Vermont Health Care Innovation Project
Steering Committee Meeting Agenda

December 14, 2016, 1:00pm-2:30pm

Elm Conference Room, Waterbury State Office Complex, State Drive, Waterbury

Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action?
1	1:00-1:05pm	Welcome and Introductions; Minutes Approval	Steven Costantino & Al Gobeille	Attachment 1: Draft October 26, 2016, Meeting Minutes	Approval of Minutes
2	1:05-1:10	Core Team Update • Population Health Plan Update *Public comment*	Lawrence Miller & Georgia Maheras		
3	1:10-1:45	VHIE Connectivity Targets	Larry Sandage	Attachment 3: VHIE Connectivity Targets	Vote to Approve
4	1:45-2:25	SIM Sustainability Plan Review and Discussion	Georgia Maheras	Attachment 4: SIM Sustainability Plan Slides Full Draft Sustainability Plan available at: http://healthcareinnovation.vermont.gov/content/vermont-sim-sustainability-plan-draft-november-2016.	
5	2:25-2:30	Steering Committee Closing and Thanks *Public comment*	Steven Costantino, Al Gobeille, & Georgia Maheras	Attachment 5: SIM Work Group Transitions – How to Stay Involved	

Attachment 1: Draft October 26, 2016, Meeting Minutes

Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, October 26, 2016, 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Steven Costantino called the meeting to order at 1:03PM. A quorum was not present.	
2. Core Team Update	*All-Payer Model Update:* Lawrence Miller provided an update on the All-Payer Model. • The public comment period for the All-Payer Model closed. The GMCB and Administration received a few specific comments on the agreement, which went to CMS; the agreement was updated and returned earlier this week with CMS's signature. • The Green Mountain Care Board voted affirmatively this morning, authorizing Chairman Gobeille to sign. • Governor Shumlin and Secretary Cohen will officially sign tomorrow afternoon at the Governor's Ceremonial Office. • Responses to comments are completed and posted on the GMCB website and the Office of Health Care Reform website. This includes responses general responses to most verbal comments. • CMS confirmed today that under their Quality Payment Program, they have designated the Vermont ACO Model as an Advanced Alternative Payment Model (AAPM) for MIPS/MACRA purposes. The group discussed the following: • Susan Aranoff asked whether the Green Mountain Care Board was presented with the Shared Savings Program (SSP) results prior to voting. Lawrence replied that the SSP results have been public for a few weeks, but noted that there is a substantial difference between the two models. Pat Jones confirmed that Board members have seen results. *Brief Sustainability Update:* Lawrence Miller provided a brief sustainability update. We received a first draft of the plan this week; it will be reviewed by the Sustainability Sub-Group on Friday, and released to all VHCIP	

Agenda Item	Discussion	Next Steps
	participants next week (expected 11/2) following a first round of edits. The draft plan will be reviewed and discussed at all Work Groups in November, and will also be the subject of a webinar on 11/17. Written and verbal comments are also welcome; please send them to Georgia Maheras (georgia.maheras@vermont.gov) or Sarah Kinsler (sarah.kinsler@vermont.gov).	
3. Overview: Year 2 Shared Savings Program Results	Pat Jones and Alicia Cooper presented high-level results from Year 2 of Vermont's Medicaid and Commercial Shared Savings Programs (SSPs) as well as the Medicare Shared Savings Program. • The Shared Savings Programs (SSPs) are part of a broader context in Vermont and nationally: in 2015, the federal government passed the Medicare Access and Children Health Insurance Program Reauthorization Act (MACRA). MACRA creates 2 tracks for payment reform under Medicare: 1) Merit-Based Incentive Payment System (MIPS) – reimburses providers based on results of quality measures (upside or downside); 2) Advanced Alternative Payment Models – provides financial incentives for providers who chose to participate and disincentives for those who do not. Vermont's current SSPs do not qualify as Advanced Alternative Payment Models; however, the All-Payer Model would qualify. • Cautions in interpreting results: The three ACOs have different populations and different SSP start dates/levels of maturity. In addition, Commercial targets continue to be based on Vermont Health Connect premiums, rather than actual claims experience. • Takeaways from the 2015 SSP results: Medicaid SSP: CHAC earned modest savings; PMPM declined from 2014 to 2015. Overall quality scores improved. Commercial SSP: CHAC and OneCare PMPM financial results closer to targets; no change in OneCare's PMPM from 2014 to 2015; VCP's farther away from target. Targets still based on premiums in 2015, rather than claims experience. Overall quality scores improved by 5 percentage points for CHAC and 2 percentage points for OneCare; VCP overall quality score declined by 2 percentage points (still would have qualified VCP for 100% of savings). Medicare SSP: CHAC and OneCare aggregate financial results farther away from targets; Medicare doesn't report PMPM results. Quality improved by 7 percentage points for OneCare; 2015 was first reporting year for CHAC; both had quality scores greater than 90%. • A few notes regarding Medicaid and Commercial payment measures: o Medicaid and Commercial payment measure set was mostly stable between 2014 and 2015; outcome measures added in 2015 o Multiple years of data for Commercial SSP members resulted in adequate denominators for measures with look-back periods o Medicaid "Quality Gate" more rigorous in 2015 (35% to 55%) o Data collection and analysis is challenging, but there continues to be impressive collaboration among ACOs in clinical data collection • Medicaid SSP Quality Results: Payment Measures – (Slide 36).	

