VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Agenda

September 15, 2015; 10:30 AM to 12:00 PM
ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	10:30 to 10:35	Welcome; Introductions; Approval of Minutes (Bea Grause is meeting facilitator)	**Attachment 1:** July meeting minutes	Yes (approval of minutes)
2	10:35 to 10:50	Year 2 Milestones and Cross Pollination activities related to CMCM Work Group ***Public Comment***	**Attachment 2:** Year 2 Milestones	
3	10:50 to 11:00	Project Rebasing and Workgroup Consolidation ***Public Comment***	**Attachment 3:** Rebasing Slides	
4	11:00 to 11:30	Care Management in Vermont: Summary of Gaps and Duplication Christine Hughes, Bailit Health Purchasing ***Public Comment***	**Attachment 4:** Care Management in Vermont: Gaps and Duplication	
5	11:30 to 11:50	Program Updates: Regional Blueprint/ACO Committees Integrated Communities Care Management Learning Collaborative: • Cohorts 2 and 3 – Learning Session #1 • Cohort 1 – Learning Session #4 Core Competency Training RFP ***Public Comment***		
6	11:50 to 12:00	Wrap-Up and Next Steps Plans for Next Meeting:		

Attachment 1: July meeting minutes

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Minutes
Pending Work Group Approval

Date of meeting: July 14, 2015; 10:30 AM – 12:30 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approval of minutes	Bea Grause called the meeting to order at 10:31 AM. A roll call was taken and a quorum was present. A motion to accept the May minutes by exception was made by Laural Ruggles and seconded by Patricia Launer. The motion carried with one abstention.	
2. Updates:	**June 17 Convening** On June 17th a VHCIP convening of Co-chairs, Core Team and Staff was held to review goals, priorities, and work group progress against project milestones. Generally speaking, the CMCM work group is on track to achieve their milestones. The group's attention was drawn to Page 3 of the Milestones – Care Delivery and Practice Transformation The CMCM work group is on track to meet its milestones and the work outlined in its work plan. The Integrated Communities Care Management Learning Collaborative is currently in the process of being expanded to 8 new communities, and will continue into Year 3. Regarding the sub-grant program, second quarter progress reports are arriving this week and a summary of the projects will be compiled and shared with the Core Team and Steering Committees. There are some exciting results coming out of the sub-grantees programs. For example, the partnership between the Vermont Medical Society Foundation and the UVM Medical Center focused on reducing the number of unnecessary and potentially harmful lab tests showed a 40% decrease in the number of standing lab orders for adult inpatient stays between the fall of 2014 and late spring 2015. Additional sub-grant information is available on the VHCIP website. **Initial Discussion of Year 3 activities, Sustaining Work Group Initiatives**	

Agenda Item	Discussion	Next Steps
	After summarizing work group activities to date, Bea Grause asked if there was anything that participants wished to include in the Year 3 activities planning. Dale Hackett observed that there seems to be a gap in the learning collaborative that it doesn't currently include students. Dale also raised concerns around issued of funding and sustainability of the work group's initiatives beyond the time frame of the SIM Grant. Bea commented that these are the kinds of questions that we will be seeking to answer this year: How do we create a sustainable learning model and who will carry this work moving forward? Pat Jones also commented that the concept of sustainability of SIM initiatives beyond the grant funding period is a key concern to top level leadership and decision makers. Dale Hackett noted that we want to capture good health care practices as well as healthy behaviors, and it is important to start this work as early as possible. This is why it is important to include youth and students in this work as early and as often as possible. Sue Aranoff pointed out that there is a real need for an understood and applied transitions of care process – and the ability to share the information that comes out of that coordinated care. Michael Bailit added that we should be evaluating what works and what hasn't worked in the learning collaboratives.	
	Unified Community Collaboratives Jenney Samuelson, Assistant Director of the Blueprint for Health, Miriam Sheehy, Assistant Director of the Clinical Unit at OneCare Vermont, and Patricia Launer, Community Health Quality Manager for Bi-state Primary Care/CHAC provided an update on the progress of the Unified Community Collaboratives (UCCs). Miriam Sheehy referenced the UCC/RCPC progress report (attachment 3) that illustrates some key features of these work groups including health service area, regional meeting name, whether or not a charter has been developed, whether or not a consumer is participating in the group, priority areas of focus and other attendees. Miriam also noted the high level of interest in hospice and palliative care (7 of the groups have chosen to focus on this work) A question was posed, how will we know if the groups are successful? Miriam responded that several useful metrics are included in the progress report at attachment 3. There is also data being shared with the health service areas to provide insight on quality improvement progress related to the priority areas they have chosen.	

Agenda Item	Discussion	Next Steps
	A comment was made that some groups have a number of priority areas identified which could indicate that their focus is too broad to make an impact on so many areas. Miriam noted that in many cases this work is being carried over from previously existing initiatives and working groups. For example, in St. Johnsbury community members have been meeting to work on quality improvement initiatives for some time. The UCC often represents leaders from other forums within the community. In other words, the UCC is not responsible for doing all of the work, but rather as a shared leadership and decision making forum. Maura Graff from Planned Parenthood asked for clarification on the process of joining a UCC. Miriam responded that while there is a process for some groups, there is not a universal answer as each group is managing membership differently. Some groups have a leadership team who can grant permission to participate. Most groups welcome observers and participation varies after that. How did the groups choose their priorities? The goal is that all participants representing the entire health service area as a whole are driving decision making, rather than any one single entity. **Relationship between the UCCs and the Learning Collaboratives** Many of the regional UCCs have identified the Integrated Communities Care Management Learning Collaborative as a quality improvement project for their HSA, and have created working groups under the structure of their UCC to address this work. Dale Hackett asked about the decision of one of the UCCs to focus on "ACEs" (Adverse Childhood Experiences) and how it will be measured. Miriam responded that this is a new project and the team has not yet chosen the measures they want to use in their community. Patty Launer added that in quality improvement work in general, it is common to focus on improvement around process measures before thinking of larger scale outcomes measures. Mary Moulton added that the Washington County group is talking about ACEs as well as how to better integrate all of their health and community services in general, and will be participating in Round 2 of the Integrated Communities Care Management Learning Collaborative. **Integrated Communities Care Management Learning Collaborative Expansion Update** Pat Jones provided an update on the expansion of the Integrated Communities Care Management Learning Collaborative program. An additional 8 communities have agreed to participate, for a total of 11 including the initial 3 pilot communities. There is also a possibility that an additional group will join by the end of 2015. In order to maximize expert faculty resources, the learning sessions will be held on consecutive days in two locations throughout the state (Burlington area for the "West Coast" communities and White River area for "East Coast" communities). On September 8th and 9th the Camden Coalition of Healthcare Providers will be returning to present on using data to identify	

