VT Health Care Innovation Project
Practice Transformation Work Group Meeting Agenda

August 2nd, 2016; 10:00 AM to 12:00 PM
AHS - WSOC Oak Conference Room, 280 State Drive, Waterbury, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:00 – 10:10	**Welcome & Introductions; Approval of Minutes** Deborah Lisi-Baker and Laural Ruggles	**Attachment 1:** June Meeting Minutes	Yes (approval of minutes)
2	10:10 – 11:10	**Medicaid Pathways Update** Selina Hickman	**Attachment 2:** Medicaid Pathway Integrated Designs	
3	11:10 – 11:40	**Identifying and Addressing Practice Transformation Challenges and Barriers** Pat Jones and Erin Flynn	**Attachment 3:** Opportunities/Challenges/Barriers Table	No
4	11:40 – 11:55	**Project Updates** • **Integrated Communities Care Management Learning Collaborative** • **Core Competency Training** Pat Jones and Erin Flynn		
5	11:55 – 12:00	Wrap-Up and Next Steps; Plans for Next Meeting		

Attachment 1: June Meeting Minutes

Vermont Health Care Innovation Project
Practice Transformation Work Group Meeting Minutes
Pending Work Group Approval

Date of meeting: June 7, 2016; 10:00 AM to 12:00 PM; Red Oak Room, State Office Complex, 280 State Drive, Waterbury, VT

Agenda Item	Discussion	Next Steps
1. Welcome, Introductions **Approval of minutes**	Deborah Lisi-Baker opened the meeting at 10:05. Roll call attendance was taken and a quorum was not achieved.	
2. Program Updates: • Operational Plan Submission • CMMI Site Visit • Core Competency Training	Georgia Maheras provided the following programmatic updates: • Operational Plan Submission: The VHCIP Performance Period 3 Operational Plan was submitted to CMMI on April 28, 2016. Thanks to many staff and stakeholders for their contributions to the over 150 page report! • CMMI Site Visit – May 2 and 3, 2016: CMMI sent three representatives to Vermont in early May for two days of meetings to discuss the status of the VHCIP project and plans for the final year of the Grant. Erin Flynn provided the following update on the Core Competency Training Series • June 16 and 17, 22nd and 23rd: the next round of trainings will be occurring. The focus will be on cultural competency and universal accessibility. There are still some openings for these next trainings – please visit the website for more information and contact Holly Stone at Holly.Stone@partner.vermont.gov to sign up! • There are 240 spots available for the series and a rough estimate is that approximately 85-90 different organizations are participating in this statewide training series. Joelle Judge provided an update on the upcoming Provider Subgrant Symposium: On June 16th, the VHCIP will convene all of the Provider Sub-grantees at the Capitol Plaza in Montpelier. The event starts at 8 am and runs through 12:30 pm. Sub-grantees will be making short presentations to highlight case studies and best practices and lessons learned throughout their projects. Many projects will also feature poster or table displays with more information, papers and other materials available for review.	

