VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Agenda

March 23, 2015; 10:00 AM to 12:00 PM
4th Floor Conference Room, Pavilion Office Building, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:00 to 10:10	Welcome; Introductions; Approval of Minutes	**Attachment 1:** February meeting minutes	Yes (approval of minutes)
2	10:10 to 10:25	Updates: • ACO Care Management Standards • Update on Regional Blueprint/ACO Committees • Care Management Inventory Report (http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/CMCM/CMCM%20Survey%20Report%202015-03-09%20FINAL.pdf) ***Public Comment***	**Attachment 2:** ACO Care Management Standards, as recommended by Core Team	
3	10:25 to 10:40	2015 CMCM Work Plan; Review of VHCIP Goals and Key Activities; Potential Topics for Future Meetings ***Public Comment***	**Attachment 3a:** 2015 CMCM Work Plan **Attachment 3b:** VHCIP Goals and CMCM Future Topics	
4	10:40 to 11:05	Integrated Communities Care Management Learning Collaborative: • Status of Quality Improvement Facilitator procurement • March 10th Learning Session • Next Steps: April Webinar and May 12th Learning Session • Discussion of Expansion to Additional Communities ***Public Comment***	**Attachment 4a**: Summary of Evaluation Results from March 20 Learning Session **Attachment 4b:** Learning Collaborative Expansion Power Point	Yes (vote on recommending expansion of Learning Collaborative to additional communities)
5	11:05 to 11:30	Discussion with Representatives from Population Health Work Group: • Population Health Definition and Frameworks • Accountable Health Communities ***Public Comment***	**Attachment 5a:** Population Health in VHCIP **Attachment 5b:** Comparison of ACO, TACO AHC **Attachment 5c:** Essential Characteristics of an AHC	

7	11:45 to 12:00	Wrap-Up and Next Steps ***Next Meeting:*** *Tuesday, April 14, 10:30 AM – 12:30 PM, Calvin Coolidge Conference Room, National Life, Montpelier VT*		

Attachment 1

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

Pending Work Group Approval

Date of meeting: Tuesday, February 10, 2015, 10:30am-12:30pm; ACCD – Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Introductions, and Approval of Minutes	There was no quorum at the start of the meeting. There was a quorum after second agenda item. Trinka Kerr motioned to approve October minutes. Nancy Breiden seconded. Minutes accepted with two abstentions. Bea Grause motioned to approve November minutes. Nancy Breiden seconded. Minutes accepted with three abstentions.	
2. Update on Regional Blueprint and ACO Committees	Vicki Loner and Jenney Samuelson provided an update on the Regional Blueprint and ACO Committees: All of the ACOs and the Blueprint have been working over the past 3-4 months to stand up community forums across the state. Some build on already existing groups, others are new. The goal is to create formal governance in all 14 HSAs that creates opportunities for continuum of care providers to work together to further the goals of ACOs. Merged committees will include with physician leadership, nursing leadership, ACOs, representatives from Medicaid program and VDH, pediatrics, and other entities involved in care coordination. SIM grant funding for OneCare helps support this in a few ways: Making sure each community has physician leadership participation, support by VHCIP funding for part of their time; hiring 7 clinical consultants to support these communities with BP facilitators; making sure data is avail and usable; and formalizing QI activities, leveraging OneCare's resources and trying to get a statewide learning collaborative to work on those priorities. <u>St. Johnsbury</u> (Laural Ruggles): An existing group included CEOs and EDs of hospitals, mental health, FQHC, housing, food bank, home health, AAA, and Blueprint has become the region's UCC group, meeting once a month for over a year. The physician lead is Karen Kenny, also on the OneCare Physician Advisory Board. The	

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	group has struggled to get doctors away from clinical time to attend meetings. Priorities: This group hasn't settled entirely on an initiative yet, but the community is leaning toward something on hunger or housing, and may try to leverage work around the state tying those issues together. Poverty is this region's big health disparity, as in most of the state, so housing and food are critical issues. These priorities have been echoed in hospital Community Health Needs Assessment focus groups – synergy around community health needs assessments is an area of interest for OneCare. Data: No resources to develop data at this level; participating groups each have metrics. Rutland (Sarah Narkewicz): Rutland has a number of initiatives going on. A regional clinical performance committee focused on COPD meets monthly, with almost weekly sub-committee meetings. Nine organizations are participating in the CMCM Integrated Communities Care Management Learning Collaborative pilot. Also an active participant in a local clinical integration committee, a partnership between FQHC/primary care and specialists. These activities need leadership/oversight to ensure they are well coordinated; key leaders in the community are working together to ensure work groups are aligned and, as they complete their work, identify priorities for the next quality improvement effort. Physician leadership comes from the FQHC and the hospital, both of which are represented by OneCare; HealthFirst and CHAC are also represented. Central Vermont (Monika Morse): This is the first joint effort between RCPC and Integrated Health System Work Group; the group's initial meeting, on 2/9, was a great success. The physician lead is Dr. Fama, with backup from Dr. Eckhaus. One project is underway, started as the original RCPC project: a 6-month case management pilot (now in month 2) with 15 patients in intervention group, and 15 patients in a control group. All 30 have diabetes, CHF, COPD, or a combination; some interaction with Central Vermont Home Health and Hospice or Washington County Mental Health Services; and ER use. Key intervention components include an in-person home evaluation at initial assessment; monthly in-person meetings at the PCP's office, in the community or at home; weekly phone contact; close monitoring and aggressive management of care transitions; medication reconciliation; and PCP engagement. The pilot will measure patient and provider satisfaction and utilization in comparison with the control group. The group is considering taking on two larger projects and is discussing structure and governance. OneCare is involved, CHAC is invited (no PCPs engaged with HealthFirst in this area). Bennington (Jennifer Fels): Started with 2 committees, both in existence for a long time. The Blueprint Integration Team had leaders from community agencies including home health, the Department of Health, the Council on Aging, etc. The OneCare Clinical Communication Group has been in existence for ~2 years (OneCare is the only ACO in the area). Each looked at membership and combined into one leadership team – the RCPC – including housing, the Designated Agency, long-term care, home health, the Department of Health, and human services agencies. The combined committee is co-chaired by Jennifer and a physician who also participates in the OneCare Clinical Advisory Board and Quality Committee; the group has a charter which focuses on building the medical neighborhood. Each meeting has a formal agenda and uses a project tool to keep track of activities (Results Based Accountability). Project teams report back to the committee on a regular basis. The committee receives data from OneCare and Blueprint HSA profiles. Some projects are showing positive early results.	

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3. ACO Care Management Standards	Pat Jones gave an update on the process for refining the ACO Care Management Standards, which has involved staff from many AHS departments as well as other stakeholders.
	
	Work Group staff are scheduling meetings in March with GMCB, DVHA, and the ACOs to discuss what ACOs are doing around care management using a defined set of questions. There will also be a request for documentation from the ACOs to assess how they're meeting these standards.
	
	Bea Grause noted that this has been a long process but that this will be an important tool going forward.
	
