VT Health Care Innovation Project
Core Team Meeting Agenda

January 29, 2016 10:30am-12:00pm
109 State Street, Pavilion Building, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	10:30-10:40	Welcome and Chair's Report a. Update on HIT Activities b. Update on resource allocation	Lawrence Miller	
Core Team Processes and Procedures:				
2	10:40-10:45	Approval of meeting minutes	Lawrence Miller	Attachment 2: January 15, 2016 *Decision needed.*
Policy Recommendations:				
3	10:45-11:15	Episode of Care Milestone Discussion	Georgia Maheras and Alicia Cooper	Attachment 3a: Memo to CMMI Attachment 3b: Staff Recommendation to Core Team *Decision needed.*

Spending Recommendations:				
4	11:15-11:45	Funding requests: a. New: LTSS Gap Remediation-$785,000 (Y2: $167,000; Y3: $618,000) b. VPQHC Sub-Grant Revision-downward by $300,000	Georgia Maheras	Attachment 4a: Financial Request Attachment 4b: VPQHC Proposal *Decision needed.*
5	11:45-11:55	*Public Comment*	Lawrence Miller	
6	11:55-12:00	Next Steps, Wrap-Up and Future Meeting Schedule: February 8th, 1:00pm-3:00pm, Pavilion Building, 109 State Street, Montpelier	Lawrence Miller	

Attachment 2: Draft
January 15, 2016 Minutes

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Friday, January 15, 2016, 10:30am-12:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 10:33. A roll-call was taken and a quorum was present. Lawrence announced that Spenser Weppler and Cecelia Wu have left their positions, and Richard Slusky has announced his retirement in March. **Chair's Report:** *New Milestones:* Georgia Maheras noted that our Year 2 No-Cost Extension required a review of our milestones. During that process, CMMI requested the addition of milestones for Year 2 related to our Population Health Plan and Sustainability Plan. We have added interim milestones in each of these areas that require us to have outlines finalized by the end of the No-Cost Extension Period (June 30, 2016); we have also committed to securing a Sustainability Plan contractor by the end of the No-Cost Extension period. The deadline for both final plans is June 30, 2017. *CMMI Accountable Health Communities Grant Opportunity:* Robin Lunge noted that this new opportunity offers three grant tracks. CMMI has clarified that SSP participants are eligible to apply for an AHC grant; though the grant cannot duplicate other funding already available. The State is not eligible to apply, though a town or municipality can – the opportunity is aimed at the provider community. Georgia noted that we will provide more information to SIM participants as we have it. Paul Bengtson noted that there is significant interest in his community, but that the minimum population size may be too large for most Vermont communities. Paul suggested coordinating webinar viewing; Sarah Kinsler will coordinate this. *Next Meeting:* The Core Team will meet again on 1/29. • VPQHC will come back to present again, at the Core Team's request.	

Agenda Item	Discussion	Next Steps
	• Another HIT proposal related to DLTSS gap analysis and gap remediation, including a budget. *Last Steering Committee Meeting:* At their 12/2 meeting, the Steering Committee discussed four HIT proposals, and approved two with significant enthusiasm (DA/SSA Data Quality Improvement, which will be discussed today, and DLTSS Gap Remediation, which will likely be discussed on 1/29). The Steering Committee requested those two proposals be moved on to the Core Team for a decision, and wanted to make sure the Core Team understood their strong support for those proposals. The other two proposals also had support but need further development. Georgia noted that these votes are for Year 2 funds – Year 3 will be a bulk proposal in March. *No-Cost Extension, December Status Reports, Work Group Workplans:* Linked in materials.	
2. Approval of Meeting Minutes	Paul Bengtson moved to approve the 12/9 minutes (Attachment 2). Al Gobeille seconded. A roll call vote to approve the minutes was taken. The motion carried.	
3. Funding Proposals	Georgia Maheras provided a financial update (Attachment 3a): • Year 1 Actuals to Date: Note that Year 1 is a 15-month year (plus a 12-month carryover period). Some invoices are outstanding, so there will be a bit more spending. We expect about $500,000 in pending invoices – final spending will be presented in February. • Year 2 Actuals to Date: No-Cost Extension approved in December, additional approvals pending. Not as much contract spending because invoices are pending – many contracts are processed, expecting more Year 2 spending to show up in February. o Continued underspending in Year 2 will allow us to bring forward new proposals using Year 2 funds. Refined spending estimates indicate savings from Evaluation (data file contract no longer necessary, savings on self-evaluation contractor following re-bid), Abernathey (contractor has fewer available hours than anticipated), and IHS Global (work pushed to Year 3). Savings are in lines indicated on Slide 5. Georgia presented several funding proposals (Attachments 3a and 3b): *New – IFS Contract ($5,000 Y2 TBD funds):* Funds would support a small contract with a consultant to support development of IFS service delivery framework. This is an existing contractor; funds would allow expansion to new communities coming online with IFS. *New – DA/SSA Data Quality Improvement ($75,000 Y2 TBD funds):* This is a request from the HDI Work Group and Steering Committee. This is very similar to 2015 work with VITL's e-health specialists, and would support 2 FTEs for the January-June 2016 period; the rest of the request (total $150,000) will come to this group as part of the Year 3 approval process. This will capitalize on significant data quality improvement made in the last year.	

