# Care Models and Care Management

# Work Group Meeting

# Agenda 7-14-15

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

**July 14, 2015; 10:30 AM to 12:30 PM**
**ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT**
**Call-In Number: 1-877-273-4202; Passcode 2252454**

| Item # | Time Frame | Topic | Relevant Attachments | Vote To Be Taken |
|---|---|---|---|---|
| 1 | 10:30 to 10:40 | Welcome; Introductions; Approval of Minutes<br>(Bea Grause is meeting facilitator) | **Attachment 1:** May meeting minutes | Yes (approval of minutes) |
| 2 | 10:40 to 10:55 | Updates:<br>• June 17 Convening<br>• Year 2 Milestones related to CMCM Work Group<br>• Initial Discussion of Year 3 Priorities; Sustaining Work Group Initiatives<br>***Public Comment*** | **Attachment 2:** Year 2 Milestones | |
| 3 | 10:55 to 11:05 | Regional Blueprint/ACO Committees - Progress Report<br>***Public Comment*** | **Attachment 3:** UCC/RCPC Progress Report | |
| 4 | 11:05 to 11:20 | Integrated Communities Care Management Learning Collaborative:<br>• Pilot communities next steps<br>• Timeframe for expansion to additional communities<br>• Core Competency Training for Frontline Care Coordinators<br>***Public Comment*** | **Attachment 4:** Timeframe for Expansion | |
| 5 | 11:20 to 12:05 | Presentation on Caledonia and Southern Essex Counties (St. Johnsbury Health Service Area) Learning Collaborative and Dual Eligible Project<br>***Public Comment*** | **Attachment 5:** St. Johnsbury Presentation | |
| 6 | 12:05 to 12:15 | Wrap-Up and Next Steps; Plans for September Meeting:<br>• Summary of gaps, duplication, opportunities for coordination, risks<br>• Continue discussion of Year 3 priorities and sustaining work group initiatives<br>***AUGUST MEETING CANCELLED***<br>***Next Meeting:*** *Tuesday, September 15th, 2015, 10:30 AM – 12:30 PM, Calvin Coolidge Conference Room, National Life, Montpelier VT* | | |

# Attachment 1

# May Minutes

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

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

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **1. Welcome and Introductions; Approval of minutes** | Nancy Eldridge called the meeting to order at 10:31 AM. A roll call was taken and a quorum was present. A motion to accept the minutes by exception was made by Trinka Kerr and seconded by Susan Aranoff. The motion carried with one abstention. | |
| **2. Legislative/ Health Policy Update (Co-Chair Bea Grause, VAHHS)** | Bea Grause presented Attachment 2 on the payment reform landscape in Vermont and discussed the roles that payers, providers and others might play in the formation of an all payer approach. She noted that the movement is only just beginning and that there will be ongoing discussions about connectivity, collaboration, alignment of payment incentives, stakeholder engagement, and much more as the effort evolves. The hope is that by 1/1/17, Vermont will move to a multi-payer model using different forms of payment. There will still likely be a fee for service aspect even as reform takes place.<br><br>Laural Ruggles noted that payment reform is not going to work unless a variety of organizations beyond hospitals and practices are involved. The whole system needs to change. There are no payment incentives to coordinate care. Bea responded that the plan is to evolve the model over time to include more organizations.<br><br>While there are some challenges and questions specifically noted in the presentation, there are likely many more. The process is only just beginning, but CMS is showing interest in pursuing this in Vermont. Nancy Eldridge asked whether there is any sense of a timeline for this work, and where the discussions will take place. Bea responded that the negotiations are between the State of Vermont and CMS at this time. A key question is whether the federal government will offer Vermont a better model under the waiver. The answer has to be yes or it's not worth doing.<br><br>Beverly Boget asked about the relationship between VHCIP with its funding resources and the waiver. Bea responded that an all-payer model would build on the connections supported by VHCIP, and would aid in sustainability. Sarah Kinsler added that CMS is looking for significant synergy between VHCIP and the waiver work. | |

| Agenda Item | Discussion | Next Steps |
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| | Susan Aranoff pointed out that there's an opportunity to use remaining VHCIP resources and time to consider global budgets. She mentioned the following proposal from St. Johnsbury: *Design a multi-phased pilot project in the St. Johnsbury Hospital Service Area. The project will begin with a design phase focusing on using global budgets for Medicaid medical services. The design phase will include discussion of expanding beyond Medicaid medical services and to other payers.*<br><br>Laural Ruggles added that most of the organizations outlined in Bea's slides are participating in the accountable health community proposal in St. Johnsbury. Most organizations get some kind of Medicaid funding, so they are examining if they can get the combined funding in one lump sum, determine locally how to distribute it among organizations, deliver services better and more efficiently, and not have organizations say they can't deliver services because they don't get paid for them. Trust is key to bringing everyone to the table and everyone has to be willing to take the risk; determining numbers may be the easier part.<br><br>Mike Hall asked what a global budget looks like if all services are not in the budget. He suggested that there should be discussion about the role of the continuum of providers other than hospitals, and asked how we change care if the incentives aren't aligned for all providers. Bea suggested that we could change the incentives for hospitals to work differently with their community providers. | |
| **3. Update on Regional Blueprint/ACO Committees** | Jenney Samuelson and Patty Launer gave an update on the regional Blueprint/ACO committees. Jenney noted that there was not much change since last month's update. The communities continue to progress in forming their committees, conducting meetings, developing charters, defining priorities, deciding on projects and getting started on their work.<br><br>Susan Aranoff noted that last month's handout inadvertently did not include specific mention of OneCare's participation in the regional committees, and asked that this handout be updated to reflect her request.<br><br>Jenney noted that while communities may use different terms for the committees (e.g., Unified Community Collaboratives (UCCs) and Regional Clinical Performance Committees (RCPCs)), the committees are serving similar functions in each community. She also noted that groups such as the Blueprint integrated health services work groups were in existence prior to UCC/RCPC formation, and that the goal is to expand on existing efforts while avoiding duplication. | |
| **4. Integrated Communities Care Management Learning Collaborative Update** | Erin Flynn provided an update on the Integrated Communities Care Management Learning Collaborative:<br>• A webinar was held on 4/15 and Lauran Hardin led participants through an exercise in root cause analysis to build upon the curriculum from the March learning session.<br>• The next in-person learning session is on 5/19 at Norwich University. 75-80 people are currently registered. Jeanne McAllister from the University of Indiana will serve as expert faculty, and the curriculum will focus on implementing shared plans of care across interdisciplinary teams. The session will also include cross-community breakout sessions in order to allow participants to share their learnings with each other.<br>• The VHCIP Steering Committee and Core Team approved the expansion request put forth by the CMCM work group. Erin reviewed the approved budget detail as follows: | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | ▪ $100,000 in estimated costs for one additional quality improvement facilitator<br>▪ $110,000 in learning session faculty costs (includes travel)<br>▪ $90,000 (includes Train-the-Trainer costs) in core competency training costs<br>▪ $200,000 in facility, logistical support, and supply costs<br>▪ **Total request: $500,000 (not to exceed amount)**<br><br>Erin noted that several communities have already come forward expressing their desire to participate in the next round; the planning team will reach out to additional communities throughout the state to gauge interest and readiness.<br><br>Regarding core competency training, the planning group is currently working on a scope of work for an RFP for training front-line care coordinators. The planning group is partnering with the DLTSS work group to ensure that disability-specific training is woven throughout the design, and that levers (such as a train-the-trainer model) ensure continued sustainability beyond the life of VHCIP.<br><br>Quality Improvement facilitators Nancy Abernathy and Bruce Saffron presented an update on pilot community progress:<br>• Bruce has been working with communities to collect data, measure outcomes, and generally implement evaluation of the learning collaborative. He described the data collection tool to track several process measures (e.g., Has a lead care coordinator been identified? Has a shared care plan been developed?). Communities have provided data beginning with a January 2015 baseline and progressing through two rounds of data collection. Additional measures will include ED utilization and hospital admissions; person engagement; and person and provider experience.<br>• Nancy has been working on facilitation and supporting leadership within the community teams. She is currently assisting communities in developing work flow diagrams to guide them as they implement and systematize the processes they have been designing and developing.<br><br>The following questions and dialogue followed:<br>• Susan Aranoff asked whether data is currently being collected on how often the individual is participating in the care conference. Bruce and Nancy responded that this measure is not currently being collected as the communities are still working on implementing care conferences. Teams are currently working on effectively engaging the individual in their care plan and care conference. Sue asked whether individuals are being asked to sign their shared care plans. Nancy replied that the three communities have not currently built in a place in their care plan templates for the individual (or lead care coordinator) to sign the document; this idea will be bought back to the communities. Susan noted that this is included in the recent HCBS rules, and may become relevant to the integrated teams as they progress in their work.<br>• Jenney Samuelson noted it is the nature of this type of learning collaborative to test promising interventions, and make changes and improvements based on what the communities learn from their own work and each other. The communities are at the stage where they are conducting Plan-Do-Study-Act cycles around development and implementation of a shared care plan, and convening of care conferences. More lessons will be learned and shared as | |

