State Innovation Model
Performance Period 2 Annual Report

Prepared by the State of Vermont
For the Centers for Medicare and Medicaid Services
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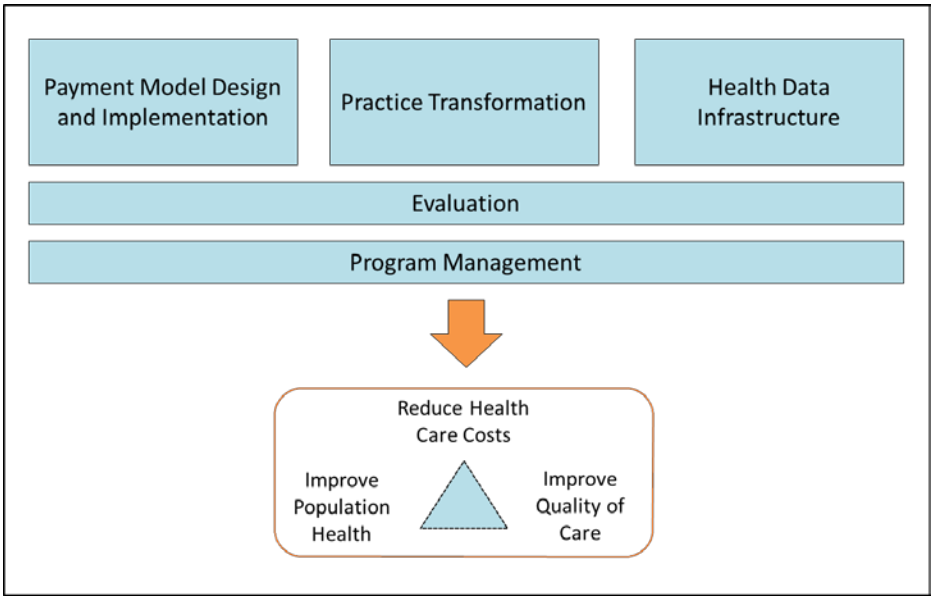
Introduction

Vermont's Performance Period 2 Annual Report describes Vermont's progress toward improvements in the state's health care system supported by the State Innovation Models (SIM) grant in Performance Period 2 (January 2015-June 2016). This document builds on our Performance Period 2 Operational Plan, submitted in November 2014; our Performance Period 2 Operational Plan Addenda, submitted in August 2015; our initial Year 3 Operational Plan, submitted in November 2015 (rescinded in November 2015); and our Year 2 No-Cost Extension request, submitted in December 2015. This document reports on activities undertaken during Performance Period 2 to meet our programmatic milestones, as well as major accomplishments and challenges during that period. It also includes evaluation findings for Performance Period 2 activities and describes Vermont's sustainability strategy.

Vermont organizes its SIM activities and programmatic milestones into five focus areas:

- **Payment Model Design and Implementation**: Supporting creation and implementation of value-based payments for providers in Vermont across all payers.
- **Practice Transformation**: Enabling provider readiness and encouraging practice transformation to support creation of a more integrated system of care management and care coordination for Vermonters.
- **Health Data Infrastructure**: Supporting provider, payer, and State readiness to participate in alternative payment models by building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management.
- **Evaluation:** Assessing whether program goals are being met.
- **Program Management and Reporting:** Ensuring an organized project.

Figure 1: Vermont's SIM Focus Areas



Throughout Performance Period 2, Vermont worked to achieve milestones that are required as part of our grant terms and conditions. These milestones are discussed in more detail in Table 1 below.

The remainder of this introduction describes a few major accomplishments and challenges that impacted the project as a whole during Performance Period 2. More detail about work stream-specific accomplishments and challenges are described later in this report. Table 1, which begins on Page 6, provides a summary of Vermont's Performance Period 2 milestones across all focus areas and indicates whether the milestone was achieved, delayed, or discontinued.

Major Accomplishment

Governance Reorganization and Continued Stakeholder Engagement. Project leadership approved a new governance structure as a result of a mid-project risk assessment in mid-2015. This reorganization consolidated work from Vermont's seven SIM work groups into four main work groups: Payment Model Design and Implementation; Practice Transformation; Health Data Infrastructure; and Health Care Workforce. The activities and membership of the Quality & Performance Measures, Population Health, and Disabilities, Long Term Services and Supports (DLTSS) Work Groups were incorporated into the Payment Model Design and Implementation, Practice Transformation, and Health Data Infrastructure Work Groups starting in October 2015. DLTSS and Population Health Work Groups have continued to meet quarterly to provide stakeholders a chance to share information from across project work groups.

Despite this change, Vermont has maintained strong stakeholder participation in project activities, including: work group meetings; a webinar series launched in 2016; convenings; and sub-groups. Vermont has received continued feedback about the importance of SIM governance in developing new relationships that are critical in supporting current and future health care innovation.

Challenges during Performance Period 2

Delays in Milestone and Contract Approvals. Delays in approvals for Performance Period 2 Milestones and Contracts in mid-2015 resulted in significant delays in contract work in 2015. In order to be fiscally responsible and prudent, the state stopped or slowed the work of many contractors for which we had not yet received federal approval. Throughout the period, Vermont worked to adapt project-specific timelines to account for this delay and minimize impact on project goals. Issues behind these delays were resolved through intensive collaboration with our Project Officer and OAGM over many months, and Vermont entered Performance Period 3 with no outstanding issues.

Staff Departures. During Performance Period 2, Vermont's SIM project experienced departures of significant staff and project key personnel at the Department of Vermont Health Access

(DVHA), Vermont Department of Health (VDH), Department of Disabilities, Aging, and Independent Living (DAIL), and the Green Mountain Care Board (GMCB). Vermont's SIM-funded positions are limited service and the majority are scheduled to conclude in December 2016, so staff departures are not unexpected; however, they do create challenges for our staff team. Vermont's SIM leadership reassigned responsibilities to ensure we continued to meet program goals and milestones, while identifying which work requires additional staffing to be filled by new State staff and which can be delegated to SIM contractors, including Vermont's project management contractor.

Table 1: Performance Period 2 Milestone Status Summary – All Milestones

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
Project Implementation	Continue to implement project statewide. Implement all Performance Period 2 Milestones by 6/30/16.	Achieved.
Payment Models	60% of Vermonters in alternatives to fee-for-service by 6/30/16.	In progress: 54% of Vermonters in alternatives to fee-for-service as of June 2016, based on unduplicated counts.
Population Health Plan	Finalize Population Health Plan outline by 6/30/16.	Achieved: Draft outline finalized.
Sustainability Plan	Finalize Sustainability Plan outline and procure contractor to support Plan development by 6/30/16.	Achieved: Sustainability Plan outline and contractor support in place.
Payment Model Design and Implementation Focus Area		
ACO Shared Savings Programs (SSPs)	ACO Shared Savings Programs (SSPs): Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/Commercial program provider participation target: 950. Medicaid/Commercial program beneficiary attribution target: 130,000.	Achieved: 1015 providers were participating in the Medicaid and commercial SSPs. Nearly Achieved: 123,911 individuals were attributed to the programs.
Episodes of Care	Research, design, and draft implementation plan for one EOC based off of the IFS program by 6/30/16.	Activity discontinued; decision made in collaboration with CMMI in April 2016.
Pay-for-Performance	Roll-out of new P4P investments for Blueprint Community Health Teams (CHTs) by 7/1/15 and enhanced direct payments to Blueprint practices by 1/1/16, according to approved P4P plan (using new funds that were appropriated by the legislature).	Achieved: New P4P investments launched on 7/1/15 and 1/1/16, respectively, according to the approved P4P plan.
Health Home (Hub & Spoke)	Reporting on program's transition and progress: Quarterly reporting of program progress to CMMI, VHCIP stakeholders.	Achieved: Vermont reported quarterly on the program to CMCS, CMMI, and SIM stakeholders throughout the performance period.
Accountable Communities for Health	Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16.	1. Achieved: ACH feasibility discussed in September and October 2015. 2. Achieved: Basic design for an ACH Peer Learning Laboratory for interested communities completed and recruitment materials released prior to 1/31/16; work to refine and plan

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
	3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.	peer learning activities was ongoing through Spring 2016, with a kick-off webinar and initial in-person convening in June 2016. 3. Achieved: Applications from interested communities received in February 2016. 4. Achieved: Research with St. Johnsbury community completed. No financial model will be developed at this time.
Prospective Payment System – Home Health	1. Creation of a project plan and begin Phase 1 activities as required by project plan for PPS-HH by 12/31/15. 2. Design PPS program for home health for launch 7/1/16.	Activity discontinued; decision made in collaboration with CMMI in April 2016.
Prospective Payment System – Designated Agencies	Submit planning grant for Certified Community Behavioral Health Clinics to SAMHSA by 8/5/15. If awarded, begin alignment of new opportunity with SIM activities. (Note: No SIM funds used to support this effort.)	Achieved: Planning grant submitted by 8/5/15. Activity discontinued; work stream to be replaced with Medicaid Pathway milestones.
All-Payer Model	1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.	1. Achieved: Research and analytics to inform decision-making conducted. 2. Achieved: Timeline for decision-making in 2016 developed and agreed upon by 12/31/15.
State Activities to Support Model Design and Implementation – GMCB	1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16. 2. Specific regulatory activities and timeline are dependent on discussions with CMMI.	1. Achieved: Research and planning to identify necessary components of APM regulatory activities identified by 6/30/16. Act 113 of 2016 sets out regulatory criteria and the certification process of Accountable Care Organizations (ACOs) by the Green Mountain Care Board. GMCB oversight of ACOs will occur via the adoption of an ACO Oversight rule per Act 113. This rule provides for a certification process for ACOs based on criteria laid out in legislation, budget oversight for ACOs including an assessment of ACO capacity for risk. 2. Achieved: Regulatory activities and timeline responsive to ongoing negotiations.
State Activities to Support Model Design and	Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate:	1. Achieved: Maximus contract in place. 2. Achieved: SPA for Year 2 of the Medicaid SSP was approved in September 2015. 3. Revised: SPA is no longer required for revised EOC milestone.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
Implementation – Medicaid	1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16. 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16. 7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.	4. Achieved: SSP Year 1 and Year 2 monitoring and compliance plan implementation completed. 5. Revised: EOC monitoring and compliance plan no longer needed due to revised milestone. 6. Revised: The IFS delivery and payment model has been rolled into the Medicaid Pathway work stream which will target providers across the entire state. Contractors are working with SIM staff and stakeholders to create a system ready for implementation on 7/1/17. 7. Achieved: Project kicked off in November 2015 after federal contract approval was received; recommendations presented to VHCIP work groups and Steering Committee in June 2016.
Practice Transformation Focus Area		
Learning Collaboratives	Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	Achieved: Vermont expanded the Integrated Communities Care Management Learning Collaborative to an additional 8 communities in September 2015. 1. Achieved: Expansion plan proposed in April 2015. 2. Achieved: Expansion to 8 new communities began in September 2015.
Sub-Grant Program – Sub-Grants	Continue Sub-Grant Program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	Achieved: Sub-Grant Program continued throughout Performance Period 2. 1. Achieved: Convening held for all sub-grantees on June 17, 2016. 2. Achieved: Quarterly reports were collected, reviewed, and disseminated project-wide each quarter during Performance Period 2.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
Sub-Grant Program – Technical Assistance	Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.	Achieved: Technical support is available upon request to all of the sub-grantees. 1. Achieved: Sub-grantees receive frequent communications about the project and are reminded of the opportunity to avail themselves of technical assistance as necessary. 2. Achieved: Technical assistance contracts are reviewed on a periodic basis and amended as necessary to ensure that resources are fully available to meet the needs of sub-grantees.
Regional Collaborations	Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	Achieved: All 14 HSAs developed Regional Collaborations – including drafting a charter and establishing a governing body and a decision-making process – by 6/30/16.
Workforce – Demand Data Collection and Analysis	1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval). 2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.	1. Achieved (with delay): A contract for micro-simulation demand modeling was executed in May 2016. 2. Achieved (with delay): Preliminary data was provided to micro-simulation demand modeling contractor in May 2016.
Workforce – Supply Data Collection and Analysis	Continue to use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 4 times between 1/1/15 and 6/30/16. 2. Publish data reports/analyses on website by 12/31/15. 3. Distribute reports/analyses to project stakeholders by 12/31/15.	1. Achieved: Workforce supply data was presented to the Workforce Work Group five times between 1/1/15 and 6/30/16. 2. Achieved: Surveys and statistical reports for each profession are published on the VDH website on a rolling basis. 3. Achieved: Reports and analyses are distributed to project stakeholders and other interested parties on a rolling basis, including at Workforce Work Group meetings and by posting to the VDH website.
Health Data Infrastructure Focus Area		
Expand Connectivity to HIE – Gap Remediation	Remediate data gaps that support payment model quality measures, as identified in gap analyses: 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15.	1. Achieved: The number of ACO Organizations with live interfaces to the VHIE increased from 14 to 68 by 12/31/2015, while the percentage of OneCare Vermont beneficiaries that were able to be represented in Quality Measure reporting increased from 17% to 64%. 2. Achieved: In late 2015, planning for the DLTSS Gap Remediation project began to address technical and policy

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
		challenges to connecting the Home Health Agencies (HHAs) and Area Agencies on Aging (AAAs) to the Vermont Health Information Exchange (VHIE); the project was formally approved in January 2016.
Improve Quality of Data Flowing into HIE	1. Implement terminology services tool to normalize data elements within the VHIE by 6/30/16. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.	1. Achieved: Terminology Services hardware and software implementation were completed in June 2016. 2. Achieved: Workflow improvement activities in at least 30% of provider practices began in late 2015.
Telehealth – Strategic Plan	Develop telehealth strategic plan by 9/15/15.	Achieved: Telehealth Strategic Plan finalized in September 2015.
Telehealth – Implementation	1. Release telehealth program RFP by 9/30/15. 2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.	1. Achieved: RFP released on 9/18/15. 2. Achieved (with delay): Two successful bidders were selected in November 2015; contract execution occurred in July 2016 due to delays in contract negotiation and approval.
EMR Expansion	1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16). 2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.	1. Achieved: EMR implementation for both the Vermont State Psychiatric Hospital and five Vermont Specialized Services Agencies (SSAs) was completed by June 2016. 2. Partially Achieved: Discussion is ongoing to help identify solutions for providers without EMRs, although financial and technical barriers present significant challenges for these organizations. The release of the new State Medicaid Director's Letter in February 2016 is influencing this work. Vermont anticipates meeting this milestone in Performance Period 3.
Data Warehousing	1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan). 2. Procure clinical registry software by 3/31/16. 3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.	1. Achieved: Implementation Phase 1 of the DA/SSA data warehousing solution complete. 2. Achieved: The clinical registry software was acquired in January 2016 and the system successfully went live in June 2016.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
		3. Delayed: Planning for the aggregation, analytics, and management of clinical and clinically related data in Vermont in ongoing; a diverse team of stakeholders are making steady progress and have expanded planning to include data governance. Vermont anticipates meeting this milestone in Performance Period 3.
Care Management Tools	Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out. 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.	1. Achieved: All 14 Vermont hospitals are connected to the Event Notification Service. 2. Achieved: All timelines for this project were met; a technical proposal for this work stream was presented to the HDI Work Group in November 2015.
General Health Data – HIE Planning	1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015. 2. HDI Work Group will identify connectivity targets for 2016-2019 by 6/30/16.	1. Achieved: Throughout 2015 and early 2016, the HDI Work Group has participated on multiple occasions in the 2015 revision of Vermont Health Information Technology Plan (VHITP), which was submitted to the GMCB for approval in April 2016. 2. Delayed: The connectivity target methodology was proposed to the HDI Work Group in July 2016. The team will work with Vermont Information Technology Leaders (VITL) and additional stakeholders to utilize this methodology and provide final targets in Performance Period 3.
General Health Data – Expert Support	Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	Achieved: Vermont is deploying IT-specific support for health data initiatives as necessary and appropriate.
Evaluation Focus Area		

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
Self-Evaluation Plan and Execution	1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities. 2. Continue to execute self-evaluation plan using staff and contractor resources.[1] 3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.	1. Achieved: Contract with John Snow, Inc. (JSI) executed in March 2016. 2. Achieved: Self-evaluation plan has been initiated and execution has continued. 3. Achieved: Quarterly and Annual reporting streamlined.
Surveys	Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.	Achieved: Vermont's patient experience contractor (DataStat) fielded the Year 2 patient experience survey from August 2014-July 2015 and November 2015-April 2016.
Monitoring and Evaluation Activities within Payment Programs	1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers. 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.	1. Achieved: The Blueprint for Health (Vermont's PCMH program) provided bi-annual comprehensive performance reports to participating primary care practices and health service area leaders, most recently in November 2015 and May 2016. 2. Achieved: Interim and final analyses of Year 1 of the commercial and Medicaid Shared Savings Programs were provided during Performance Period 2.
Project Management Focus Area		
Project Management and Reporting – Project Organization	Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature.	1. Achieved: Project Management contract scope of work and tasks performed on time. 2. Achieved: Staff meetings, co-chair meetings, and Core Team meetings conducted each month with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Achieved: Reports submitted quarterly to CMMI and the Vermont Legislature.

[1] Vermont's self-evaluation plan relies on numerous staff and contractors, which are described in the Evaluation Remediation Plan submitted on November 25, 2015.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status (as of 6/30/2016)**
Project Management and Reporting – Communication and Outreach	Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 6/30/16. 2. Distributing all-participant emails at least once a month. 3. Updating website at least once a week.	1. Achieved: Core Team, Steering Committee, and Work Groups convened each month through the end of Performance Period 2. 2. Achieved: Vermont's SIM project communicates with all participants via email at least once a month. 3. Achieved: Vermont's SIM website is continually updated with new documents and information.

Milestones Achieved, Major Accomplishments, and Challenges: Milestones Supporting CMMI Requirements

The terms of Vermont's SIM grant include requirements that have been translated into four overarching milestones that support CMMI requirements:

- Ongoing *Project Implementation*;
- Increasing the number of Vermonters included in non-fee-for-service *Payment Models*;
- Development of a *Population Health Plan*; and
- Development of a *Sustainability Plan* that looks beyond the end of the SIM grant.

Table 2, below, summarizes progress across these milestones during Performance Period 2. The remainder of this section details accomplishments and challenges within the Population Health Plan and Sustainability Plan work streams.

Table 2: Performance Period 2 Milestone Summary – CMMI Required Milestones

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
Project Implementation	Continue to implement project statewide. Implement all Performance Period 2 Milestones by 6/30/16.	Achieved. Some Performance Period 2 milestones were delayed, with completion later in Performance Period 2 or expected in Performance Period 3. In cases where delays were anticipated, Vermont communicated with our Project Officer to ensure CMMI was aware of delays and potential impact on project activities.
Payment Models	60% of Vermonters in alternatives to fee-for-service by 6/30/16.	In progress: 54% of Vermonters in alternatives to fee-for-service as of June 2016, based on unduplicated counts.
Population Health Plan	Finalize Population Health Plan outline by 6/30/16.	Achieved: Draft outline finalized. • The Population Health Plan will build upon the existing State Health Improvement Plan and offer a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes. • During 2014 and 2015, the Population Health Work Group and staff developed a definition of population health, came to consensus on core concepts, and developed documents to communicate concepts to project stakeholders. • In the first half of 2015, project staff developed an outline for the Population Health Plan with technical assistance support from CDC and CHCS. This outline was refined and finalized in the first half of 2016 with input from the Population Health Work Group and other SIM work groups. • In late 2015, DVHA released an RFP seeking support for writing the Population Health Plan and a successful awardee was named in April 2016. A contract was executed in June with a start date of July 1, 2016.
Sustainability Plan	Finalize Sustainability Plan outline and procure contractor to support Plan development by 6/30/16.	Achieved: Sustainability Plan outline and contractor support in place by 6/30/16. • The Sustainability Plan is a required deliverable of Vermont's SIM grant, and will build on ongoing conversations between State leadership, project stakeholders, and CMMI. • Vermont developed a draft Sustainability Plan outline in Spring 2016. The State engaged a contractor to support development of the Sustainability Plan in Spring 2016. • Vermont will use our final test year to do more detailed planning, and to provide specificity about the activities that will be supported after the end of our SIM testing period. The Plan will be completed by the end of Performance Period 3.

