VT Health Care Innovation Project
Practice Transformation Work Group Meeting Agenda

December 6th, 2016; 10:00 AM to 12:00 PM
AHS - WSOC Oak Conference Room, 280 State Drive, Waterbury, VT
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** Deborah Lisi-Baker and Laural Ruggles	**Attachment 1:** November Meeting Minutes	Yes (approval of minutes)
2	10:10 – 11:10	**Review of Vermont SIM Sustainability Plan** Georgia Maheras and Sarah Kinsler	**Attachment 2:** Vermont SIM Sustainability Slides Link to draft Sustainability Plan	No
3	11:10 – 12:00	**Practice Transformation Work Group Final Reflection and Celebration** Deborah Lisi-Baker, Laural Ruggles, Erin Flynn and Pat Jones	**Attachment 3:** Practice Transformation Work Group Celebration Slides **Attachment 3a:** State-wide councils and advisory groups	No

Attachment 1: November Meeting Minutes

Vermont Health Care Innovation Project
Practice Transformation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Tuesday, November 8, 2016, 10:00am-12:00pm, Oak Conference Room, Waterbury State Office Complex

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Laural Ruggles called the meeting to order at 10:01am. A roll call attendance was taken and a quorum was not achieved.	
2. Sustainability Plan Update Georgia Maheras	**Sustainability Plan Update: Georgia J. Maheras, Esq., Deputy Director of Health Care Reform for Payment and Delivery System Reform and Director, Vermont Health Care Innovation Project** The VHCIP sub-group has been working throughout the month of October to discuss SIM sustainability. A draft document will go out for review ad public comment early next week, along with the monthly project status reports. There will be "roadshows" for all of the VHCIP work groups in November, although Practice Transformation will review the document during its December meeting. The Sustainability contractor, Meyers & Stauffer, is working on the draft document and inputs to the document include a sustainability survey that was part of a recent All-Participant email, key informant interviews, focus groups and meetings of the Sustainability sub-group. Georgia noted that many of the projects within the Practice Transformation focus area have been highlighted as some of the most well-received projects across the SIM program; several of these initiatives have been identified as ones that stakeholders would like to continue. There will be a webinar on 11/17 during which the plan will be reviewed. Comments are welcome! Dion LaShay asked for clarification of what it was meant to do. Georgia responded that the process and document is meant to identify activities that have been part of the SIM project that stakeholders feel have been valuable enough	

Agenda Item	Discussion	Next Steps
	to continue after the project ends. The process includes identifying lead organizations that be able to support and help keep those particular activities going in the future. Sue Aranoff asked about the 20% sustainability set aside, as CMMI had advised Vermont that approximately 20% of Performance Period 3 spending should target sustainability initiatives. Georgia responded the $1.2 M set aside for work related to the All-Payer Waiver at the October 31st Core Team meeting is part of sustainability as the Waiver is a key part of Vermont's sustainability plan. Deborah Lisi-Baker asked about ongoing sustainability and engagement. Georgia responded that transition planning is occurring for the change in administration, so there will be proposals going forward, but there is so much uncertainty around who will be in various positions it's hard to nail down a particular structure. She indicated that it would be a good idea to poll the work groups throughout November to ascertain if there are particular suggestions that should be included in the transition planning. Dion LaShay asked about the process to get newly elected people up to speed about the project SIM thus far. Georgia responded that all of the various departments have been tasked with creating transition materials for the incoming administration. These documents contain short and long term decisions that need to be made; highlight reports and other information. The hope is to onboard new decision makers quickly and utilize some of the SIM work and summary materials for their review. These are fairly standard processes and there are selected staff who are available to help with this process.	
3. Vermont Aging and Disability Resource Center: Care Transitions and "No Wrong Door" System **Nicole Distasio, Sandy Conrad, Audrey Winograd**	**Vermont Aging and Disability Resource Center: Care Transitions and "No Wrong Door" System** • **Nicole Distasio, State of Vermont lead for ADRC Grant and No Wrong Door Initiative** • **Sandy Conrad, Executive Director and ADRC Leadership Team Liaison, Southwestern Vermont Council on Aging** • **Audrey Winograd, Special Projects Coordinator at the Brain Injury Association of Vermont** The group heard a presentation from Attachment 3 of the materials packet: Audrey Winograd began the presentation with an overview of the program. The project based at Southwestern Vermont Medical Center is meant to identify individuals who are at high risk for readmission and to create a huddle around that person. It is very frustrating for providers to find out that their patients have been hospitalized and they haven't been informed, for whatever reasons. The idea for this project is to make sure that there are connections that can be made around the person. Nicole Distasio presented from the slides in the materials: Aging and Disability Resource Connection – • Funding identified 2003-2005; started in earnest in 2005	

Agenda Item	Discussion	Next Steps
	• First grant in 2005 to develop a model (1 of 8 states in the model) for No Wrong Door – information referral and options counseling The No Wrong Model intends to address the following challenges in the health care system: • Increase in demand for services • Reduced service budgets • Fragmented systems • Difficult for consumers to access • Confusing to navigate (for both consumers and service professionals) • Lack of focus on the consumer • Institutional bias In response to these challenges, the Aging and Disability Resource Centers are meant to: • serve every community in the nation • are highly visible and trusted by people of all incomes and ages • provide information on the full range of long term support options • act as a single point of entry for streamlined access to services 4 key components to the No Wrong Door System: • State Governance • Outreach and Coordination • Person-Centered Options Counseling • Streamlined Access Sandy Conrad added that key to the work has been public outreach and coordination of referrals – most people do not think about long term services and supports until there is a crisis and services are needed immediately. This often results in a person choosing the fastest or most immediate option and is often very costly. By providing awareness of services in advance – people will often choose the most cost effective services when they know about the services before they are needed. Dale Hackett asked how do we figure out what kind of services a person really needs? The response was that the most effective way to do that is to include someone who is unbiased and not a part of the care coordination that will happen afterwards; Have a conversation about what's important to the person; Becoming involved in the system early in the process; try to set up social work appointments to ask individuals questions about what's going on in the individual's life. This is to avoid the request happening during a time of crisis. At the Area Agency on Aging,	

Agenda Item	Discussion	Next Steps
	sometimes a call comes in through a Senior Help Line and the options counselling session can happen at the home of the individual soon after, including a family member or care giver. The current project has staff in the hospital during a hospitalization so that transitions of care are thought about ahead of time. Audrey Winograd noted that follow on work and the lead organization in the area of care coordination is meant to be individualized based on the situation – warm transfers are a key part of the transition to ensure there truly is No Wrong Door. The ADRC model is meant to get people to where they need to go. Sometimes there's a balance of what you want, versus what can be given. Round the clock nursing may not be available but even if the individual comes to the appointment with a selection already made, it's still important to have the conversation about available services to ensure they are aware of the options available, timing issues, etc. Part of the options counseling is a follow up survey to check in on the status of the plan and whether the individual has achieved goals and are getting services according to their plan. Kirsten Murphy asked about those with disabilities who may not qualify for services under the standard definition of "developmental disability;" shifting from school based services to adult services. The response is that lack of funding does indeed impact the available types of services, particularly for this population. There are some services out there for this population of youth in transition in some areas – who can fill these gaps? Questions remain about how we can get more people trained to provide options counseling for this population. The best way to do this is to follow the individual on a longer term basis – this helps through the transitions. Very person centered – what's important to you? Set no more than 3 goals and follow on according to the individuals pace and desires. There is also follow up on eligibility requirements – does the person understand the eligibility criteria? What happens if the person no longer qualifies for supports and how should follow up work be structured. Dion LaShay asked how do people with IDD get proper services they need. He pointed out that the Priority System of Care in Vermont limits services to those who are not in crisis. People fall through the gaps if they don't meet certain criteria. It is hoped that sustained funding will be found to continue this work. Kirsten Murphy elaborated that in some service categories such as home and community based, respite and employment based services, the Vermont System of Care sets up a series of gates that establish priority levels, but these are narrow in scope and often keep individuals from qualifying to receive services if they do not fall within a certain level. Nicole Distasio responded that Ideally, expansion of these kinds of programs would not have any criteria at all and would only focus on the individual's preferences and choices.	

