Vermont Care Partners

EXAMPLES OF HEALTH CARE PARTNERSHIPS
THROUGHOUT THE VCP NETWORK 2018

Clara Martin Center: The goal is to coordinate and streamline care and services for individuals in the community and to decrease confusion and duplication of services. CMC has monthly meetings with Little Rivers Health Care (LRHC) care coordinators to discuss shared clients. They also provide psychiatric consultations to LRHC. CMC also has monthly meetings with Upper Valley Pediatrics to discuss shared clients. CMC also attends the monthly UCC, CHT and SASH meetings. With Gifford Health Center, CMC has taken part in a monthly meeting with care coordinators and coordinates on shared care plans for shared clients. Gifford attends the UCC meetings, CHT meetings, Learning Collaborative meetings, SASH meetings, VCCI (VT Chronic Care Initiative) Coordination meetings and GARP meetings all of which CMC attends as well. CMC is co-located with Gifford Health Center Staff at the Chelsea Health Center. Clara Martin Center staff provides counseling services to individuals in Chelsea and the surrounding towns in Orange County. Clara Martin Center provides co-located care coordination services one day per week at White River Family Practice which includes short term counseling and referrals.

With regard to substance abuse and criminal justice programs, CMC has a quarterly DOC/SRR Case Management meeting; attends the Monthly Adult LIT (local interagency team meeting) which focuses on coordination of care for moderate to high risk offenders reentering into the community, as well as other community high need cases who need interagency coordination; has monthly SOT coordination meeting with local probation and parole office and a monthly DVAP coordination meeting with local probation and parole office as well as a quarterly blueprint MAT meeting. In addition, CMC attends the monthly Balance of State Continuum of Care meeting in Hartford to coordinate housing resources for clients. CMC also attends the quarterly meetings for the non-categorical services (the services for those affected by the personal care changes) with UVS, Hope Charkins from Children with Special Needs, a state representative from CDD, and ourselves; and LIT meetings with DCF, education, voc. Rehab, Easter Seals, and HCRS.

Clara Martin Center attends several community integration meetings for children's services. On a monthly basis, Child and Family management staff participate in coordination and planning meetings with Upper Valley Services, Orange County Parent Child Center, and the Hartford region Local Interagency Team. In addition, we participate in weekly referral and collaboration meetings for Children's Integrated Services, and Monthly administrative meetings for the CIS providers. Clara Martin Center has also participated regularly in the movement towards community readiness for Integrated Family Services, now known as Integrated Services (IS). These meetings take place monthly, and aim to support the community and providers in the creation of a fully integrated services system. These IS meetings include participants from physical health, mental health, community support providers, parent child centers and early intervention, as well as larger system stakeholders such as The Haven and Vermont Community Action.

Counseling Services of Addison County (CSAC): CSAC clinicians serve part time (typically 1-2 days per week) and work closely with Primary Care Physicians to provide brief mental health interventions, referrals, and care coordination within the primary care offices. They currently have seven clinicians contracted via either Blueprint or Integrated Family Services (IFS) funding in nine (9) different primary care practices in Addison County. Mental Health Clinicians are embedded directly within 22 schools in three (3) different school districts in Addison County. Services include direct 1:1 supportive counseling as well as home/school coordination. CSAC staff (typically a RN from our Community Rehabilitation and Treatment (CRT) Program) participate in a weekly learning collaborative that includes case presentations. Learning collaboration members include: Blueprint/Porter Hospital and Porter Practices/Other Private Primary Care Providers/Sash/Home Health/CSAC.

With regard to VMNG, seven CSAC staff members have received Care Navigator Orientation and Training. Approximately 20 cases have been assigned to CSAC staff members (not including the Care Navigator work being done by CSAC staff on contract through the Blueprint in Primary Care Practices-see above). CSAC staff have begun entering information in Care Navigator and staff are active participants in the VMNG monthly meetings as well as subgroups. The Addison County Collaborative Steering Committee has delegated decision making authority regarding ONE CARE

VMNG collaborative dollars to a small group comprised of representatives from: Porter Hospital/Practices, Age Well, Home Health, and CSAC.

Health Care and Rehabilitation Services (HCRS): HCRS partners with the Brattleboro Retreat and Brattleboro Memorial Hospital to discuss systemic issues and challenging situations that impact our system of care. We meet regularly to address issues and seek solutions to improve our systems. HCRS psychiatrists also provide phone consultation to primary care physicians around shared clients. Collaborations with Brattleboro Memorial Hospital also include a health coach who works with the Community Health Team. HCRS also has embedded clinicians in primary health care offices in Brattleboro to support children, youth, and families.

