

Care Models and Care Management
Work Group Meeting Agenda 9-12-14

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

September 12, 2014; 10:30 AM to 12:30 PM
 4th Floor Conference Room, Pavilion Building, Montpelier, VT
 Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:30 - 10:35	Welcome; Introductions; Approval of Minutes	<u>Attachment 1:</u> July meeting minutes	Yes (approval of minutes)
2	10:35 - 10:45	Co-Chair Update (<i>Bea Grause to serve as meeting facilitator</i>) <i>Public Comment</i>		
3	10:45 - 11:05	Update on Integrated Community Learning Collaborative <i>Public Comment</i>	<u>Attachment 3a:</u> RFP for Quality Improvement Facilitators <u>Attachment 3b:</u> Potential Learning Session Topics	
4	11:05 - 11:50	Care Management Survey Responses <i>Public Comment</i>	<u>Attachment 4:</u> Care Management Survey Responses Presentation (will be sent when available)	
5	11:50 - 12:20	Progress on Draft Care Management Standards <i>Public Comment</i>		
6	12:20 - 12:30	Next Steps, Wrap-Up and Future Meeting Schedule October Meeting Preview: <ul style="list-style-type: none"> • Continue work on proposed Care Management Standards • Presentation from Blueprint and OneCare Vermont 		

Attachment 1 - Care Models and Care
Management Work Group Meeting
Minutes 8-12-14



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

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 	

Agenda Item	Discussion	Next Steps
	<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. 	

Agenda Item	Discussion	Next Steps
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>Deh</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>Annie 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

Vicki	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

Attachment 3a - RFP for
Quality Improvement
Facilitators

1. OVERVIEW

The Department of Vermont Health Access (DHVA), also referred to as the State, are seeking qualified bidders to serve as “quality improvement (QI) facilitators” supporting quality improvement activities in primary care practices, integrated care teams within communities and specialty addictions and mental health programs under both the Blueprint for Health (Blueprint) Division and Vermont Health Care Innovation Project (VHCIP). The Blueprint and VHCIP are working together to develop a learning health system and seamless services for Vermonters.

The State is seeking to procure separate service contracts for the two following initiatives:

BLUEPRINT FOR HEALTH QUALITY IMPROVEMENT PRACTICE FACILITATORS:

The Blueprint for Health is a comprehensive delivery system reform program that has developed payment reforms, a health information technology infrastructure, and an evaluation framework to support the development of advanced primary care practices, regional Community Health Teams, and self-management programs.

VERMONT HEALTH CARE INNOVATION PROJECT QUALITY IMPROVEMENT PRACTICE FACILITATORS:

The VHCIP is a public/private partnership which aims to design and implement health care provider payment and health information technology that supports more effective and efficient care delivery. This project will utilize a \$45 million federal grant awarded by the Centers for Medicaid and Medicare Innovation. VHCIP will provide a forum for coordinating policy and resources to support development of the organizations including technology and financing necessary to achieve the shared public/private goals articulated in our State Health Care Innovation Plan: development of a high performance health care system for Vermont.

SCOPE AND BACKGROUND

Major components of the State’s learning health system include primary care practice transformation; implementation of Integrated Care Teams to provide seamless, well-coordinated, efficient and comprehensive care management services for people in need of such services; and expansion of treatment for substance abuse and co-occurring mental health disorders.

To support the implementation of these components, the Blueprint has developed the Expansion and Quality Improvement Program (EQuIP), a team of trained individuals known as QI facilitators with the skills to help practices, integrated care teams and programs build the capacity to improve care through use of evidence-based guidelines, innovative strategies and quality improvement approaches including data-driven Plan-Do-Study-Act (PDSA) cycles. The State is seeking quality improvement facilitators who will participate in the EQuIP team and implement these components. EQuIP QI facilitators work with multi-disciplinary teams in primary care practices, integrated care communities and specialty substance abuse and mental health treatment programs on implementing and managing continuous quality improvement. Relationships between QI facilitators and practices/integrated care teams /programs are long term and interventions are based on the needs and vision of the practice, integrated care team or organization based on their size, patient population, organizational structure, partnerships with other practices and organizations, community and type of care provided.

Requisition Number: 03410-134-14

Projects undertaken by QI facilitators may include: adopting evidence based guidelines and innovative strategies to improve care; effective use of information technology systems such as clinical registries, electronic medical records systems, the Health Information Exchange, VITLAccess and portals to improve patient care; integration of self-management support, shared decision making, and planned care visits; redefining roles and establishing team-based care within and across organizations; seamlessly connecting with community resources and specialty referrals (for example with the Community Health Team and local community supports and services); and National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition.

QI facilitators also work to disseminate information among practices, integrated care teams and organizations on innovative strategies to achieve improvements in care. This sharing of knowledge and experiences may occur by connecting entities for one-to-one consultation or mentoring, sharing change cycles from one entity with another, or facilitating collaborative learning sessions for groups of practices, integrated care teams and/or programs.

This RFP solicits applications for QI facilitators to serve (under separate contract with the Blueprint or VHCIP) primary care practices and integrated community teams in particular geographic areas, plus a specialized facilitator to support practices/programs across the state and to provide technical assistance to the other facilitators in the provision of evidence-based medication assisted treatment for the complex issues of opioid dependence in primary and specialty care settings. Medication assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance abuse disorders.

Bidders may make a proposal for the general QI facilitator role (at either the practice level or the integrated community team level) or for the specialized addictions facilitator role (specific to the Blueprint).

1.1. TERM OF AGREEMENT**BLUEPRINT FOR HEALTH QUALITY IMPROVEMENT PRACTICE FACILITATORS:**

The contract(s) arising from this RFP shall be for a period of twelve months with an option to renew for two additional twelve-month periods as agreed by both parties.

VERMONT HEALTH CARE INNOVATION PROJECT QUALITY IMPROVEMENT PRACTICE FACILITATORS:

The contract(s) arising from this RFP shall be for a period of twelve months, Contract renewal will depend on the availability of federal funds in subsequent years.

1.2. WORK TIME/LOCATION

The State believes that the effort required to complete the work under this contract will equal up to 40 hours per week and may require early morning and evening activities in addition to the regular business day. The Contractor shall be expected to work in primary care medical practices or practices providing substance abuse treatment within a designated geographic region, in integrated community teams in designated communities, or across the entire state as agreed upon between the Contractor and the State. The Contractors will be geographically distributed to ensure statewide services.



Requisition Number: 03410-134-14

The State currently needs practice facilitator services in the northeast and southeast regions of the state for primary care facilitation and across the state for practices providing substance abuse treatment. The State also needs integrated care team facilitators who could initially develop statewide learning collaboratives for the Burlington, Rutland and St. Johnsbury areas, and potentially for other areas over time.

Regular meetings in a central location in the state and/or community and participation in trainings both within and outside of the state should be anticipated.

1.3. POINTS OF CONTACT

All communications concerning this RFP shall be addressed in writing to the attention of:

BLUEPRINT FOR HEALTH QUALITY IMPROVEMENT PRACTICE FACILITATORS:

Natalie Elvidge
 Contract and Grant Management Specialist
 Department of Vermont Health Access
 312 Hurricane Lane, Suite 201
 Williston, VT 05495-2806
 E-mail: natalie.elvidge@state.vt.us

VERMONT HEALTH CARE INNOVATION PROJECT QUALITY IMPROVEMENT PRACTICE FACILITATORS:

Jessica Mendizabal
 Contract and Grant Administrator
 Department of Vermont Health Access
 312 Hurricane Lane, Suite 201
 Williston, VT 05495-2806
 E-mail: jessica.mendizabal@state.vt.us

1.4. PROCUREMENT TIMETABLE

The RFP procurement schedule is below. The State reserves the right to modify any dates pertinent to this RFP.

BLUEPRINT FOR HEALTH QUALITY IMPROVEMENT PRACTICE FACILITATORS:	
ESTIMATED PROCUREMENT SCHEDULE	DATE
Revised RFP Issued	Wednesday, August 27, 2014
Vendor Questions Due	Ongoing
State's response to questions	Ongoing



Requisition Number: 03410-134-14

Bids Due	This RFP will remain open until filled
Selection Notification	This RFP will remain open until filled
Proposed Start Date for Contract	This RFP will remain open until filled

VERMONT HEALTH CARE INNOVATION PROJECT QUALITY IMPROVEMENT PRACTICE FACILITATORS:	
ESTIMATED PROCUREMENT SCHEDULE	DATE
Revised RFP Issued	Wednesday, August 27, 2014
Vendor Questions Due	Wednesday, September 3 by 2 p.m.
State's response to questions	Monday, September 8, 2014
Bids Due	Wednesday, September 17 by 1 p.m. This RFP will remain open until filled
Selection Notification	Friday, September 26, 2014
Proposed Start Date for Contract	November 15, 2014

Questions and Answers: Any interested party requiring clarification of the content of this RFP or wishing to comment or take exception to any requirements or other portion of the RFP must submit specific questions in writing.

Questions may be e-mailed to the contact persons listed in Section 1.3 of this proposal. Any objection to the RFP or to any provision of the RFP, which is not raised in writing, is waived. A copy of all questions or comments and the State's responses will be posted on the DHVA web site at <http://dvha.vermont.gov/administration/2013-requests-for-proposals> and <http://vermontbusinessregistry.com/>.

Any vendor requiring clarification of any section of this proposal must submit specific questions in writing according to the Schedule listed in Section 1.4. Questions must be e-mailed to the RFP Contact listed Section 1.3 of this proposal. Any question not raised in writing on or before the last day of the initial question period is waived. Responses to the questions sent will be posted on the DHVA web site at <http://dvha.vermont.gov/administration/2013-requests-for-proposals> as well as to the Electronic Bulletin Board <http://vermontbusinessregistry.com/>.

2. ACRONYMS & DEFINITIONS

AHS	Vermont Agency of Human Services
Blueprint	Blueprint for Health
CMS	Centers for Medicare and Medicaid Services
DHVA	Department of Vermont Health Access

Requisition Number: 03410-134-14

HIPAA	Health Insurance Portability and Accountability Act of 1996
MAT	Medication Assisted Treatment
NCQA	National Committee on Quality Assurance
PCMH	Patient Centered Medical Home
PDSA	“Plan-Do-Study-Act” rapid cycle of quality improvement
RFP	Request for Proposal
SFY	State Fiscal Year
State	State of Vermont
VHCIP	Vermont Health Care Innovation Project

3. SCOPE OF WORK AND CONTRACTOR RESPONSIBILITIES**3.1. Role**

QI facilitators provide support to practices and integrated care teams to build capacity to continuously evaluate and implement sustained improvements in evidence based care, including treatment for substance use and co-occurring mental health disorders, and innovative strategies to improve care through increased collaboration. Facilitators will promote an environment of collaborative learning between practices, integrated care teams and programs, and across the health system. Contractor will serve as a Facilitator (1.0 FTE) to coach 8 to 10 primary care practices or practices providing substance abuse treatment, or support one or more Learning Collaboratives involving integrated care teams in pilot communities.

Facilitation requires competencies including implementing quality improvement methods, team facilitation, group dynamics, understanding and using data, and project management.

Generally, Facilitators are expected to meet weekly or bi-weekly with each multi-disciplinary practice/integrated care/program team. Work with practices and integrated care teams will include:

Change Management

- Foster practice, integrated care and program teams’ ownership for improving patient care and changing the way the services are provided.
- Coach the practice or integrated care team in forming a multi-disciplinary quality improvement team.
- Work with the practice /integrated care team/program to assess their performance and establish project goals and parameters.
- Use practice/integrated care team/program level data to assist in establishing sequences and timelines for quality improvement initiatives, and to evaluate the impact of changes.
- Train practice /integrated care/program teams in conducting PDSA cycles/model for improvement.
- Coach the practice/integrated care/program teams in measuring and interpreting results of change.
- Facilitate communication around evolving roles and relationships
- Recognize, reinforce, and celebrate success.
- Provide feedback and coaching for practice/integrated care team/organization leaders.

Technical Assistance and Training

- Identify skills based training needs and work with the State to ensure training occurs.

Requisition Number: 03410-134-14

- Technical assistance in identifying and implementing models of care, innovative strategies and evidence based guidelines including substance abuse and co-occurring mental health conditions.
- Support practice/integrated care/program teams in implementing shared decision making and self-management support.

IT

- Support the practice/integrated care/program teams in using technology to improve patient care and office efficiency.
- As appropriate, assist practice/integrated care/program teams in implementing data collection tools (e.g., clinical registry, care coordination modules, risk stratification tools) and using them to improve panel management, care management, and other aspects of patient care.

Learning Health System

- Foster a shared learning environment through practice-to-practice or organization-to-organization mentoring
- Design and implement collaborative learning sessions.
- Participate in shared learning activities of the EQuIP facilitator group (team meetings, conference calls, training and one-on-one meetings).

Connection with Community

- Support the incorporation of integrated care teams into practice and organization workflow.
- Link practice/integrated care/program teams with outside resources including specialty mental health and addictions treatment providers.

3.2. Reporting

Ongoing documentation and evaluation is required under this contract to include:

- Regular written reports of the progress of practice/integrated care/program teams.
- Documentation of PDSA cycles.
- Monthly reports of overall activities.
- Bi-weekly individual conference calls with EQuIP program director or his/her designee, and other staff as appropriate (2 times monthly).

3.3. Payment Provisions

- The total contract will not exceed \$100,000 per 1.0 FTE.
- The \$100,000 includes all payments that will be made to the contractor to meet the provisions of the contract (personnel costs, benefits, travel expenses, supplies, information technology hardware and software, etc.)

4. PROPOSALS**4.1. GENERAL CONDITIONS & REQUIREMENTS**

Cost of proposal development is the sole responsibility of the bidder.



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All bid proposals and submitted information connected to this RFP may be subject to disclosure under the State's access to public records law. The successful bidder's response will become part of the official contract file. Once the contract is finalized, material associated with its negotiation is a matter of public record except for those materials that are specifically exempted under the law. One such exemption is material that constitutes trade secret, proprietary, or confidential information. If the response includes material that is considered by the bidder to be proprietary and confidential under 1 V.S.A., Ch. 5 Sec. 317, the bidder shall clearly designate the material as such prior to bid submission. The bidder must identify each page or section of the response that it believes is proprietary and confidential and provide a written explanation relating to each marked portion to justify the denial of a public record request should the State receive such a request. The letter must address the proprietary or confidential nature of each marked section, provide the legal authority relied on, and explain the harm that would occur should the material be disclosed. Under no circumstances can the entire response or price information be marked confidential. Responses so marked may not be considered and will be returned to the bidder.

- All proposals shall become the property of the State.
- All public records of DVHA may be disclosed, except that submitted bid documents shall not be released until the Contractor and DVHA have executed the contract. At that time, the unsuccessful bidders may request a copy of their own score sheets as well as request to view the apparently successful bidder's proposal at DVHA Central Office. The name of any Vendor submitting a response shall also be a matter of public record. Other persons or organizations may also make a request at that time or at a later date.
- Consistent with state law, DVHA will not disclose submitted bid documents or RFP records until execution of the contract(s). At that time, upon receipt of a public records request, information about the competitive procurement may be subject to disclosure. DVHA will review the submitted bids and related materials and consider whether those portions specifically marked by a bidder as falling within one of the exceptions of 1 V.S.A., Ch. 5 Sec. 317 are legally exempt. If in DVHA's judgment pages or sections marked as proprietary or confidential are not proprietary or confidential, DVHA will contact the bidder to provide the bidder with an opportunity to prevent the disclosure of those marked portions of its bid.

All bid submissions must contain one original and seven complete copies of the proposal.

All bids must be marked "SEALED BID" and clearly note which of the two facilitator projects the bidder is sending to. If bidders wish to bid on both facilitator projects, they must submit separate bids for each project and address to the respective contact person:

BLUEPRINT FOR HEALTH QUALITY IMPROVEMENT PRACTICE FACILITATORS:

Natalie Elvidge
Contract and Grant Management Specialist
Department of Vermont Health Access
312 Hurricane Lane, Suite 201



Requisition Number: 03410-134-14

Williston, VT 05495-2806
E-mail: natalie.elvidge@state.vt.us

**VERMONT HEALTH CARE INNOVATION PROJECT QUALITY IMPROVEMENT
PRACTICE FACILITATORS:**

Jessica Mendizabal
Contract and Grant Administrator
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2806
E-mail: jessica.mendizabal@state.vt.us

Bid envelopes must be clearly marked with 'SEALED BID – QI Facilitators' and include name of bidder. Hard copy and an electronic copy bid proposals must be received according to the schedule listed in Section 1.4: Procurement Timetable. Hand carried bids must be delivered to a representative of DHVA on or before the due date/time and stamped by a representative with date/time received. Bids not in possession of DHVA identified single point of contact by the due date and time will not be considered and will be returned to the bidder unopened.

Faxed bids will NOT be accepted. Electronic bids will NOT be accepted.

DVHA may, at any time and at its sole discretion and without penalty, reject any and all proposals in any 'catchment' area and issue no contract in that area as a result of this RFP. Furthermore a proposal may be rejected for one or more of the following reasons or for any other reason deemed to be in the best interest of the State:

- The failure of the bidder to adhere to one or more provisions established in this RFP.
- The failure of the bidder to submit required information in the format specified in this RFP.

The failure of the bidder to adhere to generally accepted ethical and professional principles during the RFP process. If a proposal is selected for final consideration, the bidder will be invited to negotiate a Contract.

The State reserves the right to amend the RFP at any time prior to the proposal due date by issuing written addenda. Amendments, addenda, Questions and Answers and any relevant information will be posted at <http://dvha.vermont.gov/administration/2013-requests-for-proposals> and <http://vermontbusinessregistry.com/>, it is the bidders' responsibility to check periodically for such information.

Read all instructions carefully. If you do not comply with any part of this RFP, DVHA may, at its sole option, reject your proposal as non-responsive. DVHA reserves the right to waive any requirements contained in this RFP.

4.2. PROPOSAL FORMAT

To be considered, each bidder must submit a complete response to this RFP including:

- Clearly marked bid to either:
 - **Blueprint for Health Quality Improvement Practice Facilitators**
 - **Vermont Health Care Innovation Project Quality Improvement Practice Facilitators**
- Transmittal Letter
- Description of the bidder's Education and Experience (please address section 4.2.2 below)
- Professional Resume & References
- Financial Proposal

The proposal should be prepared simply and economically providing straightforward, concise descriptions of the bidder's ability to fulfill the requirements of the RFP.

In addition to providing this written material, bidders will participate in an interview with State staff.

4.2.1. Transmittal Letter: To be considered, a proposal must be accompanied by a transmittal letter signed in ink by the bidder.

The transmittal letter must include the following statements:

- RFP terms are accepted
- The price was arrived at without conflict of interest.
- A statement that the bidder agrees to the standard State contract requirements in Attachments C, E and F; which are included under Section 6. Attachments.
- A statement of any limitations on the number of hours, days of the week, or weeks in the year that the bidder would be available to perform the above scope of work.
- A statement of any other considerations or limitations, if any, related to the scope of work the bidder will be expected to perform.
- A statement of any considerations or limitations, if any, related to the geographic or hospital service area that the bidder would be available to service.
- Insurance certificate: As part of the proposal packet the Bidder must provide current certificates of insurance of which may or may not meet the minimum requirements laid out in the section 4 of this document. Any questions a bidder may have concerning the necessary insurance coverage must be raised during the question and answer period set out in section 1.5 of this document. In the absence of a question, and upon contract negotiations the apparently successful bidder must provide a certificate of insurance that meets the minimum coverage specified in section 4 of this document.

In addition, a "bidder information sheet" must be attached to the transmittal letter providing the following information:

- Full name of bidder/individual
- Mailing address
- Street address (for FedEx or other mail delivery service)
- Social Security Number
- Telephone number
- Fax number (if available)

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- E-mail Address

4.2.2. Education & Experience: To qualify to bid on these proposals, bidder must have the following experience and skills:

Clinical Experience and Orientation

Experience –

- Worked in a primary care or specialty clinical practice or other health care or community service setting
- Worked in a practice or organization that provides substance abuse and co-occurring mental health treatment (for addictions and mental health programs).

Skills –

- Knowledge of the terminology and systems used in primary care, other health care or community settings, or practices providing addictions and co-occurring mental health treatment.

Professional Skills

Skills –

- Communicate effectively with diverse professionals within multi-disciplinary primary care teams or community teams
- Identify and manage conflict
- Mediate challenging relationships and divergent viewpoints
- Resilience in the face of complex demands
- Comfort with change and evolution of program priorities
- Recognition of when a facilitator should play a leadership versus a team facilitation role and ability to foster leadership among team members (direct vs. facilitative guidance)

Quality Improvement and Systems Thinking

Skills –

- Recognize the relationship between primary care providers, community service providers, substance abuse treatment and the complex system of healthcare delivery
- Apply change processes and organizational theory to improve patient outcomes and decrease costs
- Mastery of a large area of complex change content, including information about quality improvement methods and tools, the use of data to drive improvement, supporting team development, and patient centered-planned care.

Technology Proficiency

Skills –

- Proficiency in the use of technology to facilitate business processes.
- Adept and able to quickly learn to use new information technology systems and programs.

Effective Utilization of Data to Drive Change

Experience –

- Demonstrated use of data to identify the need for change and to evaluate outcomes.

