

VHCIP Sub-grant Program Summary

Round One Grantees

- Healthfirst – ACO Management
- Rutland Area VNA and Associates – Supportive Care for Seriously Ill Patients
- NVRH – Flexible Funding for Community Care Program
- WRFPP – Innovative Care Management
- InvestEAP – Resilient Vermont (Stress Reduction)
- VMS – Choosing Wisely (Pre-Operative Testing)
- Bi-State – Community Health ACO

Healthfirst – ACO Management

- The overall goal of the grant is to increase coordination in medical homes between primary care and other clinical practitioners and increasing communication between primary care and specialty physicians
- A significant challenge is determining the optimum clinical quality data to collect and the logistics of managing the collection process

Healthfirst – Activities

Technical Assistance

- Information related to mental healthcare providers in the community
- Design real-time, actionable data to support care management for chronic conditions, such as CHF and diabetes.
- Actuarial support

Long-term Activities

- Ongoing work has started to explore and develop high value alternatives for after-hours care, testing, and procedures. Part of this work has involved the board chair, Dr. Paul Reiss, leading a team of other member doctors to develop plans to provide more convenient after-hours care for patients of Healthfirst practices.

RRVNA & RRMC – Care Coordination for Seriously Ill Patients

- The overall goal of the project is to integrate supportive care and improve quality of life for patients with complex conditions and needs and their caregivers.
- The project was initially challenged to find participants who met the diagnosis and insurance criteria.

RRVNA & RRMC – Activities

- Ongoing Activities
 - Collaborating with a local company to provide respiratory therapy consultant to the supportive care program.
- New Activities
 - Presenting to the medical staff at RRMC and local community physicians on the supportive care program.
- Long-Term Activities
 - Enroll 10 patients to the supportive care programs by the end of December 2014.

Northeastern Vermont Regional Hospital (NVRH) – Flexible Funding for Integrated Care

- This project will provide flexible funding for goods and services not normally covered by insurance, enabling an integrated multi-disciplinary community care team to better care for clients who are at risk for poor outcomes and high costs of medical care.
- The project is has communication challenges as clients often do not have phones which makes it difficult to coordinate services. As well, clients often do not have transportation to access services.

NVRH – Activities and Accomplishments

- Health coach client has lost over 100 pounds
- Client moved to stable housing from mold infected house
- Client with MS connected to PCP and receiving medications
- Client working with Voc Rehab to obtain employment
- Homeless client with seizure disorder connected to medical care and stable housing
- Process in place to distribute flexible funding

White River Family Practice (WRFP) – Innovative Management of Chronic Conditions

- The goal of the project is to measure and reduce emergency room utilization and hospital readmission among patients; use patient confidence metrics to achieve improved disease outcomes and reduced utilization; and to deploy team based care protocols targeting patients with chronic disease.
- The project has been challenged to obtain claims data from all payers; BCBSVT, VT Medicaid and Cigna are actively working to produce claims data. Obtaining Medicare data from CMS remains a significant hurdle.

WRFP - Activities

- Ongoing Activities
 - Bi-monthly grant team meetings
 - Regular meetings with DHMC to refine monthly data feed
- New Activities
 - Begin development of motivational interviewing curriculum and training in preparation for team-based care initiatives
 - Presenting Health Confidence Initiative at eCW National Users Conference
- Long-Term Activities
 - Development of interventions targeted at patients with low self-confidence and/or high utilization

Invest EAP / VTHealthEngage – Early Intervention & Prevention

- The goal of the project is to integrate an innovative stress prevention and early intervention program with traditional primary care delivery to improve health outcomes and reduce medical expenditures.
- Contracting requirements and added time required to establish collaborative relationships are primary early challenges.

Invest EAP / VTHealthEngage - Activities

- Ongoing Activities
 - Working with Community Health Center staff to integrate program.
- New Activities
 - Training in advanced treatment protocols.
 - Integrations with community resources.
 - Health Educator beginning to see patients.
- Long-Term Activities
 - Software modifications to accommodate project evaluation needs

VMS and UVM – Pursuing High Value Care for Vermonters

- The goal of this project is to reduce the rate of unnecessary laboratory testing in two groups of patients:
 - Stable medical and surgical inpatients
 - Low-risk preoperative candidates

- Initial project challenges are:
 - Administrative support and clinical sponsors in low volume hospitals
 - Data abstraction capacity from hospitals' clinical and billing data sets
 - Defining core data elements and evaluation metrics

VMS and UVM - Activities

■ Ongoing Activities

- Improvement staff outreach to hospitals to assist with building multi-disciplinary teams
- October 22nd statewide conference – DHMC and all but two VT CAHs now participating in Collaborative

■ New Activities

- Analytic staff outreach to hospitals to assist with data abstraction
- Monthly webinars and 2nd statewide conference in on February 12th

■ Long-Term Activities

- Develop regional capacity for inter-institutional measurement and improvement activity
- Develop regional inpatient cost effectiveness analytic capacity
- Assess regional economies of scale for measurement and improvement capacity

Bi-State Primary Care – Community Health Accountable Care (CHAC) Shared Savings

- The goal of the project is to grow and strengthen the Accountable Care Organization (ACO), CHAC, to participate in shared savings programs and to improve quality and reduce the cost of care, particularly for high risk patients.
- CHAC is challenged to meet the Medicare requirement that 75% of the Governing Board be made up of organizations that attribute their Medicare lives to the ACO. CHAC's Board has broad representation and many provider participants already attributed their Medicare lives to the other ACOs (OneCare and ACCGM). A Governing Board Exception Request has been filed with CMS.

CHAC – Activities

- CHAC is in the process of developing a plan for data extraction which is expected to be funded under a separate VHCIP grant.
- By the next reporting period, at least one set of new clinical guidelines will have been or will be in the process of roll-out and implementation in the participating health centers.
- CHAC is exploring telemonitoring care management to increase the quality of care for the Medicare population. There will be efforts to expand this tool to other populations if it proves to be a successful intervention.