VHCIP Core Team Agenda 8.13.14

VT Health Care Innovation Project
Core Team Meeting Agenda

August 13, 2014 1:00-3:30 pm
DFR - 3rd Floor Large Conference Room, 89 Main Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00-1:10	Welcome and Chair's Report	Anya Rader Wallack	
Core Team Processes and Procedures				
2	1:10-1:15	Approval of meeting minutes	Anya Rader Wallack	Attachment 2: July 16, 2014 meeting minutes.
Policy Update				
		None at this time		
Core Team Processes and Procedures				
3	1:15-2:00	Grant Program Update: 1. Modified timeline and process review 2. Scoring Sheet Discussion	Georgia Maheras	Attachment 3a: Subgrant Program Timeline Attachment 3b: Draft Round Two Scoring Sheet

		Public Comment		
Spending recommendations and decisions				
4	2:00-3:15	Financial Update: a. Financial Alignment Proposal *Public Comment* b. CMCM Proposal for a Learning Collaborative: $300,000 c. Arrowhead Health Analytics Proposal: $110,000 *Public Comment*	Georgia Maheras	Attachment 4a: VHCIP Revised Project Budget 8.7.14 Attachment 4b: Learning Collaborative ppt Attachment 4c: Financial memo
5	3:15-3:25	*Public Comment*	Anya Rader Wallack	
6	3:25-3:30	Next Steps, Wrap-Up and Future Meeting Schedule: 9/10: 11:00-12:30 Montpelier 9/29: 10:00-12:00 Montpelier	Anya Rader Wallack	

Attachment 2 - Core Team Minutes 7.16.14

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: July 16, 2014 **Location:** DFR 3rd Floor Conference Room, 89 Main Street, Montpelier VT

Members: Anya Rader Wallack, Chair; Robin Lunge, AOA; Susan Wehry, DAIL; Paul Bengtson, NVRH; Al Gobeille, GMCB; Mark Larson, DVHA; Doug Racine, AHS; Steve Voigt.

Attendees: Georgia Maheras, AOA; Diane Cummings, AHS; Annie Paumgarten, Richard Slusky, Spenser Weppler, Susan Barrett, GMCB; Julia Shaw, VT Legal Aid; Alicia Cooper, Kara Suter, DVHA; Julie Wasserman, Monica Light, AHS; Julie Tessler, Vermont Council; Simone Rueschemeyer, BHN; Todd Moore, Churchill Hindes, OneCare Vermont; Joyce Gallimore, CHAC; Melissa Miles, Heather Skeels, BiState Primary Care; Kirsten Murphy, Washington County Mental Health. Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's report	Anya Wallack called the meeting to order at 1:02 pm and gave an update on the CMMI site visit that took place on June 18th. CMMI provided great feedback to Vermont as part of that site visit and in particular was pleased with Vermont's level of provider engagement. CMMI has also assigned a new Program Officer to Vermont: Patti Boyce. Patti replaces Clare Wrobel who has been promoted within CMMI. Anya noted that due to changes in the Open Meeting Law the Core Team will be doing roll call for any votes at this meeting.	
2. Approval of Minutes	Al moved to approve the June 17th minutes. This was seconded by Susan. All approved with two abstentions (Doug Racine and Steve Voigt). At this point in the meeting, Mark Larson joined.	
3. Commercial SSP Standards Update	Anya introduced this topic and then Richard Slusky provided an update to the Core Team about the Commercial SSP Standards. Richard referred to Attachments 3a-3c as part of his update. The documents describe technical and substantive changes to the Commercial SSP Standards. The changes are a result of the GMCB's decisions when they approved the Commercial SSP as well as	

Agenda Item	Discussion	Next Steps
	changes recommended as a result of implementation issues that have arisen. These changes will go to the GMCB for approval. The Core Team engaged in a discussion about these changes. The Core Team requested that Richard provide the following two comments to the GMCB: 1. Regarding the possibility of an ACO to receive savings if they fail to meet the minimum quality score (#4), the Core Team recommends the GMCB engage in a public process to define "meaningful improvement" so that there is no risk to quality of care. 2. Regarding the term "GMCB facilitated process", the Core Team recommends there be additional language or a definition added to these documents so that the GMCB facilitated process is performed with guidance from the VHCIP work groups.	
4. Grant Program Application	Georgia Maheras provided an overview of the Round Two Grant Application Process and recommended changes to the application. The goal is to release the solicitation for applications by the end of July. Four of the VHCIP made recommendations to the application and criteria to the Core Team, this is provided in Attachment 4b. The Core Team discussed these recommendations and will add four of them to the application itself. The remaining recommendations will be converted into scoring/review guidelines for the Core Team. Georgia will provide draft scoring/review guidelines to the Core Team for review and discussion at their August meeting. Robin Lunge moved to approve the application for release. This was seconded by Al Gobeille and unanimously approved.	**Release of Application by July 31.**
5. Spending Recommendations and Decisions	Anya told the Core Team that Vermont would be submitting a budget to CMMI on July 31st pending Core Team approval in August. There is time and ability to make changes to the year two budget after this submission.	

