VT Health Care Innovation Project
Core Team Meeting Agenda

April 18, 3017 1:00 pm-2:30 pm
Ash Conference Room, Waterbury State Office Complex, Waterbury
Call-In Number: 1-877-273-4202; Passcode: 439-746-685

Item #	Time	Topic	Presenter	Relevant Attachments
1	1:00-1:05	Welcome and Chair's Report • *New CMMI Program Officer* • *Evaluation Update at the next meeting* • *Accountable Communities for Health Final Report is available* here*.* • *Vermont's Practice Transformation activities were* highlighted *this month!*	Mary Kate Mohlman	Attachment 1: Myers & Stauffer, LC Sustainability Plan Update. *Update.*
Core Team Processes and Procedures:				
2	1:05-1:10	Approval of meeting minutes	Mary Kate Mohlman	Attachment 2: March 1, 2017 Meeting Minutes *Decision needed.*
Core Team Financial:				
3	1:10-2:00	Budget Update and Proposed PP3 Reallocations and No-Cost Extension • What is left to accomplish?	Georgia Maheras and Diane Cummings	Attachment 3a: Budget Powerpoint Attachment 3b: Monthly Status Reports (found here) *Decision needed.*
Core Team Updates:				
4	2:00-2:20	Population Health Plan	Heidi Klein and Georgia Maheras	Attachment 4: Draft Population Health Plan *Decision needed.*
5	2:20-2:45	Sustainability Plan	Georgia Maheras and Myers and Stauffer, LC	Attachment 5: Draft Sustainability Plan *Decision needed.*
6	2:45-2:55	Public Comment	Mary Kate Mohlman	
7	2:55-3:00	Next Steps, Wrap-Up, and Future Meeting Schedule: TBD	Mary Kate Mohlman	

State of Vermont State Innovation Model (SIM)
Development of Final Sustainability Plan
Myers and Stauffer LC Monthly Progress Report to Vermont SIM Core Team

Progress Summary – March 2017

Myers and Stauffer LC (MSLC) began our work with the State of Vermont (State) on July 1, 2016 to create a Sustainability Plan for the Vermont State Innovation Model (SIM) Testing Grant. The summary of work performed in March 2017 to develop the 2nd draft of the Plan is provided below.

Second Draft of the SIM Sustainability Plan – Submitted for State Review

On 03/24/2017, Myers and Stauffer LC submitted the following to the State:

- Sustainability Plan Comments document
- Red-line version of the 2nd draft of the Sustainability Plan
- Clean PDF version of the 2nd draft of the SIM Sustainability Plan

The Sustainability Plan Comments document contains feedback solicited from the SIM stakeholder community including the SIM Work Groups, Sustainability Sub-Group, Steering Committee, and the SIM Core Team following their review of the first draft of the Sustainability Plan. The Comments document was used to create the second draft of the Sustainability Plan. Table 1 below, provides a snapshot of the elements in the Comments Document including the stakeholder comments, State and/or Myers and Stauffer LC comment(s) on the recommendation/statement, if the recommendation was added to the Plan, and where edits/additions were included within the second draft of the Plan if applicable. It is important to note that all stakeholder recommendations were considered for inclusion in the Plan. The rationale for not including a recommendation is stated within the Comments document. An example of a stakeholder comment not included in the current second draft including the rationale for the exclusion is demonstrated on Table 1. The State made all final decisions for edits/additions to include in the Plan.

Table 1: Snapshot of the SIM Sustainability Comments Document

Work Group/ State Agency	Stakeholder Comment	State/MSLC Comment	Add to Sustainability Plan (Y/N)	Status	Status Comments
PMDI Work Group	Add consumers as Key Partners for HDI and other Focus Areas.	Importance of consumer engagement will be added to the Plan.	Y	Closed	Added Consumers and Advocates to all sections.
PH Work Group	How do we connect the Population Health Plan to the Sustainability Plan?	Population Health is a recurrent theme and will be added to the Plan.	Y	Closed	Exec. Sum., p. 3 Report, p. 18

Work Group/ State Agency	Stakeholder Comment	State/MSLC Comment	Add to Sustainability Plan (Y/N)	Status	Status Comments
Vermont Department Of Health	Accountable Communities for Health: Opportunities for future include moving beyond the original 10 communities to all 14 HSA as well as the continued expansion of the Community Collaboratives to address population health outcomes. Consider VDH as co-lead entity along with Blueprint.	Keep VDH as Key Partner for now. All Lead Entities will be finalized by Core Team at a later date.	N/To Be Determined	Open	To Be Determined

Myers and Stauffer LC sent the State a red-line version of the Plan documenting all edits made throughout the document. We also included comments throughout the document where additional input was needed from the State. A synopsis of the most significant edits included in the second draft can be referenced in the January/February 2017 summary sent to the Core Team. Additionally, we provided a PDF version of the document showing no mark-up as well.

Next Steps

Table 2 provides a listing of the remaining milestones to complete this deliverable in the coming months.

Table 2: Sustainability Plan Timeline

Project Milestones	Status	Do not exceed date
Second draft of SIM Sustainability Plan to State	Completed	March 24, 2017
Second draft of SIM Sustainability Plan – MSLC to make additional edits identified by the State	Not Started	April 2017
Second Draft of the SIM Sustainability Plan to the Stakeholders	Not Started	Early May 2017
Final SIM Sustainability Plan	Not Started	June 15, 2017

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, March 1, 2017, 10:30am-12:00pm, Ash Conference Room, Waterbury State Office Complex.
Core Team Attendees: Mary Kate Mohlman, Harry Chen, Al Gobeille, Cory Gustafson, Robin Lunge, Steve Voigt (phone)

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Mary Kate Mohlman called the meeting to order at 10:34am. A roll-call attendance was taken and a quorum was present. *Chair's Report*: • Evaluation Site Visit: The federal SIM evaluation team will be visiting Vermont from March 13-16. They are reaching out to various people and organizations across the SIM project for interviews. • Shared Savings Program Standards Update: Attachments 1a and 1b are a Shared Savings Program update from the Green Mountain Care Board, including an updated version of the ACO program standards. • Sustainability Planning Update: Attachment 1c (forthcoming) is a monthly update from Myers & Stauffer, the contractor hired to support drafting of the Sustainability Plan.	
2. Approval of Meeting Minutes	Robin Lunge moved to approve the minutes from the December 20 meeting. Steve Voigt seconded. There was no discussion. A roll call vote was taken and the minutes were approved.	
3. Project Updates	Georgia Maheras introduced Attachment 3, which provides an overview of the SIM project.	
4. Evaluation Overview	Kate O'Neill provided a brief overview of the state-led SIM evaluation (Attachment 4). • The state-led evaluation is a qualitative evaluation, intended to complement the federal SIM evaluation (a mixed-methods design with a quantitative focus). The evaluation design also includes development of a Learning Dissemination Plan to share key findings. • The evaluation is guided by a public-private Evaluation Steering Committee, which includes representatives from various AHS Departments, the GMCB, and the private sector. • The April Core Team meeting will include a deep dive on the state-led evaluation. In the meantime, Core Team members should reach out to Kate with particular questions.	

Agenda Item	Discussion	Next Steps
	• JSI is working with the SIM Sustainability Planning contractor (Myers & Stauffer) to ensure key evaluation findings inform our Sustainability Plan. Discussion: • What are some of the high-value activities identified early in the evaluation or early findings? (Mary Kate Mohlman) Kate will review notes and provide additional information. Payment reform efforts vary by constituency, but early findings suggest that there is not a lot of clarity among providers about how payment reform is impacting daily practice. High-value activities include Blueprint activities supported in part by SIM, the learning collaboratives, and other practice transformation efforts, and providers are eager to see these activities continue. • A deep dive on the provider survey could be useful. (Harry Chen) • JSI has commented that Vermont's small size and close communities have a significant impact on reform in Vermont. (Mary Kate Mohlman) • Did PatientPing (the Event Notification System) come up as a high-value service? (Robin Lunge). Robin has heard from some that this is a valuable activity. Kate is not aware of any comments, but will ask JSI.	
5. Budget Update and Proposed PP2 and PP3 Reallocations	Georgia Maheras reviewed the Performance Period 2 (1/1/15-6/30/16, with no-cost extensions that have allowed continued spending from these funds) and Performance Period 3 (7/1/16-6/30/17) budget-to-actual comparisons as of February 15, and presented two budget reallocations (Attachment 5). • PP3 – Expect to present another reallocation in April due to underspending in some categories. o In addition, some contractors have underspent or are projected to underspend (PCDC, PHI/Accountable Communities for Health) o DA/SSA Medicaid Pathway – No-cost extension to allow for completion of project activities. o IHS – Funds shifting across budget periods to accommodate a slight delay. o Bailit Health Purchasing – No cost extension through 6/30. o We will request a no-cost extension for Performance Period 3 funds to allow spending through Fall 2017, to complete our Evaluation and wrap up grant activities. o The process for making final financial allocations will utilize all savings captured as of Q1 2017 (mid-April, following Q1 financial reports). A few ideas: DVHA and GMCB each have specific activities they need to do to support post-SIM activities related to the All-Payer Model and Medicaid Next Generation ACO pilot. There are also additional potential items in the health data infrastructure area. Sustainability funds have largely been pushed out into the community to support changes at the ACOs and others that are needed before 1/1/18. Georgia will write up some options within what's allowable – these expenditures must be related to sustainability. Spending funds within a current contract would ease the administrative burden and speed approval. Reallocations:	

Agenda Item	Discussion	Next Steps
	• Performance Period 2 Reallocation: Increase Burns & Associates by $257,602.01. This is to allow for additional analyses related to the Medicaid Pathway and ACO Next Gen Contract work. • Performance Period 3 Reallocation: Update scope of BHN/VCN Data Repository to allow VCN to pursue a different type of solution to achieve the project goals, within the original contract amount. The original solution was not feasible from a technical perspective, and would have caused significant cost increases ($30,000 per agency) and significant project delays. The project team worked with the DAs to identify a different solution to achieve the same goal. The new scope would also provide some additional support to the DAs to support them through this change. The data repository has the capability to accept data from DAs as well as all preferred providers; however, many preferred providers don't have electronic medical records, which makes it challenging to share data. We have considered how best to support these providers in developing some data infrastructure to enable patient care, reporting, and analysis. Discussion: • How frequently are we expecting data extracts at DA/SSAs to happen? (Robin Lunge) Monthly. Georgia believes all DAs are sending data currently, and a dashboard allows the contractor to assess the data. ONC is particularly excited that we've found a way to solve this problem, which also exists elsewhere in the country. Mary Kate pointed out that this could also be a solution for some of our other clinical data problems, where analysis and population health management are our goals. Al Gobeille moved to approve all changes as presented. Harry Chen seconded. A roll call vote was taken and the motion carried.	
6. Public Comment	There was no public comment.	
7. Next Steps, Wrap Up and Future Meeting Schedule	How does the new Federal administration impact the SIM grant? (Al Gobeille) Georgia replied that this has had a limited impact; approvals and similar have been moving along at the usual pace. Our federal partners have indicated they are very pleased with our current progress and early results. We are anticipating a letter from CMMI that indicates we have met a series of milestones for Performance Period 3 as required in our grant terms; we recently finished a verbal review of all of our Performance Period 3 milestones to support this. *Next Steps*: • Over the next few months, the Core Team will be asked to: o Approve a Population Health Plan (planned for April agenda) o Approve a Sustainability Plan (planned for April agenda) o Make final financial decisions and oversee final evaluation and grant reporting. *Next Meeting*: TBD (April).	

Budget to Actuals and Budget Reallocation for PP3

April 18, 2017

Georgia Maheras, JD

Project Director

Year 1 Budget-Complete

Vermont Health Care Innovation Project Year 1 Budget October 1, 2013 - December 31, 2015				
BUDGET CATEGORY	**BUDGET-YEAR 1**	**FINAL EXPENSES**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 2,657,072.25	$ 2,657,072.25	$ -	$ -
Operating (includes Indirect)	$ 945,675.10	$ 945,675.10	$ -	$ 0.00
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 3,631,455.14	$ 3,553,086.46	$ 78,368.68	
PAYMENT MODELS-TOTAL	$ 3,898,088.35	$ 3,725,234.22	$ 172,854.13	
CARE MODELS-TOTAL	$ 242,754.13	$ 219,429.08	$ 23,325.05	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 2,385,707.27	$ 2,376,417.48	$ 9,289.79	
EVALUATION-TOTAL	$ 1,656,538.42	$ 1,645,151.77	$ 11,386.65	
GENERAL-TOTAL	$ 680,068.17	$ 671,457.20	$ 8,610.97	
CMMI Required: Population Health Plan-TOTAL	$ 26,945.68	$ 26,945.68	$ -	
Contractual Total	$ 12,521,557.16	$ 12,217,721.89	$ 303,835.27	$ 0.00
TOTAL YEAR 1 BUDGET	**$ 16,124,304.51**	**$ 15,820,469.24**	**$ 303,835.27**	**$ 0.00**

Year 2 Budget*

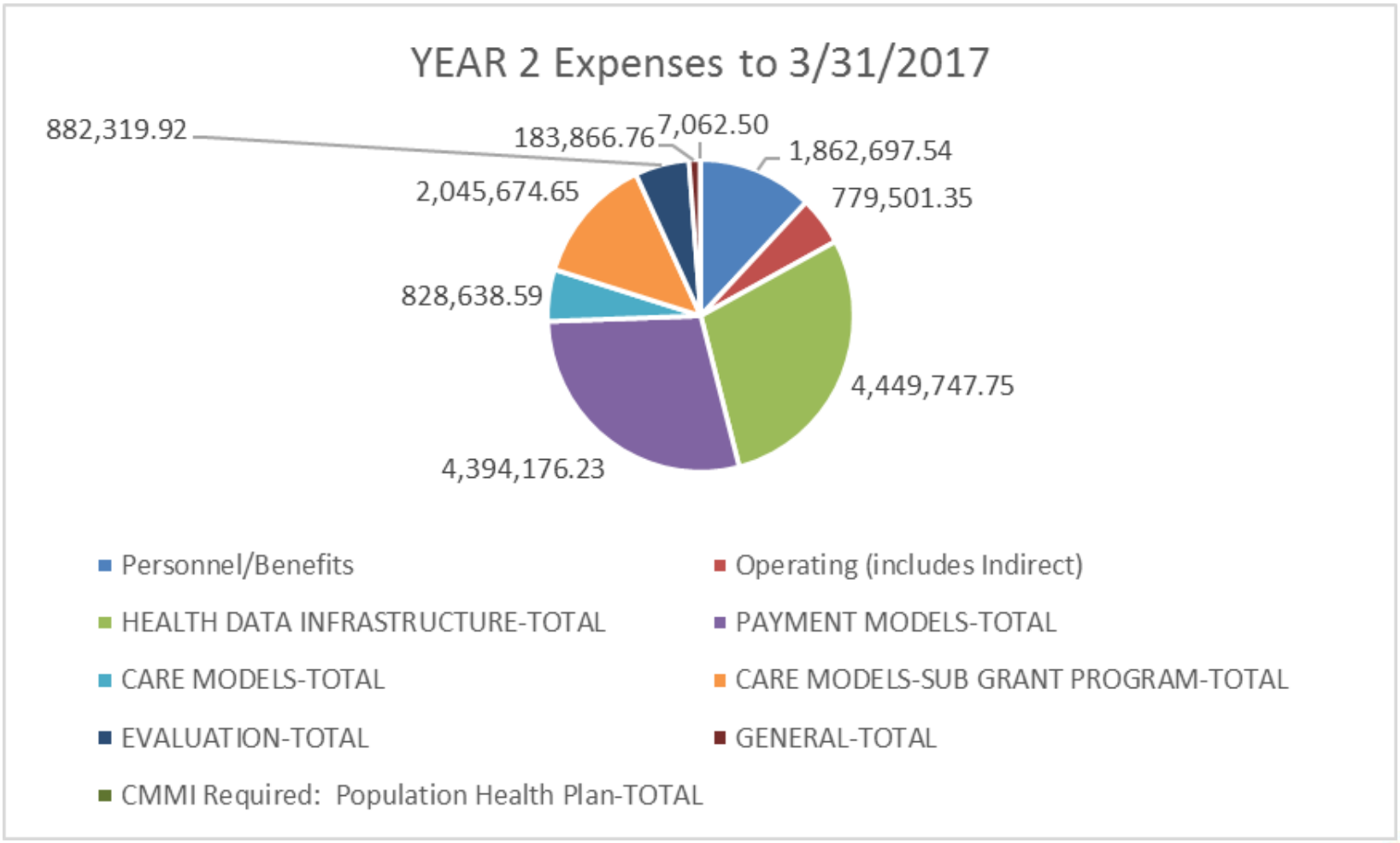
Year 2 Budget -CMS/CMMI Approved January 1, 2015 - June 30, 2017				
BUDGET CATEGORY	**BUDGET-YEAR 2**	**ACTUALS and Unpaid Contract Invoices to 03/31/17**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 1,862,697.54	$ 1,862,697.54		$ (0.00)
Operating (includes Indirect)	$ 779,501.35	$ 779,501.35		$ 0.00
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 5,083,817.92	$ 4,449,747.75	$ 634,070.17	
PAYMENT MODELS-TOTAL	$ 5,323,402.34	$ 4,394,176.23	$ 929,226.12	
CARE MODELS-TOTAL	$ 1,228,366.77	$ 828,638.59	$ 399,728.18	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 2,049,896.22	$ 2,045,674.65	$ 4,221.56	
EVALUATION-TOTAL	$ 928,444.51	$ 882,319.92	$ 46,124.59	
GENERAL-TOTAL	$ 183,866.76	$ 183,866.76	$ -	
CMMI Required: Population Health Plan-TOTAL	$ 7,062.50	$ 7,062.50	$ -	
Contractual Total	$ 14,804,857.02	$ 12,791,486.40	$ 2,013,370.62	$ -
TOTAL YEAR 2 BUDGET	**$ 17,447,055.91**	**$ 15,433,685.29**	**$ 2,013,370.62**	**$ (0.00)**

*Additional approvals received April 2017

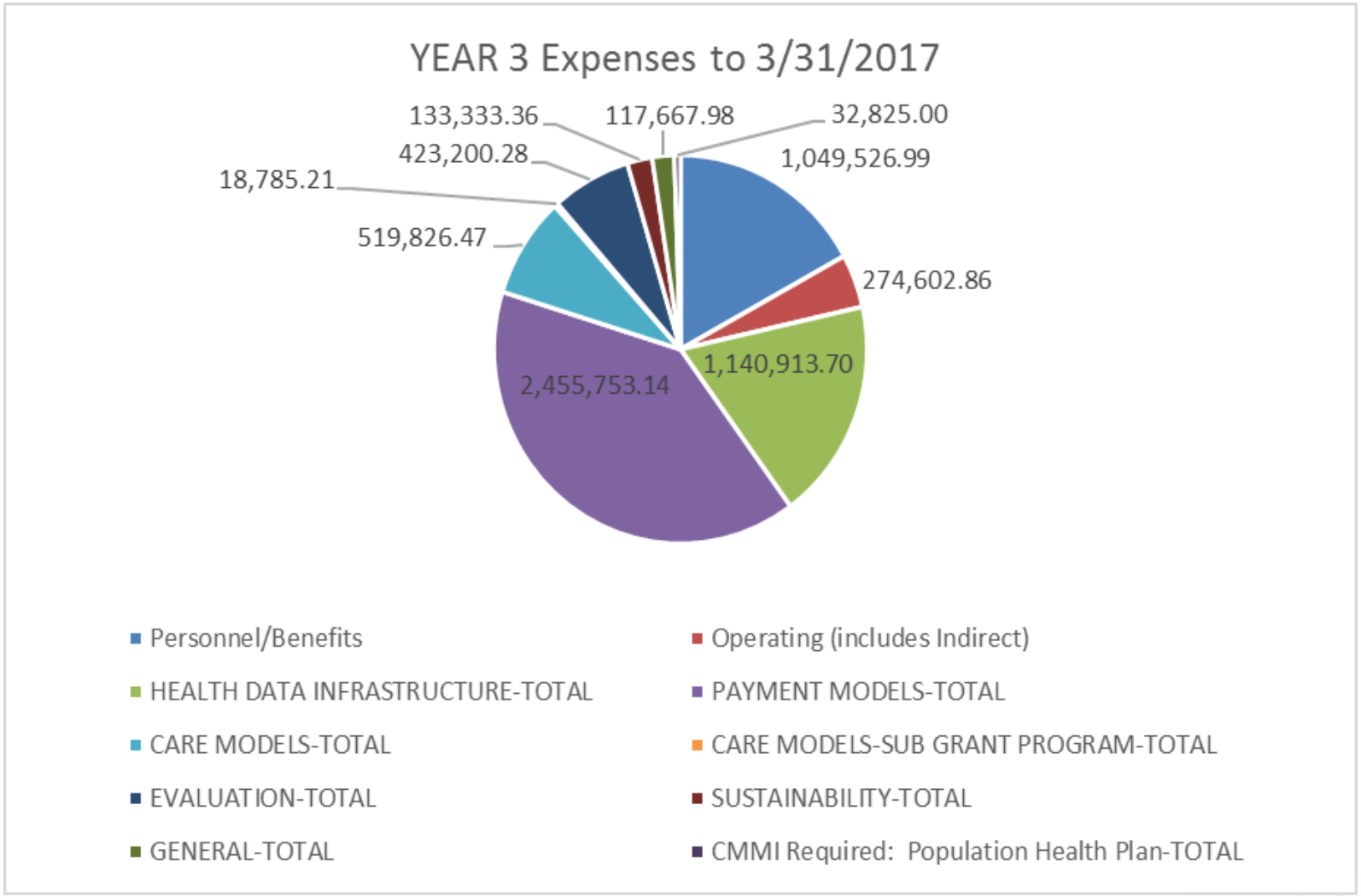
Year 3 Budget-YTD

Year 3 Budget - CMS/CMMI Approved July 1, 2016 - June 30, 2017				
BUDGET CATEGORY	**BUDGET-YEAR 3**	**ACTUALS and Unpaid Contract Invoices to 03/31/17**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 1,552,759.00	$ 1,049,526.99	$ 503,232.01	$ -
Operating (includes Indirect Actuals*except 03/31/17)	$ 659,604.57	$ 274,602.86	$ 385,001.71	$ -
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 2,090,089.00	$ 1,140,913.70	$ 949,175.30	
PAYMENT MODELS-TOTAL	$ 4,438,261.87	$ 2,455,753.14	$ 1,982,508.73	
CARE MODELS-TOTAL	$ 573,445.08	$ 519,826.47	$ 53,618.61	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 36,738.00	$ 18,785.21	$ 17,952.79	
EVALUATION-TOTAL	$ 1,562,227.49	$ 423,200.28	$ 1,139,027.21	
GENERAL-TOTAL	$ 117,667.98	$ 117,667.98	$ -	
SUSTAINABILITY-TOTAL	$ 372,326.59	$ 133,333.36	$ 66,666.64	$ 172,326.59
CMMI Required: Population Health Plan-TOTAL	$ 35,000.00	$ 32,825.00	$ 2,175.00	
Contractual Total	$ 9,225,756.01	$ 4,842,305.14	$ 4,211,124.28	$ 172,326.59
TOTAL YEAR 3 BUDGET	**$ 11,438,119.58**	**$ 6,166,434.99**	**$ 5,099,358.00**	**$ 172,326.59**

PP2 Pie chart



PP3 Pie chart



PP3 Total Budget: $11,438,119.58

- Personnel: $1,060,990
- Fringe: $491,769
- Travel: $32,987.50
- Equipment: $14,608.76
- Other: $177,572.50
- Supplies: $10,040
- CAP: $424,395.81
- Contracts: $9,225,756.01

PP3 Proposal

- The slides below include funding through 11/30/17.
- Request for extended funds due by April 30th. This request will include funding for personnel, and associated costs, plus contracts.
- Contracts are highlighted in blue and reflect requests from DVHA and the GMCB per our March Core Team meeting recommendation.

Project Management: $117,667.98
Evaluation: $676,823.04

- Project Management:
  - UMass: $117,667.98 (reduction based on actuals)
- Evaluation:
  - Self-Evaluation Plan:
    - JSI: $562,773.50
  - Surveys:
    - Datastat: $114,049.54
    - Monitoring and Evaluation Activities:
      - Lewin, Burns, and Bailit (part of the Payment Models estimates)

Practice Transformation: $4,136,089.15

- Learning Collaboratives:
  - Abernathey: $10,284.42 ($8,715.58 reduction based on actuals)
  - VPQHC: $62,198.60
  - Core Competency:
    - DDC: $128,402.47 ($16,010.03 reduction based on actuals)
    - PCDC: $191,850.98
  - Accountable Communities for Health: $130,983
- Regional Collaborations:
  - BiState/CHAC: $754,750.05 ($106,475.00 reduction)
  - OneCare: $2,245,570
- Practice Transformation:
  - DA/SSA (Medicaid Pathway): $314,000 ($86,000.00 reduction)
  - Sub-Grant TA: Policy Integrity: $21,050 ($3,950.00 reduction based on actuals)
- Workforce Demand Model:
  - IHSGlobal: $277,000

Health Data Infrastructure: $2,073,911.82

- Home Health Agency Project:
  - VITL: $618,000 (Budget Reallocation- see below)
- Designated Agency Data Quality:
  - VITL: $75,000
- ACO Gateway Support:
  - VITL: $269,370
- Work Group Support:
  - Stone: $85,000 ($8,000.00 reduction based on actuals)
- Data Warehousing:
  - BHN/VCN: $626,754
  - H.I.S.: $7,965
- Opiate Alliance: $91,822.82
- Qlik: $300,000

Payment Model Design and Implementation: $1,885,064.38

- Several contractors provide support across Payment Models:
  - Bailit Health Purchasing, Inc.: $264,920 (increased by $20,000)
  - Burns and Associates: $350,000
  - Pacific Health Policy Group: $131,660 ($48,340.00 reduction based on actuals)
  - DLB: $19,250 ($1,750.00 reduction based on actuals)
  - Maximus: $200
  - Friedman: $10,000
  - Wakely: $200,000 (Increased by $200,000)
  - Onpoint: $255,367.93 (increased by $255,367.93)
- ACO SSPs:
  - Lewin: $653,666.45 ($125,000.00 reduction based on actuals)

Sustainability and Population Health Plan: $234,025.00

- Sustainability Plan:
  - Myers & Stauffer: $200,000
- Population Health Plan:
  - VT Public Health Assn: 30,000
  - Hester: $4,025 ($975.00 reduction based on actuals)

For discussion-carryover/NCE:

Budget Categories	7/1/16-6/30/17	7/1/17-11/30/17	TOTAL BUDGET
Personnel	897,339.00	281,425.95	1,178,764.95
Fringe	415,917.00	130,440.93	546,357.93
Equipment	7,608.76	1,000.00	8,608.76
Supplies	4,040.00	2,000.00	6,040.00
Travel	17,987.50	2,500.00	20,487.50
Other	77,572.50	5,200.00	82,772.50
Contractual	8,603,967.69	519,614.05	9,123,581.74
Indirects	358,935.81	112,570.38	471,506.19
TOTALS	10,383,368.26	1,054,751.32	11,438,119.58

For discussion-proposed budget changes:

- Budget Reallocations:
  - VITL: Budget adjustment (no change in total contract amount). Reflects reduction in pass-thru cost to vendor and increased cost to VITL and conversion to deliverables-based payments.
- Contract extensions:
  - GMCB APM activities:
    - Bailit Health Purchasing, Inc.
    - Onpoint)
  - DVHA APM activities:
    - Burns and Associates
    - Wakely Consulting
  - GMCB Evaluation and SSP activities:
    - Lewin
    - JSI

State Innovation Model Population Health Plan

Prepared by the State of Vermont for the Centers for Medicare and Medicaid Services

APRIL 2017

Table of Contents

Appendices

Funding for this report was provided by
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CDFA Number 93.624
Federal Grant Number 1G1CMS 3311811-03-01

Special Thanks

The Population Health Plan builds on two years of exploration by the members of the Vermont Health Care Innovation Project (VHCIP) Population Health Work Group. The Population Health Work Group was charged with making recommendations to leverage innovations in health system delivery and payment reforms to enhance population health improvement. The work group was led by Dr. Karen Hein, former member of the Green Mountain Care Board, and Tracy Dolan, Deputy Director of the Vermont Department of Health, and staffed by Heidi Klein (Vermont Department of Health), Sarah Kinsler (Department of Vermont Health Access/ VHCIP) and Georgia Maheras (Agency of Administration/VHCIP).

