



VHCIP Provider Sub-grant Symposium

AGENDA

May 27, 2015
8:00am – 12:30pm
Capitol Plaza Hotel
and Conference
Center
Montpelier, VT

- **8:00** **Arrival**

- **8:15** **Opening Remarks**
 Robin Lunge
 Director of Health Care Reform

- **8:30** **ACO Panel Discussion**
 - **MODERATOR: Steven Costantino**, Commissioner, Vermont Department of Health Access
 - **Amy Cooper**, Executive Director, Healthfirst, Inc
 - **Joyce Gallimore**, Director, Community Health Accountable Care, LLC
 - **Victoria Loner**, Vice President, Clinical and Network Operations, OneCare Vermont, University of Vermont Health Network

- **break **

- **10:30** **Transitions of Care Panel Discussion**
 - **MODERATOR, Allan Ramsay**, Green Mountain Care Board
 - **Billie Lynn Allard**, Administrative Director of Outpatient Services and Transitions of Care, Southwestern Vermont Medical Center
 - **Pam Smart**, Care Integration Coordinator, NVRH Community Health Team, VT Blueprint for Health
 - **Toni Apgar**, Care Coordinator, White River Family Practice
 - **Sean Uiterwyk**, Physician, White River Family Practice
 - **Sara King**, Chief Financial Officer, Rutland Area Visiting Nurse Association & Hospice

- **12:15** **Debrief**
 Robin Lunge
 Director of Health Care Reform

*Please join each other for lunch at one of the many restaurants
in Montpelier!*



Welcome to the VHCIP Sub-grant Symposium

Vermont's VHCIP sub-grant program is designed to directly support providers engaged in payment and delivery system transformation. By aligning with the three aims of health care reform – improving care, improving population health and reducing health care costs – these sub-grant projects will test alternative payment models, create innovative care models, and develop infrastructure to support a high-performing health care system in Vermont.

We extend our thanks to all of our participants for coming to our event today and hope to continue to foster cross-project sharing of ideas and best practices.



VHCIP Provider Sub-grant Symposium

Moderator Biographies

Steven Costantino, Commissioner
Department of Vermont Health Access

Dr. Allan Ramsay, M.D.
Green Mountain Care Board

Steven M. Costantino Biography

Steven M. Costantino's career in public service is distinguished by his dedication to propelling progressive, thoughtful and innovative reforms resulting in a greater accountability, effectiveness, and efficiency in government. Throughout his years in public service, he has demonstrated his abilities as a dynamic communicator and visionary leader capable of bringing diverse interests to the table and creating partnerships necessary to achieving sustainable change.

As of February, 2015, Steven joined the Department of Vermont Health Access (DVHA) as Commissioner. The Department is responsible for the oversight, implementation, and management of Vermont's publicly-funded health coverage programs. These programs include Medicaid and the Children's Health Insurance Program (Dr. Dynasaur), collectively branded Green Mountain Care (GMC), as well as the State's health insurance marketplace, Vermont Health Connect (VHC). DVHA also oversees and many of Vermont's expansive Health Care Reform initiatives, designed to increase access, improve quality, and contain the cost of health care for all Vermonters, including the federally funded Vermont Health Care Innovation Project (VHCIP), Vermont's Blueprint for Health, and health information technology strategic planning, coordination and oversight.

Prior to joining the Department of Vermont Health Access, Steven was the Secretary of the State of Rhode Island's Executive Office of Health and Human Services (EOHHS)—the umbrella agency that administers the state's Medicaid program—he also was in charge of overseeing the state's principal health and human services agencies: the Department of Children, Youth and Families, the Department of Human Services and its divisions of Elderly and Veterans Affairs, the Department of Health, and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

In this position, Secretary Costantino instituted objectives and established policies beneficial to transforming the way the state organizes, finances and delivers services across the health and human services spectrum. He was instrumental in building policy collaboratives consisting of public officials, providers, and business and community leaders that positively impact on how Rhode Island pays for and delivers primary care, housing and employment opportunities, and myriad additional programs assisting the state's most vulnerable residents.

With the EOHHS serving as the Medicaid single state agency for Rhode Island, Secretary Costantino was involved in every phase of implementing Medicaid expansion and one of the nation's most successful health insurance marketplaces, HealthSource RI. He also employed his knowledge, expertise and strategic leadership to facilitate an array of ongoing initiatives that improve the integration and coordination of primary care and long-term services and supports; increase the use of home and community-based services; institute a multi-payer, patient-centered medical home; enhance program integrity; develop the state innovation model (SIM); and redesign the finance and delivery of services to encourage and reward quality, promote innovation and accountability, and assist providers and payers to adapt to changing concepts of healthcare.

Prior to being appointed to head the EOHHS, Secretary Costantino served eight consecutive terms in the Rhode Island House of Representatives. First appointed to the House Committee on Finance in 1999, he rose to the position of Chairman in 2004, retaining that leadership position for seven years, until assuming his duties as EOHHS Secretary.

Allan Ramsay, M.D.
Biography

Allan Ramsay, M.D. is a primary care physician who has practiced in Vermont for 30 years. Allan's signature work is in the area of palliative care, where he has been a leader in developing models for assuring that patients' wishes are followed at the end of their life. He is past Medical Director of Fletcher Allen Health Care's Palliative Care Service and the founder of the Rural Palliative Care Network.

In his long career in academic medicine, Allan served as Residency Director and Vice Chair in the Department of Family Medicine at UVM, where he is now Professor Emeritus. Allan is a past member of the board of the Visiting Nurse Association of Chittenden and Grand Isle Counties and the Board of the Community Health Center of Burlington.

While serving on the Green Mountain Care Board Allan has practiced family medicine at the People's Health and Wellness Clinic in Barre, Vermont.



VHCIP Provider Sub-grant Symposium

Project Summaries

Healthfirst
Capacity & Infrastructure Building and
Clinical Quality Improvement Among Independent Physicians

What We Are Doing

Healthfirst's work under our VHCIP grant has two main emphases, with a range of activities and initiatives to support these efforts. First, we are building infrastructure and capacity to support independent physicians as connected and engaged partners in Vermont's healthcare landscape. At the same time, Healthfirst is committed to supporting independent practices in delivering high-quality care by (1) introducing a collaborative care agreement between primary care and specialist physicians within our membership, (2) providing resources and support for implementing and managing data tracking and reporting, and (3) helping architect disease management programs and to implement and/or hone best practices for aiding patients through care transitions.

How Our Work Is Going

Since the award of our first round SIM grant, Healthfirst has achieved many of its initial capacity and infrastructure goals, including hiring additional staff, securing office space, and convening several committees and subcommittees in support of our accountable care activities. Highlights of our initiatives to support quality improvement with second round funding include: (1) 100% of our practices signing our collaborative care agreement, for which we are now beginning to develop plans for successful implementation; (2) completion of our first data collection for our commercial ACO practices, with many take-away lessons to improve the process in future years; (3) beginning the process of hiring a Quality and Care Coordination Manager to provide direct support to practices for data tracking/reporting, coding compliance and more; and (4) engaging member physicians in meetings and discussions within and beyond Hf's membership about healthcare around the state, including the evolution of unified community collaboratives and regional performance care communities, efforts that will help us identify local physicians who can serve as liaisons between Hf member practices and the communities and stakeholders our members serve.

Lessons We Have Learned

Changing care patterns at the practice level is hard work. It requires constant, clear communication, regular feedback on progress, good quality data, and a high level of trust among Hf network staff and individual physicians and practice managers.

Current financial incentives from ACO and Blueprint programs need to be upgraded so that practices are compensated appropriately for all the work required to implement and manage quality care initiatives. This is essential if the state and other stakeholders want to keep practitioners engaged in efforts to change care patterns.

**Rutland Area Visiting Nurse Association and Hospice, Inc
and
Rutland Regional Medical Center
Supportive Care Program**

What We Are Doing

The goal of the Supportive Care Program is to bridge the gap between inpatient palliative care and hospice, and expand beyond the existing palliative care program. Working with the primary care physicians, Rutland Regional Medical Center and the Rutland Community Health Team, this program will address the complex needs of seriously ill patients. The aim is to support patients and their caregivers in clearly identifying their goals and incorporating these goals into a suitable treatment plan in concert with their primary care providers earlier in the disease process. Higher quality communication will improve the likelihood of thoughtful planning and, therefore, the quality of care by aligning it with patient desires, promoting adherence with treatment and care plan(s) while lessening the physical emotional duress associated with serious illness.

