State of Vermont
Green Mountain Care Board
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Report to the Legislature

EVALUATION OF SOCIAL SERVICE INTEGRATION WITH ACCOUNTABLE CARE ORGANIZATIONS

In accordance with Act 52 of 2019, Section 2

Submitted to the
House Committees on Health Care and on Human Services, and the Senate Committee on Health and Welfare

Submitted by the
Green Mountain Care Board

December 1, 2019

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Executive Summary

Purpose/Background

Pursuant to Act 52 of 2019[1], the Green Mountain Care Board (GMCB or the Board) is charged with evaluating the manner and degree to which social services are integrated into accountable care organizations (ACOs) certified in accordance with 18 V.S.A. § 9382.[2] To accomplish this report, the GMCB collected and analyzed data on the extent to which ACOs have promoted integration between health care providers and social service providers. The Board specifically focused on the number of social service providers receiving payments through ACOs, analyzing relationships between social service providers and others that address childhood trauma or resilience building, and provides considerations which could enhance integration between social service providers and health care providers.

Evaluation Design

Through existing documentation from the GMCB's ACO oversight process and a series of stakeholder interviews, the GMCB conducted a comprehensive review of OneCare Vermont's (the state's only ACO) current and planned programs aimed at incorporating and integrating social service providers. As defined in Section 2 of Act 52, the provider groups that the GMCB included in this evaluation are: designated and specialized services agencies, home health, area agencies on aging, and parent-child centers. In addition, the GMCB included Supports and Services at Home (SASH) and the Community Health Teams who receive Medicare funding through OneCare Vermont. Though not explicitly named in the Act 52 report language, they are an important component of Vermont's social service integration efforts.

Results

In this evaluation, the GMCB found that OneCare Vermont is taking steps to integrate community-based social service providers. home health, the designated agencies, area agencies on aging, the Blueprint for Health, and parent-child centers who are working with pediatric primary care offices (who receive funding for childhood resilience initiatives. Integration initiatives include a) a statewide complex care coordination program that includes both financial payments to social service providers and programmatic support for care coordination and b) financial incentives to fund population health programs. Since 2017, a total of $20.9 million has been and is projected to be distributed through the end of 2019 (see Figure 2 for a yearly distribution for 2017-2020 (projected), by agency type).

While the report focuses specifically on how *ACOs in Vermont* are promoting integration with certain social service providers, it should be noted that medical and social service providers have integrated on their own accord in Vermont for years. There are many examples of social and medical service providers working together that do not have a name but have grown organically in response to community needs. For example, through the GMCB hospital process, one hospital noted contracting with their local designated agency to increase coverage at their hospital for mental health needs, and provide the designated agency with funding to support the patients in the community enrolled in their Intensive

[1] Act 52 (2019), Sec. 2, REPORT; EVALUATION OF SOCIAL SERVICE INTEGRATION WITH ACCOUNTABLE CARE ORGANIZATIONS. Available at: https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT052/ACT052%20As%20Enacted.pdf

[2] 18 V.S.A. § 9382. Available at: https://legislature.vermont.gov/statutes/section/18/220/09382

Medication Assisted Treatment Program.[3] In addition, one could posit that some of the initiatives being formally tested by the ACO are a result of historic relationship building and testing of initiatives to solve complex community problems.

Key Considerations

Studies drawing comparisons nationally and internationally have found that regions with higher ratios of social service to health care spending have better health outcomes.[4] However, these studies also show that higher ratios of social service spending alone do not reduce the overall cost of health care.[5] The All-Payer ACO Model is built on the tenant that Vermont can improve health outcomes for Vermonters and control the rate of health care cost growth if we pay for health care differently, through value-based payments and increased investments in population health, and invest in the transformation of health care delivery.

Social service agencies are tailored to address unique needs of individuals through different modalities found to work for these populations, including, but not limited to, high touch care coordination, home-based care, integration and co-location of services, and health education, allowing them to address the social risk factors that may be affecting someone's health. However, investments in population health often require a long-term perspective, with gains in health status accruing over time.[6]

To that end, there should be a continuing conversation on the integration of social services within the ACO and the state to ensure we are working in a coordinated fashion across the lifespan for Vermonters. And, based upon availability of funding, the ACO should continue to provide financial and other resources for evidence-based initiatives that improve outcomes and lower health care costs to further support integration of medical and social services.

[3] Southwestern Vermont Medical Center Fiscal Year 2019 Budget Narrative. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/B19H39_Narrative_SVMC.pdf

[4] From "Untangling The Relationship between Social Service And Health Care Spending And Health Outcomes," by E. Bradley and A. Brewster, 2019, *Health Affairs*. Available at: https://www.healthaffairs.org/do/10.1377/hblog20191112.848045/full/

[5] From "It's Still the Prices, Stupid: Why the US Spends So Much On Health Care, and A Tribute to Uwe Reinhardt," by G. Anderson, P. Hussey, and V. Petrosyan, 2019, *Health Affairs.* Available at: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05144

[6] From "Elements of Accountable Communities for Health: A Review of the Literature," by M. Mongeon, J. Levi, and J. Heinrich, 2017, *National Academy of Medicine.* Available at: https://nam.edu/elements-of-accountable-communities-for-health-a-review-of-the-literature/

Section 1. Introduction

Per Section 2 of Act 52, "On or before December 1, 2019, the Green Mountain Care Board shall submit a report to the House Committees on Health Care and on Human Services and to the Senate Committee on Health and Welfare evaluating the manner and degree to which social services, including services provided by the parent-child center network, designated and specialized service agencies, and home health and hospice agencies are integrated into accountable care organizations (ACOs) certified pursuant to 18 V.S.A. § 9382."

1.1 Purpose of Evaluation

The evaluation was intended to address three fundamental questions:

- What is the number of social service providers receiving payments through one or more ACOs, if any, and for which services?
- What is the extent to which any existing relationships between social service providers and one or more ACOs address childhood trauma or resilience building?
- What are some recommendations to enhance integration between social service providers and ACOs?[7]

1.2 Evaluation Model

To conduct this evaluation, the GMCB reviewed documentation of population health programs submitted by OneCare Vermont to the GMCB in their ACO regulatory oversight process in 2017, 2018, and 2019. In addition, GMCB conducted an in-person interview with Sara Barry, OneCare Vermont's Chief Operating Officer, and collected verbal feedback pertaining to OneCare Vermont's integration efforts with social service providers. In November 2019, the GMCB and the Agency of Human Services (AHS) hosted a stakeholder meeting which included over twenty representatives across state government, the ACO, and social service organizations to discuss Vermont's current state of integration, opportunities for future integration, and existing barriers to integration success. The GMCB also considered public comments from social service providers received during its special public comment period for its ACO Oversight process. Finally, the GMCB sought consumer feedback from Supports and Services at Home (SASH), OneCare Vermont's Medicaid Consumer Board Member, and OneCare Vermont's Patient and Family Advisory Committee to hear from individuals receiving social services from providers who participate in the ACO's network. A compilation of the information gathered was used to organize and formulate recommendations from the Board.

1.3 Background

Vermont has a long history of health care reform. Specific to payment and delivery system reform, the Blueprint for Health in 2005 laid a foundation to support primary care.[8] As the Blueprint was developed, Vermont recognized that there were three conditions necessary to promote change in health care delivery in the private sector at the provider level: 1) changing the financial incentives; 2) ensuring providers are ready to change how they deliver care; and 3) creating data and tools necessary to enable providers to change. The Blueprint began to build provider readiness for health care delivery reform with establishment of the Patient Centered Medical Home Model and Community Health Teams, which

[7] Act 52 (2019), Sec. 2, REPORT; EVALUATION OF SOCIAL SERVICE INTEGRATION WITH ACCOUNTABLE CARE ORGANIZATIONS. Available at: https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT052/ACT052%20As%20Enacted.pdf

[8] From "A Balanced Portfolio Model For Improving Health: Concept and Vermont's Experience," by J. Hester, 2018, *Health Affairs.* Available at: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1237

included new financial models to promote care coordination and regional collaboratives, assistance to primary care providers in changing operations, and the provision of health service area data and information.

