Care Models and Care Management Work Group Meeting Agenda 4-08-14

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

Tuesday, April 8, 2014; 10:00 AM to 12:30 PM
Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00-10:05	Welcome; Introductions; Approval of Minutes	Attachment 1: CMCM Minutes 03-11-2014	Yes
2	10:05-10:10	Co-Chairs' Report (e.g., Other VHCIP Work Group/Core Team Activities, Legislative Update, Provider Grant Program Update) ***Public Comment***		
3	10:10-10:15	Staff Report (Update on Inventory, Request for Additional Webinar Presentations) ***Public Comment***		
4	10:15-11:15	Population Health Work Group Presentation (Karen Hein, MD, Green Mountain Care Board and Tracy Dolan, Deputy Commissioner, Vermont Department of Health) ***Public Comment***	Attachment 4: Population Health and Vermont's Care Management and Case Management Systems	
5	11:15-11:40	CMCM/Population Health Breakout Sessions ***Public Comment***		
6	11:40-12:10	Presentation on Developmental Services (Marie Zura and Colleen Fiske, Howard Center) ***Public Comment***	Attachment 6: Developmental Services Presentation	
7	12:10-12:30	Next Steps, Wrap-Up and Future Meeting Schedule Topic for next meeting: Care Management Standards for ACOs	Attachment 7: CMCM Meeting Schedule	

Attachment 1 - Care Models and Care Management Work Group Meeting Minutes 3-11-14

Vermont Health Care Innovation Project

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

Date of meeting: March 11, 2014; 10am – 12pm, Calvin Coolidge Conference Room, National Building, 1 National Life Drive, Montpelier, VT

Attendees: Bea Grause, Nancy Eldridge, Co-Chairs; Nancy Breiden, Trinka Kerr, VT Legal Aid; Vicki Loner, OneCare; Laural Ruggles, NVRH; Audrey-Ann Spence, BCBSVT; Maura Crandall, Vermont Managed Care; Mary Moulton, Washington County Mental Health Services; Sarah Narkewicz, Rutland Regional Medical Center; Patty Launer, Bi-State; Dale Hackett, Consumer Representative; Michael Bailit, Marge Houy, Bailit Health Purchasing; Susan Besio, Pacific Health Policy Group; Eileen Girling, Amy Coonradt, Erin Flynn, Kelly Gordon, Jenney Samuelson, DVHA; Patricia Singer, DMH; Julie Wasserman, Melissa Bailey, AHS; Allan Ramsay, Christine Geiler, Pat Jones, GMCB; Lisa Viles, Area on Aging for NE VT; Heather Johnson; Ron Cioffi, Rutland Area VNA; Jane Catton, NW Regional Medical Center; Steve Dickens, DAIL; Linda Johnson, MVP Healthcare; Georgia Maheras, AoA; George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome	Bea Grause called the meeting to order at 10:05 am. Nancy Breiden made a motion to approve the February minutes, Patty Launer seconded the motion. Motion passed unanimously.	
2 Co-chairs report	Nancy and Bea met with the co-chairs of the Population Health (PH) Work Group to discuss potential work group collaboration and how the work of the population health work group can help inform the work of the CMCM work group. Population Health co-chairs will provide a presentation on determinants of health to the Care Models and Care Management (CMCM) Work Group at the next meeting on April 8th. Additionally Nancy and Bea will be meeting with the Disability and Long Term Services and Supports (DLTSS) Work Group to discuss potential work group collaboration and the model of care that DLTSS will be presenting at the May CMCM work group meeting.	

Agenda Item	Discussion	Next Steps
	Bea mentioned that the Core Team (CT) is actively reviewing provider grant applications and making decisions by March 25th and noted that she doesn't perceive anything in the legislative queue that would affect CMCM at this time. She also noted that a meeting is scheduled with Anya Rader Wallack to discuss and revise the draft work plan.	
3 Staff Report	Erin Flynn: Webinars included VCHIP & Hub and Spoke presentations this past month. Melissa Bailey from Integrated family Services (IFS) will be presenting for the March webinar. Pat Jones: Staff from Bailit Health Purchasing will assist with putting the inventory of CMCM activities into structured format using Survey Monkey. Please expect a Survey within a couple weeks. Public Comment: Mary Moulton asked if Care Management and Case Management are used interchangeably. Pat said yes and noted that definitions will be provided to the group as part of the inventory survey.	
4 Presentation Blueprint-VCCI-SASH-ACO's on Care Management Learning Collaborative	Patty Launer, Jenney Samuelson, and Vicki Loner presented a conceptual proposal for a Care Management Learning Community (attachment 4). The proposal is to create a Learning Collaborative (LC) that incorporates the community of organizations serving Vermonters, including (but not limited to) ACOs, health care and community service providers, the Blueprint for Health, VCCI, SASH, and payers. The aim is to create a supportive environment that fosters change to improve health outcomes, cost containment, and patient and provider experience. The LC can provide an opportunity to learn and adapt to needs of consumers. The key characteristics of the LC are: it will be informed by evidence based practices; focus on actionable knowledge and strives toward behavior change. The proposal is to start with 3-4 Health Service Areas in a design pilot. The pilot will convene experts to help identify best practices and measures, and develop a curriculum for all communities; work can then be broadened into a Statewide Learning Collaborative. Discussion followed, including: • What regions/communities are being considered for the LC? The pilots will be based on where the ACOs have an intensity of members: Burlington, St. Johnsbury and Rutland for	Convene interested parties, refine focus, identify resource needs, present more detailed proposal to CMCM Work Group, initiate design pilot, and implement broader learning collaborative activities.

Agenda Item	Discussion	Next Steps
	example. Those communities have agreed to participate. • Integrated Family Services would like there to be consideration for development of a sub-committee on kids and family. • The LC will be inclusive and much broader than just ACOs; designated agencies and other types of providers will be included. • What data sources will identify these patients? Data sources might include ACO tools as well as VHCURES (Vermont's All Payer Claims Database). Additional data sources could be presented by LC participants for consideration. • The curriculum content will be narrowed and will be dependent on expert recommendations of evidence based processes that focus on good care coordination. • The proposed timeline is three communities in next three months, then statewide in about eight months. • Bringing in medical specialists may be key to good results. • Collaborative teams tend to be small, what are we anticipating? Teams would be 5-8 communities, starting with 1 or 2 conditions. In larger communities, it is challenging to include all providers. • There is a need to review data in each region to develop focus and foster discussion; for example, readmission statistics by region to assess utilization patterns. • Who is initiating the LC? GMCB has facilitated these very preliminary discussions. LC participants will develop project designs; there is a desire to be inclusive. • The work group could monitor and review progress; the LC will report back to the work group. • The current inventory work will help identify existing initiatives. • The LC could provide an opportunity to address the work group's prioritized focus areas.	
5 Prioritizing activities	Michael Bailit presented the results of the survey monkey sent to the group which stemmed from the previous meeting's discussion regarding the greatest opportunities for improvement (attachment 5). The results will help the work group identify opportunities and prioritize strategies moving forward. Discussion followed, including: • Trying to take on all eight may be beyond the bandwidth of this work group. Is there a	