| Agenda Item | Discussion | Next Steps |
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| | this work progresses; the intent is to allow communities to try new ideas and make changes based on what they learn.<br>• Kirsten Murphy asked how accessible the shared care plans are to various populations who might process information differently. It was noted that for the shared care plan to be person directed, it is imperative that it is designed to meet each individual's specific needs. Deborah Lisi-Baker added that including tracking of whether the person is present and signs the plan are intended to be indicators of patient engagement. She noted that data collection is critical in order to measure quality improvement and bring forth evidence that can support the formation of best practices. Mike Hall cautioned against moving toward a 'check the box' approach as it is difficult to standardize this type of evaluation. One person engagement tool that has been piloted in all 3 communities is the "Camden Cards," which assist in root cause analysis and identification of the person's goals.<br>• Susan Aranoff noted that at DAIL, the participants in Choices for Care (CFC) are required to have a shared care plan and questioned how the various care plans in place within the different organizations on the multi-disciplinary team interact with the cross-organizational shared care plan. Laural Ruggles responded that there are different uses for care plans. Providers and organizations might keep more detailed records on their individual plans, but the goal of the cross-organization shared care plan is to facilitate communication, collaboration and integration across a community. The key is to capture the right amount of information, without including so much information that it is not useful.<br>• Susan Besio asked about the core elements across all communities that rise to the level of inclusion in a uniform shared care plan. Nancy responded that this conversation is ongoing within the communities, and this information will be shared among communities during future learning opportunities. | |
| **5. SCÜP Project Update** | Erin Flynn and Larry Sandage presented on the SCÜP Project. The SCÜP seeks to support an existing project within the HIE work group around the development of a universal transfer protocol as well as the shared care plans being developed by the multi-disciplinary community teams in the learning collaborative.<br><br>Previously, the Universal Transfer Protocol project conducted research and identified data needs within two case study communities - Bennington and St. Johnsbury. A UTP Charter and full report is available as compiled by consultants Im21. . This initial stage did not address a technology solution, but rather focused on requirements and work flow.<br><br>The overlap between the goals and use of shared care plans and universal transfer protocol is significant – as are several of the data elements. It is the goal of this project to align these tools as much as possible, and work to identify a technology solution that would streamline processes for providers as much as possible.<br><br>*Project Approach and Next Steps*<br>In the short term the project will continue to conduct research and gather information around business requirements and work flow processes within the case study communities. In the early stages, this work will remain technology agnostic and is focused on making sure that the data and business requirements are first understood. As business requirements are gathered, technical requirements will be better understood and the goal is to develop a technology recommendation by October, 2015. | |

| Agenda Item | Discussion | Next Steps |
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| | Beverly Boget asked how this aligns with the work VITL is doing. Larry responded that VITL Access is a possible platform for sharing these types of tools, but that this will become more evident once the business requirement are better understood. Jenney Samuelson noted that currently the VHIE contains discreet clinical data elements, but this may not include all aspects of the shared care plan. VITL is also currently working on ensuring data quality of existing data before they shift their focus to include additional data elements.<br><br>Patty Launer asked for further explanation of the term business requirements. Larry responded that business requirements outline the work flow within the communities in order to understand what the technology requirements are and eventually identify a solution that will meet a community's needs.<br><br>Nancy Eldridge pointed out that there has been a lot of work done already in aggregating this information; however, it is not all available electronically and therefore a huge opportunity exists to support the communities. Several members expressed concern that this work not start from scratch, rather that it build upon work that has already been done in this area. Larry confirmed that the goal is absolutely to understand and build upon existing efforts. | |
| **6. Summary of gaps, duplication, opportunities for coordination, risks** | Marge Houy provided an overview of Bailit Health Purchasing's work to support the work group in summarizing gaps, duplication, opportunities for coordination, and risks.<br><br>Since its inception, the work group has been collecting data and information on gaps, duplication, opportunities for coordination and risks from a number of sources, including presentations from various organizations conducting care management, the care management inventory survey, and findings from the integrated communities care management learning collaborative. Marge and her team will work with work group staff to review these data sources, and attempt to summarize and synthesize common themes that have been reflected across the various data sources. More information will be presented to the work group at next month's meeting. | |
| **6. Next Steps, Future Meeting** | **Next Meeting:** Tuesday, June 16, 2015; 10:30 am to 12:30 pm; Calvin Coolidge Conference Room, National Life, Montpelier. Pam Smart and Treny Burgess will present on the St. Johnsbury work with the provider sub-grant project known as the "dual eligible project" and how this intersects with St. Johnsbury's work in the learning collaborative. | |

