VT Health Care Innovation Project
Practice Transformation Work Group Meeting Agenda

March 8th, 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** Deborah Lisi-Baker and Laural Ruggles	**Attachment 1:** February meeting minutes	Yes (approval of minutes)
2	10:10 – 10:50	**Regional Blueprint/ACO Committee Presentation #1: Windsor Integrated Communities Care Management Learning Collaborative Team** Jill Lord, RN, MS, Director of Community Health Services, Project Manager Blueprint for Health Nancy McCullough, RN, MS, CDE, Care Coordinator Mt. Ascutney Physicians Practice	**Attachment 2:** Windsor Integrated Communities Care Management Learning Collaborative Team Presentation	
3	10:50 – 11:30	**Regional Blueprint/ACO Committee Presentation #2: Morrisville HSA Medication Reconciliation Initiative** Elise McKenna, Blueprint Project Manager, Morrisville HSA Corey Perpall, CHSLV QI Director/CHT Lead	**Attachment 3:** Morrisville HSA Medication Reconciliation Initiative Presentation	
4	11:30 - 11:50	**Updates:** • Integrated Communities Care Management Learning Collaborative • Core Competency Training Erin Flynn and Pat Jones	**Attachment 4:** Vermont Health Care Innovation Project Core Competency Training Series, 2016 Schedule of Training Events	
5	11:50 – 12:00	Wrap-Up and Next Steps; Plans for Next Meeting		

Attachment 1: February meeting minutes

Vermont Health Care Innovation Project
Practice Transformation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: February 2, 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 **Approval of minutes**	Deborah Lisi-Baker opened the meeting at 10:05. 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; Laural Ruggles seconded the motion. The minutes were approved with 3 abstentions: Trinka Kerr, Jackie Majoros and Deborah Lisi-Baker.	
2. Tools Enabling Information Sharing for Integrated Care Teams (Continuation from January Work Group Meeting) **Gabe Epstein – DAIL**	**Information Sharing for Integrated Care Teams** Gabe Epstein continued his presentation from the January work group meeting on consent and best practices in sharing information across integrated care teams. The presentation can be found in the meeting materials packet. The group discussed the following: The draft consent templates included in Gabe's materials are intended to be easy to read and understand, while addressing the person's consent to share their information across an integrated team. These draft forms will be shared with the teams that are participating in the Integrated Communities Care Management Learning Collaborative, and a webinar on this topic will be offered to learning collaborative participants in February. Dion LaShay asked a question – is it possible to present the consent form to individuals as a separate document, rather than in a 'pile of papers' in order to allow an individual time to read and understand the document. Gabe indicated that an ideal situation would be for a provider have a conversation with the recipient of care, and answer any questions they may have. Dion clarified that a patient could also bring the form with them to ask for	

Agenda Item	Discussion	Next Steps
	help in understanding it and also noted that the absence of a form would not prevent someone from receiving services. Gabe reviewed his recommendations for sharing information: • Be careful with information received from other providers • Keep information secure, even if you are regulated by HIPAA • Only use the information in the Care Team setting • Use caution when working with people outside the care team so as not to disclose 42 CFR Part II, FERPA or Mental Health information. Jackie Majoros noted that in her observation of teams working on care coordination, there is frequently information that comes to the team from someone outside the team (e.g. a discharge nurse may share information about a hospital stay to members of a care team without the knowledge of the recipient of care). Gabe noted that one option could be to develop two different release forms to cover sharing of information both in the care team setting, as well as outside of the team setting. Laural Ruggles added that it is critical to have agreement on consent policies across an integrated care team in order to allow teams to work together as efficiently as possible in coordinating an individual's care. Comments, thoughts and feedback are welcome – please contact Sue Aranoff (susan.aranoff@vermont.gov) or Gabe (David.epstein@vermont.gov) with your thoughts.	
3. Core Competency Training for Front Line Staff Providing Care Coordination **Erin Flynn - DVHA**	**Core Competency Training Update** Early in the Integrated Communities Care Management Learning Collaborative (ICCMLC) initiative, a need was expressed for training in both care coordination core competencies as well as focused training around DLTSS core competency training. Input was sought and received from a variety of stakeholder groups. Following an RFP process, the apparent-awardees, Primary Care Development Corporation (PCDC) and the VT Developmental Disabilities Council are in contract negotiations with the state to be the vendors to deliver core competency training. • There will be a core curriculum of 6 full days of introductory care coordination and disability trainings, to be offered between March and December 2016 for up to 180 participants. These trainings will be offered in three locations across the state (North, Central and South). Additional supplemental trainings will be offered to 40 participants in one central location. The full training curriculum includes 28 separate	

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	training events as follows: 6 full days of introductory care coordination and disability trainings2 days of advanced care coordination training • 2 days of managers/supervisor trainings • 2 days of train the trainer training • • 5 webinars In response to a question presented on this topic at the last meeting, Pat Jones noted that managers and supervisors are encouraged to attend all of the sessions to ensure that they're fully aware of the training that their staff may be receiving. PPat also made a request that if work group members have suggestions on staff who would benefit from the training, that they share this information with them. Lily Sojourner asked if the attendance is limited to those participating in the ICCMLC. Erin Flynn responded that it is not, and encouraged Lily to share the training information with any participants who might benefit. Please see the S**chedule of Trainings** at the end of these minutes for more details. Sam Liss asked whether the trainings will include focus on social determinants of health. Erin Flynn responded that addressing social determinants of health is an overarching theme woven throughout the training curriculum. A question was asked about how this project overlaps with other care delivery transformation activities underway in communities across the state. Georgia Maheras and Jenney Samuelson offered an overview of some key care delivery transformation activities as follows: • **Integrated Communities Care Management Learning Collaborative**: 11 communities are participating in the ICCMLC state-wide. This project is focused on creating protocols and processes to support care coordination for complex individuals across an integrated care team. In many communities, this learning collaborative has been adopted as a working group and quality improvement initiative under the UCC/RCPC regional collaboration teams. • **Regional collaborations (a.k.a RCPC/UCC): These are regional governance committees that bring together key leaders in a community to set quality improvement priorities, and work towards improving the health of the entire population.** • **Core Competency Training**: The core competency training outlined above is intended to build key skills and competencies in coordinating care across an integrated care team, as well as working with individuals with disabilities amongst the front line staff performing care coordination functions for individuals in their community. – These are very specific trainings for care management and DLTSS core competency (skills trainings).	