Agenda Item	Discussion	Next Steps
	The group then discussed the Bennington Care Transitions Project: In Bennington, a group of providers developed a process and identified characteristics that would trigger referrals to particular organizations or groups for additional specific supports, as well as referrals to options counseling. The Results - Readmission rate and financial savings: • The readmission rate in Bennington dropped from 41.1% to 15.5% • The monthly median cost of $88,000 per month dropped to $24,000 per month resulting in a savings of about $64,000. The average cost is around $51,000. This is what makes a difference in someone's life. Jessa Barnard asked about the connection to the Community Health Team (CHT)? In Bennington, a nurse care manager (usually a Transitional Care Nurse) will follow the person and work in tandem with the options team to create and help implement the transition plan. The links are made with the member of the CHT who may be part of the primary care practice and can help the individual follow the plan. Deborah Lisi-Baker asked about identifying the core elements of training we would want for those who are part of options counseling, to bring in social determinants of health and to promote counselors who are not connected directly to a particular part of the system. This would help to build common expectations about skills and behaviors for these independent options counselors. This could be part of sustainability to enable options counseling in an ongoing way. Dale Hackett asked about inclusion of epigenetics (environmental or otherwise). At this time there are none as part of this program, however UVM may have more information about this topic. Dale also asked about savings to the hospital – are these tracked and would they show up in the hospital budget? Can it be part of the sustainability of these services? The response is that discussions are being had about redirecting the savings back out to the ADRC participant organizations to help sustain some of these counselors from different organizations to keep providing those services. Erin Flynn asked about data collection efforts. Nicole Distasio responded that they are currently piloting a tool to see what the current need of the population is; how many individuals are being serviced, how many are eligible, etc. There are eight pilot states for this tool and Vermont just reported first round of data.	

Agenda Item	Discussion	Next Steps
	Erin also asked about the former Uniform Transfer Protocol project in Bennington. Sandy Conrad responded that they are currently trying to get connected in Southwestern Vermont to the Care Navigator tool being rolled out by OneCare Vermont. There has not been any additional work done on the Uniform Transfer Protocol project. Sue Aranoff asked if enough data was gathered to know any statistics about how many people were represented in the savings report? Nicole responded that the average savings across the program was about $8 per person. Feel free to reach out to Nicole for more information. Nicole DiStasio, MA Aging and Disability Resource Connection, Vermont State Lead DAIL-ASD, Quality Improvement Coordinator Office: 802-241-0292 Cellular: 802-760-9770 Email: Nicole.distasio@vermont.gov	
4. Wrap-Up and Next Steps; Plans for Next Meeting	**Next Meeting:** Tuesday, December 6, 2016 10:00 am – 12:00 pm AHS - WSOC Oak Conference Room 280 State Drive, Waterbury Call-In Number: 1-877-273-4202 Conference ID: 2252454	

VHCIP Practice Transformation Work Group Member List

Member		Member Alternate		Minutes	8-Nov-16
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓	Bard	Hill		AHS - DAIL
		Clare	McFadden		AHS - DAIL
Abe	Berman	Sara	Barry		OneCare Vermont
		Emily	Bartling		OneCare Vermont
		Maura	Crandall		OneCare Vermont
		Miriam	Sheehey		OneCare Vermont
Beverly	Boget ✓	Michael	Counter		VNAs of Vermont
Kathy	Brown	Stephen	Broer		DA - Northwest Counseling and Support Services
Barbara	Cimaglio				AHS - VDH
Molly	Dugan ✓	Stefani	Hartsfield		Cathedral Square and SASH Program
		Kim	Fitzgerald		Cathedral Square and SASH Program
Eileen	Girling	Heather	Bollman		AHS - DVHA
		Jenney	Samuelson		AHS - DVHA - Blueprint
Maura	Graff ✓				Planned Parenthood of Northern New England
Dale	Hackett ✓				Consumer Representative
Sarah	Jemley	Jane	Catton		Northwestern Medical Center
		Candace	Collins		Northwestern Medical Center
Linda	Johnson	Debra	Repice		MVP Health Care
Pat	Jones	Kate	O'Neill ✓		GMCB
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
Deborah	Lisi-Baker ✓				Consumer Representative

VHCIP Practice Transformation Work Group Member List

Member		Member Alternate		Minutes	8-Nov-16
First Name	Last Name	First Name	Last Name		Organization
Barbara	Prine	Nancy	Breiden		VLA/LTC Ombudsman Project
Kate	McIntosh	Judith	Franz		Vermont Information Technology Leaders
Bonnie	McKellar	Mark	Burke		Brattleboro Memorial Hopsital
Jessa	Barnard ✓	Stephanie	Winters		Vermont Medical Society
Mary	Moulton				VCP - Washington County Mental Health Services Inc.
Sarah	Narkewicz ✓				Rutland Regional Medical Center
Mike	DelTrecco				Vermont Association of Hospital and Health Systems
Laural	Ruggles ✓				Northeastern Vermont Regional Hospital
Catherine	Simonson				VCP - HowardCenter for Mental Health
Patricia	Singer ✓	Jaskanwar	Batra		AHS - DMH
		Mourning	Fox		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
Shawn	Skafelstad ✓	Julie	Wasserman ✓		AHS - Central Office
Mike	Hall	Meg	Burmeister		Area Agency on Aging (V4A)
Audrey-Ann	Spence				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
Ben	Watts				AHS - DOC
	33		26		

13
14 15

NO Q.

VHCIP Practice Transformation Work Group

Attendance Sheet

Tuesday, November 08, 2016

	First Name	Last Name		Organization
1	Nancy	Abernathy		Learning Collaborative Facilitator
2	Peter	Albert		Blue Cross Blue Shield of Vermont
3	Susan	Aranoff	here	AHS - DAIL
4	Debbie	Austin		AHS - DVHA
5	Ena	Backus		GMCB
6	Melissa	Bailey		AHS - DMH
7	Michael	Bailit		SOV Consultant - Bailit-Health Purchasing
8	Jessa	Barnard	here	Vermont Medical Society
9	Susan	Barrett		GMCB
10	Emily	Bartling		OneCare Vermont
11	Jaskanwar	Batra		AHS - DMH
12	Todd	Bauman		DA - Northwest Counseling and Support Services
13	Bob	Bick		DA - HowardCenter for Mental Health
14	Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH
15	Beverly	Boget	phone	VNAs of Vermont
16	Heather	Bollman		AHS - DVHA
17	Mary Lou	Bolt		Rutland Regional Medical Center
18	Nancy	Breiden	here	VLA/Disability Law Project
19	Stephen	Broer		VCP - Northwest Counseling and Support Services
20	Kathy	Brown		DA - Northwest Counseling and Support Services
21	Martha	Buck		Vermont Association of Hospital and Health Systems
22	Mark	Burke		Brattleboro Memorial Hopsital
23	Anne	Burmeister		Planned Parenthood of Northern New England
24	Meg	Burmeister		CV Area Agency on Aging
25	Dr. Dee	Burroughs-Biron		AHS - DOC
26	Denise	Carpenter		Specialized Community Care
27	Jane	Catton		Northwestern Medical Center
28	Alysia	Chapman		DA - HowardCenter for Mental Health
29	Joy	Chilton		Home Health and Hospice
30	Barbara	Cimaglio		AHS - VDH

31	Candace	Collins		Northwestern Medical Center
32	Amy	Coonradt		AHS - DVHA
33	Alicia	Cooper		AHS - DVHA
34	Amy	Cooper		HealthFirst/Accountable Care Coalition of the Green Mountains
35	Julie	Corwin		AHS - DVHA
36	Michael	Counter		VNA & Hospice of VT & NH
37	Maura	Crandall		OneCare Vermont
38	Claire	Crisman		Planned Parenthood of Northern New England
39	Diane	Cummings		AHS - Central Office
40	Dana	Demartino		Central Vermont Medical Center
41	Steve	Dickens		AHS - DAIL
42	Molly	Dugan	Yes	Cathedral Square and SASH Program
43	Trudee	Ettlinger		AHS - DOC
44	Kim	Fitzgerald		Cathedral Square and SASH Program
45	Erin	Flynn	Yes	AHS - DVHA
46	Mourning	Fox		AHS - DMH
47	Judith	Franz		Vermont Information Technology Leaders
48	Mary	Fredette		The Gathering Place
49	Aaron	French		AHS - DVHA
50	Meagan	Gallagher		Planned Parenthood of Northern New England
51	Lucie	Garand		Downs Rachlin Martin PLLC
52	Christine	Geiler	Yes	GMCB
53	Eileen	Girling		AHS - DVHA
54	Steve	Gordon		Brattleboro Memorial Hopsital
55	Maura	Graff	Yes	Planned Parenthood of Northern New England
56	Dale	Hackett	Yes	Consumer Representative
57	Samantha	Haley		AHS - DVHA
58	Mike	Hall		Champlain Valley Area Agency on Aging / COVE
59	Stefani	Hartsfield		Cathedral Square
60	Kathleen	Hentcy		AHS - DMH
61	Selina	Hickman		AHS - DVHA
62	Bard	Hill		AHS - DAIL
63	Breena	Holmes		AHS - Central Office - IFS
64	Christine	Hughes		SOV Consultant - Bailit-Health Purchasing
65	Jay	Hughes		Medicity
66	Jeanne	Hutchins		UVM Center on Aging
67	Sarah	Jemley		Northwestern Medical Center
68	Linda	Johnson		MVP Health Care

