2018 Budget Presentation to the Green Mountain Care Board

July 13, 2017

OneCareVermont

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OneCare Overview

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 (Medicare Shared Savings Program)
  - In year 4 of XSSP (Commercial Exchange Shared Savings Program)
  - In year 4 of Medicaid programs (first year of Vermont Medicaid Next Generation after 3 years in Vermont Medicaid Shared Savings Program)
  - Current total attribution of approximately 100,000 lives
- Statewide Network
  - Hospitals of all types (tertiary/academic, community acute, critical access, psychiatric)
  - FQHCs
  - Independent physician practices
  - Skilled Nursing Facilities
  - Home Health
  - Designated Agencies for Mental Health and Substance Abuse
  - Other providers

Board of Managers

Seat	Individual
Community Hospital - PPS (Prospective Payment System)	Jill Berry-Bowen - CEO Northwestern Vermont Health Care
Community Hospital – Critical Access Hospital	Claudio Fort - CEO North Country Hospital
FQHC	Kevin Kelley - CEO CHS Lamoille Valley
FQHC	Pam Parsons- Executive Director Northern Tier Center for Health
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 Peterson - 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	Joe Perras, MD - CEO Mt. Ascutney
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

OneCare Vermont Highlights

- Highlights
  - Nationally prominent size and network model since inception
  - Proposed and structured the idea of multi-payer aligned Shared Savings ACOs in Vermont
  - First ACO in Vermont to contract with full continuum of care
  - Proposed idea of stronger, more structured community collaboratives; received multi-year State Innovation Model grant funds and partnered with Blueprint and other ACOs to implement
  - Led vision and business plan for embracing risk and supporting Vermont All Payer Model
  - One of 25 ACOs nationally approved in first application cycle for the Medicare Next Generation Program
  - Designed and negotiated Vermont Medicaid Next Generation 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
  - Active negotiations with BCBSVT on risk-based Commercial ACO Program for 2018
  - Process for renewing for Year 2 of VMNG with DVHA
  - 2018 GMCB Budget
    - Includes risk-based program targets, payment models, reform investments, ACO operational budget, and risk management approach
    - Will include strong primary care and community-based provider support

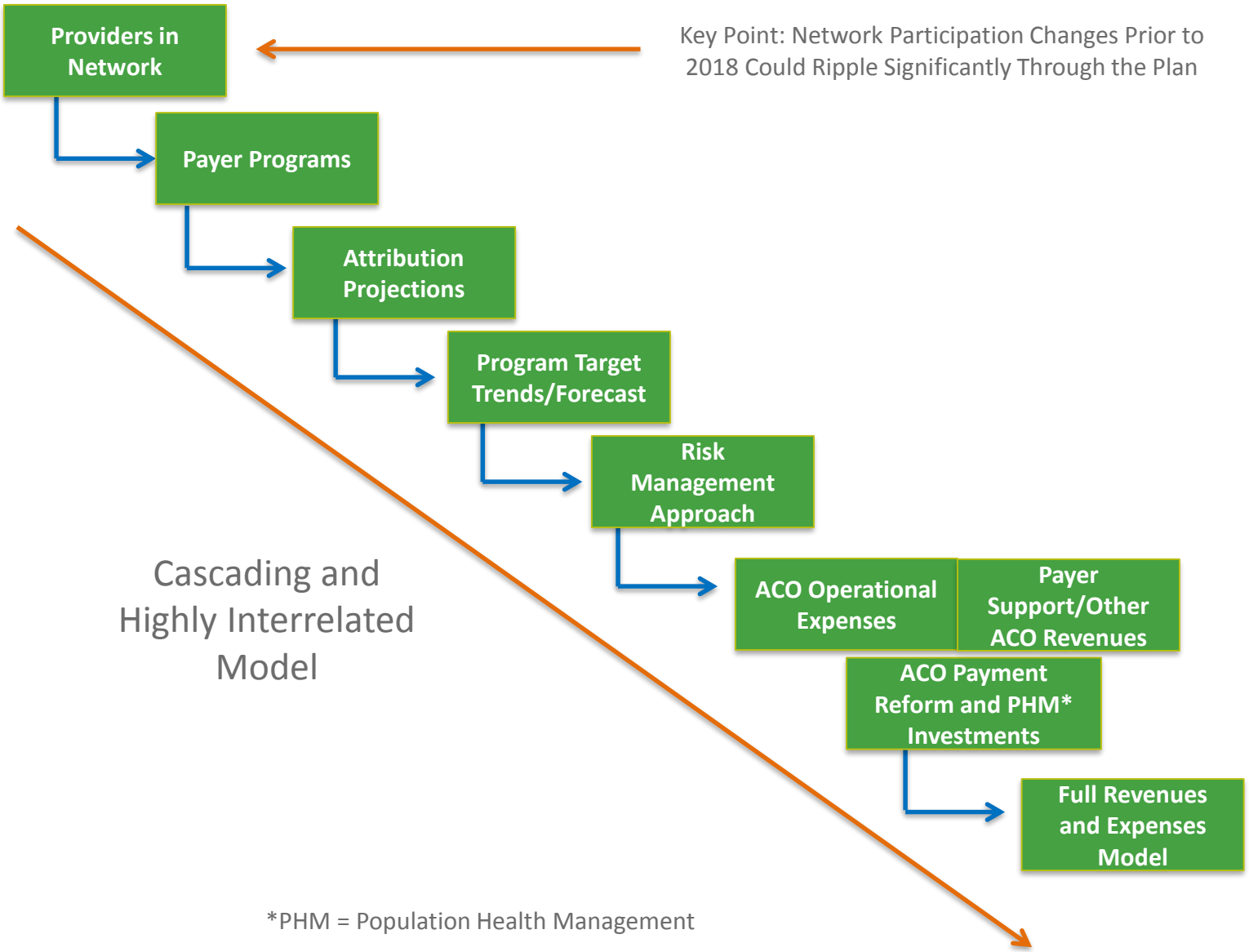
Budget Overview

2018 Budget Accomplishes Much

"Check Offs" in 2018 OneCare Budget

- ✓ All Payer Model
  - Big step toward vision and scale of Vermont APM
- ✓ Hospital Payment Reform
  - Prospective population payment model for Medicaid, Medicare, and Commercial
- ✓ Primary Care Support/Reform
  - Broad based programs for all primary care (Independent, FQHC, Hospital-Operated)
  - More advanced pilot reform program offered for independent practices
- ✓ Community-Based Services Support/Reform
  - Inclusion of Home Health, DAs for Mental Health and Substance Abuse, and Area Agencies on Aging in complex care coordination program
- ✓ Continuity of Medicare Blueprint Funds (Former Medicare Investments under MAPCP – Multi-Payer Advanced Primary Care Program)
  - Continued CHT, SASH, PCP payments included for full state
- ✓ Significant Movement Toward True Population Health Management
  - RiseVT (a major feature/partner in OneCare's Quadrant 1 approach)
  - Disease and "Rising Risk" Management (Quadrant 2)
  - Complex Care Coordination Program (Quadrants 3 and 4)
  - Advanced informatics to measure and enable model
  - Rewarding quality

Constructing the "Risk" ACO Budget

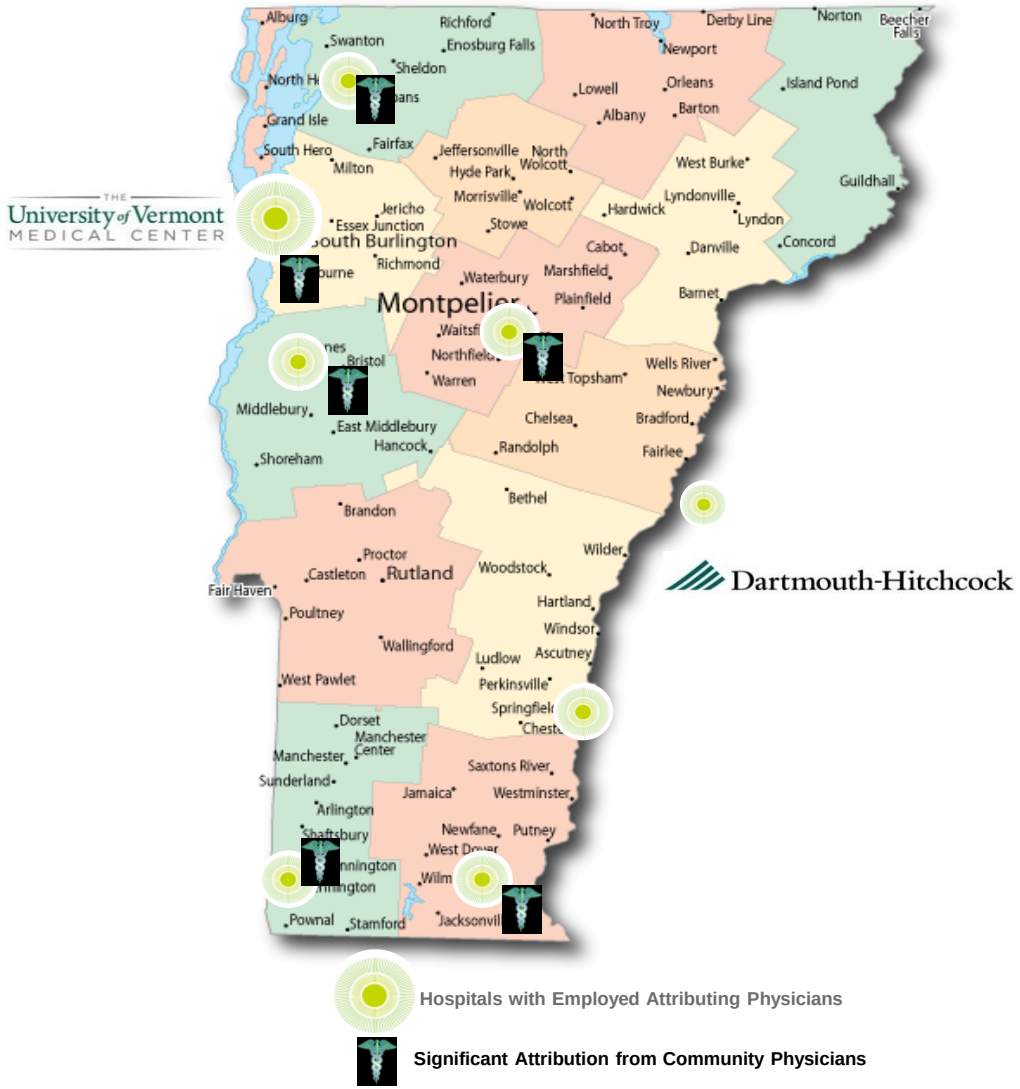


Key Point: Network Participation Changes Prior to 2018 Could Ripple Significantly Through the Plan