Agenda Item	Discussion	Next Steps
3. Update on ICCMLC program	**Erin Flynn, Jenney Samuelson and Pat Jones** **Integrated Communities Care Management Learning Collaborative (ICCMLC)** Erin Flynn began by providing a recap of progress to date, highlighting the work group's goals and how the ICCMLC was envisioned to help achieve these goals. For example, although Vermont's delivery system reforms have strengthened coordination of care and services, people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services. The learning collaborative was envisioned as a way to address these concerns. She described the near and long-term goals of the project, with the overall intent to mirror the Triple Aim of improving the experience of care, improving the health of the population and reducing the cost of health care. Sam Liss asked noted that a risk of decreasing health care costs could be decrease quality, or even rationing of services. Pat Jones indicated that the quality measurement component is key to the State's value based purchasing payment reform initiatives. Dale Hackett also commented that it is hard to measure certain impacts, particularly around medicine and pharmacy, where the delivery of actual medicine is critical to peoples' health. Jenney and Erin noted that one of the outcomes that is beginning to emerge through the ICCMLC is improved communication across an integrated care team so that providers aren't prescribing conflicting medications, as an example. Ben Watts noted that the Department of Corrections is currently exploring opportunities to improve outcomes for people being discharged from corrections facilities by connecting them to community services and supports immediately upon discharge. He also noted that it may be important to consider the 'Quadruple' Aim, rather than Triple Aim, with the 4th leg being staffing. Pat Jones also noted that there is always the option of referring folks to their local community health team. Erin next discussed the framework of the ICCMCLC. The learning model leverages the Plan, Do, Study, Act (PDSA) quality improvement model to facilitate rapid-cycle learning and implementation. The Learning Collaborative has utilized both in-person meetings and webinars to engage participants on a monthly basis. Jenney Samuelson discussed the workflow that is being used by the Learning Collaborative, and referred to the colorful "box diagram" included in the handout (noting that the order of interventions may vary). The local community teams are using data to identify patients with complex needs who might benefit from team-based care. Once identified, they then reach out to begin the process of engaging the individual such that the care is person-directed. Next providers use tools to document a person's story, goals and care team. These tools include things like Camden Cards to identify and individual's goals, and eco-mapping to determine who is on an individual's care team. Next a record review tool is used to do a 10-year look back into a person's medical record. A root cause analysis is done to help categorized that information in four quadrants (medical, psych, social and	

Agenda Item	Discussion	Next Steps
	systems) that are contributing to a person's health. Then an initial "care team huddle" or organizational meeting is convened followed by the identification of a lead care coordinator, a cross organizational care team conference, and finally the development, implementation and ultimately updating of shared care plan over time. Jenney also offered an overview of how the "community collaboratives" and the ICCMLC interface: • Community Collaboratives (CCs - often known as UCC, RCPC) have been established in each HSA and include health care, social service, and community based organizations. • CCs set community health priorities based on core measures and priorities for each area. • CCs have selected the Learning Collaborative as a performance improvement project to address priorities and support cross-organization integrated care management. • CCs are poised to sustain the work at the end of VHCIP with support from the Vermont Blueprint for Health and the ACOs. The group next discussed the tools that are being used to support the ICCMLC model and workflow described above, and noted that examples of these tools can be found in the materials packet. Dale asked if the tools will ultimately allow for someone to be able to 'read' the person's story based on the completion of the tools. Jenney and Pat both echoed that this is one of the most important pieces of the concept of team based care and person directed care that is coming out of the Learning Collaborative – learning and telling the story of the person, in their own words. Bev Boget also asked how providers would know whether and where to look to view a shared care plan and where it ultimately resides. Jenney offered one example in which a community have embedded the shared care plan in the EMR in the local hospital's emergency room. She also noted how in the absence of common accessible electronic systems for all providers across a community currently, learning collaborative teams have been sharing documents in less high tech ways including secure email, fax and hard copy. Jen also noted that we are often seeing the lead care coordinator take responsibility for ensuring that the shared care plan is up to date and accessible to all members of the care team. Next, Pat Jones presented on the program evaluation strategy for the ICCMLC. The first component of the evaluation strategy includes process measures, starting with the number of people enrolled in these pilot projects (over 200 families are currently involved!) and also recording metrics around the number of individuals who have a lead care coordinator identified, root cause analysis completed, care team identified and a share care plan completed. These measures are being reported by the participated communities on a bi-monthly basis. The project is also fielding two surveys to assess 1) the patient experience of care and 2) the provider experience within the team-based care construct.	