We are deeply grateful to the members of the Population Health Work Group, whose time, insight, and expertise greatly enhanced VHCIP and this Population Health Plan. This dedicated group set the vision, challenged assumptions, and ensured that proposed changes would build upon existing strengths to move our state forward in improving and protecting the health of all Vermonters.

BOX 1

What is Health?

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[1]

What is Population Health?

The health outcomes (morbidity, mortality, quality of life) of a group of individuals, including the distribution of such outcomes within the group.[2]

Defining Population

"Population" is often defined differently by different groups

- For Health Care Providers...
  Managing the health outcomes of the patients in their practice
- For Payers...
  Managing the clinical outcomes of enrolled patients and attributed lives
- For Community Members...
  Supporting health and well-being for people who live in a geographic area, either local, regional, state, or national

What are Population Health Strategies?[3]

- **Traditional Clinical Approaches** focus on individual health improvement for patients who use provider-based services;
- **Innovative Patient Centered Care and/or Community Linkages** include community services for individual patients; and
- **Community-Wide Strategies** focus on improving health of the overall population or subpopulations.

I. Introduction

Vermont's strategic vision for health reform is to achieve better care, better health, and lower costs through the implementation of payment and delivery system reforms based on the accountable care organization (ACO) model. Vermont's Population Health Plan is intended for use in future State policymaking efforts to support this strategic vision. It describes key principles and strategic policy options for integrating population health and community-wide prevention into health reform efforts, with the ultimate goal of improving the health and well-being of Vermonters throughout the lifespan. This document builds on the work of the State Innovation Models (SIM) Population Health Work Group and the activities performed over the life of the SIM Grant in Vermont.

Section II of the Population Health Plan presents a case for integrating population health and prevention into future reform efforts, and describes the many factors which contribute to health and well-being. Section III outlines five principles to guide future State health reform efforts. Section IV outlines policy options by which the State and/or regions and communities could pursue these principles. Section V describes how Vermont can measure successful implementation of the Population Health Plan.

The plan:

- Leverages and builds upon existing priorities, strategies, and interventions included in Vermont's State Health Improvement Plan (SHIP) (see Box 4 on pg. 5) and other state initiatives;
- Addresses the integration of public health and health care delivery;
- Leverages payment and delivery models as part of the existing and planned health care transformation efforts; and
- Includes elements to ensure the long-term sustainability of identified interventions.

BOX 2

We need to shift from focusing on health care to focusing on health. This means looking **longer** (over time), **earlier** (in terms of upstream interventions and the well-being of children and their families), **broader** (in terms of populations and partnerships), and **wider** (in terms of health determinants).

The SIM Grant, also known as the Vermont Health Care Innovation Project, provided Vermont with a unique opportunity to test its ability to transform the health care system in support of the Triple Aim:[4]

Better Care **Better Health** **Lower Costs**

In order to achieve this, the SIM grant has:

- Designed value-based payment models for all payers;
- Supported provider readiness for increased accountability; and
- Invested in health data infrastructure to enable timely clinical decision-making and policymaking.

A hallmark of these activities has been collaboration between the public and private sectors. The SIM process has created commitment to change and synergy between public and private cultures, policies, and behaviors. Vermont's SIM activities have invested significant resources in transforming our health care system by changing the way care is paid for and delivered, and by building critical health data infrastructure to support these changes.

Vermont's payment and delivery system efforts are occurring within the context of significant federal reforms. Since the passage of the Affordable Care Act in 2010, there have been major shifts across the country not only in the way providers think about health care, but in efforts to improve quality and moderate system costs.

Additionally, federal and state reforms have put new momentum behind actions to address the social determinants of health which shape life expectancy and health status across the lifespan and drive population health outcomes (see Box 6 and Figure 1 on pg. 6, and Figure 2 on pg. 7).

BOX 3

All-Payer Model

Vermont's All-Payer ACO Model, signed by the State and federal government in 2016, seeks to support Vermont's strategic vision for health reform. The Vermont All-Payer ACO Model builds on existing all-payer alternative payment models to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Value-based payments that shift risk onto health care providers and that are aligned across all payers encourage collaboration across the care continuum and with non-health care system partners that can improve health.

BOX 4

State Health Improvement Plan – Priorities for Population Health Improvement[5]

Vermont's State Health Improvement Plan (SHIP) is a five-year blueprint that sets the top priorities for population health improvement for 2013-2017. The SHIP includes three broad Healthy Vermonters 2020 goals, thirteen indicators, and recommended evidence-based strategies and interventions.

- **GOAL 1:**
  Reduce the prevalence of chronic disease (e.g., heart disease, diabetes, cancer, and respiratory diseases)
- **GOAL 2:**
  Reduce the prevalence of individuals with or at risk of substance use or mental illness (e.g., suicide, prescription drug use, and opioid use)
- **GOAL 3:**
  Improve childhood immunization rates (vaccinate against preventable diseases)

The development committee, led by the Vermont Department of Health, utilized the following set of guiding principles to create the SHIP:

- Determination of priority areas based on available data;
- Prevention as the highest priority for improving population health;
- Addressing conditions that impact social determinants of health;
- Achieving health equity among population groups;
- Choosing evidence-based interventions that incorporate policy and environmental approaches; and
- Monitoring progress of interventions through a strong performance management system.

BOX 5

"Population health initiatives aim to improve the health of populations by focusing the health care system on prevention and wellness rather than illness."[6]

Crawford, McGinnis, Auerbach, and Golden

BOX 6

Social Determinants of Health[7]

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

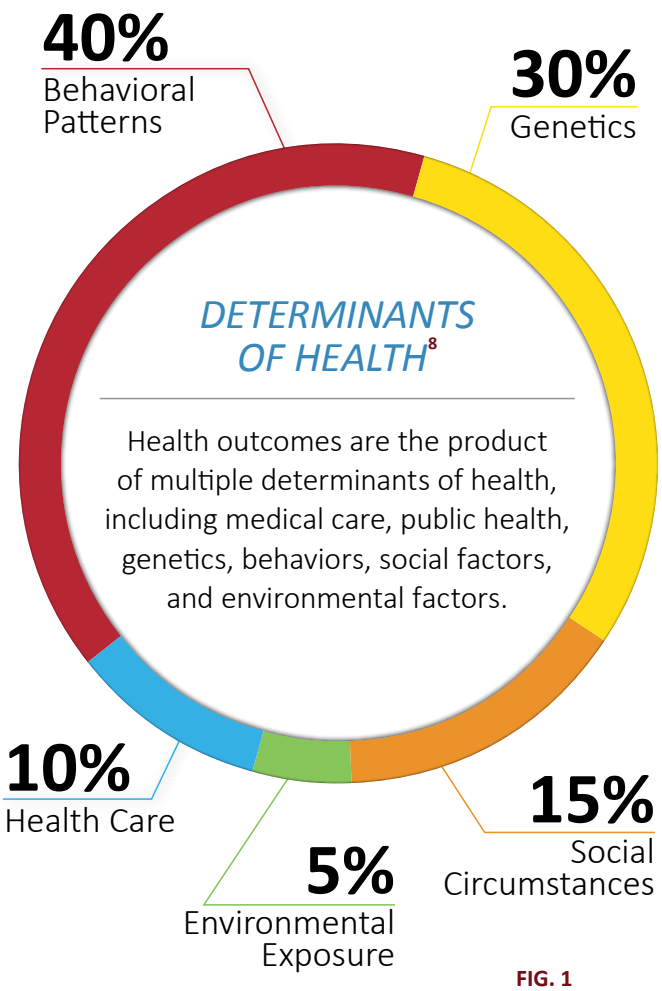


FIG. 1

II. Background

Statewide health care payment and delivery system reforms focused on individual and clinical solutions have demonstrated their ability to help slow health care cost growth and improve health care quality. However, these reforms alone cannot fully achieve Triple Aim goals and often fall short of creating equal opportunity for health and well-being across all populations and across the lifespan.

Figures 1 and 2 provide two examples of models that consider the impact of an array of factors on health outcomes. While these models are based on different research and attribute slightly different shares of health outcomes to each determinant, they make the same point: to improve population health outcomes, policies and strategies must address the social, economic, and environmental factors that contribute far more to premature death and poor quality of life than access to and quality of health care. Health improvement necessarily involves prevention, early intervention, and working across sectors to ensure that the collective policy environment becomes one that supports health and well-being.

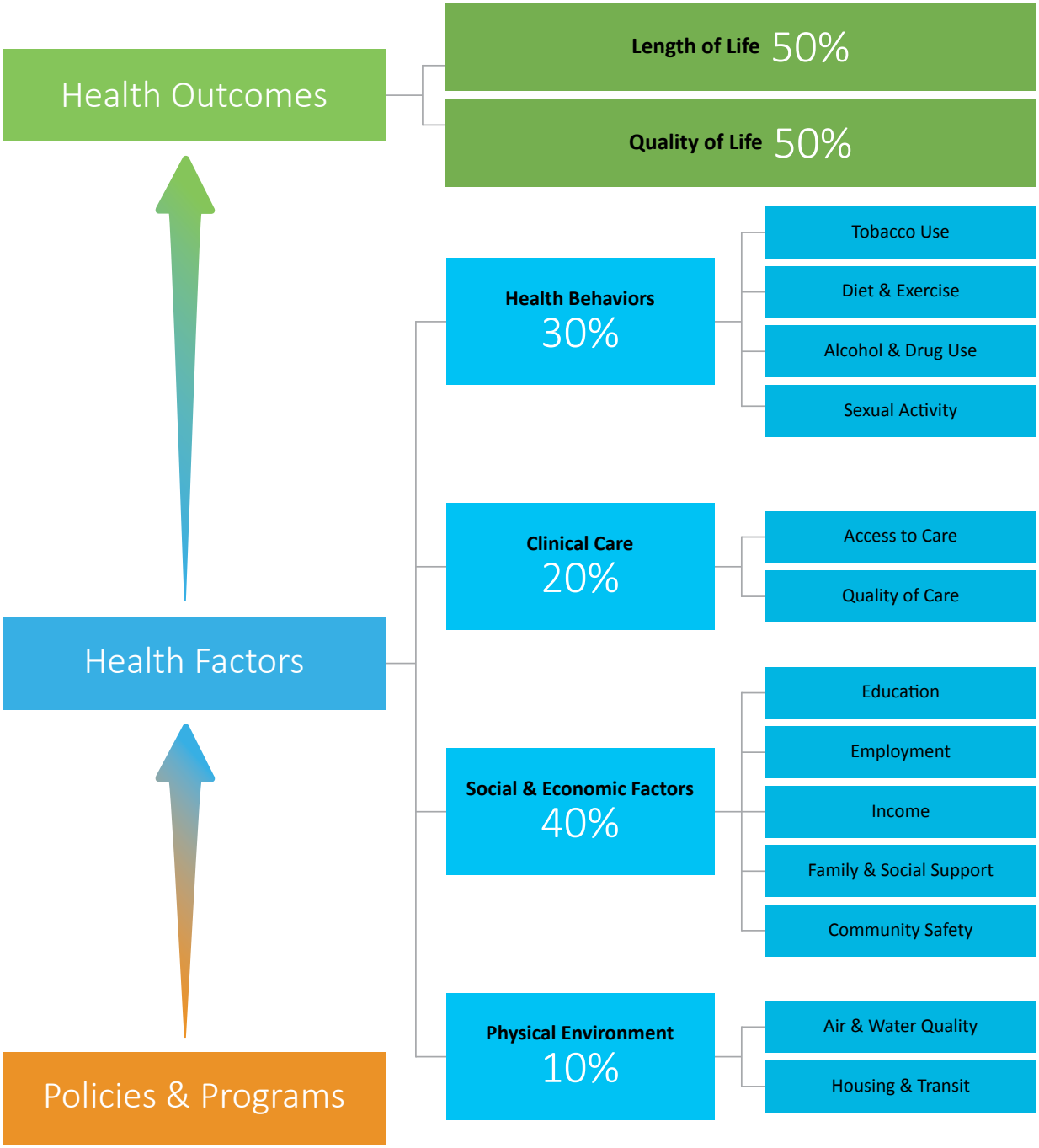
To achieve the Triple Aim, many state and federal health policymakers are partnering with communities to implement population health initiatives that engage new community partners to address both health behaviors and the social factors influencing health such as housing, food, work, and community life.

This Population Health Plan offers policymakers and payers options to more fully engage the health care sector in prevention; to incentivize partnerships that align goals and strategies across clinical care, social services, and population health improvement efforts; and to increase broad accountability for the health of a community.

County Health Rankings[9]

The County Health Rankings Model of population health emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play.

FIG. 2



BOX 7

The 9 Core Elements of an ACH are:

1. Mission
2. Multi-Sectoral Partnership
3. Integrator Organization
4. Governance
5. Data and Indicators
6. Strategy and Implementation
7. Community Member Engagement
8. Communications
9. Sustainable Financing

In many Vermont communities, ACHs are explicitly building on the governance structures and partnerships developed by the Community Collaboratives (see Box 10, pg. 12), bringing in partners to integrate population health and prevention (including VDH, public health and community prevention coalitions, ACOs, and additional partners from the social and community services sector), as well as a new framework and set of tools to help Community Collaboratives develop and meet population health goals. A visual model showing the relationship between ACHs and Community Collaboratives (see Figure 3, pg. 13). ACHs are one way to embody the principles for improving population health described in this Population Health Plan in Vermont's regions.

Accountable Communities for Health[10]

The Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic area, and not limited to a defined group of patients. An ACH supports the integration of high-quality medical care, mental health services, substance use disorder treatment, and long-term services and supports, and incorporates social services (governmental and non-governmental) for those in need of care. It also supports community-wide primary and secondary prevention efforts across its defined geographic area to promote health and wellness and reduce disparities. For more information, see Box 7 at left.

Prevention Strategies Framework: The 3 Buckets[11]

The Centers for Disease Control and Prevention (CDC) has developed a framework which identifies opportunities to incorporate prevention activities to improve population health outcomes through simultaneous action in three different domains:

- **Traditional Clinical Approaches**
  This category includes increasing the use of prevention and screening activities routinely conducted by clinical providers. Examples include: annual influenza vaccination, use of aspirin for those at increased risk of a cardiovascular event, screening for tobacco use, screening for substance use, and screening for domestic or other violence.

- **Innovative Patient-Centered Care and/or Community Linkages**
  This category includes innovative, evidence-based strategies offered within the community that are not typically leveraged by health care systems under fee-for-service payment models. Examples include: community-based preventive services, health education to promote health literacy and individual self-management, and routine use of community health teams, medication assistance treatment teams, and community health workers.

- **Community-Wide Strategies**
  This category includes specific system-wide action steps demonstrating investment in total population health. Examples include: funding for smoking-cessation groups and chronic disease self-management groups in the larger community, supporting legislation that addresses public health issues (i.e., smoking bans in bars and restaurants), and providing healthier food options at State-operated and other public venues (i.e., State offices, public schools) and in all meetings, whomever the host.

The Prevention Change Packets, developed by the Vermont Department Health in partnership with Vermont's ACOs, use this CDC framework. The Packets are intended to provide users with suggested evidence-based and best practices to include prevention in addressing health issues through simultaneous action in the three domains.

III. Five Principles for Improving Population Health

Vermont's Population Health Plan seeks to integrate population health and community prevention into the reforms that will shape Vermont's future health system. The five principles below are intended to guide State efforts to meet this goal, and should act as a framework by which to assess State policy options and efforts.

These principles are based on efforts by the SIM Population Health Work Group, a public-private partnership of health care, public health, community, and consumer leaders which met from 2014 to 2016.

1. Use Population-Level Data on Health Trends and Burden of Illness to Identify Priorities and Target Action.

Consider the health outcomes of a group of individuals, including the distribution of such outcomes within the group, in order to develop priorities and target action. Select state priorities given burden of illness, known preventable diseases, and evidence-based actions that have proven successful in changing health outcomes.

2. Support Prevention, Wellness, and Well-Being at All Levels–Individual, Health Care System, and Community.

Focus on actions taken to maintain wellness rather than solely on identifying and treating disease and illness. Particular focus should be on strategies to address mental health issues, substance use disorder, long-term services and supports, and childhood health and wellness. Prevention can be woven into all levels of the health system to improve health outcomes.

3. Address Social Determinants of Health.

Identify the circumstances in which people are born, grow up, live, work, and age. These circumstances are in turn shaped by a wider set of forces, or root causes, including race, class, gender, economics, and social policies. Consider risk factors that lower the likelihood of positive outcomes, as well as protective factors that enhance the likelihood of positive outcomes while lessening the likelihood of negative consequences from exposure to risk.

4. Engage Community Partners in Integrating Clinical Care and Service Delivery with Community-Wide Prevention Activities.

Build upon existing infrastructure (Community Collaborations, Accountable Care Organizations, and public health programs), to connect a broad range of community-based resources, and to address the interrelationships among physical health, mental health, and substance use.

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

Direct savings, incentives, and investments at efforts aimed at primary prevention, self-care, and maintaining wellness. Ensure funding priorities explicitly demonstrate spending and/or investments in prevention and wellness activities.

BOX 8

"Viewing community health as a long-term, capital-investment venture will be essential to realize population health improvement."

Centers for Disease Control and Prevention[12]

BOX 9

Health in All Policies[13]

Health in All Policies approaches seek to more fully integrate health considerations into all programs and policies, and promote better health outcomes through cross-sector collaboration and partnership. Health in All Policies considers potential impacts of every policy on health and well-being, and utilizes all available authorities, policies, budgets, and programs to improve health.

IV. Policy Options

Vermont has historically been on the leading edge of health reform relative to other states. The State has supported policy development, implementation, funding, and regulation, which sets the necessary foundation for statewide reforms. Many of these reforms include changes that must be adopted by partners both at the state and regional levels. The State recognizes the need for reform efforts to be responsive to the needs of each community or region's unique population, noting that success depends on building upon local resources and partnerships. Flexibility to allow for local innovation and community leadership have been a key thread running through many reforms implemented over the past decade.

There are four strategic levers that enable the State to continue to support local innovation and flexibility in health reform: governance, care delivery requirements and incentives, measurement, and payment and financing methodologies. It also offers policy options for each lever to support integration of population health and prevention, in line with the five principles described in Section III of the Population Health Plan.

- **Governance:** Who participates in decision-making? Governance can include: setting strategic vision and direction; formulating high-level goals and policies; overseeing management and organizational performance; and ensuring that an organization or project is achieving the desired outcomes while acting prudently, ethically, and legally.

- **Care Delivery Requirements and Incentives:** How is care delivered? Care delivery requirements and incentives can push health care providers and organizations to change their behavior to better support population health improvement goals.

- **Measurement:** What is the impact? By integrating measurement of population health outcomes, Vermont can increase provider, policymaker, and community attention to priority community health concerns and the factors that drive them. Additionally, measuring population health outcomes can allow for payment incentives or penalties tied to population health goals.

- **Payment and Financing Methodologies:** How are population health and prevention activities funded? Payment and financing methodologies can incentivize providers and the system as a whole to increase their focus on population health goals and social determinants of health.

Table 1 summarizes these four levers and identifies Vermont-specific policy options which are described in the remainder of Section IV.[14]

Table 1:
Levers and Policy Options to Promote Integration of Population Health and Prevention into Health Reform

Lever	Descriptions and Examples of Potential Levers	Vermont-Specific Policy Options
Governance	» Require public health representatives on regional and statewide governance or advisory structures. » Require or encourage partnerships across sectors, including criminal justice, transportation, recreation, food system, and education.	» Ensure public health and prevention representation in state-level payment & delivery system reforms like the Blueprint for Health, Medicaid Pathway, All-Payer Model oversight and monitoring. » Ensure public health representation in regional governance like the Community Collaboratives. » Maintain a statewide stakeholder group that makes recommendations to State health policy leadership to encourage population health integration and coordination. » Expand partnerships like the Governor's Health in All Policies Task Force and sponsor local Health in All Policies efforts (see Box 9, pg. 10).
Care Delivery Requirements and Incentives	» Create opportunities for integration of primary care, mental health services, substance use disorder treatment, and long-term services and supports (as described in the Vermont Model of Care, see Box 11, pg. 14). » Increase referrals to specific public health improvement programs, such as tobacco cessation. » Offer comprehensive preventive and social services. » Include non-medical services that can improve health, such as housing, in total cost of care calculations. » Support programs that bridge medical care with efforts to impact social determinants.	» Embed integration requirements into regulation, contracting, and evaluation and monitoring activities for all state-level payment and delivery system reforms. » Utilize Prevention Change Packets to incorporate prevention strategies into clinical care settings. » Incentivize regional efforts to support population health improvement goals. Examples include: Accountable Communities for Health, Community Collaboratives, and Learning Collaboratives.
Measurement	» Begin the development process by identifying the most significant contributors to the health outcomes that drive morbidity and mortality in the state or in a region or community (e.g., physical activity, tobacco use, and diet lead to diabetes, heart disease, respiratory disease, and cancer). » Develop population health metrics that incorporate both short-term actions/processes and longer-term outcomes. » Develop and require metrics that capture population health interventions. » Leverage existing data sources to identify population health needs and support collaborations.	» Include statewide measures of population health to measure success of major reforms, and to drive priority-setting for improvement initiatives. » Include screening measures for key conditions in payment and reporting measure sets for payment reforms. » Use local data to assess community health needs within each Hospital Service Area. » Provide region-specific data like Blueprint Profiles and Vermont Department of Health Community Assessments to each region.
Payment and Financing Methodologies	» Use financing to help provider groups address social determinants of health and initiatives that impact future health status. » Employ value-based payment mechanisms that hold providers financially accountable for community-level performance to encourage partnerships across provider organizations and with prevention and public health.	» Utilize existing regulatory oversight mechanisms — like Certificate of Need, Health Resource Allocation Planning, Insurance Rate Review, and Hospital Budget Review — to support investment in population health and prevention activities. » Embed public health accountability requirements into payment, monitoring, and evaluation activities for all state-level payment and delivery system reforms. » Encourage alternative, region-specific financing and funding activities. Examples include recent investments in Chittenden County to provide support for the homeless population.

BOX 10

Community Collaboratives

Community Collaboratives are local structures within each of Vermont's 14 Hospital Service Areas[15], which support provider collaboration and alignment between Blueprint and ACO quality measurement, data analysis, clinical priorities, and improvement efforts. They convene leaders from the health care provider community, as well as social service and community organizations. These collaboratives seek to build an integrated health system including: care for individuals with substance use disorders, mental health needs, and/or those who are in need of long-term services and supports. Integrated care would provide necessary programs, services, and infrastructure to address the circumstances in individuals' lives which contribute to health.

Many Community Collaboratives include representatives from the public health and prevention sector, which has been promoted by participation in the Accountable Communities for Health Peer Learning Laboratory, and are increasingly engaging in strategic planning for community-based prevention activities as a result of Peer Learning Laboratory participation. A visual model showing the relationship between ACHs and Community Collaboratives is shown in Figure 3.

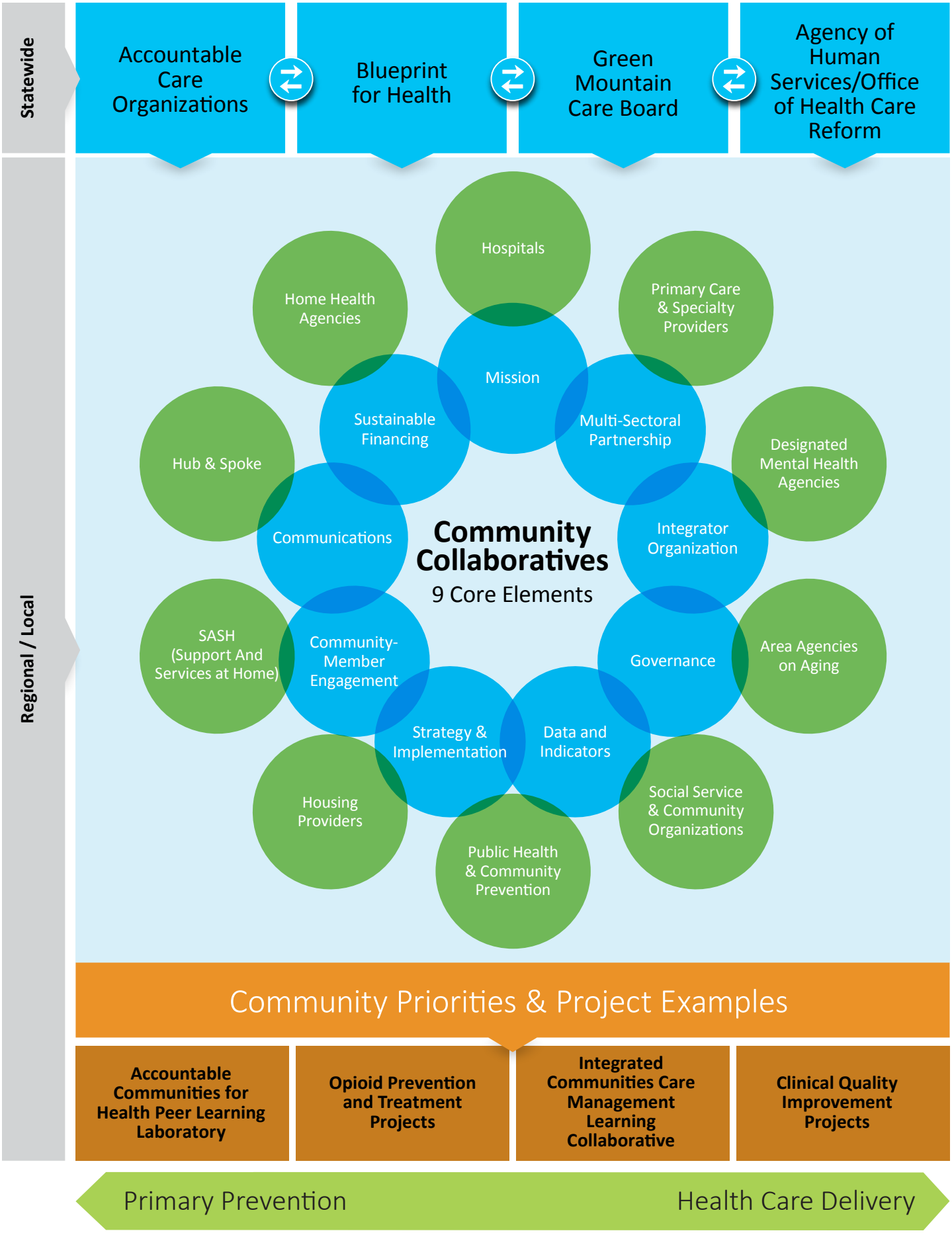
Governance

Governance dictates which partners are included in decision-making for projects and organizations through formal boards or through informal advisory structures. State regulation or other actions can outline expectations for governance of entities utilizing government funding or requiring governmental licensing and approval. Increased public health and prevention participation in governance structures can add meaningful authority and can ensure integration of data and community-wide strategies to impact the factors that contribute to positive health and well-being.