	• Trinka Kerr commented that these seem like loose standards and suggested strengthening some language ("we recommend the ACOs be guided by the following standards…"). Language in standards is also loose.
	  o Pat Jones noted that this language was very intentional. NCQA standards provided a starting point – they focus on a centralized ACO approach, and we wanted to permit a regional approach since we have so much infrastructure in place at the regional level. "Be guided by" was a recent change since the last meeting; it previously read "we recommend the ACOs *agree to* the following standards…" but there was concern about the balance between regulatory requirements and innovation. Had support from the Medical Society and others for this change.
	• Nancy Breiden agreed with Trinka. New language feels watered down – accountable care organizations need to be accountable to at least these loose standards.
	• Sue Aranoff asked about the relationship between the standards and the contracts with ACOs. Standards by themselves don't have accountability built in regardless of the language, but a contract would. Will the contracts link to these standards?
	  o Bea Grause: Yes.
	  o Erin Flynn noted that Year 2 contract negotiations with ACOs are underway, and include leadership from across AHS and ACOs. Contracts will be publically available. It is our hope that they will be based on this document.
	  o Vicki Loner commented that OneCare will seek a additional clarity on these standards through the contracting process so that they can fully understand them and how they will be evaluated.
	• Patricia Singer also expressed concerns. DMH leadership prefers "agree to" and that this document be attached to contracts.
	• Dale Hackett commented that he opposes the change to "be guided by" and emphasizes the need for ACOs to be accountable for care and outcomes at the patient level.
	• Trinka Kerr expressed concerns about leaving the language like this when the DVHA contracts are going to follow this. Contract language needs to be stronger.
	  o Georgia Maheras clarified that the intent is that this would be an addendum/appendix to the contract. The compliance part is going to be written into the contract, not in the addendum. This will feed DVHA contract, BCBS contracts, but will also be in the hands of respective	

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	organizations' lawyers. We need a document with common sense consensus agreement behind it; contracts themselves will be the enforcement mechanisms. • Sue Aranoff thanked everyone for the work that went into this. She commented that DAIL Commissioner Susan Wehry suggested an amendment to return this language to its original form: "ACOs agree to the following standards." o Bea Grause asked if anyone opposed this amendment. o Miriam Sheehy commented that ACOs will abide by contractual agreements, but are uncomfortable saying they will agree to a standard that is high-level and not fully clear. o Vicki Loner commented that most ACOs in the state are not gearing up for centralized care coordination – they want to continue to support local communities in providing this. o Tom Simpatico commented that all parties want clarity but are approaching this with different language – we want to avoid ambiguity but there may be a limit to how much this is possible in this document. These are aspirational standards – "be guided by" embraces the notion of further clarification and being able to operationalize with further clarity. o Sue Aranoff pointed out that the full language is "we recommend the ACOs agree to…" – the ACOs are not committing to anything, it's a recommendation from the group. • Bea entertained the motion to change the language from "be guided by…" to "agree to…." Seconded by Trinka Kerr. o Dale Hackett asked whether, whatever we do to the wording, we still have a problem supporting patient outcomes. Bea Grause noted that we can't answer that question now. o The motion carried with 4 against and 1 abstention. o Tom Simpatico suggested a conversation around whether these standards are stifling innovation and creativity and suggested there be a process to amend these standards if that is found to be the case. Bea Grause noted that this is a first pass. These are aspirational standards. We'll be coming back next year to assess what we learned and whether we need to make changes to these. o Michael Bailit notes that there have already been modifications to other standards that have been made. • Sue Aranoff made a motion to pass as amended. Seconded by Dale Hackett. o The motion carried with 2 against.	
4. Care Management Inventory Report (Marge Houy and Christine Hughes, Bailit Health Purchasing)	Marge Houy and Christine Hughes provided an update on the Care Management Inventory Report, focusing on the 6 takeaways identified by Bailit Health Purchasing: 1. <u>Increase use of CMMI Best Practices:</u> CMMI best practices were used consistently by approximately half of respondents. Planning and managing transitions of care and medication management had the lowest percentages. Post-discharge follow up and high-risk patient management reported lower than optimal. • Home health is not represented here; staff can re-share the survey with them. 2. <u>Opportunities for More Formal, Structured Relationships:</u> Community service providers have	**Consider sharing results of Care Management Inventory Report with relevant VHCIP Work Groups (DLTSS, Workforce, etc.)**

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	substantially lower formal relationships with other providers or have ad-hoc relationships. This is an area that could be improved with the rise of integrated delivery systems, particularly relationships between community service providers and ACOs. • Marge Huoy asked where there are opportunities for community service providers, and what action, if any, the CMCM Work Group should take. • Pat Jones noted that this takeaway and others are things communities are already addressing. • Lily Sojourner suggested that this be shared strategically with local communities to be used in building their priorities. • Dale Hackett noted that this survey was distributed to people Pat Jones and Erin Flynn selected, and suggested that this is not transparent. Pat Jones noted that staff relied on this group to build the list of survey recipients and helped to disseminate the survey to their membership. 3. <u>More Robust Implementation of Team-Based Care:</u> Low participation from physicians, substance abuse, and mental health in teams. 4. <u>Enhance services to People Discharged from Skilled Nursing Facilities:</u> This could support reduced readmissions. 5. <u>Staffing Types and Resource Allocation:</u> RNs, social workers, and case managers are most common; pharmacists, Pas, Mas, peer counselors, and CHWs are less common and suggest that non-traditional staffing could support these efforts. 6. <u>Addressing Common Challenges:</u> Top four are insufficient funding, challenges in recruiting staff, technical barriers in data sharing, and engaging individuals. Marge Houy asked the groups whether any of these resonate; one next step was already suggested (presenting these to the Learning Collaborative pilot communities). Bea Grause suggested that the challenge of engaging individuals is being addressed by the Learning Collaboratives. Sue Aranoff suggested that these findings could be presented to related VHCIP Work Groups (i.e., DLTSS, HIE/HIT, Workforce) to support coordinated work on these issues. Bea Grause agreed, especially on Workforce Work Group. Beverly Boget suggested that these are very relevant to home health agencies and hopes that we will reach out to home health for a response. Dale Hackett commented that he likes this survey and feels it reflects issues this group has already raised; he suggests pharmacists are an important group for care management and their full importance may not be reflected in the results of this survey. Kirsten Murphy seconded Sue Aranoff's point that this go to the DLTSS Work Group as a follow-up item.	
5. Update on Integrated Care Management Learning Collaboratives	Pat Jones gave an update on the Integrated Care Management Learning Collaborative. The first in-person session was on January 15th, and was very well attended. Pat thanked the local leaders in each of the pilot communities for their work in engaging people in the Learning Collaborative. Attendees included representatives from AAAs, home health and VNAs, DAs, private mental health practitioners, care coordinators, hospitals, VCCI, ACOs, and insurers. Attendees heard from Hagan, Rinehart, and Connolly, a pediatric practice in Burlington – a physician, care	

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	coordinator, and parent presented together on the benefits of care coordination to the family, the practice, and the practitioner – as well as two staff members of the Camden Coalition in Camden, New Jersey, which has done nationally recognized work around identifying high-risk patients and performing targeted care management. Each pilot community had multiple opportunities to discuss how to implement these ideas in their pilot area. • Laural Ruggles commented that this Learning Collaborative will really move St. Johnsbury's work forward by formalizing their structure around care coordination activities. Pat Jones noted that the project has contracted with Nancy Abernathy, a skilled practice facilitator, to work with the pilot communities. Nancy will be doing training on the PDSA (Plan-Do-Study-Act) quality improvement model, as well as helping with measure specification, data collection, and agendas for upcoming sessions. The next event is a webinar on February 18th; communities will be asked to report on how they're identifying at-risk people, and will be introduced to the measures, which will include process/participation measures as well as utilization. March meeting will focus on shared transitions of care and identifying care coordination leads.	
6. Next Steps, Wrap Up and Future Meeting Schedule	**Next meeting: March 23 from 10am-12pm.** Trina notes that this conflicts with the Medicaid and Exchange Advisory Board (every 4th Monday).	

Attachment 2

Care Models and Care Management Work Group
Proposed ACO Care Management Standards
As Approved by CMCM Work Group
February 10, 2015

Definition of Care Management:
Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services. It is understood that in order to support individuals and to strengthen community support systems, care management services need to be culturally competent, accessible and personalized to meet the needs of each individual served.

In order for care management programs to be effective, we recommend that ACOs agree to the following standards:

A. Care Management Oversight (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO consults with its consumer advisory board regarding care management goals and activities.

B. Guidelines, Decision Aids, and Self-Management (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C)

#4: The ACO supports its participating providers in the consistent adoption of evidence-based guidelines, and supports the exploration of emerging best practices.

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of each individual's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.

#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: a) educational resources to assist in self-management of health and disability, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

C. Population Health Management (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E)

#7: The ACO has and/or supports its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance

abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations.

#8: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes:

- Collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers.
- Developing processes for effective care coordination, exchanging health information across care settings, and facilitating referrals.
- Recognizing disability and long terms services and supports providers as partners in serving people with high or complex needs.

