

Care Models and Care Management

Work Group Meeting

Agenda 4-14-15

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Agenda
April 14, 2015; 10:30 AM to 12:30 PM
ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:30 to 10:40	Welcome; Introductions; Approval of Minutes (Co-Chair Bea Grause is meeting facilitator)	<u>Attachment 1:</u> March meeting minutes	Yes (approval of minutes)
2	10:40 to 10:50	Update on Regional Blueprint/ACO Committees (Jenney Samuelson, Miriam Sheehey and Patty Launer) <i>Public Comment</i>		
3	10:50 to 11:20	Integrated Communities Care Management Learning Collaborative: <ul style="list-style-type: none"> • Next Steps: April 15th Webinar, May 19th In-Person Learning Session • Expansion to Additional Communities <i>Public Comment</i>	<u>Attachment 3:</u> Learning Collaborative Expansion Power Point	Yes (vote to recommend expansion of Learning Collaborative to additional communities)
4	11:20 to 12:05	Presentation by Vermont's Area Agencies on Aging and Visiting Nurse Associations (Lisa Viles, NEVAAA; Peter Cobb, VNAs of Vermont) <i>Public Comment</i>	<u>Attachment 4:</u> <i>pending</i>	
5	12:05 to 12:25	Payment Reform Update (Co-Chair Bea Grause, VAHHS) <i>Public Comment</i>	<u>Attachment 5:</u> <i>pending</i>	
7	12:25 to 12:30	Wrap-Up and Next Steps <i>Next Meeting:</i> <i>Tuesday, May 12th, 2015, 10:30 AM – 12:30 PM, Calvin Coolidge Conference Room, National Life, Montpelier VT</i>		

Attachment 1

March Minutes

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
1. Welcome and Introductions	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.	
2. Updates	<p>ACO Care Management Standards: ACO Care Management standards were approved by the Core Team. They reflect a great deal of hard work from the group.</p> <p>Regional Blueprint/ACO Committees: 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>	

Agenda Item	Discussion	Next Steps
	<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>Care Management Inventory Survey Report: 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>	
3. Work Plan	<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>	
4. Feb. Minutes	<p>The February minutes were approved by roll call vote, with four abstentions.</p>	
5. Integrated Communities Care Management Learning Collaborative -Update -Expansion Proposal	<p>Pat Jones provided updates on the Integrated Communities Care Management Learning Collaborative.</p> <p>Facilitator Update: 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>In-Person Learning Session Update: 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>Pilot Community Updates: 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>	

Agenda Item	Discussion	Next Steps
	<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>	

Agenda Item	Discussion	Next Steps
	<p>Upcoming Activities: A webinar is scheduled for April 15, and the next in-person learning session is May 19th 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>Learning Collaborative Expansion Proposal: The goals of the Learning Collaborative are focused on priorities identified by the CMCM work group:</p> <ol style="list-style-type: none"> 1) To reduce fragmentation with better coordination of care management 2) To better integrate health and social services to address social determinants of health <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>	

Agenda Item	Discussion	Next Steps
	<p>Nancy Eldridge asked if a member would like to make a motion recommending expansion contingent upon collaboration with the DLSS 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 DLSS 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 DLSS Work Group leadership. DLSS leadership was invited to provide a representative to the learning collaborative planning group. The intervention topics coincide with elements from the DLSS model of care (e.g., lead care coordinator, shared plan of care). The DLSS 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>6. Population Health Update</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"> • 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. • Offer recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms. • Identify promising new financing vehicles that promote financial investment in population health interventions. • 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. • Develop the “Plan for Integrating Population Health and Prevention in VT Health Care Innovation.” <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>	

Agenda Item	Discussion	Next Steps
	<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>	
6. Public Comment	In response to a question, it was clarified that there was no Attachment 4b for today’s discussion of the Learning Collaborative Expansion.	
8. Next Steps, Future Meeting	Next Meeting: 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	

VHCIP CMCM Work Group Member List

Roll Call: 3/23/2015

*Sue Trauff 10
Nancy Breiden 20
Laurel Ruggles 10
Bea Grause 10
Mth Carved - 20
2 Abstentions*

