

Care Models and Care Management Work Group Meeting Agenda 5-13-14

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

Tuesday, May 13th, 2014; 10:00 AM to 12:00 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	<u>Attachment 1:</u> CMCM Minutes April 2014	
2	10:05 – 10:10	Co-Chair Update <i>Public Comment</i>		
3	10:10 – 10:15	Staff Update <i>Public Comment</i>		
4	10:15 - 10:50	Debrief from April Meeting: Summary of Break Out Sessions, State Health Improvement Plan, and Development of Demand Side Problem Statement <i>Public Comment</i>	<u>Attachment 4a:</u> Notes from April Work Group Meeting Break-Out Sessions <u>Attachment 4b:</u> State Health Improvement Plan Summary (to be provided when available)	
5	10:50 - 11:50	Discussion of Care Management Standards for ACOs; Breakout Groups to Refine Categories for Standards <i>Public Comment</i>	<u>Attachment 5a:</u> Potential Topics for Care Management Standards <u>Attachment 5b:</u> Proposed DLTSS Care Model Elements	
6	11:55 - 12:00	Next Steps, Wrap-Up and Future Meeting Schedule Upcoming Webinar (5/20) : Review of Inventory Survey Tool		

Attachment 1 - Care Models and Care
Management Work Group Meeting
Minutes 4-08-14



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

Date of meeting: Tuesday, April 8, 2014; 10:00 AM to 12:30 PM, Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT

Call in: 877-273-4202, Passcode: 2252454

Attendees: Bea Grause, Nancy Eldridge, Co-Chairs; Georgia Maheras, AoA; Marie Zura and Colleen Fiske, Howard Center; Trinka Kerr, Legal Aid; Kelly Gordon, Erin Flynn, Amy Coonradt, Kara Suter, DVHA; Charlie Biss, DMH/IFS; Dana Demartino, CVMC; Dale Hackett, Consumer; Patty Launer, Bi-State; Steve Dickens, Jen Woodard, DAIL; Susan Besio, Pacific Health Policy Group; Maura Crandall, VT Managed Care; Tracy Dolan, Breena Holmes, Dept. of Health; Karen Hein, GMCB, Laural Ruggles, NVRH; Jenney Samuelson, Blueprint for Health; Marlys Waller, VT Council of Dev. and MH Services; Barbara Cimaglio, Julie Wasserman, AHS; Madeleine Mongan, Pamela Farnham, Fletcher Allen Health Care; Jane Catton, NMC; Michael Bailit, Bailit Health Purchasing; Audrey Spence, BCBS; Debbie Rapizzi, MVP; Jessica Mendizabal, Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome and Introductions, Approval of meeting minutes	Nancy Eldridge called the meeting to order at 10:05 am. Trinka Kerr moved to approve the minutes. Patty Launer seconded the motion and it passed unanimously, without edits to the minutes.	
2 Co-Chairs' Report (e.g., Other VHCIP Work Group/Core Team Activities, Legislative Update, Provider Grant	Co-Chair update: the provider grants were awarded to eight recipients. Several applications that were not approved have been referred to certain work groups. The CMCM work group expects to receive 10 applications and the co-chairs will meet with Anya and Georgia next week to discuss next steps. Bea Grause gave a legislative update: ACT 252 has passed the Senate, which contains Act 48	

