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VERMONT Blueprint for Health

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Integrated Care Coordination in a Local Community

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Middlebury HSA

Objectives

- Previous Challenges to Integrating Care Coordination in a Community
- Two Key Approaches to Enhancing Care Coordination:
  - New Payment Model: VT Medicaid Next Generation
  - Integrated Communities Care Coordination Model
- Implementing Integrated Care Coordination into a Community

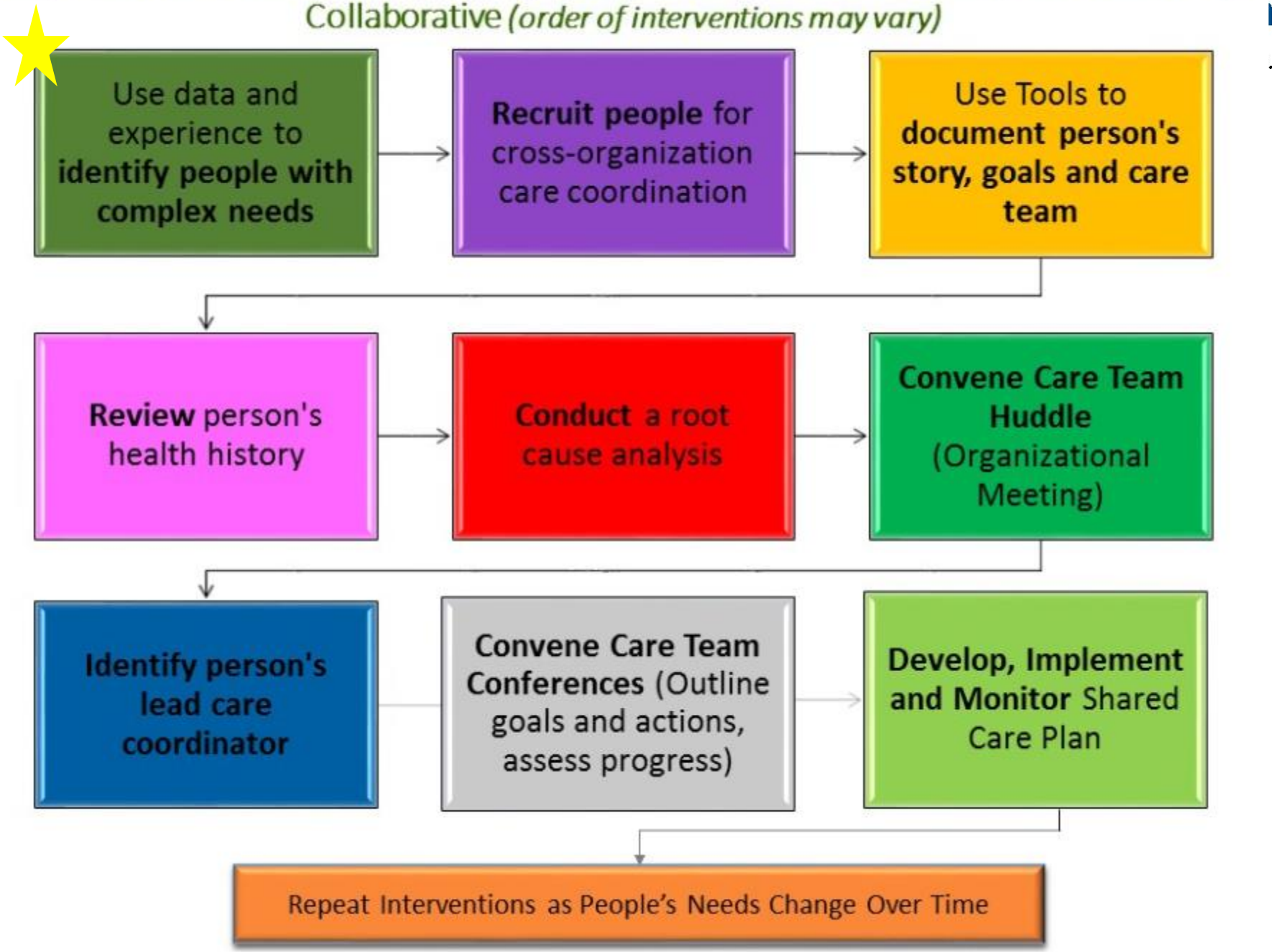
Challenges to Implementing an Integrated Care Coordination Model

- Lack of an integrated electronic health record
  - Ex: Middlebury HSA has at least 10 EHRs
- Community organizations and agencies had competing priorities and/or were still working on aligning priorities
- Models of care and coordinated care differed significantly between medicine and social and mental health
  - Lack of shared tools and framework for assessing a person's needs and goals
- Previous payment model did not support the work being done with or for the patient outside of a visit or face to face interaction with a licensed individual
  - This caused a huge barrier when it came to implementing the care coordination model in the Inpatient Department and Emergency Department

