VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, February 19, 2015; 10:00 PM to 12:30 PM

4th Floor Conference Room, Pavilion Building

109 State Street, Montpelier

Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:10	**Welcome; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from December 4, 2014 • Attachment 1c: Minutes from January 22, 2014	 Yes Yes
2	10:10 - 11:00	**Central Vermont Health Service Area Collaborative: Informational presentation and progress to date** Mary Moulton and partners	• Attachment 2: Central Vermont HSA Collaborative – Care Coordination	
3	11:00 – 11:30	**An Introduction to the All-Payer Waiver**	• Attachment 3: All-Payer Waiver Intro 2-19-15	
4	11:30 – 12:15	**ACTT Project Overview and Accomplishments to date** Larry Sandage, Simone Rueschemeyer, Elise Ames, Terry O'Malley	• Attachment 4: ACTT Projects Update 2-19-15	
5	12:15 – 12:30	**Public Comment/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: Thursday, March 26th 10:00 am - 12:30 pm in Williston	

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, December 4, 2014, 10:00 pm – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1. Welcome; Introductions; Approval of Minutes	Deborah Lisi-Baker welcomed the group and sought approval of the November 21, 2014 meeting minutes which were approved.	
2. Population Health Work Group Presentation	Tracy Dolan, Acting VDH Commissioner and Karen Hein, MD presented on the recent work of VHCIP's Population Health Work Group (PHWG) and their recommendations on ways to incorporate population health improvement and social determinants of health into VCHIP activities and results. Highlights of their presentation included plans to develop a public health plan for Vermont that focuses on building systemic capacity to promote public health, aligning health expenditures to social determinants of health, and recommending adoption of performance measures and financing models that will help Vermont eliminate or reduce health disparities and build shared accountability for improving the health of all Vermonters. The PHWG is promoting support for prevention initiatives and greater integration of clinical services, public health programs and community-based services. The presentation included "frameworks" to guide Population Health and a summary of the known contributors to health outcomes. Following the presentation, topics discussed included Accountable Health Communities, the importance of mental health, discussion of the concept of a health budget for the State, and the importance of community health needs assessments.	

Agenda Item	Discussion	Next Steps
3. ACOs and the DLTSS System -- Questions Posed by VT Legal Aid and VCDMHS with Responses from ACOs	Work Group participants included providers, ACOs, advocates and others who engaged in an in-depth discussion of the DLTSS system of care as it relates to ACOs and the State. The overall focus of the discussion was to build upon the existing system as we form partnerships to improve care and outcomes for Vermonters with DLTSS needs. **Please refer to Attachment 3 for the ACOs' written responses to questions 1-7. Questions 1-4 were discussed at the November 21, 2014 DLTSS Work Group meeting and documented in the minutes from that meeting.** **<u>Discussion Highlights for Questions 5-7:</u>**	
<u>Question 5</u> **Have any of the ACOs adopted new care management protocols or standards internally (while waiting on the Care Models/Care Management workgroup) that establish different expectations of DLTSS case managers than those in their existing roles?**	OneCare stated its commitment to the Care Management Standards being created by the VHCIP CM/CM Work Group. CHAC is oriented toward community partnerships with DLTSS providers with a focus on collaboration. Participants encouraged PCPs to have greater knowledge of the DLTSS system, and DLTSS providers to have a better understanding of the role of primary care practitioners. It is hoped that the Integrated Communities Care Management Learning Collaborative will achieve that goal. One of the most important elements is "effective communication" among the different domains.	
<u>Question 6</u> **How will DLTSS providers manage to meet operational, financial and quality expectations of multiple ACOs and at the same time meet these**	Participants felt the challenge of multiple ACOs with varying sets of expectations needs to be addressed locally by ACOs working in concert with one another. There is a desire for alignment of expectations among ACOs and this work has already begun. The Blueprint is working on the concept of regional collaboration to represent the array of providers. Regional collaboration efforts are especially important given that not all Vermonters are attributed to an ACO. (The DLTSS Work Group agreed this is a topic for future conversations.) The ACOs can provide advice and counsel but funding is not available.	

Agenda Item	Discussion	Next Steps
expectations for individuals who are not covered by the ACOs (because they do not see an affiliated primary care physician) whose funding continues to come through AHS and its Departments? ***<u>Question 7</u>*** **Will disability and long term services and supports (DLTSS) providers have sufficient voice in the governance and operation of ACOs? How will this voice be operationalized?**	OneCare has a statewide multidisciplinary Clinical Advisory Board; however, it is primarily a medical/clinical group with representation from other provider groups. OneCare will provide a list of its Clinical Advisory Board members to the DLTSS Work Group. OneCare has three consumer representatives (beneficiaries of Medicare, Medicaid, and Commercial-Health Exchange) on its Board.	
4. Update on the All-Payer Waiver and the Consolidated Global Commitment Waiver	The ACA put into place options for new waivers, one of which is the 1332 Waiver for development of universal coverage. The other is an All-Payer Waiver which is focused on payment methodology for better alignment between Medicare, Medicaid and commercial payers. One primary goal of the All-Payer Waiver would be a reduction in the variation of payment by payers and a resulting decrease in the cost shift. The All-Payer Waiver would not allow Vermont to control Medicare funding. Pursuit of waivers is contingent upon being a "good deal" for Vermont. The Consolidated Global Commitment (GC) Waiver entails consolidating two separate but similar waivers (Global Commitment and Choices for Care) into one Waiver for administrative simplification and streamlining of Federal reporting requirements. The Consolidated Global Commitment Waiver would be embedded in the All-Payer and 1332 Waivers. An in-depth	