Agenda Item	Discussion	Next Steps
	connection between the LC and the priorities? Should the top two be the initial scope of work? • The LC should be considered applied research/ policy-to-practice/ implementation of best practices for the work group. Long term goals will be addressed in stages; however, there are near term goals that the group can actively work on. • Although there should be consideration of cost savings, the focus remains on improving the delivery system. • Is there going to be an environmental scan? The inventory will assess what care management activities are occurring now and by whom. • Specific areas of focus may lead to unanticipated results; for example, a potential scenario could be that if medical services are reduced as a result of improved care coordination, social services costs may increase. • How might we advance progress to reduce fragmentation and increase coordination and integration with social services? • The LC is one vehicle; it might be worthwhile to consider other strategies. • The Core Team is in the process of reviewing provider grant applications and expects that some might be contributory to this work group. Some awardees might be required to report back to this work group.	Refining these 2 very big topics in the context of the work plan; considering LC pilots, and learning about provider grant awards.
6 Next Steps, Wrap-Up	Nancy noted that there is a need to add clarity around the Learning Collaborative's role and CMCM Work Group's role, which would be a helpful conversation for next meeting. Nancy also suggested creating work teams when the work group moves from information sharing to operationalizing. Bea noted that this is an iterative process and that clarity would be achieved over time. She greatly appreciates everyone's contribution and commitment to the work group. Public Comment: None offered Next meeting: Tuesday, April 8, 2014, at the ACCD Calvin Coolidge Conference Room, National Life (6th Floor), Montpelier.	

Attachment 4 - Population Health and Vermont's Care Management and Case Management Systems

Population Health and Vermont's Care Management and Case Management Systems

- Vermont's demographics, current and trends into the future
- Examining the continuum of care/interventions/social conditions that contribute to our health

April 8, 2014

Karen Hein and Tracy Dolan

Population Health Working Group of VCHIP, co-chairs

Vermont Demographics

Vermont Demographics

Vermont 2nd oldest state population in 2009

Median Age: 41.2 (Maine: 42.2) (US: 36.8)

Vermont in 2000

- Median Age: 37.7
- Age 65+ 12.7%

Vermont projected to 2030

- Median Age: 43.9
- Age 65+ 24.4%

Vermont Department of Health Population Estimates – derived from U.S. Census

Vermont Demographics

	Vermont	U.S
Persons under 5 years, percent, 2012	4.9%	6.4%
Persons under 18 years, percent, 2012	19.8%	23.5%
Persons 65 years and over, percent, 2012	15.7%	13.7%
Bachelor's degree or higher, persons age 25+, 2008 – 2012	34.2%	28.5%
Median household income, 2008 – 2012	$54,168	$53,046
Persons below poverty level, percent, 2008 – 2012	11.6%	14.9%
Homeownership rate, 2008 – 2012	71.2%	65.5%

U.S. / Vermont Census Facts

Vermont Demographics

Vermont is often called one of the least “diverse” states in the country.

Vermont’s non-Hispanic, White, percent in 2012 was estimated at 95.4%.

- For the U.S., the percentage is estimated at approximately 78%.
- Vermont has the 2nd highest proportion of non-Hispanic Whites. (Maine is estimated at a tenth of one percent higher.)

Recent data for Vermont shows:

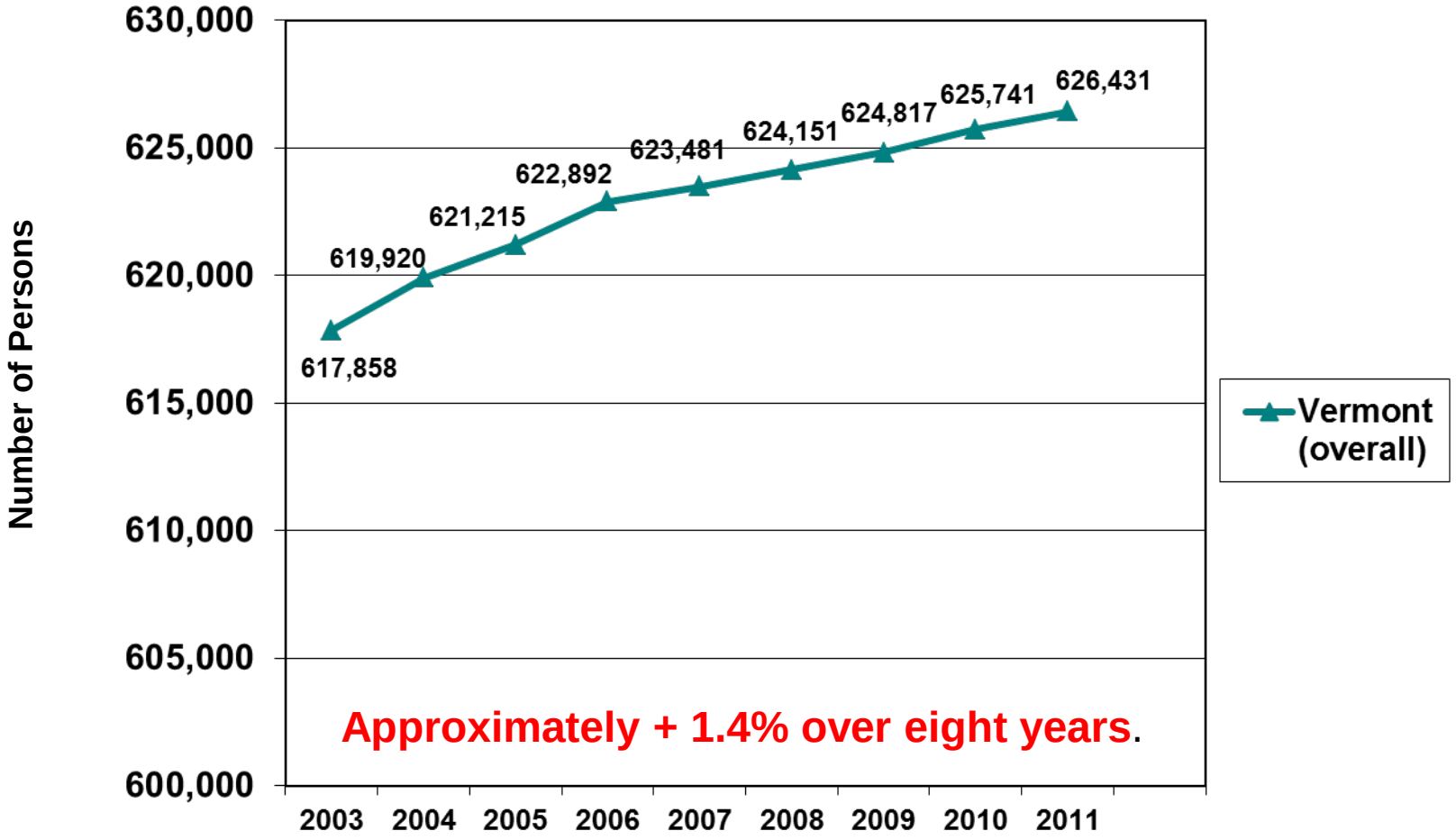
41st highest proportion of Asians	1.3%
49th highest proportion of Hispanics	1.5%
48th highest proportion of African-Americans	1.0%

