UPDATE

from

OneCare Vermont

Vicki Loner, Vice President and Chief Operating Officer
Sara Barry, Director, Clinical and Quality Improvement
Marissa Parisi, Executive Director, RiseVT

August 8, 2018

OneCareVermont

onecarevt.org

Population Health Approach: A plan for every person

- **44% of the population**
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Key Activities:**
  - Preventive care (e.g. wellness exams, immunizations, health screenings)
  - Wellness campaigns (e.g. health education and resources, wellness classes, parenting education)
  - RiseVT

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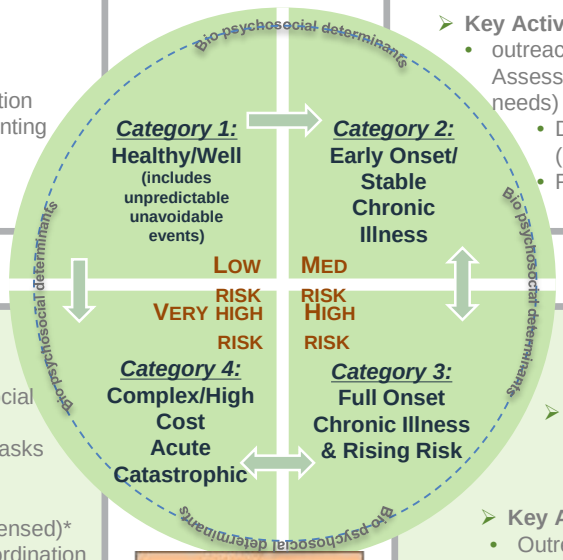

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  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

16% Lives
40% Spending
89% Multiple Chronic
67% MH Condition

- **10% of the population**
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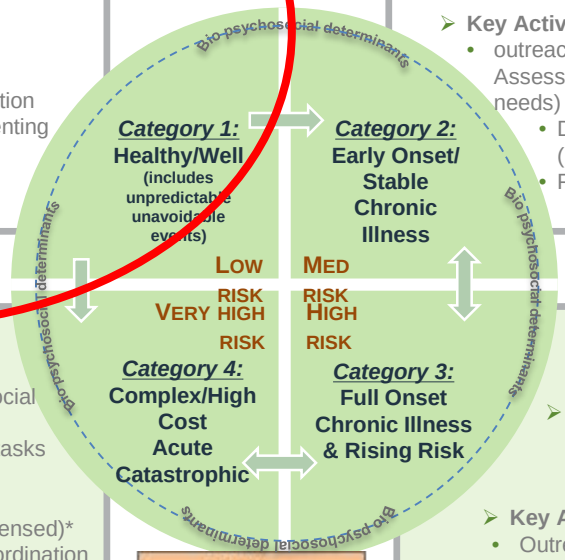