Agenda Item	Discussion	Next Steps
	Strengths: ○ 10 of 14 measures of ACO results were above the 50th percentile nationally; 6 of 14 were above the 75th percentile Both ACOs met the quality gate and CHAC will receive shared savings Opportunities: ○ 4 of 14 measures were below the 50th percentile ○ Opportunity to improve Chlamydia Screening measure across both participating ACOs ○ Some variation among ACOs • Commercial SSP Quality Results: Payment Measures Strengths: ○ 16 of 22 measures were above the 50th percentile nationally; 15 of 22 were above the 75th percentile Opportunities: ○ 6 of 22 measures were below the 50th percentile ○ Opportunity to improve Alcohol and Other Drug Dependence Treatment measure across all ACOs ○ Even when performance compared to benchmarks is good, potential to improve some rates ○ Some variation among ACOs The group discussed the following: • Dr. Batra asked how 2015 Medicaid SSP targets were set. Alicia replied that 2015 expenditure targets were set based on a three-year baseline period, from 2011-2013. • Dale Hackett asked if OneCare and Healthfirst could speak to why they exceeded targets. Alicia replied the 10/28 webinar on this topic will expand on this theme. Dale noted that CHAC's quality score was lower than OneCare's, yet CHAC achieved savings and OneCare did not. Pat recommended caution in interpreting the relative quality scores. • Dr. Batra noted that CHAC saw an actual reduction in PMPM costs for the Medicaid SSP in Year 2. • Dale again noted that as quality scores rose across the ACOs within the commercial program, costs rose. Steven Costantino and Pat replied that different populations (and risk adjustment) make it challenging to compare across ACOs. • Susan Aranoff asked what percent of Vermont's Medicare lives are attributed to an ACO. Pat estimated a bit more than half. Pat noted that a recent Health Affairs blog reported that nationally, lower-cost ACOs are not as likely to achieve savings in the Medicare SSP (Vermont's Medicare expenses are on the low side). • Dr. Batra noted that common wisdom is that Medicaid is the leanest of health insurers, but the Medicaid SSP is achieving savings. Alicia replied that SSP design is not exactly the same across payers, which makes it hard to compare. She added that the Medicaid expansion in 2014 had an impact as new	

Agenda Item	Discussion	Next Steps
	Medicaid enrollees began using more services. Lawrence suggested that new enrollees expanded the population, and skewed young and healthy. • Dale noted that Exchange premiums increased across the country for the coming plan year. Lawrence cautioned against equating these two conversations. He commented that total enrollment was approximately as anticipated and actuarial data was fairly good for Vermont's exchange population. In other states, actuarial error in early years resulted in artificially low premiums; major price increases were necessary to correct this. In addition, claims on the federal co-insurance pool (which was intended to help participating insurers recoup some costs if, for example, Exchange enrollees were significantly sicker than the general population) for Exchange plans was 8.7 times higher than input into that pool, which left insurers to make up losses by increasing premiums over the first few years of the exchanges. • Julie Wasserman noted that Dr. Batra's comment related to savings in the Medicaid SSP might link to public concern about Medicaid within the All-Payer Model – why are savings being achieved only for a program that some consider underfunded, and are these savings funding ACO operations within the other SSP programs? Dr. Batra commented that Julie describes the reverse of the actual cost-shift we see between payers. Lawrence replied that no one has presented a business argument for this scenario– we need real, specific concerns so that we can put appropriate language in contracting to protect against issues like these. Steven added that the SSP model is very different from the APM, and noted that no insurer wants to subsidize another – there will be contractual firewalls to prevent this. • Susan noted that we are moving away from fee-for-service and that the SSP model doesn't have downside risk. She asked why OneCare chose to delay NextGen launch and when they will be able to take on financial risk. Lawrence noted that OneCare will start NextGen for Medicare in 2018; the DVHA program based on NextGen is expected to begin in 2017, with commercial in 2018 or 2019 depending on readiness. • Dale noted that MACRA/MIPS penalizes providers for remaining in FFS payment. Pat clarified that there could be a penalty or a payment increase depending on reported quality measures. Up to 9% of payments will be at risk once the program has fully scaled up. Pat clarified that FFS is changing with the advent of MACRA/MIPS – providers will either end up in FFS with MIPS or join an alternative payment model. Dale asked whether FFS rates will become more expensive if providers are assessed penalties. Lawrence replied that within their Medicare base (where MIPS/MACRA applies), Medicare has a rate they are going to pay – those rates are set by Medicare. Individual practices are unlikely to be able to negotiate better rates with commercial payers to make up for this, and instead would have to work more hours/see more patients or improve quality. Dr. Batra noted that providers could choose not to participate in Medicare or to stay with current FFS rates with no inflation, which means rates will decrease compared to inflation over time. • Susan asked about the implications of declining Medicare ACOs performance compared to previous years. She suggested that research on whether ACOs work is mixed. Older ACOs might perform better	