Agenda Item	Discussion	Next Steps
	Revision – Terminology Services ($135,900 Y2 TBD funds): This is a revision to previously approved work. Due to delays in federal requests and other factors, VITL is requesting a revision in price and scope to accommodate our timeframe (February to June 2016). Focus on Labs and Medications since they are high volume. Lots of opportunity to prove additional data sets in the future (future budget request). This would improve the overall quality of information in the VHIE, which the ACOs and the Blueprint have indicated would be valuable to them. *Revision – CVMC Sub-Grant Budget Change Request (no change in total amount):* CVMC is implementing a program that links Screening, Brief Intervention, and Referral to Treatment (SBIRT) with medical homes. The reallocation is due to underspending in certain line items, and would add a clinician to support expansion to a pediatric practice, and small increases to Equipment, Supplies, Professional Development, and Mileage. Slide 12 includes an error – CVMC is only asking for $1,000 increase in the Professional Development line. • Ginger Cloud (CVMC): Underspending is related to challenges in hiring qualified staff and clinicians. • How many patients have been screened, and how many referred? CVMC has screened 3900 patients and referred 279 patients, resulting in 170 appointments thus far. SBIRT in EDs tends to capture about 10% of the population related to marijuana use; medical homes capture 4% related to opiates – a very high needs population. SBIRT is looking at patients who are not yet in treatment, and involves multiple levels of screening and motivational interviewing, brief intervention, and referral to further treatment if patients are willing. Screening tools help identify people at risk. Model is based on behavioral therapy and motivational interviewing based on patient goals. Lawrence invited a motion to approve these items as proposed. Paul Bengtson moved to approve these items. Steve Voigt seconded. Lawrence noted that this approval is pending resolution of CMMI discussions about funds for clinician time. A roll call vote was taken; the motion carried unanimously.	
4. Payment Models Work Group	*Medicaid SSP Year 3 Total Cost of Care Update:* Alicia Cooper provided a brief update on total cost of care (TCOC) for the Medicaid SSP in Year 3. Per the VMSSP standards, the State had the option to annually reconsider which services are included in TCOC. After assessing operational feasibility in 2015, and seeking to align services included in TCOC in Year 3 with potential future models. Steven Costantino commented that we're continuing the status quo. Alicia noted that the shared savings methodology has also not changed. Steven noted that the first year of the SSPs, 2014, had some unique trends in terms of newly insured populations and use of services, and asked whether algorithms account for this. Alicia responded that those populations are treated the same as others, and that Medicaid expansion did have some impact on PMPM expenditures in 2014. Without the same surge of new beneficiaries in Years 2 and 3, it will potentially be a different situation for future calculations. Lawrence noted that the renewal process could potentially move healthy people off the rolls as well. Alicia said that new enrollees in 2014 might use more services in future years as well. Robin noted that our algorithm went through CMS's Office of the Actuary.	

