

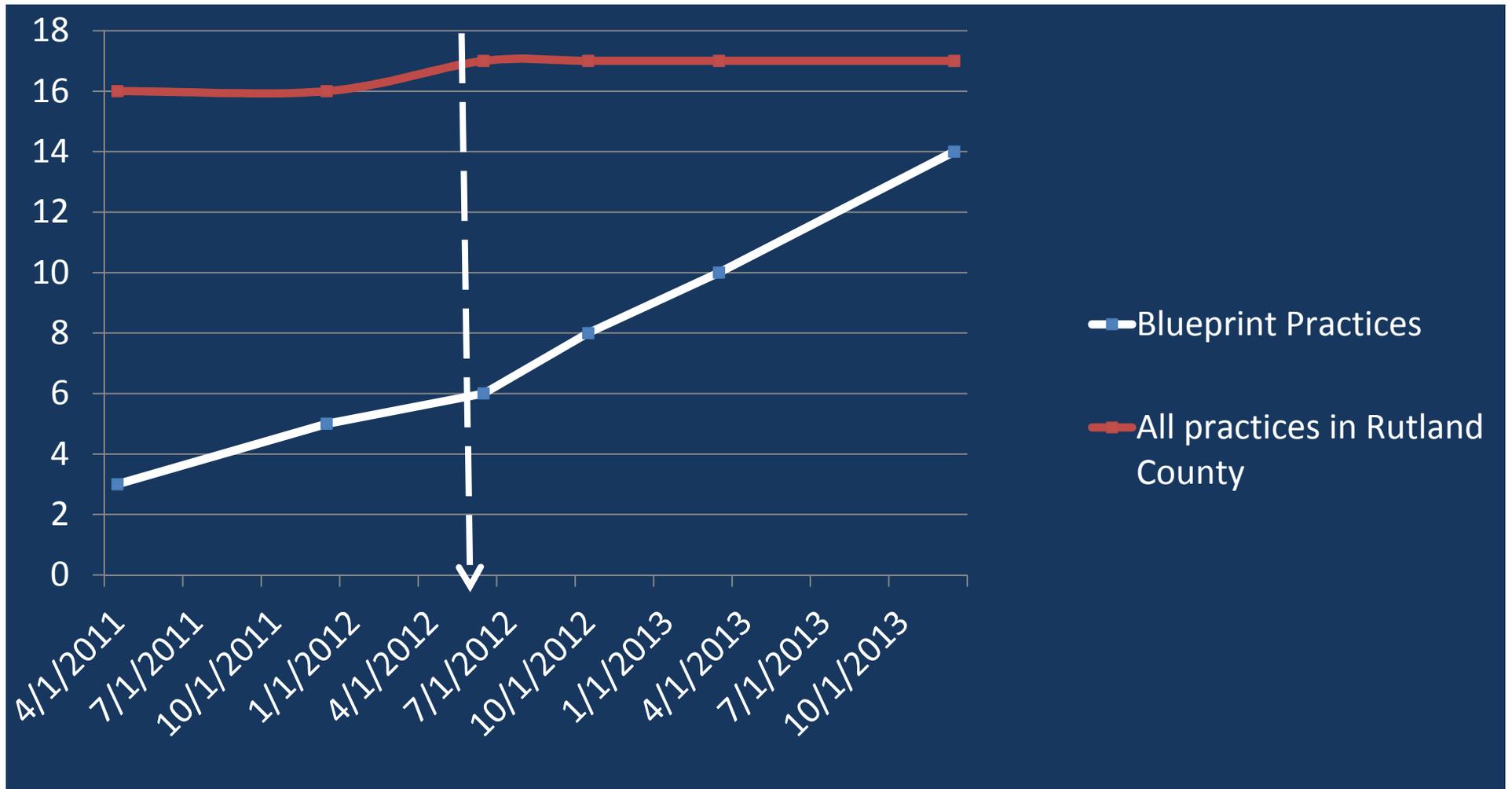


# Rutland County Blueprint

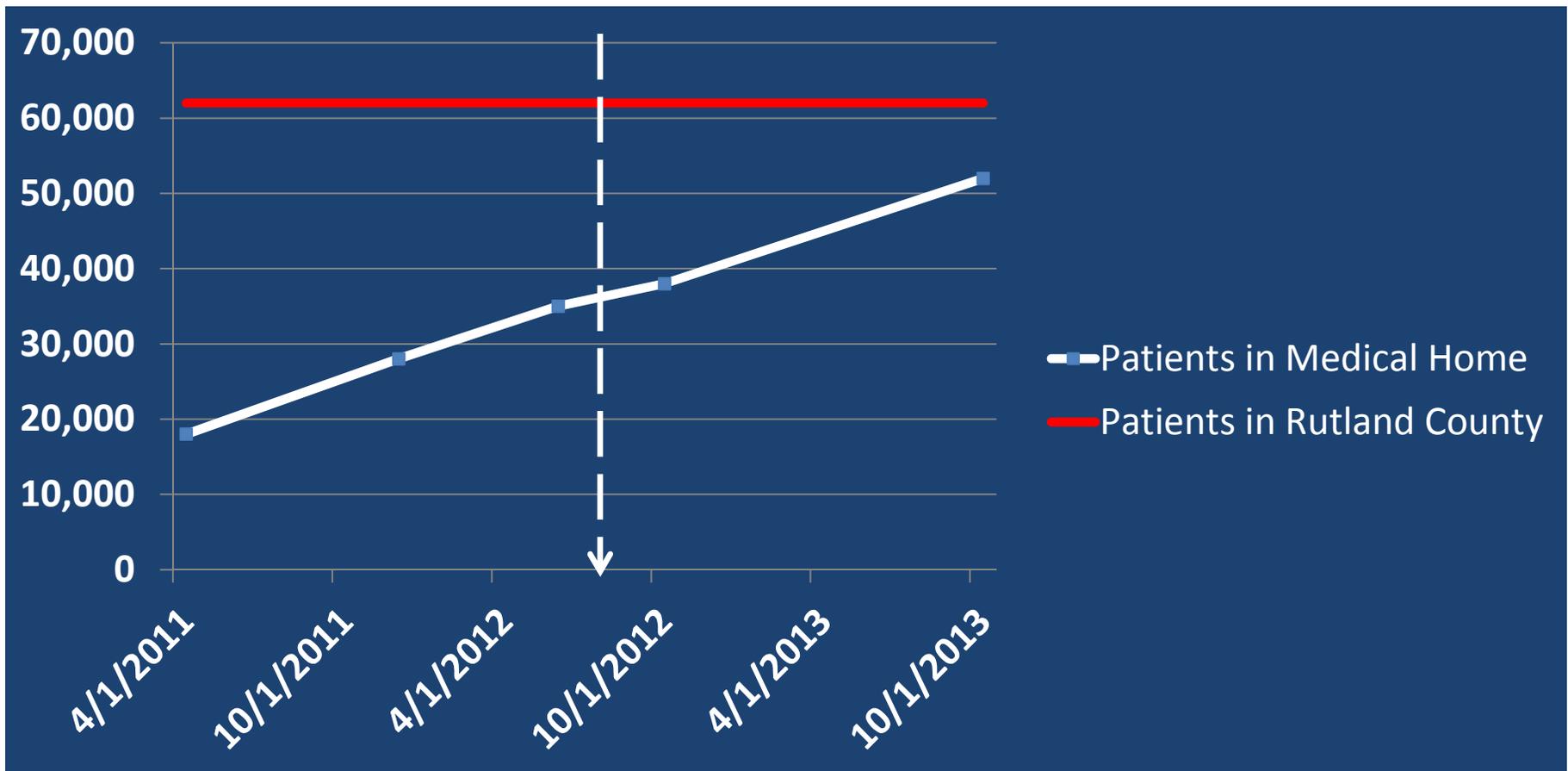
Community Health Team

