VT Health Care Innovation Project
Practice Transformation Work Group Meeting Agenda

November 10, 2015; 10:30 AM to 12:30 PM
ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:30 to 10:40	Welcome & Introductions; Approval of Minutes	**Attachment 1:** September CMCM meeting minutes	Yes (approval of minutes)
2	10:40 to 10:55	Orientation to Work Group Rebasing; Review of Merged Work Plan	**Attachment 2a:** New VHCIP Governance Structure **Attachment 2b:** Draft Practice Transformation Work Group Year Two Work Plan	
3	10:55 to 11:05	Updates: • Core Competency Training ***Public Comment***	**VHCIP Learning Collaborative Trainers RFP can be found at: https://www.vermontbusinessregistry.com/BidPreview.aspx?BidID=12877**	
4	11:05 to 11:25	Regional Blueprint/ACO Committees Progress Report ***Public Comment***	**Attachment 4:** UCC/RCPC Progress Report	
5	11:25 to 11:45	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***		
6	11:45 to 12:20	Accountable Community For Health Update ***Public Comment***	**Attachment 6a:** Accountable Communities for Health Learning System Discussion	

			Attachment 6b: Developing Accountable Communities for Health, Phase II	
7	12:20 to 12:30	Wrap-Up and Next Steps; Plans for Next Meeting		

Attachment 1: September CMCM meeting minutes

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Minutes
Pending Work Group Approval

Date of meeting: September 15, 2015; 10:30 AM – 12:30 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approval of minutes	Bea Grause called the meeting to order at 10:31 AM. A roll call was taken and a quorum was present. A motion to accept the July minutes by exception was made by Susan Aranoff and seconded by Nancy Breiden. The motion carried with three abstentions.	
2. Year 2 Milestones and Cross Pollination activities related to CMCM Work Group	Staff provided updates on the following milestones: Learning Collaborative: The next round of the Learning Collaborative has begun with 9 new communities, for a total of 12 communities engaged in this process across the state. The first in-person learning session for the new cohorts occurred last week. Sub-grant Program: The 14 provider sub-grant projects are underway with the next symposium to be held on October 7, 2015. There will be two panel discussions that include the sub-grantees who did not participate in a panel discussion during the May symposium. More information is available here on the VHCIP website. Workforce: The Workforce Work Group is currently in the process of executing a contract with a vendor to create a micro-simulation tool to predict Vermont's future health care workforce needs. The model will be created to utilize inputs from a number of variables in order to provide predictions for future workforce needs. Kirsten Murphy asked what definition of "provider" is being used for the model. • For the demand side, the definition is intentionally broad so as to capture as many providers and provider types as possible. On the supply side it's related to licensure, so the definitions are more narrow. Julie Wasserman commented that projections are on the rise for Long Term care/personal care attendants and those are not licensed. • More discussion on that topic will continue. Column headings will be added to the milestones document to make it more understandable.	Add column headings to milestones document.

Agenda Item	Discussion	Next Steps
3. Project Rebasing and Workgroup Consolidation	Georgia Maheras reviewed the Rebasing slides that were presented and approved by the Core Team last month. SIM has several focus areas and three major buckets of work: Payment Model Design and Implementation, Care Delivery and Practice Transformation, and Health Data Infrastructure, along with Evaluation and Program Management. Bev Boget asked if the episodes had been selected for the work on episodes of care. Georgia responded that data is still undergoing review, but there will likely be a small number of episodes worked into the Medicaid program. Maura Graff asked if implementing episodes of care required a Medicaid State Plan Amendment (SPA). Georgia explained the process for submission and approval of SPAs. If an amendment is necessary, staff responsible for that work are prepared to make it happen in a timely manner. Georgia continued to review the milestones for other groups: Payment Models: • Medicaid and commercial SSP: Year 3 implementation. • Medicaid Episodes of Care implementation. • Feasibility/Analysis: Accountable Communities for Health and All-Payer Model. • Home Health PPS. Practice Transformation: • Expand Learning Collaboratives to remainder of state. • Sustain sub-grants, regional collaborations. • Do micro-simulation demand modeling. Population Health • Finalize Population Health Plan. Health Data Infrastructure: • Launch Event Notification System. • Continue data quality and gap remediation efforts. • Invest in shared care plan and uniform transfer protocol solution. • Invest in telehealth pilots. • Design and implement registry and data warehousing solutions. A question was posed about the transfer of the existing DocSite clinical registry, specifically around who is doing the work and where the information will be housed. It was reported that Capitol Health Associates is helping to manage the data migration from its current location to a server that will be housed at VITL. There are multiple vendors working together on this solution.	

