

VHCIP Workforce
Work Group
Agenda 6-24-15

***VT Health Care Innovation Project
Health Care Workforce Work Group Meeting Agenda***

**Wednesday, June 24, 2015; 3:00-5:00pm
Vermont State College, Conference Room 101**

575 Stonecutters Way, Montpelier

Call-in Number: 1-877-273-4202; Conference ID: 420-323-867

Item #	Time Frame	Topic	Presenter	Decision Needed? (Y/N)	Relevant Attachments (describe document type: powerpoint, word, excel, etc...)
1	3:00-3:05	Welcome and Introductions	Mary Val Palumbo Robin Lunge	N	<ul style="list-style-type: none"> • <u>Attachment 1: 6-24-15 Meeting Agenda</u>
2	3:05-3:10	Approval of Meeting Minutes	Mary Val Palumbo Robin Lunge	Y	<ul style="list-style-type: none"> • <u>Attachment 2: 4-22-15 Meeting Minutes</u>
3	3:10-3:20	Updates: <ul style="list-style-type: none"> - Demand Modeling update - status of workforce-related initiatives/grants around the state - Issues to watch 	Mary Val Palumbo Robin Lunge Group Discussion	N	
4	3:20 – 4:05	Payment Models updates and discussion: <ul style="list-style-type: none"> - ACO Shared Savings Program - Episodes of Care - Blueprint - Pay for Performance 	Alicia Cooper Jenney Samuelson	N	<ul style="list-style-type: none"> • <u>Attachment 4a – PMWG Update (SSP and EOC)</u> • <u>Attachment 4b – VT ACO SSP Table</u> • <u>Attachment 4c – BP P4P Update</u>
5	4:05-4:50	Discussion and Review: Strategic Plan	Charlie MacLean – Group Discussion	N	<ul style="list-style-type: none"> • <u>Attachment 5– Strategic Plan Priorities Matrix</u>
6	4:50-5:00	Public Comment/Wrap Up/Next Steps	Mary Val Palumbo Robin Lunge	N	

Attachment 2

April 22, 2015

Minutes

Vermont Health Care Innovation Project Workforce Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, April 22, 3:00-5:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Mary Val Palumbo called the meeting to order at 3:03pm. A roll call attendance was taken and a quorum was not present.	
2. Approval of February Meeting Minutes	Approval of the February minutes was delayed due to lack of a quorum; the Work Group will vote on the February meeting minutes at the June Workforce Work Group meeting, assuming a quorum is present.	
3. Updates: Demand Modeling; Strategic Plan; Workforce-Related Initiatives/Grants around the State	<p><i>Demand Modeling Update:</i> Amy Coonradt provided an update. The Department of Vermont Health Access (DVHA) has received five bids for the Demand Modeling work; Amy, Charlie MacLean, Mat Barewicz, Jess Mendizabal, and Georgia Maheras are on the bid review team and will receive demonstrations from bidders in the next few weeks. Janet Kahn raised a concern: Demand modeling may not include professions that have not historically been part of the health care workforce (for example, acupuncturists). Dawn Philibert noted that Mat Barewicz would be better able to speak to this. Amy noted that the scope of work for the Demand Modeling RFP includes alternative medicine professions, and many bidders responded to this item.</p> <p><i>Strategic Plan Update:</i> Mary Val provided an update on work to update the Workforce Strategic Plan. A sub-committee to discuss updates to the Strategic Plan has now met three times. It will soon be ready for input from the rest of the Work Group; Amy will distribute the revised plan to Work Group members by the end of May. Mary Val requested member input on the plan before the June meeting. (The sub-committee will also request specific feedback from members with expertise in particular areas.) Amy will compile comments for discussion and a vote at the June Work Group meeting; after which the approved plan will be presented back to the Green Mountain Care Board (GMCB).</p> <p><i>Workforce-Related Initiatives/Grants around the State:</i> Mary Val pushed this topic to Item #7.</p>	Members will receive an updated version of the Workforce Strategic Plan by the end of May, and will be asked to provide input on the Workforce Strategic Plan for discussion at the June Workforce Work Group meeting.

Agenda Item	Discussion	Next Steps
<p>4. Discussion/ Inventory of Workforce-Related Surveys around VT</p>	<p>Mary Val Palumbo introduced this agenda item, which rose out of Strategic Plan revisions. Mary Val requested attendees share information on work at their organizations or agencies to collect information on workforce demand.</p> <ul style="list-style-type: none"> • Bi-State Primary Care Association is collecting self-reported vacancy information for primary care providers and some specialists in non-primary care specialties. This is typically information collected via phone, but it is not a global survey – only practices that have requested to participate. • The Area Health Education Center (AHEC) has a workforce specialist that tracks vacancies around the state with the purpose of placing residents who are graduating and seeking jobs, or to place others who “owe” time to the state based on participation in programs like Educational Loan Repayment. It was noted that this is a supply survey and does not contain vacancies, but benchmarks. • The Vermont Psychological Association, in partnership with the Social Work Association and Counselors Association, is developing an online survey of membership to assess whether membership are practicing full- or part-time providing mental health services in private practice. (Mary Val points out that this is supply data.) • Peter Cobb will seek information on current demand information collection at VNAs of Vermont. Local VNAs post job information on the VNAs of Vermont website, but no analysis has ever been performed. Peter will request an analysis from human resources. • Mary Val noted that the nursing survey, a phone interview of 11 of 14 hospital HR departments, was conducted last year. This is published on the AHEC website. That survey will be repeated this year. • Dawn Philibert noted that the Department of Health (VDH) is also collecting supply-side data through licensure. • Stephanie Pagliuca volunteered to reach out to Vermont Association of Hospital and Health Systems (VAHHS) to inquire about their survey activities. • What about alcohol and drug treatment providers? Madeleine Mongan suggested that someone reach out to the Designated Agencies (DAs). Dawn Philibert noted that there’s current legislation about a registry of substance abuse providers that is of concern for VDH because it would represent a significant reporting and maintenance burden. • Lori Lee Schoenbeck noted that there are areas where there is demand for naturopathic providers where there are no providers or providers are overwhelmed with demand – how is this need assessed? How do we survey a community of prospective patients about demand? Madeleine Mongan suggested surveying practices about vacancies. • Ellen Grimes suggested that demand data for dentistry may be off – there is unmet need, but graduating students are not finding openings. It was noted that both VDH’s dental division and the dental society both track supply and demand of dentists to some extent. • Charlie MacLean suggested that benchmarking could be helpful, and noted that maldistribution is the biggest issue for many specialties – there are geographic areas with oversupply and areas with 	

Agenda Item	Discussion	Next Steps
	<p>undersupply. To look at newer professions, it may be helpful to consider selecting benchmarks to assess penetration. Charlie also looks at providers per population compared to other states; Vermont far exceeds many states in terms of primary care providers per population, for example. Demand analyses could help us decide whether we need more or fewer providers than what we have in various specialties. Mary Val asked whether there are national benchmarks for naturopaths per population, in response to Lori Lee’s earlier question.</p> <ul style="list-style-type: none"> • Peter Cobb asked whether we would like to collect demand data about non-licensed professions like direct care workers, personal care assistants, etc. He suggested that those positions have high turnover, so can be hard to capture consistent demand, but he will put out a survey in late spring or early summer. 	
<p>5. Review 2015 Workforce Work Group Workplan</p>	<p>Sarah Kinsler introduced the Workforce Work Group Workplan and described the process by which the Workplan was created.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> • On Row 4, Dawn Philibert suggested that the target date be ongoing. • Madeleine Mongan suggested that on the Strategic Plan item (Row 3), the note about the RFP be removed since we have since decided not to pursue • Mary Val Palumbo asked about funding associated with this Work Group. Is funding specifically tied to supply and demand research, as Georgia had suggested at a previous meeting, or is it broader? Could we specifically fund a proposal like Lori Lee’s or Peter’s, for demand modeling for specific provider types like naturopaths or visiting nurses associations (VNAs)? This group previously had funding proposals that were outside the SIM funding scope. Mary Val suggested that it would be good to get an accounting from Georgia: How much will Demand Modeling work cost, and how much total is available? How much is allocated to support Work Group staff? • Peter Cobb asked whether Demand Modeling RFP responses have taken into account private duty nursing. Charlie MacLean noted that the contractor the review team selects can include this information if we give ask them to; Mary Val noted that there will be assumptions that we will verify. Madeleine Mongan noted that some hospitals and other care settings that employ traveling nurses or other providers that might not show up in these models, though supply side data might fill this gap. Madeleine and Charlie suggested we seek more information on the minimum dataset for licensing data. • Charlie requested an update on efforts to hear from the Payment Models and Care Models and Care Management (CMCM) Work Groups. This group heard from the CMCM Work Group on their Integrated Communities Care Management Learning Collaborative in February; their other activities have focused on developing ACO Care Management Standards and a provider survey. Dawn Philibert noted that this highlights the intersectional nature of the Workforce Work Group’s work. Madeleine Mongan suggested that that the group look at the ACO Care Management standards and see whether they are relevant. Beth Tanzman suggested the group wait until the three Learning Collaborative communities have had more 	<p>Sarah Kinsler will follow up with Georgia on funding questions.</p>

Agenda Item	Discussion	Next Steps
	<p>time to assess outcomes.</p> <ul style="list-style-type: none"> Mary Val noted that this group has not presented to other work groups; Lori Lee Schoenbeck and Dawn Philibert suggested that this could be a good step. Mary Val suggested that presenting the Workforce Strategic Plan following approval by GMCB could be a good topic for presentations. Madeleine Mongan agreed. Mary Val noted that all VHCIP Work Group Co-Chairs do meet semi-regularly and that she would connect with other co-chairs at the next meeting. 	
<p>6. Presentation/ Discussion: VDH/Office of Professional Regulation (OPR) Survey Reports</p>	<p>Dawn Philibert introduced Rich McCoy, Chief of Public Health Statistics at VDH. Peggy Brozicevic was unable to participate in today’s meeting, so Rich will be providing an overview with Dawn leading discussion. A sample of VDH’s reporting format was also distributed.</p> <ul style="list-style-type: none"> Rich provided an overview of the survey process. Rich noted the challenges of gathering a full census report for the 2012 survey due to a change in procedure: specifically, that the relicensing process has moved to an online portal, and requires a great deal of follow up and administrative work. Previously 5 provider types had been surveyed, beginning in the 1990s; now surveying 25+ specialties. This work is supported by coordination with Licensing, but still requires a great deal of manual data entry and follow up. VDH is focused on data quality. One key data element is full-time equivalent (FTE) information – an important piece for policy-making. However, this often requires a significant amount of follow-up. <ul style="list-style-type: none"> Lori Lee Schoenbeck asked whether the FTE includes patient time only, or paperwork as well. Rich responded that this isn’t made clear in the survey, though the survey generally defines work hours to include paperwork, reporting, etc. (though not on-call hours). Data is reported in two ways: a statistical report, and a report with a summary that highlights changes and other key data points. VDH has been behind on their reporting cycle and had hoped to get back on track this summer. Rich will connect with Peggy to get a timeline to this group. <p>The group discussed the following:</p> <ul style="list-style-type: none"> Staff and contractors are struggling to extract data; VDH expects this to be easier going forward. Mary Val Palumbo asked whether VDH had considered dropping their desired response rate to 90% or lower given the work associated with collecting this information. Charlie MacLean suggests that it would be easy to test this by throwing out the last 10% collected and comparing results. Rich responded that for some specialties, it is easy to collect the last 10%; for others it’s a challenge. Rich and Mary Val noted that VDH needs to balance how many resources to put to this task, as well as how long to delay reports in order to collect data that is as complete as possible (“census-level”). Rich noted that the physician survey is the top priority. Lori Lee Schoenbeck suggested the survey include provider capacity and patients currently served as a source for demand data. Charlie MacLean thought this was unlikely to come from a survey; the closest is 	