Agenda Item	Discussion	Next Steps
	Anya recused herself at this point in the meeting pursuant to the VHCIP conflict of interest policy due to connections with both the evaluation sub-contractor and Dartmouth Hitchcock Medical Center. Anya asked Robin to Chair the meeting. Robin introduced the first financial request: an increase in funding for the evaluation contract due to contracting delays and changes in the scope of work. Georgia provided more detail about what work the additional funds would support highlighting that the increase in work was due, in part, to additional guidance from CMMI. The funds for this are available within the Evaluation line item in the budget. Susan Wehry moved to approve this increase and Steve Voigt seconded it. It was unanimously approved. Paul Bengtson recused himself at this point in the meeting due to NVRH's participation in OneCare Vermont. Robin introduced the chart review proposal. Georgia provided background as to why this proposal was before the Core Team and how it would impact measure collection. Susan raised the concern about ensuring we have sufficient oversight and also flexibility. The Core Team agreed that this balance is challenging and that this should be monitored. The Core Team also expressed the desire that this be a one-time expense and not a recurring cost. Georgia explained that the HIE/HIT investments previously approved by the Core Team should help to ensure this is not a recurring cost. Kara provided additional information about this proposal: this process ensures we get data in year one and better positions us for evaluating that data and potentially using those measures for payment in subsequent years. Georgia explained that the funding for this would come from the system-wide analysis portion of the workforce line-item. Steve moved to approve this request. This was seconded by Al and approved unanimously. Robin introduced to ACO proposal. Georgia provided background as to why this proposal was before the Core Team. Georgia walked through the various line items that were adjusted to accommodate this expense. Susan asked why this was not coming through as part of the sub-grant program. Georgia explained that there is a timing issue related to OneCare: the hospitals	

Agenda Item	Discussion	Next Steps
	are in the middle of the hospital budget approval process, which concludes in September before the sub-grant program decisions will be made. The community hospitals need to know if there will be any SIM money provided to OneCare to offset their contribution to the ACO prior to the decision about their hospital budgets by the GMCB. Robin added that initially the grant program second round was to happen earlier in 2014, but it was pushed back and we didn't realize this timing was an issue. Susan said that despite OneCare's data showing a need to do more work to improve care for those with disabilities and in need of long term services and supports, their proposal does not include that as an area of clinical focus. Church Hindes and Todd Moore from OneCare concurred with this comment and agreed that they would focus, with their community partners, on this issue. There was additional discussion about whether CMMI would approve an expenditure like this and Georgia responded that CMMI was funding work like this in other states. Doug confirmed that the work proposed needed to be performed and that the costs were consistent with earlier proposals. Steve moved to approve this proposal and it was seconded by Al. It was approved unanimously.	
5. Public Comment	Julie Tessler concurred with Commissioner Wehry's earlier comments about focusing on DLTSS and commented that there needs to be an increase in investment in mental health services and planning around them for adults. Kirsten Murphy concurred with Commissioner Wehry's earlier comments and suggested the Core Team reconsider the reduction in the support for the one line item that related to DLTSS by $400,000. Julia Shaw suggested that the Core Team allow for public comment before voting on each issue. She commented that regarding the changes to the Commercial SSP Standards, Legal Aid was concerned about #4: 1. There was a bad process regarding this at the GMCB; 2. This was not discussed at the work group;	

Agenda Item	Discussion	Next Steps
	3. It is unclear how this would work with the gate and ladder methodology; 4. It makes more sense to make a modification like this once the baseline line data is available. Joyce Gallimore thanked the Core Team for the investment in CHAC. She said that CHAC understands the need for performance evaluation and making sure the quality of care does not decline. She said that CHAC will also focus on the DLTSS population.	
6. Next Steps, Wrap up	**Next meeting:** August 13, 2014, 1-3:30 pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier.	