How Our Work Is Going

Initially there was difficulty getting non-Medicare patients who met the illness criteria to participate; therefore it was necessary to expand the criteria to include Medicare patients. In addition, collaborating with local nursing homes to integrate our services and theirs for CHF/COPD patients has allowed for an easier transition back home after rehabilitating in the facility has increased referrals into the program.

To date, RAVNAH has seen 25 patients under this program since expanding the payer criteria.

Lessons We Have Learned

In order to provide traditional home care services to Medicare patients, the patients are required to be home bound. By broadening the payer criteria to include the non-homebound Medicare patient was critical to the success of this program.

One of the biggest hurdles that we continue to meet is the difficulty convincing referrals who are currently stable to utilize our services. Patients are resistant to discussing end of life planning when they are not immediately faced with that situation.

White River Family Practice High Risk Population Management in Advanced Primary Care Practices

What We Are Doing

We have identified a registry of patients within our practice comprised of patients who demonstrate one or more of the following characteristics: (a) frequent ER usage; (b) frequent hospital admissions or readmissions; (c) a diagnosis of asthma with treatment for this condition either in the ER or through hospital admission within the past 24 months; and (d) a diagnosis of poorly controlled diabetes with coexisting depression. These patients' self-reported confidence in managing their own health issues (Health Confidence, HC) is assessed at every visit. Employing increased and dedicated Care Coordination services, intensive pre-visit planning and post-visit communications, and our staff's newly acquired (and ongoing) motivational interviewing training, we are focusing on improving patients' HC and health understanding.

How Our Work Is Going

Our initial patient registry is composed of 76 patients, about half of whom have responded with measures of HC (as of 3/29/15). We have developed discreet "flow maps" defining office care processes for each of our four target patient populations, as well as templates within the electronic record to document pre-visit-planning, patient Care Plans, and post-visit patient contact including pathways to facilitate meeting with Mental Health provider, if needed. Although we have requested insurance claims data from all payers regarding healthcare provided to WRFPP patients, to date only BCBSVT and DVHA have been willing to share claims data, compromising our ability to employ our population health management software in predictive analytics for risk stratification.

Lessons We Have Learned

Patients are not as engaged in their healthcare as we might assume. At least half of the patients in our panel don't necessarily welcome intense case management or RN involvement in helping them get better. They don't return our calls; they frequently don't show up for office visits. Negotiating the paradigm shift within the entire office to attend to "What matters to the patient" and address deficiencies in patients' self-reported Health Confidence is a challenge. Social determinants of health play havoc with primary care practitioners' efforts to keep patients healthy; primary care is not equipped to deal with difficult socioeconomic factors such as homelessness, poverty, lack of transportation, and the complex and difficult family dynamics so often found to accompany poor health states.

**Northeastern Vermont Regional Hospital
Caledonia & S. Essex Dual Eligible Project**

What We Are Doing

This project is providing a health coach for people dually covered by Medicare and Medicaid, and funding for goods and services not normally covered by insurance; thus enabling an integrated multi-disciplinary community care team to provide better care for clients who are at risk for poor outcomes and high costs of medical care.

How Our Work Is Going

The health coach currently has over 40 active clients and is working with numerous other organizations to coordinate care including mental health, home health, area agency on aging, and primary care. With the help of the Care Models Care Management Workgroup Learning Collaborative, the project is making great strides toward identifying a lead care coordinator for dually eligible clients, and also piloting a shared care plan.

Lessons We Have Learned

Many dually eligible clients do not currently have case/care management services; therefore, the case load for the health coach filled up quickly. We need to be flexible and adaptable as patient's/client's needs are met and consequently change. Creating a system to allocate flexible funds is harder than it sounds!

**Vermont Medical Society Education and Research Foundation and
UVM Medical Center
Optimizing Laboratory Testing Collaborative**

What We Are Doing

Our global aim is to reduce harm to patients and conserve system resources by optimizing the use of laboratory tests for patients cared for in our region's hospitals. We are using a collaborative approach considering the best medical evidence and quality improvement science. We began with an evaluation of current test ordering profiles and patterns followed by an organized plan to optimize testing; our effort ends with a plan to sustain these practices.

How Our Work Is Going

Guided by a faculty of clinical, QI and analytic professionals, eight regional hospitals (University of Vermont Medical Center, Dartmouth Hitchcock Medical Center, Rutland Regional Medical Center, Central Vermont Medical Center, Porter Medical Center, Northeastern Vermont Region Hospital, Brattleboro Memorial Hospital, Southwestern Vermont Health Care) have uploaded a 2 year baseline of billing and laboratory data of all adult inpatients to a secure data enclave at University of Chicago; the baseline data base comprises more than 90% of hospital beds in the region. The data set is updated monthly; monthly all-collaborative and hospital specific performance reports are sent to hospital teams to support their investigations of problems and tests of changes targeting reducing harm and conserving resources - <http://www.vmsfoundation.org/simgrant> .

Lessons We Have Learned

The Laboratory Collaborative effort represents change not forced from the outside in, but change led from the inside out; change based on professionalism and trust among leaders who work in the trenches every day. Acceleration of innovation and reform require: 1) the will to improve; 2) ideas about alternatives to the status quo; and 3) actualization through execution; all three have to be arranged by leaders – they are not automatic. This rigorous improvement project is a model for retooling the regional delivery system in a meaningful and transparent process closing the gap between practice and policy, reducing harm and conserving resources.

Invest EAP Resilient Vermont

What We Are Doing

Employee Assistance Programs (EAPs) have been demonstrated to reduce employee stress that may otherwise increase cortisol and epinephrine levels that can lead to chronic stress and disease. If such prevention and early intervention is effective in the workplace, what would be the impact on health outcomes and expenditures if we offered these same services to all patients at a healthcare center? We are investigating the combined effects of EAP and behavioral health screenings and interventions at the St. Johnsbury Healthcare Center.

How Our Work Is Going

We have seen many patients to-date. We have provided them with short-term solution-focused counseling and resources to enable them successfully resolve a number of life challenges. The health center has been screening patients for key behavioral risk factors and those who screen positive are referred to our on-site health coach. This is working well.

Lessons We Have Learned

Individuals who are not working are proving easier to engage for repeated visits.
Individuals almost always benefit from simply sharing their story and receiving support.

Community Health Accountable Care, LLC.
Furthering Community Health Accountable Care, Collaborations and Analytics

What We Are Doing

The VHCIP Provider Grant funding is truly the backbone of Community Health Accountable Care (CHAC) as it has funded basic infrastructure including core staffing, facility costs, meeting costs, professional services, and IT support. Accomplishments of the last year include implementation of CHAC's four standing committees; development, adoption of, and implementation of clinical recommendations for COPD, CHF, Falls Risk Assessment, and Diabetes; implementation of a telemonitoring pilot; and operationally supporting all ACO requirements (i.e. beneficiary notification mailings and report submission including quality reporting).

How Our Work Is Going

CHAC officially became an ACO as of January 1, 2014 so we are just beginning to receive the results of the required ACO reporting for our first year, but CHAC is very proud of the many accomplishments thus far and looks forward to even more in the upcoming terms. The progress of our clinical committee has been remarkable as they have invested substantial time to develop through a consensus driven process best practice clinical recommendations that have been shared within our network, with community partners, and throughout the state. The telemonitoring program, especially the care coordination aspect, has received rave reviews from providers and patients, and demonstrates CHAC's commitment to being the integrator for primary care with community partners and other support services.

Lessons We Have Learned

Adoption and implementation of new processes can be challenging to disseminate across a statewide network of individual organizations and requires a champion at each location to advocate for the changes. Our clinical committee members, who are deeply invested in the clinical recommendations they developed and agreed to adopt have taken on the role of champions in an effort to unite our provider network and establish the expectation for ongoing quality improvements. CHAC is still in the early stages of learning from the results of our data reporting, but what was evident from the data collection process was that collaborations between the three ACOs was valuable in making the process as seamless as possible. There will be more lessons to share in the near future and CHAC will be sharing them individually with our health centers, network wide, and with the QPM Work Group.

OneCare Vermont

Accountable Care Organization Operations

What We Are Doing

OneCare Vermont's work through the contract complements other successful Vermont health reform efforts, such as the Vermont Blueprint for Health, by bringing together Vermont's provider continuum (e.g., primary care, academic centers, community hospitals, specialists, rehab and nursing facilities, home health and hospice agencies, mental health and substance abuse providers, housing supports and those who provide for Vermonters with special needs). OneCare Vermont is using the grant to further innovative, highly reliable, evidenced based population health management strategies by providing support to:

- Collect, analyze and disseminate data for targeted performance improvement priorities.
- Fund local medical leadership, clinical facilitation, analytic support, and performance improvement training.
- Design and disseminate tools, best practices, and trainings to guide and support performance improvement targets.
- Facilitate performance improvement work through 14 Regional Clinical Performance Committees (RCPCs) serving every Vermont community.

