State of Vermont *Agency of Human Services*
Department of Vermont Health Access
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Combined Meeting of the Blueprint Executive Committee and the Blueprint Expansion, Design, and Evaluation Committee
Notes of
November 20, 2013

Present: D. Andrews, P. Biron, N. Eldridge, J. Evans, P. Farnham, L. Francis, B. Groff, B. Grause, K. Hein, V. Harder, P. Jackson, C. Jones, K. Lang, P. Launer, W. Little, N. Lovejoy, M. McAdoo, D. Noble, K. Novak, C. O'Hara, S. Hartsfield, L. McLaren, S. Narkewicz, C. Oliver, M. Olszewski, J. Peterson, A. Ramsey, P. Reiss, J. Samuelson, C. Schutz, J. Shaw, R. Stout, K. Suter, B. Tanzman, M. Tarmy, B. Warnock, L. Watkins, D. Weening, S. Wehry, B. Wheeler

The meeting opened at 8:35 a.m.

I. *Status of Blueprint Expansion: Craig Jones* (PowerPoint Attachment A)

- As of the 4th quarter, 120 practices have been NCQA recognized. We now have good distribution in each Health Service Area.
- 500,000 Vermonters now have access to medical homes.
- MVP has requested receiving administrative funding data from the Health Service Areas. It would be very helpful to know the exact funding for the CHT's and to understand the ratios. Nick Lovejoy agreed to check into this and report back to the Committee.

II. *Planning for a Paid for Performance Model: Craig Jones*

- We will be working on Pay for Performance models over the next few months. We will be working closely with the SIM process as we move forward.
- Dr. Jones asked for input/ideas on how to work in an integrated way with the ACO's. How can our networks fit in and work with the ACO's around the state?
- We are looking at distributing the Practice Profiles every 6 months.
- Our measures are endorsed by the National Quality Forum. Our source is the all claims database. We will send out the "Methods" document to this Committee.

III. *Community Health Teams & Community Networks*

1. Intro to Network Analysis – Craig Jones
    - To get a better sense of what our networks look like today, we have asked UVM to conduct a network analysis. We plan to present the results at our January meeting.
2. Burlington Health Service Area Network Presentation.

- Pam Farnham, Manager Community Health Team and Kristin Novak, Assistant Manager Community Health Team gave a Burlington Heath Service Area Network presentation. (PowerPoint Attachment B)
- Pam introduced the Medical Home Model for Burlington as well as how services are currently being provided. Pam explained the roles and break down of Burlington's FTE's which included Nursing, Registered Dieticians, Health Coaches, and Social Workers working in the Burlington Health Service Area. Community partners were recognized and outcomes data presented. Kristin shared a case study with the committee as an example of one of Burlington's success stories.
- In summary, better coordination is a key opportunity. Everything being done is changing the ability to support patients but concern was raised that the reallocation of resources has not lessened the work of the physician.

IV. *Other Business*

- The Blueprint Executive Committee has received copies of the ***First Annual Report of the CMS MAPCP Demonstration.*** The leadership at CMMI has requested that this report not be distributed beyond our key stakeholders and we appreciate your cooperation in respecting CMMI's request. In summary, trends in Vermont are favorable.

The meeting adjourned at 10:35 a.m.

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Community Networks of Health Services

Executive Committee
Design, Planning, Evaluation Committee

11/20/13

Agenda

1. Status of Blueprint Expansion
2. Planning for a P4P model
3. Community Health Teams & Networks
   - Introduction to Network Analysis
   - Burlington HSA Network Presentation