Agenda Item	Discussion	Next Steps
	<p>whether or not providers are accepting more patients. Charlie suggested Vermont’s all-payer claims database could provide much of this information but that this would require a great deal of analysis.</p> <ul style="list-style-type: none"> • Mary Val asked whether this group could have a one-pager that summarizes all professions. Madeleine Mongan suggested that this is included in the report’s executive summary. Charlie MacLean suggested that interpreting this information could be a good task for this group – VDH’s task is descriptive but does not draw out the key lessons. Mary Val suggested this could be a good task for a contractor, in conjunction with review of the literature. This group could inform conclusions or discussion. • Burt Wilcke noted that the number of specialty physician assistants has grown remarkably over the past decade; the group discussed possible reasons for this. • Dawn Philibert asked whether there was some benefit to creating summaries of each provider type. Madeleine Mongan noted that much of this information is already in reports. Mary Val suggested that VDH’s job is to get this data as soon as possible, and again asked whether 100% response rates are necessary. Dawn asked Rich whether there is a statistically acceptable way to assess this. Rich suggested that a few rounds of follow-up are important; additional response can be critical in situations where there is low response rate in a particular county, for example. Mary Val suggested a preliminary report when 80% of responses are in to support quicker reporting and reduce VDH workload. Rich responded that this could work in some situations but will depend on the data. Charlie MacLean suggested that if this is a mandate, providers would complete it; Mary Val suggests licensing boards would need to be involved. <p>Mary Val Palumbo and Dawn Philibert suggested we table this issue for now.</p>	
<p>7. Other topics: Discussion, Non-SIM Funding Proposals</p>	<p><i>Status of Workforce-Related Initiatives and Grants around the State:</i> (Moved from Item #3) Mary Val Palumbo suggested that this group continue to regularly discuss workforce-related grants this group has received, submitted or is considering submitting.</p> <ul style="list-style-type: none"> • Grants funded: <ul style="list-style-type: none"> ○ Madeleine Mongan offered to report on this on behalf of Vermont Medical Society Foundation at the next meeting. ○ Lori Lee Schoenbeck noted that the Blueprint has funded grants to support participating practices who are transferring from one EHR to a new EHR for participating practices; funds can support hiring additional staff to perform data entry/transfer records. • Grants submitted: <ul style="list-style-type: none"> ○ Charlie MacLean and Mary Val Palumbo submitted a large grant application to the Health Resources and Services Administration (HRSA) on workforce development within training programs/continuing education activities related to elderly patients. Expect to hear this summer. ○ Peter Cobb announced that Home Health agencies as a group and VNAs of Vermont have submitted an application for a grant around palliative care for hospice-eligible patients who have 	

Agenda Item	Discussion	Next Steps
	<p>not elected hospice. Expect to hear within a few weeks.</p> <ul style="list-style-type: none"> • Possible future grant opportunities: <ul style="list-style-type: none"> ○ Mary Val Palumbo noted that the second round of the Future of Nursing State Implementation Grant is due in June. Two focus areas – academic progression (marketing to encourage nurses to go back to school for a bachelor’s degree) and a nurse practitioner residency program within three independent nurse practitioner-led practices in the state. Requires a match of \$75,000; Mary Val requests suggestions about possible sources of match funding. 	
8. Public Comment, Wrap-Up, Next Steps, Future Agenda Topics	<p>No further comments were offered.</p> <p>Next Meeting: June 24, 2015, 3:00-5:00pm, Conference Room 101, Vermont State Colleges, 575 Stone Cutters Way, Montpelier.</p>	

VHCIP Workforce Work Group Member List

Roll Call: 4/22/2015

Member		Member Alternate		February Minutes		Organization
First Name	Last Name	First Name	Last Name			
David	Adams					UVM Medical Center
Tom	Alderman					Department of Education
Molly	Backup					Consumer Representative
Mat	Barewicz					Department of Labor
Rick	Barnett					Vermont Psychological Association
Ethan	Berke					Dartmouth Institute for Health Policy & Clinical Practice
David	Blanck					Consumer Representative
Peggy	Brozicevic					AHS - VDH
Denise	Clark					Consumer Representative
Peter	Cobb					VNAs of Vermont
Tim	Donovan					Vermont State Colleges
Ellen	Grimes					Vermont Technical College
Lorraine	Jenne					DA - HowardCenter for Mental Health
Janet	Kahn					UVM College of Medicine
Nicole	LaPointe					Northeastern Vermont Area Health Education Center
Robin	Lunge					AOA
Charlie	MacLean					University of Vermont
Madeleine	Mongan					Vermont Medical Society
Stephanie	Pagliuca					Bi-State Primary Care
Mary Val	Palumbo					University of Vermont
Dawn	Philibert					AHS - VDH
Lori Lee	Schoenbeck					Consumer Representative
Stuart	Schurr	Susan	Aranoff			AHS - DAIL
Beth	Tanzman					AHS - DVHA - Blueprint
Deborah	Wachtel					Consumer Representative
Burton	Wilcke					University of Vermont
	26		0			

~~12~~ - 13 No Quorum

VHCIP Workforce Work Group Participant List

Attendance:

4/22/2015

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

First Name	Last Name		Organization	Workforce
David	Adams		UVM Medical Center	M
Tom	Alderman		Department of Education	M
Susan	Aranoff	<i>None</i>	AHS - DAIL	S
Molly	Backup		Consumer Representative	M
Ena	Backus		GMCB	X
Mat	Barewicz		Department of Labor	M
Rick	Barnett	<i>None</i>	Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Paul	Bengston		Northeastern Vermont Regional Hospital	X
Ethan	Berke		Dartmouth Institute for Health Policy & Clinical Practice	M
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
David	Blanck		Consumer Representative	M
Peggy	Brozicevic		AHS - VDH	M
Amanda	Ciecior	<i>None</i>	AHS - DVHA	S
Denise	Clark		Consumer Representative	M
Peter	Cobb	<i>None</i>	VNAs of Vermont	M

Amy	Coonrad	here	AHS - DVHA	S
Elizabeth	Cote		Area Health Education Centers Program	X
Karen	Crowley		AHS - Central Office - IFS	X
Kathy	Demars		Lamoille Home Health and Hospice	X
Tim	Donovan		Vermont State Colleges	M
Terri	Edgerton		AHS - Central Office - IFS	X
Erin	Flynn		AHS - DVHA	S
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Ellen	Grimes	phone	Vermont Technical College	M
Bryan	Hallett		GMCB	S
Karen	Hein			X
Deanna	Howard		Dartmouth	X
Lorraine	Jenne		DA - Howard Center for Mental Health	M
Joelle	Judge	here	UMASS	S
Janet	Kahn	phone		M
Sarah	Kinsler	here		S
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Nicole	LaPointe		Northeastern Vermont Area Health Education Center	M
Robin	Lunge		AOA	IC
Charlie	MacLean	here	University of Vermont	M
Georgia	Maheras		AOA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	X
Mike	Maslack			X
John	Matulis	here	DHMC	X
Angel	Means		Visiting Nurse Association of Chittenden and Grand Isle Counties	X
Marisa	Melamed		AOA	S
Sarah	Merrill		DNH	X
Madeleine	Mongan	here	Vermont Medical Society	M
Meg	O'Donnell		UVM Medical Center	A
Stephanie	Pagliuca	phone	Bi-State Primary Care	M
Mary Val	Palumbo	here	University of Vermont	C
Annie	Paumgarten		GMCB	S
Dawn	Philibert	here	AHS - VDH	S/M
Luann	Poirer		AHS - DVHA	S

Ken	Schatz		AHS - DCF	X
Lori Lee	Schoenbeck	None	Consumer Representative	M
Stuart	Schurr		AHS - DAIL	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Nancy	Solis		Dartmouth Institute for Health Policy & Clinical Practice	A
Kara	Suter		AHS - DVHA	S
Joy	Sylvester		Northwestern Medical Center	X
Beth	Tanzman	None	AHS - DVHA - Blueprint	M
Tony	Treanor		DA - Northwest Counseling and Support Services	X
Deborah	Wachtel		Consumer Representative	M
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West			X
James	Westrich		AHS - DVHA	S
Burton	Wilcke	None	University of Vermont	M
Cecelia	Wu		AHS - DVHA	S
				66

Rich McCoy ~~here~~/phone . VDH - Public Health Statistics Chief

Attachment 4a
Payment Models Work Group
Update (SSP and EOC)

Payment Models Work Group Update

- ACO Shared Savings Program

- Episodes of Care

Health Care Work Force Work Group
Meeting

June 24, 2015

Presentation Agenda:

- 1.) Background on ACO Shared Savings Programs
- 2.) Vermont ACO SSP to date
- 3.) Episodes of Care (EOC) work to date

Background: ACO Shared Savings Program

WHAT IS AN ACO SHARED SAVINGS PROGRAM (SSP)?

What is an ACO Shared Savings Program (SSP)?

A performance-based contract between a payer and provider organization that sets forth a value-based program to govern the determination of sharing of savings between the parties.



ACO model graphic property of the Premier health care alliance.
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VERMONT STATE INNOVATION MODEL



http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

Vermont Health Care Innovation Project

How are Patients Attributed to an ACO?

People see their Primary Care Provider (PCP) as they usually do

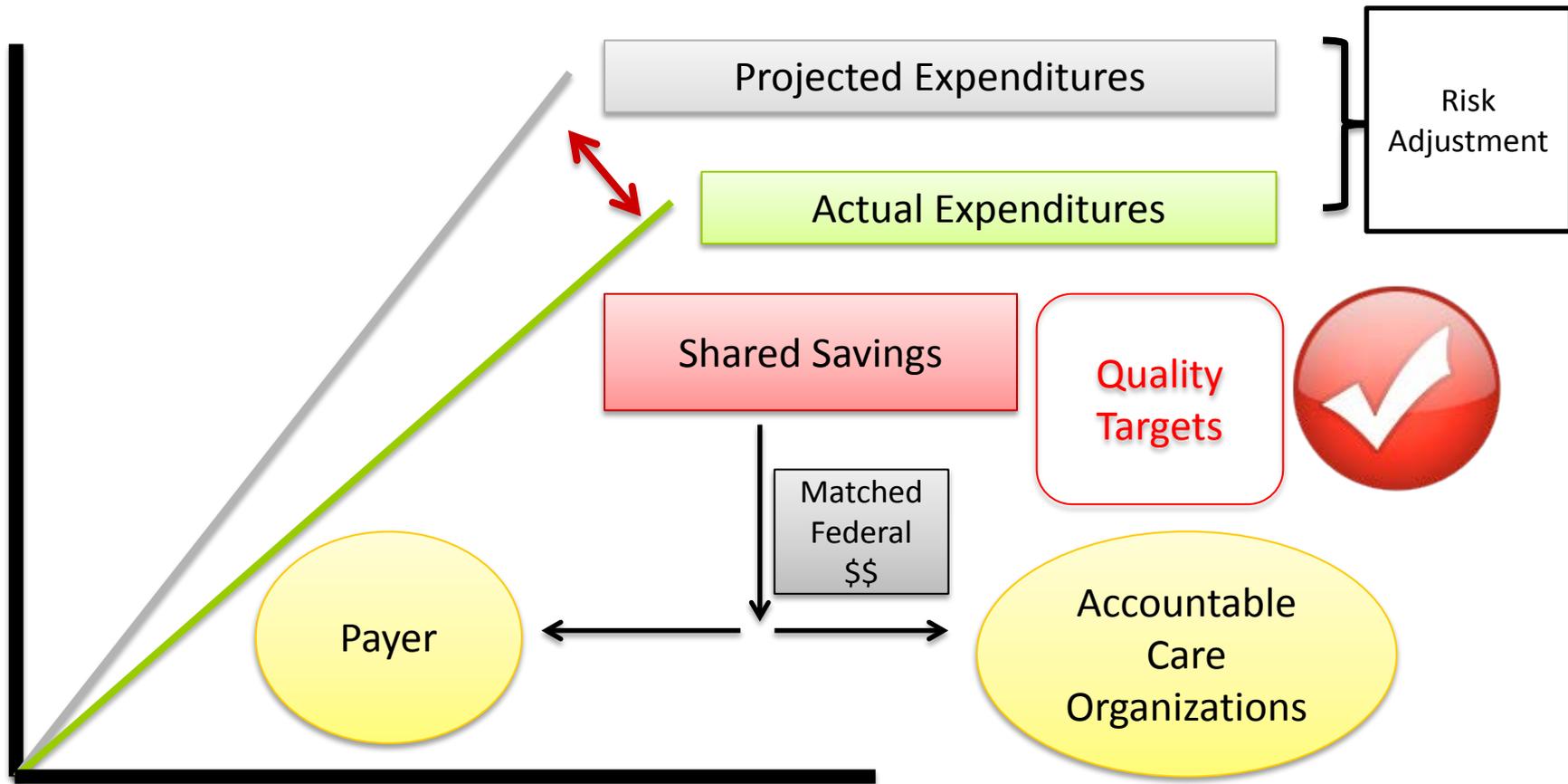


If their PCP belongs to an ACO, the ACO can share savings based on the cost and quality of services provided to that person



