Report to
The Vermont Legislature

Reducing Duplication of Services

In Accordance with:
Act 172, Section E.300.2 - Reducing Duplication of Services

Submitted to: **Senate Committee on Health and Welfare**
Senate Committee on Appropriations

House Committee on Appropriations
House Committee on Health Care
House Committee on Human Services

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Report Date: 11/15/2016

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VERMONT

AGENCY OF HUMAN SERVICES

Act 54 Section 25 - Reducing Duplication of Services

Introduction

Section 25 of Act 54 of 2015 required the Agency of Human Services (AHS/Agency) to evaluate the services offered by each entity licensed, administered, or funded by the State, including the designated agencies, to provide services to individuals receiving home- and community-based long-term care services or who have developmental disabilities, mental health needs, or a substance use disorder. The legislation asked that AHS determine areas in which there are gaps in services and areas in which programs or services are inconsistent with the Health Resource Allocation Plan or are overlapping, duplicative, or otherwise not delivered in the most efficient, cost-effective, and high-quality manner. The 2015 report listed several reasons why duplication may occur. These include: Funding Silos, Data Systems, Documentation and Reporting, Monitoring and Oversight and Organizational Culture and Development. The legislation also required AHS to develop recommendations for consolidation or other modifications to maximize high-quality services, efficiency, service integration, and appropriate use of public funds. The recommendations include the continued development of; Payment and Delivery System Reform; Integrated Services and Teams; Oversight and Monitoring; and Information Systems. Sec. In Act 172, Section E.300.2, the Agency of Human Services was asked to report on its progress in implementing the recommendations. The progress on each recommendation is the focus of this report.

I. Recommendation on Payment and Delivery System Reform

Vermont has been engaged in payment and delivery system reform for several years. Building on earlier reforms, Vermont's Blueprint for Health Patient-Centered Medical Home Initiative provides significant care coordination within Vermont's primary care system. Vermont's ACO Shared Savings Program has built on the Blueprint effort by expanding care coordination activities to a broader network of providers. More recently, AHS has been developing payment reforms for children's mental health services, adult mental health services, and substance abuse treatment. All of these reforms have contributed to the evolution of the Medicaid Pathway and All Payer model as AHS continues to transition from fee-for-service payment and other payments that do not include quality measurement, to those that do. AHS plans to continue with these reforms which will reduce service duplication and service gaps, support integrated and streamlined services, improve outcomes and result in the efficient use of resources.

Progress on Recommendation

There is a growing national recognition that fee-for-service (FFS) payment to providers (whether through direct contracts with the state or through Medicaid managed care organizations) has been responsible for the development and maintenance of a delivery system which does not adequately address the needs of the most complex Medicaid beneficiaries. The elderly, disabled, those with severe mental illness, and children with complex medical needs all constitute some of the most vulnerable and costly Medicaid members. Many of them are still served by fragmented delivery systems which are driven by historically separate funding streams. It is also important to recognize prevention and early intervention for these populations can also have an impact on outcomes and costs.

Blueprint Payment and Delivery System Reform

The Blueprint works closely with the existing Accountable Care Organizations (ACOs) and the emerging Vermont Care Organization (VCO) on aligning delivery system reforms that will be foundational for the All-Payer Model (APM). This work includes designing a community governance model with the ACOs under the new VCO structure.

Community Collaborative

In each Hospital Service Area (HSA) in Vermont, there is a Community Collaborative (CC) comprised of local health and human services providers designed to focus on systems-level, cross-organizational quality improvement efforts. Through the CC, the Blueprint works with the existing ACOs to mount local infrastructure for community-level accountability and influence on healthcare reform priorities and financing. Additionally, the Blueprint and the ACOs have supported the Community Collaboratives in establishing governance teams in each HSA to ensure the alignment of local resources behind priorities, which range from prevention, to detection, to treatment for complex conditions.

Performance-Based Component of Blueprint Primary Care Payment Model

In the past year, the Blueprint worked closely with the ACOs to update the payment model for primary care practices participating in the Blueprint. The updated payment model supports the vision of statewide healthcare reform priorities by including a quality component of this payment, which is calculated based on performance against four core ACO measures at the HSA level. By tying a quality payment to the performance of an entire community, rather than to an individual organization, an incentive exists for primary care practices to work with community partners on joint initiatives to improve on the selected measures.

