BLUEPRINT EXECUTIVE COMMITTEE AND
BLUEPRINT EXPANSION DESIGN EVALUATION
COMMITTEE MEETING
JULY 16, 2014

MS. CHETTI: Blueprint Executive Committee and Blueprint Expansion Design Evaluation Committee Meeting taking place on Wednesday, July 16th.

DR. JONES: Let's go ahead and get started. Quite a group this morning and we really -- first of all, the whole team wants to thank all of you for taking time out of incredibly busy schedules and being willing to come and be part of the meeting today. We really appreciate it.

This is a big effort, and this is following along a discussion that really started in each of the communities around the state meeting with the different clinicians and community health team and leadership groups talking about ideas around payment modifications, and, frankly, next steps; you know, what happens to the Blueprint, what should be brought to play for the medical homes and community health teams around the state, and been working these series of discussions into now we are in this forum, and with state innovation model testing, and Green Mountain Care Board we can really try to bring some sound ideas to the table. So that is what this is about and this morning is going to be a continuation of that.

I want to focus on a couple key issues and so again I thank you all for coming. It represents a

large and diverse group of people, all of whom have an interest around this in the state.

Before we get started I wanted to check a couple things. First, can those on the phone hear okay?

UNKNOWN SPEAKER: Yes.

DR. JONES: And did the people on the phone get the slide sets?

UNKNOWN SPEAKER: Yes.

DR. JONES: One slide set. Okay. Great. And anybody able to get on the WebEx? Are you all on the WebEx okay?

UNKNOWN SPEAKER: Yes.

DR. JONES: All right. Good. So the technical stuff is out of the way. That's usually our biggest challenge. Also we're not obviously going to go around the room and have people introduce themselves this morning. That would just about kill the morning. So we thank you all. We will be passing around a sign-up sheet and really appreciate it if all of you can sign in. We do want to have a record of the meeting.

For those that are logging on or calling in, Casey from our team has been on collecting the names and the participants. Anybody who is on the phone who didn't sign in with Casey, if you can just e-mail us and let us know that you were part of the meeting, that would

be really helpful.

So I think we can jump right into the discussion, the meat of the discussion this morning, and oh another -- for those of you who haven't seen it we do have coffee in the back and juice if you want it. So it's hidden back there, but go ahead and take it if anybody didn't get it.

So the way we're going to start this off this morning --

UNKNOWN SPEAKER: Can I have a clarification, Craig? Who all is invited? I don't want to know everyone's name, but who is here in addition to the usual people at these meetings?

DR. JONES: In addition to the Blueprint Executive Committee and the Planning and Design Evaluation Committee what we did was extend invitations to all of the Blueprint project managers, their medical home clinicians, the community health team leaders in each of the communities. So it's the full spectrum of those involved in medical homes and community health teams across the state. Charlie, thanks for bringing that in.

The purpose really of this morning is to talk about two major things. One is modifications to the payments that the medical homes and community health teams have been receiving over the last five years and some --

and recommendations and your input on that. Most importantly is an additional step.

All the discussions some ideas around linking the ACO and Blueprint work that has formed in this emerging in each community, and we want to talk about both and bring them together in one single conversation. So that really is the nature of the discussion this morning and we'll put some specifics to it.

We've asked whatever clinicians and community health team leaders and others want to have input in the meeting to be able to do that. This affects directly what they are doing across the state, and in the end the work that's been going on for the last five years to organize medical homes and community health teams is a reflection of hundreds and hundreds of people spending an incredible amount of time around the state, and that's what the room reflects and we wanted that voice to come into play in looking at recommendations and helping to inform those recommendations. So that's the purpose really of the meeting this morning.

There are a couple clinicians who couldn't join us for the full length of the meeting but may have wanted to have some input and some comments, and we wanted to make sure to have room upfront for them to be able to do that. They have to then go off and do what

they do. So I want to open up and just ask if there's any of the clinicians, particularly on the phone, who couldn't stay with us through the course of the meeting and wanted to make any kind of opening comments or remarks, or if you're able to keep them until we get to the discussion part of this meeting. Anybody on?

UNKNOWN SPEAKER: This is Bernie (inaudible). Can you hear me?

DR. JONES: Sure, Bernie. Thank you.

UNKNOWN SPEAKER: So I've got a fairly poor phone connection here. I can only hear your voice and no one else, and I don't think there's any reason for me to stay on the phone for any period of time. So if it makes sense I would probably offer the comments I would offer now.

DR. JONES: That's fine, Bernie. Hopefully -- we do have microphones around the room today so my hope is you will be able to hear the discussion if we can coerce you into staying on, but please feel free.

UNKNOWN SPEAKER: I'll give it a try.

DR. JONES: All right. Great. Do you want to wait then until we get to the discussion section?

UNKNOWN SPEAKER: Sure.

DR. JONES: Thanks, Bernie.

DR. RINEHART: This is Jill Rinehart

too. I have comments also, but I can stick around a little bit. I don't know if I can stay until ten, but I can stay until 9:30.

DR. JONES: Okay.

DR. RINEHART: If you want to hear them now or later, I don't mind either way.

DR. JONES: Well the best may be to put it into the full discussion, if that's okay, and we'll try and get there quickly for you.

DR. RINEHART: Appreciate it. Thank you.

DR. JONES: Thanks. Anybody else?

UNKNOWN SPEAKER: This is (inaudible). I guess the question is how long is it going to take? (Inaudible) Again I called in because of time constraints.

DR. JONES: Sure. Well we're happy to have you go ahead now and if that would be more comfortable for you. It probably is -- these discussions tend to be not just a presentation but the discussion goes as the presentation is going. We have a very short set of information so that we can set some context. We have a large group today that normally aren't part of these meetings. So we did want to frame it out a little bit. So we're probably thinking about a half hour, but the

discussion starts pretty quickly.

UNKNOWN SPEAKER: Hey, Craig, should we be expecting to hear everyone who is on the phone through these speakers because we're not and we're blinking and you're solid green. So I'm trying to figure out -- and Kelly is hitting buttons with abandon which is fabulous and she's doing it with great authority, but nothing has changed. So --

DR. JONES: Let's check. Could those on the phone hear (inaudible) LeClair speaking?

UNKNOWN SPEAKER: No. Not very well.

UNKNOWN SPEAKER: Okay. Then something is awry. I have been in front of the mike and I've never been accused of being soft spoken.

DR. JONES: All right. We'll check on that. We did check them out earlier and they were working, but who knows. What's the chance of us actually get a meeting started without some technology problem? All right. All right.

While Tim is checking on that, and you may want to speak into it, Tim, and check do you want to just speak in and see if anybody can hear you?

UNKNOWN SPEAKER: Good morning. Can you hear me?

DR. JONES: Could you all hear Laurel?

UNKNOWN SPEAKER: No.

DR. JONES: All right. Yours is the only working mike right now. We'll continue. All right. Let's go ahead and get started.

This is an opening basis for what we really hope to hit on today. Two major points, as I said, strengthening the medical home and community health team foundation during this transition phase. We are in a period of incredible transition in health care delivery in Vermont. 2015 and '16 are two years leading into 2017 when it's expected or anticipated that some form of Green Mountain Care financing will take hold. During this two-year transition phase we want to really maintain a strong investment, build a strong foundation of great health services, primary care, preventive health services. So maintaining and strengthening, frankly, that foundation is a key topic of a discussion this morning. Under that includes increasing the payments for medical homes and community health teams, and really linking that to number two, which I'll get to in a minute.

We also want to continue the requirement of medical home recognition. There's been all types of variable opinion about that around the state. The data is emerging to suggest that medical home recognition and even level of medical home recognition is associated with

outcomes. We have enough data and enough variation to suggest there's an association justifying the importance of those standards and the recognition despite the fact that they are pretty difficult and they are difficult to meet and they take a lot of work.

Third, also talking about shifting the community health team payments. They started out as a shared cost based on some arbitrary interest and even arbitrary breakup of percentages for the insurers when it was a pilot, and nobody understood how they were -- they would distribute and how they would expand that made sense. At this point being statewide there is a strong call to shift that payment and link it to attribution similar -- exactly the way the medical home payment is made. So count the attribution in each setting, how many of each insurer's members are part of that attribution and have them contribute their payment based on that attribution.