Agenda Item	Discussion	Next Steps
	Commercial SSP Downside Risk Update: Richard Slusky provided a brief update on the Commercial SSP Downside Risk, initially planned for Year 3 of the program. Richard reminded the Core Team that initial Commercial SSP targets and expenditures may have been set too low, since they were linked to Blue Cross's exchange plan premiums (set with limited information for a new population with no historical trends). There was concern about moving to downside risk in Year 3 due to outstanding questions about the methodology used to set expenditures and targets in Years 1 and 2. This, combined with the movement toward an all-payer model and potentially capitation payments, led to the decision not to pursue downside risk in Year 3. Year 3 will continue to use premiums as the basis for calculations, but with more emphasis on historical trends. • This decision was made at a public meeting of the Green Mountain Care Board; there was no public comment. • Are there any practice considerations that need to be dealt with before downside risk? Al Gobeille commented that shared savings standards will have to be updated, as well as a great deal of actuarial work on Blue Cross's side. GMCB is discussing the process to come to an accurate rate now. Al noted that if the rate is depressed or inflated, it hurts either payers or providers. Al also noted that 2014 was a transitional year in health insurance, and we might not have launched these programs in 2014 if we could make that decision again. • Paul Bengtson asked whether targets are being reconsidered – if the Medicaid target is set too high, will it be recalibrated lower? Al noted that for the Commercial program, this is done every year, and emphasized that getting this right is critical for the program. Richard commented that Blue Cross is doing this now for 2016 and 2017, when it will matter even more. Al added that the GMCB got a rate review grant which required an assessment with findings. This assessment has suggested that GMCB's rate review is very accurate.	
5. Public Comment	There was no additional public comment.	
6. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Friday, January 29, 2016, 10:30am-12:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Core Team Member List
Roll Call:

1/15/2016

Member		12/9/2015 Minutes	Funding Proposals				
			IFS Contract	DA/SSA Quality Imp	Terminology Services VITL	CVMC	
First Name	Last Name						Organization
Paul	Bengston ✓	✓	✓			→	Northeastern Vermont Regional Hospital
Hal	Cohen x						AHS -CO
Steven	Costantino ✓	✓	✓			→	AHS - DVHA
Al	Gobeille ✓	✓	✓			→	GMCB
Monica	Hutt x						AHS - DAIL
Robin	Lunge ✓	✓	✓			→	AOA - Director of Health Care Reform
Lawrence	Miller ✓	✓	✓			→	AOA - Chief of Health Care Reform
Steve	Voigt ✓	✓	✓			→	ReThink Health

1° Paul
2° Al
App'd

1° Paul
2° Steve
App'd

VHCIP Core Team Participant List

Attendance: 1/15/2016

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

First Name	Last Name		Organization	Core Team
Susan	Aranoff	here	AHS - DAIL	S
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Paul	Bengston	here	Northeastern Vermont Regional Hospital	M
Beverly	Boget		VNAs of Vermont	X
Harry	Chen		AHS - VDH	X
Amanda	Ciecior	here	AHS - DVHA	S
Hal	Cohen		AHS-CO	M
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper	here	AHS - DVHA	S
Steven	Costantino	phone	AHS - DVHA, Commissioner	M
Mark	Craig			X
Diane	Cummings	here	AHS - Central Office	S
Gabe	Epstein		AHS - DAIL	S

Jaime	Fisher		GMCB	A
Erin	Flynn	here	AHS - DVHA	S
Joyce	Gallimore		Bi-State Primary Care	X
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard		OneCare Vermont	X
Al	Gobeille	here	GMCB	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Sarah	Gregorek		AHS - DVHA	A
Thomas	Hall		Consumer Representative	X
Carrie	Hathaway		AHS - DVHA	X
Selina	Hickman		AHS - Central Office	X
Monica	Hutt		AHS - DAIL	M
Kate	Jones		AHS - DVHA	S
Pat	Jones		GMCB	S
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein		AHS - VDH	S
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Robin	Lunge	here	AOA	M
Carole	Magoffin	here	AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Mike	Maslack			X
Marisa	Melamed		AOA	S
~~Jessica~~	~~Mendizabal~~		AHS - DVHA	S
Lawrence	Miller	here	AOA - Chief of Health Care Reform	C
Meg	O'Donnell	here	UVM Medical Center	X
Annie	Paumgarten	here	GMCB	S
Luann	Poirer		AHS - DVHA	S
Frank	Reed		AHS - DMH	X
Lila	Richardson	here	VLA/Health Care Advocate Project	X
Larry	Sandage		AHS - DVHA	S

Suzanne	Santarcangelo		PHPG	X
Julia	Shaw		VLA/Health Care Advocate Project	X
Kate	Simmons		Bi-State Primary Care	X
Richard	Slusky	phone	GMCB	S
Carey	Underwood			A
Steve	Voigt	phone	ReThink Health	M
Julie	Wasserman		AHS - Central Office	S
~~Spenser~~	~~Weppler~~		GMCB	S
Kendall	West		Bi-State Primary Care	X
James	Westrich		AHS - DVHA	S
Katie	Whitney			A
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	X
Sharon	Winn		Bi-State Primary Care	X
Cecelia	Wu		AHS - DVHA	S
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Ginger Cloud - CVMC
Patrick Clark - CVMC
Mike Gagnon - VITL
Judith Franz - VITL
Simone R
Mike Hall - V4A
Leah Korce - DVHA