Member		Member Alternate		Minutes	LC Expansion	Organization
First Name	Last Name	First Name	Last Name			
Susan	Aranoff ✓	Sara	Lane	Y	Y	AHS - DAIL
Nancy	Breiden ✓	Rachel	Seelig	Y	N	VLA/Disability Law Project
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger			AHS - DOC
Barbara	Cimaglio					AHS - VDH
Peter	Cobb	Beverly ✓	Boget	Y	A	VNAs of Vermont
Dana	Demartino					Central Vermont Medical Center
Nancy	Eldridge ✓			A	Y	Cathedral Square and SASH Program
Joyce	Gallimore					CHAC
Eileen	Girling ✓	Heather ✓	Bollman	Y	Y	AHS - DVHA
Bea	Grause ✓			Y	Y	Vermont Association of Hospital and Health Systems
Dale	Hackett <i>UTA</i>					None
Linda	Johnson	Cameron	Erickson			MVP Health Care
Pat	Jones ✓	Richard	Slusky	Y	Y	GMCB
Trinka	Kerr	Julia	Shaw			VLA/Health Care Advocate Project
Patricia	Launer ✓	Joyce ✓	Gallimore	A	Y	Bi-State Primary Care
Vicki	Loner ✓	Maura ✓	Crandall	Y	Y	OneCare Vermont
Madeleine	Mongan ✓			A	O	Vermont Medical Society
Judy	Morton ✓			Y	A	Mountain View Center
Mary	Moulton					Washington County Mental Health Services Inc.
Paul	Reiss ✓	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Laural	Ruggles ✓			Y	Y	Northeastern Vermont Regional Hospital
Keri	Schatz					AHS - DCF
Catherine	Simonson					DA - Howard Center for Mental Health
Patricia	Singer					AHS - DMH
Shawn	Skafelstad ✓	Robert <i>Sommer</i>	Wheeler <i>Sommer</i>	Y	Y	AHS - CO
Audrey-Ann	Spence ✓	Robert <i>Amy</i>	Wheeler <i>Wheeler</i>	Y	Y	Blue Cross Blue Shield of Vermont
Jason	Wolstenholme ✓	Jessica	Oski			Vermont Chiropractic Association
Lisa	Viles ✓			A	Y	Area Agency on Aging for Northeastern Vermont
28		13				

Lily Sommer voting member AHS

*Minutes approved
2 Abstentions*

VHCIP CMCM Work Group Participant List

Attendance:

3/23/2015

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

First Name	Last Name		Organization	Care Models
Peter	Albert	here	Blue Cross Blue Shield of Vermont	X
Susan	Aranoff	here	AHS - DAIL	S/M
Ena	Backus		GMCB	X
Melissa	Bailey	here		X
Michael	Bailit	phone	SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Susan	Besio		SOV Consultant - Pacific Health Policy Group	S
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
Beverly	Boget	phone	VNAs of Vermont	MA
Heather	Bollman		AHS - DVHA	MA
Mary Lou	Bolt		Rutland Regional Medical Center	X
Nancy	Breiden	here	VLA/Disability Law Project	M
Stephen	Broer		DA - Northwest Counseling and Support Services	X
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Anne	Burmeister		Planned Parenthood of Northern New England	X

