Care Models and Care Management Work Group Meeting Agenda 5-13-14

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Agenda

Tuesday, May 13th, 2014; 10:00 AM to 12:00 PM
Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00 - 10:05	Welcome; Introductions; Approval of Minutes	**Attachment 1:** CMCM Minutes April 2014	
2	10:05 – 10:10	Co-Chair Update ***Public Comment***		
3	10:10 – 10:15	Staff Update ***Public Comment***		
4	10:15 - 10:50	Debrief from April Meeting: Summary of Break Out Sessions, State Health Improvement Plan, and Development of Demand Side Problem Statement ***Public Comment***	**Attachment 4a:** Notes from April Work Group Meeting Break-Out Sessions **Attachment 4b:** State Health Improvement Plan Summary	
5	10:50 - 11:50	Discussion of Care Management Standards for ACOs; Breakout Groups to Refine Categories for Standards ***Public Comment***	**Attachment 5a:** Potential Topics for Care Management Standards **Attachment 5b:** Proposed DLTSS Care Model Elements	
6	11:55 - 12:00	Next Steps, Wrap-Up and Future Meeting Schedule Upcoming Webinar (5/20) : Review of Inventory Survey Tool		

Attachment 1 - Care Models and Care Management Work Group Meeting Minutes 4-08-14

Vermont Health Care Innovation Project

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Minutes

Date of meeting: Tuesday, April 8, 2014; 10:00 AM to 12:30 PM, Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT

Call in: 877-273-4202, Passcode: 2252454

Attendees: Bea Grause, Nancy Eldridge, Co-Chairs; Georgia Maheras, AoA; Marie Zura and Colleen Fiske, Howard Center; Trinka Kerr, Legal Aid; Kelly Gordon, Erin Flynn, Amy Coonradt, Kara Suter, DVHA; Charlie Biss, DMH/IFS; Dana Demartino, CVMC; Dale Hackett, Consumer; Patty Launer, Bi-State; Steve Dickens, Jen Woodard, DAIL; Susan Besio, Pacific Health Policy Group; Maura Crandall, VT Managed Care; Tracy Dolan, Breena Holmes, Dept. of Health; Karen Hein, GMCB, Laural Ruggles, NVRH; Jenney Samuelson, Blueprint for Health; Marlys Waller, VT Council of Dev. and MH Services; Barbara Cimaglio, Julie Wasserman, AHS; Madeleine Mongan, Pamela Farnham, Fletcher Allen Health Care; Jane Catton, NMC; Michael Bailit, Bailit Health Purchasing; Audrey Spence, BCBS; Debbie Rapizzi, MVP; Jessica Mendizabal, Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome and Introductions, Approval of meeting minutes	Nancy Eldridge called the meeting to order at 10:05 am. Trinka Kerr moved to approve the minutes. Patty Launer seconded the motion and it passed unanimously, without edits to the minutes.	
2 Co-Chairs' Report (e.g., Other VHCIP Work Group/Core Team Activities, Legislative Update, Provider Grant	Co-Chair update: the provider grants were awarded to eight recipients. Several applications that were not approved have been referred to certain work groups. The CMCM work group expects to receive 10 applications and the co-chairs will meet with Anya and Georgia next week to discuss next steps. Bea Grause gave a legislative update: ACT 252 has passed the Senate, which contains Act 48	

Agenda Item	Discussion	Next Steps
Program Update)	amendments concerning how Green Mountain Care would become operationalized. Most of them will become studies and won't significantly redirect the course of Act 48.	
3 Staff Report (Update on Inventory, Request for Additional Webinar Presentations)	Erin Flynn reminded the group that if anyone wants to present to the work group via a webinar they should reach out to her and she will help coordinate it. Staff is also working together with the consulting team at Bailit Health Purchasing to put the final touches on the inventory survey tool.	

4 Population Health Work Group Presentation (Karen Hein, MD, Green Mountain Care Board and Tracy Dolan, Deputy Commissioner, Vermont Department of Health)	Tracy Dolan and Karen Hein presented on the topic of the Population Health Work Group and how the goals of this work group interact with the goals of the Care Models and Care Management work group (attachment 4).
	
	Nancy prefaced the conversation by asking the group to think about what success looks like for CMCM. She noted that it's not just payments. The problem is about health status and they want to know more about the health goals of Vermont.
	
	The following points were discussed during the presentation:
	• The 65+ population is becoming more employed over time, so the working age population may need to be redefined.
	• The VT workforce information presented includes all professions, not just health care.
	• The State Health Improvement Plan (SHIP) is based on a framework called "Healthy People 2020", and includes national benchmarks for health improvement.
	• Tobacco and obesity are two priorities for VT.
	• The SHIP includes three major goals: 1) reducing the prevalence of chronic disease 2) reducing the prevalence of substance abuse and mental illness 3) increasing childhood immunization rates in VT, which has been lower than optimal for the past 10 years.
	• Key risk factors and how to prevent conditions and implement system changes that impact behavior:
	  o Tobacco use was a key driver in 2010: 16% for adults, 13% for youth. Goals for 2020 are to bring it down to 12% for adults and 10% for youth.
	  o We have moved away from 1-1 counseling which is resource intensive, and moved toward broader system changes such as smoke free laws.
		Additional slides will be distributed to the group via email after this meeting.
		
		Tracy will send the VT state objectives to the work group.

Agenda Item	Discussion	Next Steps
	o In VT you can see drops in specific interventions: tax increases correlate to people smoking less; evidence based strategies around tobacco cessation services. o Policy changes are the other key piece where people don't start smoking in the first place (such as reduced advertising and visibility). • Regarding obesity: o Get unhealthy foods out of the school altogether, and focus on nutrition and physical activity. o Build in activity naturally into your daily routine, such as walking to school or work. o Worksite wellness is also effective and brings down health care costs. • Binge drinking is a significant issue in VT: recent survey shows 19% of high school students responded to having five or more drinks within a few hours during the past 30 days. However, this is a decrease from the 21% in 2011. Karen asked the group to think about how we can connect social determinants with care models. She discussed the CDC impact pyramid (last slide): • 80% on the dollar yields little impact (top of pyramid), less dollars yield a bigger impact (bottom). • She recommended that the CMCM work group think about social determinants and consider socioeconomic factors when making recommendations on care models for the future. • She referenced slides for tobacco and obesity (distributed via email) where they looked at the context of eating to see what we can change in the environment. • There was also a recommendation to consider population health as it relates to global climate change. • The GMCB dashboard is using the "Well-Being Vermonters" reports from the 1990s, which encompass the entire pyramid. • Bea noted that this work group is trying to change the context for providers and health care professionals to help them encourage participants to change their behavior. CMCM will strategize with providers to be more impactful in addressing the needs of the Vermonters they serve. • Karen noted human services needs to evolve in a future payment reform world. GMCB needs input on the unified health care budget: looking at what is being spent on	

Agenda Item	Discussion	Next Steps

	preventative services; expanding the expenditure analysis to include agriculture, education, etc.; and understanding what the return is on investing more resources in children.
	• The State will look into further detail for the aging population as well.
	• Mental health is always a key issue, not just mental illness- there needs to be a good model for this. Example: having a safe place for kids in the community. This is changing from the current model where issues are in silos.
	• Success by Six is a great model to follow and could be applied to the 65+ population. New York is doing similar work for the aging population and had success (instituting walkable locations, etc.)
	• Regarding mental health:
	  o Washington County Mental Health Services builds wellness collaboratives into their programs including yoga, gardening, etc. Payment mechanisms are a challenge. Example: open studio for art "resource and recovery" youth in transition in Barre. They are looking at how to bill it and seeking a grant. Another example is having kids work at Random Rescue with animals, which has been very successful showing improvement in school performance.
	  o Many different organizations around the state are working on similar efforts.
	  o Tracy noted we need to look at the incentive driving the payment systems.
	  o Kara Suter stated that we do need to promote healthy lifestyles but it may not need to be a health care expenditure, which is taking resources that are already strained and therefore some people might not benefit.
	  o The Population Health Work Group is working with Jim Hester to research three exemplars around VT that are currently working on community coalition building, and trying to apply this in other areas of the State.
	  o Dale Hackett provided an example of taking children to state parks in the summer as an investment and how it relates to the work of CMCM. The state department employees would be a good partner.	

5 CMCM/Population Health Breakout Sessions	The group discussed the following questions in the breakout sessions: • What will health care reform success look like based on the Population Health presentation?	**The notes from the breakout discussions will be distributed to work group**

Agenda Item	Discussion	Next Steps
	• What is missing? • What care management practices, principles or protocols will be most impactful in achieving the Population Health goals?	**members and discussed at the next meeting.**
6 Presentation on Developmental Services	Marie Zura and Colleen Fiske from the Howard Center presented Service Coordination for Developmental Services (attachment 6). The following points were noted: • Services are not guaranteed based on eligibility. The Howard Center serves 25% of the population that is eligible for services. • One case manager coordinates all services, helping to assist with continuity of care. • They currently serve a large refugee population. • Case managers often act as sitters in hospitals as well. • Vermont is ranked 5th in the nation because they focus on getting those with disabilities into the workforce. • The case studies presented demonstrate where in-home care can cost less but also show how VT values quality of life. • Comprehensive case management is about relationships and having the entire picture. Long Term Care is a large part of this effort.	

Agenda Item	Discussion	Next Steps
7 Next Steps, Wrap-Up and Future Meeting Schedule	Next Meeting: May 13th 10 am – 12:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier. Topics for next meeting: • Care Management Standards for ACOs. • The DLTSS work group will present on a Care Management model. Recommendations will go to the Steering Committee, then the Core Team. • Continued discussion on Population Health. • Each scribe from the breakout groups will share their notes to be discussed.	

Attachment 4a - Notes from April Work Group Meeting Break-Out Sessions

Care Models and Care Management Work Group: March 11th Break Out Session Notes

Group #: 1

Participants: Trinka Kerr, Colleen Fiske, Charlie Biss, Jenney Samuelson, Nancy Eldridge

(1) What will health care reform success look like based on the Population Health presentation?

Successful reform will focus on risk and protective factors rather than on diagnosis of illness (example: the benefits of physical activity on mental health)

We will have a Global Health Budget that will include transportation, labor, agriculture and education. Our break out group added the Commerce Agency because of its economic development and housing role. Hospital and designated agencies and other budgets would be one.

We would get to people before "the horse leaves the barn" (aka Tracy's description of trying to get people to stop smoking as opposed to the less costly option of preventing them from starting).

Vermont communities would look at how inextricably linked the well being of its citizens is to all aspects of community life – everything is connected to health.

We would define "health expenses" very broadly and keep bringing in more resources and partners to advance health (aka the Integrated Family Services model).

More money would be spent on social services and less on traditional medical services. In other countries that have more successful health care systems, a larger proportion of the budget goes to social supports.

There ought to be more investment in the bottom of the pyramid.

We discussed what the workforce would look like in successful reform – probably more social workers than doctors? We did not want to demean the physician role in any way and thought there may be areas where a doctor is what is needed.