Population Health Plan

Performance Period 2 Milestone: Finalize Population Health Plan outline by 6/30/16.

The Population Health Plan is a required deliverable of Vermont's SIM grant, and will build on ongoing work of State leadership and key stakeholders, particularly those who have participated in Vermont's SIM Population Health Work Group. During Performance Period 2, Vermont finalized a Population Health Plan outline and executed a contract with a vendor to support Population Health Plan writing during Performance Period 3.

Major Accomplishments

Finalization of Population Health Plan Outline. During 2015, project staff developed a rough outline for the Population Health Plan with technical assistance support from CDC and CHCS. This outline was repeatedly refined in the first half of 2016 with input from the Population Health Work Group and other Vermont SIM work groups, and finalized prior to the end of the performance period. This finalized outline will act as a guide for project leadership and the contractor hired to support Population Health Plan writing.

Selection of Vendor to Write Population Health Plan. In 2015, Vermont made the decision to pursue a contractor to support Population Health Plan writing. This decision was made in light of other significant deliverables due at the end of the SIM grant (i.e., Sustainability Plan), and in hopes that the vendor team could include graphic design or similar skills to ensure the final Plan is both professional-looking and useful to an array of audiences. A contract was executed in June 2016, with a contractor start date of July 1, 2016, aligned with the start of Performance Period 3.

Sustainability Plan

Performance Period 2 Milestone: Finalize Sustainability Plan outline and procure contractor to support Plan development by 6/30/16.

The Sustainability Plan is a required deliverable of Vermont's SIM grant, and will build on ongoing conversations between State leadership, project stakeholders, and CMMI. During Performance Period 2, Vermont developed a Sustainability Plan outline and executed a contract with a vendor to support consumer engagement and Sustainability Plan development during Performance Period 3.

Major Accomplishments

Development of a Sustainability Plan Outline. Vermont developed a draft Sustainability Plan outline in Spring 2016; this outline will be refined throughout Performance Period 3 in response to conversations with State leaders and private sector partners.

Procurement of Contractor to Support Sustainability Plan Development. Vermont released an RFP seeking a contractor to support sustainability planning in March 2016. An agreement was executed in June 2016. The contractor began work in July 2016 and will work with Vermont throughout Performance Period 3.

Milestones Achieved, Major Accomplishments, and Challenges: Payment Model Design and Implementation

Payment reforms are a central feature of Vermont's SIM activities. The payment reforms Vermont has pursued under SIM have evolved over the course of the grant, with planned activities discontinued and new activities added based on State and private-sector stakeholder feedback and the changing needs of our state.

Activities during this period included:

- Continuing and expanding existing Vermont's Medicaid and commercial *Shared Savings Programs*;
- Research and design for a Medicaid *Episodes of Care* payment model (activity discontinued);
- Continued implementation of the Blueprint for Health *Pay-for-Performance* investments, including enhancements to and rebasing of Community Health Team investments and enhancements of payments to participating primary care practices;
- Continued implementation of Vermont's *Health Home (Hub & Spoke)* program;
- Completion of research on the *Accountable Communities for Health* model and launch of a peer learning opportunity for regions around the state;
- Design of a *Prospective Payment System for Home Health Agencies* (activity discontinued);
- Submission of a planning grant to support design for a *Prospective Payment System for Designated Agencies* (activity merged with Medicaid Value-Based Purchasing work stream);
- Continued planning and negotiations with federal partners around the *All Payer Model*;
- Ongoing *State Activities to Support Model Design and Implementation.*

Table 3, below, summarizes progress across the Payment Model Design and Implementation Focus Area for all Performance Period 2 milestones; the remainder of this section details accomplishments and challenges within each work stream.

Table 3: Performance Period 2 Milestone Summary – Payment Model Design and Implementation Focus Area

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
ACO Shared Savings Programs (SSPs)	ACO Shared Savings Programs (SSPs): Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/Commercial program provider participation target: 950. Medicaid/Commercial program beneficiary attribution target: 130,000.	Achieved: As of 6/30/16, 1015 providers were participating in the Medicaid and Commercial SSPs, and 123,911 individuals were attributed to the programs. • Modeled closely after the Medicare Shared Savings Program, this alternative payment model for commercial and Medicaid beneficiaries in Vermont was launched in 2014 as a three-year program. Beneficiaries are attributed to one of three accountable care organizations (ACOs) in the State. ACOs must meet quality targets to be eligible to share in any savings. • Participation in the commercial and Medicaid SSPs continues to increase as providers are added and beneficiaries are attributed to participating ACOs. By the end of Performance Period 2, both payer programs had participation from 1015 providers (note significant overlap in provider participation across payer programs, including the Medicare Shared Savings Program) and a combined beneficiary attribution of 123,911 (179,800 including individuals attributed to the Medicare SSP). • In Performance Period 2, the project focused on continued program implementation and evolution of program standards based on cost and quality results from the first performance period of both the Medicaid and commercial SSPs.
Episodes of Care	Research, design, and draft implementation plan for one EOC based off of the IFS program by 6/30/16.	*Activity discontinued; decision made in collaboration with CMMI in April 2016.* In April 2016, following internal discussion and discussion with CMMI, Vermont's SIM leadership team elected to discontinue this activity due to estimated episode launch date (7/1/17, following the end of Vermont's SIM Model Testing period) and inability to evaluate the model prior to the end of SIM. The initiative had been previously delayed; provider and stakeholder support for this work stream was never fully realized due to significant provider fatigue and concurrent competing payment reform priorities. The State will continue work on IFS program payment models through the Medicaid Pathway work stream in Performance Period 3.
Pay-for-Performance	Roll-out of new P4P investments for Blueprint Community Health Teams (CHTs) by 7/1/15 and enhanced direct payments to Blueprint practices by 1/1/16, according to approved P4P plan	Achieved: New P4P investments launched on 7/1/15 and 1/1/16, respectively, according to an approved P4P plan • The Blueprint for Health provides performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	(using new funds that were appropriated by the legislature).	disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement. • During 2014 and 2015, the Blueprint for Health engaged with its Executive Committee, DVHA and AHS leadership, and Vermont SIM stakeholders to discuss and decide on modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payments. The program elected to make three modifications: shifting payers' CHT payments to reflect current market share (planned to implement 7/1/2015); increasing the base payments to PCMH practices (planned to implement 7/1/2015 for Medicaid, 1/1/2016 for commercial insurers); and adding an incentive payment component to PMCH payments based on a combination of practice and regional performance on a composite of select quality measures (implemented 1/1/2016). State payment increases were funded by a $2.4 million legislative appropriation for Medicaid Blueprint payments (both CHT and PCMH) in State Fiscal Year 2016. • Quality measures were selected as the basis for the performance incentive payment in the summer of 2015; these measures are aligned with those being used for the Medicaid and commercial SSPs. • Starting in 2014, the Blueprint has been working on a model for integrating efforts with the ACOs. As part of that effort clinical leadership from all three ACOs recommended and selected the performance measures for payment based on the ACOs' key priorities.
Health Home (Hub & Spoke)	Reporting on program's transition and progress: Quarterly reporting of program progress to CMMI, VHCIP stakeholders.	Achieved: Vermont reported quarterly on the program to CMCS, CMMI, and SIM stakeholders throughout the performance period. • The Hub and Spoke initiative is a Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with the chronic condition of opioid addiction. The Health Home integrates addictions care into general medical settings and links these settings to specialty addictions treatment programs in a unifying clinical framework. Two payments are used: bundled monthly rate for Hubs and a capacity-based payment for Spokes. • Access to treatment has steadily expanded, from 2,867 Medicaid beneficiaries receiving treatment in January 2013 to 5,792 in June 2016.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
		• The Hub & Spoke program transitioned from enhanced 90/10 federal match to Vermont's usual Medicaid match rate after an initial eight quarters of implementation through two Health Home State Plan Amendments in July 2015 and January 2016, respectively. • Program implementation and reporting are ongoing.
Accountable Communities for Health	Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.	Achieved: 1. Achieved: ACH feasibility discussed in September and October 2015. 2. Achieved: Basic design for an ACH Peer Learning Laboratory for interested communities completed and recruitment materials released prior to 1/31/16; work to refine and plan peer learning activities was ongoing through Spring 2016, with a kick-off webinar and initial in-person convening in June 2016. 3. Achieved: Applications from interested communities received in February 2016. 4. Achieved: Research with St. Johnsbury community completed. No financial model will be developed at this time. • This effort seeks to align programs and strategies related to integrated care and services for individuals and community-wide prevention efforts to improve health outcomes within a geographic community. Phase I of this work, which took place during 2015, focused on research to further define the Accountable Communities for Health (ACH) model and identify core elements. Phase II brings together multi-disciplinary teams from communities across the state in an Accountable Communities for Health Peer Learning Laboratory to further explore how this model might be implemented and develop community capacity. • The ACH Peer Learning Laboratory seeks to support participating communities in increasing their capacity and readiness across the nine core elements of the ACH model through a curriculum that utilizes in-person and distance learning methods to support peer learning, as well as community facilitation to support each community's development. The project will result in a report that documents findings and lessons learned, and includes recommendations to inform future State decision-making, focusing on what ACH-related infrastructure and resources are needed at the community/regional level and the State level. • The ACH Peer Learning Lab launched in January 2016 with the release of recruitment materials and an informational webinar. Ten communities were selected to participate in February. A kick-off webinar was held on June 1, and the first of three in-person convenings with participating communities was held on June 7. Local facilitation to support communities

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
		in developing ACH competencies also began in June and will continue through the conclusion of the Peer Learning Laboratory in January 2017. • There is ongoing work to identify population health improvement opportunities to enhance Vermont's health delivery system models, such as the Blueprint for Health and ACOs. This would include better integration of clinical services, public health programs, and community-based services at both the practice and the community levels. • A group of Vermont SIM and AHS leadership and contractors worked with leaders from key health care and social services organizations in the St. Johnsbury area between June 2015 and February 2016 to identify existing challenges to meeting the key goals of an ACH, and to discuss the possibility of an ACH pilot in that region incorporating a payment component. This included regular meetings, as well as deployment of contractor resources to perform data analyses and financial analyses. These discussions were incorporated into the Medicaid Pathway process in 2016. No payment component for an ACH is being pursued at this time.
Prospective Payment System – Home Health	1. Creation of a project plan and begin Phase 1 activities as required by project plan for PPS-HH by 12/31/15. 2. Design PPS program for home health for launch 7/1/16.	*Activity discontinued; decision made in collaboration with CMMI in April 2016.* As a result of stakeholder support in the state, legislation was passed in 2015 requiring that DVHA, in collaboration with the State's home health agencies, develop a prospective payment system (PPS) for home health payments made by DVHA under traditional Medicaid to be put in place by July 1, 2016. At the request of home health providers, Vermont's Legislature delayed implementation of this model until July 1, 2017. In April 2016, after internal discussion and discussion with CMMI, Vermont's SIM project suspended this effort in response to this change and eliminated this milestone from Performance Period 3.
Prospective Payment System – Designated Agencies	Submit planning grant for Certified Community Behavioral Health Clinics to SAMHSA by 8/5/15. If awarded, begin alignment of new opportunity with SIM activities. (Note: No SIM funds used to support this effort.)	Achieved: Planning grant submitted by 8/5/15. *Activity discontinued; work stream to be replaced with Medicaid Pathway milestones.* Vermont decided not to pursue this opportunity, and replaced this work with the Medicaid Pathway milestone category in Performance Period 3.
All Payer Model	1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI.	1. Achieved: Research and analytics to inform decision-making conducted. 2. Achieved: Timeline for decision-making in 2016 developed and agreed upon by 12/31/15.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.	• Vermont continues to explore an All-Payer Model which will build on existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Value-based payments that shift risk on to health care providers and that are aligned across all payers encourages collaboration across the care continuum and can result in better health outcomes for Vermonters. • Negotiations between CMMI and SOV continue. SOV proposed a term sheet to CMMI on January 25, 2016 which sets out the basic outline for a potential all-payer model agreement, including the legal authority of the State to enter into such an agreement, the performance period for the agreement, waivers necessary to facilitate payment change and additional covered services, data sharing, and an evaluation of the demonstration. Stakeholder outreach and public process to vet the term sheet and potential model design, including legislative testimony, took place throughout the first half of 2016. • On May 1, representatives from Community Health Accountable Care (CHAC), Healthfirst/Vermont Collaborative Physicians (VCP), and OneCare Vermont Accountable Care (OneCare) voted unanimously to form a unified Accountable Care Organization ("Vermont Care Organization" (VCO)) by June 1, 2016. • The State of Vermont would participate in the All-Payer Model as a payer via Medicaid. Vermont selected OneCare Vermont as the apparently successful bidder in its procurement for an ACO to participate in a Next Generation-type model for Medicaid in 2017.
State Activities to Support Model Design and Implementation – GMCB	1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16. 2. Specific regulatory activities and timeline are dependent on discussions with CMMI.	1. Achieved: Research and planning to identify necessary components of APM regulatory activities identified by 6/30/16. Act 113 of 2016 sets out regulatory criteria and the certification process of ACOs by the Green Mountain Care Board. GMCB oversight of ACOs will occur via the adoption of an ACO Oversight rule per Act 113. This rule provides for a certification process for ACOs based on criteria laid out in legislation, budget oversight for ACOs including an assessment of ACO capacity for risk. 2. Achieved: Regulatory activities and timeline responsive to ongoing negotiations. • For all payment models that are designed and implemented as part of Vermont's State Innovation Model grant activity, there are a number of processes specific to the Green Mountain Care Board (GMCB) that must occur. The GMCB engages in ongoing activities related to design, implementation, and monitoring of all payment and delivery system models. For example, the Board developed and adopted all payer standards for payers

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
		participating in the current Shared Savings Programs (SSPs). The Board monitors ACOs on aligned quality and performance measures as well as Total Cost of Care for the SSPs. The Board also adjusts any payment of earned savings based on the ACO's performance on quality measures. • Vermont merged this work stream with the All-Payer Model work stream in Performance Period 3.
State Activities to Support Model Design and Implementation – Medicaid	Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16. 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16.	1. Achieved: Maximus contract in place. 2. Achieved: SPA for Year 2 of the Medicaid SSP was approved in September 2015. 3. Revised: SPA is no longer required for revised EOC milestone. 4. Achieved: SSP Year 1 and Year 2 monitoring and compliance plan implementation completed. 5. Revised: EOC monitoring and compliance plan no longer needed due to revised milestone. 6. Revised: The IFS delivery and payment model has been rolled into the Medicaid Pathway work stream which will target providers across the entire state. Contractors are working with SIM staff and stakeholders to create a system ready for implementation on 7/1/17. 7. Achieved: Project kicked off in November 2015 after federal contract approval was received; recommendations presented to Vermont SIM work groups and Steering Committee in June 2016. • For all Medicaid payment models that are designed and implemented as part of Vermont's State Innovation Model grant activity, there are a number of Medicaid-specific state activities that must occur. These activities ensure that Vermont Medicaid is in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries. • Both Year 1 and 2 SSP State Plan Amendments were approved in 2015. • ACO SSP data sharing is ongoing. • Beneficiary call-center is operational and will continue through program duration. • Frail Elders project recommendations presented to Vermont SIM work groups and Steering Committee in June 2016.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.	

ACO Shared Savings Programs (SSPs)

Performance Period 2 Milestone: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16:

Medicaid/commercial program provider participation target: 950.

Medicaid/commercial program beneficiary attribution target: 130,000.

In Performance Period 2, the ACO Shared Savings Programs for commercial and Medicaid payers in Vermont focused on expanding the number of participating providers and attributed beneficiaries in the SSPs.

Major Accomplishments

Expansion of Medicaid and commercial Programs. Both payer programs (commercial and Medicaid) showed a steady increase in provider and beneficiary participation and attribution during Performance Period 2. Provider participation in the Medicaid and commercial SSPs increased to 1,015 providers at the end of June 2016. Beneficiary attribution to the Medicaid and commercial SSPs also increased to 123,911 (beneficiary attribution including Medicare is 179,867) at the end of June 2016.

Challenges

Potential Inconsistencies with All—Payer Model Work. Vermont is designing an All—Payer Model framework while the ACO Shared Savings Programs are in their final performance years. Planning for Shared Savings Program evolution could be inconsistent with programmatic activities proposed for the All—Payer Model in 2017. Vermont has taken steps to mitigate this risk by including key Shared Savings Program operational personnel in planning conversations around the All—Payer Model framework. This will ensure alignment across these related initiatives. We do not anticipate that this will be an issue in the future.

Episodes of Care

Performance Period 2 Milestone: Research, design, and draft implementation plan for one EOC based off of the IFS program by 6/30/16.

During the Performance Period 2, Vermont SIM staff time and contractor resources were devoted to planning work for an Episodes of Care payment model. Stakeholder work groups were convened to discuss how Vermont might approach possible payment models based on episodes of care, how episode-based data may be used to support practice transformation, and whether any particular episodes would be applicable to multiple payer populations. As a result of these discussions, focus shifted to the development of a Medicaid-only Episodes of Care

payment model (several of the commercial payers in Vermont already had episode-based initiatives underway, and providers in the state were already participating in Medicare's Bundled Payments for Care Improvement program). Staff also consulted with other SIM states that have been pursuing episode-based payment models to further inform the design process. After a period focused on analytics to identify 'candidate' episodes for a Medicaid payment model, three episodes were selected that met the three criteria established for feasibility assessments:

- Sufficient Medicaid beneficiary volume to allow for valid assessment;
- Sufficient Medicaid provider participation to allow for meaningful comparisons; and
- Sufficient annual Medicaid expenditure (and variation in expenditure across impacted providers) to provide an opportunity for savings.

The three identified episodes were proposed to the broader SIM stakeholder base for feedback. Comments on the proposed episodes were generally focused in three areas:

- Concern about the launch of another payment model when so many providers were already participating in other health care reform initiatives in the state (including multi-payer ACO Shared Savings Programs, and the Blueprint for Health).
- Concern about how best to coordinate payments and incentives for an Episodes of Care program that would have service, beneficiary, and provider overlap with the existing Shared Savings Programs.
- Concern about the proposed timing of the Episodes of Care payment model implementation (which had an anticipated start date of July 2016) relative to other reforms that Vermont is contemplating for 2017—in particular, the desire to move more broadly toward all-inclusive population-based payments as part of an All-Payer Model in 2017 (and the potential need to either carve out episode-based payments from broader population-based payments, or to discontinue an episode program after only 6 months of operation).

Based on the preliminary analyses that were conducted to identify potentially feasible Medicaid Episodes, the number of Medicaid beneficiaries that would have been *newly* impacted by the proposed episode models (i.e. beneficiaries that have not previously been impacted by any of Vermont's other payment models) would have been quite modest for a statewide initiative. As a result, the overall impact of a Medicaid-only Episodes of Care program on Vermont's goal of moving 80% of beneficiaries into value-based purchasing models would have been minimal, especially relative to the impacts of other broader-based, multi-payer programs that are in place presently.

Given these concerns on the part of both public and private stakeholder partners, as well as concerns about Vermont's ability to fully evaluate the program's efficacy during the life of the SIM testing period, Vermont requested the discontinuation of the Episodes of Care Payment Model milestone for Performance Period 3. This was approved by CMMI.

Major Accomplishments

Establishment of Episodes of Care Sub-Group. The establishment of a sub-group of the broader Payment Model Design and Implementation work group focused on planning for Episodes of Care was a notable success. In January 2015, the sub-group was chartered to focus explicitly on better understanding the intricacies of Episodes of Care and to aid payers and other stakeholders in exploring the potential for, and challenges involved with, developing an Episode-based payment model. Based on priorities and concerns expressed by both public and private stakeholder participants, the State received key insights to inform decision-making around this work stream.

Episode of Care Analytics for Medicaid. The Episodes of Care work stream allowed Vermont to conduct more robust analytics around potential episodes for the Medicaid population than had previously been undertaken. Such analytics highlighted potential opportunities and challenges associated with a number of candidate episodes, and allowed for much richer feasibility assessments.

Challenges

Implementation Timeline. Given the intended implementation date for the Episodes of Care program, there was significant concern about the potential for programmatic misalignment with other payment models planned for Vermont in 2017. There would also have been challenges associated with a reduced ability to evaluate the effectiveness of the project given the implementation timeline relative to Vermont's SIM grant period.