Agenda Item	Discussion	Next Steps
	at-risk individuals. Introductory webinars were held on July 7th and July 22nd to orient the new communities to participation in the program. Additional pre-work includes recruiting local community team members, conducting PDSA training, and beginning to collect data to identify at risk individuals. Lauren Hardin was very well-received by the pilot communities and we will be bringing her back in November for a similar presentation in round 2. Plans are underway to film an entire set of learning sessions for one of the cohorts in an effort to make educational resources available to communities and participants beyond the life of the SIM grant. Additionally, planning is underway to develop a curriculum of core competency training for front line care managers in collaboration with the DLTSS work group. Julie Wasserman created a draft RFP which CMCM work group staff is currently reviewing. Dale Hackett asked what resources are available to a community should they 'get stuck?' The quality improvement facilitators funded by the learning collaborative serve as key resources to communities in working through challenges and staying on track. Additionally, we have identified and made tools available from our expert faculty through the learning collaboratives. Finally, as communities find success in various areas, the shared learning environment allows them to share their learnings with other communities. Erin Flynn pointed out that the difficult work is being done on the ground in the communities and while staff and facilitators are doing everything we can to support the communities in this work, their success is largely attributed to a strong commitment by all community members to come together and work in a different way. Maura Graff asked for clarification around the requirement that a patient centered medical homes 'must' participate in at least one Blueprint UCC quality improvement initiative. Jenney Samuelson clarified that this is not related to the learning collaborative, but is rather related to the enhanced Blueprint payments to primary care practices effective July 1, 2015.	
4. Presentation on Caledonia and Southern Essex Counties (St. Johnsbury Health Service Area) Learning	**Presentation on Caledonia and Southern Essex Counties (St. Johnsbury Health Service Area) Participation in the Integrated Communities Care Management Learning Collaborative and the Dual Eligible Provide Sub-Grant Project** Pam Smart of Northeastern Vermont Regional Hospital and Treny Burgess of Caledonia Home Health and Hospice presented on the above topic. This community has been fortunate to pair their participation in the Integrated Communities Care Management Learning Collaborative with their Dual Eligible Sub-Grant Program to better support Dual-Eligible individuals with some additional resources such as a health coach and some flexible funding to better meet individual's needs.	

Agenda Item	Discussion	Next Steps
Collaborative and Dual Eligible Project	One of the key focuses of this work is to ensure that care delivery is not only integrated, but also person centered. One example of a helpful engagement tool that has come out of this work are the "Camden Cards" that the St. Johnsbury team has been using to work with individuals on goal setting. An additional tool that has been identified through this work is an Eco-map to help draw/illustrate the relationships that exist around the individual. **Shared care plan** The benefit of shared care plans has emerged from this work as well. It has been challenging to develop this tool in a way that meets the needs of all members of the community team, and eventually the team decided that they needed to stop editing the plan and begin using it for a period of time to better understand it effectiveness. At this point 65 to 70% of individuals participating in the pilot have shared care plans in place. Another challenge has been mapping out the workflows and identifying an overall process for achieving integrated care management. Overarching questions include: At what point in the process should various interventions be introduced? How do we get the right people at the table? What if the person doesn't want to participate? What if they don't want certain providers to come? Another positive outcome of this work has been that through new collaborations community partners have identified additional sources of funding and have found ways to support each other and the needs of their community. Many community partners have funds to willingly contribute – and now that the partnerships have been formed, the funds are being spent where they're needed most. Regarding one of the case studies presented, Patricia Singer asked how housing issues were addressed specifically. Pam responded that it was difficult – they worked extensively with Rural Edge, the local housing authority/support service provider. The care coordinator accompanied the individual in viewing 18 apartments; and ultimately had to file an appeal and write letters of reference and support on the individual's behalf. The housing group is part of the collaborative and the patient was also part of the Duals cohort - a team approach was key. Because the housing authority saw the support of the individual's care team behind her, they were willing to offer her housing when they hadn't been willing to in the past. A question was asked, how did you choose the initial patient panel for the learning collaborative? Treny Burgess responded that everyone in the community team brought their lists of dually eligible people. They also brought the high spending lists from the hospitals and just talked through each person to identify whether they were a good candidate for the program. It helped that there was already a project going in the community and that the various team members were already used to working together.	

Agenda Item	Discussion	Next Steps
	Dale Hackett asked if we can apply the learnings and lessons from St. Johnsbury to communities across the state and noted that it is critical to relay these findings to top level leadership so that the work will be sustained in the long term. Bea responded that these are exactly the questions and issues that we'll be exploring over the next two years of the SIM grant.	
6. Next Steps, Future Meeting	***AUGUST MEETING CANCELLED*** **Next Meeting:** *Tuesday, September 15th, 2015, 10:30 AM – 12:30 PM, Calvin Coolidge Conference Room, National Life, Montpelier VT*	

Attachment 2: Year 2 Milestones

Learning Collaboratives/Care Delivery Transformation					
Learning Collaboratives	Provide quality improvement and care transformation support to a variety of stakeholders.	1. Planning completed for Care Management Learning Collaborative, with November kick-off for regional work groups in 3 pilot communities. One component of Learning Collaborative is CQI training. 2. Primary care practices recognized as patient centered medical homes, or in the process of recognition, have access to practice facilitation. 3. Vermont has worked with professional associations and individual providers to ensure that they have working knowledge of Vermont's transformation initiatives. 4. Beginning in January 2015, the Learning Collaborative was implemented in three pilot communities. 5. 2. To date in 2015, three in-person meetings have been held, and five	Launch 1 cohort of Learning Collaboratives to 3-6 communities.	1. 1. 1.Learning Collaboratives have now been offered to the remaining communities in the state. 2. In-person meetings and webinars planned for these communities.	Offer at least two cohorts of Learning Collaboratives to 3-6 communities.