How Our Work Is Going

- Successful completion of quality measurement training and collection process (winter 2015) between Vermont's three (3) ACOs.
- Alignment with the Blueprint for Health on quality measures linked to medical home payments.
- Selection of clinical priorities that align with and complement other statewide reform initiatives.
- Regional Clinical Performance Committees started in collaboration with the continuum of care providers, the Blueprint for Health, and the other ACO's throughout the state.
- Launch of a statewide learning collaborative forum to support performance improvement work on OneCare Vermont's emergency room and readmission/admission clinical priorities.

Lessons We Have Learned

- Creating, identifying and adopting better ways to keep individuals and communities well is a goal everyone can agree on. The work is hard and it takes longer than you would like but the cooperative effort by Vermont's provider continuum brings greater value than would be possible if the initiatives proceeded independently.
- Designing and acquiring the necessary sophisticated information technology resources, skilled analytics capabilities and dedicated clinical leadership is foundational.

**Northwestern Medical Center
RiseVT**

What We Are Doing

RiseVT is a community initiative to embrace healthy lifestyles. RiseVT motivates, inspires and works with individuals and families to help them make small changes in their lives that will have a big impact on their health. In addition, RiseVT has strategically placed Health Advocates around Franklin and Grand Isle to work with schools, businesses and municipalities to wrap around our residents to create an environment where the healthy choice is the easiest choice.

How Our Work Is Going

We are currently in our Pilot Phase of the project with a launch of June 1. So far we have worked with eight businesses, two schools, one municipality, and 250 individuals have actively signed the pledge to embrace healthy lifestyles. We have successfully certified four businesses in Breast Feeding Friendly state certification, reestablished a Wellness Committee in a local business, brought Safe Routes to School to a rural school setting and are working collaboratively with three non-profits to provide health coaching and biometric screenings. Our media presence has been widespread including actively engaging with our community in social media to help spread the mission of RiseVT to embrace healthy lifestyles.

Lessons We Have Learned

Piloting has been key as we have learned from our different entities how to engage and make a meaningful impact on their environment. Developing relationships with community members, leaders, schools, etc., will be an ongoing process and the importance of making these connections has been and will continue to be a vital component of our success.

**Vermont Developmental Disabilities Council, in partnership with Green Mountain Self Advocates
The Inclusive Health Care Partnership Project**

What We Are Doing

People with intellectual and developmental disabilities (I/DD) now enjoy a life expectancy almost equal to that of the general population. However, as a group, people with disabilities fare far worse than their nondisabled counterparts across a broad range of health indicators and social determinants of health. The goal of the Inclusive Healthcare Partnership Project (IHPP) is to identify and recommend a set of innovative best practices in the delivery of health services to adult Vermonters with I/DD that will improve their care experience and their health while reducing cost.

How Our Work Is Going

During the first five months of this one-year planning grant, IHPP has established a strong staff team, which includes a self-advocate, and recruited an eight member Planning Team composed of three other self-advocates, a family care-giver, three physicians, and a nurse from the developmental services system. All Planning Team members have received an orientation to the project, and IHPP will have hosted the first of its seven planning meetings by the end of May.

In preparation for these meetings, the Project coordinator has collected considerable information through stakeholder interviews, conversations with national leaders in the emerging field of developmental medicine, surveys and the first of five scheduled focus groups with self-advocates, families, and providers. With technical support from VHCIP, project staff have been able to use Medicaid claims data to quantify the health status and utilization patterns of Vermonters with I/DD. IHPP is on schedule to complete its research and share its recommendations by the end of 2015.

Lessons We Have Learned

IHIP is unique within VCHIP's portfolio of community grants in the degree to which health care consumers, specifically those with disability-related long term support and service needs (DLTSS), provide leadership and expertise. The Lesson Learned that we would most like to share with the group is that while it takes some additional time and planning to involve self-advocates in meaningful conversations about the health care that they want to receive, it can be done. In fact, many of the tools we use to support self-advocate participation are also best practices that we anticipate recommending to improve the communication between health providers and individuals with I/DD during medical appointments – for example, visual supports and cognitively accessible materials.

University of Vermont Health Network at Central Vermont Medical Center Screening in the Medical Home (SiMH)

What We Are Doing

University of Vermont Health Network at Central Vermont Medical Center (UVMHN-CVMC) aims to implement screening and behavioral interventions for patients that present with risky levels of tobacco, alcohol and drug use. Our approach is to utilize the **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment (SBIRT) model in medical homes throughout CVMC with the goal of reducing and preventing health related consequences, disease, accidents and injuries that are associated with substance misuse. Additionally we have initiated the use of a SMS text messaging intervention for patients engaging in binge drinking behaviors.

How Our Work Is Going

We have established universal screening templates in the medical home's electronic medical records system. Two medical homes now have incorporated the SBIRT model into their practice and have full time SBIRT counselors on staff. Outreach for enrollment into the SMS texting intervention is happening in these practices through face to face engagement and flyers. The remaining five medical homes have expressed interest in adopting the SBIRT model and accessing counselors for their practice.

Lessons We Have Learned

Adoption of the screening in the medical home by the medical providers and nursing staff requires an ongoing investment of time and training. An enthusiastic SBIRT champion team from each practice is essential. There appears to be a concrete need for SBIRT services in the medical homes. The process of adding screenings to a workforce that is already burdened with numerous health screening tasks presents a unique challenge. Discomfort with the expanding expectations placed on routine patient visits combine with the cultural stigmas associated with substance misuse/dependence creates staff hesitancy in a comprehensive adherence to the SBIRT model.

Southwestern Vermont Medical Center Transitional Care Program

What We Are Doing

SVHC, in close cooperation with the Bennington Blueprint and community partners across the service area, is creating an integrated care delivery system to better serve our population in preparation for the global budget anticipated in 2017. We have re-deployed acute care resources (Clinical Nurse Specialists, Pharmacists, Social Worker) to partner with high risk, chronic care patients in primary care practices and are successfully navigating them from one setting to another and decreasing resources utilization (ED visits and inpatient hospitalizations.) Through this process, we have identified gaps in care delivery and developed solutions to bridge these gaps including:

- Development of a Community Care Team meeting monthly to provide wrap around care planning for high ED use behavioral health and clients with addictions
- Hiring of a nurse educator to assist with implementation of Interact program in all area nursing homes (Evidence based program with interventions to reduce transfers to the hospital) to decrease unnecessary readmissions from this setting
- Standardization of care for CHF and COPD patients across the care continuum (primary care, hospital, long term care, home care)
- Use of clinical pharmacist for patient education and MD consultation in primary care and long term care setting to increase medication adherence and decrease polypharmacy

How Our Work Is Going

Since the inception of the Transitional Care Nurse program in the fall of 2013, we have demonstrated consistent decreases in inpatient hospitalization ranging from 63-68% measured at 120 and 180 day intervals for patients using this program. ED utilization has also decreased but not as consistently during the same time frames ranging from 28-44% for 120 days and 0-30% for 180 days. We are forging a strong partnership with Primary Care Practices, Medical Home Case Managers and all community care partners to identify opportunities to better coordinate care and maximize use of appropriate resources. Each of the new programs being implemented will target other identified opportunities to decrease cost, improve quality and the patient experience.

Lessons We Have Learned

- Partner with all care providers and community agencies and maximize appropriate referral and usage of what exists in your service area.
- Find opportunities to meet the patient /family where they are and bring appropriate resources to them whenever possible.
- Transitional Care nurses “partnering over time” and developing relationships with patients in the hospital, office, nursing home and home care setting can bridge the gaps from one care setting and provider to the next and assist with development of a realistic, patient centered plan of care.
- Seldom are there opportunities for meaningful education for patients in the hospital setting due to short length of stay, acuity of illness and anxiety and discomfort of the patient. Realistic plans for follow-up are essential to improve chronic disease management and patient engagement in the plan.
- Medication reconciliation, management and education are key drivers in decreasing the cost of healthcare

**Vermont Program for Quality in Health Care
American College of Surgeons National Surgical Quality Improvement Program**

What We Are Doing

The Vermont Program for Quality in Health Care, Inc. (VPQHC) is coordinating the implementation of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) in 12 hospitals across the state of Vermont. Participation in the ACS NSQIP assists hospitals in identifying and reducing preventable surgical complications by extracting relevant clinical data. Other hospitals that have participated in ACS NSQIP have seen improvements in quality of care, patient safety, and patient satisfaction, in addition to reduced costs.