Agenda Item	Discussion	Next Steps
	• **ACOs** – The three Vermont ACOs are also conducting other activities related to quality improvement for their beneficiaries. • **Other Groups** – The VHCIP has the Provider Sub-grant program, with sub-grantees such as RiseVT, focusing on wellness. • **Accountable Communities for Health Learning Lab** – This is intended to be a learning lab. To get beyond the four walls of practice transformation and get at the community health factors (it is also another opportunity for regional teams to get technical assistance and support) Jenney added that many of the communities involved in the regional groups may be interested in participating in the ACH peer learning lab.	
4. Updated Report: Care Management in Vermont – Gaps and Opportunities for Coordination **Pat Jones – GMCB**	**Care Management in Vermont: Gaps and Duplications** • Pat Jones provided some background on the report. In 2014, the former Care Models and Care Management Work Group contracted with Bailit Health Purchasing to conduct a Care Management Inventory Survey In an effort to better understand the care management/care coordination workforce infrastructure in Vermont. The group then took the report a step further and incorporated presentations made by many organizations who presented at the CMCM work group. After incorporating many comments and feedback received from work group members, the report is considered final, and is posted on the VHCIP website. Specific comments and feedback include: A methods and Limitations sections were added • A table in the first draft was removed • A summary of the DLTSS model of care was added	
5. Regional Blueprint/ACO Committees Progress Report	**Regional Blueprint/ACO Committees Progress Report** Jenney Samuelson – DVHA – Blueprint Maura Crandall – OneCare Vermont Jenney noted that we've seen the table before, and that we are continuing to see communities move forward with their projects under their priority areas and that consumers are being added to the groups. Maura Crandall from OneCare Vermont agreed with Jenney and noted that Quality Improvement initiatives are underway state-wide, and that she has seen communities embrace the work of the ICCMLC as well as other quality improvement initiatives.: She also noted that the OCV Clinical Advisory Board asks for participants to present on their quality improvement activities every other month.	

Agenda Item	Discussion	Next Steps
	Sue Aranoff asked whether these groups are talking about individual patients when they meet. The response was that different groups talk about different topics on different days. Jenney opined that when the RCPC leadership group gets together, they are more focused on looking at measures and higher level quality goals. Laural Ruggles also added that the reason why some groups don't welcome additional participants is so that they they cando their work and discuss individuals and their health care needs in a protected setting.	
6. Integrated Communities Care Management Learning Collaborative: **Summary of January Webinar**	**Integrated Communities Care Management Learning Collaborative Update** **January Webinar** Pat Jones provided a brief Learning Collaborative Update: The program began with 3 pilot communities and expanded last fall to 11 of the VT state health service areas. 4 in person learning sessions were held throughout 2015; work continued via the webinars which included the second cohort as well. The 3 pilot communities are also serving as mentors to the 8 new communities. In September 2015 new cohorts were added – they have attended 2 in-person sessions and 2 webinars thus far. Pat provided an example from the field as follows: Middlebury is working on person engagement/Camden cards; they are also using Eco-mapping to identify who should be part of an individual's care team. The AHS Integrated Family Services initiative (IFS) is up and running in Addison County so there is an alignment of tools and approaches. Randolph is working to establish team roles; Windsor has had 5 local in-service events to use the tools that have been part of the learning collaboratives (Camden cards and eco-mapping.) An in-person session is also scheduled in March with expert faculty Jeanne McAllister andDr. Jill Rinehart who will talk about shared care plans and care conferencing. All the communities are in different places but the level of engagement is very high. Pat suggested that we might invite a community to present on their PDSA's at next month's meeting. A question was posed about how the Learning Collaborative and the Core Competency training inter-relate: The Learning Collaborative initiative can be viewed as a project where we kicked off improvement of care coordination across organizations – aka Phase 1. The Core Competency training series can be viewed as Phase 2 of the same project; intending to support people doing this work. Additional phases are underway (for example the development of electronic shared care plans). This work is about support the needs of the communities at the right time, and there are many building blocks to achieving our goals. There are topic areas that overlap, such as how to engage people in their own care? The Learning Collaboratives has assisted in bringing best practices (Camden Cards and eco-mapping) into the work. As	

Agenda Item	Discussion	Next Steps
	the VHCIP staff work with the apparent core competency vendors to negotiate the contracts, they are sharing these tools so that they can reference them as part of the trainings.	
8. Next Steps	The next meeting is Tuesday, March 8, 2016, from 10:00 am – 12:00 pm Red Oak Conference Room, 280 State Drive, Waterbury This is in the new State Office Complex (New Building - the meeting space is located on the 2nd floor above the main entrance) Call-In Number: 1-877-273-4202 Conference ID: 2252454	

SCHEDULE OF CORE COMPETENCY TRAININGS

January – June 2016	Jan	Feb	March	Apr	May	June
Event	Curriculum development Two two-hour remote planning meetings Bi-weekly Check-in phone meeting(s)	Curriculum development Bi-Weekly Check-in phone meeting(s)	3 sessions of Introductory Care Coordination training, Day 1 Curriculum development Check-in phone meeting(s) as needed	3 sessions of Disability Competency Training Day 1. Covers Module 1: Introduction, Module 2: Disability and Wellness, Module 3: Universal Design and Accessibility, Module 4: Communication and interaction Webinar Curriculum development Check-in phone meeting(s) as needed	3 sessions of Introductory Care Coordination training, Day 2 Curriculum development Check-in phone meeting(s) as needed	3 sessions of Disability Competency Training Day 2. Covers Module 5: Tools to Improve Communication, Module 6: Person-Centered Care and Person-Directed Planning, Module 7: Transition from Pediatric to Adult Care, Module 8: Cultural Competency Webinar Curriculum development Check-in phone meeting(s) as needed