Vermont Medicaid Next Generation

- Change in funding model
  - Capitated payments to the Hospitals
  - PMPM Payment for Panel Management and Implementation
  - 3 Levels of Care Coordination payments
    - Primary Care
    - Designated Mental Agencies
    - AAA
    - Home Health
- Access to data analytics and care coordination shared care plan software
  - Workbench One
  - Care Navigator

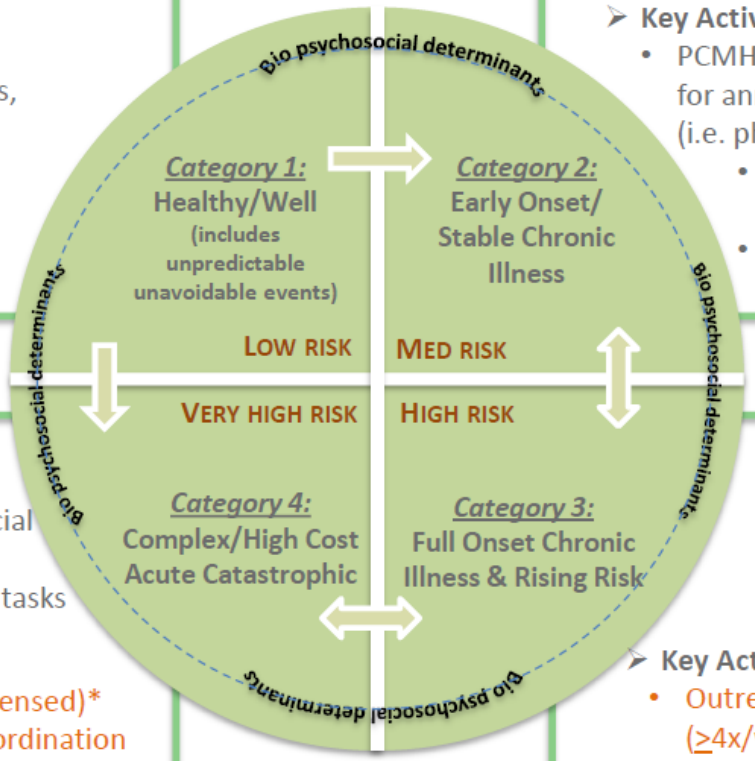
Key Interventions in Vermont's Integrated Communities Care Management Learning Collaborative *(order of interventions may vary)*



Population Health Approach to Care Coordination

- **44% of the population**
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Key Activities:**
  - PCMH panel management
  - Preventive care (e.g. wellness exams, immunizations, health screenings)
  - Wellness campaigns (e.g. health education and resources, wellness classes, parenting education)

- **40% of the population**
- **Focus:** Optimize health and self-management of chronic disease
- **Key Activities:** Category 1 plus
  - PCMH panel management: outreach (≥2/yr) for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
    - Disease & self-management support* (i.e. education, referrals, reminders)
    - Pregnancy education



- **6% of the population**
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Key Activities:** Category 3 plus
  - Designate lead care coordinator (licensed)*
  - Outreach & engagement in care coordination (at least monthly) recorded in Encounter Log*
  - LCC: coordinate with care team members*
  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

- **10% of the population**
- **Focus:** Active skill-building for chronic condition management; address co-occurring social needs
- **Key Activities:** Category 2 plus
  - Outreach & engagement in care coordination (≥4x/yr) recorded in Encounter Log*
  - Create & maintain shared care plan*
  - LCC: coordinate with care team members*
  - Emphasize safe & timely transitions of care
  - SDoH management strategies*