4.2.3. Professional Resume and References: Bids shall include a professional resume of the bidder/individual who will perform the consultative services. Bids shall also include references as follows:

- A list of three references, including relationship, address and telephone contact number.
- Names of organizations for which you have done related work and contact information for a person at the organization who can speak about your past success including their professional title, address, email address and telephone contact number

4.2.4. Financial Proposal: The financial proposal must include:

- The proposed hourly rate or salary
- The proposed annual cost with itemization for travel, office expenses, insurance and other fringe benefits as relevant.

5. PROPOSAL EVALUATION**5.1. General Evaluation Process**

DHVA will conduct a comprehensive and impartial evaluation of proposals received in response to this RFP.

The following are the components and point system for the evaluation:

Evaluation of RFP Minimum Requirements (Pass or Fail)	0 points
Evaluation of the Bidder's Education & Experience	20 points
Evaluation of Bidder's References	20 points
Evaluation of Bidder's Interview	50 points
Evaluation of Financial Proposals	10 points
Ranking of Proposals	0 points

5.1.1. Minimum Requirements: Each proposal will be reviewed to ensure it is sufficiently responsive to the RFP to allow a complete evaluation. Failure to comply with the instructions to bidders shall deem the proposal non-responsive and subject to rejection without further consideration. The DHVA reserves the right to waive minor irregularities.

Proposals will be deemed to have either passed or failed the Minimum Requirements. The State reserves the right to reject any and all proposals.

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5.1.2. Evaluation of the Bidder's Education & Experience and References: Only those proposals passing minimum requirements will be considered.

DHVA will evaluate the education and experience of the bidder. DHVA will determine to what extent the bidder has the capabilities to take on the additional workload to be generated by the resulting Contract. References will be checked.

5.1.3. Evaluation of the Financial Proposals: The financial proposal will be examined to determine if it meets requirements and is consistent with industry pricing.

Any pricing proposal that is incomplete, exceeds \$100,000 per year, 1.0 per full time equivalent or in which there are significant inconsistencies or inaccuracies may be rejected by the State.

5.1.4. Ranking of Proposals: After the proposals have been rated, awarded points will be totaled to determine proposal rankings.

5.2. Award

Award will be made in the best interest of the state. The State's fundamental commitment is to contract for results and "best value". This RFP primarily describes the State's requirements and desired results. "Best value" is the optimum combination of economy and quality that is the result of fair, efficient, and practical business processes that meet the requirements and the State's desired results as set forth in this RFP.

6. ATTACHMENTS

- 6.1. Certificate of Compliance
- 6.2. Attachment C: State Customary Provisions for Contracts (revised: 11/7/2012)
- 6.3. Attachment E: Business Associate Agreement (revised: 9/21/13)
- 6.4. Attachment F: AHS Customary Contract Provisions (revised: 12/10/10)

Attachment 3b - Potential Learning Session Topics

Potential Learning Session Topics for Care Management Learning Collaborative

Topics Currently Under Consideration:

(Note: The planning group is looking for work group feedback regarding edits to this list, including any suggestions for additional topics)

- Orientation to Learning Collaborative, what goals are we trying to achieve?
- Quality Improvement/Learning Collaborative Process (PDSA)
- Establishing Integrated Communities/Medical Neighborhoods
- Understanding Data Sources and Using Them Effectively
 - Panel Management
- Identifying a Lead Care Coordinator
- Designing, Implementing and Communicating Shared Plans of Care
- Transitions in Care: Handoffs, Timing, Communication
 - Care Conference as a Care Planning Strategy
 - Care Management Rounds and Other Communication Strategies
- Person-Directed Care
 - Engaging People Needing Care Management Services and Their Caregivers
 - Motivational Interviewing
- Creating Effective Team-Based Care/Strategies for Developing:
 - Shared goals
 - Clear Roles
 - Mutual Trust
 - Effective Communication
 - Measurable Processes and Outcomes
- Addressing Social Determinants of Health
 - Housing, food, money, culture, etc. How Does a Care Manager Address These?
- Core Competencies/Tools for Care Managers

Attachment 4 - Care Management Survey Results Presentation

CMCM Survey Analysis Part 1

August 12, 2014

Christine Hughes

Senior Consultant, Bailit Health Purchasing

Number and Type of Responding Organizations

Type of Organization	Number of Respondents
ACO	2
Blueprint Community Health Team	11
Health Plan	3
State Agency	3
Community Service Provider	14
Health Care Provider	9
Other	0
Total	42

Note: All who responded “Other” were re-categorized as shown on slides that follow.

Responding Organizations: ACOs

Organization Name	Contact Person Name
ACCGM	Jill McKenzie
OneCare Vermont	Vicki Loner

Note: Vermont's third ACO, Community Health Accountable Care (CHAC), elected to have its member providers respond on its behalf, rather than developing one aggregated ACO response. The FQHCs that responded were categorized as Health Care Providers.

Responding Organizations: Blueprint Community Health Teams

Organization Name	Contact Person Name
Barre HSA Community Health Team	Patrick Clark
Brattleboro Memorial Hospital Community Health Team	Wendy Cornwell
CHT for Rutland County HSA	Mary Lou Bolt
Fletcher Allen Health Care	Pam Farnham
Gifford Medical Center	LaRae Francis
Mt. Ascutney Hospital and Health Center	Jill Lord, RN
North Country Hospital Blueprint HSA	Julie Riffon
Springfield Medical Care Systems	Joshua Dufresne
St Albans HSA Blueprint Program	Candace Collins
Bennington Hospital Service Area/United Health Alliance	Dana Noble
VT Blueprint for Health Middlebury HSA	Susan Bruce

Responding Organizations: Community Service Providers

Organization Name	Contact Person Name
Cathedral Square/SASH	Nancy Eldridge
Champlain Community Services	Elizabeth Sightler
Counseling Service of Addison County	Robert Thorn
Families First	Julie Cunningham, LICSW
Healthcare and Rehabilitation Services of Southeastern Vermont (HCRS)	Alice Bradeen
HowardCenter	Catherine Simonson
Lamoille County Mental Health Services	Jennifer Stratton
Lincoln Street Inc.	Cheryl Thrall Executive Director
Northwestern Counseling & Support Services	Amy Putnam
United Counseling Service	Ralph Provenza
Upper Valley Services	William Ashe
Washington County Mental Health Services	Mary Moulton
Clara Martin Center	Melanie Gidney
Community Care Network/Rutland Mental Health Services	Daniel Quinn

Responding Organizations: Health Care Providers

Organization Name	Contact Person Name
Community Health Centers of Burlington	Jonathan Bowley
Community Health Services of Lamoille Valley	Corey Perpall
Invest EAP / VTHealthEngage	Steve Dickens
Little Rivers Health Care, Inc.	Gail Auclair
Mountain Health Center	Martha
Mountain View Center	Judy Morton
Northeastern Vermont Regional Hospital	Laural Ruggles
Northern Tier Centers for Health (NoTCH)	Unknown
Otter Creek Associates and Matrix Health Systems	Melissa Bailey

Responding Organizations: Health Plans

Organization Name	Contact Person Name
BCBSVT	Audrey Spence
DVHA/VCCI	Eileen Girling
MVP Health Care	Linda Johnson, Director Population Health Management

Responding Organizations: State Agencies

Organization Name	Contact Person Name
Vermont Department of Health - Alcohol and Drug Abuse Programs	Kerrie Taylor
Ladies First: Breast and Cervical Cancer and Heart Health Screening Program	Nicole Lukas
Vermont Department of Disabilities, Aging and Independent Living (DAIL)	Jen Woodard

Changes to Categorization of Organization Type (1 of 2)

Organization Name	Contact Name	Identified 'Org Type' by Organizations	Changed 'Org Type' for Consistency in the Analysis
Cathedral Square/SASH	Nancy Eldridge	Other	Community Service Provider
Champlain Community Services	Elizabeth Sightler	Other	Community Service Provider
HowardCenter	Catherine Simonson	Other	Community Service Provider
Northwestern Counseling & Support Services	Amy Putnam	Other	Community Service Provider
Northeastern Vermont Regional Hospital	Laural Ruggles	Other	Health Care Provider

Changes to Categorization of Organization Type (2 of 2)

Organization Name	Contact Name	Identified 'Org Type' by Organizations	Changed 'Org Type' for Consistency in the Analysis
Otter Creek Associates and Matrix Health Systems	Melissa Bailey	Other	Health Care Provider
DVHA/VCCI	Eileen Girling	Community Service Provider	Health Plan
Vermont Department of Health - Alcohol and Drug Abuse Programs	Kerrie Taylor	Community Service Provider	State Agency
Ladies First: Breast and Cervical Cancer and Heart Health Screening Program	Nicole Lukas	Health Plan	State Agency

Responding Organizations by Geographic Area

County	# of Organizations	% of Responses
Statewide	13	31%
Addison County	6	14%
Bennington County	4	10%
Caledonia County	2	5%
Chittenden County	4	10%
Essex County	2	5%
Franklin County	4	10%
Grand Isle County	2	5%
Lamoille County	2	5%
Orange County	7	17%
Orleans County	1	2%
Rutland County	4	10%
Washington County	6	14%
Windham County	5	12%
Windsor County	6	14%

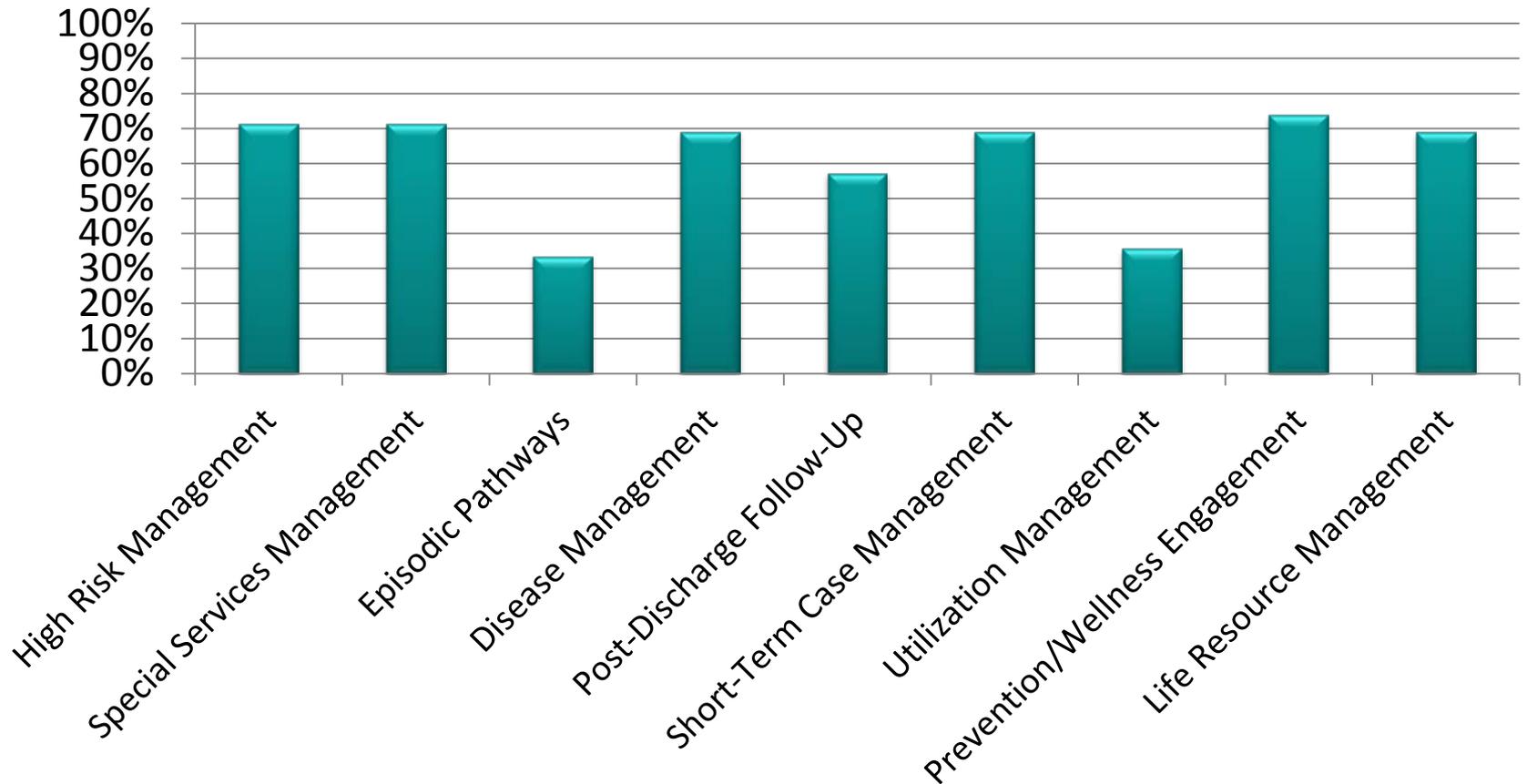
Care Management (CM) Services Definitions

- **High Risk Management** is the deliberate organization of care activities for high risk individuals, designed to improve their health status and reduce the need for expensive services. High risk people may include individuals experiencing serious illness, high utilization of health care services and/or transitions in care (e.g., changes in setting, service, practitioner, or level of care).
- **Special Services Management** is the deliberate organization of care activities for a specified population requiring ongoing management (other than high risk individuals and those receiving disease management services), for an undetermined time frame. Examples of specified populations include people with mental health or substance abuse needs, and children with special health needs.
- **Episodic Pathways** are standardized care processes used to promote organized and efficient care based on evidence-based practice for a specific group of individuals with a condition that is characterized by a predictable clinical course with a limited time frame (e.g. pregnancy, joint replacements). The interventions involved in the evidence-based practice are defined, optimized and sequenced; they are also known as clinical pathways, care pathways, critical pathways, integrated care pathways, or care maps.
- **Disease Management** is a system of coordinated interventions and communications for specific groups of people with chronic conditions for which self-care efforts can have significant impact. Disease management supports the practitioner/person relationship, development of a plan of care, and prevention of exacerbations and complications. It is characterized by evidence-based practice guidelines and strategies that empower people.

CM Services Definitions (Continued)

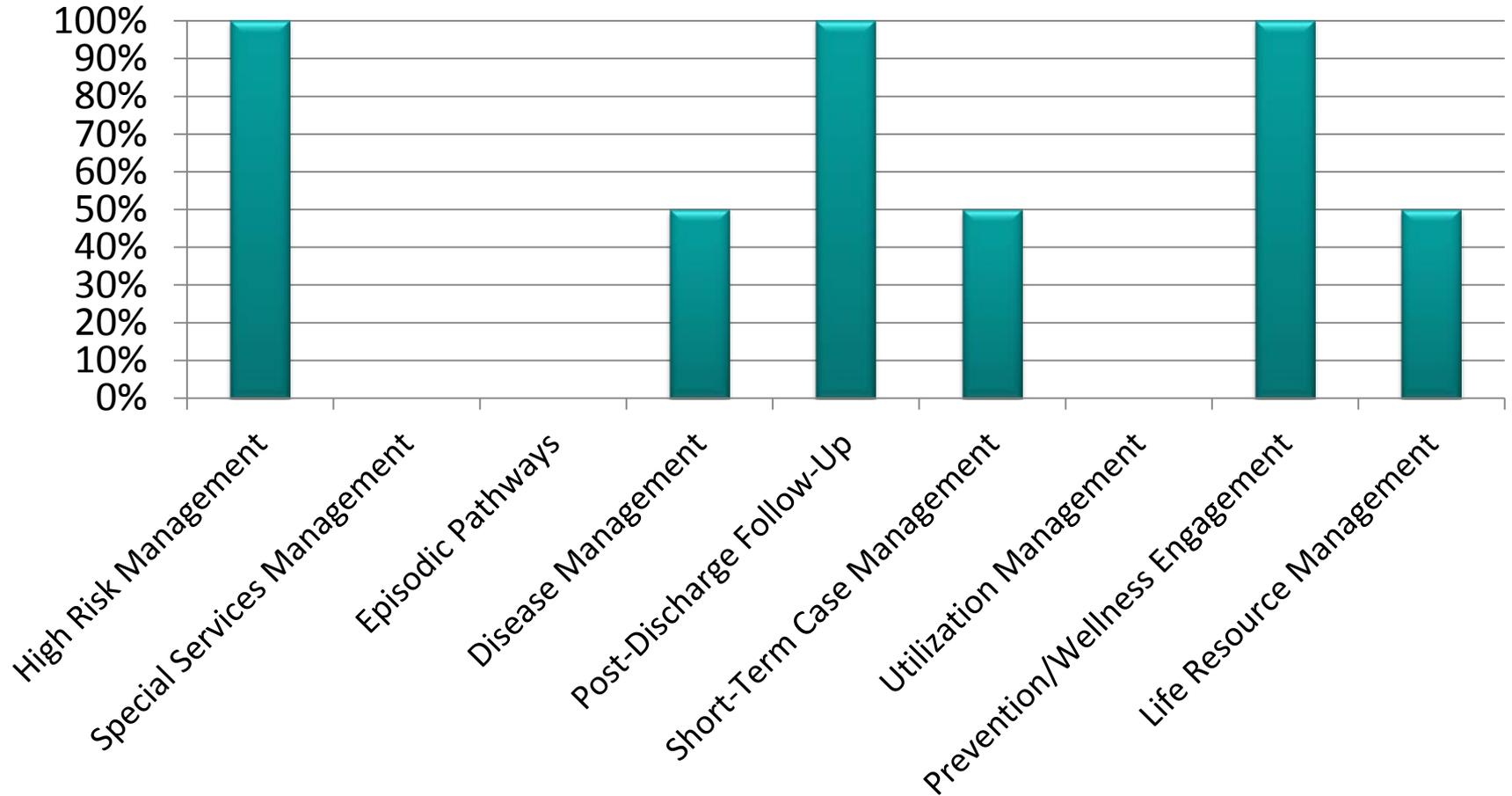
- **Post-Discharge Follow-Up** consists of a phone call or visit to discharged individuals within 48 to 72 hours of their departure from a care facility. The purpose is to ask about the individual's condition, adherence to and understanding of medication orders and other treatment orders, general understanding of his or her condition, and intent to attend follow-up appointments. Post-discharge follow-up is for individuals other than those served by High Risk Care Coordination, Special Services Care Coordination, Episodic Pathways, or Disease Management.
- **Short-Term Case Management Programs** are targeted and short term (30-60 days maximum) interventions with the goals of empowering individuals to better understand their illnesses and manage their own conditions, and coordinating care between individuals, providers and the community.
- **Utilization Management** is the set of organizational functions and related policies, procedures, criteria, standards, protocols and measures to ensure appropriate access to and management of the quality and cost of health care services provided to health plan members or other populations.
- **Prevention/Wellness Engagement activities** are interventions designed to increase engagement and activation and promote positive behavior across populations, such as obtaining preventive care, exercising regularly, and modifying dietary habits. These activities may draw on the principles of positive psychology and the practices of motivational interviewing and goal setting (e.g., health coaching).
- **Life Resource Management** involves providing resources and counseling to help mitigate acute and chronic life stressors; and may include health care as well as social and/or community services.

