



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

Date of meeting: May 12, 2015; 10:30 AM – 12:30 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approval of minutes	<p>Nancy Eldridge called the meeting to order at 10:31 AM. A roll call was taken and a quorum was present. A motion to accept the minutes by exception was made by Trinka Kerr and seconded by Susan Aranoff. The motion carried with one abstention.</p>	
2. Legislative/ Health Policy Update (Co-Chair Bea Grause, VAHHS)	<p>Bea Grause presented Attachment 2 on the payment reform landscape in Vermont and discussed the roles that payers, providers and others might play in the formation of an all payer approach. She noted that the movement is only just beginning and that there will be ongoing discussions about connectivity, collaboration, alignment of payment incentives, stakeholder engagement, and much more as the effort evolves. The hope is that by 1/1/17, Vermont will move to a multi-payer model using different forms of payment. There will still likely be a fee for service aspect even as reform takes place.</p> <p>Laural Ruggles noted that payment reform is not going to work unless a variety of organizations beyond hospitals and practices are involved. The whole system needs to change. There are no payment incentives to coordinate care. Bea responded that the plan is to evolve the model over time to include more organizations.</p> <p>While there are some challenges and questions specifically noted in the presentation, there are likely many more. The process is only just beginning, but CMS is showing interest in pursuing this in Vermont. Nancy Eldridge asked whether there is any sense of a timeline for this work, and where the discussions will take place. Bea responded that the negotiations are between the State of Vermont and CMS at this time. A key question is whether the federal government will offer Vermont a better model under the waiver. The answer has to be yes or it's not worth doing.</p> <p>Beverly Boget asked about the relationship between VHCIP with its funding resources and the waiver. Bea responded that an all-payer model would build on the connections supported by VHCIP, and would aid in sustainability. Sarah Kinsler added that CMS is looking for significant synergy between VHCIP and the waiver work.</p>	

