Steering Committee Meeting

Agenda 4-29-15

Vermont Health Care Innovation Project
Steering Committee Meeting Agenda

April 29, 2015, 1:00pm-2:45pm
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	1:00-1:05pm	Welcome, Introductions, and Minutes Approval	Al Gobeille & Steven Costantino	Attachment 1: Draft April 1 Meeting Minutes	Approval of Minutes
2	1:05-1:10pm	Core Team Update *Public comment*	Lawrence Miller		
3	1:10-1:15pm	Updates: • Year 3 Commercial SSP Update *Public comment*	• Catherine Fulton		
4	1:15-1:50pm	Advancing Care Through Technology (ACTT) Program Update • DA/SSA Data Quality & Data Repository • DLTSS Data Planning • Shared Care Plans/Universal Transfer Protocol *Public comment*	Georgia Maheras & Simone Rueschemeyer	Attachment 2: Advancing Care Through Technology (ACTT) Program Update	
5	1:50-2:05pm	Sub-Grantee Program Update *Public comment*	Georgia Maheras	Attachment 3: Sub-Grantee Program Summary	
6	2:05-2:40pm	Work Group Funding Recommendations • Integrated Communities Care Management Learning Collaborative Expansion *Public comment*	Georgia Maheras • Erin Flynn	Attachment 4a: Steering Committee Financial Proposal, April 29, 2015 Attachment 4b: Vermont's Integrated Communities Care Management Learning Collaborative: Round 1 Progress and Request for Expansion	Yes – Approval of recommendation to fund Learning Collaborative expansion
7	2:40-2:45pm	Next Steps, Wrap-Up and Future Meeting Schedule ***Next Meeting:*** *May 27, 2015, 1:00pm-3:00pm, Montpelier*	Al Gobeille		

VT Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, April 1, 2015; 1:00-3:00 pm, Vermont League of Cities and Towns, 89 Main Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Al Gobeille called the meeting to order at 1:01 pm. A roll call attendance was taken and a quorum was present.	
2. Core Team Update ***Public Comment***	Georgia Maheras presented the update on behalf of Lawrence Miller, who was unable to attend. • Georgia and Lawrence are currently working on a risk assessment process and mitigation plan since we are mid-way through the VHCIP. • Two bills are currently in the Senate that will require quarterly updates to the legislature on the VHCIP. • Recently the House Health Care committee heard testimony on the data repository procurement currently underway as part of the Designated Agency (DA)/Specialized Service Agency (SSA) data quality project. The information presented at that testimony remains confidential until the contract is executed. No public comments were offered.	
3. Minutes Approval	Ed Paquin moved to approve the minutes from the February 25th Steering meeting. Dale Hackett seconded. A vote in the form of an exception was taken and the motion passed with three abstentions.	
4. HIE Work Group Update	Simone Rueschemeyer presented an update on the following projects: • Event Notification System Project: Vermont Information Technology Leaders (VITL) is in contract negotiations for this work. Work should begin mid-April, ending in August with reporting in September. • Accountable Care Organization (ACO) Gateway Project: Of seven total Gateways, one is complete and two are in progress. • Gap Remediation: immunization and other interfaces are going live.	

Agenda Item	Discussion	Next Steps
	Regarding pilot sites for the Event Notification System Project: • Pilot practices will need procedures in place to deal with events when they receive notifications. • We need to understand what burdens and benefits a practice. • VITL will work with the pilot sites to address some success criteria. Currently, notifications do not include personal health information (PHI); this will require a second step. VITL is looking at this and trying to address alert fatigue as well.	
Public comment	No public comments were offered.	
5. Work Group Policy Recommendation	Alicia Cooper presented on behalf of the Payment Models Work Group the Proposed Changes to the Year 2 Vermont Medicaid Shared Savings Program (VMSSP) Gate and Ladder Methodology (Attachments 2a,b,c). • The first year Gate and Ladder settings for Medicaid were developed based on estimates of performance for the full Vermont Medicaid population. • There is now data available specific to the populations attributed to the ACOs to support raising the Gate in Year 2 (from 35% of total available quality points to ~55% of total available quality points). • Patients are attributed to ACOs based on their relationship with a Primary Care Provider. • Risk adjustments account for socio-economic factors. • Improved performance verses good performance: how should this be measured, and how does the Gate and Ladder methodology reward improvement versus high performance? Did leadership consider comparing Vermont's Medicaid ACOs' improvement to a regional performance where national benchmarks were unavailable? This conversation occurred early in the planning process; leadership did not consider comparison to regional performance where national benchmarks were unavailable. • Some stakeholders, including federal partners, felt the 35% Gate – which was less than the national average – was too low. The methodology linking performance to shared savings eligibility is evolving over time in response to this feedback. • Under the proposed methodology, ACOs are eligible to receive quality points for performance relative to national benchmarks and for improvement relative to their own past performance – these are additional opportunities for the ACOs to be rewarded for both improvement *and* attainment. • Payment measures selected were areas that presented opportunity for performance improvement within the State. • Improvement points are available for ACOs that demonstrate statistically significant improvement compared to their past performance on those measures that have an external (national) benchmark. • Where do savings come from? For VMSSP, a projected cost trend for a specific set of services is calculated based on a consistent methodology which is compared to actual fee-for-service spending for that specified set of services. The difference between projected trend and actual spending is the savings.	