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Marissa Parisi

Executive Director, RiseVT

Statewide Expansion Update

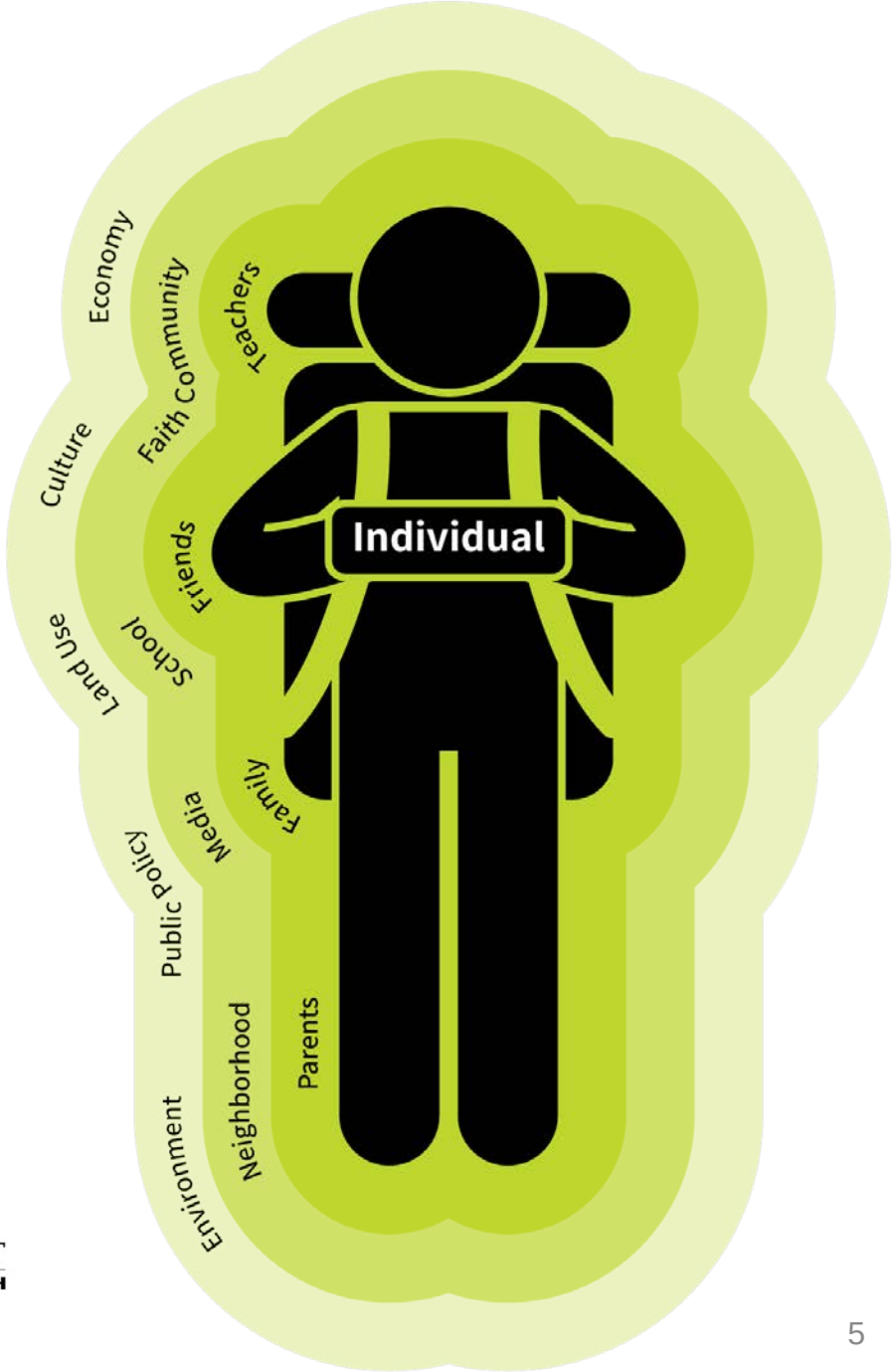
Green Mountain Care Board

August 8th, 2018

RISE VT
Embracing Healthy Lifestyles

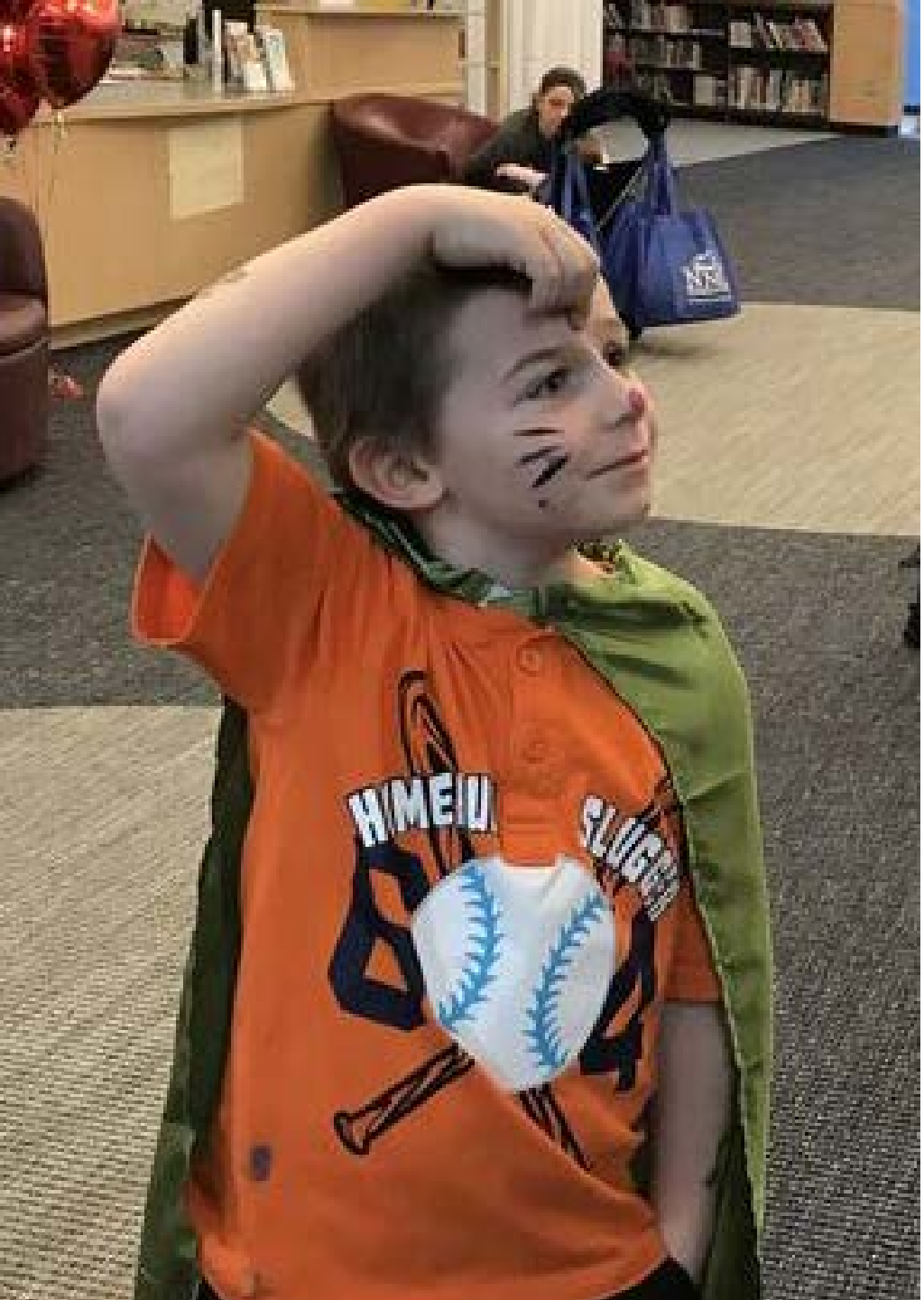
Creating Healthy Environments to Foster Healthy Lifestyles

- Our model:
  - Linking Healthcare and Prevention
  - Public-Private Partnership
  - Social Marketing
  - Monitoring and Evaluation
  - Political Commitment



RISE VT
Embracing Healthy Lifestyles

VERMONT
DEPARTMENT OF HEALTH



Numbers

- The **adult obesity** rate in Vermont is projected to reach **48% by 2030**, and childhood rates are tracking the same. The current rate of adult obesity is **27.1%**
- In 2011, **48% of ED visits mentioned obesity***.
- The projected growth rate of diabetes is **53% by 2030 from the 2010 rate.** The 2016 rate was **8.4% so by 2030 as many as 1 in 10 Vermonters could have or be at risk for the disease**.**
- The projected growth rate of heart disease is **400% by 2030 from the 2010 rate** which means **1 in 5 Vermonters could have or be at risk for the disease**.**

*Vermont Uniform Hospital Discharge Data Set (VUHDDS) 2005-2011.
**RWJ State of Obesity Report 2017.

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WINDSOR COUNTY 2018 PROFILE

HEALTHY WEIGHT

Adult Obesity

- 25% — Percentage of adults with BMI ≥ to 30. Vermont: 25%

Adolescent Obesity

- 14% — Percentage of adolescents with BMI ≥ to 30. Vermont: 12%

Food Insecurity

- 12% — Factors that contribute to a healthy food environment (scale of 1-10). Vermont: 12%

PHYSICAL ACTIVITY

Physical Inactivity

- 20% — Percentage of adults reporting no leisure-time physical activity. Vermont: 20%

Access to exercise opportunities

- 79% — Percentage of population with adequate access to locations for physical activity. Vermont: 79%

TOBACCO USE

Adult Smoking

- 14% — Percentage of adults who are current smokers. Vermont: 17%

SUBSTANCE ABUSE

Excessive Drinking

- 21% — Percentage of adults reporting binge or heavy drinking. Vermont: 21%

Drug Overdose Deaths

- 23 — Number of drug poisoning deaths per 100,000 population. Vermont: 16

● At or above the state of Vermont value ● Below the state of Vermont value

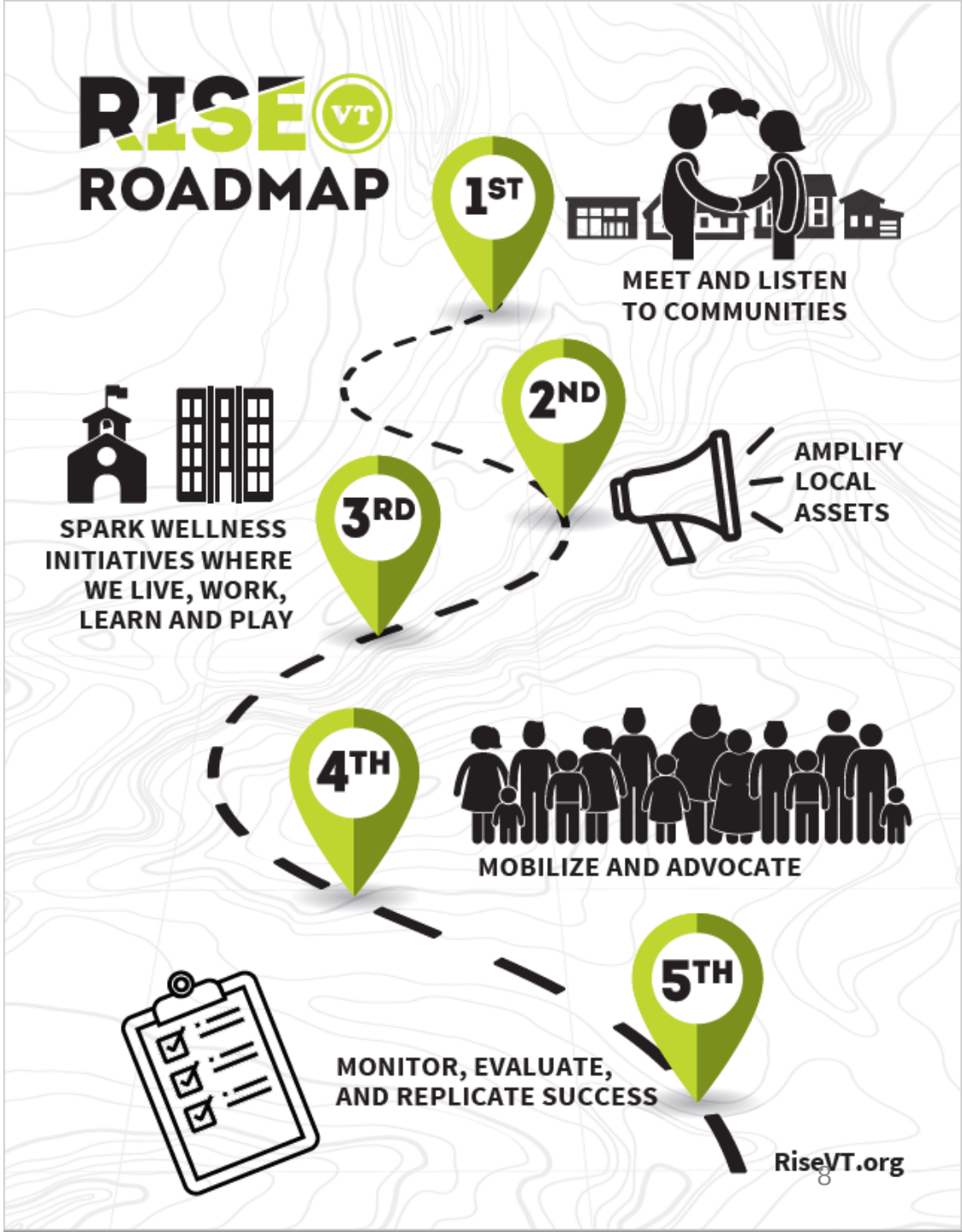
Data in this Dashboard are available from the 2018 County Health Rankings and the 2015 Youth Risk Behavioral Survey.

