Core Team

Meeting Agenda 3-9-2015

VT Health Care Innovation Project
Core Team Meeting Agenda

March 9, 2015 12:30 pm-2:00pm
4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	12:30-12:35	Welcome and Chair's Report a. Mid-project risk analysis	Lawrence Miller	
Core Team Processes and Procedures				
2	12:35-12:40	Approval of meeting minutes	Lawrence Miller	Attachment 2: February 2, 2015 minutes *Decision needed.*
3	12:40-12:55	Core Team Role	Lawrence Miller	Attachment 3a: Expenditure process Attachment 3b: Core Team Role (ppt)
Policy Update				
4	12:55-1:15	1. DLTSS Work Group Letter to the Governor 2. Care Management Standards *Public Comment*	4.1 Georgia Maheras 4.2 Pat Jones/Erin Flynn	Attachment 4.1a: Steering Committee Memo Attachment 4.1b: DLTSS Work Group Letter Attachment 4.2: Care Management Standards

Financial Update:				
5	1:15-1:45	a. Frail Elders Proposal b. Hester contract amendment *Public Comment*	Georgia Maheras	Attachment 5a: Financial Memo Attachment 5b: Frail Elders Proposal
6	1:45-1:55	*Public Comment*	Lawrence Miller	
7	1:55-2:00	Next Steps, Wrap-Up and Future Meeting Schedule: 4/6: 1-3p, Hurricane Lane, Williston	Lawrence Miller	

Attachment 2

Meeting Minutes 2-2-2015

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: February 2, 2015 **Location:** DVHA-Large Conference Room, 312 Hurricane Lane, Williston, VT

Members: Lawrence Miller, Chair; Robin Lunge, AOA; Paul Bengtson, NVRH (arr. 1:49); Al Gobeille, GMCB; Harry Chen, AHS; Mark Larson, DVHA; Susan Wehry, DAIL.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's report	Lawrence Miller called the meeting to order at 1:09 pm. The Chair's report included two updates: a. CMMI transition: *Karen Murphy, previous head of the SIM unit, is moving to a new role in and there will be an interim appointed soon.* b. Medicaid SSP update: Georgia Maheras provided an update regarding the Medicaid SSP Total Cost of Care expansion. Neither OneCare nor CHAC took the optional track of expanding the Total Cost of Care for 2015.	
2. Minutes approval	Al Gobeille moved to approve the minutes. Harry Chen seconded. All approved. Paul Bengtson was not present for this vote.	
3. Project Update: Meeting project goals	Georgia provided a project update to the Core Team regarding the 2014 Carryover Request and Quarterly Report. The Carryover Request was submitted on 1/30/15 and included funds to pay for expenses incurred, but not paid in 2014 as well as funds that were unspent. The Quarterly Report was also submitted on 1/30/15 and is available on the VHCIP website.	
4. Policy Update	1. Steering Committee Proposal Georgia provided a brief overview of the purpose of this proposal, which was to clarify the Steering Committee's role and responsibilities. Mark Larson and Al Gobeille then discussed the proposal and responded to questions raised by the Core Team. In particular, the Steering	

Agenda Item	Discussion	Next Steps
	Committee should ensure that proposals are complete and meet the goals of the SIM grant. They should also ensure there was a thorough and good process for proposals, but are not the arbitrator. This latter role is for the Core Team. The Steering Committee may send proposals back to a work group if they are not thoroughly vetted or there are missing pieces. The role clarification will be presented to the Steering Committee at their next meeting. 2. Learning Collaboratives: Pat Jones provided an update on the Learning Collaboratives. The first in-person meeting was on January 13th. The first meeting included a local provider and family and individuals from Camden, NJ providing lessons on their 'hotspotting'. There was good representation from all three communities and significant breadth and depth in the participants. The day should be considered a success and the team is looking forward to the upcoming meetings. 3. Sub-grantees progress to date: Georgia provided a summary of the Round One sub-grantee reports. The Core Team requested additional conversation at a future Core Team meeting to better understand the transition at Health*first.* The Core team also wants to ensure these funds are well spent and to have these reports indicate sub-grantee progress on their projects relative to the sub-grant period.	
5. VCN Data Repository	Georgia provided an overview of this proposal: the Core Team provisionally approved this project last year and required VCN to come back with a specific proposal around the data repository. VCN provided the project background and a recommendation to go out to bid for this scope of work. The Core Team engaged in discussion about the use of the data, data-sharing limitations (DA/SSA data is governed by 42 CFR Part 2, a SAMHSA regulation), how this project will support integrated care, and the need for this system to be portable and interoperable with other health data systems. Robin made a motion to approve this project. This was seconded by Susan Wehry and unanimously approved.	
6. Public Comment	N/A	
7. Next Steps, Wrap	**Next meeting:** TBD. It was previously scheduled for 3/2 and is being changed.	

