VHCIP

Steering Committee Meeting

Agenda 8-26-15

Vermont Health Care Innovation Project
Steering Committee Meeting Agenda

August 26, 2015, 1:00pm-3:00 pm
4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	1:00-1:10pm	Welcome and Introductions	Steven Costantino		
2	1:10-1:15pm	Minutes Approval	Steven Costantino	Attachment 1: Draft May 27 Meeting Minutes	Approval of Minutes
3	1:15-1:50pm	Core Team Update: • Mid-Project Risk Assessment and CMMI Site Visit: Progress on Year 2 Milestones, Report Out from 6/17 VHCIP Project-Wide Convening, and CMMI Approvals • All-Payer Model Update *Public comment*	Lawrence Miller & Georgia Maheras	Attachment 2a: VHCIP Project Re-Basing Attachment 2b: Year 2 Milestones – Progress Attachment 2c: VHCIP Convening Wrap-Up Notes Attachment 2d: CMMI Site Visit Overview Slides, July 23, 2015 Attachment 2e: Achieving the Triple Aim in Vermont (APM Presentation to QPM Work Group on June 22)	
4	1:50-2:05pm	Work Group Policy Recommendations: • Work Group Policy Recommendations: HIE/HIT Work Group – Telehealth Strategy *Public comment*	• Georgia Maheras & Karen Bell	Attachment 3: Statewide Telehealth Strategy (.ppt)	Approval of Telehealth Strategy
5	2:05-2:20pm	Work Group Funding Recommendations: • HIE/HIT Work Group – Telehealth Pilots *Public comment*	• Georgia Maheras & Karen Bell	Attachment 4a: Steering Committee Financial Proposals, August 26, 2015 Attachment 4b: Telehealth Implementation RFP Scope	Approval of Funding Requests
6	2:20-2:35pm	Work Group Update: SCÜP Status Report and Checkpoint *Public comment*	Georgia Maheras & Larry Sandage	Attachment 5: SCÜP Status Report and Checkpoint	Approval of Checkpoint

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
7	2:35-2:55pm	Work Group Update: Population Health Work Group – Accountable Health Communities Update *Public comment*	Tracy Dolan	Attachment 6: Accountable Health Communities Research Full report is available at: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Pop_Health/VT ACH Opportunities and Recommendations.pdf	
8	2:55-3:00pm	Next Steps, Wrap-Up and Future Meeting Schedule	Steven Costantino	Next Meeting: Monday, September 28, 2015, 1:00-3:00pm, Montpelier	

Attachment 1

May Minutes

VT Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, May 27, 2015; 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions and Minutes Approval	Steven Costantino called the meeting to order at 1:04 pm. Robin Lunge served as Co-Chair in Al Gobeille's absence. A quorum was present. Steven announced a change to the agenda: the Work Group Funding Recommendation will be discussed following the Work Group Policy Recommendation.	
2. Work Group Policy Recommendations	Cathy Fulton presented the Year 2 ACO Shared Savings Program updates (Attachments 1a & 1b). The group discussed the following: - Hypertension measure will follow the basic recommendation for blood pressure (140/90); hypertension control is critical for stroke prevention. - How do reporting mechanisms account for changes to measures to determine the effectiveness of actually measuring these things? How effective is this measurement? How do changes to measures impact our ability to compare performance across program years? When the evidence changes, we want to make sure that we're in step with national guidelines. We can still track improvement over time by ACO. - There is clinical merit to these changes, but from a collection and use point of view, this simplifies the process. These are easier to collect from EMRs, from VITL, from clinical registries – complex composites are harder to collect and less consistently reported. The D2 component of the diabetes measures is already included in the Year 2 measure set. - These measures are specifically tied to the Medicare Shared Savings Program (MSSP). The ACOs are already measuring these for MSSP. - No provider wants to be measuring something that's not supported by evidence.	

Agenda Item	Discussion	Next Steps
	Steven Costantino entertained a motion. Sue Aranoff moved to approve these recommendations by exception. Dale Hackett seconded. Approved with none opposed and Ed Paquin and Deborah Lisi-Baker abstaining.	
Public Comment	No public comments were offered.	
3. Work Group Funding Recommendations	Simone Rueschemeyer presented the HIE/HIT Work Group request for the Shared Care Plan/Universal Transfer Protocol (SCÜP) Project Funding Request (Attachments 3a & 3b). The group discussed the following: - Business and workflow requirements will precede a discussion of technical requirements. The project team will look at potential solutions after business and workflow requirements are developed. - Current target audience for use: home health, mental health, hospitals – providers in general. - How does 42 CFR Part 2 fit into this? The State has a work group focusing on Part 2 data – no progress yet. Also, waiting for SAMHSA to write rules on this. - Business analyst is proposed to assess what data is currently being shared and what providers would like to see shared. They will look at clinical use cases, business requirements to support the use cases (who/what/when/how) and match this information to what is feasible on the technology side. - Concerns about IT solutions not being able to deliver the required information. Provider input will be a large component of this assessment and be factored into the design phase. - ACOs are also considering how to best support care coordination across settings, and would like to be involved in the discussion and planning over the next few months. - From business and technical points of view, it's essential that providers and staff have a single place to go to get the information they need. The focus of this project is to provide efficiencies and enhance communications in areas where that is lacking. It is not meant to add another administrative burden for providers. - The RFP Phase on slide 3 is a potential recommendation – if the VHIE is capable of providing the technical solution, that is an option the project team will consider. - The final deliverable: Set of needs from the various providers around the State to support smooth care transitions and shared care planning, and an assessment of what is needed to serve the needs and the technical requirements. - The IM21 charter is focused specifically on transitions of care and this next phase would aim to look system-wide and Statewide. - Recommendation to solicit input from the DLTSS work group on this project. Care plans need to be person-directed, which is maybe lost here; though this care plan is different than care plans required by Home- and Community-Based Services waiver rules, Choices for Care, and more. This is a way to let different care providers stay informed about each other's activities. The project team will talk to the DLTSS Work Group	

Agenda Item	Discussion	Next Steps
	going forward. Robin entertained a motion. Dale Hackett moved to approve by exception the proposal as stated in the presentation (for $36,500), with the idea that the project team will report back to the HIE/HIT Work Group and Steering Committee after this phase. Sue Aranoff seconded. The motion passed with one abstention (Richard Slusky).	
Public comment	No further comments were offered.	
4. Core Team Update	Robin Lunge noted that the Core Team is engaged in a mid-project risk assessment with the Center for Medicare and Medicaid Innovation (CMMI) to assess progress toward our end-of-grant Milestones. One CMMI-required Milestone is to have 90% of population under alternative payment methodologies; currently at ~60%. As a result of this gap, CMMI has asked the leadership team to revise the milestones and tie the current budget to the new milestones. Until the revised milestones are approved, they are holding the approval of nine SIM-related contracts and the revised Year 2 budget. The Core Team engaged in a financial risk mitigation plan which involves putting some contract work under the SIM program on hold. Year 1 Milestones will be made available for the June 1 Core Team meeting and Year's 2 and 3 Milestones will be made available after they are approved by CMMI. Decisions on how SIM Project implementation will support meeting the Milestones will be discussed within the various VHCIP Work Groups, Steering Committee, and Core Team in order to align with the work we're already doing. CMMI has asked for us to identify how the current budget and contract work supports the work of the All-Payer Model. All-Payer Waiver: The State is in a preliminary phase with CMMI and working on financial and data modeling to complete the CMMI "term sheet" (negotiation starting point) related to projections over the next five years. Anticipated completion for the term sheet is late June. This will remain confidential until it is approved, which is expected by the end of the summer. The next phase would be negotiating the waiver terms and conditions, which would go through the end of next year. The draft term sheet would be able to give a broad sense of which providers will be included once it's completed. The term sheet is similar to, but not, an official application. It begins the formal approval process – the outcome, if approved, is a waiver that is signed and treated like a contract. The group discussed the following: - Is the 90% target realistic? This target was assigned to Vermont based on an inaccurate assessment of Blueprint attribution at the time of our original SIM grant application; the State believed it already had 87%	**The related All-Payer Model presentation will be distributed to the group.**

Agenda Item	Discussion	Next Steps
	of attributed lives under the Blueprint, which was not the case. All other SIM states have an 80% target; we will be requesting that this Milestone change to align with other SIM states. A discussion with Health Care Reform leadership and CMMI will take place on June 17th. Georgia Maheras gave an update on the Sub-Grantee Symposium that took place the morning of May 27, which was very successful. The symposium included a discussion with ACO leaders about systems and infrastructure, and a provider panel to talk about work to improve transitions of care at the patient level. Notes will be shared with those who were not able to attend. There will be a second symposium in October involving the second round of sub-grantees. Robin reminded the group that we have reached the spending point in our grant phase where we qualify for an external audit of SIM grant spending. The State's external auditor, KPMG, will be working mostly with internal staff but may be looking at contracts and grants.	
Public Comment	No public comments were offered.	
5. Minutes Approval	Sue Aranoff moved to approve the minutes from the April 29th Steering Committee meeting by exception. Trinka Kerr seconded. The motion carried with two abstentions.	
6. Updates	Deborah Lisi-Baker presented the DLTSS-Specific Core Competency Curriculum Development and Training proposal (Attachment 4). - The focus is an opportunity for physicians to learn about the needs of the DLTSS community. - Ideas and suggestions are welcome from the group and can be sent to Julie Wasserman or Deborah.	
Public comment	No further comments were offered.	
7. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Wednesday, July 1, 2015, 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

motion passed by exception 1° Sue A. 2° Dale

motion passed by exception 1° Sue A. 2° Trinka

motion passed by exception 1° Dale 2° Sue A.

VHCIP Steering Committee Member List

Roll Call: 5/27/2015

Member		Member Alternate		Year 2 ACO Measures	April Minutes	SCÜP Resource	
First Name	Last Name	First Name	Last Name				Organization
Susan	Aranoff ✓						AHS - DAIL
Rick	Barnett ✓	left at 2:25 (here for ACO + SCÜP)					Vermont Psychological Association
Bob	Bick						DA - HowardCenter for Mental Health
Peter	Cobb ✓						VNAs of Vermont
Steven	Costantino ✓	left @ 2pm		(here for ACO)			AHS - DVHA, Commissioner
Elizabeth	Cote phone ✓						Area Health Education Centers Program
Tracy	Dolan ✓	~~Heidi~~	~~Klein~~ left @ 2pm		(here for ACO)		AHS - VDH
~~Susan~~	~~Donegan~~	David	Martini ✓				AOA - DFR
~~Paul~~	~~Dupre~~	Jaskanwar	Batra ✓				AHS - DMH
Nancy	Eldridge						Cathedral Square and SASH Program
John	Evans ✓						Vermont Information Technology Leaders
Catherine	Fulton ✓						Vermont Program for Quality in Health Care
Joyce	Gallimore						Bi-State Primary Care/CHAC
Don	George						Blue Cross Blue Shield of Vermont
Al	Gobeille X						GMCB
Bea	Grause ✓						Vermont Association of Hospital and Health Systems
Lynn	Guillett						Dartmouth Hitchcock
Dale	Hackett ✓						None
Mike	Hall ✓	~~Angela~~	~~Smith-Dieng~~				Champlain Valley Area Agency on Aging / COVE
Paul	Harrington						Vermont Medical Society
Debbie	Ingram ✓				Abstain		Vermont Interfaith Action
Craig	Jones phones ✓						AHS - DVHA - Blueprint
Trinka	Kerr ✓						VLA/Health Care Advocate Project
Deborah	Lisi-Baker ✓			Abstain	Abstain		SOV - Consultant

Jackie	Majoros ✓						VLA/LTC Ombudsman Project
Todd	Moore ✓	~~Vicki~~	~~Loner~~				OneCare Vermont
Mary Val	Palumbo						University of Vermont
Ed	Paquin ✓			Abbigail ✓			Disability Rights Vermont
Laura	Pelosi						Vermont Health Care Association
Judy	Peterson						Visiting Nurse Assoc. of Chittenden and Grand Isle Counties
Allan	Ramsay ✓						GMCB
Paul	Reiss						Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓						Vermont Care Network
Howard	Schapiro						University of Vermont Medical Group Practice
Shawn	Skafelstad ✓						AHS - Central Office
Julie	Tessler ✓						DA - Vermont Council of Developmental and MH Services
Sharon phone	Winn ✓	Left @ 1:45 pm		(here for ACO)			Bi-State Primary Care
	36		5				

VHCIP Steering Committee Participant List

Attendance: 5/27/2015

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

First Name	Last Name		Organization	Steering Committee
Susan	Aranoff		AHS - DAIL	S/M
Ena	Backus		GMCB	X
Melissa	Bailey		Vermont Care Network	X
Heidi	Banks		Vermont Information Technology Leaders	X
Rick	Barnett		Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Anna	Bassford		GMCB	A
Jaskanwar	Batra		AHS - DMH	MA
Susan	Besio		SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		DA - HowardCenter for Mental Health	M
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Amanda	Ciecior		AHS - DVHA	S
Sarah	Clark		AHS - CO	X
Peter	Cobb		VNAs of Vermont	M
Lori	Collins		AHS - DVHA	X
Amy	Coonradt		AHS - DVHA	S

Alicia	Cooper	Alicia Cooper	AHS - DVHA	S
Steven	Costantino		AHS - DVHA, Commissioner	C
Elizabeth	Cote	phone	Area Health Education Centers Program	M
Diane	Cummings	DCummings	AHS - Central Office	S
Susan	Devoid		OneCare Vermont	A
Tracy	Dolan		AHS - VDH	M
Richard	Donahey		AHS - Central Office	X
Susan	Donegan	DAVID Martini	AOA - DFR	M
Paul	Dupre		AHS - DMH	M
Nancy	Eldridge		Cathedral Square and SASH Program	M
Gabe	Epstein	here	AHS - DAIL	S
John	Evans	here	Vermont Information Technology Leaders	M
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn	here	AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Catherine	Fulton		Vermont Program for Quality in Health Care	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Don	George		Blue Cross Blue Shield of Vermont	M
Al	Gobeille		GMCB	C
Bea	Grause		Vermont Association of Hospital and Health Systems	M
Sarah	Gregorek		AHS - DVHA	A
Lynn	Guillett		Dartmouth Hitchcock	M
Dale	Hackett		None	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M
Janie	Hall		OneCare Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Paul	Harrington		Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Diane	Hawkins		AHS - DVHA	X
Karen	Hein			X
Debbie	Ingram		Vermont Interfaith Action	M

Craig	Jones	phone	AHS - DVHA - Blueprint	M
Kate	Jones		AHS - DVHA	S
Pat	Jones		GMCB	S
Joelle	Judge		UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	M
Sarah	Kinsler		AHS - DVHA	S
Heidi	Klein		AHS - VDH	S/MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Monica	Light		AHS - Central Office	X
Deborah	Lisi-Baker		SOV - Consultant	M
Sam	Liss		Statewide Independent Living Council	X
Vicki	Loner		OneCare Vermont	MA
Robin	Lunge		AOA	X
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	M
Carol	Maloney		AHS	X
David	Martini		DFR	MA
Mike	Maslack			X
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Darcy	McPherson		AHS - DVHA	X
Marisa	Melamed		AOA	S
Jessica	Mendizabal	here	AHS - DVHA	S
Madeleine	Mongan		Vermont Medical Society	X
Todd	Moore		OneCare Vermont	M
Brian	Otley		Green Mountain Power	X
Dawn	O'Toole		AHS - DCF	X
Mary Val	Palumbo		University of Vermont	M
Ed	Paquin		Disability Rights Vermont	M
Annie	Paumgarten		GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Judy	Peterson		Visiting Nurse Association of Chittenden and Grand Isle Counties	M
Luann	Poirer		AHS - DVHA	S
Allan	Ramsay		GMCB	M
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M

Simone	Rueschemeyer		Vermont Care Network	M
Jenney	Samuelson		AHS - DVHA - Blueprint	X
Larry	Sandage	phone	AHS - DVHA	S
Howard	Schapiro		University of Vermont Medical Group Practice	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Shawn	Skaflestad	(Interim)	AHS - Central Office	M
Mary	Skovira		AHS - VDH	A
Richard	Slusky	here	GMCB	S
Angela	Smith-Dieng		Area Agency on Aging (Association)	MA
Kara	Suter		AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler	here	DA - Vermont Council of Developmental and Mental Health Serv	M
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Julie	Wasserman	JW	AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State Primary Care Association	X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Sharon	Winn	phone	Bi-State Primary Care	M
Cecelia	Wu		AHS - DVHA	S
				105