Percent of All Responding Organizations Providing CM Services By Type of Service



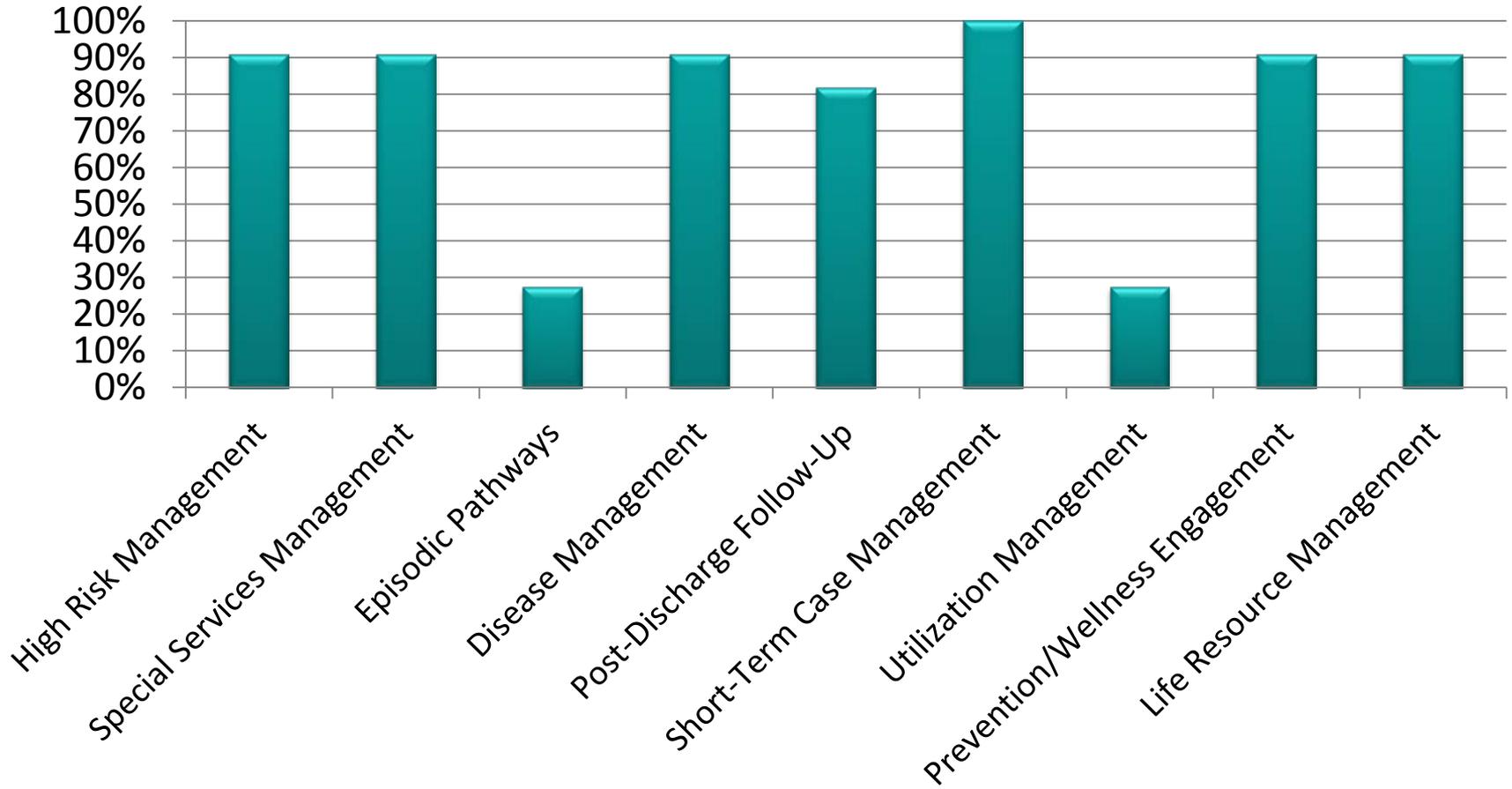
Number of Respondents: 42

Percent of ACOs Providing CM Services By Type of Service



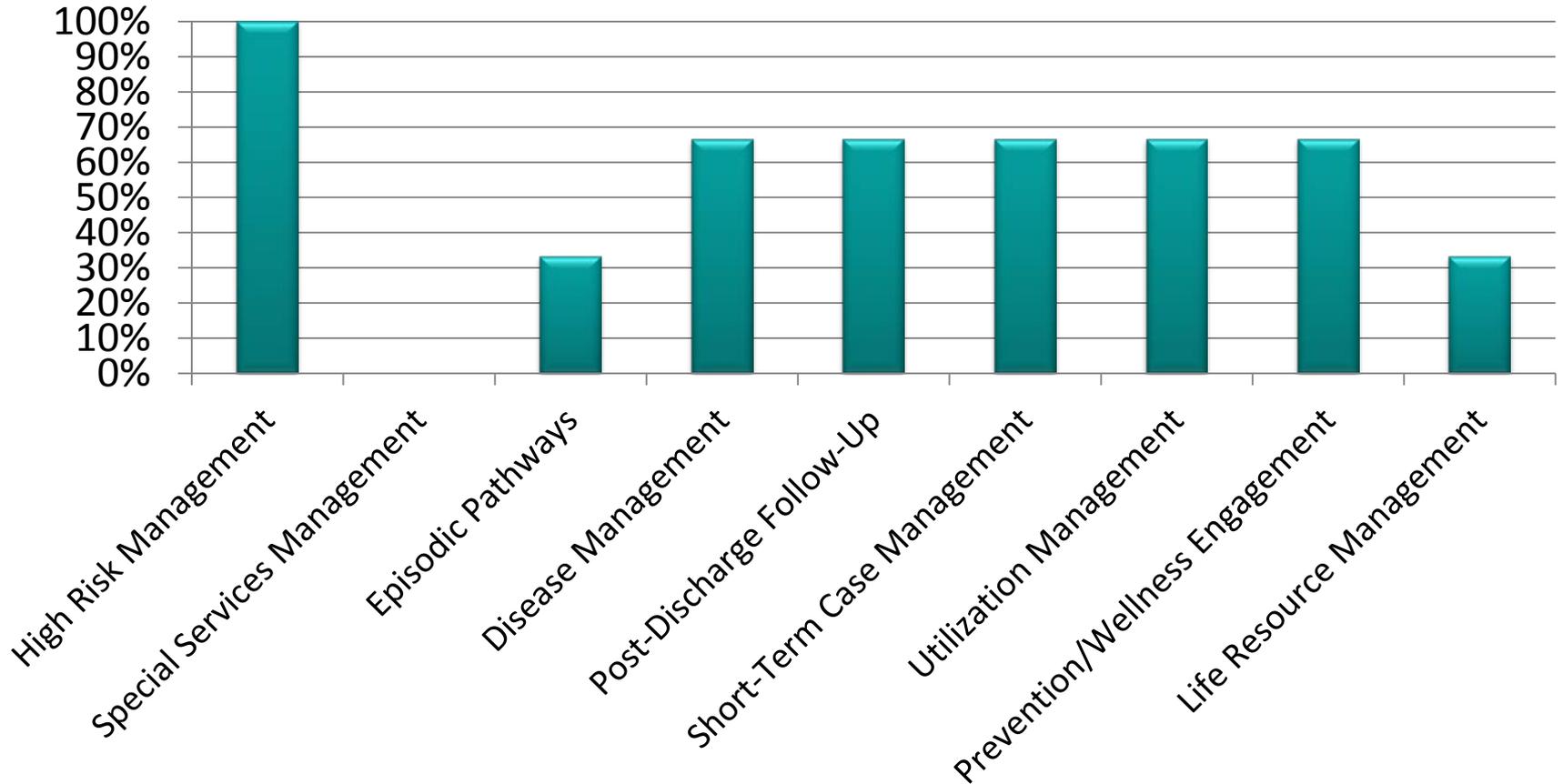
Number of Respondents: 2

Percent of Blueprint Community Health Teams Providing CM Services By Type of Service



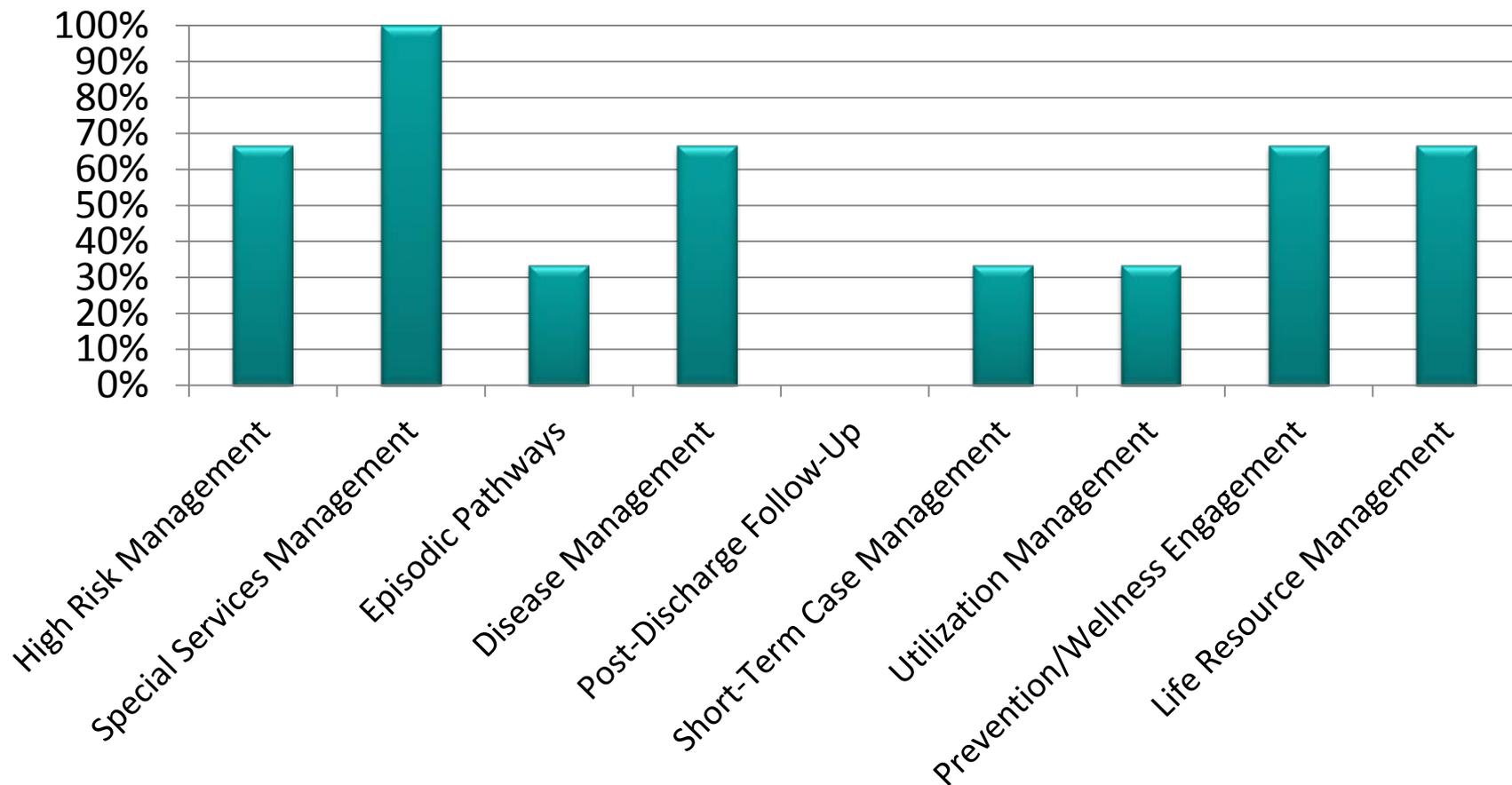
Number of Respondents: 11

Percent of Health Plans Providing CM Services By Type of Service



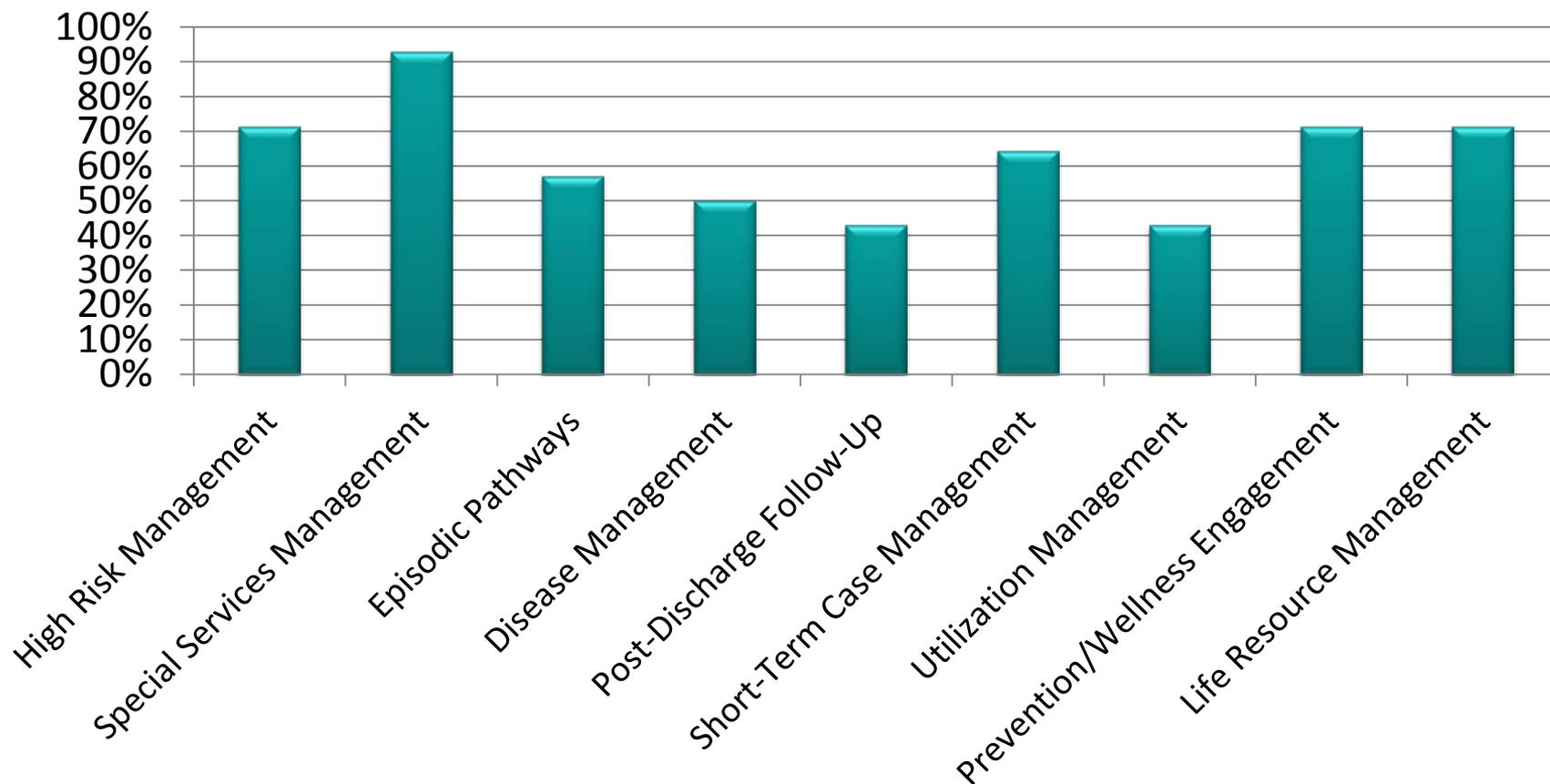
Number of Respondents: 11

Percent of State Agencies Providing CM Services By Type of Service



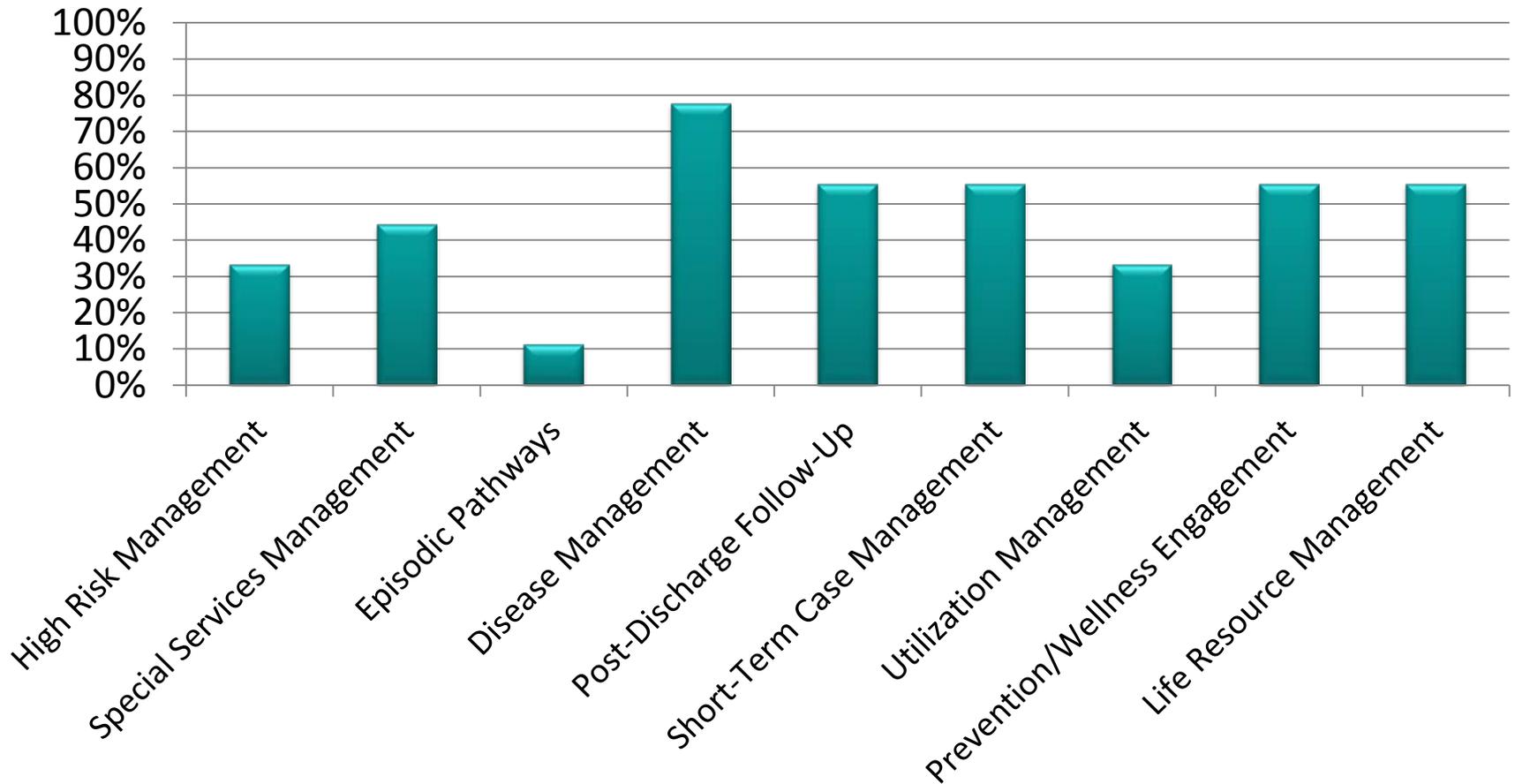
Number of Respondents: 3

Percent of Community Service Providers Providing CM Services By Type of Service



Number of Respondents: 14

Percent of Health Care Providers Providing CM Services By Type of Service



Number of Respondents: 9

CMCM Survey Analysis Part 2

September 12, 2014

Christine Hughes

Senior Consultant, Bailit Health Purchasing

Recap from Part 1

Number and Type of Responding Organizations

Type of Organization	Number of Respondents
ACO	2
Blueprint Community Health Team	11
Health Plan	3
State Agency	3
Community Service Provider	14
Health Care Provider	9
Other	0
Total	42

Populations Most Likely to Receive Higher than Average Allocation of CM Services

- People with Multiple Co-morbidities
 - High Risk Management
 - Disease Management
 - Short-Term Case Management
 - Prevention/Wellness Engagement
- People with Mental Health & Substance Abuse Needs
 - High Risk Management
 - Special Services Management
 - Episodic Pathways
 - Life Resource Management

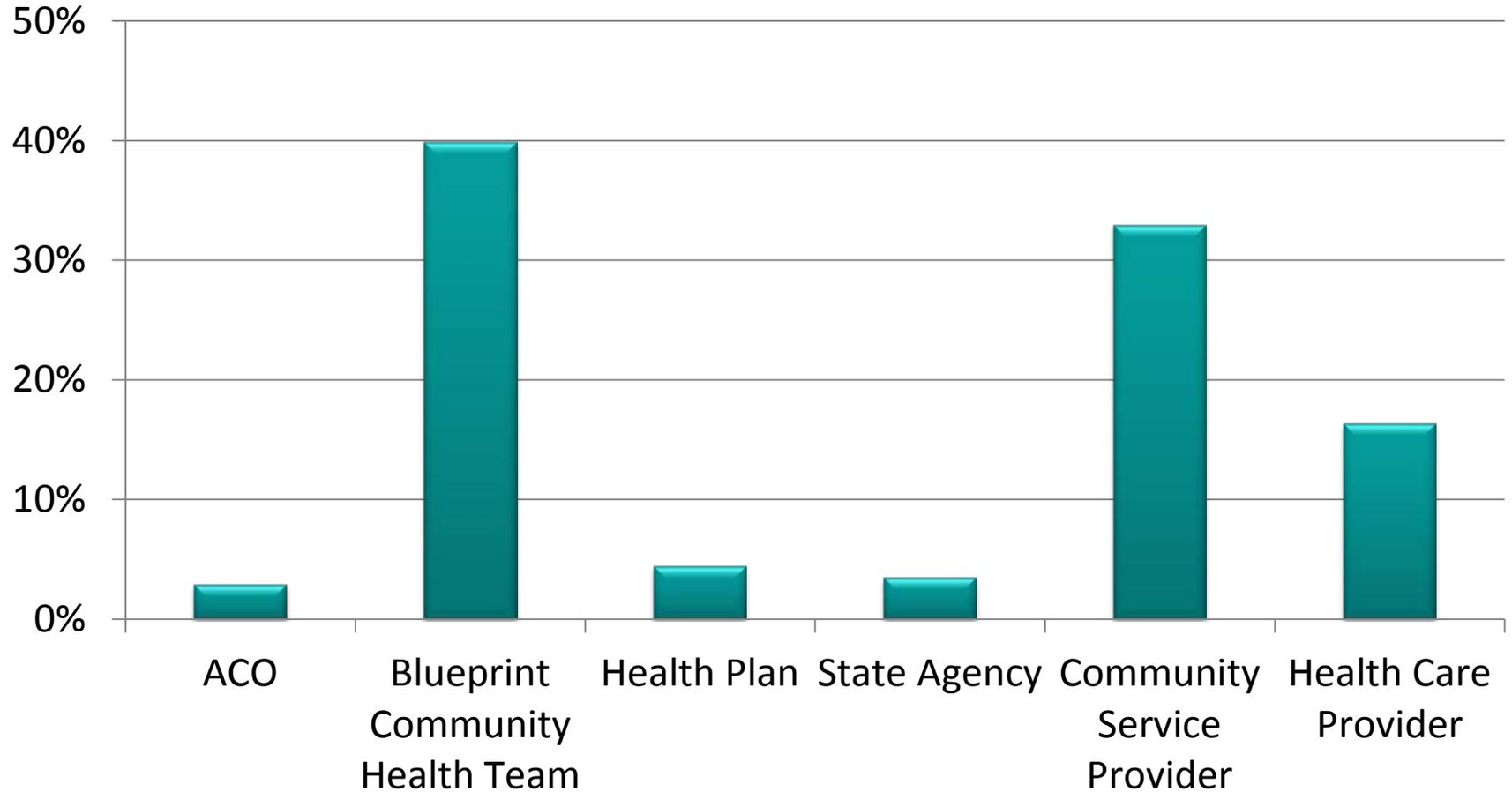
Populations Most Likely to Receive Higher than Average Allocation of CM Services (continued)

