Identify measures of best practices
 - Develop curriculum for all communities
- Work can then be broadened into a Statewide Learning Collaborative

Learning Collaborative Structure

(Jenney)

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- **Combination of in-person and technology assisted sessions**
- **Participants engage in process improvement projects between sessions**
- **Session content includes:**
 - Expert discussion on process; less etiology
 - Case studies and real life examples
 - Tools (reflect an understanding of EMR world)
 - Presentation of participant process improvement work
 - ✦ Looking at systems
 - ✦ Conducting small tests of change
 - ✦ Collecting data and presenting results to peers
 - Team time (breaks, planning time, etc.)

Activities to Date in Vermont

(Vicki)

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- **Facilitated discussions around care management collaboration opportunities between the ACOs, Blueprint, VCCI and SASH**
- **Goals:**
 - Build upon existing health care reform delivery models
 - Identify areas of opportunity within the delivery system
 - Identify and test models of improvement on behalf of populations who could benefit from care coordination activities

Start with identification of high risk patients

- Engage interested stakeholders
- Identify specific aims of what we would like to improve for the target population
- Identify measures of success
- Start to test improvement ideas

Work towards a total population health approach



Let's Start: Proposed Focus of the Learning Community

(Vicki)

Secondary Research on Innovative Community Based Models for High Risk Patients (Vicki)

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● Health Care Partners

- Population: Medicare - moved to targeting high risk in 2010
- Criteria: Stratified patients into 5 progressively higher risk levels (dx and admission driven)
- Care Team: High Touch community based care team (i.e. 62% in-person/38% at home)
- Lessons: Continuous participant engagement, frequent in-person contact, communication, training and performance monitoring of the care team

● Camden Coalition

- Population: High utilizers
- Criteria: 2 or more inpatient admissions in the last 6 months (+ select dx)
- Care Teams: Outreach team: no source of primary care & Embedded team: stable primary care
- Lessons: Need to be in the community, data driven screening and targeting, project management-clinical dyad, micro-targeting

Another Model: Medical Home Neighborhoods

(Jenney)

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- **Medical Home Neighborhoods engage in shared accountability by linking primary care, specialty care and other providers to support integrated, person-directed services.**
- **Primary care and specialty care providers (medical and non-medical) mutually agree on how to coordinate care.**
- **Clear expectations are developed for primary care providers, specialists, people in need of services, and their families.**

Areas Of Agreement Among Medical Neighborhood Participants (Jenney)

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- **Transitions of Care**
 - On-site point of contact
 - Definition of documents exchanged in standard transition
 - Pre-referral workup
- **Access**
 - Provider access
 - Access to people needing services
- **Collaborative Care Management**
 - Defined responsibilities
 - Joint care plan
- **Communication**
 - Outline who will communicate what with people in need of services
 - Identify and support person and family choices

Next Steps for Vermont Collaborative

(Patty)

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- **Convene interested parties from different geographic areas**
- **Refine focus**
- **Identify resource needs**
- **Present more detailed proposal to CMCM Work Group**
- **Initiate Design Pilot**
- **Implement broader Learning Collaborative activities**

Discussion

(Work Group)

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Attachment 5 - CMCM Priorities Survey