Cascading and Highly Interrelated Model

*PHM = Population Health Management

2018 Risk Network Communities



- Seven Vermont Communities
  - Bennington
  - Berlin
  - Brattleboro
  - Burlington
  - Middlebury
  - St. Albans
  - Springfield
- Plus Lebanon, New Hampshire for BCBSVT program
- Local hospital participation in all communities (required)
- Participation of other providers in each Vermont community

2018 Risk Network as of Budget Submission

	Bennington	Berlin	Brattleboro	Burlington	Lebanon	Middlebury	St. Albans	Springfield
Hospital	SWVMC	CVMC	BMH	UVMMC	DH	PMC	NWMC	SH
FQHC	Declined	Declined	N/A	CHCB	N/A	N/A	NOTCH	SMCS
Independent PCP Practices	6 Practices	1 Practice	2 Practices	14 Practices	N/A	2 Practices	4 Practices	NA
Independent Specialist Practices	5 Practices	4 Practices	1 Practices	21 Practices	N/A	5 Practices	4 Practices	NA
Home Health	VNA & Hospice of the Southwest Region; Bayada	Central VT Home Health & Hospice	Bayada	VNA Chittenden/ Grand Isle; Bayada	N/A	Addison County Home Health & Hospice	Franklin County Home Health & Hospice	N/A
SNF	2 SNFs	4 SNFs	3 SNFs	3 SNFs	N/A	1 SNF	2 SNFs	1 SNF
DA	United Counseling Service of Bennington County	Washington County Mental Health	NA	Howard Center	N/A	Counseling Service of Addison County	Northwestern Counseling & Support Services	Health Care and Rehabilitation Services of Southeastern Vermont
All other Providers (# of TINs)	2 other providers	1 other provider	1 (Brattleboro Retreat)	2 other providers	N/A	NA	NA	1 other provider

Note: AAAs contracted members of network but do not do traditional medical billing and therefore are not formally submitted TINs in our risk network

OCV 2018 Program Summary

Payer	Program	Risk Model
Medicare	• Modified Next Generation Medicare ACO Program under APM (MMNG)	• 100% or 80% Risk Sharing Percentage (Our Choice) • 5% to 15% Corridor (Our Choice) • Budget assumes minimum model risk on TCOC which is 4% (= 5% * 80%)
Medicaid	• Vermont Medicaid Next Generation ACO Program (VMNG) Year 2 Renewal	• For 2017: 100% Risk Sharing Percentage on 3% Corridor • Budget assumes continuity of that model at 3% on TCOC
Commercial Exchange	• Move Exchange Shared Saving Program (XSSP) to 2-sided Risk with BCBSVT	• In discussion for 50% Risk Sharing Percentage on a 6% Corridor • Budget will apply that draft model for total maximum risk of 3% on TCOC (= 6% * 50%)

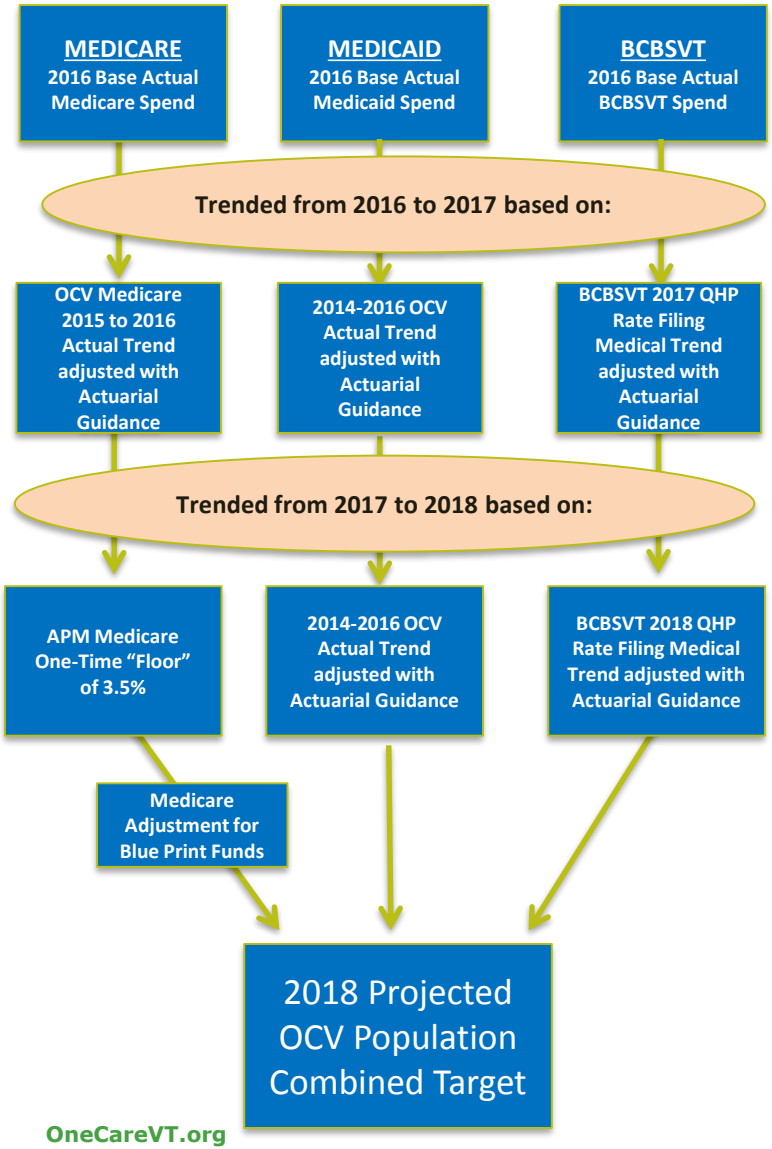
Glossary:
Risk Sharing Percentage = Percentage of savings or losses received by ACO within Corridor
Corridor = Maximum Range of ACO Savings and Losses (Payer covers performance outside of Corridor)
TCOC = Total Cost of Care

Network Attribution Model

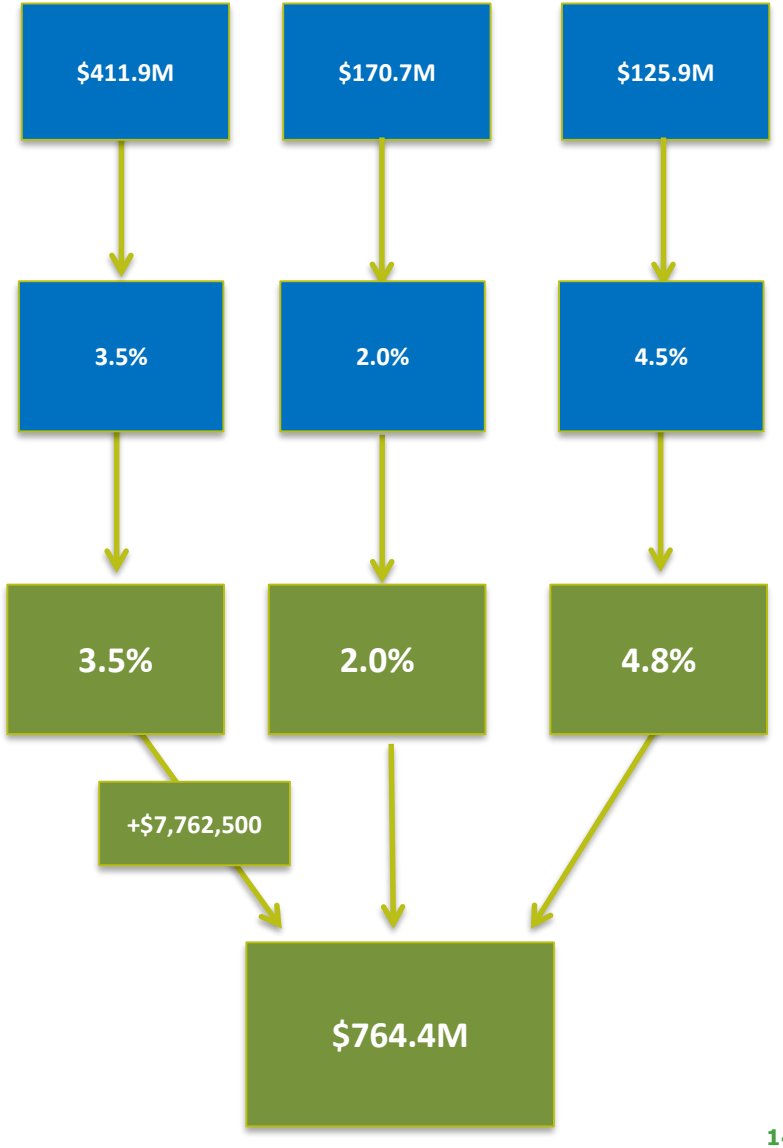
Service Area	Medicare	Medicaid	BCBSVT	TOTAL
Bennington	6,244	5,748	3,720	15,712
Berlin	6,077	6,790	5,310	18,177
Brattleboro	2,345	3,895	1,869	8,109
Burlington	17,306	24,053	17,290	58,649
Lebanon	0	0	2,703	2,703
Middlebury	3,637	4,261	3,382	11,280
Springfield	2,430	5,112	2,624	10,166
St. Albans	4,575	4,733	3,042	12,350
	42,614	**54,592**	**39,940**	**137,146**

