VT Health Care Innovation Project
Practice Transformation Work Group Meeting Agenda

June 7th, 2016; 10:00 AM to 12:00 PM
AHS - WSOC Oak Conference Room, 280 State Drive, Waterbury, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:00 – 10:10	**Welcome & Introductions; Approval of Minutes** Deborah Lisi-Baker and Laural Ruggles	**Attachment 1:** April meeting minutes	Yes (approval of minutes)
2	10:10 – 10:25	**Program Updates:** • **Operational Plan Submission** • **CMMI Site Visit** • **Core Competency Training** Georgia Maheras, Erin Flynn		No
3	10:25 – 11:10	**Integrated Communities Care Management Learning Collaborative: Recap of Progress to Date, Future Plans and Sustainability** Jenney Samuelson, Pat Jones and Erin Flynn	**Attachment 3:** ICCMLC Presentation	No
4	11:10 - 11:50	**Review & Discuss 2016 Practice Transformation Workgroup Work Plan** Deborah Lisi-Baker and Laural Ruggles	**Attachment 4:** 2016 Practice Transformation Workgroup Work Plan	No
5	11:50 – 12:00	Wrap-Up and Next Steps; Plans for Next Meeting		

Attachment 1: April meeting minutes

Vermont Health Care Innovation Project
Practice Transformation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: April 5, 2016; 10:00 AM to 12:00 PM; Red Oak Room, State Office Complex, 280 State Drive, Waterbury, VT

Agenda Item	Discussion	Next Steps
1. Welcome, Introductions **Approval of minutes**	Deborah Lisi-Baker opened the meeting at 10:03. A roll call was taken and a quorum was present. Sue Aranoff made a motion to approve the minutes of the last meeting by exception; Dale Hackett seconded the motion. The minutes were approved with 3 abstentions: Trinka Kerr, Sam Liss and Maura Graff.	
2. Accountable Community for Health, Peer Learning Lab Update	**Accountable Community for Health, Peer Learning Lab Update** Heidi Klein – Director of Health Surveillance; Vermont Department of Health Heidi Klein presented on the Accountable Communities for Health, Peer Learning Lab. She began with an overview of the concept of Accountable Communities for Health and discussed how the VHCIP has approached the idea of how we might create an accountable community for health in Vermont. Following on the work of the Prevention Institute and the creation of the report that was completed as part of Phase I of this project, we decided to pursue a peer learning model. Vermont has several communities who are interested in taking the next step in the process and they are all at different points of developing at least some of the components of an accountable community for health. The lab is designed to facilitate a forum where these communities can learn from one another by participating in in-person learning events interspersed with webinars. Dale Hackett asked about how this type of work might be sustained in the long term? Heidi responded that New and innovative payment models may allow us to be creative around how we currently fund	

Agenda Item	Discussion	Next Steps
	things. Additionally, alternative funding sources could help support this type of model. For example, Jim Hester is part of a work group that is investigating ways to find alternative funding models to help impact the social determinants of health. Laural Ruggles reinforced the complexity of our current payment models, and illustrated this by noting the large volume of disparate funding streams her local designated mental health agency receives from Medicaid alone. Sam Liss asked Heidi to elaborate on the goal of addressing the social determinants of health through an accountable communities for health model. Heidi responded that under the community collaboratives there are work groups state wide that are thinking how to improve things like housing, transportation and other social determinants of health. One positive development that is occurring in the community collaborative teams is the involvement of leadership from key organizations that are working together to set priorities for the community as a whole.	
3. Update on the Medicaid Pathway	**Update on the Medicaid Pathway** **Michael Costa, Deputy Director of Health Care Reform and Selina Hickman, Director of Health Care Operations and Quality at the AHS Secretary's Office** Michael Costa began with a brief update on the All Payer Model and reviewed the slides in the meeting packet starting on page 18. Vermont is negotiating with the federal government (CMS) to work out the details that would eventually form the basis for an all payer waiver for Vermont. He highlighted that we also want to start changing the way that we talk about health care reform so that we keep the goal in sight: An integrated health system that can achieve the Triple Aim. Sue Aranoff asked whether the all payer model approach must include an ACO because the model in Maryland does not utilize one. Michael responded that it does not, but that Vermont has determined that in order to encourage provider led reform, and to increase the likelihood that we will gain CMS approval, an ACO model has been determined to be the way forward for Vermont. Dale Hackett asked why DVHA is issuing an RFP soliciting ACO involvement in the all payer model while AHS central office is overseeing the Medicaid Pathways initiative. Michael and Selina responded that in this scenario DVHA is the 'payer' in State Government that is looking to contract with an ACO for payments related to those services that are similar to Medicare A&B services. However, DVHA and AHS more broadly cover a wide range of services outside of that definition. The Medicaid Pathways initiative is a critical step to understanding how to expand the all payer model to include additional services over time. Ben Watts from the Department of Corrections offered several points to include in the conversation:	

Agenda Item	Discussion	Next Steps
	1) The notion of the Triple Aim – 'Staffing/Workforce" can be considered a 4th Aim. 2) New York State has the ability to pay for services for incarcerated individuals who are within 30 days of release under a Medicaid waiver. It would be very beneficial to include this benefit under any new waivers that are being negotiated on behalf of the State of Vermont. 3) Alignment of incentives – it appears there are not enough financial incentives for DAsThey are beginning to be included in reform conversations, but the payments have not yet followed. 4) PCPs and DAs – these should be seen as the front line in delivering care. Michael Costa expressed appreciation for the observations and likened the tasks to creating a doorway: our job is to build the door – can we make it attractive enough for the DAs (among others) to walk through it? Selina Hickman next reviewed the Medicaid Pathway slides in the materials packet – starting on page 29. She noted that there is a great deal of work needed to make this initiative possible. For example, the work group that is reviewing the designated agency and mental health services has allotted 6 months for that work and up to a year to implement the payment model. Dale asked about the providers who are participating in the ACO Shared Savings Program – it's mostly the groups of hospitals and physicians and community providers who are participating. Maura Graff also asked about the "TBD" category of departments – what are the plans for including them? Selina responded that this is primarily a human resources issue in that we don't have enough people to work on everything at once and that the TBD was meant more to refer to the timing. It seems that several of the departments listed are indeed already engaging in the process. Selina described the slide on page 32 of the materials packet and noted that the first column that is colored green should really be about a third of the whole picture as it represents more of the total than it graphically appears to show. This slide is meant to show how complicated the model and its implementation will be as all the items must be in alignment in order to be eligible for payment under the model. Patricia Singer pointed out that the DMH 1115A waiver already includes both hospital and community based care payments – and they manage it within their utilization reviews. Sam Liss asked if the model of care incorporates not only the concept of person/family *centered* care but also person/family *directed* care. Selina noted that the Medicaid Pathways initiative draws heavily from the DLTSS Model of Care that absolutely includes an emphasis on person directed care.	