Agenda Item	Discussion	Next Steps
Care Management in Vermont: Gaps and Duplication	Christine Hughes from Bailit Health Purchasing presented a report related to gaps and duplication of care. The report drew information from two sources, a) the inventory survey completed by Vermont organizations providing care management and b) presentations made by organizations to the Care Models and Care Management (CMCM) Work Group. The Care Management in Vermont: Gaps and Duplication report summarizes gaps and duplication in care management services and recommendations on how to address them. Bea Grause pointed out the numerous links between the recommendations and the ongoing work of the SIM project. The learning collaborative is one method of addressing recommendations regarding duplication in care, and various projects under the HIT work group are addressing some of the technology recommendations found in the report. She also noted that process standardization will likely be a longer term, evolutionary goal. Lily Sojourner acknowledged the work at AHS related to coordinating children's service delivery as an area that addresses ways of changing organizations so that people in the field feel supported. Eileen Girling reported that VCCI has done some work around avoiding redundancy. Julie Wasserman suggested that the DLTSS Model of Care that was presented to the work group might provide additional information for the report. Pat Jones said that this information would be added to the next draft of this document. Sue Aranoff asked about the next steps for this report. Bea invited members of the work group to identify key audiences with whom we should share this, and how. Laural Ruggles suggested that perhaps the group can prioritize the recommendations and place them into a timeline – along with information about how these recommendations are being currently addressed and progress in specific communities. Christine reminded the group that the slides from which the information for this report was drawn represented only about 10-20% of the presentations from the various organizations. Most of the slides in the presentations related to the various services that the organizations provide, rather than gaps and duplication. The information in the report is contingent on who responded to the inventory survey and who made presentations to the group, so it is not all-encompassing. Dale Hackett noted the tension between standardization and the desire to have person centered care. Providers can't standardize too much or they will lose the person centeredness. He wondered if this was pointed out as a gap.	Revise report.
4. Program Updates	Due to the lack of time, the program updates were tabled to October.	
6. Next Steps, Future Meeting	**Next Meeting:** TBD – Consolidated Group; current CMCM meeting is scheduled for October 13, 2015	

Sue Aranoff 1°
Nancy Breiden 2°
Motion to approve minutes by exception
Motion Carried
- 3 Abstentions

VHCIP CMCM Work Group Member List

Roll Call: 9/15/2015

Member		Member Alternate		July Minutes		
First Name	Last Name	First Name	Last Name			Organization
Susan	Aranoff ✓	Sara	Lane			AHS - DAIL
Nancy	Breiden ✓	Rachel	Seelig			VLA/Disability Law Project
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger			AHS - DOC
Barbara	Cimaglio					AHS - VDH
Beverly	Boget ✓	Peter	Cobb			VNAs of Vermont
Dana	Demartino					Central Vermont Medical Center
~~Nancy~~	~~Eldridge~~	Molly	Dugan ✓	A		Cathedral Square and SASH Program
Joyce	Gallimore					CHAC
Eileen	Girling ✓	Heather	Bollman	A		AHS - DVHA
Maura	Graff ✓					Planned Parenthood of NNE
Bea	Grause ✓					Vermont Association of Hospital and Health Systems
Dale	Hackett ✓					None
Linda	Johnson					MVP Health Care
Pat	Jones ✓	Richard	Slusky			GMCB
Trinka	Kerr	Julia	Shaw			VLA/Health Care Advocate Project
Patricia	Launer ✓					Bi-State Primary Care
Vicki	Loner	Maura	Crandall ✓			OneCare Vermont
David	Martini					DFR
Madeleine	Mongan ✓					Vermont Medical Society
Judy	Morton					Mountain View Center
Mary	Moulton					Washington County Mental Health Services Inc.
Paul	Reiss	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Laural	Ruggles ✓					Northeastern Vermont Regional Hospital
Catherine	Simonson					DA - HowardCenter for Mental Health
Patricia	Singer ✓					AHS - DMH
Lily	Sojourner ✓	Shawn	Skafelstad	A		AHS - CO
Audrey-Ann	Spence ✓	Robert	Wheeler			Blue Cross Blue Shield of Vermont
Lisa	Viles ✓					Area Agency on Aging for Northeastern Vermont
Jason	Wolstenholme	Jessica	Oski			Vermont Chiropractic Association
	29		13			

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VHCIP CMCM Work Group Participant List