How Our Work Is Going

Over the past four months, VPQHC has hired the Statewide Surgical Collaborative Program Coordinator, facilitated statewide meetings of our surgeon champions, and provided ongoing outreach and education to Vermont hospitals. Seven of the twelve hospitals will be submitting hospital participation agreements and enrolling in one of the program options within the next few weeks, three hospitals are discussing ACS NSQIP internally with no decision yet, and one hospital is uncommitted, but may enroll if other hospitals join. Only one hospital has reported they will not be enrolling in ACS NSQIP at this time. After enrollment, the next step is for hospitals to hire a surgical case reviewer to extract the clinical data.

Lessons We Have Learned

The success of a complex project requires a strategic plan that is structured but has flexibility to allow for changes necessary to move the process forward. If the project has several stakeholders or is large in scope, establishing a collaborative will help engage, educate, and motivate participants toward a shared and sustainable goal.

InvestEAP and King Arthur Flour Behavioral Screening and Intervention

What We Are Doing

Employee Assistance Programs (EAPs) serve a number of employees with a wide range of presenting issues each year. However, most employees who come to EAP do so on their own usually in response to some acute issue in their lives. While this produces many positive outcomes, a more active behavioral screening process could identify key risk factors for adverse health outcomes that may otherwise go undetected. Providing such screening in person would enable EAP counselors to apply evidence based Motivational Interviewing techniques to specifically address these behaviors beginning at the time of the screening.

How Our Work Is Going

This project only recently began. We have screened and treated a few employees thus far. We will be integrating a new software program into our approach to ensure fidelity to key aspects of Motivational Interviewing and to enable us to provide detailed action plan printouts to clients.

Lessons We Have Learned

Working closely with the employer's HR department is key to an effective rollout and adoption of the project. Offering employees the choice of meeting with us at their worksite or at our offices is important as individuals have divergent preferences related to time, ease of access and confidentiality.



VHCIP Provider Sub-grant Symposium

Notes from ACO Panel Discussion

VHCIP Provider Sub-grant Symposium

ACO Panel Discussion

Moderator – Steven Costantino

Speakers:

- Amy Cooper
- Joyce Gallimore
- Vicki Loner

Amy Cooper – Healthfirst: an infrastructure building grant recipient.

Background on Healthfirst

- VT's independent physician association, since 2010 – started by group of local independent physicians, now 160 physician members throughout the state
- 60% in Chittenden county, also located in Franklin and WRJ area
- Membership is made up of about 60% primary care physicians and 40% specialists, they represent a large portion of the independent primary care and specialists in state.
- They first started their involvement with ACOs in 2012 when leadership partnered with Collaborative Health Systems who sought out independent physician groups and started developing a number of models and pilots
- Governance structure is designed to execute accountable care goals (triple aim)
 - o Developed infrastructure around several things:
 - ACO management committee (12 physicians, mostly primary care from big independent practices and 3 specialty care members) – getting primary care and specialists to work together, particularly on protocols for communication and coordination, seamless transitions, and to support primary care medical home model
 - Clinical/Quality Improvement Committee – includes representatives from both primary and specialty care. They work to prioritize what clinical programs are going to be for the ACO. Ex: Used a Medicare claims data analysis to identify CHF as a main ambulatory care sensitive condition after they noticed they were performing worse than other ACOs in peer group (nationally); then built a program to help take care of these patients.
 - Clinical Implementation Committee – made up of mostly practice managers at big primary care practices. Physicians had a hand in practice change, but needed to get others involved. PAs/NPs are champions on population health.
 - Consumer Advisory Board – meets quarterly in order to update representatives on the ACO's activity. Constantly trying to discover how to engage patients to be active participants in their own health, especially those with chronic conditions.

Explaining what an ACO is isn't always easy, but they need patient engagement in order to realize better population health.

Joyce Gallimore – Community Health Accountable Care:

- CHAC is made up of 11 Community Health Centers across the state, 9 certified home health agencies and 14 designated agencies
- Board – 18 members: consumer members from each enrollment product
 - Representative board configured to bring community partners and health centers together in order to provide comprehensive primary care as they recognize that their unique population health relies on a number of factors, not just medical.

How CHAC has used SIM grant:

- SIM funding has helped to support essentials for the first year such as staffing, completing contracts with provider networks and orienting and beginning to work with the board
- Comprised of Several Committees
 - o Operations Committee
 - o Finance Committee
 - o Clinical Committee – Medical Directors from FQHCs and clinical representative from each provider organization meet monthly in order to help develop a quality improvement program, and analyze data; working closely with Blueprint and DVHA.
 - Identified prevalent conditions – falls risk, CHF, obesity, diabetes
 - Clinical leaders bring expertise to these areas to develop guidelines, and conducted webinars to share this information to the larger VT provider community; strong message is that they want to deliver good uniform care across populations. Approached it in a collaborative fashion.
 - o Beneficiary engagement, CHAC also finds it important to satisfy consumer needs; beneficiary representatives are from Medicare and Medicaid and there is a constant desire to bring their voices to the forefront

Vicki Loner – OneCare VT:

- One Care first started in 2013 as a Medicare only ACO with one dedicated staff person. When the ACO went from Medicare only to incorporating Commercial and Medicaid payers they immediately had more members, measures, rules and committees and this proved to be a significant challenge for them.
- They are currently in a world of upside risk, but will begin to look at downside with the NextGen ACO option. And if they go forward with it, the training wheels will come off quickly
- Appreciative of SIM grant– provided for a great forum amongst the ACOs and payers to get together and to think about what we're trying to do as an entire state in order to get out of silos and do things together.

- Collaboration amongst the ACOs: quality collection is a great example - ACOs worked together to define and collect measures by developing a common language and training on how to collect them
- Collaboration around care coordination: helps to inform ACOs on how to provide high-quality care to complex, at risk individuals; examine factors other than medical issues. Also collaborating with VCHIP on pediatric coordination.

Questions -

Steven: What was your “AHA” moment in this process?

CHAC: providers were able to look at the data for various conditions and noticed variation in performance between practices. Over time, physicians became comfortable with sharing their performance with each other and developing best practices. Having good data and seeing variations was essential to identify best practices and find opportunities to develop future guidelines.

OCVT: After the first round of quality collection occurred, they were able to put together report card and examine how each of the 14 HSAs were doing on quality measurement. They were surprised that they were not doing so well on a number of conditions; and decided to pay special attention to them. To do this, they went out and showed the HSAs their scores – where they went through a phases of data denial. OneCare then sent out clinical consultants and supported them in their efforts and to see what sort of changes could be made. They then re-measured six months later, saw some improvement and made sure to share those best practices. They have found it difficult to share individual practice learnings broadly across the ACO – but are learning.

Healthfirst: Discovered that healthcare is hard to get, format and present to the physician community. Physicians are a tough audience and they want detail in order to truly change daily practices and behavior. The most successful way to do this is to take high level claims data and match it to the clinical data in order to be actionable. It is also a challenge for them to build the needed change into the practice’s daily workflow so that it’s not overly burdensome for them.

Steven: How do you make sure that providers don’t get burnt out by all of the quality measures?

OneCare: As OneCare’s network bridges two states, it is important to understand the cultural differences between states. The healthcare reform landscape is very different in both states; but with that, they are able to learn a lot from one another. Another advantage is that VT/NH are part of NNEACC, which brings together ACOs from NH/VT/ME where they can discuss successes and failures of initiatives, quality measurement, and share best practice successes. In terms of not overloading OneCare’s network on quality initiatives they feel that providers need and deserve to have a voice at the table. Any way to align quality initiatives is extremely important, so that networks can see that we’re collaborating.

HealthFirst: They have found it important to make quality measures relevant to all providers and practices. Additionally, ensuring providers have a voice with their regional clinical performance

committees/UCCs plays will continue to play an important role. A significant challenge is that total healthcare spend is 40% or higher at hospitals, and they need to understand what's going on in the hospital setting. They have made inroads getting census data from hospitals and making sure physicians participating in the ACO have real time info on admissions and discharges in a hospital setting.