Attachment 3a: Memo to CMMI

To: Bridget Harrison, Project Officer
Fr: Georgia Maheras, Esq., Deputy Director of Health Care Reform for Payment and Delivery System Reform, Agency of Administration, and Director, Vermont Health Care Innovation Project
Date: December 3, 2015
Re: SOV Episodes of Care Considerations

This memo serves to provide information to CMMI regarding Vermont's consideration to reduce the number of Medicaid Episodes of Care proposed for implementation by July 2016. VHCIP project staff have dedicated the last several months to analysis and modeling to identify the most promising candidate episodes for Vermont's Medicaid population. At present, the following episodes have been selected for further model design, and stakeholders have been invited to provide comment:

1) Perinatal
2) Neonatal
3) Potentially avoidable repeat ED visits
4) Integrating Family Services

Vermont has been committed to further development of three pilot Episodes of Care for the Medicaid population for implementation in July 2016. However, as the analytic work for these three Episodes has progressed, a number of challenges have arisen.

a) The provider population affected would be limited. In order to establish episodes that would be statistically robust enough for statewide implementation, Vermont SIM staff elected to target for inclusion those providers that had 5 or more qualifying episodes in a single measurement year. This exclusion alone significantly reduces the number of providers that would be impacted by implementation of the above episodes.
b) The beneficiary population affected would be limited. Given the relatively small number of Vermont Medicaid beneficiaries in total, Vermont has been limited to considering only the highest volume episodes, recognizing that the population potentially impacted by any episode payment model would be significantly diminished once all episode exclusion criteria are applied. As a result the number of Medicaid beneficiaries that would be *newly* impacted by the proposed episode models (i.e. beneficiaries that have not previously been impacted by any of Vermont's other payment models) would be modest for a statewide initiative.
c) With implementation beginning in July 2016, data on the first full program year would not be available until mid- to late 2017. This would hinder Vermont's ability to fully evaluate the program's efficacy during the life of the SIM testing period.

d) The services included in the perinatal, neonatal, and ED episodes have the potential to overlap with those being considered for inclusion in the All-Payer Model, creating the potential for misalignment of models in January of 2017. Given the proposed launch of the episodes payment model in mid-2016, such misalignment has the potential to either shorten the proposed implementation timeline for the episode model or to affect design considerations for any model that will be in place beginning in 2017.

With these concerns around provider and beneficiary impact as well as the timeframe in which to implement, Vermont is considering moving forward with a single Episode of Care instead of three. The Integrating Family Services (IFS) model is currently in place in two Vermont counties, and is undergoing analysis by Vermont SIM staff (with contractor support from Burns & Associates) to support programmatic modifications and expansion to additional communities. This program targets a population not widely impacted by existing Vermont payment models--namely children of high need, many of whom have developmental disabilities or mental illness. The services provided to this population under the IFS model would complement those being considered for inclusion in the All-Payer Model in 2017.

Vermont seeks feedback from CMMI regarding the proposal to reduce the number of targeted Episodes for implementation in July 2016.

Attachment 3b: Staff Recommendation to Core Team

EOC Milestone-Staff Recommendation

January 29, 2016

Georgia Maheras, JD

Project Director

Current Milestone:

3 EOCs designed for Medicaid – implementation of data reports by 3/1/16.

Implementation of data reports means: episodes selected, outreach plan to providers designed, first run of historic data provided to providers participating in program.

Staff Recommendation

- Implement 1 Episode of Care built off of the IFS Program by 7/1/17.
  - Performance Period 2 Milestone: Research, Design, and Draft Implementation Plan developed by 6/30/16.
  - Performance Period 3 Milestone: Implement EOC Payment Model impacting IFS Program's services.

Attachment 4a: Financial Request

DISABILITY AND LONG TERM SERVICES AND SUPPORTS DATA GAP REMEDIATION PROJECT: NEXT STEPS

Susan Aranoff, Esq.

Judith A. Franz

Kristina S. Choquette

January 29, 2016

BACKGROUND

- Since its inception, increasing the Health Information Technology capacity of Vermont's Disability and Long Term Services and Supports (DLTSS) Providers and other "non-meaningful use providers" has been a stated goal of the Vermont Health Care Innovation Project. (See- application, operational plans, work plans, and milestones).