Agenda Item	Discussion	Next Steps
up		

Attachment 3a

Expenditures Process

Type 1 expenditures:

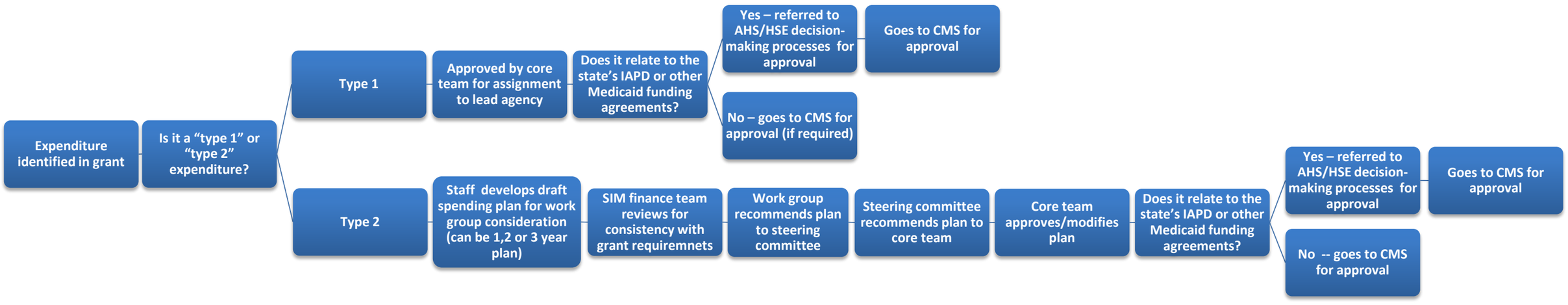
- Personnel, fringe, travel, equipment, supplies, other, overhead, interagency coordination, staff training and change management (as identified in approved grant budget)
- Provider grant program (with input from work group and steering committee on criteria)
- Expenditures approved by the Core Team prior to 10/1/13 (Project Management contract $, Evaluation contract $, VITL contract $)
- Ongoing project management resources, with Core Team approval
- Base support for each work group (extension of existing contractor technical assistance or new contract), with Core Team approval
- Base support for each lead agency, with Core Team approval

Type 2 expenditures:

- All other

NOTE: all contract expenditures are subject to state procurement rules and all recommendations/decisions of work groups, Steering Committee and Core team are subject to conflict-of-interest rules

Decision-making process for SIM grant expenditures Approved by SIM Core Team in October 2013



