Care Models and Care Management

Work Group Meeting

Agenda 5-12-15

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

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

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:30 to 10:40	Welcome; Introductions; Approval of Minutes (Co-Chair Nancy Eldridge is meeting facilitator)	**Attachment 1:** April meeting minutes	Yes (approval of minutes)
2	10:40 to 11:00	Legislative/Health Policy Update (Co-Chair Bea Grause, VAHHS) ***Public Comment***	**Attachment 2**: Understanding Payment Reform in Vermont	
3	11:00 to 11:10	Update on Regional Blueprint/ACO Committees ***Public Comment***		
4	11:10 to 12:00	Integrated Communities Care Management Learning Collaborative: • April 15th Webinar and May 19th In-Person Learning Session • Steering Committee and Core Team Vote on Expansion • Core Competency Training for Frontline Care Coordinators • Progress Report from Quality Improvement Facilitators ***Public Comment***		
5	12:00 to 12:20	Intersection of HIE and CMCM: Universal Transfer Protocol and Shared Care Plan (Erin Flynn and Larry Sandage) ***Public Comment***	**Attachment 5:** SCUP Presentation	
6	12:20 to 12:30	Wrap-Up and Next Steps; Plans for Upcoming Meetings: • Summary of gaps, duplication, opportunities for coordination, risks • Presentation on Caledonia and Southern Essex Counties (St. Johnsbury Health Service Area) Learning Collaborative and Dual Eligible Project ***Next Meeting:*** *Tuesday, June 16th, 2015, 10:30 AM – 12:30 PM, Calvin Coolidge Conference Room, National Life, Montpelier VT*		

Attachment 1

April Minutes

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

Date of meeting: April 14, 2015; 10:30 AM – 12:30 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Bea Grause called the meeting to order at 10:31 AM. A roll call was taken and a quorum was not present at the start of the meeting. Approval of the March minutes was postponed until later in the meeting once a quorum was established.	
2. Update on Regional Blueprint/ ACO Committees	Miriam Sheehey from OneCare Vermont, Patty Launer from CHAC and Jenney Samuelson from the Blueprint for Health provided an update on the regional ACO/Blueprint committees (known as Unified Community Collaboratives [UCCs] or Regional Clinical Performance Committees [RCPCs]). A handout was made available at the meeting and is included in the updated meeting materials that are posted to the VHCIP website here. The regional Blueprint / ACO Committees have engaged a variety of attendees; and have discussed the following topics: • Establishing a leadership team that will facilitate the decision-making process with respect to clinical priorities on which the group wishes to focus; • Understanding gaps in care and services available in the community; and • Working on clinical priority areas identified by the group Each UCC/RCPC is building a governance structure that includes a variety of members and supports the role that each member organization plays in the community, establishing meeting processes, and developing their charters. At least one group has included a consumer on the leadership team; other groups are still trying to become more established before recruiting consumers. Some of the same organizations that are participating in the Integrated Communities Care Management Learning Collaborative are also participating in the UCCs/RCPCs. The group discussed strategies for engaging and providing supportive training for consumers to participate. A specific example from Central Vermont demonstrates the type of work that is occurring within regions. A risk scoring model was used to predictively model and analyze care patterns of a cohort of at-risk people, by looking at costs, demographics, ED and primary care utilization, etc. They have developed a care model with the goal of ensuring close	

