Care Models and Care Management Work Group Meeting Agenda 11-18-14

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Agenda

November 18, 2014; 10:00 AM to 12:00 PM
ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:00 to 10:10	Welcome; Introductions; Approval of Minutes *(Bea Grause to serve as meeting facilitator)*	**Attachment 1:** October meeting minutes	Yes (approval of minutes)
2	10:10 to 10:20	Update on Integrated Communities Care Management Learning Collaborative: *-Status of Quality Improvement Facilitator procurement* *-November Kickoff Webinars* *-Potential Learning Session Topics* ***Public Comment***	**Attachment 2:** Power Point from Kick-Off Webinars	
3	10:20 to 10:50	ACO Care Management Standards ***Public Comment***	**Attachment 3a**: Draft Care Management Standards **Attachment 3b:** Summary of Comments on Draft Standards	Yes (vote to recommend standards)
4	10:50 to 11:35	Support and Services at Home (SASH) Evaluation Results *-Molly Dugan, SASH Director* ***Public Comment***	**Attachment 4:** SASH Presentation	
5	11:35 to 11:55	Care Models and Care Management Work Plan Review and Revision ***Public Comment***	**Attachment 5:** Care Models and Care Management Work Plan	
6	11:55 to 12:00	Wrap-Up and Next Steps ***No meeting in December; next meeting is in January.***		

Attachment 1 - CMCM Work Group Meeting
Minutes 10-31-14

Vermont Health Care Innovation Project

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Minutes

Date of meeting: Friday, October 31st, 2014: 9:00 AM to 11:00 AM, 4th Floor Conference Room, Pavilion Building, Montpelier, VT

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	Due to delays caused by building security, Co-Chair Nancy Eldridge called the meeting to order at 9:30 and asked for a motion to approve the August and September meeting minutes. Dale Hackett moved approval of the August and September meeting minutes as is, and Laural Ruggles seconded the motion. There was no discussion, and Georgia Maheras took a roll call vote. The motion to approve August and September meeting minutes passed.	
2. Co-Chairs Update	In light of the delayed start, Co-Chairs Bea Grause and Nancy Eldridge elected to skip updates this month to allow sufficient time for the presentation from the Blueprint for Health and One Care Vermont.	
3. Presentation on Blueprint-OneCare Vermont Collaboration	Co-Chair Nancy Eldridge introduced Craig Jones, MD, Executive Director of the Blueprint for Health, and Todd Moore, CEO of OneCare Vermont to present ***Attachment 3a*** regarding OneCare Vermont and the Blueprint for Health collaboration. Additionally, a report submitted to the Vermont Legislature titled "Blueprint for Health Report: Medical Homes, Teams and Community Health Systems" was provided as attachment 3b to the meeting materials. Craig and Todd reviewed the presentation in detail and covered an agenda including: background and context, unified community health systems, payment modifications, and solicitation of input for strategies and implementation from the work group. Discussion of the presentation ensued, and the following comments/questions were raised: • Co-Chair Bea Grause commented that the actual conversation is very granular and comes down the process surrounding each individual. How does this fit into the high level picture? Craig Jones responded that at a high level we have an opportunity to better understand the population, and the people who are doing the work can execute these recommendations. This is one example of how ACOs can add value in a collaborative way by enforcing common principles. Pat Jones noted that the integrated communities learning collaborative is seeking to better understand and support people at the community level. • Lily Sojourner asked for clarification about the differences amongst communities. What is the plan to make sure that each HSA is developing to meet its community's specific needs? The ACOs have	

Agenda Item	Discussion	Next Steps
	started to collaborate on this, but what about non-medical providers? Do they know that these meetings are occurring? Craig Jones responded that the Blueprint teams will utilize their resources to do just that. For example, most Blueprint staff already organize meetings with medical and non-medical providers, and will utilize these relationships to pull together those larger groups. Right now, discussions amongst leadership are being utilized as a forum to figure this out and to better understand who needs to be there, who isn't there already, and what is the framework to formalize this process. • Dale Hackett asked how to address people who get their care out of state, or organizations that provide services and don't realize that they are impacting health outcomes. Co-Chair Bea Grause responded that there isn't necessarily one answer, and it happens in many ways. The conversation needs to happen in the community, at a local level you can try to figure it out. It is a very iterative process. Craig Jones noted that Medicaid on average spends more on social services than other payers in its efforts to link beneficiaries with social support systems. He offered three ways that we can do a better job at this: measure effectively to better understand the need, use the results to do better planning, and finally where there are fundamental gaps in support, raise the issue up the ranks to get the problem fixed. • In response to Dale's question, Laural Ruggles noted that at the local level communities work hard to meet their population's needs every day. She suggested that it would be helpful if decision/policy makers from several departments across the state (transportation, housing, education, etc.) came to these meetings to engage in more integrated discussion of how to best serve all needs of Vermonters in an integrated way. Co-Chair Bea Grause noted that the Department of Health is initiating a Health in All program to better understand how all state policies can impact health. • Trinka Kerr noted that clearer consumer involvement is important. We are addressing issues that are important to consumers, and they need to be engaged. Todd Moore responded that consumers are generally being engaged through the consumer advisory boards as well as the unified community health system collaboratives, and the hope is that this will continue in a more formalized way as the process is further refined. Trinka noted that especially at the local community level, consumer involvement will be important. • Julie Wasserman asked why there are more people attributed to Blueprint than ACOs? Craig Jones indicated that the programs follow different attribution methodologies, and Pat Jones indicated that another reason is that the commercial shared savings program is based off of the state's health insurance exchange population, not the full commercial population served by the Blueprint. Craig added that eventually the goal is that attribution will align and that everyone in Vermont will have a meaningful relationship with a medical home. • Joyce Gallimore added that the learning collaborative is another way we are collaborating, and that there is a lot of work going on around consumer engagement.	

Agenda Item	Discussion	Next Steps
	• Susan Besio suggested that it may be more effective to insist that all organizations become involved in these collaborations. Craig responded that collaboration is happening, and that there are already meetings being convened with representatives from the full continuum of care. There is a lot more work to be done, but we are making progress. • Beverly Boget noted that it is one thing to get people at a meeting, and another to change the funding model so that they are part of the fundamental change. Increasing team capacity in each community is a core part of this. • Co-Chair Bea Grause added that it is one thing to get people to come to the table, another to stay at the table, and another to do something meaningful when they are at the table. There needs to be clarity around this work, for example, charters, leadership and clear objectives. Todd Moore responded that he agrees that priorities will have to be set, and that you can't solve every issue in the first week. He also noted that the unified community health system collaboratives need to be representative of the community so that people buy in and really take ownership. • Craig Jones noted that another key activity is focusing on the capability to produce shared core measures of effective care. The Blueprint has been putting out practice profiles for a couple years that have been helpful to practices, as well as at an HSA level. Right now work is underway to try to include ACO performance measures in these practice profiles. He also noted that it is important that all participants contribute to the collection of data as part of a fundamental new way of contributing and working together in a collaborative system. • Dale Hackett asked if these programs are just looking at data, or if you really look at the person as a whole? Craig Jones responded that while it is important to utilize data in making decisions, data is never going to fully explain a person or their needs. Therefore, we need to keep working together across all organizations and departments to get the most complete picture that we can.	
4. Draft Care Management Standards	Time did not allow for a discussion of the draft care management standards for ACOs and comments received to date. Pat Jones and Erin Flynn reminded work group members that they need to submit their comments by Tuesday November 11th at 5:00pm, and that the work group will further discuss these comments and vote on the care management standards for ACOs at its November work group meeting.	
5. Next Steps, Wrap-Up and Future Meeting Schedule	**Next Meeting:** *Tuesday, November 18, 2014 10:00 AM – 12:00 PM, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.*	