		more are planned for the remainder of 2015. Three webinars have been held, and at least three more are planned for 2015.			
	Procure learning collaborative and provider technical assistance contractor.	Cohort launched.	Launch 1 cohort of Learning Collaboratives to 3-6 communities.	Cohorts will launch September, 2015.	Offer at least two cohorts of Learning Collaboratives to 3-6 communities.
Sub-Grant Program – Sub-Grants	Develop technical assistance program for providers implementing payment reforms.	1. 14 awards made to 12 awardees. 2. Sub-grantees shared learning at May 27, 2015 convening with each other and with project leadership and staff.	Continue sub-grant program; convene sub-grantees at least once; use lessons from sub-grantees to inform project decision-making.		N/A
Sub-Grant Program – Technical Assistance	N/A	1. Contractors selected and contracts executed for learning collaborative and sub-grantee technical assistance. 2. Technical assistance program developed and implemented. 3. Sub-grantees are accessing technical assistance program.	Provide technical assistance to sub-grantees as requested by sub-grantees.		N/A
Regional Collaborations	N/A	1. ACOs and the Blueprint are working together to	Establish 14 regional collaborations, each including	1. ; joint Blueprint-ACO performance reports	Continue to develop and expand 14 regional

		establish regional collaborations. 2. All regions have established collaborations with Charters, governing body, and decision-making process.	a Charter, governing body, and decision-making process.	under development; priority areas of clinical focus have been selected.	collaborations, each including a Charter, governing body, and decision-making process.
Workforce – Care Management Inventory	N/A	1. Complete 2. Health Care Workforce Work Group will review results of Care Management Inventory Survey at 2015 Work Group meeting.	Obtain snapshot of current care management activities, staffing, people served, and challenges.		N/A
Workforce – Demand Data Collection and Analysis	N/A	N/A	N/A	RFP released; bids obtained. Plan is to select vendor by August 2015, create model, and initiate implementation of model.	Obtain micro-simulation demand model to identify future workforce resource needs.
Workforce – Supply Data Collection and Analysis	N/A	Staff develop and administer surveys to accompany provider re-licensure applications, perform analysis on licensure data and develop provider reports on various health care professions. Results are expected in Summer 2015.	Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan.		N/A
	Vermont Department of Labor to develop a comprehensive	N/A	N/A	N/A	N/A

	review of all such programs offered by each agency/department of state government - due by the end of 2013.				
	SIM will expand all existing efforts (Blueprint, VITL, providers, VCCI, SASH, Hub and Spoke).	N/A	N/A	N/A	N/A

Attachment 3: Rebasing Slides

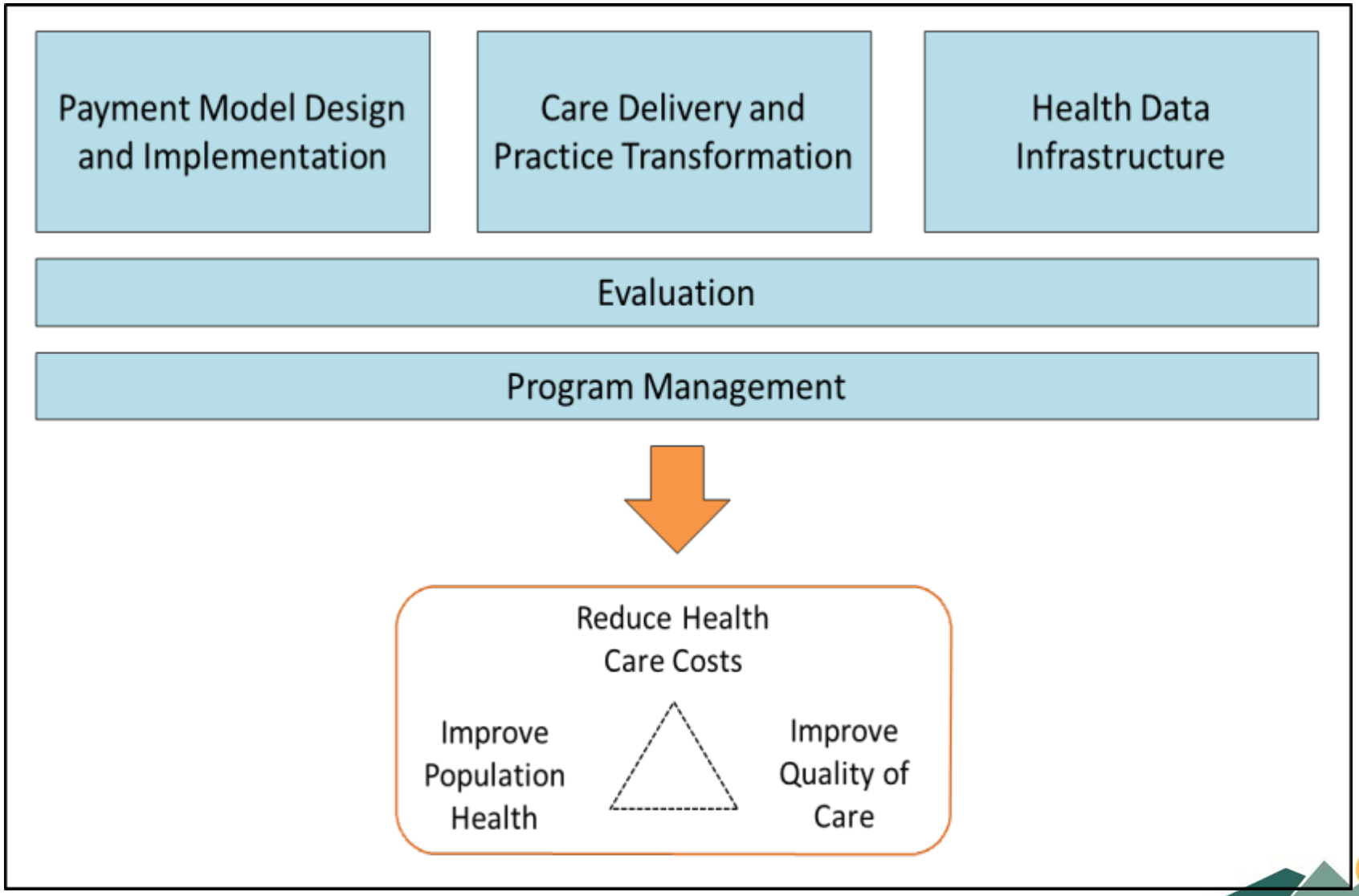
VHCIP Project Rebasing presented to VHCIP Core Team

Lawrence Miller, Chair, Core Team

Georgia Maheras, Project Director

August 31, 2015

Vermont's SIM Focus Areas and Goal:



Vermont Health Care Innovation Project

What is success?

