# *VT Health Care Innovation Project*
# *Practice Transformation Work Group Meeting Agenda*

**February 2, 2016; 10:00 AM to 12:00 PM**
**AHS - WSOC Oak Conference Room, 280 State Drive, Waterbury, VT**
**Call-In Number: 1-877-273-4202; Passcode 2252454**

| Item # | Time Frame | Topic | Relevant Attachments | Vote To Be Taken |
|---|---|---|---|---|
| 1 | 10:00 – 10:10 | **Welcome & Introductions; Approval of Minutes**<br>Deborah Lisi-Baker | **Attachment 1:** January meeting minutes | Yes (approval of minutes) |
| 2 | 10:10 – 10:40 | **Tools to Enabling Information Sharing for Integrated Care Teams (Continuation from January Work Group Meeting**<br>Gabe Epstein, DAIL | **Attachment 2a:** Care Team Consent guide<br>**Attachment 2b:** Example Notice to Providers<br>**Attachment 2c:** Team Release Template | |
| 3 | 10:40 – 11:10 | **Core Competency Training for Front Line Staff Providing Care Coordination**<br>Erin Flynn, DVHA | **Attachment 3:** Overview of Core Competency Training for Front Line Staff Providing Care Coordination | |
| 4 | 11:10-11:20 | **Updated Report; Care Management in Vermont: Gaps and Opportunities for Coordination**<br>Pat Jones, GMCB | **Attachment 4:** Updated Report; Care Management in Vermont: Gaps and Opportunities for Coordination | |

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| 5 | 11:20 – 11:40 | **Regional Blueprint/ACO Committees Progress Report**<br><br>Miriam Sheehey, OneCare Vermont | **Attachment 5:** UCC/RCPC Progress Report | |
| 6 | 11:40 – 11:55 | **Integrated Communities Care Management Learning Collaborative:**<br>• **Summary of January Webinar; upcoming learning opportunities**<br><br>Pat Jones, GMCB & Erin Flynn, DVHA | | |
| 7 | 11:55 – 12:00 | Wrap-Up and Next Steps; Plans for Next Meeting | | |

# Attachment 1:  January meeting minutes

# *Vermont Health Care Innovation Project*
# *Practice Transformation Work Group Meeting Minutes*

## *Pending Work Group Approval*

**Date of meeting:** January 5, 2016; 10:00 AM to 12:00 PM; Red Oak Room, State Office Complex, 280 State Drive, Waterbury, VT

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **1. Welcome, Introductions**<br><br>**Approval of minutes** | Bea Grause opened the meeting at 10:12 and welcomed everyone to the meeting. The group met in the Waterbury complex and there was some delay as we worked through the new security process.<br><br>Bea also announced that the next meeting will likely be her last meeting as the co-chair of the VHCIP Practice Transformation work group as she is leaving to take the position of President and CEO of the Health Care Association of New York State.<br><br>A roll call was taken and a quorum was present. Sue Aranoff made a motion to approve the minutes of the last meeting by exception; Kirsten Murphy seconded the motion. The minutes were approved with 4 abstentions: Kirsten Murphy, Sam Liss, Vicki Loner and Angela Smith-Dieng. | |
| **2. Review of 2015 Progress; Report Highlighting Integrated Communities Care Management Learning Collaborative**<br>**note the agenda was re-ordered during the meeting* | **2015: Year in Review**<br>Georgia Maheras reviewed the slides related to the Year in Review (beginning on page 26 of the materials packet) and highlighted several notable achievements related to the Practice Transformation Work Group. In particular, the Integrated Communities Care Management Learning Collaborative program has been very successful and has been expanded to additional communities in 2016.<br><br>Each of the overall VHCIP focus areas has an achievement in the spotlight:<br><u>Payment Model Design and Implementation:</u><br>• Much work has been done to more accurately count beneficiaries who participate in alternatives to fee-for-service (FFS) programs. Currently, 55% of all eligible Vermonters are in an alternative to FFS program.<br><u>Practice Transformation:</u><br>• Integrated Communities Care Management Learning Collaborative is now almost statewide and has expanded to encompass 11 communities. | |

| Agenda Item | Discussion | Next Steps |
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| | Health Data Infrastructure:<br>• A Shared Care Plan/Universal Transfer Protocol solution will be piloted in 2016; communities expressed significant enthusiasm for this solution and business requirements gathering was completed in 2015.<br>Evaluation and Project Management:<br>• A new self-evaluation contractor has been selected and we will be implementing the self-evaluation plan this year.<br>• The project governance structure was overhauled and we have been working toward a redesigned website.<br><br>**What's coming up in 2016?**<br>Payment Model Design and Implementation:<br>– Final year of Shared Savings Programs.<br>– Discussion with CMMI regarding launch of 3 Medicaid Episodes of Care.<br>– Peer learning opportunity to develop Accountable Communities for Health.<br>– Continued work to launch new payment models for Home Health Agencies and mental health/substance abuse providers.<br>Practice Transformation:<br>– Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.<br>– Wrap up Integrated Communities Care Management Learning Collaboratives.<br>– Wrap up Sub-Grant program.<br>– Workforce Demand Modeling, Supply Data Collection and Analysis.<br>Health Data Infrastructure:<br>– Continue Data Quality efforts for ACO providers and DAs.<br>– Launch Telehealth pilots.<br>– Continue work on DA/SSA Data Warehousing solution, and begin to implement cohesive strategy for developing data systems to support analytics.<br>– Launch Shared Care Plan solution pilot, launch Universal Transfer Protocol solution.<br>Evaluation:<br>– Launch of new self-evaluation contract.<br>– Implementation of Self-Evaluation Plan.<br><br>Additional activities will include:<br>-Population Health Plan development;<br>-Sustainability Planning;<br>-Launch of final suite of HDI projects that could include additional gap remediation (all pending Core Team approval);<br>-Gathering lessons learned from across the project.<br>Dale Hackett asked a question regarding the Learning Collaborative initiative – how do we prevent the inadvertent discrimination (against the poor, or those with complex needs because they are expensive) within the population? | |

| Agenda Item | Discussion | Next Steps |
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| | Georgia responded that the communities themselves who are doing the work are the best to answer that – but they are developing tools and continue to develop tools to work through the process. Laural Ruggles added that any kind of avoidance of taking care of the neediest groups has not actually happened in St. Johnsbury; care partners keep working to break down barriers and find solutions.<br><br>Jim Hester asked if this work group is thinking about the impact of the All Payer Waiver. Georgia answered that the GMCB and AOA are co-spearheading the initiative and that once the negotiations with CMS are final, there will be an opportunity to gather stakeholder input, when CMS gives Vermont permission to take that next step.<br><br>Dale asked about Lessons Learned, and observed that there are many. Georgia indicated that lessons learned will be integral to sustainability planning. Suggestions are welcome as to how to disseminate lessons learned (webinars, symposiums, etc.). The Core Team will be receiving some recommendations in this area in February.<br>Sarah Kinsler added that there is also a line item in the Practice Transformation Work Group work plan for this year, to begin gathering information on lessons learned.<br><br>Erin Flynn noted that The Center for Health Care Strategies, Inc. (CHCS) recently published a paper in which the Integrated Communities Care Management Learning Collaborative was highlighted as a best practice. The paper is titled Opportunities to Improve Models of Care for People with Complex Needs and is linked here. | |
| **3. Update on Year 3 No-Cost Extension; Review of Year 3 Merged Work Plan** | **No Cost Extension Update**<br>As a result of our application for a No Cost Extension with CMMI, VHCIP's Program Year 2 is extended to 6/30/16; Year 3 will be from 7/1/16 to 6/30/17. The work that we planned to do will continue with little disruption as the impact is more related to which 'buckets' of federal dollars we will use to pay for the work. Some HDI projects are slightly delayed due to the way that we have to budget for the split years, but the overall impact is relatively minimal. There does appear to be some funding available in the January to June 2016 timeframe.<br><br>More specifically related to the Practice Transformation Work Group is that the No Cost Extension gives us a little leeway in the Core Competency training work so that we have more time to plan a thoughtful and coordinated rollout of that program alongside the learning collaborative work.<br><br>Dale asked how to avoid the situation where data that we've already collected will not be negatively impacted by the Year 2 extension. Georgia answered that there has been significant budget analysis, "dollar stretching" planning, and careful review of contracts to ensure that they are adequately funded so that this does not happen.<br><br>**Review of Year 3 Merged Work Plan**<br>Sarah Kinsler walked through the PT work plan for 2016, with thanks to the staff and co-chairs for their work to pull it together. There was a concerted effort to align the work plan with the milestones and overall project schedule, with the understanding that the work for 2016 is not set in stone and as things come on line, the work plan will be updated. | |

| Agenda Item | Discussion | Next Steps |
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| | Kirsten Murphy commented that she wanted to highlight Line 4, which speaks to the Home and Community Based waiver work. She noted that there is a broad base of interested stakeholders who are working on that beyond those who are part of the DLTSS work group. | |
| **4. Core Competency Training for Front Line Staff Providing Care Coordination Updated Report;**<br><br>**Care Management in Vermont: Gaps and Duplication** | **Core Competency Training Update**<br>Contract negotiations are in their final stages. Trainings will be starting in March; the anticipated format is that there will be monthly trainings between March and December. Core Competency Training for broader skills will be staggered with disability-specific trainings. The hope is to offer trainings in 3 locations (possibly North, Central and South).<br><br>Dale Hackett asked whether those who are intended to be helped by this training will also be part of the sessions to provide their feedback about how they perceive it will help them. Pat Jones responded that the intended audience is front line care coordinators and not just those who are licensed. It's not just for learning collaborative participants, although there are limits on group sizes in order to maintain training effectiveness. The goal is to provide the training to a broad range of people who work for a variety of organizations. The RFP requested plans for sustainability – e.g., videotaping, recording and train-the-trainer approaches. This is an ambitious project that could become a lasting program.<br><br><u>Proposed Curriculum:</u><br>• 6 staggered monthly training sessions (alternating fundamentals with disability-specific training)<br>• 2 consecutive days of train the trainer training – key component to sustainability<br>• 2 days of advanced care coordination training<br>• 2 days of managers/supervisor training<br><br>Patricia Singer observed that in her experience there is more value in training supervisors as opposed to the front line staff, as they are so important in their roles as leaders and mentors to their staff. Lily Sojourner offered to connect the planning team to the Secretary's Office in AHS to help coordinate training, noting that the SOV human resources department is working on supervisory training curriculum.<br><br>**Care Management in Vermont: Gaps and Duplication (Opportunities for Coordination) Report**<br>Pat Jones provided some background on the report. In 2014, the former Care Models and Care Management Work Group conducted a Care Management Inventory Survey to gather information on care management in Vermont. The final report was issued in March 2015 and included information from 42 respondents. The group went a step further and synthesized information from the survey and work group presentations from various organizations to identify potential gaps and opportunities for coordination. Comments are still being received from the presenting organizations. We hope to issue the final report within the next three weeks. | |
| **5. Regional** | **Regional Blueprint/ACO Committees Progress Report** | |