We discussed what we mean by the word "provider". If provider is narrowly defined, then we wanted to make sure that it is not just the traditional providers that should be doing care management. If broadly defined, providers could include peers, family, us!

We discussed whether the pyramid concept is new and agreed that it is not entirely new in some parts of the state – however – without a payment method it is difficult to lead efforts such as those in St. Johnsbury.

(2) What is missing (cognitive health, reduced hospital infections, etc)?

This was a difficult question to answer because we did not have the Statewide Health Improvement Plan in front of us to determine what is missing.

But the point was made that efforts to combat hospital infection rates began with public health efforts in Europe – so public health is very broad and inclusive.

One member stated that what's missing is the investment of dollars in the bottom of the pyramid. We discussed the use of Social Impact Bonds or other investment vehicles that Karen referenced. We thought this would be a way to address the concern that it is difficult to add investments in social determinants of health before we see the savings associated with that investment.

(3) What care management practices, principles or protocols will be most impactful in achieving those goals (meaning the PH goals)?

We had a discussion about whether care management should be at the top of the pyramid or at the base of the pyramid and acknowledged that it is hard to tease it out.

One practice that was proposed is to focus on improving units of populations whether it is a neighborhood, zip code, work place, housing or school.

It was suggested that we need some focus and perhaps it should be on people who suffer from inequities.

It was noted that a look at other states shows that we must take a "and/both" approach to targeting. Vermont has been successful because it brings everyone into the Blueprint and targets from there. States that just target do not save.

As a principle, one member suggested that we move away from talking about scarcity of resources and recognize that it is really a matter of allocation of resources.

Group #: 2
Participants: Tracy Dolan, Mary Moulton, Susan Besio, Dana DeMartino, Marlys Waller, Patty Launer and Bea Grause.

Group discussed how to ensure there is a connection from the care setting to population health.

What's missing?

1. The realities of population health/demographics - we will see an increase in services whether it's for obesity-related reasons or runner's knee.

2. Impact of trauma on medical services

3. Veterans/TBI/PTSD

Use population health thinking in primary care settings. e.g. Change the context - treat the whole family, not just the child.

Match up the principles with resources. e.g. patient centered care/patient led care with payments to support; team health with aligned payments to support cooperation.

Group #: 3

Participants: Erin Flynn, Kara Suter, Dale Hackett, Julie Wasserman, Laural Ruggles, Marie Zura

- Importance of Environmental vs. Person-Drive Change:
  - Have to find the right balance between proactive and reactive behavior change.
  - Suggestion that policy levers like smoking bans are top-down government imposed policies. Recommendation to stay away from government imposed policies as much as possible and allow for community based person-driven change.
  - Another recommendation to change societal norms to make the health way the normal way.
  - Potential to see change start on the ground in small communities and roll out state-wide.
  - People need to take accountability and responsibility for their health.
  - Businesses and other public sector actors also need to be responsible for their contribution to public health.
  - Put control in the hand of the individual person and empower people to feel ownership of their own health, with the adequate support and resources to surround the person.

- Focus on Preventive vs. Reactive Health Care:
  - We need to move away from reacting once the problem has already surfaced to more preventative measures that identify problem as early as possible and build the structure to respond once a problem is identified.
  - Use of screening tools and making timely referrals that are actionable. Ex: working with schools on screening tools, connecting the school with outside resources.

- Leadership is disjointed, need more collaboration across diverse sectors (as well as at the community level).

- Need to understand gaps, how referrals can be strengthened and how we can fill the gaps.

- Need to facilitate connections between generations, and across the health care system on a personal level.
  - Suggestion to draw from the most impactful relationship, ie – closest to the patient in the way that is most relevant to each individual.
  - Person centered/self-directed care

- Be thoughtful of the whole family when making decisions. Be aware that any changes that are imposed on one part of a family will have an impact on the other.

- Focus is currently on acute medical care, long term services and supports needs to be in the full spectrum.
  - Can't be solely medical.
  - Long-term care services and supports can focus on the bottom of the pyramid (socio-economic factors).
  - Strengthen the link between LTSS's and focus on socio-economic factors to the traditional medical spend.

Group #: Phone participants
Participants: Michael (Bailit Health and facilitator), Pam Farnham (FAHC), Barbara Cimaglio (DOH), Steve Dickens (Invest EAP), Maura Crandall (OneCare)

(1) What will health care reform success look like based on the Population Health presentation?

- Maura: loved presentation since background in public health; would love to see integration of population health and providers working together holistically to have resources available; integrate AHS and community services that differ in each HSA; make clear when issues come up to whom you refer people so we are working as a team and not in silos; take advantage of our small size to get us all on the same page within each HSA, knowing the resources and knowing population health information
- Barbara: agree with much of Maura; think need planning at the local level (HSA or AHS) and community (not just health care providers) deciding what to do; a lot of keeping healthy and recovering is not about health care; communities would be aware of opportunities and risks, what they are trying to enhance and promote, an shared ways to address. Sounds "pie in the sky", but it is achievable.
- Steve: we are trying to address socioeconomic factors when trying to address stress people experience; we should all be working with that pyramid in mind; we need to be able to articulate a broad vision of health that goes beyond the fields of health
- Pam: need to get away from separating mental health from population health and incorporate the whole body
- Michael: integrate health care and health by holding health care providers receiving population-based payment or global payment accountable for population health in their geographic region to a degree that is reasonable - there is growing attention to doing this in other states (Bailit Health recently did work on this for Maryland)

(2) What is missing (cognitive health, reduced hospital infections, etc.)?

- Steve: pyramid model compelling, but also a little reductionist and simplistic (e.g., suggesting counseling doesn't work) - counseling and education can be population-based
- Maura: doesn't recognize differences in health literacy; some people "need to be carried" - e.g., need home visits because can't follow instruction - help people do what they can do up to their ability
- Barbara: thinking that health is holistic - integration in mind ; make it OK for people to talk about how they are caring for themselves

(3) What care management practices, principles or protocols will be most impactful in achieving those goals?

- Maura: knowing where to go in the community to get help for specific needs; knowing who needs what levels of support and that they are available
- Steve: providers need to seek out information that is germane to their practices
- Barbara: think we are all talking about bring population-based sensibility to health care reform; for care management, we need to streamline and eliminate silos - we still have too many - there needs to be a place for where this is all coordinated for patients with

complex medical and social issues - it's all in the local - need to know people in the local community

- Michael: Why have CHTs not broken down the silos?
- Pam: we are focused on individual patients - we don't have resources to do larger population health work - and providers don't want to take the time to do it (e.g., look at the panel report)

Attachment 4b - State Health Improvement Plan Summary

Improving the health of Vermonters – our shared agenda

VERMONT
DEPARTMENT OF HEALTH

Deb Wilcox • Director of Planning and Healthcare Quality

• May, 2014

Presentation to Care Models and Care Management Working Group, VHCIP

Presentation includes:

- Review of data (demographics, cause of death/hospitalization, preventive and risk behaviors, chronic disease prevalence)
- Brief view of State Health Assessment (Healthy Vermonters 2020) and State Health Improvement Plan
- Measurement/reporting

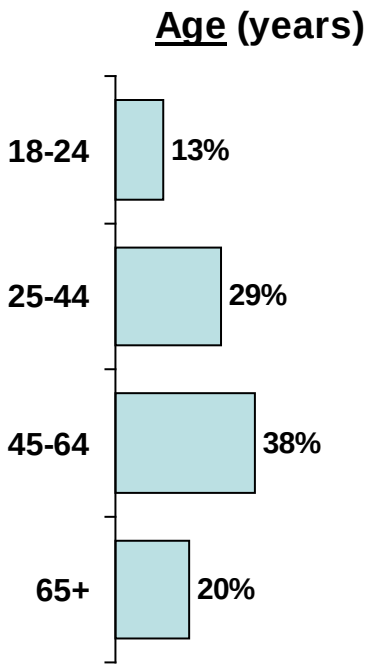
The data in this presentation is draft.

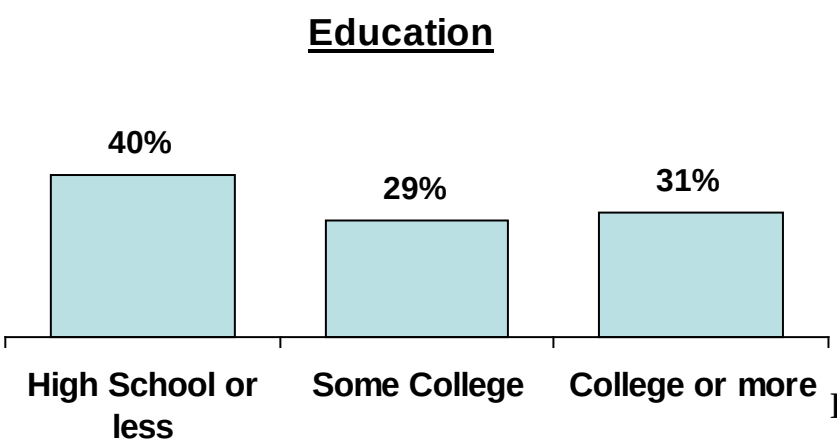
Demographics of Adult Vermonters

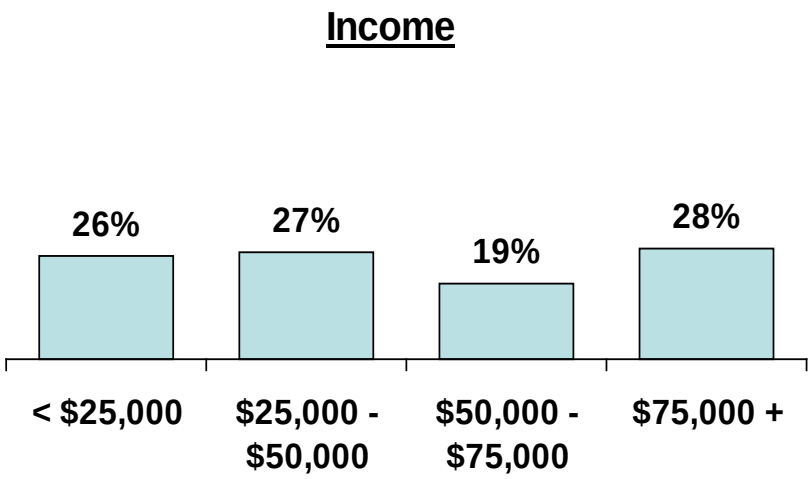
Vermont has an aging adult population. One-fifth of the adult population is 65 or older and nearly two-fifths are between age 45 and 64 years of age. Nearly a third of adults are age 25 to 44 years and slightly more than one in ten are age 18 to 24 years.

Nearly a third of adult Vermonters have at least a four-year college degree. However, a significant proportion of the population do not have any education beyond high school (40%).

Slightly more than half of Vermonters earn less than $50,000; while slightly less than half earn more than $50,000 a year.



