GMCB 2017 Test Year ACO Budget Review
Questions for OneCare Vermont
August 4, 2017

I. ACO Information and Background (Part 1)

1. Please provide a full set of bylaws, including voting rules.

Attached is OneCare's Operating Agreement which includes its full bylaws and voting rules.

2. Please provide more information on how existing staff meets the care coordination needs of the population.

OneCare has two full-time staff members dedicated to care coordination, a Care Coordination Program Administrator and a Care Coordination Implementation Specialist. Staff is supported by five full-time OneCare Clinical Consultants whom are deployed to all participating health service areas to support OneCare initiatives and services in local communities. OneCare's care coordination team works in close partnership with the state and local leaders with the Blueprint for Health Program and its partners to align and deploy care coordination strategies to support our community-based care coordination model (Figure 1). In this model, OneCare is advancing the organization of community-based care coordinators from a multitude of care delivery organizations including: Primary Care, Designated Mental Health and Substance Abuse Agencies, Area Agency on Aging, Supports and Services at Home, Home Health Agencies, as well as partners in the Agency of Human Services (e.g. DVHA, VDH, DAIL, DMH) and other community services providers (e.g. housing, transportation, non-profits). OneCare tracks the engagement of care team members though its care coordination software platform, Care Navigator. To date, in the five (5) health service areas currently participating in OneCare's care coordination model, more than 400 care team members are actively connected to patients and caregivers. The number of care team members varies by patient and ranges from one to eight team members. With the introduction of a new payment model in July 2017 (Figure 2), OneCare is supporting community conversations about how best to utilize those funds to identify gaps in care and determine if and where hiring needs to occur; all in an effort to avoid duplication and to facilitate care delivery by appropriately trained staff based on the unique needs identified in each community. OneCare and the Blueprint continue to support care coordination staff competency assessments, trainings, and skill-building to ensure a robust workforce. As we move forward as new opportunities for training are identified, we will deploy them in coordination with guidance and facilitation of local care coordination core team members who serve as our "eyes and ears" on the ground regarding the execution of this model.

