Joint Testimony for Senate Health and Welfare And House Health Care

Vicki Loner, CEO

Sara Barry, COO

Marissa Parisi, Executive Director of RiseVT

January 17, 2020

OneCare Vermont

onecarevt.org

"Instead of working in silos, we can approach this as a system. We are developing stronger relationships."

-Jill Lord
Mount Ascutney Hospital
and Health Center

Selected Highlights of OneCare's Strategies to Address APM Population Health Goals

Goal #1
Increase Access to Primary Care

- Invest in Primary Care (PHM, Care Coordination, Quality)
- Comprehensive Payment Reform (CPR) program for independent practices
- Test innovations such as the Building Strong Families clinic in Burlington's New North End
- Tools, data, and education on annual wellness visits
- Deploy a Patient Engagement toolkit and support practices to encourage primary care engagement

Goal #2
Reduce Deaths Related to Suicide and Drug Overdose

- Ongoing support of SASH / Howard Mental Health Pilot
- Innovation fund pilots addressing access to child psychiatry, avoiding readmissions for individuals with serious mental illness, creating urgent child psychiatric care outside of the ED in Bennington
- Ongoing support for suicide prevention training across the state
- Focus on improving opioid prescribing practices and access to medication assisted treatment

Goal #3
Reduce Prevalence and Morbidity of Chronic Disease

- Clinical education on Asthma and COPD
- Expansion of RiseVT to support health and wellness across communities
- Innovation fund pilots screening for diabetic retinopathy, cardiac & pulmonary prevention program, home-based care for patients with neurodegenerative disease
- Collaboration with VDH on creation of State Health Improvement Plan including focus areas and key actions

RISEVT EXPANSION

2015 Pilot

1. Northwestern Medical Center

2018

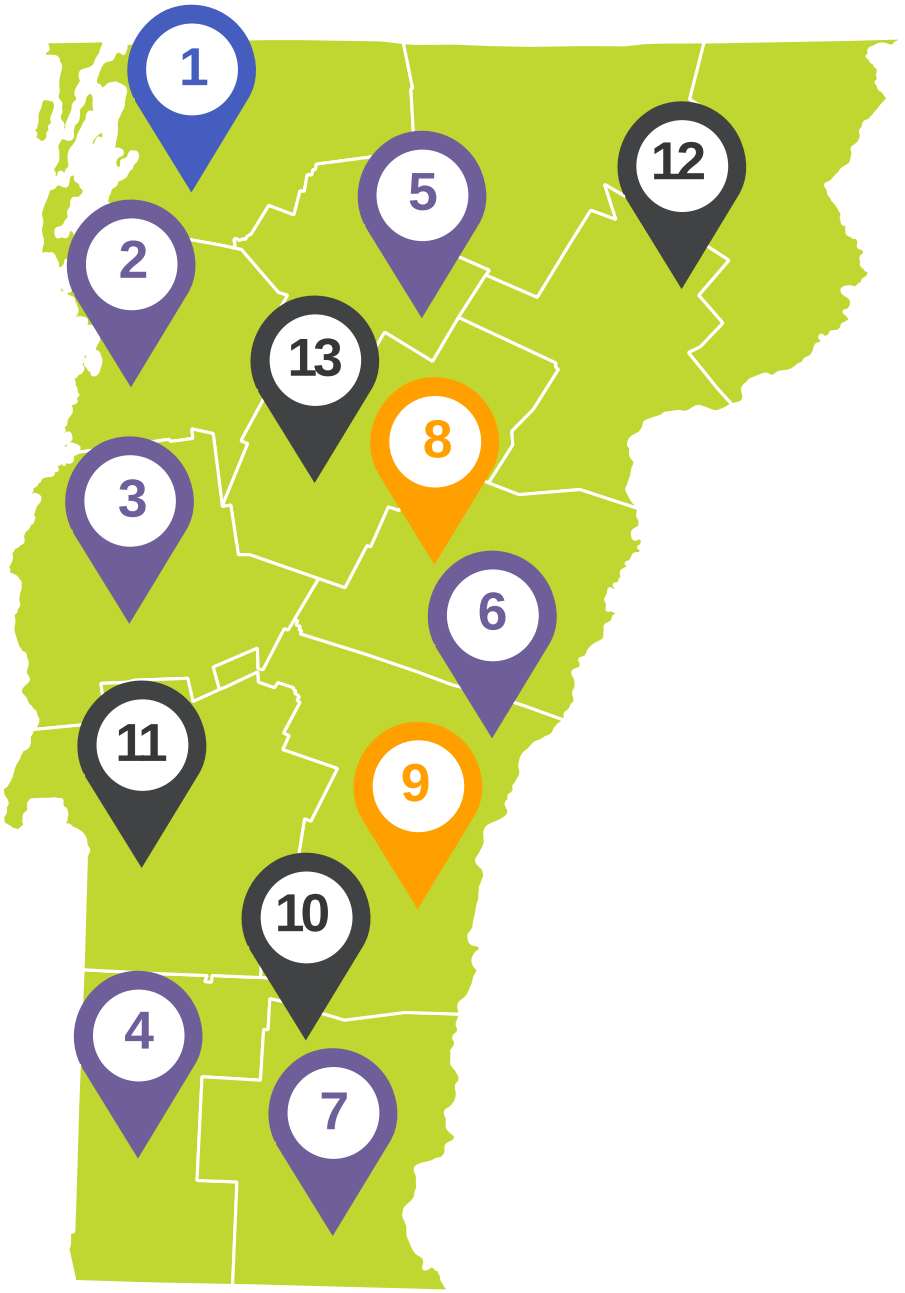
2. UVM Medical Center
3. Porter Medical Center
4. Southwestern Vermont Medical Center
5. Copley Hospital
6. Mt. Ascutney Hospital
7. Brattleboro Memorial Hospital

