Vermont Health Care Innovation Project
Steering Committee Meeting Agenda

June 29, 2016, 1:00pm-3:00pm
4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action?
1	1:00-1:10pm	Welcome and Introductions; Minutes Approval	Steven Costantino & Al Gobeille	Attachment 1: Draft May 25, 2015, Meeting Minutes	Approval of Minutes
2	1:10-1:15pm	Core Team Update • Project Update *Public comment*	Lawrence Miller & Georgia Maheras		
3	1:15-1:30pm	VHCIP Work Group Workplans Overview – June-December 2016 *Public comment*	Georgia Maheras & Sarah Kinsler	Attachment 3: Work Group Workplans – June-December 2016	
4	1:30-2:40pm	Frail Elders Project Update *Public comment*	Cy Jordan & Frail Elders Team	Attachment 4a: Frail Elders Project Slides Attachment 4b: Frail Elders – Final Report and Recommendations Frail Elders Video: http://www.vmsfoundation.org/elders	
5	2:40-2:55pm	Sustainability Preview – Timeline and Contract *Public comment*	Georgia Maheras	Attachment 5: SIM Sustainability Timeline and Scope of Work	
6	2:55-3:00pm	Next Steps, Wrap-Up and Future Meeting Schedule	Steven Costantino & Al Gobeille	Next Meeting: Wednesday, July 27, 2016, 1:00-3:00pm, Montpelier	

Attachment 1: Draft May 25, 2015, Meeting Minutes

Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

<mark>Pending Committee Approval</mark>

Date of meeting: Wednesday, May 25, 2016, 1:00pm-2:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Steven Costantino called the meeting to order at 1:03pm. A quorum was not present. A quorum was present after the second agenda item. *Minutes Approval:* Dale Hackett moved to approve the March 30, 2016, meeting minutes by exception. Jaskanwar Batra seconded. The minutes were approved with no abstentions.	
2. Core Team Update	Sarah Kinsler provided a Core Team update. • *Year 3 Operational Plan:* The VHCIP Year 3 Operational Plan was submitted on April 28. The full plan is available on the VHCIP website. We have received positive comments from federal partners and are responding to a relatively light Request for Additional Information at this time. • *CMMI Site Visit:* CMMI came to Vermont for a site visit on May 2-3. Key topics were practice transformation activities and successes, planned Year 3 activities, sustainability, and the All-Payer Model. The group discussed the following: • Performance Period 3 runs from July 1, 2016-June 30, 2017. We expect a few months of extension in summer/fall 2017 to wrap up evaluation and grant activities. • When Performance Period 2 was extended (original dates: January 1, 2015-December 31, 2015; new dates: January 1, 2015-June 20, 2016), the timeline for most project activities did not change; most SIM activities will still wrap up in December 2016, with a handful continuing into the first half of 2017. • Sustainability planning is a significant focus of Performance Period 3. High-level sustainability planning is already underway internally; starting in July, VHCIP will engage a broader group of stakeholders and partners in planning for sustainability with the support of a contractor (bidder selected and negotiations completed; contract execution expected in June).	

Agenda Item	Discussion	Next Steps

3. Performance Period 2 Budget Update	Sarah Kinsler provided an update on the Performance Period 1 and 2 budgets (Attachment 3):
	• Performance Period 1 budget has been fully wrapped up.
	• Performance Period 2 budget: Spending is low, especially in funds that are allocated but not yet expended.
	   ○ Two causes of low spending:
	     1. Slow federal approval, especially approval of Performance Period 2 contracts and contract amendments, has led to delays in spending. We're expecting a block of federal approvals shortly, so allocated but Significant underspending contractual obligations not paid (under spending, contractors underspending, back log of Federal approvals) Expecting these pending approvals to happen within the next few days and weeks, which will allow us to spend the majority of these pending funds.
	     2. Underspending due to vacancy savings and lower than budgeted contractual spending. This is consistent with previous budget periods.
	   ○ This will lead to a carryover request following the end of Performance Period 2. We anticipate a request of $3-5 million. At the Core Team's request are planning for Year 3 as if this request will not be approved in order to be fiscally prudent.	

4. Performance Period 3 Budget and Activities	Sarah Kinsler provided an overview of Performance Period 3 budget and activities (Attachments 4a and 4b).
	• Project Management and Evaluation:
	   ○ Project management is UMass contract, which includes general project support and significant project management in a few areas, including core competency training, the all-payer model, and HDI projects.
	   ○ State-led evaluation is a significant area of work this year.
	• Practice Transformation:
	   ○ J Batra asked for more information on the Accountable Communities for Health Peer Learning Lab. The Peer Learning Lab will have first in-person meeting in June; 10 regions will participate.
	   ○ Judy Peterson asked what contracts with CHAC and OneCare support for Regional Collaborations. Regional Collaborations funds support a learning activities and support for UCCs, including some support for CHAC/OneCare personnel. Sarah will share additional information with Judy Peterson.
	   ○ Budget information included in Attachment 4a reflects the July 2016-June 2017 performance period, though some contracts do not last the full twelve months.
	   ○ Paul Harrington asked how will Regional Collaborations/UCCs be maintained after SIM? These regional structures will likely be supported by a combination of support at the community level, support from ACOs, and support from other areas of State government (e.g., the Blueprint).	

Agenda Item	Discussion	Next Steps

	○ Sarah noted that generally, SIM planned activities to be sustainable; this has been a known issue since the start of the grant. SIM made a number of investments in one-time activities, as well as activities that we expect will be taken over by the private sector (ACOs/providers/communities) or in some cases, other areas of State government. This will be an ongoing conversation with stakeholder engagement in Performance Period 3. For more information on the current state of planning, see Sustainability section of Year 3 Operational Plan, available here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/April%202016%20-%20Vermont%20Year%203%20Operational%20Plan%20with%20attachments.pdf
	    ○ Selina Hickman noted that Medicaid Pathway builds on the UCC structure in particular.
	    ○ Judy Peterson commented that participating organizations invest a lot of staff time into the collaborative efforts and requested the group consider how to compensate organizations for this in-kind support.
	    ○ Dale Hackett asked how the NextGeneration ACO model relates to this, and how we'll transition these activities to NextGeneration? Sarah replied that this question is about the transition between payment models; practice transformation supports are building a foundation to help providers be successful under new models. CMMI will not provide more funding under a SIM-like model, but we're working to figure out how to support providers in a post-SIM world.
	• We're likely to receive a response from CMMI on our carryforward request in August or September; we'll submit the request in July. Mike Hall asked how much of our Performance Period 3 budget is still uncommitted, and requested an accounting of the projects competing for remaining resources and the decision-making process for selecting projects to receive remaining funds; this ties back to a discussion at the January Steering Committee meeting. Diane Cummings noted that carryover funds will support specific programs and obligations, if approved. Sarah clarified that the Performance Period 3 budget reflects the budget developed and approved by the Core Team in March and April; we will follow up with more detail before the June meeting. Mike expressed concern that the Steering Committee had insufficient input into the Performance Period 3 budget. Would like to have this before June meeting. Sarah noted that contracts and projects included in this presentation are projects that were already approved by the Core Team.
	• Health Data Infrastructure:
	    ○ Home Health: This is one of the items approved by the Core Team in January. There is still an unresolved issue with the AAAs.
	    ○ HIS Professionals provides project management and subject matter expertise to the VCN Behavioral Health Data Repository project.
	    ○ Maximus (consumer help line for questions related to the SSP) is a very low amount ($200) because we are paying for a very small subset of work.
	• Payment Model Design and Implementation:	

Agenda Item	Discussion	Next Steps

	o Mike Hall asked whether this budget reflects implementation costs if an SSP track is extended through the All-Payer Model. Michael Costa clarified that this possibility is a very recent development. Sarah Kinsler noted that the SIM budget was developed and submitted in March and April; newer developments are not included.
	    o Mike Hall requested a breakdown of contractual dollars supporting payment model design vs. payment model implementation.
	• Sustainability & Population Health
	    o Dale Hackett asked why actuals are lower than approved amounts for the Population Health Plan contract and others. Sarah replied that in this case, the Core Team approved an amount but RFP bids and contract negotiations resulted in a lower contract amount.	

5. Medicaid Pathway	Selina Hickman provided an update on the Medicaid Pathway project (Attachment 5). • Medicaid Pathway seeks to promote Vermont Model of Care. • State is currently working internally and with provider partners to review organized delivery system options with various levels of organizational/financial integration and link to the All-Payer Model. • Broader stakeholder engagement to come in this summer. The group discussed the following: • Person-centered care is a challenge under current siloed funding streams. The Medicaid Pathway seeks to support person-centered care by providing more flexible funding streams that allow providers to tailor care to the needs of each individual. Learning opportunities like the Integrated Communities Care Management Learning Collaborative also support person-centered care. • Some functions of an organized delivery system are currently performed within State government. There is a parallel effort to examine State activities and identify transformation opportunities across AHS (including AHS-CO, DVHA, DAIL, DMH) where currently siloed funding streams could be integrated. DVHA's role as an MCO and a payer shapes these conversations, as do 1115 waiver discussions currently underway. DVHA is also reassessing its role with respect to ACO(s). The DA/SSA master grants are an existing example of a pass-through of managed care responsibilities; how much to delegate and what risk accompanies that choice is an ongoing discussion. • There is ongoing discussion of which organizational structure could best support the Vermont Model of Care, as well as payment models that could support necessary functions. "Provider-led reform should be provider-led" – the State is working not to be too prescriptive regarding structure to allow room for provider-led reform and innovation. • How and when does this model move to full integration with the All-Payer Model? There is some language in the DVHA RFP that speaks to this, and opportunities over time to reevaluate the full array of services, organization in communities, and progress in the provider-led arena. The State has stepped back from indicating one answer to this question	

Agenda Item	Discussion	Next Steps
6. Public Comment, Next Steps, Wrap Up and Future Meeting Schedule	There was no additional public comment. **Next Meeting:** Wednesday, June 29, 1:00-3:00pm, Montpelier.	