Figure 1. OneCare Care Coordination Model

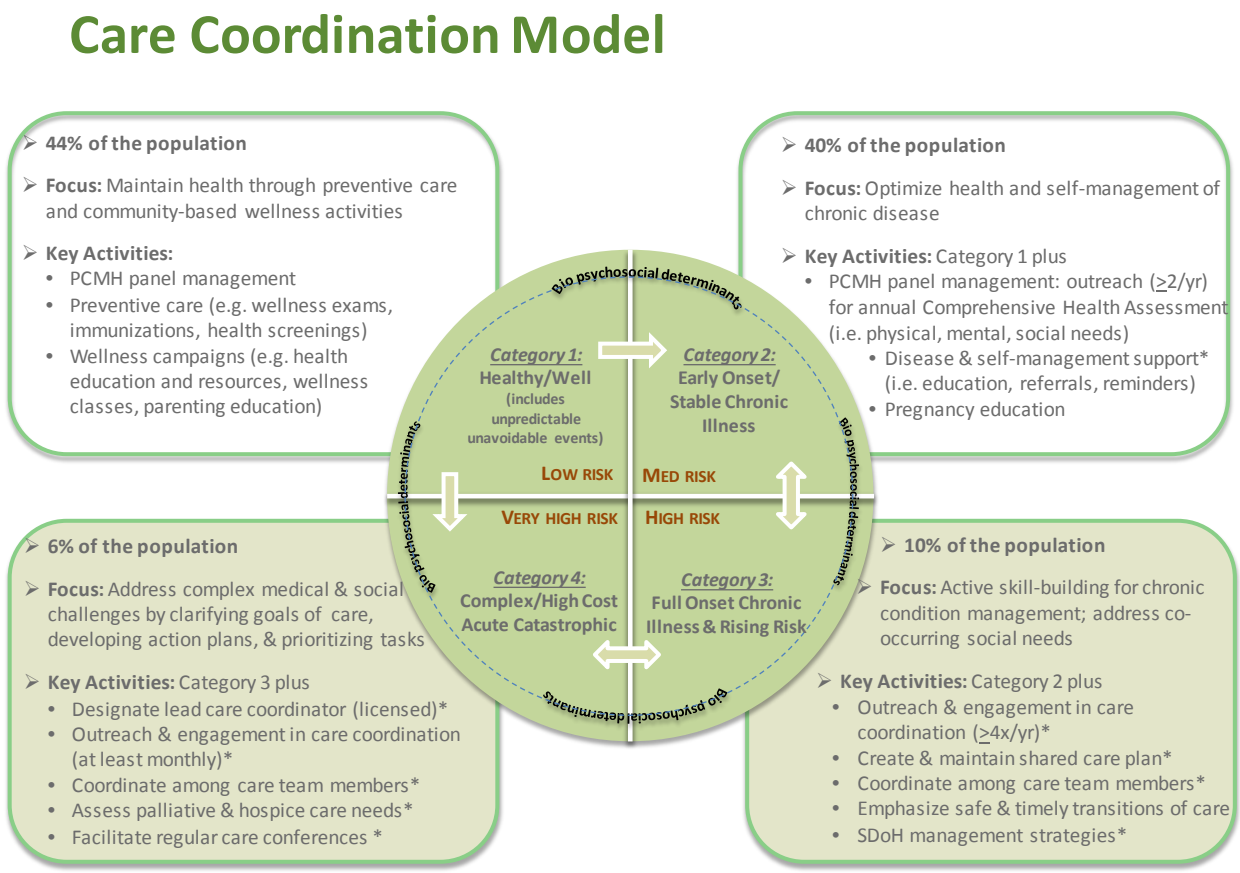
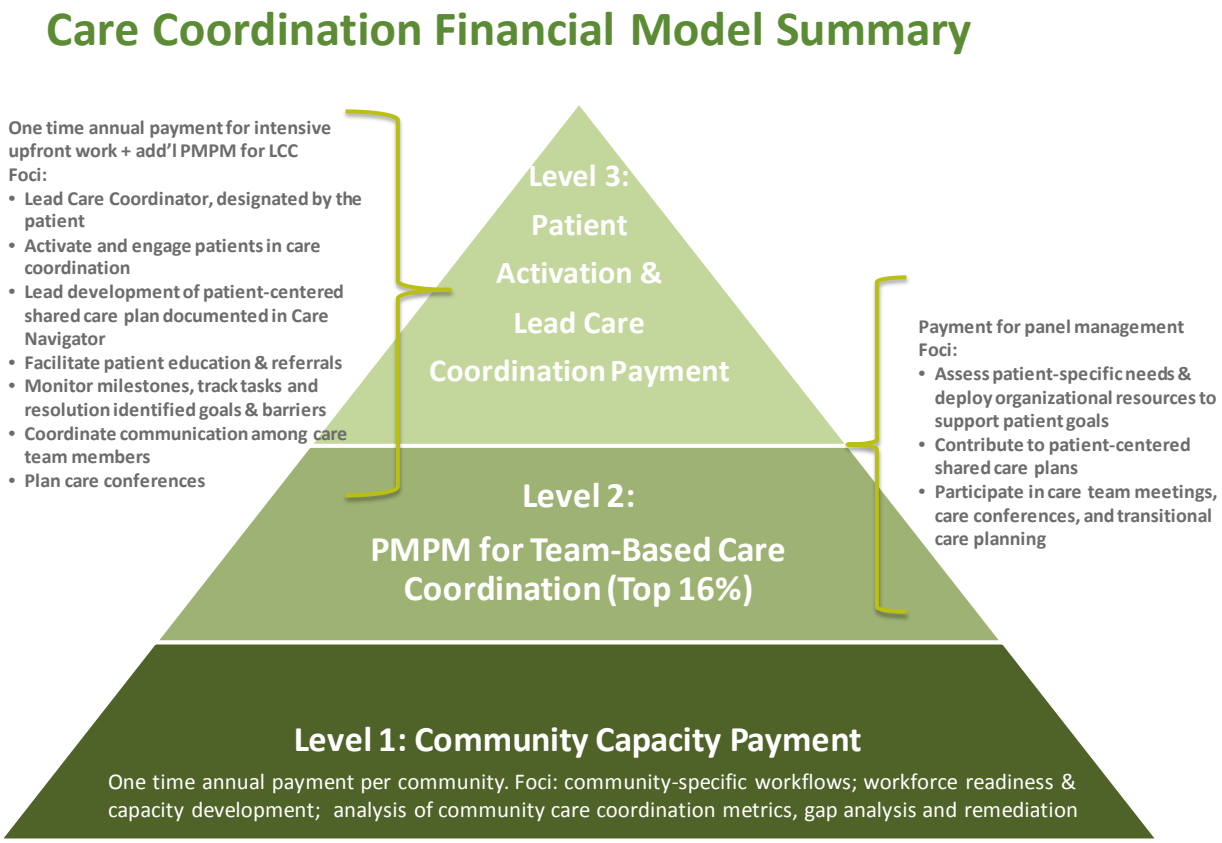


