OneCare Vermont Update

Green Mountain Care Board

May 11, 2017

OneCareVermont

Reintroducing OneCare Vermont

- Founded in 2012
  - Pioneered concept of representational governance by provider type
  - Offered shared savings if earned as a equal split between primary care and hospitals/other providers
- Multi-Payer
  - In year 5 of MSSP
  - In year 4 of XSSP
  - In year 4 of Medicaid programs (first year of VMNG after 3 years in VMSSP)
  - Current total attribution of approximately 100,000
- Large Statewide Network
  - Hospitals
  - FQHCs
  - Independent physician practices
  - SNFs
  - Home Health
  - DA's for Mental Health and Substance Abuse
  - Other providers

Reintroducing OneCare Vermont

OneCare Vermont Board as of May 2017

Seat	Individual
Community Hospital - PPS	**Jill Berry-Bowen -** CEO Northwestern Vermont Health Care
Community Hospital – Critical Access	**Claudio Fort -** CEO North Country Hospital
FQHC	**Kevin Kelley -** CEO CHS Lamoille Valley
FQHC	**Open –** Must be VMNG-participating
Independent Physician	**Lorne Babb, MD -** Independent Physician
Independent Physician	**Toby Sadkin, MD -** Independent Physician
Skilled Nursing Facility	**Judy Morton -** Executive Director Genesis Mountain View Ctr.
Home Health	**Judy Petersen -** CEO VNA of Chittenden/Grande Isle Counties
Mental Health	**Mary Moulton -** CEO Washington Country Mental Health
Consumer (Medicaid)	**Angela Allard**
Consumer (Medicare)	**Betsy Davis -** Retired Home Health Executive
Consumer (Commercial)	**John Sayles -** CEO Vermont Foodbank
Dartmouth-Hitchcock Health	**Steve LeBlanc -** Executive Vice President
Dartmouth-Hitchcock Health	**Kevin Stone -** Project Specialist for Accountable Care
Dartmouth-Hitchcock Health	**James Ebert, MD -** ACO Medical Director
UVM Health Network	**Steve Leffler, MD -** Chief Population Health Officer
UVM Health Network	**Todd Keating -** Chief Financial Officer
UVM Health Network	**John Brumsted, MD -** Chief Executive Officer

