VT Health Care Innovation Project
Practice Transformation Work Group Meeting Agenda

January 5, 2015; 10:00 AM to 12:00 PM
AHS - WSOC Oak Conference Room, 280 State Drive, Waterbury, VT
(Note that this is a New Building. The meeting space is located on the 2nd floor above the main entrance.)
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:00 – 10:10	Welcome & Introductions; Approval of Minutes ***Public Comment***	**Attachment 1:** November meeting minutes	Yes (approval of minutes)
2	10:10 – 10:20	Update on Year 3 No-Cost Extension; Review of Year 3 Merged Work Plan ***Public Comment***	**Attachment 2:** 2016 Practice Transformation Work Group Work Plan	
3	10:20 – 10:35	Review of 2015 Progress; Report Highlighting Integrated Communities Care Management Learning Collaborative ***Public Comment***	**Attachment 3:** Vermont Health Care Innovation Project, 2015 Year in Review **Opportunities to Improve Models of Care for People with Complex Needs:** **http://www.chcs.org/media/HNHC_CHCS_Report_Final.pdf**	
4	10:35-10:55	Updates: • Core Competency Training for Front Line Staff Providing Care Coordination • Updated Report; Care Management in Vermont: Gaps and Duplications ***Public Comment***	**VHCIP Learning Collaborative Trainers RFP can be found at: https://www.vermontbusinessregistry.com/BidPreview.aspx?BidID=12877**	

5	10:55 – 11:10	Regional Blueprint/ACO Committees Progress Report ***Public Comment***	**Attachment 5:** UCC/RCPC Progress Report	
6	11:10 – 11:40	Integrated Communities Care Management Learning Collaborative: • Summary of November Learning Sessions, December Webinar; upcoming learning opportunities • Tools for Enabling Information Sharing for Integrated Care Teams ***Public Comment***	**Attachment 6a:** Care Team Consent guide **Attachment 6b:** Example Notice to Providers **Attachment 6c:** Team Release Template	
7	11:40 – 11:55	Strategic Alignment to Improve Health: Linking the Health and Community Development Sectors ***Public Comment***	**Attachment 7:** Overview, Strategic Alignment to Improve Health: Linking the Health and Community Development Sectors	
8	11:55 – 12:00	Wrap-Up and Next Steps; Plans for Next Meeting		

Attachment 1: November meeting minutes

Vermont Health Care Innovation Project
Practice Transformation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: November 10, 2015; 10:30 AM to 12:30 PM; ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT

Agenda Item	Discussion	Next Steps
1. Welcome, Introductions **Approval of minutes**	Pat Jones opened the meeting at 10:32 and welcomed everyone to the newly constituted work group. The group then made introductions around the room and over the phone. Dale Hackett moved to approve the September minutes of the former Care Models and Care Management (CMCM) work group, by exception. Jenney Samuelson seconded the motion. No abstentions or nay votes were heard and the minutes were approved.	
2. Orientation to Work Group Rebasing; Review of Merged Work Plan	Sarah Kinsler, Senior Health Policy Analyst from DVHA, reviewed the slides in the presentation related to the reorganization of the Vermont Health Care Innovation project. She then walked through the merged work plan for this group noting that the plans were merged in a way that ensured the work was reflective of the prior focus areas of each of the group. She thanked members for providing valuable feedback.	
3. Updates: **Core Competency Training** **Public Comment**	**Core Competency Training** Pat Jones offered an update on the status of the core competency training project. An RFP was posted at the end of August and several bids were received in response to the RFP. The RFP asks bidders to propose training in 3 categories; basic skills in care coordination and care management; skills specific to working with people with disabilities; and special topics to include things like trauma informed care, mental health and other areas. Bidders were invited to bid on some or all categories, knowing that this might result in multiple awards. A key component of the RFP is a sustainability plan, which could include online repositories, train-the-trainer models and the like. The RFP also specified that materials be available to all who would like to access them. The bid review team is currently reviewing the bids with the goal to begin offering training in early 2016. The overarching goal of this project is to create capacity in the workforce and resources that will continue beyond the life of SIM grant. Mark	

Agenda Item	Discussion	Next Steps
	Burke asked where these resources would physically reside – Pat noted that there are several agencies who currently house electronic information of that nature, although the decision is not yet final. The goal is to ensure the content is available online for those who enter the field later on. Sarah Narkewicz commented that through Rutland's participation in the Integrated Communities Care Management Learning Collaborative (ICCMLC), the Rutland team has identified a need for core competency training particularly as it relates to the skills needed to work in a team based model of care to deliver integrated care management. She shared that their team is anxiously awaiting the development of an opportunity to acquire that kind of training. Sarah Jemley noted that this is the kind of training that she has been working to create as she has grown her own team of new care managers from 2 to 6 in the last year – this kind of training does not currently exist and she is looking forward to leveraging it for her team. Barb Cimaglio noted that type of training would be helpful to staff in the wide array of AHS programs, and that steps should be taken to ensure that this training is as widely available and sustainable as possible so that organizations do not have to reinvent the wheel each time there is a need for content of this nature. Pat noted that the training will ideally have content that is useful for community health workers and other similar roles. In summary, the goal is that the training will be designed with as broad of an audience as possible in mind. Bea also stated that there is no barrier to entry to this training – it's up to the individual agencies or groups to identify whomever they feel could benefit. Deborah Lisi-Baker also reinforced the importance of building capacity in this kind of training by leveraging the train the trainer model, or other types of collaborations in order to glean as much as possible from the training.	
4. Regional Blueprint/ACO Committees Progress Report Public Comment	**Regional Blueprint/ACO Committees Progress Report** Jenney Samuelson provided an update on the regional community collaboratives. She referenced the materials in the packet and noted that although communities have labeled their groups differently, the goal is the same – to form a collaborative group of representatives from health and human services organizations across the community that come together to use data to identify quality improvement opportunities, and ultimately improve outcomes for their population. To date, all of the communities have convened and identified their quality improvement goals. The chart (attachment 4) has a newly added column for measures, which is not complete in all cases. Jenney noted that this reflects the information available at the time to meeting materials were distributed, and that new information has emerged since that time. She will update the group on additional progress at the next work group meeting. Jenney also noted an emergence of some common topics – hospice care is one area that many communities have chosen to focus on.	

Agenda Item	Discussion	Next Steps
	Dale asked how quality improvement goals were identified – Jenney responded that the groups used data from the Blueprint, ACOs and other sources to identify the needs of the community and potential opportunities for quality improvement. Additionally qualitative data and the knowledge of team and communities members are often used to better understand the story that the quantitative data tells. Communities often have a sense of what the needs of their population are, what is currently in place, and what initiatives are likely to be successful. Bev Boget commented that half of the groups have chosen hospice utilization, which indicates that this is a high priority across the state. She noted that the University of Maine Muskie School of Public Service recently conducted a survey on hospice utilization that work group members and regional collaborative members may want to review. Jenney noted that the Blueprint is holding joint meetings of experts in this area to offer an opportunity to share best practices. She also noted the opportunity to connect the regional work groups with the vast expertise represented in the practice transformation work group. Nick Nichols asked what kinds of quality improvement opportunities are most commonly identified by communities. Jenney responded that many groups are focusing on the integrated communities care management learning collaborative to impact unnecessary ER utilization, for example. Maura Graff noted that some of the UCC meetings are not currently open to the public. Jenney responded that although the majority of communities are opening their meetings to whoever would like to come, a few are choosing to limit participation in their meetings as they work to create cohesiveness and shared goals in these early stages. Mark Burke offered that in some cases the decision to manage membership has been made so as to be able to function effectively – not everyone can be there or the numbers will become too cumbersome to manage. It is remarkable, he noted, to see the level of buy-in from the community – CEO level leaders from across the community are attending these meetings and that is remarkable to see. Gabe Epstein asked if the groups are sharing their minutes or perhaps accepting public comments. Jenney also mentioned that several groups are still working through some complicated governance and leadership issues and as such, are not yet ready for a broader participation from members outside the group. Further, these meetings don't qualify for the open meeting law requirements. She added that some of them are not ready for that level of transparency as they work through internal decision making. Laural Ruggles stated that she would not hesitate to share their (St. Johnsbury) minutes to anyone who asks and they are open to attendance by anyone. Sue Aranoff recently attended the Central Vermont meeting and was impressed with the breadth of coverage from a broad spectrum of organizations. The presentations were engaging and everyone participated well. She also attended a community health team meeting in St. Johnsbury that was similar in nature. She further noted	