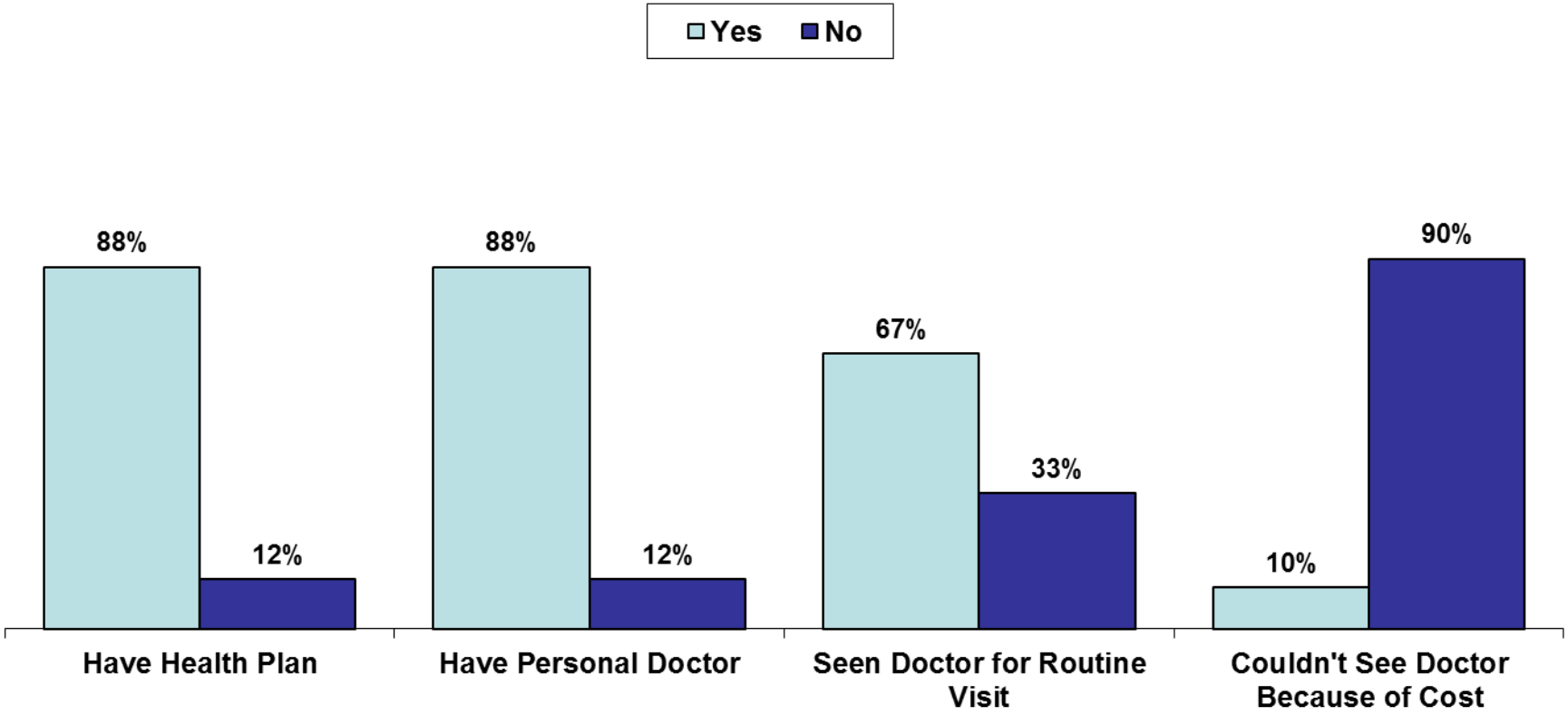




DRAFT

Health Care Access

Nine out of ten Vermonters have access to health insurance, have someone they consider their personal doctor and did not find “cost” to be a barrier to seeing a doctor in the past year. Two-thirds have been to see their doctor for a routine care visit in the past year.



DRAFT

Health Care Access Trends

None of the health care access measures have changed significantly since 2000.

	Do Not Have Health Plan (18-64 yrs)	Do Not Have Personal Physician	Not Seen Doc in 12 Months	Could Not See Doctor Due To Cost
2002	*14%*	*15%*	*--*	*--*
2003	*12%*	*15%*	*--*	*9%*
2004	*15%*	*14%*	*--*	*11%*
2005	*14%*	*12%*	*38%*	*10%*
2006	*13%*	*12%*	*36%*	*10%*
2007	*13%*	*14%*	*35%*	*10%*
2008	*13%*	*11%*	*34%*	*10%*
2009	*12%*	*13%*	*36%*	*11%*
2010	*10%*	*10%*	*35%*	*9%*
2011	11%	12%	33%	11%
2012	12%	12%	33%	10%

DRAFT

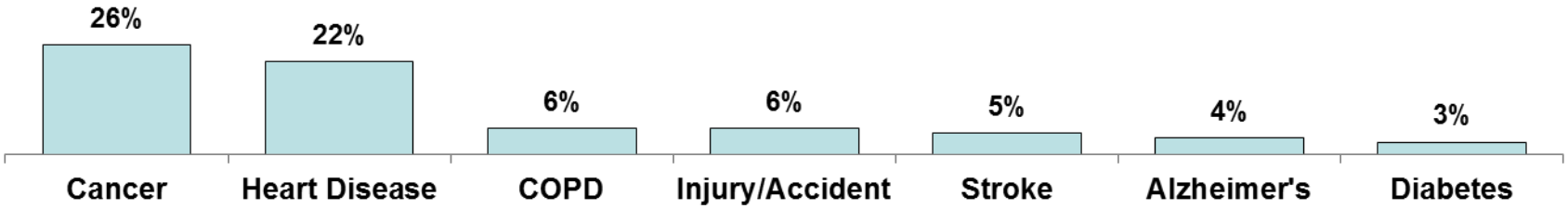
Leading Causes of Death

The three leading causes of death in Vermont are related to chronic disease. Nearly half of all deaths are caused by cancer or heart disease. Chronic lower respiratory disease is the third leading cause of death.

The fourth leading cause of death is not related to chronic disease – accidental injury accounts for about six percent of death in Vermont.

The fifth leading cause of death is stroke. Alzheimer's and diabetes are responsible for slightly fewer deaths in the state, but are still in the top 10 leading causes of death.

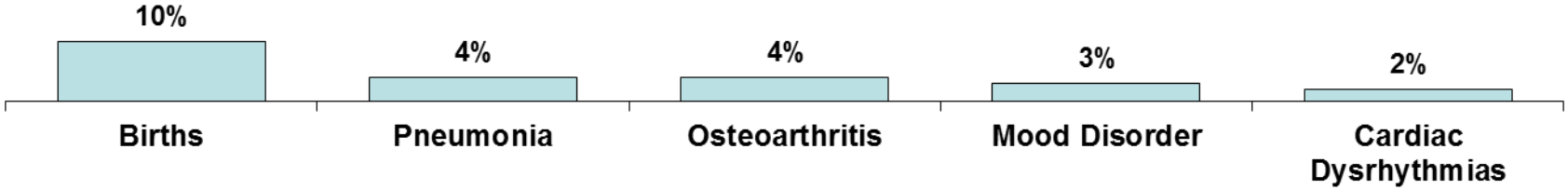
Leading causes of death (% of all deaths among Vermonters)



Leading Diagnoses of Hospital Discharges

The leading primary diagnosis associated with a hospital discharge among Vermonters is not related to chronic disease. Live births were the most common hospital discharges in 2009. Independently, pneumonia and osteoarthritis, were the next most common primary diagnoses associated with a hospital discharge.

Chronic conditions include: diabetes, depression, arthritis, cardiovascular disease, asthma, COPD, cancer, and obesity.

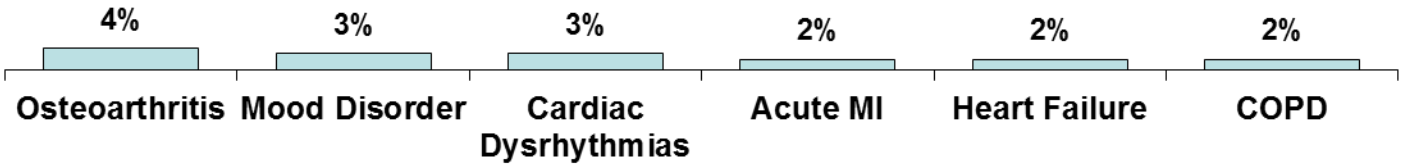


DRAFT

Leading diagnoses of Hospital Discharges – For Chronic Disease

The leading chronic disease discharges for hospitalizations are osteoarthritis, mood disorders, and cardiac dysrhythmias.

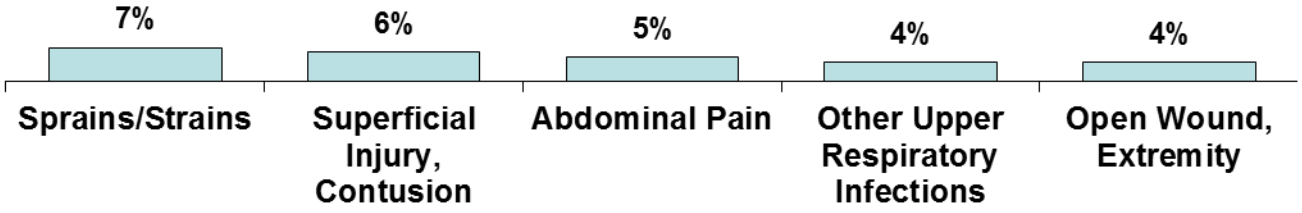
Three of the six leading chronic disease diagnosis are related to cardiovascular disease. Combined, these three diagnosis make up 7% of all hospitalizations.



DRAFT

Leading Diagnoses of Emergency Department Discharges

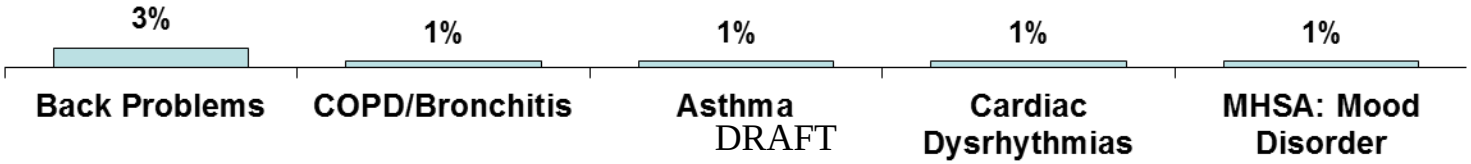
As with hospitalizations, chronic disease does not account for the leading causes of emergency department visits in Vermont. Injury accounts for four of the top five causes and abdominal pain is the third leading cause of an ED visit.



DRAFT

Leading Diagnoses of Emergency Department Discharges-For Chronic Disease

The primary chronic conditions diagnosed upon emergency department discharge include: back problems, respiratory problems, cardiac events and mental health/substance abuse.