Also, languages other than English spoken at home (2008 – 2012) were 5.3% for Vermont, but 20.5% for the U.S. overall.

Vermont Population

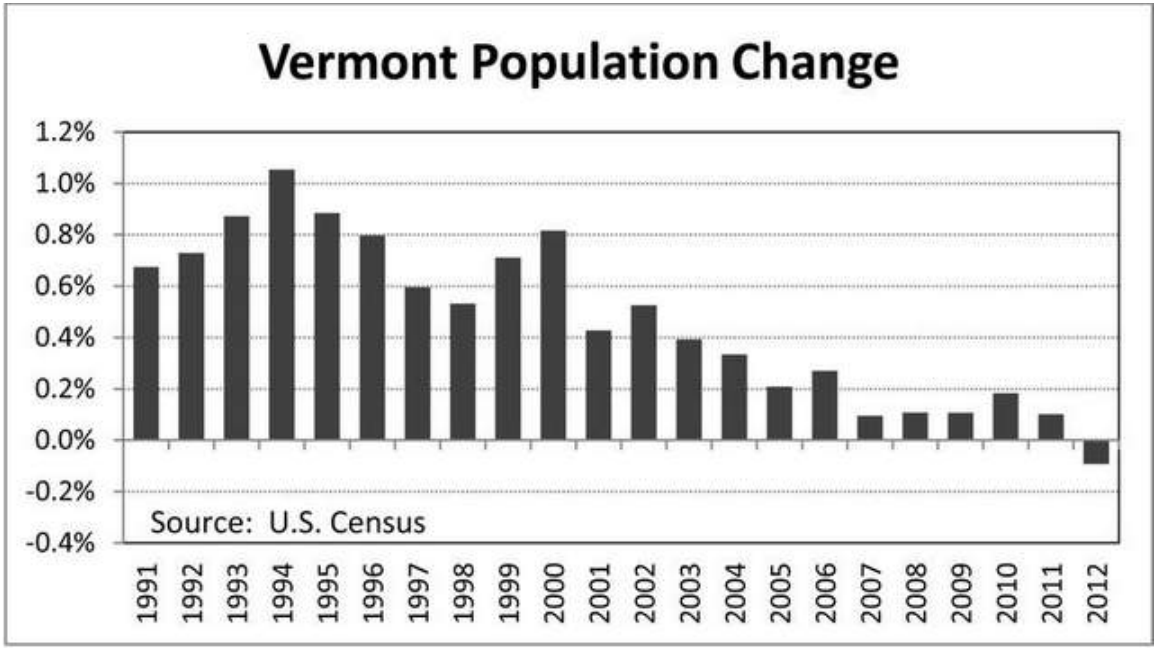
Vermont Population

Vermont (all counties): 2003 - 2011



Vermont Population Change

Vermont (all counties): 1991 - 2012

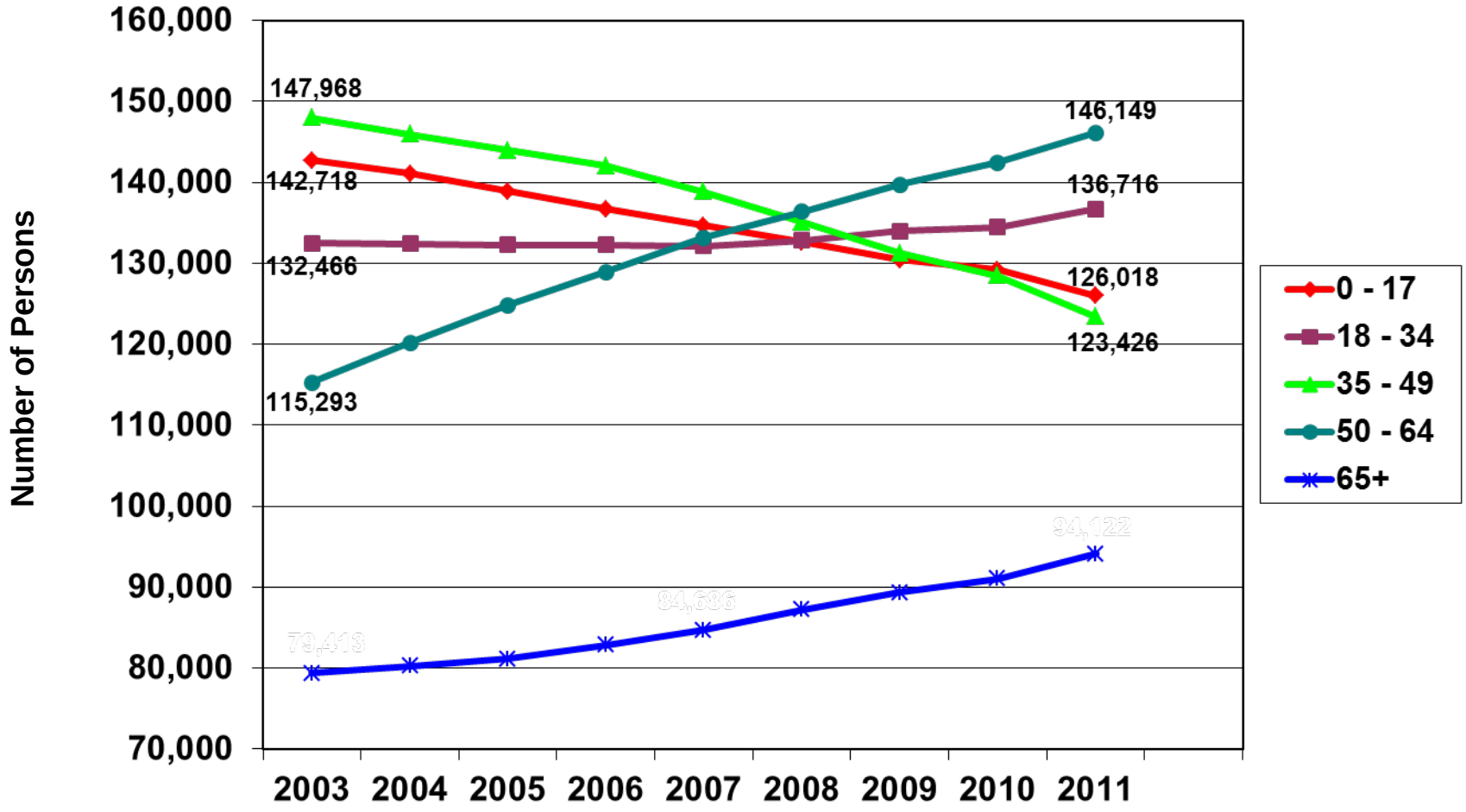