69	Craig	Jones		AHS - DVHA - Blueprint
70	Pat	Jones		GMCB
71	Margaret	Joyal		Washington County Mental Health Services Inc.
72	Joelle	Judge	here	UMASS
73	Sarah	Kinsler	here	AHS - DVHA
74	Tony	Kramer		AHS - DVHA
75	Sara	Lane		AHS - DAIL
76	Dion	LaShay	phone	Consumer Representative
77	Patricia	Launer	here	Bi-State Primary Care
78	Deborah	Lisi-Baker	here	SOV - Consultant
79	Sam	Liss		Statewide Independent Living Council
80	Vicki	Loner		OneCare Vermont
81	Carole	Magoffin	here	AHS - DVHA
82	Georgia	Maheras	here	AOA
83	David	Martini		AOA - DFR
84	James	Mauro		Blue Cross Blue Shield of Vermont
85	Lisa	Maynes		Vermont Family Network
86	Clare	McFadden		AHS - DAIL
87	Kate	McIntosh		Vermont Information Technology Leaders
88	Bonnie	McKellar		Brattleboro Memorial Hopsital
89	Elise	McKenna		AHS - DVHA - Blueprint
90	Jeanne	McLaughlin		VNAs of Vermont
91	Darcy	McPherson		AHS - DVHA
92	Monika	Morse		
93	Judy	Morton	phone	Mountain View Center
94	Mary	Moulton		VCP - Washington County Mental Health Services Inc.
95	Kirsten	Murphy	here	AHS - Central Office - DDC
96	Reeva	Murphy		AHS - Central Office - IFS
97	Sarah	Narkewicz		Rutland Regional Medical Center
98	Floyd	Nease		AHS - Central Office
99	Nick	Nichols		AHS - DMH
100	Monica	Ogelby		AHS - VDH
101	Miki	Olszewski		AHS - DVHA - Blueprint
102	Kate	O'Neill	here	GMCB
103	Jessica	Oski		Vermont Chiropractic Association
104	Ed	Paquin		Disability Rights Vermont
105	Eileen	Peltier		Central Vermont Community Land Trust
106	John	Pierce		

107	Luann	Poirer		AHS - DVHA
108	Rebecca	Porter		AHS - VDH
109	Barbara	Prine		VLA/Disability Law Project
110	Betty	Rambur		GMCB
111	Allan	Ramsay		GMCB
112	Paul	Reiss		HealthFirst/Accountable Care Coalition of the Green Mountains
113	Virginia	Renfrew		Zatz & Renfrew Consulting
114	Debra	Repice		MVP Health Care
115	Julie	Riffon		North Country Hospital
116	Laural	Ruggles	here	Northeastern Vermont Regional Hospital
117	Bruce	Saffran		VPQHC - Learning Collaborative Facilitator
118	Jenney	Samuelson		AHS - DVHA - Blueprint
119	Jessica	Sattler		Accountable Care Transitions, Inc.
120	Rachel	Seelig		VLA/Senior Citizens Law Project
121	Susan	Shane		OneCare Vermont
122	Maureen	Shattuck		Springfield Medical Care Systems
123	Julia	Shaw		VLA/Health Care Advocate Project
124	Miriam	Sheehey		OneCare Vermont
125	Catherine	Simonson	Phone	VCP - HowardCenter for Mental Health
126	Patricia	Singer	Phone	AHS - DMH
127	Shawn	Skaflestad	phone	AHS - Central Office
128	Pam	Smart		Northern Vermont Regional Hospital
129	Lily	Sojourner		AHS - Central Office
130	Audrey-Ann	Spence		Blue Cross Blue Shield of Vermont
131	Holly	Stone		UMASS
132	Beth	Tanzman		AHS - DVHA - Blueprint
133	JoEllen	Tarallo-Falk		Center for Health and Learning
134	Julie	Tessler	phone	VCP - Vermont Council of Developmental and Mental Health Services
135	Bob	Thorn		DA - Counseling Services of Addison County
136	Win	Turner		
137	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing
138	Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Services
139	Nancy	Warner		COVE
140	Julie	Wasserman		AHS - Central Office
141	Ben	Watts		AHS - DOC
142	Kendall	West		Bi-State Primary Care/CHAC
143	James	Westrich		AHS - DVHA
144	Robert	Wheeler		Blue Cross Blue Shield of Vermont

145	Jason	Williams		UVM Medical Center
146	Stephanie	Winters		Vermont Medical Society
147	Jason	Wolstenholme		Vermont Chiropractic Association
148	Mark	Young		
149	Marie	Zura		DA - HowardCenter for Mental Health
149				

Audrey Winograd - TBI
Sandy Conrad - AAA, Bennington
Nicole Distasio - State of Vermont
Deb Gaylord - Agewell Vermont

Attachment 2: SIM Sustainability Slides Nov 2016

Vermont State Innovation Model (SIM)
Draft Sustainability Plan

Georgia Maheras, Project Director,
Vermont Health Care Innovation Project
(SIM)

Vermont Health Care Innovation Project


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Vermont SIM Sustainability Plan Overview

Vermont Health Care Innovation Project

Purpose of the Plan

- Identify and document the process for sustainability.
- Consider the lessons learned from the various SIM investments, and how they might contribute to program sustainability.
- Determine activities and investments to sustain.
- Determine lead entities and key partners.

Sustainability Defined

Sustainability is defined as an organization's ability to maintain a project over a defined period of time. Elements of sustainability include:

- Leadership support;
- Financial support;
- Legislative/regulatory/policy support;
- Provider-partner support;
- Stakeholder (community and advocacy) support;
- Data support;
- Health information technology (HIT) and health information exchange (HIE) system support;
- Project growth and change support;
- Administrative support; and
- Project management support.

(Program Sustainability Assessment Tool, https://sustaintool.org/understand, 2016)

Plan Research and Development: Vermont SIM Research

Myers and Stauffer, a contractor with the State, used the following methods to assist in the development of the Sustainability Plan:

- Conducted research on Vermont's Medicaid program, legislature, government structure, geography, relevant legislation, policy, and political environment.
- Met with JSI, the SIM State-Led Evaluation contractor, and reviewed available evaluation materials.
- Deployment of an electronic stakeholder survey. Survey was sent to over 300 SIM participants to seek input on the sustainability priorities within each focus area; 47 responses received. A copy of this survey, including results, can be found in Appendix B of the Plan.

Plan Research and Development: Vermont SIM Research (cont.)

Myers and Stauffer also conducted key informant interviews:

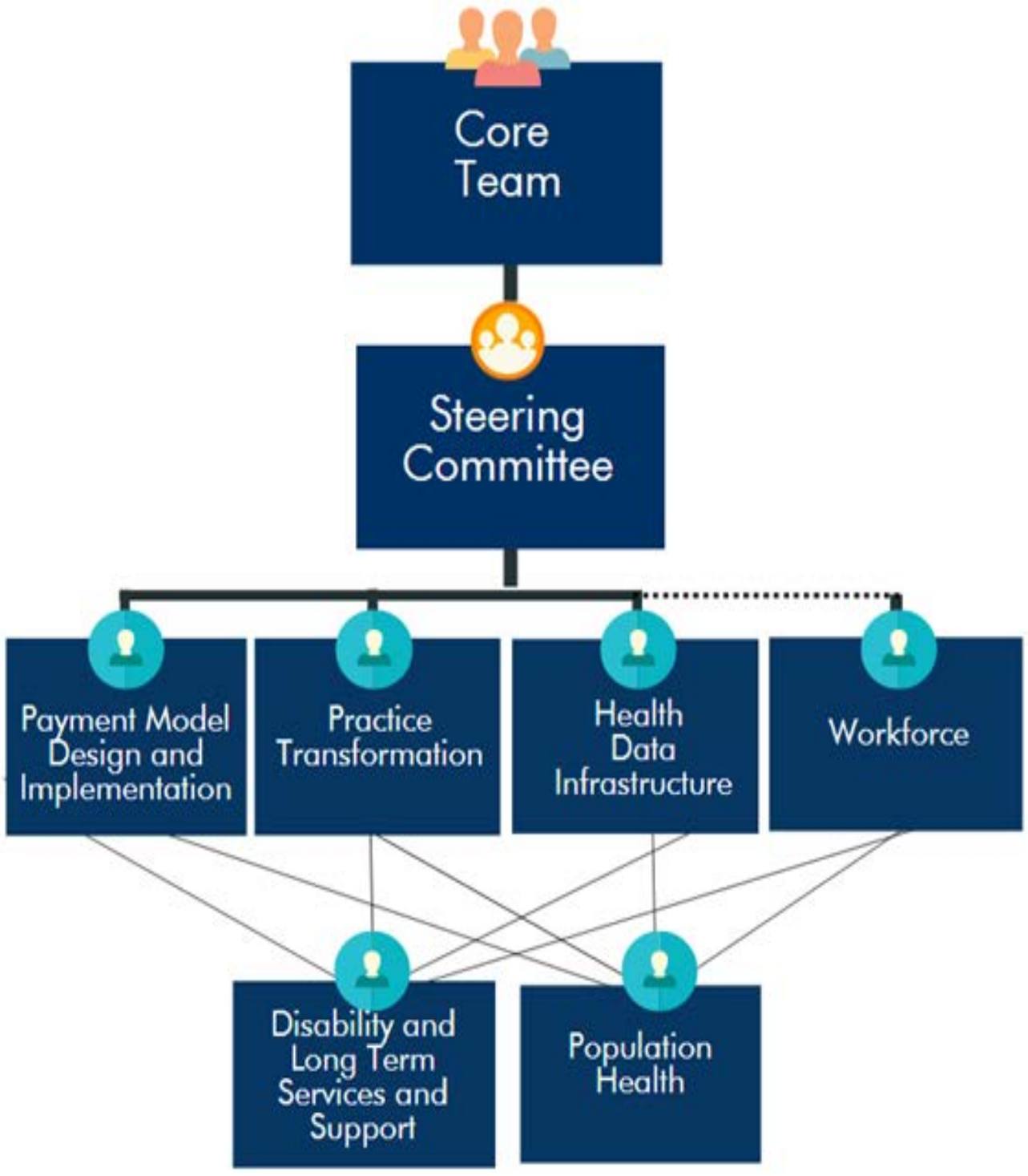
Vermont SIM Interview Participants

- 12 individuals from the private and public sector were interviewed.
- Interviews were performed to identify areas of successful SIM investment that should be sustained and barriers to sustainability.
- A comprehensive summary of the key informant interviews can be found in Appendix C of the Plan.

Plan Research and Development: Sustainability Sub-Group

- Lawrence Miller, Sub-Group Chair and Core Team Chair
- Paul Bengtson, Northeastern Vermont Regional Hospital (NVRH), Core Team Member
- Steve Voigt, ReThink Health, Core Team Member
- Cathy Fulton, VPQHC, Payment Model Design & Implementation Work Group Co-Chair
- Laural Ruggles, NVRH, Practice Transformation Work Group Co-Chair
- Simone Rueschemeyer, Vermont Care Network, Health Data Infrastructure Work Group Co-Chair
- Deborah Lisi-Baker, UVM, DLTSS Work Group Co-Chair
- Karen Hein, Population Health Work Group Co-Chair
- Mary Val Palumbo, Health Care Workforce Work Group Co-Chair
- Andrew Garland, BCBSVT, Payment Model Design and Implementation Work Group Co-Chair
- Lila Richardson, Office of the Health Care Advocate
- Vicki Loner, OneCare
- Kate Simmons, CHAC
- Holly Lane, Healthfirst
- Paul Harrington, Vermont Medical Society
- Dale Hackett, consumer, member of PMDI, PT, HDI, DLTSS, and PH Work Groups
- Stefani Hartsfield, Cathedral Square, HDI Work Group member
- Kim Fitzgerald, Cathedral Square, Steering Committee and PMDI Work Group member

SIM Governance



- Stakeholders have reported that the governance structure, particularly the Work Groups, are the cornerstone of Vermont's SIM experience and have served to bring about unprecedented collaboration, shared learning, and cross-program innovation.

- **The plan recommends that the functions of SIM governance be sustained, even if the SIM-specific governance structure is not continued.**

Sustainability

Recommendations

Three Categories of Investment

The State views SIM investments in three categories with respect to sustainability:

- **One-time investments** to develop infrastructure or capacity, with limited ongoing costs;
- **New or ongoing activities** which will be supported by the State after the end of the Model Testing period; and
- **New or ongoing activities** which will be supported by private sector partners after the end of the Model Testing period.

Some projects remain ongoing at the time of the delivery of the initial draft report. In these cases, we have indicated sustainability status is pending the project's completion.

Lead Entities

Lead Entities – The organization recommended to assume ownership of a project once the SIM funding opportunity has ended.

A Lead Entity may be a public or private sector organization from the Vermont health care community. These entities may not have complete governance over a project, but they do have a significant leadership role and responsibility. This includes the responsibility to convene the Key Partners.

Lead Entities are likely to include, but are not limited to State Agencies, Departments, programs, and regulatory bodies, including:

VERMONT Agency of Administration

VERMONT AGENCY OF HUMAN SERVICES

VERMONT Blueprint for Health Smart choices. Powerful tools.

VERMONT GREEN MOUNTAIN CARE BOARD

It will also include the Vermont Care Organization (VCO).

Key Partners

Key Partners – A more comprehensive network of State partners, payers, providers, consumers, and other private-sector entities who will be critical partners in sustaining previously SIM-funded efforts.

Key Partners may be public or private sector entities within or outside of the Vermont health care community. These entities represent the broader community and overlapping concerns inherent in a project's mission and objectives.

Vermont's SIM efforts have relied on active participation and input from a diverse group of stakeholders. Consumer and consumer advocate engagement and input have been critical in accomplishing the goals and objectives of the SIM initiative. The State of Vermont, in continuing to champion transparency in health care reform, is committed to working with consumers and advocates to ensure they have a visible role and are collaborative partners in future activities.

Key Partners (cont'd)

Depending on the project, Key Partners may include those listed above as Lead Entities. Key Partners also are likely to include:

- Additional State Agencies and Departments, including the Vermont Department of Health (VDH), the Department of Labor (DOL), and the Department of Information and Innovation (DII);
- Payers, including commercial and public (Medicare and Medicaid)
- Providers and provider organizations;
- The Community Collaboratives active in each region of Vermont;
- Key statewide organizations and programs like the Vermont Program for Quality in Health Care, Inc. (VPQHC), Support and Services at Homes (SASH), and Vermont Information Technology Leaders (VITL); and
- Federal partners: CMS, the Center for Medicare & Medicaid Innovation (CMMI), and the Office of the National Coordinator for Health Information Technology (ONC).

Recommendations:
Payment Model Design and Implementation

Investment Category			
SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Payment Model Design and Implementation			
ACO Shared Savings Programs (SSPs)		●	●
Pay-for-Performance (Blueprint for Health)		●	●
Health Home (Hub & Spoke)		●	●
Accountable Communities for Health		●	●
Prospective Payment System – Home Health		●	●
Medicaid Pathway		●	●
All-Payer Model		●	●

Recommendations:
Payment Model Design and Implementation (cont'd)

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
ACO Shared Savings Programs (SSPs)	GMCB	Payers (DVHA, BCBSVT, CMS), ACOs, VCO	Activity continued through transitional period.
Pay-for-Performance (Blueprint for Health)	VCO	AHS (DVHA-Blueprint) and GMCB	Note that both VCO and AHS will be engaged in subsequent P4P activities.
Health Home (Hub & Spoke)	AHS	DVHA-Blueprint, VDH	Anticipating additional Health Home initiatives for different services. Leverage Blueprint experience.
Accountable Communities for Health	Blueprint/VCO	VDH, AOA	Aligned with Regional Collaborations/CCs. (See Practice Transformation.) Additional information can be found in Vermont's Population Health Plan.
Prospective Payment System – Home Health	AHS/DAIL	VNAs of Vermont and New Hampshire, HHAs	Anticipate additional PPS for different services.
Medicaid Pathway	AHS	Provider Partners	A comprehensive list of key partners can be found here.
All-Payer Model	GMCB	AOA, AHS, ACOs, CMMI, Payers (DVHA, BCBSVT, CMS), providers	

Payment Model Design and Implementation: ACO Shared Savings Programs (SSPs)

- Designed to align with the Medicare Shared Savings Program (SSP) Track 1, but will end after a transitional period.
- The State will implement a Medicare Next Generation ACO concept through the All-Payer Model framework.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** GMCB
  - **Recommended Key Partners:** DVHA, BCBSVT, CMS, ACOs, VCO

Payment Model Design and Implementation: Blueprint for Health (Pay-for-Performance)

- Provides performance payments to advanced primary care practices recognized as patient-centered medical homes (PCMHs).
- Provides multi-disciplinary support services in the form of community health teams (CHTs); a network of self-management support programs; comparative reporting from statewide data systems; and activities focused on continuous improvement.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** VCO
  - **Recommended Key Partners:** AHS, DVHA-Blueprint, and GMCB

Payment Model Design and Implementation: Health Home / Hub and Spoke

- Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with opioid addiction.
- Integrates addictions care into general medical settings (Spokes) and links these settings to specialty addictions treatment programs (Hubs) in a unifying clinical framework.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partners:** DVHA-Blueprint, VDH

Payment Model Design and Implementation: Accountable Communities for Health

- Provides peer learning activities to support integration of community-wide prevention and public health efforts with integrated care efforts through a Peer Learning Laboratory.
- Peer learning activities and local facilitation to support communities in developing ACH competencies began in June 2016 and will continue through the conclusion of the Peer Learning Laboratory in January 2017.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** VDH, AOA

Payment Model Design and Implementation: Medicaid Pathway

- Process designed to advance payment and delivery system reform for services not included in the initial implementation of Vermont's All-Payer Model.
- The goal is to support a more integrated system for all Vermonters; including integrated physical health, long-term services and supports, mental health, substance abuse treatment, developmental disabilities services, and children's service providers.