- People with Multiple ED Visits
 - Utilization Management
- People at risk due to Social Determinants of Health
 - Short Term Case Management
- People discharged from IP services
 - Post-Discharge Follow-up

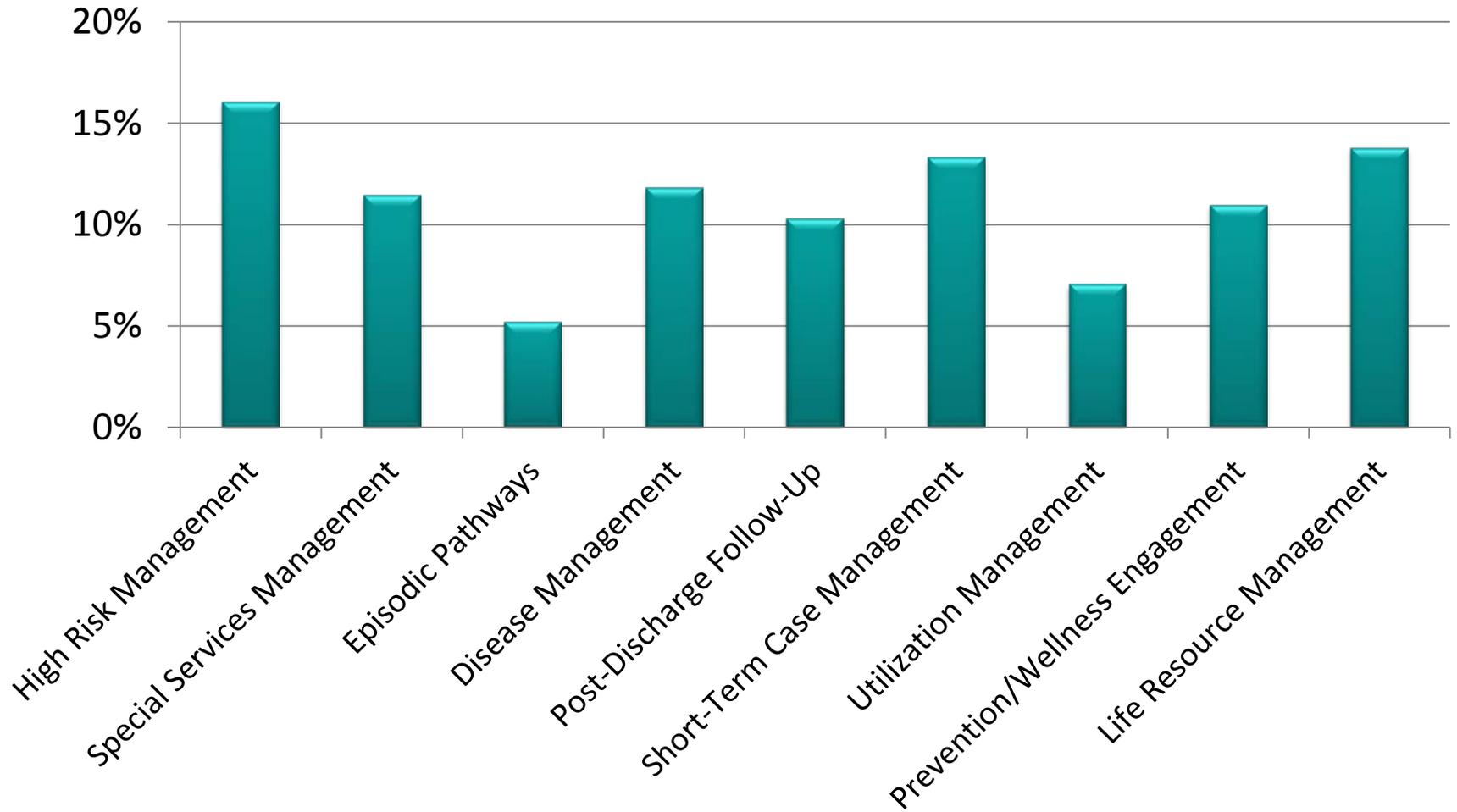
Percentage of Responding Organizations Providing CM Services by Type of Service

Type of Care Management Service	% of Respondents Providing the Service
High Risk Mgmt	51%
Special Services Mgmt	44%
Episodic Pathways	17%
Disease Mgmt	43%
Post-Discharge Follow-Up	39%
Short-Term Case Mgmt Programs	46%
Utilization Mgmt	26%
Prevention / Wellness Engagement	41%
Life Resource Mgmt	51%

Estimated Percentage of People Receiving CM Services by Type of Organization



All Organization Types: Estimated Percent of People Receiving CM Services Provided by Service Types

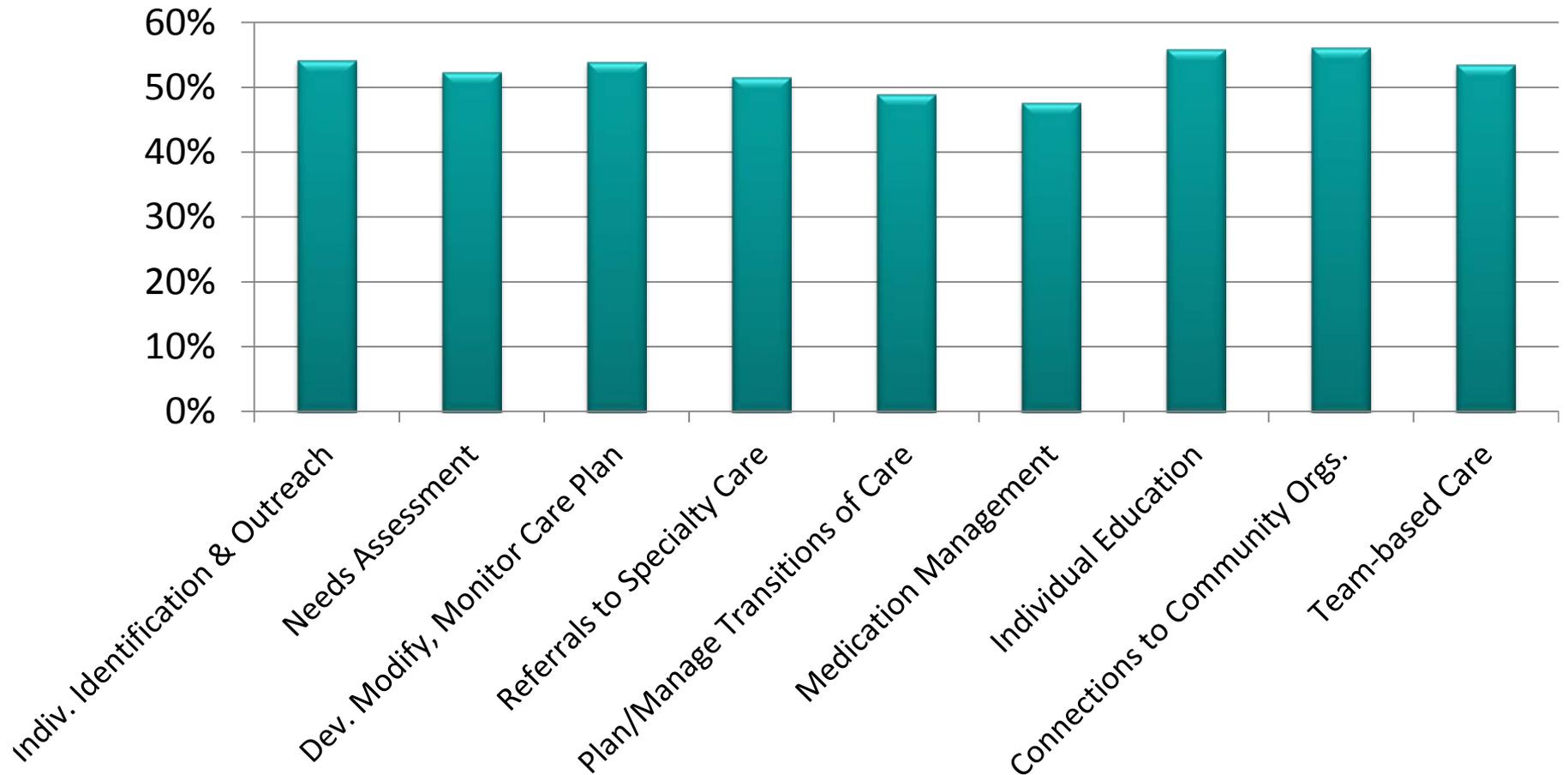


Key CM Functions

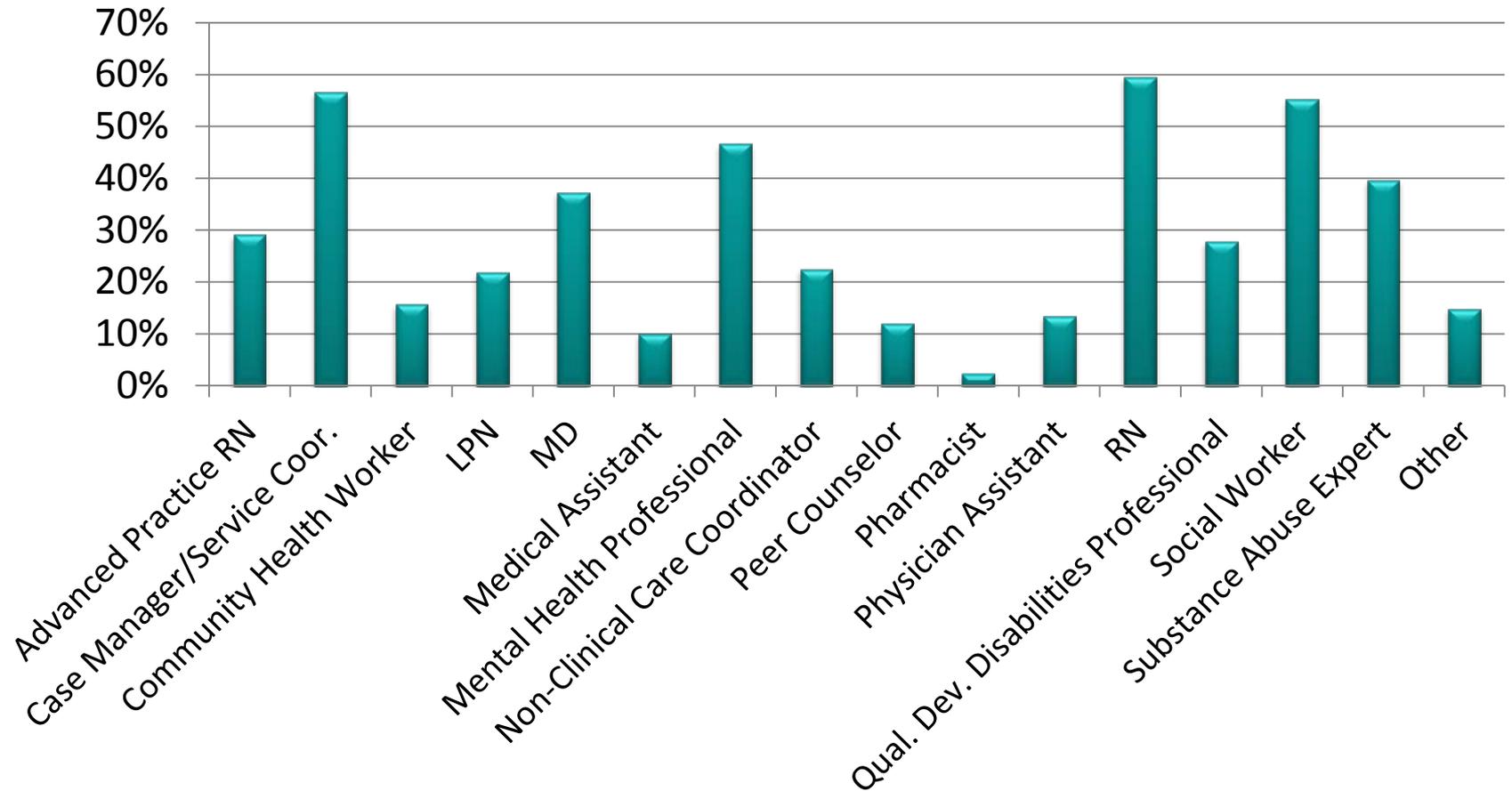
Center for Medicare and Medicaid Innovation

- Individual Identification and Outreach
- Needs Assessment
- Develops, Modifies, Monitors Care/Support Plan
- Referrals to Specialty Care
- Planning and Managing Transitions of Care
- Medication Management
- Individual Education
- Connections to Community/Social Service Organizations
- Team-based Care

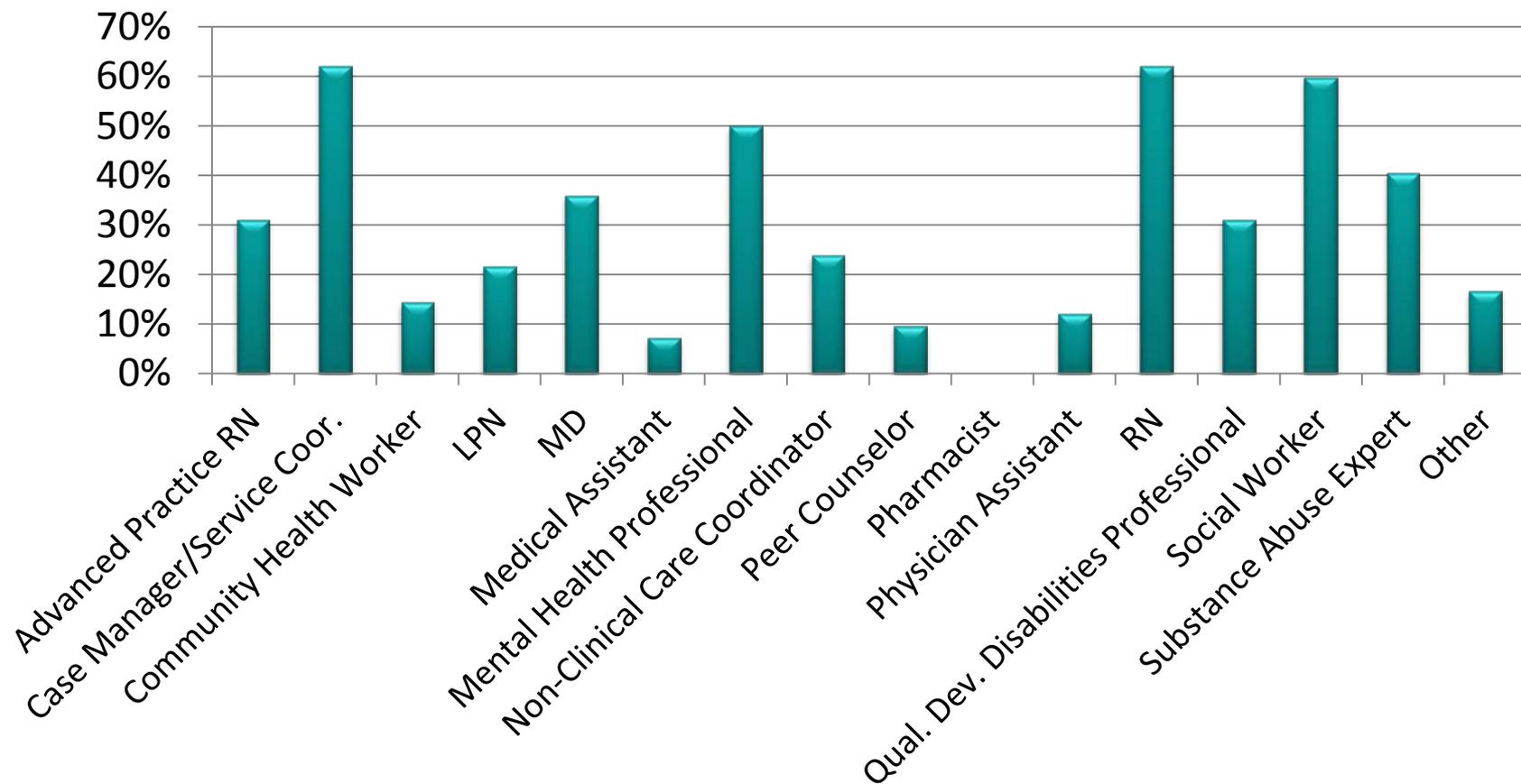
Percent of Responding Organizations Performing Key CM Functions



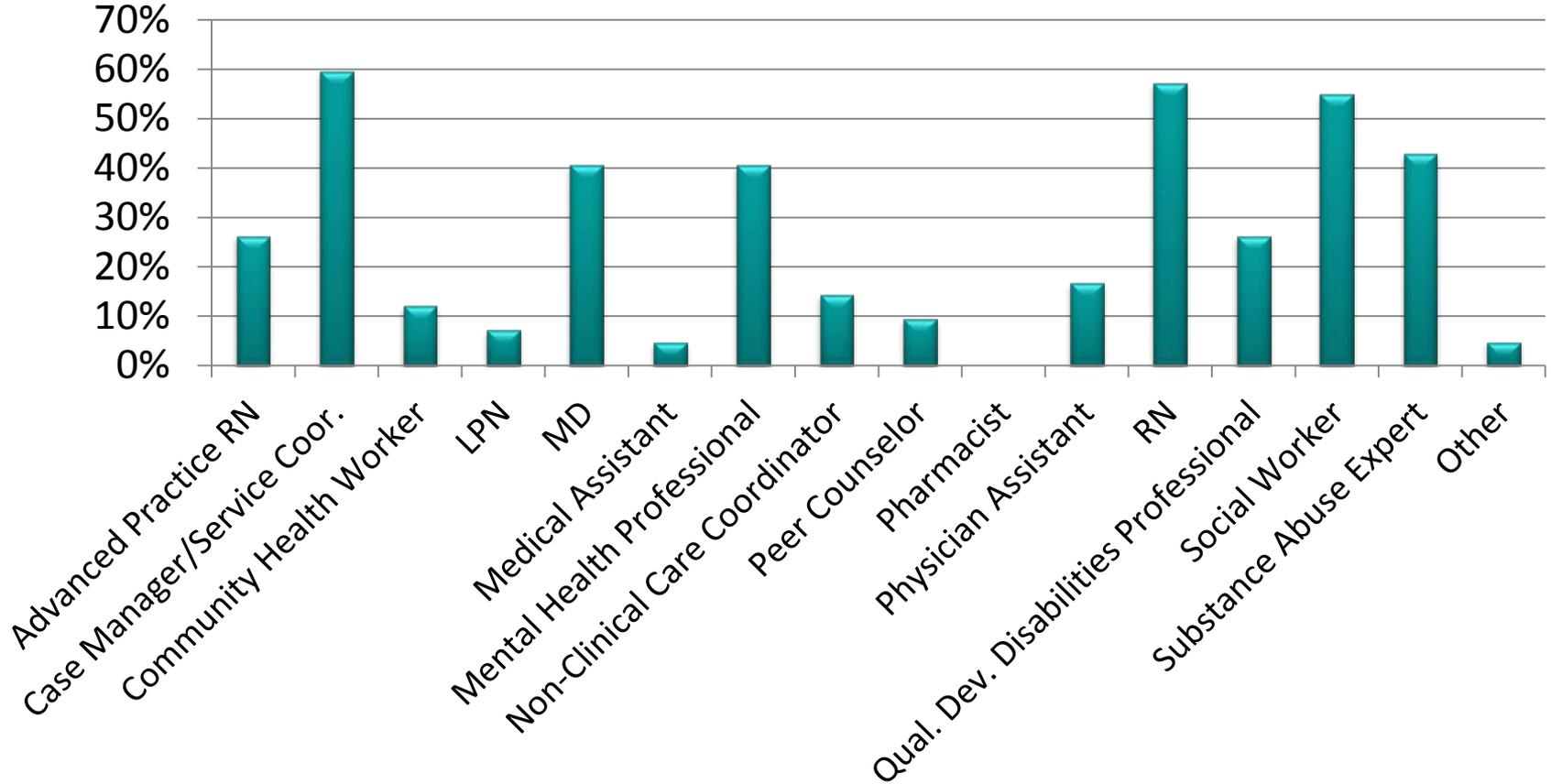
All Responding Organizations' Staffing by Type