Agenda Item	Discussion	Next Steps
	Deborah Lisi-Baker asked about efforts to include advocates and consumer representatives in the development of this model, as they often feel left out of the conversation around what the best outcomes for families will be. Selina indicated that the plan will come back through the SIM work groups so that the public process of SIM will be engaged there. As well, any changes to Medicaid requires a robust public process and will likely involve MEAB. As well, the next legislative session will need to address the changes proposed to the funding streams. Deborah also pointed out that providers have always been interested in streamlining the administrative relationship with AHS. She hopes that the Medicaid Pathway will develop some congruence and integration in the way that AHS will work with providers. Selina noted that the goal is to indeed do that and also that she is cognizant that providers may find themselves in a very complicated place if they are left with feet in both worlds for too long, hence the need for a fast pace of change. Laural Ruggles also noted the anxiety level in the communities and amongst providers is very high: What can we tell them to alieve that anxiety? Michael responded by asking this question "Do we want to keep walking down this road?" Are the providers willing to keep walking on this path based on the facts of today and the potential opportunity that is presented? We don't have to commit the full model at this time, but rather to keep the conversation going as facts materialize over time.	
4. Core Competency Training Update **Erin Flynn – DVHA** **Learning Collaborative Update** **Pat Jones - GMCB**	**Core Competency Training Update** Erin Flynn provided an update on the Core Competency Training Series. The response has been strong and the training sites have been chosen to try to cover the state as widely as possible. The interest has been so high that an additional session has been scheduled for the Burlington area. The materials packet contains a listing of the whole training schedule and the materials have all be posted to a new page on the VHCIP website, linked here. 240 people have signed up already; with a waitlist for all locations. Staff is doing everything possible to meet the training needs of all those interested. **Learning Collaborative Update** Pat Jones provided an update on the ongoing Integrated Communities Care Coordination Learning Collaborative program. In person learning sessions for 2nd and 3rd cohorts were held March 16th and 17th. These focused on care coordination conferences and shared care plans. Nationally recognized faculty member Jill Rinehart, along with Shelley Waterman, and Kristy Trask presented. As well, Jeanne McAllister from the Indiana School of Medicine was invited back to present.	

Agenda Item	Discussion	Next Steps
	There was great participation including members of the original pilot communities – highlights include the use of UVM trained actors (Standardized Patients) to role play the implementation of multi-organizational care conferences. On May 24th and 25th expert faculty member Lauran Hardin will return for a series of in person learning sessions focused on sustainability. Sarah Narkewicz will also be presenting on how to train others in your community to use the tools. Also, the agenda will highlight the Patient Ping ENS statewide system. A future in person learning session will focus on transitions of care and how peoples acuity and needs change over time. –The team continues to work with ACO partners, Blueprint and community partners to carry on this work. We are seeing participants in the Core Competency referencing the tools we've developed as part of the LC so it is wonderful to see the synergies circling around the same topics and tools. Finally, the team is nearing completion of a tool kit that will be made publicly available highlighting the tools and teachings of the last two years of the Integrated Communities Care Management Learning Collaborative model.	
6. Next Steps	Please note that the May Practice Transformation work group meeting is cancelled! The next meeting is Tuesday, June 7, 2016 10:00 am – 12:00 pm Red Oak Conference Room, 280 State Drive, Waterbury This is in the new State Office Complex (New Building - the meeting space is located on the 2nd floor above the main entrance) Call-In Number: 1-877-273-4202 Conference ID: 2252454	

VHCIP Practice Transformation Work Group Member List

Sue A 1°
~~Hinkel~~ K 2°
Dale H
3 abstentions
motion carried.

Tuesday, April 05, 2016

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Susan	Aranoff ✓	Gabe	Epstein		AHS - DAIL
		Bard	Hill		AHS - DAIL
		Clare	McFadden		AHS - DAIL
Beverly	Boget	Peter	Cobb		VNAs of Vermont
		Michael	Counter		VNA & Hospice of VT & NH
Kathy	Brown	Todd	Bauman		DA - Northwest Counseling and Support Services
		Stephen	Broer		DA - Northwest Counseling and Support Services
Barbara	Cimaglio				AHS - VDH
Molly	Dugan	Stefani	Hartsfield		Cathedral Square and SASH Program
		Kim	Fitzgerald		Cathedral Square and SASH Program
Eileen	Girling	Heather	Bollman		AHS - DVHA
		Jenney	Samuelson		AHS - DVHA - Blueprint
Maura	Graff ✓			A	Planned Parenthood of Northern New England
Deborah	Lisi-Baker ✓				UVM; Co-chair
Dale	Hackett ✓				Consumer Representative
Sarah	Jemley	Jane	Catton		Northwestern Medical Center
		Candace	Collins		Northwestern Medical Center
Linda	Johnson	Debra	Repice		MVP Health Care
Pat	Jones ✓	Annie	Paumgarten ✓		GMCB
Trinka	Kerr ✓	Nancy	Breiden	A	VLA/Health Care Advocate Project
Jackie	Majoros ✓	Barbara	Prine		VLA/LTC Ombudsman Project
Dion	LaShay				Consumer Representative
Patricia	Launer ✓	Kendall	West		Bi-State Primary Care
Sam	Liss ✓			A	Statewide Independent Living Council

VHCIP Practice Transformation Work Group Member List

Member		Member Alternate			Tuesday, April 05, 2016
First Name	Last Name	First Name	Last Name	Minutes	Organization
Sara	Barry	Emily	Bartling		OneCare Vermont
Miriam		Maura	Crandall		OneCare Vermont
Kate	McIntosh	Judith	Franz		Vermont Information Technology Leaders
Bonnie	McKellar	Mark	Burke		Brattleboro Memorial Hopsital
Madeleine	Mongan	Stephanie	Winters		Vermont Medical Society
Julie	Tessler				VCP - Vermont Council of Developmental and Mental Health Services
		Mary	Moulton		VCP - Washington County Mental Health Services Inc.
		Catherine	Simonson		VCP - HowardCenter for Mental Health
		Stephen	Broer		VCP - Northwest Counseling and Support Services
Sarah	Narkewicz				Rutland Regional Medical Center
Laural	Ruggles				Northeastern Vermont Regional Hospital; Co-chair
Patricia	Singer	Jaskanwar	Batra		AHS - DMH
		Mourning	Fox		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
Angela	Smith-Dieng	Mike	Hall		V4A
Shawn	Skaflestad	Kirsten	Murphy		AHS - Central Office
		Julie	Wasserman		AHS - Central Office - DDC
Audrey-Ann	Spence	Teresa	Voci		Blue Cross Blue Shield of Vermont
JoEllen	Tarallo-Falk				Center for Health and Learning
Lisa	Viles				Area Agency on Aging for Northeastern Vermont
Kirsten	Murphy				VT Developmental Disabilities Council