Stakeholder Reform Fatigue. As with other reforms, the successful implementation of an Episodes of Care program would have relied on robust support from providers, payers, and other stakeholders within the state. Given the myriad other payment models being either tested or contemplated, stakeholders expressed reservations about the potential unintended consequences of layering on a new program, and questioned whether efforts might be better spent focusing on learning key lessons from the models already being implemented and preparing for models being contemplated for future years that would represent a broader commitment to value-based purchasing in the state (i.e. an All—Payer Model that relies on Population-Based Payments).

Pay-for-Performance

Performance Period 2 Milestone: Roll-out of new P4P investments for Blueprint Community Health Teams (CHTs) by 7/1/15 and enhanced direct payments to Blueprint practices by 1/1/16, according to approved P4P plan (using new funds that were appropriated by the legislature).

During Performance Period 2, Vermont's Blueprint for Health implemented planned payment changes, including: shifting payments to CHTs to reflect insurers' current market share; increasing direct payments to Blueprint practices (PCMH payments); and adding an incentive component to PCMH payments that rewards practices based on a combination of practice and regional performance on a composite of quality and utilization measures.

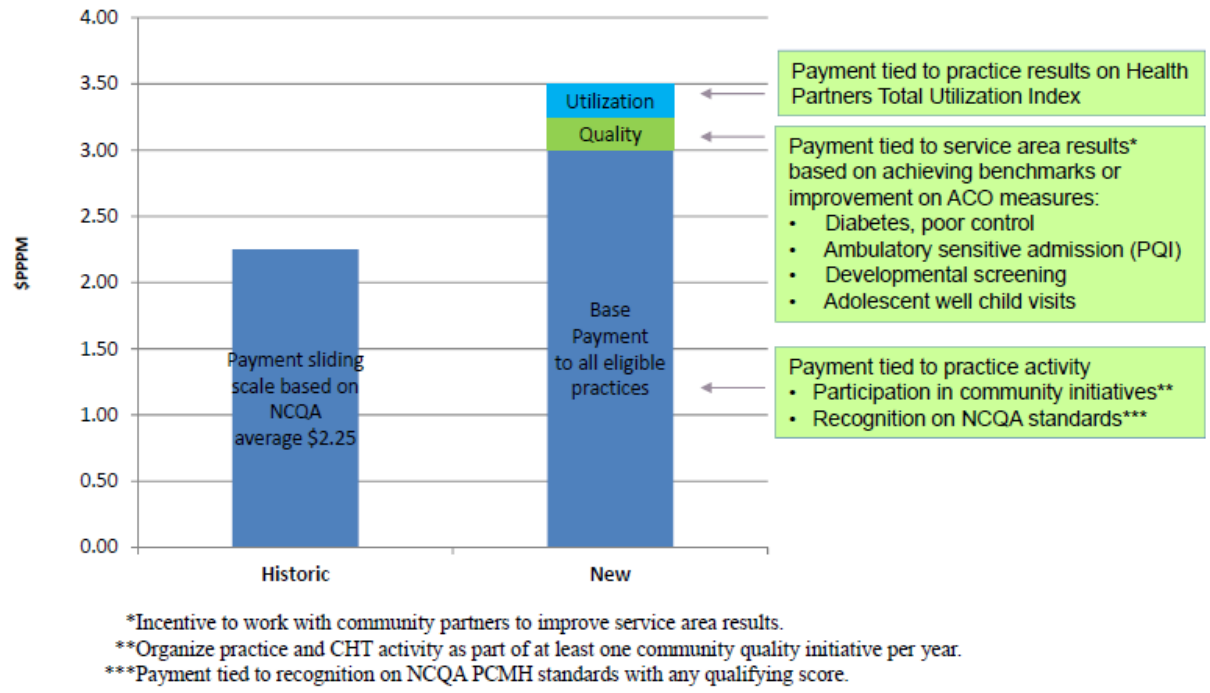
For more information on the Blueprint for Health program, visit the program website or view the 2015 Blueprint Annual Report.

Major Accomplishments

Implementation of New Payment Methodologies. The Blueprint for Health implemented payment changes as planned during the second half of 2015. New payments reflected the most significant changes to the Blueprint payment methodology since the program launched statewide in 2008: raising payments to participating practices, adding a regional quality incentive that promotes collective quality improvement efforts, and rebalanced insurers' contributions to CHTs.

Though some stakeholders were initially reticent to partner with the Blueprint program to identify and implement changes to the payment methods, many came to the table over the course of Performance Period 2. Specific effort was put into aligning the Blueprint and ACO delivery models with a focus on leveraging the payments to achieve overall health care reform goals. Over a 9-month period, the Blueprint and ACO leadership worked collaboratively to propose a payment method which involved: agreeing on the proportion of the base payment versus pay-for-performance components; identifying common priorities across the three ACOs; choosing corresponding measures to include in the performance payments that reflect those priorities, are among the SSP measure sets, and are collected through the statewide HIT system; and creating a balanced approach incenting both practice and community-wide outcomes. In the end, the PCMH payment method was modified to a two component payment with a $3.00 PMPM base payment contingent on NCQA recognition and Community Collaborative participation, with a $0.50 PMPM potential performance payment. The performance payment is a composite of $0.25 PMPM scaled based on maintaining and or improving individual practice outcomes on total utilization (the Health Partners Total Utilization Index) and $0.25 PMPM scaled based on regional performance and or improvement on a combination of four ACO quality measures (diabetes in control, ambulatory sensitive admissions (PQI), developmental screening, and adolescent well-child visits). *Figure 2*, below, compares the former Blueprint PCMH payment methodology with the new methodology.

Figure 2: Comparison of Former and Current Medical Home Payments



*Incentive to work with community partners to improve service area results.
**Organize practice and CHT activity as part of at least one community quality initiative per year.
***Payment tied to recognition on NCQA PCMH standards with any qualifying score.

More detail can be found at: http://blueprintforhealth.vermont.gov/implementation_materials.

Challenges

Working with Diverse Stakeholders to Modify an Established Program. The Blueprint for Health is a long-running successful program in Vermont, and as is often the case, working with stakeholders to agree on the best path for change was a challenge. Though some stakeholders were initially reticent to partner with the Blueprint program to identify and implement changes, many came to the table over the course of Performance Period 2 to ensure alignment across these activities.

Health Homes (Hub & Spoke)

Performance Period 2 Milestone: Reporting on program's transition and progress: Quarterly reporting of program progress to CMMI, VHCIP stakeholders.

During Performance Period 2, Vermont continued to report quarterly on the Health Home initiative, known as the Hub & Spoke initiative.

For more information on the Vermont's Health Home (Hub & Spoke) program, visit the Blueprint for Health program website or view the 2015 Blueprint Annual Report.

Major Accomplishments

Successful Transition from Enhanced Federal Match Rate. After eight quarters of enhanced 90/10 federal match, the Hub & Spoke program transitioned to Vermont's usual Medicaid match rate in July 2015 and January 2016, respectively, without interruption to services or funding.

Publications in Peer-Reviewed Journals. During Performance Period 2, two papers discussing the Hub & Spoke program were published in peer-reviewed journals.

- A baseline study in the *Journal of Substance Abuse Treatment*[2] compared expenditures and utilization rates for Vermont Medicaid beneficiaries with opioid addiction receiving medication-assisted treatment (MAT) and those not receiving MAT from 2008-2013, prior to the start of the Hub & Spoke program. The study found that MAT is associated with reduced expenditures and utilization.
- A qualitative study in the *Journal of Addiction Medicine*[3] examined the utility of provider learning collaboratives to improve buprenorphine prescribing in Vermont, with the goal of increasing provider confidence and improving MAT delivered in the primary care setting. The study found that learning collaboratives were effective in engaging physicians, patient access, and reducing practice variation.

Improved Access. The Hub & Spoke program has made significant progress in addressing persistent access issues. During Performance Period 2, the program has engaged new "Spoke" buprenorphine prescribers in underserved areas, including Chittenden County, where SUD treatment provider shortages remain. Continued increases in the number of prescribing providers is the key to meeting demand. In addition, the program engaged in planning and vendor selection for a new "Hub" in St. Albans during Performance Period 2; the Hub will launch during Performance Period 3.

Challenges

Continued Insufficient Access. Treatment capacity continues to be insufficient to meet demand in many areas of the State. As described above, Vermont made progress toward improving access during Performance Period 2 and expects continued improvements during Performance Period 3.

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[2] Mohlman, MK, B Tanzman, K Finison, M Pinette, C Jones (2016), "Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont," *Journal of Substance Abuse Treatment* 67: 9-14.

[3] Nordstrom, BR, EC Saunders, B McLeman, A Meier, H Xie, C Lambert-Harris, B Tanzman, J Brooklyn, G King, N Kloster, CF Lord, W Roberts, MP McGovern (March/April 2016), "Using a Learning Collaborative Strategy With Office-based Practices to Increase Access and Improve Quality of Care for Patients With Opioid Use Disorders," *Journal of Addiction Medicine* 10 (2): 117-123.

Continued Information Exchange Challenges. Lack of information exchange around addiction treatment records and between addictions treatment providers and other health care providers was a continued challenge during Performance Period 2. Provider electronic medical record (EMR) systems are not sufficiently able to sequester substance abuse treatment data or allow for additional protections for certain types of data. In addition, Vermont providers have varied stances and have received conflicting legal advice around 42 CFR Part 2 -- even for providers not subject to the rule -- which has caused some providers to withhold patients' entire medical records from Vermont's Health Information Exchange (VHIE) if they have received substance use treatment, or to withhold all patients' data from the VHIE regardless of substance use treatment history. This area of work is further discussed in the Health Data Infrastructure focus area under the Data Warehousing milestone.

Accountable Communities for Health

Performance Period 2 Milestone: Feasibility assessment – data analytics:

1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15.

2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16.

3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16.

4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.

Vermont's Accountable Communities for Health (ACH) work seeks to align programs and strategies related to integrated care and services for individuals, with community-wide prevention efforts to improve health outcomes within a geographic community. Phase I of this work, which took place during 2015, focused on research to further define the Accountable Communities for Health (ACH) model and identify core elements. Phase II brings together multi-disciplinary teams from communities across the state in an Accountable Communities for Health Peer Learning Laboratory to further explore how this model might be implemented and develop community capacity.

Major Accomplishments

Launch of the ACH Peer Learning Laboratory. Project leadership worked to develop a second phase of work to follow Vermont's research into the Accountable Communities for Health concept during the July-December 2015 period, including soliciting input from the Population Health Work Group and Payment Model Design and Implementation Work Group in September and October 2015. The result of this process was a design for a peer learning opportunity, which became known as the Accountable Communities for Health Peer Learning Laboratory.

This Peer Learning Lab includes a series of in-person convenings and webinars to facilitate group learning, as well as local facilitation to support participating communities in building ACH competencies. Additional Peer Learning Lab goals include: dissemination of lessons learned from earlier research to explore the ACH concept, identification of communities in Vermont that are early leaders in this field, and developing recommendations to support Vermont in moving toward this model.

The ACH Peer Learning Lab had a soft launch in January 2016 with the release of recruitment materials and an informational webinar for interested communities. Participation in the ACH Peer Learning Lab was solicited through Vermont SIM participant lists, direct outreach with Blueprint practice and ACO leaders, and presentations to the Community Collaboratives described later in this document. In February 2016, ten community teams were selected from around the state, representing the majority of Vermont communities. Each of the teams includes broad representation of medical, community, and public health partners. Participating teams vary broadly in readiness for accountability in integrating population health and prevention within its community health reforms. Vermont worked with a curriculum design and facilitation contractor during the January-June 2016 period to perform additional planning and design work, as well as to administer a needs assessment for participating communities.

A kick-off webinar for participating communities and the first of three in-person convenings for communities were both held in early June. The full-day convening, held in Waterbury, included group learning activities as well as time for participants from each community to work together to set out their vision for change; evaluations of the event were extremely positive. Local facilitation to support communities in developing ACH competencies also began in June and will continue through the conclusion of the Peer Learning Lab in January 2017.

Continued Efforts to Link ACH Efforts with Existing Reforms. This initiative seeks to align with and leverage two other SIM-supported learning opportunities available to Vermont communities, the Integrated Communities Care Management Learning Collaborative and Community Collaboratives[4] (described in the Practice Transformation Focus Area section of this document). *Figure 3*, below, illustrates how these initiatives are intended to dovetail.

[4] Vermont previously referred to Community Collaboratives as Regional Collaborations/RCPCs/UCCs. The name has now been standardized.

Figure 3: Complementary Learning Opportunities

Increased Connections with ACH Initiatives Across the Country. Vermont's previous ACH research and the Peer Learning Lab efforts have resulted in new knowledge of, and connections to, other states and communities working on similar initiatives. In addition to the case studies of communities around the country developed during Phase I of Vermont's ACH work, Peer Learning Lab participants have benefitted from a webinar featuring ACH initiatives in Minnesota and Washington, and SIM staff spoke about the Peer Learning Lab on a NASHP webinar with California, Minnesota, and Washington.

Challenges

Reform Fatigue. Some communities participating in the Peer Learning Lab have expressed confusion and concern about the number of simultaneous regional reform initiatives underway in Vermont, including the SIM-supported initiatives like the Peer Learning Lab, Community Collaboratives, the Integrated Communities Care Management Learning Collaborative, Medicaid Pathway reforms, and the Integrating Family Services program. State staff and partners are working closely together to ensure these reforms all contribute to a cohesive vision, and to coordinate activities and approach to minimize community confusion.

Prospective Payment System – Home Health

Performance Period 2 Milestone:

1. ***Creation of a project plan and begin Phase 1 activities as required by project plan for PPS-HH by 12/31/15.***
2. ***Design PPS program for home health for launch 7/1/16.***

As a result of stakeholder support in the state, legislation was passed in 2015 requiring that DVHA, in collaboration with the State's home health agencies, develop a prospective payment system (PPS) for home health payments made by DVHA under traditional Medicaid (exclusive of waivers) to be put in place by July 1, 2016.

After commencing collaboration on the design of such a system, DVHA and Vermont's home health agencies reached consensus that the PPS would be comprised of episode-based payments (60 days in length, similar to Medicare) that will be adjusted for case acuity. DVHA developed five acuity groupings and presented them to the provider association for feedback. Based on feedback received, acuity adjustment factors were finalized and a fiscal impact was developed for each provider. DVHA and providers met to review the potential fiscal impact of the model change. Based on results of these analyses, it was agreed that more time was needed to develop an incremental approach to the implementation of the prospective payment system.

At the request of home health providers around the state, Vermont's Legislature delayed implementation of this model until July 1, 2017. In April 2016, after internal discussion and

discussion with CMMI, Vermont's SIM project suspended this effort and eliminated this milestone in Performance Period 3.

Prospective Payment System – Designated Agencies

Performance Period 2 Milestone: Submit planning grant for Certified Community Behavioral Health Clinics to SAMHSA by 8/5/15. If awarded, begin alignment of new opportunity with SIM activities. *(Note: No SIM funds used to support this effort.)*

As part of a multi-stakeholder collaborative effort, Vermont successfully prepared and submitted a Certified Community Behavioral Health Clinics planning grant application during Performance Period 2. Upon additional consideration and internal discussion, it was determined that the CCBHC framework would not optimally align with the various other payment reforms either being implemented or contemplated for future implementation in Vermont.

In an attempt to prioritize payment reform development for Vermont's Designated Agencies that would be better integrated with other efforts in the state, activities in support of this work stream were transferred to the Medicaid Value-Based Purchasing/Medicaid Pathway SIM work stream. Activities in support of this transition that occurred in Performance Period 2 include the convening of providers and other key partners to determine how best to serve Vermonters through a more integrated continuum of Mental Health, Substance Abuse and Developmental Services and preliminary work toward designing a value-based payment model specifically for the Designated Agencies. Such design work and further multi-stakeholder collaboration will continue throughout Performance Period 3.

All-Payer Model and *State Activities to Support Model Design and Implementation – GMCB*

Performance Period 2 Milestone – All-Payer Model:

1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI.

2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.

Performance Period 2 Milestone – State Activities to Support Model Design and Implementation – GMCB:

1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16.

2. Specific regulatory activities and timeline are dependent on discussions with CMMI.

During Performance Period 2, Vermont continued to explore an All-Payer Model (APM) which will build on existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Vermont performed research and analytics to inform decision-making around the APM, made significant strides in coming to agreement with CMMI and CMCS on the APM and related Medicaid waivers, prepared for potential APM implementation, and performed stakeholder education on the model.

Major Accomplishments

Publishing Term Sheet. Vermont proposed a draft All-Payer Model term sheet to CMMI on January 25, 2016. The term sheet set out the basic outline for a potential All-Payer Model agreement, including the legal authority of the state to enter into such an agreement, the performance period for the agreement, waivers necessary to facilitate payment change and additional covered services, data sharing, and an evaluation of the demonstration. The draft term sheet was shared publicly, along with a one-page summary document and a companion paper explaining key facets of the model and its intended impact to support stakeholder outreach and public process, including legislative testimony by key APM project leadership and staff.

Development of Population Health Measures Aligned with State Health Improvement Plan. APM project leadership and staff worked across GMCB and AHS, including with Vermont's Department of Health, to ensure that APM goals were aligned with Vermont's State Health Improvement Plan (SHIP), a key population health vision and strategy document. Through this collaborative effort, Vermont identified population health metrics that have broad buy-in across State government and private-sector stakeholders. This effort to come to agreement on goals and measures across silos is one of the biggest achievements of the APM, in addition to the broad movement away from fee-for-service payment. If Vermont is successful in reaching a final APM agreement, we will be the only state using population health measurement on a statewide basis with such broad total cost of care. Target-setting for measures was supported by Vermont's contract with Onpoint[5], which assessed benchmarks for potential measures.

Analytics. Vermont relied on the Optimus model to provide analytics and model potential benefits from the APM. Optimus found that there was potential for savings within this ACO model. In addition, Optimus and other contractors provided iterative analyses of potential model components in real time as they were proposed for inclusion in the APM (e.g., introduction of a soft floor, impact of including fee-for-service within total cost of care targets). The analytics were also used to validate and assess proposals from CMMI.

Stakeholder Engagement. Stakeholder outreach and public process to vet the proposed APM model design have been ongoing.

[5] Not SIM funded.

- *Term Sheet Review and Vetting*: Stakeholder engagement around the draft term sheet began in late January 2016 following the release of the term sheet and companion documents, and continued throughout Spring 2016. GMCB held two days of public meetings to discuss the proposed term sheet on January 28 and 29, 2016, which were well attended by stakeholders; concurrently, key APM project leadership and staff testified before relevant legislative committees to explain the term sheet and prospective model to Vermont's policy makers.
- *Population Health Outcomes and Quality Targets*: GMCB conducted four stakeholder meetings to gather feedback on the proposed APM measure set, with the goals of ensuring a close relationship between APM measures and Vermont's health reform priorities and population health goals, as well as assessing feasibility of measure collection. Feedback from this group led to changes in targets and measure specifications to support smooth measure collection and limit administrative burden on providers.
- *ACO Payment Sub-Committee*: The ACO Payment Sub-Committee, also known as the MOU Group, was convened by GMCB staff and met over the course of 18 months. This group facilitated provider-led discussion of the APM, focusing on fostering care integration to meet health reform goals.
- *Additional Stakeholder Engagement*: APM project leadership and staff have also engaged with a variety of formal stakeholder groups not specifically convened for this purpose to review the proposed model and answer questions, including Vermont's SIM Work Groups and Steering Committee; the Blueprint for Health Field Team; and the Department of Disabilities, Aging, and Independent Living Advisory Board. The GMCB has presented to and received feedback on the APM project from its own Advisory Committee as well. Staff also delivered formal presentations and had informal information sessions with interested provider and consumer groups, including Vermont's Visiting Nurses Associations and the Coalition of Vermont Elders Board.

Regulatory Framework Development. With the passage of Act 113 of 2016, the GMCB takes on formal, ongoing regulation of ACOs, rather than solely providing guidelines for participation in alternative payment model pilot projects. Via Act 113, the GMCB will adopt a rule to formally oversee ACOs participating in alternative payment arrangements with Medicaid and/or commercial payers beginning January 1, 2018. The rule will provide for a certification process as laid out in Act 113 and oversight of ACO budgets. Used in conjunction with the Board's existing insurance premium rate setting authority, hospital budget review authority, and certificate of need approval process, ACO oversight will provide for powerful regulatory supervision of system-wide spending and changes to payment models and incentive structures. The Board will set Medicare and commercial rates for ACOs participating in a modified Next Generation risk bearing ACO program, and will review and advise on the rate for ACOs also participating in the Medicaid all-inclusive population based payment program for ACOs.

