**VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda**
**Monday, June 20, 2016 1:00 PM – 3:00 PM.**
**DVHA Large Conference Room, 312 Hurricane Lane, Williston**
**Call in option: 1-877-273-4202 Conference Room: 2252454**

| Item # | Time Frame | Topic | Presenter | Decision Needed? | Relevant Attachments |
|---|---|---|---|---|---|
| 1 | 1:00-1:05 | Welcome and Introductions; Approve meeting minutes | Cathy Fulton, Andrew Garland | Y – Approve minutes | Attachment 1: May Meeting Minutes |
| 2 | 1:05-1:15 | Program Updates<br>• ACH Peer Learning Lab<br>• PMDI Work Plan Highlights | Heidi Klein, Alicia Cooper | N | 2016 PMDI Work Plan |
| 3 | 1:15-1:55 | Vermont Collaborative Care Presentation | Joshua Plavin, Peter Albert | N | Attachment 3 - Vermont Collaborative Care Presentation |
| 4 | 1:55-2:50 | Frail Elders Project Update | Cy Jordan & team | N | Attachment 4a: Frail Elders Project Slides<br>Attachment 4b: Summary Document<br>Three detailed reports developed through this project are available online at http://www.vmsfoundation.org/elders:<br>• What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review<br>• Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review<br>• Caring for Seniors: An Interview Study |
| 5 | 2:50-2:55 | Public Comment | Cathy Fulton, Andrew Garland | N | |
| 6 | 2:55-3:00 | Next Steps and Action Items | Cathy Fulton, Andrew Garland | N | |

# Attachment 1: May Meeting Minutes

Vermont Health Care Innovation Project

# *Vermont Health Care Innovation Project*
# *Payment Model Design and Implementation Work Group Meeting Minutes*

## *Pending Work Group Approval*

**Date of meeting:** Monday, May 16, 2016, 1:00-2:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **1. Welcome and Introductions; Approve Meeting Minutes** | Andrew Garland called the meeting to order at 1:02pm. A roll call attendance was taken and a quorum was present.<br><br>Rick Dooley moved to approve the March 2016 meeting minutes by exception. Susan Aranoff seconded. The minutes were approved with one abstention (Julie Tessler). | |
| **2. Program Updates** | *Operational Plan Submission and CMMI Site Visit:* Georgia Maheras provided an update on the submission of our Year 3 Operational Plan, which was submitted on April 28. Our CMMI project officer and other federal partners visited on May 2 and 3 for a very successful site visit. The compiled Operational Plan is available on the VHCIP website. | |
| **3. Shared Savings Programs – Year 1 Analyses** | Kelly Lange from BCBSVT presented analyses of Year 1 of the commercial SSP:<br>• All three ACOs spent more than target. Financial targets in commercial SSP are set differently than in Medicaid SSP, and are related to premium calculations and benefits. Year 1 (2014) was a particularly challenging year to set targets given that exchange plans were new products and the exchange population had no claims history on which to base financial benchmarks.<br>• Years 1 and 2 were learning efforts for the ACOs and BCBS as a payer – for example, some measures had to be removed from the measure set due to small numbers.<br>    o 2014 was a partial year for some since individuals shopping for exchange plans had until April to sign up (this impacts measures that require 12-month lookback).<br>    o Year 2 data will allow for a greater lookback, and will allow us to compare within the same program year-to-year.<br>    o The ACOs serve different populations which may have impacted variations in quality scores.<br>    o Strengths and opportunities: There is room for improvement, and ACOs and payers are working together to facilitate quality improvement, as well as better and easier measure collection. | **Send additional questions on this topic to Andrew Garland or Cathy Fulton.** |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | Alicia Cooper from DVHA presented analyses of Year 1 of the Medicaid SSP (VMSSP):<br>• Both participating ACOs (OneCare Vermont and CHAC) received shared savings payments as a result of meeting financial and quality targets for the 2014 performance year.<br>• DVHA has engaged in analyses to better understand these results – both differences in unique population segments, and changes in utilization and expenditure across areas of service.<br>• Key issues in understanding the VMSSP include attribution and Medicaid expansion (impact on overall population eligible for attribution, as well as challenges in predicting patterns of care for newly eligible Medicaid beneficiaries).<br>    o For beneficiaries eligible prior to Medicaid expansion, DVHA saw decreases from 2012 to 2014 in PMPM costs across both ACOs. For beneficiaries newly eligible for Medicaid in 2014, beneficiaries assigned based on PCP of record spent much less than beneficiaries assigned based on utilization patterns (no 2012 data to compare).<br>• Alicia also presented analyses across population categories (adult; child; and aged, blind, and disabled, or ABD), as well as analyses across population categories for attributed lives who did not utilize services that fall within the "total cost of care" or TCOC services.<br>• Expenditures by Category of Service (inpatient, outpatient, physician, FQHC, and psychologist – ~90% of ACO expenditures fall within these categories). More detailed analyses comparing attributed beneficiaries to comparison groups are available in the report included in meeting materials.<br><br>Kate Simmons and Rick Dooley provided some insight on CHAC and Health*first* activities in Year 1 that may have impacted results.<br>• In 2014, CHAC worked with participating providers to do collective quality improvement initiatives driven by clinical standards. CHAC also worked to engage community partners and clinical partners to create stronger linkages and encourage full participation in ACO governance and in providing care. Also used Blueprint profiles and other informatics to target quality improvement.<br>• In 2015, CHAC worked to implement 2014 guidelines and develop 2015 guidelines based on ACO experience. CHAC also continued to engage in data analysis to drive quality improvement at the health center-level.<br>• Kate also presented data on clinical quality members from 2014 and 2015. Staff continue to analyze data to identify root of improvements and identify actionable areas for improvement.<br>• Health*first* improved on 4 of 6 clinical quality measures from 2014 to 2015. (For measures with no improvement, results are likely not statistically significant.) Some measures are new and lack benchmarks, a challenge for providers.<br>• Slow claims data is also a challenge for providers and ACOs and delays change significantly.<br>• Health*first* quality improvement efforts are practice-based. Clinical priorities are identified by committee; measurement and comparison across participating practices allow for identification of best practices and lessons learned. | |

| Agenda Item | Discussion | Next Steps |
| --- | --- | --- |
| | • Kelly Lange noted that BCBS is working to get ACOs interim quality data within three months, rather than six months; DVHA is considering this as well.<br><br>The group discussed the following:<br>• Julie Wasserman asked a question about the VMSSP cost per member-year – can we compare costs across CHAC, OneCare, and Other (non-attributed)? Alicia replied that DVHA spent limited time on this comparison. There is different composition within ACO populations (pediatric population varies across ACOs, as do aggregate risk scores), so comparisons are not apples to apples. Abe Berman from OneCare Vermont noted that non-attributed users may be non-attributed because they use a limited number of services. Alicia clarified the attribution methodology.<br>• Lawrence Miller asked a question about the quality adjuster for savings earned (slides 6 and 26). Alicia Cooper replied that both the commercial and Medicaid SSPs used "gate-and-ladder" structures related to quality measurement and eligibility to share in savings – Medicaid's "gate" was lower in the first year based on previous Medicaid population experience on the payment measures. DVHA adjusted the gate for the Medicaid program in the second year; it is now comparable to the commercial program.<br>• Shawn Skaflestad asked about the influx of Medicaid beneficiaries in 2014. He asked how we could adjust target or expected spend in light of expansion population. Alicia noted this was a methodological challenge in the first program year; it was challenging to adjust for that population not knowing whether or how utilization patterns would differ for that population and Medicaid. Another option would have been to exclude the expansion population from the program, but this was not considered during program design or actuarial certification. Alicia also noted that the VMSSP uses a three-year rolling baseline, so 2014 experience will be incorporated when setting future baselines– some of these issues will be resolved over time, but churn across Medicaid and exchange populations will continue over following years. Shawn commented that there should be some consideration of this when savings aren't identified – numbers and savings are not cut and dry. Robin Lunge commented that this is complicated, and Vermont spent 18 months with CMMI actuaries to approve this design. This is particularly challenging because of Vermont's small population; it's unlikely our federal partners will allow changes this methodology in a 3-year program.<br>• Mike Hall noted that many expected high utilization among Medicaid expansion populations in the first year of eligibility, but it seems that data indicates lower utilization. Alicia agreed, and pointed to the longer report. Expansion group had very variable utilization – some used a lot of services and demonstrated pent up demand, while others engaged very little with the health care system in the first year of eligibility. This could change in the second program year.<br>• Maura Graf asked for more information on how declining PMPM costs can be attributed to work of the ACOs. Alicia replied that there was a lot going on in 2014 – it's hard to assess whether a program in its first year is achieving those goals from the outset. She noted that there was declining utilization from baseline to 2014 and within the baseline period itself. Alicia suggested that the next two years will help to shed light on this. Andrew Garland noted that there are many levers at work here, and that it's impossible to determine causality conclusively. Rick Dooley also commented that ACOs had formed just prior to the first program year; | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | Alicia added that ACOs also may have benefited from Medicare SSP experience in 2013. Abe Berman added that there is variation year-to-year, and encouraged waiting for more data before drawing firm conclusions.<br>• Susan Aranoff asked how we can explain the differences in results across the ACO programs (Medicare, Medicaid, and commercial). She also asked how cost of ACO administration is considered in savings. Kelly Lange noted that the commercial program lacked a baseline for medical costs within benefits; no one was surprised that there would be savings or losses since there was no historical data on which to base projections.<br>• Andrew asked Sue to send additional questions to co-chairs, who will attempt to obtain answers. Unanswered questions can be discussed in the early fall when we discuss Year 2 results. | |
| **4. Public Comment** | There was no additional comment. | |
| **5. Next Steps, and Action Items** | **Next Meeting:** Monday, June 20, 2016, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston | |

# VHCIP Payment Model Design and Inplementation Work Group Member List

Rick Dooley 1°
Sue A 2°
motion to approve w/exception
- Motion carried
1 abstention

| Monday, May 16, 2016 | | | | | |
|---|---|---|---|---|---|
| **Member** | | **Member Alternate** | | | |
| **First Name** | **Last Name** | **First Name** | **Last Name** | **Minutes** | **Organization** |
| | | | | | |
| Melissa | Bailey | Shannon | Thompson | | AHS - DMH |
| | | Jaskanwar | Batra | | AHS - DMH |
| | | Kathleen | Hentcy | | AHS - DMH |
| | | Frank | Reed | | AHS - DMH |
| Jill Berry | Bowen | Devin | Batchelder | | Northwestern Medical Center |
| | | Jane | Catton | | Northwestern Medical Center |
| | | Diane | Leach | | Northwestern Medical Center |
| | | Don | Shook | | Northwestern Medical Center |
| | | Lou | Longo | | Northwestern Medical Center |
| Diane | Cummings | Shawn | Skafelstad | | AHS - Central Office |
| Mike | DelTrecco | ~~Bea~~ | ~~Grause~~ | | Vermont Association of Hospital and Health Systems |
| Tracy | Dolan | Heidi | Klein | | AHS - VDH |
| | | Cindy | Thomas | | AHS - VDH |
| | | Julie | Arel | | AHS - VDH |
| Rick | Dooley | Susan | Ridzon | | HealthFirst |
| | | Paul | Reiss | | HealthFirst |
| Kim | Fitzgerald | Stefani | Hartsfield | | Cathedral Square and SASH Program |
| | | Molly | Dugan | | Cathedral Square and SASH Program |
| Aaron | French | Erin | Carmichael | | AHS - DVHA |
| | | Nancy | Hogue | | AHS - DVHA |
| | | Megan | Mitchell | | AHS - DVHA |
| | | | | | |
| Catherine | Fulton | | | | Vermont Program for Quality in Health Care |
| Peter | Cobb | Beverly | Boget | | VNAs of Vermont |

Q ✓

# VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, May 16, 2016

| Member | | Member Alternate | | | |
|---|---|---|---|---|---|
| First Name | Last Name | First Name | Last Name | Minutes | Organization |
| | | Michael | Counter | | VNA & Hospice of VT & NH |
| Steve | Gordon ✓ | Mark | Burke | | Brattleboro Memorial Hopsital |
| Maura | Graff ✓ | Heather | Bushey | | Planned Parenthood of Northern New England |
| Dale | Hackett ✓ | | | | Consumer Representative |
| Mike | Hall ✓ | Sandy | Conrad | | Champlain Valley Area Agency on Aging / COVE |
| | | Angela | Smith-Dieng | | V4A |
| Paul | Harrington | | | | Vermont Medical Society |
| Karen | Hein | | | | University of Vermont |
| Bard | Hill ✓ | Patricia | Cummings | | AHS - DAIL |
| | | Susan | Aranoff ✓ | | AHS - DAIL |
| | | ~~Gabe~~ | ~~Epstein~~ | | AHS - DAIL |
| Jeanne | Hutchins ✓ | | | | UVM Center on Aging |
| Kelly | Lange ✓ | Teresa | Voci | | Blue Cross Blue Shield of Vermont |
| Ted | Mable ✓ | Kim | McClellan | | DA - Northwest Counseling and Support Services |
| | | Tim | Gallagan | | DA - Northwest Counseling and Support Services |
| David | Martini | | | | AOA - DFR |
| ~~Lou~~ | ~~McLaren~~ | Chris | Smith ✓ | | MVP Health Care |
| MaryKate | Mohlman | Jenney | Samuelson | | AHS - DVHA - Blueprint |
| Ed | Paquin | | | | Disability Rights Vermont |
| Abe | Berman ✓ | Miriam | Sheehey | | OneCare Vermont |

# VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, May 16, 2016

| Member | | Member Alternate | | | |
|---|---|---|---|---|---|
| **First Name** | **Last Name** | **First Name** | **Last Name** | **Minutes** | **Organization** |
| | | Vicki | Loner | | OneCare Vermont |
| | | | | | |
| | | | | | |
| Laural | Ruggles ✓ | | | | Northeastern Vermont Regional Hospital |
| | | | | | |
| Julia | Shaw ✓ | Rachel | Seelig | | VLA/Health Care Advocate Project |
| Lila | Richardson ✓ | Kaili | Kuiper ✓ | | VLA/Health Care Advocate Project |
| Trinka | Kerr ✓ | | | | |
| Kate | Simmons ✓ | Kendall | West | | Bi-State Primary Care/CHAC |
| | | Patricia | Launer | | Bi-State Primary Care |
| | | Melissa | Miles | | Bi-State Primary Care |
| | | Heather | Skeels | | Bi-State Primary Care |
| | | | | | |
| Richard | Slusky ✓ | Pat | Jones ✓ | | GMCB |
| | | | | | |
| | | | | | |
| Julie | Tessler ✓ | | | A | VCP - Vermont Council of Developmental and Mental Health Services |
| | | Sandy | McGuire | | VCP - Howard Center |
| | | | | | |
| | 31 | | 44 | | |

## VHCIP Payment Model Design and Inplementation Work Group

**Attendance Sheet** **5/16/2016** *Note: 'Phone' participation = Webinar

| | First Name | Last Name | | Organization | Payment Model Design and Implementation |
|---|---|---|---|---|---|
| 1 | Peter | Albert | | Blue Cross Blue Shield of Vermont | X |
| 2 | Susan | Aranoff | [illegible] | AHS - DAIL | MA |
| 3 | Julie | Arel | phone | AHS - VDH | MA |
| 4 | Bill | Ashe | | Upper Valley Services | X |
| 5 | Lori | Augustyniak | | Center for Health and Learning | X |
| 6 | Debbie | Austin | | AHS - DVHA | X |
| 7 | Ena | Backus | phone | GMCB | X |
| 8 | Melissa | Bailey | phone | Vermont Care Partners | M |
| 9 | Michael | Bailit | phone | SOV Consultant - Bailit-Health Purchasing | X |
| 10 | Susan | Barrett | | GMCB | X |
| 11 | Devin | Batchelder | | Northwestern Medical Center | MA |
| 12 | Jaskanwar | Batra | | AHS - DMH | MA |
| 13 | Abe | Berman | [illegible] | OneCare Vermont | MA |
| 14 | Bob | Bick | | DA - HowardCenter for Mental Health | X |
| 15 | Mary Alice | Bisbee | | Consumer Representative | X |
| 16 | Charlie | Biss | | AHS - Central Office - IFS / Rep for AHS - DM | X |
| 17 | Beverly | Boget | | VNAs of Vermont | MA |
| 18 | Mary Lou | Bolt | | Rutland Regional Medical Center | X |
| 19 | Jill Berry | Bowen | | Northwestern Medical Center | M |
| 20 | Stephanie | Breault | | Northwestern Medical Center | MA |
| 21 | Martha | Buck | | Vermont Association of Hospital and Health | A |
| 22 | Mark | Burke | | Brattleboro Memorial Hopsital | MA |
| 23 | Donna | Burkett | | Planned Parenthood of Northern New Engla | X |
| 24 | ~~Catherine~~ | ~~Burns~~ | | DA - HowardCenter for Mental Health | X |
| 25 | Heather | Bushey | | Planned Parenthood of Northern New Engla | MA |
| 26 | Gisele | Carbonneau | | HealthFirst | A |
| 27 | Erin | Carmichael | phone | AHS - DVHA | MA |
| 28 | Jan | Carney | | University of Vermont | X |

| | | | | | |
|---|---|---|---|---|---|
| 29 | Denise | Carpenter | | Specialized Community Care | X |
| 30 | Jane | Catton | | Northwestern Medical Center | MA |
| 31 | Alysia | Chapman | | DA - HowardCenter for Mental Health | X |
| 32 | Joshua | Cheney | | VITL | A |
| 33 | Joy | Chilton | | Home Health and Hospice | X |
| 34 | ~~Amanda~~ | ~~Ciecior~~ | | AHS - DVHA | S |
| 35 | Barbara | Cimaglio | | AHS - VDH | X |
| 36 | Daljit | Clark | | AHS - DVHA | X |
| 37 | Sarah | Clark | | AHS - CO | X |
| 38 | Peter | Cobb | | VNAs of Vermont | X |
| 39 | Judy | Cohen | | University of Vermont | X |
| 40 | Lori | Collins | | AHS - DVHA | X |
| 41 | Connie | Colman | | Central Vermont Home Health and Hospice | X |
| 42 | Sandy | Conrad | | V4A | MA |
| 43 | Amy | Coonradt | | AHS - DVHA | S |
| 44 | Alicia | Cooper | here | AHS - DVHA | S |
| 45 | Janet | Corrigan | | Dartmouth-Hitchcock | X |
| 46 | Brian | Costello | | | X |
| 47 | Michael | Counter | | VNA & Hospice of VT & NH | M |
| 48 | Mark | Craig | | | X |
| 49 | Diane | Cummings | phone | AHS - Central Office | M |
| 50 | Patricia | Cummings | | AHS - DAIL | MA |
| 51 | Michael | Curtis | | Washington County Mental Health Services | X |
| 52 | Jude | Daye | | Blue Cross Blue Shield of Vermont | A |
| 53 | Jesse | de la Rosa | | Consumer Representative | X |
| 54 | Danielle | Delong | | AHS - DVHA | X |
| 55 | Mike | DelTrecco | phone | Vermont Association of Hospital and Health | M |
| 56 | Yvonne | DePalma | | Planned Parenthood of Northern New Engla | X |
| 57 | Trey | Dobson | | Dartmouth-Hitchcock | X |
| 58 | Tracy | Dolan | phone | AHS - VDH | M |
| 59 | ~~Michael~~ | ~~Donofrio~~ | | GMCB | X |
| 60 | Kevin | Donovan | | Mt. Ascutney Hospital and Health Center | X |
| 61 | Rick | Dooley | here | HealthFirst | M |
| 62 | Molly | Dugan | | Cathedral Square and SASH Program | MA |
| 63 | Lisa | Dulsky Watkins | | | X |
| 64 | Robin | Edelman | | AHS - VDH | X |