Agenda Item	Discussion	Next Steps
	coordination of services between primary care and other community providers, at least one monthly care management contact, and depression screening, among other interventions. Patrick Flood reported on the UCC in the St. Johnsbury community. Their committee strives to include a broad range of community partners; as an example, they are partnering with the food bank on food security issues. Ultimately, they are attempting to establish an Accountable Community for Health. Q: What's being done to coordinate between priorities established in a region versus ACO priorities? A: ACOs participate on the UCCs/RCPCs; they can share data with UCCs/RCPCs to help identify quality improvement priorities. There is overlap; the regional group ultimately determines their priorities. Q: Does OneCare attend all of the regional committees? A: Someone from OneCare tries to attend all of the groups; there is one group that is working to better establish the group culture and develop standard operating procedures before inviting ACOs and other external groups. If an ACO does not have a presence in a particular region, it doesn't participate in that region's UCC/RCPC.	
3. Minutes Approval	A quorum was established. Susan Aranoff made a motion to approve the March minutes and Audrey Spence seconded; the minutes were approved by exception.	
4. Expansion of Learning Collaborative	Pat Jones presented an update on the Integrated Communities Care Management Learning Collaborative and a proposal to expand to additional communities in 2015; that information can be found in Attachment 3. The expansion request is proposed because additional communities have asked to join the program. The goal is to begin Round 2 in June or September (it would be challenging to initiate a collaborative during the summer). The content and scheduling would be similar to Round 1. There could be up to 4 rounds, depending on the number of interested communities. The total estimated budget is $500,000. Q: How do we know this is going to work; do we want to approve rolling out another round before the first round is done? A: We intend to look at process measures related to the interventions to see if there has been improvement over the baseline. Selected outcome measures could be used as well (e.g., inpatient admissions; ED visits). Participant experience could be evaluated via interviews or focus groups. The interventions being tested are considered to be national best practices, including best practices identified in the DLTSS model of care. Progress is already being made in the pilot communities. Q: What about patients who don't fit into the cohort as defined, but who need services? A: In St. Johnsbury, while they selected 20 or 25 people to start the process, they plan to roll out the interventions to all who would benefit if the interventions appear to be working.	

Agenda Item	Discussion	Next Steps
	At its March 23 meeting, the CMCM work group voted to recommend expansion of the learning collaborative, pending collaboration with the DLTSS work group. Since that time the Core Team met and allocated additional funds to the DLTSS work group to develop care competency training for providers, related to people with disabilities. The DLTSS and CMCM work group leadership met, and will continue to collaborate on opportunities to implement the elements of the DLTSS model of care, as well as core competency training. A motion to approve expansion of the Learning Collaborative as presented was made by Dale Hackett and seconded by Mary Moulton; then there was a second motion to approve the expansion by exception made by Dale Hackett and seconded by Trinka Kerr. The Learning Collaborative Expansion was approved with 2 abstentions.	
5. Presentation from VNAs of Vermont, Area Agencies on Aging, and Vermont Care Partners	Peter Cobb from the VNAs of Vermont, Mike Hall from Champlain Valley Area on Aging, Patrick Flood from Northern Counties Health Care, and Melissa Bailey from Vermont Care Partners presented the information in Attachment 4. Mike Hall presented the Area Agency on Aging (AAA) information, and addressed the following questions: Q: What is included in AAA person-centered case management? A: The service is limited to 48 hours of case management per year –services are arranged and coordinated; there is an effort to address acquisition of mental health or other services for those who need them. The return on investment appears to be very high; it was noted that the AAA cost information on slide 7 does not include all other services that a person might receive, so it is not directly comparable to nursing home and hospital costs. AAAs provide a broad range of services. It is increasingly apparent that there is overlap among different organizations, and that these organizations' programs could serve clients in a more integrated fashion. This means consolidation of systems and development of closer formalized relationships. Q: What are the criteria for an AAA referral? A: Formerly, the person had to be 60+; now services are provided to people under 60 such as adults with disabilities; as long as the individual meets the level of care and is financially qualified, they can be served at an AAA. This includes people at risk but not Medicaid eligible. Q: From a consumer point-of-view, the system appears to be confusing – how do we get to "any open door?" What's the vision based on Learning Collaborative participation? A: The ADRC program (Aging and Disability Resource Centers) are trying to establish a "no wrong door" policy – in practice, they are not necessarily making the referrals/routing to services as intended. It should not be mysterious for consumers. One idea is to create an entity that is jointly staffed so that the interface with the consumer and between the agencies is seamless and transparent (as opposed to operating with multiple partners that require heavy coordination). AAA representatives are participating in the Learning Collaborative in all three pilot communities.	