Attachment 3b

Core Team Role

Core Team Role

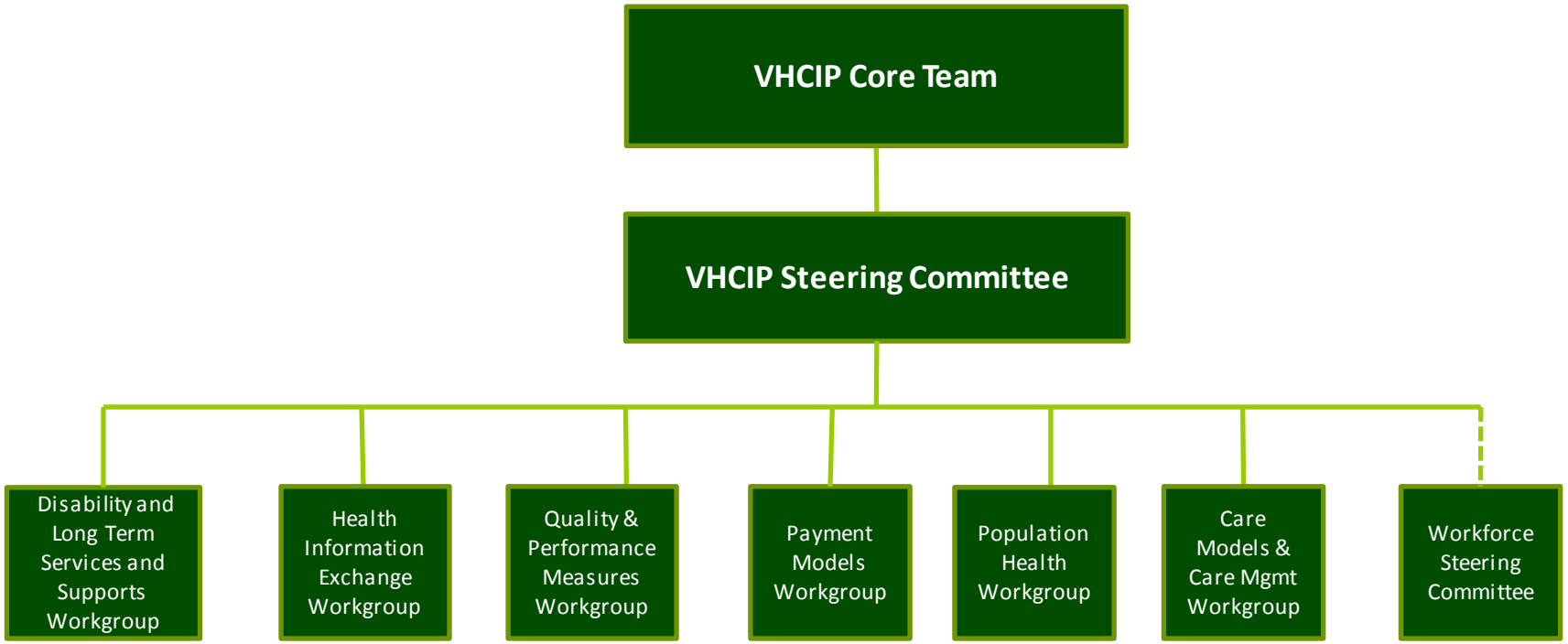
March 9, 2015

Georgia Maheras, JD
VHCIP Project Director

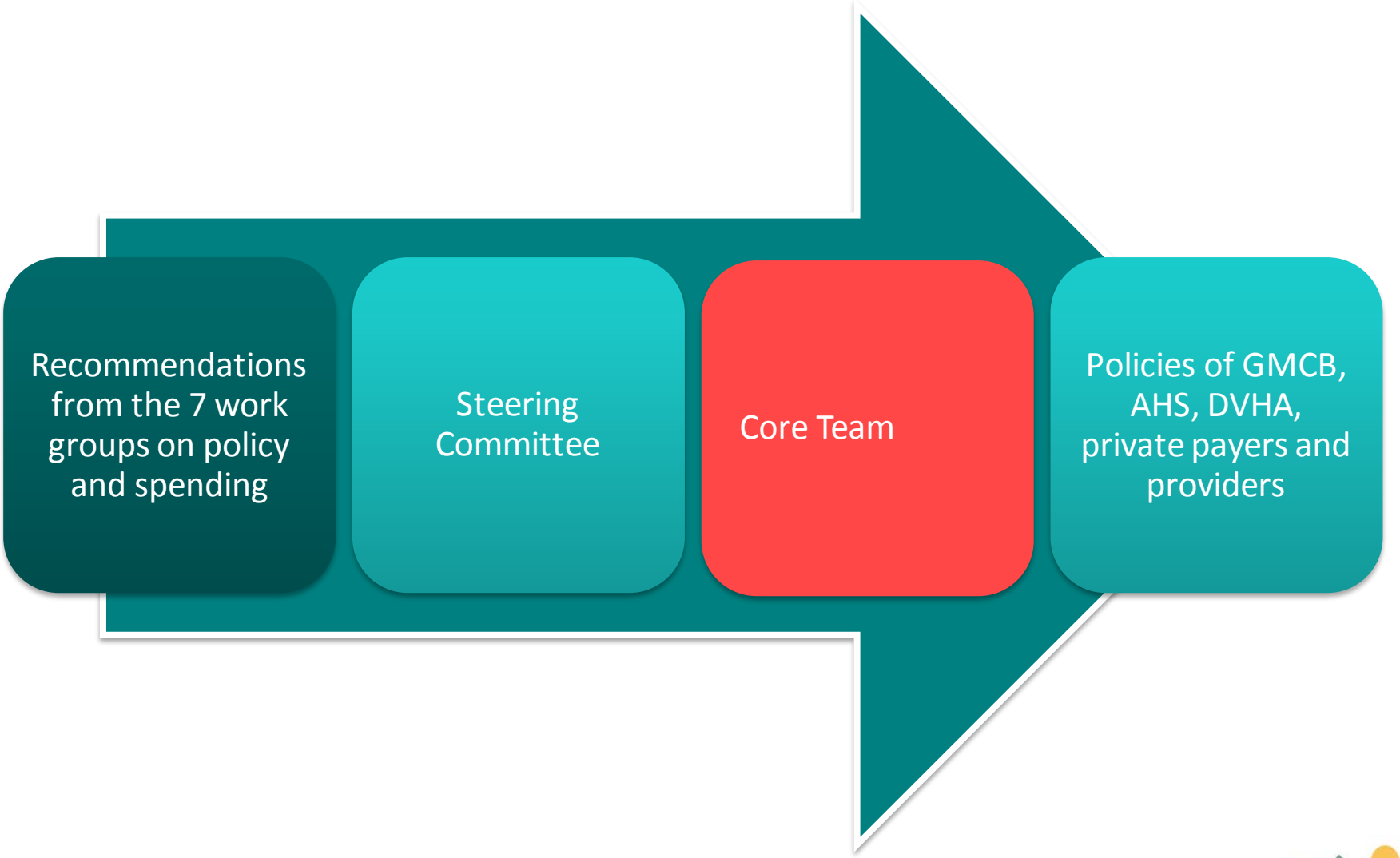
Operational Plan:

- "This group provides overall direction to the VHCIP, synthesizes and acts on guidance from the Steering Committee, makes funding decisions, sets project priorities, and helps resolve any conflicts within the project initiatives."

Project structure



How does the project work?



Attachment 4.1a

Steering Committee Memo

To: Mark Larson and Al Gobeille, Co-Chairs, VHCIP Steering Committee
Fr: Georgia Maheras, Project Director and Sarah Kinsler, Health Policy Analyst
Date: January 18, 2015
Re: Steering Committee Agendas and Role Clarity

This memo is in response to a request made at the December 3, 2014, Core Team meeting. At that meeting, the Core Team requested that Georgia Maheras work with the Steering Committee Co-Chairs to develop a proposal that would provide clarity about the Steering Committee's agendas and its role within VHCIP.

According to the 2015 Operational Plan, "the Steering Committee informs, educates and guides the Core Team in all of the work planned under the SIM grant. In particular, the group guides the Core Team's decisions about investment of project funds, necessary changes in state policy and how best to influence desired innovation in the private sector."

In order to ensure the Steering Committee has the information necessary to guide the Core Team, we recommend the following:

1. At the February Steering Committee meeting, provide a comprehensive update on activities that occurred in 2014 and a preview of what is to come in 2015. Additionally, the Steering Committee will participate in a process identifying criteria with which the group will review policy and funding proposals in 2015. A key aspect of this is to ensure the Steering Committee understands its role in terms of guiding policy and funding decisions and that the Steering Committee is not a place to re-litigate the decisions made by a work group.
    a. The comprehensive update will focus on the big picture with an emphasis on the three core areas of VHCIP activity: Payment Models, HIE/HIT infrastructure and Care Management and Care Models. The update will, at a minimum, cover:
        i. Financial update
        ii. Project evaluation update
        iii. Provider participation
        iv. Beneficiary participation
    b. Potential criteria the Steering Committee could use include to review policy and funding proposals in 2015 include:
        i. Is the recommendation consistent with the goals[1] and objectives of the grant?
        ii. Is the recommendation inconsistent with any other policy or funding priority that has been put in place[2] within the VCHIP project?
        iii. Has the recommendation been reviewed by all appropriate workgroups?
2. The Steering Committee will then be provided updates throughout the year on the following:
    a. A minimum of three updates per year for each work group and the sub-grantee program.
3. In addition to these periodic updates, the Steering Committee will continue to receive requests for approval of policy and funding recommendations on an as-needed basis.

[1] The goals as described in the Operational Plan are:

- To increase the level of accountability for cost and quality outcomes among provider organizations;
- To create a health information network that supports the best possible care management and assessment of cost and quality outcomes, and informs opportunities to improve care;
- To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
- To ensure accountability for outcomes from both the public and private sectors; and
- To create commitment to change and synergy between public and private culture, policies and behavior.

[2] The Steering Committee will be provided with a summary of these activities at their meetings.

Attachment 4.1b

DLTSS Cover Memo and Letter

109 State Street

Montpelier, VT 05609

www.healthcareinnovation.vermont.gov

To: Steve Costantino and Al Gobeille, Co-Chairs VHCIP Steering Committee
Fr: Georgia Maheras, Project Director, VHCIP
Date: February 17, 2015
Re: Letter from the DLTSS Work Group

This memo is to provide background on a letter to the Governor that the DLTSS Work Group is recommending be sent.

