Testimony to the VT Senate Finance Committee April 23, 2015

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In Caledonia County and southern Essex County many of the providers of health and human services have come together to integrate our services and to address community health needs in collaborative ways. Involved partners include NVRH, NEKHS, NCHC, NEVAAA, Caledonia Home Health, NEK Community Action, VT Health Department, Rural Edge (public housing), and the Vermont Foodbank. We meet monthly to discuss issues, and progress, but more importantly we are actually engaged in real change efforts. They include the following:

Accountable Health Community – We believe that real health reform will happen at the local level, with integration of services and focus on prevention, early intervention and addressing the "non-medical determinants of health". We have submitted a grant proposal to HRSA for funding to help us formalize such an integrated system of care, called an Accountable Health Community.

Dual eligible grant project – Dually eligible persons are the most challenging to care for and most expensive in health care. We receive funding from VHCIP to develop a system to better serve them and reduce expenditures. We are 6 months into the grant. Partners include NVRH, NEKHS, NCHC and Caledonia Home Health, and the AAA.

Care management collaborative – VCHIP has identified three areas of the state to develop care management collaboratives. Caledonia County is one area. Building on the Duals partnership, we are working to develop a seamless, integrated system of care management for all providers, including other primary care sites besides the partners noted above.

Integration of mental health and FQHC services – Integration of mental health with primary care has long been a system goal. NEKHS and NCHC are completing a pilot agreement for NEKHS to place mental health counselors in a NCHC primary care site and a nurse practitioner in an NEKHS site. This arrangement currently exists in other FQHC areas.

DART 2.0 – A group of health and services providers – including the above named organizations - has been meeting regularly to develop a response to the opiate addiction epidemic in Caledonia County. It is a fully integrated group including BAART (the hub), primary medical home practitioners (spokes), the hospital, housing providers, the Dept of Corrections, Vermont Cares, the municipal police, the Kingdom Recovery Center, Bess O'Brien (Hungry Heart producer), a NAMI representative , people in treatment, people from the faith community, and others. It is led by the Restorative Justice Center. Successes so far has included reducing the waiting list for opiate addiction treatment from about 150 to 32 in Caledonia County. We expect that waiting list to go to zero by July.

Opiate prescribing. The hospital and all primary care practices met recently to develop a unified response to pain treatment and opiate addiction. The group will develop standard practices to ensure the best opiate prescribing practices and pain management.

Self neglect – So called "self-neglect" cases are those involving an individual with a cognitive impairment in declining health, with many needs, but refusing care and services *(this definition excludes people who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style, personal preference or religious belief and who understand the consequences of their decision.).* They require a complex, unified response of several agencies. NCHC , Caledonia Home Health, NVRH, NEKHS and the AAA are working to develop such a unified approach with defined roles to ensure these challenging situations are resolved carefully and successfully, with respect for the individual's self-determination.

Strategic Planning – Agencies in the county have shared their strategic plans to, as much as possible, ensure they are in sync.

Participation on each other's boards – Agencies share members on each other's boards as a way to enhance communication and strategic planning.

We have been working with the Vermont Food Bank to develop a plan for the county that will **eliminate hunger.**

Our main goal is to find synergy among all the separate efforts to address chronic socio-economic challenges that affect the health of our communities.

