VHCIP Core Team Meeting

Agenda 6-15-15

VT Health Care Innovation Project
Core Team Meeting Agenda

June 15, 2015 2:00 pm-2:45pm
Conference Call Only
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	2:00-2:05	Welcome and Chair's Report: a. Update on negotiations with CMMI b. OneCare Vermont Financial request	Lawrence Miller	Attachment 1: OneCare Vermont's Financial Request
Core Team Processes and Procedures				
2	2:05-2:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: June 1, 2015 minutes *Decision needed.*
Evaluation				
3	2:10-2:30	Approval of Self-Evaluation Plan	Annie Paumgarten	Attachment 3: Self Evaluation Plan Draft (previously distributed) *Decision Needed*
4	2:30-2:35	*Public Comment*	Lawrence Miller	
5	2:35-2:45	Next Steps, Wrap-Up and Future Meeting Schedule: July 23rd from 2-4p, Pavilion, Montpelier	Lawrence Miller	

Attachment 1

OneCare Vermont

Financial Request

OneCare Vermont
356 Mountain View Drive
Suite 301
Colchester, VT 05446

General Information:

Lead Organization Applying: University of Vermont Medical Center, Inc
Collaborating Organizations: OneCare Vermont, LLC

Key Contact for Applicant: Todd Moore
Relationship to Applicant: employed
Key Contact Email: todd.moore@onecarevt.org
Key Contact Phone Number: 802-847-1844
Key Contact Mailing Address: 356 Mountain View Drive, Suite 301

Fiscal Officer (must be different from Key Contact): Abraham Berman
Relationship to Applicant: employed
Fiscal Officer Email: abraham.berman@onecarevt.org
Fiscal Officer Phone Number: 802-847-0887
Fiscal Officer Mailing Address (if different from Key Contact): N/A

Project Title and Brief Summary:

Expanding Population Health Management Strategies in FY 16:
The statewide full continuum of care network known as OneCare Vermont (OCV) is actively innovative—

- Redefining relationships among individual and institutional care providers across Vermont
- Broadening the concept of "care teams" to include arrays of resources in each community
- Creating, identifying and adopting better ways to keep individuals and communities well
- Building an informatics infrastructure to identify and inform care delivery opportunities at the point of care

Continuing to receive SIM funds for a second year will further our collective efforts towards innovative, highly reliable, evidenced-based population health care strategies for Vermonters by providing support to:

- Fund local medical leadership, facilitation, quality improvement training and project support
- Analyze and provide data for targeted health care performance improvement collaboratives
- Further develop and disseminate population health evidenced-based guidelines to support clinical performance improvement initiatives
- Support performance improvement activities through 14 Regional Clinical Performance Committees (RCPCs)/Unified Community Collaboratives (UCCs) serving every community in Vermont
- Fund a statewide care management tool and tracking system
- Funds to offset a portion of OCV's year 2 support fees for VITL

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Budget Request Summary

Budget Category	Total
Personnel	$ 1,552,250
Fringe	$ -
Travel, Equipment, Supplies	$ 97,750
Contracts	$ 1,850,000
Other*	$ -
Total	$ 3,500,000

Question A: Activities for which the applicant is requesting funding

OneCare Vermont (OCV) is requesting continued support, beyond its first year grant, to expand upon the work performed during the first year and to fund the data analytics infrastructure needed to combine clinical and claims data in support of strong population health management tools. Specifically we are requesting:

1. Year 2 continued project funds to support local medical leadership, quality improvement training/support and clinical facilitation in the amount of $2,000,000
    a. Continued funding of 14 Regional Clinician Representatives (physicians and/or advanced practice clinicians) serving as clinical champions for their regions
    b. OCV's Clinical Consultants deployed to assigned regions that support clinical priority performance efforts and Regional Clinical Performance Committees (RCPCs)/Unified Community Collaboratives (UCCs)
    c. Ongoing development and initiation of statewide Clinical Advisory Board (CAB) and RCPCs/UCCs
    d. Identification of statewide clinical improvement targets

e. Facilitation of statewide learning collaboratives aimed at meeting clinical improvement targets
f. Assessment and tracking of improvement efforts

Per the aim of the first grant, OCV has amassed and retained the state's largest value-based care network of hospitals, physicians and other clinicians who have worked collaboratively with the Blueprint for Health and the other two (2) ACOs to improve the quality of care of Vermonters (See Attachment A: Quality Measures 2013 v. 2014 report card). Our successful proposal for 2015 support aspired to implement a vision of service area focus on population health management by the full continuum of care and services, with all providers regardless of ACO affiliation, and with a high degree of collaboration instead of competition with Vermont Blueprint for Health programs. We believe the "on the ground" reality has achieved our greatest hopes for 2015 and is highly worthy of continued support in 2016. Our track record of impact, collaboration, and community-based focus is clear. In further support of this, we have also attached our preliminary draft "Transformation Report" as conducted and prepared on behalf of the VHCIP project based on a required review meeting. Additionally, we have attached the Blueprint for Health's Proposal for Delivery System Reform: Integrating Vermont ACO and Blueprint Activities, which provides further evidence of the momentum and convergence around this element of our request for 2016 continued support. (See Attachments F and G respectively).

2. Fees to support a statewide care management tool in the amount of $250,000. This includes setup costs associated with the implementation of a health care technology platform that enables real-time, team-based care coordination and communication.

The care management system will extend collaboration of care across the health care continuum, as well as patients and family caregivers. By providing a centralized tool at the statewide level, cost reductions for the top 5 percent most expensive patients will

be realized. This reduces inefficiencies by assuring enhanced communication of data and care needs for patients. Supporting OCV efforts on deploying this capability will support the providers who are involved in the SIM Care Models/Care Management Learning collaboratives, empowering them with the tools and systems necessary to manage complex patient populations.

3. Funds to implement a statewide post-acute care network (PACN) patient identification and tracking system (PatientPing) to be integrated with the statewide Health Information Exchange, in the amount of $500,000.

   PatientPing enables real-time admissions and discharge notifications anywhere patients receive care through a fully secure hub and spoke web-based interface. This will reduce costs associated with avoidable readmissions and over-utilization due to broken communication links. There are significant economies of scale associated with a statewide approach to this level of PACN tracking and sustainability.

   Our approach seeks to strengthen the joint effort between OCV and VITL. As with the care management system, OCV brings provider engagement in designing care processes and ensuring provider use of the system capabilities. In addition, VITL's current Event Notification System (ENS) strategy provides notification within acute care and physician office settings only. PatientPing has the potential to establish the PACN presence to provide full continuum of care notifications for long-term gains in quality care improvement and reduced costs in areas like readmissions.

4. Funds to offset a portion of OCV's year 2 support fees for VITL, in the amount of $750,000.

   As part of our support agreement with VITL, which includes fees of $0.73 PMPM for support and maintenance of the ACO Gateway infrastructure, OCV will collaborate with

VITL provider outreach staff to implement data connections to providers' EHR systems (where none presently exists) and to assess and correct deficiencies in quality of data from extant data connections. Having funds flow through OCV will create stronger mutual accountability between OCV and VITL to ensure we are receiving value from our ACO gateway infrastructure and to allow us to take a more direct role in defining priorities for interface development and remediation.

The persistent derivation of data from providers, and the storage of it in a secure, well-curated manner, is the lifeblood of any successful population health management strategy and system. OCV, as well as other value-based entities and initiatives across the state cannot improve health in a meaningful way, nor reduce costs over time, without complete and valid data sets from points of care. It is our intention to enhance efforts in creating the pipes to providers' electronic data in a secure manner. These efforts bring the totality of data closer to 100% in terms of available and mineable electronic clinical data for purposes of population health management. These funds will be used to advance the progression of high-quality data flowing through the Vermont Health Information Exchange to benefit patient care and improve population health for all Vermont patients.

Question B: Number of Providers and Patients Impacted

OCV has agreements with FQHCs, Continuum of Care providers, specialists and primary care physicians, and hospitals in order to support a multi-payer ACO construct (Medicare, Medicaid, and Commercial). The network for the three ACO Shared Savings programs consists of: UVMMC and its 1,000 plus providers; D-HH and its 800 plus providers; all community PPS and Critical Access Hospitals in VT and their employed physicians; VT's one behavioral health specialty hospital and its employed physicians; 4 FQHCs; 5 RHCs; community/private physician practices; 10 home health care and hospice organizations in VT; 28 skilled nursing facilities in VT; and all

10 designated community mental health centers in VT. OCV has over 3,000 providers in its statewide network. This combination of large geographical reach and full continuum of care under a collaborative network model has provided a powerful foundation for population health management (PHM) for our attributed population of over 100,000 Vermonters.

Question C: Relationship to VHCIP goals

Starting in December of 2013, OCV received a one (1) year funding opportunity under SIM to support medical leadership, quality improvement, analytics and data, and clinical facilitation to collectively support Vermont's Accountable Care Organizations capacity to meet the Three Part Aim. This second year request, allows OCV to evolve the foundational work undertaken with the first grant and to further strengthen our local accountable care communities RCPC/UCC in meeting the Three Part Aim.

OCV's work has complemented Vermont Blueprint for Health's successful commitment to primary care by bringing together Vermont's full provider continuum to execute on innovative, highly reliable, evidenced based population health management strategies that improve the lives of Vermonters.

To date, we have met the deliverables under the grant by:

- Selecting clinical priorities that align with and complement other statewide reform initiatives
- Supporting (financial, data and human resources) the development/transformation of 14 RCPCs/UCCs in every Health Service Area (HSA) in collaboration with the medical community, the continuum of care providers, the Blueprint for Health, and the other ACO's throughout the state (See Attachment B: Example Bennington RCPC Charter)
- Contracting with physician and advanced practice providers in all 14 HSAs to be clinical champions and support the clinical priorities of the RCPCs/UCCs

- Launching a statewide Learning Collaborative forum, with over 120 participants in attendance, to support performance improvement work on OCV emergency room and readmission/admission clinical priorities approved by the OCV CAB
- Developing and disseminating, at the Learning Collaborative, Readmission Change Packets which identify best practice based interventions and ideas for implementing small tests of change tools for addressing risk; Best Practice Risk Assessment Tools; Needs Assessments with a step by step guide, including some sample teach back tools; PDSA Tool; and Force Field Analysis
- Completing the quality measurement training and collection process for three (3) Shared Savings Programs with Vermont's other ACOs

As noted in our summary for the recent VHCIP sub-grant Symposium, we have learned that creating, identifying and adopting better ways to keep individuals and communities well is a goal everyone can agree on. The work is hard and it takes longer than you would anticipate but the cooperative effort by Vermont's provider continuum brings forward greater value than would be possible if the initiatives proceeded independently. (See Attachment F: OCV Preliminary Care Transformation Report)

We can say this with confidence as the data shows that we are well on our way to meeting the Three Part Aim in the following ways:

- Preliminarily evidence reveals we increased our Quality Scores for Medicare by five (5) percentage points between 2013 and 2014 with 11 of 14 health service areas increasing their scores
    - Increased our Medicare disabled populations quality scores by 35.6%, bringing them on par with other Medicare/Dual eligible groups
    - Increased our medication reconciliation scores from the 70th to 90th percentile
    - Increased our diabetes composite score from the 40th to 70th percentile

  - Increased our coronary artery disease composite score from the 30th to 60th percentile
- Saved $8 per beneficiary per year against CMS spending targets, for over $300,000 in savings
- Scored high on Satisfaction/Patient Experience rankings- in the 80th and 90th percentiles
- Preliminary estimates for the Medicaid and Commercial ACO programs show that quality scores were consistent with Medicare

Question D: Impact on similar projects (ongoing or anticipated)

In regards to funding request #1-4, OneCare Vermont has identified synergistic opportunities outlined in *Question J* of this request.

Question E: Applying project learning on a state-wide basis

As previously described, the combination of statewide reach and full continuum of care providers under a collaborative governance and network model has provided for a strong population health management platform able to meet the Three Part Aim for a population of over 100,000 lives.

OCV has designed a structure that allows participants significant input and a strong voice in governance and establishing the clinical and quality programs that form the basis for a result oriented statewide network.

- Clinical Advisory Board (CAB) - with over 50 providers representing every HSA in the state. The CAB also has two (2) subcommittees; the Lab and Pediatric Subcommittees thus demonstrating the commitment to other care delivery and population segments.

This is perhaps the largest organized group of actively engaged clinicians. Their charge is to identify opportunities based upon the data, prioritize network improvement projects, and provide a forum for sharing of best clinical practices. Every year the CAB identifies priorities that the network will focus on and as noted in *Question I* of this request, The CAB has identified priorities in CY 2015 that has the potential to yield significant improvements in quality and satisfaction while reducing overall costs.

- Quality Improvement Committee (QIC) - made up of OCV senior medical and nursing leadership, the directors of both the Jeffords Institute at Fletcher Allen Health Care and the Value Institute at Dartmouth-Hitchcock, and the 14 Regional Clinician Representatives (RCRs) described in this proposal. The committee helps prioritize specific elements and measures of our quality improvement efforts under the learning collaborative approach, and provide an important "bridge" between our CAB and the local Regional Clinical Performance Committees (RCPCs)/Unified Community Collaboratives (UCCs). Additionally, on a semi-annual basis this committee brings together medical leadership throughout the State, other ACOs, Payers and the Vermont Blueprint for Health to coordinate quality improvement efforts.
- RCPCs/UCCs - represent local multidisciplinary teams that carry out the clinical priorities and engage in data driven process improvement activities. The established RCPCs/UCCs in each HSA have invited participation from the following entities:

  - Leaders from the other ACO's
  - Vermont Blueprint for Health
  - OCV contracted Regional Clinician Representatives and Clinical Consultants
  - Clinical and Quality Improvement experts from local or referring hospital systems
  - Representation from care coordination entities (e.g., Blueprint Community Health Team extenders, commercial payers, SASH)
  - Continuum of care providers (home health, skilled nursing, hospice, designated agencies etc.)
  - Content experts (pediatric mental health, palliative care, chronic care etc.)

- State agencies that serve the populations (e.g., VDH, VCCI and IFS)
- Representation from the FQHC's and RHC's - affiliated with both OCV and Community Health Accountable Care

Members of the RCPC/UCC team foster involvement and ownership at the local level, leading the way on care and delivery transformation.

In May of this year, OCV launched its first statewide learning collaborative. There were 122 attendees from 13 of the 14 HSAs. Demographics were as follows: approximately 9% Administrators, 10% Vermont Blueprint Community Health Teams and Extenders, 10% Community Providers, 27% Physicians and Advanced Practice Providers, 33% Nurses/Care Coordinators/Quality, and the remaining attendees were OCV staff.

The event offered the following:

- Keynote speakers from the GMCB and VHCIP
- The Continuous Quality Improvement Director from the UVMMC Jeffords Institute
  - Provided an overview of quality Improvement process using the IHI tools
  - Delivered an overview of how learning collaboratives work and how this will be applied to OCV's selected clinical priorities
- A panel of Cardiologists from UVMMC, Dartmouth, and Brattleboro
  - Shared best practices in CHF management
- A physician from Dartmouth Hitchcock
  - Presented on improving care coordination for ER high utilizers (hot spotting)

Teams from the HSAs worked to identify and create small tests and then conducted a force field analysis on that small test of change. The exercises will help them once the full teams can coalesce and work through one of the clinical priorities with their full RCPC/UCC.

All attendees were provided with best practice tool kits, including:

- OCV Readmission Change Packet: Identifies Primary Drivers, Best Practice Based Interventions, and Ideas for Implementing Small Tests of Change
- Tools for Addressing Risk: Best Practice Risk Assessment Tools
- Needs Assessment: Step by Step Guide, including some sample tools Teach Back Tool
- PDSA Tool
- Force Field Analysis

Attendee feedback was positive with 89% rating the event a 4 or 5 (out of 5) with comments that the panel experts, networking, and team building were highlights of the day.

The improvement training tools and best practice guidelines will be used throughout the year to support the RCPCs/UCCs clinical priority projects. The next learning session is to occur in August/September of this year.

OCV is positioned to lead Vermont's clinical improvement efforts across the regions of the state and we have demonstrated high value by measurably improving performance year over year.

Question F: Data Sharing and connection with existing health information

The ability to provide comprehensive and real-time clinical information to every health care provider is an essential requirement as part of a Population Health Management infrastructure designed to reduce costs and provide better care.

OCV delivers population-level cost, quality, and utilization analytics to compare data at an HSA-level on a number of key metrics. Additionally, custom analyses and patient-level detail reports are developed from the OCV data warehouse to support RCPC/UCC quality improvement projects.

Reporting is generated by a team of highly-skilled technical and business analysts at OCV. We employ state-of-the-art approaches to covered population demographic profiles, disease state and episode registries, risk assessment, utilization analysis, cost performance, and population clinical measurement. Internal and external benchmarking, opportunity analysis, predictive modeling, and decision support are appropriately embedded in all approaches.

Specific examples of analyses performed by the OCV Analytics team to date include:

- Episode cost variation analysis by facility for Medicare beneficiaries receiving total joint replacements
- Inpatient cost and utilization comparisons between HSAs
- Readmission analysis
- Ambulatory sensitive condition admission rates by HSA
- Potentially avoidable emergency department use rates by HSA
- Home Health utilization and variation analysis by HSA
- Skilled Nursing Facility utilization and variation analysis by HSA
- Enhanced medication reconciliation reporting for a patient-centered medical home practice, combining claims and EMR data
- Beneficiary-level detail of patient risk factors for distribution to primary care providers

OCV is collaborating with the Vermont Blueprint for Health to design co-branded provider and practice level reporting using the VHCURES all-payer claims database, the DocSite clinical registry, along with clinical data from the VHIE in order to meaningfully support care delivery transformation. These reports will provide a comprehensive, multi-payer view of practice patient panels (including non-ACO beneficiaries) and will be designed to meet the measurement needs of the ACO while providing meaningful and actionable performance data for practices. These reports will be designed to directly support the work of the RCPCs/UCCs.

The combination of claims from three payers and clinical data from the HIE allows analysis and reporting to participants to support quality measurement and care management initiatives.

Question G: Alternative funding sources sought

The annual operating budget for OCV is approximately $9M and is at scale with required capabilities. In 2015, the University of Vermont Medical Center (UVMMC) and Dartmouth-Hitchcock Health (D-HH) provided combined annualized funding of $4.7M. Additional funding in the amount of $2M came from network participants through participant fees and the remaining funds came from a VHCIP SIM grant.

For 2016, OCV is proposing a level budget, however without the requested SIM funding in this application; D-HH, UVMMC, participant hospitals, and possibly other OCV providers would have to shoulder the budget gap. As the state moves towards a comprehensive payment reform structure, it is vital to provide the network with as much direct support as possible in these formative years, and especially as we attempt to maintain the network and current momentum through 2016 on our way to more comprehensive population-based payment reform expected for 2017. The requested SIM funds will help to close the budget gap, thereby financially unburdening the network and allowing them to focus their core mission of delivering quality care.

Beginning in 2017, we believe that the capitation and population-based payment models being developed by CMS may allow OCV (in conjunction with its governance and network) to determine whether it is feasible to fund budget gaps from withhold or capitated payments prior to distribution to the network.

Question H: Technical Assistance Sought

At this time, OCV is not seeking technical support from State. We will keep these resources in mind should our future needs change.