Agenda Item	Discussion	Next Steps
	presentation on the Consolidated GC Waiver will be given to the DLTSS Work Group once the Waiver is signed by Vermont and CMS. The current target date for signature is January, 2015.	
5. DLTSS Work Group letter to the Governor	The Work Group discussed the draft letter to the Governor and voted 9 to 4 to support it (with 1 abstention). Supporting points were that the DLTSS Work Group should formally support funding for DLTSS services during the Fiscal Year 2015 budget adjustment and Fiscal Year 2016 budget development process, Medicaid funding reductions of DLTSS services would lead to higher health care costs systemwide, and reductions in funding would have adverse impacts on vulnerable individuals. Opposing points were that this kind of activity was not part of the DLTSS Charter, the letter itself was too detailed, the letter needed to clearly state that State employees were excluded, and concern over the limited 24-hour comment period. The VHCIP review process for this letter could extend through early February given it would need to go to the Steering Committee and Core Team prior to final approval. It was announced that members of the DLTSS Work Group could send a separate letter to the Administration from individuals and organizations and not as a product of the DLTSS Work Group.	
6. Public Comment Updates/Next Steps	**The next meeting will be held on Thursday, January 22nd, 10:00 am – 12:30 pm in Montpelier on the 4th Floor of the Pavilion Building.**	

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, January 22nd, 2015, 10:00 pm – 12:30 pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome; Introductions; Approval of Minutes	Deborah Lisi-Baker welcomed the group and noted a change in the agenda: in order to allow for the late arrival of several group members, the vote to approve the December 4, 2014 meeting minutes was post phoned until after Agenda item 2, the VT Department of Mental Health Surveys and Findings for Adults and Children presentation. Regardless of this change to the agenda, due to the absence of a quorum, the group was not able to vote on the December meeting minutes at this time.	
2. VT Department of Mental Health Surveys and Findings for Adults and Children Presentation	Deborah Lisi-Baker introduced Tyler Blouin and Sheila Leno from the Department of Mental health to present on surveys and findings for adults and children. Tyler and Sheila provided an overview of Attachment 2: CRT and Kids Survey Presentation. Highlights of the presentation are as follows: • The purpose of the survey is to monitor the performance of the CRT (community mental health and rehabilitation) population. This survey looks at the perception of the level of care for children, including both how children view their care and how parents perceive the care that their children receive. • The surveys have been conducted since the 1990's, and are currently conducted annually. • The surveys are based upon the mental health statistics improvement program (MHSIP) and Adult Consumer Survey and the Youth Services Surveys (MHSIP). The survey is used by many states and many jurisdictions. Vermont data can be compared on a national level, although	

Agenda Item	Discussion	Next Steps
	there is not exact correlation when comparing Vermont to other states. • It is a requirement for the state of Vermont to assess the health of these specialized populations on a regular basis. • The surveys are fielded and analyzed by the Department of Mental Health with funding from the general budget and a SAMHSA grant. • Technical and executive summaries are posted on the DMH website http://mentalhealth.vermont.gov/report/survey%23adult. • The survey methodology is the same for all three populations, and consists of a majority of Likert scale questions regarding perception of care, life improvement related to services, social connectedness, arrest history, and comments. • The specific population focus is adults with serious mental illness, children and parents of children ages 14-18. • The sample Selection Process is a 75% random stratified sample. • The Children's survey is sent to all children who have received 6 or more services. A letter is sent along with a questionnaire. They survey is not anonymous; however it is treated as confidential. A second letter is sent after 2 months for those who have not responded. The findings for the most recent year survey are as follows: • Statewide, there was an 85% favorable response. The most favorable responses relate to staff and services and the least favorable relate to outcomes. There were similar results for both the children's and the parent's survey. Work group members posed several questions which were discusses as follows: • Barb Prine asked if the actual survey questions are available. Sheila responded that she will share the questions with the group. • Sam Liss asked if there are any questions that specifically pertain to the CRT population being engaged in successful employment. Sheila responded that she doesn't think there is, but will follow up by sharing the specific questions. The closest match would be "I do better at work or school". • Kirsten Murphy asked what contributed to the slight uptick in outcomes. Tyler responded that the survey is evolving and they are working on better understanding what is behind these results. For example, is there a specific example of a finding that could be leveraged across the population? • Susan Besio noted that the questionnaires have remained relatively stagnant over time and there is roughly a 1/3 turnover in the population from year to year. Therefore, there may be members of the population who receive the survey multiple times, and do not want to continually respond. Tyler indicated that this is definitely a challenge. They try to stratify to hit	