- The DLTSS Data Gap Analysis and Remediation Project began as part of the Accessing Care Through Technology (ACTT) suite of HIE/HIT projects.

- This project is a "planning phase to build a comprehensive budget request for Phase Two that allows for IT gap remediation work to occur."

- The gap analysis was submitted in April, 2015 and finalized in November, 2015.

- To date, no SIM funds have been allocated to increase HIE/HIT connectivity for Vermont's Home Health Agencies and Area Agencies on Aging.

Context

- Vermont's Home Health Agencies and Area Agencies on Aging make it possible for aging Vermonters and Vermonters with disabilities to live independently in the community – which is not only what most people prefer – it is required by law- e.g. the Olmstead decision.

- Home Health Agencies and Area Agencies on Aging need robust connections to the VHIE in order to implement the Next Generation Medicare Shared Savings Program.

- Home Health Agencies and Area Agencies on Aging need robust connections to the VHIE in order to comply with the IMPACT Act.

- Vermont's Home Health Agencies serve approximately 23,000 Vermonters per year. In FY 2013, Vermont's HHAs made nearly 950,000 home visits.

- Vermont's Area Agencies on Aging serve approximately 45,000 Vermonters per year.

Context (Continued)

- Vermont is one of the leaders in shifting the balance from people living in institutions to living in the community. At present, more than 50 % of people receiving Disability and Long Term Services and Supports live in the community.
- Vermont has the second oldest average population and the need for Disability and Long Term Services and Supports, including Home and Community Based Services, is rapidly increasing.
- Home and Community Based Services are essential for improving and maintaining the health of Vermonters- especially Vermonters living with disabilities, chronic and/or complex health conditions.

Proposal

- Expand the scope of VITL's SIM-funded work to include connecting the remaining HHAs and AAAs to the VHIE if funding is approved for additional interfaces.
- Recommend the Core Team allocate up to $785,000 of remaining funds to remediate some of the highest priority gaps identified in the DLTSS data gap analysis.
  - Year 2: $167,000
  - Year 3: $618,000
- This will be over the time period 2/15/16-12/31/16.

Proposed Solution

- Implement VITLAccess for Home Health Agencies including Bayada.
- Develop Interfaces from Home Health Agencies' EHRs to the VHIE .
- Both VITLAccess Implementation and Interface development will be accomplished utilizing a phased approach.
- Area Agencies on Aging (AAA) Issues:
  - Are not health care organizations under HIPAA.
  - Further legal and regulatory due diligence required.
  - Will provide a proposal in at a later date.

Phased Approach

- For VITLAccess, Home Health agencies will be implemented in groups (last slide).
- For Interfaces:
  - Initial Discovery phase to determine vendor capability:
    - Total of 12 agencies using 5 different EHRs.
    - Current state:
      - Four agencies are partially connected (sending ADTs).
      - One agency is connected sending both an ADT and CCD.
    - Remediation needed:
      - 18 interfaces in total need to be remediated:
        - » 7 agencies need ADTs.
        - » 11 agencies need CCDs.
  - Development by organization (based on Discovery):
    - Goal is to remediate a minimum of 50% of the number of needed Interfaces.

VITLAccess Implementation Model

Implementation model consists of three phases:

- Profile: Introductory meeting and role definition.
- Enroll: User designation and technical set up of users.
- Customized Launch will include:
  - Consent and end user training (standard approach)
  - In-person onsite training sessions at agency location (standard approach)
  - Invitational regional training sessions
  - WebEx (live online) trainings
  - Train-the-trainer method

Phase 1: February 15, 2016 - June 30, 2016

- VITLAccess Rollout $122,000

  (4 agencies, ~ 305 users)

  - **Deliverable**: Stemming from a thorough profiling of the agency, a Profile document will be created outlining key drivers of the custom approach needed for enrollment and launch components of the implementation model.

- Interface Technical Discovery $45,000

  (Required)

  - **Deliverable**: IT Gap Remediation document outlining vendor capability and cost, including a recommended implementation plan to connect Home Health agencies to the VHIE in a cost effective manner.
  - Estimate based on past experience: ~60 to 70 hours/vendor

Total $167,000

Phase 2: July 1, 2016 – December 31, 2016

- VITLAccess Rollout $68,000

  (3 agencies, ~170 users)

  - **Deliverable**: Stemming from a thorough profiling of the agency, a Profile document will be created outlining key drivers of the custom approach needed for enrollment and launch components of the implementation model.