CHAC: The FQHCs in the network have experience with the Medicaid population and know how to treat this patient type in addition to using a team approach. To deal with feeling overwhelmed, they rely on this team approach and working with peers is a way to support physicians and give them a voice. Doing things that make a difference and being able to actually see it come to fruition in the data is very gratifying.

Questions from attendees:

Allan Ramsay: How does the ACO make life better for those participating in it?

Amy Cooper/Healthfirst: It was initially thought that they would be rewarded financially, has this has not come to fruition. More likely answer is that it has brought together independent practices to learn best practices among peers.

Vicki Loner/OneCare VT: Also feels it has been beneficial to physicians to learn from peers. Instead of just giving them a process to implement, they worked with practices to establish a better process and provide them more resources in order to be successful. There is also more institutional backing and a seat at the table that didn't exist before. Finally, data is getting there, and getting better – they are now at the point where they can identify a couple of people that need additional help that previously wouldn't have been on their radar

Joyce Gallimore/CHAC: ACOs are accountable to deliver on their promises to maintain involvement of physicians. They want to improve the wellbeing of their patient populations, so CHAC tries to involve them so that they have a voice. The experience of working together and looking at data/comparing performance together is extremely rewarding to them. Joint ownership of guidelines and cascading it out to their peers has been extremely valuable. Also want to emphasize that having real time data is extremely important as they move forward.

Dale Hackett: what are you seeing change that the data doesn't capture? What subjective changes are you seeing?

Vicki Loner/OneCare VT: We would have monthly HSA calls to talk about concerns, challenges, data and what the data might be showing. This started as just a small group, and then invited more representatives to participate in calls. First was just medical personnel/community, but as it evolved, more and more participants from the community joined the call. It has been enlightening to see involvement from different aspects of community (not just medical).

Amy Cooper/Healthfirst: Communication among stakeholders has improved so much and they don't have as many barriers in place. She does not believe these changes in care are invisible to patients – they want to know what's going on and learn about the value to them and overall cost of care.

Joyce Gallimore/CHAC: They are strengthening partnerships, and making it the new norm. This is especially important for those in home health, where they want to stay home and it is more cost effective to do so. More supports are in place to help patients make better medical choices, and having appropriate services available to them.

Steven: What would you like to see at the end of all of this, as far as long term change?

Joyce Gallimore/CHAC – Would like to provide individuals the ability and support to function more fully, and help people to stay independent and have a higher quality of life. Less paperwork and less focus on things that don't make a difference.

Amy Cooper/Healthfirst – Would like to see all models of care supported in VT (independent practices as well as more hospital-based ones).

Vicki Loner/OneCare VT – Providers should feel supported in the work that they do and that they do the job they set out to do. Additionally, feel that we have a long way to go in terms of engaging consumers in the partnership of their healthcare. These sorts of experiments with ACOs and other grants will get us closer to improving the consumer experience and putting patients at the center of their healthcare.



VHCIP Provider Sub-grant Symposium

Transitions of Care

Panel Discussion Materials



Transitions in Care Panel

VHCIP Provider Sub-grant Symposium
May 27, 2015
Moderator: Allan Ramsay, MD

Panelists:
Billie Lynn Allard, SVMC
Pam Smart, NVRH
Sara King, RAVNAH
Toni Apgar, White River Family Practice
Sean Uiterwyk, MD, White River Family Practice



Objectives

1. Identify barriers that have existed to the effective transition of care and review successful transition models that have led to improved patient care and possibly reduced the total cost of care.
2. Discuss opportunities to improve care transitions that may not yet have been implemented (thinking outside the box).



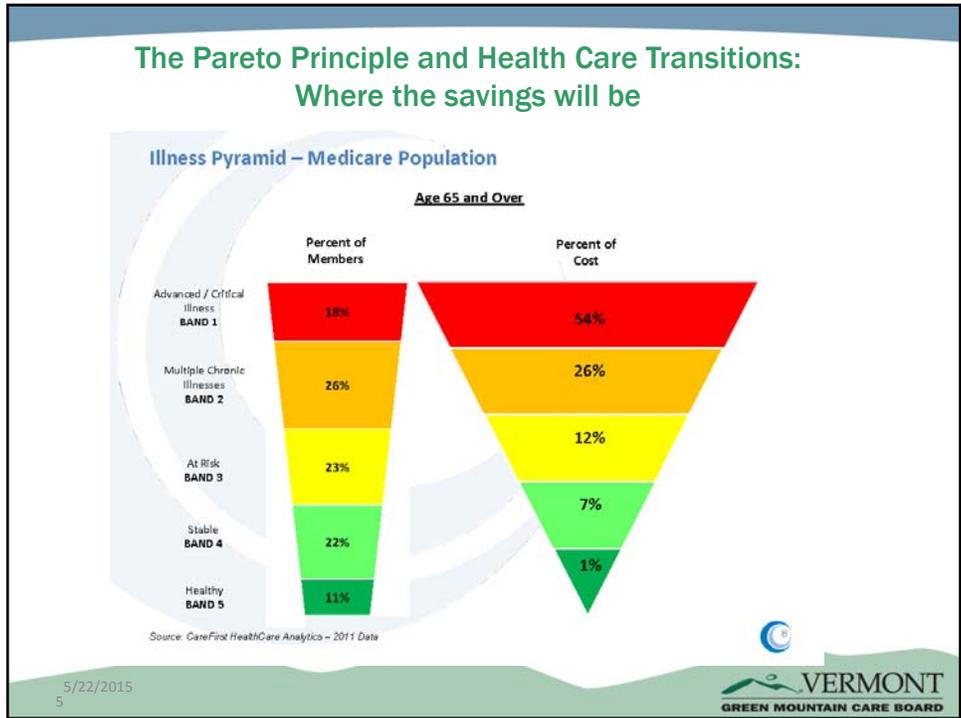
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Projected population growth in one Vermont hospital service area

	Actual 2012	Projected 2022
Total population 0-19 yrs	262,130	247,647
Total population 20-64 yrs	632,913	642,907
Total population 65-84 yrs	141,574	212,528
Total population 85+ yrs	22,001	23,702
Total	1,058,618	1,126,784

The Pareto Principle

- The Pareto principle is also known as the 80–20 rule
- Named after Italian [economist Vilfredo Pareto](#) in 1896
- For many events, roughly 80% of the effects come from 20% of the causes
- We can “roughly” apply the Pareto Principle to the target population in health care transitions



Defining the seriously ill (Vermonters who don't get good health care)

(Meier: communication, 2012).

Diagnosis	Health care utilization	Patient/family issues
Cancer: metastatic, locally advanced head neck, pancreas, CNS	> 1 hosp in 3 months unrelated to disease modifying therapy	Poor func status, > 2 symp rated moderate or severe, cog impair, caregiver stress, unavailability, MH
CHF or COPD	> 3 hosp/ED visits in past 6 months, ICU adm unrelated to a procedure, home inotrope, VAD	Poor func status, dyspnea or > 2 symp mod or severe, cog ,impair; caregiver stress, unavailability, MH
ALS	Complex homecare requirements	Dysphagia, dyspnea or > 2 symp rated mod/sev; caregiver stress, unavail
Dementias	Mult MD visits in 3 mon; pneumonia, hip fx, sepsis, dehyd in past 6 mon	Poor func status, dysphagia; caregiver stress, unavailability, MH
Advanced cirrhosis	MELD >30	Caregiver stress/unavailability, MH
* HIV+ cirrhosis, cachexia, cancer * Developmental disabilities (Ped PC)		

5/22/2015

VERMONT
GREEN MOUNTAIN CARE BOARD

What are the continuing issues related to transitions of care?

- 1) **Sadly...the Money**
 - The payment models are outdated (FFS)
 - ??
- 2) **Structural**
 - Lack of coordination of care among the many health care entities and providers (HIE)
 - The slow implementation of truly team-based care
 - ??
- 3) **Attitudinal**
 - Trust in the delegation of responsibilities
 - Misunderstanding of the principles of shared decision making
 - ??

7

The Vermont Health Care Expenditure Analysis (all spending on Vermont residents- the first barrier)

- ❖ Total health care expenditures in 2012 were \$5.1 billion
- ❖ Home health care was 1.9% of that total
 - Hospital expenditures were 38.7%
- ❖ In 2013 total expenditures increased \$272 million and again only 1.9% of the increase was attributed to home health (\$102,000)
- ❖ Average annual increase in home health expenditures 2007-2012 was 0.0%
 - Overall expenditures grew an average of 4.5%

85/22/2015

Opportunities to improve care transitions

(there is hope for a better future)



Money

- ACOs, Value based payment, shared risk
- ??