* Activities recorded in Care Navigator software platform

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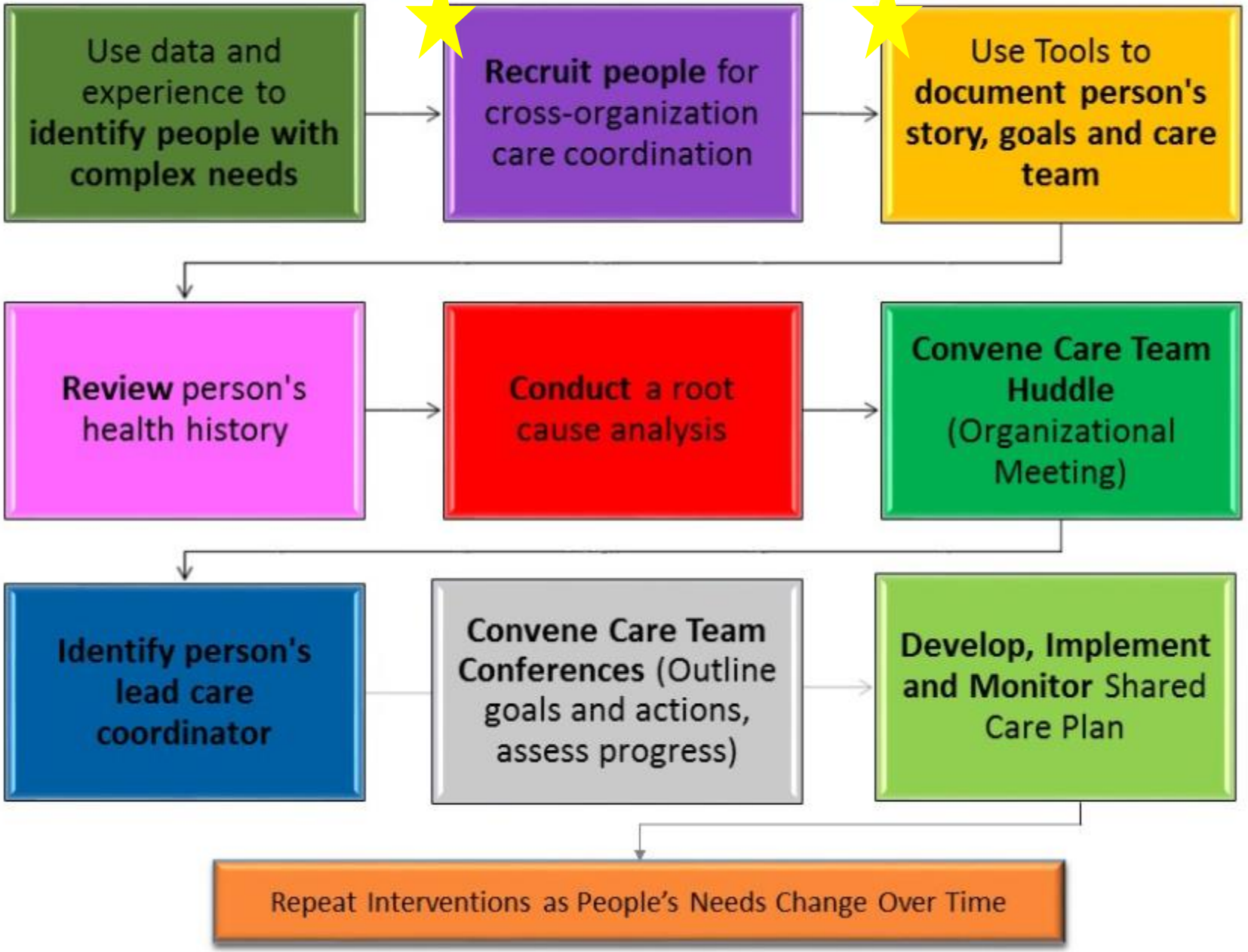
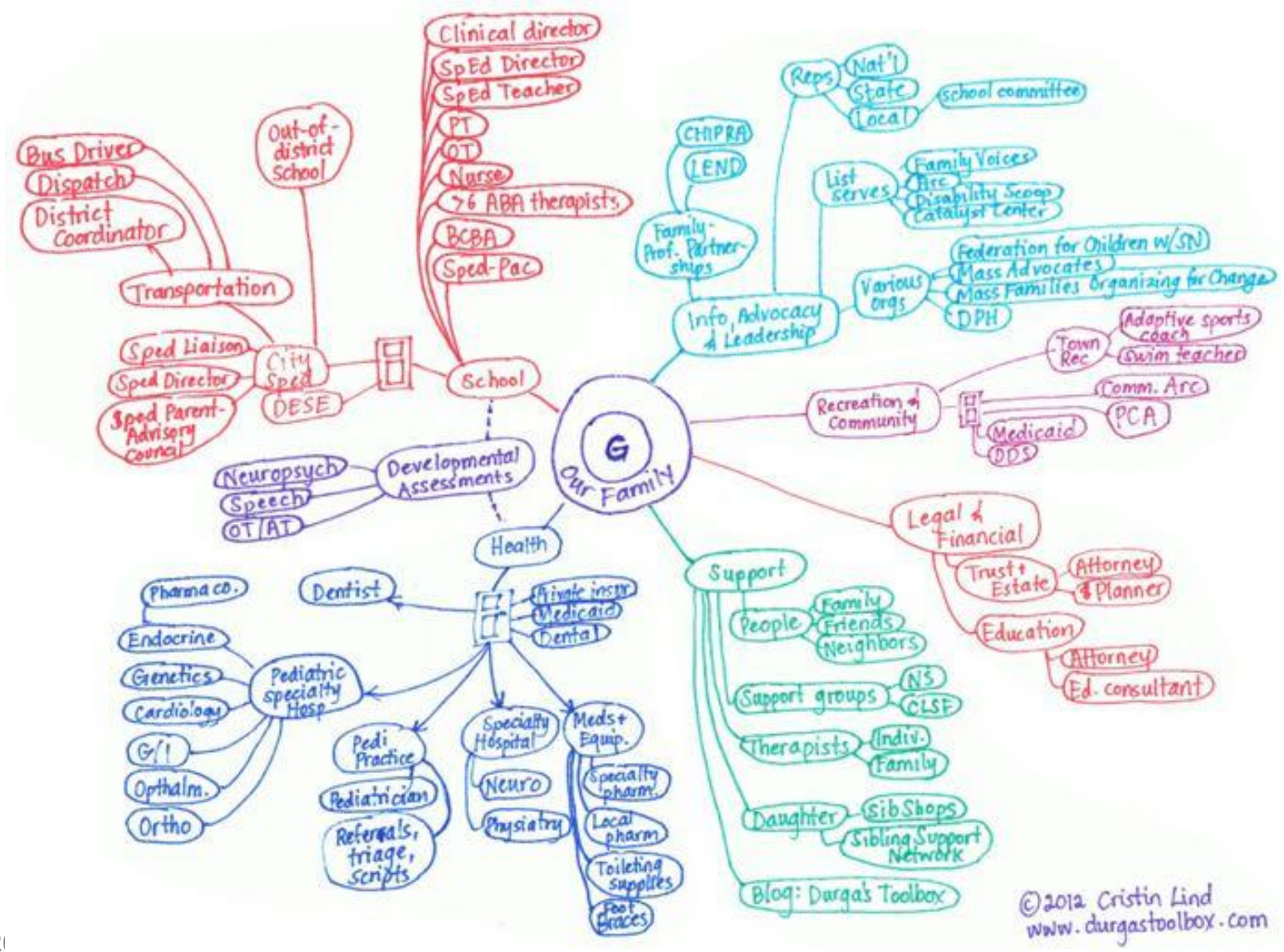