Agenda Item	Discussion	Next Steps
	on different people from year to year, but it is difficult. They are looking into trying to evolve the survey from year to year to keep the response rate fresh. Susan also noted that the IFS (integrated family services) program could be utilized as a forum to better understand how the survey results play out on the ground. • Norm Ward noted that this survey is conducted in many states and asked if there is any state comparison data? Tyler responded that through the URS reporting platform, there are certain questions that are pulled out and submitted to the federal government. This data is then aggregated to provide a national report, however it doesn't include everything. They report shows all 50 states as separate entities. • Barb Prine asked for more information about the questions that are contained in the survey? Sheila read the questions and noted that they will be distributed to the group. Sheila noted that the questions for the children and the parents are worded slightly differently. • A question was asked if a narrative or a summary of the findings is available. Tyler indicated that yes it is, but it is more of an executive summary rather than a narrative. • Deborah Lisa-Baker indicated that she is interested in how the data can be used to improve outcomes and better understand new strategies both within the mental health system and in collaboration with other providers. Tyler responded that these are essentially a single data point and are just one aspect of a person's care and the system of care. This is more of a point in time picture. A program like IFS for example works very closely on a regular basis with families. They are the boots on the ground who better understand what is needed, and they can use this information to try to inform their work. • Mike Hall asked if they have examined how these surveys overlap with the NCI's (National Core Indicators). Tyler responded that has not been any examination that he is aware of. • Mike Hall asked if the data be used to understand how our performance compares to other states. Tyler responded that not all the states have the same scales. Some questions can be compared using the URS, but not all. You can compare your state with the national average, but not always a state by state comparison. • Q: Marlyss Waller noted that there are questions that may not apply to all individuals as they are generally targeted to understand people's quality of life, not the quality of the service. Tyler responded that for the Likert scale questions, there is no N/A response. • Ed Paquin agreed that it might be helpful to add an N/A response, and noted that it is a lot easier to win high points on staff perception, but it is more difficult to impact someone's outcomes and we should recognize this. • Barb Prine commented that it is important to have high level thinking about why outcomes are not improving and what can be done to get improved outcomes. • Susan Besio offered a follow up and indicated that the outcomes should not necessarily be	

Agenda Item	Discussion	Next Steps
	perceived as bad. While there is always room for improvement, the lowest responses fell around 58% ranging up to the 90's, and it is important to recognize that there are many positive responses to the outcomes measures, which is impressive given the populations being served. • Julie Tessler also added that the situations are complex and can't always be solved by even the best services. We need to remember to put the results in context. • Sue Aranoff noted that if there is a way to add questions to the survey that get at the social determinants of health that would be helpful. . • Kirsten Murphy commented that keeping in mind the broader goals of the VHCIP, it is important to understand the link between the services and the improvements in beneficiaries' health, for example hospital readmissions and presence of chronic diseases. She asked if they track overall health care improvement as well as QOL. Georgia Maheras responded that AHS is working on better understanding all of the survey's that the agency fields and how they connect and impact each other. This work is seeking to do exactly what Kirsten was referring to, however it is a lot of work and is underway.	
3. Updates: • **Frail Elders proposal – Georgia Maheras** • **DLTSS Work Group Letter to the Governor** • **Follow-up from December 4 Work Group meeting** • **VHCIP Evaluation Survey**	• Georgia Maheras began with an update of the frail elders proposal. This proposal began in payment models work group and was discussed in the Steering Committee as well. A small group was developed to further refine the proposal. The small group met in December and produced a slightly restructured proposal. Georgia noted that the proposal includes the creation of an expert panel from many organizations with the goal of making sure the right information is being analyzed and that there is resource in this project. This will include a patient and family survey as well as patient interviews. Deliverables include: 1) billing, claims and clinical data inquiry to better understand if we can use this data to improve care. 2) Patient and family survey will be better defined by the expert panel and fielded. If work group members have comments, they are asked to please send them in writing to Georgia. We will send a follow up email with more information. Questions regarding the frail elders project update were received and discussed as follows: • Norm Ward asked what the budget for this project is. Georgia responded that originally it was around 100k, but may go up. • Mary Alice Bisbee noted her preference for the term frail elder, not frail elderly, and asked if the proposal is looking at frail elders who have no family? Georgia responded that the goal is to interview the person themselves and the family if not available. • Georgia Maheras offered an update on the DLTSS work group letter to the Governor. Attachment 3b to the meeting materials is the draft letter encompassing comments that	