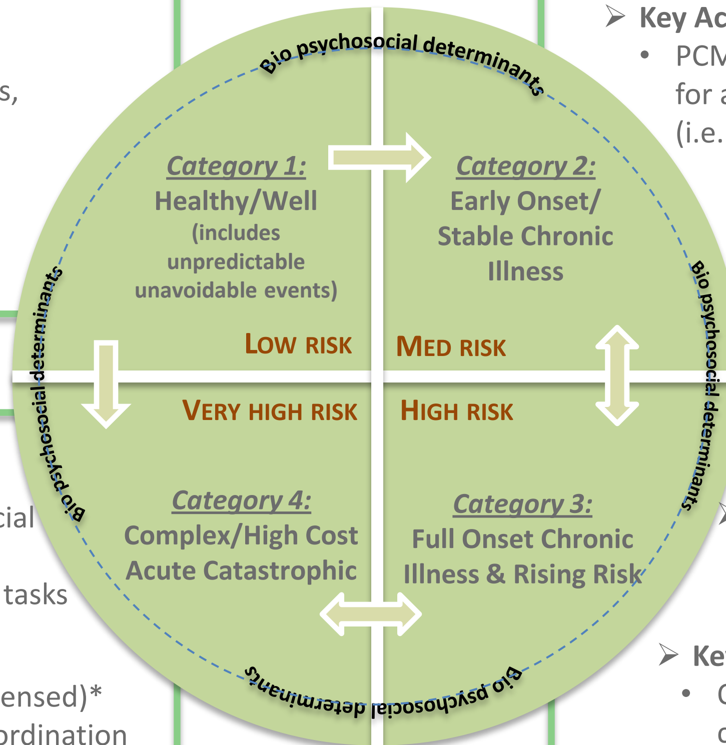
Reintroducing OneCare Vermont

- Leadership Highlights
  - Nationally prominent size and network model since inception
  - Proposed and structured the idea of multi-payer aligned SSPs in Vermont
  - First ACO in Vermont to contract with full continuum of care
  - Proposed idea of stronger, more structured community collaboratives; received multi-year SIM grant funds and partnered with Blue print and other ACOs to implement
  - Led vision and business plan for embracing risk and supporting APM
  - One of 25 ACOs nationally approved in first application cycle for the Medicare Next Generation Program
  - Designed and negotiated VMNG with DVHA with many advanced elements
  - Constructive participation in every major initiative/collaborative affecting healthcare in Vermont
  - Very strong quality improvement track record and reduced variation on total cost of care and utilization
  - Advanced informatics already in place and in deployment to the field
- Setting Course for 2018
  - Medicare Next Generation refreshed application due 5/18/17
  - Active negotiations with BCBSVT on risk-based Commercial ACO program for 2018
  - Process for renewing for Year 2 of VMNG agreed-upon with DVHA
  - 2018 Budget due to GMCB in June
    - Includes risk-based program targets, payment models, reform investment s, ACO operational budget, and risk management approach
    - Will include strong primary care and community-based provider support

Population Based Health Care Approach

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

- **40% of the population**
- **Focus:** Optimize health and self-management of chronic disease
- **Key Activities:** Category 1 plus
  - PCMH panel management: outreach (≥2/yr) for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
    - Disease & self-management support* (i.e. education, referrals, reminders)
    - Pregnancy education



- **6% of the population**
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Key Activities:** Category 3 plus
  - Designate lead care coordinator (licensed)*
  - Outreach & engagement in care coordination (at least monthly)*
  - Coordinate among care team members*
  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

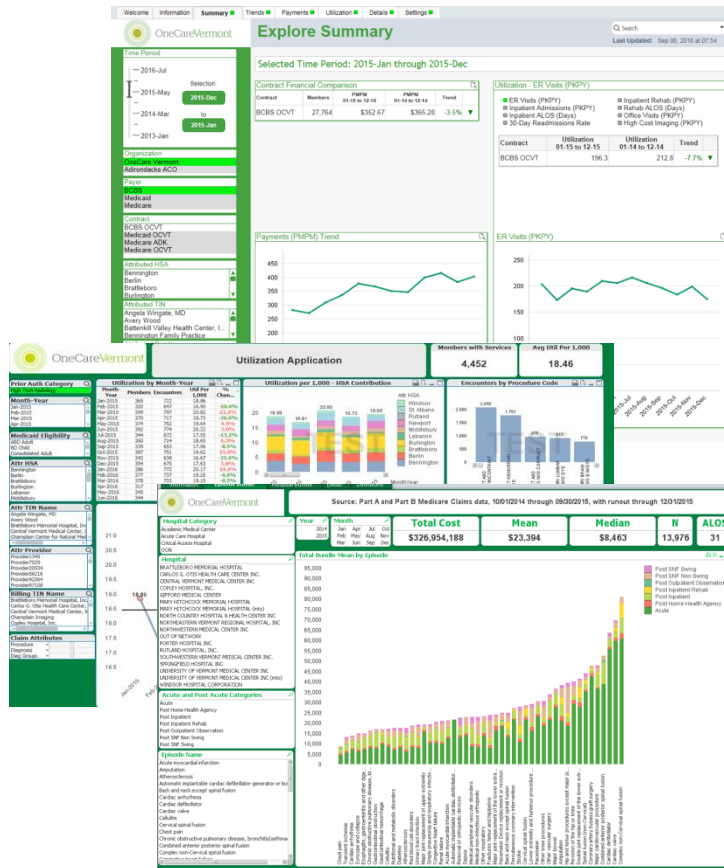
- **10% of the population**
- **Focus:** Active skill-building for chronic condition management; address co-occurring social needs
- **Key Activities:** Category 2 plus
  - Outreach & engagement in care coordination (≥4x/yr)*
  - Create & maintain shared care plan*
  - Coordinate among care team members*
  - Emphasize safe & timely transitions of care
  - SDoH management strategies*

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

* Activities coordinated via Care Navigator software platform

Two Major Information Systems

Workbench One
(Performance Data and Analysis)



Care Navigator
(Population Health Management

Gail Matthews

Patient Details

Shared Care Plan

Patient Information

Patient's Name: Gail Matthews			Mobile Phone Number: 7047689087	
Birthdate: 12/15/1938	Age: 77	Sex: Female	Home Phone Number: 645-090-8765	Email Address: Matthews@mycarenav.com
Address: 1108 CHARLES STREET St. Albans Street 0547837			Preferred Method of communication: ☐ Voice call ☐ Email ☐ Text	

Insurance Information

Emergency Contact Information

ED Plan

Gail knows the when she is short of breath and has gained 5+ pounds she needs to contact her cardiologist.