Attachment 3a - Subgrant Program Timeline

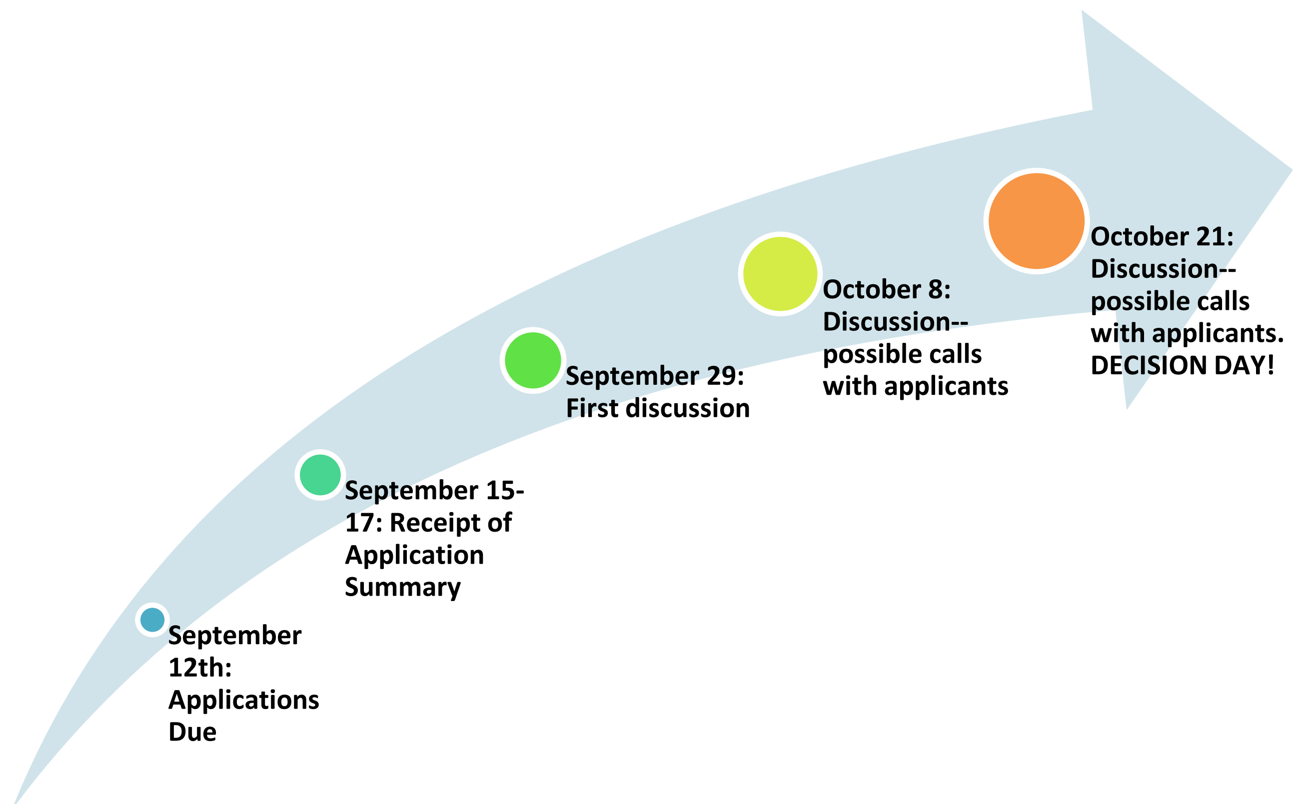
VERMONT

Vermont Health Care Innovation Project

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 8/7/14
Re: UPDATED Sub-Grant Program Timeline

The Sub-Grant Program Application was released on July 24th and applications are now due on September 12th. Below please find a timeline of Core Team activities related to this process:



Attachment 3b - Draft Round Two Scoring Sheet

VHCIP Grant Program Application Scoring Sheet						
	Application Number	**Notes**	**Application Number**	**Notes**	**Application Number**	**Notes**
*1. Presenting a good idea which reflects to goals of the grant program. Up to **40** points for this category. Items reviewed in this category include:*						
a. Idea is consistent with SIM/VHCIP;						
b. Responsive to the Grant Program application;						
c. Demonstrates collaboration and integration.						
Consideration given to the following additional items within this category:						
A focus on improving transition of care and communications between providers and care managers that offer services throughout the various domains of a person's life.						
Better integration of social services and health care services in order to more effectively understand and address social determinants of health for high-risk Vermonters.						
Inclusion of provider training as part of the proposal. In particular, these should achieve person-centered, cross-disciplinary and culturally sensitive care specific to the needs of people with disabilities and long term services and support needs, and which include consumer input/participation and statewide applicability.						
Demonstrates consistency with Vermont's plans for a high-performing health system.						
A focus on primary prevention and wellness.						
A focus on broader population and health outcomes.						
Demonstrates connections between clinical service delivery and a broad set of community partners.						
*2. Ability to perform, which clearly shows capability to do the work in the first category. Up to **60** points. Items reviewed in this category include:*						
a. Current and past experience relevant to payment and delivery system reform;						
b. Organizational capacity of applicant;						
c. Availability to perform the work described in #1 above.						
Consideration given to the following:						
Review of the proposal for cost efficacy and return on investment including project sustainability						
Description of scalability						
(if applicable) Ensure that data can be shared easily among collaborating partners						
Total Score						