Combined ACO and Blueprint Field Team Meetings

For the past year, on a monthly basis, all three ACOs and the Blueprint host all-field team meetings for field-team leadership and clinical staff. Invitees and attendees include Blueprint

Project Managers, Practice Facilitators, and Community Health Team (CHT) Leaders; Support and Services at Home (SASH) leadership; ACO clinical quality leadership and field staff; Vermont Chronic Care Initiative (VCCI) leadership and staff; Vermont Child Health Improvement Project (VCHIP) leadership and facilitators; AHS Field Services Directors; and representatives from Children's Integrated Services (CIS) and Integrated Family Services (IFS).

These meetings allow for updates on statewide healthcare reform efforts, such as the APM implementation and formation of the VCO, knowledge sharing from communities on data-driven quality improvement projects and cross-organizational collaboration efforts, updates on CC initiatives in each community, and information on new state-led initiatives, such as the AHS-sponsored Women's Health Initiative.

Medicaid Pathways

The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model. The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles through both the All Payer Model and VMP to support a more integrated system of care for all Vermonters, including integrated physical health, long-term services and support, mental health, substance use disorder treatment, developmental disabilities services, and children's service providers. The VMP work includes a focus on more fully implementing the Vermont Model of Care, which includes interdisciplinary care teams[1].

The Medicaid Pathway is a planning process facilitated by AHS in partnership with the Agency of Administration. These planning efforts are designed to systematically review delivery system expectations and payment models across AHS and the Medicaid program, and to refine State and local operations to support new payment and delivery system models. As part of this process, AHS has convened one stakeholder group to focus on mental health, substance use, and developmental services and a second stakeholder group to focuses on Choices for Care and long term supports services.

All Payer Model

In 2014, Vermont began exploring the possibility of an All Payer Model based on Medicare's Next Generation Accountable Care Organization (ACO) model with federal partners at the Centers for Medicare & Medicaid Innovation. The All-Payer Model agreement between the State and the Federal government was approved by the Green Mountain Care Board on October 26, 2016 and signed by the Governor and the Secretary of Human Services on October 27th. The agreement includes a target for a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers, and would build on past programs like

1 http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/VT%20Integrated%20Model%20of%20Care%20Overview%20May%209,%202016.pdf

Vermont's Medicaid and commercial Shared Savings Programs. When implemented, this model will focus on a set of health care services roughly equivalent to Medicare Parts A and B (hospital and physician services). The agreement includes quality and performance measurement and Next Generation's value-based payment models, such as capitation or global budgets. The State must provide a plan in 2019 for integrating any institutional long term services and supports in the total cost of care in the next waiver period.

Department of Mental Health and Department of Vermont Health Access Integration

Act 58 of the 2014-2015 Legislative Session required that the Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) present a unified service and financial allocation plan for publicly funded mental health services as part of an integrated health care system in their 2017 budget presentation.

The goal of the plan is to integrate public funding for direct mental health care services within DVHA while maintaining oversight functions and the data necessary to perform those functions within the Department of Mental Health.

At the end of calendar year 2015 a work plan was put together to identify areas between the two departments that could better unify and determine if moving public funding to DVHA made sense given the other major health reform payment efforts taking place. Each section of the work plan has been reviewed, discussed and decisions are pending as they must be aligned with the other health reform payment efforts still in progress.

II. **Recommendation on Integrated Services and Teams**

Integrated services and teams can help to reduce service duplication and service gaps. AHS should continue to encourage an internal organizational structure and process that supports integrated or interdisciplinary community case or care management teams. The Agency should increase training for case and care managers to strengthen their team-building skills and provide a structure for them to share best practices. The Agency should also improve partnerships with those providing care management and case management outside the Agency, building on the Integrated Family Services model and the Blueprint for Health Initiative.[2] *AHS should continue to support pilot initiatives to provide interdisciplinary and interagency team case management in home and community based services. AHS should continue its commitment to building co-occurring capacity and capabilities within mental health and substance abuse programs such as the current initiative to screen and refer for substance abuse across all AHS programs. AHS should develop a process to increase collaboration between DVHA and VDH clinical personnel. AHS is working on and should finalize a universal release form to support initiatives like these. AHS should support the creation of a single, unified services plan for individuals and families in order to coordinate care and ease access to services for customers, while improving outcomes.*

[2] These include SASH teams, the Community Collaborative (CC), VHCIP learning collaborative, Accountable Health Communities, and Accountable Care Organizations.