# VHCIP CMCM Work Group Member List

**Roll Call:** 5/12/2015

Trinka Kerr 1°
Sue Aranoff 2°
-Motion carried
1 abstention

| Member | | Member Alternate | | Minutes | | |
|---|---|---|---|---|---|---|
| First Name | Last Name | First Name | Last Name | | | Organization |
| Susan | Aranoff ✓ | Sara | Lane | | | AHS - DAIL |
| Nancy | Breiden ✓ | Rachel | Seelig | | | VLA/Disability Law Project |
| Dr. Dee | Burroughs-Biron | Trudee | Ettlinger | | | AHS - DOC |
| Barbara | Cimaglio ✓ | | | | | AHS - VDH |
| Beverly | Boget ✓ | Peter | Cobb | A | | VNAs of Vermont |
| Dana | Demartino | | | | | Central Vermont Medical Center |
| Nancy | Eldridge ✓ | | | | | Cathedral Square and SASH Program |
| Joyce | Gallimore | | | | | CHAC |
| Eileen | Girling | Heather ✓ | Bollman | | | AHS - DVHA |
| Maura | Graff ✓ | | | | | Planned Parenthood of NNE |
| Bea | Grause ✓ | | | | | Vermont Association of Hospital and Health Systems |
| Dale | Hackett | | | | | None |
| Linda | Johnson | | | | | MVP Health Care |
| Pat | Jones | Richard | Slusky | | | GMCB |
| Trinka | Kerr ✓ | Julia | Shaw | | | VLA/Health Care Advocate Project |
| Patricia | Launer ✓ | | | | | Bi-State Primary Care |
| Vicki | Loner | Maura | Crandall | | | OneCare Vermont |
| Madeleine | Mongan | | | | | Vermont Medical Society |
| Judy | Morton ✓ | | | | | Mountain View Center |
| Mary | Moulton | | | | | Washington County Mental Health Services Inc. |
| Paul | Reiss | Amy | Cooper | | | Accountable Care Coalition of the Green Mountains |
| Laural | Ruggles ✓ | | | | | Northeastern Vermont Regional Hospital |
| Catherine | Simonson | | | | | DA - HowardCenter for Mental Health |
| Patricia | Singer | | | | | AHS - DMH |
| Lily | Sojourner | Shawn ✓ | Skafelstad | | | AHS - CO |
| Audrey-Ann | Spence ✓ | Robert | Wheeler | | | Blue Cross Blue Shield of Vermont |
| Lisa | Viles ✓ | | | | | Area Agency on Aging for Northeastern Vermont |
| Jason | Wolstenholme | Jessica | Oski | | | Vermont Chiropractic Association |
| | 28 | | 13 | | | |

# VHCIP CMCM Work Group Participant List

## Attendance: 5/12/2015

| | |
|---|---|
| C | Chair |
| IC | Interim Chair |
| M | Member |
| MA | Member Alternate |
| A | Assistant |
| S | VHCIP Staff/Consultant |
| X | Interested Party |

| First Name | Last Name | | Organization | Care Models |
|---|---|---|---|---|
| Peter | Albert | | Blue Cross Blue Shield of Vermont | X |
| Susan | Aranoff | here | AHS - DAIL | S/M |
| Ena | Backus | | GMCB | X |
| Melissa | Bailey | | Vermont Care Network | X |
| Michael | Bailit | | SOV Consultant - Bailit-Health Purchasing | S |
| Susan | Barrett | | GMCB | X |
| Susan | Besio | here | SOV Consultant - Pacific Health Policy Group | S |
| Charlie | Biss | | AHS - Central Office - IFS / Rep for AHS - DMH | X |
| Beverly | Boget | here | VNAs of Vermont | MA |
| Heather | Bollman | here | AHS - DVHA | MA |
| Mary Lou | Bolt | | Rutland Regional Medical Center | X |
| Nancy | Breiden | here | VLA/Disability Law Project | M |
| Stephen | Broer | | DA - Northwest Counseling and Support Services | X |
| Martha | Buck | | Vermont Association of Hospital and Health Systems | A |
| Anne | Burmeister | | Planned Parenthood of Northern New England | X |

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| Dr. Dee | Burroughs-Biron | | AHS - DOC | M |
| Jane | Catton | | Northwestern Medical Center | X |
| Amanda | Ciecior | | AHS - DVHA | S |
| Barbara | Cimaglio | | AHS - VDH | M |
| Peter | Cobb | | VNAs of Vermont | M |
| Amy | Coonradt | | AHS - DVHA | S |
| Amy | Cooper | | Accountable Care Coalition of the Green Mountains | MA |
| Maura | Crandall | | OneCare Vermont | MA |
| Claire | Crisman | [illegible] | Planned Parenthood of Northern New England | A |
| Dana | Demartino | | Central Vermont Medical Center | M |
| Steve | Dickens | | AHS - DAIL | X |
| Nancy | Eldridge | here | Cathedral Square and SASH Program | C/M |
| Gabe | Epstein | here | AHS - DAIL | S |
| Trudee | Ettlinger | | AHS - DOC | MA |
| Erin | Flynn | here | AHS - DVHA | S |
| Aaron | French | | AHS - DVHA | X |
| Meagan | Gallagher | | Planned Parenthood of Northern New England | X |
| Joyce | Gallimore | | Bi-State Primary Care/CHAC | MA/M |
| Lucie | Garand | | Downs Rachlin Martin PLLC | X |
| Christine | Geiler | | GMCB | S |
| Eileen | Girling | | AHS - DVHA | M |
| Kelly | Gordon | | AHS - DVHA | X |
| Maura | Graff | here | Planned Parenthood of Northern New England | M |
| Bea | Grause | here | Vermont Association of Hospital and Health Systems | C/M |
| Dale | Hackett | | None | M |
| Bryan | Hallett | | GMCB | S |
| Selina | Hickman | | AHS - DVHA | X |
| Bard | Hill | | AHS - DAIL | X |
| Breena | Holmes | | AHS - Central Office - IFS | X |
| Marge | Houy | here | SOV Consultant - Bailit-Health Purchasing | S |
| Christine | Hughes | | SOV Consultant - Bailit-Health Purchasing | S |
| Jay | Hughes | | Medicity | X |
| Linda | Johnson | | MVP Health Care | M |
| Pat | Jones | | GMCB | S/M |

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| Joelle | Judge | here | UMASS | S |
| Trinka | Kerr | here | VLA/Health Care Advocate Project | M |
| Sarah | Kinsler | here | AHS - DVHA | S |
| Sara | Lane | | AHS - DAIL | MA |
| Kelly | Lange | | Blue Cross Blue Shield of Vermont | X |
| Patricia | Launer | here | Bi-State Primary Care | M |
| Deborah | Lisi-Baker | here | SOV - Consultant | X |
| Vicki | Loner | | OneCare Vermont | M |
| Georgia | Maheras | | AOA | S |
| Mike | Maslack | | | X |
| John | Matulis | | | X |
| James | Mauro | | Blue Cross Blue Shield of Vermont | X |
| Clare | McFadden | here | AHS - DAIL | X |
| Elise | McKenna | | AHS - DVHA - Blueprint | X |
| Jeanne | McLaughlin | | VNAs of Vermont | X |
| Darcy | McPherson | | AHS - DVHA | A |
| Madeleine | Mongan | | Vermont Medical Society | M |
| Monika | Morse | | | X |
| Judy | Morton | Phone | Mountain View Center | M |
| Mary | Moulton | | Washington County Mental Health Services Inc. | M |
| Kirsten | Murphy | here | AHS - Central Office - DDC | X |
| Reeva | Murphy | | AHS - Central Office - IFS | X |
| Sarah | Narkewicz | | Rutland Regional Medical Center | X |
| Jessica | Oski | | Vermont Chiropractic Association | MA |
| Annie | Paumgarten | | GMCB | S |
| Luann | Poirer | | AHS - DVHA | S |
| Betty | Rambur | | GMCB | X |
| Allan | Ramsay | | GMCB | X |
| Paul | Reiss | | Accountable Care Coalition of the Green Mountains | M |
| Debra | Repice | | MVP Health Care | X |
| Julie | Riffon | | North Country Hospital | X |
| Laural | Ruggles | here | Northeastern Vermont Regional Hospital | M |
| Jenney | Samuelson | here | AHS - DVHA - Blueprint | X |
| Jessica | Sattler | | Accountable Care Transitions, Inc. | X |
| Rachel | Seelig | | VLA/Senior Citizens Law Project | MA |