HCRS has had a close collaborative relationship for many years with Mt Ascutney Hospital, which includes behavioral health specialists co-located at the hospital as part of their Community Health Team, providing screening, brief intervention, and referral to treatment. HCRS has worked closely with Springfield Medical Care Systems, coordinating with primary care and the Community Health Team. In addition, HCRS has recently subcontracted a care coordinator with the Springfield Community Health Team in collaboration with Springfield Medical Care Systems' FQHC. HCRS will also be working more closely with the FQHC to provide integrated services to high risk children. At Brattleboro Memorial Hospital, HCRS staff are contracted by the Community Health Team including a health coach who supports wellness activities. HCRS also has an embedded counselor at GroundWorks Collaborative and a community based peri-natal wellness specialist.

As part of a collaborative SAMHSA grant in Springfield, HCRS and Springfield Medical Care Systems have established the CHILD team, consisting of case management, clinical, and wellness staff from HCRS and nursing and wellness staff from Springfield Medical Center. This team works to ensure seamless bi-directional care for all children and youth and includes consultation and regular team meetings with the additional participation from a pediatrician from Springfield Medical Center and HCRS' Child Psychiatrist. This collaboration also provides co-location of basic medical pediatric services.

HCRS' Developmental Services (DS) program partners with medical staff on a regular basis to support their clients. The DS program collaborates with VNA services to support individuals with complex medical needs. DS nurses interface with primary care physicians, specialty medical services, and hospital medical staff to help facilitate care.

Howard Center (HC): Howard Center has a contract with UVMMC to provide crisis services in UVMMC's Emergency Dept. Most recently, we have expanded our presence in the Emergency Department with an additional two FTEs through UVMMC investment funds. HC has a long standing position imbedded in the Milton Family Practice. Most recently, HC started a pilot project in collaboration with UVMMC to attach a Medical Home Early Childhood Clinician to a UVMMC pediatric practice. The second pilot also with UVMMC will place a licensed clinician focused on serving New American families in a targeted UVMMC Primary Care Office. Howard Center continues a collaboration with the Burlington Community Health Center (FQHC) for the provision of primary care for adults in our Community Support Program. In addition, HC recently expanded eldercare services through a partnership with SASH and funded by One Care to create an eldercare clinician position focused on targeted senior housing settings with a SASH site.

The Chittenden Clinic, HC's OTP (Hub) has expanded work with local spokes to form a local triage team that is charged with facilitating access to MAT across the Hub and Spoke model in Chittenden County. The growing partnership for the provision of Medication Assisted Treatment has resulted in the elimination of a wait list for MAT services. HC stepped up to create a new Spoke in the community to address the void when Maple Leaf Treatment Associates when out of business which is now providing MAT to 125 individuals.

The Burlington Street Outreach Program is a 17 year old partnership with the City, Downtown Merchants, UVMMC and State funding to deliver outreach services to individuals who are not connected with services and exhibit problematic behaviors. The Street Outreach Program served as an inspiration to create a Community Outreach Team

that will serve 6 surrounding Chittenden County communities with outreach clinicians imbedded in local law enforcement with a targeted start date of January 2018.

Lamoille County Mental Health Services (LCMHS): The programs of LCMHS regularly partner with a variety of healthcare providers. Most prominent is the daily engagement with the Copley Hospital Emergency Department regarding persons needing behavioral health assessment. This is primarily through the Mobile Crisis Team and ASAP, our PIP program. It also includes LCMHS Behavioral Health collaborating with the ED social worker position in identifying high utilizing patients and prioritizes getting them into a healthcare provider for health and for behavioral health as needed. Additionally, the LCMHS AOP and CRT programs participate in the Blueprint and ACO related Unified Community Collaborative and local Learning Collaborative both of which create community care planning to persons with complex health and behavioral health challenges. This relationship extends to regular consultation between LCMHS psychiatric and clinical staff and the local FQHC primary care providers. LCMHS has also worked with the VT Department. of Health to become a distribution point for the CDC Strategic National Stockpile of medications related to a severe health emergency. Most recently LCMHS has also joined with the VT Farm Health and Safety Coalition on a pilot project with the Employee Assistance Program to help implement a farm health outreach program to increase knowledge and understanding regarding physical and behavioral health for farmers, their families and workers. Since Fall of 2018 this has also included a dedicated LNA position, the Medical Care Coordinator, who collaborates with Case Managers to facilitate PCP contacts and visits to ensure optimal information sharing occurs between our agency and the medical provider community.

Northeast Kingdom Human Services (NKHS): NKHS was one of the first agencies to take advantage of EPSDT Medicaid for children to create a social work position within Newport Pediatrics. This position is housed full-time at Newport Pediatrics and provides a wide variety of services including referral, case management and treatment. NKHS has a psychiatrist that spends time in one hospital, another on the way to another hospital and they currently have a contractual relationship with the local FQHC to provide mental health services in their offices. NKHS has numerous plans for future integration efforts.