Agenda Item	Discussion	Next Steps
	that she had a different experience at another group; but recently several collaborative groups have reached out directly to invite participation.	
5. Integrated Communities Care Management Learning Collaborative: **Cohort 1 – Summary of September Learning Session; upcoming learning opportunities** **Cohorts 2 and 3 – Summary of September Learning Sessions; upcoming learning opportunities** **Public Comment**	**Integrated Communities Care Management Learning Collaborative** Pat Jones provided an update with some background on the Integrated Communities Care Management learning collaborative Project. She reminded work group members that this is a classic learning collaborative format – with a combination of in person learning sessions featuring national faculty who have done some ground breaking work in the area of coordinated care. The ICCMLC uses the Plan, Do, Study, Act model for quality improvement to test interventions with the goal of improving the overall health of people with complex health care needs. Initially, a pilot round (round 1) engaged three communities in the ICCMLC model – Rutland, St. Johnsbury and Burlington. Their energy and commitment has been astounding and is the basis for the success of the program. 8 additional communities have recently come on board as part of the expanded program. 4 in person learning sessions have been conducted, punctuated with webinars in between. Communities have been asked to use data to identify people with complex health care needs, and expert faculty from the Camden Coalition have demonstrated way to use data to help focus work on those individuals who will most benefit from these kinds of interventions. Examples of additional tools communities are piloting are "Camden Cards", which are an engagement tool that helps the team identify an individual's goals, and Eco-Maps which help identify all the relationships in an individual's life that might make up the care team. The round 2 communities will be working on developing Shared Care Coordination Documents that serve as a communication tools to assist the broad care team in working together to make progress against a defined set of goals. Nick Nichols asked if any focus has been on children/families. The VT Child Health Improvement Program is doing a similar care management learning collaborative around children with special needs and the two groups have shared information and even presenters and faculty. The two groups have turned out to be working on parallel tracks, with the groups reinforcing each other's work. The VCHIP project is focused on care coordinators in pediatric practices in different counties. They bring in people from schools and the health department – they are doing the same type of development of cross-organizational links. Maura Graff asked if it was possible to include a Camden card for the category of family planning. Laural Ruggles responded that the St. Johnsbury team has adopted the cards to better address the needs of their community, and that other communities should feel free to do the same. These are just one tool in the toolbox for patient engagement, and aren't the only way to understand a person's goals. Kirsten Murphy noted that they are well aligned with the concept of making tools more accessible for people with developmental disabilities.	
6. Accountable Community For Health Update Public Comment	**Accountable Community For Health** Heidi Klein provided an update on this initiative. As background, she reminded the group that the Population Health work group had a goal of better understanding ways that the health outcomes of the entire population can be better tied into the payment reform goals of the SIM grant. With this goal in mind, the project partnered with	

Agenda Item	Discussion	Next Steps
	the prevention institute to explore the aspirational concept of an Accountable Community for Health. She referenced the materials in the package with the definition of accountable community for health. **Accountable Community for Health (ACH):** *"An aspirational model—accountable for the health and wellbeing of the entire population in its defined geographic area and not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An ACH supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness."* She talked about how to connect the systems of care and moved to the core elements of an accountable community for health model. She reviewed the materials in the packet, including the key factors: 1. Mission 2. Multi-Sectoral Partnership 3. Integrator Organization 4. Governance 5. Data and Indicators 6. Strategy and Implementation 7. Community Member Engagement 8. Communications 9. Sustainable Funding Heidi noted that we (Vermont) is historically strong at developing multi-sectoral partnerships, but that work remains to be done around the integrator organization, step 3 above. She noted that the regional collaborative groups are working to very aligned with the goals of an AHC as they begin to look across the community to integrate services and address the social determinants of health. Goals of the future state would include looking at the needs of the population as a whole, as opposed to on a case by case basis. For example, do we have enough housing in our community, versus, does this particular patient in my care have adequate housing? The next steps for this project is to develop a shared learning opportunity for community leaders to come together to share ideas and learn from national experts working on these kinds of models. The focus of this project will be on developing community wide strategies and systems to improve the health of a population across a geographic area. Trish Singer asked what payment mechanism is envisioned for this type of model? Sarah Kinsler responded that	

Agenda Item	Discussion	Next Steps
	although the payment model is a key component of an ACH, we are a long way away from making any concrete decisions around funding. Significant work needs to be done to better understand the care delivery model, which is the goal of the shared learning opportunity. Sarah also noted that as we look to how we will operationalize a model like this, we will need to consider key elements such as how it fits this into current payment and delivery system models such as ACOs and all-payer models. The two-page description of Phase II in the materials is a helpful reference as we think about the next steps for this work. Mike Hall asked how we will enforce accountability and align practitioners to help move the conversation around payment model reform. He suggested that this be approached as more of an alternative payment model and not necessarily folded into the ACO model we have now.	
7. Next Steps	Next meeting is: Tuesday, December 8, 2015 10:30 am – 12:30 pm ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier	

VHCIP Practice Transformation Work Group Member List

Dale 1° Jemley S. 2° Motion Carried 0 abstentions

Minutes

10-Oct-15

Member		Member Alternate			
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓	Gabe	Epstein ✓		AHS - DAIL
		Bard	Hill		AHS - DAIL
		Clare	McFadden		AHS - DAIL
Beverly	Boget ✓	Peter	Cobb		VNAs of Vermont
Stephen	Broer				VCP - Northwest Counseling and Support Services
Kathy	Brown	Todd	Bauman		DA - Northwest Counseling and Support Services
Kathy	Brown	Stephen	Broer		DA - Northwest Counseling and Support Services
Barbara	Cimaglio ✓				AHS - VDH
Michael	Counter				VNA & Hospice of VT & NH
Molly	Dugan	Stefani	Hartsfield		Cathedral Square and SASH Program
		Kim	Fitzgerald		Cathedral Square and SASH Program
Eileen	Girling ✓	Heather	Bollman		AHS - DVHA
Maura	Graff ✓				Planned Parenthood of Northern New England
Bea	Grause ✓				Vermont Association of Hospital and Health Systems
Dale	Hackett ✓				Consumer Representative
~~Mike~~	~~Hall~~				~~Champlain Valley Area Agency on Aging / COVE~~
Sarah	Jemley ✓	Jane	Catton		Northwestern Medical Center
Sarah	Jemley	Candace	Collins		Northwestern Medical Center
Linda	Johnson	Debra	Repice		MVP Health Care
Pat	Jones ✓	Annie	Paumgarten		GMCB

VHCIP Practice Transformation Work Group Member List

minutes

Member		Member Alternate			10-Oct-15
First Name	Last Name	First Name	Last Name		Organization
Trinka	Kerr	Nancy	Breiden		VLA/Health Care Advocate Project
Dion	LaShay				Consumer Representative
Patricia	Launer ✓	Kendall	West		Bi-State Primary Care
Sam	Liss				Statewide Independent Living Council
Vicki	Loner	Emily	Bartling		OneCare Vermont
Vicki	Loner	Maura	Crandall		OneCare Vermont
Jackie	Majoros	Barbara	Prine		VLA/LTC Ombudsman Project
Kate	McIntosh	Judith	Franz		Vermont Information Technology Leaders
Bonnie	McKellar	Mark	Burke ✓		Brattleboro Memorial Hopsital
Madeleine	Mongan ✓	Stephanie	Winters		Vermont Medical Society
Mary	Moulton				VCP - Washington County Mental Health Services Inc.
Kirsten	Murphy ✓				AHS - Central Office - DDC
Sarah	Narkewicz ✓				Rutland Regional Medical Center
Laural	Ruggles ✓				Northeastern Vermont Regional Hospital
Jenney	Samuelson ✓				AHS - DVHA - Blueprint
Catherine	Simonson				VCP - HowardCenter for Mental Health
Patricia	Singer ✓	Jaskanwar	Batra		AHS - DMH
		Mourning	Fox		AHS - DMH