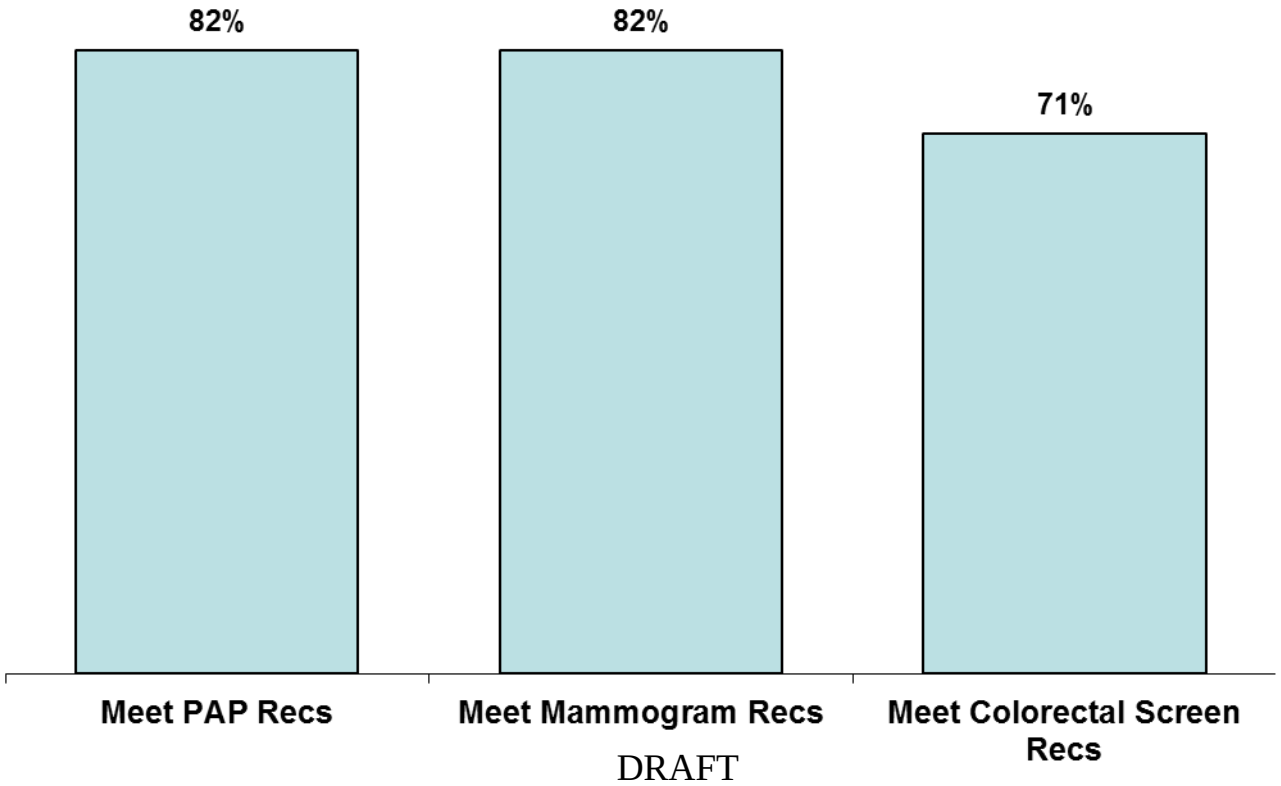


DRAFT

2009 Hospital Discharge Data

Preventative Behaviors

Of those persons recommended to have cervical, breast, and colorectal cancer screenings, many have indeed had the recommended screenings in the recommended time frame.



2012 BRFSS, *All data on this page is age adjusted to the U.S. 2000 population

Preventative Behavior Trends

None of the preventative care measures have changed significantly since 2002.

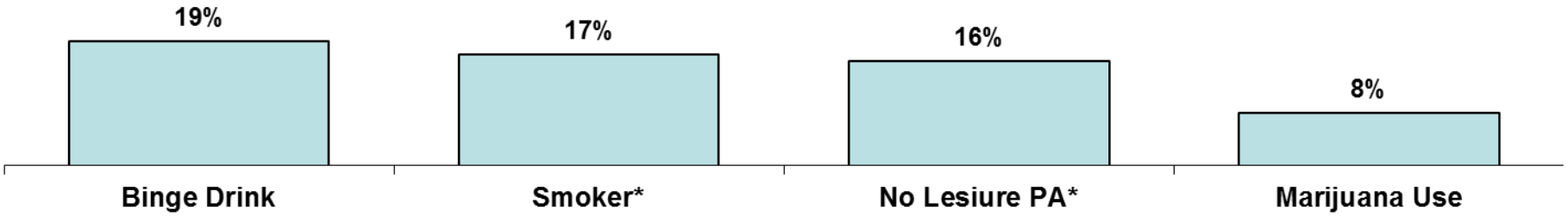
	Mammogram	PAP	Colorectal	Prostate	5 A Day	Meets PA Recs
2002	*84%*	*89%*	--	*74%*	--	--
2003	*84%*	*89%*	--	--	--	--
2004	*80%*	*88%*	--	*71%*	--	--
2005	*84%*	*88%*	--	--	--	--
2006	*84%*	*88%*	--	*74%*	--	--
2007	--	--	--	--	--	--
2008	*83%*	*87%*	*68%*	*77%*	--	--
2009	--	--	--	--	--	--
2010	*83%*	*84%*	*71%*	*78%*	--	--
2011	--	--	--	--	23%	59%
2012	82%	82%	71%	63%	--	--

DRAFT

2012 BRFSS, *All data on this page is age adjusted to the U.S. 2000 population

Risk Behaviors

Just fewer than one in five do not get any physical activity in their leisure time, binge drink or smoke. Just less than one in ten report current marijuana use.



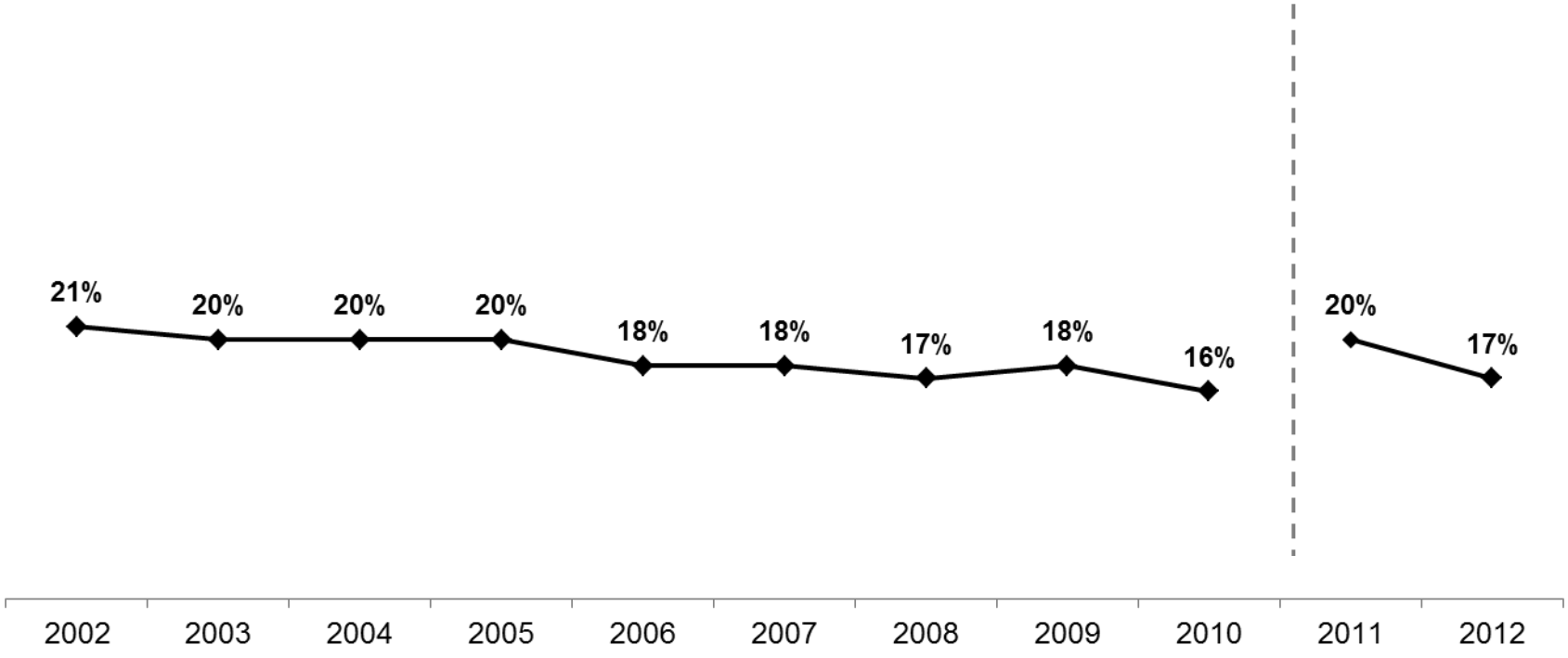
DRAFT

2012 BRFSS, *Data is age adjusted to the U.S. 2000 population

Risk Behaviors -

Smoking Prevalence

Smoking has significantly declined since 2000. While smoking prevalence in 2011 appeared to increase, this at least is partially due to the change in BRFSS weighting methodology. Smoking prevalence in 2012 did not significantly change from the previous year.



DRAFT

BRFSS 2002-2012, *All data on this page is age adjusted to the U.S. 2000 population

Risk Behaviors –

Other Risk Behavior Trends

The proportion of those reporting no leisure time for physical activity significantly decreased from 2011 to 2012. This is the only statistically significant change in trend of a risk behavior since 2006.

	No Leisure Time PA*	Binge Drink*	Marijuana Use
2006	*17%*	*17%*	*--*
2007	*18%*	*18%*	*8%*
2008	*19%*	*17%*	*7%*
2009	*20%*	*17%*	*8%*
2010	*17%*	*17%*	*8%*
2011	21%	18%	10%
2012	16%	19%	8%

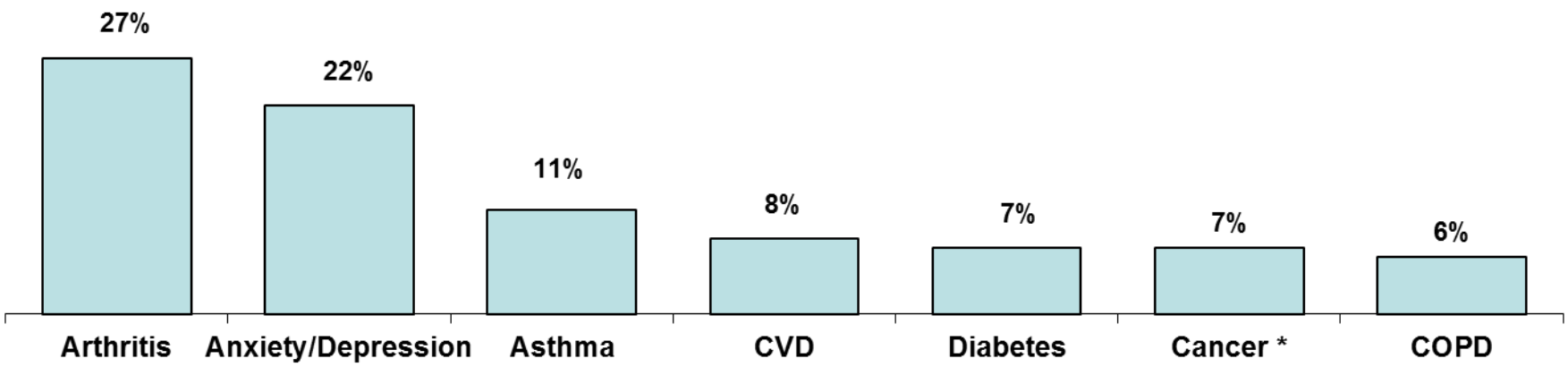
DRAFT

2012 BRFSS, *Data is age adjusted to the U.S. 2000 population

Chronic Disease Prevalence

Arthritis is the most common chronic disease in Vermont. Slightly more than one fifth of Vermonters have anxiety and/or depression issues. Asthma impacts approximately one in ten adult Vermonters. Slightly fewer Vermonters have CVD, diabetes, or cancer. COPD effects 6% of the adult population.