So those are the three key points under strengthening the medical home/community health team foundation, but having that link directly with number two and the ideas that have emerged here, and we got a lot of this around the state as we were meeting with you all how are we going to integrate the ACO work and the work of the medical homes and community health teams, and so one path

that has emerged in the discussions is this: Form a single local collaborative in each community. There are Blueprint work groups right now. There's ACO work groups that are going on in parallel. It's often the same people. In fact, most of the time the same people plus others form one single common quality collaborative. Have it focus on core ACO metrics and link eligibility for the payments -- for doubling the payments to participation in that single unified quality collaborative.

Have the medical home and community home teams work oriented toward the core ACO measures. As it says have the eligibility for increased payments dependent on participation in that effort, and add a core ACO message to the practice profiles that you all are receiving. Everybody has received practice profiles around the state. As many of you know we now have service area profiles that have gone out and even organization profiles, meaning you get the results, comparative results, of how you and your peers are doing in your community, and the recommendation is to add a new dashboard with it that takes the core ACO measures and puts it front and center. Lou.

UNKNOWN SPEAKER: Are you going to be sending out the HSA dashboard reports to the payers so that you had talked about it in some previous meetings, and I'm just wondering if that's on your agenda to

distribute soon?

DR. JONES: We certainly can distribute the service area profiles.

UNKNOWN SPEAKER: I appreciate that.

UNKNOWN SPEAKER: Paul, short question.

DR. JONES: Jump in.

UNKNOWN SPEAKER: We talk about following the ACO measures, three incentive measures; one for Medicare, one for Medicaid, and one for the commercial ACOs. In a like fashion there's three different ways of attribution. So could you kind of say if that is at all the ACO measures which are 54 or is it one Medicare, Medicaid, commercial, and then is it the attribution for all three or is this one?

DR. JONES: We would promote including a dashboard for each of the ACOs core measures. The commercial and the Medicaid on their core measures line up with the exception of one measure. Medicaid has one additional measure on their core payment metrics. Medicare are an additional set, and we would -- we would promote the taking all the key measures that the ACOs find in our central ACO operation and put them on a dashboard as part of this.

Second, the goal here is to promote unification in each community. So the ideal is that the

separate ACOs, and that's part of this discussion, would be working together to improve against these core measures in each community. Instead of segregating out the work of the ACOs promote them to work together on each of their core measure sets.

UNKNOWN SPEAKER: Thank you.

UNKNOWN SPEAKER: Related question. On the attribution side so would you have three different data sets and the total? You have overlapping, but not the same y's in each of the different pool.

DR. JONES: Well --

UNKNOWN SPEAKER: I'm sorry. Can you repeat the question?

DR. JONES: Yeah. Sure.

UNKNOWN SPEAKER: I'm not hearing the question.

DR. JONES: Sure. Thank you. The question had to do with the attribution. Would we do three different paths of attribution for each of the ACOs, and that's -- these are all details to be discussed in work and refined. It really depends on what view that you want to provide to the collaboratives in the community. One option is to do medical home attribution, take the full population and provide the results of ACO measures against the full medical home population. So there's a

single attribution to reflect outcomes in that community. There could then be breakouts done for each of the ACOs for their particular subpopulations.

So we could arrange this different ways and we could apply multiple attribution pathways. I think those are the details that we actually want to work out with you all.

The key here is if there is a willingness and a support to move in this direction is then we work through the details so that the results of these metrics meet the needs of a common learning collaborative, quality collaborative, and also the interests of the distinct ACOs. Any other questions?

UNKNOWN SPEAKER: Based on what you're outlining does that -- does it mean that all of the practices that wanted to participate could participate whether or not they belong to an ACO or does it presume that you're part of an ACO?

DR. JONES: It presumes -- what we're proposing here is that in order to be eligible for the increase in payments that you would participate in the common quality collaborative focused on the core ACO measures.

UNKNOWN SPEAKER: And that's fine and I think that's a good idea because that may -- not everybody

who is going to participate in that core collaborative has to be a member of an ACO.

DR. JONES: Well I think that would be a decision for the local -- the structure of the local collaborative, and again those are details to be worked out. This is really focused on how to bring the medical homes and community health teams --

UNKNOWN SPEAKER: Together.

DR. JONES: -- together unified against the purposes of the core measures. Does that make sense, Jack?

UNKNOWN SPEAKER: The -- can you repeat the questions that are being asked?

DR. JONES: I'll try to do that. Thanks. The last question had to do with did the participants in the local community collaboratives have to be part of ACO, and so the response was these are details that have to be worked out, but these learning -- these community collaboratives, as you've always done, would have to be organized locally. We certainly wouldn't want to exclude anybody from being an important part of that. The goal here is to unify a common purpose for the medical homes and community health teams and the ACOs. If there's others involved, as there already are in many of your local work groups and community initiatives, that seems to

be an important factor for you. Before we move on any other questions?

UNKNOWN SPEAKER: I just wanted to make sure that I understand what the CHT payment is because that's where the change is. The CHT payment is based on attributed (inaudible) by the payers as opposed to the practice counting it. My concern would be -- and I can understand it feels fair to the payers -- fair to the payers, but my concern for the practices are is that some -- there are so many exclusions with attribution any practice that's on the border, they have a lot of New York, New Hampshire, Massachusetts patients, it's doubling the CHT payment may in reality not be a double because when they look at attributed lives measured by the payers that is sometimes 50, 60 percent of the patients that are being seen, and yet how the practice thinks of them is they are all my patients and the community health team will serve that.

So I hope there will be some analysis on what that really means and is it really doubling the CHT payment which we need done and not just going up by 5 or 10 percent.

DR. JONES: For those on the phone Dana was making the comment that if community health team payments are linked to attribution that could reduce the

number of lives the community health team payments are based on. Some people are out of state but going to the practice, so on so forth, and that's true.

On the other hand, Dana also pointed out that this is more fair to insurers as we have big market shifts and covered lives and also it's a statewide initiative, and so moving the community health teams to a place where there's more of a proportionate representative support for their operations does make some sense. So there's a balance of issues here and that is -- we absolutely want to have an ongoing conversation about the best way to run the attribution.

The idea would be to have one single common attribution that was most reflective of the population that needed to be treated. How to balance out these different attribution methodologies is something we would have to work through, but your point is well taken. Yes.

UNKNOWN SPEAKER: And the attribution process still after all these years is not perfect. I mean when we -- I keep giving up on trying to reconcile my list with the payers, but occasionally have to do it and there's still wide gaps.

You know when I looked at that bullet point there I know the payers are concerned that they are disproportionately not paying their fair share, and so I

know that means that within that group of -- that pool of money if they want to divide it out more equally that's fine, but I don't like the idea that it's just based on Blue Cross pays for their patients and CIGNA pays for their's. I think that's -- I echo what Dana says. I don't think that's fair.

DR. JONES: So Laurel Ruggles was just commenting about again there may be some problems with the attribution in terms of reflecting I guess the population that's really being taken care of in the practice. Is that a fair way --

UNKNOWN SPEAKER: I just think there's computer glitches or, you know, there's just -- when we look at specific -- sometimes look at the patient level and somebody really has one payer and they are not on our list and then we have to figure out why.

DR. JONES: All right. No, and I think this methodology should be revisited and frankly looked at objectively to see what the real numbers are and what the best method is, and that's something we could do in the course of planning is take a look at the best way to count.

It is tough, you know, to reconcile the difference in numbers. One thing just to -- we did look pretty carefully this year at attribution and why the

numbers are so different; those that are reported by a practice versus those that are counted in medical home attribution. I'm not talking ACO, and it turns out that a very good portion of the patients in the medical homes are going to more than one medical home, and they will have two visits at one practice in Vermont and they will have three visits -- in a two-year look back they will have three visits to a practice in New Hampshire and they won't be attributed to the medical home in Vermont because the preponderance of their care is in New Hampshire.