Agenda Item	Discussion	Next Steps
	<p>Susan Aranoff pointed out that there's an opportunity to use remaining VHCIP resources and time to consider global budgets. She mentioned the following proposal from St. Johnsbury: <i>Design a multi-phased pilot project in the St. Johnsbury Hospital Service Area. The project will begin with a design phase focusing on using global budgets for Medicaid medical services. The design phase will include discussion of expanding beyond Medicaid medical services and to other payers.</i></p> <p>Laural Ruggles added that most of the organizations outlined in Bea's slides are participating in the accountable health community proposal in St. Johnsbury. Most organizations get some kind of Medicaid funding, so they are examining if they can get the combined funding in one lump sum, determine locally how to distribute it among organizations, deliver services better and more efficiently, and not have organizations say they can't deliver services because they don't get paid for them. Trust is key to bringing everyone to the table and everyone has to be willing to take the risk; determining numbers may be the easier part.</p> <p>Mike Hall asked what a global budget looks like if all services are not in the budget. He suggested that there should be discussion about the role of the continuum of providers other than hospitals, and asked how we change care if the incentives aren't aligned for all providers. Bea suggested that we could change the incentives for hospitals to work differently with their community providers.</p>	
3. Update on Regional Blueprint/ACO Committees	<p>Jenney Samuelson and Patty Launer gave an update on the regional Blueprint/ACO committees. Jenney noted that there was not much change since last month's update. The communities continue to progress in forming their committees, conducting meetings, developing charters, defining priorities, deciding on projects and getting started on their work.</p> <p>Susan Aranoff noted that last month's handout inadvertently did not include specific mention of OneCare's participation in the regional committees, and asked that this handout be updated to reflect her request.</p> <p>Jenney noted that while communities may use different terms for the committees (e.g., Unified Community Collaboratives (UCCs) and Regional Clinical Performance Committees (RCPCs)), the committees are serving similar functions in each community. She also noted that groups such as the Blueprint integrated health services work groups were in existence prior to UCC/RCPC formation, and that the goal is to expand on existing efforts while avoiding duplication.</p>	
4. Integrated Communities Care Management Learning Collaborative Update	<p>Erin Flynn provided an update on the Integrated Communities Care Management Learning Collaborative:</p> <ul style="list-style-type: none"> • A webinar was held on 4/15 and Luran Hardin led participants through an exercise in root cause analysis to build upon the curriculum from the March learning session. • The next in-person learning session is on 5/19 at Norwich University. 75-80 people are currently registered. Jeanne McAllister from the University of Indiana will serve as expert faculty, and the curriculum will focus on implementing shared plans of care across interdisciplinary teams. The session will also include cross-community breakout sessions in order to allow participants to share their learnings with each other. • The VHCIP Steering Committee and Core Team approved the expansion request put forth by the CMCM work group. Erin reviewed the approved budget detail as follows: 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> ▪ \$100,000 in estimated costs for one additional quality improvement facilitator ▪ \$110,000 in learning session faculty costs (includes travel) ▪ \$90,000 (includes Train-the-Trainer costs) in core competency training costs ▪ \$200,000 in facility, logistical support, and supply costs ▪ Total request: \$500,000 (not to exceed amount) <p>Erin noted that several communities have already come forward expressing their desire to participate in the next round; the planning team will reach out to additional communities throughout the state to gauge interest and readiness.</p> <p>Regarding core competency training, the planning group is currently working on a scope of work for an RFP for training front-line care coordinators. The planning group is partnering with the DLTSS work group to ensure that disability-specific training is woven throughout the design, and that levers (such as a train-the-trainer model) ensure continued sustainability beyond the life of VHCIP.</p> <p>Quality Improvement facilitators Nancy Abernathy and Bruce Saffron presented an update on pilot community progress:</p> <ul style="list-style-type: none"> • Bruce has been working with communities to collect data, measure outcomes, and generally implement evaluation of the learning collaborative. He described the data collection tool to track several process measures (e.g., Has a lead care coordinator been identified? Has a shared care plan been developed?). Communities have provided data beginning with a January 2015 baseline and progressing through two rounds of data collection. Additional measures will include ED utilization and hospital admissions; person engagement; and person and provider experience. • Nancy has been working on facilitation and supporting leadership within the community teams. She is currently assisting communities in developing work flow diagrams to guide them as they implement and systematize the processes they have been designing and developing. <p>The following questions and dialogue followed:</p> <ul style="list-style-type: none"> • Susan Aranoff asked whether data is currently being collected on how often the individual is participating in the care conference. Bruce and Nancy responded that this measure is not currently being collected as the communities are still working on implementing care conferences. Teams are currently working on effectively engaging the individual in their care plan and care conference. Sue asked whether individuals are being asked to sign their shared care plans. Nancy replied that the three communities have not currently built in a place in their care plan templates for the individual (or lead care coordinator) to sign the document; this idea will be brought back to the communities. Susan noted that this is included in the recent HCBS rules, and may become relevant to the integrated teams as they progress in their work. • Jenney Samuelson noted it is the nature of this type of learning collaborative to test promising interventions, and make changes and improvements based on what the communities learn from their own work and each other. The communities are at the stage where they are conducting Plan-Do-Study-Act cycles around development and implementation of a shared care plan, and convening of care conferences. More lessons will be learned and shared as 	