- Supporting creation and implementation of value-based payments for providers in Vermont across all payers.
- Supporting the inclusion of 80% of Vermonters in alternatives to fee-for-service.
- Creation of a system of care management that is agreed to by all payers and providers that:
  - Utilizes advanced primary care infrastructure to the greatest extent possible;
  - fills gaps;
  - eliminates duplication of effort;
  - creates clear protocols for providers;
  - reduces confusion and improves the care experience for patients; and
  - follows best practices.
- Creation of a health data infrastructure to support a high-performing health system.

- Includes activities that *support provider and payer readiness* to participate in alternative payment models.

Mid-Project Risk Assessment:

- Progress to date:
  - Snapshot of impact
- Remaining activities (milestones)
  - Rebasing
  - Realignment of work groups

Snapshot of SIM Payment Model Impacts

		Q1 2015
Beneficiaries Impacted	Commercial SSP*	40,232
	Medicaid SSP*	52,177
	Medicare SSP*	61,560
	Commercial Blueprint (APMH/P4P)	111,529
	Medicaid Blueprint (APMH/P4P)	106,818
	Medicare Blueprint (APMH/P4P)	67,621
	Medicaid Health Home	2,706
Participating Providers	Medicare, Medicaid, Commercial SSPs	977
	Blueprint (APMH/P4P)	694
	Medicaid Health Home	123
Provider Organizations	Medicare, Medicaid, Commercial SSPs	83
	Blueprint (APMH/P4P)	63
	Medicaid Health Home	5

*All SSP impact numbers reflect Q2

Snapshot of SIM Care Delivery & Health Data Infrastructure Impacts

	Impact
Health Data Infrastructure	400 Providers
Care Delivery & Practice Transformation: Learning Collaboratives	420 Providers
Care Delivery & Practice Transformation: Subgrantee Program	692 Providers 281,808 Vermonters

Remaining work to do:

Payment Models:

- Medicaid and commercial SSP: Year 3 implementation.
- Medicaid Episodes of Care implementation
- Feasibility/Analysis: Accountable Communities for Health and All-Payer Model.
- Home Health PPS

80% of Vermonters in alternatives to fee-for-service by 12/31/2016.

Remaining work to do:

Practice Transformation:

- Expand Learning Collaboratives to remainder of state.
- Sustain sub-grants, regional collaborations.
- Do micro-simulation demand modeling.

Population Health

- Finalize Population Health Plan.

Remaining work to do:

Health Data Infrastructure:

- Launch Event Notification System.
- Continue data quality and gap remediation efforts.
- Invest in shared care plan and uniform transfer protocol solution.
- Invest in telehealth pilots
- Design and implement registry and data warehousing solutions.

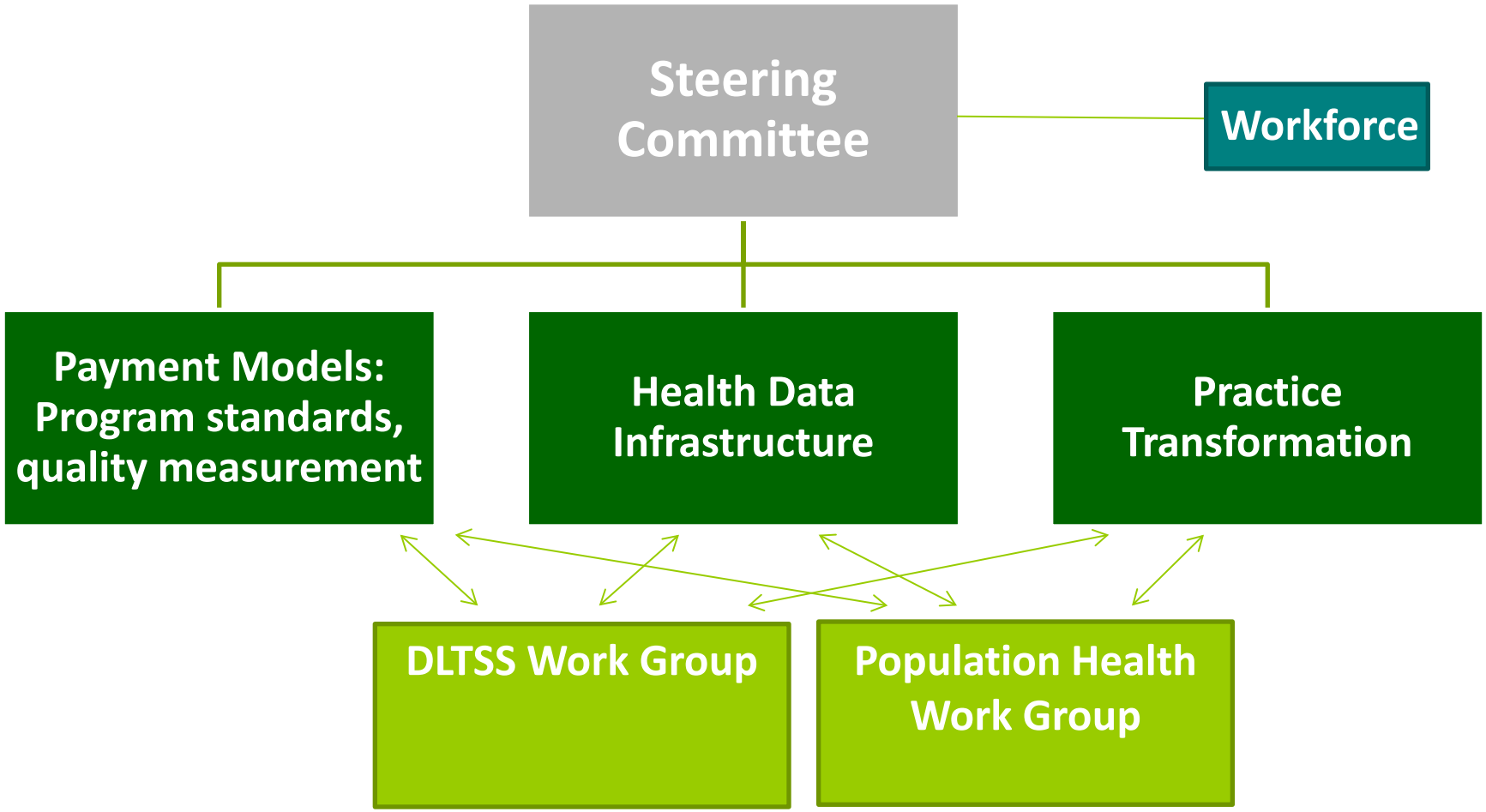
Remaining work to do:

SUSTAINABILITY

Realignment:

- Reconfigure existing structure to better align the organizational structure and the work left to perform.
- Reassign SIM staff leads accountable for each work stream.
- Written monthly updates.
- Revamped website.