Providers bill as they usually do

Calculating Shared Savings



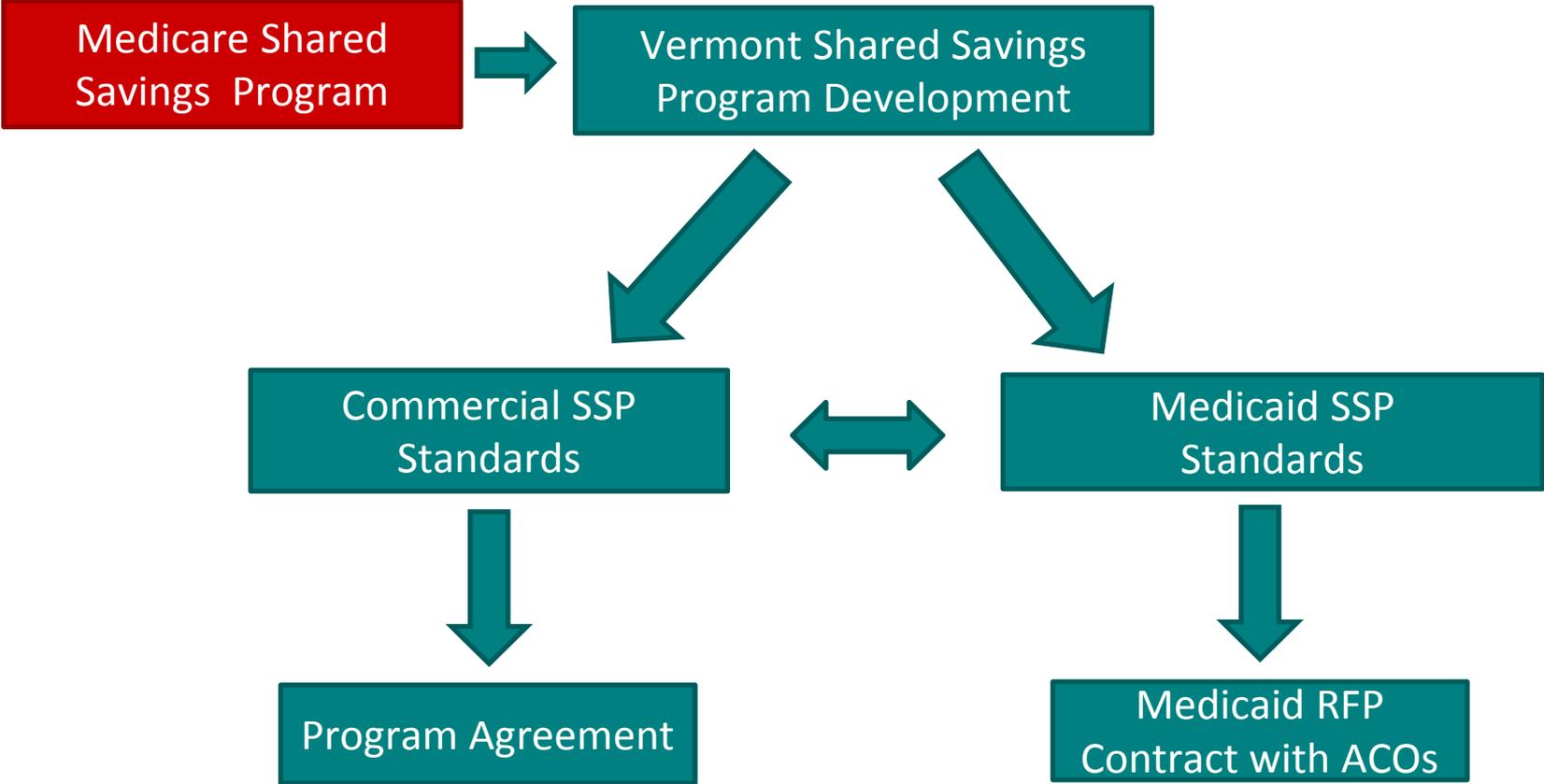
ACO Shared Savings Program

ACO SHARED SAVINGS PROGRAMS IN VERMONT

Shared Savings Programs In Vermont

- Shared Savings Program standards in Vermont were developed as a result of collaboration among payers, providers, and stakeholders, facilitated by the State
- Develop ACO/SSP standards to that include:
 - Attribution of Patients
 - Establishment of Expenditure Targets
 - Distribution of Savings
 - Impact of Performance Measures on Savings Distribution
 - Governance

Development of VT Shared Savings Program



ACO Shared Savings Program

Quality Measures

PAYMENT

Payment measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How ACO performs influences amount of shared savings.

REPORTING

Reporting measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How the ACO performs does NOT influence the amount of shared savings.

MONITORING & EVAL

Monitoring measures are collected at the State or Health Plan levels; cost/ utilization measures at the ACO level. ACO not responsible for collecting these measures. How the ACO performs does NOT influence the amount of shared savings.

PENDING

Pending measures are considered to be of interest, but are not currently collected.

Year 1 & 2 Payment Measures

Commercial &
Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite+
- Diabetes Care: HbA1c Poor Control (>9.0%)*+

Medicaid Only

- Developmental Screening in the First Three Years of Life

* Medicare Shared Savings Program measure

+ Year 2 only

Impact of Payment Measures

“Gate and Ladder” Approach:

- For most payment measures, compare each measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.
- For payment measures without national benchmarks, compare each measure to Vermont benchmark or baseline performance, and assign 0, 2 or 3 points based on whether the ACO declines, stays the same, or improves relative to the benchmark.
- If the ACO does not achieve the required percentage of the maximum available points across all payment measures, it is not eligible for any shared savings (“quality gate”).

“Gates and Ladders” for Vermont Payers

Commercial SSP

% of available points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Medicaid SSP*

% of available points	% of earned savings
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

* The Medicaid SSP was modified for Year 2, with changes including the opportunity to earn bonus points for quality improvement, increasing the “gate” from 35% to 55%, and using absolute points earned in place of percentage points, to eliminate the need for any rounding.

Changes to Medicaid Gate and Ladder Methodology – Year 2

- PMWG members voted to **approve** modifications to the VMSSP G&L Methodology for Year 2
- Presentations and public commentary occurred November 2014 through March 2015
- Changes included:
 - Increasing the minimum quality performance threshold for shared savings eligibility (ie, increased the “gate” from 35% to 55% for Medicaid);
 - Including the use of absolute points earned in place of a percentage of points earned to eliminate the need for rounding; and
 - Allowing ACOs to earn “bonus” points for significant quality improvement in addition to points earned for attainment of quality relative to national benchmarks.

ACO Landscape in Vermont

- See handout: “VT ACO SSP Table”

Episodes of Care

VHCIP EPISODES OF CARE WORK TO DATE

VHCIP & Episodes of Care

- **2012:** SIM Application
 - Propose bundled payment models based on EOC
- **2013:** Year 1 Operational Plan
 - Pursuing bundled payment models based on EOC
 - Propose developing EOC analytics tools to drive delivery system transformation
- **2014:** Year 2 Operational Plan
 - Bundled payment models not a high priority for stakeholders
 - Propose focus on EOC analytics to drive delivery system transformation and complement other VHCIP initiatives
- **2015:** PMWG develops EOC Sub-Group

EOC Sub-Group Charge

The Episodes of Care sub-group (a sub-group of the *Payment Models Work Group*) will play a key role in developing and defining the future of Episodes data use in Vermont. The sub-group will recommend a number of episodes for further exploration using already established selection criteria. The sub-group will also aid in the development of a Request for Proposals (RFP) to elicit bids from potential vendors to produce user-friendly data reports related to selected episodes in the State. Sub-group members will be asked to provide recommendations regarding:

- selection and definition of episodes
- methodological considerations
- identification of appropriate quality measures
- report development and dissemination for delivery system transformation including identification of the need for additional provider supports to enhance the use of data and analytics
- bid review and vendor selection

Sub-Group Representation

- Blue Cross Blue Shield of Vermont
- Blueprint for Health
- DAIL
- DVHA
- GMCB
- MVP Health Care
- OneCare Vermont
- Vermont Association of Hospitals and Health Systems
- Vermont Medical Society
- Vermont Program for Quality in Health Care

Episodes of Care

- Conceptually, an episode of care consists of all related services for one patient for a specific diagnostic condition from the onset of symptoms until treatment is complete
 - Operationally, episode definitions may vary
- Episodes constitute clinically and economically meaningful units of service
- Episode-based payment models are being tested in three other SIM States:
 - Round 1: Arkansas
 - Round 2: Ohio and Tennessee

Using Episodes of Care

- To identify opportunities in support of delivery system transformation:
 - Do utilization patterns for specific conditions suggest excessively high or variable rates of particular services?
 - How do cost and utilization patterns differ across providers who serve patients for clinically-similar conditions?
 - How much duplication of service occurs for patients seen by different providers in different settings over time?
 - How do different care categories (e.g. inpatient facility, pharmacy, outpatient lab, etc.) impact overall episode costs?

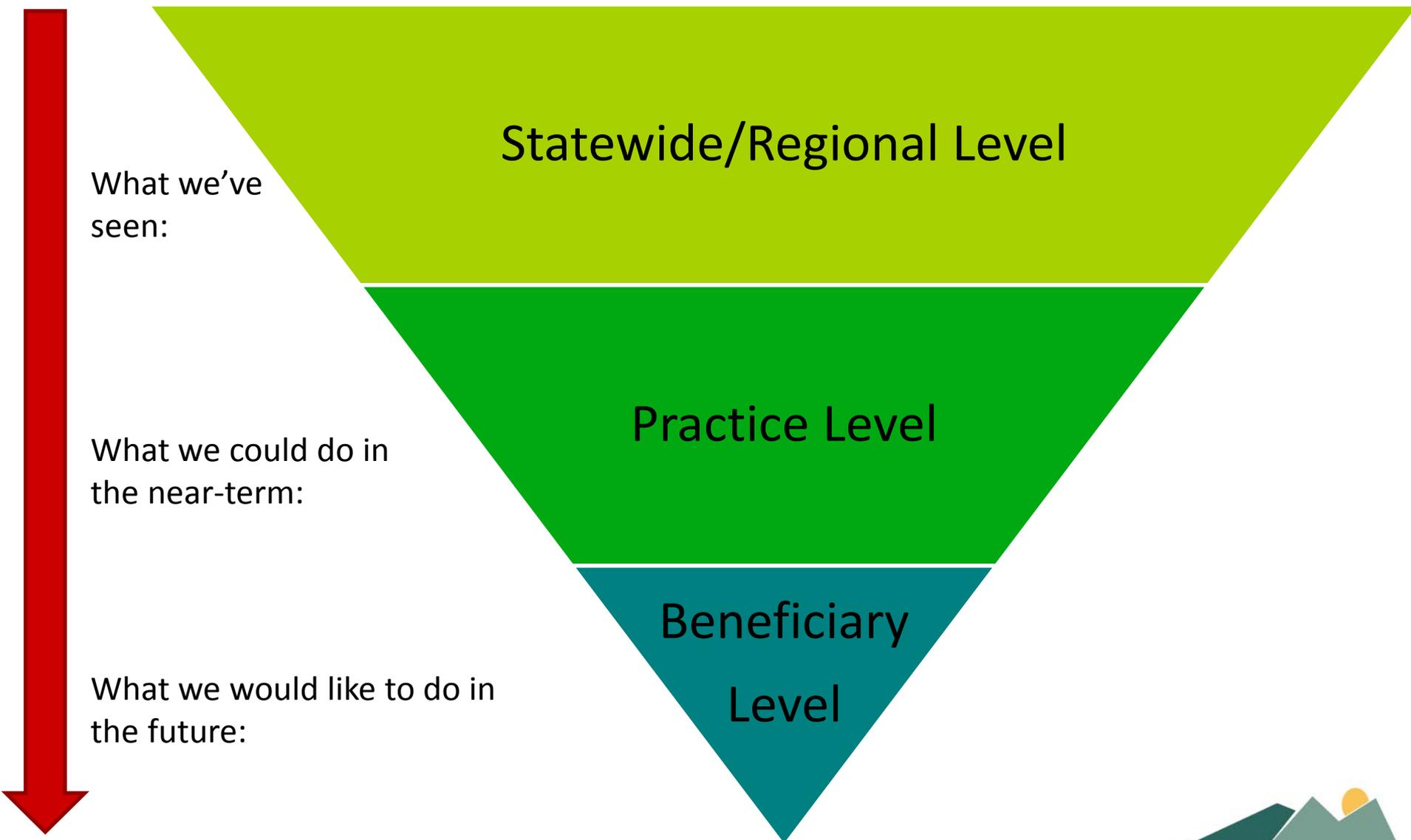
Types of Improvements Expected

- Making efficient substitutions among treatment options
- Avoiding complications
- Managing acute conditions
- Managing chronic conditions
- Reducing costs without sacrificing quality of care

Sub-Group Activity to Date (Jan-Apr)

- Reviewed preliminary PMWG EOC analyses (HCi3)
- Discussed related initiatives of interest
 - Arkansas' (SIM) EOC analytics and reporting
 - MVP's EOC analytics and reporting
 - Blueprint for Health analytics and practice & HSA profiles
- Discussed potential for use of episode analytics in Vermont
 - Potential provider types to receive episodes reports
 - Potential strategies for disseminating reports
 - Potential data sources for episodes analytics
 - Potential vendor capabilities

Phases of Episode-Based Analysis



Questions?