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|---|---|---|---|---|---|
| 65 | Jennifer | Egelhof | | AHS - DVHA | MA |
| 66 | Suratha | Elango | | RWJF - Clinical Scholar | X |
| 67 | ~~Gabe~~ | ~~Epstein~~ | | AHS - DAIL | S/MA |
| 68 | Jamie | Fisher | | GMCB | A |
| 69 | KIm | Fitzgerald | | Cathedral Square and SASH Program | M |
| 70 | Katie | Fitzpatrick | | Bi-State Primary Care | A |
| 71 | Patrick | Flood | | CHAC | X |
| 72 | Erin | Flynn | phone | AHS - DVHA | S |
| 73 | LaRae | Francis | | Blue Cross Blue Shield of Vermont | X |
| 74 | Judith | Franz | | VITL | X |
| 75 | Mary | Fredette | | The Gathering Place | X |
| 76 | Aaron | French | | AHS - DVHA | M |
| 77 | Catherine | Fulton | here | Vermont Program for Quality in Health Care | C |
| 78 | Joyce | Gallimore | | Bi-State Primary Care/CHAC | X |
| 79 | Lucie | Garand | | Downs Rachlin Martin PLLC | X |
| 80 | Andrew | Garland | here | MVP Health Care | M |
| 81 | Christine | Geiler | here | GMCB | S |
| 82 | Carrie | Germaine | | AHS - DVHA | X |
| 83 | Al | Gobeille | | GMCB | X |
| 84 | ~~Larry~~ | ~~Goetschius~~ | | Home Health and Hospice | M |
| 85 | Steve | Gordon | | Brattleboro Memorial Hopsital | M |
| 86 | Don | Grabowski | | The Health Center | X |
| 87 | Maura | Graff | here | Planned Parenthood of Northern New Engla | M |
| 88 | Wendy | Grant | | Blue Cross Blue Shield of Vermont | A |
| 89 | ~~Bea~~ | ~~Grause~~ | | Vermont Association of Hospital and Health | MA |
| 90 | Lynn | Guillett | | Dartmouth Hitchcock | X |
| 91 | Dale | Hackett | phone | Consumer Representative | M |
| 92 | Mike | Hall | here | Champlain Valley Area Agency on Aging / C | M |
| 93 | Thomas | Hall | | Consumer Representative | X |
| 94 | Catherine | Hamilton | | Blue Cross Blue Shield of Vermont | X |
| 95 | Paul | Harrington | | Vermont Medical Society | M |
| 96 | Stefani | Hartsfield | phone | Cathedral Square | MA |
| 97 | Carrie | Hathaway | | AHS - DVHA | X |
| 98 | Carolynn | Hatin | | AHS - Central Office - IFS | S |
| 99 | Karen | Hein | | University of Vermont | M |
| 100 | Kathleen | Hentcy | | AHS - DMH | MA |

| | | | | | |
|---|---|---|---|---|---|
| 101 | Jim | Hester | phone | SOV Consultant | S |
| 102 | Selina | Hickman | | AHS - DVHA | X |
| 103 | Bard | Hill | phone | AHS - DAIL | M |
| 104 | Con | Hogan | | GMCB | X |
| 105 | Nancy | Hogue | phone | AHS - DVHA | M |
| 106 | Jeanne | Hutchins | here | UVM Center on Aging | M |
| 107 | Penrose | Jackson | | UVM Medical Center | X |
| 108 | Craig | Jones | | AHS - DVHA - Blueprint | X |
| 109 | Pat | Jones | phone | GMCB | MA |
| 110 | Margaret | Joyal | | Washington County Mental Health Services | X |
| 111 | Joelle | Judge | here | UMASS | S |
| 112 | Kevin | Kelley | | CHSLV | X |
| 113 | Melissa | Kelly | | MVP Health Care | X |
| 114 | Trinka | Kerr | phone | VLA/Health Care Advocate Project | X |
| 115 | Sarah | King | | Rutland Area Visiting Nurse Association & H | X |
| 116 | Sarah | Kinsler | here | AHS - DVHA | S |
| 117 | Heidi | Klein | | AHS - VDH | MA |
| 118 | Tony | Kramer | | AHS - DVHA | X |
| 119 | ~~Peter~~ | ~~Kriff~~ | | PDI Creative | X |
| 120 | Kaili | Kuiper | phone | VLA/Health Care Advocate Project | MA |
| 121 | Norma | LaBounty | | OneCare Vermont | A |
| 122 | Kelly | Lange | here | Blue Cross Blue Shield of Vermont | M |
| 123 | Dion | LaShay | | Consumer Representative | X |
| 124 | Patricia | Launer | | Bi-State Primary Care | MA |
| 125 | Diane | Leach | | Northwestern Medical Center | MA |
| 126 | Mark | Levine | | University of Vermont | X |
| 127 | Lyne | Limoges | | Orleans/Essex VNA and Hospice, Inc. | X |
| 128 | Deborah | Lisi-Baker | phone | SOV - Consultant | X |
| 129 | Sam | Liss | | Statewide Independent Living Council | X |
| 130 | Vicki | Loner | | OneCare Vermont | MA |
| 131 | Lou | Longo | | Northwestern Medical Center | MA |
| 132 | Nicole | Lukas | here | AHS - VDH | X |
| 133 | Ted | Mable | phone | DA - Northwest Counseling and Support Se | M |
| 134 | Carole | Magoffin | here | AHS - DVHA | S |
| 135 | Georgia | Maheras | here | AOA | S |
| 136 | Jackie | Majoros | | VLA/LTC Ombudsman Project | X |

| | | | | | |
|---|---|---|---|---|---|
| 137 | Carol | Maloney | | AHS | X |
| 138 | Carol | Maroni | | Community Health Services of Lamoille Vall | X |
| 139 | David | Martini | | AOA - DFR | M |
| 140 | ~~Mike~~ | ~~Maslack~~ | | | X |
| 141 | John | Matulis | | | X |
| 142 | James | Mauro | | Blue Cross Blue Shield of Vermont | X |
| 143 | Lisa | Maynes | | Vermont Family Network | X |
| 144 | Kim | McClellan | | DA - Northwest Counseling and Support Ser | MA |
| 145 | Sandy | McGuire | | VCP - HowardCenter for Mental Health | M |
| 146 | Jill | McKenzie | | | X |
| 147 | ~~Lou~~ | ~~McLaren~~ | | MVP Health Care | M |
| 148 | Darcy | McPherson | | AHS - DVHA | X |
| 149 | Anneke | Merritt | | Northwestern Medical Center | X |
| 150 | Melissa | Miles | | Bi-State Primary Care | MA |
| 151 | Robin | Miller | | AHS - VDH | X |
| 152 | Megan | Mitchell | | AHS - DVHA | MA |
| 153 | MaryKate | Mohlman | | AHS - DVHA - Blueprint | M |
| 154 | Madeleine | Mongan | | Vermont Medical Society | X |
| 155 | Kirsten | Murphy | | AHS - Central Office - DDC | X |
| 156 | Chuck | Myers | | Northeast Family Institute | X |
| 157 | Floyd | Nease | | AHS - Central Office | X |
| 158 | Nick | Nichols | | AHS - DMH | X |
| 159 | Mike | Nix | here | Jeffords Institute for Quality, FAHC | X |
| 160 | Miki | Olszewski | | AHS - DVHA - Blueprint | X |
| 161 | Jessica | Oski | | Vermont Chiropractic Association | X |
| 162 | Ed | Paquin | | Disability Rights Vermont | M |
| 163 | Annie | Paumgarten | here | GMCB | S |
| 164 | Laura | Pelosi | | Vermont Health Care Association | X |
| 165 | Eileen | Peltier | | Central Vermont Community Land Trust | X |
| 166 | John | Pierce | | | X |
| 167 | Tom | Pitts | | Northern Counties Health Care | X |
| 168 | Joshua | Plavin | | Blue Cross Blue Shield of Vermont | X |
| 169 | Luann | Poirer | here | AHS - DVHA | S |
| 170 | Sherry | Pontbriand | | NMC | X |
| 171 | Alex | Potter | | Center for Health and Learning | X |
| 172 | ~~Amy~~ | ~~Putnam~~ | | DA - Northwest Counseling and Support Ser | MA |

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|---|---|---|---|---|---|
| 173 | Betty | Rambur |  | GMCB | X |
| 174 | Allan | Ramsay |  | GMCB | X |
| 175 | Frank | Reed | phone | AHS - DMH | MA |
| 176 | Paul | Reiss |  | HealthFirst/Accountable Care Coalition of t | MA |
| 177 | Sarah | Relk |  |  | X |
| 178 | Virginia | Renfrew |  | Zatz & Renfrew Consulting | X |
| 179 | Lila | Richardson | phone | VLA/Health Care Advocate Project | M |
| 180 | Susan | Ridzon |  | HealthFirst | MA |
| 181 | Carley | Riley |  |  | X |
| 182 | Laurie | Riley-Hayes |  | OneCare Vermont | A |
| 183 | Brita | Roy |  |  | X |
| 184 | Laural | Ruggles | here | Northeastern Vermont Regional Hospital | M |
| 185 | Jenney | Samuelson |  | AHS - DVHA - Blueprint | MA |
| 186 | Howard | Schapiro |  | University of Vermont Medical Group Pract | X |
| 187 | seashre@msn | seashre@msn.com |  | House Health Committee | X |
| 188 | Rachel | Seelig |  | VLA/Senior Citizens Law Project | MA |
| 189 | Susan | Shane | phone | OneCare Vermont | X |
| 190 | Julia | Shaw | here | VLA/Health Care Advocate Project | M |
| 191 | Melanie | Sheehan |  | Mt. Ascutney Hospital and Health Center | X |
| 192 | Miriam | Sheehey |  | OneCare Vermont | MA |
| 193 | Don | Shook |  | Northwestern Medical Center | MA |
| 194 | Kate | Simmons | here | Bi-State Primary Care/CHAC | M |
| 195 | Colleen | Sinon |  | Northeastern Vermont Regional Hospital | X |
| 196 | Shawn | Skafelstad | here | AHS - Central Office | MA |
| 197 | Heather | Skeels |  | Bi-State Primary Care | MA |
| 198 | Richard | Slusky | here | GMCB | M |
| 199 | Chris | Smith | phone | MVP Health Care | X |
| 200 | Angela | Smith-Dieng |  | V4A | MA |
| 201 | Jeremy | Ste. Marie |  | Vermont Chiropractic Association | X |
| 202 | Jennifer | Stratton |  | Lamoille County Mental Health Services | X |
| 203 | Beth | Tanzman |  | AHS - DVHA - Blueprint | X |
| 204 | JoEllen | Tarallo-Falk |  | Center for Health and Learning | X |
| 205 | Julie | Tessler | here | VCP - Vermont Council of Developmental a | M |
| 206 | Cindy | Thomas |  | AHS - VDH | MA |
| 207 | Shannon | Thompson | phone | AHS - DMH | MA |
| 208 | Bob | Thorn |  | DA - Counseling Services of Addison County | X |

