FEBRUARY 2024

Vermont Team Based Care Model Recommendations and Implementation Timeline

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Camden Coalition

Executive summary

The Vermont Agency for Human Services has a record of initiatives designed to support people with complex medical and social needs, including investing in community-level ecosystems to collaborate and make systems more accessible. This report includes recommendations for improving and expanding team-based care and a proposed implementation plan. Much of this work is already happening in various parts of the health and human services ecosystem. These recommendations will help to unify those efforts under a common framework, supportive policies, ongoing training, and greater capacity that will allow programs and staff to perform better.

The proposed Vermont Team-Based Care (TBC) 2.0 is a philosophy and set of individual and systems-level practices. It is a statewide care coordination model that can support Vermonters with complex needs, regardless of insurance status, by assessing biopsychosocial needs, helping identify goals, connecting to services and benefits, and supporting behavior change to reach those goals.

Related to this model, we propose 4 TBC-related designations for programs:

- *TBC Programs: These programs provide long-term healthcare or human services, usually with some amount of care/case management or care coordination. Staff performing case/care management functions will be competent in the TBC tools and processes with support from Field Services and VCCI. A program representative can serve as the lead care coordinator and convene case conferences.*
- *TBC Referring Programs: These provide screening and/or services to Vermonters but do not engage them for a sufficient duration or intensity to serve as the lead care coordinator and convene case conferences. Staff are trained to identify individuals with complex needs who would benefit from a TBC program and make referrals to TBC programs.*
- *TBC Specialists: This is a group of experts who will provide support for people with the highest needs who have no connections to other TBC care coordinators. They also support people, identified through referral or assessment, who are connected to other TBC providers but have a very high level of complexity that requires greater ongoing support. They also provide TBC consultation and training to other providers.*
- *TBC Systems-Level Practices: These community-level practices and teams help providers problem-solve and provide short-term coaching regarding the most complex and challenging situations and review trends across individuals for systems-level issues. They also facilitate individual and collective efforts to address systems-level issues, improve quality of care, and reduce barriers to care. They are responsible for identifying gaps in the system of care in the community and communicating those gaps back to AHS.*

The overall recommendations are:

- *Adopt team-based care as an agency-wide philosophy and policy.*[2]
- *Standardize and improve existing team-based care practices across all domains of care.*
- *Define different designations within team-based care to enable expansion of model across AHS within new programmatic settings, including non-medical settings.*
- *Model team-based care at the state level by adopting it as a philosophy, working across programmatic and departmental divisions, and training staff in the model.*
- *Develop and adopt an IT strategy, maximizing deployment and functionality of existing technology platforms (e.g., VHIE) and introducing new platforms where necessary, to enable data sharing and collaboration that includes healthcare providers and community-based organizations providing non-medical services.*
- *Identify specific metrics, including process and outcome, that can be used to evaluate the success of the model, including reduced utilization of emergency services, homeless shelters, and corrections; increased utilization of mental health and substance use treatment and primary care; decreased distal measures including deaths from overdose and suicide; improvements in measures related to social needs, and improved sense of coordination and collaboration among provider staff and clients.*

More specific recommendations are organized by domain:

- *Model codification*
- *Workforce development*
- *IT & data sharing*
- *Consumer engagement*
- *Measurement & evaluation*

Implementation of the foregoing recommendations demands significant change management activities among both AHS and provider stakeholders. The implementation recommendations are:

- *ACH Learning collaboratives (starting Q1 2024)*
- *TBC expansion/adaptation (starting Q1 2024)*
- *TBC 2.0 codification and implementation (late 2025-2026)*
- *IT design and procurement (Q1 2024-2025)*
- *Sustainably continue TBC in VT (starting 2026)*

Introduction

The Vermont Agency for Human Services has a long record of initiatives designed to support people with complex medical and social needs, including investing in community-level ecosystems to collaborate and make systems more accessible.

The Blueprint for Health program is one of Vermont's longest-running healthcare reform initiatives with a focus on increasing high-quality primary care, preventive care, and care coordination, particularly for chronic healthcare conditions in the general population.[1] Supported by multi-payer participation, the Blueprint has built a foundation with patient-centered medical homes and Community Health Teams to provide care coordination and linkages to services. The Blueprint network of Program Managers, Community Health Team Leaders, and Quality Improvement facilitators has facilitated local transformations and increased collaboration among community partners. Since its creation in 2006, the Blueprint has expanded to include other programs including a hub and spoke model to provide medication for opioid use disorder (MOUD) treatment and support health during pregnancy. The Blueprint-funded teams play an important role in convening and supporting local healthcare stakeholders to work together as coordinated ecosystem of care. In 2019, communities across the state participated in an Accountable Communities for Health (ACH) **learning lab**, which facilitated the creation of (or often the adaptation of existing) regional structures that serve the core functions in the ACH model.

Beginning in 2014, **Vermont Integrated Communities Care Management (ICCM) Learning Collaborative** engaged regions around the state to rapidly implement quality improvement initiatives focused on supporting people with complex health and social needs. This initiative, supported by a $45 million State Innovation Model (SIM) Testing grant from the federal Center for Medicare and Medicaid Innovation, was implemented through a collaborative effort of the Agency of Human Services including the Blueprint for Health and VCCI, OneCare Vermont, local community collaborative teams, and others. During this initiative, significant connections were established among a broad group of stakeholders and community health and human service organizations with the goal of better coordinated care for people with complex health conditions.

During the ICCM learning collaborative, with support from the Camden Coalition and expert faculty from across the country, programs and staff in all geographic communities developed team-based approaches and workflows for the Vermont system and received training in and access to person-centered care coordination tools and strategies to engage clients, develop a shared care plan, and identify a lead care coordinator. Although the learning collaborative's funding ended with the conclusion of the SIM grant in mid-2017, OneCare Vermont (Vermont's Accountable Care Organization) continued to use the approach and tools as part of its care model for identifying and supporting its attributed members with high and very high risk. These care coordination practices have been implemented in diverse ways and to different

degrees across the Vermont Agency of Human Services (AHS) and its funded programs. Blueprint programs, VCCI, and hospital and community-based organization partners within the OneCare Vermont ACO network have adopted and sustained the model. Its implementation was largely limited to divisions focused on healthcare delivery. For decades, other departments have also been operating under a similar relationship-based, trauma-informed team approach. This is Complex Care 1.0.

In 2023, the Camden Coalition evaluated AHS's complex care model to recommend changes and an implementation plan for programs and services across the AHS ecosystem. The name *complex care* was changed to *team-based care* to reflect that it is not exclusively a medical model of care, but instead a team-based effort of health and human service providers to support people with medical, mental health, substance use, and social needs. This type of care will be available to all Vermonters, regardless of insurance status. In this statewide shift, there is the recognition that the philosophy and practices of team-based care have long been present in programs and departments outside of the limited healthcare programs that participated in Complex Care 1.0, and that the work of the entire agency could be aligned under a common model. This is team-based care 2.0.

This report includes recommendations for improving and expanding team-based care and an implementation plan. Much of this work is already happening across the healthcare and human service ecosystem. These recommendations will help to unify those efforts under a common framework and supportive policies, ongoing training, and greater capacity will allow programs and staff to perform better.