| Agenda Item | Discussion | Next Steps |
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| **Blueprint/ACO Committees Progress Report** | Jenney Samuelson – DVHA – Blueprint, Miriam Sheehey – OneCare Vermont, and Patty Launer – Bi-State/CHAC presented the progress report.<br><br>Miriam referenced Attachment 5, which provides updated information on the progress and status of the various UCC/RCPC groups across the state, including whether the groups have chosen priority areas. Burlington has chosen to work with a large primary care practice on criteria used in referring patients to hospice or palliative care – they trained staff on the criteria and are now tracking results before and after the trainings. Morrisville is working on medication reconciliation; funding was allocated (from either Copley Hospital or the FQHC) to pilot a home-based medication reconciliation project. Rutland is working on COPD, and found a need to provide primary care providers with additional information to allow the practice to target people in the beginning stages of the disease with specific interventions.<br><br>Jenney added that the leadership team (Healthfirst, CHAC, OneCare Vermont and the Blueprint) meets once a month; this has been very helpful in ensuring consistent messaging within and across communities. She observed that there are valuable opportunities for shared learning; there is already sharing of strategies and interventions between communities.<br><br>Sue Aranoff noted that there is a Medicare model being implemented as of January 1 to increase hospice utilization. How can we get more of this information out, as it appears that several communities have chosen hospice utilization as a priority area? Bev Boget reported that all but 2 Home Health Agencies are part of the initial group working on this focus area, and offered to help in whatever way she can to get the word out. Miriam and Bev will connect off line. | |
| **6. Integrated Communities Care Management Learning Collaborative:**<br><br>**Summary of November Learning Sessions, December Webinar; upcoming learning opportunities**<br><br>**Tools for Enabling** | **Integrated Communities Care Management Learning Collaborative Update**<br>Pat Jones provided a brief update. The program began with 3 pilot communities and expanded last fall to 11 of the state's 14 health service areas. November 2015 saw in-person learning sessions for the 8 new communities, with a focus on Root Cause Analysis and gathering information from patients. A webinar was held in December using a case study from Windsor. There is another webinar on January 6, 2016 for the 3 pilot communities that will focus on updating and sharing the care plan among team members. A webinar later in January will take a deeper look at root cause analysis for the 8 expansion communities. Tools and a Training Manual are being developed to support sustainability.<br><br>Laural Ruggles provided an update from St. Johnsbury – one of the original pilot communities. She noted that they didn't want it to end, so that in itself is a measure of success; they appreciate being included in the ongoing webinars. While many of the health care partners were working with one another prior to the learning collaborative, they are now seeing other organizations reach out and create partnerships. The whole community has found a comfort level in working together that did not exist previously.<br><br>The St. Johnsbury team has expanded its focus to people with COPD, after originally focusing on people with dual eligibility for Medicare and Medicaid. They have also successfully expanded the concept of lead care coordinator within the care team. One of the main challenges is that they still haven't figured out how to best share the care plan across the multi-disciplinary team.<br>**Tools for Enabling Information Sharing for Integrated Care Teams** | |

| Agenda Item | Discussion | Next Steps |
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| **Information Sharing for Integrated Care Teams** | How do we best share information that we have right now with the tools we have?<br><br>Gabe Epstein reviewed the presentation in the materials packet. He noted that he is not providing legal advice on the topic of gaining consent to share an individual's information across an integrated care team, but rather that he is providing tools and templates that can assist communities as they work together to implement the processes of integrated care management as supported by the integrated communities care management learning collaborative. Ultimately the decision to use any consent or release form lays within each individual organization as informed by their legal counsel. Gabe noted that his research indicated that when dealing with a care team that spans across organizations it can be difficult to develop a form thatappropriately reflects the patient's actual desires to share their information. With the advice of Legal Aid and many others, Gabe has tried to boil down the required legal aspects to a form that can be used in a consumer driven, patient centered care team – so that the team and the patient are essentially on the same page.<br><br>These materials will be shared with the learning collaborative communities. They will then be able to have their own attorneys review and customize them as appropriate for their unique needs. Gabe noted that some of the information that's being shared could have implications that have not yet been considered, especially when dealing with 42 CFR Part 2 data (substance abuse-related information) and mental health data. A key suggestion is to have the conversation about how each entity will use the information before it is shared.<br><br>Sam Liss clarified that the process also intends to assure that the signer (i.e. the patient) fully understands what they're signing and what it means. Gabe stated that he tried to make the permissions section of the form as accessible as possible, noting that people tend to trust their care providers and may not always read and understand everything that they sign in the care setting. Gabe pointed out sections of the form that are intentionally set off from the rest of the form to call attention to specific items, as well as the need for the provider to review the form with the patient in person.<br><br>VHCIP will be providing a webinar on this topic as part of our on-going webinar series to allow for more in depth review of this material. Please stay tuned for the announcement of this event in the coming months. The Learning Collaborative will also be providing a webinar for participating community team members.<br><br>**Follow-up Items:**<br>As the meeting time was growing short, the group agreed to table the following two items for further discussion; Gabe Epstein will be invited to come back to a future meeting to more thoroughly discuss these issues. Dion LaShay requested that we revisit the issue of how to deal with those people who are incarcerated, have been deemed incompetent, or who have guardians and are not making decisions for themselves. These forms and the process will need to also address these situations. Patricia Singer also added that there have been issues with those people who are in mental health care or substance abuse situations refusing to sign the form. | |
| **7. Strategic** | **Strategic Alignment to Improve Health: Linking the Health and Community Development Sectors** | |

| Agenda Item | Discussion | Next Steps |
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| **Alignment to Improve Health: Linking the Health and Community Development Sectors**<br>**Public Comment** | Jim Hester began the discussion noting that the most persistent problem with population health is how to pay for it. A potential vehicle for this kind of financial support can be found in community development entities. Community Development Financial institutions (CDFIs) have the obligation to reinvest in the community. These are very sophisticated organizations and they are being encouraged to make linkages to promote better health outcomes. In December, the Federal Reserve in Boston hosted a meeting to convene selected teams of leaders from hospitals, community-based organizations, public health, municipalities, CDFIs and other organizations to explore how they might proceed down this road. Vermont was well-represented at the meeting and participants found it extremely informative, while making new connections across communities.<br><br>Laural Ruggles participated in the meeting and shared an "aha moment" from the event. In St. Johnsbury, they met with the local CDFI and community development group. They realized they need to work on economic development and didn't know how to do it – this workshop helped the different entities learn each other's language so that going forward they can develop a dialogue. The group from St. Johnsbury included representatives from the hospital, UCC, Designated Agency, FQHC, Home Health, Foodbank and the community.<br><br>Sarah Narkewicz from Rutland also attended the meeting – the group from Rutland sent a 5-member team, including the police department, which is dealing with crime and addiction. In a complicated section of Rutland, they are developing strategies to reduce crime and improve rental housing. The Boston meeting created an opportunity to brainstorm to bring the local project to the next level. What resources does the hospital have, how can community resources be managed, how can this be integrated with UCC efforts, and how can the community partner with the CDFI and discuss what the various organizations can provide to the effort? The goal is to improve population health and not just pockets of health.<br><br>Dale Hackett asked how many different languages and sub-cultures did you have to learn to have these conversations? The response was many - health care, public health, finance, public financing and CDFI. The workshop provided a setting to allow members of all of these organizations to work together and time for teams to work on their specific action plans.<br><br>How do you know who is a CDFI? You can do a Google search – there is a network, and there are regional and national CDFIs. You have to learn about the structure of the organizations and find those who are looking to make partnerships. An example of this was a CDFI from NH – they try to find the best funding to help community organizations function well. There was a local child care center that needed capital to expand the business. When they connected with their local CDFI, they asked if they could make weekly payments on a loan because that's how people pay for child care services. In this case, the CDFI was willing to change the payment frequency and the child care center was able to secure a loan that met their needs. Jim observed that sometimes there's seed money required; some organizations are willing to take their investment portfolios to create low cost loans to allow organizations the seed money to start up a program. | |
| **8. Next Steps** | The next meeting is Tuesday, February 2, 2016, from 10:00 am – 12:00 pm, Red Oak Conference Room, 280 State Drive, Waterbury (in the new State Office Complex, 2nd floor above the main entrance). Call-In Number: 1-877-273-4202; Conference ID: 2252454 | |

# VHCIP Practice Transformation Work Group Member List

Sue 1° Kirsten 2° Motion to approve w/ exception - carried w/ 4 abstentions

5-Jan-16

| Member | | Member Alternate | | | |
|---|---|---|---|---|---|
| First Name | Last Name | First Name | Last Name | Minutes | Organization |
| Susan | Aranoff ✓ | Gabe | Epstein ✓ | | AHS - DAIL |
| | | Bard | Hill | | AHS - DAIL |
| | | Clare | McFadden | | AHS - DAIL |
| | | | | | |
| Beverly | Boget ✓ | Peter | Cobb | | VNAs of Vermont |
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| Stephen | Broer | | | | VCP - Northwest Counseling and Support Services |
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| Kathy | Brown | Todd | Bauman | | DA - Northwest Counseling and Support Services |
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| Kathy | Brown | Stephen | Broer | | DA - Northwest Counseling and Support Services |
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| Barbara | Cimaglio | | | | AHS - VDH |
| | | | | | |
| Michael | Counter | | | | VNA & Hospice of VT & NH |
| | | | | | |
| Molly | Dugan ✓ | Stefani | Hartsfield | | Cathedral Square and SASH Program |
| | | Kim | Fitzgerald | | Cathedral Square and SASH Program |
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| Eileen | Girling | Heather | Bollman | | AHS - DVHA |
| | | Jenney | Samuelson ✓ | | AHS - DVHA - Blueprint |
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| Maura | Graff ✓ | | | | Planned Parenthood of Northern New England |
| | | | | | |
| Bea | Grause ✓ | | | | Vermont Association of Hospital and Health Systems |
| | | | | | |
| Dale | Hackett ✓ | | | | Consumer Representative |
| | | | | | |
| Mike | Hall | | | | Champlain Valley Area Agency on Aging / COVE |
| | | | | | |
| Sarah | Jemley | Jane | Catton | | Northwestern Medical Center |
| | | Candace | Collins | | Northwestern Medical Center |
| | | | | | |
| Linda | Johnson | Debra | Repice | | MVP Health Care |
| | | | | | |
| Pat | Jones ✓ | Annie | Paumgarten ✓ | | GMCB |
| | | | | | |
| Trinka | Kerr | Nancy | Breiden | | VLA/Health Care Advocate Project |

# VHCIP Practice Transformation Work Group Member List

| Member | | Member Alternate | | | 5-Jan-16 |
|---|---|---|---|---|---|
| First Name | Last Name | First Name | Last Name | Minutes | Organization |
| Dion | LaShay ✓ | | | | Consumer Representative |
| Patricia | Launer ✓ | Kendall | West | | Bi-State Primary Care |
| Sam | Liss ✓ | | | A | Statewide Independent Living Council |
| Vicki | Loner ✓ | Emily | Bartling | A | OneCare Vermont |
| | | Maura | Crandall | | OneCare Vermont |
| Jackie | Majoros | Barbara | Prine | | VLA/LTC Ombudsman Project |
| Kate | McIntosh | Judith | Franz | | Vermont Information Technology Leaders |
| Bonnie | McKellar | Mark | Burke | | Brattleboro Memorial Hopsital |
| Todd | Fahey | | | | |
| Madeleine | Mongan | Stephanie | Winters | | Vermont Medical Society |
| Mary | Moulton | | | | VCP - Washington County Mental Health Services Inc. |
| Sarah | Narkewicz ✓ | | | | Rutland Regional Medical Center |
| Laural | Ruggles ✓ | | | | Northeastern Vermont Regional Hospital |
| Catherine | Simonson | | | | VCP - HowardCenter for Mental Health |
| Patricia | Singer ✓ | Jaskanwar | Batra | | AHS - DMH |
| | | Mourning | Fox | | AHS - DMH |
| | | Kathleen | Hentcy | | AHS - DMH |
| Angela | Smith-Dieng ✓ | Mike | Hall | A | V4A |
| Lily | Sojourner ✓ | Shawn | Skafelstad | | AHS - Central Office |
| | | Kirsten | Murphy ✓ | A | AHS - Central Office - DDC |
| | | Julie | Wasserman ✓ | | AHS - Central Office |
| Audrey-Ann | Spence ✓ | | | | Blue Cross Blue Shield of Vermont |