| | | | | | | |
|---|---|---|---|---|---|---|
| 209 | Win | Turner | | | | X |
| 210 | Karen | Vastine | | AHS-DCF | X | |
| 211 | Teresa | Voci | | Blue Cross Blue Shield of Vermont | | MA |
| 212 | Nathaniel | Waite | | VDH | | X |
| 213 | Beth | Waldman | | SOV Consultant - Bailit-Health Purchasing | | X |
| 214 | Marlys | Waller | phone | DA - Vermont Council of Developmental an | | X |
| 215 | Nancy | Warner | | COVE | | X |
| 216 | Julie | Wasserman | here | AHS - Central Office | | S |
| 217 | Monica | Weeber | | AHS - DOC | | X |
| 218 | Kendall | West | | Bi-State Primary Care/CHAC | | MA |
| 219 | James | Westrich | here | AHS - DVHA | | S |
| 220 | Robert | Wheeler | | Blue Cross Blue Shield of Vermont | | X |
| 221 | Bradley | Wilhelm | | AHS - DVHA | | S |
| 222 | Jason | Williams | | UVM Medical Center | | X |
| 223 | Sharon | Winn | | Bi-State Primary Care | | X |
| 224 | Stephanie | Winters | | Vermont Medical Society | | X |
| 225 | Hillary | Wolfley | | | | X |
| 226 | Mary | Woodruff | | | | X |
| 227 | ~~Cecelia~~ | ~~Wu~~ | | AHS - DVHA | | S |
| 228 | Erin | Zink | | MVP Health Care | | X |
| 229 | Marie | Zura | | DA - HowardCenter for Mental Health | | X |
| | | | | | | **229** |

A.J. Ruben - phone
Kate Pierce - phone
Lawrence Miller - here
Holly Stone - phone
Steve Voigt - phone
Zachary Sullivan - phone
Deb Lisi-Baker - phone

Tom Boyd - here
Mark Podrozik - phone
Melinda Stylos-Allan - phone
Michael Bailit - phone
Noel Hudson - phone
Robin Lunge - here
Susan Grantham - phone
Mike Nix - phone
Suzanne Santarchangelo - phone

# Attachment 3 - Vermont Collaborative Care Presentation

# Vertermont Collaborative Care

# The case for change

## Integrating physical, mental health and substance abuse services

- Physical health costs associated with
    - Mental health conditions inadequately treated
    - Substance abuse inadequately treated
    - Physical health costs of persons with MHSA conditions
- Behavior change key to chronic condition care
    - Mental health skills not directed at mental health diagnosis
- Focus on partnerships with clinical community
- Add value to existing reform efforts

# BCBSVT

- Whole-person perspective
    - Claims analytics: medical, surgical, prescriptions, mental health, substance abuse
- Care plan reviews integrated across MHSA and physical health
- Focus on clinical results and outcomes
- Support integration and “health” management in clinical care

# Co-existing conditions affect cost

**24.7 percent** of BCBSVT members have coexisting medical and mental health conditions

| Patient Groups | Annual Cost of Care | Illness Prevalence | % with Comorbid Mental Condition* | Annual Cost with Mental Condition | % Increase with Mental Condition |
|---|---|---|---|---|---|
| All insured | $2,920 | | 15% | | |
| Arthritis | $5,220 | 6.6% | 36% | $10,170 | 94% |
| Asthma | $3,730 | 5.9% | 35% | $10,030 | 169% |
| Cancer | $11,650 | 4.3% | 37% | $18,870 | 62% |
| Diabetes | $5,480 | 8.9% | 30% | $12,280 | 124% |
| CHF | $9,770 | 1.3% | 40% | $17,200 | 76% |
| Migraine | $4,340 | 8.2% | 43% | $10,810 | 149% |
| COPD | $3,840 | 8.2% | 38% | $10,980 | 186% |

Cartesian Solutions, Inc.™--consolidated health plan claims data

*Approximately 10% receive evidence-based mental condition treatment

Source: 2012 *Value-Added Models of Integrated Medical and Mental Health Care*, Roger Kathol, MD, President, Cartesian Solutions , Inc.

# Costs per burden of illness categories

| Category | Percent of Cost |
|---|---|
| Healthy | 6% |
| One or More Significant Acute Diseases | 4% |
| One Minor Chronic Disease | 6% |
| Multiple Minor Chronic Diseases | 6% |
| One Significant Chronic Disease | 16% |
| Two Significant Chronic Diseases | 42% |
| Three or More Significant Chronic Diseases | 5% |
| Complicated Malignancies | 11% |
| Catastrophic Conditions | 4% |

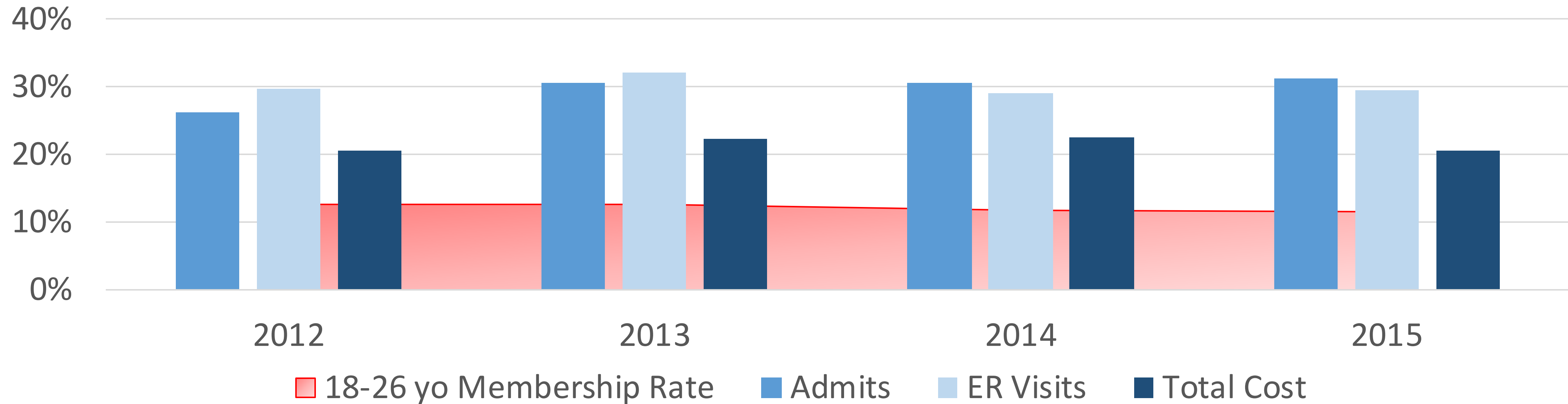
10% of Cost
*44% of Members*

70% of Cost
*54% of Members*

20% of Cost
*2% of Members*

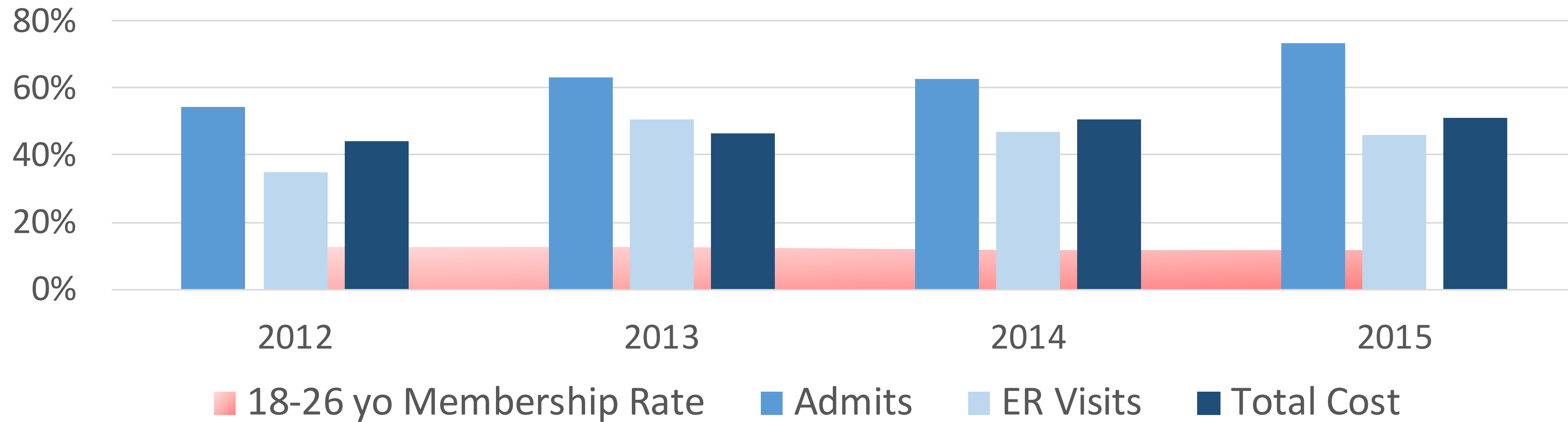
# Utilization of MHSA services in age group 18-26

30 percent of MHSA admissions and ER visits are for BCBSVT members ages 18-26. That age group makes up just 12 percent of the BCBSVT population.