On December 4, 2014, the DLTSS Work Group approved a letter related to Medicaid funding. This letter, attached herein, requests for appropriate levels of Medicaid funding as well as development of alternative payment methods for long term services and supports providers. This letter was approved on a 9-4 vote, with one abstention by the work group with all state employees either recusing themselves or opposing the letter. In addition to this letter, a separate, but similar letter was sent to the Governor in December from Vermont Legal Aid with several co-signers.

DRAFT LETTER FROM DLTSS WORK GROUP

DATE

The Honorable Peter Shumlin
109 State Street
Montpelier VT

Dear Governor Shumlin,

Several members of the Disability and Long Term Services and Support (DLTSS) Work Group of the Vermont Health Care Innovation Project (VHCIP), those who do not work for state government, would like to share our perspective on how the services that our group represents are of critical importance to both health care reform and the State's current and future fiscal status. The population that receives DLTSS is responsible for 72% of Medicaid claims, utilizing both acute and long term care services.

Given the State's fiscal projections, we want to ensure that the State is strategically utilizing health care resources for the best return on investment in order to achieve our shared goals of health care reform: better outcomes, better health care experience and reduced costs. We are particularly concerned about any proposed reductions to services for Medicaid recipients who utilize long term services and supports (developmental, mental health, elderly and disabled home-based health care). In order to achieve savings, health care reform depends on staff in these programs to manage and coordinate health care, with the stated goal that managing health care will reduce costs, by reducing the cycle in and out of more expensive settings. We therefore make the following recommendations:

1. Medicaid rates should be high enough to recruit and retain quality staff across the full continuum of health care providers to provide access to quality care. At this point, there is insufficient room left in commercial insurance rates to continue the shifting of costs from public programs to the private payers. Providers who rely solely or significantly on Medicaid for their funding are in even greater need for improved Medicaid rates as they are not able to cost shift.
2. Further, it is essential that reimbursement rates from our public programs increase on a predictable and reliable basis in order to sustain quality services.
3. The State should not delay in working with willing community-based providers to develop bundled payment models that reimburse for specific population outcomes. The current fee-for-service payment model from siloed funding streams, which come with multiple bureaucratic requirements, wastes state resources and doesn't have the flexibility to best meet the needs of Vermonters. The experience to date with Integrated Family Services (IFS), a bundled payment pilot in two areas of the State, has shown improved services, reduced administrative expenses and savings.

4. The VHCIP should move forward in developing payment models for DLTSS services which will complement the Medicaid Accountable Care Organization (ACO) Shared Savings Program, with a commitment to achieve comprehensive services and supports for individuals who have been attributed to an ACO as well as for those who have not. Many of these individuals need access to care management to achieve better health outcomes.

While we are fully cognizant of revenue shortfalls for fiscal years 2015 and 2016, we are certain that any reductions in Medicaid funding for services to individuals with DLTSS needs will only lead to higher health care costs for the entire system, most likely through increases in inpatient and institutional care. Many of the state's health care providers are already stressed and cannot further reduce expenditures without also reducing services to people with DLTSS needs. Further reductions in funding will cause detrimental impacts on vulnerable Vermonters.

There is consensus from a diverse cross-section of consumers, advocates, providers and other stakeholders on these recommendations. More importantly, we have commitment, determination and innovative ideas to move health care reform forward.

Sincerely,

The non-governmental members of the DLTSS Work Group

Cc: Secretary Cohen
Secretary Johnson
Chairman Gobeille

Attachment 4.2

ACP Care Management Standards

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 5a

VHCIP Finance Memo

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 3/4/15
Re: Request for Approval of SIM Funded Actions

I am requesting Core Team approval for the following SIM funding actions:

1. Proposal to fund a project related to frail elders for $140,329.
2. Proposal to amend and renew an existing contract with Jim Hester for $25,000.

REQUEST #1- Type 2 Proposal to identify barriers to best care for high-risk elders in two rural communities and recommend counter measures utilizing payment innovation. This comes from the Payment Models Work Group for an amount not to exceed $140,329 for 6 months.

Budget line item: Advanced Analytics: Policy and data analysis to support system design and research for all payers

The Frail Elders Project is a clinician-led quality improvement initiative designed to increase the value of the health care system – focusing on things that matter to patients, reducing harm, conserving resources and increasing system efficiencies. Redesigning how high-risk rural elders are cared for offers opportunity to improve health outcomes for a particularly high-need population while decreasing the cost of care for the target population.

