Care Models and Care Management

Work Group Meeting

Agenda 4-14-15

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

April 14, 2015; 10:30 AM to 12:30 PM
ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:30 to 10:40	Welcome; Introductions; Approval of Minutes (Co-Chair Bea Grause is meeting facilitator)	**Attachment 1:** March meeting minutes	Yes (approval of minutes)
2	10:40 to 10:50	Update on Regional Blueprint/ACO Committees (Jenney Samuelson, Miriam Sheehey and Patty Launer) ***Public Comment***		
3	10:50 to 11:20	Integrated Communities Care Management Learning Collaborative: • Next Steps: April 15th Webinar, May 19th In-Person Learning Session • Expansion to Additional Communities ***Public Comment***	**Attachment 3:** Learning Collaborative Expansion Power Point	Yes (vote to recommend expansion of Learning Collaborative to additional communities)
4	11:20 to 12:05	Presentation by Vermont's Area Agencies on Aging and Visiting Nurse Associations (Lisa Viles, NEVAAA; Peter Cobb, VNAs of Vermont) ***Public Comment***	**Attachment 4**: *pending*	
5	12:05 to 12:25	Payment Reform Update (Co-Chair Bea Grause, VAHHS) ***Public Comment***	**Attachment 5**: *pending*	
7	12:25 to 12:30	Wrap-Up and Next Steps ***Next Meeting:*** *Tuesday, May 12th, 2015, 10:30 AM – 12:30 PM, Calvin Coolidge Conference Room, National Life, Montpelier VT*		

Attachment 1

March Minutes

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

Date of meeting: March 23, 2014

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Nancy Eldridge called the meeting to order at 10:04. An initial roll call revealed that a quorum was not present. After the updates were completed, a quorum was present.	
2. Updates	**ACO Care Management Standards:** ACO Care Management standards were approved by the Core Team. They reflect a great deal of hard work from the group. **Regional Blueprint/ACO Committees:** Unified Community Collaborative (UCC) update was presented by Jenney Samuelson. Many regional committees are merging with ongoing groups that were already working on similar initiatives in health service areas. UCCs are seeking to establish a forum for identifying care gaps and improving quality (particularly around ACO performance measures); there is a similar focus in each health service area. Each ACO is represented on the UCCs in the health service areas where they are present. UCCs are developing charters to guide their work; there are charters confirmed and on file for 10 health service areas and there are several that are currently being drafted and revised. At least two UCCs have a consumer representative, and Burlington is discussing having a consumer as a voting member. Q: Does anyone approve those charters? A: The Blueprint helped by providing a draft template/sample, but the charters are customized for each health service area based on membership in the UCC. For example, some include specific notes about data sharing. Q: Are the charters available for public dissemination? A: Bennington has shared their charter with other UCCs. The draft template/sample can be shared. Vicki Loner will send out the model template to Erin Flynn for distribution to the CMCM group. No identified data is included in the charters – only aggregate clinical data from the Blueprint is shared. Jenney will ask the individual UCCs to share their charters – they are living documents that will likely become more robust over time as the initiatives evolve.	

Agenda Item	Discussion	Next Steps
	Heidi Klein reported that the Health Department is the steward of data that might be very helpful to the UCCs and is exploring ways to share that data. It would be good to disseminate population health data to further the work going of UCCs and ACOs. **Care Management Inventory Survey Report:** Pat Jones noted that the final version of the Care Management Inventory Survey Report is posted to the website with the link provided in the agenda. She noted that Bailit Health Purchasing staff members were instrumental in the compilation of this report. The narrative now includes language around home health care, at the request of the VNAs of Vermont. The findings from the report are being addressed by the Learning Collaboratives and in other efforts.	
3. Work Plan	Nancy Eldridge reported that good progress has been made on the CMCM work plan. She reviewed future topics for the CMCM Work Group, as outlined in the work plan (Attachment 3B). A key goal is to maintain good linkage with the UCCs and the Blueprint; as well as the Population Health and DLTSS work groups. The intent is also to continue to receive reports from the Integrated Communities Care Management Learning Collaborative, and to continue to make periodic reports to the Steering Committee and Core Team about the work that is occurring. Nancy also noted that with the federal and state focus on Value-Based Purchasing (VBP), the CMCM leadership group wishes to stay well informed in areas such as CMS VBP initiatives (such as the Next Generation ACO Model just announced by CMS), and the All Payer Model being discussed in Vermont. Nancy Breiden stated she wishes to stay apprised of the direction of the project. Georgia noted that SIM leadership is engaging in an extensive mid-project risk assessment that will include mitigation strategies for identified risks; the results should be available in the summer.	
4. Feb. Minutes	The February minutes were approved by roll call vote, with four abstentions.	
5. Integrated Communities Care Management Learning Collaborative **-Update** **-Expansion Proposal**	Pat Jones provided updates on the Integrated Communities Care Management Learning Collaborative. **Facilitator Update:** A contract has been finalized with Nancy Abernathey, a quality improvement facilitator with experience with practice facilitation, and a contract for a second facilitator with data experience is in process. Training has been provided to each of the three pilot communities on the Plan-Do-Study-Act (PDSA) quality improvement model. Facilitator support is provided to the communities as they test the interventions. **In-Person Learning Session Update:** The second in-person learning session was held at Norwich University; 70+ people attended with representation from a wide variety of organizations in the pilot communities. The keynote speaker was Lauran Hardin, Director of Complex Care at Mercy Hospital in Grand Rapids MI. She addressed care management across the continuum of care, identifying a lead care coordinator for at-risk people, and how organizations can work together to develop shared care plans. Also presenting were Deb Greene and Matt Tryhorne from Northern Tier Centers for Health (the FQHC in Northwestern Vermont), who spoke about coordinating care with their local community mental health center. **Pilot Community Updates:** Laural Ruggles and Lisa Viles from St. Johnsbury – Laural commended the Learning Collaborative format, with teams from various communities working on similar efforts using a rapid cycle quality	

Agenda Item	Discussion	Next Steps
	improvement model. St Johnsbury's objectives are similar to the DLTSS model of care – identify a lead point of contact, develop a shared care plan that is patient centered. Their team includes representation from AHS, mental health, the hospital, home health, the Area Agency on Aging, FQHCs, Rural Edge (SASH) and DVHA's VCCI program. The project is focusing on the dual eligible population; the participating organizations have identified 25 at-risk people for initial intervention. Lead Care Coordinators have been tentatively chosen, recognizing that this may change over time, depending on the person's wishes. St. Johnsbury has developed a template for a draft shared care plan that includes treatment goals and the person's goals. They are also using "Camden Cards" (named for the Camden Coalition of Healthcare Providers that developed these cards and presented them at the January learning session), a patient engagement tool. Each card represents a care management domain to help identify root causes of health issues. Q: Is the group using a survey to help measure patient experience? A: There is concern that surveys are burdensome; the plan is to use focus groups and interviews to measure patient experience. A comment was made that there can be challenges in translating those methods into measurement. Laural noted that a grant program for the dual eligible population in St. Johnsbury uses a health coach assessment tool that evaluates progress in various care domains with a rating scale. The tool was designed with CDC input. Deb Andrews from Burlington – Burlington has engaged 3 primary care practices and 17 organizations in the learning collaborative. Their initial cohort includes people with 3 or more ED visits in 2014, provider recommendation, and patient consent. They are relying on a trusted relationship between the person and a provider to garner participation, using talking points rather than a script. Following guidance from the March learning session, they are identifying the person's trusted provider as the lead case manager. They plan to develop eco-maps of relationships and services for each person, and have subgroups working on shared care plans. They are working on ability to share and edit documents between organizations, maybe through PRISM. They are considering adding organizations, including faith-based, school-based, social and environmental support organizations. Q: With respect to eco-maps – are characteristics and services other than clinical characteristics and services identified? A: Yes, the eco-maps are intended to establish as much information about the person as possible – with identification of factors that might impact any aspect of their health, and identification of all providers/organizations working with patients. Nancy Abernathey presented for Rutland - Their cohort is 25 at-risk people, based on ED and inpatient visits. They are initiating outreach with 5 of the most at-risk people. They have discovered that that how you approach people matters. The better the description or the program, the better the participation, so they are using talking points and allied care partners who work with the patients in various settings. They are also creating Camden Cards for person engagement and have a draft shared plan of care to be piloted soon. The Rutland team is comprised of a wide variety of participants, including representatives from home health, the hospital, the mental health agency, social work, the FQHC, area agency on aging, and skilled nursing facilities. They are working on sharing information electronically.	

Agenda Item	Discussion	Next Steps
	Upcoming Activities: A webinar is scheduled for April 15, and the next in-person learning session is May 19th at Norwich University. Jeanne McAllister from the University of Indiana will present information on shared care plans, care management rounds and care conferencing. **Learning Collaborative Expansion Proposal:** The goals of the Learning Collaborative are focused on priorities identified by the CMCM work group: 1) To reduce fragmentation with better coordination of care management 2) To better integrate health and social services to address social determinants of health The first round with 3 pilot communities is going well. There are plans to develop core competency training for front line care managers, with plans to work with the DLTSS work group to ensure that the training includes competencies for working with people with disabilities. Some funding is available through SIM to expand the Learning Collaborative to additional cohorts of interested communities. There should be opportunities to achieve economies of scale and leverage available resources, such as quality improvement facilitators from the first round, and possibly the Blueprint and ACOs. Round 1 funding was approved at up to $300,000 and the program is on target to spend that. The estimate to expand to the rest of the state is a total not to exceed $300,000, which would cover a third QI facilitator, expert faculty fees and travel expenses, facility costs, supplies, and logistical support services. An additional $200,000 would cover a train-the-trainer approach to implement Core Competency training for front-line care managers. Organization(s) with training expertise would work with Vermont-based trainers, to build capacity for ongoing training. The total estimate for the expansion is $500,000. The goal is to begin the expansion by June of 2015, in cohorts of 3 or 4 interested communities. It was noted that there are differences in participation between communities; they are coming from different places in terms of readiness. Some have already started this work in some form, some started from ground zero. Nancy Breiden commented that she hopes that lessons learned can be incorporated as this program moves forward. There was a question about the source of funding for the expansion. The DLTSS workgroup was informed that $350,000 was available; Julie Wasserman asked if this proposal intended to use that money or if separate funding was available for DLTSS. The response is that this is funding that was allocated to the CMCM Work Group for use in creating the Learning Collaborative Program, with guidance to coordinate with the DLTSS Work Group. This funding is not tied to carry over from prior years of the SIM grant. Q: Beverly Boget asked if the expansion funding would be used for Round 1 expenses. A: No. The original $300,000 is for Round 1, and will cover expenses for the initial 3-community pilot, into early 2016.	