Question I: Return on Investment (cost and quality)

As referenced in *Question C,* OCV through its QI efforts has already shown significant improvements in quality and costs in its Medicare programs from 2013 to 2014. Preliminary quality data for the Medicaid and Commercial Shared Savings programs for 2014 are showing a similar pattern. It is still premature to assess if there are any savings in the Medicaid and Commercial programs.

For 2015, OCV's CAB identified the following clinical priorities:

- Ambulatory Sensitive Condition Admission reduction of 5% for Heart Failure and COPD/Asthma
- Emergency room reduction of 5%
- 30 day all cause readmission reduction of 5%
- Increase in Hospice Utilization by 5%
- Increase overall quality report card score by 5%

Achieving these improvements in just the Medicare population is expected to conservatively yield over $2 million in savings as well as improve overall quality and experience of care.

To address the populations under the Medicaid and Commercial programs, the CAB recently voted to include the following priorities:

- Increase Adolescent Well-Care Visits by 5%
- Increase Mental Health Follow Up after Hospitalization by 5%
- Increase Developmental Screening by 5%

We do not yet have savings estimates available since these priorities were just recently adopted.

For all populations, an opportunity exists to decrease costs, increase quality and improve patient and provider experience of care for the top 5% of the highest health service utilizers. According to various research studies, the top 5% of utilizers account for approximately 32% of total medical costs. A reduction of unnecessary high cost services could affect total medical costs up to 20% or $27 million dollars in the aforementioned population. As OCV moves toward a capitated health system, decreasing costs for the highest utilizers will lead to a more financially sustainable organization. A systematic approach will be utilized to identify opportunities and continually improve program operations.

Question J: Synergy with other activities underway (avoiding duplication)

OCV has a strong history of collaboration amongst its major stakeholders. Statewide participation is significantly better than duplicating scarce resources and allows for a high degree of cooperation in OCV's efforts to promote evidence-based medicine, improve beneficiary engagement, meet quality and cost metrics and coordinate care. In addition to efforts listed in *Question C* of this proposal, OCV has also participated in the following collaborative efforts:

- Aligned with the Vermont Blueprint for Health on quality measures linked to medical home payments
- Collaborated with the Vermont Blueprint for Health to provide co-branded practice level reporting using VHCURES, DocSite, and clinical data from the VHIE in order to meaningfully support care delivery transformation. These reports will be designed to directly support the work of the RCPCs/UCCs
- Partnered with the Vermont Blueprint for Health and VITL on an ACO data exchange initiative to serve our common goal for high quality, meaningful and actionable data that would bring efficiency to our care coordination and quality collection efforts.
- Partnered with the Vermont Health Care Innovation Project, the Vermont Blueprint for Health and its providers to develop and implement learning collaboratives aimed at building high-performing, multidisciplinary care coordination systems that include

patients and families as partners. The learning collaboratives will explore whether integrated and collaborative care coordination services can improve quality of care, patient and family experience, and health and wellness while reducing the overall burden of cost to the health care system.

- Partnered with the Vermont Child Health Improvement Program and the Vermont Health Department to create a pediatric-specific collaborative to improve the skills of care coordination teams in those primary care practices. The goal was to enroll nine (9) practices in a six month effort to identify families who could benefit from care coordination interventions and look at process measures of care plans created, care conferences initiated and family satisfaction pre and post intervention.

Question K: Evidence base for proposed activities

OCV promotes evidence-based medicine (EBM) through the identification, implementation, and evaluation of EBM opportunities. OCV's comprehensive population health management informatics infrastructure provides a mechanism for combining claims and clinical data from all of its participants in order to identify evidence-based projects. EBM opportunities accompanied by guidelines are brought forward to OCV's statewide CAB for review and approval. The CAB clinical champions, who represent each HSA in VT, work through their RCPC/UCC to implement changes in their community using standardized performance improvement approaches. Evaluation is conducted at the local and statewide level with the support of OCV's informatics platform, which allows for drill down analysis at the regional and participant level to measure and improve EBM compliance and expected performance impacts.

The OCV Learning Collaborative in May was based on the Institute for Healthcare Improvement (IHI) model, encompassing the framework to guide improvement work. The IHI developed the *Breakthrough Series* to help health care organizations make "breakthrough" improvements in quality while reducing costs. The driving vision behind the *Breakthrough Series* is this: sound

science exists on the basis of which the costs and outcomes of current health care practices can be greatly improved, but much of this science lies fallow and unused in daily work. There is a gap between what we know and what we do.

The *Breakthrough Series* is designed to help organizations close that gap by creating a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements. It is a short-term (6 to 15 month) learning system that brings together teams from hospitals or clinics to seek improvement in a focused topic area. Research published by IHI shows those teams in such collaboratives have achieved dramatic results, including reducing waiting times by 50 percent, reducing worker absenteeism by 25 percent, reducing ICU costs by 25 percent, and reducing hospitalizations for patients with congestive heart failure by 50 percent. [1]

OCV utilizes a Plan-Do-Study-Act (PDSA) approach for our performance improvement activities. The PDSA approach is an integral part of the IHI Model for Improvement, a widely demonstrated simple but powerful tool for implementing quality improvement.[2] The literature has extensively borne out that IHI's PDSA model, which enables teams to conduct small tests of change in a disciplined and often rapid timeframe (i.e. rapid cycle improvement), is a valid and reliable approach to help the local care systems gain knowledge, quickly correct course when needed, and ultimately make measurable improvements in the delivery of care.[3] For the purposes of our project we are using a Jeffords Institute developed PDSA worksheet to continously monitor performance.

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[1] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003

[2] Langley GL, Nolan KM, Nolan TW, Norman, CL, Provost, LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition) San Francisco: Jossey-Bass Publishers; 2009.

[3] Singh K, Sanderson J, Glaarneau D, Keister, T, Hickman D "Quality Improvement on the acute inpatient psychiatry unit using the Model for Improvement", The Oshsner Journal, Fall 2013; (13): 380-4.

If awarded, OCV will apply the funding to continue with EBM care coordination and quality improvement activities through our communities. See project plans for more information.

Project Implementation Plan and Timeline

See Attachment C: Learning Collaborative Schedule

See Attachment D: Care Management Software Implementation Schedule

See Attachment E: Patient Tracking Implementation Schedule

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Budget Narrative

		Totals		
Position Title and Name	**FTEs**	**Time**	**Months**	**Amount Requested**
Clinical and Quality Consultant	8	90.0%	12	$ 648,000
Manager - Quality and Care Coordination	1	90.0%	12	$ 99,000
Clinical Improvement and Compliance Specialist	1	100.0%	12	$ 95,000
Director of Quality and Care Coordination	1	90.0%	12	$ 126,000
Vice President - Clinical and Network Operations	1	30.0%	12	$ 51,000
Chief Medical Officer	1	30.0%	12	$ 90,000
Director of Operations	1	30.0%	12	$ 42,000
Manager of Operations	1	35.0%	12	$ 26,250
Senior Information Analyst	3	60.0%	12	$ 144,000
Information Analyst	1	60.0%	12	$ 39,000
Programmer Analyst Sr.	1	60.0%	12	$ 54,000
Manager of Analytics	1	60.0%	12	$ 54,000
Director of Analytics	1	60.0%	12	$ 84,000
Project 1: Total Salary and Wages				$ 1,552,250
Project 1: Regional Clinician Representatives		100%		$ 350,000
Project 1: General Overhead - ~6%		6%		$ 97,750
(travel, admin support, supplies, space etc.)				
Project 1: Total				**$ 2,000,000**
Project 2: Care Management Tool		**100%**		**$ 250,000**
Project 3: Patient Tracking Tool		**100%**		**$ 500,000**
Project 4: VITL Support		**86%**		**$ 750,000**
Totals				**$ 3,500,000**

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Attachments

Attachment A: Quality Measures 2013 v. 2014 report card

Attachment B: Example Bennington RCPC Charter

Attachment C: Learning Collaborative Schedule

Attachment D: Care Management Software Implementation Schedule

Attachment E: Patient Tracking Implementation Schedule

Attachment F: OCV Preliminary Care Transformation Report

Attachment G: Blueprint for Health's Proposal for Delivery System Reform: Integrating Vermont ACO and Blueprint Activities

ATTACHMENT A: Quality Measures 2013 v. 2014 report card

OCV 2014 Quality Measure Scorecard

Version 2.0 03/26/2015

OneCareVermont

NOTICE: All data produced by OneCare VT is for the sole use of its contracted OneCare VT Participants and must not be distributed to other individuals or entities who do not hold a legally binding contract with OneCare VT. These materials are confidential and may only be used in connection with OneCare VT activities. The use of these materials is subject to the provisions of the Business Associate Agreement and/or Participation or Collaboration Agreement with OneCare VT.

Prepared by ALC 03/26/2015

OCV Quality Measure PY2 2014 Scores – Reporting and Performance Measures

Domain	Measure		PY1 2013	PY2 2014	PY3 2015	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	OCV Score	n	Quality Points
Care Coordination/ Patient Safety	12	Medication Reconciliation	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	93.41	683	2.00
	13	Falls: Screening for Fall Risk	R	P	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	47.31	594	1.70
Preventive Health	14	Influenza Immunization	R	P	P	29.41	39.04	48.29	58.60	75.93	97.30	100.00	63.81	572	1.55
	15	Pneumococcal Vaccination	R	P	P	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.80	599	1.55
	16	Adult Weight Screening and Follow-up	R	P	P	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.81	418	1.55
	17	Tobacco Use Assessment and Cessation Intervention	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	96.67	600	2.00
	18	Depression Screening	R	P	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	28.07	456	1.55
	19	Colorectal Cancer Screening	R	R	P	19.81	33.93	48.49	63.29	78.13	94.73	100.00	70.27	592	2.00
	20	Mammography Screening	R	R	P	28.59	42.86	54.64	65.66	76.43	88.31	99.56	71.12	599	2.00
	21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	66.43	414	2.00
At-Risk Population Diabetes	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	R	P	17.39	21.20	23.48	25.78	28.17	31.37	36.50	28.67	600	2.00
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00	13.10	603	1.85
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	70.57	581	1.55
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	R	P	35.00	42.86	51.41	57.14	61.60	67.29	78.81	58.81	471	2.00
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P	45.44	56.88	68.25	78.77	85.00	91.48	97.91	90.02	471	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	84.12	170	2.00
At-Risk Population CAD	CAD Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P	54.08	61.44	66.11	69.96	72.32	76.40	79.84	66.67	438	2.00

Note: Measure 27 is 'reverse scored'.

Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible Points	OCV Possible Points (using info currently available)	OCV Points Scored	OCV Domain Scores	Domain Weight
Patient/Caregiver Experience	7	7 individual survey module measures	14	-	-		25%
Care Coordination/ Patient Safety	6	6 measures, plus the EHR measure double-weighted (4 points)	14	4	3.70	93%	25%
Preventive Health	8	8 measures	16	16	14.20	89%	25%
At-Risk Population	12	7 measures, including 5-component diabetes composite measure and 2- component coronary artery disease composite measure	14	14	13.10	94%	25%
Total in all Domains	**33**	**28**	**58**	**34**	**31.00**		**100%**

Scores not available for survey-based measures and CMS-calculated claims based measures.

R = Reporting P = Performance

Performance Year 2, OneCare Vermont must report completely and accurately on all measures, however, its performance will be assessed relative to performance benchmarks for a specified set of measures. Measures 18, 19, 20, 21 ,22-26, 29, 31 and 32 -33 are still paid for reporting measures. This scorecard reflects OCV's preliminary score for reporting and performance measures in 2014.

n = number of beneficiaries included in the CMS GPRO submission for each quality measure. For measure 12, n is the number of discharge dates selected for medication reconciliation.

Preliminary Score

2014	2013
91.6%	**100.0%**

All measures were pay-for-reporting in 2013

-8.4%

OneCareVermont

ATTACHMENT B: Example Bennington RCPC Charter

OneCareVermont

Bennington Regional Clinical Performance Committee

Committee Charter

Purpose: The Bennington Health Service Area Clinical Performance Committee (Bennington RCPC) will identify and develop systems of care to better support population health management in the Bennington Health Service Area to accomplish OneCare Vermont's (Board of Managers and Clinical Advisory Board) strategies to meet Vermont's health care reform goals.

Principles: The Bennington RCPC will:

- Include leaders from the medical community, health care community, local/regional community agencies, and health care leadership.
- Ensure that members have an equal voice on the committee and will work to reach consensus on decisions.
- Identify opportunities to collaborate and utilize the Bennington Blueprint as the infrastructure to advance the health care delivery system to a Medical Neighborhood.
- With population health management, consider a "whole person" approach including physical health, mental health, and socio-economic well-being.
- Align the quality of care goals and care coordination systems with OneCareVT and the Blueprint.
- Identify and work to address gaps in services, duplication of services and rework within the health care system.
- Serve as a sounding board and make recommendations about new programs related to health care delivery within the Bennington HSA.
- Charter, monitor and evaluate performance improvement teams to reach the OneCareVT goals.
- Provide required reports, feedback and recommendations to the OneCareVT Clinical Advisory Board.
- Take direction and guidance from the OneCareVT Clinical Advisory Board.

Membership:

Co-Chairs: OneCareVT Regional Physician Representative (RPR)
Director for the Bennington Blueprint (UHA)

Operations/Administrative Support: Provider Relations Coordinator (UHA/OneCareVT)

Members: Physician Representatives and Affiliates for the Clinical Advisory Board (to include Peds)
Physician Representative to Governing Board
OneCareVT Regional Physician Representative (RPR)
Bennington HSA Representatives for OneCareVT
CEO of UHA (PHO)
Director for Planning for SVHC
CNO for SVMC
Administrative Director for Outpatient Services (SVMC)
Director for the Bennington Blueprint for UHA
Blueprint Community Health Team Leader for UHA (CHT)
Blueprint Practice Facilitator for UHA
Administrative Director for Quality, Safety and Value at SVHC
Administrator for Centers for Living and Rehabilitation (SNF/Sub-acute)
Director of Operations for SVMC Physician Practices (Specialists)
Representative from Rutland VNA (Home Health)
Executive Director for UCS (Designated Mental Health Agency)
CEO/Executive Director of FQHC (Bennington County)
ACO Clinical Coordinator for OneCareVT (Bennington/ Rutland)
Executive Director on the Council on Aging (Bennington County)
Executive Director of the Local Agency for Housing (Bennington County)
District Director of the Vermont Department of Health
Field Officer for the Vermont Agency of Human Services
Community Member
SVHC Chief Information Officer
SVHC Senior HR Specialist, Benefits Administrator

Guest: OneCareVT Network Liaison

Sub-Committees/Ad Hoc Task Forces: As assigned by the Bennington RCPC

Accountability:

The Co-Chairs will do the following:

- Plan the agenda
- Lead and facilitate the meeting
- Provide overall support to the work of the committee
- Maintain the records of the committee
- Provide required reports and feedback to the Clinical Advisory Board (CAB)

The Operations/Administrative Support Person:

- Send out agenda and meeting packets
- Take attendance
- Draft the minutes
- Arrange for meeting rooms, media technology and telephones for each meeting
- Support the co-chairs
- Schedule special meetings as necessary (Sub-Committees, Ad-Hoc Task Forces)

The members of the Bennington RCPC will:

- Represent their organization or agency and services provided
- Secure the support and commitment from their organization or agency to fully participate
- Attend seventy-five percent (75%) of the scheduled meetings
- Openly share their views and ideas
- Support the consensus and decisions of this committee
- Represent the work of this committee in a positive fashion to the community
- Facilitate the accomplishment of the goals/objectives set by Bennington's RCPC

Sub-Committees/ Ad-Hoc Task Forces:

- Chartered by the Bennington RCPC as needed. For examples, dental access or medication management
- Will be assigned a chairperson who also is a member of the Bennington RCPC
- May have subcommittee/ad-hoc taskforce members assigned who are not members of Bennington RCPC
- Quality Work Group has been established to coordinate chart reviews. It will also review data from OneCareVT and present a summary of the data to the Bennington RCPC. Required members of the Work Group are Bennington HSA Representatives for OneCareVT, OneCareVT Regional Physician Representative, and the Director for the Bennington Blueprint. Other Work Group members may be assigned.

Scope: The scope of the Bennington RCPC is to address the population health in the Bennington HSA. The focus will be on quality outcomes, cost and value. The approach will be system changes including utilizing the Bennington Blueprint infrastructure for primary care, panel management, and the Medical Neighborhood for those changes. The Bennington RCPC will be collaborative and work to establish a learning community with other health service areas both directly and through the Clinical Advisory Board.

Meeting Dates:

Bennington RCPC:

- Monthly: To be determined.
- Annual Strategic Planning and Evaluation: Spring 2015

Quality Work Group: To be determined
Adopted: November 18, 2014

ATTACHMENT C: Learning Collaborative Schedule

VHCIP

2015 Current and 2016 Proposed Learning Collaborative Schedule

			2015									2016											
#	Deliverable/Milestone	Status	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1	**Preparation and Planning**	**Complete**																					
	Stakeholder Engagement	**Complete**																					
	Identify Care Coordinators	**In Process**																					
	Activate the Regional Clinical Representatives	**Complete**																					
	Activate the RCPCs with all stakeholders represented	**Complete**																					
	Identify goals of the Learning Collaborative	**Complete**																					
	Identify CAB Quality Improvement Projects	**Complete**																					
	Identify tools (PDSA)	**Complete**																					
	2015 Review/Planning for 2016																						
	Continuous process improvement cycle	**In Process**																					
	Establish mechanisms to sustain the improvements	**In Process**																					
	Create local and ACO wide policies and procedures "best practices"	**In Process**																					
	Monitor to make sure the activities becomes routinized	**In Process**																					
	Continuously review the practices to make sure that they don't need to be changed	**In Process**																					
	2015 Learning Collaborative Implementation																						
	Kick off statewide event	Complete																					
	PDSA Track 1																						
	Plan: Identification of projects to implement	In Process																					
	Do: Implementation of project chosen	In Process																					
	Study: Monitor and track results, identify improvements	In Process																					
	Act: Review the actionable results	In Process																					
	Collaborative #2: Statewide teams gather to review results	To Do																					
	PDSA Track 2																						
	Plan: Identification of projects to implement	To Do																					
	Do: Implementation of project chosen	To Do																					
	Study: Monitor and track results, identify improvements	To Do																					
	Act: Review the actionable results	To Do																					
	2016 Learning Collaborative Implementation																						
	Quality Data Training and Collection																						
	Collaborative #3: Statewide teams gather to review results	To Do																					
	PDSA Track 3																						
	Plan: Identification of projects to implement (data collection)	To Do																					
	Do: Implementation of project chosen	To Do																					
	Study: Monitor and track results, identify improvements	To Do																					
	Act: Review the actionable results	To Do																					
	Collaborative #4: Statewide teams gather to review results	To Do																					
	PDSA Track 4																						
	Plan: Identification of projects to implement	To Do																					
	Do: Implementation of project chosen	To Do																					
	Study: Monitor and track results, identify improvements	To Do																					
	Act: Review the actionable results	To Do																					

ATTACHMENT D: Care Management Software Implementation Schedule

VHCIP

Care Management Software Implementation Schedule

			2015									2016											
#	Deliverable/Milestone	Status	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1	**Vendor Selection**																						
1.1	RFI Issue Date	Complete	4/1																				
1.2	RFI Response Date	Complete	4/27																				
1.3	Selection Top Candidates	Complete		5/15																			
1.4	Demos	In process				7/15																	
1.5	Selection Finalized	To do				7/30																	
2	**Contracting**	To do																					
2.1	Leadership and Board Approval	To do					8/15																
2.2	Finalize contract	To do					8/30																
3	**Implementation**	To do																					
3.1	Planning	To do						9/15															
3.2	Configuration and Implementation	To do									12/31												
4	**Training**	To do																					
4.1	OCV Help Desk Training	To do										1/30											
4.2	OCV Clinical Consultant Training	To do										1/30											
5	**Rollout**	To do																					
5.1	Rollout to RCPC Care Coordinators	To do												3/15									

ATTACHMENT E: Patient Tracking Implementation Schedule

VHCIP

Patient Tracking Implementation Schedule

			2015									2016											
#	Deliverable/Milestone	Status	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1	**Vendor Selection**																						
1.1	RFI Issue Date	To do				7/1																	
1.2	RFI Response Date	To do				7/15																	
1.3	Demo	To do				7/30																	
2	**Contracting**	To do																					
2.1	Leadership and Board Approval	To do					8/15																
2.2	Finalize contract	To do					8/30																
3	**Implementation**	To do																					
3.1	Planning	To do						9/15															
3.2	Configuration and Implementation	To do									12/31												
4	**Training**	To do																					
4.1	Determine training needs	To do										1/30											
5	**Rollout**	To do																					
5.1	Determine roll out plan	To do												3/15									

Vermont ACO Pilot
ACO Care Transformation Meeting Report:
OneCare Vermont
June 2, 2015

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Background

In the fall of 2012 the Green Mountain Care Board (GMCB) developed the following objectives for the Vermont ACO Pilot:

Vermont's ACOs [will] successfully transform care delivery and:

- *improve health care quality, patient experience of care and population health;*
- *reduce costs across the health care system; and*
- *maintain the financial viability of the state's health care system.*

Following the completion of the first year of the three-year Vermont ACO Pilot, GMCB and the Department of Vermont Health Access (DVHA) initiated the first of a regular series of strategic dialogues with participating ACO and payer executives regarding how ACOs are working to transform care delivery in Vermont.