Agenda Item	Discussion	Next Steps
	over time; Susan indicated that she thinks Vermont's ACOs are mature and not necessarily getting better. Pat replied that this is still a relatively recent initiative; today's presentation is based on 2014 and 2015 performance years, when ACOs and SSPs were just starting up. Some results seem potentially promising: The reduced PMPM for CHAC in Medicaid SSP and the flat PMPM for OneCare in Commercial SSP, and ACO PMPM movement towards the Commercial SSP target. Quality scores seem to be improving to some degree. It's early to draw conclusions about overall results and their implications. o Lawrence commented that complacency is not an option – the All-Payer Model will take a great deal of work to move forward, but the framework agreement is the start of the work. Susan replied that the data from the SSPs give her concerns. Lawrence replied that the evolution of contract arrangements is very important. Lack of two-sided risk might have limited change, and if we didn't have partners who were ready to move to two-sided risk he would not be confident. Significant areas we need to work on include mental health and substance abuse treatment; this agreement gives us some resources to support work in those areas. The model is intended to bring resources into behavioral health and other sectors. o Steven noted that he has been critical of the SSPs in the past, but the quality measure results are impressive and that is a critical piece. o Dale agreed with Steven regarding quality results – this is a priority. He asked whether the 3.5% cap on spending growth can fluctuate, whether this is a true cap on all health care spending, and how this will impact the Legislature's ability to make new investments in some sectors where additional funding is needed. Lawrence noted that not everything is included in the cap – only Medicare Part A and B-like services. This excludes behavioral health to allow for needed growth in that sector. Measurement of the model is based on compound annual growth rate over the demonstration period, rather than year to year. This is based on per-member per-month spend, adjusted for age and acuity on the Medicare side, and doesn't include benefit limits if we "run out of budget" in the agreement – Medicare and other payers are required to provide benefits, based on their reserves if necessary. If we fail to meet the targets, the agreement ends – Vermont doesn't write a check to CMS. DVHA increased primary care rates as of October 1. The Administration has been lobbying for rate increases for behavioral health and other sectors to support baseline increases in funding. This model will support better alignment across the system, but we do need additional support for underfunded sectors – this is why they're excluded from the model. Steven noted that results will be further discussed on a webinar from 12-1pm on 10/28.	
4. Population Health Plan	Tracy Dolan presented the draft Population Health Plan, noting that the draft Plan (summarized in Attachment 4; full draft plan available here: Population Health Plan) is a draft; we hope and expect to have comments and feedback from a broad stakeholder group.	

Agenda Item	Discussion	Next Steps
	• This is the culmination of two years of work from the Population Health Work Group. • Most attendees have seen the Plan presented previously. She gave a very high-level overview of the plan to allow additional time for discussion. • Tracy recommended reviewing the Plan draft itself for more detail. • Karen Hein suggested three ideas to keep in mind: This plan looks longer (over time), earlier (in lifespan), and wider (in terms of determinants and populations). The group discussed the following: • J Batra agreed with the tenets of the plan. He asked how he would know that a concrete idea fit within this framework (or not). He suggested getting more specific about actions. Tracy commented that this plan is meant to be a broader framework, and suggested we could be more specific about how we utilize policy levers called out in the plan. J provided an example based on mental illness prevention, which mostly relies on supporting better child development. That aligns philosophically, but how would we move forward? Cathy Fulton asked how new stakeholders could arrive at a governance table, for example, or does a stakeholder group have the power to look at data and based on this, bring new topics to the conversation and make plans based on that. Karen Hein provided an analogy based on the All-Payer Model – both are high-level guideposts or frameworks, but regional/local/individual decisions driven by this. Over time, population health representation at the local and regional levels will start to unfold. Tracy added that this is feedback we've heard elsewhere, and suggested we could find a way to represent these concerns in the plan. This plan points us to decision-points where population health can be included so that we don't need to decide these things topic-by-topic or issue-by-issue or population-by-population. J replied that layering illness prevention and health promotion that have previously ignored primary and secondary prevention, it can be challenging to keep it at the forefront. He suggested we also need outside structures to ensure primary prevention continues to be represented. Tracy noted that this has been an ongoing discussion in this field – to integrate with health care (where money is) or to remain apart? J suggested both are necessary. • Dale Hackett commented that culture has a profound impact on substance abuse rates, for example. Karen commented that this plan has an emphasis on systems – sometimes the most effective intervention is not individual counseling, for example, but making the healthy choice the easy choice. A system-wide intervention may need to emphasis and support. Dale added that it's not just the choice, but what leads individuals to make a choice. He commented that population health activities need to be responsive to local culture as well as the cultures of subpopulations within local areas or regions. Karen agreed and responded that we want to create a culture of health. • Cathy Fulton provided a patient example related to hunger and social determinants. She commented that it is the work of this group to ensure that patients' basic needs are met, including social needs/upstream needs. Tracy agreed and noted that the work of this group might be to set up systems	

