Blueprint Semi-Annual Meeting
Lake Morey Resort, Fairlee, VT
October 20, 2014

SESSION I – 10:00am-11:00am

Improving Care Coordination in Pediatric Primary Care, Lessons Learned
Pediatric medical homes across the state have embarked on a journey to improve care coordination within their practice and in collaboration with community based organizations. Learn how a multi-disciplinary team from one of the practices has made a difference in their patients' lives. Presented by Miriam Sheehey, RN, Beth Ann Maier, MD, Marinell Newton, LICSW & Kristy Trask, RN.

Raising The Bar: NCQA Patient Centered Medical Home 2014 Standards NCQA recently released the NCQA PCMH 2014 Standards. Come find out what is new for primary care practices and community health teams within these new standards. Presented by Julianne Krulewitz, PhD.

Panel What? The Ins and Outs of Improving Patient Care through Panel Management
How do you identify a panel of patients using an electronic health record (EHR), ensure the list is accurate, and outreach to patients to improve patient care? Learn how one practice and their community health team staff does it effectively across several services and conditions. Presented by Don Grabowski.

Recognizing the Impact of Traumatic Events in Primary Care Patients
The groundbreaking study on Adverse Childhood Experiences (ACES) conducted by Kaiser Permanente in California found that experiences of abuse, neglect, and traumatic events in childhood were correlated with higher rates of chronic disease, substance abuse, and depression in adults. Somewhat less expected was the finding that simply asking "what happened to you" is a helpful healing strategy. This workshop will overview how primary care can screen for ACES and discuss pathways to additional support for people with history of trauma. Presented by Margaret Joyal, Director OUT-Pt MH Services WCMHS & Kathleen Hentcy, DMH.

Profiling Primary Care Practice
The Blueprint provides profiles to participating practices with demographic and health status information for the patient population, expenditures by major categories, health care utilization and effective and preventative care measures. The reports allow comparison between practices and their area peers and to statewide trends. The newest profiles, about to be released, will include commercial, Medicaid and Medicare data; Vermont is one of very few states able to provide this kind of reporting across health insurers. The profiles can be used for practice-level QI, health area planning and care coordination and to evaluate the impact of patient-centered medical homes and community health teams statewide. During the coming year the profiles will be released on six month cycles making the data even more timely and useful. This is a unique opportunity to interact with the leader of the analytics team that creates the profiles. Presented by Karl Finison, MA Director of Analytic Development, Onpoint Health Data.

SESSION II – 11:10am-12:10pm

Community-Wide Narcotics Protocol
In the face of growing community concern about prescription drug abuse, addiction, and diversion of prescription opiates Rutland area providers came together to create common protocols for treatment of chronic pain including shared protocols for prescribing practices, patient consent, and sharing of information between providers. The group has developed a public education and awareness campaign to assist with initial roll-out. The director of RRMC Psychiatric Services will present how the Rutland community organized the common protocols and discuss adapting their approach to other communities. Presented by Jeff McKee, RRMC Director of Psychiatric Services.

Health System Alignment: Blueprint and ACO's
Come learn how the Accountable Care Organization (ACO) standards align with the Patient Centered Medical Home recognition. Gather ideas on how you can support the ACO goals in your health service areas. Presented by Miriam Sheehey, RN.

"Who's on First?" Interagency Care Coordination: The SASH Approach
Support and Services at Home (SASH) has organized a consistent approach to interagency agreements for care coordination on behalf of individuals with complex needs. Area Agencies on Aging, Home Health, Designated Mental Health and Substance Abuse Agencies, local hospitals, and housing providers all collaborate via a series of MOU's and structured meetings. Presented by Amy Perez, State-Wide Coordinator for Southern and Central VT, Kenneth Russell, Central Valley SASH, & Christine Hazzard, Brattleboro, SASH.

Preventing Suicide by People Seen in Primary Care
Nationally, 50% of the people who died by suicide were seen by a primary care provider in the month prior to their death. Suicide risk is a set of identifiable conditions that are responsive to screening and intervention. The Fletcher Allen Community Health Team will highlight the process to systematically identify risk, screen for suicide, and pathways for follow-up and care. Also discussed will be describing evidence-based approaches for treating suicidality that can be implemented in a wide variety of health and mental health treatment settings. Presented by Pam Farnham, RN, Diane Collias, LICSW & Corey Gould, LPMA.