For those types of scenarios of people shifting their primary care setting is actually the major influence in why the count for attribution is lower than what the practice believes their actual patient load is, and bringing that into the conversation, the math of that, is actually pretty impressive when we look at the numbers of people that are moving around. How you account for that is tough. Yes.

UNKNOWN SPEAKER: I can also add that --

UNKNOWN SPEAKER: This is (inaudible) can I add something to that?

DR. JONES: Sure.

UNKNOWN SPEAKER: In addition to that and in Central Vermont what my experience has been with the shift going from CIGNA to -- from CIGNA to Blue Cross

that an awful lot of those patients' information wasn't transferred from CIGNA to Blue Cross. Some of them were, some of them weren't, and a lot of our primary care patients are being attributed because of that. So any time there's a shift from one payer to another there is a potential of losing quite a bit of that attribution.

DR. JONES: No, that's a good point, and the -- I don't know for those of you in the back of the room I don't know if you can hear Bernie Noye (phonetic) was commenting.

UNKNOWN SPEAKER: You can hear him now.

DR. JONES: Oh you can hear him now. Great.

UNKNOWN SPEAKER: That's because he's on the phone.

DR. JONES: Okay. So the -- so it's -- you know, if somebody drops off, they're members of CIGNA they move to Blue Cross they have to have a visit, they are going to continue to be attributed to the old medical home until they have a visit to a new primary care practice. So that means it's going to take time for people who shift to be captured within attribution. It's not until they go, have a visit to the primary care setting, and then the next attribution sequence will capture their new movement. So there will be fluctuations

on that end. It will take time before the attribution trues up.

On the other end, you will be continued to be attributed to the practice, the old one that you used to go to until you go to a new one, and so there are lags on both ends of that attribution cycle. That's the nature of an attribution cycle unless you're trueing it up every single day.

UNKNOWN SPEAKER: I'm sorry. I'm talking about a something a little different. I'm not talking about a patient switching a medical home. I'm talking about patients who come to see me and I know they don't (inaudible). I see them a couple times a months and I don't get paid for them because the data from their old CIGNA plan wasn't transferred to Blue Cross so it can be attributed properly, and I talked to Blue Cross about this and they told me they only got partial data from CIGNA when this transfer happened and they didn't have the proper information to attribute people.

DR. JONES: All right. You know what we'll do --

UNKNOWN SPEAKER: I've seen them several times a month since the beginning of the year and I'm still not getting paid.

DR. JONES: Okay, Bernie. What we're

going to do is start down a different path of discussion, a different setting on the mechanics of the attribution. Obviously it's important that this is something that needs to be trued up to be the most reliable and the most valuable, and my sense is this really takes some detailed work groups and we really should do that, but I would like to move into the discussion into really exploring the higher level issue here, the future directions on the payments and the integration, and then work out the mechanics of the attribution as a separate process if that's okay.

Did you have a question there? Is there a question?

UNKNOWN SPEAKER: I was just going to add that another discrepancy in those attributions is the self-paying companies because there are some very large companies that are not participating --

DR. JONES: Yup.

UNKNOWN SPEAKER: -- and that in some practices is a very significant number of the attributions.

DR. JONES: Just a comment for those on the phone about -- another attribution comment about self insured not being included in the -- in all the attribution cycles. So we'll form some breakouts in the

attribution order. Yes.

UNKNOWN SPEAKER: I'm (inaudible) a doctor at (inaudible). I just want to say that item number two, the integration of the Blueprint of activities across the communities, I think it's a fabulous idea. I think we are way overdue for some leadership in this area.

My practice spends a terrific amount of time trying to just figure out what are those new updated guidelines, what are the performance measures we need to figure out now, and they have kind of one team working on this because, you know, we're trying to reduce health care costs here and what we've got is all these different ACOs and bureaucracies springing up everywhere. So the idea of unifying this I think is really great.

DR. JONES: That's very helpful. I don't know if those on the phone could hear. Could you hear the comments?

UNKNOWN SPEAKER: No.

DR. JONES: All right. Well we're going to be stuck with this I guess, but what there was, was support for the unification of all the ACO initiatives and the Blueprint so there's one single common purpose that practices are working against as opposed to all the separate administrative challenges that you may have now. Is that a fair summary of it?

UNKNOWN SPEAKER: Craig, I had a question on the doubling of the payments. Is that for more staff or more payments for the current staff?

DR. JONES: It's to increase -- actually increase the capacity of --

UNKNOWN SPEAKER: Of more people?

DR. JONES: Yeah, yeah, and we have had previous discussions in this setting about the math, some of the math behind this, the results that have come out to date, the trends. So the justification for increasing the investments is something we talked about previously. We can certainly revisit that, but the reductions in expenditures that all the people -- all of you sitting around the room who worked on this over the years have seen justifies the increase, and this still leaves a strong margin for reduction in expenditures, and so we think it's justified in terms of the results which is why we've brought it up this year. It's also necessary, we believe, just to keep participation and further stimulate the growth of this foundation.

So linking the increase in support to a single unified collaborative working against the core ACO measures it's the basis of the framework, and we just want to make sure to give a chance to have that sounded out in this forum. Yeah.

UNKNOWN SPEAKER: So, Craig, as a concept I think it makes a lot of sense, but what do you actually envision this collaborative doing? How is it actually going to work? What's it going to tackle? What's it going to be responsible for?

DR. JONES: The proposal at the high level that we've put forward is to focus on the core ACO measures because those have been worked on and selected by other work groups, not -- you know, not this. Those have been through the same process and through the ACO formation. So around the state at least at the ACO level there's been agreement on the core sets of measures. So those could be a focus for the quality work.

How the local community would be structured and community initiative would be structured, organized, and governed in relationship to the ACOs I think those details would need to be worked out, but the ACOs are already forming those types of structure in each of the communities. Each of them has governance and structure to them, and so what this does is lets those new governance structures and work structures as organizations take hold with a focus against the core measures that they have selected. It lets the ACO structure really take hold. Todd.

UNKNOWN SPEAKER: Hi, this is Todd

(inaudible) from One Care and Craig and I spent a long time talking about this. I'm actually quite excited about this because I don't think we need multiple layers of clinical committees locally, and to have one that uses the best of the Blueprint infrastructure, the emerging ACO infrastructure together over the next couple years makes perfect sense, and part of this was I'm supportive of extra money to support primary care.

I told this maybe last meeting our status, higher status practices perform better for the Medicare data. That data I can see directly. So I definitely support that, and having extra funds in the local communities to improve quality, whether it be from a status the Blueprint has always monitored or the payment and reporting measures in the ACO programs I think is what this is all about. So some sense of a joint governance among the providers in the community, the Blueprint staff, the three ACOs to the degree that all three play in a local community to jointly govern this expansion of the community health team concept is exactly what we're talking about.

UNKNOWN SPEAKER: Could I ask a followup?

DR. JONES: Yeah please.

UNKNOWN SPEAKER: Because I think it's

one thing if we're going to meet regularly, compare notes on the data, and try to identify locally what may be working or not working. I think that's all positive, and Paul Bengston is here from NVRH and that's our catchment area too, and I think we work very, very well together and I think it can be very positive, but just to pick up on what Todd said governance is a different story. So I'm just searching for exactly what is the expectation because if the concept is larger, but you run the risk, don't you, that you're going to have 12 or 14 hospital catchment areas doing things differently or proceeding differently.

Is there a guideline for this? Is there a plan for exactly who is going to do what? What impact it will have on behaviors of providers?

DR. JONES: Well these -- these seem like the issues to be worked out in the structure of the quality collaboratives in each community and through the ACOs. I think that's the very purpose of the ACO structure is to bring some common focus to an organized health system. So that would be something that could be worked through, through the ACO structure.

Again, I think there's been a tremendous amount of work over the last couple of years, year and a half particularly, for selection of these core measures that the ACOs are focused on achieving progress against,

and that gives you a target. That gives you a north star to shoot against. Whether you're a collaborative in Bennington or a collaborative in Newport you've got a core set of common measures to work against. How you organize the local learning collaborative and how you organize the work to improve against those measures I think is exactly the details to be worked through, and I think that goes to the heart of the ACO structure if I'm not mistaken. Yes.