Challenges

Project Scope. As with any major project, the APM faced challenges related to size and scope. These include logistical and implementation challenges (e.g., the development of provider capacity to implement the model and regulatory infrastructure within State government).

New Federal Policy Initiatives. New federal policy initiatives introduced during 2015 and 2016 (e.g., CPC+ and MIPS/MACRA) have created a complex policy environment for the development and negotiation of an APM framework. In particular, providers have struggled to understand these various models and what their options are under each, especially during sensitive APM negotiation periods during which the State has been unable to share information on all aspects of negotiations and potential terms.

Stakeholder Confusion. Stakeholder confusion about the APM framework and its impact has posed a significant challenge for APM project leadership. Despite available public information and public presentations on the model, its goals, and its expected outcomes, misunderstanding and misinformation are common, especially among consumers, and in particular among Medicare beneficiaries with valid concerns that their entitlement benefits could change if a state is granted waivers from the federal Medicare program. Vermont has worked to clarify key model components using materials and presentations geared toward a variety of different audiences, and will continue to do so.

State Activities to Support Model Design and Implementation – Medicaid

Performance Period 2 Milestone: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate.

1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15.

2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15.

3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16.

4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan.

5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16.

6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16.

7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.

For all Medicaid payment models that are designed and implemented as part of Vermont's SIM grant activity, there are a number of Medicaid-specific state activities that must occur. These activities ensure that Vermont Medicaid's SIM-supported activities are in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries.

During Performance Period 2, several milestones in support of this work stream were specifically related to the Vermont Medicaid Shared Savings Program. In addition to ensuring that policies and procedures were in place for appropriate member service and support (i.e. having an operational call center to address inquiries about the program) and implementing an ongoing, data-driven monitoring and compliance plan, significant time was invested in obtaining State Plan Amendment approval for both Year 1 and Year 2 of the program.

Vermont was also successful in completing research and design activities related to the Frail Elders project. This research resulted in findings and recommendations being presented to a number of Vermont SIM work groups and the Vermont SIM Steering Committee at the end of Performance Period 2. (Additional information about the project and its findings can be found at the following link: Frail Elders Project Website).

Additional milestones related to Medicaid Episodes of Care (State Plan Amendment approval; developing of monitoring and compliance plans) and Integrated Family Services were revised during the course of Performance Period 2 to reflect corresponding changes to related milestones. Where appropriate, such milestones will be addressed as a part of the Medicaid Value-Based Purchasing/Medicaid Pathway work stream during Performance Period 3.

Milestones Achieved, Major Accomplishments, and Challenges: Practice Transformation

Practice Transformation activities are critical for supporting provider readiness to transition to, and participate in, alternative payment models. During Performance Period 2, Vermont's SIM project maintained and expanded successful initiatives. Activities during this period included:

- Continuing and expanding existing *Learning Collaborative* activities;
- Continuing the *Sub-Grant Program* including sub-grant projects and technical assistance for grantees;
- Expansion and continued development of *Community Collaboratives, formerly known as Regional Collaborations,* to align Blueprint for Health and ACO governance and quality improvement activities; and
- *Workforce* activities, including continued analyses of workforce supply data and launch of a micro-simulation workforce demand modeling effort.

Table 4, below, summarizes progress across the Practice Transformation Focus Area for all Performance Period 2 milestones. The remainder of this section details accomplishments and challenges within each work stream.

Table 4: Performance Period 2 Milestone Summary – Practice Transformation Focus Area

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
Learning Collaboratives	Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	Achieved: Vermont expanded the Integrated Communities Care Management Learning Collaborative to an additional 8 communities in September 2015. 1. Achieved: Expansion plan proposed in April 2015. 2. Achieved: Expansion to 8 new communities began in September 2015. • Vermont's Learning Collaboratives share and diffuse best practices for care coordination and help multi-organizational teams deliver care most effectively. This work has grown to encompass two initiatives: The Integrated Communities Care Management Learning Collaborative and a Core Competency Training Series for front-line care management staff. • The Integrated Communities Care Management Learning Collaborative works to engage as many patient-facing care providers within each community as possible, including: nurses; care coordinators; social workers; mental health clinicians; physicians; and others from a broad spectrum of health, community and social service organizations that includes primary care practices, community health teams, home health agencies, mental health agencies, Area Agencies on Aging, housing organizations, and social service organizations. Participants are convened for at least four in-person learning sessions and multiple webinars, as well as regular local meetings to support transformation. A cohort of 8 additional communities joined the Learning Collaborative in September 2015, with the first in-person learning sessions occurring in November 2015. Activities will continue through December 2016. • The Core Competency Training initiative offers a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide. Core curricula will cover competencies related to care coordination and disability awareness. Trainings launched in March 2016; in total, there will be 34 separate training opportunities available to up to 240 participants statewide.
Sub-Grant Program – Sub-Grants	Continue Sub-Grant Program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees	Achieved: Sub-Grant Program continued throughout Performance Period 2. 1. Achieved: Convening held for all sub-grantees on June 17, 2016. 2. Achieved: Quarterly reports were collected, reviewed, and disseminated project-wide each quarter during Performance Period 2.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	using lessons from sub-grantees to inform project decision-making.	• The Vermont SIM Provider Sub-Grant Program held its third convening on June 17, 2016. The event featured representatives from the 12 sub-grantees, along with SIM work group participants and other key stakeholders. Participants were treated to a story-telling format as the projects shared case studies and significant outcomes from their work. • Quarterly reports are filed by each of the sub-grantees. These are reviewed and compiled so that the materials can be posted to the Vermont SIM website and shared project-wide via the Vermont SIM Newsletter – a monthly email communication that is sent to the entire project participant list.
Sub-Grant Program – Technical Assistance	Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.	Achieved: Technical support is available upon request to all of the sub-grantees. 1. Achieved: Sub-grantees receive frequent communications about the project and are reminded of the opportunity to avail themselves of technical assistance as necessary. 2. Achieved: Technical assistance contracts are reviewed on a periodic basis and amended as necessary to ensure that resources are fully available to meet the needs of sub-grantees. • Sub-grantees continue to receive technical assistance.
Regional Collaborations	Expansion of regional collaborations[6] to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	Achieved: All 14 HSAs developed Community Collaboratives (previously known as Regional Collaborations) – including drafting a Charter and establishing a governing body and a decision-making process – by 6/30/16. • Within each of Vermont's 14 Health Service Areas, Blueprint for Health and ACO leadership have merged their work groups and chosen to collaborate with stakeholders under a single unified health system initiative. Community Collaboratives include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and a shared governance structure with local leadership. These groups focus on reviewing and improving the results of core ACO Shared Savings Program quality measures, supporting the introduction and extension of new service models (including Learning Collaboratives and Accountable Communities for Health), and providing guidance for medical home and community health team operations.

[6] These are now referred to as Community Collaboratives.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
		• In addition to forming and developing a standardized process for operation of Community Collaboratives, teams have begun to implement some innovative and exciting quality improvement projects with a wide range of foci including: increasing hospice and palliative care utilization, reducing ED utilization, reducing readmissions, improving care for people with chronic illness, CHF reduction in admission to the hospital, improved immunization rates for adults, developmental screening rates improvement for adolescents, reduction in medication assisted treatment(MAT) waiting times, and the Integrated Communities Care Management Learning Collaborative. Evaluation of these quality improvement initiatives is ongoing, and we are just beginning to reach a point where data can be analyzed to inform future planning initiatives.
Workforce – Demand Data Collection and Analysis	1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval). 2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.	1. Achieved (with delay): A contract for micro-simulation demand modeling was executed in May 2016. 2. Achieved (with delay): Preliminary data was provided to micro-simulation demand modeling contractor in May 2016. • A micro-simulation demand model will use Vermont-specific data to identify future workforce needs for the State based on various assumptions about care delivery in a high-performing health care system. The contractor for this work will create a demand model that identifies ideal workforce needs for Vermont in the future. The model will demonstrate need under various scenarios and parameters. • Contract execution was delayed until May 2016, at which time the state and vendor conducted a kick-off meeting and begun regular monthly status calls. State staff and internal/external stakeholders have been participating in monthly calls and furnishing data to the vendor as requested. • The Vendor has run preliminary demand projections on several medical professions, with more to be added in future months, and has begun calibrating the model.
Workforce – Supply Data Collection and Analysis	Continue to use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 4 times between 1/1/15 and 6/30/16.	1. Achieved: Workforce supply data was presented to the Workforce Work Group five times between 1/1/15 and 6/30/16. 2. Achieved: Surveys and statistical reports for each profession are published on the VDH website on a rolling basis. 3. Achieved: Reports and analyses are distributed to project stakeholders and other interested parties on a rolling basis, including at Workforce Work Group meetings and by posting to the VDH website.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	2. Publish data reports/analyses on website by 12/31/15. 3. Distribute reports/analyses to project stakeholders by 12/31/15.	• Vermont's Office of Professional Regulation (OPR) and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the state's health care workforce through the collection of licensure and relicensure data and the administration of surveys to providers during the licensure/relicensure process. Surveys include key demographic information for providers, and are used for workforce supply assessment and predicting supply trends, as well as informing future iterations of Vermont's Health Care Workforce Strategic Plan and other workforce planning efforts. • Representatives from OPR and VDH report to Vermont's health care workforce stakeholder work group on a regular basis, in order to present data and obtain feedback from subject matter experts. Updates were provided to the work group in April and October 2015, and February, April, and June 2016. • Staff, work group stakeholders, and VDH have begun conducting "deep dive" analyses on specific professions, beginning in June 2016.

Learning Collaboratives

Performance Period 2 Milestone: Offer at least two cohorts of Learning Collaboratives to 3-6 communities:

1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. (Achieved)

2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16. (Achieved)

During Performance Period 2, Vermont continued to implement the Integrated Communities Care Management Learning Collaborative in 11 communities. Three communities participated in a pilot cohort, launched during Performance Period 1. Based on early success and high community demand, the Learning Collaborative expanded statewide to share tools and diffuse best practices for care coordination for Vermonters with complex needs.

The Learning Collaborative is complemented by a Core Competency Training series, newly launched in Performance Period 2. The Core Competency Training initiative offers a comprehensive training curriculum to front line staff from a wide range of medical, social, and community service organizations conducting care coordination in communities statewide. Core curricula covers competencies related to care coordination and disability awareness, and reinforces and expands upon the disability awareness briefs and the Integrated Communities Care Management Learning Collaborative curriculum.

Major Accomplishments

Expansion of Integrated Communities Care Management Learning Collaborative. The Integrated Communities Care Management Learning Collaborative expanded from an initial cohort of 3 communities to 11 communities. It now covers almost every region in the state, and has served over 250 Vermonters with complex care needs. During rollout of the second cohort, project staff were able to leverage key concepts, tools, and faculty, and harness lessons learned from the project's initial launch.

In Performance Period 2 communities across the state made significant progress in expanding the knowledge and use of care coordination tools contained in the Integrated Communities Care Management Learning Collaborative toolkit. Inspired by the work of the Blueprint Project Manager and the OneCare Vermont Clinical Consultant, many communities have developed training materials and conducted community-wide trainings following a "train-the-trainer" model. Initial reports indicate that trainings are attended both by additional staff within organizations participating in the Learning Collaborative and staff from organizations that have not previously participating in the Learning Collaborative.

Sustainability Planning. Though formal Learning Collaborative activities will wrap up during Performance Period 3, the work of improving integrated care management will continue. With support from in-person learning sessions and dedicated quality improvement facilitators, a strong network of passionate and dedicated partners has emerged in communities statewide which will continue the work of improving care coordination for complex Vermonters. A tool-kit highlighting the main interventions, tools, and workflows identified through the Learning Collaborative will be made publicly available, as will the full curriculum presented at in-person learning sessions.

Launch of Core Competency Training Series. As the impact of the Integrated Communities Care Management Learning Collaborative continues to spread, project leaders and participants identified a need for training on key skills associated with care coordination and disability awareness. Interest in this training series has exceeded expectations from the start and required Vermont to add additional training sessions in order to meet demand. The trainings continue through the remainder of 2016, including supplemental workshops in mental health and addiction, and training for managers and supervisors. Evaluations have reflected consistently positive experiences, despite the challenges of training such a diverse group of providers with varying levels of experience and expertise. Specifically, participants have reported a great value in exposure to the varying perspectives represented in the room, and have appreciated the networking opportunity as well.

In order to ensure sustainability of training materials beyond the initial training period, sessions are being filmed and all materials will be made available in an online format; the training series also includes a “train-the-trainer” workshop to ensure that trainers are embedded throughout the state to build on the long-term capacity among Vermont providers.

Challenges

Implementation and Roll Out. The Integrated Communities Care Management Learning Collaborative grew out of a collection of best practices and learning objectives identified through a combination of national literature reviews and expert findings, as well as Vermont provider experience. As the Learning Collaborative developed, staff grappled with common implementation challenges such as building momentum, articulating program goals, developing a model of care based on previously identified best practices, and identifying tools and faculty to effectively communicate.

Beneficiary Engagement. Learning Collaborative communities have occasionally struggled to engage beneficiaries in this type of person-driven care. Often, the lives of Vermonters with complex care needs are such that it can be difficult to develop trust and a recognition of the benefit of this type of program on their lives. That said, success stories of engaging even the hardest to reach Vermonters have emerged, and very experienced care coordination staff are reporting progress in areas that were previously stalled. While communities have reported

making headway in patient engagement, many still struggle with uptake of the Learning Collaborative-specific patient experience survey.

Provider Engagement and Intra-Community Dynamics. Despite great progress in provider team recruitment and engagement, tensions have arisen in some communities when providers perceive one another as in competition for resources, especially financial resources.

Information Sharing and Measurement. Despite significant progress, as described below in the Health Data Infrastructure section, health information technology systems in Vermont do not fully support the need of interdisciplinary cross-organization care teams to share information in real-time. The care teams need data related to care transitions, acute events, and ongoing maintenance of the shared care plan.

Sub-Grants

Performance Period 2 Milestone: Continue sub-grant program:

1. Convene sub-grantees at least once by 6/30/16.

2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

During Performance Period 2, Vermont continued to implement the VHCIP Provider Sub-Grant Program. The program launched in 2014, and is providing nearly $5 million in funding to directly support Vermont providers in pursuing innovation.

Major Accomplishments

Third Provider Sub-Grant Symposium. Vermont organized and held the third in a series of Provider Sub-Grant Symposia on June 17, 2016, in Montpelier. The 12 sub-grantees presented case studies to their peers, project leadership, and other stakeholders to highlight their project learnings to date in a story-telling format. Each sub-grantee provided slides and presented short case studies; featuring a discussion of lessons learned and best practices. Themes observed throughout the event include:

- *A focus on provider led reforms.* Several presenters noted that the key to the design and implementation of successful reforms will hinge upon the willingness of providers to lead innovative programs and be architects of change in their practices and communities.
- *Data.* Nearly every sub-grantee discussed the critical role of data in fostering success, including timely access to performance data, ease of sharing patient data to support clinical care, and linking outcomes with data. Sub-grantees also highlighted the need to leverage EMRs more effectively to support data collection, analysis, and reporting.
- *Promoting existing resources and community resources.* Several sub-grantees noted that they have forged new connections to help deliver better care with existing resources

within their own communities. Limited resources have forced sub-grantees to be creative and to seek out and form new alliances across the care continuum and with new potential funders.

Sub-Grantee Successes. As sub-grants wrap up, grantees and the State are gathering information on successes, challenges, and lessons learned, and have identified a handful of sub-grants with particularly exciting early results. Recent highlights include:

- The Pursuing High Value Care for Vermonters Project was led by The Vermont Medical Society Education and Research Foundation in Collaboration with Vermont's Hospitalist Physicians and the University of Vermont Medical Center Department of Pathology and Laboratory Medicine. The project was designed to reduce wasteful and unnecessary laboratory tests for low-risk surgical candidates in the region, with the goal of reducing harm to patients and conserving system resources by making the best possible use of laboratory tests. Using a collaborative approach, the project team considered the best medical evidence and quality improvement science, evaluated current test ordering profiles and patterns, and developed an organized plan to optimize testing and a plan to sustain these practices. More than 30,000 Vermonters are currently included in the collaborative data set, and the project involved ten faculty members, nine hospital teams made up of 47 members, 60 medical residents, and at least as many medical students. Targeting five procedures, the project reported an annual estimated reduction of 2,917 lab tests and a 105-liter reduction in blood drawn from hospitalized patients.
- Community Health Accountable Care (CHAC), an Accountable Care Organization (ACO) participating in Vermont's Medicaid and commercial Shared Savings Programs (SSPs) as well as in Medicare's Shared Savings Program, received a sub-grant to increase provider collaboration across the continuum of care in local communities. Under the sub-grant, CHAC cooperated with other ACOs in the region, taking part in the Community Collaboratives and participating in the Vermont SIM Integrated Communities Care Management Learning Collaborative (described above). CHAC also designed a Quality Improvement Dashboard for the ACO, making it easier for providers to track patient care and for the organization to pull relevant data. They implemented a telemonitoring pilot which reported a 41% reduction in admissions. The telemonitoring program utilized a 4-step program to identify, enroll, engage, and monitor patients through daily telecommunication with patients and tailored workflows that allow the care team to closely follow patient progress.
- The Transitional Care Program at Southwestern Vermont Medical Center sought to ensure coordinated care transitions, especially for older adults with complex health needs. Adapting the Transitional Care Model in a rural context, this project aimed to design and share plans of care, and identify gaps in the delivery of integrated health care in the Bennington Health Service Area (HSA). The project also created an interdisciplinary Community Care Team to better meet the needs of behavioral health patients and those with drug and alcohol addictions who frequent the Emergency Department(ED) at Southwestern Vermont Medical Center. One hoped-for outcome is to decrease the number of hospital admissions and ED visits of high-risk chronic care

patients in the region. Data from 120 days before and after participation in the Transitional Care Program demonstrate a 25.8% reduction in ED encounters and a 68% reduction in inpatient admissions for participants. Focusing on high risk populations, patient self-management, and shared decision making, the program received high patient satisfaction ratings.

- RiseVT is a project of Northwestern Medical Center and will continue to receive sub-grant support through November 2016. The goal of RiseVT is to increase the overall health of the population and reduce the prevalence of chronic diseases including cardiovascular disease, cancer, chronic obstructive pulmonary disease, diabetes, and asthma in Franklin and Grand Isle counties. Toward that end, the project seeks to increase the number of employers offering a wellness program in which more than 50% of their employees participate and to expand resources for biking and walking in the region. The project has engaged individual clients, schools, businesses, and municipalities, and has harnessed social media to raise awareness of the RiseVT program. RiseVT has facilitated a number of community-wide policy changes to improve the health of its residents, including: the Alburgh school district extended their school day by 15 minutes to provide recess to all students K-8; Swanton schools designated one 'Walking Wednesday' per month; the St. Albans City Pool removed all candy and soda from concession stands; Swanton, St. Albans, and Highgate collaborated to improve their sidewalks, walkability, and bikeability by engaging professional municipal planning services; and the St. Albans Select Board recently voted to mandate the creation of sidewalks as part of any development project.

Challenges

Sustainability. As the Sub-Grant Program ends, some sub-grantees have reported success in seeking out and securing new funding, while several have reported that they cannot continue their work without additional funds.

Reforms apply to a sub-set of patients. Provider practices report that they are challenged by models that apply only to a sub-set of patients. Providers aim to deliver better and more coordinated care to all of their patients, which is challenging when reforms apply to a fraction of the patient panel.

Sub-Grants – Technical Assistance

Performance Period 2 Milestone: Achieved: Technical support is available upon request to all of the VHCIP Provider Sub-Grant Program projects.

1. Achieved: Sub-grantees receive frequent communications about the project and are reminded of the opportunity to avail themselves of technical assistance, as necessary.

2. Achieved: Technical assistance contracts are reviewed on a periodic basis and amended, as necessary, to ensure that resources are fully available to meet the needs of sub-grantees.