Tools to Document a Person's Story, Goals, and Care Team

- Camden Cards and Backwards Planning
- Ecomap

Eco Map


Our Family
Clinical director
SpEd Director
SpEd Teacher
PT
OT
Nurse
~6 ABA therapists
BCBA
Sped-Pac
Out-of-district school
Bus Driver
Dispatch
District Coordinator
Transportation
Sped Liaison
Sped Director
Sped Parent-Advisory council
City Sped
DESE
School
CHIPRA
LEND
Family-Prof. Partnerships
Reps
Nat'l
State
Local
school committee
List serves
Family Voices
Arc
Disability Scoop
Catalyst Center
Info, Advocacy & Leadership
Various orgs
Federation for Children w/SN
Mass Advocates
Mass Families Organizing for Change
DPH
Recreation & Community
Town Rec
Adaptive sports coach
Swim teacher
Comm. Arc
PCA
Medicaid
DDS
Legal & Financial
Trust + Estate
Attorney & Planner
Education
Attorney
Ed. consultant
Support
People
Family
Friends
Neighbors
Support groups
NS
CLSF
Therapists
Indiv.
Family
Daughter
Sib Shops
Sibling Support Network
Blog: Durga's Toolbox
Health
Dentist
Private insur
Medicaid
Dental
Pediatric specialty Hosp
Pharma co.
Endocrine
Genetics
Cardiology
G/I
Opthalm.
Ortho
Pedi Practice
Pediatrician
Referrals, triage, scripts
Specialty Hospital
Neuro
Physiatry
Meds + Equip.
Specialty pharm.
Local pharm
Toileting supplies
Foot Braces
Developmental Assessments
Neuropsych
Speech
OT/AT
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Camden Cards