Agenda Item	Discussion	Next Steps
	Nancy Eldridge asked if a member would like to make a motion recommending expansion contingent upon collaboration with the DLTSS workgroup. Laural Ruggles made the motion; Bea Grause seconded the motion. Sue Aranoff asked about learning collaborative topics and the extent to which the DLTSS Work Group would be able to weigh in on content of the program. Erin Flynn responded that the program expansion is looking at the same interventions that are occurring in Round 1, with a focus on the specific needs of additional communities that decide to participate. Jenney Samuelson noted that initial discussions of core competency training have involved DLTSS Work Group leadership. DLTSS leadership was invited to provide a representative to the learning collaborative planning group. The intervention topics coincide with elements from the DLTSS model of care (e.g., lead care coordinator, shared plan of care). The DLTSS model of care was used as a source document when creating the program. A roll call vote was taken on the motion – which carried with one No vote and two Abstentions.	
6. Population Health Update	Tracy Dolan, Co-Chair of the Population Health Work Group, presented from Attachments 5a, 5b and 5c, included in the meeting materials. The Population Health Workgroup is charged with recommending ways to improve health, and developing a Population Health Plan; the latter was a requirement added to the SIM project by CMMI last year. Specifically, the Work Group is striving to: • 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 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 integrating 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." From page 29 of the materials, Tracy reviewed the "Signs of Successful Integration of Population Health in New Models." Page 31 of the materials provides more information and a comparison of three different structures that integrate population health into a health care system: ACOs, Total Accountable Care Organizations (TACOs), and Accountable Communities for Health (ACHs). Page 34 of the materials defines the essential characteristics of an ACH. The Population Health Work Group has contracted with the Prevention Institute to help think through what an ACH might	

Agenda Item	Discussion	Next Steps
	look like in VT. The intent is to build on structures that already exist, and also to explore what structures might be effective in building and supporting an ACH in VT. They are looking at national models – Scotland might be closer to the ACH model under consideration, as well as the Netherlands, where there is a lot of care coordination and broad budget categories that encompass many of these kinds of activities. Laural Ruggles commented that St. Johnsbury is interested in developing an ACH – they are considering making their Blueprint-ACO Unified Community Collaborative (UCC) accountable across all health care and socio-economic domains. St. Johnsbury, St. Albans and Burlington were chosen by the Prevention Institute as focus communities in a case study model; one goal is to explore what they are already doing. Q: How will Next Generation ACOs fit in with this? A: Tracy responded that financial rewards for individual participation seem to be less important than financial rewards for population health improvement. Laural Ruggles noted that global budgets are a good way to incent this kind of activity. CMS is coming out with models transitioning Medicare from fee-for-service payment to capitation or other value-based payments. Q: Does this work intersect with the learning collaborative and ACO-Blueprint collaborative efforts? A: Jenney Samuelson differentiated between the various efforts discussed at the meeting: As an example, the St. Johnsbury UCC is the group that identified high-level health goals. The Learning Collaborative focuses on on-the-ground, specific care management efforts for at-risk members of the population, whereas the UCCs focus on higher level priorities. There was a comment that it is important to note the difference in discussing these efforts in the mental health arena, versus in the clinical setting, as they are very different cultures. It would be important to ensure that mental health considerations are included in the process. Mental health agencies are recommended to be part of the UCC leadership group. The learning collaborative envisions that a mental health agency staff member could serve as the lead care coordinator if the mental health agency is central to the person's needs.	
6. Public Comment	In response to a question, it was clarified that there was no Attachment 4b for today's discussion of the Learning Collaborative Expansion.	
8. Next Steps, Future Meeting	**Next Meeting:** Tuesday, April 14, 2015, 10:30 am – 12:30 pm, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, call-In number: 1-877-273-4202, Conference ID: 2252454	

VHCIP CMCM Work Group Member List

Roll Call: 3/23/2015

Sue Aranoff 1°
Nancy Breiden 2°

Laurel Ruggles 1°
Bea Grause - 2°
motion carried
1-N
2 Abstentions

Member			Member Alternate		Minutes	LC Expansion	
First Name	Last Name		First Name	Last Name			Organization
Susan	Aranoff	✓	Sara	Lane	Y	Y	AHS - DAIL
Nancy	Breiden	✓	Rachel	Seelig	Y	N	VLA/Disability Law Project
Dr. Dee	Burroughs-Biron		Trudee	Ettlinger			AHS - DOC
Barbara	Cimaglio						AHS - VDH
Peter	Cobb		Beverly	✓ Boget	Y	A	VNAs of Vermont
Dana	Demartino						Central Vermont Medical Center
Nancy	Eldridge	✓			A	Y	Cathedral Square and SASH Program
Joyce	Gallimore						CHAC
Eileen	Girling	✓ ✓	Heather	Bollman	Y	Y	AHS - DVHA
Bea	Grause	✓			Y	Y	Vermont Association of Hospital and Health Systems
Dale	Hackett	LTA					None
Linda	Johnson	✓	Cameron	Erickson			MVP Health Care
Pat	Jones	✓	Richard	Slusky	Y	Y	GMCB
Trinka	Kerr		Julia	Shaw			VLA/Health Care Advocate Project
Patricia	Launer	✓	Joyce	Gallimore	A	Y	Bi-State Primary Care
Vicki	Loner	✓	Maura	Crandall	Y	Y	OneCare Vermont
Madeleine	Mongan	✓			A	O	Vermont Medical Society
Judy	Morton	✓			Y	A	Mountain View Center
Mary	Moulton						Washington County Mental Health Services Inc.
Paul	Reiss	✓	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Laural	Ruggles	✓			Y	Y	Northeastern Vermont Regional Hospital
~~Ken~~	~~Schatz~~						AHS - DCF
Catherine	Simonson						DA - HowardCenter for Mental Health
Patricia	Singer						AHS - DMH
Shawn	Skafelstad	✓	Lily	Sojourner	Y	Y	AHS - CO
Audrey-Ann	Spence		~~Robert~~ Amy	~~Wheeler~~ Duchaine	Y	Y	Blue Cross Blue Shield of Vermont
Jason	Wolstenholme		Jessica	Oski			Vermont Chiropractic Association
Lisa	Viles	✓			A	Y	Area Agency on Aging for Northeastern Vermont
	28			13			

Lily Sojourner voting member AHS

Minutes approved
4 Abstentions

VHCIP CMCM Work Group Participant List

Attendance: 3/23/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Care Models
Peter	Albert	here	Blue Cross Blue Shield of Vermont	X
Susan	Aranoff	here	AHS - DAIL	S/M
Ena	Backus		GMCB	X
Melissa	Bailey	here		X
Michael	Bailit	Phone	SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Susan	Besio		SOV Consultant - Pacific Health Policy Group	S
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
Beverly	Boget	Phone	VNAs of Vermont	MA
Heather	Bollman		AHS - DVHA	MA
Mary Lou	Bolt		Rutland Regional Medical Center	X
Nancy	Breiden	here	VLA/Disability Law Project	M
Stephen	Broer		DA - Northwest Counseling and Support Services	X
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Anne	Burmeister		Planned Parenthood of Northern New England	X

Deb Andrews - HC Burlington

~~Claire McFadden~~

~~Mary Tracy~~

Dr. Dee	Burroughs-Biron		AHS - DOC	M
Jane	Catton		Northwestern Medical Center	X
Amanda	Ciecior		AHS - DVHA	S
Barbara	Cimaglio		AHS - VDH	M
Peter	Cobb		VNAs of Vermont	M
Amy	Coonradt		AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Maura	Crandall		OneCare Vermont	MA
Claire	Crisman		Planned Parenthood of Northern New England	A
Dana	Demartino		Central Vermont Medical Center	M
Steve	Dickens		AHS - DAIL	X
Nancy	Eldridge	here	Cathedral Square and SASH Program	C/M
Cameron	Erickson		MVP Health Care	MA
Trudee	Ettlinger		AHS - DOC	MA
Erin	Flynn	here	AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Meagan	Gallagher		Planned Parenthood of Northern New England	X
Joyce	Gallimore		Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Eileen	Girling	here	AHS - DVHA	M
Kelly	Gordon		AHS - DVHA	X
Bea	Grause	here	Vermont Association of Hospital and Health Systems	C/M
Dale	Hackett	excused	None	M
Bryan	Hallett		GMCB	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Breena	Holmes		AHS - Central Office - IFS	X
Marge	Houy	here	SOV Consultant - Bailit-Health Purchasing	S
Christine	Hughes		SOV Consultant - Bailit-Health Purchasing	S
Jay	Hughes		Medicity	X
Linda	Johnson		MVP Health Care	M
Pat	Jones	here	GMCB	S/M
Joelle	Judge	here	UMASS	S

