Attachment 1 - Population Health Work Group Meeting Agenda 10-14-14

VT Health Care Innovation Project
Population Health Work Group Meeting Agenda

Date: Tuesday, October 14, 2014 Time: 2:30-4:00 pm
Location ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 420-323-867

All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.

AGENDA

Item #	Time	Topic	Presenter	Relevant Attachments	Action #
1	2:30	**Welcome, roll call and agenda review**	Tracy Dolan	**Attachment 1:** Agenda	
2	2:35	**Approval of minutes**	Tracy Dolan	**Attachment 2:** Minutes	
3	2:40	**Updates** Contract with PI RWJF Grant pending Escape Velocity	Karen Hein		
4	2:45	Totally Accountable Care Organization: New models considered in Medicaid • Overview of TACO as an aspirational model developed through a learning collaborative • Brief review of Shared Savings ACO Program in Vermont and potential next steps • Q & A	Rob Houston, CHCS Kara Suter, DVHA	**Attachment 4a:** CHCS TACO Fact Sheet **Attachment 4b**: SS/ACO PowerPoint **Attachment 4c**: VT TACO Webinar	
5	3:15	**Examples and Ideas for Integrating Population Health** How does this model fit with our prior discussions for building upon existing seeds of a community health system that links clinical care and community systems What else would we want to be considered to fully integrate population health?	Large Group Discussion		
6	3:55	**Next Steps** *What information do work group members need in order to continue our work together?*	Karen Hein Jim Hester		

OPEN ACTION ITEM LOG					
Date Added	**Action Number**	**Assigned to:**	**Action /Status**	**Due Date**	**Date Closed**
			• .		
			•		
			•		
			•		

Attachment 2 - Population Health Work Group Minutes 9-09-14

VT Health Care Innovation Project
Population Health Work Group Meeting
Minutes

Date of meeting: Tuesday, September 9th, 2014; 2:30 to 4:00 PM, ACCD – Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, roll call and agenda review	• Karen Hein called the meeting to order at 2:30 pm and welcomed everyone. Georgia Maheras took roll call. • Karen reviewed the agenda and gave the group context as to how the agenda fits into the group's priorities. o Karen highlighted what's in the minutes from last meeting that is pertinent to this meeting.	

2. Approval of Minutes	• Penrose Jackson moved to approve the minutes, and Laural Ruggles seconded.
	  o Georgia conducted a roll call vote for approval of the August meeting minutes.
	  ▪ Motion carried unanimously.
		The minutes will be updated and posted to the website.

3. Updates	• Karen updated the group on the status of the RFP.
	  o Prevention Institute is announced as the winning bidder of the RFP.
	  ▪ Leslie from Prevention Institute introduced the group to her team and the organization at large.
	  • Karen welcomed Leslie and her team.
	
	• Erin Flynn gave the group an update on one of the care models and care management workgroup's projects.
	  o The Integrated Communities Care Management Learning Collaborative:	

Agenda Item	Discussion	Next Steps
	➢ The purpose of the learning collaborative is to develop and/or enhance integrated and collaborative care management in order to improve quality of care, patient and family experience, health and wellness, and reduce unnecessary utilization and cost. ▪ ▪ Erin listed the Collaborative's three pilot communities: Burlington, St. J, and Rutland. • Karen asked Erin how the PHWG will interact with the Collaborative. o Erin stated that the PHWG's input would be appreciated on the goals of the Collaborative. • Heidi mentioned that PHWG has members in each of the communities that will be part of the collaborative and this may offer an opportunity for integration of efforts across work groups. • Georgia updated the group on provider grants. o She also informed the group that the deadline for provider grant applications has been extended.	
4. Continuing the Discussion Community Health System	• Heidi discussed a couple of key slides from the presentation given to the group by Jim Hester in June related a sustainable financial model for improving population health. His presentation offered a framework for the evolution of the health care delivery system from current fee for service (1.0), to accountable care organizations and integrated care delivery systems (2.0), to integrated community systems that include care delivery and community prevention efforts (3.0). • Laural Ruggles noted that the innovations that are being tested in Vermont, in fact, are to move the system from 1.0 to 2.0 to 3.0; and that we need to identify the good work being done and the challenges/barriers to moving to full 3.0 • The workgroup broke into small groups to discuss the following questions: • *What is intriguing about the concept of a Community Health System?* • *What current efforts in Vermont tare the seeds of a Community Health System? (some possible*	