# VHCIP Practice Transformation Work Group Member List

| Member | | Member Alternate | | | 5-Jan-16 |
|---|---|---|---|---|---|
| First Name | Last Name | First Name | Last Name | Minutes | Organization |
| JoEllen | Tarallo-Falk | | | | Center for Health and Learning |
| | | | | | |
| Julie | Tessler | | | | VCP - Vermont Council of Developmental and Mental Health Services |
| | | | | | |
| Lisa | Viles | | | | Area Agency on Aging for Northeastern Vermont |

## VHCIP Practice Transformation Work Group

## Attendance Sheet

**5-Jan-16**

| | First Name | Last Name | Organization | Practice Transformation |
|---|---|---|---|---|
| 1 | Nancy | Abernathy | Learning Collaborative Facilitator | X |
| 2 | Peter | Albert | Blue Cross Blue Shield of Vermont | X |
| 3 | Susan | Aranoff | AHS - DAIL | M |
| 4 | Debbie | Austin | AHS - DVHA | X |
| 5 | Ena | Backus | GMCB | X |
| 6 | Melissa | Bailey | AHS - DMH | X |
| 7 | Michael | Bailit | SOV Consultant - Bailit-Health Purchasing | X |
| 8 | Susan | Barrett | GMCB | X |
| 9 | Emily | Bartling | OneCare Vermont | MA |
| 10 | Jaskanwar | Batra | AHS - DMH | MA |
| 11 | Todd | Bauman | DA - Northwest Counseling and Support Ser | MA |
| 12 | Bob | Bick | DA - HowardCenter for Mental Health | X |
| 13 | ~~Mary Alice~~ | ~~Bisbee~~ | Consumer Representative | X |
| 14 | Charlie | Biss | AHS - Central Office - IFS / Rep for AHS - DM | X |
| 15 | Beverly | Boget | VNAs of Vermont | M |
| 16 | Heather | Bollman | AHS - DVHA | MA |
| 17 | Mary Lou | Bolt | Rutland Regional Medical Center | X |
| 18 | Nancy | Breiden | VLA/Disability Law Project | MA |
| 19 | Stephen | Broer | DA - Northwest Counseling and Support Ser | MA |
| 20 | ~~Stephen~~ | ~~Broer~~ | VCP - Northwest Counseling and Support Se | M |
| 21 | Kathy | Brown | DA - Northwest Counseling and Support Ser | M |
| 22 | Martha | Buck | Vermont Association of Hospital and Health | A |
| 23 | Mark | Burke | Brattleboro Memorial Hopsital | MA |
| 24 | Anne | Burmeister | Planned Parenthood of Northern New Engl | X |
| 25 | Dr. Dee | Burroughs-Biron | AHS - DOC | X |
| 26 | Denise | Carpenter | Specialized Community Care | X |

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|---|---|---|---|---|
| 27 | Jane | Catton | Northwestern Medical Center | MA |
| 28 | Alysia | Chapman | DA - HowardCenter for Mental Health | X |
| 29 | Joy | Chilton | Home Health and Hospice | X |
| 30 | Amanda | Ciecior ✓ | AHS - DVHA | S |
| 31 | Barbara | Cimaglio | AHS - VDH | M |
| 32 | Peter | Cobb | VNAs of Vermont | MA |
| 33 | Candace | Collins | Northwestern Medical Center | MA |
| 34 | Amy | Coonradt | AHS - DVHA | S |
| 35 | Alicia | Cooper | AHS - DVHA | S |
| 36 | Amy | Cooper | HealthFirst/Accountable Care Coalition of t | X |
| 37 | Michael | Counter | VNA & Hospice of VT & NH | M |
| 38 | Maura | Crandall | OneCare Vermont | MA |
| 39 | Claire | Crisman | Planned Parenthood of Northern New Engl | A |
| 40 | Diane | Cummings | AHS - Central Office | X |
| 41 | Dana | Demartino | Central Vermont Medical Center | X |
| 42 | Steve | Dickens | AHS - DAIL | X |
| 43 | Molly | Dugan ✓ | Cathedral Square and SASH Program | M |
| 44 | Gabe | Epstein ✓ | AHS - DAIL | MA |
| 45 | Trudee | Ettlinger | AHS - DOC | X |
| 46 | Kim | Fitzgerald | Cathedral Square and SASH Program | MA |
| 47 | Patrick | Flood | CHAC | X |
| 48 | Erin | Flynn ✓ | AHS - DVHA | S |
| 49 | Mourning | Fox | AHS - DMH | MA |
| 50 | Judith | Franz | Vermont Information Technology Leaders | MA |
| 51 | Mary | Fredette | The Gathering Place | X |
| 52 | Aaron | French | AHS - DVHA | X |
| 53 | Meagan | Gallagher | Planned Parenthood of Northern New Engl | X |
| 54 | Joyce | Gallimore | Bi-State Primary Care/CHAC | X |
| 55 | Lucie | Garand | Downs Rachlin Martin PLLC | X |
| 56 | Christine | Geiler ✓ | GMCB | S |
| 57 | Eileen | Girling | AHS - DVHA | M |
| 58 | ~~Larry~~ | ~~Goetschius~~ | Home Health and Hospice | X |
| 59 | Steve | Gordon ✓ | Brattleboro Memorial Hopsital | X |
| 60 | Maura | Graff ✓ | Planned Parenthood of Northern New Engl | M |

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| 61 | Bea | Grause | Vermont Association of Hospital and Health | C |
| 62 | Dale | Hackett | Consumer Representative | M |
| 63 | Mike | Hall | Champlain Valley Area Agency on Aging / C | MA |
| 64 | Stefani | Hartsfield | Cathedral Square | MA |
| 65 | Carolynn | Hatin | AHS - Central Office - IFS | S |
| 66 | Kathleen | Hentcy | AHS - DMH | MA |
| 67 | Selina | Hickman | AHS - DVHA | X |
| 68 | Bard | Hill | AHS - DAIL | MA |
| 69 | Breena | Holmes | AHS - Central Office - IFS | X |
| 70 | Marge | Houy | SOV Consultant - Bailit-Health Purchasing | S |
| 71 | Christine | Hughes | SOV Consultant - Bailit-Health Purchasing | S |
| 72 | Jay | Hughes | Medicity | X |
| 73 | Jeanne | Hutchins | UVM Center on Aging | X |
| 74 | Sarah | Jemley | Northwestern Medical Center | M |
| 75 | Linda | Johnson | MVP Health Care | M |
| 76 | Craig | Jones | AHS - DVHA - Blueprint | X |
| 77 | Pat | Jones | GMCB | M |
| 78 | Margaret | Joyal | Washington County Mental Health Services | X |
| 79 | Joelle | Judge | UMASS | S |
| 80 | Trinka | Kerr | VLA/Health Care Advocate Project | M |
| 81 | Sarah | Kinsler | AHS - DVHA | S |
| 82 | Tony | Kramer | AHS - DVHA | X |
| 83 | Sara | Lane | AHS - DAIL | X |
| 84 | Kelly | Lange | Blue Cross Blue Shield of Vermont | X |
| 85 | Dion | LaShay | Consumer Representative | M |
| 86 | Patricia | Launer | Bi-State Primary Care | M |
| 87 | Deborah | Lisi-Baker | SOV - Consultant | X |
| 88 | Sam | Liss | Statewide Independent Living Council | M |
| 89 | Vicki | Loner | OneCare Vermont | M |
| 90 | Carole | Magoffin | AHS - DVHA | S |
| 91 | Georgia | Maheras | AOA | S |
| 92 | Jackie | Majoros | VLA/LTC Ombudsman Project | M |
| 93 | Carol | Maroni | Community Health Services of Lamoille Vall | X |
| 94 | David | Martini | AOA - DFR | X |

| | | | | |
|---|---|---|---|---|
| 95 | Mike | Maslack | | X |
| 96 | John | Matulis | | X |
| 97 | James | Mauro | Blue Cross Blue Shield of Vermont | X |
| 98 | Lisa | Maynes | Vermont Family Network | X |
| 99 | Clare | McFadden | AHS - DAIL | MA |
| 100 | Kate | McIntosh | Vermont Information Technology Leaders | M |
| 101 | Bonnie | McKellar | Brattleboro Memorial Hopsital | M |
| 102 | Elise | McKenna | AHS - DVHA - Blueprint | X |
| 103 | Jeanne | McLaughlin | VNAs of Vermont | X |
| 104 | Darcy | McPherson | AHS - DVHA | A |
| 105 | Madeleine | Mongan | Vermont Medical Society | M |
| 106 | Monika | Morse | | X |
| 107 | Judy | Morton | Mountain View Center | X |
| 108 | Mary | Moulton | VCP - Washington County Mental Health Se | M |
| 109 | Kirsten | Murphy | AHS - Central Office - DDC | MA |
| 110 | Reeva | Murphy | AHS - Central Office - IFS | X |
| 111 | Sarah | Narkewicz | Rutland Regional Medical Center | M |
| 112 | Floyd | Nease | AHS - Central Office | X |
| 113 | Nick | Nichols | AHS - DMH | X |
| 114 | Monica | Ogelby | AHS - VDH | X |
| 115 | Miki | Olszewski | AHS - DVHA - Blueprint | X |
| 116 | Jessica | Oski | Vermont Chiropractic Association | X |
| 117 | Ed | Paquin | Disability Rights Vermont | X |
| 118 | Annie | Paumgarten | GMCB | MA |
| 119 | Laura | Pelosi | Vermont Health Care Association | X |
| 120 | Eileen | Peltier | Central Vermont Community Land Trust | X |
| 121 | John | Pierce | | X |
| 122 | Luann | Poirer | AHS - DVHA | S |
| 123 | Rebecca | Porter | AHS - VDH | X |
| 124 | Barbara | Prine | VLA/Disability Law Project | MA |
| 125 | Betty | Rambur | GMCB | X |
| 126 | Allan | Ramsay | GMCB | X |
| 127 | Paul | Reiss | HealthFirst/Accountable Care Coalition of t | X |
| 128 | Virginia | Renfrew | Zatz & Renfrew Consulting | X |