About Me

- Preferred activities: Gardening, Volunteering at NMC n
- How I learn: Verbal with written information to refer to
- Interaction tips: has difficulty discussing her illness
- Communication style: discuss non personal issues before personal
- Tips to avoid triggers/behaviors: Needs a family member present with discussing future plans
- Mobility:

My Care Plan

Gail Matthews 12/15/1938

My Care Team

VMNG Operational Highlights

Readiness Review

- All 224 DVHA Readiness Items Completed as 3/31/2017
  - Governance
  - Member Services
  - Provider Network
  - Utilization
  - Quality Management
  - Program Integrity
- OneCare Vermont Compliance Committee also did a deep dive (as part of our requirements) to identify additional refinements to improve public facing website
- Ongoing core team meetings between DVHA and OneCare to work out any process/procedural issues in order to streamline program operations

Opt Out Process

- OneCare sent Medicaid beneficiaries a letter letting them know that their Doctor/Practice is part of OneCare. Letter outlined the following:
  - Who is OneCare, who are the providers, how do they get in touch with OneCare
  - Potential benefits of their provider being part of an ACO
  - Their ability to opt-out of claims data sharing
  - Information about the Office of the Health Care Advocates
- Less than a 2% opt-out of claims for all members in the program.

Primary Care Alignment

Purpose: To identify members who have been attributed to a specialty physician or specialty advanced practice provider through DVHA's attribution methodology in order to align the member with a OneCare participating primary care provider who will be responsible for care coordination and quality measurement activities.

- 4% of beneficiaries originally attributed to specialists physicians
- Using claims data OneCare worked with providers to reattribute 74% of beneficiaries to a primary care provider
- The remaining 26% we are working with hospitals and primary care providers to assure they are assigned to a primary care medical home

Prior Authorization Exemption Efficiencies

OneCare has created for its providers a CPT code look up so that they can identify procedures for which they do and do not need to get prior authorization.

de	Included in OCV TCOC?	Prior Auth Normally Required by DVHA?	If OCV Patient and OCV Participant, do I need Prior Auth?	Description
	Yes	No	No	Anesth salivary gland"
	Yes	No	No	Anesth repair of cleft lip"
	Yes	No	No	Anesth blepharoplasty"
	Yes	No	No	Anesth electroshock"
	Yes	No	No	Anesth ear surgery"
	Yes	No	No	Anesth ear exam"
	Yes	No	No	Anesth tympanotomy"

Care Coordination Update

Care Coordination Updates

- Implemented Care Coordination Model in 4 VMNG Communities
  - Transitioned VCCI patients
  - Risk stratified VMNG population
  - Facilitated community workflows
  - Increased utilization of Care Navigator
- Created a VMNG cross-community care coordination core team to focus on care coordination strategies for population health
- Co-hosted "Tools for Effective Care Coordination" Learning Session April 18, 2017
  - Foci: EcoMaps, Domain Cards, Care Conferences, community-wide collaboration strategies
  - 60 participants across 10 HSAs representing adult and pediatric care

Care Coordination Progress

- **67** VCCI patients successfully transitioned
- Care Navigator
  - Training statistics January – April 26, 2017
    - **62** participants attended Introduction to Care Navigator Webex
    - **55** participants attended New User I
    - **78** participants attended New User II
  - 222 Care Navigator Users across 5 communities
- **29,102** VMNG patients have an JH ACG risk level, care coordination category, and qualifying visits noted in Care Navigator
  - 219 patients have $\geq$1 care team members identified (range 1-8)
  - 145 patients have a lead care coordinator assigned
  - 10 patients have a shared care plan completed (more are underway)

Patient Engagement: Panel Management

17,824 patients had ≥1 visit with their PCP or specialist between Jan – Apr 2017

% of population with a PCP and/or Disease-Specific Visit with a Specialist since 1/1/2017

Very High Risk	High Risk	Medium Risk	Low Risk	Total
83%	78%	67%	52%	61%

Care Coordination Core Team

Purpose:

To convene members …with diverse expertise and interest in care coordination in their community … to review, share, recommend and/or disseminate a variety of care coordination implementation strategies, work flows, results, and lessons learned to support continuous performance improvement in support of optimal patient/client outcomes, enhanced community alignment and integration, and success under a risk-based contract.

OneCareVermont

Care Coordination Core Team

Charter

Purpose: To convene members of the OneCare Vermont (OneCare) network participating in the Vermont Medicaid Next Generation (VMNG) program with diverse expertise and interest in care coordination in their community on a regular basis to review, share, recommend and/or disseminate a variety of care coordination implementation strategies, work flows, results, and lessons learned to support continuous performance improvement in support of optimal patient/client outcomes, enhanced community alignment and integration, and success under a risk-based contract.