Trinka	Kerr		VLA/Health Care Advocate Project	M
Sarah	Kinsler	here		S
Sara	Lane		AHS - DAIL	MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer	phone	Bi-State Primary Care	M
Deborah	Lisi-Baker		SOV - Consultant	X
Vicki	Loner	phone	OneCare Vermont	M
Georgia	Maheras	here	AOA	S
Mike	Maslack			X
John	Matulis			X
James	Mauro		Blue Cross Blue Shield of Vermont	X
Clare	McFadden	phone	AHS - DAIL	X
Elise	McKenna		AHS - DVHA - Blueprint	X
Jill	McKenzie			X
Jeanne	McLaughlin		VNAs of Vermont	X
Darcy	McPherson		AHS - DVHA	A
Madeleine	Mongan	phone	Vermont Medical Society	M
Monika	Morse			X
Judy	Morton	phone	Mountain View Center	M
Mary	Moulton		Washington County Mental Health Services Inc.	M
Kirsten	Murphy		AHS - Central Office - DDC	X
Reeva	Murphy		AHS - Central Office - IFS	X
Sarah	Narkewicz		Rutland Regional Medical Center	X
Jessica	Oski		Vermont Chiropractic Association	MA
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Betty	Rambur		GMCB	X
Allan	Ramsay		GMCB	X
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Debra	Repice		MVP Health Care	X
Julie	Riffon		North Country Hospital	X
Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson	here	AHS - DVHA - Blueprint	X
Jessica	Sattler		Accountable Care Transitions, Inc.	X
~~Ken~~	~~Schatz~~		~~AHS - DCF~~	M

Rachel	Seelig		VLA/Senior Citizens Law Project	MA
Maureen	Shattuck		Springfield Medical Care Systems	X
Julia	Shaw		VLA/Health Care Advocate Project	MA
Catherine	Simonson		DA - HowardCenter for Mental Health	M
Tom	Simpatico		AHS - DVHA	X
Patricia	Singer		AHS - DMH	M
Shawn	Skaflestad	Phone	AHS - Central Office	X
Richard	Slusky		GMCB	S/MA
Pam	Smart		Northern Vermont Regional Hospital	X
Lily	Sojourner	here	AHS - Central Office	X
Audrey-Ann	Spence	Amy Duscharme	Blue Cross Blue Shield of Vermont	M
Kara	Suter		AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Win	Turner			X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Julie	Wasserman	here	AHS - Central Office	S
Bob	West			X
James	Westrich		AHS - DVHA	S
Robert	Wheeler		Blue Cross Blue Shield of Vermont	MA
Bradley	Wilhelm		AHS - DVHA	S
Jason	Wolstenholme		Vermont Chiropractic Association	M
Cecelia	Wu		AHS - DVHA	S
Mark	Young			X
Lisa	Viles	here	Area Agency on Aging for Northeastern Vermont	M
				108

Nancy Abernathy - LC facilitator here

Sarah ~~Dewberger~~ - NWMC
Jewley

Attachment 2

Regional Blueprint and ACO Committee Update

Health Service Area	Regional Meeting Name	Charter	Consumer	Priority areas of focus	Other Attendees
Bennington	Bennington Regional Clinical Performance Committee	✓	✓	ED Utilization Transitions of Care CHF	BP, SNF, HHA, DA, community private practices, SVMC
Berlin	Community Alliance for Healthcare Excellence (CAHCE)	✓	Under discussion	Care Coordination CHF	CVMC, CVHH, WCMH, VDH, SNF, community transport, CHAC
Brattleboro	Health Reform Steering Committee oversees UC/RCPC	✓		High risk patients Hospice utilization	BMH, BP, HHA, SNF, DA. Thinking about adding Retreat
Burlington	Chittenden County Regional Clinical Performance Committee	✓	Under discussion	**Improving care coordination learning collaborative**	UVM MC, Health First, CHC B, HHA, DA, housing organizations, DAIL, VDH,
Middlebury	Community Health Action Team (CHAT)	Working on		Under discussion	Porter, BP, HHA, DA, CHAC
Morrisville	UCC	✓		30 day all-cause readmissions High Risk patient lists	Copley, CHAC, BP, DA, SNF
Newport	UCC/RCPC	Working on		CHF	North Country Hospital ,BP, HHA
Randolph	UCC/RCPC	Working on it		Under discussion	
Rutland	UCC/RCPC	✓		COPD CHF Transition of care **Improving care coordination learning collaborative**	RRMC,BP, SNF, CHAC, HHA, DA
Springfield	UCC/RCPC	Working on it		Falls risk assessments	HHA, Every practice in the Springfield health system
St. Albans	RCPC	✓		CHF admissions ED utilization 30 day all-cause readmissions	NWMC, VDH, Franklin County Rehab, CHAC, DA, HHA, BP

				Hospice utilization	
St. Johnsbury	The A Team	✓		**Improving care coordination learning collaborative**	NVRH, FQHC, United Way, BAART, Housing organization, food security organization, BP
Townshend	RCPC	✓		Diabetes	Grace Cottage, BP, considering adding more members
Windsor	UCC	Working on it		ED use COPD	Mt. Ascutney, BP, HHA, DA

CVMC Project 2014

1. Used prospective risk scoring modeling that includes demographic information, age, gender, utilization, spend, diagnoses, 70 some odd "secret sauce" predictors. This is a proprietary model.
2. Ranks from 1-100
3. High risk 95-100
4. Reviewed top 20 patients to find costs (> 1 million)
5. The average age 75. There were 8 men and 12 women. 13 of these 20 patients had at least 1 inpatient admission, average number ED visits was 7 per year. Average number of 30 day readmits was 1.3
6. 8/20 patients saw PCP **3 times or less** in one year
7. 7 saw PCP 8 times or more in one year
8. 6/20 patients had "Follow up as needed"
9. 2/10 patients had contact with CHT

What they are doing: Pilot program components (literature review):

a. Increased management of care transitions

b. Close interaction between care coordinators and PCPs

c. At least one in-person contact/month by care manager

d. PCP aware of patient's risk

e. Self-management including intense education on medication adherence

f. Depression screening

Attachment 3

Learning Collaborative Expansion

Vermont's Integrated Communities Care Management Learning Collaborative:

Round 1 Progress, and Request for Expansion

April 14, 2015

Background

- The VHCIP Care Models and Care Management Work Group identified two key priorities:
  - …to better serve all Vermonters (especially those with complex physical and/or mental health needs), **reduce fragmentation with better coordination of care management activities**…
  - …[to] better **integrate social services and health care services** in order to more effectively understand and address **social determinants of health** (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters…

- The Work Group designated a Planning Group to design a Quality Improvement Learning Collaborative to act on these priorities.

- The Work Group and Steering Committee recommended funding for the Learning Collaborative; the Core Team approved that recommendation.

Learning Collaborative Snapshot

- Vermont's delivery system reforms have strengthened coordination of care and services, but people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services.
- A number of national models have potential to address these concerns.
- **Health and community service providers from 3 health service areas (Burlington, Rutland, St. Johnsbury) were invited to participate in Round 1 of the year-long Integrated Communities Care Management Learning Collaborative to test interventions from these promising models.**

Near-Term Goals

- To increase knowledge of data sources and use data to identify at-risk people and understand their needs;
- To learn about and implement promising interventions to better integrate care management;
- To improve communication between organizations;
- To systematize referrals, transitions and co-management
- To provide tools and training for staff members who engage in care management; and
- To see if interventions improve coordination of care.

4

Longer-Term Goals

- Longer-term goals mirror the Triple Aim and Vermont's Health Care Reform goals:
  - Improving the patient experience of care (including quality and satisfaction);
  - Improving the health of populations; and
  - Reducing the per capita cost of health care.

- While the Collaborative will initially focus on at-risk populations, the ultimate goal is to develop a population-wide approach.

How we will do it – Learning Model:

Pre-Work
(November 22nd - January 12th)

The Learning Collaborative will use the Plan-Do-Study-Act (PDSA) quality improvement model.

Learning Session I
(Teams gather for a face-to-face meeting)
(January 13th)

Action Period
community teams working together to implement change)

(January 14th - March 9th)

Learning Session II
(Teams gather for a face-to-face meeting)
(March 10th)

Action Period
community teams working together to implement change)

(March 11th - May 18th)

Learning Session III
(Teams gather for a face-to-face meeting)
(May 19th)

Spreading the Change

Round 1 Participants Include:

- Primary Care Practices participating in ACOs (care coordinators)
- Designated Mental Health Agencies and Developmental Services Providers
- Visiting Nurse Associations and Home Health Agencies
- Hospitals and Skilled Nursing Facilities
- Area Agencies on Aging
- Blueprint Community Health Teams and Practice Facilitators
- Support and Services at Home (SASH coordinators)
- ACOs (OneCare, CHAC)
- Medicaid's Vermont Chronic Care Initiative
- Commercial Insurers (BCBSVT)
- Agency of Human Services Staff

Round 1 Pilot Community Activities

1. Forming Integrated Community Teams to improve care management for at-risk people.

2. Identifying current care management services and needs in the community (including gaps in services).

3. Establishing criteria to define at-risk people; identifying people in need of integrated care management; conducting outreach to those people and their families.

4. Establishing more effective communication and integration between team members, including interventions such as establishing integrated care agreements, identifying lead care coordinators, developing shared care plans, conducting care conferences, and engaging in care management rounds.

5. Developing tools to enhance integrated care services, such as care coordination protocols, referral guidelines, and data resources.

6. Participating in shared learning opportunities, including in-person learning sessions, webinars, and skills training for front-line care managers.

7. Developing performance measures to evaluate success of the interventions; collecting, analyzing and reporting data for those measures.