#9: The ACO facilitates and/or supports its participating providers in facilitating:

- Promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care, substance use care, mental health care, and disability and long term services and supports to address attributed people's needs.

D. Data Collection, Integration and Use (partially based on NCQA ACO Standard CM1, Elements A, B, C, E, F and G)

#10: To the best of their ability and with the health information infrastructure available, and with the explicit consent of beneficiaries unless otherwise permitted or exempted by law, the ACO uses and/or supports its participating providers in using an electronic system that: a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers, and c) provides people access to their own health care information as required by law.

#11: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.

Attachment 3a

Vermont Health Care Innovation Project
Year 2 Care Models and Care Management Work Group Workplan
3/9/2015

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	ACO Care Management Standards							
1	Develop ACO care management standards.	Convene subgroup of payers and ACOs to develop draft ACO care management standards.	August-January 2014/15	Staff; co-chairs; sub-group; work group members.	N/A	Steering Committee	• Subgroup convened. • Standards drafted.	Adopted standards
2		Obtain input from broader work group membership.	May-November 2014	Staff; co-chairs; work group members.			• Input obtained from DAIL staff and DLTSS Work Group Co-Chairs.	
3		Finalize and vote on standards for presentation to Steering Committee and core team.	February 2015	Staff; co-chairs; work group members.			• Edited standards considered by subgroup in preparation for presentation to full work group.	
	Understanding the Care Management Landscape							
4	Develop understanding of current landscape of care management activities, including processes for collaboration.	Identify entities that conduct care management activities.	Ongoing	Staff; consultants; co-chairs; work group members; organizations engaging in care management.	N/A	N/A	• Presentations completed from organizations performing care management (additional presentations to be scheduled upon request).	• Comprehensive Care Management Inventory • Work group members indicate understanding of current care management landscape
5		Identify data elements related to those activities (including processes for collaboration).						
6		Develop a care management inventory survey tool to facilitate collection of structured data related to care management activities.	May-June 2014				• Inventory Survey tool created and distributed to care management organizations throughout the state.	
7		Analyze results of Care Management Inventory Survey and present pertinent findings to work group.	Summary of Findings: September 2014; Full Report: February 2015				• Summary results presented to Work Group in September, 2014. • Comprehensive report scheduled for presentation in February 2015.	
8		As requested by work group, ask selected entities to attend work group meetings to describe their activities in greater detail.						
9		Provide updates and information to Steering Committee.			N/A			
10	Identify redundancies, gaps, and opportunities for coordination.	Based on written and verbal information and inventory survey results, identify gaps.	March 2015	Staff; co-chairs; consultants; work group members; organizations engaged in care management.	N/A	N/A		• Written description of gaps, redundancies, opportunities for coordination. • Presentation to Steering
11		Based on written and verbal information and survey results, identify redundancies.	March 2015	Staff; co-chairs; consultants; work group members; organizations engaged in care management.				

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
12		Based on written and verbal information and survey results, identify opportunities for coordination.	March 2015	Staff; co-chairs; consultants; work group members; organizations engaged in care management.				Committee on gaps, redundancies, and opportunities for coordination.
13	Research, summarize, and review best practices in care management. Identify characteristics and goals of ideal care models/care management activities for Vermont.	Review literature.	Ongoing	Consultant; possibly CMMI Technical Assistance.	Obtain care management best practice recommendations (Other VHCIP work groups).	N/A	• CMMI, consultants and learning collaborative planning group have identified organizations that have implemented promising practices. One of those organizations, the Camden Coalition, has been engaged for the first session of the Integrated Care Management Learning Collaborative	Knowledge of promising best practices.
14		Review best practices in other states.	Ongoing	Consultant; possibly CMMI Technical Assistance.				
15		Review best practices in Vermont.	Ongoing	Consultant; possibly CMMI Technical Assistance.				
16		Obtain recommendations from other work groups.	Ongoing	Other VHCIP Work Groups.				
17		Based on review of best practices and results of learning collaborative, discuss and identify Vermont's care model/care management goals.	Ongoing	Work group members.				Description of characteristics of ideal model and goals for Vermont.
18		Based on review of best practices, discuss and identify characteristics of ideal models.	Ongoing	Work group members.				
19	Monitor reinforcement, extension and/or adaptation of existing care models in Vermont (e.g., coordination of Blueprint & ACO models).	Obtain periodic progress reports from Blueprint and ACOs	Ongoing	Blueprint and ACO leadership; staff; co-chairs; work group members	Obtain updates on existing care models (Blueprint staff, SSP staff, ACOs).		• Initial progress report provided in October 2014	Successful extension and/or adaptation of existing care models in Vermont.
20		Provide input on model reinforcement, extension and adaptation	Ongoing	Staff, co-chairs, work group members.				
	Integrated Communities Care Management Learning Collaborative							
21	Implement Integrated Communities Care Management Learning Collaborative to test promising interventions to reduce fragmentation, gaps and duplication for people needing services from multiple organizations.	Identify pilot communities.	December 2014-December 2015	Staff; co-chairs; consultants; work group members; pilot community organizations engaged in care management	N/A	Steering Committee	• Initial pilot communities selected (Burlington, Rutland, and St. Johnsbury).	• Completion of learning collaborative. • Results used to design effective integrated care management strategies. • Measureable improvements in care and outcomes. • Scalable interventions.
22		Identify planning group.	January-March 2014	Staff; co-chairs; consultants; work group members.			• Planning group convened, meeting regularly since April/May 2014.	
23		Design learning collaborative, including interventions to be tested.	January 2014-Ongoing	Staff; co-chairs; consultants; planning group members, pilot community organizations engaged in care management			• Learning collaborative designed.	
24		Obtain funding.	August 2014	Staff.			• VHCIP funding obtained.	
25		Hire community facilitators.	December 2014	Staff.			• One facilitator hired; other in process.	
26		Hold kick-off webinars.	November 2014	Staff; co-chairs; consultants, pilot community organizations engaged in care management.			• Kick-off webinars held.	
27		Engage faculty for learning sessions.	November 2014-Ongonig	Staff.			• Faculty engaged for learning session.	
28		Develop measures based on interventions.	September 2014-February 2015	Staff; co-chairs; consultants; planning group members.			• Draft measures outlined, training for communities in data collection and reporting of measures planned.	

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29		Conduct PDSA cycles.	March-June 2015	Staff; community facilitators; pilot communities.			• PDSA trainings with community facilitator planned for February 2015.	
30		Evaluate results.	June-December 2015	Staff; co-chairs; consultants.				
31		Determine if successful interventions can be implemented statewide.	June-December 2015	Staff; co-chairs; consultants.				
32		Provide updates on progress and findings to Steering Committee, Core Team, and relevant work groups.	Ongoing	Staff.				
33		Continue Provider Training discussion with DLTSS Work Group (team-based care, grand rounds, involvement of beneficiaries and their families, etc.).	Q2 2015	Work group members; staff; consultant; DLTSS Work Group.				
34	Collaborate with other VHCIP Work Groups on topics related to the Integrated Communities Care Management Learning Collaborative.	Review and approve DLTSS-specific Core Competency Domains for service providers participating in the Integrated Communities Care Management Learning Collaborative developed by the DLTSS Work Group.	Q2 2015	CMCM Work group members; DLTSS Work Group members.	Solicit recommendations for DLTSS-specific Core Competency Domains for Learning Collaborative Providers (DLTSS Work Group).		• Initial planning meetings held with DLTSS and CMCM work group staff. • Draft domains developed, need to be further refined.	Learning Collaborative activities are well coordinated with DLTSS Work Group activities and Population Health Work Group activities.
35		Work with Population Health Work Group to explore opportunities to collaborate with Care Models Integrated Community Learning Collaborative: identify Population Health Work Group members in learning collaborative communities and link with Health Department District Office in those communities. Set regular check-ins with work group members in learning collaborative communities.	Q4 2014-Q1 2015	Staff; co-chairs; consultant; CMCM Work Group leadership.	Coordinate to increase connection with Learning Collaborative leadership and Learning Collaborative communities (Population Health Work Group).		• Health Department District Office engaged in each community.	
	Ongoing Updates, Education, and Collaboration							
36	Review and approve CMCM Work Group Workplan.	Draft Workplan.	February-March 2015	Staff.	N/A	N/A		Updated workplan adopted.
37	Coordinate and collaborate with other VHCIP Work Groups on activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Staff; co-chairs; work group members; other work groups.	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).	N/A	• Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee. • Presentation from Population Health and DLTSS Work Groups completed.	Well-coordinated and aligned activities among work groups.
38		Provide regular updates to other work groups on learning collaboratives and other CMCM Work Group activities.	Quarterly, starting Q2 2015	Staff; co-chairs; work group members; other work groups.			• Updates provided prior to Q1 include: Population health, HIE, Work Force, DLTSS, Steering Committee, and Core Team.	