Agenda Item	Discussion	Next Steps
	Melissa Bailey from Vermont Care Partners (VCP) presented information about Vermont's Designated and Special Services Agencies. Her presentation highlighted the very complicated funding streams in this area. The presentation touched upon how the VCP works with community partners and what is working well, and highlighted some health outcomes. Q: What is the age range served by VCP? A: All ages, from birth to death. Peter Cobb from the VNAs of Vermont presented the slides about home health care in Vermont. 70% of Vermont's home health patients are over age 60, which means that 30% are not. Many people assume the VNAs only serve the elderly population. Primary challenges facing delivery of care are: • Data Sharing - Community-based providers need the ability to share and receive relevant patient-specific data electronically with physicians, hospital, nursing homes, and others, to increase efficiency and improve quality. • Duplication – People sometimes receive care management services from several providers. • "No Wrong Door" vs. "Single Point of Contact" - A single point of entry is not needed; a system that provides "no wrong door" is. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the AAA, home health staff must have the knowledge and ability to arrange for the services needed. This can be achieved by Care Resource Teams which would include representatives from a variety of providers. There are opportunities within the Unified Community Collaboratives/Regional Clinical Performance Committees being developed by ACOs, the Blueprint, and community partners. The UCCs could improve coordination of care, help organizations work together, and improve the quality of health care service delivery. Patrick Flood, CEO of Northern Counties Health Care, suggested that real health reform is going to happen at the community level. He presented a case study of a 65 year old homeless man, who is terminally ill. Recently, he was in the hospital and was then referred to home health. When home health staff checked his records, he had no PCP, so they made a referral to a PCP. He was able to establish a relationship with a care manager, and he has decided that he does not want further cancer treatment. He now has a community team with a primary care site, AAA, SASH and the hospital to help ensure his needs are met. His team is seeking an apartment to allow him to qualify for hospice care, which is his preference for treatment. Without a coordinated intervention like this, he likely would have ended up in the ER and in a nursing home. This is person-centered care, directed by the patient with the support of a lead care manager. Ideally, these types of coordinated interventions can become organized and systematic, as opposed to ad-hoc interactions. The big question is how do we pay for this kind of care in a sustainable way?	
6. Next Steps, Future Meeting	**Next Meeting:** Tuesday, May 12, 2015; 10:30 am to 12:30 pm; ACCD – Calvin Coolidge Conference Room, National Life, Montpelier	

Motion to approve minutes
Sue Aranoff 1°
Audrey Spence 2°

Mtn to approve LC
Dale Hackett 1°
Mary Moulton 2°

Dale H. 1° mtn amended to approve by exception
Trinka Kerr 2°

VHCIP CMCM Work Group Member List

Roll Call: 4/14/2015

Member		Member Alternate		(1) Minutes	(2) LC Expansion	
First Name	**Last Name**	**First Name**	**Last Name**			**Organization**
Susan	Aranoff ✓	Sara	Lane			AHS - DAIL
Nancy	Breiden ✓	Rachel	Seelig			VLA/Disability Law Project
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger			AHS - DOC
Barbara	Cimaglio					AHS - VDH
Peter	Cobb ✓	Beverly	Boget	A	A	VNAs of Vermont
Dana	Demartino					Central Vermont Medical Center
Nancy	Eldridge					Cathedral Square and SASH Program
Joyce	Gallimore					CHAC
Eileen	Girling ✓	Heather	Bollman ✓			AHS - DVHA
Bea	Grause ✓					Vermont Association of Hospital and Health Systems
Dale	Hackett ✓					None
Linda	Johnson					MVP Health Care
Pat	Jones ✓	Richard	Slusky			GMCB
Trinka	Kerr ✓	Julia	Shaw	A		VLA/Health Care Advocate Project
Patricia	Launer ✓					Bi-State Primary Care
Vicki	Loner	Maura Miriam	Crandall Sweeny			OneCare Vermont
Madeleine	Mongan ✓			A		Vermont Medical Society
Judy	Morton ✓					Mountain View Center
Mary	Moulton ✓			A		Washington County Mental Health Services Inc.
Paul	Reiss ✓	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Laural	Ruggles ✓					Northeastern Vermont Regional Hospital
Catherine	Simonson ✓					DA - HowardCenter for Mental Health
Patricia	Singer					AHS - DMH
Lily	Sojourner ✓	Shawn	Skafelstad			AHS - CO
Audrey-Ann	Spence ✓	Robert	Wheeler			Blue Cross Blue Shield of Vermont
Jason	Wolstenholme	Jessica	Oski			Vermont Chiropractic Association
Lisa	Viles					Area Agency on Aging for Northeastern Vermont
	# 28		13			