Timeline for Round 1

- **Kick-Off Webinars were held on November 12 and 21:** Approximately 70 people attended
- **1st In-Person Learning Session was held on Jan. 13, 2015:** Approximately 90 people attended
- **Monthly Educational Webinars:** During months without in-person learning sessions
- **First Action/Measurement Period:** Jan.-Feb. 2015
- **2nd In-Person Learning Session was held on March 10, 2015**: Approximately 70 people attended
- **Second Action/Measurement Period:** March-April 2015
- **3rd In-Person Learning Session:** May 19, 2015
- **Third Action/Measurement Period:** May-June 2015
- **Continued Testing and Measurement:** July-Nov. 2015
- **Core Competency Training for Care Managers:** Sept. 2015-Jan. 2016
- **Final Results and Next Steps:** Jan. 2016

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Expansion Request

- Round 1 (Burlington, St. Johnsbury and Rutland) is well underway
- Other communities have initiated similar efforts and expressed interest in participation
- There is potential to leverage existing collaborative for other communities
- Skills training for front-line care managers planned for late 2015; initiating second round now could leverage train-the-trainer approach
- Seeking CMCM Work Group's endorsement of funding request for additional rounds, to allow expansion to all interested health service areas

Proposed Timeline for Round 2

- **Kick-Off Webinars:** May 2015
- **1st All-Day In-Person Learning Session:** June 2015
- **Monthly Webinars:** 1 hour (during months without in-person learning sessions)
- **First Action/Measurement Period:** June-Aug. 2015
- **2nd In-Person Learning Session**: September 2015
- **Second Action/Measurement Period:** Sept.-Oct. 2015
- **3rd In-Person Learning Session:** November 2015
- **Third Action/Measurement Period:** Nov.-Dec. 2015
- **Core Competency Training for Care Managers; Continued Testing and Measurement:** Jan.-June 2016
- **Final Results and Next Steps:** July 2016

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Estimated Budget for Rounds 2-4

- Anticipated economies of scale for quality improvement facilitators -- $100,000 in estimated costs for one additional facilitator
- Learning Session faculty costs (includes travel) estimated at $110,000 based on Round 1
- Core Competency Training costs estimated at $90,000 (includes Train-the-Trainer costs)
- Facility, logistical support, and supply costs estimated at $200,000
- Total request: $500,000 (not to exceed amount)

Questions/Discussion

Attachment 4

Area Agencies on Aging & Visiting Nurse Association

Coordinated Care Management

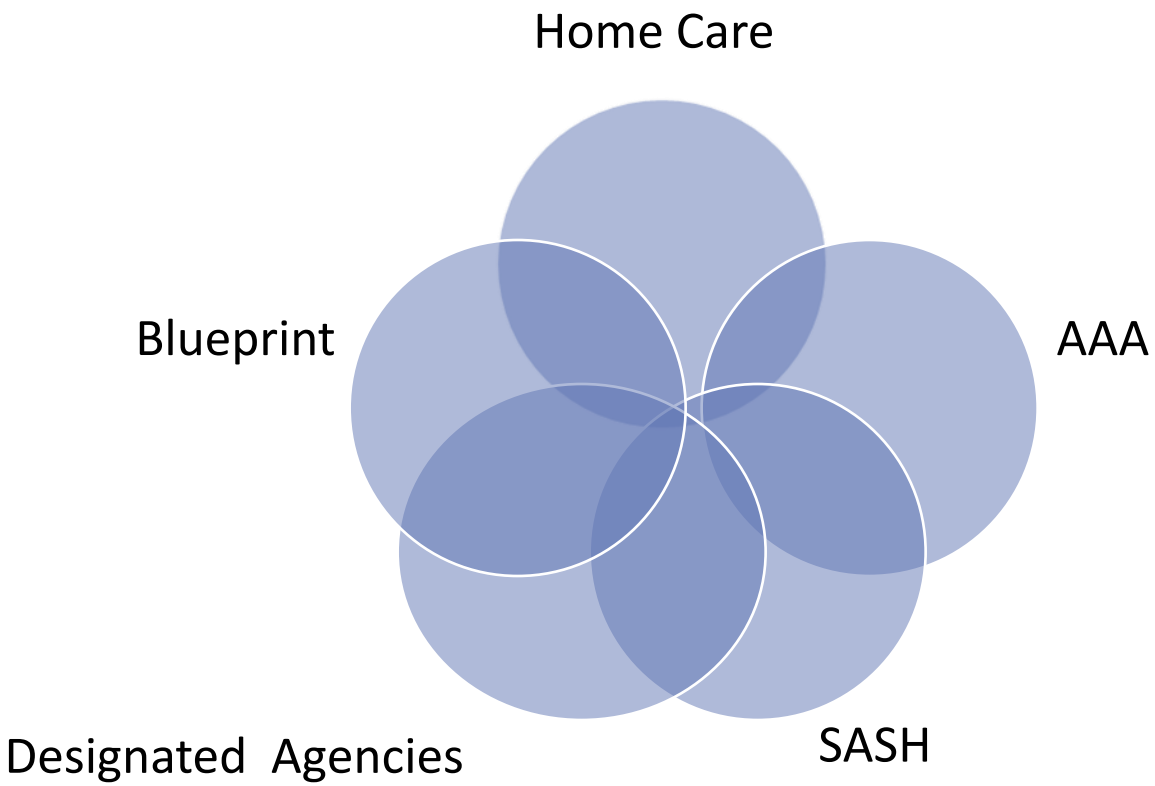
Area Agencies on Aging

Care Partners Network

VNAs of Vermont

April 14, 2015

Care Management Teams



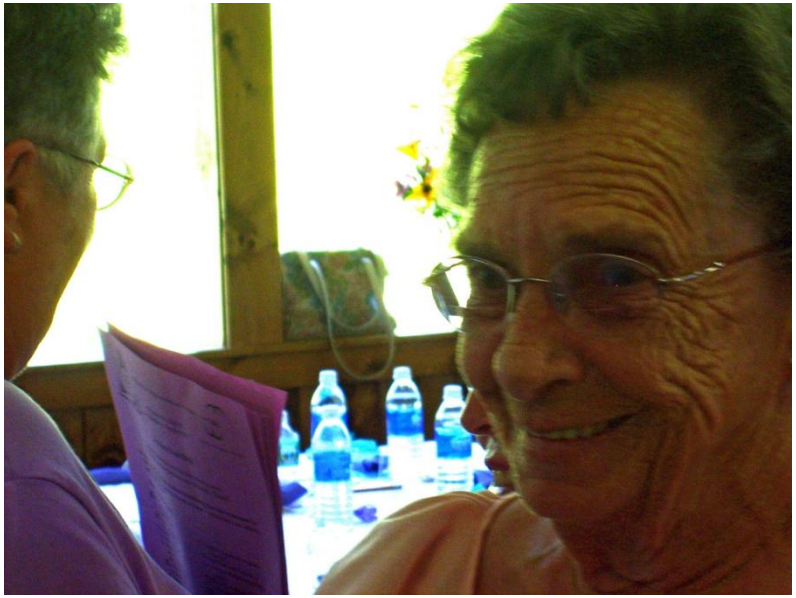
Vermont Area Agencies on Aging

Five non-profit agencies respond to the needs and directions of elders and their families by offering information and assistance in many areas affecting older adults, family caregivers, veterans and people with disabilities in Vermont.

Promoting the
Independence & Health of
Vermont Seniors & Their
Families for Over 40 Years

Programs and Services

- Family Caregiver Support
- Case Management
- Elder Care Clinician
- Senior Meals
- Exercise and Wellness Programs
- Transportation
- Assist in Applying for Benefits
- Volunteer Opportunities
- Health Insurance Counseling



Wellness and Prevention

- Assistance with transportation to assist with access to medical, wellness and nutrition need
- Dietary Counseling – chronic disease management
- Healthy Eating Programs
- Staff and volunteer training to deliver evidenced-based programs in the community
  - Growing Stronger
  - Tai Chi for Arthritis
  - Fall Prevention
  - Bone Builders

Person Centered

Community-connected . . .

Building on more than 40 years of experience and knowledge, the Agencies on Aging have developed strong partnerships and adapted to community needs.

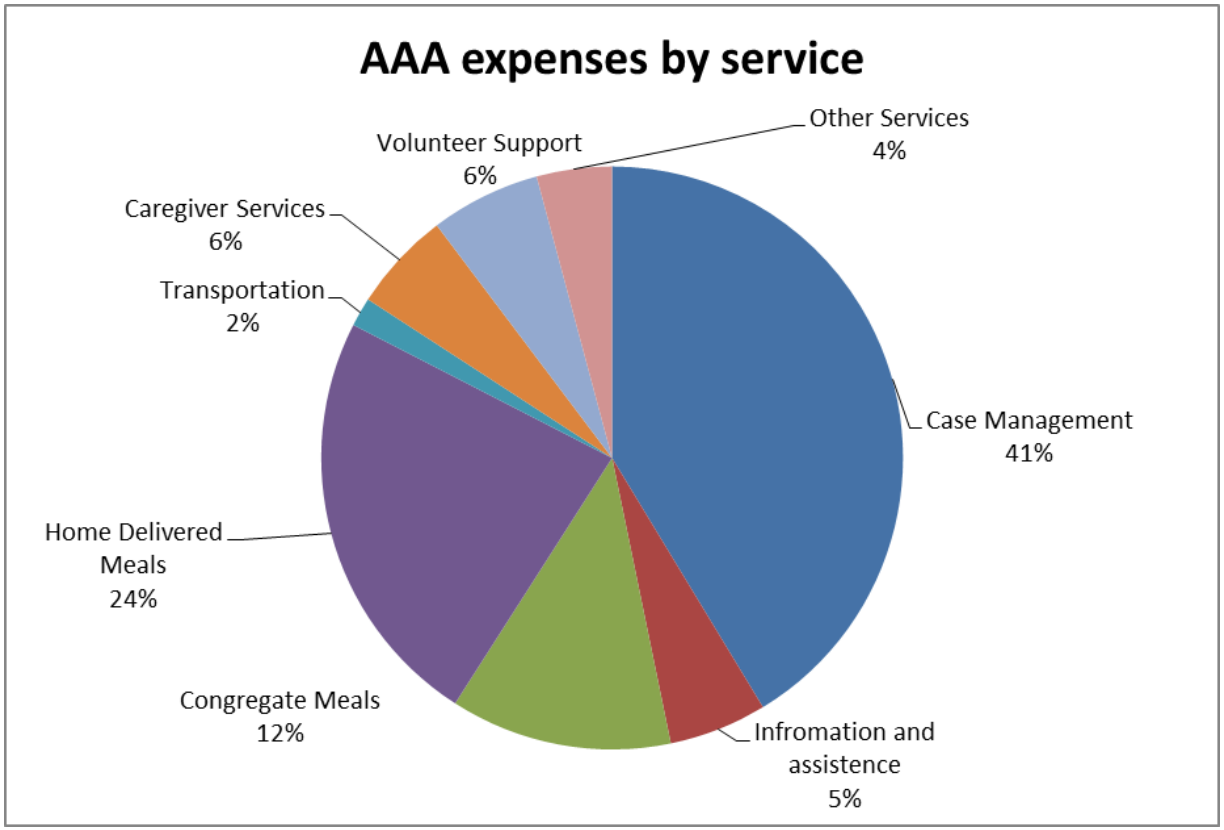
- Case Managers encourage independence by helping individuals access services and benefits that will enhance their quality of life. Case Managers empower their clients to make important decisions in their lives and support them in taking decisive action.