2019

8. Gifford Medical Center
9.. Springfield Hospital

2020

10. Grace Cottage Hospital
11. Rutland Regional Medical Center
12. Northern Counties Health Care
13. Central Vermont Medical Center






RISE VT
Embracing Healthy Lifestyles

IN NINE HOSPITALS, SERVING 36 VERMONT COMMUNITIES IN 2019

- 16 RiseVT Program Managers are embedded in local communities employed by Vermont hospitals.
- Launched **Sweet Enough**, a statewide campaign to reduce sugary beverage consumption in September of 2019.
- Awarded **$223,021** in Amplify Grants directly to Vermont communities for health and wellness activities and systems change.
- Developed comprehensive suite of program evaluation measures to ensure our initiatives are tied back to our evidence based model.
- 2020 goal is to have RiseVT in all 14 Vermont counties. Northern Counties Health Care and Rutland Regional Medical Center start January 2020.

INNOVATIVE LOCAL PROJECTS

- **Rise and Walk** programs promoted physical activity, while connecting community members with local hospital leaders.
- Implemented **Dinner Together**, a program to encourage family meal time.
- Created **Health on a Shelf**, an effort to clearly label healthy food at food pantries choices for patients trying to manage chronic illness.
- Developed the **Online Playground**, a web-based resource center for teachers.
- Partnered with **Come Alive Outside** to bring their passport program to new communities across the state.
- Supported evidence-based mindfulness programs through teacher trainings and preschool yoga offerings.

DULCE
Strengthening Families

Local Parent Child Centers employ family specialists who are embedded in the pediatric practice.

- Attend well-child visits from birth to six months.
- Support healthy growth and development
- Navigate social services
- Connect families to legal supports

Four new DULCE* sites started in September 2019 for a total of five pediatric practices using the model statewide.

*DULCE = Developmental Understanding & Legal Collaboration for Everyone

Quality and Analytics

2018 Quality Measure Performance

85% Medicaid 86% BCBSVT QHP 100% Medicare

Looking forward

In 2019, Medicare measures become aligned under APM.

In 2020, OneCare is working to align measures for new commercial programs.

OneCare continues to grow scale, likely impacting Quality Measure performance.

Caveats

OneCare's Network continued to grow from 2017 to 2018 so performance between years cannot be directly compared.

2018 was the first year of the new risk program with BCBSVT; measures changed to align with APM.

Benchmarks and measure specifications continued to vary by payer product preventing year-to-year and cross-payer comparisons.

Some new APM measures have small denominators statewide, making them subject to large percentage fluctuations while only representing a difference of a few patients.