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	The following outcome measures are being explored for potential measurement of the outcomes of the project: Emergency Department Utilization: • Potentially Avoidable ED Utilization • Outpatient ED Visits (HEDIS®) Inpatient Utilization: • Inpatient Discharges (HEDIS®) •All-Cause Readmission (HEDIS®) • Rate of Hospitalization for Ambulatory Care Sensitive Conditions (AHRQ PQI Chronic Composite) Cost/Resource Utilization • Total Expenditures Per Capita • Total Resource Use Index Primary Care Encounters The claims based outcomes measurement strategy is still being finalized, however as the number of individuals involved increases, the likelihood of reaching statistically significant results also increases. Bev Boget asked if it has been difficult to engage people in the collaborative. Pat indicated that almost all of the people who have been invited to participate are participating and staying engaged. She also noted that Lauran Hardin, who is one of the key faculty members, follows people for like and uses the term "relationship for life" to describe the work of the lead care coordinator. Jenney added that the goal of the ICCMLC was not to create a new case management program to enroll people into and to graduate people from, but rather to improve care delivery and outcomes by enhancing the "teamness" of interagency care teams through an integrated care delivery model. Jenney then provided an overview of the next in person learning session: Keeping a person's shared plan of care alive under dynamic and challenging situations. Miriam Sheehy from OneCare Vermont added that there is a great deal of synergy across the state and this work is having impact on the outcomes that the ACOs are seeing, including the inclusion of these tools into the Care Management Tool kit that OneCare Vermont uses for their provider network. Jenney noted that many of the participating organizations are using these tools in a much broader context. As a notion of sustainability, this is encouraging to see how the local teams are including this learning systematically into their work on an ongoing basis. Bev Boget asked if providers are getting paid for the various interventions being implemented under this work. Jenney noted that it's actually saving time and increasing both efficiency and satisfaction for those who were already trying to do care coordination. As well, it is being considered for inclusion in the all-payer model and	

Agenda Item	Discussion	Next Steps
	payment models as well. In the meantime, providers have found ways to make this model work for the time being, for example the are certain billing codes that can be used to attend a care conference, and conferences can be held on site for Doctors or specialists who are very strapped for time, or providers can call in for just a short portion of the conference if needed. This is allowing the communities to come up with innovative ways to work with the system in the present time while also planning for the kinds of changes that need to be made to the system overall. Bev asked about sustainability and the participation of state agencies like DVHA. Georgia Maheras responded that DVHA has been included all along, as well as GMCB and others. The makeup of the VHCIP Core Team includes representatives from DVHA, GMCB, DAIL, AHS and AOA. We will be convening a smaller group to work on more sustainability in detail.	
4. Review & Discuss 2016 Practice Transformation Workgroup Work Plan	Deborah Lisi-Baker reviewed the Practice Transformation Work Group 2016 Work Plan. She noted that the group had expressed interest in periodically reviewing the work plan and receiving updates on tasks as the projects move forward. Bev Boget suggested adding the names of lead people across the activities in the work plan. Georgia Maheras noted that the Year 3 Operational Plan does have this information in section J, as well as in the monthly status reports that are posted to the website here. Deborah noted that with respect to Home and Community based rules, AHS is seeking input to helping to design the conflict free case management rules. Legal aid is also watching for further development of these standards and Deborah highlighted the need to ensure that these are worked into the system as things like the All-Payer waiver and the Medicaid Pathway are defined and implemented. Dale also noted that there is importance to the way that these models are communicated and also worked into the planning around sustainability.	
5. Next Steps	The next meeting is Tuesday, August 2, 2016 from 10:00 am – 12:00 pm Please note: **The July meeting canceled.** Red Oak Conference Room, 280 State Drive, Waterbury This is in the new State Office Complex (New Building - the meeting space is located on the 2nd floor above the main entrance) Call-In Number: 1-877-273-4202 Conference ID: 2252454	