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| Maureen | Shattuck | | Springfield Medical Care Systems | X |
| Julia | Shaw | | VLA/Health Care Advocate Project | MA |
| Catherine | Simonson | | DA - HowardCenter for Mental Health | M |
| Tom | Simpatico | | AHS - DVHA | X |
| Patricia | Singer | | AHS - DMH | M |
| Shawn | Skaflestad | here | AHS - Central Office | X |
| Richard | Slusky | | GMCB | S/MA |
| Pam | Smart | | Northern Vermont Regional Hospital | X |
| Lily | Sojourner | | AHS - Central Office | X |
| Audrey-Ann | Spence | phone | Blue Cross Blue Shield of Vermont | M |
| Kara | Suter | | AHS - DVHA | S |
| Beth | Tanzman | | AHS - DVHA - Blueprint | X |
| Win | Turner | | | X |
| Marlys | Waller | here | DA - Vermont Council of Developmental and Mental Health Serv | X |
| Julie | Wasserman | here | AHS - Central Office | S |
| Bob | West | | Blue Cross Blue Shield of Vermont | X |
| James | Westrich | | AHS - DVHA | S |
| Robert | Wheeler | | Blue Cross Blue Shield of Vermont | MA |
| Bradley | Wilhelm | | AHS - DVHA | S |
| Jason | Wolstenholme | | Vermont Chiropractic Association | M |
| Cecelia | Wu | | AHS - DVHA | S |
| Mark | Young | | | X |
| Lisa | Viles | | Area Agency on Aging for Northeastern Vermont | M |
| | | | | 107 |

Nancy Abernathy
Kamy Sandage
~~Kirsten Murphy~~
Mike Hall
Bruce Saffron

# Attachment 2

# Year 2 Milestones

**VHCIP Year 2 Milestones and Progress to Date**
June 2015

Vermont Health Care Innovation Project

| **CMMI-Required Milestones** | | |
|---|---|---|
| *Milestone* | *Specific Tasks* | *Progress Toward Milestones* |
| **Payment Models**<br>*Year 2:* 60% of Vermonters in alternatives to fee-for-service.<br>*Year 3:* 80% of Vermonters in alternatives to fee-for-service. | | • Currently ~60% of Vermonters are in alternatives to fee-for-service. |
| **Population Health Plan**<br>*Year 2:* Draft Plan submitted to CMMI.<br>*Year 3:* Final Plan submitted to CMMI. | | • Plan outline drafted. |

| **Payment Model Design and Implementation** | | |
|---|---|---|
| *Milestone* | *Specific Tasks* | *Progress Toward Milestones* |
| **ACO Shared Savings Programs (SSPs)**<br>*Year 2:* Expand the number of people in the Shared Savings Programs in Year 2.<br>*Year 3:* Expand the number of people in the Shared Savings Programs in Year 3. | Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement. | • Medicaid and Commercial SSPs launched on 1/1/2014.<br>• Year 2 contract negotiations between DVHA and Medicaid SSP ACOs are in process.<br>• Expansion of Total Cost of Care for Year 3 will be considered later in 2015.<br><br>**Total Providers Impacted:** 977<br>**Total Vermonters Impacted:** 133,754 |
| **Episodes of Care (EOCs)**<br>*Year 2:* Design 3 EOCs for the Medicaid program with financial component.<br>*Year 3:* Launch 3 Episodes in Year 3. | Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement. | • A sub-group of the VHCIP Payment Models Work Group focused on Episodes launched in January 2015; the group has met five times.<br>• Staff have conducted a series of one-on-one meetings with stakeholder organizations to understand opportunities and concerns related to this initiative.<br><br>**Total Providers Impacted:** 0<br>**Total Vermonters Impacted:** 0 |
| **Pay-for-Performance (Blueprint)**<br>*Year 2:* Design modifications to this P4P program – dependent on additional appropriation in state budget.<br>*Year 3:* TBD, based on Year 2. | Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement. | • The Blueprint for Health has been engaging with its Executive Committee, DVHA and AHS leadership, and VHCIP stakeholders to discuss potential modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payment models. Such modifications include shifting payers' CHT payments to reflect each current market share, increasing the base payments to PCMH practices, and adding an incentive payment for regional performance on a composite of select quality measures<br>• The legislature appropriated $2.4 million for Blueprint payments (both CHT and PCMH) in State Fiscal Year 2016.<br><br>**Total Providers Impacted:** 694<br>**Total Vermonters Impacted:** 285,968 |

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| **Health Home (Hub & Spoke)**<br>*Year 2:* Reporting on program's transition and progress.<br>*Year 3:* Reporting on program's transition and progress. | Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement. | • Program implementation and reporting are ongoing.<br><br>**Total Participating Providers:** 123<br>**Total Vermonters Impacted:** 2706 |
| **Accountable Health Communities**<br>*Year 2:* Research and design feasibility.<br>*Year 3:* TBD based on design/research in Year 2. | Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement. | • Contractor selected to engage in national research; contract executed. Findings delivered to VHCIP in June 2015. |
| **Prospective Payment System – Home Health**<br>*Year 2:* Design PPS program for Home Health.<br>*Year 3:* Launch PPS on 7/1/2016. | Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement. | • Legislation to support this effort passed in 2015. |
| **Prospective Payment System – Designated Agencies**<br>*Year 2:* Submit planning grant application to SAMHSA.<br>*Year 3:* If awarded SAMHSA planning grant, plan PPS program. | Planning grant application. | • Planning grant application being drafted with contractor support in collaboration with various AHS departments and stakeholders; application due in August 2015. |
| **All-Payer Model**<br>*Year 2:* Research feasibility, develop analytics, and obtain information to inform decision-making for negotiations with CMMI.<br>*Year 3:* TBD. APM launch anticipated for 2017. | Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement. | • Negotiations between CMMI and SOV (led by AOA and GMCB) are in process. |
| **State Activities to Support Model Design and Implementation – GMCB**<br>*Year 2:* Obtain information and identify regulatory components necessary to support APM regulatory activities. Plan as appropriate based on negotiations.<br>*Year 3:* TBD. APM launch anticipated for 2017. | GMCB-specific regulatory activities. | • Contractor selected to support this work. |
| **State Activities to Support Model Design and Implementation – Medicaid**<br>*Year 2:* Pursue state plan amendments and other federal approvals as appropriate for each payment model (Year 2 SSP SPA, Year 1 EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate.<br>*Year 3:* Pursue waivers as appropriate, ensure monitoring and compliance activities are performed. | Medicaid-specific design and implementation activities (SPAs, etc.). | • Year 1 SSP State Plan Amendment approved in June 2015.<br>• Year 2 SSP State Plan Amendment draft to be developed in Summer 2015.<br>• Beneficiary call-center is operational. |