2020 Quality Measures

2020 Quality Measures	Vermont Medicare ACO Initiative	Vermont Medicaid Next Generation	BCBSVT QHP	BCBSVT Primary	MVP	Domain
30 Day Follow-Up after discharge from the ED for Alcohol and Other Drug Dependence (HEDIS FUA)	✓	✓	✓	✓	✓	Claims
30 Day Follow-Up after Discharge from the ED for Mental Health (HEDIS FUM)	-	✓	✓	✓	✓	Claims
Risk Standardized, All Condition Readmission (ACO #8)	✓	-	-	-	-	Claims
Adolescent Well-Care Visits (HEDIS AWC)	-	✓	✓	✓	✓	Claims
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (ACO#38)	✓	✓	-	-	-	Claims
Developmental Screening in the First Three Years of Life (NQF)	-	✓	✓	✓	-	Claims
Initiation of Alcohol and Other Drug Dependence Treatment (HEDIS IET)	✓	✓	-	-	-	Claims
Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS IET)	✓	✓	-	-	-	Claims
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite) (HEDIS IET)	-	-	✓	✓	✓	Claims
ACO All-Cause Readmissions (HEDIS PCR)	-	-	✓	✓	✓	Claims
Follow-Up After Hospitalization for Mental Illness (7 Days) (HEDIS FUH)	-	✓	✓	✓	✓	Claims
Influenza Immunization (Prev-7, NQF 0041)	✓	-	-	-	-	Clinical
Colorectal Cancer Screening (Prev-6, NQF 0034)	✓	-	-	-	-	Clinical
Tobacco Use Assessment and Cessation Intervention (Prev-10, NQF 0028)	✓	✓	-	-	-	Clinical
Screening for Clinical Depression and Follow-Up Plan (Prev-12, NQF 0418)	✓	✓	✓	✓	-	Clinical
Diabetes HbA1c Poor Control (>9.0%) (DM-2 NQF 0059, HEDIS, CBC)	✓	✓	✓	✓	✓	Clinical
Hypertension: Controlling High Blood Pressure (HTN-2 NQF 0018, HEDIS, CBP)	✓	✓	✓	✓	✓	Clinical
CAHPS Patient Experience	✓	✓	✓	✓	✓	Survey

Advanced Analytics Accelerate Healthcare Reform

Provide timely, useful reports

Use data to drive change and improve quality of care

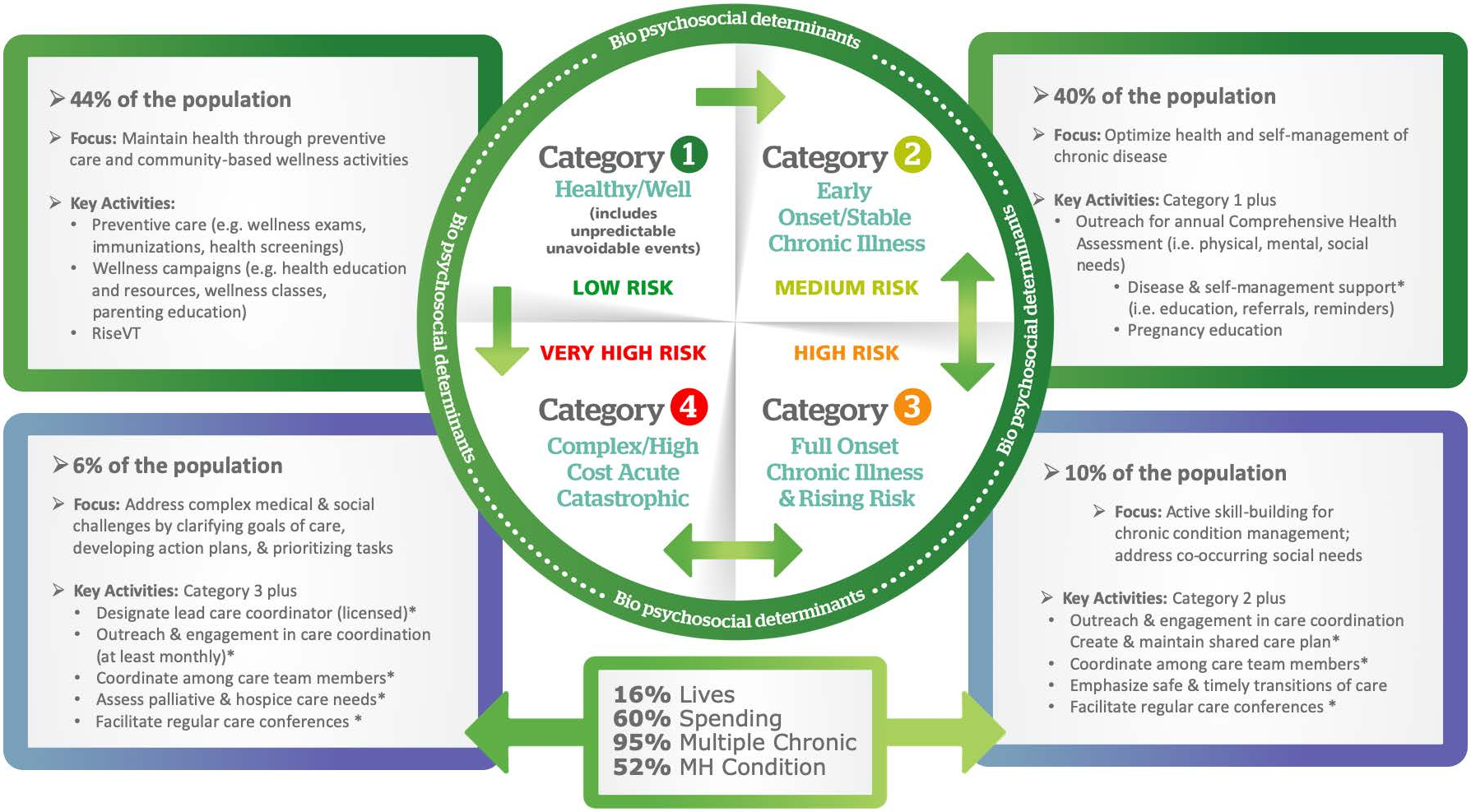
Provide insights into individual and population health needs