Attachments 2a – 2e

Core Team Update

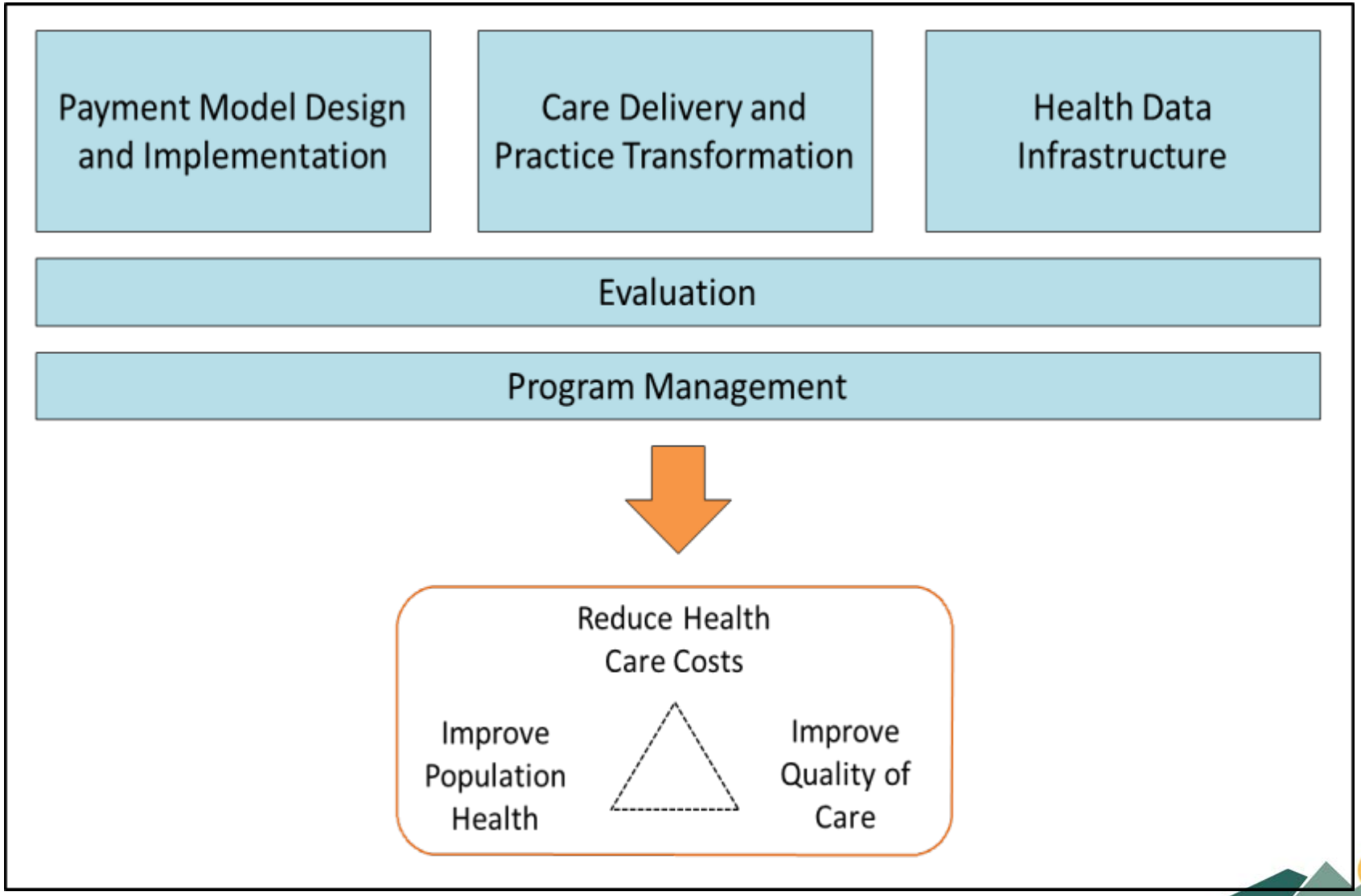
VHCIP Project Rebasing presented to VHCIP Steering Committee

Lawrence Miller, Chair, Core Team

Georgia Maheras, Project Director

August 26, 2015

Vermont's SIM Focus Areas and Goal:



Vermont Health Care Innovation Project

What is success?

- Supporting creation and implementation of value-based payments for providers in Vermont across all payers.
- Supporting the inclusion of 80% of Vermonters in alternatives to fee-for-service.
- Creation of a system of care management that is agreed to by all payers and providers that:
  - Utilizes advanced primary care infrastructure to the greatest extent possible;
  - fills gaps;
  - eliminates duplication of effort;
  - creates clear protocols for providers;
  - reduces confusion and improves the care experience for patients; and
  - follows best practices.
- Creation of a health data infrastructure to support a high-performing health system.
- Includes activities that *support provider and payer readiness* to participate in alternative payment models.

Mid-Project Risk Assessment:

- Progress to date:
  - Snapshot of impact
- Remaining activities (milestones)
  - Rebasing
  - Realignment of work groups

This proposal will be presented to the Core Team on 8/31. We request written feedback from Steering Committee from 8/19-8/30. It will also be discussed at the 8/26 Steering Committee meeting.

Send comments to: Sarah Kinsler at sarah.kinsler@vermont.gov

Snapshot of SIM Payment Model Impacts

		Q1 2015
Beneficiaries Impacted	Commercial SSP*	40,232
	Medicaid SSP*	52,177
	Medicare SSP*	61,560
	Commercial Blueprint (APMH/P4P)	111,529
	Medicaid Blueprint (APMH/P4P)	106,818
	Medicare Blueprint (APMH/P4P)	67,621
	Medicaid Health Home	2,706
Participating Providers	Medicare, Medicaid, Commercial SSPs	977
	Blueprint (APMH/P4P)	694
	Medicaid Health Home	123
Provider Organizations	Medicare, Medicaid, Commercial SSPs	83
	Blueprint (APMH/P4P)	63
	Medicaid Health Home	5

*All SSP impact numbers reflect Q2

Snapshot of SIM Care Delivery & Health Data Infrastructure Impacts

	Impact
Health Data Infrastructure	400 Providers
Care Delivery & Practice Transformation: Learning Collaboratives	420 Providers
Care Delivery & Practice Transformation: Subgrantee Program	692 Providers 281,808 Vermonters

Remaining work to do:

Payment Models:

- Medicaid and commercial SSP: Year 3 implementation.
- Medicaid Episodes of Care implementation
- Feasibility/Analysis: Accountable Communities for Health and All-Payer Model.
- Home Health PPS

80% of Vermonters in alternatives to fee-for-service by 12/31/2015.

Remaining work to do:

Practice Transformation:

- Expand Learning Collaboratives to remainder of state.
- Sustain sub-grants, regional collaborations.
- Do micro-simulation demand modeling.

Population Health

- Finalize Population Health Plan.

Remaining work to do:

Health Data Infrastructure:

- Launch Event Notification System.
- Continue data quality and gap remediation efforts.
- Invest in shared care plan and/or uniform transfer protocol solution.
- Invest in telehealth pilots
- Design and implement registry and data warehousing solutions.

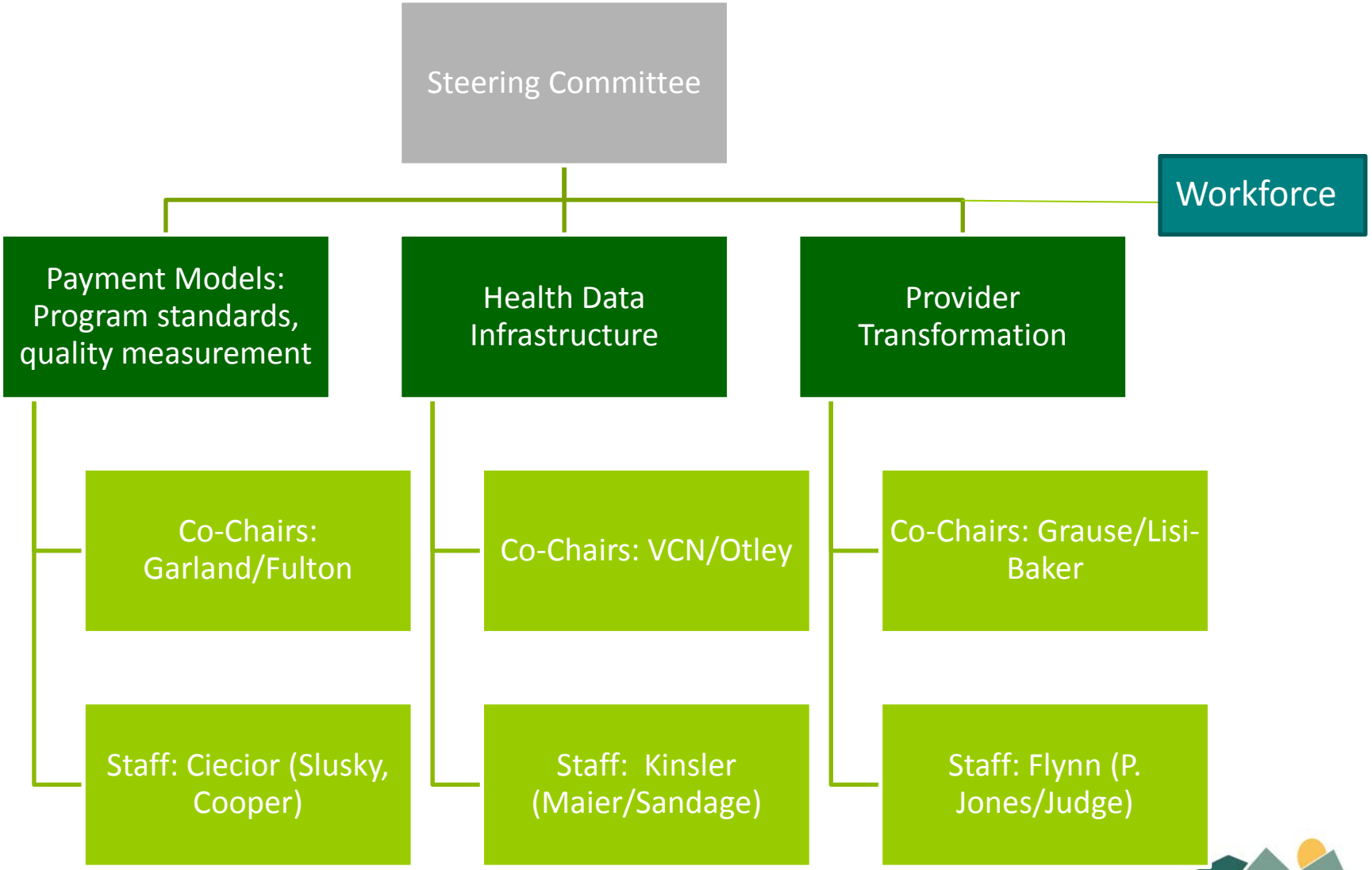
Remaining work to do:

SUSTAINABILITY

Realignment:

- Reconfigure existing structure to better align the organizational structure and the work left to perform.
- Reassign SIM staff leads accountable for each work stream.
- Written monthly updates.
- Revamped website.

New Organization Structure:



Assumes Core Team above Steering-Committee-- removed to allow for easier depiction

Vermont Health Care Innovation Project

Work stream leads: Payment Models

Project	SOV Lead
Shared Savings ACO Programs	Slusky/Wu
Episodes of Care	Cooper
PPS-DAs	Hickman
PPS-Home Health	Cooper
Pay-for-performance	C. Jones
Accountable Communities for Health	H. Klein

Work stream leads: Health Data Infrastructure

Project	SOV Lead
Telehealth	Kinsler
Connectivity and Quality	Maier/Sandage
HIT Plan	Maier
Care Management Tools	Sandage (ENS and SCUP)
Part 2	Maier
Analytics (and all steps necessary to get to that – access and availability to stand data up for analytics)	Maheras

Work stream leads: Practice Transformation

Project	SOV Lead
Learning Collaboratives	P. Jones/Flynn
Regional Collaborations	Samuelson
Sub-grantees	Judge
Workforce	Coonradt
Pay-for-performance	C. Jones
Accountable Communities for Health	H. Klein

SIM Investment 2013

Test Payment Models
- All-payer ACO SSPs
- All-payer P4P for medical homes
- Episodes of Care
- Medicaid VBP
- Accountable Communities for Health

Transform Care Delivery
- Learning Collaboratives
- Provider Sub-Grants
- Regional Collaborations
- Workforce Analyses

Health Data Infrastructure
- Provider connectivity to VHIE (high quality data)
- Care Management tools
- Telehealth strategy
- Data warehousing

Evaluation
- Finding out what works over short term and medium term through plan and M&E

SIM Results 2017+

More Value Based Payment
- 80% of VT population in alternative payment models
- Improved health

Created a Learning Culture for Providers and Payers
- Majority of providers participated in learning or regional collaborative or sub-grant program
- Providers can use data for quality improvement

Enhanced Data Infrastructure
- Majority of providers send, receive, and use high quality data
- Coordinating strategic planning:
  - Data warehousing
  - telehealth

All-Payer Model

Cost and Quality Targets
-Medicare savings
-VT savings compared to economic growth

All –Payer Rate Setting
- GMCB regulates all payers and providers
- GMCB sets system wide quality goals
- Setting the stage for capitated payment

PAYMENT MODELS

Payment Model Milestones:

- 1: ACO Shared Savings Programs (SSPs);
- 2: Episodes of Care (EOCs);
- 3: Pay-for-Performance (Blueprint);
- 4: Health Home (Hub & Spoke);
- 5: Accountable Health Communities;
- 6: Prospective Payment System – Home Health;
- 7: Prospective Payment System – Designated Agencies;
- 8: All-Payer Model
- 9: State Activities to Support Model Design and Implementation – GMCB & Medicaid

1: ACO Shared Savings Programs

- Current activities to support this task:
  - Medicaid and Commercial SSPs in operation since 1/1/2014.
    - Medicare SSPs in operation since 2013.
  - Multiple contracts to support program design, operation, and evaluation
- Anticipated activities that would support this task:
  - Exploring opportunities to expand the number of attributed lives

2: Episodes of Care

- Current activities to support this task:
  - Launched multi-stakeholder EOC sub-group in 01/2015.
  - Exploring potential episodes for Vermont's Medicaid population.
  - Ongoing communication with other SIM states that have implemented episode-based payment models.

- Anticipated activities that would support this task:
  - Release RFP for vendor analytic support to implement this model in Vermont Medicaid.

3: Pay-for-Performance (Blueprint)

- Current activities to support this task:
  - Designing and implementing modifications to current Blueprint for Health program:
    - Increasing the base payments to PCMH practices.
    - Adding an incentive payment for regional performance on a composite of select quality & utilization measures.

- Anticipated activities that would support this task:
  - TBD

4: Health Home (Hub & Spoke)

- Current activities to support this task:
  - State reporting on program implementation
  - Preparation for PY 2014 quality reporting

- Anticipated activities that would support this task:
  - N/A

5: Accountable Health Communities

- Current activities to support this task:
  - Contract with the Prevention Institute to engage in national research; findings delivered in 2015.
  - Contract with Bailit Health Purchasing to research feasibility of implementing AHC pilot(s) in Vermont.

- Anticipated activities that would support this task:
  - Continued stakeholder engagement in potential communities.

6: Prospective Payment System – Home Health

- Current activities to support this task:
  - Legislation to support the design of a PPS program for Home Health was passed in 2015.

- Anticipated activities that would support this task:
  - Leverage contract support from Bailit, Burns, and PHPG to design a PPS program that complements other Vermont payment models.

7: Prospective Payment System – Designated Agencies

- Current activities to support this task:
  - Submitting a planning grant application to SAMHSA.

- Anticipated activities that would support this task:
  - This is a new grant and will have its own internal activities. VHCIP activity is alignment and collaboration with AHS departments and other stakeholders.

8: All Payer Model

- Current activities to support this task:
  - Negotiations between CMMI and Vermont (led by AOA and GMCB) are underway.
  - Contractor support from Bailit, Burns, and HMA to research feasibility and develop analytics to inform future conversations with CMMI.

- Anticipated activities that would support this task:
  - Meetings with payers and providers to develop a framework for participation in an all-payer model.
  - Consideration of a provider led governance structure that would support a state-wide integrated delivery system.
  - Expand the regulatory capacity of the GMCB.

9: State Activities to Support Model Design and Implementation (GMCB & Medicaid)

- Current activities to support this task:
  - GMCB: Identification components necessary to support APM regulatory activities.
  - Medicaid: Seeking SPA and other federal approvals for each payment model with contract support from Burns and Wakely.
  - Medicaid: Ongoing monitoring of program compliance.

