



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

Pending Work Group Approval

Date of meeting: Tuesday, February 10, 2015, 10:30am-12:30pm; ACCD – Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Introductions, and Approval of Minutes	<p>There was no quorum at the start of the meeting.</p> <p>There was a quorum after second agenda item. Trinka Kerr motioned to approve October minutes. Nancy Breiden seconded. Minutes accepted with two abstentions.</p> <p>Bea Grause motioned to approve November minutes. Nancy Breiden seconded. Minutes accepted with three abstentions.</p>	
2. Update on Regional Blueprint and ACO Committees	<p>Vicki Loner and Jenney Samuelson provided an update on the Regional Blueprint and ACO Committees:</p> <p>All of the ACOs and the Blueprint have been working over the past 3-4 months to stand up community forums across the state. Some build on already existing groups, others are new. The goal is to create formal governance in all 14 HSAs that creates opportunities for continuum of care providers to work together to further the goals of ACOs. Merged committees will include with physician leadership, nursing leadership, ACOs, representatives from Medicaid program and VDH, pediatrics, and other entities involved in care coordination.</p> <p>SIM grant funding for OneCare helps support this in a few ways: Making sure each community has physician leadership participation, support by VHCIP funding for part of their time; hiring 7 clinical consultants to support these communities with BP facilitators; making sure data is avail and usable; and formalizing QI activities, leveraging OneCare’s resources and trying to get a statewide learning collaborative to work on those priorities.</p> <p><u>St. Johnsbury</u> (Laural Ruggles): An existing group included CEOs and EDs of hospitals, mental health, FQHC, housing, food bank, home health, AAA, and Blueprint has become the region’s UCC group, meeting once a month for over a year. The physician lead is Karen Kenny, also on the OneCare Physician Advisory Board. The</p>	

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	<p>group has struggled to get doctors away from clinical time to attend meetings. Priorities: This group hasn't settled entirely on an initiative yet, but the community is leaning toward something on hunger or housing, and may try to leverage work around the state tying those issues together. Poverty is this region's big health disparity, as in most of the state, so housing and food are critical issues. These priorities have been echoed in hospital Community Health Needs Assessment focus groups – synergy around community health needs assessments is an area of interest for OneCare. Data: No resources to develop data at this level; participating groups each have metrics.</p> <p><u>Rutland</u> (Sarah Narkewicz): Rutland has a number of initiatives going on. A regional clinical performance committee focused on COPD meets monthly, with almost weekly sub-committee meetings. Nine organizations are participating in the CMCIM Integrated Communities Care Management Learning Collaborative pilot. Also an active participant in a local clinical integration committee, a partnership between FQHC/primary care and specialists. These activities need leadership/oversight to ensure they are well coordinated; key leaders in the community are working together to ensure work groups are aligned and, as they complete their work, identify priorities for the next quality improvement effort. Physician leadership comes from the FQHC and the hospital, both of which are represented by OneCare; HealthFirst and CHAC are also represented.</p> <p><u>Central Vermont</u> (Monika Morse): This is the first joint effort between RCPC and Integrated Health System Work Group; the group's initial meeting, on 2/9, was a great success. The physician lead is Dr. Fama, with backup from Dr. Eckhaus. One project is underway, started as the original RCPC project: a 6-month case management pilot (now in month 2) with 15 patients in intervention group, and 15 patients in a control group. All 30 have diabetes, CHF, COPD, or a combination; some interaction with Central Vermont Home Health and Hospice or Washington County Mental Health Services; and ER use. Key intervention components include an in-person home evaluation at initial assessment; monthly in-person meetings at the PCP's office, in the community or at home; weekly phone contact; close monitoring and aggressive management of care transitions; medication reconciliation; and PCP engagement. The pilot will measure patient and provider satisfaction and utilization in comparison with the control group. The group is considering taking on two larger projects and is discussing structure and governance. OneCare is involved, CHAC is invited (no PCPs engaged with HealthFirst in this area).</p> <p><u>Bennington</u> (Jennifer Fels): Started with 2 committees, both in existence for a long time. The Blueprint Integration Team had leaders from community agencies including home health, the Department of Health, the Council on Aging, etc. The OneCare Clinical Communication Group has been in existence for ~2 years (OneCare is the only ACO in the area). Each looked at membership and combined into one leadership team – the RCPC – including housing, the Designated Agency, long-term care, home health, the Department of Health, and human services agencies. The combined committee is co-chaired by Jennifer and a physician who also participates in the OneCare Clinical Advisory Board and Quality Committee; the group has a charter which focuses on building the medical neighborhood. Each meeting has a formal agenda and uses a project tool to keep track of activities (Results Based Accountability). Project teams report back to the committee on a regular basis. The committee receives data from OneCare and Blueprint HSA profiles. Some projects are showing positive early results.</p>	