Agenda Item	Discussion	Next Steps
Public comment	ACOs are eligible for up to 50% of those savings based on performance on quality metrics. o Calculations of Year 1 actual spending for the ACOs participating in VMSSP are not yet complete. Paul Harrington moved to approve the recommendation of the Payment Models work group as presented at this meeting. Peter Cobb seconded. The group discussed the following: • Improvement is measured individually for each ACO based on their historic performance. The populations should be similar enough from Year 1 to Year 2 for each ACO to be compared to their past performance. The Year 1 Medicaid Savings numbers should be finalized in July 2015. • The Shared Savings model is a temporary model that we would want to learn from but it is not sustainable, nor is it the end goal of reform efforts. The Medicare Shared Savings Program offered two tracks, one that includes shared risk for providers and one with shared savings only. The same track was offered for VMSSP ACOs and each participating ACO took the track with no risk. • Vermont's Commercial Shared Savings Program includes only Blue Cross Blue Shield of Vermont insurance purchased on the Health Care Exchange. • The only Medicaid payment measure that has been added for Year 2 which does not have a national benchmark is Core 12. The new Gate and Ladder methodology will apply to all the measures, not just the newly added measures. A vote in the form of exception was taken. Allan Ramsay opposed the vote and the motion passed. Paul Harrington thanked Alicia Cooper and Kara Suter for their work on this project. Sue Aranoff agreed and noted that this methodology represents the best possible compromise considering the starting place. No further comments were offered.	
6. Population Health Work Group Update: Population Health Plan	Tracey Dolan presented an update to the Population Health Plan on behalf of the Population Health work group (Attachments 3a,b). Tracy noted the work group is looking into the following concepts: Accountable Communities for Health (ACHs), and Totally Accountable Care Organizations (TACOs) which could include a wider array of services (for example, physical and mental health service supports) than ACOs do currently. • The Prevention Institute is currently being contracted to research different ACHs and best practices statewide and nationally.	

Agenda Item	Discussion	Next Steps
	• Future funds may be used to expand upon the findings from the Prevention Institute, such as exploring the integrator function. • The communities that were selected for Prevention Institute site visits (occurred in March) or phone interviews responded to a web-based survey designed to explore whether communities had some elements of an Accountable Health Community. Whether or not this work might lead to a pilot or other additional project is unclear at this time; currently, the Prevention Institute contract is focused on researching, describing, and performing analysis based on national exemplar communities and work currently underway in Vermont. Any future activities will coordinate with other VHCIP projects. • Race is a factor that should be considered when performing this work, such as looking at health disparities related to race. • Housing and transportation are categorized under social circumstances in Attachment 3a.	
Public comment	No further comments were offered.	
7. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Wednesday, April 29, 2015 1:00 pm – 3:00 pm, DVHA Large Conference Rm, 312 Hurricane Lane, Williston.	

VHCIP Steering Committee Member List

Roll Call: 4/1/2015

1° Ed 1° Paul
2° Dale 2° Peter

Member		Member Alternate		Minutes	Changes to Gate & Ladder	
First Name	Last Name	First Nan	Last Name			Organization
Susan	Aranoff ✓			✓	✓	AHS - DAIL
Rick	Barnett					Vermont Psychological Association
Bob	Bick					DA - HowardCenter for Mental Health
Peter	Cobb ✓			✓	✓	VNAs of Vermont
Steven	Costantino ✓			✓	✓	AHS - DVHA, Commissioner
Elizabeth	Cote					Area Health Education Centers Program
Tracy	Dolan	Heidi	Klein			AHS - VDH
Susan	Donegan					AOA - DFR
~~Paul~~	~~Dupre~~ WM ✓	Jay	Batra ✓	A	✓	AHS - DMH
Nancy	Eldridge					Cathedral Square and SASH Program
John	Evans ✓			✓	✓	Vermont Information Technology Leaders
Catherine	Fulton ✓			✓	✓	Vermont Program for Quality in Health Care
Joyce	Gallimore					Bi-State Primary Care/CHAC
Don	George					Blue Cross Blue Shield of Vermont
Al	Gobeille ✓			✓	✓	GMCB
Bea	Grause					Vermont Association of Hospital and Health Systems
Lynn	Guillett					Dartmouth Hitchcock
Dale	Hackett ✓			✓	✓	None
Mike	Hall					Champlain Valley Area Agency on Aging / COVE
Paul	Harrington ✓			✓	✓	Vermont Medical Society
Debbie	Ingram ✓			✓	✓	Vermont Interfaith Action
Craig	Jones					AHS - DVHA - Blueprint
Trinka	Kerr ✓			✓	✓	VLA/Health Care Advocate Project
Monica	Light ✓			✓	✓	AHS - Central Office
Deborah	Lisi-Baker					SOV - Consultant