Progress on Recommendation

Blueprint Integrated Services and Teams

Using funds from the State Innovation Model (SIM) Testing Grant, which led to the formation of the Vermont Health Care Innovation Project (VHCIP) Practice Transformation Work Group, a collaboration of stakeholders, including the Blueprint, the Department of Vermont Health Access (DVHA), and the Green Mountain Care Board, initiated a three-part process to improve integration of services in local communities, including: Integrated Communities Care Management Learning Collaborative (ICCMLC); core competency training for care coordinators; and initiation of an electronic shared care plan. While these three processes were mounted in the above order, they are currently operating in parallel with good coordination between them (See Attachment A).

The design work for the ICCMLC, including curricula planning and development, included significant input from the Vermont Chronic Care Initiative (VCCI) within DVHA and Integrated Family Services (IFS) within the AHS Secretary's Office.

Over the past year, the ICCMLC convened national expertise and faculty to help lead Vermont through a process of creating integrated care teams in 11 of the 14 HSAs to serve individuals at risk as identified by each community. Participating communities:

- Used data and clinical judgment to identify at-risk populations
- Created a process for designating lead care coordinators for individuals who agreed to participate in enhanced care coordination
- Garnered consent
- Recruited professionals to participate in cross-organization care teams
- Created a systematic methodology for assessing the goals and care needs of each individual participating in the program
- Identified the team that would most benefit participants in the program
- Convened the team for integrated care conferences
- Developed a cross-organization shared plan of care

Current work is underway on improving communication around transitions of care between organizations. Care managers from the following organizations participate in these integrated care teams:

- Primary care
- Hospitals and Skilled Nursing Facilities
- Area Agencies on Aging
- Visiting Nurse Associations and Home Health Agencies
- Housing (Support and Services at Home program)
- Mental Health and Developmental Services Agencies

- Medicaid (Vermont Chronic Care Initiative)
- Commercial Insurers
- ACOs
- Agency of Human Services
- Blueprint Community Health Teams

By bringing together these types of diverse stakeholders at the community level with the intent of identifying and serving an at-risk population, delivery-system reform occurred collaboratively. Each participating organization redefined their processes for care coordination by becoming part of a team and working together to identify lead care coordinators, usually the professional with the closest long-term relationship with the patient, for willing participants (individuals with complex health and psychosocial needs) in the program. The lead care coordinator's role became defined as coordinating the integrated care team and serving as the lead advocate for the person being served, not simply providing care.

A plan of care is developed with the individual, either by the primary care provider or the lead care coordinator, and the person is empowered to select and prioritize the goals and actions in the plan. These common goals and actions drive the work of the integrated care team, reducing duplication of services. The teams include representatives from housing and transportation service providers, as well as meal sites, allowing the integrated care team to help the individual address the social determinants of health. Care conferences are held with the team and the individual to create an active and ongoing dialogue on how progress is being made towards the person's goals.

Closer integration between VCCI staff, CHT staff, and community partners has evolved out of local ICCMLC collaboration. VCCI involvement and expertise with the use of data to identify and work with high-risk, high-utilizing populations has created an invaluable pathway for knowledge sharing and dissemination of best practices through this work at the local level. In many communities, VCCI staff serve as lead care coordinators for Medicaid beneficiaries recruited into the program.

While, to date, most participating communities have chosen to work with primarily adult populations, a solid infrastructure is now in place to roll out a similar program for children and adolescents and to better integrate with IFS.

To complement the work of the ICCMLC, the Blueprint collaborated with VHCIP and the Department of Aging and Independent Living (DAIL) to define the curriculum requirements for statewide core competency skills training for care coordination and to draft a request for proposal. This coordination effort arose out of the need for local health and human services partners to participate successfully in a new person-centered way of care. Using SIM funding, core competency skills training, taking into account the needs of diverse populations which

include individuals being served for long-term supports and services, was developed and deployed statewide using a train-the-trainer methodology to ensure sustainability.