Cost Effective

- AAA services help Vermont elders and those under 60 who have long-term care needs to remain in their home, where they want to be.
- AAA services are cost-effective:
  - Cost of a year of home delivered meals less than $1,000
  - Cost of annual case management less than $1,000 per person.
  - The average cost of month in a nursing home $8,250
  - The average cost of a day in the hospital $3,000

AAA's work closely with local partners to identify community needs and address gaps.

Budget by program



Who the AAA's serve:

Unduplicated Clients for all services

- 45,102 Individuals

Case Management Services

- 8,773 individuals receive nearly 60,000 Hours

Nutrition and Social Connections

Home Delivered Meals

- 4,715 Vermonters received 775,369 meals in their home

Community Meals

- 10,657 elders received more than 380,000 meals in the community.

Other program services include:

50,000+ Calls answered annually by the statewide Senior HelpLine 1-800-642-5119.

State Health Insurance program (SHIP) - Trained Medicare specialists respond to more than 14,000 inquiries annually, providing assistance in navigating the complexities of the Medicare system, including deciphering and choosing Medicare plans and Medicare supplemental coverage, as well state supplemental programs.

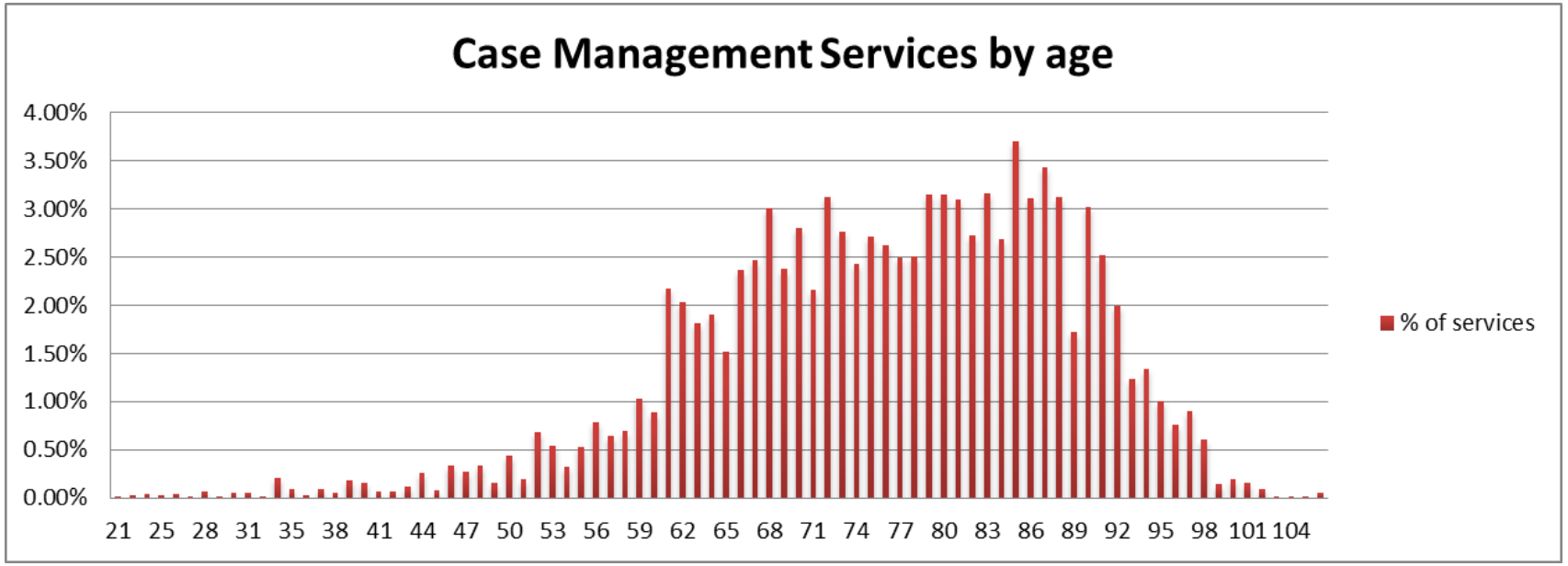
We Serve Veterans of all Ages

- Our Veterans Independence Program repays those who have served our country by completing a needs assessment and providing case management and service coordination for veterans eligible for long-term services & supports

Family Caregivers of all Ages

- Family Caregivers provide a critical link to keep individuals with chronic and terminal health conditions in the community. We provide support and respite grants to promote the health and well being of caregivers.

Aging Population



What works well?
Helping Vermonters make the link

The AAA network works closely with community partners to make home living possible

- ***providing a full spectrum of services,***
- ***supporting a network of family caregivers,***
- ***recruiting and supporting hundreds of volunteers, and***
- ***working with community partners.***

Collaboration & Interaction – Present

- VNAs
- Designated Agencies, esp. Behavioral Health
- SASH and other Interdisciplinary Teams
  (with VNAs, DAs, Senior Housing Sites, Cathedral Square et al)
- Primary Care physicians, Blueprint practices
- Hospitals & nursing facility discharge planners, Care Transition Teams
- ADRC partners (Aging & Disability Resource Centers)
- Community-based providers for nutrition services, transportation, senior centers
- RCHs & ERCs
- Community Action Programs

Collaboration & Interaction – Where We're Headed

- Increasing focus on prevention, wellness, risk mitigation -- stabilizing people in the community
- Difficult / impossible to age-in-place if you're not healthy
- Recognition that AAAs wraparound services (case management / care coordination, nutrition services, transportation, falls prevention, etc) essential to success of care transitions; avoiding hospitalization/institutionalization/readmits
- AAA services complement services and scope of other community-based providers (longitudinal)
- Collaboration / service integration will be critical
- Increasingly apparent that AAAs, VNAs, DAs & FQHCs have high degree of client overlap
- AAAs are addressing internal service integration between AAA programs (consolidating single software platform)
- While acknowledging existing collaboration / interactions with VNAs, DAs & FQHCs, SASH partner -- clear that these relationships need to be optimized
- Actively exploring closer / formalized collaborative relationships – joint case management / care coordination
- Reducing/preventing hospital/NF readmits; reducing chronic disease admits depend on coordinated care / case management

Designated and Specialized Service Agencies

Vermont Care Partners

Vermont Care Partners

VERMONT CARE PARTNERS (VCP) is a collaboration between the Vermont Council for Developmental and Mental Health Services and the Vermont Care Network. To support the sixteen Designated and Specialized Service Agencies.

- Together our mission is to provide statewide leadership for an integrated, high quality system of comprehensive services and supports. Our sixteen non-profit community-based member agencies offer care to Vermonters affected by developmental disabilities, mental health conditions and substance use disorders

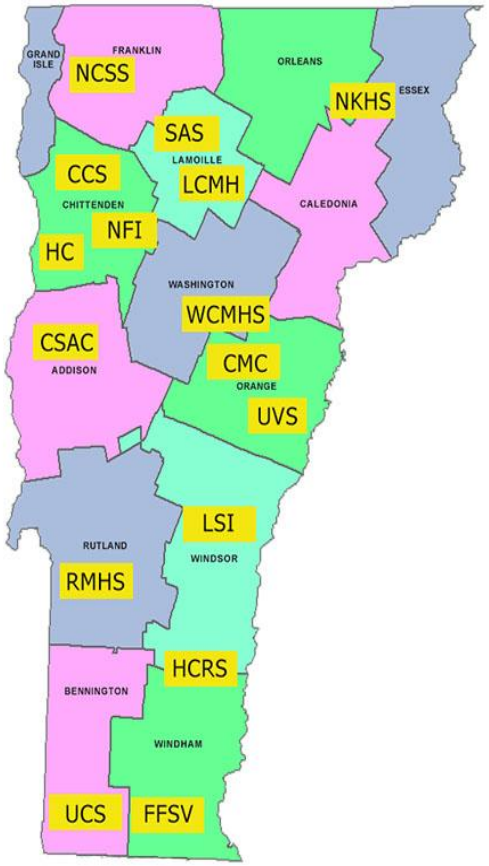
A STATEWIDE SYSTEM OF CARE IN VERMONT
DESIGNATED AND SPECIALIZED SERVICE AGENCIES

Designated Agencies

Clara Martin Center (MH only)
Counseling Services of Addison County
Health Care and Rehabilitation Services
HowardCenter
Lamoille Mental Health Services
Northwest Counseling and Support Services
Northeast Kingdom Human Services
Rutland Mental Health Services
United Counseling Services
Upper Valley Services (DS only)
Washington County Mental Heath Services

Specialized Service Agencies

Champlain Community Services (DS only)
Families First (DS only)
Lincoln Street Inc. (DS only)
Northeast Family Institute (MH youth only)
Sterling Area Services (DS only)