Jackie	Majoros ✓			A	✓	VLA/LTC Ombudsman Project
~~Todd~~	~~Moore~~	Vicki	Loner ✓	A	✓	OneCare Vermont
Mary Val	Palumbo x					University of Vermont
Ed	Paquin ✓			✓	✓	Disability Rights Vermont
Laura	Pelosi x					Vermont Health Care Association
Judy	Peterson ✓			✓	✓	Visiting Nurse Assoc. of Chittenden and Grand Isle Counties
Allan	Ramsay ✓			✓	N	GMCB
Paul	Reiss					Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓			✓	✓	Vermont Care Network
Howard	Schapiro					University of Vermont Medical Group Practice
Julie	Tessler ✓			✓	✓	DA - Vermont Council of Developmental and MH Services
Sharon	Winn					Bi-State Primary Care
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VHCIP Steering Committee Participant List

Attendance: 4/1/2015

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

First Name	Last Name		Organization	Steering Committee
Susan	Aranoff		AHS - DAIL	S/M
Ena	Backus		GMCB	X
Melissa	Bailey	here	Vermont Care Network	X
Heidi	Banks		Vermont Information Technology Leaders	X
Rick	Barnett		Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Anna	Bassford		GMCB	A
Jaskanwar	Batra		AHS - DMH	MA
Susan	Besio		SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		DA - HowardCenter for Mental Health	M
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Amanda	Ciecior		AHS - DVHA	S
Sarah	Clark		AHS - CO	X
Peter	Cobb		VNAs of Vermont	M
Lori	Collins		AHS - DVHA	X
Amy	Coonradt	here	AHS - DVHA	S

Alicia	Cooper	Alicia Cooper	AHS - DVHA	S
Steven	Costantino	Steven Costantino	AHS - DVHA, Commissioner	C
Elizabeth	Cote		Area Health Education Centers Program	M
Diane	Cummings	Diane Cummings	AHS - Central Office	S
Susan	Devoid		OneCare Vermont	A
Tracy	Dolan		AHS - VDH	M
Richard	Donahey		AHS - Central Office	X
Susan	Donegan		AOA - DFR	M
Paul	Dupre	Paul Dupre	AHS - DMH	M
Nancy	Eldridge		Cathedral Square and SASH Program	M
John	Evans	John McCann	Vermont Information Technology Leaders	M
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn	Erin Flynn	AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Catherine	Fulton	Catherine Fulton	Vermont Program for Quality in Health Care	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Don	George		Blue Cross Blue Shield of Vermont	M
Al	Gobeille		GMCB	C
Bea	Grause		Vermont Association of Hospital and Health Systems	M
Sarah	Gregorek		AHS - DVHA	A
Lynn	Guillett		Dartmouth Hitchcock	M
Dale	Hackett	here	None	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M
Janie	Hall		OneCare Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Paul	Harrington	Paul	Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Diane	Hawkins		AHS - DVHA	X
Karen	Hein	phone		X
Debbie	Ingram	here	Vermont Interfaith Action	M
Craig	Jones		AHS - DVHA - Blueprint	M

Kate	Jones		AHS - DVHA	S
Pat	Jones	Pat Jones	GMCB	S
Joelle	Judge		UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	M
Sarah	Kinsler		AHS - DVHA	S
Heidi	Klein		AHS - VDH	S/MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Monica	Light	phone	AHS - Central Office	M
Deborah	Lisi-Baker		SOV - Consultant	M
Sam	Liss		Statewide Independent Living Council	X
Vicki	Loner		OneCare Vermont	MA
Robin	Lunge		AOA	X
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	M
Carol	Maloney		AHS	X
Mike	Maslack			X
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Darcy	McPherson		AHS - DVHA	X
Marisa	Melamed		AOA	S
Jessica	Mendizabal	here	AHS - DVHA	S
Madeleine	Mongan		Vermont Medical Society	X
Todd	Moore		OneCare Vermont	M
Brian	Otley		Green Mountain Power	X
Dawn	O'Toole		AHS - DCF	X
Mary Val	Palumbo		University of Vermont	M
Ed	Paquin		Disability Rights Vermont	M
Annie	Paumgarten	here	GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Judy	Peterson	phone	Visiting Nurse Association of Chittenden and Grand Isle Counties	M
Luann	Poirer		AHS - DVHA	S
Allan	Ramsay		GMCB	M
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Simone	Rueschemeyer		Vermont Care Network	M
Jenney	Samuelson		AHS - DVHA - Blueprint	X

Larry	Sandage		AHS - DVHA	S
Howard	Schapiro		University of Vermont Medical Group Practice	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Shawn	Skaflestad		AHS - Central Office	X
Mary	Skovira		AHS - VDH	A
Richard	Slusky		GMCB	S
Kara	Suter	here	AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler		DA - Vermont Council of Developmental and Mental Health Serv	M
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Julie	Wasserman		AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State Primary Care Association	X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Sharon	Winn		Bi-State Primary Care	M
Cecelia	Wu		AHS - DVHA	S
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Attachment 2