Attachment 4a - VHCIP Revised Project Budget 8.7.14

VHCIP Funding Allocation Plan

	as of 8.7.14	Contracts Executed (or committed by Core Team)	Implementation (March-Oct 2013)	Year 1 (10/1/13-12/31/14)	Year 2 (1/1/15-12/31/15)	Year 3 (1/1/16-12/31/16)	Year 4 (1/1/17-9/30/17)	Total grant period	Category Total	Agency	Approved Budget Narrative Category	
Type 1a	Type 1A											
Proposed type 1 without base work group or agency/dept support	*Proposed Type 1 without base work group or agency/dept support (subject to Core Team approval)*											**Green indicates the money has been committed through hiring or contracts. Blue indicates the money has been approved for spending, but the contract is pending. Highlight indicates contract is pending at the Core Team.**
	Personnel, fringe, travel, equipment, supplies, other, overhead		$ 119,615	$ 2,835,875	$ 3,299,871.00	$ 3,368,455.00	621,361.00	$ 10,245,177	$ 10,245,177	GMCB, AHS, AOA, DVHA, VDH	Personnel; Fringe; etc...	Additional 150,000 for Medicare Claims Data Extracts in Years two and three. Pending approval at 8.13.14 CT meeting
	Project management								$ 630,000			
		UMASS Commonwealth Med.	$ -	$ 230,000	$ 200,000.00	$ 200,000.00	-	$ 630,000		AOA	Project Management	
	Evaluation	Remainder available			$ 67,001.00	$ 66,667.00	66,667.00	$ 200,335	$ 2,000,000	GMCB	Evaluation	
		RFP-Vendor selected pending CMMI approval	$ -	$ 194,558	$ 583,675.14	$ 583,675.00	437,756.36	$ 1,799,665		GMCB	Evaluation	
	Outreach and Engagement	Remainder available		$ 15,000	$ 135,000.00	$ 150,000.00	-	$ 300,000	$ 300,000		Outreach and Engagement	
		RFP pending								DVHA	Outreach and Engagement	
	Interagency coordination	Remainder available		$ 40,000	$ 100,988.00	$ 97,000.00	82,012.00	$ 320,000	$ 320,000	AOA	Interagency Coordination	Contract pending approval at 8.13.14 CT Meeting
	Staff training and Change management	Remainder available			$ 20,000.00	$ 20,000.00		$ 40,000	$ 55,000	DVHA	Staff Training and Change Management	
		Coaching Center of Vermont		$ 15,000				$ 15,000		DVHA	Staff Training and Change Management	
	Technology and Infrastructure								$ 1,177,846			
		VITL		$ 431,500	$ 400,000.00			$ 831,500		DVHA	Expanded Connectivity to the HIE	there will be carryover here. Not sure of exact amount. 400k is estimate by GJM
		VITL		$ 346,346				$ 346,346		DVHA	Practice Transformation	there will be carryover here. Not sure of exact amount. 400k is estimate by GJM
	Grant program	Remainder available		$ 126,878	$ 1,459,112.00	$ 1,459,112.00	-	$ 3,045,102	$ 5,295,102			

		7 Awardees		$ 560,000	$ 1,130,000.00	$ 560,000.00	-	$ 2,250,000		DVHA	TA to providers implementing payment reforms	
	Grant program- Technical Assistance								$ 500,000			
		Policy Integrity		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
		Wakely		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
		Truven		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
		VPQHC		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
		Bailit		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
	Chart Review								$ 395,000			
		Healthfirst		$ 25,000	$ 30,000.00	$ -	-	$ 55,000		DVHA	Model Testing: Quality Measurement	
		CHAC		$ 95,000	$ 100,000.00	$ -	-	$ 195,000		DVHA	Model Testing: Quality Measurement	
		OCV		$ 30,000	$ 120,000.00	$ -	-	$ 150,000		DVHA	Model Testing: Quality Measurement	

	ACO Proposal: Analytics								$ 3,135,000			
		CHAC		$ 177,800	$ 355,600.00	$ -	-	$ 533,400		DVHA	Advanced Analytics: 50%; TA Practice Transformation: 50%	
		OCV		$ 872,733	$ 1,745,467.00	$ -	-	$ 2,618,200		DVHA	Advanced Analytics: 50%; TA Practice Transformation: 50%	
	Advanced Analytics: Financial	Remainder available		$ 50,000	$ 250,000.00	$ 300,000.00		$ 600,000	$ 600,000	DVHA	Advanced Analytics: Financial and Other Modeling	
	Advanced Analytics: Policy and modeling	Remainder available			$ 220,002.00	$ 220,001.00		$ 440,003	$ 440,003	DVHA	Advanced Analytics	
	Subtotal								$ 25,093,128			
Type 1b	Type 1 B											
Proposed type 1 related to base work group support (subject to Core Team approval)	Proposed Type 1 related to base work group support (subject to Core Team approval)											
	Payment Models WG	Remainder Available			$ 137,500.00	$ 137,500.00	-	$ 275,000	$ 800,000	DVHA	Advanced Analytics	
		Bailit		$ 80,000	$ 160,000.00	$ 160,000.00	-	$ 400,000		DVHA	Advanced Analytics	
		Burns and Associates		$ 125,000	$ -	$ -	-	$ 125,000		DVHA	Advanced Analytics	
								$ -				
	Quality Perf Measures WG	Remainder Available						$ -	$ 400,000			
		Bailit		$ 80,000	$ 160,000.00	$ 160,000.00	-	$ 400,000		DVHA	Model Testing: Quality Measures	
	HIT/HIE WG	Remainder Available		$ 20,000	$ 110,000.00	$ 110,000.00	-	$ 240,000	$ 240,000	DVHA	Advanced Analytics	
								$ -				
	Population Health WG	Remainder Available			$ 100,000.00	$ 100,000.00		$ 200,000	$ 298,000	DVHA	Advanced Analytics	
		Hester		$ 21,000	$ 7,000.00	$ -	-	$ 28,000		DVHA	Advanced Analytics	
		AHC RFP		$ 5,000	$ 65,000.00	$ -	-	$ 70,000		DVHA	Advanced Analytics	
								$ -				
	Workforce	Remainder Available		$ -	$ 43,000.00	$ 43,000.00	-	$ 86,000	$ 86,000	DVHA	Workforce: System-wide capacity	

