

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

**Date of meeting:** April 14, 2015; 10:30 AM – 12:30 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Introductions</b>	Bea Grause called the meeting to order at 10:31 AM. A roll call was taken and a quorum was not present at the start of the meeting. Approval of the March minutes was postponed until later in the meeting once a quorum was established.	
<b>2. Update on Regional Blueprint/ ACO Committees</b>	<p>Miriam Sheehey from OneCare Vermont, Patty Launer from CHAC and Jenney Samuelson from the Blueprint for Health provided an update on the regional ACO/Blueprint committees (known as Unified Community Collaboratives [UCCs] or Regional Clinical Performance Committees [RCPCs]). A handout was made available at the meeting and is included in the updated meeting materials that are posted to the VHCIP website <a href="#">here</a>.</p> <p>The regional Blueprint / ACO Committees have engaged a variety of attendees; and have discussed the following topics:</p> <ul style="list-style-type: none"> <li>• Establishing a leadership team that will facilitate the decision-making process with respect to clinical priorities on which the group wishes to focus;</li> <li>• Understanding gaps in care and services available in the community; and</li> <li>• Working on clinical priority areas identified by the group</li> </ul> <p>Each UCC/RCPC is building a governance structure that includes a variety of members and supports the role that each member organization plays in the community, establishing meeting processes, and developing their charters. At least one group has included a consumer on the leadership team; other groups are still trying to become more established before recruiting consumers. Some of the same organizations that are participating in the Integrated Communities Care Management Learning Collaborative are also participating in the UCCs/RCPCs. The group discussed strategies for engaging and providing supportive training for consumers to participate.</p> <p>A specific example from Central Vermont demonstrates the type of work that is occurring within regions. A risk scoring model was used to predictively model and analyze care patterns of a cohort of at-risk people, by looking at costs, demographics, ED and primary care utilization, etc. They have developed a care model with the goal of ensuring close</p>	

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	<p>coordination of services between primary care and other community providers, at least one monthly care management contact, and depression screening, among other interventions.</p> <p>Patrick Flood reported on the UCC in the St. Johnsbury community. Their committee strives to include a broad range of community partners; as an example, they are partnering with the food bank on food security issues. Ultimately, they are attempting to establish an Accountable Community for Health.</p> <p>Q: What's being done to coordinate between priorities established in a region versus ACO priorities?  A: ACOs participate on the UCCs/RCPCs; they can share data with UCCs/RCPCs to help identify quality improvement priorities. There is overlap; the regional group ultimately determines their priorities.</p> <p>Q: Does OneCare attend all of the regional committees?  A: Someone from OneCare tries to attend all of the groups; there is one group that is working to better establish the group culture and develop standard operating procedures before inviting ACOs and other external groups. If an ACO does not have a presence in a particular region, it doesn't participate in that region's UCC/RCPC.</p>	
<b>3. Minutes Approval</b>	<p>A quorum was established. Susan Aranoff made a motion to approve the March minutes and Audrey Spence seconded; the minutes were approved by exception.</p>	
<b>4. Expansion of Learning Collaborative</b>	<p>Pat Jones presented an update on the Integrated Communities Care Management Learning Collaborative and a proposal to expand to additional communities in 2015; that information can be found in Attachment 3.</p> <p>The expansion request is proposed because additional communities have asked to join the program. The goal is to begin Round 2 in June or September (it would be challenging to initiate a collaborative during the summer). The content and scheduling would be similar to Round 1. There could be up to 4 rounds, depending on the number of interested communities. The total estimated budget is \$500,000.</p> <p>Q: How do we know this is going to work; do we want to approve rolling out another round before the first round is done?  A: We intend to look at process measures related to the interventions to see if there has been improvement over the baseline. Selected outcome measures could be used as well (e.g., inpatient admissions; ED visits). Participant experience could be evaluated via interviews or focus groups. The interventions being tested are considered to be national best practices, including best practices identified in the DLSS model of care. Progress is already being made in the pilot communities.</p> <p>Q: What about patients who don't fit into the cohort as defined, but who need services?  A: In St. Johnsbury, while they selected 20 or 25 people to start the process, they plan to roll out the interventions to all who would benefit if the interventions appear to be working.</p>	