- Interface Development $275,000

  (5 agencies; 6 interfaces)

  - $150,000 for VITL interface implementation. Estimate based on recent home health specific implementations for two vendor systems (McKesson Homecare and Hospice; Allscripts Homecare).
  - $125,000 to cover home health agency costs charged by the EHR vendors

Total $343,000

Phase 3: July 1, 2016 - December 31, 2016

- VITLAccess Rollout $50,000

  (5 agencies, ~125 users)

  - **Deliverable**: Stemming from a thorough profiling of the agency, a Profile document will be created outlining key drivers of the custom approach needed for enrollment and launch components of the implementation model.

- Interface Development $225,000

  (4 Agencies; 4 interfaces)

  - $100,000 for VITL interface implementation. Estimate based on recent home health specific implementations for two vendor systems (McKesson Homecare and Hospice; Allscripts Homecare).
  - $125,000 to cover home health agency costs charged by the EHR vendors

Total $275,000

VITLAccess Implementation Phases

Phases	Agencies	Est. Users	Cost
1	Visiting Nurse Association of Chittenden & Grand Isle Counties (including the VT Respite House)	100	40,000
	Addison County Home Health & Hospice	40	16,000
	Bayada Home Health Care	140	56,000
	Lamoille Home Health & Hospice	25	10,000
	Total Users	**305**	**$122,000**
2	Central Vermont Home Health & Hospice	50	20,000
	Visiting Nurse and Hospice for Vermont & New Hampshire	60	24,000
	Rutland Area Visiting Nurse Association & Hospice	60	24,000
	Total Users	**170**	**$68,000**
3	Bennington Area Visiting Nurse Association & Hospice	25	10,000
	Caledonia Home Health Care & Hospice	30	12,000
	Franklin County Home Health Agency	40	16,000
	Manchester Health Services	10	4,000
	Orleans, Essex VNA & Hospice	20	8,000
	Total Users	**125**	**$50,000**
	Total users all 3 phases	***600***	***$240,000***

Attachment 4b: VPQHC Proposal

Core Team Presentation: ACS NSQIP

Presented by

Vermont Statewide Surgical Services Collaborative

January 29, 2016

VPQHC

Vermont Program for Quality in Health Care, Inc.

January 15th	VPQHC Coordinator Hired; Project Coordination begins: Goal 12 hospitals
February March	Steering committee formed; monthly meetings scheduled 3/4/15 email to hospital leaders about enrollment and participation in NSQIP; ACS NSQIP schedules webinars; **9 hospitals** attend informational ACS NSQIP webinars; **1 hospital** attended initial webinar hosted by coordinator.
April	8 hospitals tentatively moving forward- working on logistics; Charter accepted; 2 hospitals need surgeon champions ; **2 hospitals enrolled; Collaborative formed**
May	Anticipate 7 hospitals enrolling; 2-3 waiting until October; 3 enrolled; 1 hospital withdrew (cost and more reasons); **3rd hospital enrolled**
June/July	6 hospitals enrolling- 1 withdrew resource constraints;
August	6 hospitals enrolling; **4 hospitals enrolled**
September	**5 hospital enrolled with 6th in process**; During the process of enrolling- ACS NSQIP determined surgical volumes extremely low; internal hospital decision to place enrollment on hold for now.
October	No further enrollments; SCR at 1 enrolled hospital left mid-training due to benefit policy change at hospital
November	**1 hospital** showing interest in enrolling; DHMC interested in joining collaborative; UVMMC in discussions about joining;
December	Awaiting 6th hospital decision about enrolling & DHMC and UVMMC decisions

