



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

Date of meeting: Tuesday, August 12th, 2014; 9:00 AM to 12:00 PM, Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	<p>Nancy Eldridge called the meeting to order at 9:05 and asked for a motion to approve the July meeting minutes. Laural Ruggles moved approval of the July meeting minutes as is, and Dale Hackett seconded the motion. There was no discussion, and Georgia Maheras took a role call vote. The motion passed unanimously.</p>	
2. Co-Chairs Update	<p>As part of the co-chair update, Nancy indicated that the problem statement was included as Attachment 2 in the meeting handouts. Nancy noted that the group requested that the reference to the Office of Quality and Care Management be removed from the definition of Care Management. Staff will make that change and ensure that all previous feedback is incorporated. An updated version reflecting this edit and any others will be distributed to the work group.</p>	
3. Response to Questions on Integrated Community Learning Collaborative	<p>Nancy reviewed Attachment 3: <i>Memo re Response to Questions on Integrated Community Learning Collaborative</i>, and indicated that this memo offers a summary of questions and comments received by work group members and others since the learning collaborative planning group presented its proposal at last month's in-person meeting, as well as responses to the questions offered by the planning group. Nancy opened up the floor to further questions/comments, and the discussion proceeded as follows:</p> <ul style="list-style-type: none"> • Dale Hackett asked the following series of questions: Can the learning collaborative operate effectively within Medicaid as well as ACOs? How will the learning collaborative incorporate best practices? How will best practices be embraced at the community level? Pat Jones responded by 	

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	<p>saying that this learning collaborative is an effort to break some new ground by looking at the best ways to integrate care management services at the community level. The planning group has reviewed the literature around best practices in this area, including team based care, shared plans of care, integrated communities, etc. That said we are trying to test models that don't have a great deal of research and application to date. Laural Ruggles also added that she thinks it is good to start with something that is proven, but then you have to adapt it to fit the needs of your community. It is important to have the freedom to innovate based on the needs of the community.</p> <ul style="list-style-type: none"> Pat Jones also shared a question that Dale had previously posed to the group, related to what field support (if any) will be offered through the learning collaborative to support people and participants at the community level. Pat noted that although the planning group explored opportunities to participate in national learning collaboratives in this arena, the decision was made to build local capacity internally within Vermont so that these resources can be utilized beyond the time frame of the learning collaborative. Moreover, additional field support will be offered to the pilot communities via the facilitators that will be hired to support the collaborative. Pat also indicated that those who voted on this proposal at the August 6 VHCIP Steering Committee unanimously agreed to recommend the funding. 	
<p>4. Summary of Care Management Inventory Survey Responses</p>	<p>Nancy summarized the number of responses to the care management inventory survey and introduced Christine Hughes from Bailit Health Purchasing to review Attachment 4, <i>Care Management Survey Responses, Summary Presentation</i>. Christine reviewed the power point presentation, which is focused on the first six questions of the survey, and offers information on who the respondents are, where they are providing services, and what services are being provided. Additional information on the survey results will be presented at the September in-person meeting. Discussion of the presentation ensued, including the following comments/questions:</p> <ul style="list-style-type: none"> Joyce Gallimore noted that regarding respondent categorization, Blueprint community health teams often cross over with FQHC activities. She noted that no change is necessary in the categorization, but she agrees that there is a certain degree of overlap amongst the respondent categories. Regarding slide 10, Dale asked if there would be confusion regarding the categorization of DVHA (VCCI's) response, as DVHA could be categorized as a state agency or a payer. Pat responded that because VCCI operates like a health plan care management program, in this case it should be categorized as a payer. Regarding slide 17, Pat noted that there is an error in the figure for the number of organizations that responded, and that the correct number should be 3. Dale Hackett asked what is included in the definition of special services management. Pat referenced 	

