VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda
Monday, July 11, 2016 1:00 PM – 3:00 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202 Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00-1:05	Welcome and Introductions; Approve meeting minutes	Cathy Fulton, Andrew Garland	Y – Approve minutes	Attachment 1: June Meeting Minutes
2	1:05-1:10	Program Updates • New Staff Introduction • Performance Period 3 Approval	Alicia Cooper, Georgia Maheras	N	
3	1:10-2:00	ACH Peer Learning Lab Presentation	Heidi Klein	N	Attachment 3: ACH Presentation
4	2:00-2:50	Medicaid Pathway Presentation	Selina Hickman, Michael Costa	N	
5	2:50-2:55	Public Comment	Cathy Fulton, Andrew Garland	N	
6	2:55-3:00	Next Steps and Action Items	Cathy Fulton, Andrew Garland	N	

Attachment 1: June Meeting Minutes

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

Pending Work Group Approval

Date of meeting: Monday, June 20, 2016, 1:00-2:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Andrew Garland called the meeting to order at 1:02pm. A roll call attendance was taken and a quorum was present. Susan Aranoff moved to approve the May 2016 meeting minutes by exception. Mike Hall seconded. The minutes were approved with one abstention (Ed Paquin).	
2. Program Updates	*ACH Peer Learning Lab:* Sarah Kinsler provided a brief update. The Accountable Communities for Health (ACH) Peer Learning Lab is a peer learning opportunity for communities interested in learning more about the ACH model and expanding capacity to meet core elements of the model; it is also an opportunity for the State to learn about how we can support communities in working toward this aspirational model. Ten Vermont communities are participating. The first Peer Learning Lab convening was held of 6/7; the first webinar is this week and will be archived on the VHCIP website. There will be a second convening in September, and a final convening in January. Participating communities are working with local facilitators (either contractors or volunteer members of community teams) through January. *PMDI Workplan Highlights:* Alicia Cooper provided a brief overview of remaining activities planned for the work group's remaining meetings; work group activities wrap up in June. Future meetings topics include the Medicaid Pathway and an in-depth ACH Peer Learning Lab update (July); Year 2 Medicaid and commercial SSP results (September); SIM Population Health Plan and all-payer model update (October); SIM Sustainability Plan (November); closing session (December).	
3. Vermont Collaborative Care	Andrew Garland introduced Dr. Josh Plavin and Peter Albert, presenting on Vermont Collaborative Care (Att. 3). • Vermont Collaborative Care is a partnership between BCBSVT and Brattleboro retreat. BCBSVT believes this partnership is unique nationally. This project began in April 2015. • BCBSVT analyses demonstrated that utilization and cost for mental health (MH) and substance abuse (SA) were focused within key population segments and diagnosis categories. BCBSVT identified key barriers to integration and worked proactively to train staff and otherwise address issues. Integrated Clinical Advisory	

Agenda Item	Discussion	Next Steps
	group has resulted in significant engagement; integrated training model includes practicing clinicians from a variety of disciplines. • BCBSVT is seeing significant results following increased integration, reduction of barriers to MH/SA care (including both inpatient days and regular outpatient care), investment in proactive treatment (rather than emergency treatment), increased focus on care transitions and after-care at discharge. • Working with Harvard Business School health outcomes measurement group. Worked with Vermont providers to identify measures of interest. • Engaging community providers to pay for clinicians on call to prevent unnecessary hospital admissions when patients present in ED. Supporting community consultation groups that give providers CEUs. The group discussed the following: • BCBSVT has not expanded CPT code office visit length. • This project is connected with UVM PCORI grant for improving clinical care integration. UVM has a diagnostic for measuring care integration and is doing a great deal of work on patient-reported outcomes, especially resiliency and well-being. • How did this project increase access to outpatient services, especially for people with comorbidities? VCC looked at administrative barriers, especially pre-authorization. It has also worked to connect people with case management upon discharge to increase connection to community providers and outpatient care. Outreach through primary care has been focused on SBIRT and integrated clinical advisory group. Julie Tessler suggested working with primary care providers to increase referrals to MH and SA. This work has focused on changing payment methodologies to encourage this. • Susan Aranoff suggested reviewing Connecticut Department of Mental Health & Addiction Services projects that may be relevant; Sue will follow up with presenters directly.	
4. Frail Elders Project	Dr. Cy Jordan of the Vermont Medical Society Foundation introduced the Frail Elders Project. • Frail Elders Project Website: www.vmsfoundation.org/elders • Collaboration with Gifford and Little Rivers Health Center. • Project team includes practicing clinicians, qualitative (literature review and interviews/focus groups) and quantitative researchers, practice facilitators/medical home experts. • Target population is high-risk seniors – including “pre-frail” elders. • Project team identified key questions and outcomes prior to project launch. • Care model: o Patient example – patient needed a quick home visit from a trusted person to take vital signs and do a brief assessment, rather than long ED visit and significant medical intervention, but medical system and payment aren’t flexible enough for this. Strengthening medical home, medical neighborhood, patient-centered care planning are key pieces of care model. o Providers are constrained by shortening visit times, increased reporting requirements, lack of reimbursement for provider home visits, lack of coordination with VNA or HH.	