Attendance: 9/15/2015

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

First Name	Last Name		Organization	Care Models
Nancy	Abernathy		Learning Collaborative Facilitator	X
Peter	Albert		Blue Cross Blue Shield of Vermont	X
Susan	Aranoff	Neve	AHS - DAIL	S/M
Ena	Backus		GMCB	X
Melissa	Bailey	Neve	Vermont Care Network	X
Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
Beverly	Boget	phone	VNAs of Vermont	MA
Heather	Bollman		AHS - DVHA	MA
Mary Lou	Bolt		Rutland Regional Medical Center	X
Nancy	Breiden	Neve	VLA/Disability Law Project	M
Stephen	Broer		DA - Northwest Counseling and Support Services	X
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Anne	Burmeister		Planned Parenthood of Northern New England	X

Dr. Dee	Burroughs-Biron		AHS - DOC	M
Jane	Catton		Northwestern Medical Center	X
Amanda	Ciecior	here	AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	M
Peter	Cobb		VNAs of Vermont	M
Amy	Coonradt	Phone	AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Maura	Crandall	Phone	OneCare Vermont	MA
Claire	Crisman		Planned Parenthood of Northern New England	A
Dana	Demartino		Central Vermont Medical Center	M
Steve	Dickens		AHS - DAIL	X
Gabe	Epstein	here	AHS - DAIL	S
Trudee	Ettlinger		AHS - DOC	MA
Erin	Flynn		AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Meagan	Gallagher		Planned Parenthood of Northern New England	X
Joyce	Gallimore		Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Eileen	Girling	here	AHS - DVHA	M
Kelly	Gordon		AHS - DVHA	X
Maura	Graff		Planned Parenthood of Northern New England	M
Bea	Grause	here	Vermont Association of Hospital and Health Systems	C/M
Dale	Hackett	here	None	M
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Breena	Holmes		AHS - Central Office - IFS	X
Marge	Houy		SOV Consultant - Bailit-Health Purchasing	S
Christine	Hughes	Phone	SOV Consultant - Bailit-Health Purchasing	S
Jay	Hughes		Medicity	X
Linda	Johnson		MVP Health Care	M
Pat	Jones	here	GMCB	S/M
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	M

Sarah	Kinsler	here	AHS - DVHA	S
Sara	Lane		AHS - DAIL	MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer	phone	Bi-State Primary Care	M
Deborah	Lisi-Baker		SOV - Consultant	X
Vicki	Loner		OneCare Vermont	M
Carole	Magoffin	here	AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Mike	Maslack			X
John	Matulis			X
James	Mauro		Blue Cross Blue Shield of Vermont	X
David	Martini		DFR	M
Clare	McFadden		AHS - DAIL	X
Elise	McKenna		AHS - DVHA - Blueprint	X
Jeanne	McLaughlin		VNAs of Vermont	X
Darcy	McPherson		AHS - DVHA	A
Madeleine	Mongan	phone	Vermont Medical Society	M
Monika	Morse			X
Judy	Morton		Mountain View Center	M
Mary	Moulton		Washington County Mental Health Services Inc.	M
Kirsten	Murphy	here	AHS - Central Office - DDC	X
Reeva	Murphy		AHS - Central Office - IFS	X
Sarah	Narkewicz		Rutland Regional Medical Center	X
Monica	Ogelby		AHS - VDH	X
Jessica	Oski		Vermont Chiropractic Association	MA
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Rebecca	Porter		AHS - VDH	X
Betty	Rambur		GMCB	X
Allan	Ramsay		GMCB	X
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Debra	Repice		MVP Health Care	X
Julie	Riffon		North Country Hospital	X
Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
Bruce	Saffran	here	VPQHC - Learning Collaborative Facilitator	X

Jenney	Samuelson	here	AHS - DVHA - Blueprint	X
Jessica	Sattler		Accountable Care Transitions, Inc.	X
Rachel	Seelig		VLA/Senior Citizens Law Project	MA
Maureen	Shattuck		Springfield Medical Care Systems	X
Julia	Shaw		VLA/Health Care Advocate Project	MA
Miriam	Sheehy	phone	OneCare Vermont	X
Catherine	Simonson		DA - HowardCenter for Mental Health	M
Tom	Simpatico		AHS - DVHA	X
Patricia	Singer	phone	AHS - DMH	M
Shawn	Skaflestad		AHS - Central Office	X
Richard	Slusky		GMCB	S/MA
Pam	Smart		Northern Vermont Regional Hospital	X
Lily	Sojourner	here	AHS - Central Office	X
Audrey-Ann	Spence	phone	Blue Cross Blue Shield of Vermont	M
Beth	Tanzman		AHS - DVHA - Blueprint	X
Win	Turner			X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Julie	Wasserman	here	AHS - Central Office	S
Bob	West		Blue Cross Blue Shield of Vermont	X
James	Westrich		AHS - DVHA	S
Robert	Wheeler		Blue Cross Blue Shield of Vermont	MA
Bradley	Wilhelm		AHS - DVHA	S
Jason	Wolstenholme		Vermont Chiropractic Association	M
Cecelia	Wu		AHS - DVHA	S
Mark	Young			X
Lisa	Viles	here	Area Agency on Aging for Northeastern Vermont	M
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Mike Hall - Cove - here

