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Combined Meeting of The Blueprint Executive Committee and Blueprint Planning and Evaluation Committee

September 21, 2016

Attendees: J. Batra; M. Beach; G. Bercy; C. Elmquist; P. Farnham; K. Fitzgerald; C. Fulton; L. Hendry; P. Jackson; J. Krulewitz; J. Le; C. MacLean; M. McAdoo; M. Mohlman; J. Plavin; J. Samuelson; B. Tanzman; T. Tremblay; R. Wheeler; M. Young

By phone: B. Bick; P. Biron; P. Clark; W. Cornwell; J. Fels; M. Gilbert; J. Hester; T. Moore; J. Peterson; L. Ruggles

The meeting opened at 8:30 a.m.

I. Opening Remarks and Announcements: Beth Tanzman

- Today's agenda and PowerPoint slide deck were distributed prior to this meeting.
- B. Tanzman introduced herself as the appointed Interim Executive Director. She expressed her honor to work with a talented team and privilege to work with our folks on the field, local communities, and partners in the Accountable Care Organization provider networks.
- B. Wheeler announced his retirement from BlueCross BlueShield of Vermont (BCBSVT) effective September 30. B. Wheeler also announced Dr. Joshua Plavin as the next Vice President and Chief Medical Officer for BCBSVT. Dr. Gabrielle Bercy will be joining BCBSVT as Senior Medical Director in November.

II. Update on All Payer Model (APM)

- B. Tanzman reviewed *slide #3*, Current State of Play in Vermont. The potential and opportunity for a unified accountable health system and all payer model is unique in the nation and is tremendously exciting.
- J. Peterson reminded the committee to include the Area Agencies on Aging (AAAs) and Home Health agencies. Blueprint outreach can be collaborative, and consideration needs to be given to augmenting, and not duplicating, efforts on the ground.
- B. Wheeler stated providers get energized when they see positive results rather than perceive they are being micromanaged.

- J. Hester mentioned the 10 communities participating in the Accountable Communities for Health Peer Learning Lab. They convene and organize the local communities to be accountable for health.
- T. Moore reported progress on the APM negotiation is looking positive. We need to keep the innovations made to date and secure the capital to implement what we have been discussing. Sharing best practices with each other will be key to remaining under the capped growth rate in healthcare spending for the State over the next few years as defined in the APM.
- Beth mentioned the energy at the State and Federal level is to bring this deal to the finish line in the next few weeks. T. Moore agreed.
- K. Fitzgerald stated she heard the Green Mountain Care Board (GMCB) will need to hold a public comment period before the APM can be signed and made official. She asked what the public comment period will look like? T. Moore responded he does not have an answer and believes more information will be forthcoming rapidly.
- B. Wheeler pointed out the opportunity to look at Statewide data. There is enough variation and best practices among local communities to do further work on gaining savings.
- B. Tanzman reminded the committee of the opportunity in 2017 as a transition year to work on building leadership and accountability into the system and working together to improve performance.

III. Community Collaboratives Next Steps

- B. Tanzman reviewed *slide #4,* Community Collaboratives. Community Collaboratives began a year and half ago when Dr. Craig Jones convened the Blueprint and the three (3) ACOs to define and implement local-level priority-setting and quality improvement committees to align the work of statewide healthcare reform initiatives. The Community Collaboratives (CCs) are working pretty well in most of our local communities.
- B. Tanzman stated local leadership teams have not developed to the level originally envisioned. B. Tanzman reviewed *slide #5*, Community Collaborative Leadership Team. B. Tanzman stated we need to dig in collectively to challenge ourselves and see what we can do to support this development.
- The committee discussed and provided feedback:
    - L. Ruggles reported on the Accountable Communities for Health work happening in St. Johnsbury. They use the Collective Impact model, working on a common issue and goal.
    - Common measurements and goals make people more involved.
    - Community needs assessments are mapped on a regular basis and are an IRS requirement for hospitals to keep their non-profit status. Often, the community needs are social determinants of health and not necessarily impacted by traditional medical processes, however, UVM Medical Center has started making investments in housing to free up inpatient beds. Significant savings have been realized. Nutrition is next. Many hospitals go through the community needs assessment exercise without addressing identified needs. More can be done.

- What are the goals? We need to set the targets at the statewide level to bring these collaboratives together. The key drivers to the shift in public health is the creativity of thinking differently in response to the data.
- It is only valuable if we generate a statewide community needs assessment and have a common initiative to reduce the duplicated efforts at the local level. The health improvement plan can provide direction.
- P. Farnham asked about the practices not involved with Blueprint or any of the ACOs. We can't forget about them.
- Need a laser focus on one or a few things, using the local communities' process in place to generate those priorities. It will be an enterprise of shared leadership to align with each partner's priorities.

With no further time, the meeting adjourned at 10:05 am.

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Executive Committee
Planning & Evaluation Committee

September 21, 2016

Agenda September 21, 2016

- Opening remarks and announcements
- Update on All Payer Model – Al Gobeille
- Community Collaborative next steps

Current State of Play in Vermont

- Statewide foundation of primary care medical homes
- Community Health Teams providing supportive services (150 FTE)
  - SASH 113 Housing Sites
  - 80 Settings with Spoke Staff and 9 Hub sites
  - Planning for Women's Health Initiative
- Statewide self-management programs
- Statewide transformation and learning network, ACO alignment
- Quality payments tied to service area results, maturing data infrastructure
- Local innovation through community collaboratives, ACO alignment
- Potential for unified accountable health system and all payer model

Community Collaboratives

- Align stakeholder work groups and QI initiatives
- Common measurement of ACO and population health indicators
- Care management collaborative, common tools and process
- Coordination of health and community based services projects
- Leadership Team?

Community Collaborative Leadership Team

- Prepare for interagency executive decision making across sectors
- Set priorities
- Balanced representation of health, housing, human services pediatrics

IOM Principles of Highly Effective Teams

- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and outcomes