Population, percent change, April 1, 2010 to July 1, 2013

Vermont: 0.1% U. S.: 2.4%

Vermont Population

2003 - 2011



Vermont Population

2003 - 2011

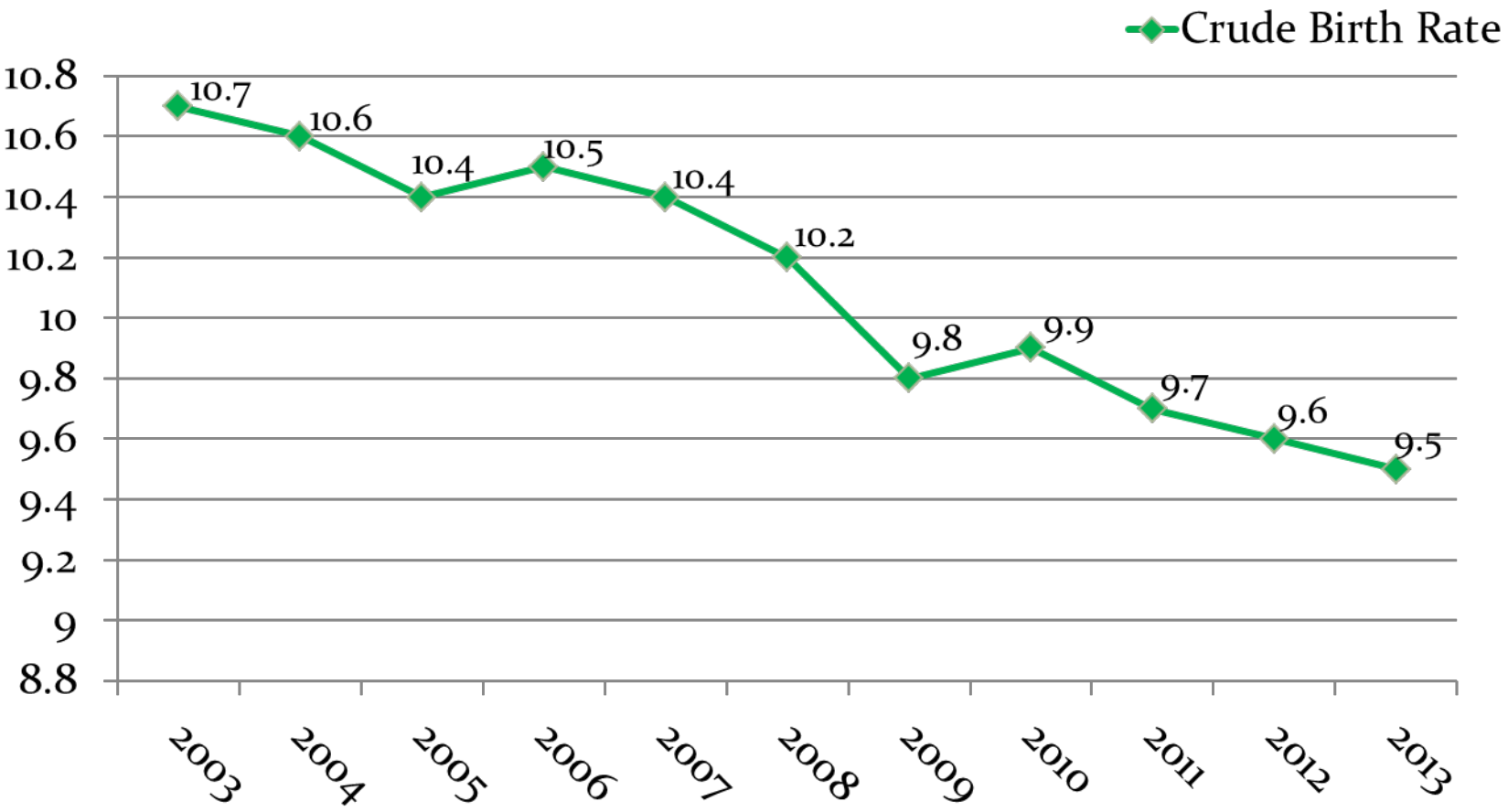
% Change 2003 - 2011

Ages	Vermont
0 – 17	- 12%
18 – 34	+ 3%
35 – 49	- 17%
50 – 64	+ 27%
65+	+ 19%

Vermont Births (and Deaths)