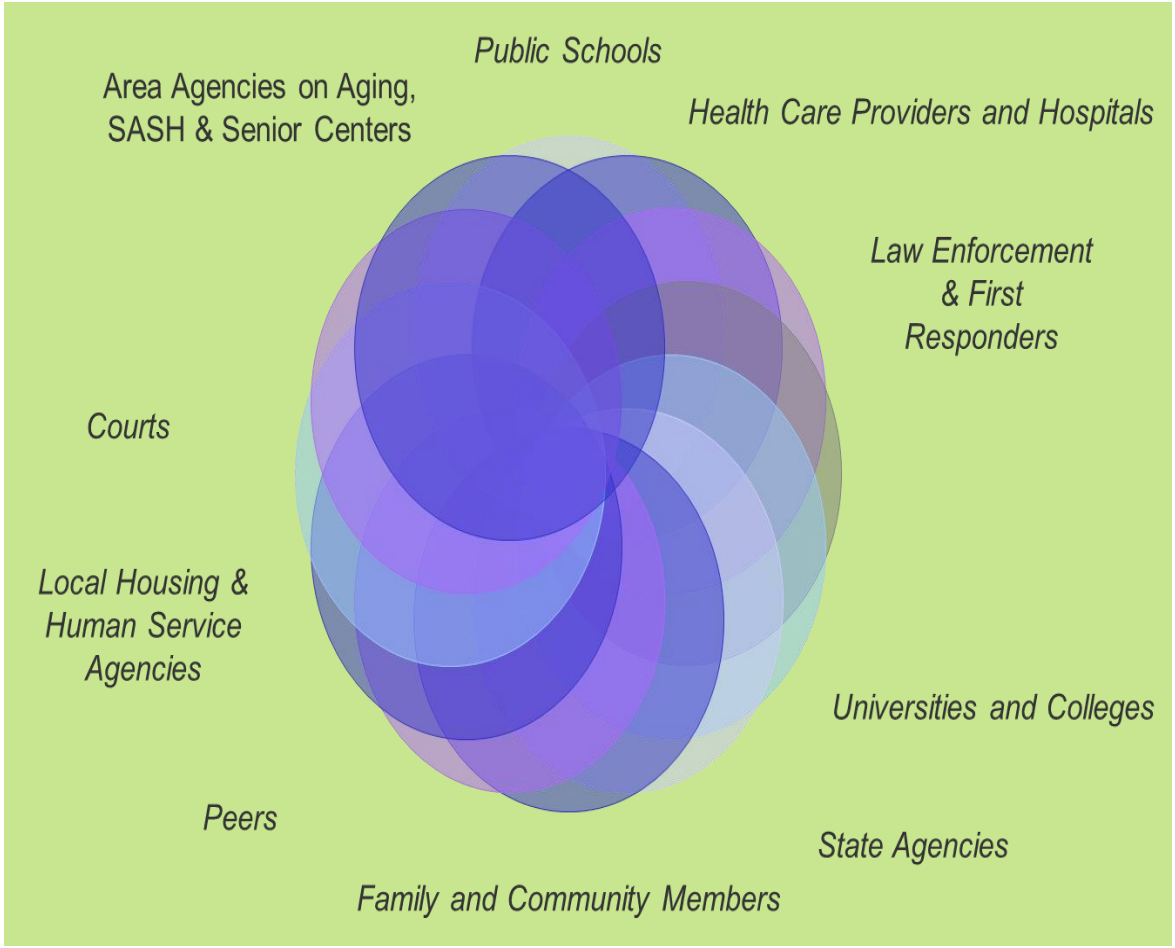


Core Functions: Designated and Specialized Service Agencies

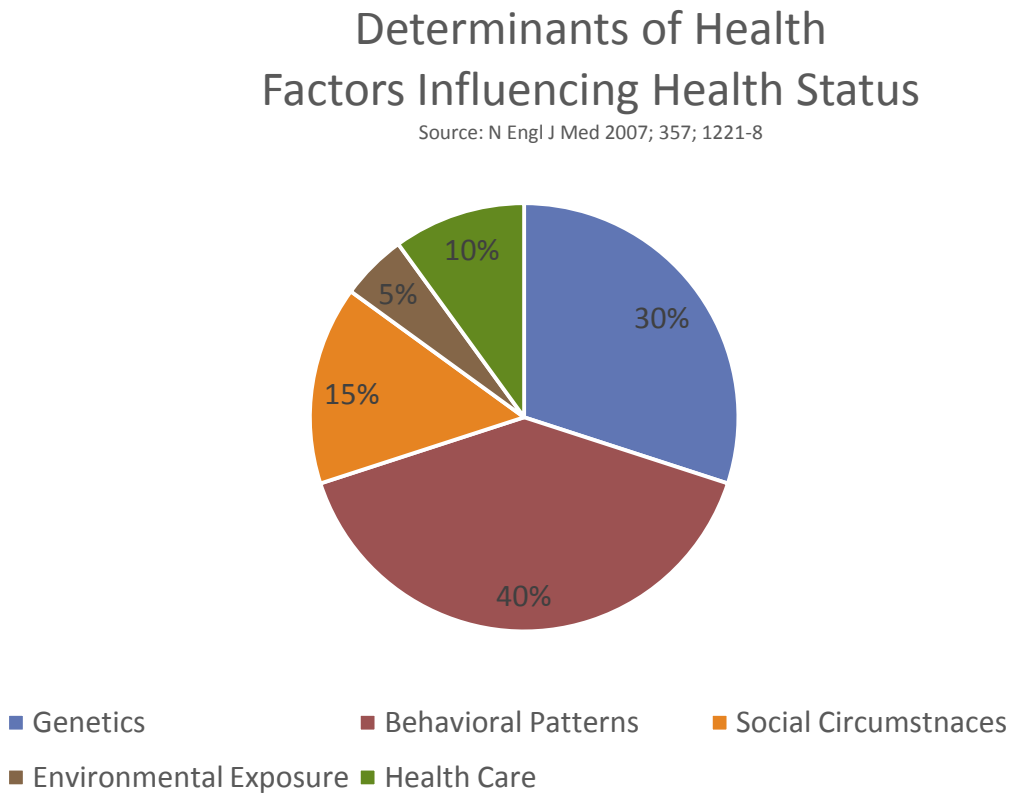
- Provide comprehensive mental health, developmental disability and substance abuse services through out the state
- Serve high needs mandated populations and crisis services to all with a no-reject policy
- Respond to the unique needs of communities
- Work in collaboration with health partners, schools, human services partners, and Blueprint Community Health Teams
- Maintain core competencies and standards of care

State Government Oversight and Funding Stream Complexity

We Work with Community Partners to Address the Social and Medical Determinants of Health



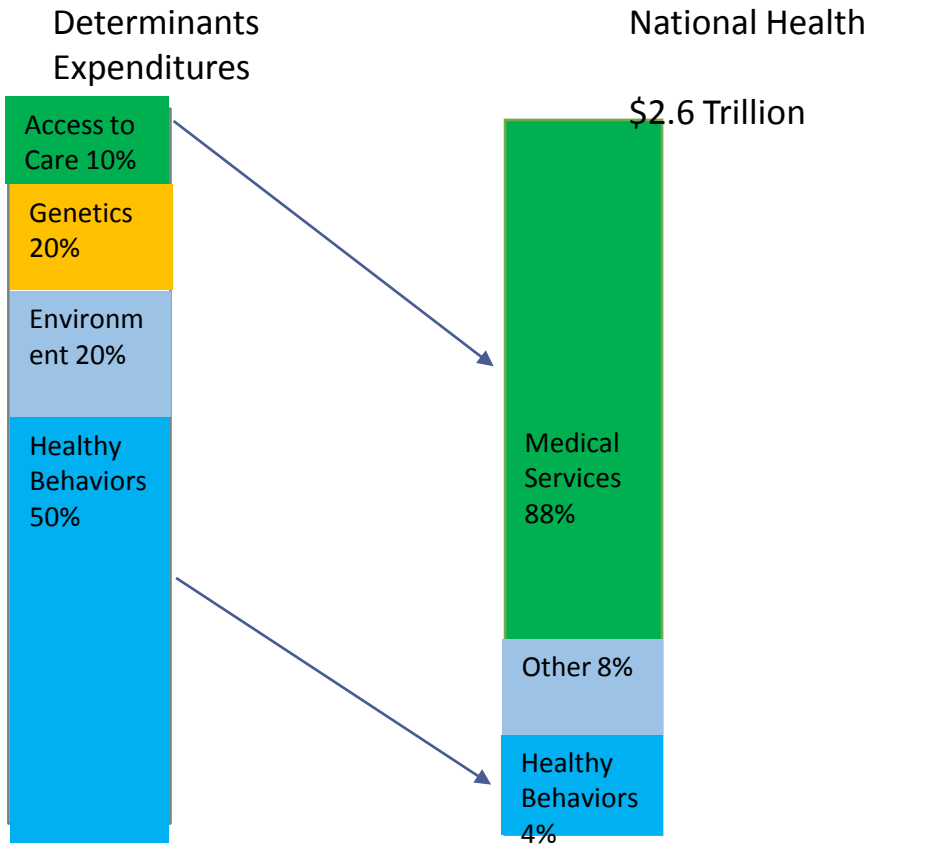
Social Determinants of Health



Spending Mismatch

Health Care and Other Key Determinants of Health

Source: NEHI 2012



How We Work With Community Partners

- When necessary establish a multi-disciplinary team to address needs, identify lead case manager and lead on identified goals and services
- Work collaboratively with other services being provided to our clients to assure delivery of a coordinated care plan
- Facilitate the Local Interagency Teams for children, youth and families to establish a coordinated service plan
- Participate in the Local Interagency Teams for adults to with complex situations
- Identify community needs and work with state and community partners to address

What is Working Well - Our Part in Health Care Reform

- Addressing the social determinants of health which is vital to the overall health of individuals, long term health outcomes and more immediate health care costs
- Addressing family systems and working on prevention and early intervention supports in order for children to be successful in school
- Treating mental health and substance use disorders and supporting people with long-term developmental needs
- Working with primary care providers to address mental health, substance use and developmental disabilities as soon as they are identified
- Providing community crisis response for individual and if there is a community crisis, to an entire catchment area
- Working with our other community partners on shared cases to assure efficient and effective use of resources

Changing Health Outcomes – Data

Highlights of the outcomes we achieved in FY14 and will continue to work on:

Decrease in psychiatric inpatient bed days and readmissions
- 27% decrease in hospital beds used between FY11 and FY14
- reduced readmissions from 13% to 8%

Compared nationally we reach more people per 1,000
- 22.1 national avg.; 39.3 VT avg.

A large percentage of Children and families report improvement at discharge
- 67% reported improvement at discharge

Clients we serve with developmental disabilities were employed
- 48% employed

Clients with substance use disorders improved
- 42% improved on discharge

The Work Today and in the Future

Each community partner will continue to share our expertise and work together to improve the lives of Vermonters and participate in the Unified Community Collaboratives to develop the most effective and efficient health care system in each community and state-wide.