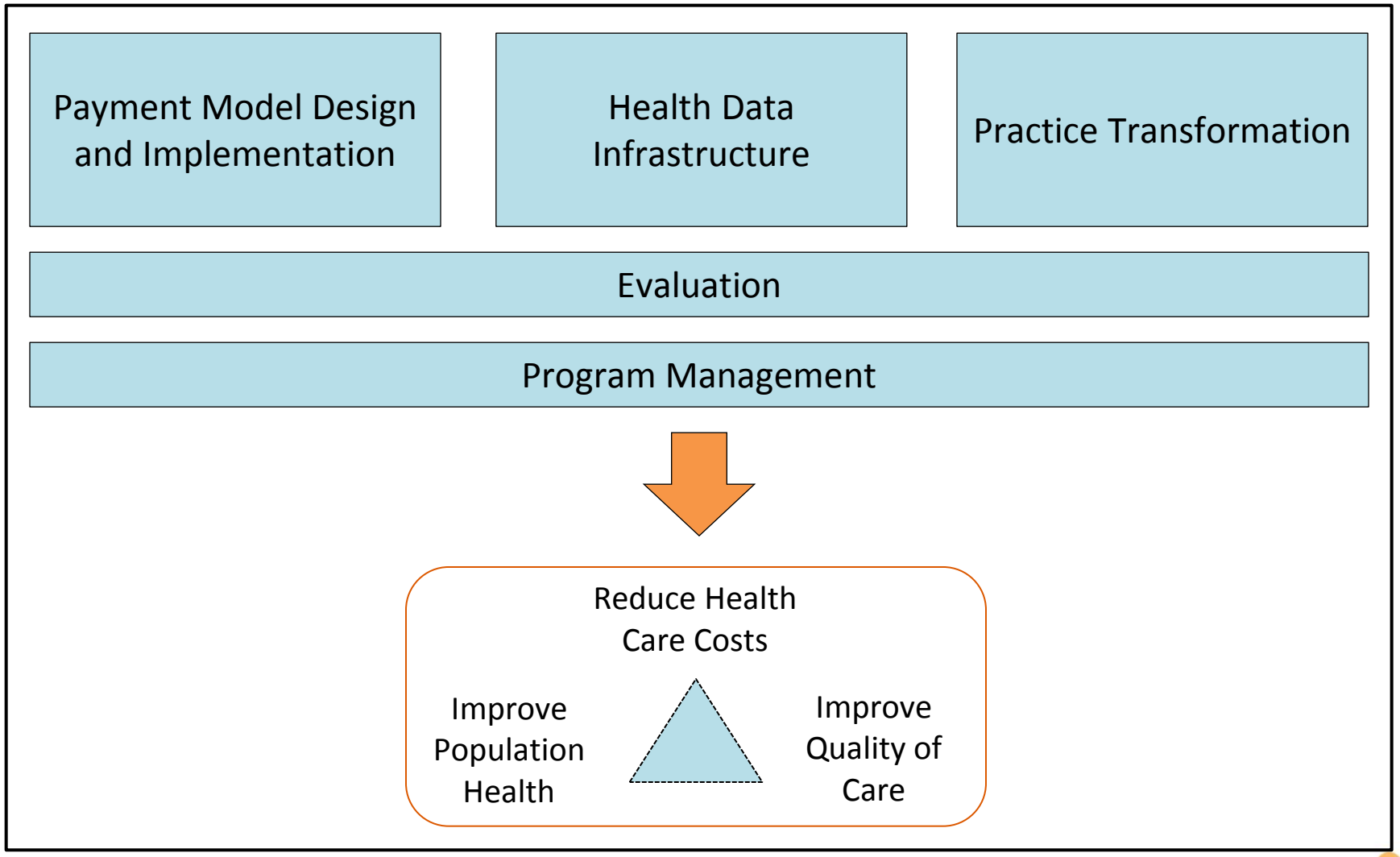
Attachment 2a: New VHCIP Governance Structure