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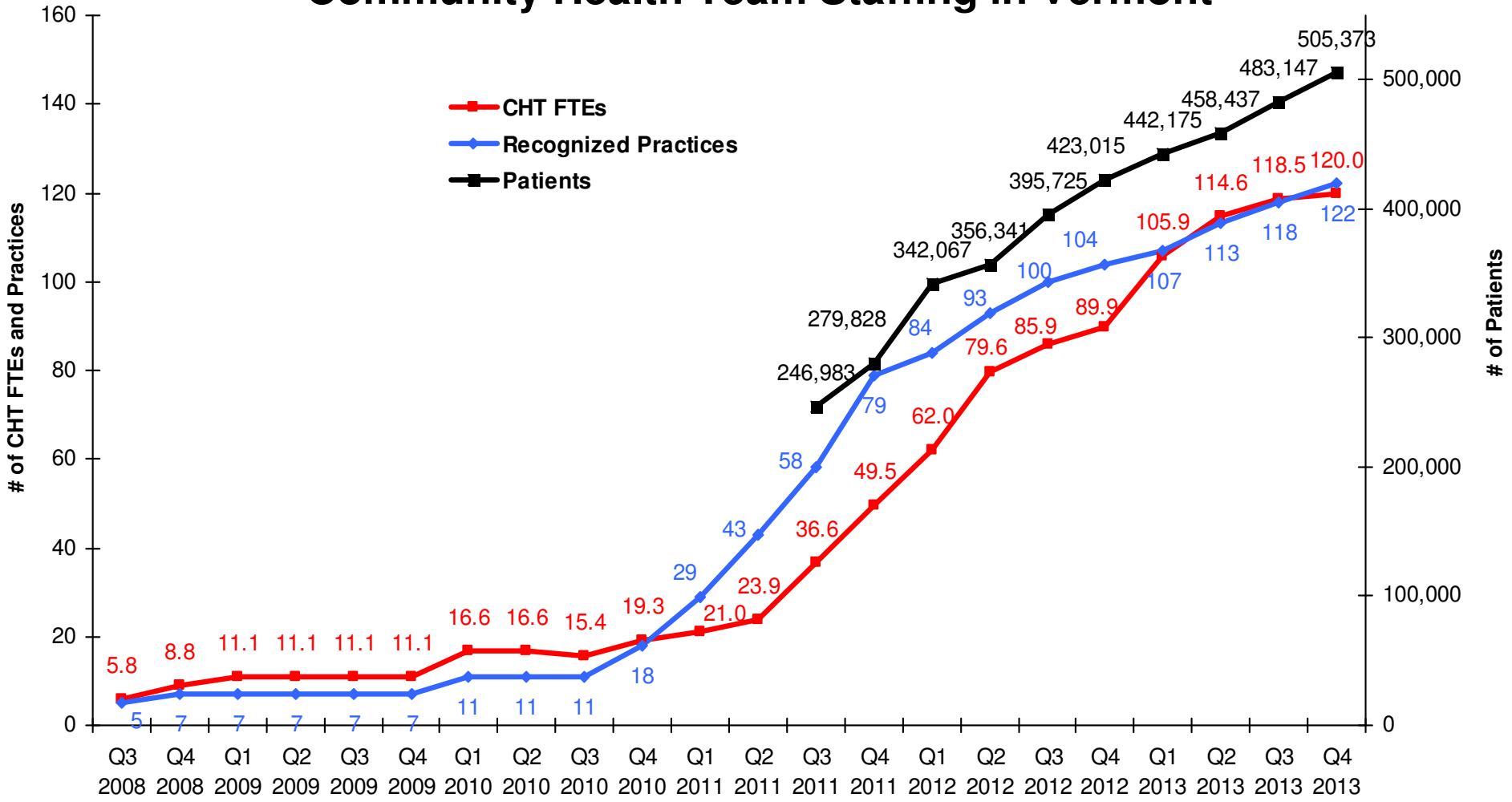
Patient Centered Medical Homes and Community Health Team Staffing in Vermont