VHCIP Steering Committee Member List

Dale 1° Jay 2° minutes approved by exception

Member		Member Alternate		Minutes	25-May-16
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓				AHS - DAIL
Rick	Barnett				Vermont Psychological Association
Bob	Bick				DA - HowardCenter for Mental Health
Peter	Cobb ✓				VNAs of Vermont
Steven	Costantino ✓				AHS - DVHA, Commissioner
Elizabeth	Cote				Area Health Education Centers Program
Tracy	Dolan ✓	Heidi	Klein		AHS - VDH
Susan	Donegan	David	Martini ✓		AOA - DFR
John	Evans ✓	Kristina	Choquette		Vermont Information Technology Leaders
Kim	Fitzgerald				Cathedral Square and SASH Program
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Joyce	Gallimore ✓				Bi-State Primary Care/CHAC
Al	Gobeille				GMCB
Lynn	Guillett				Dartmouth Hitchcock
Dale	Hackett ✓				Consumer Representative
Mike	Hall ✓	Angela	Smith-Dieng		Champlain Valley Area Agency on Aging / COVE
Paul	Harrington ✓				Vermont Medical Society

Selina	Hickman ✓	Shawn	Skafelstad		AHS - DVHA
Debbie	Ingram				Vermont Interfaith Action
Craig	Jones				AHS - DVHA - Blueprint
Trinka	Kerr ✓				VLA/Health Care Advocate Project
Deborah	Lisi-Baker				SOV - Consultant
Jackie	Majoros ✓				VLA/LTC Ombudsman Project
Todd	Moore	Vicki	Loner		OneCare Vermont
Jill	Olson	Annie	Mackin ✓		Vermont Association of Hospital and Health Systems
Mary Val	Palumbo ✓				University of Vermont
Ed	Paquin				Disability Rights Vermont
Judy	Peterson ✓				Visiting Nurse Association of Chittenden and Grand Isle Counties
Allan	Ramsay				GMCB
Frank	Reed	Jaskanwar	Batra ✓		AHS - DMH
Paul	Reiss				HealthFirst/Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer				Vermont Care Network
Howard	Schapiro				University of Vermont Medical Group Practice
Julie	Tessler ✓	Marlys	Waller		Vermont Council of Developmental and Mental Health Services
Sharon	Winn				Bi-State Primary Care
	35		9		

	Meeting Name:	VHCIP Steering Committee Meeting	
	Date of Meeting:	May 25, 2016	
	Last Name (a-z)	First Name	
1	Aranoff	Susan	hre
2	Backus	Ena	
3	Bailey	Melissa	
4	Banks	Heidi	
5	Barnett	Rick	
6	Barrett	Susan	
7	Batra	Jaskanwar	here
8	Bick	Bob	
9	Buck	Martha	
10	Choquette	Kristina	
11	Clark	Sarah	
12	Cobb	Peter	hre
13	Collins	Lori	
14	Coonradt	Amy	
15	Cooper	Alicia	
16	Costantino	Steven	hre
17	Cote	Elizabeth	
18	Cummings	Diane	hre
19	DelTrecco	Mike	
20	Dolan	Tracy	phone
21	Donahey	Richard	
22	Donegan	Susan	
23	Evans	John	phone
24	Fisher	Jamie	

25	Fitzgerald	Klm	
26	Fitzpatrick	Katie	
27	Flynn	Erin	
28	French	Aaron	
29	Fulton	Catherine	hre
30	Gallimore	Joyce	Phone
31	Garand	Lucie	
32	Geiler	Christine	
33	Gobeille	Al	
34	Guillett	Lynn	
35	Hackett	Dale	here
36	Hall	Mike	Phone / here
37	Hall	Janie	
38	Harrington	Paul	here
39	Hathaway	Carrie	
40	Hatin	Carolynn	
41	Hein	Karen	
42	Hickman	Selina	here
43	Ingram	Debbie	
44	Jones	Craig	
45	Jones	Kate	
46	Jones	Pat	Phone
47	Judge	Joelle	here
48	Kerr	Trinka	Phone
49	Kinsler	Sarah	here
50	Klein	Heidi	
51	Korce	Leah	

52	Laing	Andrew	
53	Lange	Kelly	
54	Lisi-Baker	Deborah	
55	Liss	Sam	
56	Loner	Vicki	
57	Lunge	Robin	
58	Magoffin	Carole	
59	Maheras	Georgia	
60	Majoros	Jackie	phone
61	Maloney	Carol	
62	Martini	David	none
63	McPherson	Darcy	
64	Mongan	Madeleine	
65	Moore	Todd	
66	Olson	Jill	
67	Otley	Brian	
68	O'Toole	Dawn	
69	Palumbo	Mary Val	phone
70	Paquin	Ed	
71	Paumgarten	Annie	none
72	Pelosi	Laura	
73	Peterson	Judy	phone
74	Petrow	Anne	
75	Philibert	Dawn	
76	Poirer	Luann	
77	Ramsay	Allan	
78	Reed	Frank	

79	Reiss	Paul	
80	Rueschemeyer	Simone	
81	Samuelson	Jenney	
82	Sandage	Larry	
83	Santarcangelo	Suzanne	
84	Schapiro	Howard	
85	Shaw	Julia	
86	Sinor	Karen	phone
87	Skafelstad	Shawn	
88	Slusky	Richard	hre
89	Smith-Dieng	Angela	
90	Stone	Holly	hre
91	Tanzman	Beth	
92	Tessler	Julie	here
93	Waldman	Beth	
94	Waller	Marlys	
95	Wasserman	Julie	here
96	West	Kendall	
97	Westrich	James	
98	Wilson	Nicole	
99	Winn	Sharon	
100	Yacovone	David	

Mackin, Annie - VAHHS - here
Costa, Michael - AOA - here
Nease, Floyd - phone

Attachment 3: Work Group Workplans – June-December 2016

	PMDI Work Group	Practice Transformation Work Group	HDI Work Group	Workforce Work Group	DLTSS Work Group	Population Health Work Group	Steering Committee
June 2016	• Frail Elders Update and Discussion • Vermont Collaborative Care Overview and Discussion	• ICCMLC: Progress Update • 2016 Practice Transformation WG Workplan Review	• Data Quality Update • OneCare Care Navigator Demo and RWJF Grant Update and Discussion	• VDH Supply Data – Physician Assistant 2014 Report Review and Discussion • Strategic Plan Discussion: Recommendations 7-17	NO MEETING	NO MEETING	• Core Team Update: Performance Period 3 Budget • Sustainability Preview – Timeline and Contract • Work Group Plans Overview – June-December • Frail Elders Update

July 2016	• Brief Sustainability Update
	• Peer Learning Lab Update and Discussion
	• Medicaid Pathway Update and Discussion
		NO MEETING	• Brief Sustainability Update
			• Connectivity Targets – Review Proposal and (Possible Vote)
			• APM/Medicaid Pathway Overview and Discussion
				NO MEETING	• Brief Sustainability Update
					• DLTSS Data Gap Remediation Project Update
					• Frail Elders Project Update
					• DLTSS Sub-Analysis of ACO SSP Measures Presentation and Discussion
					• DLTSS Sustainability Priorities Discussion
					• Updates:
					  a) MH/SAT/DS Medicaid Pathway
					  b) LTSS/CFC Medicaid Pathway
					  c) APM/Next Gen ACO Programs – Medicaid and Medicare
						• Brief Sustainability Update
						• Filling in the Population Health Plan: What do we believe must change in our health systems in order to improve population health outcomes?
						• Update on HiAP Task Force and RWJF Culture of Health
						• APM Update and Discussion
						• ACH Peer Learning Lab Update and Discussion
							• Core Team/Budget Update
							• Brief Sustainability Update
							• ACH Peer Learning Lab Update
							• Connectivity Targets – Review Proposal and (Possible Vote)
							• APM/Medicaid Pathway Update

August 2016	NO MEETING	• Brief Sustainability Update • Medicaid Pathway Update and Discussion • Identifying and Addressing Practice Transformation Challenges and Barriers • Community Presentation (TBD)	NO MEETING	• Brief Sustainability Update • Strategic Plan Discussion: Recommendations (GMCB and Blueprint) & Final Review • Membership Change Discussion • Demand Modeling Preliminary Projections • Tentative: VDH Supply Data (MD or DDS) Presentation and Discussion	NO MEETING	NO MEETING	NO MEETING
September 2016	• Brief Sustainability Update • Brief VITL Update – Gathering Quality Measures Through the VHIE • Year 2 Medicaid and Commercial SSP Overview and Discussion – Financial & Quality Results	• Brief Sustainability Update • Home- and Community-Based Services Rules Presentation and Discussion • Community Presentation (TBD)	• Brief Sustainability Update • Data Utility Update • Updates (some written): UTP/ICCMLC; Telehealth; HHA VITLAccess Rollout and Interface Build; ENS; VCN.	NO MEETING	NO MEETING	NO MEETING	• Core Team/Budget Update • Brief Sustainability Update • Year 2 Medicaid and Commercial SSP Overview and Discussion – Financial & Quality Results • Demand Modeling Preliminary Projections
October 2016	• Brief Sustainability Update • Population Health Plan Review and Discussion • APM Update	• Brief Sustainability Update • Population Health Plan Review and Discussion • Community Presentation (TBD)	• Brief Sustainability Update • Population Health Plan Review and Discussion • Consent Discussion	• Brief Sustainability Update • Population Health Plan Review and Discussion	• Brief Sustainability Update • Population Health Plan Review and Discussion	• Brief Sustainability Update • Population Health Plan Review and Discussion • Update on ACH Peer Learning Lab	• Core Team/Budget Update • Sustainability Update • Population Health Plan Review (Possible Vote) • APM/Medicaid Pathway Update
November 2016	• Sustainability Plan Review and Discussion • Closing: Work Group Successes	• Sustainability Plan Review and Discussion • Community Presentation (TBD)	• Sustainability Plan Review and Discussion • Data Warehousing Cohesive Strategy Review and Discussion	• Sustainability Plan Review and Discussion • Review Draft Demand Projections Report and Make Recommendations	• Sustainability Plan Review and Discussion • MH/SAT/DS Medicaid Pathway Update • LTSS/CFC Medicaid Pathway Update	• Sustainability Plan Review and Discussion	• Core Team/Budget Update • Sustainability Plan Review (Possible Vote)

