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

Date of meeting: July 14, 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	Bea Grause called the meeting to order at 10:31 AM. A roll call was taken and a quorum was present. A motion to accept the May minutes by exception was made by Laural Ruggles and seconded by Patricia Launer. The motion carried with one abstention.	
2. Updates:	**June 17 Convening** On June 17th a VHCIP convening of Co-chairs, Core Team and Staff was held to review goals, priorities, and work group progress against project milestones. Generally speaking, the CMCM work group is on track to achieve their milestones. The group's attention was drawn to Page 3 of the Milestones – Care Delivery and Practice Transformation The CMCM work group is on track to meet its milestones and the work outlined in its work plan. The Integrated Communities Care Management Learning Collaborative is currently in the process of being expanded to 8 new communities, and will continue into Year 3. Regarding the sub-grant program, second quarter progress reports are arriving this week and a summary of the projects will be compiled and shared with the Core Team and Steering Committees. There are some exciting results coming out of the sub-grantees programs. For example, the partnership between the Vermont Medical Society Foundation and the UVM Medical Center focused on reducing the number of unnecessary and potentially harmful lab tests showed a 40% decrease in the number of standing lab orders for adult inpatient stays between the fall of 2014 and late spring 2015. Additional sub-grant information is available on the VHCIP website. **Initial Discussion of Year 3 activities, Sustaining Work Group Initiatives**	

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	After summarizing work group activities to date, Bea Grause asked if there was anything that participants wished to include in the Year 3 activities planning. Dale Hackett observed that there seems to be a gap in the learning collaborative that it doesn't currently include students. Dale also raised concerns around issued of funding and sustainability of the work group's initiatives beyond the time frame of the SIM Grant. Bea commented that these are the kinds of questions that we will be seeking to answer this year: How do we create a sustainable learning model and who will carry this work moving forward? Pat Jones also commented that the concept of sustainability of SIM initiatives beyond the grant funding period is a key concern to top level leadership and decision makers. Dale Hackett noted that we want to capture good health care practices as well as healthy behaviors, and it is important to start this work as early as possible. This is why it is important to include youth and students in this work as early and as often as possible. Sue Aranoff pointed out that there is a real need for an understood and applied transitions of care process – and the ability to share the information that comes out of that coordinated care. Michael Bailit added that we should be evaluating what works and what hasn't worked in the learning collaboratives.	
	Unified Community Collaboratives Jenney Samuelson, Assistant Director of the Blueprint for Health, Miriam Sheehy, Assistant Director of the Clinical Unit at OneCare Vermont, and Patricia Launer, Community Health Quality Manager for Bi-state Primary Care/CHAC provided an update on the progress of the Unified Community Collaboratives (UCCs). Miriam Sheehy referenced the UCC/RCPC progress report (attachment 3) that illustrates some key features of these work groups including health service area, regional meeting name, whether or not a charter has been developed, whether or not a consumer is participating in the group, priority areas of focus and other attendees. Miriam also noted the high level of interest in hospice and palliative care (7 of the groups have chosen to focus on this work) A question was posed, how will we know if the groups are successful? Miriam responded that several useful metrics are included in the progress report at attachment 3. There is also data being shared with the health service areas to provide insight on quality improvement progress related to the priority areas they have chosen.	

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	A comment was made that some groups have a number of priority areas identified which could indicate that their focus is too broad to make an impact on so many areas. Miriam noted that in many cases this work is being carried over from previously existing initiatives and working groups. For example, in St. Johnsbury community members have been meeting to work on quality improvement initiatives for some time. The UCC often represents leaders from other forums within the community. In other words, the UCC is not responsible for doing all of the work, but rather as a shared leadership and decision making forum. Maura Graff from Planned Parenthood asked for clarification on the process of joining a UCC. Miriam responded that while there is a process for some groups, there is not a universal answer as each group is managing membership differently. Some groups have a leadership team who can grant permission to participate. Most groups welcome observers and participation varies after that. How did the groups choose their priorities? The goal is that all participants representing the entire health service area as a whole are driving decision making, rather than any one single entity. **Relationship between the UCCs and the Learning Collaboratives** Many of the regional UCCs have identified the Integrated Communities Care Management Learning Collaborative as a quality improvement project for their HSA, and have created working groups under the structure of their UCC to address this work. Dale Hackett asked about the decision of one of the UCCs to focus on "ACEs" (Adverse Childhood Experiences) and how it will be measured. Miriam responded that this is a new project and the team has not yet chosen the measures they want to use in their community. Patty Launer added that in quality improvement work in general, it is common to focus on improvement around process measures before thinking of larger scale outcomes measures. Mary Moulton added that the Washington County group is talking about ACEs as well as how to better integrate all of their health and community services in general, and will be participating in Round 2 of the Integrated Communities Care Management Learning Collaborative. **Integrated Communities Care Management Learning Collaborative Expansion Update** Pat Jones provided an update on the expansion of the Integrated Communities Care Management Learning Collaborative program. An additional 8 communities have agreed to participate, for a total of 11 including the initial 3 pilot communities. There is also a possibility that an additional group will join by the end of 2015. In order to maximize expert faculty resources, the learning sessions will be held on consecutive days in two locations throughout the state (Burlington area for the "West Coast" communities and White River area for "East Coast" communities). On September 8th and 9th the Camden Coalition of Healthcare Providers will be returning to present on using data to identify	