31

VHCIP Practice Transformation Work Group

Attendance Sheet

Tuesday, April 05, 2016

	First Name	Last Name	Organization	Practice Transformation
1	Nancy	Abernathy	Learning Collaborative Facilitator	X
2	Peter	Albert	Blue Cross Blue Shield of Vermont	X
3	Susan	Aranoff ✓	AHS - DAIL	M
4	Debbie	Austin ✓	AHS - DVHA	X
5	Ena	Backus	GMCB	X
6	Melissa	Bailey	AHS - DMH	X
7	Michael	Bailit	SOV Consultant - Bailit-Health Purchasing	X
8	Susan	Barrett	GMCB	X
9	Emily	Bartling	OneCare Vermont	MA
10	Jaskanwar	Batra	AHS - DMH	MA
11	Todd	Bauman	DA - Northwest Counseling and Support Ser	MA
12	Bob	Bick	DA - HowardCenter for Mental Health	X
13	Charlie	Biss	AHS - Central Office - IFS / Rep for AHS - DM	X
14	Beverly	Boget	VNAs of Vermont	M
15	Heather	Bollman	AHS - DVHA	MA
16	Mary Lou	Bolt	Rutland Regional Medical Center	X
17	Nancy	Breiden	VLA/Disability Law Project	MA
18	Stephen	Broer	DA - Northwest Counseling and Support Ser	MA
19	Stephen	Broer	VCP - Northwest Counseling and Support Se	M
20	Kathy	Brown	DA - Northwest Counseling and Support Ser	M
21	Martha	Buck	Vermont Association of Hospital and Health	A
22	Mark	Burke	Brattleboro Memorial Hopsital	MA
23	Anne	Burmeister	Planned Parenthood of Northern New Engla	X
24	~~Dr. Dee~~	~~Burroughs-Biron~~	AHS - DOC	X
25	Denise	Carpenter	Specialized Community Care	X
26	Jane	Catton	Northwestern Medical Center	MA

Samantha Hurley - DVHA

27	Alysia	Chapman	DA - HowardCenter for Mental Health	X
28	Joy	Chilton	Home Health and Hospice	X
29	~~Amanda~~	~~Ciecior~~	AHS - DVHA	S
30	Barbara	Cimaglio	AHS - VDH	M
31	Peter	Cobb	VNAs of Vermont	MA
32	Candace	Collins	Northwestern Medical Center	MA
33	Amy	Coonradt	AHS - DVHA	S
34	Alicia	Cooper	AHS - DVHA	S
35	Amy	Cooper	HealthFirst/Accountable Care Coalition of t	X
36	Michael	Counter	VNA & Hospice of VT & NH	M
37	Maura	Crandall	OneCare Vermont	MA
38	Claire	Crisman	Planned Parenthood of Northern New Engl	A
39	Diane	Cummings	AHS - Central Office	X
40	Dana	Demartino	Central Vermont Medical Center	X
41	Steve	Dickens	AHS - DAIL	X
42	Molly	Dugan	Cathedral Square and SASH Program	M
43	Gabe	Epstein ✓	AHS - DAIL	MA
44	Trudee	Ettlinger	AHS - DOC	X
45	Kim	Fitzgerald	Cathedral Square and SASH Program	MA
46	Patrick	Flood	CHAC	X
47	Erin	Flynn ✓	AHS - DVHA	S
48	Mourning	Fox	AHS - DMH	MA
49	Judith	Franz	Vermont Information Technology Leaders	MA
50	Mary	Fredette	The Gathering Place	X
51	Aaron	French	AHS - DVHA	X
52	Meagan	Gallagher	Planned Parenthood of Northern New Engl	X
53	Joyce	Gallimore	Bi-State Primary Care/CHAC	X
54	Lucie	Garand	Downs Rachlin Martin PLLC	X
55	Christine	Geiler	GMCB	S
56	Eileen	Girling	AHS - DVHA	M
57	Steve	Gordon	Brattleboro Memorial Hopsital	X
58	Maura	Graff ✓	Planned Parenthood of Northern New Engl	M
59	Dale	Hackett ✓	Consumer Representative	M
60	Mike	Hall	Champlain Valley Area Agency on Aging / C	MA

61	Stefani	Hartsfield	Cathedral Square	MA
62	Carolynn	Hatin	AHS - Central Office - IFS	S
63	Kathleen	Hentcy	AHS - DMH	MA
64	Selina	Hickman	AHS - DVHA	X
65	Bard	Hill	AHS - DAIL	MA
66	Breena	Holmes	AHS - Central Office - IFS	X
67	Marge	Houy	SOV Consultant - Bailit-Health Purchasing	S
68	Christine	Hughes	SOV Consultant - Bailit-Health Purchasing	S
69	Jay	Hughes	Medicity	X
70	Jeanne	Hutchins	UVM Center on Aging	X
71	Sarah	Jemley	Northwestern Medical Center	M
72	Linda	Johnson	MVP Health Care	M
73	Craig	Jones	AHS - DVHA - Blueprint	X
74	Pat	Jones	GMCB	M
75	Margaret	Joyal	Washington County Mental Health Services	X
76	Joelle	Judge	UMASS	S
77	Trinka	Kerr	VLA/Health Care Advocate Project	M
78	Sarah	Kinsler	AHS - DVHA	S
79	Tony	Kramer	AHS - DVHA	X
80	Sara	Lane	AHS - DAIL	X
81	Kelly	Lange	Blue Cross Blue Shield of Vermont	X
82	Dion	LaShay	Consumer Representative	M
83	Patricia	Launer	Bi-State Primary Care	M
84	Deborah	Lisi-Baker	SOV - Consultant	C
85	Sam	Liss	Statewide Independent Living Council	M
86	Vicki	Loner	OneCare Vermont	M
87	Carole	Magoffin	AHS - DVHA	S
88	Georgia	Maheras	AOA	S
89	Jackie	Majoros	VLA/LTC Ombudsman Project	M
90	Carol	Maroni	Community Health Services of Lamoille Vall	X
91	David	Martini	AOA - DFR	X
92	John	Matulis		X
93	James	Mauro	Blue Cross Blue Shield of Vermont	X
94	Lisa	Maynes	Vermont Family Network	X