Proposal Summary:

- Perform data analyses, surveys and interviews
  - Expert Panel to advise
  - 3 types of interviews
- Develop a written report
- Present findings and recommendations related to improving health outcomes for frail elders to the Payment Models Work Group

REQUEST #2- Type 2 Proposal to amend and renew the Hester contract adding $25,000 from the Population Health Work Group for 12 months:

Budget line item: Advanced Analytics: Policy and data analysis to support system design and research for all payers

Proposal Summary:

The specific tasks for this contract would be:

- assist the co-chairs of the workgroup in developing the strategy, work plan, and resource needs for the workgroup
- assist in developing agendas for the workgroup
- support/oversee project staff in analyzing payment models being tested and opportunities for integration of population health
- through ongoing work with CDC, IOM and others, identify models and resources in other states and communities that could inform the design of sustainable financing models for improving population health
- assist in identifying the population health measures and measurement systems required to support the population health financing system
- assist in developing the Population Health Improvement plan, particularly the elements for a sustainable financial model
- help formulate an approach to creating Vermont pilots of Accountable Health Communities by drawing on expertise in models being tested in other states and building on the work of the Prevention Institute

Attachment 5b

Frail Elders Proposal and Budget Narrative

VMS Education & Research Foundation
pursuing high value care for Vermonters

Frail Elders Project

Purpose, Methods, Deliverables and Budget

Purpose

The purpose of this improvement effort is to identify barriers to best care for frail elders in two rural communities and recommend counter measures utilizing payment innovation. The principal method for problem identification is interviews with patients, families, caregivers and community based health care professionals.

The Frail Elders Project is a clinician-led quality improvement initiative designed to increase the value of the health care system – focusing on things that matter to patients, reducing harm, conserving resources and increasing system efficiencies. Redesigning how high-risk rural elders are cared for offers opportunity to improve health outcomes for a particularly high-need population while decreasing the cost of care for the target population.

> ***Frail Elders Definition:*** Frailty is a geriatric syndrome characterized by weakness, weight loss, and low activity that is associated with adverse health outcomes. Frailty manifests as an age-related, biological vulnerability to stressors and decreased physiological reserves yielding a limited capacity to maintain homeostasis. The validated and widely utilized five-item frailty criteria for screening: self-reported exhaustion, slowed performance (by walking speed), weakness (by grip strength), unintentional weight loss (10 lbs. in past year), and low physical activity are composite outcomes of multiple organ systems. (Fedarko, Neal (Feb. 2011), "The Biology of Aging and Frailty," *Clinical Geriatric Medicine* 27 (1):27-37; adopted by DAIL in January 2015.)

Methods

1. Literature review

This project will begin with a literature review utilizing the library professionals at the University of Vermont. The review will target three areas of interest: 1) Identification, attribution of patients to providers, and utilization characterization of frail elderly patients using billing claims and clinical data bases; 2) Regional and national models for care – successes, failures and innovation; and 3) Regional and national investigations of patient and family medical care preferences.

2. Definition of areas of study

Drawing on the published literature, the Project Team will draft study questions for three sets of key informant interviews: 1) community based health care professionals; 2) State and private sector policy experts; and 3) Patients, families and caregivers. The Project Team will solicit feedback from a Project Expert Panel. The Expert Panel will include, but not be limited to, representatives from the following: AAAs, SASH, AHS departments, VNAs, Nursing Homes, FQHCs, primary care providers, specialists (including a geriatrician), the LTC Ombudsman, Designated Agencies, and others currently engaged in delivering care to rural elders in Vermont.

3. Key Informant Interviews

a. *Community based health care professionals* – Structured telephone interviews will be conducted with up to 15 community based health care professionals in each of the two target communities.

Identification of providers will be informed by consultation with the Project Expert Panel. Approximately 15 providers will be interviewed in each of two primary care service areas, Gifford Health Care and Little Rivers Health Care, spanning all or parts of Orange, Washington, Caledonia and Windsor counties.

Illustrative examples of focus areas in the provider interviews include:

- What things do you think matter to the frail elderly and their families?
- What are some of the unique challenges faced by your frail elderly patients and their families? What works well and what doesn't in addressing these challenges?
- What practice redesigns could improve care and frail elder health and welfare?
- What are the financial and regulatory barriers to commencing practice redesigns?
- What are practical, meaningful measures of value?

b. *Patients, families and caregivers* – Interviews will be conducted with approximately 15 patients, families and caregivers in each of two targeted primary care service areas. Interviews will be conducted in a variety of face to face settings including home based interviews and public community settings. Interviews will take advantage of existing community structures and activities; and may include focus groups. Choice of informants will be advised by input from the community based health care professionals interviews.