Home Care & Hospice

Home Health & Hospice Care

What is Home Health and Hospice Care? Home health care and hospice are health and related services provided in the patient's home.

- Home care services are provided by Medicare-certified Home Health Agencies.
- There are 11 Medicare-certified home care agencies in Vermont, 10 are not-for-profit agencies and one is a for-profit agency.
- Home care is patient-centered and evidence-based.
- Home health services are essential to a truly integrated health care system.
- More than 23,000 Vermonters receive home visits each year.
- Nearly one million home visits are made each year.
- On any given day, more patients are served by Vermont's home health agencies than are inpatients in Vermont's 14 hospitals.

Addison County Home Health & Hospice

Caledonia Home Health & Hospice

Central Vermont Home Health & Hospice

Franklin County Home Health Agency

Lamoille Home Health & Hospice

Manchester Health Services, Inc.

Orleans Essex VNA & Hospice

Rutland Area VNA & Hospice

- Dorset Area VNA & Hospice
- VNA & Hospice of the Southwestern Region

VNA of Chittenden & Grand Isle Counties

VNA & Hospice for VT/NH

Home Health & Hospice

- Vermont's 11 home care agencies made 946,795 home visits in FY 2013
- 2,600 visits every
- Total in-home service hours in 2013 - 2,011, 309.
- 5,500 in-home hours per day

vnas of Vermont
Your Nonprofit
Home Health & Hospice Agencies

Home Health & Hospice Care

What is Home Health Care? Home health and hospice care are health and related services provided in the patient's home. Services include:

Nursing

Home Health Aide

Physical, Speech and Occupational Therapy

Medical Social Services

Hospice

Maternal Child Health

Care Management

Personal Care Attendant

Other related services such as homemaking, nutrition counseling, medical supplies and equipment, laboratory services, health promotion, telemonitoring, nutrition counseling, bereavement support, and more.

VNAs of Vermont
Your Nonprofit
Home Health & Hospice Agencies

Home Care Across Care Continuum

Prevention and Wellness	Acute Cate	Chronic and Long Term Care	End-of-Life Care
Immunizations & Vaccinations	Nursing and Therapy Service	Nursing and Therapy Services	Palliative Care
Health Screening Services	Personal Care	Personal Care & Homemaker Services	Hospice Care
Wellness Nursing in Senior Housing	Care Management	Care Management	Bereavement Services
Support for At-risk Families	Referrals to Community Resources	Referrals to Community Resources	Respite House
Parenting Education and Support	Social & Emotional Support	Social and Emotional Support	
Family Caregiver Support	Telemonitoring	Telemonitoring	
	Prenatal and Post-natal Care		

Challenges

- **Data Sharing -** Community-based providers need the ability to share and receive relevant patient-specific data electronically with physicians, hospital, nursing homes. This would increase efficiency and improve the quality of the care delivered.
- **Duplication -** A patient could receive care management services from a several providers.
- **No Wrong Door vs. Single Point of Contact** - A single point of entry is not needed. What is needed, however, is a system that provides "no wrong door" for anyone seeking care. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the Area Agency of Aging, the home care staff must have the knowledge and ability to arrange for the services needed. This can be achieved by Care Resource Teams which would include representatives from a variety of providers.

Opportunities

- Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) to coordinate care management activities, strengthen Vermont's community health system infrastructure, and help the three provider networks meet their organization goals.
- The UCCs would provide a forum for organizing the way in which medical, social, and long term service providers' work together to achieve the stated goals.
- The UCCs would develop and adopt plans for improving
  - quality of health services
  - coordination across service sectors
  - access to health services

VNAs of Vermont
Your Nonprofit
Home Health & Hospice Agencies

Vermont Care Partners

Vermont Association of Area Agencies on Aging

Helping Vermonters Age with Independence and Dignity

Attachment 5

Payment Reform Update

Understanding Payment Reform in Vermont

CMCM WORKGROUP APRIL 14, 2015
2015

Payment Reform Questions

Why the drive for payment reform?

Whose payments are changing?

What's the time-line for payment reform?

Will all payers collaborate to change payments simultaneously?

What should providers and consumers pay attention to with impending changes?

Why The Drive For Payment Reform?

- Improve care, lower costs
- Limit federal/state liability for entitlement programs
- Increase the reliability of care delivered
- Avoid overtreatment without under-treatment
- Not a phase – momentum just building

Whose Payments Are Changing?

Volume

Value

Whose Payments Are Changing?

Hospitals – SSP, Bundled payments, VBP, full capitation

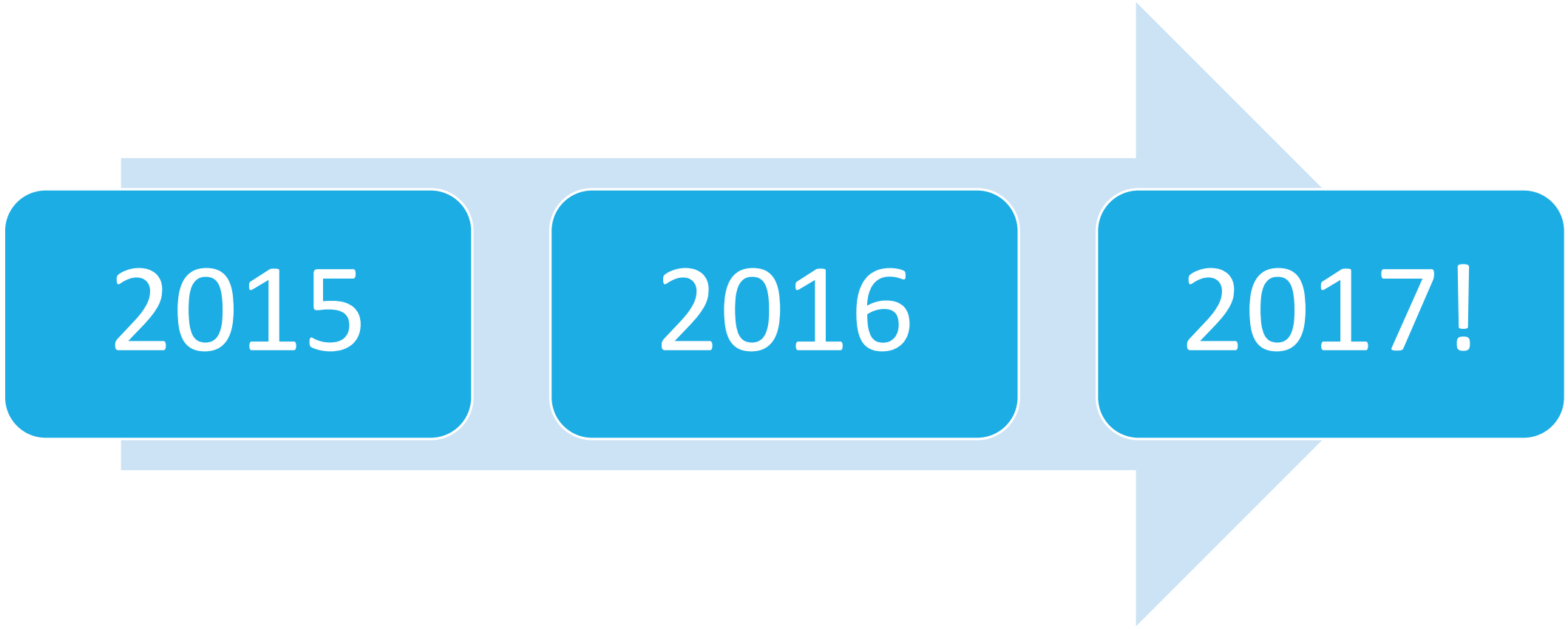
Employed Physicians – per contract, linked to hospital/ACO

ACOs

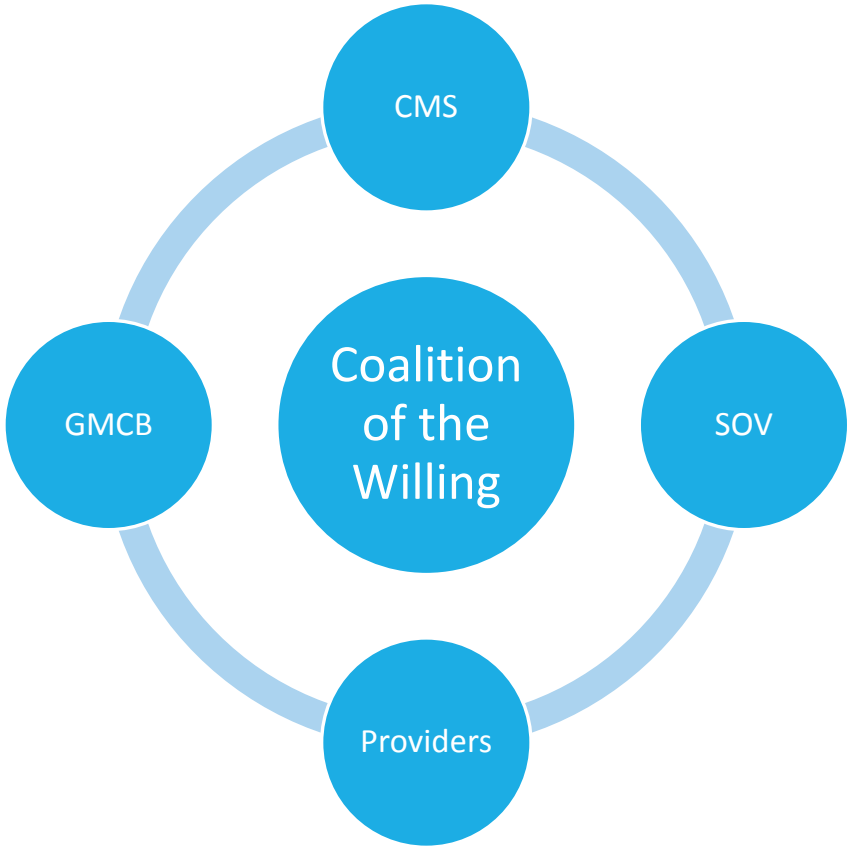
- Shared Savings Pilots
- Next Generation Guidelines