Attachment 4b

VT ACO SSP Table

Vermont Shared Savings Program ACO Table - Updated 6-16-15

MEDICARE SHARED SAVINGS PROGRAM (MSSP)								
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants ^{i, ii} (Providers with attributed lives)	ACO Network Affiliates ¹ (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network ⁱⁱⁱ	Estimated Medicare Attributed Lives		
						# and % of Total VT Medicare Enrollees (Total N= 110,916) ^{iv}	# and % of VT MSSP Eligible Enrollees (Total N=101,410) ^v	# and % of Dual Eligibles within Attributed Lives (Total N=20,018)
OneCare Vermont (OCV)	Jan 1, 2013	Statewide	<ul style="list-style-type: none"> 2 Academic Medical Centers (FAHC and UVMCC) All other VT hospitals Brattleboro Retreat 3 Federally Qualified Health Centers (FOHCs) 4 Rural Health Centers 400+ Primary Care Physician FTEs (VT & NH) <ul style="list-style-type: none"> - 2000+ Specialty Care Physicians (VT & NH) 	<ul style="list-style-type: none"> 29 of 40 Skilled Nursing Facilities 11 VNA/ Home Health All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, no Children's MH Specialized Service Agency (SSA), and no DS SSAs 	<ul style="list-style-type: none"> 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV Separate Incentive Plan Provision for OCV Network Affiliates Both depend on reporting and performance metrics 	55,114 50%	55,114 54%	13,222 = 7,619 QMB only and QMB/Medicaid coverage + 5,603 Other Dual Eligible Status 66%
Community Health Accountable Care (CHAC)	Jan 1, 2014	12 of 14 Counties (Addison, Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Rutland, Washington, Windham, Windsor)	<ul style="list-style-type: none"> 113 Primary Care Physicians Family: 70; NP/PA: 36; IM: 6; Peds: 1 	<ul style="list-style-type: none"> 5 of 9 FOHC sites 19 unique practice locations 	<ul style="list-style-type: none"> Distribution methodology to be determined. 	4,956 4%	4,956 5%	unknown
TOTALS			~513 Primary Care Providers			60,070 54% of all VT Medicare enrollees	60,070 59% of all VT MSSP Eligible enrollees	13,222+ At least 66% of all VT Duals

Vermont Shared Savings Program ACO Table - Updated 6-16-15

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	StartDate in Program	Geographic Area	ACO Network Participants ^{vi, vii} (Providers with attributed lives)	ACO Network Affiliates ⁹ (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network ^{viii}	Estimated Medicaid Attributed Lives		
						# and % of Total VT Medicaid Enrollees (Total N= 132,829) ^{ix}	# and % of VT VMSSP Eligible Enrollees (Total N=95,000) ^{xv}	# and % of Dual Eligibles within Attributed Lives (Total N=20,018)
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 2 Academic Medical Centers (FAHC and DHMC) 10 additional VT hospitals 12 Pediatric Clinics 4 Naturopathic Centers 80 unique practice sites 650+ Attributing Physician FTEs RN/PA:111; Family: 239; Peds: 109; Geriatric: 3; Internal: 194; Naturopathic: 12 	<ul style="list-style-type: none"> All 11 Mental Health Designated Agencies 13 Hospitals 241 unique practice sites 2,770 Participating Providers Specialty: 1157; PA/NP: 103; Women: 166; Mental/Counseling: 364; EMER: 292; Family: 33; General/ IM: 236; Hospice/HH: 13; Peds: 96; Social Work: 165; Other: 135 	<ul style="list-style-type: none"> 90% of shared savings distributed to OCV Network Participants and Affiliates; 10% retained by OCV Provider amount depends on reporting and performance metrics 	30,236 23%	30,236 32%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 7 FOHCs and Bi-State Primary Care Association 37 unique practice sites 229 Attributing Physician FTEs EMER: 2; Family: 124; NP/PA: 38; Internal: 34; Ger: 1; PEDS: 19 	<ul style="list-style-type: none"> 97 unique practice sites 8 State Designated Agencies 6 hospitals, 26 health centers, 21 behavioral/mental health centers 1,357 Participating Providers EMER: 61; Family: 12; NP/PA: 72; Internal: 37; Mental/Counseling: 939; General: 27; Specialty: 128; Behavioral: 20; Dental: 33; Other: 26 	<ul style="list-style-type: none"> Distribution methodology to be determined. 	17,884 13%	17,884 19%	0
TOTALS			~879 Primary Care Providers			48,120 36.2% of all current VT Medicaid enrollees	48,120 50.7% of all VMSSP Eligible enrollees	0 0% of all VT Dual Eligibles

Vermont Shared Savings Program ACO Table - Updated 6-16-15

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT)								
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants ^{xi} (Providers with attributed lives)	ACO Network Affiliates ¹⁵ (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network ^{xii}	Estimated Commercial Plan Attributed Lives		
						# and % of Total VT Commercial Plan Enrollees (Total N=341,077) ^{iv}	# and % of VT XSSP Eligible Enrollees (Total N=70,000) ^{xiii}	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Healthfirst - - Vermont Collaborative Physicians (VCP)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 111 Physicians - 26 Primary Care Practices 	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: <ul style="list-style-type: none"> Specialists Other specific entities (e.g., Visiting Nurses Association) 	<ul style="list-style-type: none"> PCP's to retain the majority of shared savings VCP to retain a portion for administration and reserves Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement 	8,130 (BCBS only) 2%	8,130 (BCBS only) 12%	0
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 2 Academic Medical Centers (UVMHC and DHMC) 10 Vermont Hospitals and 1 NH Hospital (Cheshire) Brattleboro Retreat 1 Federally Qualified Health Center (FQHC) 3 Rural Health Clinics 300+ Primary Care Physician FTEs (VT & NH Physicians) 1,900+ Specialty Care Physicians (VT & NH Physicians) 	<ul style="list-style-type: none"> 19 Skilled Nursing Facilities 10 VNA/Home Health 11 Designated Agencies (DA)s 	<ul style="list-style-type: none"> 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV Separate Incentive Plan Provision for OCV Network Affiliates Both depend on reporting and performance metrics 	22,908 (BCBS Only) 7%	22,908 (BCBS Only) 33%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Lamoille)	<ul style="list-style-type: none"> 338 Physicians Gen: 8; Specialist: 31; Counselor/Mental: 28; Dental: 19; Emer: 14; Family: 110; NP/PA: 47; IM: 32; Women: 21; Peds: 20; Social Worker: 7 	<ul style="list-style-type: none"> 33 FQHC Practice Sites 4 dental locations 3 other practice sites 	Distribution methodology to be determined.	8,048 (BCBS Only) 2%	8,048 (BCBS Only) 11%	0
TOTALS			~749 Providers			37,252 11% of all VT Commercial Plan enrollees	37,252 53% of all VT XSSP Eligible enrollees	0 0% of all VT Dual Eligibles

Vermont Shared Savings Program ACO Table - Updated 6-16-15

ⁱ Current Network Participants and Network Affiliates as of April, 2014; may change over time

ⁱⁱ ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicare performance and savings; Outcomes for each "life" can only relate to a single ACO.

ⁱⁱⁱ Under the Medicare SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

^{iv} Source: <http://hcr.vermont.gov/sites/hcr/files/2015/2014%20VHHIS%20Comprehensive%20Report%20.pdf>

^v MSSP does not include Medicare enrollees in Medicare Advantage Plans. In March 2014, 9,036 Vermonters were enrolled in these Plans. Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Downloads/2014/Mar/State-County-Penetration-MA-2015-06.zip

^{vi} Current Network Participants and Network Affiliates as of April, 2014; may change over time

^{vii} ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicaid performance and savings; outcomes for each "life" can only relate to a single ACO.

^{viii} Under the Medicaid SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

^{ix} Source: <http://hcr.vermont.gov/sites/hcr/files/2015/2014%20VHHIS%20Comprehensive%20Report%20.pdf>

^x Number provided in DVHA's VMSSP RFP; the following populations are excluded from being considered as attributed lives: Individuals who are dually eligible for Medicare and Medicaid; Individuals who have third party liability coverage; Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

^{xi} Current Network Participants and Network Affiliates as of April, 2014; may change over time

^{xii} Under the Commercial SSP, ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

^{xiii} The XSSP eligible population for attribution to an ACO includes individuals who have obtained their commercial insurance coverage through products available on the VT Health Connect Exchange (obtained through the exchange website or directly from the insurer).

^{xv} Based on DVHA SFY'15 Budget Document Insert 2, using SFY '14 BAA enrollment figures; excludes Pharmacy Only Programs and VHAP ESI, Catamount, ESIA, Premium Assistance For Exchange Enrollees < 300%, and Cost Sharing For Exchange Enrollees < 350% (i.e., all programs that financially assist individuals to enroll in commercial products)

Attachment 4c

Blueprint Pay for Performance

Update

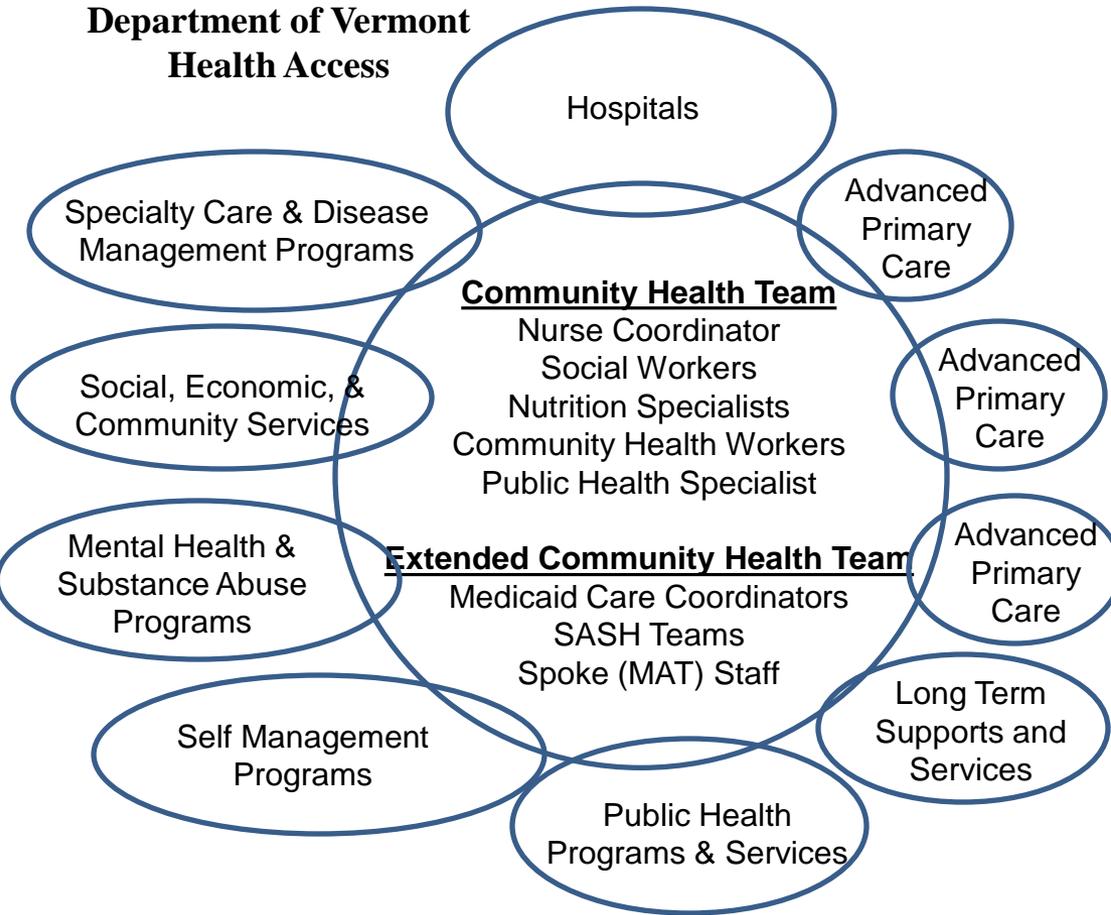
Transforming to: Community Health System

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Components of the Blueprint

- Advanced Primary Care Practices/Patient Centered Medical Homes (PCMHs)
- Community Health Teams
- Community Based Self-management Programs
- Multi-insurer payment reforms
- Health Information Infrastructure
- Evaluation & Reporting Systems
- Learning Health System Activities

Smart choices. Powerful tools.