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
39		Provide input to Population Health Work Group on activities related to care models. • Review draft Population Health Plan outline developed by Population Health Work Group. • Receive presentation on "population health" definition and Population Health 101 materials developed by Population Health Work Group. • Collaborate with Population Health Work Group to identify existing care models and features for improving population health. • Collaborate with Population Health Work Group to gather additional information about provider grants to support review for lessons learned related to population health.	Q3 2015 Q1 2015 Q1 2015 Q1 2015	Staff; co-chairs; work group members; Population Health Work Group.	• Receive PHP outline (Population Health Work Group). • Receive definition and materials (Population Health Work Group). • Collaborate to identify existing care models (Population Health Work Group; Blueprint). • Gather additional information about provider grants (sub-grantees, Population Health Work Group leadership).			
40		Coordinate with Accountable Health Communities initiative.	Ongoing	Staff; co-chairs; work group members; Population Health Work Group.	Coordinate with Accountable Health Communities initiative (Population Health Work Group).			
41		Obtain regular updates on progress to design and test payment models as they relate to models of care and care management.	Ongoing	Staff; co-chairs, work group members, Payment Models Work Group.	Obtain regular updates on progress to design and test payment models (Payment Models Work Group).			
42		Obtain regular updates on relevant sub-grantee projects.	Ongoing	Staff; co-chairs; work group members; sub-grantees.	Obtain regular updates on relevant sub-grantee projects (Sub-Grantees).			
43	Coordinate with, update, and receive education from VHCIP Core Team, Steering Committee, other VHCIP leadership and stakeholders, and AHS agencies as appropriate.	Overall VHCIP project status updates.	Ongoing	Staff; co-chairs; work group members; VHCIP leadership.	N/A	N/A		Well-coordinated and aligned activities across VHCIP.
44		Update Steering Committee, Core Team, and other VHCIP groups and stakeholders as appropriate.	Ongoing	Staff; co-chairs; work group members; VHCIP leadership	N/A	N/A		

Attachment 3b

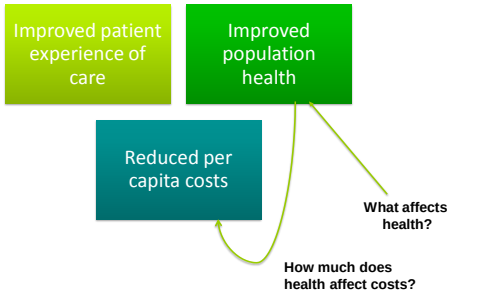
VHCIP Objectives, Key Activities, and Future Topics for CMCM Work Group

VHCIP Care Models and Care Management Work Group
March 23, 2015

What is CMMI Testing?

- Innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries.
- Can states use their unique tools to influence payment and delivery system reform?

VHCIP's goal: the "triple aim"



Three Key Areas of Activity

- **Care Delivery:** enable and reward care integration and coordination
- **HIT/HIE Investments:** develop a health information system that supports improved care and measurement of value
- **Payment Models:** align financial incentives with the three aims

VHCIP is very much a Public/Private Partnership.

What would constitute success?

A health information technology and health information exchange system that works, that providers use, and that produces analytics to support the best care management possible.

A predominance of payment models that reward better value.

A system of care management that is agreed to by payers and providers that:

- Utilizes Blueprint and Community Health Team infrastructure to the greatest extent possible
- Fills gaps the Blueprint or other care models do not address
- Eliminates duplication of effort
- Creates clear protocols for providers
- Reduces confusion and improves the care experience for patients
- Follows best practices