Policy Options: Governance Requirements

- Require organizations or projects to have public health and social services organization representatives on their boards. Embed governance requirements in Medicaid contracts with ACOs and other providers, and require ACOs, through Act 113 of 2016, to include public health and prevention leaders in their governing entities.
- Encourage continued engagement of public health and prevention partners in the Community Collaboratives (see Box 9 at left) to support regional priority-setting and foster relationships between public health, clinical care, and social services.
- Maintain a statewide public/private stakeholder group that recommends activities that improve health to State health policy leadership and encourages coordination and alignment across population health efforts throughout the state.
- Expand partnerships to other sectors that impact health. Build upon the efforts of the Governor's Health in All Policies Task Force, which brings together nine core state agencies charged with considering potential impacts to health and well-being, and with utilizing available authorities, policies, budgets, and programs to improve health (see Box 9, pg. 10).

FIG. 3


Statewide
Accountable Care Organizations
Blueprint for Health
Green Mountain Care Board
Agency of Human Services/Office of Health Care Reform
Regional / Local
Hospitals
Primary Care & Specialty Providers
Designated Mental Health Agencies
Area Agencies on Aging
Social Service & Community Organizations
Public Health & Community Prevention
Housing Providers
SASH (Support And Services at Home)
Hub & Spoke
Home Health Agencies
Mission
Multi-Sectoral Partnership
Integrator Organization
Governance
Data and Indicators
Strategy & Implementation
Community-Member Engagement
Communications
Sustainable Financing
Community Collaboratives
9 Core Elements
Community Priorities & Project Examples
Accountable Communities for Health Peer Learning Laboratory
Opioid Prevention and Treatment Projects
Integrated Communities Care Management Learning Collaborative
Clinical Quality Improvement Projects
Primary Prevention
Health Care Delivery

BOX 11

The Vermont Model of Care[16]

The Vermont Model of Care is the foundation for care delivery transformation in Vermont. It was developed and endorsed by a broad, multi-sectoral group of stakeholders.

Key elements of the Vermont Model of Care are:

1. Person/Family Centered and/or Directed Services and Supports
2. Access to Independent Options Counseling & Peer Support
3. Involved Primary Care Provider (PCP)
4. Single Point of Contact (Case Manager)
5. Medical Assessments and Disability and Long-Term Services and Support Screening by PCPs, Medical Specialists
6. Disability and Long-Term Services and Support Specific Assessments
7. Comprehensive Care Plan
8. Individual Care Team
9. Support During Care Transitions
10. Use of Technology for Information-Sharing

Care Delivery Requirements and Incentives

Care delivery requirements and incentives can push health care providers and organizations to change their behavior to better support population health goals. For over a decade, Vermont has been working to shift from a fragmented care delivery system to one that provides more coordinated care. These policy options could support efforts to build on that foundation by developing a health system that further integrates social services, public health, and community-wide prevention.

Policy Options: Care Delivery Requirements and Incentives

- Create expectations within regulatory processes and contract vehicles that require entities to demonstrate how they will support achieving the components of Healthy Vermonters 2020, the All-Payer Model population health measures, and the Vermont Model of Care (see Box 11 at left).
- Utilize the strategies in the Prevention Change Packets – developed by VDH in collaboration with Vermont's ACOs for the main ACO measures using the Prevention Strategies Framework (see pg. 8) – to assist clinical and community providers, Community Collaborative leaders, and public health partners in working across systems to incorporate prevention strategies to improve population health and well-being.
- Incentivize Community Collaboratives to fully develop into Accountable Communities for Health, resulting in an expanded focus that includes community-wide primary and secondary prevention efforts which affect broad policy changes and key community infrastructure, and which promote inclusion a broader set of partners (see Governance).

Measurement

By integrating measurement of population health outcomes and well-being, Vermont can increase provider, policymaker, and community attention to priority community health concerns and the factors that drive them.

Policy Options: Measurement

- Use statewide measures of population health to measure success of major reforms, as Vermont will do through the All-Payer Model.
- Use population health measures to drive statewide priority setting for improvement initiatives.
- Continue to include screening measures for key conditions like obesity, tobacco use, and cancer in the measure sets for payment reforms, using data already collected for other purposes wherever possible. This practice, as part of the Medicaid and commercial Shared Savings Program, has driven priority setting by Vermont's ACOs, Blueprint practices, and Community Collaboratives.
- Assess needs and resources at the community and regional levels through tools like Community Health Needs Assessments (CHNAs) (see Box 13, pg. 15).
- Provide region-specific data, like that through the Blueprint Profiles and the Health Department Community Assessments, to each hospital service area and Community Collaborative.

BOX 12

Key Data Sources

Vermont uses a variety of key data resources to inform State and regional planning and priority-setting for public health, prevention, and health care reform activities. These include Healthy Vermonters 2020, the VDH Data Encyclopedia, Blueprint for Health Hospital Service Area (HSA) Health Care Data Profiles, and the Health Care Expenditure Analysis. These reports build on multiple datasets, including the Behavioral Risk Factor Surveillance Survey (BRFSS), the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES, Vermont's all-payer claims database), the Vermont Health Information Exchange (VHIE, operated by Vermont Information Technology Leaders), and the Vermont Uniform Hospital Discharge Data Set. (For more information on health datasets, see the Vermont Health Data Inventory Report).

Healthy Vermonters 2020

This is the state health assessment plan published in 2012 by the Vermont Department of Health that documents the health status of Vermonters and will guide the work of public health through 2020. This report presents more than 100 public health indicators and goals for 2020 in 21 focus areas organized into five thematic chapters. In addition to the plan, there is a Data Explorer web page that allows for the user to search the 21 focus areas by County, Health District Offices, and Hospital Service Areas from 2001 thru 2009.

Data Encyclopedia: A Review of Data Sources and Resources Available at The Vermont Department of Health

This publication provides an overview of the commonly-used data sources to assess and track population health outcomes as well as contributors to disease in Vermont. The data sources include surveys, registries (birth, death, disease, and immunization), health care claims data, discharge data, and licensing data. Public use data sets have been developed for many of these sources. This Encyclopedia includes the Behavioral Risk Factor Surveillance Survey, Immunization Registry, Vital Records for Birth and Death, Vital Records for Marriage/Divorce/Civil Unions/Dissolutions/ITDPS, and the Youth Risk Behavior Survey.

Blueprint Hospital Service Area (HSA) Health Care Data Profiles

The Vermont Blueprint for Health's Hospital Service Area (HSA) Profiles, provide policymakers, health care providers, and other stakeholders with information on health care expenditures, utilization, and care quality measures at the HSA level. These Profiles are created using claims data and clinical data from the Blueprint Clinical Registry.

Health Care Expenditure Analysis

This report provides the history of Vermont health care spending by year, payer, and provider since 1992, including both spending on behalf of Vermont residents and spending by Vermont providers for both residents and non-residents. It allows comparisons of Vermont spending to the federal National Health Expenditures analysis.

BOX 13

Community Health Needs Assessments (CHNAs)

Federal law requires non-profit hospitals to conduct CHNAs every three years, and to develop an implementation strategy to meet identified needs. The Green Mountain Care Board has instructed Vermont's hospitals to submit their CHNAs as part of the budget review process and has established a Policy on Community Health Needs Assessments to guide their use in the budget review process. They are used by hospitals to identify areas of focus and are an integral resource for a community-benefit plan. Public health agencies are critical partners in the CHNA community engagement process, provide much of data used by Vermont hospitals and can assist in developing community-wide strategies to address identified needs.[17]

Payment and Financing Methodologies

The biggest single barrier to improving the health of Vermont's population is the lack of a sustainable financial model which supports and rewards improvements in population health. In the past, population health interventions have been financed primarily by grants and limited-term awards, which resulted in the termination of successful programs when their funding ended. Payment methodologies (how health care providers and other organizations are paid for their work) and financing methodologies (how funds move through the health system) can support population health goals by creating alternative paths to funding sustainability.

Some actions to support investment in population health activities (including non-clinical services) that maximize health outcomes include pursuing alternative payment models such as all-inclusive population-based payments, medical home payments and other pay-for-performance arrangements, Community Health Team payments, and bundled or episodic payments.

In addition to value- and population-based models currently being pursued, Vermont could explore alternative financing models for population health. A conceptual model for sustainable population health financing includes the following elements:[18]

1. **Diverse financing vehicles:**
   A more diverse set of financing vehicles to support population health interventions so that interventions are not overly dependent on grants.

2. **Balanced portfolio of interventions:**
   Meeting community needs requires a balanced portfolio of interventions: a combination of programs and initiatives which are balanced in terms of length (short-term interventions with immediate results vs. long-term interventions with results decades in the future), risk of failure, scale (total funds and staff commitment), and financing vehicle.

3. **Integrator or backbone organization:**
   The integrator brings together key community stakeholders to assess needs and build a consensus of priorities. It then builds the balanced portfolio over time, matching each intervention with an appropriate financing vehicle and an implementer organization.

4. **Reinvestment of savings:**
   One of the basic principles of long-term sustainability is shifting a greater proportion of overall spending to activities that will improve community health and decrease the overall illness burden, for example by capturing a portion of the savings from health system activities and returning them to the community for reinvestment in primary prevention activities. A community wellness fund is a useful repository for these captured savings.

Policy Options: Payment and Financing Methodologies

- Include accountability for the health of populations in payment, monitoring, and evaluation activities for state-level payment and delivery system reforms.
- Continue to support hospital investment in community health improvement priorities through the Green Mountain Care Board's policy on Community Health Needs Assessments.
- Increase payments and funding for referrals to activities that support population health improvement (e.g., by allowing physician payment for smoking cessation classes or medications).
- Incorporate mechanisms that encourage or require accountability for the health of populations in value-based contracts from the Agency of Human Services and its Departments.
- Pool resources within regions or communities to support specific initiatives like food security or ending homelessness.
- Utilize additional state regulatory and procurement activities to support population health goals:
  - Certificate of Need;
  - Health Resource Allocation Plan;
  - Insurance Rate Review;
  - Hospital Budget Review;
  - Professional Licensure; and
  - Contracting.
- Utilize existing State resources, through the State budget process, to support optimal population health investments across State government.

BOX 14

Community Spotlight:

Mt. Ascutney Hospital and Health Center

Mission, Vision, and Goals from the Community Health Needs Assessment

MISSION:

To improve the lives of those we serve.

VISION:

Development of programs based on community need and sustainability.

Overarching community goals:

1. Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death;
2. Achieve health equity, eliminate disparities, and improve the health of all groups;
3. Create social and physical environments that promote good health for all; and
4. Promote quality of life, healthy development, and healthy behaviors across all life stages.

BOX 15

"There is growing recognition among state policymakers that improving health outcomes is as much about addressing the social determinants of poor health as it is about providing high-quality medical care. … [T]he traditional fee-for-service (FFS) payment system does not support the kinds of reforms that would enable states to focus on the nonmedical factors influencing health. A number of states are…finding ways to use payment models that reward good outcomes over greater volume and allow providers to invest in nonmedical interventions that improve health."[19]

Crawford, McGinnis, Auerbach, and Golden

BOX 16

Community Spotlight:

The University of Vermont Medical Center Housing for the Homeless

The University of Vermont Medical Center (UVM Medical Center) has forged partnerships with community organizations across Vermont to develop efficient and creative solutions for long-term, sustainable housing options. Starting in the fall of 2013, the UVM Medical Center granted funds to Harbor Place, a motel that offers temporary, emergency housing and connects guests to case management and health care services to community members who lack stable housing. Since then, they have also paid for over 600 bed nights for patients. Through partnerships and collaborations with community organizations, they developed upstream approaches to combat the effects of poverty in Vermont. Over the past two years, they have supported an emergency warming shelter in Burlington through direct funding and a daily linen service. In the spring of 2015, the UVM Medical Center collaborated with the Champlain Housing Trust, Burlington Housing Authority, Safe Harbor Health Center's Homeless Healthcare Program and others to support Beacon Apartments, a permanent housing site that will provide apartments for chronically homeless adults. The result has been significant savings in health care services, as individuals are better-connected to services to keep them well and stable.

V. Measuring Successful Plan Implementation

BOX 17

To achieve the Triple Aim – better care, better health, and lower cost – Vermont must use multiple policy levers guided by the principles of population health improvement and prevention.

We will know we are on the path to success when:

- Health system actions are primarily driven by data about population health outcomes; goals and targets are tied to statewide data and priorities identified in the State Health Improvement Plan.
- The health system creates health and wellness opportunity across the care and age continuum and utilizes approaches that recognize the interconnection between physical health, mental health and substance use, and underlying societal factors and determinants of health.
- Payment and financing mechanisms are in place to: support use of prevention strategies in the clinical setting; increase clinical/community partnerships; and invest in community-wide infrastructure and action.
- An expanded number of entities are accountable for the health of the community including: health care providers, public health, community providers, and others who affect health through their work on housing, education, early childhood, economic development, transportation, and more.
- Action is taken to address the underlying social determinants of health which influence the opportunities for health and wellness for all Vermonters.

Appendix A: RESOURCES

In addition to the references cited directly in this plan (see Appendix D: References), three key frameworks for policymakers and communities are included below.

National Prevention Strategy

The Surgeon General's National Prevention Strategy outlines a unified set of goals, priorities, and strategies for the nation and communities.

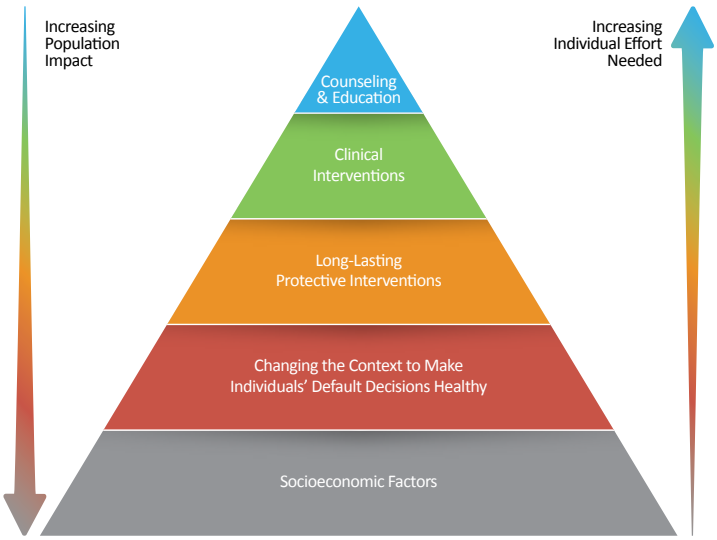
National Prevention Council. "National Prevention Strategy." 2011. Available at https://www.surgeongeneral.gov/priorities/prevention/strategy/.

Health Impact Pyramid

The Health Impact Pyramid, developed by former CDC Director Thomas R. Frieden, visualizes the impact of different types of public health interventions.

T.R. Frieden. "A framework for public health action: the health impact pyramid." American Journal of Public Health 100.4 (2010): 590-595.

FIG. 4: Health Impact Pyramid

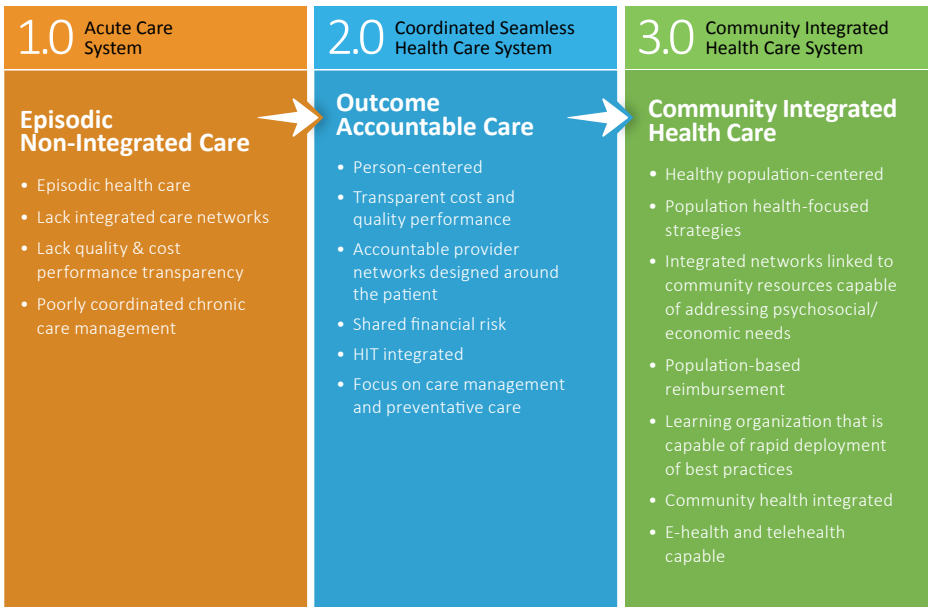


Health System Transformation Framework: 1.0, 2.0, 3.0

Vermont has effectively utilized state policy levers to create the foundation for payment and delivery system reforms that shift from fragmented care to more integrated care. In Figure 5 at right, Vermont is actively working to move from a coordinated health care system (2.0) to a community integrated health care system (3.0), building on previous work to coordinate care across clinical and social services.

Adapted from N Halfon, P Long, D Chang, et al (November 2014). "Applying A 3.0 Transformation Framework to Guide Large-Scale Health System Reform." Health Affairs (Millwood) 33(11):2003-2011. Available at: http://content.healthaffairs.org/content/33/11/2003.abstract.

FIG. 5: Vermont Health Care Delivery System Evolution

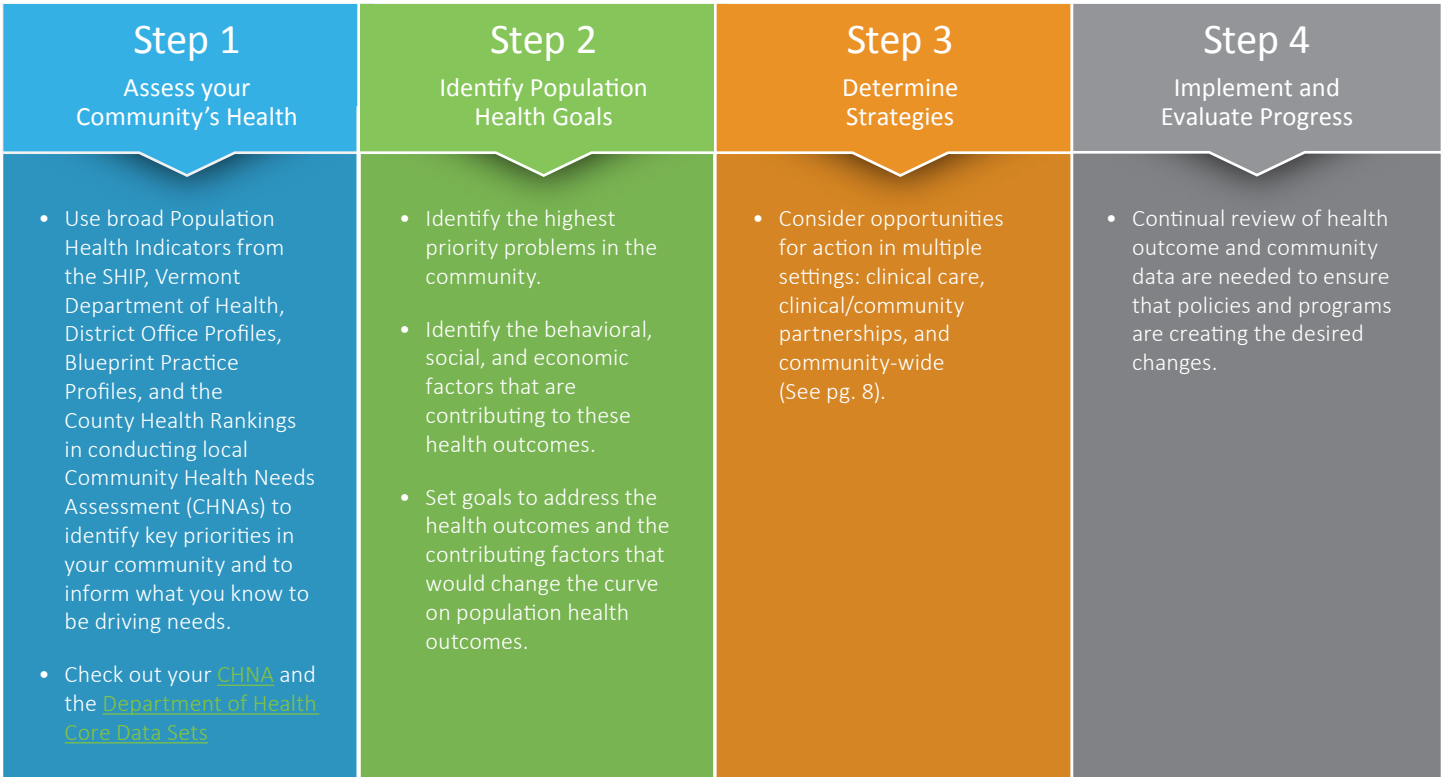


Appendix A: RESOURCES cont.

Action Steps for Improving Population Health

These action steps, adapted from a National Quality Forum Action Guide, can guide communities pursuing population health improvement.

FIG. 6



Adapted from National Quality Forum (2016). Improving Population Health by Working with Communities: Action Guide 3.0.
Available at: http://www.qualityforum.org/Publications/2016/08/Improving_Population_Health_by_Working_with_Communities__Action_Guide_3_0.aspx.

Appendix B: GLOSSARY[20]

Determinants of Health
Factors affecting the health of individuals in a population or subpopulation, such as the social and physical environment, behaviors, and healthcare.[21]

Health
A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[22]

Health Disparities
Differences in health status or health outcomes within a population.[23]

Health Equity
The absence of systematic disparities in health or major social determinants of health between groups with different underlying social or economic advantages/disadvantages.[24]

Health Inequity
Differences in health status between groups with varying social and economic advantage/disadvantage (e.g., socioeconomic status, gender, age, physical disability, sexual orientation and gender identity, race and ethnicity) that are caused by inequitable, systemic differences in social conditions (i.e., policies and circumstances that contribute to health determinants).[25]

Population (also, Total Population)
All individuals in a specified geopolitical area.[26]

Population Health
The health of a population, including the distribution of health outcomes and disparities in the population.[27]

Subpopulation
A group of individuals that is a smaller part of a population. Subpopulations can be defined by geographic proximity, age, race, ethnicity, occupations, schools, health conditions, disabilities, interests, or other shared characteristics.[28]

Appendix C: ACRONYMS

ACA
Affordable Care Act

ACH
Accountable Community for Health

ACO
Accountable Care Organization

AHS
Agency of Human Services (VT)

CAHPS
Consumer Assessment of Healthcare Providers and Systems

CHNA
Community Health Needs Assessment

CMMI
Center for Medicare and Medicaid Innovation (federal)

CMS
Centers for Medicare & Medicaid Services (federal)

DMH
Department of Mental Health (VT)

DVHA
Department of Vermont Health Access

FFS
Fee-for-Service

SIM
State Innovation Models

SHIP
State Health Improvement Plan

VDH
Vermont Department of Health

VHCIP
Vermont Health Care Innovation Project

VHCURES
Vermont Healthcare Claims Uniform Reporting and Evaluation System

Appendix D: REFERENCES

[1] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, June 19-22, 1946; signed on July 22, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on April 7, 1948. For more information, see: http://www.who.int/about/mission/en/.

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[5] To learn more about Vermont's State Health Improvement Plan, visit the Vermont Department of Health website: http://healthvermont.gov/hv2020/ship.aspx.

[6] M Crawford, T McGinnis, J Auerbach, and K Golden. Population Health in Medicaid Delivery System Reforms. New York, NY: Milbank Memorial Fund (March 2015). Available at: http://www.milbank.org/publications/population-health-in-medicaid-delivery-system-reforms/.

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[13] To learn more about Vermont's Health in All Policies effort, visit the Vermont Department of Health website: http://healthvermont.gov/about/vision/health-all-policies.

[14] This framework is adapted from a technical assistance memo developed by Katherine Heflin and Tricia McGinnis of the Center for Health Care Strategies. ("Population Health Integration Framework" [memorandum], 2015). Some examples have been adapted from a technical assistance document developed by Manatt, Phelps & Phillips ("Policy Levers Template," 2015).

[15] Hospital Service Area definitions can be found here: http://www.healthvermont.gov/GIS/.

[16] More information on the Vermont Model of Care can be found here: http://healthcareinnovation.vermont.gov/content/vt-integrated-model-care-overview-may-2016.

[17] For more information, visit the Green Mountain Care Board's website for hospital Community Health Needs Assessment reports: http://gmcboard.vermont.gov/hospital-budget/health-needs.

[18] Adapted from JA Hester, PV Stange, LC Seeff, JB Davis, and CA Craft (2015). Towards Sustainable Improvements in Population Health: Overview of Community Integration Structures and Emerging Innovations in Financing.

[19] M Crawford, T McGinnis, J Auerbach, and K Golden. Population Health in Medicaid Delivery System Reforms.

[20] All definitions are drawn from National Quality Forum (2015). Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities— Action Guide 2.0. Available at: http://www.rchnfoundation.org/wp-content/uploads/2015/08/Multistakeholder-Input-Population-Health-Action-Guide-2.pdf. Definitions are cited below according to their original sources.

[21] Adapted from World Health Organization (WHO). "Health Impact Assessment: The determinants of health" [website]. Available at http://www.who.int/hia/evidence/doh/en/. Last accessed July 2016.

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[23] Institute of Medicine (IOM). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press; 2002.

[24] Adapted from Braveman P (2006). Health disparities and health equity: concepts and measurement. Annu Rev Public Health 27:167-194.

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Vermont Health Care Innovation Project

Vermont
State Innovation Model
Sustainability Plan

Prepared by the State of Vermont for the Centers for Medicare & Medicaid Services

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Executive Summary

In 2013, Vermont was awarded a $45 million State Innovation Model (SIM) grant from the federal Centers for Medicare and Medicaid Innovation (CMMI). The resulting effort, known as SIM or as the Vermont Health Care Innovation Project (VHCIP), has worked to test innovative payment and delivery system reform models throughout our State. SIM was important for building the capacity for, and consensus to, innovate prior to testing of these new models.