Agenda Item	Discussion	Next Steps
	o Patient preference is a key factor – patients may prefer staying in their homes to increased functional status. Project team investigated relevant projects of interest – Commonwealth Care Alliance (demonstrated improvements), CMS Independence at Home demonstration (demonstrated savings), CMMI Comprehensive Primary Care Initiative (did not demonstrate savings in initial years; analysis indicates fell short of full transformation – CPC+ is the next step in this program). Evidence indicates that shifting payments is not enough, but shifting the way care is delivered is effective and saves money. Medicare Advantage plans include significant flexibility to allow for these reforms. o Some tools/principles identified through this process, including care planning that includes patient-specific goals. • Additional information on care models and recommendations are available on the project website. • Georgia Maheras reminded the group that this project is a first step. This team was not tasked with identifying a solution or a pilot project, but the State and others can gather key takeaways from this project. o The key takeaway across sectors was a focus on what matters to patients, including factors that are not part of their physical health.	
5. Public Comment	There was no additional comment.	
6. Next Steps, and Action Items	**Next Meeting:** Monday, July 18, 2016, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston	

VHCIP Payment Model Design and Inplementation Work Group Member List

minutes Sept 0 Mikkall 20 motion carried; 1 abstention

20-Jun-16

Member		Member Alternate			
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓	~~Gabe~~	~~Epstein~~		AHS - DAIL
		Bard	Hill		AHS - DAIL
		Patricia	Cummings		AHS - DAIL
Melissa	Bailey ✓	Shannon	Thompson		AHS - DMH
		Jaskanwar	Batra		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
		Frank	Reed		AHS - DMH
Abe	Berman ✓	Miriam	Sheehey		OneCare Vermont
		Sara	Barry		OneCare Vermont
		Vicki	Loner		OneCare Vermont
Jill Berry	Bowen	Stephanie	Breault		Northwestern Medical Center
		Jane	Catton		Northwestern Medical Center
DeVin Joy	Satcheldeen ✓ SCHECTER	Lou	Longo		Northwestern Medical Center
		Don	Shook		Northwestern Medical Center
Peter	Cobb	Beverly	Boget		VNAs of Vermont
Michael	Counter				VNA & Hospice of VT & NH
Diane	Cummings ✓	Shawn	Skafelstad ✓		AHS - Central Office
Mike	DelTrecco	Jill	Olson		Vermont Association of Hospital and Health Systems
Tracy	Dolan ✓	Heidi	Klein		AHS - VDH
		Cindy	Thomas		AHS - VDH
		Julie	Arel		AHS - VDH
Rick	Dooley ✓	Susan	Ridzon		HealthFirst
		Paul	Reiss		HealthFirst

VHCIP Payment Model Design and Inplementation Work Group Member List

minutes

Member		Member Alternate			20-Jun-16
First Name	Last Name	First Name	Last Name		Organization
Kim	Fitzgerald	Stefani	Hartsfield		Cathedral Square and SASH Program
		Molly	Dugan ✓		Cathedral Square and SASH Program
Aaron	French	Erin	Carmichael		AHS - DVHA
		Nancy	Hogue		AHS - DVHA
		Megan	Mitchell ✓		AHS - DVHA
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Steve	Gordon ✓	Mark	Burke		Brattleboro Memorial Hopsital
Maura	Graff ✓	Heather	Bushey		Planned Parenthood of Northern New England
Dale	Hackett ✓				Consumer Representative
Mike	Hall ✓	Sandy	Conrad		Champlain Valley Area Agency on Aging / COVE
		Angela	Smith-Dieng		V4A
Paul	Harrington ✓				Vermont Medical Society
Karen	Hein ✓				University of Vermont
Jeanne	Hutchins				UVM Center on Aging
Kelly	Lange ✓	Teresa	Voci		Blue Cross Blue Shield of Vermont
Ted	Mable	Kim	McClellan ✓		DA - Northwest Counseling and Support Services
David	Martini ✓				AOA - DFR
Chris	Smith				MVP Health Care

VHCIP Payment Model Design and Inplementation Work Group Member List

Member		Member Alternate		minutes	20-Jun-16
First Name	Last Name	First Name	Last Name		Organization
MaryKate	Mohlman	Jenney	Samuelson		AHS - DVHA - Blueprint
Ed	Paquin ✓			A	Disability Rights Vermont
Lila	Richardson ✓	Kaili	Kuiper		VLA/Health Care Advocate Project
Laural	Ruggles ✓				Northeastern Vermont Regional Hospital
Julia	Shaw ✓	Rachel	Seelig		VLA/Health Care Advocate Project
Kate	Simmons	Kendall	West		Bi-State Primary Care/CHAC
		Patricia	Launer		Bi-State Primary Care
		Melissa	Miles		Bi-State Primary Care
		Heather	Skeels		Bi-State Primary Care
Pat	Jones ✓				GMCB
Julie	Tessler ✓	Sandy	McGuire		VCP - Vermont Council of Developmental and Mental Health Services
	29		32		