Figure 2. OneCare Care Coordination Payment Model



3. **Who, of your staff, oversees provider reimbursement and network management**?

   The Operations department, led by Joan Zipko, handles network management to include the planning, execution and tracking of participant contracts to our network. The Finance Team headed up by Tom Borys is responsible for making sure the monthly provider reimbursements are paid and that the providers are supplied monthly statements of funds they are receiving, which is uploaded to the Provider Portal by the Operations department.

II. ACO Model of Care and Community Integration (Part 5)

1. OneCare's provider payment models do not appear to include strong provider incentives for quality improvement. Also, providers do not appear to be rewarded for their own performance, but rather for the performance of the ACO network. Can you explain how the payment model will provide both support and motivation to attain improvement in the APM targets and in contractual quality measures to which OneCare is subject?

At the recommendation of our provider community, we are taking a step-wise approach to creating new incentives for quality improvement. In 2017, we began by responding to our Network's request to reduce administrative burdens on primary care and have identified and implemented strategies such as waiving prior authorization and renegotiating both Medicaid and Commercial quality measures to reduce the number of measures and take bold steps to bring them into alignment with the State's All Payer Model Measures. This work is ongoing and we anticipate continued discussions with GMCB and payers about measure alignment.

Our second step, implemented in January 2017, was to design and implement a Value-Based Incentive Fund (VBIF) to reward OneCare participants for delivering high quality care. Currently in place for the Medicaid program, OneCare intends to expand the VBIF to all payer programs in 2018. During 2017 and 2018, the VBIF is designed to reward ACO-level performance with 70% returning to primary care based on attribution – this is in recognition of the fact that the preponderance of quality measures relies on primary care and they are a cornerstone to a successful population health management strategy. The stability of this two-year VBIF implementation allows providers to gain familiarity with a set of new APM quality measures and recognizes that, in order to succeed, we need to address community-wide systems of care, not only what happens within the walls of a primary care office. By 2019, OneCare intends to refine the VBIF to add a variable component for performance at an organizational level. The 2019 ACO VBIF measure set, with the variable component, will likely vary from the ACO-level quality performance measures and will need significant exploration and discussion among OneCare participants and collaborators to identify and align key measures and drivers of cost, utilization, and quality that are within our ability to impact change and improvement.

In addition to the VBIF, OneCare is actively using performance data at the ACO, health service area, site-of-care, provider, and patient level to identify opportunities for improvement. OneCare's self-service analytics tools provide both actionable data and a comparative framework (provider to provider; community to community) which can tap into the friendly competition of individuals wanting to improve relative to their peers. Together we feel these levers will continue to facilitate improvement and allow OneCare to produce the consistently high-quality results that we have demonstrated to date while also allowing us to address new areas of need as identified through the APM.