St Johnsbury Health Service Area
A Team

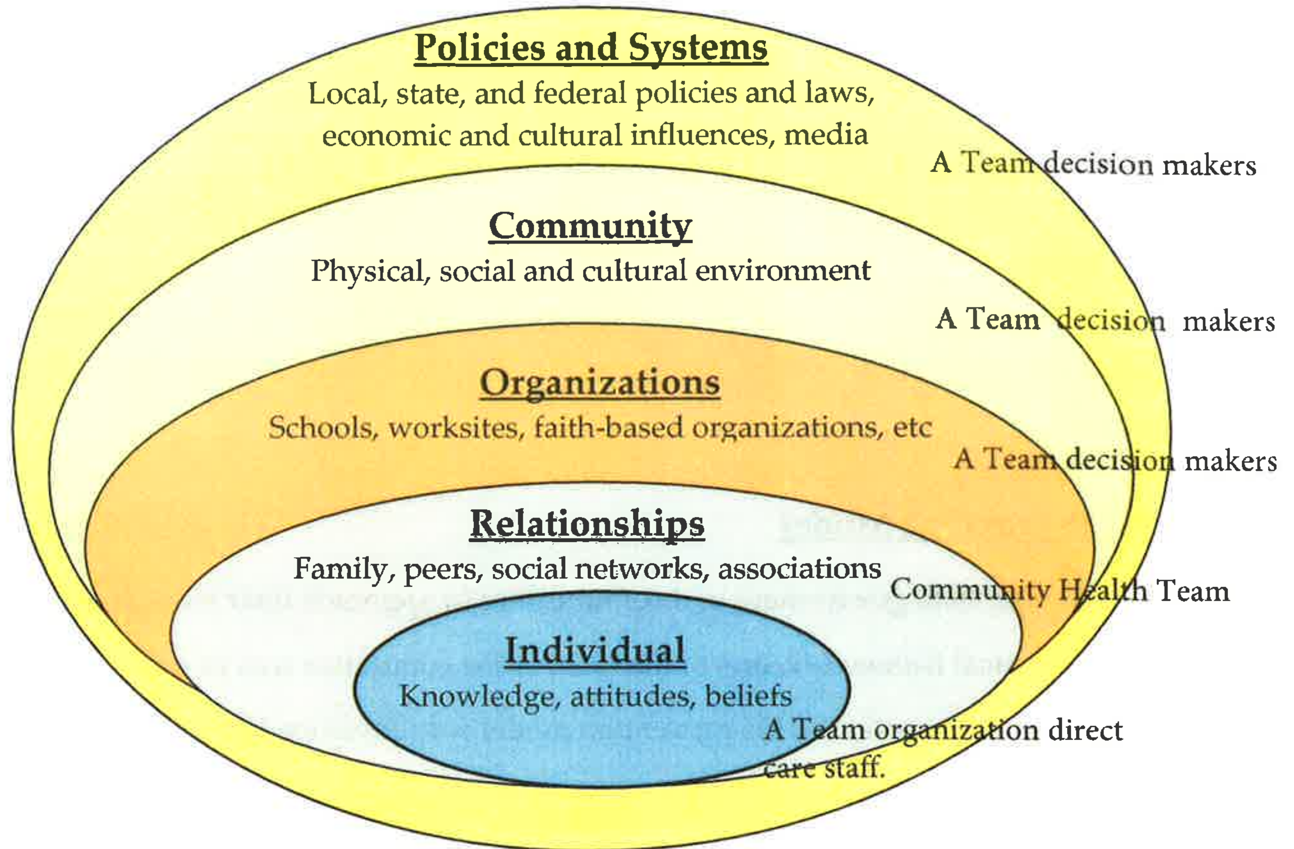
Vermont Prevention Model

In order for state government and communities to approach their work from a consistent theoretical framework, one of the tasks of the committee was to articulate a common model of prevention. This prevention model was developed by the Vermont Department of Health and adopted based upon the social ecological model of McElroy et al. In order for prevention activities to have the greatest impact, multiple levels of the model must be addressed simultaneously, with efforts particularly directed at the higher levels of community, organization, and policies/systems.

The prevention model illustrates that there are many factors in play that influence individual and population health. Prevention efforts are most likely to be effective if they are:

- Consistent with the needs and resources of the community,
- Developed with an understanding of the factors contributing to the problem,
- Designed to specifically address those factors,
- Inclusive of strategies addressing multiple levels of the model simultaneously,
- Sustainable over time,
- Age, gender and culturally appropriate, and
- Evidence-based or based on best and promising practices.

Vermont Prevention Model



Adapted from: McElroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. Health Education Quarterly 15:351-377, 1988.