Agenda Item	Discussion	Next Steps
	efforts to consider include Prevention Coalitions, Community Health Teams, and the Blueprint) • *What additional components are needed if we wanted to test out a Community Health System? (pls give special consideration to financial models)*	
5. Examples and Ideas for Vermont	The workgroup reassembled into a single group. ***Notes from the discussion are attached***.	
6. Next Steps	• The group discussed what further information is needed to continue having a fruitful conversation on the matter of community health systems. • Karen knitted the meeting to a close with a reminder about the next meeting and an appreciation for the collective efforts and intelligence of the work group's members.	

VCHIP Population Health Work Group Attendance 9-09-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

✓ via phone / webinar

First Name	Last Name		Title	Organization	Population Health
April	Allen	X	Director of Policy and Planning	AHS - DCF	M
Julie	Arel	X	Director of Health Promotion and Chr	VDH	X
Lori	Augustyniak	X		Center for Health and Learning	M
Ena	Backus	X		GMCB	X
Susan	Barrett	X	Executive Director	GMCB	X
Abe	Berman	X		OneCare Vermont	MA
Bob	Bick	✓	Director of Mental Health and Substa	HowardCenter for Mental Health	X
Mary Lou	Bolt	✓	✓	Rutland Regional Medical Center	X
Jill Berry	Bowen	✓	CEO	Northwestern Medical Center	M
Mark	Burke	✓		Brattleboro Memorial Hopsital	M
Donna	Burkett	X	Medical Director	Planned Parenthood of Northern New En	M
Dr. Dee	Burroughs-Biron	X	Health Services Director	Vermont Department of Corrections	M
Jan	Carney	X		University of Vermont	X
Amanda	Ciecior	X	Health Policy Analyst	AHS - DVHA	S
Barbara	Cimaglio	X	Deputy Commissioner	AHS - VDH	X
Daljit	Clark	X	Director for Clinical Operations	AHS - DVHA	MA
Peter	Cobb	X	Executive Director	VNAs of Vermont	M
Judy	Cohen	✓	Professor, Department of Nursing	University of Vermont	M
Amy	Coonradt	X	Health Policy Analyst	AHS - DVHA	X
Janet	Corrigan	X		Dartmouth-Hitchcock	X
Brian	Costello	X			X
Mark	Craig	✓	phone ✓		X
Wendy	Davis	X		University of Vermont	X
Jesse	de la Rosa	✓		Consumer Representative	M
Geera	Demers	X		Blue Cross Blue Shield of Vermont	M
Trey	Dobson	X	Medical Director	Dartmouth-Hitchcock	X