Advancing Care Through Technology (ACTT) Update

Advancing Care Through Technology (ACTT) Program Update

VHCIP Steering Committee

April 29, 2015

ACTT Overview

PROGRAM DESCRIPTION

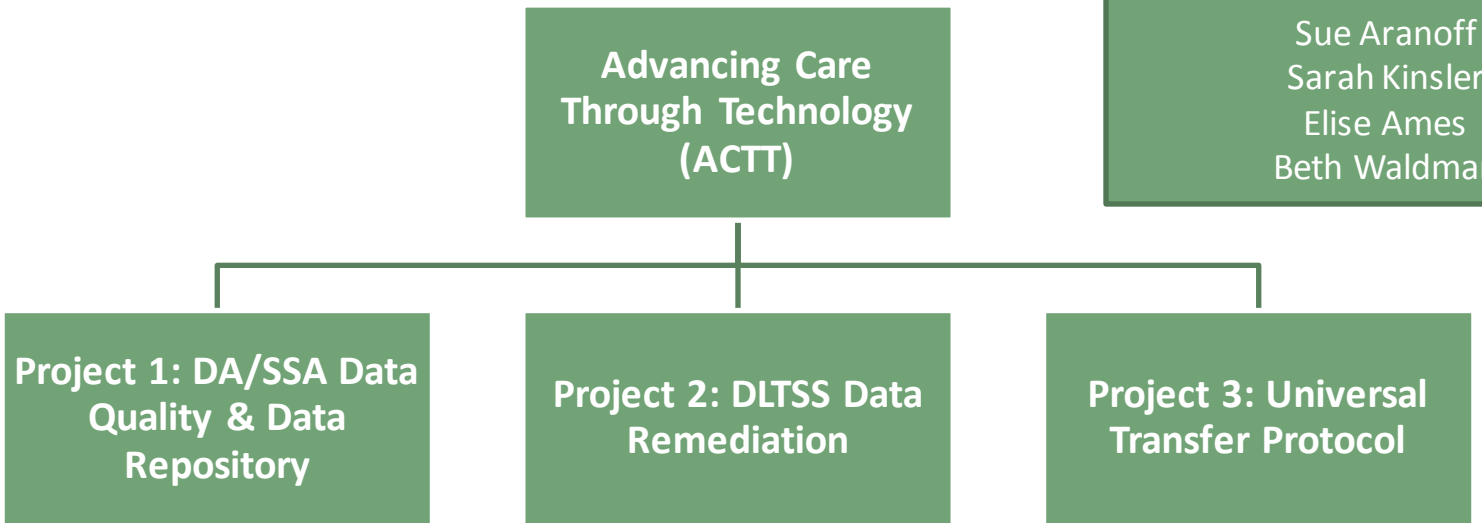
The Advancing Care through Technology (ACTT) is a consortium of Designated and Specialized Agencies (DA/SSA) and disability and long-term services and support (DLTSS) providers and their advocacy organizations, including Area Agencies on Aging, Adult Day Providers, Home Health and Hospice Agencies, Residential Care Homes, Nursing Homes and Traumatic Brain Injury Providers.

The approved program is comprised of three distinct but related efforts, as follows:

- DA/SSA Data Quality and Data Repository
- DLTSS Data Remediation Project
- Universal Transfer Protocol and Form

Former ACTT Leadership Structure

ACTT Leadership Team
Georgia Maheras
Simone Rueschemeyer
Larry Sandage
Brad Wilhelm
Julie Wasserman
Sue Aranoff
Sarah Kinsler
Elise Ames
Beth Waldman



New Leadership Structure

- Three ACTT Projects will split to move forward separately; ACTT Program will be defunct but work will continue.
- **SOV Sponsor for all three projects: Georgia Maheras**

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

DATA QUALITY PROJECT

- Through a partnership with Vermont Information Technology Leaders (VITL), Vermont Care Networks (VCN) is focusing on data quality at all member agencies.
- Advisory Team has been established.
- Meetings are being held with stakeholders.
- Initial Data Dictionary is complete.
- Agreements are signed with DA/SSAs: Business Associate Agreement (BAA), Qualified Service Organization Agreement (QSOA), and Memorandum of Understanding (MOU).

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

DATA REPOSITORY PROJECT

- Create a single location for DA/SSA data.
- Decrease the number of interfaces required to interact with: SOV, other funders, partners, the VHIE etc.
- Provide analytics for DA/SSA system of care for service quality improvement and population health improvement.
- Allow for 42 CFR Part 2 compliant data collection.
- RFP has been released & proposals are in review.

- Interoperability review for SSA unified EHR is complete.