*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.

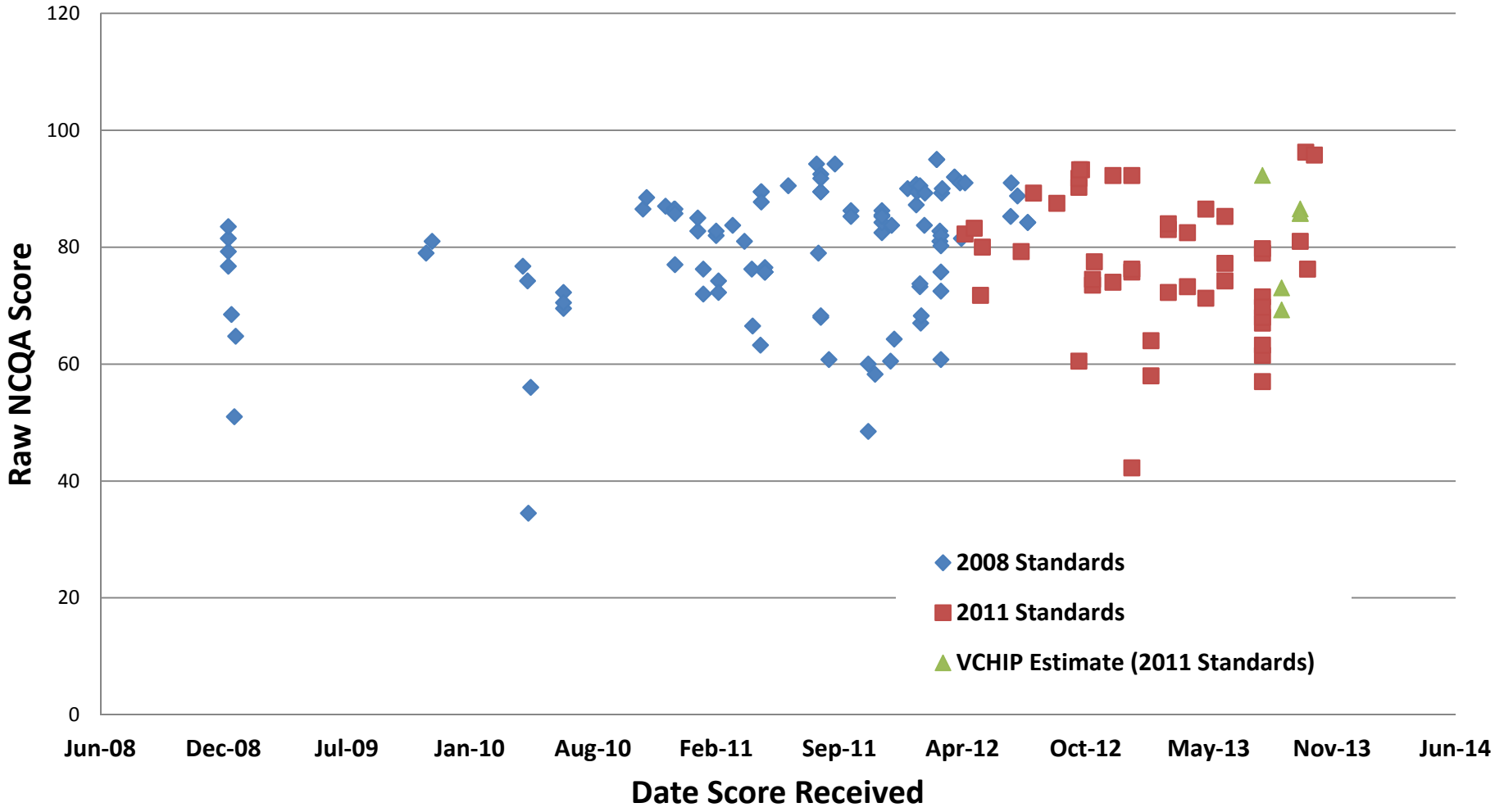
Patient Centered Medical Homes and Community Health Team Staffing in Vermont