								$ -				
	Care Models	Remainder Available			$ 100,000.00	$ 50,000.00	-	$ 150,000	$ 150,000	DVHA	Advanced Analytics	
								$ -				
	DLTSS	Remainder Available				$ 84,800.00		$ 84,800	$ 680,000	DVHA	Advanced Analytics	
		Bailit		$ 79,146	$ 105,527.00	$ 105,527.00	-	$ 290,200		DVHA	Advanced Analytics	
		PHPG		$ 90,000	$ -	$ -	-	$ 90,000		DVHA	Advanced Analytics	
		WG Support RFP		$ 53,750	$ 161,250.00		-	$ 215,000		DVHA	Advanced Analytics	
	Sub Total								$ 2,654,000			

VHCIP Funding Allocation Plan

Type 1c	Type 1 C		**Impl. Period**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Grant Total**				
Proposed type 1 related to base agency/dept support	Proposed Type 1 related to base agency/dept support											
	GMCB	Remainder Available			**$ 250,000.00**	**$ 125,000.00**	-	**$ 375,000**	**$ 2,575,000**		**Advanced Analytics**	
		Lewin		**$ 289,474**	**$ 694,737.00**	**$ 694,736.00**	**521,053.00**	**$ 2,200,000**		**GMCB**	**Advanced Analytics**	
	DVHA	Remainder Available		$ -	**$ 676,090.00**	**$ 676,090.00**	-	**$ 1,352,180**	**$ 1,425,000**	**DVHA**	**Advanced Analytics**	MMIS modifications, dissemination of info to providers, analytics, tech support
		PHPG-VBP		**$ 28,910**	**$ 28,910.00**	**$ -**	**-**	**$ 57,820**		**DVHA**	**Advanced Analytics**	
		DLB		**$ 15,000**	**$ -**	**$ -**	**-**	**$ 15,000**		**DVHA**	**Advanced Analytics**	
	Sub-Total								**$ 4,000,000**			

Type 2	Type 2		Impl. Period	Year 1	Year 2	Year 3	Year 4	Grant Total				
Total proposed type 2 (subject to staff planning, work group/steering committee review and Core Team approval)	Total proposed Type 2 (subject to staff planning, work group/steering committee review and Core Team approval)											
	HIT/HIE	Total Remainder Available						**$ 4,526,031**	**$ 10,211,947**			
		VITL: ACO Gateway Population Health Proposal		**$ 440,321**	**$ -**	**$ -**	**-**	**$ 440,321**		**DVHA**	**T&I: Practice Transformation**	
		VITL: ACO Gateway Population Health Proposal		**$ 833,333**	**$ 833,333.00**	**$ -**	**-**	**$ 1,666,666**		**DVHA**	**T&I: Expanded Connectivity btw SOV and ACOs/Providers**	
		VITL: ACO Gateway Population Health Proposal		**$ 346,346**	**$ 570,465.00**	**$ -**	**-**	**$ 916,811**		**DVHA**	**T&I: Expanded Connectivity of HIE Infrastructure**	
		Subtotal: ACO Gateway Population Health Proposal		*$ 1,620,000*	*$ 1,403,798.00*	*$ -*	*-*	***$ 3,023,798***				
		VITL: ACTT Proposal		**$ 30,308**	**$ 181,846.00**	**$ 141,537.00**	**-**	**$ 353,691**		**DVHA**	**T&I: Practice Transformation**	
		BHN: ACTT Proposal		**$ 100,141**	**$ 235,538.00**	**$ 135,398.00**	**-**	**$ 471,077**		**DVHA**	**T&I: Practice Transformation**	
		ARIS: ACTT Proposal		**$ 150,000**	**$ 125,000.00**	**$ -**	**-**	**$ 275,000**		**DVHA**	**T&I: Expanded Connectivity of HIE Infrastructure**	
		UTP-RFP: ACTT Proposal (Pending)		$ 80,000	**$ 80,000.00**			**$ 160,000**		**DVHA**	**Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA**	

		Data Repository: ACTT Proposal (pending)			$ 346,139.00	$ 346,139.00	-	692,278		DVHA	T&I: Enhancements or development of clinical registry and other centralized reporting systems.	
		Stipends: ACTT Proposal (pending)		$ 10,000	$ 20,000.00			$ 30,000		DVHA	Pending CMMI review.	
		Bailit: ACTT Proposal		$ 13,357	$ 26,715.00	$ -	-	$ 40,072		DVHA	Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA	
		HIS: ACTT Proposal		$ 40,000	$ 60,000.00	$ 20,000.00	-	$ 120,000		DVHA	T&I: Practice Transformation	
		HIS: ACTT Proposal		$ 20,000	$ 100,000.00	$ 80,000.00	-	$ 200,000		DVHA	T&I: Expanded Connectivity of HIE Infrastructure	
		HIS: ACTT Proposal		$ 34,282	$ 102,846.00	$ 68,563.00		$ 205,691		DVHA	T&I: Enhancements or development of clinical registry and other centralized reporting systems.	
		HIS: ACTT Proposal		$ 20,718	$ 62,155.00	$ 41,436.00	-	$ 124,309		DVHA	T&I: Expanded Connectivity btw SOV and ACOs/Providers	
		Subtotal: ACTT Proposal						*$ 2,662,118*				
		Remainder Available: Analysis of how to incorporate LTSS, MH/SA			$ 49,964.00	$ 49,964.00	-	$ 99,928			Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA	
		Remainder Available: Practice Transformation			$ 50,533.00	$ 50,532.00	-	$ 101,065			T&I: Practice Transformation	
		Remainder Available: Telemedicine			$ 625,000.00	$ 625,000.00	-	$ 1,250,000.00			T&I: Telemedicine	
		Remainder Available: Expanded connectivity of HIE infrastructure			$ 788,345.00	$ 788,344.00	-	$ 1,576,689.00			T&I: Expanded Connectivity of HIE Infrastructure	

