Vermont Blueprint for Health: Community Health Teams

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LEARNING OBJECTIVES

At the conclusion of this session, the participant will be able to:

Learning Objective 1: Identify five key components of an effective quality improvement team.

Learning Objective 2: Identify four factors present in complex patient situations necessitating team care.

Learning Objective 3: Identify three functions of the Community Health Team in supporting individuals with chronic medical and behavioral conditions.

Learning Objective 4: Identify two clinical, two operational, and two financial indicators of the Vermont Blueprint for Health and Community Health Teams in meeting the Triple Aim.
VT Blueprint for Health

• Governor Douglas Initiative in 2003

Goal improve and control costs for people with chronic conditions
Health Service Model

Broad set of stakeholders

Local leadership, resources & infrastructure

State grants supported local project management, practice facilitators, learning collaboratives & patient self-management programs
NCQA Standards (2008)

Patient Centered Medical Homes

4 in the country

St Johnsbury added 5 practices doubling the number in the U.S. (First in Vermont)
Vermont Blueprint for Health

- 2005 – First pilot sites in St. Johnsbury and Bennington health service areas
  - Transforming primary care delivery

- 2008 – Act 71: Medical Home and Community Health Teams. St. Johnsbury health service area first pilot site
  - Patient Centered Medical Homes
  - Community Health Teams

- 2011 – Act 128: Blueprint went from pilot to state-wide program
### Vermont Blueprint for Health

#### Follow the Money

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<th><strong>2008 – present</strong></th>
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<tr>
<td><strong>Medical Home PPPM:</strong></td>
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<td>- Paid based on attributed patients</td>
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<td>- Base amount for NCQA Medical Home, plus quality and utilization incentives</td>
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<td>- Paid by Medicare, Medicaid, Blue Cross of VT, CIGNA, MVP</td>
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<td>- Paid monthly</td>
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| **Community Health Team:** |
| - Paid based on total unique patients |
| - Paid by Medicare, Medicaid, Blue Cross of VT, CIGNA, MVP |
| - Paid monthly or quarterly |

| **Project Management and Self-Management Programs:** |
| - Paid by a State grant |
| - Includes Healthy Living Workshops, Tobacco Cessation, Diabetes Prevention Program, WRAP |
| - Paid monthly |

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<th><strong>2013 - present</strong></th>
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<tr>
<td><strong>Hub and Spoke:</strong></td>
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<td>- Paid monthly by Medicaid</td>
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<th><strong>2017 - present</strong></th>
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<td><strong>Women’s Health Initiative:</strong></td>
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<td>- Paid monthly by Medicaid</td>
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<td>- Based on patients enrolled</td>
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Building the Team in Team-based Integrated Health Care

**2018 Integrated Health Care Conference**

Hosted by Arizona State University’s Doctor of Behavioral Health Program
St. Johnsbury Area Community Health Team

Patient Centered Medical Homes
- Physicians
- Nurse Practitioners
- Physician Assistants
- Pharmacists
- Nurses
- Office Staff
- MAT* Staff: Nurse and Counselor Case Management

Community Health Team
- Community Connections
  - Community Health Workers
  - Certified Diabetes Educator
- Support and Services at Home (SASH)

Function Team
- Community Based Services
  - Mental health
  - Addiction services
  - Employment services
  - Legal and law enforcement
  - Economic development
- Self Management & Prevention
  - Chronic disease workshops
  - DART
  - Tobacco cessation
  - Support groups

Women’s Health Initiative
- Physicians, CNMs, NP
- Nurses, Office Staff, LNA, MSW

Broader Medical Community
- Home Health & Hospice, Medical Specialties, Hospital (Inpatient & Emergency), Long Term Care

*medication assisted treatment for opiate addiction

Building the Team in Team-based Integrated Health Care

2018 Integrated Health Care Conference

Hosted by Arizona State University’s Doctor of Behavioral Health Program
Comparison entire population receiving services PCMH/CHT to independent settings.

Annual investment in year 6: $17.9 million investment in program costs & payments. Decrease $482 pp, 216,505 members for total annual reduction=$104.4 million.

Annualized cost-gain ratio: Decrease in medical expenditures of $5.8 million for every $1 million spent.
On a local level...

Trying to figure it out...

Behavioral Health Specialists
Women’s Resource Network
Interdisciplinary meetings

Built on personal relationships
Effective QI Team

Development: process, roles & practices

Engage: additional healthcare partners

Leadership: collaboration/effectiveness

Reflection: how are we doing?