Methods

During the initial assessment phase, the Camden Coalition facilitated a process of stakeholder engagement and fact-finding. We conducted over two dozen interviews and focus groups with internal AHS and external community stakeholders (Appendix 1). Interviewees first completed the "Vermont team-based care (complex care) model evaluation survey," after which we used a semi-structured interview guide to assess the level of implementation of the team-based care model and to identify strengths and areas for improvement. The Camden Coalition also completed a document review. We prepared draft findings that were shared with the AHS workgroup and project team (Appendix 2) for feedback and refinement. The AHS workgroup and project team provided additional background information and review, which was incorporated into the deliverable: *Vermont Team-Based Care (Complex Care) Model Evaluation Report*.

Based on the findings of the assessment, the Camden Coalition generated proposed recommendations. It reviewed those with the AHS project team and then presented them for further feedback at in-person meetings with the AHS workgroup, the Secretary of AHS, the AHS Commissioners and Deputy Commissioners, leaders from One Care Vermont, the staff of the Vermont Chronic Care Initiative (VCCI), leaders of Designated Agencies, and other department and community stakeholders.

Recommendations

This section of the report includes recommendations for the improvement and expansion of team-based care across Vermont AHS programs. It includes both a set of baseline recommendations and more advanced recommendations that would require more significant resources. The recommendations that will ultimately be implemented will depend on urgency, feasibility, scale, and priorities.

TBC Model 2.0

The Vermont Team-Based Care (TBC) 2.0 is a philosophy and set of individual and systems-level practices (Figure 1).

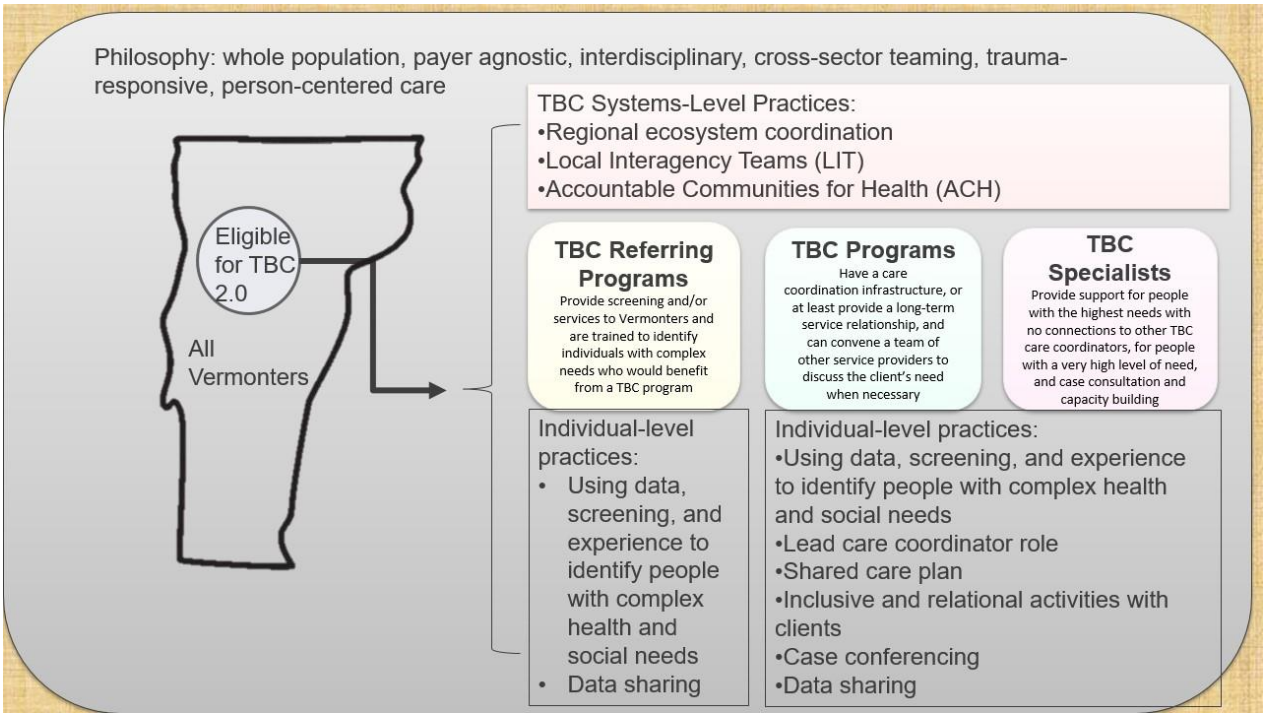

Figure 1: The key components of TBC 2.0

The TBC philosophy is applicable across the agency, across the health and human services landscape, and in the way care is delivered for all Vermonters. It requires teams to work across disciplines and sectors to support people in their medical, mental health, substance use, and social needs. The philosophy is trauma-responsive and person-centered. At every entry point into the system of care, AHS screens for other service and/or resource needs, including TBC, so that people can be connected to support if they wish. The philosophy moves care from reactive to proactive and seeks to support individuals in achieving their goals and rebuild community and individual trust.

TBC 2.0 is a statewide care coordination model that can support Vermonters with complex needs, regardless of insurance status, by assessing biopsychosocial needs, helping identify goals, connecting to services and benefits, and supporting behavior change to reach those goals. While not all care coordination in Vermont is TBC, the TBC model unifies a wide range of care coordination that is whole person focused and seeks to build an ongoing authentic healing relationship between care coordinator and client. The intensity of care coordination within TBC varies depending on the level of need and complexity of the client's needs. TBC helps to reduce duplication of services because it brings together providers from all domains of care to coordinate roles and responsibilities in serving mutual clients. The TBC model also includes system level practices that connect AHS and provider organizations across the regional health and human services ecosystem.

Who is eligible for TBC 2.0?

Team-based care serves a wide range of Vermonters who experience complex health and/or social needs. Many of the unifying practices of TBC are particularly helpful for individuals who have combinations of serious needs that require ongoing treatment and services from multiple providers or organizations. As an expanded model of TBC 2.0 is implemented, existing eligibility criteria for individual TBC programs will remain (e.g., CRT), while providers and communities will use a combination of data, clinical judgment, and referral to identify those with the most complex biopsychosocial needs. One Care Vermont will likely continue to use the Johns Hopkins ACG System to stratify their population by risk. We recommend that they consider using the **Johns Hopkins ACG System version 3.0**, which goes beyond medical risk and incorporates social risk factors to more fully understand influences on overall health.

Over time, through the learning collaborative process and model codification, data, experience, and expert opinion will help refine the prioritization of specific populations that are best served by TBC. Use of a common screening tool will help align eligibility across the agency.

The 4 TBC designations

Related to this model, there are 4 TBC-related designations for programs:

1) TBC Programs (e.g., Patient Centered Medical Homes (PCMH), Community Rehabilitation and Treatment Services (CRT), Forensic Assertive Community Treatment (FACT), Blueprint Community Health Teams, Act 264, etc.)

These programs have a care coordination infrastructure or provide a long-term service relationship and can convene a team of other service providers to discuss the client's need when necessary. Some of these programs will deliver whole person care management, relationship-building, and cross-organizational coordination. All staff performing case/care management functions in case management programs will be competent in tools and processes of the TBC model with supports from Field Services and VCCI. All these programs can be the lead care coordinator and convene case conferences. Some will have specific eligibility criteria (e.g., CRT programs) whereas others will be open to any Vermonter eligible for TBC care coordination (e.g., PCMH).

2) TBC Referring Programs (e.g., Economic Benefits, Vermont Chronic Care Initiative (VCCI) new to Medicaid screening, parole)

These are programs that provide screening and/or services to Vermonters and are trained to identify individuals with complex needs who would benefit from a TBC program. These programs may provide care coordination services that are narrow in scope and time limited. They are often focused on delivering a particular benefit or service and do not have the capacity to be TBC Programs. TBC Referring Programs should train all staff in the model, including how to identify individuals and make referrals. They should also identify staff with more experience and/or training in team-based care who can support more challenging referrals and serve as TBC champions.