July – December 2016	July	August	September	October	November	December
Event	3 sessions of Introductory Care Coordination training, day 3 Curriculum development Check-in phone meeting(s) as needed	Webinar Check-in phone meeting(s) as needed	Advanced Care Coordination Training (2 consecutive days) 3 sessions of Disability Competency Training Day 3. Covers Module 9: Sexuality and Reproductive Health, Module 10: Adverse Childhood Events, A Strength-Based Approach, Module 11: Facilitating Inclusive and Accessible Trainings Check-in phone meeting(s) as needed	Care Coordination for Managers and Supervisors Training Webinar Check-in phone meeting(s) as needed	Train-the-Trainer training (2 consecutive days) Check-in phone meeting(s) as needed	Webinar Evaluation Check-in phone meeting(s) as needed

VHCIP Practice Transformation Work Group Member List

Motion by exception Sue A. 1° Laura I R 2° 3 abstentions

2-Feb-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
		Michael	Counter		VNA & Hospice of VT & NH
Kathy	Brown	Todd	Bauman		DA - Northwest Counseling and Support Services
		Stephen	Broer		DA - Northwest Counseling and Support Services
Barbara	Cimaglio				AHS - VDH
Molly	Dugan ✓	Stefani	Hartsfield		Cathedral Square and SASH Program
		Kim	Fitzgerald		Cathedral Square and SASH Program
Eileen	Girling	Heather	Bollman		AHS - DVHA
		Jenney	Samuelson ✓		AHS - DVHA - Blueprint
Maura	Graff ✓				Planned Parenthood of Northern New England
Bea	Grause				Vermont Association of Hospital and Health Systems
Dale	Hackett ✓				Consumer Representative
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	A	VLA/Health Care Advocate Project
Jackie	Majoros ✓	Barbara	Prine	A	VLA/LTC Ombudsman Project
Dion	LaShay ✓				Consumer Representative
Patricia	Launer	Kendall	West ✓		Bi-State Primary Care
Sam	Liss ✓				Statewide Independent Living Council

VHCIP Practice Transformation Work Group Member List

Member		Member Alternate			2-Feb-16
First Name	Last Name	First Name	Last Name	Minutes	Organization
Vicki	Loner	Emily	Bartling		OneCare Vermont
		Maura	Crandall ✓		OneCare Vermont
Kate	McIntosh	Judith	Franz		Vermont Information Technology Leaders
Bonnie	McKellar	Mark	Burke ✓		Brattleboro Memorial Hopsital
Madeleine	Mongan	Stephanie	Winters		Vermont Medical Society
Julie	Tessler				VCP - Vermont Council of Developmental and Mental Health Services
		Mary	Moulton		VCP - Washington County Mental Health Services Inc.
		Catherine	Simonson		VCP - HowardCenter for Mental Health
		Stephen	Broer		VCP - Northwest Counseling and Support Services
Sarah	Narkewicz				Rutland Regional Medical Center
Laural	Ruggles ✓				Northeastern Vermont Regional Hospital
Patricia	Singer ✓	Jaskanwar	Batra		AHS - DMH
		Mourning	Fox		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
Angela	Smith-Dieng ✓	Mike	Hall		V4A
Lily	Sojourner ✓	Shawn	Skafelstad		AHS - Central Office
		Kirsten	Murphy		AHS - Central Office - DDC
		Julie	Wasserman ✓		AHS - Central Office
Audrey-Ann	Spence	Teresa	Voci		Blue Cross Blue Shield of Vermont
JoEllen	Tarallo-Falk				Center for Health and Learning
Lisa	Viles				Area Agency on Aging for Northeastern Vermont
Kirsten	Murphy				VT Developmental Disabilities Council
Deb	Lisi-Baker			A	

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VHCIP Practice Transformation Work Group

Attendance Sheet

2-Feb-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

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

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
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Holly Stone

Attachment 2: Windsor Integrated Communities Care Management Learning Collaborative Team Presentation

MT. ASCUTNEY HOSPITAL AND HEALTH CENTER
A Dartmouth-Hitchcock Affiliate

WINNER OF THE Foster G. McGaw Prize for community service
A prestigious honor in healthcare

Vermont Health Care Innovation

March 8, 2016

Jill Lord, RN, MS, Director of Community Health Services, Project Manager Blueprint for Health
Nancy McCullough, RN, MS, CDE – Care Coordinator Mt. Ascutney Physicians Practice

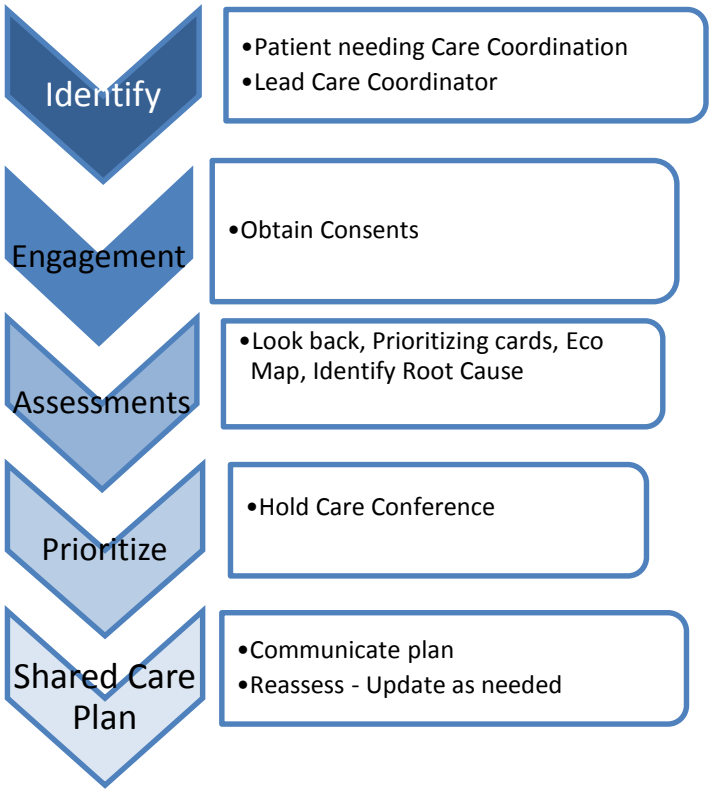
The Birthplace of Vermont

WINDSOR

Community Health Team in Windsor

A Process

Care coordination activities promote a holistic and patient centered approach to ensure that a patient's needs and goals are understood and shared among providers, patients and families to improve quality of care, patient care experience and patient engagement in care plan/treatment plan goals as a patient interacts with health providers and settings.



