VT Health Care Innovation Project
Core Team Meeting Agenda

July 28, 2015 10:00 am-11:00 pm
CONFERENCE CALL ONLY
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	10:00-10:05	Welcome and Chair's Report: a. Welcome to CMMI for Site Visit July 23rd and 24th b. Update on contract approvals	Lawrence Miller	
Core Team Processes and Procedures				
2	10:05-10:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: June 15, 2015 minutes *Decision needed.*
Policy Recommendations				
3	10:10-10:20	Consumer Representation Related to the Community Health Accountable Care ACO.	Steven Costantino	Attachment 3a: HCA Letter to DVHA Attachment 3b: CHAC response *Discussion item.*
Spending Recommendations				

4	10:20-10:50	Funding requests: a. *Patient Experience Survey Renewal (Datastat)* b. *ACO requests for funding:* i. *CHAC* ii. *OneCare*	Georgia Maheras	Attachment 4a: Financial request (ppt) Attachment 4b: Memo from G. Maheras Attachment 4c: CHAC request, questions asked, response to questions. Attachment 4d: OneCare request, questions asked, response to questions. *Decision needed*
7	10:50-10:55	*Public Comment*	Lawrence Miller	
8	10:55-11:00	Next Steps, Wrap-Up and Future Meeting Schedule: August 31st, 1-3pm, 312 Hurricane Lane, Williston	Lawrence Miller	

Attachment 2

Vermont Health Care Innovation Project

VT Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, June 15, 2015, 2:00pm – 2:45pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 2:00. A roll-call was taken and a quorum was present. **Chair's Report** There will be a project-wide convening on June 17th. The focus will be on the revised milestones for the project, with particular emphasis on how to implement them. Paul Bengston asked if there will be additional materials sent out - preparatory materials were sent out in the evening on Friday, June 12th. Invitations to the convening were sent to the Core Team, project staff, work group co-chairs, stakeholders, ACOs, VITL and the Health Care Advocate's office. **Update on negotiations with CMMI** Lawrence noted that project leadership is talking to CMMI daily with regard to approval of our pending Year 2 contracts. Submissions continue and documentation is being prepared again to divide the milestones into Year 1 and Year 2. Project leaders will be meeting with Commissioner Reardon and the CFO of AHS to discuss potential implication if the State does not receive approvals before the end of the state fiscal year. **OneCare Vermont Financial Request** Per the request of Susan Wehry and Paul Bengston at the last Core Team meeting, OneCare Vermont has provided additional information to support their proposal for additional funding in Year 2. This proposal, along with the one received from CHAC, will be discussed and voted on at the July 23rd Core Team meeting. Paul stated that he was also looking for exactly how much money was left in the overall SIM budget that could	

Agenda Item	Discussion	Next Steps
	be applied to the requests. Georgia stated that while all of the sub-grant program dollars are committed, the ACOs did not use that line item as a funding source last year. ACO funding came from three budget lines: • Quality measure • Practice transformation • Data quality Currently there are still some unallocated funds in each of these budget categories. There is approximately $2.2.M unallocated in the carryforward request that is also available for use by the Core Team. The total potential of $9M is available if larger appropriations are desired by the Core Team. With regard to these ACO funding requests, there are sufficient funds to support the requests in their entirety if the Core Team chooses to do so. Hal Cohen pointed out that in the OneCare budget there are a number of projects that appear to have overlap with what the SIM project is already doing. He asked how do we figure out what's redundant? The infrastructure costs appear to be high – in light of the potential of shared savings, at what point do we let go of funding? At the last Core Team meeting, Georgia was asked to identify those areas where there are existing projects (particularly in IT). That analysis is in progress and will be distributed well in advance of the July meeting. Additionally, the question of whether there will or will not be shared savings should be answered in July as that is when the data is expected to be available. Lastly, the Core Team will consider, philosophically, how long do we anticipate that this kind of support will be necessary. Susan Wehry stated that she will send 4 questions by email. She also announced that Monica Hutt will be new DAIL commissioner at the July meeting and Susan will be briefing her and preparing her to take over the role in the Core Team. Lawrence offered to extend an invitation to meeting with Georgia and himself in advance of the meeting, if that would be helpful. Paul Bengston extended thanks to Susan for serving on the Core Team.	

Agenda Item	Discussion	Next Steps
2. Minutes Approval	**June 1 2015 Minutes approval** Paul Bengston moved for approval as written. Susan Wehry seconded the motion. Roll Call was taken and the motion carried.	
3. Approval of Self-Evaluation Plan	**Approval of the Self-evaluation Plan** The review process is as follows: • Core team will review today; • To GMCB following incorporation of changes from today's meeting at their June 18th meeting; • To CMMI at the end of the month. Annie Paumgarten presented the feedback received from stakeholders. Joint Fiscal Office, Blue Cross and Blue Shield of Vermont, Green Mountain Care Board, Office of the Health Care Advocate, UVM Medical Center Jeffords Institute for Quality, Vermont Department of Health, Blueprint, Department of Vermont Health Access and several others have been consulted and feedback has been received and incorporated. Healthfirst and Vermont Medical Society will have meetings this week to review the document and provide feedback. Annie noted that any substantive changes will be brought back to the Core Team prior to submission to CMMI. She stated that three types of feedback were received: • Research • Methodological • Narrative/editorial She reviewed examples of the feedback given and asked if there were any questions on the document. No questions were posed. Paul Bengston moved to approve the self-evaluation plan as written The motion was seconded by Steven Costantino.	**The Self-evaluation plan will be sent to the Green Mountain Care Board**

Agenda Item	Discussion	Next Steps
	The Self-Evaluation plan was approved.	
4. Public Comment	**Public Comment** No public comment was heard.	
5. Next steps, wrap-up and Future meeting schedule:	**Next meeting** : July 23' 2015, 2:00pm to 4:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier Lawrence stated that participants will notified if anything new is heard from CMMI related to the Year 2 contract approvals.	

Attachment 3a

VERMONT LEGAL AID, INC.

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July 1, 2015

Lawrence Miller
Chair, Core Team
Vermont Health Care Innovation Project
109 State Street
Montpelier, VT 05620

Re: Community Health Accountable Care Consumer Engagement Compliance

Cc: Joyce Gallimore, Director, Community Health Accountable Care

Dear Chair and members of the Core Team,

Thank you for the opportunity to comment on the financial request made by Community Health Accountable Care (CHAC) at the Core Team meeting on May 4, 2015. Vermont Legal Aid and the Office of the Health Care Advocate (HCA) have significant concerns about CHAC's compliance with the consumer engagement requirements outlined in its contract with the Department of Vermont Health Access (DVHA). Specifically, we do not believe that CHAC is in compliance with the requirement to have a consumer advisory board as described in the following language:

> H. The Contractor must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the Contractor, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the Contractor's management and the governing body must regularly attend consumer advisory board meetings and report back to the Contractor's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.[1]

Over the past year and half we have reached out to CHAC on many occasions, met with the ACO's leadership, and provided numerous suggestions and materials regarding development of a consumer advisory board and recruitment and engagement of consumers. However, CHAC has

[1] *See,* Accountability for Cost and Quality of Health Services, Community Health Accountable Care, Contract No. 26215, pg. 11, available at http://dvha.vermont.gov/administration/chac-signed.pdf.

still not formed a consumer advisory board as required by the ACO standards and by its contract with DVHA. Instead it has formed a Beneficiary Engagement Committee which is made up of representatives from provider organizations and CHAC's three consumer board members. This committee is not an acceptable replacement for the consumer advisory board and is not comprised of "… membership drawn from the community served by the Contractor, including patients, their families, and caregivers."

A consumer advisory board is an essential, focused mechanism for including consumers in the ongoing health care reform conversations and decision-making that take place at the ACO level. The purposes of a consumer advisory board are distinct from the purpose of including consumers on the governing board. Consumers are included on the governing board because they bring a unique and important perspective to the decision-making group. However, consumers on the governing board are fiduciaries of the entity just like any other board member, and their ability to contribute the consumer perspective is necessarily limited because the population of consumers is far more diverse than any three consumers can represent. The consumer advisory board plays a unique role in an ACO's efforts at community engagement. Members of the consumer advisory board do not have the same fiduciary duty to the ACO that board members have, and can make recommendations in the interest of consumers without the limits of the ACO's fiduciaries. Having the same consumers who serve on the ACO's governing board also participate in the Beneficiary Engagement Committee is an inadequate substitute for the required consumer advisory board.

A consumer advisory board is a platform for a broad diversity of consumers to participate, creating the opportunity to get input from different geographic regions, from consumers with varying health care needs, and from patients attributed to the ACO, their families, and caregivers.[2] The feedback consumer advisory boards are able to offer can be oriented toward operational systems at a level of detail that a governing board would not necessarily consider or address. Advisory groups at the hospital level have proven valuable in improving communication, starting new services, and catching mistakes. A consumer advisory board creates an environment more conducive to speaking up and encouraging extended consumer conversation than a governing board meeting. A consumer advisory board also gives the ACO the opportunity to present new ideas and changes and get responses from consumers before implementing changes, thus increasing the likelihood of consumer buy-in. Dr. James Reinertsen, Senior Fellow at the Institute for Healthcare Improvement explains,

> We have observed that in a growing number of instances where truly stunning levels of improvement have been achieved, organizations have asked patients and families to be directly involved in the process. And those organizations' leaders often cite this change – putting patients

[2] *See,* Elna Nagasako, Community Catalyst, Best practices for Meaningful Consumer Input in New Health Care Delivery Models 6 (2012); Community Catalyst, Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities, available at http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement.

> in a position of real power and influence, using their wisdom and experience to redesign and improve care systems – as being the single most powerful transformational change in their history. Clearly this is a leverage point where a small change can make a huge difference.[3]

A consumer advisory board allows an ACO to have more involvement with its consumers and creates a powerful avenue for improving its overall operation, and the operation of its participating providers. Notably, OneCare Vermont has repeatedly extolled the value of its consumer advisory board.

We ask the Core Team not to approve CHAC's financial request until the ACO comes into compliance with its contract requirement by forming a consumer advisory board comprised of people from the community it serves including patients, families, and caregivers. The consumer advisory board should include Medicaid, Medicare, and exchange plan beneficiaries and should include patients, families, and caregivers with diverse backgrounds including income levels and health needs.

As we have previously offered on numerous occasions, HCA staff members would be happy to provide support to consumers on the ACOs' advisory and governing bodies if that would be helpful.

Thank you for your consideration of our comments.

Sincerely,

s/ Trinka Kerr, Chief Health Care Advocate

s/ Julia Shaw, Health Care Policy Analyst

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[3] *See,* James Reinertsen, et al., Seven Leadership Leverage Points for organization-Level Improvement in Health Care 17 (2d. ed., 2008).

Attachment 3b

1. *As you know, VHCIP has engaged a contractor to develop a telehealth strategy for Vermont. CHAC's request includes remote monitoring services, which fall into this area of work. Please explain how continuing these remote monitoring services comports with the telehealth strategy (as presented to the HIE/HIT Work Group at their June meeting).*

   The proposed statewide telehealth strategy for Vermont recommends that 'telehealth strategies should support advanced care coordination models, integration of care across different providers, and motivated patient engagement.' The strategy suggests an adherence to the following guiding principles: patient centeredness, improved access to care, alignment with health reform programs, support for existing programs and efforts, and consistent outcome measures. Below describes how CHAC's remote monitoring aligns directly with recommended strategies and principles, increasing access to timely, appropriate care.

   The CHAC remote monitoring services project is an advanced care coordination model that supports patients and providers by identifying and engaging CHAC's Medicare beneficiaries who have COPD, CHF, and Diabetes and are in the rising risk pool toward hospitalizations. The project is a collaboration between CHAC and the Visiting Nurses Association (VNA) for care coordination, and has 200 participants at five health centers, with an anticipated enrollment of 300 individuals by the fall. The project requires the patient only to have a telephone or computer to log their data daily, and the VNA Care Coordinator follows up on patients whose data is out of the recommended parameter and does a nursing triage with them. She then may provide education, monitor, or refer to the FQHC for primary care triage. These records are then sent to the FQHC to be stored in the Electronic Health Record. This project has allowed "risking risk" patients to be identified sooner, triaged appropriately, and stabilized, all while the patient increases their knowledge of their own illness, increasing patient engagement.

   The remote monitoring used by the Home Health Agencies is recognized as a 'strong' program. CHAC's collaboration with the VNA for care management has allowed a swift and natural alignment of respective remote monitoring systems in several ways. We have found that CHAC's remote monitoring is the 'light touch.' The VNA provides the more intensive remote monitoring services for patients who are post-hospitalization. Once they are stabilized, patients have graduated from the VNA remote monitoring to the CHAC remote monitoring. The VNA has also identified very fragile patients who are enrolled in the CHAC program, but actually need to be placed on the VNA's remote monitoring system. We are confident that we have reduced emergency room admissions and unnecessary hospitalizations, and are eager to see the outcome results in September.

2. *What is the return on investment for the funds provided to CHAC to date? How has this investment improved the quality of health care for Vermonters, reduced cost, and fostered integration?*

CHAC understands from preliminary data that it has likely achieved savings of approximately $5-6 M (~9-10%) in the VMSSP product line for Program Year 2014. This should be confirmed in July or August, and provides evidence of a strong quantitative return on its investment of ~500%. CHAC accounts for this initial return on investment by the local collaborations that that ACO model has catalyzed and the cost-effectiveness of the FQHC model. CHAC is particularly eager to see the results of PY2015, as those results will include several major centralized CHAC initiatives: shared evidence-based guidelines in the areas of Diabetes Management, COPD, CHF, and Falls Risk Assessment; our Medicare Tele-monitoring program; and our efforts to identify, benchmark, and improve results for various quality process and outcomes metrics.

CHAC offers Vermonters several qualitative returns on its investment. The CHAC structure has promoted local collaborations amongst health centers, community mental health centers, home health agencies, and community hospitals – all to improve continuity of care for Vermonters. These newly-structured collaborations are strikingly apparent in the work of CHAC's Clinical Committee, as the groups hammer out and implement shared recommendations, triage protocols, etc.

CHAC additionally offers the State qualitative returns on its investment. CHAC's existence offers the state an alternative ACO approach, with the ability to test different projects (e.g., telemonitoring), collect additional data, and provide different perspectives during this period of innovation. This perspective and experiences will assist the State in shaping a model for 2017 and beyond.

3. *If the Core Team does not approve this request, how will CHAC perform the services described in the request?*

CHAC's funding request includes three major components:

- Extension of CHAC's capacity until the end of calendar year 2016,
- Extension of CHAC's care management model which includes a tele-monitoring outreach program, and
- Establishment of a claims based analytics system.

CHAC's highest priority is funding the extension of centralized capacity through the end of CY2016. If the request for these dollars is not approved, the CHAC Board would likely prioritize funding this amount out of savings anticipated in the VMSSP product line, as CHAC's staffing is "bare bones" and required at current levels to keep the ACO functioning and compliant with requirements. This use of funding would be made in lieu of other possible CHAC Board-directed reinvestments of savings, particularly within the local communities.

If the request for extending the CHAC care management model is not approved in full, CHAC would request the consideration of a partial approval (including funding to VNAs of VT to continue the VNA Care Coordinator position and services through 6/30/2016),

and would likely end both components of the remote monitoring project at that time. If no funding for the care management model is provided, the CHAC Board would need to determine whether to reinvest some of the savings anticipated in the VMSSP product line to extend the VNA of VT contract through 6/30/2016. This use of funding would be made in lieu of other possible CHAC Board-directed reinvestments of savings, particularly within the local communities. Alternatively, the CHAC Board could decide to delegate remote monitoring care coordination duties to local care coordinators within the FQHCs, though CHAC has been advised that a decentralized model is less effective, and in so doing, CHAC would lose a well-qualified and enthusiastic VNA Care Coordinator.

If the request for funding of a claims based analytics system is not approved, the CHAC Board would need to determine whether this is an investment that could be supported out of savings anticipated in the VMSSP product line. This is a centralized investment that they likely will prioritize, however it will compete against other possible CHAC Board-directed reinvestments of savings, particularly within the local communities, and the time spent making these determinations will likely delay considerably the possible implementation of an analytics-system or the contracting with another entity to perform CHAC analytics.

Consumer Advisory Board Update: July 22, 2015

1. Have new members been added to the committee? It seems the committee currently is composed mostly of CHAC Board Members.

Recruitment Progress and CHAC Corrective Action:

Yes, Eight (8) new consumers have been added to the Beneficiary Engagement Committee (to fulfill the expectations for the consumer advisory board). CHAC has been diligently seeking to expand its consumer input through the addition of consumer members, an objective that has been in place since the beginning; however, realization of that objective has been more challenging than anticipated. We are pleased to report that CHAC has made significant progress in recruitment. Please refer to the Attachment 1: "CHAC Beneficiary Engagement Committee Membership (consumer advisory board)".

In order to fully comply and to demonstrate immediate actions and commitment, CHAC is filing its "Plan of Action/Correction" to the GMCB and DVHA staff with a request for review and approval. CHAC is pleased to report that we have five (8) new consumer members (five (5) Medicaid, of which one is also the family caregiver of a Medicare beneficiary, plus one (1) Medicare and two (2) commercially insured) of which six (6) were approved by the CHAC Board on July 15 and the last two will be approved at the August 19th CHAC Board meeting. CHAC is committed to continuing to recruit including additional consumers who are commercially insured or Medicaid beneficiaries up to 12 members. A list of the members without the names of the members is included with a request not to circulate the list. This information is an update from the initial CHAC response to Lawrence Miller dated July 10, 2015.

As noted above, CHAC has been in the process of recruitment since Fall 2014. CHAC implemented all the following actions to recruit and seek consumer involvement and feedback: developed a position description of a consumer member for our committee, posted this description on our website and in health delivery sites, requested help from CHAC board members in identifying nominees, requested help from staff at the FQHCs, advertised the position with flyers, and conducted outreach forums at two health center sites. We continue to actively recruit from their communities. The most effective recruitment to date was recruiting with the help of the navigators who were able to draw from their pool of consumers and the personal relationships they had established with those individuals. This led to our recent success in recruiting since July 1.

Outreach Forums: CHAC's consumers and members of the Beneficiary Engagement Committee developed and implemented an outreach to consumers in addition to recruiting more consumers as part of the consumer advisory board. FQHCs are required to have Governing Boards composed of 50% actual consumers. These are community consumers who are served by the health centers. CHAC conducted two of a series of on-going consumer forums in Newport and Swanton. The summary of findings is included and is titled, "Consumer Outreach Forums". This is a valuable source of information on the consumer experience and has been designed to offer a broad set of topic areas that will enable consumers to share their experience. The results are being reported to the Board after each forum.

2. What progress has been made in identifying the role of the committee?

The Beneficiary Engagement Committee (BEC) understands its role in seeking input from a broader set of beneficiaries, their families and caregivers and satisfying the requirements of a consumer advisory board that will meet at least quarterly. The CHAC board intended the BEC to ensure that the requirements for the consumer advisory board and the consumer input from a diverse group of consumers throughout the service area are met. There is a Charter for the Committee that reflects this intent. The BEC/CAB are a combined Committee and Board fulfilling Medicare, Medicaid and GMCB requirements. To make this clearer, CHAC will formally name the committee with the dual name in order to ensure that the scope and mission are clear. To this end, CHAC has added new consumer members so that consumers are clearly the focus of this Committee. CHAC is continuing to recruit members, so that we expect the committee to grow to include a total of eight new consumer members in addition to the existing members, by September 15, 2015. The BEC/CAB is exploring a variety of methods to obtain consumer input including but not limited to reaching out to consumers in service areas of the participating community health centers since their Boards are composed of 50% consumers. CHAC's BEC/CAB has and will consult with advocacy groups and organizational staff and make recommendations to the Members regarding potential candidates to serve as the beneficiary members of the Governing Board.

The Medicaid program agreement states that the members of the governing board must attend the consumer advisory board and report back to the governing board. CHAC's Board demonstrated its commitment to consumer feedback and involvement by integrating the consumer members of the governing board with the outside consumers on the Beneficiary Engagement Committee. Based on feedback expressed in the letter from the Office of the Health Care Advocate directly to CHAC in our periodic meetings, and the concerns that were expressed again in the recent letter to Lawrence Miller, CHAC is going to convene the consumer members as an independent and distinct consumer advisory group that meets quarterly and that is supported by CHAC. One or

more Board members will attend as representatives of the CHAC Governing Board to take back the findings to the Beneficiary Engagement Committee. This represents an additional action to ensure that consumers have an independent voice that results in feedback to the BEC and the Board, that will be used to develop initiatives to improve the delivery of care and operations. This will be made part of the Plan of Action to be presented to DVHA on July 23, 2015 for approval and to the GMCB for their review. This means the BEC will have membership that continues to include the current membership, while the consumer advisory board/Consumer Advisory Group will have exclusively the eight (8) new consumers and additional consumers that will be created going forward. Following acceptance of the Plan of Action by DVHA and GMCB, the plan will be implemented and the consumer group will be convened in August for orientation and its first meeting.