VHCIP CMCM Work Group 10-31-14 Member Roll Call

1° Dale
2° Laural
Motion carries

Member		Member Alternate		Avg. minutes	Sept. minutes		
First Name	**Last Name**	**First Name**	**Last Name**				**Organization**
Nancy	Breiden	Rachel	Seelig				VLA/Disability Law Project
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger				Vermont Department of Corrections
Barbara	Cimaglio X						AHS - VDH
Peter	Cobb X						VNAs of Vermont
Dana	Demartino X						Central Vermont Medical Center
Nancy	Eldridge ✓			✓			Cathedral Square and SASH Program
Joyce	Gallimore ✓						Bi-State Primary Care/CHAC
Eileen	Girling ✓	Dawn	Weening	✓			AHS - DVHA
Bea	Grause ✓			✓			Vermont Association of Hospital and Health Systems
Dale	Hackett ✓			A			None
Linda	Johnson X	Cameron	Erickson				MVP Health Care
Pat	Jones ✓	Richard	Slusky	✓			GMCB
Trinka	Kerr ✓	Julia	Shaw	A			VLA/Health Care Advocate Project
Patricia	Launer ✓			✓			Bi-State Primary Care
Vicki	Loner ✓	Maura	Crandall	✓			OneCare Vermont
Clare	McFadden ✓			A			AHS - DAIL
Jeanne	McLaughlin X						Visiting Nurse Association & Hospice of VT & NH
Madeleine	Mongan ✓			✓			Vermont Medical Society
Judy	Morton ✓			✓			Mountain View Center
Mary	Moulton X						Washington County Mental Health Services Inc.
Paul	Reiss X	Amy	Cooper				Accountable Care Coalition of the Green Mountains
Laural	Ruggles ✓			✓			Northeastern Vermont Regional Hospital
Ken	Schatz X	April	Allen				AHS - DCF
Catherine	Simonson X						HowardCenter for Mental Health
Patricia	Singer X						AHS - DMH
Lily	Sojourner ✓			A			AHS - Central Office
Audrey-Ann	Spence ✓	Robert	Wheeler	✓			Blue Cross Blue Shield of Vermont
Jason	Wolstenholme X	Jessica	Oski				Vermont Chiropractic Association

VHCIP CMCM Work Group 10-31-14 Attendance List

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Care Models
Peter	Albert		Blue Cross Blue Shield of Vermont	X
April	Allen		AHS - DCF	MA
Ena	Backus		GMCB	X
Melissa	Bailey		Otter Creek Associates and Matrix Health	X
Michael	Bailit	phone	SOV Consultant - Bailit-Health Purchasing	X
Susan	Barrett		GMCB	X
Susan	Besio	here	SOV Consultant - Pacific Health Policy Gro	X
Charlie	Biss		AHS - Central Office - IFS	X
Beverly	Boget	here		X
Heather	Bollman		AHS - DVHA	X
Mary Lou	Bolt		Rutland Regional Medical Center	X
Nancy	Breiden		VLA/Disability Law Project	M
Stephen	Broer		Northwest Counseling and Support Servic	X
Martha	Buck		Vermont Association of Hospital and Heal	A
Dr. Dee	Burroughs-Biron		Vermont Department of Corrections	M
Nick	Carter		Planned Parenthood of Northern New Eng	X
Jane	Catton		Northwestern Medical Center	X
Amanda	Ciecior	phone	AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	M
Peter	Cobb		VNAs of Vermont	M

Amy	Coonradt		AHS - DVHA	X
Amy	Cooper		Accountable Care Coalition of the Green M	M
Maura	Crandall		OneCare Vermont	MA
Claire	Crisman		Planned Parenthood of Northern New Eng	A
Dana	Demartino		Central Vermont Medical Center	M
Steve	Dickens	here	AHS - DAIL	X
Nancy	Eldridge	here	Cathedral Square and SASH Program	C/M
Cameron	Erickson		MVP Health Care	MA
Trudee	Ettlinger		Vermont Department of Corrections	MA
Erin	Flynn	here	AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Meagan	Gallagher		Planned Parenthood of Northern New Eng	X
Joyce	Gallimore	phone	Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler	here	GMCB	S
Eileen	Girling	phone	AHS - DVHA	M
Kelly	Gordon		AHS - DVHA	X
Bea	Grause	here	Vermont Association of Hospital and Heal	C/M
Dale	Hackett	here	None	M
Bryan	Hallett		GMCB	X
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Breena	Holmes		AHS - Central Office - IFS	X
Marge	Houy	phone	SOV Consultant - Bailit-Health Purchasing	X
Christine	Hughes		SOV Consultant - Bailit-Health Purchasing	X
Jay	Hughes		Medicity	X
Linda	Johnson		MVP Health Care	M
Pat	Jones	here	GMCB	S/M

Joelle	Judge	here	UMASS	S
Trinka	Kerr	here	VLA/Health Care Advocate Project	M
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer	phone	Bi-State Primary Care	M
Diane	Leach		Northwestern Medical Center	X
Deborah	Lisi-Baker		Unknown	X
Vicki	Loner	phone	OneCare Vermont	M
Georgia	Maheras	here	AOA	S
Mike	Maslack			X
John	Matulis			X
James	Mauro		Blue Cross Blue Shield of Vermont	X
Clare	McFadden	here	AHS - DAIL	M
Elise	McKenna		AHS - DVHA - Blueprint	X
Jill	McKenzie			X
Jeanne	McLaughlin		Visiting Nurse Association & Hospice of V	M
Darcy	McPherson		AHS - DVHA	A
Madeleine	Mongan	here	Vermont Medical Society	M
Monika	Morse	here		X
Judy	Morton	here	Mountain View Center	M
Mary	Moulton		Washington County Mental Health Servic	M
Kirsten	Murphy	here	AHS - Central Office - DDC	X
Reeva	Murphy		AHS - Central Office - IFS	X
Sarah	Narkewicz	phone	Rutland Regional Medical Center	X
Jessica	Oski		Vermont Chiropractic Association	MA
Annie	Paumgarten	here	GMCB	X
Luann	Poirer		AHS - DVHA	X
Betty	Rambur		GMCB	X
Allan	Ramsay		GMCB	X

Helen	Reid		Planned Parenthood of Northern New En	X
Paul	Reiss		Accountable Care Coalition of the Green M	M
Debra	Repice		MVP Health Care	X
Julie	Riffon		North Country Hospital	X
Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson	here	AHS - DVHA - Blueprint	X
Jessica	Sattler		Accountable Care Transitions, Inc.	X
Ken	Schatz		AHS - DCF	M
Rachel	Seelig		VLA/Senior Citizens Law Project	MA
Maureen	Shattuck		Springfield Medical Care Systems	X
Julia	Shaw		VLA/Health Care Advocate Project	MA
Catherine	Simonson		HowardCenter for Mental Health	M
Tom	Simpatico		AHS - DVHA	X
Patricia	Singer		AHS - DMH	M
Shawn	Skaflestad	here	AHS - Central Office	X
Richard	Slusky		GMCB	MA
Pam	Smart		Northern Vermont Regional Hospital	X
Lily	Sojourner		AHS - Central Office	M
Audrey-Ann	Spence	here	Blue Cross Blue Shield of Vermont	M
Kara	Suter		AHS - DVHA	X
Beth	Tanzman		AHS - DVHA - Blueprint	X
Win	Turner			X
Anya	Wallack		SIM Core Team Chair	X
Marlys	Waller		Vermont Council of Developmental and M	X
Julie	Wasserman	here	AHS - Central Office	X
Dawn	Weening		AHS - DVHA	MA
Kendall	West	here		X
Robert	Wheeler		Blue Cross Blue Shield of Vermont	MA

Bradley	Wilhelm		AHS - DVHA	X
Jason	Wolstenholme		Vermont Chiropractic Association	M
Cecelia	Wu	phone	AHS - DVHA	X
Mark	Young			X
Susan	Aranoff			
Lisa	Viles			

Attachment 2 - Power Point from Kick-Off Webinars

Welcome to the Nov. 12 Kick-Off Webinar for:

Vermont's "Integrated Communities" Care Management Learning Collaborative

Working Together to Improve Care for Vermonters

The webinar will begin shortly. Please note that all participants will be placed on mute during the webinar. If you have a question for the presenters, please either "raise your hand" so that we can take you off mute, or type your question into the text box.

Background:

- Vermont has several statewide health care reform work groups, including the Care Models and Care Management Work Group.

- This Work Group identified two key priorities:
  - …to better serve all Vermonters (especially those with complex physical and/or mental health needs), **reduce fragmentation with better coordination of care management activities**…
  - …[to] better **integrate social services and health care services** in order 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…

- The Work Group designed a Quality Improvement Learning Collaborative to act on these priorities.

Welcome and Introductions:

Community Contacts (for questions about participation):

- **Burlington:** Deb Andrews, University of Vermont Medical Center; Blueprint Project Manager; (802) 847-7260; Deborah.Andrews@vtmednet.org
- **Rutland:** Sarah Narkewicz, Rutland Regional Medical Center; Blueprint Project Manager; (802) 747-3770; snarkewicz@rrmc.org
- **St. Johnsbury:** Laural Ruggles, Northeastern Vermont Regional Hospital; VP Marketing and Community Health Improvement/ Blueprint Project Manager; (802) 748-7590; l.ruggles@nvrh.org

State Contacts (for questions about statewide Learning Sessions):

- **Department of Vermont Health Access:** Erin Flynn, Senior Health Policy Analyst; (802) 878-7852; erin.flynn@state.vt.us
- **Green Mountain Care Board:** Pat Jones, Health Care Project Director; (802) 828-1967; pat.jones@state.vt.us

Learning Collaborative Snapshot:

- Vermont's delivery system reforms have strengthened coordination of care and services, but people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services.
- A number of national models have potential to address these concerns.
- **Health and community service providers are invited to participate in the year-long Integrated Communities Care Management Learning Collaborative to test interventions from these promising models on behalf of at-risk people in 3 communities: Burlington, Rutland and St. Johnsbury.**

What we want to do – Near-Term:

- Near-term goals are to:
  - Learn about and implement promising interventions to better integrate care management;
  - Increase knowledge of data sources; use data to identify at-risk people and understand their needs;
  - Improve communication between organizations;
  - Reduce fragmentation, duplication, and gaps in care; and
  - Determine if interventions improve coordination of care.