Family Relationships

Safety

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

Budgeting/Finances

Health Insurance

Transportation

Housing

Drugs or Alcohol

Food & Nutrition

Utilities

Education & Jobs

Work with Health Care Team

Mental Health

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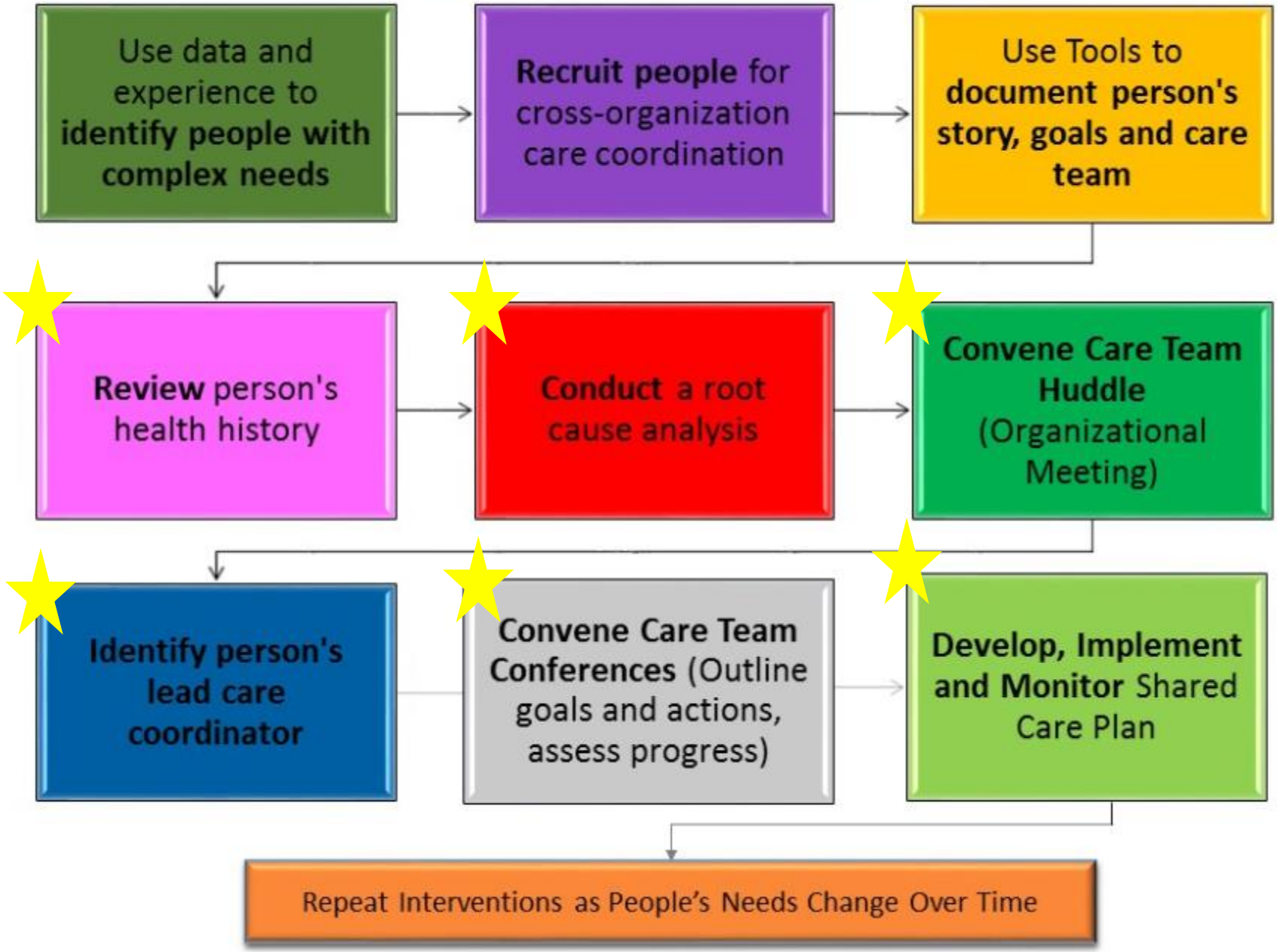
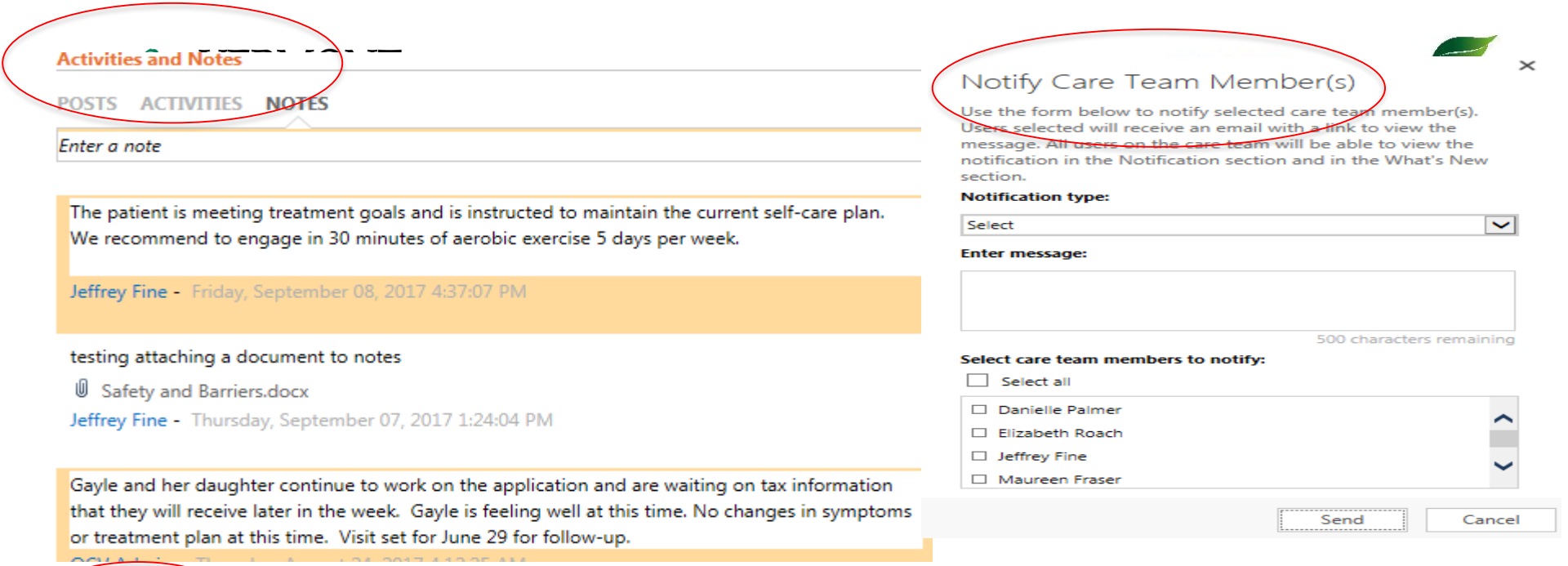
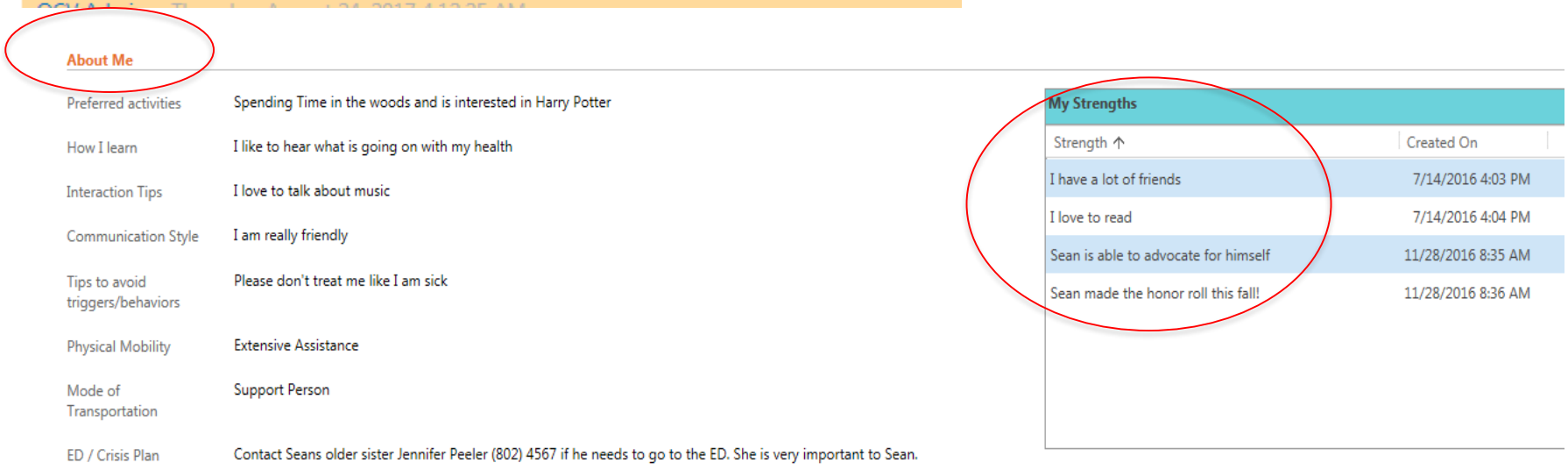