Sub-acute providers – Bundled payments

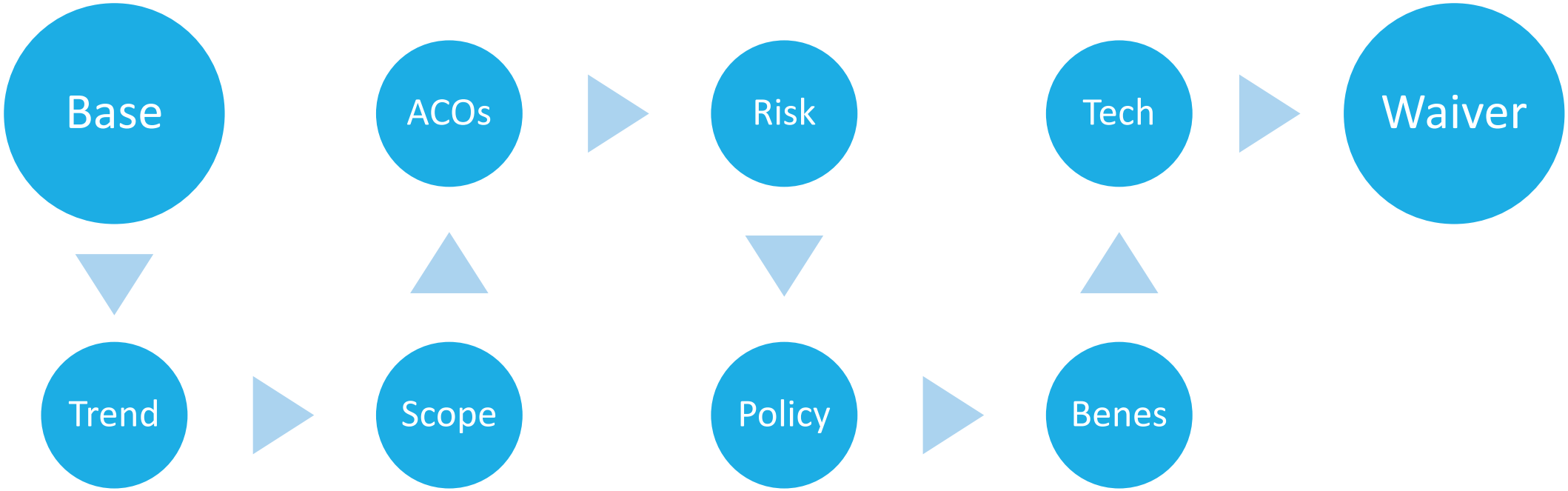
What's The Timeline?



Will Payers (and Providers) Collaborate?

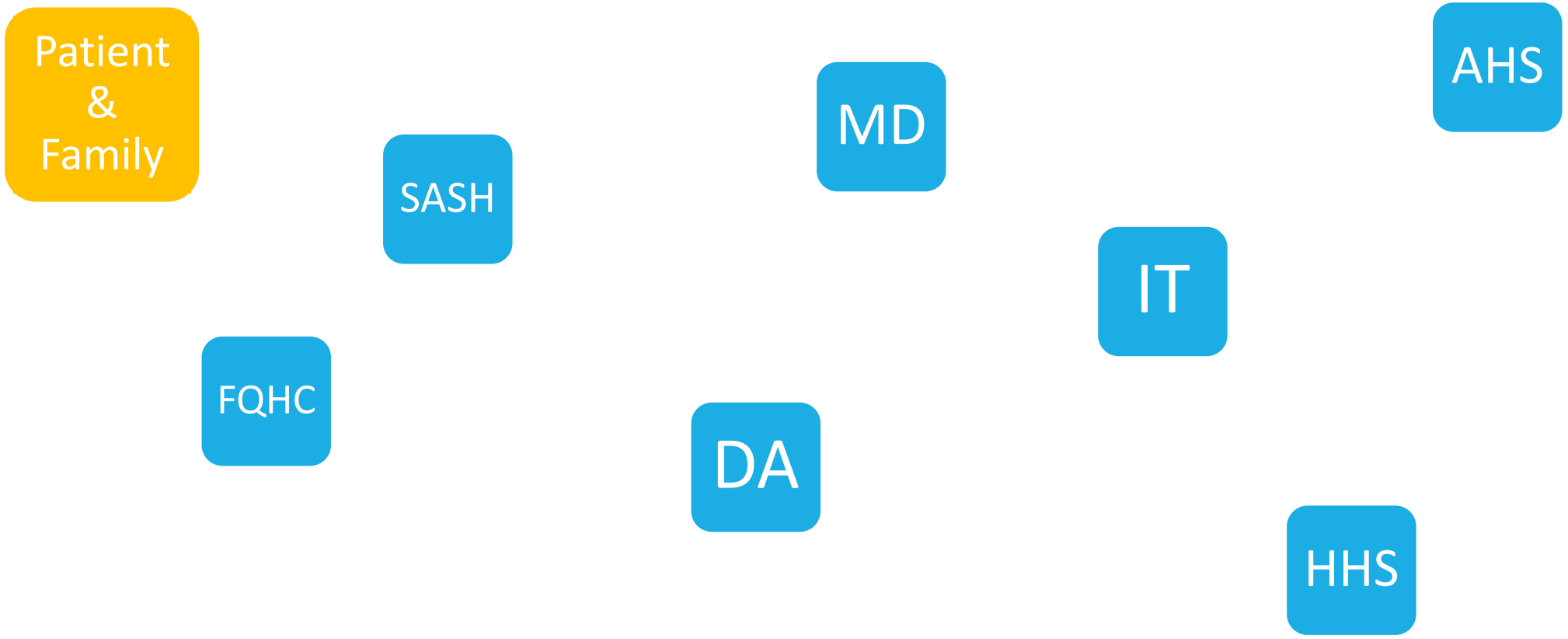


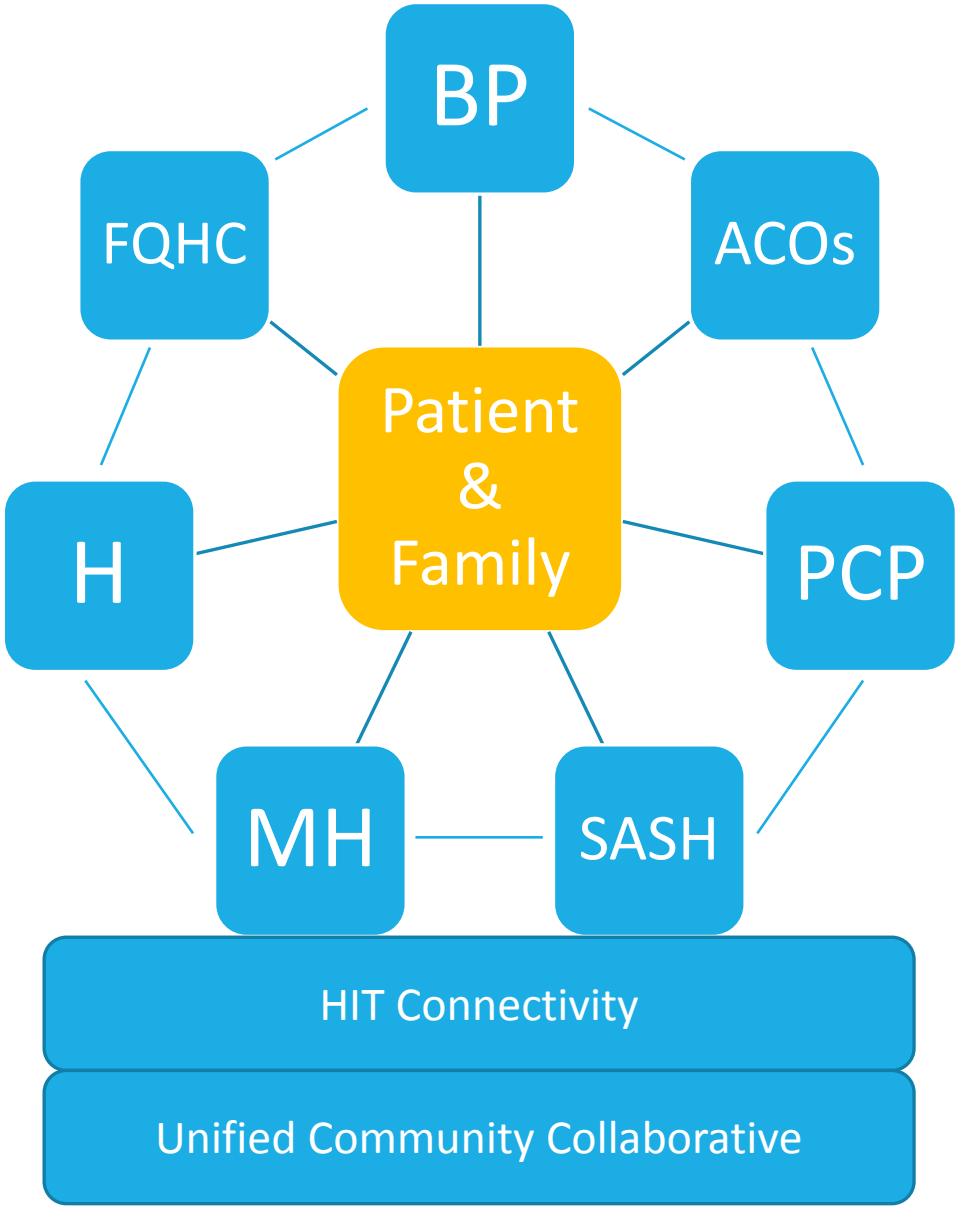
All Payer Process – a 7 year conversation



Green Mountain Care Board

Payment Reform Won't Succeed WO/ Care Coordination




BP
FQHC
ACOs
Patient & Family
H
PCP
MH
SASH
HIT Connectivity
Unified Community Collaborative

Payment Reform Challenges & Questions

Aligning provider incentives to provide the right care at the right time, every time for all consumers

Appropriate use of data for measurement, improvement, patient engagement

Managing improvements in practice/payment over time

Paying for infrastructure: HIT, training