Agenda Item	Discussion	Next Steps
	people had as well as a cover memo providing some background to the co-chairs of the steering committee. This will be on the February Steering Committee meeting agenda. The core team did also discuss this letter briefly and felt that it is important that these issues be raised in the steering committee for discussion. Susan Aranoff noted that she does not think that the disclaimer of state employees is adequate, and would like to suggest alternate language. Julie Tessler suggested that this type of language would be more appropriate in the cover memo; however Susan does not agree that this is what the group voted on. • Georgia Maheras provided some project wide staffing updates primarily that Anya Rader Wallack will be leaving the project and Lawrence Miller will be replacing Anya as the chair of the core team. • Brian Hallett offered an update on the project's evaluation survey that is being fielded for each of the project's work groups. The survey is completely anonymous, and will take about 10 minutes. The link to the survey was distributed to the group, and the results will be reported to the group in the future. • Jason Williams asked if this group could get an update on the status of the all payer waiver, and how it impacts the proposed budget. Georgia noted that Al Gobeille and Lawrence Miller are state leads in this process. There is funding proposed in the budget to enhance the GMCB to perform this type of regulatory work. One key piece in the negotiations is making sure that Medicaid can pay its fair share. We have to be sure that Medicaid will be able to fund the needs of the waiver. The services and scope of the waiver is still very much unknown. We are following the federal government's lead through this process, and are gathering a significant amount of data. There are meetings coming up in the near future, and the leaders of this project would be happy to provide an update on the progress. Georgia will convey to Lawrence and Al the desire of this group to receive an update. Finally, Georgia noted that the federal government has been clear that they will expect that any proposals and discussions have been thoroughly vetted amongst stakeholders throughout the state before rising to the level of discussion with the federal government.	
4. Public Comment/Next Steps	Deborah Lisi-Baker asked for public comment, and the following was received: • Dion LaShay asked if the 1332 waiver connected to the all payer waiver. Georgia responded that it is something different and at this point the state is not pursuing it. • Susan Aranoff offered updated information re the ACTT project. She noted that Susan Besio will now be involved in the project and Julie Wasserman will be part of the ACTT leadership team. She indicated that the planning phase of the UTP project will expire in the end of February, and provided a report with a list of agencies that have been interviewed to date encouraging work group members to become part of the interview process if they have not	

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	already. Georgia Maheras recommended that this work group receive an update on the ACTT proposal in the near future and Deborah Lisi-Baker added that this may include an opportunity to receive an update from the UTP project specifically.	

Central Vermont Health Services Area Collaborative

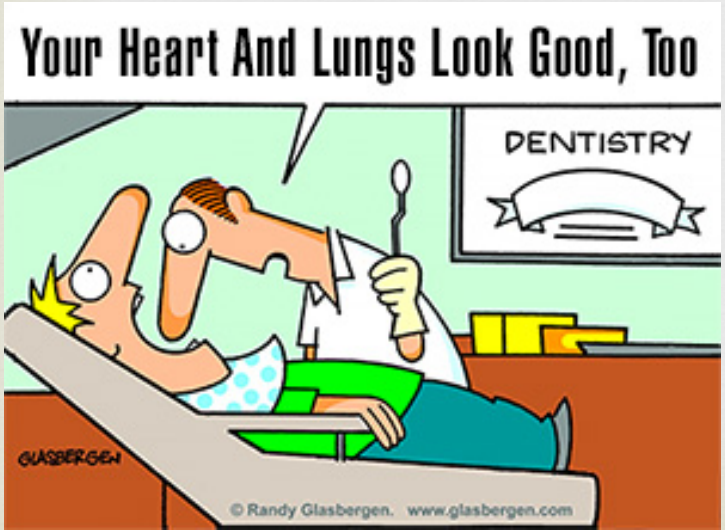
Design for a Regional Care Coordination and Integration Model

Goals

- Improve patients/clients experience of care
- Improve health outcomes
- Lower per capita health care costs
- Enhance collaboration amongst community partners

Objectives

- **Achieve Goals Through Care Coordination**
  - Implement strategies to prevent unnecessary ER visits
  - Provide supports that will reduce necessity for hospital readmissions
  - Streamline services/reduce redundancy



Keep Your Sense of Humor Alive and Well!

Current System

- Providers work in separate systems with good will to interface when possible
- Regional Impact Team meets quarterly on critical cases
- Treatment teams invite outside providers to clinical discussions
- Excellent case management and support strategies exist; all systems troubleshoot problems on behalf of individuals

Change Elements of Regional Model

- Time for a group to meet to accomplish a coordinated system
- Creation of a governance structure for regional participants to meet and discuss cases and a system for coordination
- Navigation Through System for People with Complex Needs and system of communication
- Care Management Components
- Health Coaching & Training of All Providers
- Advance Regional Treatment Plan
- Adherence to the Basic Tenets of the DLTSS Model
- Common or Interface Capacity with Electronic Health Records
- Develop Agreed Upon Outcomes
- Perform Cost Analysis

Plunging Into the Process

Participants

- Central Vermont Medical Center
  - (Quality, Emergency Room)
- Community Health Teams
  - (Medical Group Practices)
- Washington County Mental Health Services
- Central Vermont Home Health and Hospice

Stage 1

- Hire a care management model coordinator
- Develop a method to determine lead case management within a treatment team for each patient/client
- Cross-train all providers on lead case management competencies agreed upon by CVHSA collaborative team
- Implement the care coordination model within a pilot project (identifying 30 moderate risk)