3. Has the CHAC Board formally received a report(s) from the Beneficiary Engagement Committee?

Yes, the committee reports to the Governing Board at least quarterly. Activities of the BEC have been reported in the executive summaries sent to the governing body. There will be a report on all significant activities of the BEC and the new consumer advisory board/Consumer Advisory Group at the August and September meetings of the Governing Board.

Consumer Outreach Forums

The CHAC Beneficiary Engagement Committee (BEC) is conducting a series of consumer outreach meetings at FQHCs in CHAC's network. The purpose of the meetings was for the BEC to gather feedback from the consumers who sit on the FQHC Boards and hear about their experiences on the topics of communication, access, coordination of care, and information sharing. The discussion began with a brief introduction to CHAC, the purpose of the presentation, and how the ACO affects patients. The Boards were then guided through each of the topics beginning with communication and ending with access to care. Members of the BEC helped facilitate the discussion and added valuable insights. The Board members were mostly engaged and shared personal experiences that exemplified processes in the health care system they thought worked well and those which they believe are currently causing barriers to quality care. The meetings have been successful as the BEC was able to collect valuable consumer input on all four areas of focus. This summary is worded with generic language to maintain confidentiality.

Topic Areas- Positive Steps Suggested			
Communication & Follow-up	**Coordination & Integration of Care**	**Access to Care**	**Information Sharing**
• Providers being proactive; assist on next steps • Having a stable support system • Clear language-> know your patients and emphasize importance • Always send reminders • Simplify instructions and billing • Have a central communication system • Collaboration with Dental for sharing processes • Less satisfaction surveys • Written explanations of PCP visit still helpful • Use consistent medium for communication	• Consistency & shared care plan (with other providers and the patient) • Listen to patients and their family members • Easier transitions between health systems o Release of information o Preventative measures • Handle billing insurance and management of referrals • Specialist should loop back to PCPs • Patient education around insurance and medication costs	• Set aside time for emergencies/day of care • Waiting list for no-shows? • Intermediate guidance (ie: phone triage) • Increase patient education • Cost transparency • Physicians v.s. NPs, etc. • Increase availability w/ multiple sites in different communities • Increase access to specialists/ quicker appointments • Increase access for those new to the system (young and new residents)	• Email Access • Text Messages • Differentiate information sharing by age • Consumer friendly patient portals • Better integration of EHRs for smoother referrals • Provision of pharmacy services and phone refilling/ordering

Consumer Stories/ Examples:

- I have two young children and it is easy for me to call their pediatrician's office and get quick guidance without having to take them in.
- When a family member was sick we had a hard time knowing what was going on. There were bills and notices coming from all different types of providers. There was no set plan that we knew about. Can there be one central location for us to find information?

Consumer Outreach Forums

- My doctor sends me text messages! This is a great tool!
- When we were taking care of a family member, every doctor we took her to changed her medications. The doctors refused to listen to family members even though they knew which dosages worked best.
- I would love to be able to email my doctor.
- I kept being told that I needed a colonoscopy, but I did not understand why or the importance of it until my current doctor said “You are going to get a colonoscopy. Tell me where you want it done.” This worked for me and I recommend other providers do the same.
- When I need to see a specialist, my appointment is often delayed for months.
- It is difficult to get young people in the system. My children are now young adults and do not understand the importance of having a PCP. They would rather go to Urgent Care since new patient appointments can take a while to get at the primary care office.
- I had visitors from out of town and they were able to get a same day appointment at the health clinic.
- I love the ease of ordering my prescriptions on the phone from our health center’s pharmacy.
- There has been an overload of satisfaction surveys. If I go for any kind of test or check-up I always have to fill out a survey.
- My doctor still provides me with a written report of my visit that includes what we discussed and what was decided for my treatment. I find this to be the most helpful.

Note: The meeting at NCHC was held on April 22nd, 2015. The meeting at NoTCH was held on June 10th, 2015.

Community Health Accountable Care - Lessons Learned about Consumer Recruitment for the Consumer Advisory Board

Community Health Accountable Care (CHAC)would like to share the following "lessons learned" related to our experience with seeking consumer feedback and involvement in the implementation of our Accountable Care Organization.

Recruitment of consumers to a consumer advisory board is a very challenging process because:

1) Finding the right way to offer an invitation that is understandable, attractive and feasible is not easy, so reaching eligible individuals and getting a "yes" response can be much slower than expected.
2) Consumers see so many competing requests or advertisements, that posters, calls, emails, or letters go unnoticed in recruitment of consumers for board participation.
3) CHAC requested staff of the Office of the Health Care Advocate to educate our staff and Beneficiary Engagement Committee/Consumer Advisory Board (BEC/CAB) starting in the Fall 2014 on available resources and approaches to recruitment and implemented the recommendations but CHAC did not receive any positive responses from consumers to serve on the CHAC BEC/CAB as of June 2015.
4) Many people are not aware that FQHCs must have 50% of their Governing Boards composed of consumers who are an on-going source of consumer feedback. In the Spring 2015, CHAC was concerned about the difficulty of successfully recruiting consumers to the BEC/CAB so CHAC developed and implemented a process of consumer forums in which we went to the Board meetings of selected FQHCs to invited the consumers to tell us the qualities of their experience with obtaining health care with the qualities of the good experience and any qualities of an unsatisfactory experience, so that we could take feedback and make recommendations to the Governing Board about strategies to improve consumer engagement and satisfaction. The feedback will be extremely valuable as we identify the findings that are most often reported.
5) The method of recruiting that was successful, was the one we pursued after the individual suggestions that we had been given did not result in consumers for the BEC/CAB. That was to ask two health care navigators to identify any consumers that they could identify who were insured by Medicaid, Medicare or the Health Exchange, and to assertively reach out to those consumers to ask them to participate. We asked three existing members of the BEC/CAB to personally recruit one or more individuals that they had worked with and talk them through an orientation to CHAC and its goals and the importance of participation on behalf of consumers. . In addition, we used a combination of all other tools including the position description, CHAC descriptions, reducing the frequency of meetings and expectations and offering to plan meetings as telephone meetings so travel would not be necessary. We will also offer monetary support in the form of mileage if the consumers wish to come and if they otherwise cannot get to the meetings or call into the meetings.
6) The main lesson that can be applied to future recruitment efforts is that the key for success is to build off of personal relationships and to support those that show interest in a project with developed targeted materials.

7) When reaching out to consumers who are good candidates, those reachable consumers are often already overcommitted since they get nominated as a result of participation in a similar consumer group.
8) In order to reach the targeted population who have Medicaid, Medicare or Health Exchange insurance coverage, that population has to be identified and that step becomes a barrier since it reflects a process that intrudes on privacy of individuals based on identifying their insurance status even if it is for a well-intentioned reason.
9) Understanding the meaning of consumers is not as obvious as it seems, so CHAC was proceeding with the understanding that that consumers on the Board were considered to be eligible and equal consumers for the purpose of the consumer advisory board, as starting membership. It came as a surprise that those consumer Board members were viewed as no longer representing consumers for the purpose of a “consumer advisory board”.

Attachment 4a

Financial Request: July 2015

Georgia Maheras, Project Director

July 28, 2015

Request for renewal:

- Datastat:
  - Approved Amount: $117,278.16
  - New Amount: $217,278.16
  - Rationale: Expansion of patient experience survey capacity including intensified sampling of targeted populations and additional content for specific health services to determine the impact of specific interventions on patient experience, as well as patient experience in settings outside the APCP [advanced primary care practices] setting (e.g. mental health, substance use, specialty care, social services, long term services and supports, home health, public health and community prevention programs.

Request for additional funding:

- Community Health Accountable Care:
  - Requested Amount: $764,982.99
  - Proposed amount: $ 678,433
  - Rationale: see attached memo
- OneCare Vermont:
  - Requested Amount: $3,500,000
  - Proposed Amount: $2,091,140
  - Rationale:

The majority of funds expended will be in 2016, but a portion will be expended in 2015 (estimated at $300,000).

Attachment 4b

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 7/22/2015
Re: Request for approval for ACO support

The Core Team requested that each of the ACOs submit a request for funding for another year of support. CHAC and OneCare each provided requests for additional funding and responded to supplemental questions (provided in Appendix A and B respectively).

Project summaries:
OneCare Vermont submitted a proposal to support their activities. OneCare proposed the following:

> Continuing to receive SIM funds for a second year will further our collective efforts towards innovative, highly reliable, evidenced-based population health care strategies for Vermonters by providing support to:
>
> - Fund local medical leadership, facilitation, quality improvement training and project support
> - Analyze and provide data for targeted health care performance improvement collaboratives
> - Further develop and disseminate population health evidenced-based guidelines to support clinical performance improvement initiatives
> - Support performance improvement activities through 14 Regional Clinical Performance Committees (RCPCs)/Unified Community Collaboratives (UCCs) serving every community in Vermont
> - Fund a statewide care management tool and tracking system
> - Funds to offset a portion of OCV’s year 2 support fees for VITL

CHAC’s grant application requested funding for similar activities:

- Extension of CHAC’s capacity until the end of calendar year 2016,
- Extension of CHAC’s care management model which includes a tele-monitoring outreach program, and
- Establishment of a claims based analytics system.

In response to both of these requests, I propose the following:

The VHCIP provide support to the two ACOs distributing funds based on the number of attributed lives each ACO is serving. The Core Team should not provide separate funds to OneCare related to care management tools or event notification because of other ongoing projects. The per-attributed life payment would be $19 (this amount was arrived at based on the available funds in the overall SIM budget). This is a one-time investment. If an ACO's attributed lives increase by more than 1,000 lives over the course of 2015, we would alter the amount paid to reflect the actual attributed lives retrospectively.

	Medicare	Medicaid	Commercial	Total Est Att Lives	$ Per Att Life	Total	Total requested in this memo
OCV	55,114	30,964	23,982	**110,060**	19	2,091,140	**2,091,140**
CHAC	6,446	21,213	8,048	**35,707**	19	678,433	**678,433**

Recommendation:

Provide $2,091,140 in funds to OneCare Vermont to support activities described in their application submitted to the Core Team on May 27th and June 5th. These funds cannot be used for a stateside care management tool and tracking system, nor can they be used to support an event notification system as those are projects receiving separate SIM funds.

Provide $678,433 to CHAC to support activities described in their application submitted to the Core Team on May 27th. CHAC should coordinate its telemonitoring activities with the HIE/HIT Work Group and the telehealth strategy developed therein.

Attachment 4c

General Information:

Lead Organization Applying: Bi-State Primary Care Association____________________

Collaborating Organizations: in support of Community Health Accountable Care, LLC

Key Contact for Applicant: Kate Simmons, MBA, MPH, Director VT Operations_______

Relationship to Applicant: employed

Key Contact Email: ksimmons@bistatepca.org___________

Key Contact Phone Number: 802-229-0002, ext. 217

Key Contact Mailing Address: 61 Elm Street, Montpelier, VT 05602

Fiscal Officer (must be different from Key Contact): Abby Mercer, CFO_

Relationship to Applicant: employed

Fiscal Officer Email: amercer@bistatepca.org

Fiscal Officer Phone Number: 603-228-2830 ext 118

Fiscal Officer Mailing Address (if different from Key Contact): 525 Clinton Street; Bow NH 03304

Project Title and Brief Summary:

Project Title (limit to 40 characters):

Furthering Community Health Accountable Care in FY16 and FY17______

CHAC is an FQHC-led ACO with a vision to achieve better care for individuals, better health for populations, and lower growth in expenditures in connection with both public and private payment systems. Extension of CHAC's capacity is necessary to maintain adequate staffing, an operating budget, and continue a patient centered telemonitoring program which has already made an impact in the lives of many attributed at-risk patients. A robust analytics solution, including the selection of a vendor and the purchase of visualization software, will enable CHAC to identify opportunities for further clinical and operational innovations at the population and individual provider levels. The outcome will be improved quality and reduced cost of care, particularly for high risk patients.

Budget Request Summary

Budget Category	FY16 7/1/15-6/30/16	FY17 7/1/16-12/31/16	Total
Personnel		$117,059.73	$117,059.73
Fringe		$26,923.74	$26,923.74
Travel		$10,000.00	$10,000.00
Equipment			
Supplies		$4,806.80	$4,806.80
Modified Total Direct Cost	$8,500.00	$23,361.80	$31,861.80
Contracts	$246,500.00	$250,500.00	$497,000.00
Other*	$40,000	$37,830.92	$77,830.92
Total	$295,000	$470,482.99	$764,982.99

*Please see separate budget justification.

Activities for which the applicant is requesting funding

Bi-State, on behalf of Community Health Accountable Care, LLC (CHAC) including the Federally Qualified Health Centers (FQHC) providers, and other community stakeholders are pleased to have the opportunity to request VHCIP funding for the following activities (also found in the workplan):

- Extension of CHAC's capacity until the end of calendar year 2016,
- Extension of CHAC's care management model which includes a tele-monitoring outreach program, and
- Establishment of a claims based analytics system.

Capacity:

To create efficiencies and enable flexibility, CHAC has executed a management services agreement with Bi-State for Bi-State to provide administrative, clinical, financial, and leadership support. Funding from VHCIP will provide partial funding for key Bi-State staff positions in support of the ACO activities, including the ACO Director (Bi-State's Director of Community

Health Payment Systems), Director of Healthcare Informatics, Clinical QI lead (Community Health Quality Manager), Project Manager, Project Coordinator for Payment Reform Implementation, and other partial staff positions to manage this project and support functions of the ACO (FTEs and additional information is provided in the budget). Bi-State was fortunate to receive original funding from VHCIP which became effective July 14th, 2014 and is set to end on June 30th, 2016. With this funding CHAC was able to fulfill the scope of work promised which included:

- Hiring and maintaining appropriate staffing including a Community Health Accountable Care LLC (CHAC) Director and Project Coordinator,
- Executing and monitoring activities, including a quality compliance program, to ensure compliance with CHAC's Medicaid and Commercial Shared Savings Program and regulatory Agreements and requirements.
- Recruiting providers who will participate and collaborate with CHAC.
- Providing leadership for CHAC's activities regarding budget, quality improvement, data repository and reporting services in collaboration with CHAC's senior management staff.
- Reporting for CHAC's Medicaid and Commercial Shared Savings Program Agreements according to schedule.
- Supporting CHAC's Board of Directors Meetings.
- Supporting CHAC's Clinical, Financial, Beneficiary Engagement, and Operations Committees in collaboration with the respective Chairs.
- Maintaining CHAC's website to meet compliance requirements, and provide general information for beneficiaries and the public.
- Representing CHAC at State meetings.

- Presenting programmatic reports to the VHCIP work groups, Steering Committee, and Core Team, as requested.

CHAC's three Shared Savings Program contracts extend through December 31, 2016. Bi-State would like to request an additional six months of funding for existing staff at approximately current levels to support their continued work in this otherwise unfunded period of time.

With further funding Bi-State will be able to continue supporting other programmatic expenses such as meeting costs, legal and professional services, insurances, travel, supplies, postage, facility expenses, etc. through the end of calendar year 2016. In particular, the use of legal and professional services has become an ongoing necessity within the ever changing environment of payment reform to ensure that CHAC remains compliant with all requirements of the Medicaid and Commercial Shared Savings Program.

For performance year 2014, Bi-State contracted with Westaff to engage 3 temporary staff members and increased the partial staff positions of some FTEs to conduct the ACO quality reporting. This team of individuals proved to be essential for the success of this endeavor. Extension of CHAC's capacity will allow for Bi-State to ensure that adequate staffing is allocated for the required performance year 2015 ACO quality reporting.

Extension of Medicare Telemonitoring Intervention:

CHAC has developed a care management model that includes a telemonitoring program. In 2014, CHAC contracted with a telemonitoring provider, Pharos Innovations, LLC, to run a daily monitoring system for Medicare beneficiaries with COPD, CHF, and Diabetes. Enrollment began in February 2015, and CHAC currently has approximately 190 beneficiaries enrolled. There is

national evidence that telemonitoring and active engagement with patients who have these conditions will reduce readmissions. CHAC's target population for this intervention is 300-375 individuals, targeting the patients at the health centers who are participating in the Medicare contract. Patients are engaged daily through a telephone call, and are followed up on if they have an 'alert'. CHAC has contracted through VNA of VT to engage Central Vermont Home Health and Hospice (CVHHH) to hire 1.5 FTE for centralized care coordination, follow up on the alerts, provision of patient education, and facilitation of referrals if necessary. The CHAC Clinical Committee developed three triage protocols on COPD, CHF, and Diabetes for home health to use when the Care Coordinator is determining whether to refer the patient. The CVHHH Centralized Care Coordinator has already shared a number of stories of the impact the program is making in the lives of CHAC's patients. This is just one that speaks to the population health focus CHAC is working toward: There was an FQHC patient who was legally blind with the diagnosis of Congestive Heart Failure. She alerted in the system, and the Care Coordinator followed up with a phone call to her. The patient had transportation issues that the Centralized Care Coordinator helped her to work out, and upon her visit at the FQHC it was found that she had pneumonia and was sent home with antibiotics. Upon further investigation, the Centralized Care Coordinator discovered through the patient's alerts that is she is not able to weigh herself daily due to her blindness. So, the Centralized Care Coordinator made a referral to Home Health, which will include telemonitoring, and a referral to Occupational Therapy and to the MSW to help fit her with a scale that will work for her. CHAC expects to see an impact on admissions and readmissions from the use of this telemonitoring program by the summer of 2015.

Currently the contract with Pharos Innovations, LLC lasts through June 30, 2016 and the contract with the Central Vermont Home Health and Hospice is only funded through December 31, 2015. Bi-State is requesting funding to extend both contracts through December 31, 2016 to align with the end of the contract for the Medicare Shared Savings Program.

Contract with Analytics Vendor:

Bi-State and the CHAC members remain eager to invest in an analytics solution to consume claims data and produce actionable reports. While CHAC has implemented an intervention program for the Medicare population, it has been a challenge to create viable interventions for the Medicaid and Commercial populations. In this proposal and related project plan, Bi-State is requesting VHCIP provider funding to adopt and implement an analytics solution that would enable Bi-State and the CHAC members to address this challenge by identifying key areas for quality improvement that would lead to innovative interventions in an effort to reduce admissions and readmissions for the Medicaid and Commercial populations. Funding for this type of investment would allow Bi-State to contract with a vendor that could use Medicaid and Commercial claims data to report and display information with a user friendly interface at the ACO, participant, and individual provider levels. The analytics platform will allow us to identify high-cost or high-utilizing patients across the spectrum, track interventions, identify transitions in care, ED utilization, and comparison against ACO quality benchmarks. The FQHCs and their community partners identified this type of system as a critical need, as it will allow the FQHCs to proactively manage patients that they serve.

Ultimate selection of an analytics vendor will be made by the CHAC Board upon receipt of funding. Bi-State staff have continued to vet vendors and explore the terms of a procurement.

The vendor that has over the past few months seemed most promising (and the best leverage of past State investment) is The Lewin Group for their Optum Healthview Tableau software. Lewin is a current VHCIP evaluator, very familiar with CHAC's claims data already, and Lewin has already begun populating the Tableau software with CHAC's claims data feeds. The goal is to successfully analyze the Medicaid and Commercial claims data with a future aspiration to expand the system to include feeds from the VITL HIE and feeds directly from the EHRs at the FQHCs.

Number of Providers and Patients Impacted

CHAC was founded by seven Federally Qualified Health Centers (FQHCs). Since inception CHAC's network has grown to include ten FQHCs, five hospitals, fourteen designated agencies, and nine certified home health agencies. In total our network consists of almost 300 attributing providers and participant agreements with community partners and support service providers. As an ACO we serve about 35,000 patients in total with about 20,000 on Medicaid, about 6,000 on Medicare, and about 8,000 in the commercial exchange population. All providers and patients in CHAC's network would be impacted by the receipt of further funding as we are requesting funds to further support CHAC's infrastructure, continuity of already existing programs, and funding for an investment in an analytics platform that would enable CHAC to analyze data from and generate supplementary interventions for our patient populations.

Project Relationship to VHCIP Goals

Bi-State received original funding to use CHAC as a testing model for payment reform under the State Innovation Models and Testing Grant. This proposal is requesting funding to further this project and to invest in analytics that will allow more opportunities for innovation to be realized.

CHAC's goals as a Shared Savings Program Accountable Care Organization are perfectly aligned with VHCIP's: to improve care; improve population health; and reduce health care costs.

Dissemination of Lessons Learned

Bi-State staff and CHAC members participate in and attend all of the VHCIP workgroups as well as the statewide learning collaboratives and the Blueprint Unified Community Collaboratives. CHAC values collaboration with the other ACOs and our community partners and strives to be inclusive in every aspect. For example, CHAC's clinical committee members, including partners from the behavioral health network and the home health agencies, had significant input on the statewide Care Management Standards. The best practice recommendations on COPD, CHF, falls risk assessment, and Diabetes have been adopted and are being implemented within CHAC's statewide network, and CHAC is currently sharing these recommendations outside of our network with the other ACOs and the Blueprint UCCs. With further funding it is CHAC's goal to continue pursuing quality improvement and care management interventions based on the ACO quality measures. We intend to continue participating in all relevant work groups and learning collaboratives.