Maura Graff #12 Planned Parenthood A A

(1) Minutes approved by exception with 5 Abstentions

(2) Learning Collaborative expansion approved by exception with 2 abstentions

VHCIP CMCM Work Group Participant List

Attendance: 4/14/2015

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

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

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

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

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

Attachment 2

Understanding Payment Reform in Vermont

Understanding Payment Reform in Vermont

CMCM WORKGROUP APRIL 14, 2015
2015

Payment Reform Questions

Why the drive for payment reform?

Whose payments are changing?

What's the time-line for payment reform?

Will all payers collaborate to change payments simultaneously?

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

Why The Drive For Payment Reform?

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

Whose Payments Are Changing?

Volume

Value

Whose Payments Are Changing?

Hospitals – SSP, Bundled payments, VBP, full capitation

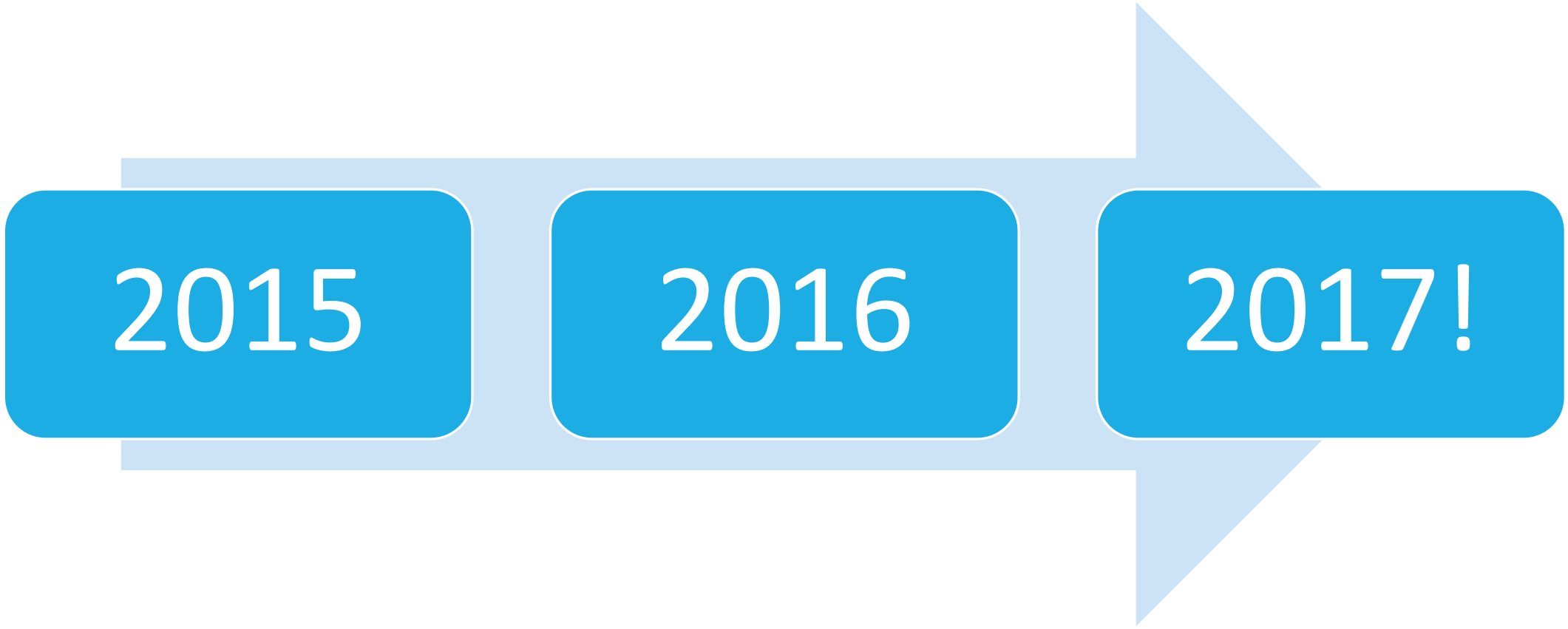
Employed Physicians – per contract, linked to hospital/ACO