New Organization Structure:



Assumes Core Team above Steering-Committee-- removed to allow for easier depiction

Work stream leads: Payment Models

Project	SOV Lead*
Shared Savings ACO Programs	Slusky/Wu
Episodes of Care	Cooper
PPS-DAs	Hickman
PPS-Home Health	Cooper
Pay-for-performance	C. Jones
Accountable Communities for Health	H. Klein

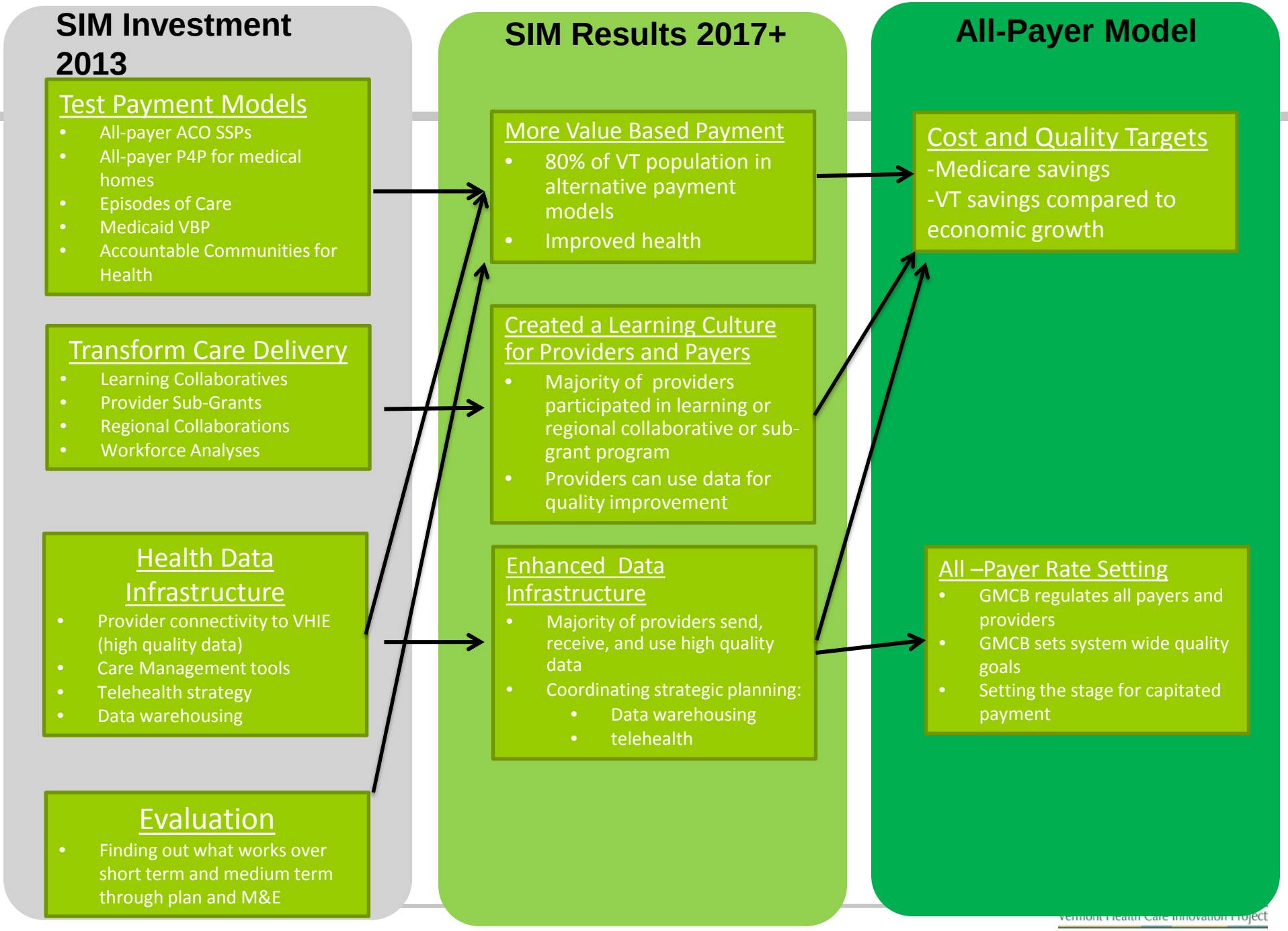
*All leads identified on slides 13-15 are illustrative and not yet confirmed.

Work stream leads: Health Data Infrastructure

Project	SOV Lead
Telehealth	Kinsler
Connectivity and Quality	Maier/Sandage
HIT Plan	Maier
Care Management Tools	Sandage (ENS and SCUP)
Part 2	Maier
Analytics (and all steps necessary to get to that – access and availability to stand data up for analytics)	Maheras

Work stream leads: Practice Transformation

Project	SOV Lead
Learning Collaboratives	P. Jones/Flynn
Regional Collaborations	Samuelson
Sub-grantees	Judge
Workforce	Coonradt
Pay-for-performance	C. Jones
Accountable Communities for Health	H. Klein


SIM Investment 2013
Test Payment Models
All-payer ACO SSPs
All-payer P4P for medical homes
Episodes of Care
Medicaid VBP
Accountable Communities for Health
Transform Care Delivery
Learning Collaboratives
Provider Sub-Grants
Regional Collaborations
Workforce Analyses
Health Data Infrastructure
Provider connectivity to VHIE (high quality data)
Care Management tools
Telehealth strategy
Data warehousing
Evaluation
Finding out what works over short term and medium term through plan and M&E
SIM Results 2017+
More Value Based Payment
80% of VT population in alternative payment models
Improved health
Created a Learning Culture for Providers and Payers
Majority of providers participated in learning or regional collaborative or sub-grant program
Providers can use data for quality improvement
Enhanced Data Infrastructure
Majority of providers send, receive, and use high quality data
Coordinating strategic planning:
Data warehousing
telehealth
All-Payer Model
Cost and Quality Targets
-Medicare savings
-VT savings compared to economic growth
All –Payer Rate Setting
GMCB regulates all payers and providers
GMCB sets system wide quality goals
Setting the stage for capitated payment