What we want to do – Longer-Term:

- Longer-term goals mirror the Triple Aim and Vermont's Health Care Reform goals:
  - Improving the patient experience of care (including quality and satisfaction);
  - Improving the health of populations; and
  - Reducing the per capita cost of health care.

- While the Collaborative will initially focus on at-risk populations, the ultimate focus will be on all Vermonters.

What we want to do – Objectives:

Each site will form a multi-organization team. The team will participate in local and statewide learning activities. Key objectives are to:

- Provide tools and training for staff members who engage in care management
- Improve integration and reduce fragmentation among organizations offering care management
- Reduce gaps in care for at-risk people with complex health needs
- Establish care management protocols to systemize referrals, transitions and co-management
- Reduce unnecessary ED and inpatient utilization
- Establish efficient, effective, integrated, and financially sustainable care management system

How we will do it – Community Commitment:

1. Form Integrated Community Teams to improve care management for at-risk people.

2. Identify current care management services and needs in the community (including gaps in services).

3. Agree on criteria to define at-risk people; identify people in need of integrated care management; conduct outreach to those people and their families.

4. Establish more effective communication and integration between team members, on behalf of people in need of care management services, using interventions such as shared care plans, care conferences, and care management rounds.

5. Develop tools to enhance integrated care services, such as transition protocols, referral guidelines, and data resources.

6. Participate in shared learning opportunities, including in-person learning sessions, webinars, and skills training for front-line care managers.

7. Develop performance measures to evaluate success of the interventions; collect, analyze and report data for those measures.

How we will do it – Learning Model:

Pre-Work
(November 22nd - January 12th)

The Learning Collaborative will use the Plan-Do-Study-Act (PDSA) quality improvement model.

Learning Session I
(Teams gather for a face-to-face meeting)
(January 13th)

Action Period
community teams working together to implement change)

(January 14th - March 9th)

Learning Session II
(Teams gather for a face-to-face meeting)
(March 10th)

Action Period
community teams working together to implement change)

(March 11th - May 11th)

Learning Session III
(Teams gather for a face-to-face meeting)
(May 12th)

Spreading the Change

How we will do it – Proposed Timeline:

- **Monthly Educational Webinars:** 1 hour (during months without in-person learning sessions)
- **1st In-Person Learning Session:** Jan. 13, 2015; full-day
- **First Action/Measurement Period:** Jan.-Feb. 2015
- **2nd In-Person Learning Session:** March 10, 2015; full-day
- **Second Action/Measurement Period:** March-April 2015
- **3rd In-Person Learning Session:** May 12, 2015; full-day
- **Third Action/Measurement Period:** May-June 2015
- **Core Competency Training for Care Managers; Continued Testing and Measurement:** July-Nov. 2015
- **Final Results and Next Steps:** Dec. 2015

Sample Learning Session Agenda

Time	Topic	Presenter
8:30-9:00	Registration	
9:00-9:15	Welcome and Opening Remarks	
9:15-10:30	Design, implementation and communication of shared plans of care	
10:30-10:45	Break	
10:45-12:00	Care Conference as a Care Planning Strategy	
12:00-12:45	Lunch	
12:45-1:45	Engaging people: how to reach out to people needing care management services and their caregivers	
1:45-2:30	Team Working Time	
2:30-3:00	Report Out and Closing Remarks	

Who will do it – Potential Team Members:

- People in need of care management services and their families
- Primary Care Practices participating in ACOs (including care coordinators)
- Designated Mental Health Agencies and Developmental Services Providers
- Visiting Nurse Associations and Home Health Agencies
- Hospitals and Skilled Nursing Facilities (including their case managers)
- Area Agencies on Aging
- Community Health Teams and Practice Facilitators (Vermont Blueprint for Health)
- Support and Services at Home (including SASH coordinators and wellness nurses)
- ACOs (OneCare, CHAC, ACCGM/VCP)
- Medicaid: Vermont Chronic Care Initiative (including case managers)
- Commercial Insurers (BCBSVT, MVP, Cigna)
- Agency of Human Services

How Team Members will Benefit:

The Learning Collaborative will:

- Provide expert faculty and skilled facilitators to assist participating organizations in improving care management services for at-risk people;
- Help to build “Integrated Communities” to serve broader populations;
- Create a statewide “Learning Community” to provide continuing education for front-line care management staff;
- Connect participants with Vermont’s Health Care Reform initiatives

How Team Members will Benefit – Facilitator Support:

Two full-time skilled quality improvement facilitators will support communities by:

- Promoting an environment of shared learning
- Meeting with community teams on a regular basis to provide:
  - Change management support
  - Technical assistance and training
  - Data analysis, measurement and IT support
  - Assistance in creating of a learning health system, and
  - Connections within and between pilot communities.

Next Steps:

- December 2014: Continued work within pilot communities
- Preliminary identification of at-risk people who could benefit from care management from multiple organizations
- Brief participant survey
- Background reading suggestions
- January 13, 2015: First In-Person Learning Session!

Questions and Answers

Attachment 3a - Draft Care Management Standards

DRAFT
Care Models and Care Management Work Group
Proposed ACO Care Management Standards
November 14, 2014

Definition of Care Management:
Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services.

In order for care management programs to be effective, we recommend that ACOs agree to the following standards:

A. Care Management Oversight (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO consults with its consumer advisory board regarding care management goals and activities.

B. Guidelines, Decision Aids, and Self-Management (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C)

#4: The ACO supports the consistent adoption of evidence-based clinical guidelines and/or supports its participating providers in the consistent adoption of evidence-based clinical guidelines.

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of positive health behaviors and self-advocacy.

#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: a) educational resources to assist in self-management, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

C. Population Health Management (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E)

#6: The ACO has and/or supports its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations.

#7: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes:

- Collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers.
- Developing processes for exchanging health information across care settings and facilitating referrals.

#8: The ACO facilitates and/or supports its participating providers in facilitating:

- Promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care and long term services and supports to address attributed people's needs.

D. Data Collection, Integration and Use (partially based on NCQA ACO Standard CM1, Elements A, B, C, E, F and G)

#9: To the best of their ability and with the health information infrastructure available, the ACO uses and/or supports its participating providers in using an electronic system that a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, and b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers.

#10: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.

Attachment 3b- Summary of Comments on Draft Standards

VHCIP Care Models and Care Management Work Group
Draft Care Management Standards: Comments by Organization
November 14, 2014

Commenter	Organization	Comment Summary
Nancy Eldridge	SASH, Cathedral Square Corporation	Under Care Management Oversight, add "The ACO and its primary care practices partner with community based organizations providing care management services."
Laural Ruggles	Northeastern Vermont Regional Hospital	Add language indicating that ACOs will support participating providers in achieving care management standards.
Vicki Loner	OneCare Vermont	Cite related NCQA standards.
Trinka Kerr	Vermont Legal Aid, Office of Health Care Advocate	Under Care Management Oversight, add "The ACO includes consumers in all bodies responsible for implementation and oversight of the following care management standards, as well as the ACO's care management goals." In standard #4, add "and self-advocacy." Change "Population Health Management" to "Panel Management."
Lily Sojourner	Agency of Human Services	Agreed with a number of comments made on previous versions of the standards.
Judy Peterson	VNA of Chittenden and Grand Isle Counties	Better define "supports" in standards #2; replace "considering" with "including" in third bullet of standards #7.
Dale Hackett	Consumer Advocate	Asks how ACOs will interpret and use these standards.
Marybeth McCaffrey	Department of Disabilities, Aging and Independent Living	Added ACO to title, edited definition of Care Management and questioned meaning of "systems" in that definition, asked if these are principles or standards and described what she sees as difference between the two, added two new standards related to Medicaid beneficiaries and one new standard related to HIE operability, added "service plan" to standard #9, added language related to person-centered planning and electronic exchange across settings to standard #10, made numerous style edits.
Julie Riffon	North Country Hospital	In accordance with 2014 NCQA PCMH standards, requests that language be added to support prioritizing people who may benefit from care management, by considering behavioral health conditions, high cost/high utilization, poorly controlled or complex conditions, social determinants of health, or referrals by outside organizations.