ACOs

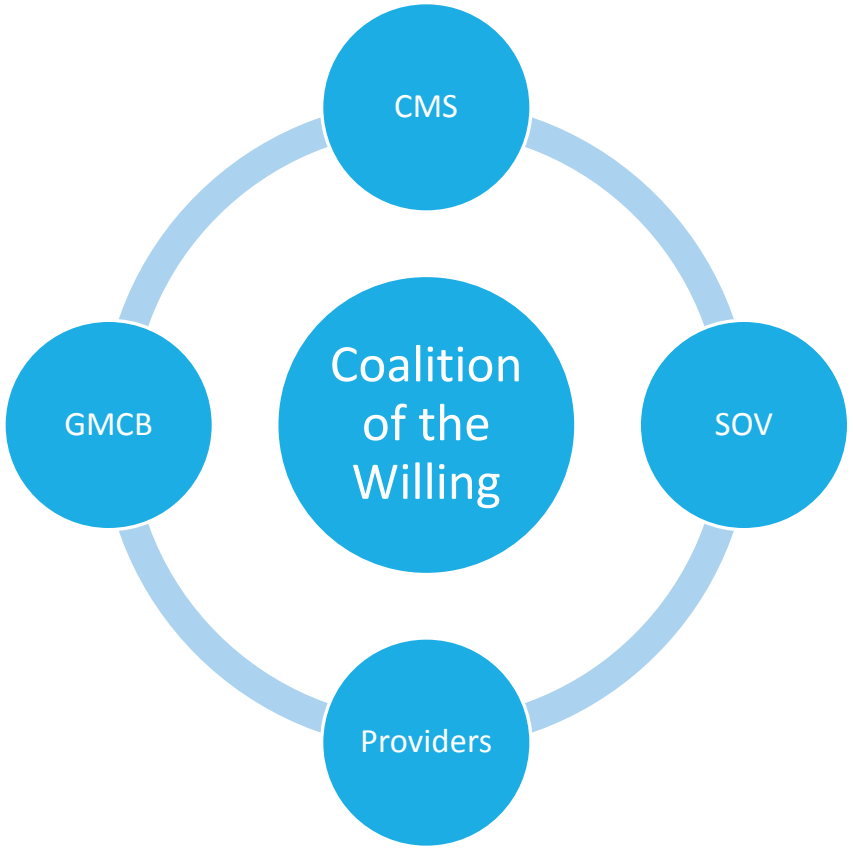
- Shared Savings Pilots
- Next Generation Guidelines