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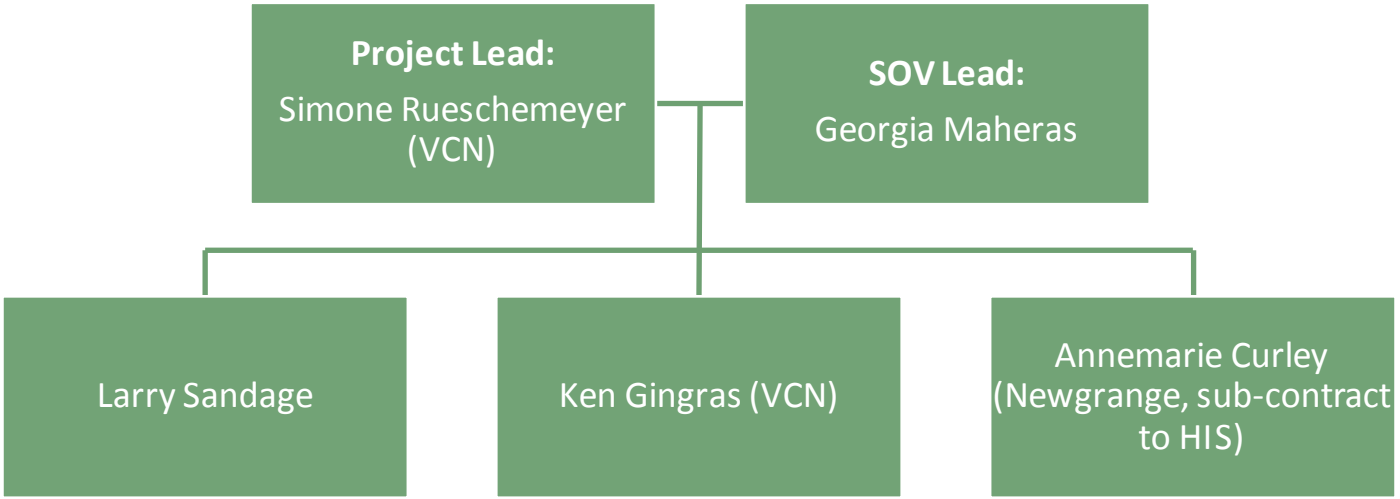
New Project Team, Project 1: DA/SSA Data Quality & Data Repository

- Leads:
  - Simone Rueschemeyer (VCN; project leadership; subject matter expertise, HIT/HIE and behavioral health)
  - Georgia Maheras (SOV lead)
- Project Team:
  - Larry Sandage (contractor; subject matter expertise, HIT/HIE; project management)
  - Ken Gingras (VCN; subject matter expertise, HIT/HIE and behavioral health)
  - Annemarie Curley (Newgrange, sub-contractor to HIS; project management)



Project #2 – DLTSS Data Remediation Project

PHASE 1 IN PROGRESS:

Goals:

- Assess HIT/HIE capabilities of DLTSS providers (Area Agencies on Aging, Adult Day Centers, Traumatic Brain Injury providers, Support and Services and Home [SASH]).
- Update prior HIT assessments of long term care facilities (June 2013), home health and hospice agencies (October 2012), and behavioral health (DAs and SSAs) (February 2012).
- Perform new assessments for long-term care facilities not previously assessed. (12 Nursing Homes and 67 Residential Care facilities)

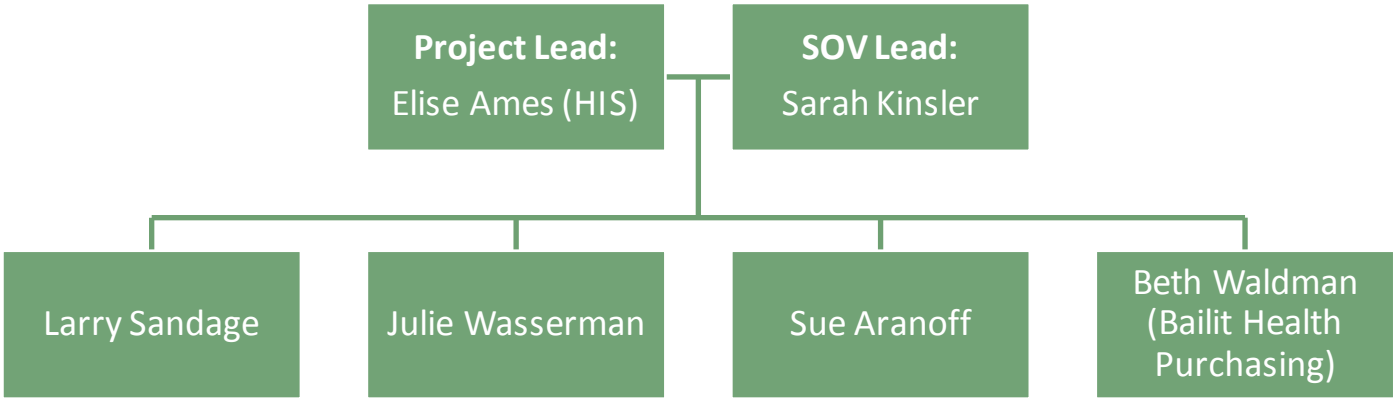
Deliverable Submitted: DLTSS Assessment Report

NEXT STEPS:

- Due in May: Phase 2 proposed budget to address the recommendations identified in the DLTSS Assessment Report.
- The project team is reviewing the report results.
- The Project team to propose scope for the next phase of the project.