Data Infrastructure Alignment

As stated previously, CHAC's proposed claims based analytics solution, particularly if Lewin is selected, will leverage the past investment made by the State. This solution is also compatible with VITL's work on the HIE, and could be a repository at the other end of CHAC's "ACO Gateway." More generally, it is important to note that CHAC's Director of Health Care Informatics, Kate Simmons, has been an integral stakeholder in the ACO Gateway and HIE remediation projects, and Project Manager Heather Skeels is a regular and active participant in the VHCIP HIE Work Group.

Alternative Funding Sources Sought and Rationale for Requesting SIM Funds

As we submitted in our original proposal, Bi-State's work supporting CHAC had been self-funded, with cash contributions from the original members – which are themselves non-profits with carefully constructed budgets (7 FQHCs and Bi-State) – to fund legal and consultant costs and the beginning of CHAC's staff. Bi-State was able to leverage previously existing federal grants for some activities and partial funding of some staff positions. The original funding from the VHCIP Provider grant was necessary to sustain and augment Bi-State's efforts on behalf of CHAC and other providers to maintain CHAC's basic infrastructure, launch the work of the CHAC Board and four standing committees including support of the work on the best practice recommendations, and to launch a care management model that incorporates a telemonitoring program for our at-risk Medicare population. Since then, CHAC has received cash contributions from two new FQHC members, and Bi-State on behalf of CHAC submitted a proposal in response to an RFP from RCHN's Community Health Foundation with the goal of using funding to support further development and implementation of the clinical best practice recommendations throughout our network. A new VHCIP Provider grant is necessary to sustain CHAC's infrastructure, staffing, and telemonitoring program through the end of the Shared Savings Program time frame; and to supply CHAC with an analytics system to enhance the capacity for analysis and development of measures based clinical interventions and recommendations.

Technical Assistance Needs

As in our original proposal Bi-State is very interested in technical assistance around data analysis. As stated in this proposal, funding for analysis of claims data through the contracted use of vendor software would fulfill the technical assistance services previously sought. Additionally, we remain interested in approaching other national foundations to help support our work and ask whether VHCIP could support this effort as requested with letters of support, etc.

Potential Return on Investment

The overall goal of the telemonitoring program is to avert admissions and help patients manage their care through daily monitoring and enhanced referral patterns. Within the first two months of use, there had already been over 2000 interactions with patients that made a positive impact on their health. With increased patient awareness of their health and reduced health care spending through averted admission, this program could have a huge impact to create savings for program years two (CY2015) and three (CY2016).

The quality measures of the Medicare, Medicaid and Commercial ACOs have influenced CHAC's processes for targeted decision making and projects for performance improvement. The analytics software will help identify additional conditions that require system-wide care management, will identify populations and patients with the highest health care utilization and associated costs, and will support specified care coordination to improve the health of these patients. Our current partnerships with the community mental health centers, home health agencies, and other community service providers will continue to allow for great success in developing best practice care models and transitions across the continuum of care. Further integration will help reduce duplication, enhance patient experience, and improve health outcomes.

CHAC will continue to focus on quality improvement and cost reduction efforts for all patients, regardless of insurance status. The data produced by the analytics tool would be shared with all VT FQHCs, the CHAC Board, and appropriate committees. This means that potentially 133,600 patients, who receive approximately 500,000 medical visits annually, will be impacted by the quality improvement activities the analytics tool will support as quality improvements are not be limited to only attributed patients. Approximately one quarter of the Medicaid population in the

state receives care at an FQHC, so these quality improvement initiatives and associated cost savings will continue to have an immense direct impact on the state's economy.

Avoiding Duplication and Complementing Existing Effort

The Furthering Community Health Accountable Care in FY16 and FY17 project will enable the extension of CHAC's current initiatives and build on existing collaborative efforts throughout the state. First, CHAC is an FQHC-led ACO, which created a unique opportunity for VT and for collaborations with the other two ACOs. As stated previously, the FQHCs in VT have a long history of cooperation amongst themselves and with their community partners. CHAC originally utilized these existing relationships to create an integrated network that has thus far been very efficient in producing tangible outcomes as evidenced by the clinical recommendations on COPD, CHF, falls risk, and Diabetes that have been adopted throughout our network. The quick implementation of our telemonitoring program, which has already helped many patients, is another example of this efficiency and enthusiasm for providing the best care to our patient population. The analytics system will leverage the State's past investment and use current data feeds. Through current and future collaborations and participation with the other ACOs, VHCIP Work Groups, Blueprint, and learning collaboratives, and by building on an existing data sharing structure CHAC will avoid duplication and complement activities that are currently underway in VT.

Summary of Evidence Base for Proposed Activities

Telemonitoring of individuals with chronic diseases continues to be proven as a best practice. In a study from a 2011 Health Affairs, chronically ill Medicare patients enrolled in a telehealth program had reduced health care expenditures of 7.7-13% per quarter compared to similar patients who did not have the benefit of daily contact. Numerous articles show reductions in

hospital admissions and re-admissions and better adherence to medication. Patient satisfaction is consistently high and patient's have a higher understanding of their own diseases.

Earlier findings on ACOs indicated the greatest cost savings occurred in patients with multiple co-morbidities (McWilliams, Landon and Chernew, 2013); the use of an analytics solution will enable CHAC providers to identify and manage care for these complex and high-cost patients.

References Cited:

McWilliams, J.M., Landon, B.E., and Chernew, M.E. (2013). Changes in health care spending and quality for Medicare beneficiaries associated with a commercial ACO contract. *JAMA, 310*(8), 829-836, doi:10.1001/jama.2013.276302

Budget Justification

Furthering Community Health Accountable Care in FY16 and FY17

Salaries and Wages

Bi-State requests VHCIP support for the following positions for the time period of July 1, 2016 through December 31, 2016. This represents Bi-State's current VHCIP funded positions at approximately current FTE levels.

Furthering Community Health Accountable Care in FY16 and FY17				
Personnel				
Salaries		FTE	6 mo adj.	Request
CHAC Director (Joyce Gallimore)				$ 42,000.00
Project Coordinator (Kendall West)				$ 22,491.00
Director, Healthcare Informatics (Kate Simmons)				$ 9,177.32
Administrative Assistant (TBH)				$ 3,570.00
Data Coordinator (Katie Fitzpatrick)				$ 5,355.00
Community Health Quality Manager (Patty Launer)				$ 8,201.03
Project Manager (Heather Skeels)				$ 6,965.39
Finance / IT / Compliance / Communication				$ 19,300.00
Salaries	$ 117,059.73			$ 117,059.73
Benefits	$ 26,923.74			$ 26,923.74
Total Personnel	*$ 143,983.46*	*$ -*		*$ 143,983.46*

Fringe Benefits

Bi-State's fringe benefits are calculated as a percentage of employee salaries/wages each year. Bi-State's FY16 fringe rate is 23%. Fringe benefits include 12% for health, dental, long-term disability and life insurance, and 403(b) retirement plan; 11% for FICA & Medicare taxes, workers compensation and unemployment insurance.

Fringe calculations are presented on the staffing table, above.

Travel

Bi-State is requesting $5,000 for in-state travel (mileage) and an additional $5,000 for out-of-state travel (conferences). This line item supports CHAC's participation in regional and national conferences as well as in-state travel to participant sites, meetings, etc.

Consultant / Contractual Costs

Bi-State anticipates four major contracts utilizing VHCIP funding.

(1) Contract with Pharos Innovations, LLC, to extend telemonitoring intervention for six months through December 31, 2016 (current 18-month contract ends June 30, 2016). This intervention, implemented in February 2015, enrolls 200-375 Medicare beneficiaries for daily telemonitoring. Beneficiaries flagged by Pharos' proprietary "Tel-Assurance" software are contacted by a triage care coordinator for appropriate triage and follow-up. Bi-State's current contract with Pharos was negotiated to the rate of $16,000/month (or $42.67 PPPM, when fully enrolled with 375 patients) –

Bi-State's current request for an additional $96,000 was estimated by multiplying the current monthly rate by 6 months..

(2) Contract with VNA of VT to extend triage care coordination services through December 31, 2016 (current 12-month contract ends December 31, 2015). This work is being provided by Central VT Home Health and Hospice, under a subgrant from VNA of VT. This contract complements the Pharos contract and provides local and high quality care coordination expertise utilizing the Tel-Assurance software for CHAC's enrolled Medicare beneficiaries. Bi-State's current one-year contract with VNA of VT is for $150,138 – Bi-State's current request for an additional $165,000 was estimated by increasing the current rate by 10% to reflect a full year at full care coordination capacity (the Y1 rate included lower initial FTEs for initial months).

A note on (1) and (2): When Bi-State originally negotiated a contract with VNA of VT, Bi-State only had funding to support 12 months of VNA of VT, forcing the VNA of VT contract to be out of alignment with the Pharos contract. Bi-State appreciates the opportunity for additional VHCIP funds to align both complementary contracts onto the same schedule and to continue the intervention for a complete ACO program year (instead of ending the intervention arbitrarily mid-year).

(3) Contract with Analytics vendor - ***NEW***. Bi-State and the CHAC members remain eager to invest in an analytics solution to consume claims data and produce actionable reports. Although ultimate selection will be made by the CHAC Board upon receipt of funding, Bi-State staff have continued to vet vendors and explore the terms of a procurement. The vendor that has consistently seemed most promising (and the best leverage of past State investment) is The Lewin Group for their Optum Healthview Tableau software. Lewin is a current VHCIP evaluator and already uses the Tableau software and CHAC claims data feeds in its evaluation work for the State. Bi-State staff have engaged in demonstrations with Lewin and are preparing the CHAC Board to demo the product. Bi-State staff have additionally requested a preliminary quote from Lewin. Lewin estimates the cost to Bi-State to be $144,000/year (assumes data feeds for Medicaid and Commercial claims data). It is possible that this amount could be reduced to approximately $130,000/year if Lewin is permitted (via DUAs, etc.) to utilize their existing CHAC data feeds to populate Bi-State's instance of the analytics software. Bi-State's current request for $216,000 was estimated as 1.5 times the $144,000 quote (and assumes an 18-month contract).

(4) Contract with Westaff for temporary contract staffing. To accomplish the PY2014 ACO quality reporting, Bi-State contracted with Westaff and another temporary contract staffing firm to engage short-term staff for chart abstraction. Bi-State was highly satisfied with the caliber of staff that Westaff offered, and anticipates utilizing them as the sole vendor for temporary contract staff for PY2015 reporting. (PY2015 reporting will also necessitate the time of Bi-State employees). PY2014 reporting required ~1,200 hours of employee and contract staff time. Bi-State's current request for $20,000 assumes 600 hours times at an estimated hourly rate of $33.33.

Supplies

Bi-State budgets $1,576 per FTE for office general office supplies.

Other

Bi-State anticipates other costs to include meeting expenses, legal costs, beneficiary engagement, insurance, and facility costs.

Meeting expenses for Board, Committee, and Other meetings are budgeted at $200/month and include facility rental, A/V rental, etc. (Meals/food is not included in this estimate.). Bi-State has budgeted for 6 months of meeting expenses for a total request of $1,200.

Legal expenses are estimated at 100 hours in FY16 and 25 hours in FY17 at $350/hour for a total of $43,750. 100 hours are estimated in FY16 as CHAC anticipates there will be work needed for contract review and development (e.g., new contract with analytics vendor, contract amendments to VNA of VT and Pharos contracts), revisions to CHAC's participant agreement and operating agreement, and CHAC will need assistance with review of a compliance plan. $350/hour is the rate charged by Feldesman Tucker Leifer Fiddell, one of Bi-State's counsels expert in FQHCs, federal programs, and network development. This rate represents a 50% discount from their commercial rates (because of Bi-State's non-profit status and work with FQHCs).

Bi-State requests $10,000 for beneficiary engagement. These funds are needed for beneficiary opt-out mailings and to provide reimbursement to beneficiaries for travel associated with their participation in CHAC Board and Committee meetings.

Bi-State requests $4,845 to purchase business insurances for our CHAC work through December 2016. Insurances include: general liability, Directors & Officers, Errors and Omissions, professional liability, and cyberliability.

Facility costs are Bi-State's expenses related to office facilities. These are currently calculated at $14.98/square foot/year for the estimated 2408 square feet required from project staff (for a 6 month period), for a request of $18,035.93.

Total Direct Costs **$733,621.18**

Modified Total Direct Costs **$31,861.80**

Modified Total Direct Cost (MTDC) includes all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and up to the first $25,000 of each subaward (regardless of the period of performance of the subawards under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward in excess of $25,000.

Furthering Community Health Accountable Care in FY16 and FY17			
		FY16	*FY17*
Personnel	*Total*	*7/1/15-6/30/16*	*7/1/16-12/31/16*
Salaries	$ 117,059.73		$ 117,059.73
Benefits	$ 26,923.74		$ 26,923.74
Total Personnel	*$ 143,983.46*		*$ 143,983.46*
Contractual			
Analytics (e.g., Lewin for Optum HealthView Tableau)	$ 216,000.00	$ 144,000.00	$ 72,000.00
Temporary Staffing Agency (Chart Abstraction for PY2015)	$ 20,000.00	$ 20,000.00	
Triage Care Coordination: VNA of VT	$ 165,000.00	$ 82,500.00	$ 82,500.00
Telemonitoring Intervention: Pharos Innovations, LLC	$ 96,000.00		$ 96,000.00
Total Contractual	*$ 497,000.00*	*$ 246,500.00*	*$ 250,500.00*
Travel			
Mileage	$ 5,000.00		$ 5,000.00
Conferences	$ 5,000.00		$ 5,000.00
Total Travel	*$ 10,000.00*	*$ -*	*$ 10,000.00*
Other			
Legal Services (Compliance, Contract Expertise)	$ 43,750.00	$ 35,000.00	$ 8,750.00
Beneficiary Engagement (e.g., reimbursement for travel, mailings, etc.)	$ 10,000.00	$ 5,000.00	$ 5,000.00
Insurances	$ 4,845.00		$ 4,845.00
Meetings	$ 1,200.00		$ 1,200.00
Facility	$ 18,035.93		$ 18,035.93
Supplies	$ 4,806.80		$ 4,806.80
Total Other	*$ 82,637.73*	*$ 40,000.00*	*$ 42,637.73*
Modified Total Direct Cost			
Modified Total Direct Cost	$ 31,861.80	$ 8,500.00	$ 23,361.80
Total MTDC	*$ 31,861.80*	*$ 8,500.00*	*$ 23,361.80*
Total Request	**$ 765,482.99**	**$ 295,000.00**	**$ 470,482.99**

Furthering Community Health Accountable Care in FY16 and FY17
Deliverables and Implementation Timeline for VCHIP Provider Grant Proposed Activities
Q1: January – March; Q2: April-June. Q3: July-September. Q4: October-December.

Need 1: Original funding for CHAC's basic infrastructure is currently set to end on June 30, 2016.

Goal 1: Extend CHAC's capacity through December 31, 2016.

Objective 1.1: Maintain the adequate and appropriate staffing for CHAC through Bi-State's management services agreement and an operating budget for CHAC expenses and infrastructure.

Activities	Anticipated Outcomes	Milestone	Implementation Timeline	Person Responsible	Comment
Revise CHAC's operating budget	Staff will understand funding is secure through CY16	Approval of revised budget by CHAC Board	Q4 2015	CHAC Director	
	CHAC will have an operating budget that will extend through CY 2016	Approval of revised budget by CHAC Board	Q4 2015	CHAC Director, CHAC CFO, CHAC Informatics Director	
Obtain legal and professional services when needed	Bi-State and CHAC members will be able to seek legal and professional guidance on important issues, including vendor contracting, compliance, etc.	Contracted legal review of current policies and procedures	Q3 2015; ongoing	CHAC Director	

Need 2: Vendor contracts pertinent to the telemonitoring program currently end on December 31, 2015 and June 30, 2016.					
Goal 1: Extend CHAC's care management model which includes a telemonitoring outreach program through duration of Medicare Shared Savings Program.					
Objective 1.1: To extend the existing contracts with the Pharos Innovations, LLC and the VNA of Vermont for the telemonitoring program and the care coordination aspect, respectively, through the end of calendar year 2016 to align with the end of the MSSP time frame.					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Extend vendor contracts	Vendor contracts will be extended through CY 2016 and at least 1.0 FTE from the VNA will be maintained for the remainder of the project.	Timely execution of VNAVT contract amendment. Timely execution of Pharos contract amendment.	Q4 2015 Q2 2016	CHAC Informatics Director CHAC Informatics Director	
Maintain patient enrollment in telemonitoring program	Patient enrollment in the telemonitoring program will be maintained through CY 2016	At least 200 patients will continuously be enrolled in the telemonitoring program	Ongoing through Q4 2016	CHAC Informatics Director	

Need 3: Bi-State and the CHAC Members have recognized the lack of current capacity to effectively analyze claims data in a meaningful way.

Goal 3: Invest in an analytics solution to consume claims data and produce actionable information

Objective 3.1: Contract with a vendor for analytic services and for visualization software that will leverage past investments by the State and use current claims feeds to create drilled down data reports for use within CHAC's network.

Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Select vendor	Vendor will be selected adhering to Bi-State's procurement policy. Selected vendor will be endorsed by CHAC Board.	CHAC Board approval of vendor selection	Q3 2015	CHAC Informatics Director	Subset of CHAC Board is participating in demonstration of Lewin product on 5/27/2015.
Contract with analytics vendor	Bi-State will execute contract with a selected vendor for analytics services and to purchase visualization software	Timely execution of contract	Q3 2015	CHAC Informatics Director	

Objective 3.2: Use the vendors services and the visualization software to report out health center level and individual provider level data to the FQHCs and our community partners to increase awareness of improvement areas and aid the selection of new population based interventions					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Develop evaluation plan once vendor is selected	Bi-State will be able to test the effectiveness of the data and provide health centers with individualized reports.	Evaluation plan will include education, implementation, data testing, and use metrics (e.g. risk stratification, QI, and care coordination)	Q4 2015	CHAC Informatics Director	
Select focus areas for quality improvement initiatives	CHAC committee members will be able to select new areas of focus based on analysis of the claims data.	Three to four improvement areas will be chosen and approved by CHAC's Clinical Committee and/or Board.	Q4 2015	CHAC Informatics Director	
Develop clinical and operational best practice recommendations or intervention programs	Best practice recommendations or intervention programs for new focus areas will be adopted by CHAC's network	Implementation of best practice recommendations or intervention programs	Q1 2016	CHAC Informatics Director	
Evaluate impact of improvement initiatives	Bi-State and CHAC members will be able to analyze the impact of initiatives using the claims based analytics on a quarterly or more frequent basis	Reporting dashboard will be created and shared for past and new focus areas of improvement.	Q4 2015& ongoing quarterly	CHAC Informatics Director	

1. *As you know, VHCIP has engaged a contractor to develop a telehealth strategy for Vermont. CHAC's request includes remote monitoring services, which fall into this area of work. Please explain how continuing these remote monitoring services comports with the telehealth strategy (as presented to the HIE/HIT Work Group at their June meeting).*

   The proposed statewide telehealth strategy for Vermont recommends that 'telehealth strategies should support advanced care coordination models, integration of care across different providers, and motivated patient engagement.' The strategy suggests an adherence to the following guiding principles: patient centeredness, improved access to care, alignment with health reform programs, support for existing programs and efforts, and consistent outcome measures. Below describes how CHAC's remote monitoring aligns directly with recommended strategies and principles, increasing access to timely, appropriate care.

   The CHAC remote monitoring services project is an advanced care coordination model that supports patients and providers by identifying and engaging CHAC's Medicare beneficiaries who have COPD, CHF, and Diabetes and are in the rising risk pool toward hospitalizations. The project is a collaboration between CHAC and the Visiting Nurses Association (VNA) for care coordination, and has 200 participants at five health centers, with an anticipated enrollment of 300 individuals by the fall. The project requires the patient only to have a telephone or computer to log their data daily, and the VNA Care Coordinator follows up on patients whose data is out of the recommended parameter and does a nursing triage with them. She then may provide education, monitor, or refer to the FQHC for primary care triage. These records are then sent to the FQHC to be stored in the Electronic Health Record. This project has allowed "risking risk" patients to be identified sooner, triaged appropriately, and stabilized, all while the patient increases their knowledge of their own illness, increasing patient engagement.

   The remote monitoring used by the Home Health Agencies is recognized as a 'strong' program. CHAC's collaboration with the VNA for care management has allowed a swift and natural alignment of respective remote monitoring systems in several ways. We have found that CHAC's remote monitoring is the 'light touch.' The VNA provides the more intensive remote monitoring services for patients who are post-hospitalization. Once they are stabilized, patients have graduated from the VNA remote monitoring to the CHAC remote monitoring. The VNA has also identified very fragile patients who are enrolled in the CHAC program, but actually need to be placed on the VNA's remote monitoring system. We are confident that we have reduced emergency room admissions and unnecessary hospitalizations, and are eager to see the outcome results in September.