Scope: The scope of this charter includes all activities related to the organization, integration, performance and results of care coordination activities within and across VMNG-participating communities.

Goals:

1. **Care Coordination Model Development & Implementation**

   Review and develop community workflows, processes, and strategy recommendations for care coordination and/or care management that maintain alignment with OneCare's Care Coordination Model.

2. **Care Coordination Administrative Organization**

   Review and develop key community-level administrative process changes, communication strategies, and potential business model changes to support alignment and integration of care coordination activities within and across organizations. Develop strategies for appropriate identification of VMNG populations, including the need to prospectively risk stratify populations and align interventions accordingly (more intensive for higher acuity). Support and facilitate adoption of multi-disciplinary communication tools including the use of Care Navigator.

3. **Quality and Clinical Recommendations**

   Regular review of community-specific and cross-community care coordination metrics including: cost, quality, and utilization data for high and very high risk patients; reports on VMNG care coordination implementation progress; identification of gaps/barriers to optimal care coordination and possible solutions; and review of evidence-based practices. Participate in within and across community performance improvement projects and assist in disseminating results. Provide input

DRAFT

March Recruitment | April Kickoff WebEx | May 5 First in-person 4-hour session

Care Coordination Core Team Members

Vermont Medicaid Next Generation Care Coordination Core Team			
BERLIN			
Monika Morse, RN	CVMC – Blueprint	Blueprint Quality Improvement Facilitator	Blueprint, practice facilitation, quality improvement
Mark Young, RN	CVMC – Medical Group, Blueprint	Director - Operations/Primary Care, Blueprint Project Manager	Practice Administration – hospital-owned primary care, Quality
Jenna Corneille, MSW, LICSW	The Health Center	Health and Wellness Coordinator	FQHC, Quality improvement, Social Work
Heather Colangelo, MSW	WCMH	Project Manager – Quality Assurance & Improvement	Designated Agency, Mental Health, process improvement, complex care coordination
Mary Moulton, MPA	WCMH	Executive Director	Designated Agency, Mental Health, executive leadership
BURLINGTON			
Penrose Jackson	UVMMC – Blueprint	Director – Community Health Improvement	Blueprint, community health
Melissa Jarvis	UVMMC – Medical Group	Director – Family Medicine & General Internal Medicine	Practice Administration – hospital-owned primary care
Kristy Trask, RN, CLC	Hagan, Rinehart and Connolly Pediatrics	Care Coordinator/Nurse Manager	Pediatric care coordination – Independent practice
Molly Dugan	SASH	Director	Statewide program development, community care coordination
Angel Means, RN, MS	VNA Chittenden & Grand Isle Counties	VP – Quality & Education	Community Health Alliance, home health
Jeffrey Fine, PA	Primary Care Health Partners	EHR Clinical Consultant	Information Systems, Electronic Health Records, Provider
MIDDLEBURY			
Alexandra Jasinowski, BS	Blueprint	Quality Improvement Facilitator	Blueprint, practice facilitation, quality improvement
Tom Manion	Porter Medical Group	VP – Porter Medical Group	Practice Administration, process improvement, healthcare reform
Wendy Marton	Age Well	Case Management Supervisor	Community Case Management
Alison Wurst, APRN	Porter Medical Group	Director of Case Management	Hospital Case Management, provider
Keith Grier, MBA	CSAC	Compliance and Quality Assurance Officer	Designated Agency, Mental Health, Quality
ST. ALBANS			
Lesley Hendry	NMC – Blueprint	Blueprint Project Manager	Blueprint, practice facilitation, process improvement
Amy Putnam	NMC – Physician Services	VP Physician Services	Practice Administration – hospital-owned primary care, senior leadership
Matt Tryhorne, RN	NOTCH	Director of Operations	FQHC, Quality, process improvement
Anne-Marie Lajoie, RN, TTS	Cold Hollow Family Practice	RN Care Coordinator	Primary care care coordination – independent practice, process improvement
Julie Parker, LCMHC	NCSS	Program Manager – Crisis, Integrated Health & Outpatient Services	Designated Agency, Mental Health, care coordination model development

Population Health Management and Quality Improvement Initiative: *Hypertension*

Moving from Disease Management to Population Health Management (PHM)

