

Conference Call Notes

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Overall design of Community Health Teams (CHTs) in Vermont

- CHTs were strategically designed and developed locally to allow sites to build around community needs.
- The design of CHTs preceded ACOs, and efforts are now underway to incorporate CHTs into the ACO construct.
- Project Managers (PMs) were assigned to various geographic regions and tasked with convening groups of providers within the communities capable of caring for ~350K people. The core groups of providers included:
 - Hospitals;
 - Designated mental health providers;
 - VNAs; and
 - PCPs.
- Through convening providers and assessing gaps of care, the State tasked PMs with establishing relationships with local social services organizations.
- With these partnerships, PMs were provided flexibility to determine what local gaps in care existed and then to reorganize services to create a functional team capable of filling those gaps. The focus of that team was on encouraging coordination across sites of care and more care management and then using new resources to fill continued gaps. Teams initially had designations of core CHTs, functional, and then extended. The core team hired with funds, the functional team reorganized, and the extended teams included local variations specific to insurers. CHT managers determined clinical protocols and procedures in the practices.
- Because of various organizational structures and legal sensitivities, the State provided general guidance along with basic supporting documents, but protocols and governance over partnerships were determined locally. Certain policies/regulations (e.g. statewide HIT policy) were enforced though. Relationships by organizations were usually initiated by MOU.
- Population needs ended up being similar across geographies although the infrastructure developed to address problems was different. The variation between local communities was expected as the focus was the needs of local populations (e.g. – one community tackled behavioral health needs by contracting with local mental health counselors to embed in PCPs while another hired individuals directly as part of the CHT).
- Overall the intent was to build a hub-and-spoke model with the hiring being done by the entity who receives the CHT dollars in coordination with the various community organizations. Most often this entity is the hospital, but certain communities opted for FQHCs because of certain

primary care capabilities and alignment with population needs. The core characteristic to be the lead entity included capabilities around enhanced primary care.

“Systematizing” CHTs to enhance Primary Care

- Enhanced PC is at the core of the CHT design, both philosophically and functionally with payments and model design. Care plans and model documents reside in PC EHRs. Hiring is also done by central PC entity (receiving CHT dollars). Sometimes this included nurse coordinators hired directly by practices (sometimes taking from CHT fund). Other members of team (e.g. dietician) were not as frequently embedded in practices but would wrap around PC either by doing visits in home or as an extension of PC reporting back to central coordinator.
- Over time as relationships solidified, CHTs moved on to focus on individuals requiring complex care. The State provided technical assistance to look as far back in records as possible (ideally 10 years) to assess for medical, social, mental, and systems-level root causes of the patient’s conditions. The CHTs then designed a care plan as needed with the responsible lead working to address the care needs and to build communication protocols to ensure coordination. A particularly helpful component of the assessment was the eco-map of all the providers that touch the patient.
- This shift was enabled by more systematic protocols, familiarity of working together, and more sophisticated care coordination skills creating uniformity across communities.
- Challenges, though, included technology and sharing of care plans. Some organizations were still using faxes while others were creating word documents to share securely and then to update in everyone’s EMR. Without the care plan, certain aspects of care important to individual were not adhered to (e.g. wheelchair anecdote).

Alignment with ACOs to improve care

- Development of CHTs before ACOs has facilitated ACO development, in particular with relationships to core hospitals/conveners, with identification of high-risk individuals in the communities, and with engaging networks of providers to improve quality. Many ACOs did not hire centralized care coordinators but rather utilized locally based CHTs.
- However, challenges in integration exist. The State’s focus now with CHTs and ACOs are threefold:
 - Unified Community Collaborative – expanding on original IDT to improve governance infrastructure and to incorporate thought leadership of each organization to focus on quality improvement and more efficient allocation of PC resources addressing the core needs of the population;
 - Data Utilization – create community digestible data reports on health area outcomes and utilization patterns. They are working on aligning ACO specific data with the all payer claims database; and
 - Common incentives and priorities – PMPM reimbursement structure through Blueprint flows to all practices and is based on NCQA performance metrics.

Key Lessons for CT SIM

- Technology challenges are crucial to success – Vermont is still assessing how to incorporate care plans into their HIE and include a provider portal. The State is still investigating its ability to do this, but even then it may not be the most efficient way to share information. Most providers would prefer more streamlined information systems that do not involve logging into portals and that enable direct communication with automatic updating of plans.
- Continuity of care plans are important – care teams should have frequent conferences on the POC and individual's development, either telephonically, in-person, or via other telehealth mechanism. Development of agendas and efficient use of time/resources help manage care of complex patients and work best when patients are not in crisis.
- Legal complexities favor flexibility in local design – the enforcement and management of statewide protocols, policies, and procedures proved to be too much of a burden on Vermont and would have likely discouraged adoption of the model. Connecticut can reviews MOUs, protocols, and agreements of Vermont to determine how applicable it could be for the State's framework.
- Integration challenges in Vermont favor Connecticut's effort at alignment now – Vermont's challenges of merging ACO and CHT infrastructure compels Connecticut to address alignment challenges now and to build the CHT into the ACO. This will save resources retrofitting ACOs down the road.
- LTSS and payer agnostic capabilities are an integral part of the question – when designing the CHT, Connecticut needs to identify roles for individual/organization who can provide LTSS and how to provide continuity of care for complex individuals. The anecdote about the patient whose health and wellbeing improved to the point of being ineligible for Medicaid (and thus access to behavioral health services discontinued) just to fall backwards highlights the liability of discontinuity of payers and benefits.
- Connecticut needs to determine the right mix of statewide standards and local flexibility – Vermont allowed local communities to determine whether, for example, they would own certain capabilities or share. Connecticut could benefit from a more in-depth assessment of how to most efficiently allocate resources dependent on capabilities already in existence in local communities (e.g. insurer-based care management programs).