Northeastern Family Institute of Vermont (NFI): NFI believes that prevention and early intervention of childhood trauma (ACES) are the most humanely and financially important issues for today's healthcare systems to effectively address. NFI has extensive expertise in the area of assessing and treating youth and adults who have experienced Complex Trauma. NFI currently presents about and provides consultation about Complex Trauma to primary care providers, school systems, judicial authorities, child welfare experts, and other service providing organizations across Vermont, the U.S., and British Columbia, Canada. They work with state agencies and organizations to increase adoption of trauma informed practices and policies. NFI hosts internationally renowned trauma researchers and thought leaders to present in Vermont. NFI recently facilitated conversations on trauma and health care between state policymakers (AHS & DCF leaders) and the international experts on developmental trauma, Allan Schore, Ph.D. and Bessel van der Kolk, M.D., while they were in Vermont doing workshops. NFI coordinates with PCP's, especially pediatric groups around individualized care for consumers.

Northwest Counseling and Support Services (NCSS): Within the Blueprint, NCSS and Primary Care have formed strong partnerships with Primary Care. There is an NCSS Social Worker embedded in 100% of local Patient Centered Medical Homes. These partnerships have improved care coordination through an integrated approach in which PCP can make direct referrals to NCSS. These NCSS Social Workers assure integrated coordination of care by acting as a liaison between Primary Care offices and NCSS. In the event of a behavioral health crisis, NCSS partners with primary care to provide mobile crisis outreach directly to the PCP's facility. NCSS has one Crisis Clinician embedded directly within our local NMC Emergency Department. This collaboration has allowed them to identify high Emergency Department utilizers and provide targeted home and community based care coordination resulting in a significant decrease in Emergency Department utilization. The NOTCH (FQHC) contracts with NCSS for social workers at their 5 sites. Through this relationship, NCSS has developed a direct referral process with all PCP offices. NCSS provides some one-time consultations at the nursing home. NCSS also utilizes telemedicine services for medicine checks between the NOTCH and NCSS. Lastly, NCSS and the NOTCH (local FQHC) have teamed up to secure the SAMHSA

Grant *Vermont Family-Centered Health Care Home Project*. This 5 year grant will help to strengthen partnerships and promote a holistic approach to promoting wellness within children, their families, and their communities.

NCSS collaborates with NMC Primary Care Physicians to provide adolescent substance abuse treatment directly within the primary care setting. In addition to their local partnerships with Primary Care, NCSS also has partnerships with 92% of the local schools. NCSS also has two Crisis Clinicians embedded directly within local and state law enforcement. This partnership has allowed law enforcement to better manage volatile situations and improve outcomes.

Rutland Mental Health Services (RMHS): Rutland Mental Health Services (RMHS): RMHS has partnered with Community Health Centers of the Rutland Region and has placed a clinical case manager in CHCRR's offices; CHCRR is the local FQHC. The role of this position is to reach people who are struggling with chronic mental health issues and who consequently have a hard time making or keeping primary care appointments, and receiving care. The RMHS Master's-level clinician sees patients who are referred by CHCRR primary care providers and nurse managers. The clinician spends much of her time spent visiting people in remote, rural locations and doing in-home assessments. The clinician can provide therapy, assessment, coping skills, and has a better understanding of an individual's mental health condition. By building relationships with her clients, the clinician has greater success connecting them to the right services. CHCRR and RMHS are in discussions about placing another clinical case manager in a CHCRR location due to the success of this new model. In addition, RMHS's Crisis Team has an office in the local emergency room. They also have an integrated crisis worker at the Rutland City Police Department and are connected with many local schools.

United Counseling Service of Bennington County (UCS): UCS has clinical staff in 13 spoke and primary care offices throughout the county as part of the Blueprint for Health model. Included in those numbers is staff in four pediatric offices. Clinicians placed in pediatric offices are trauma informed and provide consultation and education to the community health team. In addition to training such as ACEs and trauma informed practices, Blueprint clinicians have provided additional training, most recently a presentation to physicians on the use of Cognitive Behavior Therapy for Insomnia rather than medications.