2. **While OneCare has board and advisory committee central planning functions for population health, clinical care and quality improvement, the ACO has adopted a highly de-centralized QI model that lets communities pick their projects.**
   - **How will this structure support ACO accountability on APM and individual payer measures?**
   - **What will OneCare do to change care delivery across its network?**

   OneCare uses a two-prong strategy that both supports local control and decision-making about what and how to drive change in local health service areas with a structured approach that drives focus on specific areas of need. For example, in the current performance year, OneCare worked with its provider network to identify a set of five clinical priority areas from a list of more than 70 topics proposed. For each priority area, there was discussion and agreement on a specific measure and a goal. These priority areas were then disseminated to our network participants and collaborators via clinical governance committee meetings, using our clinician representatives (i.e. Regional Clinical Representatives) in each community, and through active discussions at "All Field Team" meetings, which consist of Blueprint and ACO staff and partners that support local community efforts. In addition, OneCare conducted an in-depth analysis early in 2017 and identified a quality measure that had sub-optimal performance across payer programs – controlling hypertension – and worked collaboratively with the Blueprint for Health, Vermont Department of Health, the QIN/QIO, SASH, and CHAC to design and execute a quality improvement learning collaborative. Currently 10 primary care and one home health agency are actively participating in the collaborative which takes place through December of 2017.

   In 2018, we plan to continue to deploy this two-pronged strategy and will work to align local and ACO efforts with the APM goals and measures. We are also actively working with GMCB and DVHA to obtain key de-identified data that will be necessary to drive change and improvement in the delivery of mental health care (e.g. claims that can track progress on the 30-day follow-up from the emergency department for mental health and substance use measures for which OneCare is precluded from receiving direct, identifiable data).

3. **There are a large number of quality improvement initiatives happening in the state, among varying organizations that include VCHIP, VPQHC, and CHAC. How do you coordinate with these other quality improvement initiatives to coordinate and ensure there is not duplication?**

   The Clinical and Quality team at OneCare conducts environmental scans to identify existing activities as well as those in the planning stages and then we outreach to develop partnerships and collaborative efforts where all organizations can benefit from alignment and contributions of resources such as staff time, recruitment methods, identification of best practices, and execution strategies. In addition to the controlling hypertension learning collaborative described in question 2 above, OneCare has partnered with VCHIP on their CHAMP Learning Collaborative to improve pediatric ACO measures. We helped recruit 22

OneCare practices to participate in this quality improvement project and have provided data and content expertise in the project's execution. OneCare will also be partnering with VCHIP on the 2018 project around social determinants of health, specifically screening for food insecurity and depression. OneCare continues to meet regularly with SASH, VPQHC, CHAC, Blueprint, QIN/QIO, VDH, and others to keep abreast of new priority areas among our partners and to seek opportunities to work together.

4. OneCare's response to Section 5.1 of the Budget Review Guidance submission document included limited detail about the ACO's Model of Care. Please describe strategies in the following areas:

- **How will the ACO work with its network to support person-directed care?**

  OneCare promotes shared-decision making strategies that support timely and effective patient/provider conversations that elicit the patient's needs and desires for their health. For example, OneCare has begun offering quarterly "Grand Rounds" for network participants. These 90-minute sessions highlight a clinical topic or area of concern to the network and facilitate a panel-based discussion of best practices, insights from providers demonstrating success in the area, and open space for conversations and questions about how others can change/improve. For example, a June Grand Rounds focused on the Medicare Annual Wellness Visit benefit and several nurse-based care delivery models that have demonstrated high patient engagement and satisfaction in the early stages. Through qualitative data, patients shared that they felt they had more time with the nurse to share their concerns, to ask questions, and address preventive care and it allowed them to then focus on follow-up appointments for specific chronic conditions or other patient-driven topics. In addition, OneCare's care coordination model is centered around a person-directed approach to identifying areas of concern, prioritizing them, developing a shared care plan (in the patient's own words) and then identifying the tasks or milestones along the way to attainment of the health-related goals. Finally, OneCare participates in annual patient surveys and shares that information with its network to facilitate dialogue and improvement opportunities.

- **How will the ACO work with its network to support appropriate utilization (e.g., to reduce overuse and misuse of services and protect against underuse)?**

  OneCare routinely tracks utilization data and reports it to our Board and participants through monthly reports and through direct access to our self-service analytics platform, WorkBenchOne. In addition, OneCare has formed an internal team consisting of a medical director, nurse, coder, and data analyst that meet regularly to monitor utilization (over and under) and has developed a detailed policy to address instances of unwarranted variation. The policy includes deeper case review and analysis, interviews with provider, and development of remediation strategies and recommendations to our Population Health Strategy Committee of our Board of Managers.