Structural

- PCMH/CHT
- Hospice/palliative care programs
- ??

Attitudinal

- Community wide coalitions
- ??



VHCIP Provider Sub-grant Symposium

Notes from Transitions of Care Panel Discussion

Sub-grant symposium
Wednesday, May 27, 2015
10:30 AM

Panel #2

Transitions of care

Alan Ramsey - Moderator

Panel Members:

- Billie Lynn Allard – Administrative Director of Outpatient Services and Transitions of Care, Southwestern Vermont Medical Center
- Sarah King – Chief Financial Officer, Rutland Area Visiting Nurse Association and Hospice
- Pam Smart – Care Integration Coordinator, Northeastern Vermont Regional Hospital
- Toni Apgar – Care Coordinator, White River Family Practice
- Sean Uiterwyk – Physician, White River Family Practice

Introduction

(Refer to slides in the packet)

Objectives

- Identify barriers to transition of care
- Discuss out of the box opportunities

The 65-84 aged population will be growing hugely by 2022.

- This group has significant social determinants issues
- May on some kind of social assistance
- Can't adjust for the social determinants needs well

Pareto Principle

- The 80-20 rule, the bell curve causes 80% of the effects to come from 20% of causes
- This can apply to health costs

Panel management slide: Carefirst, a group from Maryland, managed to reduce variance between their highest users and the rest of their population. The idea is to focus the quality and coordination resources on the highest utilizers.

It is not just about cost. 10% of Medicare insured Vermonters are seriously ill. In this case, seriously ill can be defined. It means having certain clinical indicators (for example CHF or COPD) AND family status/issues which combine to mean seriously ill.

Three categories of reform targets/opportunities

- Money
- Structural
- Attitudinal

Home care expenditure represents roughly 1.9% of the total health care expenditure of \$5.1B. While overall health care expenditures are growing at approximately 4.5% between 2007 and 2012, the home care expenditure was 0%.

Panel Discussion – Barriers and opportunities that came from addressing and overcoming those barriers

Dr. Sean Uiterwyk, White River Family Practice

- Wanted to organize conversation around barriers
 - With limited resources in primary care, how do you effectively deploy staff and time to make a difference?
 - Patient Experience Reporting:
 - Track patient response to the question “How confident are you that you can manage most of your health care issues”
 - Asked of admissions, emergency room, asthma in the hospital, diabetes and depression
 - Patient-centeredness: The patient experience is seen as an outcome
 - Benefits from a population health standpoint: Begin to stratify patients based on response and then organize and strategically deploy resources based on answers.
 - Can improve visit experience
 - Example: One of Dr. Uiterwyk’s patients:
 - Older fellow with COPD/heart disease
 - Recently left doctor's office in ambulance for near heart attack
 - Came back to the PCP, given oxygen, sent to x-ray
 - O2 concentrator ran out of battery power, patient said nothing, got in trouble waiting for x-ray, decompensated, required more
 - Asked on third visit what is your confidence
 - About a 5"
 - They talked about it with him, discovered he really wanted to go to church
 - His oxygen concentrator was very noisy
 - Did not have portable oxygen at home
 - They got him portable oxygen so he could go to church
 - He probably would have gone to church anyway, without concentrator, and had another episode
 - Addressed quality of life
 - Feed back to providers
 - Providers can see the effect of the measured interventions
 - Very critical to the work. See the graphs on their website
 - Drives the providers' behaviors
 - Toni Apgar chimed in: Dr. Uiterwyk, as the provider in the room, had to ask the question. It wasn't the patient's measured indicators
 - They then came to Toni to get the patient another oxygen delivery system
 - Not easy, especially to find a payer able/willing to cover it
 - Part of this enhanced care management is driven by the patient

- Knowing goals, health confidence, ability to afford medicines, experience taking medicines, feeling effects. Once you do this, you can treat the patient more effectively

Pam Smart – Northeastern Vermont Regional Hospital, Dual Eligible Program

- Felt there was a real need for care management for duals population
 - Used SIM money to hire a health coach to look at social determinants of health
 - Barrier was identifying the population for the care manager to serve
 - Used reports from hospital database to identify about 1300 individuals
 - Worked with the hospital and health center as partners, a unique and great partnership
 - Also brought in mental health, SASH, etc.
 - Nominated a 25 person panel
 - Identifying who takes the lead was initially a barrier
 - Based it on who has the best relationship
 - They asked the providers, not the patients
 - Found out that the providers were often working with the same patients and did not know it
 - Health coach would work with providers
 - Also identified patient issues while in the field
 - Works with patients doing special things not gotten from other providers
 - Tobacco cessation, walking, exercise, etc
 - Coach had the ability to identify the full range of care and service providers
 - In one instance, discovered that the patient mistakenly believed one of her care providers to be a mental health professional
 - Finding the lead person was not a huge barrier
 - Huge barriers to needed home improvements
 - Many people needed things in their house like ramps, home improvements, etc.
 - The capacity is not there for VCIL, some had been waiting 2 years for repairs
 - Also requires housing and zoning and construction expertise
 - They've found that they are getting measurable success very quickly

Sara King, RAVNAH - Supportive care program

- The program focuses on seriously ill patients with CHF and COPD
- Barriers
 - Physicians don't understand what home care does, even though agencies have been available for a long time
 - Home care is under reimbursed, underutilized, but very effective and cost-effective
 - 5 days in hospital
 - 30 days in SNF
 - 140 days in home care
 - Referrals from physician and other referral sources, working on that reducing barriers
- Payment model barrier
 - Fee For Service is how home care is paid. There needs to be some kind of pay for performance that rewards home care
- Excluding the Medicare population from the project cohort was a big problem/barrier
 - The project has seen an increased number of referrals since they changed the criteria to include the Medicare population
- Patient is a barrier

- Patients leave hospital stabilized, then they get home and their health deteriorates
- The patients need to be educated regarding encouraging them to utilize home care services
- They're trying to include emotional/psycho-social needs into plans of care to get at home services

Billie Lynn Allard, Southwestern Vermont Health Care, Transitional Care Model

- Hospitals were seeing decreasing inpatient stays, shorter admissions, and then readmissions
- Clinical expertise is frontloaded in hospital
 - Patients are being funneled out of hospital, getting less exposure to the workforce expertise
- Looked at redeploying acute care resources
 - Move clinical nurse specialists (CNS) out to home care and nursing home and primary care office
 - Many aha moments:
 - Got to understand patient centric care
 - Got to understand care in the home
 - Saw flaws in complicated unrealistic discharge plans
- This has been exciting and rewarding, seeing resources as something that should be deployed to WHERE the patient needs them
- Method
 - Looking at high users in practices, their health issues and things
 - The CNS nurse follows these users around to
 - Communicate the crucial information from one setting to another
 - Now the family practice doc can be notified ahead of time that someone is coming to visit.
- Finding gaps and plugging with help of SIM
 - What patients did physicians want the program to take on right away?
 - Docs wanted behavioral health and substance abuse referred to the program because that population can be the hardest to manage
 - They put together a community care team to respond to this, because the hospital couldn't do that alone
 - They created an integrated care plan
 - In 2.5 months they've seen gratifying success
 - Other gaps we don't have time to address, mostly centered around supporting the PCP and the medical home
 - They go in where VNA can't go, so there's no overlap

Allan Ramsay - Moderator

All good things begin with the providers, not administrators, not executives, they start at the ground level

Discussion: Project successes and also opportunities to scale up initiatives to achieve successes on a broader scale

Dr. Sean Uiterwyk, White River Family Practice

- Motivational interviewing training for entire office
 - Not just physician or nurse, but whole office needs to respond to the questions and answers during a patient interview
- Team based care

- Many places give lip-service to the team care concept, but to make that real, you have to place resources down at the front line, again, the entire office. IT costs money to put in that training and awareness during operating hours
- Medical records and data
 - Lots of powerful and useful info, but it is needed at the provider level, not at the ACO level
 - Data needs to reside in the practices: there are administrative, data use agreement hurdles, but it would produce meaningful results

Toni Apgar, White River Family Practice

- What is scalable?
 - WRFP receives data and information on every hospital discharge and ER visit for the panel of patients
 - Each notification initiates a cascade of opportunities and interventions:
 - Phone call to patient
 - Do you have medications you were prescribed?
 - What are barriers?
 - Use motivational interview training about "what is important, will medicine help?"
 - Identified cohort:
 - high users
 - Asthma event
 - Diabetes and depression
 - Asked
 - What are we going to do differently now that we have identified them?
 - When a SIM patient
 - Calls, arrives, checks out, touches on provider, EMR is flagged as SIM patient
 - Intervention around Office visit event is scalable
 - Contact SASH, motivational interview, other things can happen BEFORE the patient gets in to the office
 - Behavioral specialist in the office once per week
 - Made a huge difference
 - SIM and Blueprint funds
 - Free of charge, there is little stigma attached because it's in the doctor's office

Moderator question: Is there a tracking ability to measure how many phone calls per patient, how often? What gap can you improve?