Access to information about care received anywhere

Share data to reduce duplication of services and address gaps in care

Evaluate the impact of interventions and investments

Population Health Approach:
A Plan for Every Person



➢ **44% of the population**

➢ **Focus:** Maintain health through preventive care and community-based wellness activities

➢ **Key Activities:**
- Preventive care (e.g. wellness exams, immunizations, health screenings)
- Wellness campaigns (e.g. health education and resources, wellness classes, parenting education)
- RiseVT

➢ **40% of the population**

➢ **Focus:** Optimize health and self-management of chronic disease

➢ **Key Activities:** Category 1 plus
- Outreach for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
  - Disease & self-management support* (i.e. education, referrals, reminders)
  - Pregnancy education

➢ **6% of the population**

➢ **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks

➢ **Key Activities:** Category 3 plus
- Designate lead care coordinator (licensed)*
- Outreach & engagement in care coordination (at least monthly)*
- Coordinate among care team members*
- Assess palliative & hospice care needs*
- Facilitate regular care conferences *

➢ **10% of the population**

➢ **Focus:** Active skill-building for chronic condition management; address co-occurring social needs

➢ **Key Activities:** Category 2 plus
- Outreach & engagement in care coordination Create & maintain shared care plan*
- Coordinate among care team members*
- Emphasize safe & timely transitions of care
- Facilitate regular care conferences *