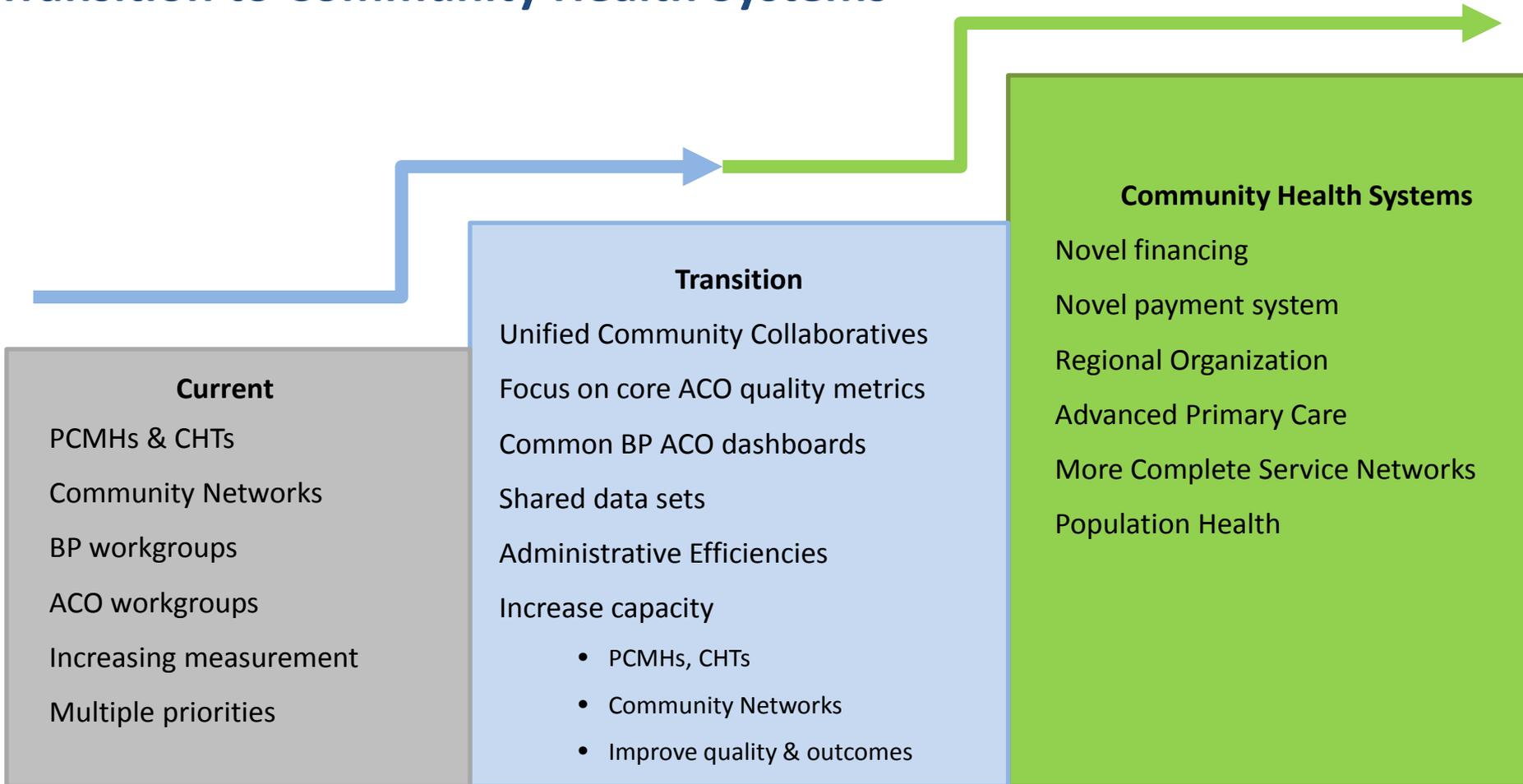


- Service implementation designed locally through multi-agency collaboration bridging health, human services, and community resources
- Foundation of medical homes and community health teams that support complex care coordination and population management and is linked to broad range of community services
- Multi Insurer Payment Reforms fund medical home transformation and capacity for community health teams
- Health information technology infrastructure including EMRs, hospital data sources, and a health information exchange for data aggregation
- Evaluation infrastructure that produces actionable reports for practices, HSAs, organizations, ACOs and the State

All-Insurer Payment Reforms
Local leadership, Practice Facilitators, Workgroups
Local, Regional, Statewide Learning Forums
Health IT Infrastructure
Evaluation & Comparative Reporting

Continued Evolution: BP and ACO Collaboration

Transition to Community Health Systems



In Progress: Building a Community Health System

- Unified community collaborative (coordination, quality)
- Balanced leadership team (ACOs, VNAs, DAs, AAAs, Housers, Peds, others)
- New PCMH & CHT payment models
- Focus transformation support through Blueprint grants
- Comparative performance reporting to guide initiatives
- New NCQA scoring process

Strategy for Building Community Health Systems

Action Steps

- Unified Community Collaboratives (quality, coordination)
- Unified Performance Reporting & Data Utility
- Increase support for medical homes and community health teams
- Novel medical home payment model

Unified Community Collaboratives

- Unified local quality collaboratives (blend BP and ACO groups)
- Focus on core ACO measures (add ACO measure dashboard)
- Leadership team includes clinical leadership from ACOs, Mental Health Agency, Area Agency on Aging, Home Health Agency, Pediatrics, Housing Organization, to form a leadership team of up to 11 members
- Convene community stakeholders
- Regular leadership and workgroup meetings
- Local groups adopt charter and select leadership
- Guide quality and coordination initiatives

Unified Performance Reporting

- Co-produce comparative profiles
- Service area and practice level profiles
- Comparative results for expenditures, utilization, and quality
- Include dashboard with results for core ACO measures
- Possible through a linkage of claims and clinical data
- Objective basis for planning and extension of best practices

Data Utility

- Integration of diverse data sets for advanced measurement
- HSA profiles incorporate claims, clinical, BRFSS data, IOM Core Metrics
- Claims and clinical data are linked for hybrid measures
- Produce analytic data sets to meet ACO measurement needs
- Share analytic data sets with ACOs
- Collaborative work (VITL, others) to build data infrastructure

Practice Profiles Evaluate Care Delivery Commercial, Medicaid, & Medicare

Welcome to the 2014 *Blueprint Practice Profile* from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services. Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Practice Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the prior year.

Demographics & Health Status

	Practice	H.S.A.	St.
Average Members	4,081	84,070	
Average Age	50.6	50.1	
% Female	55.6	55.5	
% Medicaid	14.5	13.0	
% Medicare	23.7	22.2	
% Maternity	2.1	2.1	
% with Selected Chronic Conditions	50.1	38.8	
Health Status (CRG)			
% Healthy	39.0	43.9	
% Acute or Minor Chronic	18.8	20.5	
% Moderate Chronic	27.9	24.5	
% Significant Chronic	15.4	12.3	
% Cancer or Catastrophic	1.4	1.3	

Table 1: This table provides comparative information on the demographics status of your practice, all Blueprint practices in your Hospital Service Area (HSA) as a whole. Inclusion measures reflect the types of information used to adjust rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial enrollment during the year. In addition, special attention has been given to Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's practice, percentage of membership in Medicaid, Medicare eligibility or end-of-stage renal disease status, and the member requires special Medicaid services that are not found in common populations (e.g. day treatment, residential treatment, case management, services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of members through the claims data as having one or more of seven selected chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, cancer, diabetes, hypertension, diabetes, and depression.

The Health Status measure aggregates 3M™ Clinical Risk Groups (CRG) for the year for the purpose of generating adjusted rates. Aggregated risk class include: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (e.g., CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (e.g., amyotrophy, cystic fibrosis).

Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Total Expenditures per Capita

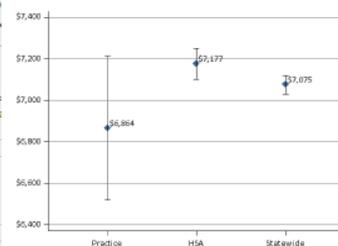


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Expenditures by Major Category

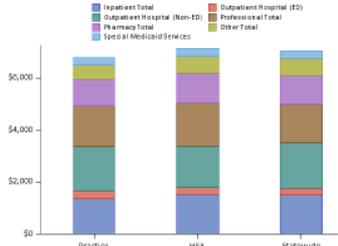


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medical Services.

Total Expenditures Excluding SMS

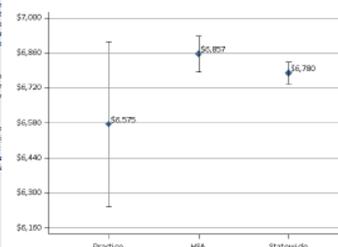


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medicaid Services capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Resource Use Index (RUI) Excluding SMS

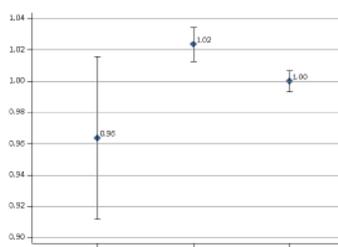
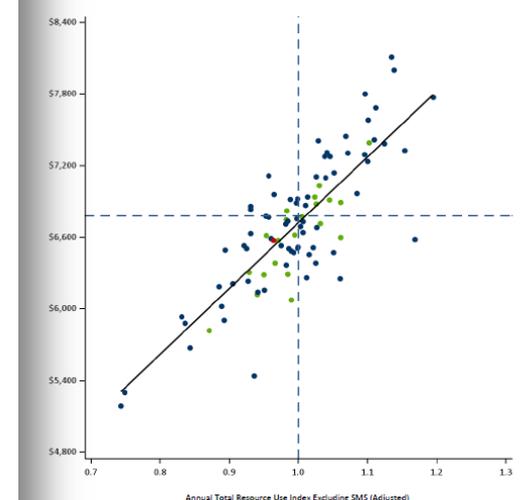


Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per service varies across Vermont, a measure of expenditure based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects an aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medicaid Services. The practice and HSA are indeed to the statewide average (1.00).

Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)



This graphic demonstrates the relationship between risk-adjusted expenditures excluding SMS and RUI for Blueprint practices. This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint (i.e., the blue dots). The dotted lines show the average expenditures per capita and average RUI statewide (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand corner with lower expenditures and utilization are in the lower left-hand corner. An RUI value indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than average utilization. A trend line has been included in the graphic, which demonstrates that, in general, practices with utilization had higher risk-adjusted expenditures.

Claims Data – PQI Composite (Chronic): Rate of Hospitalization for ACS Conditions (Core-12)

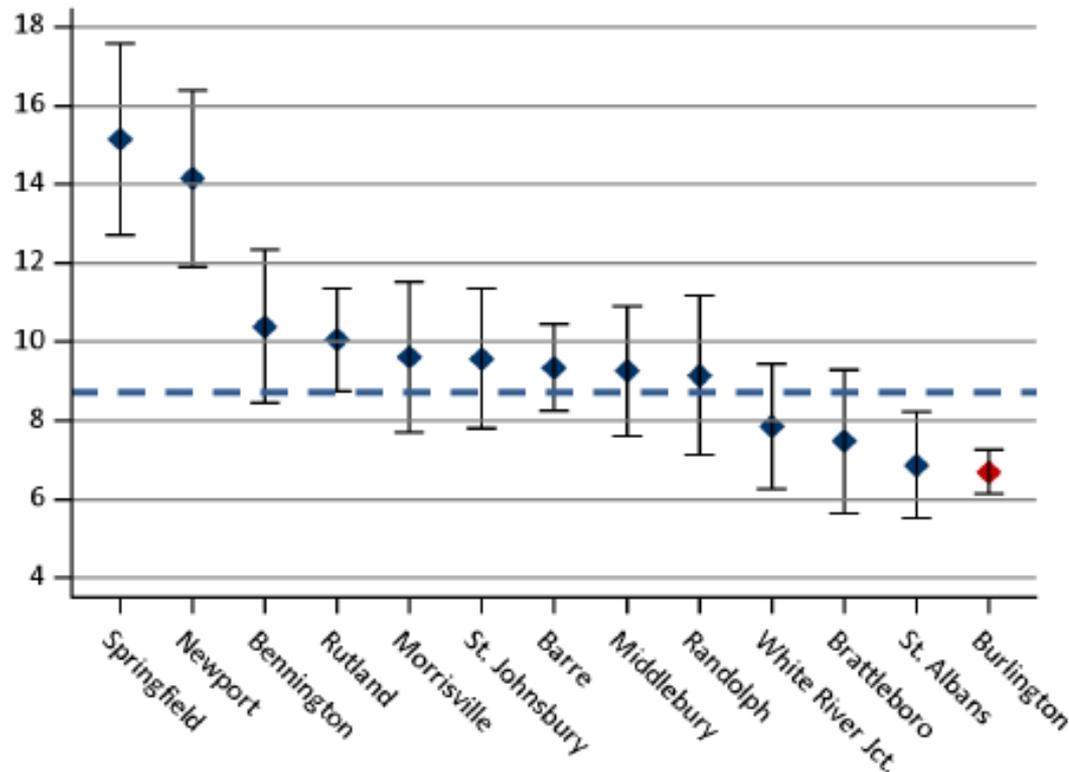


Figure 27: This Prevention Quality Indicator (PQI) presents a composite of chronic conditions per 1,000 members, ages 18 years and older. This measure includes admissions for at least one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The blue dashed line indicates the statewide average.