- **How will the ACO work with its network to support seamless coordination of care across various providers in the care continuum, especially during care transitions (e.g., facilitate timely communication across ACO and non-ACO providers)?**

  OneCare has invested in Care Navigator, our care coordination platform, as the primary mechanism to support communication and coordination of care across the continuum of care. All ACO participants and collaborators can access patient-level information based on appropriate permissions. We will be expanding Care Navigator functionality this fall to incorporate event notification so that care team members can receive timely notifications of admissions, discharges, and can outreach to support patients to ensure effective transitions of care during this period of vulnerability. Further, Care Navigator allows care team members to store information about other non-ACO providers in notes fields so that the care team is fully informed and can proactively address communication needs. Much of this work is led by the lead care coordinator, who is a care team member identified by the patient to take the "team lead" role. In addition, OneCare is facilitating monthly cross-community meetings of core care coordination leaders to develop and refine community-specific workflows that can address unique opportunities and challenges in the local care delivery system. For example, the workflow development discussion might lead to the recognition that a key community partner is not part of the ACO and the core team can outreach and engage that organization in a conversation about how best to bring them into the communication and coordination and then document this in a workflow followed by training for local care team members. Care Navigator can also be customized to deliver reminders and trigger specific tasks for care team members and patients based on specific parameters set in advance – for example, sending a patient a reminder it's time to fill a prescription or schedule a next appointment with their specialist.

- **How will the ACO work outside of its network to coordinate care, improve quality and manage costs? Will any tools be provided to out of network providers?**

  OneCare is very cognizant of the care delivered to ACO-attributed patients outside of our Network, particularly in some border communities. OneCare is beginning to monitor that "leakage" and share information with communities on when and where it is occurring so that they can explore "why" it is happening. Over time we expect this will lead to increased conversations and planning about referral networks, local workforce needs/gaps, and enhancements to patient education and outreach. OneCare continues to support out-of-network providers through the Community Collaborative structures in place between OneCare and the Blueprint that facilitate local quality improvement efforts, including care coordination. OneCare provides data, quality improvement support and tools to facilitate local change in recognition that by supporting non-ACO providers it will help improve care for the entire population.

- **How will the ACO support integration efforts with the Blueprint, RCCs, and other state care coordination activities (e.g., how will these activities be integrated into ACO strategy and operations)?**

  OneCare has been meeting biweekly with Blueprint for Health and other ACO leadership to align strategies including financing, care models, and quality improvement activities. One area of mutual development over the past year has been how to evolve the Community Collaboratives (formerly called UCCs or RCPCs) so that they become "accountable communities for health" (ACH) – moving to a true, whole population focus, while retaining their focus on clinical priority areas. Together this spring we successfully transitioned this pilot ACH work from its initial SIM funded scope into an enduring model by taking on co-leadership of statewide training sessions and working together to align the Blueprint Health Service Area contracts with ACO priorities and the ACH framework. Initial feedback from communities has been very positive and we anticipate continuing this work and building on it together moving forward. A second example was the close partnership that emerged between OneCare and the Blueprint in evolving the Integrated Communities Care Management Learning Collaborative framework into a complex care coordination model that could expand initial capacity and provide a structured approach to spread care coordination strategies statewide. Blueprint and OneCare continue to co-sponsor care coordination training events, facilitate community dialogue at "All Field Team" meetings, and we will continue to work collaboratively to monitor utilization and make adjustments in the model and associated payment methodology.

- **How will the ACO work with its network to provide care coordination interventions for high risk and very high-risk patients (e.g., development and provision of consistent and effective care management services for these patients)?**

  Building on existing capacity and expertise in local communities, OneCare developed a care coordination model and strategy to address the needs of all patients, with a particular focus on high and very high risk patients. This model requires the identification of care team members with knowledge of a patient and the identification of an initial lead care coordinator to conduct outreach to engage the patient into a care coordination process. Once engaged, time is spent supporting the patient to identify his/her goals and creating a shared care plan. This person-centered tool guides the conversation to identify what is most important to the patient and then supports the creation of patient-narrated goals and specific next steps, or tasks, which will facilitate attainment of those goals. Standardized tools developed through previous statewide collaboratives are being utilized such as shared care plans, Eco Maps, Camden Cards, as well as new tools OneCare is providing such as risk stratification data, identification of disease panels, identification of opportunities to re-engage the patient with primary care through panel management, as well as assessments and, in the coming months, patient education materials. OneCare is developing care coordinator competency assessment tools and facilitating ongoing discussions and training sessions where gaps are identified. Further work on community-specific workflows will highlight local variations based on

community provider access and will allow communities to customize workflows to maintain their strengths while identifying and addressing barriers or potential areas of duplication of services.