In 2010 the federal government passed the Patient Protection and Affordable Care Act, which created the Centers for Medicare and Medicaid Innovation (CMMI), an organization under the Centers for Medicare and Medicaid Services (CMS) to support the development and testing of innovative payment models, including ACOs.[9] CMMI then began providing funding to states through a 'State Innovation Model' (SIM) grant program to allow states to develop statewide models to incentivize communication around the healthcare delivery system. Vermont was one of the first states in the nation to receive SIM funding, which the state used to enable delivery reform in the private sector through projects directed by the Vermont Health Care Innovation Project (VHCIP).[10] Based on the work completed during the VHCIP, coupled with Medicare's focus on delivery reform through the ACO model, Vermont designed legislation to balance an ACO model who could serve as a vehicle to drive health care reform, allowing for adoption and promotion of evidence-based initiatives balanced by local decision making in communities and the OneCare Vermont board committees.

State-led delivery system reform has been enabled by the following state legislation and federal agreements: 18 V.S.A. § 706 (the Blueprint for Health) 18 V.S.A. § 702, Act 48 of 2011 (Vermont Health Care Reform Law), Act 54 of 2015 (All-Payer Model), Act 113 of 2016 (Oversight of Accountable Care Organizations), the Global Commitment to Health Section 1115 Medicaid waiver, and the All-Payer Model ACO Agreement between the state and CMMI.

Health Care Reform History of Initiatives

The Blueprint for Health

The Blueprint for Health (the Blueprint) was codified by law in 2006 by the Vermont Legislature to promote care coordination through primary care medical homes and community health teams. Over the past decade, the Blueprint evolved and expanded to include additional programs. Current Blueprint delivery system programs include Patient-Centered Medical Homes, Community Health Teams, the Hub & Spoke system of opioid use disorder treatment, the Women's Health Initiative, Support and Services at Home (SASH), and Self-Management and Healthier Living Workshops. The Blueprint promotes delivery system reform through a transformation network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators, who work with ACO and community-based partners to lead the implementation of these innovations in practices and communities across Vermont. The Blueprint has conducted a series of studies that show reduced health care expenditures as a result of these interventions across the Vermont population.[11]

The Vermont State Innovative Model Vermont Health Care Innovation Project (VHCIP)

Through a State Innovations Model grant of $45 million by CMMI in 2014, Vermont's State Innovative Model Vermont Health Care Innovation Project (VHCIP), focused on three priority areas for health care reform: payment reform, care transformation, and health data transformation. VHCIP tested several

[9] Centers for Medicare & Medicaid Services: https://innovation.cms.gov/
[10] Health Care Innovation Project: https://healthcareinnovation.vermont.gov/resources/about-us
[11] Blueprint for Health: https://blueprintforhealth.vermont.gov/about-blueprint

types of payment reform models and held ongoing stakeholder conversations on the topics of Care Management, Payment Reform, Long Term Services, Population Health, and Information Technology.[12]

Work performed under VHCIP further identified areas to increase provider and community readiness and alignment for payment reform. For example, the Care Models and Care Management (CMCM) Work Group conducted a survey to better understand current care management activities in Vermont and how to build a more integrated delivery system. An analysis of the recommendations that emerged from this workgroup and a discussion of how OneCare Vermont and the state have worked together to implement this system is provided in Section 2.1.2 in this document.[13]

In an effort to align existing care management efforts for at-risk Vermonters and their families, teams throughout the state then participated in a VHCIP facilitated "Integrated Communities Care Management Learning Collaborative." The teams identified best practices for reducing fragmentation, eliminating duplication, and closing gaps in care for those with complex care needs. OneCare Vermont, the Blueprint, and Vermont's communities have been continuing this work since VHCIP ended, as described in OneCare Vermont's written submissions to the GMCB and the Blueprint's 2018 Annual Report.[14]

VHCIP also led to the creation of a population health workgroup, who produced a plan in 2017 that outlined five priority areas to improve population health in Vermont: 1) using population-level data to identify priorities and target actions, 2) supporting prevention and wellness, 3) addressing social determinants and health equity, 4) engaging community partners in integrating clinical care and service delivery with community-wide prevention activities, and 5) creating sustainable funding models which support and reward improvements in population health, including primary prevention and wellness. Ten Vermont health service areas participated in a learning lab to increase understanding of the Accountable Communities for Health model. This was meant to broaden the Community Collaborative model and incorporate stakeholders to address a whole community, not just a defined group of patients.[15] The Blueprint for Health has continued to support the Accountable Communities for Health initiative in conjunction with the Vermont Department of Health and OneCare Vermont.[16]

The Accountable Care Organization Model, the Vermont All-Payer ACO Model Agreement, and Act 113

In 2011, the state renewed its priority to contain health care costs and improve heath quality in Vermont by simultaneously pursuing policy changes to promote universal health care and value-based payment and delivery system reform. While the state decided not to continue work on universal health care in 2014 it continued work on value-based payment and delivery system reform, through negotiations with CMMI, which culminated in the All-Payer ACO Model Agreement.

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[12] Health Care Innovation Project: https://healthcareinnovation.vermont.gov/

[13] Health Care Innovation Project, PT Reference Materials: https://healthcareinnovation.vermont.gov/tags/pt-reference-materials

[14] Id.

[15] From "VT ACH Peer Learning Lab Report," by VT Accountable Communities for Health, 2017. Available at: https://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/ACH%20FINAL%20REPORT%203.25.17_0.pdf

[16] Blueprint for Health: Accountable Communities for Health: https://blueprintforhealth.vermont.gov/about-blueprint/accountable-communities-health

CMMI released their first nationwide Accountable Care Model in 2012, and in 2014 VHCIP initiated a three-year pilot to test this model with Medicare, including also Medicaid and Commercial payers with the goal to move from volume-based payments toward a payment system that reinforces efforts to improve health, quality of care, and contain the rate of growth in health care costs. In the shared savings model, if a network achieves savings, it shares these savings with the associated payer. However, if the network does not save money, there is no penalty nor repayment. At the time of the pilot there were three Vermont ACOs, all of which participated.[17]

At a national level, CMMI continued to test new payment models, and expanded the shared savings ACO model to one that included stronger financial and provider incentives, assessing whether 'strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, improve health outcomes and reduce expenditures for Medicare beneficiaries.' The Medicare Next Generation program is a two-sided risk model in which the ACO would not only share in the savings, but also in any losses if they failed to meet their financial targets. Research suggested that a two-sided risk model would provide greater motivation for providers to engage in care transformation. The Next Generation Program allows providers to set predictable financial targets, enables providers and beneficiaries' greater opportunities to coordinate care, and aims to attain the highest quality standards of care. The Medicare Next Generation Program waives several traditional Medicare reimbursement rules, allowing ACOs to test and implement alternative programs in telehealth, hospital transitions to skilled nursing facilities, and home visits.[18] Findings released on CMMI's inaugural Next Generation Program year showed a reduction in Medicare spending without a reduction in quality, mostly in hospital and SNF spending. CMMI noted that over half of this savings were achieved by four of the 18 ACOs participating.[19] As described in the previous paragraph, at the time Vermont ACOs were piloting the shared savings program model with Medicare, Medicaid through the Department of Vermont Health Access, and participating commercial payers, working on improving quality while reducing total costs. VHCIP, through the previously described stakeholder engagement, played a role in the development of this model, aimed at containing health care costs and improving quality, especially in the event of a possible move to a single payer system.[20]