VHCIP Practice Transformation Work Group Member List

Member		Member Alternate			Tuesday, June 07, 2016
First Name	Last Name	First Name	Last Name	Minutes	Organization
Susan	Aranoff	Gabe	Epstein		AHS - DAIL
		Bard	Hill		AHS - DAIL
		Clare	McFadden		AHS - DAIL
Beverly	Boget	Peter	Cobb		VNAs of Vermont
		Michael	Counter		VNA & Hospice of VT & NH
Kathy	Brown	Todd	Bauman		DA - Northwest Counseling and Support Services
		Stephen	Broer		DA - Northwest Counseling and Support Services
Barbara	Cimaglio				AHS - VDH
Molly	Dugan	Stefani	Hartsfield		Cathedral Square and SASH Program
		Kim	Fitzgerald		Cathedral Square and SASH Program
Eileen	Girling	Heather	Bollman		AHS - DVHA
		Jenney	Samuelson		AHS - DVHA - Blueprint
Maura	Graff				Planned Parenthood of Northern New England
Deborah	Lisi-Baker				UVM; Co-chair
Dale	Hackett				Consumer Representative
Sarah	Jemley	Jane	Catton		Northwestern Medical Center
		Candace	Collins		Northwestern Medical Center
Linda	Johnson	Debra	Repice		MVP Health Care
Pat	Jones	Annie	Paumgarten		GMCB
Trinka	Kerr	Nancy	Breiden		VLA/Health Care Advocate Project
Jackie	Majoros	Barbara	Prine		VLA/LTC Ombudsman Project
Dion	LaShay				Consumer Representative
Patricia	Launer	Kendall	West		Bi-State Primary Care
Sam	Liss				Statewide Independent Living Council

VHCIP Practice Transformation Work Group Member List

Member		Member Alternate			Tuesday, June 07, 2016
First Name	Last Name	First Name	Last Name	Minutes	Organization
Sara	Barry	Emily	Bartling		OneCare Vermont
Miriam	Sheehey ✓	Maura	Crandall		OneCare Vermont
Kate	McIntosh	Judith	Franz		Vermont Information Technology Leaders
Bonnie	McKellar	Mark	Burke		Brattleboro Memorial Hopsital
Madeleine	Mongan	Stephanie	Winters		Vermont Medical Society
Julie	Tessler				VCP - Vermont Council of Developmental and Mental Health Services
Marlys	Waller ✓	Mary	Moulton		VCP - Washington County Mental Health Services Inc.
		Catherine	Simonson		VCP - HowardCenter for Mental Health
		Stephen	Broer		VCP - Northwest Counseling and Support Services
Sarah	Narkewicz				Rutland Regional Medical Center
Laural	Ruggles				Northeastern Vermont Regional Hospital; Co-chair
Patricia	Singer	Jaskanwar	Batra		AHS - DMH
		Mourning	Fox		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
Angela	Smith-Dieng	Mike	Hall		V4A
Shawn	Skaflestad ✓	Julie	Wasserman ✓		AHS - Central Office
Audrey-Ann	Spence	Teresa	Voci		Blue Cross Blue Shield of Vermont
JoEllen	Tarallo-Falk				Center for Health and Learning
Lisa	Viles				Area Agency on Aging for Northeastern Vermont
Kirsten	Murphy ✓				VT Developmental Disabilities Council

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VHCIP Practice Transformation Work Group

Attendance Sheet

Tuesday, June 07, 2016

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

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

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

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

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

163	Jason	Wolstenholme	Vermont Chiropractic Association	X
164	Mark	Young		X
165	Marie	Zura	DA - HowardCenter for Mental Health	X
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Attachment 2 - Medicaid Pathway Integrated Designs

Payment and Delivery System Reform:

Mental Health, Substance Abuse Treatment, Developmental Disabilities Services

Medicaid Pathway to an Integrated Health Care System

Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.

Discussion Topics

- Overview
  - Medicaid Pathway Context
  - Organized Delivery System Objectives
  - Medicaid Pathway Process
- Continuum of Integration Models
  - Delivery and Payment Reform
  - Quality Oversight and Outcomes
  - Resources
- Discussion
- Next Steps

Medicaid Pathway Context

- Older people and those with disabilities or multiple chronic conditions (substance use disorder, mental health challenges and other medical conditions) are the most complex and expensive populations that Medicaid supports.
  - In VT approximately 25% of Medicaid beneficiaries are enrolled in Specialized Programs; however, they account for 72% of Medicaid Expenditures (55% in specialized programs and 17% in physical health care).
- Evidence suggests that the integration of care (primary care, acute care, chronic care, mental health, substance abuse services and disability and long term services and supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care and lower costs.
- Community based supports help prevent the need for care in more expensive, acute care settings, thus improving well-being, quality and controlling costs.
- Research has shown that environmental and socio-economic factors are crucial to overall health.
- Integration is a fundamental component of comprehensive, person-centered care.