Key Components	December 2013
PCMHs (scored by UVM)	122
PCPs (unique providers)	613
Patients (per PCMHs)	505,373
CHT FTEs (core staff)	120
SASH provider FTEs (extenders)	46.5
Spoke Staff FTEs (extenders)*	24.1

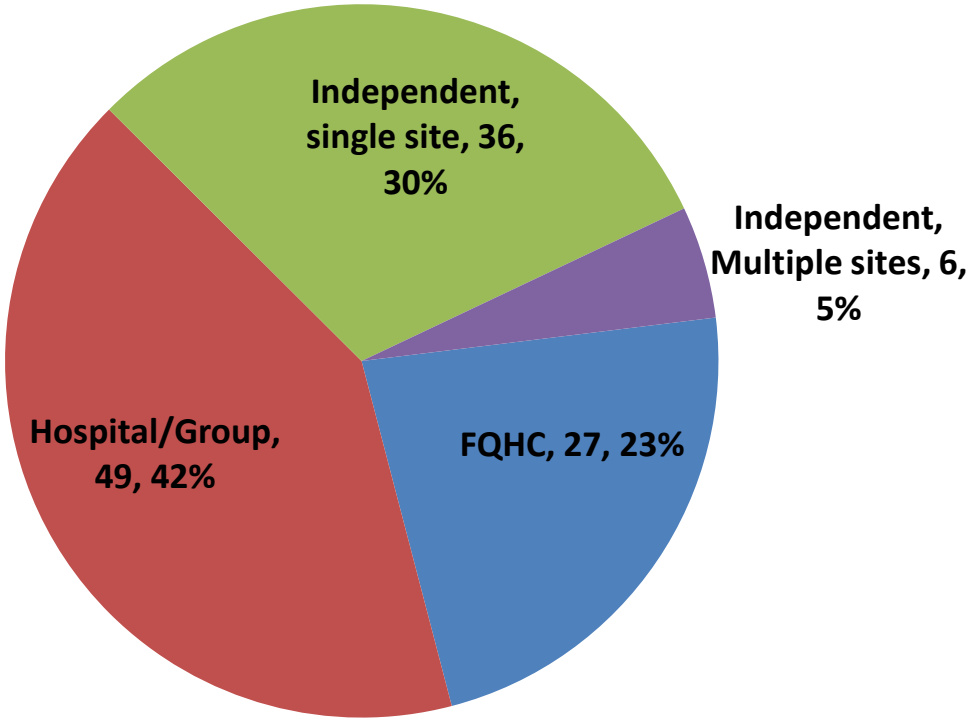
*Spoke Staff FTE as of September 2013

NCQA Scores Over Time

November 2013



Affiliation & Ownership of PCMHs
November 2013