Claims & Clinical Data – Hypertension: Blood Pressure in Control (Core-39, MSSP-28)

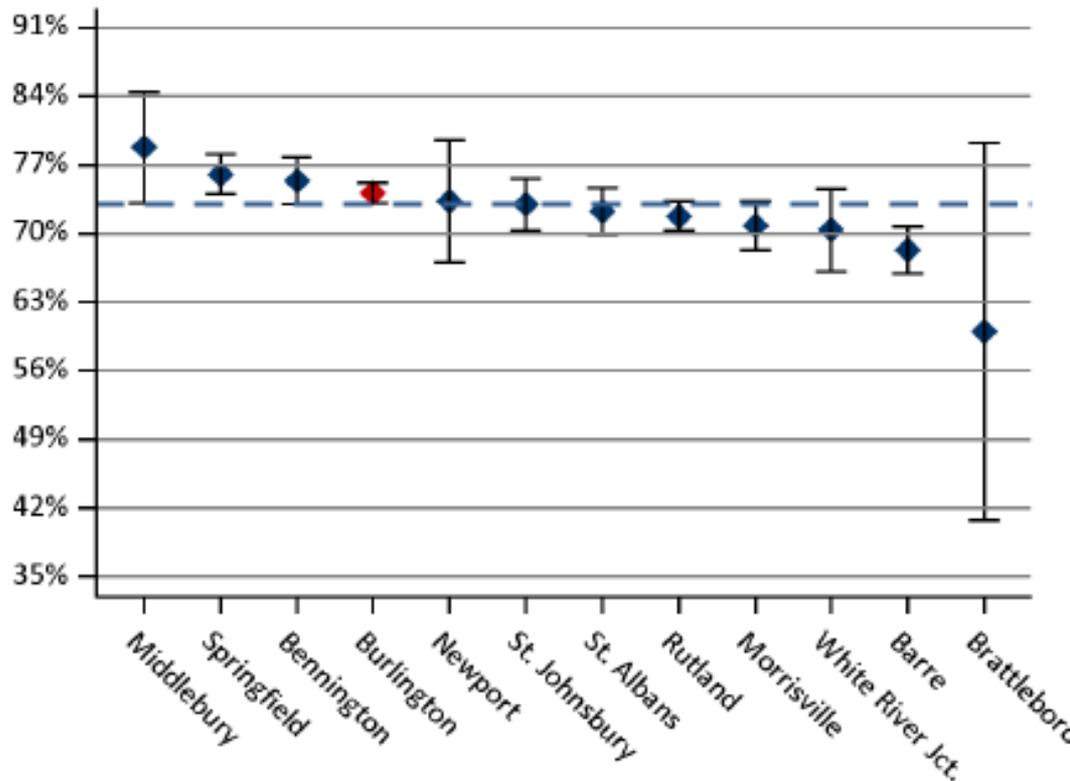


Figure 34: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with hypertension, ages 18–85 years, whose last recorded blood pressure measurement in the DocSite clinical database was in control (<140/90 mmHg). Members with hypertension were identified using claims data. The denominator was then restricted to those with DocSite results for a blood pressure reading during the measurement year. The blue dashed line indicates the statewide average.

Claims & Clinical Data – Diabetes: Poor Control (Core-17, MSSP-27)

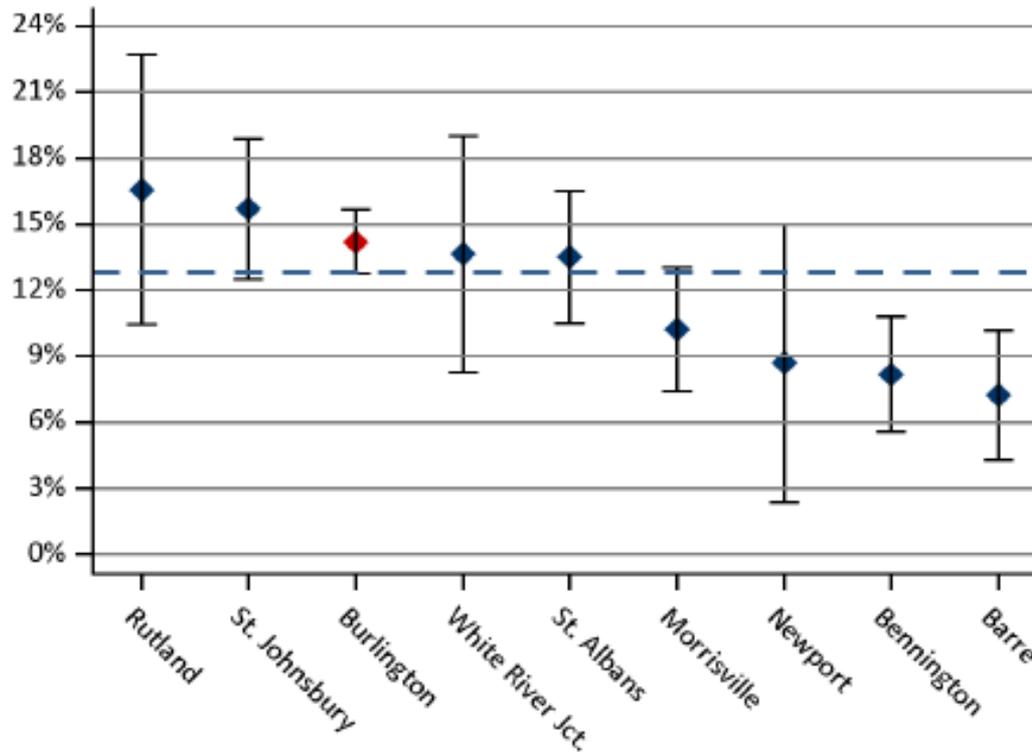


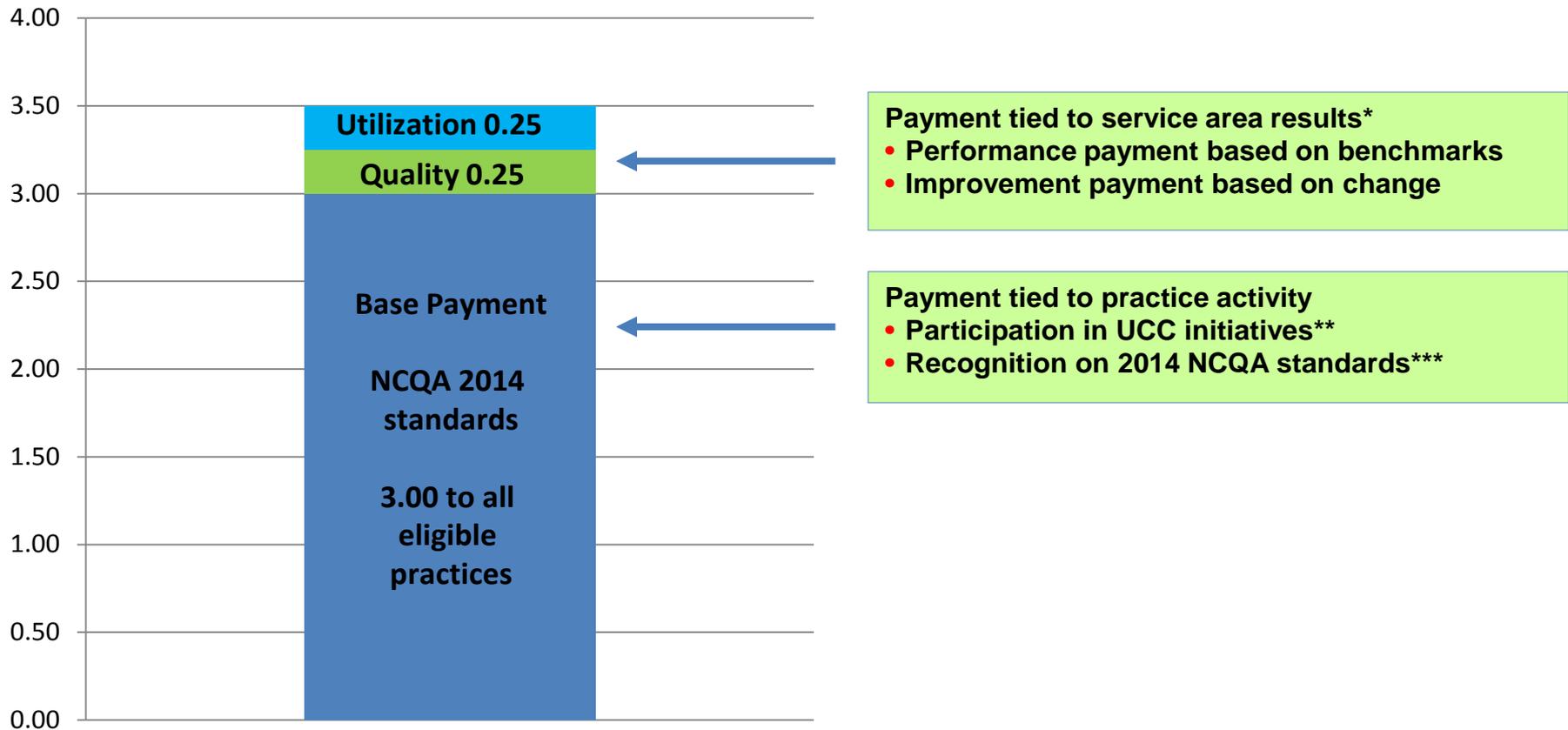
Figure 33: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the DocSite clinical database was in poor control (>9%). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

New PCMH & CHT Payment Models

1. Total appropriation = \$2,446,075
2. \$1,189,646 allocated to Medicaid CHT Market Share starting July 1, 2015
3. \$1,216,934 allocated to Medicaid PCMH Payment starting July 1, 2015
4. Additional \$300,000 for Medicaid on an annual basis

Action	Year	Start	End	Additional Cost
PCMH Payment	1.0 FY16	07/01/2015	06/30/2016	\$1,216,933
CHT Market Share	1.0 FY16	07/01/2015	06/30/2016	\$1,189,646
Total				\$2,406,579

Medical Home Payment Model – Option 3



*Incentive to work with UCC partners to improve service area results.