Tracy	Dolan	X		Deputy Commissioner	AHS - VDH	C/M
Kevin	Donovan	X		CEO	Mt. Ascutney Hospital and Health Center	X
Trudee	Ettlinger	X			Vermont Department of Corrections	MA
Sandy	Floersheim	X			Orleans/Essex VNA and Hospice, Inc.	M
Joyce	Gallimore	X		Director, Community Health Payment	Bi-State Primary Care/CHAC	M
Lucie	Garand	X		Senior Government Relations Special	Downs Rachlin Martin PLLC	X
Christine	Geiler	✓		Grant Manager & Stakeholder Coordi	GMCB	S
Don	Grabowski	X			The Health Center	X
Wendy	Grant	X			Blue Cross Blue Shield of Vermont	A
Thomas	Hall	X			Consumer Representative	X
Bryan	Hallett	X				X
Catherine	Hamilton	X			Blue Cross Blue Shield of Vermont	MA
Carolynn	Hatin	✓			AHS - Central Office - IFS	X
Karen	Hein	✓		Board Member	GMCB	C/M
Jim	Hester	X			Consultant	X
Churchill	Hindes	X		COO	OneCare Vermont	X
Penrose	Jackson	✓	Penrose		FAHC - Community Care	M
Pat	Jones	X			GMCB	MA
Frances	Keeler	✓	phone ✓	Director	AHS - DAIL	MA
Heidi	Klein	✓			AHS - VDH	MA/S
Norma	LaBounty	X			OneCare Vermont	A
Kelly	Lange	X		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
Patricia	Launer	X		Clinical Quality Improvement Facilitat	Bi-State Primary Care	MA
Mark	Levine	X			University of Vermont	X
Diane	Lewis	X			AOA - DFR	A
Nicole	Lukas	X		Cancer & Cardiovascular Disease Prev	AHS - VDH	X
Ted	Mable	X		Executive Director	Northwest Counseling and Support Servic	M
Georgia	Maheras	✓			AOA	S
David	Martini	X			AOA - DFR	M
Mike	Maslack	X				X
Marybeth	McCaffrey	X		Principal Health Reform Administrato	AHS - DAIL	X
Jill	McKenzie	X				X
Kimberly	McNeil	X		Payment Reform Policy Intern	AHS - DVHA	X
Melissa	Miles	✓		Project Manager	Bi-State Primary Care	M
Chuck	Myers	✓		Executive Director	Northeast Family Institute	X

Nick	Nichols	X		Planning/Development/Policy Directo	AHS - DMH	M
Annie	Paumgarten	✓		Eveluation Director	GMCB	X
Luann	Poirer	X		Administrative Services Manager I	AHS - DVHA	X
Laural	Ruggles	✓		Marketing/~~Development~~ Community Health Director	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson	X		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	M
seashre@msn.com	seashre@msn.com				House Health Committee	X
Deborah	Shannon	X		Chief of Change	Shannon Resources, LLC	X
Julia	Shaw	✓		Health Care Policy Analyst	VLA/Health Care Advocate Project	M
Melanie	Sheehan	X	X		Mt. Ascutney Hospital and Health Center	M
Miriam	Sheehey	X	X	Clinical Improvement and Compliance	OneCare Vermont	M
Shawn	Skaflestad	✓		Quality Improvement Manager	AHS - Central Office	M
Mary	Skovira	X		Executive Staff Assistant	AHS - VDH	A
Chris	Smith	X			MVP Health Care	M
Kaylan	Sobel	X			The Council of State Governments	X
Kara	Suter	X		Reimbursement Director	AHS - DVHA	X
JoEllen	Tarallo-Falk	X			Center for Health and Learning	M
Nathaniel	Waite	X			VDH	X
Anya	Wallack	X		Chair	SIM Core Team Chair	X
Marlys	Waller	X			Vermont Council of Developmental and M	X
Kendall	West	X				X
Bradley	Wilhelm	✓		Senior Policy Advisor	AHS - DVHA	X
Stephanie	Winters	X			Vermont Medical Society	M
Jennifer	Woodard	X		Long-Term Services and Supports Hea	AHS - DAIL	M
Mary	Woodruff	X	X			X
Cecelia	Wu	X		Healthcare Project Director	AHS - DVHA	X
Dave	Yacovone	X		Commissioner	AHS - DCF	X
Erin	Flynn			DVHA-VHCIP Staff		S
	Dale Hackett			Interested Party		
Leslie	Mikkelson	+ William		Harr - Prevention Inst.		