Our Process

- Analysis of top 5% risk patients from Beneficiary Detail Report (hierarchical chronic conditions, gender and cost/healthcare utilization)
  - Identified patients currently cared for by CHT
  - Follow-up done for patients not currently served by CHT
  - Selection of patients for interagency care planning

Our Process

- Attended Integrated Care Management Collaborative to learn best practice tools
- Provided five local in-services on use of best practice tools for community partners
- Obtained many copies of Camden cards to distribute to partners
- Invited partners to “play” with the tools as part of their practice
- Trialed an initial six patients with use of the entire process

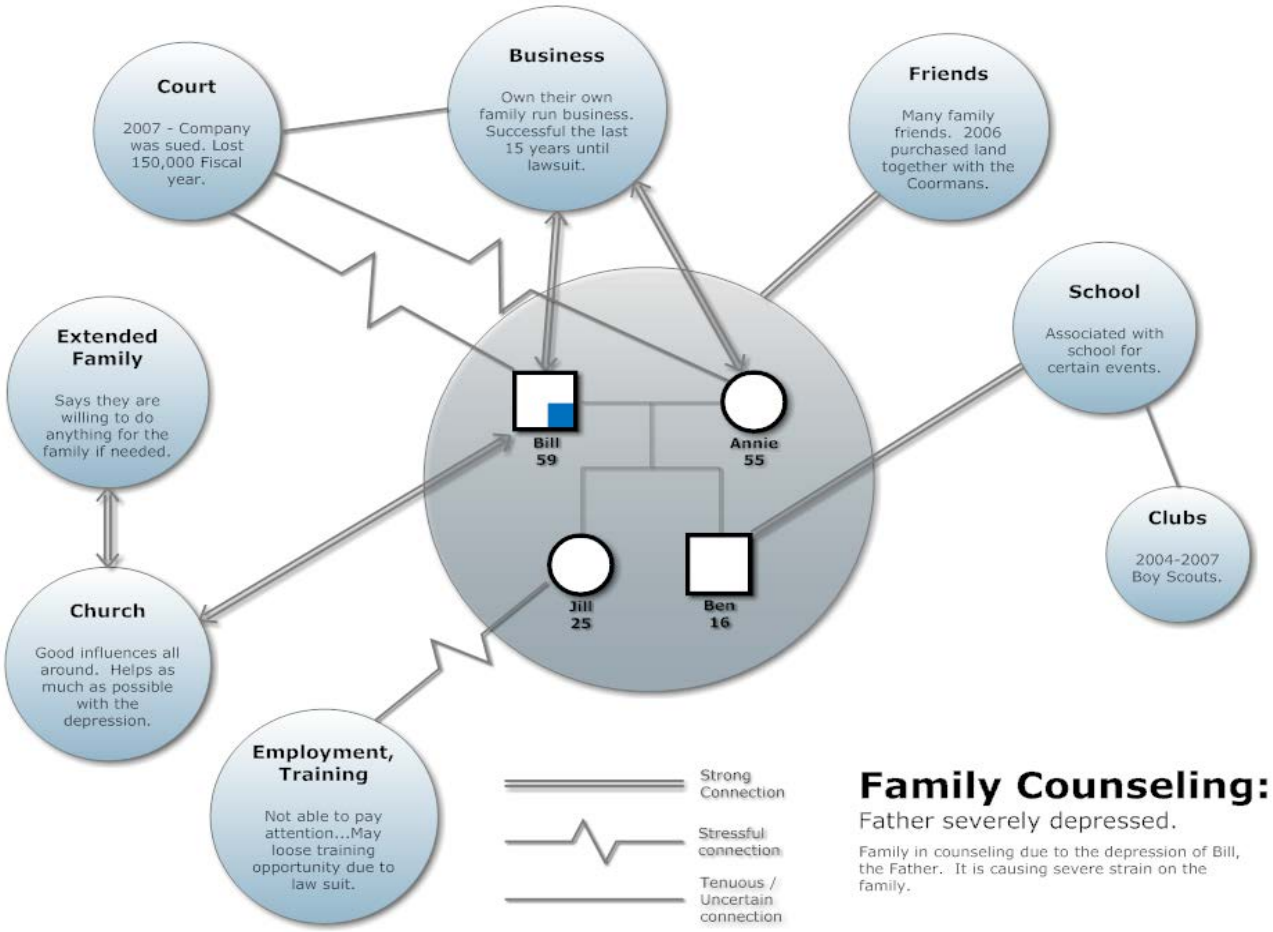
Interdisciplinary Team Assignments

- Team reviews all patients and Lead Care Coordinator chosen for each patient
- Lead Care Coordinator speaks with patient to discuss program and get consent

Individual Care Plan

- Needs Based
- Person Centered – Use of Eco Maps and Camden Cards
- Informed Choices
- Agreed outcomes and goal setting should be the result in an individualized Care Plan
- Copy of care plan given to patient and all community partners involved in the Action Plan

Eco Map



Family Counseling:

Father severely depressed.

Family in counseling due to the depression of Bill, the Father. It is causing severe strain on the family.