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	<p>the definition provided to survey respondents as indicated on slide 12 and noted that we tried to define the categories so that the same person wouldn't end up in multiple categories. For purposes of the survey, special services is meant to describe services for people who need ongoing special services for an undefined period of time.</p> <ul style="list-style-type: none"> • Pat reminded the group that this particular presentation is focused on the demographics of the survey and who responded. Next month we will bring more information, and ultimately a detailed analysis of the survey will be incorporated into a report that will be shared with the work group. • Steve Dickens asked if the group would be able to access information regarding, for example, how individual health plans responded to the questions. Michael Bailit noted that it may also be interesting to look at these results from a consumer centric point of view; for example, how do consumers view the services they are receiving? Perhaps a qualitative consumer survey could be utilized to sample consumers who are served by one or more of these programs to get a sense of how many care managers they are interacting with, and for which types of services. Pat noted that the learning collaborative may offer an opportunity to better gauge the consumer perspective. Georgia Maheras also indicated that the state fields multiple consumer surveys that we could use to get a sense of this information. Marge Houy observed that the data shows some interesting opportunities for cross-organization collaboration. 	
<p>5. DLTSS Work Group Presentation: Proposed DLTSS Model of Care</p>	<p>Nancy introduced Deborah Lisi-Baker, co-chair of the Disability and Long Term Services and Supports (DLTSS) work group, and Susan Besio of PHPG, consultant to the DLTSS work group, to present Attachment 5, <i>Proposed DLTSS Model of Care Presentation</i>. Deborah began the presentation by noting that it includes “core elements” of a care model that can be utilized across diverse settings and populations, and that it incorporates best practices on many levels. It is applicable to all settings and populations, and is not specific to just the DLTSS population. Furthermore, the model includes elements of person centered planning, decision making tools, consumer involvement, and a collaborative team model. The systems and practices should be applicable for people of all backgrounds, institutional and non-institutional settings. The model highlights the importance of working across and collaborating amongst all settings and sectors.</p> <p>Deborah then turned the presentation over to Susan who reviewed the slides in more detail. Discussion of the presentation ensued, and the following comments/questions were raised:</p> <ul style="list-style-type: none"> • Laural Ruggles commented that she likes how the presentation focuses on core elements that can be broadly applicable, as we don't want to create more silos by grouping people into models. It's good that the elements can be applied across populations. She then asked how many people might be falling through the cracks (e.g., those who could benefit from care management but are not connected to a care manager in any way). Susan responded that when a similar analysis was done in 	

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	<p>preparation for the duals demonstration, 1/3 of the 22,000 dual eligible population was not receiving care management (roughly 7,500 individuals). If we extrapolate that figure to the broader Medicaid population receiving DLTSS services, 1/3 could be roughly 12,000 people. This is only a proxy as the analysis has not been done. Furthermore, Susan noted that people enrolled in commercial plans and Medicare aren't necessarily receiving the full spectrum of services that they need, because these services aren't always covered.</p> <ul style="list-style-type: none"> • Deborah commented that people's health is constantly changing and they can move in and out of needing particular services. Steve Dickens agreed, and further commented that there are many people who have been functioning with disabilities for a long time, but then something happens and their needs change. It is important to capture those evolving needs as soon as possible. The PCP's office is a good place to start, but there may be other potential venues. • Susan noted that the single point of contact is key so that the needs of the individual can be followed over time. She noted that CHTs can be focused on short term interventions, and asked if they could be the single point of contact on an ongoing basis. Laural responded that it depends on who is involved. They don't typically function as case managers, but they are able to find the right person. There are no eligibility criteria for CHT services, and CHTs know how to access resources that are available for people and can direct them to those resources. Laural also noted that the integrated care plan is hard given current HIT infrastructure. Although we may not be there electronically, care plans could be shared on paper in the interim. • Marlys Waller asked about people who want to manage their own services as an individual or family but don't have adequate resources. Deborah noted that the goal is not to give people more coordination than they want. The single point of contact could work behind the scenes to avoid the need for individuals and families to interact with so many people. • Mary Moulton commented that in Washington County the CRT population is slightly over 300 and about 130 (1/3) needed a PCP and/or more coordination. About 15% of those served on an outpatient basis have not seen a PCP in the last year. They decided to shift care coordination to the person that the patient thinks is the best fit. Washington County is trying this model out, and they recognize that there are HIT challenges. Whatever approach it is, it needs to be team based. She also noted that these services could take more time than a care manager has, and asked how it could be funded. Susan responded that the Medicaid health home program could be an option, which offers 90/10 funding for 8 quarters, and offers funding on an ongoing basis for "health home services". Additional research needs to be done to explore the feasibility of this option moving forward. Another funding opportunity was identified via the federal Mental Health Act adopted earlier this year, but this will take some time to unfold. It would potentially be a one year planning grant, but full funding would not be available until 2017. • Jenney Samuelson commented that CHTs have staff embedded in PCPs who are doing long term 	