QV

Jim Hester
Mike Nix
Carrie Germaine
Michael Bailit

Steve Kappel
Erin Mansfield

Cy Jordan
Randy Messier
~~Nancy Bianchi~~
Fay Homan
Milt Fowler
Erica Garfin

} Frail Elders Project

	Meeting Name:	VHCIP PMDI Work Group Meeting	
	Date of Meeting:	June 20, 2016	
	First Name	Last Name	
1	Peter	Albert	here
2	Susan	Aranoff	here
3	Julie	Arel	
4	Bill	Ashe	
5	Lori	Augustyniak	
6	Devin	Bachelder	phone
7	Ena	Backus	
8	Melissa	Bailey	phone
9	Michael	Bailit	phone
10	Susan	Barrett	
11	Sara	Barry	
12	Jaskanwar	Batra	
13	Abe	Berman	phone
14	Bob	Bick	
15	Charlie	Biss	
16	Beverly	Boget	
17	Mary Lou	Bolt	
18	Jill Berry	Bowen	
19	Stephanie	Breault	
20	Martha	Buck	
21	Mark	Burke	
22	Donna	Burkett	
23	Heather	Bushey	
24	Gisele	Carbonneau	

25	Erin	Carmichael	
26	Jan	Carney	
27	Denise	Carpenter	
28	Jane	Catton	
29	Alysia	Chapman	
30	Joshua	Cheney	
31	Joy	Chilton	
32	Barbara	Cimaglio	
33	Daljit	Clark	
34	Sarah	Clark	
35	Peter	Cobb	
36	Judy	Cohen	
37	Lori	Collins	
38	Connie	Colman	
39	Sandy	Conrad	
40	Amy	Coonradt	here
41	Alicia	Cooper	here
42	Janet	Corrigan	
43	Brian	Costello	here
44	Michael	Counter	
45	Mark	Craig	
46	Patricia	Cummings	
47	Diane	Cummings	phone
48	Michael	Curtis	
49	Jude	Daye	
50	Jesse	de la Rosa	
51	Danielle	Delong	

52	Mike	DelTrecco	
53	Yvonne	DePalma	
54	Trey	Dobson	
55	Tracy	Dolan	phone
56	Kevin	Donovan	
57	Rick	Dooley	here
58	Molly	Dugan	phone
59	Lisa	Dulsky Watkins	
60	Robin	Edelman	
61	Jennifer	Egelhof	
62	Suratha	Elango	
63	Jamie	Fisher	
64	Kim	Fitzgerald	
65	Katie	Fitzpatrick	
66	Patrick	Flood	
67	Erin	Flynn	here
68	Judith	Franz	
69	Mary	Fredette	
70	Aaron	French	
71	Catherine	Fulton	here
72	Joyce	Gallimore	
73	Lucie	Garand	
74	Andrew	Garland	here
75	Christine	Geiler	
76	Carrie	Germaine	phone
77	Al	Gobeille	
78	Steve	Gordon	here

79	Don	Grabowski	
80	Maura	Graff	here
81	Wendy	Grant	
82	Lynn	Guillett	
83	Dale	Hackett	phone
84	Mike	Hall	here
85	Catherine	Hamilton	
86	Paul	Harrington	here
87	Stefani	Hartsfield	
88	Carrie	Hathaway	
89	Carolynn	Hatin	
90	Karen	Hein	phone
91	Kathleen	Hentcy	
92	Jim	Hester	phone
93	Selina	Hickman	
94	Bard	Hill	
95	Con	Hogan	
96	Nancy	Hogue	
97	Jeanne	Hutchins	
98	Penrose	Jackson	
99	Craig	Jones	
100	Pat	Jones	
101	Margaret	Joyal	
102	Joelle	Judge	here
103	Kevin	Kelley	
104	Melissa	Kelly	
105	Trinka	Kerr	

106	Sarah	King	
107	Sarah	Kinsler	here
108	Heidi	Klein	
109	Tony	Kramer	
110	Kaili	Kuiper	
111	Norma	LaBounty	
112	Andrew	Laing	
113	Kelly	Lange	phone
114	Dion	LaShay	
115	Patricia	Launer	
116	Mark	Levine	
117	Lyne	Limoges	
118	Deborah	Lisi-Baker	
119	Sam	Liss	
120	Vicki	Loner	
121	Lou	Longo	
122	Nicole	Lukas	here
123	Ted	Mable	
124	Carole	Magoffin	here
125	Georgia	Maheras	here
126	Jackie	Majoros	
127	Carol	Maloney	
128	David	Martini	here
129	James	Mauro	
130	Lisa	Maynes	
131	Kim	McClellan	none
132	Sandy	McGuire	