				• Wrap Up SIM Work: Successes	• Accountable Communities for Health Update
					• Year 2 Medicaid and Commercial SSP Overview and Discussion – Financial & Quality Results
					• Home- and Community-Based Rules/Independent Options Counseling Update
					• Updates:
					  a) Disability-Specific and General Core Competency Trainings
					  b) Shared Care Plans
					  c) All Payer Model
					  d) Next Gen ACO Programs – Medicaid (DVHA) and Medicare (OneCare)
							• Data Warehousing Cohesive Strategy Review and Discussion

December 2016	NO MEETING	• Closing: Work Group Successes	• Financial Summary and Final Project Updates • Closing – Work Group Successes	NO MEETING	• Closing: Work Group Successes	• Discuss PHWG Sustainability and Continuity • Closing: Work Group Successes	• Core Team/Budget Update • Financial Summary and Final Project Updates • Closing – Steering Committee Successes

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 Steering Committee June 29, 2016

VMS Education & Research Foundation

helping physicians help patients & communities

VHCIP Frail Elders Project

Target Population

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

Global Aim

Identify barriers to best primary care for high-risk elders in 2 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.

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

5 Research Arms

- **Structured interviews/focus groups– elders/caregivers; home bound**

- **Literature search/UVM Medical Library**

- **33 Provider interviews**

- **5 policy/subject matter experts**

- **VT Household /CMS Current Beneficiary Surveys (MCBS)**

5 Reports

- **What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review**
  http://www.vmsfoundation.org/elders/matters

- **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review**
  http://www.vmsfoundation.org/elders/atrisk

- **Caring for Seniors: An interview Study**
  http://www.vmsfoundation.org/elders/caring

- **What Survey Data Tell Us**
  http://www.vmsfoundation.org/elders/surveydata

- **Final Report and Recommendations**
  http://www.vmsfoundation.org/elders/recommendations

VHCIP Frail Elders Project

Remarkably consistent themes in findings across all 5 research arms:

- Mismatches between what gets paid for and what's important to seniors;

- Today's payment policies create significant inefficiencies/harm VT's seniors;

- Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;

- Physical health matters to seniors, but remaining at home, retaining autonomy, not feeling like a burden matter at least as much;

- Care should go to patients, not patients having to come to care;

- Control over health care budgets needs more community level influence;

- Primary care is in critical condition, 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!

What Survey Data Tell Us

VHCIP Steering Committee Meeting

June 29, 2016

Two Key Sources of Data

- MCBS – the Medicare Current Beneficiary Survey
  - Includes clinical, financial, and opinion data
  - Nationally representative
  - Done annually
- VHHIS – the Vermont Household Health Insurance Survey
  - Vermont-specific
  - Representative of non-institutionalized population
  - Insurance coverage, family structure, income
  - Approximately 110,000 Medicare beneficiaries

Two Step Process

- First, evaluate the comparability of MCBS and VHHIS

  - How do the Medicare beneficiaries in VHHIS compare to the MCBS population?

- If that comparison is satisfactory, apply proportions from MCBS to Vermont-specific Medicare numbers. Note that the proportions used in this presentation are from reports posted on the CMS website.

- For additional flexibility, future analyses will use record-level MCBS data.

Step 1 - Compare
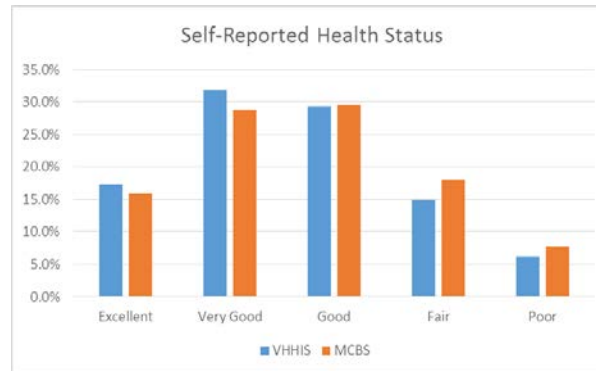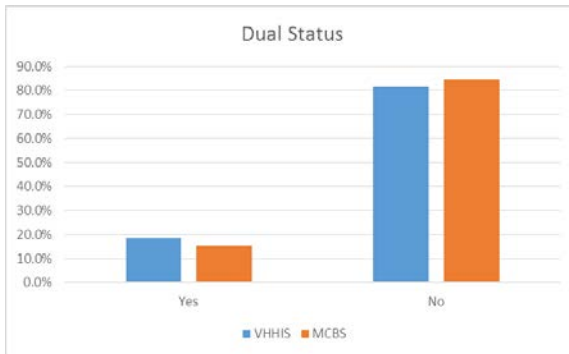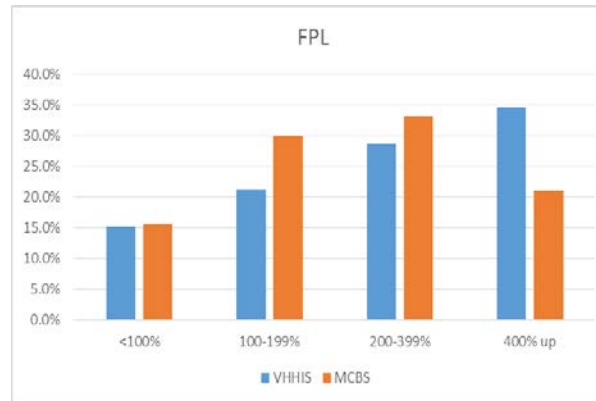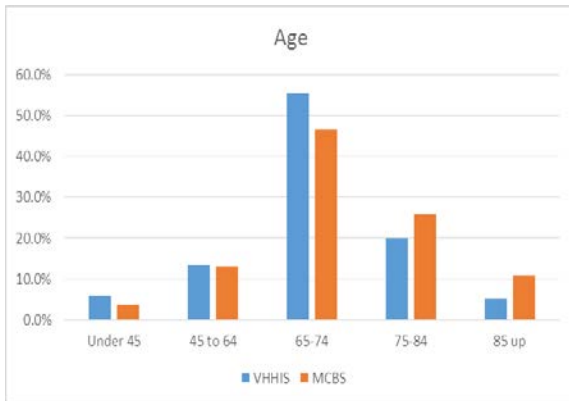
Step 2 - Merge

Based on 110,000 Vermont
Medicare beneficiaries living in
the community
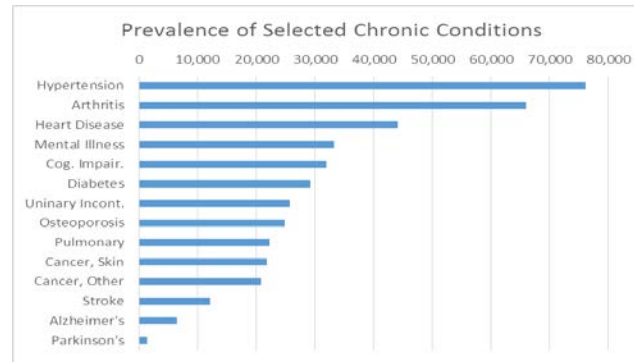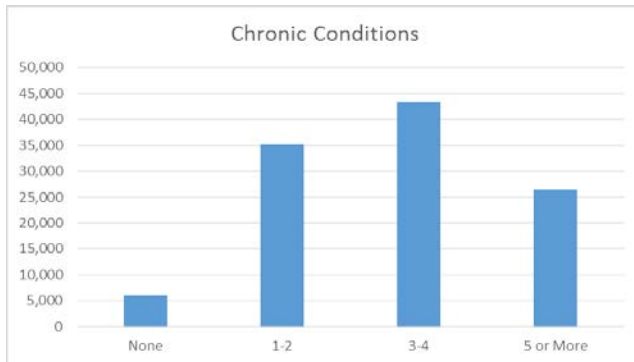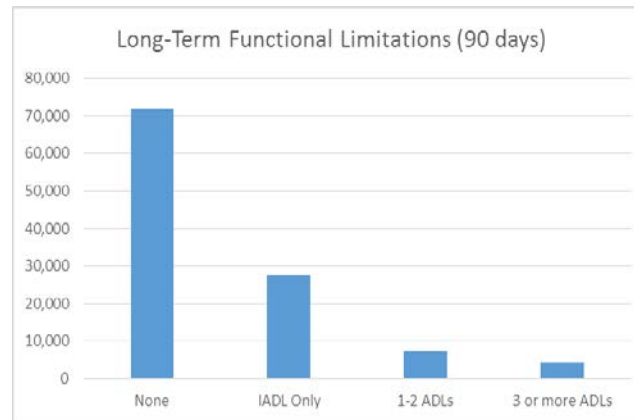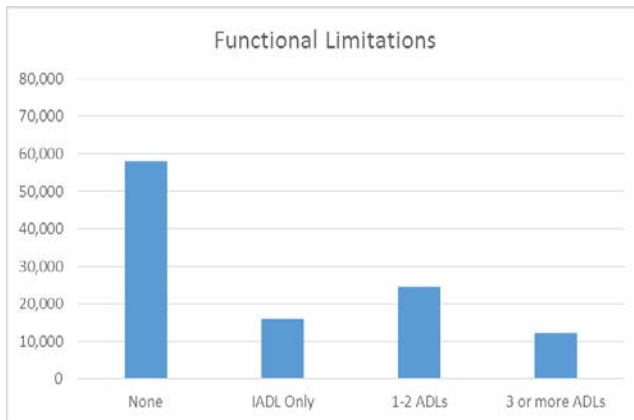
VHCIP Frail Elders Project

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

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

- **Multiple chronic conditions**
- **Functional impairment**
- **Impaired mobility, gait and balance problems**
- **cognitive impairment, depression**
- **high utilization of health care and social services**
- **More likely to be low-income, live alone, lack caregiver availability, and lack an adequate support system of family and friends**
- **Social determinants of health as critical factors in the well-being of seniors**

How will we identify them?