# Utilization of Substance Abuse* services in age group 18-26

Over 60 percent of SA*-related admissions and over 40 percent of ER visits are for BCBSVT members ages 18-26.




BCBSVT members participating in Hubs since April 2014

- all ages - 172 members
- 18 to 26 yo - 62 members (36% of BoB with MHSA benefits)

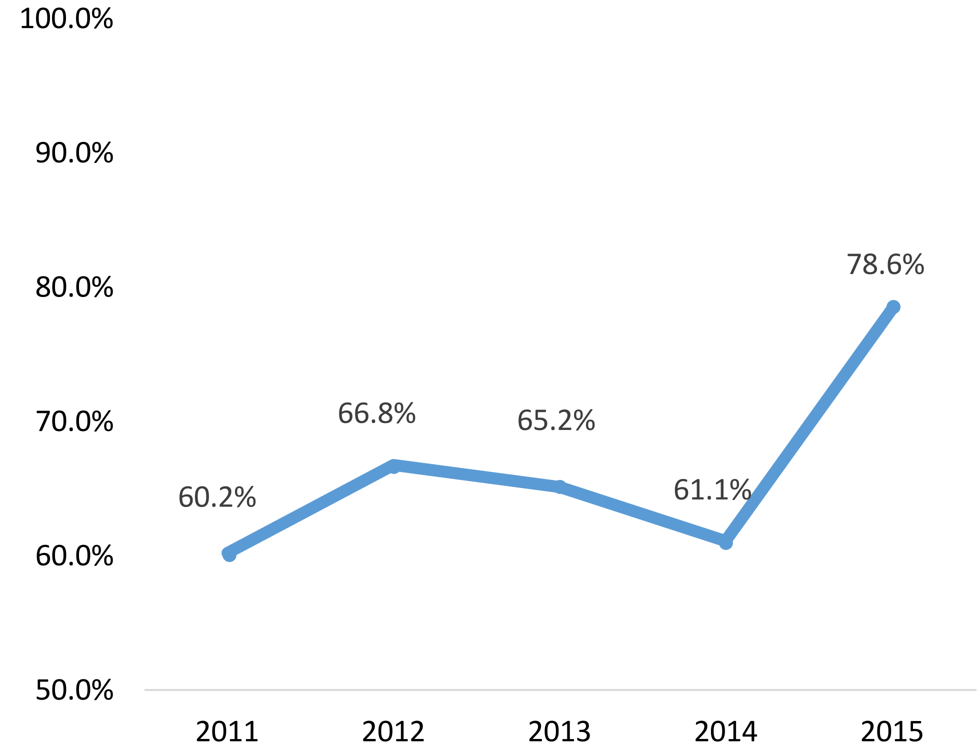
* Alcohol abuse not included

# Barriers to integration

- Professional compartmentalization
    - Mind-body dichotomy
    - Separate professions
    - Separate locations
- Culture clash and use of language
- Blame, stigma, misunderstanding
- Conflicting regulations
    - Mental health parity
    - MHSA special confidentiality protections

# Ensuring positive member experiences

- Improved member and clinician satisfaction
- Development of an integrated clinical and member advisory group
- Integrated training and supervision model
- Integrated customer service and intake coordination
- Integrated training in care management with CMSA model
- Integrate and collaborate with CHT statewide
- Predictive modeling for opiate outreach and case management
- Eliminate administrative prior authorization barriers to care
- Full compliance with both federal and state parity regulations
- Paying more for value and outcomes
- Sharing analytics and mapping payment to clinical need

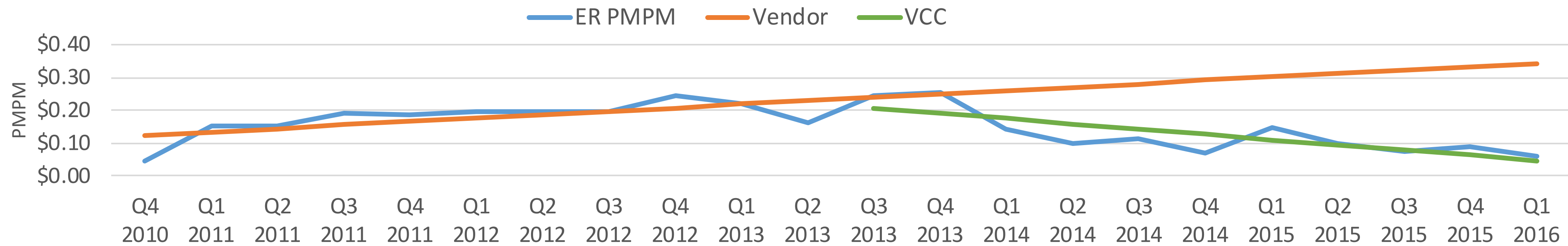


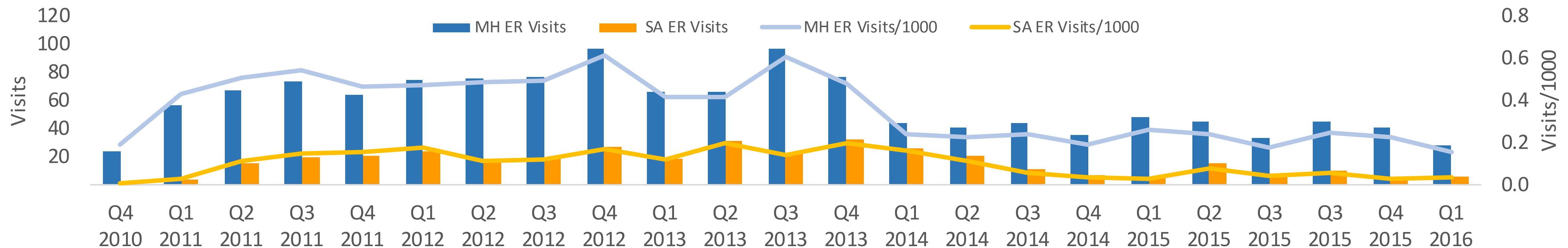

We'll see you through.

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

# ER visits related to MHSA^




**12-month savings*:**

SA-related ER visits were reduced by 28%*

MH-related ER visits were reduced by 44%*

***ER Visits with "denied payment" removed from calculations**

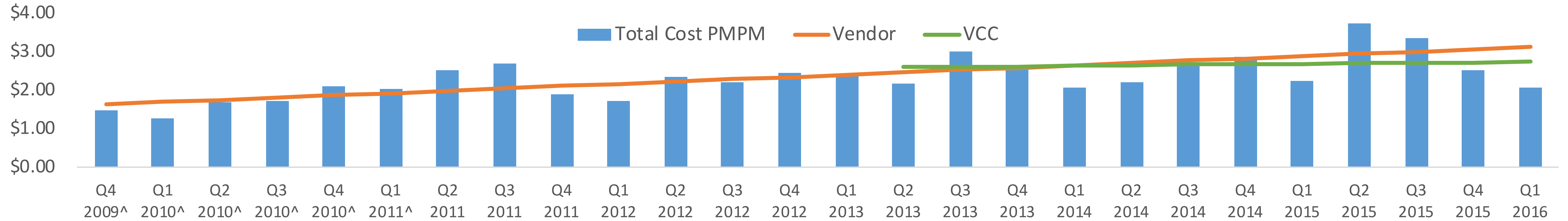
**^ MHSA managed, MHSA not managed indicator applied**

We'll see you through.

BlueCross BlueShield of Vermont

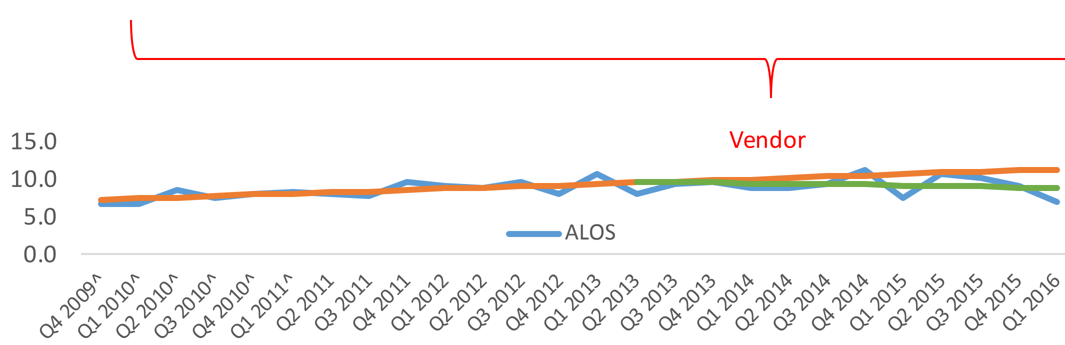
An Independent Licensee of the Blue Cross and Blue Shield Association.