Agenda Item	Discussion	Next Steps
Program Update)	amendments concerning how Green Mountain Care would become operationalized. Most of them will become studies and won't significantly redirect the course of Act 48.	
3 Staff Report (Update on Inventory, Request for Additional Webinar Presentations)	Erin Flynn reminded the group that if anyone wants to present to the work group via a webinar they should reach out to her and she will help coordinate it. Staff is also working together with the consulting team at Bailit Health Purchasing to put the final touches on the inventory survey tool.	
4 Population Health Work Group Presentation (Karen Hein, MD, Green Mountain Care Board and Tracy Dolan, Deputy Commissioner, Vermont Department of Health)	<p>Tracy Dolan and Karen Hein presented on the topic of the Population Health Work Group and how the goals of this work group interact with the goals of the Care Models and Care Management work group (attachment 4).</p> <p>Nancy prefaced the conversation by asking the group to think about what success looks like for CMCM. She noted that it's not just payments. The problem is about health status and they want to know more about the health goals of Vermont.</p> <p>The following points were discussed during the presentation:</p> <ul style="list-style-type: none"> • The 65+ population is becoming more employed over time, so the working age population may need to be redefined. • The VT workforce information presented includes all professions, not just health care. • The State Health Improvement Plan (SHIP) is based on a framework called "Healthy People 2020", and includes national benchmarks for health improvement. • Tobacco and obesity are two priorities for VT. • The SHIP includes three major goals: 1) reducing the prevalence of chronic disease 2) reducing the prevalence of substance abuse and mental illness 3) increasing childhood immunization rates in VT, which has been lower than optimal for the past 10 years. • Key risk factors and how to prevent conditions and implement system changes that impact behavior: <ul style="list-style-type: none"> ○ Tobacco use was a key driver in 2010: 16% for adults, 13% for youth. Goals for 2020 are to bring it down to 12% for adults and 10% for youth. ○ We have moved away from 1-1 counseling which is resource intensive, and moved toward broader system changes such as smoke free laws. 	<p>Additional slides will be distributed to the group via email after this meeting.</p> <p>Tracy will send the VT state objectives to the work group.</p>

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> ○ In VT you can see drops in specific interventions: tax increases correlate to people smoking less; evidence based strategies around tobacco cessation services. ○ Policy changes are the other key piece where people don't start smoking in the first place (such as reduced advertising and visibility). ● Regarding obesity: <ul style="list-style-type: none"> ○ Get unhealthy foods out of the school altogether, and focus on nutrition and physical activity. ○ Build in activity naturally into your daily routine, such as walking to school or work. ○ Worksite wellness is also effective and brings down health care costs. ● Binge drinking is a significant issue in VT: recent survey shows 19% of high school students responded to having five or more drinks within a few hours during the past 30 days. However, this is a decrease from the 21% in 2011. <p>Karen asked the group to think about how we can connect social determinants with care models. She discussed the CDC impact pyramid (last slide):</p> <ul style="list-style-type: none"> ● 80% on the dollar yields little impact (top of pyramid), less dollars yield a bigger impact (bottom). ● She recommended that the CMCM work group think about social determinants and consider socioeconomic factors when making recommendations on care models for the future. ● She referenced slides for tobacco and obesity (distributed via email) where they looked at the context of eating to see what we can change in the environment. ● There was also a recommendation to consider population health as it relates to global climate change. ● The GMCB dashboard is using the "Well-Being Vermonters" reports from the 1990s, which encompass the entire pyramid. ● Bea noted that this work group is trying to change the context for providers and health care professionals to help them encourage participants to change their behavior. CMCM will strategize with providers to be more impactful in addressing the needs of the Vermonters they serve. ● Karen noted human services needs to evolve in a future payment reform world. GMCB needs input on the unified health care budget: looking at what is being spent on 	

Agenda Item	Discussion	Next Steps
	<p>preventative services; expanding the expenditure analysis to include agriculture, education, etc.; and understanding what the return is on investing more resources in children.</p> <ul style="list-style-type: none"> • The State will look into further detail for the aging population as well. • Mental health is always a key issue, not just mental illness- there needs to be a good model for this. Example: having a safe place for kids in the community. This is changing from the current model where issues are in silos. • Success by Six is a great model to follow and could be applied to the 65+ population. New York is doing similar work for the aging population and had success (instituting walkable locations, etc.) • Regarding mental health: <ul style="list-style-type: none"> ○ Washington County Mental Health Services builds wellness collaboratives into their programs including yoga, gardening, etc. Payment mechanisms are a challenge. Example: open studio for art “resource and recovery” youth in transition in Barre. They are looking at how to bill it and seeking a grant. Another example is having kids work at Random Rescue with animals, which has been very successful showing improvement in school performance. ○ Many different organizations around the state are working on similar efforts. ○ Tracy noted we need to look at the incentive driving the payment systems. ○ Kara Suter stated that we do need to promote healthy lifestyles but it may not need to be a health care expenditure, which is taking resources that are already strained and therefore some people might not benefit. ○ The Population Health Work Group is working with Jim Hester to research three exemplars around VT that are currently working on community coalition building, and trying to apply this in other areas of the State. ○ Dale Hackett provided an example of taking children to state parks in the summer as an investment and how it relates to the work of CMCM. The state department employees would be a good partner. 	
5 CMCM/Population Health Breakout Sessions	<p>The group discussed the following questions in the breakout sessions:</p> <ul style="list-style-type: none"> • What will health care reform success look like based on the Population Health presentation? 	The notes from the breakout discussions will be distributed to work group