133	Darcy	McPherson	
134	Anneke	Merritt	
135	Melissa	Miles	
136	Robin	Miller	
137	Megan	Mitchell	here
138	MaryKate	Mohlman	
139	Madeleine	Mongan	
140	Kirsten	Murphy	
141	Chuck	Myers	
142	Nick	Nichols	
143	Mike	Nix	here
144	Jill	Olson	
145	Miki	Olszewski	
146	Jessica	Oski	
147	Ed	Paquin	here
148	Annie	Paumgarten	here
149	Eileen	Peltier	
150	John	Pierce	
151	Tom	Pitts	
152	Joshua	Plavin	here
153	Luann	Poirer	
154	Sherry	Pontbriand	
155	Alex	Potter	
156	Betty	Rambur	
157	Allan	Ramsay	
158	Frank	Reed	
159	Paul	Reiss	

160	Sarah	Relk	
161	Virginia	Renfrew	
162	Lila	Richardson	Phone
163	Susan	Ridzon	
164	Brita	Roy	
165	Laural	Ruggles	Phone
166	Jenney	Samuelson	
167	Suzanne	Santarcangelo	
168	Howard	Schapiro	
169	seashre@msn.com	seashre@msn.com	
170	Rachel	Seelig	
171	Susan	Shane	
172	Julia	Shaw	here
173	Melanie	Sheehan	
174	Miriam	Sheehey	
175	Don	Shook	
176	Kate	Simmons	
177	Colleen	Sinon	
178	Shawn	Skafelstad	here
179	Heather	Skeels	
180	Chris	Smith	
181	Angela	Smith-Dieng	
182	Jeremy	Ste. Marie	
183	Holly	Stone	
184	Jennifer	Stratton	
185	Beth	Tanzman	
186	JoEllen	Tarallo-Falk	

187	Julie	Tessler	here
188	Cindy	Thomas	
189	Shannon	Thompson	
190	Bob	Thorn	
191	Win	Turner	
192	Karen	Vastine	
193	Teresa	Voci	
194	Nathaniel	Waite	
195	Beth	Waldman	
196	Marlys	Waller	
197	Nancy	Warner	
198	Julie	Wasserman	here
199	Kendall	West	
200	James	Westrich	here
201	Robert	Wheeler	
202	Jason	Williams	
203	Sharon	Winn	
204	Stephanie	Winters	
205	Hillary	Wolfley	
206	David	Yacovone	
207	Erin	Zink	
208	Marie	Zura	

Attachment 3: ACH Presentation

VT Accountable Community for Health

Linking Clinical Care and Community Wide Prevention to Improve Health Outcomes

Building a High-Performing Health System for Vermont

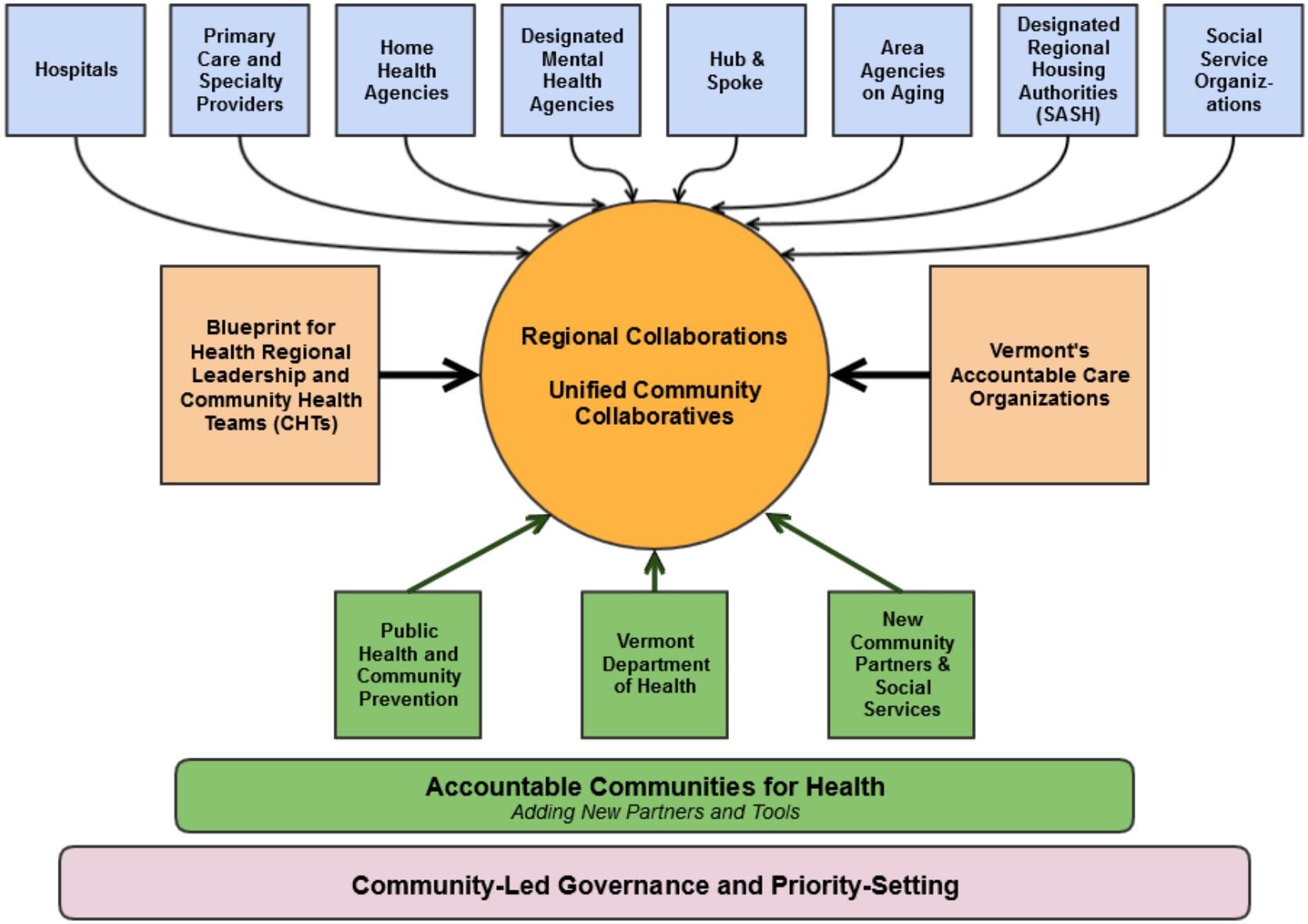
Big Goal:
Integrated Health System able to achieve the Triple Aim

