

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

Date of meeting: March 23, 2014

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Introductions</b>	Nancy Eldridge called the meeting to order at 10:04. An initial roll call revealed that a quorum was not present. After the updates were completed, a quorum was present.	
<b>2. Updates</b>	<p><b>ACO Care Management Standards:</b> ACO Care Management standards were approved by the Core Team. They reflect a great deal of hard work from the group.</p> <p><b>Regional Blueprint/ACO Committees:</b> Unified Community Collaborative (UCC) update was presented by Jenney Samuelson. Many regional committees are merging with ongoing groups that were already working on similar initiatives in health service areas. UCCs are seeking to establish a forum for identifying care gaps and improving quality (particularly around ACO performance measures); there is a similar focus in each health service area. Each ACO is represented on the UCCs in the health service areas where they are present.</p> <p>UCCs are developing charters to guide their work; there are charters confirmed and on file for 10 health service areas and there are several that are currently being drafted and revised. At least two UCCs have a consumer representative, and Burlington is discussing having a consumer as a voting member.</p> <p>Q: Does anyone approve those charters?  A: The Blueprint helped by providing a draft template/sample, but the charters are customized for each health service area based on membership in the UCC. For example, some include specific notes about data sharing.</p> <p>Q: Are the charters available for public dissemination?  A: Bennington has shared their charter with other UCCs. The draft template/sample can be shared. Vicki Loner will send out the model template to Erin Flynn for distribution to the CMCM group. No identified data is included in the charters – only aggregate clinical data from the Blueprint is shared. Jenney will ask the individual UCCs to share their charters – they are living documents that will likely become more robust over time as the initiatives evolve.</p>	

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	<p>Heidi Klein reported that the Health Department is the steward of data that might be very helpful to the UCCs and is exploring ways to share that data. It would be good to disseminate population health data to further the work going of UCCs and ACOs.</p> <p><b>Care Management Inventory Survey Report:</b> Pat Jones noted that the final version of the Care Management Inventory Survey Report is posted to the website with the link provided in the agenda. She noted that Bailit Health Purchasing staff members were instrumental in the compilation of this report. The narrative now includes language around home health care, at the request of the VNAs of Vermont. The findings from the report are being addressed by the Learning Collaboratives and in other efforts.</p>	
<b>3. Work Plan</b>	<p>Nancy Eldridge reported that good progress has been made on the CMCM work plan. She reviewed future topics for the CMCM Work Group, as outlined in the work plan (Attachment 3B). A key goal is to maintain good linkage with the UCCs and the Blueprint; as well as the Population Health and DLTSS work groups. The intent is also to continue to receive reports from the Integrated Communities Care Management Learning Collaborative, and to continue to make periodic reports to the Steering Committee and Core Team about the work that is occurring. Nancy also noted that with the federal and state focus on Value-Based Purchasing (VBP), the CMCM leadership group wishes to stay well informed in areas such as CMS VBP initiatives (such as the Next Generation ACO Model just announced by CMS), and the All Payer Model being discussed in Vermont. Nancy Breiden stated she wishes to stay apprised of the direction of the project. Georgia noted that SIM leadership is engaging in an extensive mid-project risk assessment that will include mitigation strategies for identified risks; the results should be available in the summer.</p>	
<b>4. Feb. Minutes</b>	<p>The February minutes were approved by roll call vote, with four abstentions.</p>	
<b>5. Integrated Communities Care Management Learning Collaborative -Update -Expansion Proposal</b>	<p>Pat Jones provided updates on the Integrated Communities Care Management Learning Collaborative.</p> <p><b>Facilitator Update:</b> A contract has been finalized with Nancy Abernathey, a quality improvement facilitator with experience with practice facilitation, and a contract for a second facilitator with data experience is in process. Training has been provided to each of the three pilot communities on the Plan-Do-Study-Act (PDSA) quality improvement model. Facilitator support is provided to the communities as they test the interventions.</p> <p><b>In-Person Learning Session Update:</b> The second in-person learning session was held at Norwich University; 70+ people attended with representation from a wide variety of organizations in the pilot communities. The keynote speaker was Lauran Hardin, Director of Complex Care at Mercy Hospital in Grand Rapids MI. She addressed care management across the continuum of care, identifying a lead care coordinator for at-risk people, and how organizations can work together to develop shared care plans. Also presenting were Deb Greene and Matt Tryhorne from Northern Tier Centers for Health (the FQHC in Northwestern Vermont), who spoke about coordinating care with their local community mental health center.</p> <p><b>Pilot Community Updates:</b> Laural Ruggles and Lisa Viles from St. Johnsbury – Laural commended the Learning Collaborative format, with teams from various communities working on similar efforts using a rapid cycle quality</p>	