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<p>3. ACO Care Management Standards</p>	<p>Pat Jones gave an update on the process for refining the ACO Care Management Standards, which has involved staff from many AHS departments as well as other stakeholders.</p> <p>Work Group staff are scheduling meetings in March with GMCB, DVHA, and the ACOs to discuss what ACOs are doing around care management using a defined set of questions. There will also be a request for documentation from the ACOs to assess how they're meeting these standards.</p> <p>Bea Grause noted that this has been a long process but that this will be an important tool going forward.</p> <ul style="list-style-type: none"> • Trinka Kerr commented that these seem like loose standards and suggested strengthening some language (“we recommend the ACOs be guided by the following standards...”). Language in standards is also loose. <ul style="list-style-type: none"> ○ Pat Jones noted that this language was very intentional. NCQA standards provided a starting point – they focus on a centralized ACO approach, and we wanted to permit a regional approach since we have so much infrastructure in place at the regional level. “Be guided by” was a recent change since the last meeting; it previously read “we recommend the ACOs <i>agree to</i> the following standards...” but there was concern about the balance between regulatory requirements and innovation. Had support from the Medical Society and others for this change. • Nancy Breiden agreed with Trinka. New language feels watered down – accountable care organizations need to be accountable to at least these loose standards. • Sue Aranoff asked about the relationship between the standards and the contracts with ACOs. Standards by themselves don’t have accountability built in regardless of the language, but a contract would. Will the contracts link to these standards? <ul style="list-style-type: none"> ○ Bea Grause: Yes. ○ Erin Flynn noted that Year 2 contract negotiations with ACOs are underway, and include leadership from across AHS and ACOs. Contracts will be publically available. It is our hope that they will be based on this document. ○ Vicki Loner commented that OneCare will seek a additional clarity on these standards through the contracting process so that they can fully understand them and how they will be evaluated. • Patricia Singer also expressed concerns. DMH leadership prefers “agree to” and that this document be attached to contracts. • Dale Hackett commented that he opposes the change to “be guided by” and emphasizes the need for ACOs to be accountable for care and outcomes at the patient level. • Trinka Kerr expressed concerns about leaving the language like this when the DVHA contracts are going to follow this. Contract language needs to be stronger. <ul style="list-style-type: none"> ○ Georgia Maheras clarified that the intent is that this would be an addendum/appendix to the contract. The compliance part is going to be written into the contract, not in the addendum. This will feed DVHA contract, BCBS contracts, but will also be in the hands of respective 	

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	<p>organizations’ lawyers. We need a document with common sense consensus agreement behind it; contracts themselves will be the enforcement mechanisms.</p> <ul style="list-style-type: none"> • Sue Aranoff thanked everyone for the work that went into this. She commented that DAIL Commissioner Susan Wehry suggested an amendment to return this language to its original form: “ACOs agree to the following standards.” <ul style="list-style-type: none"> ○ Bea Grause asked if anyone opposed this amendment. ○ Miriam Sheehy commented that ACOs will abide by contractual agreements, but are uncomfortable saying they will agree to a standard that is high-level and not fully clear. ○ Vicki Loner commented that most ACOs in the state are not gearing up for centralized care coordination – they want to continue to support local communities in providing this. ○ Tom Simpatico commented that all parties want clarity but are approaching this with different language – we want to avoid ambiguity but there may be a limit to how much this is possible in this document. These are aspirational standards – “be guided by” embraces the notion of further clarification and being able to operationalize with further clarity. ○ Sue Aranoff pointed out that the full language is “we recommend the ACOs agree to...” – the ACOs are not committing to anything, it’s a recommendation from the group. • Bea entertained the motion to change the language from “be guided by...” to “agree to...” Seconded by Trinka Kerr. <ul style="list-style-type: none"> ○ Dale Hackett asked whether, whatever we do to the wording, we still have a problem supporting patient outcomes. Bea Grause noted that we can’t answer that question now. ○ The motion carried with 4 against and 1 abstention. ○ Tom Simpatico suggested a conversation around whether these standards are stifling innovation and creativity and suggested there be a process to amend these standards if that is found to be the case. Bea Grause noted that this is a first pass. These are aspirational standards. We’ll be coming back next year to assess what we learned and whether we need to make changes to these. ○ Michael Bailit notes that there have already been modifications to other standards that have been made. • Sue Aranoff made a motion to pass as amended. Seconded by Dale Hackett. <ul style="list-style-type: none"> ○ The motion carried with 2 against. 	
<p>4. Care Management Inventory Report (Marge Houy and Christine Hughes, Bailit Health Purchasing)</p>	<p>Marge Houy and Christine Hughes provided an update on the Care Management Inventory Report, focusing on the 6 takeaways identified by Bailit Health Purchasing:</p> <ol style="list-style-type: none"> 1. <u>Increase use of CMMI Best Practices:</u> CMMI best practices were used consistently by approximately half of respondents. Planning and managing transitions of care and medication management had the lowest percentages. Post-discharge follow up and high-risk patient management reported lower than optimal. <ul style="list-style-type: none"> • Home health is not represented here; staff can re-share the survey with them. 2. <u>Opportunities for More Formal, Structured Relationships:</u> Community service providers have 	<p>Consider sharing results of Care Management Inventory Report with relevant VHCIP Work Groups (DLTSS, Workforce, etc.)</p>