**Organize practice and CHT activity as part of at least one UCC quality initiative per year.

***Payment tied to recognition on NCQA 2014 standards with any qualifying score. Emphasize priority 'must pass' elements

Proposed Medical Home Payments

- **Base Component: Based on NCQA recognition & UCC Participation.**
 - Requires successful recognition on 2014 NCQA standards (any qualifying score)
 - Requires active participation in the local UCC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum requirement is active participation with at least one UCC priority initiative each calendar year.
 - All qualifying practices receive \$3.00 PPPM

- **Quality Performance Component: Based on HSA results for Quality Index.**
 - Up to \$ 0.25 PPPM for results that exceed benchmark or for significant improvement if result is below benchmark

- **Utilization Performance Component: Based on HSA results for Utilization Index.**
 - Up to \$ 0.25 PPPM for results that exceed benchmark or for significant improvement if result is below benchmark

Total Payment = Base + HSA Quality Performance + HSA TUI Performance

Total Payment ranges from \$3.00 to \$3.50 PPPM (Mean \$3.25)

PCMH & CHT Market Share Start July 1, 2015

1. Total appropriation = \$2,446,075
2. \$1,189,646 allocated to Medicaid CHT Market Share starting July 1, 2015
3. \$1,216,934 allocated to Medicaid PCMH Payment starting July 1, 2015

	Option 3 PCMH Payment Increases			
	Start Date	Average PPM	Total FY16 Increase	Annualized Increase
Medicaid	07/01/15	\$3.25	\$1,508,409	\$1,508,409
BCBS	01/01/16	\$3.25	\$696,971	\$1,393,942
MVP	01/01/16	\$3.25	\$70,297	\$140,594
Cigna	01/01/16	\$3.25	\$9,575	\$19,150
Total			\$2,285,252	\$3,062,095

PCMH Payment Changes

Payer	Current Annualized PCMH Costs Paid Based On PCMH Attrib Patients 2014-Q4	Count of Payer-Reported Claims-Based Blueprint PCMH Attrib Patients 2014-Q4	Market Share of PCMH Attrib Patients 2014-Q4	Increased Annualized PCMH Costs At \$3.25 Avg PPPM	Increased Annualized Cost Difference At \$3.25 Avg PPPM	Percent Change From Current Costs
BCBSVT	\$2,509,918.60	100,099	35.51%	\$3,903,861.00	\$1,393,942.40	55.54%
Cigna	\$30,965.36	1,285	0.46%	\$50,115.00	\$19,149.64	61.84%
Medicaid	\$2,433,867.00	101,084	35.86%	\$3,942,276.00	\$1,508,409.00	61.98%
Medicare*	\$1,619,289.88	67,568	23.97%	\$1,619,289.88	\$0.00	0.00%
MVP	\$321,322.32	11,844	4.20%	\$461,916.00	\$140,593.68	43.75%
Total	\$6,915,363.16	281,880	100.00%	\$9,977,457.88	\$3,062,094.72	44.28%

Community Health Team Payment Based on Market Share

- Insurer market share has changed dramatically. In order for CHTs to be stable, CHT payments need to be based on market share and adjusted on a routine basis
- Cigna reduced CHT payments since 01/01/15, resulting in a 4.5% funding gap for total CHT payments (~\$400,000 per year). Cigna plans to reduce payments to market share levels (07/01/15)
- MVP plans to reduce CHT payments to market share levels (07/01/15)
- Without Medicaid and BCBS increases, these reductions (Cigna, MVP) will result in an additional \$1,173,275 funding gap (July to December 2015)

CHT Market Share Adjustments

Payer	Current Share of CHT Costs Paid	Current Annualized CHT Costs Paid Based On CHT Attrib Patients 2014-Q4	Count of Payer-Reported Claims-Based Blueprint CHT Attrib Patients 2014-Q4	Market Share of CHT Attrib Patients 2014-Q4	Market-Share Annualized CHT Costs	Market-Share Annualized Cost Difference	Percent Change From Current Costs
BCBSVT	24.22%	\$2,170,385.44	100,099	36.04%	\$3,327,290.76	\$1,156,905.32	53.30%
Cigna	13.66%	\$1,224,090.22	1,285	0.46%	\$42,713.40	-\$1,181,376.82	-96.51%
Medicaid	24.22%	\$2,170,385.44	101,084	36.40%	\$3,360,032.16	\$1,189,646.72	54.81%
Medicare*	22.22%	\$1,991,162.86	67,568	24.33%	\$2,002,715.52	\$11,552.66	0.58%
MVP	11.12%	\$996,477.54	7,672	2.76%	\$255,017.28	-\$741,460.26	-74.41%
Total	95.44%	\$8,552,501.51	277,708	100.00%	\$8,987,769.12	\$435,267.61	5.09%

Community Oriented Health Systems



- Core measures & NCQA standards provide a statewide framework
- PCMH payment model incents quality & coordination
- Community collaboratives guide quality & coordination initiatives
- More effective health services & community networks
- Health System (Accessible, Equitable, Patient Centered, Preventive, Affordable)

Blueprint Website:

<http://blueprintforhealth.vermont.gov/>

Questions?

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Attachment 5

Strategic Plan Priorities Matrix

	Who has been working on it	Contact person or entity (primary responsibility)	Progress (None, Some, Considerable)	Cost (Low, Mod, High)	Overall priority	Tasks (pending and ongoing)	Tasks (completed)	Questions/Comments
RECOMMENDATIONS: OVERSIGHT AND PLANNING								
<i>Recommendation #1: Under the auspices of the Agency of Administration, the Secretary of Administration shall convene and staff from within the Agency a permanent health care workforce working group (Workgroup) to monitor workforce trends, develop strategic objectives and activities, direct and pursue funding for health care workforce development activities, and advise and report to the Secretary on its efforts. The Workgroup shall include state government interagency representation as well as representation from health care employers, clinicians, membership organizations, secondary and higher education, and other relevant interest groups.</i>	Workforce Workgroup	Chair(s) of Workforce Workgroup	The work force workgroup first convened in November of 2013. Since that time, the group has been meeting regularly to discuss topics of interest to stakeholders. See subrecommendations for more detailed progress to date.	low	high	1. PENDING: Workgroup discussion of some of the process issues described in the comments section 2. PENDING: Final report for FY2015. 3. PENDING: Workplan update for FY2016		Are the right people at the table? How does this get decided? What is the process to add/adjust? Should this be evaluated and addressed annually? Are the members actively participating? How does this group seek/receive broader input from nonmembers?
• <i>Sub-recommendation #1a: Monitor Track and discuss federal, state, and foundation private funding and collaboration opportunities on an ongoing basis. Serve as advisory group to selected grants or projects.</i>	Workforce Workgroup	Chair(s) of Workforce Workgroup	Some progress to date: The workgroup spends a portion of every meeting discussing current funding opportunities and if they would be of benefit to Vermonters. A streamlined process for better tracking and dissemination of opportunities across stakeholders is a next step for this workgroup.	low	MOD	1. ONGOING: The work group will spend the beginning of every meeting sharing status reports and updates on any current or future being pursued or worked on. 2. ONGOING: Review opportunities for primary care and rural programs, e.g. Teaching Health Centers, Advanced Primary Care (moved from new recommendation below).		What is the structure/process for monitoring? What is the purpose of "monitoring?" Need to communicate opportunities, facilitate collaboration, awareness of proposals underway/submitted/grants secured (beyond only the work group membership). Where is this info tracked/posted? Can group serve as "advisory group" for many of these grant projects--similarly to what WDP was attempting? Prevent lots of different advisory groups/redundant meetings, often with the same people, all working on the same things--streamline. This is a foundational item...
• <i>Sub-recommendation #1b: Develop short and long term workforce supply and demand and performance - measures (factor current supply data, demand modeling data, as well as available vacancy data) in order to conduct ongoing strategic planning which direct workforce development activities.</i>	OPR, VDH, DOL, AHEC (primary care practitioners)	Chair(s) of Workforce Workgroup	The work group is in the process of gathering data (supply, demand--through demand modeling, and vacancy--see "Tasks"). In order to move forward on this recommendation, the group will need to 1.) seek clarification on what is meant by "performance measures, and 2.) determine how to incorporate data into ongoing strategic planning for workforce development activities.	mod	HIGH	1. ONGOING: Assist with design and interpretation of VDH analyses and reports to ensure they are meaningful and relevant. 2. PENDING: Review demand modelling inputs and outputs		1. Seek clarification on what is meant by "performance measures." 2. Should we set as a task to produce an annual report of our activities?
• <i>Sub-recommendation #1c: Work with the Green Mountain Care Board (GMCB) to develop and align workforce supply performance measurement and data collection and goals with overall goals and measurements for assessing - health care reform (i.e, workforce matches to the transformed system; such as its focus on primary care) progress to assure all data collected is streamlined and not overly burdensome.</i>	GMCB, work group co-chairs/staff	Chair(s) of Workforce Workgroup	No progress to date: the Group should seek clarification on role of GMCB in relation to the WFWG before progress can be made.	low	high	1. ONGOING: annual report and meeting with GMCB (this is being facilitated now by the SIM grant processes)		1. Seek clarification on role of GMCB in relation to WFWG 2. Ensure aligned with annual budgeting process.
• <i>Sub-recommendation #1d: Work with the Green Mountain Care Board to assure that overall performance workforce supply data and measures are reported in a unified manner and able to be exchanged or transmitted in formats which can be manipulated for data analysis.</i>	GMCB, ? OPR, VDH, DOL?	Chair(s) of Workforce Workgroup	Some progress to date: Work group working with VDH/OPR to review workforce supply reports (licensure survey data) to ensure accessibility of formats and reports--the group has not yet engaged GMCB on this front			1. PENDING: Workforce working group shall conduct periodic inventory of surveys of workforce data collection throughout the state.		should this be moved to be a subset of #1c? It is just best practice.
• <i>Sub-recommendation #1e: Work with the Department of Labor to expand the availability of internship, certificate or training programs through the provision of workforce development grants to health care employers, including leveraging existing programs within the Department.</i>	DOL	Mat Barewicz	No progress to date: Work group members need to assess the current list of programs through DOL to identify areas where the State is falling short to better support Vermonters looking to enter the State's healthcare workforce.	mod		1. PENDING: Obtain inventory from Mat of DOL programs		1. Is this specifically referring to DOL's WET Funds and its programs? Otherwise seems applicable to higher ed institutions and tech ed centers. 2. Are there other, more "on-the-ground" programs occurring? Who can we reach out to regarding these?
• <i>Sub-recommendation #1f: Assess and make data-driven recommendations regarding the resources available to, and number of professions eligible for, Vermont's Educational Loan Repayment Program.</i>	VDH, AHEC	VDH, AHEC	Progress made, recommendation is ongoing: The work group has issued recommendations on FY2016 budget cut to Educational Loan Repayment Program and will continue to make recommendations in future years as need arises.	low to recommend, but costs to implement		1. PENDING: Workgroup discussion regarding role the workgroup should be playing in priority setting	COMPLETED: Issued recommendation on current FY2016 budget cut to the Loan Repayment Program.	1. issues include: how to prioritize, resources to implement, not changing priorities too frequently 2. This should be parallel for the VDH-VSAC incentive scholarships (nursing, dental hygiene, dentists) 3. State policy for VSAC need-based scholarships for granduate level health professions educations (e.g. currently available for medical students)
• <i>Sub-recommendation #1g: Work with the UVM and Regional VT AHEC Network Programs, UVM Office of Continuing Medical Education and professional membership organizations to increase identify and offer relevant and timely continuing education opportunities for existing health care professionals</i>	AHEC, UVM-CE, Bi-State, various professional membership orgs	Charles MacLean	AHEC, UVM-CE, Bi-State, and various professional membership orgs across the State are working on this initiative. Workgroup needs to determine if more programs is really what Vermont needs, or a change of emphasis and promotion of those currently in existence.	mod		none		1. there are many existing organizations and initiatives in this area.
• <i>Sub-recommendation #1h: Recommend activities to recruit health care professionals and expand community based recruitment and retention activities and national marketing of Vermont.</i>	DOL, GMCB, AHEC, UVM, professional membership orgs	Chair(s) of Workforce Workgroup	Some progress to date: Work has been done by Bi-State on the National Outreach Proposal. Additionally, we are exploring the ideas of VT Loan Repayment, AHEC MD Placement Program, VT Dentist Recruiter Program, and the UVM MC Residency Programs.	low	HIGH	1. PENDING: Workgroup to take an inventory of what is currently happening for professions other than those listed in comments. Any new efforts will require resources. 2. PENDING: Workgroup discussion regarding identifying and overcoming barriers (e.g. spousal employment)		1. National Outreach Proposal from Bi-State (see 4/2/14 meeting materials), VT Loan Repayment, work of AHEC MD Placement Program, work of VT Dentist Recruiter Program, UVM MC Residency Programs
• <i>Sub-recommendation #1i: Convene the Department of Education and UVM, VSC system, and VT AHEC Network Regional AHEC Programs - to develop statewide efforts which increase the overall awareness of health care careers within secondary education.</i>	DOE, AHEC, UVM, federal HRSA and AHEC HCOP	Nicole LaPointe	Little progress to date - work group members should work with stakeholders convene a meeting to discuss this topic	mod	high	1. ONGOING: Activities related to Act 77 flexible pathways personalized learning plans (e.g. College Quest and Health Career Opportunities Program)		