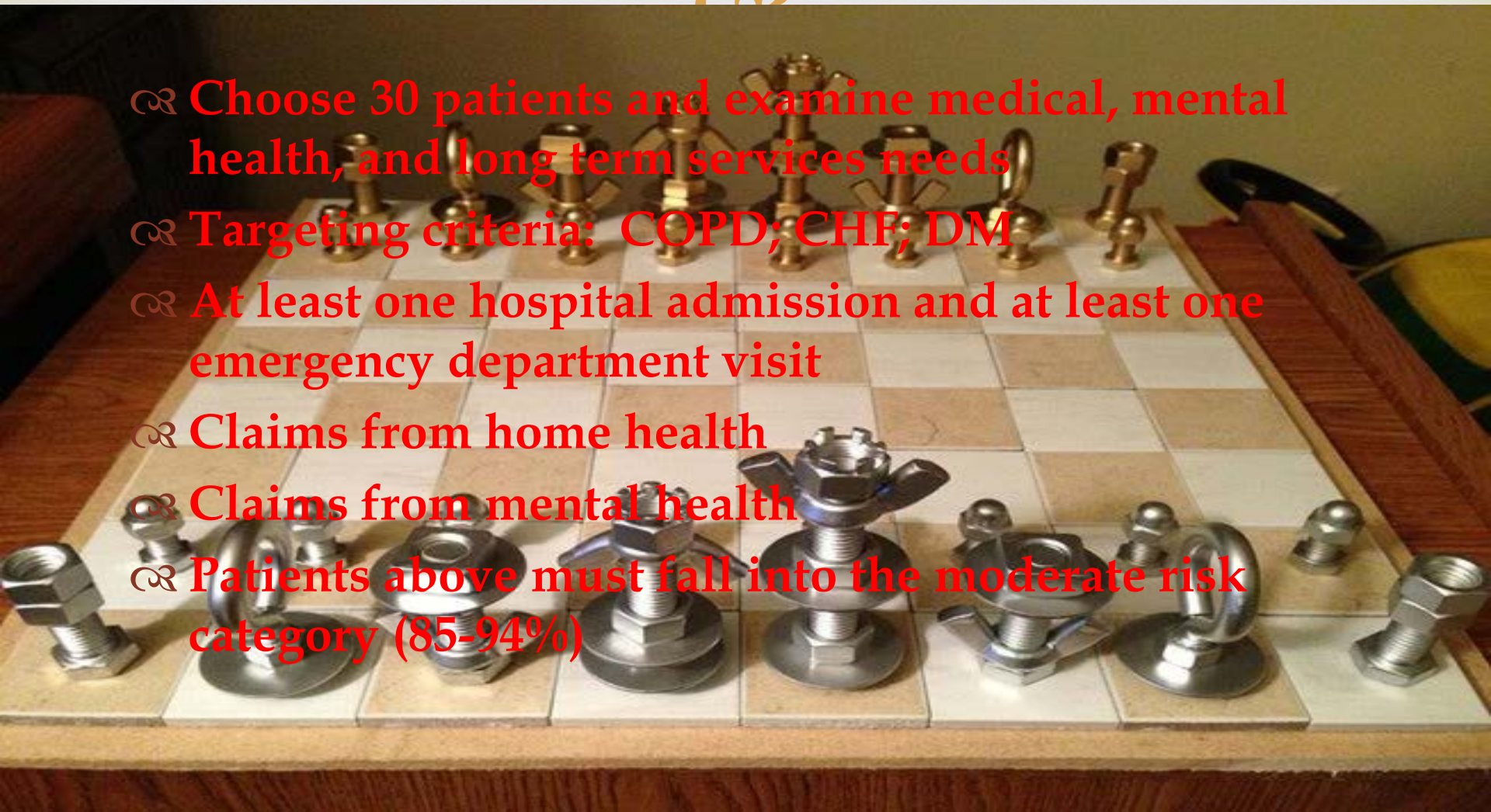
Stage 1

- Analyze fidelity to the model
- Facilitate discussion and agreement regarding components of the integrated treatment plan and health information technology systems interface
- Monitor chosen set of quality indicators, expanding those determined by CVHSA collaborative
- Arrange for training for motivational interviewing/health coaching for regional providers

Stage 1

- Organize and catalog health-related workshops/trainings/seminars across all providers
- Expand the provider group to include AAA; SASH; Nursing Homes; Substance Abuse Services; Housing; Transportation, Family Center of Vermont, etc.