May 31, 2012

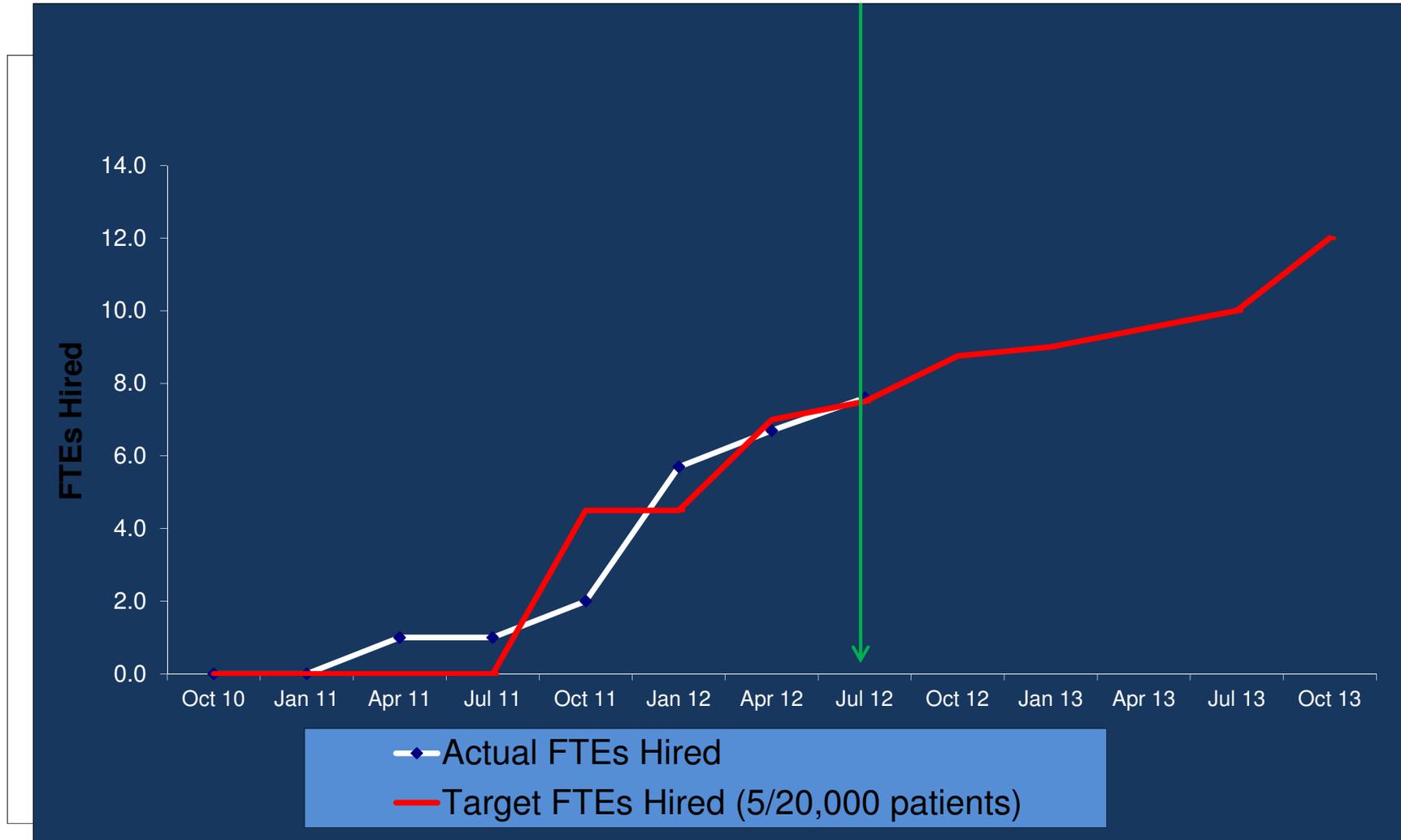
# Expansion of Blueprint in Rutland County: Practice Sites