Agenda Item	Discussion	Next Steps
	<p>this work progresses; the intent is to allow communities to try new ideas and make changes based on what they learn.</p> <ul style="list-style-type: none"> • Kirsten Murphy asked how accessible the shared care plans are to various populations who might process information differently. It was noted that for the shared care plan to be person directed, it is imperative that it is designed to meet each individual’s specific needs. Deborah Lisi-Baker added that including tracking of whether the person is present and signs the plan are intended to be indicators of patient engagement. She noted that data collection is critical in order to measure quality improvement and bring forth evidence that can support the formation of best practices. Mike Hall cautioned against moving toward a ‘check the box’ approach as it is difficult to standardize this type of evaluation. One person engagement tool that has been piloted in all 3 communities is the “Camden Cards,” which assist in root cause analysis and identification of the person’s goals. • Susan Aranoff noted that at DAIL, the participants in Choices for Care (CFC) are required to have a shared care plan and questioned how the various care plans in place within the different organizations on the multi-disciplinary team interact with the cross-organizational shared care plan. Laural Ruggles responded that there are different uses for care plans. Providers and organizations might keep more detailed records on their individual plans, but the goal of the cross-organization shared care plan is to facilitate communication, collaboration and integration across a community. The key is to capture the right amount of information, without including so much information that it is not useful. • Susan Besio asked about the core elements across all communities that rise to the level of inclusion in a uniform shared care plan. Nancy responded that this conversation is ongoing within the communities, and this information will be shared among communities during future learning opportunities. 	
<p>5. SCÜP Project Update</p>	<p>Erin Flynn and Larry Sandage presented on the SCÜP Project. The SCÜP seeks to support an existing project within the HIE work group around the development of a universal transfer protocol as well as the shared care plans being developed by the multi-disciplinary community teams in the learning collaborative.</p> <p>Previously, the Universal Transfer Protocol project conducted research and identified data needs within two case study communities - Bennington and St. Johnsbury. A UTP Charter and full report is available as compiled by consultants Im21. . This initial stage did not address a technology solution, but rather focused on requirements and work flow.</p> <p>The overlap between the goals and use of shared care plans and universal transfer protocol is significant – as are several of the data elements. It is the goal of this project to align these tools as much as possible, and work to identify a technology solution that would streamline processes for providers as much as possible.</p> <p><i>Project Approach and Next Steps</i></p> <p>In the short term the project will continue to conduct research and gather information around business requirements and work flow processes within the case study communities. In the early stages, this work will remain technology agnostic and is focused on making sure that the data and business requirements are first understood. As business requirements are gathered, technical requirements will be better understood and the goal is to develop a technology recommendation by October, 2015.</p>	

Agenda Item	Discussion	Next Steps
	<p>Beverly Boget asked how this aligns with the work VITL is doing. Larry responded that VITL Access is a possible platform for sharing these types of tools, but that this will become more evident once the business requirements are better understood. Jenney Samuelson noted that currently the VHIE contains discreet clinical data elements, but this may not include all aspects of the shared care plan. VITL is also currently working on ensuring data quality of existing data before they shift their focus to include additional data elements.</p> <p>Patty Launer asked for further explanation of the term business requirements. Larry responded that business requirements outline the work flow within the communities in order to understand what the technology requirements are and eventually identify a solution that will meet a community's needs.</p> <p>Nancy Eldridge pointed out that there has been a lot of work done already in aggregating this information; however, it is not all available electronically and therefore a huge opportunity exists to support the communities. Several members expressed concern that this work not start from scratch, rather that it build upon work that has already been done in this area. Larry confirmed that the goal is absolutely to understand and build upon existing efforts.</p>	
<p>6. Summary of gaps, duplication, opportunities for coordination, risks</p>	<p>Marge Houy provided an overview of Bailit Health Purchasing's work to support the work group in summarizing gaps, duplication, opportunities for coordination, and risks.</p> <p>Since its inception, the work group has been collecting data and information on gaps, duplication, opportunities for coordination and risks from a number of sources, including presentations from various organizations conducting care management, the care management inventory survey, and findings from the integrated communities care management learning collaborative. Marge and her team will work with work group staff to review these data sources, and attempt to summarize and synthesize common themes that have been reflected across the various data sources. More information will be presented to the work group at next month's meeting.</p>	
<p>6. Next Steps, Future Meeting</p>	<p>Next Meeting: Tuesday, June 16, 2015; 10:30 am to 12:30 pm; Calvin Coolidge Conference Room, National Life, Montpelier. Pam Smart and Treney Burgess will present on the St. Johnsbury work with the provider sub-grant project known as the "dual eligible project" and how this intersects with St. Johnsbury's work in the learning collaborative.</p>	