2. *What is the return on investment for the funds provided to CHAC to date? How has this investment improved the quality of health care for Vermonters, reduced cost, and fostered integration?*

CHAC understands from preliminary data that it has likely achieved savings of approximately $5-6 M (~9-10%) in the VMSSP product line for Program Year 2014. This should be confirmed in July or August, and provides evidence of a strong quantitative return on its investment of ~500%. CHAC accounts for this initial return on investment by the local collaborations that that ACO model has catalyzed and the cost-effectiveness of the FQHC model. CHAC is particularly eager to see the results of PY2015, as those results will include several major centralized CHAC initiatives: shared evidence-based guidelines in the areas of Diabetes Management, COPD, CHF, and Falls Risk Assessment; our Medicare Tele-monitoring program; and our efforts to identify, benchmark, and improve results for various quality process and outcomes metrics.

CHAC offers Vermonters several qualitative returns on its investment. The CHAC structure has promoted local collaborations amongst health centers, community mental health centers, home health agencies, and community hospitals – all to improve continuity of care for Vermonters. These newly-structured collaborations are strikingly apparent in the work of CHAC's Clinical Committee, as the groups hammer out and implement shared recommendations, triage protocols, etc.

CHAC additionally offers the State qualitative returns on its investment. CHAC's existence offers the state an alternative ACO approach, with the ability to test different projects (e.g., telemonitoring), collect additional data, and provide different perspectives during this period of innovation. This perspective and experiences will assist the State in shaping a model for 2017 and beyond.

3. *If the Core Team does not approve this request, how will CHAC perform the services described in the request?*

CHAC's funding request includes three major components:

- Extension of CHAC's capacity until the end of calendar year 2016,
- Extension of CHAC's care management model which includes a tele-monitoring outreach program, and
- Establishment of a claims based analytics system.

CHAC's highest priority is funding the extension of centralized capacity through the end of CY2016. If the request for these dollars is not approved, the CHAC Board would likely prioritize funding this amount out of savings anticipated in the VMSSP product line, as CHAC's staffing is "bare bones" and required at current levels to keep the ACO functioning and compliant with requirements. This use of funding would be made in lieu of other possible CHAC Board-directed reinvestments of savings, particularly within the local communities.

If the request for extending the CHAC care management model is not approved in full, CHAC would request the consideration of a partial approval (including funding to VNAs of VT to continue the VNA Care Coordinator position and services through 6/30/2016),

and would likely end both components of the remote monitoring project at that time. If no funding for the care management model is provided, the CHAC Board would need to determine whether to reinvest some of the savings anticipated in the VMSSP product line to extend the VNA of VT contract through 6/30/2016. This use of funding would be made in lieu of other possible CHAC Board-directed reinvestments of savings, particularly within the local communities. Alternatively, the CHAC Board could decide to delegate remote monitoring care coordination duties to local care coordinators within the FQHCs, though CHAC has been advised that a decentralized model is less effective, and in so doing, CHAC would lose a well-qualified and enthusiastic VNA Care Coordinator.

If the request for funding of a claims based analytics system is not approved, the CHAC Board would need to determine whether this is an investment that could be supported out of savings anticipated in the VMSSP product line. This is a centralized investment that they likely will prioritize, however it will compete against other possible CHAC Board-directed reinvestments of savings, particularly within the local communities, and the time spent making these determinations will likely delay considerably the possible implementation of an analytics-system or the contracting with another entity to perform CHAC analytics.

Attachment 4d

OneCareVermont

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General Information:

Lead Organization Applying: University of Vermont Medical Center, Inc
Collaborating Organizations: OneCare Vermont, LLC

Key Contact for Applicant: Todd Moore
Relationship to Applicant: employed
Key Contact Email: todd.moore@onecarevt.org
Key Contact Phone Number: 802-847-1844
Key Contact Mailing Address: 356 Mountain View Drive, Suite 301

Fiscal Officer (must be different from Key Contact): Abraham Berman
Relationship to Applicant: employed
Fiscal Officer Email: abraham.berman@onecarevt.org
Fiscal Officer Phone Number: 802-847-0887
Fiscal Officer Mailing Address (if different from Key Contact): N/A

Project Title and Brief Summary:

Expanding Population Health Management Strategies in FY 16:
The statewide full continuum of care network known as OneCare Vermont (OCV) is actively innovative—

- Redefining relationships among individual and institutional care providers across Vermont
- Broadening the concept of "care teams" to include arrays of resources in each community
- Creating, identifying and adopting better ways to keep individuals and communities well
- Building an informatics infrastructure to identify and inform care delivery opportunities at the point of care

Continuing to receive SIM funds for a second year will further our collective efforts towards innovative, highly reliable, evidenced-based population health care strategies for Vermonters by providing support to:

- Fund local medical leadership, facilitation, quality improvement training and project support
- Analyze and provide data for targeted health care performance improvement collaboratives
- Further develop and disseminate population health evidenced-based guidelines to support clinical performance improvement initiatives
- Support performance improvement activities through 14 Regional Clinical Performance Committees (RCPCs)/Unified Community Collaboratives (UCCs) serving every community in Vermont
- Fund a statewide care management tool and tracking system
- Funds to offset a portion of OCV's year 2 support fees for VITL

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Budget Request Summary

Budget Category	Total
Personnel	$ 1,552,250
Fringe	$ -
Travel, Equipment, Supplies	$ 97,750
Contracts	$ 1,850,000
Other*	$ -
Total	$ 3,500,000

Question A: Activities for which the applicant is requesting funding

OneCare Vermont (OCV) is requesting continued support, beyond its first year grant, to expand upon the work performed during the first year and to fund the data analytics infrastructure needed to combine clinical and claims data in support of strong population health management tools. Specifically we are requesting:

1. Year 2 continued project funds to support local medical leadership, quality improvement training/support and clinical facilitation in the amount of $2,000,000
    a. Continued funding of 14 Regional Clinician Representatives (physicians and/or advanced practice clinicians) serving as clinical champions for their regions
    b. OCV's Clinical Consultants deployed to assigned regions that support clinical priority performance efforts and Regional Clinical Performance Committees (RCPCs)/Unified Community Collaboratives (UCCs)
    c. Ongoing development and initiation of statewide Clinical Advisory Board (CAB) and RCPCs/UCCs
    d. Identification of statewide clinical improvement targets

e. Facilitation of statewide learning collaboratives aimed at meeting clinical improvement targets
f. Assessment and tracking of improvement efforts

Per the aim of the first grant, OCV has amassed and retained the state's largest value-based care network of hospitals, physicians and other clinicians who have worked collaboratively with the Blueprint for Health and the other two (2) ACOs to improve the quality of care of Vermonters (See Attachment A: Quality Measures 2013 v. 2014 report card). Our successful proposal for 2015 support aspired to implement a vision of service area focus on population health management by the full continuum of care and services, with all providers regardless of ACO affiliation, and with a high degree of collaboration instead of competition with Vermont Blueprint for Health programs. We believe the "on the ground" reality has achieved our greatest hopes for 2015 and is highly worthy of continued support in 2016. Our track record of impact, collaboration, and community-based focus is clear. In further support of this, we have also attached our preliminary draft "Transformation Report" as conducted and prepared on behalf of the VHCIP project based on a required review meeting. Additionally, we have attached the Blueprint for Health's Proposal for Delivery System Reform: Integrating Vermont ACO and Blueprint Activities, which provides further evidence of the momentum and convergence around this element of our request for 2016 continued support. (See Attachments F and G respectively).

2. Fees to support a statewide care management tool in the amount of $250,000. This includes setup costs associated with the implementation of a health care technology platform that enables real-time, team-based care coordination and communication.

The care management system will extend collaboration of care across the health care continuum, as well as patients and family caregivers. By providing a centralized tool at the statewide level, cost reductions for the top 5 percent most expensive patients will

be realized. This reduces inefficiencies by assuring enhanced communication of data and care needs for patients. Supporting OCV efforts on deploying this capability will support the providers who are involved in the SIM Care Models/Care Management Learning collaboratives, empowering them with the tools and systems necessary to manage complex patient populations.

3. Funds to implement a statewide post-acute care network (PACN) patient identification and tracking system (PatientPing) to be integrated with the statewide Health Information Exchange, in the amount of $500,000.

   PatientPing enables real-time admissions and discharge notifications anywhere patients receive care through a fully secure hub and spoke web-based interface. This will reduce costs associated with avoidable readmissions and over-utilization due to broken communication links. There are significant economies of scale associated with a statewide approach to this level of PACN tracking and sustainability.

   Our approach seeks to strengthen the joint effort between OCV and VITL. As with the care management system, OCV brings provider engagement in designing care processes and ensuring provider use of the system capabilities. In addition, VITL's current Event Notification System (ENS) strategy provides notification within acute care and physician office settings only. PatientPing has the potential to establish the PACN presence to provide full continuum of care notifications for long-term gains in quality care improvement and reduced costs in areas like readmissions.

4. Funds to offset a portion of OCV's year 2 support fees for VITL, in the amount of $750,000.

   As part of our support agreement with VITL, which includes fees of $0.73 PMPM for support and maintenance of the ACO Gateway infrastructure, OCV will collaborate with

VITL provider outreach staff to implement data connections to providers' EHR systems (where none presently exists) and to assess and correct deficiencies in quality of data from extant data connections. Having funds flow through OCV will create stronger mutual accountability between OCV and VITL to ensure we are receiving value from our ACO gateway infrastructure and to allow us to take a more direct role in defining priorities for interface development and remediation.

The persistent derivation of data from providers, and the storage of it in a secure, well-curated manner, is the lifeblood of any successful population health management strategy and system. OCV, as well as other value-based entities and initiatives across the state cannot improve health in a meaningful way, nor reduce costs over time, without complete and valid data sets from points of care. It is our intention to enhance efforts in creating the pipes to providers' electronic data in a secure manner. These efforts bring the totality of data closer to 100% in terms of available and mineable electronic clinical data for purposes of population health management. These funds will be used to advance the progression of high-quality data flowing through the Vermont Health Information Exchange to benefit patient care and improve population health for all Vermont patients.

Question B: Number of Providers and Patients Impacted

OCV has agreements with FQHCs, Continuum of Care providers, specialists and primary care physicians, and hospitals in order to support a multi-payer ACO construct (Medicare, Medicaid, and Commercial). The network for the three ACO Shared Savings programs consists of: UVMMC and its 1,000 plus providers; D-HH and its 800 plus providers; all community PPS and Critical Access Hospitals in VT and their employed physicians; VT's one behavioral health specialty hospital and its employed physicians; 4 FQHCs; 5 RHCs; community/private physician practices; 10 home health care and hospice organizations in VT; 28 skilled nursing facilities in VT; and all

10 designated community mental health centers in VT. OCV has over 3,000 providers in its statewide network. This combination of large geographical reach and full continuum of care under a collaborative network model has provided a powerful foundation for population health management (PHM) for our attributed population of over 100,000 Vermonters.

Question C: Relationship to VHCIP goals

Starting in December of 2013, OCV received a one (1) year funding opportunity under SIM to support medical leadership, quality improvement, analytics and data, and clinical facilitation to collectively support Vermont's Accountable Care Organizations capacity to meet the Three Part Aim. This second year request, allows OCV to evolve the foundational work undertaken with the first grant and to further strengthen our local accountable care communities RCPC/UCC in meeting the Three Part Aim.

OCV's work has complemented Vermont Blueprint for Health's successful commitment to primary care by bringing together Vermont's full provider continuum to execute on innovative, highly reliable, evidenced based population health management strategies that improve the lives of Vermonters.

To date, we have met the deliverables under the grant by:

- Selecting clinical priorities that align with and complement other statewide reform initiatives
- Supporting (financial, data and human resources) the development/transformation of 14 RCPCs/UCCs in every Health Service Area (HSA) in collaboration with the medical community, the continuum of care providers, the Blueprint for Health, and the other ACO's throughout the state (See Attachment B: Example Bennington RCPC Charter)
- Contracting with physician and advanced practice providers in all 14 HSAs to be clinical champions and support the clinical priorities of the RCPCs/UCCs

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- Launching a statewide Learning Collaborative forum, with over 120 participants in attendance, to support performance improvement work on OCV emergency room and readmission/admission clinical priorities approved by the OCV CAB
- Developing and disseminating, at the Learning Collaborative, Readmission Change Packets which identify best practice based interventions and ideas for implementing small tests of change tools for addressing risk; Best Practice Risk Assessment Tools; Needs Assessments with a step by step guide, including some sample teach back tools; PDSA Tool; and Force Field Analysis
- Completing the quality measurement training and collection process for three (3) Shared Savings Programs with Vermont's other ACOs

As noted in our summary for the recent VHCIP sub-grant Symposium, we have learned that creating, identifying and adopting better ways to keep individuals and communities well is a goal everyone can agree on. The work is hard and it takes longer than you would anticipate but the cooperative effort by Vermont's provider continuum brings forward greater value than would be possible if the initiatives proceeded independently. (See Attachment F: OCV Preliminary Care Transformation Report)

We can say this with confidence as the data shows that we are well on our way to meeting the Three Part Aim in the following ways:

- Preliminarily evidence reveals we increased our Quality Scores for Medicare by five (5) percentage points between 2013 and 2014 with 11 of 14 health service areas increasing their scores
    - Increased our Medicare disabled populations quality scores by 35.6%, bringing them on par with other Medicare/Dual eligible groups
    - Increased our medication reconciliation scores from the 70th to 90th percentile
    - Increased our diabetes composite score from the 40th to 70th percentile

- Increased our coronary artery disease composite score from the 30th to 60th percentile

- Saved $8 per beneficiary per year against CMS spending targets, for over $300,000 in savings
- Scored high on Satisfaction/Patient Experience rankings- in the 80th and 90th percentiles
- Preliminary estimates for the Medicaid and Commercial ACO programs show that quality scores were consistent with Medicare

Question D: Impact on similar projects (ongoing or anticipated)

In regards to funding request #1-4, OneCare Vermont has identified synergistic opportunities outlined in *Question J* of this request.

Question E: Applying project learning on a state-wide basis

As previously described, the combination of statewide reach and full continuum of care providers under a collaborative governance and network model has provided for a strong population health management platform able to meet the Three Part Aim for a population of over 100,000 lives.

OCV has designed a structure that allows participants significant input and a strong voice in governance and establishing the clinical and quality programs that form the basis for a result oriented statewide network.

- Clinical Advisory Board (CAB) - with over 50 providers representing every HSA in the state. The CAB also has two (2) subcommittees; the Lab and Pediatric Subcommittees thus demonstrating the commitment to other care delivery and population segments.

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This is perhaps the largest organized group of actively engaged clinicians. Their charge is to identify opportunities based upon the data, prioritize network improvement projects, and provide a forum for sharing of best clinical practices. Every year the CAB identifies priorities that the network will focus on and as noted in *Question I* of this request, The CAB has identified priorities in CY 2015 that has the potential to yield significant improvements in quality and satisfaction while reducing overall costs.

- Quality Improvement Committee (QIC) - made up of OCV senior medical and nursing leadership, the directors of both the Jeffords Institute at Fletcher Allen Health Care and the Value Institute at Dartmouth-Hitchcock, and the 14 Regional Clinician Representatives (RCRs) described in this proposal. The committee helps prioritize specific elements and measures of our quality improvement efforts under the learning collaborative approach, and provide an important "bridge" between our CAB and the local Regional Clinical Performance Committees (RCPCs)/Unified Community Collaboratives (UCCs). Additionally, on a semi-annual basis this committee brings together medical leadership throughout the State, other ACOs, Payers and the Vermont Blueprint for Health to coordinate quality improvement efforts.
- RCPCs/UCCs - represent local multidisciplinary teams that carry out the clinical priorities and engage in data driven process improvement activities. The established RCPCs/UCCs in each HSA have invited participation from the following entities:

  - Leaders from the other ACO's
  - Vermont Blueprint for Health
  - OCV contracted Regional Clinician Representatives and Clinical Consultants
  - Clinical and Quality Improvement experts from local or referring hospital systems
  - Representation from care coordination entities (e.g., Blueprint Community Health Team extenders, commercial payers, SASH)
  - Continuum of care providers (home health, skilled nursing, hospice, designated agencies etc.)
  - Content experts (pediatric mental health, palliative care, chronic care etc.)

- State agencies that serve the populations (e.g., VDH, VCCI and IFS)
- Representation from the FQHC's and RHC's - affiliated with both OCV and Community Health Accountable Care

Members of the RCPC/UCC team foster involvement and ownership at the local level, leading the way on care and delivery transformation.

In May of this year, OCV launched its first statewide learning collaborative. There were 122 attendees from 13 of the 14 HSAs. Demographics were as follows: approximately 9% Administrators, 10% Vermont Blueprint Community Health Teams and Extenders, 10% Community Providers, 27% Physicians and Advanced Practice Providers, 33% Nurses/Care Coordinators/Quality, and the remaining attendees were OCV staff.

The event offered the following:

- Keynote speakers from the GMCB and VHCIP
- The Continuous Quality Improvement Director from the UVMMC Jeffords Institute
  - Provided an overview of quality Improvement process using the IHI tools
  - Delivered an overview of how learning collaboratives work and how this will be applied to OCV's selected clinical priorities
- A panel of Cardiologists from UVMMC, Dartmouth, and Brattleboro
  - Shared best practices in CHF management
- A physician from Dartmouth Hitchcock
  - Presented on improving care coordination for ER high utilizers (hot spotting)

Teams from the HSAs worked to identify and create small tests and then conducted a force field analysis on that small test of change. The exercises will help them once the full teams can coalesce and work through one of the clinical priorities with their full RCPC/UCC.

All attendees were provided with best practice tool kits, including:

- OCV Readmission Change Packet: Identifies Primary Drivers, Best Practice Based Interventions, and Ideas for Implementing Small Tests of Change
- Tools for Addressing Risk: Best Practice Risk Assessment Tools
- Needs Assessment: Step by Step Guide, including some sample tools Teach Back Tool
- PDSA Tool
- Force Field Analysis

Attendee feedback was positive with 89% rating the event a 4 or 5 (out of 5) with comments that the panel experts, networking, and team building were highlights of the day.

The improvement training tools and best practice guidelines will be used throughout the year to support the RCPCs/UCCs clinical priority projects. The next learning session is to occur in August/September of this year.

OCV is positioned to lead Vermont's clinical improvement efforts across the regions of the state and we have demonstrated high value by measurably improving performance year over year.

Question F: Data Sharing and connection with existing health information

The ability to provide comprehensive and real-time clinical information to every health care provider is an essential requirement as part of a Population Health Management infrastructure designed to reduce costs and provide better care.

OCV delivers population-level cost, quality, and utilization analytics to compare data at an HSA-level on a number of key metrics. Additionally, custom analyses and patient-level detail reports are developed from the OCV data warehouse to support RCPC/UCC quality improvement projects.

Reporting is generated by a team of highly-skilled technical and business analysts at OCV. We employ state-of-the-art approaches to covered population demographic profiles, disease state and episode registries, risk assessment, utilization analysis, cost performance, and population clinical measurement. Internal and external benchmarking, opportunity analysis, predictive modeling, and decision support are appropriately embedded in all approaches.

Specific examples of analyses performed by the OCV Analytics team to date include:

- Episode cost variation analysis by facility for Medicare beneficiaries receiving total joint replacements
- Inpatient cost and utilization comparisons between HSAs
- Readmission analysis
- Ambulatory sensitive condition admission rates by HSA
- Potentially avoidable emergency department use rates by HSA
- Home Health utilization and variation analysis by HSA
- Skilled Nursing Facility utilization and variation analysis by HSA
- Enhanced medication reconciliation reporting for a patient-centered medical home practice, combining claims and EMR data
- Beneficiary-level detail of patient risk factors for distribution to primary care providers

OCV is collaborating with the Vermont Blueprint for Health to design co-branded provider and practice level reporting using the VHCURES all-payer claims database, the DocSite clinical registry, along with clinical data from the VHIE in order to meaningfully support care delivery transformation. These reports will provide a comprehensive, multi-payer view of practice patient panels (including non-ACO beneficiaries) and will be designed to meet the measurement needs of the ACO while providing meaningful and actionable performance data for practices. These reports will be designed to directly support the work of the RCPCs/UCCs.

The combination of claims from three payers and clinical data from the HIE allows analysis and reporting to participants to support quality measurement and care management initiatives.

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Question G: Alternative funding sources sought

The annual operating budget for OCV is approximately $9M and is at scale with required capabilities. In 2015, the University of Vermont Medical Center (UVMMC) and Dartmouth-Hitchcock Health (D-HH) provided combined annualized funding of $4.7M. Additional funding in the amount of $2M came from network participants through participant fees and the remaining funds came from a VHCIP SIM grant.