Attachment 4 - SASH Presentation

SASH Presentation
Care Models and Care Management Workgroup

November 18, 2014

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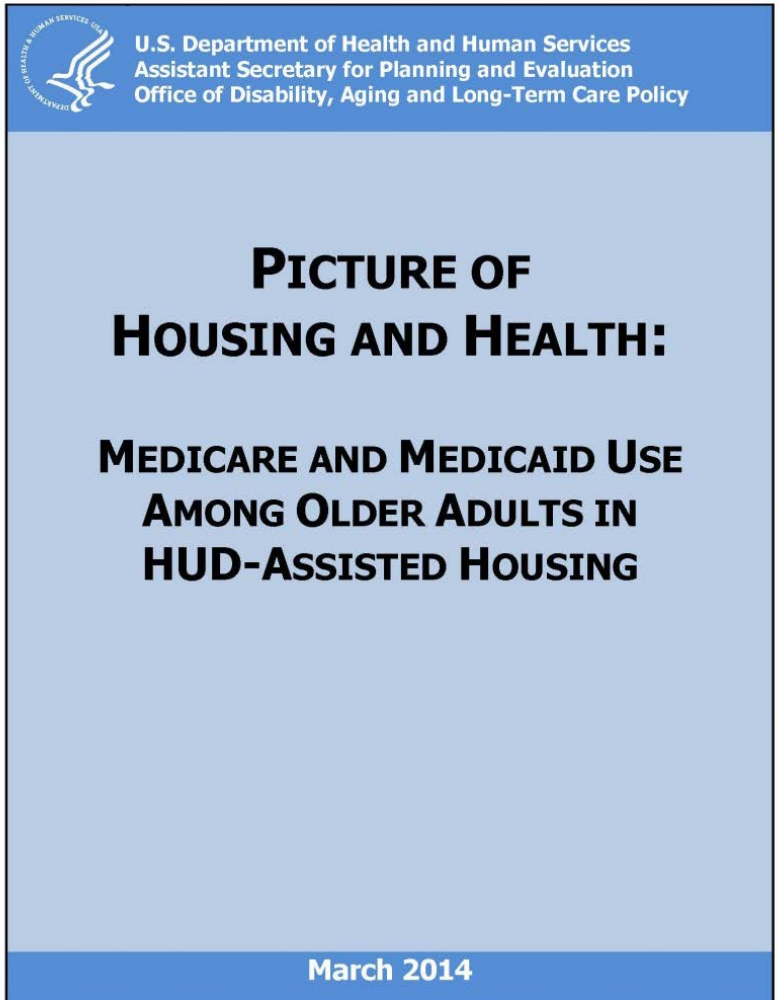
Social Circumstances and Health


U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

PICTURE OF HOUSING AND HEALTH:

MEDICARE AND MEDICAID USE AMONG OLDER ADULTS IN HUD-ASSISTED HOUSING

March 2014

- PMPM costs for Medicaid FFS were 32% higher for HUD-assisted (HA)
- Of the HA Medicare beneficiaries, 68% were dually eligible
- 55% of HA had 5+ chronic conditions
- Medicare costs 16% for HA due to higher usage

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SASH at 118 Locations Statewide

SASH Panels by County

Franklin
Fourwinds – St. Albans
Meadowlane, St. Albans, Swanton
Swanton School

Orleans
Barton/Orleans
Newport/Derby

Essex
Island Pond
Passumpsic/Darling, Concord

Grand Isle
Grand Isle/Round Barn, Alburg

Lamoille
Morrisville Jeffersonville

Chittenden
Burlington Community
Cathedral Square Senior Living, Burlington
Champlain Apt/South Square, No Champlain St, Burlington
Decker Towers, St. Paul Street, Burlington
Grand Way Commons, So Burlington
Heineberg, Heinberg Road, Burlington
Holy Cross, Colchester
Jeri Hill, Jericho
Kelly's Field - Hinesburg
McAuley Square, Mansfield Ave, Burlington
Meadowlane, Milton
Old North End Community
Richmond Terrace, Richmond
Ruggles House, Mansfield Ave, Burlington
Thayer, North Ave, Burlington
Town Meadow, Carmichael, Essex Junction
Whitcomb Woods/Terrace, West St., Essex Jct
Whitney Hill, Williston
Williston Community
Winooski Housing Authority (Courtyard)
Wright House, Shelburne

Caledonia
Passumpsic/Darling, Lyndonville
St. Johnsbury Community

Washington
Evergreen/Mad River, Waitsfield
Montpelier
North Barre Manor, Barre
Northfield
Tilden House/Jefferson Apts, Barre
Washington/Avery/Quarry Hill, Barre

Addison
Middlebury Commons
Shoreham/Orwell
Vergennes

Orange
Orange East/Groton
Randolph

Windsor
Huber/Maples, Springfield
Upper Valley, Hartford
Whitcomb Building, Springfield
Windsor village, Windsor

Rutland
Castleton/Fair Haven
Housing Trust Portfolio, Benson, Brandon, Fair Haven, Rutland and West Rutland
Maple Village/Village Manor, Rutland
Parker House/Community, Rutland
Rutland Community, Rutland
Sheldon Towers, Rutland
Templewood Court, Rutland

Windham
Melrose Terrace, Brattleboro Community

Bennington
Brookside/Community, Bennington
Cora B Whitney, Bennington
Deerfield Valley, Bennington
Northshire, Manchester
Walloomsac Apts, Bennington

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Who SASH Serves

- Over 4,000 Participants
- 80% Medicare
- 26% live in a community setting
- 73% 65 +
- 27% under 65
- Participants span all health care needs
- We have a “no discharge” policy

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SUPPORT AND SERVICES at HOME

What are the Essential Elements of the SASH Model?

- Person-centered
- SASH Staff in the community
- Partnerships
- Information Sharing
- Prevention and Wellness through Healthy Living Planning

SASH Focuses on the Three Components of Care Management

- Coordinates with discharge staff, family and neighbors
- Personal visit to review discharge instructions
- Helps ensure a safe home transition

Transitional Care

- Develops healthy living plan
- Coaches SASH Participants
- Provides reminders and in person check ins
- Organizes presentations and evidence based programs

Self Management

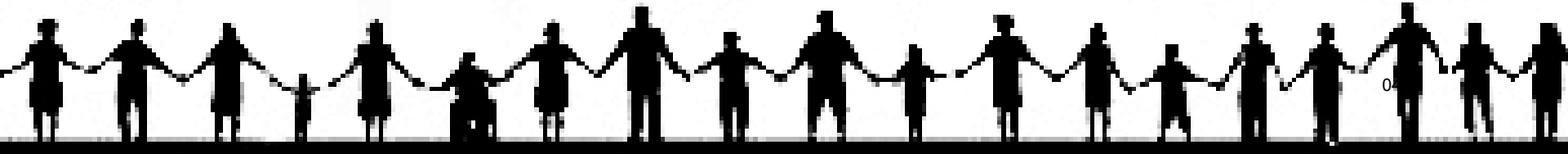
- Conducts wellness assessment
- Convenes SASH team
- Understands participants needs and preferences
- Coordinates individual and community healthy living plans