95	Clare	McFadden	AHS - DAIL	MA
96	Kate	McIntosh	Vermont Information Technology Leaders	M
97	Bonnie	McKellar	Brattleboro Memorial Hopsital	M
98	Elise	McKenna	AHS - DVHA - Blueprint	X
99	Jeanne	McLaughlin	VNAs of Vermont	X
100	Darcy	McPherson	AHS - DVHA	A
101	Madeleine	Mongan	Vermont Medical Society	M
102	Monika	Morse		X
103	Judy	Morton	Mountain View Center	X
104	Mary	Moulton	VCP - Washington County Mental Health Se	M
105	Kirsten	Murphy	AHS - Central Office - DDC	MA
106	Reeva	Murphy	AHS - Central Office - IFS	X
107	Sarah	Narkewicz	Rutland Regional Medical Center	M
108	Floyd	Nease	AHS - Central Office	X
109	Nick	Nichols	AHS - DMH	X
110	Monica	Ogelby	AHS - VDH	X
111	Miki	Olszewski	AHS - DVHA - Blueprint	X
112	Jessica	Oski	Vermont Chiropractic Association	X
113	Ed	Paquin	Disability Rights Vermont	X
114	Annie	Paumgarten	GMCB	MA
115	Laura	Pelosi	Vermont Health Care Association	X
116	Eileen	Peltier	Central Vermont Community Land Trust	X
117	John	Pierce		X
118	Luann	Poirer	AHS - DVHA	S
119	Rebecca	Porter	AHS - VDH	X
120	Barbara	Prine	VLA/Disability Law Project	MA
121	Betty	Rambur	GMCB	X
122	Allan	Ramsay	GMCB	X
123	Paul	Reiss	HealthFirst/Accountable Care Coalition of t	X
124	Virginia	Renfrew	Zatz & Renfrew Consulting	X
125	Debra	Repice	MVP Health Care	MA
126	Julie	Riffon	North Country Hospital	X
127	Laural	Ruggles	Northeastern Vermont Regional Hospital	C
128	Bruce	Saffran	VPQHC - Learning Collaborative Facilitator	X

129	Jenney	Samuelson	AHS - DVHA - Blueprint	MA
130	Jessica	Sattler	Accountable Care Transitions, Inc.	X
131	Rachel	Seelig	VLA/Senior Citizens Law Project	X
132	Susan	Shane	OneCare Vermont	X
133	Maureen	Shattuck	Springfield Medical Care Systems	X
134	Julia	Shaw	VLA/Health Care Advocate Project	X
135	Miriam	Sheehey	OneCare Vermont	X
136	Catherine	Simonson	VCP - HowardCenter for Mental Health	M
137	Patricia	Singer	AHS - DMH	M
138	Shawn	Skaflestad	AHS - Central Office	M
139	Richard	Slusky	GMCB	X
140	Pam	Smart	Northern Vermont Regional Hospital	X
141	Angela	Smith-Dieng	V4A	M
142	Lily	Sojourner	AHS - Central Office	X
143	Audrey-Ann	Spence	Blue Cross Blue Shield of Vermont	M
144	Holly	Stone	UMASS	S
145	Beth	Tanzman	AHS - DVHA - Blueprint	X
146	JoEllen	Tarallo-Falk	Center for Health and Learning	M
147	Julie	Tessler	VCP - Vermont Council of Developmental a	M
148	Bob	Thorn	DA - Counseling Services of Addison County	X
149	Win	Turner		X
150	Lisa	Viles	Area Agency on Aging for Northeastern Ver	MA
151	Beth	Waldman	SOV Consultant - Bailit-Health Purchasing	X
152	Marlys	Waller	DA - Vermont Council of Developmental an	X
153	Nancy	Warner	COVE	X
154	Julie	Wasserman	AHS - Central Office	S/MA
155	Kendall	West	Bi-State Primary Care/CHAC	MA
156	James	Westrich	AHS - DVHA	S
157	Robert	Wheeler	Blue Cross Blue Shield of Vermont	X
158	Bradley	Wilhelm	AHS - DVHA	S
159	Jason	Williams	UVM Medical Center	X
160	Stephanie	Winters	Vermont Medical Society	MA
161	Jason	Wolstenholme	Vermont Chiropractic Association	X
162	Mark	Young		X

163	Marie	Zura	DA - HowardCenter for Mental Health	X
				163

Ben Watts - AHS-DOC

Attachment 3: ICCMLC Presentation

Vermont Health Care Innovation Project

Integrated Communities Care Management Learning Collaborative (ICCMLC): Recap of progress, future plans and sustainability

Why Did We Form a Learning Collaborative?

- Vermont's delivery system reforms have strengthened coordination of care and services, but people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services.

- A number of national models have potential to address these concerns.

What Are We Trying To Achieve?

Near-term goals are to:

- Learn about and implement promising interventions to better integrate cross-organization care coordination for at-risk people;
- Improve communication between organizations;
- Reduce fragmentation, duplication, and gaps in care; and
- Determine if interventions improve coordination of care.

Longer-term goals mirror the Triple Aim and Vermont's Health Care Reform goals:

- Improving experience of care (quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Learning Collaborative Framework

- Blueprint Learning Health System/infrastructure was used as the foundation

- Health and human service providers from Vermont's 14 Health Service Areas were invited to participate in the Integrated Communities Care Management Learning Collaborative to test interventions from these promising models.

- Participate in monthly learning sessions with national faculty rotating between in-person sessions and webinars

- Locally meet to implement strategies (typically at least twice a month)

The Learning Model:

Pre-Work

The learning collaborative uses the plan-do-study-act (PDSA) quality improvement model.