VHCIP Practice Transformation Work Group Member List

minutes

Member		Member Alternate			10-Oct-15
First Name	Last Name	First Name	Last Name		Organization
		Kathleen	Hentcy ✓		AHS - DMH
Angela	Smith-Dieng	Mike	Hall ✓		V4A
Lily	Sojourner ✓	Shawn	Skafelstad		AHS - Central Office
Audrey-Ann	Spence	Colleen	Sanford ✓		Blue Cross Blue Shield of Vermont
JoEllen	Tarallo-Falk				Center for Health and Learning
Julie	Tessler ✓				VCP - Vermont Council of Developmental and Mental Health Services
Lisa	Viles				Area Agency on Aging for Northeastern Vermont

20

37 total

VHCIP Practice Transformation Work Group

Attendance Sheet 10/10/2015

	First Name	Last Name		Organization	Practice Transformation
1	Nancy	Abernathy		Learning Collaborative Facilitator	X
2	Peter	Albert		Blue Cross Blue Shield of Vermont	X
3	Susan	Aranoff	phone	AHS - DAIL	M
4	Debbie	Austin		AHS - DVHA	X
5	Ena	Backus		GMCB	X
6	Melissa	Bailey		AHS - DMH	X
7	Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	X
8	Susan	Barrett		GMCB	X
9	Emily	Bartling		OneCare Vermont	MA
10	Jaskanwar	Batra		AHS - DMH	MA
11	Todd	Bauman		DA - Northwest Counseling and Support Ser	MA
12	Bob	Bick		DA - HowardCenter for Mental Health	X
13	Mary Alice	Bisbee		Consumer Representative	X
14	Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DM	X
15	Beverly	Boget	here	VNAs of Vermont	M
16	Heather	Bollman		AHS - DVHA	MA
17	Mary Lou	Bolt		Rutland Regional Medical Center	X
18	Nancy	Breiden		VLA/Disability Law Project	MA
19	Stephen	Broer		DA - Northwest Counseling and Support Ser	MA
20	Stephen	Broer		VCP - Northwest Counseling and Support Se	M
21	Kathy	Brown		DA - Northwest Counseling and Support Ser	M
22	Martha	Buck		Vermont Association of Hospital and Health	A
23	Mark	Burke	here	Brattleboro Memorial Hopsital	MA
24	Anne	Burmeister		Planned Parenthood of Northern New Engla	X
25	Dr. Dee	Burroughs-Biron		AHS - DOC	X
26	Denise	Carpenter		Specialized Community Care	X
27	Jane	Catton		Northwestern Medical Center	MA

28	Alysia	Chapman		DA - HowardCenter for Mental Health	X
29	Joy	Chilton		Home Health and Hospice	X
30	Amanda	Ciecior	nye	AHS - DVHA	S
31	Barbara	Cimaglio	phone	AHS - VDH	M
32	Peter	Cobb		VNAs of Vermont	MA
33	Candace	Collins		Northwestern Medical Center	MA
34	Amy	Coonradt		AHS - DVHA	S
35	Alicia	Cooper		AHS - DVHA	S
36	Amy	Cooper		HealthFirst/Accountable Care Coalition of t	X
37	Michael	Counter		VNA & Hospice of VT & NH	M
38	Maura	Crandall		OneCare Vermont	MA
39	Claire	Crisman		Planned Parenthood of Northern New Engl	A
40	Dana	Demartino		Central Vermont Medical Center	X
41	Steve	Dickens		AHS - DAIL	X
42	Molly	Dugan		Cathedral Square and SASH Program	M
43	Gabe	Epstein	nne	AHS - DAIL	MA
44	Trudee	Ettlinger		AHS - DOC	X
45	Kim	Fitzgerald		Cathedral Square and SASH Program	MA
46	Patrick	Flood		CHAC	X
47	Erin	Flynn	nne	AHS - DVHA	S
48	Mourning	Fox		AHS - DMH	MA
49	Judith	Franz		Vermont Information Technology Leaders	MA
50	Mary	Fredette	phone	The Gathering Place	X
51	Aaron	French		AHS - DVHA	X
52	Meagan	Gallagher		Planned Parenthood of Northern New Engl	X
53	Joyce	Gallimore		Bi-State Primary Care/CHAC	X
54	Lucie	Garand		Downs Rachlin Martin PLLC	X
55	Christine	Geiler		GMCB	S
56	Eileen	Girling		AHS - DVHA	M
57	Larry	Goetschius		Home Health and Hospice	X
58	Steve	Gordon		Brattleboro Memorial Hopsital	X
59	Maura	Graff	nne	Planned Parenthood of Northern New Engl	M
60	Bea	Grause	nne	Vermont Association of Hospital and Healt	C
61	Dale	Hackett	nope	Consumer Representative	M

62	Mike	Hall	here	Champlain Valley Area Agency on Aging / C	MA
63	Stefani	Hartsfield		Cathedral Square	MA
64	Carolynn	Hatin		AHS - Central Office - IFS	S
65	Kathleen	Hentcy	here	AHS - DMH	MA
66	Selina	Hickman		AHS - DVHA	X
67	Bard	Hill		AHS - DAIL	M
68	Breena	Holmes		AHS - Central Office - IFS	X
69	Marge	Houy		SOV Consultant - Bailit-Health Purchasing	S
70	Christine	Hughes		SOV Consultant - Bailit-Health Purchasing	S
71	Jay	Hughes		Medicity	X
72	Jeanne	Hutchins	Phone	UVM Center on Aging	X
73	Sarah	Jemley	Phone	Northwestern Medical Center	M
74	Linda	Johnson		MVP Health Care	M
75	Craig	Jones		AHS - DVHA - Blueprint	X
76	Pat	Jones	here	GMCB	M
77	Margaret	Joyal		Washington County Mental Health Services	X
78	Joelle	Judge	here	UMASS	S
79	Trinka	Kerr		VLA/Health Care Advocate Project	M
80	Sarah	Kinsler	here	AHS - DVHA	S
81	Tony	Kramer		AHS - DVHA	X
82	Sara	Lane		AHS - DAIL	X
83	Kelly	Lange		Blue Cross Blue Shield of Vermont	X
84	Dion	LaShay		Consumer Representative	M
85	Patricia	Launer	Phone	Bi-State Primary Care	M
86	Deborah	Lisi-Baker	Phone	SOV - Consultant	X
87	Sam	Liss		Statewide Independent Living Council	M
88	Vicki	Loner		OneCare Vermont	M
89	Carole	Magoffin	here	AHS - DVHA	S
90	Georgia	Maheras		AOA	S
91	Jackie	Majoros		VLA/LTC Ombudsman Project	M
92	Carol	Maroni		Community Health Services of Lamoille Vall	X
93	David	Martini		AOA - DFR	X
94	Mike	Maslack			X
95	John	Matulis			X

96	James	Mauro		Blue Cross Blue Shield of Vermont	X
97	Lisa	Maynes		Vermont Family Network	X
98	Clare	McFadden		AHS - DAIL	MA
99	Kate	McIntosh		Vermont Information Technology Leaders	M
100	Bonnie	McKellar		Brattleboro Memorial Hopsital	M
101	Elise	McKenna		AHS - DVHA - Blueprint	X
102	Jeanne	McLaughlin		VNAs of Vermont	X
103	Darcy	McPherson		AHS - DVHA	A
104	Madeleine	Mongan	Phone	Vermont Medical Society	M
105	Monika	Morse			X
106	Judy	Morton	Phone	Mountain View Center	X
107	Mary	Moulton		VCP - Washington County Mental Health Se	M
108	Kirsten	Murphy	Neic	AHS - Central Office - DDC	M
109	Reeva	Murphy		AHS - Central Office - IFS	X
110	Sarah	Narkewicz	Phone	Rutland Regional Medical Center	M
111	Floyd	Nease		AHS - Central Office	X
112	Nick	Nichols	Neic	AHS - DMH	X
113	Monica	Ogelby		AHS - VDH	X
114	Miki	Olszewski		AHS - DVHA - Blueprint	X
115	Jessica	Oski		Vermont Chiropractic Association	X
116	Ed	Paquin		Disability Rights Vermont	X
117	Annie	Paumgarten		GMCB	MA
118	Laura	Pelosi		Vermont Health Care Association	X
119	Eileen	Peltier		Central Vermont Community Land Trust	X
120	John	Pierce			X
121	Luann	Poirer		AHS - DVHA	S
122	Rebecca	Porter		AHS - VDH	X
123	Barbara	Prine		VLA/Disability Law Project	MA
124	Betty	Rambur		GMCB	X
125	Allan	Ramsay		GMCB	X
126	Paul	Reiss		HealthFirst/Accountable Care Coalition of t	X
127	Virginia	Renfrew		Zatz & Renfrew Consulting	X
128	Debra	Repice		MVP Health Care	MA
129	Julie	Riffon		North Country Hospital	X