RISE VT Embracing Healthy Lifestyles

Local Data Profiles

RISE VT Embracing Healthy Lifestyles

Describing the Approach



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The Power of Collective Impact

Founding Team in Franklin & Grand Isle Counties

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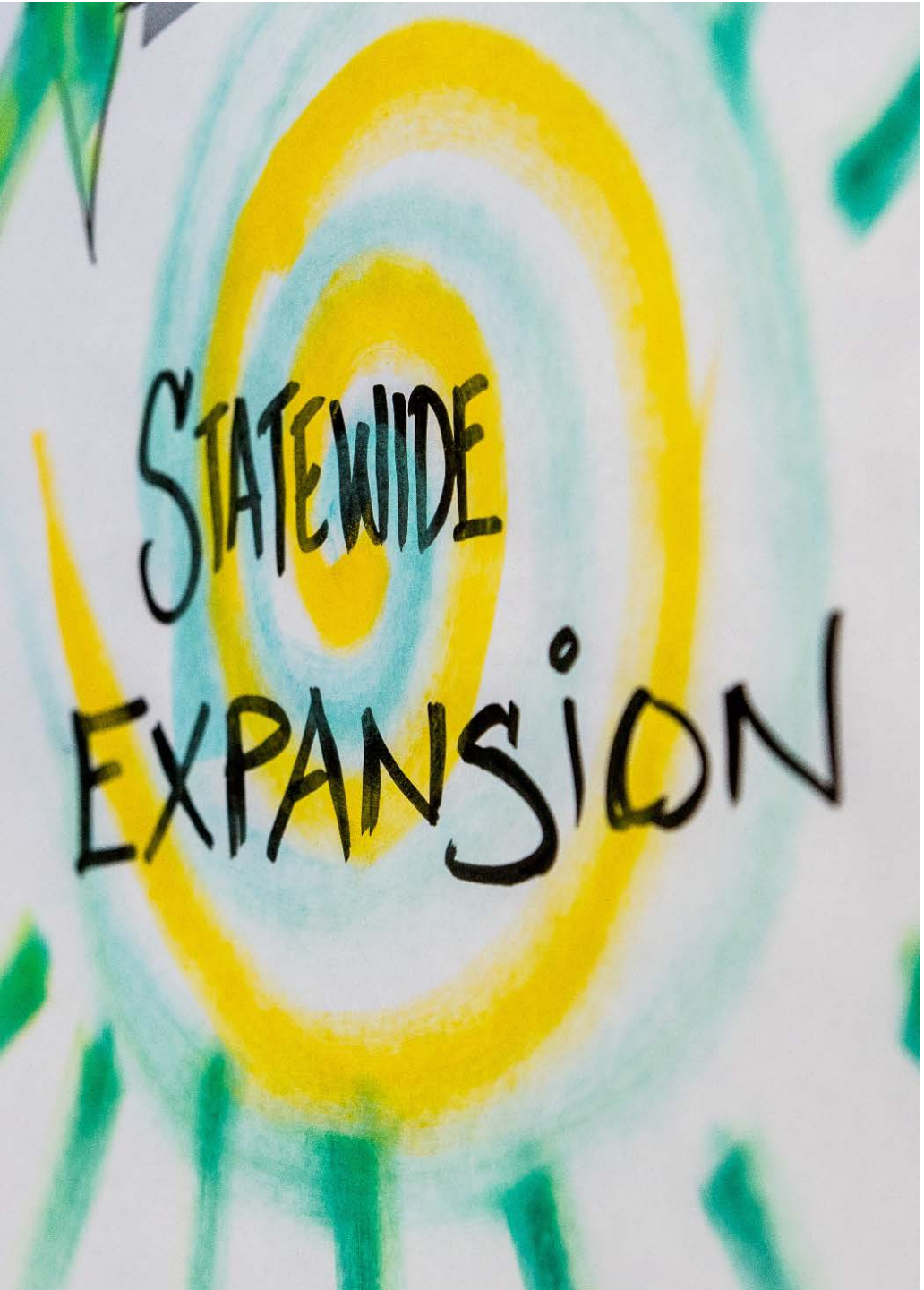
Embracing Healthy Lifestyles



Program Expansion Update

RISE VT
Embracing Healthy Lifestyles

Statewide Board of Directors

- **Jill Berry Bowen**-CEO, Northwestern Medical Center
- **Eileen Whalen**-COO, UVMMC
- **Chris Hickey**-CFO, Northwestern Medical Center
- **Don George**-CEO, Blue Cross, Blue Shield of Vermont
- **Winn Goodrich**-Superintendent of Schools, Franklin Northwest Supervisory Union
- **Steve Gordon**-CEO, Brattleboro Memorial Hospital
- **Deanne Haag, MD**- Physician, Northwestern Pediatrics
- **Mark Levine, MD**-Vermont Commissioner of Health, Vermont Department of Health
- **Janet McCarthy**-Franklin County Home Health Agency
- **Todd Moore**-CEO, OneCare Vermont
- **Beth Tanzman**-Executive Director, Vermont Blueprint for Health
- **Lisa Ventriss**-Executive Director, Vermont Business Roundtable

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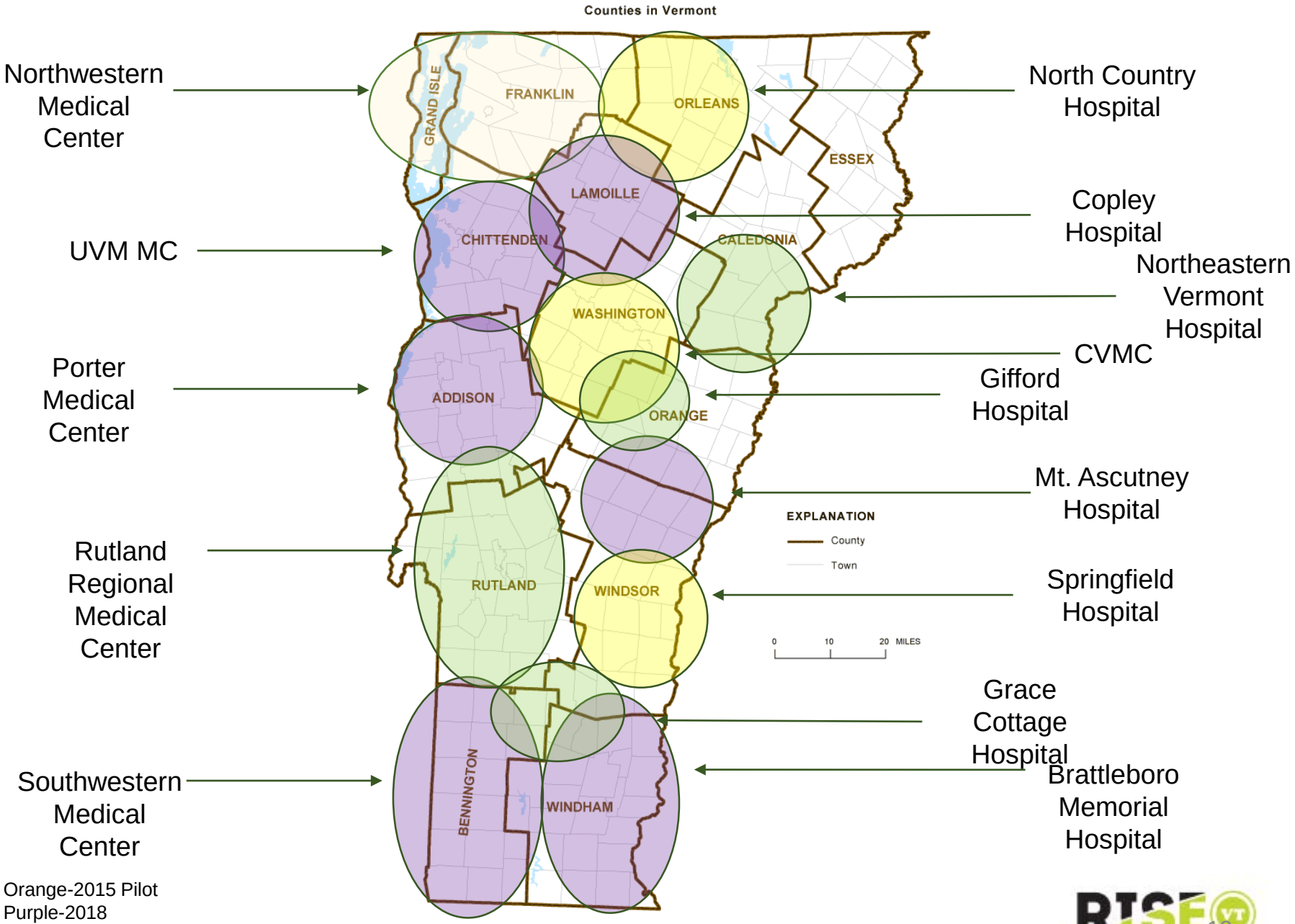
Building Our Tools