- We do currently track it at that level , and other "little data" analysis as well
- Little data: there's no skepticism on the part of the provider

Pam Smart, NVRH

- The St. Johnsbury health care community is pretty seasoned at team based care. When they found their panel, they even included a group of middle and low utilizers to look at prevention strategies
- Struggling with shared care plan
 - How do we share the care plan? Technology is a huge barrier
- Example: 25 year old, athlete, lost use of legs in diving accident, came home to Vermont from Texas
 - No doctor, no connection to health care

- Denial of disabled status
- Health coach connected, formed a community health care team around him
 - Fixed truck
 - Got a PCP
 - When they found that there were two missed appointments, front desk staff alerted to problems with attendance
- How do we get information to and from providers?
 - Connect with Voc Rehab
 - PCP
 - Health agency
 - Etc.
- They have to use paper and pen for a lot of this
 - Fax machine, paper towels
- Physician would say they are able to practice medicine better because agency is addressing social determinants of health via the community approach to team-based care

Sara King, RAVNAH

- Educate patient: get them on board with people coming into the home, show them how they will benefit
- They go into the home and find that patient has all kinds of case managers working on their care, and they don't know which manager is doing what, managers don't know what one another are doing.
- A good example is the Rutland-area child services team, where they combined many kinds of service, brought the number of care managers from 5 down to 1
- What is the best way to educate providers?
 - VNA has NP go into the office and tell physician about the tools available to patients:
 - 'Start the Conversation' program, talk to patient now about how end of life could go

Billie Lynn Allard, SWVHC

- So many patients say no thank you to home visit. Transitional care nurse establishes relationship with patient, can go into the home and sell patient on VNA
 - Amazing how many patients say no
- Scalable:
 - In general, patients spend 3.6 days in hospital, and are very sick the whole time
 - The opportunity to educate them about disease, symptoms and medication is not available because of the short amount of time available to conduct interventions in hospital and primary care settings.
 - How to bridge these gaps
 - Transitional care nurse can bridge those gaps, but that is an expensive solution, not sustainable
 - Listening to primary care doctors: They need help unraveling multi-med patients, get clinical pharmacists working with patients to decrease medications, educate, discharge with a clear medication list and instructions
 - The visiting nurse, transition nurse, can talk to the patient and unlock information about patient needs, preferences, goals, etc.
 - They've seen a 68% decrease in hospital admissions

Closing statements

Could these have been done without the subgrant, if not, should the grant or initiative or opportunity to innovate at the ground level be expanded?

Sean Uiterwyk, WRFPP

- Patient unwillingness to participate, engage home care; more willingness to let in someone associated with PCP.
 - It's important to embed the community providers in the office or locally
- Is SIM required?
 - This kind of thing gives us the space to stop 'bumping our heads'
 - Couldn't do it in the office without weekends, after hours, late at night work efforts
 - CAN do it within SIM context, with SIM grant
- Absolutely should be continued

Toni Apgar, WRFPP

- WRFPP is a small family practice, it would have been impossible to do this project without the SIM grant
- Long term solution is expensive, but maybe with savings on readmissions or things
- HOW DO WE GET THAT ACROSS?!? To payers
- (Moderator) risk shared with payers would help
- The tree in the slide: she likes that there are focuses on "what is your life like and how do we make it better together?"

Pam Smart, NVRH

- SIM grant with the health coach is a huge help
- All the relationships that are formed are vital
- Asks "how do you want to live" and gets palliative care introductions by doing that
- Flexible funds give some good options
 - Yoga
 - Personal trainer
 - Vermont Center for Independent Living
 - Etc.

Sara King, RAVNAH

- The SIM grant is helping to cover salaries of nurse practitioners, etc, who are seeing populations which would not be reimbursed under Medicare
- Reimbursement, somehow, is needed

Billie Lynn Allard, SWVHC

- SIM grant allowed medical center to reach out to and partner with PCP/medical homes
- Allowed the collection of data to see if savings pay for intervention
- Really showed how health care went in the wrong direction as providers simply followed the rules as opposed to working with people. This is providing some HOPE.

Participant Questions

Q: How do you share care plans

Billie: Transitions of care in the documents section of the EHR

- Pharmacist
- Nurse
- Social worker, etc
- It's cumbersome to get to that
- We replicate the note and ship it to agency however the agency asks for it
 - This is shortening the care plan, and personalizing it for the practitioner
 - Not ideal, but it helps

Q: Very concerned about dental care not being included

- No sliding scale
- Wish we had a better solution

Q: What about those above poverty level?

Q: What about working with AAAs? Do you have to be a nurse to do the discharge planning/follow-up
Changing the whole system

- Reengineered discharge
- But no sense of region-wide unified approach to making real change
- We're going to need the intensive focus to really blow things up to rebuild them on a large scale while supporting the functioning of the system

Q: New roles in the health care community: health coach, transitional care nurse, duplicative care managers; how do you see these additional roles fitting into the current system, are they filling gaps or adding another layer onto what's already happening in the communities? Can this be integrated into the system long term? Can you create a real integrated team? Can you identify a lead care coordinator role?

- Billie: Community care team, 25-30 team members with a little bit of information, coming together helps, and allows the team to make an informed decision
 - Done monthly for behavioral health and addiction
 - Trying to find ways to hard wire the wrap around services into the record
 - At least that puts the information in one place, even without a lead care coordinator
- Allan: Health care reform needs to be a job engine, an engine for the economy. Romneycare lead to growth in health care sector, but most of that growth was in administration. In Vermont we want the growth to be in actual care providers
 - Clinical social workers, nursing aids, team based care, not administrators

Q: Dr. Mark Nunlist to Billie Allard: Optimization of care is not the practice doing its job most efficiently, but for the patient, there are other objectives and goals. What provided the support to allow changes and integration?

- Billie: CEO and CFO realized the importance of health care reform, nursing personnel was preparing, a hospital closed, the literature (Mary Naylor's transitional care model) provided a pattern for a pilot to show that you can help patients by bridging to one care office. Executive management supported a shift in resources and focus, out of the hospital to go into homes.
- Follow up: This was the product of extra thinking, attention, and thought outside of the traditional hospital work
 - B: Fresh eyes on the problem, with knowledge of community and relationships with providers, found these opportunities.



VHCIP Provider Sub-grant Symposium

Debrief

Robin Lunge, Director of Health Care Reform: Debrief

The symposium brought out some common themes:

- Patients have lives, not just medical conditions
 - If you don't ask the questions and listen to the answers, you can't improve the care
- Relationships are important
 - Educate the patient and the provider
- Thinking about patients in terms of their lives allows providers to practice the way they really want to
- Stages of data denial
 - Data needs to be timely
 - Needs to reside at practice level
 - There will be push-back when we share data until we can establish our credibility
- We need to move away from Fee For Service payment model
- This is hard work
 - Disruptive
 - Ground level
 - Changing day to day life for people