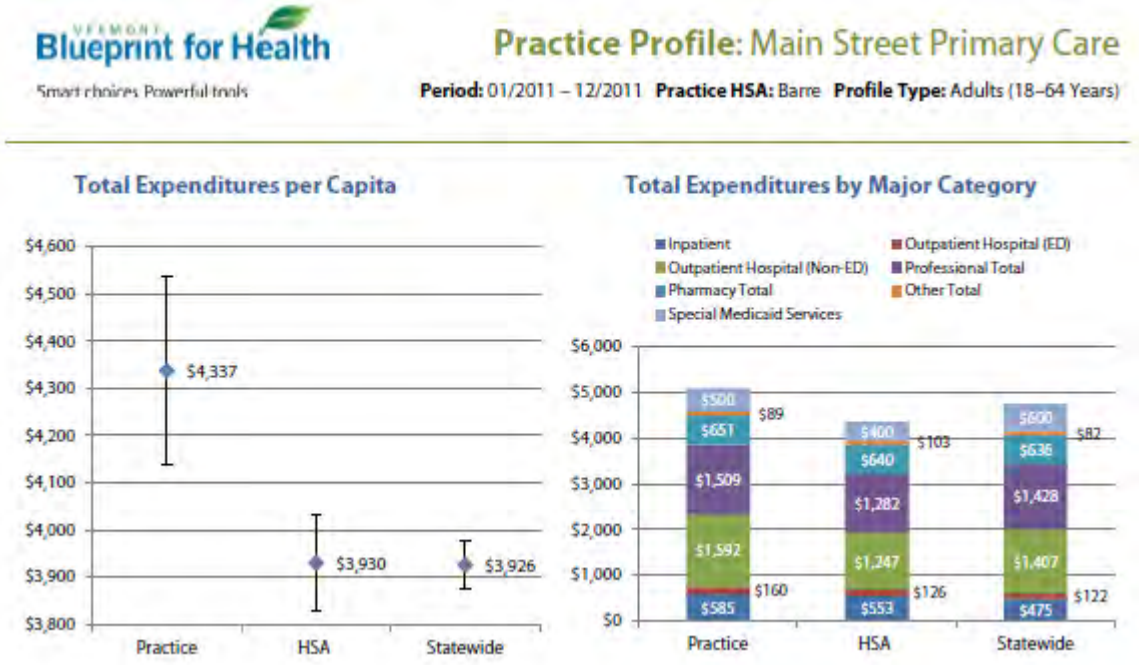
Participating PCMH Primary Care Providers

Charting System	# of practices	%
Electronic	100	79%
Paper	22	17%
Paper & Registry	4	3%
Paper & Electronic	0	0%
All Systems	126	

Pay For Outcomes

Quality Data Leads to Quality Improvement

All-payer Claims Database



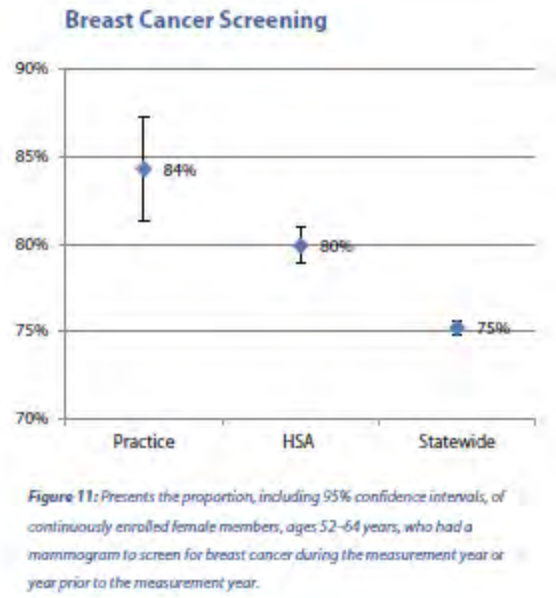
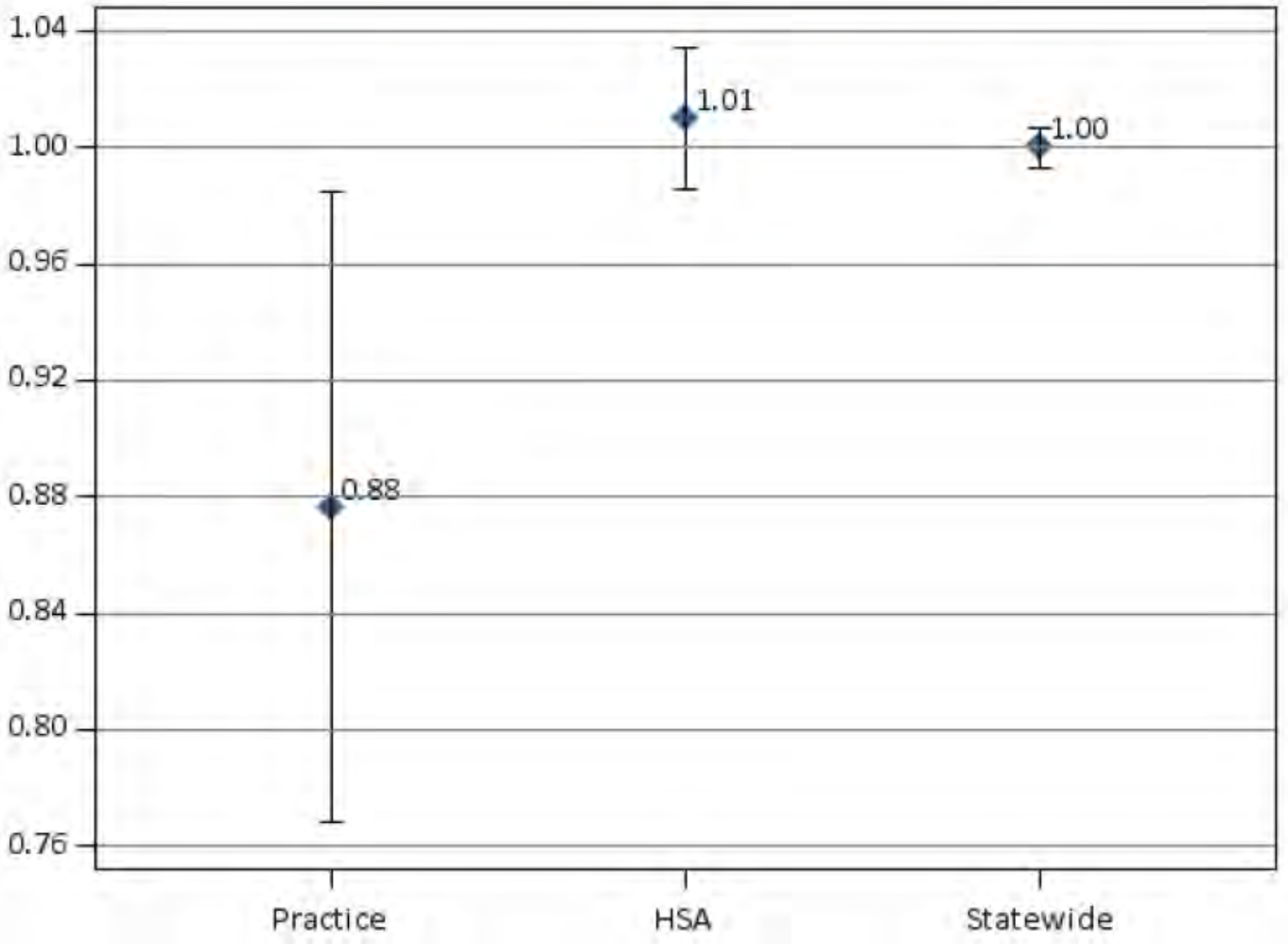