- Support PHM through effective care coordination in partnership with each attributed patient
  - Patient-centered care principles, shared decision-making
  - Consider the social and economic determinants of health and wellbeing
- Identify current best practices (e.g. survey, review & compile resources)
- Implement patient-centered care strategies:
  - Support providers in high quality panel management, assessment and outreach to patients with rising risk scores
  - Patient education and self-management supports
  - Referrals to specialists and/or community resources
  - Monitor progress and track outcomes
- Develop a comprehensive patient resource library in Care Navigator
- Ensure high risk/high need populations have supports in place to foster optimal wellbeing
- Initial focus on patients with $\geq$1 high risk/high cost conditions: CAD, COPD, CHF, DM, Asthma, HTN, tobacco use, high risk pregnancy

Focus for 2017: Controlling Hypertension (HTN)

- HTN is the most significant cardiac risk factor in older adults
- Research demonstrates that lowering blood pressure by 10 mm Hg in patients with hypertension reduces cardiovascular and stroke mortality by 25% and 40%, respectively
- Controlling hypertension is an ACO quality measure

~30% of patients with HTN in OCV's network are not well controlled

Controlling HTN Toolkit & Peer Learning Community

- Multi-organization collaboration led by VDH to create a *Controlling Hypertension Toolkit*
  - Organizations involved: VDH, QIN-QIO, Blueprint, OCV, CHAC, UVMMC physicians (Maclean, Calkins, Landry), SASH
  - The Toolkit focuses on strategies to improve quality of care in the hypertensive patient and development of a population health management approach in practice through panel management

- Educational offering to promote the Toolkit became the *Controlling Hypertension Peer Learning Community*
  - Aim is to improve the NQF-18 measure 10% by December 2017
  - Kickoff is May 15th there will be 2 in-person all day learning sessions (June and September) and monthly webinars with subject matter experts
  - Practices will be pulling HTN patient panels, evaluating baseline measurements, analyzing workflows, PDSA cycles and reporting regularly on findings.
  - Recruitment (underway): participants from Berlin, Brattleboro, Burlington, Middlebury, St. Albans, and Rutland

HTN Peer Learning Community: Change Strategies

Strategy	Description	Rationale	Domain
Use a consistent approach across practice and monitor adherence to the clinical practice guidelines.	Healthcare team members agree on clinical practice guidelines for hypertension management that all can support and implement.	Team buy-in is essential to developing a continuously improving system.	Decision Support
Use the electronic health record to create and maintain a registry. Use the registry to reach out to patients to provide continuity of care.	Hypertensive patients are entered onto a registry. A designated person is identified who is responsible for maintaining the registry.	Registry functionality is needed in order to produce population health summaries and identify patients who are at risk because of being out of range.	Clinical Information System
Implement a pre-visit planning process.	Healthcare team members develop a pre-visit planning process, document the workflow, and monitor adherence to the process.	Pre-visit planning is an important element to managing hypertensive patients in order to maximize the office visit with the healthcare team.	Delivery System Design
Document in a systematic and standardized method in the EHR	Healthcare team members document in a systematic and standardized method in the EHR and are meaningfully using CDS.	Consistent documentation and measurement is required for comparison across the team or across practices.	Clinical Information System
Integrate clinical decision supports (CDS) for pre-visit planning, primary care hypertension visits, and continuity of care.	Healthcare team members are meaningfully using clinical decision supports.	Data is integrated with knowledge to improve targeted decisions and outcomes.	Clinical Information System
Measure blood pressure accurately and consistently in the office.	Ensure that hypertension is accurately and consistently measured by all members of the healthcare team.	Consistent measurement is required for comparison across the team or across practices.	Delivery System Design
Identify specific resources for patient education and insert into the workflow.	Educate patients regarding self-management, lifestyle modification (including diet, exercise and sodium intake), and community resources.	Patient engagement improves outcomes.	Promote Self-Management
Encourage home blood pressure monitoring and incorporate into decision-making as appropriate.	Ensure that patients are knowledgeable about home monitoring and performing it as appropriate.	Patient engagement improves outcomes and allows for safe and efficient management between visits.	Promote Self-Management
Assess medication adherence.	Ensure that all patients are assessed for medication adherence periodically, or at each visit, if the patient has a history of non-adherence.	Medication adherence improves outcomes; medication reconciliation reduces errors.	Delivery System Design
Provide team-based care to support education, adherence, patient engagement, and to maximize self-management.	Develop clinical decision guidelines for referring to and providing care management among health care team members including, but not limited to; nurses, behavioral health clinicians, dieticians, health coaches, and panel managers.	Team-based care improves outcomes.	Decision Support