Prioritizing Cards

Family Relationships

Health Insurance

Housing

Food & Nutrition

	Urgent	Non-Urgent
Really Important To Me	Need to work on right now	
Somewhat Important To Me		

Safety

Budgeting/Finances

Transportation

Drugs or Alcohol

Utilities

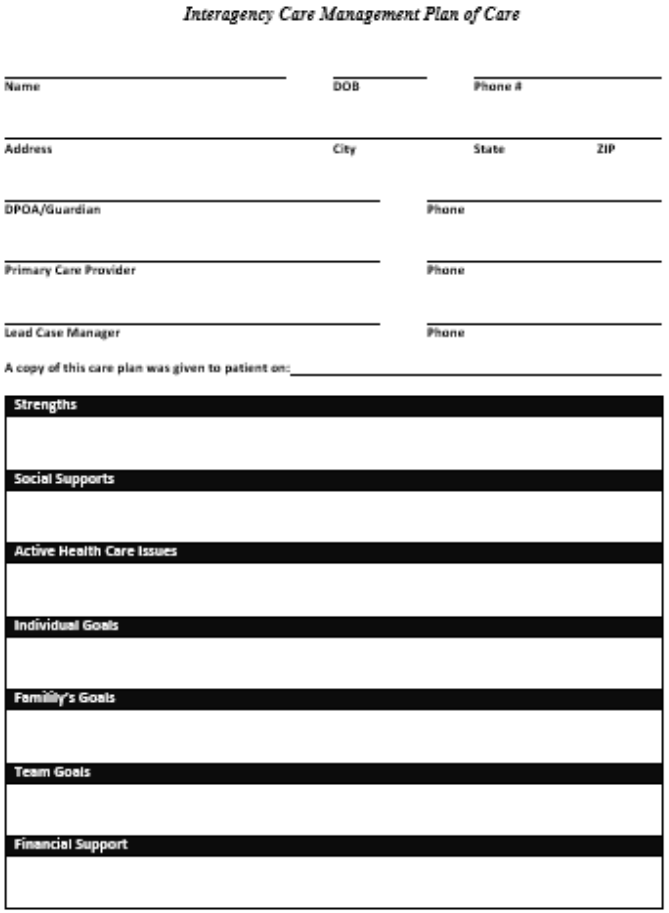
Education & Jobs

Work with Health Care Team

Mental Health

Shared Care Plan
Interagency Care Plan

- Strengths and Social Support
- Active Health Care Issues
- Individual/Family Goals
- Team Goals
- Financial/ Insurance
- Inventory of Resources and Supports for Self–Management
- Action Plan



Interagency Care Management Plan of Care

Name _____ DOB _____ Phone # _____

Address _____ City _____ State _____ ZIP _____

DPOA/Guardian _____ Phone _____

Primary Care Provider _____ Phone _____

Lead Case Manager _____ Phone _____

A copy of this care plan was given to patient on: _____

Strengths

Social Supports

Active Health Care Issues

Individual Goals

Family's Goals

Team Goals

Financial Support

Lessons Learned

Richness of the Tools

- Eco Maps
  - Patients revealed, without hesitation, the supports they had that may not ever been mentioned prior to using Eco Maps
  - Patients were able to easily sort out and recognize what they needed to work on first, and what could wait until later
- Camden Cards
  - Assisted the patient to focus on what is important and engages the patient/family in an action plan
  - Assisted the care coordinator to match programs with community partners and services with patient/family needs

Richness of the Process

- Formal involvement with other agencies increased trust with families
- Interagency involvement added insight and information for more comprehensive and successful care plan
- Communication was improved
- Patients were viewed as the experts and central to decision making, i.e., shift in focus to patient-centered approach

Case Study #1

66 yr. old female retired factory worker who lives alone in a mobile home in rural Vermont. Active health issues include Chronic Depression, Diabetes T2 poorly controlled, Morbid Obesity, PTSD, OB, PCOS, and Arthritis right knee. Patient walks with 2 canes.

Services included:

- ✓ Care coordinator/CDE did home visits weekly for several weeks, training patient to participate in her own self care management.
- ✓ VNA, PT, HHA in home to oversee education on DM, self management, wound care, and help with personal care.
- ✓ SASH was involved for financial support assistance, and wellness nurse for self management support.
- ✓ Ottauquechee Health Foundation and Stagecoach provided grants to support her transportation challenges.
- ✓ Home Behavioral Health and Eldercare visits and psychiatric medication intervention
- ✓ Aging in Hartland assisted pt. with prescription pick up, getting her groceries and light house cleaning.

Case Study #1 (Continued)

Challenges:

- ✓ Negative attitude and skepticism re: options of care for pain control and depression.
- ✓ Patient's weight - 380# and she does not fit into a regular sized car – refuses to wear a seat belt.
- ✓ Dismissed the importance of portion control and SMBG.

Outcome:

- ✓ A1c dropped from 8.9% to 7% with no insulin changes from initial dosing and subtle diet modification. Checks fs 2x daily.
- ✓ Wounds have healed. Patient reports less hopelessness, daily “crying jags,” and improved pain control.

Case Study #2

59 yr. old single illiterate male who owns his own junkyard with an old mobile home in the midst of the property. Fifteen cats live with him. Primary health issues include poorly controlled Type 2 DM, right foot ulceration, s/p skin grafting right foot with 30 days inpatient stay for antibiotics 12/15. Labeled a “noncompliant” patient.

Services included:

- ✓ Bayada RN - homecare with every other day dressing change.
- ✓ CHT Care Coordinator/CDE facilitated the coordination of care between all disciplines and made weekly home visits.
- ✓ VCCI assisted with getting patient a stove, microwave and refrigerator, vacuum through a grant from Senior Solutions.
- ✓ VCCI assisted with application for Moderate Needs assist.
- ✓ VCCI assisted in collaboration with COVER to replace pt.’s windows and possible replacement of toilet.
- ✓ SEVCA assisted pt. with additional funding for fuel and furnace repair when his burner failed on 2 occasions.
- ✓ VCIL through Volunteers in Action are providing MOW and he now has a freezer to store frozen meals. Patient’s Surgeon and Podiatrist see patient weekly and include care coordinator in the updates of patient’s healing.