While shared care plans were developed to coordinate care a core barrier identified by integrated care teams for care planning is the limited ability for providers in each community to share real-time updates to the care plan. The ICCMLC developed a person-centered process that takes into account a broad set of psychosocial and social determinants of health. The challenge continues to be allowing community partners who are not covered entities under HIPAA to access a system to share an electronic health record (EHR) to be used by medical and non-medical community partners.

The Regional Partnership Program

The Regional Partnership Program is a statewide collaborative effort between the Department for Children and Families/Family Services Division (FSD), the Vermont Department of Health (VDH)/Alcohol and Drug Abuse Programs (ADAP) and the Lund Family Center. This program provides for a Lund substance use disorder screener to be co-located in the Family Services district office to accompany social workers to meet with individuals during an assessment or investigation when substance use is a concern. The screener completes the UNCOPE[3] screening tool with the individual and if further assessment/treatment is needed, the screener refers and helps the client follow through with the referral to a substance use treatment provider. The implementation of this program is an example of cross system collaboration that promises to improve the outcomes for families affected by substance use disorder.

Agency of Human Services/Department of Mental Health and Agency of Education Coordination

AHS and AOE have a long history of working together beginning with Act 264, passed in 1988, which requires coordination of services through Coordinated Service Plans (CSP) and allows for local and state oversight of the System of Care as memorialized in a 2005 interagency agreement. During the following years, resources and staff were reduced and the technical assistance that was available to support local teams from the State was diminished resulting in a negative impact on the teams' ability to coordinate. Act 46 (2016) provided an opportunity to revisit the System of Care planning. This past year AHS and AOE met with several schools and local providers (primarily Designated Agencies) to understand successes, opportunities and challenges in addressing the needs of children and families. AHS and AOE are now finalizing a work plan to improve the Act 264 System of Care. This plan will be complete by December 2016[4].

Co-Occurring Competency E-Learning Community Pilot

[3] The UNCOPE is an evidenced-based screening tool. SAMSHA, 2016.

[4] *Act 46; section 49 2016) asked the Agency of Human Services (AHS) and the Agency of Education (AOE) to produce a report describing how the two agencies work together for the betterment of children and their families. You can review the full report at http://legislature.vermont.gov/*

DMH and the Vermont Department of Health – Division of Alcohol and Drug Abuse Programs (ADAP) collaborate with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) on an initiative to support mental health and substance use programs in adopting integrated treatment services for individuals and families in Vermont with co-occurring mental health and substance use disorders. This initiative has offered several trainings, consultations and technical assistance opportunities for participating programs[5]. The initiative also includes the evaluation of online learning platforms and to evaluate their effectiveness as a modality to support workforce development, staff training and competency. VCPI has synthesized the data collected during this pilot, and is looking at ways to continue and expand this innovative model. Another round of this program, co-sponsored by DMH and ADAP, will be held in early 2017.

Children's Integrated Services (CIS)

Children's Integrated Services requires that there be one lead case manager (within a teaming model) for a pregnant/postpartum women or child. The case manager is the primary contact for the family and any other CIS services the family is receiving. CIS case managers are responsible for the CIS plan of care which is called the One Plan. The CIS case manager will gather information from the family and conduct screenings and evaluations to determine if there are other service needs. If other service needs are identified in this process options are discussed with the family and with consent, other CIS or community based service providers are brought into the team. The team, inclusive of the family, works together to identify goals and strategies to meet the needs identified through this process. Due to the team working together in developing the One plan, members are aware of the goals and strategies the family and other service providers are working on. Currently, CIS does not have an electronic case management system, which continues to be a barrier to true integration across CIS services.