Deb Andrews - LC Burlington
 Claire McFadden

Mary Tracy

Dr. Dee	Burroughs-Biron		AHS - DOC	M
Jane	Catton		Northwestern Medical Center	X
Amanda	Ciecior		AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	M
Peter	Cobb		VNAs of Vermont	M
Amy	Coonradt		AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Maura	Crandall		OneCare Vermont	MA
Claire	Crisman		Planned Parenthood of Northern New England	A
Dana	Demartino		Central Vermont Medical Center	M
Steve	Dickens		AHS - DAIL	X
Nancy	Eldridge	here	Cathedral Square and SASH Program	C/M
Cameron	Erickson		MVP Health Care	MA
Trudee	Ettlinger		AHS - DOC	MA
Erin	Flynn	here	AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Meagan	Gallagher		Planned Parenthood of Northern New England	X
Joyce	Gallimore		Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Eileen	Girling	here	AHS - DVHA	M
Kelly	Gordon		AHS - DVHA	X
Bea	Grause	here	Vermont Association of Hospital and Health Systems	C/M
Dale	Hackett	excused	None	M
Bryan	Hallett		GMCB	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Breana	Holmes		AHS - Central Office - IFS	X
Marge	Houy	here	SOV Consultant - Bailit-Health Purchasing	S
Christine	Hughes		SOV Consultant - Bailit-Health Purchasing	S
Jay	Hughes		Medicity	X
Linda	Johnson		MVP Health Care	M
Pat	Jones	here	GMCB	S/M
Joelle	Judge	here	UMASS	S

Trinka	Kerr		VLA/Health Care Advocate Project	M
Sarah	Kinsler	here		S
Sara	Lane		AHS - DAIL	MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer	phone	Bi-State Primary Care	M
Deborah	Lisi-Baker		SOV - Consultant	X
Vicki	Loner	phone	OneCare Vermont	M
Georgia	Maheras	here	AOA	S
Mike	Maslack			X
John	Matulis			X
James	Mauro		Blue Cross Blue Shield of Vermont	X
Clare	McFadden	phone	AHS - DAIL	X
Elise	McKenna		AHS - DVHA - Blueprint	X
Jill	McKenzie			X
Jeanne	McLaughlin		VNAs of Vermont	X
Darcy	McPherson		AHS - DVHA	A
Madeleine	Mongan	phone	Vermont Medical Society	M
Monika	Morse			X
Judy	Morton	phone	Mountain View Center	M
Mary	Moulton		Washington County Mental Health Services Inc.	M
Kirsten	Murphy		AHS - Central Office - DDC	X
Reeva	Murphy		AHS - Central Office - IFS	X
Sarah	Narkewicz		Rutland Regional Medical Center	X
Jessica	Oski		Vermont Chiropractic Association	MA
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Betty	Rambur		GMCB	X
Allan	Ramsay		GMCB	X
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Debra	Repice		MVP Health Care	X
Julie	Riffon		North Country Hospital	X
Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson	here	AHS - DVHA - Blueprint	X
Jessica	Sattler		Accountable Care Transitions, Inc.	X
Ken	Schatz		AHS - DCF	M

Rachel	Seelig		VLA/Senior Citizens Law Project	MA
Maureen	Shattuck		Springfield Medical Care Systems	X
Julia	Shaw		VLA/Health Care Advocate Project	MA
Catherine	Simonson		DA - HowardCenter for Mental Health	M
Tom	Simpatico		AHS - DVHA	X
Patricia	Singer		AHS - DMH	M
Shawn	Skaflestad	phone	AHS - Central Office	X
Richard	Slusky		GMCB	S/MA
Pam	Smart		Northern Vermont Regional Hospital	X
Lily	Sojourner	here	AHS - Central Office	X
Audrey-Ann	Spence	Amy Duscharne	Blue Cross Blue Shield of Vermont	M
Kara	Suter		AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Win	Turner			X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Julie	Wasserman	here	AHS - Central Office	S
Bob	West			X
James	Westrich		AHS - DVHA	S
Robert	Wheeler		Blue Cross Blue Shield of Vermont	MA
Bradley	Wilhelm		AHS - DVHA	S
Jason	Wolstenholme		Vermont Chiropractic Association	M
Cecelia	Wu		AHS - DVHA	S
Mark	Young			X
Lisa	Viles	here	Area Agency on Aging for Northeastern Vermont	M
				108

Nancy Hernandez - LC facilitator here
Sarah ~~Dembinger~~ - NWMC
Jemley

Attachment 3

Learning Collaborative Expansion

**Vermont's Integrated Communities
Care Management
Learning Collaborative:
Round 1 Progress, and
Request for Expansion**

April 14, 2015

Background

- The VHCIP Care Models and Care Management Work Group identified two key priorities:
 - ...to better serve all Vermonters (especially those with complex physical and/or mental health needs), **reduce fragmentation with better coordination of care management activities...**
 - ...[to] better **integrate social services and health care services** in order to more effectively understand and address **social determinants of health** (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters...
- The Work Group designated a Planning Group to design a Quality Improvement Learning Collaborative to act on these priorities.
- The Work Group and Steering Committee recommended funding for the Learning Collaborative; the Core Team approved that recommendation.