# Expansion of Blueprint in Rutland County: Vermont Patients Covered

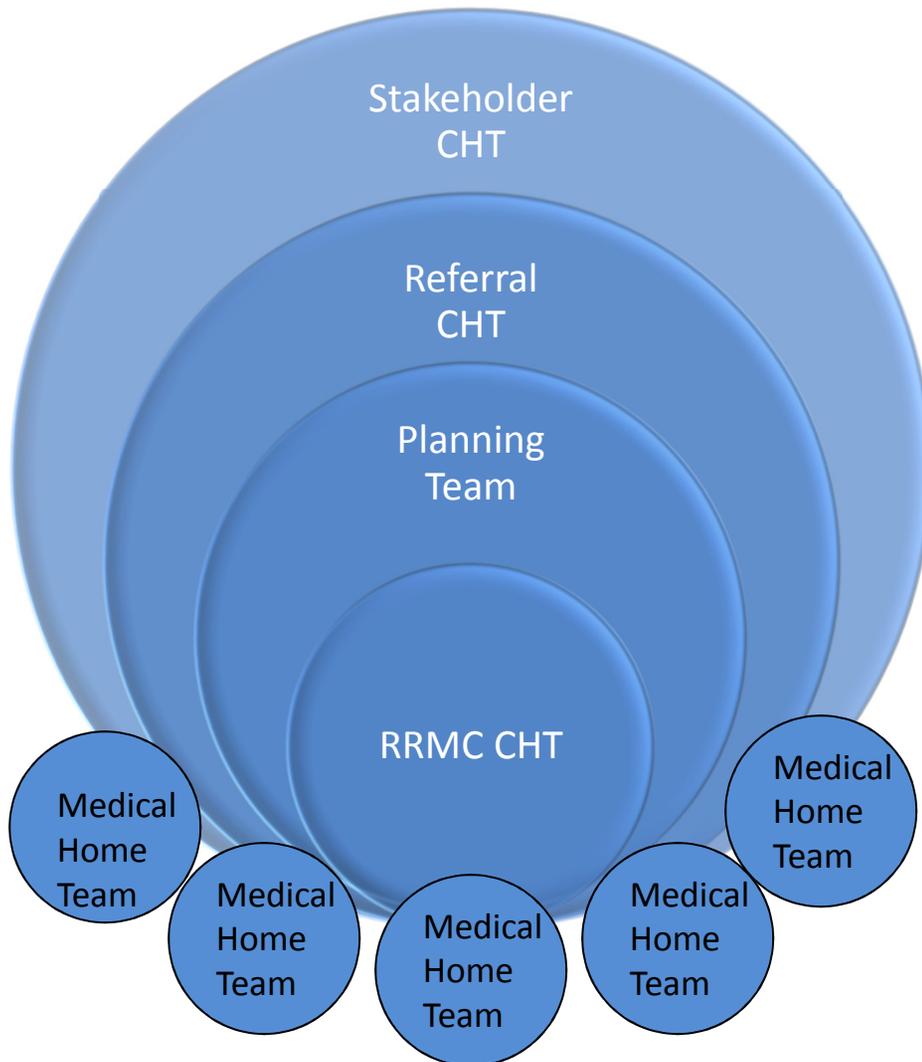


# CHT Hiring Timeline



CHT Staffing	Name	Date Hired	FTE
1.CHT Manager	Mary Lou Bolt	4/26/2011	1
2. RN	Sharon Decato	7/15/2011	1
3. PM Castleton	Kate McManus	1/1/2012	1
4. PM Rutland	Mariah Lensing	2/1/2012	1
5. PM Brandon and Mettowee	Nancy Cotnoir and Terri Saxton	1/1/2012	1
6. Commons PM .25	TBA	TBA	0.25
7. MSW	Sarah Wimbuscus	4/9/2012	1
8. Intern	Morgan Gibeault	12/15/2011	0.15
9. Adm Data Manager .7	Kathryn Lulek	11/7/2011	0.7
10. Health Coach RT .3	Sarah Cosgrove	4/9/2012	0.3
11. RD .2	Kathy Clark	5/21/2012	0.2
<b>TOTAL FTEs</b>			<b>7.6</b>

# Community Health Team Components



## Stakeholders

- Represent community health and human service agencies
- Meets quarterly

## Referral Committee

- Case managers
- Meets monthly
- Discusses systems and specific patient needs.