3) TBC Specialists (e.g., VCCI, Children with Special Health Needs (CSHN) Regional Care Consultants)

TBC Specialists are a group of experts who will provide support for people with the highest needs who have no connections to other TBC care coordinators. They also support people connected to other TBC providers who have a very high level of complexity that requires greater ongoing support. TBC Specialists also provide TBC consultation for individuals with extreme complexity and training to other providers.

4) TBC Systems-Level Practices (e.g., Local Interagency Team (LIT), child and family LIT, Community Health Team (CHT), Accountable Communities for Health)

These community-level practices and designated teams help problem-solve and provide coaching regarding the most complex and challenging situations. They also facilitate individual and collective efforts to identify and address systems-level issues, improve quality of care, and reduce barriers to care. They are responsible for identifying gaps in the system of care in the community and communicating those gaps back to AHS. The teams vary in structure and scope across communities and often include organizational decision-makers.

See Appendix 3 for example workflows between these entities.

Overall recommendations

Full implementation of TBC 2.0 requires the participation of many stakeholders, including both state employees and private healthcare and human service agencies. AHS leadership will need to prioritize implementation activities to spread TBC across the entire system in a coordinated way, either fitting into or intentionally disrupting existing structures.

The initial rollout of complex care was limited to certain areas of AHS, including the ACO, the Blueprint, Act 264 legislation for children and youth, and the Vermont Chronic Care Initiative (VCCI). With TBC 2.0 there is an opportunity to align on a common approach across the entire AHS. There are several infrastructures that can be relied upon to support statewide application.

In this process, AHS will need to work with the larger health and human services ecosystem to take full advantage of existing best practice while thoughtfully redesigning and expanding TBC model in ways that provide immediate value to both providers and Vermonters with complex needs.

The overall recommendations are:

1. Adopt team-based care as the overarching agency philosophy and policy.[2]
2. Standardize and improve existing team-based care practices across all domains of care.
3. Define different designations within team-based care to enable expansion of model across AHS with new programmatic settings, including non-medical settings, and different levels of responsibility.
4. Model team-based care at the state level by working across programmatic and departmental divisions and training staff in the model.
5. Pursue an IT strategy that maximizes deployment and functionality of existing technology (e.g., VHIE) and introduces new platforms where necessary, to enable data sharing and collaboration among healthcare providers and community-based organizations providing non-medical services.
6. Identify specific metrics, including process and outcome, to evaluate the success of the model, including reduced utilization of emergency services, homeless shelters, and corrections; increase in appropriate utilization of mental health and substance use treatment and primary care; decreased distal measures including deaths from overdose and suicide; improvements in measures related to social needs, and improved sense of coordination and collaboration among provider staff and clients.

More specific recommendations are organized by domain:

- *Model codification*
- *Workforce development*
- *IT & data sharing*
- *Consumer engagement*
- *Measurement & evaluation*

Model codification

Individual-level model codification

Care coordination activities exist in many health and human services programs across Vermont and can vary in scope, duration, and services. For individuals with very complex needs spanning physical health, mental health, substance use, and social health, multiple organizations are often working with the same person and the person may even have multiple care coordinators. Vermont's policy of self-determination requires that individual Vermonters be able to choose whether they want services and who they want to work with, when possible, i.e., a lead care coordinator. Within current practice, due to varying levels of team-based care knowledge, skills and confidence among staff, teams, programs, and organizations, there will continue to be differences with the initiation and implementation of complex care conferencing.

In TBC 2.0, there are 4 TBC-related designations: TBC Programs, TBC Referring Programs, TBC Specialists, and TBC System Level Practices (see the section *TBC Model 2.0* for more). This model will need to be further codified and communicated to stakeholders. This will build off existing resources, including the **ICCM Toolkit**.

The individual-level model codification recommendations are:

1. Create a simplified, easy-to-digest visual of the model and disseminate it across key stakeholders.
2. Develop a TBC 2.0 playbook, which sets expectations around model components and definitions, including dictionary of terms, and the model's application to AHS and to delivery organizations. This includes defining the scope of care planning and case conferencing and the means of participation, the job description and core tasks of lead care coordinator, the various levels of case conferencing, and the purpose and function of the TBC engagement tools.
3. Co-design standard workflows, tools, and templates for TBC 2.0 programs including social drivers of health (SDOH) screening, referrals into TBC Programs, shared care plan templates, and case conference tools with communities through ACH learning collaborative.

4. Document existing screening and care coordination programs across the state, with consideration to the level of intensity, the population served, and TBC designation of the program (i.e., TBC Program, TBC Referring Program, TBC Specialist, TBC System-Level Practices).
5. Audit the 211 system to ensure it is a comprehensive and well utilized directory. Explore enhanced functionality of directory-based referral platforms. Consider the lessons learned by the 3 communities using Findhelp and the others in the demo phase (See section IT & data sharing for more related recommendations and information).

Systems-level model codification

Vermont has long cultivated collaboration at the local/regional level through establishment of systems-level structures that include a wide range of healthcare and human services provider organizations as well as representatives from AHS. Vermont AHS has adopted the Accountable Communities for Health (ACH) model, though different communities may have more than one group that brings together system stakeholders at the local/regional level and may use different names to describe them. In 2018 and 2019, the **ACH Peer Learning Lab** brought together multi-disciplinary community structures from across the state to implement the nine core elements of the ACH model and develop community capacity. These structures share strengths as spaces of collaboration that address systems-level problems; they benefit from the leadership of the Blueprint Program Manager, the AHS Field Service Directors, and the Blueprint QI lead. With a more clearly defined purpose and best practices to maximize the value of existing funding, there is an opportunity for these groups to expand their value by partnering with the state to identify gaps in the ecosystem and developing quality improvements and pilot programs to address those gaps in ways that can potentially be shared and scaled across the state.

The systems-level model codification recommendations are:

1. Further clarify the purpose, participants, and funding of the regional systems-level structures in light of the breadth of programs involved in TBC 2.0. Build off the ACH experiences, practices, and networks and the existing infrastructure in each community. Clarify the relationship that these entities have to the state while retaining local ownership and innovation.
2. Leverage the leadership dyad of the AHS Field Service Directors and Blueprint Program Managers, while recognizing other key stakeholders, including the Blueprint QI lead, and OCV and Designated Agency leaders.
3. Create a statewide forum for systems-level structures to collaborate across regions and capture and share best practices and tools from across the state to support a culture of ongoing improvement and acknowledge progress.
4. Explore the potential to differently leverage ACHs to play a more formal and robust role in the expansion of Blueprint processes and activities, including innovation and quality improvement as regional partners with the state.[1]

Workforce development

High-quality, well-trained workforce is a scarce resource across the state of Vermont. The unemployment rate in the state is 2.4%, which is lower than the national rate, and it is particularly hard for health and human service organizations to recruit and retain their workforce due to high stress and low pay (especially for CBOs) relative to other sectors. In some places, the workforce is comprised of an increasing number of new professionals who need additional training and support to be able to serve people with complex health and social needs. Because of this, there are significant workforce deficits, especially in designated agencies (e.g., 7 vacancies on a 21 person CRT case management staff), and agencies are often hiring people away from other agencies.