New VHCIP Governance Structure

Sarah Kinsler, Senior Health Policy Analyst

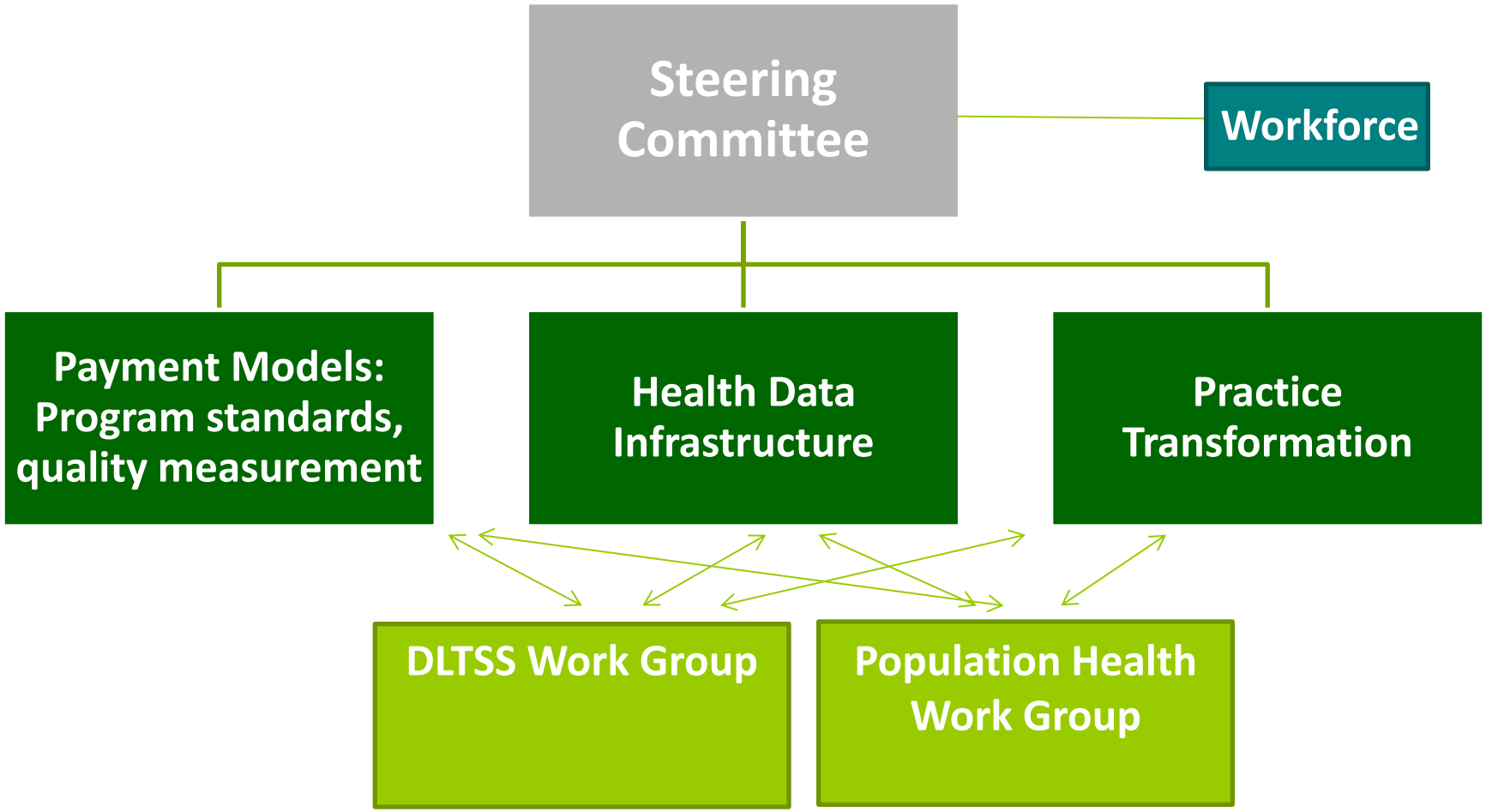
November 10th, 2015

Vermont's SIM Focus Areas and Goal:



Vermont Health Care Innovation Project

New Organization Structure:



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

Attachment 2b: Draft Practice Transformation Work Group Year Two Work Plan

Vermont Health Care Innovation Project
Year 2 Practice Transformation Work Group Work Plan
DRAFT 10/8/2015