Attachment 4: Care Management in Vermont: Gaps and Duplication

CARE MANAGEMENT IN VERMONT: GAPS AND DUPLICATION

Prepared for the Vermont Care Models and Care Management Work Group

By

Bailit Health Purchasing, LLC

September 14, 2015

Executive Summary

Drawing on information collected from surveys completed by Vermont organizations providing care management and from presentations made by care management organizations to the Care Models and Care Management (CMCM) Work Group, Bailit Health has summarized gaps and duplication in care management services. Bailit Health has also summarized recommendations from presenters on how to address gaps and duplication.

In assessing the recommendations, we organized the responses into the following categories:

- Vision for Coordinated Delivery System
- Targeted Areas Needing Coordination
- Recommendations Regarding New Models of Care
- Recommendations Regarding Creating New Organizational Structures to Standardize and Coordinate Care
- Recommendations Regarding Standardized Tools and Practices
- Recommendations Regarding Data and Evaluation Infrastructure
- Recommendations Regarding Technical Support

While some of the recommendations may be inconsistent, it seems clear that Work Group members believe that there needs to be:

- Increased process standardization, including increased use of common care management tools;
- Creation of an organizational mechanism to coordinate the "family of care coordinators;"
- Increased development and use of IT resources to coordinate care management activities;
- Increased use of a shared data set to coordinate care and measure effectiveness; and
- Increased opportunities for care managers to build their skills through initiatives to share best practices and learn new skills.

A. Summary of Responses

As part of its work, the Care Models and Care Management Work Group surveyed organizations providing care management services to collect information on existing activities, perceived barriers to doing their work, and recommendations on improving care management in Vermont. 42 organizations responded to the survey. In addition, 13 organizations volunteered to present more detail to the Work Group regarding their care management programs; when presenting they were asked to identify specific areas of gaps and overlaps. This report summarizes observations and recommendations for closing gaps and eliminating duplication that survey participants included in their response and presenters identified in their presentations. To understand this qualitative information, we have organized the material into several categories, which we discuss in detail below.

Table II provides a summary of identified areas of duplication, gaps and barriers in care management that were included in the presentations made to the Work Group.

Vision for Coordinated Delivery System

Several respondents included vision statements regarding how the ideal system would be structured. We include these statements because they serve as a "North Star" for the CMCM Committee. One respondent described a system of easy access and highly coordinated care:

> "Develop a system that provides 'no wrong door' for anyone seeking care. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the Area Agency on Aging, the home care staff must have the knowledge and ability to arrange for the services needed."

A few respondents identified specific services for which improved access should be achieved. Those services included:

- prevention, wellness, risk mitigation and stabilizing people in the community;
- mental health services, affordable housing, food and fuel assistance;
- Early Intervention and Essential Early Education services for children ages 3 to 4;
- adult dental care;
- transportation;
- affordable behavioral health services, especially for seniors on fixed incomes and who are homebound; and
- accessible Gerontology services.

Targeted Areas Needing Coordination

Several respondents identified specific areas of inter-agency activities that needed to be better coordinated. They included:

- Improve inter-agency coordination with integration of social services and the criminal justice system.
- Optimize interactions between Visiting Nurse Associations, Designated Mental Health Agencies, Federally Qualified Health Centers, and SASH (Support and Services at Home) partners.

Recommendations Regarding New Models of Care

Two of the respondents proposed implementing new models of care as solutions to eliminate duplication and fill in gaps in care. One recommended designing and testing peer support/family engagement models, but provided no more details. The other suggested developing an integrated care model for seriously ill people that includes: team-based care, communication across disciplines, and process and outcome measures. This model would be supported by a new payment strategy, such as episodes of care/bundled payments, or enhanced per member per month (PMPM) payments. The respondent suggested testing the model in a pilot setting.

Recommendations Regarding Creating New Organizational Structures to Standardize and Coordinate Care

Most of the recommendations from the participants centered on creating more infrastructure to improve coordination. One recommendation was to create or identify organizations to drive coordination across

multiple entities. Some suggestions focused on creating totally new organizational structures other focused on using existing organizations in new ways. Specific recommendations for new or repurposed organizations include:

- Develop "Care Resource Teams" which would include representatives from a variety of providers;
- Use Area Agency on Aging (AAA) services to complement services and scope of other community-based providers.
- Use AAA wraparound services (case management/care coordination, nutrition services, transportation, falls prevention, etc.) to improve success of care transitions and avoid hospitalizations, institutionalization and readmissions.
- Use the Unified Community Collaborative (UCC) in each Health Service Area (HSA) to coordinate care management activities, strengthen Vermont's community health system infrastructure, and help the three provider networks (i.e., the Accountable Care Organizations) meet their organization goals.
    - The UCCs would provide a forum for organizing the way in which medical, social, and long term service providers work together to achieve the stated goals.
    - The UCCs would develop and adopt plans for improving:
        - quality of health services,
        - coordination across service sectors, and
        - access to health services.

<u>Recommendations Regarding Standardized Tools and Practices</u>

Others recommended establishing processes among existing organizations that would result in better coordination among different agencies. These recommendations include:

- When coordinating services across multiple organizations with their own care managers, identify a central case manager (or team leader) to address coordinating the "family of case managers."
- Develop formalized collaborative relationships, including joint case management and care coordination.

Improved, standardized processes were recommended as a way to reduce duplication and gaps in care. Suggestions included:

- Develop a site visit tool for state staff;
- Create Utilization Management tools for state and provider staff;
- Create standards for uniform Early and Periodic Screening, Diagnostic and Treatment (EPSDT) developmental screening, assessment and treatment planning across physical and mental health, early childhood, and school-based Medicaid and (Children's Health Insurance (CHIP) programs;
- Design and test population-based developmental and mental health promotion and prevention practices for statewide implementation; and
- Design a treatment plan across domains of a person's life.