All-Payer Model (Next Gen-type ACO):
- Way to pursue goal of integrated system for certain services and providers.
- Enables Medicare, Medicaid, and Commercial payers to align value-based payments for health care.

Medicaid Pathway:
- Way to pursue goal of integrated system for services and providers outside of All-Payer Model.
- Enables Medicaid to align value-based payment models with All-Payer and ACO design.

Complementary Delivery System Reform and Care Delivery Transformation Efforts, including…
- Blueprint for Health (multi-payer patient-centered medical homes)
- Community Health Teams (CHTs)
- CHT Extensions – Hub & Spoke, Support and Services at Home (SASH)
- Regional Governance (Unified Community Collaboratives)
- Provider Learning Collaboratives
- **Accountable Communities for Health**

Vermont: Regional Integration



Building Blocks for Population Health Improvement

Integrated Care Management	+	Unified Community Collaboratives	+	Accountable Communities for Health
How do we enhance team-based care for high risk individuals?		How do we improve the quality of care, integrate services and improve health outcomes?		How do we connect integrated services for individuals with community-wide prevention strategies?
Focus integrated care teams for **at-risk individuals**		Focus at **regional level on collaborative medical and social systems integration**		Focus on planning for **community-wide systems and strategies to improve population health outcomes across a geographic area**
Support for **design and implementation of cross-organization, team-based care**		Support for **design and implementation of cross-organization, team-based care and coordination of services**		Support for high-level **convening, planning, and community level environmental and policy changes to address social determinants**
Working with **organizational leadership and front-line care managers** from health and social service organizations		Working with **organizational leadership** from health and social service organizations		Working with **organizational leadership** from health and social service organizations, and community prevention partners