This is the Sustainability Plan (Plan) for Vermont's SIM grant. This Plan describes recommendations for sustaining the projects implemented under SIM following the end of the grant in June 2017. In-depth recommendations can be found in the Sustainability Recommendations by Focus Area section; a high-level summary is in Appendix A.

The State, in partnership with a contractor, Myers and Stauffer LC, has developed these sustainability recommendations in collaboration with VHCIP stakeholders. The State sought stakeholder feedback through a variety of means, including: an electronic survey on sustainability that was sent to over 300 SIM participants; 12 key informant interviews; and a Sustainability Sub-Group of private-sector partners representing all VHCIP Work Groups, consumers, advocates, and other key stakeholders. A detailed description on these activities can be found in the Research and Methods section of the Plan.

Five SIM Focus Areas

Payment Model Design and Implementation: Supporting creation and implementation of value-based payments for providers in Vermont across all payers.

Practice Transformation: Enabling provider readiness and encouraging practice transformation.

Health Data Infrastructure: Supporting provider, payer, and State readiness to participate in alternative payment models.

Evaluation: Ongoing evaluation of investments and policy decisions.

Project Management: Support for all VHCIP activities.

Vermont's SIM work has occurred in five focus areas: Payment Model Design and Implementation, Practice Transformation, Health Data Infrastructure, Evaluation, and Project Management. More information about all of Vermont's SIM activities can be found here.

Payment Model Design and Implementation: *Supporting creation and implementation of value-based payments for providers in Vermont across all payers.*

VHCIP's payment model design activities were performed on a multi-payer basis as much as possible. These payment models were designed to meet providers where they are, whether they are ready to assume financial risk or need additional readiness supports. They were also designed to ensure that the payers can operationalize the new structures and the State can evaluate each program. By establishing a path for all providers, we phased in reforms broadly, but responsibly.

Building off of the successful launch of our patient-centered medical home efforts (the Blueprint for Health program), Vermont launched Medicaid and commercial Shared Savings ACO Programs in 2014. Nearly 60% of Vermonters were participants in these two programs, which aligned with the Medicare Shared Savings ACO Program. The three ACOs that participated in these programs included the majority of Vermont's health care

providers—including many of our long-term services and supports and mental health providers. The commercial Shared Savings ACO Program continued into calendar year 2017.

VHCIP supported the design and testing of various other value-based payment models intended to promote improved care, better health, and reduced costs, including prospective payment systems, bundled payments, and capitation.

In October 2016, Vermont reached agreement with CMS on an All-Payer Model that builds on the reforms and infrastructure developed and piloted under VHCIP, and will be the next big step forward in Vermont's health system transformation. The Vermont All-Payer ACO Model is an agreement between the State and the federal government on a sustainable rate of growth for health care spending in that state; it includes strict quality and performance measurement and is intentionally aligned with Vermont's Global Commitment for Health 1115 waiver renewal. Under the All-Payer ACO Model, the State will apply the Next Generation ACO payment model across all payers as a move away from fee-for-service (FFS). The focus on the ACO and existing CMS ACO programming, along with Vermont's strong stakeholder network, SIM investments, and the current SSP program, is a timely and realistic evolution of Vermont's multi-payer reform. Eventually, an integrated ACO in Vermont could attract and involve the vast majority of people, payers, and providers. As a first step in the All-Payer Model implementation, the State and OneCare Vermont signed a contract in February 2017 to launch a risk-bearing Medicaid ACO under a Vermont Medicaid Next Generation program for a pilot performance period of calendar year 2017.

Practice Transformation: *Enabling provider readiness and encouraging practice transformation.*

VHCIP's care delivery transformation activities were designed to enable provider readiness to participate in alternative payment models and accept higher levels of financial risk and accountability. This area of work included designing transformation activities that support provider readiness and spur innovation, as well as monitoring Vermont's existing workforce supply and demand. Two areas of early success were the Integrated Communities Care Management Learning Collaborative and the Provider Sub-Grant Program (detailed information on the Sub-Grant Program can be found in Appendix E).

The Integrated Communities Care Management Learning Collaborative, launched in late 2014, sought to improve care and reduce fragmentation for at-risk Vermonters and their families by enhancing integrated care management across multi-organizational teams of health and human services providers. The first cohort of the Learning Collaborative included three communities and 90 providers, and the initiative expanded to add two new cohorts with teams of health care and service providers from 8 additional interested communities in the state. The Learning Collaborative utilized a Plan-Do-Study-Act quality improvement model punctuated with periodic in-person and virtual learning sessions. The program evaluated whether these interventions improved coordination of care and services.

In addition, VHCIP invested nearly $5 million over 3 years in a Sub-Grant Program to support provider-level innovation. The Sub-Grant Program supported over 15,000 Vermont providers in transforming care delivery models and impacted over 300,000 Vermonters from all over the state. The program acted as a testing ground for provider-led change, with most projects driven by provider practices and collaborations.

Health Data Infrastructure: *Supporting provider, payer, and State readiness to participate in alternative payment models.*

VHCIP's health data infrastructure development activities supported the development of clinical, claims, and survey data systems to support alternative payment models. VHCIP made strategic investments in clinical data systems to allow for passive quality measurement – reducing provider burden while ensuring accountability for health care quality – and supporting real-time decision-making for clinicians. VHCIP also worked to strengthen Vermont's data infrastructure to support interoperability of claims and clinical data, and predictive analytics.

These investments yielded significant improvements in the quality and quantity of data flowing from providers' electronic medical records (EMRs) into the Vermont Health Information Exchange (VHIE). Through these investments, we expanded connectivity to the VHIE for an additional 400 providers in Vermont. We also improved data quality for ACO-attributing providers and Designated Agencies through targeted projects. Our investments supported several planning activities including: the identification of baseline EMR/VHIE connectivity metrics and 10-year targets; systemic identification and cataloguing of challenges; and, identification of data gaps for non-Meaningful Use providers to support strategic planning around data use for all providers across the continuum. Notably, we identified several challenges to interoperability including: transmission of unstructured data fields; limitations to data sharing among non-HIPAA covered entities; and usability of data collected for one purpose, but used for another.

Evaluation: *Ongoing evaluation of investments and policy decisions.*

All VHCIP efforts were evaluated to ensure they supported positive outcomes for Vermont, including its residents, payers, and providers. Rapid-cycle evaluations occurred by program, by population, and by region throughout the project to ensure that VHCIP did not inadvertently cause negative unintended consequences, to support dissemination of lessons learned, and expand use of best practices. State-led evaluation confirms that overall, communities are engaged in capacity building, quality improvement, and advancement in care integration and coordination. State guidance and local innovation have driven reform efforts statewide. Shared savings and sub-grant investment have also served to increase redesign efforts.

Project Management*: Support for all VHCIP activities.*

VHCIP activities were supported by staff and contractors who ensured the project was organized, had sufficient resources, and met all goals and milestones. This included public engagement activities: since the launch of the SIM grant, Vermont actively engaged hundreds of stakeholders and members of the public as participants in the various SIM work groups, as well as through existing groups and additional forums. VHCIP engaged stakeholders through email communications, our website, in-person meetings, and webinars. Of note, the project's work group, Steering Committee, and Core Team meetings were open to the public, and public comment was solicited at each meeting.

Collaboration Across Focus Areas

Vermont's payment and delivery system reforms are designed to help Vermont achieve the Triple Aim of better care, better health, and lower costs. In order to achieve this goal, Vermont designed a population health approach that includes value-based payment models for all payers, support for provider readiness and increased

accountability, and health data infrastructure improvements to enable timely[1] information for clinical decision-making, evaluation, and policy-making. In addition, the State made efforts to ensure that workforce needs were strategically considered. A hallmark of VHCIP activities was collaboration between the public, private sectors, consumers, and advocates which created commitment to change and synergy between public and private cultures, policies, and behaviors.

SIM focus areas and underlying projects were developed and refined in response to needs identified by the Vermont health care community according to a multifaceted population health approach. The work required coordinated effort to ensure that challenges were not addressed in silos, but collaboratively with inputs from all relevant partners. In addition, it was vital to develop infrastructure to support projects, the communities they serve, and all of their participants. Investments in functional models such as The Vermont Model of Care (more information on this is found on page 23), as well as, documents like the Population Health Plan, provided a common conceptual framework necessary to ensure continued collaboration and integration toward that goal. Furthermore, the VHCIP website provided a high level of transparency to stakeholders by providing current status reports, calendars, and other resource materials in a timely manner.

In addition to the Population Health Plan, there are other fundamental planning and statement documents, tools, and other items developed, built upon, or strengthened through the SIM process that outline foundational principles, recommendations, and strategies that are integrated into the State's overall work. These include, but are not limited to:

- The State Health Improvement Plan (SHIP) (see pg. 15);
- The Health Care Workforce Strategic Plan (see pg. 24); and
- The State Health Information Technology (HIT) Plan (see pg. 26).

Project Impact: All Performance Periods

By June 2017, Vermont's payment and delivery system reform efforts impacted hundreds of providers and hundreds of thousands of beneficiaries across multiple payers. Throughout its SIM Grant, Vermont engaged in activities to support innovative payment model design and implementation, practice transformation, health data infrastructure investments, evaluation, and project management. Below is an abbreviated list of progress to date:

- Through Vermont's ACO SSPs, the Blueprint for Health's PCMH program (pay-for-performance model), and Vermont's Hub & Spoke model (a Section 2703 Medicaid Health Home program), a collective 309,387 Vermonters – more than half of the State's eligible population – participated in payment reform activities.
    - We continued expansion of a *Pay-for-Performance* program, implemented through the Blueprint for Health. The PCMH *Pay-for-Performance* component of the Blueprint has approached a saturation point where the program has recruited most of the primary care practices in the State, and the rate of onboarding of new practices has slowed.
    - We continued expansion of the *Medicaid Health Home* program, also known as the Hub and Spoke program[2]. As of January 2017, the Hub and Spoke program was impacting 5,858 Vermonters through 196 participating Spoke providers and 5 Hubs.

[1] Depending on the clinical decision, timely can mean within hours or within a few days. This is based on technical standards established for systems and clinical goals. For example, the Event Notification System requires data to be transmitted within hours of the admission, discharge, or transfer being sent to the VHIE.
[2] This program is jointly led by the Blueprint and Vermont's Department of Health.

  - We engaged in design and analyses to support decision-making related to the *All-Payer Model* and *Medicaid Value-Based Purchasing* (Medicaid Pathway) activities. The *All-Payer Model* began in January 2017 with the Vermont Medicaid Next Generation payment model and Year 0 of the Medicare Next Generation payment model.

- Through initiatives aimed at improving health care delivery, Vermont's SIM grant engaged 420 providers in a Learning Collaborative focused on care delivery and practice transformation, and 692 providers and 281,808 Vermonters through the Sub-Grant Program.
  - *Learning Collaboratives* support improved and integrated care management in Vermont communities, including a Core Competency Training Series for front-line care management staff.
- Improvements to health data infrastructure impacted over 400 providers. This work includes larger projects that continue the expansion of electronic health records (EHRs) to small and rural providers, as well as more targeted efforts that provide technical assistance to improve provider workflows for data entry.
  - We engaged in several activities to expand provider connectivity to the VHIE, in particular, *Gap Remediation* work built on gap analyses conducted during Performance Periods 1 and 2. This work focused on ACO-attributing providers and Designated Agencies and improved the quantity of data flowing through EMRs and into the VHIE.
  - Vermont worked to improve the *Quality of Data Flowing into the VHIE*. In June 2016, the Terminology Services hardware and software implementation was complete. This improved the quality of data within the VHIE translating data to standardized nomenclature. Throughout 2015 and 2016, we worked with providers on data quality work flow improvement activities resulting in better quality data being input into EMRs and more usability by those providers, ACOs, and the State.
- We finalized the SIM *Population Health Plan*, which offers a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes.
- *Execution of the VHCIP State-Led Evaluation Plan.* Vermont's State-Led Evaluation contractor completed and submitted three deliverables in June 2016: 1) Environmental Scan Findings and Site Visit Plan; 2) initial draft of Learning Dissemination Plan; and 3) list of secondary data sources that will be incorporated into VHCIP evaluation reporting. They continue to work through the end of the grant to deliver final evaluation deliverables.

SIM Sustainability Definitions

The State views SIM investments in three categories with respect to sustainability:

- One-time investments to develop infrastructure or capacity, with limited ongoing costs;
- New or ongoing activities which will be supported by the State after the end of the Model Testing period; and
- New or ongoing activities which will be supported by private sector partners after the end of the Model Testing period.

One-time investments have been an intentional focus of much of Vermont's SIM work. This has included many of Vermont's health data infrastructure investments, as well as work to launch new payment models. Most project management activities are also included in this category.

This report describes each SIM work stream and makes recommendations for sustainability starting on page 15. Appendix A provides a high-level summary of sustainability recommendations.

This Plan assigns responsibility for sustaining previously SIM-funded efforts to two groups:

Lead Entities – A Lead Entity is the organization recommended to assume ownership of a project once the SIM funding opportunity has ended. A Lead Entity may be a public or private sector organization from the Vermont health care community. These entities may not have complete governance over a project, but they do have a significant leadership role and responsibility and will serve as coordinating bodies to ensure work continues to move forward. They will not act as the sole decision-making body for projects, but will convene and work with Key Partners (below) and other entities to sustain projects by securing funding and providing direction. Lead Entities are likely to include, but are not limited to:

- State Agencies, Departments, programs, and regulatory bodies, including the Agency of Administration (AOA); the Agency for Human Services (AHS) and its Departments; the Blueprint for Health program; the Department of Disabilities, Aging, and Independent Living (DAIL); the Green Mountain Care Board (GMCB); and
- The Vermont Care Organization (VCO).

Key Partners – Key Partners are a more comprehensive network of State partners, payers, providers, consumers, and other private-sector entities who will be critical partners in sustaining previously SIM-funded efforts. Key Partners will be responsible for communicating across program areas to ensure consistency in development through appropriate ongoing evaluation. In addition, Key Partners may provide logistics support or disseminate information to consumers – providing information regarding in-person participation or how to access materials electronically.

They may be public or private sector entities within or outside of the Vermont health care community. These entities represent the broader community and overlapping concerns inherent in the project's mission and objectives. Depending on the project, Key Partners may include those listed above as Lead Entities. Key Partners also are likely to include:

- Additional State Agencies and Departments, including the Vermont Department of Health (VDH), the Department of Labor (DOL), and the Department of Information and Innovation (DII);
- Payers, including commercial payers, CMS/Medicare, and the Department of Vermont Health Access (DVHA)/Medicaid;
- Providers and provider organizations,
- Consumers and advocates;
- The Community Collaboratives active in each region of Vermont;
- Key statewide organizations and programs like the Vermont Program for Quality in Health Care, Inc. (VPQHC), Support and Services at Homes (SASH), and Vermont Information Technology Leaders (VITL); and
- Federal partners: CMS, CMMI, and the Office of the National Coordinator for Health Information Technology (ONC).

The Plan's recommendations for Lead Entities and Key Partners are made based on anticipated program capacity, roles, functions, and program needs. It is possible that Lead Entities and Key Partners, as well as their relationships to individual projects, will change in the future; this Plan's recommendations reflect the best possible leadership

and participation options at this point in time. The Vermont health care community must continue to be flexible as it moves forward with reform – evaluating and revising roles and functions as necessary.

While the work of SIM occurs in different areas, and is often performed by different stakeholders, there is a concerted effort to ensure open communication and sharing of information across activities, projects, and participants. As evidenced by the success of the VHCIP governance structure, this communication network has allowed Vermont to minimize duplication of effort and resource waste.

As in any innovative testing opportunity, some areas of SIM investment have had mixed or limited success. These activities were identified through Vermont's sustainability planning process, ensuring lessons learned are harvested and incorporated into future planning. For example, while some projects funded under the Provider Sub-Grant Program were not successful in meeting stated goals, all projects have furthered State and provider learning.

More detailed information on the work accomplished by Vermont's SIM initiative can be found at http://healthcareinnovation.vermont.gov/.

Introduction

The State Innovation Models (SIM) Initiative is a grant program for states, administered by the Center for Medicare and Medicaid Innovation (CMMI). The purpose of the SIM program is to improve health system performance, foster quality of care, and decrease costs for all citizens including Medicare, Medicaid, and Children's Health Insurance Program recipients. CMMI is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models. CMMI is analyzing states' ability to use policy and regulatory levers, engage a comprehensive range of stakeholders, and build on existing efforts to lead system transformation. The SIM initiative capitalizes on the role of states as purchasers and regulators to facilitate health care transformation. Noting states' tradition of leading health care innovation, the Centers for Medicare & Medicaid (CMS) hopes to avoid obstacles of previous reform models by aligning public and private efforts.

In the first round of SIM Initiative funding, which began April 1, 2013, CMMI awarded Model Testing cooperative agreements to six states—Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont. These Round 1 Model Testing states designed and implemented statewide health care innovation plans to accelerate transformation, including testing innovative, multi-payer health care delivery system and payment models. The State of Vermont was awarded a $45 million SIM grant, which began in 2013.[3] Vermont's SIM Grant built on an infrastructure of reforms already underway and accelerated our ability to design, test, and implement new reforms. It also provided us with an opportunity to leverage successful initiatives such as our Blueprint for Health. The Blueprint for Health is a transformation engine that establishes state and local infrastructure to do both program implementation and quality improvement/practice transformation work. It puts in place project managers and practice facilitators, which comprise a transformation network allowing for the launch of statewide initiatives.

Vermont's SIM Testing Grant began with the overarching goal of meeting the Triple Aim. This would be met through three primary drivers:

- Improving payment models by aligning financial incentives with the three aims;
- Improving care delivery models by enabling and rewarding integration and coordination; and
- Improving the exchange and use of health information by developing a health information system that supports improved care and measurement of value.

During Vermont's first Performance Period, the State launched the Medicaid and commercial Shared Savings (SSP) Accountable Care Organization (ACO) Programs, continued expansion of the Blueprint for Health pay-for-performance patient-centered medical home (PCMH) program, and began evaluating episodes of care. In conjunction with these payment model design and implementation efforts, Vermont embarked on a process to create a unified regional practice transformation structure that would be codified as Community Collaboratives in Performance Period 2. Performance Period 1 also included significant investments in health information technology (HIT) to support payment and delivery system reforms.

[3] Vermont SIM Performance Period Timeline:
Performance Period 1: October 2013-December 2014
Performance Period 2: January 2015-June 2016
Performance Period 3: July 2016-June 2017 (extended through November 2017)

During the latter part of Performance Period 1 and first half of Performance Period 2, Vermont engaged in significant project analyses, including a mid-project risk assessment, to ensure that all activities were meeting project goals and enabling the State to progress further towards meeting the Triple Aim.

Performance Period 2 also focused on supporting key practice transformation initiatives, which included an expansion of the Learning Collaboratives and the Provider Sub-Grant Program. During this time, Vermont began to analyze its health data infrastructure and launched data warehousing solutions for Designated Agencies and the Blueprint for Health program and began long-term data warehouse planning. Vermont also began conversations with CMMI regarding an All-Payer Model that would follow the SIM Test period.

In addition to the yearly operational and evaluation requirements of SIM, the State of Vermont is required to produce a Sustainability Plan for submission to CMMI by June 30, 2017. The plan must address all areas of Vermont's SIM work including governance, communications, projects launched within each of the three main VHCIP focus areas: Payment Model and Design Implementation (PMDI), Practice Transformation (PT), Health Data Infrastructure (HDI), as well as, Evaluation and Project Management. Vermont contracted with Myers and Stauffer LC to assist the State in developing the Sustainability Plan.

This Plan documents the process for sustainability for Vermont's SIM-funded activities to support the statewide goals of better care, better health, and lower costs; it also identifies Lead Entities and Key Partners to guide future efforts in each area identified as an ongoing investment. In addition, this Plan considers lessons learned from the various SIM investments and how they might contribute to program sustainability.

This Sustainability Plan is organized into five sections:

- Background and Overview;
- SIM Governance;
- Research and Methods;
- Sustainability Recommendations by Focus Area; and
- Conclusion.

It also includes six appendices:

- Appendix A summarizes recommendations by focus area;
- Appendix B includes the result of an online survey to assess stakeholder sustainability priorities;
- Appendix C describes themes from key informant interviews;
- Appendix D lists members of the private-sector Sustainability Sub-Group;
- Appendix E describes projects funded under the provider Sub-Grant Program; and
- Appendix F provides a glossary of terms used throughout the Plan.

SIM Governance

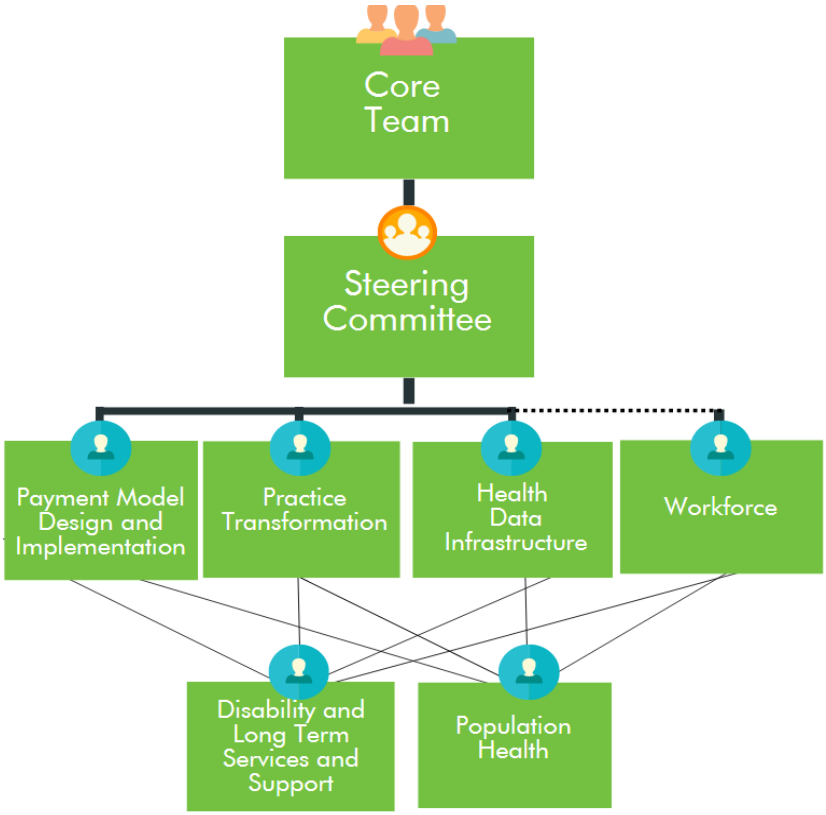
Vermont's SIM efforts were guided by a Core Team, a Steering Committee, and six Work Groups, all of whom met publicly for discussion and decision-making. The Core Team met monthly to provide overall direction to Vermont's SIM project; synthesized and acted on guidance from the Steering Committee; made funding decisions; set project priorities; and helped resolve any conflicts within the project initiatives. The Steering Committee also met on a monthly basis and informed, educated, and guided the Core Team in all of the work planned and conducted under the SIM grant. In particular, the group guided the Core Team's decisions about investment of project funds; necessary changes in State policy; and how to best influence desired innovation in the private sector. VHCIP's Work Groups were made up of representatives from an array of organizations affected by reform in health care policy and practice, including providers, insurers, and individual consumer participants. *Figure 1. Vermont SIM Governance Structure* below depicts the SIM governance structure. The Work Groups included: Payment Model and Design Implementation; Practice Transformation; Health Data Infrastructure; Health Care Workforce; Disability and Long-Term Services and Supports (DLTSS); and Population Health.

SIM allowed for a very distinct governance structure that supported collaboration across models, programs, and payers to make decisions about SIM-funded projects within the State. Stakeholders reported that the governance structure, particularly the Work Groups, were a cornerstone of Vermont's SIM success and served to bring about unprecedented collaboration, shared learning, and cross-program innovation.

This Plan recommends that future governance structures be responsive to State and private sector priorities, look across all populations, including special populations, and address upstream prevention. These structures should also address current and anticipated health care workforce issues.

More information, including lists of Work Group participants can be found here: http://healthcareinnovation.vermont.gov/stakeholders/work-groups.

Figure 1. Vermont SIM Governance Structure



Research and Methods

Myers and Stauffer LC used a variety of sustainability resources from notable health care and non-health care entities to develop a sustainability framework for this project. Myers and Stauffer utilized information gathered from document reviews, key informant interviews, Sustainability Sub-Group meetings, and other research to further refine the sustainability framework for this project.

In general, sustainability is defined as an organization's ability to maintain a project over a defined period of time.[4] Long-term sustainability depends on an organization's ability to move a project from a demonstration phase to a program phase – transitioning the project to a standard, resourced operation in support of the organization's mission.

The elements of sustainability are the organizational and contextual supports, or resources, needed to maintain a project over time. They include:

- Leadership support;
- Financial support;
- Legislative/regulatory/policy support;
- Provider-partner support;
- Consumer and advocacy community support;
- HIT and health information exchange (HIE) system support;
- Data support;
- Project growth and change support;
- Administrative support; and
- Project management support.

Myers and Stauffer used this framework to ground State leadership and stakeholder discussions of sustainability.

Vermont SIM Research

Myers and Stauffer LC performed a thorough document review of SIM information from CMS and other sources concerning innovation projects occurring throughout the states. In addition, SIM-related documents developed by the State were obtained and reviewed. The team also researched media sources related to the Vermont SIM project, including statewide and regional information, Vermont's Medicaid program, legislature, government structure, geography, relevant legislation, policy, and political environment. Additionally, Myers and Stauffer LC met with John Snow, Inc., Vermont's SIM State-Led Evaluation contractor, and reviewed available evaluation materials.

Electronic Stakeholder Survey

[4] This definition is generic and references any organization or entity that seeks to maintain a project. Program Sustainability Assessment Tool (2012). Center for Public Health Systems Science, George Warren Brown School of Social Work, Washington University in St. Louis. Available at: https://sustaintool.org/understand.

Myers and Stauffer, LC deployed a survey in August 2016 to seek input from over 300 SIM participants on sustainability priorities, based on a review of projects within each SIM focus area. The anonymous survey consisted of eight questions. Participants were provided a list of concrete examples to rate as "Highly Important", "Somewhat Important", "Neutral", "Less Important", "Not Important", or "I don't know". Forty-seven SIM participants, a 15% response rate, completed the survey during August-September 2016. These survey results were shared with the SIM Sustainability Sub-Group to inform their discussions.

The three top projects determined by respondents to be important within each focus area are as follows:

Payment Model Design and Implementation

- Activities related to quality and performance measurement, including efforts to reach consensus on quality measure sets and to simplify measurement and provider accountability for new and existing payment models;
- Readiness activities and development of payment reforms to support integration of community-wide prevention and public health efforts with integrated care efforts (*Accountable Communities for Health*); and
- Payment reforms to support integration of physical health and substance abuse services (*Health Home/Hub and Spoke Program*).