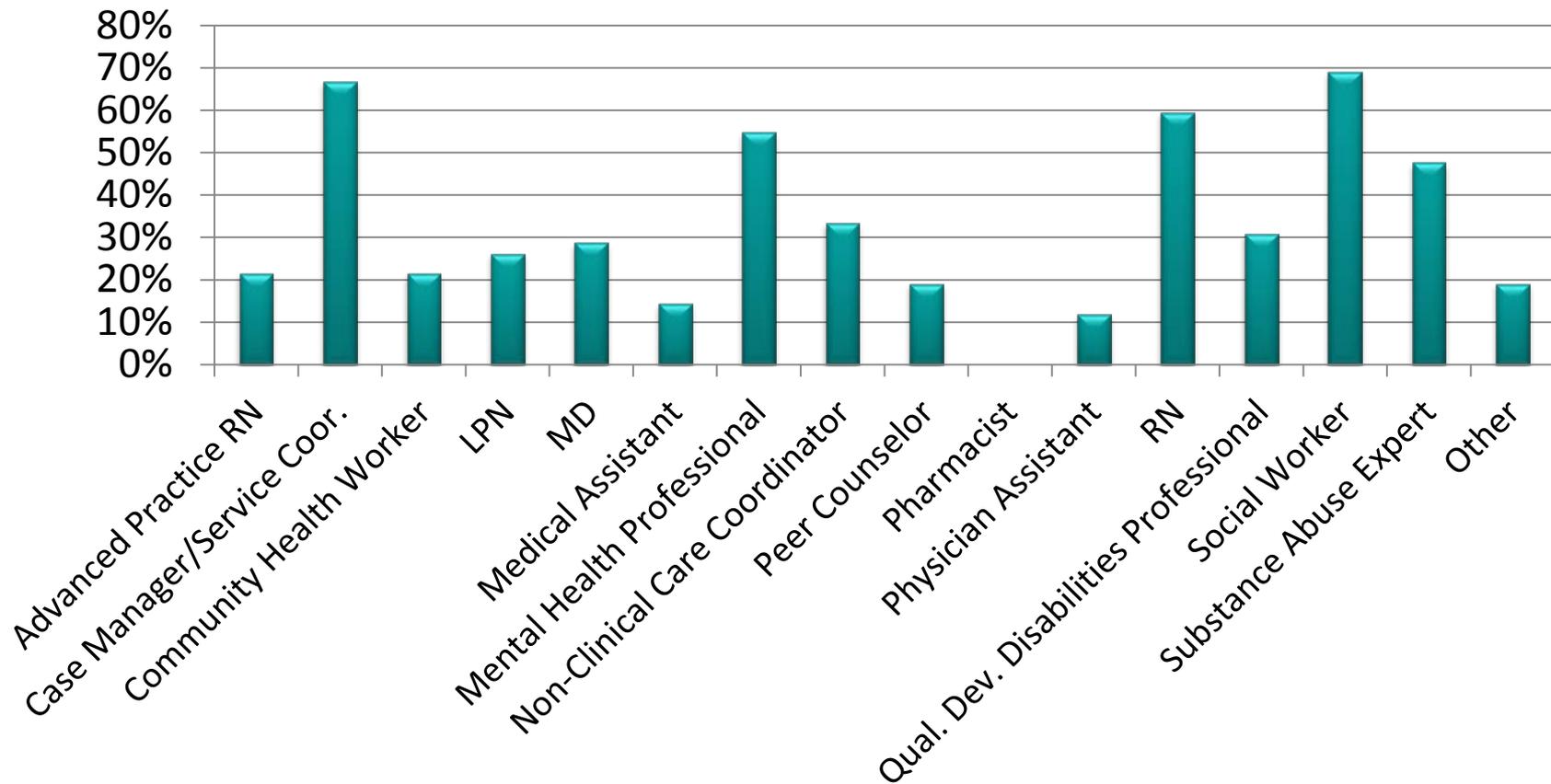
Responding Organizations' Staffing to Perform Key CM Functions: Develops, Modifies, Monitors Care / Support Plan



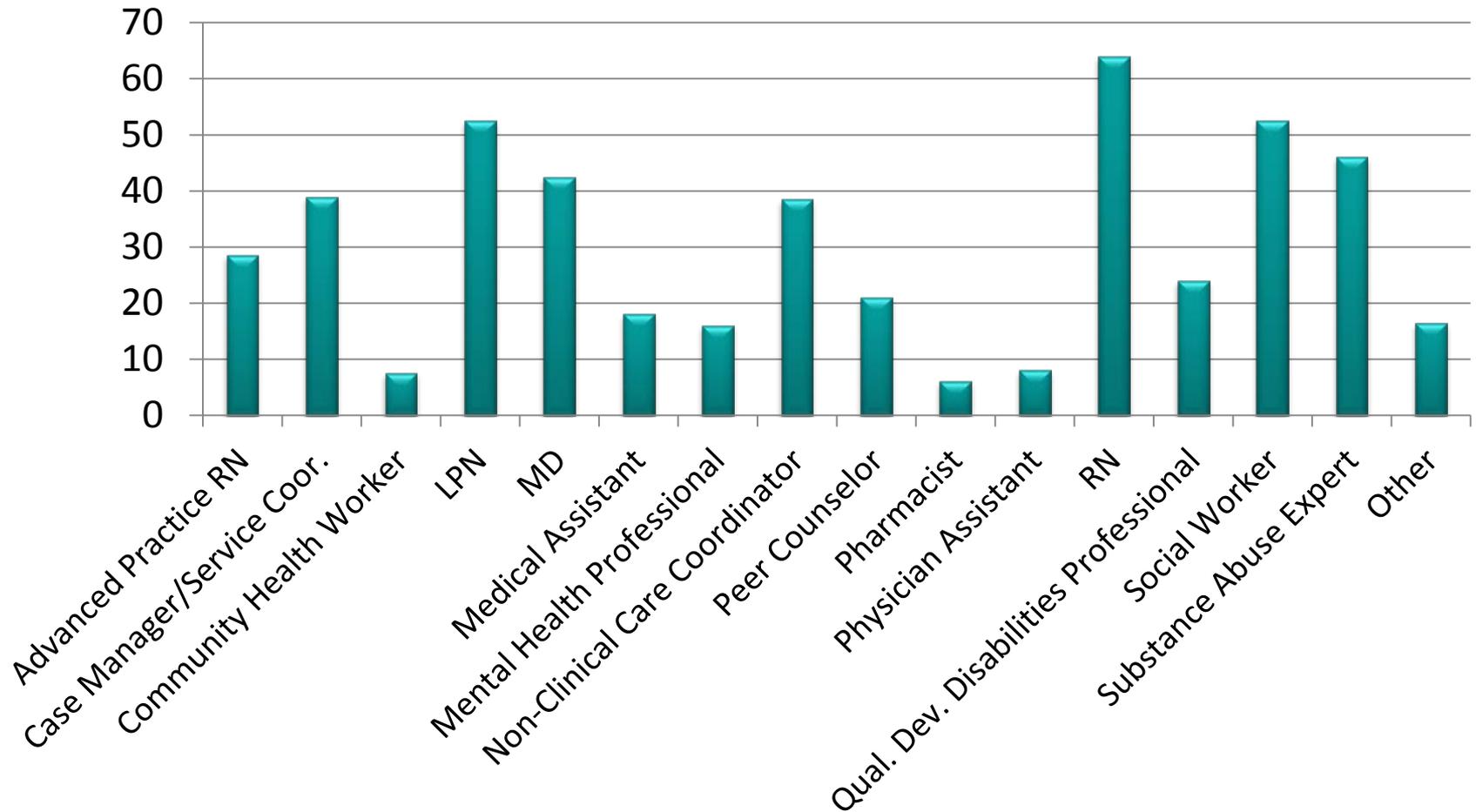
Responding Organizations' Staffing to Perform Key CM Functions: Planning and Managing Transitions of Care



Responding Organizations' Staffing to Perform Key CM Functions: Connections to Community / Social Service Organizations

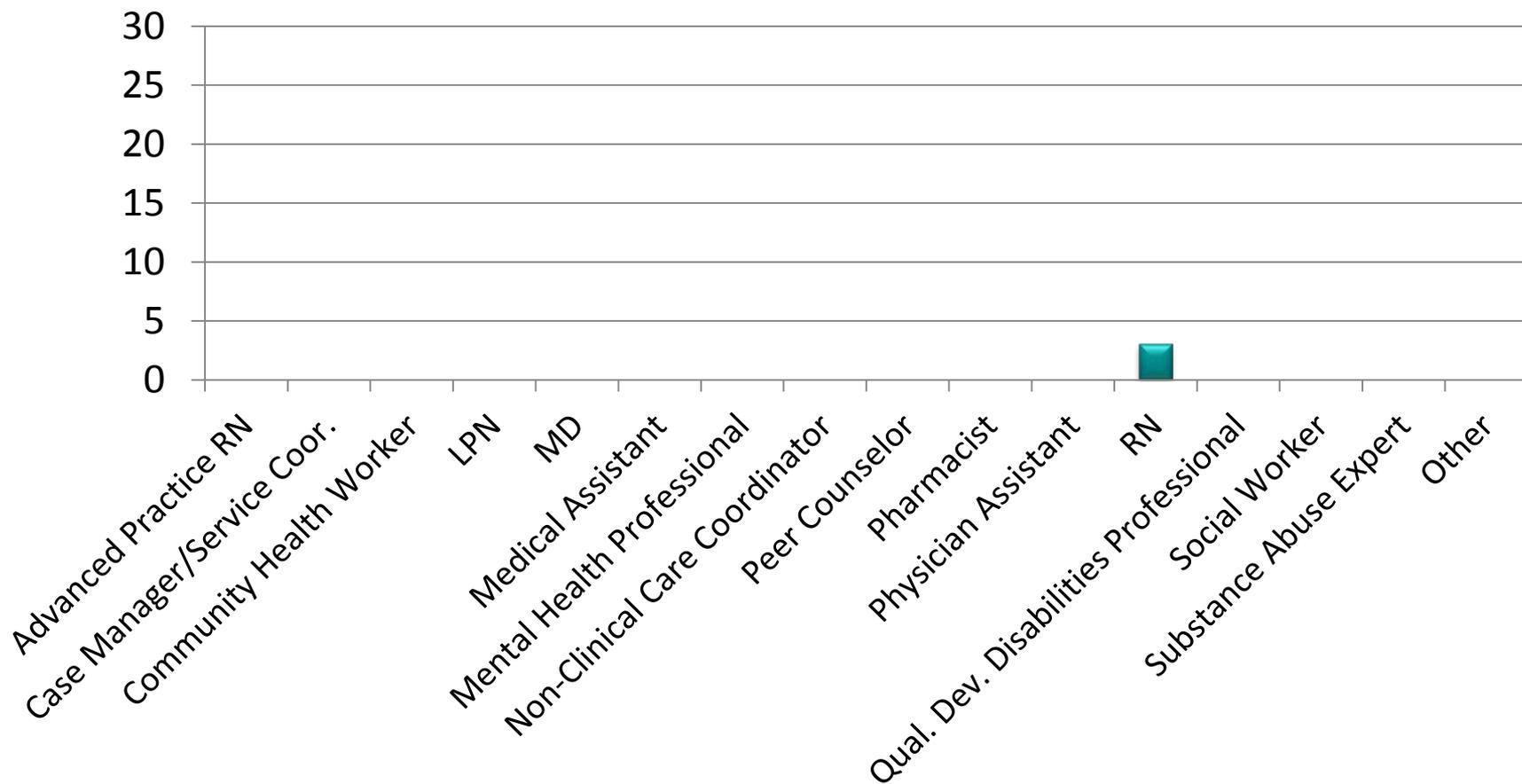


Total Number of FTEs by Staffing Type Across All Responding Organizations

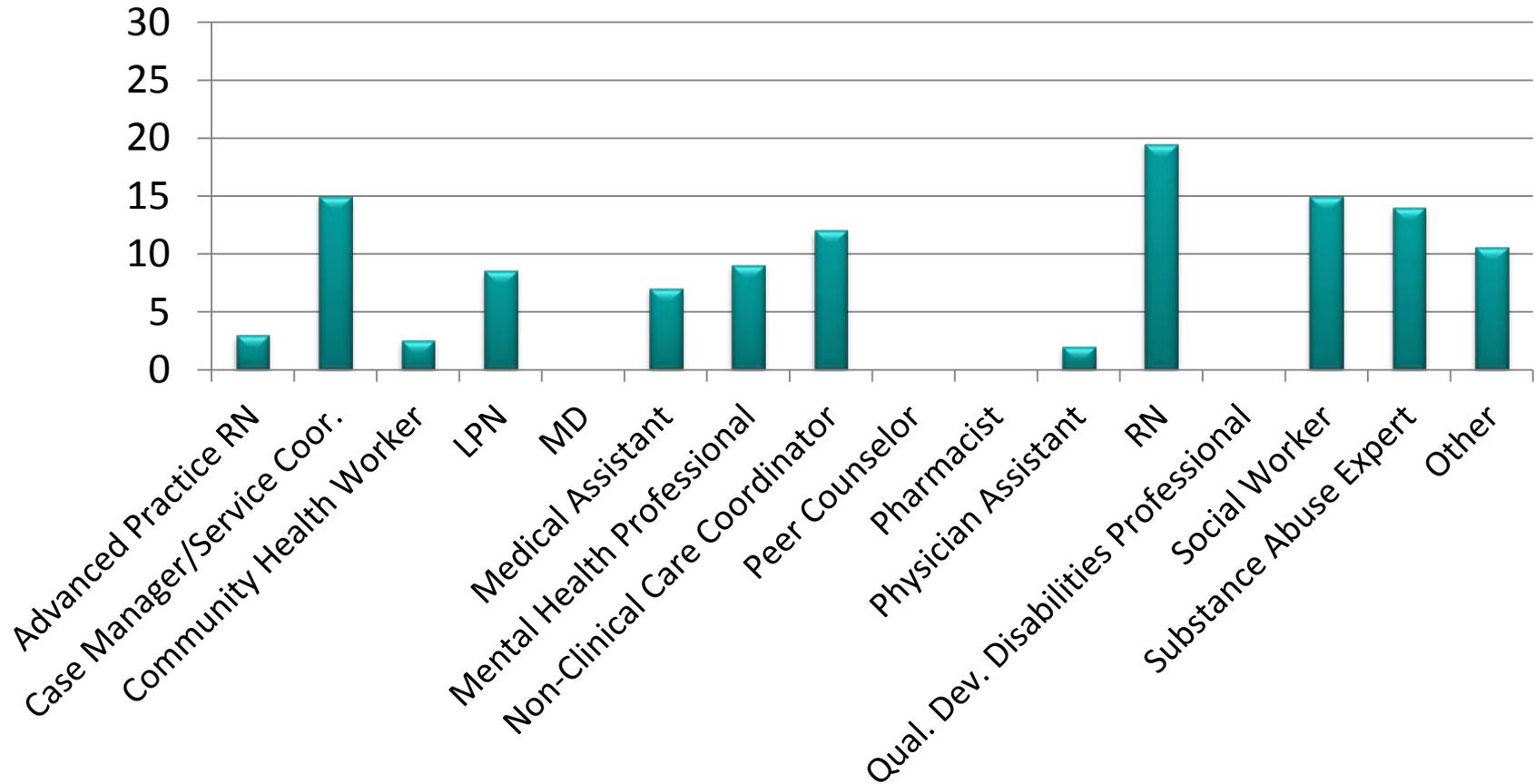


Total FTEs Reported = 481

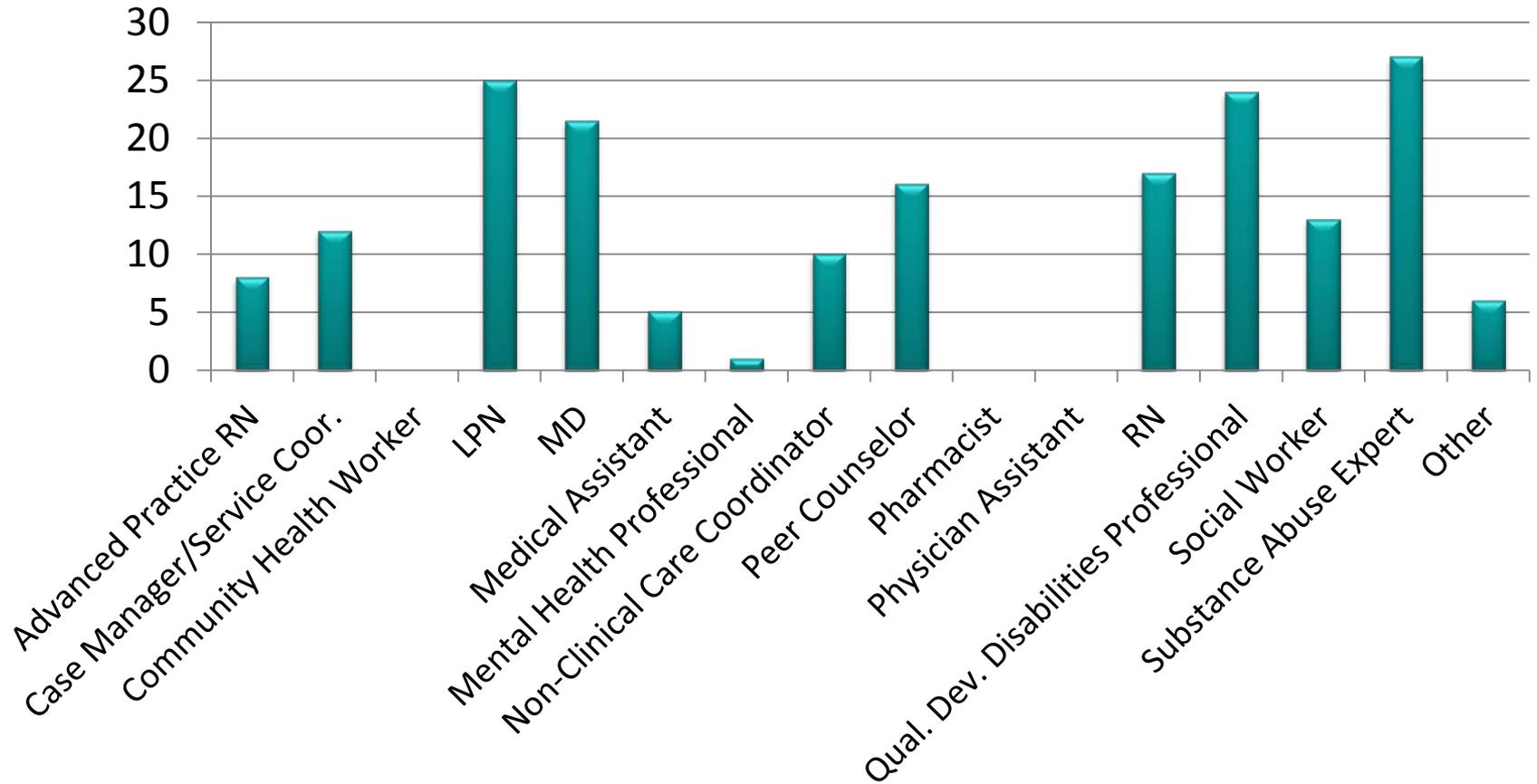
ACOs: Total Number of FTEs Providing CM Services by Staffing Type



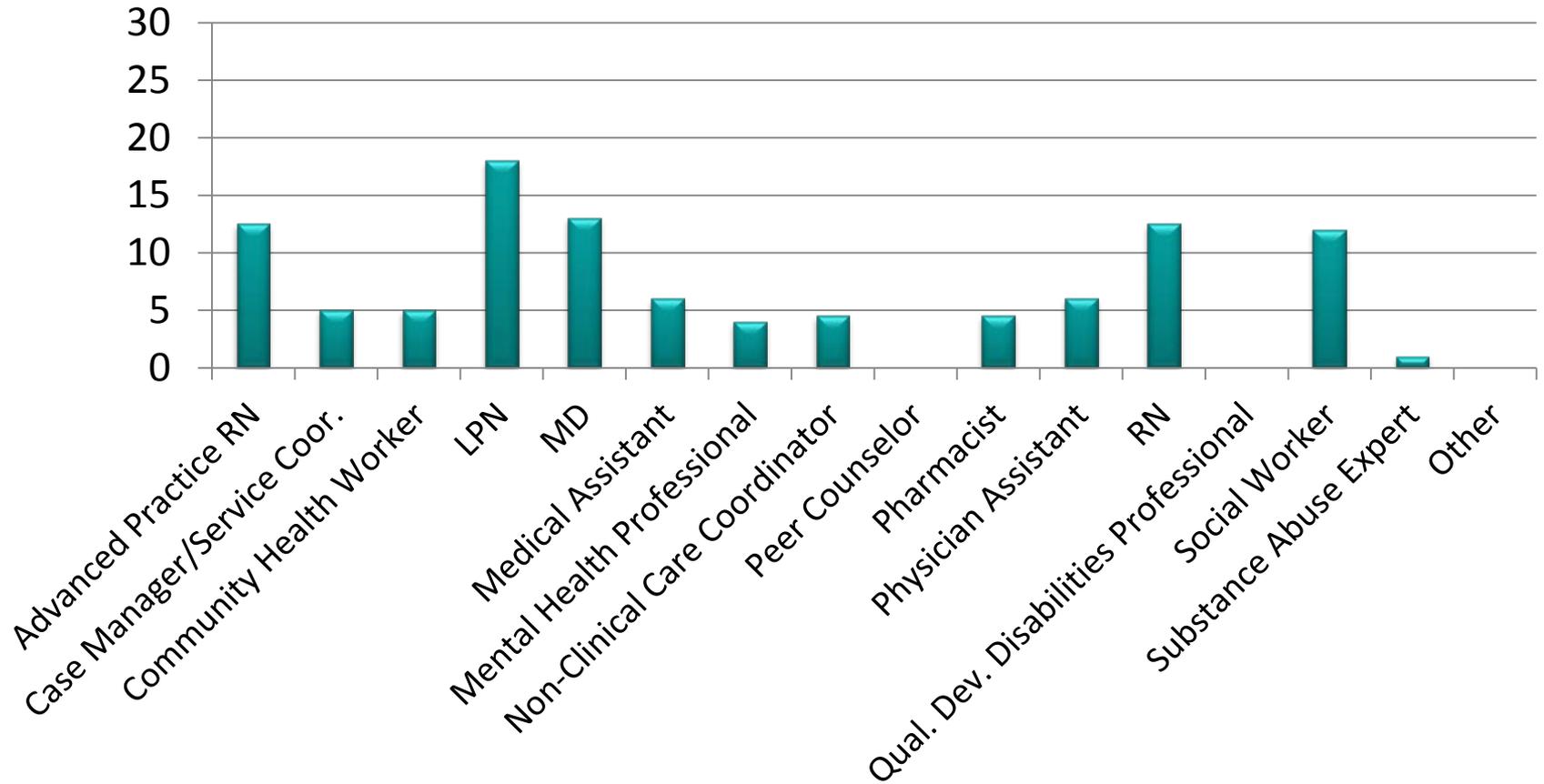
Blueprint Community Health Teams: Total Number of FTEs Providing CM Services by Staffing Type