| | | | | |
|---|---|---|---|---|
| 129 | Debra | Repice | MVP Health Care | MA |
| 130 | Julie | Riffon | North Country Hospital | X |
| 131 | Laural | Ruggles | Northeastern Vermont Regional Hospital | M |
| 132 | Bruce | Saffran | VPQHC - Learning Collaborative Facilitator | X |
| 133 | Jenney | Samuelson | AHS - DVHA - Blueprint | MA |
| 134 | Jessica | Sattler | Accountable Care Transitions, Inc. | X |
| 135 | Rachel | Seelig | VLA/Senior Citizens Law Project | X |
| 136 | Susan | Shane | OneCare Vermont | X |
| 137 | Maureen | Shattuck | Springfield Medical Care Systems | X |
| 138 | Julia | Shaw | VLA/Health Care Advocate Project | X |
| 139 | Miriam | Sheehey | OneCare Vermont | X |
| 140 | Catherine | Simonson | VCP - HowardCenter for Mental Health | M |
| 141 | Patricia | Singer | AHS - DMH | M |
| 142 | Shawn | Skafelstad | AHS - Central Office | MA |
| 143 | Richard | Slusky | GMCB | X |
| 144 | Pam | Smart | Northern Vermont Regional Hospital | X |
| 145 | Angela | Smith-Dieng | V4A | M |
| 146 | Lily | Sojourner | AHS - Central Office | M |
| 147 | Audrey-Ann | Spence | Blue Cross Blue Shield of Vermont | M |
| 148 | Beth | Tanzman | AHS - DVHA - Blueprint | X |
| 149 | JoEllen | Tarallo-Falk | Center for Health and Learning | M |
| 150 | Julie | Tessler | VCP - Vermont Council of Developmental a | M |
| 151 | Bob | Thorn | DA - Counseling Services of Addison County | X |
| 152 | Win | Turner | | X |
| 153 | Lisa | Viles | Area Agency on Aging for Northeastern Ver | MA |
| 154 | Beth | Waldman | SOV Consultant - Bailit-Health Purchasing | X |
| 155 | Marlys | Waller | DA - Vermont Council of Developmental an | X |
| 156 | Nancy | Warner | COVE | X |
| 157 | Julie | Wasserman | AHS - Central Office | S/MA |
| 158 | Kendall | West | Bi-State Primary Care/CHAC | MA |
| 159 | James | Westrich | AHS - DVHA | S |
| 160 | Robert | Wheeler | Blue Cross Blue Shield of Vermont | X |
| 161 | Bradley | Wilhelm | AHS - DVHA | S |
| 162 | Jason | Williams | UVM Medical Center | X |

| | | | | |
|---|---|---|---|---|
| 163 | Stephanie | Winters | Vermont Medical Society | MA |
| 164 | Jason | Wolstenholme | Vermont Chiropractic Association | X |
| 165 | Cecelia | Wu | AHS - DVHA | S |
| 166 | Mark | Young | | X |
| 167 | Marie | Zura | DA - HowardCenter for Mental Health | X |
| | | | | **167** |

# Attachment 2a: Care Team Consent guide

# Tools for Sharing Private Client Information in an Interdisciplinary Care Team

January 5, 2016

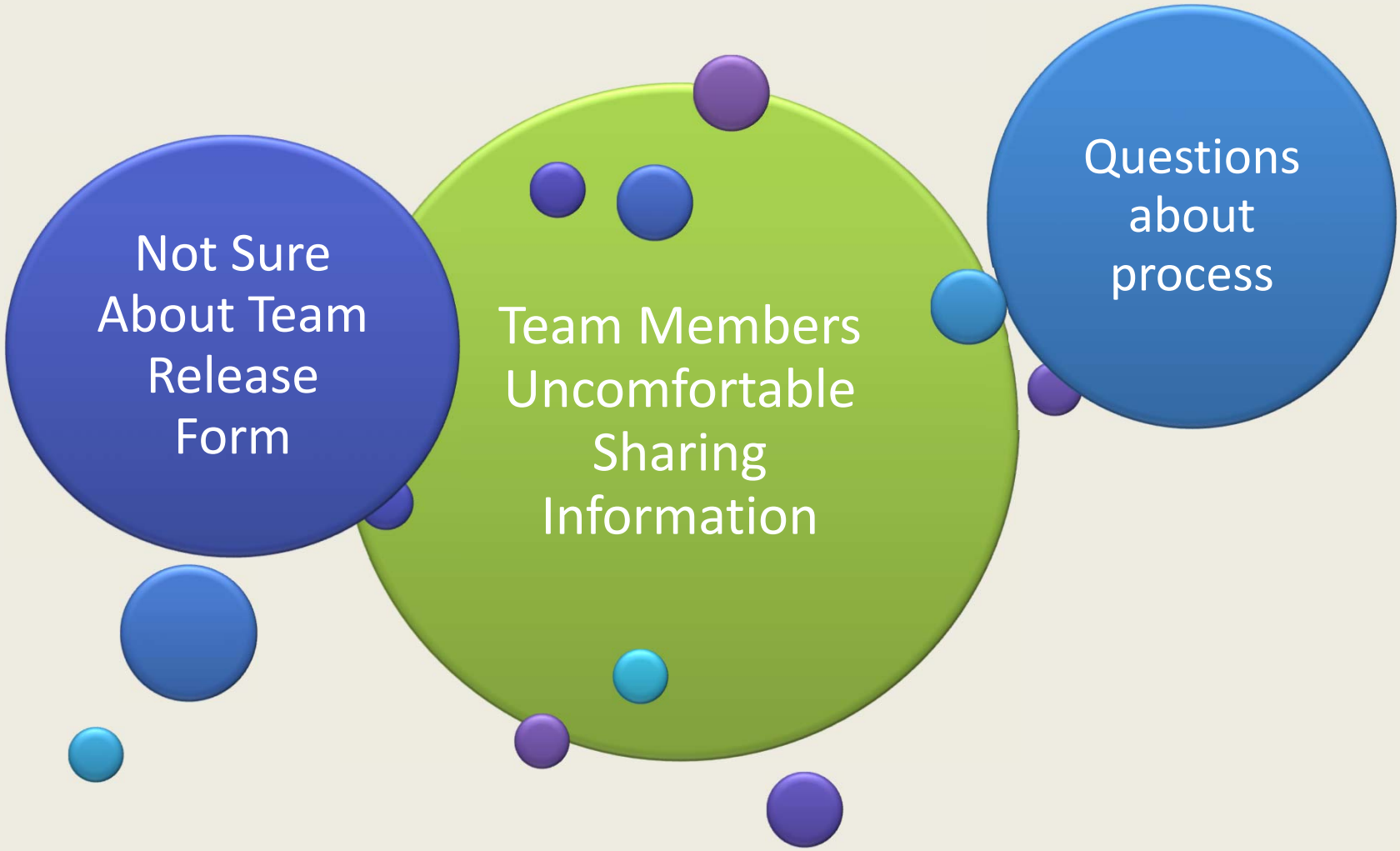
Gabe Epstein – Health Policy Analyst
DAIL

# Level Setting – In this Presentation:

- "Consent", "Release", and "Authorization" all mean a form that documents a client's permission to share private information
- Interdisciplinary Care Teams can be any team of providers from different organizations working together to help one client

For Informational Purposes Only - This is not legal advice

# Problem: Team Members Unwilling to Share Client Information



# Release Forms Are Easy

- A client has the right to access and to share private information
- A valid release form is essentially documentation of the client's decision to exercise that right
- A properly written release form can be relied on by virtually any provider; aside from HIPAA, Part 2, most laws simply require "written permission"

# Release Forms Are SO HARD

- Releases are treated as a formality, clients are not meaningfully engaged on their wishes
- No one reads releases, some don't even understanding what they are signing
- Providers may hesitate to honor a release form if they believe that doing so will violate the law or an ethical duty to their clients

# How to Disclose with Confidence

- ✓ Have a legally valid consent form
- ✓ Ensure client's choice to share information is informed and voluntary
- ✓ Have a reliable procedure to communicate when the client's consent has been revoked
- ✓ Take the guesswork out of expiration

# Release Form Design Choices

- Readable
  - Plain Language: 7.5 Grade Reading Level
  - Accessible fonts, distinct sections
- Attempts to engage clients
  - Spells out options, including option to opt out
  - Solicits affirmative choice when possible
  - Choice of team members, limits on sharing
- Addresses what happens to data after it is shared
  - Disclosure to non-HIPAA providers
  - Risks of re-disclosure
  - Possibility of disclosure without authorization
- Provides guidance on revocation process

# Next Steps

- The form will be presented to Learning Collaborative teams
- The teams will be able to customize the form
- The teams will then need to have the form reviewed by their own attorneys
- If necessary, the team needs to assess and reach a consensus on consent and sharing processes

# Consent Process Recommendations

To facilitate sharing:

- Document consent with a release
- Practice with the form and be ready to help the client use it – Develop a script
- Have a plan to clarify, document, and honor a client's wishes to stop sharing
- "Scrub in" at the team meetings


# Scrubbing In

- Only identify and share information about patients who have provided a release; don't rely on exemptions
- Agree ahead of time how to use the information they receive
- Give clear instructions if sharing Part 2, FERPA, or Mental Health Information

# Recommended Standards

Be a little more careful with information received from other providers

- Keep information secure, even if you are not regulated by HIPAA
- Only use the information in the Care Team context

Use caution when working with people outside the care team so as not to disclose Part 2, FERPA, or Mental Health Information

# Written Guidance for the Team

- Example Notice form lists standards and provides redisclosure warnings

# Questions and Feedback

# Attachment 2b: Example Notice to Providers

**[For informational purposes - not legal advice]**

Ideas for provider teams to consider when sharing information

## Agree on Group Privacy Standards

Some relevant examples:

1. Only individuals authorized by the Care Team Release form may receive the protected information specified in the release.
2. Distinguish between information that is received pursuant to the release – the care plan and information discussed at the team meeting – and information obtained directly from the client in the course of practice.
3. Be careful with part 2, mental health, or FERPA protected educational information, especially with materials that will be shared outside of team.
4. Have all team members use the same minimum level of caution when protecting the information.

## Be ready to deal with laws more stringent than HIPAA

Part 2, FERPA, and V.S.A. Title 18 Part 8 protect specific kinds of private information. HIPAA also has special restrictions on sharing psychotherapy notes. Providers who receive this information should be given a warning about these special protections, both for the client's protection and for the provider, who may not be familiar with the applicable laws.

For examples of privacy standards and warnings, see the attached document.

**[For informational purposes - not legal advice]**

## [INTERDISCIPLINARY CARE TEAM] NOTICES FOR PROVIDERS REGARDING REDISCLOSURE OF PRIVATE INFORMATION

### Notice of Privacy Standards

Only individuals authorized by the **[CARE TEAM] RELEASE OF INFORMATION FORM** may receive the protected information specified in the release.

Providers are advised to keep the information they receive pursuant to the release separate and distinct from the information obtained directly from the client in the course of practice.

Providers are expected to follow the confidentiality laws and ethical standards of their practice. Providers are also asked to do the following with information received pursuant to the release, even when not required to do so:

- Keep this information secure
- Use or disclose this information only as authorized by the release or with the client's written permission
- Seek legal advice if required to disclose records by law or in an emergency situation

## NOTICES FOR PROVIDERS REGARDING PRIVACY REQUIREMENTS OF LAWS MORE STRINGENT THAN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The laws referenced below protect specific kinds of private information. This information should not be used or disclosed except as described in the release. Providers should contact the source of this information and/or seek legal advice if such use or disclosure is:

- Requested by the client or required for the client's treatment
- Required by law
- Made without permission or in an emergency

### Part 2 Warning for [Part 2 Facility]'s Records

Information disclosed by [Part 2 Facility] in this team is protected by 42 CFR Part 2.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**[For informational purposes - not legal advice]**

## FERPA Warning for [Educational institution]

Personally identifiable information from an educational records disclosed by [Educational Institution] is protected by the Family Educational Rights and Privacy Act ( 34 CFR part 99 ). The disclosure of this information is made on the condition that the parties receiving this information will not disclose the information to any other party without the prior consent of the parent or eligible student, except as permitted by FERPA.