| Care Delivery and Practice Transformation | | |
|---|---|---|
| *Milestone* | *Specific Tasks* | *Progress Toward Milestones* |
| **Learning Collaboratives**<br>*Year 2:* Offer at least two cohorts of Learning Collaboratives to 3-6 communities.<br>*Year 3:* Offer at least two cohorts of Learning Collaboratives to 3-6 communities. | Design and launch at least two cohorts of learning collaboratives: in-person meetings, webinars, core competency components. At least 6 in-person meetings/year; at least 6 webinars/year. | • First Learning Collaborative cohort launched in 3 communities in November 2014; participants have convened for three in-person learning sessions and three webinars, as well as regular local meetings to support work.<br>• Planning for additional Learning Collaborative cohorts is underway, with funds approved by the Core Team.<br>• Planning to support development of core competency training is underway (collaboration between VHCIP Care Models & Care Management and DLTSS Work Groups). |
| **Sub-Grant Program – Sub-Grants**<br>*Year 2:* Continue sub-grant program; convene sub-grantees at least once; use lessons from sub-grantees to inform project decision-making.<br>*Year 3:* Continue sub-grant program; convene sub-grantees at least once; use lessons from sub-grantees to inform project decision-making. | 14 sub-grants to 12 grantees. | • The sub-grant program is ongoing.<br>• Sub-grantees continue to report on activities and progress.<br>• All sub-grantees convened in Montpelier on May 27, 2015, for a Symposium. |
| **Sub-Grant Program – Technical Assistance**<br>*Year 2:* Provide technical assistance to sub-grantees as requested by sub-grantees.<br>*Year 3:* Provide technical assistance to sub-grantees as requested by sub-grantees. | 5 technical assistors. | • Sub-grantee technical assistance contracts are executed; contractors are available for technical assistance as requested. |
| **Regional Collaborations**<br>*Year 2:* Establish 14 regional collaborations, each including a Charter, governing body, and decision-making process.<br>*Year 3:* TBD, dependent on Year 2 activities. | Establishing regional collaborations that unite Blueprint, ACO, and other local delivery organizational structures. | • Unified Regional Collaboratives are established in each of the State's 14 Health Service Areas. |
| **Workforce – Care Management Inventory**<br>*Year 2:* Obtain snapshot of current care management activities, staffing, people served, and challenges.<br>*Year 3:* N/A | Care Management Inventory Survey. | • Care Management Inventory Survey was administered in 2014.<br>• Results were presented to the VHCIP Care Models & Care Management Work Group in February 2015. |
| **Workforce – Demand Data Collection and Analysis**<br>*Year 2:* Obtain micro-simulation demand model to identify future workforce resource needs.<br>*Year 3:* Perform micro-simulation demand models and use data for decision-making. | Demand data collection and analysis. | • An RFP for this work was released in January 2015; DVHA received 5 responses. DVHA expects to select a contractor in August 2015. |
| **Workforce – Supply Data Collection and Analysis**<br>*Year 2:* Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan.<br>*Year 3:* Use supply data to inform workforce planning. | Supply data collection and analysis. | • The Vermont Department of Health has hired additional staff to develop and administer surveys to accompany provider re-licensure applications, and perform analysis on licensure data and develop provider reports on various health care professions.<br>• Results are expected in Summer 2015. |

| Health Data Infrastructure | | |
|---|---|---|
| *Milestone* | *Specific Tasks* | *Progress Toward Milestones* |
| **Expand Connectivity to HIE – Gap Analyses**<br>*Year 2:* Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity of non-Meaningful Use(MU) providers.<br>*Year 3:* Perform gap analyses related to quality measures for each payment program, as appropriate. | Gap analyses – Payment Model Measures, LTSS, and mental health providers. | • VHCIP HIE/HIT Work Group working with VITL and three ACOs to perform a gap analysis of member providers and their ability to contribute data for quality measures and analysis through the HIE.<br>• VHCIP HIE/HIT Work Group received an LTSS Technology Assessment Report. |
| **Expand Connectivity to HIE – Gap Remediation**<br>*Year 2:* Remediate data gaps that support payment model quality measures, as identified in gap analyses.<br>*Year 3:* Remediate data gaps that support payment model quality measures, as identified in gap analyses. | Gap remediation for data elements that flow through the VHIE – Payment Model Measures, LTSS, and mental health providers. | • VITL contract in place to remediate gaps identified in ACO gap analysis to connect member providers and improve data quality for those providers.<br>• The HIE/HIT Work Group is evaluating next steps based on the receipt of the LTSS Technology Assessment. |
| **Expand Connectivity to HIE – Data Extracts from HIE**<br>*Year 2:* Develop tools to support data extracts from the HIE to analytic entities as necessary for provider and state use.<br>*Year 3:* Develop tools to support data extracts from the HIE to analytic entities as necessary for provider and state use. | Data extracts from the HIE. | • Gateway for data feeds in place for OneCare Vermont; VITL contract in place to create a data feed for CHAC. |
| **Improve Quality of Data Flowing into HIE**<br>*Year 2:* Engage in work flow improvement activities at provider practices to improve the quality of the data flowing into the VHIE. These will be identified in gap analyses and analytics.<br>*Year 3:* Engage in work flow improvement activities at provider practices to improve the quality of the data flowing into the VHIE. These will be identified in gap analyses and analytics. | Data quality improvement. | • VITL contract in place includes a Terminology Services project to provide services to translate clinical data sets submitted to the HIE into standardized code sets.<br>• VITL contract in place to work with providers and the ACOs to improve the quality of clinical data in the HIE for use in population health metrics within the Shared Savings Program.<br>• Contracts with Vermont Care Network and VITL to improve data quality and work flows at Designated Mental Health Agencies. |
| **Telehealth – Strategic Plan (Year 2 Only)**<br>*Year 2:* Develop Telehealth Strategic Plan. | Strategic plan. | • Contractor selected.<br>• Telehealth Strategic Plan and draft Scope of Work for Telehealth Implementation RFP due to DVHA in July and on track for delivery on that date. |
| **Telehealth – Implementation**<br>*Year 2:* Launch telehealth program as defined in Telehealth Strategic Plan.<br>*Year 3:* Complete telehealth program. | Program implementation. | • Draft Scope of Work for Telehealth Implementation RFP due to DVHA in July.<br>• RFP for pilot projects to be released later in Summer 2015; 12-month pilot period expected to begin in Fall 2015. |
| **EMR Expansion**<br>*Year 2:* Implement EMRs for non-MU providers; explore non-EMR solutions for providers without EMRs. | Implement EMRs or EMR-type systems. (Could include a design component.) | • The VITL contract, Vermont Care Network contract, and ARIS Solutions contract support procurement of an EMR solution for five Specialized Service Agencies.<br>• LTSS Technology Assessment Report identified non-MU providers that could be targeted for EMR |

| | | |
|---|---|---|
| *Year 3:* Implement EMRs for non-Meaningful Use providers; explore non-EMR solutions for providers without EMRs. | | expansion in Years 2 & 3.<br>• VITL contract with the Department of Mental Health to support procurement of the EMR system for the State's new hospital. |
| **Data Warehousing**<br>*Year 2:* Research data warehousing needs; develop cohesive strategy for warehousing solutions supporting practices in care transformation; identify solutions for data registry and warehousing needs; implement solutions approved by the HIE/HIT Work Group according to timelines developed in design phase.<br>*Year 3:* Research data warehousing needs; develop cohesive strategy for warehousing solutions supporting practices in care transformation; design solutions for data registry and warehousing needs; implement solutions according to timelines developed in design phase | Design and implement data registries and warehouses. | • Vermont Care Network is working on behalf of DA & SSAs to develop a behavioral health-specific data repository, which will to aggregate, analyze, and improve the quality of the data stored within the repository and to share extracts with appropriate entities.<br>• More work to come later in 2015. |
| **Care Management Tools**<br>*Year 2:* Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development.<br>*Year 3:* TBD based on Year 2. | Discovery, design, and implementation of care management tools. | • Contractor performed discovery and drafted a Universal Transfer Protocol charter in 2014 and early 2015.<br>• Integrated Care Management Learning Collaborative Cohort 1 communities requested shared care planning tools.<br>• Universal Transfer Protocol and Shared Care Plan projects have merged. New project, SCÜP, currently in discovery and design phase. |
| **General Health Data – Data Inventory**<br>*Year 2:* Conduct data inventory.<br>*Year 3:* TBD. | Data inventory. | • Contractor selected and contract executed; work on hold pending federal approval.<br>• Work on data inventory is nearly complete. |
| **General Health Data – HIE Planning**<br>*Year 2:* Identify HIE connectivity targets; provide input into HIT Plan.<br>*Year 3:* TBD. | HIE planning. | • Contractor selected; pending federal approval. |
| **General Health Data – Expert Support**<br>*Year 2:* Procure appropriate IT-specific support to further health data initiatives.<br>*Year 3:* Procure appropriate IT-specific support to further health data initiatives. | Engage Enterprise Architects, Project Managers, Business Analysts, and Subject-Matter Experts as needed. | • IT-specific support to be engaged as needed.<br>• Enterprise Architect, Business Analyst and Subject Matter Experts identified to support the design phase of SCÜP. |