- Anticipated activities that would support this task:
  - Medicaid SPA approvals for new programs and changes to existing programs

PRACTICE TRANSFORMATION

Care Delivery and Practice Transformation Milestones:

- 1: Learning Collaborative: Offer at least two cohorts of Learning Collaboratives to 3-6 communities;
- 2: Regional Collaborations: Establish 14 regional collaborations, each including a Charter, governing body, and decision-making process;
- 3: Sub-grant Program-Technical Assistance: Provide technical assistance to sub-grantees as requested by sub-grantees;
- 4: Sub-grant Program: Continue sub-grant program, convene sub-grantees at least once, use lessons from sub-grantees to inform project decision-making;
- 5: Workforce-Care Management Inventory: Obtain snapshot of current care management activities, staffing, people served, and challenges;
- 6: Workforce-Demand Data Collection and Analysis: Obtain micro-simulation demand model to identify future workforce resource needs;
- 7: Workforce-Supply Data Collection and Analysis: Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan.

1: Learning Collaborative: Offer at least two cohorts of Learning Collaboratives to 3-6 communities

- Current activities to support this task:
  - Contracts with Nancy Abernathy and Vermont Program for Quality Health Care to serve as quality improvement facilitators and provide community level outreach and training.
  - Ongoing development of core competency trainings regarding Disability and Long Term Services and Supports.

- Anticipated activities that would support this task:
  - Expanding to 8 new communities joining in 2015.

2: Regional Collaborations: Establish 14 regional collaborations, each including a Charter, governing body, and decision-making process

- Current activities to support this task:
  - Unified Regional Collaboratives have been established in each of Vermont's 14 Health Service Areas.
    - These include representatives from the Blueprint for Health, ACOs, regional clinicians, human service agency representatives.
- Anticipated activities that would support this task:
  - Support implementation of these governance structures and priority activities

3: Sub-grant Program-Technical Assistance: Provide technical assistance to sub-grantees as requested by sub-grantees

- Current activities to support this task:
  - Contracted with Bailit Health Purchasing; Policy Integrity; Truven Health Analytics; Vermont Program for Quality Health Care; Wakely Actuarial to provide technical assistance to sub-grantees as requested.

- Anticipated activities that would support this task:
  - Continue providing support as necessary.

4: Sub-grant Program: Continue sub-grant program, convene sub-grantees at least once, use lessons from sub-grantees to inform project decision-making

- Current activities to support this task:
  - 14 Sub-grants have been awarded and are actively engaged in their projects.
  - All sub-grantees convened on May 27, 2015, for a Symposium.

- Anticipated activities that would support this task:
  - 2nd sub-grantee convening later in 2015.

5: Workforce-Care Management Inventory: Obtain snapshot of current care management activities, staffing, people served, and challenges

- Current activities to support this task:
  - Contract with Bailit Health Purchasing to field and analyze Care Management Inventory Survey.

- Anticipated activities that would support this task:
  - Present the Care Management Inventory Survey to the Health Care Workforce Work Group in 2015.

6: Workforce-Demand Data Collection and Analysis: Obtain micro-simulation demand model to identify future workforce resource needs

- Current activities to support this task:
  - RFP for vendor support was released in January 2015, and the state is in the procurement process

- Anticipated activities that would support this task:
  - Select vendor by August of 2015 to:
    - Build and populate a Vermont specific demand model
    - Begin modeling of future demand for the health care work force

7: Workforce-Supply Data Collection and Analysis: Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan

- Current activities to support this task:
  - Staff hired to develop and administer surveys to accompany provider re-licensure applications, perform analysis on licensure data and develop provider reports on various health care professions

- Anticipated activities that would support this task:
  - Present results of these surveys to the Health Care Workforce Work Group in 2015

HEALTH DATA INFRASTRUCTURE

HIT/HIE Milestones:

- 1: Expand connectivity to the HIE;
- 2: Improve quality of data flowing into the HIE;
- 3: Telehealth program design and implementation;
- 4: Electronic Medical Record Expansion;
- 5: Data Warehousing, registries and repositories;
- 6: Care management tools: transfer protocols, care plans, event notification systems;
- 7: General health data support (technical expertise such as Business Analysts, Subject Matter Experts, and Enterprise Architects).

1: Expand Connectivity to the HIE

- Current activities to support this task:
  - Contract with VITL to:
    - Remediate data gaps for quality measures related to the Shared Savings Program.
    - Establish gateways between the HIE and each ACO.
- Anticipated activities that would support this task:
  - Contract with VITL to add connections to the HIE for more providers.
  - Support activities related to integrate 42 CFR Part 2 data.

2: Improve quality of data flowing into the HIE

- Current activities to support this task:
  - Contract with VITL to:
    - Provide data quality specialists to meaningful use and non-meaningful use providers.
  - Contract with H.I.S. Professionals to:
    - Provide project management and Subject Matter Expertise to non-meaningful use providers.
  - Contract with Vermont Care Network (VCN) to:
    - Provide stakeholder outreach activities to non-meaningful use providers.
- Anticipated activities that would support this task:
  - Continued data quality improvements for meaningful use and non-meaningful use providers.

3: Telehealth program design and implementation

- Current activities to support this task:
  - Contract with JBS International to :
    - Develop a strategic plan for telehealth investments

- Anticipated activities that would support this task:
  - Investment in telehealth strategies

4: Electronic Medical Record Expansion

- Current activities to support this task:
  - Contract with ARIS to:
    - Provide funds to assist in procurement of a new electronic medical record system for the five Specialized Service Agencies.
  - Contract with VITL to:
    - Assist Vermont's Department of Mental Health in procurement of a new electronic medical record system.
    - Assist ARIS in procurement of EMR system.
- Anticipated activities that would support this task:
  - TBD depending on gap analyses and technical assessments of provider connectivity and readiness.

5: Data Warehousing, registries and repositories

- Current activities to support this task:
  - Contract with VCN to develop a data repository for designated mental health and specialized service agency data to include 42 CFR Part 2 data.
- Anticipated activities that would support this task:
  - Strategic, cohesive plan for data warehousing for integrated clinical and claims data.

6: Care management tools: transfer protocols, care plans, event notification systems

- Current activities to support this task:
  - VITL Contract: develop an event notification system.
  - Im21: research and discovery regarding uniform transfer protocol.
  - Research and discovery regarding shared care plan.
- Anticipated activities that would support this task:
  - Launch of event notification system.
  - Design of shared care plan/uniform transfer protocol

7: General health data support

- Current activities to support this task:
  - Stone: health data inventory
- Anticipated activities that would support this task:
  - Procurement of Business Analysts, Enterprise Architects, Project Managers, and Subject Matter Experts as appropriate.

VHCIP Year 2 Milestones and Progress to Date
June 2015

Vermont Health Care Innovation Project

CMMI-Required Milestones		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
Payment Models *Year 2:* 60% of Vermonters in alternatives to fee-for-service. *Year 3:* 80% of Vermonters in alternatives to fee-for-service.		• Currently ~60% of Vermonters are in alternatives to fee-for-service.
Population Health Plan *Year 2:* Draft Plan submitted to CMMI. *Year 3:* Final Plan submitted to CMMI.		• Plan outline drafted.

Payment Model Design and Implementation		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
ACO Shared Savings Programs (SSPs) *Year 2:* Expand the number of people in the Shared Savings Programs in Year 2. *Year 3:* Expand the number of people in the Shared Savings Programs in Year 3.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Medicaid and Commercial SSPs launched on 1/1/2014. • Year 2 contract negotiations between DVHA and Medicaid SSP ACOs are in process. • Expansion of Total Cost of Care for Year 3 will be considered later in 2015. **Total Providers Impacted:** 977 **Total Vermonters Impacted:** 133,754
Episodes of Care (EOCs) *Year 2:* Design 3 EOCs for the Medicaid program with financial component. *Year 3:* Launch 3 Episodes in Year 3.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• A sub-group of the VHCIP Payment Models Work Group focused on Episodes launched in January 2015; the group has met five times. • Staff have conducted a series of one-on-one meetings with stakeholder organizations to understand opportunities and concerns related to this initiative. **Total Providers Impacted:** 0 **Total Vermonters Impacted:** 0
Pay-for-Performance (Blueprint) *Year 2:* Design modifications to this P4P program – dependent on additional appropriation in state budget. *Year 3:* TBD, based on Year 2.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• The Blueprint for Health has been engaging with its Executive Committee, DVHA and AHS leadership, and VHCIP stakeholders to discuss potential modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payment models. Such modifications include shifting payers' CHT payments to reflect each current market share, increasing the base payments to PCMH practices, and adding an incentive payment for regional performance on a composite of select quality measures • The legislature appropriated $2.4 million for Blueprint payments (both CHT and PCMH) in State Fiscal Year 2016. **Total Providers Impacted:** 694 **Total Vermonters Impacted:** 285,968

Health Home (Hub & Spoke) *Year 2:* Reporting on program's transition and progress. *Year 3:* Reporting on program's transition and progress.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Program implementation and reporting are ongoing. **Total Participating Providers:** 123 **Total Vermonters Impacted:** 2706
Accountable Health Communities *Year 2:* Research and design feasibility. *Year 3:* TBD based on design/research in Year 2.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Contractor selected to engage in national research; contract executed. Findings delivered to VHCIP in June 2015.
Prospective Payment System – Home Health *Year 2:* Design PPS program for Home Health. *Year 3:* Launch PPS on 7/1/2016.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Legislation to support this effort passed in 2015.
Prospective Payment System – Designated Agencies *Year 2:* Submit planning grant application to SAMHSA. *Year 3:* If awarded SAMHSA planning grant, plan PPS program.	Planning grant application.	• Planning grant application being drafted with contractor support in collaboration with various AHS departments and stakeholders; application due in August 2015.
All-Payer Model *Year 2:* Research feasibility, develop analytics, and obtain information to inform decision-making for negotiations with CMMI. *Year 3:* TBD. APM launch anticipated for 2017.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Negotiations between CMMI and SOV (led by AOA and GMCB) are in process.
State Activities to Support Model Design and Implementation – GMCB *Year 2:* Obtain information and identify regulatory components necessary to support APM regulatory activities. Plan as appropriate based on negotiations. *Year 3:* TBD. APM launch anticipated for 2017.	GMCB-specific regulatory activities.	• Contractor selected to support this work.
State Activities to Support Model Design and Implementation – Medicaid *Year 2:* Pursue state plan amendments and other federal approvals as appropriate for each payment model (Year 2 SSP SPA, Year 1 EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate. *Year 3:* Pursue waivers as appropriate, ensure monitoring and compliance activities are performed.	Medicaid-specific design and implementation activities (SPAs, etc.).	• Year 1 SSP State Plan Amendment approved in June 2015. • Year 2 SSP State Plan Amendment draft to be developed in Summer 2015. • Beneficiary call-center is operational.

Care Delivery and Practice Transformation		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
Learning Collaboratives *Year 2:* Offer at least two cohorts of Learning Collaboratives to 3-6 communities. *Year 3:* Offer at least two cohorts of Learning Collaboratives to 3-6 communities.	Design and launch at least two cohorts of learning collaboratives: in-person meetings, webinars, core competency components. At least 6 in-person meetings/year; at least 6 webinars/year.	• First Learning Collaborative cohort launched in 3 communities in November 2014; participants have convened for three in-person learning sessions and three webinars, as well as regular local meetings to support work. • Planning for additional Learning Collaborative cohorts is underway, with funds approved by the Core Team. • Planning to support development of core competency training is underway (collaboration between VHCIP Care Models & Care Management and DLTSS Work Groups).
Sub-Grant Program – Sub-Grants *Year 2:* Continue sub-grant program; convene sub-grantees at least once; use lessons from sub-grantees to inform project decision-making. *Year 3:* Continue sub-grant program; convene sub-grantees at least once; use lessons from sub-grantees to inform project decision-making.	14 sub-grants to 12 grantees.	• The sub-grant program is ongoing. • Sub-grantees continue to report on activities and progress. • All sub-grantees convened in Montpelier on May 27, 2015, for a Symposium.
Sub-Grant Program – Technical Assistance *Year 2:* Provide technical assistance to sub-grantees as requested by sub-grantees. *Year 3:* Provide technical assistance to sub-grantees as requested by sub-grantees.	5 technical assistors.	• Sub-grantee technical assistance contracts are executed; contractors are available for technical assistance as requested.
Regional Collaborations *Year 2:* Establish 14 regional collaborations, each including a Charter, governing body, and decision-making process. *Year 3:* TBD, dependent on Year 2 activities.	Establishing regional collaborations that unite Blueprint, ACO, and other local delivery organizational structures.	• Unified Regional Collaboratives are established in each of the State's 14 Health Service Areas.
Workforce – Care Management Inventory *Year 2:* Obtain snapshot of current care management activities, staffing, people served, and challenges. *Year 3:* N/A	Care Management Inventory Survey.	• Care Management Inventory Survey was administered in 2014. • Results were presented to the VHCIP Care Models & Care Management Work Group in February 2015.
Workforce – Demand Data Collection and Analysis *Year 2:* Obtain micro-simulation demand model to identify future workforce resource needs. *Year 3:* Perform micro-simulation demand models and use data for decision-making.	Demand data collection and analysis.	• An RFP for this work was released in January 2015; DVHA received 5 responses. DVHA expects to select a contractor in August 2015.
Workforce – Supply Data Collection and Analysis *Year 2:* Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan. *Year 3:* Use supply data to inform workforce planning.	Supply data collection and analysis.	• The Vermont Department of Health has hired additional staff to develop and administer surveys to accompany provider re-licensure applications, and perform analysis on licensure data and develop provider reports on various health care professions. • Results are expected in Summer 2015.

Health Data Infrastructure		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
Expand Connectivity to HIE – Gap Analyses *Year 2:* Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity of non-Meaningful Use(MU) providers. *Year 3:* Perform gap analyses related to quality measures for each payment program, as appropriate.	Gap analyses – Payment Model Measures, LTSS, and mental health providers.	• VHCIP HIE/HIT Work Group working with VITL and three ACOs to perform a gap analysis of member providers and their ability to contribute data for quality measures and analysis through the HIE. • VHCIP HIE/HIT Work Group received an LTSS Technology Assessment Report.
Expand Connectivity to HIE – Gap Remediation *Year 2:* Remediate data gaps that support payment model quality measures, as identified in gap analyses. *Year 3:* Remediate data gaps that support payment model quality measures, as identified in gap analyses.	Gap remediation for data elements that flow through the VHIE – Payment Model Measures, LTSS, and mental health providers.	• VITL contract in place to remediate gaps identified in ACO gap analysis to connect member providers and improve data quality for those providers. • The HIE/HIT Work Group is evaluating next steps based on the receipt of the LTSS Technology Assessment.
Expand Connectivity to HIE – Data Extracts from HIE *Year 2:* Develop tools to support data extracts from the HIE to analytic entities as necessary for provider and state use. *Year 3:* Develop tools to support data extracts from the HIE to analytic entities as necessary for provider and state use.	Data extracts from the HIE.	• Gateway for data feeds in place for OneCare Vermont; VITL contract in place to create a data feed for CHAC.
Improve Quality of Data Flowing into HIE *Year 2:* Engage in work flow improvement activities at provider practices to improve the quality of the data flowing into the VHIE. These will be identified in gap analyses and analytics. *Year 3:* Engage in work flow improvement activities at provider practices to improve the quality of the data flowing into the VHIE. These will be identified in gap analyses and analytics.	Data quality improvement.	• VITL contract in place includes a Terminology Services project to provide services to translate clinical data sets submitted to the HIE into standardized code sets. • VITL contract in place to work with providers and the ACOs to improve the quality of clinical data in the HIE for use in population health metrics within the Shared Savings Program. • Contracts with Vermont Care Network and VITL to improve data quality and work flows at Designated Mental Health Agencies.
Telehealth – Strategic Plan (Year 2 Only) *Year 2:* Develop Telehealth Strategic Plan.	Strategic plan.	• Contractor selected. • Telehealth Strategic Plan and draft Scope of Work for Telehealth Implementation RFP due to DVHA in July and on track for delivery on that date.
Telehealth – Implementation *Year 2:* Launch telehealth program as defined in Telehealth Strategic Plan. *Year 3:* Complete telehealth program.	Program implementation.	• Draft Scope of Work for Telehealth Implementation RFP due to DVHA in July. • RFP for pilot projects to be released later in Summer 2015; 12-month pilot period expected to begin in Fall 2015.
EMR Expansion *Year 2:* Implement EMRs for non-MU providers; explore non-EMR solutions for providers without EMRs.	Implement EMRs or EMR-type systems. (Could include a design component.)	• The VITL contract, Vermont Care Network contract, and ARIS Solutions contract support procurement of an EMR solution for five Specialized Service Agencies. • LTSS Technology Assessment Report identified non-MU providers that could be targeted for EMR

Year 3: Implement EMRs for non-Meaningful Use providers; explore non-EMR solutions for providers without EMRs.		expansion in Years 2 & 3. • VITL contract with the Department of Mental Health to support procurement of the EMR system for the State's new hospital.
Data Warehousing *Year 2:* Research data warehousing needs; develop cohesive strategy for warehousing solutions supporting practices in care transformation; identify solutions for data registry and warehousing needs; implement solutions approved by the HIE/HIT Work Group according to timelines developed in design phase. *Year 3:* Research data warehousing needs; develop cohesive strategy for warehousing solutions supporting practices in care transformation; design solutions for data registry and warehousing needs; implement solutions according to timelines developed in design phase	Design and implement data registries and warehouses.	• Vermont Care Network is working on behalf of DA & SSAs to develop a behavioral health-specific data repository, which will to aggregate, analyze, and improve the quality of the data stored within the repository and to share extracts with appropriate entities. • More work to come later in 2015.
Care Management Tools *Year 2:* Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development. *Year 3:* TBD based on Year 2.	Discovery, design, and implementation of care management tools.	• Contractor performed discovery and drafted a Universal Transfer Protocol charter in 2014 and early 2015. • Integrated Care Management Learning Collaborative Cohort 1 communities requested shared care planning tools. • Universal Transfer Protocol and Shared Care Plan projects have merged. New project, SCÜP, currently in discovery and design phase.
General Health Data – Data Inventory *Year 2:* Conduct data inventory. *Year 3:* TBD.	Data inventory.	• Contractor selected and contract executed; work on hold pending federal approval. • Work on data inventory is nearly complete.
General Health Data – HIE Planning *Year 2:* Identify HIE connectivity targets; provide input into HIT Plan. *Year 3:* TBD.	HIE planning.	• Contractor selected; pending federal approval.
General Health Data – Expert Support *Year 2:* Procure appropriate IT-specific support to further health data initiatives. *Year 3:* Procure appropriate IT-specific support to further health data initiatives.	Engage Enterprise Architects, Project Managers, Business Analysts, and Subject-Matter Experts as needed.	• IT-specific support to be engaged as needed. • Enterprise Architect, Business Analyst and Subject Matter Experts identified to support the design phase of SCÜP.