- **How will the ACO work with its network to support use of comprehensive integrated/shared care plans and interdisciplinary care teams (e.g., implementation of shared care plan and support for interdisciplinary care team conferences with high risk patients)?**

  See questions above. In addition, OneCare has built fields into Care Navigator to track the Camden Card domains (e.g. legal, education, and housing) that align with the patient-narrated goals in order to capture these data systematically for use in local community planning as well as ACO-wide gap analysis and remediation planning.

- **How will the ACO work <u>outside</u> of its network to coordinate care, improve quality and manage costs? Will any tools be provided to out of network providers?**

  Please see sub-bullet #4 above.

5. **OneCare's response to Section 5.2 and 5.3 of the Budget Review Guidance submission document included limited detail about new strategies for bringing primary care providers into the network, and strategies to expand capacity in existing primary care practices. For example, with respect to the latter, the ACO could describe strategies that allow primary care practices to:**
   - **decrease the time they have to spend on service authorization, documentation, or reporting, and/or**
   - **see more patients and see patients at new times, and/or**
   - **care for patients through new modalities (e.g., e-visits, telemedicine), and/or**
   - **augment primary care practice teams, and/or**
   - **other strategies of OneCare's choosing.**

   OneCare Vermont's complex care coordination model delivers significant financial resources to all participating primary care practices to help defray the cost of care coordination services imbedded in the PCMH. These resources significantly augment existing supports provided by the Blueprint practice payments and Community Health Team.

   Hospital owned primary care practices under OneCare's new financial model are already capitated for their attributed lives since the fixed hospital payments include historical expenditures for hospital inpatient, outpatients and physician services (including primary care services.) Thus, the preponderance of primary care clinicians can immediately adopt and grow more facile with innovative non face-to-face clinical care – telephone discussion, video visits, virtual (e.g., store/forward/reply) visits, EMR portal responses, active use of Care Navigator to promote better complex care coordination activities, interdisciplinary care planning conferences, and others. OneCare will be targeting network provider education to promote these innovative methods of care.

Starting in 2018, OneCare intends to pilot a payer agnostic primary care capitation model for independent practices of at least 500 attributed patients to promote similar innovative approaches. Practices are being recruited for this pilot and focus groups have begun.

OneCare has successfully negotiated relief from prior authorization and utilization review for the Vermont Medicaid Next Generation program for part A and B services which is a bona fide demonstration of reducing practice and hospital burden of personnel time and expense for these activities. The OneCare Utilization Review Committee monitors data for over and underutilization but the majority of our participants will experience a real reduction in administrative burden. While we do not have risk for pharmaceutical spending in current contracts, taking on some future financial risk for drug spending will likely result in reduced resources needed to comply with pharmacy benefit manager formulary authorization rules.

In the new paradigm, "Seeing more patients" will become an outdated phrase since it emphasizes the fact that face-to-face billable office visits are essential elements in a fee-for- service world. "Meeting the care needs of patients conveniently, expertly, and in the communication format that they desire" will become the more appropriate characterization of future patient care. Norms of documentation will evolve but the current need to bill in a compliant fashion (federal documentation criteria, National Coverage Decisions, Local Cover Decisions, payer benefit limits) that also meets the needs of professional licensing and medico-legal considerations will offer few immediate major changes.

As discussed above, OneCare has prioritized reducing the burdens of quality measure reporting by emphasizing claims-based measures that do not require painstaking human data gathering in charts.