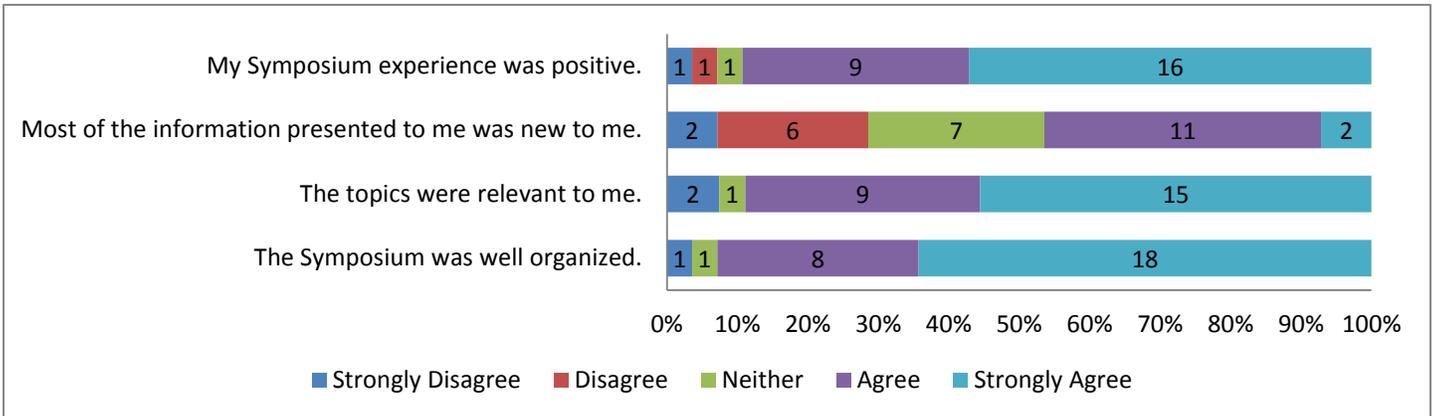
VHCIP Provider Sub-grant Symposium

Symposium Evaluation Results



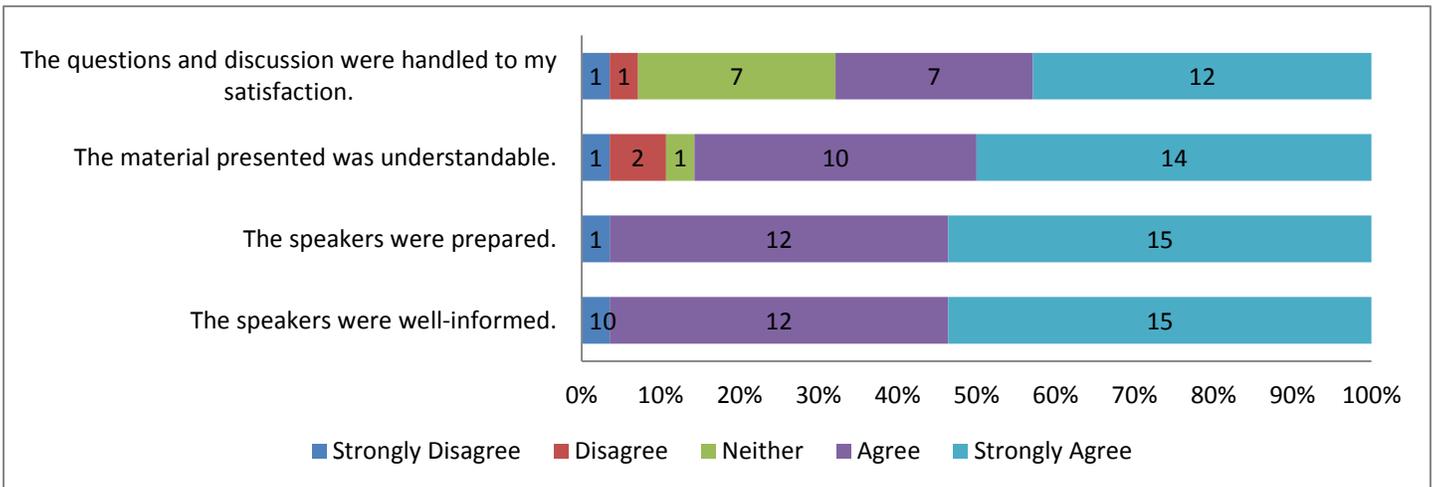
SUB-GRANT SYMPOSIUM EVALUATION FORM RESULTS

Overall Symposium Ratings



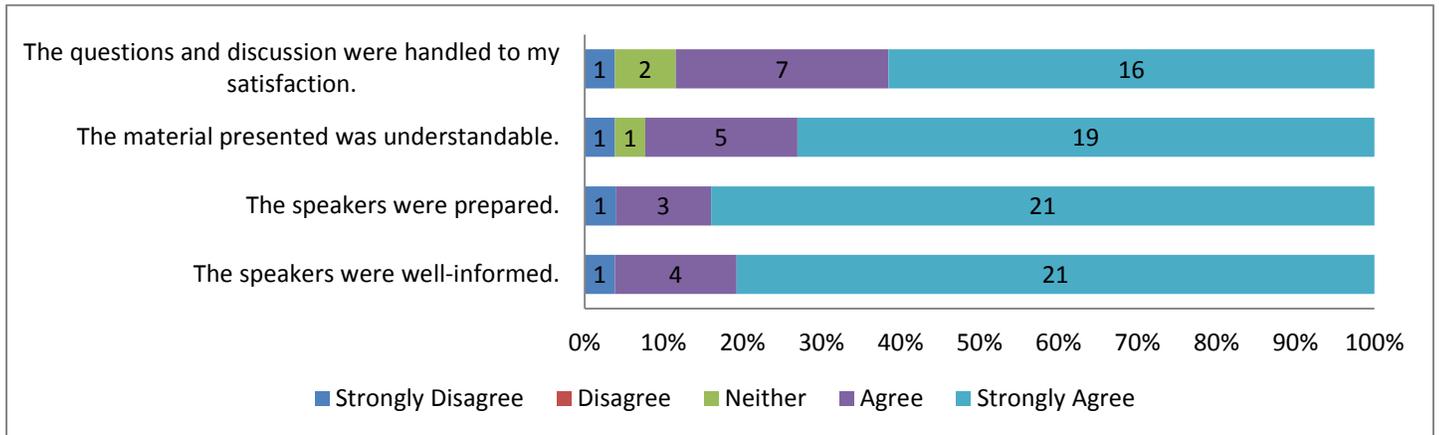
- Comments and suggestions for improvement:
- “Remarkable presentations and well organized”, “Good length”
 - Requests for more visuals and stories
 - Topics didn’t apply to all sub-grants
 - Bring Community Catalyst organization to the next Symposium to present on Consumer Engagement
 - Create an experience that involves all participants, not just listening to speakers

ACO Panel Discussion Ratings



- Comments and suggestions for improvement:
- Comments range from saying they already knew the material, to saying the material was not understandable
 - Some felt the material was not applicable or helpful
 - ACOs should have covered activities at 30K level first

Transitions of Care Panel Ratings



Comments and suggestions for improvement:

- “Great and frustrating to hear everyone talk about the same challenges and barriers”
- Clinical patient-level focus was very helpful
- Interesting and engaging compared to the ACO panel

What is the single biggest challenge Vermont faces in working to achieve the triple aim (better care, improved health, reduced costs)?

- Payment model and financial challenges were most cited including:
 - Bringing agencies that influence the social determines of health into the financial fold
 - Adequate funding for PCPs and out of hospital care
 - Models that encourage local innovation
 - Overcoming current siloes of funding streams
 - Including \$ for community health workers and flexible funds
 - Lack of consistent and predictable investment in change/innovation leadership
 - Lack of frontline provider input into payment models
- Inclusiveness at the community level, giving up “turf” to come to consensus for person-centered care, self-interested parties not taking the “bigger” social view
- Data sharing including timely and clinically relevant data and sharing information between providers
- Lack of Vermonter/consumer engagement and ensuring that the triple aim reflects what patients need and want.
- Retaining and attracting quality providers and continuum of care staff – providers are stressed
- Inability to address the social determines of health given their relevance to adherence to health behaviors
- Red tape, administrative waste
- Inside the box thinking where healthcare is centered around hospitals, PC and ACOs
- Lack of support when VTers leave the hospital/PC settings

What is a key strength Vermont should leverage in working to achieve the triple aim (better care, improved health, reduced costs)?

- Hard work
- Willingness to work together in communities and strong community networks
- Bernie Sanders as a mentor
- Innovation
- Resource flexibility
- Person-directed models
- Size and support of GMCB
- Small size of the State of Vermont
- Vermont landscapes offer much opportunity for improved built environments which would improve both physical activity and nutrition and thus overall health
- Relationships being created via SIM
- Recognition of problems and willingness to work on them
- Committed passionate quality providers
- Existing delivery system reforms in place
- Our “can-do” attitude
- Acknowledgement of different interests while collaborating

What is one thing from today's meeting that you will take back to your project?

- Respect for providers who are doing their work so well and willing to share
- Points made by the speakers
- Great ideas
- Importance of learning about other programs and taking away the positives
- Integration of services is clear, integration of reimbursement is not
- Educating patients and providers is important to increasing the quality of care
- Ideas and outcomes of health coaching, transitions of care and how to help MDs not burn out
- Learning about work on the ground level
- The need for flexible funding
- Enthusiasm for the work
- Goals being achieved as a group
- We need mixed methods data – quantitative and qualitative
- Importance of local interventions, every community is different
- Transitional care information