However, while the state decided that universal health care was not feasible in 2014, it continued to work on value-based payment and delivery system reform. In 2015, the Vermont State Legislature passed Act 54, allowing the Board and Agency of Administration to "jointly explore an all-payer model". This laid out Vermont-specific requirements for a workable all-payer reimbursement model and to jointly design an agreement acceptable to both Vermont and federal government. Then in 2016, as d conversations continued with the GMCB Board Chair and staff members, working with the Agency of Administration, the legislature had extensive discussion in the development of H.812 (Act 113) which included criteria for an all-payer model and oversight of an ACO. In October 2016, the Vermont All-Payer ACO Model Agreement was executed with federal and state partners. The signatories included the

[17] Green Mountain Care Board: ACO Shared Savings: https://gmcboard.vermont.gov/payment-reform/ACO-shared-savings
[18] Centers for Medicare & Medicaid Services: https://innovation.cms.gov/initiatives/next-generation-aco-model/
[19] From "Next Generation Accountable Care Organization (NGACO) Model: Evaluation of Performance Year 1," by CMS, 2018. Available at: https://innovation.cms.gov/Files/reports/nextgenaco-fg-firstannrpt.pdf
[20] From "Vermont All-Payer Model Term Sheet Proposal," by Green Mountain Care Board, 2016, *State of Vermont*. Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM-Companion-Paper-Formatted%20FINAL2.pdf

Governor of the State of Vermont, the Chair of the GMCB, the Secretary for the Vermont Agency of Human Services (AHS), and the Director of the State Innovations Group for CMMI. The APM outlines statewide targets to achieve over five years, utilizing an ACO as the payment reform vehicle to allow providers to work together in a network to reduce cost and improve quality.[21],[22]

At a high level, the model allows the state to shift from fee-for-service to population-based payments, providing opportunity to improve health care delivery to Vermonters, in changing the emphasis from seeing patients more routinely for episodic illness to providing preventive care across a lifespan. As referenced in the Board's decision to sign the APM, primary care is recognized as imperative to the model's success, as consensus shows that a strong foundation of primary care, with a focus on preventive services, can improve health care quality, improve the health of the population, and help reduce growth in health care costs. The Agreement has three broad population health goals: a) increase access to primary care, b) reduce deaths due to suicide and drug overdose, and to c) reduce morbidity and mortality due to chronic disease while reducing the rates in the growth of health care, of which the second and third goal tie to Vermont's 2019-2023 State Health Improvement Plan.[23,24] The APM also provided the ability for Vermont to continue Medicare support for the Blueprint.[25]

Additionally, Act 113 gave the GMCB the responsibility for providing regulatory oversight of ACOs, which included ensuring that ACOs were not duplicating work with the foundational work of the Blueprint for Health and were coordinating closely with community-based providers. In addition, if an ACO is going to receive Medicaid and Commercial dollars on behalf of their provider network, they must be certified by the GMCB and have an annual budget review and approval. In response to 18 V.S.A. § 9382, the GMCB finalized the GMCB Rule 5.000 Oversight of Accountable Care Organizations in November 2017.[26] There are specific sections of 18 V.S.A. § 9382 which relate directly to integration of social services.[27]

For 2018, the GMCB implemented an ACO Oversight process, which includes a yearly review of the payer and provider networks, revenues, expenses, risk, alignment with the Blueprint for Health, and incentives and investments in primary care, community-based providers, social determinants of health, and resilience building.[28]

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[21] Vermont All-Payer ACO Model: https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/

[22] From "Vermont All-Payer Accountable Care Organization Model Agreement," by Green Mountain Care Board, 2016, *State of Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM-FINAL-Justification.pdf

[23] Id.

[24] From "Vermont State Health Improvement Plan 2019-2023," by Vermont Department of Health, 2018, *State of Vermont.* Available at: https://www.healthvermont.gov/sites/default/files/documents/pdf/ADM_State_Health_Improvement_Plan_2019-2023.pdf

[25] From "Vermont All-Payer Accountable Care Organization Model Agreement," Green Mountain Care Board, 2016, *State of Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/All%20Payer%20Model%20ACO%20Agreement.pdf

[26] From "Rule 5.00: Oversight of Accountable Care Organizations," Green Mountain Care Board, 2017, *State of Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/Rule%205.000.pdf

[27] 18 V.S.A. § 9382, Sec. 2, 17, (b)(1)(F, H, J). Available at: https://legislature.vermont.gov/statutes/section/18/220/09382

[28] ACO Oversight: https://gmcboard.vermont.gov/aco-certification-and-budget-review

Accountable Care Organization Model(s) in Vermont

The state currently has one ACO, OneCare Vermont (OneCare), which the GMCB regulates. OneCare Vermont is a member-managed limited liability company, whose mission, per their website is "joining together providers and communities to improve the health of Vermonters and lower health care cost." OneCare Vermont has an Executive Board comprised of 21 members who provide direction toward this mission. Then, through OneCare Vermont's Population Health Strategy, Patient and Family Advisory, Pediatric, Clinical and Quality, Finance, and Executive Committees, population health strategies are identified to improve quality and reduce total costs of care for Vermonters. In 2019, OneCare Vermont is contracting with 13 hospitals in 12 Vermont hospital service areas, 6 Federally Qualified Health Centers, 30 independent providers and 46 social service agencies who include Designated Agencies, Area Agencies on Aging, Specialized Service Agencies, Home Health, and Skilled Nursing Facilities.[29,30]

OneCare Vermont reports to the GMCB annually on the criteria outlined in Act 113, including updates on ways they are collaborating at the state and local levels to build integration with the existing community-based provider network and the foundational work of the Blueprint, which brought medical and social service providers together in the Community Health Teams which grew into community workgroups. Evidence of this integration is stated by OneCare Vermont in their 2020 budget submission, "health and social service providers and other community members have spent years building multi-disciplinary workgroups that aim to improve health for their citizens, with awareness of the importance of the social determinants of health." OneCare Vermont noted that these workgroups go by varying names, including: Community Collaboratives, Community Health Action Teams, Regional Clinical Performance Committees, Accountable Communities for Health, and more. Communities are not building their efforts from scratch, but rather using the model to deepen their collaborations and improve their effectiveness.[31] Additionally, as stated in the 2018 Blueprint for Health Annual Report: "The Blueprint and OneCare Vermont purposefully avoid duplication of efforts and investments, but rather leverage each other's networks where they will be most effective."[32]

Through yearly agreements with Medicare, Medicaid, and Commercial payers, OneCare Vermont and their network are accountable for cost and quality measure targets through the two-sided risk Next Generation model previously described. OneCare Vermont's payer contracts provide flexibility in how the ACO pays for health care and allows them to test models of interest to the payers. For example, the skilled nursing facilities (SNF) are working with OneCare Vermont to implement the Medicare SNF waiver, allowing more timely access to benefits, such as physical, occupational or speech therapy without unnecessary inpatient hospitalization. OneCare has ranked third in comparison to other ACOs in the nation on its utilization of this benefit.[33]

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[29] OneCare Vermont: https://www.onecarevt.org/

[30] From "Annual Report on the Vermont Blueprint for Health," by B. Tanzman, 2019, *Vermont Agency of Human Services, State of Vermont.* Available at: https://blueprintforhealth.vermont.gov/sites/bfh/files/2018_Blueprint_for_Health_Annual_Report_final.pdf

[31] From "OneCare Vermont ACO 2020 Fiscal Year Budget Submission," by V. Loner, 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/GMCB%20ACO%20Budget%20Submission%202020%20Final.pdf

[32] Id.