Vermont continues to support sub-grantees with technical assistance as requested through the end of the sub-grant program. As in past performance periods, contractors are available for technical assistance as requested by sub-grantees and approved by project leadership. Several sub-grantees have taken advantage of technical assistance available to support the design of evaluation methodologies, as well as data profiling and analytics services.

Major Accomplishments

Sub-Grantees Continue to Receive Technical Assistance as Needed. Sub-grantees continue to receive technical assistance from a variety of contractors upon request.

Challenges

Concerns Over Future Access to Sub-Grant Data. Some sub-grantees have used technical assistance available through the Sub-Grant Program to perform data analyses that support their work. Some are worried about losing access to this data once sub-grant support and technical assistance contracts end. Vermont is currently working to find solutions to address these needs.

Regional Collaborations

Performance Period 2 Milestone: Expansion of regional collaborations[7] to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.

During Performance Period 2, Community Collaboratives -- formerly known as Regional Collaborations -- continued to mature and evolve within each of Vermont's 14 Health Service Areas. Community Collaboratives, led by Blueprint for Health and ACO leadership, work together with local stakeholders to develop a single unified regional health system. Community Collaboratives include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and follow a shared governance structure with local leadership. These groups focus on reviewing and improving the results of core ACO Shared Savings Program quality measures, supporting the introduction and extension of new delivery system models (including Learning Collaboratives and Accountable Communities for Health), and providing guidance for medical home and community health team operations.

[7] These are now referred to as Community Collaboratives.

Major Accomplishments

Establishing Collaboratives and Unifying Communities Around Shared Vision. During Performance Period 2, communities made great progress in their efforts to establish shared community-wide governance structures, and then to work together to define the needs, priorities, and overarching vision for each community. Collaborations in all 14 HSAs matured in key ways during Performance Period 2, developing Charters and identifying focus areas for quality improvement efforts. Regions have also worked to engage consumer representatives to help guide quality improvement activities and support person-centeredness. Additionally, teams have established protocols for regular sharing of ACO and Blueprint for Health data profiles to ensure that all quality improvement efforts are data driven and evidence-based.

Identifying and Implementing Key Focus Areas for Quality Improvement. Based on the local data, Community Collaboratives in all 14 HSAs have identified key focus areas and implemented quality improvement projects, and are just beginning to analyze and understand the results of these interventions. In addition to adoption of the Integrated Communities Care Management Learning Collaborative (see Learning Collaboratives, above) as a quality improvement initiative in 11 regions, additional areas of focus include: increasing hospice and palliative care utilization, reducing Emergency Department utilization, reducing readmissions, improving care for people with chronic illness, Congestive Heart Failure reduction in admission to hospital, improved immunization rates for adults, developmental screening rates improvement for adolescents, and reduction in wait times for medication assisted treatment (MAT) for opioid addiction.

Establishing Community Data Profiles. Blueprint for Health and ACO leadership worked closely together to develop community profiles during Performance Period 2. These profiles, which merge clinical and claims-based data in a common accessible format, are a unique resource for community-based reform at all levels, from individual providers to Community Collaboratives to the State, and support: identification of priority focus areas within regions; quality comparison within and across regions; and payment models like the Blueprint for Health pay-for-performance reforms discussed in the Payment Model Design and Implementation Focus Area section of this report.

Challenges

Aligning Existing and New Infrastructure Around Common Reform Goals. With the establishment and maturation of ACOs in Vermont, much work was needed to understand how to align the ACO model with existing infrastructure and established programs in communities statewide. Establishing buy-in from local leaders, and then coming to agreement around numerous and diverse opinions was difficult, yet extremely important to the success of the Community Collaboratives. While work remains, communities have come a long way in unifying as a common team with shared goals and vision for the future.

Workforce – Demand Data Collection and Analysis

Performance Period 2 Milestone:

1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval).

2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.

During Performance Period 2, project staff worked with a vendor to finalize and execute a contract for micro-simulation demand modeling for various health care professions in an "ideal" state health care reform environment. The flexibility of the model will allow for inputting of various assumptions, scenarios, and parameters about care delivery in a high-performing health care system. Workforce Work Group members, along with other key stakeholders, inform development of model assumptions and scenarios.

Major Accomplishments

Demand Modeling Contract Kick-off. A contract was executed with IHSMarkit[8] in April 2016 to complete a microsimulation demand model. A kick-off meeting was held in May 2016. State personnel (including SIM staff, representatives from the Vermont's Department of Health, and Department of Labor) and several Workforce Work Group members attended as subject matter experts. Topics discussed at the kick-off included: a project timeline, with completion scheduled for January 2017; potential demand scenarios; and potential data sources to be used to tailor the demand model to Vermont's needs.

Monthly Meetings and Preliminary Data Runs. In June of 2016, State staff and IHSMarkit began holding monthly check-in meetings as a regular opportunity to share work completed to date and review any outstanding issues or questions that have arisen over the past month. By the end of Performance Period 2, IHSMarkit had completed Vermont-specific population projections, a preliminary run of demand projections for registered nurses, and began examining potential demand scenarios that would be specific to the Vermont health reform environment.

Challenges

Impact of Contract Execution Delays on Project Timeline. Due to delays in contract execution, the timeline for work to be performed under the demand modeling contract has been significantly compressed, with work beginning in May 2016 and final deliverables expected in December 2016-January 2017. This delay is not anticipated to negatively impact the work product under this contract, nor is it expected to impact other work streams. Both IHSMarkit and the State of Vermont have met all contract and timeline deliverables to date.

[8] Formerly IHSGlobal.

Workforce – Supply Data Collection and Analysis

Performance Period 2 Milestone: Continue to use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan.

1. ***Present data to Workforce Work Group at least 4 times between 1/1/15 and 6/30/16.***
2. ***Publish data reports/analyses on website by 12/31/15.***
3. ***Distribute reports/analyses to project stakeholders by 12/31/15.***

In Performance Period 2, Vermont staff worked closely with VDH and the Workforce Work Group to coordinate presentations of relicensure data to the work group and provide opportunities for VDH to obtain work group feedback on format and content of surveys and statistical reports. During this time, VDH staff began working with work group members who represent different professions as subject matter experts to further analyze data from their professions and present findings to the larger work group. These "deep dive" analyses will be used to inform the Workforce Strategic Plan, as well as identify potential areas (geographic and programmatic) for care delivery and workforce supply improvement. Survey and statistical reports for each profession are published on the VDH website as they are finalized.

Major Accomplishments

Data Presentations to Work Group. During Performance Period 2, VDH staff provided five presentations on survey and relicensure data from its most recent surveys for Dentist, Medical Doctor, and Physician Assistant professions in Vermont. VDH received feedback from work group members on the data, and the work group developed a process for moving forward with examining the data in a way that would be meaningful to stakeholders and their organizations. The work group piloted this new process at their April 2016 work group meeting, at which members from VDH and physician assistant members of the work group presented a deeper dive into the 2014 Physician Assistant Survey and Statistical Report that was published by VDH. The conversation continued at the group's June 2016 meeting, with the aim of using the data to increase the utilization of Physician Assistants in order to increase access to primary care in Vermont. The "pilot" was viewed as a success, and in the next Performance Period, there will be discussions about other professions in the primary care team and a number of mental health professions.

Challenges

Staff Turnover. At the beginning of Performance Period 2, an additional staff person (1 FTE) was hired to assist with survey development/administration and analysis at the Vermont Department of Health. The position became vacant at the end of 2015 for several months, with new staff hired at the end of Performance Period 2. Staff turnover presents challenges, such as increased work load for other staff, and lost productivity due to training and a steep learning curve for new staff.

Milestones Achieved, Major Accomplishments, and Challenges: Health Data Infrastructure

Vermont is implementing a statewide approach toward achieving interoperability and accessibility of clinical and patient information at the point of care and for use in population health management. Vermont has identified sharing of high quality, timely data as a necessary component of a successfully reformed system. Health data infrastructure that allows for accurate, timely, and analyzable health information exchange supports providers' readiness to participate in alternative payment models by enabling high-quality, coordinated care across the care continuum. It also supports ACOs, payers, and the State in targeting interventions, making policy decisions, and evaluating the effectiveness of interventions.

During Performance Period 2, Vermont's SIM project maintained and expanded successful initiatives. Activities during this period included:

- Continued *Gap Remediation* efforts that seek to expand connectivity and completeness of the data within the VHIE;
- Continued work to *Improve Quality of Data Flowing into the VHIE*;
- Development of a *Telehealth Strategic Plan* and implementation of *Telehealth Pilots*;
- Continued work on *EMR Expansion* to providers who previously lacked Electronic Medical Record (EMR) systems;
- Development and strategic planning related to *Data Warehousing*;
- Continued efforts to design and implement *Care Management Tools*; and
- Ongoing *HIE Planning*, with *Expert Support* as necessary.

Table 5, below, summarizes progress across the Health Data Infrastructure Focus Area for all Performance Period 2 milestones; the remainder of this section details accomplishments and challenges within each work stream.

Table 5: Performance Period 2 Milestone Summary – Health Data Infrastructure Focus Area

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
Expand Connectivity to HIE – Gap Remediation	Remediate data gaps that support payment model quality measures, as identified in gap analyses: 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15.	1. Achieved: The number of ACO Organizations with live interfaces to the VHIE increased from 14 to 68 by 12/31/2015, while the percentage of OneCare Vermont beneficiaries that were able to be represented in Quality Measure reporting increased from 17% to 64%. 2. Achieved: In late 2015, planning for the DLTSS Gap Remediation project began to address technical and policy challenges to connecting the Home Health Agencies (HHAs) and Area Agencies on Aging (AAAs) to the VHIE; the project was formally approved in January 2016. • The Gap Remediation project addresses gaps in connectivity and clinical data quality of health care organizations (HCOs) to Vermont's Health Information Exchange. The ACO Gap Remediation component improves the connectivity for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Network (VCN/BHN) Gap Remediation improves the data quality for the 16 Designated Mental Health and Specialized Service Agencies (DAs and SSAs). The DLTSS Gap Remediation effort to increase connectivity for Home Health Agencies was approved in January 2016 based on the results of the DLTSS Information Technology Assessment. Gap Remediation efforts for ACO member organizations and Vermont Care Partners dovetail with the data quality improvement efforts described under the "Improve Quality of Data Flowing into HIE" work stream.
Improve Quality of Data Flowing into HIE	1. Implement terminology services tool to normalize data elements within the VHIE by 6/30/16. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.	1. Achieved: Terminology Services hardware and software implementation were completed in June 2016. 2. Achieved: Workflow improvement activities in at least 30% of provider practices began late in 2015. • The Data Quality Improvement Project includes analyses performed of ACO members' Electronic Medical Records on each of sixteen data elements. Additional data quality work with Designated Agencies seeks to improve the quality of data and usability of data for this part of Vermont's health care system. Vermont Information Technology Leaders (VITL) has engaged providers and makes workflow recommendations to change data entry to ensure the data elements are captured. In addition, VITL is performing comprehensive analyses to ensure that each data element from each HCO is formatted identically. VITL is working with the HCOs to perform some or all of the following: (1) changing the method of data entry; (2) changing the format used to capture data in partnership

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
		with the EMR vendor; and (3) using a terminology service to transform and standardize the data within the VHIE.
Telehealth – Strategic Plan	Develop telehealth strategic plan by 9/15/15.	Achieved: Telehealth Strategic Plan finalized in September 2015. • Telehealth Strategic Plan contractor JBS International convened the Vermont Telehealth Steering Committee in March 2015 to guide Telehealth Strategy development. Steering Committee members met biweekly via phone between March and July to come to consensus on a telehealth definition, identify guiding principles for the strategy, review key features on telehealth programs across the country, and develop strategy elements. • A draft Statewide Telehealth Strategy was submitted to DVHA in June 2015; JBS worked with State staff to refine the Strategy between June and September 2015. • The final strategy elements were approved by Vermont's SIM HIE/HIT Work Group (now the HDI Work Group), Steering Committee, and Core Team in August 2015. • The State of Vermont finalized the Strategy in September 2015 and released the final Telehealth Strategic Plan in mid-September 2015.
Telehealth – Implementation	1. Release telehealth program RFP by 9/30/15. 2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.	1. Achieved: RFP released on 9/18/15. 2. Achieved (with delay): Two successful bidders were selected in November 2015; contract execution occurred in July 2016 due to delays in contract negotiation and approval. • Vermont is funding pilot projects that can address a variety of geographical areas, telehealth approaches and settings, and patient populations. The primary purpose is to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. Projects were selected based on demonstration of alignment with the health reform efforts currently being implemented as part of Vermont's SIM project.
EMR Expansion	1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16). 2. Explore non-EMR solutions for providers without EMRs: develop	1. Achieved: EMR implementation for both the Vermont State Psychiatric Hospital and five Vermont Specialized Services Agencies was completed by June 2016. 2. Partially Achieved: Discussion is ongoing to help identify solutions for providers without EMRs, although financial and technical barriers present significant challenges for these organizations. The release of the new State Medicaid Director's Letter in February 2016 is influencing this work. Vermont anticipates meeting this milestone in Performance Period 3.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	plan based on LTSS technical gap analysis.	• The EMR Expansion work stream focuses on assisting in the procurement of EMR systems for non-Meaningful Use (MU) providers.
Data Warehousing	1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan). 2. Procure clinical registry software by 3/31/16. 3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.	1. Achieved: Implementation Phase 1 of the DA/SSA data warehousing solution complete. 2. Achieved: The clinical registry software was acquired in January 2016 and the system successfully went live in June 2016. 3. Delayed: Planning for the aggregation, analytics, and management of clinical and clinically related data in Vermont in ongoing; a diverse team of stakeholders are making steady progress and have expanded planning to include Data Governance. Vermont anticipates meeting this milestone in Performance Period 3. • The VCN Data Repository will allow the Designated Mental Health Agencies (DA) and Specialized Service Agencies (SSA) to send specific data to a centralized data repository. Long-term goals of the data repository include ensuring connectivity to the Vermont Health Information Exchange (VHIE), as well as Vermont State Agencies, other stakeholders, and interested parties. In addition to connectivity, it is expected that this project will provide VCN members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services, to demonstrate value, and to participate in payment and delivery system reforms. As of May 2016, the Data Repository had received 100% of member agency data for 2014 and 2105. • The Blueprint Clinical Registry project began in July 2015; it migrated Blueprint for Health clinical data from its previous environment to VITL's hosted infrastructure. • Statewide planning activities focus on developing a long-term strategy for data systems to support analytics. Vermont has convened a team of State stakeholders to discuss strategies for developing data systems to support the State's analytic needs.
Care Management Tools	Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development:	1. Achieved: All 14 Vermont hospitals are connected to the Event Notification Service. 2. Achieved: All timelines for this project were met; a technical proposal for this work stream was presented to the HDI Work Group in November 2015. • The Event Notification System (ENS) project has implemented a system to proactively alert participating providers regarding their patient's medical service encounters. VITL and the Vermont ACOs worked with the State to perform discovery and design of proposed ENS solutions. The selected ENS solution provides admission, discharge, and transfer data to participating providers.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out. 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.	Provider feedback on the service has been very positive. As of September 2016, notifications are being generated for 60,260 Vermonters. • The Shared Care Plan (SCP) project (formerly part of the SCÜP project) sought to provide a Shared Care Plan solution to Vermont's provider organizations. After electing not to pursue a technical Shared Care Plan solution, the project has refocused on reviewing and recommending revisions to consent policy and architecture to better enable shared care planning in the future. • The Universal Transfer Protocol (UTP) project (formerly part of the SCÜP project) sought to provide a Universal Transfer Protocol to Vermont's provider organizations. This project will provide support services to transform practice workflows to support UTP goals by helping providers across the care continuum to exchange critical data and information as they work together in a team-based, coordinated model of care; particularly when people transition from one care setting to another.
General Health Data – HIE Planning	1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015. 2. HDI Work Group will identify connectivity targets for 2016-2019 by 6/30/16.	1. Achieved: Throughout 2015 and early 2016, the HDI Work Group has participated on multiple occasions in the revision of Vermont Health Information Technology Plan (VHITP), which was submitted to the Green Mountain Care Board for approval in April 2016. 2. Delayed: The connectivity target methodology was proposed to the HDI Work Group in July 2016. The team will work with VITL and additional stakeholders to utilize this methodology and provide final targets in Performance Period 3. • The HIE Planning project resulted from a perceived gap in high-level planning and research in local and national best practices for developing a robust, interoperable health data infrastructure that is able to transmit accurate and current health information to providers across the care spectrum.
General Health Data – Expert Support	Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	Achieved: Vermont is deploying IT-specific support for health data initiatives as necessary and appropriate. • This is a companion project to all of the projects within the Health Data Infrastructure focus area. Due to the nature of those projects, Vermont needs specific skills to support the State and stakeholders in decision-making and implementation. The specific skills needed are IT Enterprise Architects, Business Analysts, and Subject-Matter Experts.

Expand Connectivity to HIE – Gap Remediation

Performance Period 2 Milestone: Remediate data gaps that support payment model quality measures, as identified in gap analyses:

1. ***Remediate 50% of data gaps for SSP quality measures by 12/31/15.***
2. ***Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15.***

The Gap Remediation project addresses gaps in connectivity and clinical data quality of Health Care Organizations (HCOs) to the Vermont Health Information Exchange (VHIE). The ACO Gap Remediation component improves the connectivity for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Network (VCN) Gap Remediation component improves the data quality for the 16 Designated Mental Health and Specialized Service Agencies (DAs and SSAs). Gap Remediation efforts for ACO member organizations and Vermont Care Partners dovetail with the data quality improvement efforts described under the "Improve Quality of Data Flowing into HIE" work stream. In addition, a DLTSS Gap Remediation effort to increase connectivity for Home Health Agencies and Area Agencies on Aging was approved in January 2016 based on the results of the DLTSS Information Technology Assessment.

Major Accomplishments

ACO Gap Remediation. In March of 2015, Vermont Information Technology Leaders (VITL), the State's designated vendor for managing the VHIE, began work with ACO member organizations to remediate gaps in clinical data quality, including interface development, electronic medical record (EMR) installation, clinical data analysis, and clinical data formatting. This work was initiated through Gap Analysis work completed in Performance Period 1 and the Performance Period 1 Carryover Period, which helped Vermont understand the current status of the health information landscape in Vermont. The ACO Gap Remediation project has achieved its connectivity and capability goals in Performance Period 2. The number of ACO Organizations with live interfaces to the VHIE increased from 14 to 68 by 12/31/2015. The percentage of OneCare Vermont beneficiaries that were able to be represented in Quality Measure reporting increased from 17% to 64%.

DLTSS Gap Remediation. In late 2015, planning began for the remediation of the identified DLTSS connectivity gaps. In January of 2016, the DLTSS Gap Remediation project was approved to address challenges to connecting the Home Health Agencies (HHAs) and Area Agencies on Aging (AAAs) to the VHIE. This project intends to connect the HHAs to the VHIE and appropriately onboard and educate HHA users onto the VHIE Provider Portal, known as VITLAccess. Efforts to connect AAAs has been more challenging because AAAs are not

considered Health Care Organizations under State definitions. This means they do not fall within the usual legal framework for health data.

Further gap analysis work was completed by VITL in the Spring of 2016. Moving forward, the focus will be to complete connections with the HHAs. Further policy and legal investigation will be necessary to begin work to connect the AAAs.

Challenges

Financial Challenges. The consistent issue in connecting HCOs to the VHIE continues to be funding and resource availability. While collaboration between Vermont's SIM team and the ACOs has helped ease the burden of both of these challenges, availability of implementation resources and ongoing operational costs are continually an obstacle for the HCOs.

Information Sharing and Measurement. Communities' information technology systems do not fully support the needs of interdisciplinary cross-organization care teams, both in terms of communicating around patients' needs, and in measurement and data collection.

Improve Quality of Data Flowing into HIE

Performance Period 2 Milestone:

1. Implement terminology services tool to normalize data elements within the VHIE by TBD.

2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.

The effort to improve the quality of the data flowing into the VHIE is centered around an initial analysis performed of ACO members' EMR on each of 16 data elements. Subsequently, workflow improvement activities occurred with participating practices to improve the data quality at the source systems. In addition, VITL performed comprehensive analyses to ensure that each data element from each HCO is formatted identically. VITL is working with the HCOs to perform some or all of the following: (1) changing the method of data entry; (2) changing the format used to capture data in partnership with the EMR vendor; and (3) using a terminology service to transform the data, which normalizes the clinical codes sent from the source system prior to integrating into the HIE.