Evaluation		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
Self-Evaluation Plan and Execution *Year 2:* Design Self-Evaluation Plan; engage in Year 2 activities as identified in the plan. *Year 3:* Engage in Year 3 activities as identified in the Self-Evaluation Plan.	Design and implement Self-Evaluation Plan.	• Self-evaluation contractor selected. • Draft self-evaluation plan submitted to Core Team and GMCB in June 2015. On track for final plan by 6/30/15.
Surveys *Year 2:* Conduct annual patient experience survey and other surveys as identified in payment model development. *Year 3:* Conduct annual patient experience survey and other surveys as identified in payment model development.	Patient experience surveys and others.	• Patient experience surveys for the patient-centered medical home and shared savings program fielded for 2014. Anticipate fielding Patient experience surveys annually for these programs.
Monitoring and Evaluation Activities Within Payment Programs *Year 2:* Conduct analyses as required by payers related to specific payment models. *Year 3:* Conduct analyses as required by payers related to specific payment models.	Monitoring by payer and by program to support program modifications.	• Ongoing monitoring and evaluation by SOV staff and contractors occurring as needed.

General Program Management		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
Project Management and Reporting – Project Organization *Year 2:* Ensure project is organized. *Year 3:* Ensure project is organized.	Project organization.	• Project management contract in place to support project organization and reporting.
Project Management and Reporting – Communication and Outreach *Year 2:* Engage stakeholders in project focus areas. *Year 3:* Engage stakeholders in project focus areas.	Communication and outreach.	• Contractor selected; presented to VHCIP in Spring 2015; work on hold pending federal contract approval.

VERMONT

Vermont Health Care Innovation Project

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Montpelier, VT 05609
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Wrap-Up Notes: June 2015 VHCIP Project-Wide Convening

Persistent Questions and Thoughts:

1. Sustainability.
2. How to share learnings across transformation activities.
3. What happens after SIM?
4. The pace of change is hard and there is a lot to accomplish.

Challenges:

1. The timeframe.
2. Clarity around some milestones from CMMI.
3. It is hard to connect the dots between different systems of care.
4. We need to make care delivery changes 'the norm'.
5. We need communications supports across care settings.
6. We need coordination of data systems.
7. Providers need to see we are building on previous work.
8. There should be one way for providers to access information.
9. Cost- especially of care delivery systems and health data infrastructure.
10. There are so many health data projects- when can we see the forest through these trees?
11. Some regulations and laws, across all of the topics, pose challenges (i.e., 42 CFR Part 2 and licensure).
12. Data needs to be useful.

Opportunities:

Payment Models:

1. Count who we aren't counting.
2. Review attribution methodologies in Blueprint and SSP.
3. Get clarity on denominator.
4. Expand within existing programs (self-funded as a target).
5. EOCs- populations not otherwise impacted.
6. Identify who we are missing.

Care Delivery:

1. Connect all activities in this area.
2. Lots of progress, but need shared learnings to be disseminated better.
    a. Use to explain what we do in the future.
3. Flexible funding is key for care management.
4. Better use workforce levers and connect to skills and curricula.
5. Include students in learning collaboratives.
6. Expansion beyond initial population.
7. Well positioned to go from UCC to AHC.

Health Data Infrastructure:

1. Providers really want to share information.
2. Enforce existing connectivity criteria.
3. Need to know where we are (who is left to connect?).
4. Improve data quality through provider training- impacts measures.
5. Feedback data (sniff test) to providers.
6. Sharing info about data systems and goals.
7. Collect and transmit high quality data.
8. Regional approaches.

Achieving the Triple Aim in Vermont

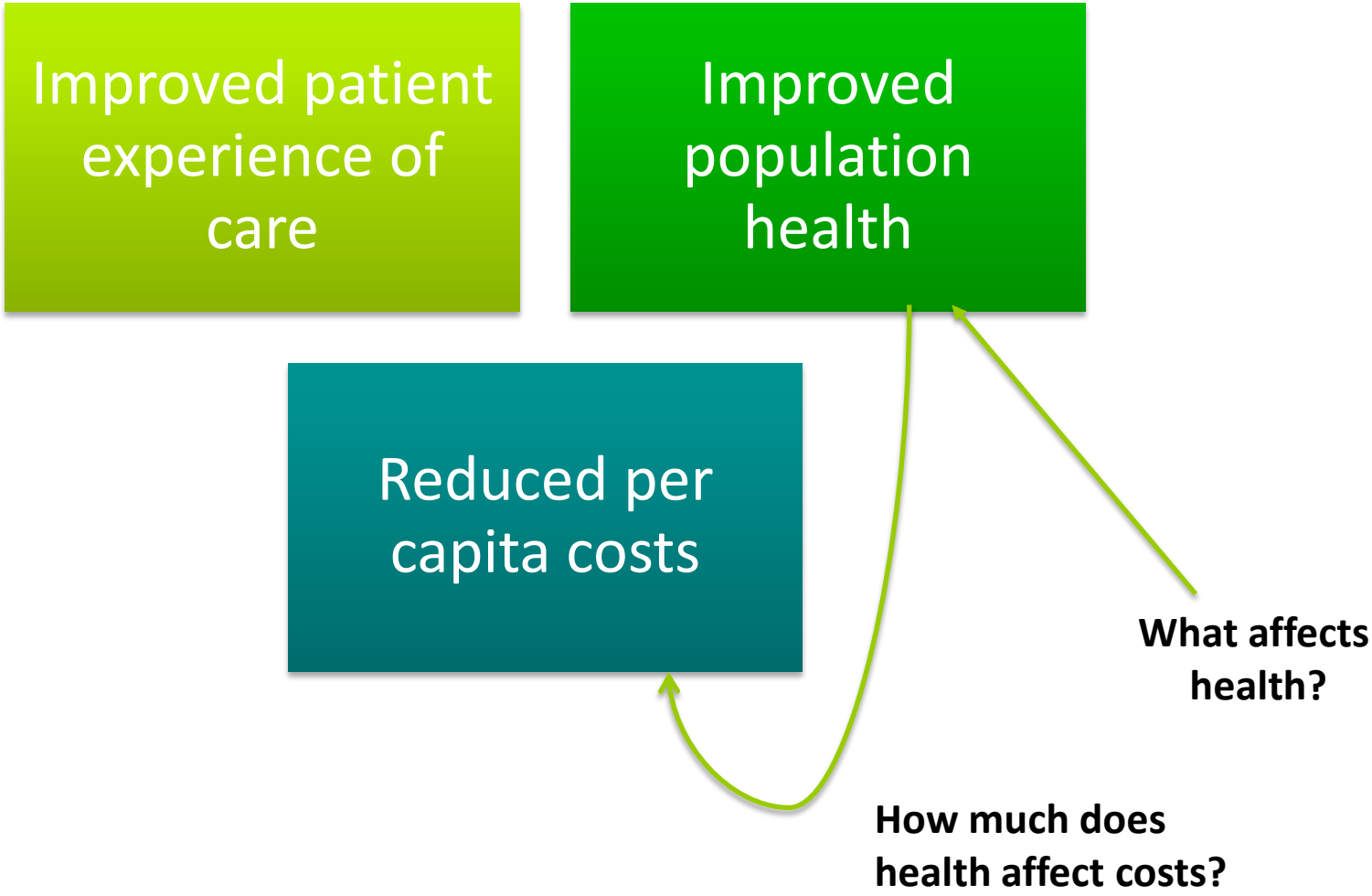
QPM Work Group

Lawrence Miller, Chief of Health Care Reform, Governor's Office

June 22, 2015

Vermont Health Care Innovation Project

Goal: Achieve the Triple Aim



Vermont's Delivery Reform Goals

Vermont Health Care Innovation Project (SIM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and coordination and support provider transformation (Care Delivery)
- **Develop** a health information system that supports improved care and measurement of value (Health Data Infrastructure)

All Payer Model (APM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and better coordinate care for Vermonters (Care Delivery)
- **Sustain** a health information system that supports the triple aim (Health Data Infrastructure)
- **Create** a sustainable growth trend for Vermonters while ensuring high quality care

Achieving Multi-Payer Payment and Delivery System Reforms: *5 Components for Success*

- **Payment Models**
  - Financial and quality measurement (payer side)
- **Care Delivery**
  - Practice transformation (provider side)
- **Health Data Infrastructure**
  - Information to make it all work (provider, payer, and state)
- **Evaluation**
  - Determine what is working (state side)
- **Federal Waivers & Funding**
  - Regulatory flexibility through the Global Commitment Medicaid waiver and All Payer Model Agreement
  - All Payer Model Implementation funding through the State Innovation Model Testing Grant (SIM)

Payment Models: *Programs*

- **Blueprint for Health**, Advanced Practice Medical Homes and Community Health Teams
  - Multi-Payer Advanced Primary Care Practice (MAPCP) & Medicaid Health Home (opiate addiction).
  - Implemented capitated payments to housing authorities for Support and Services at Home (SASH) as part of MAPCP.
  - Adding a pay for performance payment that ties a portion of medical home payment to service area outcomes (community interdependencies).
  - Payment and Quality measurement aligned across payers & creates a framework for All Payer Model primary care components.
- **Shared Savings Programs with ACOs**
  - Implemented for Medicare and commercial payers.
  - Medicaid program implemented with state plan amendment pending.
  - Quality Measurement largely aligned across payers.
  - "Training Wheels" for providers to get ready for capitation under APM.
- **Episodes of Care/Bundled Payments**
  - In design phase through VHCIP.
  - Low risk method to identify inefficiencies in the health care system, in particular around specialty care.

Care Delivery: *Programs*

- **Blueprint for Health**
  - Practice Transformation
    - State staff and contract assistance for practice transformation funded through Global Commitment and other state funding.
    - Provides practice facilitation to assist primary care practices with NCQA certification and enables medical homes to change operations on the ground to improve quality and reduce costs.
  - Community Health Teams
    - Provide care coordination and wrap-around support for advance practices funded through Global Commitment and other state funding.
    - Includes Medicaid care coordination staff on team.
  - Regional Planning Teams
    - integrated and used as the ACO regional teams.
    - Directs resources at the community level.

Care Delivery: *Programs*

- **Accountable Care Organizations**
  - Key, provider led organizational component for care delivery.
  - Integrate care beyond primary care, establish regional priorities.
  - Infrastructure funding through VHCIP.
  - Likely to become key organizations in APM.
- **Learning Collaboratives**
  - Provides a forum for sharing information among health care providers in order to ensure readiness for payment reform and to promote change at the service delivery level.
  - Organized and funded through VHCIP.
  - Assists with provider readiness for capitation through the APM.

Care Delivery: *Programs*

- **Provider Transformation Sub-Grants**
  - Funding through VHCIP to promote innovative delivery or payment reforms at the health care provider level.
  - Encourages transformation in care delivery and determines models which may be scaled or shared with other providers.
  - Assists with provider readiness prior to capitation through the APM.

Health Data Infrastructure Investments

- **Clinical data –** *providers need information in a usable format in order to create efficiencies and reduce utilization.*
  - **Blueprint for Health Clinical Data Registry** – funded through Global Commitment and other state funding.
  - **Health Information Exchange (VITL)**--funding from multiple sources, including SIM, to create interoperability between electronic medical records and to provide access to high quality clinical information between providers through *VITLAccess.*
  - **Shared Care Plans/Transfer protocols**—design funded through SIM.
  - **Event notification system** -- design and implementation funded through SIM.
- **Claims data –** *the state, providers, and payers need utilization and expenditure for health system planning and regulation.*
  - **VHCURES** –funded through Global Commitment and other state funding.
- **Survey data –** *providers and others need to understand what patients are experiencing in order to ensure quality and access are not compromised.*
  - **Numerous including Patient Experience Surveys**– funded through SIM, Global Commitment, and other state and federal funding.

Evaluation

- **Vermont Health Care Innovation Project**
  - Ongoing quality measurement & evaluation of specific components of the project.
  - Facilitate: a regular, robust reporting to CMMI; inform the need to adjust implementation activities as needed to maximize project impact; provide a rigorous, empirical basis for recommendations to scale-up and broadly diffuse VHCIP initiatives.
- **Blueprint for Health**
  - On-going quality measurement & evaluation of the program interventions on cost impacts.
  - Recent Medicare evaluation shows model is one of most successful in MAPCP program.
  - For more information see the Blueprint for Health Annual Report
    - http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/VTBlueprintforHealthAnnualReport2014_Final.2015.01.26.pdf

Federal Waivers and Funding

- Global Commitment to Health Waiver
  - An 1115 Medicaid waiver that:
    - Creates a public managed care entity with flexibility and funding to support the health of Vermont's Medicaid beneficiaries.
      - Must comply with Medicaid Managed Care regulations
    - Creates flexible eligibility for long-term services and supports to allow access to home and community based services on the same basis as nursing home care.
- State Innovation Model Grant
  - Testing grant to provide funding for payment and delivery reform innovations.
- All Payer Model Agreement
  - See next slides!

What is an all-payer model?

- A system of health care provider payment under which all payers – Medicare, Medicaid and commercial insurers such as Blue Cross and Blue Shield – pay doctors, hospitals and other health care providers on a consistent basis, within rules prescribed by a state or national government
- Can be used to promote desirable outcomes and reduce or eliminate cost-shifting between payers
- In the U.S., the only example of an all-payer model is in Maryland (currently only for hospital payments)
- A number of other countries use all-payer systems to assure that provider payments are fair, transparent and consistent with desired policies such as promoting primary care, prevention, quality of care and cost containment

Why an All Payer Model as the next evolution?

- The all-payer model/system will encourage providers to strengthen their relationships with patients and better coordinate care for Vermonters.
- The system will have incentives to promote health and support Vermonters in choosing healthier behaviors.
- The system will allow Vermonters to better understand the total and out-of-pocket costs they face and the quality of the services they receive.
- The system will ensure treatment is done is the least costly setting and that patients are engaged in their health care and health outcomes.