[33] From "OneCare Vermont 2020 Budget Presentation," 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/2020%20OneCare%20Budget%20Presentation%20DF2%20SUBMIT.pdf

In 2020, OneCare Vermont estimates that 35% of the total funding they are accountable for will be distributed in population-based payments to hospitals and primary care for medical care services. The remaining medical services not included in the population-based payments are distributed through fee-for-service payments by the payers.[34]

Section 2. Evaluation Results

OneCare Vermont aims to serve as a statewide vehicle to further integration, at the local level, for community-based medical and social service providers to improve coordination of care for patients. OneCare Vermont provides healthcare analytics and a care coordination platform to their network, Workbench One and Care Navigator respectively, and began testing a statewide structure and tools tied to financial incentives for care coordination that each community implements together at the local level in their 2017 Vermont Medicaid Next Generation Program.[35] OneCare Vermont has built off the VHCIP work previously mentioned and is collaborating with the Blueprint for Health to align efforts. To be clear, OneCare does not hire or direct the work of local care coordinators and does not direct the community's priorities, since those functions are delegated to communities in the Blueprint for Health model. However, OneCare Vermont is testing population health initiatives to drive Vermont's health care reform efforts to determine what works and could be scaled more broadly. Each of these topics will be further described below.

2.1 Current Degree of Social Service Integration with the ACO

Social service providers are being integrated into the ACO's care model through a financial distribution from the ACO's payer contracts and hospital ACO participation fees for initiatives which include:

- A Complex Care Coordination Program (paid per attributed life, per month)
- Population health programs (paid through innovation funds and special initiatives) and
- A Medicare distribution at the start of each calendar year, through a collaboration with the Blueprint for Health, to support payments for the Patient Centered Medical Homes, Community Health Teams (CHT) and Supports and Services at Home (SASH).[36]

In Vermont, 10 of 11 of the state's Designated Agencies, all 11 Home Health and Hospice Agencies, and all 5 Area Agencies on Aging have signed agreements to participate in the ACO and/or have signed contracts for OneCare Vermont's Innovation Fund grants and initiatives. Additionally, through their agreements, they participate in OneCare Vermont's complex care coordination program. Furthermore, 5 of 15 parent-child centers are working with primary care offices to implement an evidence-based model for childhood resilience with the ACO.[37] Additionally, OneCare also works with nine regional housing authorities (SASH). See Figure 1 for organization list.

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[34] Id.

[35] From "Transforming Complex Care Profile: OneCare Vermont," 2017, *Center for Health Care Strategies, Inc.* Available at: https://www.chcs.org/media/TCC-Profile-OneCare_022217.pdf

[36] From "Vermont Medicare ACO Initiative Participation Agreement," Center for Medicare and Medicaid Innovation, 2018, *Centers for Medicare &Medicaid Services.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/VAPAM%202019%20Participation%20Agreement_fully%20executed.pdf

[37] From "OneCare Vermont ACO 2020 Fiscal Year Budget Submission," by V. Loner, 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/GMCB%20ACO%20Budget%20Submission%202020%20Final.pdf

	Social Service Providers Participating in OneCare Vermont					
	Health Service Area	Parent-Child Center with Pediatric Practice Collaboration	Designated Service Agencies	Home Health and Hospice Agencies	Area Agencies on Aging	Support and Services at Home (SASH)
Medicare, Medicaid, Commercial	Bennington	--	United Counseling Service of Bennington County	VNA & Hospice of the SW Region, Bayada**	Southwest Vermont AAA	Shires Housing, Inc.
	Berlin	--	Washington County Mental Health	Centeral VT Home Health & Hospice	Central Vermont Council on Aging	Downstreet Housing & Community Development, Inc., Vermont State Housing Authority
	Brattleboro	--	Health Care & Rehab Services of SE VT	VNA of VT & NH, Bayada**	Southwest Vermont AAA	Brattleboro Housing Authority, Windham & Windsor Housing Trust, Inc.
	Burlington	Lund Family Center (Timberlane Pediatrics South Burlington)	Howard Center	UVM Health Network Home Health & Hospice, Bayada**	Champlain Valley AAA	Burlington Housing Authority, Cathedral Square Corporation, Champlain Housing Trust, Inc., Winooski Housing Authority
	Lebanon	--	Health Care & Rehab Services of SE VT	VNA of VT & NH	--	Twin Pines Housing Trust
	Middlebury	--	Counseling Service of Addison County	Addision County Home Health & Hospice	Champlain Valley AAA	Addison County Community Trust
	St. Albans	Family Center of Northwestern Counseling and Support Services (Timberlane Pediatrics Milton)	Northwestern Counseling & Support Services	Franklin County Home Health Agency	Champlain Valley AAA	--
	Windsor	The Family Place (Ottauquechee Health Center)	Health Care & Rehab Services of SE VT	VNA of VT & NH	Senior Solution--Council on Aging for SE VT	--
Medicaid, Commercial	Newport	--	Northeast Kingdom Human Services	Orleans Essex VNA & Hospice	Northeast Vermont AAA	--
	Springfield	Springfield Area Parent Child Center (Mt. Ascutney Hospital)	Health Care & Rehab Services of SE VT	VNA of VT & NH	Senior Solution--Council on Aging for SE VT	Housing Authority of the Town of Springfield
Medicaid	Morrisville	Lamoille Family Center (Appleseed Pediatrics)*	Lamoille County Mental Health Services	Lamoille Home Health Agency	Central Vermont Council on Aging	Lamoille Housing Partnership, Inc.
	Randolph	--	Clara Martin Center	VNA of VT & NH	Central Vermont Council on	--
	Rutland	--	Rutland Mental Health Services	VNA & Hospice of the SW Region, Bayada**	Southwest Vermont AAA	National Church Residences of Pittsford Vermont, National Church Residences of Rutland, Vermont, Rutland Housing Authority, Rutland SASH, LLC
	St. Johnsbury	--	Human Services, Lamoille County Mental Health Services	Lamoille Home Health Agency, Caledonia Home Health & Hospice	Northeast Vermont AAA	Gilman Housing Trust, Inc.
Does not participate	Townshend	--	--	--	--	Valley Cares, Inc.
	Totals*	5	10	11	5	19
	*Does not receive funding directly from OneCare Vermont, but is part of the network of parent-child centers enrolled in the DULCE model. **Totals based on unique providers. **Bayada has offices in the HSAs indicated above, yet serves the entire state of Vermont.					**Total* Social Service Providers: 50**

Figure 1: *Social Service Providers in OneCare Vermont's Network*

Social Service Providers: Distribution of Dollars by OneCare Vermont, by year					
	2017	2018	2019 Projected	2020 Planned	Total
Area Agencies on Aging	$94,830	$572,180	$931,162	$535,415	$2,133,587
Designated Agencies	$229,557	$1,355,499	$2,266,795	$3,398,514	$7,250,365
Home Health	$170,679	$1,029,575	$1,684,128	$1,913,538	$4,797,920
Parent-Child Centers	$0	$0	$465,000	$800,000	$1,265,000
Community Health Teams	$0	$2,245,853	$2,321,670	$2,379,711	$6,947,233
SASH	$0	$3,704,400	$3,834,054	$3,968,246	$11,506,700
Total	**$495,066**	**$8,907,507**	**$11,502,807**	**$12,995,424**	**$33,900,804**

Figure 2: Total dollars distributed to s*ocial service providers in OneCare Vermont's Network*

In relation to Figures 1 and 2 above: The Morrisville Health Service Area is still funded through the federal demonstration project they are participating in. The GMCB chose to list them as a participating

parent-child center with OneCare Vermont, since they may be involved in the statewide activities that OneCare Vermont is hosting in relation to DULCE. Secondly, in 2017, the Blueprint for Health (including the Community Health Teams and SASH) received $7.5 million directly through the All-Payer ACO Model Agreement with the federal government to continue Medicare support of the Blueprint (Section 9c ii). In 2018, these dollars were directed through the Next Generation relationship that the ACO has with CMS and CMMI.

In addition to financial payments, social service providers in OneCare Vermont access a care management electronic platform, common forms, and trainings, some of which were laid out by the VHCIP Care Management Group in 2015, for further alignment of social service providers. An analysis is provided in Section 2.1.2.