	Objectives/Milestones	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Sub-Grant Program						
1	Continue sub-grant program; convene sub-grantees at least once; use lessons from sub-grantees to inform project decision-making.	Provide quarterly reports to work group.	Ongoing	N/A	Steering Committee	Quarterly reports distributed project-wide.	Reports provided.
2		Sub-grantees present to work group.	At least 2 per meeting			Ongoing.	Presentations delivered.
3		Develop lessons learned distribution plan.	November 2015			Not yet started.	Distribution plan developed.
4	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	N/A	N/A	Ongoing.	Technical assistance provided.
	Integrated Communities Care Management Learning Collaborative						
5	Offer at least two cohorts of Learning Collaboratives to 3-6 communities.	Launch in-person Learning Collaboratives.	September 2015	N /A	Steering Committee	• Launched in 8 additional communities in September 2015.	• Completion of learning collaborative. • Results used to design effective integrated care management strategies. • Measureable improvements in care and outcomes. • Scalable interventions. • Sustainable practice changes.
6		Release RFP for Core Competency Training (including DLTSS-specific Core Competencies).	September 2015			• RFP released.	
7		Expand release of disability briefs.	October 2015			• Not yet started.	
8		Engage faculty for learning sessions, including those focused on DLTSS-specific Core Competencies.	November 2014-Ongonig			• Faculty engaged for learning session.	
9		Develop measures based on interventions.	September 2014-February 2015			• Draft measures outlined, training for communities in data collection and reporting of measures planned.	
10		Conduct PDSA cycles.	March-June 2015			• PDSA trainings with community facilitator planned for February 2015.	
11		Evaluate results, including results for DLTSS competencies.	June-December 2015			In progress.	

	Objectives/Milestones	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
12		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 planning process).	Ongoing			Ongoing.	
	Regional Collaborations						
13	Establish 14 regional collaborations, each including a Charter, governing body, and decision-making process.			Blueprint for Health	N/A	Regional collaborations begun.	Regional collaborations established.
	Ongoing Updates, Education, and Collaboration						
14	Overview of Year 3 milestones		December 2015			Not yet started.	Overview provided.
15	Review and approve 2016 Practice Transformation Work Plan	Draft Workplan with DLTSS and Population Health input.	December 2015-January 2016	N/A	N/A	Not yet started.	Updated workplan adopted.
16	Coordinate and collaborate with other VHCIP Work Groups on 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).	N/A	Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities among work groups.
17		Provide regular updates to other work groups on Practice Transformation Work Group activities.	Monthly starting Oct 2015.				
18		Obtain regular updates from other work groups.	Monthly starting October 2015	Obtain regular updates on progress to design and test payment models we are implementing.			

	Objectives/Milestones	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
19	Coordinate with, update, and receive education from VHCIP Core Team, Steering Committee, other VHCIP leadership and stakeholders, and AHS agencies as appropriate.	Overall VHCIP project status updates.	Ongoing	N/A	N/A	Ongoing.	Well-coordinated and aligned activities across VHCIP.
20		Update Steering Committee, Core Team, and other VHCIP groups and stakeholders as appropriate.	Ongoing	N/A	N/A		

Attachment 4: UCC/RCPC Progress Report

Regional Committees/Areas of Quality Improvement Work 10/2015

Health Service Area	Regional Meeting Name	Charter	Consumer	Priority Areas of Focus	Measure 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 • Hospice utilization • Adverse Childhood Events		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	• Emergency room utilization • Hospice utilization	IC Care Coordination Learning Collaborative	BMH, BP, HHA, SNF, DA, OCV, substance abuse treatment, PCPs, VDH, CHT, ED, SASH, housing/SASH, HCRS, senior solutions
Burlington **Contact: Dr. Claudia Berger** **Claudia.berger@uvmhealth.org**	Chittenden County Regional Clinical Performance	☑	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,

Regional Committees/Areas of Quality Improvement Work 10/2015

	Committee						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? • Hospice?		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
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

Regional Committees/Areas of Quality Improvement Work 10/2015

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 • Hospice utilization – terminal care		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	36 ACO Measures	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 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

Regional Committees/Areas of Quality Improvement Work 10/2015

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		IC Care Coordination Learning Collaborative	Mt. Ascutney, OCV, BP, HHA, DA
Upper Valley 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 10/14/15

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)

Attachment 6a: Accountable Communities for Health Learning System Discussion

November 10, 2015

ACCOUNTABLE COMMUNITIES FOR HEALTH LEARNING SYSTEM DISCUSSION

Vermont Health Care Innovation Project

Objectives for Discussion

Note: *Steering Committee and Core Team previously voted to approve the Accountable Communities for Health Learning System proposal.*

- Provide background information to work group members and answer outstanding questions.
- Gather input and suggestions for next steps based on members' knowledge and experience.