For 2016, OCV is proposing a level budget, however without the requested SIM funding in this application; D-HH, UVMMC, participant hospitals, and possibly other OCV providers would have to shoulder the budget gap. As the state moves towards a comprehensive payment reform structure, it is vital to provide the network with as much direct support as possible in these formative years, and especially as we attempt to maintain the network and current momentum through 2016 on our way to more comprehensive population-based payment reform expected for 2017. The requested SIM funds will help to close the budget gap, thereby financially unburdening the network and allowing them to focus their core mission of delivering quality care.

Beginning in 2017, we believe that the capitation and population-based payment models being developed by CMS may allow OCV (in conjunction with its governance and network) to determine whether it is feasible to fund budget gaps from withhold or capitated payments prior to distribution to the network.

Question H: Technical Assistance Sought

At this time, OCV is not seeking technical support from State. We will keep these resources in mind should our future needs change.

Question I: Return on Investment (cost and quality)

As referenced in *Question C,* OCV through its QI efforts has already shown significant improvements in quality and costs in its Medicare programs from 2013 to 2014. Preliminary quality data for the Medicaid and Commercial Shared Savings programs for 2014 are showing a similar pattern. It is still premature to assess if there are any savings in the Medicaid and Commercial programs.

For 2015, OCV's CAB identified the following clinical priorities:

- Ambulatory Sensitive Condition Admission reduction of 5% for Heart Failure and COPD/Asthma
- Emergency room reduction of 5%
- 30 day all cause readmission reduction of 5%
- Increase in Hospice Utilization by 5%
- Increase overall quality report card score by 5%

Achieving these improvements in just the Medicare population is expected to conservatively yield over $2 million in savings as well as improve overall quality and experience of care.

To address the populations under the Medicaid and Commercial programs, the CAB recently voted to include the following priorities:

- Increase Adolescent Well-Care Visits by 5%
- Increase Mental Health Follow Up after Hospitalization by 5%
- Increase Developmental Screening by 5%

We do not yet have savings estimates available since these priorities were just recently adopted.

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For all populations, an opportunity exists to decrease costs, increase quality and improve patient and provider experience of care for the top 5% of the highest health service utilizers. According to various research studies, the top 5% of utilizers account for approximately 32% of total medical costs. A reduction of unnecessary high cost services could affect total medical costs up to 20% or $27 million dollars in the aforementioned population. As OCV moves toward a capitated health system, decreasing costs for the highest utilizers will lead to a more financially sustainable organization. A systematic approach will be utilized to identify opportunities and continually improve program operations.

Question J: Synergy with other activities underway (avoiding duplication)

OCV has a strong history of collaboration amongst its major stakeholders. Statewide participation is significantly better than duplicating scarce resources and allows for a high degree of cooperation in OCV's efforts to promote evidence-based medicine, improve beneficiary engagement, meet quality and cost metrics and coordinate care. In addition to efforts listed in *Question C* of this proposal, OCV has also participated in the following collaborative efforts:

- Aligned with the Vermont Blueprint for Health on quality measures linked to medical home payments
- Collaborated with the Vermont Blueprint for Health to provide co-branded practice level reporting using VHCURES, DocSite, and clinical data from the VHIE in order to meaningfully support care delivery transformation. These reports will be designed to directly support the work of the RCPCs/UCCs
- Partnered with the Vermont Blueprint for Health and VITL on an ACO data exchange initiative to serve our common goal for high quality, meaningful and actionable data that would bring efficiency to our care coordination and quality collection efforts.
- Partnered with the Vermont Health Care Innovation Project, the Vermont Blueprint for Health and its providers to develop and implement learning collaboratives aimed at building high-performing, multidisciplinary care coordination systems that include

patients and families as partners. The learning collaboratives will explore whether integrated and collaborative care coordination services can improve quality of care, patient and family experience, and health and wellness while reducing the overall burden of cost to the health care system.

- Partnered with the Vermont Child Health Improvement Program and the Vermont Health Department to create a pediatric-specific collaborative to improve the skills of care coordination teams in those primary care practices. The goal was to enroll nine (9) practices in a six month effort to identify families who could benefit from care coordination interventions and look at process measures of care plans created, care conferences initiated and family satisfaction pre and post intervention.

Question K: Evidence base for proposed activities

OCV promotes evidence-based medicine (EBM) through the identification, implementation, and evaluation of EBM opportunities. OCV's comprehensive population health management informatics infrastructure provides a mechanism for combining claims and clinical data from all of its participants in order to identify evidence-based projects. EBM opportunities accompanied by guidelines are brought forward to OCV's statewide CAB for review and approval. The CAB clinical champions, who represent each HSA in VT, work through their RCPC/UCC to implement changes in their community using standardized performance improvement approaches. Evaluation is conducted at the local and statewide level with the support of OCV's informatics platform, which allows for drill down analysis at the regional and participant level to measure and improve EBM compliance and expected performance impacts.

The OCV Learning Collaborative in May was based on the Institute for Healthcare Improvement (IHI) model, encompassing the framework to guide improvement work. The IHI developed the *Breakthrough Series* to help health care organizations make “breakthrough" improvements in quality while reducing costs. The driving vision behind the *Breakthrough Series* is this: sound

science exists on the basis of which the costs and outcomes of current health care practices can be greatly improved, but much of this science lies fallow and unused in daily work. There is a gap between what we know and what we do.

The *Breakthrough Series* is designed to help organizations close that gap by creating a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements. It is a short-term (6 to 15 month) learning system that brings together teams from hospitals or clinics to seek improvement in a focused topic area. Research published by IHI shows those teams in such collaboratives have achieved dramatic results, including reducing waiting times by 50 percent, reducing worker absenteeism by 25 percent, reducing ICU costs by 25 percent, and reducing hospitalizations for patients with congestive heart failure by 50 percent. [1]

OCV utilizes a Plan-Do-Study-Act (PDSA) approach for our performance improvement activities. The PDSA approach is an integral part of the IHI Model for Improvement, a widely demonstrated simple but powerful tool for implementing quality improvement.[2] The literature has extensively borne out that IHI's PDSA model, which enables teams to conduct small tests of change in a disciplined and often rapid timeframe (i.e. rapid cycle improvement), is a valid and reliable approach to help the local care systems gain knowledge, quickly correct course when needed, and ultimately make measurable improvements in the delivery of care.[3] For the purposes of our project we are using a Jeffords Institute developed PDSA worksheet to continously monitor performance.

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[1] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003

[2] Langley GL, Nolan KM, Nolan TW, Norman, CL, Provost, LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition) San Francisco: Jossey-Bass Publishers; 2009.

[3] Singh K, Sanderson J, Glaarneau D, Keister, T, Hickman D "Quality Improvement on the acute inpatient psychiatry unit using the Model for Improvement", The Oshsner Journal, Fall 2013; (13): 380-4.

If awarded, OCV will apply the funding to continue with EBM care coordination and quality improvement activities through our communities. See project plans for more information.

Project Implementation Plan and Timeline

See Attachment C: Learning Collaborative Schedule

See Attachment D: Care Management Software Implementation Schedule

See Attachment E: Patient Tracking Implementation Schedule

OneCare Vermont
356 Mountain View Drive
Suite 301
Colchester, VT 05446

Budget Narrative

		Totals		
Position Title and Name	**FTEs**	**Time**	**Months**	**Amount Requested**
Clinical and Quality Consultant	8	90.0%	12	$ 648,000
Manager - Quality and Care Coordination	1	90.0%	12	$ 99,000
Clinical Improvement and Compliance Specialist	1	100.0%	12	$ 95,000
Director of Quality and Care Coordination	1	90.0%	12	$ 126,000
Vice President - Clinical and Network Operations	1	30.0%	12	$ 51,000
Chief Medical Officer	1	30.0%	12	$ 90,000
Director of Operations	1	30.0%	12	$ 42,000
Manager of Operations	1	35.0%	12	$ 26,250
Senior Information Analyst	3	60.0%	12	$ 144,000
Information Analyst	1	60.0%	12	$ 39,000
Programmer Analyst Sr.	1	60.0%	12	$ 54,000
Manager of Analytics	1	60.0%	12	$ 54,000
Director of Analytics	1	60.0%	12	$ 84,000
Project 1: Total Salary and Wages				$ 1,552,250
Project 1: Regional Clinician Representatives		100%		$ 350,000
Project 1: General Overhead - ~6% (travel, admin support, supplies, space etc.)		6%		$ 97,750
Project 1: Total				**$ 2,000,000**
Project 2: Care Management Tool		**100%**		**$ 250,000**
Project 3: Patient Tracking Tool		**100%**		**$ 500,000**
Project 4: VITL Support		**86%**		**$ 750,000**
Totals				**$ 3,500,000**

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Attachments

Attachment A: Quality Measures 2013 v. 2014 report card

Attachment B: Example Bennington RCPC Charter

Attachment C: Learning Collaborative Schedule

Attachment D: Care Management Software Implementation Schedule

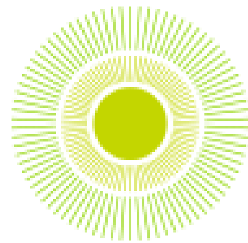
Attachment E: Patient Tracking Implementation Schedule

Attachment F: OCV Preliminary Care Transformation Report

Attachment G: Blueprint for Health's Proposal for Delivery System Reform: Integrating Vermont ACO and Blueprint Activities

OCV 2014 Quality Measure Scorecard

Version 2.0 03/26/2015



OneCareVermont

NOTICE: All data produced by OneCare VT is for the sole use of its contracted OneCare VT Participants and must not be distributed to other individuals or entities who do not hold a legally binding contract with OneCare VT. These materials are confidential and may only be used in connection with OneCare VT activities. The use of these materials is subject to the provisions of the Business Associate Agreement and/or Participation or Collaboration Agreement with OneCare VT.

Prepared by ALC 03/26/2015

OCV Quality Measure PY2 2014 Scores – Reporting and Performance Measures

Domain	Measure		PY1 2013	PY2 2014	PY3 2015	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	OCV Score	n	Quality Points
Care Coordination/ Patient Safety	12	Medication Reconciliation	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	93.41	683	2.00
	13	Falls: Screening for Fall Risk	R	P	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	47.31	594	1.70
Preventive Health	14	Influenza Immunization	R	P	P	29.41	39.04	48.29	58.60	75.93	97.30	100.00	63.81	572	1.55
	15	Pneumococcal Vaccination	R	P	P	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.80	599	1.55
	16	Adult Weight Screening and Follow-up	R	P	P	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.81	418	1.55
	17	Tobacco Use Assessment and Cessation Intervention	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	96.67	600	2.00
	18	Depression Screening	R	P	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	28.07	456	1.55
	19	Colorectal Cancer Screening	R	R	P	19.81	33.93	48.49	63.29	78.13	94.73	100.00	70.27	592	2.00
	20	Mammography Screening	R	R	P	28.59	42.86	54.64	65.66	76.43	88.31	99.56	71.12	599	2.00
	21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	66.43	414	2.00
At-Risk Population Diabetes	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	R	P	17.39	21.20	23.48	25.78	28.17	31.37	36.50	28.67	600	2.00
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00	13.10	603	1.85
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	70.57	581	1.55
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	R	P	35.00	42.86	51.41	57.14	61.60	67.29	78.81	58.81	471	2.00
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P	45.44	56.88	68.25	78.77	85.00	91.48	97.91	90.02	471	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	84.12	170	2.00
At-Risk Population CAD	CAD Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P	54.08	61.44	66.11	69.96	72.32	76.40	79.84	66.67	438	2.00

Note: Measure 27 is 'reverse scored'.

Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible Points	OCV Possible Points (using info currently available)	OCV Points Scored	OCV Domain Scores	Domain Weight
Patient/Caregiver Experience	7	7 individual survey module measures	14	-	-		25%
Care Coordination/ Patient Safety	6	6 measures, plus the EHR measure double-weighted (4 points)	14	4	3.70	93%	25%
Preventive Health	8	8 measures	16	16	14.20	89%	25%
At-Risk Population	12	7 measures, including 5-component diabetes composite measure and 2- component coronary artery disease composite measure	14	14	13.10	94%	25%
Total in all Domains	**33**	**28**	**58**	**34**	**31.00**		**100%**

Scores not available for survey-based measures and CMS-calculated claims based measures.

Preliminary Score

2014	2013
91.6%	**100.0%**

-8.4%

All measures were pay-for-reporting in 2013

R = Reporting P = Performance

Performance Year 2, OneCare Vermont must report completely and accurately on all measures, however, its performance will be assessed relative to performance benchmarks for a specified set of measures. Measures 18, 19, 20, 21 ,22-26, 29, 31 and 32 -33 are still paid for reporting measures. This scorecard reflects OCV's preliminary score for reporting and performance measures in 2014.

n = number of beneficiaries included in the CMS GPRO submission for each quality measure. For measure 12, n is the number of discharge dates selected for medication reconciliation.

ATTACHMENT B: Example Bennington RCPC Charter

OneCareVermont

Bennington Regional Clinical Performance Committee

Committee Charter

Purpose: The Bennington Health Service Area Clinical Performance Committee (Bennington RCPC) will identify and develop systems of care to better support population health management in the Bennington Health Service Area to accomplish OneCare Vermont's (Board of Managers and Clinical Advisory Board) strategies to meet Vermont's health care reform goals.

Principles: The Bennington RCPC will:

- Include leaders from the medical community, health care community, local/regional community agencies, and health care leadership.
- Ensure that members have an equal voice on the committee and will work to reach consensus on decisions.
- Identify opportunities to collaborate and utilize the Bennington Blueprint as the infrastructure to advance the health care delivery system to a Medical Neighborhood.
- With population health management, consider a "whole person" approach including physical health, mental health, and socio-economic well-being.
- Align the quality of care goals and care coordination systems with OneCareVT and the Blueprint.
- Identify and work to address gaps in services, duplication of services and rework within the health care system.
- Serve as a sounding board and make recommendations about new programs related to health care delivery within the Bennington HSA.
- Charter, monitor and evaluate performance improvement teams to reach the OneCareVT goals.
- Provide required reports, feedback and recommendations to the OneCareVT Clinical Advisory Board.
- Take direction and guidance from the OneCareVT Clinical Advisory Board.

Membership:

Co-Chairs: OneCareVT Regional Physician Representative (RPR)
Director for the Bennington Blueprint (UHA)

Operations/Administrative Support: Provider Relations Coordinator (UHA/OneCareVT)

Members: Physician Representatives and Affiliates for the Clinical Advisory Board (to include Peds)
Physician Representative to Governing Board
OneCareVT Regional Physician Representative (RPR)
Bennington HSA Representatives for OneCareVT
CEO of UHA (PHO)
Director for Planning for SVHC
CNO for SVMC
Administrative Director for Outpatient Services (SVMC)
Director for the Bennington Blueprint for UHA
Blueprint Community Health Team Leader for UHA (CHT)
Blueprint Practice Facilitator for UHA
Administrative Director for Quality, Safety and Value at SVHC
Administrator for Centers for Living and Rehabilitation (SNF/Sub-acute)
Director of Operations for SVMC Physician Practices (Specialists)
Representative from Rutland VNA (Home Health)
Executive Director for UCS (Designated Mental Health Agency)
CEO/Executive Director of FQHC (Bennington County)
ACO Clinical Coordinator for OneCareVT (Bennington/ Rutland)
Executive Director on the Council on Aging (Bennington County)
Executive Director of the Local Agency for Housing (Bennington County)
District Director of the Vermont Department of Health
Field Officer for the Vermont Agency of Human Services
Community Member
SVHC Chief Information Officer
SVHC Senior HR Specialist, Benefits Administrator

Guest: OneCareVT Network Liaison

Sub-Committees/Ad Hoc Task Forces: As assigned by the Bennington RCPC

Accountability:

The Co-Chairs will do the following:

- Plan the agenda
- Lead and facilitate the meeting
- Provide overall support to the work of the committee
- Maintain the records of the committee
- Provide required reports and feedback to the Clinical Advisory Board (CAB)

The Operations/Administrative Support Person:

- Send out agenda and meeting packets
- Take attendance
- Draft the minutes
- Arrange for meeting rooms, media technology and telephones for each meeting
- Support the co-chairs
- Schedule special meetings as necessary (Sub-Committees, Ad-Hoc Task Forces)

The members of the Bennington RCPC will:

- Represent their organization or agency and services provided
- Secure the support and commitment from their organization or agency to fully participate
- Attend seventy-five percent (75%) of the scheduled meetings
- Openly share their views and ideas
- Support the consensus and decisions of this committee
- Represent the work of this committee in a positive fashion to the community
- Facilitate the accomplishment of the goals/objectives set by Bennington's RCPC

Sub-Committees/ Ad-Hoc Task Forces:

- Chartered by the Bennington RCPC as needed. For examples, dental access or medication management
- Will be assigned a chairperson who also is a member of the Bennington RCPC
- May have subcommittee/ad-hoc taskforce members assigned who are not members of Bennington RCPC
- Quality Work Group has been established to coordinate chart reviews. It will also review data from OneCareVT and present a summary of the data to the Bennington RCPC. Required members of the Work Group are Bennington HSA Representatives for OneCareVT, OneCareVT Regional Physician Representative, and the Director for the Bennington Blueprint. Other Work Group members may be assigned.

Scope: The scope of the Bennington RCPC is to address the population health in the Bennington HSA. The focus will be on quality outcomes, cost and value. The approach will be system changes including utilizing the Bennington Blueprint infrastructure for primary care, panel management, and the Medical Neighborhood for those changes. The Bennington RCPC will be collaborative and work to establish a learning community with other health service areas both directly and through the Clinical Advisory Board.

Meeting Dates:

Bennington RCPC:

- Monthly: To be determined.
- Annual Strategic Planning and Evaluation: Spring 2015

Quality Work Group: To be determined
Adopted: November 18, 2014

ATTACHMENT C: Learning Collaborative Schedule

VHCIP

2015 Current and 2016 Proposed Learning Collaborative Schedule

#	Deliverable/Milestone	Status	2015									2016											
			APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1	**Preparation and Planning**	Complete																					
	Stakeholder Engagement	Complete																					
	Identify Care Coordinators	In Process																					
	Activate the Regional Clinical Representatives	Complete																					
	Activate the RCPCs with all stakeholders represented	Complete																					
	Identify goals of the Learning Collaborative	Complete																					
	Identify CAB Quality Improvement Projects	Complete																					
	Identify tools (PDSA)	Complete																					
	2015 Review/Planning for 2016																						
	Continuous process improvement cycle	In Process																					
	Establish mechanisms to sustain the improvements	In Process																					
	Create local and ACO wide policies and procedures “best practices”	In Process																					
	Monitor to make sure the activities becomes routinized	In Process																					
	Continuously review the practices to make sure that they don’t need to be changed	In Process																					
	2015 Learning Collaborative Implementation																						
	Kick off statewide event	Complete																					
	PDSA Track 1																						
	Plan: Identification of projects to implement	In Process																					
	Do: Implementation of project chosen	In Process																					
	Study: Monitor and track results, identify improvements	In Process																					
	Act: Review the actionable results	In Process																					
	Collaborative #2: Statewide teams gather to review results	To Do																					
	PDSA Track 2																						
	Plan: Identification of projects to implement	To Do																					
	Do: Implementation of project chosen	To Do																					
	Study: Monitor and track results, identify improvements	To Do																					
	Act: Review the actionable results	To Do																					
	2016 Learning Collaborative Implementation																						
	Quality Data Training and Collection																						
	Collaborative #3: Statewide teams gather to review results	To Do																					
	PDSA Track 3																						
	Plan: Identification of projects to implement (data collection)	To Do																					
	Do: Implementation of project chosen	To Do																					
	Study: Monitor and track results, identify improvements	To Do																					
	Act: Review the actionable results	To Do																					
	Collaborative #4: Statewide teams gather to review results	To Do																					
	PDSA Track 4																						
	Plan: Identification of projects to implement	To Do																					
	Do: Implementation of project chosen	To Do																					
	Study: Monitor and track results, identify improvements	To Do																					
	Act: Review the actionable results	To Do																					

ATTACHMENT D: Care Management Software Implementation Schedule

VHCIP
Care Management Software Implementation Schedule

			2015									2016											
#	Deliverable/Milestone	Status	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1	**Vendor Selection**																						
1.1	RFI Issue Date	Complete	4/1																				
1.2	RFI Response Date	Complete	4/27																				
1.3	Selection Top Candidates	Complete		5/15																			
1.4	Demos	In process				7/15																	
1.5	Selection Finalized	To do				7/30																	
2	**Contracting**	To do																					
2.1	Leadership and Board Approval	To do					8/15																
2.2	Finalize contract	To do					8/30																
3	**Implementation**	To do																					
3.1	Planning	To do						9/15															
3.2	Configuration and Implementation	To do									12/31												
4	**Training**	To do																					
4.1	OCV Help Desk Training	To do										1/30											
4.2	OCV Clinical Consultant Training	To do										1/30											
5	**Rollout**	To do																					
5.1	Rollout to RCPC Care Coordinators	To do												3/15									

ATTACHMENT E: Patient Tracking Implementation Schedule

VHCIP

Patient Tracking Implementation Schedule

#	Deliverable/Milestone	Status	2015									2016											
			APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1	**Vendor Selection**																						
1.1	RFI Issue Date	To do				7/1																	
1.2	RFI Response Date	To do				7/15																	
1.3	Demo	To do				7/30																	
2	**Contracting**	To do																					
2.1	Leadership and Board Approval	To do					8/15																
2.2	Finalize contract	To do					8/30																
3	**Implementation**	To do																					
3.1	Planning	To do						9/15															
3.2	Configuration and Implementation	To do									12/31												
4	**Training**	To do																					
4.1	Determine training needs	To do										1/30											
5	**Rollout**	To do																					
5.1	Determine roll out plan	To do												3/15									

Vermont ACO Pilot
ACO Care Transformation Meeting Report:
OneCare Vermont
June 2, 2015

Preliminary & Confidential

Background

In the fall of 2012 the Green Mountain Care Board (GMCB) developed the following objectives for the Vermont ACO Pilot:

Vermont's ACOs [will] successfully transform care delivery and:

- *improve health care quality, patient experience of care and population health;*
- *reduce costs across the health care system; and*
- *maintain the financial viability of the state's health care system.*

Following the completion of the first year of the three-year Vermont ACO Pilot, GMCB and the Department of Vermont Health Access (DVHA) initiated the first of a regular series of strategic dialogues with participating ACO and payer executives regarding how ACOs are working to transform care delivery in Vermont.