Agenda Item	Discussion	Next Steps
	for this, so connections don't need to be made anew each time. Mike Hall commented that the AAAs, HHAs, ACOs, and other partners have been discussing how to integrate social services, health coaching, and mental health more securely into health care. Tracy agreed and suggested we want every new system to have this integrated fully. She also suggested that financing and reinvestment of savings may be key to making this work in the long-term. Mike commented that Act 113 includes language on parameters for how APM and ACO models should be built out to include these. Sarah Kinsler added that this plan seeks to identify those linkages as well as how we can ensure community-wide population health and primary prevention activities are integrated. • Dale Hackett provided another example of a town where officials have set up regular open discussions with community members over coffee, and suggested this was a positive model. Tracy commented that regional models where many groups are invited and represented that haven't previously participated in conversations about health has created some new discussions. The plan seeks to broaden the lens of what impacts health and broaden the group of stakeholders included in these conversations. Please feel free to send additional comments to Sarah Kinsler, Heidi Klein, or Georgia Maheras.	
5. Public Comment, Next Steps, Wrap Up and Future Meeting Schedule	There was no additional public comment. **Next Meeting:** Wednesday, November 30, 2016, 1:00pm-3:00, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Steering Committee Member List

Member		Member Alternate		Minutes	Wednesday, October 26, 2016
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff				AHS - DAIL
Rick	Barnett				Vermont Psychological Association
Bob	Bick				DA - HowardCenter for Mental Health
Beverly	Boget				VNAs of Vermont
Steven	Costantino				AHS - DVHA, Commissioner
Elizabeth	Cote				Area Health Education Centers Program
Tracy	Dolan	Heidi	Klein		AHS - VDH
David	Martini				DFR
John	Evans	Kristina	Choquette		Vermont Information Technology Leaders
Kim	Fitzgerald				Cathedral Square and SASH Program
Catherine	Fulton				Vermont Program for Quality in Health Care
Kate	Simmons				Bi-State Primary Care/CHAC
Al	Gobeille	Kate	O'Neill		GMCB
Lynn	Guillett				Dartmouth Hitchcock
Dale	Hackett				Consumer Representative
Mike	Hall				Champlain Valley Area Agency on Aging / COVE
Paul	Harrington				Vermont Medical Society

Selina	Hickman	Shawn	Skafelstad		AHS - DVHA
Debbie	Ingram				Vermont Interfaith Action
~~Craig~~	~~Jones~~	Beth	Tanzman		AHS - DVHA - Blueprint
Julia	Shaw ✓	(Interim)			VLA/Health Care Advocate Project
Deborah	Lisi-Baker				SOV - Consultant
(vacant)					VLA/LTC Ombudsman Project
Todd	Moore	Vicki	Loner		OneCare Vermont
Jeffrey	Tieman				Vermont Association of Hospital and Health Systems
Mary Val	Palumbo				University of Vermont
Ed	Paquin				Disability Rights Vermont
Judy	Peterson				Visiting Nurse Association of Chittenden and Grand Isle Counties
Allan	Ramsay				GMCB
Frank	Reed	Jaskanwar	Batra ✓		AHS - DMH
Paul	Reiss				HealthFirst/Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓				Vermont Care Network
Howard	Schapiro				University of Vermont Medical Group Practice
Julie	Tessler	Marlys	Waller		Vermont Council of Developmental and Mental Health Services
Sharon	Winn				Bi-State Primary Care
	34		8		