Illustrative examples of focus areas in the patient/family interviews include:

- Do you consider yourself frail? Yes/No? Why/Why not?
- What things matter to you and your families? What are your concerns and challenges? What programs or resources exist in your communities to support frail elders in meeting these challenges, and do they meet your/your family's needs? Possible sub-areas include:
    - Care transitions and discharge planning
    - Access to regular health screenings and immunizations
    - Access to mental health services
    - Fall prevention
    - Memory health
    - Advanced directives
    - Wellness activities
    - Supportive services
    - Transportation
    - Personal care/homemaking needs
    - Financial management

c. *State and private sector policy experts* – Structured telephone interviews will be conducted with public and private professionals with expertise in the field of aging and support- and care-giving for the elderly. Informants will include those who determine eligibility for Vermonters for publicly funded programs. Approximately 10 policy experts will be interviewed.

The results of the three sets of interviews will generate three separate analyses as well as a single overview summary.

4. Billing and Clinical Data Set Analytics

The analytic component will look principally at existing public claims data bases. Analytic foci will address: 1) Can the frail elderly population be identified using claims data; 2) Can utilization patterns of

the population be characterized; and 3) Can claims data be used proactively to identify the target population? Investigation will be directed at issues of attributing patients to various providers. If possible, reconciliation between private billing data and/or private clinical data with the results of claims-based analyses will be studied. The claims and clinical data analyses will be performed by in-state experts, including Steve Kappel from Policy Integrity.

Deliverables

The Project Team will deliver a written report and a formal presentation to the VHCIP Payment Models Work Group on findings and recommendations for next steps to increase the value of health care to frail elders. The expected length of the effort is six months.

Budget

Pursuing High Value Care for Vermonters		
Frail Elderly VHCIP Payment Models		
April - October 2015		
Personnel		
Director	$	62,352
Business Manager	$	3,741
Operations Director	$	3,741
Administrative Assistant	$	1,871
Personnel subtotal	$	71,705
Fringe		
	$	-
Travel		
Mileage	$	848
Parking and Tolls	$	25
Equipment		
	$	-
Supplies, meetings		
Conference calls; webinars	$	500
Website	$	500
Supplies subtotal	$	1,000
Indirect		
	$	-
Contracts		
Clinical champion	$	6,126
Clinical content expert	$	3,063
Clinical content expert	$	3,063
Qualitative Researcher	$	40,500
QI and Measurement content expert	$	3,000
Patient and Family surveyor	$	10,000
UVM Dana Library	$	1,000
Contracts subtotal	$	66,751
Total		
	$	140,329

VMS Education & Research Foundation
pursuing high value care for Vermonters

Frail Elders Project

Budget Narrative

The budget is built around the principal activities of the Committee anticipated to occur over the span of six months.

1. Project management
2. Three literature reviews
3. Definition of areas of study
4. Key Informant Interviews
5. Billing and Clinical Data Set Analytics
6. Written report and a formal presentation to the VHCIP Payment Models Work Group on findings and recommendations for next steps.

The budget is organized in six categories and total direct costs:

A. **Personnel**
B. **Fringe**
C. **Travel**
D. **Equipment**
E. **Supplies and meetings**
F. **Indirect costs**
G. **Contracts**
H. **Total direct costs**

A. Personnel -

Position and Title	Rate/hr	Hrs/wk	Wks/mth	Mos	Amount requested
Foundation Director - Cyrus Jordan	$150	16	4.33	6	$62,352
Business manager - Colleen Mange	$37.5	4	4.33	6	$3,741
Operations manager - Stephanie Winters	$37.5	4	4.33	6	$3,741
Admin Assistant - Deb Fernandez	$12	4	4.33	6	$1,871

<u>Director – Cyrus Jordan MD MPH</u>

This position directs the overall operation of the project including contact with the State and all contractors including: all communications, document management, convening meetings, recruitment of key informants, interface with the Expert Panel, coordination of all tasks, editorial responsibility for all reports and presentations and all unassigned tasks. The Director is responsible for managing the other VMS personnel for their duties related to this effort.

<u>VMS Business manager – Colleen Mange</u>

The Business manager is responsible for all accounting tasks including payments to contractors, vendors and related state and federal income tax filings.