VCHIP Population Health Work Group Member Roll Call

C	Chair
M	Member
MA	Member Alternate

minutes

1° Penrose
2° Laural

First Name	Last Name		Title	Organization	Population Health
Shawn	Skaflestad	✓	Quality Improvement Manager	AHS - Central Office	M
Frances	Keeler	phone ✓	Director	AHS - DAIL	MA
~~Jennifer~~	~~Woodard~~		~~Long-Term Services and Supports Hea~~	~~AHS - DAIL~~	~~M~~
April	Allen		Director of Policy and Planning	AHS - DCF	M
Nick	Nichols		Planning/Development/Policy Directo	AHS - DMH	M
Daljit	Clark		Director for Clinical Operations	AHS - DVHA	MA
Jenney	Samuelson		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	M
Tracy	Dolan		Deputy Commissioner	AHS - VDH	C/M
Heidi	Klein	✓		AHS - VDH	MA/S
David	Martini			AOA - DFR	M
Patricia	Launer		Clinical Quality Improvement Facilita	Bi-State Primary Care	MA
Melissa	Miles	✓	Project Manager	Bi-State Primary Care	M
Joyce	Gallimore		Director, Community Health Payment	Bi-State Primary Care/CHAC	M
Geera	Demers			Blue Cross Blue Shield of Vermont	M
Catherine	Hamilton			Blue Cross Blue Shield of Vermont	MA
Mark	Burke	A		Brattleboro Memorial Hopsital	M
Lori	Augustyniak			Center for Health and Learning	M
JoEllen	Tarallo-Falk			Center for Health and Learning	M
Jesse	de la Rosa	✓		Consumer Representative	M
Penrose	Jackson	✓		FAHC - Community Care	M
Karen	Hein	✓	Board Member	GMCB	C/M
Pat	Jones			GMCB	MA
Melanie	Sheehan	✓		Mt. Ascutney Hospital and Health Center	M
Chris	Smith			MVP Health Care	M
Laural	Ruggles	✓	Marketing/Development Director	Northeastern Vermont Regional Hospital	M
Ted	Mable		Executive Director	Northwest Counseling and Support Servic	M
Jill Berry	Bowen	A	CEO	Northwestern Medical Center	M
Abe	Berman			OneCare Vermont	MA

Miriam	Sheehey		Clinical Improvement and Compliance	OneCare Vermont	M
Sandy	Floersheim			Orleans/Essex VNA and Hospice, Inc.	M
Donna	Burkett		Medical Director	Planned Parenthood of Northern New En	M
Judy	Cohen		Professor, Department of Nursing	University of Vermont	M
Dr. Dee	Burroughs-Biron		Health Services Director	Vermont Department of Corrections	M
Trudee	Ettlinger			Vermont Department of Corrections	MA
Stephanie	Winters			Vermont Medical Society	M
Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	M
Peter	Cobb		Executive Director	VNAs of Vermont	M

Attachment 4a - CHCS TACO Fact Sheet

CHCS Center for Health Care Strategies, Inc.

FACT SHEET

Introducing Totally Accountable Care Organizations (TACOs)*

What are Totally Accountable Care Organizations (TACOs)?

- Totally accountable care organizations, or TACOs, represent 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 for all populations. Ideally, these activities would be reimbursed under a global payment to align financial incentives and reduce costs.
- While fully realized TACOs do not yet exist, several Medicaid ACOs are nearing this vision for targeted subsets of the population (see table below). Ultimately, TACOs would involve a multi-payer focus, including Medicare, Medicaid, and commercially insured patients.

Why are TACOs needed?

- The social and economic environment in which people live, work and age are widely recognized to be far greater drivers of health status (and costs) than medical care itself. TACOs can coordinate services across traditionally siloed health care, social services, and public health organizations. By aligning these resources, TACOs can give patients better care at lower cost.
- Medicaid beneficiaries, in particular, often have many chronic physical and behavioral health conditions and face social obstacles best addressed by the alignment that a TACO can provide.
- Global payments can address the perverse incentives that drive volume and costs in the fee-for-service system. Such prepayments to the TACO to cover all services related to a patient's health should lead to more effective and efficient use of resources with significant potential to produce better health outcomes.