130	Laural	Ruggles	phone	Northeastern Vermont Regional Hospital	M
131	Bruce	Saffran		VPQHC - Learning Collaborative Facilitator	X
132	Jenney	Samuelson	here	AHS - DVHA - Blueprint	M
133	Jessica	Sattler		Accountable Care Transitions, Inc.	X
134	Rachel	Seelig		VLA/Senior Citizens Law Project	X
135	Susan	Shane		OneCare Vermont	X
136	Maureen	Shattuck		Springfield Medical Care Systems	X
137	Julia	Shaw		VLA/Health Care Advocate Project	X
138	Miriam	Sheehey	phone	OneCare Vermont	X
139	Catherine	Simonson		VCP - HowardCenter for Mental Health	M
140	Patricia	Singer	here	AHS - DMH	M
141	Shawn	Skafelstad		AHS - Central Office	MA
142	Richard	Slusky		GMCB	X
143	Pam	Smart		Northern Vermont Regional Hospital	X
144	Angela	Smith-Dieng		V4A	M
145	Lily	Sojourner	here	AHS - Central Office	M
146	Audrey-Ann	Spence		Blue Cross Blue Shield of Vermont	M
147	Beth	Tanzman		AHS - DVHA - Blueprint	X
148	JoEllen	Tarallo-Falk		Center for Health and Learning	M
149	Julie	Tessler	here	VCP - Vermont Council of Developmental a	M
150	Bob	Thorn		DA - Counseling Services of Addison County	X
151	Win	Turner			X
152	Lisa	Viles		Area Agency on Aging for Northeastern Ver	MA
153	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X
154	Marlys	Waller	here	DA - Vermont Council of Developmental an	X
155	Nancy	Warner		COVE	X
156	Julie	Wasserman	here	AHS - Central Office	S
157	Kendall	West		Bi-State Primary Care/CHAC	MA
158	James	Westrich		AHS - DVHA	S
159	Robert	Wheeler		Blue Cross Blue Shield of Vermont	X
160	Bradley	Wilhelm		AHS - DVHA	S
161	Jason	Williams		UVM Medical Center	X
162	Stephanie	Winters		Vermont Medical Society	MA
163	Jason	Wolstenholme		Vermont Chiropractic Association	X

164	Cecelia	Wu		AHS - DVHA	S
165	Mark	Young			X
166	Marie	Zura		DA - HowardCenter for Mental Health	X
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Leah Korse - DVHA - phone
Colleen Sanford - BCBSVT - phone
Todd Fahey - Brattleboro Mem. Hosp. - here
Lila Richardson - VT Legal Aid - here

Attachment 2: 2016 Practice Transformation Work Group Work Plan

Vermont Health Care Innovation Project
DRAFT 2016 Practice Transformation Work Group Workplan
DRAFT 12/28/2015

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
Integrated Communities Care Management Learning Collaborative							
1	Support continued implementation of Integrated Communities Care Management Learning Collaborative, including monitoring and reporting.	Continue implementation of Integrated Communities Care Management Learning Collaborative to all interested communities	Ongoing			Active implementation in 11 communities state-wide.	Increased uptake of identified process measures, provider and recipient of care satisfaction surveys; and identified program outcome measures.
2		Develop tools, with the assistance of expert faculty and project staff, to support participating communities in implementing the principles of integrated care management. Examples include: shared care plans, eco-maps, root cause analysis, and tools for sharing private client information in a multi-organizational care team.	Ongoing	Receive input from DLTSS Work Group regarding tools for sharing private client information in a multi-organizational care team.		Comprehensive tool-kit expected by end of first quarter, 2016.	Increased use of key tools across participating communities.
3		Develop measures of program effectiveness to support internal reporting and evaluate impact.	Ongoing			Process measures collected on a bi-monthly basis. Recipient of care satisfaction survey in pilot phase. Provider satisfaction survey and outcome measures in development.	Implementation of all components of evaluation strategy.
4		Compile and share information with participants regarding "conflict-free" case management practices contained in CMS Home and Community-Based Services (HCBS) regulations.	Q1 or Q2 2016	Receive input from DLTSS Work Group and subject matter experts.		Subject matter experts identified, research underway.	Information made available for all participants in the learning collaborative.
5		Provide updates on progress, findings, and lessons learned to Steering Committee, Core Team, and relevant work groups; identify processes and tools to support continued work after SIM (i.e., shared care plan forms, HIPAA-compliant releases to support shared care	Ongoing			Updates provided on an ad hoc basis.	Updates provided and feedback incorporated into project planning and implementation.

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
		planning process).					
6		Collect Learning Collaborative lessons learned for incorporation into VHCIP Sustainability Plan.	Sept 2016			Lessons learned captured on an ongoing basis as revealed through implementation activities.	Lessons learned incorporated into VHCIP sustainability plan.
7	Support the development of Core Competency Trainings for front line care managers and other service providers, focused on general care management skills and DLTSS-specific competencies.	Execute contract with vendor(s) to develop Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.	January 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Vendor selection completed; contracts under development.	Vendor selected and implementation plan and timeline finalized.
8		Support and monitor core competency training development in collaboration with vendor(s).	January -March 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Training development in early stages, pending contract execution.	Development of content for Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.
9		Develop and execute implementation plan for Core Competency Trainings focused on general care management skills and DLTSS-specific competencies on a state-wide basis; including incorporation of a sustainability plan.	April – Dec 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Implementation plan in early states, pending contract execution.	Core competency training provided.
10		Develop and disseminate tool kit for Disability Awareness Briefs developed by DLTSS Work Group.	Ongoing	Provide updates to and receive guidance from DLTSS and Workforce Work Groups.	DLTSS Work Group	Disability awareness briefs developed, tool-kit dissemination plan in early stages.	Disability awareness tool-kit available across the state.
11		Develop measures of program effectiveness to support internal reporting and evaluate impact.	Ongoing			Program monitoring and evaluation plan in early stages pending contract execution.	Monitoring and evaluation plan executed.
	Regional Collaborations						
12	Support continued implementation and expansion of regional collaborations in 14 Health Service Areas.	Continue implementation of regional collaborations in 14 Health Service Areas.	Ongoing	Continued partnership with Blueprint for Health and all Vermont ACOs.		Ongoing.	Regional collaboratives established and implementing quality improvement projects.
13		Provide updates on progress, findings, and lessons learned to Steering Committee, Core Team, and relevant work groups.	Ongoing			Updates occurring on an ad hoc basis.	Updates provided on an ad hoc basis.