Process improvement: PDSA cycles
Complex Patient Care

Requires a team: Individuals bring unique experience & skills

Creativity, out of the box thinking

Commitment and cooperation

Interdisciplinary examination
The Big Picture – Why do Team Based Care?

At the state and national levels, more recognition of the value of coordinating care with a team, including the individual (Patient/Client).

With “recognition” comes more structure, requirements, documentation, and also reimbursement ($).
What is Team Based Care?

Is an important component of individual and family centered care

Creates an environment of dignity and respect where individuals, their family, and professionals work together

Involves individuals and families as important members of the care team

Reduces duplication of services

Team Based Care Workflow
Team Based Care Tool Box

Engagement Tools:
• Relationship Map
• Camden Cards
• To/For Worksheet
• Care Team Release

Care Team Tools:
• Chart Review Tool
• Shared Care Plan
Relationship Map: What is it?

The “Relationship Map”

People Map for:

People who support me at work or school

Family

People whose job is to support me at home and other places

Friends From The Learning Community for Person Centered Practices
The “Relationship Map”

People Map for:
JOE

People who support me at work or school

People whose job is to support me at home and other places

From The Learning Community for Person Centered Practices

PCP
NEK COA Case Manager

VA Case Worker
Diabetic Educator

PCP Behavioral Health Specialist

Daughter (TN)

Granddaughter

Neighbors
Breakfast buddies

Friends

Family

JOE
Why is it important to use an Relationship Map?

Powerful visual tool that identifies the strengths of relationships
Identifies negative supports
Identifies areas of limited supports
Clarifies professional vs personal roles
Camden Cards: What are they?

- Get a job and/or go back to school/work
- Medication or Medical Equipment
- Legal Issues
- Talk to someone about my Mental Health
- Have Transportation
- Have a better Living Situation
- Have a better relationship with my doctor or nurses
- See if I qualify for Insurance and other Programs
- Help people in my Community
- Identification
- Feel Supported
- Learn more about my Medical health (diabetes, COPD, etc)
- Talk to someone about my drug or alcohol use
- Food & Nutrition
Why is it important to use Camden Cards?

Expands the conversation beyond one that is solely health-focused
Includes the social determinants of health
Useful for individuals with limited English proficiency or low literacy
Helps individuals organize and prioritize complex information
Clarifies what is most important to the individual receiving services
Identification of Complex Needs Individuals

Identification of individuals who are at the highest risk for poor outcomes and who would benefit from care coordination interventions is vital.

Data that can help identify individuals:
- Risk stratification tools
- Claims
- Clinical and/or utilization data
- Screenings
- Assessments
- Chart reviews
Individuals with 3 or more of these…

Multiple providers involved
Co-morbidities (more than one chronic health condition)
# of hospitalizations and/or ER visits
Mental health challenges
Substance abuse
Social determinants with insecurities
  • Housing
  • Food access
  • Transportation
  • Safety
  • Education
  • Gender
  • Religion

May be the best candidates for Team Based Care
Engagement of Complex Needs Individuals:

Once you have identified an individual likely to benefit from team based care introduce them to this concept.

Engagement can prove to be the most time-consuming aspect of the process.

It's important to remember that these individuals are the center of this process.

Ideally the individual is approached by someone he/she knows and trusts.
Recruiter Role

The Recruiter:

• Talks to the individual about being part of team based care
• Identifies the “team” with the individual (may be based on the relationship map or other tools)
• Has the individual sign the release
• Discusses the role of the Lead Care Coordinator and works with the individual to identify a potential Lead Care Coordinator
• Calls and facilitates the pre-team meeting or works with the Lead Care Coordinator to do so
Lead Care Coordinator

The Lead Care Coordinator (LCC) may ultimately be the same individual responsible for introducing team based care. It may become clear there is a more appropriate team member for this role.

Lead Care Coordinators are “chosen” collaboratively by the individual and the care team, rather than “assigned.”

It may be best that the LCC is someone who has a long term role in the individuals care. In cases where this is not possible, the team will work to ensure that there is a warm handoff to the most appropriate individual on the care team.
Role of the Lead Care Coordinator

Serves as the central and primary point of contact for the individual and all members of the care team

Identifies with the individual who should be included in the care team

Helps the individual identify their priorities and goals

May begin to populate basic information on the Shared Care Plan
Introducing the Person to Team Based Care (sample script)

“I know it can be a lot of work keeping track of everything when you receive services from multiple providers. I think we can provide better care by improving the way we all work together.