Budgeting 2018 Program Targets

Target Budget Methodology



Modeled Target Calculation



Risk Management Model

- **Participating Hospitals to Bear the Risk under OneCare ACO Programs**
  - Current OneCare model has service area's "Home Hospital" (the one physically located in the community) bearing the risk for the spending target for its locally-attributed population
  - Other providers NOT at risk (e.g. FQHCs, Independent practices, other community providers)
- **Budget Assumes "zero-sum" Performance on Risk Programs at ACO level**
  - i.e. OneCare exactly meets targets on all programs
  - Some programs have "up front" discounts applied where applicable
  - Risk hospital payments are source of some "off the top" investments and operational expense coverage; hospitals will need to generate savings to do well under fixed payments received
- **OneCare Risk Management Support**
  - Risk declines (diversifies) with participation in multiple programs across Medicare, Medicaid, and Commercial populations
  - OneCare provides analysis and formal actuarial review to ensure program targets are understood and acceptable
  - OneCare to provide reinsurance program to limit risk from very high utilization year overall and/or much larger number of very high cost cases
  - WorkBenchOne analytic tools to (i) identify areas of opportunity and (ii) understand risk performance throughout the year
  - Community support and facilitation of clinical and quality models associated with high value, prevention, and avoidance of waste

2018 Operations Budget Summary

Category	Sub-Category	Budgeted Expense	Percent of Operations Budget
Personnel	Finance and Accounting	$840,144	6.7%
	ACO Program Strategy	$465,640	3.7%
	Clinical/Quality/Care Management	$2,560,416	20.5%
	Informatics/Analytics	$1,332,012	10.7%
	Operations	$1,149,066	9.2%
	SUB-TOTAL PERSONNEL	**$6,347,277**	**50.8%**
General Administrative	Health Catalyst (Core Information System)	$1,084,680	8.7%
	VITL Data Gateway	$900,000	7.2%
	Other	$1,586,312	12.7%
Contracted Services	Reinsurance	$1,500,000	12.0%
	Other Contracted Services	$1,074,465	8.6%
TOTAL EXPENSES		**$12,492,735**	**100.0%**

PHM/Payment Reform Program Investments

Program	2018 Investment	
Basic OCV PMPM for Attributing Providers	$ 5,348,694	Supporting Primary Care and Community-Focused Elements of PHM Approach
Complex Care Coordination Program	$ 7,580,109	
RiseVT Program	$ 1,200,000	
CHT Funding Risk Communities	$ 1,746,360	Supporting Blueprint for Health Continuity and Ongoing Collaboration with ACO Model
CHT Funding Non-Risk Communities	$ 772,538	
SASH Funding Risk Communities	$ 2,417,942	
SASH Funding Non-Risk Communities	$ 852,012	
PCP Payments Risk Communities	$ 1,319,336	
PCP Payments Non-Risk Communities	$ 654,313	
Value-Based Incentive Fund	$ 5,559,260	Rewarding High Quality
PCP Comprehensive Payment Reform Pilot	$ 1,800,000	Supporting True Innovation in Independent PCP Practices
Total	**$ 29,250,563**	

2018 Budget Revenues and Expenses

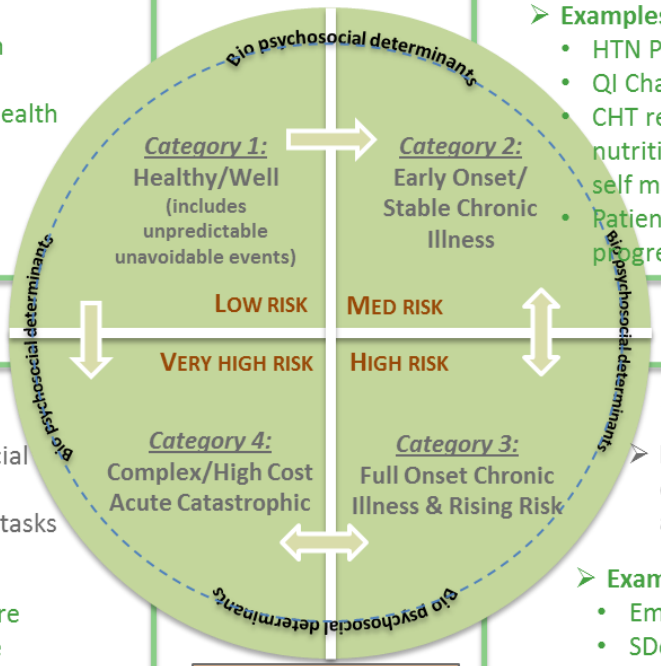
Revenues	ACO Payer Targets	$764,430,113
	Payer-Provided Program Support	$9,658,176
	RiseVT Transformation Support	$1,200,000
	State HIT Support	$3,500,000
	Grants and MSO Revenues	$371,851
	TOTAL REVENUES	**$779,160,140**
Expenses	Health Services Spending (Payer Paid FFS)	$289,626,898
	Health Services Spending (OneCare Paid Fixed/Capitated Payments)	$447,789,945
	Operational Expenses	$12,492,734
	Population Health Management/Payment Reform Programs	$29,250,563
	TOTAL EXPENSES	**$779,160,140**
NET INCOME		**$0**

Improving Population Health Outcomes

Population Based Health Care Approach

- 44% of the population
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Examples:**
  - Rise VT primary prevention program
  - PCMH panel management
  - Wellness campaigns (e.g. 3-40-50, health education and resources, wellness classes, parenting education)
  - Home visiting programs

- 40% of the population
- **Focus:** Optimize health and self-management of chronic disease
- **Examples:**
  - HTN Peer-to-Peer Learning Collaborative
  - QI Change Packages
  - CHT resources (e.g. tobacco cessation, nutrition & physical activity coaching, diabetes self management
  - Patient resource library in Care Navigator (in progress)



- 6% of the population
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Examples:**
  - Complex care coordination: lead care coordinator, shared care plans, care conferences
  - Community QI projects on hospice utilization
  - Provider and patient education on palliative care (e.g. September OCV Grand Rounds)

- 10% of the population
- **Focus:** Active skill-building for chronic condition management; identify & address co-occurring SDoH
- **Examples:**
  - Embedded mental health in primary care
  - SDoH screening (e.g. food insecurity in/out patient peds; VT Self Sufficiency Outcomes Matrix for patients with complex CC needs)
  - Care coordination: coordinate among care team members; shared care plans; transitions of care

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

Budget Check

Sample Activities Supporting Vermont APM Population Health Goals

- **Percent of Adults with Usual Primary Care Provider**
  - Promote primary care connection for VMNG patients attributed to specialists
  - Improve viability of primary care through payment reform
- **Deaths Related to Suicide/Deaths Related to Drug Overdose**
  - Embedding mental health services in primary care
  - Provider education & training: SBIRT, suicide prevention, new VPMS opiate prescribing requirements & clinical workflows
  - Expand data sources to refine risk stratification to inform community-based care coordination
- **Statewide Prevalence of Chronic Disease: COPD, HTN, DM**
  - Disease-specific panel management through Care Navigator
  - Conduct Quality Improvement (QI) Learning Collaborative on Controlling HTN
  - Develop QI initiatives on pre-HTN and pre-DM
  - Community Collaboratives promote local primary prevention (e.g. RiseVT, 3-4-50, VT Quit Line)

Glossary:
VMNG = Vermont Medicaid Next Generation
SBIRT = Screening, Brief Intervention, and Referral to Treatment (screening tool)
VPMS = Vermont Prescription Monitoring System
COPD = Chronic Obstructive Pulmonary Disease
HTN = Hypertension (High Blood Pressure)
DM = Diabetes Mellitus (Diabetes)

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Social Determinants of Health

- Complex Care Coordination
  - Shared Care Plans
  - Camden Cards
  - VT Self Sufficiency Outcomes Matrix
  - Plans to add SDoH to risk adjustment

Vermont Self-Sufficiency Outcome Matrix — Department of Mental Health

Instructions:
A. Complete this form with all adults at entry, every 6 months while in the program for permanent supportive housing and at exit.
B. Select only one level in each of the 9 areas below by marking the box next to the appropriate level.
C. Level Categories:
1 = In Crisis
2 = Vulnerable
3 = Safe
4 = Building Capacity
5 = Empowered/Thriving

Assessment Date: | Client Name: | ☐ Entry ☐ 6 Month Interval ☐ Exit
Program Name: | Client ID (Service Point Assigned):

Category	1. In Crisis	2. Vulnerable	3. Safe	4. Building Capacity	5. Empowered/Thriving
1. Housing	☐ Homeless or threatened with eviction	☐ In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable.	☐ In stable housing that is safe but only marginally adequate.	☐ Household is safe, adequate, subsidized housing.	☐ Household is safe, adequate, unsubsidized housing.
2. Employment	☐ No Job	☐ Temporary, part-time or seasonal; inadequate pay; no benefits.	☐ Employed full-time; inadequate pay; few or no benefits.	☐ Employed full-time with adequate pay and benefits.	☐ Maintains permanent employment with adequate income and benefits.
3. Income	☐ No Income	☐ Inadequate income and/or spontaneous or inappropriate spending.	☐ Can meet basic needs with subsidy; appropriate spending.	☐ Can meet basic needs and manage debt without assistance.	☐ Income is sufficient, well managed, has discretionary income and is able to save.
4. Legal	☐ Current outstanding tickets or warrants.	☐ Current charges/trial pending; noncompliance with probation/parole.	☐ Fully compliant with probation/parole terms.	☐ Has successfully completed probation/parole within past 12 months; no new charges filed.	☐ No felony criminal history and/or no active criminal justice involvement in more than 12 months.
5. Mental Health	☐ Danger to self or others; Recurring suicidal ideation, experiencing severe difficulty in day-to-day life due to psychological problems.	☐ Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	☐ Mild symptoms may be present but are transient; only moderate difficulty in function due to mental health problems.	☐ Minimal symptoms that are expected responses to life stressors; only slight impairment in functioning.	☐ Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns.
6. Substance Abuse	☐ Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	☐ Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	☐ Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems that have persisted for at least one month.	☐ Client has used during last 6 months but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	☐ No drug use/alcohol abuse in last 6 months.