- Finalized the Community Toolkit as a resource for program managers



Orange-2015 Pilot
Purple-2018
Yellow-Q1&Q2 2019
Green-Q3 &Q4 2019

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Local Stakeholder Engagement

- Over 100 new local stakeholders are participating in RiseVT steering committees to advise the new work and campaigns.
- Currently 11 towns are starting new RiseVT campaigns. We anticipate at least 3 more starting by the end of 2018.

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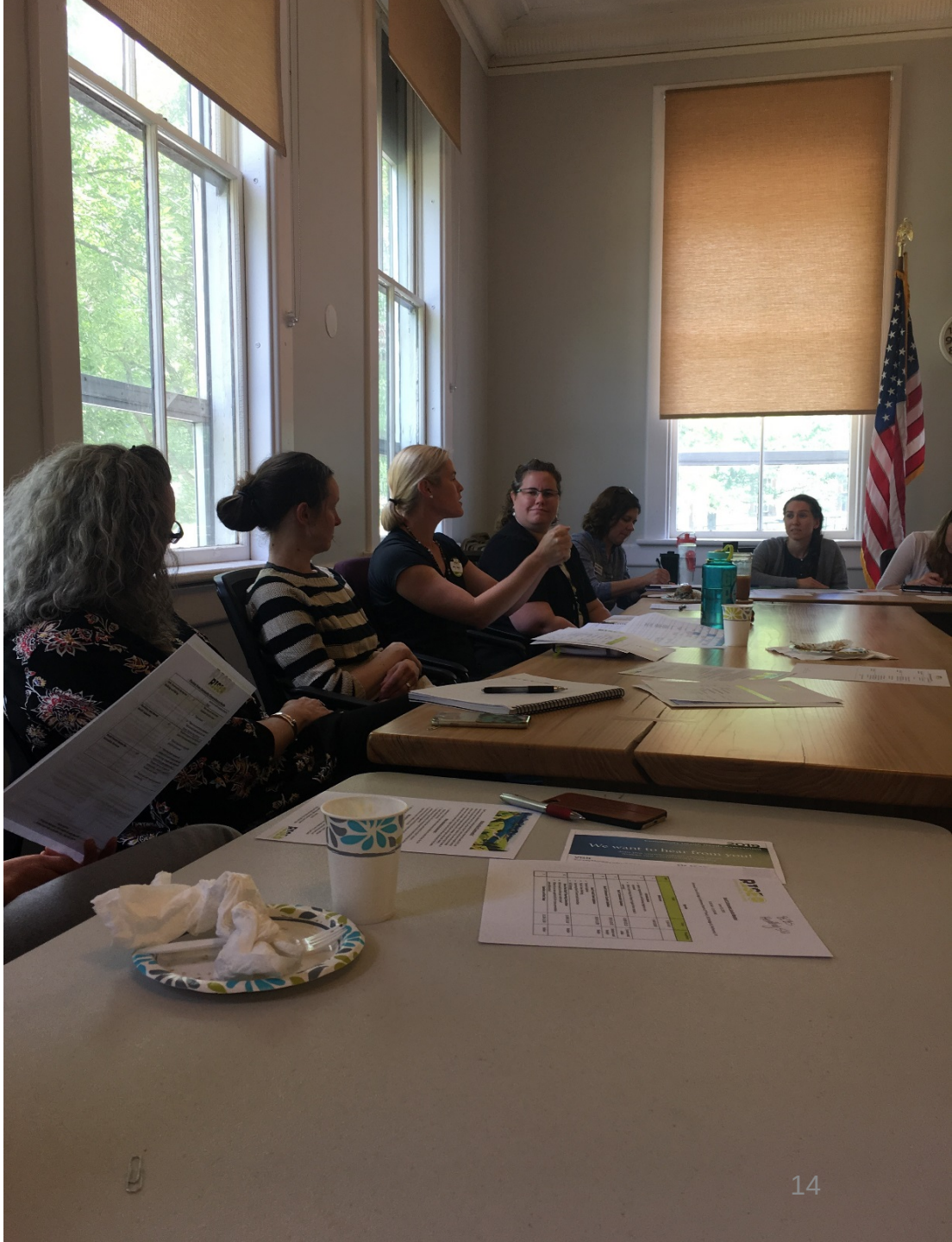

Evaluating Engagement & Awareness

- Using standardized methods for tracking programmatic impact locally.
- Using YRBS, BRFSS, and Medicaid data to track statewide trends.
- Special studies and investigations will be undertaken by Scientific Advisory Board.

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Embracing Healthy Lifestyles

RISE VT

SUPPORTS HEALTHY SUMMER MEAL AND ACTIVITY PROGRAMS FOR ALL VERMONT KIDS

TEXT "FOOD" TO 877-877

To find out what programs are available in your community!

Learn more about RiseVT by visiting **RISEVT.ORG**

Summer meal programs are made possible by Hunger Free Vermont and the Vermont Agency of Education

VERMONT AGENCY OF EDUCATION

HUNGER FREE VERMONT

https://risevt.org/

RiseVT Statewide | RiseVT

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CHOOSE YOUR COUNTY

BENNINGTON CHITTENDEN FRANKLIN / GRAND ISLE LAMOILLE WINDSOR RISEVT STATEWIDE

RISE VT

Home About Us Join Us Blog Calendar Counties

RISEVT WANTS YOU TO GET OUT AND PLAY!

Vermont State Parks and Vermont Fish & Wildlife have teamed up to create Reel Fun, a program at 19 state parks which offers fishing equipment to visitors on a loaner basis. To teach the basics of fishing, Vermont Fish and Wildlife offers Let's Go Fishing Clinics!

Participate in Reel Fun this summer and enter to win a weekly drawing of a $25 Gift Card to Orvis.

REEL FUN RADIO SPOT

00:00

ENTER TO WIN

100%

https://www.facebook.com/pg/RiseVTBennington/events/?ref=p

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3 dates left

ACT Coalition Meeting

Community Room @ CCV. 324 Main Street, Bennington, VT 05201

ACT is an organization in Bennington working to prevent youth substance use. And we need your help! It takes a village to raise a child, and it's going to take... More

AUG 3 Fri 8 AM | SEP 7 Fri 8 AM | +1

Causes | Interested

Upcoming Events

Share Events

AUG 1	World Breastfeeding Week 2018 Aug 1 - Aug 7 · 9 guests	Catamount Connections Bennington, VT	Interested
AUG 1	Breastfeeding Luncheon to Learn, Celebrate... Wed 11:30 AM · 26 guests	Catamount Connections	Interested
AUG 3	Free Family Concert Fri 4 PM · 42 guests	Lake Paran - North Benningt... North Bennington, VT	Interested
AUG 4	Children's Art Walk Aug 4 - Aug 5 · 1 guest	Bennington Museum Bennington, VT	Interested
AUG 6	RiseVT Show Up Event - Disc Golf Mon 5:30 PM · 2 guests	Willow Park Bennington, VT	Interested

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RISEVT BLOG

EAT WELL, HAVE FUN ON INDEPENDENCE DAY

July 4th is often a fun time to meet up with friends and family and barbeque it up! To help keep your potluck items on the healthy side, our friends at Eating Well have created a refreshing treat with a fruit p izza recipe that has a healthier watermelon “crust”...

read more

RISEVT EVENTS

MON 16

RSVP BONE BUILDERS: JOHNSON

July 16 @ 10:00 am - 11:00 am EDT

TUE 17

PRE-SCHOOL STORYTIME: MORRISTOWN CENTENNIAL LIBRARY

July 17 @ 6:30 am - 7:30 am EDT

TUE 17

RSVP BONE BUILDERS: MORRISVILLE

July 17 @ 1:00 pm - 2:00 pm EDT

WED 18

RISEVT AT WEDNESDAY NIGHT LIVE IN MORRISVILLE

July 18 @ 1:30 pm - 3:30 pm EDT

RSVP BONE BUILDERS: JOHNSON

Copley Hospital-Morrisville & Johnson

- Hosted 2 stakeholder meetings to begin planning.
- Hosting *Run for the Heart* in September. A RiseVT mini-grant is paying for a local coach to help people train for the run and paying registrations for first time runners.
- Cole is at Wednesday Night Live in Oxbow Park in Morrisville sizing and giving out bike helmets to children.