Implementing an All Payer Model

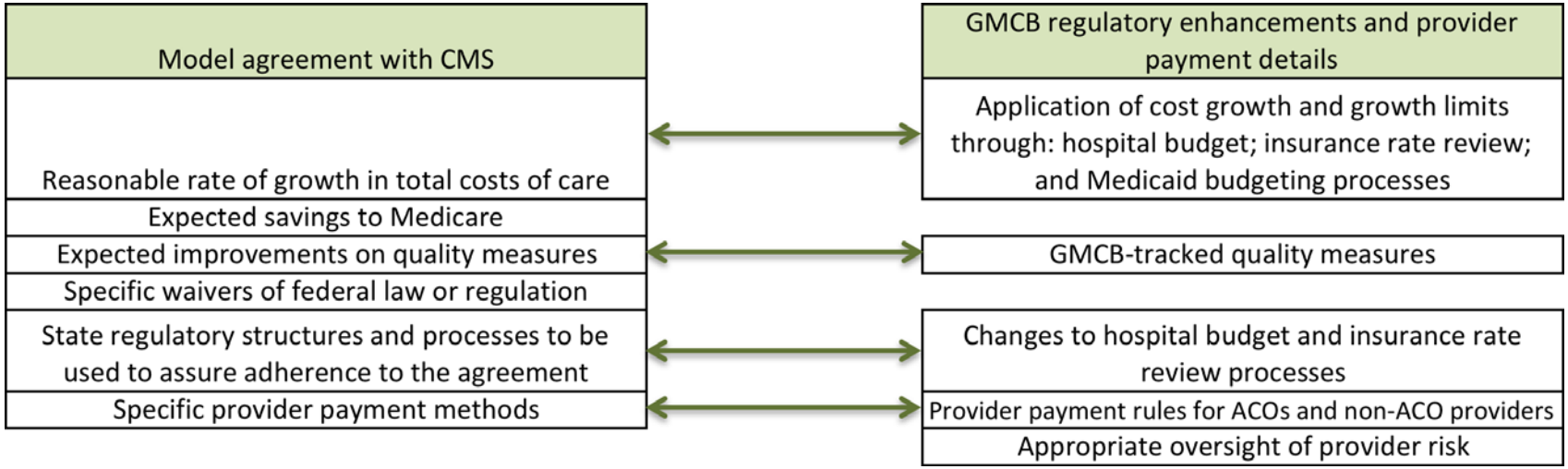
- Create a rate-setting agency at GMCB, which allows for regulation across all payers and which provides cost control while improving quality.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
  - APM agreement and GC create the base, trend, and savings targets.
- Evolve payment methodologies from payment models implemented by payers and supported by Blueprint & SIM grant.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
- Evolve quality measures from payment models implemented by payers and supported by Blueprint & SIM grant.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.

One project, two major components

Vermont All-Payer Model Project Structure and Responsibilities		
	Model agreement with CMS	GMCB regulatory enhancements and provider payment details
Purpose	To establish the parameters of an agreement with the federal government that would permit Medicare inclusion in a Vermont all-payer system	To establish the specific rules and processes governing provider payment, ACO oversight and all-payer oversight
Lead agency(ies)	GMCB and AOA	GMCB
Coordinating agencies	AHS	DFR, AHS, AOA

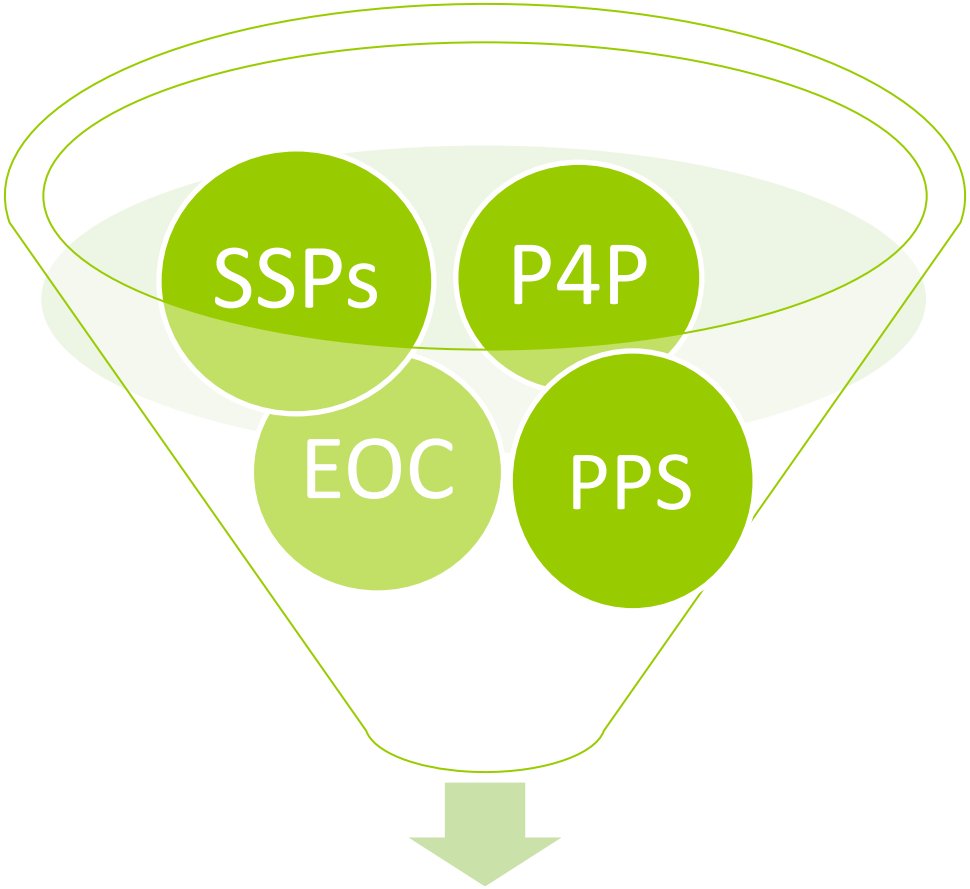
Related processes
Legislative oversight: Regulatory and Medicaid budgets
Administrative rules process

Examples of technical issues to be addressed in each process, and inter-relationship between them



All-Payer Model: Payment Models

- **Builds on reforms:**



All-Payer Model

Vermont Health Care Innovation Project

All Payer Model: Care Delivery

- **Builds on reforms by:**
  - Ensuring more providers, including DLTSS providers, are ready to take accountability for cost and quality over time.
  - Creating provider readiness for capitation prior to implementation to ensure that patient access and quality of care is not compromised.
  - Enabling providers to change operations on the ground, so savings do not compromise quality of care, patient experience, or access to care.

All Payer Model: Health Data Infrastructure

- **Use current investments and continue to build infrastructure over time by:**
  - Continuing to build an interoperable health data infrastructure for clinical decision-making to ensure provider community is ready to take accountability for cost and quality prior to implementation of rate-setting and capitation.
  - Building infrastructure across more provider types, such as DLTSS, over time.
  - Using and continuing to refine the data infrastructure necessary for quality reporting after capitation.
  - Reducing duplication in reporting and simplifying, where possible.
  - Demonstrating reliable information in order to build trust by providers in the data provided and to ensure it is used by providers to create efficiencies.

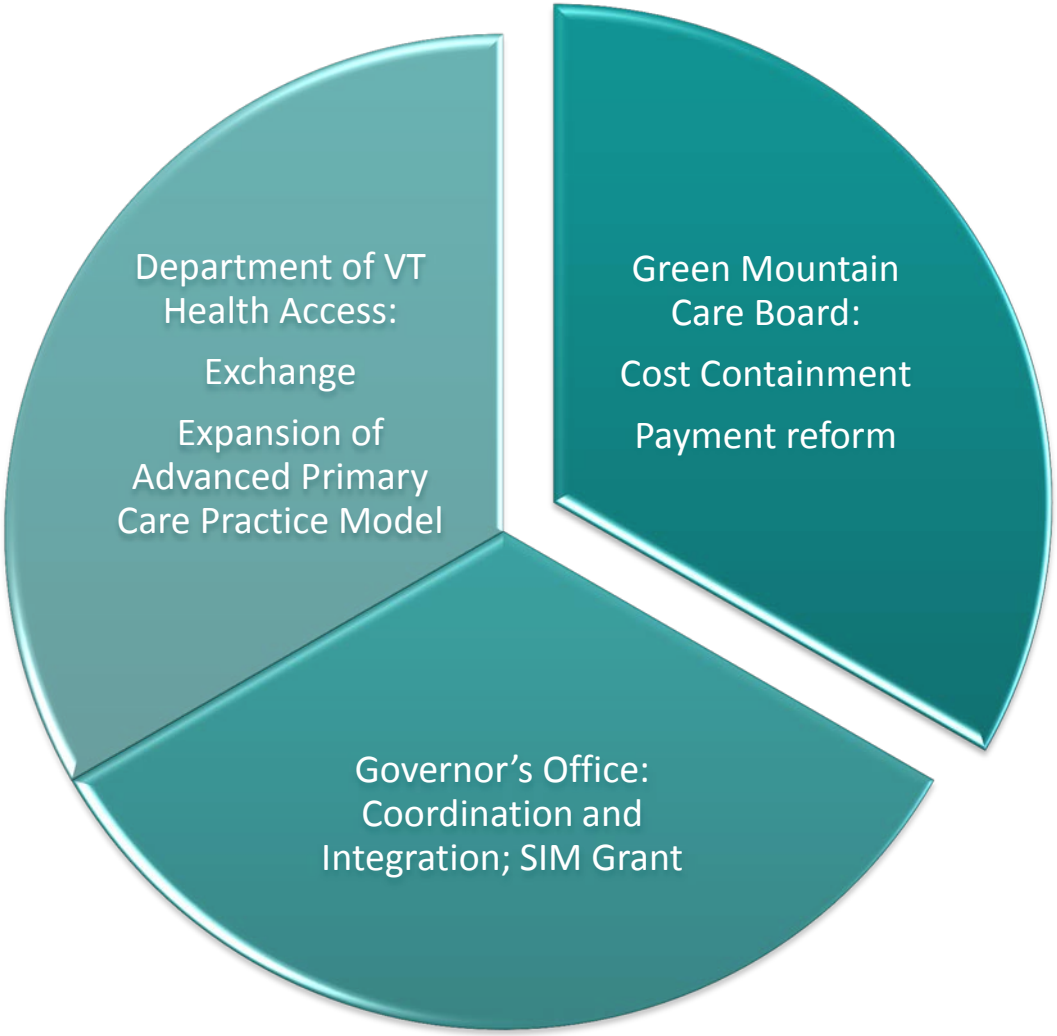
CMMI Site Visit

July 23, 2015

Vermont Health Care Innovation Project

INTRODUCTIONS

Who does what in Vermont health reform?



Vermont Health Care Innovation Project

Vermont's Health Reform Plan

Act 48 of 2011
Path to move away from FFS
Promotes Integrated Delivery System

Green Mountain Care Board
Facilitates payment and delivery reforms
Regulates health care system with budget targets
Evaluates system and reform efforts

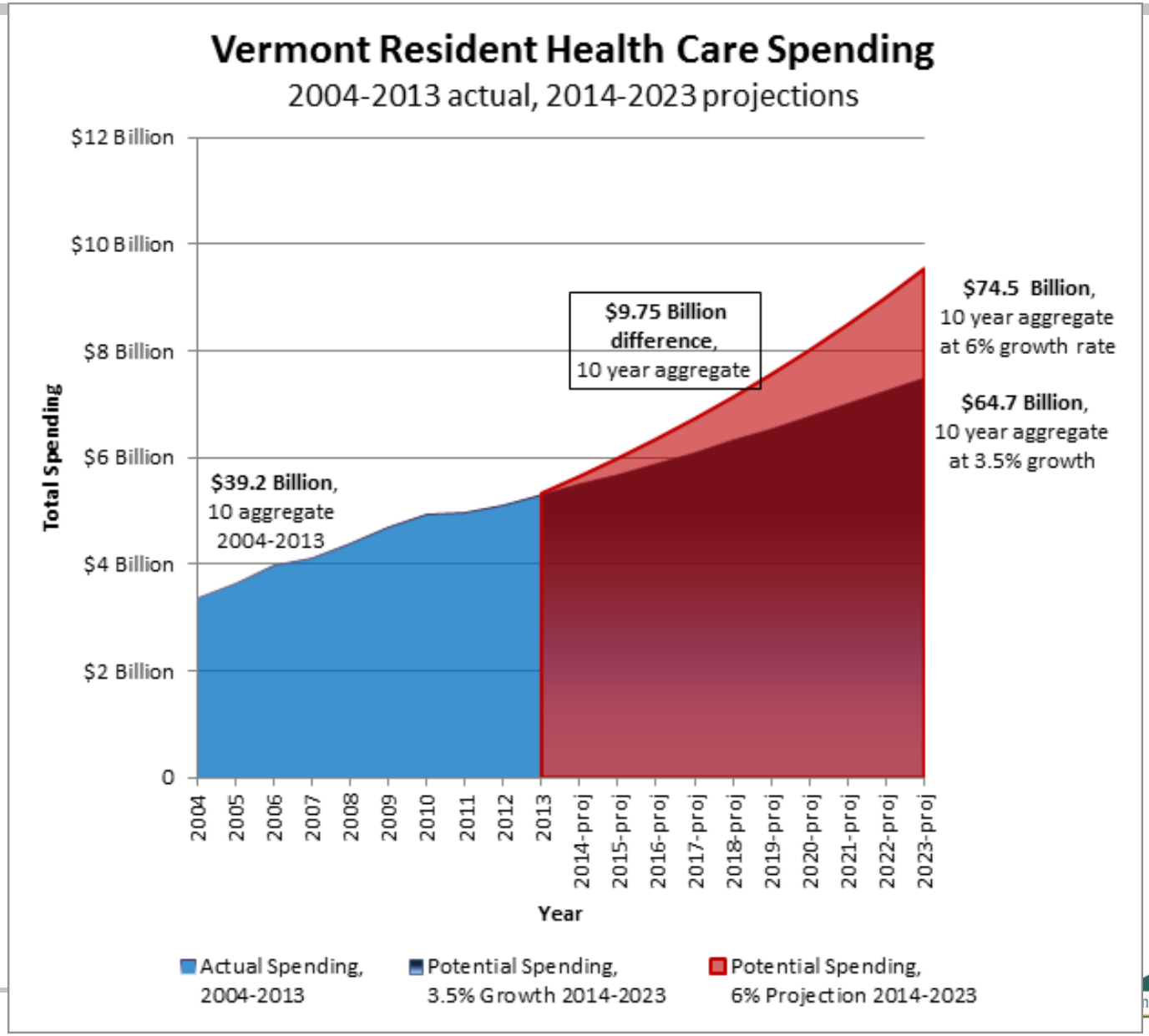
Agency of Human Services
Implements payment and delivery reforms in Medicaid
Manages Medicaid 1115 waiver

State Innovation Model Grant
Supports payment and delivery reforms

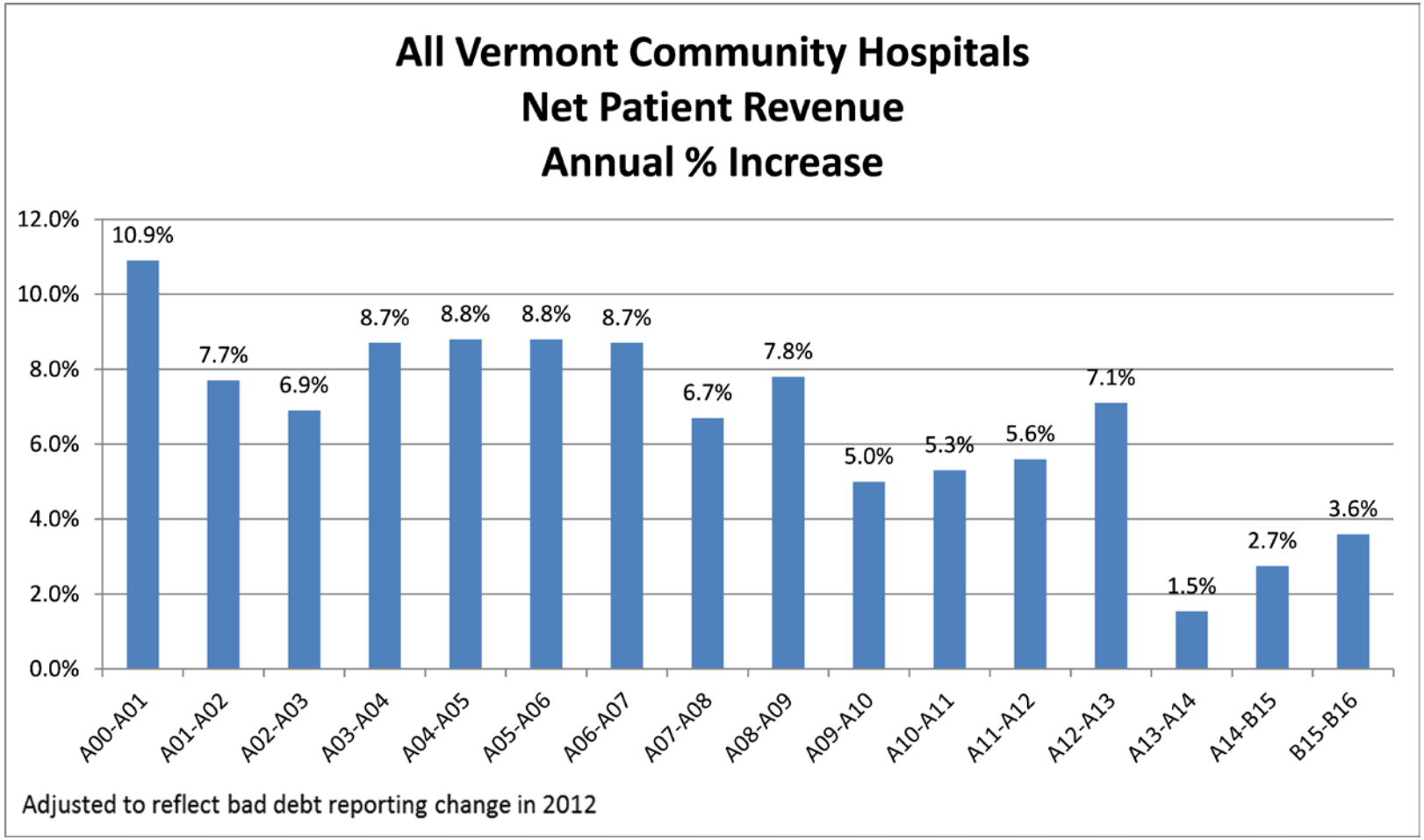
Innovation support better equips providers to meet budget targets

OVERVIEW: VERMONT PAYMENT & DELIVERY SYSTEM REFORM

The Problem: Health Care Costs growing faster than overall inflation



Net Patient Revenue for Vermont Hospitals



Vermont Health Care Innovation Project

What would constitute SIM success?