When the complex care model was originally introduced in 2016, only a portion of the AHS staff and care managers in the OneCare network were trained. Those trained were primarily in healthcare. Now, with the improvement and expansion of TBC, there is the opportunity to train a wider range of the public-facing workforce within both AHS and the broader delivery system. There are existing resources that can be leveraged, including the TBC training developed by the Community Health Team from Northeastern Vermont Regional Hospital in St. Johnsbury, the state **Center for Achievement in Public Service (CAPS)** and **SOV LINC** training system, the **Blueprint training and**

[1] **https://www.milbank.org/wp-content/uploads/2023/02/CamdenCoalition_2.16.pdf**

resources, and OCV's **Vermont Health Learn.** Despite these resources, training for many care coordinators new to the field often is limited to shadowing more experienced care coordinators.

The workforce development recommendations are:

1. Assess the current state of workforce development, including the availability of staff to provide training and ongoing maintenance of competencies, to develop the core curricula for TBC Programs, TBC Referring Programs, and TBC Specialists.

- *Provide ongoing training for client-facing staff from a wide range of organizations, including AHS and its contracted provider agencies. This can include separate tracks for individuals already familiar with TBC and those new to TBC, as well as for TBC programs and TBC referring programs. Training should include education on the key model components, including the model philosophy, practices, and tools; the* **complex care core competencies***, and relationship-building.*
- *Provide support to a dedicated system-wide workforce training function, including both live and asynchronous/self-paced training resources, that ensures availability and accessibility of training. Plan for the long-term and build the capacity to train new staff and provide refresher and advanced training courses for existing staff, including clinical supervisory training.*

IT & data sharing

Data sharing is essential to the TBC model to facilitate collaboration and coordination among multiple service providers. Effective data sharing can produce value for the client, the payer, the provider, and policymakers. There is a need for IT solutions accessible by all TBC providers (including TBC referring programs) that allow for sharing of screening and joint care plan documents, event-based alerts, and secure messaging. There may not be one IT solution but a combination of solutions that enable connection through a common platform such as the VHIE.

For several years, AHS and One Care Vermont utilized a platform known as Care Navigator to facilitate sharing of health and care coordination information as well as allow secure messaging and alerts amongst network providers. The system was ultimately abandoned because it required providers to go outside their normal IT system and perform double entry, which was administratively burdensome. It also only included a subset of Vermonters and only covered providers were able to access the tool. To date, Care Navigator has not been replaced, though both AHS and One Care Vermont have begun to explore alternatives.

The Vermont Health Information Exchange (VHIE) is a statewide data sharing asset that can be leveraged to help achieve the goals of TBC 2.0, though many in the health and human services field are not currently using the HIE. As part of its **Health Information Strategic Plan,** the state is actively working to expand access to the HIE. It also plans to engage in "initial phases of scoping and gathering requirements for a future procurement of a care coordination and referral platform with a broad stakeholder group" in 2024, the state is actively working to expand access to the HIE. It also plans to engage in "initial phases of scoping and gathering requirements for a future procurement of a care coordination and referral platform with a broad stakeholder group" in 2024,

This plan is aligned with our findings and recommendations. Stakeholders reported that they want access to IT systems that can share information and can integrate with existing electronic health record (EHR) platforms to avoid dual data entry. This IT functionality (using one or multiple IT platforms) should host screenings, assessments, and shared care plans and enable providers to understand who else is involved in an individual's care. It should be comprehensive of the types of providers who can use it, provide access to clients, and include all Vermonters. While this is a tall order, there are a growing set of IT solutions that can integrate or interface with existing IT tools through APIs to enable the sharing of information in a more comprehensive and streamlined fashion.

Beyond the lack of a common IT platform, challenges exist around provision of individual consent to share information between providers and across departments and compliance with privacy and confidentiality requirements. Although AHS developed a unified consent or release of information (ROI) for CCHRT, some organizations have developed their own unique ROIs which can vary in slight ways from one another. Many will not provide information unless their own ROI is signed by the client. One substance use treatment provider reported that their

compliance officer recommends against securing prior authorized releases thereby impeding sharing, particularly in times of crisis, that would otherwise be legal and appropriate.

The IT and data sharing recommendations are:

1. Engage in retrospective review to identify shortcomings and successes of previous and current attempts to develop and implement a platform for sharing health data.
2. Leverage existing platforms (including the VHIE) by maximizing functionality and adding providers, including mental health and substance use treatment providers, correctional medical providers, human service providers, and other AHS and contracted providers. This will require collaboration with legal teams to recognize expanded definition of who provides "treatment" for purposes of HIPAA as well as allowing consent-based access.
3. Perform a formal planning and requirements-gathering process to define and procure one or more IT solutions that will, in concert with existing IT systems, enable Vermont health and human services providers to share key information, including screening, care plans, and service providers identity, and enable secure messaging and alerts. Such a platform should allow for bidirectional sharing of data with the VHIE and practice EMRs and should be accessible to as wide an array of AHS providers as possible. The requirements-gathering process must include broad stakeholders that span AHS departments and medical and social providers.
4. Develop state guidance and tools, including a guidance on the use of and communication around a standard team-based care release of information consistent with privacy and confidentiality requirements, to promote broader data sharing and ensure that providers have access to data (including mental health and substance use data) when the client is in crisis.

Consumer engagement

Consumer participation and leadership has the potential to strengthen TBC, helping ensure that it is truly person-centered and trauma-informed:

- *Individuals with lived experience of complex health and social needs who have navigated a variety of health and human service systems can provide important insights from their own experience that can help identify system challenges and inform system improvements. Such individuals are important participants in person-centered design as well as community engaged research. Their personal stories and reflections also provide powerful lessons to providers about the dignity and resilience of all individuals and the harm inflicted by stigma and discrimination.*
- *Individuals with lived experience serve as important parts of the workforce, often as peers or community health workers, and are particularly well positioned to build rapport and trust and provide ongoing support to historically and currently marginalized populations experiencing complex needs.*
- *Individuals with lived experience, particularly those who have benefited from TBC programs, can serve as effective community liaisons, helping build trust, empathy, and relationships between AHS, agencies, and the community.*

There is already some inclusion of people with lived experience receiving services in various oversight structures throughout AHS and its funded programs. However, many of these structures are relatively formal and may not allow for the level of engagement and contribution that is necessary to achieve the forementioned goals. Developing meaningful consumer engagement and participation is a years-long process that requires both focused intention and resources. There are a couple of opportunities to pilot new forms of consumer engagement that would add value and may reveal additional opportunities that could be pursued over time.

The consumer engagement recommendations are:

1. Identify through learning collaboratives where and how people with lived experience of complex needs are currently engaged and partnering meaningfully with AHS, ACHs, and/or individual organizations (e.g., Patient and Family Advisory Committee and Community Advisory Committees).[2] Identify experts within the state on consumer engagement initiatives.
2. Recruit VCCI graduates to speak at a VCCI staff meeting about their experience, participate in developing training (by storytelling or review of content), and/or be in a focus group that informs the learning collaborative and/or curriculum development.[3] Use these opportunities as a pilot and then begin including consumers of the system in other relevant trainings and ACH meetings.
3. Include consumers in team-based care human-centered design and process improvement. Listen to consumers' journeys and, together, identify the barriers and gaps in care. Identify together how workflows and partnerships can improve to close these gaps.

Measurement & evaluation

Loss of the data sharing platform Care Navigator has created challenges around care management reporting, data collection, and accountability. It represented a major loss of information and may have masked a decline in care management activity. Excel reports have replaced Care Navigator as a form of accounting for care management activities to the ACO and AHS, but this post-hoc reporting doesn't provide a shared real-time platform, means of communication, or the same level of data for true accountability. Additionally, there are currently varied and limited financial incentives for programs to report process and outcome measures.