Sub-acute providers – Bundled payments

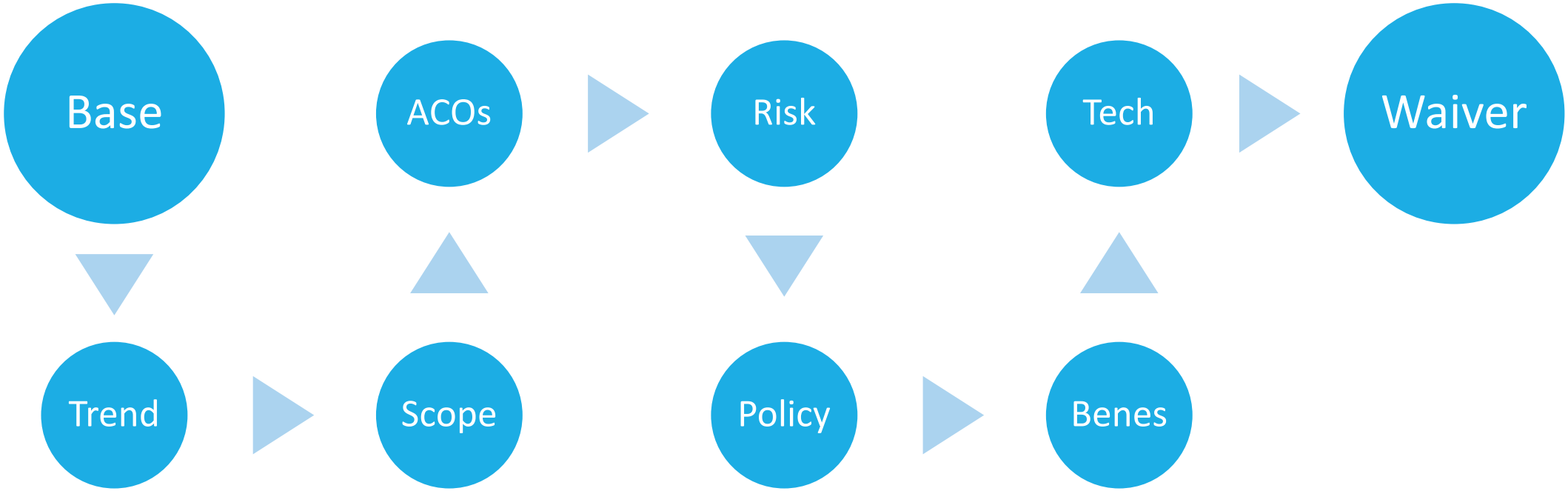
What's The Timeline?



Will Payers (and Providers) Collaborate?