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

Action Period
community teams working together to implement change)

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

Action Period
community teams working together to implement change)

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

Action Period
community teams working together to implement change)

Learning Session IV
(Teams gather for a face-to-face meeting)

Spreading the Change

Learning Collaborative Participants

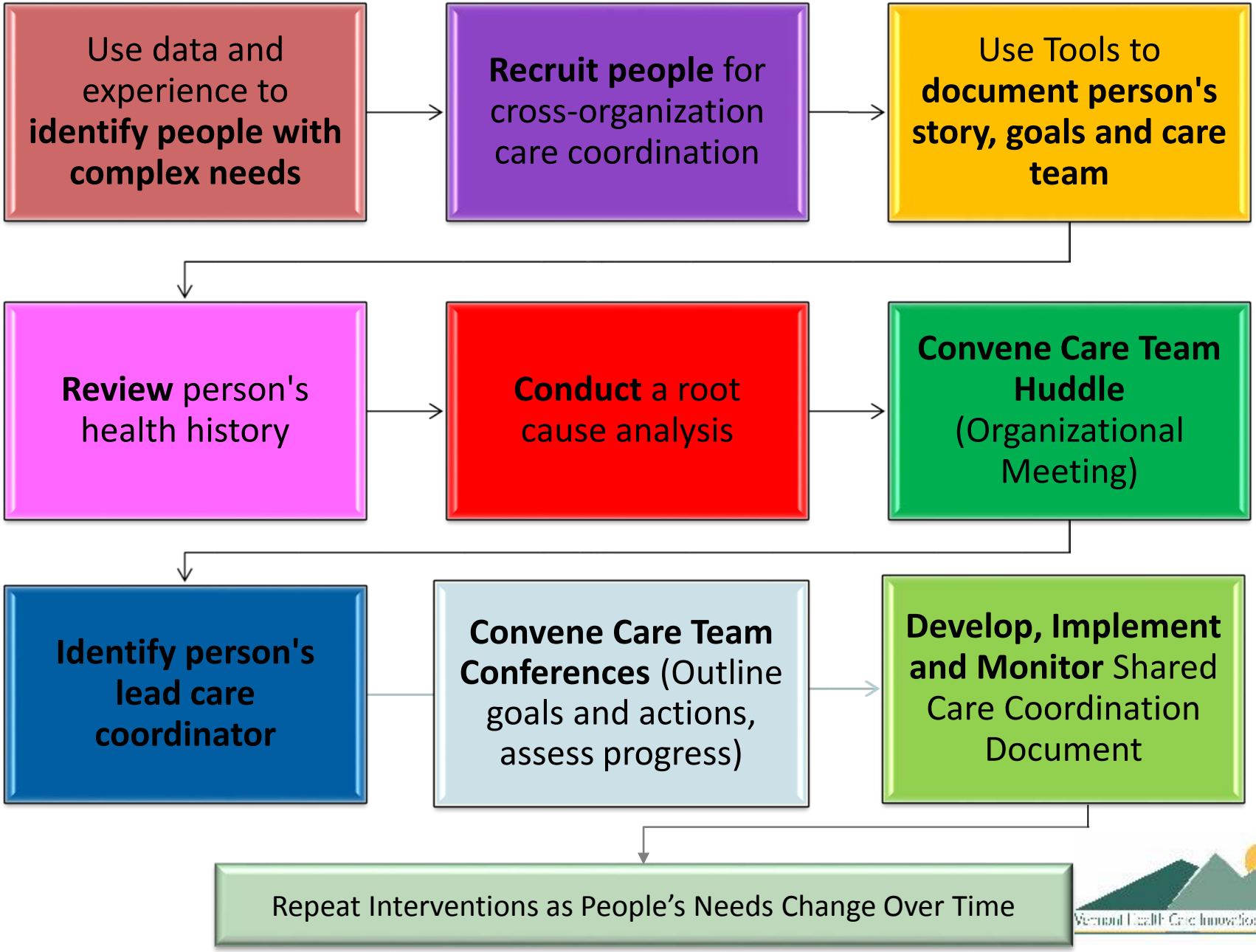
11 of the 14 HSAs are participating. Team members include:

- People in need of care management services and their families
- Primary Care Practices participating in ACOs (including care coordinators)
- Designated Mental Health Agencies and Developmental Services Providers
- Visiting Nurse Associations and Home Health Agencies
- Hospitals and Skilled Nursing Facilities (including their case managers)
- Area Agencies on Aging
- Community Health Teams and Practice Facilitators (Vermont Blueprint for Health)
- Support and Services at Home (including SASH coordinators and wellness nurses)
- ACOs (OneCare, CHAC, ACCGM/VCP)
- Medicaid: Vermont Chronic Care Initiative (including case managers)
- Commercial Insurers
- Agency of Human Services

Interface with Community Collaboratives

- Community Collaboratives (CCs - often known as UCC, RCPC) have been established in each HSA and include health care, social service, and community based organizations.
- CCs set community health priorities based on core measures for each area.
- CCs have selected the Learning Collaborative as a performance improvement project to address priorities and support cross-organization integrated care management.
- CCs are poised to sustain the work at the end of VHCIP with support from the Vermont Blueprint for Health and the ACOs.

Key Interventions in Vermont's Integrated Communities Care Management Learning Collaborative *(order of interventions may vary)*



Overview of Key Tools

Use Data/Experience to Identify People	• Clinical Risk Stratification tool
Recruit Participants	• Sample recruitment letter and script • Sample group and team release forms
Document Person's Story, Goals and Care Team	• Backwards planning cards ("Camden Cards") and game board • Eco Map
Review Person's Health History	• Care management chart review tool
Conduct a Root Cause Analysis	• Root cause analysis work sheet
Convene Care Team Conference	• Tips for conducting care conferences (time management, facilitation, how to get PCP involved • Sample agenda
Identify Lead Care Coordination	• How to identify a lead care coordinator • Lead care coordinator duties and responsibilities
Develop, Implement and Monitor Shared Care Plan	• Sample shared care plans