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Sub-Grant Program						
14	Continue sub-grant program; convene sub-grantees at least twice; use lessons from sub-grantees to inform project decision-making.	Continue to provide quarterly reports on sub-grantee activities and progress to Work Group; provide updates on progress, findings, and lessons learned to Steering Committee, Core Team, and other relevant work groups as requested.	Ongoing			Sub-Grant program underway, updates provided on an ad hoc basis.	Sub-grantees convened at least twice, updates provided to work group and lessons learned carried forward.
15		Sub-grantees present to Work Group.	At least 6 throughout 2016			Sub-grantee presentations planned for upcoming meetings.	
16		Collect sub-grant program lessons learned for incorporation into VHCIP Sustainability Plan.	Sept 2015			Ongoing.	
17	Provide technical assistance to sub-grantees as requested by sub-grantees.	Provide technical assistance to sub-grantees as requested; requests to be reviewed and approved by VHCIP staff according to written process currently in place.	Ongoing			Ongoing.	Technical assistance provided.
	Ongoing Updates, Education, and Collaboration						
18	Reporting on all milestones in the Practice Transformation focus area; review DLTSS and Population Health activities and recommendations.	Review one-page monthly status updates for all Practice Transformation work streams.	Monthly			Ongoing.	Written and verbal monthly updates on all practice transformation activities; lessons learned and scalable interventions identified.
19		Identify lessons learned from Practice Transformation Work Group activities, focusing on scalable interventions, processes, and tools that can be used beyond SIM.	Ongoing			Not yet started.	
20	Review 2016 Practice Transformation Work Group Work Plan.	Review and discuss draft workplan, developed with DLTSS and Population Health staff and co-chair input.	December 2015-January 2016			Not yet started.	Work plan finalized.
21	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
22		Provide updates to other work groups on Practice Transformation Work Group activities.	Ongoing			Not yet started.	
23		Obtain regular updates from other work groups. Projects of interest include: • Shared Care Plan and Universal Transfer Protocol • Accountable Communities for Health Peer Learning Opportunity • Population Health Plan	Monthly	Obtain regular updates on work groups' progress as appropriate.		Not yet started.	
24	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016	Plan outline or draft developed by Population Health Work Group.	Population Health Work Group; Steering Committee; Core Team	Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
25		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016	Plan outline or draft developed by project leadership.	Core Team	Not yet started.	
26	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Monthly webinars conducted on staff- and participant-developed topics.

Attachment 3: Vermont Health Care Innovation Project, 2015 Year in Review

Vermont Health Care Innovation Project 2015: Year in Review

January 2016

Successes: Payment Model Design and Implementation

- Medicaid and Commercial **Shared Savings Programs** (SSPs): Year 2 program implementation; Year 1 savings analyses and distribution; State Plan Amendments approved for Years 1 and 2 of Medicaid SSP; continued provider capacity development.
- Analyses to select and develop **Medicaid Episodes of Care**.
- Continued implementation of Blueprint for Health and Hub & Spoke programs.
- Research to explore and define **Accountable Communities for Health**.
- Collaboration to support development of new payment models for DLTSS providers, including a **Prospective Payment System for Home Health Agencies** and **Medicaid Value-Based Purchasing for Mental Health and Substance Abuse providers**.

Spotlight on: PMDI: Counting our Beneficiaries

- Summer 2015 – Stakeholders and CMMI requested we develop unduplicated counts of Vermonters in alternatives to fee-for-service (FFS)
- VHCIP staff worked with payers and other State staff to identify this new number, and to develop a denominator of Vermonters eligible to participate in payment reforms*
- Total number of Vermonters in an alternative to FFS: 317,922 or 55% of all eligible Vermonters (no duplicates across programs)

* Non-eligible: Medicare Advantage enrollees, Military personnel, uninsured individuals, incarcerated individuals

Successes: Practice Transformation

- **Integrated Communities Care Management Learning Collaborative** continued first cohort and launched second cohort.
- **Disability Awareness Briefs** developed.
- Continued implementation of **Regional Collaboratives**.
- Continued implementation of **Sub-Grant Program**, including two well-attended symposiums.
- **Care Management Inventory** finalized.
- Contractor selected to perform **Workforce Demand Modeling** work.
- **Workforce Supply Data Collection and Analysis** is ongoing.

Spotlight on Practice Transformation: Integrated Communities Care Management Learning Collaborative

- Learning Collaborative is now statewide – expanded to 8 additional communities (11 total).
- Communities are developing processes and tools to better serve at-risk individuals, and engaging in continuous quality improvement.
- Key lessons learned identified:
  - Some of most complex individuals do not have a case manager.
  - Lead case manager may change as individual's needs change.
  - Some individuals have many community partners working with them without realizing this.
- Communities are reporting positive anecdotal results and starting to explore more formal evaluation.

Successes: Health Data Infrastructure

- **Gap Analyses** for ACO and DLTSS providers completed.
- **Gap Remediation** begun for ACO member organizations and Designated Mental Health and Specialized Service Agencies.
- **ACO Gateways** for OneCare and CHAC completed.
- **Data Quality** improvement efforts launched for ACO providers and Designated Agencies.
- **Telehealth Strategic Plan** finalized; RFP for **Telehealth Pilots** released and bidders selected.
- **EMRs acquired** for five Specialized Services Agencies (SSAs) and for the Dept. of Mental Health/State Psychiatric Hospital.
- Contract executed for **Vermont Care Network Data Repository**.
- Business and technical requirements developed for **Universal Transfer Protocol** and **Shared Care Plan** solutions.
- **Event Notification System** contractor selected.
- **Health Data Inventory** completed.

Spotlight on HDI: Shared Care Plans

- Business requirements gathering through the Shared Care Plan/Universal Transfer Protocol project uncovered significant community enthusiasm for a solution:
  - Says one team member: “It not only turned up the pressure on the team to provide a useful tool but really energized us to deliver a high performing solution that would change the way health care was being delivered in those communities.”
- The project completed initial requirement-gathering (both business requirements and technical requirements) and is currently developing a proposal for a solution, to be piloted in 2016.

Successes: Evaluation and Project Management

Evaluation

- **Self-Evaluation Plan** draft submitted to CMMI.
- New **Self-Evaluation Contractor** selected based on revised self-evaluation scope.

Project Management and Reporting

- Launched **Outreach and Communication** activities, including work toward website redesign.
- Successfully overhauled **Project Governance** structure to support robust stakeholder engagement and expedited decision-making.

Challenges

- Delayed Year 2 budget approval.
- Shift to new governance structure.

Looking Ahead: 2016!

- **Payment Model Design and Implementation:**
  - Final year of Shared Savings Programs.
  - Discussion with CMMI regarding launch of 3 Medicaid Episodes of Care.
  - Peer learning opportunity to develop Accountable Communities for Health.
  - Continued work to launch new payment models for Home Health Agencies and mental health/substance abuse providers.

- **Practice Transformation:**
  - Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.
  - Wrap up Integrated Communities Care Management Learning Collaboratives.
  - Wrap up Sub-Grant program.
  - Workforce Demand Modeling, Supply Data Collection and Analysis.

Looking Ahead: 2016! (Continued)

- **Health Data Infrastructure**:
  - Continue Data Quality efforts for ACO providers and DAs.
  - Launch Telehealth pilots.
  - Continue work on DA/SSA Data Warehousing solution, and begin to implement cohesive strategy for developing data systems to support analytics.
  - Launch Shared Care Plan solution pilot, launch Universal Transfer Protocol solution.

- **Evaluation**:
  - Launch of new self-evaluation contract.
  - Implementation of Self-Evaluation Plan.

Looking Ahead: 2016! (Continued)

- Also: **Population Health Plan** development;
- **Sustainability Planning**;
- Launch of final **suite of HDI projects** that could include additional gap remediation (all pending Core Team approval).
- Gathering **lessons learned** from across the project.