14 No Quorum

	Meeting Name:	VHCIP Steering Committee Meeting	
	Date of Meeting:	October 26, 2016	
	First Name	Last Name	
1	Susan	Aranoff	here
2	Ena	Backus	
3	Melissa	Bailey	
4	Heidi	Banks	
5	Rick	Barnett	
6	Susan	Barrett	
7	Jaskanwar	Batra	here
8	Bob	Bick	
9	Martha	Buck	
10	Kristina	Choquette	
11	Sarah	Clark	
12	Lori	Collins	
13	Amy	Coonradt	here
14	Alicia	Cooper	here
15	Steven	Costantino	here
16	Elizabeth	Cote	
17	Diane	Cummings	
18	Mike	DelTrecco	
19	Tracy	Dolan	here
20	Richard	Donahey	
21	John	Evans	phone
22	Jamie	Fisher	
23	Kim	Fitzgerald	here
24	Katie	Fitzpatrick	

25	Erin	Flynn	here
26	Aaron	French	
27	Catherine	Fulton	here
28	Lucie	Garand	
29	Christine	Geiler	
30	Al	Gobeille	
31	Lynn	Guillett	
32	Dale	Hackett	here
33	Mike	Hall	here
34	Paul	Harrington	here
35	Carrie	Hathaway	
36	Karen	Hein	here
37	Selina	Hickman	
38	Debbie	Ingram	
39	Craig	Jones	
40	Kate	Jones	
41	Pat	Jones	here
42	Joelle	Judge	here
43	Sarah	Kinsler	here
44	Heidi	Klein	
45	~~Leah~~	~~Korce~~	
46	Andrew	Laing	
47	Deborah	Lisi-Baker	
48	Sam	Liss	
49	Vicki	Loner	
50	Robin	Lunge	
51	Carole	Magoffin	

52	Georgia	Maheras	
53	David	Martini	here
54	Todd	Moore	
55	Kate	O'Neill	here
56	Brian	Otley	
57	Dawn	O'Toole	
58	Mary Val	Palumbo	
59	Ed	Paquin	
60	Judy	Peterson	
61	Anne	Petrow	
62	Luann	Poirer	
63	Allan	Ramsay	
64	Frank	Reed	
65	Paul	Reiss	
66	Simone	Rueschemeyer	Phone
67	Jenney	Samuelson	
68	Larry	Sandage	
69	Suzanne	Santarcangelo	
70	Howard	Schapiro	
71	Julia	Shaw	Phone
72	Shawn	Skafelstad	
73	~~Holly~~	~~Stone~~	
74	Beth	Tanzman	
75	Julie	Tessler	
76	Beth	Waldman	
77	Marlys	Waller	
78	Julie	Wasserman	here

79	Kendall	West	
80	James	Westrich	
81	Sharon	Winn	
82	David	Yacovone	

Karen Sivior - DUHA - phone
Lawrence Miller - AOA - here

Attachment 3: VHIE Connectivity Targets

HEALTH INFORMATION EXCHANGE CONNECTIVITY TARGET PROPOSAL

Larry Sandage

December 14, 2016

Project Background

- Intent: *From 2016 HDI Workplan* – Discuss connectivity targets for 2016-2019 and make a recommendation to the Steering Committee and Core Team.
  - During review, this was expanded to a 10 year outlook.
- *Connectivity* is defined in this project as an information connection between Vermont Health Care Organizations (HCOs) and the Vermont Health Information Exchange (VHIE).
  - Many types of information can be passed over a connection including: demographics, clinical, lab orders, lab results, immunizations, transcriptions, etc.
- *Connectivity Targets* are intended to provide stakeholders with a reasonable framework on progress towards connecting all HCOs to the VHIE over the next 10 years.

HDI Work Group Presentation

- The Connectivity Targets were presented to the HDI Work Group on 10/28/16. The Connectivity Targets were approved unanimously "as a starting point that will be revisited in six months" as "this is a point in time but provides a framework for moving forward."

- The proposed targets were based off of the "Health Care Organization Connectivity Report", submitted by Vermont Information Technology Leaders (VITL) to the State on July 13, 2016 and revised in September 2016.
  - This report provided a comprehensive overview of VITL's progress to date in connecting Health Care Organizations to the VHIE.

HDI Work Group Presentation (Cont'd)

- The presentation to the HDI Work Group included:
  - Assumptions needed to be considered while developing the targets.
  - The Methodology utilized to develop the Connectivity targets.
  - Ten year connection projections for 7 categories of Health Care Organizations that make up Vermont's health care environment:
    - Designated Agencies
    - FQHCs
    - Home Health Agencies
    - Hospitals
    - Long Term Care
    - Primary Care
    - Specialty Care

Assumptions

- Proposed criteria are based on the following premises:
  - Certain provider sites will only require certain types of connections
  - For estimating purposes, each provider site requiring a type of connection will have only a maximum of one connection per type calculated.
  - The level of effort involved in developing a connection will vary depending on the HCO type, vendor, or connection type.
- All estimates are contingent on willing HCO participation, HCO capabilities, resource, vendor capability, and funding.
- Replacement connections for HCOs that either change or upgrade their EHR system account for a significant amount of effort and are difficult to estimate. To account for this, the estimates for *new connections* are deliberately set at a lower rate to allow for the fluctuation of replacement connection rates. Replacement connections are not included as part of this proposal.