GMCB and DVHA staff identified a series of structured questions to provide an organizing framework for conversation. ACOs were asked to come to the meetings prepared to share information that will respond to each of the questions.

This report summarizes GMCB and DVHA findings from a meeting with OneCare Vermont (OneCare) on April 3, 2015. Findings are organized around the topical areas and specific questions that were the focus of the state's inquiry.

Overarching Strategies

1. *What are the principal strategies your ACO is currently employing (individually and/or in collaboration with other entities) to slow down per capita cost growth for your Medicare, commercial and Medicaid (as appropriate) ACO-attributed populations?*
    a. *What, if anything, are you doing differently for each of your respective payer populations?*
2. *What are the principal strategies your ACO is currently employing (individually and/or in collaboration with other entities) to improve the health status of your Medicare, commercial and Medicaid (as appropriate) ACO-attributed populations?*
    a. *What, if anything, are you doing differently for each of your respective payer populations?*

OneCare reported having one principal strategy for slowing per capita cost growth and improving health status - a federated clinical management model - that empowers local communities with data. Under that strategy, it defined four component strategies:

1. identification of actionable and data driven priorities;
2. proactive application of interventions across the continuum of care (well-to-chronic) to improve population health;
3. adoption and deployment of clinical best practice standards across the state (via change management and learning forums), and
4. rigorous monitoring of outcomes.

In terms of 2014 areas of clinical focus, OneCare reported the following:

- coronary artery disease;
- diabetes;
- emergency room utilization;
- high risk patients, and
- readmissions.

Each UCC/RCPC was asked to select one topic for 2014 upon which to focus its work.

For 2015, OneCare reported adding:

- chronic obstructive pulmonary disease/asthma;
- congestive heart failure, and
- hospice.

OneCare reported that Medicaid and commercial population-specific topics are under discussion. OneCare added that the evolution of the federated relationships will depend on how fast it can align "the economics" (i.e., tying financial risk to performance).

<u>Successes:</u>

- overarching strategy articulation and identification of clinical improvement opportunities
- initial implementation through Regional Clinical Performance Committees (RCPCs) and Unified Community Collaboratives (UCCs)

<u>Opportunities for Improvement:</u>

- development and implementation of specific systematized clinical interventions through the UCCs and RCPC, eventually including more than one topical area per region
- identification of areas of clinical focus specific to commercial and Medicaid populations;
- development of systems to measure cost and health status impact of strategy implementation

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Care Management and Coordination

3. *How is your ACO improving care management for the following populations (individually and/or in collaboration with other entities), relative to how their care was being managed prior to your ACO's formation?*
    a. *High-cost, high intensity patients who utilize inpatient and specialty services*
    b. *Patients with one or more chronic conditions that are not well-controlled*
    c. *Patients with mental illness*
    d. *Patients with chemical dependency*
    e. *People with long-term services and supports needs*
4. *What is your ACO (individually and/or in collaboration with other entities) doing to improve coordination of services across the care continuum? And, what is your vision for expansion of services in the near term (1-2 years) and long term (3-5 years)?*
5. *How is your ACO (individually and/or in collaboration with other entities) promoting teamwork across primary and specialty providers, as well as with community-based non-physician providers, hospitals and the state's health promotion and health management initiatives?*

In addition to the UCC/RCPC-directed work described under "overarching strategies", OneCare described activities to stratify its attributed population by risk level, coordinate care for the highest 5% at-risk patients, improve transitions of care, and test innovations in care coordination (care management).

- Stratification of population by risk and conditions: OneCare reported building a population health model to stratify its attributed lives by health status and risk, using the NNEACC "Impact" tool with Medicare claims and lab data, as well as BCBSVT-supplied patient risk reports. OneCare intends to develop a plan with strategies for each stratified quadrant. Medicaid and commercial claims will be used in the future. For now, stratified lists of only Medicare beneficiaries are sent to practices.
- Care coordination for the top 5% high risk population: OneCare has seven centralized care coordinators for its Medicare beneficiaries. These care coordinators are required to work with regional care coordinators in each of the 14 HSAs and use common tracking forms and a patient high-risk registry. OneCare continues to define the care coordinator function, and is currently defining its "seven pillars" for care coordination.
- Improving clinical handoffs/transitions of care: OneCare reported that the UCCs/RCPCs are conducting "deeper dives" to find opportunities here.
- SIM pilots in three communities: Regarding shared clinical care plans among clinicians, OneCare described the three integrated care coordination learning collaboratives that are supported by SIM funds and being piloted in St. Johnsbury,

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Rutland and Burlington. It also referenced a pediatric care coordination pilot in 2014 for complex needs children which will continue with grant funding.

OneCare reported that it is making plans to evaluate care management performance, including central registry use and compliance with best practice guidelines, and more broadly studying "what works."

Successes:

- development and implementation of population risk stratification tools
- implementation of a care management function for highest-risk Medicare beneficiaries, including use of common tracking forms and a registry
- consideration of how best to coordinate central and regional efforts to avoid duplication and confusion

Opportunities for Improvement:

- continuation and completion of development of a care management (coordination) strategy that includes systematized approaches to care management implementation and operation and that draw upon national, state and ACO-specific experience, for:
  - high-intensity need patient subpopulation care management
  - coordination across the continuum
  - teamwork with medical specialists and community-based non-physician providers
- expansion of care management activities to the Medicaid and commercial populations
- addressing barriers to sharing data and information across care coordinators and providers
- ensuring engagement and performance accountability across all UCCs/RCPCs

Information Analysis and Sharing

6. *How is your ACO using data to identify opportunities for performance improvement and patients in need of attention at a) the ACO level, b) the regional level, and/or c) the provider level? Please explicitly address the use of claims, clinical and survey data, as appropriate.*
7. *How is your ACO using data to track how it is performing relative to organizational goals and targets?*
   a. *Does your ACO have a dashboard or other measurement tool for assessing performance?*
   b. *If so, what measures are included and how often is the dashboard updated?*
   c. *Is it reviewed by your ACO's governing body?*
8. *How is your ACO sharing performance information with ACO-participating providers?*
   a. *What information is being shared, in what format, and with what frequency?*

OneCare reported that it generates and distributes the following reports:

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- ACO Level
  - Monthly board "flash" reports on key statistics
  - Quarterly dashboard on clinical priorities and top 5% risk
  - Annual payer report cards
  - Annual patient experience reports
- HSA/Regional Level
  - Blueprint and OneCare aligned quality measure reports
  - Quarterly and ad-hoc dashboard reports monitoring utilization, costs, and quality metrics
  - Quality dashboards on clinical priorities
- Provider Level
  - Beneficiary detail reports for practitioner and practice-level use
  - High-risk patient ("5%") report

OneCare explained how its contractor, NNEACC, has combined clinical and claims data for OneCare, and how the ACO also maintains its own claims data warehouse for standard reports and "deep dive" analytics. OneCare reported that NNEACC is not fully functional, but OneCare is working towards one analytic solution in the future, either through NNEACC or some other solution.

At present the analytic strategy is driven by the chief medical officer. There are plans to conduct analyses to identify variation. Decisions regarding which performance opportunities to pursue were reported to be decided by a committee of the board of managers.

Successes:

- staffing an analytics team
- developing and utilizing a data warehouse for claims data
- developing a suite of reports for use at multiple levels

Opportunities for Improvement:

- realizing the potential of an integrated claims/clinical data warehouse
- systematizing variation analysis to identify opportunities for improvement at the ACO, regional and provider levels for Medicare, Medicaid and commercial populations
- expanding performance measurement and analysis to institutional providers

Clinical Performance Improvement and Accountability

9. *How is your ACO working to redesign care processes (e.g., develop clinical pathways) in order to improve quality and efficiency, reduce waste and reduce variability, if at all?*
   a. *Has your ACO adopted, defined or developed any care processes? (e.g., transitions of care procedures to prevent avoidable readmissions)*
   b. *If so, how will they/how have they been implemented?*

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c. *If so, how will you/how have you assessed adherence?*

10. *What, if anything, is your ACO doing to help engage and activate patients in managing their own care?*
11. *In addition to information sharing, how is the ACO, if at all, supporting:*
    a. *Network provider performance improvement?*
    b. *Network provider performance accountability?*

In responding, please differentiate between primary care, specialty care, hospital and non-physician community providers.

As described earlier, OneCare reported that it is in the process of transforming to an integrated, regionally-administered standards-based model of care delivery. Using a format created by RTI, OneCare prepares segmented investigations of various diagnoses, and provides the results to providers, by TIN and attributed patients.

Efforts to engage patients in their care currently consists of placement of consumers on UCCs/RCPCs, on a Consumer Advisory Group that informs ACO policies, and in two care models pilots that focus on shared care plans. In addition, OneCare has informed its members regarding the availability of educational programs and self-management tools available to them via the Blueprint Community Health Teams. The ACO noted that most hospitals across the state have shared decision- making tools and patient portals. OneCare stated that it has been reluctant to duplicate these efforts.

Efforts to support provider performance improvement and accountability were reported to focus on the ACO's clinical governance model and on ongoing monitoring and adjustment based on state and regional variability. Regarding the latter, the ACO reported that it uses its quality score cards to identify variability across HSAs for select quality measures and that some communities lack the resources to tackle variations, particularly if doing so involves changing entrenched processes.

<u>Successes:</u>

- supporting UCC/RCPC work to improve care in areas of identified opportunity

<u>Opportunities for Improvement:</u>

- continuing early efforts at redesigning care processes, and then assessing adherence and impact
- designing and executing strategies for engaging and activating patients in managing their own care
- actively supporting individual network provider performance improvement and performance accountability beyond the work of the UCCs/RCPCs

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Provider Payment and ACO Risk Assumption

12. *What strategies is your ACO developing to align incentives for network providers, including compensation strategies for those who are employed by hospitals and medical groups and those who are not, with the performance incentives in the pilot ACO contracts?*
13. *What is your ACO doing to prepare to manage risk in the future, in addition to the activities you have already described?*

OneCare explained that it is seeking to align incentives for network providers, including those employed by hospitals and medical groups and those who are not, through its method of distribution for any earned savings:

- Primary Care Providers
  - 45% of the savings to primary care providers who meet the following criteria:
    - submit complete data to the ACO
    - meet a minimum quality score of 30 out of 100 points
- Hospital/Specialty Physicians
  - 45% of the savings to hospitals and to specialists based upon their percentage of Medicare net revenues

OneCare explained that it is looking to the all-payer model as the means by which it will assume risk in the future.

<u>Successes:</u>

- none yet achieved

<u>Opportunities for Improvement:</u>

- developing payment and compensation models that move away from fee-for-service volume incentives and towards rewarding quality and efficiency

Summary

OneCare made impressive strides in 2014 in building its ACO clinical and data infrastructure. It has built a robust team of managers and has a clear vision as to the functionalities it seeks to develop. The GMCB and DVHA found its conversation with OneCare leadership edifying and wish to continue the practice in a similar format on a periodic (approximately annual) basis.

While OneCare has accomplished much in a short time, there are several opportunities for continued evolution by the ACO during 2015. The GMCB and DVHA look forward to following and supporting VCP's progress in addressing these important opportunities.

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Proposal for Delivery System Reforms:

Integrating Vermont ACO and Blueprint Activities

Phase II Payment Reforms

Developed in Collaboration

Vermont Blueprint for Health

One Care

CHAC

Health First

Introduction

This proposal presents a plan for a next phase of delivery system reforms in Vermont to increase the capacity of primary care, provide citizens with better access to team based services, and strengthen the basis for a community oriented health system structure across Vermont. The suggested programmatic and payment changes are designed to establish a more systematic approach to coordinating local services and quality initiatives across the state. This will be achieved thru integration of Accountable Care Organization (ACO) and Blueprint program activities in a unified collaborative to guide quality and coordination initiatives in each service area; and, an aligned medical home payment model that promotes coordination and better service area results on core measures of quality and performance. The proposed changes represent a natural next phase for the evolution of health services in Vermont by building on delivery system advancements in each community, and on the organizational capabilities of the three ACO provider networks (OneCare, CHAC, and Healthfirst). The structural, programmatic and payment changes proposed in this plan are designed to achieve the aim of providing citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services; and more affordable services.

Background

Blueprint. During the last six years, stakeholders across the state have worked with the Blueprint program to implement a novel healthcare model designed to provide citizens with better access to preventive health services, and to improve control over growth in healthcare costs. The statewide model includes:

- high quality primary care based on national standards for a patient centered medical home
- community health teams providing the medical home population with access to multi-disciplinary staff such as nurse care coordinators, social workers, and dieticians
- integrated health services workgroups to strengthen networks in each community and improve coordination between medical and social services and
- a statewide learning health system thru data guided quality initiatives at the practice, community, and statewide levels.

Implementation of the model has been supported by Multi-insurer payment reforms, as well as Blueprint grants to each area of the state that support project managers, practice facilitators, self-management programs, and assistance with health information technology and data quality. Results of a six year trend analysis demonstrate improvements in healthcare utilization,

healthcare expenditures, better linkage of Medicaid beneficiaries to social support services, and improvements in healthcare quality (HEDIS).

Provider Networks. At the same time, Vermont's healthcare reform initiatives have continued to push forward on several fronts including implementation of an insurance exchange in alignment with the Affordable Care Act (Vermont Health Connect), and the introduction of shared savings programs designed to improve quality and control over health care costs. As part of this process, healthcare providers have established three statewide ACO networks based on common business interests. The three networks include OneCare, CHAC, and HealthFirst. Each of the three provider networks has established an administrative structure to guide participation in Vermont's healthcare reform processes including participation in shared savings programs. These new provider networks, and in particular their ability to organize initiatives and represent the interests of their constituents, adds important organizational capacity to Vermont's healthcare landscape.

Integration. The three ACO provider networks can help to organize healthcare improvement priorities with their members (vertical organization). The Blueprint program with Community Health Teams and Integrated Workgroups has helped to organize coordination at a community level, across settings and provider types (horizontal). This plan blends these strengths and adds meaningful participation of additional provider types, in a formal collaborative structure that will improve services for citizens in each service area in Vermont. Modifications to current medical home payments are proposed which are integral to support coordination in each community, and to align medical home incentives with the quality and performance goals of the new collaboratives.

Programmatic Changes

Unified Community Collaboratives - Principles & Objectives. Presently, an array of meetings focused on quality and coordination are taking place in communities across Vermont. Most areas have Blueprint integrated health services workgroups as well as workgroups for participants in the provider network shared savings programs (ACOs). The Blueprint meetings are oriented towards coordination of community health team operations and services across providers in the community (community, horizontal) while the ACO meetings are oriented towards meeting the goals of the participating provider network (organizational, vertical). The same providers may be participating in multiple meetings, with overlapping but distinct work on coordination of services and quality.

This proposal calls for development of a Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) in order to coalesce quality and coordination activities, strengthen Vermont's community health system infrastructure, and to help the three provider networks meet their organization goals. In many areas of the state the proposed collaboratives represent a significant advancement in terms of the assortment of provider types who would participate in, and help lead, a unified forum. They build on a strong community oriented culture in the state

with the underlying premise that the UCC structure, with administrative support and an aligned medical home payment model, will result in more effective health services as measured by:

- Improved results for priority measures of quality
- Improved results for priority measures of health status
- Improved patterns of utilization (preventive services, unnecessary care)
- Improved access and patient experience

Unified Community Collaboratives – Activities. As proposed, the UCCs will provide a forum for organizing the way in which medical, social, and long term service providers' work together to achieve the stated goals including:

- Use of comparative data to identify priorities and opportunities for improvement
- Use of stakeholder input to identify priorities and opportunities for improvement
- Develop and adopt plans for improving
    - quality of health services
    - coordination across service sectors
    - access to health services
- Develop and adopt plans for implementation of new service models
- Develop and adopt plans for improving patterns of utilization
    - Increase recommended and preventive services
    - Reduce unnecessary utilization and preventable acute care (variation)
- Work with collaborative participants to implement adopted plans and strategies including providing guidance for medical home and community health team operations

Unified Community Collaboratives – Structure & Governance. To date, Blueprint project managers have organized their work based on a collaborative approach to guiding community health team operations and priorities. In most cases, this has stimulated or enhanced local innovation and collaborative work. The three new medical provider networks have each established a more formal organizational structure for improving quality and outcomes among their constituents. The provider networks are looking to establish improved collaboration and coordination with a range of service providers in each community. The proposed collaboratives build from these complimentary goals and capabilities, enhance community coordination, and improve the ability for each provider network to achieve their goals. This is accomplished using a formal structure with a novel leadership team that balances the influence of the three medical provider networks, and the influence of medical, social, and long term providers.