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	<p>substantially lower formal relationships with other providers or have ad-hoc relationships. This is an area that could be improved with the rise of integrated delivery systems, particularly relationships between community service providers and ACOs.</p> <ul style="list-style-type: none"> • Marge Huoy asked where there are opportunities for community service providers, and what action, if any, the CMCM Work Group should take. • Pat Jones noted that this takeaway and others are things communities are already addressing. • Lily Sojourner suggested that this be shared strategically with local communities to be used in building their priorities. • Dale Hackett noted that this survey was distributed to people Pat Jones and Erin Flynn selected, and suggested that this is not transparent. Pat Jones noted that staff relied on this group to build the list of survey recipients and helped to disseminate the survey to their membership. <ol style="list-style-type: none"> 3. <u>More Robust Implementation of Team-Based Care</u>: Low participation from physicians, substance abuse, and mental health in teams. 4. <u>Enhance services to People Discharged from Skilled Nursing Facilities</u>: This could support reduced readmissions. 5. <u>Staffing Types and Resource Allocation</u>: RNs, social workers, and case managers are most common; pharmacists, Pas, Mas, peer counselors, and CHWs are less common and suggest that non-traditional staffing could support these efforts. 6. <u>Addressing Common Challenges</u>: Top four are insufficient funding, challenges in recruiting staff, technical barriers in data sharing, and engaging individuals. <p>Marge Houy asked the groups whether any of these resonate; one next step was already suggested (presenting these to the Learning Collaborative pilot communities). Bea Grause suggested that the challenge of engaging individuals is being addressed by the Learning Collaboratives. Sue Aranoff suggested that these findings could be presented to related VHCIP Work Groups (i.e., DLSS, HIE/HIT, Workforce) to support coordinated work on these issues. Bea Grause agreed, especially on Workforce Work Group. Beverly Boget suggested that these are very relevant to home health agencies and hopes that we will reach out to home health for a response. Dale Hackett commented that he likes this survey and feels it reflects issues this group has already raised; he suggests pharmacists are an important group for care management and their full importance may not be reflected in the results of this survey. Kirsten Murphy seconded Sue Aranoff’s point that this go to the DLSS Work Group as a follow-up item.</p>	
<p>5. Update on Integrated Care Management Learning Collaboratives</p>	<p>Pat Jones gave an update on the Integrated Care Management Learning Collaborative. The first in-person session was on January 15th, and was very well attended. Pat thanked the local leaders in each of the pilot communities for their work in engaging people in the Learning Collaborative. Attendees included representatives from AAAs, home health and VNAs, DAs, private mental health practitioners, care coordinators, hospitals, VCCI, ACOs, and insurers.</p> <p>Attendees heard from Hagan, Rinehart, and Connolly, a pediatric practice in Burlington – a physician, care</p>	

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	<p>coordinator, and parent presented together on the benefits of care coordination to the family, the practice, and the practitioner – as well as two staff members of the Camden Coalition in Camden, New Jersey, which has done nationally recognized work around identifying high-risk patients and performing targeted care management. Each pilot community had multiple opportunities to discuss how to implement these ideas in their pilot area.</p> <ul style="list-style-type: none"> • Laural Ruggles commented that this Learning Collaborative will really move St. Johnsbury’s work forward by formalizing their structure around care coordination activities. <p>Pat Jones noted that the project has contracted with Nancy Abernathy, a skilled practice facilitator, to work with the pilot communities. Nancy will be doing training on the PDSA (Plan-Do-Study-Act) quality improvement model, as well as helping with measure specification, data collection, and agendas for upcoming sessions. The next event is a webinar on February 18th; communities will be asked to report on how they’re identifying at-risk people, and will be introduced to the measures, which will include process/participation measures as well as utilization. March meeting will focus on shared transitions of care and identifying care coordination leads.</p>	
<p>6. Next Steps, Wrap Up and Future Meeting Schedule</p>	<p>Next meeting: March 23 from 10am-12pm. Trina notes that this conflicts with the Medicaid and Exchange Advisory Board (every 4th Monday).</p>	