Objective for Reform Planning

Develop an *organized delivery system* for serving individuals and promote integration across services for:

- Mental Health
- Substance Abuse Treatment
- Long-Term Services and Supports for individuals with developmental service needs
- Physical Health
- Long-Term Services and Supports for individuals with physical disabilities and older Vermonters

Medicaid Pathway Process

Delivery System Transformation (VT Integrated Model of Care)

- What will providers be doing differently?
- What is the scope of the transformation?
- How will transformation support integration?

Payment Model Reform (Reimbursement Method, Rate Setting)

- What is the best reimbursement method to support the Model of Care (e.g. fee for service, case rate, episode of care, capitated, global payment)?
- Rate setting to support the model of care, control State cost and support beneficiary access to care
- Incentives to support the practice transformation

Quality Framework (including Data Collection, Storage and Reporting)

- What quality measures will mitigate any risk inherent in preferred reimbursement model (e.g. support accountability and program integrity); allow the State to assess provider transformation (e.g. structure and process); and assure beneficiaries needs are met?

Outcomes

- Is anyone better off?

Readiness, Resources and Technical Assistance

- What resources are necessary to support the desired change and/or fund the delivery system?

Long Term Goal – Discussion Draft

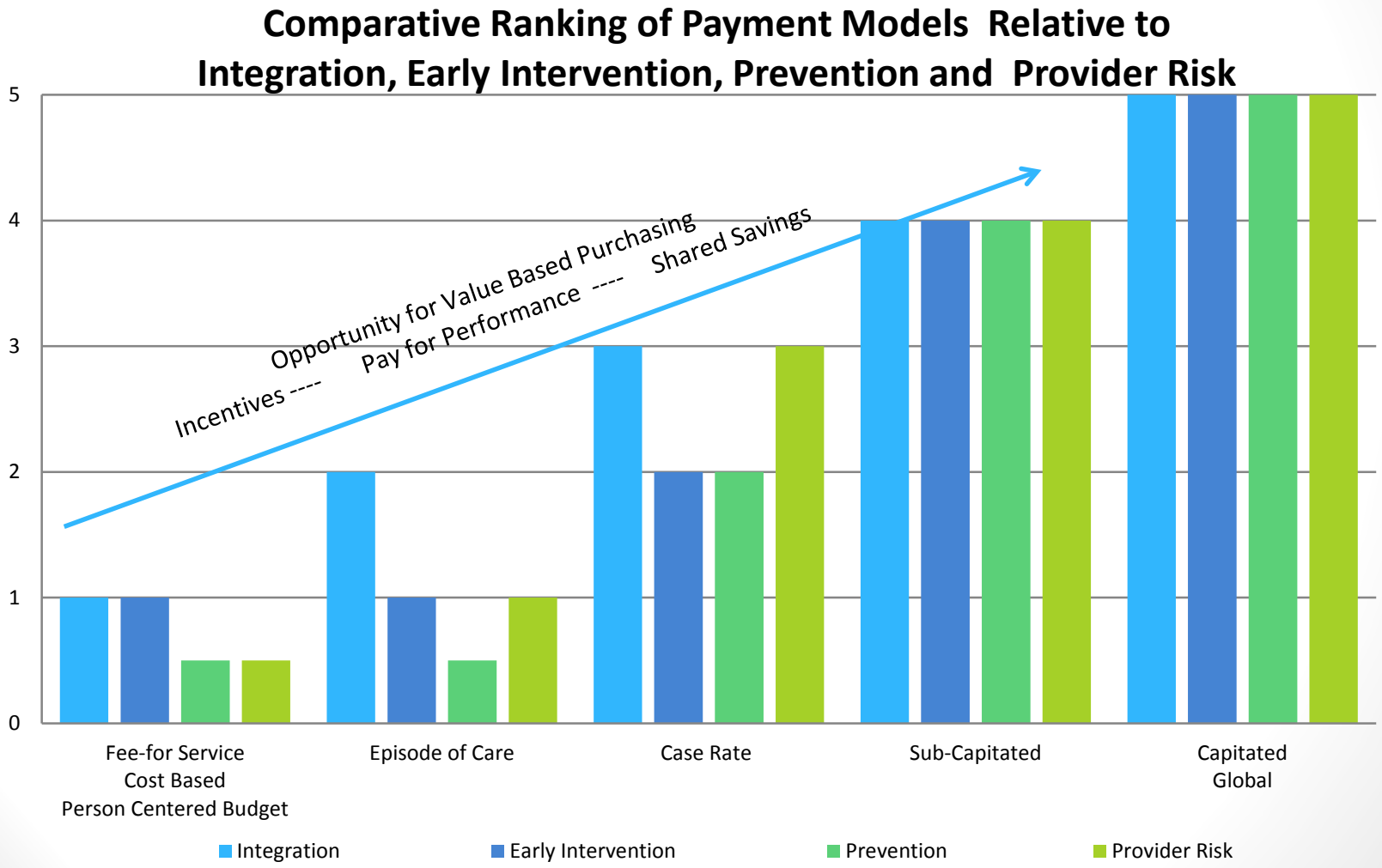
To support the creation of an organized, provider-led delivery system, such as an Accountable Care Organization or other structure, that can support the full continuum of AHS Medicaid funded services from pre-natal through end of life care, seamlessly integrated with physical health care.