Accountable Community for Health

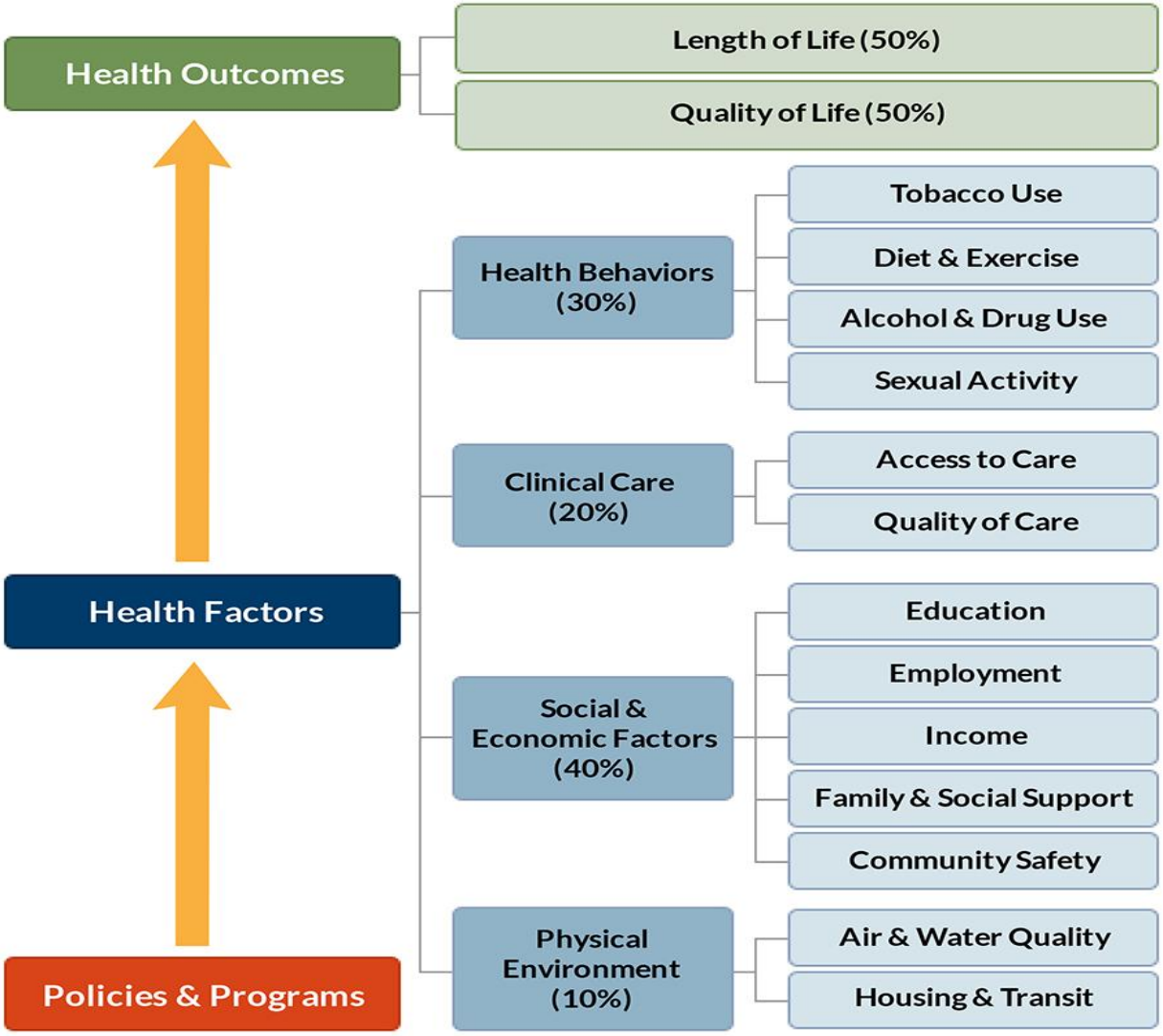
Key Elements for Exploration

What is an Accountable Community for Health?

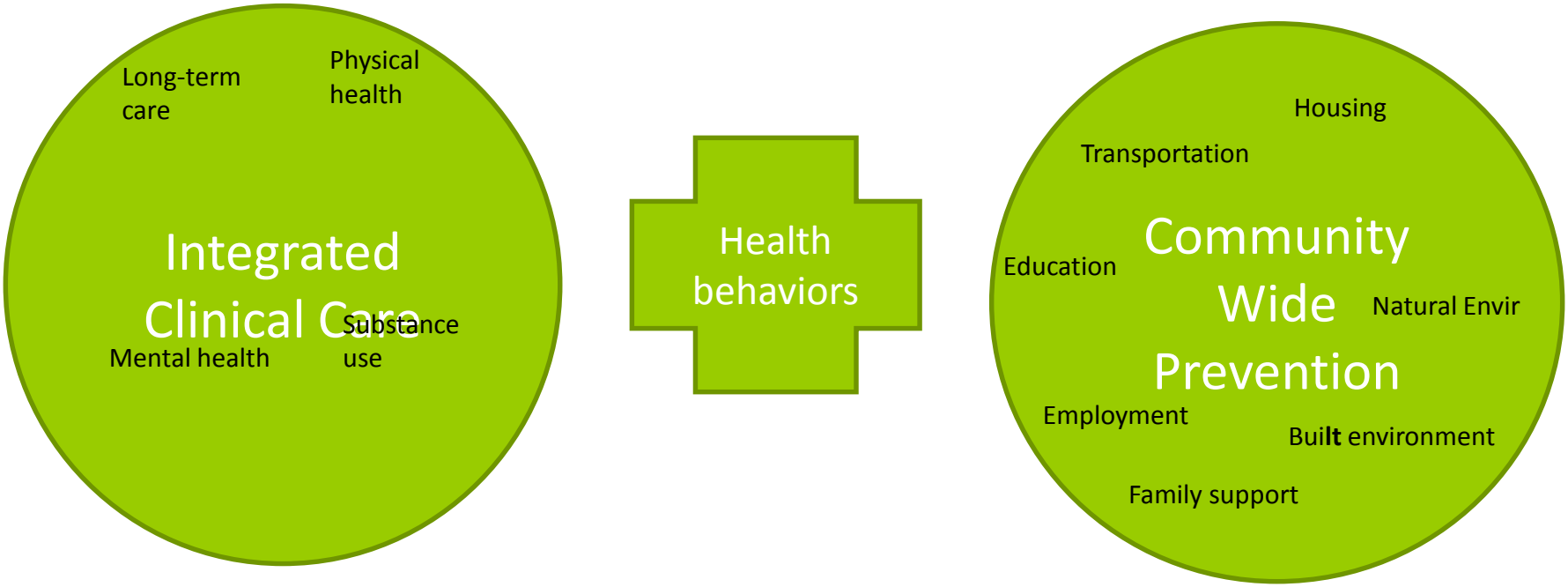
Accountable for the health and well-being of the entire population in its defined geographic area

Supports the integration of high-quality medical care, mental and behavioral health services, and social services for those in need of care

Supports community-wide prevention efforts to reduce disparities in the distribution of health and wellness.