- **Sustainability Recommendation:** New activities and investments.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partners:** Provider Partners

Payment Model Design and Implementation: All–Payer Model

- The All-Payer Model will build on Vermont's existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth.
- Through the legal authority of the Green Mountain Care Board (GMCB) and facilitated by an All-Payer Accountable Care Organization Model Agreement with CMMI, the state can enable the alignment of commercial payers, Medicaid, and Medicare in an Advanced Alternative Payment Model. Specifically, the State will apply the Next Generation ACO payment model, with modifications, and subsequently, a Vermont Medicare ACO Initiative model across all payers. The GMCB will set participating ACO rates on an all-payer basis to enable the model.

- **Sustainability Recommendation:** New activities and investments.
  - **Recommended Lead Entity:** GMCB
  - **Recommended Key Partners:** AOA, AHS, ACOs, CMMI, payers (DVHA, BCBSVT, CMS), and providers

Recommendations:
Practice Transformation

SIM Focus Areas and Work Streams	Investment Category: One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Practice Transformation			
Learning Collaboratives		●	●
Sub-Grant Program		●	●
Regional Collaborations		●	●
Workforce – Care Management Inventory	●		
Workforce – Demand Data Collection and Analysis	*Project Delayed*		
Workforce – Supply Data Collection and Analysis		●	

Recommendations:
Practice Transformation

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
Learning Collaboratives	Blueprint/VCO	Community Collaboratives, VPQHC, SASH	This work stream also includes the Core Competency Training. Aligned with Regional Collaborations/CCs. Note there are contract obligations related to this in the DVHA-ACO program for 2017.
Sub-Grant Program	AHS	AOA	
Regional Collaborations	Blueprint/VCO	AHS, VDH	Aligned with Learning Collaboratives, Accountable Communities for Health.
Workforce – Care Management Inventory	**One-time Investment**		
Workforce – Demand Data Collection and Analysis	AOA	DOL, VDH, GMCB, provider education, private sector.	AOA to coordinate across DOL, VDH, provider education, private sector.
Workforce – Supply Data Collection and Analysis	AOA		

Practice Transformation: Learning Collaboratives and Core Competency Training

- The Integrated Communities Care Management Learning Collaborative is a hospital service area-level rapid cycle quality improvement initiative.
- It is based on the Plan-Do-Study-Act (PDSA) quality improvement model, and features in-person learning sessions, webinars, implementation support, and testing of key interventions.
- The Core Competency Training series provides a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide.
- Core curriculum covers competencies related to care coordination and disability awareness.

- **Sustainability Recommendation:** On-going activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** Community Collaboratives, VPQHC, and SASH

Practice Transformation: Sub-Grant Program

- The VHCIP Provider Sub-Grant Program launched in 2014, has provided 14 awards to 12 provider and community-based organizations who are engaged in payment and delivery system transformation.
- Awards range from small grants to support employer-based wellness programs, to larger grants that support statewide clinical data collection and improvement programs. The overall investment in this program is nearly $5 million. The Core Competency Training series provides a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide.
- Sub-grantees performed a self-evaluation and some have engaged in sustainability planning.

- **Sustainability Recommendation:** Status is pending project's completion. Ongoing evaluations of individual sub-grant projects continue.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partner:** AOA

Practice Transformation: Sub-Grant Technical Assistance

- The Sub-Grant Technical Assistance program was designed to support the awardees of provider sub-grants in achieving their project goals.
- Direct technical assistance to sub-grant awardees has been valuable to the SIM experience, but will prove costly if sustained over a considerable period of time. Additionally, it will become less necessary as awardees get farther along in their programs. Sub-grantees performed a self-evaluation and some have engaged in sustainability planning.
- The State of Vermont will develop a contractor skills matrix as a resource for future awardees. Awardees would be responsible for selecting and securing contractor resources for technical assistance.

- **Sustainability Recommendation:** One-time Investment.

Practice Transformation: Regional Collaborations

- Within each of Vermont's 14 hospital service areas (HSAs), Blueprint for Health and ACO leadership have merged their regional clinical work groups and chosen to collaborate with stakeholders using a single unified health system initiative.
- These groups focus on reviewing and improving the results of core ACO Shared Savings Program quality measures; supporting the introduction and extension of new service models; and providing guidance for medical home and Community Health Team operations.

- **Sustainability Recommendation:** On-going activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** AHS and VDH

Practice Transformation: Care Management Inventory

- Survey administered to provide insight into the current landscape of care management activities in Vermont.
- The survey aimed to better understand State-specific staffing levels and types of personnel engaged in care management, in addition to the populations being served.
- The project was completed as of February 2016.

- **Sustainability Recommendation:** One-time investment.

Practice Transformation: Demand Data Collection and Analysis

- A “micro-simulation” demand model uses Vermont-specific data to identify future workforce needs for the State by inputting various assumptions about care delivery in a high-performing health care system.
- The selected vendor for this work will create a demand model that identifies ideal workforce needs for Vermont in the future, under various scenarios and parameters.
- This project is delayed.

- **Sustainability Recommendation:** Status is pending project completion.

Practice Transformation: Supply Data Collection and Analysis

- The Vermont Office of Professional Regulation (OPR) and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the State's health care workforce for health care work force planning purposes, through collection of licensure and re-licensure data and the administration of surveys to providers during the licensure/re-licensure process.
- Surveys include key demographic information for providers, and are used for workforce supply assessment and predicting supply trends.
- Infrastructure to support the continued use of this data exists, and it will continue to be supported by the State of Vermont, OPR and VDH.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA
  - **Recommended Key Partners:** DOL, VDH, GMCB, provider education, and private sector

Recommendations:
Health Data Infrastructure

SIM Focus Areas and Work Streams	Investment Category: One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Health Data Infrastructure			
Expand Connectivity to HIT – Gap Analysis	●		
Expand Connectivity to HIT – Gap Remediation		●	●
Expand Connectivity to HIT – Data Extracts from HIE	●		
Improve Quality of Data Flowing into HIE		●	●
Telehealth – Strategic Plan	●		
Telehealth - Implementation		●	●
Electronic Medical Record Expansion		●	●
Data Warehousing		●	●
Care Management Tools –Event Notification System			●
Care Management Tools – Shared Care Plan		●	●
Care Management Tools –Universal Transfer Protocol	●		
General Health Data – Data Inventory		●	
General Health Data – HIE Planning	●		
General Health Data – Expert Support	●		

Recommendations:
Health Data Infrastructure (cont'd)

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
Expand Connectivity to HIT – Gap Analysis	**One-Time Investment**		
Expand Connectivity to HIT – Gap Remediation	AOA*	ITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Expand Connectivity to HIT – Data Extracts from HIE	**One-Time Investment**		
Improve Quality of Data Flowing into HIE	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Telehealth – Strategic Plan	**One-Time Investment**		
Telehealth - Implementation	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Electronic Medical Record Expansion	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Data Warehousing	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools –Event Notification System	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools – Shared Care Plan	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools –Universal Transfer Protocol	**One-Time Investment**		
General Health Data – Data Inventory	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
General Health Data – HIE Planning	**One-Time Investment**		
General Health Data – Expert Support	**One-Time Investment**		

Health Data Infrastructure:
Expand Connectivity to HIE – Gap Analysis

- The Gap Analysis is an evaluation of the EHR system capability of health care organizations, interface ability of the EHR system, and the data transmitted within those interfaces.
- Created a baseline determination of the ability of health care organizations to produce Year 1 Medicare, Medicaid, and commercial Shared Savings ACO Program quality measure data. Evaluated data quality among the 16 designated and specialized service agencies.
- Reviewed the technical capability of DLTSS providers statewide.

- **Sustainability Recommendation**: One-time investment.