Additionally, data quality work was conducted with Vermont's Designated Agencies (DAs) to improve the quality of data and usability of data for this segment of Vermont's health care system. VITL worked with the DAs and SSAs to continually engage providers and made workflow recommendations to improve data entry and ensure the data elements are properly captured. This work stream is discussed above under the Gap Remediation milestone section.

Major Accomplishments

Terminology Services. The Terminology Services Project was initiated to enhance clinical data quality in the VHIE by examining clinical data elements and translating those data elements into standardized code sets. Data elements converted into a standardized format are more interoperable across provider organizations and EMR systems. Implementation work began in February 2016, with ongoing configuration and user training through June 2016. This service also provides valuable data quality improvement for the ACO Clinical data quality measures.

Challenges

Resource Challenges. Data quality improvement relies heavily on the availability of the resources within HCOs to engage on workflow improvement initiatives. The need to allocate significant resources to these projects is an ongoing obstacle for HCOs to overcome as they prioritize internal information technology work.

Telehealth – Strategic Plan

Performance Period 2 Milestone: Develop telehealth strategic plan by 9/15/15.

In Performance Period 2, Vermont contracted with JBS International to develop a Statewide Telehealth Strategy to guide future telehealth investments. The Strategy, developed in collaboration between the State of Vermont and private sector stakeholders, includes four core goals: a coordinating body to support telehealth activities; alignment of state policies relevant to telehealth; telehealth technology investments that are secure, accessible, interoperable, cloud-based, and aligned with Vermont's HIT infrastructure; and clinician engagement. The Telehealth Strategy guided development of the telehealth pilots described below under the Telehealth – Implementation work stream.

Major Accomplishments

Convening of Telehealth Steering Committee. Vermont convened a public-private Telehealth Steering Committee to guide Telehealth Strategy development and make recommendations. This group included representatives from key State and private organizations and constituencies. They convened biweekly between March and July to come to agreement on a telehealth definition, identify guiding principles for the strategy, review key features on telehealth programs across the country, and develop strategy elements.

The commitment and diversity of the Telehealth Steering Committee was a critical success factor in developing a thoughtful and informed Telehealth Strategy. Diverse group membership assured development of a strategy that incorporated the knowledge, needs, and recommendations of a variety of sectors, and strengthened cross-organizational connections among individuals and organizations working on telehealth in Vermont.

Development and Approval of Telehealth Strategy. The Telehealth Strategic Plan will guide Vermont's future telehealth investments, and will ensure they are aligned with broader health reform goals as well as with existing and planned reforms. The Telehealth Strategic Plan identifies a consensus definition for telehealth, as well as some guiding principles for future telehealth activities in Vermont. The Telehealth Strategic Plan reviewed telehealth initiatives currently active in Vermont and across the country, describes four goals for telehealth in Vermont, discusses barriers to telehealth implementation, and identifies specific recommendations for State policymakers. It also seeks to align telehealth activities with future payment reform activities through a Roadmap intended to guide prioritization of telehealth projects based on how they could support clinical care within value-based payment methodologies as Vermont transitions away from volume-based payment for health care services.

Challenges

Rapidly Changing Technology and Environment. The Telehealth Steering Committee and contractor that supported development identified rapidly changing telehealth technology as a key challenge in developing a Telehealth Strategic Plan. Members noted that early telehealth technologies had significant drawbacks; for example, many active telehealth programs which provide real-time consultations rely on stationary videoconferencing equipment which is costly, hard to update, and often underused. Secure cloud-based interactive audiovisual approaches are emerging, as are wearables, increasingly popular devices which track person-generated data.

Telehealth – Implementation

Performance Period 2 Milestone:

1. Release telehealth program RFP by 9/30/15.

2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.

In September 2015, Vermont released an RFP seeking telehealth pilot projects to meet the principles and roadmap described in the Statewide Telehealth Strategic Plan and address a variety of geographical areas, telehealth approaches and settings, and patient populations. The primary purpose was to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. During late Fall and Winter 2016, Vermont worked with the two successful awardees to finalize contract terms and ensured proposals met State and federal guidelines.

Major Accomplishments

Launch of Telehealth Pilots. Both successful bidders launched work on telehealth pilot projects prior to the end of Performance Period 2.

- The VNA of Chittenden and Grand Isle Counties is developing its telehealth infrastructure by building connections among providers and enabling the timely sharing of clinical information. They are connecting telemonitoring records of several VNAs with their respective EMRs and then connecting that data to the VHIE through interfaces.
- The Howard Center, a major mental health and substance abuse treatment provider in the State, is developing an opiate treatment pilot that uses novel technology, "Med-O-Wheels", to facilitate and monitor home-based opiate treatment for some clients.

Challenges

Contracting and Implementation Delays. Contracting delays with both selected awardees led to significant delays in pilot launch. Both contractors have promised accelerated implementation as they have begun their work. Delays will not impact the overall project timeline or other work streams.

EMR Expansion

Performance Period 2 Milestone:

1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16).

2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.

The Electronic Medical Record (EMR) Expansion focuses on assisting in the procurement of EMR systems for non-Meaningful Use (MU) providers. These efforts include providing technical assistance to identify appropriate solutions and exploration of alternative solutions.

Major Accomplishments

EMR Procurement for non-MU providers. In January 2015, work began to identify and procure a unified EMR system for the five Vermont Specialized Service Agencies (SSAs). As of June 2016, the SIM-funded portion of the EMR implementation is complete for the SSAs.

VITL also assisted the Vermont Department of Mental Health (DMH) with procuring a new EMR solution for the Vermont Psychiatric Care Hospital from January to June of 2015.

Challenges

Developing a plan for non-EMR solutions for providers without EMR Systems. The DLTSS Technical Gap Analysis finalized in March 2015 identified the need for a variety of solutions for DLTSS providers to manage and communicate to support clinical care and to inform evaluation and policymaking. Many DLTSS providers may not need full EMR systems and providers frequently do not have the financial or technical resource to implement EMR solutions. Discussion around this topic occurred in multiple HDI Work Group meetings. Considerable research has been initiated by Vermont's federal partners to address implementation issues.

Data Warehousing

Performance Period 2 Milestone:

1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan).

2. Procure clinical registry software by 3/31/16.

3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.

The Data Warehousing work stream includes three independent projects: the Vermont Care Network Data Repository Project; acquisition and launch of a clinical registry to support the Blueprint for Health; and statewide planning around data warehousing.

- The *Vermont Care Network Data Repository project* will allow the Designated Agencies and Specialized Service Agencies (DAs and SSAs) to send specific data to a centralized data repository. Vermont's DAs and SSAs are 42 CFR Part 2-covered agencies and cannot, due to federal regulatory issues, share data within the VHIE at this time. It is expected that this project will provide VCN members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services, and to support the Triple Aim. This project supports the agencies as Vermont transitions from a fee-for-service reimbursement structure to a value-based payment methodology.
- Vermont migrated the Blueprint for Health *Clinical Registry* from its previous environment to VITL's hosted infrastructure. The Blueprint Clinical Registry includes a client-facing user interface for data entry and reporting for Blueprint programs including Community Health Teams (CHTs), self-management support programs, and tobacco cessation, and support for four Blueprint practice sites using the system as a lite EMR solution.
- Vermont has identified *Statewide Data Warehousing Planning* as a key step toward data aggregation, management, and analytics to support reporting, measurement, and clinical care. Vermont's SIM team has worked with a broad group of stakeholders to identify solutions to meet many of these needs and to develop a strategy for developing data systems in support of analytics.

Major Accomplishments

VCN Data Repository Implementation. Implementation of the VCN Data Repository project began in late 2015 and will continue into Performance Period 3. As of May 2016, the VCN Data Repository project had received 100% of member agency data for 2014 and 2105. The web portal has been deployed and training for agency administrators is in progress. Training has begun on a dashboard including a Key Performance Indicator (KPI) summary, demographic analyses, service delivery analyses, staff service delivery analyses, and crisis services analyses.

Blueprint Clinical Registry Migration. Work began on this project in July 2015 and over the course of the next 12 months, the project team migrated the code, set up the new data schema, converted interfaces to the new environment, and performed User Acceptance Testing. The software itself was acquired in January 2016 and the system successfully went live in June 2016.

Data Warehousing Strategic Planning. Vermont's SIM team, in collaboration with federal partners at the Office of the National Coordinator, convened a diverse team of stakeholders in June 2016 to begin to discuss and develop a plan for clinical and clinically-related data aggregation, analytics, and management. Though this work was delayed in Performance Period 2, the team has made steady progress and has expanded its planning to include Data Governance; work continues into Performance Period 3.

Challenges

Understanding of Legal Parameters. There are numerous federal and state rules surrounding data sharing and aggregation and they are not universally understood. Unfortunately, this means that there is need for significant education around the legal parameters prior to the design of technical solutions in this area.

Care Management Tools

Performance Period 2 Milestone: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development:

1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out.

2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.

Vermont continues to focus on supporting Vermont providers and the individuals they serve by encouraging the development and deployment of care management tools to support timely communication and coordination across provider organizations, especially during care transitions. This work stream encompasses three projects: an Event Notification System, a Shared Care Plan project, and a Universal Transfer Protocol project.

- The *Event Notification System* provides notification to Vermont's providers about admissions, discharges, and transfers of patients to and from hospitals, skilled nursing facilities, and other health care settings.
- The *Shared Care Plan* and *Universal Transfer Protocol* projects performed exploration and planning to support development of Shared Care Plan and Universal Transfer Protocol solutions. The Shared Care Plan and Universal Transfer Protocol were previously combined through the SCÜP Project.
    - The Shared Care Plan (SCP) project worked to identify the information most needed by providers and social services organizations to serve high-needs clients across the care continuum and to gather business and technical requirements for a possible technical solution.
    - The Universal Transfer Protocol (UTP) project identified the critical data and information needed to ease the transition of care between facilities, or between a health care setting and home. This project provided analysis and support services to transform practice workflows as care teams work together in a team-based, coordinated model of care.

Major Accomplishments

Event Notification System (ENS) Launch. In March 2016, the contract for ENS was executed with the selected vendor. The contractor has launched an ambitious and successful implementation and rollout of the service in collaboration with the Vermont SIM team, VITL, and the Blueprint. By the end of Performance Period 2, 15 hospitals (including all of Vermont's 14 hospitals plus Dartmouth-Hitchcock Medical Center in New Hampshire) were connected to the service and continue to engage the full continuum of care in enrollment. As of September 2016, notifications are being generated for 60,260 Vermonters.

Shared Care Plans and Universal Transfer Protocol. After significant discovery and data gathering on the Universal Transfer Protocol in Performance Period 1, Vermont's SIM Team engaged providers in three Vermont communities to review use cases and gather requirements. In August 2015, requirements were validated and the team proceeded with a review of existing technical solutions to meet the requirements. In November 2015, the technical proposal for the combined SCP and UTP project was submitted to the HDI Work Group. This work culminated in the decision in March 2016 not to pursue technology solutions for either of these work streams in part due to the numerous solutions already planned or implemented around Vermont (at least eight are active as of this writing). UTP and SCP work continues through the Integrated Communities Care Management Learning Collaborative.

Participating communities continue to refine community-specific shared care plan processes, some of which include technological exchange of information and are receiving support to transform practice workflows to support the UTP use case. Further discovery was recommended to meet the complex consent and consent management requirements for a full care continuum shared care plan.

Challenges

ENS Provider Engagement. The primary challenge for the ENS project has been provider adoption. Like many new technologies, there were early adopters of the ENS service. However, many HCOs are waiting and observing carefully to better understand the benefits.

Rapidly Changing Technology and Environment. As with telehealth, technology to support care management is a rapidly evolving field. As of early 2016, at least eight Vermont communities, ACOs, provider organizations, and State agencies were piloting or preparing to deploy care management tools that met some or all of the SCP and UTP requirements. This crowded environment was a critical factor behind Vermont's decision not to pursue a technical solution for the SCP or UTP projects.

Log-in Fatigue. Vermont providers, during requirements gathering sessions, reported "log-in fatigue" – the fact that providers would need to log-in to several systems to view all available information about a particular individual – as a barrier to adoption of new tools and systems. Both SCP and UTP included this concern in their risk identification process.

General Health Data – HIE Planning

Performance Period 2 Milestone:

1. ***VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015.***
2. ***HDI Work Group will identify connectivity targets for 2016-2019 by 6/30/16.***

The HIE Planning work stream resulted from a perceived gap in high-level planning and research in local and national best practices for developing a robust, interoperable health data infrastructure that is able to transmit accurate and current health information to providers across the care spectrum. During Performance Period 2, work in this area included commenting on the 2015 update of the Vermont Health Information Technology Plan (VHITP) and developing a methodology to identify connectivity targets for 2016-2019.

Major Accomplishments

Vermont Health Information Technology Plan Comment. The State engaged the HDI Work Group for comment and feedback on the VHITP throughout 2015 and early 2016, leveraging

this diverse and robust group of stakeholders as valuable subject matter experts to help ensure the validity of the strategic direction for that document. The VHITP was submitted to the Green Mountain Care Board for approval in April 2016.

Connectivity Targets. The HIE planning team is currently developing 5 and 10 year targets for provider connectivity to the Vermont Health Information Exchange (VHIE). Though this work stream was delayed in Performance Period 2, Vermont expects to meet it during Performance Period 3. The connectivity target methodology was proposed to the HDI Work Group in July 2016 and staff are working with VITL and stakeholders to develop targets based on this methodology in Fall 2016. The HDI Work Group will vote on final proposed targets by December 2016.

General Health Data – Expert Support

Performance Period 2 Milestone: Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.

This is a companion project to all of the projects within the Health Data Infrastructure focus area. Due to the nature of those projects, Vermont needs specific skills to support the State and stakeholders in decision-making and implementation. The specific skills needed are IT Enterprise Architects, Business Analysts, and Subject-Matter Experts.

Milestones Achieved, Major Accomplishments, and Challenges: Evaluation

All of Vermont's SIM efforts are evaluated to assess processes, experiences, and outcomes of innovation efforts for Vermont, its residents, payers, and providers. Evaluation occurs by program, by population, and by region to ensure that there are not unintended consequences and to allow rapid dissemination of lessons learned and expansion of best practices.

Table 6, below, summarizes progress across the Evaluation focus area for all Performance Period 2 milestones; the remainder of this section details accomplishments and challenges within each work stream.

Table 6: Performance Period 2 Milestone Summary – Evaluation Focus Area

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
Self-Evaluation Plan and Execution	1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities. 2. Continue to execute self-evaluation plan using staff and contractor resources.[9] 3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.	1. Achieved: Contract with John Snow, Inc. (JSI) for executed in March 2016. 2. Achieved: Self-evaluation plan has been initiated and execution has continued. 3. Achieved: Quarterly and Annual reporting streamlined. • Vermont is implementing a mixed-methods study that includes site visits and surveys focused on: care integration, use of clinical and economic data for performance improvement, and payment reform incentives. Vermont's self-evaluation plan includes several components: an environmental scan and site visit plan; implementation of site visits, interviews, and focus groups; provider surveys; evaluation findings from SIM-supported pilots; and a learning dissemination plan. The draft environmental scan was completed in June 2016. It includes information about Vermont's health reform landscape; SIM activities to inform evaluation methods; context for evaluation results; recommended site visit locations that will best inform the three evaluation themes; and material to inform site visit and focus group guides, interview content, the sampling approach for provider and care integration surveys, and survey content. To conduct the environmental scan, JSI spoke with approximately 30 key stakeholders, reviewed data and documents specific to SIM and complementary initiatives, and reviewed literature in each of the three theme areas. • The public-private Vermont SIM Evaluation Steering Committee was established and continued to meet during Performance Period 2, providing valuable feedback on the self-evaluation activities. • Vermont's State-Led Evaluation contractor completed and submitted three deliverables in June 2016: 1) Environmental Scan Findings and Site Visit Plan; 2) initial draft of Learning Dissemination Plan; and 3) list of secondary data sources that will be incorporated into Vermont's State-Led evaluation reporting. In July, the contractor shared the draft Environmental Scan Findings and Site Visit Plan with the multi-stakeholder Evaluation Steering Committee, developed site visit protocols, initiated site visits, and began working with the State on data visualization. Site visits began in July 2016.
Surveys	Conduct annual patient experience survey and other surveys as identified in payment model development:	Achieved: Vermont's patient experience contractor (DataStat) fielded the Year 2 patient experience survey in August 2014-September 2015 and November 2015 through April 2016.

[9] Vermont's self-evaluation plan relies on numerous staff and contractors, which are described in the Evaluation Remediation Plan submitted on November 25, 2015.

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
	Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.	• Vermont implements the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey annually, using the PCMH version with additional custom questions that are specific to Vermont. The survey evaluates the experiences of Vermonters participating in the Patient Centered Medical Home and ACO shared savings programs. • The survey was fielded by DataStat to patients from more than 90 primary care practices from August 2014 to July 2015 and November 2015 to April 2016. Most primary care practices opted to participate in the survey, though it is not compulsory.
Monitoring and Evaluation Activities within Payment Programs	1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers. 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.	1. Achieved: The Blueprint for Health (Vermont's PCMH program) provided bi-annual comprehensive performance reports to participating primary care practices and health service area leaders, most recently in November 2015 and May 2016. 2. Achieved: Interim and final analyses of Year 1 of the Commercial and Medicaid Shared Savings Programs were provided during Performance Period 2. • Reports on the Blueprint for Health included results for quality measures, patient experience measures, and cost of care measures for each Hospital Service Area (HSA), with comparisons to other HSAs and the state as a whole. A key innovation is the linkage of clinical and claims data for some of the measures. The reports have been adapted to include ACO Shared Savings Program measures, reinforcing the importance of these measures to providers. HSA-level reports are publicly reported on the DVHA website. • Analyses and accompanying reports for the 2014 ACO Shared Savings Programs were finalized and released publicly in October 2015, and included quality measures, patient experience measures, and savings calculations. These reports are publicly reported on the GMCB website.

Self-Evaluation Plan and Execution

Performance Period 2 Milestone:

1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities.

2. Continue to execute self-evaluation plan using staff and contractor resources.

3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.

During Performance Period 2, Vermont's SIM project made progress in the development and implementation of the State-Led Evaluation Plan. Vermont worked with stakeholders and CMMI to design a State-Led Evaluation Plan to study care integration, use of clinical and economic data for performance improvement, and payment reform initiatives. In March 2016, Vermont fully executed a State-Led Evaluation contract with John Snow, Inc. (JSI) for self-evaluation activities in three key areas: conducting a state-led evaluation study, providing evaluation findings, and creating and assisting in implementing a learning dissemination plan.

Through the State-Led Evaluation Plan, Vermont proposes to answer research questions in three topical areas, all key to Vermont's progress towards achieving an integrated delivery system that rewards value-based care:

Care Integration and Coordination: Integrated care is a key feature of many SIM-funded activities, and a major activity contributing to the goals of improving patient experience, improving population health, and reducing the per capita cost of health care. Across Vermont, care integration and coordination supported by the SIM grant takes a variety of forms, such as identifying, reaching out to, and offering enhanced services to vulnerable populations at risk of admission to nursing homes; coordinating care for patients with particular diseases across a spectrum of social service and medical providers; improving care transitions to avoid hospital readmissions; and building on activities of existing community health teams. These models vary, but understanding the features of each that are most effective is critical to guide scaling up effective innovations related to care integration and coordination.

Use of Clinical and Economic Data to Promote Value-Based Care: Data collection, aggregation, sharing, analysis, and utilization play pivotal roles in Vermont's efforts to transform its health system. Various Vermont SIM project activities address the different uses of clinical and cost data: to inform providers; for internal and external monitoring and improvement of population health; for quality improvement initiatives; for payment; and to identify opportunities for efficiency. Clinical and cost data are shared with various audiences and come from a variety of sources including: VHCURES, Vermont's multi-payer claims database, and other sources of claims data; automated

extracts from EMRs; manual abstraction of medical records; and surveys. Data may not always be perceived by providers as interpretable or actionable, and data collection may impose a burden on providers. It is important to understand the ways in which providers interpret, perceive, and use data in order to ensure that needed data is provided accurately and effectively.