We are proposing that the UCC in each HSA have a leadership team with up to 11 people based on the following structure:

- 1 local clinical lead from each of the three provider networks in the area
    - OneCare

    - CHAC
    - HealthFirst (not present in all HSAs)
- 1 local representative from each of the following provider types that serves the HSA
    - VNA/Home Health
    - Designated Agency
    - Designated Regional Housing Authority
    - Area Agency on Aging
    - Pediatric Provider
- Additional representatives selected by local leadership team (up to total of 11)

The proposal is for the leadership team to guide the work of the UCC in their service area with responsibilities including:

- Developing a plan for their local UCC
- Inviting the larger group of UCC participants in the local service area (including consumers)
- Setting agendas and convening regular UCC meetings (e.g. monthly)
- Soliciting structured input from the larger group of UCC participants
- Making final decisions related to UCC activities (consensus, vote as necessary)
- Establishing UCC workgroups to drive planning & implementation as needed

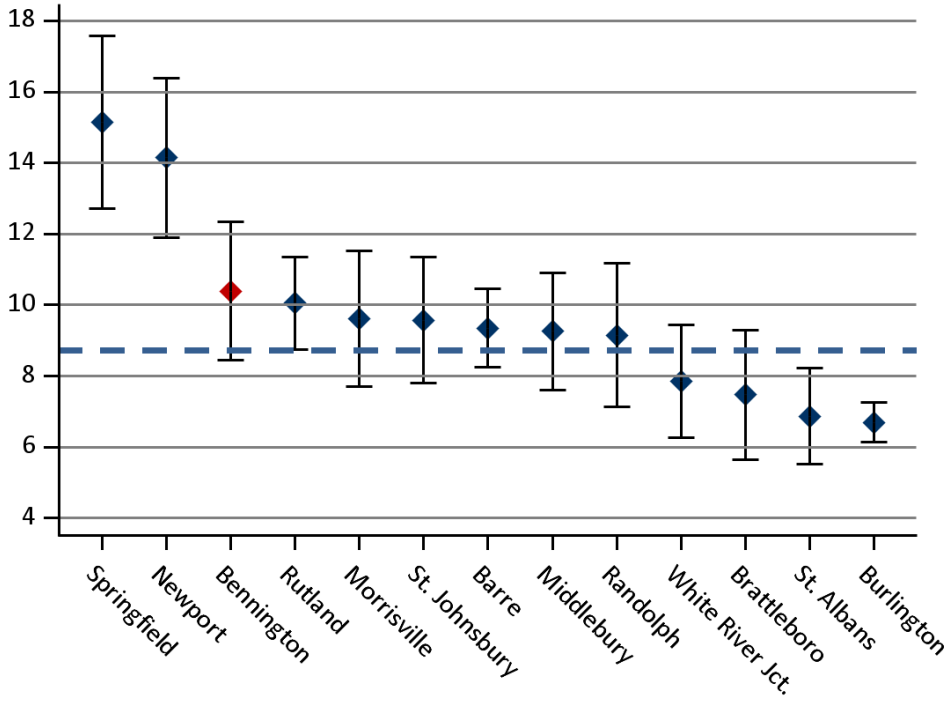
The UCC leadership team will be supported in their work with the following resources:

- Leadership team participation from each ACO provider network in the area
- Organizational support from the ACO provider networks
- Goals and objectives established by ACO provider networks
- Convening and organizing support from the Blueprint project manager
- Support on quality work from Blueprint practice facilitators
- Blueprint HSA grants structured to support the work of the UCC
- Collaboration between the Blueprint and UCC leaders on analytics & evaluation
- ACO Provider network performance reporting on the ACO population
- Blueprint profiles with comparative performance reporting on the whole population, including the results of core ACO measures (practice, HSA levels)
- Ongoing programmatic collaboration (Blueprint, Provider Networks, UCC leaders, others)
- Modification to medical home payments to support provider networks and UCC goals

Unified Community Collaboratives – Basis for Regional Health Systems. As UCCs mature, they have the potential to emerge as governing and fiscal agents in regionally organized health systems. This could include decision making and management of community health team funds, Blueprint community grants, and ultimately budgets for sectors of health services (e.g. pre-set capitated primary care funds). In order to be effective an agent for cohesive regional systems, it

is essential for UCCs to establish leadership teams, demonstrate the capability to engage a range of providers in sustained collaborative activity (medical, social, and long term support providers), demonstrate the capability to lead quality and coordination initiatives, and demonstrate the ability to organize initiatives that tie to overall healthcare reform goals (e.g. core measures). Ideally, UCCs will demonstrate effective regional leadership to coincide with opportunities offered by new payment models and/or a federal waiver in 2017.

Unified Community Collaboratives – Opportunity to Guide Improvement. Current measurement of regional and practice level outcomes across Vermont highlights opportunities for UCCs to organize more cohesive services and lead improvement. When adjusted for differences in the population, there is significant variation in measures of expenditures, utilization, and quality. The variation across settings offers an opportunity for UCC leadership teams and participants to examine differences, and to plan initiatives that can reduce unnecessary variation and improve rates of recommended services. One example is the Prevention Quality Indicator (PQI) measuring the rate of hospitalizations per 1,000 people, ages 18 and older, for a composite of chronic conditions including: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The 2013 service area results for this indicator, which is included in Vermont's core measure set for shared savings programs, highlights the variation that is seen with most core quality and performance measures.



Overall improvement in this measure, and reduction in variation across settings, is most likely with well-planned coordination across provider types including primary care, specialty care, and community services that improve self-management capabilities for vulnerable populations such as seniors without adequate support. Hospitalization rates for these types of conditions are driven by complex life circumstances, often related to social, economic, and behavioral factors that influence the ability to engage in daily preventive care. While the measure is one of traditional healthcare utilization, outcomes will be better with cohesive integration of health and human services addressing non-medical as well as medical needs. The UCC, and the proposed leadership team, is designed to establish a structured forum to guide this level of integration. A coordinated effort to identify those at risk in the community, to assess the factors that limit effective management, and to organize a community team approach to prevention will have the greatest opportunity to improve outcomes.

Governance – Balancing Statewide Standardization, Regional Control, & Local Innovation. During the development of this plan, there was a strong interest expressed by major stakeholders in a higher level (statewide) leadership team that mirrors the local UCC leadership team. The state level leadership team would guide coordination and quality priorities including: adoption and implementation of statewide standards (e.g. medical home standards); recommendations on selection of core measure subsets for payment models; eligibility requirements and structure of payment models; methods for assessment of compliance with standards; methods for attribution and empanelment; review of measure results and performance; recommendations for statewide improvement on key outcomes; and recommendations for service models to meet statewide needs. This work would be intended to inform, evaluate, and guide the work of the regional UCCs. In order to be successful, the state level leadership team would be balanced and represent the same key provider groups that are on the local UCC leadership teams including: a representative for each of the three ACO networks; a representative for VNAs and Home Health; a representative for the Designated Agencies; a representative for the Area Agencies on Aging; a representative for the regional Housing Authorities; and a representative for Pediatric providers. This leadership team could choose to add additional members up to a recommended total of 11 in order to be able to function as a leadership team and make decisions. The leadership team could convene a larger group of stakeholders to inform decision making as part of a state level collaborative, and convene workgroups as necessary. The central Blueprint team would serve a convening and support role for the state level leadership team in a similar manner as proposed for the regional UCCs. In effect, a state level structure would be established that would mirror the regional structures, and help to guide their work for matters where standardization and consistency are necessary. It is worth emphasizing that the recommendation for this type of structure emerged widely during the development of the plan and was expressed by stakeholders including: leadership for the three ACOs; leadership for VNAs and Home Health; leadership for the Designated Agencies; leadership for the Area Agencies on Aging; and leadership for Designated Regional Housing Authorities.

What also emerged was the need for balance, primarily the need to preserve the role for regional leadership to guide local decision making, organization, and innovation. Regional UCC leadership teams would respond to state level guidance and recommendations with local decisions on matters such as: methods for implementation of statewide standards; balancing statewide clinical priorities with local needs; and determination of methods for local implementation, organization, and ongoing improvement of service models. This structure highlights the design principle of regional innovation applied to common standards and guidelines. Regional energy and ownership, with comparative reporting and shared learning across regions, is likely to result in the emergence of more effective coordination and quality initiatives.

Another key design principle is a leadership continuum with mirrored leadership teams at the state and local levels. This design increases the likelihood that the state and local leadership teams share similar overarching interests and priorities, and that state level guidance will be relevant for local UCCs.

Payment Model

Current payment structure. To date, two payments have been adopted by all major insurers to support the roll out and maturation the Blueprint program. The first payment is made to primary care practices based on their score on NCQA medical home standards. In effect, this represents a payment for the quality of services provided by the practice as assessed by the NCQA standards. The second is a payment to support community health team staff as a shared cost with other insurers. This represents an up-front investment in capacity by providing citizens with greater access to multi-disciplinary medical and social services in the primary care setting. Both are capitated payments (PPPM) applied to the medical home population. Although these two payments are relatively low compared to the overall revenue that primary care practices generate; when combined with the dedication of primary care practice teams and the Blueprint program supports, they have led to statewide expansion of medical homes and community health teams. There is growing evidence that medical homes and community health teams favorably impact healthcare expenditures, utilization, and quality. However, the medical home payments have not been increased in the last six years and are widely perceived as inadequate to support the effort required to comply with increasingly demanding NCQA standards. Some practices, particularly independent practices that don't have the administrative support that hospital affiliated practices and health centers have, may choose not to continue participating at the current payment levels due to the time and costs associated with medical home recognition and operations. Similarly, community health team payments have not kept up with the administrative costs that are required to operate the expanded program, or the salary and compensation costs to employ the workforce. In some cases, this has led to a reduction in the staffing that is available to patients as adjustments are made to accommodate administrative and staff salary pressures. Lastly, while these payments have stimulated successful program expansion, it is important to consider whether a modified medical home payment model can be

used to support collaborative activity and the effectiveness of a community health system infrastructure.

Proposed medical home payment structure. The proposed medical home payment model is designed to more adequately fund medical home costs, and to directly align medical home incentives with the goals of the collaboratives and the ACO provider networks. The proposed payment changes anticipate multi-payer participation, a doubling of medical home payments, and a new performance component to the payment model. In this proposal, the total capitated payment to medical homes is based on a composite of medical home recognition, collaborative participation, and performance. The outcome measures driving the performance component include a Quality Index comprised of core ACO quality measures, and a Total Utilization Index. Improvement on these metrics, such as higher scores on the quality index and less variation on the utilization index, is directly aligned with the goals of Vermont's health reforms. The new medical home payment model includes the following elements:

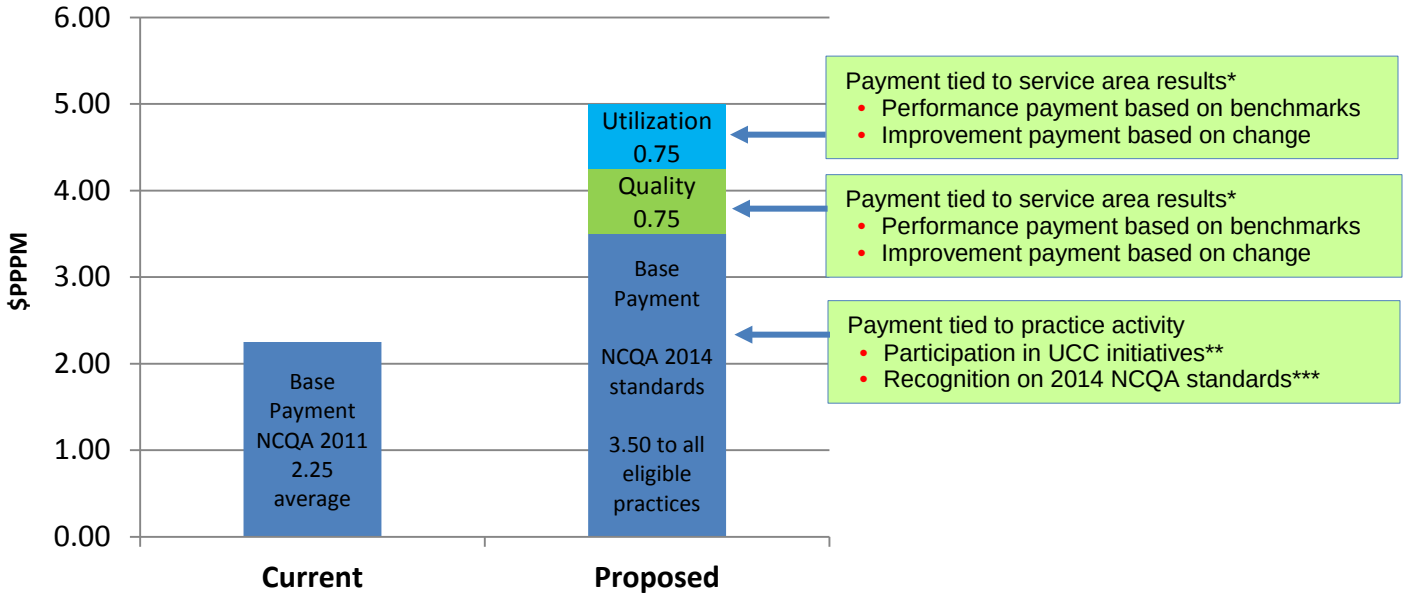
- Base Component: Based on NCQA recognition & UCC Participation.
    - Requires successful recognition on 2014 NCQA standards (any qualifying score)
    - Requires active participation in the local UCC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum requirement is active participation with at least one UCC priority initiative each calendar year.
    - All qualifying practices receive $3.50 PPPM

- Quality Performance Component: Based on HSA results for Quality Index.
    - Up to $ 0.75 PPPM for results that exceed benchmark, or
    - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

- Utilization Performance Component: Based on HSA results for Utilization Index.
    - Up to $ 0.75 PPPM for results that exceed benchmark, or
    - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

- Total Payment = Base + HSA Quality Performance + HSA TUI Performance
- Total Payment ranges from $3.50 to $5.00 PPPM

Comparison of current and proposed medical home payments



*Incentive to work with UCC partners to improve service area results.
**Organize practice and CHT activity as part of at least one UCC quality initiative per year.
***Payment tied to recognition on NCQA 2014 standards with any qualifying score. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

The new payment model is designed to promote collaboration and interdependent work by linking a portion of each practices potential earnings to measure results for the whole service area (HSA). It is also intended to more directly focus efforts on improved health outcomes and reduced growth in health expenditures. In theory, the combination of the UCC structure and decision making process, with the interdependent nature of the payment model, will lead to better organization and coordination across provider groups. In contrast, a medical home payment linked solely to practice quality is less likely to stimulate better coordination across a service area. Although fee for service is still the predominate payment, this suggested payment model is an important *step* towards a more complete capitated payment structure with a performance component that is anticipated for 2017. It will help to stimulate the culture and activity that is essential for a high value, community oriented health system. The implementation of this payment model is only possible with an increase in payment amounts to more adequately support the work that is required to operate a medical home and the multi-faceted payment structure. The incentive structure that is woven into the payment model includes:

- Requires active and meaningful participation in UCCs including: attention to variable and unequal outcomes on core measures; and, coordination with collaborative partners to improve services.

- Requires that practices maintain NCQA recognition, however shifts the emphasis to the most important Must Pass elements in the medical home standards and de-emphasizes the intensive documentation that is required to achieve the highest score.
- Introduces a balance between payment for the quality of the process (NCQA standards) and payment for outcomes (quality and utilization)
- Rewards coordination with UCC partners to achieve better results on service area outcomes for a composite of core quality measures (directly links incentives for medical homes to statewide healthcare reform priorities)
- Rewards coordination with UCC partners to achieve better service area results for the total utilization index (case mix adjusted), which has a predictable impact on healthcare expenditures (directly links incentives for medical homes to statewide healthcare reform priorities)

Opportunity to improve care and reduce variation. It is important to note that across Vermont there is significant variation in the results of quality and utilization measures, after adjustment for important differences in the populations served. Unequal quality and utilization, for comparable populations with comparable health needs, provides an opportunity to examine differences in regional health services, and to plan strategies that improve the overall quality of healthcare that citizens receive. The Blueprint currently publishes Profiles displaying adjusted comparative measure results for each participating practice and for each service area. The profiles include the results of core quality measures which have been selected thru a statewide consensus process. The objective display of the variation that exists across service areas, and across practices within each service area, can support the work of the UCCs including identification of opportunities where quality and utilization should be more equal, and implementation of targeted strategies to reduce undesirable variation.

Proposed changes for community health team payments. This proposal calls for a doubling of the total community health team investments that are made by Vermont's insurers (commercial, Medicaid) to increase service capacity, and to more adequately support salary and administrative costs for a community team infrastructure. In addition to the increase, the proposal is to adjust each insurer's share of community health team costs to reflect their proportion of attributed medical home patients in the Vermont market. Each insurer's share of costs will be calculated by applying their percentage of the attributed medical home population to the total community health team costs. Total community health team costs will be based on the number of unique medical home patients (attribution), with an adjustment to the per person basis to assure that the total CHT investment is doubled. Insurer's proportion of the medical home population will be updated with a new attribution count quarterly. Due to the terms in the current Multi-Payer Demonstration Program with CMS, Medicare's share will remain constant with a 22.22% share

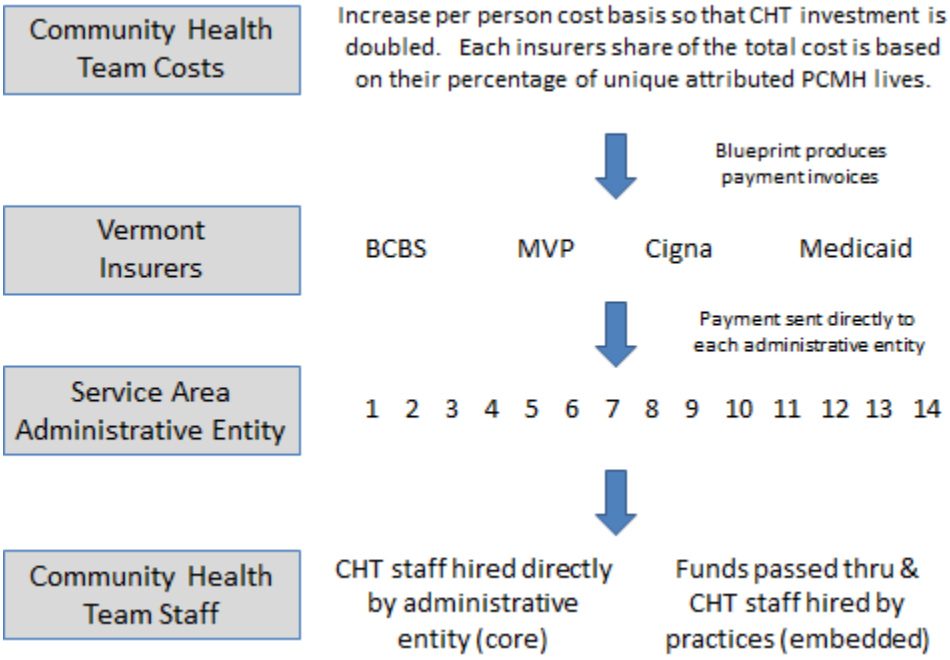
of community health team costs which is in close alignment with their market share. An example of the change to each insurer's share of costs, based on their current proportion of attributed medical home patients, is shown below along with the proposed payment process.

Market share basis for community health team costs.

	Current share of CHT Costs	Proposed share of CHT Costs*
Medicare	22.22%	22.22%
Medicaid	24.22%	35.66%
BCBS	24.22%	36.92%
MVP	11.12%	4.71%
Cigna	18.22%	0.49%
Total	100.00%	100.00%

*Each insurer's percentage of community health team cost is based on their attributed proportion of the total medical home population.

Proposed payment process for community health teams.