Vermont Population

Crude birth rate = total number of births per 1,000 population



*** 2012 and 2013 data are preliminary**

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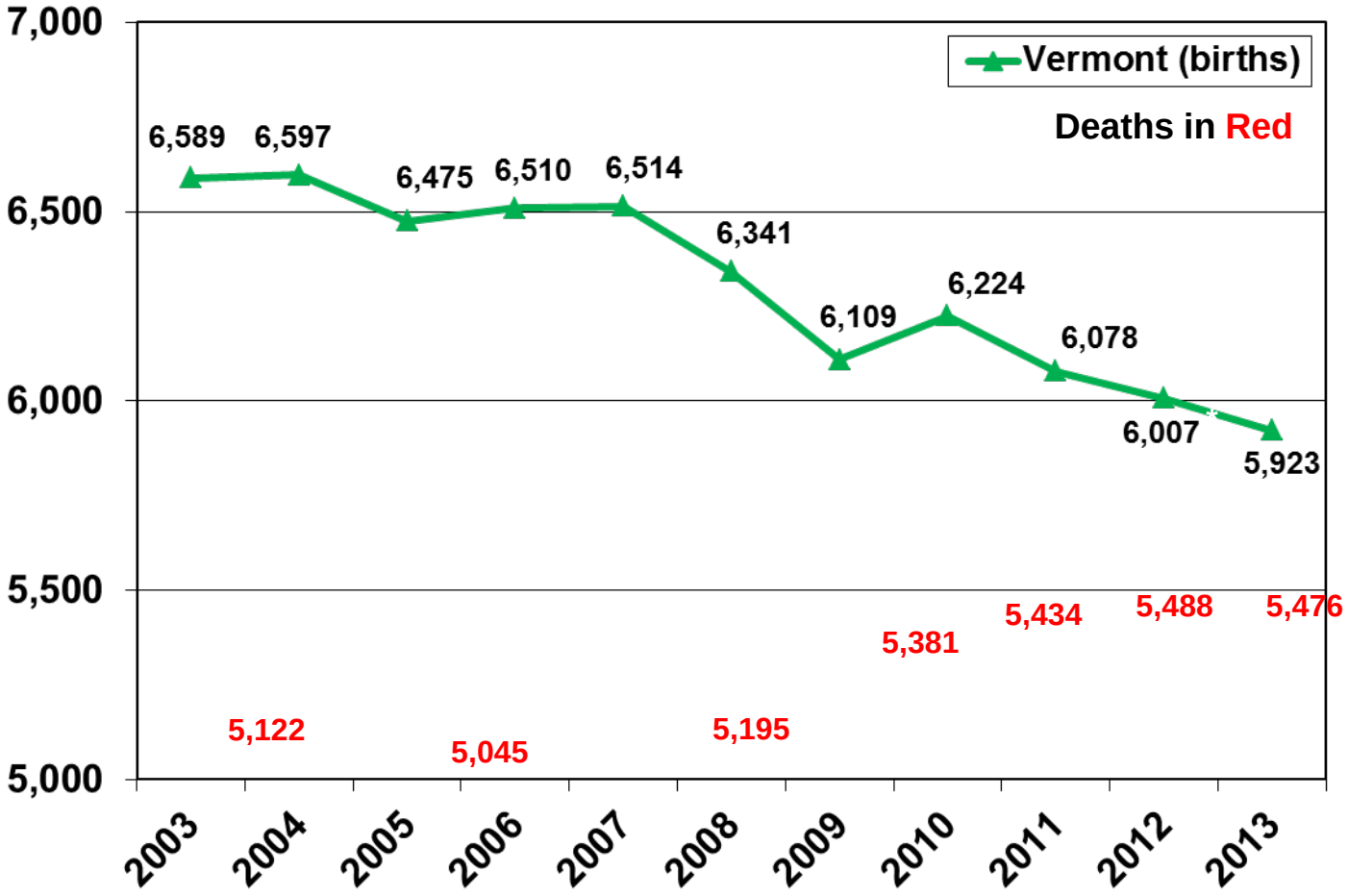
(2013 is expected to be slightly below 6000 births and above 5500 deaths.)

Vermont Births

Residents (all counties): 2003 – 2013*



Vermont Workforce

Projected Vermont Population Growth 2004 – 2030
Workforce Ages 15 - 65
(Annual % Growth)

Vermont's working age population growth rate is forecast to decline for the foreseeable future (ages 15 - 65).

Vermont's population growth begins to decline in 2012 / 2013.

Projected decline:	2012	- .1%
	2013	- .2%
	2020	- .6%
	2025	- .4%
	2030	- .1%

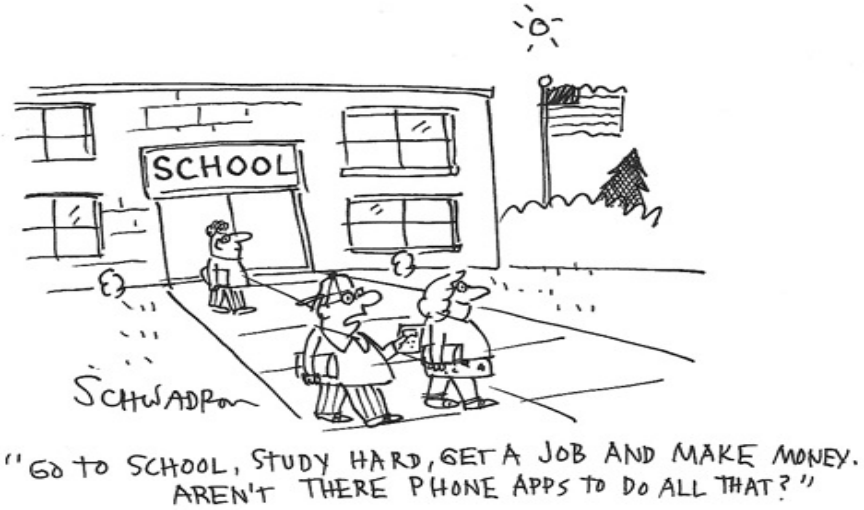
Source: Vermont Department of Labor

Projected Vermont Population Growth 2004 – 2030
Workforce Ages 15 - 65
(Annual % Growth)

The 15 -19 age cohort is the primary source of new workforce in the state.

Vermont's 15 – 19 age cohort will decline through at least the early 2020's.

Projections indicate a negative 1 - 3% each year



Projected Vermont Population Growth 2004 – 2030
Workforce Ages 15 - 65
(Annual % Growth)

Vermont's 20 - 34 age cohort will grow until approximately 2014, then begin to decline.

This age cohort represents those currently leaving college and entering the full-time work force as well as the other younger components of our full-time workforce.

Projections indicate a negative 1 - 2% each year starting in 2015.