- Primary Care
  - Increased screening (e.g. ACES, food insecurity, parental depression)
  - Improved coordination of referrals and warm-handoffs to continuum of care and social service providers
- Accountable Communities for Health

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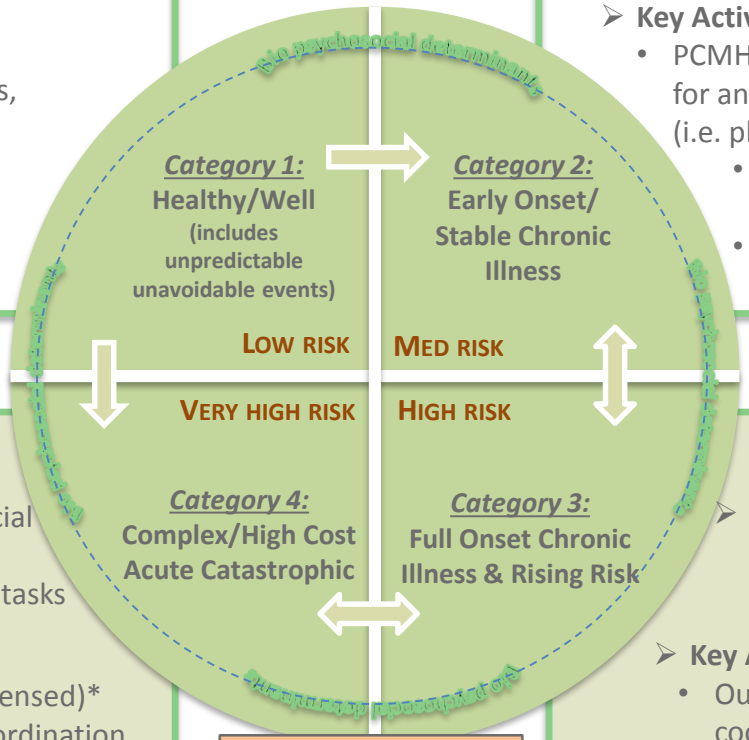
Care Coordination Model

- **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

Care Coordination Financial Model Summary

One time annual payment for intensive upfront work + add'l PMPM for LCC
Foci:

- Lead Care Coordinator, designated by the patient
- Activate and engage patients in care coordination
- Lead development of patient-centered shared care plan documented in Care Navigator
- Facilitate patient education & referrals
- Monitor milestones, track tasks and resolution identified goals & barriers
- Coordinate communication among care team members
- Plan care conferences

Level 3: Patient Activation & Lead Care Coordination Payment

Level 2: PMPM for Team-Based Care Coordination (Top 16%)

Level 1: Community Capacity Payment

One time annual payment per community. Foci: community-specific workflows; workforce readiness & capacity development; analysis of community care coordination metrics, gap analysis and remediation

Payment for panel management
Foci:

- Assess patient-specific needs & deploy organizational resources to support patient goals
- Contribute to patient-centered shared care plans
- Participate in care team meetings, care conferences, and transitional care planning

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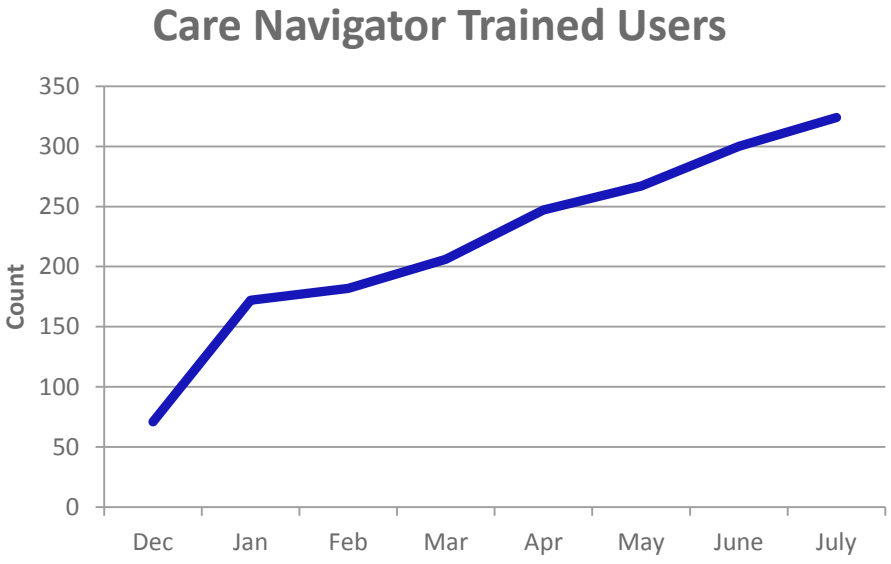
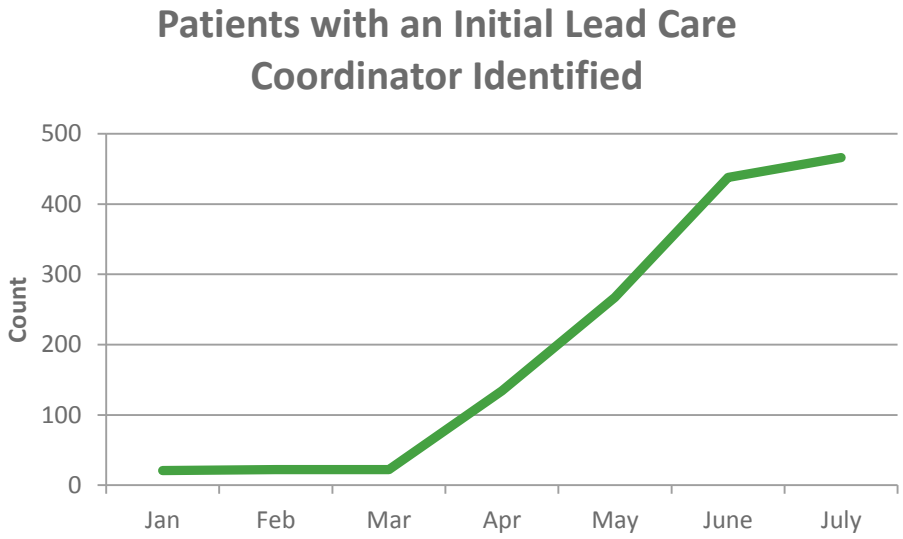
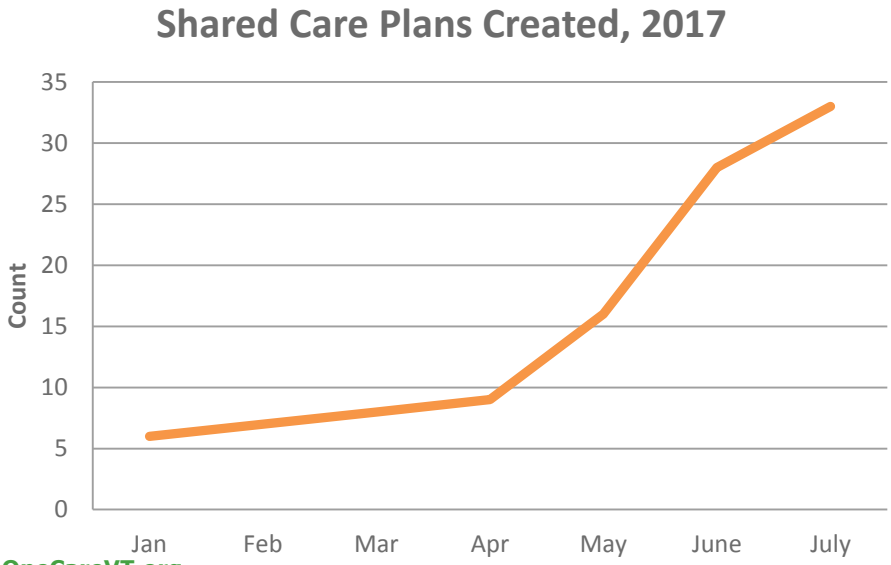
Care Coordination Engagement Metrics







As of July 1, 2017:

- 599 patients ≥ 1 care team member
- Range: 1-8 care team members

Community Collaboratives: Showcasing Community Improvements in ACTION

St. Albans:
- ED utilization
- Rise VT
- 30-day all-cause readmission
- Developmental screening

Morrisville:
- 30-day all-cause readmission
- Developmental screening

Newport:
- COPD
- Obesity
- Hospice utilization

Burlington:
- Hospice utilization
- ED utilization
- Adolescent well child visit rates