## Planning Team

- Meets monthly
- Plans CHT activities

## RRMC Community Health Team Practice Based Teams – Medical Homes

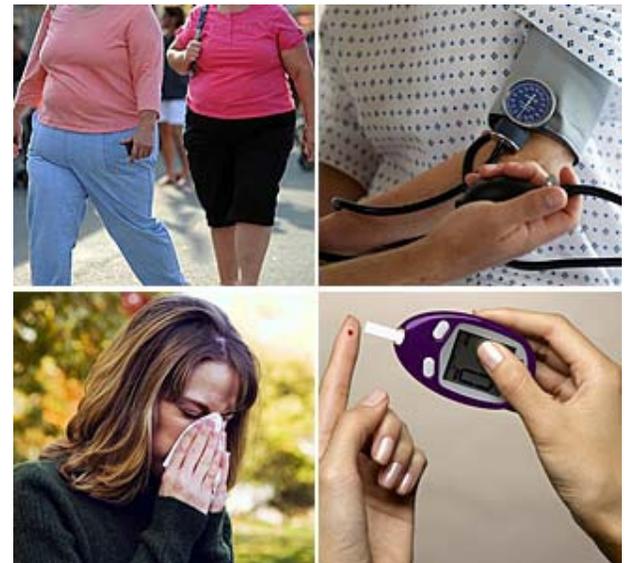
- care coordinators
- panel managers

# **Rutland County CHT Stakeholder Coalition**

- Mission: *To collaborate with stakeholders throughout the Rutland Region to maximize access to reliable and well-coordinated health and human services, as defined by the community.*
- Meets Quarterly
- Co-Chairs: CHT Manager and VDH Chronic Disease Coord.
- Members: Over 70 Representatives from Health and Human Service Providers
- Outcomes: Produce a Community Resource Guide

# Rutland County Health Improvement

- Grants:
  - CDC ACHIEVE \$30,000
  - VDH 2013 Nutrition, PA, Tobacco \$110,000
  - Building Healthy communities RCPC - \$10,000
  - Bowse Health Trust Grants
  - BCBS Wellness Grants
  - SASH Transformation Grant



# Rutland County Coalitions

- AIRR
  - Rutland Asthma Pilot



- Nurse Family Partnership

- BAMBI:
  - Community Response Team for opioid addicted mothers
  - Family & Clinical Work groups- Hub and Spoke



- Breastfeeding Project
  - 10 Steps to Empower Mothers and Nurture Babies
    - VCHIP, WIC, VTAAP, VTAFP



# Rutland County CHT Referral Committee

- Mission: *Coordinate Area case management services for patients and families whose complex needs involve multiple agencies*
- Meets monthly
- Members: CHT, SASH, VCCI, Rutland Free Clinic, Home Health Services, RRMCM S.W. and C.M., Choices, RMH, ECF MSW, PACE, BCBS, SVCOA
- Outcomes:
  - Reduced duplication of services,
  - Increased knowledge of community resources,
  - Improved collaboration.

# Rutland County CHT Planning Committee

- Mission: *To assure the implementation and evaluation of on going development of the CHT*
- Meets Monthly
- Members: Reps from CHT, Medical Homes, VCCI, SASH, VDH, Practice Facilitator
- Outcomes:
  - Communicate and coordinate the expansion efforts
  - Identify barriers to implementation efforts

# RRMC CHT Staff

- Mary Lou Bolt, Community Health Team Manager
- Sharon Decato, RN Community Health Team Case Manager
- Sarah Wimbiscus, MSW Community Health Team Case Manager
- Kathryn Lulek, Community Health Team Data Coordinator
- Peggy Young, RN Self-Management Support
- Sarah Cosgrove, RT Health Coach (Tobacco and Asthma)
- Kathy Clark, RD
- Morgan Gibeault, Intern

# RRMC CHT



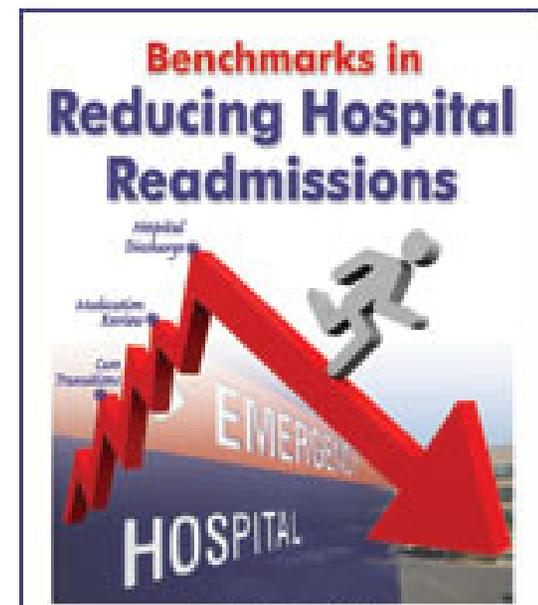
- Activities: Care coordination, System Improvements, Transitions of Care, Identifying patterns of ER usage
- Process Measures:
  - DocSite data entry started 4/1/12
  - Excel spreadsheet as of 5/28:
    - 258 referrals
    - 168 of those referrals are still active
    - 34 patients have been graduated
- Outcomes:
  - Improved communication between RRMC, PCPs and CHT
  - Improved workflow for patient care through system improvements and communication,