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • What is missing? • What care management practices, principles or protocols will be most impactful in achieving the Population Health goals? 	<p>members and discussed at the next meeting.</p>
<p>6 Presentation on Developmental Services</p>	<p>Marie Zura and Colleen Fiske from the Howard Center presented Service Coordination for Developmental Services (attachment 6).</p> <p>The following points were noted:</p> <ul style="list-style-type: none"> • Services are not guaranteed based on eligibility. The Howard Center serves 25% of the population that is eligible for services. • One case manager coordinates all services, helping to assist with continuity of care. • They currently serve a large refugee population. • Case managers often act as sitters in hospitals as well. • Vermont is ranked 5th in the nation because they focus on getting those with disabilities into the workforce. • The case studies presented demonstrate where in-home care can cost less but also show how VT values quality of life. • Comprehensive case management is about relationships and having the entire picture. Long Term Care is a large part of this effort. 	

Agenda Item	Discussion	Next Steps
7 Next Steps, Wrap-Up and Future Meeting Schedule	<p>Next Meeting: May 13th 10 am – 12:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.</p> <p>Topics for next meeting:</p> <ul style="list-style-type: none"> • Care Management Standards for ACOs. • The DLTSS work group will present on a Care Management model. Recommendations will go to the Steering Committee, then the Core Team. • Continued discussion on Population Health. • Each scribe from the breakout groups will share their notes to be discussed. 	

Attachment 4a - Notes from April
Work Group Meeting Break-Out
Sessions

Care Models and Care Management Work Group: March 11th Break Out Session Notes

Group #: 1

Participants: Trinka Kerr, Colleen Fiske, Charlie Biss, Jenney Samuelson, Nancy Eldridge

(1) What will health care reform success look like based on the Population Health presentation?

Successful reform will focus on risk and protective factors rather than on diagnosis of illness (example: the benefits of physical activity on mental health)

We will have a Global Health Budget that will include transportation, labor, agriculture and education. Our break out group added the Commerce Agency because of its economic development and housing role. Hospital and designated agencies and other budgets would be one.

We would get to people before “the horse leaves the barn” (aka Tracy’s description of trying to get people to stop smoking as opposed to the less costly option of preventing them from starting).

Vermont communities would look at how inextricably linked the well being of its citizens is to all aspects of community life – everything is connected to health.

We would define “health expenses” very broadly and keep bringing in more resources and partners to advance health (aka the Integrated Family Services model).

More money would be spent on social services and less on traditional medical services. In other countries that have more successful health care systems, a larger proportion of the budget goes to social supports.

There ought to be more investment in the bottom of the pyramid.

We discussed what the workforce would look like in successful reform – probably more social workers than doctors? We did not want to demean the physician role in any way and thought there may be areas where a doctor is what is needed.

We discussed what we mean by the word “provider”. If provider is narrowly defined, then we wanted to make sure that it is not just the traditional providers that should be doing care management. If broadly defined, providers could include peers, family, us!

We discussed whether the pyramid concept is new and agreed that it is not entirely new in some parts of the state – however – without a payment method it is difficult to lead efforts such as those in St. Johnsbury.