New Project Team, Project 2: DLTSS Data Remediation Project

- Leads:
  - Elise Ames (HIS; project management and subject matter expertise)
  - Sarah Kinsler (SOV lead)
- Project Team:
  - Larry Sandage (contractor; subject matter expertise, HIT/HIE)
  - Julie Wasserman (SOV; subject matter expertise, DLTSS)
  - Sue Aranoff (SOV; subject matter expertise, DLTSS)
  - Beth Waldman (Bailit Health Purchasing; subject matter expertise, DLTSS; project management)



Project #3 – Shared Care Plans/ Universal Transfer Protocol

PHASE 1 COMPLETED:

Goals:

- Discovery process and business requirements gathering effort.
- Investigate the ability of diverse service providers to share information with each other electronically in a timely, standardized fashion across the continuum of care, using a common data set.
- Final Deliverable Submitted: UTP Charter & Final Report

NEXT STEPS:

- The UTP Project team has identified that the scope of the UTP Project aligns with work on Shared Care Plans currently underway through the Integrated Communities Care Management Learning Collaborative (VHCIP CMCM Work Group). The project teams are in the process of aligning staff and workplans and informing stakeholders.
- The Project team is developing a high-level project plan.

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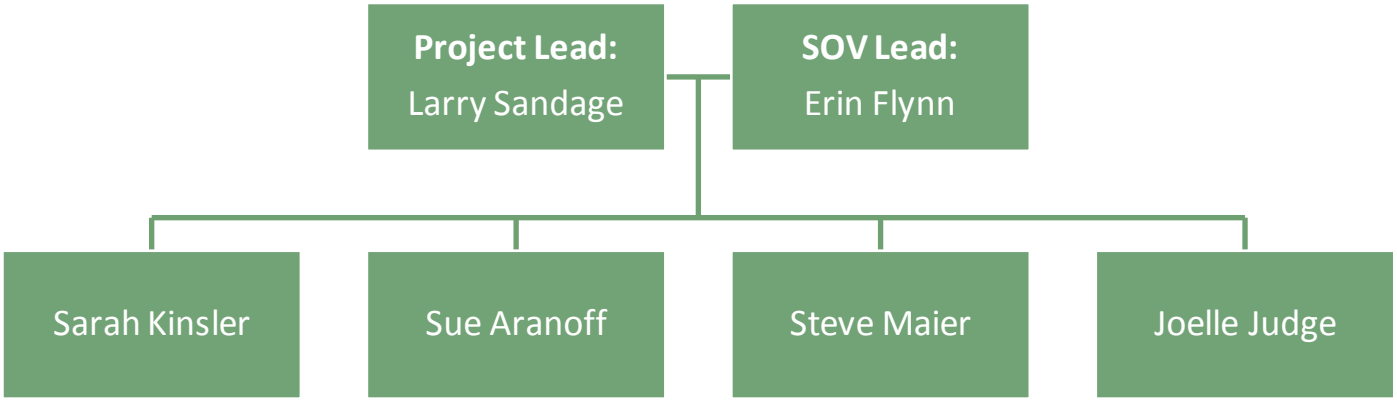
New Project Team, Project 3: Shared Care Plans/Universal Transfer Protocol

- Leads:
  - Larry Sandage (contractor; subject matter expertise, HIT/HIE)
  - Erin Flynn (SOV lead; subject matter expertise, care models)
- Project Team:
  - Sarah Kinsler (SOV; contract management; project support)
  - Sue Aranoff (SOV; subject matter expert, DTLSS)
  - Steve Maier (SOV; subject matter expert, HIT/HIE)
  - Joelle Judge (contractor; project management)
  - Project team will consult with numerous provider representatives including: Laural Ruggles and Heather Johnson



Attachment 3

Sub-grantee Program Summary

VHCIP Sub-Grant Program Summary

April 29, 2015

Georgia Maheras, JD

Project Director

Vermont Health Care Innovation Project

Program Summary: Round One Grantees

- Health*first* – ACO Management
- Rutland Area VNA and Associates – Supportive Care for Seriously Ill Patients
- Northeastern Vermont Regional Hospital – Flexible Funding for Community Care Program
- White River Family Practice – Innovative Care Management
- InvestEAP – Resilient Vermont (Stress Reduction)
- VMS Foundation – Pursuing High Value Care (Pre-Operative Testing, Inpatient Lab testing)
- Bi-State – Community Health ACO

Health*first* – ACO Management

- Goal: Increase coordination and communication in medical homes between primary care and other clinical practitioners.

- Opportunity to expand membership via the Clear Choice Urgent Care centers in 4 locations in VT.
- Awaiting a new report on better coordinating mental health care services provided through technical assistance from Bailit Health Purchasing.
- Pan-ACO quality reporting tool successfully used during March for quality data collection.

RRVNA & RRMC – Care Coordination for Seriously Ill Patients

- Goal: Integrate supportive care and improve quality of life for patients with complex conditions.