OneCare Vermont also recognizes that current requirements for NCQA certification as a Patient Centered Medical Home to qualify for Blueprint practice payments and attribution is considered a significant burden by many primary care practices. Despite some recent simplifications to the NCQA re-certification methods, our network has not yet been able to assess how much reduction in time and opportunity-cost investments practices will experience. The OneCare network is willing to explore alternative methods to assure practices have essential operational capabilities to effectively serve patients in a population health paradigm.

OneCare is promoting the use of registered nurses to expand the primary care workforce by involving them in performance of the Medicare Wellness Visit. This compliant strategy frees up physician and APP level clinicians to manage other acute and chronic illness patients. Patients benefit from having more time to discuss their health concerns

with the nurse and have those concerns addressed immediately (e.g., Advanced Directive completion, immunization updating) or recorded for future follow up (e.g., new symptoms or complaints.)

The Vermont All Payer Model paves the way for new benefit waivers in the Medicare Next Generation program as well as in Medicaid Next Generation and the Commercial Exchange Next Generation programs. The standard Medicare waivers in 2018 will help primary care by providing for better supported hospital discharge transitions of care home health agency home visits, permitting both billable telemedicine visits (contemporaneous video/audio communication) and non-billable telemedicine interactions with patients in their home, and making nursing home (sub-acute rehabilitation) services available to patients without the burden of the current three-day hospital stay requirement. These waivers support primary care in significant ways to provide care more flexibly and conveniently. Recommendations for additional waivers to be considered for our three programs are currently being assembled for analysis and negotiation with the Green Mountain Care Board and payer partners.

OneCare is optimistic that the transformed health system consisting of prepaid financial models, stronger community continuum of care communications, less administrative burden, patients more engaged in their health, Blueprint supports being maintained in the form of ongoing Community Health Team support services, SASH activities, and payment streams to primary care office based care coordination will usher in a favorable future for primary care practice in Vermont. In addition, skilled nursing facility dedicated medical staff models ("SNF-ists") represent improved care of complex sub-acute rehabilitation patients and long-term care nursing home patients. More emphasis on expert and reliable transitions of care from hospital to home or SNF, SNF to home, and home health to independent living, will contribute to improved quality of care and a more favorable primary care clinician experience.

OneCare is also involved in promotion of innovative models of integrated mental health services in primary care settings to help address the significant contribution of mental illness on the outcome and resource use for physical health care. These models include deployment of designated agency personnel in the PCMH setting and increased use of primary clinician/psychiatric consultation direct communication for improved diagnosis and medication management. Such interventions can rely on "consultants on retainer" compensation models (at first within the hospital-owned practices) made possible by the fixed hospital payments in the OneCare financial model.

6. **OneCare's response to Section 5.4 of the Budget Review Guidance submission document included limited detail about the participation and role of community-based providers that are included in the ACO. Please describe planned ACO investments in community-based provider capacity, efforts to include community-based providers in decision-making and policy development, and efforts to avoid duplication of resources.**

OneCare's population health management strategy requires active participation of the full continuum of care to improve care delivery and health outcomes. Community-based providers are represented at all levels of OneCare's governance, from the Board of Managers to our Clinical and Quality Advisory Committee. As such they have a direct impact on the development and execution of our ACO vision and strategy. For example, community providers had direct influence on the selection of OneCare's clinical priority areas which contributed to the selection of a priority area on reducing skilled nursing facility length of stay as well as a priority on wellness and prevention. One of the most visible areas of collaboration across the continuum was in OneCare's creation of a payment model to support our community-based care coordination strategy. Early in the process, OneCare established a goal of ensuring that community partners that provide care coordination supports and services would be compensated. This led to discussions and a focus on providing payments for team-based care coordination. As conversations evolved it became apparent that the Designated Agencies, Home Health, and Area Agencies on Aging needed resources to be active care team members and if a patient desired to become the lead care coordinator. This payment model facilitates alignment of community resources, reduces duplication, and recognizes the varying expertise of community-based providers in meeting the needs of patients and families.

Community-based providers are also recognized in OneCare's Value Based Incentive Fund, described previously, with 30% of the earned incentive being shared across Network participants based on the health service area's performance. Beginning in 2018, community-based providers such as home health will engage in OneCare's benefit enhancement waivers as we work together to optimize transitions of care. Finally, OneCare is interested in continuing conversations with community providers about how to design future payment models that align care delivery in more efficient and effective ways.