# System Improvements

- Admits and discharge reports
- Vermont Prescription Monitoring System
- Motivational Interviewing Training
- In home Asthma Intervention
- Diabetes Education Collaboration
- Substance Abuse Treatment Expansion
- Documentation issues

# CHF Readmission Reduction

- Meets monthly
- Based on Colemans' Transition of Care Model
- Identified the need to expand palliative care
- Improves communication between PCP and Cardiologist
- Focus improvements on:
  - Medication reconciliation
  - Consistent Patient Education



# Coming Soon

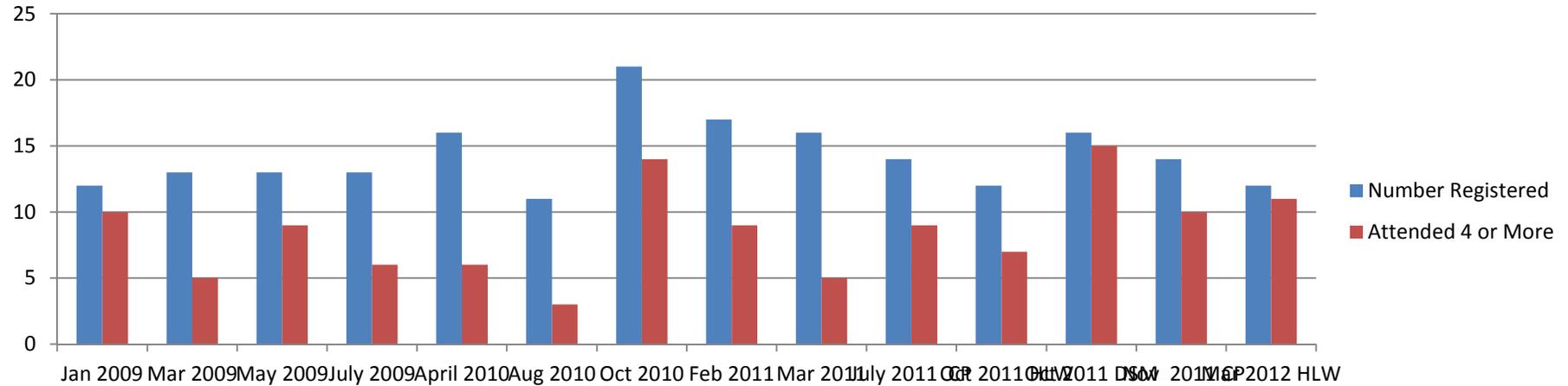
- Advance Directives Coaching
- WRAP program
- Physical Activity supports
  - CSC athletic training course to provide supervised physical activity
  - Walk Rutland Coach



# Delivery of Healthier Living Workshops

- Strategies to increase retention of participants in at least 4 out of 6 sessions for all types of CDSMWS
  1. Pre-screen at registration
  2. Use most popular locations
  3. Build rapport in class through incentives
  4. Use concurrent phone messaging to encourage return to workshop when individuals miss a session
    - Messaging should be “caring and encouraging”*
- Strategies began October 2011 & fully instituted for March 2012 HLW.

# Healthier Living Workshops Attendance



Date	Jan 2009	Mar 2009	May 2009	July 2009	April 2010	Aug 2010	Oct 2010	Feb 2011	Mar 2011	July 2011 CP	Oct 2011 HLW	Oct 2011 DSM	Nov 2011 CP	Mar 2012 HLW
Number Registered	12	13	13	13	16	11	21	17	16	14	12	16	14	12
Number Attended 4 or more	10	5	9	6	6	3	14	9	5	9	7	15	10	11
%	83	38	69	46	38	27	66	52	31	64	58	94	71	91

# Tobacco Cessation Program

- Average workshops / month = 3
- Average attendees / workshop session = 7
- Current # of Clients = 138 with 39% quit rate
- Total QIP-Group enrollment = 325 (May 1, 2011 – April 30, 2012)
- Information only = 800 contacts average for FY 10 & 11

Last reported survey results at 7 months post quit = 29% remain quit (Aug 2010-June 2011)

# Tobacco Cessation Program

**Goal: To Improve collaboration with PCP offices**

Effort	Method	Outcomes
Improve EHR documentation of patient's participation in program	<ul style="list-style-type: none"><li>• Letters to PCPs at the end of each month</li><li>• CHCRR Staff documents patient's participation in program in EMR</li><li>• Non-CHCRR offices receive letters for their records</li></ul>	<ul style="list-style-type: none"><li>• Tobacco Cessation Intervention Data Capture in CHCRR up 1.37% in two weeks</li></ul>
Increase referrals from PCP offices to Vermont Quit Network services and resources	<ul style="list-style-type: none"><li>• Increased communication with PCP offices to increase awareness of this program; ex/ letters to providers</li><li>• Future plan: outreach to PCP offices</li></ul>	<ul style="list-style-type: none"><li>• FY2011 – PCP office referrals = 6% of all referrals</li><li>• First 7 months of FY2012 – PCP office referrals = 18% of all referrals</li></ul>

# RRMC CHT DocSite Reports

- Initiated DocSite April 1, 2012
- Initial impressions: system has potential to be used as the CHT EMR
- Challenges:
  - adding data is a slow process;
  - a black and white structure
- Reporting: the options will be useful in determining patient needs (provider, dx, needs, insurance, and actions)