Practice Transformation

- Activities to engage Vermont regions in quality improvement initiatives to develop cross-organizational relationships and teams to support integrated care (*Integrated Communities Care Management Learning Collaborative*);
- Activities to support development of regional unified health systems, including governance and quality improvement infrastructure, across ACOs, Blueprint for Health, and other initiatives (*Regional Collaborations/Community Collaboratives*); and
- Funding to providers and/or community-based organizations engaged in payment and delivery system transformation to transform practice and test promising models (*Sub-Grant Program*).

Health Data Infrastructure

- Support for development of shared *Care Management Tools* (Shared Care Plan Project; Universal Transfer Protocol Project; Event Notification System);
- Activities to evaluate non-Vermont HIE (VHIE)-connected providers' HIT/EHR capabilities to assess gaps in ability to connect to the VHIE, especially for DLTSS providers (*Gap Analyses*); and
- Activities to remediate identified gaps in HIT and HIE capabilities for providers not already connected to the VHIE, especially for DLTSS providers (*Gap Remediation).*

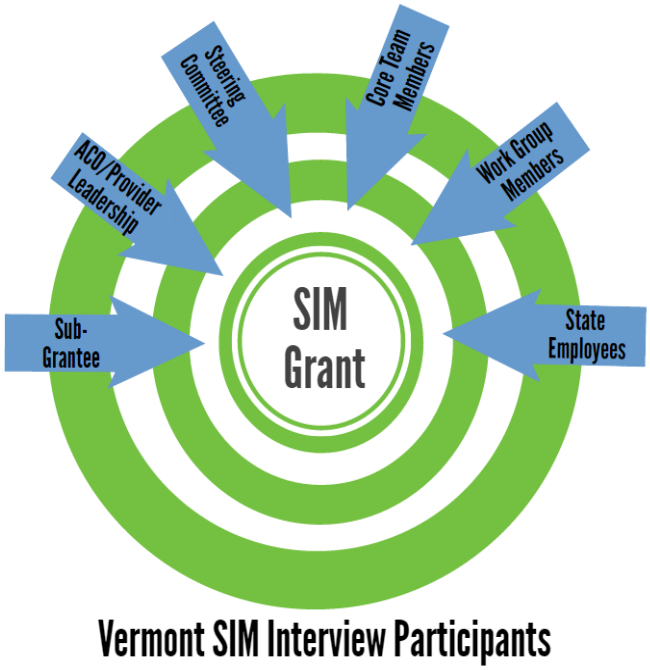
A copy of this survey, including results, can be found in Appendix B.

Key Informant Interviews

Also, during the months of August and September 2016, Myers and Stauffer LC interviewed 12 individuals from the private and public sector. These individuals were selected in collaboration with State personnel. Interviews were performed either in-person or on the phone to identify areas of successful SIM investment that should be sustained and barriers to sustainability. All interviewee responses were kept anonymous with only the contractor knowing which responses came from which individuals. *Figure 2. Roles of Persons Interviewed Related to SIM* lists the collective various roles of the 12 individuals who were interviewed by Myers and Stauffer LC.

Interviewees were asked about sustainability, in particular, what SIM projects or aspects of SIM should be sustained at the end of the grant. Interviewees were also asked to state what barriers they saw in sustaining these projects. The following results are listed by focus area. A more comprehensive summary of the key informant interviews can be found in Appendix C.

Figure 2. Roles of Persons Interviewed Related to SIM



Payment Model Design and Implementation

Several interviewees cited the uncertainty regarding the *All-Payer Model* as a potential barrier. Between the interviews and the submission of this Plan, Vermont began implementation of the All-Payer Model. Stakeholders expressed concern about the governance and structure of the model. Programs or efforts that interviewees spoke highly of were:

- *Pay for Performance (*Blueprint for Health).
- *ACO Shared Savings Programs* (SSPs).

Practice Transformation

Interviewees stated they supported the continuation of the *Learning Collaboratives*, *Core Competency Trainings*, and *Regional Collaborations/Community Collaboratives*. Interviewees noted the SIM dollars allowed for support of the Learning Collaboratives on a statewide level, which has hosted national experts speaking on clinical topics and provided for in-person training sessions.

Health Data Infrastructure

Interviewees agreed that HDI investments must continue for future health care reform efforts to succeed; many noted that current HDI efforts are a work in progress.

Projects under the HDI focus area that interviewees believe should continue to be sustained are as follows:

- *Improve Quality of Data Flowing into VHIE*.
- *Care Management Tools*: Shared Care Plan, Universal Transfer Protocol (UTP), Event Notification System.

Sustainability Sub-Group

In September 2016, the State convened a group of private sector stakeholders who have participated in a wide spectrum of our SIM activities to inform Sustainability Plan development in concert with State-side planning and priority-setting. This group, called the Sustainability Sub-Group, met six times from September to December 2016 to provide input on which projects to sustain within each focus area and for the project overall. A copy of the membership list can be found in Appendix D.

This document contains recommendations from this Sub-Group. The SIM Work Groups, the Steering Committee, and the Core Team reviewed and commented on draft recommendations in November and December 2016. This

version of the plan has been revised based on stakeholder comments, and will be presented to the Core Team again in spring 2017 for review and final approval, followed by submission to CMMI in June 2017.

Sustainability Recommendations by Focus Area

Vermont's payment and delivery system reforms are designed to help Vermont achieve the Triple Aim: better care, better health, and lower costs. The State has adopted a multi-faceted approach to health care innovation by designing value-based payment models for all payers, supporting provider readiness for increased accountability, and improving health data infrastructure. In addition, the State has made great efforts to ensure collaboration across payers, providers, and stakeholder groups. The role of the consumer and consumer advocate has been a vital component of Vermont's SIM achievements.

Sustained work streams/projects cross all three main focus areas – Payment Model Design and Implementation, Practice Transformation, and Health Data Infrastructure – as well as Project Management and Evaluation.

This section provides a description of work streams by focus area, including current status, and recommendations for sustaining the project beyond the SIM funding opportunity. Sustainability recommendations fall into three categories:

- One-time investments to develop infrastructure or capacity, with limited ongoing costs;
- New or ongoing activities which will be supported by the State after the end of the Model Testing period; and
- New or ongoing activities which will be supported by private sector partners after the end of the Model Testing period.

One-time investments have been an intentional focus of much of Vermont's SIM work. This has included many of Vermont's health data infrastructure investments, as well as work to launch new payment models. Most project management activities are also included in this category.

This Plan assigns responsibility for sustaining previously SIM-funded efforts to two groups:

Lead Entities – A Lead Entity is the organization recommended to assume ownership of a project once the SIM funding opportunity has ended. A Lead Entity may be a public or private sector organization from the Vermont health care community. These entities may not have complete governance over a project, but they do have a significant leadership role and responsibility. will serve as coordinating bodies to ensure work continues to move forward. They will not act as the sole decision-making body for projects, and will convene and work with Key Partners (below) and other entities to sustain projects by securing funding and providing direction. Lead Entities are likely to include, but are not limited to:

- State Agencies, Departments, programs, and regulatory bodies, including the Agency of Administration (AOA); the Agency for Human Services (AHS) and its Departments; the Blueprint for Health program; the Department of Disabilities, Aging, and Independent Living (DAIL); the Green Mountain Care Board (GMCB); and
- The Vermont Care Organization (VCO).

Key Partners – Key Partners are a more comprehensive network of State partners, payers, providers, consumers, and other private-sector entities who will be critical partners in sustaining previously SIM-funded efforts. Key Partners will be responsible for communicating across program areas to ensure consistency in development through appropriate ongoing evaluation. In addition, Key Partners may provide logistics support or disseminate

information to consumers – providing information regarding in-person participation or how to access materials electronically.

They may be public or private sector entities within or outside of the Vermont health care community. These entities represent the broader community and overlapping concerns inherent in the project's mission and objectives. Depending on the project, Key Partners may include those listed above as Lead Entities. Key Partners also are likely to include:

- Additional State Agencies and Departments, including the Vermont Department of Health (VDH), the Department of Labor (DOL), and the Department of Information and Innovation (DII);
- Payers, including commercial payers, CMS/Medicare, and the Department of Vermont Health Access (DVHA)/Medicaid;
- Providers and provider organizations,
- Consumers and advocates;
- The Community Collaboratives active in each region of Vermont;
- Key statewide organizations and programs like the Vermont Program for Quality in Health Care, Inc. (VPQHC), Support and Services at Homes (SASH), and Vermont Information Technology Leaders (VITL); and
- Federal partners: CMS, CMMI, and the Office of the National Coordinator for Health Information Technology (ONC).

The Plan's recommendations for Lead Entities and Key Partners are made based on anticipated program capacity, roles, functions, and program needs. It is possible that Lead Entities and Key Partners, as well as their relationships to individual projects, will change in the future; this Plan's recommendations reflect the best possible leadership and participation options at this point in time. The Vermont health care community must continue to be flexible as it moves forward with reform – evaluating and revising roles and functions as necessary.

Some projects remain ongoing at the time of the delivery of this initial draft report. In these cases, we have indicated sustainability status is pending the project's completion.

Additional work will be required to provide recommendations on the future ownership of the project, including future roles and responsibilities. A template providing this information at a high-level can be found in Appendix A. This template, like this Plan, is a draft only and subject to change based on feedback received.

Population Health:

The State Innovation Model Population Health Plan

Vermont's Population Health Plan describes the State's plan builds on the work of the SIM Population health work group and the activities performed over the life of the SIM Grant in Vermont. It also outlines the State's strategies to improve the health and well-being of all Vermonters.

The plan:

- Leverages Vermont's State Health Improvement Plan (SHIP) and other state initiatives to address the integration of public health and health care delivery;
- Includes a data-driven implementation plan that identifies measurable goals, objectives, and interventions that will enable the State to improve the health of the entire State population; and
- Includes elements to ensure the long-term sustainability of identified interventions.

To learn more about the objectives of the Population Health Plan, please access via: http://healthcareinnovation.vermont.gov/.

State Health Improvement Plan (SHIP)

In 2013, the Vermont Department of Health led a collaborative endeavor to develop the State Health Improvement Plan. Using Healthy Vermonters 2020, the state's health assessment, as a foundation, key department and external stakeholders reviewed health status indicators of Vermonters with the goal of identifying three to five statewide strategic health priorities.

The State Health Improvement Plan presents the priorities and improvement strategies agreed upon by multiple public health partners. It provides the framework for creating healthier Vermont communities through 2017, and a strategic focus for SIM improvement projects.

The guiding principles called for a focus on:

- Determination of priority areas based on available data;
- Prevention as the highest priority for improving population health;
- Addressing conditions that impact social determinants of health;
- Achieving health equity among population groups;
- Choosing evidence-based interventions that incorporate policy and environmental approaches; and
- Monitoring progress of interventions through a strong performance management system.

Focus Area: Payment Model Design and Implementation

The PMDI focus area supports the creation and implementation of value-based payments for providers in Vermont across all payers.

ACO Shared Savings Programs (SSPs)

Vermont's SSPs were designed to align with Track 1 of the Medicare SSP where ACOs can earn shared savings without downside risk, as long as financial quality targets are met. Vermont launched this alternative payment model for commercial and Medicaid beneficiaries in 2014 as three-year programs.

Vermont's three ACOs participated in these programs. The ACOs are Community Health Accountable Care, LLC (CHAC), Accountable Care Coalition of the Green Mountains/Vermont Collaborative Physicians (ACCGM/VCP – also known as Health*First*) and OneCare Vermont (OCV). Collectively, these ACOs include all of the State's hospitals, plus Dartmouth-Hitchcock, most of the State's physicians, all of the State's federally-qualified health centers (FQHCs), and many of the State's home health and mental health providers. All Vermont ACOs participated in SSPs with Medicare and Vermont commercial payers. Two participated in a Vermont Medicaid SSP through 2016. ACCGM/VCP withdrew from the Medicare SSP in 2016.

While the commercial SSP has extended to Year 4 (CY2017), Vermont's Medicaid SSP ended. DVHA launched a risk-based Medicaid Next Generation ACO Pilot Program for CY2017. Key SSP operational staff continued to participate in the program implementation, preserving program knowledge and ensuring alignment across related initiatives. Vermont's payers will continue to offer SSPs as a transitional model that builds towards the Next Generation-style model of the All-Payer Model over the next five years. Because of this transition, this will be an ongoing activity for several years.

Sustainability Recommendation

Ongoing activities and investments. Recommended Lead Entity: GMCB. Recommended Key Partners: Payers (DVHA, BCBSVT, and CMS), ACOs, AHS, and its Departments, Consumers, and Advocates.

Pay-for-Performance (Blueprint for Health)

During Vermont SIM, the Blueprint for Health program provided performance payments to advanced primary care practices recognized as PCMHs, as well as provided multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement.

The Blueprint is a transformation engine that has fueled much innovation within Vermont. However, it's *Pay-for-Performance* component has limited opportunity for continued growth, having reached most eligible practices in Vermont. The Blueprint is a key partner to ACOs as the state transitions to the All-Payer Model.

Medicare provided financial payments in the Blueprint from 2011-2016 through the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration. Medicare continued payments in 2017 through one-time funds included the All-Payer Model agreement; after 2017, the Medicare funding for Medicare beneficiaries in this program will flow through as part of population-based payments.

Ongoing activities and investments. Recommended Lead Entity: VCO. Recommended Key Partners: AHS, (DVHA-Blueprint), GMCB, Consumers, and Advocates.

Health Home/Hub and Spoke

During Vermont SIM, the Hub and Spoke initiative was a Medicaid Health Home initiative created under Section 2703 of the Affordable Care Act which served Vermont Medicaid beneficiaries with opioid addiction. The Hub and Spoke model integrated addictions care into general medical settings (spokes) and linked these settings to specialty addictions treatment programs (hubs) in a unifying clinical framework.

The Hub and Spoke program is operated under an amendment to Vermont's Medicaid State Plan. Program implementation and reporting are ongoing, and will continue until there are changes to the Medicaid State Plan.

Ongoing activities and investments. Recommended Lead Entity: AHS. Recommended Key Partners: DVHA-Blueprint, VDH, Consumers, and Advocates.

Accountable Communities for Health

The Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic area, and not limited to a defined group of patients. An ACH supports the integration of high-quality medical care, mental health services, substance use disorder treatment, and long-term services and supports, and incorporates social services (governmental and non-governmental) for those in need of care. It also supports community-wide primary and secondary prevention efforts across its defined geographic area to improve the health of the population, and to reduce disparities in the distribution of health and wellness.

In Vermont, SIM sought to bridge community-wide prevention and public health efforts with integrated care efforts through a Peer Learning Laboratory. Peer learning activities and local facilitation to support communities in developing ACH competencies began in June 2016 and continued through the conclusion of the Peer Learning Laboratory in March 2017.

ACHs explicitly build on the governance structures and partnerships developed by the Community Collaboratives, bringing in a new set of partners to integrate population health and prevention (including VDH, public health and community prevention coalitions, and additional partners from the social and community services sector) as well as a new framework and set of tools to help Community Collaboratives develop and meet population health goals. A visual model showing the relationship between ACHs and Community Collaboratives is shown in *Figure 3. Accountable Communities for Health and Community Collaboratives.*

Ongoing activities and investments. Recommended Lead Entity: Blueprint/VCO/VDH. Recommended Key Partners: Consumers, and Advocates.

Figure 3. Accountable Communities for Health and Community Collaboratives

Prospective Payment System – Home Health

As a result of stakeholder support in the state, legislation was passed in 2015 requiring that DVHA, in collaboration with the State's home health agencies, develop a prospective payment system (PPS) for home health payments made by DVHA under traditional Medicaid (exclusive of waivers). DVHA and providers met to review the potential fiscal impact of the model change. Based on results of these analyses, it was agreed that more time was needed to develop an incremental approach to the implementation of the prospective payment system. This delay was authorized by the Vermont legislature in 2016. In April 2016, after discussion with CMMI, Vermont's SIM project suspended this effort in response to this Legislative change and eliminated this milestone in Performance Period 3. It is anticipated that additional prospective payment systems for different services will be developed in the future.

One-Time investment.

Medicaid Pathway

The Vermont Medicaid Pathway was a process designed to advance payment and delivery system reform for services that are not subject to the financial caps within Vermont's All-Payer Model. The ultimate goal of this multi-year planning effort was the alignment of payment and delivery system principles through both the All-Payer Model and Medicaid Pathway to support a more integrated system of care for all Vermonters, including integrated physical health, long-term services and supports, mental health, substance abuse treatment, developmental disabilities services, and children's service providers. Specifically, the All-Payer Model requires Vermont to provide a plan for inclusion of these services in the APM by the end of 2020. The Medicaid Pathway was designed to address specific needs and barriers to innovation for providers who receive a large proportion of funding from Medicaid.

The Medicaid Pathway was facilitated by the Vermont Agency for Human Services. These planning efforts were designed to systematically review payment models and delivery system expectations across AHS and the Medicaid program, and to refine State and local operations to support new payment and delivery system models. As part of this process, AHS convened two stakeholder groups from 2015-2016: one focused on mental health, substance use, and developmental services; and a second focused on long-term services and supports.

Starting in 2017, as part of the All-Payer Model planning efforts, Vermont began a more comprehensive review of Medicaid services and payments. The review builds on the work previously conducted through SIM and the Medicaid Pathway and will result in the necessary plan due at the end of 2020.

One-Time investment.

The Vermont All-Payer ACO Model

In October 2016, Vermont reached final agreement with CMS and CMMI on an All-Payer ACO Model, and the agreement document was signed on October 27, 2016. The All-Payer Model grants the State authority and flexibility to continue work toward its health care reform goals. The Vermont All-Payer ACO Model is an agreement between the state and the federal government on a sustainable rate of growth for health care spending in that state; it

includes strict quality and performance measurement and is intentionally aligned with Vermont's Global Commitment for Health 1115 waiver renewal. It builds on the reforms and infrastructure developed and piloted under VHCIP and will be the next big step forward in Vermont's health system transformation. Through the legal authority of the Green Mountain Care Board (GMCB) and facilitated by an All-Payer Accountable Care Organization Model Agreement with CMMI, the state can enable the alignment of commercial payers, Medicaid, and Medicare in an Advanced Alternative Payment Model. Specifically, the State will apply the Next Generation ACO payment model across all payers with modifications, with all-payer rates set by the GMCB to enable the model. The focus on the ACO and existing CMS ACO programming, along with Vermont's strong stakeholder network, SIM investments, and the SSP program, is an evolution of Vermont's multi-payer reform. Eventually, an integrated ACO and All-Payer Model in Vermont could attract and involve the vast majority of people, payers, and providers.

The All-Payer Model is in a planning year in 2017, allowing the State, payers, ACOs, and providers to develop the necessary tools and guidance to support this new payment model. A contract between the State and OneCare Vermont to launch a risk-bearing Medicaid ACO under a Vermont Medicaid Next Generation program, signed in February 2017 for a pilot performance period of calendar year 2017, is the first step of All-Payer Model Implementation. Additional steps include the GMCB's development of regulations, establishment of rates, and ACO budget review.

Ongoing activities and investments. Recommended Lead Entity: GMCB. **Recommended** Key Partners: AOA, AHS, and its Departments, ACOs, CMMI, Payers (DVHA, BCBSVT, and CMS), Providers, Consumers, and Advocates.

State Activities to Support Model Design and Implementation for Medicaid

For all Medicaid payment models that are designed and implemented as part of Vermont's SIM grant, there are a number of Medicaid-specific State activities that occurred. These activities ensured that Vermont Medicaid's SIM-supported activities were in compliance with its Medicaid State Plan and its Medicaid 1115 waiver, and that newly established programs were monitored for their impact on Medicaid beneficiaries.

For any future efforts, the State will continue to administer its Medicaid program, ensuring applicable regulations including authority, finance, beneficiary access, and provider payment are met.

The Vermont Model Of Care

The Vermont Model of Care grew out of Vermont's Dual Eligibles Demonstration planning efforts and the SIM DLTSS work group. The Model of Care was then adopted by many of the SIM work groups. The Model of Care is a set of key principles focusing on physical and mental health integration, while establishing expectations for key relationships, tools, and infrastructure components necessary for an optimally integrated health system.

Core Elements	Principles Defined
Person/Family Centered and Person/Family Directed Services and Supports	Care that is life-affirming, comprehensive, continuous and respectful in its focus on health needs (medical, behavioral, long term care) as well as social needs (housing, employment), while promoting empowerment and shared decision-making through enduring relationships. "One size does not fit all" organizational/systemic capacity is needed to effectively respond to a range of preferences regarding services and coordination.
Access to Independent Options Counseling & Peer Support	Independent, easy-to-access information and assistance to assist individuals and families/caregivers to: understand insurance options, eligibility rules and benefits; choose services and providers; obtain information and make informed decisions about services, including Peer and Recovery Support.
Involved Primary Care Physician (PCP)	All people with specialized needs will have an identified PCP that is actively involved in their care and who has knowledge about specialized service options (via training, resource materials, etc.), and helps make connections (but does not function as a gatekeeper) to these options.
Single Point of Contact (Case Manager)	To ensure person centered care; coordination across all of the individual's physical, mental health, substance abuse, developmental, and long-term care service needs; relevant assessments are completed; develop and maintain comprehensive care plan; ensure support during transitions in care and settings.
Medical Assessments and Disability and Long Term Services and Support Screening by PCPs, Medical Specialists	PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits. If person has functional, cognitive, mental health, or substance abuse impairment, PCP should be informed about specialized services, use a brief screening tool (if necessary) and refer to specialized providers for more in depth assessments as necessary.
Disability and Long Term Services and Support Specific Assessments	The Individual's Case manager is responsible for assuring that all screening and assessment results (medical and specialized program related) are included in, and inform, the individual's Comprehensive Care Plan and are shared with the Individual's Care Team members.
Comprehensive Care Plan	For individuals with specialized service needs that go beyond PCP care, the case manager is responsible for developing and maintaining a single Comprehensive Care Plan that includes all identified needs, goals, preferences, services and supports (paid and unpaid).
Individual Care Team	For individuals with specialized needs that go beyond PCP care, the case manager is responsible for ensuring that the Individual Care Team includes providers associated with the needs identified in the Individual Care Plan, including the individual's PCP.
Support During Care Transitions	For individuals with specialized needs that go beyond PCP care, the case manager is responsible for: initiating and maintaining contact at the beginning, during, and at the end of the care transition (including such things as identifying barriers to care and working with the individual, family and providers to overcome barriers)
Use of Technology for Information-Sharing	A technological infrastructure that would: ➢ House a common case management database/system. ➢ Enable integration between the case management database and electronic medical records and between all providers of an Individual's ICT to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information. ➢ Allow for communication and sharing of information within a secure, confidential environment which allows for both low-tech and high-tech communication options. ➢ Adheres to Federal and State / AHS consumer information and privacy rules and standards, including informed consent.

Focus Area: Practice Transformation

The Practice Transformation (PT) focus area enabled provider readiness and encouraged practice transformation to support creation of a more integrated system of care management and care coordination for Vermonters. Activities were designed to enable provider readiness to participate in alternative payment models and accept higher levels of financial risk and accountability, as well as to monitor Vermont's workforce and identify areas of current and future need. These activities impacted a broad array of Vermont's providers and are undertaken as precursors to, or in concert with, alternative payment models. They were intended to ensure that providers impacted by alternative financial models were supported in making the accompanying practice changes necessary for success, as well as to improve the health of individuals and the population through an integrated system of care management and care coordination.

Learning Collaboratives and Core Competency Training

The Integrated Communities Care Management Learning Collaborative was a health service area-level rapid cycle quality improvement initiative. It was based on the Plan-Do-Study-Act (PDSA) quality improvement model, and featured in-person learning sessions, webinars, implementation support, and testing of key interventions. The Collaborative initially focused on improved cross-organization care management for at-risk populations.

The Core Competency Training series provided a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide. Core curriculum covered competencies related to care coordination and disability awareness. Both the Learning Collaborative and Core Competency Training used a train-the-trainer model and developed online toolkits to support dissemination and sustainability. The Learning Collaborative toolkit was completed and publicly posted on the VHCIP website. The toolkit will be reviewed and updated on an ad hoc basis in the future to ensure incorporation of new tools, improvements to existing tools, and alignment with ACO tools and trainings. A state-wide care coordination toolkit training was held in December 2016 for providers across the state. Blueprint for Health and VCO staff continue to meet to identify learning opportunities and develop curriculum for 2017 and beyond.

80% of the SIM sustainability survey respondents rated the Learning Collaboratives as either "Highly Important" or "Somewhat Important." This work stream/project connected stakeholders through shared knowledge and created valuable opportunities for participants to learn from experts within and outside of the Vermont community.

To maximize the long-term value of the Learning Collaborative, as well as the Core Competency Training, it will be necessary to focus on specific models or providers. In addition, continued, consistent, and widespread efforts should be made to structure a learning cycle that is efficient in disseminating experience, results, best practices, and obstacles. The infrastructure for maintaining the Learning Collaboratives and Core Competency Training is built and can be used to implement other trainings and quality improvement initiatives. Responsibility for sustaining this effort will span both public and private sector stakeholders with the administrative support falling to a branch of State government, and some portions of the financial and operational support to the private sector.

Ongoing activities and investments. Recommended Lead Entity: Blueprint/VCO. Recommended Key Partners: Community Collaboratives, VPQHC, SASH, Consumers, and Advocates.

Sub-Grant Program

The VHCIP Provider Sub-Grant Program, launched in 2014, provided 14 awards to 12 provider and community-based organizations who engaged in payment and delivery system transformation. Awards ranged from small grants to support employer-based wellness programs, to larger grants that supported statewide clinical data collection and improvement programs (Detail about the sub-grants is provided in *Appendix E.)*. The overall investment in this program was nearly $5 million. Sub-grantees each performed a self-evaluation and many engaged in sustainability planning. A final report on the sub-grant program developed by Vermont's self-evaluation contractor is also on the VHCIP website.

Many of the sub-grant projects proved valuable to the SIM experience and, either through anecdotal evidence or evaluation, demonstrated meaningful progress. One example is the Lab Collaborative, which resulted in reduction in unnecessary pre-operative lab testing and blood draws for Vermonters. More information about these projects is found in Appendix E. This Plan recommends the development of a new multi-payer supported sub-grant program to foster continued innovation. This Plan also includes specific recommendations about sub-grant projects: some will not be sustained based on a number of factors including SIM experience, the structure of the program, or general stakeholder agreement on the limitations of the project. Of note, two specific programs, the Lab Collaborative and RiseVT, were identified in key informant interviews as projects that should be sustained.

Ongoing activities and investments. Please see *Appendix E* for sustainability planning as outlined by SIM grantees. Recommended Lead Entity: AHS. Recommended Key Partner: Consumers, and Advocates.

Sub-Grant Technical Assistance

The Sub-Grant Technical Assistance program was designed to support sub-grant awardees in achieving their project goals. VHCIP recognized that while the provider sub-grantees are focused on creating innovative programs to transform their practices and test models of unique care delivery, they required support to develop the infrastructure and perform specialized tasks (e.g., actuarial analyses).