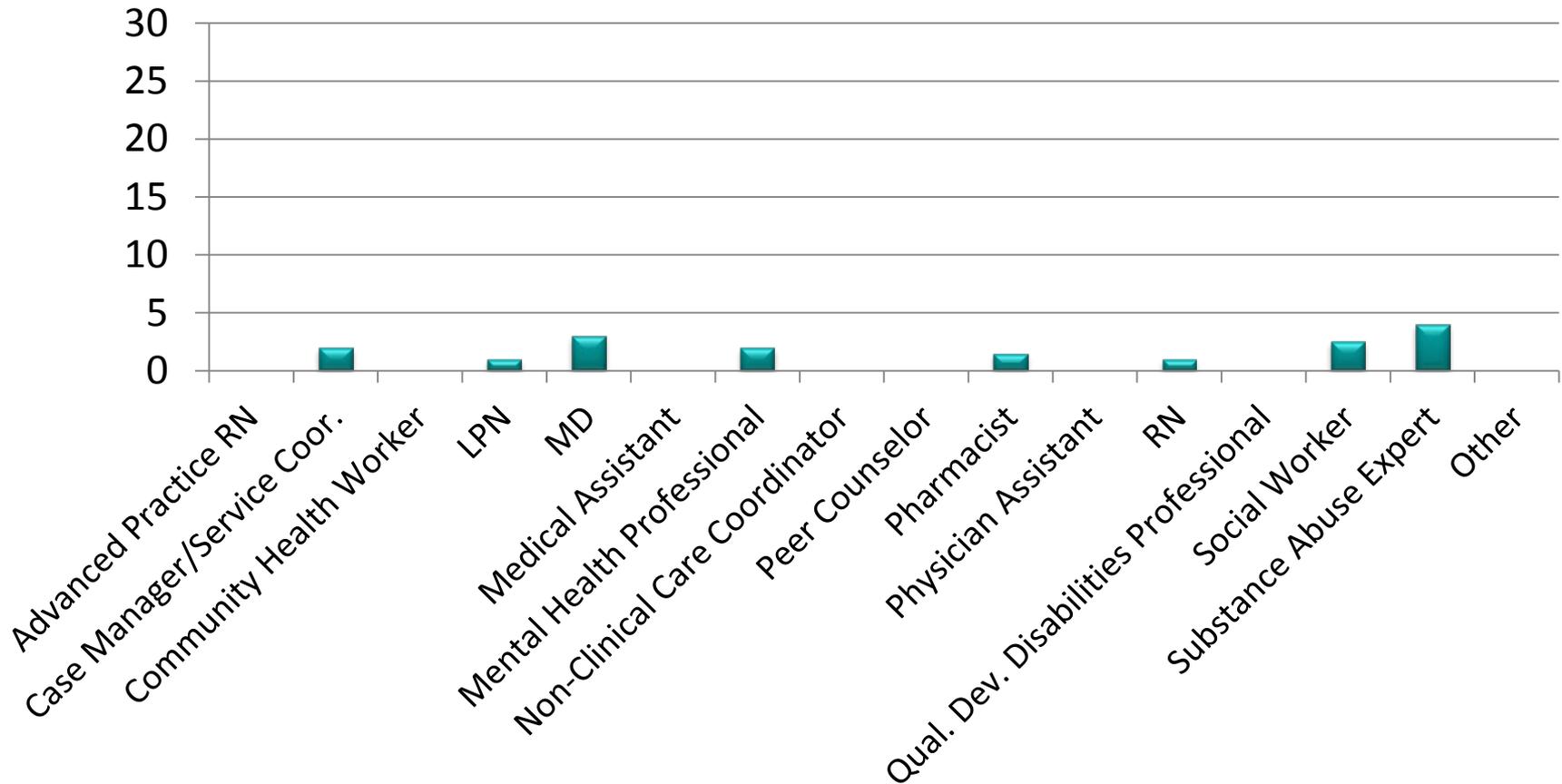
Community Service Providers: Total Number of FTEs Providing CM Services by Staffing Type



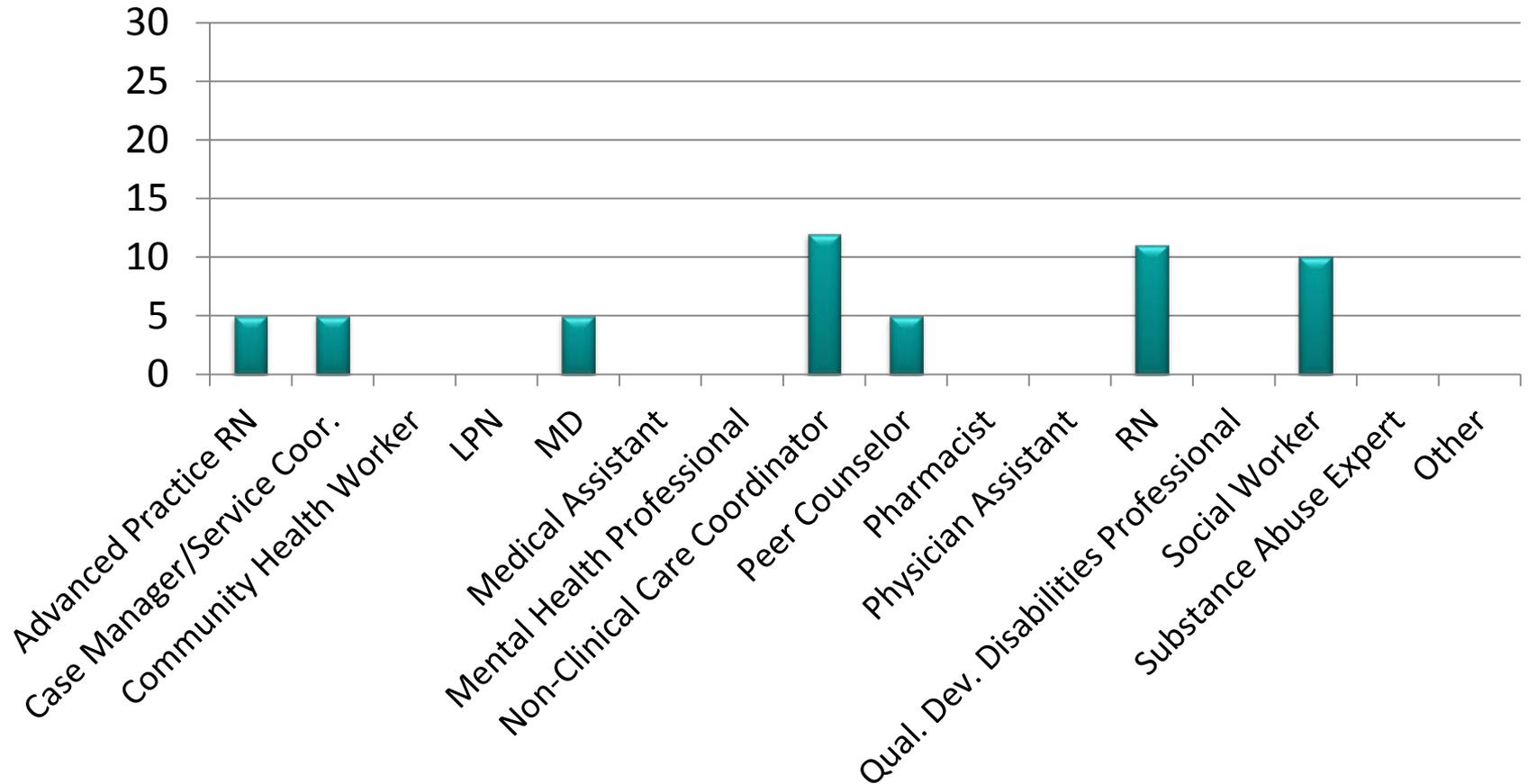
Health Care Providers: Total Number of FTEs Providing CM Services by Staffing Type



Health Plans: Total Number of FTEs Providing CM Services by Staffing Type



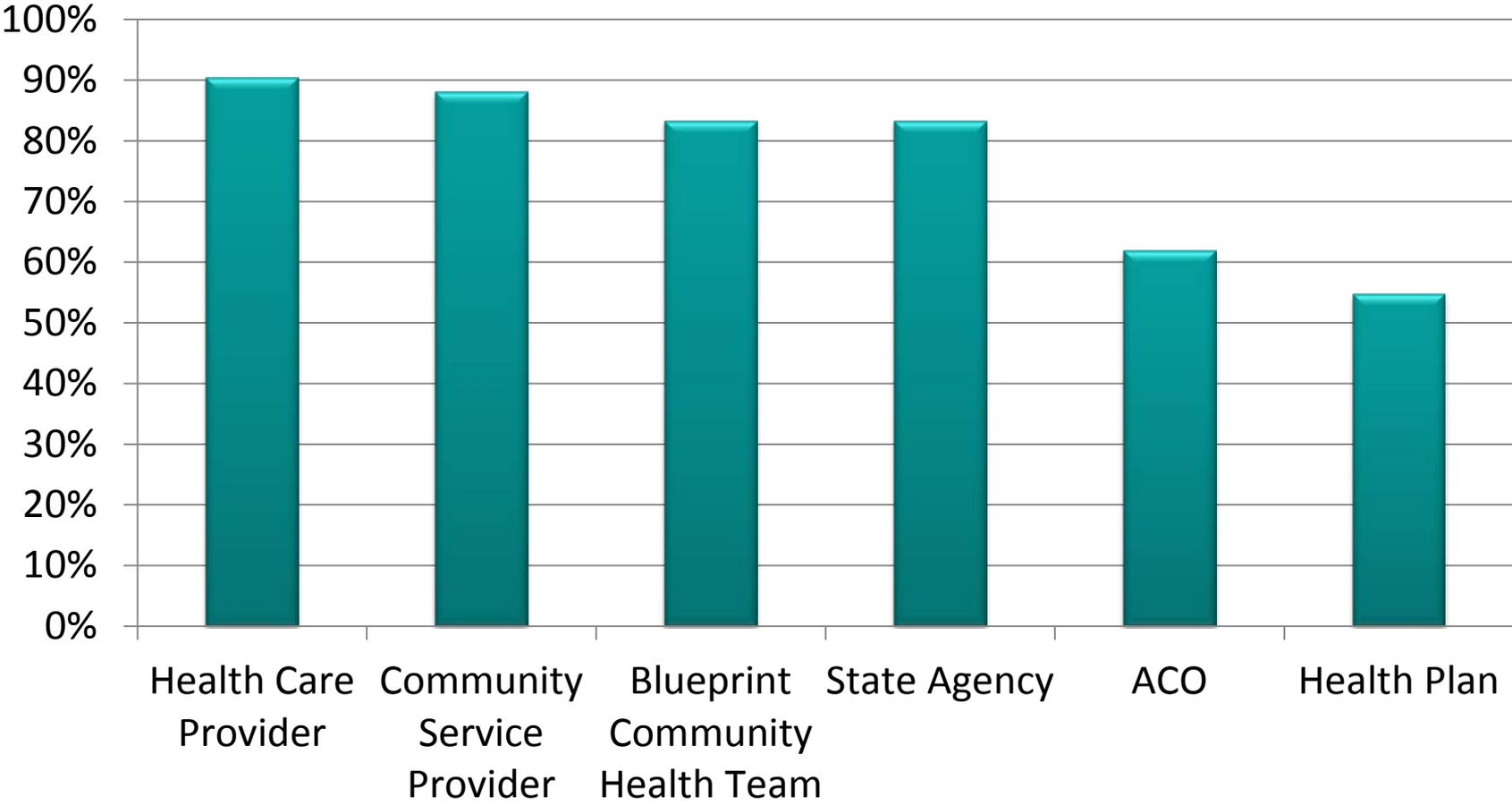
State Agencies: Total Number of FTEs Providing CM Services by Staffing Type



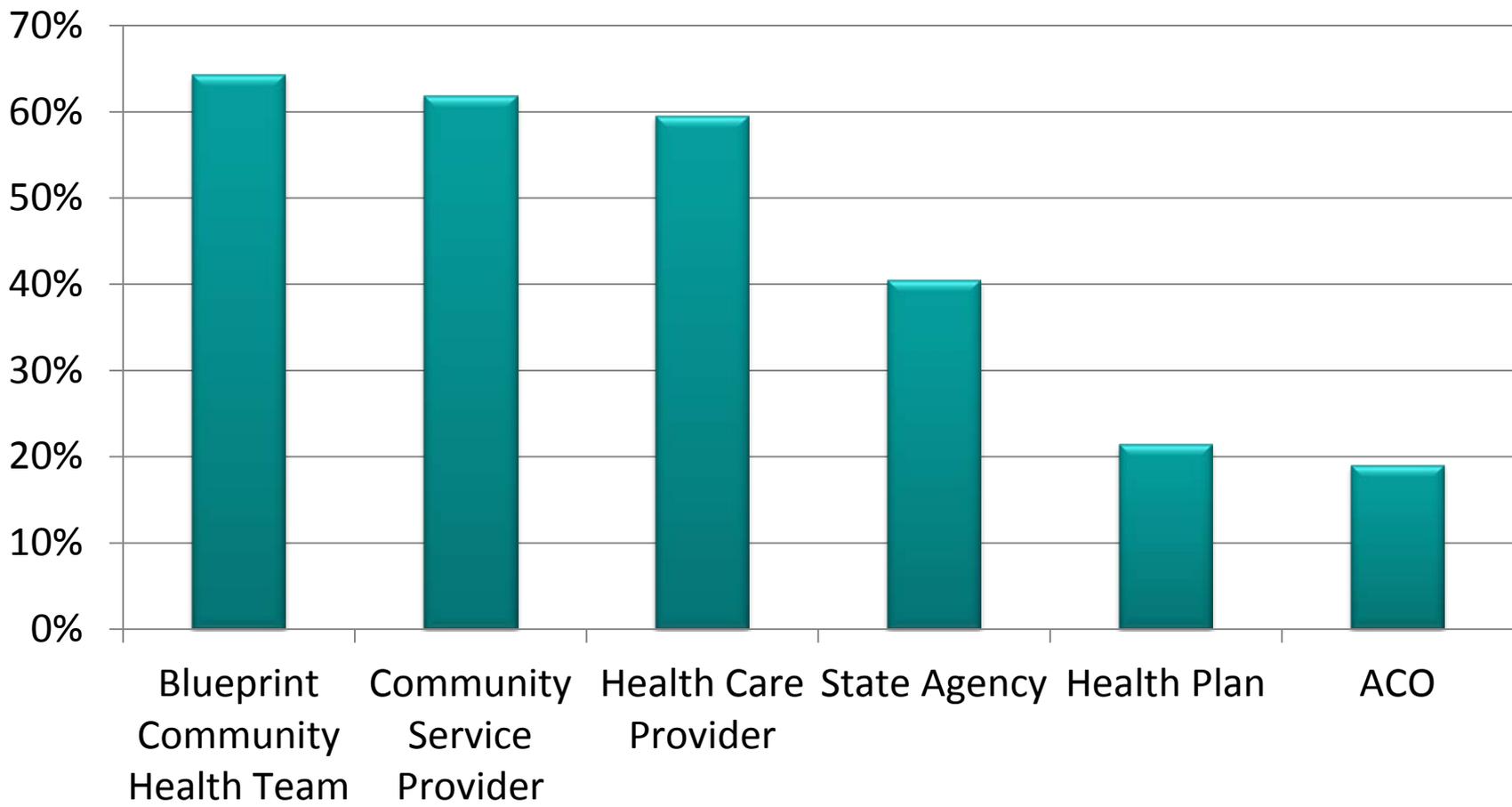
Frequency of Interaction for All Responding Organizations by Type of Interaction

Organizations with which responding organizations Indicated interactions	Percent of all responding organizations indicating that they share information with this organization	Percent of all responding organizations indicating that they share resources with this organization	Percent of all responding organizations indicating that they make referrals to this organization	Percent of all responding organizations indicating that they receive referrals from this organization
ACO	62%	19%	17%	29%
Blueprint Community Health Team	83%	64%	74%	71%
Community Service Provider	88%	62%	81%	88%
Health Care Provider	90%	60%	86%	88%
Health Plan	55%	21%	24%	36%
State Agency	83%	40%	62%	67%
Count of Organizations Reporting	42			

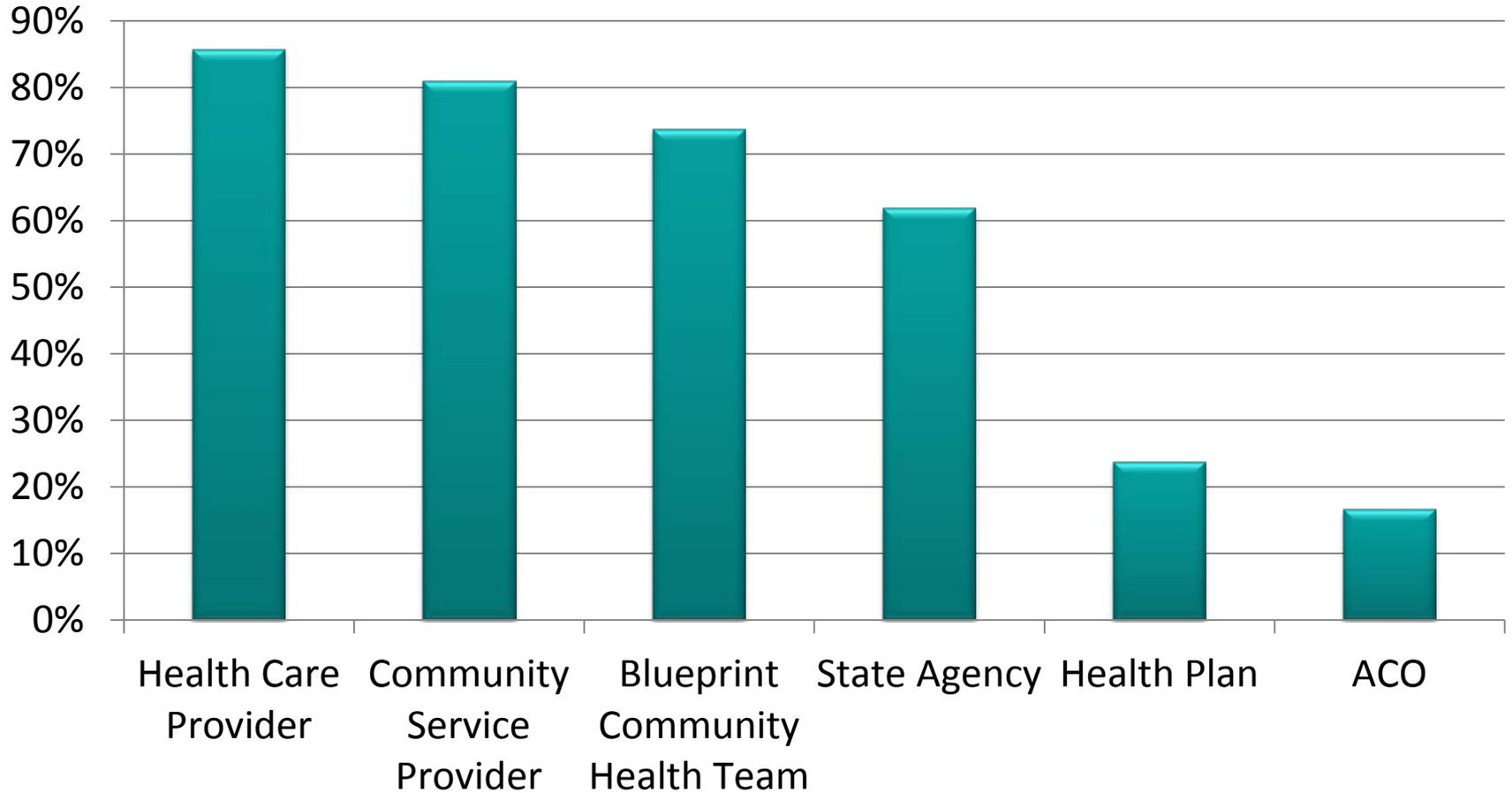
Frequency With Which Responding Organizations Answered, “We share information with this organization,” by Organization Type