DR. RINEHART: This is Jill Rinehart. Is it okay if I speak my part now? I think it might be relevant.

DR. JONES: Sure, Jill, please.

DR. RINEHART: So I'm Jill Rinehart. I'm in primary care pediatrics, Hagan Rinehart & Connelly here in Chittenden County, and I do think that all the good work that we have seen from the community health team in both the pediatric population that we serve and in relation to the families that we serve in their work with their adult care teams is really about providing effective care coordination and building relationships for patients and families, and that is where the strength is of the cost savings and improvement in the triple aims, and I think that we're seeing those measures of that strategy come to light when we think about the benefits that we anecdotally and, you know, I think, you know, furthermore

what we really think about effective care coordination, which is I think different than case management, is really about an assessment driven family centered process that addresses all these issues of financial, behavioral, developmental needs of a family, identifying the needs, and then having our community health needs be the way we meet those needs that we identify in the medical home.

I think that transcends pediatrics and all, you know, family medicine and internal medicine as a medical homes need, and that's really what (inaudible) and medical home is about, about that relationship building. So I do think we have a structure in place that's beginning an effort of care coordination within practices that is improving health care outcomes, and I just want to mention that one of the benefits that we've see from pediatrics through -- here in Chittenden County is that we've been able to correlate across four big group of practices and represent over 20,000 child lives, that's how this works, to rally around the cause of care coordination in families that make a difference, get people to their appointments, et cetera, (inaudible) and now larger we have a pediatric learning collaborative that's sponsored by VCHIP and CHIPRA that is allowing us then to (inaudible) 11 right now other pediatric practices effective (inaudible) children I should say. We have some

family medicine folks involved too. That then we have this great network of Blueprint supported care coordination. So the structure is starting to form and I think that's where these innovations can transcend and form (inaudible). Thank you.

DR. JONES: Jill, thank you. So just to double-check it sounds like you're endorsing the principle of this sort of common quality collaborative. That you and pediatrics admittedly have done an incredible job of pulling together in this area.

Just for those in the room that may not know Jill and the pediatricians in the community were an incredible engine to drive coming to agreement on community health team operations areas of focus a long time ago. They really brought that spirit into this.

So just to double-check, Jill, so you're endorsing a move -- a general movement along the same lines where there is a common focused quality collaborative in each of the areas, maybe a separate one for peds and a separate one for adults?

DR. RINEHART: Yeah. I think we can learn from the pediatric group, similar to medical home, where there's sort of embedded a bit in the culture based on AAC work of medical home and care coordination being a function of a -- function of an effective medical home,

and both in adult and pediatric practices. I think we have the beginnings now of what's working and the idea that patients have one person they can contact to ask (inaudible) access of effective care coordination.

I'm saying what I think works about the Blueprint is effective care coordination and each community is working to see how their practices will bear community resources to improve these relationships and outcomes for families, and I think right now what they have done is provided us with those (inaudible) across the state (inaudible) is although they are all serving children they are in Bennington, they are in Windsor, they are throughout the whole state very -- so that's been delightful to see the way that the state has kind of come together in pediatrics around this goal of improving relationships for families about transition from hospital to home, from, you know, really has been tremendously effective, and I would say this is a structure that will (inaudible) behind it to improve outcomes for the adult practices. Forget that you would (inaudible) that as a common theme, and we can talk about hemoglobin AICs and we can talk about, you know, developmental screening for pediatrics, things that we need to check off for our measures, but really what we would be measuring is this idea of relationships and improvement in care outcomes

based on that relationship. It starts with pediatrics, but it transcends into whole like (inaudible).

DR. JONES: Thanks, Jill.

UNKNOWN SPEAKER: I wanted to follow up on (inaudible) governance then so -- and maybe this has been discussed before, but I was curious what the proposal is regarding the fact that you have three ACOs all with three different governances, and as you're talking about sort of a combined governance for Blueprint and ACOs, I know there's one (inaudible) after that, but how would the other ACO models be integrated with that governance structure, first of all, and those that are unaffiliated with the ACOs who would they be following in terms of governance? Is there one governing body for all ACOs?

DR. JONES: So could those on the phone hear the question?

UNKNOWN SPEAKER: Could you have the people on the phone put themselves on mute too?

DR. JONES: Yeah. For those on the phone if you could, if you're not speaking, put yourself on mute. That will help with the background noise.

The question really went to the heart of governance because there's three different ACOs and government structures and how would that all be organized. I think those details really need to be flushed out and

are probably going to be flushed out through similar groups and other processes, but in general, and I would really like to open this up actually and get more input from the people that are frankly doing a lot of this in the communities, in general you have, you know, you have some Blueprint work groups now and you have ACO work groups, and in some communities they have already brought them together and they have organized them as a single process, and -- and they organize around a common purpose, and so I think melding these different groups together to work against a single common set of measures probably is not as difficult as it may seem at first, but let me open it up because I think this goes to the heart of the discussion and I would really like to get everybody's feedback. Tom, go ahead.

MR. HUEBNER: Tom Huebner, Rutland Regional. So we -- I think this approach is the exact right next step. It's not the last step and a lot of questions we're raising aren't going to be resolved in the next step. So to me it's -- we've done something very good with the Blueprint. Certainly in Rutland we feel very strongly that it's created a foundation for us to be ready for a triple A rural to be ready for a value based rural that has really done a lot primarily around care coordination, and that we need to continue to build on

that foundation by aligning that work now with the ACOs' quality objectives and find some money for that feels exactly right.

In our community we believe a regional structure must be the core of that. Is there a state overlay where we can learn across the state from each other and some centralized pieces? Entirely think that's right, but we all know about our own communities have very different infrastructures in them and are going to have some discrete ways that we solve these problems, and it's going to -- we're going to need to allow for that as we go forward.

I don't think in this step you're going to solve all the governance issues across three ACOs. I don't think you need to take the next step. I think this step drives us towards an even more common base to go forward and provides us the resources to continue to do good work.

Having said that, I think it's not the last step. I think there's a really important next step. I strongly support the approach, but don't for a moment think that we're at the end of the journey yet, and frankly if we tried to get to the end of the journey in the next step I think we crash and burn because we are continuing to build infrastructure and trust and

relationships that will allow us to get to that last step. We ain't there yet. At least in Rutland we're not there yet, and -- but I think we're really making great progress.

So that's how I think about it. Some detail, technical details about attribution and all that do need to be resolved, but, you know, stay -- my point of view is stay on what's positive about it. Stay on what would be a good next step without getting too caught on what the final, final, final version is. We're not going to get there quite today.

DR. JONES: Thanks, Tom. Let's just work our way up on the room.

UNKNOWN SPEAKER: I think that there has to be recognition that we're talking about systems that are small rural systems that have finite resources, and when you create expectations that there's recording for this and then this and then this and you overlay this on newly emerging EMRs and lack of administrative or data and financial and data analysis staff, that's a burden that detracts from actually the care.

So simplifying and standardizing the expectations across the state will -- you know, it will actually reduce the resources put into developing the reports and then looking at the outcomes and also unified

the groups that, you know, for one standard.

I look at if there's different governance structures that adopt the same outcomes you're still making a big input and impact on simplifying the systems that can both get access to the data and then react to that. So, you know, and then I just would echo what people have said that marrying those standardized quality outcomes with an already existing infrastructure for the Blueprint teams I mean, you know, when you look at the outcomes there's best practice guidelines and there's some standards that you can approach clinically. When rubber hits the road is meeting with -- we're talking about relationships, is developing and addressing barriers that -- that families have to face to actually get to those outcomes. They can't get to them because of the barriers of poverty and transportation and food and all the things that -- that the education and jobs that the community health teams and the care coordination work with to help them overcome that. So it's a link that's a natural, I think, road to reducing costs and improving success in outcomes.

DR. JONES: So do you think these steps would help strengthen that?

UNKNOWN SPEAKER: Absolutely.

DR. JONES: Richard.

UNKNOWN SPEAKER: Yeah, I just --

DR. JONES: We'll get on the phone in a second. Richard, go ahead.

UNKNOWN SPEAKER: Maybe I can give an example of how this might work from a different context but similar perspective.