Case Study #2 (Continued)

Challenges:

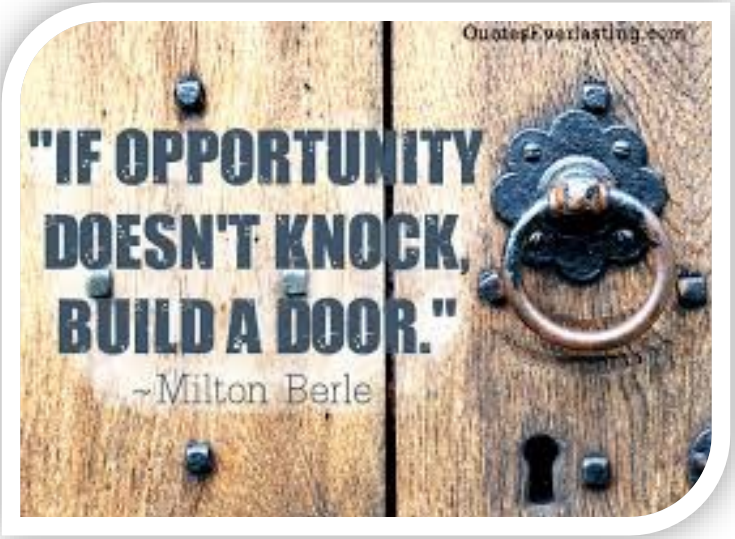
- ✓ Home environment was dirty and cat boxes overflowed, and there were inoperable or no appliances for cooking. Patient ate at local store.
- ✓ Patient adamantly refused to go back to the hospital for antibiotics when his wound was assessed as not healing. It was imperative to create a cleaner setting at home for healing.
- ✓ Patient's anxiety escalated when he was advised to stay off foot and not drive. This compromised his driving to local store, laundromat, getting cat food and soup, and working transporting metal earning cash to cover monthly expenses.

Case Study #2 (Continued)

Outcomes:

- ✓ Patients wound is healing and donor sites are healed!!!
- ✓ Blood sugars are running near target level 70-130.
- ✓ A1c lowered 4 % from 11.1%-> 7.1%.
- ✓ Lantus insulin dosing has been lowered from 65 units to 50 units due to hypoglycemia!
- ✓ Patient has made strides to keep his house cleaner with his friend's help; cat boxes now covered, and cleaned regularly.
- ✓ Patient's meal plan has improved despite a stretched food budget and he has a balanced meal daily.
- ✓ Patient is participating in his own plan of care coordinated by several community partners who communicate weekly on his progress. With a friends help he makes it to ALL of his appointments and calls all of us regularly! He is now activated and an engaged patient!

Opportunities



Opportunities

- There is an opportunity to measure the impact of interagency care management through comparison of the ranking of risk and healthcare costs/ utilization at baseline and after the interventions of the interagency care management team.
- Experience gained through study and lessons learned will be used to evolve ongoing interagency care management system development and individual care.
- Critical team members participate from the continuum of care—free clinic, inpatient, Senior Solutions, Home Health, HCRS, VCCI, SASH, SEVCA.
- Found new funding sources when working together.

Opportunities (Continued)

- Recognition that changes do not occur overnight, they come in small steps and should be celebrated.
- Listen, listen, listen and hear what's important in a patient-centered approach.
- Patients are able to accomplish realistic goals when they have an active role in the plan.
- It may take more than one patient encounter to use the tools and build and document the action plan in the EMR.

Attachment 3: Morrisville HSA Medication Reconciliation Initiative Presentation

Medication Reconciliation

A Morrisville HSA Initiative

Presented by Elise McKenna Blueprint Project Manager, Morrisville HSA
and Corey Perpall, CHSLV QI Director/CHT Lead

March 8, 2016

Morrisville HSA Demographics

- Encompasses all of Lamoille County and surrounding towns in region
- Population of Lamoille Valley: 33,000
- Seven medical homes with one soon to be accredited
- **100%** of primary care practices in the HSA are accredited, which is inclusive of FQHCs, independent practices, and pediatrics
- 6.2 FTE Community Health Team Staff (Consisting of Registered Nurses, Registered Dietitian, and Case workers/panel managers)
- 3.6 FTE Spoke Staff
- 1.0 FTE SASH Staff

History of the Medication Reconciliation Initiative

It all started when.....

- Five years ago, the Community Health Team conducted an informal community needs assessment to identify gaps in care.
- One recurring theme from the assessment was the need for medication assistance for older adults.
- A short-lived pilot project was implemented with home health that would send social worker and/or nurse to the home. However, at that time the referral processes were still in development and there was a lack of integration among the community. Thus, the project did not yield any notable results.
- One important piece of our foundation is that Home Health has been an integral partner with the Community Health Team from the very beginning. They have a strong presence within the community.

Alignment of the forces...

After years of discussing the need, there was a perfect storm.

- Having identified the need and evidenced based rationale for medication reconciliation to help reduce hospital readmissions
- Receiving data from hospitals, primary care, and the Accountable Care Organizations
- Creating an infrastructure over the years (i.e. Functional CHT, Care Coordinators in every primary care practice, and the UCC)
- Participating in programs with monetary incentives for improvement for reducing hospital readmissions

It was time to do something.

The new project...

Objective

- All patients 65 and older, or any other patient identified as benefiting from this service, discharged home from an in-patient hospitalization at Copley Hospital that live in Lamoille County, will be offered a home health visit for medication reconciliation.