2.1.1 The Complex Care Coordination Program - Funding to Social Service Providers

The participation and collaboration agreements that OneCare Vermont signs with each agency outline their role and reimbursement levels for providing team-based care coordination for their attributed patient panel. Providers who are eligible to receive these payments are primary care providers, home health agencies, and designated agencies for mental health and substance abuse treatment.

The following deliverables, found in OneCare Vermont's participation and preferred provider agreement, are listed as requirements for one or more community-shared resource staff to execute in order to be eligible to receive payment:

1. attend a care coordination training session
2. conduct outreach to a set population, identified in OneCare Vermont data, to patients identified as high and very high risk
3. engage the identified high and very high-risk patients in care coordination (with parameters for how often these individuals should be touched based on their risk level)
4. utilize Care Navigator or other methods agreed upon by OneCare Vermont to create shared care plans, communicate with providers, and document outreach to attributed individuals
5. define the roles and relationships with continuum of care partners (home health, designated agencies, primary care, and skilled nursing facilities) and human service organizations (Department for Children and Families (DCF), housing transportation)
6. participate in person-centered shared care planning and care conferences
7. support effective transitions in care (*for primary care providers only).*

Based on OneCare Vermont's ongoing analysis of their patient population, OneCare Vermont has determined that a 15% target is appropriate for the total number of attributed lives who would benefit from active care management. However, the network has not yet achieved this level of care coordination engagement, reporting 7-8% engagement thus far for the Medicare and Medicaid populations in 2019. To discuss the data and identify opportunities for change in the care coordination program, they held 5 focus groups in February and March of 2019 to evolve the payment model. Over July and August of 2019, OneCare Vermont met with over 250 senior leaders from each Health Service Area in Town Hall meetings. These conversations resulted in a restructuring of the payments for 2020. One insight that resulted from the focus groups was that to maintain appropriate staffing levels, the investments needed to be adequate. The 2017-2019 model was structured as a capacity-building framework to ensure that participating organizations were paid based on anticipated engagement levels. In 2020, the perspective is that this will change the program to a value-based model, paying for

care coordination engagement and outcomes. Below documents the 2017-2019 program payments and the increase in payments for 2020.[38]

The payment structure for these deliverables for 2017-2019 was the following:

1. Care Coordination - $15.00 per adult attributed life per month (PMPM): must meet all the deliverables above
2. Patient Activation Payment – a onetime payment of $150.00: distributed once a patient has been engaged
3. Activation of Shared Care Plan - $10 per adult attributed life per month: distributed once a patient has a shared care plan entered into Care Navigator.

The 2020 complex care coordination payment structure for returning ACO participants:

1. Lead Care Coordinator - $80.00 per adult attributed life per month: effective the month the Lead Care Coordinator and Shared Care Plan are designated in Care Navigator
2. Care Team - $60.00 per adult attributed life per month: effective the month the Care Team member and Shared Care Plan are designated in Care Navigator.
3. Care Conference: Lead Care Coordinator - $300.00 per adult attributed life per year: paid once per year after a qualifying care conference is documented in Care Navigator.
4. Care Conference: Care Team - $150.00 per adult attributed life per year: paid once per year after an eligible provider who participates in the Care Team and in the care conference for the attributed life.[39]

2.1.2 The Complex Care Coordination Program - Program Support for Social Service Providers

OneCare Vermont measures these activities of the care team members with statewide electronic tools, statewide process and outcome metrics for measuring success, and policies and procedures for implementing the complex care coordination program. In reviewing the history of Vermont's payment reform initiatives, GMCB reviewed a report from the VHCIP Care Management and Care Models Workgroup in 2015 which identified areas to reduce duplication and improve care management in Vermont. GMCB has provided an analysis on steps OneCare Vermont has taken, with state and local partners, to implement a statewide integrated care management model utilizing the local social service provider network:

[38] From "OneCare Vermont ACO 2020 Fiscal Year Budget Submission," by V. Loner, 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/GMCB%20ACO%20Budget%20Submission%202020%20Final.pdf

[39] From "Risk-Bearing Participant & Preferred Provider Agreement," 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/Part%202%20Attachment%20E%20-Provider%20Contracts%20and%20Addendums.pdf

A Comparison of the VHCIP's 'Care Management in Vermont: Gaps and Duplication' Report and OneCare Vermont's Care Model	
Findings from 2015 Care Management and Care Models Workgroup[40]	**OneCare Vermont's Integrated Care Model**
Increased process standardization, including increased use of common care management tools;	• Adopted a Unified Shared Care Plan for all care coordinators to use with patients across the state.[41] • Developed a Care Coordination Toolkit for all care coordinators to use with information detailing stratifying risk, screening patients, assessing and planning for patients' needs, and implementing care plans and following up with patients. [42] • Use an online electronic care coordination platform (Care Navigator), which allows multiple care coordinators to view and coordinate one patient.[43]
Creation of an organizational mechanism to coordinate the "family of care coordinators;"	• Allow a patient to designate one provider as their "lead care coordinator" in their Unified Shared Care Plan and Care Navigator. This reduces duplication but allows all coordinators to still be involved in the patients care.[44]
Increased development and use of IT resources to coordinate care management activities;	• Built an online platform (Care Navigator) that services as a communication and coordination tool to coordinate care. The system contains medical risk data, population health data, and flags to support patient identification and prioritization for care coordination. It also captures care team composition and encounters. • Build applications within WorkBench One that allow providers to monitor their process

[40] From "Care Management in Vermont: Gaps and Duplication," 2015, *Bailit Health Purchasing, LLC.* Available at: https://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Care%20Management%20in%20VT%20-%20Gaps%20and%20Duplication%202015-08-31.pdf

[41] From "2019 Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC," Green Mountain Care Board, 2018, *State of Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/2019%20Certification%20FINAL.pdf

[42] From "OneCare Vermont Care Coordination Toolkit," 2019, *OneCare Vermont.* Available at: https://www.onecarevt.org/wp-content/uploads/2019/07/OneCare-Vermont-Care-Coordination-Toolkit-2019.pdf

[43] Id.

[44] From "Risk-Bearing Participant & Preferred Provider Agreement," 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/Part%202%20Attachment%20E%20-Provider%20Contracts%20and%20Addendums.pdf

	toward engagement of patients in the care model.[45]
Increased use of a shared data set to coordinate care and measure effectiveness; and	• Has network-wide measures for Care Coordination that are built into WorkBench One. • Provides data literacy training to support population health management through increased understanding of OneCare's data, standard reports, analytics tools, and elbow-to-elbow support to address specific clinical questions. OneCare has specific quality and health management requirements in their agreement with the state, including number of trainings for quality improvement and data. OneCare Vermont self-reported that, as of October 2019, they have conducting 37 trainings on data with more than 160 users.[46] • Has provided 75 trainings in 2019 on Care Navigator, educational forums on Care Management, and educational sessions on evidence-based care for certain clinical diseases.
Increased opportunities for care managers to build their skills through initiatives to share best practices and learn new skills.	• Convenes monthly Northern and Southern Care Coordination Core Teams to advance adoption of the model, address systems barriers, and share lessons learned across communities.