Attachment 5: UCC/RCPC Progress Report

Regional Committees/Areas of Quality Improvement Work 12/2015

Health Service Area	Regional Meeting Name	Charter	Consumer	Priority Areas of Focus	Project(s)	Other Attendees
Bennington **Contact: Jennifer Fels** **Jennifer.fels@svhealthcare.org**	Bennington Regional Clinical Performance Committee	☑	☑	• Medication reconciliation • ED Utilization • 30 day all cause readmissions • CHF • COPD • ADRC		BP, OCV, SNF, HHA, DA, private practices, SVMC CHAC (if Battenkill involved), HF & OCV, SASH, Council on Aging, VDH, AHS
Central Vermont **Contact: Mark Young** **mark.young@cvmc.org**	Community Alliance for HealthExcellence (CAHE)	☑	☑	Use of decision matrix tool to arrive at: • Care Coordination • CHF • Adverse Childhood Events- maybe in relation to ED visits • SBIRT	IC Care Coordination Learning Collaborative	CVMC, CVHH, WCMH, VDH, SNF, community transport, BP, OCV CHAC, housing, AAA, Substance abuse treatment agency, Family Center
Brattleboro **Contact: Wendy Conwell** **wcornwell@bmhvt.org**	ACO Steering Committee oversees RCPC	☑	☑	• Reduce emergency room use and improve quality of life for people who experience symptom of a mental health or substance abuse condition • Hospice utilization and improve quality of life for hospice patients • CHF	IC Care Coordination Learning Collaborative	BMH, BP, HHA, SNF, DA, OCV, substance abuse treatment, PCPs, VDH, CHT, ED, SASH, housing/SASH, HCRS, senior solutions

Regional Committees/Areas of Quality Improvement Work 12/2015

Burlington **Contact: Dr. Claudia Berger** **Claudia.berger@uvmhealth.org**	Chittenden County Regional Clinical Performance Committee	☑	Under discussion	• Improving care coordination learning collaborative • Reduction in ED utilization • Increase in hospice utilization	IC Care Coordination Learning Collaborative	UVM MC, CHCB, HHA, DA, housing, DAIL, VDH, QIO, VCCI, SNF, SASH, pediatrician, CVAA, CHAC, HF & OCV
Middlebury **Contact: Susan Bruce** **sbruce@portermedical.org**	Community Health Action Team (CHAT)	☑		• Improving care coordination for high risk patients • Opioid use management? • ED Utilization	IC Care Coordination Learning Collaborative	Porter, BP, HHA, DA, PCPs, VCCI, AAA, transportation, VDH, PPNE, SASH, Elder Services, Turning Point, United Way, FQHC, Parent Child Center CHAC, HF and OCV
Morrisville **Contacts: Corey Perpall** **cperpall@chslv.org** **Adrienne Pahl** apahl@chslv.org	UCC	☑		• 30 day all-cause readmissions/medication reconciliation • Care coordination for people who have high levels of risk • ED utilization • Developmental screening	IC Care Coordination Learning Collaborative	Copley, BP, DA, SNF , Health First, Private practices, Home Health CHAC & OCV
Newport **Contact: Julie Riffon** **jriffon@nchsi.org**	UCC/RCPC	☑	☑	• ED utilization • Obesity • Increased hospice utilization	IC Care Coordination Learning Collaborative	North Country Hospital ,BP, HHA, VCCI, DA CHAC & OCV

Regional Committees/Areas of Quality Improvement Work 12/2015

Randolph **Contact: Jennifer Wallace** jwallace@GiffordMed.org	Randolph Executive Community Council	✓		• Enhancing care coordination and shared care planning	IC Care Coordination Learning Collaborative	OCV, CHAC, VNA, Home Health, DA, SASH/Housing, transporation, SNF, Food bank, BP, AAA
Rutland **Contacts: Darren Childs, Rick Hildebrandt** dchilds@rrmc.org rhildebrandt@rrmc.org	RCPC	✓		• COPD- ways to rank /stratify • CHF • Transition of care • CM Learning Collaborative • Palliative care- increase in referrals	IC Care Coordination Learning Collaborative	RRMC,BP, SNF, pharmacy, CHCRR, homeless prevention enter, MVHW, HHA, DA CHAC, HF and OCV
Springfield **Contact: Maureen Shattuck** **mshattuck@springfieldmed.org** **Trevor Hanbridge** **thanbridge@pringfieldme.org**	UCC/RCPC	✓		• Care Management Learning Collaborative: adults with 5+ ED visits/12 months with MH dx and 3+ chronic health conditions	IC Care Coordination Learning Collaborative	HHA, Every practice in the Springfield health system, BP, CHAC, OCV, Adult day, housing/SASH, 211, SNF, DCF, VDH, SEVCA,
St. Albans **Diane Leach** **Contact:** dleach@nmcinc.org	RCPC	✓	Working on it	• CHF admissions • ED utilization • 30 day all-cause readmissions • Hospice utilization	IC Care Coordination Learning Collaborative Primary Care Learning Collaborative	NWMC, VDH, Franklin County Rehab, DA, HHA, BP, HF, FQHC, CHAC & OCV
St. Johnsbury **Contact: Laural Ruggles** **L.Ruggles@nvrh.org**	The A Team	✓	✓	• Improving care coordination learning collaborative • Reduction in all cause readmissions • Increase hospice utilization • Food insecurity • Housing	IC Care Coordination Learning Collaborative	NVRH, NCHC, VDH, community action, DA, AAA, HHA, FQHC, Housing organization, food security

Regional Committees/Areas of Quality Improvement Work 12/2015

						organization, BP, CHAC & OCV,
Townshend **Contact: Danny Ballantine** **dballantine@gracecottage.org**	RCPC	✓		• Decrease ED utilization (looking at those who use > 4x/year) • CHF – use of Brattleboro clinic		Grace Cottage, BP, SASH, VCCI, VDH, CHAC & OCV
Windsor **Contact: Jill Lord** Jill.m.lord@mahhc.org	UCC	✓		• Decrease ED utilization- use of survey tool for high utilizers as well as those with COPD who use ED • Opioid use management • COPD • Shared Care Plan	IC Care Coordination Learning Collaborative	Mt. Ascutney, OCV, BP, HHA, DA
Upper Valley **see note below** HealthFirst: White river service area BP: White River = Windsor & Bradford meeting CHAC = upper valley (Bradford meeting) OCV: Lebanon and White River = Randolph				• Follow-up for patients with ER/hospitalization for a mental health reason		CHAC, DA, HHA, substance abuse treatment

*Updated 12/28/15

CHAC = Community Health Accountable Care
HF= Health First
OCV = OneCare Vermont
BP= Vermont Blueprint for Health
SNF= Skilled Nursing Facility
HHA= Home Health Agency
DA= Designated Mental Health Agency
VDH = Vermont Department of Health
AAA = Area Agency on Aging

** Note high of projects around palliative care/hospice
*** Potential areas of sharing: Decision Matrix (Berlin)
ACE work (Berlin)
Strategies for sharing of clients
ED surveys (Windsor)

Regional Committees/Areas of Quality Improvement Work 12/2015

1. This catchment area is not uniform in representation from various organizations. For OCV this area is identified as Lebanon because the DHMC providers have attribution for Medicaid and Commercial programs. CHAC refers to it as the upper valley and is starting a community meeting in Bradford and the BluePrint puts this area into Windsor. We will continue to work on the commonalities of this service area to assure representation and identification of needs.