Process

- Home Health attends discharge planning at the hospital to identify potential patients meeting criteria;
- They obtain patient consent to receive this service;
- Request current list of medication from Primary Care office;
- The Home Health RN reconciles discharge summary medications, medications actually in the home, and current list of medications from primary care;
- RN Communicates medication discrepancies with primary care office

Evaluation

- Monthly data report by Home Health at UCC meeting
- Six month review to determine if any patients that received this service had a 30-day readmission

Data collection

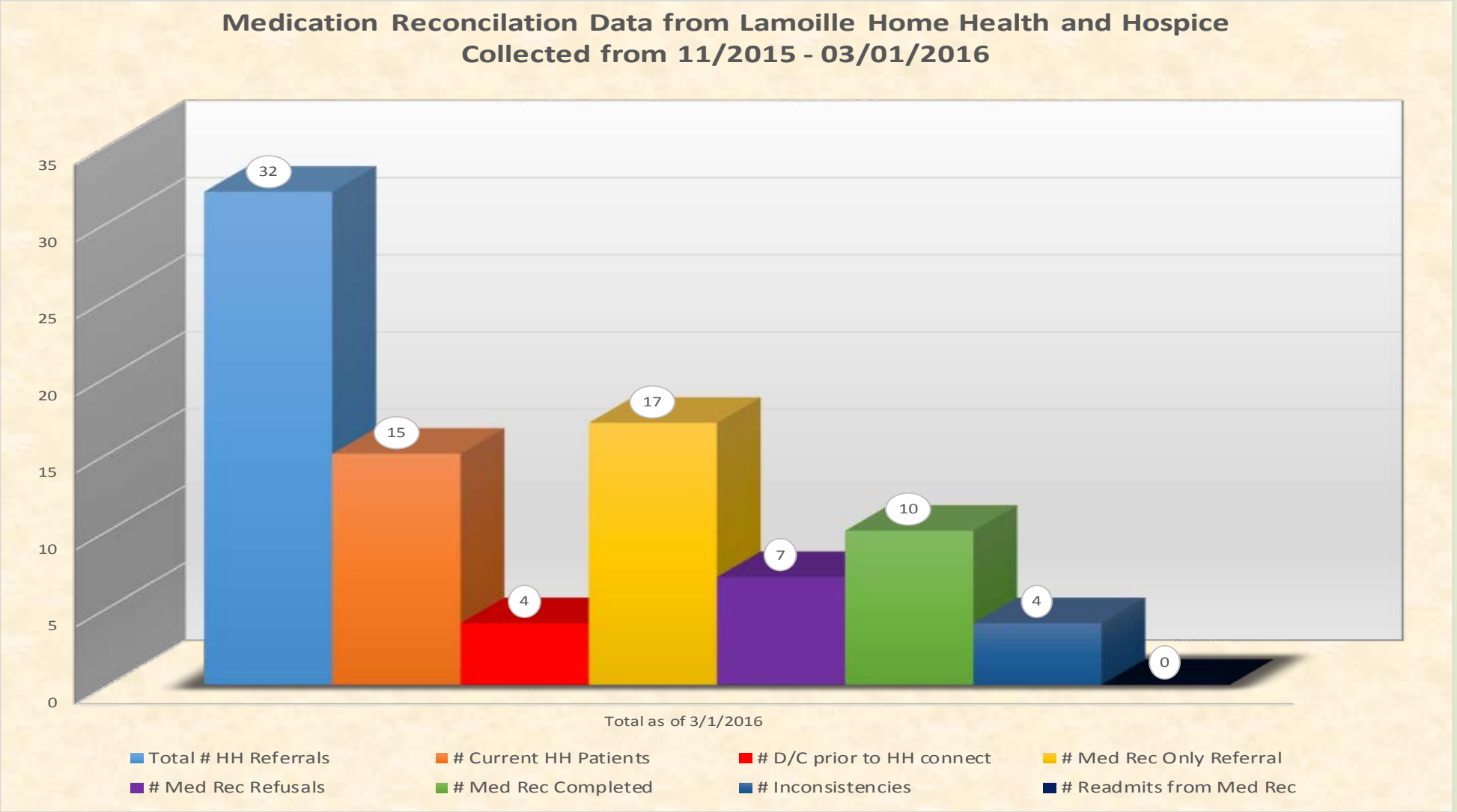
Home Health collects the following data:

- Number of patients discharged from Copley Hospital that meet criteria
- Number of patients refusing the service
- Number of patients already connected to Home Health
- Number medication reconciliations with discrepancies
- Number of patients who receive the medication reconciliation service that are readmitted to the hospital

Funding

- Initial pilot estimated cost was $15,000 for one year
  - Cost based on number of patients discharged from hospital and estimated number of how many patients would be eligible for home health or fit project criteria.
  - CHSLV (Blueprint Grantee) CEO decided to fund this initiative based on evidence that this may lower the hospital readmissions costs.
- This a precursor to an integrated model of sharing resources to fulfill a community health need.

Data


Medication Reconcilation Data from Lamoille Home Health and Hospice
Collected from 11/2015 - 03/01/2016
35
30
25
20
15
10
5
0
32
15
4
17
7
10
4
0
Total as of 3/1/2016
Total # HH Referrals
Current HH Patients
D/C prior to HH connect
Med Rec Only Referral
Med Rec Refusals
Med Rec Completed
Inconsistencies
Readmits from Med Rec

Results

- 58% of patients offered the service have accepted it and have received an in-home medication reconciliation
- Out of those patients, 40% have had inconsistencies in their medication lists which needed to be clarified with the Primary Care Practitioner
- Zero patients who have received this service have been readmitted to Copley Hospital

Questions???

Attachment 4: Vermont Health Care Innovation Project Core Competency Training Series, 2016 Schedule of Training Events

You are invited to participate in a learning opportunity through the Vermont Health Care Innovation Project! Please share with others who might have interest!

CORE COMPETENCY TRAINING SERIES FOR FRONT-LINE CARE COORDINATORS (Day 1 of a 6 day training; see next page for a complete schedule)

Training Site	Date	Registration Link
Burlington The Film House at Main Street Landing, 60 Lake Street, Burlington VT	March 29th, 2016 9:00AM – 4:00PM	https://www.eventbrite.com/e/vermont-health-care-innovation-project-core-competency-training-series-day-1-introductory-care-registration-21531307721
Waterbury Vermont State Office Complex 280 State Drive, Waterbury VT	March 30th, 2016 9:00AM – 4:00PM	https://www.eventbrite.com/e/vermont-health-care-innovation-project-core-competency-training-series-day-1-introductory-care-registration-21568072686
Brattleboro Elks Lodge 75 Putney Road, Brattleboro VT	March 31st, 2016 9:00AM – 4:00PM	https://www.eventbrite.com/e/vermont-health-care-innovation-project-core-competency-training-series-day-1-introductory-care-registration-21569120821

This course is designed for a variety of staff members from health and community service organizations who provide care coordination services. It is appropriate for nurses, social workers, medical assistants, community health workers, case managers, educators, health coaches, and other staff and their supervisors working in team-based care environments.