Middlebury:
- Decreasing opiate prescriptions
- ED utilization

Rutland:
- All cause readmission
- Tobacco cessation
- CHF, COPD

Berlin:
- Adverse Childhood Experiences
- SBIRT
- Hospice utilization
- CHF

Windsor:
- COPD
- Opioid use management

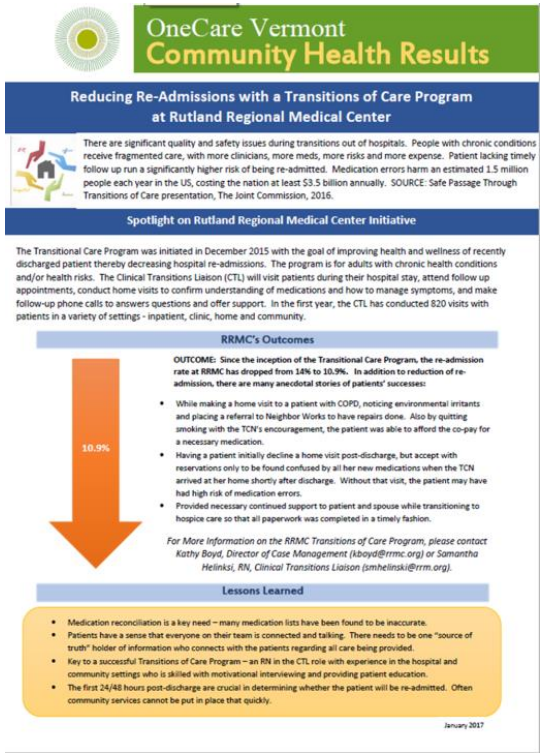
Bennington:
- CHF Admissions
- ED utilization
- All-cause readmission
- Care Coordination

Brattleboro:
- Hospice utilization
- Decreasing post acute LOS
- Care coordination

Clinical Priority Area-Related Projects

1. **High Risk Patient Care Coordination**
   - ➢ 33 projects across 11 HSAs
2. **Episode of Care Variation**
   - ➢ 9 projects across 5 HSAs
3. **Mental Health and Substance Use**
   - ➢ 40 projects across 12 HSAs
4. **Chronic Disease Management Optimization**
   - ➢ 31 projects across 12 HSAs
5. **Prevention & Wellness**
   - ➢ 38 projects across 11 HSAs

Community Successes



OneCare Vermont
Community Health Results

Reducing Re-Admissions with a Transitions of Care Program at Rutland Regional Medical Center

There are significant quality and safety issues during transitions out of hospitals. People with chronic conditions receive fragmented care, with more clinicians, more meds, more risks and more expense. Patient lacking timely follow up run a significantly higher risk of being re-admitted. Medication errors harm an estimated 1.5 million people each year in the US, costing the nation at least $3.5 billion annually. SOURCE: Safe Passage Through Transitions of Care presentation, The Joint Commission, 2016.

Spotlight on Rutland Regional Medical Center Initiative

The Transitional Care Program was initiated in December 2015 with the goal of improving health and wellness of recently discharged patient thereby decreasing hospital re-admissions. The program is for adults with chronic health conditions and/or health risks. The Clinical Transitions Liaison (CTL) will visit patients during their hospital stay, attend follow up appointments, conduct home visits to confirm understanding of medications and how to manage symptoms, and make follow-up phone calls to answers questions and offer support. In the first year, the CTL has conducted 820 visits with patients in a variety of settings - inpatient, clinic, home and community.

RRMC's Outcomes

10.9%

OUTCOME: Since the inception of the Transitional Care Program, the re-admission rate at RRMC has dropped from 14% to 10.9%. In addition to reduction of re-admission, there are many anecdotal stories of patients' successes:

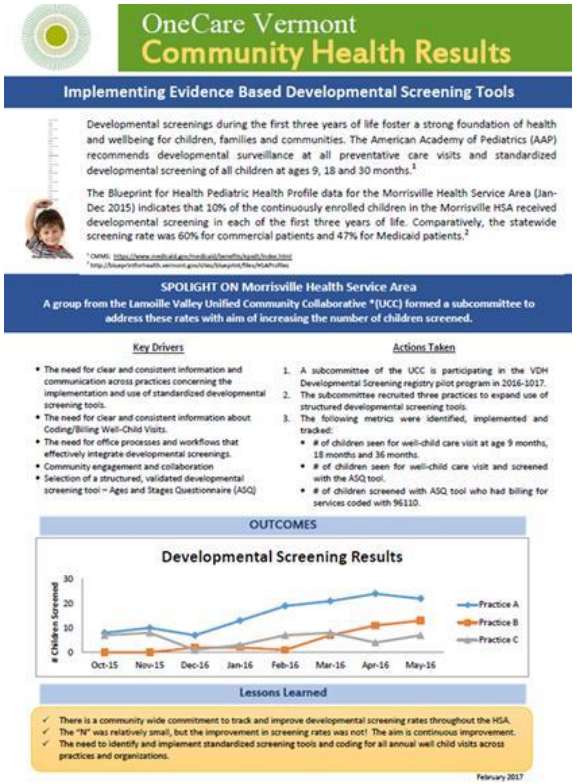
- While making a home visit to a patient with COPD, noticing environmental irritants and placing a referral to Neighbor Works to have repairs done. Also by quitting smoking with the TCN's encouragement, the patient was able to afford the co-pay for a necessary medication.
- Having a patient initially decline a home visit post-discharge, but accept with reservations only to be found confused by all her new medications when the TCN arrived at her home shortly after discharge. Without that visit, the patient may have had high risk of medication errors.
- Provided necessary continued support to patient and spouse while transitioning to hospice care so that all paperwork was completed in a timely fashion.

For More Information on the RRMC Transitions of Care Program, please contact Kathy Boyd, Director of Case Management (kboyd@rrmc.org) or Samantha Helinksi, RN, Clinical Transitions Liaison (smhelinski@rrm.org).

Lessons Learned

- Medication reconciliation is a key need – many medication lists have been found to be inaccurate.
- Patients have a sense that everyone on their team is connected and talking. There needs to be one "source of truth" holder of information who connects with the patients regarding all care being provided.
- Key to a successful Transitions of Care Program – an RN in the CTL role with experience in the hospital and community settings who is skilled with motivational interviewing and providing patient education.
- The first 24/48 hours post-discharge are crucial in determining whether the patient will be re-admitted. Often community services cannot be put in place that quickly.

January 2017



OneCare Vermont
Community Health Results

Implementing Evidence Based Developmental Screening Tools

Developmental screenings during the first three years of life foster a strong foundation of health and wellbeing for children, families and communities. The American Academy of Pediatrics (AAP) recommends developmental surveillance at all preventative care visits and standardized developmental screening of all children at ages 9, 18 and 30 months.[1]

The Blueprint for Health Pediatric Health Profile data for the Morrisville Health Service Area (Jan-Dec 2015) indicates that 10% of the continuously enrolled children in the Morrisville HSA received developmental screening in each of the first three years of life. Comparatively, the statewide screening rate was 60% for commercial patients and 47% for Medicaid patients.[2]

[1] CMMS: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html
[2] http://blueprintforhealth.vermont.gov/sites/blueprint/files/HSAProfiles

SPOLIGHT ON Morrisville Health Service Area

A group from the Lamoille Valley Unified Community Collaborative *(UCC) formed a subcommittee to address these rates with aim of increasing the number of children screened.

Key Drivers

- The need for clear and consistent information and communication across practices concerning the implementation and use of standardized developmental screening tools.
- The need for clear and consistent information about Coding/Billing Well-Child Visits.
- The need for office processes and workflows that effectively integrate developmental screenings.
- Community engagement and collaboration
- Selection of a structured, validated developmental screening tool – Ages and Stages Questionnaire (ASQ)

Actions Taken

1. A subcommittee of the UCC is participating in the VDH Developmental Screening registry pilot program in 2016-1017.
2. The subcommittee recruited three practices to expand use of structured developmental screening tools.
3. The following metrics were identified, implemented and tracked:
   - # of children seen for well-child care visit at age 9 months, 18 months and 36 months.
   - # of children seen for well-child care visit and screened with the ASQ tool.
   - # of children screened with ASQ tool who had billing for services coded with 96110.

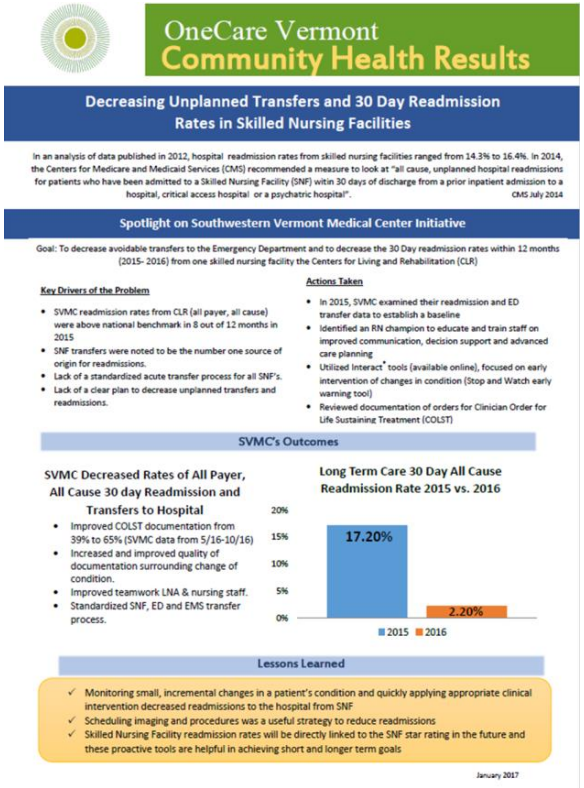
OUTCOMES

Developmental Screening Results

Lessons Learned

- ✓ There is a community wide commitment to track and improve developmental screening rates throughout the HSA.
- ✓ The "N" was relatively small, but the improvement in screening rates was not! The aim is continuous improvement.
- ✓ The need to identify and implement standardized screening tools and coding for all annual well child visits across practices and organizations.