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	<p>management, as well as doing assessments to connect patients with specialized services. Furthermore, she commented that regarding the joint care plan, if the family is acting as their own single point of contact, they need to share their care plan with someone so the providers can be aware and help coordinate on their behalf.</p> <ul style="list-style-type: none"> • Dale Hackett commented that we don't have a sense of how much money we are spending on care coordination right now, so it is difficult to know how much more we would spend. He also noted that this model may be challenging to people and may cause discomfort, but that doesn't mean it isn't the right thing. 	
<p>6. Proposed Process for Developing Care Management Standards</p>	<p>Nancy Eldridge introduced this agenda item by drawing the group's attention to Attachment 6, <i>Timeline re Proposed Process for Developing Care Management Standards</i>. She explained that the staff and co-chairs suggest that we bifurcate the development of the aspirational standards with operationalizing and assessing compliance with the standards. At the next meeting, staff, co-chairs and consultants will bring broad care management principles for work group consideration. A smaller working group would be utilized in the future to better understand implementation and compliance needs.</p> <p>Discussion ensued and the following comments/questions were posed:</p> <ul style="list-style-type: none"> • Madeleine Mongan commented that the NCQA standards are a nationally recognized source, but she wondered about the source of recognition for the other standards. Erin noted that slide 15 of the DLTSS model of care presentation offers sources for those best practice elements contained within. Madeleine asked if those sources could be distributed to the work group, and Susan Besio noted that she will pull those documents together for distribution. • Jenney Samuelson asked how we will reflect updates to the NCQA standards as they are generally updated from time to time. Georgia responded that just as with many other elements of the ACO programmatic standards, we will have an opportunity to reflect on needed updates on a periodic (perhaps annual) basis. • Pat reminded the group that in the case of the NCQA standards, we are looking at the ACO Level standards, although they do build on elements of the PCMH standards. The intent is not to include excessive detail or to require all care management activities to be centralized at the ACO. Rather, the approach so far is to indicate that the ACO should ensure that certain care management standards are met, either by the ACO or by its participating providers. 	

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7. Next Steps, Wrap-Up and Future Meeting Schedule	Next Meeting: <i>Tuesday September 9th, 10:00 am – 12:00 pm, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier</i>	