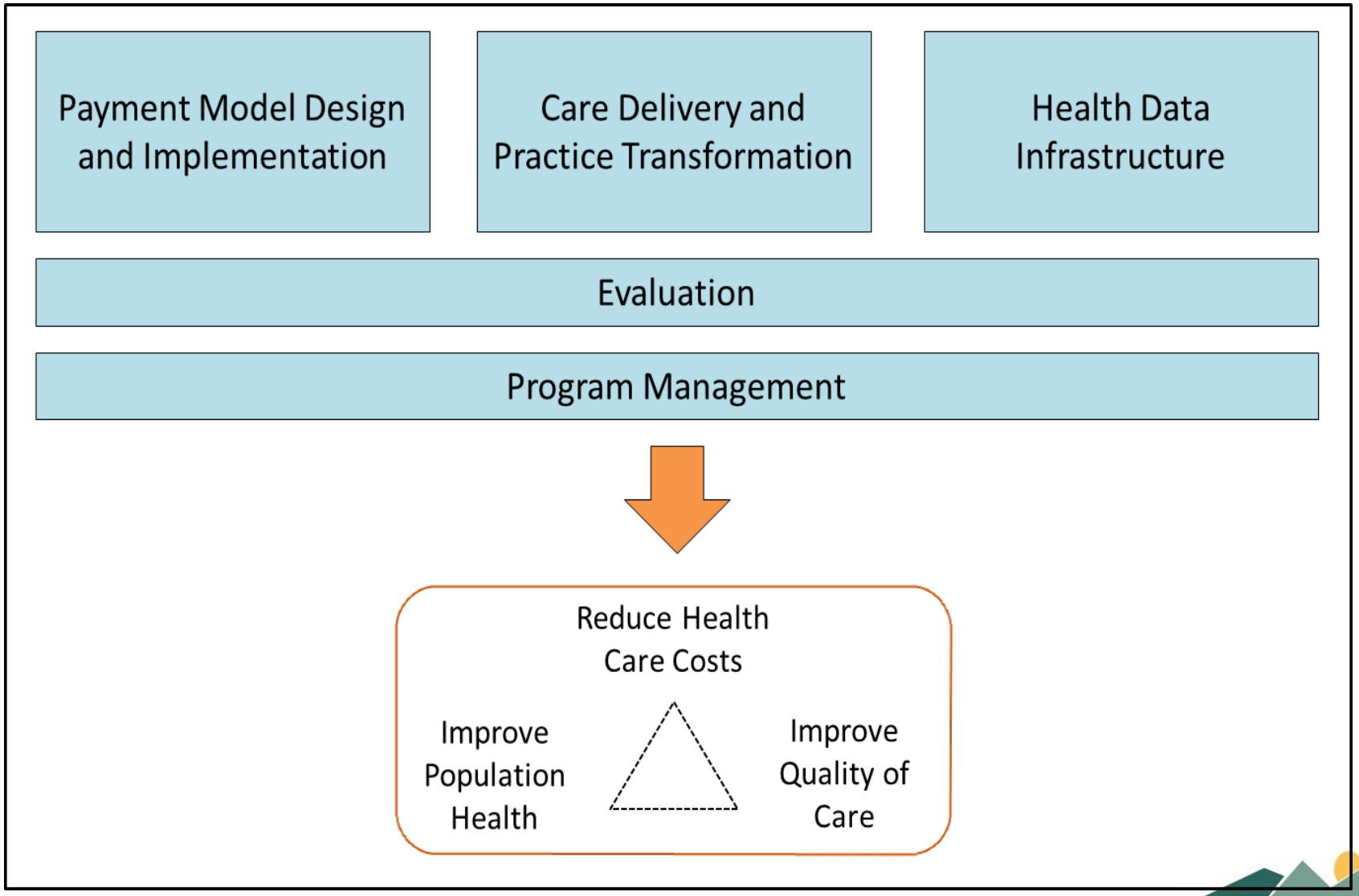
A health information technology and health information exchange system that works, that providers use, and that produces analytics to support the best care management possible.

A predominance of payment models that reward better value.

A system of care management that is agreed to by all payers and providers that:

- Utilizes advanced primary care infrastructure to the greatest extent possible
- fills gaps
- eliminates duplication of effort
- creates clear protocols for providers
- reduces confusion and improves the care experience for patients
- follows best practices

Vermont's SIM Focus Areas and Goal:



Vermont Health Care Innovation Project

Snapshot of SIM Payment Model Impacts

		Q1 2015
Beneficiaries Impacted	Commercial SSP*	40,232
	Medicaid SSP*	52,177
	Medicare SSP*	61,560
	Commercial Blueprint (APMH/P4P)	111,529
	Medicaid Blueprint (APMH/P4P)	106,818
	Medicare Blueprint (APMH/P4P)	67,621
	Medicaid Health Home	2,706
Participating Providers	Medicare, Medicaid, Commercial SSPs	977
	Blueprint (APMH/P4P)	694
	Medicaid Health Home	123
Provider Organizations	Medicare, Medicaid, Commercial SSPs	83
	Blueprint (APMH/P4P)	63
	Medicaid Health Home	5

*All SSP impact numbers reflect Q2

Snapshot of SIM Care Delivery & Health Data Infrastructure Impacts

	Impact
Health Data Infrastructure	400 Providers
Care Delivery & Practice Transformation: Learning Collaboratives	420 Providers
Care Delivery & Practice Transformation: Subgrantee Program	692 Providers 281,808 Vermonters

SIM Investment 2013

Test Payment Models
- All-payer ACO SSPs
- All-payer P4P for medical homes
- Episodes of Care
- Medicaid VBP
- Accountable Communities for Health

Transform Care Delivery
- Learning Collaboratives
- Provider Sub-Grants
- Regional Collaborations
- Workforce Analyses

Health Data Infrastructure
- Provider connectivity to VHIE (high quality data)
- Care Management tools
- Telehealth strategy
- Data warehousing

Evaluation
- Finding out what works over short term and medium term through plan and M&E

SIM Results 2017+

More Value Based Payment
- 80% of VT population in alternative payment models
- Improved health

Created a Learning Culture for Providers and Payers
- Majority of providers participated in learning or regional collaborative or sub-grant program
- Providers can use data for quality improvement

Enhanced Data Infrastructure
- Majority of providers send, receive, and use high quality data
- Coordinating strategic planning:
  - Data warehousing
  - telehealth

All-Payer Model

Cost and Quality Targets
-Medicare savings
-VT savings compared to economic growth

All –Payer Rate Setting
- GMCB regulates all payers and providers
- GMCB sets system wide quality goals
- Setting the stage for capitated payment

Attachment 3

Telehealth Strategy

Telehealth Strategy

Georgia Maheras

August 26, 2015

Today's Objective

Approval of Strategy based on feedback received- THANK YOU!

Principles/Goals of the Strategy

- Patient-centeredness such that telehealth meets the needs of patients wherever and whenever the needs arise for care, health, and well-being;
- Improved access to care where access may be limited by geography, service limitations, and personal limitations;
- Measurable outcomes that will demonstrate improvements in patient engagement, quality of care, and costs;
- Interoperability such that the clinical data generated through telehealth encounters can be exchanged and ingested by other types of health information technologies;
- Alignment with currently active telehealth programs including but not limited to interactive audiovisual programs in support of teleconsultation with patients and between clinicians, any store and forward efforts currently underway, existing remote monitoring programs, and e-visits; and
- Alignment with other statewide provider initiatives related to value based payment reform.

Strategy Elements

- Creation or designation of a coordination body to support expansion of telehealth services that promote patient-centered care and health care reform.
- State policies align telehealth initiatives and planning with the goals of health reform and maintain a patient-centered approach to care.
- Telehealth technologies can be used easily and incorporate interoperability and security standards such that data and information can flow through Vermont's health information exchange either directly or through provider electronic medical record systems throughout the state.
- Resources are available to engage clinician interest in and adoption of telehealth products and services, and to provide ongoing support for the effective and efficient implementation of those products and services to the benefit of patients.

Attachment 4

Funding Proposals

Financial Proposals

August 26, 2015

Georgia Maheras, JD

Project Director

AGENDA

1. HIE/HIT Work Group: Telehealth Pilots

CMCM Work Group: Integrated Communities Care Management Learning Collaborative Expansion

- Request from the Work Group: Recommend approval of draft RFP scope with revisions specified by HIE/HIT Work Group.
  - Project timeline: 12-month pilot period (est. November 1, 2015-October 31, 2016) with 2-month evaluation period
  - Project estimated cost: $155,000
  - Project Summary: One or more telehealth pilots to provide coordination of telehealth strategies that align with Vermont's payment and delivery system reform goals.
  - Budget line item: *Technology and Infrastructure*: Telemedicine
- The HIE/HIT Work Group is responsible for exploring and recommending technology solutions to achieve SIM's desired outcomes.

Scope of Work

- Grantees will participate in DVHA-required meetings, submit quarterly reports, provide budget and spending reports, create a final evaluation report, and present to VHCIP Work Groups, Steering Committee, and Core Team.
- RFP is open-ended to encourage innovative proposals and allow for a variety of responses; however, all respondents must:
  - Demonstrate alignment with elements and principles of Vermont's Statewide Telehealth Strategy;
  - Describe plans for engaging users (provider and patient) and partners in telehealth activities;
  - Describe whether and how they will procure and implement telehealth technology (if applicable);
  - Demonstrate project management capabilities;
  - Describe evaluation plans; and
  - Discuss sustainability and scalability.

For Steering Committee Consideration

- Is the recommendation consistent with the goals and objectives of the grant?
- *Yes. VHCIP's Operational Plan outlines the following tasks:*

HIE/HIT Work Group

This group will build on the work of the work group to date and:

- Identify the desired characteristics and functions of a high-performing statewide information technology system;
- Explore and recommend technology solutions to achieve VHCIP's desired outcomes;
- Develop criteria for a telehealth pilot program and launch that program;
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
  - Support for enhancements to EHRs and other source data systems;
  - Expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers;
  - Implementation of and/or enhancements to data repositories; and
  - Development of advanced analytics and reporting systems.

For Steering Committee Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No.
- Has the recommendation been reviewed by all appropriate Work Groups?
  - The HIE/HIT Work Group reviewed the proposal and voted unanimously to approve the RFP scope pending revisions to add interoperability specifications and a question on accessibility for people with disabilities.

Draft Draft Draft

State of Vermont Request for Proposals:
Vermont Health Care Innovation Project Telehealth Pilot Projects

The Department of Vermont Health Access (hereafter referred to as DVHA) invites the submission of proposals for telehealth pilot projects that improve care integration and coordination; increase individuals' access to and engagement in their care; expand system capacity; and achieve efficiencies in health care delivery. Proposed projects should be innovative, scalable, replicable, align with Vermont's State Innovation Model (SIM) grant purposes, and support the Triple Aim of better health, better care, and lower costs.

Background

Vermont's health reform reimbursement strategy is designed to reward providers for the value of care rather than the volume of services rendered as its multiple payers move to these alternative to fee-for-service payment approaches. In order to enable telehealth support for this transition, DVHA directed the formation of a Telehealth Steering Committee, reporting to the HIE/HIT Work Group, to guide the development of a coordinated state-wide telehealth strategy that aligns with the state-wide reimbursement strategy and the subsequent funding of pilot projects to implement part of that strategy.

In this context, telehealth is defined as the HIPAA-compliant use of health information communicated from one site to another electronically to provide care and/or improve a person's health and well-being. As such, telehealth refers to a broad application of technologies to facilitate health care delivery and health management as well as improve access to care and patient health. In addition to telehealth technologies that are used for educational and administrative purposes, telehealth products and services include applications that collect and transmit patient information, clinical services that provide health care remotely through means such as secure video conferencing, and patient engagement tools such as remote monitoring devices.

Specific components and types of telehealth use that have been identified include:

- Interactive real time audio-visual technologies that can be used outside health system facilities, with an emphasis on interoperability of data and information;
- Store and forward technologies;
- Tele-monitoring, also known as remote monitoring, using devices that assess multiple physiological parameters; and
- Technologies that support tele-education through interactive case/problem presentations involving multiple participants.

DVHA seeks pilot projects that can address a variety of geographical areas, telehealth approaches and settings, and patient populations over a 12-month time period. We are specifically seeking organizations that can provide coordination of telehealth strategies that comport with Vermont's payment and delivery system reform goals. This RFP's primary purpose is to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the state of Vermont. Successful proposals must demonstrate how they align with the health reform efforts currently being implemented as part of the SIM Grant process. As such they must describe how the project will coordinate its telehealth efforts with providers who are moving towards value based reimbursement and with other telehealth initiatives in order to leverage technology investment, align telehealth services at the provider level, monitor a consistent set of outcomes measures, and assure that any health data generated can be shared through the state's health information exchange.

Overall goals of these projects include:

- Coordinated telehealth programs and initiatives that align with the evolving landscape of value based reimbursement and can scale statewide;
- Better access to care and services and better care experiences for patients, especially those with higher risk of poor health outcomes;
- Better health outcomes; and
- Lower costs.

Eligible Applicants

This opportunity is open broadly to proposals from Vermont-based organizations with the capacity and ability to perform the tasks outlined. Applicants may be not-for-profit, or for profit. Technology vendors are not eligible to apply. Preference will be given to proposals that pilot infrastructure, technology, coordination, and approaches beyond expansion of existing programs to a wider audience. Projects that only focus on upgrading existing equipment will not be considered.

Project Period

DVHA anticipates awarding Telehealth Pilot Program grant funds to one or more projects. The project period is 12 months, starting November 1, 2015, and ending October 31, 2016. Grantees will then have two months to compile their final evaluation report (due December 31, 2016).

Grantee Requirements

Grantees will be required to:

- Take part in periodic telephone and on-site meetings with DVHA representatives and other grantees, if applicable;
- Report quarterly on agreed upon indicators using a DVHA-developed template;
- Compile qualitative and quantitative project results for a final evaluation report, which will be publically available;

- Provide budget and spending reports at the request of DVHA; and
- Create a presentation on their project and present to the Vermont Health Care Innovation Project HIE/HIT Work Group, Steering Committee, and other VHCIP groups during the project period and following the close of the project period as requested.

Statement of Work

I. Executive Summary

Provide a brief summary of the proposed project that includes the following

A. The goals of the proposed project.
B. The proposed project intervention.
C. The proposed population that will be served.
D. The actual users of the telehealth technology.
E. How the proposed project aligns with Vermont's value based payment reform efforts.
F. Why your organization is particularly qualified to conduct the project.

II. Project Tasks/Requirements

In order to expedite both the crafting of the pilot project proposals and DVHA's evaluation, we are presenting a series of requirements in outline format. Please complete all responses using this outline.

A. Project alignment with the elements of Vermont's statewide telehealth strategy. Please describe how the proposed pilot would align with the following telehealth strategy elements:

1. Coordination with other telehealth programs and projects across the state;
2. Migration to or use of cloud based or wireless technologies;
3. Support for Vermont's health and payment reform efforts and programs;
4. Informational support for statewide policy with respect to telehealth.

B. Project alignment with strategy principles. The Vermont Telehealth Strategy includes a set of principles to guide the development of the pilot projects. Please describe how the proposed pilot meets the intent of the following principles:

1. Patient-centeredness such that telehealth meets the needs of patients wherever and whenever the needs arise for care, health, and well-being;
2. Improved access to care where access may be limited by geography, service limitations, and personal limitations;
3. Measurable outcomes that will demonstrate improvements in patient engagement, quality of care, and costs;
4. Interoperability such that the clinical data generated through telehealth encounters can be exchanged and ingested by other types of health information technologies;
5. Alignment with currently active telehealth programs including but not limited to interactive audiovisual programs in support of teleconsultation with patients and between clinicians, any store and forward efforts currently underway, existing remote monitoring programs, and e-visits; and
6. Alignment with other statewide provider initiatives related to value based payment reform.