GMCB and DVHA staff identified a series of structured questions to provide an organizing framework for conversation. ACOs were asked to come to the meetings prepared to share information that will respond to each of the questions.

This report summarizes GMCB and DVHA findings from a meeting with OneCare Vermont (OneCare) on April 3, 2015. Findings are organized around the topical areas and specific questions that were the focus of the state's inquiry.

Overarching Strategies

1. *What are the principal strategies your ACO is currently employing (individually and/or in collaboration with other entities) to slow down per capita cost growth for your Medicare, commercial and Medicaid (as appropriate) ACO-attributed populations?*
    a. *What, if anything, are you doing differently for each of your respective payer populations?*
2. *What are the principal strategies your ACO is currently employing (individually and/or in collaboration with other entities) to improve the health status of your Medicare, commercial and Medicaid (as appropriate) ACO-attributed populations?*
    a. *What, if anything, are you doing differently for each of your respective payer populations?*

OneCare reported having one principal strategy for slowing per capita cost growth and improving health status - a federated clinical management model - that empowers local communities with data. Under that strategy, it defined four component strategies:

1. identification of actionable and data driven priorities;
2. proactive application of interventions across the continuum of care (well-to-chronic) to improve population health;
3. adoption and deployment of clinical best practice standards across the state (via change management and learning forums), and
4. rigorous monitoring of outcomes.

In terms of 2014 areas of clinical focus, OneCare reported the following:

- coronary artery disease;
- diabetes;
- emergency room utilization;
- high risk patients, and
- readmissions.

Each UCC/RCPC was asked to select one topic for 2014 upon which to focus its work.

For 2015, OneCare reported adding:

- chronic obstructive pulmonary disease/asthma;
- congestive heart failure, and
- hospice.

OneCare reported that Medicaid and commercial population-specific topics are under discussion. OneCare added that the evolution of the federated relationships will depend on how fast it can align "the economics" (i.e., tying financial risk to performance).

<u>Successes:</u>

- overarching strategy articulation and identification of clinical improvement opportunities
- initial implementation through Regional Clinical Performance Committees (RCPCs) and Unified Community Collaboratives (UCCs)

<u>Opportunities for Improvement:</u>

- development and implementation of specific systematized clinical interventions through the UCCs and RCPC, eventually including more than one topical area per region
- identification of areas of clinical focus specific to commercial and Medicaid populations;
- development of systems to measure cost and health status impact of strategy implementation

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Care Management and Coordination

3. *How is your ACO improving care management for the following populations (individually and/or in collaboration with other entities), relative to how their care was being managed prior to your ACO's formation?*
   a. *High-cost, high intensity patients who utilize inpatient and specialty services*
   b. *Patients with one or more chronic conditions that are not well-controlled*
   c. *Patients with mental illness*
   d. *Patients with chemical dependency*
   e. *People with long-term services and supports needs*
4. *What is your ACO (individually and/or in collaboration with other entities) doing to improve coordination of services across the care continuum? And, what is your vision for expansion of services in the near term (1-2 years) and long term (3-5 years)?*
5. *How is your ACO (individually and/or in collaboration with other entities) promoting teamwork across primary and specialty providers, as well as with community-based non-physician providers, hospitals and the state's health promotion and health management initiatives?*

In addition to the UCC/RCPC-directed work described under "overarching strategies", OneCare described activities to stratify its attributed population by risk level, coordinate care for the highest 5% at-risk patients, improve transitions of care, and test innovations in care coordination (care management).

- <u>Stratification of population by risk and conditions</u>: OneCare reported building a population health model to stratify its attributed lives by health status and risk, using the NNEACC "Impact" tool with Medicare claims and lab data, as well as BCBSVT-supplied patient risk reports. OneCare intends to develop a plan with strategies for each stratified quadrant. Medicaid and commercial claims will be used in the future. For now, stratified lists of only Medicare beneficiaries are sent to practices.
- <u>Care coordination for the top 5% high risk population</u>: OneCare has seven centralized care coordinators for its Medicare beneficiaries. These care coordinators are required to work with regional care coordinators in each of the 14 HSAs and use common tracking forms and a patient high-risk registry. OneCare continues to define the care coordinator function, and is currently defining its "seven pillars" for care coordination.
- <u>Improving clinical handoffs/transitions of care</u>: OneCare reported that the UCCs/RCPCs are conducting "deeper dives" to find opportunities here.
- <u>SIM pilots in three communities</u>: Regarding shared clinical care plans among clinicians, OneCare described the three integrated care coordination learning collaboratives that are supported by SIM funds and being piloted in St. Johnsbury,

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Rutland and Burlington. It also referenced a pediatric care coordination pilot in 2014 for complex needs children which will continue with grant funding.

OneCare reported that it is making plans to evaluate care management performance, including central registry use and compliance with best practice guidelines, and more broadly studying "what works."

Successes:

- development and implementation of population risk stratification tools
- implementation of a care management function for highest-risk Medicare beneficiaries, including use of common tracking forms and a registry
- consideration of how best to coordinate central and regional efforts to avoid duplication and confusion

Opportunities for Improvement:

- continuation and completion of development of a care management (coordination) strategy that includes systematized approaches to care management implementation and operation and that draw upon national, state and ACO-specific experience, for:
    - high-intensity need patient subpopulation care management
    - coordination across the continuum
    - teamwork with medical specialists and community-based non-physician providers
- expansion of care management activities to the Medicaid and commercial populations
- addressing barriers to sharing data and information across care coordinators and providers
- ensuring engagement and performance accountability across all UCCs/RCPCs

Information Analysis and Sharing

6. *How is your ACO using data to identify opportunities for performance improvement and patients in need of attention at a) the ACO level, b) the regional level, and/or c) the provider level? Please explicitly address the use of claims, clinical and survey data, as appropriate.*
7. *How is your ACO using data to track how it is performing relative to organizational goals and targets?*
    a. *Does your ACO have a dashboard or other measurement tool for assessing performance?*
    b. *If so, what measures are included and how often is the dashboard updated?*
    c. *Is it reviewed by your ACO's governing body?*
8. *How is your ACO sharing performance information with ACO-participating providers?*
    a. *What information is being shared, in what format, and with what frequency?*

OneCare reported that it generates and distributes the following reports:

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- ACO Level
    - Monthly board "flash" reports on key statistics
    - Quarterly dashboard on clinical priorities and top 5% risk
    - Annual payer report cards
    - Annual patient experience reports
- HSA/Regional Level
    - Blueprint and OneCare aligned quality measure reports
    - Quarterly and ad-hoc dashboard reports monitoring utilization, costs, and quality metrics
    - Quality dashboards on clinical priorities
- Provider Level
    - Beneficiary detail reports for practitioner and practice-level use
    - High-risk patient ("5%") report

OneCare explained how its contractor, NNEACC, has combined clinical and claims data for OneCare, and how the ACO also maintains its own claims data warehouse for standard reports and "deep dive" analytics. OneCare reported that NNEACC is not fully functional, but OneCare is working towards one analytic solution in the future, either through NNEACC or some other solution.

At present the analytic strategy is driven by the chief medical officer. There are plans to conduct analyses to identify variation. Decisions regarding which performance opportunities to pursue were reported to be decided by a committee of the board of managers.

Successes:

- staffing an analytics team
- developing and utilizing a data warehouse for claims data
- developing a suite of reports for use at multiple levels

Opportunities for Improvement:

- realizing the potential of an integrated claims/clinical data warehouse
- systematizing variation analysis to identify opportunities for improvement at the ACO, regional and provider levels for Medicare, Medicaid and commercial populations
- expanding performance measurement and analysis to institutional providers

Clinical Performance Improvement and Accountability

9. *How is your ACO working to redesign care processes (e.g., develop clinical pathways) in order to improve quality and efficiency, reduce waste and reduce variability, if at all?*
    a. *Has your ACO adopted, defined or developed any care processes? (e.g., transitions of care procedures to prevent avoidable readmissions)*
    b. *If so, how will they/how have they been implemented?*

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    c. *If so, how will you/how have you assessed adherence?*

10. *What, if anything, is your ACO doing to help engage and activate patients in managing their own care?*
11. *In addition to information sharing, how is the ACO, if at all, supporting:*
    a. *Network provider performance improvement?*
    b. *Network provider performance accountability?*

    In responding, please differentiate between primary care, specialty care, hospital and non-physician community providers.

As described earlier, OneCare reported that it is in the process of transforming to an integrated, regionally-administered standards-based model of care delivery. Using a format created by RTI, OneCare prepares segmented investigations of various diagnoses, and provides the results to providers, by TIN and attributed patients.

Efforts to engage patients in their care currently consists of placement of consumers on UCCs/RCPCs, on a Consumer Advisory Group that informs ACO policies, and in two care models pilots that focus on shared care plans. In addition, OneCare has informed its members regarding the availability of educational programs and self-management tools available to them via the Blueprint Community Health Teams. The ACO noted that most hospitals across the state have shared decision- making tools and patient portals. OneCare stated that it has been reluctant to duplicate these efforts.

Efforts to support provider performance improvement and accountability were reported to focus on the ACO's clinical governance model and on ongoing monitoring and adjustment based on state and regional variability. Regarding the latter, the ACO reported that it uses its quality score cards to identify variability across HSAs for select quality measures and that some communities lack the resources to tackle variations, particularly if doing so involves changing entrenched processes.

<u>Successes:</u>

- supporting UCC/RCPC work to improve care in areas of identified opportunity

<u>Opportunities for Improvement:</u>

- continuing early efforts at redesigning care processes, and then assessing adherence and impact
- designing and executing strategies for engaging and activating patients in managing their own care
- actively supporting individual network provider performance improvement and performance accountability beyond the work of the UCCs/RCPCs

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Provider Payment and ACO Risk Assumption

12. *What strategies is your ACO developing to align incentives for network providers, including compensation strategies for those who are employed by hospitals and medical groups and those who are not, with the performance incentives in the pilot ACO contracts?*
13. *What is your ACO doing to prepare to manage risk in the future, in addition to the activities you have already described?*

OneCare explained that it is seeking to align incentives for network providers, including those employed by hospitals and medical groups and those who are not, through its method of distribution for any earned savings:

- Primary Care Providers
  - 45% of the savings to primary care providers who meet the following criteria:
    - submit complete data to the ACO
    - meet a minimum quality score of 30 out of 100 points
- Hospital/Specialty Physicians
  - 45% of the savings to hospitals and to specialists based upon their percentage of Medicare net revenues

OneCare explained that it is looking to the all-payer model as the means by which it will assume risk in the future.

Successes:

- none yet achieved

Opportunities for Improvement:

- developing payment and compensation models that move away from fee-for-service volume incentives and towards rewarding quality and efficiency

Summary

OneCare made impressive strides in 2014 in building its ACO clinical and data infrastructure. It has built a robust team of managers and has a clear vision as to the functionalities it seeks to develop. The GMCB and DVHA found its conversation with OneCare leadership edifying and wish to continue the practice in a similar format on a periodic (approximately annual) basis.

While OneCare has accomplished much in a short time, there are several opportunities for continued evolution by the ACO during 2015. The GMCB and DVHA look forward to following and supporting VCP's progress in addressing these important opportunities.

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Proposal for Delivery System Reforms:

Integrating Vermont ACO and Blueprint Activities

Phase II Payment Reforms

Developed in Collaboration

Vermont Blueprint for Health

One Care

CHAC

Health First

Introduction

This proposal presents a plan for a next phase of delivery system reforms in Vermont to increase the capacity of primary care, provide citizens with better access to team based services, and strengthen the basis for a community oriented health system structure across Vermont. The suggested programmatic and payment changes are designed to establish a more systematic approach to coordinating local services and quality initiatives across the state. This will be achieved thru integration of Accountable Care Organization (ACO) and Blueprint program activities in a unified collaborative to guide quality and coordination initiatives in each service area; and, an aligned medical home payment model that promotes coordination and better service area results on core measures of quality and performance. The proposed changes represent a natural next phase for the evolution of health services in Vermont by building on delivery system advancements in each community, and on the organizational capabilities of the three ACO provider networks (OneCare, CHAC, and Healthfirst). The structural, programmatic and payment changes proposed in this plan are designed to achieve the aim of providing citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services; and more affordable services.

Background

Blueprint. During the last six years, stakeholders across the state have worked with the Blueprint program to implement a novel healthcare model designed to provide citizens with better access to preventive health services, and to improve control over growth in healthcare costs. The statewide model includes:

- high quality primary care based on national standards for a patient centered medical home
- community health teams providing the medical home population with access to multi-disciplinary staff such as nurse care coordinators, social workers, and dieticians
- integrated health services workgroups to strengthen networks in each community and improve coordination between medical and social services and
- a statewide learning health system thru data guided quality initiatives at the practice, community, and statewide levels.

Implementation of the model has been supported by Multi-insurer payment reforms, as well as Blueprint grants to each area of the state that support project managers, practice facilitators, self-management programs, and assistance with health information technology and data quality. Results of a six year trend analysis demonstrate improvements in healthcare utilization,

healthcare expenditures, better linkage of Medicaid beneficiaries to social support services, and improvements in healthcare quality (HEDIS).

Provider Networks. At the same time, Vermont's healthcare reform initiatives have continued to push forward on several fronts including implementation of an insurance exchange in alignment with the Affordable Care Act (Vermont Health Connect), and the introduction of shared savings programs designed to improve quality and control over health care costs. As part of this process, healthcare providers have established three statewide ACO networks based on common business interests. The three networks include OneCare, CHAC, and HealthFirst. Each of the three provider networks has established an administrative structure to guide participation in Vermont's healthcare reform processes including participation in shared savings programs. These new provider networks, and in particular their ability to organize initiatives and represent the interests of their constituents, adds important organizational capacity to Vermont's healthcare landscape.

Integration. The three ACO provider networks can help to organize healthcare improvement priorities with their members (vertical organization). The Blueprint program with Community Health Teams and Integrated Workgroups has helped to organize coordination at a community level, across settings and provider types (horizontal). This plan blends these strengths and adds meaningful participation of additional provider types, in a formal collaborative structure that will improve services for citizens in each service area in Vermont. Modifications to current medical home payments are proposed which are integral to support coordination in each community, and to align medical home incentives with the quality and performance goals of the new collaboratives.

Programmatic Changes

Unified Community Collaboratives - Principles & Objectives. Presently, an array of meetings focused on quality and coordination are taking place in communities across Vermont. Most areas have Blueprint integrated health services workgroups as well as workgroups for participants in the provider network shared savings programs (ACOs). The Blueprint meetings are oriented towards coordination of community health team operations and services across providers in the community (community, horizontal) while the ACO meetings are oriented towards meeting the goals of the participating provider network (organizational, vertical). The same providers may be participating in multiple meetings, with overlapping but distinct work on coordination of services and quality.

This proposal calls for development of a Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) in order to coalesce quality and coordination activities, strengthen Vermont's community health system infrastructure, and to help the three provider networks meet their organization goals. In many areas of the state the proposed collaboratives represent a significant advancement in terms of the assortment of provider types who would participate in, and help lead, a unified forum. They build on a strong community oriented culture in the state

with the underlying premise that the UCC structure, with administrative support and an aligned medical home payment model, will result in more effective health services as measured by:

- Improved results for priority measures of quality
- Improved results for priority measures of health status
- Improved patterns of utilization (preventive services, unnecessary care)
- Improved access and patient experience

Unified Community Collaboratives – Activities. As proposed, the UCCs will provide a forum for organizing the way in which medical, social, and long term service providers' work together to achieve the stated goals including:

- Use of comparative data to identify priorities and opportunities for improvement
- Use of stakeholder input to identify priorities and opportunities for improvement
- Develop and adopt plans for improving
    - quality of health services
    - coordination across service sectors
    - access to health services
- Develop and adopt plans for implementation of new service models
- Develop and adopt plans for improving patterns of utilization
    - Increase recommended and preventive services
    - Reduce unnecessary utilization and preventable acute care (variation)
- Work with collaborative participants to implement adopted plans and strategies including providing guidance for medical home and community health team operations

Unified Community Collaboratives – Structure & Governance. To date, Blueprint project managers have organized their work based on a collaborative approach to guiding community health team operations and priorities. In most cases, this has stimulated or enhanced local innovation and collaborative work. The three new medical provider networks have each established a more formal organizational structure for improving quality and outcomes among their constituents. The provider networks are looking to establish improved collaboration and coordination with a range of service providers in each community. The proposed collaboratives build from these complimentary goals and capabilities, enhance community coordination, and improve the ability for each provider network to achieve their goals. This is accomplished using a formal structure with a novel leadership team that balances the influence of the three medical provider networks, and the influence of medical, social, and long term providers.

We are proposing that the UCC in each HSA have a leadership team with up to 11 people based on the following structure:

- 1 local clinical lead from each of the three provider networks in the area
    - OneCare

- CHAC
- HealthFirst (not present in all HSAs)

- 1 local representative from each of the following provider types that serves the HSA
  - VNA/Home Health
  - Designated Agency
  - Designated Regional Housing Authority
  - Area Agency on Aging
  - Pediatric Provider
- Additional representatives selected by local leadership team (up to total of 11)

The proposal is for the leadership team to guide the work of the UCC in their service area with responsibilities including:

- Developing a plan for their local UCC
- Inviting the larger group of UCC participants in the local service area (including consumers)
- Setting agendas and convening regular UCC meetings (e.g. monthly)
- Soliciting structured input from the larger group of UCC participants
- Making final decisions related to UCC activities (consensus, vote as necessary)
- Establishing UCC workgroups to drive planning & implementation as needed

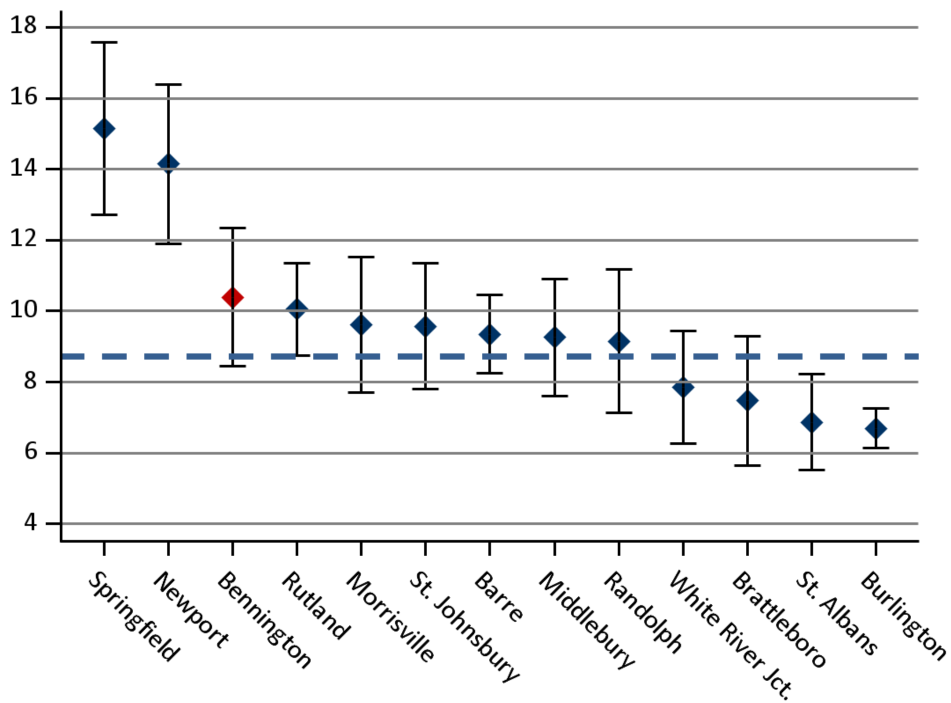
The UCC leadership team will be supported in their work with the following resources:

- Leadership team participation from each ACO provider network in the area
- Organizational support from the ACO provider networks
- Goals and objectives established by ACO provider networks
- Convening and organizing support from the Blueprint project manager
- Support on quality work from Blueprint practice facilitators
- Blueprint HSA grants structured to support the work of the UCC
- Collaboration between the Blueprint and UCC leaders on analytics & evaluation
- ACO Provider network performance reporting on the ACO population
- Blueprint profiles with comparative performance reporting on the whole population, including the results of core ACO measures (practice, HSA levels)
- Ongoing programmatic collaboration (Blueprint, Provider Networks, UCC leaders, others)
- Modification to medical home payments to support provider networks and UCC goals

Unified Community Collaboratives – Basis for Regional Health Systems. As UCCs mature, they have the potential to emerge as governing and fiscal agents in regionally organized health systems. This could include decision making and management of community health team funds, Blueprint community grants, and ultimately budgets for sectors of health services (e.g. pre-set capitated primary care funds). In order to be effective an agent for cohesive regional systems, it

is essential for UCCs to establish leadership teams, demonstrate the capability to engage a range of providers in sustained collaborative activity (medical, social, and long term support providers), demonstrate the capability to lead quality and coordination initiatives, and demonstrate the ability to organize initiatives that tie to overall healthcare reform goals (e.g. core measures). Ideally, UCCs will demonstrate effective regional leadership to coincide with opportunities offered by new payment models and/or a federal waiver in 2017.