CMCM “Priorities” Survey

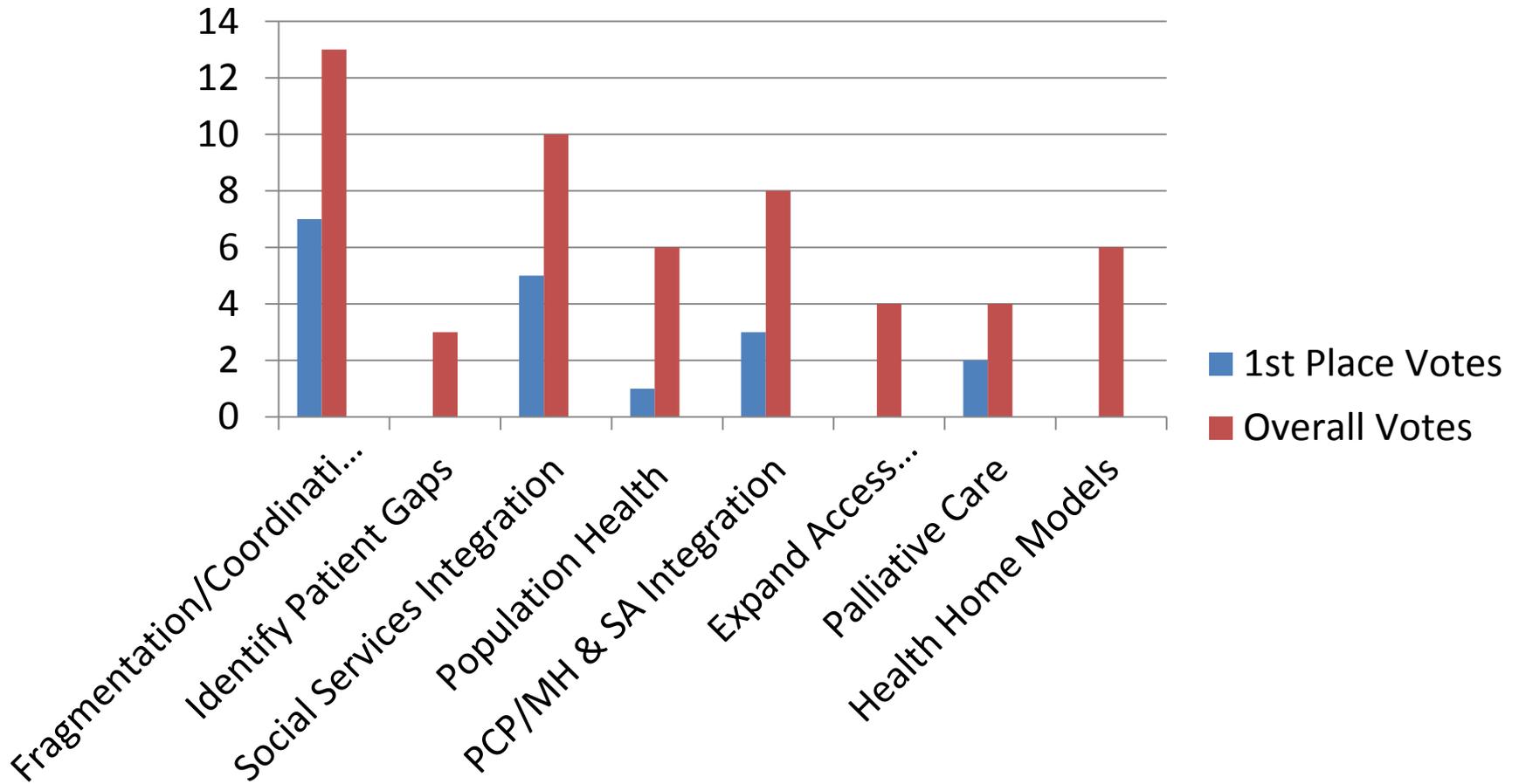
Goal: To gauge work group members’ interest in and support of potential areas of focus to direct the work group’s future activities.

Process:

- “Brainstorming Activity” conducted at February 11th in-person work group meeting; work group members offer suggestions for potential areas of focus.
- Staff and consultants work together to summarize and synthesize ideas presented via brainstorming activity and various work group presentations.
- Survey of 8 “priority topics” distributed to all voting members.
- Members asked to rank priorities, with 1 being the highest priority, 2 being the second highest, and 3 being the third highest.
- 18 responses received as of March 10th.
- Results collected, tabulated and presented to work group at March in-person meeting.