Quality and Performance Framework

Design Principles. This plan calls for use of Vermont's core performance and quality measures, in conjunction with comparative performance reporting, to help guide UCC activities and medical home payments. This approach ties the work of medical homes and UCCs directly to priorities for state led health reforms as reflected by the core measure set, which was selected using a statewide consensus process as part of the Vermont Healthcare Improvement Program (SIM). The three medical provider networks share a common interest in the results of the core measures which are used to determine whether network clinicians are eligible for payment as part of shared savings programs (SSP).

The proposal calls for use of a subset of these measures, which can be consistently reported using centralized data sources, to provide targeted guidance for the work of the UCCs. The intent is that UCCs will work to improve the results on some or all of the subset, depending on local priorities and the decisions made by each UCC. The subset of measures will be also be used to generate an overall composite result for the service area (quality composite). The composite result will be used to determine whether medical homes are eligible for a portion of their augmented payment (see payment model).

In addition to the subset of core quality and performance measures, this plan incorporates use of the Total Resource Utilization Index (TRUI), a standardized and case mix adjusted composite measure designed for consistent and comparable evaluation of utilization and cost across settings. Comparative results of the TRUI, adjusted for differences in service area populations, can be used in combination with more granular utilization measures to identify unequal healthcare patterns and opportunities for UCC participants to reduce unnecessary utilization that increases expenditures but doesn't contribute to better quality. Similar to the core quality and performance composite, the service area result for the TRUI will be used to determine whether medical homes are eligible for an additional portion of their augmented payment (see payment model).

Used together, the two composite measures promote a balance of better quality (core quality and performance) with more appropriate utilization (TRUI). Linking payment to measure results for the whole service area establishes interdependencies and incentives for medical home providers to work closely with other collaborative participants to optimize outcomes. Routine measurement and comparative reporting provides UCCs with the information they need to guide ongoing improvement. In this way, the proposed measurement framework serves as the underpinning for a community oriented learning health system and helps UCCs to:

- Establish clear measurable goals for the work of the collaborative
- Guide planning and monitoring of quality and service model initiatives
- Align collaborative activities with measurable goals of state led reforms
- Align collaborative activities with measurable goals of shared saving programs

Measure Set. Implementation of this plan depends on selection of a subset of quality and performance measures from the full core measure set that was established thru VHCIP. The intent is for a *meaningful* limited set that can be measured consistently across all service areas, using centralized data sources that are populated as part of daily routine work (e.g. all payer claims database, clinical data warehouse). Ideally, measures will be selected that maximize measurement capability with existing data sources, prevent the need for additional chart review, and avoid new measurement burden for providers. At the same time, work should continue to build Vermont's data infrastructure so that more complete data sets and measure options are available. Vermont's full set of core measures are shown in Appendix A, with the subset that can currently be generated using centralized data sources shown below:

- Plan All-Cause Readmissions
- Adolescent Well-Care Visit
- Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)
- Follow-up after Hospitalization for Mental Illness, 7 Day
- Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Developmental Screening in the First Three Years of Life
- Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
- Mammography / Breast Cancer Screening
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite
- Appropriate Testing for Children with Pharyngitis
- Cervical Cancer Screening
- Influenza Vaccination
- Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg
- Pneumonia Vaccination (Ever Received)
- Ambulatory Sensitive Condition Admissions: Congestive Heart Failure
- Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use - Adult
- Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) – Adult
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Process to select measures. Given the importance of these measures, a stepwise process is recommended to select a subset that will be used to help guide the work of UCCs, and as the basis for a performance portion of medical home payments.

- Leadership from the three provider networks recommends a consensus subset. It is essential for medical home clinicians to help prioritize the subset since their payment is partly tied to service area results. This first step allows the primary care community to coalesce around a subset of measures, which are selected from an overall set that represents state level reform priorities (statewide consensus process).
- The consensus subset, recommended by the three provider networks, should be vetted thru key committees to assure that a balanced subset is selected (meaningful, practical, and usable). Committees to be considered include: VHCIP - Quality & Performance Measurement Workgroup, Payment Models Workgroup, Core Committee; BP - Executive Committee, Planning & Evaluation Committee.

Attributes that should be considered when selecting the subset include:

- Will improvement in these measures contribute in a meaningful way to the goals of Vermont's health reforms (e.g. quality, health, affordability)
- Is there a real opportunity for service areas to improve the results of these measures with better quality and coordination (UCC work, medical homes)?
- Is sufficient data currently available so that these measures can be measured in all service areas?
- Can measure results be generated and routinely reported, in a usable format, for use by UCC participants?
- Are regional and national benchmarks available for these measures?

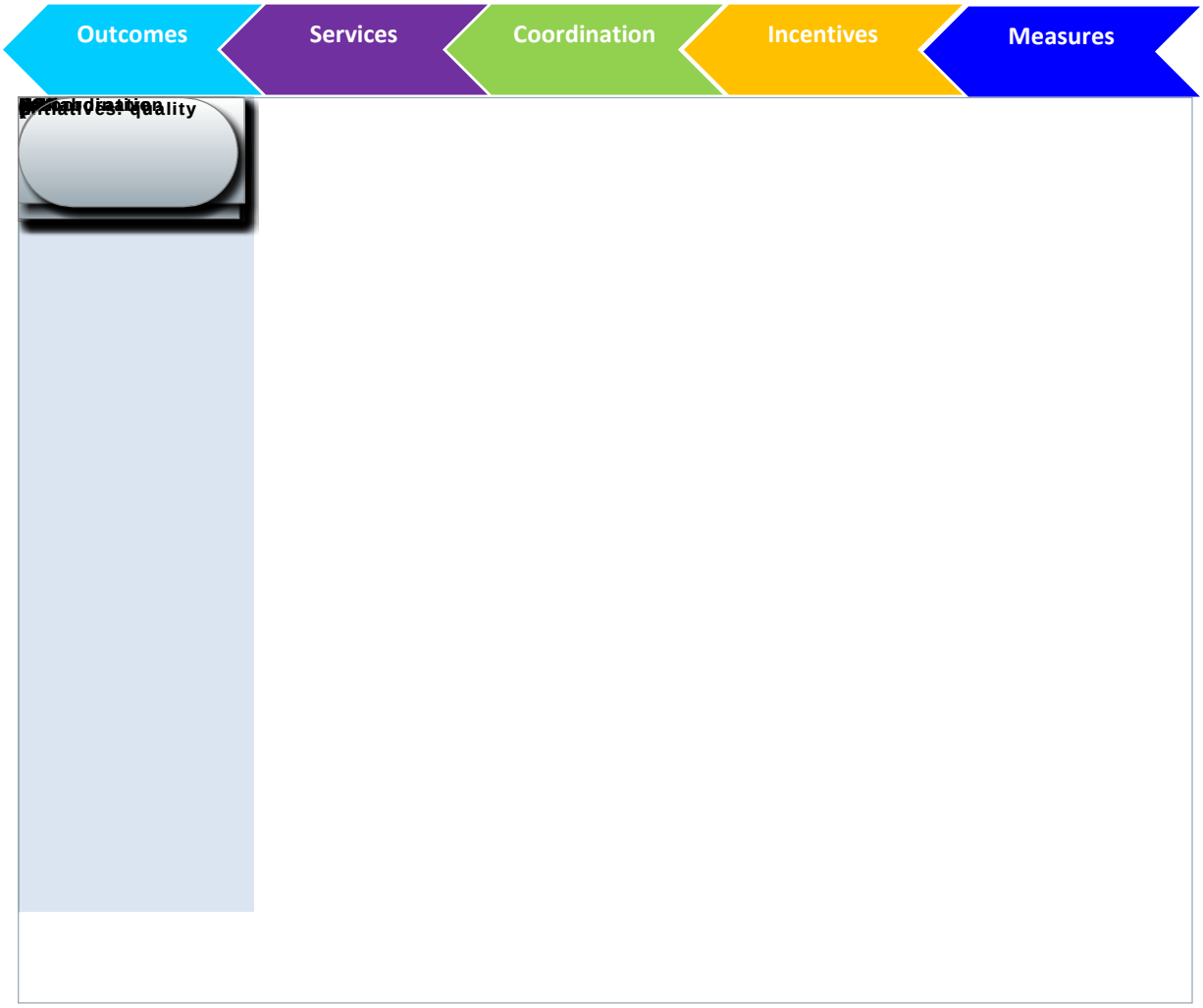
Linking Healthcare & Population Health. The most substantial improvement in results for these core performance and quality measures is likely to be achieved by addressing the medical, social, economic, and behavioral components that converge to drive poor health outcomes. Although the core measures are oriented to the healthcare sector, the program and payment strategies outlined in this plan stimulate interdependency and coordination of a broader nature. The makeup of the collaborative leadership team, decision making process, and link between medical home payment and service area outcomes are all designed to assure that citizens have access to more cohesive and complete services. Collectively, the plan is a first step in using comparative measurement as a driver for a broader community health system. However, an important next step would be to incorporate measures that reflect non-medical determinants as part of the framework to guide community health system activities. As part of this plan, it is recommended that the VHCIP Population Health workgroup work with provider network leadership and other stakeholders to identify a subset of core population health measures that can be reliably measured and used in concert with the current core quality and performance measures.

Strategic Framework for Community Health Systems

This plan is intended to provide Vermont's citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services;

and more affordable services. Strategically, the plan starts with Vermont's consensus based core performance and quality measures, and positions these measures as drivers for local community level learning health systems. Medical home financial incentives are in part tied to service area results for these core measures and to their participation in local collaborative initiatives. The collaboratives are designed to lead initiatives which will improve quality and performance, including the results of core measures, thru better coordination. Ultimately, data guided community initiatives, involving medical and non-medical providers, will provide citizens with direct access to more complete and effective services. The use of core measures as proposed, with detailed information on local variation and outcomes, is a substantial step towards a performance oriented community health system. Results to date in Vermont suggest that medical homes working with community health teams, and other local providers, will lead to a measurable increase in recommended preventive services and a reduction in unnecessary and avoidable services. The strategic framework to achieve the desired aims is outlined below.

Strategic Framework.



Key Issues & Decision Points.

Successful implementation of this plan depends on several key actions and decision points. First, the plan depends on an increase in medical home and community health team payment levels. As part of his budget proposal to the Vermont state legislature, Governor Shumlin announced his intention to increase Medicaid's portion of these payments starting January 1, 2016. His proposal calls for a doubling of current amounts which will support the new performance based payment model, an essential ingredient to maintain primary care participation and to stimulate community health system activity across Vermont. To be effective, these increases need to be multi-payer, involving all major insurers in Vermont.

Second is the selection of a subset of Vermont's consensus measures that will be used to comprise the quality index portion of the payment model. These measures are important since they will help set priorities for community improvement and medical home payment. They must be consistently measurable across all service areas with sufficient historical data so that benchmarks for payment and improvement can be set. Pragmatically, the data should be available in Vermont's central data sources so that additional local data collection is not necessary.

Third is the structure of the payment model. This includes the number of components that are included in the composite payment structure, the weight of each component, and the use of service are results to drive a portion of the payments. This proposal calls for three components with the following weights; Base ($3.50 PPPM for all eligible practices), Quality (up to $0.75 PPPM based on performance), and Utilization (up to $0.75 PPPM based on performance). It also calls for the use of service area results to determine whether practices receive the performance portions of the payment. This represents an increase in the base payment for all participating medical home practices while introducing performance based components with an incentive to coordinate closely with other local providers.

Fourth is the consideration as to whether there should be a phasing in of the medical home payment eligibility requirements for independent practices. Healthfirst has requested a delay in requirements independent practices since they do not have the same level of administrative and financial supports as hospital owned practices and health centers. The request includes a delay in the requirement for scoring on new NCQA medical home standards, and a delay in linking the performance component of the payments to service area results.

This plan is based on extensive discussion and input with the three ACO provider networks, Blueprint committees and local program participants, Vermont's insurers, and with VHCIP committees. While there is not unanimous agreement, this structure provides a strong consensus based plan with incentives that are designed to elevate community health system coordination and learning health system activity to a new level.

Appendix A. VHCIP Core Quality & Performance Measures

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-1		Plan All-Cause Readmissions	NQF #1768, HEDIS measure	Adult	For members 18 years and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.
Core-2		Adolescent Well-Care Visit	HEDIS measure	Pediatric	The percentage of members 12-21 years who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)	NQF #0075, NCQA	Adult	The percentage of members 18-75 years who were discharged alive for acute myocardial infarction, coronary artery bypass grafting, or percutaneous coronary intervention in the year prior to the measurement year or who had a diagnosis of Ischemic Vascular Disease during the measurement year and one year prior, who had LDL-C screening.

Core-4		Follow-up after Hospitalization for Mental Illness, 7 Day	NQF #0576, HEDIS measure	Adult	The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Core-5		Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement	NQF #0004, HEDIS measure	Adult	(a) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment within 14 days. (b) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and had two additional services with a diagnosis of AOD within 30 days of the initiation visit.
Core-6		Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	NQF #0058, HEDIS measure	Adult	The percentage of adults 18-64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic.
Core-7		Chlamydia Screening in Women	NQF #0033, HEDIS measure	Adult and Pediatric	The percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period.
VT Measure ID	**Medicare Shared Savings Program Measure ID**	**Measure Name**	**Nationally Recognized/ Endorsed**	**Included in HSA Profile?**	**Measure Description**
Core-8		Developmental Screening in the First Three Years of Life	NQF #1448	Pediatric	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.
Core-10	MSSP-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF, AHRQ (Prevention Quality Indicator (PQI) #5)	Adult	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.
Core-11	MSSP-20	Mammography / Breast Cancer Screening	NQF #0031, HEDIS measure	Adult	The percentage of women 50-74 years who had a mammogram to screen for breast cancer in the last two years.

Core-12		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite	NQF, AHRQ (Prevention Quality Indicator (PQI) Chronic Composite)	Adult	Prevention Quality Indicators' (PQI) overall composite per 100,000 population, ages 18 years and older; includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.
Core-13		Appropriate Testing for Children with Pharyngitis	NQF #0002	Pediatric	Percentage of children 2-18 years who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode.
Core-14		Childhood Immunization Status (Combo 10)	NQF #0038, HEDIS measure	No	The percentage of children 2 years of age who had each of nine key vaccinations (e.g., MMR, HiB, HepB, etc.).

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-15		Pediatric Weight Assessment and Counseling	NQF #0024	No	The percentage of members 3-17 years who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
Core-16	MSSP-22,-23,-24,-25,-26	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	NQF #0729 (composite)	Adult	(a) MSSP-22: Percentage of patients 18-75 years with diabetes who had HbA1c <8% at most recent visit; (b) MSSP-23: Percentage of patients 18-75 years with diabetes who had LDL <100 mg/dL at most recent visit; (c) MSSP-24: Percentage of patients 18-75 years with diabetes who had blood pressure <140/90 at most recent visit; (d) MSSP-25: Percentage of patients 18-75 years with diabetes who were identified as a non-user of tobacco in measurement year; (e) MSSP-26: Percentage of patients 18-75 years with diabetes and IVF who used aspirin daily -- Aspirin use was not included as part of the profile composite.
Core-17	MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059, NCQA	Adult	Percentage of patients 18-75 years with diabetes whose HbA1c was in poor control >9%.
Core-18	MSSP-19	Colorectal Cancer Screening	NQF #0034, NCQA HEDIS measure	No	The percentage of members 50-75 years who had appropriate screening for colorectal cancer.
Core-19	MSSP-18	Depression Screening and Follow-Up	NQF #0418, CMS	No	Patients 12 years and older who had negative screening or positive screening for depression completed in the measurement year with an age-appropriate standardized tool. Follow-up for positive screening must be documented same day as screening.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-20	MSSP-16	Adult Weight Screening and Follow-Up	NQF #0421, CMS	No	Patients 18 years and older who had BMI calculated during the last visit in the measurement year or within the prior 6 months. In cases where the BMI is abnormal, a follow-up plan must be documented during the visit the BMI was calculated or within the prior 6 months.
Core-21		Access to Care Composite	NCQA	No	NCQA Survey - percentage of patients who could get appointments or answers to questions from providers when needed.
Core-22		Communication Composite	NCQA	No	NCQA Survey - percentage of patients who felt they received good communication from providers.
Core-23		Shared Decision-Making Composite	NCQA	No	NCQA Survey - percentage of patients whose provider helped them make decisions about prescription medications.
Core-24		Self-Management Support Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about specific health goals and barriers.
Core-25		Comprehensivenes s Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about depression, stress, and other mental health issues.
Core-26		Office Staff Composite	NCQA	No	NCQA Survey - percentage of patients who found the clerks and receptionists at their provider's office to be helpful and courteous.
Core-27		Information Composite	NCQA	No	NCQA Survey - percentage of patients who received information from their provider about what to do if care was needed in the off hours and reminders between visits.
Core-28		Coordination of Care Composite	NCQA	No	NCQA Survey - percentage of patients whose providers followed-up about test results, seemed informed about specialty care, and talked at each visit about prescription medication.
Core-29		Specialist Composite	NCQA	No	NCQA Survey - percentage of patients who found it easy to get appointments with specialists and who found that their specialist seemed to know important information about their medical history.
VT Measure ID	**Medicare Shared Savings Program Measure ID**	**Measure Name**	**Nationally Recognized/ Endorsed**	**Included in HSA Profile?**	**Measure Description**
Core-30		Cervical Cancer Screening	NQF #0032, HEDIS measure	Adult	The percentage of females 21-64 years who received one or more PAP tests to screen for cervical cancer in the measurement year or two years prior to the measurement year.

Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #0068, NCQA	No	Percentage of patients 18 years and older with IVD who had documentation of using aspirin or another antithrombotic during the measurement year.
Core-35	MSSP-14	Influenza Vaccination	NQF #0041, AMA-PCPI	Adult	Patients 6 months and older with an outpatient visit between October and March who received an influenza vaccine.
Core-36	MSSP-17	Tobacco Use Assessment and Cessation Intervention	NQF #0028, AMA-PCPI	No	Percentage of patients 18 years and older who had a negative tobacco screen or positive tobacco screen with cessation intervention in the two years prior to the measurement year.
Core-38	MSSP-32	Drug Therapy for Lowering LDL Cholesterol	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and an outpatient visit in the measurement year whose LDL-C <100 mg/dL or LDL-C >=100 mg/dL and who received a prescription of a statin in the measurement year.
Core-38	MSSP-33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and a LVEF < 40% or diagnosis of CAD and diabetes who received a prescription of ACE/ARB medication in the measurement year.
Core-39	MSSP-28	Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg	NQF #0018, NCQA HEDIS measure	Adult	Percentage of patients 18-85 years with hypertension whose BP was in control <140/90 mmHg.
Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented	Not NQF-endorsed; MSSP	No	Percentage of patients 18 years and older seen during the measurement period who were screened for high blood pressure and a recommended follow-up plan is documented based on the current blood pressure reading as indicated.
VT Measure ID	**Medicare Shared Savings Program Measure ID**	**Measure Name**	**Nationally Recognized/ Endorsed**	**Included in HSA Profile?**	**Measure Description**
Core-47	MSSP-13	Falls: Screening for Fall Risk	NQF #0101	No	Percentage of patients 65 years and older who had any type of falls screening in the measurement year.
Core-48	MSSP-15	Pneumonia Vaccination (Ever Received)	NQF #0043	Adult	Patients 65 years and older who had documentation of ever receiving a pneumonia vaccine.
	MSSP-1	CG CAHPS: Getting Timely Care, Appointments, and	NQF #0005, AHRQ	No	CMS Survey - Getting Timely Care, Appointments, and Information

		Information			
	MSSP-2	CG CAHPS: How Well Your Doctors Communicate	NQF #0005, AHRQ	No	CMS Survey - How Well Your Doctors Communicate
	MSSP-3	CG CAHPS: Patients' Rating of Doctor	NQF #0005, AHRQ	No	CMS Survey - Patients' Rating of Doctor
	MSSP-4	CG CAHPS: Access to Specialists	NQF #0005, AHRQ	No	CMS Survey - Access to Specialists
	MSSP-5	CG CAHPS: Health Promotion and Education	NQF #0005, AHRQ	No	CMS Survey - Health Promotion and Education
	MSSP-6	CG CAHPS: Shared Decision Making	NQF #0005, AHRQ	No	CMS Survey - Shared Decision Making
	MSSP-7	CG CAHPS: Health Status / Functional Status	NQF #0006 , AHRQ	No	CMS Survey - Health Status/Functional Status
	MSSP-8	Risk-Standardized, All Condition Readmission	CMS, not submitted to NQF (adapted from NQF #1789)	No	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
	MSSP-10	Ambulatory Sensitive Condition Admissions: Congestive Heart Failure	NQF #0277, AHRQ (Prevention Quality Indicator (PQI) #8)	Adult	All discharges with an ICD-9-CM principal diagnosis code for CHF in adults ages 18 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with CHF. This is an observed rate of discharges per 1,000 members.
	MSSP-11	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CMS EHR Incentive Program Reporting	No	Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Program incentive payment.
	MSSP-12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #0554	No	Percentage of patients 65 years and older who were discharged from any inpatient facility in the measurement year and had an outpatient visit within 30 days of the discharge who had documentation in the outpatient medical record of reconciliation of discharge medications with current outpatient medications during a visit within 30 days of discharge.
	MSSP-31	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #0083	No	Percentage of patients 18 years and older with a diagnosis of heart failure who also had LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
M&E-2		Comprehensive Diabetes Care: Eye Exams for Diabetics	NQF #0055, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received an eye exam for diabetic retinal disease during the measurement year.
M&E-3		Comprehensive Diabetes Care: Medical Attention for Nephropathy	NQF #0062, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received a nephropathy screening test during the measurement year.

Attachment 2

June 1, 2015

Minutes

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, June 1, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 1:02. A roll-call was taken and a quorum was present. **Chair's Report:** *Update on Negotiations with CMMI:* Revised milestones were submitted to CMMI on May 26th; there was a call with CMMI on Friday, 5/29. We have a new project officer, Bridget Harrison, who is also working closely with our All-Payer Model team at CMMI. We reviewed the milestones chart at a high level as well as the All-Payer Model alignment spreadsheet. CMMI was pleased with these and requested some additional documents. Georgia submitted a clarification on the status of each of our contracts and federal approvals. Georgia and Robin are pushing to resolve this as soon as possible, and to have an in-person meeting to support this goal if needed. Lawrence noted that Georgia and Robin also provided an update to the Steering Committee on the mid-project risk assessment process at its meeting last week. Lawrence also noted that there will be no vote on the Self-Evaluation Plan at this meeting, but that Core Team members should expect a vote at the June 15th meeting.	
2. Approval of Meeting Minutes	Paul Bengtson moved to approve the April 2015 meeting minutes (Attachment 2). Steve Voigt seconded. A roll call vote to approve the minutes was taken and passed unanimously.	
3. Policy Recommendation: Request for Approval of Modifications to Quality	Pat Jones from the Green Mountain Care Board (GMCB) introduced proposed changes to the Year 2 quality measures (Attachments 3a and 3b). Two changes are proposed in response to changes in national guidelines; approval of changes would keep Vermont's ACO Shared Savings Program measure set in line with best practice and national measure sets. The QPM Work Group approved both changes unanimously; the changes were also approved with none opposed at the Steering Committee.	

Agenda Item	Discussion	Next Steps
Measures from QPM Work Group	The group discussed the following: • Does this do anything to reduce the total number of measures collected? Pat noted that proposal does reduce collection efforts in going from the D5 composite measure to the D2 composite measure. The ACOs indicated this would be an improvement in terms of administrative burden and ability to focus on a smaller set of measures for improvement; this is also something the QPM Work Group will examine for Year 3. Lawrence commented that moving from active to passive collection is also a major shift that we're working toward; Pat agreed and noted that some of the clinical data here can be captured electronically. Steve Voigt moved to accept the changes. Robin Lunge seconded. A roll call vote was taken and the motion passed unanimously. Lawrence asked how this mid-year change impacts data collection. Pat noted that affected parties are well aware and voted in favor of this recommendation; all agree that identifying necessary changes earlier would be helpful. These recommendations will also be included in the Year 3 measure set recommendation.	
Public Comment	There was no additional public comment.	

4. Presentation of Self-Evaluation Plan	Annie Paumgarten from the Green Mountain Care Board introduced the Self-Evaluation Plan. She reminded the group that CMMI requires two evaluations for all SIM projects: a federal evaluation being conducted by RTI (qualitative and quantitative; audience: CMMI) and a State Self-Evaluation (audience: State leadership). The goal of the self-evaluation is to produce actionable results.
	
	Brad Smith from IMPAQ presented the Self-Evaluation Plan. (Attachment 4)
	• The Self-Evaluation Plan proposes a thematic approach focused on three high-priority areas: Use of data and performance measurement; care coordination/integration; and payment reform effects. IMPAQ produced a literature review to compile evidence in relevant areas.
	  o Steve Voigt asked how the selected themes are addressed by the federal evaluation. Brad noted that the evaluations are based on different logic models; there may be some overlap in the value-based care focus area, but the research questions are different.
	• Brad described the self-evaluation methods.
	  o Susan Wehry asked whether a 35% response rate on provider surveys is acceptable. Brad responded that physicians are challenging to survey, and CMMI rules prevent us from offering monetary incentives.
	  o Paul Bengtson asked how these methods will result in actionable findings. Brad responded that these methods may result in options for policies or structures that could reduce provider burden. Georgia Maheras noted that we're looking for a product that is highly usable in crafting policy and regulations, rather than an academic document.	

Agenda Item	Discussion	Next Steps
	• Brad described reporting plans, which include frequent "just in time" reports (monthly), interim reports; the final report; and issue briefs on State-selected topics that summarize final report topics for dissemination to a lay audience. The group discussed the following: • Lawrence asked whether there were additional activities that were dropped because of timeline, scope, cost, or other concerns. Brad noted that there are some challenges with the topics selected – payment reform, for example, is moving very quickly in the state, and findings might not be relevant in one or two years. He also noted that the State and the evaluation team were in agreement that care coordination and use of data were key issues; there were no looming issues that were excluded. • Paul Bengtson noted that this appears very focused on care models and payment models and asked how this will involve the other VHCIP Work Groups. Paul would like to vet this plan with providers and others working in these areas; Lawrence encouraged Paul to share any feedback with Annie and solicit other feedback. Paul noted that provider desire for easily shared plans of care has continued to come up, as an example. Annie will be in touch with Paul. • Lawrence reminded the group that the Core Team will vote on this in a few weeks. Georgia noted that the budget included in today's materials is preliminary and could change.	
Public Comment	There was no additional public comment.	
5. Financial Requests **a) No Cost Extensions:** Stone Environmental, Coaching Center, Deborah Lisi-Baker **b) Shared Care Plan and Universal Transfer Protocol (SCÜP) Project**	**a) No-Cost Extensions:** Georgia reviewed the contracts for which we are requesting approval to extend contracts through the end of the year, using already approved carryforward funds: • *Stone Environmental* • *Coaching Center* • *Deborah Lisi-Baker* Paul Bengtson moved to approve these requests. Steve Voigt seconded. A roll call vote was taken and the motion was approved unanimously. **b) Shared Care Plan and Universal Transfer Protocol (SCÜP) Project (HIE/HIT Work Group):** Georgia hopes that this request will be sent to CMMI for approval soon based on other work in process with CMMI; however, no contracts would be executed and no work would begin prior to CMMI approval. Simone Rueschemeyer presented the request from the HIE/HIT Work Group. • The project will be approved in waves to allow for continuous updates to the HIE/HIT Work Group, and to allow the Work Group to regularly reassess project utility and progress to date before recommending approval of additional funds. • How will this align with other projects, including Blueprint practices? Simone responded that part of this next phase is to ensure connection with other efforts. The project will focus on three regions	

Agenda Item	Discussion	Next Steps
	(Bennington, St. Johnsbury, Rutland) during business requirements gathering, as well as incorporating feedback from the Blueprint and others to prevent duplication. The group discussed the following: 1. Susan Wehry asked how the Business Analyst and Subject Matter Expert would be supervised. Georgia noted that the Business Analyst would likely be through an existing contract or resource already in place at AHS. We have a SME in mind who would be brought in on a sole source contract. Lawrence clarified that contract management would take place wherever the contracts are owned.	
Public Comment	Susan Wehry moved to approve this request. Paul Bengtson moved to second. The motion passed unanimously.	
6. ACO Proposals a) Community Health Accountable Care (CHAC) b) OneCare	Lawrence introduced proposals from OneCare and CHAC; there will be no vote on this today. Lawrence noted that Paul Bengtson is a member of an ACO, but that this has not risen to the level of conflict of interest in the past; he invited members to comment on this issue and received no comment. **a) Community Health Accountable Care (CHAC)** Kate Simmons from CHAC presented CHAC's proposal with Joyce Gallimore. 1. Funding for Existing Operational Capacity: Requesting funding for this team through December 2016 (currently funded through June 2016), along with associated costs. 2. 2015 Quality Reporting: To take place in early 2016. CHAC has a good sense of costs and effort associated. 3. Telemonitoring: Care management intervention with Medicare beneficiaries, pilot launched in February 2015 (includes telemonitoring contractor and local care coordinator) with the goal of preventing unnecessary hospital admissions. Requesting funding to extend through the end of the Shared Savings Program at the end of 2016. 4. Analytic Solution: Would allow CHAC to turn claims feeds from all payers into actionable reports. Greatest unmet need. Have begun researching possible solutions; staff and board think solutions have tremendous promise to support improved care. The group discussed the following: • Georgia reminded the group that chart abstraction was funded for all ACOs as a separate activity for 2015. Georgia is anticipating getting recommendations from the QPM Work Group on this and will follow up with them. • Paul Bengtson commented that he is interested in where these efforts are heading. He noted that organizations can often gather real-time data rather than waiting for an analytic solution. He suggested that the ownership of CHAC and OneCare are administratively expensive, and suggested organizational structures could change to be more efficient and better integrate lessons learned. • Susan Wehry requested more information on the telemonitoring pilot; while the evidence is supportive	

Agenda Item	Discussion	Next Steps
	of this strategy, how will it be sustained when funding ends? Susan believes Medicare now allows billing for this, and that VNAs are also doing this. Kate responded that this is a different model from the VNAs, because it does not require any special equipment or skills. CHAC will assess value of the program at the time funding ends. Kate will request more information on Medicare billing. • Joyce Gallimore commented that CHAC was founded by FQHCs, which are important health care access points. The SSPs were an opportunity to form an ACO that applies the FQHC model and is based on strong primary care and can test whether there are things we can learn from each ACO model (CHAC and OneCare). CHAC wants to be able to bring Medicaid and commercial data and learnings to their Clinical Advisory Committee to support change at the practice level, comparison across the state, and identification of best practices. **b) OneCare** Greg Robinson from OneCare presented OneCare's proposal with Martita Giard. 1. Continued Funding to Offset Participant Fees ($2 million): This funds infrastructure, operations, and other expenses. These funds are looked at to support OneCare as it moves into its next phase of operations, which will be aligned with Vermont's All-Payer Model OR as a Next Generation ACO through Medicare. A Next Generation ACO model would support reduced reliance on participant fees. 2. Technical Assistance Funds to Support Additional EHR Connectivity and High Data Quality ($750,000): To support VITL in creating a data stream to move provider data. 3. Care Management Tool Implementation ($250,000): A centralized care management tool to help providers manage care for large populations. Not looking to replace EHRs, but rather to share care plans, provide population-wide analytics to support targeting patients at-risk (financial and clinical). OneCare will carry ongoing costs; this request represents set-up. 4. Statewide Post-Acute Care Network Patient Identification and Tracking ($500,000): PatientPing is a real-time admission, discharge, and transfer (ADT) notification tool. Would not be limited to OneCare members; PatientPing would live at VITL and would be provided at the statewide level, and would allow VITL to devote energy to bringing more data into the VHIE. This tool can also be extended to incorporate the functions for VITLAccess. The group discussed the following: • Georgia noted that there could be overlaps between requests #2 and #3 above and existing State- and VHCIP-funded projects. Georgia noted that there is an Event Notification System (ENS) project in development phase that does overlap with request #4 (PatientPing); this project is going less than optimally and there is a meeting next week to discuss next steps, and there are strong possibilities of alignment. • Paul Bengtson asked how PatientPing would help if a patient was in the hospital and needed nursing home or skilled nursing support. How would this support decision-making for and with patients and	

Agenda Item	Discussion	Next Steps
	families? Greg noted that PatientPing is a lightweight ADT mechanism; it is not a decision-making tool. • Susan Wehry noted that there are some redundancies here – she would love to see that overlap prior to a vote. She commented that CHAC provided significantly more backup for their funding request than OneCare, and requested more information on how funds will be spent. She also noted that the previous request to fund participant fees was for a specific reason, and asked why we are being asked to fund again. Georgia clarified that last year's funding cut participant fees in half for parts of the OneCare network. • Paul Bengtson noted that participant fees are new money paid by provider organizations to reduce their income. Susan Wehry asked what happens when VHCIP funds go away. • Al Gobeille commented that the Core Team's efforts can be summed up by asking how our money is being spent, how it is contributing to change, and where we're getting the most change for the least funding. Lawrence noted that this is an introduction, and requested members communicate any questions or comments to Georgia, and reminded the group that this will be discussed again at future meetings.	
Public comment	There was no additional public comment.	
7. Public Comment	There was no additional public comment.	
8. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Thursday, June 15, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	**Joelle will assess whether the June 15th meeting could be moved from 2-4pm.**

VHCIP Core Team Member List
Roll Call:

6/1/2015

Member		5/20/2015 Minutes	Year 2 ACO Measures	Financial Proposals: No-cost Extensions	Financial Proposals: SCUP Request	
		1° Paul 2° Steve V.	1° Steve V. 2° Robin	1° Paul 2° Steve V.	1° Susan 2° Paul	
First Name	**Last Name**					**Organization**
Paul	Bengston ✓	✓	✓	✓	✓	Northeastern Vermont Regional Hospital
Hal	Cohen ✓	✓	✓	✓	✓	AHS -CO
Steven phone	Costantino ✓	✓	✓	✓	✓	AHS - DVHA
Al phone	Gobeille ✓	✓	✓	✓	✓	GMCB
Robin	Lunge ✓	✓	✓	✓	✓	AOA - Director of Health Care Reform
Lawrence	Miller ✓	✓	✓	✓	✓	AOA - Chief of Health Care Reform
Steve	Voigt ✓	✓	✓	✓	✓	ReThink Health
Susan	Wehry ✓	✓	✓	✓	✓	AHS - DAIL
		motion carries	motion carries	motion carries	motion carries	

phone: Pat Jones, Larry Sandage, Ena Backus
Brad Smith, Alex Duncan, Camille, Paul G. (MPAG)

in room: Simone Reeschemeyer
Julia Shaw
Susan Barnett
Annie Paumgarten
Diane Cummings
Joelle Judge
Sarah Kinsler
Jake Wasserman
Sharon Winn
Martita Girard
Gabe Epstein
Kate Simmons
Grey Robinson
Dale Hackett
Lila Richardson
Joyce Gallinne
Alicia Cooper
Bea Grause

Attachment 3

Self-Evaluation Plan

1 BACKGROUND

1.1 State Innovation Model Initiative

Created by the Patient Protection and Affordable Care Act (ACA), the Center for Medicare & Medicaid Innovation (CMMI) supports the development and testing of innovative health care payment and service delivery models. On April 1, 2013, CMMI awarded cooperative agreements to six states, including the State of Vermont, to design and implement a statewide health care innovation plan intended to accelerate over a four-year period health care transformation with the goal of achieving higher quality health care, improved health, and lower health care costs.

The overarching goal of the program, referred to as the State Innovation Model (SIM) Initiative, is to test whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored Health Care Innovation Plan.[1] SIM Initiatives are comprised of two complementary components:

- **State Innovation Models**. Comprehensive approaches to transforming the health system of a state that include new payment and delivery models as well as a broad array of other strategies to improve population health.
- **Payment and delivery models**. Specific models, such as accountable care organizations (ACOs), patient-centered medical homes (PCMHs), or other integrated care models, that when combined with new payment methodologies can reward the provision of better care and health improvements at lower cost.

The SIM initiative is based on the premise that Governor-sponsored, multi-payer payment and delivery models that have broad stakeholder input and engagement, and set in the context of broader state innovation, will achieve sustainable delivery system transformation that significantly improves health system performance. The SIM Initiative tests whether State Governors and their executive agencies, working in collaboration with key public and private stakeholders and CMS can accelerate community-based health system improvements, with greater sustainability and effect, to produce better results for Medicare, Medicaid, and CHIP beneficiaries.

1.2 Vermont Health Care Innovation Program

Vermont's SIM grant project, referred to as the Vermont Health Care Innovation Program (VHCIP), is expending $45 million in SIM grant funds to promote the "Triple Aim" objectives

[1] State Innovation Models Initiative: Round Two Funding Opportunity Announcement (FOA) http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf

through the transformation of the State's volume-driven delivery system to one that is value-driven.

1.2.1 VHCIP Overview

As shown in the evaluation's logic model in Exhibit 1, VHCIP strives to increase provider-level accountability for cost and quality, monitoring and assessment of cost and quality, sharing of health information across settings, and management of population health. To achieve these outcomes, VHCIP is supporting the design, implementation, and evaluation of a variety of activities and implementation resources that build upon the State' health insurance reforms and experiences gained as an early adopter of innovative delivery and payment models. These activities are organized around three focus areas:

Using financial incentives to promote value-based care – VHCIP is supporting the development and implementation of new payment models that promote the creation of a delivery system that strives to reward the efficient provision of high quality health care. As a part of this work, organizations are involved in strengthening performance-based payments to Blueprint PCMHs, testing three ACO models, and providing analytic support for the future development of episode-based bundled payments.

Facilitating care coordination & integration – VCHIP is supporting the creation of a delivery system that provides more integrated and coordinated care. By providing care that involves both the clinicians, patients and other support services in the coordination and management of care, Vermont hopes to capitalize on opportunities to improve care and reduce costs in areas such as decreases in readmissions and reducing overuse of testing and procedures.