Chronic conditions include: diabetes, depression, arthritis, cardiovascular disease, asthma, COPD, cancer, and obesity.



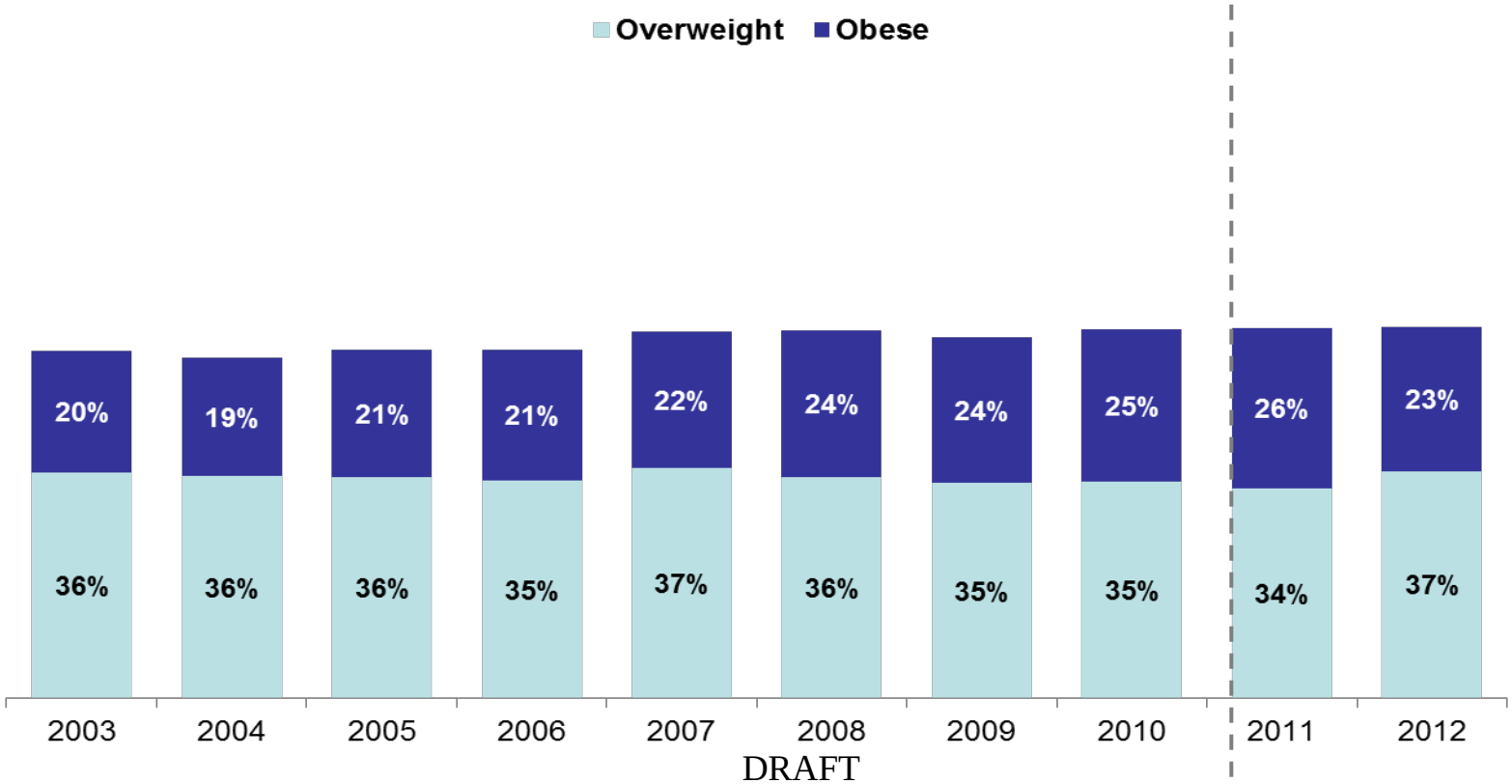
DRAFT

2012 BRFSS,
*Cancer prevalence does not include aquamous cell or basil cell carcinomas and is calculated according to cancer program methods

Chronic Disease Prevalence –

Obesity and Overweight

More than a third of Vermonters, age 20 and older, were overweight, and another quarter were considered obese in 2012. Neither obesity nor overweight prevalence significantly increased from 2011 to 2012. In 2003, 20% of Vermonters were obese and it increased to a quarter of adult Vermonters in 2010, a statistically significant increase.



BRFSS 2002-2012, *All data on this page includes Vermonters age 20 and older and data is age adjusted to the U.S. 2000 population

Chronic Disease Prevalence Trends

No other chronic disease prevalence has increased significantly since 2002.

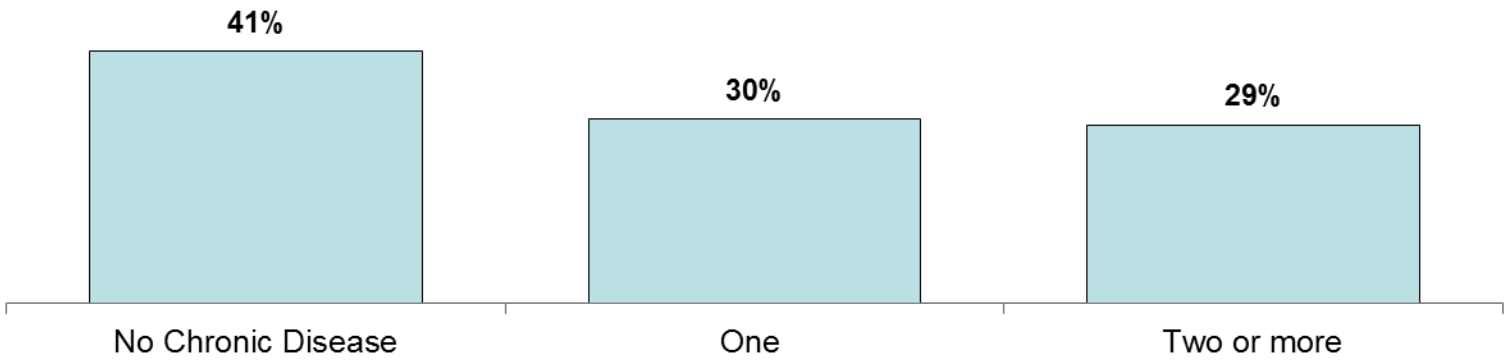
	Arthritis	Cancer	COPD	CVD	Hypertension	Depressive Disorder
2002	*25%*	*--*	*4%*	*--*	*--*	*--*
2003	*27%*	*--*	*4%*	*8%*	*22%*	*--*
2004	*--*	*--*	*4%*	*8%*	*--*	*--*
2005	*27%*	*--*	*5%*	*7%*	*22%*	*--*
2006	*25%*	*--*	*--*	*7%*	*--*	*20%*
2007	*28%*	*--*	*2%*	*7%*	*23%*	*--*
2008	*--*	*--*	*3%*	*8%*	*--*	*21%*
2009	*29%*	*--*	*--*	*7%*	*25%*	*--*
2010	*--*	*--*	*--*	*7%*	*--*	*21%*
2011	27%	7%	5%	8%	27%	23%
2012	27%	7%	6%	8%	--	22%

DRAFT

Multiple Chronic Conditions

More than half of adult Vermonters have at least one chronic condition.

Chronic conditions include: diabetes, depression, arthritis, cardiovascular disease, asthma, COPD, cancer, and obesity.



DRAFT

State Health Assessment Plan • Healthy Vermonters 2020

HEALTHY VERMONTERS 2020

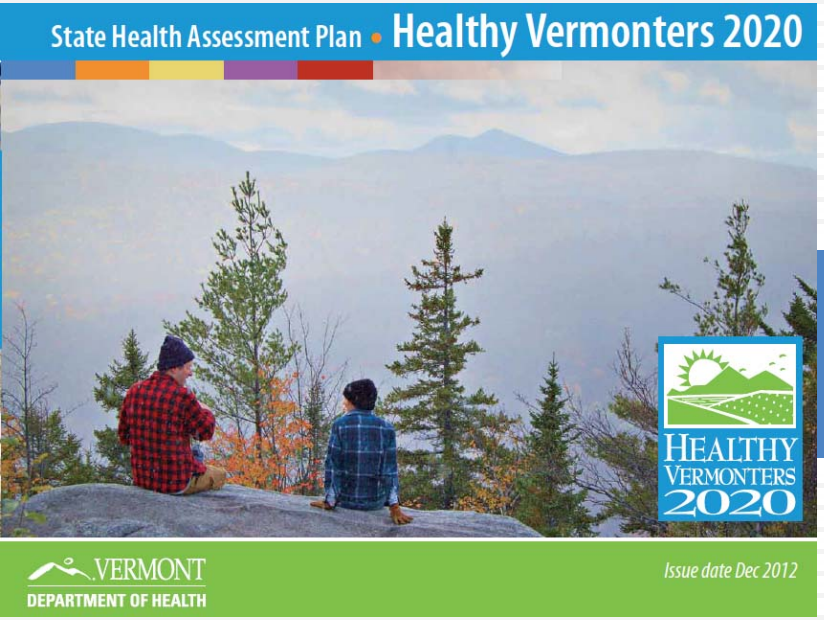
VERMONT
DEPARTMENT OF HEALTH

Issue date Dec 2012

10-year goals:

Documents the health status of Vermonters in 2010, and the population health indicators & goals that will guide our work through 2020

100+ goals • 21 focus areas • 5 themes



Five Themes:

A Healthy Lifetime

Providing for Better Health

Behaviors, Environment & Health

Diseases & Health Conditions

Public Health Preparedness

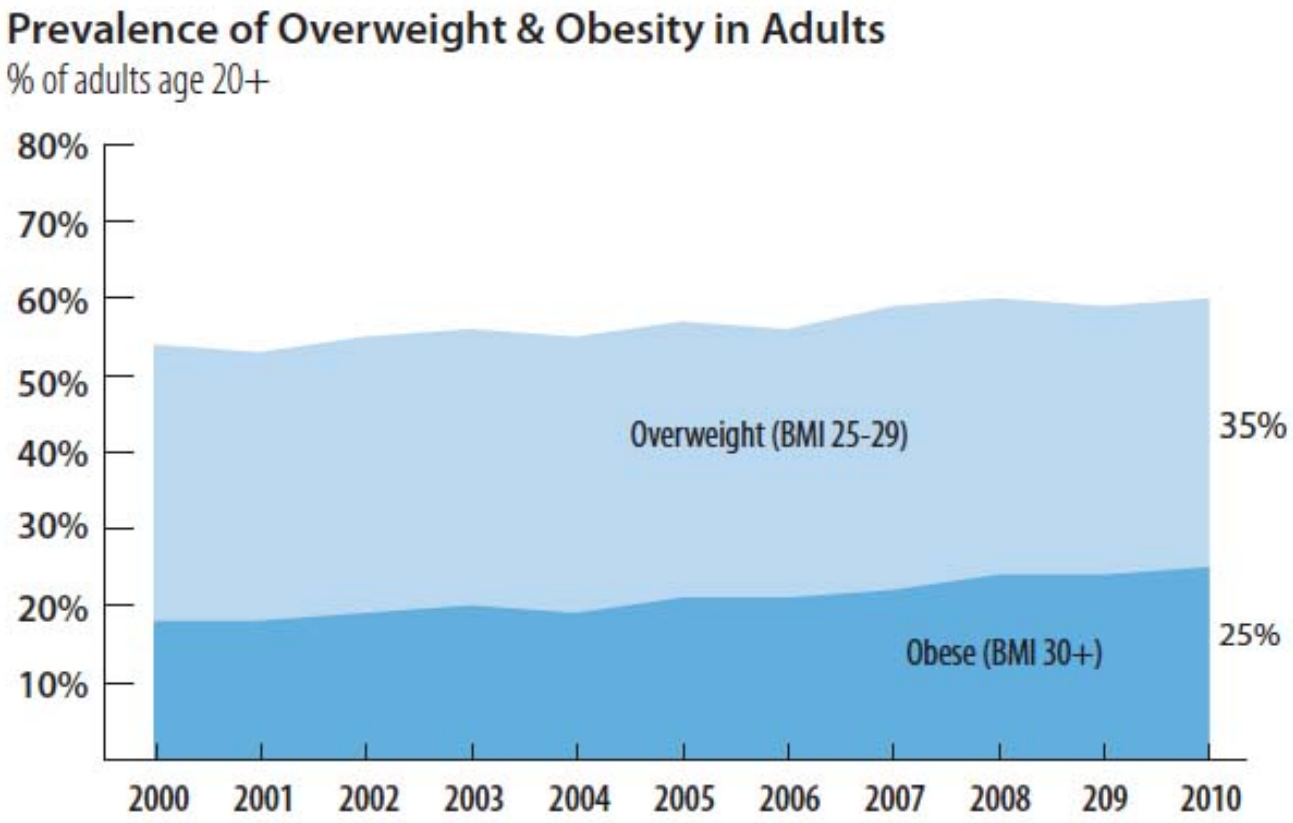
Healthy Vermonters 2020 • Nutrition & Weight

GOAL –

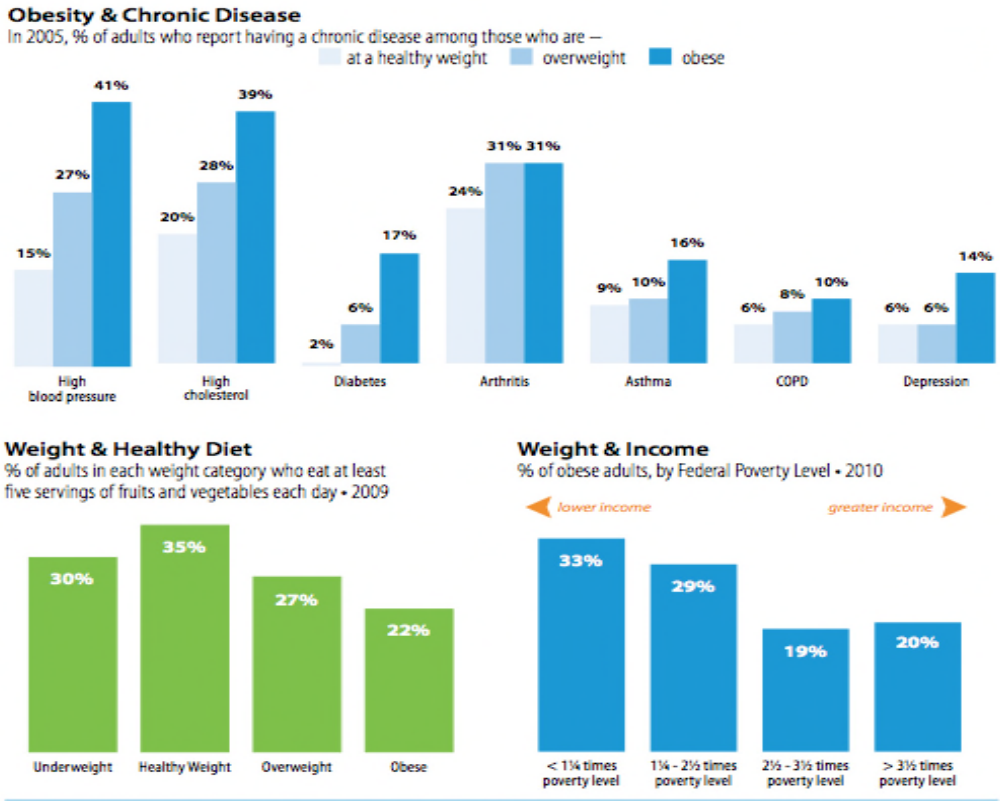
By 2020, reduce % of people who are obese:

20% = Adults

8% = Youth



Healthy Vermonters – Nutrition & Weight



• Obesity is the #2 Real Killer
Vermonters, like other Americans, are growing more overweight—a trend that holds true for both adults and children. Obesity is a highly complex and multi-facteted condition but, very simply stated, it is the result of eating too much and moving too little.

• Link to Chronic Disease
The terms 'overweight' and 'obese' describe weight ranges that are above what is medically considered to be healthy. Being overweight or obese greatly increases a person's risk for many serious health conditions, including high blood pressure, high cholesterol, Type 2 diabetes, heart disease and stroke, gallbladder disease, osteo-arthritis, sleep apnea and some cancers. Even modest weight loss can lower risk.

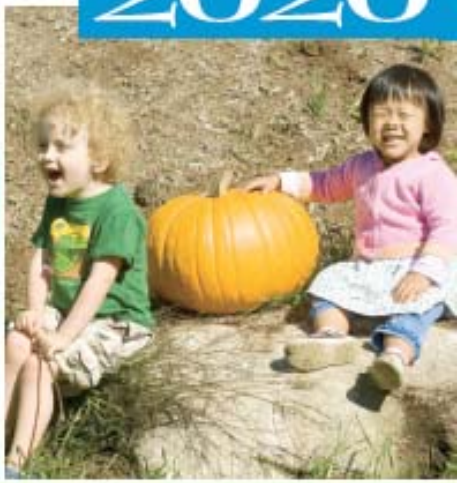
• Who is at Risk?
Obesity affects people of all racial and ethnic backgrounds, income and education levels. In Vermont, highest rates are among those people who have lower incomes.

• The Problem with Food Insecurity
Food insecurity means not having enough food to eat and not enough money to buy food. Adults who do not have food security must often compromise quality for quantity, buying less nutritious and higher-calorie, but lower-cost foods for themselves and their families.

• Eat More Colors!
A healthy diet includes at least five servings of fruit and vegetables every day. Vermont youth of racial or ethnic minority groups are more likely to eat five servings than white youth.

State Health Improvement Plan • 2013–2017

HEALTHY VERMONTERS 2020



VERMONT
DEPARTMENT OF HEALTH

Issue date Jan 2013

Five-year priorities

Broad goals from Health Vermonters 2020 –

- Reduce prevalence of chronic disease
- Reduce prevalence of substance abuse/mental illness
- Improve childhood immunization rates

Reduce prevalence of chronic disease

GOAL 1: **Reduce the prevalence of chronic disease**

Tobacco Use

Tobacco use is the single most preventable cause of disease, disability and death in the U. S. It is associated with increased risk for some cancers, heart disease and other chronic diseases. Of the estimated 75,500 adult Vermonters who were smokers in 2010, half of those who continue will likely die of a smoking related cause.

About one-third of very low income (31%) and uninsured (35%) adults smoke. Those who did not graduate from high school are more likely to smoke (39%), and an estimated 38 percent of adults with mental illness smoke. Also in Vermont, 27 percent of adults and 19 percent of youth of racial and ethnic minorities are current smokers, compared to 17 percent of adults and 13 percent of youth who are white.

- Reduce % of adults who smoke cigarettes
  - 2020 Goal: 12%
  - 2010 Baseline: 16%

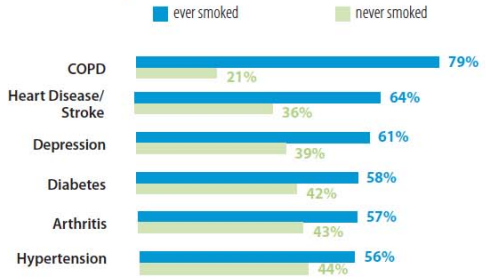
- Reduce % of youth in grades 9-12 who smoke cigarettes
  - 2020 Goal: 10%
  - 2011 Baseline: 13%

Evidence-based strategies

- Promote creation of smoke-free environments.
- Reduce point-of-sale marketing and product placement.
- Participate in statewide adult cessation media campaigns.

Smoking & Chronic Disease

Smoking status of adults who have chronic illnesses • 2010

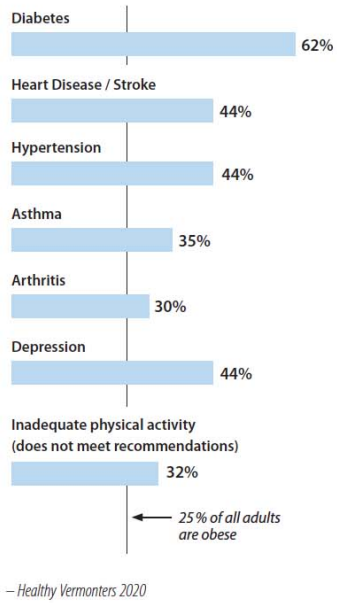


54% of all adults have never smoked

– Healthy Vermonters 2020

7

Reduce prevalence of chronic disease



– *Healthy Vermonters 2020*

Nutrition and Physical Activity

Poor nutrition and physical inactivity are associated with a number of chronic conditions. This includes obesity, the second leading cause of preventable death in the U.S., after tobacco use. Being overweight or obese greatly increases a person's risk for many serious health conditions, including high blood pressure, high cholesterol, Type 2 diabetes, heart disease and some cancers. For the first time in history, children may not live as long as their parents.