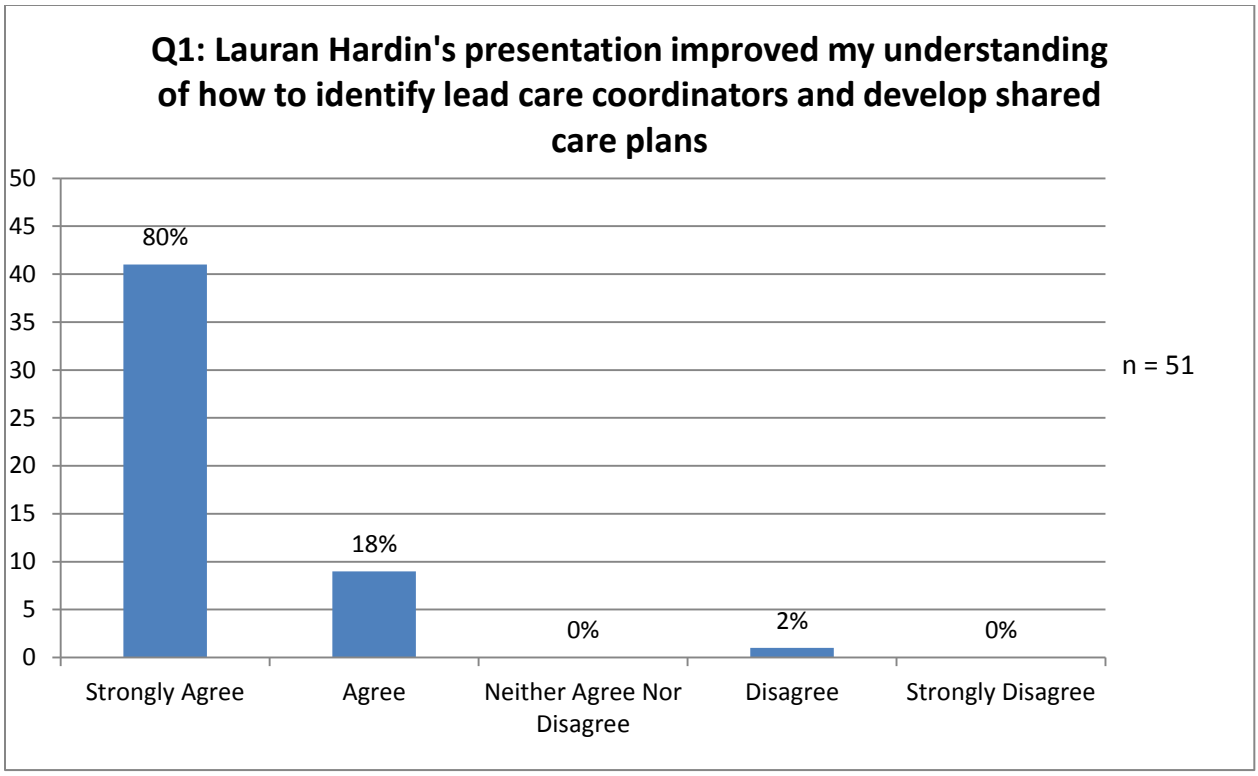
CMCM Work Group Future Topics

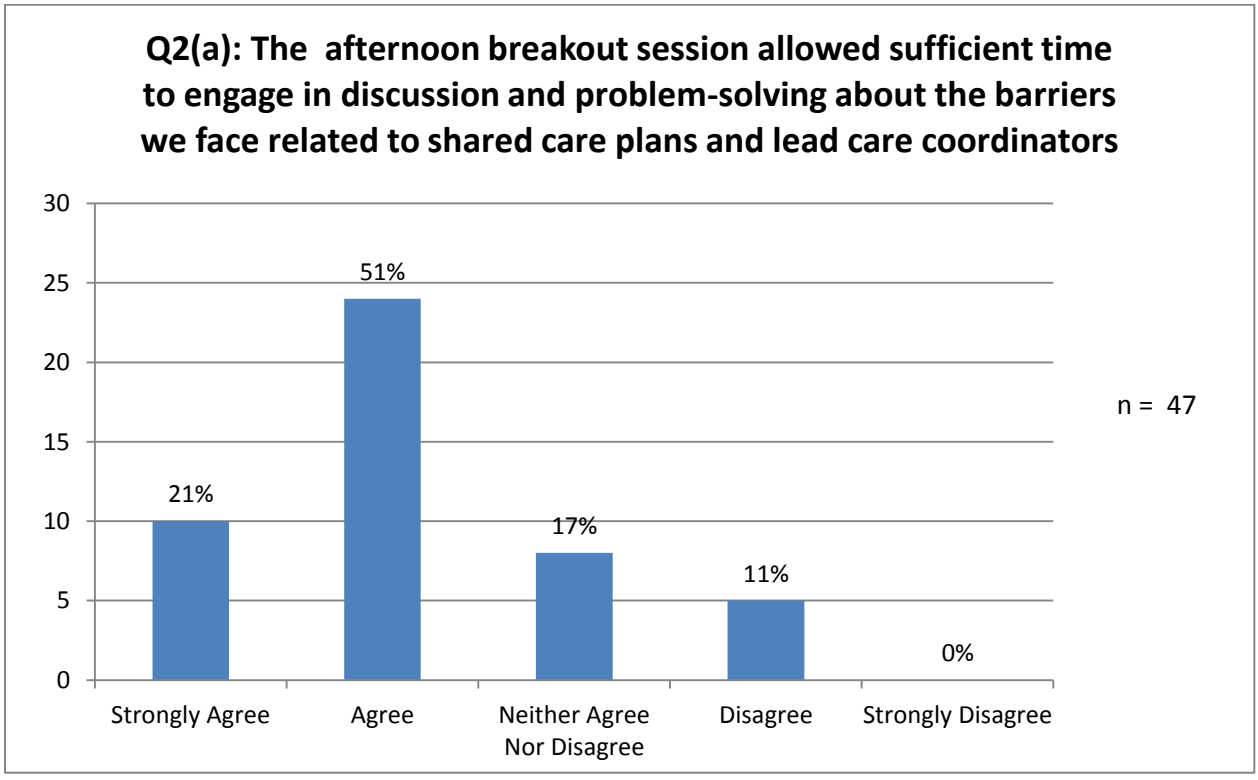
- Standing Agenda Items and Regular Updates
  - Blueprint/ACO Unified Community Collaboratives
  - Integrated Communities Care Management Learning Collaboratives
  - Relevant Population Health Work Group Activities
  - Relevant DLTSS Work Group Activities
  - Federal and state health care reform priorities and initiatives

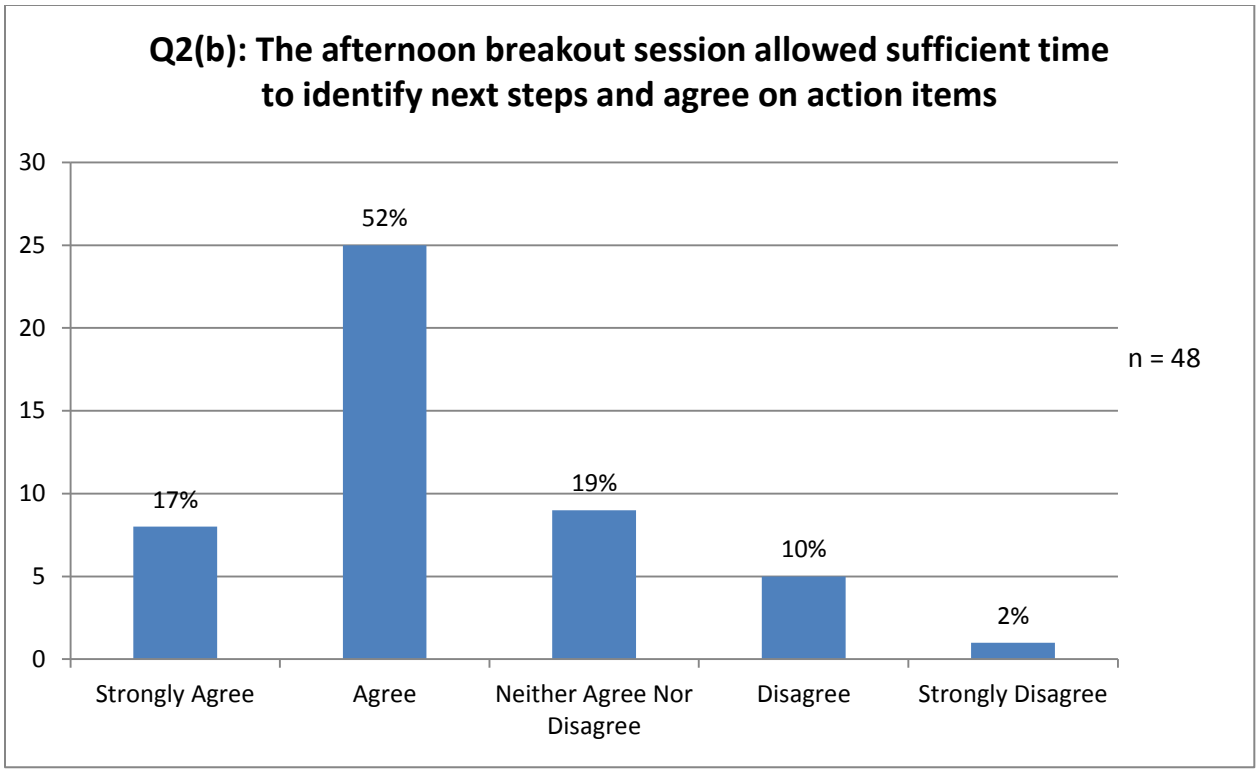
CMCM Work Group Future Topics (continued)