- **3 step identification process**
- **Billing data and structured data in medical records analyzed by a predictive algorithm**
- **Risk stratified based on significant events, high utilization patterns, key diagnoses, social determinants of health and impairment in ADLs and IADLs**
- **Reviewed for appropriateness by a dedicated practice seniors' care team**
- **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**
- **Partner community support service providers invited to recommend others**

VHCIP Frail Elders Project

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

- **Multi-dimensional balanced evaluation**

- **No single index of success is sufficient**

- **Existing validated metrics directly relevant to the process or system being evaluated**

- **Annual ongoing comparisons to appropriate benchmarks rather than pre and post measures**

- **Social, clinical, mental health, substance use, healthy behaviors (diet, exercise) as it relates to a person's ability to maintain or improve their health**

- **Functional measures - patient reported outcomes ADLs, IADLs**

- **Measures of patient goals being met**

- **Measures of independence with sufficient self-management support**

- **Provider reported measures directly related to the systems of care and the care needs of this population of patients**

- **Utilization, financial measures - hospitalizations, ED visits, long term SNF placement and claims paid**

VHCIP Frail Elders Project

3) How will we care for them?

- **Multidisciplinary Primary Care Team**
  - **Comprehensive initial assessment**
  - **Primary medical practitioner**
  - **Practice nurse**
  - **Practice's integrated care coordinator**
  - **Patient and/or their caregiver**
  - **Home visit**
  - **Discussion of needed home based services to support independence**
  - **Care Plan - guidance for patient, family and clinical and community support providers**

VHCIP Frail Elders Project

3) How will we care for them?

Neighborhood Team

- Representatives of practice team
- representatives of appropriate community support and service providers
- Patient and family and patient and family consent
- Neighborhood Team meets with sufficient frequency to review new and emergency cases as well as periodic reviews of all high-risk seniors in the community
- Patients and families will always be able to choose not to have their Care Plan discussed outside of the practice
- Privacy concerns will be respected.

A third layer of community coordination

- Periodic meetings of representatives of both practice and community partners
- Adequacy of the overall needs of the community's seniors and available local, state and federal resources
- Focus for community advocacy for their senior citizens

VHCIP Frail Elders Project

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

- **Special status in the practice, e.g. "The Gold Team"**
- **Priority same-day appointments**
- **Home visits by PCP, office nurse and care coordinator**
- **24/7 access to phone assistance by someone who knows them**
- **Group medical visits for those who are able and comfortable with the format**
- **Group visits may include community resource representatives and Practice Team**
- **Gold Team membership will promote sense special place in practice; foster a sense of a community group; raise community awareness of the program**
- **Enhanced services will decrease inappropriate calls to 911 and unneeded hospitalizations**
- **Individualized Care Plan**
  - **May include Advanced Directives and Vermont DNR/COLST form**
  - **Specific, personal and individualized information on life and health goals**
  - **E.g. avoiding hospitalization, dying at home or making it to a granddaughter's wedding**
  - **List of people to call (to avoid getting sicker due to "not wanting to trouble anyone")**
  - **Name and contact information for their primary care practitioner**
  - **Personal goals, e.g. what the patient agree to work on, exercising or socializing**

VHCIP Frail Elders Project

4) How will we pay for their care?

The Commonwealth Care Alliance Senior Options Program

http://commonwealthcaresco.org/

The Independence at Home Project

https://innovation.cms.gov/initiatives/independence-at-home/
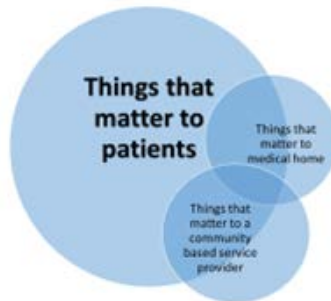
Monthly bundled risk adjusted population health payment/incentive based on outcomes important to patients within a larger all payer model system

VHCIP Frail Elders Project

Risk and Accountability?

Things that matter to patients

Things that matter to medical home

Things that matter to a community based service provider

VHCIP Frail Elders Project

4) How will we pay for their care?

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.

VHCIP Frail Elders Project

- 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;

- Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;

- Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;

- When possible, 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

http://www.vmsfoundation.org/elders

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VHCIP Steering Committee June 29, 2016

VMS Education & Research Foundation

helping physicians help patients & communities

Attachment 4b: Frail Elders – Final Report and Recommendations

VMS Education & Research Foundation
Pursuing High Value Care for Vermonters

The Frail Elderly Project

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Executive Summary

The Frail Elders Project was undertaken in order to promulgate actionable recommendations for improving the primary care delivery system in Vermont. 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 often the case in 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; a reform paradigm offering hope for the future of the practice of primary care in our rural communities.

As the project matured its scope, it was broadened to include all seniors at risk of poor health outcomes or a decline in the quality of their lives. Those seniors that already meet the clinical criteria of frailty are still included, but the project team and all those that contributed to its research feel strongly that preventing or delaying frailty is equally important as caring for those already frail.

Underlying project recommendations are findings that are remarkably consistent across all sources of information:
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. Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;
4. Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;
5. When possible care should go to patients rather than patients having to come to care;;
6. Control over health care budgets needs more community level influence;
7. Primary care is in critical condition, and we all need to rethink how to support it;
8. There are proven examples of how to do it better; and
9. There is a lot that can be done right now!

Our recommendations are all founded on what we were told by seniors, by community based clinical practitioners and support service providers who aid the elderly every day, by 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 subsequent policy will not spin away from what seniors say matters to

them and the knowledge of their caregivers who know them so well. The reader is encouraged to read the four sets of research findings as they are rich in nuance as well as actionable detail.

1. Who are our high risk seniors?

Both the project's literature review and key informant interview study found that frail and high-risk seniors are characterized by having multiple chronic conditions, functional impairment, impaired mobility, gait and balance problems, cognitive impairment, and depression. In addition, this subset of seniors frequently has high utilization of health care and social services. They are also more likely to be low-income, live alone, lack caregiver availability, and lack an adequate support system of family and friends. Key informants universally identified social determinants of health as critical factors in the well-being of 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 analyzed by a predictive algorithm. Identified patients are then risk stratified based on 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 seniors' 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, substance use and healthy behaviors (diet, exercise) as it relates to a person's ability to maintain or improve their health
- Functional measures including patient reported outcomes such as activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Measures of patient goals being met
- Measures of independence with sufficient self-management support
- Provider reported process and outcome measures directly related to the systems of care and the care needs of this population of patients
- Utilization and financial measures including hospitalizations, ED visits, long term nursing home placement and claims paid

3. How will we care for them?

Each senior in the high risk group will have a comprehensive initial assessment by the practice's multidisciplinary Primary Care Team. Key members of the Team will be the primary medical

practitioner, a practice nurse, the practice's integrated care coordinator 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.

Outside of the practice, but including key representatives of the practice team, will be a Neighborhood Team. The Neighborhood Team will include representatives of appropriate community support and 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 all high-risk seniors in the community. Patients and families will always be able to choose not to have their Care Plan discussed outside of the practice; their privacy concerns will be respected.

A third layer of community coordination will occur at periodic meetings of representatives of both practice and community partners. 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 and serve as a focus for community advocacy for their senior citizens.

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

While the design of a financing system must follow design of a delivery system, financing can have a strong effect on all aspects of system performance, including patient and provider satisfaction, quality of care, and value. We recommend that the payment model be focused first and foremost on addressing what matters to the patient. Evidence shows that what patients want is not always reflected in the current health care system. It should recognize the risk of patients being cared for in a more comprehensive way than current risk-adjustment methodologies do. It should permit the use and coordination of a broad range of services, both medical and social. There is an increasing body of evidence that appropriate use of social services can reduce the need for higher-cost medical interventions.

Several funding mechanisms are in operation in the US and Canada that support parts of the recommended care model. None of them support all the components of the recommended model nor do many of them cast a wide enough net to capture all the high-risk seniors in our rural communities. Two programs are presented to highlight key issues: 1) The Commonwealth Health Alliance's Senior Options Program; and, 2) the CMS demonstration project, Independence at Home. We are highlighting these two programs because they are in operation presently, demonstrate remarkable success in delivering care in a manner that matters to seniors and illustrate the potential for innovative care models and payment policy. The reader should be cautioned that eligibility for both these programs is directed at seniors with either the most limited financial resources or a very high need of clinical care. If these programs were to be implemented as is in the two target Vermont communities, many seniors would be left out. However, elements of both these programs, if adapted to address the needs of Vermont's high-risk seniors, would be an improvement over the status quo.

A more profound suggestion is a monthly bundled risk adjusted population health payment for this subset of patients with incentive on outcomes important to patients within a larger all payer model system as might be conceived in Vermont in the near future. This model would be unique to Vermont and could be part of the larger Medicare waiver program. Program management could be accomplished through the evolving accountable care organizations landscape.

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, our recommendations are based on the key findings from seniors themselves, practitioners who know them so well, subject matter experts and a comprehensive literature search. 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; and can be expanded to other special populations of Vermonters and other community based primary care settings.