Learning Collaborative Snapshot

- Vermont's delivery system reforms have strengthened coordination of care and services, but people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services.
- A number of national models have potential to address these concerns.
- **Health and community service providers from 3 health service areas (Burlington, Rutland, St. Johnsbury) were invited to participate in Round 1 of the year-long Integrated Communities Care Management Learning Collaborative to test interventions from these promising models.**

Near-Term Goals

- To increase knowledge of data sources and use data to identify at-risk people and understand their needs;
- To learn about and implement promising interventions to better integrate care management;
- To improve communication between organizations;
- To systematize referrals, transitions and co-management
- To provide tools and training for staff members who engage in care management; and
- To see if interventions improve coordination of care.

Longer-Term Goals

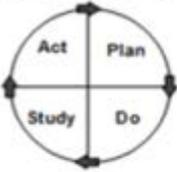
- Longer-term goals mirror the Triple Aim and Vermont's Health Care Reform goals:
 - Improving the patient experience of care (including quality and satisfaction);
 - Improving the health of populations; and
 - Reducing the per capita cost of health care.
- While the Collaborative will initially focus on at-risk populations, the ultimate goal is to develop a population-wide approach.

How we will do it – Learning Model:

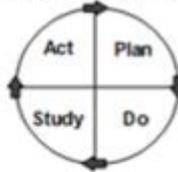
Pre-Work
(November 22nd - January 12th)

The Learning Collaborative will use the Plan-Do-Study-Act (PDSA) quality improvement model.

Learning Session I
(Teams gather for a face-to-face meeting)
(January 13th)

Action Period
community teams working together to implement change)

(January 14th - March 9th)

Learning Session II
(Teams gather for a face-to-face meeting)
(March 10th)

Action Period
community teams working together to implement change)

(March 11th - May 18th)

Learning Session III
(Teams gather for a face-to-face meeting)
(May 19th)

Spreading the Change

Round 1 Participants Include:

Primary Care Practices participating in ACOs (care coordinators)

Designated Mental Health Agencies and Developmental Services Providers

Visiting Nurse Associations and Home Health Agencies

Hospitals and Skilled Nursing Facilities

Area Agencies on Aging

Blueprint Community Health Teams and Practice Facilitators

Support and Services at Home (SASH coordinators)

ACOs (OneCare, CHAC)

Medicaid's Vermont Chronic Care Initiative

Commercial Insurers (BCBSVT)

Agency of Human Services Staff

Round 1 Pilot Community Activities

1. Forming Integrated Community Teams to improve care management for at-risk people.
2. Identifying current care management services and needs in the community (including gaps in services).
3. Establishing criteria to define at-risk people; identifying people in need of integrated care management; conducting outreach to those people and their families.
4. Establishing more effective communication and integration between team members, including interventions such as establishing integrated care agreements, identifying lead care coordinators, developing shared care plans, conducting care conferences, and engaging in care management rounds.
5. Developing tools to enhance integrated care services, such as care coordination protocols, referral guidelines, and data resources.
6. Participating in shared learning opportunities, including in-person learning sessions, webinars, and skills training for front-line care managers.
7. Developing performance measures to evaluate success of the interventions; collecting, analyzing and reporting data for those measures.