Vermont Health Care Innovation Project

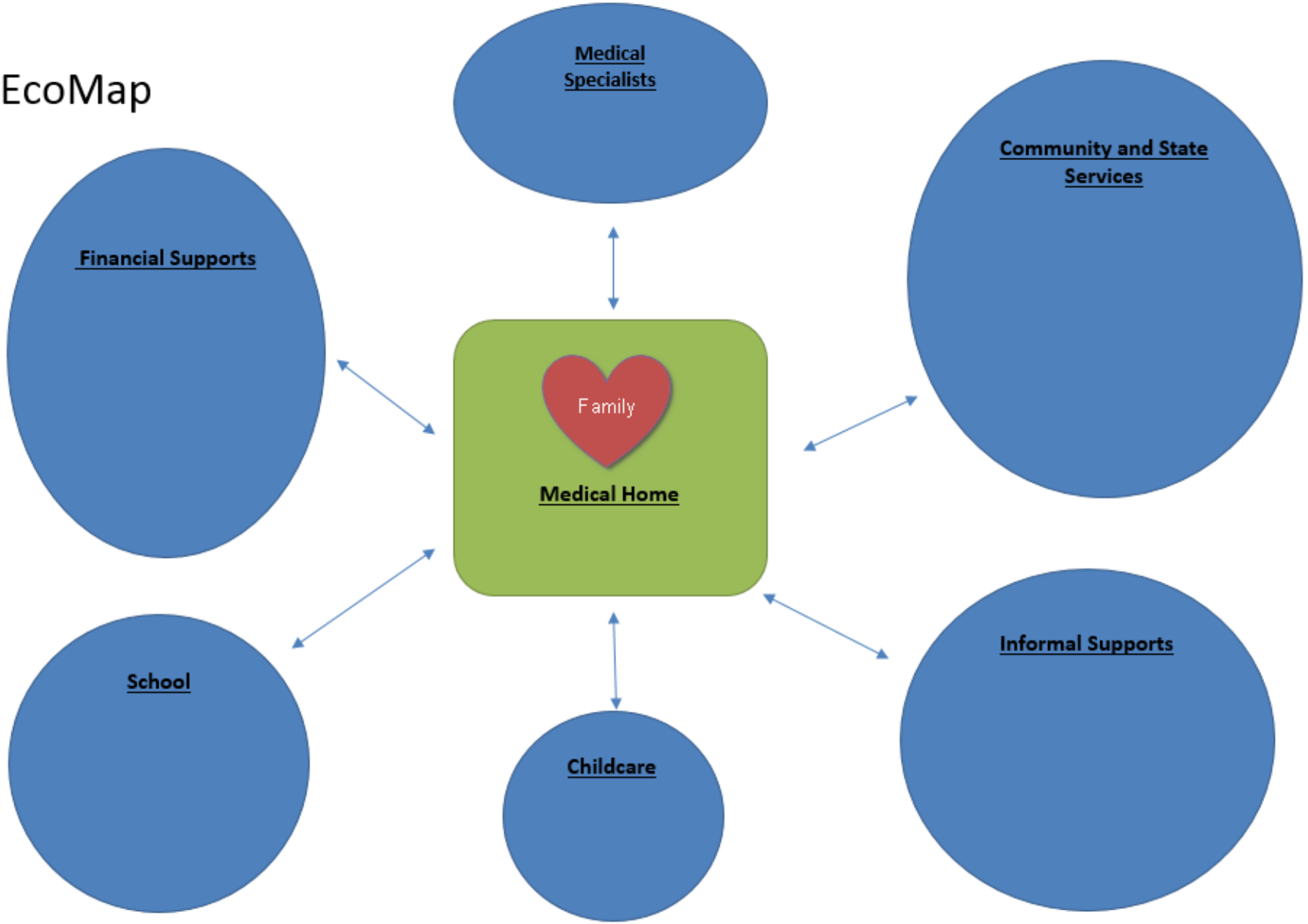
Get a job and/or go back to work (Education & Employment)	
Have medical equipment & medication (Medication & Equipment Support)	
Legal issues (Legal Assistance)	

Backwards Planning Game Board

Domain Cards

	RIGHT NOW	LATER
NEED TO WORK ON		
DONT NEED TO WORK ON		

EcoMap



Newton, Marinell, McAllister, Jeanne, et. Al, "The Comprehensive, Integrated Care Plan (CICP)," The Lucille Packard Foundation for Children's Health, 2013

Care Management Chart Review Tool

DEMOGRAPHIC

Name: _____ DOB: _____Gender: _____Insurance: _____
PCP Name: _____ Phone Number:_____
Care Manager: _____Phone Number:_____

Health team/community supports:	Role (Mental Health provider, health coach, SASH, etc):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIMARY DX: _____
OTHER KEY DIAGNOSES (include Active and Historical): _____
_____
_____

MEDICAL NEIGHBORHOOD

Two or more admissions to the hospital in the past 6 month?	YES	NO
Three or more Emergency room visits in the past 6 months?	YES	NO
Has not been to PCP in past year?	YES	NO
No documented Goals of Care conversation or Advanced Directive on file?	YES	NO

COMMENTS:

MEDICAL STATUS/HEALTH TRAJECTORY

Uses 5 or more medications?	YES	NO
Greater than 3 chronic health conditions?	YES	NO
Requires assistance with ADLs (Activities of Daily Living)?	YES	NO

COMMENTS:

Care Management Chart Review Tool

SOCIAL SUPPORT

Communication Barriers (language, sensory deficits)?	YES	NO
Cognitive barriers?	YES	NO
Does not have stable housing?	YES	NO
Limited social support?	YES	NO
Is not currently employed?	YES	NO
Financial barriers (including underinsured, unable to afford meds)?	YES	NO
Transportation issues?	YES	NO
Literacy issues (difficulty with reading/writing)?	YES	NO
Issues with bereavement (losses/grieving)?	YES	NO

COMMENTS:

SELF MANAGEMENT/MENTAL HEALTH

Non-adherence to previous treatments?	YES	NO
Hospital admission(s) in the past year for mental health-related reason?	YES	NO
Current Behavioral Health diagnosis/substance abuse?	YES	NO

COMMENTS:

OTHER IMPORTANT INFORMATION

Other underlying issues not noted above?	YES	NO

If yes, please comment:

V. 11.20.2015

ROOT CAUSE ANALYSIS WORKSHEET

MEDICAL ROOT CAUSE examples include:

1. Is the person receiving the right treatment for this disease?
2. Are symptoms well managed?
3. Have appropriate referrals been made?
4. Has the patient seen the specialist she was referred to?
5. Do all providers agree on the disease management plan?

PSYCH ROOT CAUSE examples include:

1. Depression
2. Trauma
3. Anxiety
4. Addiction
5. Social Isolation

SYSTEM ROOT CAUSE examples include:

1. Access to care
2. Fragmented Fee-for- Service model
3. Eligibility criteria limit patient's options
4. Poor communication among providers
5. HIPPA restrictions
6. Provider coverage or vacation schedule
7. Capacity

SOCIAL ROOT CAUSE examples include:

1. Poverty
2. Violence
3. Housing
4. Transportation
5. Education
6. Childcare
7. Bias and labeling ("non-compliant", "difficult" etc.)