Attachment 6a: Care Team Consent guide

Tools for Sharing Private Client Information in an Interdisciplinary Care Team

January 5, 2016

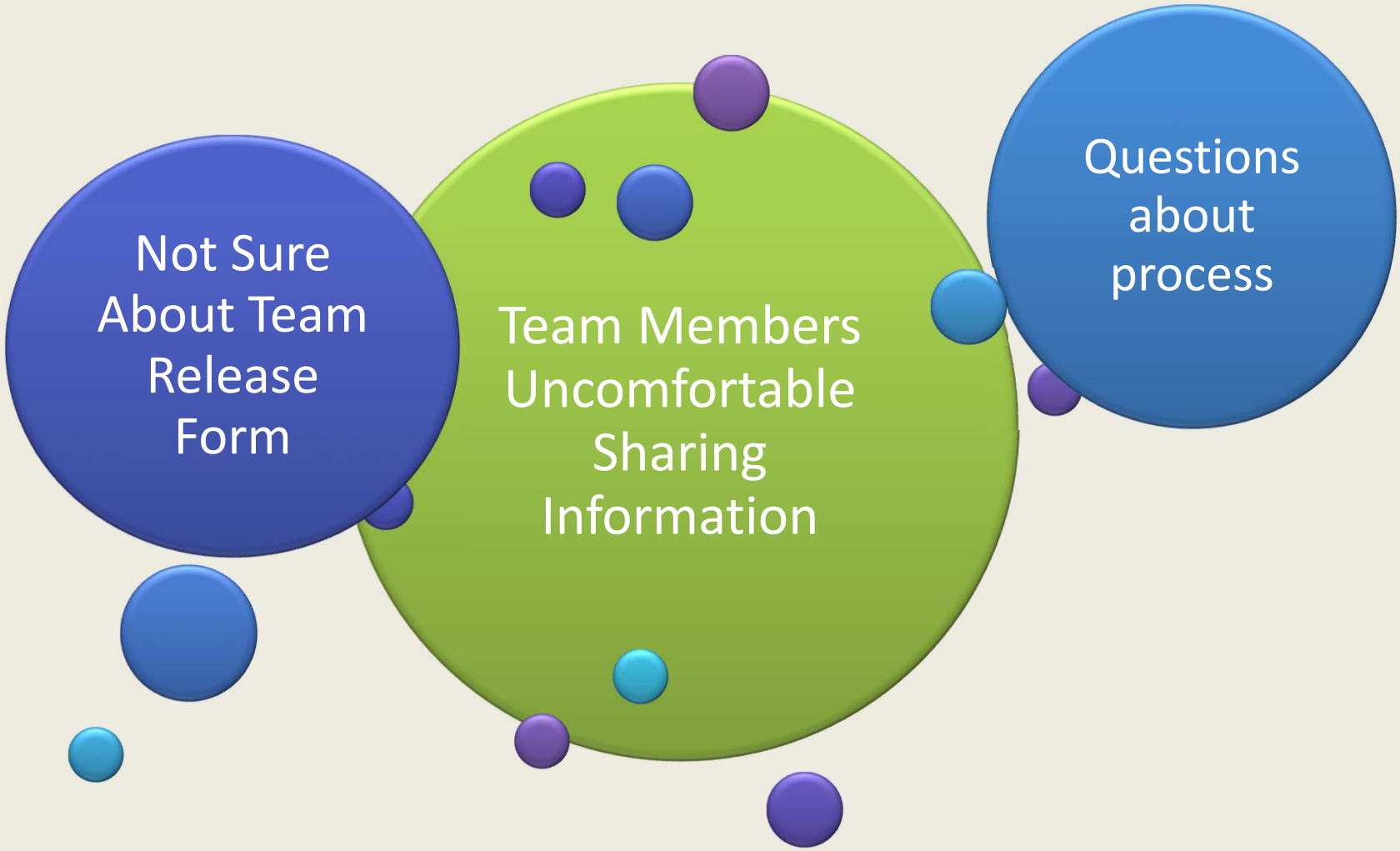
Gabe Epstein – Health Policy Analyst
DAIL

Level Setting – In this Presentation:

- "Consent", "Release", and "Authorization" all mean a form that documents a client's permission to share private information
- Interdisciplinary Care Teams can be any team of providers from different organizations working together to help one client

For Informational Purposes Only - This is not legal advice

Problem: Team Members Unwilling to Share Client Information



Release Forms Are Easy

- A client has the right to access and to share private information
- A valid release form is essentially documentation of the client's decision to exercise that right
- A properly written release form can be relied on by virtually any provider; aside from HIPAA, Part 2, most laws simply require "written permission"

Release Forms Are SO HARD

- Releases are treated as a formality, clients are not meaningfully engaged on their wishes
- No one reads releases, some don't even understanding what they are signing
- Providers may hesitate to honor a release form if they believe that doing so will violate the law or an ethical duty to their clients

How to Disclose with Confidence

- ✓ Have a legally valid consent form
- ✓ Ensure client's choice to share information is informed and voluntary
- ✓ Have a reliable procedure to communicate when the client's consent has been revoked
- ✓ Take the guesswork out of expiration

Release Form Design Choices

- Readable
  - Plain Language: 7.5 Grade Reading Level
  - Accessible fonts, distinct sections
- Attempts to engage clients
  - Spells out options, including option to opt out
  - Solicits affirmative choice when possible
  - Choice of team members, limits on sharing
- Addresses what happens to data after it is shared
  - Disclosure to non-HIPAA providers
  - Risks of re-disclosure
  - Possibility of disclosure without authorization
- Provides guidance on revocation process

Next Steps

- The form will be presented to Learning Collaborative teams
- The teams will be able to customize the form
- The teams will then need to have the form reviewed by their own attorneys
- If necessary, the team needs to assess and reach a consensus on consent and sharing processes

Consent Process Recommendations

To facilitate sharing:

- Document consent with a release
- Practice with the form and be ready to help the client use it – Develop a script
- Have a plan to clarify, document, and honor a client's wishes to stop sharing
- "Scrub in" at the team meetings

Scrubbing In

- Only identify and share information about patients who have provided a release; don't rely on exemptions
- Agree ahead of time how to use the information they receive
- Give clear instructions if sharing Part 2, FERPA, or Mental Health Information

Recommended Standards

Be a little more careful with information received from other providers

- Keep information secure, even if you are not regulated by HIPAA
- Only use the information in the Care Team context

Use caution when working with people outside the care team so as not to disclose Part 2, FERPA, or Mental Health Information

Written Guidance for the Team

- Example Notice form lists standards and provides redisclosure warnings

Questions and Feedback

Attachment 6b: Example Notice to Providers

[For informational purposes - not legal advice]

Ideas for provider teams to consider when sharing information

Agree on Group Privacy Standards

Some relevant examples:

1. Only individuals authorized by the Care Team Release form may receive the protected information specified in the release.
2. Distinguish between information that is received pursuant to the release – the care plan and information discussed at the team meeting – and information obtained directly from the client in the course of practice.
3. Be careful with part 2, mental health, or FERPA protected educational information, especially with materials that will be shared outside of team.
4. Have all team members use the same minimum level of caution when protecting the information.

Be ready to deal with laws more stringent than HIPAA

Part 2, FERPA, and V.S.A. Title 18 Part 8 protect specific kinds of private information. HIPAA also has special restrictions on sharing psychotherapy notes. Providers who receive this information should be given a warning about these special protections, both for the client's protection and for the provider, who may not be familiar with the applicable laws.

For examples of privacy standards and warnings, see the attached document.

[For informational purposes - not legal advice]

[INTERDISCIPLINARY CARE TEAM] NOTICES FOR PROVIDERS REGARDING REDISCLOSURE OF PRIVATE INFORMATION

Notice of Privacy Standards

Only individuals authorized by the **[CARE TEAM] RELEASE OF INFORMATION FORM** may receive the protected information specified in the release.

Providers are advised to keep the information they receive pursuant to the release separate and distinct from the information obtained directly from the client in the course of practice.

Providers are expected to follow the confidentiality laws and ethical standards of their practice. Providers are also asked to do the following with information received pursuant to the release, even when not required to do so:

- Keep this information secure
- Use or disclose this information only as authorized by the release or with the client's written permission
- Seek legal advice if required to disclose records by law or in an emergency situation

NOTICES FOR PROVIDERS REGARDING PRIVACY REQUIREMENTS OF LAWS MORE STRINGENT THAN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The laws referenced below protect specific kinds of private information. This information should not be used or disclosed except as described in the release. Providers should contact the source of this information and/or seek legal advice if such use or disclosure is:

- Requested by the client or required for the client's treatment
- Required by law
- Made without permission or in an emergency

Part 2 Warning for [Part 2 Facility]'s Records

Information disclosed by [Part 2 Facility] in this team is protected by 42 CFR Part 2.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[For informational purposes - not legal advice]

FERPA Warning for [Educational institution]

Personally identifiable information from an educational records disclosed by [Educational Institution] is protected by the Family Educational Rights and Privacy Act (34 CFR part 99). The disclosure of this information is made on the condition that the parties receiving this information will not disclose the information to any other party without the prior consent of the parent or eligible student, except as permitted by FERPA.

Title 18 Part 8 Warning

Any records created pursuant to State Mental Health Statutes (18 V.S.A. §§ 7101 - 9335) are protected by Vermont state law as well as HIPAA. Written consent is required for certain disclosures, including some disclosures which are otherwise permissible without written consent under HIPAA. Seek legal advice before disclosing such information without permission.