A common set of metrics that can be easily collected and evaluated is required to demonstrate the value of the model and sustain its investment. Furthermore, measurement enables identification of strong and weak performers that can be used for accountability and quality improvement efforts.

The measurement and evaluation recommendations are:

1. Identify a common set of metrics covering effectiveness/quality of services, equity, health and well-being, service delivery, and cost/utilization that matter across health and human services. Consider using non-claims-based quality metrics, including quality of life indicators, functional status, housing status, and client experience of care coordination.
2. Review and update existing reporting, monitoring, and evaluation tools to reflect the goals and practices of TBC. Attention should be paid to equity in how outcomes are spread across the population. This should be done in coordination with the IT recommendations above to ensure ease of electronic capture.
3. Collaborate with external evaluators to assess elements of the TBC model using mixed methods, possibly focusing on specific aspects of the TBC model, for ongoing quality improvement.

Implementation

Observations

Implementation of the foregoing recommendations demands significant change management activities among both AHS and provider stakeholders. While team-based care is one of AHS Secretary's top priorities, the agency is constantly managing competing priorities, including significant changes to the Medicaid program to be negotiated with CMS. Full implementation of TBC 2.0 requires building strong and sustained

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[2] A helpful resource is The National Academy of Medicine's **Assessing Meaningful Community Engagement**.
[3] The Camden Coalition has developed a robust set of consumer engagement opportunities and programs, including **National Consumer Scholars**, **Community Advisory Committee**, and Amplify**: A consumer voices bureau**. Mental health consumers are partners in design and implementation of **Pledge to Connect** and people with lived experience participated in the development of the **Complex Care Certificate** through review and storytelling.

buy-in from senior leadership within AHS to ensure the availability of required resources and requisite bandwidth from staff across the agency. This level of change also requires translating the vision and value of TBC 2.0 to AHS staff across departments and divisions, as well as external stakeholders, including organizations previously unfamiliar with complex care 1.0 and key TBC stakeholders like OneCare Vermont, Designated Agencies, and PCMHs. Fortunately, the Secretary and AHS leadership have been working to introduce new departments to elements of team-based care and have piloted new programs (e.g., FACT, CCHRT) that embody the philosophy and practices of TBC 2.0. Moreover, this one-year evaluation and planning process has systematically engaged major stakeholders both across the agency and throughout the provider ecosystem who recognize the value of team-based care. The next phase of work will require frequent consultation and collaboration with stakeholders to ensure ongoing alignment and inclusion of a wide range of viewpoints in the actual implementation and sustaining of a TBC 2.0 system (see Appendix 4 for a Gantt Chart of implementation activities).

Recommendations

1. ACH learning collaboratives (starting Q1 2024)

Community-level buy-in and co-design of TBC 2.0 is critical for success. Many of the foregoing recommendations can be advanced through a series of learning collaboratives using the ACH structure. Additional support through dedicated workforce or consultants is required to facilitate the learning collaboratives and capture discussion and best practices that can be packaged in formal documentation of TBC 2.0.

Before the learning collaborative begins, as part of the planning process in Q1-Q2 2024, AHS should develop a *TBC Implementation Process Document for Communities*, a guide to help communities launch the learning collaborative. This document should include:

- *A high-level outline of TBC 2.0 with references to existing resources and practices*
- *Endorsement by AHS leadership of the importance of TBC and the value of clarifying, documenting, and improving regional workflows to do this work*
- *Where and how TBC is currently done in each district*
- *A list of the key organizations and players that should be involved in the community efforts, including One Care Vermont*

The ACH learning collaborative initiative should be chartered and launched in each ACH region across the state. This state-wide learning collaborative should meet monthly and last for six to nine months from Q2 2024 – Q1 2025. Each community should ensure participation of the relevant representatives. The Field Services Director and Blueprint Project Manager should work together, with external facilitation support, to guide their ACH through the learning collaborative, and in so doing develop their shared leadership (see Appendix 5 for a sample charter).

The goals of the ACH learning collaborative are:

- *Relaunch TBC at leadership level*
- *Review and enhance cross-organizational workflows and practices specific to each community to implement team-based care. Communities will have their own set of practices based upon their local resources, and best practices will be identified from across all communities to develop a statewide playbook.*
- *Build resources and tools to do panel management, measure outcomes, and conduct process improvements at a community-wide level*
- *Identify opportunities to improve TBC through programmatic innovation, policy, payment, and IT investments*
- *Identify priority populations for application of TBC*
- *Inform AHS plan for expansion of TBC to new AHS programs, including inclusion of new stakeholders at ACH, and the sustainability of TBC*
- *Explore potential expanded role for ACH as a partner in regional health improvement efforts*

Each learning collaborative should include the following activities:

- *Define TBC program eligibility (needs to be same statewide for equity) and define streamlined pathways for getting people TBC*

- *Develop a roadmap for TBC work in their communities that outlines how they will work together with processes and flows that guide their work in serving people with complex health and social needs*
- *Review existing resources and identify additional resources that they need to do work well*
- *Use a common set of tools to identify best practices and areas for improvement*
- *Leadership training around the philosophy and model*
- *Skills based training for any provider/care manager, including facilitation (learning collaborative would provide basic training, which would be further supplemented in phase two rollout of refined model)*
- *Pilot incorporation of consumer representatives in at least one learning collaborative*
- *Discuss current collaboration with other AHS departments and explore expansion of TBC to new AHS programs*

At the conclusion of each set of learning collaboratives, representatives from each participating ACH would come together to share best practices and needs to go to the next level at a statewide TBC 2.0 LC conference. The learning collaborative facilitators will generate an updated TBC manual based on best practices and lessons from LCs. This would include recommended structures for incorporating consumer perspectives and decision-making input at the system level.

2. TBC expansion/adaptation (starting Q1 2024)

The application of TBC 2.0 to new programs/departments within AHS is both a core component of the design of TBC 2.0 and a major undertaking in and of itself. It is preferable to undertake the two activities simultaneously with robust communication and coordination to ensure they result in an aligned system.

Although the implementation of team-based care across the agency does not mean that there will be huge changes in the day-to-day work of staff, this will be a new framework for some and for this initiative to achieve the benefits of team-based care collaboration and unity, it will require some ongoing conversations. AHS staff and contracted providers will need to understand the goals of the new TBC 2.0 and how it both reflects elements of their current work and offers new opportunities and improvements to how their work is done. It also requires deft change management from Central Office to ensure that all stakeholders feel as if their work and perspective is valued. The Director of Complex Care and the Assistant Director of the Vermont Blueprint for Health are positioned well within AHS to steward cross-agency change management initiatives focused on implementation of TBC 2.0 priorities. It will be an ongoing process to communicate about the team-based care model and changes going into effect through existing department structures.