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	<p>At its March 23 meeting, the CMCM work group voted to recommend expansion of the learning collaborative, pending collaboration with the DLTSS work group. Since that time the Core Team met and allocated additional funds to the DLTSS work group to develop care competency training for providers, related to people with disabilities. The DLTSS and CMCM work group leadership met, and will continue to collaborate on opportunities to implement the elements of the DLTSS model of care, as well as core competency training. A motion to approve expansion of the Learning Collaborative as presented was made by Dale Hackett and seconded by Mary Moulton; then there was a second motion to approve the expansion by exception made by Dale Hackett and seconded by Trinkia Kerr. The Learning Collaborative Expansion was approved with 2 abstentions.</p>	
<p><b>5. Presentation from VNAs of Vermont, Area Agencies on Aging, and Vermont Care Partners</b></p>	<p>Peter Cobb from the VNAs of Vermont, Mike Hall from Champlain Valley Area on Aging, Patrick Flood from Northern Counties Health Care, and Melissa Bailey from Vermont Care Partners presented the information in Attachment 4.</p> <p>Mike Hall presented the Area Agency on Aging (AAA) information, and addressed the following questions:</p> <p>Q: What is included in AAA person-centered case management?  A: The service is limited to 48 hours of case management per year –services are arranged and coordinated; there is an effort to address acquisition of mental health or other services for those who need them. The return on investment appears to be very high; it was noted that the AAA cost information on slide 7 does not include all other services that a person might receive, so it is not directly comparable to nursing home and hospital costs.</p> <p>AAAs provide a broad range of services. It is increasingly apparent that there is overlap among different organizations, and that these organizations’ programs could serve clients in a more integrated fashion. This means consolidation of systems and development of closer formalized relationships.</p> <p>Q: What are the criteria for an AAA referral?  A: Formerly, the person had to be 60+; now services are provided to people under 60 such as adults with disabilities; as long as the individual meets the level of care and is financially qualified, they can be served at an AAA. This includes people at risk but not Medicaid eligible.</p> <p>Q: From a consumer point-of-view, the system appears to be confusing – how do we get to “any open door?” What’s the vision based on Learning Collaborative participation?  A: The ADRC program (Aging and Disability Resource Centers) are trying to establish a “no wrong door” policy – in practice, they are not necessarily making the referrals/routing to services as intended. It should not be mysterious for consumers. One idea is to create an entity that is jointly staffed so that the interface with the consumer and between the agencies is seamless and transparent (as opposed to operating with multiple partners that require heavy coordination). AAA representatives are participating in the Learning Collaborative in all three pilot communities.</p>	

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	<p>Melissa Bailey from Vermont Care Partners (VCP) presented information about Vermont’s Designated and Special Services Agencies. Her presentation highlighted the very complicated funding streams in this area. The presentation touched upon how the VCP works with community partners and what is working well, and highlighted some health outcomes.</p> <p>Q: What is the age range served by VCP?  A: All ages, from birth to death.</p> <p>Peter Cobb from the VNAs of Vermont presented the slides about home health care in Vermont. 70% of Vermont’s home health patients are over age 60, which means that 30% are not. Many people assume the VNAs only serve the elderly population. Primary challenges facing delivery of care are:</p> <ul style="list-style-type: none"> <li>• Data Sharing - Community-based providers need the ability to share and receive relevant patient-specific data electronically with physicians, hospital, nursing homes, and others, to increase efficiency and improve quality.</li> <li>• Duplication – People sometimes receive care management services from several providers.</li> <li>• “No Wrong Door” vs. “Single Point of Contact” - A single point of entry is not needed; a system that provides “no wrong door” is. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the AAA, home health staff must have the knowledge and ability to arrange for the services needed. This can be achieved by Care Resource Teams which would include representatives from a variety of providers.</li> </ul> <p>There are opportunities within the Unified Community Collaboratives/Regional Clinical Performance Committees being developed by ACOs, the Blueprint, and community partners. The UCCs could improve coordination of care, help organizations work together, and improve the quality of health care service delivery.</p> <p>Patrick Flood, CEO of Northern Counties Health Care, suggested that real health reform is going to happen at the community level. He presented a case study of a 65 year old homeless man, who is terminally ill. Recently, he was in the hospital and was then referred to home health. When home health staff checked his records, he had no PCP, so they made a referral to a PCP. He was able to establish a relationship with a care manager, and he has decided that he does not want further cancer treatment. He now has a community team with a primary care site, AAA, SASH and the hospital to help ensure his needs are met. His team is seeking an apartment to allow him to qualify for hospice care, which is his preference for treatment. Without a coordinated intervention like this, he likely would have ended up in the ER and in a nursing home. This is person-centered care, directed by the patient with the support of a lead care manager. Ideally, these types of coordinated interventions can become organized and systematic, as opposed to ad-hoc interactions. The big question is how do we pay for this kind of care in a sustainable way?</p>	
<b>6. Next Steps, Future Meeting</b>	<b>Next Meeting:</b> Tuesday, May 12, 2015; 10:30 am to 12:30 pm; ACCD – Calvin Coolidge Conference Room, National Life, Montpelier	