Figure 3: *Comparison of VHCIP Care Management and Care Models Workgroup with OneCare Vermont's Care Coordination Model*

Outcomes of the Complex Care Coordination Program to date

The following detail was provided OneCare Vermont's 2020 Budget Submission to the GMCB on the current utilization of Care Navigator (the electronic care coordination platform for social service providers to enter and track patient care to increase communication across the care continuum):

- 157,000 enrolled patients in Care Navigator
- 700 providers actively using Care Navigator across 75 organizations
- 11,360 patients in Care Navigator with active care coordination status. The patient's care team has a Lead Care Coordinator, and then may have the additional composition of team members from home health, primary care, the designated agency, the area agency on aging, and SASH.[47]

OneCare Vermont has also noted preliminary results from the last 12 months from the complex care coordination program. Trends are showing a decrease in Emergency Department (ED) utilization rates

[45] OneCare Vermont: Clinical Programs: https://www.onecarevt.org/patient-programs/

[46] From "Contract for Personal Services: Amendment and Restatement," DVHA, 2018, *State of Vermont.* Available at: https://dvha.vermont.gov/administration/1onecare-aco-32318-3-final-signed-with-exhbits.pdf

for the high and very high-risk cohorts. A pre and post analysis of the intervention group demonstrated statistically significant reductions in ED utilization in the first 6 months of the intervention for Medicare (33%) and Medicaid (13%). OneCare states that other outcomes will be monitored, but due to small numbers and limited time in the intervention cohorts, conclusions cannot yet be made. They are updating numbers monthly and expect to be able to perform a more robust analysis in 2020-2021.[48,49]

2.1.3 Innovation and Special Initiative Funding

Since 2017, OneCare Vermont has expanded funding for community initiatives, divided in two ways: a) special initiatives identified by their Board and subcommittees and b) a grant-based program started in 2019 called the OneCare Vermont Innovation Fund. Both are based upon evidence, replicability, and alignment with OneCare Vermont's clinical goals. It is to be acknowledged that OneCare Vermont has other initiatives, and that this report only reports on the list of projects *specific to social service providers noted by this report*, including home health, designated agencies, and the parent-child centers.

Below you will find them shown by year, and then described in the special initiative and innovation fund sections respectively.

2017-current

- Supports and Services at Home (SASH)
- A portion of Community Health Team funding (CHT)

2018-current

- Howard Center and Cathedral Square (designated agency services at a SASH housing site)

2019-current

- DULCE (parent-child center and legal aid services at a pediatric practice)
- Emergency Room Support (designated agency services at a hospital site)
- Longitudinal Care Pilot (hospitals and home health)
- United Counseling Service (UCS) of Bennington, in collaboration with Southwestern Vermont Medical Center (designated agency services at a hospital site)
- University of Vermont Medical Center (UVMMC) Children's Hospital and the Janet S. Munt Family Room (primary care services at a parent-child center)

2.1.4 Description of Special Initiatives

1. **Supports and Services at Home (SASH) and Community Health Teams (CHTs)** (~$5M yearly) Originally funded by the Medicare Advanced Primary Care Program, the Vermont All-Payer ACO Agreement allows OneCare Vermont to receive a financial distribution from Medicare to continue the funding for SASH, CHTs, and the Medicare per member per month payments for primary care (which otherwise was to end at the end of 2016). SASH works to reduce Medicare expenditures by providing transition support after a hospital or rehabilitation stay, self-management education for chronic conditions and health maintenance, and care coordination. The CHTs are led by local

[48] From "OneCare Vermont ACO 2020 Fiscal Year Budget Submission," by V. Loner, 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/GMCB%20ACO%20Budget%20Submission%202020%20Final.pdf

[49] From "OneCare Vermont 2020 Budget Presentation," 2019, *OneCare Vermont.* Available at: https://gmcboard.vermont.gov/sites/gmcb/files/documents/2020%20OneCare%20Budget%20Presentation%20DF2%20SUBMIT.pdf

Blueprint leadership and provide supplemental patient and population health management to support patients with social and economic services that can help support healthy living.[50]

2. **Developmental Understanding & Legal Collaboration for Everyone** (DULCE) ($465,000 in 2019; $800,000 in 2020)

In collaboration with the Vermont Department of Health (VDH), in 2019 OneCare Vermont funded an expansion of the evidence-based DULCE program from 1 to 5 parent-child centers, including funding for a statewide program coordinator and for research to measure the program's outcomes.[51] DULCE began as a randomized controlled trial at Boston Medical Center's Pediatrics Department in 2010. VDH and Lamoille County have been part of a national DULCE pilot since 2016, with the Lamoille County Parent Child Center employing a DULCE Family Specialist who is embedded in a Lamoille County Federal Qualified Health Center's pediatric practice. The Family Specialist works with families who are receiving services at the parent child center to identify additional social, medical, and legal support (through a contract with Vermont Legal Aid) needed during the first six months of a child's life.[52] The following are the parent-child centers who are collaborating with their local pediatric offices through funding that is distributed to their local pediatric office by OneCare Vermont:

- Northwestern Counseling & Support Services
- Lund Family Center
- The Family Place
- Springfield Area Parent Child Center

3. **Emergency room support provided by designated agencies** ($500,000 in 2019)

are working in collaboration with OneCare Vermont, Vermont Care Partners and local hospitals to assure that individuals, who present at the Emergency Department with a mental health and/or substance use issue, are offered follow-up treatment and support services to match their needs. The value of coordinated care and the importance of timely follow-up after an emergency department visit cannot be understated. Beginning in late 2019, OneCare Vermont's one-year investment in this project will support staff in the Emergency Departments to ensure available follow-up care:

- Washington County Mental Health Services
- Northwestern Counseling & Support Services
- Northeast Kingdom Human Services

4. **Howard Center and Cathedral Square** ($152,000 between 2017-2019; $55,000 in 2020)

OneCare Vermont worked with the Howard Center and SASH to improve access and utilization of mental health and substance abuse services by residents in low-income housing. It has funded a full-time mental health clinician through the Howard Center to support residents at two Burlington congregate housing locations where SASH has programs (e.g. hosting groups, meeting residents one-on-one, and joining staff meetings and team discussions on SASH participants).[53]

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[50] From "Annual Report on the Vermont Blueprint for Health," by B. Tanzman, 2019, *Vermont Agency of Human Services, State of Vermont.* Available at: https://blueprintforhealth.vermont.gov/sites/bfh/files/2018_Blueprint_for_Health_Annual_Report_final.pdf

[51] Id.

[52] Id.

[53] From "Memorandum: 2019 Certification Eligibility Verification for OneCare Vermont," Green Mountain Care Board, 2019, *State of Vermont.* Available at:

Preliminary outcomes as documented in the 2018 Annual Blueprint for Health Report include:

- Greater and faster access to mental health supports – 78% of pilot participants had their first encounter with the clinician within 0-1 days of a referral- with the majority seen the same day.
- Increased self-management of mental health conditions – 80% of surveyed participants reported being "more able to cope with daily life" due to pilot services.
- Reduced stigma to seeking mental health supports – 30% of referrals to clinician were self-referrals and almost 80% of surveyed participants felt there was less stigma associated with seeking support for emotional issues due to the pilot.

The following is an account of a patient, provided by a SASH coordinator, who was impacted by the Howard Center and Cathedral Square collaboration:

A senior participant was formerly homeless and moved into Cathedral Square SASH housing in June 2019. Initially refused to sign up for SASH and not interested in seeing the embedded mental health clinician. Participant had immediate issues- he had failed an apartment inspection 3 times due to unsafe amounts of stuff in apartment leaving inadequate egress. Participant was not paying rent and was issued seven notices for non-payment of rent. Police report was sent to SASH staff regarding his assault of another resident. After many attempts by property management to resolve issues, Participant was issued a "notice to quit." Participant stated to housing staff that he was going to take his life if evicted from apartment. SASH Coordinator immediately met with him and went through suicide prevention protocol. Participant agreed to meet with embedded mental health clinician and sign up for the SASH program. A SASH assessment conducted by Wellness Nurse and learned that he has multiple chronic conditions including alcoholism, lacked all his medications and was at high nutrition and loneliness risk. Participant has been fully wrapped around with SASH and mental health pilot services and has had no issues living at the apartment since September. He has had all his prescriptions transferred to the local pharmacy, is seeing a primary care provider and the mental health clinician on his terms (usually on the bench outside where he can smoke).

5. The Longitudinal Care Pilot ($500,000)

Over the last two years, the UVM Health Network Home Health and Hospice (UVMHHH) has successfully demonstrated that "longitudinal care" reduces hospital admissions and emergency department visits for certain at-risk patients. OneCare Vermont reported during their October 30, 2019 GMCB Budget Hearing that the program resulted in a 30% reduction in total cost, a $1,150 savings on a PMPM basis. Costs were reduced largely as the result of decreases in emergency department visits (20%) and inpatient admissions (26%) for people participating in the program, comparing their utilization pre and post intervention.