Provider staff view work together as one of a single team and the principle of treating the whole person is applied to total population, not just identified target groups.

Long Term Delivery System Transformation

Delivery System Transformation	
What will providers be doing differently?	**How will Transformation Elements Support Integration with Physical and Mental Health, Substance Abuse Treatments and LTSSS**
Adopting the Vermont Integrated Model of Care	Through Consumer Experience of Integrated Care such as: • Person-centered planning • Bi-directionality of referrals between PCP and Community Service Providers • Standardized and comprehensive assessments • Active involvement of PCP in service planning • Single/Lead case manager • Interdisciplinary Teaming • Use of IT to support information sharing & outcomes
Shared governance to support, at a minimum: • Achieving the Model of Care • Assessing community needs and gaps • Using community profile and quality data to make decisions about community services, gaps, assets • Creating consensus regarding community investments to support population health and the integrated model of care	Through integration of delivery systems across physical and mental health, substance abuse treatment and long term services and supports shared: • Governance of community goals & progress • Assessments of community assets & gaps • Decision-making regarding resources and priorities • Accountability • Quality monitoring , improvement goals and outcomes
Promoting Population Health (Population-Based Health, Adoption of Best Practices; Address social determinates of health and early intervention)	Through coordination and accountability at the community level to promote innovation and monitor quality and outcome measures that “everyone can get behind” (i.e., all providers can impact)
Ensuring Efficient Operations and Oversight, including non-duplication of services and supports	Through consolidation of functions at provider and state level such as care coordination, data reporting and IT platforms across AHS programs

Continuum of Payment Models to Support Objectives



Quality & Outcome Framework

- Overall quality and outcome framework is related to, but broader than, quality metrics that may be used to determine incentive payments
- Quality and outcome framework becomes the foundation for program oversight, provider monitoring, provider reporting, corrective action and quality improvement planning
  - *Accountability*: Confirm that contracted services were delivered. Did you get what you paid for? At minimum, requires submission of encounter data:
    - Service type, location, provider, duration, date
  - *Appropriateness*: Were the services delivered based on best practice and State standards (e.g., process and clinical, Model of Care, HCBS, Trauma, Recovery, Reliance, etc.)? Requires submission of data and medical records audits:
    - Core Data Elements – Build from HSE/SPP Task 5 Report
  - *Outcomes:* Did the services delivered produce the expected results?
    - Build from current AHS Dashboard and Comprehensive GC/Medicaid Quality Strategy work

Continuum of Integration Models

Based on Discussions to Date Several Integration Models are Emerging:

- Coordinated Model
- Specialized Delivery System Integration (Minimum Service Array)
- Integrated Community Delivery System (Minimum Service Array plus Additional Health Care Partners)
- ACO Affiliated or Similar Model (Fully Integrated Statewide or Regional)