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	at-risk individuals. Introductory webinars were held on July 7th and July 22nd to orient the new communities to participation in the program. Additional pre-work includes recruiting local community team members, conducting PDSA training, and beginning to collect data to identify at risk individuals. Lauren Hardin was very well-received by the pilot communities and we will be bringing her back in November for a similar presentation in round 2. Plans are underway to film an entire set of learning sessions for one of the cohorts in an effort to make educational resources available to communities and participants beyond the life of the SIM grant. Additionally, planning is underway to develop a curriculum of core competency training for front line care managers in collaboration with the DLTSS work group. Julie Wasserman created a draft RFP which CMCM work group staff is currently reviewing. Dale Hackett asked what resources are available to a community should they 'get stuck?' The quality improvement facilitators funded by the learning collaborative serve as key resources to communities in working through challenges and staying on track. Additionally, we have identified and made tools available from our expert faculty through the learning collaboratives. Finally, as communities find success in various areas, the shared learning environment allows them to share their learnings with other communities. Erin Flynn pointed out that the difficult work is being done on the ground in the communities and while staff and facilitators are doing everything we can to support the communities in this work, their success is largely attributed to a strong commitment by all community members to come together and work in a different way. Maura Graff asked for clarification around the requirement that a patient centered medical homes 'must' participate in at least one Blueprint UCC quality improvement initiative. Jenney Samuelson clarified that this is not related to the learning collaborative, but is rather related to the enhanced Blueprint payments to primary care practices effective July 1, 2015.	
4. Presentation on Caledonia and Southern Essex Counties (St. Johnsbury Health Service Area) Learning	**Presentation on Caledonia and Southern Essex Counties (St. Johnsbury Health Service Area) Participation in the Integrated Communities Care Management Learning Collaborative and the Dual Eligible Provide Sub-Grant Project** Pam Smart of Northeastern Vermont Regional Hospital and Treny Burgess of Caledonia Home Health and Hospice presented on the above topic. This community has been fortunate to pair their participation in the Integrated Communities Care Management Learning Collaborative with their Dual Eligible Sub-Grant Program to better support Dual-Eligible individuals with some additional resources such as a health coach and some flexible funding to better meet individual's needs.	

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Collaborative and Dual Eligible Project	One of the key focuses of this work is to ensure that care delivery is not only integrated, but also person centered. One example of a helpful engagement tool that has come out of this work are the "Camden Cards" that the St. Johnsbury team has been using to work with individuals on goal setting. An additional tool that has been identified through this work is an Eco-map to help draw/illustrate the relationships that exist around the individual. **Shared care plan** The benefit of shared care plans has emerged from this work as well. It has been challenging to develop this tool in a way that meets the needs of all members of the community team, and eventually the team decided that they needed to stop editing the plan and begin using it for a period of time to better understand it effectiveness. At this point 65 to 70% of individuals participating in the pilot have shared care plans in place. Another challenge has been mapping out the workflows and identifying an overall process for achieving integrated care management. Overarching questions include: At what point in the process should various interventions be introduced? How do we get the right people at the table? What if the person doesn't want to participate? What if they don't want certain providers to come? Another positive outcome of this work has been that through new collaborations community partners have identified additional sources of funding and have found ways to support each other and the needs of their community. Many community partners have funds to willingly contribute – and now that the partnerships have been formed, the funds are being spent where they're needed most. Regarding one of the case studies presented, Patricia Singer asked how housing issues were addressed specifically. Pam responded that it was difficult – they worked extensively with Rural Edge, the local housing authority/support service provider. The care coordinator accompanied the individual in viewing 18 apartments; and ultimately had to file an appeal and write letters of reference and support on the individual's behalf. The housing group is part of the collaborative and the patient was also part of the Duals cohort - a team approach was key. Because the housing authority saw the support of the individual's care team behind her, they were willing to offer her housing when they hadn't been willing to in the past. A question was asked, how did you choose the initial patient panel for the learning collaborative? Treny Burgess responded that everyone in the community team brought their lists of dually eligible people. They also brought the high spending lists from the hospitals and just talked through each person to identify whether they were a good candidate for the program. It helped that there was already a project going in the community and that the various team members were already used to working together.	

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	Dale Hackett asked if we can apply the learnings and lessons from St. Johnsbury to communities across the state and noted that it is critical to relay these findings to top level leadership so that the work will be sustained in the long term. Bea responded that these are exactly the questions and issues that we'll be exploring over the next two years of the SIM grant.	
6. Next Steps, Future Meeting	***AUGUST MEETING CANCELLED*** **Next Meeting:** *Tuesday, September 15th, 2015, 10:30 AM – 12:30 PM, Calvin Coolidge Conference Room, National Life, Montpelier VT*	