The rollout of TBC across the agency requires ongoing leadership and formal governance. Specifically, we recommend:

- *Keep AHS Workgroup together as a steering committee (Appendix 2)*
- *Achieve ongoing and invested deputy commissioner/commissioner championship/buy-in through regular communication both in writing and at weekly commissioner meetings*
- *Recruit, train, and support champions from TBC designated programs, including TBC Referring Programs and newly designated TBC Programs, to encourage adoption and sustainability*
- *Assign strong, dedicated project management resources to project*
- *Explore new agency practices (e.g., quarterly meeting/newsletter from Secretary) that communicate a common purpose and priority from the top*
- *Collaborate with OneCare on design and implementation of TBC 2.0 through inclusion in ACH learning collaboratives and regular leadership level meetings*

The proposed TBC 2.0 framework includes new designations of TBC Programs, TBC Referring Programs, and TBC Specialists. Application of TBC to the entire agency requires defining the key features of each of these TBC designations and working with the department and program leaders to assign TBC designations to relevant programs. Each department will need to develop implementation plans that include workforce development, new provider requirements (through contracting and regulation), IT investments, and potential inclusion in intra-AHS and community-level structures (e.g., ACH, Local Interagency Teams (LIT), etc.). It is expected that workforce training would occur in stages with

some preliminary training necessary for staff to be participating in ACH learning collaboratives and piloting new referral processes. Implementation of full TBC 2.0 would occur in concert with the rollout described in TBC 2.0 Codification and Implementation below.

3. TBC 2.0 codification and implementation (2025)

The learning collaboratives and TBC 2.0 adaptation process should generate a combination of agreed upon definitions, workflows, and best practice tools and activities, which can be documented in a codified TBC 2.0 Manual. The development of this Manual, with frequent consultation and review by key stakeholders, will enable statewide implementation of the model. Using the new Manual and a workforce assessment process (see Workforce recommendations), AHS will design comprehensive training and ongoing support to roll out the new model across AHS as well as the entire health and human services ecosystem. This full rollout will build upon the strong foundation of TBC relaunch that took place through the ACH learning collaborative process.

4. IT requirements gathering, design and procurement (2024-2025)

Maximizing adoption and functionality of existing IT platforms and implementing new IT systems that can effectively connect IT systems to enable collaborative work across the entire ecosystem is essential. Ongoing efforts to onboard designated agencies and other non-medical providers onto the VHIE and other platforms is an important first step. AHS should leverage information from related projects (e.g., **Shared Care Plans & Universal Transfer Protocol: Final Report**), maximize platform functionality, and establish a formal project to undertake requirements gathering, formal design, procurement and implementation of one or more IT systems. Such work must be inclusive of the breadth of AHS departments as well as healthcare and human service provider organizations. It will also require close coordination with the ACH learning collaboratives and TBC 2.0 expansion across AHS. The design, procurement, and implementation of new IT systems should occur in parallel and ideally be ready for launch alongside the fully codified TBC 2.0 in early 2026.

5. Sustainably continue TBC in Vermont (2025 and beyond)

Once TBC has been refreshed at a leadership and programmatic level and new programs are activated into TBC, the efforts must continue. Long-term sustainability of TBC will include ongoing refresher training for existing staff, onboarding training for new staff, reflection on practice, and ongoing quality improvement efforts at both the community and programmatic levels. These efforts will require champions throughout AHS to continue the momentum both at the leadership level and on the ground, as well as dedicated staff time and resources.

Risks and limitations

The successful implementation of TBC 2.0 is at risk and limited in several ways. Implementing this model across AHS and its partners requires increased capacity, which requires paying more for those services, reducing other work, or making the work more efficient. It requires asking human service programs to participate in new activities without the compensation that medical programs receive for the same activities (e.g., case conferences). Additionally, the human services landscape in Vermont can reorganize and restructure, but if the services and/or workforce are not fully functional and available, referrals will not be completed, and people will not receive the services that they need.

Other competing priorities that could limit the implementation and expansion of TBC 2.0 are the high demand for housing, high needs systems of care, and facilities. Vermont is also subject to potential changes from CMS to its state specific ACO model. It is for all of these reasons that this work is so critical.

An additional risk is the 2024 Vermont gubernatorial election and potential change in administration, which could result in a shift in priorities. It will be important to gather data in ways that enable the state to demonstrate cost-effectiveness for the purposes of ongoing support from CMS, state legislature, and the governor.

Conclusion

The state of Vermont has the opportunity to codify, improve, and expand the team-based care that is provided to people with complex health and social needs. By building on its strengths, Vermont AHS can create a system in which all Vermonters receive well-coordinated, trauma-responsive, and appropriate healthcare and human services. Vermont is poised to lead the country in community level collaboration to address the needs of populations with complex health and social needs.

Appendices

Appendix 1: Consulted stakeholders

The consulted stakeholders from AHS:

Name	Position	Division/Department/Organization
Adam Poulin	Clinical Services Director	Department of Health
Tony Folland	Clinical Services Manager and Opioid Treatment Authority Director	Department of Health, Division of Substance Use Programs (DSU)
Megan Mitchell	Director of Clinical Services	Department of Health, Division of Substance Use Programs (DSU)
-	Opioid Treatment Program (OTP) Hub Directors	Vermont Department of Health
Sue Graff	Field Service Director	Central Office: Field Services
Cheryle Wilcox	Mental Health Collaborations Director	Department of Mental Health
Dale Crook	Director of Field Services	Department of Corrections
Jennifer Herbert	Clinical Director	Department for Children and Families
Dr. John M. Saroyan	Blueprint Program Executive Director	Central Office: Blueprint for Health
Dr. Michael Rapaport	Medical Director	Department of Vermont Health Access (DVHA)
Kristin McClure	Health Care Reform Integration Director	Vermont Agency of Human Services
Heather McPhee, RN, CCM Angie White, RN Lou-Anne Wood, RN Jody Taylor, RN Amy Blanchard, RN Genette Hoffman, RN Guylaine Daoust Halle Bloom Jennifer Whitaker, RN Tanner Kadleck, RN Anni Savage-Prusaczyk, RN Debora Eaton, RN Jessica Massey, RN Tammie Bruso, RN Jennifer Shooer, RN Niki Twohig, RN Shannon Bradley, RN Heather Walton	Nurses	Central Office: Vermont Chronic Care Initiative (VCCI)
Wendy Trafton	AHS Deputy Director of Healthcare Reform	Central Office: Healthcare Reform
David Riegel	AHS Director of Strategic Operations & Performance Improvement	Central Office: Healthcare Reform
Geoffrey Pippenger	Director of Policy & Planning	Department for Children and Families
Heather McPhee	VCCI Nurse Administrator	Central Office: Vermont Chronic Care Initiative

Kerri Duquette-Hoffman	AHS Field Service Director	Central Office: Field Services
Chris Mitchell	AHS Field Service Director	Central Office: Field Services
-	Consumers, Medicaid Exchange Advisory Committee (MEAC)	Department of Vermont Health Access

The consulted stakeholders external to AHS:

- *Jodi Frei, Assistant Director Population Health Model Integration, OneCare Vermont*
- *OneCare Vermont leadership*
- *Northeast Kingdom Human Services Focus Group*
- *Vermont Medical Society*
- *Consumers/People with Lived Experience (PWLE) Focus Group*
- *Preferred Provider Network, Vermont Association of Addiction Treatment Providers (VAATP)*

Community Based Organizations engaged:

- *Pathways Vermont*
- *AgeWell*
- *Community Health Center of Burlington*
- *Health Care and Rehabilitation Services Vermont (DA)*
- *Children's Integrated Services*
- *Brattleboro Housing Partnerships CEO (Public housing/SASH)*
- *Grace Cottage*
- *Seniors Solutions Vermont*
- *Brattleboro Retreat*
- *United Way of Windham County*
- *Northeast Kingdom Council on Aging*
- *Northeastern Vermont Regional Hospital*
- *Northeast Kingdom Community Action*
- *Northeast Kingdom Human Services (DA)*

Appendix 2: Workgroup and project team

AHS workgroup members:

Name	**Position**	**Division/Department/Organization**
Adam Poulin	Clinical Services Director	Department of Health
Tony Folland	Clinical Services Manager and Opioid Treatment Authority Director	Department of Health, Division of Substance Use Programs (DSU)
Megan Mitchell	Director of Clinical Services	Department of Health, Division of Substance Use Programs (DSU)
Dale Crook	Director of Field Services	Department of Corrections
Jennifer Herbert	Clinical Director	Department for Children and Families
Dr. John M. Saroyan	Blueprint Program Executive Director	Central Office: Blueprint for Health

Dr. Michael Rapaport	Medical Director	Department of Vermont Health Access (DVHA)
Wendy Trafton	AHS Deputy Director of Healthcare Reform	Central Office: Healthcare Reform
David Riegel	AHS Director of Strategic Operations & Performance Improvement	Central Office: Healthcare Reform
Geoffrey Pippenger	Director of Policy & Planning	Department for Children and Families
Katie Collette	Nurse Case Manager	Department of Vermont Health Access (DVHA)
Angela McMann	LTSS Program Manager	The Department of Disabilities, Aging and Independent Living (DAIL)
Gary Marvel	DOC Field Services Operations Manager	The Department of Corrections
Justin Davis	AHS Director of Strategic Operations & Performance Improvement	Central Office: Secretary's Office
Ken Hammond	AHS Field Service Director	Central Office: Field Services
Dawn Weening	Nurse Administrator I	The Department of Disabilities, Aging and Independent Living (DAIL)

AHS project team members:

Name	**Position**	**Division/Department/Organization**
Renee Weeks	Director of Complex Care & Field Services	Agency of Human Services
Julie Parker	Assistant Director, Vermont Blueprint for Health	Central Office: Blueprint for Health
Erin Flynn	Deputy Director of Payment Reform	Department of Vermont Health Access (DVHA)
Pat Jones	Interim Director of Health Care Reform	Central Office: Healthcare Reform
Cheryle Wilcox	Mental Health Collaborations Director	Department of Mental Health
Heather McPhee	VCCI Nurse Administrator	Central Office: Vermont Chronic Care Initiative
Monica Ogelby	Medicaid Director	Central Office: Secretary's Office
Chris Mitchell	AHS Field Service Director	Central Office: Field Services

Appendix 3: Example workflows

These example workflows will be customized to each community and refined during the learning collaboratives.

WHO IS ELIGIBLE FOR TBC?

TBC serves a wide range of Vermonters who experience complex health and/or social needs. TBC is particularly useful for people who have combinations of serious needs that require ongoing treatment and services from multiple providers or organizations.

TBC REFERRING PROGRAMS

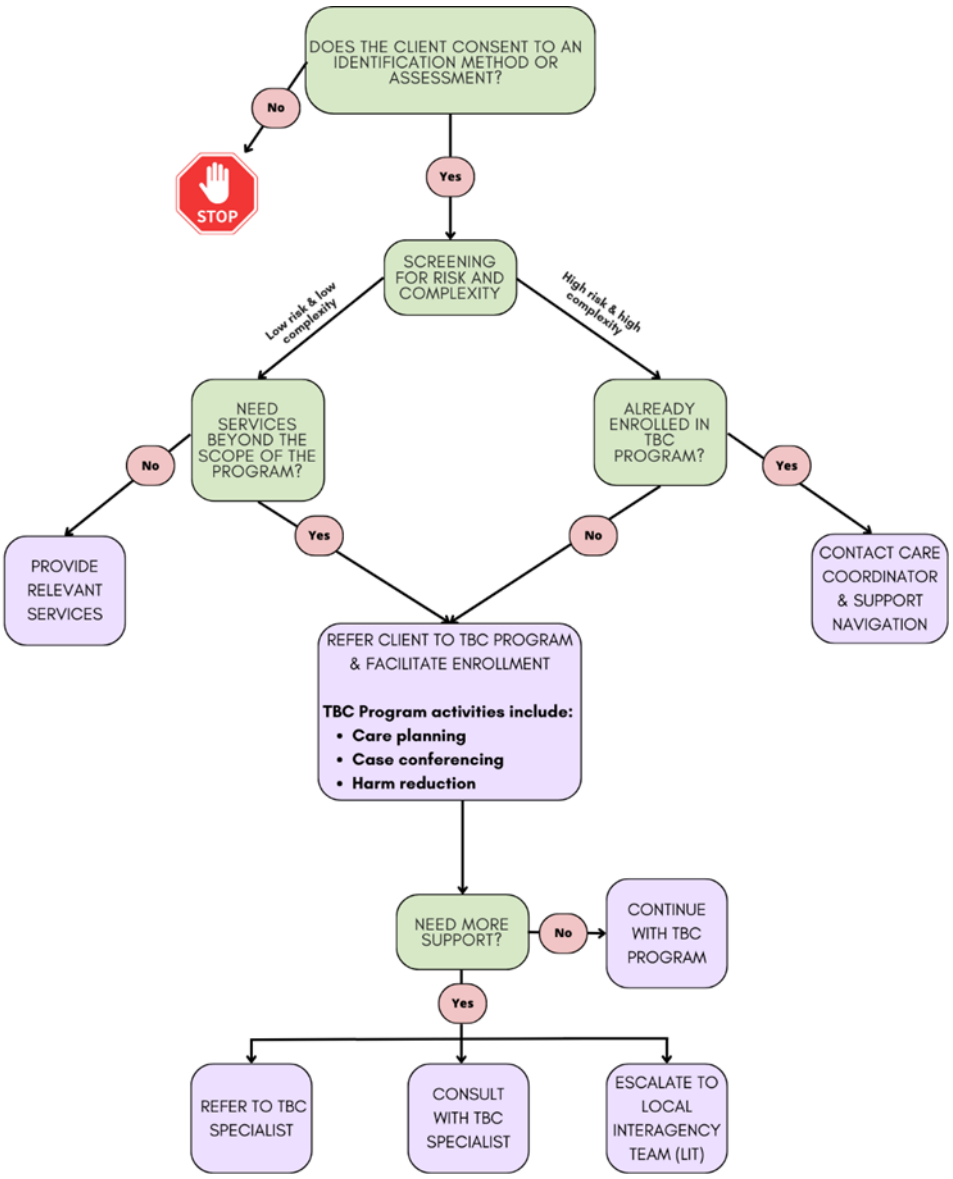
These programs provide screening and/or services but do not engage for a sufficient duration or intensity to serve as lead care coordinator and convene case conferences. Staff are trained to identify individuals who would benefit from TBC and make referrals to TBC Programs.