<u>Recommendation Regarding Data and Evaluation Infrastructure</u>

Many of the respondents made recommendations regarding better use of data to reduce duplication and gaps in care. Their data-oriented recommendations included:

- Develop standard processes for evaluation and continuous quality improvement for collaborative projects.
- Integrate and analyze as a system rather than just by provider (e.g., analyze home care data with data from other settings).
- Coordinate common measures across programs providing like services, including standardized and streamlined provider reporting requirements.
- Manage "gaps in care" data from payers.

The participants also made recommendations regarding data infrastructure improvements to reduce gaps and duplications in care management services, which included:

- Design and implement health information exchange (HIE) interfaces, communication and integrated clinical information sharing and information technology (IT) structures (state and local).
- Create new business processes and state IT tools for standard decision support and outcome tracking.
- Address internal service integration between AAA programs by continuing to consolidate to a single software platform.
- Decrease resource burden of Transitional Care Management for CMS billing by using a platform called ACT.md.

<u>Recommendations Regarding Technical Support</u>

To enhance care manager skills to reduce gaps in care and duplication of services, the respondents made recommendations with regard to both mentoring and skill development. Their recommendations included:

- Create regional Technical Assistance Staff/System of Care Facilitators.
- Develop public best-practice forums (e.g., for top-scoring HSAs in each component).
- Develop workforce training and provider development to support:
    - early intervention;
    - family centered clinical models;
    - family wellness;
    - local governance and affiliation agreements;
    - mitigation of social determinants of health, etc.

B. Conclusion

In order to harmonize and coordinate all the different care management programs, the CMCM Work Group members appear to believe that changes need to be made in multiple areas and that there is no simple solution. While some of the recommendations may be inconsistent, it seems clear that Work Group members believe that there needs to be:

- Increased process standardization, including increased use of common care management tools;
- Creation of an organizational mechanism to coordinate the "family of care coordinators;"
- Increased development and use of IT resources to coordinate care management activities;
- Increased use of a shared data set to coordinate care and measure effectiveness; and
- Increased opportunities for care managers to build their skills through initiatives to share best practices and learn new skills.

C. Tables

Table I summarizes the information identified in presentations made to CMCM Work Group members regarding specific areas of duplication in care management services. Many of the presentations did not identify specific organizational duplication; therefore, only those that did are included in this analysis. Table II summarizes needs, gaps, barriers and areas of duplication regarding care management services that were identified in each presentation made to the CMCM Work Group. The presenting organization is also included in the table.

Table I: Summary of Duplication of Services Identified by Presenters

	Programs Reporting Duplication				
Potential Overlapping Programs	**Community Rehabilitative Services – Designated Mental Health Agencies**	**Care Alliance for Opioid Addiction: "Hub and Spoke"**	**VCCI High Risk Pregnancy Program**	**Area Agencies on Aging + Care Partners Network + VNAs of Vermont**	**VNAs of Vermont Care Management**
VNAs, Home Health and Hospice Agencies	X				
Support And Services at Home (SASH)	X				X
Area Agencies on Aging	X				
Hospital Social Workers/Discharge Planners	X				X
Blueprint Community Health Teams	X		X		X
"Hub and Spoke" Medication Assisted Therapy Teams			X		
Designated Mental Health Agencies		X			X
Vermont Chronic Care Initiative (Medicaid)		X			
Agency of Human Services (AHS) Case Management		X			
Criminal Justice Case Management		X			
Maternal Child Health			X		
Reach-up Case Management			X		
FQHCs				X	

Table II: Summary of VT CMCM Presentations

Presenter	Program Name	Needs/Gaps/Barriers	Duplication

Washington County Mental Health	Designated Agency Case Management for Community Rehabilitative Treatment (CRT) Services (Community Support Program)	Process for <u>assignment of a care coordinator/team leader:</u>
		• Develop qualification for coordinator
		• Develop process for coordination
		• Address "family of case managers"
		  ▸ Mental Health
		  ▸ Home Health
		  ▸ SASH
		  ▸ AAA
		  ▸ Hospital Social Worker
		  ▸ Blueprint
		• Develop treatment plan across domains of a person's life
		• Establish electronic interface with other components of the health care system
		• Coordinate common measures across programs providing like services
			None indicated

Peter Cobb, VNAs of Vermont Director	VNAs of Vermont: Home Health Care Management	• Improved system of interagency communication and information sharing to assure appropriate coordination among the various providers serving a client or patient. • Ability to integrate and analyze home care data with data from other settings. Ability to share data across settings. Member agencies currently are working with VITL to create a two-way system of IT information exchange.	• Several organizations provide care management including home health, SASH, hospitals, nursing homes, Blueprint, and mental health agencies. • Mostly, the care management provided is not duplicative as each agency provides a valuable service to its patients.
Agency of Human Services Melissa Bailey, MA, LCMHC	Integrated Family Services (IFS)	• Design and test peer support/family engagement models. • Create Regional Technical Assistance Staff/System of Care Facilitators. • Improve coordination and create standards for	None Indicated

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		uniform EPSDT developmental screening, assessment and treatment planning across physical and mental health, early childhood, and school based Medicaid and CHIP programs. • Design and test population-based developmental and behavioral health promotion and prevention practices for statewide implementation. • Workforce training and provider development to support: early intervention; family centered clinical models; family wellness; local governance and affiliation agreements; mitigation of social determinants of health, etc. • Create new utilization management tools for state and provider staff. • Design and implement HIE interfaces, communication and integrated clinical information sharing and IT structures (state and local). • Analyze and align data dictionaries and create core data reporting requirements across programs, including standardization and streamlined provider reporting requirements. • Create new business processes and state IT tools for standard decision support and outcome tracking. • Create new quality oversight standards and site visit tools for state staff.	
	Care Alliance for Opioid Addiction: "Hub and Spoke"	• New approach – start-up issues • Lack of private insurance coverage • Lack of physicians willing to treat population • Challenge with integration of social services • Link with criminal justice system poses unique challenges	• Co-Occurring Mental Health Services/Models – D.A.s • Other Chronic Care Initiatives: VCCI, Community Health Teams • Other AHS Case Management • Criminal Justice Case Management
	Vermont Chronic Care Initiative High Risk Pregnancy Program	• Difficulty in obtaining early referrals, and finding women early in pregnancy in order to make an impact. • There is no incentive for member or provider to	None indicated