So I think you're all aware that all three of the ACOs have to report on their performance. They have performance measures that they have to report to Medicare to -- and ultimately to the commercial payers and to Medicaid, and one of the issues is where do they get the data to actually make these reports. I mean there's a lot of concerns about, you know, the electronic health records and what elements are needed to collect in order to create these reports, and so we were -- we recently within the past year brought the three ACOs together and had a discussion about how we could collectively work with VITL on the collection of this data, and then looking at what gaps might exist in that collection, create a remediation plan to help resolve that, close those gaps, and also build bridges to the analytics contractors that the ACOs might select, and also develop a patient system so when patients go to a system or an emergency room the ACOs would be notified.

Now this is something that if the ACOs didn't

work on collectively they would probably all three individually be going to VITL to try to work out their decisions and solutions which would be I think more expensive, probably more timely, and it would -- it may not produce a result that would meet the state's interest to be honest. So we brought them together. We had -- we reached agreement on the goals that the ACOs would like to achieve. We presented an application -- they presented an application to the SIM committee structures through the HIA work group, Steering Committee and core team and Green Mountain Care Board which was approved, and so we now have a collective effort to work on this particular problem with the focus on the core ACOs measures.

So it's an example and this didn't require new governance structure. It didn't require that the ACOs come under one -- one single governing umbrella, but they are working together and there is a process going forward where they will continue to meet and review the progress that's being made toward this goal, which I think is similar to what you're proposing.

So I think it is a good way to go. I think it avoids a lot of the duplication that could result from not working together, and I'm optimistic that we're going to achieve some good results and, Patrick, you were involved in the subsequent TSS proposal which brought together a

lot of the long term care providers for similar purpose with VITL working on these kind of data and elements.

So I think the worries about -- this is about building relationships, building trust, and learning how to work together, and I think the governance issues will evolve over time potentially, but they don't have to be addressed I don't think immediately. So I hope that's helpful, but I think it's a good example of what could be achieved.

DR. JONES: No, I appreciate it, and I think Tom and Jill and your comments all kind of go to the heart of having the common purpose to organize around and having iterative evolution in how these organizations work together over time makes a lot of sense. Bea.

MS. GRAUSE: Bea Grause from the Hospital Association. I'm also co-chair of the Care Models and Care Management Work Group as part of the same effort, and I guess my recommendation -- I support everything that has been said and certainly support this direction.

My -- my hope is and recommendation is that we pay attention to the process because there is going to be a lot of work happening and in a lot of venues, and certainly as part of the care models/care management work group we've just started a learning collaborative around

developing care management standards across the ACOs, and a number of the people who are involved in that work group, I'm looking at Jenny and Laurel and others are part of that effort, and it's certainly related to -- to this work, and I think paying attention to synchronizing and building on the good work that's happening in some of those different venues and taking that -- creating more opportunity for creating a system that's at the local level can happen, but we have to pay attention to that process.

DR. JONES: Yeah. Could you envision the local unified collaboratives, whatever, you know, the structure of them is would be a good place to be responsive to the work coming out of SIM in the care models group?

MS. GRAUSE: Yes because I think it would be like the movie Groundhog Day because it's all the same people.

DR. JONES: I think that therein lies the -- there is unification by definition.

MS. GRAUSE: That's the beauty of Vermont. It's -- I mean same players.

DR. JONES: Before we go down the other side of the room can we go on the phone.

UNKNOWN SPEAKER: I'm sorry. This is

(inaudible) Boardman (inaudible) and I sit on the (inaudible) committee and we actually had this discussion at our monthly meeting yesterday and we strongly felt that we were happy to accept more money.

The Blueprint and the CHP teams are already in place because we see such good things in all of our practices spread throughout the state, and we feel like the individual practices have their own issues that the local people know best, but we were also hoping that with the possibility of, you know, more money per member per month that there could be greater standardization of the practices looking at the ACO requirements.

DR. JONES: Thank you.

UNKNOWN SPEAKER: Can I add a comment? This is Karen.

DR. JONES: Sure.

UNKNOWN SPEAKER: Okay. Going back to Bea's comment about the role of the similar group I think there's another phenomenon that's contributing to building custom relationships within the sub work groups and that is the cross fertilization among the groups.

So I co-chaired the (inaudible) health care group with Tracy Dolan and we worked very closely with Bea's group on the care models but also with measures group. So we were able this year, as we reviewed last

year and look ahead to next year, to work very well together to work in some population health measures that are not burdensome, but would help widen the scope of the measures.

DR. JONES: Thank you, Karen, and that makes sense. I think, again, another great example of investing in the foundation, but having it across the state oriented toward these common measures which includes input from population health which includes key metrics from the federal government on ACO organization includes a series of things, but they have been brought together through all the great work of the SIM effort and the work groups. This is a way of unifying and focusing a common purpose in all the communities against those measures, and I think that was the intent in the design here. Paul.

UNKNOWN SPEAKER: Yeah, Paul Bengston from Northeastern in St. Johnsbury for the Northeast Kingdom.

I do believe that the success again is going to come at organizing ourselves sort of universally at the local level. It's -- I think it's all well and good to talk about the foundation as to primary care, medical home, and community health needs, but in our -- in our community meetings with the leaders I still see, first of all, all of these programs that we now have in place

only cover a portion of Vermont's population. So when we're having frank discussions at the local level my observation is well, you know, the long term care people really don't know how they fit into all of this, how is this going to work, you know, how do you really bring them in as a partner.

Those are questions maybe people are succeeding at, but it's going to be a challenge. The same thing for the designated mental health agencies. You know, they are sitting there, you know, again yeah you guys have the medical homes, but we're the health homes for a lot of people who are part of the medical homes. So those are the kinds of things that we're working on, but there are concerns, and maybe there are some of those agencies representatives here today, but they are sitting there thinking well, you know, how do I really fit into this as a leader. Is the ACO going to tell me to do something I know how to do better myself?

So there are a lot of different groups that need to be brought in here. I mean I'm curious as to where all of this is going in terms of covering, again, the long term care organizations, the home health organizations, and again the substance use disorder organizations. We've got a broad group of people to really bring together to -- around an unified vision.

DR. JONES: So, Paul, just -- absolutely, Todd. Before -- Todd wants to comment on that. Just for those on the phone this really has to do with basically a more complete holistic health system and how to include all the different groups and people that are frankly critical of that and I couldn't agree more.

I want to just echo the point that Tom Huebner outlined earlier of viewing this as a step, and probably viewing the next couple years as a transition period toward Green Mountain Care which may bring into play a more global budget that allows better integration and all the planning and the work that's going to take place and that is going to be critical, but just to keep this viewed as a transitory step during an important transition period.

UNKNOWN SPEAKER: Yeah, I agree with that, but we have to be clear about what these transitory steps are and how they affect people who are going to have to be brought into this.

UNKNOWN SPEAKER: That's it. That's exactly what these are and that's what (inaudible) and we thought rather than do that in isolation (inaudible) providers signed up for one care it doesn't make sense to (inaudible) local community and bring it all together. I think that's part of what's bringing this change about is

a broader continued care approach in these collaboratives.

DR. JONES: Guys, can I get the other side of the room? They are about to throw something. Let me just move over here really quick, make our way down. Lewis please.

UNKNOWN SPEAKER: Excuse me. Mark (inaudible) from White River Family Practice. I'm sure we completely support the collaborative alignment of goals, but I am questioning whether the potential increase in payments to PCMH and community health teams, which is contingent on the integration, means that that payment increase would be filtered through an ACO if the local practice were a member, and the payment then to the practice would be proportional to the entire ACO's performance and benefits of these increased measures or whether the local practice would continue to recognize the benefit in the increased payments proportional to that practice's achievement of benchmarks?

DR. JONES: Our starting point on this approach was that the payment streams would continue directly to the practices and the local administrative entities as they are now, and then again as this transitory planning comes to a more global budget that may all be under consideration, but for the moment we were proposing that these would -- these would come in play as

they are now, and actually your -- your point brings something out that's intended here and that is to -- you know, there's been a lot of gains in the state, but all of the work you have all done, your practice and others, and this is a chance to make sure there is some continued share of investment in that while the bigger picture changes are taking place.