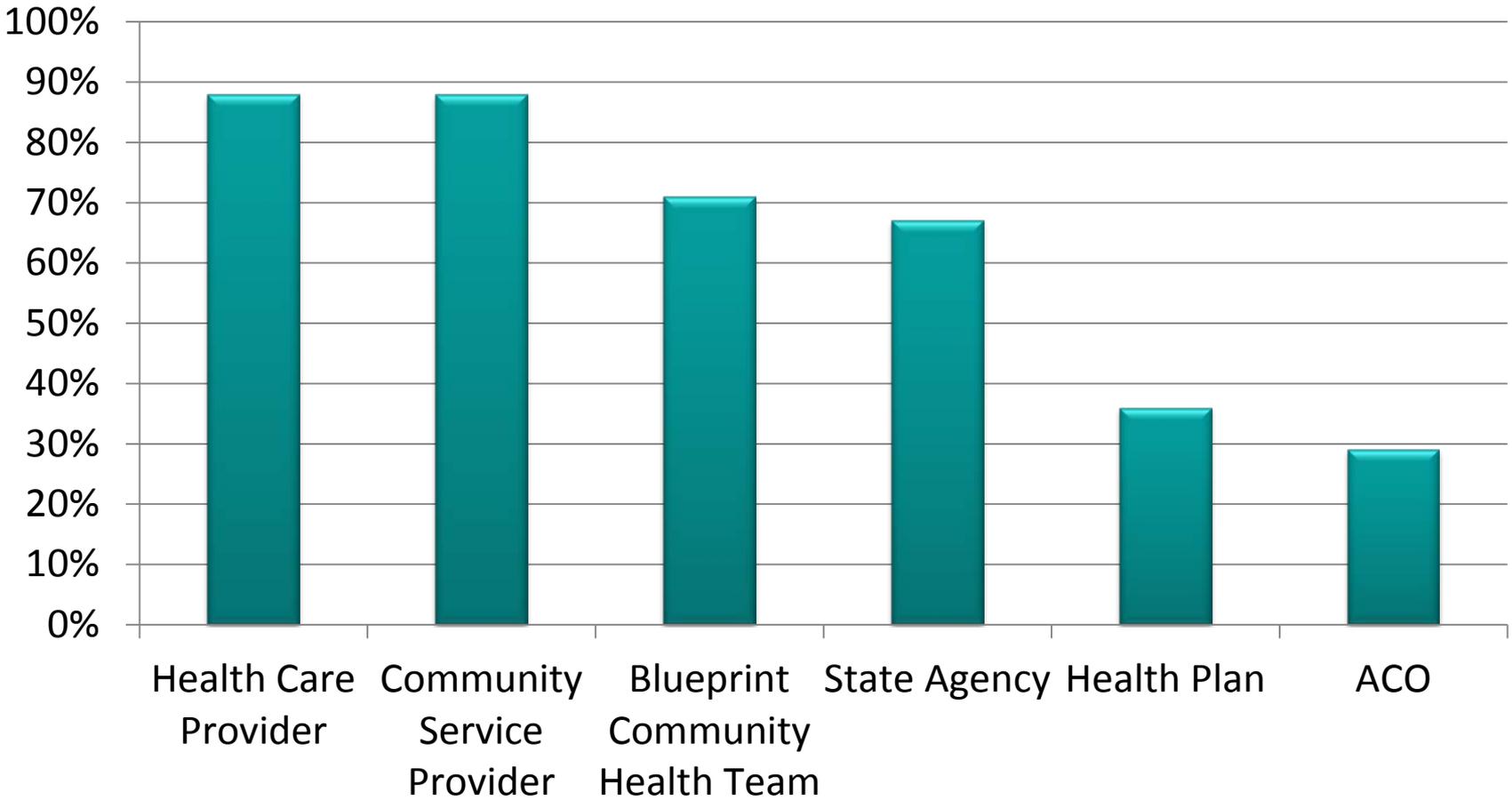
Frequency With Which Responding Organizations Answered, “We share resources with this organization,” by Organization Type



Frequency With Which Responding Organizations Answered, “We make referrals to this organization,” by Organization Type



Frequency With Which Responding Organizations Answered, “We receive referrals from this organization,” by Organization Type

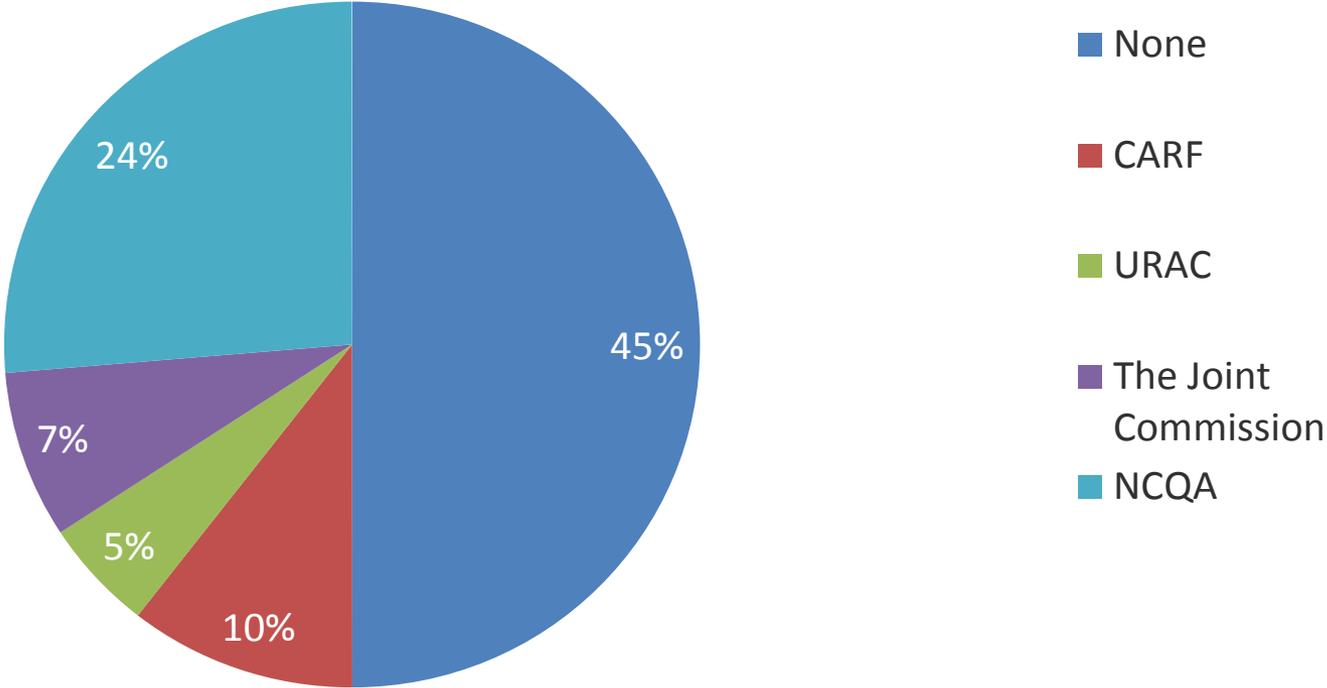


Relatively High (H) and Low (L) Numbers of Relationships by Type of Relationship and Type of Organization

Nature of Interactions Between Organizations (Functional Care Mgmt Teams)	Legal Relationship (e.g., contract, MOU)	Financial Relationship (funding supports team interaction)	Regular, Structured Interaction (e.g., scheduled meetings)	Ad Hoc Interaction Using Established Communication Mechanisms
<u>Average Rate for All Respondents</u>	<u>24%</u>	<u>19%</u>	<u>43%</u>	<u>54%</u>
ACOs	H			L
Adult Day Providers	L	L	L	
Blueprint Community Health Teams	H	H	H	
Children with Special Health Needs Providers	L			
Community Action Agencies	L	L		
EPSDT Providers			L	L
Faith-Based Organizations	L	L	L	
Fitness Providers			L	L
Health Care Provider Offices	H		H	H
Health Insurers		H		
Home Health Agencies/VNAs			H	H
Hospitals	H	H	H	H
Housing Organizations				H
Medicaid VCCI		L		
Mental Health Providers (Designated Agencies)	H	H	H	
Schools				H
Transportation Providers				H

Percent of Accredited CM Programs by Accrediting Organization

All Organization Types



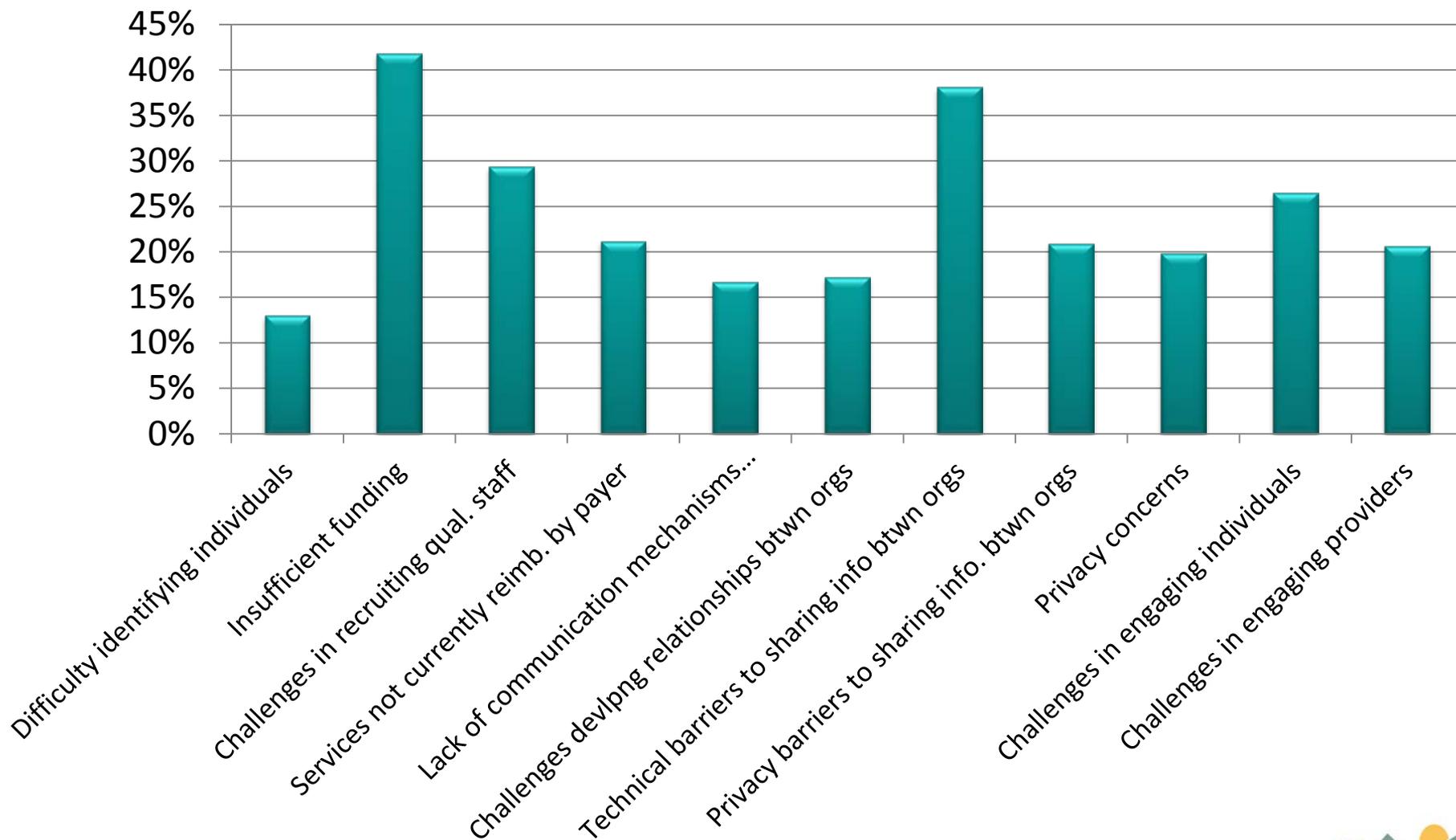
Top Four Challenges Experienced by CM Organizations (In Bold)

- Difficulty identifying individuals
- **Insufficient funding**
- **Challenges in recruiting qualified staff**
- Services not currently reimbursed by payer
- Lack of communication mechanisms with other organizations
- Challenges to developing relationships between organizations
- **Technical barriers to sharing information between organizations**
- Privacy barriers to sharing information between organizations
- Privacy concerns
- **Challenges in engaging individuals**
- Challenges in engaging providers

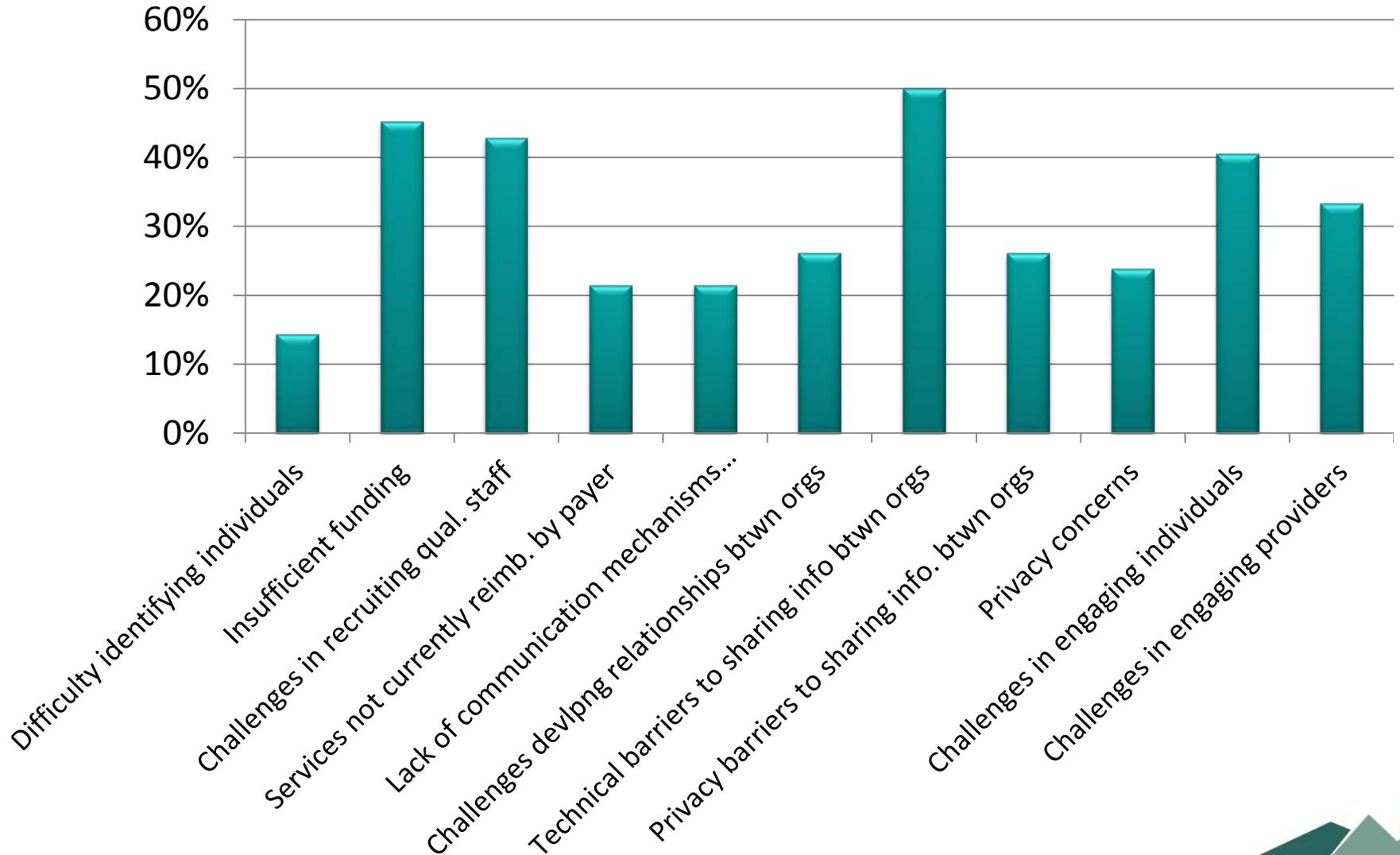
Responding Organizations' Top Challenges by Type of CM Service

Type of Challenges	High Risk Mgmt	Special Services Mgmt	Episodic Pathways	Disease Mgmt	Post-Discharge Follow-Up	Short-Term Case Mgmt Programs	Utilization Mgmt	Prevention / Wellness Engagement	Life Resource Mgmt
Difficulty identifying individuals									
Insufficient funding	X	X	X	X	X	X	X	X	X
Challenges in recruiting qualified staff	X	X	X	X		X	X	X	X
Services not currently reimbursed by payer								X	
Lack of communication mechanisms with other organizations									
Challenges to developing relationships between organizations									
Technical barriers to sharing information between organizations	X	X	X	X	X	X	X	X	X
Privacy barriers to sharing information between organizations		X		X					
Privacy concerns					X				
Challenges in engaging individuals	X			X		X		X	X
Challenges in engaging providers			X						

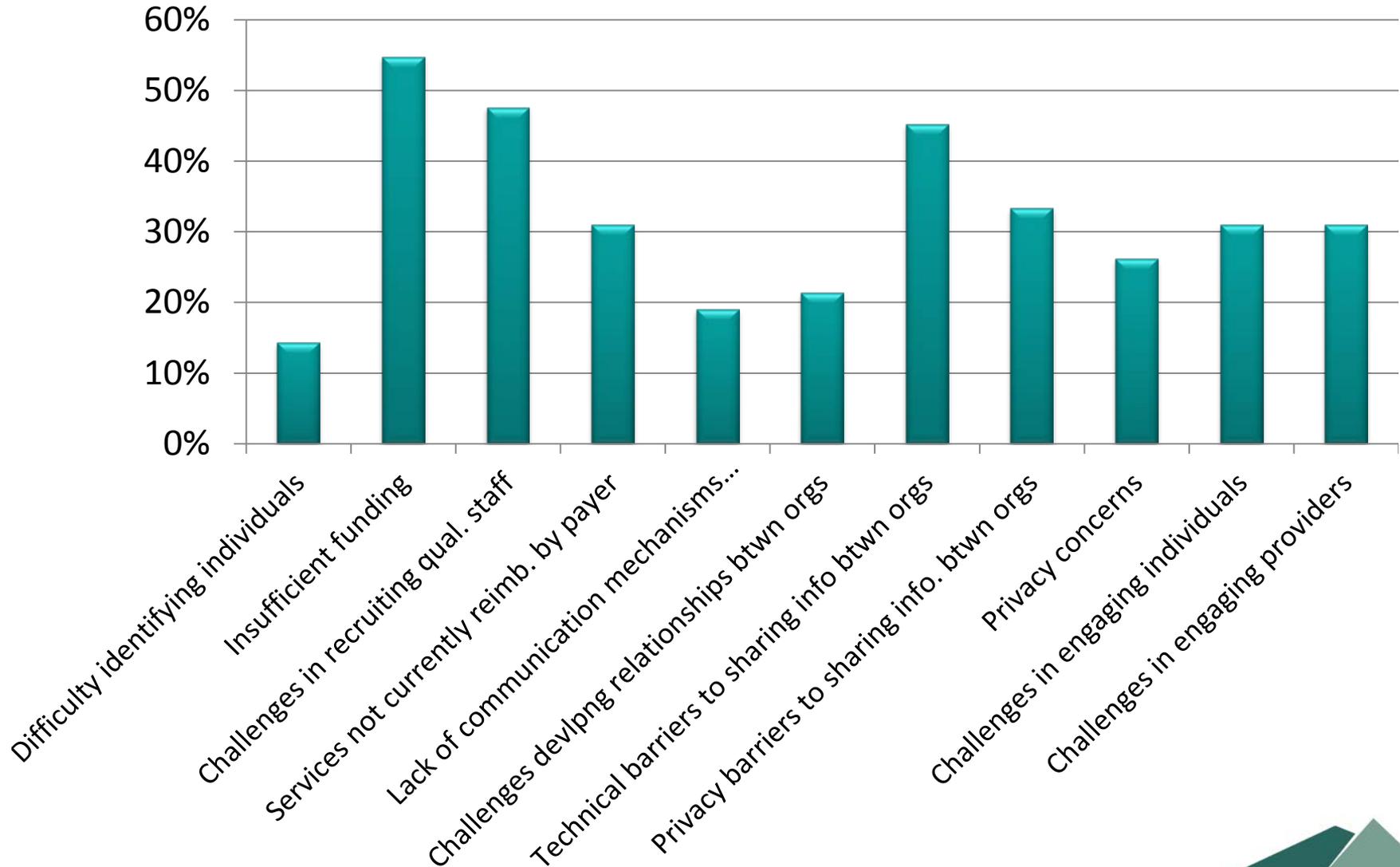
Frequency of Challenges Experienced by Responding Organizations, by Type of Challenge