Levels of Influence

Individual

- Factors that influence behavior such as knowledge, attitudes and beliefs
- Strategies addressing this level of influence are designed to affect an individual's behavior

Relationships

- Factors that influence personal relationships and interactions
- Strategies addressing this level of influence promote social support through interactions with others including family members, peers, and friends

Organizations

- Norms, standards and policies in institutions or establishments where people interact such as schools, worksites, faith based organizations, social clubs and organizations for youth & adults
- Strategies addressing this level of influence are designed to affect multiple people through an organizational setting

Community

- The physical, social, and cultural environments where people live, work and play
- Strategies addressing this level of influence are designed to affect behavioral norms through interventions aimed at the physical environment, community groups, social service networks and the activities of community coalitions and partnerships

Policies and Systems

- The local, state and federal policies, laws, economic influences, media messages and national trends that regulate or influence behavior
- Strategies at this level are designed to have wide-reaching impact through actions affecting entire populations

County Health Rankings
Caledonia County
2015, 2014, 2013, and 2012

	2015	2014	2013	2012	Vermont 2015	National Benchmark 2015	Status 2015/2014
Health Outcome	Rank 9	Rank 7	Rank 8	Rank 11			Worse
Length of Life	Rank 8						
Premature Death	5,864	5,450	5,450	6,309	5,430	5,200	
Quality of Life	Rank 10						
Poor or Fair Health	12%	12%	13%	13%	11%	10%	
Poor physical health days	3.1	3.1	3.2	3.3	3.2	2.3	
Poor mental health days	3.6	3.6	3.6	3.6	3.4	2.4	
Low birth weight	6.8%	7.1%	7.1%	6.9%	6.5%	5.9%	Improved

Health Factors	Rank 9	Rank 10	Rank 9	Rank 10			Improved
Health Behaviors	Rank9	Rank 9	Rank 7	Rank 8			
Adult Smoking	18%	18%	18%	20%	16%	14%	
Adult Obesity	28%	28%	26%	26%	24%	25%	
Food environmental index	7.9	8.3			8.1	8.4	Worse
Physical Inactivity	21%	22%	22%	22%	18%	20%	Improved
Access to Exercise Opportunities	63%	63%			78%	92%	
Excessive Drinking	15%	15%	16%	16%	19%	10%	
Alcohol Impaired Driving Death	55%	58%			37%	14%	Improved
Sexually Transmitted Infections	264	215	157	190	275	138	Worse
Teen Birth Rate	23	23	24	29	19	20	

Clinical Care	Rank 3	Rank 4	Rank 8	Rank 7			Improved
Uninsured	8%	9%	11%	12%	8%	11%	Improved
Primary Care Physicians	1,197:1	1,154:1	1,300:1	1,009:1	922:1	1,045:1	Worse
Dentists	1,484:1	1,623:1	1,628:1	NA	1,567:1	1,377:1	Improved
Mental Health Providers	346:1	471:1			373:1	386:1	Improved
Preventable Hospital Stays	42	50	50	48	48	41	Improved
Diabetic Screening	91%	88%	87%	87%	88%	90%	Improved
Mammography Screening	71.1%	71%	74%	74%	69.5%	70.7%	Improved

Social & Economic Factors	Rank 10	Rank 11	Rank 10	Rank 11			Improved
High School Graduation	88%	90%	92%	90%	88%		Worse
Some College	55.2%	56%	57%	54%	65.8%	71%	Worse
Unemployment	5.3%	6.4%	6.5%	7.1%	4.4%	4.0%	Improved
Children In Poverty	20%	21%	21%	22%	15%	13%	Improved
Income Inequality	4.6				4.4	3.7	
Social associations	15.1				13.1	22.0	
Children in Single-Parent Households	33%	34%	34%	35%	30%	20%	Improved
Violent Crime Rate	138	126	120	111	136	59	Worse
Injury Deaths	74	72			69	50	Worse

Physical Environment	Rank 5	Rank 8	Rank 4	Rank 3			Improved
Air pollution – particulate matter	10.7	10.7	9.5	NA	10.7	9.5	
Drinking Water Safety	5%	4%	4%	NA	7%	0%	
Severe Housing Problem	17%	17%			17%	9%	
Driving alone to work	76%	77%			74%	71%	Improved
Long commute – driving alone	28%	27%			29%	15%	Worse

Population Health Integration in the Vermont Health Care Innovation Project

ACOs, TACOs and Accountable Community for Health

The following is intended to offer a basic overview of the different structures that are being explored for integrating population health as part of the Vermont Health Care Innovation Project.