February 2017



OneCare Vermont
Community Health Results

Decreasing Unplanned Transfers and 30 Day Readmission Rates in Skilled Nursing Facilities

In an analysis of data published in 2012, hospital readmission rates from skilled nursing facilities ranged from 14.3% to 16.4%. In 2014, the Centers for Medicare and Medicaid Services (CMS) recommended a measure to look at "all cause, unplanned hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) within 30 days of discharge from a prior inpatient admission to a hospital, critical access hospital or a psychatric hospital". CMS July 2014

Spotlight on Southwestern Vermont Medical Center Initiative

Goal: To decrease avoidable transfers to the Emergency Department and to decrease the 30 Day readmission rates within 12 months (2015- 2016) from one skilled nursing facility the Centers for Living and Rehabilitation (CLR)

Key Drivers of the Problem

- SVMC readmission rates from CLR (all payer, all cause) were above national benchmark in 8 out of 12 months in 2015
- SNF transfers were noted to be the number one source of origin for readmissions.
- Lack of a standardized acute transfer process for all SNF's.
- Lack of a clear plan to decrease unplanned transfers and readmissions.

Actions Taken

- In 2015, SVMC examined their readmission and ED transfer data to establish a baseline
- Identified an RN champion to educate and train staff on improved communication, decision support and advanced care planning
- Utilized Interact* tools (available online), focused on early intervention of changes in condition (Stop and Watch early warning tool)
- Reviewed documentation of orders for Clinician Order for Life Sustaining Treatment (COLST)

SVMC's Outcomes

SVMC Decreased Rates of All Payer, All Cause 30 day Readmission and Transfers to Hospital

- Improved COLST documentation from 39% to 65% (SVMC data from 5/16-10/16)
- Increased and improved quality of documentation surrounding change of condition.
- Improved teamwork LNA & nursing staff.
- Standardized SNF, ED and EMS transfer process.

Long Term Care 30 Day All Cause Readmission Rate 2015 vs. 2016

Lessons Learned

- ✓ Monitoring small, incremental changes in a patient's condition and quickly applying appropriate clinical intervention decreased readmissions to the hospital from SNF
- ✓ Scheduling imaging and procedures was a useful strategy to reduce readmissions
- ✓ Skilled Nursing Facility readmission rates will be directly linked to the SNF star rating in the future and these proactive tools are helpful in achieving short and longer term goals

January 2017

Changing Care Delivery

Medicare Next Generation Waivers

- Expanded patient benefits:
  - Access to skilled nursing facilities without a 3-day inpatient stay requirement
  - Access to two home health visits following hospital discharge
  - Access to telehealth services not currently allowed by CMS
  - Still accrues against ACO “risk” target but facilitates compliant service delivery and revenue flow
- Future topics under consideration through Vermont APM:
  - “Virtual PACE program” – funding of adult day care for patients in complex care coordination
  - Home IV antibiotics
- Expansion to other payers

Flexible Care Models

- "Virtual Visits" – store and forward enhancements to electronic health record patient portals
- Telemedicine visits
  - Direct patient care
  - Support of continuum of care community providers
    - Home Health agency
    - SASH
    - Designated Agencies
    - Agency on Aging
- Pharmacist patient support and consultative services
- PCMH imbedded mental health services
- More Medication Assisted Treatment (MAT) in PCMH
- Population health compensation models
- RN performed Medicare Annual Wellness Visits

Medicare Annual Wellness Visit

- Focuses on prevention, safety, and coordination of care
- Includes health risk assessments, measurements and screenings, and personalized health advice and referrals
- OCV clinical priority area: aligns with 7 Medicare quality measures; OCV performance <20% (2015); focus on primary or secondary prevention of chronic disease
- Innovation:
  - RNs perform Medicare AWV
  - Developed & refined communication
  - Staff Training
  - Evaluated impact
- Outcomes:
  - Increased patient satisfaction
  - Increased provider & staff satisfaction
  - Improved access to care
  - Improved quality performance
  - Improved revenue to practice

"The nurse spent a lot of time with me and was incredibly thorough, I will do this again"

- Patient from Central Vermont

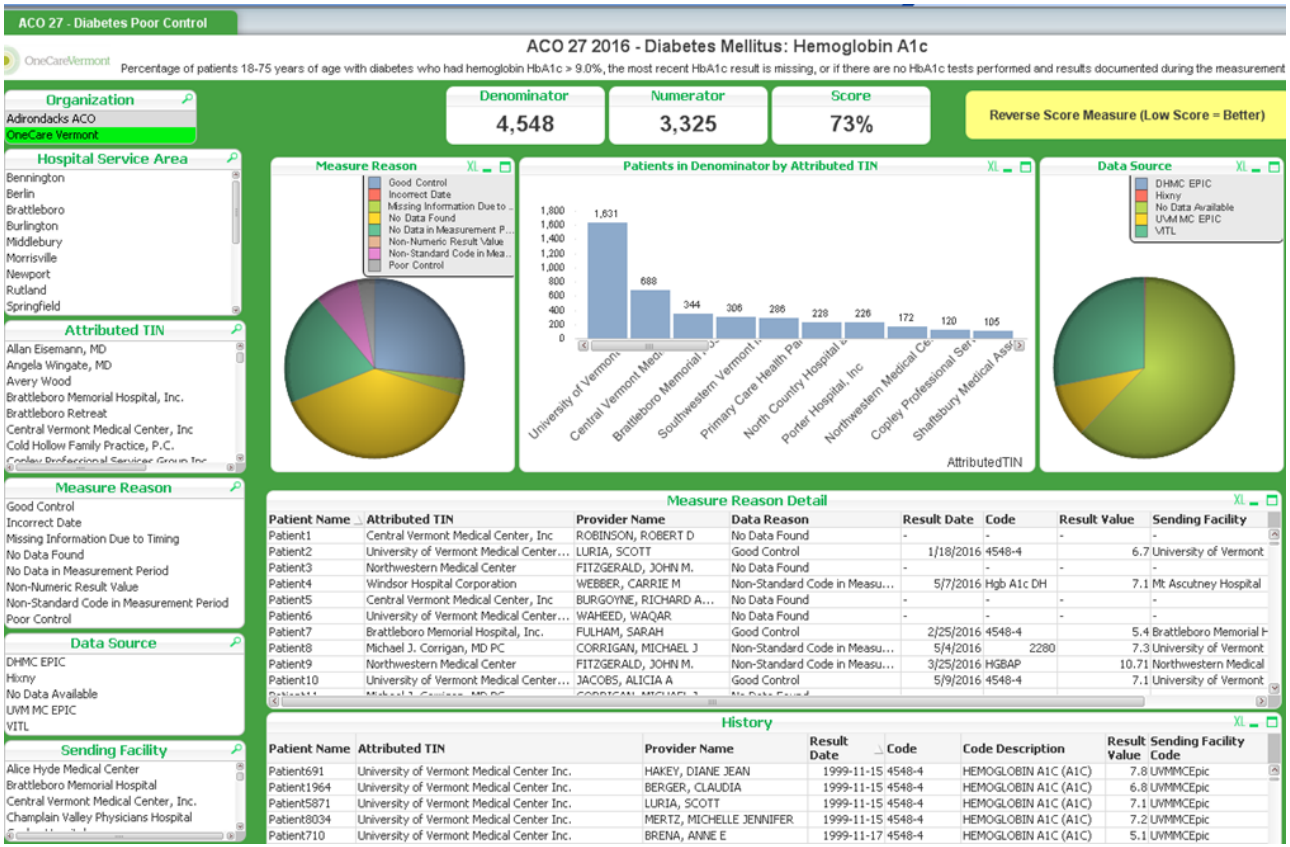
"I find the focused visits after the patient has had an AWV to be quite rewarding. Patients are coming in to talk about specific questions related to their Advance Directives or other issues found during their AWV, and we are able to devote the time to those things. Conversations are meaningful and less distracted by the requirements of the AWV"