16% Lives
60% Spending
95% Multiple Chronic
52% MH Condition

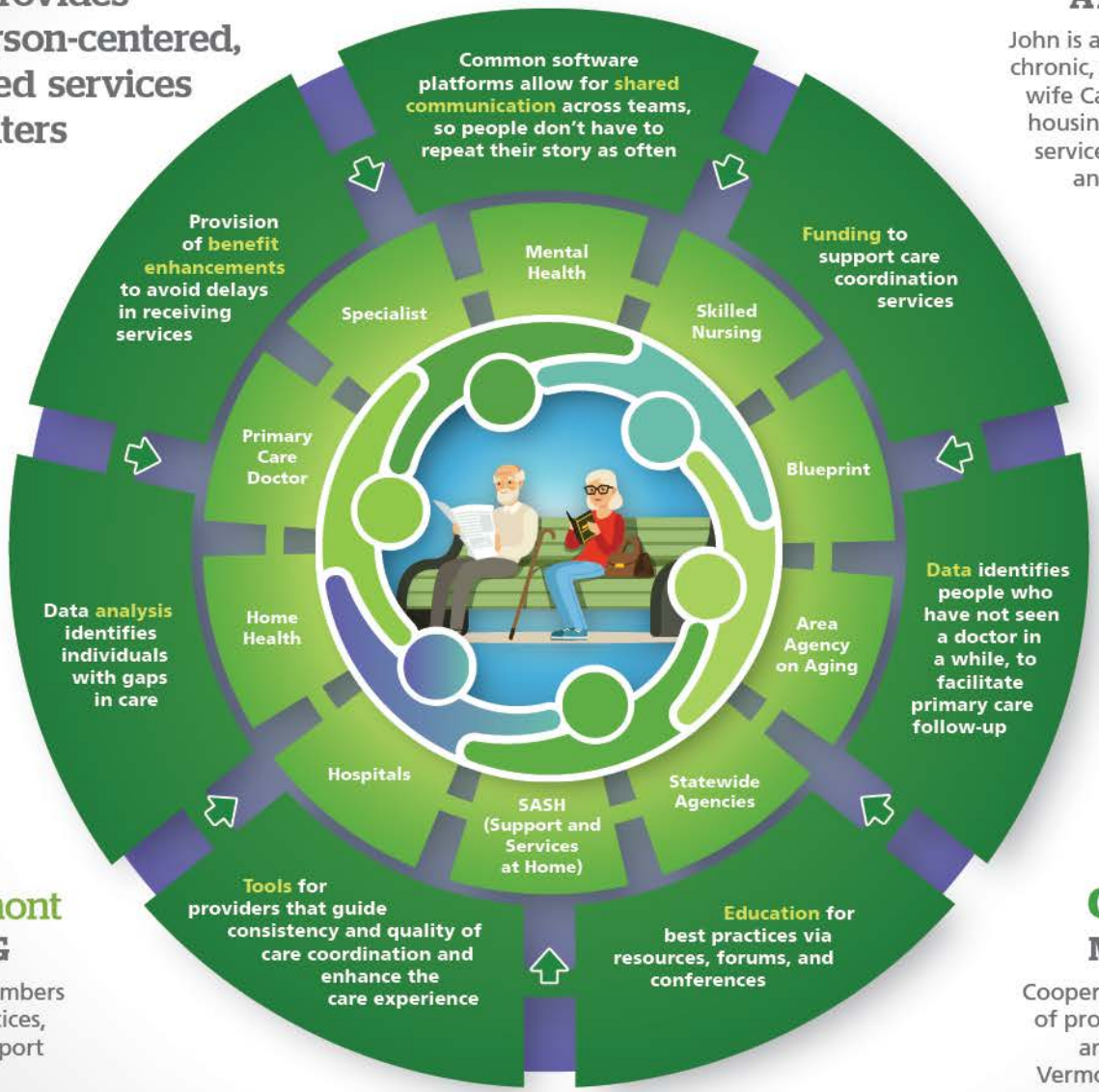
* Activities coordinated via Care Navigator software platform

The Care Model:

A system that provides high-quality, person-centered, community-based services to keep Vermonters healthy.

Vermonters
AT THE CENTER

John is a Vermonter with complex, chronic, medical needs. He and his wife Carol have concerns about housing, availability of medical services, food, transportation, and other social issues.



OneCare Vermont
OUTER RING

Provides care team members with tools, best practices, and resources to support better health.

The Care Team
MIDDLE RING

Cooperative effort of thousands of providers sharing resources and expertise to keep Vermonters healthy and well.

Investments in Innovation

Youth Psychiatric Urgent Care Model
Area of Impact:
Bennington HSA

Telemedicine and Home Health for ALS Patients
Area of Impact:
Statewide

Community Embedded Well Child Care "Building Strong Families Clinic"
Area of Impact:
Burlington HSA

Child Pyschiatric Consultation Clinic
Area of Impact:
Burlington HSA;
Statewide via telehealth

Ocular Telehealth in Primary Care
Area of Impact:
Middlebury HSA

Wellness Plus "Pre Hab" Cardiac and Pulmonary Program
Area of Impact:
Brattleboro HSA