Accountable Care Organization (ACO) is a health care organization that agrees to be responsible for the quality and cost of health care for its patients. Providers who are part of an ACO work together to coordinate care, improve the quality of health care provided to patients, and reduce health care costs for a defined group of patients. ACOs are intended to organize providers to better control health care cost growth and shift the focus from providing their separate services to coordinating with each other for the benefit of the people they serve.

A key feature of ACOs is that they participate in reimbursement programs that hold them accountable for the quality of services performed as well as the costs. In Vermont, reimbursement mechanisms for services by ACO providers have not changed, but the ACO and its providers benefit from "shared savings" arrangements with payers. Reimbursement models for ACOs are designed to evolve over time, starting with 'one-sided risk' where they share only in savings, shifting to two-sided risk where they share in both savings and losses, and ultimately evolving to population based payments. ACOs can and have contracted with multiple payers including Medicare, Medicaid and commercial health plans.

Totally Accountable Care Organization (TACO) represents an aspirational vision for a health care system where all physical health, behavioral health, long-term services and supports (LTSS), and elements of social services and public health are integrated. A TACO is today's ACO with a wider number of service providers. The model aspires to serve all populations yet builds upon the integration of care for a defined group of patients. Ideally, these activities would be reimbursed under a reimbursement that aligns financial incentives and reduce costs.

Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. However, like ACOs and TACOs, there would need to be some patient attribution to measure cost and quality. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An ACH supports the integration of high quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness.

Definition of Population Health

The definition of population health may vary depending upon the perspective of a given group. For a medical provider, "population" may be either the "panel of patients" (all patients who use the provider, regardless of whether they see other providers more frequently) or "attributed lives", which refers only to those patients who receive most of their care from that provider. For a health insurer or payer, the definition of "population" is "covered lives" which refers to the health plan beneficiaries. For the community, the "population" includes everyone who lives in a defined geographic area. Similarly, the definition of "health" varies from a narrow definition limited to physical health to an expanded definition which includes mental health and well-being.

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ACOs, TACOs and Accountable Community for Health

The Population Health Work Group of VHCIP has adopted the following definition of Population Health based on Kindig and Stoddart (2003) referenced by CMS for the SIM initiative:

Population Health ... the health outcomes of a group of individuals, including the distribution of such outcomes within the group ... While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

Institute Of Medicine, Roundtable on Population Health Improvement http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Structures for Integrating Population Health

Features	VT Medicare ACO SSP	VT Medicaid ACO SSP	VT Commercial ACO SSP	TACOs	ACHs
Population	Attributed lives	Attributed lives	Attributed lives	Attributed lives	Defined geographic area
Physical health	x	x[1]	x[2]	x	x
Mental health and substance use services Behavioral health[3]	x	x	x	x	x
LTSS				x	x
Social services				x	x
Public health services				x	x
Community wide prevention strategies					x
Prevention	Preventive Medical Care	Preventive Medical Care	Preventive Medical Care	Preventive Medical Care	Primary through tertiary[4]

Payment and Financing of Population Health

1 Excludes dental and pharmacy

2 Excludes dental and pharmacy

3 Current ACO SSPs include limited mental health and substance use services

4 Primary prevention aims to prevent disease from developing in the first place; Secondary prevention aims to detect and treat disease at an early stage or slow the progress; Tertiary prevention is directed at those who already have symptomatic disease.

Population Health Integration in the Vermont Health Care Innovation Project

ACOs, TACOs and Accountable Community for Health

The mechanisms for payment and financing are not discreetly connected to a particular structure. This project is currently testing different models and options to determine the best fit that will cover necessary costs, ensure continuing high quality care and improve health outcomes.

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