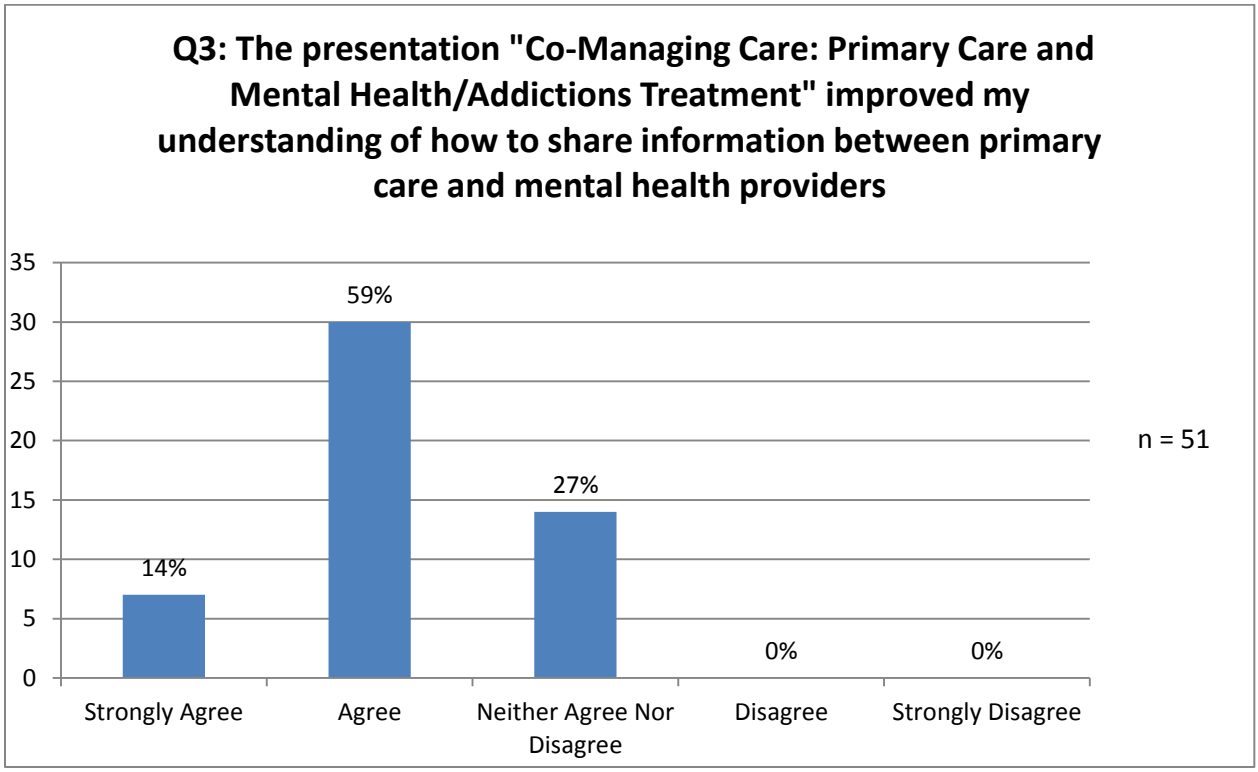
- Work Group Activities
  - Identify redundancy, gaps, and opportunities for coordination (summarize from previous presentations)
  - Continue to review best practices in care management
  - Monitor adaptation of existing models in Vermont (e.g., Blueprint/ACO collaboration)
  - Continue to implement and expand Integrated Communities Care Management Learning Collaboratives
  - Build understanding of state and federal health care reform initiatives (e.g., CMS value-based purchasing and Next Generation ACOs, All-Payer Model, VHCIP payment models, GMCB payment and delivery system pilots)
  - Collaborate with other work groups

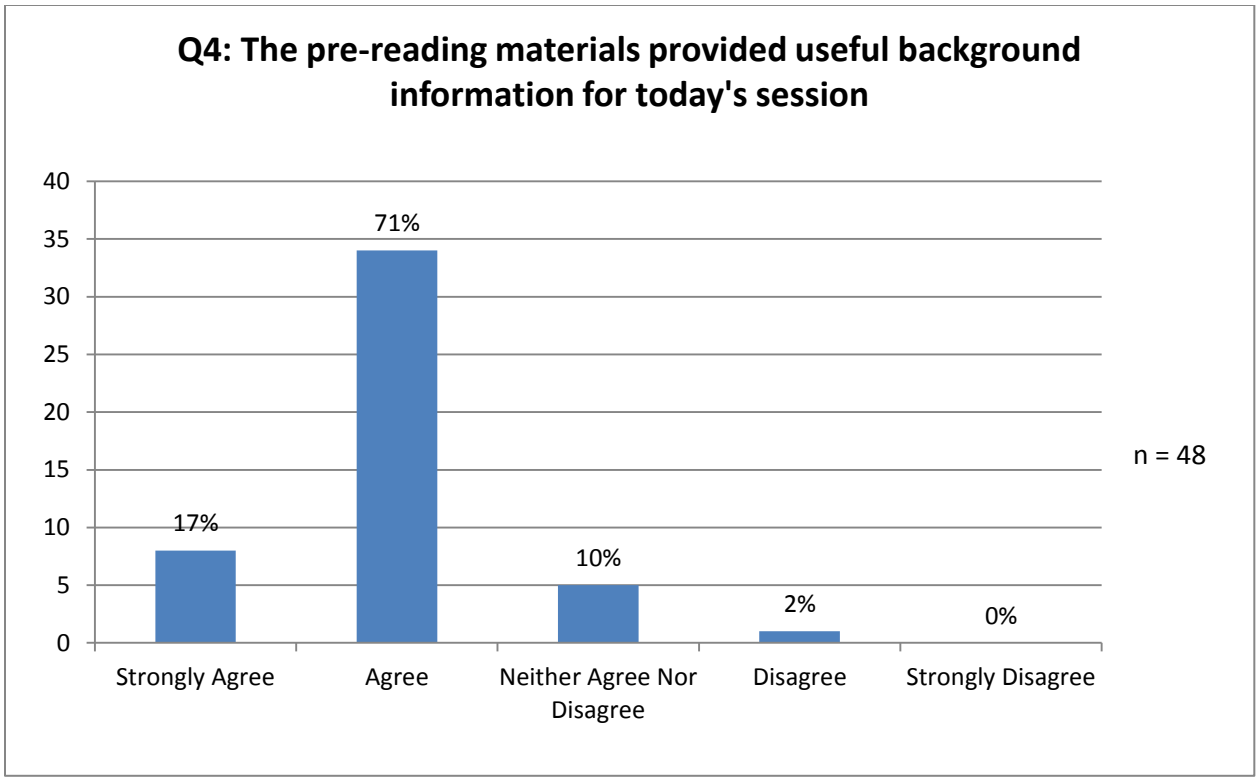
Attachment 4a

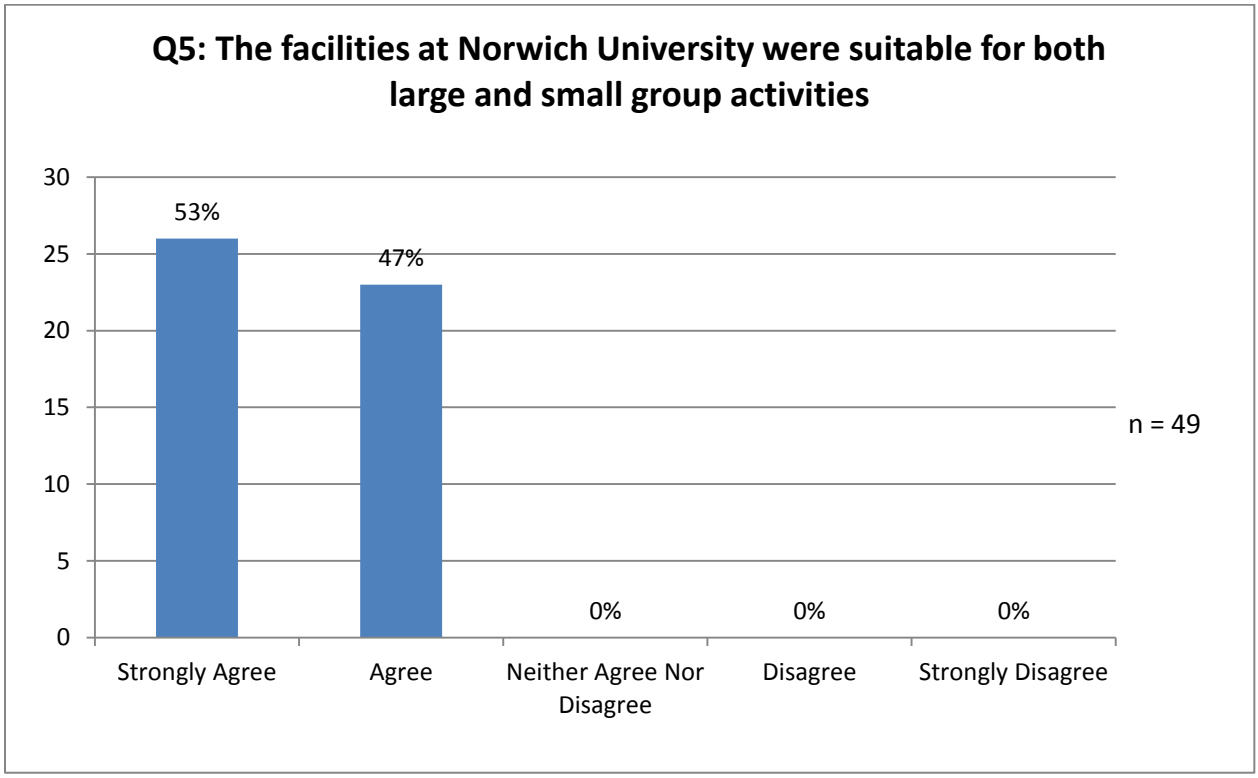

Q1: Lauran Hardin's presentation improved my understanding of how to identify lead care coordinators and develop shared care plans
50
45
40
35
30
25
20
15
10
5
0
80%
18%
0%
2%
0%
n = 51
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree

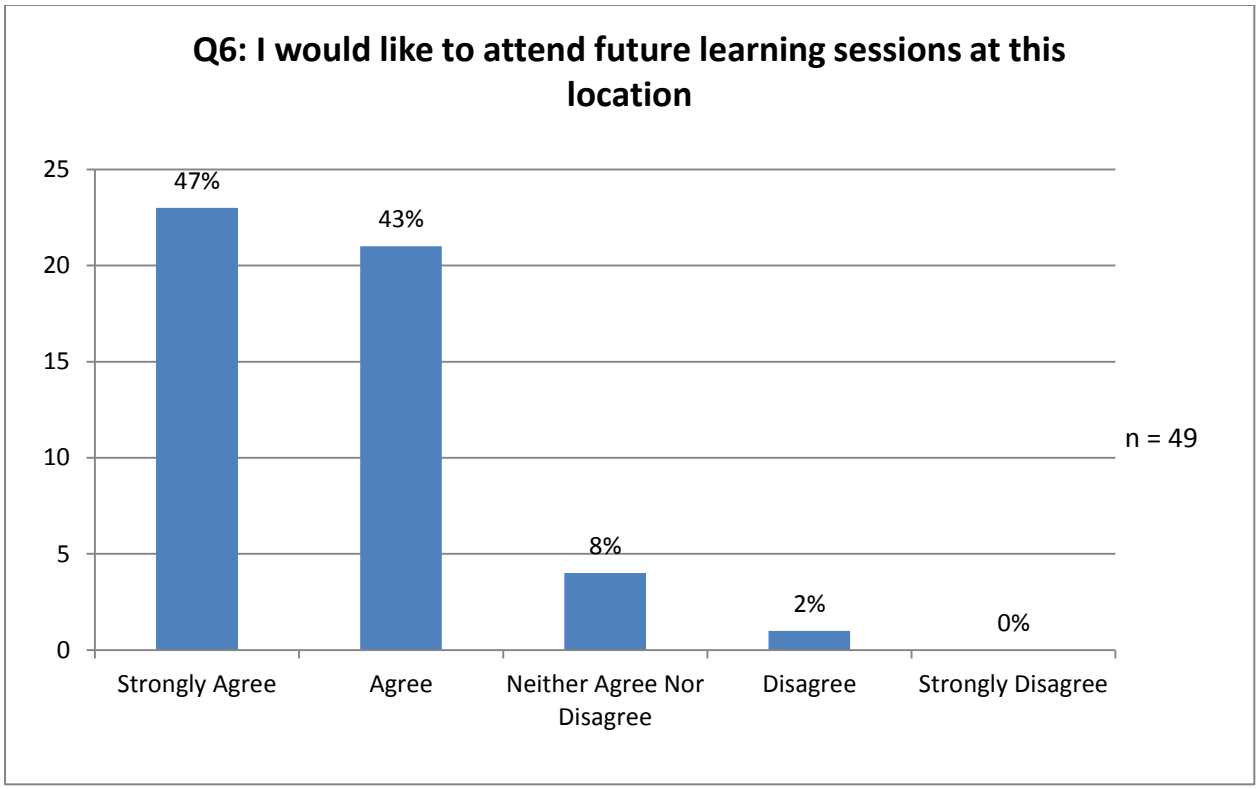

Q2(a): The afternoon breakout session allowed sufficient time to engage in discussion and problem-solving about the barriers we face related to shared care plans and lead care coordinators
30
25
20
15
10
5
0
21%
51%
17%
11%
0%
n = 47
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree


Q2(b): The afternoon breakout session allowed sufficient time to identify next steps and agree on action items
30
25
20
15
10
5
0
52%
17%
19%
10%
2%
n = 48
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree


Q3: The presentation "Co-Managing Care: Primary Care and Mental Health/Addictions Treatment" improved my understanding of how to share information between primary care and mental health providers
35
30
25
20
15
10
5
0
59%
27%
14%
0%
0%
n = 51
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree


Q4: The pre-reading materials provided useful background information for today's session
40
35
30
25
20
15
10
5
0
71%
17%
10%
2%
0%
n = 48
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree


Q5: The facilities at Norwich University were suitable for both large and small group activities
30
25
20
15
10
5
0
53%
47%
0%
0%
0%
n = 49
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree


Q6: I would like to attend future learning sessions at this location
25
20
15
10
5
0
47%
43%
8%
2%
0%
n = 49
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree

Attachment 5a

Population Health Integration in the Vermont Health Care Innovation Project

The Vermont Health Care Innovation Project (the Project) is testing new payment and service delivery models as part of larger health system transformation to deliver Triple Aims outcomes of better care, lower costs and improved health. The charge of the Population Health Work Group (PHWG) is to recommend ways the Project could better coordinate population health improvement activities and more explicitly improve population health[1].

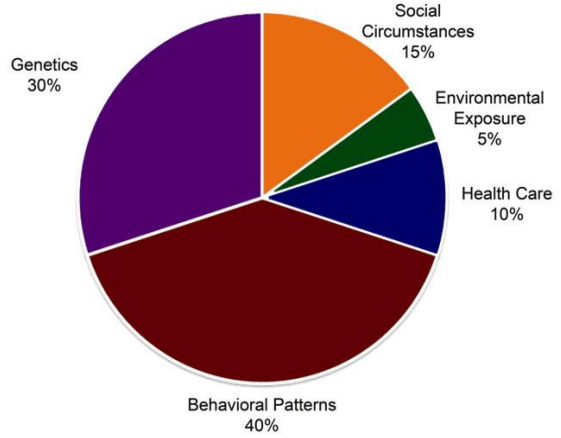
To accomplish the charge of integration of population health and primary prevention within the models being tested in Vermont, the PHWG is committed to several key tasks:

- Develop consensus on a robust set of population health measures to be used in tracking the outcomes of the Project and to be incorporated in the new payment models.
- Offer recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms.
- Identify promising new financing vehicles that promote financial investment in population health interventions.
- Identify opportunities to enhance current initiatives and health delivery system models (e.g. the Vermont Blueprint for Health and Accountable Care Organizations) to improve population health by better integration of clinical services, public health programs and community based services at the practice and community levels. One potential model is an Accountable Communities for Health.
- Develop the "Plan for Integrating Population Health and Prevention in VT Health Care Innovation."

Frameworks to Guide Population Health

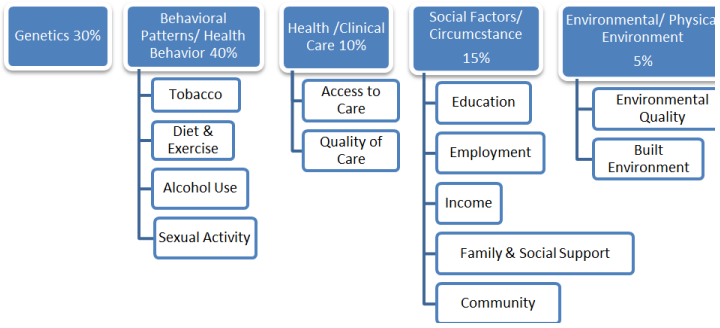
To meet the Triple Aim of moderating cost, improving quality and improving health, increasing access to health care will be insufficient. Access to health care and the quality of medical care account for 10% proportionately to the factors that contribute to premature death (see Figure 1). Therefore, we must seek opportunities to address the multiple factors affecting health outcomes (see Figure 2).

Figure 1: Proportional Contribution to Premature Death



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8
Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion.* Health Aff (Millwood) 2002;21(2):78-93.