How are TACOs different from ACOs?

- TACOs move beyond physical health and address many other causes of poor health by integrating health and social services. While a number of Medicaid ACOs have begun to integrate additional services (e.g., behavioral health) and typically offer some kind of shared savings arrangement, fully realized TACOs would integrate all services and pay for them through a global payment mechanism.

Evolution from ACOs to TACOs with Existing Examples

Attribute	Basic ACOs	Coordinated Care Organizations (Oregon)	Hennepin Health (Hennepin County, MN)	TACOs
Physical health	X	X	X	X
Behavioral health		X	X	X
LTSS				X
Social services		For some CCOs	County-based services	X
Public health		For some CCOs	X	X
Population preponderance (all patients in defined area)				X
Global payment for all services		For PH and BH services	For PH/BH w/braided financing for social services	X
Multi-payer				X

Made possible through support from The Commonwealth Fund.

Updated January 2014

* For more information, see S. Somers and T. McGinnis. "Broadening the ACA Story: A Totally Accountable Care Organization." *Health Affairs* blog, Jan. 23, 2014. Available at http://healthaffairs.org/blog/2014/01/23/broadening-the-aca-story-a-totally-accountable-care-organization/

Attachment 4b - SS/ACO PowerPoint

Vermont Health Care Innovation Project

MEDICAID SHARED SAVINGS ACO PROGRAM

Kara Suter, MS, Director of Payment Reform, DVHA

We get what we pay for under a fee-for-service system

A lack of accountability about the range and types of care that patients may receive

Limited payments for coordinating care across clinicians and providers or over time

Limited incentives for improving quality or reducing costs

No incentives for constraining the volume of care

What do we mean by “payment reform”

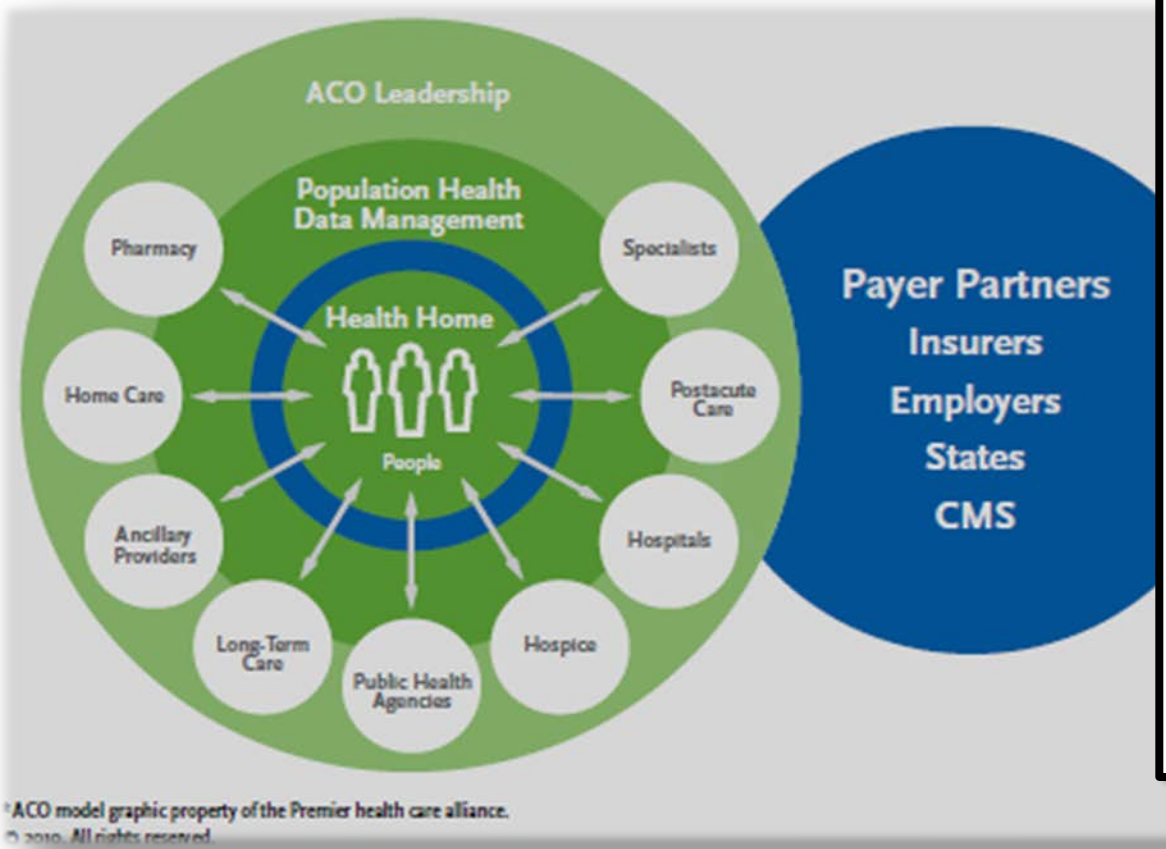
“The ultimate objective of any payment reform is to motivate behavioral change that leads to lower costs, better care coordination, and better quality.