Health Data Infrastructure:
Expand Connectivity to HIE – Gap Remediation

- The Gap Remediation project addresses gaps in connectivity and clinical data quality of health care organizations to the Health Information Exchange.
- The ACO Gap Remediation component improves the connectivity for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Partners (VCP) Gap Remediation improves the data quality for the 16 Designated Mental Health and Specialized Service agencies (DAs and SSAs). In addition, a DLTSS Gap Remediation effort to increase connectivity for Home Health Agencies was approved in January 2016 based on the results of the DLTSS Information Technology Assessment. Infrastructure to support the continued use of this data exists, and it will continue to be supported by the State of Vermont, OPR and VDH.
- Gap Remediation efforts for ACO member organizations and Vermont Care Partners dovetail with data quality improvement efforts.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Expand Connectivity to HIE – Data Extracts from HIE

- This project provides a secure data connection from the VHIE to the ACOs' analytics vendors for their attributed beneficiaries.
- Allows ACOs direct access to timely data feeds for population health analytics.

- **Sustainability Recommendation:** One-time investment.

Health Data Infrastructure: Improve Quality of Data Flowing into the HIE

- The Data Quality Improvement Project is an analysis performed of ACO members' EHRs on each of 16 data elements. Allows ACOs direct access to timely data feeds for population health analytics.
- VITL engages providers and makes workflow recommendations to change data entry to ensure the data elements are captured. In addition, VITL performs comprehensive analyses to ensure that each data element from each health care organization (HCO) is formatted identically.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Telehealth

- *Strategic Plan* - The strategy includes four core elements and a road map based on the prioritization of telehealth projects and their alignment with new clinical processes adopted as payment reform evolves.
  - **Sustainability Recommendation:** One-time investment.

- *Implementation* - Vermont is funding two pilot projects that can address a variety of geographical areas, telehealth approaches and settings, and patient populations. The primary purpose is to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout Vermont. Projects were selected in part based on demonstration of alignment with the health reform efforts currently being implemented as part of the SIM Grant process.
  - **Sustainability Recommendation:** Ongoing activities and investments in the area of telehealth; not necessarily these two pilots.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Electronic Medical Record Expansion

- Electronic medical record (EMR) expansion focuses on assisting in the procurement of EMR systems for non-Meaningful Use (MU) providers.
- Includes technical assistance to identify appropriate solutions and exploration of alternative solutions.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Data Warehousing

- The Vermont Care Network (VCN) Data Repository will allow the Designated Mental Health Agencies and Specialized Service Agencies to send specific data to a centralized data repository.
- Long-term goals of the data repository include accommodating connectivity to the Vermont Health Information Exchange (VHIE), as well as Vermont State agencies, other stakeholders, and interested parties.
- It is expected that this project will provide VCN members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Care Management Tools

- *Shared Care Plan Project* - A planning activity that ensures that the components of a shared care plan are captured in a technical solution that allows providers across the care continuum to electronically exchange critical data and information as they work together in a team based, coordinated model of care.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, HHS (CMS, ONC).
- *Universal Transfer Protocol* - Sought to provide a Universal Transfer Protocol to Vermont's provider organizations. Pursued through provider workflow activities.
  - **Sustainability Recommendation:** One-time investment

Health Data Infrastructure: Care Management Tools (cont.)

- *Event Notification System* – A system to proactively alert participating providers regarding their patient's medical service encounters.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: General Health Data Inventory

- A health data inventory that will support future health data infrastructure planning.
- This project built a comprehensive list of health data sources in Vermont, gathered key information about each, and catalogued them in a web-accessible format.
- The resulting data inventory is a web-based tool that allows users (both within the State and external stakeholders) to find and review comprehensive information relating to the inventoried datasets.
- Periodic updates will be needed.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: HIE Planning

- The HIE planning project resulted from a perceived gap in high-level planning and research in local and nationwide best practices for providing a robust, interoperable ability to transmit accurate and current health information throughout the Vermont health care landscape.
- This project will conduct further research in best practices around improving clinical health data quality and connectivity resulting in recommendations to the HIE/HIT work group.
- Additionally, the HDI work group has participated on multiple occasions in the 2015 revision of Vermont HIT Plan.
- Plan is to finalize connectivity targets for 2016-2019 by December 31, 2016.

- **Sustainability Recommendation:** One-time investment.

Recommendations: Evaluation

Investment Category			
SIM Focus Areas and Work Streams	**One-Time Investment**	**Ongoing Investments** *State-Supported*	**Ongoing Investment** *Private Sector*
Evaluation			
Self-Evaluation Plan and Execution	**One-Time Investment**		
Surveys		●	●
Monitoring and Evaluation Activities within Payment Programs		●	●

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
Self-Evaluation Plan and Execution	**One-Time Investment**		
Surveys	VCO	Providers, AHS, Consumers, Office of the Health Care Advocate, GMCB	Patient experience surveys. Note that there are numerous patient experience surveys that are deployed annually in addition to the one used as part of the SSP.
Monitoring and Evaluation Activities within Payment Programs	AHS/GMCB	Payers, VCO, Office of the Health Care Advocate, AOA	Payers, State regulators, and VCO/providers will monitor and evaluate payment models. There are specific evaluation requirements for the GMCB and AHS as a result of the 1115 waiver and APM. Patient experience surveys are a tool for monitoring and evaluation.

Evaluation

- *Self-Evaluation Plan and Execution* - The State works with an independent contractor to perform a State-Led Evaluation of Vermont's SIM effort.
  - **Sustainability Recommendation:** One-time investment.
- *Surveys* - As part of broader payment model design and implementation and evaluation efforts, the State conducts annual patient experience surveys and other surveys as identified in payment model development. There are numerous patient experience surveys that are deployed annually, in addition to the one used as part of the SSP.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** VCO
    - **Recommended Key Partners:** Providers, AHS, Consumers, OHCA, GMCB.

Evaluation

- *Monitoring and Evaluation Activities within Payment Programs* - The state conducts analyses as necessary to monitor and evaluate specific payment models. Monitoring occurs by payer and by program to support program modifications. Ongoing monitoring and evaluation by State of Vermont staff and contractors occurs as needed.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AHS/GMCB
    - **Recommended Key Partners:** Payers, VCO, OHCA, and AOA

Project Management

- Vermont SIM is managed through a combination of State personnel and outside vendors with project management expertise.
- The project management function under SIM considers both the program and administration functions of government such as soliciting public comment, ensuring appropriations, and managing resources; as well as managing the various projects, groups, and relationships that SIM initiated.
- As SIM projects transition from the demonstration phase to the program phase, project management functions will transition to program staff in Medicaid, or other partners.

- **Sustainability Recommendation:** Ongoing activities and investments.

Plan Timeline

- November and December 2016 – First draft complete and under review by SIM Work Groups and Steering Committee. Core Team will review a revised draft in late December.
- Spring 2017 – Second draft of the SIM Sustainability Plan will be developed based on feedback from SIM Work Groups, Steering Committee, Core Team, and Sustainability Sub-Group.
- June 2017 – Following Core Team approval, final SIM Sustainability Plan will be submitted to CMMI. The Sustainability Plan is due June 30, 2017.

The plan is currently in draft.
Please provide comments and questions to:
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Attachment 3: Practice Transformation Work Group Celebration Slides

Vermont Health Care Innovation Project
Practice Transformation Work Group
"Final Reflection and Celebration"

December 6th, 2016

Vermont Health Care Innovation Project

Agenda:

- Review work group history
- Review progress and impact of work group initiatives
- Group reflection, discussion, and celebration

History:

- Former Care Models and Care Management Work Group began meeting in late 2013. Early work group initiatives included efforts to better:
  - understand and document the current care management/care coordination landscape;
  - define common care management and care coordination terms;
  - understand both gaps and areas of duplication of services;
  - and identify what the key goals and priorities of the work group would be.
- Since that time we have come a long way and accomplished much!

Key Priorities

- …to better serve all Vermonters (especially those with complex physical and/or mental health needs), reduce fragmentation with better coordination of care management activities…

- …[to] better integrate social services and health care services in order to more effectively understand and address social determinants of health (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters…

It Was a Group Effort:

- Work group members (and co-chairs) have come and gone, but the hard work and dedication of all never wavered. Credit for the success and impact of work group initiatives is due to a partnership of many organizations including (but not limited to):

- Agency of Human Services (DAIL, DVHA, DMH, DCF, VDH, AHS CO, DOC); ACOs (OneCare, CHAC, HealthFirst); Visiting Nurse Associations and Home Health Agencies; Designated Mental Health Agencies; SASH; Planned Parenthood of Northern New England; Hospitals and Primary Care Practices; Commercial Insurers (BCBSVT, MVP); GMCB; AOA; Vermont Legal Aid and the Long Term Care Ombudsman Project; Consumers; VCIL; VITL; Vermont Medical Society and VAHHS; Vermont Council of Developmental and Mental Health Services; Area Agencies on Aging; Vermont Developmental Disabilities Council; and many more!

