Background of Team Based Care in Vermont
Vermont benefits from a long history of diverse health care and human services funded by a combination of Medicaid and other Human Services programs; combined with private, non-profit and philanthropic contributions. Noteworthy programming under the Agency of Human Services (AHS) includes:

- The Blueprint for Health (Vermont's statewide advanced primary care program),
- The Vermont Chronic Care Initiative (VCCI),
- A partnership with OneCare Vermont, the statewide Accountable Care Organization,
- Medicaid State Plan home and community-based services and special programs under Vermont's 1115 demonstration waiver including:
    - Pediatric palliative care,
    - Community Rehabilitative Treatment (CRT),
    - Mental Health under 22
    - Development Disabilities Services,
    - Choices for Care, and
    - Brain Injury Program.

All of these programs have included a focus on serving people with complex needs.

People with complex needs often seek care from a wide spectrum of health and human services providers to support comprehensive treatment of mental health conditions, substance use disorders, other health conditions, social determinant of health needs, and conditions requiring long-term services and supports. Research and experiences of national leaders have demonstrated that person-centered integrated team-based care helps to ensure optimal care management and care coordination for those members, and that well-functioning complex care ecosystems are a key element in supporting effective integrated team-based care. The State believes that both integrated team-based care and complex care ecosystmes are critical components of a Complex Care Model that will address Vermont's goals.

In 2015, through the support of a State Innovation Model (SIM) grant, Vermont engaged in a statewide learning collaborative to bring various provider organizations and front-line care coordination staff together to address the first component (person-centered integrated team-based care). Overarching goals were to:

- Better serve all Vermonters (especially those with complex physical and/or mental health needs) by reducing fragmentation through better coordination of care and care management activities; and
- Better integrate social services and health care services to more effectively understand and address social determinants of health (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters.

Over the course of multiple years, this initiative, known as the Integrated Communities Care Management Learning Collaborative, resulted in the development of a complex care model that described and used the following interventions to better address the needs of individual Vermonters with complex needs:

- Identify people with complex needs using data, clinical judgement, and cross-organization referrals;
- Recruit people to participate in cross-organization care management;
- Use tools (e.g., backwards planning, "Camden Cards" to support discussion of priorities, eco-maps) to document the person's story, goals and care team;
- Review the person's health history;
- Conduct a root cause analysis;
- Convene an initial care team conference;
- Identify the person's lead care coordinator (ideally selected by the person);
- Develop, implement, and monitor a shared care plan; and
- Convene subsequent care conferences to implement the care plan to address the person's goals.

To some degree, these interventions from the complex care model have been embedded in ongoing Blueprint for Health, OneCare Vermont, VCCI, and other programs' operations. The willingness of these entities to adopt and reinforce the model has been an asset. But this is incredibly challenging work to initiate and sustain, and there are numerous factors that can create distractions and barriers to full implementation. Turnover in workforce and organizational leadership, staffing shortages, intensive workloads, variation between regions, the number of independent organizations providing health and human services and care coordination even in a small state like Vermont, the COVID-19 public health emergency, and structural siloes are just a few of those factors.

Team Based Care Project 2023

The Vermont Agency of Human Services (hereinafter the "State") contracted with the Camden Coalition to provide technical assistance to the State in further advancing a model to support complex care teams working on behalf of individual Medicaid members and local complex care ecosystems working to address regional population health improvement. The goals were to:

- Build on existing efforts to provide integrated team-based care for individual Medicaid members with complex needs who need services from multiple provider types and who would benefit from strong communication and collaboration between those providers,
- Support and enhance high-functioning complex care ecosystems within each region of the State, and
- Ensure coordination and alignment with other efforts that impact complex care, such as conflict free case management, compliance with federal requirements for care and coordination of services, and assessment of health information exchange (HIE) needs for HCBS providers to support planning for an HIE incentive program.

The Camden Coalition worked with State leaders and community-based providers to assess the current Team Based Care landscape. The report below is the outcome of that exploratory work which is a set of recommendations to Vermont to enhance Team Based Care systems.

What's next for VTBC?

Providers across Vermont are already doing VTBC. Over the next year, with support from the Camden Coalition, we will systematically document best practices in VTBC while also developing online, self-paced training and education materials to ensure that all staff now and in the future are appropriately trained and supported on the core elements and practices of VTBC. Your feedback on what's working and what's not will be crucial in making VTBC better statewide. Our goal is to make sure people with complex health and social needs have a better experience and that you feel supported in treating them as a whole person.

In an effort to strengthen and continuously advance VTBC, we are launching a statewide learning collaborative. The community in each health service area will identify 1-2 priority areas for improvement and designate change teams to work on small tests of change to address those focus areas. The change teams will receive support from the Blueprint team, Field Director, and an expert facilitator from the Camden Coalition. At several points throughout the learning collaborative, change teams will come together with one another to share their progress and learning.

At the end of the year, each community will share what they've achieved so we can learn from each other and develop next steps and recommendations for the Agency of Human Services. We want everyone involved in VTBC to share the same goals and values and to have clear ways of working together to improve care for both providers and patients. By working together, we can make sure Vermonters have better health outcomes. We're committed to keep improving VTBC to make it more engaging, client-centered, holistic, integrated, fair, responsive to trauma, and sustainable.

Today, we are working with Camden Coalition along with State and community partners through Learning Collaboratives to further enhance our collective work and to build care cultures within communities that embrace a team based care approach. We are also developing a series of 4 Team Based Care self-paced online trainings which will be accessible to State department staff and community partner staff.