Figure 11: Presents the proportion, including 95% confidence intervals, of continuously enrolled female members, ages 52-64 years, who had a mammogram to screen for breast cancer during the measurement year or year prior to the measurement year.

Total Resource Use Index (RUI)



Community Networks

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Barre HSA

Full Network

Node color indicates sub-network membership

Node size indicates Betweenness Centrality

Blueprint Team

Diane Hawkins
Terri Price
Kyle Mooney

Craig Jones, MD
Lisa Dulsky Watkins, MD
Jenney Samuelson
Beth Tanzman
Nick Lovejoy
Miki Olszewski
Michelle Lavalle

Steve Maier
Larry Sandage
Terry Bequette
Tim Tremblay
Lorraine Sicilliano
Heather Kendall
Casey O'Hara

In service to the PATIENT, COMMUNITY *and* MEDICINE *since 1879.*

Burlington Service Area Community Health Team

Blueprint Evaluation Committee | September 18, 2013

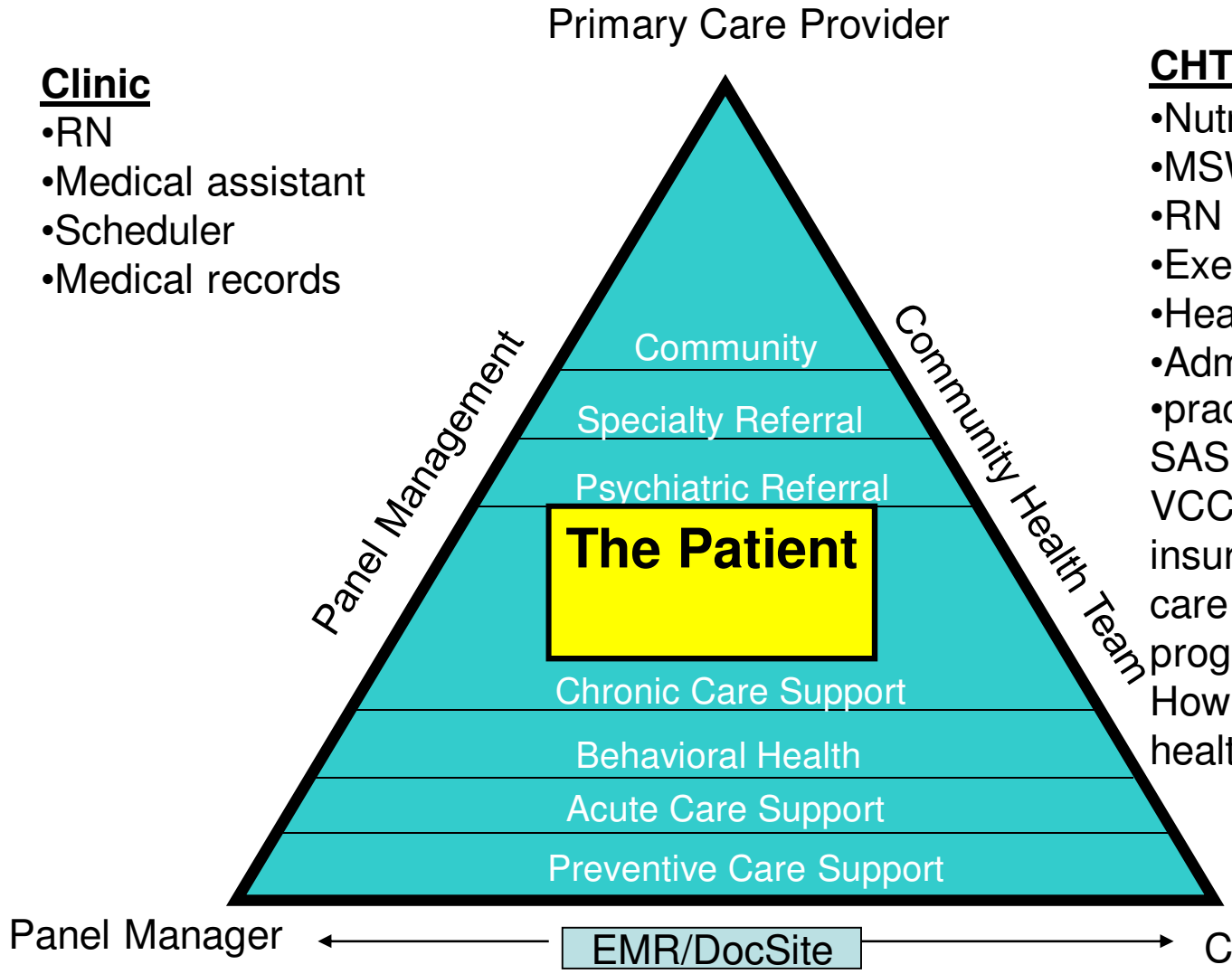
Pam Farnham, Manager Community Health Team
Kristin Novak, Assistance Manager Community Health Team

Fletcher Allen HEALTH CARE
In alliance with The University of Vermont

Medical Home Model

Fletcher Allen HEALTH CARE
In alliance with The University of Vermont

Clinic
- RN
- Medical assistant
- Scheduler
- Medical records



CHT
- Nutrition/CDE
- MSW
- RN
- Exercise/Fitness
- Health Educator
- Admin
- practice extenders SASH, VNA, VCCI,VMC, other insurance/hospital care management programs Howard Mental health

Models of CHT Services Provided

- **Core or functional CHT** – employees employed by the HAS (Fletcher Allen) that are deployed to the NCQA practices in our services area as needed
- **Embedded CHT services-** NCQA clinic employed staff that are doing work that is paid for with CHT dollars: care coordination, panel management, RD support, Health Coaching support
- **Core/embedded blended services-** HSA and NCQA clinic staff supporting patients in positive behavior change

Core Community Health Team (CHT)

- Patients referred via EMR, e-fax form or paper fax
- Regular, ongoing support 1:1, in groups or by phone
- Help patients set realistic goals & timelines for improving health, accessing resources and facilitating patients becoming active self managers

Nursing Role

- Care Coordination
- Medication Reconciliation
- Chronic Disease Management
- Acute Assessments
- Transitions of Care Coordination
- Connections to Appropriate Community Resources

Nutrition Roles

Fletcher Allen HEALTH CARE
In alliance with The University of Vermont

Registered Dietician

- Pregnancy and lactation support
- Healthy eating around infancy, childhood, adolescence and adulthood
- Chronic Disease nutrition support: healthy weight loss and gain, nutrition education for diabetes management, hypertension management, cardiovascular disease, GI issues, GERD
- Sports Nutrition supports
- Eating disorders supports for clients working with counseling

Health Coach

- Basic nutrition and lifestyle supports using food logging, group supports

Social Work Role

- Psychosocial assessments of patients
- Home visits for older/disabled patients (who have difficulty getting out) assessing level of care and providing counseling for long range planning
- Assistance with connection to community and financial resources
- Support and assistance to caregivers of patients with dementia or other difficult chronic conditions
- Brief mental health assessments ensuring follow-up and recommendations with primary care provider as well as making appropriate referrals for mental health and substance abuse counseling
- Consult with other team members and primary care providers regarding patients with complex social and mental health needs
- Short term care management
- Utilize motivational interviewing with patients to help create readiness for change

CHT Fitness Center Overview

Community Health Team Fitness Center Program Description

- Two one-on-one (1 hour) sessions scheduled with a Personal Trainer
- A full body land base strength and aerobic circuit training program is the basis of instruction
- Referred patient then receives a free 1 month membership

Fitness Centers options

- Body Resolution: South Burlington
- Greater Burlington YMCA: Burlington, Winooski
- Marketplace Fitness: Burlington
- Middlebury Fitness: Middlebury
- RehabGym: Burlington, Colchester, Williston
- Shelburne Health & Fitness: Shelburne
- Synergy Fitness: Williston
- The Edge: Essex, South Burlington, Williston
- Ultimate Fitness: Milton