Timeline for Round 1

- **Kick-Off Webinars were held on November 12 and 21:**
Approximately 70 people attended
- **1st In-Person Learning Session was held on Jan. 13, 2015:**
Approximately 90 people attended
- **Monthly Educational Webinars:** During months without in-person learning sessions
- **First Action/Measurement Period:** Jan.-Feb. 2015
- **2nd In-Person Learning Session was held on March 10, 2015:**
Approximately 70 people attended
- **Second Action/Measurement Period:** March-April 2015
- **3rd In-Person Learning Session:** May 19, 2015
- **Third Action/Measurement Period:** May-June 2015
- **Continued Testing and Measurement:** July-Nov. 2015
- **Core Competency Training for Care Managers:** Sept. 2015-Jan. 2016
- **Final Results and Next Steps:** Jan. 2016

Expansion Request

- Round 1 (Burlington, St. Johnsbury and Rutland) is well underway
- Other communities have initiated similar efforts and expressed interest in participation
- There is potential to leverage existing collaborative for other communities
- Skills training for front-line care managers planned for late 2015; initiating second round now could leverage train-the-trainer approach
- Seeking CMCM Work Group's endorsement of funding request for additional rounds, to allow expansion to all interested health service areas

Proposed Timeline for Round 2

- **Kick-Off Webinars:** May 2015
- **1st All-Day In-Person Learning Session:** June 2015
- **Monthly Webinars:** 1 hour (during months without in-person learning sessions)
- **First Action/Measurement Period:** June-Aug. 2015
- **2nd In-Person Learning Session:** September 2015
- **Second Action/Measurement Period:** Sept.-Oct. 2015
- **3rd In-Person Learning Session:** November 2015
- **Third Action/Measurement Period:** Nov.-Dec. 2015
- **Core Competency Training for Care Managers;
Continued Testing and Measurement:** Jan.-June 2016
- **Final Results and Next Steps:** July 2016

Estimated Budget for Rounds 2-4

- Anticipated economies of scale for quality improvement facilitators -- \$100,000 in estimated costs for one additional facilitator
- Learning Session faculty costs (includes travel) estimated at \$110,000 based on Round 1
- Core Competency Training costs estimated at \$90,000 (includes Train-the-Trainer costs)
- Facility, logistical support, and supply costs estimated at \$200,000
- Total request: \$500,000 (not to exceed amount)

Questions/Discussion

Attachment 4

Area Agencies on Aging &
Visiting Nurse Association

Attachment 5

Payment Reform Update



Understanding Payment Reform in Vermont

CMCM WORKGROUP APRIL 14, 2015
2015

Payment Reform Questions

Why the drive for payment reform?

Whose payments are changing?

What's the time-line for payment reform?