C. User engagement. There are a number of challenges that telehealth programs must face related to both provider and patient/consumer engagement. Please describe how you intend to meet the following challenges:

1. Recruiting primary care clinicians;
2. Recruiting specialty care clinicians;
3. Recruiting patients for whom the intervention is appropriate;
4. Identification of accepted guidelines for the use of telehealth and assurance that they are followed;
5. Incorporation of telehealth approaches into the workflow of busy clinicians;
6. Identification of organizations with whom partnering conserves resources in this area; and
7. Development of an incentive plan for clinicians who engage in telehealth in lieu of revenue generated by face to face encounters.

D. Procurement and implementation of scalable telehealth technology (if applicable). Depending on the scope of the proposed project, the bidder will leverage existing technology or procure new technology, and implement the telehealth technology where it is currently not in use or available. Please describe any proposed telehealth technology procurement and implementation:

1. Describe the type of technology that will support the pilot (e.g., stationary or cloud based interactive A-V, store and forward, remote monitoring, wearables, etc.);
2. Identify any technology in existing programs that will be used in the proposed pilot;
3. Describe how you intend to proceed with resource conservative procurement;
4. Describe how you will assure that the data generated by the technology used in the pilot can be shared/exchanged securely with other types of HIT such that it is as available as data generated from face to face encounters; and
5. Describe the extent to which the proposed technology is scalable across the state (and beyond).

E. Project management. Bidders must demonstrate the ability to manage the pilot project they are proposing with respect to available human resources and experience.

F. Project Evaluation. Please describe the proposed pilot's evaluation plan.

G. Sustainability and scalability. Funding from your project may come from sources other than this grant. If your funding is 100% grant dependent, you will need to develop a plan for sustainability after the funding has ended. The plan must take into account how the project can scale across Vermont.

Attachment 5

SCÜP Update

SCÜP Status Report & Checkpoint

(Shared Care Plans & Universal Transfer Protocol)

August 19, 2015

Vermont Health Care Innovation Project

SCÜP Project Status

Overview:

This project will provide a technological solution that supports Vermont's providers and caregivers in successfully navigating transitions between care settings.

Project Accomplishments:

- The project team has completed business requirements gathering sessions with three communities (Bennington, Rutland, & St. Johnsbury).
- The project team is close to finalization of the business requirements and is currently validating these requirements with the three participating communities.
- Review of the requirements of the MMIS Care Management implementation is in progress and nearing completion.
- The timeline has been necessarily condensed due to time lost on the availability of the Enterprise Architect & Business Analyst resources.

- **The project continues to be on-track for scope, schedule, and budget. Some milestones have been adjusted due to resource constraints.**

SCÜP Project Budget & Risk Status

Budget Update:

All work to date has been completed by current State and State affiliated resources. A professional business analyst has been hired and is funded through the Heath Services Enterprise. No additional resource is being requested at this time.

Risks:

RISK: The highest priority project risk at this time is the lack of Enterprise Architect resource availability. The project team has mitigated the risk by re-structuring and overlapping tasks and due dates as much as possible, while still being able to hit the target of completing the project by the first week of November. The Enterprise Architect is scheduled to be available in the coming weeks pending DII's approval.

RISK: The State and national technical assessment work has not seen the anticipated progress due to the technical resource's availability. The project team has reduced the scope of the technology assessments to ensure that there is adequate time to complete them and include recommendations in the technology proposal.

SCÜP Project Timeline Status

The SCÜP Project team will provide an additional checkpoint on October 21st. The Work Group will review and provide any approvals of the project:

1. **Identify SCÜP Project Team & Initial Outreach:** April, 2015 - **Complete**

2. **Develop Business Requirements:** May – July, 2015 - **In Progress**
   - **Project Kickoff - Complete**
   - **Extract business req. from UTP final report - Complete**
   - **Requirements gathering: 3 regions - Complete**
   - **Compile/refine requirements for 3 regions - Complete**
   - **Business requirements draft Complete**
   - **Validate draft w/ appropriate regions - In Progress - (8/27/15)**
   - **Business requirements finalized - In Progress - (9/1/15)**

3. **Develop Technical Requirements:** May – September, 2015 – **In Progress (Delayed)**
   - **Conduct National research on SCP & UTP - In Progress**
   - **Conduct State assessment of tech capabilities - In Progress (9/7/15)**
   - **Build tech reqs from business requirements – In Progress (9/8/15)**
   - **Tech requirements draft (9/16/15)**
   - **Validate draft w/ appropriate regions** (9/30/15)
   - **Tech requirements finalized (10/8/15)**

4. **Technology Proposal:** August – October, 2015
   - **Integrate technology assessment with business & technology requirements (10/15/15)**
   - **Technology proposal draft (10/23/15)**
   - **Validate draft w/ appropriate regions (10/30/15)**
   - **Technology proposal finalized (11/6/15)**

For Steering Committee Consideration

- Is the recommendation consistent with the goals and objectives of the grant?
  - This recommendation is consistent with the following goals and objectives of the grant (outlined in the Operational Plan):
    - To create a health information network that supports the best possible care management and assessment of cost and quality outcomes, and informs opportunities to improve care; and
    - To create commitment to change and synergy between public and private culture, policies and behavior.

For Steering Committee Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No.
- Has the recommendation been reviewed by all appropriate workgroups?
  - The HIE WG formally reviewed, discussed, and approved the recommendation to proceed with the project in the August WG meeting. The CMCM WG reviewed the recommendation and supported the project, though there was no formal request for approval.

Attachment 6

Accountable Communities for Health

Accountable Communities for Health Research

VHCIP Steering Committee
Aug 26, 2015

Leslie Mikkelsen, MPH, RD
Managing Director, Prevention Institute

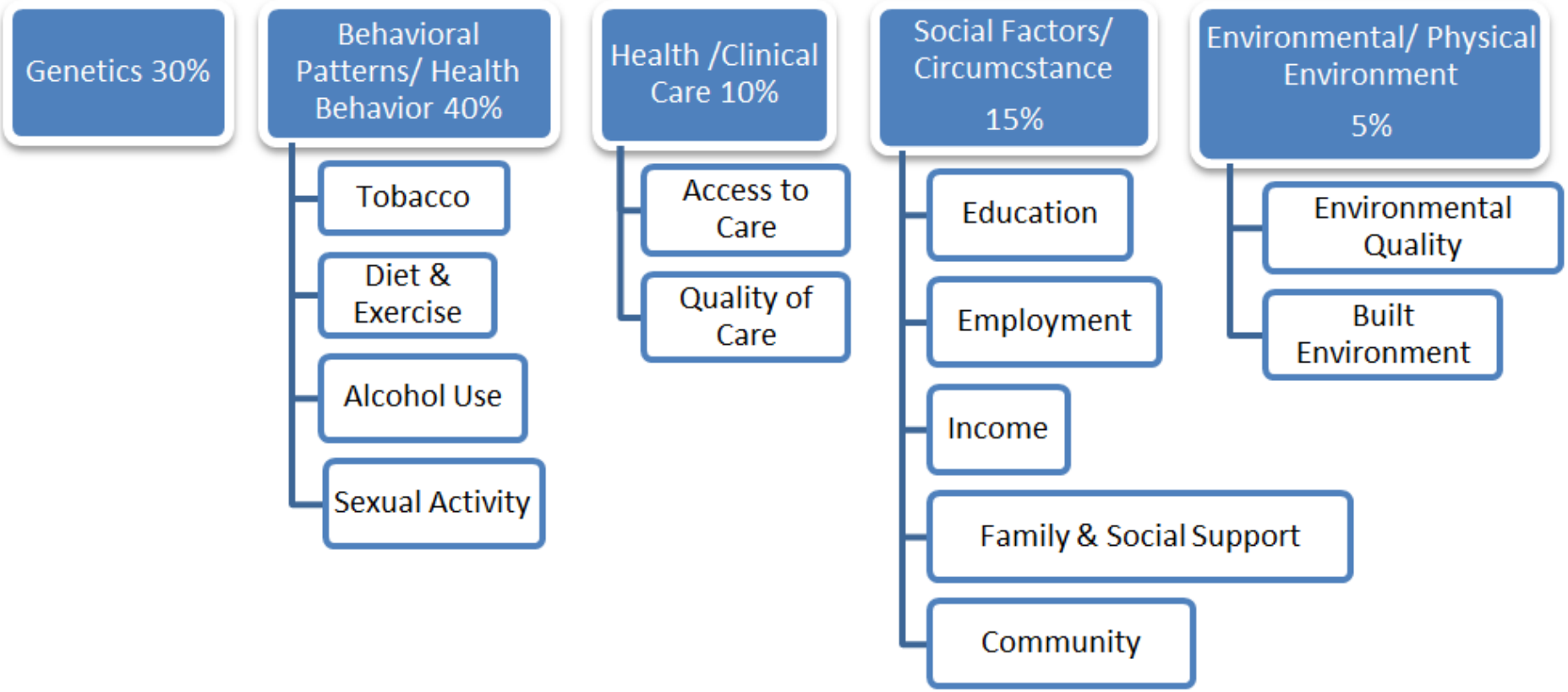
William L. Haar, MPH, MSW
Program Coordinator, Prevention Institute

Lisa Dulsky Watkins, MD
Principal, Granite Shore Consulting, LLC

Kalahn Taylor-Clark, PhD, MPH
Senior Advisor, Center for Health Policy Research & Ethics

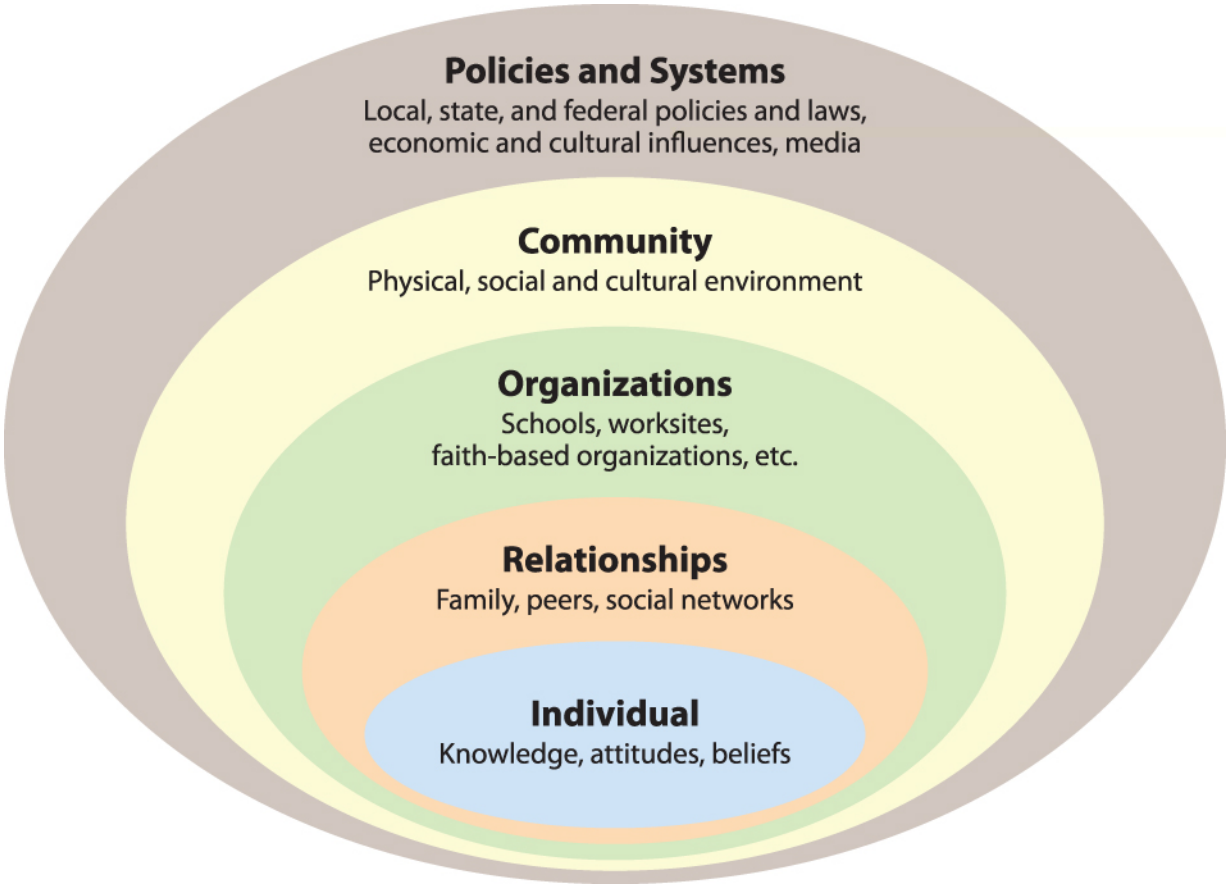
Prevention Institute
Prevention and equity at the center of community well-being

Factors Affecting Health Outcomes



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8
Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion.* Health Aff (Millwood) 2002;21(2):78-93.

Vermont Prevention Model



Accountable Communities for Health (ACH) Definition

An ACH works across the entire population of its defined geographic area to support the integration of:

- Medical Care
- Mental and Behavioral Health Services
- Social and Community Services
- Community-Wide Prevention Efforts

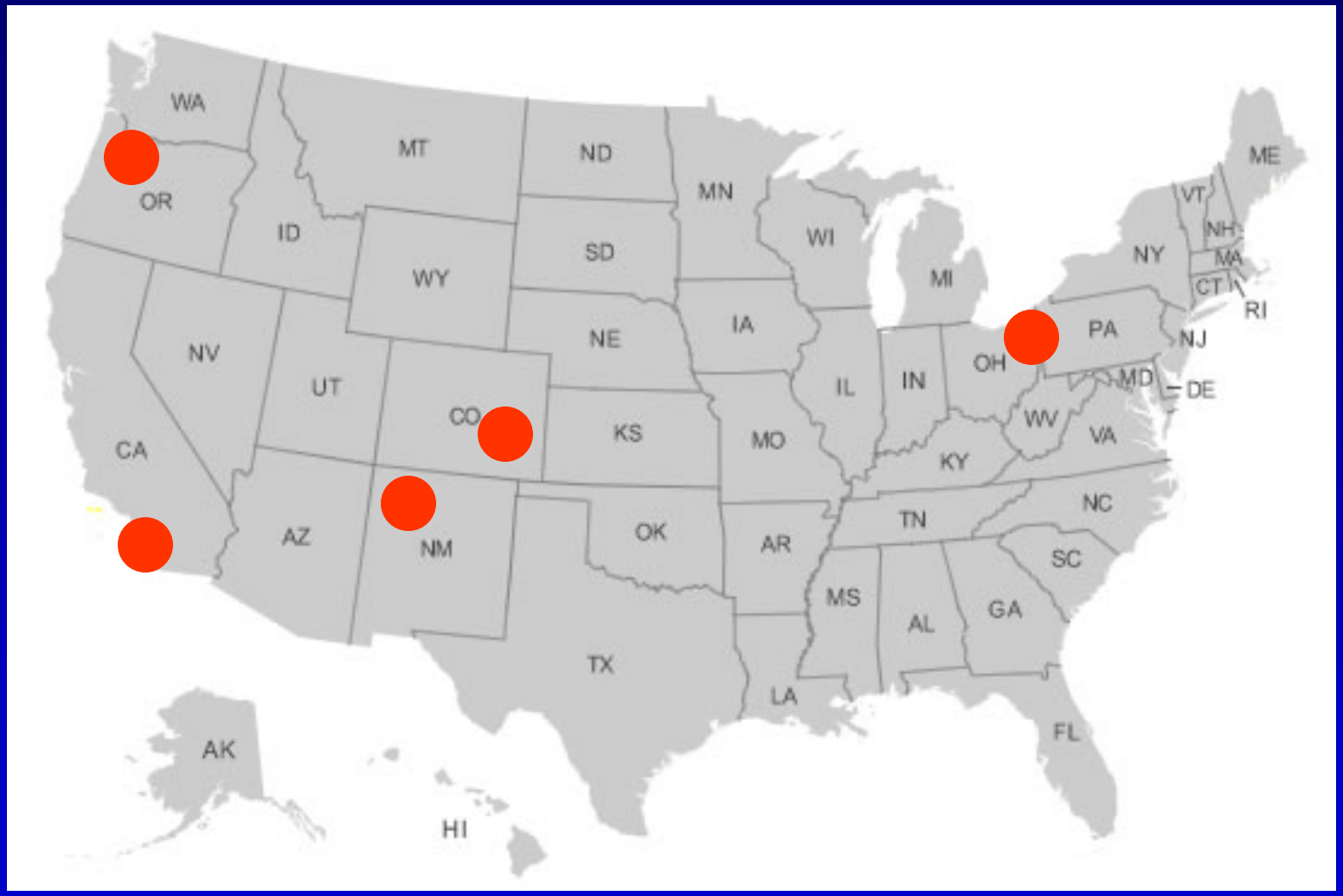
Elements of Accountable Communities for Health