Care Coordination

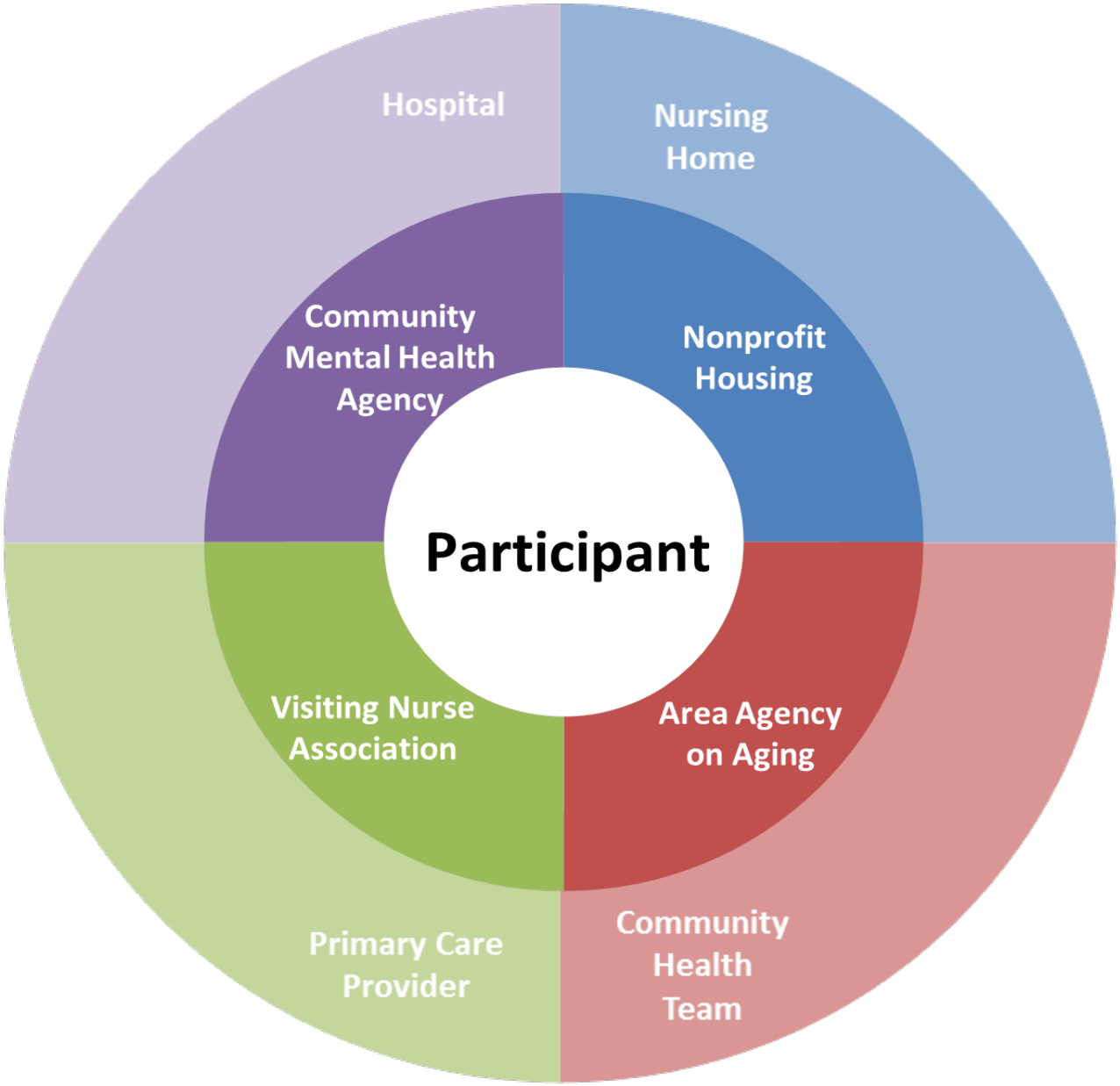
VERMONT
Blueprint for Health

Smart choices. Powerful tools.

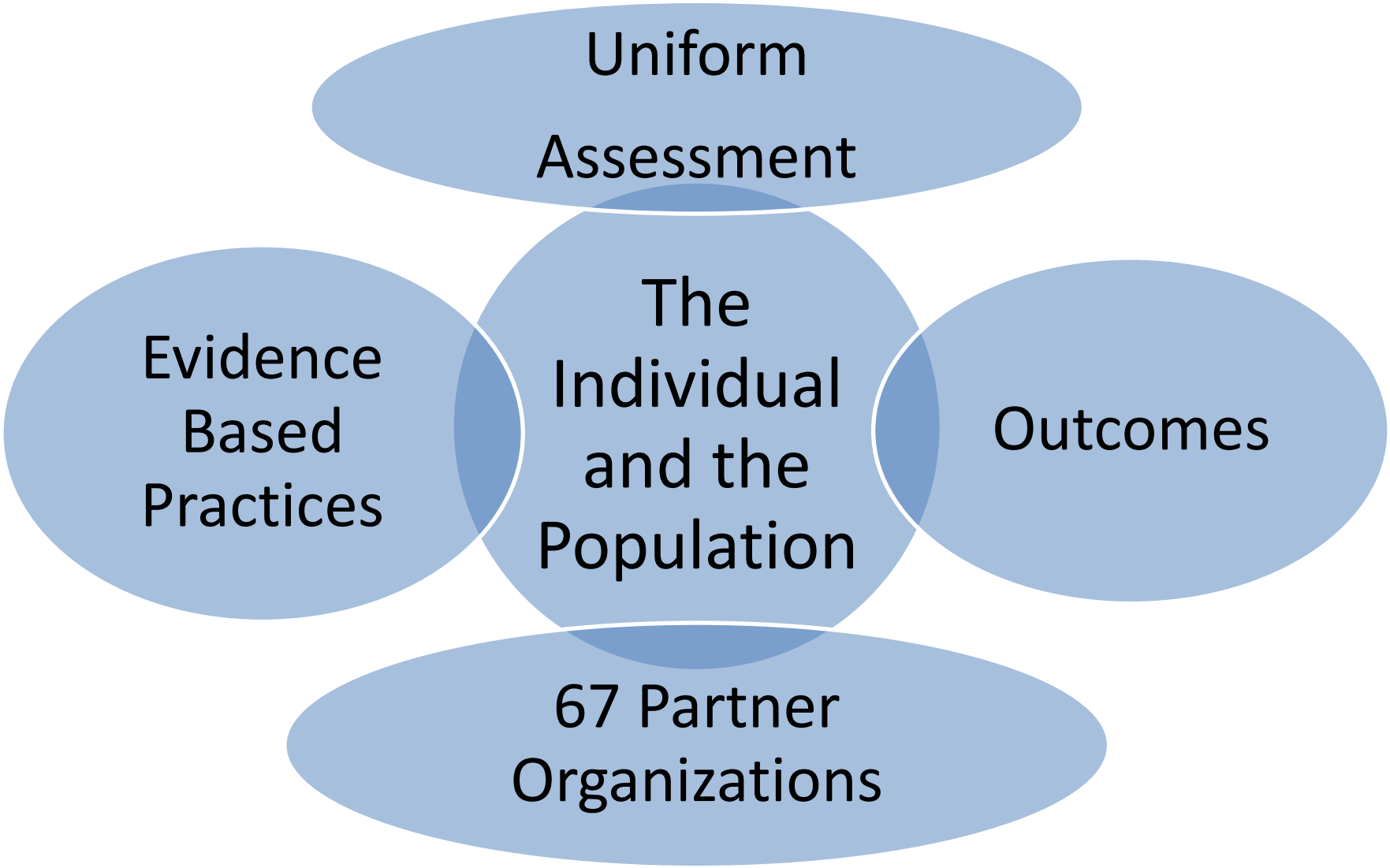
One Team Supporting One Panel of 100 Participants



Interprofessional Team Approach



Information Gathering and Sharing



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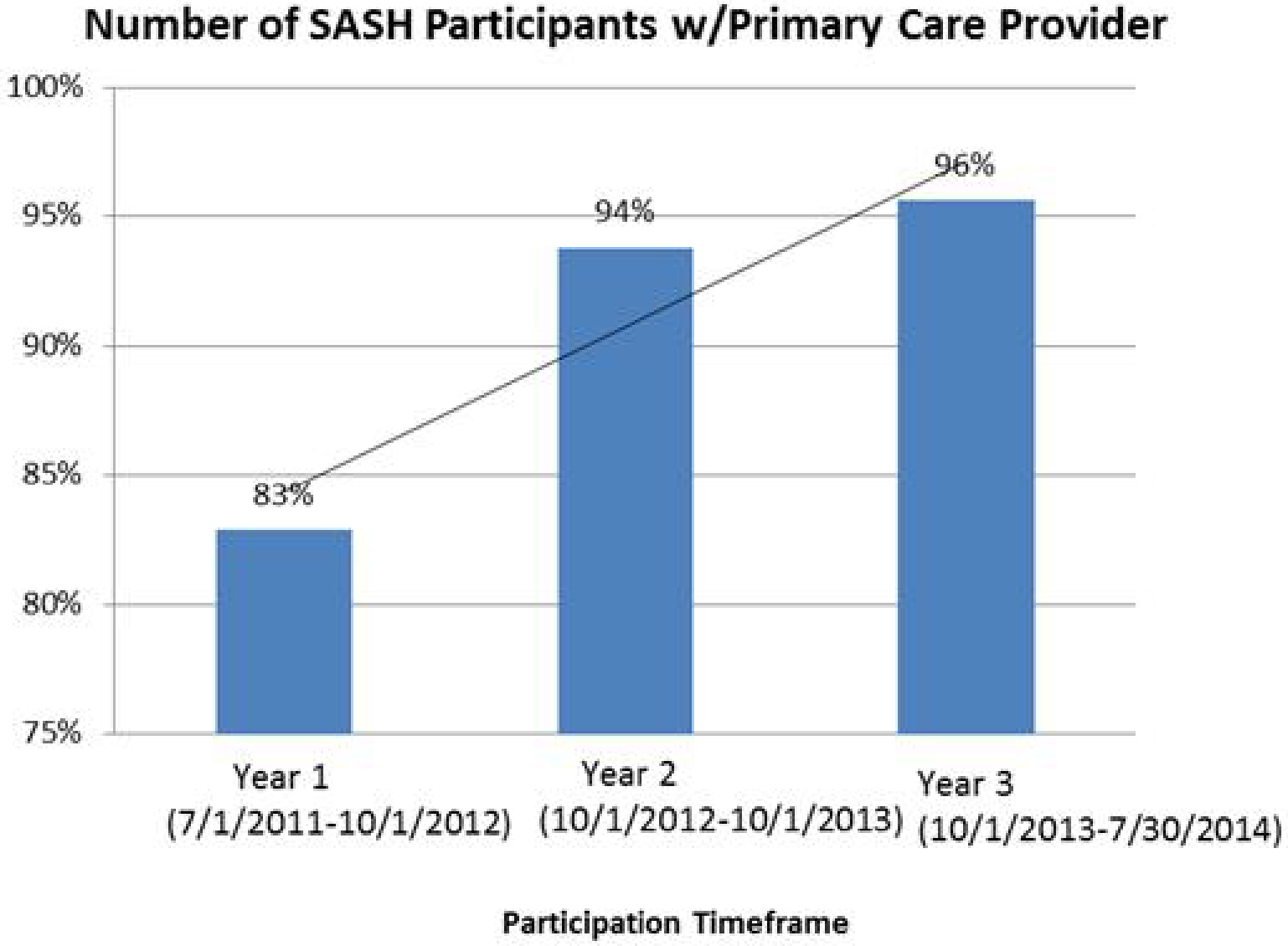