Nuts and Bolts of a 6-Month Pilot



- Choose 30 patients and examine medical, mental health, and long term services needs
- Targeting criteria: COPD; CHF; DM
- At least one hospital admission and at least one emergency department visit
- Claims from home health
- Claims from mental health
- Patients above must fall into the moderate risk category (85-94%)

6-Month Pilot (continued)

- 15 patients will receive care management intervention
- 15 patients will receive care as usual (no extraordinary attempt to coordinate)
- Reps of CVHSA will meet with PCPs to explain the pilot - goals and roles
- CVHSA will meet with specialty providers to identify potential risks and contingency plans
- Rep from Community Health Team (or care coordinator from specialty provider, if chosen) will contact patients
- Create and share care plan and action plan with patient and family or with peer supports (in lay terms)

Case Manager to Work Toward Delivery Components Within The Pilot

- Aggressive (pro-active and assertive) management of care transitions
- Informing PCP regarding patient's risk and program
- Facilitation of close interaction and sharing of information between care coordinator, PCP, or identified case manager/clinician/support network within a specialized service
- At least one in person contact/month

6-Month Pilot Project (continued)

- Self-management including intense education on medication/treatment adherence
- Application of evidence-based education on behavior change
- Depression screening
- Behavioral stage of change assessment (when health coaching is applied)

6-Month Pilot Project

- Required documentation by Case Manager
  - Establish Advance Directive/Clinician Order for Life Sustaining Treatment; review and update
  - Thorough review of medication with physician and reconcile with specialty providers
  - Review medication with patient; ensure taking properly
  - Refer to specialty services, as needed
  - Interview caregivers, as permitted
  - Facilitate completion of depression screen, or coordinate with specialty providers regarding completion and results

Quality Indicators for Pilot Project

Stage 1

- Activity logs by patient across all providers
- Track in-patient hospital visits including ER visits
- Track home health and mental health visits; skilled nursing facility, other specialty providers
- Readmissions to hospital within 30 days
- Patient satisfaction (at least SF-36 measure – “how do you rate your health”)
- PCP satisfaction and Specialty Provider satisfaction

Stage 2
Expansion and Evaluation of Pilot

- Review claims data and examine whether reduction targets are being achieved
- Expand the cohort of patients for review to 100 following the 6-month pilot
- Quality indicators for Stage 1 will be applied to the expanded cohort

Health Coaching

- Principles of motivational interviewing embedded across providers to achieve collaborative relationships amongst providers
- Motivate patients/clients toward healthier lifestyles
- Health coach will assess stage of change regarding harmful behaviors and work with the care coordinator on referral to helpful wellness programming initiatives offered by specialty providers, Healthier Living Workshops through Blueprint, etc.
- Care Management Model coordinator will be cataloguing available programs throughout this period

Health Coaching

- 20% of patients will be ready for change
- Approximately 1000 patients will be chosen for monitoring and affecting change over 2-years
- Treatment plans will reflect stages of change
- Cost analysis, pre and post health coaching
- Agree upon indicators of improved health across health and social determinants of health (same domains measured by all involved providers)

Cost Analysis - Stage 3

- Arrange for cost analysis of current funding stream with periodic reports to the CVHSA collaborative and subsequent recommendation regarding episode-based, bundled payment, or pay-for-performance model

Short Term Realized Benefits/Challenges

- Benefits
  - Expansion of social determinants of health within health and vice versa
  - Conversation amongst providers on behalf of patients/clients
  - Governance for Steering Committee Emerges
  - Collaborations & Agreement Regarding Projects
  - Clinical Advisory Team Established
  - Health Coaching
- Challenges
  - Planning Time
  - System Coordination Implementation – Need Human Resources and Funding
  - IT Interface

Considerations for Enhanced Regional Care Coordination

- Develop a Network of Care
- Set up Regional Monthly Meetings: How to work together? How to choose special projects agreed upon by regional collaborative
- Seek Grants to Implement Plans
- Embedded Behaviorists or Health Coaches in Medical Practices
- Create no wrong door and referral process
- Create a web-based tool – a survey for all clients which triggers immediate referrals based on agreed upon domains
- Incentivizing desired outcomes and reinvesting in regional projects
- Might consider creating a 501 (c) 3 of partners

Contact Information

For Further Information Please Contact:

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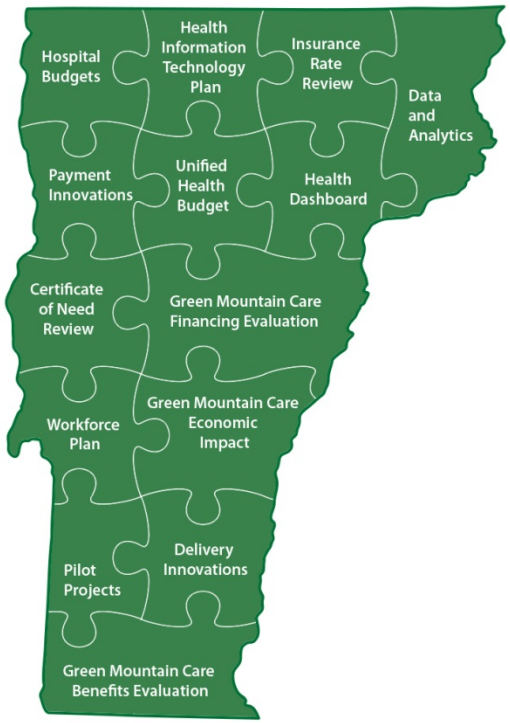


Vermont's All Payer Model

Presentation to the DLTSS Work Group

February 19, 2015

VERMONT
GREEN MOUNTAIN CARE BOARD

What is an all-payer model?