Direct technical assistance to sub-grant awardees was valuable to the SIM experience, but could prove costly if sustained over a considerable period of time. Additionally, it becomes less necessary as awardees get farther along in their projects. In order to maintain awardee access to sub-grant technical assistance, the State of Vermont developed a contractor skills matrix as a resource for future awardees. If a Sub-Grant program continued, awardees would be responsible for selecting and securing contractor resources for technical assistance.

One-time investment.

Regional Collaborations/Community Collaboratives

Within each of Vermont's 14 hospital service areas, Blueprint for Health and ACO leadership merged their regional clinical work groups and jointly collaborate with stakeholders through a unified health system initiative (known as Regional Collaborations or Community Collaboratives). Regional Collaborations included medical and non-medical providers (e.g., long-term services and supports providers and community providers), and a shared governance structure with local leadership. These groups focused on reviewing and improving the results of core ACO SSP quality measures; supporting the introduction and extension of new service models; and providing guidance for medical home and CHT operations.

Consistent with other collaborative groups operating under the Vermont SIM project, Regional Collaborations served to bridge the gap between stakeholders across communities and industry sectors. The infrastructure to support Regional Collaborations exists, but varies by region based on resource availability, stakeholder engagement, and basic logistics. Stakeholders have expressed the need for consistency in structure and other aspects of the collaborations. In addition, concerns have been raised about having a representative group of stakeholders. Still other Regional Collaborations have decided to include elements of the Accountable Communities for Health in their local structures by participating in the ACH Peer Learning Lab and shifting the focus of their work more broadly toward population health.

This effort will continue to be coordinated on a statewide level by the Blueprint for Health and VCO, and is intentionally aligned with sustainability recommendations for Accountable Communities for Health efforts.

Ongoing activities and investments. Recommended Lead Entity: Blueprint/VCO. Recommended Key Partners: AHS, VDH, Consumers, and Advocates.

Workforce

The Health Care Workforce Work Group was established by Executive Order to coordinate activities at both state and local levels in partnership with various State Agencies and Departments as well as private sector members representing the medical, long-term services and supports, and dental provider communities, and medical education. This group was then used to provide guidance and recommendations for Vermont's SIM project.

VHCIP initiated three sets of workforce activities: a care management inventory; workforce demand data collection and analysis; and workforce supply data collection analysis. Each of these activities is designed to help the State assess current and future workforce needs.

Care Management Inventory

In 2014, VHCIP designed and fielded a survey to various organizations engaged in care management to provide insight into the current landscape of care management activities in Vermont. Forty-two organizations provided information regarding services provided by the organization, population (and number of people) receiving care management services, staffing of care management services, key care management functions by type of service, type of relationships among care management organizations, care management accreditation status, and challenges facing care management programs. The survey sought to identify existing care management infrastructure in order to better understand potential areas of overlap and duplication, as well as gaps and opportunities. High level findings suggested opportunity for growing and developing newer care management functions, and also pointed to the need for more formalized structures for coordination and collaboration across care management organizations to support team-based care. Additionally, the survey showed

The Health Care Workforce Strategic Plan

Development of a Health Care Workforce Strategic Plan was required by Act 48 and submitted in 2013. The Workforce Work Group engaged in periodic updates to this plan throughout the SIM Grant.

The plan takes a systemic approach to reviewing workforce challenges and assessing the capacity of the Vermont health care workforce. In addition, the plan examines factors that impact education, recruitment, retention, and practice in the State. It also provides recommendations that serve as a roadmap for addressing issues affecting the delivery of quality care and access within the State.

The Health Care Workforce Strategic Plan is a key tool for targeting training resources, as well as for ensuring coordination between the various public and private entities in the state that work on health care workforce initiatives.

that certain clinician types, such as nurses and social workers, were more familiar with aspects of team-based care than doctors and medical assistants, and that pharmacists and physicians assistants engaged in care management activities less frequently. The project was intended to be a one-time activity to assess the existing landscape in order to inform practice transformation goals and decision making under SIM. It was completed as of February 2016.

One-time investment.

Demand Data Collection and Analysis

A micro-simulation health care workforce demand model identified future workforce needs by inputting assumptions about care delivery in a high-performing health care system, along with Vermont's population demographics and anticipated utilization needs. The vendor for this work created a demand model that produced workforce demand projections for Vermont in the future, under various scenarios and parameters that would be considered characteristics of an "ideal" health system. Such ideal characteristics for Vermont include movement in care from an inpatient to outpatient/community-based settings, more effective management of chronic diseases, and increased targeting of population health interventions (including statewide smoking cessation and weight loss campaigns). Preliminary demand projections show that these characteristics and scenarios would lead to higher demand for clinicians in outpatient and team-based settings, as well as social workers, care coordinators, and case managers. Any projections will be compounded by Vermont's aging population, which will also lead to increased demand for residential care facilities, home health, nursing homes, and specialties such as cardiology, radiology and oncology Final projections will become available mid-2017, at which time the vendor will prepare and submit a final report, with input from Vermont stakeholders including the Workforce Work Group.

Status is pending project's completion. Recommended Lead Entity: AHS. Recommended Key Partners: AOA, VDOL, VDH, GMCB, Providers, Private Sector, Consumers, and Advocates.

Supply Data Collection and Analysis

The Vermont Office of Professional Regulation and VDH worked in tandem to assess current and future supply of providers in the State's health care workforce for health care workforce planning purposes. This was done through collection of licensure and re-licensure data and the administration of surveys to providers during the licensure/re-licensure process. Surveys included key demographic information for providers, and are used for workforce supply assessment and predicting supply trends, as well as informing future iterations of Vermont's Health Care Workforce Strategic Plan.

Ongoing analyses of these data will continue. These data are widely used by State agencies and stakeholders for decision-making. Infrastructure to support the continued use of these data exist, and it will continue to be supported by the State.

Ongoing activities and investments. Recommended Lead Entity: AHS. Recommended Key Partners: AOA, DOL, VDH, GMCB, Providers, Private Sector, Consumers, and Advocates.

Focus Area: Health Data Infrastructure

The Health Data Infrastructure (HDI) focus area supported provider, payer, and State readiness to participate in alternative payment models by building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management. Work in this focus area built on the State's 2009 Vermont HIT Plan (VHITP) developed prior to SIM implementation.

Vermont SIM's health data infrastructure activities supported the development of clinical, claims, and survey data systems to support alternative payment models. The State made investments in clinical data systems to allow for increased passive data collection to support quality measurement – reducing provider burden while ensuring accountability for health care quality – and to support real-time decision-making for clinicians through improved information sharing.

Coordinating HDI Sustainability and Governance

The Agency of Administration (AOA) and the Agency of Human Services (AHS) are the recommended lead entities for health data infrastructure planning.

These investments yielded significant improvements in the quality and quantity of data flowing from providers' electronic health record (EHR) systems into Vermont's HIE. Through these investments, we expanded connectivity to the VHIE for an additional 400 providers in Vermont. We also improved data quality for ACO-attributing providers and Designated Agencies through targeted projects. Our investments supported several planning activities including: the identification of baseline EMR/VHIE connectivity metrics and 10-year targets; systemic identification and cataloguing of challenges; and, identification of data gaps for non-Meaningful Use providers to support strategic planning around data use for all providers across the continuum.

The Vermont Health Information Technology Plan (VHITP)

The current draft VHITP sets a high-level strategy and roadmap for the electronic collection, storage, and exchange of clinical or service data in support of improved patient care, improved health of Vermonters, and lower growth in health care costs – the Triple Aim. In addition, it provides direction on how the systems managing the clinical information can align with other State health technology projects and initiatives.

The draft VHITP outlines six goals:

1. Establish strong, clear leadership and governance for statewide Health Information Technology/Health Information Exchange (HIT/HIE) with a focus on decision-making and accountability.
2. Continue – and expand – stakeholder dialogue, engagement, and participation.
3. Expand connectivity and interoperability.
4. Provide high quality, reliable health information data.
5. Ensure timely access to relevant health data.
6. Continue the protection of a person's privacy as a high priority.

These goals are equally relevant to continuing SIM related projects in a manner that fosters alignment and continued stakeholder engagement.

The activities in this focus area will, for the most part, transition to the existing HIT strategic planning efforts and funding sources.

Expand Connectivity to HIE – Gap Analyses

Vermont SIM performed three point-in-time gap analyses of the EHR system capability of health care organizations, interface ability of the EHR system, and the data transmitted within those interfaces. These are listed below:

1. The ACO gap analysis, which created a baseline of the ability of health care organizations to produce Year 1 Medicare, Medicaid, and commercial SSP ACO quality measure data.
2. The Vermont Care Partners (VCP) gap analysis evaluated data quality among the 16 designated and specialized service agencies.
3. The DLTSS Gap Analysis reviewed the technical capability of DLTSS providers statewide.

Additionally, one survey participant had the following to state about the *Expand Connectivity to HIE – Gap Remediation and Gap Analyses* projects: "While data quality is very important, gap analysis and remediation is equally important to bring all providers to a place where they can be part of the VHIE and exchange data." Ongoing analyses of the status of the clinical data exchanged and housed in Vermont health care systems will be one of the areas of focus of continued HIT planning as Vermont evolves its abilities to efficiently gather and evaluate clinical quality measures.

One-time investment.

Expand Connectivity to HIE – Gap Remediation

The Gap Remediation project addressed gaps in connectivity and clinical data quality of health care organizations to the HIE. The ACO Gap Remediation component improved the connectivity for all Vermont SSP measures among ACO member organizations. The VCP Gap Remediation improved the data quality for the 16 Designated Mental Health and Specialized Service Agencies (DAs and SSAs). In addition, there was a DLTSS Gap Remediation effort to increase connectivity for home health agencies to the HIE. Gap Remediation efforts for ACO member organizations and VCP dovetail with the data quality improvement efforts described under the "Improve Quality of Data Flowing into HIE" work stream.

Ongoing activities and investments. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

Expand Connectivity to HIE – Data Extracts from HIE

This project created a secure data connection from the VHIE to the ACOs' analytics vendors for their attributed beneficiaries. The information available through these connections provided the ACOs with additional beneficiary data that they could analyze for population health activities. Methodologies such as these will continue to be developed under the State's HIT planning efforts.

One-time investment.

Improve Quality of Data Flowing into VHIE

The Data Quality Improvement Project was an analysis performed of ACO members' EHR systems on each of the 16 clinical data elements that were included as part of the ACO quality measures. This analysis evaluated the ability of ACO member systems readiness to send the clinical information needed for these measures, including the technical ability and the quality of the information exchanged by the EHR systems. Additional data quality work with the Designated Agencies worked to improve the quality and usability of data for this part of Vermont's health care system. VITL[5] worked with providers and made workflow recommendations to change data entry to ensure the information was entered into the systems consistently. In addition, VITL performed a comprehensive analysis to ensure that each data element from each health care organization (HCO) follows the same format.

Data infrastructure and support are important to sustain health care innovation. Moving forward, the State will use the existing HIT infrastructure and resources to continue gap remediation efforts for all providers, including acute, non-acute, and community providers. This work will include improvements to data quality at the source and enabling data extracts from the HIE. In addition, VITL will continue to assess and provide workflow improvements for providers connected to the HIE.

Ongoing activities and investments. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

Telehealth

Telehealth Strategic Plan

Vermont SIM developed a statewide telehealth strategy to guide future investments in this area. The strategy, developed in collaboration with the State of Vermont and private sector stakeholders, includes four core elements: a coordinating body to support telehealth activities; alignment of State policies relevant to telehealth; telehealth technology investments that are secure, accessible, interoperable, cloud-based, and aligned with Vermont's HIT infrastructure; and clinician engagement. The strategy also includes a roadmap based on Vermont's transition from volume-based to value-based reimbursement methodologies to guide prioritization of telehealth projects and their alignment with new clinical processes adopted as payment reform evolves.

While this activity is recommended as a one-time investment, the Telehealth Strategic Plan is intended to guide Vermont's future telehealth investments, and to ensure they are aligned with broader health reform goals as well as with existing and planned reforms.

One-time investment.

[5] Vermont Information Technology Leaders, Inc. (VITL) is a nonprofit organization that advances health care reform efforts in Vermont through the use of health information technology, and is the legislatively designated operator of the VHIE. VITL collects and manages patient data such as demographics, laboratory results, discharge summaries, radiology reports, and medication histories from multiple sources including hospitals, primary and specialty care, FQHCs, home health, long-term care, designated agencies and commercial labs. With patient consent, the information in the VHIE network is available to authorized, treating providers, to help them make more informed clinical decisions at the point of care.

Telehealth Implementation

Vermont funded two pilot projects that addressed a variety telehealth approaches, settings, and patient populations. The primary purpose was to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout Vermont.

Ongoing activities and investments in the area of telehealth; not necessarily these two pilots. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

Electronic Medical Record Expansion

SIM's EMR (or EHR) expansion efforts focused on assisting in the procurement of EHR systems for non-MU providers. This work included providing technical assistance to the Specialized Service Agencies (SSAs) and the Vermont Psychiatric Care Hospital (VPCH) to identify appropriate solutions as well as the exploration of alternative solutions, if appropriate. The technical assistance was provided by the VITL team, who has supported several Health Care Organizations in this process. The effort to expand resources in this area are essential to creating change and innovation across the spectrum of Vermont providers who do not have EHRs.

Ongoing activities and investments. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

Data Warehousing

The Data Warehousing work stream included three independent projects: the VCP Data Repository project, the Clinical Registry Migration project, and statewide planning to develop a cohesive data warehousing strategy.

- The VCP Data Repository allowed the DAs and SSAs to send specific data to a centralized data repository. In addition, this project provided VCP members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services, to demonstrate value, and to participate in payment and delivery system reforms.
- The Clinical Registry Migration project moved the Blueprint for Health Clinical Registry from its previous environment to hosting with VITL's infrastructure. This was a one-time investment.
- Statewide planning activities focused on developing a long-term strategy for data systems to support analytics.

To support quality health care and innovation, the DA/SSA data warehousing solution will be sustained. However, additional financial supports will be identified, and financial responsibility will be transitioned over time.

Ongoing activities and investments. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

Care Management Tools

Generally, the care management tools tested during SIM were indicated as important efforts to sustain on both the sustainability survey and in conversations with key informants.

Shared Care Plan Project

The Shared Care Plan project was developed in response to a common need voiced by providers: a technical solution to allow health care and social services organizations to share patient care plans across organizations, with the goal of improved care coordination and management across the care continuum.

The project, jointly with Universal Transfer Protocol project described below, focused on gathering business and technical requirements for a possible technical solution, in partnership with State leadership, ACO leadership, and providers in three communities. The information gathering process revealed that at least eight Vermont communities, ACOs, provider organizations, and State agencies were piloting or preparing to deploy care management tools that met some or all of the SCP requirements as of early 2016. This crowded and fast-evolving environment was a critical factor behind the project team's decision in March 2016 not to pursue a technical solution for the SCP project.

After electing not to pursue a technical Shared Care Plan solution, the project refocused on reviewing and recommending revisions to consent policy and architecture to enable shared care planning in the future. The State continues to review VHIE consent policy and architecture to better support shared care planning.

Ongoing activities and investments. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

Universal Transfer Protocol

The Universal Transfer Protocol (UTP) project identified the critical data and information needed to ease the transition of care between facilities, or between a health care setting and home, with the original goal of developing a technical solution to share this information across health care settings and organizations. As with the Shared Care Plan project, this work launched in response to a provider-identified need for tools to support care transitions, and included extensive information gathering across Vermont communities and with key State and provider partners.

In response to the environment surfaced jointly by the Shared Care Plan and UTP projects, the project team decided in March 2016 not to pursue a technical solution for the UTP project. Instead, the project refocused on supporting workflow analysis and improvements at provider practices participating in the Integrated Communities Care Management Learning Collaborative. This work was completed in December 2016, and will not continue after the SIM period.

One-time investment.

Event Notification System

The event notification system (ENS) project implemented a system to proactively alert participating providers regarding their patient's medical service encounters. This ENS solution notifies providers in real-time if one of their patients is admitted to the hospital, discharged from the hospital, or transferred between care settings (ADT alerts),

based on information flowing through the Vermont Health Information Exchange (VHIE). This allows providers to follow up with one another or with patients directly, to ensure that care is coordinated and care transitions are smooth.

Under SIM, the State supported connections between the ENS vendor and the VHIE, and supported early provider costs to receive ADT alerts for their patient roster.

Key informants saw value in this tool. The tool will continue to be available after the end of SIM, but providers will be responsible for paying ongoing costs to continue receiving alerts for their patients.

Ongoing activities and investments. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

General Health Data

Data Inventory

Vermont engaged a contractor to complete a statewide health data inventory to support future health data infrastructure planning. This project built a comprehensive list of health data sources in Vermont, gathered key information about each, and catalogued them in a web-accessible format. The resulting data inventory is a web-based tool that allows users (both within the State and external stakeholders) to find and review comprehensive information relating to the inventoried datasets. There will, however, need to be occasional updates to the inventory and possibly the infrastructure. The State and its partners will engage in periodic data inventories. Resources will be identified and secured for planning activities related to HDI as part of the HIT Strategic Plan funding.

Ongoing activities and investments. Recommended Lead Entity: AOA and AHS. Recommended Key Partners: AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, and Advocates.

HIE Planning

The HIE planning project resulted from a perceived gap in high-level planning and research in local and nationwide best practices for providing a robust, interoperable ability to transmit accurate and current health information throughout the Vermont health care landscape. This project conducted research in best practices around improving clinical health data quality and connectivity resulting in recommendations to the HDI work group. The State will engage in ongoing activities of this nature as appropriate in the future.

One-time investment.

Focus Area: Evaluation

The Evaluation focus area assessed whether program goals were met. SIM project evaluations were conducted by program, by population, and by region. Evaluations were ongoing throughout the grant period, to anticipate unintended consequences and to help staff take action quickly on lessons that have been learned. The evaluation focus area applied to all projects in the main three areas of focus: PMDI, PT, and HDI.

Self-Evaluation Plan and Execution

Like all SIM grant recipients, Vermont was required to perform a self-evaluation to complement federal program evaluations. The State worked with an independent contractor to perform a State-Led Evaluation of Vermont's SIM effort to meet this requirement. While efforts to monitor and evaluate reforms will continue, the SIM-specific self-evaluation will end at the conclusion of the grant.

Sustainability Recommendation

One-time investment.

Surveys

As part of broader payment model design and implementation and evaluation efforts, the State conducted annual patient experience surveys and other surveys as identified in payment model development. There are numerous patient experience surveys that are deployed annually, in addition to the one used as part of the SSP. Building on established Blueprint patient experience surveys processes, which collect data at the practice level, the SIM project added ACO SSP survey collection at the ACO-level by adding ACO flags to surveys to capture the proportion of respondents attributed to an ACO. This process streamlined survey distribution and data collection, and avoided sending multiple surveys to the same attributed individual; however, it also resulted in small returns for sub-populations of interest and prevented deeper analyses. Survey results are provided to practices and to the ACOs for the purpose of evaluating and improving patient experience at both levels. Overall, experience of care has improved in a number of areas including: communication, customer service, and coordination of care. ACOs will continue to use patient experience as part of their quality measurement and Blueprint will continue to support the ACO flag to allow for both ACO-level and practice-level survey analysis. This work is ongoing and will continue after the conclusion of the SIM grant.

Sustainability Recommendation

Ongoing activities and investments. Recommended Lead Entity: VCO Recommended Key Partners: Providers, AHS, Office of the Health Care Advocate, GMCB, Consumers, and Advocates.

Monitoring and Evaluation Activities within Payment Programs

The State conducted analyses as necessary to monitor and evaluate specific payment models through SIM. Monitoring occurred by payer and by program to support program modifications. Ongoing monitoring and evaluation by State of Vermont staff and contractors will occur as needed.

Sustainability Recommendation

Ongoing activities and investments. Recommended Lead Entity: AHS/GMCB Recommended Key Partners: Payers, VCO, Office of the Health Care Advocate, AOA, Consumers, and Advocates.

Focus Area: Project Management

Vermont SIM project was managed through a combination of State personnel and outside vendors with project management expertise. The entire management structure was overseen by the VHCIP Project Director, who reported directly to the VHCIP Core Team. The Project Director was responsible for coordinating all aspects of project management. The Project Director oversaw a team from within five State departments and agencies (the GMCB; AHS; DVHA; the Department of Disabilities, Aging and Independent Living; and the Department of Mental Health), augmented by the project management vendor, who were assigned to provide support to the SIM Work Groups and all SIM work streams.

The project management function under SIM is twofold: it considered both the program and administration functions of government such as soliciting public comment, ensuring appropriations, and managing resources; as well as managing the various projects, groups, and relationships that SIM initiated. The SIM project management function was imperative to maintaining the gains achieved under SIM.

As SIM projects transition from the demonstration phase to the program phase, project management functions will transition to program staff in Medicaid, or within external partner organizations. Lead Entities and Key Partners across sustained work streams will work together to continue project management efforts, including managing project tasks and continued engagement of stakeholders. It is recommended that the use of a website or similar tool be developed by the Lead Entity and/or Key Partner to guarantee continued efforts are being communicated efficiently and effectively to all stakeholders.

Sustainability Recommendation

Ongoing activities and investments. This functional area transitions to all Lead Entities and Key Partners on a project-by-project basis. Project Management needs will continue for each activity that is sustained, and will need to be considered by each organization that takes on a work stream as a Lead Entity or Key Partner.

Conclusion

The State of Vermont's health care community has been engaged in innovative reform for decades. The State continues to build on existing success and modify programs for sustainability. Not every project that launched or was proposed under SIM has been successful; however, the State is well-positioned to identify successful programs to continue, and Vermont's stakeholder community is knowledgeable and aware of the challenges facing the State's push for change and innovation.

Appendix A: Vermont Sustainability

Vermont Sustainability: At a Glance

The following presents an overview of all the State Innovation Model (SIM) investments in the focus areas of Practice Transformation, Payment Model Design and Implementation, and Health Data Infrastructure. Additionally, it provides recommendations regarding sustaining these projects.

One-time Investments
Develops infrastructure or capacity with limited ongoing costs.

Public Sector Partner
An agency or organization funded by and run by the State of Vermont.

Private Sector Partner
Group or organization run by private individual(s) that is not owned by the State. Examples of potential private sector partners: Vermont's accountable care organization (ACO), hospitals, etc.

New/Ongoing Investments: State Supported
Activities which will be supported by the State after the end of the Model Testing period.

New/Ongoing Investments: Private Sector Supported
Activities which will be supported by private sectors after the end of the Model Testing period.

New/Ongoing Investments: Public/Private Sector Supported
Some ongoing investments will have both state and private sector support. They will work in partnership with roles and responsibilities delineated before the onset of the project.

Lead Entity
Group recommended to assume primary ownership of the project after the SIM grant opportunity ends.

Key Partners
Organization of a comprehensive network of consumers, physicians, hospitals, insurers, regulators, not-for-profit groups and other stakeholders to participate in various aspects of the project.

Evaluation
Assessment of whether program goals are being met.

Vermont's SIM efforts have relied on active participation and input from a diverse group of stakeholders. Consumer and consumer advocate engagement and input have been critical in accomplishing the goals and objectives of the SIM initiative. The State of Vermont, in continuing to champion transparency in health care reform, is committed to working with consumers and advocates to ensure they have a visible role and are collaborative partners in future activities.

Recommendations: Payment Model Design and Implementation

Investment Category			
SIM Focus Areas and Work Streams	**One-Time Investment**	**Ongoing Investments** *State-Supported*	**Ongoing Investment** *Private Sector*
Payment Model Design and Implementation			
ACO Shared Savings Programs (SSPs)		●	●
Pay-for-Performance (Blueprint for Health)		●	●
Health Home (Hub and Spoke)		●	●
Accountable Communities for Health		●	●
Prospective Payment System – Home Health	●		
Medicaid Pathway	●		
All-Payer Model		●	●

Ongoing Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
ACO Shared Savings Programs (SSPs)	**GMCB**	**Payers (DVHA, BCBSVT, CMS), ACOs, AHS, and its Departments, Consumers, Advocates**	**Activity continued through transitional period.**
Pay-for-Performance (Blueprint for Health)	**VCO**	**AHS (DVHA-Blueprint), GMCB, Consumers, Advocates**	**Note that both VCO and AHS will be engaged in subsequent Pay for Performance activities.**
Health Home/ Hub and Spoke	**AHS**	**DVHA-Blueprint, VDH, Consumers, Advocates**	**Anticipating additional Health Home initiatives for different services. Leverage Blueprint experience.**
Accountable Communities for Health	**VDH/Blueprint /VCO**	**Consumers, Advocates**	**Aligned with Regional Collaborations/Community Collaboratives. (See Practice Transformation.) Additional information can be found in Vermont's Population Health Plan.**
All-Payer Model	**GMCB**	**AOA, AHS Departments, ACOs,**	

		CMMI, Payers (DVHA, BCBSVT, CMS), Providers, Consumers, Advocates	

Recommendations: Practice Transformation

Investment Category			
SIM Focus Areas and Work Streams	**One-Time Investment**	**Ongoing Investments** *State-Supported*	**Ongoing Investment** *Private Sector*
Practice Transformation			
Learning Collaboratives and Core Competency Training		●	●
Sub-Grant Program		●	●
Regional Collaborations		●	●
Workforce – Care Management Inventory	●		
Workforce – Demand Data Collection and Analysis	*Project Delayed*		
Workforce – Supply Data Collection and Analysis		●	

Ongoing Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
Learning Collaboratives and Core Competency Training	**Blueprint/VCO**	**Community Collaboratives, VPQHC, SASH, Consumers, Advocates**	**Aligned with Regional Collaborations/Community Collaboratives. Note there are contract obligations related to this in the DVHA-ACO program for 2017.**
Sub-Grant Program	**AHS**	**Consumers, Advocates**	
Regional Collaborations	**Blueprint/VCO**	**AHS, VDH, Consumers, Advocates**	**Aligned with Learning Collaboratives, Accountable Communities for Health.**
Workforce – Care Management Inventory	**One-time Investment**		
Workforce – Demand Data Collection and Analysis	**AHS**	**AOA, VDOL, VDH, GMCB, Providers, Private Sector, Consumers, Advocates**	**AHS to coordinate across AOA, DOL, VDH, provider education, private sector.**
Workforce – Supply Data Collection and Analysis	**AHS**		

Recommendations: Health Data Infrastructure

Investment Category			
SIM Focus Areas and Work Streams	**One-Time Investment**	**Ongoing Investments** *State-Supported*	**Ongoing Investment** *Private Sector*
Health Data Infrastructure			
Expand Connectivity to HIT – Gap Analysis	●		
Expand Connectivity to HIT – Gap Remediation		●	●
Expand Connectivity to HIT – Data Extracts from HIE	●		
Improve Quality of Data Flowing into HIE		●	●
Telehealth – Strategic Plan	●		
Telehealth - Implementation		●	●
Electronic Medical Record Expansion		●	●
Data Warehousing		●	●
Care Management Tools –Event Notification System			●
Care Management Tools – Shared Care Plan		●	●
Care Management Tools –Universal Transfer Protocol	●		
General Health Data – Data Inventory		●	
General Health Data – HIE Planning	●		
General Health Data – Expert Support	●		

Recommendations: Health Data Infrastructure (cont'd)

Ongoing Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
Expand Connectivity to HIT – Gap Analysis	**One-Time Investment**		
Expand Connectivity to HIT – Gap Remediation	**AHS, AOA[6]**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
Expand Connectivity to HIT – Data Extracts from HIE	**One-Time Investment**		
Improve Quality of Data Flowing into HIE	**AHS, AOA**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
Telehealth – Strategic Plan	**One-Time Investment**		
Telehealth - Implementation	**AHS, AOA**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
Electronic Medical Record Expansion	**AHS, AOA**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
Data Warehousing	**AHS, AOA**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
Care Management Tools –Event Notification System	**AHS, AOA**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
Care Management Tools – Shared Care Plan	**AHS, AOA**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
Care Management Tools –Universal Transfer Protocol	**One-Time Investment**		

[6] As referenced earlier in the report, AOA and AHS are the recommended lead entities, pending further planning.