Resources / VT Reports

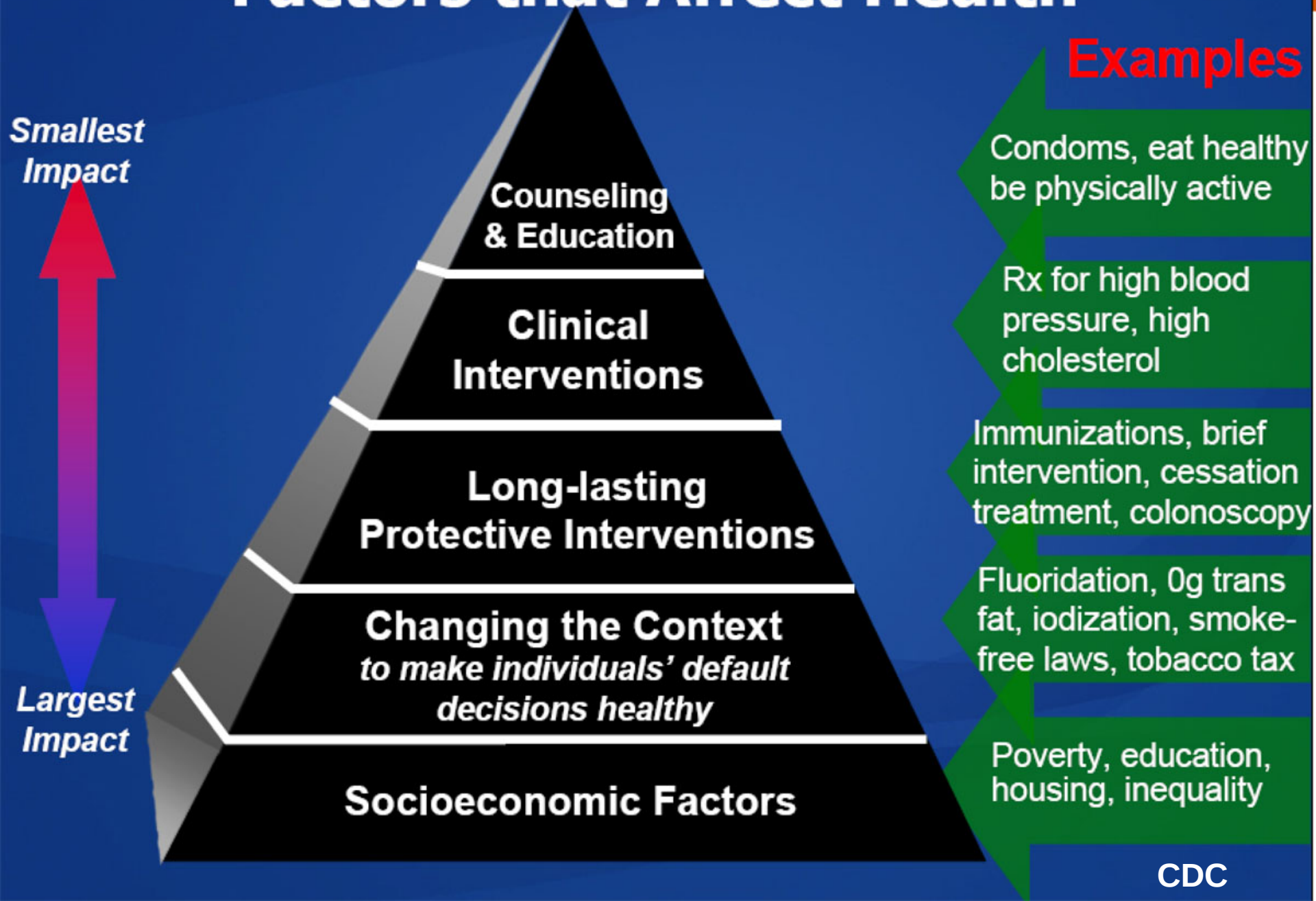
Vermont in Transition: A Summary of Social Economic and Environmental Trends
Source: Vermont Council on Rural Development (Dec. 2008)
http://vtrural.org/sites/default/files/library/files/futureofvermont/documents/VTTransitions_Ch1_0.pdf

U.S. Department of Commerce
United States Census Bureau (2013)
http://quickfacts.census.gov/qfd/states/50000.html

Population growth projections for Vermont's working age population: 2004 - 2030
Source: Vermont Department of Labor (2005)
http://www.makingsensene.org/pdfs/demographic-projections-2004-2030.pdf

Vermont Economic and Demographic Profile Series 2013
Source: Vermont Department of Labor (2013)
http://www.vtlmi.info/lmipub.htm#profile

Factors that Affect Health



Attachment 6 - Developmental Services Service Coordination Presentation

Service Coordination for Developmental Services

Designated and Specialized Agency System

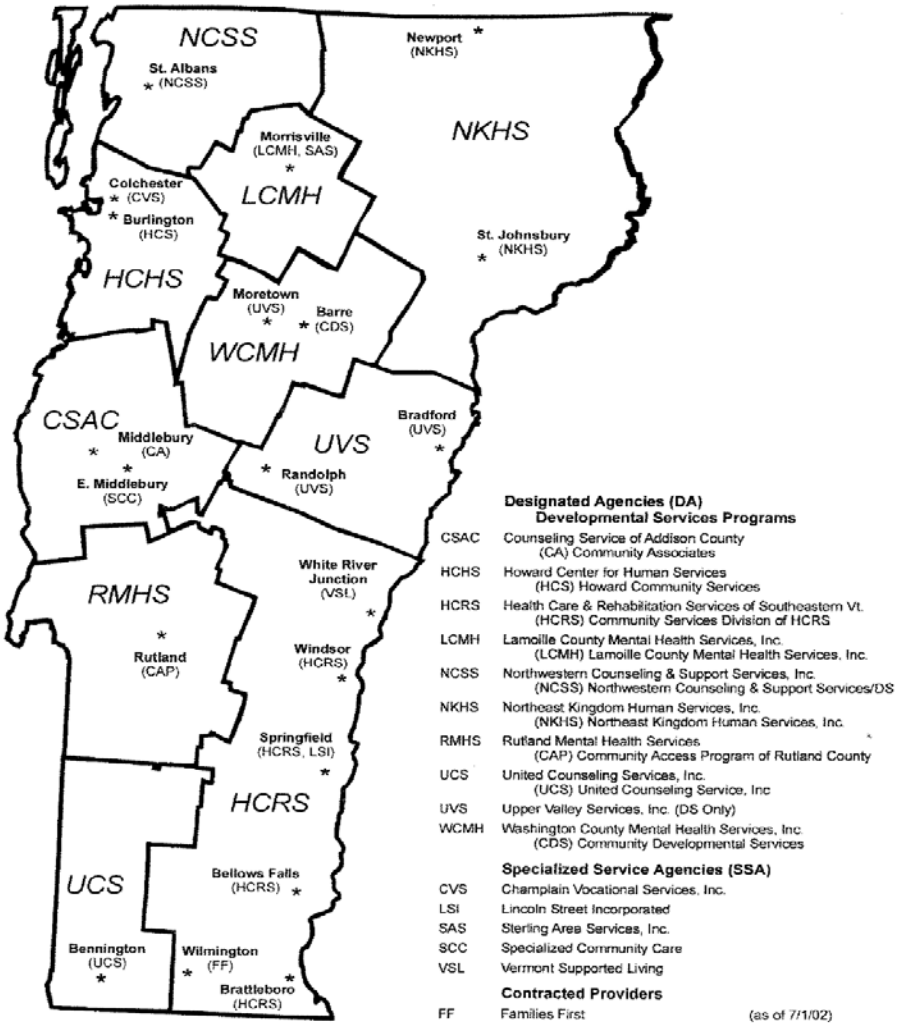
Service Coordination

Definition:

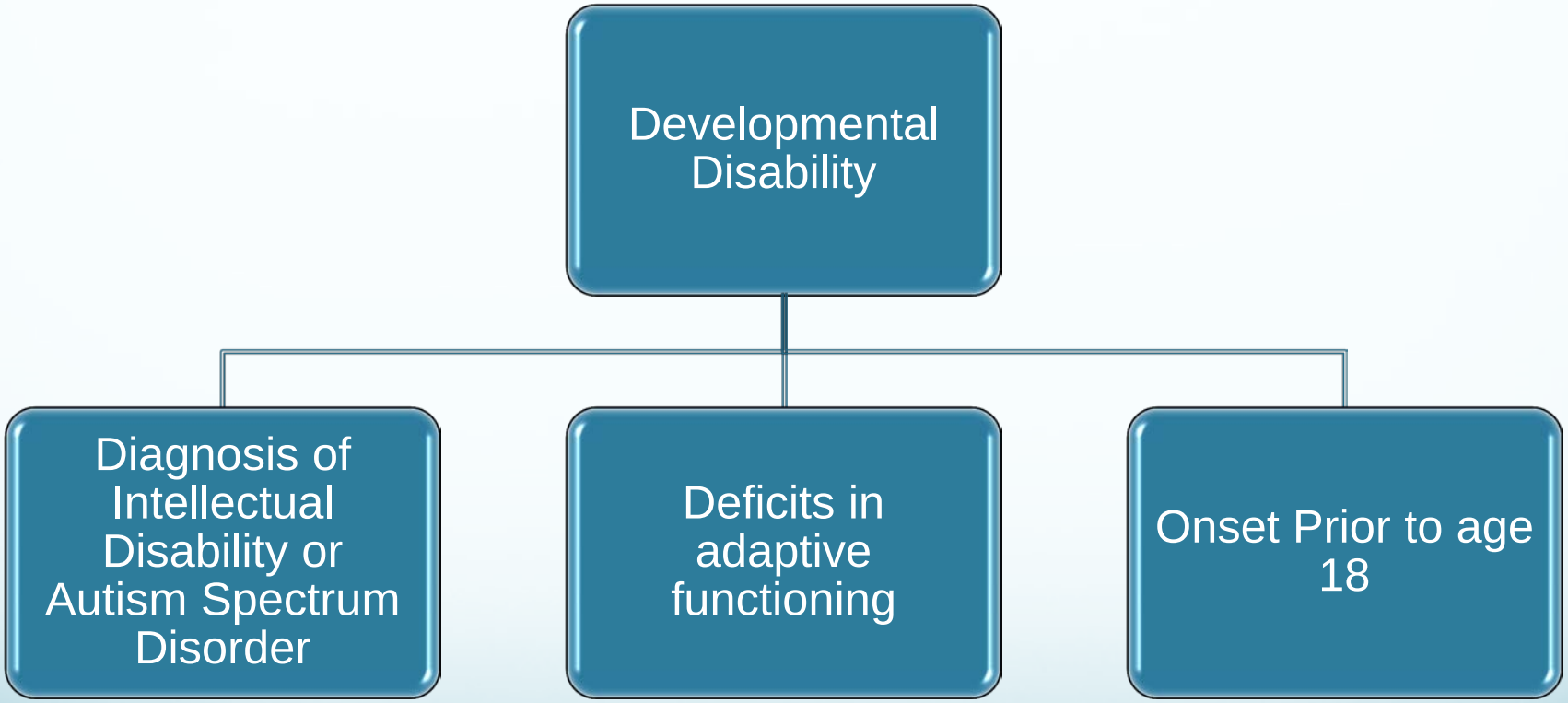
"Assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services for a specific individual."

http://www.ddas.vermont.gov/ddas-programs/programs-dds/programs-dds-default-page#services

Vermont Developmental Service Providers



Eligibility Criteria



Medicaid Funded Services

Vermonters Served in 2013:			
2,770 Home and community-based services (FY13)	385 Targeted Case Management (unduplicated in FY13)	446 Bridge (FY13)	1,077 FFF (FY13)

Strengths of DS System

Statutory foundation for principle-driven services

Continuity of care – Long Term Care service

- Comprehensive coordination of services
- Help people throughout their lifespan
- Whole person/Whole team responsibility

Person-Centered Planning

Primary/Lead on care coordination while multiple systems involved

Service Coordination Professional Qualifications

QDDP=

Qualified Developmental Disabilities Professional

Client
Medical
Benefits
Judiciary
Crisis
Employment
Education
Family Support
Residential
Community
Clinical

Role of Service Coordinator in Coordinating Supports

Medical

- Primary Care Physician
- Nursing
- Specialists (psychiatry, neurology, ortho. Etc.)
- Hospitals (incl.staffing during hospitalizations)
- Home Health/Hospice

Clinical

- Individual therapy
- Interpreter & cultural liaison svcs.
- Communication Supports
- Dialectical Behavior Therapy

Community

- Support Staff
- Businesses
- Landlords
- Transportation

Residential

- Shared Living Providers
- Families
- Licensing (group homes)

Role of Service Coordinator in Coordinating Supports

Family Support

- Respite Providers
- ARIS/Payroll
- Employer Education
- Recruitment and referral

Education

- IEP teams
- High Schools
- Colleges

Employment

- Local Businesses
- Benefits Manager
- Social Security
- Vocational Rehab

Role of Service Coordinator in Coordinating Supports

Crisis

- First Call- CYFS
- Adult Mobil- MHSAS
- Emergency Room

Judiciary

- Police
- Courts
- Corrections

Benefits

- SSA/Representative Payee
- Economic Services
- Medicaid

Outcomes

Individualized Support

- 95% of people receiving residential supports live in settings of 1-3 people as compared to 49% nationally

Meaningful Choices

- 95% of people say they decide, either independently or with help, when to do things each day
- 96% of people see themselves as a self-advocate
- 97% of people said they decide, either independently or with help, how they spend their free time