Shared Care Plan

- Focuses on person's strength, personal goals and action plans, treatment goals and action plans, barriers, and long term goals

- Tool support sharing across agencies:
  - Care Navigator
    - All care team members can access and update information in real time


Activities and Notes
POSTS ACTIVITIES NOTES
Enter a note
The patient is meeting treatment goals and is instructed to maintain the current self-care plan. We recommend to engage in 30 minutes of aerobic exercise 5 days per week.
Jeffrey Fine - Friday, September 08, 2017 4:37:07 PM
testing attaching a document to notes
Safety and Barriers.docx
Jeffrey Fine - Thursday, September 07, 2017 1:24:04 PM
Gayle and her daughter continue to work on the application and are waiting on tax information that they will receive later in the week. Gayle is feeling well at this time. No changes in symptoms or treatment plan at this time. Visit set for June 29 for follow-up.
Notify Care Team Member(s)
Use the form below to notify selected care team member(s). Users selected will receive an email with a link to view the message. All users on the care team will be able to view the notification in the Notification section and in the What's New section.
Notification type:
Select
Enter message:
500 characters remaining
Select care team members to notify:
Select all
Danielle Palmer
Elizabeth Roach
Jeffrey Fine
Maureen Fraser
Send
Cancel


About Me
Preferred activities
Spending Time in the woods and is interested in Harry Potter
How I learn
I like to hear what is going on with my health
Interaction Tips
I love to talk about music
Communication Style
I am really friendly
Tips to avoid triggers/behaviors
Please don't treat me like I am sick
Physical Mobility
Extensive Assistance
Mode of Transportation
Support Person
ED / Crisis Plan
Contact Seans older sister Jennifer Peeler (802) 4567 if he needs to go to the ED. She is very important to Sean.
My Strengths
Strength
Created On
I have a lot of friends
7/14/2016 4:03 PM
I love to read
7/14/2016 4:04 PM
Sean is able to advocate for himself
11/28/2016 8:35 AM
Sean made the honor roll this fall!
11/28/2016 8:36 AM

CARE PLAN : INFORMATION

Patient *	Gayle Matt	DOB	12/15/1938	Age	77	Gender	Female
Phone (Home)	8888888888	Phone (Mobile)	802-999-7833				

Goals

Personal Goals

Goal Category	Activity Name ↑	Regarding	Status	Assigned To	Priority	Estimated End Date	Actual Start Date
Housing	Fill out application by 9/1/2016	Gayle Matt	Completed	Elisabeth Perin	High		8/29/2016 12:00 AM
Education	Get GED	Gayle Matt	In Progress		Medium		8/5/2016 12:00 AM
Medication	apply for medicaid	Gayle Matt	Not Started		Medium		
Dental	contact affordable dentures	Gayle Matt	Not Started		Medium		