VHCIP CMCM Work Group Attendance Sheet 8-12-14

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

	First Name	Last Name	Title	Organization	Care Models	
1	Peter	Albert		Blue Cross Blue Shield of Vermont	X	
2	April	Allen	Director of Policy and Planning	AHS - DCF	MA	
3	Ena	Backus		GMCB	X	
4	Melissa	Bailey	<i>Melissa Bailey Dir of operations + Clinical Services</i>	Otter Creek Associates and Matrix Health	X	
5	Michael	Baillit	<i>phone</i>	Baillit-Health Purchasing	X	
6	Susan	Barrett	Executive Director	GMCB	X	
7	Susan	Besio	<i>here</i>	Pacific Health Policy Group	X	
8	Charlie	Biss		AHS - Central Office - IFS	X	
9	Beverly	Boget			X	
10	Heather	Bollman	VCCI Clinical Manager	AHS - DVHA	X	
11	Mary Lou	Bolt		Rutland Regional Medical Center	X	
12	Nancy	Breiden	DLP Director	VLA/Disability Law Project	M	
13	Stephen	Broer	Director - Behavioral Health Services	Northwest Counseling and Support Service	X	
14	Martha	Buck		Vermont Association of Hospital and Health Care	A	
15	Dr. Dee	Burroughs-Biron	Health Services Director	Vermont Department of Corrections	M	
16	Nick	Carter	VT Public Policy	Planned Parenthood of Northern New England	X	
17	Jane	Catton	COO/CNO	Northwestern Medical Center	X	
18	Amanda	Ciecior	Health Policy Analyst	AHS - DVHA	S	
19	Barbara	Cimaglio	Deputy Commissioner	AHS - VDH	M	
20	Ron	Cioffi	CEO	Rutland Area Visiting Nurse Association & Hospice	M	
21	Amy	Coonradt	<i>here</i>	Health Policy Analyst	AHS - DVHA	X
22	Amy	Cooper	Executive Director	Accountable Care Coalition of the Green Mountains	M	
23	Maura	Crandall	<i>phone</i>	OneCare Vermont	MA	
24	Dana	Demartino	Health Coordinator	Central Vermont Medical Center	M	
25	Steve	Dickens	<i>here</i>	Voc-Rehab Employee Assist.	AHS - DAIL	X
26	Nancy	Eldridge	<i>here</i>	Executive Director	Cathedral Square and SASH Program	C/M
27	Cameron	Erickson		MVP Health Care	MA	
28	Trudee	Ettlinger		Vermont Department of Corrections	MA	
29	Pamela	Farnham		Fletcher Allen Health Care	M	

30	Erin	Flynn	<i>here</i>	Health Policy Analyst	AHS - DVHA	S
31	Aaron	French		Deputy Commissioner	AHS - DVHA	X
32	Meagan	Gallagher		VP of Business Operations	Planned Parenthood of Northern New En	X
33	Joyce	Gallimore	<i>phone</i>	Director, Community Health Paymen	Bi-State Primary Care/CHAC	MA/M
34	Lucie	Garand	<i>Deborah</i>	Senior Government Relations Special	Downs Rachlin Martin PLLC	X
35	Christine	Geiler		Grant Manager & Stakeholder Coord	GMCB	S
36	Eileen	Girling		Director	AHS - DVHA	M
37	Kelly	Gordon		Project and Operations Director	AHS - DVHA	X
38	Bea	Grause	<i>Deborah</i>	President	Vermont Association of Hospital and Hea	C/M
39	Dale	Hackett		Consumer Advocate	None	M
40	Bryan	Hallett				X
41	Selina	Hickman		Policy Director	AHS - DVHA	X
42	Bard	Hill		Director - Policy, Planning & Data Un	AHS - DAIL	X
43	Breena	Holmes			AHS - Central Office - IFS	X
44	Marge	Houy	<i>phone</i>		Bailit-Health Purchasing	X
45	Christine	Hughes	<i>phone</i>		Bailit-Health Purchasing	X
46	Linda	Johnson	<i>Deborah from My P on phone</i>		MVP Health Care	M
47	Pat	Jones	<i>Pat Jones</i>		GMCB	S/M
48	Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	M
49	Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
50	Patricia	Launer		Clinical Quality Improvement Facilita	Bi-State Primary Care	M
51	Diane	Leach		VP Quality	Northwestern Medical Center	X
52	Suzanne	Leavitt		Director Quality Choices for Care	AHS - DAIL	X
53	Diane	Lewis			AOA - DFR	A
54	Deborah	Lisi-Baker	<i>here</i>	Disability Policy Expert	Unknown	X
55	Vicki	Loner		Director of Quality and Care Manage	OneCare Vermont	M
56	Georgia	Maheras	<i>here</i>		AOA	S
57	David	Martini			AOA - DFR	M
58	Mike	Maslack				X
59	John	Matulis				X
60	James	Mauro			Blue Cross Blue Shield of Vermont	X
61	Marybeth	McCaffrey		Principal Health Reform Administrato	AHS - DAIL	X
62	Clare	McFadden		Senior Specialized Services Superviso	AHS - DAIL	M
63	Elise	McKenna		Project Manager	AHS - DVHA - Blueprint	X
64	Jill	McKenzie	<i>phone</i>			X
65	Jeanne	McLaughlin			Visiting Nurse Association & Hospice of V	M
66	Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
67	Darcy	McPherson		Program Technician	AHS - DVHA	A