		Remainder Available: Integrated platform and reporting system			**$ 500,000.00**	**$ 500,000.00**	-	**$ 1,000,000.00**			**T&I: Integrated Platform and Reporting System**	
		Remander Available: Expanded connectivity between SOV data sources and ACOs/providers			**$ 98,159.00**	**$ 98,159.00**	-	**$ 196,318**			**T&I: Expanded Connectivity btw SOV and ACOs/Providers**	
		Remainder Available: Enhancements or development of clinical registry and other centralized reporting systems.			**$ 151,016.00**	**$ 151,016.00**	-	**$ 302,031**			**T&I: Enhancements or development of clinical registry and other centralized reporting systems.**	
								$ -				
	Workforce	Total Remainder Available			$ 98,332.00	$ 546,667.00		**$ 644,999**	**$ 644,999**		**Workforce Assessment: System-wide capacity**	
		Remainder Available: System-wide analysis		**$ -**	$ 98,332.00	$ 546,667.00	-	**$ 644,999**		**DVHA**		
	CMCM	Total Remainder Available		$ 60,000	$ 1,100,000.00	$ 1,040,000.00	-	**$ 2,200,000**	**$ 2,200,000**			
		Remainder Available: Service delivery for LTSS, MH, SA, Children			$ 700,000.00	$ 700,000.00		**$ 1,400,000**		**DVHA**	**Model Testing: Service Delivery to support enhancement and maintenance of best practice as payment models evolve**	**Coordinate with DLTSS**
		Remainder Available: Learning Collaboratives		$ 60,000	$ 325,000.00	$ 265,000.00		**$ 650,000**		**DVHA**	**TA: Learning Collaboratives**	**Pending CT Approval at 8.13.14 Meeting**
		Remainder Available: Integration of MH/SA		$ -	$ 75,000.00	$ 75,000.00		**$ 150,000**		**DVHA**	**Model Testing: integration of MH/SA**	**Coordinate with DLTSS**
	QPM	Total Remainder Available			$ 14,541.00	$ 14,541.00		**$ 29,082**	**$ 205,000**		**Model Testing: Quality Measures**	
		Data stat (Patient Exp Survey)		**$ 58,639**	**$ 58,639.00**	**$ 58,639.00**	-	**$ 175,918**		**DVHA**	**Model Testing: Quality Measures**	
	Sub-Total							**$ 13,261,946**				

VHCIP Funding Allocation Plan

Type 1a	$ 25,093,128											
Type 1b	$ 2,654,000											
Type 1c	$ 4,000,000											
Type 2	$ 13,261,946											
Unallocated	$ -											
Grant Total	$ 45,009,074											

Attachment 4b - Learning Collaborative ppt

Proposal for Vermont's Multi-Organization "Integrated Community" Care Management Learning Collaborative

Building Capacity for Population-Wide Care Management, Beginning With Effective Care Management for At-Risk Populations

Working Concepts

- Care management should be:
  - Integrated and person centered/directed
  - Ensure that individuals have a coordinated plan of care that optimizes health, wellness, and quality of life.

- Each panel of people receiving care management services should have an Integrated Community Team

- Each person receiving care management services should have a designated lead contact, based on the person's needs at a given point in time. The lead contact (with the person, their caregivers and the Integrated Community Team) should:
  - Partner with the person and their caregivers,
  - Develop a shared plan of care,
  - Ensure that services are appropriate and coordinated,
  - Identify who is responsible for providing services, and
  - Ensure accountability for implementing the care plan

Aim

To develop and/or enhance integrated and collaborative care management, beginning with at-risk populations in the near term and expanding to the broader population over the longer term.

Goals

Learning collaborative sites will demonstrate that integrated and collaborative care management services can:

a) Improve quality of care, patient and family experience, health and wellness

and

b) Reduce unnecessary utilization and cost

- Provide tools and core competency training opportunities for team members engaged in care management
- Improve coordination, support integration, and decrease fragmentation among different organizations that provide care management services
- Reduce unnecessary ER and inpatient utilization
- Reduce gaps in care for at-risk people with complex health conditions
- Establish efficient, financially sustainable care management system as we consider changes in investments in care management

Objectives

Demonstration sites will form Learning Collaborative Pilot Planning Teams to identify:

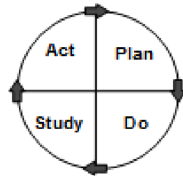
- Existing care management services and resources
- Gaps in services
- Needed care management tools and training resources
- Care management protocols that would systematize referrals, transitions, and co-management
- Measures of success and accountability