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Treatment Goals

Goal Category	Activity Name ↑	Regarding	Status	Assigned To	Priority	Estimated End Date	Actual Start Date
Physical activity	Exercise	Gayle Matt	In Progress	Alan Beams	Medium		
Food and Nutrition	Improve eating habits	Gayle Matt	Not Started	Alan Beams	High	8/31/2016 12:00 AM	
Management of health conditions	Daily weights	Gayle Matt	Completed	Patient	Medium		5/31/2016 8:00 PM

Middlebury HSA

- Population: ~37,000
- 8 Primary Care Practices
- Community Hospital
- Local Blueprint for Health Team:
  - Blueprint for Health Project Manager
  - Blueprint for Health QI Facilitator
  - Community Health Team
    - Care Coordinators
    - Licensed Social Worker (shared staff with CSAC)
    - Registered Dietitians
  - Spoke Team:
    - Nurse Case Manager
    - Social Worker (shared staff with CSAC)
  - Support and Services at Home (SASH)

Integrated Communities Care Management Team

- **Local team**: VT Dept of Health, Blueprint for Health, Porter Hospital, Porter Medical Group (Practices), Mountain Health Center FQHC, Middlebury Family Health, OneCare VT, AgeWell, Support and Services at Home, Addison County Home Health & Hospices, Bayada Home Health Care, Counseling Service of Addison County, Turning Point Center of Addison County, Addison County Parent Child Center, Elderly Services

- **Aim**: To prevent persons/families from increasing their risk level and utilization by providing well coordinated and communicated wrap around services
  - The team focuses on developing processes to allow for cross agency communication and implementing person-centered care coordination tools

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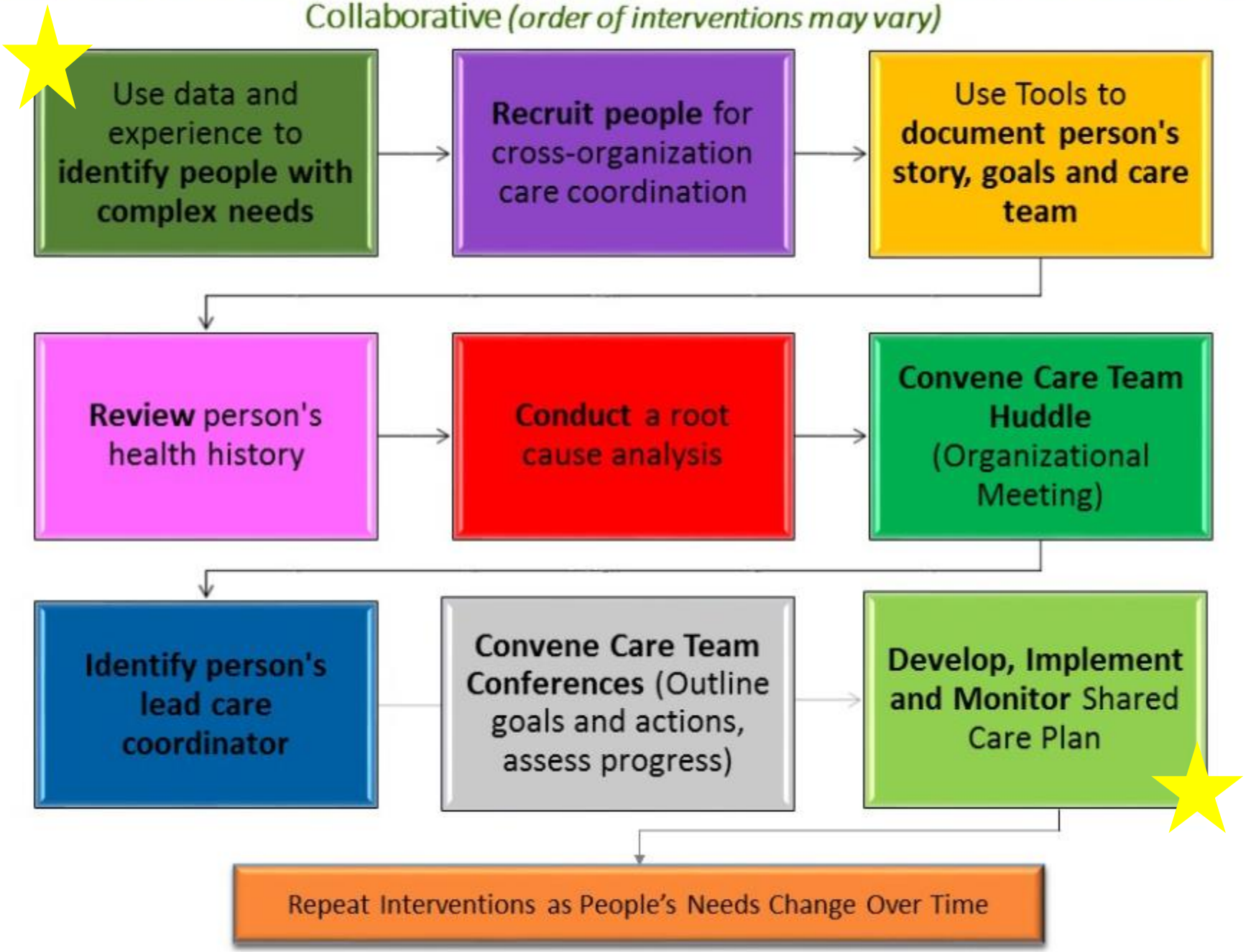