NCQA recognized Medical Homes in the Burlington HSA

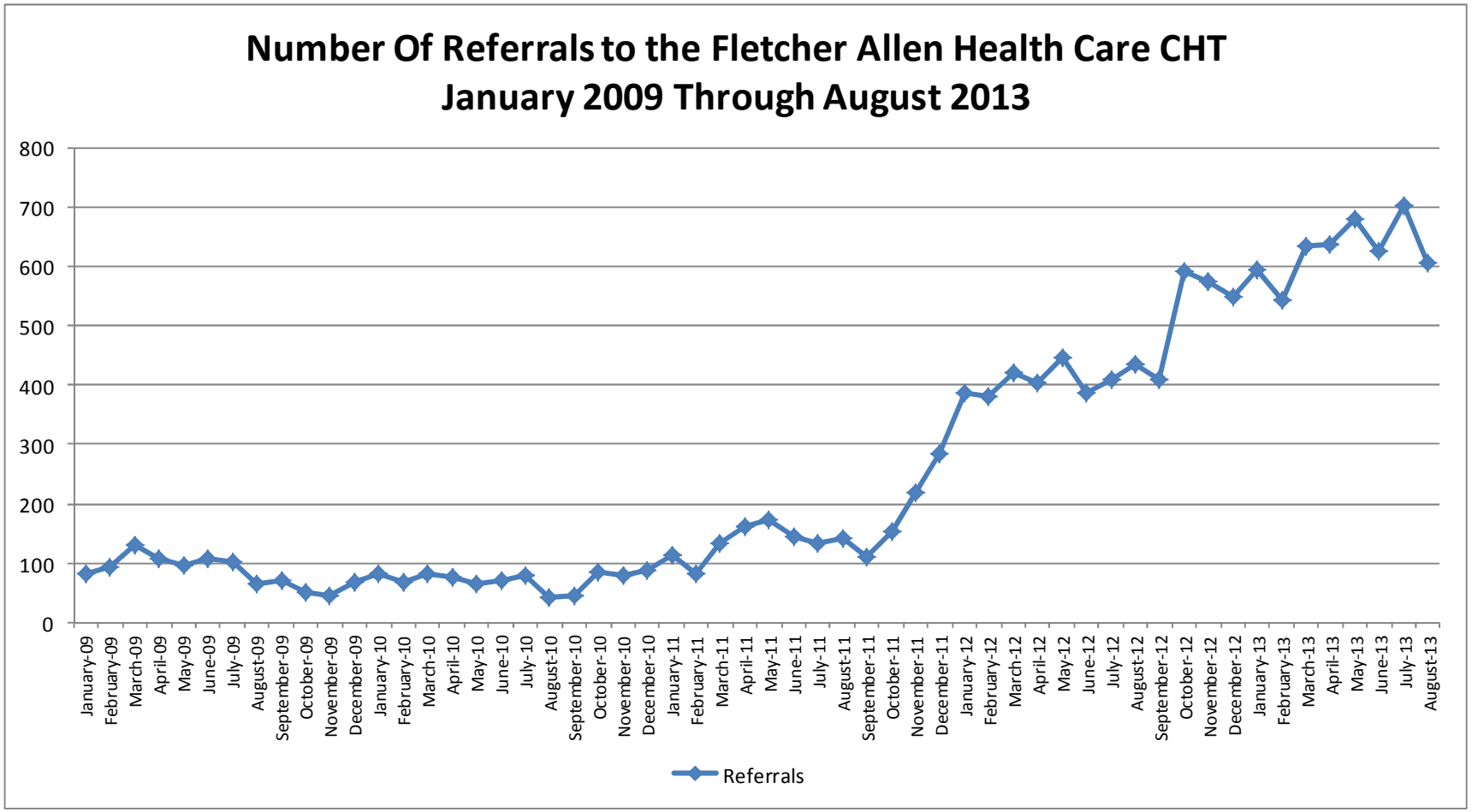
Current

- Aesculapius Medical Center
- Alderbrook
- Burlington Primary Care
- Charlotte Family Health Center
- Community Health Center of Burlington
- Colchester Family Practice
- Essex Pediatrics
- Evergreen Family Health
- Given Burlington
- Given Essex
- Given Williston
- Goodhealth
- Hagan, Rinehart & Connolly
- Herbert, Dr.
- Hinesburg Family Practice
- Milton Family Practice
- Moore, Dr.
- Mountain View Natural Medicine
- Richmond Family Medicine
- South Burlington Family Practice
- Thomas Chittenden Family Health
- Timberlane Pediatrics
- University Pediatrics
- Winooski Family Health

Expected to join in the next 12 months:

- Champlain Center for Natural Medicine
- Sam Russo naturopathic Medicine

Number of CHT Referrals



Burlington HSA Statistics

- There have been a total of 2101 graduated referrals.
- Number of patients (individual people counted by MRN) the CHT has served since 1/2009 – 7,289
- Total number of patients currently marked as active = 1,889