Ongoing Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
General Health Data – Data Inventory	**AHS, AOA**	**AHS Departments, GMCB, Providers across the continuum, ACOs, DII, HHS (CMS, ONC), Consumers, Advocates**	
General Health Data – HIE Planning	**One-Time Investment**		
General Health Data – Expert Support	**One-Time Investment**		

Recommendations: Evaluation

Investment Category			
SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Evaluation			
Self-Evaluation Plan and Execution	One-Time Investment		
Surveys		●	●
Monitoring and Evaluation Activities within Payment Programs		●	●

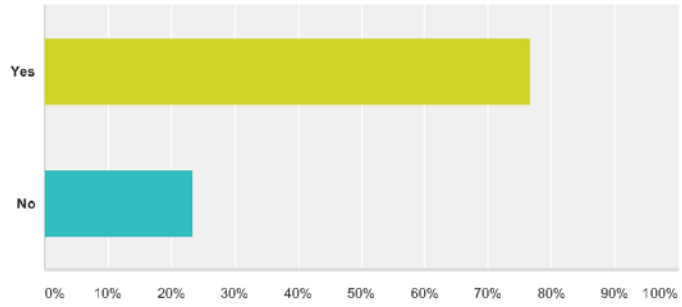
Ongoing Sustainability: Task Owner			
SIM Focus Areas and Work Streams	Lead Entity *(Primary Owner)*	Key Partners	Special Notes
Self-Evaluation Plan and Execution	One-Time Investment		
Surveys	VCO	Providers, AHS, Consumers, Office of the Health Care Advocate, GMCB, Consumers, Advocates	Patient experience surveys. Note that there are numerous patient experience surveys that are deployed annually in addition to the one used as part of the SSP.
Monitoring and Evaluation Activities within Payment Programs	AHS/GMCB	Payers, VCO, Office of the Health Care Advocate, AOA, Consumers, Advocates	Payers, State regulators, and VCO/providers will monitor and evaluate payment models. There are specific evaluation requirements for the GMCB and AHS as a result of the 1115 waiver and APM. Patient experience surveys are a tool for monitoring and evaluation.

Appendix B: Vermont SIM Sustainability On-Line Survey Results

Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q1 Are you or have you been, a voting member on a VHCIP Work Group?

Answered: 47 Skipped: 0



Answer Choices	Responses	
Yes	76.60%	36
No	23.40%	11
Total		47

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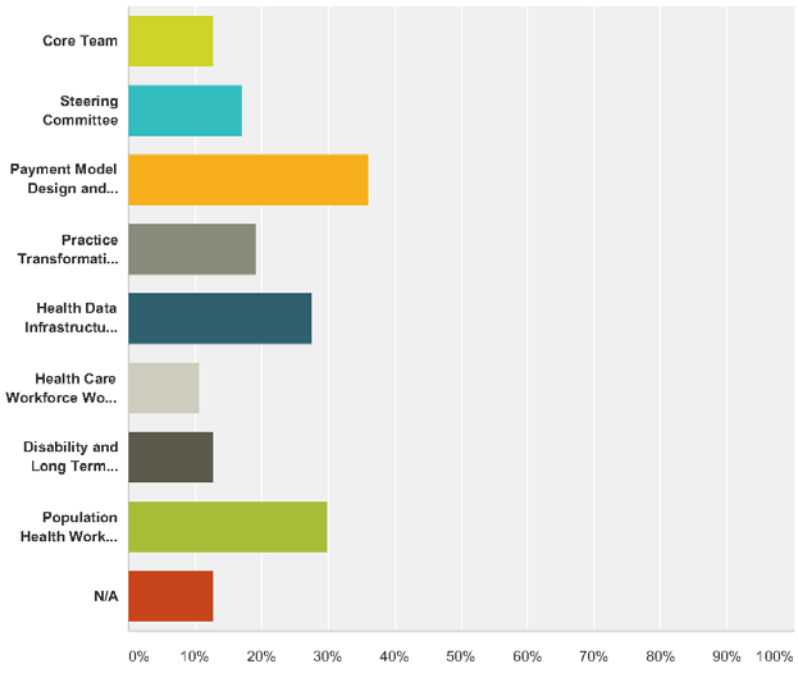
Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q2 Of which Work Group(s) were / are you a member or non-voting participant? (select all that apply)

Answered: 47 Skipped: 0



Answer Choices	Responses	
Core Team	12.77%	6
Steering Committee	17.02%	8
Payment Model Design and Implementation Work Group	36.17%	17
Practice Transformation Work Group	19.15%	9
Health Data Infrastructure Work Group	27.66%	13
Health Care Workforce Work Group	10.64%	5
Disability and Long Term Services and Supports Work Group	12.77%	6
Population Health Work Group	29.79%	14
N/A	12.77%	6
Total Respondents: 47		

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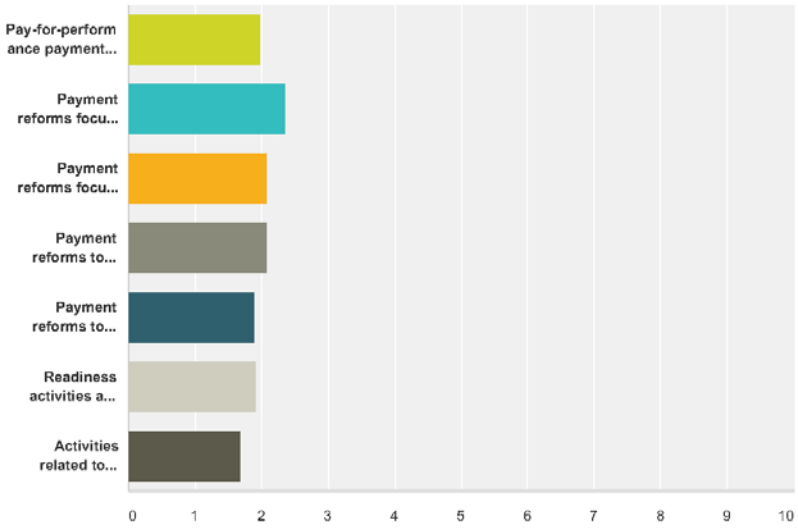
Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q3 Payment Model Design and Implementation Focus Area: Supports the creation and implementation of value based payments for providers in Vermont across all payers.Please reflect on the following efforts and rate which are most important to sustain after the end of VHCIP/the SIM grant. Concrete project examples are in parentheses.

Answered: 46 Skipped: 1



	Highly Important	Somewhat Important	Neutral	Less Important	Not Important	I don't know	Total	Weighted Average
Pay-for-performance payment reforms focused on hospital and/or ambulatory care services (Blueprint for Health)	43.90% 18	26.83% 11	14.63% 6	9.76% 4	2.44% 1	2.44% 1	41	1.98
Payment reforms focused on hospital and/or ambulatory care services which incorporate shared savings (Medicaid and Commercial ACO Shared Savings Programs)	23.68% 9	31.58% 12	26.32% 10	7.89% 3	5.26% 2	5.26% 2	38	2.36
Payment reforms focused on hospital and/or ambulatory care services which incorporate shared risk (All-Payer Model)	38.46% 15	28.21% 11	15.38% 6	7.69% 3	5.13% 2	5.13% 2	39	2.08
Payment reforms to support integration of and simplify payment to providers of mental health, substance abuse, developmental services, and long-term services and supports (Medicaid Pathway)	34.15% 14	36.59% 15	17.07% 7	4.88% 2	4.88% 2	2.44% 1	41	2.08

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Payment reforms to support integration of physical health and substance abuse services (Health Home/Hub & Spoke Program)	**42.50%** 17	**37.50%** 15	**12.50%** 5	**2.50%** 1	**5.00%** 2	**0.00%** 0	40	1.90
Readiness activities and development of payment reforms to support integration of community-wide prevention and public health efforts with integrated care efforts (Accountable Communities for Health)	**40.00%** 18	**28.89%** 13	**24.44%** 11	**4.44%** 2	**0.00%** 0	**2.22%** 1	45	1.93
Activities related to quality and performance measurement, including efforts to reach consensus on quality measure sets and to simplify measurement and provider accountability for new and existing payment models	**44.19%** 19	**41.86%** 18	**9.30%** 4	**2.33%** 1	**0.00%** 0	**2.33%** 1	43	1.69

#	Other (please specify)	Date
1	State funding to support existing PMPM models with proven cost reduction models through community clinical linkages = SASH and Blueprint.	8/19/2016 3:38 PM
2	"Consensus on quality measure sets"??? The federal government and readily-available national programs have ALREADY identified these. HEDIS, PCMH Levels, CPC+, etc. etc. Fixed budgets and focus on population health outcomes need to be the goals: focus on the person, not on the costly hospital services - improve the health of the population and there will be less hospitalizations.	8/19/2016 7:59 AM
3	ROI or die	8/18/2016 2:57 PM
4	with goals of lowering costs and reductingredundancy, those services originally via Blue print may best be incorporated elsewhere: data and quality reporting from EHRs and ACOs, embedded SW, dietician, Care coordinator, etc supported through alternate funding (up front with APM, via savings etc.). however-those wrap around services remain vital and best embedded in PCMH	8/18/2016 12:33 PM
5	Activities to reduce the cost of health care to real people - to improve access and outcomes to real people and improve the experience and quality for people - and not improve everything to the benefit of the profit making hospitals and hospital lead ACOs	8/18/2016 9:01 AM
6	Need to focus on payment reforms that address integration of clinical and community services that begin to address social determinants of health and interventions that are further upstream that reducing ED visits and improve quality in disease management settings.	8/17/2016 3:02 PM
7	Shared savings programs sound good, but for several years BCBSVT has reported that, "unfortunately," despite the work done at the practice site, there are no savings to be shared. Shared risk programs are not tenable to small practices - at least until there is substantial up-front investment in the staffing and programmatic changes required to reliably produce quality. Otherwise, the practice is at substantial risk before it has understood and developed that which is required to avoid downside experiences.	8/17/2016 12:42 PM
8	since payment reforms will be mandated and managed a the federal level, ACH can be a local priority to ensure alignment of medical treatment with social services to improve health and lower cost. Quality measures are the distinguishing characteristic from the HMO models of the 1980s and 90's that ensures the accountability for performance relative to financial incentives.	8/5/2016 3:12 PM

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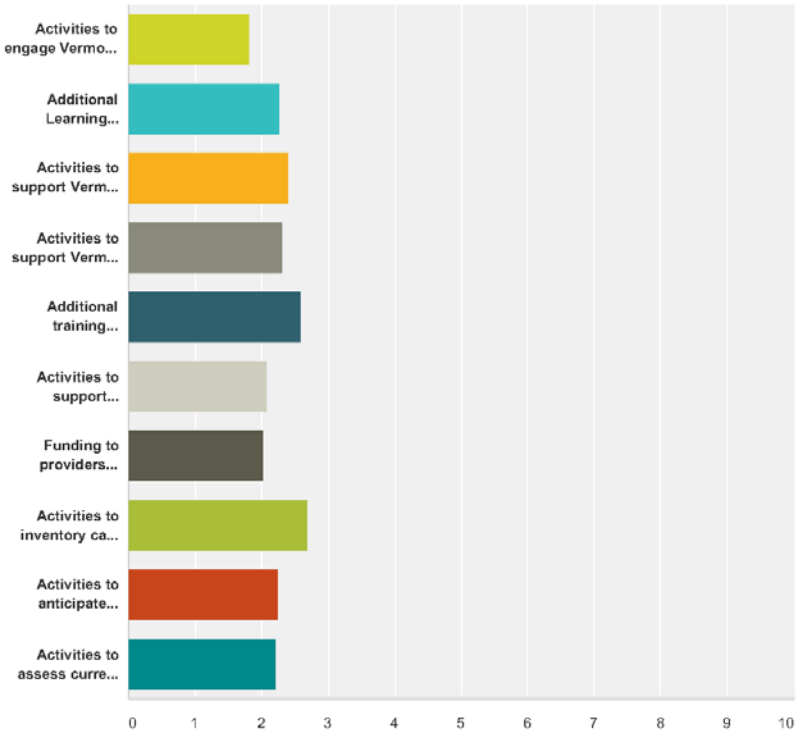
Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q4 Practice Transformation Focus Area: Enables provider readiness and encourages practice transformation.Please reflect on the following and rate which are most important to sustain after the end of VHCIP/the SIM grant. Concrete project examples are in parentheses.

Answered: 46 Skipped: 1



	Highly Important	Somewhat Important	Neutral	Less Important	Not Important	I don't know	Total	Weighted Average
Activities to engage Vermont regions in quality improvement initiatives to develop cross-organizational relationships and teams to support integrated care (Integrated Communities Care Management Learning Collaborative)	**45.00%** 18	**35.00%** 14	**10.00%** 4	**5.00%** 2	**2.50%** 1	**2.50%** 1	40	1.82
Additional Learning Collaborative-style activities to engage Vermont regions in quality improvement initiatives to achieve other identified care transformation goals	**27.03%** 10	**27.03%** 10	**35.14%** 13	**5.41%** 2	**2.70%** 1	**2.70%** 1	37	2.28

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Activities to support Vermont providers in developing care management competencies (Core Competency Trainings)	**21.05%** 8	**34.21%** 13	**26.32%** 10	**13.16%** 5	**2.63%** 1	**2.63%** 1	38	2.41
Activities to support Vermont providers in increasing disability awareness and improving disability competent care (Core Competency Trainings)	**22.22%** 8	**36.11%** 13	**30.56%** 11	**2.78%** 1	**5.56%** 2	**2.78%** 1	36	2.31
Additional training activities to support Vermont providers in developing other competencies of interest	**13.51%** 5	**40.54%** 15	**29.73%** 11	**5.41%** 2	**10.81%** 4	**0.00%** 0	37	2.59
Activities to support development of regional unified health systems, including governance and quality improvement infrastructure, across ACOs, Blueprint for Health, and other initiatives (Regional Collaborations/Community Collaboratives)	**37.50%** 15	**32.50%** 13	**20.00%** 8	**5.00%** 2	**5.00%** 2	**0.00%** 0	40	2.08
Funding to providers and/or community-based organizations engaged in payment and delivery system transformation to transform practice and test promising models (Sub-Grant Program)	**33.33%** 14	**35.71%** 15	**21.43%** 9	**7.14%** 3	**0.00%** 0	**2.38%** 1	42	2.02
Activities to inventory care models in place around the state (Care Management Inventory)	**12.20%** 5	**29.27%** 12	**34.15%** 14	**14.63%** 6	**4.88%** 2	**4.88%** 2	41	2.69
Activities to anticipate future health care workforce demand across various provider types and professions (Workforce – Demand Data Collection and Analysis)	**27.03%** 10	**35.14%** 13	**18.92%** 7	**8.11%** 3	**5.41%** 2	**5.41%** 2	37	2.26
Activities to assess current and future health care workforce supply across various provider types and professions (Workforce – Supply Data Collection and Analysis	**30.00%** 12	**27.50%** 11	**27.50%** 11	**7.50%** 3	**2.50%** 1	**5.00%** 2	40	2.21

#	Other (please specify)	Date
1	The focus needs to be on increaing the health of the population and quality care rendered to members, not creating more levels of bureacracy and "development of systems". Put the efforts and the money to work directly for the Vermonters.	8/19/2016 7:59 AM
2	incubators/pilots must be setup with key providers that will exhibit ROI for those providers, then a viral adoption will occur.	8/18/2016 2:57 PM
3	I wonder if workforce demand data is already being collected (AHEC)? It is unclear what is meant by 'provider' - a very diluted term these days. Physicans and APP should not be the focus of care management (or care coordination) training as this will likely fall to RNs. I believe regional unified health systems are under development in the state via blueprint and ACO efforts. it would only be fair to have a core competency training that includes ALL areas requiring increased awareness: disabilities, language fluency, homelessness, new Americans, different ethnicities and religions, etc	8/18/2016 12:33 PM
4	We need a competent work force - paid living and sustainable wages to provide home and community services to individuals and communities so that people can actually make the changes they need to make- e.g. smoking cessation, diabetes management, etc. And of extreme importance in an aging state - a workforce to support the needs of Vermonters who wish to age in place and never go to a nursing home	8/18/2016 9:01 AM
5	Help with assessing behavioral health workforce is especially important and not traditionally as included in system development efforts.	8/17/2016 5:39 PM
6	Inventory of care modes and who is doing care management and not duplicating efforts is very necessary	8/17/2016 2:46 PM
7	A tremendous amount of good work has been done through the Learning Collaboratives and Core Competencies. It is not always aligned/integrated with other forms of case and care management. There are some aspects that are unique and some aspect that could be leveraged. This could be an area for exploration so the work does not remain isolated (and it should be done thoughtfully so it is not forced into arenas where it doesn't make sense).	8/17/2016 2:27 PM
8	as part of any ssp the providers should have basic core competencies with all populations served, especially DS or MH, at least knowing the resources to refer them to and how best to intervene with current state wide resources. I am not convinced that the Blueprint or regional collabs are the way tog at this. Standardized quality measurements and documentation should be an easy target by Vital, but has not proved so.	8/17/2016 12:56 PM
9	(Perhaps this is intended, but checking some circles voids previous responses in other circles....)	8/17/2016 12:42 PM

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

10	Very difficult to choose in this category because all of the activities listed are interdependent and necessary for success to support continuing practice transformation efforts.	8/5/2016 3:12 PM

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q5 Health Data Infrastructure Focus Area: Supports provider, payer, and State readiness to participate in alternative payment models through implementation of health information technology (HIT) and by improving health information exchange (HIE). Please reflect on the following and rate which are most important to sustain after the end of VHCIP/the SIM grant. Concrete project examples are in parentheses.

Answered: 46 Skipped: 1

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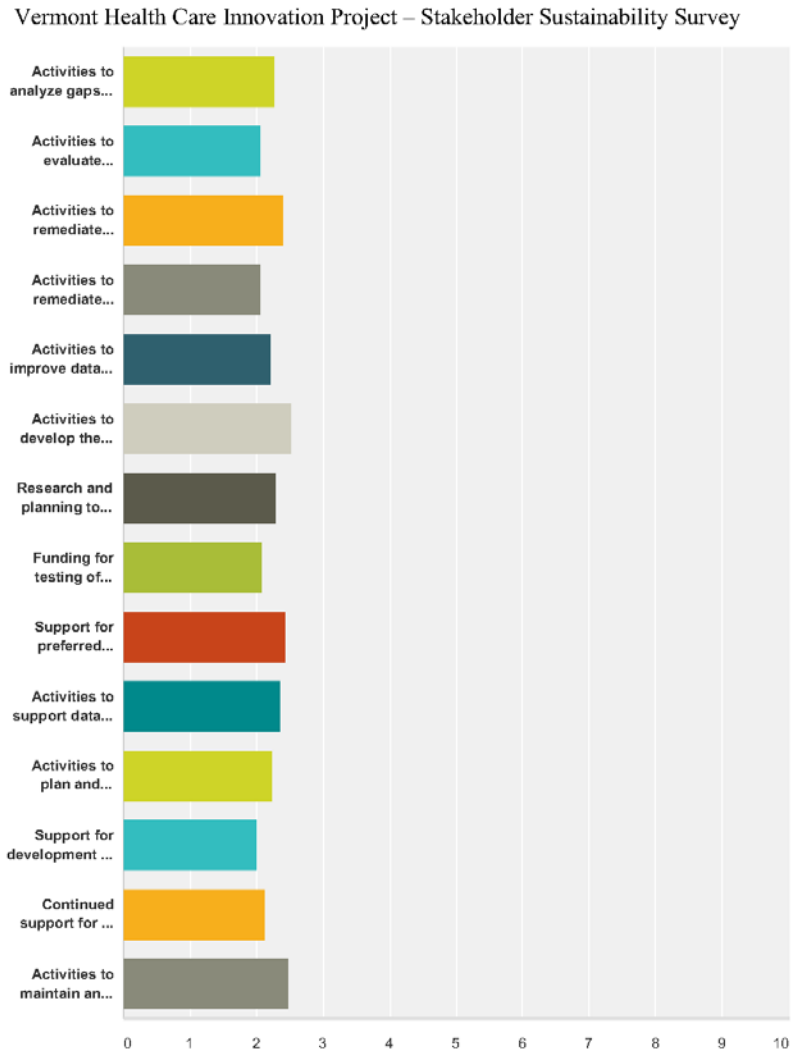

	Highly Important	Somewhat Important	Neutral	Less Important	Not Important	I don't know	Total	Weighted Average
Activities to analyze gaps in measurement capabilities/data quality for providers already connected Vermont Health Information Exchange (VHIE) (Gap Analyses – ACO and Vermont Care Network)	**23.68%** 9	**36.84%** 14	**10.53%** 4	**2.63%** 1	**10.53%** 4	**15.79%** 6	38	2.28
Activities to evaluate non-VHIE-connected providers' HIT/electronic health record (EHR) capabilities to assess gaps in ability to connect to the VHIE, especially for DLTSS providers (Gap Analyses – DLTSS)	**32.43%** 12	**32.43%** 12	**8.11%** 3	**2.70%** 1	**8.11%** 3	**16.22%** 6	37	2.06
Activities to remediate identified data gaps in measurement capabilities for providers already connected to the VHIE (Gap Remediation Activities – ACO)	**22.22%** 8	**33.33%** 12	**11.11%** 4	**5.56%** 2	**11.11%** 4	**16.67%** 6	36	2.40

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Activities to remediate identified gaps in HIT and EHR capabilities for providers not already connected to the VHIE (Gap Remediation Activities – DLTSS; for example, Home Health Agency VHIE interface development and VITLAccess implementation	**32.50%** 13	**32.50%** 13	**10.00%** 4	**2.50%** 1	**7.50%** 3	**15.00%** 6	40	2.06
Activities to improve data quality and usability of data prior to entry into the VHIE through provider workflow improvements (Data Quality Improvement – Vermont Care Partners)	**20.00%** 8	**50.00%** 20	**12.50%** 5	**2.50%** 1	**7.50%** 3	**7.50%** 3	40	2.22
Activities to develop the analytic capacity of the VHIE and/or to connect the VHIE to external analytic vendors (Data Extracts from the VHIE/ACO Gateways)	**21.62%** 8	**29.73%** 11	**21.62%** 8	**2.70%** 1	**13.51%** 5	**10.81%** 4	37	2.52
Research and planning to support strategic and coordinated investment in new technologies (Telehealth Strategic Plan)	**28.21%** 11	**33.33%** 13	**12.82%** 5	**5.13%** 2	**10.26%** 4	**10.26%** 4	39	2.29
Funding for testing of innovative technologies to support patient care through pilots (Telehealth Pilots)	**29.27%** 12	**39.02%** 16	**17.07%** 7	**2.44%** 1	**4.88%** 2	**7.32%** 3	41	2.08
Support for preferred providers in procuring electronic health records (EHR) systems or other HIT (EMR expansion to SSAs and State Hospital)	**27.78%** 10	**22.22%** 8	**19.44%** 7	**2.78%** 1	**13.89%** 5	**13.89%** 5	36	2.45
Activities to support data collection and warehousing for providers subject to 42 CFR Part 2 (VCN Data Warehousing project)	**21.05%** 8	**28.95%** 11	**21.05%** 8	**2.63%** 1	**7.89%** 3	**18.42%** 7	38	2.35
Activities to plan and implement a cohesive data warehousing strategy for Vermont (Data Warehousing Strategy Development project)	**23.68%** 9	**28.95%** 11	**15.79%** 6	**5.26%** 2	**5.26%** 2	**21.05%** 8	38	2.23
Support for development of shared care management tools (Shared Care Plan Project; Universal Transfer Protocol Project)	**43.59%** 17	**20.51%** 8	**12.82%** 5	**7.69%** 3	**5.13%** 2	**10.26%** 4	39	2.00
Continued support for an event notification system to notify providers of hospital admissions, discharges, or transfers (ENS Project/PatientPing)	**29.27%** 12	**41.46%** 17	**9.76%** 4	**4.88%** 2	**7.32%** 3	**7.32%** 3	41	2.13
Activities to maintain an inventory of health data sources in the state to support future planning and coordination (Health Data Inventory Project)	**18.42%** 7	**31.58%** 12	**13.16%** 5	**10.53%** 4	**7.89%** 3	**18.42%** 7	38	2.48

#	Other (please specify)	Date
1	Telehealth is technology that's been around for years now - is not innovative whatsoever. Need to have an over-arching strategy statement, such as: "Improving the ability to accumulate and measure advances in the health of Vermonters". The state should oversee that data collection, report out on standard HEDIS quality measures and reward the providers that complynia extra funding/quality bonuses (i.e. CMS' PCMH Levels). Don't comply and there is no extra money for the provider. Don't submit data and don't improve the health of Vermonters, then that provider is paid less. That carrot/stick approach will do more to implement connectivity among all providers (all of whom have computers) for compliance toward realization of the "Improving the ability to accumulate and measure advances in the health of Vermonters" strategic goal.	8/19/2016 7:59 AM
2	We should be past the Research/Planning/Design phase, and there is enough research that exists to support implementations that reach the patient. If it doesn't actually touch or reach the patient it should rely on exhisting knowledge base.	8/18/2016 2:57 PM
3	the health information industry is huge, growing and lucrative. I am overwhelmed by the costs of systems and the repeated findings that they cannot perform promised functions. one of the most important things Vermont could do is pass legislation stating any EMR sold here must be able to 'talk to' another system. otherwise we are just creating 21st century silos of care. there should be capacity for notifications within an EMR and therefore Patient Ping is not needed. let's be sure the state is coordinating/collaborating with others around the state regarding new tools to allow improved communication, reduced redundancy and hopefully reduced cost	8/18/2016 12:33 PM

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

4	Establishment of consent structure- policies and culture that supports individuals to know what their rights are and be able to exercise their rights without any additional burdens or loss of services - inc luding the service of care coordination	8/18/2016 9:01 AM
5	We have already spent too much on these issue with not enough to show for it. My neutrality on these issues is a reflection of frustration that we still have a long way to go in this area.	8/17/2016 5:52 PM
6	Population level health extracts from health data to inform public health priorities, efforts and monitor results of interventions	8/17/2016 4:11 PM
7	It is a sad state that much of this has not been accomplished as of yet. If VITL cannot do the job, it is time to move on. We have spend millions and accomplished minimal in terms of using data to make clinical decision, determine program need, intervention at the right time with the right patient is lacking due to a not so robust IT infrastructure state wide.	8/17/2016 2:46 PM
8	The part 2 barrier is a huge issue and until we can figure it out, I believe we are only seeing have the picture.	8/17/2016 2:38 PM
9	There should be a larger strategic plan that links any of these priorities to efforts within AHS and with providers. There are too many gaps and too many redundancies, there should be a thoughtful inventory and plan.	8/17/2016 2:27 PM
10	shared usage of the state purchased care management system, mandating usage of this system for Medicaid population at the very least, otherwise the state has misspent $9 Million! The system is robust, has data analytics, risk stratification!	8/17/2016 12:56 PM

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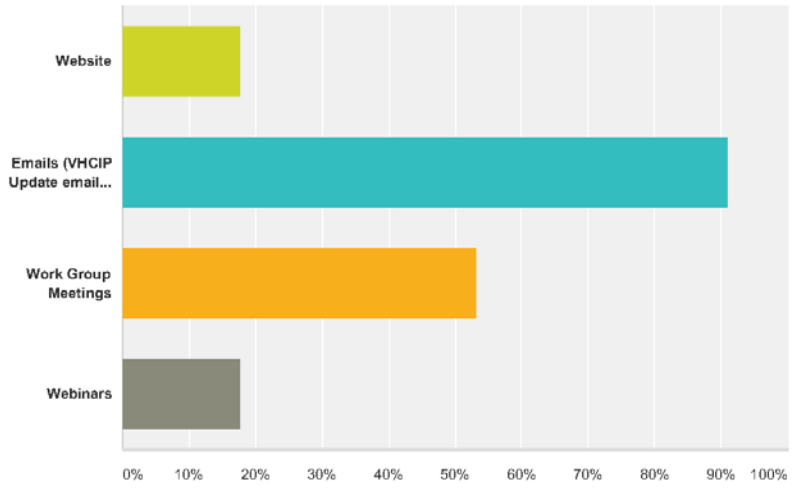
Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q6 Which mode of communication have you found to be the most informative and effective for transparency and communication among SIM project participants? (select all that apply)

Answered: 45 Skipped: 2



Answer Choices	Responses	
Website	17.78%	8
Emails (VHCIP Update emails, meeting reminders, meeting materials)	91.11%	41
Work Group Meetings	53.33%	24
Webinars	17.78%	8
Total Respondents: 45		

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q7 Are there any thoughts or ideas you would like to share regarding priorities for SIM sustainability?