University of Vermont Medical Center-Richmond, Huntington, & Bolton

- Launched RiseVT with a scavenger hunt for kids at the Richmond July 4th Parade.
- At the Richmond Farmers' Market weekly with a RiseVT booth doing education on nutrition and physical activity.
- Working in Huntington and Bolton on promoting use of the town forests.

Southwestern Medical Center-Bennington & North Bennington

- New smoothie bike has been at several events this summer in partnership with the Bennington Fire Department and John McCullough Free Library.
- Free bikes now available for loan at the Vermont Health Department.
- 14th Annual Bennington Battle Day 5K.

Quadrants 2-4

Sara Barry, Director, Clinical and Quality Improvement

2018 Clinical Priorities

High-risk patient care coordination
Measure: Reduce acute admissions and ED utilization by 5% each in this high risk cohort

Episode of care variation
Measure: Reduce Medicare risk adjusted skilled nursing facility length of stay by 5%

Mental health and substance abuse
Measure: Increase within-30-day ambulatory care follow-up for emergency room discharges for mental health and substance abuse diagnoses by 5% each

Chronic disease management optimization
Measure: Reduce ambulatory sensitive condition admissions/readmissions for COPD and heart failure by 5% each

Prevention and wellness
Measure: Increase network utilization of Medicare annual wellness visit, adolescent well child visit, and developmental screening by 5% each

Social Determinants of Health
Measure: Establish a baseline to measure food insecurity screening

APM Goal 1	APM Goal 2	APM Goal 3
Improve Access to Primary Care	Reduce Deaths from Suicide and Drug Overdoses	Reduce Prevalence and Morbidity of Chronic Disease (COPD, DM, HTN)

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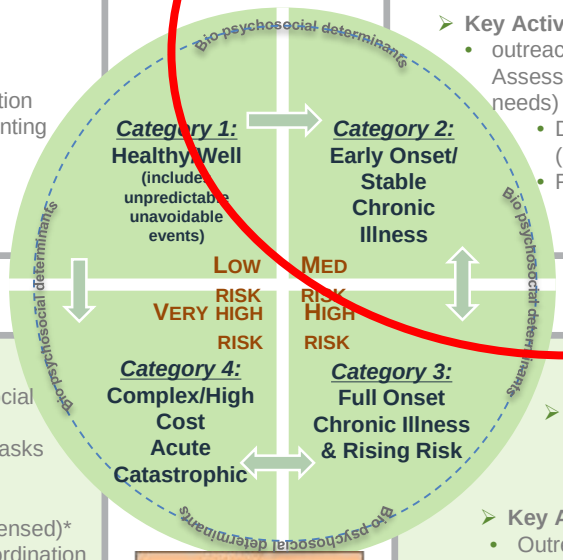

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Diabetes Prevention and Management Learning Collaborative (2018)

Objective: To provide support and strategies to meet practices where they are in improving the prevention and maintenance of diabetes in their patient panels

- **15 teams are participating from eight Vermont counties**
- Four full-day, in-person sessions planned:
  - April 20: Standards of care and patient panels
    - 12 of 15 teams attended; a total of 31 participants
    - Attendees reported high satisfaction with presenters and work sessions
  - June 1: Self-management and motivational interviewing
    - 12 of 15 teams attended; a total of 41 participants
    - Attendees reported continued high satisfaction with content
  - September 14: Pharmacology and med. management
  - January 11, 2019: Screening and referrals for mental health and social determinants of health
- Between each session, at least one webinar is scheduled and teams will receive bi-weekly 1:1 support from a dedicated QI Coach.

OneCareVermont

SASH a caring partnership SUPPORT AND SERVICES at HOME

VERMONT Blueprint for Health Smart choices. Powerful tools.

VERMONT DEPARTMENT OF HEALTH

Quality Improvement Organizations Sharing Knowledge. Improving Health Care. CENTERS FOR MEDICARE & MEDICAID SERVICES

NEW ENGLAND QUALITY INNOVATION NETWORK Administered By Healthcentric Advisors in Partnership with QualityLogic

OneCare Vermont

Network Success Story

CONTROLLING HYPERTENSION

In June of 2017, OneCare Vermont and its partners[1] came together to recruit practices from around the state to participate in a six month quality improvement initiative focused on hypertension. The goal of the project was to educate and support practices in achieving an 80% in-control rate for hypertensive patients. This goal is in alignment with the National Quality Forum (NQF 18) measure for patients with hypertension to maintain a blood pressure below 140/90. The project was informed by a collaboratively developed Hypertension Management Toolkit. [2] Six practices and one home health agency completed the six month peer learning collaborative, represented in six different health service areas from around the state.

[1] Blueprint for Health, Vermont Department of Health, Quality Improvement Network-Quality Improvement Organization (QIN-QIO), Vermont Program for Quality in Health Care (VPQHC), Community Health Accountable Care (CHAC), Support and Services at Home (SASH), and the University of Vermont Medical Center

[2] http://www.healthvermont.gov/sites/default/files/documents/pdf/HPDP%20Hypertension-Management-Toolkit_v1.0.pdf

PEER LEARNING COMMUNITY

Key Drivers

- Hypertension is one of the leading causes of heart disease and stroke
- Eighty million adults (1 in 3) have high blood pressure in the United States today and prevalence increases with age
- There are an estimated 13 million people in the US with uncontrolled hypertension
- Vermont data from OneCare, the Blueprint and FQHCs indicates that hypertension control is around 70%
- Ambulatory care practices need education and support to implement quality improvement initiatives
- Peer learning communities are a highly effective way to translate best practice into action and provide a positive forum for accountability

Actions Taken

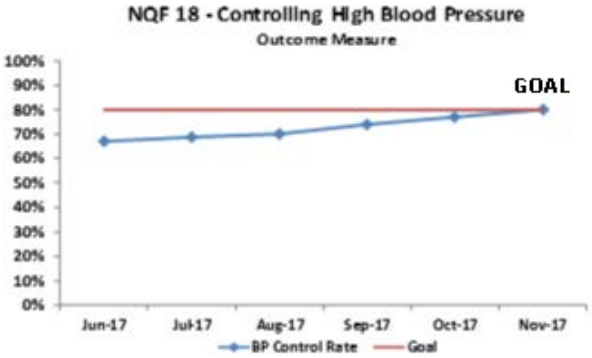
- Recruit practices throughout the state interested in participating in the learning collaborative
- Three in-person sessions were held with subject matter experts presenting materials directly related to hypertension control
- Planning committee with representatives from all participating organizations met weekly to plan monthly WebEx and in-person sessions for participants
- Blueprint facilitators and OneCare Clinical Consultants assisted practices with the implementation of the project
- Monthly check-ins were held via WebEx for practices to share data and lessons learned
- Support practices with quality improvement initiatives and process flows

OUTCOMES: SPOTLIGHT ON PRIMARY CARE HEALTH PARTNERS – ST. ALBANS

St. Albans Primary Care participated in the Hypertension Peer Learning Collaborative using one of their provider's patient panel as the pilot group for this project. The total panel consisted of 1,648 patients, which included 498 with a diagnosis of hypertension. The percent of patients with hypertension control at the start of the project was 67.1%.