Methodology

- The Connectivity Targets were developed by analyzing the previous five years of VITL connection development and using that progress to estimate a reasonable connection trend over the next 10 years, assuming funding and resources remain constant.
- As the targets were developed, certain considerations must be made:
  - Type and capability of the Health Care Organization
  - Technical and financial resource
  - Some types of HCOs may never have a need to connect (For instance, a retiring practice)
  - Vendor capability
  - Privacy & Security Regulations (42 CFR Part 2, FERPA)

Vermont Health Care Innovation Project

Proposal Emphasis

The HDI Work Group requested an emphasis on:

- Clinical information (CCD) connections in general since they provide the most robust and comprehensive data.
- Admission/Discharge/Transfer (ADT) connections for LTSS providers as they provide crucial information regarding transition of care and patient demographics.
- Clinical information connections for Specialty Care and Nursing Homes.

Results

The Connectivity Target exercise provided a roadmap for Vermont's connection trends over the next 10 years. Using this roadmap, Vermont can reasonably expect:

- **DA/SSAs:** Connections to be completed by 2020.
- **Home Health Agencies:** Every HHA will have a Clinical and Admission/Discharge/Transfer connection by 2023.
- **Hospitals:** Every Vermont area hospital will be completely connected (all necessary connections) by 2022.

Results (Cont'd)

- **Long Term Care:** Connections for Long Term Care facilities will increase from 7 today to 176 by 2026 with all current LTC facilities having a Admission/ Discharge/Transfer connection by 2025.
- **FQHCs:** FQHCs will be completely connected (all necessary connections) by 2026.
- **Primary Care:** Primary Care facilities will have the majority of their connections (including Clinical & all Admission/Discharge/Transfer) by 2026.
- **Specialty Care:** Specialty Care will greatly accelerate, increasing from 81 connections today to 648 by 2026.

Overall, connections will increase from 902 to 2866 in 2026.

Attachment 4: Presentation – Draft Sustainability Plan

Vermont State Innovation Model (SIM) Draft Sustainability Plan

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

IT'S JUST A FIRST DRAFT.
Baloo
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Vermont SIM Sustainability Plan Overview

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)

Vermont Health Care Innovation Project

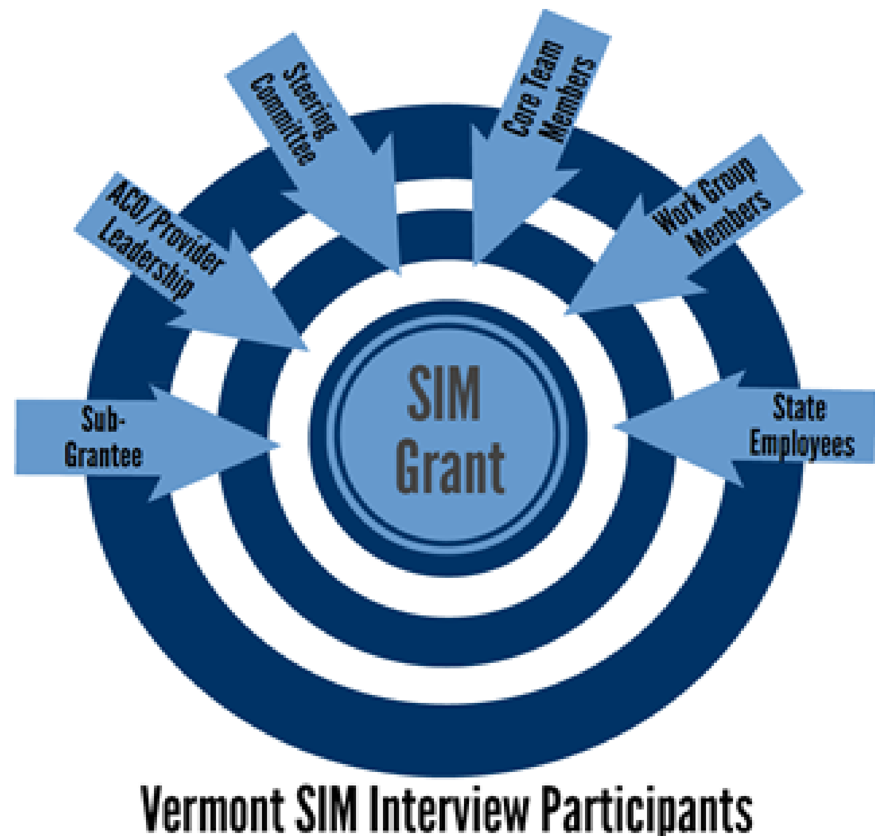
Plan Research and Development: Vermont SIM Research