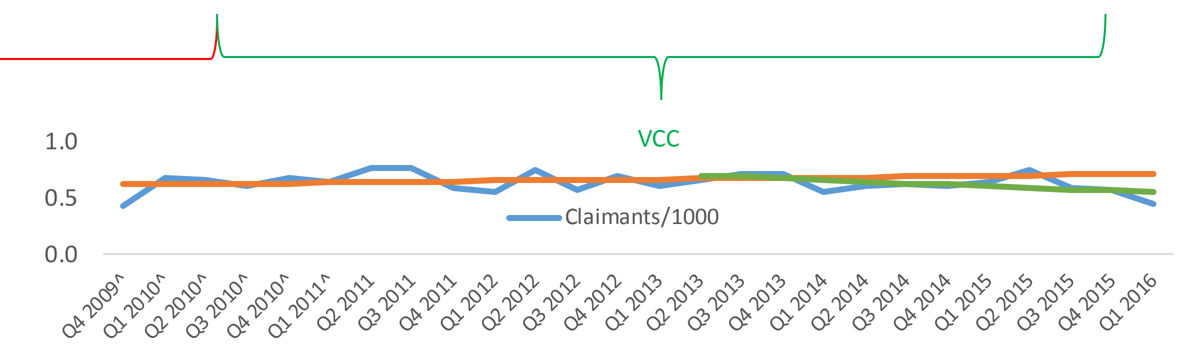
# MHSA inpatient cost and utilization trend

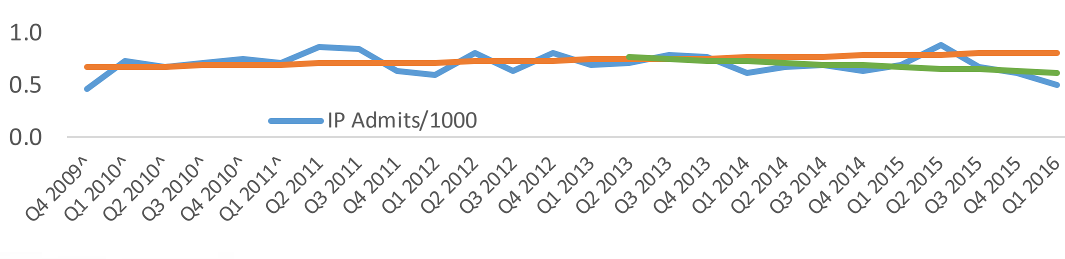


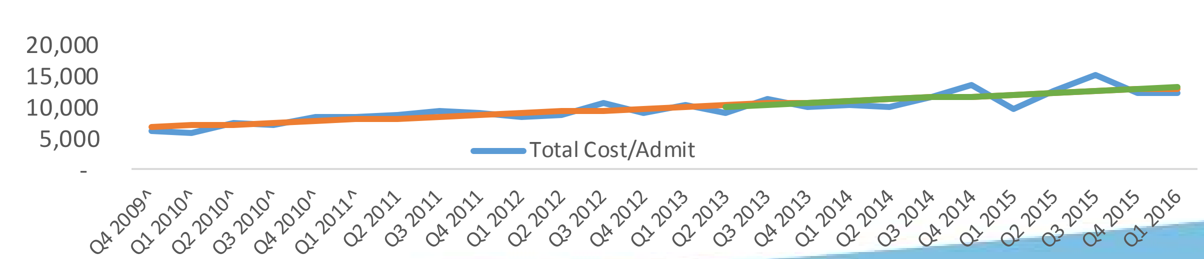

Vendor

VCC



# Preliminary HUB impact

Members in Hubs use the ER less and are admitted to the hospital fewer times than prior to engagement

Number of Claimants or visits

45
40
35
30
25
20
15
10
5
0

44%
49%
30%
50%

Before HUBS
During Hubs
ER Claimants

Before HUBS
During Hubs
Admits

Before HUBS
During Hubs
Admits Claimants

Before HUBS
During Hubs
Admits

Medical
MHSA
Before Hubs

Medical
MHSA
After Hubs

# Readmissions—All diagnoses medical + MHSA

| | 2014 | 2015 |
|---|---|---|
| 30-day local readmission rate (BCBSVT) | 5.27% | 5.95% |
| Number of local readmissions | 494 | 587 |
| National readmission rate (Commercial Insurance)* | 8.9% | 8.9% |
| Difference between of BCBSVT LOCAL readmissions per year and National Rate AHRQ | 3.63% | 2.95% |

*Source: Agency for Healthcare Research and Quality (AHRQ), 2013

# Mood disorders readmissions

| Incurred Date | Admits | Readmission Rate Same Dx |
|---|---|---|
| 2012 Vendor | 235 | 11.06% |
| 2014 VCC | 239 | 8.79% |

| National Benchmark* Readmission Rate Same Dx | |
|---|---|
| Medicare | 16.00% |
| Medicaid | 14.40% |
| Commercial Insurance | 9.10% |
| Uninsured | 10.40% |

*Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Readmissions Database (NRD), 2012; approximately 847,000 hospital stays for mood disorders

# Next steps

Using the ICHOM philosophy: Measure what matters to the member by re-defining the role of a health plan

- SBIRT

  *Growth and integration*

- Feedback Informed Treatment

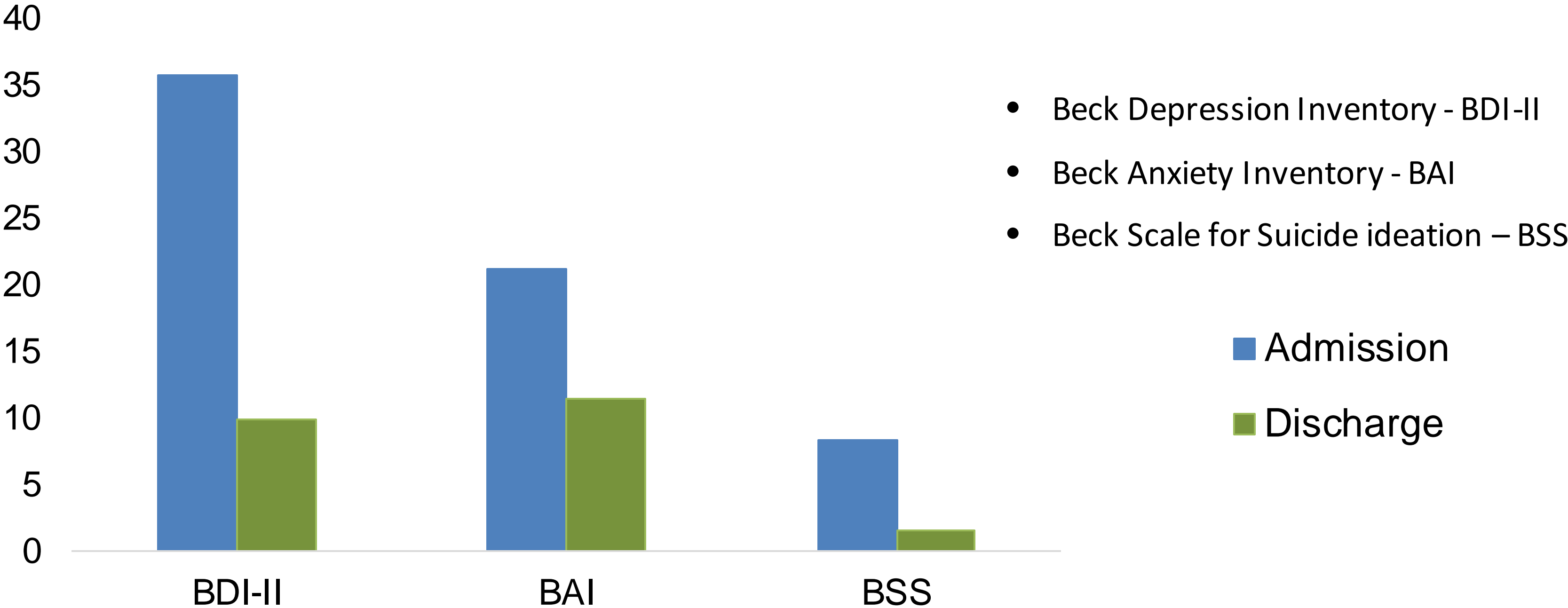
  *The role of MHSA community clinicians*

- Crossroads

  *Measuring outcomes and value by listening to and partnering with clinicians*

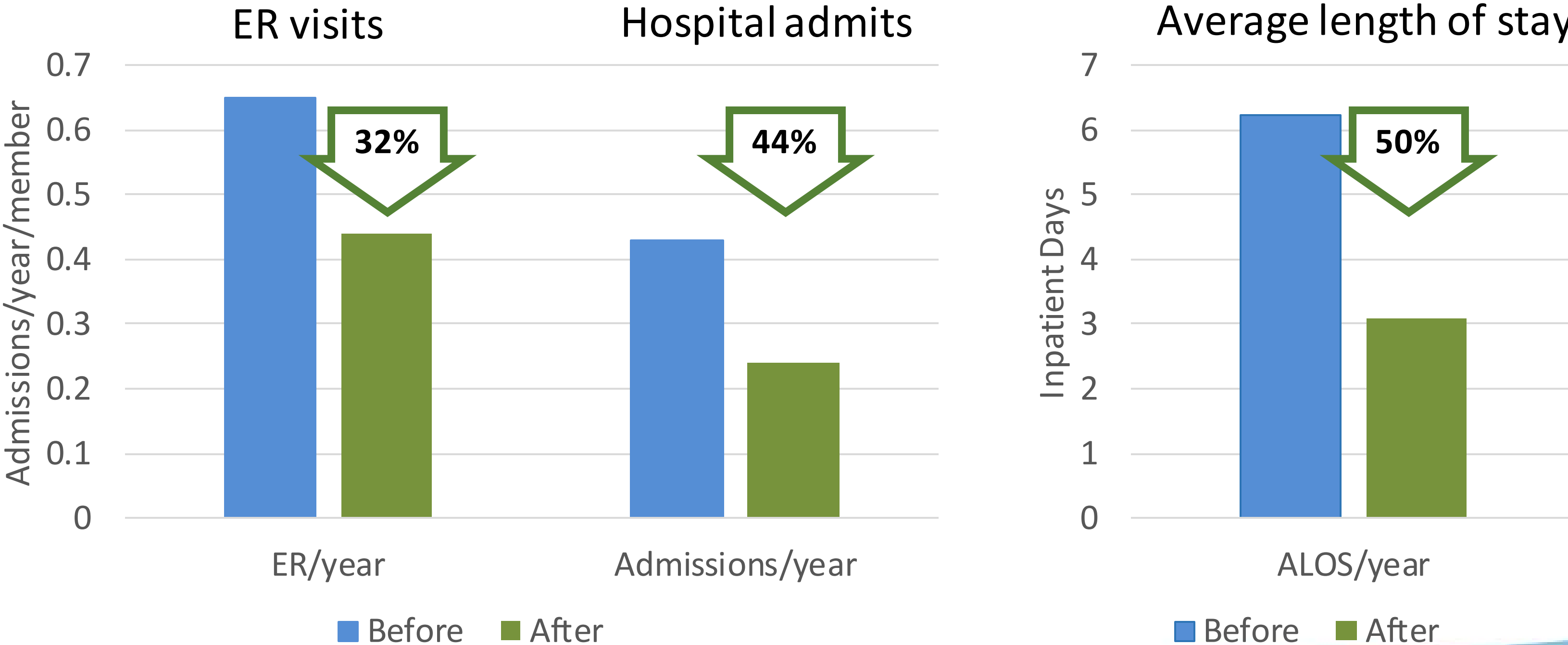
# Crossroads

Crossroads has seen a reduction in the depression, anxiety and suicide risk scores between time of admission into program and discharge from program.