Delivery System Integration Continuum

Delivery System Models: DRAFT for Discussion					
Level of Delivery System Integration	**Characteristics**	**Support for Objectives**	**Governance Model Elements**	**Shared Functions**	**Flow of Funds**
Coordinated Model	Provider & contract specific work and populations	Provider Specific (incentives could be created for adoption of some aspects)	Provider Specific	None	Provider Specific
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Provider Led. State standards and oversight ; integrated care for target population	Allows for adoption of model of care within targeted programs, limited early intervention, limited to no impact on population health and prevention	Optional based on scope of services and local decisions regarding shared functions	Optional and could include: IT; data analysis and reporting; quality and outcome monitoring; assessment of community assets and gaps; claims processing ; etc.	Provider Specific . At discretion of local partnerships some funds could flow to defined local entity for shared administrative and quality incentive payments
Integrated Community Delivery System - Minimum Service Array plus additional health care partners	Same as above ; integrated care for whole or subset of population ; some streaming of Medicaid fund sources ; shared investments	Same as above with more flexibility for early intervention, population health and prevention based on partners	Required if shared investments are part of local agreements	Same as above	Same as above
ACO Affiliated or Similar Model (statewide or regional)	Same as above ; streamlining of Medicaid fund sources	Supports all objectives	Required for resource decisions, priority setting and shared quality and outcome tracking	All of the above plus budget monitoring, priority setting and resource planning	Single Entity with shared investments

Payment Models Based on Level of Integration - DRAFT for Discussion

Payment Model Reform (Reimbursement Method, Incentives and Rates) Based on Level of Integration				
Level of Delivery System Integration	**Target Population**	**Potential Reimbursement Approach**	**Potential Incentives**	**Potential Rate Base and Annual Adjustments**
Coordinated Model	Provider Specific	No change	Could have incentive payments for certain aspects of care	Rates Determined Annually
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Provider Specific	Provider Specific Case Rate Payment (Monthly per active member; e.g., persons needs to engage in services within the month for provider to receive payment); Child and Adult Rate	Quality Incentive Bonus for Achieving Pre-Defined Targets and/or Integration	Rates based on 3 year average, allocation and caseload, increased annually by defined percentage; consistent rate setting approach across all Medicaid fund sources
Integrated Community Delivery System - Minimum Service Array plus additional health care partners	Whole or Target Group in Region	Provider Specific Global Budget (1/12th annual allocation paid monthly; not based on client accessing services in a given month)	Shared Savings AND Quality Incentive Bonus for Achieving Pre-Defined Targets and/or Integration	Rates based on 3 year average allocation, increased annually based on % of savings achieved; consistent rate setting approach across all Medicaid fund sources
ACO Affiliated or Similar Model (statewide or regional)	Whole or Target Group in Region	Regional Capitation Payment PMPM; not based on client accessing services in a given month)	Shared Savings AND Quality Incentive Bonus for Achieving Pre-Defined Targets	Same as above

Quality & Outcomes Framework Draft

Quality			
Level of Delivery System Integration	**Accountability**	**Outcomes**	**Reporting**
Coordinated Model	Provider specific	Provider specific	Provider specific
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Provider specific; there could be shared community targets	Provider specific; there could be shared community targets	Could be shared reporting
Integrated Community Delivery System - Minimum Service Array plus additional health care partners	Provider specific , there could be shared community targets	Provider specific ; there could be shared community targets	Could be shared reporting
ACO Affiliated or Similar Model (statewide or regional)	Required Targets	Required Targets	Unified Reporting required

Resources (Identified to Date)