One of the ways we can do this is to have a team meeting with everyone involved to discuss what is important to you. This will help your team to better understand what they can do to help you access the services you need and want.

How do you feel about participating in a team meeting?”
What is It?

• Empowers the individual to identify the members of their team
• Allows for permission to share information
• Informs individual of laws that protect their privacy
• Begins conversation about team based care and potential for care team meetings
• Identifies the lead care coordinator

Why is it Important?

• Ensures the individual has complete control over who is on their team
• Protects privacy
• Helps team members adhere to privacy laws
• Helps to identify team members to avoid silos
Pre Team Meeting

Getting team members on the same page
Be clear on who is involved in care
Discuss the Lead Care Coordinator role
Identify a facilitator for the meeting
Share critical information
Identify transitions of care
Decide if a chart review is appropriate
Care Management Chart Review Tool: What is it?

A record review tool that provides a closer look at pertinent diagnoses and the social determinants that impact health outcomes

Helps to Identify:

- Recent utilization of ED and inpatient services
- Polypharmacy
- Multiple chronic conditions
- Social support
- Mental health diagnoses or issues
Care Management Chart Review Tool: Why is it important?

Allows identification of trends/ contributing factors that may identify strengths and barriers

TIPS:

• If you think the individual would benefit from a 10 year medical look back, talk to the Care Coordinator in his/her Primary Care Providers office
• Review of other types of records may be helpful (home health, Council on Aging, mental health agencies, etc)
• Remember you should NOT read everything in the chart. This is not a complete health history
Key Roles in a Team Meeting:

• Lead Care Coordinator (LCC)
• Facilitator
• Scribe
• Timekeeper

These may all be the same person
Shared Care Plan: What is it?

A document developed by the individual receiving services, their family and care team

It tells the individual’s story by describing:

- strengths and interests
- short and long term needs
- personal goals and priorities
A Shared Care Plan

Is not Intended to replace an organizations service record, but serves as a tool of integrated care management across organizations

Is not Intended to be maintained by multiple people. The Lead Care Coordinator updates and disseminates it as needed

Is not meant to be confusing or overwhelming
Why is it Important?

The care plan identifies strategies and a timeline for achieving goals.

It identifies the team and who is responsible for each part of the plan.

A Shared Care Plan is a tool to facilitate communication between all team members:
  • The Individual
  • Family/friends/supports
  • Professionals

Challenges to overcome:

Sharing and storing it

Keeping it up to date
Team Meeting Steps

1. The LCC invites key members of the individual’s social and medical support system (as identified by the individual)

2. The LCC sends the agenda to all members of the Care Team prior to the meeting (if appropriate)

3. The LCC facilitates or appoints a facilitator

4. Hold the Care Team Meeting- Identify Important To, Important For and prioritize the top 3

5. Conclude the meeting by completing a Shared Care Plan that outlines an Action Plan and identifies next steps, responsible parties, and a time line

6. Schedule the next meeting date or clarify what circumstances would warrant another team meeting
Team Meeting: Things to Consider

Location

* Allows for privacy
* Accommodates the entire team
* Easily accessible by wheelchair if applicable

Transportation

* Arrange if needed

Time

* Allow for at least one hour but may require more time

Assign Roles such as scribe and timekeeper

Have additional consents signed if needed (for family members/friends)

Remember that there may be some topics that are not appropriate for a team meeting
Care Team Meeting Process:

Welcome

Introductions

Ensure all parties are included on the waiver/release or have new consents signed

Ask individual or representative to identify what is Important To them (goals they would like to achieve. Are there concerns/barriers?)

Allow for team members to identify what is Important For the individual (medication adherence, housing or food security, safety, etc.)

Ask individual or representative to prioritize their top 3 goals or concerns

Brainstorm/ Problem Solve solutions

Identify action plan and Next Steps to include who is responsible for each action

Summarize and schedule next meeting (if applicable)

Share care plan with individual and all team members
Ongoing Roles of the Lead Care Coordinator:

Updates and shares the Care Plan with all team members as needed

Convenes and facilitates care team meeting, or appoints facilitator, as appropriate

Identifies interval between care conferences based on individual need and convenes team meetings as appropriate
Team Based Care Workflow

You are here!
Triple AIM

The IHI Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost
Stories
Special thanks...

Laural Ruggles, MBA, MPH
Northeastern Vermont Regional Hospital
Blueprint Project Manager
References