Defining Accountable Communities for Health

- **Accountable Community for Health (ACH):** "An aspirational model—accountable for the health and well-being 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."

Background

- VHCIP contracted with the Prevention Institute, a nationally recognized non-profit based in Oakland, to explore the ACH concept, identify communities in Vermont and nationwide that are early leaders in this field, and develop recommendations to support Vermont in moving toward this model.
  - Report, "Accountable Communities for Health: Opportunities and Recommendations" (July 2015)
  - Prevention Institute also presented findings and recommendations to the Population Health Work Group; Tracy Dolan presented them to the Steering Committee in August.

Key Concepts

- Engages a **broad set of partners outside of healthcare** to improve overall population health;
- **Brings together major medical care, mental and behavioral and social services**, across a geographic area, and requires them to operate as partners rather than competitors while also connecting systems set up to integrate/coordinate services for individuals with community-wide prevention efforts;
- Focuses on the **health of all residents in a geographic area** rather than just a patient panel; and
- Identifies multiple strands of resources that can be applied to ACH-defined objectives that **explore the potential for redirecting savings from healthcare costs** in order to sustain collaborative efforts.

Core Elements of the ACH Model

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

Accountable Communities for Health Learning System

- **Goal:** Explore this concept with interested communities to support them in building Accountable Health Communities from the ground up.
  - Communities will learn with and from one another and from national innovators;
  - Identify the practical steps and developmental stages in creating an Accountable Community for Health; and
  - Inform the development of necessary state-level policy and guidance to support regional efforts.

Accountable Communities for Health Learning System

- Will aim to achieve high community interest and engagement through a variety of learning opportunities.
  - 12-month project, with 3-month planning/design phase
  - Combination of full-day in-person learning sessions; webinars to reinforce concepts and discuss progress and challenges; and local facilitation to support ongoing community-level work.
    - Quarterly **learning sessions** and **webinars** would engage national experts as faculty.
    - Ongoing **facilitative support** will help communities pull together local leadership; identify potential integrators; review existing data and systems; and determine opportunities for increased coordination/connection.

Accountable Communities for Health Learning System

- Community interest is high
  - Six community efforts in Vermont were profiled for the Prevention Institute's report:
    - Rise VT (Franklin and Grand Isle Counties)
    - St. Johnsbury Collective Impact (Caledonia and Southern Essex Counties)
    - Environment Community Opportunity Sustainability (Chittenden County)
    - Windsor Health Service Area Accountable Care Community for Health (Windsor County)
    - ReThink Health Upper Connecticut River Valley (Upper Valley)
    - Accountable Community (Windham County)
  - Additional communities have expressed interest in continued engagement and support

QUESTIONS?

Attachment 6b: Developing Accountable Communities for Health, Phase II

Developing Accountable Communities for Health: Phase II

Vision align programs and strategies related to integrated care and services for individuals and community-wide prevention efforts to improve health outcomes within a geographic community

> **Accountable Community for Health:** "An aspirational model—accountable for the health and well-being 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."

Goal Regional goals will be developed based on data regarding existing population health status and opportunities for improvement.

The Vermont State Health Improvement Plan identifies 3 statewide goals, with corresponding measures and evidence-based strategies for meeting those goals**.** The three goals were chosen based on data reflecting the health status of Vermonters and an interest in choosing priorities that are strategic. As a result, the focus of Vermont's plan is on conditions that are preventable and when improvements are made, will have a positive impact on multiple health outcomes in the future

Goal 1: Reduce the prevalence of chronic disease
Goal 2: Reduce the prevalence of individuals with or at risk of substance abuse or mental illness
Goal 3: Improve childhood immunization rates

Additionally, hospitals carryout community health needs assessments for their hospital service areas. Through this process hospitals engage the communities they serve and learn more about the most pressing health care concerns and needs. Based on community health data provided by the state health department and others, combined with the feedback that the hospitals gather, each hospital develops an implementation strategy to address prioritized community health needs.

In combination, the statewide and hospital service area goals provide a foundation for determining regional goals for population heath improvement.

Scope Given the impact of factors beyond the medical office on health outcomes, this effort will seek to establish alignment among programs/strategies related to integrated care and services for individuals and community-wide prevention efforts to improve health outcomes.