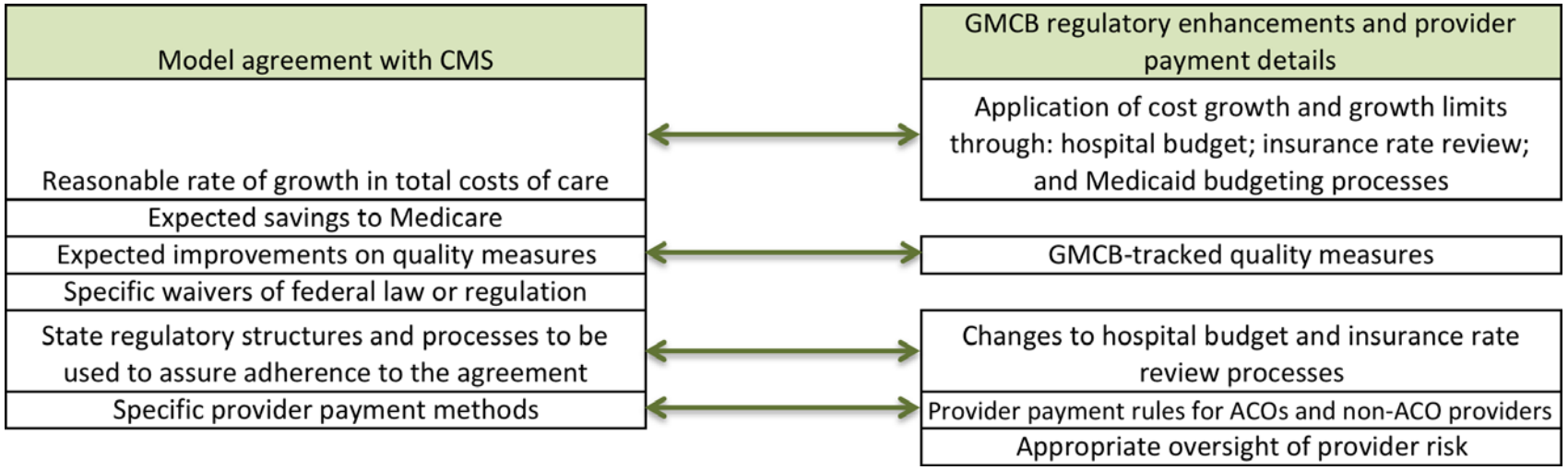
- A system of health care provider payment under which all payers – Medicare, Medicaid and commercial insurers such as Blue Cross and Blue Shield – pay doctors, hospitals and other health care providers on a consistent basis, within rules prescribed by a state or national government
- Can be used to promote desirable outcomes and reduce or eliminate cost-shifting between payers
- In the U.S., the only example of an all-payer model is in Maryland (currently only for hospital payments)
- A number of other countries use all-payer systems to assure that provider payments are fair, transparent and consistent with desired policies such as promoting primary care, prevention, quality of care and cost containment

One project, two major components

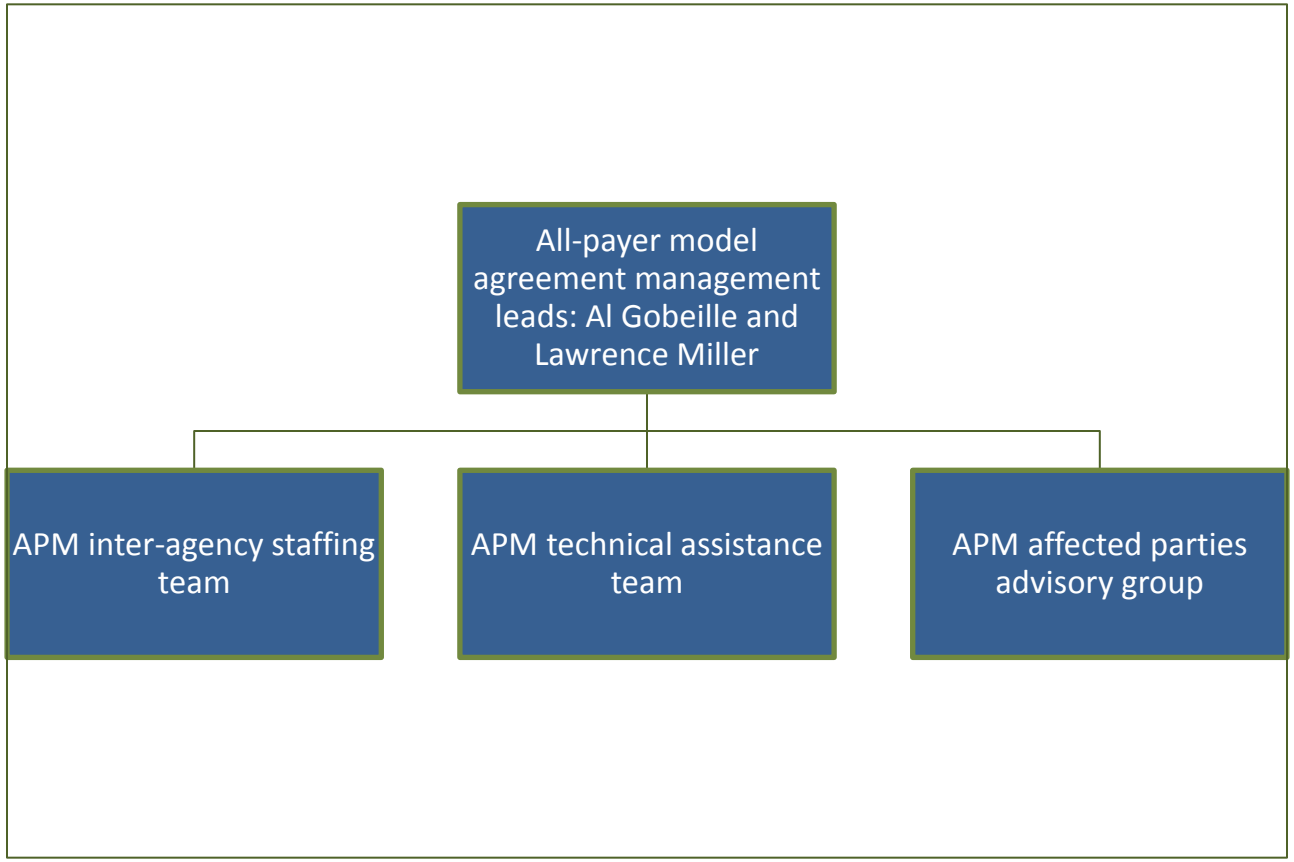
Vermont All-Payer Model Project Structure and Responsibilities		
	Model agreement with CMS	GMCB regulatory enhancements and provider payment details
Purpose	To establish the parameters of an agreement with the federal government that would permit Medicare inclusion in a Vermont all-payer system	To establish the specific rules and processes governing provider payment, ACO oversight and all-payer oversight
Lead agency(ies)	GMCB and AOA	GMCB
Coordinating agencies	AHS	DFR, AHS, AOA