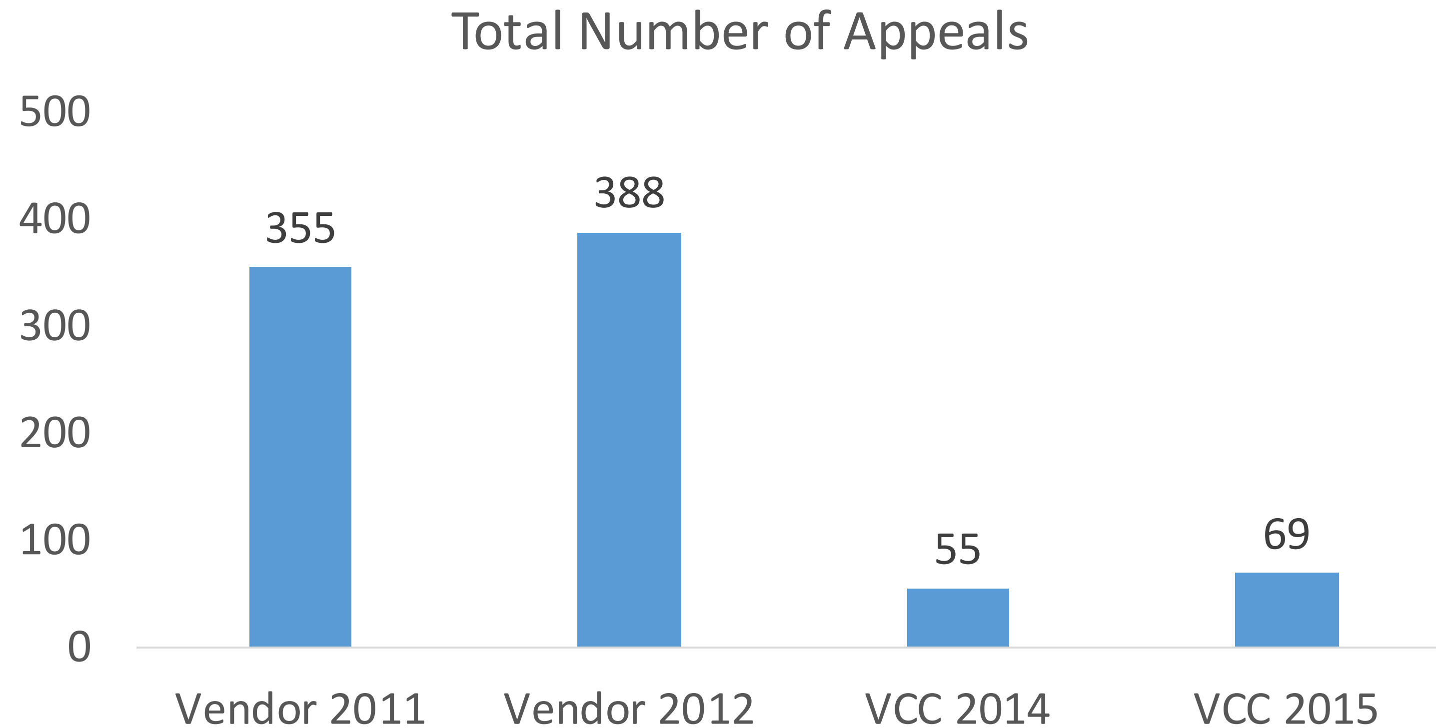
# Shift in ER and hospital utilization before and after Crossroads

Members in the program were admitted to the ER and hospitals less frequently after discharging from Crossroads than before their participation in the program.



# Collaborating with clinicians

…it's not about saying no



# Attachment 4a: Frail Elders Project Slides

# VHCIP Frail Elders Project

http://www.vmsfoundation.org/elders

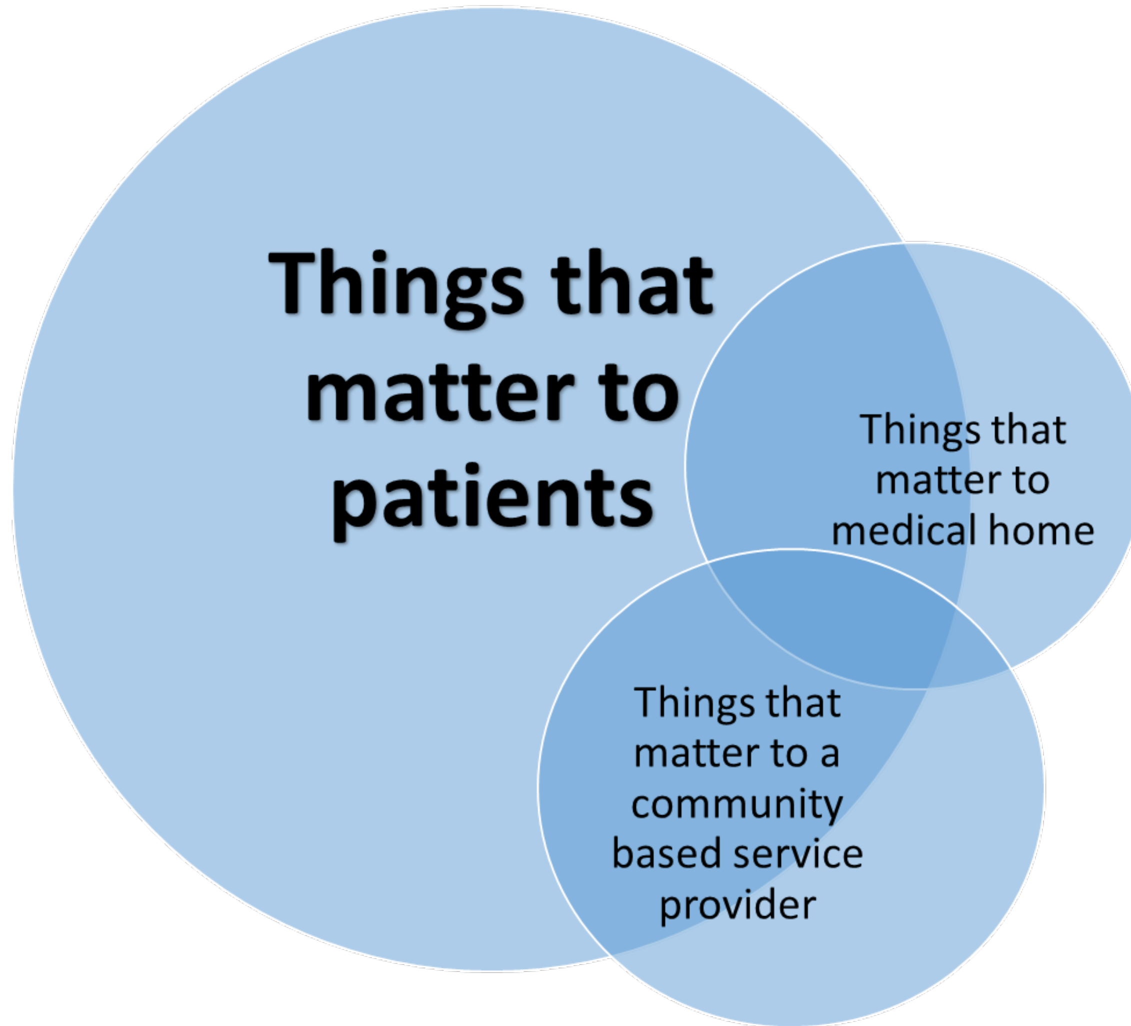
**Josh Plavin MD MPH**
**Brian Costello MD**
**Nancy Bianchi MSLIS**
**Fay Homan MD**
**Milt Fowler MD**
**Erica Garfin MA**
**Steve Kappel MPA**
**Randy Messier MT, MSA, PCMH CCE**
**Cyrus Jordan MD MPH**

VHCIP Work Group June 20, 2016

VMS Education & Research Foundation

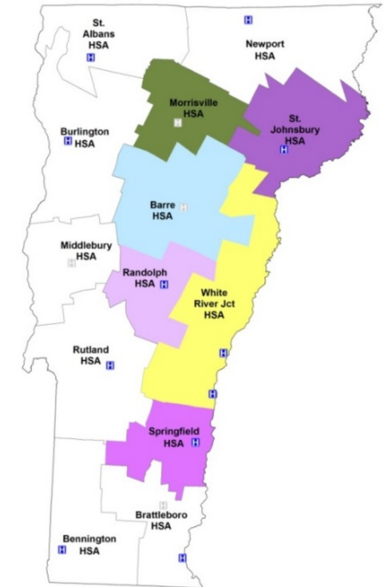
*helping physicians help patients & communities*

# VHCIP Frail Elders Project



# Thursday December 12th, 2013

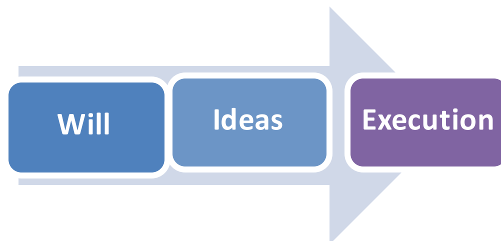
## Rural Clinicians Community
## GMCB Presentation




### Better care, better health, lower costs

### How can leaders accelerate innovation?

"You have to have the ***will*** to improve; You have to have ***ideas*** about alternatives to the status quo; and then you have to make it real through ***execution***. All three have to be arranged by leaders – they are not automatic."