Cutler, David M., Ph.D., and Ghosh, Kaushik , Ph.D. (March 22, 2012) The Potential for Cost Savings through Bundled Episode Payments, *N Engl J Med 2012*; 366:1075-1077. DOI: 10.1056/NEJMp1113361

ACO SSP

- System-wide performance
- Wide range of providers across specialty types and sites of care
- Total resource use and quality for attributed population across all providers who provide care
- Focus on collaboration and use of data to inform better care delivery and experience of care
- Leads to more organized system of care

Multi-Payer Shared Savings ACO Program



A **performance-based contract** between a **payer and provider organization** that sets forth a **value-based program** to govern the **determination of sharing of savings** between the parties.

VERMONT STATE INNOVATION MODEL

http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

What Does this Mean for Beneficiaries?

The Program is designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of beneficiaries
- Requiring coordinated care for all services provided under FFS systems
- Encouraging investment in infrastructure and redesigned care processes

Care delivery redesign is expected to reduce:

- lost or unavailable medical charts
- duplicated medical procedures
- having to share the same information over and over with different doctors
- Reduce complications
- Reduce avoidable readmissions
- Acute admissions and ED visits

ACOs versus HMOs

- No restrictions on access or choice in health care providers
- No "gate keeper"
- No change to coverage and benefits
- Governed by the same providers who provide care

HMOs	ACOs
Economic growth period	Challenging financial climate
Insurance industry driven	Provider driven
Shift risk to PCPs	Shift risk to aligned, integrated systems
Capitated/fixed payment	Pay for outcomes and value
Provider centric	Patient centric
Sickness model of care	Wellness model of care
Fragmented delivery system	Clinically integrated delivery system
No consistent system entry point	Health home
Lack of data at the point of care	Data rich at the point of care