Unified Community Collaboratives – Opportunity to Guide Improvement. Current measurement of regional and practice level outcomes across Vermont highlights opportunities for UCCs to organize more cohesive services and lead improvement. When adjusted for differences in the population, there is significant variation in measures of expenditures, utilization, and quality. The variation across settings offers an opportunity for UCC leadership teams and participants to examine differences, and to plan initiatives that can reduce unnecessary variation and improve rates of recommended services. One example is the Prevention Quality Indicator (PQI) measuring the rate of hospitalizations per 1,000 people, ages 18 and older, for a composite of chronic conditions including: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The 2013 service area results for this indicator, which is included in Vermont's core measure set for shared savings programs, highlights the variation that is seen with most core quality and performance measures.



Overall improvement in this measure, and reduction in variation across settings, is most likely with well-planned coordination across provider types including primary care, specialty care, and community services that improve self-management capabilities for vulnerable populations such as seniors without adequate support. Hospitalization rates for these types of conditions are driven by complex life circumstances, often related to social, economic, and behavioral factors that influence the ability to engage in daily preventive care. While the measure is one of traditional healthcare utilization, outcomes will be better with cohesive integration of health and human services addressing non-medical as well as medical needs. The UCC, and the proposed leadership team, is designed to establish a structured forum to guide this level of integration. A coordinated effort to identify those at risk in the community, to assess the factors that limit effective management, and to organize a community team approach to prevention will have the greatest opportunity to improve outcomes.

Governance – Balancing Statewide Standardization, Regional Control, & Local Innovation. During the development of this plan, there was a strong interest expressed by major stakeholders in a higher level (statewide) leadership team that mirrors the local UCC leadership team. The state level leadership team would guide coordination and quality priorities including: adoption and implementation of statewide standards (e.g. medical home standards); recommendations on selection of core measure subsets for payment models; eligibility requirements and structure of payment models; methods for assessment of compliance with standards; methods for attribution and empanelment; review of measure results and performance; recommendations for statewide improvement on key outcomes; and recommendations for service models to meet statewide needs. This work would be intended to inform, evaluate, and guide the work of the regional UCCs. In order to be successful, the state level leadership team would be balanced and represent the same key provider groups that are on the local UCC leadership teams including: a representative for each of the three ACO networks; a representative for VNAs and Home Health; a representative for the Designated Agencies; a representative for the Area Agencies on Aging; a representative for the regional Housing Authorities; and a representative for Pediatric providers. This leadership team could choose to add additional members up to a recommended total of 11 in order to be able to function as a leadership team and make decisions. The leadership team could convene a larger group of stakeholders to inform decision making as part of a state level collaborative, and convene workgroups as necessary. The central Blueprint team would serve a convening and support role for the state level leadership team in a similar manner as proposed for the regional UCCs. In effect, a state level structure would be established that would mirror the regional structures, and help to guide their work for matters where standardization and consistency are necessary. It is worth emphasizing that the recommendation for this type of structure emerged widely during the development of the plan and was expressed by stakeholders including: leadership for the three ACOs; leadership for VNAs and Home Health; leadership for the Designated Agencies; leadership for the Area Agencies on Aging; and leadership for Designated Regional Housing Authorities.

What also emerged was the need for balance, primarily the need to preserve the role for regional leadership to guide local decision making, organization, and innovation. Regional UCC leadership teams would respond to state level guidance and recommendations with local decisions on matters such as: methods for implementation of statewide standards; balancing statewide clinical priorities with local needs; and determination of methods for local implementation, organization, and ongoing improvement of service models. This structure highlights the design principle of regional innovation applied to common standards and guidelines. Regional energy and ownership, with comparative reporting and shared learning across regions, is likely to result in the emergence of more effective coordination and quality initiatives.

Another key design principle is a leadership continuum with mirrored leadership teams at the state and local levels. This design increases the likelihood that the state and local leadership teams share similar overarching interests and priorities, and that state level guidance will be relevant for local UCCs.

Payment Model

Current payment structure. To date, two payments have been adopted by all major insurers to support the roll out and maturation the Blueprint program. The first payment is made to primary care practices based on their score on NCQA medical home standards. In effect, this represents a payment for the quality of services provided by the practice as assessed by the NCQA standards. The second is a payment to support community health team staff as a shared cost with other insurers. This represents an up-front investment in capacity by providing citizens with greater access to multi-disciplinary medical and social services in the primary care setting. Both are capitated payments (PPPM) applied to the medical home population. Although these two payments are relatively low compared to the overall revenue that primary care practices generate; when combined with the dedication of primary care practice teams and the Blueprint program supports, they have led to statewide expansion of medical homes and community health teams. There is growing evidence that medical homes and community health teams favorably impact healthcare expenditures, utilization, and quality. However, the medical home payments have not been increased in the last six years and are widely perceived as inadequate to support the effort required to comply with increasingly demanding NCQA standards. Some practices, particularly independent practices that don't have the administrative support that hospital affiliated practices and health centers have, may choose not to continue participating at the current payment levels due to the time and costs associated with medical home recognition and operations. Similarly, community health team payments have not kept up with the administrative costs that are required to operate the expanded program, or the salary and compensation costs to employ the workforce. In some cases, this has led to a reduction in the staffing that is available to patients as adjustments are made to accommodate administrative and staff salary pressures. Lastly, while these payments have stimulated successful program expansion, it is important to consider whether a modified medical home payment model can be

used to support collaborative activity and the effectiveness of a community health system infrastructure.

Proposed medical home payment structure. The proposed medical home payment model is designed to more adequately fund medical home costs, and to directly align medical home incentives with the goals of the collaboratives and the ACO provider networks. The proposed payment changes anticipate multi-payer participation, a doubling of medical home payments, and a new performance component to the payment model. In this proposal, the total capitated payment to medical homes is based on a composite of medical home recognition, collaborative participation, and performance. The outcome measures driving the performance component include a Quality Index comprised of core ACO quality measures, and a Total Utilization Index. Improvement on these metrics, such as higher scores on the quality index and less variation on the utilization index, is directly aligned with the goals of Vermont's health reforms. The new medical home payment model includes the following elements:

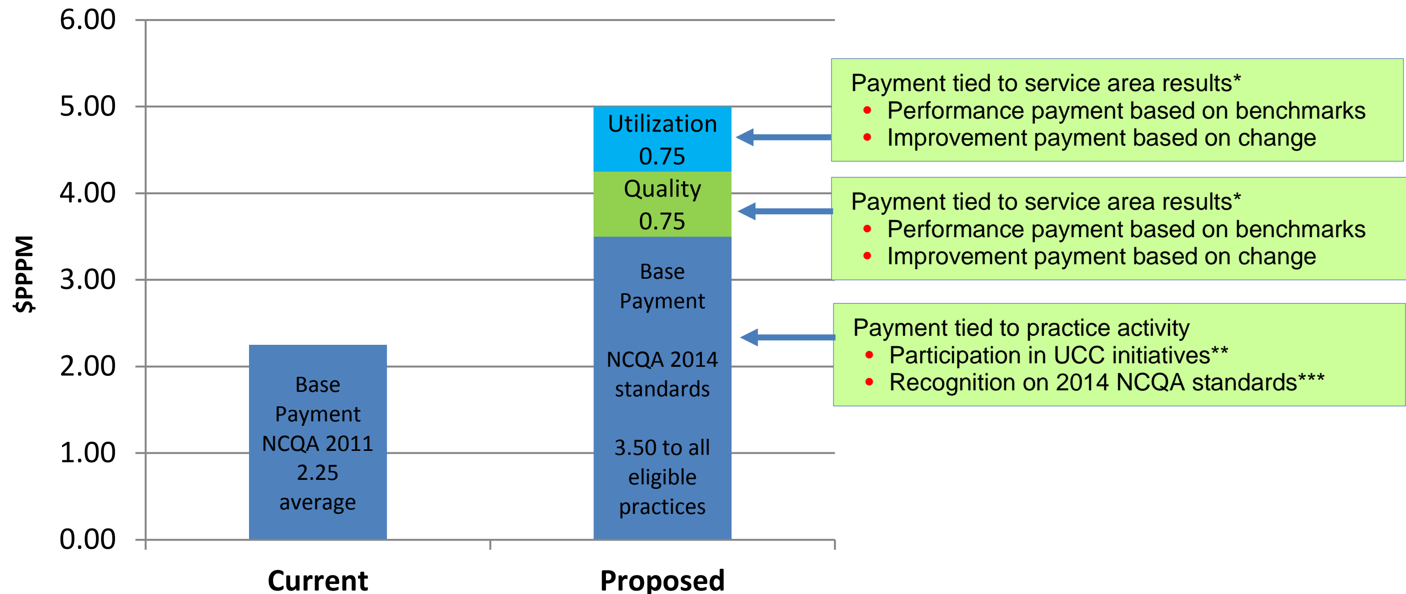
- Base Component: Based on NCQA recognition & UCC Participation.
  - Requires successful recognition on 2014 NCQA standards (any qualifying score)
  - Requires active participation in the local UCC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum requirement is active participation with at least one UCC priority initiative each calendar year.
  - All qualifying practices receive $3.50 PPPM

- Quality Performance Component: Based on HSA results for Quality Index.
  - Up to $ 0.75 PPPM for results that exceed benchmark, or
  - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

- Utilization Performance Component: Based on HSA results for Utilization Index.
  - Up to $ 0.75 PPPM for results that exceed benchmark, or
  - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

- Total Payment = Base + HSA Quality Performance + HSA TUI Performance
- Total Payment ranges from $3.50 to $5.00 PPPM

Comparison of current and proposed medical home payments



*Incentive to work with UCC partners to improve service area results.

**Organize practice and CHT activity as part of at least one UCC quality initiative per year.

***Payment tied to recognition on NCQA 2014 standards with any qualifying score. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

The new payment model is designed to promote collaboration and interdependent work by linking a portion of each practices potential earnings to measure results for the whole service area (HSA). It is also intended to more directly focus efforts on improved health outcomes and reduced growth in health expenditures. In theory, the combination of the UCC structure and decision making process, with the interdependent nature of the payment model, will lead to better organization and coordination across provider groups. In contrast, a medical home payment linked solely to practice quality is less likely to stimulate better coordination across a service area. Although fee for service is still the predominate payment, this suggested payment model is an important *step* towards a more complete capitated payment structure with a performance component that is anticipated for 2017. It will help to stimulate the culture and activity that is essential for a high value, community oriented health system. The implementation of this payment model is only possible with an increase in payment amounts to more adequately support the work that is required to operate a medical home and the multi-faceted payment structure. The incentive structure that is woven into the payment model includes:

- Requires active and meaningful participation in UCCs including: attention to variable and unequal outcomes on core measures; and, coordination with collaborative partners to improve services.

- Requires that practices maintain NCQA recognition, however shifts the emphasis to the most important Must Pass elements in the medical home standards and de-emphasizes the intensive documentation that is required to achieve the highest score.
- Introduces a balance between payment for the quality of the process (NCQA standards) and payment for outcomes (quality and utilization)
- Rewards coordination with UCC partners to achieve better results on service area outcomes for a composite of core quality measures (directly links incentives for medical homes to statewide healthcare reform priorities)
- Rewards coordination with UCC partners to achieve better service area results for the total utilization index (case mix adjusted), which has a predictable impact on healthcare expenditures (directly links incentives for medical homes to statewide healthcare reform priorities)

Opportunity to improve care and reduce variation. It is important to note that across Vermont there is significant variation in the results of quality and utilization measures, after adjustment for important differences in the populations served. Unequal quality and utilization, for comparable populations with comparable health needs, provides an opportunity to examine differences in regional health services, and to plan strategies that improve the overall quality of healthcare that citizens receive. The Blueprint currently publishes Profiles displaying adjusted comparative measure results for each participating practice and for each service area. The profiles include the results of core quality measures which have been selected thru a statewide consensus process. The objective display of the variation that exists across service areas, and across practices within each service area, can support the work of the UCCs including identification of opportunities where quality and utilization should be more equal, and implementation of targeted strategies to reduce undesirable variation.

Proposed changes for community health team payments. This proposal calls for a doubling of the total community health team investments that are made by Vermont's insurers (commercial, Medicaid) to increase service capacity, and to more adequately support salary and administrative costs for a community team infrastructure. In addition to the increase, the proposal is to adjust each insurer's share of community health team costs to reflect their proportion of attributed medical home patients in the Vermont market. Each insurer's share of costs will be calculated by applying their percentage of the attributed medical home population to the total community health team costs. Total community health team costs will be based on the number of unique medical home patients (attribution), with an adjustment to the per person basis to assure that the total CHT investment is doubled. Insurer's proportion of the medical home population will be updated with a new attribution count quarterly. Due to the terms in the current Multi-Payer Demonstration Program with CMS, Medicare's share will remain constant with a 22.22% share

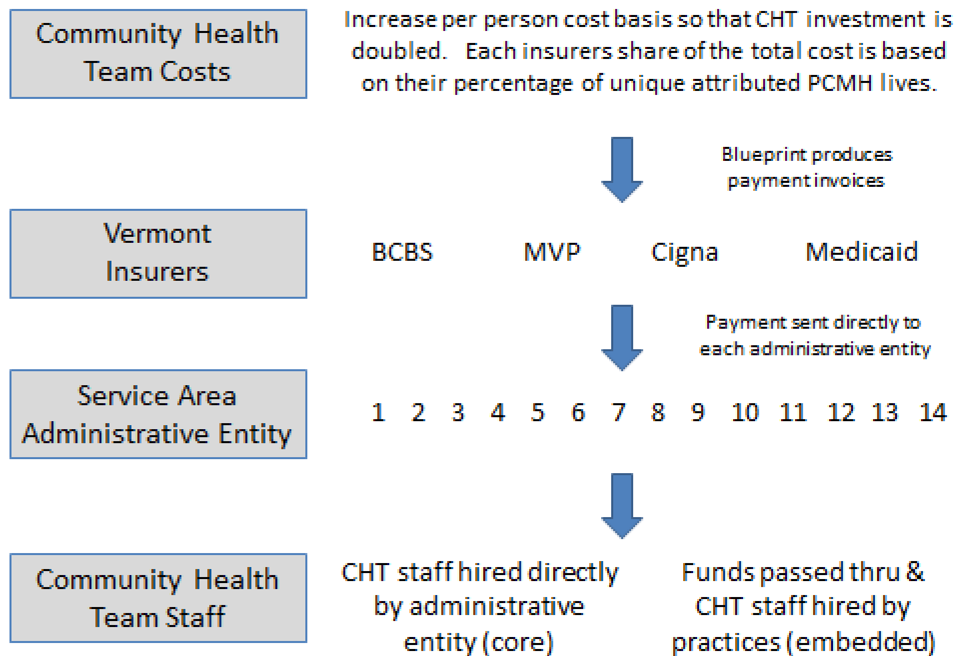
of community health team costs which is in close alignment with their market share. An example of the change to each insurer's share of costs, based on their current proportion of attributed medical home patients, is shown below along with the proposed payment process.

Market share basis for community health team costs.

	Current share of CHT Costs	Proposed share of CHT Costs*
Medicare	22.22%	22.22%
Medicaid	24.22%	35.66%
BCBS	24.22%	36.92%
MVP	11.12%	4.71%
Cigna	18.22%	0.49%
Total	100.00%	100.00%

*Each insurer's percentage of community health team cost is based on their attributed proportion of the total medical home population.

Proposed payment process for community health teams.



Quality and Performance Framework

Design Principles. This plan calls for use of Vermont's core performance and quality measures, in conjunction with comparative performance reporting, to help guide UCC activities and medical home payments. This approach ties the work of medical homes and UCCs directly to priorities for state led health reforms as reflected by the core measure set, which was selected using a statewide consensus process as part of the Vermont Healthcare Improvement Program (SIM). The three medical provider networks share a common interest in the results of the core measures which are used to determine whether network clinicians are eligible for payment as part of shared savings programs (SSP).

The proposal calls for use of a subset of these measures, which can be consistently reported using centralized data sources, to provide targeted guidance for the work of the UCCs. The intent is that UCCs will work to improve the results on some or all of the subset, depending on local priorities and the decisions made by each UCC. The subset of measures will be also be used to generate an overall composite result for the service area (quality composite). The composite result will be used to determine whether medical homes are eligible for a portion of their augmented payment (see payment model).

In addition to the subset of core quality and performance measures, this plan incorporates use of the Total Resource Utilization Index (TRUI), a standardized and case mix adjusted composite measure designed for consistent and comparable evaluation of utilization and cost across settings. Comparative results of the TRUI, adjusted for differences in service area populations, can be used in combination with more granular utilization measures to identify unequal healthcare patterns and opportunities for UCC participants to reduce unnecessary utilization that increases expenditures but doesn't contribute to better quality. Similar to the core quality and performance composite, the service area result for the TRUI will be used to determine whether medical homes are eligible for an additional portion of their augmented payment (see payment model).

Used together, the two composite measures promote a balance of better quality (core quality and performance) with more appropriate utilization (TRUI). Linking payment to measure results for the whole service area establishes interdependencies and incentives for medical home providers to work closely with other collaborative participants to optimize outcomes. Routine measurement and comparative reporting provides UCCs with the information they need to guide ongoing improvement. In this way, the proposed measurement framework serves as the underpinning for a community oriented learning health system and helps UCCs to:

- Establish clear measurable goals for the work of the collaborative
- Guide planning and monitoring of quality and service model initiatives
- Align collaborative activities with measurable goals of state led reforms
- Align collaborative activities with measurable goals of shared saving programs

Measure Set. Implementation of this plan depends on selection of a subset of quality and performance measures from the full core measure set that was established thru VHCIP. The intent is for a *meaningful* limited set that can be measured consistently across all service areas, using centralized data sources that are populated as part of daily routine work (e.g. all payer claims database, clinical data warehouse). Ideally, measures will be selected that maximize measurement capability with existing data sources, prevent the need for additional chart review, and avoid new measurement burden for providers. At the same time, work should continue to build Vermont's data infrastructure so that more complete data sets and measure options are available. Vermont's full set of core measures are shown in Appendix A, with the subset that can currently be generated using centralized data sources shown below:

- Plan All-Cause Readmissions
- Adolescent Well-Care Visit
- Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)
- Follow-up after Hospitalization for Mental Illness, 7 Day
- Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Developmental Screening in the First Three Years of Life
- Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
- Mammography / Breast Cancer Screening
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite
- Appropriate Testing for Children with Pharyngitis
- Cervical Cancer Screening
- Influenza Vaccination
- Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg
- Pneumonia Vaccination (Ever Received)
- Ambulatory Sensitive Condition Admissions: Congestive Heart Failure
- Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use - Adult
- Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) – Adult
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Process to select measures. Given the importance of these measures, a stepwise process is recommended to select a subset that will be used to help guide the work of UCCs, and as the basis for a performance portion of medical home payments.

- Leadership from the three provider networks recommends a consensus subset. It is essential for medical home clinicians to help prioritize the subset since their payment is partly tied to service area results. This first step allows the primary care community to coalesce around a subset of measures, which are selected from an overall set that represents state level reform priorities (statewide consensus process).
- The consensus subset, recommended by the three provider networks, should be vetted thru key committees to assure that a balanced subset is selected (meaningful, practical, and usable). Committees to be considered include: VHCIP - Quality & Performance Measurement Workgroup, Payment Models Workgroup, Core Committee; BP - Executive Committee, Planning & Evaluation Committee.