# CHCRR Medical Homes

- Castleton Family Health Center
  - 14 providers
  - 12,000 CHT patients
- Brandon Health Center
  - 4 providers
  - 3668 CHT patients
- Commons Street
  - 1 provider
  - 1,937 CHT patients
- Rutland Health Center
  - 8 providers
  - 10,072 CHT patients
- Mettowee Valley Health
  - 5 providers
  - 3,102 CHT patients



Rutland



Mettowee



COMMUNITY HEALTH CENTERS  
OF THE RUTLAND REGION

# CHCRR Site Based Teams

- Providers - all sites
- RN Care Coordinators – 2 sites
- Panel Managers – 4 sites
- Referral Specialists – all sites
- Behavioral Health – 3 sites
- Registered Dietitian – currently serving 2 sites

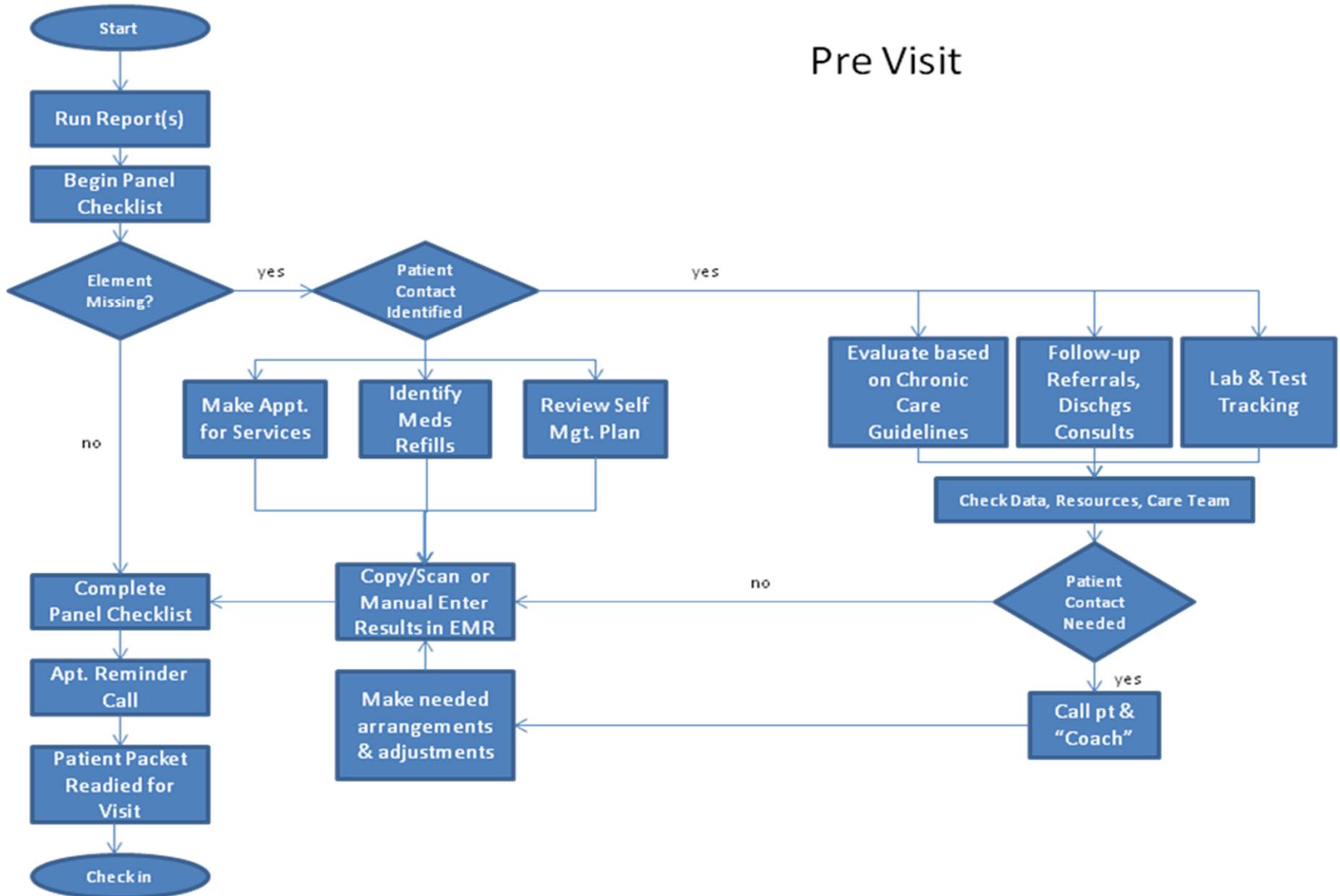


# Panel Managers

- Pre visit-planning
- Disease Guidelines- see data
- Health Maintenance Screening
- Test and Consult Reports
- Keeping the patient informed!
- Provider has what he needs to make he visit complete