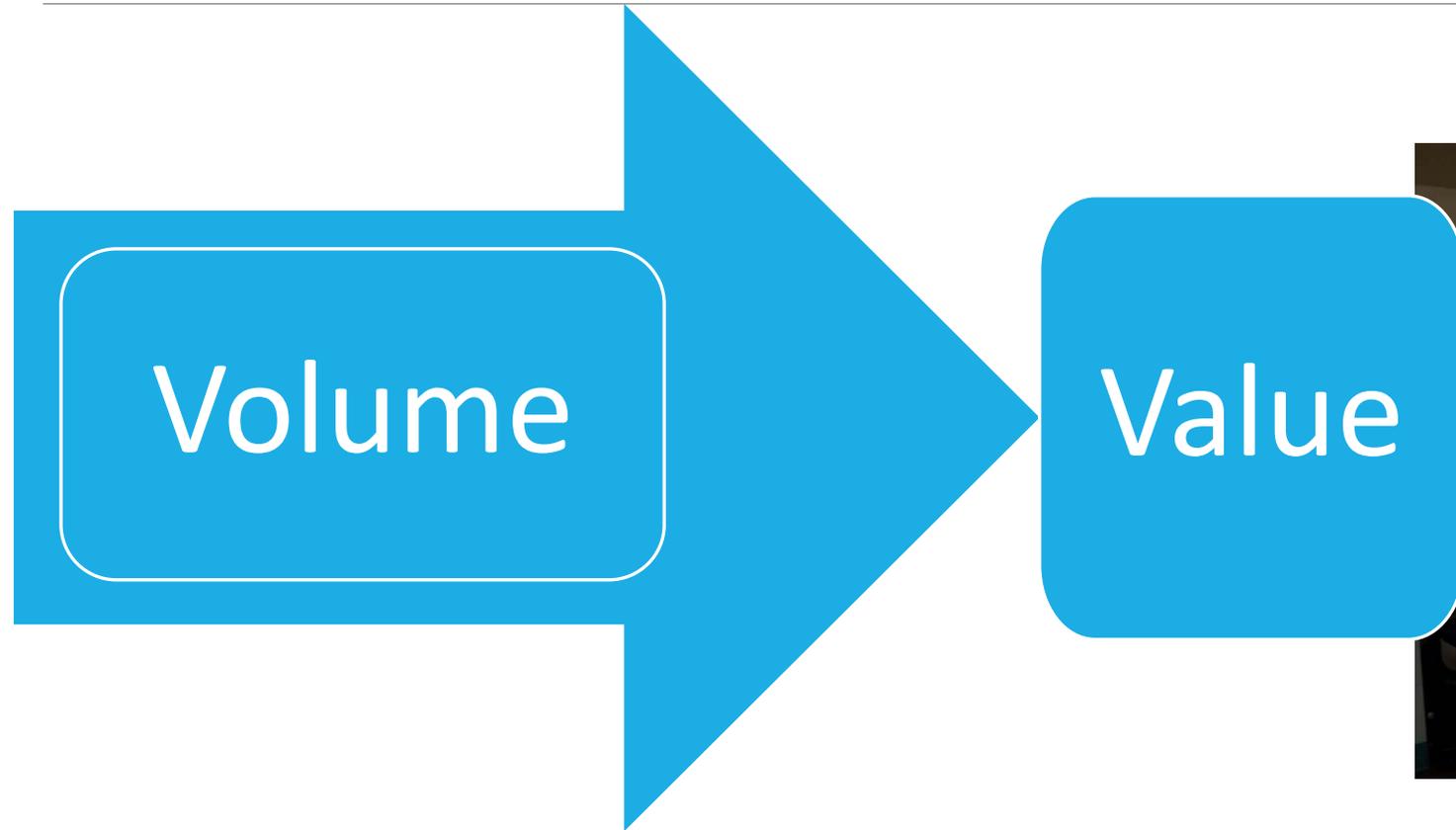
Will all payers collaborate to change payments simultaneously?

What should providers and consumers pay attention to with impending changes?

Why The Drive For Payment Reform?

- Improve care, lower costs
- Limit federal/state liability for entitlement programs
- Increase the reliability of care delivered
- Avoid overtreatment without under-treatment
- Not a phase – momentum just building

Whose Payments Are Changing?



Whose Payments Are Changing?