A prominent ubiquitous theme in every research arm has been the critical condition of primary care in our rural communities. We all need to rethink how to provide quality primary care in our state. The Project Study Design and Recommendations target making things that matter to seniors better, but the authors also hope that, if implemented, the recommendations will help ease some of the strain on our rural primary care practices. The recommendations purposely attempt to move care to the patient, and by doing so hope that care will not only be more in line with patients' wishes, but that it will make our rural practices more efficient, the burden of documentation and measurement more transparent and meaningful and bring more professional satisfaction and joy to the primary care workforce.

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.

This report and all of the supporting research reports can be accessed on the project web site http://www.vmsfoundation.org/elders

Introduction

In 2012, a small group of primary care practitioners began to discuss ways primary care practitioners in Vermont could improve the primary care delivery system across the state by providing better, more coordinated care and improving the workplace for the primary care work

force. The context for the initial conversations were the early phases of an aggressive health care reform effort at the state level, a growing sense of the need for more coordination and integration of medical care with community support services and emerging frustration within both the medical and community support services with change being forced on them from the outside rather than change being led from inside of the communities.

Initial support for the effort was a physician leadership grant from the Physicians Foundation of Cambridge, MA http://www.physiciansfoundation.org/ Subsequent support was a contract with Vermont's Green Mountain Care Board, the deliverable of which was to suggest to the State appropriated goals for the State's Health Resource Allocation Plan which gives the Board authority to allocation medical resources justly across the state. The result of that contract were two Whitepapers, http://www.vmsfoundation.org/news/foundation-presents-whitepaper-physician-opinion-optimizing-hospital-based-care-gmcb#overlay-context=reports-whitepapers and http://www.vmsfoundation.org/news/foundation-presents-rural-care-whitepaper-gmcb . Both papers were enthusiastically received by the Board. The Board asked the authors to propose a project with actionable recommendations. The Frail Elderly Project was subsequently designed.

At its inception, the scale and scope of the project were small and focused principally on addressing barriers and improvement opportunities more medical than community service based. The proposal was reviewed by an initially skeptical audience. As a result of the broad public critique and input, the proposal was modified and eventually gained universal support from all interested partners. The project was subsequently awarded a $140,329 grant from the Vermont Health Care Improvement Project in November 2015. The Project was awarded an additional $11,500 in March 2016 in order to expand the scope of the literature search analysis and patient particularly home-bound individuals. A report and presentation of its findings and recommendations is due in June 2016.

The key to the project's survival was the insight of its initial proponents to always keep it focused on what matters to patients. Eventually, a culture of trust grew around the effort and it has received extraordinarily generous support from everyone involved in the discussions about its relevance and importance.

The principals of the Project Research Team expect and hope that their findings and recommendations will be seriously discussed and improved as a result. The Team hopes that when there is controversy over a recommendation or next step that the intent of the decisions on how to move forward will always be measured by whether they make things better that matter to patients.

Project Design

This qualitative research project was carried out by a nine-person multidisciplinary research team: 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 and Cyrus Jordan MD MPH.

Team leader Cyrus Jordan met regularly with a designated project manager from the Vermont Health Care Improvement Project (VHCIP). The VHCIP contract is with the Vermont Medical Society Education and Research Foundation (the Foundation), a non-profit public benefit corporation recognized as a 501© (3) corporation by the IRS. All members of the Research Team are independent sub-contractors to the Foundation or independently contracted by VHCIP to offer technical support to the grantee.

The project is purposely limited to the Little Rivers Health Care Primary Care Service Area (PCSA) and the Gifford Health Care PCSA. Little Rivers Health Care has health centers in Wells River, Bradford, and East Corinth. Gifford Health Care has health centers in Randolph, Bethel, Chelsea, and Rochester. Both Little Rivers and Gifford are Federally Qualified Health Centers (FQHCs). Both these communities are rural. Their principal hospitals are both critical access hospitals. The FQHC provides the vast majority of all medical services in the communities.

The Project utilized four methodologies to accomplish its objectives:

1. A literature review
2. Analysis of Vermont and federal survey data
3. Focus groups and interviews with seniors and their caregivers/surrogates
4. Structured key informant interviews with health care providers, community-based service providers, and policy experts.

1. Literature review
The literature review was conducted by Brian Costello MD with the contracted assistance of Nancy Bianchi MSLIS at the University of Vermont Dana Medical Library.

2. Analysis of Vermont and federal survey data
The data analysis was conducted by Policy Integrity, LLC. Two surveys were analyzed: the federal Medicare Current Beneficiary Survey (MCBS) and the Vermont Household Health Insurance Survey (VHHIS). Each of these can provide useful information but their value increases substantially if their information can be combined. The MCBS is a national survey, containing a wide range of information on Medicare beneficiaries, including both utilization of medical services, health status, specific chronic diseases, and ADLs (activities of daily living). Because it is a national survey, too few Vermont residents would be included to allow for any analysis. VHHIS is currently managed by the Vermont Department of Health.

3. Focus groups and structured interviews with seniors and their caregivers/surrogates
Focus groups and interviews with seniors and their caregivers were conducted by Brian Costello MD. Informants were recruited by the target practices and community support service providers.

4. Structured key informant interviews with health care providers, community-based service providers, and policy and content experts Structured key informant interviews were conducted by Erica Garfin Consulting. Two physician leaders who were part of the Frail Elderly Project Team identified and recruited key informants in their respective communities. Community-based informants were drawn from a variety of fields: primary care (physicians, nurse practitioners, physician assistants, nurses), mental health/substance abuse, home health, hospital discharge planning, care coordination, quality improvement, Blueprint for Health, Support and Services at Home (SASH), adult day program, area agency on aging, senior center and clergy. A state advisory panel to the project identified key informants from the arena of geriatrics and aging who could provide policy and content expertise on the systems level.

The Research Team developed a set of consensus foundational constructs to guide the project: a target population, a project global aim and 10 research focus areas:

Target Population
Seniors at risk of a decline in the quality of their lives or a poor health outcome.

Project 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.

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.

It is important to work on this now because as health care professionals we can play an important role in health care reform by designing more patient-centered, efficient and high value care. Redesigning how high-risk rural elders are cared for offers opportunity to improve health outcomes for a particularly high-need population while decreasing the cost of care for the target population.

Research Focus Areas
The research was guided by the following questions**:**
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?

The Research Team used a consensus approach to promulgating the recommendations. The recommendations are based on the Team's analysis of the aggregate findings. All recommendations reference the findings on which they are based.

Findings

The research effort was based on five separate sources of information:

- 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 findings are presented in four discrete research reports:
1. **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review;**
2. **What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review;**
3. **Caring for Seniors: An interview Study** (includes both provider and policy/content expert interviews)**;** and
4. **What Survey Data Tell Us**

Several themes are remarkably consistent across all five research arms and influence project recommendations:
- 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;
- Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;
- Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;
- When possible 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!

Key findings from each of the four research reports are highlighted in the following paragraphs. The full text of the research studies themselves can be accessed on the project web site - http://www.vmsfoundation.org/elders

1. What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review
http://www.vmsfoundation.org/elders/matters
For models of care that target frail and high-risk seniors to successfully deliver high-quality, high-value care, it is critical to understand seniors' perspectives on health and well-being and their perspectives on the health care and social service system. Understanding these perspectives at the onset makes it possible to choose and/or design a model of care aligned with what matters to seniors.

This study identified several factors important to seniors. Of these factors, maintaining independence was the most frequently cited response. Other factors that participants identified as important for their health, wellbeing, and quality of life included physical health, functional capacity, financial security, social connection to friends and family, being treated with dignity and respect, and reducing their burden on others.

"To me I look at [good health] as being able to live a reasonably normal life. To be able to do some things that have to be done. To enjoy life as much as I can."

"Being able to be independent is the main thing. I don't like to rely on other people to do things for me. I want to be as independent as I can be. I've always made my own way in life and I want to do that as long as I can."

The participants also identified several barriers to health care, including transportation, social isolation, caregiver burden, financial constraints, and limited availability of health care providers.

"I can see the time where I am not going to be able to drive and that unnerves me and that makes me want to make sure there is transpiration available."

"Pills are very expensive. Operations are very expensive. A lot of people are putting them off because they cannot afford to have them. I think that the whole medical system has to change. If you have plenty of money it doesn't matter, but if you don't people just don't go."

Participant opinions were divided regarding their experiences with primary care. Many recalled very positive experiences of compassionate providers delivering individualized care. Others, however, described negative experiences with providers who lacked empathy. Multiple participants commented on the difficulty of recruiting and retaining primary care physicians in rural areas. Some participants suggested that the inability to speak with the primary care provider over the phone led to increased use of the emergency department. One suggestion

that came out of the focus groups was that primary care offices provide more information about local health and social services.

"[My PCP] has made it very easy to be who I am. You just feel better when you walk in the office. He represents health. In a wonderful way, you laugh. [My PCP was helpful] especially at times when I have had about of depression. . . . He was always there, and he helped me to embrace health."

"The doctor … always made me feel 'why are you here?' I always felt that I was not sick enough to be there. I didn't like that, and I was very aware of that."

"You cannot get through to the doctors at Gifford. If you call, you get an answering machine. What kind of an answer is that when what you have is vital, but you do not need to use the ER services. You are forced to use those services. There is no other way."

Amongst participants who discussed emergency services, many described a lack of alternatives to the emergency department in rural areas, which led to inappropriate use of the emergency department. In general, participants felt that care in the emergency department was costly, impersonal, and not timely. Participant opinions were divided regarding hospital and specialist care at Gifford Medical Center and Dartmouth-Hitchcock Medical Center. Some appreciated the intimacy and personal nature of care at Gifford, whereas others preferred the more comprehensive services available at Dartmouth.