That Resulted In Several Major Initiatives:

- "Care Management Inventory Survey" and "Gaps and Duplication Report"
- Integrated Communities Care Management Learning Collaborative
- Core Competency Training Series for front-line care coordinators
- Provider Sub-grant Program
- Regional Collaborations, a.k.a. "Community Collaboratives"

Care Management Inventory and Gaps and Duplications Report:

Care Management Inventory Report:

- In 2014, the Care Models and Care Management (CMCM) Work Group designed and fielded a survey to provide insight into the current landscape of care management activities in Vermont including staffing levels, types of personnel engaged in care management, populations being served, gaps and duplications in services.

- The project was completed in February 2016, the final report can be found at http://healthcareinnovation.vermont.gov/content/care-management-inventory-survey-report-march-2015

Gaps and Duplications Report:

- Draws on information collected from the survey report and work group presentations, can be found at http://healthcareinnovation.vermont.gov/content/care-management-vermont-gaps-and-duplication-august-2015

Special thanks to Pat Jones, Erin Flynn, Bea Grause and Nancy Eldridge with support from Marge Houy and Christine Hughes of Bailit Health Purchasing

Review of Opportunities and Responses:

Opportunities Identified in Care Management Presentations and Inventory Survey Responses	Responses from VHCIP and Others
Increased process standardization, including increased use of **common care management tools**	• Learning Collaborative • Vermont Model of Care • Core Competency Training • Care Management Toolkit
Creation of an organizational mechanism to **coordinate the "family of care coordinators"**	• Learning Collaborative • Vermont Model of Care
Increased development and use of **IT resources to coordinate care management activities**; improved communication and relationships across an integrated care team supported by **health data infrastructure and exchange**; increased use of a **shared data set** to coordinate care and measure effectiveness	• EQHealthworks (State of Vermont) • Patient Ping (event notification) • Care Navigator (OneCare) • Accessing Care Through Technology (ACTT) • ACO Gateways • Telehealth Initiatives
Increased **opportunities for care managers to build their skills** through initiatives to share best practices and learn new skills	• Core Competency Training • Learning Collaborative • Care Management Toolkit
Improved **identification of and outreach** to people with complex needs, **increased engagement of individuals in their care**	• Learning Collaborative • Vermont Model of Care • Core Competency Training
Insufficient funding or lack of reimbursement mechanisms to support care coordination functions, leading to challenges in recruiting and retaining qualified staff	• ACO Shared Savings Programs • Medicaid Pathway • Potential All Payer Model
Overcoming privacy barrier to sharing information across an integrated care team	• DAIL and Designated Agency Templates

Review of Opportunities and Responses cont'd:

Opportunities Identified in Care Management Presentations and Inventory Survey Responses	Responses from VHCIP and Others
Challenges **engaging providers** across the continuum of care **in an integrated care team**	• Learning Collaborative • Selected Provider Sub-grants • Unified Community Collaboratives • Accountable Communities for Health
…improve the rate of implementing CMMI's key care management functions…**educational opportunity to train care managers**…on these key care management functions.	• Core Competency Training
…establish **more formal and structured relationships** to create stronger ties for providing care management services across care settings and community service organizations, and **provide opportunities to develop truly integrated delivery systems** that include organizations traditionally on the periphery of traditional health care delivery.	• Learning Collaborative • Unified Community Collaboratives • Accountable Communities for Health • Potential All Payer Model • Medicaid Pathway
…opportunity to provide **additional training on implementing Team Based Care**.	• Learning Collaborative • Core Competency Training
Ensuring the provision of…[certain care management] **services**, when appropriate, **for people being discharged from skilled nursing facilities** could result in fewer readmissions, which is a very important focus for cost containment	• ACTT UTP Project • Learning Collaborative
Examining the roles that…[certain] disciplines could play in improving care management, and recruiting additional FTEs if warranted, could impact resource allocation.	• Workforce Work Group Demand Modeling

Integrated Communities Care Management Learning Collaborative:

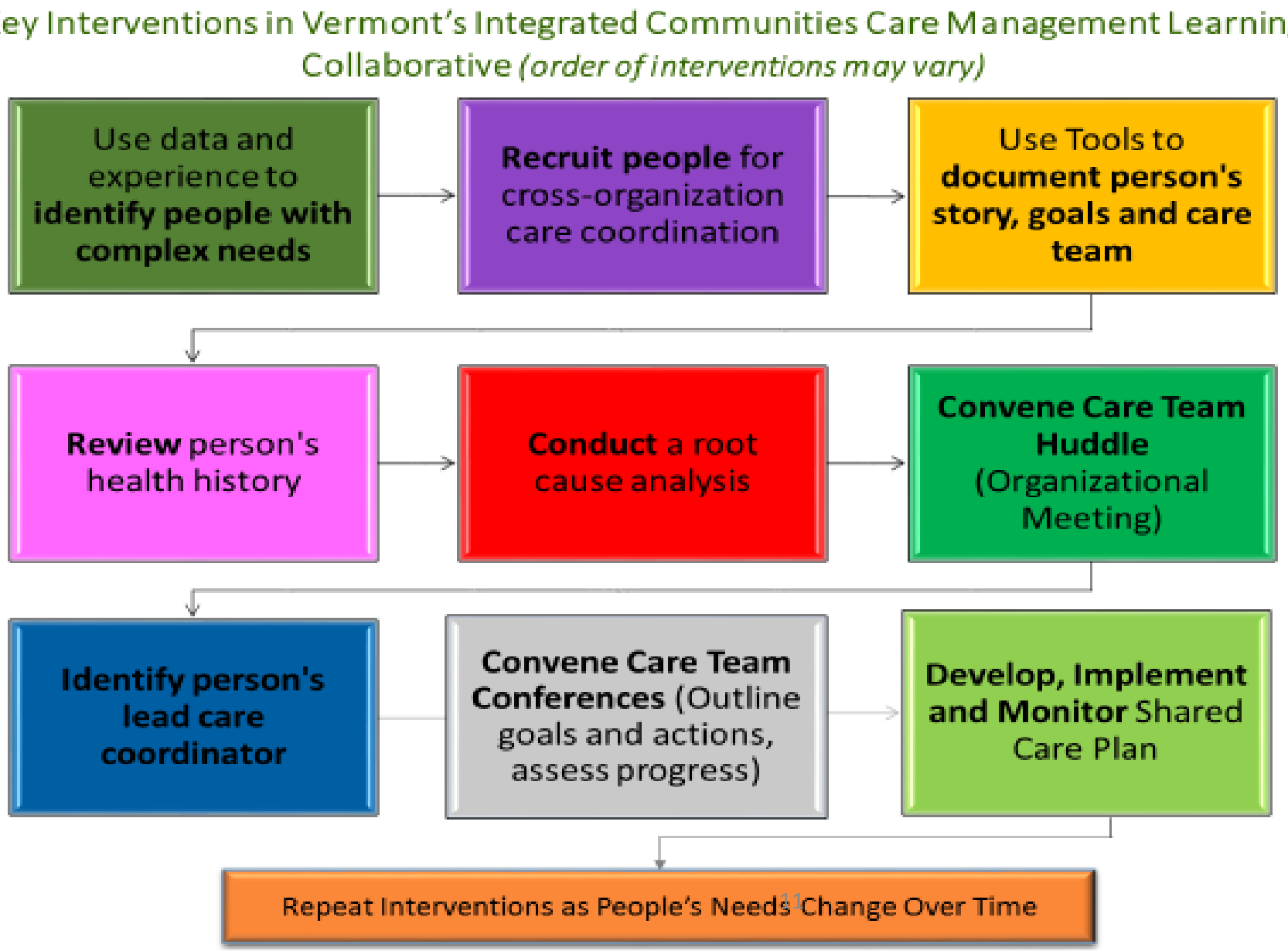
Overview:

- The Integrated Communities Care Management Learning Collaborative is a Health Service Area level rapid cycle quality improvement initiative. It is based on the Plan-Do-Study-Act (PDSA) quality improvement model, and features in-person learning sessions, webinars, and implementation support. The Collaborative has focused on improved cross-organization care management for at-risk populations; however, the ultimate goal is to develop this approach population-wide.

History:

- Began on a pilot basis in three communities in 2015, expanded statewide in 2016, active in 11 Health Service Areas
- Approximately 200 providers engaged and 318 complex individuals enrolled to date; including 303 with a lead care coordinator and 229 with a shared care plan!