Hospitals – SSP, Bundled payments, VBP, full capitation

Employed Physicians – per contract, linked to hospital/ACO

ACOs

- Shared Savings Pilots
- Next Generation Guidelines

Sub-acute providers – Bundled payments

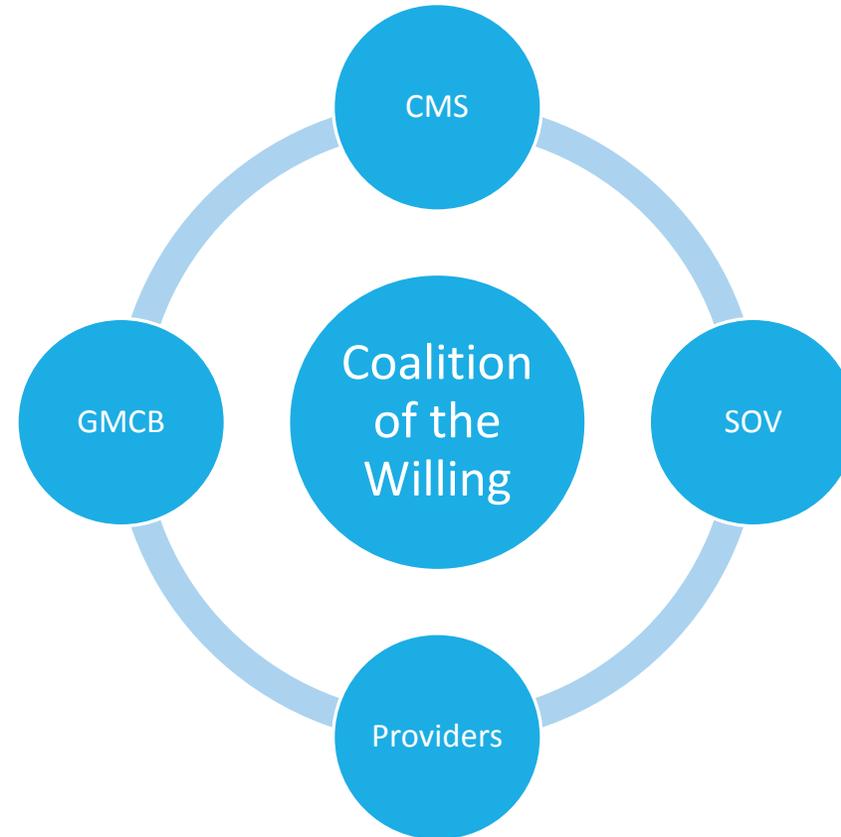
What's The Timeline?

2015

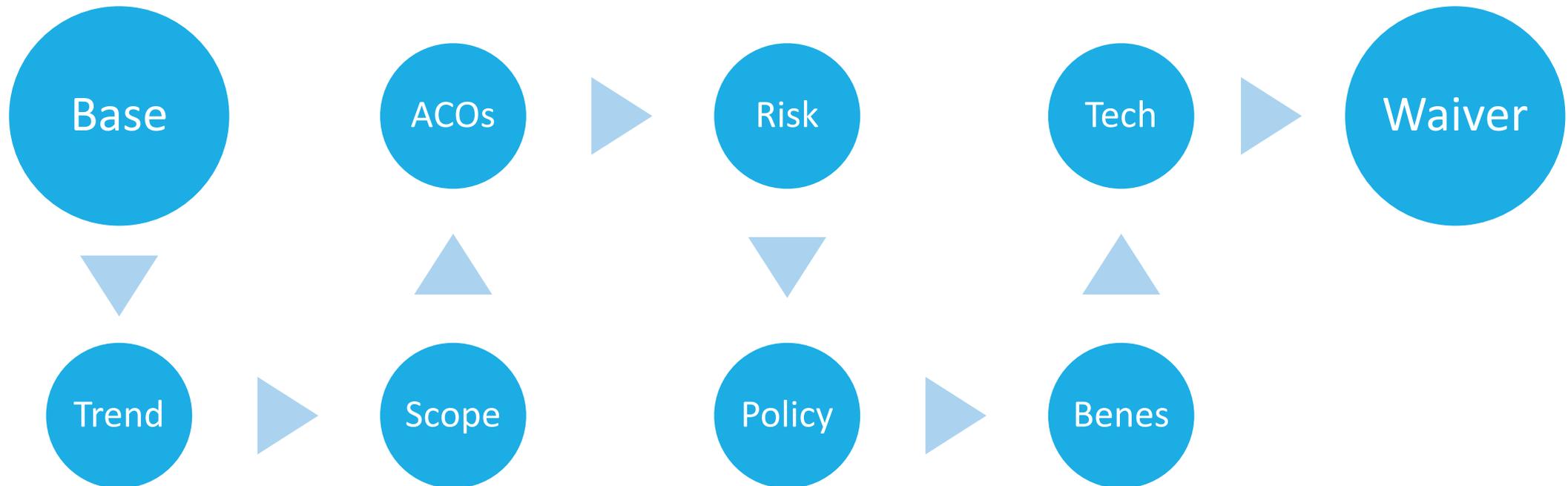
2016

2017!

Will Payers (and Providers) Collaborate?