Learning Collaborative Process

Pre-Work

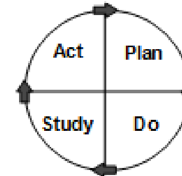
Learning Session I
(Teams gather for a face-to-face meeting)

Action Period
(approximately 3 months – community teams working together to implement change)



Learning Session II
(Teams gather for a face-to-face meeting)

Action Period
(approximately 3 months – community teams working together to implement change)



Learning Session III
(Teams gather for a face-to-face meeting)

Spreading the Change

Potential Team Members include*:

*(but are not limited to, and not necessarily all on every team)

- People in need of care management services and their families
- Primary Care Practices participating in ACOs (practice team includes care coordinator)
- Designated Mental Health Agencies
- Visiting Nurse Associations and Home Health Agencies
- Hospitals and Skilled Nursing Facilities (including their case managers)
- Area Agencies on Aging
- Community Health Teams and Practice Facilitators (Vermont Blueprint for Health)
- Support and Services at Home (including SASH coordinators and wellness nurses)
- ACOs (OneCare, CHAC, ACCGM/VCP)
- Medicaid: Vermont Chronic Care Initiative (including care coordinators)
- Commercial Insurers (BCBSVT, MVP, Cigna)

Integrated Community Team Members' Charge:

1. Form new (or enhance existing) Integrated Community Teams in each health service area to meet about specific at-risk people on a regular basis.

2. Identify current care management services and needs (includes a gap analysis).

3. Define current care management systems and tools.

4. Review existing reports and tools for identification of at-risk populations (e.g., Blueprint practice reports, VCCI high risk patient reports, NNEACC prospective at-risk patients, DocSite reports, Medicare portal reports).

5. Agree on criteria to define at-risk person using one or more of the systems above.

Integrated Community Team Members’ Charge (cont’d):

6. Define which at-risk people and how many or what proportion will initially receive outreach for care management services. Consider asking each team member to provide a list of at-risk people that they think could benefit from an Integrated Community approach.

7. Develop and implement protocols that systematize referrals, transition, and co-management between primary care and other team members in the Integrated Community (e.g., accountabilities and triage protocols).

8. Based on care plan and Integrated Community team process (including person in need of services),determine which services will initially be offered to the person.

9. Develop written agreements that include guidelines and expectations for referrals and transitions.

10. Develop a tracking tool to monitor transitions.

Potential Measures (measures should relate to pilot goals, be limited in number, and have clearly specified numerators and denominators)

1. Number of people each quarter for each health service area who meet at-risk criteria (and/or who are participating in pilot)

2. Percentage of people participating in pilot each quarter who have met in person with lead contact

3. Percentage of people participating in pilot each quarter whose care plans followed the protocols for referrals, transitions, and co-management

4. Percentage of people participating in pilot each quarter who have a shared plan of care

5. Percentage of people participating in pilot each quarter who have an emergency plan of care

Potential Measures (cont'd):

6. Percentage of people participating in pilot each quarter who have updates to their shared plan of care

7. Percentage of people participating in pilot each quarter with avoidable ED visits, ambulatory care sensitive admissions, and readmissions

8. Patient experience of care survey results for people participating in pilot, pre- and post-shared plan of care development

Proposed Timeline

- Kick-Off Webinar: (September 2014)
- Learning Sessions 1-3: (October-November 2014)
- Action Period: (December 2014-February 2015)
- Learning Sessions 4-5: (March-May 2015)
- Action Period: (June-August 2015)
- Learning Session 6: (September 2015)

Proposed Budget

- Learning Collaborative Facilitator to coordinate Collaborative design, team member outreach and communications, and logistics: 1 FTE for 1 Year, $95,000 (contractor, includes travel and training)
- Learning Collaborative Facilitator to work with team members on data resource identification, data analysis, panel management and measurement activities: 1 FTE for 1 Year, $95,000 (contractor, includes travel and training)
- Expenses for 6 Learning Sessions during the year, including expert faculty and travel expenses, rental of meeting space, meals, materials: estimated $60,000
- TOTAL ESTIMATED BUDGET FOR YEAR 1 OF THE LEARNING COLLABORATIVE: $250,000; consider a not-to-exceed amount of $300,000

Questions

Appendix

Care Management Defined:

"Care Management programs apply systems, science, incentives and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services."

-- (State of Washington Office of Quality and Care Management; currently under revision by VHCIP Care Models and Care Management Work Group)

Sample Learning Session Agenda

Time	Topic	Presenter
8:30-9:00	Registration and breakfast	
9:00-9:15	Welcome and Opening Remarks	
9:15-10:30	Design, implementation and communication of shared plans of care	
10:30-10:45	Break	
10:45-12:00	Care Conference as a Care Planning Strategy	
12:00-12:45	Lunch	
12:45-1:45	Engaging people: how to reach out to people needing care management services and their caregivers	
1:45-2:30	Team Working Time	
2:30-3:00	Report Out and Closing Remarks	

Ideas for Learning Session Topics:

- What is Care Management and Why is it Important?
- Establishing Integrated Communities
- Creating Effective Team-Based Care
- Understanding Data Sources and Using them Effectively
- Care Conferences
- Care Management Rounds and Other Communication Strategies
- Engaging People Needing Care Management Services

Attachment 4c - Financial Memo

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 8/7/14
Re: Request for Approval of SIM Funding Actions

I am requesting Core Team approval for two SIM funding actions:

1. Proposal to fund a learning collaborative in three pilot areas. This will rely on an existing DVHA-Blueprint RFP for facilitators and programmatic costs. Cost: $300,000. Duration: October 1, 2014-September 30, 2015.
2. Proposal to contract for services with Arrowhead Health Analytics for technical assistance related to the VHCIP. Cost: $110,000. Duration: August 27, 2014-August 26, 2015.