As emerging, the ACH concept:

- Engages a broad set of partners outside of healthcare to improve overall population health;
- Brings together major medical care, mental and behavioral and social services, across a geographic area, and requires them to operate as partners rather than competitors while also connecting systems set up to integrate/coordinate services for individuals with community-wide prevention efforts;
- Focuses on the health of all residents in a geographic area rather than just a patient panel; and
- Identifies multiple strands of resources that can be applied to ACH-defined objectives that explore the potential for redirecting savings from healthcare costs in order to sustain collaborative efforts

Structure

The regional hub/integrator is an essential entity that looks across the geographic community to determine systems, services and networks to identify opportunities for alignment among existing entities and to identify gaps which need to be filled to achieve improved population health outcomes. The integrator convenes regional leadership to establish charter and strategic plan related to key health outcomes and objectives. Once the Accountable Community for Health structure is established, the integrator helps carry the vision, shepherd the planning, implementation, and improvement efforts of collaborative work; and ensure shared responsibility among collaborative members.

A regional integrator will be identified by regional leaders best positioned to build on the excellent foundation for the integration of services for individuals establish via Hospital/BP/ACO collaboration and other cross-disciplinary collaborations aimed at population health improvement in the regions. Options include: hospital, UCC, Health Department District Office, Community Collaborative, Foundations

Next Steps: Building Accountable Communities from the Ground Up

We have developed a conceptual framework for Accountable Communities for Health in VT based on research and interviews. Now we need to spend time fleshing out the model based on the real world practical experiences and questions of those who would be the leaders within an Accountable Community for Health. This year will be a year of exploration and peer-learning supported by resources of the VHCIP staff and technical assistance providers. We will convene on-the-ground innovators to inform the next set of decisions.

Establish Statewide Framework

- Bring the State Health Improvement Plan (SHIP) to VHCIP, GMCB, AHS and stakeholders
- Share PHWG frameworks for Population Health Improvement
- Highlight the shared accountability across sectors for health outcomes

Produce Guidance to Regions

- Goals and Indicators
    - State Health Improvement Plan (SHIP)
    - Hospital Community Health Needs Assessment (CHNA)
- Evidence based strategies

Build capacity and learning – PHWG will hire TA/Facilitator to Convene

- Who: Integrator and team leads from established Regions – UCC and/or Community Wide Health/Prevention Structure
- How: monthly facilitated peer learning labs
    - Share evidence based strategies and best practices across the continuum of health
    - Identify outstanding issues –information or decisions needed
- How: technical assistance based on research of other communities nationwide seeking similar outcomes or exploring similar ACHs

Explore Financing Opportunities

- VHCIP research and paper
- Options for funding for AHCs will be part of this exploration together

Accountable Communities for Health: Phase II
Project Design (3 Months Planning + 12 Month Project)

Planning Phase: October-December 2015 (3 Months)

1. **Refine project design. (Internal staff)**
    - Develop timeline for activities/calendar of events
    - Produce initial package of materials to describe project, goals, objectives and methods
    - Determine desired/eligible participants and the commitments asked of them
    - Identify innovators to include in project and invite them
    - Hire additional technical assistance providers as needed

2. **Curriculum design. (With contractor support)**
    - Develop curriculum and meeting design
    - Invite speakers (as appropriate)

Project Phase: January-December 2016 (12 Months)

1. **Bring together potential integrators/leaders from emerging ACHs** within Vermont to: a) learn with/from one another and from national innovators; b) identify the practical steps and developmental stages in creating an Accountable Community for Health; and c) inform the development of necessary state-level policy and guidance to support regional efforts.
    - Secure meeting location and manage meeting logistics
    - Facilitate four in-person meetings and four webinars

2. **Provide facilitative support to innovating communities** in moving toward the Accountable Communities for Health model by systematically connecting integrated care management efforts for individuals with community-wide prevention strategies for an entire geographic area. Facilitative support will help communities: a) pull together local leadership; b) identify potential integrators; c) review existing data and systems; and d) determine opportunities for increased coordination/connection.
    - Determine schedule of meetings – 4-6 meetings per community
    - Design meeting agendas based on consultation with project staff and community leaders
    - Gather and distribute meeting materials
    - Facilitate meetings and report out results
    - Consult with project staff and community leaders on next steps

3. **Develop statewide guidance to support emerging needs of innovating ACHs.**
    - Research ideas/efforts in other states
    - Identify options and analyze strategic levers and barriers
    - Draft guidance