HOSPITALS	WEBINAR ATTENDEES
Brattleboro Memorial Hospital	Dr. Kathleen McGraw-CMO ; Dr. Greg Gadowski- surgeon champion Mike Rogers CFO; Steve Gordan CEO
Gifford Medical Center	Thom Goodwin Sr. Director Quality/ Risk; Monica Boyd Quality Management Specialist; Jamie Floyd, surgical services nurse manager
Mt. Ascutney Hospital	Dr. Catherine Schneider- Surgeon Champion; Joseph L. Perras Chief Medical Officer; Patti M. Strohla Director of Clinical Transformation Julie A. Weld Nurse Manager of the OR; Margaret W. Hugg- Infection Prevention/Quality Assurance Nurse
North Country Hospital	Avril Cochran – Quality; Deb Beauchesne Surgical Services Director Dr. Larry Sisson-Surgeon Champion
Northeastern VT Regional	Colleen Sinon, RN, CPHQ, CPHRMVP Quality Management Programs Paul Bengtson, CEO;Seleem Choudhury, CNO; Andrea Dineen, CIO Julie Schneckenburger, Director of Ambulatory and Surgical Services Peter Tomczyk, OR Supervising RN; James Coulson, Infection Prevention/Compliance Officer; Kim Darby, QI Specialist
Northwestern VT Medical Center	Dr. Joseph Salomone- Surgeon Champion;Stephania Fregeau, BSN, RN Surgical Services Clinical Informaticist;Scott Bork, Director of Surgical Services;Nilda Gonnella-French, Quality & Risk Manager;Gina Leclair, RN
Porter Medical Center	Marianne Collins Director Quality and Risk Management; Fred Kniffin-CMO Jean Cotner-Interim CEO; Charleen Ryan-Interim CNO; Dr. Brad Fuller Surgeon Champion
Rutland Regional Medical Center	Surgeon Champion: Dr. Matt Conway; Darren Childs- PI
Southwestern VT Medical Center	Evelyn Schlosser-Administrative Director for Quality, Safety and Value

Hospitals	Enrolled NSQIP	2013 Surgeon Champion	2016 Surgeon Champion	Reason for Lack of SC
Brattleboro Memorial	YES	Dr. Greg Gadowski	Dr. Greg Gadowski	
Central VT Medical Center		Dr. Eduard Ziedins	Dr. Chris Meriam	
Copley Hospital		Dr. Brian Smale	VACANT	Retired
Gifford Medical Center		Dr. Ovleto Ciccarelli	Dr. Ovleto Ciccarelli	
Mt. Ascutney Hospital	YES	Dr. Catherine Schneider	Dr. Catherine Schneider	
North Country Hospital		Dr. Larry Sisson	Dr. Larry Sisson	
Northeastern VT Regional		Dr. Chris Danielson	Dr. Chris Danielson	
Northwestern VT Medical Center		Dr. Joseph Salomone	Dr. Joseph Salomone	
Porter Medical Center	YES	Dr. Brad Fuller	Dr. Brad Fuller	
Rutland Regional Medical Center	YES	Dr. Matt Conway	Dr. Matt Conway	
Springfield Hospital		Dr. Kevin Berman	VACANT	Relocated?
Southwestern VT Medical Center	YES	Dr. Charles Salem	Dr. Charles Salem	

HOSPITAL CHALLENGES

- An SCR who only wants part-time work; initial training is 160 hours (FT); concerned re: case mix, ability to benchmark; EMR challenges
- No Collaborative discount
- Sustainability of this initiative; Process for seeking additional funding
- Limited staffing to perform QI projects once data collected and trends noted
- Wanted to share SCR
- Interim surgeons
- Some misinformation about program eligible cases
- Cost $80-90; strong QI program; surgeons busy
- Do not have capacity to sustain the effort
- Need surgeon champion (2 hospitals)
- Too busy

IF A HOSPITAL…….	PREVENTED THIS NUMBER OF SSI'S NSQIP TOTAL PROGRAM COSTS WOULD BE COVERED(ENROLLMENT AND SCR SALARY/BENEFITS)
BRATTLEBORO MEMORIAL HOSPITAL	2.9
CENTRAL VERMONT MEDICAL CENTER	3.39
COPLEY HOSPITAL	1.6
GIFFORD MEDICAL CENTER	1.6
MT. ASCUTNEY HOSPITAL	0.94
NORTH COUNTRY HOSPITAL	0.94
NORTHEASTERN VERMONT REGIONAL HOSPITAL	2.09
NORTHWESTERN MEDICAL CENTER	3.39
PORTER MEDICAL CENTER	1.6
RUTLAND REGIONAL MEDICAL CENTER	3.39
SOUTHWESTERN VERMONT MEDICAL CENTER	2.9
SPRINGFIELD HOSPITAL	1.6

Potential Savings

Complication	Average Cost per case	# Inpatient Cases in VT (2013)	Total Costs / Potential Savings
Cardiac Complications	$15,000		
Deep Vein Thrombosis	$11,000		
Pulmonary Embolism	$17,000		
Any VTE	$28,000		
Pneumonia	$22,000		
Unplanned Intubation	$21,000		
Sepsis / Septic Shock	$39,000		
Surgical Site Infection	$28,000	405	$ 11.3 Million
Renal Complications	$28,000	60	$ 1.6 Million
Urinary Tract Infection	$13,000		
On Ventilator > 48 hours	$28,000		

VPQHC
Vermont Program for Quality in Health Care, Inc.