Over the course of six months, St. Albans Primary Care tested a series of interventions to address their goal, including:

* Creation of patient panel
* Workflow changes - if initial blood pressure (BP) is high, repeat
* Purchased new chairs and BP cuffs
* Skills training for staff, e.g. taking accurate BP reading
* Monthly office visits for those with uncontrolled BP
* Home blood pressure log monitoring
* Educational posters and materials
* Diet, exercise and lifestyle goals



Results:
The percent of patients with hypertension and blood pressure <140/90 improved from 67.1% to 80.1% at the end of the project. The initiative will next be spread to all the providers in the practice.

LESSONS LEARNED

- Paying close attention to the technique used to take a blood pressure reading is essential for accurate blood pressure readings.
- Having practices from around the state share lessons learned about quality improvement initiatives is an excellent way to improve the health of Vermonters.
- A collaborative project organized and supported by many organizations is valuable to the provider community.

OneCare Vermont

Network Success Story

INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE IN VERMONT

Patient Centered Medical Homes (PCMH) throughout Vermont provide timely, comprehensive and collaborative care to Vermonters. According to the American Psychiatric Association (APA) "the integration of behavioral health and general medical services has been shown to improve patient outcomes, save money, and reduce stigma related to mental health." Six practices in the St. Albans Health Service Area (HSA) participated in a year-long learning collaborative to integrate behavioral health and substance use screenings, services, and personnel into primary care. The learning collaborative leveraged the expertise, relationships, and resources of primary care practices, the local hospital and Federally Qualified Health Center (FQHC), the Designated Agency (DA), Blueprint, and OneCare.

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained/about-collaborative-care

ST. ALBANS HEALTH SERVICE AREA

KEY DRIVERS

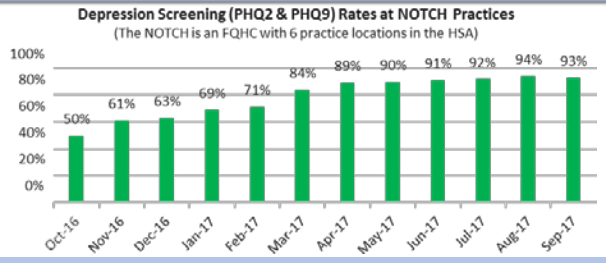
- Co-hiring agreements and collaboration between the DA and the hospital, FQHC, Blueprint, Primary Care (private and hospital owned), Women's Health, and Pediatrics.
- Motivated, engaged and expert staff who support the integration of behavioral health and substance use screening, interventions and personnel in the medical home.
- Office processes and flow (e.g., visit planner, rooming plan, panel management, and the use of screening tools) to support patient identification, screening and follow-up.
- Training for providers and office staff concerning effective 'scripts' to use for screening and follow-up.
- Coding for positive behavioral health or substance use screenings, warm-hand-offs and follow-up.
- EHR optimization to support the recording, reporting and panel management for positive behavioral health or substance use screenings, warm-hand-offs and follow-up.

ACTIONS TAKEN

- Identified and integrated screening tools into workflow and EHR (PHQ2 & PHQ9 Depression Screening and the DAST-10 Drug Abuse Screening Test).
- Created scheduling, tracking and processes for warm hand-offs, referrals and follow-up appointments with integrated behavioral health staff for positive screens.
- Developed and implemented a follow up plan and/or referral to treatment process for patients with a positive PHQ2 or PHQ9.
- All six FQHC practices conducted chart audits to track changes in PHQ9, attendance for depression follow-up appointments, and the number of patients who were offered medication therapy, education, in-house referral for therapy, engagement with self-management and the patient's response to treatment plan.

OUTCOMES at the FQHC - NORTHERN TIER HEALTH CENTER (NOTCH)

- Achieved a 43% increase in universal depression screening rates
- Met their screening rate target of 80%
- Transformed practice workflow



LESSONS LEARNED

- **Working with Designated Agencies through shared hiring and aims improves access to screening and care for patients, and strengthens relationships and collaboration among providers and practices.**
- **The use of quality improvement strategies to identify and integrate coding, tracking and reporting for screenings, warm hand-offs, referrals and follow-ups is essential to successful integration.**
- **Support and engagement from practice leaders, provider champions and quality improvement leaders strengthens clinical and administrative staff engagement and**

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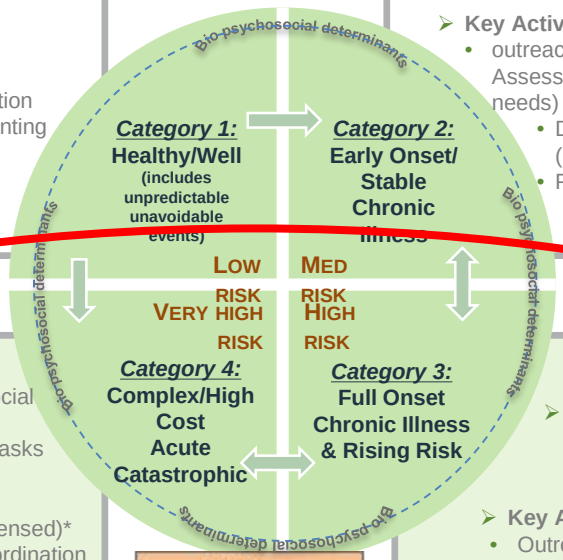

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Central Components of the Care Coordination Model

Vision

To provide high-quality, person-centered, community-based care coordination services in an integrated delivery system to achieve optimal health outcomes

1. Person-Centered Shared Care Plan
2. Multi-disciplinary Care Teams
3. Risk Stratification
4. Tools & Training
5. Inclusive Payment Model

Core Team Composition

- Meet monthly alternating WebEx and in-person
- Develop care coordination workflows
- Review care coordination data
- Disseminate best practices

One Team

Shared purpose & commitment
ACO-facilitated statewide cross-organizational and cross-community workgroups

Shared Vision

10 communities with 5-7 key stakeholders from each, all working collaboratively with a statewide vision

Integrated Care Coordination

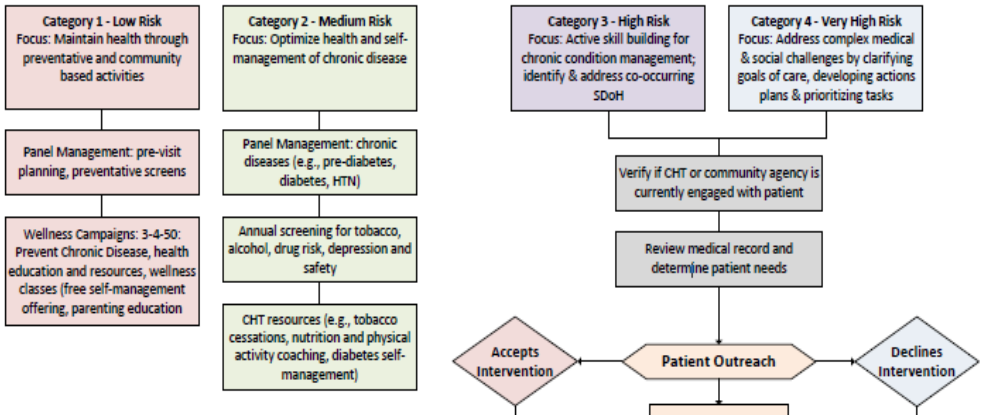
Hospitals, Adult & Pediatric Primary Care (Independent, FQHC, hospital-owned), DAs, SASH, AAA, Blueprint, Home Health

Organizations

Practice Administration, Social Work, Care Management, Quality/Risk Management, Finance, Education, Clinical, Process Improvement

Areas

Central Vermont Medical Center
Vermont Next Generation
Care Coordination Workflow