The Substance Use Treatment Coordination Initiative (SATC)

AHS recognizes the substantial burden that substance use disorders have on individuals and families seeking AHS services, particularly those who need multiple services and therefore enter the AHS system through different doors. Intervening early with individuals and families struggling with substance use can improve outcomes in multiple areas. The SATC is a coordinated approach to serving Vermonters with substance use disorders across all departments. Action items of the SATC that are underway include; training on substance use to all AHS staff and managers who have direct contact with individuals seeking services; coordination of referrals to treatment among all AHS Departments; completing regional needs assessments and

[5] *Training examples: Access to a library of E-Learning training modules from the nationally recognized Focus on Integrated Treatment (FIT) Distance Learning Course developed by Hazelden and Dartmouth. Core Orientation and a virtual Learning Community combining online video training with continuing improvement and evaluation of staff competency in coordination with regular mentoring sessions for agency/program teams of staff participating in the pilot. Mentoring sessions were facilitated by Dr. Ken Minkoff, who is a national expert on integrated services and systems, and a founding partner of VCPI.*

plans for addressing treatment service gaps; adopting a standard definition of case management across AHS, investigating how to integrate with case management systems; and development of an AHS housing plan for high need individuals, particularly those being released from residential treatment or the Department of Corrections.

Reach Up Substance Use and Mental Health Program

The Reach Up Substance Use and Mental Health Program is a great example of integrating systems and cross-disciplinary teaming. This initiative increased access to treatment and case management through the Designated Agency system. Each district provides these services through a substance use and mental health case manager and clinician, or a clinical case manager. Reach Up serves a total of 4,433 participants; 2,690 of these participants have a work requirement, are screened for substance use and mental health conditions, and have access to the substance use and mental health program. The substance use and mental health case managers provide specialized screening and referral for assessments and facilitation and coordination of treatment team meetings while the clinicians provide; diagnosis; emergency services; individual, group and family therapy; intensive out-patient treatment; and medication management. State-wide, sixty-four percent of Reach Up participants engaged in substance use and mental health treatment after being screened.[6]

III. Recommendation on Oversight and Monitoring

AHS needs to expand and improve the consistent use of performance measures and performance improvement activities across AHS. AHS should also continue and expand current efforts to minimize the reporting burden on providers and align performance measurement targets across programs. AHS should leverage passive reporting as much as possible and increase the quantity and quality of performance reports to providers delivering services to Medicaid beneficiaries. There should be a process for greater collaboration between the Agency of Education (AOE) and DVHA to improve clinical oversight and reduce gaps and duplication of services for those students supported by IEPs. This should include greater coordination of clinical personnel to ensure integrated clinical oversight of school based services, including instruction for therapists, special educators, auditors, and Medicaid clerks. This would mean greater oversight of the non-primary care providers who are making medical necessity determination within the fee-for-service system.

Progress on Recommendation

Department of Vermont Health Access (DVHA) and Agency of Education (AOE) Partnership Primary Care in Education

[6] Based upon data supplied by the Designated Agencies quarterly.

One example of collaboration between the AOE and DVHA is the work being done to maximize the opportunities for the primary care provider to be the physician determining the medical necessity of services for the student's Individualized Education Plan (IEP). Currently, consulting physicians who may never have met the child are permitted to make this determination. This may result in gaps or duplication of services. The AOE and DVHA are working together to enable the primary care physicians to determine the need, ensure that medical and school model services are not duplicative, and to ensure a medical home for the child and the child's medical record. The next phase of the AOE/DVHA partnership is to explore the clinical oversight of school based services. The benefits of clinical oversight are: to ensure best practice and best results, and to ensure proper alignment of services with the federal Individuals with Disabilities Education Act (IDEA).

AHS Performance Measurement and Common Measures

AHS is committed to expanding and improving the use of performance measurement, monitoring, and improvement activities across AHS in order to better understand the quality and impact of our services and to improve outcomes for the people we serve. As established in the 2016-2019 AHS Strategic Plan, the Agency is adopting a Performance Framework and associated Performance Management Organizational Competencies as a way to promote a standard of best practice for managing performance. An assessment of how Performance Management Organizational Competencies are currently embedded across our organization will guide improvements in how each Department and AHS uses data and information about our services, programs, and administrative activities to systematically drive value-based decision making while reducing duplication of services.

The implications for better performance measurement and management across the Agency include establishing common measures of individual outcomes for programs that share a common goal; establishing standard performance measure sets for like-services; monitoring our performance as an Agency, across programs and services that comprise a comprehensive strategy to impact a population or condition of well-being; and continuously improving performance to realize value within services, programs, and in a coordinated way across service systems.