- Increase % of people who eat 2+ servings of fruit/day

Youth in grades 9-12		Adults age 18+	
2020 Goal:	40%	2020 Goal:	45%
2011 Baseline:	26%	2009 Baseline:	38%

- Increase % of people who eat 3+ servings of vegetables/day

Youth in grades 9-12		Adults age 18+	
2020 Goal:	20%	2020 Goal:	35%
2011 Baseline:	17%	2009 Baseline:	30%

- Increase % of people who meet physical activity guidelines

Youth in grades 9-12		Adults age 18+	
2020 Goal:	30%	2020 Goal:	65%
2011 Baseline:	24%	2009 Baseline:	59%

Evidence-based strategies:

- Create or enhance access to locations for physical activity and healthy eating.
- Provide incentives to food retailers to locate in underserved areas and to offer healthier food and beverage choices.
- Promote increased physical activity and healthy eating options at worksites.
- Encourage increased availability of healthier food and beverage choices at public service venues, including schools.
- Restrict availability of less healthy foods and beverages at public service venues, including child care settings.

8

Vermont Department of Health

Reduce prevalence of substance abuse/mental illness

Goal 2: **Reduce the prevalence of individuals with or at risk of substance abuse or mental illness**

Substance Abuse

Alcohol contributes to motor vehicle crash fatalities, suicides, domestic violence and unintentional injuries. The age when a young person starts drinking strongly predicts alcohol dependence. Although the binge drinking rate among 12- to 20-year-old Vermonters has declined since 2007-2008, Vermont still has the highest rate of underage binge drinking in the country among this age group.

- Decrease % of youth age 12-17 years who binge drink

2020 Goal:	10%
2008-09 Baseline:	11%

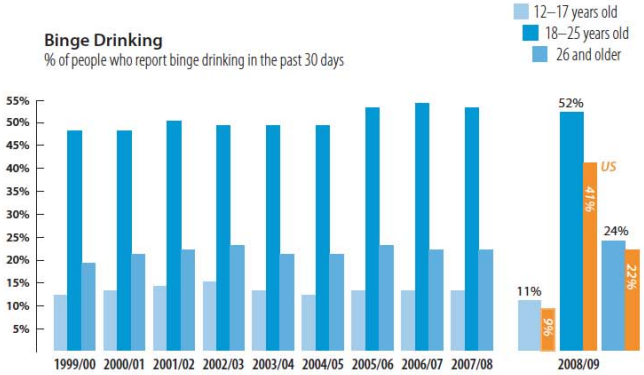
- Reduce % of people age 12+ years who need and do not receive treatment for alcohol use

2020 Goal:	5%
2008-09 Baseline:	7%

Evidence-based strategies:

- Encourage use of the Addictions Severity Index and the Comprehensive Health Assessment for Teens (ASI/CHAT) tool among treatment providers.
- Develop policies that restrict hours of operation of alcohol outlets and limit locations of alcohol service.
- Implement Parent Family Education Programs that have been tested and shown to increase coping, communication and family management skills with parents and youth.

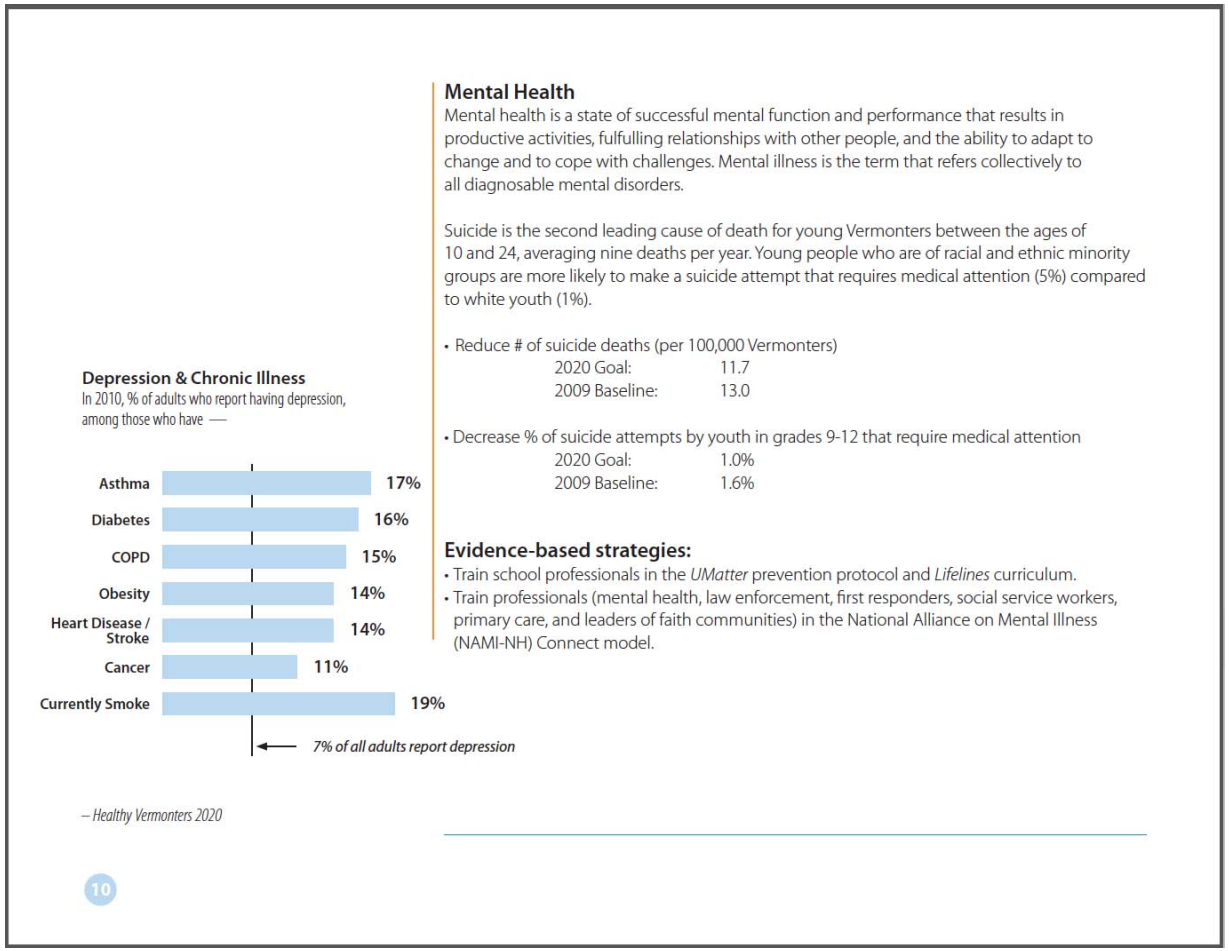
Binge Drinking
% of people who report binge drinking in the past 30 days



– *Healthy Vermonters 2020*

9

Reduce prevalence of substance abuse/mental illness



Mental Health

Mental health is a state of successful mental function and performance that results in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental illness is the term that refers collectively to all diagnosable mental disorders.

Suicide is the second leading cause of death for young Vermonters between the ages of 10 and 24, averaging nine deaths per year. Young people who are of racial and ethnic minority groups are more likely to make a suicide attempt that requires medical attention (5%) compared to white youth (1%).

- Reduce # of suicide deaths (per 100,000 Vermonters)
  - 2020 Goal: 11.7
  - 2009 Baseline: 13.0
- Decrease % of suicide attempts by youth in grades 9-12 that require medical attention
  - 2020 Goal: 1.0%
  - 2009 Baseline: 1.6%

Evidence-based strategies:

- Train school professionals in the *UMatter* prevention protocol and *Lifelines* curriculum.
- Train professionals (mental health, law enforcement, first responders, social service workers, primary care, and leaders of faith communities) in the National Alliance on Mental Illness (NAMI-NH) Connect model.

Vermont Department of Health

Improve childhood immunization rates

Goal 3: Improve childhood immunization rates

A person who is fully immunized is protected against vaccine preventable disease or severe illness, and helps protect the community from disease outbreaks. Some parents question whether all vaccines are still needed, and are concerned by the increased number of vaccines that are recommended and misinformation about vaccine safety. Overall immunization rates in Vermont have trended downward until recently. For the 2010/11 school year, 6 percent of children entering Kindergarten had a religious or philosophical exemption. Another 11 percent entered provisionally, without being up to date on their vaccinations. Because immunity to some diseases wanes over time, adolescents need one dose of Tdap booster vaccine by age 15.

- Increase % of children age 19-35 months who receive recommended vaccines
  - 2020 Goal: 80%
  - 2010 Baseline: 41%
- Increase % of Kindergarteners with two or more doses of MMR (measles, mumps, rubella) vaccine
  - 2020 Goal: 95%
  - 2010-11 Baseline: 91%
- Increase % of youth age 13-15 who are vaccinated with one dose of Tdap (tetanus, diphtheria, pertussis) vaccine
  - 2020 Goal: 90%
  - 2010 Baseline: 83%

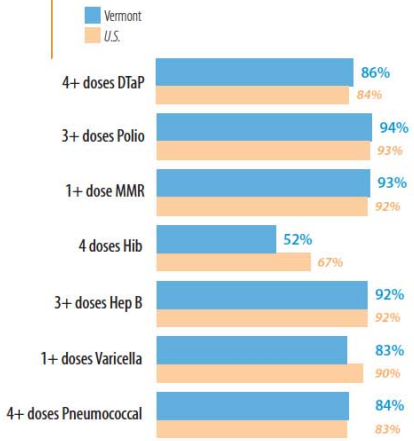
Evidence-based strategies:

- Encourage client reminder-recall systems in provider practices.
- Support vaccination requirements for child care, school and college attendance.
- Conduct site visits with all provider practices enrolled in Vaccines for Children (VFC) and Vaccines for Adults (VFA) annually.

Vaccine Series for Babies

% of babies age 19-35 months who are fully immunized with five universally recommended vaccines • 2010 *

DTaP to prevent Diphtheria, Tetanus and Pertussis (Whooping Cough)
Polio to prevent Polio
MMR to prevent Measles, Mumps and Rubella
Hib to prevent Haemophilus Influenzae b
Hep B to prevent Hepatitis B
Varicella to prevent Varicella (Chickenpox)
Pneumococcal Vaccine to prevent Pneumococcal Disease



* *A national shortage of Hib vaccine contributed to lower rates of fully immunized babies in Vermont and the U.S. for 2009 and 2010.*

11

Vermont Department of Health

Monitoring and Reporting

How are we monitoring and reporting on our success in changing population health indicators and program performance measures?