| **Evaluation** | | |
|---|---|---|
| *Milestone* | *Specific Tasks* | *Progress Toward Milestones* |
| **Self-Evaluation Plan and Execution**<br>*Year 2:* Design Self-Evaluation Plan; engage in Year 2 activities as identified in the plan.<br>*Year 3:* Engage in Year 3 activities as identified in the Self-Evaluation Plan. | Design and implement Self-Evaluation Plan. | • Self-evaluation contractor selected.<br>• Draft self-evaluation plan submitted to Core Team and GMCB in June 2015. On track for final plan by 6/30/15. |
| **Surveys**<br>*Year 2:* Conduct annual patient experience survey and other surveys as identified in payment model development.<br>*Year 3:* Conduct annual patient experience survey and other surveys as identified in payment model development. | Patient experience surveys and others. | • Patient experience surveys for the patient-centered medical home and shared savings program fielded for 2014. Anticipate fielding Patient experience surveys annually for these programs. |
| **Monitoring and Evaluation Activities Within Payment Programs**<br>*Year 2:* Conduct analyses as required by payers related to specific payment models.<br>*Year 3:* Conduct analyses as required by payers related to specific payment models. | Monitoring by payer and by program to support program modifications. | • Ongoing monitoring and evaluation by SOV staff and contractors occurring as needed. |

| **General Program Management** | | |
|---|---|---|
| *Milestone* | *Specific Tasks* | *Progress Toward Milestones* |
| **Project Management and Reporting – Project Organization**<br>*Year 2:* Ensure project is organized.<br>*Year 3:* Ensure project is organized. | Project organization. | • Project management contract in place to support project organization and reporting. |
| **Project Management and Reporting – Communication and Outreach**<br>*Year 2:* Engage stakeholders in project focus areas.<br>*Year 3:* Engage stakeholders in project focus areas. | Communication and outreach. | • Contractor selected; presented to VHCIP in Spring 2015; work on hold pending federal contract approval. |

# Attachment 3

# UCC/RCPC Progress Report

## Progress Report: Unified Community Collaboratives/Regional Clinical Performance Committees

| Health Service Area | Regional Meeting Name | Charter | Consumer | Priority areas of focus | Other Attendees (partial list) |
|---|---|---|---|---|---|
| Bennington | Bennington Regional Clinical Performance Committee | ✓ | ✓ | ED Utilization<br>30 day all cause readmissions<br>CHF | BP, OCV, CHAC, SNF, HHA, DA, community private practices, Hospital |
| Berlin | Community Alliance for Healthcare Excellence (CAHE) | ✓ | ✓ | Use of Decision matrix tool to arrive at:<br>Care Coordination<br>COPD<br>CHF<br>Hospice utilization<br>ACE's | Hospital, HHA, DA, VDH, SNF, community transport, CHAC, BP, OCV |
| Brattleboro | Brattleboro RCPC ACO Steering Committee | ✓ | | High risk patients<br>Hospice utilization<br>Pediatric learning collaborative on care coordination (7/15)<br>Care Coordination in ED | Hospital, BP, HHA, SNF, DA, OCV<br>Thinking about adding Retreat /others from Townshend |
| Burlington | Chittenden County Regional Clinical Performance Committee | ✓ | Under discussion | Improving care coordination learning collaborative<br>Reduction in ED utilization<br>CHT planning<br>Increase in hospice utilization | Hospital, BP, HF, CHAC, HHA, DA, OCV, SASH, DAIL, VDH, VCCI, pediatrician, SNF |
| Middlebury | Community Health Action Team (CHAT) | ✓ | | Improving care coordination for high risk patients | Hospital, OCV, BP, HHA, DA, CHAC |
| Morrisville | UCC | ✓ | | 30 day all-cause readmissions<br>High Risk patient lists<br>ED utilization | Hospital, CHAC, OCV, BP, DA, SNF, HHA, VDH |
| Newport | UCC | ✓ | | COPD<br>Obesity<br>Reduction of all cause readmissions | Hospital, BP, OCV, HHA, VDH |
| Randolph | UCC/RCPC | Working on it | | Under discussion : May join improving care coordination collaborative<br>Extended CHT: Tobacco | BP, CHAC, OCV |

## Progress Report: Unified Community Collaboratives/Regional Clinical Performance Committees

| | | | | | |
|---|---|---|---|---|---|
| Rutland | UCC/RCPC<br>The CHF, COPD Collaborative |  | | COPD- ways to rank /stratify CHF<br>Transition of care<br>Improving care coordination learning collaborative<br>Hospice utilization – terminal care | Hospital ,BP, SNF, CHAC, HHA, DA , OCV, VCCI |
| Springfield | QI Collaborative<br>Community Advisory Committee | Working on it | | Depression screening and follow-up: Does this impact ED utilization?<br>F/U after mental health hospitalization | HHA, Every practice in the Springfield health system, BP, OCV, CHAC |
| St. Albans | RCPC |  | | ED utilization<br>30 day all-cause readmissions<br>Hospice utilization<br>At-risk population based care pathways<br>Preventive care screening protocol | Hospital- multiple departments, VDH, Franklin County Rehab, CHAC, DA, HHA, BP, OCV |
| St. Johnsbury | The A Team |  | | Improving care coordination learning collaborative<br>Reduction in all cause readmissions<br>Increase hospice utilization | Hospital, CHAC, United Way, BAART, Housing organization, food security organization, BP, OCV, VCCI, VDH |
| Townshend | RCPC |  | | Decrease ED utilization (looking at those who use > 4x/year)<br>CHF – use of Brattleboro clinic<br>Improving hospice utilization | Hospital, BP, OCV, VCCI, VITL considering adding more members |
| Windsor | Windsor HSA Coordinated Care Committee | Voting on it | Under discussion | 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 | Hospital, OCV, BP, HHA, DA, VDH, VCCI, SASH, SNF, multiple departments of the hospital system |

*Updated 6/24/15

## Progress Report: Unified Community Collaboratives/Regional Clinical Performance Committees

VCCI= Vermont Chronic Care Initiative
OCV = OneCare Vermont
CHAC= Community Health Accountable Care
HF= Health First Acct Care
BP= Vermont Blueprint for Health
SNF= Skilled Nursing Facility
HHA= Home Health Agency
DA= Designated Mental Health Agency
VDH= Vermont Department of Health
SASH= Support and Services at Home

** 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)

Formation of teams takes a long time, QI work and inclusion of consumers is a goal

# Attachment 4

# Timeframe for LC Expansion

# Integrated Communities Care Management Learning Collaborative:
# Schedule of Events for Cohort 2 and Cohort 3

Two additional cohorts began participation in the Integrated Communities Care Management Learning Collaborative in June 2015; for a total of three cohorts currently active across the state.