TeleFriend Pilot: Addressing Mental Health at Home
Area of Impact:
Statewide

TeleCare Connection: Hospital to Home Transitions
Area of Impact:
Burlington HSA

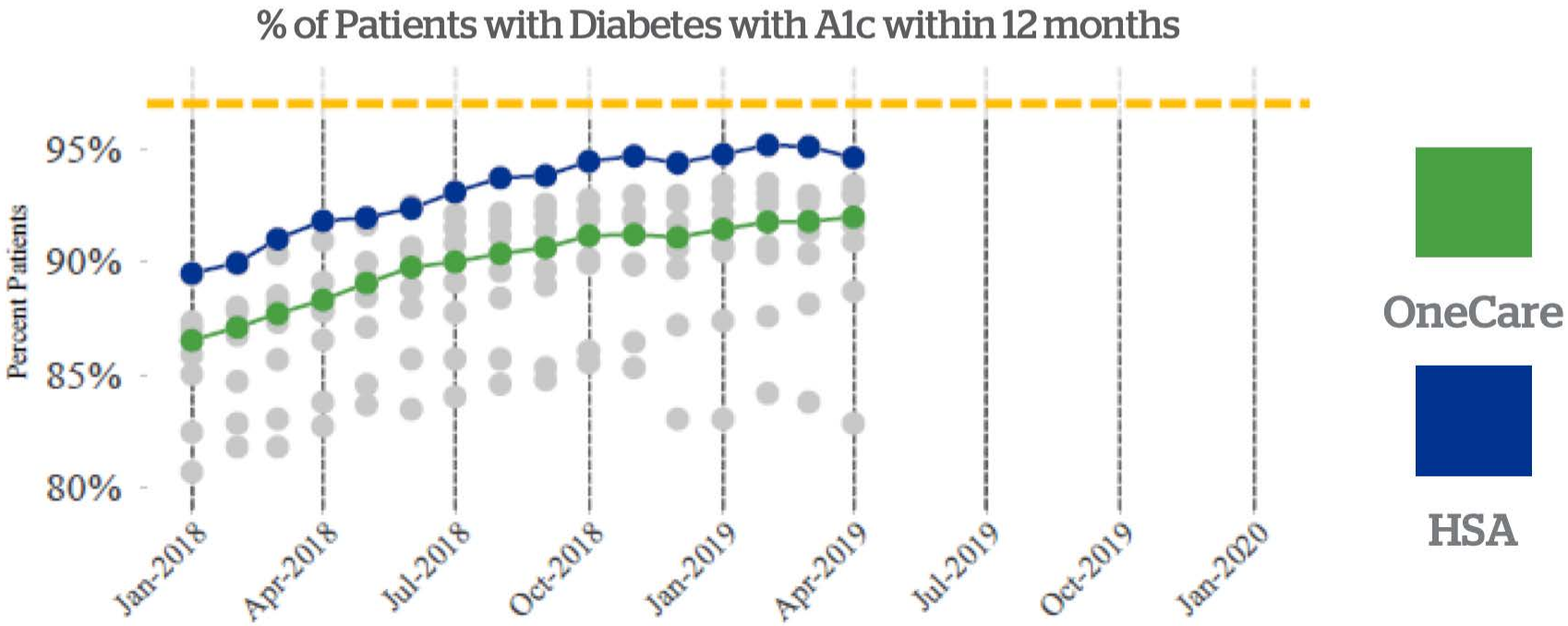
Photo: Open House for the Building Strong Families Clinic
Tuesday, Sept. 24, 2019

Early Outcomes

Improvement Story:
Berlin Health Service Area

KEY Takeaway:

CVMC's focus on **panel management** and **aligned provider incentives** has resulted in a steady increase in the number of Medicaid patients with Diabetes with an A1c test across the Berlin HSA.



Connecting Patients
To Primary Care

KEY Takeaway:

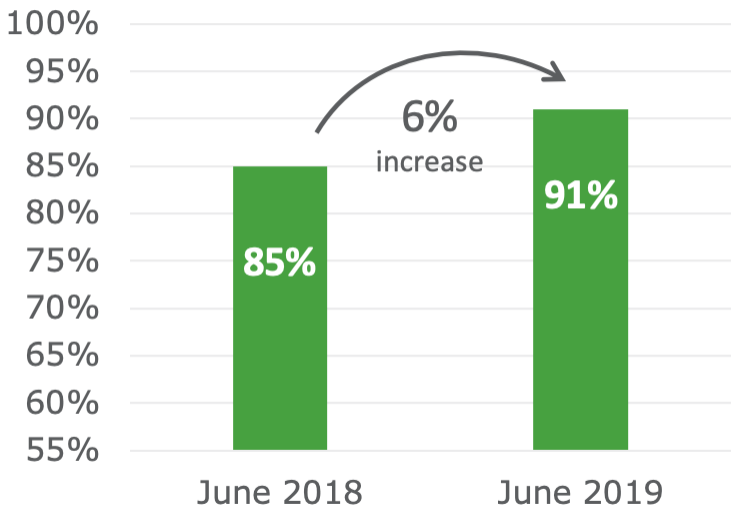
- Medicaid and Medicare patients are satisfied with their access to primary care services (CAHPS 2018)
- By June 2019, 8,384 (91%) of high and very high risk Medicare patients had a visit with primary care