Community Participation

- 93% of people said they were happy with their community activities

Employment

- Vermont ranked 5th in the nation in the proportion of people in supported employment – 43% in Vermont with the national average 20%
- 91% of people like where they work
- 96% of people said the work they did was important
- 97% of people said they are respected by those with whom they work

Outcomes Continued

Health and Safety

- Health and health care expenditures are positively impacted through the comprehensive service coordination and supports in the developmental disabilities system for people who are both Medicaid and Medicare eligible:
  - Per capita annual Emergency Department service payments were $124 as compared to $278 for all Vermonters who are dually eligible
  - Per capita Inpatient Hospitalization payments were $1,176 versus $3,522 for all Vermonters who are dually eligible
  - Per capita Outpatient Hospital payments were $170 compared to $639 for all Vermonters who are dually eligible

Fiscal Integrity

- Vermont's average per person cost for HCBS and ICF-ID in FY2011 was $54,664 as compared to the national average of $57,740
- Vermont's average per person cost for HCBS and ICF-ID in FY2011 was over $4,000 less than the average per person cost of $58,850 in FY1993

Case Study “Baby M.”

About Baby M.

- Referred to DS by DCF at 6 months of age
- Life threatening head injury
- Intensive care needs- g-tube fed, awake overnight care needs.
- Not expected to live to first birthday- end of life care

- Service Coordination
  - Trained and Supported SLP and care team
  - Coordination of Medical care

Baby M. Continuted

- Baby M. Outcomes
  - Prevented institutionalization
  - Only lived with one family after coming into services
  - The Shared Living Providers adopted baby M.
  - Lived to age 3

Case Study “Eliot”

About “Eliot”

- Dually diagnosed Intellectual Disability & Mental Health diagnosis with substance abuse
- Daily street drug use
- At risk of homelessness, losing HUD voucher
- Frequent ER visits in search of prescription drugs
- Threatening behaviors, unsafe social situations
- At risk of incarceration due to drug use and related illegal activity
- Resistant to services

Service Coordinator

- Coordinated services with Methadone clinic, Safe Recovery, Street Outreach etc.
- Ongoing coordination with Emergency Department, Police, crisis services
- Preserved housing voucher, repaired relationships with landlord
- Became Representative Payee of Social Security Income

“Eliot” Continued

Eliot’s outcomes

- Secured stable housing
- Lives in Winooski- away from previous risky environment
- Now accepting limited individual supports to target skill building, emotional regulation, safe choices
- Able to utilize services at Methadone clinic – engaged in treatment
- Prevented incarceration

Case Study: “Marcy”

- About “Marcy”
  - Vermont State Hospital (VSH) in 1958 at age of 22
  - Moved to a relatives house for awhile followed by 8 community placements
  - Was placed at Brandon Training School
  - Returned to the community but was placed back at Brandon within days
  - Transferred to VSH
  - Discharged from VSH in September 1980
  - Lived with increasing levels of independence from 1980-2006

- Service Coordination
  - Supported with transition out of institutionalization
  - Supported into maintain of independent living status for over 20 years through comprehensive coordination.
  - When health began to deteriorate, supported with Safety Connections
  - When diagnosed with pancreatic cancer, coordinated increased personal care and medical interventions

“Marcy” continued

Outcomes

- Prevention of MUCH higher levels of care over her life span
- Prevented institutionalization even when needs met criteria for nursing home care
- Supported behaviorally/emotionally in hospital setting during periods of hospitalization and throughout cancer treatment.
- Services respectful of Marcy’s desires- always self-directed, never forced- ex. Apartment supervision

Contact Information

Marie Zura, Developmental Services Director

HowardCenter

802-488-6503

Colleen Fiske, Team Lead

HowardCenter

802-488-6320

Clare McFadden, Senior Specialized Services Supervisor

Department of Disability and Aging

802-871-3062

Marlys Waller, Developmental Services Coordinator

Vermont Council of Developmental and Mental Health Services

802-233-1773

Attachment 7 - Care Models and Care Management Work Group Meeting Schedule 2014

Vermont Health Care Innovation Project

2014 Meeting Schedule for Care Models and Care Management Work Group

In-Person Meetings: Second Tuesday of Each Month from 10:00 AM to 12:00 Noon

Webinars: Third Tuesday of Each Month from 10:00 AM to 12:00 Noon

**Beginning in May, presentations relating to the inventory of care management activities will be scheduled during webinar time slots to allow for sufficient working time at in-person meetings.*

Date	Format	Presenter	Location
January 14, 2014	In-Person	Designated Agencies	
January 21, 2014	Webinar	• Allan Ramsay, MD on Care Models for Supportive Care of the Seriously Ill • Vermont Assembly of Home Health Agencies	
February 11	In-Person	Blueprint CHT Leaders	
February 18	Webinar	• VCHIP on Blueprint Network Analysis • Hub and Spoke	
March 11, 2014	In-Person		ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
March 18, 2014	Webinar	Melissa Bailey, IFS	289 Hurricane Lane, Lower Level Conference room B
April 8, 2014	In-Person	Population Health Work Group	Office of Professional Regulation - Large Conference Room, 3rd Floor, 89 Main Street, Montpelier
April 8, 2014	In-Person	Vermont Council of Developmental and Mental Health Services	Office of Professional Regulation - Large Conference Room, 3rd Floor, 89 Main Street, Montpelier
April 15, 2014	Webinar	OPEN	Office of Professional Regulation - Large Conference Room, 3rd Floor, 89 Main Street, Montpelier
May 13, 2014	In-Person	Disability and Long Term Services and Supports Work Group	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
May 20, 2014	Webinar	OPEN	DVHA Large Conference Room
June 10, 2014	In-Person	OPEN	Office of Professional Regulation - Large

Date	Format	Presenter	Location
			Conference Room, 3rd Floor, 89 Main Street, Montpelier
June 25, 2014	Webinar	OPEN	AHS Training Room
July 8, 2014	In-Person	OPEN	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
July 15, 2014	Webinar	OPEN	DVHA Large Conference Room
August 12, 2014	In-Person	OPEN	Office of Professional Regulation - Large Conference Room, 3rd Floor, 89 Main Street, Montpelier
August 19,2014	Webinar	OPEN	DVHA Large Conference Room
September 9, 2014	In-Person	OPEN	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
September 16, 2014	Webinar	OPEN	DVHA Large Conference Room
October 14, 2014	In-Person	OPEN	Office of Professional Regulation - Large Conference Room, 3rd Floor, 89 Main Street, Montpelier
October 21, 2014	Webinar	OPEN	DVHA Large Conference Room
November 18, 2014	In-Person	OPEN	ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
November 25, 2014	Webinar	OPEN	DVHA Large Conference Room