## Title 18 Part 8 Warning

Any records created pursuant to State Mental Health Statutes ( 18 V.S.A. §§ 7101 - 9335 ) are protected by Vermont state law as well as HIPAA. Written consent is required for certain disclosures, including some disclosures which are otherwise permissible without written consent under HIPAA. Seek legal advice before disclosing such information without permission.

# Attachment 2c: Team Release Template

Release form provided by (name and organization): _____

**[INTERDISCIPLINARY CARE TEAM]'S RELEASE OF INFORMATION FORM**
**[For informational purposes - not legal advice]**

Name _____ Date of Birth _____

## I WANT MY PROVIDERS TO WORK AS A TEAM

[Name of team] is a group of providers who are working together to help people in my area get healthy. **I want them to work on my care as a team**. I am in charge of this team. I will choose the information my team can share to work on my care.

The [name of team] providers will be part of my team. They are:

- [List core team members who meet to talk about every client]
- [Hospital]
- [A]
- [B]
- [C]
- [D]
- [E]
- [F]

The providers listed below will also be part of my team if I write my initials next to the words "Add this provider." **I can keep seeing my providers even if I do not put them on my team.**

| | |
|---|---|
| [Housing agency] | ____ Add this provider |
| [Patient Advocate/Legal Advocate] | ____ Add this provider |
| [See list of suggestions] | ____ Add this provider |
| [A] | ____ Add this provider |
| [B] | ____ Add this provider |
| [C] | ____ Add this provider |
| [D] | ____ Add this provider |

I can also add other providers to my team by listing them here:

_____

_____

## LAWS THAT PROTECT MY PRIVACY

I know that some of the providers on my team do not have to follow the privacy law known as HIPAA. These providers will be careful to protect my privacy, but **HIPAA does not protect the records I share with them**.

I know that **some of my records could still be protected by other laws**. I know that my team will be warned not to share these records with anyone who is not on the team without my permission. These include records of substance use treatment from [part 2 facility/facilities], educational records from [FERPA entity], and mental health treatment from [Title 18 Part 8 mental health treatment].

## MY TEAM HAS PERMISSION TO SHARE MY PRIVATE INFORMATION

**I give the whole team permission** to give the information that I choose on this form to other members of the team. My whole team has permission to receive this information, and to repeat or pass it along to other members of the team.

### HOW MY TEAM WILL USE MY INFORMATION

**My team is allowed to use my private information to help me make a plan for my care.** It could list private things like my need for help with my money, mental health, education, disability, substance use issues, or medical care. **My team will be allowed to share this plan with each other and give each other updates about my care.**

**Members of my team will also be allowed to use my private information to help me apply for services.**

### WHAT HAPPENS TO MY INFORMATION ONCE IT IS SHARED

I know that **my health records could be shared again**. Information that is shared may no longer by protected under the privacy law known as HIPAA. This could include some information about substance use, HIV/AIDS status, and mental health.

I know that I can cancel this release in writing at any time. I know that **even if I cancel this release, my providers may still have a right to keep and use information that has already been shared.**

## OTHER WAYS MY INFORMATION CAN BE SHARED

I know that I can have **other releases** that let my providers share my private information for other reasons. If I want to cancel those releases, I have to talk to those providers and ask them how to do that.

I know that **my providers can share some of my private information without asking me**. If I want to know more about this, I can ask each of my providers to tell me about their privacy practices.

## INFORMATION MY TEAM CAN SHARE

My team has permission to share the information I have chosen on this page.

I can write a date next to the words "Do not share records from before this date" if I want to keep my older records private.

Do not share records from before this date:_____

## BASIC INFORMATION

I give the providers on my team permission to:

1. Share my [name and date of birth]
2. Share my health needs, my goals and my care plan
3. Share information about the services and public assistance I receive
4. Share a list of my income and resources
5. Say whether I am one of their clients
6. Tell each other when I have appointments and if I miss appointments
7. Give each other updates on my progress
8. [List any other info needed to run the team]

## HEALTH INFORMATION

I give my team permission to share the health information listed here:

- [Diagnoses]
- [Medication list]
- [List other common types of information that might be helpful.]
- [D]
- [E]
- [F]

## OPTIONAL INFORMATION

I give my team permission to share the information I have selected from the list below. **It can be shared only if I write my initials on the line next to it**.

_____[Substance Use]
_____[Mental Health]
_____[List other sensitive types of information]
_____[D]
_____[E]
_____[F]
_____[G]
_____[H]

I also give my providers permission to share the private information that I list here:

_____

_____

_____

## HOW TO END OR CHANGE THIS RELEASE

I know that this release will end on its own if I do not see any of the providers on my team for one year.

I can also set my own end date here: _____

End Date

I can cancel or change this release by contacting:

[Person X]
[Address]
[City], VT [ZIP]
[Phone]

[Person X] will then tell my team members that this release has been cancelled. I know that even if I cancel this release, my providers may still have a right to keep and use information that has already been shared.

I know that I have a right to keep working with my providers even if I tell them not to share my information.

## SIGNATURE

I know this release will only start once I sign and date this page. I know that **if I do not give the team permission to share my information, they will not be able to work together as a team or share a plan for my care.**

**I know that I have a right to keep working with my providers even if I tell them not to share my information.**

**I know I have a right to get a copy of this form.**

_____ _____

Signed by me or my representative Date

_____

Reason why my representative is allowed to sign for me

_____

Signature of my parent or guardian if I am too young to sign by myself

# Attachment 3: Overview of Core Competency Training for Front Line Staff Providing Care Coordination

# Core Competency Training for Front Line Care Coordination Staff

# Practice Transformation Work Group Meeting
# February 2, 2016

Vermont Health Care Innovation Project

# Background:

- Participants in the Integrated Communities Care Management Learning Collaborative (ICCMLC) expressed a need for training on key core competencies related to delivering person-directed care coordination and care management support as part of an integrated care team.

- DLTSS work group members identified need for training on key core competencies related to delivering person-directed care coordination and care management support to individuals with DLTSS needs, as highlighted in the "Disability Awareness Briefs" http://healthcareinnovation.vermont.gov/node/863

- Care Models and Care Management Work Group Members, DLTSS Work Group Members, and ICCMLC participants provided input on desired training curriculum, which was incorporated into a Training RFP.

# Background (cont'd):

- After a competitive bidding process, two apparently successful awardees have been selected and contract negotiation is nearing completion.
- Two organizations will deliver a comprehensive training series:
  - **Primary Care Development Corporation** (http://www.pcdc.org/), is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities. PCDC will provide training on core competencies related to care coordination and care management.
  - **The Vermont Developmental Disabilities Council** (http://www.ddc.vermont.gov/) is a state-wide board that works to increase public awareness about critical issues affecting people with developmental disabilities and their families. VTDDC and its partners, including Green Mountain Self Advocates, Vermont Family Network, and Vermont Federation of Families for Children's Mental Health, will provide training on core competencies related to working with individuals with DLTSS needs.

# Overview of Training Opportunities:

- **28** separate training events to be offered between March and December 2016 as part of a robust training curriculum covering core competencies in care coordination and working with individuals with disabilities and long term services and supports (DLTSS) needs.
- **180** training spots available for 3 full days of Introductory care coordination training, and three full days of DLTSS training beginning on March 29th, 2016. These trainings will be offered in three regions of the State: North, Central and South (exact dates and locations TBD).
- Additional training opportunities for a smaller subset of participants include: Advanced Care Coordination Training, Care Coordination for Managers and Supervisors Training, and Train-the-Trainer Training.

# Schedule of Training Events:

| Jan. – June 2016 | Jan | Feb | March | Apr | May | June |
|---|---|---|---|---|---|---|
| | Pre-Planning with Training Organizations | Pre-Planning with Training Organizations | 3 sessions of Introductory Care Coordination Training, Day 1 | 3 sessions of Disability Competency Training, Day 1<br><br>Webinar 1 | 3 sessions of Introductory Care Coordination Training, Day 2 | 3 sessions of Disability Competency Training, Day 2<br><br>Webinar 2 |
| **July – December 2016** | **July** | **August** | **September** | **October** | **November** | **December** |
| | 3 sessions of Introductory Care Coordination Training, Day 3 | Webinar 3 | Advanced Care Coordination Training (2 consecutive days)<br><br>3 sessions of Disability Competency Training, Day 3 | Care Coordination for Managers and Supervisors Training (I day)<br><br>Webinar 4 | Train-the-Trainer Training (2 consecutive days) | Webinar 5<br><br>Evaluation |

# Overview of Training Content:

**Introductory Care Coordination Training may include the following general topics:**

- Introduction to Care Coordination
- Principles of team-based care
- Outreach and engagement
- Conducting comprehensive assessments
- Communication skills
- Bias, culture and values, and health disparities
- Accessing community and social supports
- Transitions of care, home visits, and supporting caregivers
- Development and implementation of care plans
- Motivational interviewing
- Health coaching
- Professional boundaries

# Overview of Training Content (cont'd):

**DLTSS Training may include the following general topics:**

- Health disparities and social determinants of health
- Understanding disability and the intersection with wellness
- Universal design and accessibility
- Adverse Childhood Events: A Strength-Based Approach
- Facilitating inclusive and accessible trainings
- Communication and interaction
- Tools to improve communication
- Person-centered care and person-directed planning
- Transition from pediatric to adult care
- Cultural competency
- Sexuality and reproductive health

# Overview of Training Content (cont'd):

**Advanced Care Coordination Training may include the following general topics:**

- Impact of adverse childhood events, mental illness, and addiction disorders on health status
- Screening for substance abuse and domestic violence
- Crisis management and suicide prevention
- Coordinating care for people with mental health conditions
- Coordinating care for people who are homeless
- Care management for people who are elderly
- Palliative care and end of life care

# Overview of Training Content (cont'd):

**Train-the-Trainer Training may include the following general topics:**

- Preparing to facilitate group care management/care coordination training
- Framing topics to clarify roles of front-line care managers
- Best practices for facilitating group discussions and activities, including techniques for encouraging and managing discussion
- Facilitating discussion about controversial or challenging topics
- Managing conflict and multiple opinions among students
- Facilitating role play activities for motivational interviewing, health coaching, and communication skills

# Overview of Training Content (cont'd):

**Care Coordination for Managers and Supervisors Training may include the following general topics:**

- Handling large caseloads
- Risk stratification
- Supervision of staff
- Setting up training systems
- Working effectively with leadership and physicians
- Identifying and serving as a lead care coordinator.

# Help us Spread the Word!

- Save the date for March 29th, 30th and 31st for the first day of introductory core competency training at North, Central and Southern locations.
- More information, including registration links with exact dates, times, and locations will be distributed in the near future.
- Contact Carole.Magoffin@vermont.gov with questions, or to get added to the distribution list.