(2) What is missing (cognitive health, reduced hospital infections, etc)?

This was a difficult question to answer because we did not have the Statewide Health Improvement Plan in front of us to determine what is missing.

But the point was made that efforts to combat hospital infection rates began with public health efforts in Europe – so public health is very broad and inclusive.

One member stated that what's missing is the investment of dollars in the bottom of the pyramid. We discussed the use of Social Impact Bonds or other investment vehicles that Karen referenced. We thought this would be a way to address the concern that it is difficult to add investments in social determinants of health before we see the savings associated with that investment.

(3) What care management practices, principles or protocols will be most impactful in achieving those goals (meaning the PH goals)?

We had a discussion about whether care management should be at the top of the pyramid or at the base of the pyramid and acknowledged that it is hard to tease it out.

One practice that was proposed is to focus on improving units of populations whether it is a neighborhood, zip code, work place, housing or school.

It was suggested that we need some focus and perhaps it should be on people who suffer from inequities.

It was noted that a look at other states shows that we must take a “and/both” approach to targeting. Vermont has been successful because it brings everyone into the Blueprint and targets from there. States that just target do not save.

As a principle, one member suggested that we move away from talking about scarcity of resources and recognize that it is really a matter of allocation of resources.

Group #: 2

Participants: Tracy Dolan, Mary Moulton, Susan Besio, Dana DeMartino, Marlys Waller, Patty Launer and Bea Grause.

Group discussed how to ensure there is a connection from the care setting to population health.

What's missing?

1. The realities of population health/demographics - we will see an increase in services whether it's for obesity-related reasons or runner's knee.
2. Impact of trauma on medical services
3. Veterans/TBI/PTSD

Use population health thinking in primary care settings. e.g. Change the context - treat the whole family, not just the child.

Match up the principles with resources. e.g. patient centered care/patient led care with payments to support; team health with aligned payments to support cooperation.

Group #: 3

Participants: Erin Flynn, Kara Suter, Dale Hackett, Julie Wasserman, Laural Ruggles, Marie Zura

- Importance of Environmental vs. Person-Drive Change:
 - Have to find the right balance between proactive and reactive behavior change.
 - Suggestion that policy levers like smoking bans are top-down government imposed policies. Recommendation to stay away from government imposed policies as much as possible and allow for community based person-driven change.
 - Another recommendation to change societal norms to make the health way the normal way.
 - Potential to see change start on the ground in small communities and roll out state-wide.
 - People need to take accountability and responsibility for their health.
 - Businesses and other public sector actors also need to be responsible for their contribution to public health.
 - Put control in the hand of the individual person and empower people to feel ownership of their own health, with the adequate support and resources to surround the person.

- Focus on Preventive vs. Reactive Health Care:
 - We need to move away from reacting once the problem has already surfaced to more preventative measures that identify problem as early as possible and build the structure to respond once a problem is identified.
 - Use of screening tools and making timely referrals that are actionable. Ex: working with schools on screening tools, connecting the school with outside resources.

- Leadership is disjointed, need more collaboration across diverse sectors (as well as at the community level).

- Need to understand gaps, how referrals can be strengthened and how we can fill the gaps.

- Need to facilitate connections between generations, and across the health care system on a personal level.
 - Suggestion to draw from the most impactful relationship, ie – closest to the patient in the way that is most relevant to each individual.
 - Person centered/self-directed care

- Be thoughtful of the whole family when making decisions. Be aware that any changes that are imposed on one part of a family will have an impact on the other.
- Focus is currently on acute medical care, long term services and supports needs to be in the full spectrum.
 - Can't be solely medical.
 - Long-term care services and supports can focus on the bottom of the pyramid (socio-economic factors).
 - Strengthen the link between LTSS's and focus on socio-economic factors to the traditional medical spend.

Group #: Phone participants

Participants: Michael (Bailit Health and facilitator), Pam Farnham (FAHC), Barbara Cimaglio (DOH), Steve Dickens (Invest EAP), Maura Crandall (OneCare)

(1) What will health care reform success look like based on the Population Health presentation?