- Clinician from Central Vermont

Workbench One Analytics Platform

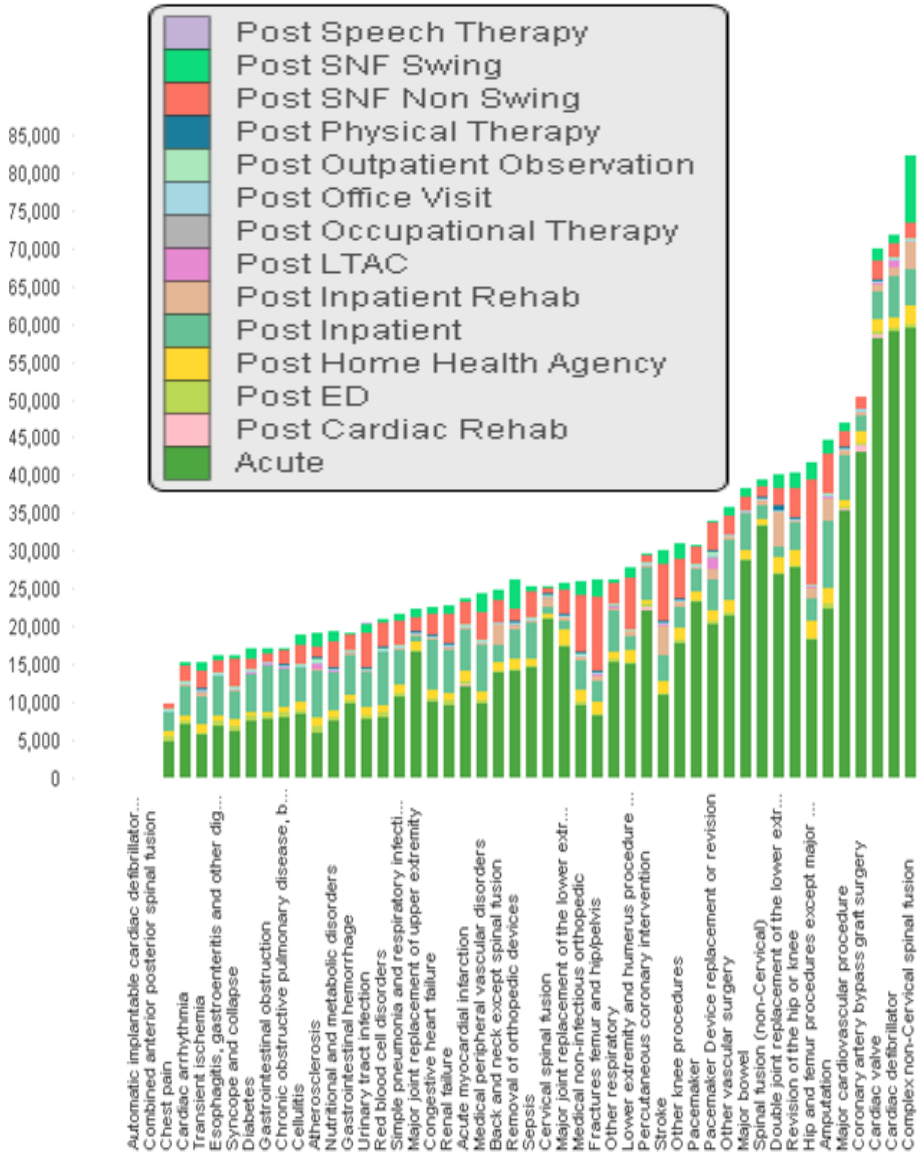
Clinical data feeds from the VITL ACO Gateway enable:

- Population-level Dashboards
- Self-Service Analytic Applications
- Quality Measure Scorecards
- Standard Reports

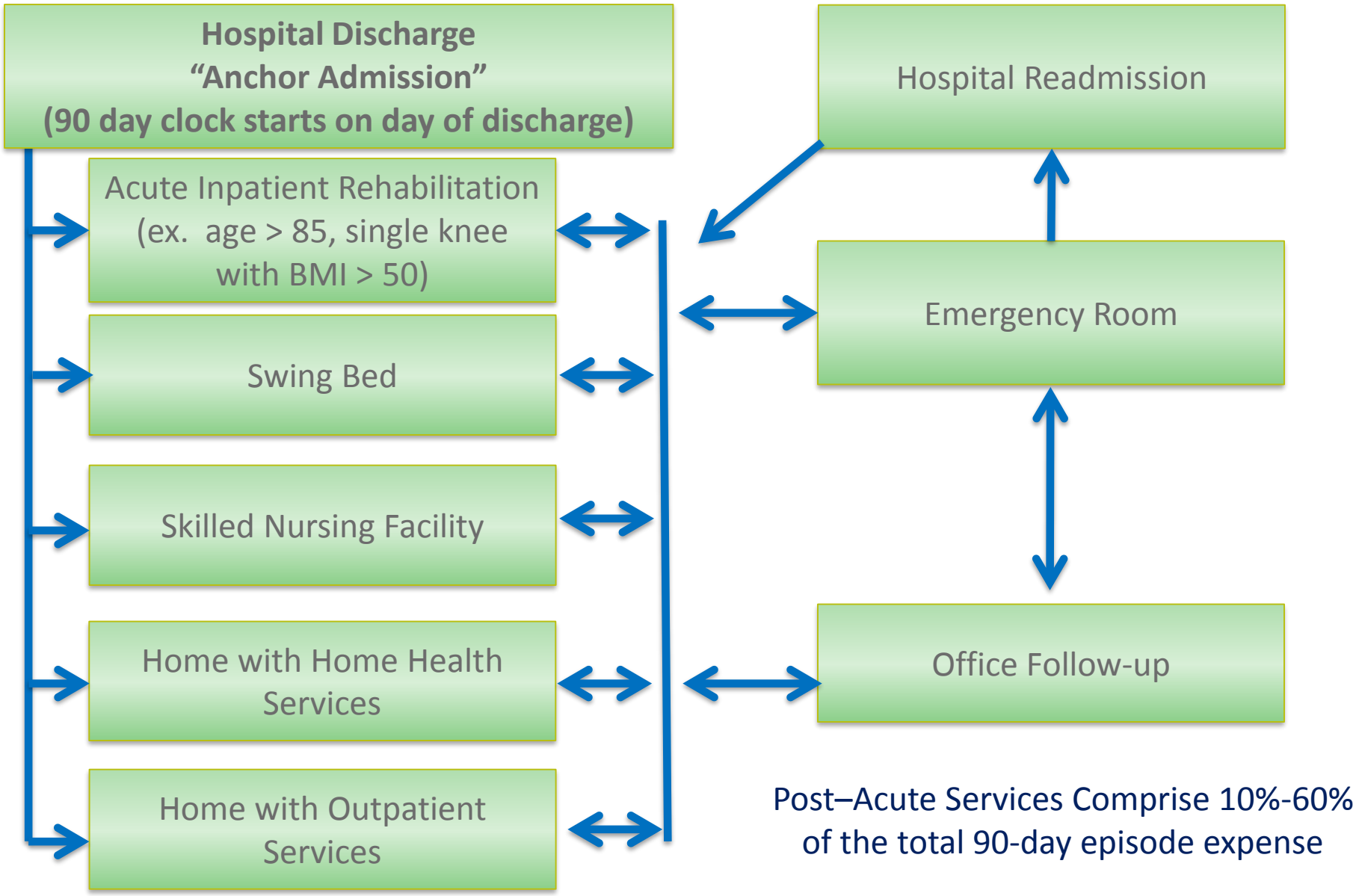


Episodes of Care (Bundles) Analysis – Care Standardization

- Acute hospitalization payments, physician billings, plus all post acute services for 90 days
- Large proportion of total cost of care
- CMI and RUG risk adjusted data
- Mechanism to educate network concerning significant community variation in type and amount of services
  - Hospital, skilled nursing, home health length of stay
  - Post acute services "pathways"
  - "SNF…ISTS" – onsite medical coverage in nursing homes – an important paradigm shift
- Promote patient engagement and setting post acute care expectations



Episode of Care (Bundle) Pathway



Post–Acute Services Comprise 10%-60%
of the total 90-day episode expense

Supporting High Quality Care

Quality Improvement Strategies to Achieve the Triple Aim

- **Timely and Accurate Data**
  - Identify gaps in care
  - Drive decision-making
- **Support Local Communities to Improve**
  - Aligned clinical priority areas
  - Representation on clinical governance committees
  - Blueprint/OCV aligned staffing & resources
- **Resources, Training, and Tools**
  - A3 QI reporting processes
  - All Field Team staff trainings
- **Dissemination of Results**
  - Network Success Stories
  - OneCare Grand Rounds, Topic Symposia, Conferences
  - Facilitated sharing on clinical committees

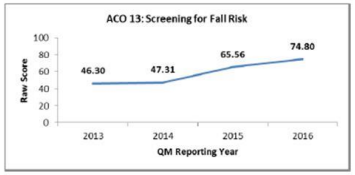
Quality Measurement, Analysis, & Reporting

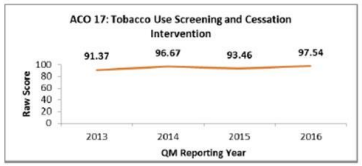
OneCareVermont

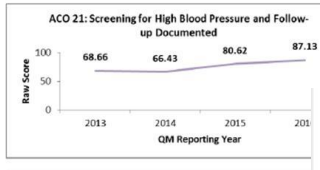
Appendix:

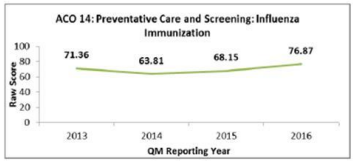
Raw Score Trends for Measures Included in all Performance Years (2013- 2016):