Shared Care Plan

Patient Information

Patient's Name:			Mobile Phone Number:	
Birthdate:	Age:	Sex:	Home Phone Number:	Email Address:
Address:			Preferred Method of communication: ☐ Phone ☐ Email ☐ Text ☐ Other:	

Insurance Information

Primary Insurance:		ID Number:
Policy Holder:	Policy Holder birthdate:	Employer:
Secondary Insurance:		ID Number:
Policy Holder:	Policy Holder birthdate:	Employer:

Emergency Contact Information

Name:	Relationship:
Home Phone Number:	Work Phone Number:
Legal Decision Maker Information:	

ED Plan

About Me

Insert picture here	Preferred activities:
	How I learn:
	Interaction tips:
	Communication style:
	Tips to avoid triggers/behaviors:
	Mobility:

My Care Plan

My Care Team

Lead Care Coordinator:		Phone:	
Organization:		Email:	
Primary Care Physician:		Phone:	
Organization:		Email:	

Name	Organization & Role	Email	Phone Number

My Strengths

My Goals

Personal Goals	Steps needed to achieve the goal	Person Responsible	Date Completed
1.			
2.			
3.			
4.			
5.			

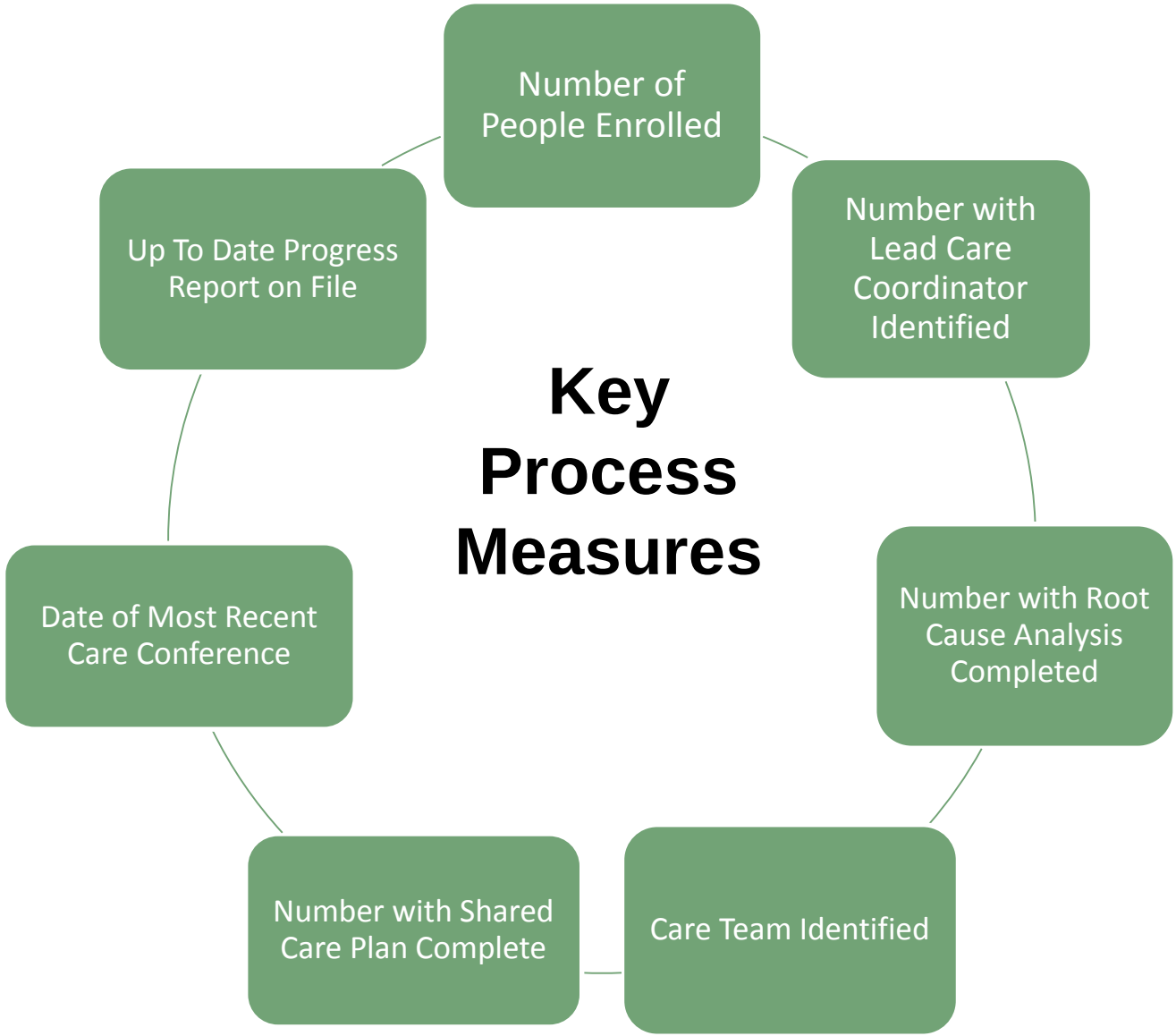
Medical Goals	Steps needed to achieve the goal	Person Responsible	Date Completed
1.			
2.			
3.			
4.			
5.			

Possible challenges with meeting a goal	Plans for how to handle these challenges

Future Goals

Participant's signature _____ Date:_____

Lead Care Coordinator's signature _____ Date:_____


Number of People Enrolled
Number with Lead Care Coordinator Identified
Number with Root Cause Analysis Completed
Care Team Identified
Number with Shared Care Plan Complete
Date of Most Recent Care Conference
Up To Date Progress Report on File
Key Process Measures

Initiating Survey-Based Measures

- Person/Family Experience Survey fielded periodically, to determine impacts of specific interventions

- Team-based care survey fielded periodically, to gauge provider experience with team-based care

Potential Outcome Measures

Emergency Department Utilization:

- Potentially Avoidable ED Utilization
- Outpatient ED Visits (HEDIS®)

Inpatient Utilization:

- Inpatient Discharges (HEDIS®)
- All-Cause Readmission (HEDIS®)
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions (AHRQ PQI Chronic Composite)

Cost/Resource Utilization

- Total Expenditures Per Capita
- Total Resource Use Index

Primary Care Encounters

Future Plans

- Currently preparing for next in person learning session, scheduled for September 6-7

- Theme is **"Keeping a Person's Shared Care Plan Alive Under Dynamic and Challenging Situations."**
- Expert faculty, including Dr. Terrance O'Malley will explore how to identify common transitions in care, determine how much and how quickly information must flow between organizations, and determine what information is crucial.