So that was the intent that was behind this, but that's why we're having this discussion.

UNKNOWN SPEAKER: Can I? I am a physician who came to this meeting because I was told you wanted to hear from clinicians.

DR. JONES: Absolutely.

DR. MOSLEY: My name is Thomas Mosley. I run a private practice organized as a rural health center in Newport which sees about 70 percent Medicaid patients and 30 percent insured patients.

I want to applaud the increase in the payment intended obviously and endorse the statement that was made earlier about how the micronature of our delivery system can have big impacts if there are shifts at the top that don't take into account the impact on individual practices, and I want to go back to this attribution thing. I realize people talked about it and you answered it.

From my point of view I'm sort of present on the ground while elephants are mating, and I just want you to know that there are consequences for being down there in the dust. Not long ago a major -- a major employer switched from Blue Cross to -- from Blue Cross to a CIGNA plan. We've been receiving -- and the payments changed. We've been receiving Blueprint per member per month from CIGNA on the tune of about a thousand dollars every quarter, which doesn't sound like much but in a small practice it's noticeable. The next payment was $6 and our local hospital had switched to CIGNA as its coverage and it took us several months to figure out what had happened, but basically it boiled down to CIGNA wasn't going to be paying per member per month on when they were the contract administrator rather than the insurer.

Now we're still seeing those patients. They are the same patients regardless and we're still doing the same things and we're still trying to give the same quality. It makes little or no sense to me that the per member per month stuff would disappear because of the decisions of the insurer.

I don't know if this is something that is policy that's been discussed, but it had a huge impact and CIGNA was a big one, but several of the others also. So that's one.

Two, philosophically I am in a hundred percent agreement of the idea you're going towards unified standards of quality, a lot of collaboration, but the details of attribution are so important. You know prior to the fix where the primary care Medicaid system we got a roster every month of who we were responsible for, and we would look at the names and if we haven't seen them we would call them, and if they were people who didn't come to us we would tell them, tell Medicaid.

Now we don't get that. We can get that from Blue Cross. We can't get it from Medicaid any more, and more importantly at the level where the individual recipient is trying to sign up there seems to be a major glitch in saying who your primary care doctor is. We've been told -- our patients have been told things like well they are not accepting patients or my partner isn't a pediatrician or when people who aren't on our roster and I know them. We have no way of knowing what our roster is now.

So unless those very technical things, I think everybody agrees the speedometer ought to work, is this ought to work before you decide where you're going and you know what the destination is, and I'm sorry to sound a little cranky about it, but like I say the elephants are stomping away, and I would hope that as much attention was

being paid to telling the major insurers please provide this information. The method of waiting and seeing how many visits they have made somewhere doesn't help us for months or a year, and so maybe I'm talking about something you guys all know the answer to and I'm sorry for taking time, but this is a -- I think this is a micro perspective that may be -- may be actually in play.

DR. JONES: No. I think it's very important and I -- and I think we need to have full intention to put together some, first of all, really solid input on the attribution methods and then adjust those attribution methods to be as responsive to need as we can. There's no doubt about that, and I think that's got to be one of the avenues that comes out of this.

UNKNOWN SPEAKER: What about the self insured or self-managed groups?

DR. JONES: Well the one thing we can do, and I will move to the other side, the one thing we can do around self insured, obviously we do not require self insured to participate in this. That's federal law. That's their decision. What we can do is try and work with their third-party administrator, the insurers that are administrating their cases, and try to build a business case for them, for their customers, or their self insured, and give them the data and give them the

information that helps them convince their customers to participate, but we can't require self insured to participate. They are exempt from by federal law.

UNKNOWN SPEAKER: Right, but you have reached the voluntary arrangement with insurance companies that this all made sense. So why -- why not try to actively pursue that with the insurance companies right now?

DR. JONES: Right. Makes sense. Let's --

UNKNOWN SPEAKER: Craig, I would like to bring up another subject or transition at least for a period of time here if we can, because I do agree with the concept everything everybody says is all worthy and we should pursue it. Details at 11, right? And I'm fine with that for right now, but I think we need to -- I think everybody is happy to see payments to the Blueprint teams doubled, but in fact I don't think that's enough money.

I think the conversation we need to transition to is how are we actually going to help the community health teams and the Blueprint practices achieve the outcomes that we all want them to achieve, and that's going to require more resources.

I have two of our physicians with me today and I wish they would speak up. We had a great conversation

on the way over about -- but no seriously the issues that we're facing in the practices in terms of actually trying to change behaviors so that people will get better and will maintain health and therefore reduce costs are really the heart of all this, and I understand attribution and I understand ACOs and I understand all this, but as Mike says the elephants are up here, meanwhile down here people are trying make a difference in patients' lives, and it's going to take investments in the kind of thing that the community health team did.

We know the community health team has had an impact on people's lives. We have that anecdotal information. We need to provide more behavioral health. We need to provide more care coordination. We need to provide more support from nutritionists. That's the heart of what we really need to do, and spend more time talking about it in my opinion. So let's go forward with this, but I don't think doubling it is enough.

UNKNOWN SPEAKER: So I'm a family doctor down in Middlebury and we just recertified for medical health. We scored 97 percent. It took two of our employees two weeks full time just to score. We have two binders that are this high. They weigh about 30 pounds of rules and regulations that we need to go through, and it's so time consuming to do all this stuff that we've

actually, even though we're, you know, one of the highest rated practices, we've actually had really serious discussions about whether it's worth continuing. Whether it's really worth the effort.

We were doing a lot of this stuff anyway, and certainly we really have risen to a higher level with the Blueprint For Health and part of this community health team. You know, I can't tell you the number of times I have literally walked a patient in crisis down the hall and handed her off to a social worker. Things like that are really valuable, but for especially small independent practices that don't have huge bureaucracies supporting them it's touch and go for us.

DR. JONES: Would the increase help with that?

UNKNOWN SPEAKER: Yeah without a doubt, but doubling, yes, but I mean I think I would advocate --

DR. JONES: He is --

UNKNOWN SPEAKER: That's exactly our experience. The money went to certification process.

UNKNOWN SPEAKER: Yeah.

UNKNOWN SPEAKER: Something we are already doing.

UNKNOWN SPEAKER: Exactly.

DR. JONES: I'm going to share my

continued employment.

UNKNOWN SPEAKER: I'm (inaudible.) I work at the Danville Health Center as one of the health (inaudible.) Just a few comments.

It takes time to keep a tidy medical home. Not just certification. We've been a medical home for many years and sort of this ongoing data processing, needing to understand things, trying to control costs, but looking up records in other places and it takes more time than I can do. I'm a health care provider, but I'm not. I'm a sickness -- I treat sickness. I treat health and I use the team that treats health because I don't have time in my staff and I can't coordinate enough to worry about the last colonoscopy, when you're due for the next mammogram, diabetes, renal failure, can't afford medicine. Those things are in my face. So the team helps to throw that in, and my biggest problem we don't have enough time from the team who are sharing a chronic care coordinator, we have a part-time behavioral health specialist, and a lot of times when you want to act, just as the example here, the person is ready to do it and you want to walk them down the hall and they are not there because they are off somewhere else.

DR. JONES: Thanks. Paul.

UNKNOWN SPEAKER: So my name is

(inaudible) and I have a small family medicine practice in Winooski and I'm going to echo the increased payments are essential and two times is not enough at all. It needs to be at least twice that.

I'm also a little disappointed that the performance measures have been taken off the table from our meeting in January. We're at the bottom right-hand corner in terms of cost and quality, and so we've been struggling to be able to provide this care and feel like we need some recognition. All of those coordination of care have been -- streamlining collaboratives mean more time, more staff time to be able to do those collaboratives, to go to those meetings, to be at the table. Where is that money going to come from? At this rate we are barely surviving, and we echo as well we're recertifying now. We really questioned whether it was worth the time and effort. It's a huge amount of stress. Huge amount of effort on our time, and it's marginally cost effective at this point.