Attributes that should be considered when selecting the subset include:

- Will improvement in these measures contribute in a meaningful way to the goals of Vermont's health reforms (e.g. quality, health, affordability)
- Is there a real opportunity for service areas to improve the results of these measures with better quality and coordination (UCC work, medical homes)?
- Is sufficient data currently available so that these measures can be measured in all service areas?
- Can measure results be generated and routinely reported, in a usable format, for use by UCC participants?
- Are regional and national benchmarks available for these measures?

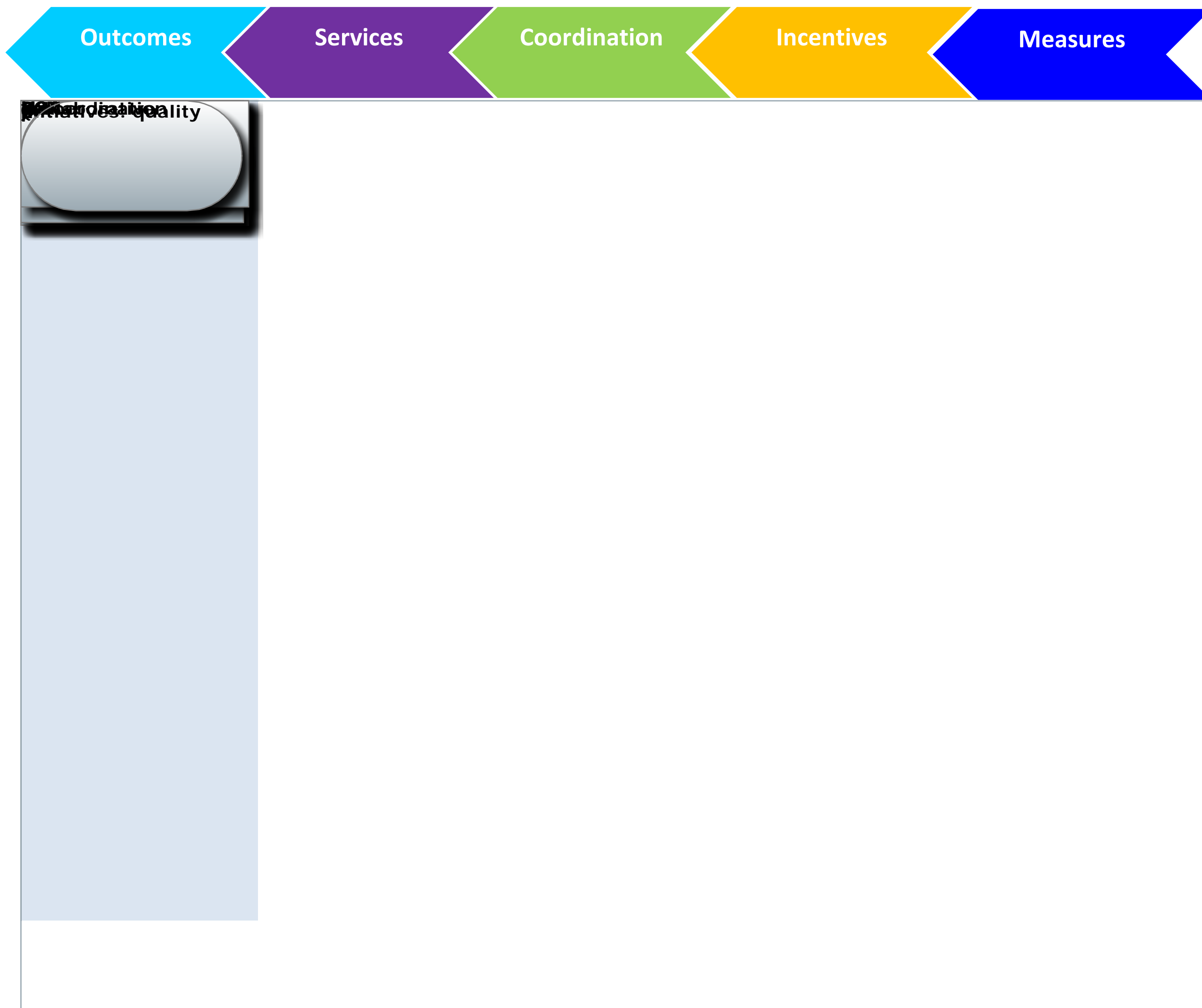
Linking Healthcare & Population Health. The most substantial improvement in results for these core performance and quality measures is likely to be achieved by addressing the medical, social, economic, and behavioral components that converge to drive poor health outcomes. Although the core measures are oriented to the healthcare sector, the program and payment strategies outlined in this plan stimulate interdependency and coordination of a broader nature. The makeup of the collaborative leadership team, decision making process, and link between medical home payment and service area outcomes are all designed to assure that citizens have access to more cohesive and complete services. Collectively, the plan is a first step in using comparative measurement as a driver for a broader community health system. However, an important next step would be to incorporate measures that reflect non-medical determinants as part of the framework to guide community health system activities. As part of this plan, it is recommended that the VHCIP Population Health workgroup work with provider network leadership and other stakeholders to identify a subset of core population health measures that can be reliably measured and used in concert with the current core quality and performance measures.

Strategic Framework for Community Health Systems

This plan is intended to provide Vermont's citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services;

and more affordable services. Strategically, the plan starts with Vermont's consensus based core performance and quality measures, and positions these measures as drivers for local community level learning health systems. Medical home financial incentives are in part tied to service area results for these core measures and to their participation in local collaborative initiatives. The collaboratives are designed to lead initiatives which will improve quality and performance, including the results of core measures, thru better coordination. Ultimately, data guided community initiatives, involving medical and non-medical providers, will provide citizens with direct access to more complete and effective services. The use of core measures as proposed, with detailed information on local variation and outcomes, is a substantial step towards a performance oriented community health system. Results to date in Vermont suggest that medical homes working with community health teams, and other local providers, will lead to a measurable increase in recommended preventive services and a reduction in unnecessary and avoidable services. The strategic framework to achieve the desired aims is outlined below.

Strategic Framework.



Key Issues & Decision Points.

Successful implementation of this plan depends on several key actions and decision points. First, the plan depends on an increase in medical home and community health team payment levels. As part of his budget proposal to the Vermont state legislature, Governor Shumlin announced his intention to increase Medicaid's portion of these payments starting January 1, 2016. His proposal calls for a doubling of current amounts which will support the new performance based payment model, an essential ingredient to maintain primary care participation and to stimulate community health system activity across Vermont. To be effective, these increases need to be multi-payer, involving all major insurers in Vermont.

Second is the selection of a subset of Vermont's consensus measures that will be used to comprise the quality index portion of the payment model. These measures are important since they will help set priorities for community improvement and medical home payment. They must be consistently measurable across all service areas with sufficient historical data so that benchmarks for payment and improvement can be set. Pragmatically, the data should be available in Vermont's central data sources so that additional local data collection is not necessary.

Third is the structure of the payment model. This includes the number of components that are included in the composite payment structure, the weight of each component, and the use of service are results to drive a portion of the payments. This proposal calls for three components with the following weights; Base ($3.50 PPPM for all eligible practices), Quality (up to $0.75 PPPM based on performance), and Utilization (up to $0.75 PPPM based on performance). It also calls for the use of service area results to determine whether practices receive the performance portions of the payment. This represents an increase in the base payment for all participating medical home practices while introducing performance based components with an incentive to coordinate closely with other local providers.

Fourth is the consideration as to whether there should be a phasing in of the medical home payment eligibility requirements for independent practices. Healthfirst has requested a delay in requirements independent practices since they do not have the same level of administrative and financial supports as hospital owned practices and health centers. The request includes a delay in the requirement for scoring on new NCQA medical home standards, and a delay in linking the performance component of the payments to service area results.

This plan is based on extensive discussion and input with the three ACO provider networks, Blueprint committees and local program participants, Vermont's insurers, and with VHCIP committees. While there is not unanimous agreement, this structure provides a strong consensus based plan with incentives that are designed to elevate community health system coordination and learning health system activity to a new level.

Appendix A. VHCIP Core Quality & Performance Measures

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-1		Plan All-Cause Readmissions	NQF #1768, HEDIS measure	Adult	For members 18 years and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.
Core-2		Adolescent Well-Care Visit	HEDIS measure	Pediatric	The percentage of members 12-21 years who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)	NQF #0075, NCQA	Adult	The percentage of members 18-75 years who were discharged alive for acute myocardial infarction, coronary artery bypass grafting, or percutaneous coronary intervention in the year prior to the measurement year or who had a diagnosis of Ischemic Vascular Disease during the measurement year and one year prior, who had LDL-C screening.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-4		Follow-up after Hospitalization for Mental Illness, 7 Day	NQF #0576, HEDIS measure	Adult	The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Core-5		Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement	NQF #0004, HEDIS measure	Adult	(a) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment within 14 days. (b) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and had two additional services with a diagnosis of AOD within 30 days of the initiation visit.
Core-6		Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	NQF #0058, HEDIS measure	Adult	The percentage of adults 18-64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic.
Core-7		Chlamydia Screening in Women	NQF #0033, HEDIS measure	Adult and Pediatric	The percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period.
VT Measure ID	**Medicare Shared Savings Program Measure ID**	**Measure Name**	**Nationally Recognized/ Endorsed**	**Included in HSA Profile?**	**Measure Description**
Core-8		Developmental Screening in the First Three Years of Life	NQF #1448	Pediatric	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.
Core-10	MSSP-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF, AHRQ (Prevention Quality Indicator (PQI) #5)	Adult	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.
Core-11	MSSP-20	Mammography / Breast Cancer Screening	NQF #0031, HEDIS measure	Adult	The percentage of women 50-74 years who had a mammogram to screen for breast cancer in the last two years.

Core-12		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite	NQF, AHRQ (Prevention Quality Indicator (PQI) Chronic Composite)	Adult	Prevention Quality Indicators' (PQI) overall composite per 100,000 population, ages 18 years and older; includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.
Core-13		Appropriate Testing for Children with Pharyngitis	NQF #0002	Pediatric	Percentage of children 2-18 years who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode.
Core-14		Childhood Immunization Status (Combo 10)	NQF #0038, HEDIS measure	No	The percentage of children 2 years of age who had each of nine key vaccinations (e.g., MMR, HiB, HepB, etc.).

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-15		Pediatric Weight Assessment and Counseling	NQF #0024	No	The percentage of members 3-17 years who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
Core-16	MSSP-22,-23,-24,-25,-26	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	NQF #0729 (composite)	Adult	(a) MSSP-22: Percentage of patients 18-75 years with diabetes who had HbA1c <8% at most recent visit; (b) MSSP-23: Percentage of patients 18-75 years with diabetes who had LDL <100 mg/dL at most recent visit; (c) MSSP-24: Percentage of patients 18-75 years with diabetes who had blood pressure <140/90 at most recent visit; (d) MSSP-25: Percentage of patients 18-75 years with diabetes who were identified as a non-user of tobacco in measurement year; (e) MSSP-26: Percentage of patients 18-75 years with diabetes and IVF who used aspirin daily -- Aspirin use was not included as part of the profile composite.
Core-17	MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059, NCQA	Adult	Percentage of patients 18-75 years with diabetes whose HbA1c was in poor control >9%.
Core-18	MSSP-19	Colorectal Cancer Screening	NQF #0034, NCQA HEDIS measure	No	The percentage of members 50-75 years who had appropriate screening for colorectal cancer.
Core-19	MSSP-18	Depression Screening and Follow-Up	NQF #0418, CMS	No	Patients 12 years and older who had negative screening or positive screening for depression completed in the measurement year with an age-appropriate standardized tool. Follow-up for positive screening must be documented same day as screening.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-20	MSSP-16	Adult Weight Screening and Follow-Up	NQF #0421, CMS	No	Patients 18 years and older who had BMI calculated during the last visit in the measurement year or within the prior 6 months. In cases where the BMI is abnormal, a follow-up plan must be documented during the visit the BMI was calculated or within the prior 6 months.
Core-21		Access to Care Composite	NCQA	No	NCQA Survey - percentage of patients who could get appointments or answers to questions from providers when needed.
Core-22		Communication Composite	NCQA	No	NCQA Survey - percentage of patients who felt they received good communication from providers.
Core-23		Shared Decision-Making Composite	NCQA	No	NCQA Survey - percentage of patients whose provider helped them make decisions about prescription medications.
Core-24		Self-Management Support Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about specific health goals and barriers.
Core-25		Comprehensiveness Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about depression, stress, and other mental health issues.
Core-26		Office Staff Composite	NCQA	No	NCQA Survey - percentage of patients who found the clerks and receptionists at their provider's office to be helpful and courteous.
Core-27		Information Composite	NCQA	No	NCQA Survey - percentage of patients who received information from their provider about what to do if care was needed in the off hours and reminders between visits.
Core-28		Coordination of Care Composite	NCQA	No	NCQA Survey - percentage of patients whose providers followed-up about test results, seemed informed about specialty care, and talked at each visit about prescription medication.
Core-29		Specialist Composite	NCQA	No	NCQA Survey - percentage of patients who found it easy to get appointments with specialists and who found that their specialist seemed to know important information about their medical history.
VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-30		Cervical Cancer Screening	NQF #0032, HEDIS measure	Adult	The percentage of females 21-64 years who received one or more PAP tests to screen for cervical cancer in the measurement year or two years prior to the measurement year.

Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #0068, NCQA	No	Percentage of patients 18 years and older with IVD who had documentation of using aspirin or another antithrombotic during the measurement year.
Core-35	MSSP-14	Influenza Vaccination	NQF #0041, AMA-PCPI	Adult	Patients 6 months and older with an outpatient visit between October and March who received an influenza vaccine.
Core-36	MSSP-17	Tobacco Use Assessment and Cessation Intervention	NQF #0028, AMA-PCPI	No	Percentage of patients 18 years and older who had a negative tobacco screen or positive tobacco screen with cessation intervention in the two years prior to the measurement year.
Core-38	MSSP-32	Drug Therapy for Lowering LDL Cholesterol	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and an outpatient visit in the measurement year whose LDL-C <100 mg/dL or LDL-C >=100 mg/dL and who received a prescription of a statin in the measurement year.
Core-38	MSSP-33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and a LVEF < 40% or diagnosis of CAD and diabetes who received a prescription of ACE/ARB medication in the measurement year.
Core-39	MSSP-28	Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg	NQF #0018, NCQA HEDIS measure	Adult	Percentage of patients 18-85 years with hypertension whose BP was in control <140/90 mmHg.
Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented	Not NQF-endorsed; MSSP	No	Percentage of patients 18 years and older seen during the measurement period who were screened for high blood pressure and a recommended follow-up plan is documented based on the current blood pressure reading as indicated.
VT Measure ID	**Medicare Shared Savings Program Measure ID**	**Measure Name**	**Nationally Recognized/ Endorsed**	**Included in HSA Profile?**	**Measure Description**
Core-47	MSSP-13	Falls: Screening for Fall Risk	NQF #0101	No	Percentage of patients 65 years and older who had any type of falls screening in the measurement year.
Core-48	MSSP-15	Pneumonia Vaccination (Ever Received)	NQF #0043	Adult	Patients 65 years and older who had documentation of ever receiving a pneumonia vaccine.
	MSSP-1	CG CAHPS: Getting Timely Care, Appointments, and	NQF #0005, AHRQ	No	CMS Survey - Getting Timely Care, Appointments, and Information

		Information			
	MSSP-2	CG CAHPS: How Well Your Doctors Communicate	NQF #0005, AHRQ	No	CMS Survey - How Well Your Doctors Communicate
	MSSP-3	CG CAHPS: Patients' Rating of Doctor	NQF #0005, AHRQ	No	CMS Survey - Patients' Rating of Doctor
	MSSP-4	CG CAHPS: Access to Specialists	NQF #0005, AHRQ	No	CMS Survey - Access to Specialists
	MSSP-5	CG CAHPS: Health Promotion and Education	NQF #0005, AHRQ	No	CMS Survey - Health Promotion and Education
	MSSP-6	CG CAHPS: Shared Decision Making	NQF #0005, AHRQ	No	CMS Survey - Shared Decision Making
	MSSP-7	CG CAHPS: Health Status / Functional Status	NQF #0006 , AHRQ	No	CMS Survey - Health Status/Functional Status
	MSSP-8	Risk-Standardized, All Condition Readmission	CMS, not submitted to NQF (adapted from NQF #1789)	No	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
	MSSP-10	Ambulatory Sensitive Condition Admissions: Congestive Heart Failure	NQF #0277, AHRQ (Prevention Quality Indicator (PQI) #8)	Adult	All discharges with an ICD-9-CM principal diagnosis code for CHF in adults ages 18 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with CHF. This is an observed rate of discharges per 1,000 members.
	MSSP-11	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CMS EHR Incentive Program Reporting	No	Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Program incentive payment.
	MSSP-12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #0554	No	Percentage of patients 65 years and older who were discharged from any inpatient facility in the measurement year and had an outpatient visit within 30 days of the discharge who had documentation in the outpatient medical record of reconciliation of discharge medications with current outpatient medications during a visit within 30 days of discharge.
	MSSP-31	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #0083	No	Percentage of patients 18 years and older with a diagnosis of heart failure who also had LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
M&E-2		Comprehensive Diabetes Care: Eye Exams for Diabetics	NQF #0055, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received an eye exam for diabetic retinal disease during the measurement year.
M&E-3		Comprehensive Diabetes Care: Medical Attention for Nephropathy	NQF #0062, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received a nephropathy screening test during the measurement year.

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July 16, 2015

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Dear Ms. Maheras:

I am writing in response to your email dated July 8, 2015 outlining additional questions the VHCIP Core Team had related to our 2016 SIM Grant Application. Below please find the questions and our responses in the order they were presented.

Q1. What is the return on investment for the funds provided to OCV to date? How has this investment improved the quality of health care for Vermonters, reduced cost, and fostered integration?

A1. To date, SIM funds have been put to excellent use on the development of ACO infrastructure and establishment of its presence and continued support within the local HSA communities. In 2014, in addition to beating the national FFS equivalents on key hospital metrics, such as inpatient discharges, OCV's network has a preliminary score of 92.4% on the Medicare Quality Measure Scorecard based on survey data and quality measure abstraction. These improvements to the quality of health care are only the beginning of the services provided by OCV to Vermonters in its quest for the reduction of system costs and integration. Another area where SIM funds awarded to OCV have been used toward building improved quality for Vermonters and fostering integration is in the area of collaboration with VITL. OCV has, and intends to continue to work with VITL and key stakeholders to enable directed focus on core tasks of the HIE to improve data quality and the velocity of data they are able to produce. The infrastructure that has been built thus far with SIM funds has created the required foundation for payment reform, as OCV has served as a leader in developing next wave of ACO models by working collaboratively with the state's other ACO's and regulator, the GMCB.

Q2. If the Core Team does not approve this request, how will OCV perform the services described in the request?

A2. Should the Core Team decide not to approve our request for SIM funding, the services described in our application will not be able to be fulfilled. We believe that Vermonters would be unduly harmed as the mission of OCV and the successes created to date will not continue, nor be able to be sustained. Also important to note is the important role that OCV plays at the state and local level with regard to the regional collaboratives. These SIM Grant funds support OCV's involvement

in the work of the regional collaboratives which are listed in the VHCIP Year 2 Milestone and Progress Report for care delivery and practice transformation. We believe our continued efforts toward these collaboratives are critical for the success of both the local delivery system and the State.

Q3. Your proposal includes a request for a "statewide care management tool". Please explain how this tool integrates with the VHCIP project to implement shared care plans (SCUP).

A3. Our request for a "statewide care management tool" is separate and distinct from the VHCIP SCUP project. There could be well integrated features at some point, however, the SCUP project is in the very early stages and remains exploratory at this point in time around feasibility analysis. The care management tool OCV plans to implement will be fully integrated into its new Population Health Management platform, Health Catalyst. The joining of risk-stratified populations as ratified by local community health teams and OCV's Clinical Advisory Board, with the integrated care management tool will be a powerful combination that will provide value to providers and Vermonters overall, and in rapid timelines.

Q4. Your proposal indicates that OCV will collaborate with VITL provider outreach staff to implement data connections. Please indicate how this relates to the existing VHCIP gap remediation efforts and core State of Vermont funding for interface development and data quality improvement. Specifically, how will this additional investment be complementary to those other investments and what assurances can you provide that the investment will not be duplicative?

A4. The data connections proposal OCV has put forth centers around efforts to integrate a third party, nationally recognized expert vendor named PatientPing, into the VITL development efforts. This will have the effect of bringing a highly skilled Event Notification System to the state, while additionally enabling VITL's core platform to be integrated with a growing national network of patient identification and tracking. Resources for development of this system within VITL will be enabled to be redirected back to the core HIE mission of increasing data connections and improving data quality from those connections, rather than development of new systems.

I trust that our responses provide you and the VHCIP Core Team with the clarification needed to proceed in the review of our application. I am always happy to provide further clarification should you and the team deem it necessary.

Sincerely,

Todd B. Moore
Chief Executive Officer

C: Greg Robinson, VP Informatics & Finance
Vicki Loner, VP Clinical & Network Operations

S:\...\OneCare Vermont\Government Programs\SIM Grant 2016\Follow up Question Response