***Table adopted from October 18, 2013 Dartmouth Hitchcock presentation "Creating a Sustainable Health System"*

How the program works

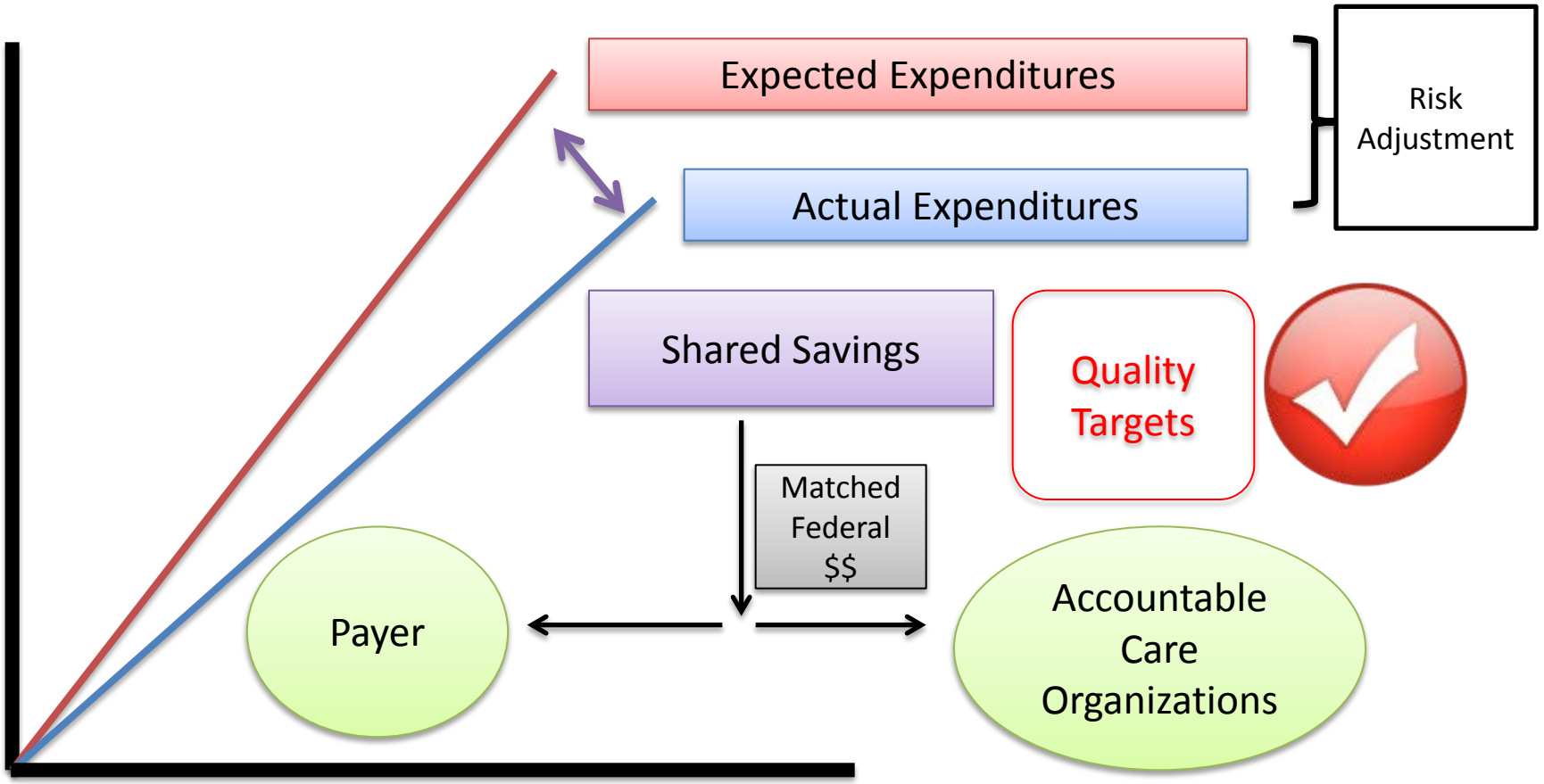
People see their PCP as they usually do

If their PCP belongs to an ACO, the ACO accepts responsibility for the cost and quality of care provided to that person

ACO

Providers bill FFS as they usually do

How the program works



Attachment 4c - VT TACO Webinar

CHCS Center for Health Care Strategies, Inc.