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:



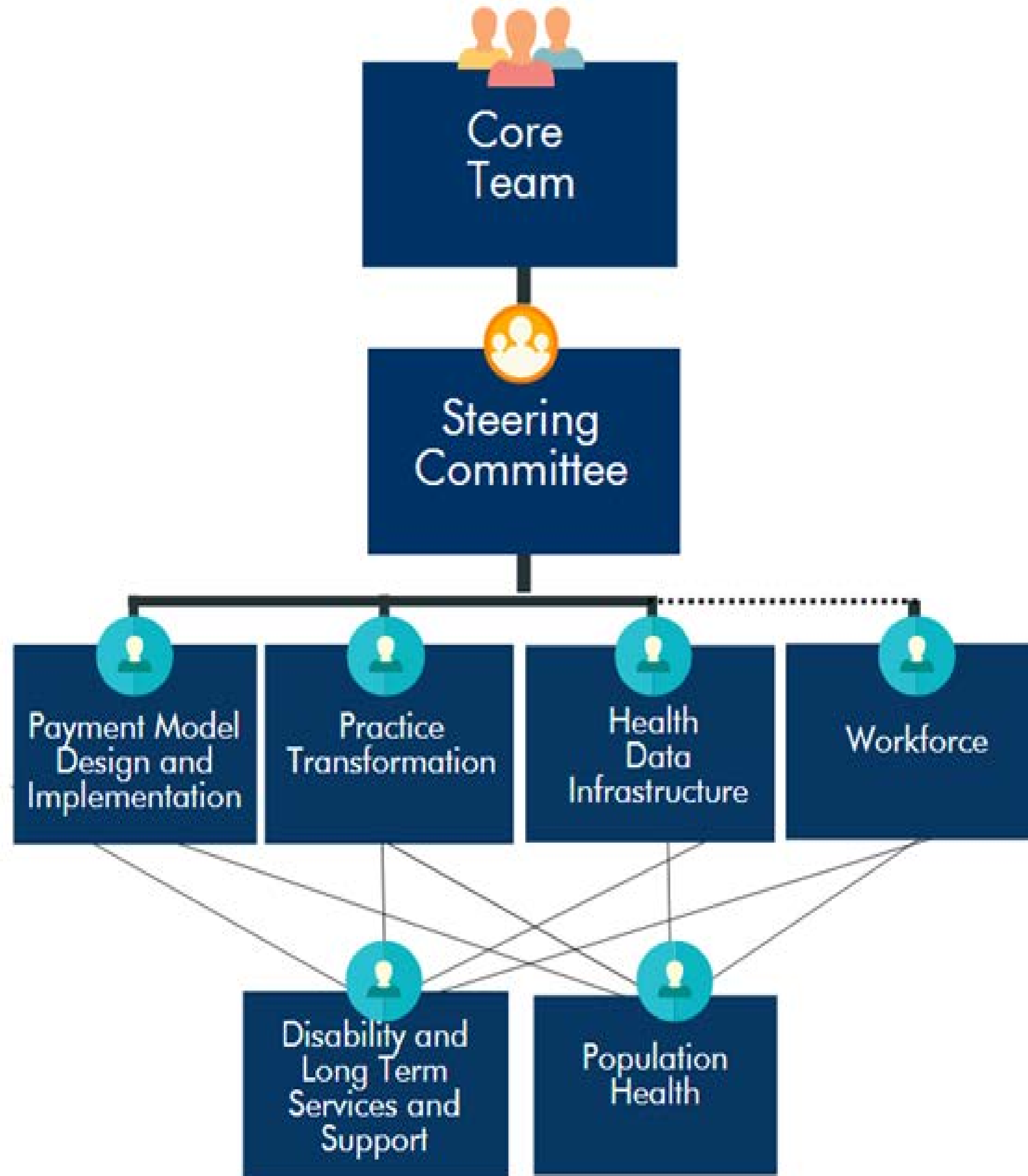
Vermont SIM Interview Participants

- 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:

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).

BlueCross BlueShield of Vermont

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

Vermont Health Care Innovation Project

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	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		●	

(Table header spanning all columns: Investment Category)

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		

Vermont Health Care Innovation Project

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.

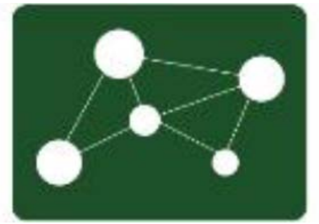
- **Sustainability Recommendation:** Status is pending project completion.