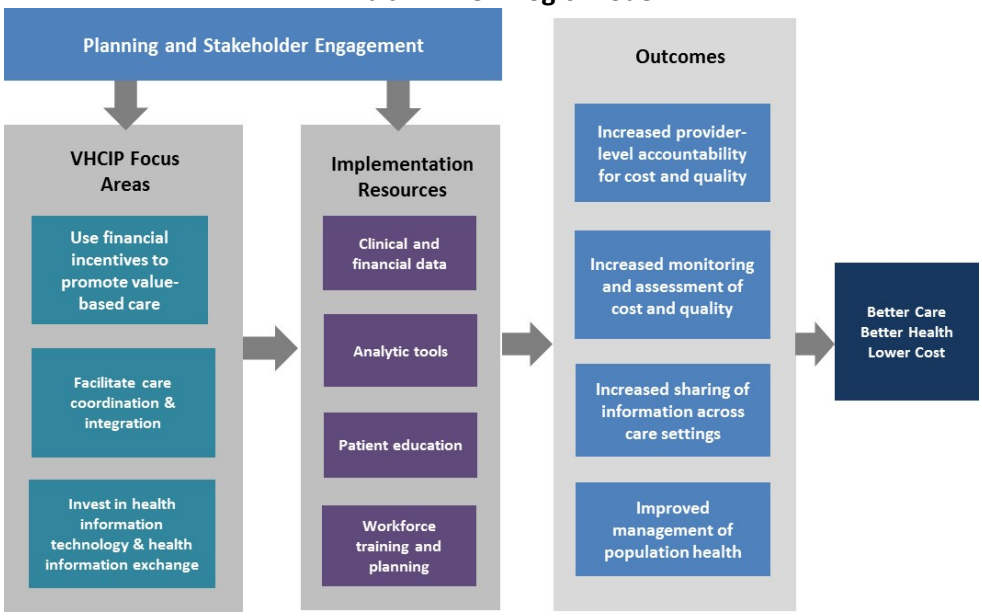
Investing in health information technology & health information exchange – VHCIP is supporting the construction of an interoperable system through which providers input, extract, and exchange electronic health information to support optimal care delivery and population health management. Investing in this technology and data infrastructure has potential effects on health care processes such as more timely delivery of appropriate care and avoidance of unnecessary duplication of imaging and testing.

To support transformation, VHCIP is also supporting a variety of activities intended to provide the information and tools needed to deliver and manage care in a system that holds provider organizations accountable for cost and quality.

- *Clinical and financial data* – Activities that support the improved collection, transmission, and reporting of clinical and financial data;
- *Analytic tools* – Activities that identify, evaluate or use tools to collect, analyze and/or report clinical and financial data and to define and manage episodes of care;

- *Patient education* - Activities undertaken to teach the patient how to improve their health status; and
- *Workforce training and planning* – Activities geared towards workforce/employee planning and training that seek to improve care, coordination, quality and cost.

Exhibit 1: VHCIP Logic Model[2]



In designing and targeting VHCIP-sponsored initiatives and implementation support resources, health reform leaders have prioritized poor and medically vulnerable Vermonters, many of whom are elderly and have disabilities and/or chronic illnesses. Closing gaps in care for these state- and federally-vulnerable individuals will result in improved health and quality of life as well as cost savings that benefit all Vermonters.

During the first year, VHCIP supported capacity-building activities by implementing project governance procedures, initiating operations and developing structures and processes for promoting stakeholder engagement. In its second year, VHCIP is focusing on preparing for the transition from a shared savings to a capitated, population-based payment model. In addition to activities focused on laying the groundwork for analyzing and reporting provider performance data and building a unified, regional system of care management, VHCIP is engaged in a focused program of sub-grants to support HIE capacity, innovative demonstrations and other activities aligned to its three focus areas.

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[2] Exhibit 1 updates the logic model presented in the 2014 VHCIP Operational Plan submitted to GMCB October 2014.

1.2.2 The Vermont Context

These activities are being implemented within a state that has a strong foundation and leadership for health reform. Vermont is a mainly rural state, with fourteen acute care hospitals and a wide range of independent physicians. The state, facilitated through Act 48 in 2011, embarked on a move away from volume-based payment by testing innovative payment and healthcare service delivery models that will lead to better health and behavioral health care for individuals, better health for populations, and better control of growth in health spending. As detailed in Act 48, these payment reforms are expected to align with, and build on, the Blueprint for Health and the statewide health information technology plan and clinical registry, and emphasize coordinated patient care. The Green Mountain Care Board (GMCB), the entity charged with broad authority to implement health reform, implemented several pilot innovations upon which SIM activities are built. Another key feature of Vermont's foundation for health system reform is Blueprint for Health, which has transformed the delivery of primary care through payment reform and the establishment of Community Health Teams.

1.2.3 VHCIP Self-Evaluation

Terms of the federal SIM grant require two evaluations: one conducted by the federal government and another conducted by the state. IMPAQ International, LLC (IMPAQ) has been selected by the state of Vermont to conduct the state evaluation. IMPAQ and its partner Brandeis University (the IMPAQ Team) will design and implement Vermont's self-evaluation plan. Additionally, IMPAQ will collaborate with Vermont staff, stakeholders, the federal evaluation contractor (Research Triangle Institute) and CMMI to minimize duplication of evaluation efforts, reduce burden on project participants and support the development of actionable evaluation results for Vermont. The self-evaluation has two primary goals:

1. Provide timely feedback to inform mid-course corrections in the implementation and operation of VHCIP sponsored-initiatives, and
2. Generate actionable recommendations to guide Vermont state-leadership's decisions to scale-up and diffuse VHCIP-supported initiatives.

To achieve these objectives, the evaluation team will utilize a mixed-methods approach, analyzing a complementary combination of qualitative and quantitative data. Qualitative data will be obtained from document reviews and key informant interviews conducted with strategically-selected VHCIP leaders, system- or sub-system level leaders (e.g. ACOs, unified community collaboratives), practice managers and administrators, and frontline care providers. The quantitative portion of the work will use two surveys of frontline care providers to assess how generalizable qualitative findings.

1.2.4 Research Questions

Based on discussions with VHCIP leaders on their priorities, the IMPAQ Team's knowledge of VHCIP-focused activities and a thorough feasibility assessment, we propose that the following research questions guide the VHCIP self-evaluation. The questions are organized into three themes that were identified as high priority by VHCIP and GMCB leaders: Care Coordination, Use of Clinical and Economic Data to Promote Value-Based Care, and Payment Reform. The proposed research questions cover all three of the VHCIP logic model focus areas as summarized in Exhibit 1 (on page 3).

Care Integration and Coordination. Care integration and coordination are key features of many SIM activities, and a major activity contributing to the goals of improving patient experience, improving population health, and reducing the per capita cost of health care. The majority of health spending is driven by patients with multiple conditions, multiple providers, and complex care needs. Nationally, there is a growing literature that defines frameworks for care integration and coordination, and recommends measures for assessing its effectiveness.[3] Across Vermont, care integration and coordination supported by the SIM grant takes a variety of forms, including, for example, identifying, reaching out to, and offering enhanced services to vulnerable populations at risk of admission to a nursing home; coordinating care for patients with particular diseases across a spectrum of social service and medical providers; improving care transitions to avoid hospital readmissions; and in some cases building on activities of existing community care teams. These models vary, but understanding the features of each that are most effective is critical to guide scaling up of care integration and coordination. The following research questions will inform Vermont in directing SIM activities in this area:

1. What are key examples of care coordination/integration approaches being tested/implemented across the state?
2. What are the key characteristics of each approach in the sites that are studied, and how do they vary in evidence base, design, setting, focus, resource utilization, and cost, and in comparison to national care models?
3. What evidence is available to demonstrate effectiveness of each approach? How solid is the evidence? What are the key lessons learned from each?
4. What environmental and organizational features enhance care coordination/integration approaches? What features result in barriers?
5. Based on resources, cost, and perceived success, which appear to be most suitable for scaling up?
6. What information do health care providers (physicians, nurses, care coordinators, social workers, others) need from other providers/care settings in order to provide high

[3] Agency for Health Care Research and Quality, *Care Coordination, Overview and Literature Review*. (http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html; http://integrationacademy.ahrq.gov/literaturecollection). Collins C, Hewson DL, Munger R, Wade T. *Evolving Models of Behavioral Health Integration in Primary Care.* New York, NY: Milbank Memorial Fund;2010.

quality, coordinated and integrated care? How available, timely and high of quality is this information?

Use of Clinical and Economic Data to Promote Value-Based Care. Data play a pivotal role in Vermont's efforts to transform its health system through VHCIP. Various project activities use clinical and cost data in different ways: to inform providers, for internal and external monitoring, for quality improvement, for payment, and to identify opportunities for efficiency. Clinical and cost data are shared with various audiences and come from a variety of sources including VHCURES, automated extracts from EMRs, and manual abstraction of medical records. The high data flow occurs in an environment that places numerous competing demands on providers, including tracking an ever-changing regulatory environment, running a business, providing compassionate, coordinated care and complying with a long list of reporting requirements. Examples of such data include: regular reports sent to providers with information to identify high cost conditions and target outreach and education; cost information regarding hospitalizations and hospital readmissions; services where utilization and spending vary across regions or providers, thus identifying opportunities for gaining efficiency; and quality metrics that inform clinical care.

However, data is not always perceived by providers as interpretable or actionable. The way in which providers interpret, trust, and use data is important to know in order to provide necessary content in a user-friendly format. For this theme, we will visit practices to examine the process of producing, communicating and sharing data in support of transformation, as well as how these data are received, understood and applied by providers. The research questions outlined below will guide the evaluation for this theme:

1. What data are being communicated, by whom, how are they being communicated (and through what intermediary structures) and for what purposes are they being communicated?
2. What assistance or support is provided to those intended to use data?
3. How are data being received, understood and applied?
    a. Are the right data being communicated?
    b. What do providers perceive as most and least useful about the processes and data shared? What elements are most and least useful to improve patient care and practice efficiency? Do the data contain information that providers want and think they can make use of?
    c. How could the content or communication mode of the data be modified to make it coincide more closely with provider needs and allow effective provider responses?
    d. What data-related burdens or redundancies do providers/practices cite?

Payment Reform and Financial Incentive Structures. In the early phases of VHCIP implementation, physicians are operating in a system which simultaneously employs multiple—and likely intersecting—payment models and financial incentive structures. These models may

include capitated, fee-for service and/or shared savings payments. As VHCIP accelerates Vermont's health system transformation, the variety of payment models and incentives confronting providers is likely to become yet more complex, adding additional models and incentives even while fee-for-service payment remains in place for some care. For this theme, the following research questions will guide the project:

1. Under what financial incentive structure(s) do providers practice in Vermont?
    a. How do providers view the current incentive structure(s) under which they practice? Why?
    b. What changes, if any, have taken place in the way providers practice as a result of these incentive structures?
    c. How do attitudes toward incentives and changes providers have made in practice (if any) differ across provider types (primary care, specialty care), practice sizes (solo, small and large group), and ownership (hospital-owned vs independent).
2. What further adaptations at the practice and provider level do providers anticipate in the transition to next generation payment models, such as shared savings with downside risk, episode-of-care based payment, and global budgeting? What additional support or technical assistance do providers anticipate needing in making this transition?

Research Questions and Logic Model Focus Areas. Exhibit 2 summarizes the relationship between research themes and VHCIP logic model focus areas. Both the payment reform and use of clinical and economic data themes directly address efforts to promote value-based care in Vermont. The care coordination/integration theme has an obvious linkage to the logic model's focus on facilitating care coordination/integration but also addresses health information exchange (HIE) due to the importance of having the information necessary to provide optimal care accessible to the right people at the right time. The HIE emphasis is reflected in the research questions proposed for the Care Coordination/Integration theme.

Exhibit 2: Mapping of Proposed Research Questions to Logic Model Focus Areas

	Logic Model Focus Areas		
Research Question Themes	**Promote Value-Based Care**	**Facilitate Care Coordination/ Integration**	**Invest in HIT and HIE**
Care Coordination/Integration		X	X
Use of Clinical and Economic Data to Promote Value-Based Care	X	X	
Payment Reform	X		

1.3 Task Structure

We propose to address the research questions summarized in Section 1.2 through a project structured around six tasks, summarized in Exhibit 3. Section 2 of the document details the IMPAQ Team's proposed approach to each task.

Exhibit 3: Proposed Task Structure

Task	Deliverable(s)	Deliverable Timeline
Task 1: Develop Site Visit Plan Conduct environmental scan and background research to definitively identify sites that will be visited or interviewed by phone as part of Task 2.	Draft Site Visit Plan Final Site Visit Plan	October 9, 2015 7 days after receiving written comments on draft plan
Task 2: Conduct Site Visits and Analyze Qualitative Data Execute the approved site visit plan by visiting or conducting phone calls with sites, performing analysis of qualitative data.		
Task 3: Provider Surveys Identify key ideas from the findings developed as part of Task 2 and assess whether the findings are typical in statewide surveys focused on 1) uses of data for transformation among physicians/providers and 2) strengths and challenges related to care integration/coordination	Draft survey instruments Final survey instruments Field reports	November 28, 2016 December 19, 2016 Weekly while surveys are being fielded (TBD)
Task 4: Reporting Provide a comprehensive written report summarizing and integrating findings from Tasks 2 and 3	JIT Reports Draft Interim Reports Final Interim Reports Draft final report Final report	Monthly from January-June 2016 October 17, 2016 November 14, 2016 July 24, 2017 August 14, 2017
Task 5: Evaluation Support Support the Vermont SIM Self-Evaluation as directed by the Evaluation Director, including reviewing plans for synthesizing and disseminating findings, documents summarizing self-evaluation findings generated by Vermont, attending and conducting analysis of meetings (ACO, sub-grantee meetings)	As requested	As requested
Task 6: Project Management Ensuring the self-evaluation is completed on time, within budget and within scope	Revised Management Plan Monthly Progress Reports	July 22, 2017 Monthly on the 18th

2 APPROACH

2.1 Task 1: Develop Site Visit Plan

The IMPAQ Team proposes to complete 20 in-person site visits through a total of six one-week trips to Vermont to be made between November 2015 and June 2016. Each trip will involve from 3-5 visits to different sites (e.g., a physician practice, Community Health Team office, ACO administrative office, Unified Community Collaborative meeting) identified as relevant to the self-evaluation. Site visits will be supplemented by 10 additional hour-long phone conferences with moderate priority sites or sites we are not able to schedule for in-person visits.

The specific sites to be visited or scheduled for phone conferences will be identified through the following three-step process:.

1. *Environmental Scan.* We will collect and review Vermont-specific information related to each of the three research themes. For the care coordination/integration theme, for example, we would want to identify, collect and review materials from the published and grey literature that are related in any way to care coordination or care integration in Vermont. We will also review the list of VHCIP activities that served as the basis for the literature review/best practices issue brief. Conversations with VHCIP leaders or other individuals with expertise related to any of the three research themes will be combined with review of relevant documents.
2. *Develop a preliminary list of sites.* Based on interviews with VHCIP leaders and the environmental scan, the IMPAQ Team will develop a preliminary list of sites to consider. Where there is doubt as to appropriateness of a site we will err on the side of inclusion and formally assess its suitability later, as summarized below. The preliminary site visit list will be shared with VHCIP leaders in order to assess if any essential sites have been omitted or whether any sites known to be unsuitable have been included.
3. *Identify a final set of sites to be visited.* The IMPAQ Team will review the preliminary list of sites and select a final set of candidate sites based on the following criteria:
    - <u>Relevance to multiple research themes:</u> We will favor sites where we can conduct discussions that are relevant to more than one research theme. For example, we would favor a primary care practice that has an innovative care management model and also participates in OneCare Vermont's clinical and economic data communication over a practice that has a key feature that addresses one theme alone. Selecting sites in this way will make the most efficient use of travel time and resources by enabling us to ask questions across multiple research themes to multiple informants at the same site.

- Generalizability: Does the site have the potential to yield findings that are broadly applicable or is the site unique in many ways that would limit generalizability?
- Operational maturity: Has the site been in place long enough to yield experiences that informants can reflect upon?
- Scope and scale: Is the site involved in programs or activities that are intended to reach a large portion of Vermont residents?
- Successful implementation: Has the site had at least some success in the programs or activities with which it is involved?
- Diversity: We will work to ensure that sites selected for visits represent the diversity of activities that are taking place in Vermont both in and out of the SIM initiative. At a minimum we will consider sites across the following categories:
    - **Trans-provider organizations.**
        - Unified Community Collaboratives, Local Interagency Teams or other interdisciplinary teams that drive care and service coordination at the policy level.
        - Community Health Teams, Vermont Chronic Care Initiative, Children's Integrated Services teams and other interdisciplinary teams that drive care and service coordination at the individual case level
    - **Institutional Providers**
        - Hospitals
        - Long term care facilities
    - **Individual Provider Practices**
        - Primary care practices and specialist practices
        - Small independent practices and larger hospital-owned practices
        - PCMH and Non-PCMH
        - ACO participant and non-participant
        - Heavy VHCIP and/or Blueprint involved and no involvement
        - High performing practices and underperforming practices
        - PCMHs with unique approaches to coordination/integration of behavioral health, substance abuse, alternative health and/or other multi-disciplinary care coordination
    - **Geography/demographics**
        - Across HSAs
        - Rural/urban
        - Serving low socio-economic status (SES) and non-low SES Vermonters

DELIVERABLES

- The IMPAQ Team will provide a Draft Site Visit Plan detailing the final list of proposed sites to be visited by October 9, 2015.
- Within 7 days of receiving written feedback from Vermont on the Draft Site Visit Plan, the IMPAQ Team will provide a Final Site Visit Plan.

2.2 Task 2: Conduct Site Visits and Analyze Qualitative Data

2.2.1 Schedule Site Visits

Site visits will be scheduled with the goal of minimizing travel time and expense. After Vermont approves the final site visit plan we will first identify a rough sequence of trips that will permit us to consolidate visits to sites that are reasonably close to each other. For example, if there were four sites between Burlington and Montpelier included in the final Site Visit Plan, we would identify a tentative window of 2-3 weeks during the field period where a trip to that region might occur. After a window has been identified, we will reach out via telephone to contacts at each site to ascertain availability for the personnel with whom we need to meet. Where availability of the majority of interviewees does not match with the tentative site visit window, we will adjust the window as necessary.

2.2.2 Conduct Site Visits

Once the schedule has been finalized, we will prepare to conduct the site visits. In addition to arranging for logistical details such as travel and a community-based (library, community center) location for any focus groups, we will prepare site- and interviewee-specific interview guides based on the research themes appropriate to the site. For example, at a large primary care practice that participates in an ACO and participates in a VHCIP-funded care model project, we would likely draw from the care coordination, data use and payment model themes. Interview guides will be further customized by interviewee type. A practice manager interviewee, for example, would be unlikely to get detailed questions on the adequacy of clinical data exchange for care coordination/integration while a social worker involved in coordinating community services on hospital discharge would be unlikely to get detailed questions on the impact of financial incentives on clinical practice.

Develop Interview Guides. Following initial meetings with State staff, the IMPAQ Team will develop draft interview guide(s) for each site visit. Semi-structured interview protocols will employ the Lofland and Lofland model.[4] In this model a series of relatively broad questions are asked of each respondent and they are encouraged to provide what information on the subject that they see as most important. In this way it is possible to solicit information that might be missed by a more narrowly constructed instrument. It also allows us to determine what the respondents believe are more important of the factors we wish to explore, rather than imposing the interviewers' priorities on them. Finally this allows unanticipated issues to be revealed which may be added to the protocol in subsequent interviews.

We will prepare our broad questions with a number of "probe questions" that reflect key theories underlying the analysis. This will allow us to address issues of specific interest identified by Vermont. We will not ask probe questions if the respondent spontaneously

[4] Lofland, J. and Lofland L. "Analyzing Social Settings", University of California, Davis 1995

provides the information sought. However, if that information is not provided, we will ask the questions. This allows the research to benefit from both a semi-structured interview model, which allows maximum input from knowledgeable respondents, and the consistency and completeness of information characteristic of a more structured interview questionnaire.