Payment Reform and Incentive Structures: As new payment models are in various stages of implementation, providers find themselves operating in a system that employs multiple—and sometimes conflicting—financial incentive structures. As SIM accelerates Vermont's health system transformation, payment models and incentives confronting providers may become more complex, adding additional models and incentives even while fee-for-service payment remains in place for some care. For successful payment reform structures to take hold, it is important to understand providers' awareness of financial and non-financial incentive structures, how payment reform impacts care delivery (including integration and coordination of care), and attitudes toward incentives and practice transformation.

Major Accomplishments

Execution of State-Led Evaluation Contract. Vermont executed a contract with John Snow, Inc. (JSI) in March 2016 to implement a mixed-methods study that includes site visits and surveys focused on care integration, use of clinical and economic data for performance improvement, and payment reform incentives. This evaluation will ensure: that Vermont has access to meaningful quality improvement data in three areas stakeholders deem key to our success; can adequately harvest and disseminate best practices identified through Vermont SIM initiatives; and receives actionable recommendations on the scaling of Vermont SIM initiatives from a synthesis of information culled from project-wide evaluation activity.

Progress on State Evaluation Plan. JSI completed numerous tasks and deliverables between March 2016 and June 2016, detailed below.

State-Led Evaluation Contract Deliverables and Key Tasks

Deliverables Submitted	Tasks Conducted
Key Informant Interview Guide	Stakeholder interviews conducted
Environmental Scan Findings and Site Visit Plan	Outreach and engagement conducted with leaders from sites identified in Site Visit Plan; interview guides developed; many site visits scheduled.
Initial draft of Learning Dissemination Plan	Monthly Evaluation Steering Committee e meetings held to obtain input and guidance in all areas of self-evaluation plan.
List of secondary data sources that will be incorporated into Vermont SIM evaluation	Preliminary list developed.

Challenges

Contracting Challenges. Early in Performance Period 2, Vermont executed a self-evaluation contract, but in Fall 2015 the State released the vendor from the contract due to significant differences between planned implementation activities and original contract scope. Vermont procurement guidelines required a new competitive bidding process, so in November of 2015, Vermont released a new Request for Proposals (RFP) for a State-Led Evaluation Study. This process delayed Vermont's execution of some components of the Self-Evaluation Plan. In December 2015, Vermont selected a new bidder, contingent upon state and federal approvals, and by March 2016, Vermont had a fully executed contract with John Snow, Inc. (JSI) for State-Led Evaluation. The work has proceeded at a rapid pace since the execution of the contract.

Surveys

Performance Period 2 Milestone: Conduct annual patient experience survey and other surveys as identified in payment model development:

Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.

Vermont fields the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey annually, using the PCMH version with additional custom questions that are specific to Vermont. The survey evaluates the experiences of Vermonters participating in the Patiently Centered Medical Home (PCMH) and ACO shared savings programs, as well as supporting PCMH recognition for Blueprint-participating practices. Most primary care practices opted to participate in the survey, though it is not compulsory.

Major Accomplishments

Fielded Patient Experience Surveys as Planned. From August 2014-July 2015 and again from November 2015-April 2016, Vermont's contractor DataStat fielded patient experience surveys to evaluate the experiences of Vermonters who are patients of practices participating in the PCMH and/or ACO Shared Savings Programs. The survey instrument is the PCMH version of the CG-CAHPS survey, with the addition of eight custom questions related to care from specialists, long-term services and supports, and chronic illness. Datastat provided practice-level results to participating practices after each round of surveys. Datastat also provided results to Onpoint Health Data after each round to support aggregation of results for ACOs, HSAs, and the State as a whole (Onpoint is an analytics contractor that develops performance reports for Vermont's PCMH program).

Challenges

Practice Recruitment and Administrative Burden. Recruiting practices to participate in this voluntary initiative and trying to minimize administrative burden for practices and patients have presented significant challenges during Performance Period 2. Most eligible primary care practices have opted to participate in this survey, which is a positive outcome given that they have expressed concerns about burden in the past and may be affiliated with organizations that have been using different surveys. The State decided to use the same survey for the PCMH and ACO programs specifically to minimize the burden of having multiple surveys in the field. Using the same survey for the two programs requires extra steps for the State and its contractors in order to flag the subset of respondents who are attributed to each ACO for analysis of ACO-level results, but it has helped with practice recruitment. It should be noted that Vermont's largest hospital-owned primary care system has decided to continue to use a slightly different survey (the CG-CAHPS visit-based survey) for its practices, but has been willing to add questions to its survey during a few weeks of the year and to report results to the State. An additional challenge is that the State's smallest ACO did not attain an adequate number of responses from ACO-attributed patients affiliated with its participating primary care practices. During Performance Period 3, Vermont and DataStat will be exploring whether there are ways to address that issue.

Monitoring and Evaluation Activities within Payment Programs

Performance Period 2 Milestone:

1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers.

2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.

In Performance Period 2, Vermont performed ongoing monitoring and evaluation activities to support development and successful implementation of innovative payment models. These activities focus on Vermont's Medicaid and commercial Shared Savings Programs, as well as Vermont's Pay-for-Performance investments (the Blueprint for Health). These activities will continue in Performance Period 3, in addition to new activities in this area that will support the All-Payer Model and Medicaid Value-Based Purchasing[10] work streams.

Major Accomplishments

Development of Performance Reports for Blueprint for Health PCMH Program. During Performance Period 2, Vermont provided two performance reports for its PCMH program to providers and to health service area leaders, in November 2015 and May 2016. These robust

[10] Also known as the Medicaid Pathway.

reports are publicly reported at the hospital service area level.[11] These reports use data from claims (including VHCURES), the Blueprint Clinical Registry, and the CG-CAHPS survey noted above to provide results for quality measures, financial measures, utilization measures, and patient experience measures. They are used by practice and regional leaders to assess performance and drive quality improvement.

Completion of ACO Shared Savings Program Analyses for Year 1 (2014). In addition, commercial and Medicaid ACO Shared Savings Program results for calendar year 2014 were provided to ACOs and the public in October 2015.[12] Interim results for 2015 have been provided to the ACOs and the payers as they are available, and final results for calendar year 2015 should be available to the ACOs, payers, and the public in October 2016.

Challenges

Obtaining Timely and Complete Claims Data to Support ACO Shared Savings Program Analyses. During Performance Period 2, Vermont continued to confront challenges in collecting and analyzing data from the Medicaid and commercial ACO Shared Savings Programs, including obtaining timely and complete claims data from payers, reconciling that data and the analysis between the payers and the Lewin Group (Vermont's Shared Savings Program analytics contractor), collecting clinical data, and compiling results in an understandable fashion. The lag in obtaining claims data has also presented a continued challenge. Vermont has responded to this challenge by working with its contractors, payers, and ACOs to develop process improvements as challenges arise (e.g., improved process for clinical data collection; reduction in claims runout period for interim reports), and expects to see improvements in this process during data collection and analysis for SSP Program Year 3 (2016).

[11] Blueprint for Health HSA Data Profiles can be found at: http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles.
[12] Commercial and Medicaid ACO Shared Savings Program Year 1 (2014) Results: http://gmcboard.vermont.gov/payment-reform/ACO-shared-savings

Milestones Achieved, Major Accomplishments, and Challenges: Project Management

The Vermont SIM project is supported by a project management team that oversees project-wide coordination and reporting, as well as communication and outreach. Project management is focused on achieving milestones and meeting accountability targets across the project. Table 7, below, summarizes progress across the Project Management focus area for all Performance Period 2 milestones.

Table 7: Performance Period 2 Milestone Summary – Project Management Focus Area

	Performance Period 2 (PP2)	
	Performance Period 2 Milestone	**Current Status and Progress Update**
Project Management and Reporting – Project Organization	Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature.	1. Achieved: Project Management contract scope of work and tasks performed on time. 2. Achieved: Staff meetings, co-chair meetings, and Core Team meetings conducted each month with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Achieved: Reports submitted quarterly to CMMI and the Vermont Legislature. • Vermont's SIM project is supported by a project management team that oversees project-wide coordination and reporting, as well as communication and outreach. Project management is focused on achieving milestones and meeting accountability targets across the project.
Project Management and Reporting – Communication and Outreach	Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 6/30/16. 2. Distributing all-participant emails at least once a month. 3. Updating website at least once a week.	1. Achieved: Core Team, Steering Committee, and Work Groups convened each month through the end of Performance Period 2. 2. Achieved: Vermont's SIM project communicates with all participants via email at least once a month. 3. Achieved: Vermont's SIM website is continually updated with new documents and information. • SIM Work Groups and other stakeholder engagement activities ongoing. • Website updates ongoing; new site launched in August 2016 will continue to receive regular updates. The new site is easier to navigate and allows for easier communication with stakeholders.

Evaluation Findings

This section of the Performance Period 2 Annual Report presents available evaluation findings from Performance Period 2 activities, including:

- State-Led Evaluation Plan findings and Environmental Scan;
- Patient experience surveys implemented in Performance Period 2;
- Year 2 of the ACO Shared Savings Programs (SSPs);
- Early findings from Sub-Grant Program evaluation activities.

State-Led Evaluation Findings and Environmental Scan

In March 2016, the Green Mountain Care Board contracted with John Snow, Inc. (JSI), to conduct three major components of Vermont's State-Led Evaluation for SIM grant. JSI's evaluation work focuses on: 1) care integration; 2) use of economic and clinical data; and 3) payment reform.

The main activity performed by the State-Led Evaluation contractor, JSI, during PP2 was the completion of an environmental scan which includes refinements to evaluation questions, and planning for site visits, focus groups, provider and care integration surveying, and learning dissemination. To conduct the environmental scan, JSI spoke with approximately 30 key stakeholders, reviewed data and documents specific to VCHIP and complementary initiatives, and studied peer-reviewed and grey literature in each of the three theme areas.

Environmental Scan Interviews. By May 2016, approximately 30 interviews were conducted with stakeholders and experts, including members of Vermont SIM Work Groups); representatives from the payer, long-term services and supports, hospital, primary care, and specialist sectors; consumer advocates; and representatives aligned with complementary and intersecting initiatives, such as the Blueprint for Health. Interviewees had geographical representation, service population diversity (e.g., pediatrics/adults, private/safety net), and institutional diversity.

Site Visit Guide Development. In June 2016, JSI presented a site visit guide to the State-Led Evaluation Steering Committee, to inform site visits with Community Collaboratives, ACOs, and provider organizations, which are scheduled to take place in Performance Period 3. Site visit structure includes interview questions in the following categories: care integration; payment reform; and data and data infrastructure

Learning Dissemination Plan Presented. In June 2016, JSI presented a draft Learning Dissemination Plan. The purpose of this draft Learning Dissemination Plan is to translate findings from the Vermont SIM State-Led Evaluation into real world language, visuals and tools that will impact the practice and perception of health care. The draft Learning Dissemination

Plan identifies ways to deliver evaluation findings to the target audiences through a multi-faceted (webinars, issue briefs, non-technical report summaries, white papers, blog posts, discussion sessions) and incremental approach to learning that encourages the audience to incorporate evaluation findings into their work, language, and communication with other stakeholders. Implementation of activities in the Learning Dissemination Plan will occur during Performance Period 3.

Key Evaluation Findings: Environmental Scan

A key finding from the Environmental Scan is that a defining feature of Vermont SIM is its integration and coordination with other health reform programs. Rather than creating new or parallel systems, the majority of Vermont's SIM activities build on existing programs. Vermont SIM often serves as the impetus for bringing stakeholders together to work collaboratively on payment and delivery system reform efforts.

Care integration. Key SIM care integration activities include supporting regional and statewide collaborative structures such as Learning Collaboratives and the Community Collaboratives; supporting sub-grant investments; and expanding models of care implemented by Vermont's Blueprint for Health, including Community Health Teams, Support and Services at Home, and Health Home (Hub & Spoke) models. Findings from the Environmental Scan indicate that it will be important to assess care integration at both the system level and the site level.

The following principles/measures have been identified for successful care integration:

- Information technology, access to information;
- Commitment and incentives to delivering integrated care;
- Clinical care model with clearly defined roles;
- Organizational culture and effective communication;
- Access to educational opportunities;
- Aligned financial incentives; and
- Quality improvement and performance measurement.

Health Infrastructure Technology to Improve Use of Clinical and Economic Data. Vermont's SIM project has strategically created a data use approach by building upon and leveraging existing data aggregation and dissemination activities. While policy considerations and infrastructure building continues to require an influx of resources beyond the SIM timeline, SIM has developed a fuller understanding of the future needs of clinical and non-clinical providers. This has been accomplished by focusing on infrastructure development, stakeholder engagement, and long term planning. An implication for the evaluation is that assessing the usability of the technology (e.g., intuitive design, subjective satisfaction, efficiency of use, ease of learning) will further inform stakeholders of the potential for moving forward regarding the use of clinical and economic data at the practice level.

Payment Reform and Financial Incentive Structures. Advancing system transformation through payment reform has been a constant in Vermont's health care reform efforts. Through SIM, Vermont developed Medicaid and commercial SSPs that build on the Medicare SSP and leveraged ACOs' early experience with the Medicare model. Relationship building and collaboration across the State, payers, providers, and other stakeholders is a key positive outcome of Vermont's SIM efforts, and provides a strong foundation for future reforms.

Other Implications. Findings from the Environmental Scan resulted in some refinement of the initial evaluation questions. It also led to a site selection approach based on HSA, which: 1) ensures each region of the State is represented; 2) provides a means of grouping organizations that already work together in communities; and 3) enables the matching of existing quantitative data organized by HSA to add context to qualitative data obtained during the site visits.

Patient Experience Surveys Implemented in Performance Period 2

As noted above, from August 2014-July 2015 and November 2015-April 2016, Vermont's contractor, Datastat, fielded patient experience surveys to evaluate the experiences of Vermonters who are patients of practices participating in the PCMH and/or ACO Shared Savings Programs. The survey instrument is the PCMH version of the CG-CAHPS survey, with the addition of custom questions related to care from specialists, long-term services and supports, and chronic illness. ACO results for the first performance period for the composite measures included in the survey is shown in the table below. Results for the second period will be available in October 2016.

Table 8: CAHPS Patient-Centered Medical Home Annual Adult Survey

	CAHPS® Patient Centered Medical Home Annual Adult Survey (August 2014-July 2015) % Responding "Always" or "Yes"					
	Community Health Accountable Care Medicaid and Commercial	**OneCare Vermont** Medicaid and Commercial	**Vermont Collaborative Physicians** Commercial	**All Vermont ACOs**	**Vermont Statewide**	**2013 National Average**
Access to Care Composite	50%	62%	63%	57%	59%	60%
Communication Composite	77%	82%	84%	79%	82%	82%
Self-Management Support Composite	51%	53%	47%	51%	51%	52%
Office Staff Composite	71%	74%	84%	74%	79%	75%
Coordination of Care Composite	74%	75%	74%	74%	75%	--
Information Composite	72%	69%	69%	70%	70%	--
Specialist Care Composite	49%	50%	44%	49%	52%	--
Shared Decision-Making Composite	63%	67%	--	64%	64%	66%
Comprehensiveness Composite	60%	55%	43%	56%	51%	46%

Year 2 ACO Shared Savings Program (SSP) Results

Performance Period 2 included Year 2 of Vermont's Medicaid and Commercial Shared Savings Programs, which coincided with calendar year 2015. Results for Year 2 payment and reporting measures for each of the two programs (Medicaid and commercial) will be available in October 2016.

Early Findings from Sub-Grant Program Evaluation Activities

Five sub-grant projects came to a close during Performance Period 2, and reported significant accomplishments based on evaluation activities conducted by the sub-grantees themselves. The following is a brief description of early findings from the five completed projects, drawn from sub-grantee final reports; a complete report will be provided at the conclusion of the Provider Sub-Grant Program in Performance Period 2. For more information on the Sub-Grant Program, see the Practice Transformation Focus Area section of this report.

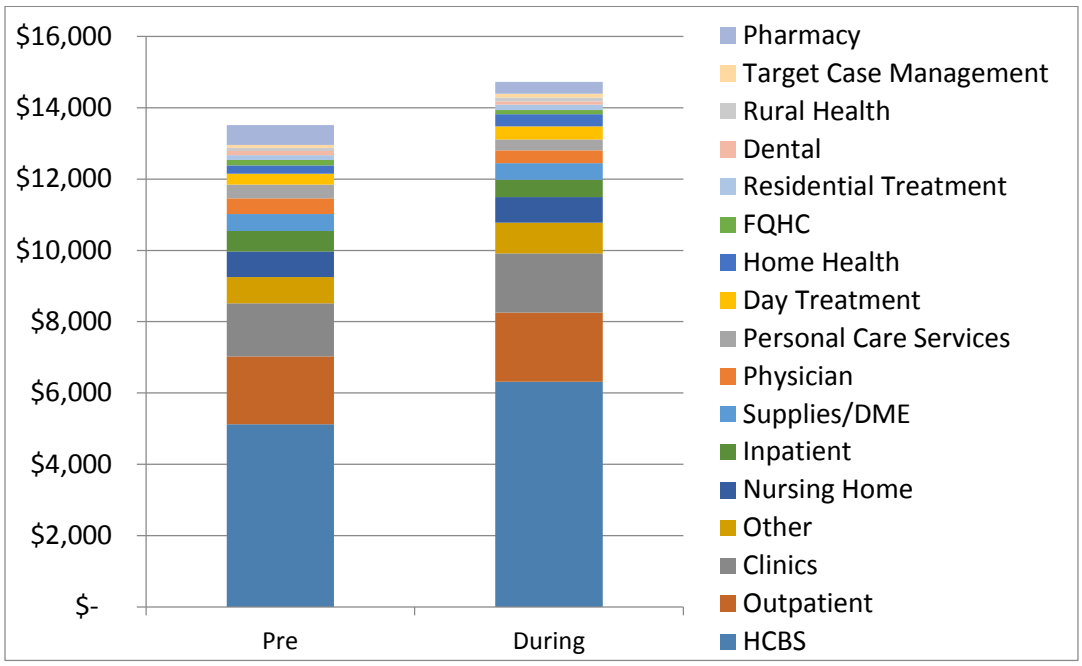
Northeastern Vermont Regional Hospital: Caledonia and Southern Essex Dual Eligibles Project

The Caledonia and Southern Essex Dual Eligibles Project provided a health coach to individuals dually enrolled in Medicare and Medicaid, as well as funding for goods and services not normally covered by insurance. This enabled local multi-disciplinary care teams to better meet the needs – especially social needs – of clients who are at risk for poor outcomes and high costs of medical care.

The project, combined with the region's participation in the Integrated Communities Care Management Learning Collaborative, has helped advance care coordination in the Northeast Kingdom region of Vermont. Specific advancements include: strengthening and building new partnerships; improved cross-organizational understanding and enhanced trust between organizations, creating new partnerships to leverage existing funding structures; identification of lead care coordinators; more efficient processes for sharing information across care teams; shared care planning; and expanded use of patient engagement tools. The addition of a health coach furthered this project's mission to improve the health of the community by providing more resources for support, education, and care coordination and facilitation to access services.

The chart below provides a graphic depiction of Medicaid spending by category of service for clients receiving one or both project interventions. Results show an overall increase in health services during the intervention program, with the increase of the use of Choices for Care waiver services, home health, and targeted case management. These results demonstrate that some of the more complex patients are accessing additional care in home- and community-

based settings. There is ongoing evaluation to determine if Emergency Department and other acute care costs have been reduced over the same time period.



FQHC = Federally Qualified Health Center
DME = Durable Medical Equipment
HCBS = Home and Community-Based Services, Choice for Care

For more information on this project, see the final report.

Community Health Accountable Care: Furthering Community Health Accountable Care Project

The Furthering Community Health Accountable Care Project supported basic infrastructure for Community Health Accountable Care (CHAC), including: core staffing, facility costs, meeting costs, professional services, and IT support. Accomplishments include implementation of CHAC's standing committees; development, adoption of, and implementation of clinical recommendations for Chronic Obstructive Pulmonary Disorder, Congestive Heart Failure, Falls Risk Assessment, Diabetes, and Depression; implementation of a telemonitoring pilot; implementation of PatientPing, the contractor for the event notification system discussed above, for all members; development of care management, operational, and compliance standards with successful execution of training programs; support for continuous quality improvement though use of Plan-Do-Study-Act (PDSA) cycles; completion of chart abstraction and quality reporting; and operationally supporting all ACO requirements (i.e. beneficiary notification mailings and report submission including quality reporting). The target population for this initiative included CHAC's designated contract employees, Governing Board, Standing

Committees, participating organizations, providers, contractors, and 57,000 attributed lives. Approximately 340 CHAC-attributing providers were directly impacted by the sub-grant project.