# Attachment 4: Updated Report; Care Management in Vermont: Gaps and Opportunities for Coordination

# CARE MANAGEMENT IN VERMONT: GAPS AND OPPORTUNITIES FOR COORDINATION

Prepared for the

Vermont Health Care Innovation Project's

Practice Transformation Work Group

with assistance from Bailit Health Purchasing, LLC

January 27, 2016

## Executive Summary

Drawing on information collected from surveys completed by Vermont organizations providing care management and from presentations made by care management organizations to the Vermont Health Care Innovation Project (VHCIP) Care Models and Care Management (CMCM) Work Group[1], this report identifies gaps and opportunities for coordination in care management services and summarizes recommendations on how to address those gaps and opportunities.

In assessing the recommendations, we organized the responses into the following categories:

- Vision for Coordinated Delivery System
- Targeted Areas Needing Coordination
- Recommendations Regarding New Models of Care
- Recommendations to Create New Organizational Structures to Standardize and Coordinate Care
- Recommendations Regarding Standardized Tools and Practices
- Recommendations Regarding Data and Evaluation Infrastructure
- Recommendations Regarding Technical Support

While responses were not always consistent, it seems clear that Work Group members believe that there needs to be:

- Increased process standardization, including increased use of common care management tools;
- Creation of an organizational mechanism to coordinate the "family of care coordinators;"
- Increased development and use of IT resources to coordinate care management activities;
- Increased use of a shared data set to coordinate care and measure effectiveness; and
- Increased opportunities for care managers to build their skills through initiatives to share best practices and learn new skills.

As part of its work, the CMCM Work Group surveyed organizations providing care management services to collect information on: existing activities, perceived barriers to doing their work, and recommendations on improving care management in Vermont. 42 organizations responded to the survey. In addition, more than a dozen organizations volunteered to present more detail to the Work Group regarding their care management programs; when presenting they were asked to identify specific gaps and opportunities for coordination. This report summarizes observations and recommendations for addressing gaps and opportunities for coordination that were identified in survey responses and presentations. To understand this qualitative information, we have organized the material into several categories, which we discuss in detail below.

[1] The VHCIP Care Models and Care Management Work Group was the predecessor work group of the current Practice Transformation Work Group.

# Care Management in Vermont: Gaps and Opportunities for Coordination

This report summarizes possible gaps and opportunities for coordination in care management services identified by organizations that responded to the care management inventory survey and presented to the CMCM Work Group. The report presents its findings in the form of specific recommendations that address the identified gaps and opportunities for coordination.

**Methods and Limitations**

Information included in this report was obtained from two sources: responses to the care management inventory survey[2], and in-person presentations to the CMCM Work Group (now called the Practice Transformation Work Group) in response to an invitation to all organizations represented on the Work Group to describe their care management service models. In response to the invitation, presentations on 14 programs were provided. Presenters were given general guidelines for structuring their presentations to encourage some consistency in topics covered[3]. The PowerPoint presentation documents, supplemented when needed with website research, were the primary sources for developing an understanding of existing care management services. This information was used to identify what appeared to be gaps and opportunities for improved coordination. The initial report was presented to the CMCM Work Group members and feedback received from them has been incorporated.

There are three major limitations associated with this report. First, all information was self-reported by each survey respondent and presenting organization. None of the information has been independently verified. Second, care management terminology can mean different things to different audiences, so the presenters did not necessarily use the same terminology in a consistent manner. As a result, the report's authors to some extent had to rely on their knowledge and experience to assess perceived gaps and opportunities for improved coordination. This potential bias has been addressed in part through feedback provided by Work Group members to the initial report. Third, the organizations responding to the survey and offering presentations that were included in this report do not represent all of the organizations in Vermont that offer care management services. Therefore, this report does not represent the entire universe of care management services being offered in Vermont.

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[2] The Care Management Inventory Survey Report can be found at: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/CMCM/CMCM%20Survey%20Report%202015-03-09%20FINAL.pdf

[3] Some early presentations were made before the presentation guidelines were created. Presentation guidelines are as follows: Description of Program (including eligibility criteria, funding sources, estimated number of people served, staff licensure/credentialing); Interactions with Other Programs and Providers; Description of What is Working Well; Gaps, Barriers and Disincentives in Receiving Services; Opportunities for Coordination; Data Needs; Financial Parameters (barriers to financing and innovative financing structures); Case Study Illustrating Above Points.

**Vision for Coordinated Delivery System**

Several respondents and presenters included vision statements regarding how the ideal system would be structured. These statements are included because they can serve as a "North Star" for the Work Group. One respondent described a system of easy access and highly coordinated care:

> "Develop a system that provides 'no wrong door' for anyone seeking care. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the Area Agency on Aging, the home care staff must have the knowledge and ability to arrange for the services needed."

A few respondents and presenters identified specific services for which improved access should be achieved. Those services included:

- Prevention, wellness, risk mitigation and stabilizing people in the community;
- Mental health services, affordable housing, food and fuel assistance;
- Early Intervention and Essential Early Education services for children ages 3 to 4;
- Adult dental care;
- Transportation;
- Affordable behavioral health services, especially for seniors on fixed incomes and who are homebound; and
- Accessible Gerontology services.

**Targeted Areas Needing Coordination**

Several respondents and presenters identified specific areas of inter-agency activities that needed to be better coordinated. They included:

- Improve inter-agency coordination with integration of social services and the criminal justice system.
- Optimize interactions between Visiting Nurse Associations (VNAs), Designated Mental Health Agencies (DAs), Federally Qualified Health Centers (FQHCs), and Support and Services at Home (SASH) partners.[4]

**Recommendations Regarding New Models of Care**

Three presenters proposed implementing new models of care as solutions to address opportunities for coordination and reduce gaps in care. One recommended designing and testing peer support/family engagement models, but provided no more details. Another suggested developing an integrated care model for seriously ill people that includes: team-based care, communication across disciplines, and process and outcome measures. This model would be supported by a new payment strategy, such as episodes of care/bundled payments, or enhanced per member per month (PMPM) payments. This presenter suggested testing the model in a pilot

[4] The SASH program currently has 65 individually signed MOUs between each local VNA, Area Agency on Aging (AAA), DA and Housing Organization to coordinate care.

setting. The third presenter outlined a detailed model of care for people with Disabilities and Long-term Services and Support (DLTSS) Needs that is outlined in Appendix A.

**Recommendations to Create New Organizational Structures to Standardize and Coordinate Care**

Most of the recommendations from the presenters and survey respondents centered on creating more infrastructure to improve coordination. One recommendation was to create or identify organizations to drive coordination across multiple entities. Some suggestions focused on creating totally new organizational structures; others focused on using existing organizations in new ways. Specific recommendations for new or repurposed organizations include:

- Develop "Care Resource Teams" which would include representatives from a variety of providers;
- Use Area Agency on Aging (AAA) services to complement services and scope of other community-based providers.
- Use AAA wraparound services (case management/care coordination, nutrition services, transportation, falls prevention, etc.) to improve success of care transitions and avoid hospitalizations, institutionalization and readmissions.
- Use the Unified Community Collaborative (UCC) in each Health Service Area (HSA) to coordinate care management activities, strengthen Vermont's community health system infrastructure, and help the three provider networks (i.e., the Accountable Care Organizations) meet their organization goals.
    - The UCCs would provide a forum for organizing the way in which medical, social, and long term service providers work together to achieve the stated goals.
    - The UCCs would develop and adopt plans for improving:
        - quality of health services,
        - coordination across service sectors, and
        - access to health services.

**Recommendations Regarding Standardized Tools and Practices**

Others recommended establishing processes among existing organizations that would result in better coordination among different agencies. These recommendations include:

- When coordinating services across multiple organizations with their own care managers, identify a central case manager (or team leader) to address coordinating the "family of case managers."
- Develop formalized collaborative relationships, including joint case management and care coordination.

Improved, standardized processes were recommended as a way to address opportunities for coordination and reduce gaps in care. Suggestions included:

- Develop a site visit tool for state staff;
- Create utilization management tools for state and provider staff;
- Create standards for uniform Early and Periodic Screening, Diagnostic and Treatment (EPSDT) developmental screening, assessment and treatment planning across physical and

mental health, early childhood programs, and school-based Medicaid and Children's Health Insurance (CHIP) programs;
- Design and test population-based developmental and mental health promotion and prevention practices for statewide implementation; and
- Design a treatment plan across domains of a person's life.

**Recommendations Regarding Data and Evaluation Infrastructure**

Many of the respondents and presenters made recommendations regarding better use of data to enhance opportunities for coordination and reduce gaps in care. Their data-oriented recommendations included:

- Develop standard processes for evaluation and continuous quality improvement for collaborative projects.
- Integrate and analyze as a system rather than just by provider (e.g., analyze home care data with data from other settings).
- Coordinate common measures across programs providing like services, including standardized and streamlined provider reporting requirements.
- Manage "gaps in care" data from payers.

Respondents and presenters also made recommendations regarding data infrastructure improvements to reduce gaps and address opportunities for coordination in care management services, which included:

- Design and implement health information exchange (HIE) interfaces, communication and integrated clinical information sharing and information technology (IT) structures (state and local).
- Create new business processes and state IT tools for standard decision support and outcome tracking.
- Address internal service integration between AAA programs by continuing to consolidate to a single software platform.
- Decrease resource burden of Transitional Care Management for CMS billing by using a platform called ACT.md.

**Recommendations Regarding Technical Support**

To enhance care manager skills to reduce gaps in care and address opportunities for coordination of services, respondents and presenters made recommendations with regard to both mentoring and skill development. Their recommendations included:

- Create regional Technical Assistance Staff/System of Care Facilitators.
- Develop public best-practice forums (e.g., for top-scoring HSAs in each component).
- Develop workforce training and provider development to support:
    - early intervention;
    - family centered clinical models;
    - family wellness;
    - local governance and affiliation agreements;
    - mitigation of social determinants of health, etc.

## Conclusions

In order to harmonize and coordinate all the different care management programs, CMCM Work Group members appear to believe that changes need to be made in multiple areas and that there is no simple solution. While some of the recommendations were not always consistent, it seems clear that Work Group members believe that there needs to be:

- Increased process standardization, including increased use of common care management tools;
- Creation of an organizational mechanism to coordinate the "family of care coordinators;"
- Increased development and use of IT resources to coordinate care management activities;
- Increased use of a shared data set to coordinate care and measure effectiveness; and
- Increased opportunities for care managers to build their skills through initiatives to share best practices and learn new skills.

## Table and Appendix

Table I summarizes needs, gaps, barriers and opportunities for coordination regarding care management services that were identified in each presentation made to the CMCM Work Group. The presenting organization is also included in the table.

Appendix A summarizes the Model of Care for People with Disabilities and Long Term Services and Supports Needs that was presented to the CMCM Work Group.