All IMPAQ Team members who will participate in one or more site visits will receive training on how to use the interview guides, proper procedures for gaining consent to record interviews, and on expectations for note taking.

Conduct Interviews. The majority of interviews will be conducted by one senior and one junior team member. The senior member will lead the interviews and the junior member will serve as note taker. In isolated circumstances, scheduling constraints may require a team to split up to conduct two interviews simultaneously. Where no note taker is present, we will ensure that any interview conducted by junior staff is recorded and reviewed the same day by the senior staff on the site visit. Where discussion exceeds the time available for the interview and the interviewee is interested in sharing more observations, a follow-up phone call will be scheduled at a mutually convenient time. Where last-minute scheduling conflicts prevent an interview from occurring, a follow-up phone call will be scheduled to collect data as soon as possible after the team returns home.

Develop discussion guides for focus groups. In addition to the key informant interviews we plan to conduct on the site visits, we have budgeted for two care-coordination focus groups to be conducted with Vermonters whose lives have been affected by care coordination, broadly defined. We will develop discussion guides for these groups based on the IMPAQ Team's knowledge of the relevant literature and of the care coordination/integration landscape in Vermont.

Recruit for focus groups. Participants will be recruited by the IMPAQ team using a list of names and contact information obtained from staff of one or more car coordination/integration sites which we visit. We will send a pre-notification letter on IMPAQ, state or program/practice letterhead as is most appropriate inviting the individual to attend the group and confidentially share their experiences. Members of the IMPAQ Team will call each potential participant to explain the purpose of the group, to answer any questions and to secure participation in the group. Individuals who agree to participate will receive a confirmation letter with details on time, date and location within 7 days of expressing a willingness to participate and a phone call from an IMPAQ Team member the night before the focus group.

Conduct focus groups. We will conduct focus groups in the late afternoon or early evening in a library or community center conference room that is within 30 minutes driving time for each prospective participant. We will provide light refreshments for each group and limit the group to between 90 minutes and 2 hours total duration. Each group will be led by an experienced moderator and a note-taker. With participants' permission, the proceedings will be recorded and transcribed for qualitative analysis.

2.2.3 Qualitative Data Analysis

Data Sources and Coding. For coding and sorting of data, IMPAQ will use N-Vivo version 10.1. We will load transcripts of interviews and focus groups conducted during site visits into NVivo for coding. If our site visits yield planning documents or internal memoranda that are relevant to the discussions conducted with key informants, these will also be loaded into NVivo for analysis.

Coding of textual materials will take place in several steps. All interview or focus group transcripts will first undergo a structural coding, intended to identify text associated with a particular question in the interview guide[5]. Subsequent to structural coding, all transcripts and other documents will be subject to advanced systematic coding and analysis.[6] This approach is compatible with the systematic structural coding that will have already been applied to the transcripts and also with a grounded theory approach. Grounded theory utilizes an iterative, inductive and deductive process and places great value on simple systematic procedures to allow emergence of findings or themes from qualitative data.[7]

During the initial coding phase, the IMPAQ Team will review transcripts to develop codes and categories, and to identify emergent themes. We will then apply open coding to larger segments of text. During axial coding, we will note possible relationships between codes and code groups and develop descriptive subcodes and categories. Through constant comparative analysis, analysts may refine, restructure and reapply codes until saturation is reached. Saturation will be assessed in real time and is defined as the point in the coding process where new codes/themes no longer emerge from transcripts. As themes are identified and codes established they will be shared with the PD and IMPAQ Team members who participated in site visits for review and agreement.

Analysis. Coded and sorted analysis files from NVivo will be shared with the entire IMPAQ Team and will serve as the basis for creating written reports. Report authors, drawn from the Team's senior staff, will review the codes most commonly assigned to transcripts to develop an idea of key themes or findings which emerged from the interviews and focus groups. Where possible, themes will be compared across different types of sites (small vs. large practices, primary vs specialty care, Community Health Teams staff vs provider office-based care coordinators). Quotes from interviews that effectively illustrate key themes will be extracted from transcripts to enhance the written report.

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[5] Guest, G. and MacQueen, K.M. (2008) Handbook for Team-Based Qualitative Research. Rowman & Littlefield Pub Incorporated, Washington DC.

[6] Boeije, H. (2002) A purposeful approach to the constant comparative method in the analysis of qualitative interviews. Quality & Quantity, 36, 391-409. doi:10.1023/A:1020909529486

[7] Strauss, A., J. Corbin (1998) Basics of qualitative research: techniques and procedures for developing grounded theory.[Sec.ed.] London: Sage

2.3 Task 3: Provider Surveys

The evaluation team will design and field two mail-to-web surveys to document the experiences and perceptions of frontline care providers. One survey will focus on primary care and specialty physicians and another will focus on providers involved in care coordination/integration activities (possibly including CHT staff, social workers, case managers and others to be determined). The survey effort will generate generalizable and consistently measured perspectives related to each of the research themes included in the self-evaluation. Each survey instrument will draw from and complement the qualitative findings generated as part of Task 2 that provide in-depth information from a relatively small number of individuals acting in a diverse array of roles and settings.

While a provider survey is planned as part of the RTI national evaluation of the SIM program, it is not well-positioned to meet Vermont's needs for the self-evaluation. In addition to an expected response rate of 5%, there are indications from CMMI that state-level survey responses will not be shared. The surveys proposed as part of the self-evaluation are designed to achieve a higher response rate and directly address the topics of primary concern to VHCIP leaders.

2.3.1 Survey Development

Two separate survey instruments will be developed, one for physicians and one for providers engaged in care coordination/integration. While the surveys will be targeted at distinct audiences and consist of different questions, there may be some overlap between the two instruments related to the care coordination research theme which is relevant to both target audiences.

In order to minimize respondent burden, the instruments developed by the IMPAQ Team will be designed to be completed in no more than 15 minutes. Each survey will begin with a short introduction describing the purpose of the survey, the role of the IMPAQ Team, and a statement regarding the confidentiality of responses. Each survey will contain roughly 20-30 questions depending on the length and complexity of the items. Questions will be developed by the IMPAQ Team based on findings that emerge from Task 2. Related to care coordination/integration, for example, we might find that lack of access to high speed internet is a challenge to effective coordination of care cited by informants across a number of sites. This finding could be developed into a closed-ended survey item that asks respondents to agree or disagree with the statement "Lack of high speed internet makes it hard to provide the best possible care for the patients I serve." Questions in both surveys will be designed to be broadly applicable to the population of respondents rather than targeting topics likely to be of concern only to a minority of respondents. Where possible, we will adapt items from established survey instruments whose reliability and validity is known.

Each survey instrument will be carefully pre-tested before being fielded. We will conduct initial pretests with IMPAQ staff members who are not part of the team. Each survey instrument will

be further tested by 3-5 individuals identified by VHCIP staff who meet the sample criteria (physician or care coordination/integration professional) and are willing to serve as volunteer testers. Phone or e-mail debriefs will be conducted with all respondents participating in testing in order to confirm that the questions are being interpreted as intended and that the wording of instructions and survey items is clear. The survey will be revised to take into account feedback gained from pilot participants before it is finalized and fielded.

2.3.2 Sample Design

For the physician provider survey, we intend to survey the universe of primary care and specialty physicians in Vermont, a total of approximately 1900 providers.[8] With the assistance of VHCIP leaders, we will request physician contact information from the Vermont Department of Health licensing database.

The care coordination/integration survey design will also focus on the universe of care coordination/integration providers, based on the operational definition of care coordination/ integration established as part of the site visit plan. For budget purposes, we have estimated that a total of 500 care coordination/integration providers will be surveyed.

2.3.3 Survey Protocol

Both the physician and care coordination/integration provider surveys will be administered following the same protocol. The distribution of the survey will be preceded by communication through existing channels (existing email distribution lists, provider professional association newsletters) to announce that a survey is forthcoming and to emphasize the importance of responding so that everyone's opinions can be recorded.

The survey will be distributed through a hybrid mail/web strategy designed to enhance response rates among busy professionals. Respondents will first receive a USPS Priority Mail envelope containing a letter on State of Vermont letterhead signed by a State official. The letter will explain the purpose of the survey, request the respondent's participation, and provide a link to the web-based survey along with a unique token code to associate the respondent's answers with their identity in the sample file. Non-responders will receive additional follow-up with a second letter and paper questionnaire provided approximately three weeks after the initial mailing, a postcard reminder five weeks after the initial mailing and another letter/questionnaire approximately seven weeks after the initial mailing. The follow-up protocol also includes up to two reminder phone calls placed to each non-respondent.

[8] http://healthvermont.gov/research/HlthCarePrvSrvys/documents/phys10bk.PDF

2.3.4 Survey Analysis

Survey analysis will focus on descriptive and comparative techniques subject to the limitations of response rates. For example, we expect to be able to compare attitudes and experiences of primary care providers who participate in Blueprint with those who do not participate in Blueprint, and to be able to compare responses from care coordination/integration providers who practice in rural communities to responses from those who practice in urban areas.

DELIVERABLES

- Draft survey instruments by January 27, 2017
- Final survey instruments by February 28, 2017
- Field reports weekly while surveys are being fielded (TBD)

2.4 Task 4: Reporting

The goal of reporting of results of the evaluation will be to provide Vermont feedback in a variety of ways to meet short-term and longer-term information needs. While the site visits are in progress, we will share emergent findings though a series of monthly "Just-in-Time" reports. After the site visits have concluded, we will summarize qualitative findings in a series of theme-based interim reports. Near the end of the project, we will summarize overall evaluation findings and provide recommendations to VHCIP leaders through a final report.

2.4.1 Just-in-Time Findings Reporting

The evaluation team will communicate preliminary findings through "Just-in-Time" (JIT) reports. JIT reports are provisional in nature and provide a vehicle for disseminating actionable, high-interest findings from qualitative investigations and trend analyses. The aim of JIT reporting will be to provide timely information that may be helpful for program modification, expansion and/or replication. It is important to recognize that the reporting of qualitative findings are constrained by the need to protect the confidentiality of key informants. This will place some limits on report format, but it is a practical necessity to ensure candid responses to what may sometimes be sensitive questions.

JIT reports will be presented as written memos and presented verbally at Monthly Vermont SIM leadership meetings. The JIT format will be the primary vehicle through which the IMPAQ Team will provide timely feedback to site visit participants and the opportunity for site staff to ask clarifying questions. Our goal is to communicate in a JIT format at least monthly while site visits are ongoing to generate findings of broad interest to VHCIP leaders and stakeholders. The format will also provide opportunity for the evaluation team to use feedback shared by the audience to refine their interpretation of their findings and, in the early phases of the evaluation, to inform refinements in site visit interview guides and survey questionnaire design.

2.4.2 Interim Reports

After the completion of site visits and qualitative analysis that pertains to a particular theme, the evaluation team will generate Interim Reports (IRs) that address findings for each theme. IRs will extend and refine information communicated through JITs by summarizing and synthesizing a wider range of findings and incorporating accumulated feedback to inform implications for on-the-ground practice.

IRs will be submitted to the GMCB Evaluation Director in draft form and will be finalized based on comments and suggestions provided by VHCIP leaders and relevant stakeholders. IRs will be formatted in a manner suitable for dissemination to CMMI and other State-level stakeholders. It is our intention to finalize each IR within 30 days of receiving written feedback on the initial draft. IR content will be presented (in either final or draft form) in a Power Point format in Monthly Progress updates or in-person to broader stakeholder audiences or through IMPAQ-hosted webinars, as requested and scheduled by the GMCB Evaluation Director.

2.4.3 Final Report and Issue Briefs

Following the final phase of the self-evaluation, the IMPAQ Team will provide a high-level summary of the evaluation methodology, a summary and synthesis of key findings, and a set of findings-based recommendations in a final report (FR). The FR will be submitted to the GMCB Evaluation Director in draft form and be finalized based on comments and suggestions provided by VHCIP staff and relevant stakeholders. The FR will be formatted in a manner suitable for dissemination to CMMI and other State-level stakeholders. To maximize accessibility to a broad audience of stakeholders, the findings and recommendations presented in the FR will be organized around the three research themes proposed for the self-evaluation. Findings and recommendations contained in the FR will be presented in an in-person briefing to stakeholder audiences and/or through an IMPAQ-hosted webinar, as requested and scheduled by the GMCB Evaluation Director. In addition, the team will prepare up to three issue briefs based on report content for wider dissemination.

DELIVERABLES

- Just-in-time reports monthly from January 2016 through June 2016
- Draft interim qualitative reports October 17, 2016
- Final interim qualitative reports November 14, 2016
- Draft final report July 24, 2017
- Finalized final report August 14, 2017

2.5 Task 5: Evaluation Support

In this Task, the IMPAQ Team will make team members available to the GMCB Evaluation Director on an as-needed basis to extend and enhance the State of Vermont's capacity to

evaluate various VHCIP activities. To date, members of the IMPAQ team have attended ACO meetings and meetings of VHCIP to serve an additional set of eyes and ears to provide an independent, expert assessment of meeting proceedings and to help contextualize them within VHCIP activities.

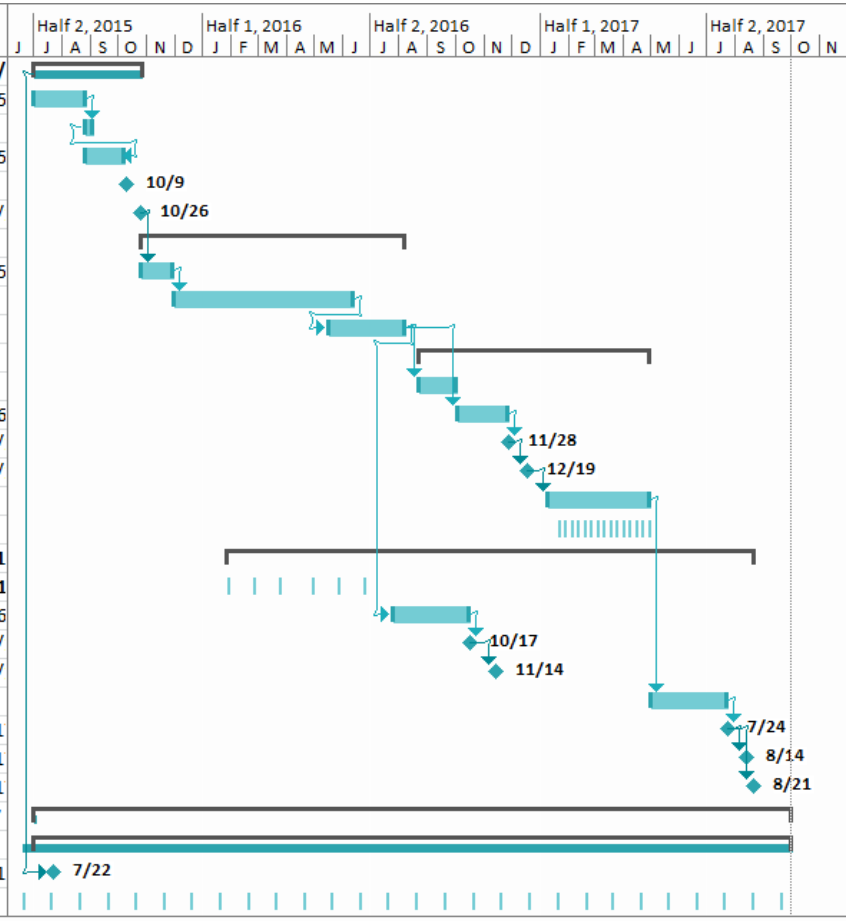
Moving forward, the IMPAQ team is available to review and comment on documents related to evaluations conducted of sub-grantee and other VHCIP-related activities. This might include reviewing the State's plan to synthesize and disseminate findings from the evaluations and later to review and comment on documents designed to disseminate findings from the evaluations. Other activities will be performed only at the direction of the GMCB evaluation director.

2.6 Task 6: Project Management

The IMPAQ Team will manage the project as detailed in the Management Plan approved by Vermont in March 2015. A revised Management Plan reflecting the new task structure will be provided to Vermont within 30 days of approval of the self-evaluation design. While the procedures outlined in the Management Plan are meant to ensure a high level of performance, the IMPAQ Team remains flexible and will adjust the management approach should project needs evolve. A proposed high-level work breakdown structure is provided in Exhibit 4.

DELIVERABLES

- Revised management plan by July 22, 2015
- Monthly progress reports by the 18th of each month

Exhibit 4: Proposed Work Breakdown Structure

ID		Task Mode	Task Name	Duration	Start	Finish
1			**Task 1: Develop Site Visit Plan**	**84 days**	**Wed 7/1/15**	**Mon 10/26/**
2			Conduct environmental scan	40 days	Wed 7/1/15	Tue 8/25/15
3			Generate preliminary site list	5 days	Wed 8/26/1	Tue 9/1/15
4			Generate final site list	30 days	Wed 8/26/1	Tue 10/6/15
5			Draft Site Visit Plan	0 days	Fri 10/9/15	Fri 10/9/15
6			Final Site Visit Plan	0 days	Mon 10/26/	Mon 10/26/
7			**Task 2: Conduct Site Visits and Analyze Qualitati**	**205 days**	**Mon 10/26/**	**Fri 8/5/16**
8			Schedule site visits	25 days	Mon 10/26/	Fri 11/27/15
9			Conduct site visits	140 days	Mon 11/30/	Fri 6/10/16
10			Perform qualitative analysis	60 days	Mon 5/16/1	Fri 8/5/16
11			**Task 3: Provider Surveys**	**180 days**	**Mon 8/22/1**	**Fri 4/28/17**
12			Develop survey samples	30 days	Mon 8/22/1	Fri 9/30/16
13			Develop survey instruments	40 days	Mon 10/3/1	Fri 11/25/16
14			Draft survey instruments	0 days	Mon 11/28/	Mon 11/28/
15			Final survey instruments	0 days	Mon 12/19/	Mon 12/19/
16			Field survey	80 days	Mon 1/9/17	Fri 4/28/17
17			**Survey field status reports**	**71 days**	**Fri 1/20/17**	**Fri 4/28/17**
33			**Task 4: Reporting**	**408 days**	**Wed 1/27/1**	**Mon 8/21/1**
34			**Just-in-time reports**	**106 days**	**Wed 1/27/1**	**Wed 6/22/1**
41			Write interim qualitative reports	60 days	Mon 7/25/1	Fri 10/14/16
42			Draft interim qualitative reports	0 days	Mon 10/17/	Mon 10/17/
43			Final interim qualitative reports	0 days	Mon 11/14/	Mon 11/14/
44			Write draft final report	60 days	Mon 5/1/17	Fri 7/21/17
45			Deliver draft final report	0 days	Mon 7/24/1	Mon 7/24/1
46			Deliver final report	0 days	Mon 8/14/1	Mon 8/14/1
47			Deliver issue briefs	0 days	Mon 8/21/1	Mon 8/21/1
48			**Task 5: Evaluation Support**	**589 days**	**Wed 7/1/15**	**Sat 9/30/17**
50			**Task 6: Project Management**	**588 days**	**Wed 7/1/15**	**Fri 9/29/17**
51			Revised management plan	0 days	Wed 7/22/1	Wed 7/22/1
52			**Monthly Progress Reports**	**588 days**	**Wed 7/1/15**	**Fri 9/29/17**