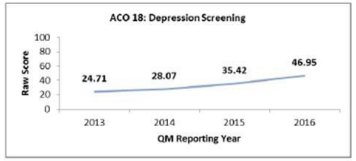
Medicare

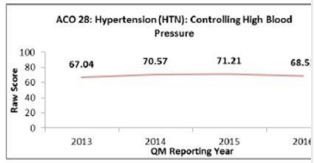


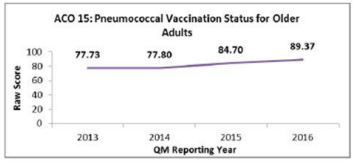


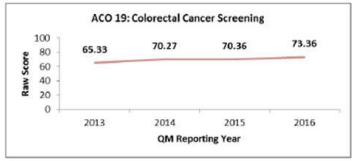


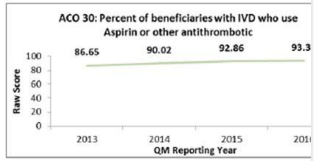


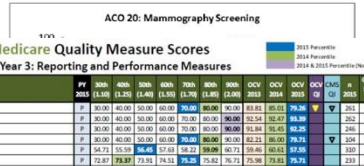


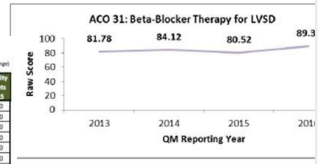


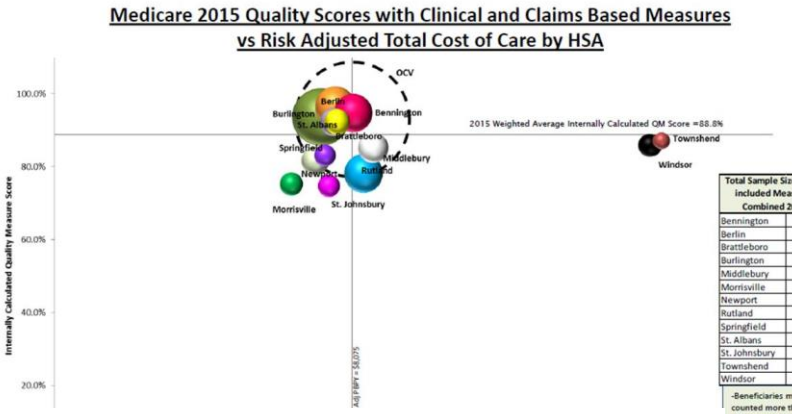


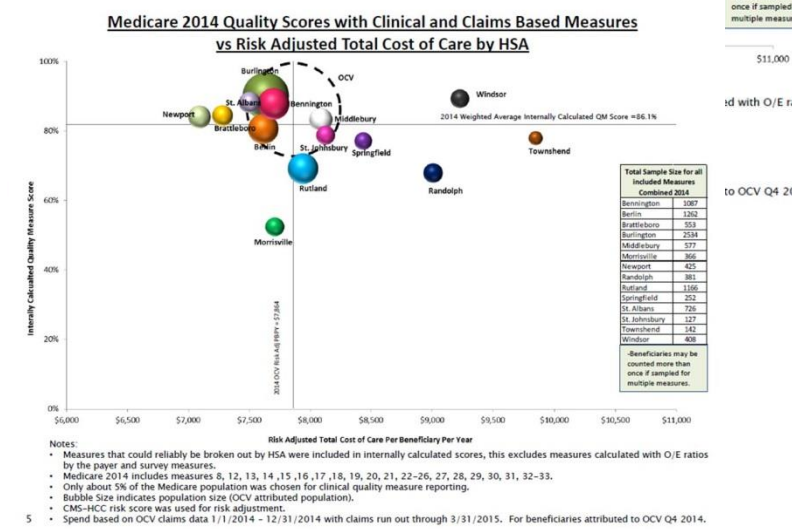












Notes:
- Measures that could reliably be broken out by HSA were included in internally calculated scores, this excludes measures calculated with O/E ratios by the payer and survey measures.
- Medicare 2014 includes measures 8, 12, 13, 14 ,15 ,16 ,17 ,18, 19, 20, 21, 22-26, 27, 28, 29, 30, 31, 32-33.
- Only about 5% of the Medicare population was chosen for clinical quality measure reporting.
- Bubble Size indicates population size (OCV attributed population).
- CMS-HCC risk score was used for risk adjustment.
- Spend based on OCV claims data 1/1/2014 – 12/31/2014 with claims run out through 3/31/2015. For beneficiaries attributed to OCV Q4 2014.

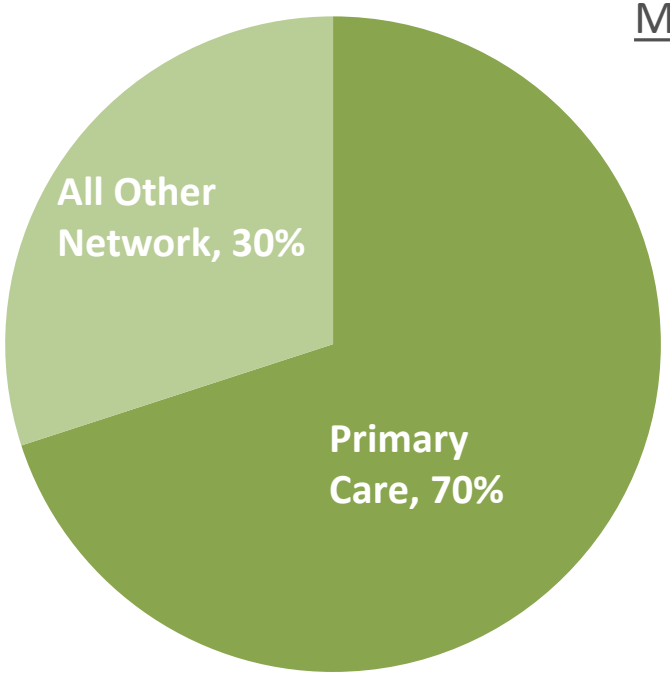
Value-Based Incentive Fund Distribution Method

Budget Check

Approach:

- Familiarize network with new measures
- Recognize on-ramp for new practices in early years
- Recognize the entire network in the transition to a value-based care delivery model
- Move towards variable incentives that are aligned with measures

DISTRIBUTION OF FUNDS:



Measurement Year	Strategy
2017/18	• 70% to primary care based on attributed population • 30% to rest of network based on % of total Medicaid spend in calendar year
2019+	• 70% variable to primary care based on practice-level performance on a standard measure set • 30% variable to entire network based on HSA-level performance on a standard set of measures

Support to Primary Care

Bringing it Together: 2018 OneCare Primary Care Model

Attributed Population

Full Attributed Panel

High Risk

NOTE: PCP and OCV Collaborate with Full Continuum of Care on Population Health

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OCV Complex Care Coordination $15-$25 PMPM

OCV Basic PHM Payment $3.25 PMPM

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Care Navigator (Population Health Management System)

OneCareVermont

Value-Based Quality Incentive (Annual Eligibility for Attributed Lives)

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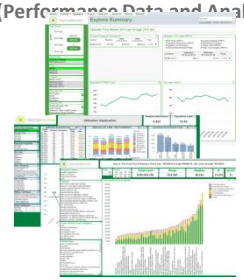
Supporting Data and Systems at No Charge

Workbench One (Performance Data and Analysis)



NOTE: Base Revenue Model Remains as usual FFS; Primary Care is Under No Financial Risk

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OCV Provides Blueprint Continuity for Medicare Practice Payments and CHT Support Funds (plus SASH program)

Blueprint Payments/Programs Continue

BlueCross BlueShield of Vermont

VERMONT AGENCY OF HUMAN SERVICES

Budget Check

Independent PCP Comprehensive Payment Reform Pilot

- **Budget model includes a $1.8M supplemental investment to develop a multi-payer blended capitation model for primary care services**
  - Voluntary program offered to *independent PCP practices* with at least 500 attributed lives across all programs
  - Would supplant and simplify model on previous page
  - Designed to test sustainable model for independent practices <or> pilot offering to all primary care in future years
- **Operational model is monthly PMPM prospective payment to cover primary care services delivered to the attributed population by the practice**
  - Enables innovation and more flexible care models
  - Provides predictable and adequate financial resources for the practice
- **Exact model under development starting in August with eligible and interested practices**

Budget Check

Program	2018 Investment	
Basic OCV PMPM for Attributing Providers	$ 5,348,694	Supporting Primary Care and Community-Focused Elements of PHM Approach
Complex Care Coordination Program	$ 7,580,109	
RiseVT Program	$ 1,200,000	
CHT Funding Risk Communities	$ 1,746,360	Supporting Blueprint for Health Continuity and Ongoing Collaboration with ACO Model
CHT Funding Non-Risk Communities	$ 772,538	
SASH Funding Risk Communities	$ 2,417,942	
SASH Funding Non-Risk Communities	$ 852,012	
PCP Payments Risk Communities	$ 1,319,336	
PCP Payments Non-Risk Communities	$ 654,313	
Value-Based Incentive Fund	$ 5,559,260	Rewarding High Quality
PCP Comprehensive Payment Reform Pilot	$ 1,800,000	Supporting True Innovation in Independent PCP Practices
Total	$ 29,250,563	

Reducing Practice Burdens

- Eliminating prior authorization of services in VMNG program
- Aligning quality measures (QM) across payer programs. For example, 2017 VMNG negotiations resulted in:
  - Reduction in the number of QM
  - Increase in the number of QM tied to claims, resulting in less interruption for practices
  - Alignment with Vermont APM measures
- ACO participation eliminates additional Medicare Incentive Payment System (MIPS) reporting requirements
- Developing a set of clinical priority areas to drive focused QI activities
- OneCare and Blueprint leadership working in close alignment to identify priorities and deploy shared resources
- Implementing current and future benefit waivers to improve access, efficiency, effectiveness, and timeliness of care for patients

Patient Experience of Care

Patient-Focused System of Health

- Vision:
  - Seamless, proactive, patient- and family-centered, community-based care
  - Designed to help patients better engage in their own health care
- Examples across PHM Model:*
  - 9 yo boy with elevated BMI with access to new preferred walking route to school from his neighborhood and encouragement to do so by pediatrician and throughout community
  - 42 yo woman with pre-diabetes referred to YMCA Diabetes Prevention Program (DPP) upon first elevated lab result
  - 57 yo man with uncontrolled diabetes and ED visit for depression; care transition ambulatory follow up plan addressing transportation and insurance challenges
  - 75 yo woman with multiple heart failure admissions with improved medication adherence and assignment of a lead care coordinator for further questions as a result of post-discharge home visit

*Population Health Management Model

Summary


Making sure each person gets the care they need
in the **right place** at the **right time**