Identifying Patients

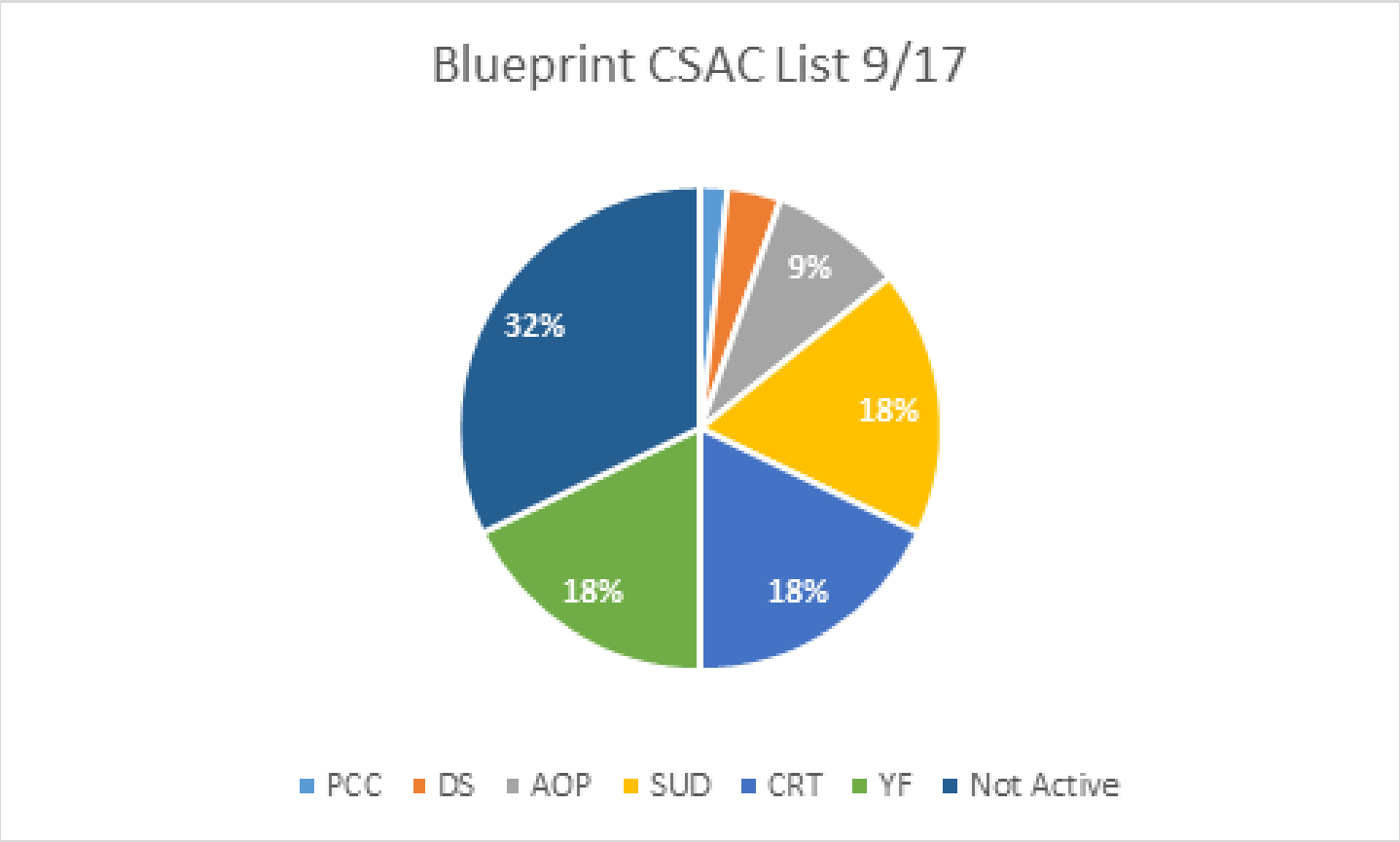
Pre – Care Navigator	Post – Care Navigator
Primarily based intuition and knowledge of people direct providers thought would benefit from person-centered care coordination. Used the following reports to inform intuition: 1. High Emergency Room Utilization 2. Inpatient Readmissions 3. Beneficiary Detail Report The data was reviewed within each organization and was rarely shared across organizations.	Major change: The data is driving the identification process instead of intuition. Reports being used: 1. VMNG Level 3s and 4s 2. LACE Report 3. Emergency Room Utilization The VMNG level 3 and 4 panels are now shared with community partners and we can share and analyze the data together, instead of doing that in silos.

Goals of Engagement

- Meet people where they are
- Make sure the engagement comes from a person they trust or relate it back to the person they trust
- Communicate with known team members when the person isn't showing up for appointments and returning calls

Example of analyzing patients together to recruit staff and assigning care coordinators

Individuals that have been or currently engaged with CSAC



Questions