Resource Needs Identified to Date				
Level of Delivery System Integration	**IT & Data Infrastructure**	**Budget**	**Staff**	**TA and Workforce Development**
Coordinated Model	Provider Specific	Incentives to support adoption of model of care	No Unique Considerations	Workforce Training • Model of Care • DLTSS core competencies • Learning Collaborative for best practice
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Data collection and reporting system that allows for consistent measurement of quality and outcome standards	• Funding to support workforce salaries and predictable COLA • Funding for quality incentives bonuses • Increased availability of options counseling • Independent evaluation of effectiveness of delivery system and outcomes • Funding for IT gaps at State and local level	Data Analytics State and Local TBD	
Integrated Community Delivery System - Minimum Service Array plus additional health care partners				
ACO Affiliated or Similar Model (statewide or regional)				

Next Steps

- Information Gathering and Feedback
  - Solicit input from local regions through a formal information gathering process
    - State staff and workgroup to develop a request for feedback with key questions and solicit formal input from each region
    - Expected Date of Release: TBD
  - Use formal feedback responses to inform planning
    - What model options are most viable over short term and long term?
    - What are the operational considerations of moving to a regional (or statewide) governance and decision making model?
    - Implementation Planning: What is necessary for year one?
- Implementation Timeline and Steps
- Coordinated Medicaid Pathway discussions between provider work groups
- Continue work on rate development methodology that can be used regardless of final payment model approach (e.g., capitated, case rate or global budget)
- Additional Consumer/Stakeholder Outreach– TBD

Attachment 3: Opportunities/Challenges/ Barriers Table

Identifying and Addressing Practice Transformation Challenges and Barriers

Opportunities Identified in Care Management Presentations and Inventory Survey Responses	Responses from VHCIP and Others
Increased process standardization, including increased use of **common care management tools**	• Learning Collaborative • Vermont Model of Care • Core Competency Training • Care Management Toolkit
Creation of an organizational mechanism to **coordinate the "family of care coordinators"**	• Learning Collaborative • Vermont Model of Care
Increased development and use of **IT resources to coordinate care management activities**; improved communication and relationships across an integrated care team supported by **health data infrastructure and exchange**; increased use of a **shared data set** to coordinate care and measure effectiveness	• EQHealthworks (State of Vermont) • Patient Ping (event notification) • Care Navigator (OneCare) • Accessing Care Through Technology (ACTT) • ACO Gateways • Telehealth Initiatives
Increased **opportunities for care managers to build their skills** through initiatives to share best practices and learn new skills	• Core Competency Training • Learning Collaborative • Care Management Toolkit
Improved **identification of and outreach** to people with complex needs, **increased engagement of individuals in their care**	• Learning Collaborative • Vermont Model of Care • Core Competency Training
Insufficient funding or lack of reimbursement mechanisms to support care coordination functions, leading to challenges in recruiting and retaining qualified staff	• ACO Shared Savings Programs • Medicaid Pathway • Potential All Payer Model
Overcoming privacy barrier to sharing information across an integrated care team	• DAIL and Designated Agency Templates

Identifying and Addressing Practice Transformation Challenges and Barriers

Opportunities Identified in Care Management Presentations and Inventory Survey Responses	Responses from VHCIP and Others
Challenges **engaging providers** across the continuum of care **in an integrated care team**	• Learning Collaborative • Selected Provider Sub-grants • Unified Community Collaboratives • Accountable Communities for Health
…improve the rate of implementing CMMI's key care management functions…**educational opportunity to train care managers**…on these key care management functions.	• Core Competency Training
…establish **more formal and structured relationships** to create stronger ties for providing care management services across care settings and community service organizations, and **provide opportunities to develop truly integrated delivery systems** that include organizations traditionally on the periphery of traditional health care delivery.	• Learning Collaborative • Unified Community Collaboratives • Accountable Communities for Health • Potential All Payer Model • Medicaid Pathway
…opportunity to provide **additional training on implementing Team Based Care**.	• Learning Collaborative • Core Competency Training
Ensuring the provision of…[certain care management] **services**, when appropriate, **for people being discharged from skilled nursing facilities** could result in fewer readmissions, which is a very important focus for cost containment	• ACTT UTP Project • Learning Collaborative (upcoming session on transitions in care)
Examining the roles that…[certain] disciplines could play in improving care management, and recruiting additional FTEs if warranted, could impact resource allocation.	• Workforce Work Group Demand Modeling