<ul style="list-style-type: none"> Sub-recommendation #1j: Work with the Department of Labor to develop a statewide marketing campaign aimed at increasing the number of non-traditional adult students pursuing careers in health care and accessing supportive services through regional Career Resource Centers. 	DOL	Mat Barewicz	Some progress has been made - AHEC does some outreach to adults. Work group members will reach out to DOL to determine whether marketing campaign activities are tracked, and strategize re: targeted outreach.	mod	HIGH	1. PENDING: Question for Mat Barewicz - are actions around marketing campaigns targeted to this group tracked? (for example: getting information on health careers to workers affected by plant closures)		
<ul style="list-style-type: none"> Sub-recommendation #1k: Gather data and continue planning efforts in order to prioritize the long term recommendations set forth in this plan. The Workgroup shall work with state departments and other stakeholders to determine the timing and ongoing financial resources necessary to initiate and complete its long term recommendations and present to the legislature a more detailed, action-oriented plan for appropriating funds towards workforce development that enhances health care reform success for review during the 2016 legislative session. The Workgroup shall present an overview of its activities and progress to the GMCB twice annually. 	WFWG co-chairs/staff	WFWG co-chairs/staff	No progress to date - this recommendations needs to be updated to be more specific in Work Group's advisory role to administration, and to modify the process for the future.	low				CONSIDER: strike this sub-recommendation and blend with #1c and #1d above (Maybe simplify to "Administration" alongside GMCB)
<p><u>Recommendation #2:</u> The Secretary of Administration should direct the Office of Professional Regulation and other state licensing bodies to collect and analyze workforce supply data.</p>	OPR/VDH	Chris Winters, Peggy Brozicevic, Dawn Philibert	Considerable progress has been made: staff from OPR and VDH are collecting and analyzing survey report data; work group provided feedback to make provider reports more meaningful.		HIGH	none	COMPLETED: VDH hired new staff to review data from OPR and design physician survey reports/analyze survey report data	Should the Work Force Work Group play a role in formulating workforce-related questions and task VDH staff with specific reports? YES, this task is now in sub-recc #1b
<p><u>Recommendation #3:</u> The reporting of workforce-related planning data by health care professionals should be mandatory in order to issue licenses, certifications or registration.</p>	OPR	Chris Winters	Reporting of this data has been made mandatory - can this recommendation be considered completed? Can we remove?	low		none	COMPLETED	
RECOMMENDATIONS: RECRUITMENT AND RETENTION								
<p><u>Recommendation #4:</u> Based upon input and documentation from the Workgroup, <u>the Vermont Department of Health, Area Health Education Center (AHEC) and Bi-State Primary Care Association, the Secretary of Administration</u> should educate and work with Vermont's congressional delegation to encourage changes in how National Health Service Corp assignees are placed. The delegation should work with other similarly affected states' delegations in this effort.</p>	UVM-OPC, VDH, AHEC, Bi-State	Elizabeth Cote	Considerable progress: work was done by UVM-OPC/AHEC, which led to Vermont's eligibility for consideration in the federal NHSC SLRP program, based on adjusted guidelines. Continued work on this item is of low priority and should be revisited annually.	low	LOW	none	COMPLETED: Work done by David Reynolds, UVM-OPC/AHEC, congressional delegation (spec. Bernie Sanders) and Bi-State over several years. Resulted in VT eligible for consideration in the federal NHSC SLRP program, based on adjusted guidelines.	Additional work on the NHSC federal LRP is not high priority at this time due to political climate and change very unlikely.
<p><u>Recommendation #5:</u> In the selection criteria and admission of qualified students, the state college system, UVM (including the UVM Medical School and the UVM Medical Center Medical and Dental Residency Programs) should include assessment of the qualities which make a student more likely to specialize in primary care and practice in rural, underserved areas.</p>	UVM-COM	Charlie MacLean	Some progress has been made: an update has been requested at UVM-COM, but work group needs to discuss how to move forward.	low	LOW	1. PENDING: Workgroup discussion regarding how to narrow this to do-able tasks.		
<p><u>Recommendation #6:</u> In the education and training of students in the health field, the state college system, including the UVM Medical School and UVM Medical Center Residency Program, should create a culture which promotes primary care specialties, serving disadvantaged populations and practicing in rural areas.</p>	UVM-COM; UVM-MC GME		Some progress has been made: regional AHECS do some of this work, but the group could develop a method to track the initiatives that support this recommendation (there are many supporting programs)	low		1. PENDING: Workgroup discussion regarding how to narrow this to do-able tasks. For example could we focus here on the rural rotations in Family Medicine (task for GME?)		There are issues surrounding limited educational capacity of preceptors and competition for preceptors
RECOMMENDATIONS: IMPROVING, EXPANDING AND POPULATING THE EDUCATIONAL PIPELINE								
<p><u>Recommendation #7:</u> The state college system, including the University of Vermont College of Medicine and the Residency Program at UVM MC Fletcher Allen Health Care, UVM CNHS, should prepare health care profession students for practice in a health care reform environment (as called for by, for example, IOM, Blueprint for Health, ACO initiatives, and Act 48) through post-secondary curriculum redesign.</p>	Many, UVM-OPC, AHEC		Little progress to date: the work group should coordinate a meeting with these stakeholders (see Tasks column), and identify a contact from the technical school system.	low	LOW	1.PENDING: Workgroup should coordinate DOE/DOL/VSC to attend a work group meeting and speak about their top priorities and activities around this recommendation. 2. PENDING: Workgroup should identify a contact from the technical school system		1. Potential curricular redesign could include: emphasis on population management, interprofessional practice 2. This curricular redesign should also include nursing and social work.
<p><u>Recommendation #8:</u> The Department of Education, VSCs, and the UVM and Regional AHEC Programs should coordinate activities which increase student enrollment in AHEC health career awareness programs and expose students to health care careers through hands on experiences through programs which promote internships, externships and job placements with health profession organizations</p>	AHEC (to lead), DOE, UVM, VSC		Some progress has been made, but more coordination between stakeholders is needed to maximize resources, in current fiscally constrained environment	low	LOW	1. PENDING: Workgroup discussion re how to narrow this to doable tasks. (Stakeholders should maximize existing resources and focus on coordination in the event that funds for new programs is not available.)		1. AHEC programs with middle and high schools 2. MedQuest 3. CollegeQuest, AHEC HCOP; C-SHIP, 4. Future of Nursing grant 5. Current programs are limited by funding; there is room for expansion of these and new programs 6. See proposal to WFWG Committee from NVAHEC re: CollegeQuest (Jan, 2014)
<p><u>Recommendation #9:</u> The Department of Education should accelerate efforts to align secondary education coursework with skills necessary for entry into the field of health care and to define career paths in terms of post-secondary education requirements. These efforts should consider coursework offered K-12.</p>	DOE	Tom Alderman	No progress to date - work group should receive update from DOE.		MOD	1. PENDING: Workgroup shall coordinate meeting from DOE to give Workgroup a sense of DOE's short and long-term plans on this topic		
<p><u>Recommendation #10:</u> The Department of Education, Department of Labor and the UVM and Regional AHEC Programs should develop continuing education opportunities for guidance counselors to better prepare them to assist students considering a career in health care.</p>	DOE, DOL, UVM, AHEC		Considerable progress has been made: AHEC conducts ongoing outreach to guidance counselors, through its website and presentations	low	LOW	none	COMPLETED: AHEC outreach to guidance counselors. Promotion of AHEC programs and www.vthealthcareers.org, and October as Health Care Careers Awareness Month. AHEC has reached out to VT guidance counselors' association and offered presentations for in-service days and/or conferences.	
<p><u>Recommendation #11:</u> Vermont state colleges and tech centers should develop career ladders by facilitating enrollment of Vermont students into health care educational programs. Strategies include but are not limited to articulation agreements and dual enrollment.</p>	VT State Colleges, AHEC Nsg	VSH Contact (Nancy Shaw?), MV Palumbo	Plan written for increasing academic progression (AD to BS) in nursing	Marketing plan - Mod cost		1. PENDING: Workgroup discussion regarding developing specific tasks	COMPLETED: Future of Nursing State Implementation Program Grant (11/13-10/15). Community Health Worker certification being considered by Center on Aging.	Include the ed centers. Career ladders need to link to workforce needs...
<p><u>New Proposed Sub-recommendation #11a:</u> Hospitals and FQHCs should identify opportunities for joint continuing education that could take place through the state college and University of Vermont educational system. This could include, but not be limited to, identifying the needs of employees for training and communicate/coordinate on a regular basis.</p>	Hospital associations, home health, DOL, DOE	Paul Bengtson	New recommendation - no progress to date.			1. PENDING: Workgroup discussion regarding developing specific tasks		

Recommendation #12: Vermont <i>higher education institutions, state colleges and the Fletcher Allen Medical Residency program</i> should evaluate the potential to expand enrollment in health profession education, training and residency programs.	UVM, VT State/Community Colleges		Some progress to date - this is an ongoing, complex task (see Tasks column)	low	MOD	1. ONGOING: See previous work exploring a joint rural family medicine residency program at UVM Medical Center & DMHC in ~2011 2. ONGOING: new FM residency program in Plattsburg, NY, start date summer 2016 3. ONGOING: very preliminary discussion underway for expansion of FM residency in VT 4. ONGOING: PA program in Rutland at St. Joseph's College; enrolling 2016 5. ONGOING: possible grant opportunity for NP residency program in Rutland	1.This is an ongoing needs assessment with a high degree of complexity 2. Expansion of PA/NP programs lead to competition for preceptors.
Recommendation #13: Vermont <i>higher education institutions</i> should evaluate the potential to create abbreviated education and training programs.	VT State Colleges	VSC contact (Nancy Shaw?)	No progress - research needs to be done			1. ONGOING: Workgroup members and staff to research and find examples from around the country, to inform Vermont	How to push discussion about undergrad work in less than 4 years? Med school in less than 4 years? Innovate... Shorter programs, infuse workforce more quickly, less ed debt (and also less reveue to the high ed institution).
Recommendation #14: Vermont <i>higher education institutions</i> should make easier the transition of health career students and their existing academic credits from one state college to another.	VT State Colleges	VSC contact (Nancy Shaw?)	Some progress to date, but more research needs to be done.			1. ONGOING: Future of Nursing Grant - Academic Progression barriers, challenges, and incentives are being studied	
Recommendation #15: Within each Vermont state college, departments should collaborate to develop coursework where health care profession students can be educated together, allowing for interdisciplinary learning.	VT State Colleges/UVM	VSC contact (Nancy Shaw?); Mary Val Palumbo	Some progress to date - need an update on activities from VSC			1. PENDING: Discussion re any tasks for Workgroup?	1. College of Nursing & Health Sciences (Palumbo IPP HRSA grant 2013-16) 2. IPE Task Force in College of Medicine (Jan 2014) 3. SAMHSA grant (UVM Kessler) Also online learning and distance learning opps.
Recommendation #16: The Department of Labor in collaboration with the UVM and Regional AHEC Programs should expand programming of its Regional Career Centers to include guidance and counseling for individuals seeking to pursue a career in health care.	DOL, UVM, AHEC	Mat Barewicz	No progress - need DOL to inform re: RCCs at future meeting and determine potential for expansion			1. PENDING: Workgroup to invite someone from DOL to inform the work group on initiatives at the RCCs on this topic	
Recommendation #17: State programs, such as those within the Department of Education, Department of Labor, Refugee Resettlement Program and others should work with state colleges and Regional AHEC Programs to increase representation of disadvantaged and under-represented populations in health	DOE, DOL, AHEC, State Colleges	Palumbo	Some progress has been made with Future of Nursing grant, but need status of any existing AOE/DOL programs and collaboration			1. ONGOING: UVM Future of Nursing Grant (school outreach, LNA SL tutoring)	
RECOMMENDATIONS: GREEN MOUNTAIN CARE BOARD AND BLUEPRINT							
Recommendation #18: The Green Mountain Care Board and the Blueprint for Health should evaluate the impact of incentives and penalties for reaching workforce <i>performance</i> -measures.	GMCB, BP	GMCB/BP/SIM	No progress			none	
Recommendation #19: The Blueprint for Health shall establish systems of care re-engineering which identify workforce needs and enable professions to work to their highest clinical ability, and provide staff dedicated to ongoing re-engineering analysis.	GMCB, BP/AHEC nsg, OPC and licensing boards?	GMCB/BP/SIM; Palumbo?	Some progress - see Tasks column, but need to determine next steps/future actions			none	1. COMPLETED: Panel Manager training (session completed in 2013 by FAHC in Chittenden County). There is a demand for more training across the state 2. COMPLETED: Survey conducted about incentives for BSNs in Blueprint practice - little incentives found but BSN is appropriate for population management skills
Recommendation #20: The Blueprint for Health and Green Mountain Care Board shall commit to spreading care re-engineering innovations system- wide.	GMCB, BP	GMGB/BP/SIM	No progress - members from group to meet with GMCB annually in order to collaborate on this and other issues.			none	
Recommendation #21: In its movement toward payment reform, the Green Mountain Care Board should examine and be sensitive to its impact on health care professional pay and the potential benefit a redesigned payment mechanism can have for recruitment and retention of health care professionals.	GMCB, BP	GMCB/BP/SIM	No progress to date, but the work group will monitor payment reforms/potential impacts and utilize demand modeling resources.			1. PENDING: Workgroup should monitor payment reforms enacted by the Board, and examine potential impacts on Vermont's work force (as an ongoing task).	How to do this? Could demand modeling help with these sorts of questions and scenarios?