"I also know that if I go to the [ED], they are going to do so much, and I don't want any part of it."

Most of the participants had utilized local social and health care services. Participants universally praised the Central Vermont Council on Aging, but had mixed experiences with other services, such as Meals on Wheels and the Visiting Nurse Association. Satisfaction with home health services correlated with financial resources. Those who could afford private home health had a positive experience, whereas those with less financial resources expressed a need for additional subsidized home health services. Most participants were either reluctant to discuss the mental health system or did not have experience with it. One participant who had a positive experience receiving mental health services cited her relationship with her primary care provider as critical to enabling her to reach out for help and receive needed care. Many participants acknowledged the role of community organizations and volunteers as an important complement to the more tradition social service delivery system.

Lastly, participants were nearly universally enthusiastic about the concept of home visits from their primary care provider or a representative of the primary care office.

"[Home visits]. That would be the dream!"

The supporting literature review aligned with the viewpoints of the participants regarding factors that contribute to health, wellbeing, and quality of life, and barriers to care. The literature review also identified the following components of care as important to high-risk seniors: convenient access to providers, individualized and coordinated care, continuity of care, providers who listen well, and clear communication of a care plan.

2. Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review http://www.vmsfoundation.org/elders/atrisk

As is well documented and frequently discussed in health care circles, there is a significant imbalance in health care spending in the United States. Over 50 percent of health care costs are incurred by only 5 percent of the population. This concentration of spending also exists within the senior population. Amongst seniors, there is a subset of individuals often termed frail or high-risk who face functional decline, decreased quality of life, and significant health care spending. The frail and high-risk population has complex health and psychosocial needs. If these individuals are prospectively identified, their needs can be addressed through comprehensive models of care that lead to improved health outcomes and a reduction of health care utilization.

The literature review identified several overlapping characteristics for frail and high-risk seniors. These seniors have multiple chronic conditions, functional impairment, and poor self-rated health and quality of life. Multiple instruments are available to assess frailty and level of risk amongst seniors. However, unlike risk-assessment instruments, frailty assessment instruments were designed to evaluate current health and functional status, not to measure or predict health care utilization. In addition, risk assessment instruments more frequently include health care utilization history, demographic factors, and psychosocial factors.

Although feasible in theory, population-level screening through practitioner or patient-administered instruments is time-intensive and requires universal adoption by primary care providers. Predictive algorithms that utilize claims data, clinical data, or other available datasets to risk-stratify a patient population can be easier to implement at the population level, and in some cases they can more accurately predict poor outcomes (such as functional decline or hospitalization). For these analytic methods to most accurately predict risk, the datasets need to include data from multiple domains including diagnostic information, demographic information, functional status, and prior health care utilization. One approach to identifying high-risk seniors who could benefit from more comprehensive health care and services is to combine predictive algorithms with direct health and social service provider referral. This identification process should be followed by comprehensive in-person assessments of the highest-risk seniors to determine individual health and social needs.

What Models of Care Support Them?

The literature review identified several models of care targeting frail and high-risk seniors that led to improved outcomes. Two categories of models of care identified were Home-Based Primary Care (HBPC) and non-HBPC integrated care models. HBPC includes comprehensive assessments, individualized care plans, house calls by primary care teams, 24/7 availability by phone, mobile diagnostic technologies, coordinated subspecialty and mental health care, social services, and pharmacy services. Of note, HBPC has primarily been implemented in urban settings. The non-HBPC models identified in the review varied but components of these models included comprehensive assessments, individualized care plans, multidisciplinary team-based care, integration of social services and community resources, mental health services, self-

management education, pharmacy services, and family member/caregiver support. Other approaches identified to support high-risk and frail seniors include community paramedics, community health workers, and care transition models.

Research has found that both HBPC models and non-HPBC integrated care models have improved patient satisfaction, decreased hospitalizations, decreased the number of skilled-nursing facility visits, and increased cost savings. Cost savings are generally achieved by shifting spending from higher cost hospitalizations, emergency department visits, and skilled nursing facility stays to lower costs primary care and social services.

Payment reform is central to the success of these models of care. Payment reform that supports these models includes shared savings, capitated payments, and care management fees. Multi-payer reform can enable a broader pay base and greater financial support for these models of care. Workforce approaches, such as Community Health Workers and Community Paramedics, can be supported through reform that enables billing for services provided by these professionals.

3. **Caring for Seniors: An interview Study** http://www.vmsfoundation.org/elders/caring
Social determinants of health were universally identified by informants as critical factors in the well-being of seniors, particularly financial issues, social isolation, absence of a support system, living alone, and lack of transportation. Informants also cited medication issues, depression, and substance use as significant risk factors for seniors.

 "Social determinants play an even bigger role than the chronic medical conditions that we tend to focus on."

"People need a social convoy. Those who are connected with friends, family, and neighbors do so much better than those who are isolated."

Although electronic medical records were seen as having some potential as a source for identifying at-risk seniors, primary care providers felt that there is no substitute for face-to-face interaction with their patients.

"You have to lay eyes on the person to get the whole picture."

Home visits were widely viewed as an excellent way for primary care providers to get a full picture of their senior patients' status, including both clinical and functional status and the critical social determinants of health and wellbeing.

"If they don't come in [to the office], then it's too late and things are already happening. We're not sure why they're not coming in, if it's money or transportation or what. We've talked about how good it would be if nursing staff could go out to homes and do an assessment and also find out if people can make it to the office or does the doctor need to go to their home. But insurance doesn't pay for nurses to make home visits."

The study found a number of systemic barriers to providing care and supporting seniors to achieve outcomes that matter to them. The most significant barriers fall into the categories of time constraints, reimbursement for home visits, Medicare limitations on home health agency services, inadequate access to home-based support services, and communication among providers.

"You see it when someone's eligible for [home health] services. Nursing services are covered only for patients who are homebound and when there is a need for skilled care, but not for things like monitoring blood pressure, blood thinners, or fluid retention for patients with congestive heart failure. They get all kinds of services—nurses, physical therapy, occupational therapy, home aides. They do well for a few months, then they don't qualify and boom they go downhill and then boom it happens again. A lot of people fall through that gap where they don't qualify. Things fall apart, and the cycle repeats. There's no intermediate level of home care they can qualify for where they can get medication reconciliation or checks on their status. The more services they can get in the home, the better they're going to do. That would be so helpful for providers and patients."

"My one wish would be a sliding scale agency for home care, for aide-level care. That level of care is what most people need."

"It's hard to send information and wasteful to print and fax over and over when we could simply be coordinating if we all used the same EMR."

Key informants identified aspects of their local delivery systems that are working well to support seniors in the domains of primary care, other health-related services, and community-based supportive services. They also identified services that are inadequate to meet seniors' needs. With the exception of access to primary care and mental health services and a difference in the care coordinator model in the two areas, the study generally found consistency in informants' reports about many aspects of the local delivery systems across the two PCSAs.

Care coordinators were viewed as key members of the primary care team, and informants expressed a strong preference for a model that has care coordinators based on site and fully integrated into the practice.

"The care coordinator can fill the gaps for important things that inhibit care if they're not addressed but that the primary care provider doesn't have time or knowledge of resources to address. In some ways it's more important than what the primary care provider does. It certainly makes my job [as a PCP] more doable. It would be great to have them here more than once a week so I can hand people off right there at the time of the appointment. That works the best."

Informants suggested care models and practice processes that would enhance the ability of primary care providers to care for seniors and potentially reduce cost. The study found particular interest in home-based primary care models as well as practice processes that use a team approach where primary care physicians are freed up to provide the care they are uniquely qualified to provide. The study also found interest in models that use other provider types, such a community paramedicine and community health nurses, to reduce the burden on primary care practices.

Although not all informants expressed views on the topic of payment reform, those who responded showed consistent support for a move away from the current fee-for-service system and its encounter-based reimbursement model to a capitated system that aligns payment with quality and outcomes. Payment reform will also need to address numerous barriers to caring for seniors that are presented by Medicare policies regarding eligibility and reimbursement.

4. What Survey Data Tell Us http://www.vmsfoundation.org/elders/surveydata
There are two surveys that can provide information in support of the Frail Elders project – the federal Medicare Current Beneficiary Survey (MCBS) and the Vermont Household Health Insurance Survey (VHHIS). Each of these can provide useful information but their value increases substantially if their information can be combined.

The MCBS is a national survey, containing a wide range of information on Medicare beneficiaries, including both utilization of medical services, health status, specific chronic diseases, and ADLs (activities of daily living). Because it is a national survey, too few Vermont residents are included to allow for any analysis of the Vermont population alone.

VHHIS is currently managed by the Vermont Department of Health. In the past, it has been managed by the Department of Financial Regulation. VHHIS is a large survey, designed to analyze health insurance coverage, socioeconomics, and knowledge of the health care system among Vermont families. While it provides excellent information in these areas, it does not include any health status information that would be useful to understand the needs of frail elders other than self-reported health status.

In order to provide information useful to this project, we explored the possibility of merging information from the two files. An example of a merger would be to apply the percentage of Medicare beneficiaries with Diabetes (from MCBS) to the number of Medicare beneficiaries aged 65 and over in Vermont (from VHHIS).

Prior to actually merging information, we looked at how comparable variables common to both surveys were. The table below shows a typical comparison. "Community" means MCBS information is limited to those who were not in long-term care for the year, which matches the scope of VHHIS (which does not include those living in institutions such as nursing homes).

Self-Reported Health Status	VHHIS	Community MCBS
Excellent	17.4%	15.9%
Very Good	31.8%	28.8%
Good	29.4%	29.6%
Fair	15.0%	18.0%
Poor	6.2%	7.7%

DK / UNK   0.3%

As can be seen, there is good agreement between the two sources. The next step was to apply MCBS percentages to the Vermont Medicare population (example below).