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		participate in program • Potential Duplication: External and internal partners – CHT, Maternal Child Health, Reach-up, MAT (Hub and Spoke) teams, etc.	
Allan Ramsay, M.D.	Green Mountain Care Board (including palliative care for the seriously ill in a care management system)	• Convene the stakeholders ▸ PCMH, DA, LTSS, VAHHS, ACO, others? • Develop an integrated care model for the seriously ill ▸ Team-based care ▸ Communication across disciplines ▸ Process and outcome measures • Identify a new payment strategy ▸ Episode of care/Bundle ▸ Enhanced payment ▸ PMPM • Test the model in a pilot setting	None indicated
Area Agencies on Aging + Care Partners Network + VNAs of Vermont	Coordinated Care Management	• Increasing focus on prevention, wellness, risk mitigation -- stabilizing people in the community • Difficult/impossible to age-in-place if you're not healthy • Recognition that AAA wraparound services (case management/care coordination, nutrition services, transportation, falls prevention, etc.) essential to success of care transitions; avoiding hospitalization/ institutionalization / readmits • Collaboration / service integration will be critical • AAAs are addressing internal service integration between AAA programs (consolidating single software platform) • While acknowledging existing collaboration / interactions with VNAs, DAs & FQHCs, SASH partner, it is clear that these relationships need to be optimized. Actively exploring closer / formalized collaborative relationships – joint case management / care coordination	• Increasingly apparent that AAAs, VNAs, DAs & FQHCs have high degree of client overlap

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		• Reducing/preventing hospital/SNF readmits; reducing chronic disease admits depend on coordinated care / case management	
Designated and Specialized Service Agencies	Vermont Care Partners (VCP) is a collaboration between the Vermont Council for Developmental and Mental Health Services and the Vermont Care Network to support the sixteen Designated and Specialized Service Agencies.	**Challenges** • **Data Sharing -** Community-based providers need the ability to share and receive relevant patient-specific data electronically with physicians, hospital, nursing homes. This would increase efficiency and improve the quality of the care delivered. • **No Wrong Door vs. Single Point of Contact** - A single point of entry is not needed. What is needed is a system that provides "no wrong door" for anyone seeking care. If a patient seeks help from a home health agency but what is needed most is assistance from a financial advisor at the Area Agency of Aging, the home care staff must have the knowledge and ability to arrange for the services needed. This can be achieved by Care Resource Teams which would include representatives from a variety of providers. **Opportunities** • Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) to coordinate care management activities, strengthen Vermont's community health system infrastructure, and help the three provider networks meet their organization goals. • The UCCs would provide a forum for organizing the way in which medical, social, and long term service providers work together to achieve the stated goals. • The UCCs would develop and adopt plans for improving ▸ quality of health services	• A patient could receive care management services from a several providers.

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
		▸ coordination across service sectors ▸ access to health services	
Howard Center	Service Coordination for Developmental Services Designated and Specialized Agency System	None indicated	None indicated
Blueprint Community Health Teams	Community Health Teams across Vermont	• Access to Mental Health Services, affordable housing, food and fuel assistance. • The size of Chittenden county and the large number of practices Biggest Gaps in Care - Services for ages three to four between Early Intervention and Essential Early Education services, adult dental care, transportation, affordable mental health services, especially for seniors on fixed incomes and who are homebound, accessible Gerontology services. • Transitional Care Management for CMS billing is time-consuming. • Managing "gaps in care" data from payers. • Prioritizing single-patient needs (tyranny of the urgent) vs. getting entire panels of patients to adopt healthier habits. • Juggling Transitional Care Management PLUS Care Coordination PLUS Panel management—self-management & education of smokers, diabetics, asthma patients PLUS Reduce ER visits and hospital admissions PLUS Work with multiple payers on reducing # of high-risk patients. • Communication, Releases, HIPAA Barriers • Motivating people who have been in "the system" for a few years to realize it is possible that they can gain control of their lives and future. • Identifying additional ways to quantify our team's efforts.	• Chittenden County is rich in services/resources, creating a challenge to really work on avoiding duplication. • Strong communication avoids many duplicated efforts, but it can sometimes be challenging to obtain certain information without proper releases in place.
Nancy Eldridge	Support & Services at Home (SASH)	• MAPCP demonstration capped at 5,400 participants • Need for more Wellness Nursing Hours	• Opportunity for more integration by SASH, VCCI and CHTs with shared participants

Presenter	Program Name	Needs/Gaps/Barriers	Duplication

		• Need for telemedicine capacity at home
		• Need for more root cause data
		• Move toward population management within which targeting can occur
		• Workforce gaps
		  o Need to push tasks down to paraprofessionals or community health workers
		Data Needs
		• DocSite capacity significant
		• Integrated Health Record barriers
		• VITL barriers:
		  o Who should have access?
		  o Risk when transforming systems
		• How can we build one data system
			o Blending Episodic expertise with coaching and ongoing team support
			• Dual Eligible teams and SASH teams
			• Data collection
			• ACO performance measurement

VCCI and DAIL	Care Models and Case Management: a Long Term Services and Supports (LTSS) Perspective	None Indicated	None indicated
Vermont Blueprint for Health	Community Health Network Analysis of Blueprint HSAs	Organizations are less likely to measure the work they are doing together. Evaluation and continuous quality improvement should be encouraged. No one HSA always rated at the top or bottom of the score distribution. It may be beneficial for top-scoring HSAs to share their practices in a public forum, so that the other HSAs can learn from those best practices. Respondents experienced drawbacks far less frequently. Two worth watching are: • taking too much time and resources—reported by 60% • difficulty in dealing with partner organizations—reported by 46%	Key Player Analysis shows that these are fairly durable networks, as modelling removal of the 3 "key players" in each network causes fragmentation but not complete network breakdown Information about key players (not necessarily duplication): • Blueprint Community Health Teams are key players in the majority of HSAs—around 60%. • At least 1 State agency (e.g., Agency of Human Services, Vermont Department of Health) is a key player in about a third of HSAs. • Other key players include organizations that provide mental health and substance abuse services , services for the aging population and home-based care groups. • Each community network is substantially larger

Presenter	Program Name	Needs/Gaps/Barriers	Duplication
			than its "core health team" and includes a range of public and private health and social service organizations that support a diverse swath of each community's population • It's common to see sub-networks that serve a specific population within the community, for instance area youth (see the St. Johnsbury HSA for an example) or area elders (see the Randolph HSA for an example).