Health Outcomes
Length of Life (50%)
Quality of Life (50%)
Health Factors
Health Behaviors (30%)
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Clinical Care (20%)
Access to Care
Quality of Care
Social & Economic Factors (40%)
Education
Employment
Income
Family & Social Support
Community Safety
Physical Environment (10%)
Air & Water Quality
Housing & Transit
Policies & Programs
County Health Rankings model © 2014 UWPHI

Systematic Clinical - Community Linkages



Core Elements of Vermont's ACH Model

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

Mission, Multi-Sectoral and Governance

- Building on the Unified Community Collaboratives in most communities
- Expanding to include public health and community prevention partners
- Broadening mission and governance

Data and Indicators -- DRAFT

	Measures of Accountability	Measure Sources
Clinical Care	NCQA, NQF, HEDIS	Clinical and Claims
Accountable Care Organizations	Select ACO quality measures	Clinical and Claims
Accountable Community for Health	Community-wide health outcomes Social determinants	Healthy Vermonters 2020 Community Health Needs Assessments
State Health and Well Being	State-level health outcomes Social determinants	State Health Improvement Plan (SHIP) Act 186 --Social Well Being of Vermonters

Three Levels of Strategy and Implementation

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

VERMONT
DEPARTMENT OF HEALTH

Strategies to Improve Developmental Screening Rates

The following table highlights evidence-based strategies and best practices to improve developmental screening rates in clinical and community settings.

ACO Measure: Core-8 (NCQA HEDIS): Developmental Screening in the First Three Years of Life
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life, that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Strategies
Patient education & tools • Adopt *Bright Futures* (i.e. pre-visit questionnaires, documentation, education handouts) • Educate families on developmental milestones • Establish a multidisciplinary team within your practice to implement universal developmental screening **Validated screening tool and protocol** • Review and identify a primary structured, validated developmental screening tool • Implement structured developmental screening using a validated tool at the 9, 18 and 30 month well visits • Implement developmental screening at other visits **Training and roles** • Ensure practitioners and staff are trained on accurate administration of screening tool • Identify and assign roles/responsibilities across the practice	**Parent/Family resources** • Increase parental education on early child development • Provide parents/caregivers with 2-1-1-phone number and encourage outreach to *Help Me Grow* (HMG) • Provide informational materials customized for specific audiences to increase knowledge of HMG resources • Provide information on community-based resources and education in support of early childhood development (e.g. parenting classes, library services) **Partnership building/referral resources** • Promote educational resources and materials with providers and partners (e.g. *Bright Futures*, Learn the Signs Act Early) • Outreach to community stakeholders (e.g. early care and education providers, CIS, schools) • Identify appropriate referral resources and capacity	**Help Me Grow** • Enhance utilization of *Help Me Grow* (HMG) by providers, families, and community resources • Collect feedback from HMG community stakeholders and families to improve service delivery **Quality improvement** • Integrate QI activities in support of universal developmental screening (i.e. medical home, early care and education, Unified Community Collaboratives) • Connect providers (medical home and early care and education) to VCHIP-supported quality improvement activities • Spread VCHIP's early care and education learning collaboratives by adding new regions each year **Improvements to the system of care** • Strengthen referral and evaluation systems at the community-level • Build relationships to improve communication and collaboration around referrals • Conduct a community-level gap analysis and needs assessment to identify levers to enhance the system of care

Financing and Sustaining ACHs in Vermont

- **Current:** ACH Peer Learning Lab is technical assistance to interested regions to facilitate visioning, provide an additional framework and set of tools, and engage a broader group of partners.

- **Future:**
  - State Level: All-Payer Model, Medicaid Pathway, and other care delivery transformation efforts.