Under the program, patients who meet certain criteria are enrolled in the program when they are "discharged" from traditional Medicare-eligible skilled home health services. Because the patients are enrolled at discharge from home health services, they are well-known to the agency. Patients in the program have full onset chronic illness with rising risk or they are complex/high cost with acute catastrophic conditions. The VNAs of Vermont is partnering with OneCare to expand the program to nine additional health services areas in 2020. The program will provide for extended support and chronic care management for high-risk patients when they are no longer eligible for traditional

https://gmcboard.vermont.gov/sites/gmcb/files/Updated%20Memo%20re%202019%20Certification%20Eligibility%20for%20OneCare%20Vermont.pdf

home health care. It will provide continuity of care through acute episodes to give patient's more time to stabilize. It will allow for coordination of care across medical and non-medical care providers using a patient-centered care model that provides tools and supports to enable patients and their family members to better manage care.

Eligible patients will be selected using the following criteria:

- One or more high-risk chronic diagnosis (CHF, COPD, Diabetes)
- Recent hospitalizations or emergency department utilization
- Barriers to self-management such as anxiety and depression

2.1.5 OneCare Vermont Innovation Fund Projects

6. **Building Strong Families Clinic** ($245,223 funding award)

In 2019, through a partnership between the University of Vermont Medical Center (UVMMC) Children's Hospital and the Janet S. Munt Family Room, a Building Strong Families (BSF) Clinic[54] has been designed to provide pediatric checkups on the second floor of the Janet S. Munt Family Room. While families come in for pediatric checkups for new Americans, newly hired family strengthening workers (FSWs) will support families by providing guidance and assistance to groups who are dealing with increased risk to social determinants of health, such as poverty, housing, and employment.[55]

7. **TeleCare Connection** ($205,381 funding award)

This is a partnership to use technology to offer 24-hour remote monitoring with in-person professional support to individuals transitioning from hospital to home in the Burlington Health Service Area. TeleCare Connection (TCC) is an integration of Howard Center's overnight Tele-support Solution and UVMHN HHH's Tele-monitoring Program. This program intends to reduce hospital readmissions, avoid out-of-home care.[56]

8. **Telemedicine and Home Health for ALS Patients** ($143,300 funding award)

The UVM Medical Center Neurology department in Burlington and UVM Health Network Home Health & Hospice in Colchester are partnering to provide home-based, patient-centered care to patients with amyotrophic lateral sclerosis (ALS), a neuro-degenerative disease. The proposal uses a combination of telemedicine and in-home care by a visiting nurse to allow patients with ALS from across Vermont to receive care and connect with their specialists without the need to travel.[57]

9. **Psychiatric Urgent Care for Kids** ($124,660 funding award)

United Counseling Service (UCS) of Bennington will work to reduce emergency room trips for students requiring behavioral intervention services during school hours. Over 260 students per quarter are transported from school to the emergency room at Southwestern Vermont Medical Center (SVMC) when their behavior becomes unmanageable. The grant funds a therapeutic

[54] From "All Are Welcome at the New Building Strong Families Clinic," by A. Wack, 2019, *OneCare Vermont.* Available at: https://www.onecarevt.org/bsf-clinic/

[55] From "OneCare Vermont Awards over $500,000 in Funding to Local Communities in First Funding Cycle," by A. Bodette, 2019, *OneCare Vermont.* Available at: https://www.onecarevt.org/wp-content/uploads/2019/06/2019-Innovation-Fund-press-release.pdf

[56] From "Five projects from across Vermont selected in the second round of the Innovation Fund," by OneCare Vermont, 2019, *VermontBiz.* Available at: https://vermontbiz.com/news/2019/november/07/five-projects-across-vermont-selected-second-round-innovation-fund

[57] Id.

psychiatric urgent care center[58] at UCS's office, directly across the street from SVMC, where children can receive short-term, family focused interventions. UCS's urgent care center intends to reduce emergency room visits, support students and their families through behavior intervention, increase accessibility to mental health services for children, and bridge the gap between health and social care services.

10. Telefriend ($71,613 funding award)
An Automated Tele-health Intervention – The Brattleboro Retreat's TeleFriend project will provide individuals with serious mental illness (SMI) a personalized tablet-based, tele-health intervention during their first 30 days post-discharge from inpatient psychiatric treatment with the intent to reduce hospital readmissions and improve patient outcomes for people with SMI. The tablet has been used for over a decade for people with chronic or unstable medical conditions and has been piloted for use in outpatient mental health settings. This will be the first application of Telefriend to help patients transition from inpatient psychiatric care to the community.[59]

2.2 Extent to which OneCare Vermont is Addressing Childhood Trauma and Resilience Building

OneCare Vermont is addressing trauma and resilience building through funding of the DULCE model (previously described), developing partnerships at the state and national level, and direct care coordination. The GMCB recognizes that Section 3 of Act 52 also recognizes the leadership role of AHS in resilience building and trauma and looks forward to their presentation in the legislature in January 2020. Per certification and budget requirements in GMCB's Oversight Process, OneCare Vermont reported in April 2019 three areas of focus with associated activities:[60]

1) Systems Alignment and Integration

- Collaborating with the Mental Health & Health Care Integration Director at the Department of Mental Health and the Director of Quality at an FQHC to potentially introduce trainings around NEAR science—Neurobiology, Epigenetics, ACES, and Resiliency—to medical and social service providers in order to increase proficiency and align providers with "new knowledge, resources and techniques to promote resiliency."[61]
- Working to bring school nurses into the care teams addressing the needs of Vermont children in public schools.

2) Coordination of Care

- Funding four parent-child centers/pediatric practices for DULCE model (previously described)
- Provided opportunity for fifteen DULCE local team members to Washington DC for a national training to focus on the "reduction of toxic stress in early childhood through preventative screening, outreach, and connection to community services."[62]
- The OneCare Vermont Pediatric Subcommittee is exploring possible options for improving the pediatric complex care coordination program, including how to identify and screen children for social, economic, and legal risks that could be impacting their health.

[58] Id.
[59] Id.
[60] FY2019 Budget Order Monitoring and Reporting: https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/1Q19_ACO%20reporting_post%20to%20web.zip
[61] Id.
[62] Id.

3) Advancing Data-Driven Approaches Population Health Management

- Developing a data-driven approach to identify populations at increased risk of social determinants of health through a collaboration with Algorex Health. The goal of this program is to increase coordination and improve timeliness and communication between providers.
- Collecting, monitoring, and tracking data focused on specific clinical priority areas in the ACO network, such as the emergency department visit rates for pediatric patients with asthma.
- Collaborating with the Agency of Human Services to develop better pathways to integrate social needs data in order to enhance care and reduce duplication of services.

Additional to this report, OneCare Vermont, AHS, and DVHA will be participating in an initiative through the Robert Wood Johnson Foundation, *Advancing Integrated Models* (AIM), to identify best practices through learning and technical assistance that will improve care for individuals with complex social and health needs. The four main focuses of the grant are: complex care management, trauma-informed care, physical and behavioral health integration, and mechanisms to address health related social needs. Vermont was chosen in September 2019 as one of eight national sites.[63] The focus for Vermont will be to address the technical and legal challenges associated with sharing data across health and human services to support both person-centered identification of needs and opportunities to connect to community resources and programs (e.g. WIC, fuel assistance), and examining population-level variation and considering ways in which this added social determinant of health data could inform future payment model and care delivery transformation initiatives.

2.3 Input from Individuals or Families Attributed to the ACO and Receiving Services

OneCare Vermont has a Patient and Family Advisory Committee that meets regularly and is comprised of individuals enrolled in OneCare Vermont who utilize social services, whom the GMCB posed several questions to in order to hear ideas and suggestions for further integration. Largely, the group was most interested in ensuring that medical and social service organizations are working together, and not, in the committee's words, 'triangulating through OneCare Vermont.'