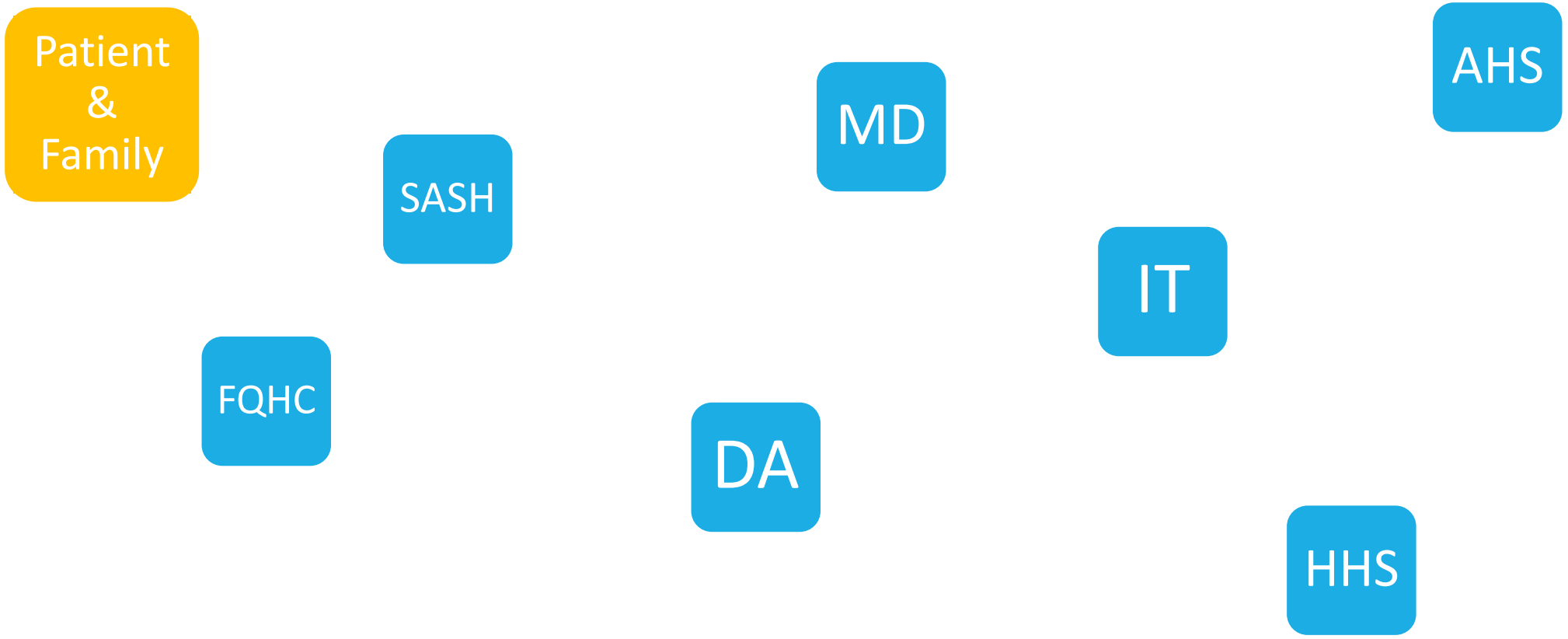


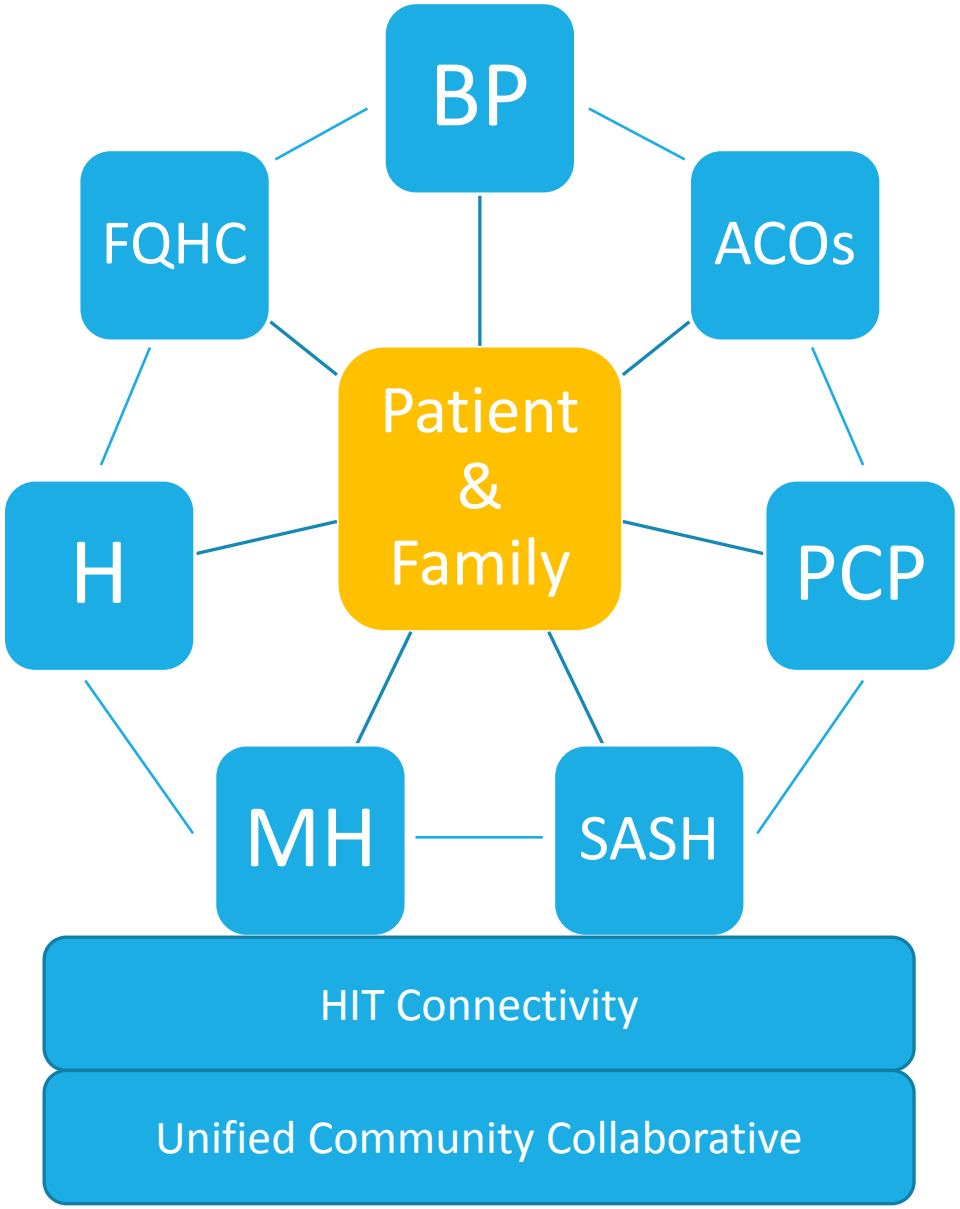
All Payer Process – a 7 year conversation