Attachment 6c: Team Release Template

Release form provided by (name and organization): _____

[INTERDISCIPLINARY CARE TEAM]'S RELEASE OF INFORMATION FORM
[For informational purposes - not legal advice]

Name _____ Date of Birth _____

I WANT MY PROVIDERS TO WORK AS A TEAM

[Name of team] is a group of providers who are working together to help people in my area get healthy. **I want them to work on my care as a team**. I am in charge of this team. I will choose the information my team can share to work on my care.

The [name of team] providers will be part of my team. They are:

- [List core team members who meet to talk about every client]
- [Hospital]
- [A]
- [B]
- [C]
- [D]
- [E]
- [F]

The providers listed below will also be part of my team if I write my initials next to the words "Add this provider." **I can keep seeing my providers even if I do not put them on my team.**

[Housing agency]	____ Add this provider
[Patient Advocate/Legal Advocate]	____ Add this provider
[See list of suggestions]	____ Add this provider
[A]	____ Add this provider
[B]	____ Add this provider
[C]	____ Add this provider
[D]	____ Add this provider

I can also add other providers to my team by listing them here:

_____

_____

LAWS THAT PROTECT MY PRIVACY

I know that some of the providers on my team do not have to follow the privacy law known as HIPAA. These providers will be careful to protect my privacy, but **HIPAA does not protect the records I share with them**.

I know that **some of my records could still be protected by other laws**. I know that my team will be warned not to share these records with anyone who is not on the team without my permission. These include records of substance use treatment from [part 2 facility/facilities], educational records from [FERPA entity], and mental health treatment from [Title 18 Part 8 mental health treatment].

MY TEAM HAS PERMISSION TO SHARE MY PRIVATE INFORMATION

I give the whole team permission to give the information that I choose on this form to other members of the team. My whole team has permission to receive this information, and to repeat or pass it along to other members of the team.

HOW MY TEAM WILL USE MY INFORMATION

My team is allowed to use my private information to help me make a plan for my care. It could list private things like my need for help with my money, mental health, education, disability, substance use issues, or medical care. **My team will be allowed to share this plan with each other and give each other updates about my care.**

Members of my team will also be allowed to use my private information to help me apply for services.

WHAT HAPPENS TO MY INFORMATION ONCE IT IS SHARED

I know that **my health records could be shared again**. Information that is shared may no longer by protected under the privacy law known as HIPAA. This could include some information about substance use, HIV/AIDS status, and mental health.

I know that I can cancel this release in writing at any time. I know that **even if I cancel this release, my providers may still have a right to keep and use information that has already been shared.**

OTHER WAYS MY INFORMATION CAN BE SHARED

I know that I can have **other releases** that let my providers share my private information for other reasons. If I want to cancel those releases, I have to talk to those providers and ask them how to do that.

I know that **my providers can share some of my private information without asking me**. If I want to know more about this, I can ask each of my providers to tell me about their privacy practices.

INFORMATION MY TEAM CAN SHARE

My team has permission to share the information I have chosen on this page.

I can write a date next to the words "Do not share records from before this date" if I want to keep my older records private.

Do not share records from before this date:_____

BASIC INFORMATION

I give the providers on my team permission to:

1. Share my [name and date of birth]
2. Share my health needs, my goals and my care plan
3. Share information about the services and public assistance I receive
4. Share a list of my income and resources
5. Say whether I am one of their clients
6. Tell each other when I have appointments and if I miss appointments
7. Give each other updates on my progress
8. [List any other info needed to run the team]

HEALTH INFORMATION

I give my team permission to share the health information listed here:

- [Diagnoses]
- [Medication list]
- [List other common types of information that might be helpful.]
- [D]
- [E]
- [F]

OPTIONAL INFORMATION

I give my team permission to share the information I have selected from the list below. **It can be shared only if I write my initials on the line next to it**.

_____[Substance Use]
_____[Mental Health]
_____[List other sensitive types of information]
_____[D]
_____[E]
_____[F]
_____[G]
_____[H]

I also give my providers permission to share the private information that I list here:

_____

_____

_____

HOW TO END OR CHANGE THIS RELEASE

I know that this release will end on its own if I do not see any of the providers on my team for one year.

I can also set my own end date here: _____

End Date

I can cancel or change this release by contacting:

[Person X]
[Address]
[City], VT [ZIP]
[Phone]

[Person X] will then tell my team members that this release has been cancelled. I know that even if I cancel this release, my providers may still have a right to keep and use information that has already been shared.

I know that I have a right to keep working with my providers even if I tell them not to share my information.

SIGNATURE

I know this release will only start once I sign and date this page. I know that **if I do not give the team permission to share my information, they will not be able to work together as a team or share a plan for my care.**

I know that I have a right to keep working with my providers even if I tell them not to share my information.

I know I have a right to get a copy of this form.

_____ _____

Signed by me or my representative Date

_____

Reason why my representative is allowed to sign for me

_____

Signature of my parent or guardian if I am too young to sign by myself

Attachment 7: Overview, Strategic Alignment to Improve Health: Linking the Health and Community Development Sectors

University of New Hampshire
Carsey School of Public Policy

PUBLIC HEALTH INSTITUTE

Strategic Alignment to Improve Health:
Linking the Health and Community Development Sectors

Boston, Massachusetts

Hospitals in the United States are faced with an array of challenges in the implementation of health reform. One of the most significant challenges is the movement from volume- to value-based payment for services. While the pace of change varies by state and region, U.S health care policy will increase financial incentives for hospitals, community health centers, and other patient-centered delivery systems to invest in prevention. The shift in financial incentives will require a fundamental change in approach, since most of the drivers of poor health are outside of the delivery of health care services. It will be essential for hospitals and other provider organizations to build partnerships with diverse stakeholders to improve the social and physical environments in low income communities that present obstacles to desired health behaviors.

Community Development Financial Institutions (CDFIs) and other community development entities are natural allies of hospitals and other health care organizations. CDFIs have a purpose of using finance to invest in and improve opportunities and assets in low income communities. The average annual capital investment is $150 billion, for supportive and affordable housing, healthy foods access, early childhood education, small business and micro-loans, and other support services in low-income communities. These investments present immense opportunities for alignment with programs, services, and related prevention activities supported by health care organizations and other health sector stakeholders in the same communities.

Two common examples of alignment include the development of affordable housing and wrap around services for homeless populations and/or isolated seniors with chronic diseases, or a grocery store or healthy food corner store that is linked to nutrition education, physical activity programs, and public policies that incentivize healthy food consumption. Strategic engagement of CDFIs and other local stakeholders in the community development and health sectors extends the reach of health care organizations and leverages their resources to better address the social determinants of health.

With generous support from the **MacArthur Foundation**, the **Annie E. Casey Foundation**, and the **Robert Wood Johnson Foundation**, the Carsey School of Public Policy at the

University of New Hampshire, in partnership with the Public Health Institute, Boston Community Capital, and the New Hampshire Community Loan Fund will convene selected teams of leaders from hospitals, CDFIs, and other key stakeholders in **Boston on the afternoon of December 14 and all day on the 15th at the Federal Reserve Bank** offices to explore specific opportunities for alignment in their communities. Teams could include, but are not limited to, leaders from hospitals, community-based organizations, public health, municipalities, and philanthropy. Over the course of one-and-a-half days, selected teams will hear from industry leaders in community development and community health to build common understanding of alignment opportunities, and will be assisted in the development of action plans for implementation of strategies in specific communities.

The meeting itself will be the opportunity for two sectors -- hospital systems and other health sector stakeholders and community development finance -- to learn how the other works, thinks, defines goals, and makes decisions, and the constraints and challenges of each. Understanding how CDFIs are funded, the options open to them, and their regulatory link to banks is critically important for hospitals and health systems in expanding their capacity to improve health. Understanding hospital community benefit policies and the emerging practices of hospitals, health systems, and other health sector stakeholders is critically important for CDFIs in building strategically upon investments to date.

If you'd like to receive more information or you'd like to participate, please contact us by November 15. There is limited space for this special meeting; a total of seven to eight teams will be selected for participation. We will provide interested organizations with an application to outline the composition of their local team and provide a brief profile of the community (ies) under consideration for an alignment strategy. Hospital and health system staff members, and CDFI staff members selected for participation, will cover their own travel expenses to Chicago.

Thank you,

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