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.

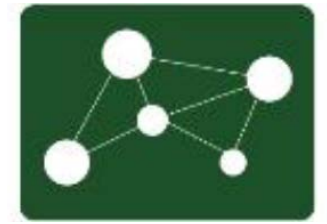
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA
  - **Recommended Key Partners:** DOL, VDH, GMCB, provider education, and private sector

Recommendations: Health Data Infrastructure



Investment Category			
SIM Focus Areas and Work Streams	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	●		

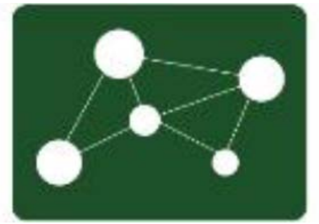
Recommendations:
Health Data Infrastructure (cont'd)



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**		

**AOA is the recommended lead entity, pending establishment of a coordinating entity as recommended in the HIT Plan.*

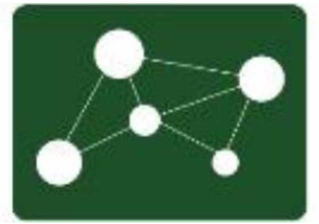
Health Data Infrastructure: Expand Connectivity to HIE – Gap Analysis



- 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.

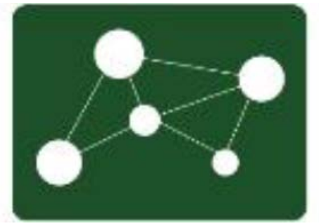
Health Data Infrastructure: Expand Connectivity to HIE – Gap Remediation



- 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

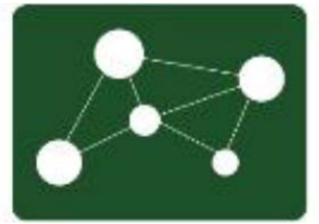


- This project provides a secure data connection from the VHIE to the ACOs’ analytics vendors for their attributed beneficiaries.
- Allows ACOs direct access to timely data feeds for population health analytics.

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

Vermont Health Care Innovation Project

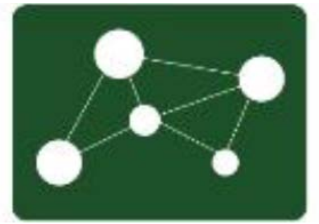
Health Data Infrastructure: Improve Quality of Data Flowing into the HIE



- 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)

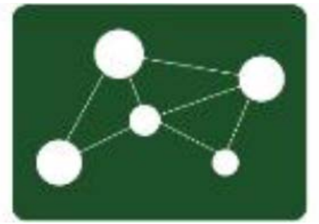
Health Data Infrastructure: Telehealth



- *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)

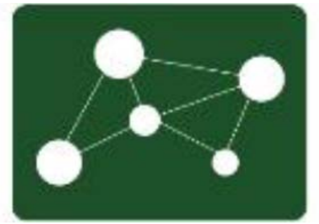
Health Data Infrastructure: Electronic Medical Record Expansion



- 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)

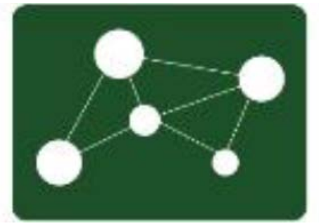
Health Data Infrastructure: Data Warehousing



- 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.

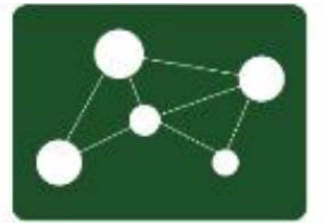
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Care Management Tools



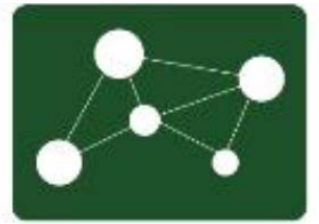
- *Shared Care Plan Project* - A planning activity that ensures that the components of a shared care plan are captured in a technical solution that allows providers across the care continuum to electronically exchange critical data and information as they work together in a team based, coordinated model 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)

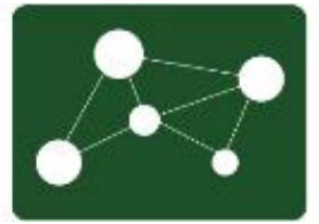
Health Data Infrastructure: General Health Data Inventory



- 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

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

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.

Table title: On-Going Sustainability: Task Owner

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:

Georgia Maheras
(georgia.maheras@vermont.gov, 802-505-5137)
or **Sarah Kinsler**
(sarah.kinsler@vermont.gov, 802-798-2244)

Attachment 5: 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.