PLEASE NOTE: In order to provide the best possible educational experience, class sizes are limited to 60 people at each location for this training. If more than 60 people "Request to Attend" at a particular site, the training coordinators will review the list and consult with leaders from requesting organizations to ensure that the final participant list contains a representative cross-section of organizations and geographic locations. Once final registrant lists are compiled, you will receive confirmation of your registration (or notice that the training capacity has been exceeded) via e-mail. Participation at an alternative site will be offered to people who can't be accommodated, if the alternative site has fewer than 60 registrants.

Vermont Health Care Innovation Project Core Competency Training Series
2016 Schedule of Training Events

Training Event	Tentative Date & Location[1]	Tentative Curriculum Modules[2]
6 Day "Core" Training Series ***(Participants are strongly encouraged to attend all 6 days of core training)***		
Day 1: Introductory Care Coordination Training, Part 1	**3/29/2016:** Burlington, Main Street Landing **3/30/2016:** Waterbury, State Office Complex **3/31/2016:** Brattleboro, Elks Lodge	• Roles and responsibilities of staff who provide care coordination • How care coordination is related to patient navigation • Typical care coordination services • Qualities and skills needed by staff members providing care coordination
Day 2: Disability Awareness Training, Part 1	**4/22/2016:** Brattleboro, TBD **4/25/2016:** Montpelier, Capitol Plaza Hotel **4/26/2016:** Burlington, Main Street Landing	• Introduction to disability awareness • Disability and wellness • Person Centered Care
Day 3: Introductory Care Coordination Training, Part 2	**5/17/2016**: Montpelier, Capitol Plaza Hotel **5/18/2016:** Burlington, Main Street Landing **5/19/2016:** Brattleboro, TBD	• Communication skills • Bias, culture and values • Accessing community and social supports • Transitions of care, home visits, and supporting care givers
Day 4: Disability Awareness Training, Part 2	**6/17/2016:** Burlington, Main Street Landing **6/22/2016**: Waterbury, State Office Complex **6/23/2016:** Brattleboro, TBD	• Universal design/accessibility • Communication and interaction • Tools for improved communication • Cultural competence • Facilitating inclusive and accessible training
Day 5: Introductory Care Coordination Training, Part 3	**7/19/2016:** Burlington, Main Street Landing **7/20/2016:** Montpelier, Capitol Plaza Hotel	• Development and implementation of care plans • Motivational Interviewing

	7/21/2016: Brattleboro, TBD	• Health coaching • Professional boundaries
Day 6: Disability Awareness Training, Part 3	**9/14/2016:** Montpelier, Capitol Plaza Hotel **9/16/2016:** Burlington, Main Street Landing **9/28/2016:** Brattleboro, TBD	• Transition from pediatric to adult care • Sexuality and reproductive health • Trauma-informed care
Webinar Series (5 one-hour webinars will offer supplemental content to 6-day core training series)	**Webinar 1:** April, date TBD **Webinar 2:** June, date TBD **Webinar 3:** August, date TBD **Webinar 4:** October, date TBD **Webinar 5:** December, date TBD	• Using data to identify people needing services • Principles of person centeredness • Care coordination by phone • Coordinating care for patients with specific chronic conditions such as DM, HTN, heart disease, asthma, and HIV and mental illnesses • Navigating the insurance system • Risk stratifying patient panels
Supplemental Training Opportunities		
Advanced Care Coordination Training	**9/20-9/21/2016:** Montpelier, Capitol Plaza Hotel	• Impact of adverse childhood events, mental illness, an addiction disorders on health status • Screening for substance abuse and domestic violence • Crisis management and suicide prevention • Coordinating care for patients with mental health conditions • Coordinating care for homeless patients • Care management for elderly patients • Palliative care and end of life care
Care Coordination for Managers & Supervisors	**10/27/2016:** Montpelier, Capitol Plaza Hotel	• Handling large case loads • Risk stratification • Supervision of staff • Setting up training systems • Working effectively with leadership and

		physicians • Identifying and serving as a lead care coordinator
<u>Train the Trainer Training Workshop</u>[3]	**11/15-11/16/2016:** Montpelier, Capitol Plaza Hotel	• Preparing to facilitate group care management/coordination training • Framing topics to clarify roles of front line care managers • Best practices for facilitating group discussions and activities • Facilitating discussions about controversial or challenging topics • Managing conflict and multiple opinions among participants • Facilitating role play activities for motivational interviewing, health coaching, and communication skills

PLEASE NOTE: In order to provide the best possible educational experience, class sizes are limited to 60 people at each location for this training. If more than 60 people "Request to Attend" at a particular site, the training coordinators will review the list and consult with leaders from requesting organizations to ensure that the final participant list contains a representative cross-section of organizations and geographic locations. Once final registrant lists are compiled, you will receive confirmation of your registration (or notice that the training capacity has been exceeded) via e-mail. Participation at an alternative site will be offered to people who can't be accommodated, if the alternative site has fewer than 60 registrants.

[1] VHCIP staff is working diligently to secure and finalize all logistical details for the VHCIP Core Competency Training Series. We have provided the **<u>LIKELY</u>** Dates and locations for all events, but these may change. Our goal is to offer training in three locations across the state that will be accessible to participants statewide.

[2] Curriculum will cover those general training modules listed. Specific training content may be refined to better meet participant needs.

[3] In order to participate in the Train the Trainer Workshop, the expectation is that participants will have attended all components of the Core Competency Training Series, and that they will commit to training staff in their own communities.