Green Mountain Care Board

Payment Reform Won't Succeed WO/ Care Coordination




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

Payment Reform Challenges & Questions

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

Appropriate use of data for measurement, improvement, patient engagement

Managing improvements in practice/payment over time

Paying for infrastructure: HIT, training

Attachment 5

SCÜP Presentation

Shared Care Plans & Universal Transfer Protocol

May 12, 2015

Vermont Health Care Innovation Project

Project Overview: Shared Care Plans/Universal Transfer Protocol

VISION:

This project will provide a technological solution that supports Vermont's providers and caregivers in successfully navigating transitions between care settings.

This solution will support:

- Coordinating and managing patient care through transitions from one care setting to another
- Maintaining an up to date person-directed care plan that captures:
  - key elements of a person's clinical and non-clinical goals
  - primary functions of different members of their care team

History/Background

- Seeks to address the goals of two projects:
  - Universal Transfer Protocol Project (one of the ACTT projects) in the HIE work group
  - Shared Care Plans as part of the integrated care management learning collaborative in the CMCM work group

- Strong overlap between the two tools, goal is to not create two disparate processes

- Learning collaborative communities and CMCM work group members have identified challenges in sharing and updating care plans across multi-disciplinary teams, including:
  - Lack of HIT infrastructure
  - Lack of interoperability

- Project is focused on developing a solution to facilitate transfer of information during transitions of care; as well as support communication amongst a multi-disciplinary community based team.

SCP & UTP – What are they?

Shared Care Plans (SCP):

Shared care plans are a tool to document and share information necessary to identify issues that impact a person's health care needs, as well as the activities and accountable parties for addressing those needs in a multi-disciplinary team-based care setting.

Universal Transfer Protocol (UTP):

The universal transfer protocol is a paper-based or electronic form that allows providers to exchange a core set of patient information as patients' transition between health care settings.

Why Both?:

The data elements necessary for the UTP very clearly aligned with what was already in scope for Shared Care Plans, so it was a natural alignment of projects.

Phases

1. Identify SCÜP Project Team & Perform Initial Outreach:
April, 2015

2. Develop Business Requirements: May – July, 2015

3. Develop Technical Requirements: May – September, 2015

4. Technology Proposal: August – October, 2015

Project Phase	April	May	June	July	August	September	October	November	December
Identify SCP/UTP Project Team & Initial Outreach	■								
Develop Business Requirements		■	■	■					
Develop Technical Requirements		■	■	■	■				
Technology Proposal					■	■	■		

SCÜP Team:

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