68	Madeleine	Mongan	<i>M. A. Mongan</i>	Deputy Executive Vice President	Vermont Medical Society	M
69	Judy	Morton	<i>phone</i>		Mountain View Center	M
70	Mary	Moulton	<i>phone</i>	CEO	Washington County Mental Health Service	M
71	Kirsten	Murphy			AHS - Central Office - DDC	X
72	Reeva	Murphy			AHS - Central Office - IFS	X
73	Sarah	Narkewicz			Rutland Regional Medical Center	X
74	Jessica	Oski			Sirotkin & Necrason	MA
75	Annie	Paumgarten	<i>Anne Paumgarten</i>	Evaluation Director	GMCB	X
76	Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
77	Betty	Rambur		Board Member	GMCB	X
78	Allan	Ramsay		Board Member	GMCB	X
79	Helen	Reid			Planned Parenthood of Northern New England	X
80	Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green Mountains	M
81	Debra	Repice		Manager - Population Health	MVP Health Care	X
82	Julie	Riffon			North Country Hospital	X
83	Laural	Ruggles	<i>here</i>	Marketing/Development Director	Northeastern Vermont Regional Hospital	M
84	Jenney	Samuelson	<i>here</i>	Assistant Director of Blueprint for Health	AHS - DVHA - Blueprint	X
85	Jessica	Sattler			Accountable Care Transitions, Inc.	X
86	Rachel	Seelig	<i>here</i>	Attorney	VLA/Senior Citizens Law Project	MA
87	Maureen	Shattuck			Springfield Medical Care Systems	X
88	Julia	Shaw	<i>here</i>	Health Care Policy Analyst	VLA/Health Care Advocate Project	MA
89	Catherine	Simonson		Director of Child, Youth & Family Services	HowardCenter for Mental Health	M
90	Tom	Simpatico			AHS - DVHA	X
91	Patricia	Singer	<i>Seen</i>	Adult Service Utilization Director	AHS - DMH	M
92	Shawn	Skaflestad		Quality Improvement Manager	AHS - Central Office	M
93	Richard	Slusky		Payment Reform Director	GMCB	MA
94	Pam	Smart			Northern Vermont Regional Hospital	X
95	Audrey-Ann	Spence			Blue Cross Blue Shield of Vermont	M
96	Kara	Suter		Reimbursement Director	AHS - DVHA	X
97	Beth	Tanzman		Assistant Director of Blueprint for Health	AHS - DVHA - Blueprint	X
98	Emily	Therrien		HCO Administrative Coordinator	Planned Parenthood of Northern New England	A
99	Win	Turner				X
100	Lisa	Viles		Executive Director	Area Agency on Aging for Northeastern Vermont	M
101	Anyia	Wallack		Chair	SIM Core Team Chair	X
102	Marlys	Waller	<i>here</i>		Vermont Council of Developmental and Disabilities	X
103	Julie	Wasserman	<i>here</i>	VT Dual Eligible Project Director	AHS - Central Office	X
104	Dawn	Weening			AHS - DVHA	MA
105	Robert	Wheeler	<i>phone</i>	Vice President & CMO	Blue Cross Blue Shield of Vermont	MA