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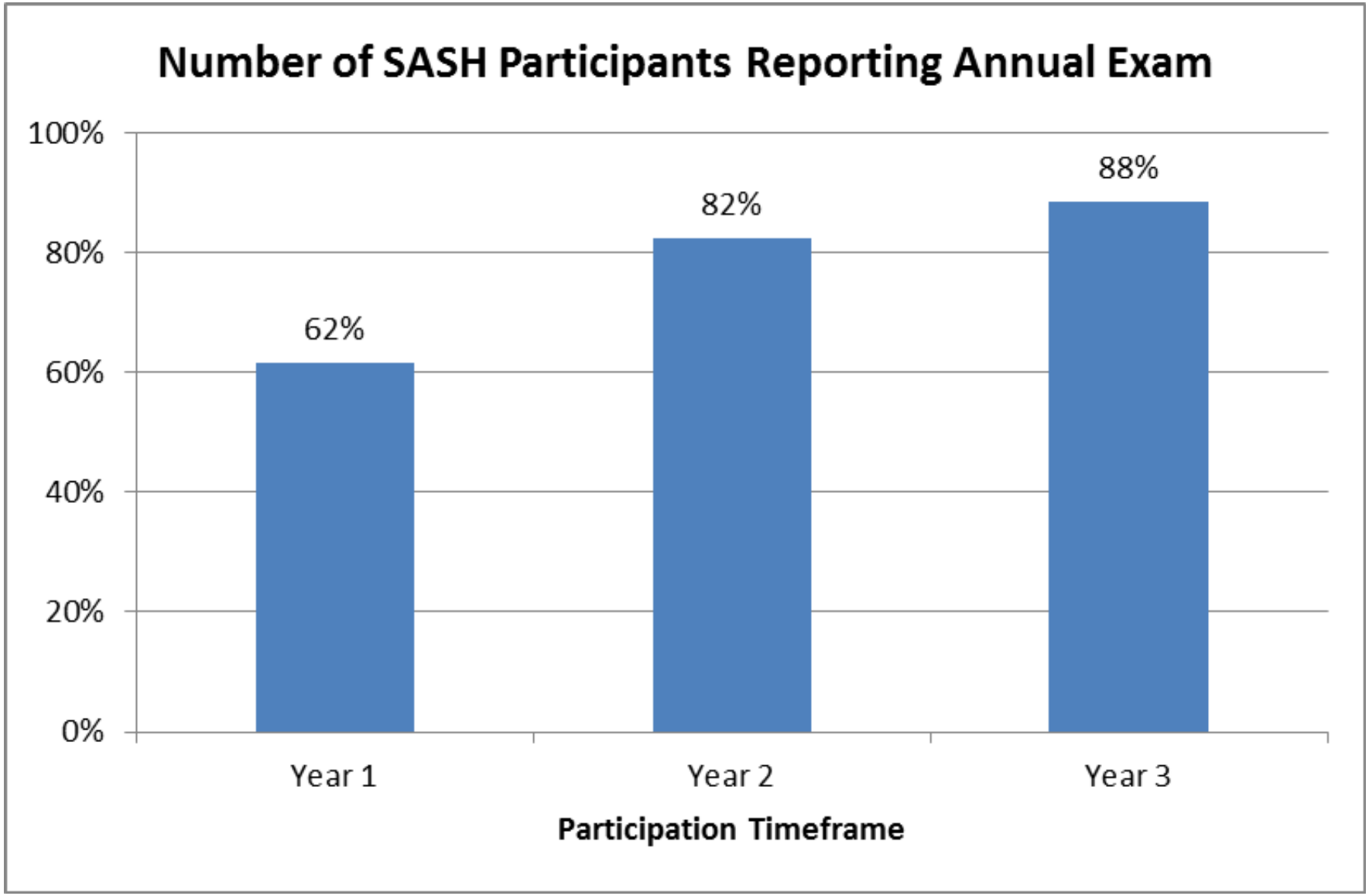

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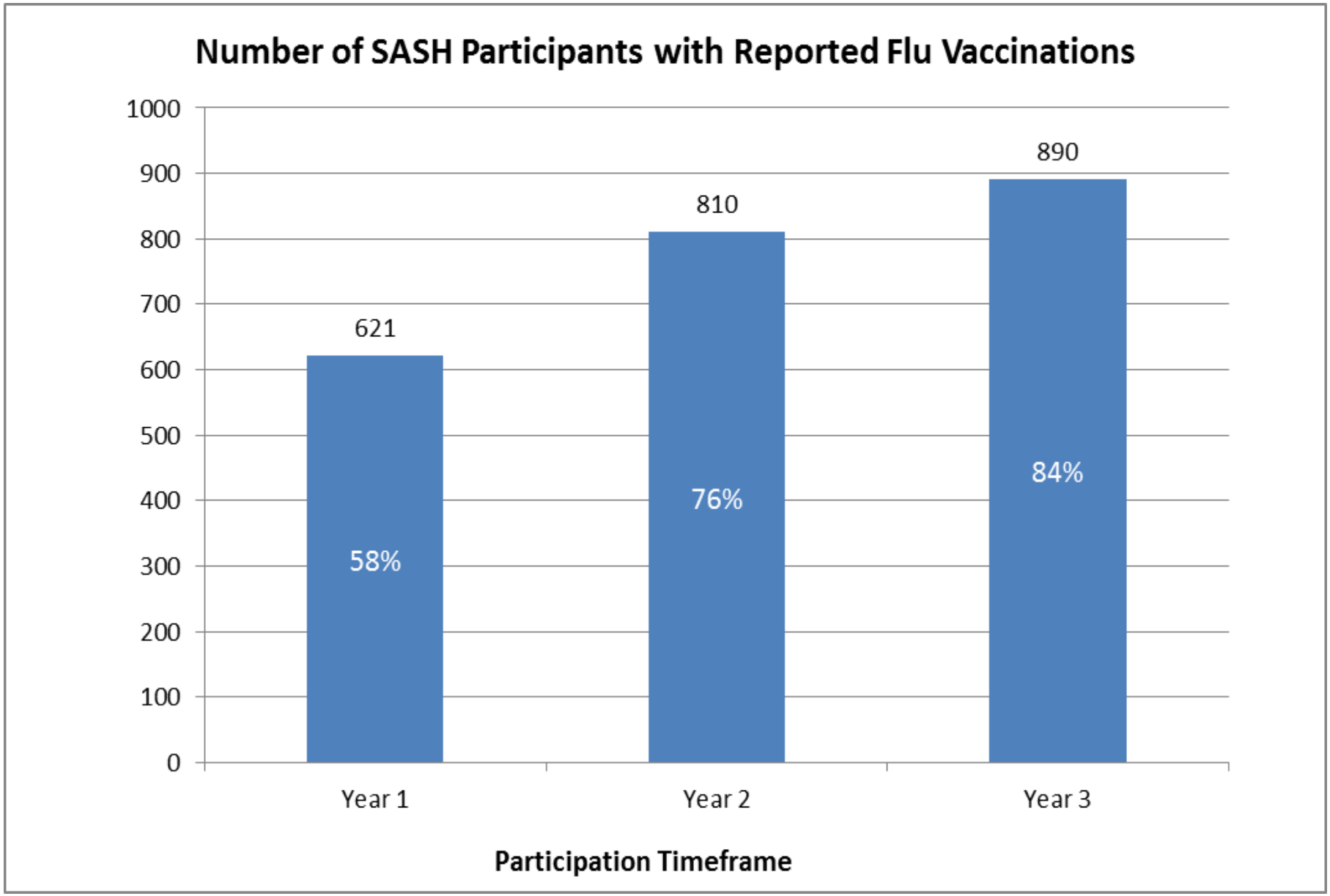
SUPPORT AND SERVICES at HOME