7. **OneCare's response to Section 5.5 of the Budget Review Guidance submission document often did not respond directly to the following areas of GMCB interest in terms of population health initiatives. Please provide information on the ACO's programs in the following areas, including how the ACO will measure success and what will constitute success:**
   - **preventing hospital admissions or readmissions**
   - **reducing length of hospital stays**
   - **providing benefit enhancements resulting from delivery system flexibility**
   - **improving population health outcomes**
   - **addressing social determinants of health (e.g. Adverse Childhood Events)**
   - **supporting and rewarding healthy lifestyle choices**

   OneCare's four-quadrant population health model provides a framework to address the GMCB's areas of interest. The overarching goal of our model is to ensure all Vermonter's in the ACO have access to primary care and the community-based supports and services that can aid them in maintaining health, managing disease, and avoiding preventable

hospitalizations. To accomplish this goal, OneCare uses analytics tools to segment the population into four categories from health/well through acute/catastrophic care. OneCare is working to develop and refine strategies in each quadrant to ensure a balanced portfolio of evidence-based strategies to support our beneficiaries. Beginning with the healthy/well population, OneCare is supporting and rewarding healthy lifestyle choices by investing in RiseVT, a community-wide collective impact model that supports healthy lifestyles by bringing together disparate sectors of the community (e.g. municipalities, businesses, schools, healthcare) to align strategies and resources that can impact service delivery, land use planning, education/outreach, among others. Currently RiseVT exists in Franklin County, but though mutual investments of OneCare, hospitals, and other stakeholders, there is momentum to spread RiseVT statewide over the next few years. OneCare intends to begin by investing $1.2M in 2018 to support the first spread phase and will, under the direction of the RiseVT Board, hire and support the statewide RiseVT Executive Director and Program Manager.

Vermonters in quadrant two whom are often experiencing one or more chronic conditions care benefit from self-management skills, regular connection with primary care, and screening to assess their physical, mental, and social needs. OneCare, through its provider network, promotes referrals to Community Health Teams to support self-management education. In addition, through our care coordination software platform, Care Navigator, ACO participants can monitor utilization data and patient cohorts (e.g. patients with COPD or CHF) to identify gaps in care.

In quadrant three and four, representing the top 10 and 6% of high risk/high needs individuals respectively, OneCare is deploying a comprehensive care coordination model that facilitates team-based care that is person-centered and flexible to meet the goals the patient identifies. This model requires the use of shared care plans, shared-decision making, and appropriate communication and coordination by diverse care team members to support patient attainment of health-related goals. It is likely that these high risk patients are the ones most likely to benefit from the three benefit enhancement waivers OneCare intends to deploy in 2018 – a post-acute discharge waiver allowing for home health visits for patients not currently eligible for these services, a waiver of the 3-day inpatient stay requirement before a patient can be discharged to a skilled nursing facility, and the removal of the rural geographic requirement for telehealth services which will allow their expansion into Chittenden, Franklin, and Grand Isle counties. OneCare intends to closely track these benefit enhancement waivers and related investments to assess patient outcomes and will continue to work with GMCB and payers to explore future benefit enhancement waivers for 2019 and beyond. Together our care coordination and transitions of care strategies along with our data-driven approach to identifying high-risk individuals and cohorts will facilitate improvement in inpatient length of stay and our focus on health and wellness and identification of "rising risk" populations will directly impact preventable hospital admissions and readmissions.

Finally, OneCare is committed to refining and improving our use of data to segment the population, focusing on building community partnerships to facilitate the systematic collection and sharing of social determinant of health data to improve our collective understanding of whom is at risk and how best to coordinate care and service delivery to optimize patient outcomes. This is a long-term strategy that will begin with a planning process in 2018 to gather information on existing resources, gaps, and opportunities. In the meantime, other efforts are underway to address social determinants of health including piloting the use of screening tools for patients in care coordination (VT Self Sufficiency Outcomes Matrix), use of Camden Cards to identify the lifestyle factors of most concern to patients and then support of their shared care plan development, screening in pediatric-service primary care practices for food insecurity and parental depression, and other emerging innovative pilot projects occurring in local communities.