- Presented program to multiple local organizations (nursing homes, Heart Clinic and Cardiology Group, case managers at RRMC).
- The project is encountering difficulty in convincing stable patients who are referred to the program to utilize services.
- Collaboration with a local company to provide respiratory therapy consultation.

Northeastern Vermont Regional Hospital (NVRH) – Flexible Funding for Integrated Care

- Goal: Reduced overall healthcare costs; more efficient use of Medicaid special services; improved well-being of clients. Population served: Dual Eligibles.

- Piloting use of 'Camden Cards' – introduced via the Integrated Communities Care Management Learning Collaborative.
- Health coach has added more home visit clients (41 total; 10 receiving tobacco cessation counseling).
- Green Mountain United Way/VT211 for emergency care now in use for all Duals seen by health coach.

White River Family Practice (WRFP) – Innovative Management of Chronic Conditions

- Goal: Reduce ER utilization; measure patient self-confidence to target chronic disease interventions; deploy team-based protocols.

- Motivational Interviewing training provided to entire office to support team-based care.
- Care plans and process maps developed for high utilization group.
- Intra-office newsletter developed for VHCIP project updates.

Invest EAP / VTHealthEngage – Early Intervention & Prevention

- Goal: Employ prevention and early intervention services to reduce stress-related antecedents of chronic disease.

- Completed software training and 5-day evidence-based treatment protocol course.
- Health educator provided services to 40 FQHC patients, 6 in crisis with numerous success stories.

VMS Foundation and UVM – Pursuing High Value Care for Vermonters

- Goal: Reduce the rate of unnecessary laboratory testing for stable medical and surgical inpatients and low-risk preoperative candidates.

- Two collaborative regional learning sessions and a webinar have been held to consider the best medical evidence and quality improvement science to be used to support the initiative.
- Regional billing and clinical research database containing all billing and routine lab data for 8 hospitals (~90% inpatient beds) producing monthly performance reports.
- Expansion to all hospitals with easier data extraction and upload process.

Bi-State Primary Care – Community Health Accountable Care (CHAC) Shared Savings

- Goal: Increase provider collaboration across the continuum of care in local communities.

- Actively participating in the Blueprint Unified Community Collaboratives.
- Chart abstraction and quality reporting completed successfully for Medicare; quality reporting for Medicaid and Commercial targeted for completion in April or May 2015.
- Approximately 900 invitations were sent to patients to participate in the 'rising risk' program; a program care coordinator hired and triage protocols for CHF, COPD and Diabetes developed and implemented.

Program Summary: Round Two Grantees

- CVMC – Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Medical Home
- Developmental Disabilities Council – Inclusive Partnership Project
- Vermont Program for Quality in Health Care (VPQHC) – Statewide Surgical Collaborative
- Northwestern Medical Center – RiseVT Project
- Southwestern Vermont Health Care – Transitions of Care
- InvestEAP – King Arthur Flour

CVMC – Screening, Brief Intervention and Referral to Treatment in the Medical Home

- Goal: Implement SBIRT in the medical homes in Central VT with focus on tobacco, alcohol and drug misuse.

- Two medical homes identified to deliver SBIRT services (Montpelier Integrative Health and Barre Internal Medicine).
- The SMS text messaging system Caring Txt VT is now available.
- Initial and secondary screening tools have been implemented at both locations; electronic referrals are made to the SBIRT clinician for quick follow up and risk scores, clinical interventions and progress notes are stored centrally in the medical record.

Developmental Disabilities Council – Inclusive Healthcare Partnership Project

- Goal: Establish a set of innovative best practices for delivery of care to adults with intellectual and developmental disabilities (I/DD).

- Individual with I/DD identified to join project staff as a consumer representative.
- Planning Team assembled to review promising tools and policies from Vermont and around the nation.
- Analysis of claims data to identify health status and utilization patterns; results to be supplemented with focus group and interview data to identify opportunities for improvement.
- Leverage other VHCIP projects and participants – Frail Elders, Blueprint and Integrated Communities Care Management Learning Collaborative.

VPQHC – Statewide Surgical Collaborative

- Goal: Collect and submit surgical clinical data to the American College of Surgeons National Quality Improvement Program (NSQIP) to improve surgical outcomes and performance.

- Established Steering Committee of surgeons to lead statewide collaborative.
- Statewide outreach and NSQIP education to 100% hospitals achieved.
- Multiple EMRs used by hospitals inhibits sharing of surgical clinical records.

Northwestern Medical Center – RiseVT

- Goal: To decrease the percentage of overweight individuals; increase the number of employer-sponsored wellness programs with >50% participation; expand resources for biking and walking.

- Established a robust website, social media (Pintrest, Twitter, Instagram, Facebook) and marketing campaign.
- Piloting wellness scorecard and processes with 10 businesses, 12 families, 3 schools and 1 municipality.
- Official launch in June including a multi-faceted media campaign, event attendance, guerilla marketing strategies and more.

Southwestern Vermont Health Care – Innovations in Transitional Care Management in a Rural Setting

- Goal: To decrease the number of admissions and ED visits for high risk chronic care patients; create shared plans of care and an interdisciplinary team to deliver integrated services.