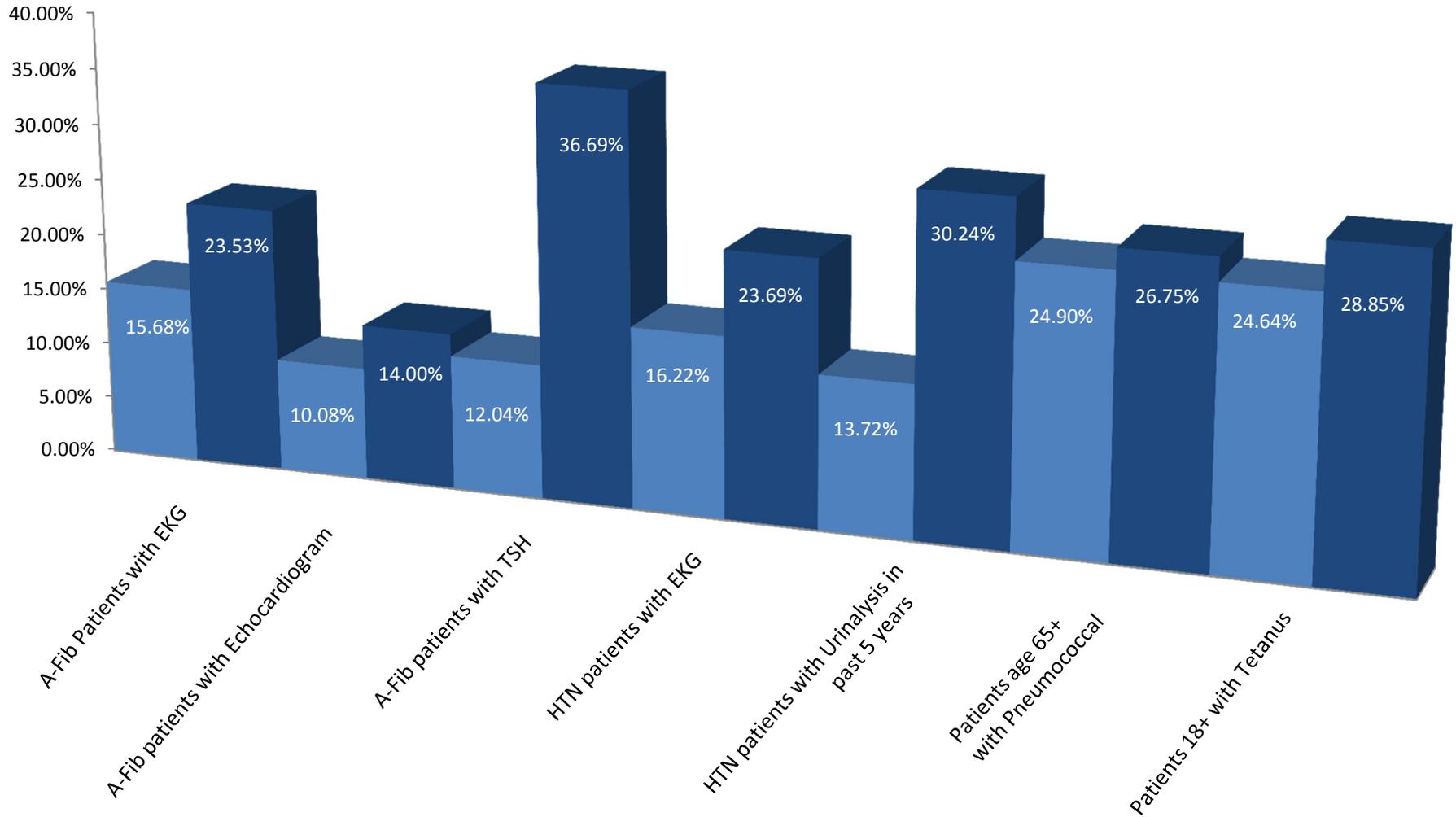
# Panel Manager Work Flow



### CFHC Panel Manager Log Sheet

Date	Pre-Planning Chart Reviews	Reporting Chart Reviews	Phone Encounters	Pre-Loading	Lab Review	Referrals	Cerner Requests	Scanning
5/1/2012	24	235	4		8		3	
5/2/2012				1		137	2	
5/3/2012	25	188	4		5		2	
5/4/2012	22	122	2		3		1	
5/7/2012	21	276	1		9		3	
5/8/2012	31	215	3		8		2	
5/9/2012		1				129		
5/10/2012	14	106	2		2		3	
5/11/2012	Day off due to weekend rotation							
5/14/2012	20	36	2		6		4	
5/15/2012	25	96			4		1	
5/16/2012	15	179		5	6		2	
5/17/2012	25	6			4		2	
5/18/2012	37		3				5	
5/21/2012	33			1	2		5	
5/22/2012	26	3	4		10		2	15
5/23/2012						100		
5/24/2012	7	48	3	3	3			29
5/25/2012	15	52			3		2	
<b>Totals</b>	<b>340</b>	<b>1563</b>	<b>28</b>	<b>10</b>	<b>73</b>	<b>366</b>	<b>39</b>	<b>44</b>

# CHCRR PCMH Summary 2011 4th Quarter- 2012 Mid-way through 2nd Quarter



# RN Care Coordinator Role

- Medically complex Patients
  - High risk, high need
  - Discharges from the hospital
  - Emergency Room admits
  - Nursing home Panel

- Paid for with the PMPM



# Panel Management Challenges

- Provider resistance
- Patient reluctance related to high deductible insurance plans
- EMR interface and mapping
- Need more panel managers
- Need Care Coordinators at each site
- EMR documentation
  - Fields, consistency of data entry, EMR updates and education