**Table I: Summary of CMCM Work Group Presentations**

| Presenter | Program Name | Needs/Gaps/Barriers | Opportunities for Coordination |
|---|---|---|---|
| Washington County Mental Health | Designated Agency Case Management for Community Rehabilitative Treatment (CRT) Services (Community Support Program) | Process for assignment of a care coordinator/team leader:<br>• Develop qualification for coordinator<br>• Develop process for coordination<br>• Address "family of case managers"<br>▸ Mental Health<br>▸ Home Health<br>▸ SASH<br>▸ AAA<br>▸ Hospital Social Worker<br>▸ Blueprint<br>• Develop treatment plan across domains of a person's life<br>• Establish electronic interface with other components of the health care system<br>• Coordinate common measures across programs providing like services | None indicated |
| Peter Cobb, VNAs of Vermont Director | VNAs of Vermont: Home Health Care Management | • Improved system of interagency communication and information sharing to assure appropriate coordination among the various providers serving a client or patient.<br>• Ability to integrate and analyze home care data with data from other settings. Ability to share data across settings. Member agencies currently are working with VITL to create a two-way system of IT information exchange. | • Several organizations provide care management including home health, SASH, hospitals, nursing homes, Blueprint, and mental health agencies.<br>• Mostly, the care management provided is not duplicative as each agency provides a valuable service to its patients. |
| Agency of Human Services Melissa Bailey, MA, LCMHC | Integrated Family Services (IFS) | • Design and test peer support/family engagement models.<br>• Create Regional Technical Assistance Staff/System of Care Facilitators.<br>• Improve coordination and create standards for uniform EPSDT developmental screening, assessment and treatment planning across physical and mental health, early childhood, and school based Medicaid and CHIP programs.<br>• Design and test population-based developmental and behavioral health promotion and prevention practices for statewide implementation. | None Indicated |

| Presenter | Program Name | Needs/Gaps/Barriers | Opportunities for Coordination |
|---|---|---|---|
| | | • Workforce training and provider development to support: early intervention; family centered clinical models; family wellness; local governance and affiliation agreements; mitigation of social determinants of health, etc.<br>• Create new utilization management tools for state and provider staff.<br>• Design and implement HIE interfaces, communication and integrated clinical information sharing and IT structures (state and local).<br>• Analyze and align data dictionaries and create core data reporting requirements across programs, including standardization and streamlined provider reporting requirements.<br>• Create new business processes and state IT tools for standard decision support and outcome tracking.<br>• Create new quality oversight standards and site visit tools for state staff. | |
| | Care Alliance for Opioid Addiction: "Hub and Spoke" | • New approach – start-up issues<br>• Lack of private insurance coverage<br>• Lack of physicians willing to treat population<br>• Challenge with integration of social services<br>• Link with criminal justice system poses unique challenges | • Co-Occurring Mental Health Services/Models – D.A.s<br>• Other Chronic Care Initiatives: VCCI, Community Health Teams<br>• Other AHS Case Management<br>• Criminal Justice Case Management |
| | Vermont Chronic Care Initiative High Risk Pregnancy Program | • Difficulty in obtaining early referrals, and finding women early in pregnancy in order to make an impact.<br>• There is no incentive for member or provider to participate in program<br>• Potential Opportunities for coordination: External and internal partners – CHT, Maternal Child Health, Reach-up, MAT (Hub and Spoke) teams, etc. | None indicated |
| Allan Ramsay, M.D. | Green Mountain Care Board (including palliative care for the seriously ill in a care management system) | • Convene the stakeholders<br>  ▸ PCMH, DA, LTSS, VAHHS, ACO, others?<br>• Develop an integrated care model for the seriously ill<br>  ▸ Team-based care<br>  ▸ Communication across disciplines | None indicated |

| Presenter | Program Name | Needs/Gaps/Barriers | Opportunities for Coordination |
|---|---|---|---|
| | | ▸ Process and outcome measures<br>• Identify a new payment strategy<br>▸ Episode of care/Bundle<br>▸ Enhanced payment<br>▸ PMPM<br>• Test the model in a pilot setting | |
| Area Agencies on Aging +<br>Care Partners Network +<br>VNAs of Vermont | Coordinated Care Management | • Increasing focus on prevention, wellness, risk mitigation -- stabilizing people in the community<br>• Difficult/impossible to age-in-place if you're not healthy<br>• Recognition that AAA wraparound services (case management/care coordination, nutrition services, transportation, falls prevention, etc.) essential to success of care transitions; avoiding hospitalization/ institutionalization / readmits<br>• Collaboration / service integration will be critical<br>• AAAs are addressing internal service integration between AAA programs (consolidating single software platform)<br>• While acknowledging existing collaboration / interactions with VNAs, DAs & FQHCs, SASH partner, it is clear that these relationships need to be optimized. Actively exploring closer / formalized collaborative relationships – joint case management / care coordination<br>• Reducing/preventing hospital/SNF readmits; reducing chronic disease admits depend on coordinated care / case management | • Increasingly apparent that AAAs, VNAs, DAs & FQHCs have high degree of client overlap |
| Designated and Specialized Service Agencies | Vermont Care Partners (VCP) is a collaboration between the Vermont Council for Developmental and Mental Health Services and the Vermont Care Network to support the sixteen Designated and Specialized Service Agencies. | **Challenges**<br>• **Data Sharing -** Community-based providers need the ability to share and receive relevant patient-specific data electronically with physicians, hospital, nursing homes. This would increase efficiency and improve the quality of the care delivered.<br>• **No Wrong Door vs. Single Point of Contact** - A single point of entry is not needed. What is needed is a system that provides "no wrong door" for anyone seeking care. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor | • A patient could receive care management services from a several providers. |

| Presenter | Program Name | Needs/Gaps/Barriers | Opportunities for Coordination |
|---|---|---|---|
| | | at the Area Agency of Aging, the home care 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.<br>**Opportunities**<br>• Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) to coordinate care management activities, strengthen Vermont's community health system infrastructure, and help the three provider networks meet their organization goals.<br>• The UCCs would provide a forum for organizing the way in which medical, social, and long term service providers work together to achieve the stated goals.<br>• The UCCs would develop and adopt plans for improving:<br>▸ quality of health services<br>▸ coordination across service sectors<br>▸ access to health services | |
| Howard Center | Service Coordination for Developmental Services<br>Designated and Specialized Agency System | None indicated | None indicated |
| Blueprint Community Health Teams | Community Health Teams across Vermont | • Access to Mental Health Services, affordable housing, food and fuel assistance.<br>• The size of Chittenden county and the large number of practices<br>• Biggest Gaps in Care - Services for ages three to four between Early Intervention and Essential Early Education services, adult dental care, transportation, affordable mental health services, especially for seniors on fixed incomes and who are homebound, accessible Gerontology services.<br>• Transitional Care Management for CMS billing is time-consuming.<br>• Managing "gaps in care" data from payers. | • Chittenden County is rich in services/resources, creating a challenge to really work on opportunities for coordination.<br>• Strong communication avoids many duplicated efforts, but it can sometimes be challenging to obtain certain information without proper releases in place. |

| Presenter | Program Name | Needs/Gaps/Barriers | Opportunities for Coordination |
|---|---|---|---|
| | | • Prioritizing single-patient needs (tyranny of the urgent) vs. getting entire panels of patients to adopt healthier habits.<br>• Juggling Transitional Care Management PLUS Care Coordination PLUS Panel management—self-management & education of smokers, diabetics, asthma patients PLUS Reduce ER visits and hospital admissions PLUS Work with multiple payers on reducing # of high-risk patients.<br>• Communication, Releases, HIPAA Barriers<br>• Motivating people who have been in "the system" for a few years to realize it is possible that they can gain control of their lives and future.<br>• Identifying additional ways to quantify our team's efforts. | |
| Nancy Eldridge | Support & Services at Home (SASH) | • MAPCP demonstration capped at 5,400 participants<br>• Need for more Wellness Nursing Hours<br>• Need for telemedicine capacity at home<br>• Need for more root cause data<br>• Move toward population management within which targeting can occur<br>• Workforce gaps<br>▸ Need to push tasks down to paraprofessionals or community health workers<br>Data Needs<br>• DocSite capacity significant<br>• Integrated Health Record barriers<br>• VITL barriers:<br>▸ Who should have access?<br>▸ Risk when transforming systems<br>How can we build one data system | • Opportunity for more integration by SASH, VCCI and CHTs with shared participants<br>o Blending Episodic expertise with coaching and ongoing team support<br>• Dual Eligible teams and SASH teams<br>• Data collection<br>• ACO performance measurement |
| VCCI and DAIL | Care Models and Case Management: a Long Term Services and Supports (LTSS) Perspective | None indicated (presentation preceded guidelines requesting information on needs/gaps/barriers) | None indicated (presentation preceded guidelines requesting information on opportunities for coordination) |

| Presenter | Program Name | Needs/Gaps/Barriers | Opportunities for Coordination |
|---|---|---|---|
| Vermont Blueprint for Health | Community Health Network Analysis of Blueprint HSAs | Organizations are less likely to measure the work they are doing together. Evaluation and continuous quality improvement should be encouraged.<br><br>No one HSA always rated at the top or bottom of the score distribution. It may be beneficial for top-scoring HSAs to share their practices in a public forum, so that the other HSAs can learn from those best practices.<br><br>Respondents experienced drawbacks far less frequently. Two worth watching are:<br>• taking too much time and resources—reported by 60%<br>• difficulty in dealing with partner organizations—reported by 46% | Key Player Analysis shows that these are fairly durable networks, as modelling removal of the 3 "key players" in each network causes fragmentation but not complete network breakdown. Information about key players (not necessarily duplicative):<br>• Blueprint Community Health Teams are key players in the majority of HSAs—around 60%.<br>• At least 1 State agency (e.g., Agency of Human Services, Vermont Department of Health) is a key player in about a third of HSAs.<br>• Other key players include organizations that provide mental health and substance abuse services, services for the aging population and home-based care groups.<br>• Each community network is substantially larger than its "core health team" and includes a range of public and private health and social service organizations that support a diverse swath of each community's population<br>• It's common to see sub-networks that serve a specific population within the community, for instance area youth (see the St. Johnsbury HSA for an example) or area elders (see the Randolph HSA for an example). |
| Susan Besio, Pacific Health Policy Group<br><br>Julie Wasserman, Agency of Human Services | Proposed Model of Care for People with DLTSS Needs | The traditional medical system has not been designed to meet the diverse needs of people with DLTSS needs | See Appendix A |

## Appendix A

## Summary of Model of Care for People with Disabilities and Long-term Services and Support (DLTSS) Needs

The Vermont Agency of Human Services has developed a proposed model for coordinating care for people with disabilities and long-term services and support needs (DLTSS). These 40,000 Vermonters often have intense health care needs and potentially qualify for services from numerous state and federal programs. Currently, specialized mental health, developmental disability and substance abuse treatment services and supports are provided by 11 Designated Agencies and 6 Specialized Service Agencies. Other long-term services and supports are provided by diverse entities, including 112 Residential Care Homes, 36 Therapeutic Community Residences, 40 Nursing Homes, 12 Home Health Agencies, 5 Area Agencies on Aging, 14 Adult Day Providers, 6 Designated Regional Housing Organizations, 16 Housing Authorities/Land Trusts, Vocational Rehabilitation, Peer Support Organizations, Guardians, and thousands of direct care/personal care workers/other providers. Individuals who receive DLTSS-related Medicaid specialized services and programs also use traditional medical service providers, and may also receive other support and case management services from Blueprint Community Health Teams, the "Hub and Spoke" Health Home Program for opioid dependence, the Vermont Chronic Care Initiative, Support and Services at Home, commercial insurer and long-term care insurance programs, Veterans Administration and other military programs, and Federally Qualified Health Centers.