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	<p>improvement model. St Johnsbury’s objectives are similar to the DLTSS model of care – identify a lead point of contact, develop a shared care plan that is patient centered. Their team includes representation from AHS, mental health, the hospital, home health, the Area Agency on Aging, FQHCs, Rural Edge (SASH) and DVHA’s VCCI program. The project is focusing on the dual eligible population; the participating organizations have identified 25 at-risk people for initial intervention. Lead Care Coordinators have been tentatively chosen, recognizing that this may change over time, depending on the person’s wishes. St. Johnsbury has developed a template for a draft shared care plan that includes treatment goals and the person’s goals. They are also using “Camden Cards” (named for the Camden Coalition of Healthcare Providers that developed these cards and presented them at the January learning session), a patient engagement tool. Each card represents a care management domain to help identify root causes of health issues.</p> <p>Q: Is the group using a survey to help measure patient experience?  A: There is concern that surveys are burdensome; the plan is to use focus groups and interviews to measure patient experience. A comment was made that there can be challenges in translating those methods into measurement. Laural noted that a grant program for the dual eligible population in St. Johnsbury uses a health coach assessment tool that evaluates progress in various care domains with a rating scale. The tool was designed with CDC input.</p> <p>Deb Andrews from Burlington – Burlington has engaged 3 primary care practices and 17 organizations in the learning collaborative. Their initial cohort includes people with 3 or more ED visits in 2014, provider recommendation, and patient consent. They are relying on a trusted relationship between the person and a provider to garner participation, using talking points rather than a script. Following guidance from the March learning session, they are identifying the person’s trusted provider as the lead case manager. They plan to develop eco-maps of relationships and services for each person, and have subgroups working on shared care plans. They are working on ability to share and edit documents between organizations, maybe through PRISM. They are considering adding organizations, including faith-based, school-based, social and environmental support organizations.</p> <p>Q: With respect to eco-maps – are characteristics and services other than clinical characteristics and services identified?  A: Yes, the eco-maps are intended to establish as much information about the person as possible – with identification of factors that might impact any aspect of their health, and identification of all providers/organizations working with patients.</p> <p>Nancy Abernathey presented for Rutland - Their cohort is 25 at-risk people, based on ED and inpatient visits. They are initiating outreach with 5 of the most at-risk people. They have discovered that that how you approach people matters. The better the description or the program, the better the participation, so they are using talking points and allied care partners who work with the patients in various settings. They are also creating Camden Cards for person engagement and have a draft shared plan of care to be piloted soon. The Rutland team is comprised of a wide variety of participants, including representatives from home health, the hospital, the mental health agency, social work, the FQHC, area agency on aging, and skilled nursing facilities. They are working on sharing information electronically.</p>	

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	<p><b>Upcoming Activities:</b> A webinar is scheduled for April 15, and the next in-person learning session is May 19<sup>th</sup> at Norwich University. Jeanne McAllister from the University of Indiana will present information on shared care plans, care management rounds and care conferencing.</p> <p><b>Learning Collaborative Expansion Proposal:</b> The goals of the Learning Collaborative are focused on priorities identified by the CMCM work group:</p> <ol style="list-style-type: none"> <li>1) To reduce fragmentation with better coordination of care management</li> <li>2) To better integrate health and social services to address social determinants of health</li> </ol> <p>The first round with 3 pilot communities is going well. There are plans to develop core competency training for front line care managers, with plans to work with the DLTSS work group to ensure that the training includes competencies for working with people with disabilities.</p> <p>Some funding is available through SIM to expand the Learning Collaborative to additional cohorts of interested communities. There should be opportunities to achieve economies of scale and leverage available resources, such as quality improvement facilitators from the first round, and possibly the Blueprint and ACOs.</p> <p>Round 1 funding was approved at up to \$300,000 and the program is on target to spend that. The estimate to expand to the rest of the state is a total not to exceed \$300,000, which would cover a third QI facilitator, expert faculty fees and travel expenses, facility costs, supplies, and logistical support services. An additional \$200,000 would cover a train-the-trainer approach to implement Core Competency training for front-line care managers. Organization(s) with training expertise would work with Vermont-based trainers, to build capacity for ongoing training. The total estimate for the expansion is \$500,000. The goal is to begin the expansion by June of 2015, in cohorts of 3 or 4 interested communities.</p> <p>It was noted that there are differences in participation between communities; they are coming from different places in terms of readiness. Some have already started this work in some form, some started from ground zero. Nancy Breiden commented that she hopes that lessons learned can be incorporated as this program moves forward.</p> <p>There was a question about the source of funding for the expansion. The DLTSS workgroup was informed that \$350,000 was available; Julie Wasserman asked if this proposal intended to use that money or if separate funding was available for DLTSS. The response is that this is funding that was allocated to the CMCM Work Group for use in creating the Learning Collaborative Program, with guidance to coordinate with the DLTSS Work Group. This funding is not tied to carry over from prior years of the SIM grant.</p> <p>Q: Beverly Boget asked if the expansion funding would be used for Round 1 expenses.  A: No. The original \$300,000 is for Round 1, and will cover expenses for the initial 3-community pilot, into early 2016.</p>	