TBC PROGRAMS

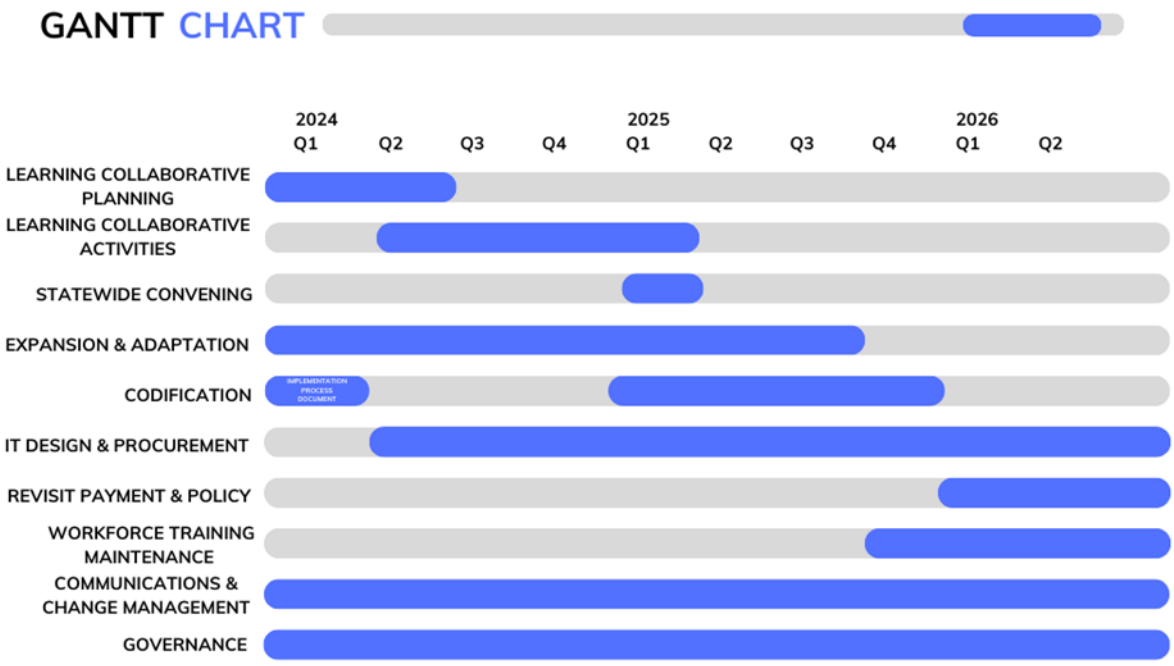
These programs provide long-term healthcare or human services. Staff will be competent in TBC tools and processes and a program representative can serve as lead care coordinator and convene case conferences.

TBC SPECIALISTS

This is a group of experts who provide support for people with the highest needs. They provide TBC consultation and training to other providers.



Appendix 4: Gantt chart of implementation



Appendix 5: Sample learning collaborative charter

Statement of need

The Vermont Agency for Human Services (AHS) has a long record of initiatives designed to support people with medical and social needs, including investing in community-level ecosystems to collaborate and make systems more accessible. Beginning in 2014, Vermont Integrated Communities Care Management (ICCM) Learning Collaborative engaged regions around the state to rapidly implement quality improvement initiatives focused on supporting people with complex health and social needs. This initiative, supported by a $45 million State Innovation Model (SIM) Testing grant from the federal Center for Medicare and Medicaid Innovation, was implemented through a collaborative effort of the Agency of Human Services including the Blueprint for Health and VCCI, OneCare Vermont, local community collaborative teams, and others. During this initiative, significant connections were established among a broad group of stakeholders and community health and human service organizations with the goal of better coordinated care for people with complex health conditions. The practices developed within this learning collaborative and beyond have been implemented in diverse ways and to different degrees across the Vermont Agency of Human Services (AHS) and its funded programs. Blueprint programs, VCCI, and hospital and community-based organization partners within the OneCare Vermont ACO network have adopted and sustained the model. Its implementation was largely limited to divisions focused on healthcare delivery. In 2019, AHS adopted the Accountable Communities for Health model to organize the local/regional collaboratives that existed and pursued an ACH learning collaborative led by the Blueprint for Health. This is complex care 1.0.

The Vermont Team-Based Care (TBC) 2.0 is a philosophy and sets of individual and systems-level practices. It is the improvement and expansion of complex care 1.0 and is available to all Vermonters with complex health and social needs, regardless of insurance coverage.

TBC is a statewide care coordination model that can support Vermonters with complex needs, regardless of insurance, to assess biopsychosocial needs, help individual identify goals, connect individuals and families to services and benefits, and support behavior change to reach those goals. The TBC model includes a philosophy, practices, and activities.

The philosophy is applicable across the agency, in programs and services across the health and human services landscape, and in the care for all Vermonters. It requires teams to work across disciplines and sectors to support people in both their medical and their social needs. The philosophy is trauma-responsive and person-centered. At every entry point into the system of care, AHS screens for other service and/or resource needs, including TBC, so that people can be connected to support if they wish. The philosophy moves care from reactive to proactive and seeks to support individuals in achieving their goals and rebuild community and individual trust.

While not all care coordination in Vermont is TBC, the TBC model unifies a wide range of care coordination that is whole-person focused, trauma-responsive, and seeks to build an ongoing authentic healing relationship between care coordinator and client. The intensity of care coordination within TBC varies depending on the level of need and complexity of the client. TBC helps to reduce duplication of services because it brings together providers from all domains of care to coordinate roles and responsibilities in serving mutual clients. The TBC model also includes a system level component that connects AHS and provider organizations across the regional health and human services ecosystem.

Purpose

ACH learning collaboratives are the structure for TBC codification and expansion.

Goals

The goals of the ACH learning collaborative are to:

- *Relaunch TBC at leadership level*
- *Train staff in TBC practices*
- *Identify best practices in TBC*
- *Identify needs to improve TBC (including future policies and investments in payment reform; where are gaps, necessary payment mechanisms to reimburse providers fairly and consistently for doing this work and IT & data sharing and other LT areas identified)*
- *Identify priority populations for application of TBC*
- *Develop plan for expansion of TBC to new AHS programs, including inclusion of new stakeholders at ACH*
- *Explore potential expanded role for ACH as a state partner in regional health improvement efforts*

Membership

Community-level buy-in and co-design of TBC 2.0 and leadership support is critical for success. Each learning collaborative will be co-led by:

- *AHS Field Service Director*
- *Blueprint Program Manager*
- *Blueprint QI lead*
- *OneCare Vermont representative*

The learning collaboratives will be overseen and receive support from the Director of Complex Care as well as the AHS Commissioners and Deputy Commissioners.

The participants will include ACH members as well as other relevant stakeholders, including VCCI, as determined by each community. Participants will attend monthly 1.5-hour meetings and will coordinate outside of meetings as needed.

Activities

Each learning collaborative will include the following activities:

- *Identification and incorporation of relevant community stakeholders*
- *Leadership training around the philosophy and model*
- *Skills based training for any provider/care manager (learning collaborative would provide basic training, which would be further supplemented in phase two rollout of refined model)*
- *Pilot incorporation of consumer representatives in at least one learning collaborative*
- *Review existing resources and identifying resources that they need to do work well*
- *Use a common set of tools to identify best practices and areas for improvement*
- *Discuss current collaboration with other AHS departments and explore expansion of TBC to new AHS programs*
- *Discuss opportunity for ACH to play a more significant role with existing funding*
- *Develop a roadmap for TBC work in their communities that outlines how they will work together with processes and flows that guide their work in serving people with complex health and social needs*

At the conclusion of each set of learning collaboratives, representatives from each participating ACH would come together to share best practices and needs to go to the next level at a statewide TBC 2.0 Learning Collaborative Conference. The learning collaborative facilitators will generate an updated TBC manual based on best practices and lessons from learning collaboratives. This would include recommended structures for incorporating consumer perspectives and decision-making input at the system level.

Anticipated Timeline

Each learning collaborative will meet monthly for 1.5 hours and last for six to nine months, with new cohorts of two to four ACH communities launching every six months.

About the Camden Coalition

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of **complex care** by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals **in Camden** and **regionally**.

Through our **National Center for Complex Health and Social Needs** (National Center), an initiative of the Camden Coalition, we connect complex care practitioners with each other and support the field with tools and resources that move complex care forward.