Figure 2: Factors Affecting Health Outcomes



County Health Rankings adapted to include genetics and McGinnis weighting of factors
http://www.countyhealthrankings.org/our-approach

[1] Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003)... While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Institute Of Medicine, Roundtable on Population Health Improvement** http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Population Health Integration in the Vermont Health Care Innovation Project

Signs of Successful Integration of Population Health in New Models

Focus on the Whole Population in an area, not just attributed patients

- Use data on health trends and burden of illness to identify priorities and target evidence-based actions that have proven successful in preventing diseases and changing health outcomes.
- Expand efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. Focus specific attention on the health and wellness of subpopulations most vulnerable in the future due to disability, age, income and other factors.

Focus on Prevention, Wellness and Well-Being by Patient, Physician and System

- Focus on primary prevention[i] and actions taken to maintain wellness rather than solely on identifying and treating disease and illness.
- Utilize proven evidence-based prevention strategies to address risk and protective factors[ii] and personal health behaviors such as tobacco use, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

Address the Multiple Contributors to Health Outcomes

- Support integrated approaches that recognize the interconnection between physical health, mental health and substance abuse.
- Identify the social determinants of health[iii] and circumstances in which people are born, live, work, and age (e.g. education, employment, income, family support, community, the built and natural environment).

Create Accountability for Health

- Use measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health.
- Build upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, Accountable Care Organizations and public health programs) to connect community resources for health in a geographic area.
- Include partners and resources able to influence the determinants of health and the circumstances in which people live, work and play.

Create Sustainable Funding Models Which Support and Reward Improvements in Population Health including Primary Prevention and Wellness

- Incentivize payers and health systems to invest in community-wide prevention efforts and to encourage delivery of physical health, mental health and substance use prevention services
- Direct savings, incentives and investments to efforts aimed at primary prevention and wellness including efforts that address the social determinants of health (e.g. housing, transportation, education).
- Develop budgets that explicitly demonstrate spending and/or investments in prevention and wellness.

  Identify long and short term multi-sector impacts and capture a portion of those benefits for reinvestment

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[i] Primary prevention aims to prevent disease from developing in the first place. Secondary prevention aims to detect and treat disease that has not yet become symptomatic. Tertiary prevention is directed at those who already have symptomatic disease, to prevent further deterioration, recurrent symptoms and subsequent events. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

[ii] http://www.who.int/hiv/pub/me/en/me_prev_ch4.pdf

[iii] (http://www.cdc.gov/socialdeterminants/).

Attachment 5b

Population Health Integration in the Vermont Health Care Innovation Project

ACOs, TACOs and Accountable Communities for Health

The following is intended to offer a basic overview of the different structures that are being explored for integrating population health as part of the Vermont Health Care Innovation Project.

Accountable Care Organization (ACO) is a health care organization that agrees to be responsible for the quality and cost of health care for its patients. Providers who are part of an ACO work together to coordinate care, improve the quality of health care provided to patients, and reduce health care costs for a defined group of patients. ACOs are intended to organize providers to better control health care cost growth and shift the focus from providing their separate services to coordinating with each other for the benefit of the people they serve.

A key feature of ACOs is that they participate in reimbursement programs that hold them accountable for the quality of services performed as well as the costs. In Vermont, reimbursement mechanisms for services by ACO providers have not changed, but the ACO and its providers benefit from "shared savings" arrangements with payers. Reimbursement models for ACOs are designed to evolve over time, starting with 'one-sided risk' where they share only in savings, shifting to two-sided risk where they share in both savings and losses, and ultimately evolving to population based payments. ACOs can and have contracted with multiple payers including Medicare, Medicaid and commercial health plans.

Totally Accountable Care Organization (TACO) represents an aspirational vision for a health care system where all physical health, behavioral health, long-term services and supports (LTSS), and elements of social services and public health are integrated. A TACO is today's ACO with a wider number of service providers. The model aspires to serve all populations yet builds upon the integration of care for a defined group of patients. Ideally, these activities would be reimbursed under a reimbursement that aligns financial incentives and reduce costs.

Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. However, like ACOs and TACOs, there would need to be some patient attribution to measure cost and quality. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An ACH supports the integration of high quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness.

Definition of Population Health

The definition of population health may vary depending upon the perspective of a given group. For a medical provider, "population" may be either the "panel of patients" (all patients who use the provider, regardless of whether they see other providers more frequently) or "attributed lives", which refers only to those patients who receive most of their care from that provider. For a health insurer or payer, the definition of "population" is "covered lives" which refers to the health plan beneficiaries. For the community, the "population" includes everyone who lives in a defined geographic area. Similarly, the definition of "health" varies from a narrow definition limited to physical health to an expanded definition which includes mental health and well-being.

Population Health Integration in the Vermont Health Care Innovation Project

ACOs, TACOs and Accountable Communities for Health

The Population Health Work Group of VHCIP has adopted the following definition of Population Health based on Kindig and Stoddart (2003) referenced by CMS for the SIM initiative:

Population Health … the health outcomes of a group of individuals, including the distribution of such outcomes within the group ... While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

Institute Of Medicine, Roundtable on Population Health Improvement
http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Structures for Integrating Population Health

Features	VT Medicare ACO SSP	VT Medicaid ACO SSP	VT Commercial ACO SSP	TACOs	ACHs
Population	Attributed lives	Attributed lives	Attributed lives	Attributed lives	Defined geographic area
Physical health	x	x[1]	x[2]	x	x
Mental health and substance use services Behavioral health[3]	x	x	x	x	x
LTSS				x	x
Social services				x	x
Public health services				x	x
Community wide prevention strategies					x
Prevention	Preventive Medical Care	Preventive Medical Care	Preventive Medical Care	Preventive Medical Care	Primary through tertiary[4]

Payment and Financing of Population Health

The mechanisms for payment and financing are not discreetly connected to a particular structure. This project is currently testing different models and options to determine the best fit that will cover necessary costs, ensure continuing high quality care and improve health outcomes.

[1] Excludes dental and pharmacy

[2] Excludes dental and pharmacy

[3] Current ACO SSPs include limited mental health and substance use services

[4] Primary prevention aims to prevent disease from developing in the first place; Secondary prevention aims to detect and treat disease at an early stage or slow the progress; Tertiary prevention is directed at those who already have symptomatic disease.

Attachment 5c

Describing an Accountable Health Community

"An AHC would be accountable for the health of the population in a geographic area, including reducing disparities in the distribution of health."

- From the "Accountable Health Community Program" Request for Proposals issued by the Department of Vermont Health Access in July, 2014

This preliminary description of the fundamentals of an Accountable Health Community was prepared for Vermont's Population Health Work Group by Prevention Institute in December, 2014. The content is based upon the *Accountable Health Community Program* Request for Proposals issued by the Department of Vermont Health Access in July, 2014, the discussion on AHCs held by the Population Health Work Group on September 9, 2014, the paper *Healthier by Design: Creating Accountable Care Communities*, describing similar work conducted in Summit County, Ohio, a review of State Innovation Model program plans being developed in other states, and internal analysis and discussion.

Essential characteristics of an Accountable Health Community:

- An Accountable Health Community (AHC) is accountable for the health and well-being of the entire population in its defined geographic area, including reducing disparities in the distribution of health.

- An AHC is a structured partnership of health care delivery systems, clinicians, social services, public health departments and other government agencies, and community organizations. The member organizations of the AHC may be linked through a limited or comprehensive payment structure, or have no formal shared financial system.

- An AHC is coordinated by an integrator organization that coordinates the capacities of the partners within the AHC.

- An AHC supports the integration of high quality medical care, mental and behavioral health services, and social services across its defined geographic area.

- An AHC works to change the community and environmental conditions that create health with a focus on primary prevention.

- An AHC prioritizes authentic community participation throughout its assessment, planning, and implementation processes.

- An AHC includes a robust data sharing model, where its member organizations contribute to an interactive community health database that can be employed to assess and develop strategies to improve population health.

- An AHC uses measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health.

- An AHC builds upon existing innovations in payment reform and fosters sustainable funding models that support and reward improvements in population health.