VMS Operations manager – Stephanie Winters

The Operations manager is responsible for managing all VMS information systems and office spaces which house the VMS Foundation. Ms. Winters is also the Executive Director for the Vermont chapters of the national professional societies for all Vermont Family Physicians, Pediatricians, Psychiatrists, Ophthalmologists, Anesthesiologists and Orthopedic Surgeons. Ms. Winters will be responsible for all communications regarding the effort with these specialty societies as well as the 1,300 physician members of the VMS and the physician assistant associate VMS members.

VMS Administrative Assistant – Debra Fernandez

The Administrative assistant will be responsible for all administrative support to the Director and the VMS staff during the project.

B. Fringe - $0

Fringe benefits are included in VMS employee contract expenses. No fringe is applied to the Director's wage.

C. Travel - $873

Travel expenses are limited to instate mileage for the VMS Foundation Director. Mileage estimate is for 1500 at $0.565 dollars per mile. No mileage will be expensed for by contractors. $25 has been budgeted for parking expenses.

D. Equipment - $0

There are no equipment expenses.

E. Supplies and meetings - $1000

$500 has been budgeted for conference call services and webinars. $500 has been budgeted for a project website which will serve both as a project resource for all participants and as an publically accessible center for pertinent literature, project progress reports and other key documents.

F. Indirect costs - $0

No in direct costs have been budgeted; though part of the expense for VMS staff support could be viewed as indirect cost.

G. Contracts -

Position and Title	Annual	% FTE for 6 months	Contracted by deliverable	Amount requested
Clinician Community Champion – Josh Plavin MD MPH	$245,025	5%		$6,126
Regional clinical opinion leader – Barbara Lazar MD	$245,025	2.5%		$3,063
Regional clinical opinion leader – Fay Homan MD	$245,025	2.5%		$3,063
Erica Garfin MA			Yes/$150 per hr	$40,500 (270 hrs)
Brian Costello MD			Yes/$40 per hr	$10,000 (67 hours)
UVM Library Science professional			$1000	
Tupelo Group – Randy Messier			Yes/ $145 per hour	$,3000 (20 hours)

Clinician Community Champion – Josh Plavin MD MPH

The Community Champion, Josh Plavin MD MPH, is a Medical Director at BCBS of Vermont and the former Medical Director of Gifford Health Care. Dr. Plavin is an active practicing clinician and a regional opinion leader on the clinical focus area. The Champion is charged to recruit additional Community members who share his interest in the topic and are respected thoughtful clinicians in their own right. The Champion has frequent contact with the Director and improvement expert; he participates in all telecommunication events and all face to face meetings including regular meetings with the funder during the course of the project. Dr. Plavin is a clinical faculty member of the Dartmouth Medical School.

Regional Clinical Opinion Leader –Barbara Lazar MD

Dr Lazar is a family practitioner at Gifford Health Care whose practice has a concentration in geriatric medicine. Dr. Lazar is the former medical director of the PACE program in Rutland, Vermont.

Regional Clinical Opinion Leader – Fay Homan MD

Dr. Homan is a mid-career practitioner in Wells River Vermont and now a member of the Little Rivers Health Care FQHC. She has a special interest in team based care and is a recognized opinion leader in the family practice profession in the region being on the executive committee of the Vermont Academy of Family Physicians. Her role will be to contribute her considerable knowledge of practice management and models for team based care as well as her influence and professional networking with family physicians across Vermont. She is a clinical faculty member at the UVM College of Medicine.

Tupelo Group – Randy Messier

The Tupelo group assists the Director with activity planning as well as assisting the Community members with project concept development and implementation planning. The Tupelo Group has supplied the VMS Foundation with support for the past three years. The Tupelo Group was the key quality improvement resource utilized by the Chronic Care and Medical Home Collaboratives that preceded the Blueprint. The Tupelo Group has had recent contracts with FAHC, BiState and VITL to offer quality improvement consultation, facilitation and training.

Mr. Messier recently was certified as an NCQA Primary Care Medical Home Content Expert by NCQA; he is only one of three such accredited individuals in the region. He is also a Clinical Microsystems faculty and consultant for The Dartmouth Institute.

A. Total direct costs

Personnel	**$71,705**
Fringe	**$0**
Travel	**$873**
Equipment	**$0**
Supplies and meetings	**$1000**
Indirect	**$0**
Contracts with Practitioners	**$66,751**
Total direct costs	**$140,329**