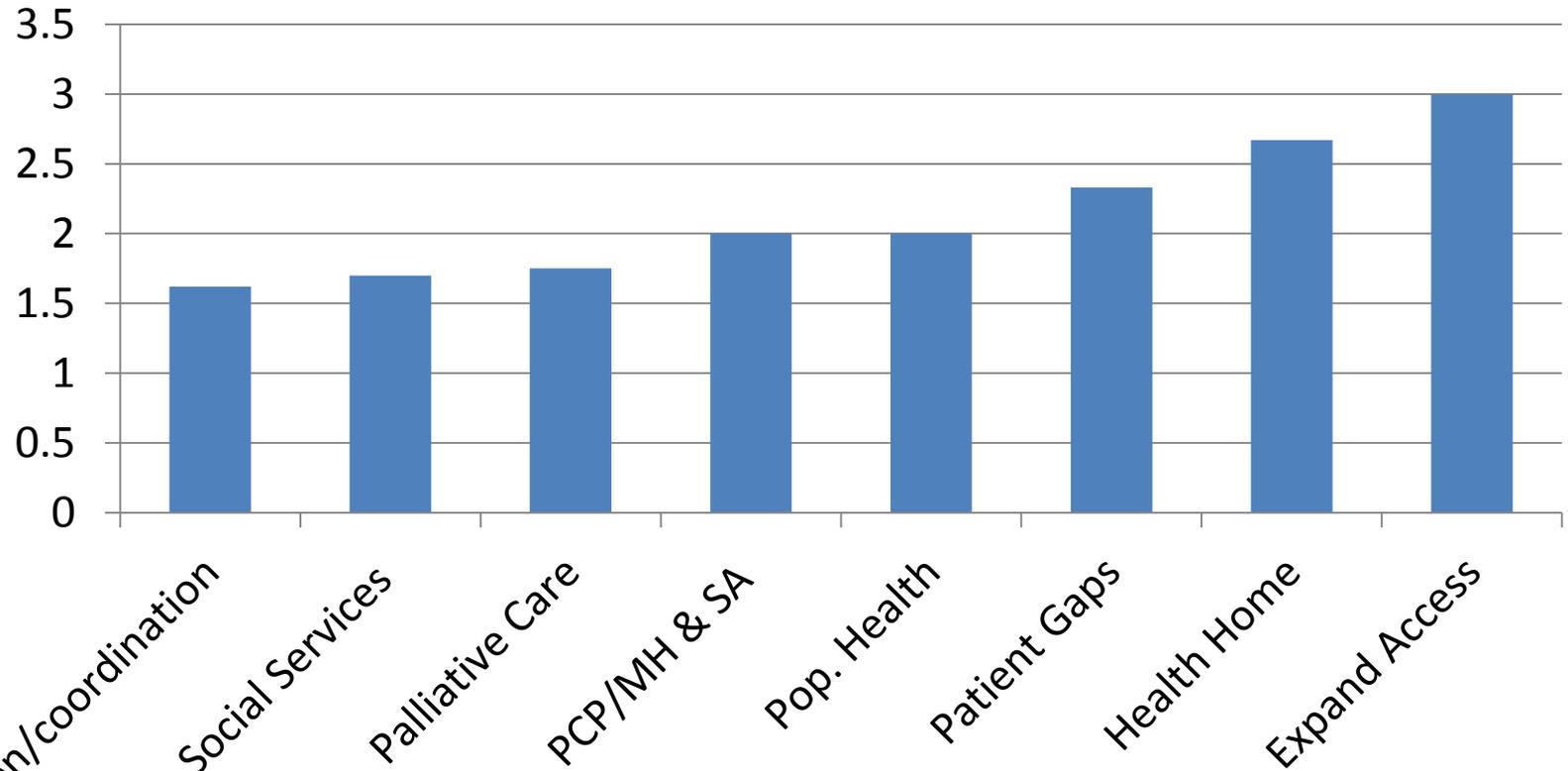
Priority (Defined by Work Group and Presented via Survey)	# of '1' Votes	# of '2' Votes	# of '3' Votes	Total # of Votes	Weighted Score (lower is better)	Ranking Number
In order to better serve all Vermonters (especially those with complex physical and/or mental health needs), reduce fragmentation with better coordination of provider/CHT/health plan and other care management activities. Focus on improving transitions of care and communications between providers and care managers that offer services throughout the various domains of a person's life.	7	4	2	13	1.62	1
Develop improved processes to identify people needing care management services who have not yet been identified as benefitting from care management services. Develop mechanisms for providing those services	0	2	1	3	2.33	6
Better integrate social services (e.g., housing, food, fuel, education, transportation) & health care services in order to more effectively understand and address social determinants of health (e.g., lack of housing, food insecurity, loss of income, trauma) for high-risk Vermonters.	5	3	2	10	1.70	2
Improve population health patient and caregiver self-management capabilities by enhancing primary care and Community Health Team capabilities, conducting more in-home assessments, and providing more health coaching support.	1	4	1	6	2.00	4(tie)
Promote primary care/mental health/substance abuse treatment integration through activities such as supporting designated agencies in improving access to medical home services for the people they serve and by enhancing collaboration with PCPs, expanding primary care clinician training in treating mental health and substance abuse issues, and developing a common data-sharing consent form & agency service agreement.	3	2	3	8	2.00	4(tie)
Expand access to services, including dental services, school-based health clinics, and use of telemedicine/telehealth services.	0	0	4	4	3.00	8
For the most seriously ill, expand models of care that support delivery of lifelong, compassionate care; increased access to palliative care; & an integrated care model for the seriously ill. Consider a "Home Hospitalization" program (similar to Johns Hopkins).	2	1	1	4	1.75	3
Investigate current health home or similar models in use nationally for specialized populations with complex physical and/or mental health needs for their applicability in VT.	0	2	4	6	2.67	7