LETTERS OF SUPPORT

ORGANIZATIONS

- BCBSVT
* OneCare
- UVMMC
- VAHHS
- ACS NSQIP
- VT Children's Hospital

SURGEONS

- Dr. Neil Hyman
- Dr. Bradbury Fuller
- Dr. Catherine Schneider
- Dr. Charles Salem
- Dr. Kenneth Sartorelli
- Dr. Larry Sisson
- Dr. Chris Danielson

* NEW 2016

VPQHC
Vermont Program for Quality in Health Care, Inc.

VERMONT STATEWIDE SURGICAL SERVICES COLLABORATIVE

NSQIP – Core Team Discussion – January 29, 2016

- Physician/Surgeon led initiative
- The Surgeons approached VPQHC – role of application and award logistics
- Support of Surgeon Champions across the state and key stakeholders: GMCB, VAHHS, VMS, BCBS
- Opportunity to bend the surgical cost curve by eliminating the approximately $13 million annually related to certain surgical complications (Surgical site infections and acute renal failure)

Why not Statewide? What Changed?

- ACO did NOT exist at the start of this project – in process of forming up
- ACO challenged resources and commitment energy – also new and unknown (like NSQIP)
- Hospital commitments were extended to the ACO, not NSQIP
- Additional allotted Net Patient Revenue (NPR - .8%) insufficient to cover ALL health care reform initiatives – additional .8% for health care reform initiatives covered OneCare administrative fees, meaningful use, ICD-10, etc.
- In at least one hospital, insufficient numbers of eligible cases

Efforts:

- Multiple outreach/webinars/visits from Linda O. and NSQIP representatives
- Surgeons calls – peer-to-peer contact/outreach
- Quarterly Quality Director meetings
- Monthly meetings initially with Surgeon Champions but then also included Surgical Care Reviewers as they came on board
- Surgeons meeting regularly to discuss/review quality surgical outcomes in VT
- Continuing support for Surgical Care Reviewers and Surgical Champions across the state

Next Steps:

- Preserve funding for activities of enrolled hospitals (4 – 3 mid-size, 1 – CAH) – NSQIP information will be especially important if the State is positioning for concentration of volume for certain surgical services (particularly orthopedics) in only a few hospitals
- Surgical Services Coordinator position at 50% level to support hospitals and surgeons
- Preserve funding for collaborative meetings/webinars as submitted in the second application
- Continue presentations and business plan development to pursue external funders, i.e. insurers, captives and other supportive, interested parties and support of VT ACS Chapter efforts to continue to reduce surgical complications
- Return a little more than $300,000 to the VHCIP Provider Sub-grant Program for reallocation to additional payment reform initiatives

VERMONT STATEWIDE SURGICAL SERVICES COLLABORATIVE

Revised with hospital costs:

Total cost of project for 2 years	$1,244,284
VHCIP Funding	$ 592,190
% funded by VCHIP	47.59%

	Original VHCIP Grant Total	Revised VHCIP Grant Total	Original Hospital Cost Share Total	Revised Hospital Cost Share Total	Original Total VHCIP Grant and Hospital Cost Share Total	Revised Total VHCIP Grant and Hospital Cost Share Total
Personnel:						
Salaries and Fringe; Fewer SCR's; reduce Coordinator position to 50% February 2016	614,086	423,015	1,187,931	652,094	1,802,017	1,075,109
Program Costs:						
Training fee for Coordinator	2,500	2,321	-		2,500	2,321
Travel to hospitals and meetings; Greatly reduced travel based on participation of hospitals	11,559	1,724	-		11,559	1,724
Computer Equipment; Fewer participating hospitals	12,000	4,000	-		12,000	4,000
Meetings including addition of one Statewide All Day Collaborative	2,600	10,298			2,600	10,298
(1) Conference sponsorship for one SCR to attend the National NSQIP Conference San Diego	-	3,000			-	3,000
NSQIP Enrollment fees - annual ; Fewer participating hospitals; request to pay for second year of enrollment fees for eligible participating hospitals	180,000	97,000	180,000		360,000	97,000
Total Program Costs	208,659	118,343	180,000		388,659	118,343
9.39% Indirect Costs	77,256	50,832	-		77,256	50,832
Total Costs; Request to reduce project budget by $307,809	**900,000**	**592,190**	**1,367,931**	**652,094**	**2,267,931**	**1,244,284**