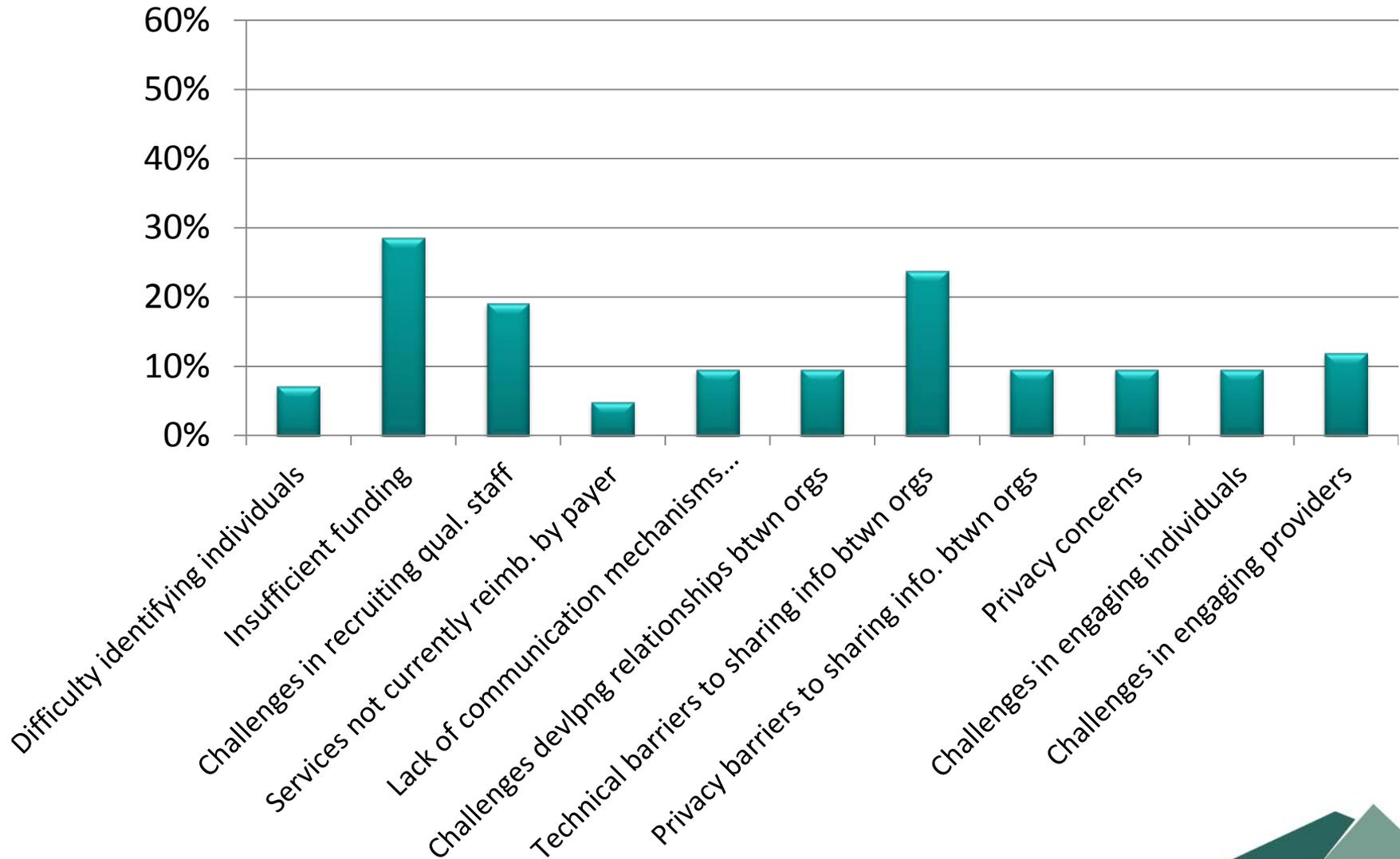
Frequency of Challenges Experienced by Responding Organizations, by Type of Service: High Risk Management



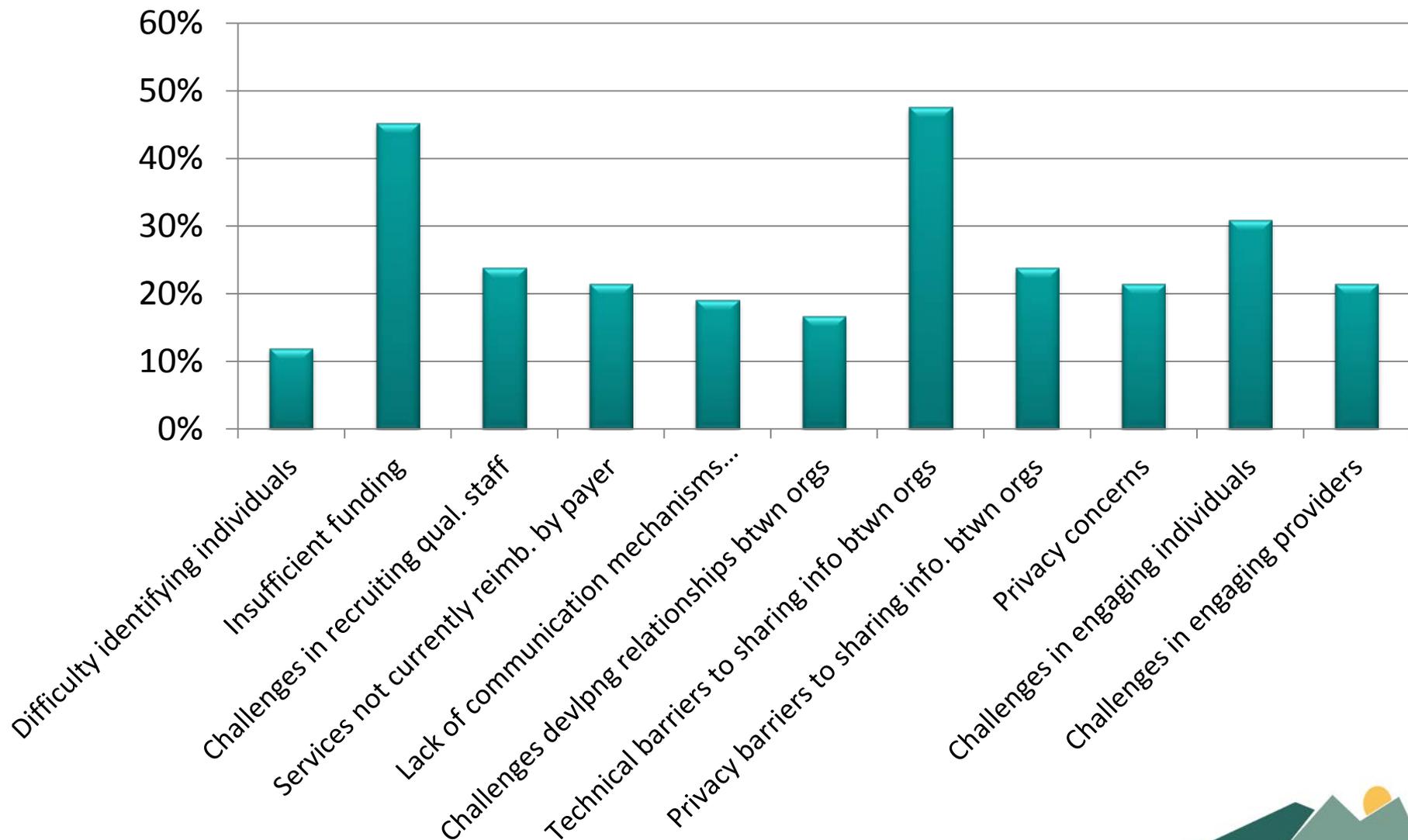
Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Special Services Mgmt.



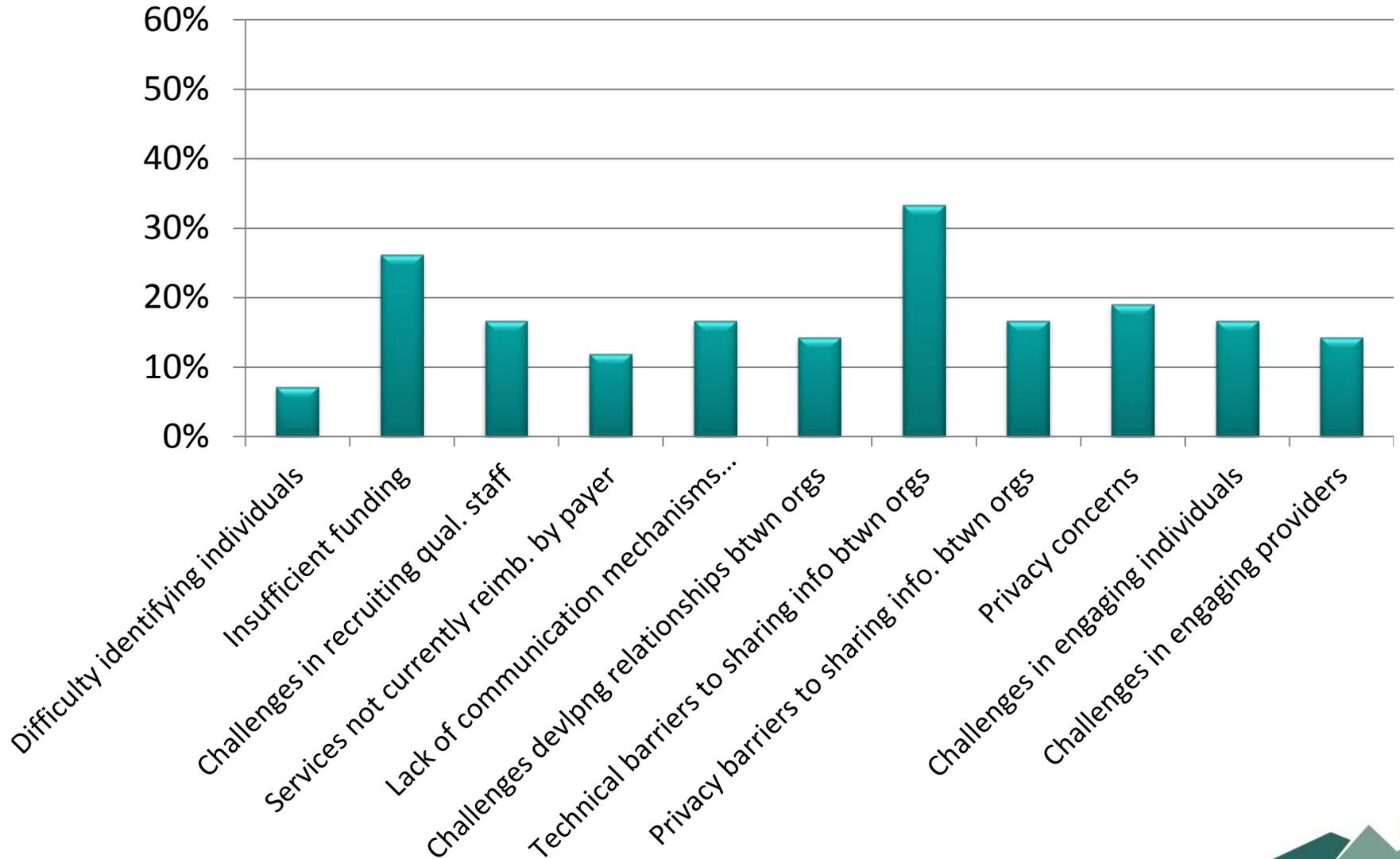
Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Episodic Pathways



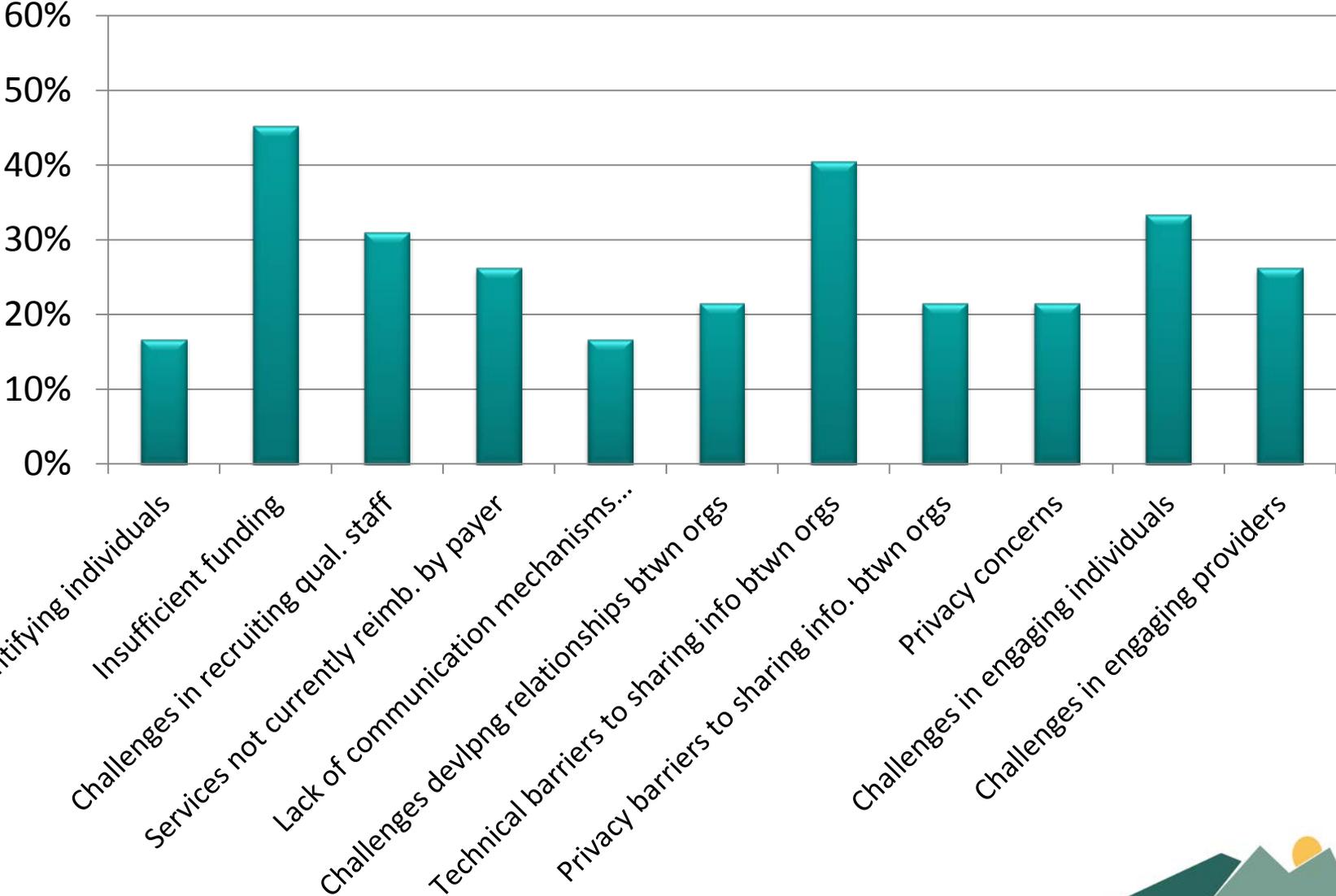
Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Disease Management



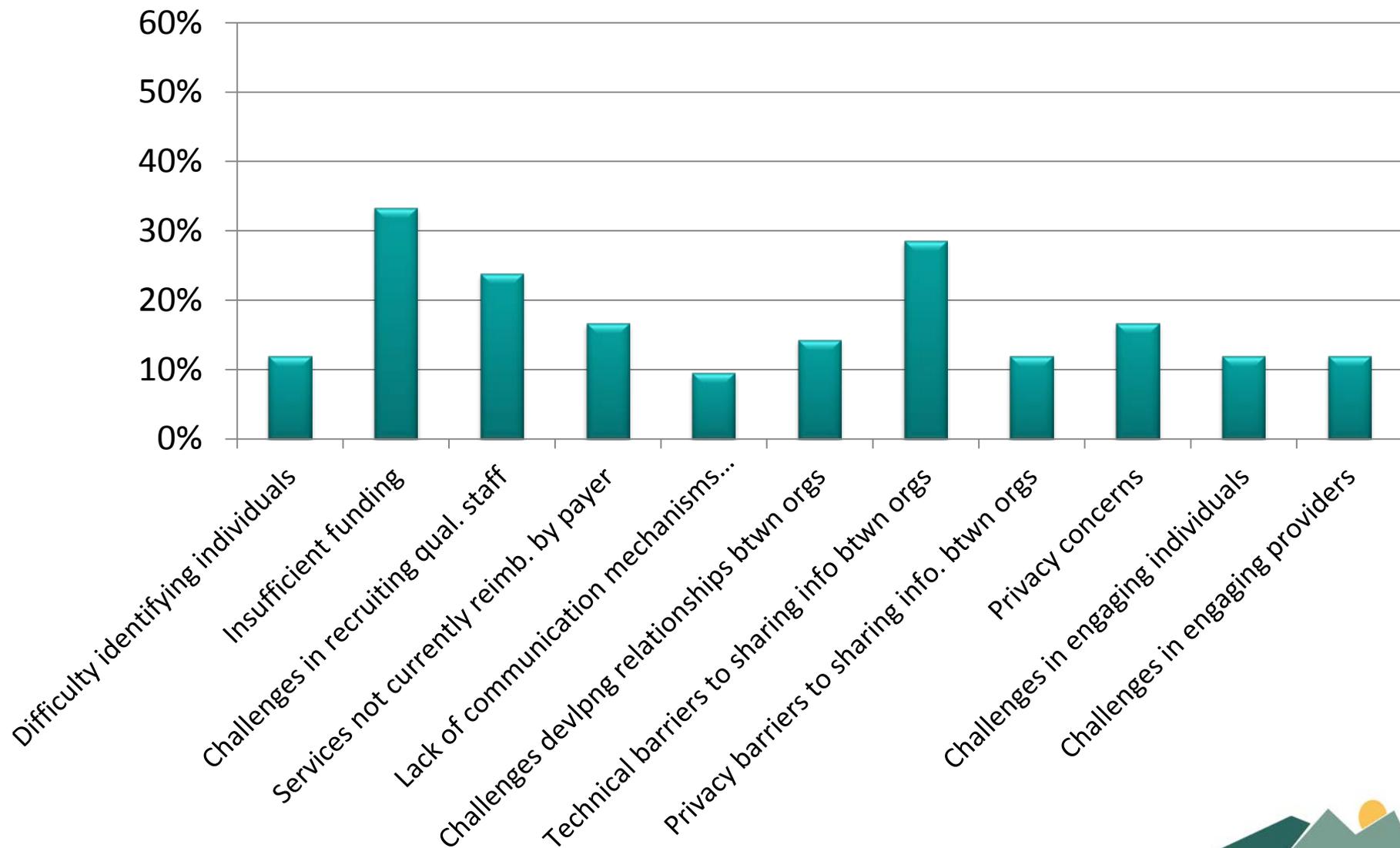
Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Post-Discharge Follow-Up



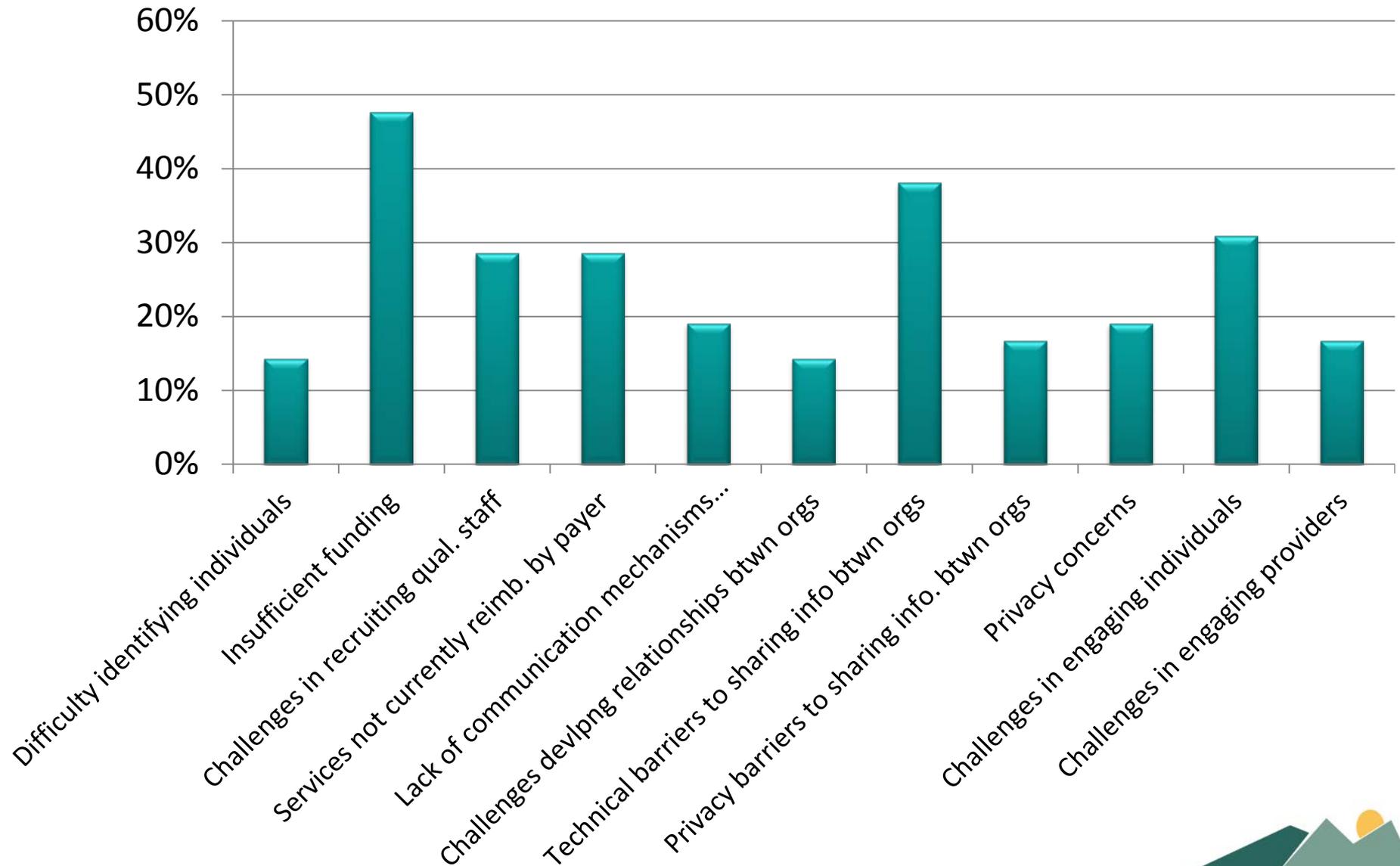
Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Short-Term Case Mgmt. Programs



Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Utilization Mgmt



Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Prevention / Wellness Engagement



Frequency of Challenges Experienced by Responding Organizations, by Type of Service: Life Resource Mgmt