- Integrator
- Partnership
- Assessment, Planning, and Comprehensive Strategies
- Data, Metrics, and Accountability
- Community Resident Engagement
- Funding and Sustainability

National Sites

- Live Healthy, Summit County, Ohio
- Pueblo Triple Aim Coalition, Colorado
- Trillium Community Health Plan, Oregon
- Live Well San Diego, California
- Pathways to a Healthy Bernalillo County, New Mexico

National Sites



Prevention Institute

Integrator

- Facilitated by an internal or external integrator that coordinates the roles and capacities of the partners within the ACH according to its governance structure

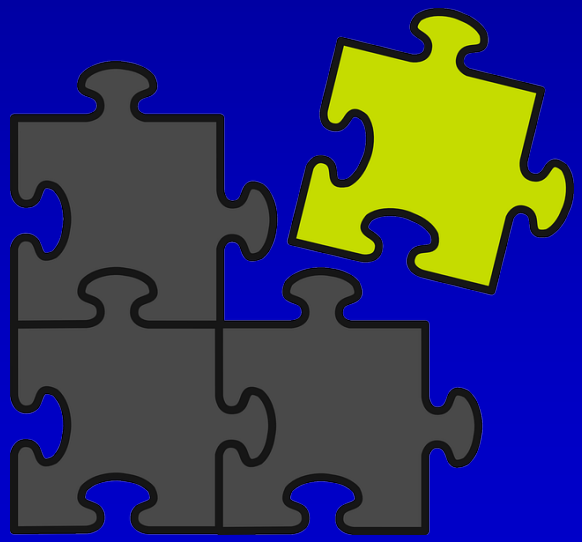
Prevention Institute

Integrator

- San Diego/Summit (California/Ohio): HHSA/public health is integrator
- Lane County (Oregon): Health plan is integrator
- Bernalillo/Pueblo (Colorado): External integrators
- No significant difference observed between internal and external integrators

Partnership

- Structured, integrated partnership of healthcare delivery systems, social service agencies, public health departments, government, and community organizations

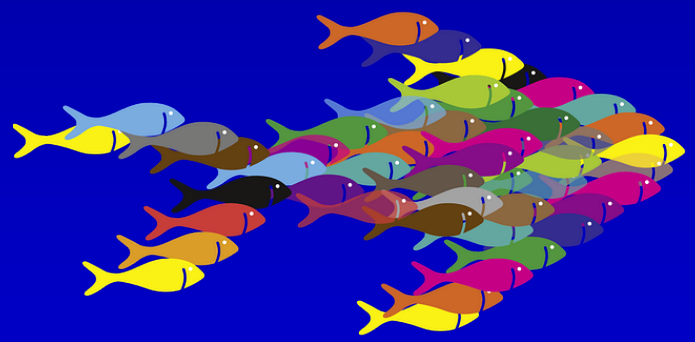


Partnership

- Hospitals and public health always included (except Bernalillo)
- Pueblo: Signed commitments to a work plan
- Lane: CHIP assigns responsibility to specific organizations for work
- Pueblo: External integrator's board requires C-Suite participation from partners

Assessment, Planning, and Comprehensive Strategies

- Engages all partners in a process for assessing and planning health improvement approaches, as well as implementing a comprehensive set of strategies that span the Spectrum of Prevention



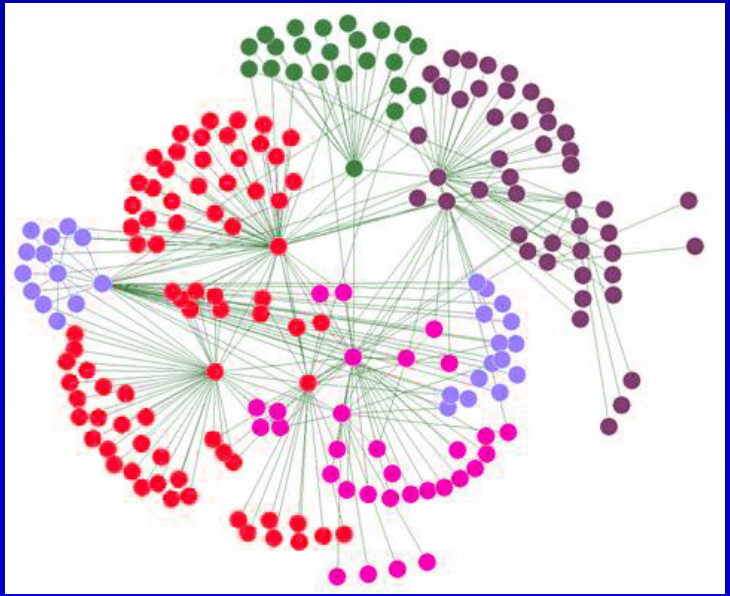
Spectrum of Prevention

Assessment, Planning, and Comprehensive Strategies

- Lane/Pueblo: Metrics span the entire spectrum of prevention
- All CHIPs include a broad spectrum of strategies
- Health education and services are emphasized, while community prevention is less well represented
- San Diego: Partnership structure allows coalition to pursue policy work even though county government is at the center of the effort

Data, Metrics, and Accountability

- Includes the exchange of health and community data useful for assessing and developing strategies to improve population health. Measures of quality and performance ensure accountability in planning and implementation



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Data, Metrics, and Accountability

- San Diego: Data central to planning, evaluation, and communications. Public annual reports on progress.
- Pueblo: Hospitals share proprietary data with other sectors to measure success
- Lane: Health plan receives incentivized awards if it meets metrics
- Bernalillo: Evaluation determines pay. Lack of health outcome data self-identified as limitation

Community Resident Engagement

- Prioritizes authentic community participation throughout assessment, planning, implementation, and evaluation processes

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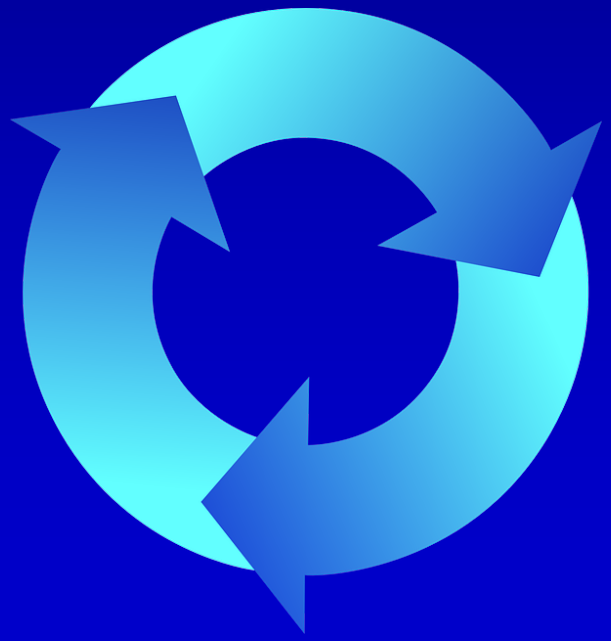
Community Resident Engagement

- Lane: Community Advisory Council has representation on executive board
- Overall, community participation is far more likely to involve “grass tops” than grassroots.

Funding and Sustainability

- Fosters sustainable and generalizable delivery and financing models that support and reward improvements in population health



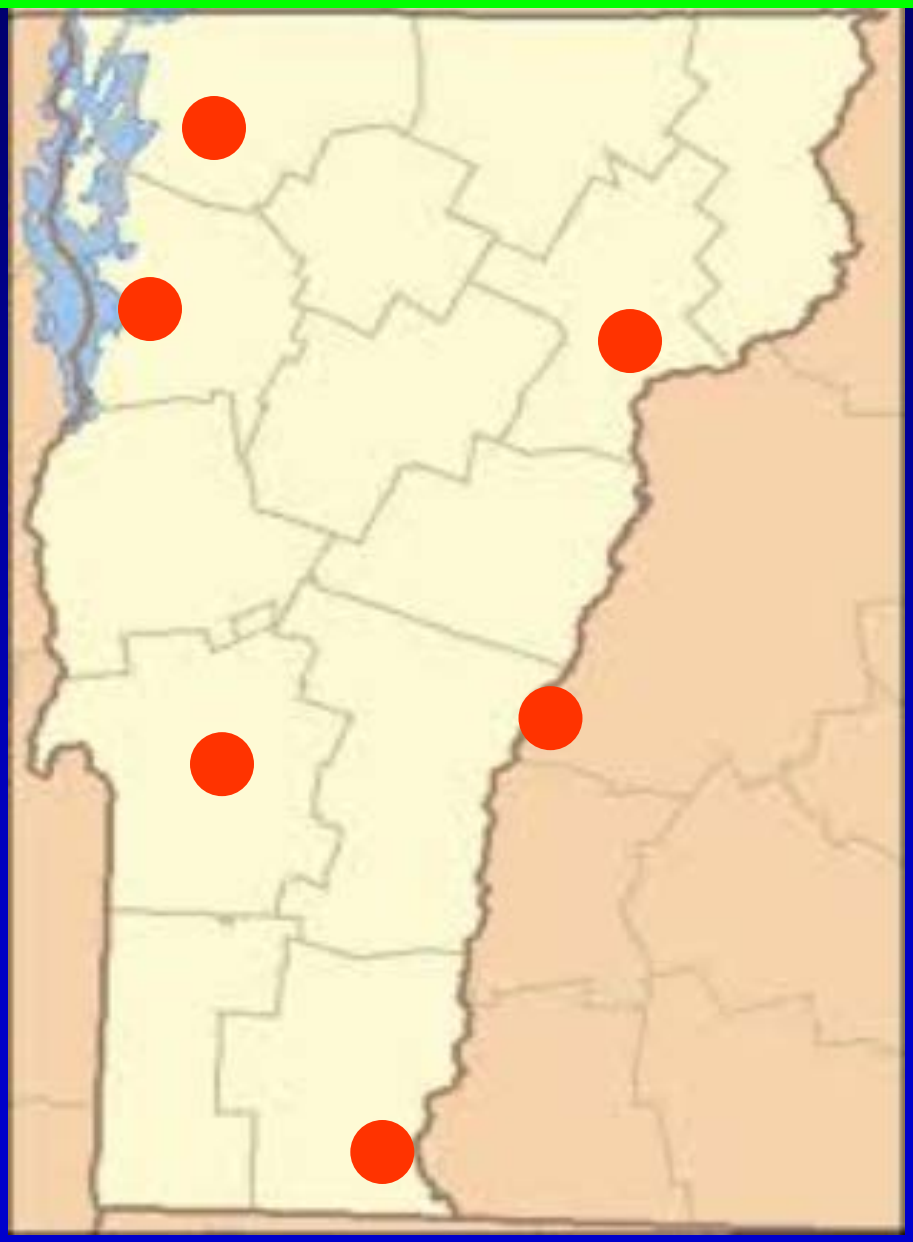
Funding and Sustainability

- Bernalillo: Set-aside portion of mill levy funds integrator
- Pueblo: Grant funded, contract work
- Lane: Global Medicaid payments, set-aside for prevention
- San Diego/Summit : County general funds, grants

Vermont Sites

- Franklin and Grand Isle Counties
- Northeast Kingdom
- Chittenden County
- Windsor County
- Upper Connecticut River Valley
- Windham County

Map and List of Vermont Sites



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Integrators

- Franklin and Grand Isle Counties: Northwestern Medical Center
- Northeast Kingdom: Northeastern Vermont Regional Hospital
- Chittenden County: Regional Planning Commission
- Windsor: Mt. Ascutney Hospital and Health Center
- Upper Connecticut River Valley: ReThink Health UCRV
- Brattleboro: Brattleboro Memorial Hospital (planning)

Priorities

- Healthy lifestyles
- Access to mental, behavioral, social, and economic services
- Substance abuse treatment
- Poverty – housing, economic development, jobs
- Aging in Place

Partners

- Hospitals, FQHCs
- Public Health districts
- Social Services, AAA, other service providers
- Regional Planning
- Business community, media

Strategies

- Individual and group health education
- Service referrals – working with CHTs
- Model organizational practices to promote healthy lifestyles
- Regional plans, local tobacco policies, state sugary beverages tax

Funding

- In-kind staff contributions
- Monetary contribution by hospital
- Grants

Building Blocks in Vermont

- Communities organizing around ACH concepts
- The right size for innovation
- Communities taking action to create healthy environments
- Vermont Blueprint for Health
- Hospital system leadership

Issues for Reflection

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Seeking Balance

Service delivery and integration

Community prevention

Opportunities to Consider

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Recommendations

- Foster an overarching statewide approach to support ACH effectiveness
- Provide guidance to enable regions to effectively establish ACHs
- Build capacity and create an environment of ongoing learning
- Explore sustainable financing models for ACHs

Ensuring a Strong Role for Community Prevention in the ACH

- Make the co-benefits for multi-sector partnership explicit
- Promulgate a comprehensive framework for population health
- Establish a set of core community level metrics for use by communities
- Cultivating leadership

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Prevention and equity at the center of community well-being

Questions, Comments? Contact us:

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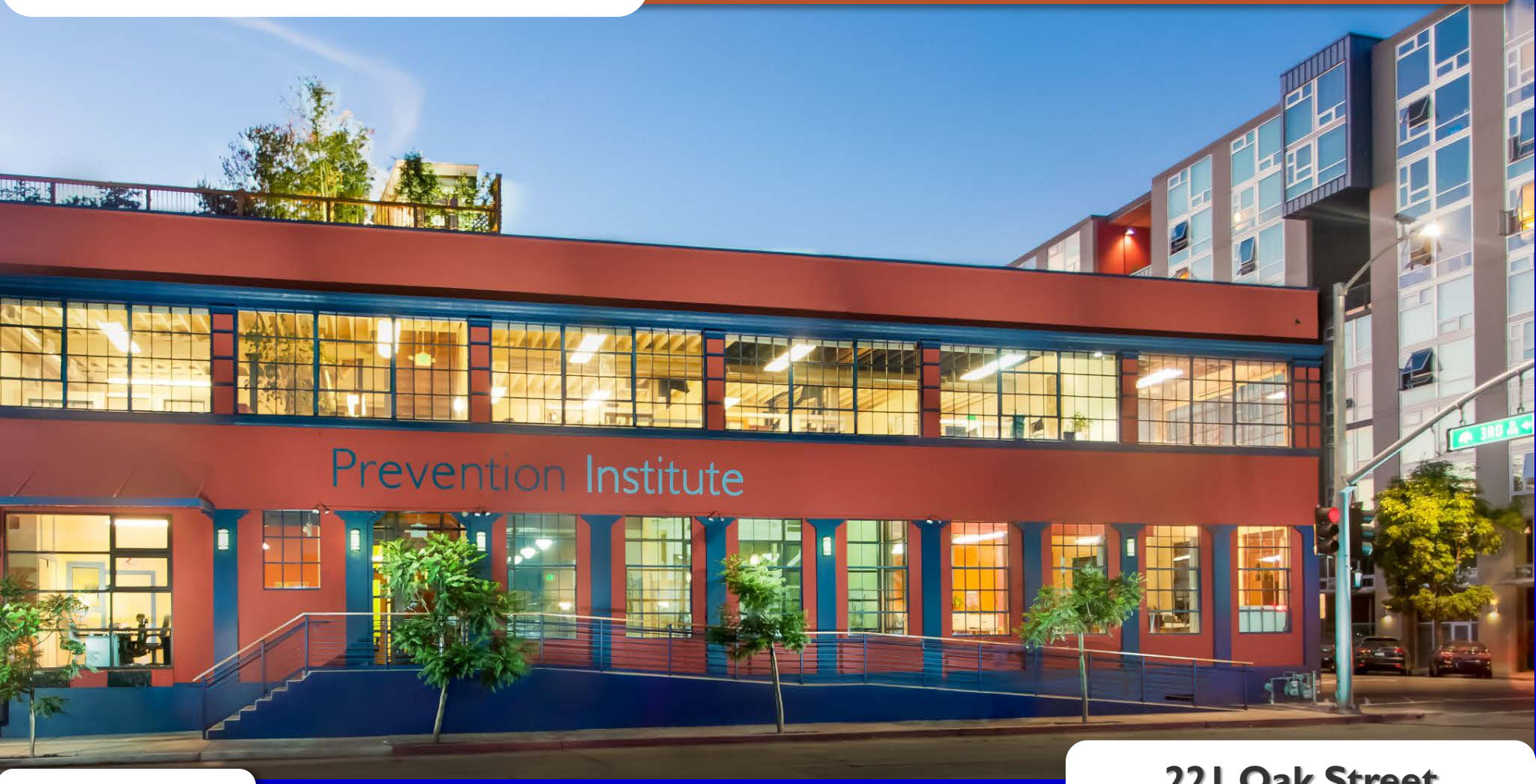

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