All Payer Process – a 7 year conversation



Green Mountain Care Board



Payment Reform Won't Succeed WO/ Care Coordination

Patient
&
Family

SASH

MD

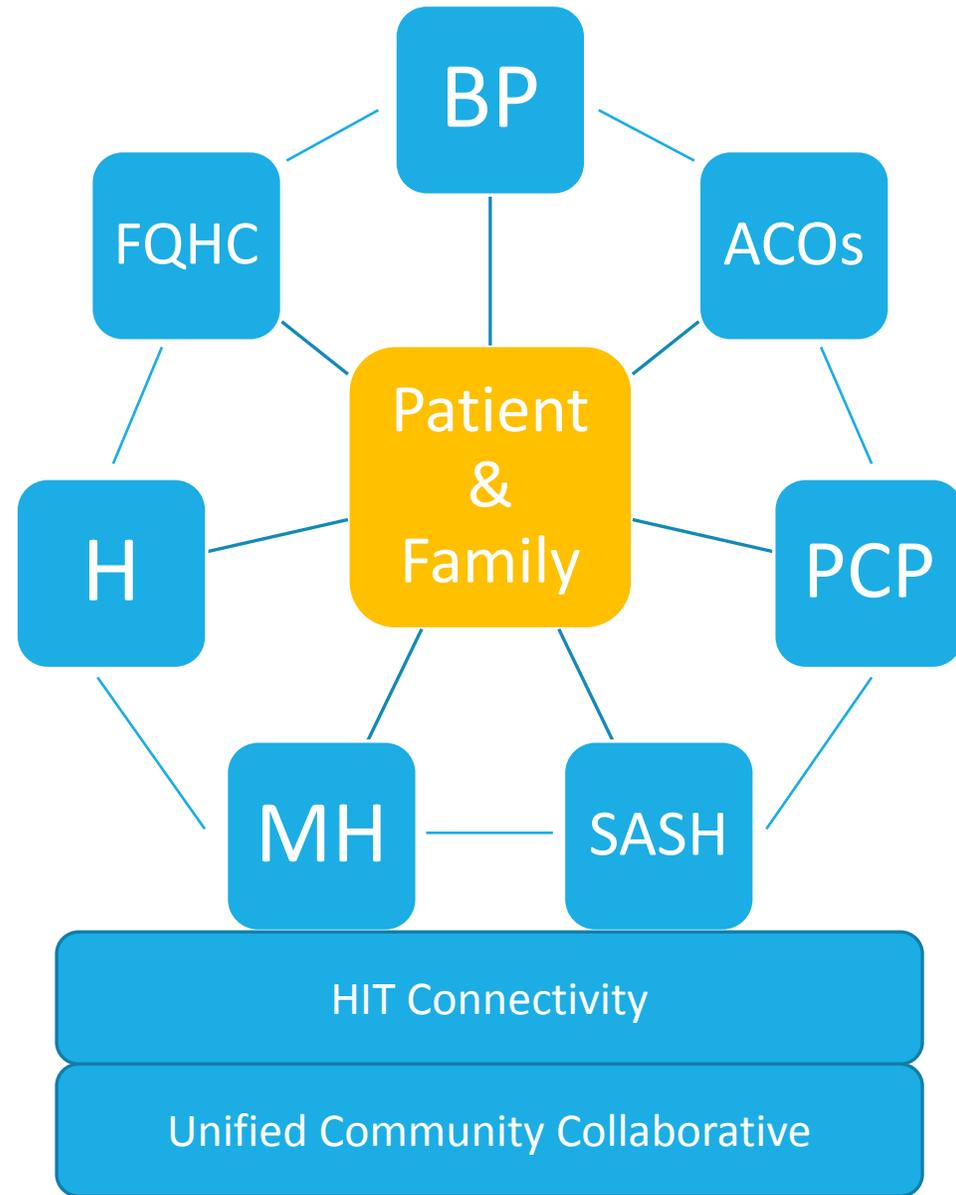
AHS

IT

FQHC

DA

HHS



Payment Reform Challenges & Questions

Aligning provider incentives to provide the right care at the right time, every time for all consumers

Appropriate use of data for measurement, improvement, patient engagement

Managing improvements in practice/payment over time

Paying for infrastructure: HIT, training