- Cohort 1: St. Johnsbury, Burlington and Rutland *(began in Fall of 2014)*
- Cohort 2: St. Albans, Middlebury, Central Vermont, Morrisville *(began in summer of 2015)*
- Cohort 3: Springfield, Brattleboro, Windsor, Randolph *(began in summer of 2015)*

| Event | Time Frame |
|---|---|
| **Pre-Work Period**: Each community will be responsible for:<br>• Recruiting community team members,<br>• Attending quality improvement training,<br>• Beginning to use data to identify improvement priorities and at-risk people | June – August 2015 |
| **Kick-Off Webinar for Participants** | Two Dates:<br>• July 8th 12:00 – 1:00<br>• July 22nd 12:00 – 1:00 |
| **Bi-Weekly Community Team Meetings** | Starting in late July, continuing twice a month for at least six months |
| **Learning Session 1:** Using Data to Identify People in Need of Integrated Care Management services | Cohort 2: September 9th, all-day<br>Cohort 3: September 8th, all-day |
| **Webinar 1:** Using New Tools to Engage Individuals in Integrated Care Management | October 14th, 12:00 – 1:00 |
| **Learning Session 2:** Identification of Lead Care Coordinator & Development of Shared Care Plan | November *(Exact date TBD pending expert faculty availability)* |
| **Webinar 2:** Applying the Integrated Care Management Model to Our Communities, Case Studies with Expert Faculty Lauran Hardin | December 9th, 12:00 – 1:00 |
| **Learning Session 3:** Implementing, Utilizing and Updating Shared Care Plan; Conducting Care Conferences | January (Exact date TBD pending expert faculty availability) |

# Attachment 5

# St. Johnsbury Presentation

# *Caledonia & Southern Essex Dual Eligible Project*

***Date: July 14, 2015***

***Treny Burgess, Caledonia Home Health & Hospice***

***Pam Smart, Northeastern VT Regional Hospital***

# Project Overview

- Vermonters who are eligible for both Medicare and Medicaid are some of the most challenging and expensive persons to care for.
- Desired outcome is to provide better, person-centered care and reduce expenditures for Medicare and Medicaid by:
  - Hiring Health Coach to work with clients
  - Establish Dual Eligible Core Team to meet bi-monthly to discuss individuals' services, situations, and problem solve
  - Use flexible funds to fill gaps in service

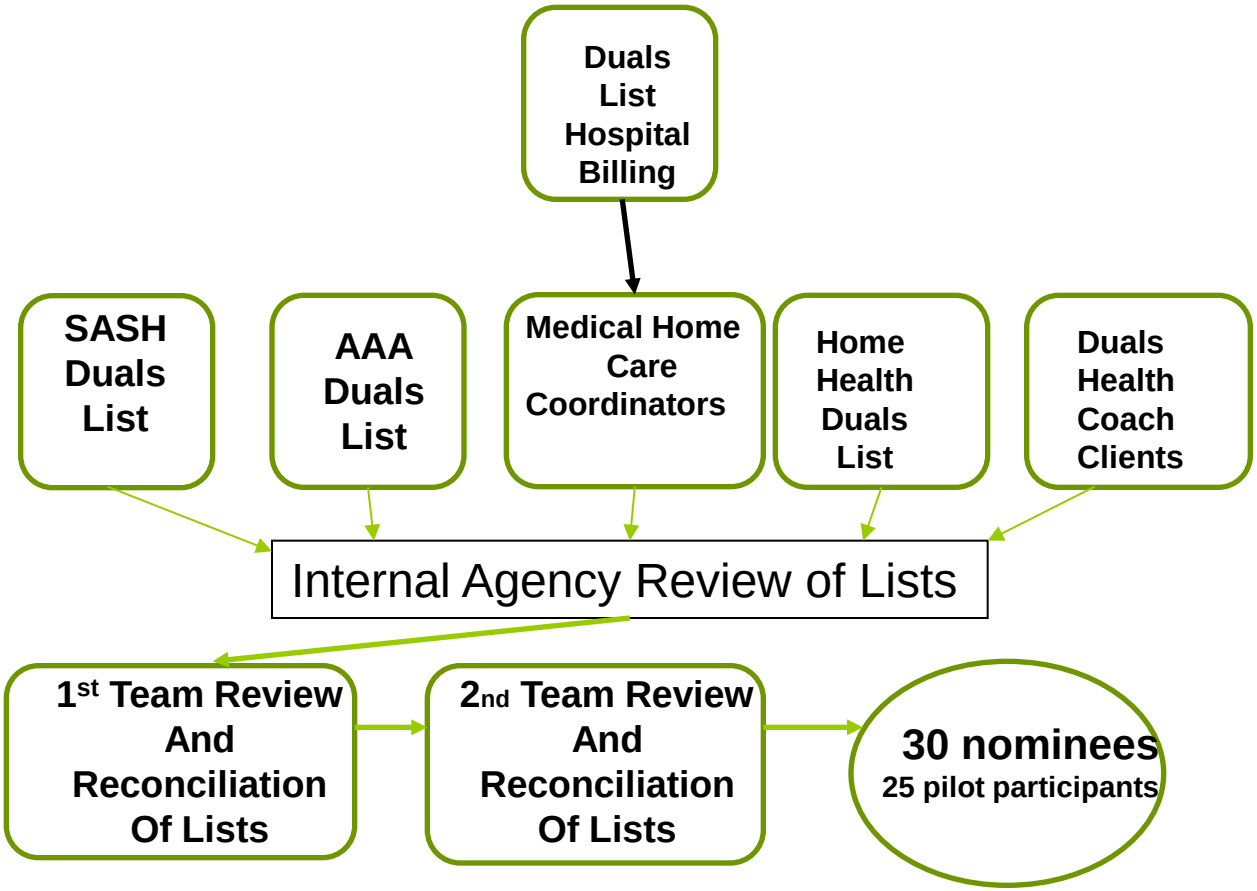
# Project Objectives

- Identify dually eligible individuals at risk of harm, unnecessary nursing home stays or hospitalization
- Assign the individuals to a community interdisciplinary team
- Assign a lead case manager to be the primary contact with the individual and their support network
- Use a comprehensive assessment and care planning process to identify individual strengths and needs
- Develop a comprehensive person-centered plan of services

# Our Community

- **30,000 people; Caledonia and s. Essex**
- **Collaborative Team:**
  - **AHS**
  - **Northeast Kingdom Human Services (mental health)**
  - **Northeastern VT Regional Hospital (primary care, inpatient, ER, Community Connections)**
  - **Northeastern Vermont Council on Aging**
  - **Northern Counties Health Care (FQHC & home health)**
  - **RuralEdge (housing and SASH)**
  - **VCCI**