REQUEST #1- Type 2 Proposal to fund a learning collaborative in three pilot areas. This will rely on an existing DVHA-Blueprint RFP for facilitators and programmatic costs for an amount not to exceed $300,000:

This proposal comes from the Care Models and Care Management Work Group and uses funds from the Learning Collaboratives line item for that work group. It was recommended for Core Team approval by the Steering Committee on 8/6/14. The project timeline is October 1, 2014-September 30, 2015 and estimated cost is $300,000.

Proposal Summary:

This is a request from Care Models and Care Management Work Group: Funding to support a year-long learning collaborative that will improve integration of care management activities for at-risk people and provide learning opportunities for best practices for care management in at least 3 pilot communities (Burlington, Rutland and St. Johnsbury).

The Learning collaborative aims to:

- Identify existing care management services and resources and gaps in services in the pilot communities
- Implement and test best practices for integrating care management, such as shared care planning, and care management protocols for referrals and transitions in care
- Develop care management tools and training resources to support implementation and testing
- Develop and collect measures of success and accountability
- Provide shared learning opportunities for participating organizations

Deliverables:

- Multi-organization teams in pilot communities will identify existing and needed care management resources; implement selected best practices in care management integration; adopt tools and training resources to support those best practices; measure results; and engage in learning opportunities.
- Facilitators will promote an environment of collaborative learning within and between the pilot communities and across the health system, through mechanisms that include multiple learning sessions with expert faculty.
  - Facilitators will meet with teams in pilot communities on a regular basis to provide the following services:
  - Change Management Support
  - Technical Assistance and Training
  - Data Analysis, Measurement and IT Support
  - Creation of a Learning Health System
  - Development of Connections Within and Between Pilot Communities

Relationship to VHCIP/CMCM goals:
This work aligns with the CMCM work group's charge to develop an integrated delivery system that leads to coordination, collaboration, and improved care for Vermonters; and also with the overarching goals of the VHCIP to improve care, improve population health, and reduce health care costs.

The learning collaborative will ground its work in the Plan-Study-Do-Act model for quality improvement; the Integrated Community Care Management Learning Collaborative will demonstrate that integrated care management services based on best practices can:

- Improve quality of care, person and family experience, health outcomes, and wellness, and
- Reduce unnecessary utilization and cost.

Recommendation: Authorize using the existing request for proposals to procure two learning collaborative facilitators and additional funds to support learning sessions in three pilot communities. The total project cost is an amount not to exceed $30,000. The term is October 1, 2014-September 30, 2015.

<u>REQUEST #2- Type 1 Proposal to contract for services with Arrowhead Health Analytics. Cost: $110,000. Duration: August 27, 2014-August 26, 2015.</u>

This is a request to amend an existing contract with Arrowhead Health Analytics (Arrowhead). The amendment would add $110,000 for a term of one year. This would be funded by the Interagency Coordination line item within the VHCIP budget.

Background

The Agency of Administration entered into a sole-source contract with Arrowhead in August 2013 for Anya Rader Wallack, President to serve as Chair of the State Innovation Models (SIM) Core Team, provide leadership for that project and advise the Governor on project related policy matters related to the project to assist the Governor in deliberations and decision-making related to the project and its implementation.

The SIM initiative builds on existing statewide health reform efforts aimed at developing or enhancing integrated provider organizations, integrated health information technology and value-based payment in Vermont's health care system. Through this project, Vermont will implement an array of value-based payment models on an all-payer basis and will greatly enhance the state's health information network to serve effective care management and integration. This project is managed through the Core Team and a project management structure that includes a stakeholder steering committee and seven subject-specific work groups. The Core Team will provide overall leadership for the project, establish priorities and resolve conflicts.

Qualifications

Ms. Wallack is uniquely suited for this role for the following reasons. She has served as the Core Team Chair for the past 11 months leading the SIM project's Core Team through significant policy and financial decisions. She served as the Green Mountain Care Board (GMCB) Chair from its inception in October 2011 through August 1, 2013. In both these roles, Ms. Wallack has led Vermont's efforts in payments and delivery system reform including in the planning efforts which led up to the application for and receipt of the SIM Grant. Ms. Wallack has extensive knowledge of Vermont's health reform efforts, Vermont's delivery system and relevant stakeholders in this effort.

Recommendation: Execute contract amendment with Arrowhead Health Analytics to perform work in support of the VHCIP. The total project cost is: $110,000. The term is August 27, 2014-August 26, 2015.