Patients like small practices. It's their home care coordination. I think that's the best care coordination comes from retained staff and we're trying to hire more nurses. We cannot retain staff and we have to have five to ten thousand dollar deductibles for our health care insurance plans because that's what we can

afford as health insurance plans go up. So there's many aspects and we also need to look at the future providers in this state, and if we're not going to support primary care family medicine, pediatric providers with a better reimbursement, all of this can be blown up. (Inaudible).

So I think we have to go back to the people that are on the ground and give us the support that we need.

DR. JONES: Thank you.

UNKNOWN SPEAKER: What's on the table right now is not adequate. It's not sufficient. That's the bottom line for us.

DR. JONES: Yeah, no, thanks for that. I just want to make one comment. The pay for performance ideas that were proposed around utilization and quality measures it's not that it's off the table. It's being and going to be considered through the SIM work process in terms of P for P models. So it's not off the table. We wanted to make sure that there was a separate discussion about the direct investment in medical homes and community health teams during this transition period in addition to the opportunity for P for P. So it's not off the table. It was just -- it's going through the -- thanks. Paul.

UNKNOWN SPEAKER: So trying to keep -- trying to keep it positive as Tom says. I agree. Paul

(inaudible) family medicine and represent Health First (inaudible) and you know agree that trying to integrate this with the ACO efforts is terrific because the practices are really feeling the stress of things coming out all different directions, whether it's regulations or standards or certifications or care management directives.

I think, you know, taking this in this direction today goes back to the roots of why we did Blueprint and patient centered medical home. It was to strengthen our primary care base so we can do these other things like the ACOs. However, I think if you talk with the practices, especially on the front lines, we have not strengthened primary care. We have made a lot of these practices much weaker because of all the scattering we've done with their resources in the practices.

Now we're an independent practice so, you know, the money does mean something and that's why you're hearing from Dr. Mosley over there about the attribution. Well that's real money to him. It's from his pocket. It's not from an employer who then somehow moves it down.

There's no history in the Blueprint of the practices, the actual providers and the practices, having a forum for input. That's why you're hearing from us today. We're not part of this process. We're the one providing care, but there's no physician group that has

input.

The CHT folks meet and in some respects represent the practices, but the doctors themselves, the other practitioners who were actually providing the care have no forum for input. So the design evaluation committee here, this is it, this is the only place we have input, and, you know, there's -- there's probably 10 actual physicians here who provide this level of services in their practices and are not being paid enough for it and haven't been for five years. They have really gone on the faith this is the right thing to do, but our practices are not able to recruit new doctors because we're stronger and that should be -- they are not. They are weaker and they don't have the resources, especially the independent ones who should be somewhat of a barometer of how we're funding this to recruit and to retain their staff let alone their doctors themselves.

So we would suggest, the independent doctors would suggest at least a tripling of the amount of money for PPM with no strings attached to that. I mean don't attach new strings to the new money because this new money we have all agreed is five years overdue. It was underfunded from the beginning. So we would recommend at least a tripling of that. How the CHT money is dealt with that's -- we do need more resources to support our

practices and I don't see the CHT. I don't know they are not -- they are not hurting to the level that the practices are. We need to support the practices, hear from them, and there's a few other practices here we should hear from as to what their situation is. Let's go back to the roots of this.

Moving forward we're all assuming everything is good. We've got a good primary care base. We've done good work and we have provided better patient care no question, but at the expense of a lot of our practices and our physicians. So if some of the other physicians could be heard, this is their only chance.

DR. JONES: No, and I really want to emphasize that. This -- this -- that was the purpose of today was to bring as many clinicians into this conversation as possible because to all the points that are being made they are generally not part of these conversations and it's very important in the planning of it. So I appreciate that.

The -- for those that aren't familiar I would encourage you to take a serious read through the NCQA standards to understand exactly some of the descriptions that you're hearing, and the full document, and look at what it takes to score. It is an incredible intensive amount of work. There's great standards. There

are things that are important to people, but if you walk through them they are really rigorous. They weren't five years ago. They are now and they are getting stronger, and I just want to point out to those in the room this is the number that have scored on their first run. This is the number rescoring against stronger standards. The hundreds of clinicians, the hundreds of clinicians around the state that have made a dedicated effort to working against those standards underpaid and stuck with it is exactly the purpose of this forum.

At the same time we want to not make sure there is a duplication with ACO requirements and all the different quality initiatives. So these are the -- this is the theme and we want to make sure people understand. That line is an incredible amount of dedication as Dr. Mosley and the others have pointed out. Let's start here and then we'll come back.

DR. HADOCK: My name is Joe Hadock. I have a family practice in Thomas Chittenden Health Center, about two miles through the woods, and I may be a relic that attrition may get rid of in this paradigm whatever it is, but the number of clicks that we do on computers now for all this stuff is now becoming inhibiting to getting new doctors to go to primary care notwithstanding the money, notwithstanding any of the other stuff, and I

applaud integrating this.

Young physicians are not going into primary care. Only one or two of the family medicine residents we have had at Fletcher Allen last year are going into primary care. They are going into palliative care, the ER, sports medicine, and virtually none of the internal medicine residents go into primary care internal medicine.

One of the inhibiting factors when these students are sitting in our office seeing us doing all these extra things, which may be extraneous, may be not, but my goal for being here, my goal for still doing it I guess is to try to get people to go into primary care and this is as much inhibiting as it is attracting to.

I think we all, sure, would like more money. I think more money for young students may help pay off their loans more, but the incremental difference isn't going to attract them into primary care and physicians are going to become hospitalists. They are going to become all these other things rather than doing primary care -- primary internal care or primary internal medicine. I think the pediatricians are probably doing really well for a different -- doing really well at attracting physicians rather than the adult primary care physicians.

So my goal for all this is we do all this other stuff and whether it's the elephants or the people

at 30,000 feet we're just not getting people in the trenches. Our practice had 11 physicians just three or four years ago and now we have five physicians, six nurse practitioners and PAs. Some left to go do other things, some left to different practices, but while I think nurse practitioners and PAs can achieve a lot of same results we're going to need some primary care docs and this stuff right now is inhibiting. It's not enticing. That's my two cents.

DR. JONES: Yeah. Let me just ask Joe to follow up on that really quick. Does that equation change if you're able to afford more people to make the standards operate as routine? So does money help?

DR HADOCK: Well I think the money helps a lot, but I tell you now I used to play guitar an hour every night and now I'm working on that computer, and that's a big difference for me and that's a big difference for the young physician coming in sees I can't play the music instrument, but we're taking more and more time. It takes two or three times as long to finish your charts, it takes two or three times as long to finish your charts, or if you're in a situation to hire somebody else to finish the charts than it did before and that's inhibiting to get people to come into our primary care.

DR. JONES: Let's just jump to the

phone. Jeremiah, go ahead.

UNKNOWN SPEAKER: Thanks. I just wanted to speak to that actually because that's a really important point, and one of the biggest motivators for me getting involved in this work and being passionate about it was what I was seeing was the clinicians, not just the physicians but the nurse practitioners and passionate as well watching the clinicians burn out on this work because really when we talked about -- we looked at health care transformation, what was happening, it was just increasing amounts of work that was being put on the clinicians' plates, and I was watching them burn out in front of my eyes. In fact I was burning out myself.

So really to reiterate the importance of the CHT to me is that, you know, yes we had help coaching, and yes we have panel management, yes we have care coordination and social work, but really facilitating practice change and process improvement that has been one of the biggest bonuses, and without it I don't think we would have gotten to the point where we are right now, which is we are seeing the clinician burnout reversing itself and clinicians are having more time because we're transforming our practice to do more team based care and I really think that's important. If we don't have team based care, we have clinicians burning out.

So I echo what has been said so far that we need more funding. We need more staff. I would also like to see more training related to motivational interviewing. I think that, you know, motivational interviewing and training helps to reduce clinician burnout as well, and I think that training should be accessible to all the staff that work in medical homes.

I also think how do we extend the medical home to patients who don't necessarily come to the medical home in our communities and thinking about how we might develop some type of training program for community health workers that can extend the work of our CHT even further into communities, patient homes. So anyway those are my thoughts.

DR. JONES: Thank you. Those are really helpful. Thank you.