Results-Based Accountability in All Grants

AHS is also committed to efforts to strengthen the management of grants using Results-Based Accountability, which involves the piloting of an "Attachment A – Scope of Work" template in FY18 grants within each Department and in the FY17 Designated Agency Master Grant. The template emphasizes the purpose of the grant, population served, specific strategies and services to be provided, performance measurement to accomplish the purpose of the grant (distinguished by type – quantity, quality, or impact performance measure), and performance monitoring activities through which AHS and grantee can better identify areas to improve.

IV. Recommendation on Information Systems Development

Information systems can provide tools to support payment reform and integrated care. AHS should increase the development and use of integrated information technology to coordinate

care management activities. AHS will continue to support the strategies and recommendations of the Vermont Health Information Technology Plan and increase the use of a shared data to coordinate care and measure effectiveness. AHS is moving to implement a new Medicaid Management Information System under a current procurement project with a unified data system for all claims including service level data for bundled payments and case rates made across AHS. AHS will work to improve the system for edits on codes and services within this new system. AHS should continue to implement the new Care Management System to support a single treatment plan and effective communication across the AHS[7]. AHS should reduce the duplication or lack of coordination in prescribing of therapeutic medications and ensure that all prescribing providers consult the Vermont Prescription Monitoring System (VPMS) tool before prescribing medications. Additionally, Case Managers providers and pharmacists will be able to utilize the new Care Management system in the near future to verify member's medications. Currently, the pharmacy management system, to which Case Managers have access, has flags to identify known potential contra-indications for medications, but the utilization of the VPMS and the Care Management system would provide additional tools.

Progress on Recommendation

Health Information Exchange/Vermont Information Technology Leaders (VITL)

The Vermont Health Information Exchange (VHIE), operated by Vermont Information Technology Leaders (VITL), has collected and indexed clinical information for Vermonters since 2005. Over 200 provider locations, including hospitals, primary care, and specialty care providers, contribute clinical data to the VHIE. These data are used to inform clinical decisions at the point of care and to provide valuable health care reform insights through population health measurement. The Vermont Department of Health currently receives approximately 25% of their immunization records from the VHIE. Additionally, AHS is working with VITL to enable the VHIE to provide valuable clinical and lab information to Agency of Human Services entities in SFY17.

Medicaid Management Information System (MMIS) – Care Management

The Care Management Project is a new cloud-based software technology that replaces the system previously used by the Vermont Chronic Care Initiative (VCCI), a DVHA program that provides intensive care management to the highest risk and costliest Medicaid members. VCCI began using the system at the end of December 2015, with additional features being developed, tested, and implemented at regular intervals. Development work is underway to expand the new system to support other care management efforts across the Agency of Human Services, beginning with Children's Integrated Services (CIS) in the Department for Children and Families (DCF) and Children with Special Health Needs (CSHN) in the Department of Health. The care management system, in conjunction with other planned technology enhancements, is intended to

[7] Include Designated Agencies, Specialized Service Agencies, Home Health, hospitals and FFS providers.

support AHS' vision of providing more integrated and holistic services to individuals and families. It is being designed to support coordination of care across the health and human services continuum, and will be used to:

- Support coordination of care among various providers and between state agencies and community partners;
- Use analytics to identify Vermonters who may benefit from care management services and support prevention, wellness, outreach, and early interventions;
- Provide automated, evidence-based assessments and shared care plans among care team members;
- Track and monitor activities and services as they are provided; and
- Use integrated clinical, utilization, and financial data for program administration, evaluation of results, and quality improvement.