- Maura: loved presentation since background in public health; would love to see integration of population health and providers working together holistically to have resources available; integrate AHS and community services that differ in each HSA; make clear when issues come up to whom you refer people so we are working as a team and not in silos; take advantage of our small size to get us all on the same page within each HSA, knowing the resources and knowing population health information
- Barbara: agree with much of Maura; think need planning at the local level (HSA or AHS) and community (not just health care providers) deciding what to do; a lot of keeping healthy and recovering is not about health care; communities would be aware of opportunities and risks, what they are trying to enhance and promote, an shared ways to address. Sounds "pie in the sky", but it is achievable.
- Steve: we are trying to address socioeconomic factors when trying to address stress people experience; we should all be working with that pyramid in mind; we need to be able to articulate a broad vision of health that goes beyond the fields of health
- Pam: need to get away from separating mental health from population health and incorporate the whole body
- Michael: integrate health care and health by holding health care providers receiving population-based payment or global payment accountable for population health in their geographic region to a degree that is reasonable - there is growing attention to doing this in other states (Bailit Health recently did work on this for Maryland)

(2) What is missing (cognitive health, reduced hospital infections, etc.)?

- Steve: pyramid model compelling, but also a little reductionist and simplistic (e.g., suggesting counseling doesn't work) - counseling and education can be population-based
- Maura: doesn't recognize differences in health literacy; some people "need to be carried" - e.g., need home visits because can't follow instruction - help people do what they can do up to their ability
- Barbara: thinking that health is holistic - integration in mind ; make it OK for people to talk about how they are caring for themselves

(3) What care management practices, principles or protocols will be most impactful in achieving those goals?

- Maura: knowing where to go in the community to get help for specific needs; knowing who needs what levels of support and that they are available
- Steve: providers need to seek out information that is germane to their practices
- Barbara: think we are all talking about bring population-based sensibility to health care reform; for care management, we need to streamline and eliminate silos - we still have too many - there needs to be a place for where this is all coordinated for patients with

complex medical and social issues - it's all in the local - need to know people in the local community

- Michael: Why have CHTs not broken down the silos?
- Pam: we are focused on individual patients - we don't have resources to do larger population health work - and providers don't want to take the time to do it (e.g., look at the panel report)

Attachment 5a - Potential
Topics for Care Management
Standards

Potential Topics for Care Management Standards for Vermont's Medicaid and Commercial ACO Shared Savings Programs

Potential Domains: ACO Care Management Program Structure, ACO Care Managers' Relationships with Other Organizations, ACO Care Management Activities, ACO Care Management Program Evaluation

Potential Topics:

1. Role of partnerships among ACOs and social and community service organizations
2. Activation and engagement of people needing services
3. Role of existing foundation of advanced primary care and health home models
4. Setting of care management services
5. Role of panels of participants/people needing services
6. Self-management support for people needing services
7. Composition, function, and role of Clinical Advisory Boards, and how they relate to locally-based care management teams
8. Use of screening and assessment tools
9. Use of and access to care management plans
10. Measurement of care management performance, including impact on people needing services
11. Roles and communication protocols for those involved in care management for ACO members needing services, including informal supports

For additional topics, see Attachment 5b – Proposed DLTSS Care Model Elements

Attachment 5b - Proposed DLTSS Care Model Elements

Basis for Design of Proposed DLTSS Model of Care

NATIONAL EVIDENCED-BASED DLTSS MODEL OF CARE ELEMENTS				
Core Elements	Commission on Long-Term Care, September 2013 Report to Congress	CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered and Directed Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	✓		✓
Actively Involved Primary Care Physician		✓	✓	
Provider Network with Specialized DLTSS Expertise	✓	✓	✓	✓
Integration between Medical & DLTSS Care	✓	✓	✓	✓
Single Point of Contact for person with DLTSS Needs across All Services	✓	✓	✓	
Standardized Assessment Tool	✓	✓		✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services		✓	✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