Testimony to: Senate Health and Welfare
By: Mary Moulton, Executive Director, Washington County Mental Health Services
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Subject: *How is a publicly funded model accountable to the public: cost, quality and access to health care*

Good Morning. My name is Mary Moulton. I am the Executive Director for Washington County Mental Health Services, one of 10 designated agencies in the State. I am also a Board Member on the Community Health Accountable Care (CHAC) organization , a member of the MOU ACO Steering Committee, working on consideration of bringing the 3 ACOs into one; and the Project Coordinator for the Learning Collaborative in Central Vermont. The Designated and Specialized Service Agencies bring important value and play a critical role in in Vermont's health care system. We have substantial expertise, knowledge and relationships with many of the complex and high needs populations and we have all been participating to some degree within our regions on health care coordination, collaboration and integration. Designated agency staff participates on multiple committees now generated by the ACOs in order to bring the community voice to the table.

The social determinants of health are crucial to the success of health care and we have been successful in addressing them to support our clients. We are also seeing a growing appreciation by our health care colleagues of their importance. ACES research shows the importance of family based mental health services on long term health outcomes. The national data shows that over 40% of health care costs are related to co-occurring MH/SA conditions.

As community based providers, we have a sound foundation in working toward regional integration and have always found that having an involved primary care provider can make a considerable difference in bending the curve. Our regions now gather with an eye on specialized focused projects directly related to identifying individuals who have high utilization, high spend, chronic conditions. In Washington County, we are engaged on different fronts. With One Care, we have established the Learning Collaborative and are receiving training, across provider groups, on similar assessment tools with the goal of establishing a shared care plan. With CHAC, we have identified common clients and shared releases and are working throughout the state on similar care coordination efforts. In one pilot, we already have results where we identified interventions that were put in place by specialty services through the VNA and mental health referrals to reduce primary care provider and emergency room visits. Again, this accentuates the importance of home-based treatment and supports. In our area, we have also been increasing the collaboration within PCP offices/clinics through provision of therapists on-site. Learning how to best balance governance, financing and service delivery models is all a work in progress. We are pleased to have legislative involvement in developing this process and to point out that, for us, all of this work has been performed with no additional infrastructural support.

The Administration has recently committed to move forward with the development of payment and delivery system reforms for designated agencies during the 3rd year of the SIM demonstration and in preparation for participation in the All-Payer Model waiver. We are hopeful that working together, we will design a value based payment and will invest in provider readiness for this change. The stated goal is to establish a new payment methodology, which will align with the all-payer model arrangement; the structure and pathways for inclusion in the APM and in the ACO will be designed within the first year of APM implementation. We are not currently included in the APM and believe that, if Vermont continues

on this course, the construct of both the ACO governance and the APM is crucial to creation of a health care system that allows clients/patients to navigate seamlessly between the doctor's office and specialized services, treating Vermont's most vulnerable populations. We believe that the APM has great potential in the creation of a complete system of care, but currently the model presented is far from complete. We believe we are the most cost effective and impactful sector of the health care system and in order to fully participate in development of a concentric health care system, we must see a greater investment in adequate resources for services. You know the challenges we face with 27.5% average statewide turnover rate, as well staff vacancies that can't be filled, because the state, schools and hospitals are paying sometimes $10,000 to $35,000 more for staff than our reimbursement rates allow. In fact, due to the reductions in group therapy rates and Applied Behavioral Analysis rates by DVHA, we are closing successful and needed programs down.

I would offer, lastly, that although dollars are tight this is a value-based discussion. Health dollars spent on the designated agency and specialized services system will make the most impact on the triple aim if we have enough resources to fully and effectively address population health with well-paid, experienced and qualified staffing. This means that money now slated for the top tier of the health care arena needs to come down to the community and we advocate looking toward the APM allowable trend rate as a place where money can be specifically allocated for these crucial services and the creation of an integrated system of care.

We would be wise to remember that it is community services that emptied out state hospital beds and maintains that system on a thread; and it is the community that closed Brandon Training School, developing one of the most advanced systems for people with developmental challenges in the country; and it is the community that closed nursing home beds throughout the state, achieving more and more home based care.

It is essential that the investment in community based services, to include home health, Area Agencies on Aging and Designated and Specialized Service Agencies be made up front, just like we did in the other efforts to deinstitutionalize populations. The All Payer Model will require a significant investment of resources in both the ACO(s) and in the community infrastructure to start shifting the balance from high cost hospital care to more cost effective community care. We should not proceed with the expectation of savings, unless we fully enable community providers to do our jobs. We are ready and able, but given our current underfunding we are working with "one arm tied behind our back".

If we think about where we want to be tended when we are ill, most of us would say, "at home." If we think about how to best improve health, most of us know the answer is in community based care.

Thank you for allowing me to testify today.