Many individuals (and their families) must navigate through different provider systems to try to get all their needs met. They often have multiple care managers providing services independently from one another. To better coordinate DLTSS services, the Agency of Human Services has developed a proposed model to integrate and coordinate all care management services provided to the DLTSS community. Key elements include:

- Person-centered and person-directed services and supports.
- Access to independent options counseling and peer support.
- Involved primary care provider.
- Single point of contact that would serve as the person's case manager, coordinating across all of the individual's medical, mental health, substance abuse, developmental and long-term care service needs, including assuring that all appropriate assessments are completed.
- Assessments and DLTSS screening by primary care providers and other medical specialists.
- Comprehensive care plan.
- Individual, interdisciplinary care team.
- Support during care transitions.
- Use of technology for information sharing.

The model is designed to improve the beneficiary's experience through better coordination and patient involvement in decision-making, improved staff experience through improved collaboration and communications between medical and DLTSS providers, improved consumer outcomes through decreased use of avoidable medical services, decreased provider cost-shifting across payers and decreased overall health care costs.

# Attachment 5: UCC/RCPC Progress Report

## Regional Committees/Areas of Quality Improvement Work 01/2016

| Health Service Area | Regional Meeting Name | Charter | Consumer | Priority Areas of Focus | Project(s) | Other Attendees |
|---|---|---|---|---|---|---|
| **Bennington**<br>**Contact: Jennifer Fels**<br>Jennifer.fels@svhealthcare.org | Bennington Regional Clinical Performance Committee | ☑ | ☑ | • New for 2016: Accountable Community for Health<br>• Medication reconciliation<br>• Transitional Care<br>• ED Utilization<br>• 30 day all cause readmissions<br>• CHF<br>• COPD<br>• ADRC (Aging and Disability Resource Connection, a partnership of Council on Aging, BP, SVMC, VCIL and Brain Injury Association for options counseling and a shared care plan) | • Community Care Team (Community Services/Agencies meet to address the needs of patients with high ED Utilization)<br>• April Retreat of RCPC and Community Partners re: Accountable Community for Health | BP, OCV, SNF, HHA, DA, private practices, SVMC, HF (pending) & OCV, SASH, Council on Aging, VDH, AHS, Bennington Free Clinic |
| **Central Vermont**<br>**Contact: Mark Young**<br>mark.young@cvmc.org | Community Alliance for HealthExcellence (CAHE) | ☑ | ☑ | Use of decision matrix tool to arrive at:<br>• Care Coordination<br>• CHF<br>• Adverse Childhood Events- maybe in relation to ED visits<br>• SBIRT | IC Care Coordination Learning Collaborative | CVMC, CVHH, WCMH, VDH, SNF, community transport, BP, OCV CHAC, housing, AAA, Substance abuse treatment agency, Family Center |
| **Brattleboro**<br>**Contact: Wendy Conwell**<br>**wcornwell@bmhvt.org** | Integrated Communities Care Management Collaborative<br><br>End of Life Care Project Group | ☑ | ☑ | • Reduce emergency room use and improve quality of life for people who experience symptom of a mental health and/or substance abuse disorder<br>• Hospice utilization and improve quality of life for hospice patients<br>• Considering a third RCPC based on | Integrated Communities Care Management Learning Collaborative<br><br>Hospice RCPC<br><br>RCPC Leadership Group | BMH, BP, HHA, SNF, DA, OCV, VNAs, Brattleboro Retreat, PCPs, VDH, CHT, ED, SASH, Housing Authority, HCRS, Senior Solutions, |

## Regional Committees/Areas of Quality Improvement Work 01/2016

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|---|---|---|---|---|---|---|
| | RCPC Leadership Group<br><br>Note: ACO Steering Committee oversees RCPC | | | findings of 2015 Community Health Needs Assessment | | BMH Care Coordinator, GroundWorks, Turning Point, Brattleboro Hospice, Oncology |
| **Burlington**<br><br>**Contact: Dr. Claudia Berger**<br>**Claudia.berger@uvmhealth.org** | Chittenden County Regional Clinical Performance Committee | ☑ | Under discussion | • Improving care coordination learning collaborative<br>• Reduction in ED utilization<br>• Increase in hospice utilization | IC Care Coordination Learning Collaborative | UVM MC, CHCB, HHA, DA, housing, DAIL, VDH, QIO, VCCI, SNF, SASH, pediatrician, CVAA, Planned Parenthood, CHAC, HF & OCV |
| **Middlebury**<br>**Contact: Susan Bruce**<br>**sbruce@portermedical.org** | Community Health Action Team (CHAT) | ☑ | | • Improving care coordination for high risk patients<br>• Opioid use management?<br>• ED Utilization | IC Care Coordination Learning Collaborative | Porter, BP, HHA, DA, PCPs, VCCI, AAA, transportation, VDH, PPNE, SASH, Elder Services, Turning Point, United Way, FQHC, Parent Child Center<br><br>CHAC, HF and OCV |
| **Morrisville**<br>**Contacts: Corey Perpall**<br>**cperpall@chslv.org**<br><br>**Adrienne Pahl**<br>apahl@chslv.org | UCC | ☑ | | • 30 day all-cause readmissions/medication reconciliation<br>• Care coordination for people who have high levels of risk<br>• ED utilization | IC Care Coordination Learning Collaborative | Copley, BP, DA, SNF , Health First, Private practices, Home Health<br><br>CHAC & OCV |

## Regional Committees/Areas of Quality Improvement Work 01/2016

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|---|---|---|---|---|---|---|
| | | | | • Developmental screening | | |
| **Newport**<br>**Contact: Julie Riffon**<br>**jriffon@nchsi.org** | UCC/RCPC | ✓ | ✓ | • ED utilization<br>• Obesity<br>• Increased hospice utilization and length of stay<br>• CHF/COPD | IC Care Coordination Learning Collaborative | North Country Hospital ,BP, HHA, VCCI, DA CHAC & OCV, VDH, AHS,AAA, Local housing Authority/SASH |
| **Randolph**<br>**Contact: Jennifer Wallace**<br>jwallace@GiffordMed.org | Randolph Executive Community Council | ✓ | | • Enhancing care coordination and shared care planning | IC Care Coordination Learning Collaborative | OCV, CHAC, VNA, Home Health, DA, SASH/Housing, transporation, SNF, Food bank, BP, AAA |
| **Rutland**<br>**Contacts: Darren Childs, Rick Hildebrandt**<br>dchilds@rrmc.org<br>rhildebrandt@rrmc.org | RCPC | ✓ | | • COPD- ways to rank /stratify<br>• CHF<br>• Transition of care<br>• Palliative care- increase in referrals<br>• EMR Order set<br>• Patient Education | Supportive Services VHCIP grant<br><br>New transitions of care staff | RRMC (Respiratory, PI, CHT, Heart Center, Cancer Center, Case Management, Hospitalist, pharmacy) SNF, , CHCRR, MVHW, HHA, DA CHAC, HF and OCV |
| **Springfield**<br>**Contact: Maureen Shattuck**<br>**mshattuck@springfieldmed.org**<br><br>**Trevor Hanbridge**<br>**thanbridge@pringfieldme.org** | Springfield Unified Community Collaborative | ✓ | SMCS Panel Reports created; further extraction ongoing. CMLC participants identifying 5 people served | • Care Management Learning Collaborative: adults with 5+ ED visits/12 months with MH dx and 3+ chronic health conditions | IC Care Coordination Learning Collaborative | HHA, Every practice in the Springfield (SMCS) health system, BP, CHAC, OCV, Adult day, 211, SNF, DCF, VHC, AAA, |

## Regional Committees/Areas of Quality Improvement Work 01/2016

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|---|---|---|---|---|---|---|
| | | | by each participating organization for participation in CMLC. | | | housing/SASH, VDH, SEVCA, DA |
| **St. Albans**<br>**Diane Leach**<br>**Contact:** dleach@nmcinc.org | RCPC | ☑ | Working on it | • CHF admissions<br>• ED utilization<br>• 30 day all-cause readmissions<br>• Hospice utilization | IC Care Coordination Learning Collaborative<br>Primary Care Learning Collaborative | NWMC, VDH, Franklin County Rehab, DA, HHA, BP, HF, FQHC, CHAC & OCV |
| **St. Johnsbury**<br><br>**Contact: Laural Ruggles**<br>**L.Ruggles@nvrh.org** | Cal-Essex Accountable Health Community | ☑ | ☑ | • Improving care coordination learning collaborative<br>• Reduction in all cause readmissions<br>• Increase hospice utilization<br>• Food insecurity<br>• Housing<br>• Focus on COPD and Vulnerable Families and Children | IC Care Coordination Learning Collaborative<br>Collective Impact | NVRH, NCHC, VDH, community action, DA, AAA, HHA, FQHC, Housing organization, food security organization, BP, CHAC & OCV |
| **Townshend**<br>**Contact: Danny Ballantine**<br>**dballantine@gracecottage.org** | RCPC | ☑ | | • Decrease ED utilization (looking at those who use > 4x/year)<br>• CHF – use of Brattleboro clinic | | Grace Cottage, BP, SASH, VCCI, VDH, CHAC & OCV |
| **Windsor**<br>**Contact: Jill Lord**<br>Jill.m.lord@mahhc.org | Windsor HSA Coordinated Care Committee | ☑ | | • Decrease ED utilization- use of survey tool for high utilizers as well as those with COPD who use ED<br>• Opioid use management<br>• COPD<br>• Shared Care Plan | IC Care Coordination Learning Collaborative | Mt. Ascutney, OCV, BP, HHA, DA, SASH, AAA, SNF, VDH, Homeless, CMS/Qualidigm, Southern VT. Health Education Center, White River Family Practice, VPQHC, VCCI |

## Regional Committees/Areas of Quality Improvement Work 01/2016

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|---|---|---|---|---|---|---|
| **Upper Valley** **see note below**<br>**Contact: Donna Ransmeier**<br>**dransmeier@littlerivers.org**<br>HealthFirst: White River service area<br>BP: White River = Windsor & Bradford meeting<br>CHAC = Upper Valley (Bradford meeting)<br>OCV: Lebanon and<br>White River = Randolph | UCC/RCPC | ☑ | ☑ | • Follow-up for patients with ER/hospitalization for a mental health reason within 7 days of d/c<br>• COPD<br>• CHF<br>• Chronic Pain and Opioid Use Mgmt | VCHIP & CHAMP Collaboratives:<br>• Children With Special Health Needs<br>• Asthma<br>Adolescent Well Care Visits | CHAC, DA, HHA, Pediatric Services, Dartmouth Hitchcock, VNA, BP, substance abuse treatment, VDH |

*Updated 01/14/2016

CHAC = Community Health Accountable Care
HF= Health First
OCV = OneCare Vermont
BP= Vermont Blueprint for Health
SNF= Skilled Nursing Facility
HHA= Home Health Agency
DA= Designated Mental Health Agency
VDH = Vermont Department of Health
AAA = Area Agency on Aging

** Note high of projects around palliative care/hospice
*** Potential areas of sharing: Decision Matrix (Berlin)
ACE work (Berlin)
Strategies for sharing of clients
ED surveys (Windsor)

1. This catchment area is not uniform in representation from various organizations. For OCV this area is identified as Lebanon because the DHMC providers have attribution for Medicaid and Commercial programs. CHAC refers to it as the upper valley and is starting a community meeting in Bradford and the BluePrint puts this area into Windsor. We will continue to work on the commonalities of this service area to assure representation and identification of needs.