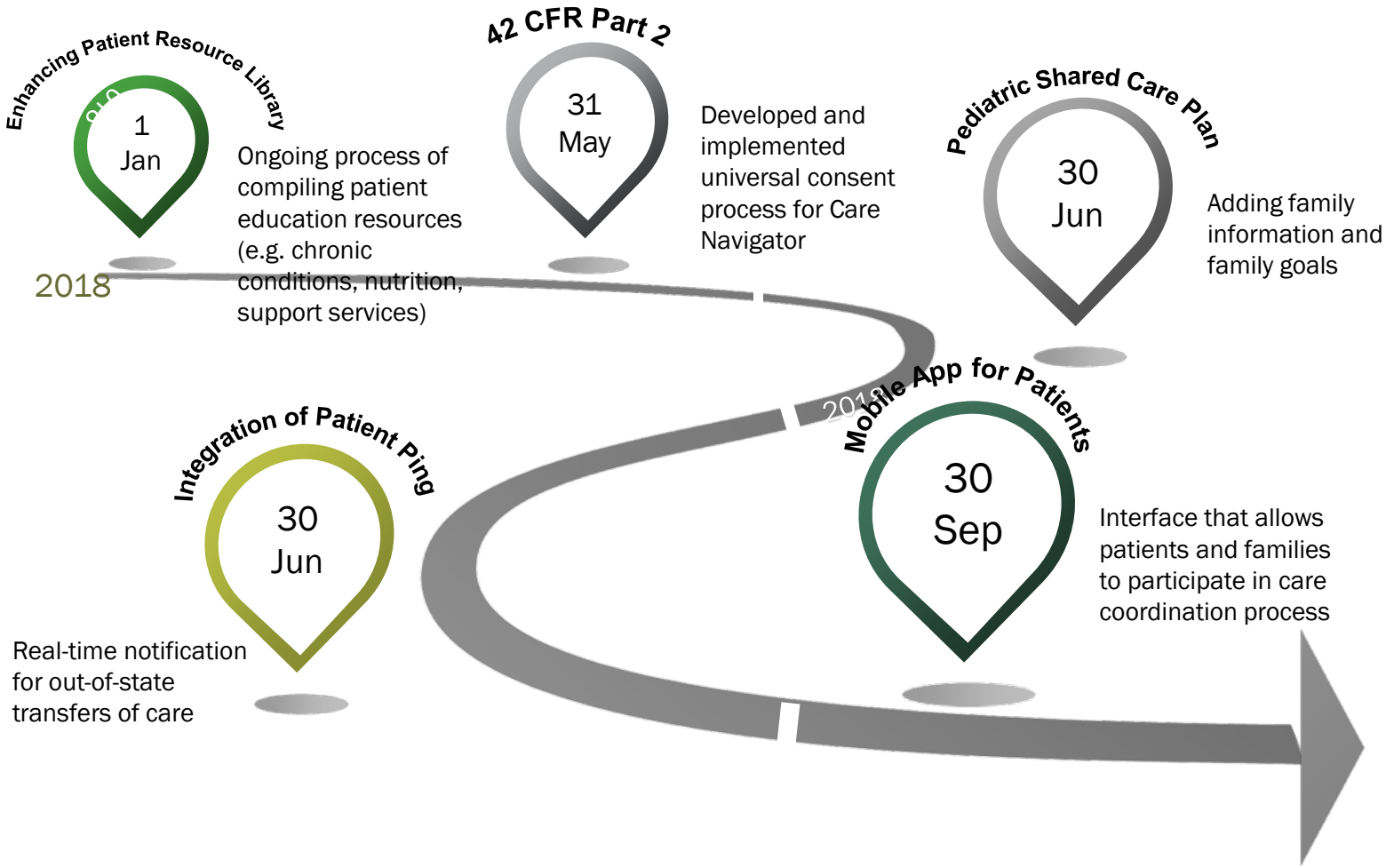


Care Coordination Training

- **Strategies:**
  - Trains all levels of care coordination workforce, regardless of ACO participation
  - Provides clear, conceptual framework focused on practical applications
  - Promotes professional development and team building

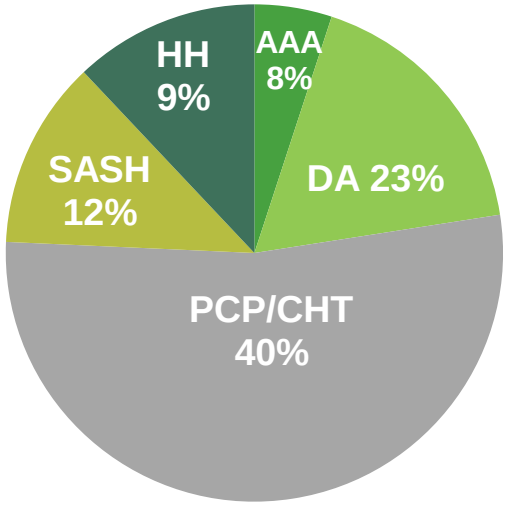
- **Training Workshops:**
  - Core Skills - focused on core skills for effective care coordination (e.g. Share Care Plans, Ecomaps)
  - Care Conferences – guidance on how to successfully facilitate a person-centered care conference
  - Leader and Staff Teams Training - enhance knowledge base and build workflows within the organization
  - Senior Leader Training - engage in cross-community and cross-organizational networking, information sharing and learning
  - Putting Care Coordination Tools into Practice - advancing skills knowledge and practice by developing multidisciplinary workflows, patient engagement strategies and integrating Care Navigator into daily work

Care Navigator Major Milestones 2018



Training Progress (Jan – July 2018)

- **552** Participants attended Care Coordination trainings, representing **328** unique individuals
- **291** People were trained in Care Navigator
- Currently greater than **400** active users in Care Navigator from **56** different organizations



Early Progress (Jan – June 2018)

- **16,112 high/very high risk members across OneCare's payer programs, of those:**
  - 2,080 have (or had) a lead care coordinator
  - 1,158 have 2+ care team members identified
  - 269 have a shared care plan initiated or fully in place
  - 936 have documented participation in community programs

The Commonwealth Fund

e-Alert

May 10, 2018

Vermont's Experiment in Community-Driven Health Reform

Vermont is undertaking an ambitious effort to move away from traditional fee-for-service health care and to a value-based payment system that rewards hospitals, physicians, and other providers for controlling costs and improving health outcomes. Medicaid, Medicare, and Blue Cross and Blue Shield of Vermont have each agreed to enter into contracts that require providers to assume risk for meeting financial targets and performance benchmarks.

A new Commonwealth Fund case study takes a deep dive into OneCare Vermont, a large accountable care organization (ACO) that is a key player in the state's plan. The ACO's mission is to unite the physical health, mental health, and social services sectors to better serve patients with complex needs.

Mark Fiegener, Sarah Klein, and Douglas McCarthy describe OneCare's community-driven care coordination, which the ACO piloted in 2017 among a portion of the state's beneficiaries. The authors say Vermont's experiment in forging partnerships among health care organizations, and social service providers offers lessons about wringing value from a fragmented health system.

"Vermont's Bold Experiment in Community-Driven Health Care Reform"- Case Study recently published by the Commonwealth Fund

OneCare Recognized in Commonwealth Fund Case Study

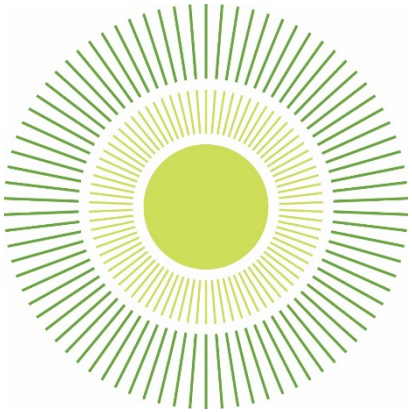
A Vermont ACO's community-driven approach to care coordination may offer lessons about wringing greater value out of a fragmented health care system.

For more Information:

Read the Case Study

By encouraging collaboration among social workers, nurses, and others coordinating patients' care, Vermont's OneCare hopes to engage patients and help them achieve their goals.

Innovations



Patient Benefit Enhancements *Waivers*

Three-Day Skilled Nursing Facility *Waiver*

Waives the requirement of a 3-day inpatient and/or previous SNF stay prior to a SNF admission. SNF must have 3 star minimum rating to be eligible.

Post-Acute Home Discharge *Waiver*

Allows for a physician to contract with, and bill for, a licensed clinician to provide up to nine patient home visits post-acute discharge with “general supervision” by the patient’s physician.

Telehealth *Waiver*

Eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary’s home, and allows use of asynchronous telehealth services for dermatology and ophthalmology.