Burlington HSA FTEs

RNs: 1 Manager, 1 Assistant Manager	2.0 FTE
• 2 Core CHT RNs	
• 3 Pediatric Care Coordinators	
• 3 Adult/Family Care Coordinators	6.0 FTE
• Panel Managers	3.0 FTE
Social Work: 1 Supervisor	
6 Licensed Social Workers	7.0 FTE
1 Community Health Worker	.5 FTE
Dietitians: 1 Supervisor	1.0 FTE
6 Health Coach	5.4 FTE
5 Registered Dietitians	5.0 FTE
Administration and Scheduling: 1 Supervisor	
5 Team Members	6.0 FTE
Psychology	.07 FTE
Psychiatry	.02 FTE
TOTAL FTE	36

Community Partners

- Visiting Nurses Association
- Other Home Health Providers
- VCCI
- Private Insurance Care Managers
- SASH
- Howard Center
- FAHC Case Management
- ACO Nurses (ONE Care, Health First)
- Fitness Centers
- NCQA Clinic Leadership & Care Coordinators

Outcomes Data

- Referred for Diabetes Related Issues (n=144)
- Weight loss: For those patients with a recorded weight loss (n=58) the average amount of weight lost = 14.05 pounds. Collectively the 58 patients lost 815.35 pounds.
- Change in BMI: For those patients with a recorded BMI (on initial intake and on six-month follow-up (n=57)), 61.4% had an improvement in their BMI.
- Change in HbA1c: For those patients with a recorded decrease in their HbA1c (n=63) the average decrease was 1.09. For those patients with a recorded A1c (on initial intake and on six-month follow-up (n=97)), 65% had an improvement in their A1c.
- Change in LDL: For those patients with a recorded decrease in their LDL (n=37) the average decrease was 26.86. For those patients with a recorded LDL (on initial intake and on six-month follow-up (n=94)), 39.36% had an improvement in their LDL.

Outcomes Data, continued

- Referred for Exercise/Nutrition Related Issues (n=265)
- Weight loss: For those patients with a recorded weight loss (n=123) the average amount of weight lost = 10.9 pounds. Collectively the 123 patients lost 1,345 pounds.
- Change in BMI: For those patients with a recorded BMI (on initial intake and on six-month follow-up (n=149)) 53.0% had an improvement in their BMI. Average decrease was 1.9
- Change in LDL: For those patients with a recorded decrease in their LDL (n=46) the average decrease was 25.3. For those patients with a recorded LDL (on initial intake and on six-month follow-up (n=136)), 33.8% had an improvement in their LDL

Success Stories

A Charlotte patient who was initially referred for weight loss and hypertension: During our work together the patient mentioned that he had been uninsured for 2 years, and therefore could not seek medical help for some of his issues, including ongoing pain management. We connected him with Our Health Assistance Program. They helped him complete the insurance forms, and now he has insurance. He was later referred to our CHT RD because of his severe, ongoing GERD issues, and when they met post-insurance activation, she marched him downstairs at the practice to make an appointment with a doctor. The result of working with the CHT hleped this patient cut out salt completely (this is a guy who used to salt his fruit!), eating more fruits and vegetables, clearing out his pantry of less healthy foods, portion sizes of beef, label reading; and has made enough healthy changes in his eating habits that his teenage daughter who lives with him part-time, is now eating healthier and has lost weight.

Iraqi refugee family: father works full time, mother surviving with trauma / anxiety symptoms, six children ages 3, 6, 10, 12, 15, and 18. Partnered with CHT SW to help with navigating child care support of the youngest child. Utilized Child Care Subsidy and Child Care Resource to complete child care search. Three year old is now successfully participating in full day care M, W, and F so mom can attend ELL classes and receive treatment for her behavioral health. In addition, with the partnership of another CHT SW working with Mom, we were able to support family in applying for Champlain Housing Trust, they were able to successfully move into larger home to accommodate their family.

Success Stories

Transition aged young adult, age 19, meets with CHT SW: Gain rapport and trust. Assist this young person to link to supports including housing, insurance and financial assistance through 3Squares. This young woman has a previous experience of homelessness and is currently under-housed. At this time we are working on appealing a decision made by Champlain Housing Trust to assist she and her partner to move into their own apartment.

Seven year old female who struggled with peer interactions and finding her voice: Six visits with CHT SW that focused on skill building around self-esteem, self-worth, emotion identification / regulation and assertive language skills. Mom reports this youngster continues to use skills taught in context of care with her family-centered medical home.

Single mother, three young children residing in Alburgh VT: Use of collaborative teaming with the VNA, NCSS, OT and SLP providers to work together in partnership with this mom. Goal of reducing her distress and improving family's overall well-health. CHT SW provides space for this single mother to be listened to fully and helps to communicate among the team. The youngest child was diagnosed with a seizure disorder that mom continues to struggle to come to acceptance; helping Mom recognize themes of grief / loss while she simultaneously is caring for her family.