- Community Team kickoff held with presentations to community agencies, medical homes, nursing homes, home care agencies and expansion to primary care practices.
- HIPAA and privacy training conducted with Community Team to ensure patient confidentiality is maintained among diverse program participants; includes HIPAA agreements, Information Release forms and information sheets for patients.

Invest EAP – Behavioral Screening and Intervention Partnership with King Arthur Flour

- Goal: Demonstrate and evaluate impact of prevention and early intervention services in an employment setting using behavioral health screenings and evidence-based interventions.

- Completed software training and 5-day evidence-based treatment protocol course.
- Outreach materials developed for employees.

VHCIP Provider Sub-grant Symposium

- May 27, 2015 8:30 – 12:30
- Two Panel Discussions
  - ACO Group
  - Transitions of Care Group
    - RAVNA – Care Coordination for Seriously Ill Patients
    - SVHC – TCM in a Rural Setting
    - NVRH – Dual Eligible Care/Flexible Funding
    - WRFP – Innovative Care Management
- Goals:
  - Learn from each other
  - Inform the VHCIP work groups
  - One thing participants will bring back to their project

Attachment 4a

Financial Proposal

Financial Proposals

April 29, 2015

Georgia Maheras, JD

Project Director

AGENDA

1. Care Models and Care Management Work Group: Integrated Communities Care Management Learning Collaborative Expansion

Care Models and Care Management Work Group: Integrated Communities Care Management Learning Collaborative Expansion

- Request from the Work Group :
  - Project timeline: May 1, 2015-June 30, 2016
  - Project estimated cost: $500,000
  - Project Summary: Expand the Integrated Communities Care Management Learning Collaborative to additional cohorts of interested health service areas.
  - Budget line item: Technical Assistance: Learning Collaboratives
- The Care Models and Care Management Work Group is responsible for providing funding and policy recommendations that support development of an integrated delivery system that leads to coordination, collaboration, and improved care for Vermonters.

Intent of Contract/Relationship to VHCIP Goals

- *VHCIP's Operational Plan outlines the following tasks:*

Care Models and Care Management Work Group

This group will build on the work of the work group to date and:

- Launch learning collaboratives in multiple communities;
- Align Blueprint for Health and ACO care management activities; and
- Identify large-scale population-based care or health improvement models that might complement or integrate with the above.

The group will recommend mechanisms for assuring greater consistency and/or coordination across these programs and models in terms of service delivery, financial incentives, quality measurement, or other key model or program components. The goal will be to maximize effectiveness of the programs and models in improving Vermonters' experience of care, reducing unnecessary costs and improving health, and minimizing duplication of effort or inconsistencies between the models.

Scope of Work

- Hire one additional quality improvement facilitator, who will work with two existing facilitators to support organizations that provide care management services to work together in a multi-disciplinary team based care approach; implementing best practices, tools, and training resources; and measuring results.
- At least three in-person learning sessions (including faculty, location, and logistical support) and at least three webinars.
- Core Competency Training for Care Management Professionals (DLTSS-specific component to follow in separate request).

Attachment 4b

Learning Collaborative

Round One Progress

Request for Expansion

Vermont's Integrated Communities Care Management Learning Collaborative:

Round 1 Progress, and Request for Expansion

April 29, 2015

Vermont Health Care Innovation Project

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 in August 2014.

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.**

Learning Collaborative 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.

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

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

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 Learning Collaborative for other communities
- Seeking Steering Committee's endorsement of funding request for additional Learning Collaborative rounds to allow expansion to all interested health service areas

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 costs
- 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)**

For Steering Committee Consideration

- Is the recommendation consistent with the goals and objectives of the grant?
  - This recommendation is consistent with the following goals and objectives of the grant (outlined in the Operational Plan):
    - To create commitment to change and synergy between public and private culture, policies and behavior;
    - To increase the level of accountability for cost and quality outcomes among provider organizations; and
    - To ensure accountability for outcomes from both the public and private sectors.
  - The recommendation also supports one of three major goals of VHCIP by supporting efforts to transform care delivery by enabling and rewarding care integration and coordination.

For Steering Committee Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No; learning collaboratives were identified in the operational plan as a promising tool for quality improvement and care delivery transformation. Vermont's Integrated Communities Care Management Learning Collaborative is aligned with the CMCM Work Group's charter and workplan (specifically, with the objective of identifying redundancies, gaps, and opportunities for innovation and coordination in order to address unmet needs, minimize duplication, and improve alignment between the models and management of activities).

For Steering Committee Consideration

- Has the recommendation been reviewed by all appropriate Work Groups?
  - The CMCM Work Group reviewed the proposal and voted unanimously (with two abstentions) to approve expansion of the integrated communities care management learning collaborative.
  - In light of the strong correlation between the learning collaborative goals and the elements of the DLTSS Model of Care, co-chairs and staff of both work groups have been and will continue to collaborate closely.
  - Specifically, the DLTSS work group is developing DLTSS-specific core competency training modules that will be made available to Learning Collaborative participants.

Questions/Discussion