UNKNOWN SPEAKER: This is Bernie. I'm going to jump in. Sorry if I'm interrupting somebody, but I didn't hear -- sounds like he's finished. I would just say Jeremiah's comments is a really powerful tool and we can use more training. In general I think the biggest impacts we could have is on our care improving the access to the community health teams.

My experience being a medical home since February has been I'm only able to access about 30 to 50

percent of the community health team that I can access based on the population because of the lack of funding that's available, and there are other practitioners that would -- that we would like to bring in access, but we can't because of lack of funding. So increased funding would dramatically improve the community health team, would improve our ability to care for patients.

I would also like to see a larger scope to the community health teams. The nutritionist, the social workers, the population management has all been enormously beneficial, but being able to do more things on a community level rather than just on an one-to-one level with patients would be helpful too. Being able to provide selective programs, you know, groups, physical programs in the community would be enormously helpful, for example, for a lot of our patients, and particularly for the low income patients who want to be active but can't afford gym memberships, don't have access to a pool, et cetera, and want to help, but the options are very, very limited, and I would also just say ditto on the comments about the PMPM funding. I'm a small individual independent practitioner in Montpelier, Vermont and our cost to become medical home is probably $20,000 and that's far in excess of what the reimbursement has been.

So I think that the idea of an universal --

I'm sorry, I forget the name -- universal collaborative is great, but I think the devil is in the details. There's significant extra work involved to participate in that process that can be a real barrier to participation.

DR. JONES: Thanks.

UNKNOWN SPEAKER: I think that's it. Thanks.

DR. JONES: Thank you, Bernie. Andrew.

UNKNOWN SPEAKER: Hi. It is Andrew from MVP Health Care. I'm amazed to say I think I agree with everything that's been said here today, including the thought that more resources should be directed at the community health teams and the primary care physicians, but I would like us to keep in mind that of the five major payers that participate in Vermont two are government and two are not-for-profit, which means, and I'm just doing rough math, that 92 to 95 percent of the dollars that we're talking about will come directly in the form of taxation or premium increases. There's simply no other source for those funds.

So if we proceed down this path, and I'm very supportive of the structural changes we're proposing here, I think we need to take accountability as a group for resource management as well as for quality. I believe the early data that you're showing us about cost savings is

promising, but we still have rate increases that are far greater than the consumer price index across the board. So quick math says the trade-offs are people dropping coverage, people reducing coverage, people avoiding care since they have more money --

UNKNOWN SPEAKER: I can't hear anything you're saying.

UNKNOWN SPEAKER: I'll try to repeat this. If we don't find another pot of money from which to draw these resources, we exacerbate part of the problem we're trying to solve, and I think that resource accountability should be built into what we take responsibility for as an executive committee. It's a very serious consideration for us.

DR. JONES: Thanks, Andrew. No, for those on the phone I certainly can't repeat what Andrew said. It wouldn't be clear if I tried. The short summary is being supportive of the structural changes and the nature of the recommendations here, the challenge for the insurers being where does it come from, and how will this impact people's premiums, rate increases are continuing to go up, and so there's a challenge on the other side of the balance, the ledger sheet, if you will, which I believe is what Andrew was articulating for us.

UNKNOWN SPEAKER: And actually if you

let me clarify I want us to differentiate it's not just a challenge for the insurers but payers. I think it is a challenge that we all have to own responsibility for. We're not-for-profit organizations. We can't take this from shareholders. We can't go to our boards and say we want to finance this.

This is going to come from our ratepayers who are your patients and people you are trying to care for.

DR. JONES: So Andrew's point amplified is that this is a challenge for all of us given people are buying insurance, and one way or the other this is going to be passed through, and so I think that was the nature, on the other hand, supportive of the principles, the design and the direction. Is that fair, Andrew? And we do have -- by the way we are recording the session and it will be available for anybody who wants it -- detail aside from the audio.

UNKNOWN SPEAKER: If people actually in the back step up to the table where the microphones are, people will now be able to hear. That will help.

DR. JONES: If you can't hear Jenny, which is rarely the case, you can step up to the microphones and use them and that -- people on the phone will be able to hear. Let's keep going. Allen, did you --

DR. RAMSEY: Yeah. This is Allen Ramsey from the Green Mountain Care Board. Being mindful of the time I just have to say hearing so many heartfelt and passionate remarks from the clinicians around the table I would hate to end this meeting without focusing on -- my colleagues know this, one of my favorite sayings is that soon is not a time and some is not an amount. So what are the next steps in terms of responding to the clinicians here who have made themselves so phenomenally accountable to a delivery system that we now know is working. So soon is not a time, when is the time, and some is not an amount, what is the amount that we need to do for them, the payers are all here, to make sure this is not strengthened this is solidified. It's a foundation that needs to be solidified.

DR. JONES: So from the simplicity of the Blueprint perspective we have a report due to the Legislature in October with recommendations. A couple different things could happen to your question of a timeline, Allen. One is we could have agreement around a number and a direction prior to that report being submitted or we could not and then make recommendations in the report, but the goal here is to try and build toward agreement, and it seems like there's directional agreement around the integration and the increase, and then there's

questions around the amounts and frankly the accounting for the financing of it. So -- and quite a bit of questions which may take longer around the attribution structures.

What our promise to you and to the others in this room is to work through the models and the details with all the different partners that are involved in this and have a recommendation. We would hope this would be able to start by January. There does have to be time to account by budgets, but that's as much as I can promise you in this. There does have to be at some point an agreement around this and that's the purpose of this is to engineer that agreement. We weren't walking in with a deadline. We were walking in to broaden the conversation from what typically takes place and flush out, first of all, is the direction right, the principles right, and then what details do we need to flush out.

UNKNOWN SPEAKER: I just have one question and just sort of piggybacks on what you're talking about. You say everybody is in the room. I would sort of disagree with that.

(Inaudible) Rosenberg from United Health Alliance in Bennington, and I'm just curious, Craig, in your recommendation to the Legislature are you going to be making any recommendations as it relates to the self-

funded population because we do know that they are getting benefit of using the medical home and the resources that is being carried by two payers.

The reality is that we need to really take that into consideration. We have a little bit of a different situation. So we self-fund ourselves and had to contribute.

DR. JONES: Appreciate it. In fact, while we're here, we have to close out, but can I get representations on how to approach the self insured?

UNKNOWN SPEAKER: Absolutely.

DR. JONES: Go ahead.

UNKNOWN SPEAKER: Well I mean the recommendations I really think many times it comes at the community level from -- our approach was to really go to self-funded employers in our community, we are very much aware of who they are, and have the conversation about they are getting benefit of this without any contribution to this. So it's very difficult, we understand, for it to be regulated into that, but we do believe that it can be sort of finessed into that from the local level.

DR. JONES: So just to -- just to quickly get that point because that makes a lot of sense, what we're talking about here in some places we waited for maybe the third-party administrator, the insurer, to make

a business case and sell it to their self-insured customers.

What you're saying is your community took ownership and went to the major businesses and made the case for them. Is that --

UNKNOWN SPEAKER: You need to educate the employer not the TPA.

DR. JONES: All right. That's very helpful.

UNKNOWN SPEAKER: Can I just say I have spent a lot of time with all three major payers in the state and all three of them say at one point they believe there's such a broad based distributed approach to population based medical management, medical cost management, quality management that they are willing to partner with us to anticipate them unplugging some of their central resources. That's another pot of the money that right now is being done centrally by payers in their administrative cost structure. This may be a broad based enough approach between three ACOs and the Blueprint For Health success to date to maybe anticipate the 2015 and '16 (inaudible).

DR. JONES: First of all, I know everybody has got to go and I can't thank all of you enough. You have come from virtually every corner of the

state and we did want to make sure to bring your voices into it and this isn't the last of that. All this information will help drive, I guarantee you, the recommendations going forward and so thank you very much.

Are there any other burning issues people would like to bring up before -- again thank you and wrap up the meeting? All right. Thank you all. Really appreciate it.

(End of recording.)

C E R T I F I C A T E

I, JoAnn Q. Carson, do hereby certify that I transcribed the recorded discussion to the best of my ability.

Dated this 31st day of July, 2014.

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JoAnn Q. Carson