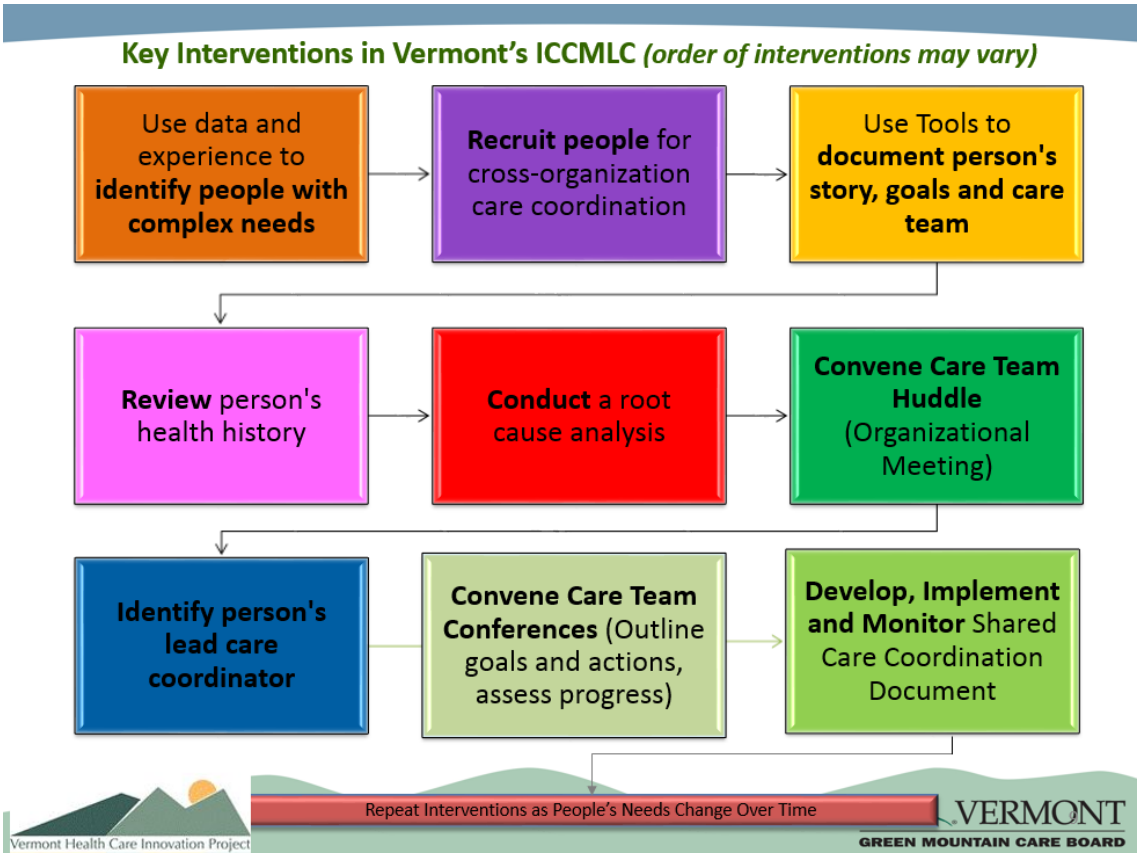
Vermont Prescription Monitoring System (VPMS)

The VPMS has implemented a number of improvements in order to help prescribing providers in coordinating care and reducing duplication of services including:

- Prescribers are now able to utilize delegates in order to run patient queries on their behalf. It is possible to run a batch request on all patients who are scheduled for a day at once, eliminating the need for logging in individually with each one. This also allows for easier integration into workflow, and for scheduling required regular maintenance queries for existing patients.
- VPMS has connected with New York's, New Hampshire's and Massachusetts's Prescription Drug Monitoring Program (PDMP) in order to ensure that prescribers have more complete access to their patient's dispensing histories in both New York and Vermont.
- Training has been provided for the Blueprint facilitators to ensure they are able to assist prescribers to include the use of VPMS into their office workflows.
- Prescribers who are not registered with VPMS and who have prescribed within the last two years have been identified and will be notified about the VPMS and assisted in how to use the system. Outdated and un-utilized accounts have been identified and the prescribers associated with those accounts will be notified on how to re-register and use the new improvements to the system.

Compliance standards have been implemented and ensure that data available in the VPMS for prescriber use is up-to-date, consistent and quality data. This has meant significant work with all Vermont-licensed pharmacies to ensure that all prescriptions dispensed to Vermonters or in Vermont are loaded into the system in a timely manner.

Attachment A:


Key Interventions in Vermont's ICCMLC (order of interventions may vary)
Use data and experience to identify people with complex needs
Recruit people for cross-organization care coordination
Use Tools to document person's story, goals and care team
Review person's health history
Conduct a root cause analysis
Convene Care Team Huddle (Organizational Meeting)
Identify person's lead care coordinator
Convene Care Team Conferences (Outline goals and actions, assess progress)
Develop, Implement and Monitor Shared Care Coordination Document
Repeat Interventions as People's Needs Change Over Time
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