UCS and Southwestern Vermont Medical Center (SVMC) have entered into their second year of collaboration in offering an "Intensive Medication Assisted Treatment" (IMAT) program which provides treatment including observed daily dosing. Within the IMAT program are nursing, case management and physician staff through the Blueprint who are fully integrated with the clinical, management and administrative staff from UCS who share office space and documentation systems. In addition, the Rocking Horse program is also held within the IMAT office. UCS partnered with SVMC to improve patient access to mental health services by embedding psychiatry and nurse practitioner services within the Emergency Department as well as to those hospitalized at SVMC who have a primary or secondary mental health diagnosis. Given that approximately 40% of all patients being treated at SVMC have a behavioral health diagnosis it is essential to assist with policy and development, attend to providers during rounds and conduct educational sessions for staff. The psychiatry and NP staffing are available to SVMC staff and patients 20 hours per week, on-site. UCS contracts with SVMC to provide crisis clinical services within the Emergency Department. UCS and SVMC continue to discuss ways to increase integration of health care including but not limited to the development of an Atypical Behavior Unit at the Center for Living and Rehabilitation.

UCS staff is active members of the Bennington Community Care Team in order to prioritize support for high users of the ED. The Executive Director is a member of the United Health Alliance (UHA) Board, the Bennington Community Collaborative, and the Alliance for Community Health (ACH) Team.

UCS also employs a Wellness Nurse who provides Wellness care and health screenings for staff and occasionally for clients at UCS facilities. UCS provides EAP services to the Bennington Rescue Squad and SVMC.

Washington County Mental Health Services (WCMHS)
WCMHS has therapists in five doctor's offices through CVMC Community Health Teams for adults and has created a trauma screening for all patients. They provide clinical supervision for SBIRT clinicians working in the CVMC

Emergency Room. With the local FQHC, WCMHS provides outreach and case management for common clients. With two pediatrics offices, WCMHS has initiated a pediatric information exchange project to systemize a process for information exchange to improve health and mental health. In addition, an Adverse Childhood Experiences (ACEs) project has recently been initiated with Central Vermont Pediatric Primary Care, which embeds a collaborative position held jointly by WCMHS and the Family Center of Washington County for a family support specialist within the practice to accept up to 100 child and family referrals the first year, tracking pre and post intervention results.

The WCMHS Wellness Collaborative offers complementary approaches to traditional psychotherapy through mindfulness-focused groups, with improved outcomes on decreasing stress and increasing coping strategies. Medical practices refer patients to these programs. WellSpace in Barre, Vermont is a physical space specifically created for focus on alternatives to traditional treatment to broaden options for individuals who would not otherwise access such programs due to income, transportation, or social barriers. Programs are trauma-informed and include: open art studio, life skills programming, Jobs for transitional youth, Wellness Collaborative programming and other groups, kettle bells, cross fit, boot camp (for staff and clients); and a Doula program in collaboration with Central Vermont Medical Center, specifically for women who have experienced Adverse Childhood Events.

WCMHS also has a contract with CVMC for crisis response to the Emergency Room and the Psychiatric Unit, where over 60% of individuals screened are diverted from hospitalization. WCMHS is working with CVMC on the development of a Regional Referral Hub model that would accept referrals of individuals who do not have established follow-up treatment from primary care, emergency rooms, and psychiatric units. The purpose will be to enhance access through a single point of contact, which will include information on both public and private resources. In the past year, WCMHS has cross trained with the Emergency Room to offer a co-occurring social de-tox bed for brief support, assessment, and treatment, accepting referrals directly from the Emergency Room with immediate response.

WCMHS has worked collaboratively with CVMC to create an Integrated Health Home within the Granite City Primary Care Practice. This model assists individuals with extreme health challenges, who were not able to maintain a primary care provider, to connect through intensive case management, nursing, and psychiatric supports with the practice. The results of this model have been extremely positive with 87% success rate in successful and enduring engagement over one year for those participating.

Recently the Children, Youth, and Family Division has added one emergency room diversion bed for those Medicaid eligible children who are awaiting, or diverting from, a hospital bed. 24/7 staff provides assessment, treatment and support during a brief stay. WCMHS has also been leading its risk-bearing community with trainings and implementation of the Patient Care Navigation system through One Care Vermont. This process assigns a lead care coordinator with the goal of bringing together multi-disciplinary teams to assist individuals who have high risk health issues in accessing appropriate care and receiving at-home supports to reduce costs and improve outcomes. WCMHS also facilitates the regions monthly care coordination meeting for all community providers and the Community Health Team.

Champlain Community Services, Upper Valley Services, Families First in Southern Vermont, Green Mountain Support Services and Lincoln Street are all developmental disability agencies. Each agency coordinates with primary care and other medical teams. Developmental disability agencies take a person centered, team based approach in supporting individuals with developmental and intellectual disabilities to lead satisfying lives. This includes coordinated supported employment, home and shared living, school to career transition and community supports. In addition, the developmental disability agencies provide mental health and other clinical services as well as specialized medical care services for those who need such supports.