The committee's ideas included:
1) Increase connections with schools who interact with Vermont youth every day, stating that school nurses, counselors, social workers, and teachers could have an increased role to bridge the gap between social determinants of health identified in schools and their providers.
2) Expand the use of Care Navigator to include more individuals than just the higher risk populations, because as risk for an individual is elevated, they suggested Care Navigator could be used to drive earlier interventions to prevent a patient from reaching 'high risk.'
3) Increase interaction between social service providers and the medical community, building on connections and establishing relationships within communities. For example, the committee suggested that social service providers go to medical practices in their area and discuss how they can work together to serve the needs of their community. There could be more conferences, workshops, and fairs to increase communication for the social service and medical fields, allowing them to identify how they can support one another.

[63] From "OneCare Vermont Selected for National Multi-Site Demonstration for Advancing Integrated Care Models for People with Complex Needs," by A. Wack, 2019, *OneCare Vermont.* Available at: https://www.onecarevt.org/aim-2019/

The committee was also asked what OneCare Vermont could be doing to better support development of integration. In response, the group suggested that OneCare Vermont increase communication with social service organizations to determine what the current connections between medical and social service providers are, and then have conversations to help further those connections. The committee also agreed that OneCare Vermont should increase communication with the Vermont Developmental Disability Council and the Green Mountain Self Advocates as additional populations, such as individuals receiving long- term services and supports (LTSS), should be incorporated into the model.

GMCB and AHS also held a stakeholder meeting that included state and community-based participants, OneCare Vermont's COO, and a Board Member who is their Medicaid representative. The group discussed Vermont's current state of integration, benefits and barriers of integration, and untapped opportunities currently existing in the state. Recommendations from the meeting centered on aligning goals, accountability, and metrics across state agencies, increasing the scale and scope of care coordination, and using community needs assessments to identify integration opportunities. See Appendix I for a summary of the meeting and a list of stakeholders in attendance.

Section 3. Key Considerations

For this report the GMCB was asked to provide recommendations, if appropriate, on ways to further integration of Vermont's social service providers into the ACO. While the GMCB does not currently have specific recommendations for the legislature, the GMCB offers the following considerations and reflections.

GMCB observes that OneCare Vermont and Vermont's social service providers are working through a data driven approach to test and implement a care coordination model that utilizes local, community-based providers at home health, designated agencies, area agencies on aging, SASH, parent-child centers, and primary care. The GMCB will continue to monitor, using authority under Act 113 for ACO oversight, how a value-based payment model can fund and test new initiatives while integrating social service providers within the health reform design. The Board will be receiving ongoing reporting on initiatives that OneCare Vermont is testing, and will look for effectiveness of programming, plans for scaling successful initiatives, sunsetting those that are not, and opportunities for sustainability.

Vermont's history of health care reform, as demonstrated earlier in this report, illustrates the desire of community partners to harness and align their existing knowledge and skills and local resources rather than create new, potentially duplicative programs or services. During the stakeholder meeting held by the GMCB and AHS, state and local representatives were excited to engage on the topic of integration, acknowledged that the definitions of social services and integration up for interpretation, and often listed common priorities and barriers to success. For example, the group identified the same social determinants of health, housing, food, and transportation that are listed in the Vermont State Health Improvement Plan of 2019-2023 as barriers to wellness for Vermonters. Integration efforts in Vermont must continue to take into consideration availability and/or limitations of funding, operational, legal and technological barriers around sharing of data, payment limitations, state and federal regulatory requirements, state agency priorities, and the state's goals for population health, including the All-Payer ACO Model Agreement goals.

Section 4. Appendix

The GMCB consulted with a group of stakeholders on November 1, 2019 to discuss the integration of social services into the ACO and Vermont. The over twenty-five participants included social service providers, state employees, and representatives of the ACO.

Facilitated by Board member Jessica Holmes, Ph.D., the participants of the stakeholder meeting broke out into small groups to answer the following questions:

1. Which social services should be integrated into the ACO and which should not (if any)?
2. What do we really mean by *integration* of social services into the ACO (e.g., financial integration, care model integration, co-location of services, shared financial accountability, shared quality accountability, etc.)? How should we prioritize the various types of integration and their relative impact?
3. What value is generated from integration and if we are successful at integration, how will we know? What specific metrics should we use to assess the impact of integration?
4. Where is there evidence of successful integration in the current system? Are there best practices in other states where we might draw inspiration?
5. Where do you see untapped opportunities for successful integration in the current system? How might we unleash these untapped opportunities?
6. Where do you see barriers to successful integration? How might we overcome barriers to successful integration?

Coming together to discuss the answers to the questions, the stakeholders collectively agreed that defining integration of social services was one of the most difficult parts of the conversation. Integrating social services can be a broad conversation that can include more than integrating solely into the ACO, which is how Act 52 narrowly dictates this report focus on.

The group generally agreed that the priority in integration should be for alignment of goals, metrics, and accountability across health, human service, and education agencies. There was discussion of applying a protective framework that is evidence-informed, such as the Strengthening Families approach,[64] across the lifespan of Vermonters to help align population health goals. Removing organizational barriers to integration will be key as well. Stakeholders identified that current barriers include deep rooted history and culture of organizations that prevent growth and collaboration across sectors, workforce shortages, a lack of consistent data, among others. The group also discussed the need for increased services in Vermont by increasing the scale and scope of care coordination. This will have to incorporate an identification of need for the communities around Vermont.

The conversation at the stakeholder meeting was robust and comprehensive. Participants felt as if this is only the beginning of the conversation about integration and that further discussion is required to explicitly outline next steps.

[64] From "Five Protective Factors," by Strengthening Families, a project of the Center for the Study of Social Policy, 2009, *U.S. Department of Health and Human Services.* Available at: http://nationalacademies.org/hmd/Reports/2019/integrating-social-care-into-the-delivery-of-health-care.aspx

Attendance List for the November 1, 2019 Stakeholder Meeting

Name	Title	Organization
Bard Hill	Director of Policy and Planning	AHS, DAIL
Monica Hutt	Commissioner	AHS, DAIL
Megan Tierney-Ward	Division Director	AHS, DAIL, Adult/Seniors Division
Karen Vastine	Senior Advisor to the Commissioner	AHS, DCF
Selina Hickman	Director of Policy	AHS, DMH
Mourning Fox	Deputy Commissioner	AHS, DMH
Jenney Samuelson	Deputy Commissioner	AHS, DVHA
Pat Jones	Deputy Director of Payment Reform	AHS, DVHA
Auburn Watersong	Director of Trauma Prevention and Resilience Development	AHS, Secretary's office
Ena Backus	Director of Health Care Reform	AHS, Secretary's office (by phone)
Helen Labun	Director of Public Policy	Bi-State Primary Care Association
Molly Dugan	Director	Cathedral Square Corporation, SASH
Kim Fitzgerald	CEO	Cathedral Square Corporation, SASH
Lucie Garand	Government Relations Manager	DRM
Scott Johnson	Consultant	DULCE Vermont Team
Jessica Holmes	Board Member	GMCB
Alena Berube	Director of Value Based Programs and ACO Regulation	GMCB
Sarah Tewksbury	Health Policy Analyst	GMCB
Danielle Lindley	Director	Northwestern Counseling & Support Services
Sara Barry	COO	OneCare Vermont
Sierra Lowell	Consumer Representative	OneCare Vermont
Rosemary Greene	Business Operations	Southwestern Vermont Center on Aging
Judy Peterson	President and COO	UVM Home Health Network
Simone Rueschemeyer	Executive Director	Vermont Care Partners
Breena Holmes	Maternal and Child Director	Vermont Department of Health
Jill Olson	Executive Director	VNAs of Vermont