# VCCI – CHT Interface

- **Staff:** 5 FTE's - field based or embedded in RRMC ED & FQHC's
- **RRMC ED co-location:** test site for VCCI expansion model
  - .4 FTE in ED for direct referrals/service coordination
  - staff access to RRMC data system (Cerner)
  - ED utilization reports for proactive case management
  - bi-directional referrals between VCCI and CHT
  - direct referrals from ED & hospital discharge planners
  - CHT, VCCI, ED 'piloting' POC status update on high users
  - VCCI, CHT & ED providers meet monthly on high users
- **Communication/Integration:**
  - member of CHT planning, referral & stakeholder groups
  - NCQA practice reports on Medicaid top 5% users
  - disease specific MD reports on gaps in care

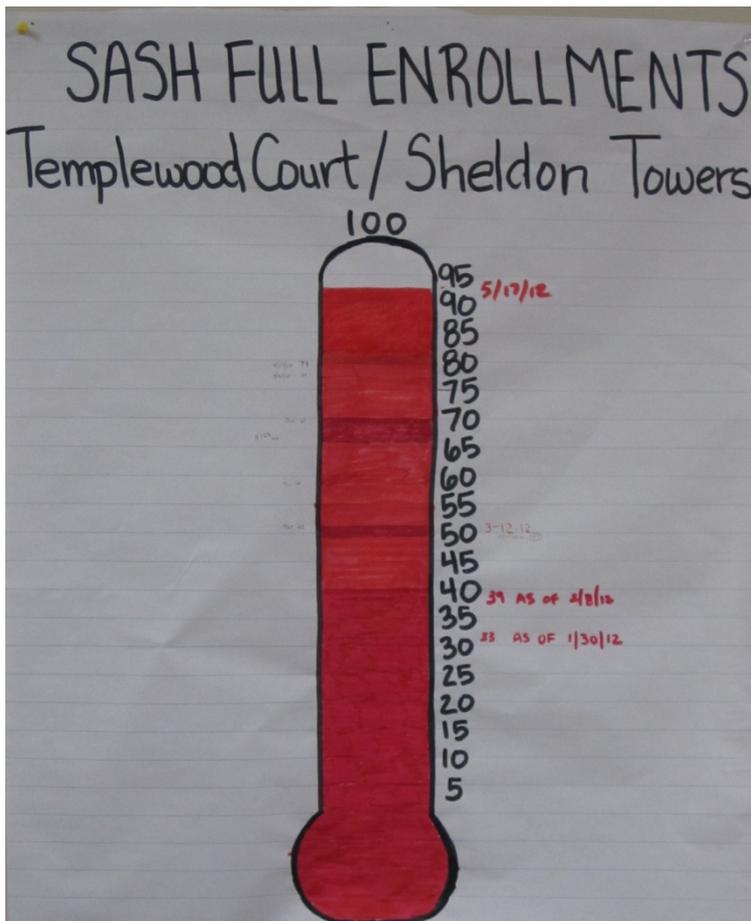


**RUTLAND  
HOUSING AUTHORITY**



Started October 1st, 2011

# Progress To Date



Total Number of  
Residents Enrolled  
**89**

Total Number of  
Residents With  
Completed Assessments  
**83**

# Profile of Residents

## **Templewood Court**

- 49 residents enrolled
  - 39 females
  - 10 males
- Average age: 72 years old
- Average # of prescription medications taken: 7
- Have 3 or more medical conditions: 90%
- Have 5 or more medical conditions: 55%

## **Sheldon Towers**

- 40 residents enrolled
  - 17 female
  - 23 male
- Average age: 58 years old
- Average # of prescription medications taken: 6
- Have 3 or more medical conditions: 80%
- Have 5 or more medical conditions: 55%

# Profile of Residents

## Templewood Court

- Top 5 Medical Conditions
  - Vision
  - Arthritis
  - High Blood Pressure
  - Heart or Circulatory Problems
  - Chronic Pain
- 33% have fallen in last year

## Sheldon Towers

- Top 5 Medical Conditions
  - Vision
  - High Blood Pressure
  - Arthritis
  - Depression
  - Chronic Pain
- 33% have fallen in last year

# Team-Based Care Management

## Our SASH Team

- SASH Coordinator, Karyn Colburn
- Wellness Nurse, Patti Kent
- RAVNAH Skilled Nurse, Roxanne Klafehn
- SWCOA Case Manager, Linda Klopchin
- PACE Representative, Marlee Mason
- CHT Rep. Sharon DeCato

Meets twice a month – Care Coordination

# Information Sharing



# Community Program Partnerships

- Castleton State College Nursing Programs - Internship Program
- Vermont Center for Independent Living - Hunger Free Vermont Nutritional Program
- Council on Aging; AmeriCorps Members – Tai Chi, Walking Program
- Beauchamp & O'Rourke Pharmacy – Brown Bag Medication Review, Diabetes Education
- Castleton Community Center – A Matter of Balance
- RRMC – Eat Well Feel Great

# Roll Outs

- July 2012
  - RHA Community Full Panel (inclusive of Parker House & Linden Terrace)
  - National Church Residences Half Panel (inclusive of Maple Village, Village Manor)
- October 2012
  - Rutland Housing Trust Half Panel (inclusive of Conant Square, Colonial Apartments, Adams House & possibly Neshobe House)

# Future Efforts and Challenges

- Allowing the staff we have hired to become proficient in the work before needing to add more CHT supports.
- Documentation and communication across care settings while adhering to HIPPA compliance.
- Minimizing double documentation
- Keeping all partners informed of expansion efforts

# Questions