Satisfaction rate with receiving timely care

KIDS
MEDICAID: 94%

ADULTS
MEDICARE: 85%
MEDICAID: 88%

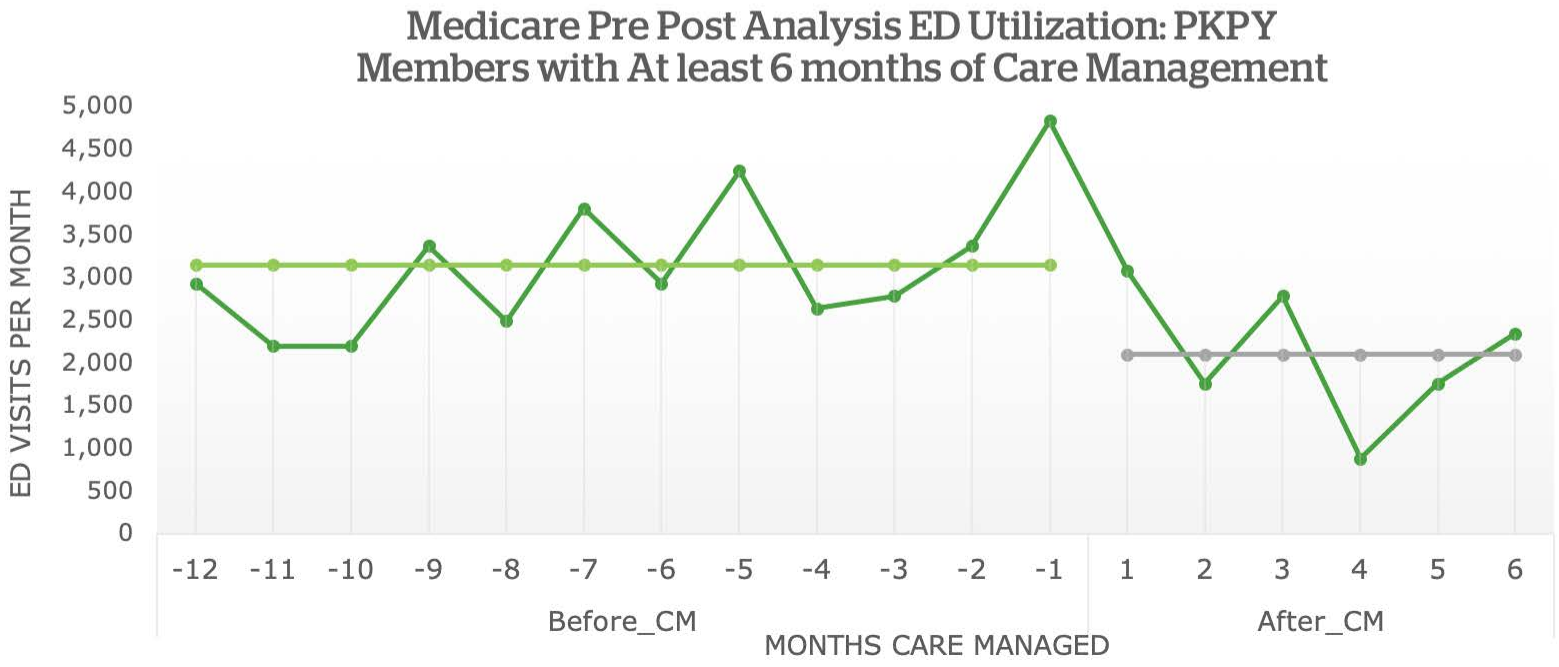
High/Very High Risk Medicare Patient Engagement with Primary Care



Improvement Story:
Care Coordination Impact on ED Utilization

KEY Takeaway:

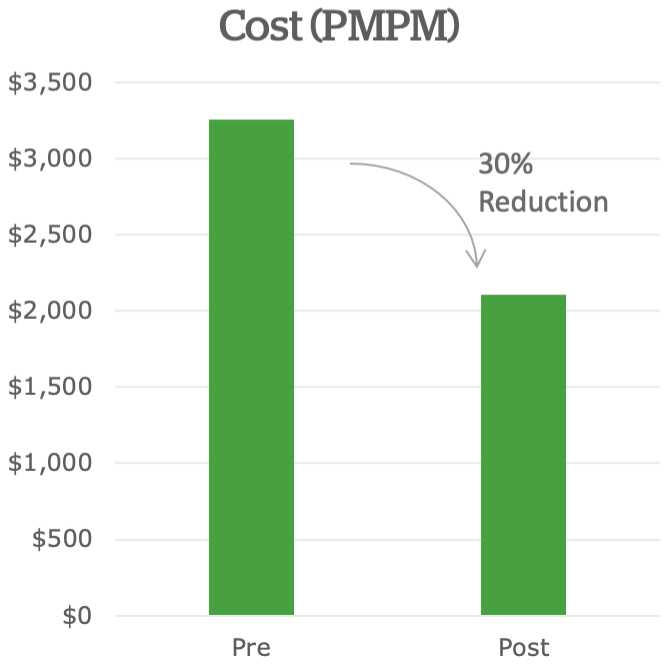
- 33% reduction (3,246 to 2,098 PKPY; P<.001) in ED utilization among care managed Medicare patients
- 13% reduction (1,774 to 1,534 PKPY; P<.001) in ED utilization among care managed Medicaid patients

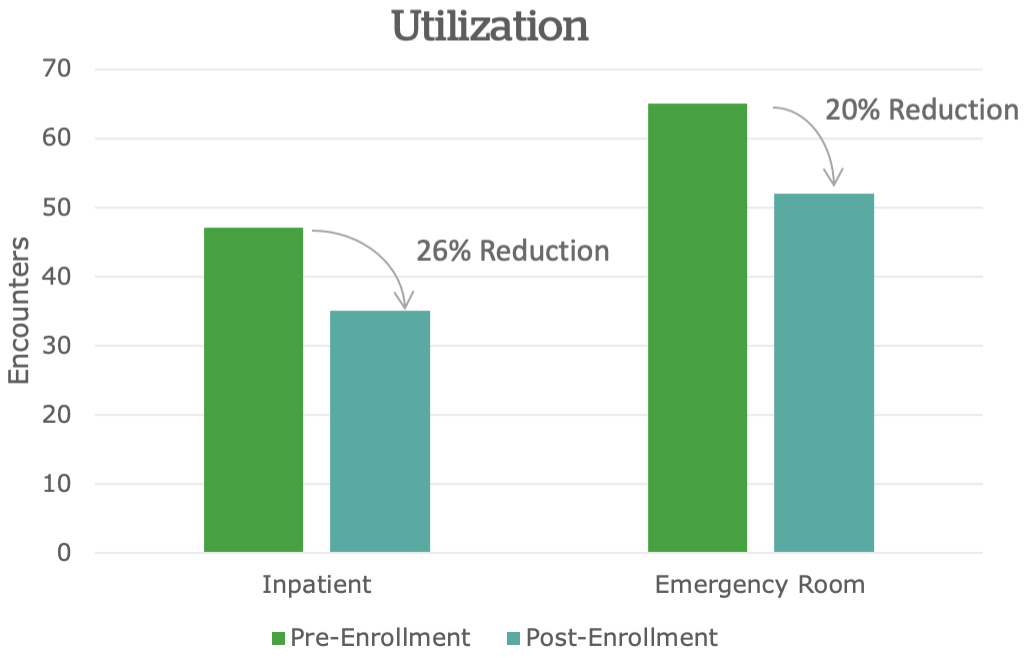


Improvement Story:
Care Coordination Impact on Cost and Utilization

KEY Takeaway:

- UVMHN HHH achieved decreases of: $1,150 PMPM, 26% in IP admits, and 20% in ED utilization in their longitudinal care pilot
- OneCare is investing to spread this change to nine additional HSAs in 2020





"The Care Coordinators that we have hired through OneCare's program have been extremely beneficial. Care coordination has reduced the fragmentation of the health care system and has resulted in fewer hospitalizations."

-Joe Haddock, MD
Thomas Chittenden Health Center