The CHAC evaluation measured whether it achieved savings within any of the three ACO SSPs in which it participated; whether those savings surpassed the minimum savings rates (MSR) for each program to result in shared savings payments; and whether the ACO improved quality of care as measured by the ACO measure set by successful implementation of CHAC Clinical Recommendations.

- 2014 Program Year (Year 1 of Vermont's Medicaid and Commercial SSPs): CHAC did achieve savings during the 2014 SSP program year, surpassing the MSR, under the Vermont Medicaid Shared Savings Program. CHAC's quality score entitled it to 85% of the shared savings, as well as identifying several areas of improvement and areas for future quality improvement efforts. CHAC did not achieve savings under the commercial SSP during the 2014 program. CHAC achieved savings under the Medicare SSP during the 2014 program year, but did not surpass the Medicare MSR.

For more information on this project, see the final report.

Rutland Area Visiting Nurse Association & Hospice – Supportive Care Program

The Supportive Care Program sought to address the needs of seriously ill patients in the Rutland region by expanding Rutland's existing palliative care program and bridging the gap between inpatient palliative care and hospice. Working with the primary care physicians, Rutland Regional Medical Center, and Rutland's Community Health Team, the program worked to support patients and their caregivers in identifying health goals and incorporating these goals into treatment plans in partnership with their primary care providers. The program's hypothesis was that improved communication would support thoughtful care planning aligned with patient goals and preferences, and would promote adherence to treatment and care plans while lessoning physical and emotional duress associated with serious illness.

On completion of the project, forty-nine patients had enrolled in the program. Each patient enrolled in the program was tracked by start of care and discharge dates. Of the forty-nine patients admitted, forty were admitted with COPD, and nine with CHF. A total of twenty-two different providers referred patients to the program, primarily from pulmonology.

The program surveyed patient and provider satisfaction with the program:

- Patient Satisfaction: 81% of respondents rated the program ≥4 on a 1-5 scale.
- Provider satisfaction: 79% of respondents rated the program ≥4 on a 1-5 scale.

Additional outcomes include:

- 45% of patients (n=22) worked with the social worker to complete their advanced directives. Once these were completed they were sent to all providers involved with the patient and put in the state registry.
- 29% of patients (n=14) transitioned into either palliative home care or hospice. These patients were identified by the nurse or social worker and with the comfort and trust of the patient and family, conversations about end of life decisions and planning occurred.

For more information on this project, see the final report.

Vermont Medical Society Foundation: Pursuing High-Value Care for Vermonters

The goal of the Vermont Medical Society Foundation project was to reduce harm, avoid unnecessary care, and promote regional integration. All Vermont hospitals and Dartmouth Hitchcock Medical Center in New Hampshire were invited to participate. The Pursuing High Value Care Collaborative included over 70 professionals from ten regional hospitals.

The Pursuing High Value Care Collaborative initially targeted optimizing laboratory testing in hospitalized adults. Results suggest significant decreases in lab tests ordered, resulting in fewer needle sticks, reduced blood loss, reduced interrupted sleep, and lower health care costs. The program resulted in significantly fewer blood draws for this patient population saving over 100 liters of blood.

The Collaborative's second target was to improve COPD care across the region. The Collaborative introduced a standardized diagnostic and treatment pathway for adults admitted with acute exacerbation of chronic obstructive pulmonary disease (COPD).

For more information on this project, see the final report.

Vermont Disabilities Council: Inclusive Health Care Partnership Project

Vermont Developmental Disabilities Council was awarded a one-year planning grant for the Inclusive Health Care Partnership Project (IHPP) to address health disparities among adults with disabilities. The Council, in collaboration with Green Mountain Self-Advocates (GMSA), engaged in an inclusive planning process to identify and recommend a set of innovative best practices in the delivery of health services to adult Vermonters with intellectual and developmental disabilities (I/DD) that will support the Triple Aim.

The IHPP Planning Team included three self-advocates, two parents of children with developmental disabilities, three physicians (an internist, a family practitioner, and an emergency medicine doctor), and a registered nurse from a Designated Agency providing mental health and developmental services. In all, more than 100 individuals from across Vermont provided input to the Inclusive Health Care Partnership Project (IHPP).

This process resulted in twenty recommendations in the following four categories:

- Improve Transition to Adult Care;
- Improve Medical Education and Provider Training;
- Improve Care Delivery for Adults with I/DD; and
- Improve Health and Wellness for Adults with I/DD.

Each category provides concrete, practical recommendations to address health disparities and identifies opportunities within organizations and networks to improve the health care experience and outcomes for adult Vermonters with I/DD.

For more information on this project, see the final report.

Sustainability Strategy

Vermont embarked on a bold set of reforms with the passage of Act 48 of 2011. These reforms charge the Executive Branch and the Green Mountain Care Board (GMCB) with creating a high-performing health system that provides Vermonters with the highest quality of care at a sustainable cost. These reforms require that we use our regulatory and policy levers to develop evidence-based financial models for health system financing. Vermont's SIM Testing Grant provides significant resources to support Vermont in achieving the goals set out in Act 48 by testing payment reforms, supporting delivery system transformation, and investing in health data infrastructure.

Vermont began a robust sustainability planning process during Performance Period 2 and is engaging in detailed planning around sustainability during Performance Period 3 to identify specific activities that will be supported after the end of our SIM testing period. A significant focus of this work will be SIM interaction with, and transition to, the planned All-Payer Model and related reforms such as the Medicaid Pathway.

Sustainability Overview

Vermont has been planning for post-SIM sustainability since the start of the Model Testing Grant in 2013. Broadly, Vermont's sustainability strategy is to sustain needed contract support and personnel using payment model savings and through re-deployment of vacant positions and changes in contractor scope in light of new models of provider oversight and financing. Vermont SIM leadership is currently engaged in a more granular sustainability planning process that includes review of each SIM activity and investment.

The State views SIM investments in three categories with respect to sustainability:

- **One-time investments** to develop infrastructure or capacity, with limited ongoing costs;
- **New or ongoing activities which will be supported by the State** after the end of the Testing period; and
- **New or ongoing activities which will be supported by private sector partners** after the end of the Testing period.

Project leadership are working with stakeholders and Vermont's SIM evaluation team to identify areas of successful investment in need of on-going support, areas of investment that have not furthered our goals, and areas of investment that have served their purpose and do not need on-going support.

One-time investments have been the intentional focus of the majority of Vermont's SIM work. This has included many of Vermont's health data infrastructure investments, as well as some

work to launch new payment models. Most project management activities are also included in this category.

As in any innovative testing opportunity, some areas of SIM investment have had mixed or limited success. Vermont's sustainability planning process will identify these activities, while ensuring lessons learned are harvested and incorporated into future planning. For example, Vermont has supported provider sub-grants to foster innovation in the community. Not all of the funded efforts will be successful in meeting the stated goal of the intervention, but even so, will have furthered the learning of the State and the provider community.

Analysis to support sustainability planning, as well as drafting of the Sustainability Plan document, will be supported by a contractor, by a private-sector sub-group of SIM stakeholders, and a parallel group of State leaders. The contractor was selected during Spring 2016 and a contract executed in June, as required by Vermont's Sustainability Plan milestone for Performance Period 2. The stakeholder sub-group was formed in August 2016. Vermont's Sustainability Plan will be finalized by June 30, 2017, and will include specific next steps for all SIM-related activities. A high-level outline was finalized by the end of Performance Period 2 and a draft plan will be shared with SIM work groups in early November 2016.

SIM Investments by Focus Area

This section of Vermont's Performance Period 2 Annual Report provides a summary of sustainability planning activities currently underway across each of the project's five focus areas. It also discusses sustainability and transition planning related to the SIM governance and stakeholder engagement structure and the SIM staff team.

Table 9, below, provides a high-level overview of SIM investments by focus area and SIM work stream across the three sustainability categories identified above. Vermont will populate this table with specific sustainability recommendations during Performance Period 3 through the sustainability planning process described above.

Table 9: High-Level Sustainability Overview by SIM Work Stream

	Sustainability Categories		
SIM Focus Areas and Work Streams	**One-Time Investments**	**Ongoing Investments** *State-Supported*	**Ongoing Investments** *Private Sector*
Payment Model Design and Implementation			
ACO Shared Savings Programs			
Pay-for-Performance (Blueprint for Health			
Health Homes (Hub & Spoke)			
Accountable Communities for Health			
Medicaid Value-Based Purchasing			
All-Payer Model			
Practice Transformation			
Learning Collaboratives			
Sub-Grant Program			
Regional Collaborations			
Workforce – Care Management Inventory			
Workforce – Demand Data Collection and Analysis			
Workforce – Supply Data Collection and Analysis			
Health Data Infrastructure			
Expand Connectivity to HIE – Gap Analyses			
Expand Connectivity to HIE – Gap Remediation			
Expand Connectivity to HIE – Data Extracts from HIE			
Improve Quality of Data Flowing into HIE			
Telehealth – Strategic Plan			
Telehealth – Implementation			
EMR Expansion			
Data Warehousing			
Care Management Tools (Event Notification System)			
Care Management Tools (Shared Care Plan)			
Care Management Tools (Universal Transfer Protocol)			
General Health Data – Data Inventory			
General Health Data – HIE Planning			
General Health Data – Expert Support			
Evaluation			
Self-Evaluation Plan and Execution			
Surveys			
Monitoring and Evaluation Activities Within Payment Programs			
Program Management and Reporting			
Project Organization			
Communication and Outreach			
Governance and Stakeholder Engagement			

Payment Model Design and Implementation

The All-Payer Model and Medicaid Pathway frameworks are the centerpiece of Vermont's SIM sustainability planning within the Payment Model Design and Implementation focus area. Vermont has been engaged in ongoing discussions with CMMI regarding a potential All-Payer Model framework (APM) in Vermont, which would build on SIM's investments in payment model design and implementation, practice transformation, and health data infrastructure to act as a next step in Vermont's efforts to achieve the Triple Aim. The framework, if implemented, will be based on Medicare's Next Generation ACO model. Negotiations with CMMI and discussions with Vermont State officials and stakeholders have also revealed a mutual desire to consider how additional services could be included in the APM over time, especially services where the majority of spending is by Medicaid. These accompanying reforms are known as the Medicaid Pathway.

This is currently an area of intensive work among State officials, key stakeholders, and contractors. Vermont aims to resolve All-Payer Model negotiations in Fall 2016, and recently launched an Information Gathering Process to solicit stakeholder reactions to a draft Medicaid Pathway payment model for mental health, substance use disorder, and developmental disability services provided by Designated Agencies and Specialized Service Agencies.

Vermont's sustainability planning will collect lessons learned from the payment models researched, designed, and tested under the SIM grant, and incorporate these into future activities:

- Vermont's Medicaid and commercial Shared Savings Programs;
- Episodes of Care;
- Prospective Payment Systems for Home Health;
- A pay-for-performance program (the Blueprint for Health patient-centered medical home program);
- Vermont's Health Home initiative (known as the Hub & Spoke program);
- Development and exploration of a Vermont-specific Accountable Communities for Health model; and
- Medicaid-specific value-based purchasing activities to support providers of mental health and substance abuse services that will feed into the Medicaid Pathway.

These lessons learned will inform the All-Payer ACO model and the Medicaid Pathway frameworks.

In concept and practice, SIM has supported provider, payer, and State readiness for increased financial risk and delivery integration. SIM investments through Performance Period 3 will continue :supporting providers and ACOs so that they are more able to accept aggressive

payment models such as population-based payments; Vermont's health data infrastructure has increased capacity for data integration; and the State is ready for initial, necessary modifications to regulatory and administrative processes within the Green Mountain Care Board or the Agency of Human Services. SIM investments also support readiness for the Medicaid Pathway through work on integration of behavioral/mental health, substance use, and long-term services and supports.

Practice Transformation

Shifting to alternative payment systems requires collaboration among providers, payers, and government. It also requires a willingness to continually learn and build towards a high performing health system. More work in this area will be necessary to completely fulfill the APM and Medicaid Pathway vision of an integrated, person-focused system.

Vermont currently convenes entities from across sectors, supported both by SIM funds and by other State and non-State funds, including: the Blueprint for Health, Departments within the State's Agency of Human Services, the ACOs, hospitals, community-led quality improvement and integration projects, and others.

Vermont's SIM investments in this area have focused on:

- Launching Learning Collaboratives to support system integration and improve care management capacity;
- Developing Community Collaboratives across provider types and care settings to provide local governance across initiatives, identify community priorities, and tackle community-wide quality improvement;
- A sub-grant program to test innovative delivery system models; and
- A variety of workforce-related activities.

Some of these efforts were designed to develop provider capacity in a way that should be self-sustaining. For example, a Core Competency Training initiative launched under the Learning Collaborative work stream in Performance Period 2 uses a "train the trainer" model to ensure that our State's providers can continue to pass on their new knowledge.

Vermont will continue to evolve its learning health system after SIM funds are expended through both public and private programs. Some of this future support will be State-funded through our Blueprint for Health and AHS departments; the State's specific approach to these activities will depend on the outcome of All-Payer Model framework discussions with CMMI. We expect that Vermont's ACOs, hospitals, and other private sector partners will also continue to invest in practice transformation activities.

Health Data Infrastructure

The State of Vermont has used SIM funds to make sizeable investments in health data infrastructure. In addition to SIM funds, Vermont has leveraged a number of funding sources to support health data infrastructure investments, including Vermont's health information technology claims assessment, Medicaid, and HITECH.

Specifically, Vermont has devoted funds to:

- Building connections between providers, the State's data sources, and the Vermont Health Information Exchange (VHIE);
- Improving the quality of data flowing into the VHIE;
- Electronic Medical Record expansion;
- Provision of care management tools;
- Work to enhance the clinical registry and integrating the state's clinical registry and claims data reporting systems; and
- A varied suite of projects and activities, including: telehealth pilots, a health data inventory, technical support for health data projects, and health data planning activities.

SIM funding has allowed Vermont to build some of the health data infrastructure necessary to support new payment models and educate providers on these new data systems. This infrastructure development has required large investments to develop key technologies, or complete critical project elements. Ongoing costs, though not insignificant, are a fraction of initial costs for many of these projects. Once Vermont has developed these electronic connections, we will need to maintain those connections and improve them as new technologies emerge. Data systems also require significant ongoing maintenance, as well as new development deemed necessary, for upgrades. We anticipate that the remaining existing sources of non-SIM funding will be sufficient to support the ongoing maintenance for the data systems developed during the SIM testing period.

Evaluation

A key piece of Vermont's SIM Sustainability Plan will be to ensure we maintain high-quality evaluation of our programs as we continue innovations over time. Vermont's SIM project currently supports three work streams related to evaluation:

- The State's SIM State-Led Evaluation;
- Surveys to assess patient experience within SIM payment models; and
- Additional activities to monitor and evaluate SIM payment models.

As required by our SIM grant terms, Vermont is performing a State-Led Evaluation that covers all of our project areas – this allows for rapid-cycle and more intensive review of activities.

Activities related to the SIM State-Led Evaluation will conclude at the end of the SIM testing period.

Following the end of the SIM testing period, the State expects to resume the standard evaluation and monitoring protocol in place in the state that predated the project. For payment models that continue following SIM, surveys and evaluation and monitoring activities will be subsumed within those programs and the State agencies and departments with jurisdiction over those topics. Vermont expects that these activities will be sufficient to properly monitor and evaluate Vermont's health system once the SIM funding is completed.

Project Management and Reporting

SIM-related project management and reporting activities will largely conclude at the end of the SIM Testing period. Project-specific project management may be absorbed by State agencies as deemed appropriate.

Governance and Stakeholder Engagement

Vermont's SIM project has engaged in robust, formal, and frequent stakeholder engagement activities through its governance structure. This has been an intentional investment of staff time and resources, ensuring that Vermont's SIM activities are driven by collaborative decision-making across the public and private stakeholders and allowing for regular reviews of provider readiness and change fatigue. Perhaps most importantly for our state's long-term health system reform goals, SIM provided an opportunity for high-level figures from across our health care system and social services to interact on a regular basis, bridging services and programs which were previously siloed and helping to develop a collective vision for health system reform in the state.

Having successfully fostered these public/private relationships through SIM, we will assess what governance and stakeholder engagement structure would best support the All-Payer Model and Medicaid Pathway frameworks.

While most SIM governance is planned to transition to new structures in December 2016, the SIM Core Team will continue to meet through the end of the SIM testing period, providing direction to the project and making funding decisions.

Staffing

Vermont has structured its SIM funding to provide infrastructure and capacity for the transition from existing payment and delivery systems to alternate payment and delivery systems.

Vermont uses SIM funding to support the development of tools and new models, while at the same time maintaining existing structures until they are no longer needed. As new payment mechanisms come online, we will no longer need staff and contracts to perform current tasks and will reduce our SIM workforce or train those staff for new roles. Vermont is intentionally seeking contract services to provide the subject matter and technical expertise necessary to conduct this transition with staff and contractors.

At the end of the SIM grant, the majority of the positions funded by SIM will no longer exist. There are a handful of positions that will be retained by DVHA and the GMCB respectively and the funding to support those will come from other revenue sources.

Federal Funding Beyond the SIM Grant

Vermont continues to work with its federal partners to identify opportunities for funding to support federal and state health system goals. Much of this work is currently focused on All-Payer Model framework discussions; however, Vermont will engage all payers, including Medicare, in discussions about ongoing engagement in Vermont's payment and delivery system initiatives regardless of the outcome of All-Payer Model framework discussions.

Glossary

AAA	Area Agencies on Aging
ACA	Affordable Care Act
ACH	Accountable Community for Health
ACO	Accountable Care Organization
AHEC	Area Health Education Center
AHS	Agency of Human Services (VT)
AOA	Agency of Administration (VT)
APM	All-Payer Model
ARIS	Area Resources for Individualized Services
BCBSVT	Blue Cross and Blue Shield of Vermont
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CHAC	Community Health Accountable Care (VT ACO)
CMMI	Center for Medicare and Medicaid Innovation (federal)
CMS	Centers for Medicare and Medicaid Services (federal)
DA	Designated Agency for Developmental and Mental Health Services
DAIL	Department of Disabilities, Aging and Independent Living (VT)
DCF	Department for Children and Families (VT)
DD	Developmental disability
DMH	Department of Mental Health (VT)
DVHA	Department of Vermont Health Access
EHR	Electronic Health Record
EMR	Electronic Medical Record
FFS	Fee for service
FQHC	Federally Qualified Health Center
GMCB	Green Mountain Care Board
HCBS	Home and Community-Based Services
HCBW	Home and Community-Based Waiver
HCO	Health Care Organization
HDI	Health Data Infrastructure
HEDIS	Health Plan Employer Data and Information Set
HHA	Home Health Agency
HIE	Health Information Exchange (Also Vermont SIM Work Group)
HIPAA	Health Insurance Portability & Accountability Act (federal)
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
HSA	Health Service Area (VT)
IFS	Integrating Family Services (VT)

LTC	Long term care
LTSS	Long term services and supports
MH	Mental health
MMIS	Medicaid management information system
MOU	Memorandum of understanding
NCQA	National Committee for Quality Assurance
P4P	Pay for Performance
PCMH	Patient Centered Medical Home
PCP	Primary Care Physician
PMPM	Per member per month
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (federal)
SNF	Skilled Nursing Facility
SSA	Specialized Service Agency for the Department of Developmental and Mental Health Services
SSP	Shared Savings Program
VAHHS	Vermont Association of Hospitals & Health Systems
VCHIP	Vermont Child Health Improvement Project
VCN	Vermont Care Network
VCP	Vermont Care Partners
VDH	Vermont Department of Health
VHCIP	Vermont Health Care Innovation Project
VHCURES	Vermont Healthcare Claims Uniform Reporting and Evaluation System
VITL	Vermont Information Technology Leaders
VNA	Visiting Nurse Association
VPQHC	Vermont Program for Quality in Health Care