Related processes
Legislative oversight: Regulatory and Medicaid budgets
Administrative rules process

Examples of technical issues to be addressed in each process, and inter-relationship between them



Structure for leadership, staffing and stakeholder input on model agreement



ACTT Program Update

DLTSS Work Group Meeting

February 19, 2015

Project #1 – DA/SSA Data Quality and Data Repository

DATA QUALITY PROJECT

- Through a partnership will VITL, we are focusing on data quality at all of our member agencies.
- Advisory Team has been established.
- Meetings are being held with stakeholders.
- Initial Data Dictionary is complete.
- Agreements are being signed with DA/SSAs: BAA, QSOA and MOU
- Tools are being developed

Project #1 – DA/SSA Data Quality and Data Repository

DATA REPOSITORY PROJECT

- Create a single location for DA/SSA data.
- Decrease the number of interfaces required to interact with, SOV, other funders, partners, the VHIE etc.
- Provide analytics for DA/SSA system of care for service quality improvement and population health improvement.
- Allow for 42 CFR Part 2 compliant data collection.
- Business requirements for Data Repository are defined.
- RFP to be released by the end of February.

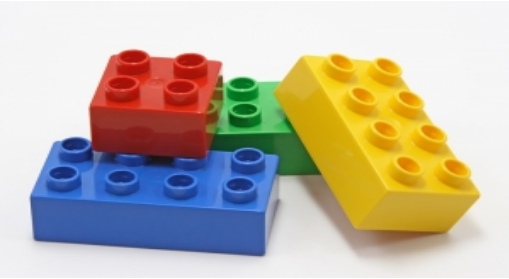
- Interoperability review for SSA unified EHR is complete.

Project #2 – DLTSS Data Planning Project

- Phase 1 Goals:
  - Assess HIT/HIE capabilities of DLTSS providers (AAA, Adult Day Centers, TBI providers, SASH).
  - Update prior HIT assessments of long term care facilities (June 2013), home health and hospice agencies (October 2012), and behavioral health (DAs and SSAs) (February 2012).
  - Perform new assessments for LTC facilities not previously assessed. (12 Nursing Homes and 67 Residential Care facilities)
  - Create preliminary budget to acquire technology needed to enable these providers to participate in HIE, and report clinical quality measures. 2015 DLTSS measures are being developed by the AHS Performance Accountability workgroup.
- Work in Progress:
  - Data gathering (including 60 facilities/agencies as of 2/10.)
  - Research national efforts, EHR vendors, evolving standards, and projects in other states
  - Drafting reports
- Phase 1 Deliverables and Timeline:
  - Assessment report drafts (4) ready for review March 2015

Project #3 – Universal Transfer Protocol (UTP)

- *"Universal Transfer Protocol (UTP) is a process across the entire system that gives all partners who have a role in the patient's care access to the same standardized information and the responsibility to ensure that the information is accurate, current, and supports the patient's goals and quality of life."* Heather Johnson, ADRC project manager



- UTP Defined
- UTP Phase One Focus
- UTP Phase One Scope
- UTP Methodology
- UTP Next Steps