  - Regional Level:
    - global budgets
    - non profit hospital community benefit
    - community development financial institutions
    - engagement with private sector
    - social impact bonds/pay for performance
    - community wellness fund

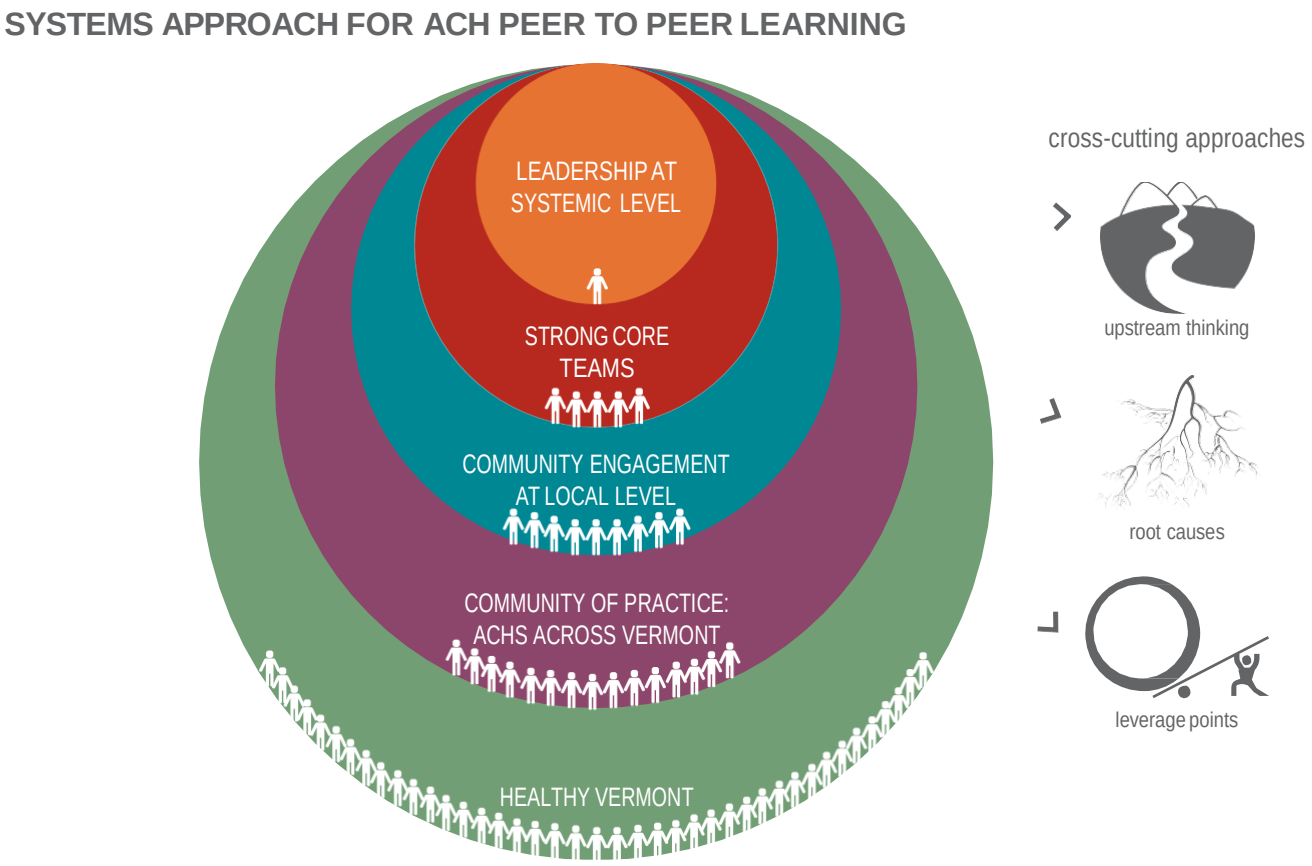
Accountable Communities for Health

Peer Learning Laboratory

Participating Communities

- Bennington
- Burlington
- Caledonia- Essex ACH (St. Johnsbury)
- Middlebury
- Newport
- Rutland
- Springfield
- St Albans
- Upper Valley
- Windsor

Peer Learning Lab Principles



Baseline Assessment

What do you hope to gain by participating in the learning lab?

Strategies for addressing population health	79.4%
Improved understanding of what an ACH is or can do	76.5%
Skills for addressing complex challenges	70.6%
Collaboration with members of my ACH site	73.5%
Improved communication at the statewide level	55.9%
Statewide alignment on ACH priorities	52.9%
Collaboration with members of other ACH sites	44.1%
Statewide alignment on ACH strategies	44.1%

Peer Learning Lab Design

Current Team Functioning

The core leadership team is: (Mark all that apply)		
	Response Percent	Response Count
Still being formed or identified	33.3%	11
Still learning about the ACH	48.5%	16
Struggling to work well together	6.1%	2
Working well together	30.3%	10
Making progress toward achieving its goals	24.2%	8

On-going Support

- ACH Website
- LinkedIn space for participants
- Local facilitation and monthly calls with presentations of what is happening on the ground
- Knowledge camps
  - ACH in WA and MN
  - ACH Financial Sustainability
  - Community Development 101

Vermont's ACH Implementation Challenges

- **Vermont is on the verge of transformative change** with All-Payer Waiver and Medicaid Pathway.
- **Health reform fatigue** and competing priorities at the community and provider levels.
- **Emphasis on local control** has resulted in significant variation across communities – a strength and a challenge!