Integrated Communities Care Management Learning Collaborative cont'd:



Integrated Communities Care Management Learning Collaborative cont'd:

- In addition to project staff and co-chairs, special thanks are due to many including:
  - Jenney Samuelson, Jennifer Le, and MaryKate Mohlman of the Blueprint for Health, as well as ALL Blueprint field staff
  - Vicki Loner, Miriam Sheehey, Elisa Gagne and Maura Crandall of OneCare Vermont and ALL OneCare field staff
  - Patty Launer of Community Health Accountable Care
  - Eileen Girling and Heather Bollman of Vermont Chronic Care Initiative and ALL VCCI staff
  - Nancy Eldridge and Stefani Hartsfield of SASH and ALL SASH field staff
  - QI facilitators Nancy Abernathey, and Bruce Saffran, and Liz Winterbauer and Cathy Fulton from VPQHC
  - Gabe Epstein of DVHA (formerly of DAIL)
  - Most importantly, ALL LEARNING COLLABORATIVE TEAM MEMBERS representing: VNAs, Home Health Agencies, Designated Agencies, Area Agencies on Aging, ACOs, VCCI, BCBSVT, Agency of Human Services, primary care practices, hospitals, skilled nursing facilities, and many more!

Core Competency Training Series :

The Core Competency Training Series provided skills training to front line staff providing care coordination from a wide range of medical, social, and community service organizations statewide. The curriculum covered competencies related to care coordination and disability awareness, and reinforced and expanded upon the disability awareness briefs and the Integrated Communities Care Management Learning Collaborative curriculum. *In total, 36 separate training opportunities were offered to up to 240 participants state-wide!*

Topics included:

- motivational interviewing
- health coaching
- health literacy
- bias, culture and values
- communication skills
- transitions in care
- domestic and sexual violence
- working with complex cases
- principles of team-based care,
- disability and wellness
- person-centered care
- universal design/accessibility
- facilitating inclusive meetings and trainings
- cultural competence
- transition from pediatric to adult care
- sexuality and reproductive health
- trauma-informed care

Additional training opportunities included advanced care coordination training for individuals facing challenges with mental health, substance use or homelessness, care coordination training for managers and supervisors, and "train the trainer" training.

Core Competency Training Series cont'd:

- In addition to project staff and co-chairs, special thanks are due to many including:
  - Carole Magoffin, Holly Stone, Amy Coonradt, James Westrich, Chrissy Geiler, Julie Wasserman and many others
  - Contractors including: Vermont Developmental Disabilities Council, Vermont Family Network, Green Mountain Self-Advocates, Vermont Federation of Families for Children's Mental Health, and Primary Care Development Corporation
  - Most importantly ALL of the front line staff, managers, and supervisors who dedicated MANY MANY hours out of their time to attend!

Provider Sub-Grant Program:

Launched in 2014, 14 awards to provider and community-based organizations who are engaged in payment and delivery system transformation. Awards range from small grants to support employer-based wellness programs, to larger grants that support statewide clinical data collection and improvement programs. The overall investment in this program is nearly $5 million.

Sub-grant projects include:

- Supportive Care Program Pilot
- The Caledonia and Essex County Dual Eligible Project
- Patient Self-Confidence Leads to Improved Chronic Disease Management and Less Hospitalization
- Resilient Vermont
- Implementing a Vermont Hospital Medicine Choosing Wisely Program, Including Reducing Unnecessary Laboratory Testing in Low Risk Surgical Candidates
- Capacity Grant for Accountable Care Organization Development (CHAC, Healthfirst)
- Vermont Prevention Model Campaign to Improve the Health of Franklin County Residents
- The Inclusive Health Care Partnership Project
- NSQIP Statewide Surgical Services Collaborative
- Innovative Adaptation of the Transitional Care Model (TCM) in a Rural Setting
- Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Medical Home
- Healthfirst Clinical Performance Improvement
- Behavioral Health Screening and Intervention

Regional Collaborations:

Overview:

- Blueprint for Health and ACO leadership merged work groups in all 14 Health Service Areas to collaborate with stakeholders using a single unified health system initiative. Regional Collaborations include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and a shared governance structure with local leadership. Groups monitor and improve upon the results of core Blueprint and ACO Shared Savings Program quality measures, support the introduction and extension of new service models, provide guidance for medical home and community health team operations, and facilitate community priority-setting.

Examples of key quality improvement initiatives include:

- Integrated Communities Care Management Learning Collaborative
- Accountable Communities for Health Peer Learning Lab
- Transitional care
- Combating opiate addiction
- ED utilization
- Readmissions
- COPD
- Hospice and palliative care utilization
- Obesity
- Adolescent well visits
- Developmental screenings
- Oral health
- Unplanned pregnancy
- chronic pain
- Depression
- CHF
- SBIRT

Group Discussion

Reflect on how far we have come, where we are headed, and most importantly:

To all and THANK YOU for your hard work and contributions over the years!

Acronyms:

- AHS CO : Agency of Human Services Central Office
- DVHA: Department of Vermont Health Access
- DAIL : Department of Disabilities Aging and Independent Living
- DMH: Department of Mental Health
- DCF: Department of Children and Families
- VDH: Vermont Department of Health
- DOC: Department of Corrections
- VCCI: Vermont Chronic Care Initiative
- ACO: Accountable Care Organization
- CHAC: Community Health Accountable Care
- SASH: Support and Services at Home
- BCBSVT: Blue Cross Blue Shield Vermont
- GMCB: Green Mountain Care Board
- AOA: Agency of Administration
- VCIL: Vermont Center for Independent Living
- VITL: Vermont Information Technology Leaders
- VAHHS: Vermont Association of Hospitals and Health Systems
- CMMI: Center for Medicare and Medicaid Innovation
- ACTT UTP: Advancing Care Through Technology Universal Transfer Protocol Project
- VPQHC: Vermont Program for Quality in Health Care
- VNA: Visiting Nurse Association
- COPD: Chronic Obstructive Pulmonary Disease
- CHF: Congestive Heart Failure
- SBIRT: Screening Brief Intervention and Referral to Treatment

Attachment 3a: SIM Work Group Transitions: How to Stay Involved

SIM Work Group Transitions: How to Stay Involved

December 1, 2016

Purpose: *The purpose of this document is to provide information to individuals who have served on SIM Work Groups regarding new and existing opportunities to stay involved in Vermont health care reform work.*

Email distribution lists: Various State entities involved in health care reform maintain email distribution lists that provide information about Vermont's health care reform activities. Please contact the individuals below if you would like to be added to the distribution lists:

Email distribution list	**Contact person**
Agency of Human Services Global Commitment	Ashley Berliner[1]
Green Mountain Care Board	Jaime Fisher
Department of Disabilities, Aging, and Independent Living	Bard Hill

Websites: In addition to these email distribution lists, State Agencies and Departments maintain websites that provide information about health care reform and other activities:

- *Agency of Administration Office of Health Care Reform:* hcr.vermont.gov
- *Agency of Human Services:* humanservices.vermont.gov
- *AHS-Department of Disabilities, Aging, and Independent Living:* http://dail.vermont.gov/
- *AHS-Department of Health:* healthvermont.gov
- *AHS-Department of Vermont Health Access:* dvha.vermont.gov
- *Green Mountain Care Board:* gmcboard.vermont.gov

Advisory Boards and Committees: Some Agencies, Departments, and Divisions regularly consult stakeholders through formal Advisory Boards or other bodies. In many cases, members are appointed by the Governor following an application process. Below are a some examples of the boards and committees that may be of interest:

- *Agency of Human Services:* See http://humanservices.vermont.gov/boards-committees. Includes Human Services Board, Children and Family Council for Prevention Programs, Developmental Disabilities Council, Vermont Council on Homelessness, Institutional Review Board, and the Tobacco Evaluation and Review Board.
- *AHS-Department of Disabilities, Aging, and Independent Living:* See http://dail.vermont.gov/dail-boards. Includes DAIL Advisory Board, the Developmental Services State Program Standing Committee, the Governor's Commission on Alzheimer's Disease and Related Disorders, and numerous Division Advisory Boards and Committees.
- *AHS-Department of Vermont Health Access:* See http://dvha.vermont.gov/advisory-boards. Includes Medicaid and Exchange Advisory Board, Clinical Utilization Review, Drug Utilization Review Board, and multiple committees related to the Blueprint for Health.
- *Green Mountain Care Board:* See http://gmcboard.vermont.gov/board/advisory-committee. Includes GMCB Advisory Committee.

In addition to these groups, AHS' Medicaid Pathway process currently convenes two stakeholder groups. For more information about these groups, please contact Julie Corwin.

[1] All individuals listed use the State of Vermont email convention: firstname.lastname@vermont.gov.