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	<p>Nancy Eldridge asked if a member would like to make a motion recommending expansion contingent upon collaboration with the DLTS workgroup. Laural Ruggles made the motion; Bea Grause seconded the motion.</p> <p>Sue Aranoff asked about learning collaborative topics and the extent to which the DLTS Work Group would be able to weigh in on content of the program. Erin Flynn responded that the program expansion is looking at the same interventions that are occurring in Round 1, with a focus on the specific needs of additional communities that decide to participate.</p> <p>Jenney Samuelson noted that initial discussions of core competency training have involved DLTS Work Group leadership. DLTS leadership was invited to provide a representative to the learning collaborative planning group. The intervention topics coincide with elements from the DLTS model of care (e.g., lead care coordinator, shared plan of care). The DLTS model of care was used as a source document when creating the program.</p> <p>A roll call vote was taken on the motion – which carried with one No vote and two Abstentions.</p>	
<p><b>6. Population Health Update</b></p>	<p>Tracy Dolan, Co-Chair of the Population Health Work Group, presented from Attachments 5a, 5b and 5c, included in the meeting materials.</p> <p>The Population Health Workgroup is charged with recommending ways to improve health, and developing a Population Health Plan; the latter was a requirement added to the SIM project by CMMI last year. Specifically, the Work Group is striving to:</p> <ul style="list-style-type: none"> <li>• Develop consensus on a robust set of population health measures to be used in tracking the outcomes of the project and to be incorporated in new payment models.</li> <li>• Offer recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms.</li> <li>• Identify promising new financing vehicles that promote financial investment in population health interventions.</li> <li>• Identify opportunities to enhance current initiatives and health delivery system models (e.g. the Vermont Blueprint for Health and Accountable Care Organizations), to improve population health by better integrating clinical services, public health programs and community based services at the practice and community levels. One potential model is an Accountable Communities for Health.</li> <li>• Develop the “Plan for Integrating Population Health and Prevention in VT Health Care Innovation.”</li> </ul> <p>From page 29 of the materials, Tracy reviewed the “Signs of Successful Integration of Population Health in New Models.” Page 31 of the materials provides more information and a comparison of three different structures that integrate population health into a health care system: ACOs, Total Accountable Care Organizations (TACOs), and Accountable Communities for Health (ACHs). Page 34 of the materials defines the essential characteristics of an ACH.</p> <p>The Population Health Work Group has contracted with the Prevention Institute to help think through what an ACH might</p>	

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	<p>look like in VT. The intent is to build on structures that already exist, and also to explore what structures might be effective in building and supporting an ACH in VT. They are looking at national models – Scotland might be closer to the ACH model under consideration, as well as the Netherlands, where there is a lot of care coordination and broad budget categories that encompass many of these kinds of activities. Laural Ruggles commented that St. Johnsbury is interested in developing an ACH – they are considering making their Blueprint-ACO Unified Community Collaborative (UCC) accountable across all health care and socio-economic domains. St. Johnsbury, St. Albans and Burlington were chosen by the Prevention Institute as focus communities in a case study model; one goal is to explore what they are already doing.</p> <p>Q: How will Next Generation ACOs fit in with this?  A: Tracy responded that financial rewards for individual participation seem to be less important than financial rewards for population health improvement. Laural Ruggles noted that global budgets are a good way to incent this kind of activity. CMS is coming out with models transitioning Medicare from fee-for-service payment to capitation or other value-based payments.</p> <p>Q: Does this work intersect with the learning collaborative and ACO-Blueprint collaborative efforts?  A: Jenney Samuelson differentiated between the various efforts discussed at the meeting: As an example, the St. Johnsbury UCC is the group that identified high-level health goals. The Learning Collaborative focuses on on-the-ground, specific care management efforts for at-risk members of the population, whereas the UCCs focus on higher level priorities.</p> <p>There was a comment that it is important to note the difference in discussing these efforts in the mental health arena, versus in the clinical setting, as they are very different cultures. It would be important to ensure that mental health considerations are included in the process. Mental health agencies are recommended to be part of the UCC leadership group. The learning collaborative envisions that a mental health agency staff member could serve as the lead care coordinator if the mental health agency is central to the person’s needs.</p>	
<b>6. Public Comment</b>	In response to a question, it was clarified that there was no Attachment 4b for today’s discussion of the Learning Collaborative Expansion.	
<b>8. Next Steps, Future Meeting</b>	<b>Next Meeting:</b> Tuesday, April 14, 2015, 10:30 am – 12:30 pm, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, call-In number: 1-877-273-4202, Conference ID: 2252454	