Toolkit:

- Indicators/performance measures linked to Healthy Vermonters 2020
- Captures our efforts to effect positive change
- Progress is tracked over time
- Publically accessible

Healthy Vermonters Toolkit

www.healthvermont.gov/hv2020/index.aspx

Plans

Healthy Vermonters 2020
is the State Health Assessment Plan that documents the health status of Vermonters at the start of the decade, and the population health indicators and goals that will guide the work of public health through 2020.

State Health Improvement Plan
is a five-year plan that prioritizes broad Healthy Vermonters 2020 goals: reducing prevalence of chronic disease, reducing prevalence of substance abuse and mental illness, and improving childhood immunizations. Includes strategies and planned interventions.

Health Department Strategic Plan
is a three-year plan that sets the strategic direction and priorities, based on Healthy Vermonters 2020 data, to guide the Health Department's work, quality and system improvements.

Dashboard, Maps & Trends

Performance Dashboard

The Performance Dashboard is built on the concepts of *Results Based Accountability*™ and displays current information to show "how we are doing":

- **Population Indicators** (such as smoking prevalence) are measures for which the Health Department, with state government and community partners, share responsibility for making change. All Healthy Vermonters 2020 indicators are displayed.
- **Performance Measures** (such as the percentage of smokers registered with the Vermont Quit Network), are measures for which Health Department programs are responsible for the performance of interventions that, over time, will improve health, as reflected in the population indicators (such as reduced smoking prevalence).

Maps & Trends

The Health Department routinely uses three ways to assess population indicators(such as smoking prevalence) at the local level: by county, by Health Department district office area, and by hospital service area (HSA). Maps & Trends links you to interactive InstantAtlas™ pages, with maps, tables and graphs for all Healthy Vermonters 2020 indicators and goals.

Performance Dashboard: Statewide Tobacco

What are our state health priorities and what is VDH doing to address these priorities?

Population Results

Name	Prior Period	Current Value	Trend Over # of Periods	Target Value	Most Recent Period
Tobacco: Reduce the number of Vermonters who smoke					
Tobacco: % of adults smoking cigarettes	16%	20%	1	10%	2011
Tobacco: % of adolescents smoking cigarettes	18%	13%	1	10%	2011
Tobacco: % of adult smokers who attempted to quit in the last year	62%	55%	1	80%	2011
Tobacco: # of statewide laws on smoke-free indoor air to prohibit smoking in public places	N/A	8	0	12	2011

Program Performance

Name	Prior Period	Current Value	Trend Over # of Periods	Target Value	Most Recent Period
Tobacco: Tobacco					
Tobacco: % of Medicaid (or proxy thereof) Quit by Phone clients who complete 4 or more sessions	N/A	4.6%	0	5.5%	Q3 2012
Tobacco: # of registrants to the Vermont Quit Network	N/A	701	0	720	Q3 2012
Tobacco: # of smokers who were referred via fax to the Vermont Quit Network Quit by Phone Program	N/A	121	0	165	Q3 2012
Tobacco: Anti-tobacco media campaign intensity for low-income adults, in Gross Rating Points (GRP) per quarter	N/A	0	0	0	Q3 2012
Tobacco: % of youth coalitions that educate local or state decisionmakers on smoke free policy and retailer tobacco advertising restrictions	N/A	0%	0	100%	2012
Tobacco: Anti-tobacco media campaign intensity for teens in Gross Rating Points (GRP) per quarter	N/A	0	0	0	Q3 2012

Done | Local intranet | Protected Mode: Off | 100%

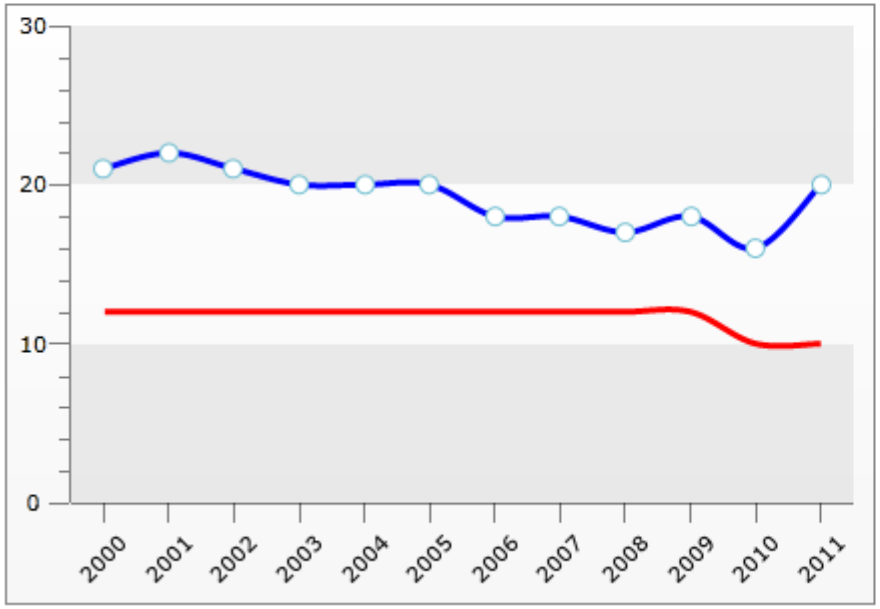
Performance Dashboard: Statewide Tobacco – Trend data

How have we done over time?

Tobacco:Reduce the number of Vermonters who smoke

Display Setting | Apply

Tobacco:% of adults smoking cigarettes



Time Period	Target Value	Actual Value
2011	10%	20%
2010	10%	16%
2009	12%	18%
2008	12%	17%
2007	12%	18%
2006	12%	18%
2005	12%	20%
2004	12%	20%

Maps & Trends: Statewide Tobacco

How are we doing by County, HSA, or District area?

Tobacco Use

Percent of adults who currently smoke (BRFSS, 2008-2010)

*This is a Healthy Vermonters 2020 objective

VERMONT DEPARTMENT OF HEALTH

Additional Objectives | Performance Dashboard | Data Notes | Export Data | Screen Capture | Print | Help

County / State	% current smokers	Statistically compared to state
Addison	13	Better
Bennington	21	Same
Caledonia	19	Same
Chittenden	12	Better
Essex	29	Worse
Franklin	19	Same
Grand Isle	18	Same
Lamoille	20	Same
Orange	20	Same
Orleans	22	Worse
Rutland	20	Same
Washington	17	Same
Windham	18	Same
Windsor	17	Same
Vermont	16	N/A

Using this webpage

This webpage is interactive. To sort, click table column headings. To display data on the TREND chart, select the table, map, or legend (ctrl-click for multiple selections). To watch a slideshow of changes over time, click Play on the TREND slider bar below. To view by a different geography, choose below the LEGEND.

About this indicator

Survey Question: Among adults who have smoked more than 100 lifetime cigarettes and answered "everyday" or "some days" to, "Do you now smoke cigarettes everyday, some days, or not at all?"

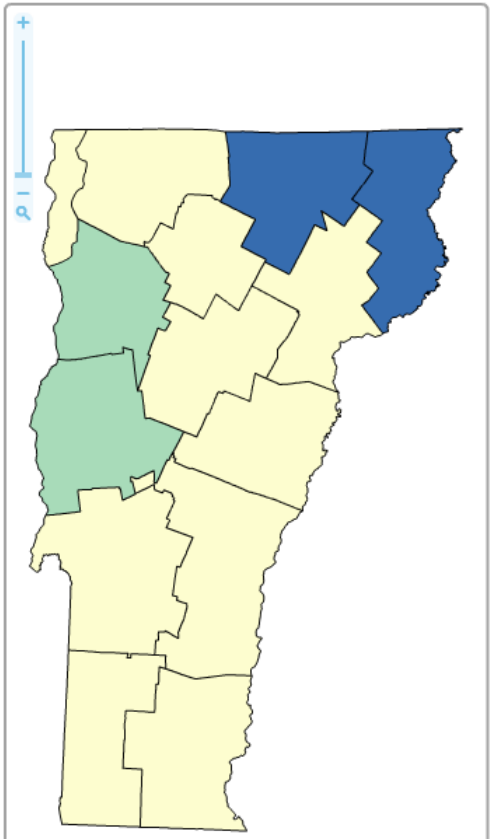
LEGEND - Counties

- Better
- Same
- Worse
- N/A

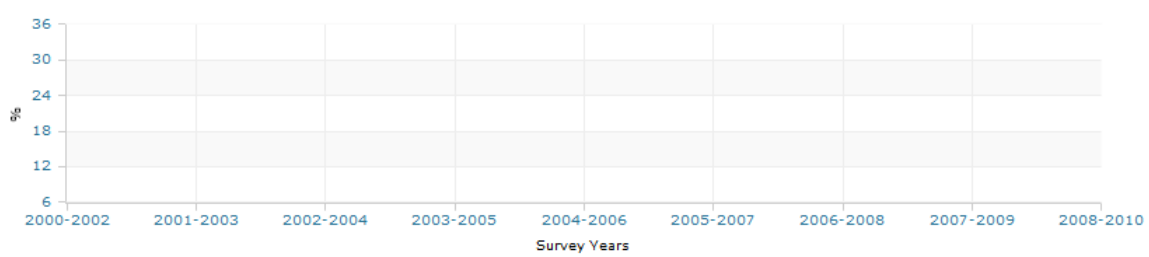
Health District Offices

Hospital Service Areas

TREND 2000



TREND - to view trend, scroll over tables, map, or legend



Thank you!

Attachment 5a - Potential Topics for Care Management Standards

Potential Topics for Care Management Standards for Vermont's Medicaid and Commercial ACO Shared Savings Programs

Potential Domains: ACO Care Management Program Structure, ACO Care Managers' Relationships with Other Organizations, ACO Care Management Activities, ACO Care Management Program Evaluation

Potential Topics:

1. Role of partnerships among ACOs and social and community service organizations
2. Activation and engagement of people needing services
3. Role of existing foundation of advanced primary care and health home models
4. Setting of care management services
5. Role of panels of participants/people needing services
6. Self-management support for people needing services
7. Composition, function, and role of Clinical Advisory Boards, and how they relate to locally-based care management teams
8. Use of screening and assessment tools
9. Use of and access to care management plans
10. Measurement of care management performance, including impact on people needing services
11. Roles and communication protocols for those involved in care management for ACO members needing services, including informal supports

For additional topics, see Attachment 5b – Proposed DLTSS Care Model Elements

Attachment 5b - Proposed DLTSS Care Model Elements

Basis for Design of Proposed DLTSS Model of Care

NATIONAL EVIDENCED-BASED DLTSS MODEL OF CARE ELEMENTS				
Core Elements	Commission on Long-Term Care, September 2013 Report to Congress	CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered and Directed Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	✓		✓
Actively Involved Primary Care Physician		✓	✓	
Provider Network with Specialized DLTSS Expertise	✓	✓	✓	✓
Integration between Medical & DLTSS Care	✓	✓	✓	✓
Single Point of Contact for person with DLTSS Needs across All Services	✓	✓	✓	
Standardized Assessment Tool	✓	✓		✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services		✓	✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