Questions? Feedback?

Attachment 4: 2016 Practice Transformation Workgroup Work Plan

Vermont Health Care Innovation Project
2016 Practice Transformation Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
Integrated Communities Care Management Learning Collaborative							
1	Support continued implementation of Integrated Communities Care Management Learning Collaborative, including monitoring and reporting.	Continue implementation of Integrated Communities Care Management Learning Collaborative to all interested communities.	Ongoing			Active implementation in 11 communities state-wide.	Increased uptake of identified process measures, provider and recipient of care satisfaction surveys; and identified program outcome measures.
2		Develop tools, with the assistance of expert faculty and project staff, to support participating communities in implementing the principles of integrated care management. Examples include: shared care plans, eco-maps, root cause analysis, and tools for sharing private client information in a multi-organizational care team.	Ongoing	Receive input from DLTSS Work Group on tools for sharing private client information in a multi-organizational care team.		Comprehensive tool-kit expected by end of first quarter, 2016.	Increased use of key tools across participating communities.
3		Develop measures of program effectiveness to support internal reporting and evaluate impact.	Ongoing			Process measures collected on a bi-monthly basis. Recipient of care satisfaction survey in pilot phase. Provider satisfaction survey and outcome measures in development.	Implementation of all components of evaluation strategy.
4		Compile and share information with participants regarding “conflict-free” case management practices contained in CMS Home and Community-Based Services (HCBS) regulations.	Q1 or Q2 2016	Receive input from DLTSS Work Group and subject matter experts.		Subject matter experts identified, research underway.	Information made available for all participants in the learning collaborative.
5		Provide updates on progress, findings, and lessons learned to Steering Committee, Core Team, and relevant work groups; identify processes and tools to support continued work after SIM (i.e., shared care plan forms, HIPAA-compliant releases to support shared care planning process).	Ongoing			Updates provided on an ad hoc basis.	Updates provided and feedback incorporated into project planning and implementation.
6		Collect Learning Collaborative lessons learned for incorporation into VHCIP Sustainability Plan.	Sept 2016			Lessons learned captured on an ongoing basis as revealed through implementation activities.	Lessons learned incorporated into VHCIP sustainability plan.

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
7	Support the development of Core Competency Trainings for front line care managers and other service providers, focused on general care management skills and DLTSS-specific competencies.	Execute contract with vendor(s) to develop Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.	January 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Vendor selection completed; contracts under development.	Vendor selected and implementation plan and timeline finalized.
8		Support and monitor core competency training development in collaboration with vendor(s).	January -March 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Training development in early stages, pending contract execution.	Development of content for Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.
9		Develop and execute implementation plan for Core Competency Trainings focused on general care management skills and DLTSS-specific competencies on a state-wide basis; including incorporation of a sustainability plan.	April – Dec 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Implementation plan in early states, pending contract execution.	Core competency training provided.
10		Develop and disseminate tool kit for Disability Awareness Briefs developed by DLTSS Work Group.	Ongoing	Provide updates to and receive guidance from DLTSS and Workforce Work Groups.	DLTSS Work Group	Disability awareness briefs developed, tool-kit dissemination plan in early stages.	Disability awareness tool-kit available across the state.
11		Develop measures of program effectiveness to support internal reporting and evaluate impact.	Ongoing			Program monitoring and evaluation plan in early stages pending contract execution.	Monitoring and evaluation plan executed.
	Regional Collaborations						
12	Support continued implementation and expansion of regional collaborations in 14 Health Service Areas.	Continue implementation of regional collaborations in 14 Health Service Areas.	Ongoing	Continued partnership with Blueprint for Health and all Vermont ACOs.		Ongoing.	Regional collaboratives established and implementing quality improvement projects.
13		Provide updates on progress, findings, and lessons learned to Steering Committee, Core Team, and relevant work groups.	Ongoing			Updates occurring on an ad hoc basis.	Updates provided on an ad hoc basis.
	Sub-Grant Program						
14	Continue sub-grant program; convene sub-	Continue to provide quarterly reports on sub-grantee activities and progress to Work Group; provide updates on progress, findings, and	Ongoing			Sub-Grant program underway, updates provided on an ad hoc basis.	Sub-grantees convened at least twice, updates

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	grantees at least twice; use lessons from sub-grantees to inform project decision-making.	lessons learned to Steering Committee, Core Team, and other relevant work groups as requested.					provided to work group and lessons learned carried forward.
15		Sub-grantees present to Work Group.	At least 6 through-out 2016			Sub-grantee presentations planned for upcoming meetings.	
16		Collect sub-grant program lessons learned for incorporation into VHCIP Sustainability Plan.	Sept 2015			Ongoing.	
17	Provide technical assistance to sub-grantees as requested by sub-grantees.	Provide technical assistance to sub-grantees as requested; requests to be reviewed and approved by VHCIP staff according to written process currently in place.	Ongoing			Ongoing.	Technical assistance provided.
	Ongoing Updates, Education, and Collaboration						
18	Reporting on all milestones in the Practice Transformation focus area; review DLTSS and Population Health activities and recommendations.	Review one-page monthly status updates for all Practice Transformation work streams.	Monthly			Ongoing.	Written and verbal monthly updates on all practice transformation activities; lessons learned and scalable interventions identified.
19		Identify lessons learned from Practice Transformation Work Group activities, focusing on scalable interventions, processes, and tools that can be used beyond SIM.	Ongoing			Not yet started.	
20	Review 2016 Practice Transformation Work Group Work Plan.	Review and discuss draft workplan, developed with DLTSS and Population Health staff and co-chair input.	Dec 2015-January 2016			Not yet started.	Work plan finalized.
21	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
22		Provide updates to other work groups on Practice Transformation Work Group activities.	Ongoing			Not yet started.	

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
23		Obtain regular updates from other work groups. Projects of interest include: • Shared Care Plan and Universal Transfer Protocol • Accountable Communities for Health Peer Learning Lab • Population Health Plan	Monthly	Obtain regular updates on work groups' progress as appropriate.		Not yet started.	
24	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016	Plan outline or draft developed by Population Health Work Group.	Population Health Work Group; Steering Committee; Core Team	Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
25		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016	Plan outline or draft developed by project leadership.	Core Team	Not yet started.	
26	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Monthly webinars conducted on staff- and participant-developed topics.