Answered: 11 Skipped: 36

#	Responses	Date
1	too many workgroups with duplication of reporting. Same leaders at the meetings. We need more coming together of priorities, project development and funding allocation. People are still splitting. We need a strong leadership voice in the state to determine a clear path.	8/19/2016 3:38 PM
2	Need to link it to a strategy with specific quality outcomes (measures), not just add more adminstrative costs and red tape. There should be a goal to improve the health of Vermonters, not to create more state rules, regulations and increase the number of state employees.	8/19/2016 7:59 AM
3	Continued convening of stakeholders is essential to ensure that decisions are informed by the many sectors and partners needed to meet the Triple Aim. A real bonus of the project has been this cross-sector discussion and deliberation.	8/18/2016 5:27 PM
4	How many working models with positive ROI are there currently?	8/18/2016 2:57 PM
5	Wish I did ... but no.	8/18/2016 9:49 AM
6	SIM should complete its work before using funds to sustain the work it completed for those who have ample funding and excess profits to support their own HIT improvements	8/18/2016 9:01 AM
7	state needs to buy into investments. proof of effectiveness is a must, this includes understanding of cost of not making investments.	8/17/2016 7:36 PM
8	While data quality is very important, gap analysis and remediation is equally important to bring all providers to a place where they can be part of the VHIE and exchange data.	8/17/2016 3:25 PM
9	42 cfr should be focus. Smaller bites of the cookie. Focus on fewer indicatives and do it well then expand. Don't boil the ocean. We need better accountability, preferably State oversight and ownership of the VHIE, the contracts with medicity and ownership of the data. Those contracts should be State contracts owned by the people, with oversight and management by the people. The current black hole of who owns the data and single point of failure(VITL) is a huge risk long term.	8/17/2016 2:38 PM
10	I would like to see a brief status report of what VHCIP initiatives have gone well and been hardwired into current operations, and which have some significant way to go to reach our initial goals.	8/10/2016 4:21 PM
11	Leveraging technology to electronically capture key data elements that will support robust performance reporting without additional effort/burden on providers.	8/5/2016 3:12 PM

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Vermont Health Care Innovation Project – Stakeholder Sustainability Survey

Q8 (Optional) If we have questions regarding your answers, may we contact you? If yes, please leave your name and telephone number or email address below:

Answered: 5 Skipped: 42

#	Responses	Date
1	mdcraig@criticalc.com	8/18/2016 2:57 PM
2	Brian Isham 585-5233 Brian.Isham@Vermont.gov	8/17/2016 2:38 PM
3	Definitely! p.bengtson@nvrh.org Thanks!	8/10/2016 4:21 PM
4	Cathy Fulton catherinef@vpqhc.org 802-229-2449	8/5/2016 3:12 PM
5	Not sure the survey instrument was working properly via my iPhone because when I clicked certain options on one question it wouldn't let me use the same category for the next question. Karen Hein karen.hein10@gmail.	8/1/2016 2:42 PM

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Appendix C: Key Informant Interview Results

Vermont State Innovation Model (SIM) Sustainability Plan
Stakeholder Engagement Process
Key Informant Interview Results
Prepared by Myers and Stauffer LC

As the Sustainability Plan contractor for the State of Vermont (SOV), Myers and Stauffer LC collaborated with the State to identify individuals for key informant interviews. These interviews were performed to identify areas of successful SIM investment that should be sustained and barriers to the sustainability. A total of 12 key informant interviews were conducted, either in-person or via telephone between August 2, 2016 and September 15, 2016. Additionally, Myers and Stauffer met with John Snow Inc. (JSI), the Evaluation contractor for the State, to gain an understanding of their role as the SIM Evaluator and benefit from their insight on the project in an effort to avoid duplication of efforts.

It is noted that some interviewees sat on multiple SIM stakeholder workgroups. Membership and/or chair for the following SIM Work Groups or committees are represented:

- Steering Committee
- Payment Model Design and Implementation
- Practice Transformation
- Health Data Infrastructure
- Population Health
- Disability and Long-term Services and Supports

ACO leadership interviewees were from Community Health Accountable Care (CHAC) and OneCare respectively.

Interview Results[7]

Interviewees were asked about sustainability; in particular, what SIM projects or aspects of SIM should be sustained at the end of the grant period. Interviewees were also asked to state what barriers they saw in sustaining these projects. The following results are listed by focus area.

Payment Model Design and Implementation (PMDI)

The PMDI focus area supports the creation and implementation of value based payments for providers in Vermont across all payers. Programs/work interviewees spoke highly of were:

- Blueprint for Health. One interviewee thought that the infrastructure of the Blueprint for Health will be the responsibility of the ACOs in the future.
- Support and Services at Home (SASH) program.
- Two interviewees spoke positively of the Shared Savings Programs (SSP), however it was noted by one interviewee that the SSP model has a limited life span.

[7] As the SIM Sustainability on-line survey responses could be submitted anonymously, there is a chance of duplication of results when comparing survey results and interview results.

- One interviewee would like to see more done with the St. Johnsbury pilot (Medicaid Pathway) as they believe "there is flexibility there. We need to look at that pilot and not just at costs."
- Bailit Consulting group. This contractor assisted with measure selections and as a national resource on measure specifications. One interviewee states this contractor is needed to support continuing work in this area.

Several interviewees cited the current imprecision regarding the All-Payer Model was a potential barrier for sustainability in the area of PMDI. Additionally, uncertainty surrounding the governance and structure of the Vermont Care Organization (VCO) was expressed. Comments/Concerns voiced:

- ACOs will need to be a leader in transparency.
- Two ACOs working together under one financial model will allow them to reallocate resources.
- Once the All-Payer Model is developed, the disability community will be shut out by the ACO.
- One interviewee felt that the State had responsibility to govern the work operations of the ACOs.

Discussions around developing payment models led to the topic of staffing. Two interviewees believed the State would need to retain some SIM staff to continue to work on payment model innovation.

Practice Transformation (PT)

The PT focus area enables provider readiness and encourages practice transformation. Interviewees stated they supported the continuation of the Learning Collaboratives, Core Competency Trainings (Care coordination, "Train the Trainer" model) and Regional Collaborations. Interviewees noted the SIM dollars allowed for support of the LC on a greater statewide level which has hosted national experts speaking on clinical topics and provided for in-person training sessions. There was concern expressed that after the SIM grant ended the LC would not have the funding to continue to operate at the same level.

Specific sub-grants discussed during interviews as needing to be sustained are RiseVT and the Lab Collaborative. Comments relating to both programs are as follows:

- RiseVT was mentioned as a worthwhile program because it engages children. One interviewee noted that SIM is lacking a focus on children.
- The Lab Collaborative was successful in reaching its goal to reduce unnecessary laboratory testing in hospitalized adults. Noted barriers to sustaining this program are funding and ownership. Interviewee believes the Lab Collaborative owner needs to be a neutral conveyor. Interviewee noted that hospitals can add monies to their budget to continue this work if they choose to.

One interviewee felt that the Workforce- Demand Data Collection and Analysis project may be considered to be sustained depending on the outcome, noting the State may want to use that type of model in the future if it is determined to be useful. This would not likely be done yearly, but more on a periodic basis.

Health Data Infrastructure (HDI)

Vermont's SIM HDI focus area aids provider, payer, and State readiness to participate in alternative payment models through implementation of HIT and by improving HIE.

Interviewees who spoke about the HDI focus area agreed that in terms of sustainability, HIT advancements will continue. Many interviewees noted that continued investment is needed to bring HIT to complete fruition. One interviewee noted that this is not really SIM sustainability, but sustainability of effort.

Comments about HIT/HIE:

- HIE feels "like a bottomless hole now" and expectations are high.
- Not getting good data from HIE; fairly recently HIE has capacity for data translation and data mapping.
- There has been a decrease in provider burden due to electronic advancements made.
- Lack of interoperability is a concern; provider burden in having to use up to 10 different portals.
- Limited ability of some providers to access HIE.
- 40% of interface work is related to remediation as provider gets new EHR or some EHR change.

Projects under the HDI focus area that interviewees believe should continue to be sustained are as follows:

- Continued investment in quality of data. The terminology services tool, which is part of the "Improve Quality of Data Flowing into VHIE" project, was noted as assisting in the progress made in data quality.
- Care Management Tools: Shared Care Plan, Universal Transfer Protocol (UTP), Event Notification System (ENS)
    - PatientPing, a SIM-supported ENS launched in 2016, alerts providers to real-time admissions and discharge notifications should be sustained. One interviewee noted that the cost for PatientPing should shift to providers and not be a State funded effort.
- The original electronic transfer tool started as simple tool (face sheet; demographics). An interviewee would like the earlier version back as the tool has become too complicated.
- Investments in telehealth need to continue as it is linked to the Triple aim and improving population health. One interviewee recommended a review of the financial return on telehealth should be performed.

Common Themes

This section lists common themes identified after review of the collective interview notes.

Potential barriers to sustainability:

- Funding for ongoing resources
- Delay with decision on the All-Payer Model
- Uncertainty with State administration change

Stakeholder engagement – Several interviewees strongly stated that stakeholder engagement is the most important or one of the most important results from the SIM grant. This occurred on multiple levels. Interviewees noted the following:

- SIM brought stakeholders together that fostered creative thinking in decision-making.
- Communication between various communities has been a key take away from the SIM work.
- Sustainability is about having the right parties at the table.

- The SIM communication network across providers created cohesion.
- Work Groups created new leadership and central repository of skills.
- "Connections, it's all about connections."

Reform fatigue – The majority of interviewees referenced fatigue with the process. This is stated to be occurring on different levels including at the Work Group level and provider level. One particular concern described was the number of quality measures required to be collected by providers.

Other Comments

Other pertinent comments documented during the course of the interviews are listed below:

- Hospitals and Designated Agencies are in survival mode, the same with home health.
- Social determinants of health /population health are always a top talking point. For example: one clinical measure was measurement ofA1C levels, which only looks at process. In population health, what contributes to the A1C level is important: noncompliance with medications, affordability, transportation, living in food desert, education on nutritious food, ability to prepare food, exercise, etc. We must look at social determinants.
- Care Navigator (shared care management software) being piloted by OneCare should continue.
- Physician leadership falls into 2 camps. One camp appreciates measures and the opportunities for improving. The other camp resents having to do it (old school), especially in primary care in underserved areas.
- "You can't manage what you cannot measure."
- Population health wasn't built into VT SIM grant.
- We have very dedicated skilled and well-meaning people, but we need to have a wider view. Money is not being allocated in ways that will accomplish our goals. We are focused on health care, not health.
- Rural areas will continue experience disconnection if infrastructure support isn't in place to support uniform collaboration.
- Population health is morphing into Accountable Communities for Health. There are communities in Vermont that would be natural for picking up that activity, but not statewide.

Appendix D: Sustainability Sub-Group Membership List

SIM Sustainability Sub-Group Membership List

First Name	Last Name	Organization/SIM affiliation
Lawrence	Miller	Sub-Group Chair; Core Team Chair
Paul	Bengtson	Core Team Member
Steve	Voigt	Core Team Member
Kate	Slocum	Green Mountain Care Board
Susan	Barrett	Green Mountain Care Board
Cathy	Fulton	Payment Model Design and Implementation Work Group Co-Chair
Laural	Ruggles	Practice Transformation Work Group Co-Chair
Simone	Rueschemeyer	Health Data Infrastructure Work Group Co-Chair
Deborah	Lisi-Baker	DLTSS Work Group Co-Chair
Karen	Hein	Population Health Work Group Co-Chair
Mary-Val	Palumbo	Health Care Workforce Work Group Co-Chair
Andrew	Garland	Blue Cross Blue Shield of Vermont
Lila	Richardson	Office of the Health Care Advocate
Vicki	Loner	OneCare
Kate	Simmons	CHAC
Holly	Lane	Health*first*
Paul	Harrington	Vermont Medical Society
Dale	Hackett	consumer; member of PMDI, PT, HDI, DLTSS, and Population Health Work Groups
Stefani	Hartsfield	Cathedral Square; HDI Work Group member
Kim	Fitzgerald	Cathedral Square; member of Steering Committee and Population Health Work Group
Georgia	Maheras	State of Vermont
Sarah	Kinsler	State of Vermont

Appendix E: Provider Sub-Grant Program Projects

The VHCIP Provider Sub-Grant Program, launched in 2014, has provided 14 awards to 12 provider and community-based organizations who are engaged in payment and delivery system transformation. Awards ranged from small grants to support employer-based wellness programs, to larger grants that support statewide clinical data collection and improvement programs. The overall investment in this program is nearly $5 million. Sub-grantees performed a self-evaluation and some have engaged in sustainability planning.

Accountable Care Organization (ACO) Infrastructure Support Projects

- HealthFirst in collaboration with all participating providers and affiliates of their ACOs: Accountable Care Coalition of the Green Mountains and Vermont Collaborative Physicians.
    - **Status:** This grant has helped transform HealthFirst over the past two years by enabling them to hire personnel, establish an office, create an identity with a new logo and website, and expand their outreach and support to their members. Sub-grant funding for this project ended on 10/31/16.
    - **Sustainability Planning:** HealthFirst board's finance committee has been meeting regularly to examine possible options and revenue streams, including a member dues increase and participation in the All-Payer Model.
    - The final report can be found here: http://healthcareinnovation.vermont.gov/content/health-first-vhcip-provider-sub-grant-final-report
- Bi-State Primary Care Association in Collaboration with all Participating Providers and Affiliates of Community Health Accountable Care (CHAC):
    - **Status:** The goal of this project has been to grow and strengthen CHAC, which has participated in all three Shared Savings Programs (SSPs), and to increase provider collaboration across the continuum of care in local communities. Sub-grant funding for this project ended on 6/30/16.
    - **Sustainability Planning:** CHAC is part of the ongoing statewide health care reform work. Currently, CHAC is transitioning to the non-risk role as part of unified ACO Vermont Care Organization. This transition will impact CHAC's operations and scope as it expands to include new participants and aligns its work more closely with that of OneCare Vermont. CHAC will continue to collaborate with community partners, OneCare Vermont, the State, and other organizations.
    - The final report can be found here: http://healthcareinnovation.vermont.gov/content/bi-state-vhcip-provider-sub-grant-final-report

Community-Wide Public Health Approaches

- RiseVT Coalition: Northwestern Medical Center in collaboration with all of Franklin County.
  - **Status:** RiseVT is a community coalition whose goal has been to increase the overall health of the population by decreasing the percentage of overweight and obese individuals. They continue to engage businesses, schools, and municipalities with a strong presence at local events and initiatives. Project leaders are actively participating in infrastructure meetings, sidewalk committees, and recreation committees. Sub-grant funding for this project ended on 11/30/16.
  - **Sustainability Planning:** RiseVT is working with a non-profit planning organization to develop plans for sustainability and identify how best to align best practice approaches.
  - The final report can be found here: http://healthcareinnovation.vermont.gov/content/rise-coalition-vhcip-provider-sub-grant-final-report

Models that Target High-Utilizers Projects

- Developmental Disabilities Council with Green Mountain Self-Advocates.
  - **Status:** The Institute for Health Policy and Practice worked to identify and recommend best practices in the delivery of health services to adults with intellectual and developmental disabilities (I/DD) in Vermont. Sub-grant funding for this project ended on 12/31/15.
  - **Sustainability Planning:** A final report was issued in March 2016.
- Northeastern Vermont Regional Hospital, in collaboration with Northern Counties Health Care, Rural Edge Affordable Housing, the Support and Services at Home (SASH) Program, the Northeastern Vermont Area Agency on Aging, and Northeast Kingdom Community Services.
  - **Status:** The Caledonia and Essex Dual Eligibles Project aimed to reduce overall health care costs, make more efficient use of Medicaid special services, and improve the well-being of clients in their region who are eligible for both Medicare and Medicaid. Accomplishments noted are the health coach has served 80 clients during this grant period and flexible funds have been distributed to 110 individuals. Sub-grant funding for this project ended on 12/31/15.
  - **Sustainability Planning:** Many of the tools and processes learned from this project have already been hardwired into care coordination work. The program has spread its work to a new population of people – those with COPD. A health coach has been hired permanently by NVRH as a community health worker in the Community Connections program. The health coach will continue to work with dual eligibles and with people in need of his services regardless of insurance.
  - The final report can be found here: http://healthcareinnovation.vermont.gov/content/nvrh-vhcip-provider-sub-grant-final-report
- Rutland Area Visiting Nurse Association & Hospice in collaboration with Rutland Regional Medical Center, Community Health Centers of the Rutland Region, and the Rutland Community Health Team.

- **Status:** The project was to design and implement a supportive care program for seriously ill patients with congestive heart failure and/or chronic lung disease. Rutland Area Visiting Nurse Association & Hospice collaborated with the new Transitional Care Nurses from both Rutland Regional Medical Center (RRMC) and the Community Health Centers of Rutland Region (CHCRR). Sub-grant funding for this project ended on 6/30/16.
- **Sustainability Planning:** While this program has demonstrated significant outcomes in a self-evaluation, it was determined there is not a feasible way to continue the program currently. Rutland Area Visiting Nurse Association & Hospice continues to work together with community partners to provide patients in their community with a collaborative approach to health care.
- The final report can be found here: http://healthcareinnovation.vermont.gov/content/ravnah-vhcip-provider-sub-grant-final-report

- Southwestern Vermont Hospital.
  - **Status:** Project aimed to design and share plans of care and identify gaps in the delivery of integrated health care in the Bennington Service area. INTERACT, the long-term care program for early identification of condition changes and prompt implementation of clinical interventions (implemented at Southwestern Vermont Medical Center's (SVMC) Center for Living and Rehabilitation), has further expanded to include five Bennington area long-term care facilities. Sub-grant funding for this project ended on 11/30/16.
  - **Sustainability Planning:** SVMC conducted a financial analysis of the Transitional Care Nursing Program. This demonstrated a decrease in overall health care costs due to a decrease in utilization of high-cost services such as Emergency Department visits and inpatient hospital admissions and observation encounters. SVMC has committed to supporting the continuation of the Transitions in Care program within the its operational budget.
  - The final report can be found here: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/SVMC%202016%20VHCIP%20Final%20Report_0.pdf

- White River Family Practice (WRFP), in collaboration with the Geisel School of Medicine at Dartmouth College.
  - **Status:** The purpose of this project was to measure and reduce emergency room use and hospital readmission by intervening to increase patients' level of self-confidence with respect to their health. Accomplishments include: acceptance of whitepaper to Family Practice Management with information learned to date regarding the project; ongoing development of patient interviewing strategy and focus group with support the Dartmouth Co-op; reallocation of care coordination work to new nurse within the practice; continued monitoring of health confidence with patients; and continued monitoring of utilization of patients at Dartmouth Hitchcock Medical Center (DHMC). Sub-grant funding for this project ended on 11/30/16.

- **Sustainability Planning:** WRFP plans to continue assessing patients' health confidence and using the results of these queries to guide individual health care interactions. WRFP will be focus on patient care and will offer less in the way of research results to other practices.
- The final report can be found here: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/WRFP%20-%20VHCIP%20Provider%20Sub-grant%20Final%20Report.pdf

Screening and Interventions Projects

- InvestEAP with King Arthur Flour.
  - **Status:** This project evaluated the usefulness of screening and evidence-based, short-term treatment for improving the behavioral health of employees at a private workplace. Sub-grant funding for this project ended on 11/30/16.
  - **Sustainability Planning:** Grantee will leverage existing relationships with large commercial insurance companies interested in paying for these services to sustain this effort.
- InvestEAP in collaboration with the Burlington Community Health Center and Northern Counties Health Care.
  - **Status:** The Resilient Vermont project evaluated whether providing Employee Assistance Program (EAP) prevention and early intervention services to Federally Quality Health Center patients can mitigate life stressors that would otherwise lead to chronic disease. Recent accomplishments include: Increased participant enrollment in their project by 66% and continued follow-up intervention services to employees. Sub-grant funding for this project ended on 11/30/16.
  - **Sustainability Planning:** Grantee will leverage existing relationships with large commercial insurance companies interested in paying for these services to sustain this effort.
  - The final report can be found here: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/InvestEAP%20-%20VHCIP%20Provider%20Sub-grant%20Final%20Report.v2.pdf
- The University of Vermont Health Network – Central Vermont Medical Center.
  - **Status:** The project aimed to intervene in tobacco, alcohol, and drug misuse by establishing Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the patient-centered medical homes at Central Vermont Medical Center (CVMC). Accomplishments to date: Integration of the SBIRT model into five medical homes, Granite City Primary Care, and Women's Health Clinic here at UVMHN-CVMC. Sub-grant funding for this project ended on 11/30/16.
  - **Sustainability Planning:** The SBIRT team has been absorbed by the Community Health Team, allowing the grantee to provide the services free of charge.
  - The final report can be found here: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/CVMC%20VHCIP%202016%20Grantee%20FINAL%20Report.pdf

Surgical Variation and Lab Ordering Projects

- The Vermont Medical Society Education and Research Foundation in collaboration with Vermont's Hospitalist Physicians and the University of Vermont Medical Center Department of Pathology and Laboratory Medicine.
    - **Status:** This project was designed to reduce wasteful and unnecessary laboratory tests for low-risk surgical candidates in the region. Sub-grant funding for this project ended on 6/30/16.
    - **Sustainability Planning:** The final report indicates that: "The Faculty and interested hospital team leaders have put together a proposal that has been circulated to all hospital teams with the hope that clinical leaders at these institutions will begin discussions with hospital budget decision makers."
- Vermont Program for Quality in Health Care, in collaboration with Vermont Association of Hospitals and Health Systems, Vermont College of American College of Surgeons, all Vermont hospitals, and DHMC.
    - **Status:** Project goal was to collect and submit surgical clinical data to the American College of Surgeons National Surgical Quality Improvement Program database for the purpose of improving surgical outcomes and performance through data analysis and comparative performance monitoring. Currently, facilitating meetings of collaborative members and surgical clinical reviewers (SCRs); reviewing and trending data entered into National Surgical Quality Improvement Program (NSQIP) workstation; coordinating face-to-face collaborative meetings; providing clinical and technical support to hospitals, Quality Directors, and SCRs for clinical abstraction; and communicating NSQIP to hospital leadership. Sub-grant funding for this project ended on 11/30/16.
    - **Sustainability Planning:** Project leaders continue to seek opportunities to find additional funding.
    - A final report can be found here: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/VT%20DDC%20-%20VHCIP%20Provider%20Sub-grant%20Final%20Report.pdf

Appendix F: Glossary

ACCGM/VCP - Accountable Care Coalition of the Green Mountains/Vermont Collaborative Physicians or Health*first*

ACH – Accountable Communities for Health

ACO – Accountable Care Organization

AHS – Agency of Human Services

AOA – Agency of Administration

APM – All-Payer Model

BCBSVT - Blue Cross and Blue Shield of Vermont

CHAC – Community Health Accountable Care, LLC

CHT – Community Health Team

CMMI – Center for Medicare and Medicaid Innovation

CMS – Centers for Medicare & Medicaid Services

DAIL – Department of Disabilities, Aging, and Independent Living

DII- Department of Information and Innovation

DAs – Designated (mental health) Agencies

DHMC – Dartmouth Hitchcock Medical Center

DLTSS – Disability and Long Term Services and Supports

DOL- Department of Labor

DVHA – Department of Vermont Health Access

EHR – Electronic Health Record

EMR – Electronic Medical Record

ENS – Event Notification System

FQHC – Federally Qualified Health Center

GMCB – Green Mountain Care Board

HDI – Health Data Infrastructure

HHAs – Home Health Agencies

HIE – Health Information Exchange

HIT – Health Information Technology

MU – Meaningful Use

OCV – OneCare Vermont

PCMH – Patient-Centered Medical Home

PDSA – Plan-Do-Study-Act

PMDI – Payment Model Design and Implementation

PPS – Prospective Payment System

PT – Practice Transformation

SASH – Support and Services at Homes

SBIRT – Screening, Brief Intervention, and Referral to Treatment

SCR – Surgical Clinical Reviewers

SCP – Shared Care Plan

SIM – State Innovation Model

SOV – State of Vermont

SSA – Specialized Service Agency

SSP – Shared Savings Program

SVMC – Southwestern Vermont Medical Center

VAHHS – The Vermont Association of Hospitals & Health Systems

VCO – Vermont Care Organization

VCP – Vermont Care Partners

VDH – Vermont Department of Health

VHCIP – Vermont Health Care Innovation Project

VHIE – Vermont's Health Information Exchange

VHITP – Vermont Health Information Technology Plan

VITL – Vermont Information Technology Leaders

VMS – The Vermont Medical Society

VPQHC – Vermont Program for Quality in Health Care

WRFP – White River Family Practice