Number of Chronic Conditions	MCBS Percent	Estimated VT Medicare
None	5.4%	5,989
1-2	31.7%	35,160
3-4	39.1%	43,368
5 or More	23.8%	26,398
Total		110,916

As this analytic effort proceeds, additional information will be posted on the project website.

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, by 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?**
4. **How will we pay for their care?**

1. **Who are our high-risk seniors?**
The literature review found that frail and high-risk seniors are characterized by having multiple chronic conditions, functional impairment, impaired mobility, gait and balance problems, cognitive impairment, and depression. In addition, this subset of seniors frequently have high utilization of health care and social services and they are also more likely to be low-income, live alone, and have a lack of care giver availability.

The findings from the key informant interview study reflected similar characteristics for this population. Of note, key informants universally identified social determinants of health by as

critical factors in the well-being of seniors, particularly financial issues, social isolation, absence of a support system, living alone, and lack of transportation. Informants also cited medication issues, depression, and substance use as significant risk factors for seniors.

Although electronic medical records were seen by key informants as having some potential as a source for identifying at-risk seniors, primary care providers felt that there is no substitute for face-to-face interaction with their patients. Home visits were widely viewed as an excellent way for primary care providers to get a full picture of their senior patients' status, including both clinical and functional status and the critical social determinants of health and wellbeing.

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 analyzed by a predictive algorithm; and patients risk stratified based on 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.

"The people we're not catching are the people we don't see regularly."

This identification process is based on the findings in the literature search and is consistent with what seniors, providers and subject matter experts said in their interviews. As with all the project recommendations, the reader is asked to consider the recommendation as an initial test of change. It will need to be monitored for success or failure in a continual cycle of improvement. The literature findings suggest that an initial test of change combine predictive algorithms with direct health and social service provider referral in order to identify high-risk seniors who could benefit from more comprehensive health care and supportive services. This identification process should be followed by comprehensive home-based medical and functional assessments of the highest-risk seniors to determine individual health and social needs.

Special mention must be made of the impact of failing functional status in terms of increasing risk to seniors for poor health outcomes and decline in the quality of their lives. Gauging functional status is complex and difficult. Changes in functional status are often gradual, nuanced and subtle. Change in functional status is rarely adequately documented in medical records. In-person assessment by a competent professional is extremely important and should be a core aspect of a comprehensive initial assessment and all periodic monitoring.

"You really need to see people and have a conversation about their lives."

"Body language, eye contact, general hygiene—the whole slew of human interaction."

For additional background on the suggested process, the reader is referred to the full study on this topic, **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review** http://www.vmsfoundation.org/elders/atrisk

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, substance use and the presence or absence of healty behaviors (diet, exercise and tobacco use) 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 (ADLs) and instrumental activities of daily living (IADLs), 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 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 should be considered.

For additional background on measurement, the reader is referred to the sections of how care models are evaluated in the literature search study **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review** http://www.vmsfoundation.org/elders/atrisk

3. **How will we care for them?**
We propose redesigning care with the goal of providing healthcare when and where patients need it. The proposed redesign will support collaboration between healthcare and community services. 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 practice nurse, the practice's integrated care coordinator and the patient and/or their caregiver. The comprehensive assessment will evaluate and consider clinical

status, functional status, medical history, social history, knowledge of healthy behaviors (diet, exercise and tobacco use), mental health and substance use, social service needs, and long-term service and support needs.

The assessment will include a visit to the patient's home and a discussion of needed home-based services to support independence.

"It always helps for someone to see the home environment, even it's not the doctor. You can order a safety evaluation from home health. But it would be good if someone from the practice could go in and see. You get all kinds of clues from seeing them at home that you don't get when they're in the clinic."

Outside of the practice, but including the key representatives of the practice team, will be a Neighborhood Team. The Neighborhood Team will include representatives of appropriate community support and service providers with the patient and family's consent, such the Senior Center, Senior Meals, clergy, Support and Service at Home and the Area Agency on Aging. The patient and their caregivers are central members of both teams. The Neighborhood Team will support health and well-being in its broadest sense, addressing the seniors' need for socializing, exercise, food security, transportation, and access to state and community programs. The Neighborhood Team will meet with sufficient frequency to review new and emergency cases as well as periodic reviews of all high risk seniors in the community. Patients and families will always be able choose not to have their Care Plans discussed outside of the practice; their privacy concerns will be respected. The Practice Care Coordinator will be the principal contact between the Practice Team and appropriate community support providers represented on the Neighborhood Team.

The cohort of identified patients is given a special status in the practice, e.g. "The Gold Team" Identified hi-risk seniors will receive priority same-day appointments, home visits by PCP, office nurse and care coordinator, 24/7 access to phone assistance by someone who knows their special "Gold Team" status. We envision group medical visits for those who are able and comfortable with the format. Group visits may include community resource representatives as well as Practice Team members. Gold Team membership will hopefully promote a sense of having a special place in the practice and foster a sense of a community group. It may also raise community awareness of the program. These enhanced services are likely to decrease inappropriate calls to 911 and unnecessary hospitalizations

The Primary Care Team will work with seniors to develop their individualized Care Plan. Care Plans may include Advanced Directives and Vermont DNR/COLST form (a document that conveys patients' wishes for CPR, intubation, transfer to the hospital, antibiotics, artificial nutrition and hydration, as well as overall treatment goals).

Care Plans will include specific, personal and individualized information on life and health goals, such as, avoiding hospitalization, dying at home or making it to a granddaughter's wedding. They will include a list of people the patient and caregivers should feel free to call if needing

help or not feeling well (to avoid getting sicker due to "not wanting to trouble anyone"), e.g. friend, family, visiting nurse and the name and contact information for their primary care practitioner. Care Plans will include personal goals, e.g. what the patient agree to work on, exercising or socializing for example.

The Primary Care and Neighborhood teams will work to support the Care Plans. Both teams will encourage as much home based care as possible, with visits from the practice team members and involved community support services. Patients should be encouraged to have their Care Plans conveniently accessible to community care givers. All appropriate community service and clinical providers should have a copy with appropriate patient consent. Regular meetings including members from both teams will occur to review Care Plans in an effort to increase communication and ensure that all involved parties are aware of the patient's goals.

"What we really need most is more basic support—aides, housekeepers, someone to help with bathing, dressing, socializing, shopping, shoveling the walk."

The potential for creating a new community resource, community paramedicine, was mentioned in the provider interviews and identified in the literature search. Paramedicine is an evolving concept building on our current EMT system, in which specially trained EMTS provide home visits for some services, such as wound care and vital signs checks - "paramedicine programs aim to address critical problems in local delivery systems, such as insufficient primary and chronic care resources, overburdened EDs, and costly, fragmented emergency and urgent care networks". Despite growing enthusiasm for these programs, however, their performance has rarely been rigorously evaluated, and they raise important questions about training, oversight, care coordination, and value."[1]

Interviews with providers highlighted two related innovative programs building on the current EMS system in the two target PCSA's[2]. These Informants identified two programs that currently provide some home-based services to residents of some towns in the Gifford and Little Rivers PCSAs.

- Upper Valley Ambulance Service's Home-Sweet-Home Home-Safe Home program provides free home safety and injury prevention assessments.
  http://www.uppervalleyambulance.com/site/services/home-sweet-home-home-safe-home/
- First Branch Ambulance, through its grant-funded House Calls Program, does bandage changes and lab draws as well as blood pressure and glucose checks for patients who are unable to get to the clinic, follows up on ER visits, organizes medications, and does home safety assessments. http://www.firstbranchambulance.com/house-calls.html

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[1] Community Paramedicine n engl j med 374;12 nejm.org March 24, 2016 Community Paramedicine Community Paramedicine — Addressing Questions as Programs Expand Lisa I. Iezzoni, M.D., Stephen C. Dorner, M.Sc., and Toyin Ajayi, M.B., B.S.n engl j med 374;12 nejm.org March 24, 2016

[2] Caring for Seniors: An interview Study http://www.vmsfoundation.org/elders/caring pg. 19

Another recommendation from the provider interviews and the literature review is exploring the concept of community nurses (formerly known as parish nurses in the last century) as an additional community resource to complement the primary care team and be a member of the neighborhood team. Typically, community nurses are RNs who are based in the community and unaffiliated with a primary care practice. They are not care providers; rather, at no cost to patients, they can help patients to navigate the health care system, assess home safety, provide medication education and organization, and connect people to resources in their communities. Informants noted that there are community nurses in Thetford and Hartland, and preliminary conversations about feasibility have occurred in Bradford. Both community paramedicine and community nursing are examples of redesigns that bring care to patients in the home, and could easily be included in the Primary Care Team model.

A third layer of community coordination are periodic meetings of representatives of both practice and community partners involved with staffing the Neighborhood Team to review and discuss the adequacy of the overall needs of the community's seniors and available local, state and federal resources. These meetings will serve as a basis for community advocacy on behalf of their seniors for redress of mismatches between community needs and available resources.

In summary, we propose practice redesign that stresses collaboration and communication between community and health care resources, places priority on the patients' own wishes, and increases capacity to deliver services to the patients when and where they need it.
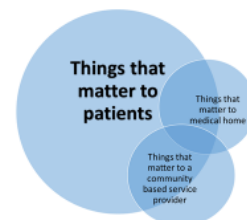
For the basis of the care model recommendations, the reader is referred to the interview study with direct care providers and subject matter experts **Caring for Seniors: An interview Study** http://www.vmsfoundation.org/elders/caring ; as well as the Care Models section of the literature search **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review**   http://www.vmsfoundation.org/elders/atrisk

4.   How will we pay for their care?

While the design of a financing system must follow design of a delivery system, financing can have a strong effect on all aspects of system performance, including patient and provider satisfaction, quality of care, and value. We recommend that the payment model be focused first and foremost on addressing what matters to the patient. Evidence shows that what patients want is not always reflected in the current health care system. For example, a patient may rank staying in her home above her functional status.