106	Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
107	Jason	Wolstenholme			MoveWell Spine & Sport	M
108	Jennifer	Woodard	<i>here</i>	Long-Term Services and Supports He	AHS - DAIL	X
109	Cecelia	Wu	<i>here</i>	Healthcare Project Director	AHS - DVHA	X
110	Dave	Yacovone		Commissioner	AHS - DCF	M
	<i>KATHY</i>	<i>HENTLEY</i>		<i>MI & HC INTER. DIR</i>	<i>D MI</i>	

CMCM

minutes ① Laurel
② Dale

VHCIP CMCM Work Group Roll Call

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate

First Name	Last Name		Title	Organization	Care Models
Amy	Cooper	n/A	Executive Director	Accountable Care Coalition of the Green	M
Paul	Reiss	n/A	Executive Director,	Accountable Care Coalition of the Green	M
Shawn	Skaflestad	✓	Quality Improvement Manager	AHS - Central Office	M
Clare	McFadden	n/A	Senior Specialized Services Supervisor	AHS - DAIL	M
April	Allen	n/A	Director of Policy and Planning	AHS - DCF	MA
Dave	Yacovone	n/A	Commissioner	AHS - DCF	M
Patricia	Singer	n/A	Adult Service Utilization Director	AHS - DMH	M
Eileen	Girling	n/A	Director	AHS - DVHA	M
Dawn	Weening	n/A		AHS - DVHA	MA
Barbara	Cimaglio	n/A	Deputy Commissioner	AHS - VDH	M
David	Martini	n/A		AOA - DFR	M
Lisa	Viles	n/A	Executive Director	Area Agency on Aging for Northeastern V	M
Patricia	Launer	n/A	Clinical Quality Improvement Facilita	Bi-State Primary Care	M
Joyce	Gallimore	✓	Director, Community Health Paymen	Bi-State Primary Care/CHAC	MA/M
Audrey-Ann	Spence	n/A		Blue Cross Blue Shield of Vermont	M
Robert	Wheeler	✓	Vice President & CMO	Blue Cross Blue Shield of Vermont	MA
Nancy	Eldridge	✓	Executive Director	Cathedral Square and SASH Program	C/M
Dana	Demartino	n/A	Health Coordinator	Central Vermont Medical Center	M
Pamela	Farnham	n/A		Fletcher Allen Health Care	M
Pat	Jones	✓		GMCB	S/M
Richard	Slusky		Payment Reform Director	GMCB	MA
Catherine	Simonson	n/A	Director of Child, Youth & Family Ser	HowardCenter for Mental Health	M
Judy	Morton	✓		Mountain View Center	M
Jason	Wolstenholme	n/A		MoveWell Spine & Sport	M
Cameron	Erickson	n/A		MVP Health Care	MA
Linda	Johnson	n/A		MVP Health Care	M
Dale	Hackett	✓	Consumer Advocate	None	M
Laurel	Ruggles	✓	Marketing/Development Director	Northeastern Vermont Regional Hospital	M
Maura	Crandall	✓		OneCare Vermont	MA

Viola	Ehler		Director of Quality and Care Manager	OneCare Vermont	M
Ron	Cioffi	n/A	CEO	Rutland Area Visiting Nurse Association &	M
Jessica	Oski	n/A		Sirotkin & Necrason	MA
Bea	Grause	n/A	President	Vermont Association of Hospital and Health	C/M
Dr. Dee	Burroughs-Biron	n/A	Health Services Director	Vermont Department of Corrections	M
Trudee	Ettlinger	n/A		Vermont Department of Corrections	MA
Madeleine	Mongan	n/A	Deputy Executive Vice President	Vermont Medical Society	M
Jeanne	McLaughlin	n/A		Visiting Nurse Association & Hospice of V	M
Nancy	Breiden	abstain	DLP Director	VLA/Disability Law Project	M
Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	M
Julia	Shaw ✓	abstain	Health Care Policy Analyst	VLA/Health Care Advocate Project	MA
Rachel	Seelig ✓	abstain	Attorney	VLA/Senior Citizens Law Project	MA
Mary	Moulton ✓		CEO	Washington County Mental Health Services	M