Survey Results: Number of Votes (1st Place and Overall)



Survey Results: Weighted Average (remember less is more)

Weighted Average



fragmentation/coordination

Social Services

Palliative Care

PCP/MH & SA

Pop. Health

Patient Gaps

Health Home

Expand Access

Attachment 6 - CMCM Meeting Schedule (with Webinar dates)

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

Date	Format	Presenter	Location
January 14, 2014	In-Person	Designated Agencies	
January 21, 2014	Webinar	<ul style="list-style-type: none"> • Allan Ramsay, MD on Care Models for Supportive Care of the Seriously Ill • Vermont Assembly of Home Health Agencies 	
February 11	In-Person	Blueprint CHT Leaders	
February 18	Webinar	<ul style="list-style-type: none"> • VCHIP on Blueprint Network Analysis • Care Alliance for Opioid Addiction (Hub & Spoke) 	
March 11, 2014	In-Person		ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
March 18, 2014	Webinar	Melissa Bailey, IFS	TBD
April 8, 2014	In-Person	<ul style="list-style-type: none"> • VHCIP WORK GROUP PRESENTATION: Population Health Work Group • Vermont Council of Developmental and Mental Health Services 	Office of Professional Regulation - Large Conference Room, 3 rd Floor, 89 Main Street, Montpelier
April 15, 2014	Webinar	OPEN	TBD
May 13, 2014	In-Person	VHCIP WORK GROUP PRESENTATION: Disability and Long Term Services and Supports Work Group	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
May 20, 2014	Webinar	OPEN	DVHA Large Conference Room
June 10, 2014	In-Person	OPEN	Office of Professional Regulation - Large Conference Room, 3 rd Floor, 89 Main Street, Montpelier
June 25, 2014	Webinar	OPEN	AHS Training Room
July 8, 2014	In-Person	OPEN	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
July 15, 2014	Webinar	OPEN	DVHA Large Conference Room

Date	Format	Presenter	Location
August 12, 2014	In-Person	OPEN	Office of Professional Regulation - Large Conference Room, 3 rd Floor, 89 Main Street, Montpelier
August 19, 2014	Webinar	OPEN	DVHA Large Conference Room
September 9, 2014	In-Person	OPEN	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
September 16, 2014	Webinar	OPEN	DVHA Large Conference Room
October 14, 2014	In-Person	OPEN	Office of Professional Regulation - Large Conference Room, 3 rd Floor, 89 Main Street, Montpelier
October 21, 2014	Webinar	OPEN	DVHA Large Conference Room
November 18, 2014	In-Person	OPEN	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
November 25, 2014	Webinar	OPEN	DVHA Large Conference Room