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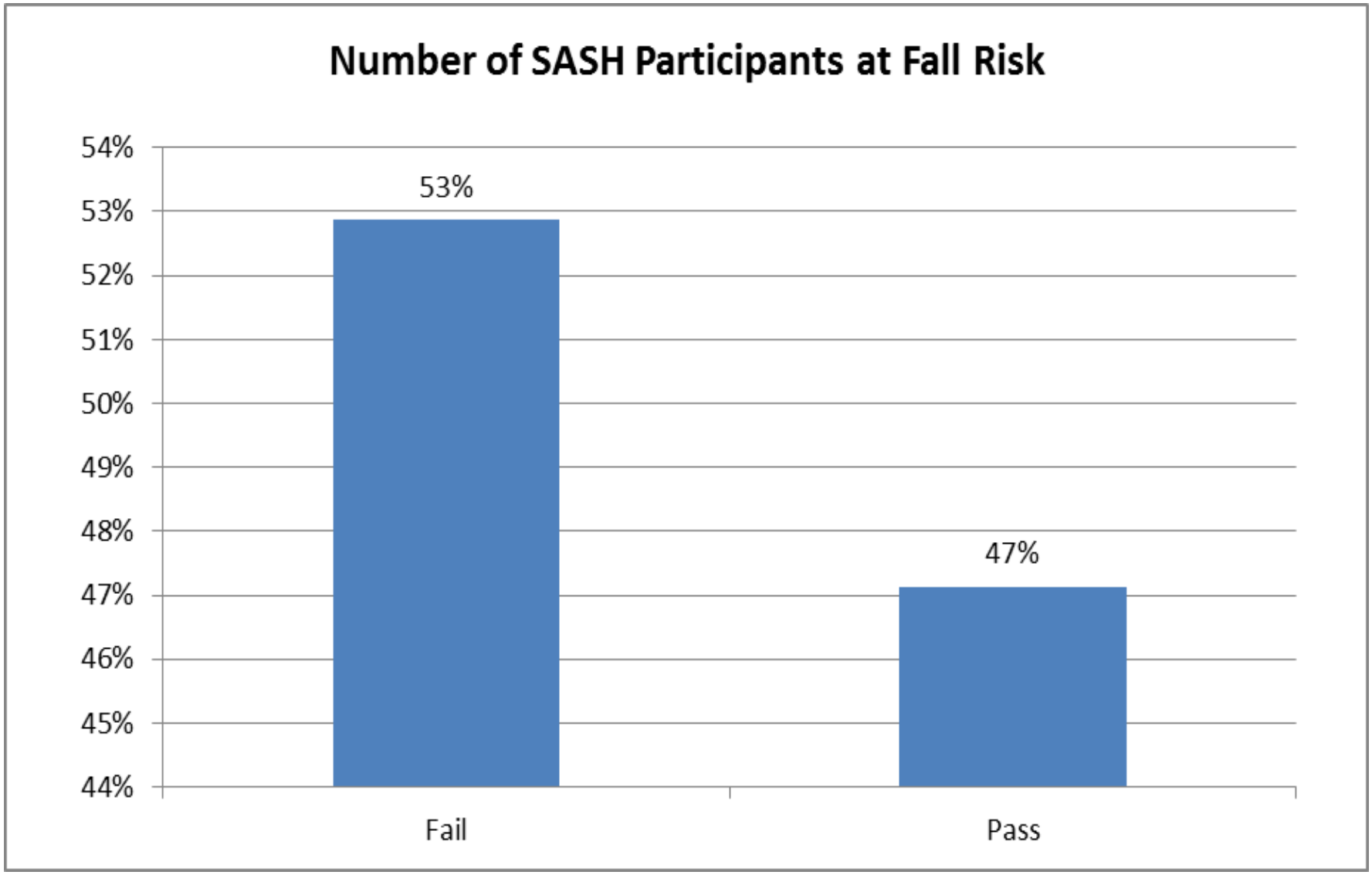
SUPPORT AND SERVICES at HOME



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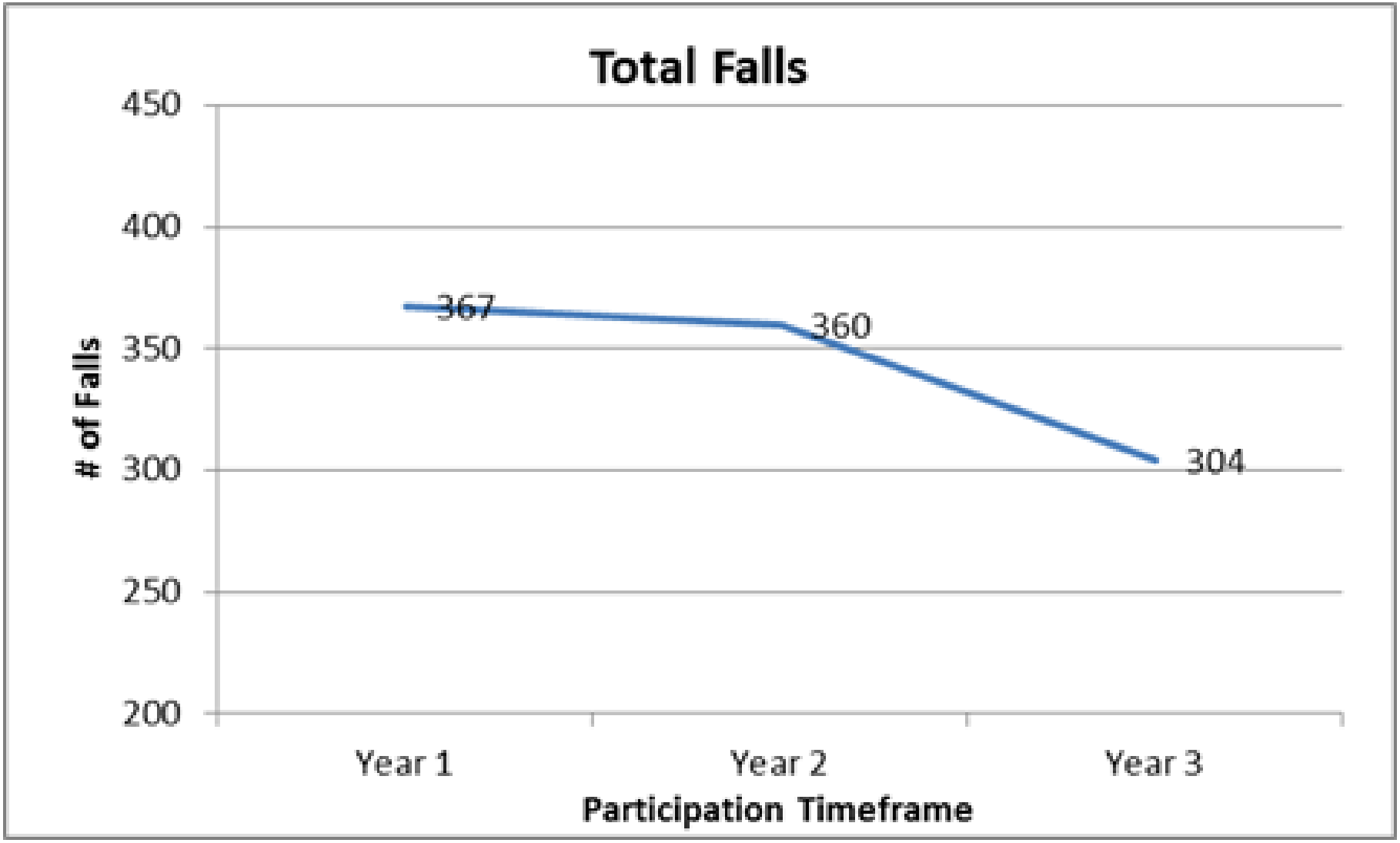
SUPPORT AND SERVICES at HOME