Future Waiver Opportunities

Quality Improvement Work in 2018

Data Collection and Improvement

- Conducted gap analysis of clinical data received from VITL; initiated collaboration with VITL, the Blueprint and Capital Health Partners to improve data quality
- Payers sharing aggregate data on substance use claims-based quality measures
- Monthly data collection on key clinical quality measures began to provide enhanced, timely feedback to Network

Network Success Stories

- Monthly Network Success Stories disseminated across the OneCare Network
- Highlights include:
  - Diabetes management
  - Behavioral health integration
  - Hospice

Partnerships

- Partnering with **DVHA** to improve initiation and engagement of substance use treatment (IET) quality measure
- Co-host monthly clinical and quality focused trainings for OneCare and **Blueprint** staff
- Participate on planning committee for Accountable Communities for Health with **VDH, DVHA**
- Pilot with **SASH** and **Howard Center** to embed mental health clinician with two Burlington-area SASH communities
- Partner with **Vermont Ethics Network** to advance the “Who’s Your Person” (advance care planning) campaign

SASH Mental Health Pilot: Embedding a mental health clinician within Burlington SASH communities

Goal: Improve access and utilization of mental health and substance abuse services by residents of SASH communities

Key Strategies:

- Fund a full time mental health clinician through HowardCenter to support pilot at two SASH communities in Burlington
- Educate SASH staff on pilot to promote use of the pilot clinician by staff and make referrals
- Measure rates of referrals, days between referral and first contact by pilot clinician, and number of patients/residents engaged with pilot clinician
- Draft narrative report with recommendations in summer 2018

Activities as of May 2018:

- The embedded clinician met with 74 SASH participants
- 37 participants referred to the embedded clinician by SASH staff
- 12 participants were opened to Howard Center services
- The embedded clinician has attended 130 consulting meetings and full staff meetings, combined, with SASH staff
- The embedded clinician hosted four psychoeducational groups/discussions with a total attendance of 114 participants across the groups/discussions

"Alison has a gentle… manner and spirit that seem to help others participate with ease and openness. She creates a safe feeling space."
– feedback from a SASH participant

Alison Miley, MSW
SASH pilot clinician

SASH® a caring partnership
SUPPORT AND SERVICES at HOME

HOWARD CENTER

Clinical Quality Measure Education to Network Providers

- During the 2017 data abstraction period (January-March 2018), OneCare network providers asked for more timely resources to assist with the clinical ACO quality measures (QMs) during the 2018 measurement year.
  - Example: Updating EMR language from "never smoked" to "never used tobacco"

- In response, OneCare developed short, user-friendly guides for each of the 19 clinical-based measures across all payer programs. Shared these resources across the network to enhance understanding.

ACO MEASURE: MMNG PREV-10 & VMNG #11
PREVENTIVE CARE AND SCREENING: TOBACCO USE SCREENING AND CESSATION INTERVENTION

OneCareVermont

Measure Steward: PCPI

Measure Domain: Preventive Health

Alternative Measure Numbers: Quality ID #226; ACO 17; NQF 0028; CMS138v6

Measure Specifications

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months (1/1/2017-12/31/2018) AND who received tobacco cessation intervention if identified as a tobacco user.

Three rates are reported:

a) Percentage of patients aged 18 years and older who were screened for tobacco use **(ie, smokes or uses smokeless tobacco)** one or more times within 24 months

b) Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention

c) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Please note: **The intent of the measure is to screen for all tobacco use;** both smoking and smokeless (i.e. Are you a tobacco user?). The intent of the measure is for the eligible clinician to screen for tobacco use and provide cessation intervention if needed. If the eligible clinician only ask "Do you smoke?" then it is assumed the clinician is not screening smokeless tobacco users (i.e. chew, snuff). **The statement "non-smoker", or "never smoked" does not meet the intent of the measure as it does not cover all types of tobacco use.**

Denominator:

Initial population: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.

Population 1: Equals initial population
Population 2: Equals initial population who were screened for tobacco use and identified as a tobacco user
Population 3: Equals initial population

Denominator exclusions:
- None

Denominator exceptions:
- Population 1: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)
- Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (eg, limited life expectancy, other medical reason)
- Population 3: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco uses (eg, limited life expectancy, other medical reason)

V.1_201805

Update on Vermont Medicaid Next Generation (VMNG)

Vicki Loner, MHCDS, RN, CCM, CMCN, PAHM

Vice President and Chief Operating Officer

2017 Program Elements

Vermont Medicaid Next Generation (VMNG) Program Highlights

- Attribution is prospectively assigned based on Prior Year data
- Risk-based Collaborative Program between Medicaid and OneCare
  - 3% Upside/ Downside Risk Corridor
- Hospitals paid a fixed prospective basis
- No financial risk for physician practices, FQHCs, support agencies in the network
- Additional Investments made to all primary care and the community
  - $3.25 PMPM to providers with attribution for population health management; &…
  - Complex care coordination PMPM payments:
    - $15 PMPM for every attributed patient in the High and Very High risk cohorts (16% Medicare/Medicaid, 3% Commercial)
    - Lead Care Coordinator ($10 PMPM, if selected)
    - Shared Care Plan creation ($150)

Vermont Medicaid Next Generation (VMNG) Program Highlights (cont'd)

- Quality Measures Aligned with All Payer ACO Model Measures
- Value Based Incentive Fund created to reward Quality
- Benefits continue to be set by DVHA for all Medicaid beneficiaries including those in VMNG
- Prior Authorization waiver- ** Critical for Provider Acceptance**

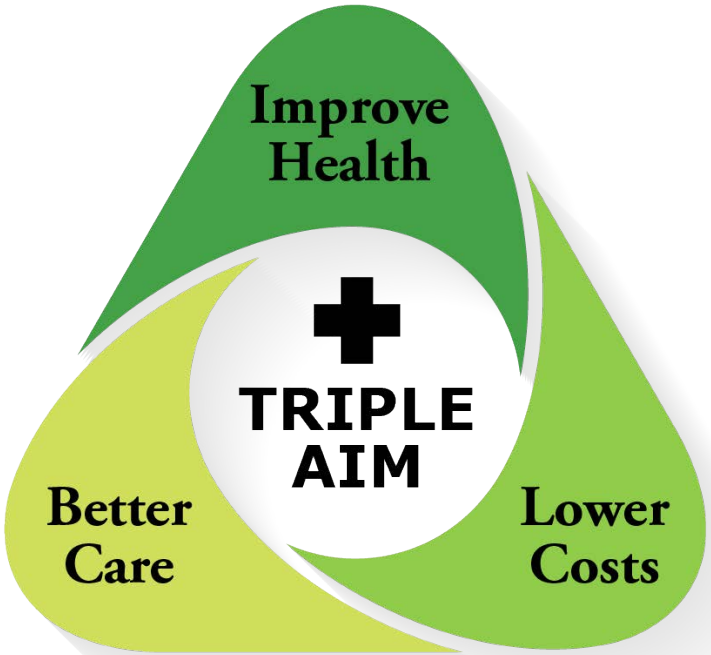
2017 Successes

2017 Success Highlights

- Strengthened Public Private Partnership
- Moved Hospital Payments to Reward Value over Volume
- Increased Financial Support to Primary Care
- Bolstered Community-Based Services Support Model
- Achieved Administrative Simplification
- Significant Movement Toward True Population Health Management
- Improved Person Centered Care Approaches
- Quality Improvement

Strengthened Public Private Partnership

Rewarding Value Over Volume



Increased Support to Primary Care

Bolstered Community Based Services Support Model

VNAs of Vermont
Your Nonprofit
Home Health & Hospice Agencies

SASH® a caring partnership
SUPPORT AND SERVICES AT HOME

BAYADA®
Home Health Care

Vermont Care Partners

V4A
advocacy | action | answers
Vermont Association of Area Agencies on Aging

Achieved Administrative Simplification

Significant Move Toward True Population Health Management

Improved Person Centered Care Approach

Encounter-Based Delivery System

- Optimized for high quality provider visits to treat a specific illness, injury, or problem

Person-Based Delivery System

- Optimized to proactively partner with all patients to manage health and plan care needs

Quality Improvement

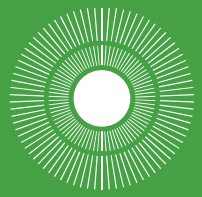
2018 Network Expanded…

~112,00 attributed lives
~$580M accountable spend

- 10 Hospitals
- 95 Primary Care Practices
- 172 Specialty Care Practices
- 2 FQHCs
- 21 Skilled Nursing Facilities
- 8 Home Health Agencies
- 6 Designated Agencies for Mental Health and Substance Use
- Area Agencies on Aging

* Vermont Medicaid Next Generation only

Questions & Discussion



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