VHCIP Frail Elders Project

Risk and Accountability?

Things that matter to patients

Things that matter to medical home

Things that matter to a community based service provider

It should recognize the risk of patients being cared for, in a more comprehensive way than current risk-adjustment methodologies do.

"We just need more time" was a common refrain in the interviews. A physician summed it up this way: "The big issue is time. Mine, other providers, nurses. Whether it's my time to do home visits, then call the daughter, have thoughtful communications with a given patient. Or time for a home health nurse to dress a wound, cut toenails, be in the home, call the doctor, fill out a thousand pieces of paper. It's a system-wide issue. It's a huge barrier. If the system wants to avoid ER visits, avoid falls, hospitalizations, ideally primary care providers would have plenty of time to field phone calls, see patients acutely, do home visits, and see people before they get sick to cut down more costly services."

It should hold the care organization accountable, but only for the outcomes that are within its control. One way of thinking about risk in health care is to divide it into three types – patient choices, provider choices, and the unpredictable ("insurance risk"). While the care organizations that would develop under this model should be accountable for the consequences of its own choices, they should not be held accountable for the actual cost of major health events that would be expected in a typical group of high-risk elders. However, ways should be explored to identify and reward reductions in the rate of those events below expected.

It should permit the use and coordination of a broad range of services, both medical and social. There is an increasing body of evidence that appropriate use of social services can reduce the need for higher-cost medical interventions.

"We need to refocus on keeping people well through payment reform, and change metrics and dynamics so dollars can be spent on transportation, the elder care [mental health] clinician program, senior meals. Focus on social determinants of health rather than within the walls of the hospital. This is smart health care spending."

Several funding mechanisms are in operation in the US and Canada that support parts of the recommended care model. None of them support all the components of the recommended model nor do many of them cast a wide enough net to capture all the high risk seniors in our rural communities. Two programs are presented below to highlight key issues: 1) The Commonwealth Health Alliance's Senior Options Program; and, 2) the CMS demonstration project, Independence at Home. We are highlighting these two programs because they are in operation presently, demonstrate remarkable success in delivering care in a manner that matters to seniors and illustrate the potential for innovative care models and payment policy. The reader should be cautioned that eligibility for both these programs is directed at seniors with either the most limited financial resources or a very high need of clinical care. If these programs were to be implemented as is in the two target Vermont communities, many seniors would be left out. However, elements of both these programs, if adapted to address the needs of Vermont's high-risk seniors, would be an improvement over the status quo.

The Commonwealth Care Alliance Senior Options Program
http://commonwealthcaresco.org/
Traditional Medicare FFS part B does not have the flexibility of payment methodologies to support our recommended care model. However, alternative payment models exist that provide

this flexibility. One example is a Medicare Advantage Special Needs Plan. This program allows a private company to contract with Medicare and then provide all Part A and B benefits to its members as well as enhanced benefits such as vision and dental services. In the case of Special Needs Plans they may limit membership to those with specific chronic and disabling conditions such as heart failure and diabetes. The specific list of conditions covered is likely to encompass all at-risk elders and allow eligibility. The plan can provide coverage for all services within the recommended care model in addition to other services such as care coordination.

"If they don't come in [to the office], then it's too late and things are already happening. We're not sure why they're not coming in, if it's money or transportation or what. We've talked about how good it would be if nursing staff could go out to homes and do an assessment and also find out if people can make it to the office or does the doctor need to go to their home. But insurance doesn't pay for nurses to make home visits."

The Commonwealth Care Alliance Senior Options Program is a coordinated care plan which is a successful example of a Medicare Advantage Special Needs Plan. The plan provides many of the aspects of the recommended care model as part of their routine care. In addition members receive vision and dental coverage (including dentures), person to person comprehensive medication reviews with a pharmacist, coverage for home health services and also health related services such as personal care attendant services and homemaker/chore services. The plan has been in existence for many years and is highly rated by the Medicare quality rating system (4.5 out of 5 stars).

The Independence at Home Project

https://innovation.cms.gov/initiatives/independence-at-home/

The Independence at Home demonstration is a project of the CMS Innovation Center and currently has 14 participating sites in the United States. The project supports the delivery of comprehensive primary care services at home for Medicare beneficiaries with multiple chronic conditions. Practices were measured on multiple quality measures and if they exceeded minimum quality thresholds were eligible for shared savings through the payment model. The practices had to have experience caring for patients with multiple chronic conditions and serve at least 200 eligible beneficiaries. The primary care teams also include physician assistants, pharmacists, social workers, and other staff.

The CMS analysis found that Independence at Home participants saved over $25 million in the demonstration's first performance year – an average of $3,070 per participating beneficiary – while delivering high quality patient care in the home. Patients who participated in the project had on average:

- Fewer hospital readmissions within 30 days;
- Follow-up contact from their provider within 48 hours of a hospital admission, hospital discharge, or emergency department visit;
- Have their medications identified by their provider within 48 hours of discharge from the hospital;

- Have their preferences documented by their provider; and
- Use inpatient hospital and emergency department services less for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection.

The total shared savings practices received at the end of year one of the project as of June 2015 were $11,668,023.

One step further might be a monthly bundled risk adjusted population health payment for this subset of patients with incentive based on outcomes important to patients within a larger all payer model system as might be conceived in Vermont in the near future. This model would be unique to Vermont as part of the larger Medicare waiver program and administered by the accountable care organizations.

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.

For additional background on payment of innovative care models for seniors, the reader is referred to the sections on care models in the literature search study- **Who are Frail and High-Risk Seniors and What Models of Care Support Them? A Literature Review**
http://www.vmsfoundation.org/elders/atrisk

Conclusions

The Project Recommendations are all based on what Vermonters told the Research Team or can be found in the existing peer reviewed literature. These Vermont voices are rural seniors and their caregivers, rural community medical and support service providers and Vermont content experts.

The Findings of the Project capture what was shared and learned. The Project Findings are at least as important as the Recommendations in that they collectively offer a set of very defensible goals for health care reform and expansion of support services in our rural communities. Nine themes are consistent across the 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. Personal finances matter; and many seniors get caught "in the middle" between eligibility for public support and sufficient personal resources;
4. Physical health matters to seniors, but remaining at home, retaining autonomy, social engagement and feeling useful and valued matter at least as much;
5. When possible, care should go to patients rather than patients having to come to care;
6. Control over health care budgets needs more community level influence;

7. Primary care is in critical condition, and we all need to rethink how to support it;
8. There are proven examples of how to do it better; and
9. There is a lot that can be done right now!

The Research Team took care to be as objective as possible in promulgating the Recommendations. That being the case, some subjectivity is unavoidable. The Recommendations represent our sincere effort to make practical suggestions to improve the care of the seniors in at least the two targeted rural communities. Adding to the credibility of the recommendations is that the membership of the Team includes three primary care physicians who practiced in both the target communities for many years.

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; and can be expanded to other special populations of Vermonters and other community based primary care settings.

The Recommendations are also offered with the hope that, if implemented, some of the stress on our rural primary care practices will be eased through increased practice efficiencies, replacing current documentation requirements with more meaningful and transparent measurement and increasing professional satisfaction and joy in the workplace.

Since the initial discussions in 2012 that evolved into the Frail Elders Project, the underlying impetus for the effort has always been to improve the primary care delivery system in Vermont. 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. All those who have been part of the effort have hoped for broad impact. They want 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. And with the hope of taking a small step towards setting right what's wrong with primary care in the State.

Attachment 5: SIM Sustainability Timeline and Scope of Work

VHCIP Performance Period 3 Timeline

Performance Period 3
July 2016-June 2017

PP3 Carryover
July 2017-Nov 2017

July 2016 | Aug 2016 | Sept 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 | March 2017 | April 2017 | May 2017 | June 2017 | July 2017 | Aug 2017 | Sept 2017 | Oct 2017 | Nov 2017

Performance Period 3 Begins

Mid-Performance Period 3
- VHCIP Work Groups wrap up
- Most SIM activities conclude
- Majority of SIM staff positions end

Spring 2017
- Remaining SIM activities conclude

Performance Period 3 Ends
- Sustainability Plan due
- Population Health Plan due

SIM Closeout
- Final program and financial reporting
- Final staff positions end or transition (Oct-Nov 2017)

Vermont Health Care Innovation Project.

Sustainability Plan Review

Performance Period 3
July 2016-June 2017

Timeline (left to right): July 2016, Aug 2016, Sept 2016, Oct 2016, Nov 2016, Dec 2016, Jan 2017, Feb 2017, Mar 2017, April 2017, May 2017, June 2017, July 2017

Performance Period 3 Begins

Sustainability Plan Outline Due

Draft Sustainability Plan Reviewed by Work Groups and Presented to Steering Committee

Second Draft Sustainability Plan Due

Sustainability Plan Submitted to CMMI by 6/30/17

Advisory Group Convened

Contractor: Scope of Work

- **Project Management**

- **Perform Background Research; Kick-Off Meeting; Goals/Priority Identification**

- **Advisory Group:** The Contractor shall convene this group at least once a month from August 2016- January 2017.

- **Incorporate Feedback**

- **Outline:** 9/15/16.

- **Draft Sustainability Plan:** 11/15/16.

- **2nd Draft Sustainability Plan:** 3/31/17.

Contractor: Scope of Work cont.

- **Stakeholder Engagement:**
  - Monthly Sustainability Plan updates to the Core Team in writing and participate, as requested, in SIM Core Team meetings.
  - The Contractor shall also participate in Steering Committee meetings as requested.
  - The Contractor will also make available a survey tool to collect virtual feedback from additional stakeholders (including steering committee and the Contractor will engage in targeted follow-up interviews to ensure feedback is appropriately incorporated.
- **Final Sustainability Plan:** 6/15/17.