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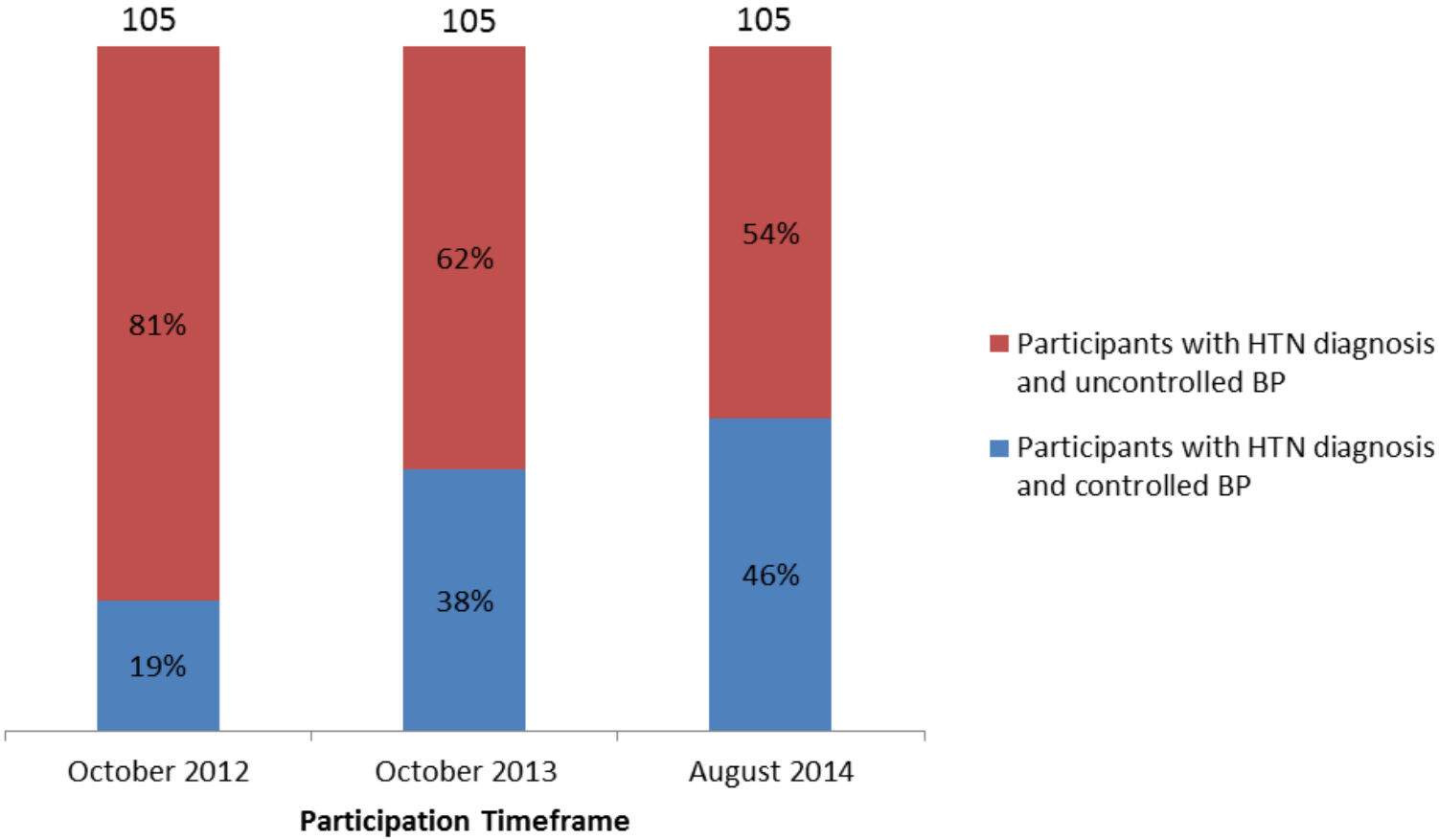
SUPPORT AND SERVICES at HOME

Percent of SASH Participants with HTN Diagnosis and Controlled BP *



*National Quality Forum NQF Measure 18:Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled(<140/90 mmHg)during the measurement period

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SUPPORT AND SERVICES at HOME

RTI Evaluation Results

- For Vermonters receiving care from a medical home, supplemented by SASH services provided by experienced, well-established panels, the growth in annual total Medicare expenditures was $1,756 - $2,197 lower than the growth in expenditures among Medicare fee-for-service beneficiaries in the two comparison groups.

SASH a caring partnership
SUPPORT AND SERVICES at HOME

RTI Qualitative Findings

- The major SASH program implementation success has been the linkages the program has created among different community organizations.

- 67 partner organizations have signed onto the SASH MOU.

Attachment 5 - Care Models and Care Management Work Plan

Work Plan for Care Models and Care Management Work Group
(as adopted by Work Group on 6-10-14)

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Group logistics: charter, membership, meeting schedule, etc.	• Review and refine draft charter • Review membership list for gaps • Develop 2013-2014 meeting schedule • Identify resource needs	December 2013	Staff; co-chairs; work group members	• Finalized charter available on VHCIP website • Membership list finalized • 2013 – 2014 meetings scheduled	• Final Charter • Comprehensive membership list • 2013-14 meeting schedule • Resources are adequate to accomplish objectives
Obtain consultants to assist with selected work group activities	• Identify activities that could benefit from consultant expertise • Develop scope of work and RFP for consultant resources • Issue RFP • Review bids • Select vendor • Execute contract	March 2014	Staff; co-chairs; work group members; Core Team	• Executed contract with Bailit Health Purchasing	• Contract in place
Coordinate and collaborate with other work groups	• Identify activities led by other work groups that relate to activities of the Care Models and Care Management Work Group • Develop mechanisms for reporting about related activities to other work groups, and for obtaining information about related activities from other work groups	Ongoing	Staff; co-chairs; work group members; other work groups	• Mechanisms established for monthly co-chair meetings and work group reports to steering committee • Presentation from Population Health Work Group completed • Presentation from DLTSS Work Group scheduled • Presentation from Payment Models Work Group scheduled	• Well-coordinated and aligned activities among work groups

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
Develop understanding of current landscape of care management activities, including processes for collaboration.	• Identify entities that conduct care management activities • Identify data elements related to those activities (including processes for collaboration) • Develop a care management inventory survey tool to facilitate collection of structured data related to care management activities • Analyze results of Care Management Inventory Survey and present pertinent findings to work group • As requested by work group, ask selected entities to attend work group meetings to describe their activities in greater detail	July 2014	Staff; co-chairs; work group members; organizations engaging in care management	• Presentations completed from organizations performing care management (additional presentations to be scheduled upon request) • Inventory Survey tool created and distributed to care management organizations throughout the state	• Comprehensive Care Management Inventory • Work group members indicate understanding of current care management landscape
Identify redundancies, gaps, and opportunities for coordination.	• Based on written and verbal information and inventory survey results, identify gaps • Based on written and verbal information and survey results, identify redundancies • Based on written and verbal information and survey results, identify opportunities for coordination	August 2014	Staff; co-chairs; work group members; organizations engaging in care management		• Written description of gaps, redundancies, opportunities for coordination
Research, summarize, and review best practices in care management.	• Review literature • Review best practices in other states • Review best practices in Vermont • Obtain recommendations from other work groups	September 2014	Consultant; possibly CMMI Technical Assistance Staff		• Description of promising best practices
Identify characteristics and goals of ideal care models/care management activities for Vermont.	• Based on review of best practices, discuss and identify Vermont's care model/care management goals • Based on review of best practices, discuss and identify characteristics of ideal model(s)	October 2014	Work group members		• Description of characteristics and goals for Vermont
Develop strategic plan with recommendations on characteristics of ideal care models/care management activities; ACO care management	• Discuss and develop strategic plan to support achievement of Vermont's goals, including proposed: o Characteristics of ideal care models/care management activities o ACO care management standards	November 2014	Staff; co-chairs; work group members		• Written strategic plan adopted by work group

Objectives	Supporting Activities	Target Date	Responsible Parties	Status of Activity	Measures of Success
standards; mechanisms to reduce fragmentation and duplication; reinforcement, extension and/or adaptation of existing care models; and/or criteria to be considered in the adoption of additional care management activities, to support achievement of Vermont's goals.	o Mechanisms to reduce fragmentation and duplication o Recommendations to reinforce, extend or adapt existing models o Criteria to be considered in the adoption of new models				
Identify Additional implementation needs (e.g., care management standard development, learning collaboratives, electronic and other information, communication, provider engagement) and potential resources to meet those needs.	• Develop care management standards • Recommend whether and to what extent to support proposed learning collaboratives related to care management • Address other implementation needs as they arise, on an ad hoc basis • Review strategic plan to identify additional implementation needs not previously identified • Identify mechanisms and resources to meet implementation needs	September 2014 (care management standards) December 2014 (initial learning collaboratives) January 2015 (review strategic plan) Ongoing (ad hoc implementation needs, identification of mechanisms and resources to meet those needs)	Staff; co-chairs; work group members	• Care management learning collaborative subgroup meeting to refine proposal • ACO care management standards under development	• Written implementation plan, including proposed care management standards, proposed learning collaboratives, HIE needs, communication mechanisms, provider engagement activities, implementation resources