# Identify Dual Eligible Individuals



# Interdisciplinary Team and Lead Case Manager

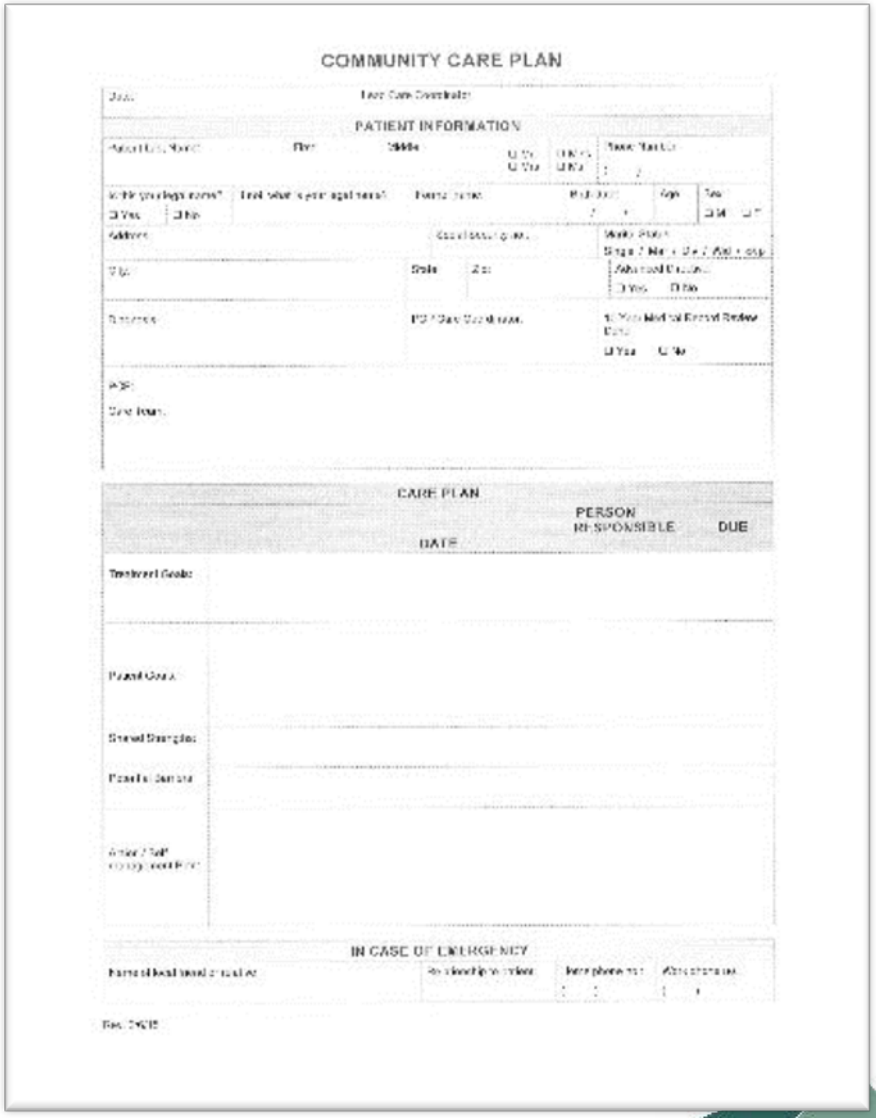
- Team reviews all nominated individuals to determine community partner with closest relationship to act as lead case manager
- Lead case manager visits with individual to discuss project and get signed consent to participate

# Identify Individual Strengths and Needs

- Discussion in bi-monthly meetings
- Shared Care Plan
- Camden Cards

# Shared Care Plan

- Care Plan includes
  - Care Team members
  - Individual action plan and goal
  - Medical treatment plan
  - Identified lead case manager
  - Strengths of individual
  - Barriers for Individual


COMMUNITY CARE PLAN

PATIENT INFORMATION

CARE PLAN

DATE

PERSON RESPONSIBLE

DUE

IN CASE OF EMERGENCY

# Camden Cards



| | Income: | $1,000 | |
|---|---|---|---|
| **Categories** | **Percentages** | **$/Month** | **$/Week** |
| Rent/Mortgage | 20% | $ 200.00 | $ 50.00 |
| Food (Exclusive of Eating Out) | 15% | $ 150.00 | $ 37.50 |
| **Car Payment** | 7% | $ 70.00 | $ 17.50 |
| Car Essentials (Gas, Insurance, Maint.) | 8% | $ 80.00 | $ 20.00 |
| Medical/Life Insurance | 3% | $ 30.00 | $ 7.50 |
| Clothing/Gifts/Toiletries | 3% | $ 30.00 | $ 7.50 |
| Entertainment (Eating Out,Movies) | 4% | $ 40.00 | $ 10.00 |
| Savings | 10% | $ 100.00 | $ 25.00 |
| Debt Repayment | 30% | $ 300.00 | $ 75.00 |
| **Budget Totals** | 100% | **$1,000.00** | **$250.00** |

- Health Education & Management
- Housing Assistance
- Mental Health
- Education
- Health Insurance
- Utilities
- Medication & Supplies
- Legal
- Family Relationships
- Relationship & Safety
- Budgeting/Finances
- Food & Nutrition
- Transportation
- Wild Card

# Lessons Learned

- Some of most complex individuals do not have a case manager
- Lead case manager may change as individual's needs change
- Some individuals have many community partners working with them without realizing this
- Individuals may be reluctant to participate due to collaborative release

# Challenges

- How do we share information across organizations
- Need for stronger partnership with VCIL
- Lack of funding for preventative wellness
- Lack of funding for Dental Needs
- More dual eligible individuals in the community than the health coach has the capacity to serve
- Need documentation from PCP to justify equipment needs
- Individuals may leave the project due to death, relocation, or choosing to remove themselves.

# Opportunities

- Brings domains of medical/mental/social health together
- Find alternate funding sources when working together
- Green Mountain United Way/ VT211 Registry for emergency care now in use for all Duals seen by the Health Coach

# Recent Accomplishments

- Alternative medicine (yoga) offered to a client with chronic pain from injury to spine
- One client regularly attending local fitness center for strength training for joint disease
- Another client seeing a personal trainer for weight loss and strength training (lost 15 more pounds)
- Partnership with VCIL improving e.g. ramp assessment done at client
- Health Coach has added more home visit clients; services include walking with clients in their neighborhoods

# Case Study

- D.D.-55 year old morbidly obese female with hypertension, atrial fibrillation, seasonal depression and anxiety
  - Services:
    - Health Coach visited with Home Health PT to learn exercise program and assist with follow through
    - Flexible funds for seasonal lamp and cardiac monitor for use during exercise.  Flexible funds for personal trainer in home ($690)
  - Outcome:
    - Weight loss of 85 pounds
    - Individual reports improvement in symptoms of depression

# Case Study

- B.L.- 25 year old male, former athlete, paraplegic, recently returned to the area without PCP
  - Services:
    - Flexible Funds for shower seat and repairs to wheelchair lift on truck ($2163)
    - Health Coach has weekly interactions by phone or visits
    - Health Coach assisted in connecting with PCP and voc rehab
    - Health Coach assisted in obtaining benefits and appt at wheelchair clinic
  - Outcome:
    - Independent with activities of daily living
    - Independent transportation
    - Has been hospitalized once since returning to area, CCC at PCP office knows to contact individual if missed appt to prevent transportation or other factors from contributing to health decline

# Case Study

- C.C.- 65 yr old female with Rheumatoid Arthritis, Respiratory Disease due to mold. Living in unsafe housing, no water, electricity, heating with small wood stove, leaking roof, mold and rodent infested. Individual is angry, frustrated, and lonely. Has restraining orders from most agencies. APS identified as not self-neglect. Referral from AHS to Community Connections.
  - Services:
    - Assisted individual with housing applications and appeals, set up transportation to Fletcher Allen for Infusions
    - Flexible funds purchased new therapeutic mattress that was mold-free and necessary for arthritis relief, gas and food cards, and gym membership ($1891)
  - Outcome:
    - Fewer ER visits- 6-8 visits yearly prior to intervention, 0 ER visits since intervention from Duals project