Mapping Community Networks
Last year the Blueprint commissioned the first formal analysis of the growing networks of health, human services and community supports in each Health Services Area. The resulting maps show the depth of connection and diversity of partners and raise new questions about how we can best work together to serve clients and patients in local communities. The second round of this study launches at the beginning of November. If you haven't heard about this research before, this is a great introduction -- if you have, come learn what's new for this year! Presented by Maurine Gilbert.

SESSION III – 1:00pm-2:00 pm

A Roadmap for Diabetes Care: Coordination Between Primary and Specialty Care
We all need to work together to improve the health of our patients. The diabetes roadmap is the first of several efforts to coordinate care delivery between primary care and specialty medicine. Fletcher Allen Health Care will discuss our process, the product and our outcomes. Presented by Dr. Jennifer Gilwee & Dr. Joel Schnure.

Medicaid EHR Incentive Program Audits
The auditor for The Vermont Medicaid EHR Incentive Program, will present an overview of the program's audit and appeals process, as well as provide tips on how to prepare for an audit. Presented by Heather Kendall, PhD.

Emergency Department Utilization: A Tale of Two Health Service Areas
Two HSAs share their strategies to reduce avoidable emergency department use by assisting patients in enrolling in a patient center medical homes. Presented by Elise McKenna, RN, MPH, MSEd & Claudia Courcelle, RN, BSN, MSA.

Targeting Support & Services to Families with Young Children
Research shows that supporting pregnant women and young children can strengthen families and reduce adverse outcomes including health. In 2012, the Vermont Department of Health implemented an evidence-based home visiting model called the Nurse Partnership to support Medicaid eligible first time moms and their children. Discussed will be the key components of nurse home visiting and the many opportunities to coordinate home visiting and outreach to families with the Blueprint pediatric, family medicine, and community health team staff. Presented by Dr. Breena Holmes & Becca Rainville, NFP.

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SESSION IV – 2:10pm-3:10 pm

Co-Managing Care: Primary Care and Specialty Mental Health / Addictions Treatment
Although the benefits of integrating health and mental health care are widely recognized and patients are often seen in both settings, formal arrangements between primary care and mental health providers are not common. Representatives from the Bennington and St. Albans communities will share example referral and co-managements agreements, discuss the development process they used and share insights into addressing implementation challenges. Presented by Jennifer Fels, Kim Turner, Julie Parker & Deb Green, RN.

Vermont Information Technology Leaders (VITL) Present VITLAccess
Access to patient clinical data at the point of care is at the core of improving health care outcomes for Vermont citizens. This session provides an overview of VITLAccess, VITL's new statewide provider portal that assembles patient information received from health care organizations across the state and, with patient consent, provides access to this information through a single secure portal. The statewide VITLAccess roll-out plan and the role of Blueprint Community Health teams in that roll-out plan will also be shared during this session. Presented by Judith Franz & Rob Gibson, CAHIMS.

Aligning ACO and Blueprint Infrastructure
In the rapidly evolving ACO landscape local leaders are being asked to develop resources for complex care management and quality improvement. The Blueprint platform of patient-centered medical home, community health teams, and evaluation & measurement reporting seems ideal to support the developing ACOs. Aligning the Blueprint and ACO work, enhancing the existing infrastructure, and consolidating disparate initiatives takes purposeful and focused leadership. Presented by Patrick Clark & Josh Dufresne.

Screening, Brief Intervention and Referral to Treatment SBIRT This evidence-based approach to initial engagement in changing risky substance abuse behavior is being implemented in a variety of Vermont primary care and treatment settings through one-time grants. The techniques are easily generalizable and useful for Community Health Teams and Patient-Centered Medical Homes. The presenters will overview the SBIRT model and describe how it is being implemented in primary care settings. Presented by Naya Pyskacek, LICSW, LADC.

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