1. Actualize 3 planned levels of care
2. Make VT a magnet for the workforce
3. Become the national benchmark for measurement
4. Reduce the gap between practice and policy

# VHCIP Frail Elders Project

**Target Population**

**Seniors at risk of a decline in the quality of their lives or a poor health outcome**

**Frail Elderly Global Aim**

**We aim to identify barriers to providing the best primary care for high-risk elders in two rural communities; and recommend: 1) Practice changes to primary care, community based care and supportive services which will improve outcomes that matter to patients; 2) Payment innovations to support the redesigns; and 3) Measures to track changes in outcomes that matter to patients.**

**The project begins with a literature search serving as the cornerstone for our research and recommendations. The principal method for problem identification will be structured interviews with patients, families, caregivers and community based health care professionals. State and regional policy and content experts will be interviewed. Analysis of public claims data bases will complement the qualitative research.**

**The effort ends with a written report and public presentation of our findings and recommendations to the VHCIP Payment Models Work Group in June 2016.**

**By undertaking this effort we expect to increase the value of the health care system – focusing on outcomes that matter to patients, reducing harm, conserving resources and increasing system efficiencies.**

# VHCIP Frail Elders Project

**Five sets of research findings guide the recommendations:**

- **A literature search in partnership with the University of Vermont Dana Medical Library;**
- **Key informant interviews with community-based health and supportive service providers in two rural primary care service areas;**
- **Key informant interviews with state policy and subject matter experts;**
- **Structured interviews with frail elders and their caregivers including home bound individuals in two rural primary care service areas, using both individual interviews and focus groups;**
- **Comparative analyses of the Vermont Household Survey and the Medicare Current Beneficiary Survey.**

# VHCIP Frail Elders Project

**Research Focus Areas**

1. **What characterizes a frail or high risk senior?**
2. **What are the characteristics of their service utilization?**
3. **What matters to seniors?**
4. **Are there care models known to produce better value (outcomes/cost)?**
5. **What systemic barriers to providing care exist?**
6. **What aspects of the delivery system are and are not working locally?**
7. **How could the local delivery system be improved?**
8. **What are practical and meaningful measures of value? (things that matter to patients/cost of meaningful episodes of care)**
9. **What are unnecessary costs and how could they be reduced?**
10. **How can payment reform support the achievement of things that matter to patients?**

# VHCIP Frail Elders Project

**Underlying project recommendations are themes that are remarkably consistent across all five project research arms:**

- **There are mismatches between what gets paid for and what's important to seniors;**
- **Today's payment policies create significant inefficiencies and harm Vermont's seniors;**
- **Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;**
- **Care should go to patients rather than patients having to come to care;**
- **Control over health care budgets needs more community level influence;**
- **Primary care is in critical condition, and we all need to rethink how to support it;**
- **There are proven examples of how to do it better; and**
- **There is a lot that can be done right now!**

# VHCIP Frail Elders Project

**Our recommendations are presented as answers to four core questions:**

1) **Who are our high risk seniors?**

2) **How will we measure success?**

3) **How will we care for them?**

4) **How will we pay for their care?**

# VHCIP Frail Elders Project

**Target Population**

**Seniors at risk of a decline in the quality of their lives or a poor health outcome**

**Frail Elderly Global Aim**

**We aim to identify barriers to providing the best primary care for high-risk elders in two rural communities; and recommend: 1) Practice changes to primary care, community based care and supportive services which will improve outcomes that matter to patients; 2) Payment innovations to support the redesigns; and 3) Measures to track changes in outcomes that matter to patients.**

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VHCIP Work Group June 20, 2016

VMS Education & Research Foundation

*helping physicians help patients & communities*

# Attachment 4b: Summary Document

VMS Education & Research Foundation

*Pursuing High Value Care for Vermonters*

In 2012, a small group of primary care practitioners began to discuss ways primary care practitioners in Vermont could better serve our most vulnerable seniors. The Frail Elders Project grew out of those conversations. Diverse practitioners from across the state, as well as state policy makers and subject matter experts have all since contributed. The Project Team now offers recommendations for retooling primary care in Vermont in ways that will improve the health and security of our seniors. The project has had funding from the Vermont Health Care Improvement Project between November 2015 and June 2016. Earlier support was generously offered by the Physicians Foundation of Cambridge, MA and Vermont's Green Mountain Care Board.

The project's research and recommendations focus on seniors, but contain relevant improvements that could improve health care for most Vermonters. The recommendations are based on five complementary research arms designed to highlight the priorities of seniors themselves regarding their health and the quality of life. The project team chose to focus on frail and high risk seniors knowing: 1) care could be better; 2) improvements could potentially effect multiple practice and community services; and 3) recommendations could be generalized to other patients and communities. The project team purposely did not choose to focus on individual diagnoses, as is common in health reform efforts. They wanted a broader impact. They wanted to foster a rethinking of primary care. They wanted to create a reform paradigm in which payment innovation serves practice innovation, with things that matter to patients as the paramount driver of reform.

The five sets of research findings guiding the project Team's recommendations are
:

- A literature search in partnership with the University of Vermont Dana Medical Library;
- Key informant interviews with community-based health and supportive service providers in two rural primary care service areas;
- Key informant interviews with state policy and subject matter experts;
- Structured interviews with frail elders and their caregivers including home bound individuals in two rural primary care service areas, using both individual interviews and focus groups;
- Comparative analyses of the Vermont Household Survey and the Medicare Current Beneficiary Survey

The full text of the research studies can be accessed on the project web site
http://www.vmsfoundation.org/elders

Underlying project recommendations are research themes that are remarkably consistent across all five project research arms:

1. There are mismatches between what gets paid for and what's important to seniors;
2. Today's payment policies create significant inefficiencies and harm Vermont's seniors;
3. Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;
4. Care should go to patients rather than patients having to come to care;
5. Control over health care budgets needs more community level influence;
6. Primary care is in critical condition, and we all need to rethink how to support it;
7. There are proven examples of how to do it better; and
8. There is a lot that can be done right now!

Recommendations

Our recommendations are all founded on what we were told by seniors, by community based clinical practitioners and support service providers who aid their elders every day, from Vermont subject matter experts and from a review of published literature with the assistance of our University library system. The recommendations are our sincere attempt to design a care model that reflects what we were told or has been published in the peer reviewed literature. We anticipate and encourage serious discussion about our recommendations. We also encourage efforts to increase the breadth or depth of our research where needed. That being said, we hope that discussion and policy will not spin away from what seniors say matters to them and the knowledge of their caregivers who know them so well. Our recommendations are presented as answers to four core questions: 1) Who are our high risk seniors? 2) How will we measure success? 3) How will we care for them? And, 4) How will we pay for their care?

1) Who are our high risk seniors?

A three step identification process is recommended. Initially, existing data such as billing data and structured data in medical records for all patients known to a practice should be screened for significant events, high utilization patterns, key diagnoses, social determinants of health and impairment in ADLs and IADLs if available. The resulting list of Identified patients should be reviewed for appropriateness by a dedicated practice senior care team. Subsequently practice team members can recommend additional patients known to them to be at risk of poor health outcome or a decline in the quality of their lives. All partner community support service providers are invited to recommend additional people in the community.

2) How will we measure success

A multi-dimensional balanced evaluation is recommended. No single index of success is sufficient. Existing validated metrics should be used when possible and directly relevant to the process or system being evaluated. Annual ongoing comparisons to appropriate benchmarks should be utilized rather than pre and post measures. The evaluation should include measures in the following domains:

- Social, clinical, mental health and behavioral health as it relates to a person's ability to maintain or improve their health, e.g. PHQ9 screen for depression http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1
- Functional measures including patient reported outcomes, e.g. Activities of daily living (ADL's) and instrumental activities of daily living (IADL's), measures of patient goals being met and independence with sufficient self-management support, e.g. modified CAHPS http://www.ahrq.gov/
- Provider reported process and outcome measures including measures of access, provider satisfaction, number of patients meeting clinical goals, number of eligible patients and number of patients moved to a lower level (better) of care.
- Utilization and financial measures including hospitalizations, ED visits, long term nursing home placement and claims paid (both numbers of claims and dollar amounts as well as site of service. This data should be evaluated on the chosen cohort of patients for a minimum of two years prior to entry into of the program and followed annually thereafter.

The clinical practices may have already developed measures for this population of patients that could be utilized to evaluate and monitor the population and this work that should be considered.

3) How will we care for them?

Each senior in the high risk group will have a comprehensive assessment by the practice's multidisciplinary primary care team. Key members of the team will be the primary medical practitioner, a care coordinator who is fully integrated into the primary care practice, and the patient and/or their caregiver. The assessment will include a visit to the patient's home and a discussion of needed home based services to support independence. Based on the assessment every high risk senior will have a care plan with guidance for the patient, for the family and for both clinical and community support providers. The care coordinator will be responsible for communicating with the appropriate community support providers.

Outside of the practice, but including the key representatives of the practice team, will be a primary neighborhood team. The neighborhood team will also include a representative of the primary care team as well as appropriate community health and supportive service providers, with the patient and family's consent. The neighborhood team will meet with sufficient frequency to review new and emergency cases as well as periodic reviews of shared patients and clients.

A third layer of community coordination will occur at periodic meetings of representatives of the practice and community partners – a primary community team. This tertiary level of coordination will focus on the adequacy of the overall needs of the community's seniors and available local, state and federal resources.

4) How will we pay for their care?

Several funding mechanisms are in operation in the US and Canada that support all parts of the recommended care model. None of them support all the components of the recommended model, nor do any of them cast a wide enough net to capture all the high risk seniors in our rural communities. A few programs will be presented to highlight key issues including the Commonwealth Health Alliance's Senior Options Program and the CMS demonstration project, Independence at Home.

The paramount issue about payment is that a payment methodology should be the last question to be addressed. What matters to seniors as presented in the project findings needs to always be of primary importance and the final guide to any decisions about care model design, measures of success and funding mechanisms to support care.

As mentioned above our recommendations are based on the key findings from the five research arms. There is no existing system of care exactly like the proposed model; however, every component exists elsewhere, and most have been rigorously evaluated by independent qualified experts. Taken together, our recommendations outline a new model of care that is driven by the priorities identified by the seniors in our communities.