Improving the quality and cost-effectiveness of publicly financed health care

Totally Accountable Care Organizations (TACOs)

Vermont Population Health Work Group

October 14, 2014

Rob Houston

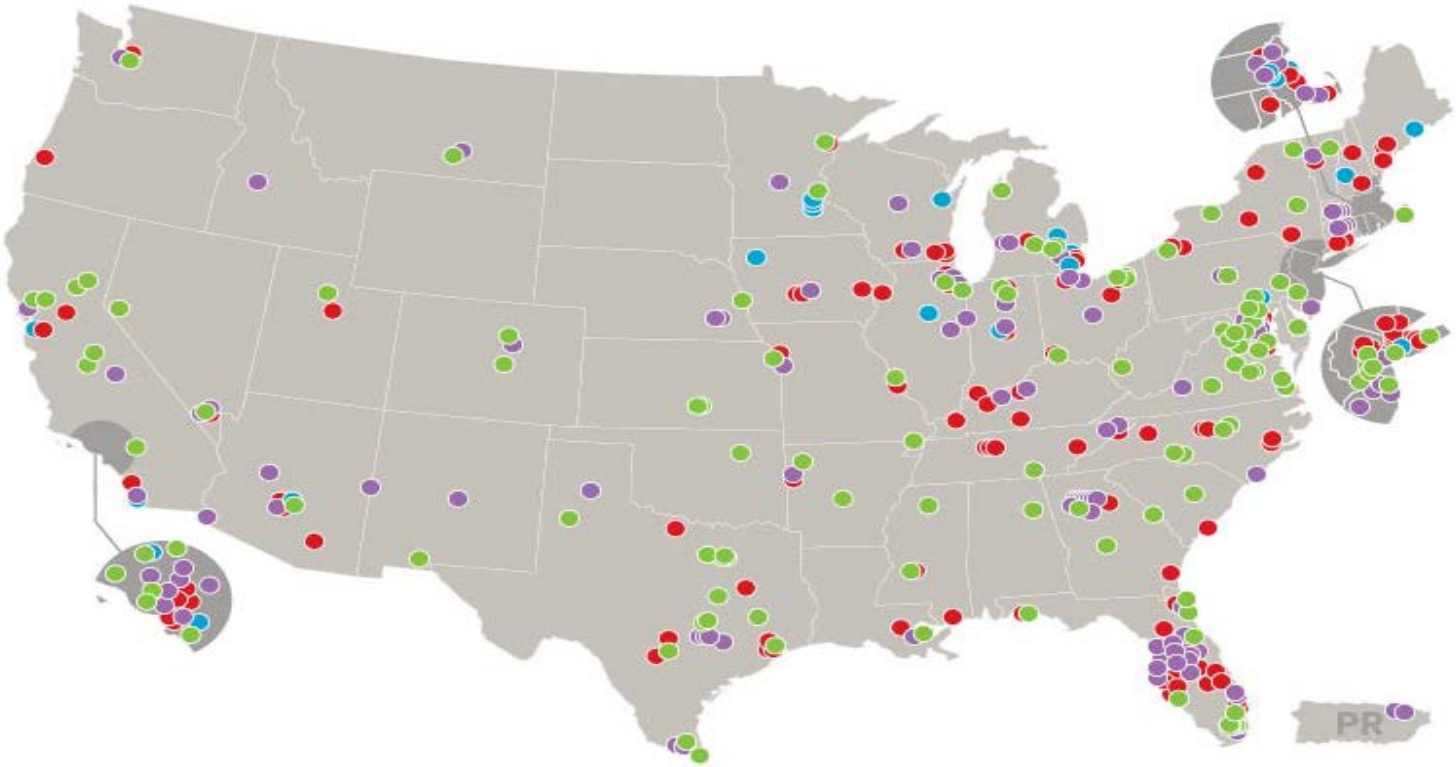
Center for Health Care Strategies

ACO Overview

- **Accountable Care Organizations (ACOs) are designed to hold providers accountable for improving health outcomes and controlling costs**
- **Key ACO features include:**
  - On the ground care coordination and management
  - Payment incentives that promote value, not volume
  - Provider/community collaboration
  - Financial accountability and risk
  - Robust quality measurement
  - Data sharing and integration
  - Multi-payer opportunities

Medicare ACO Distribution

All but five states have at least one Medicare ACO

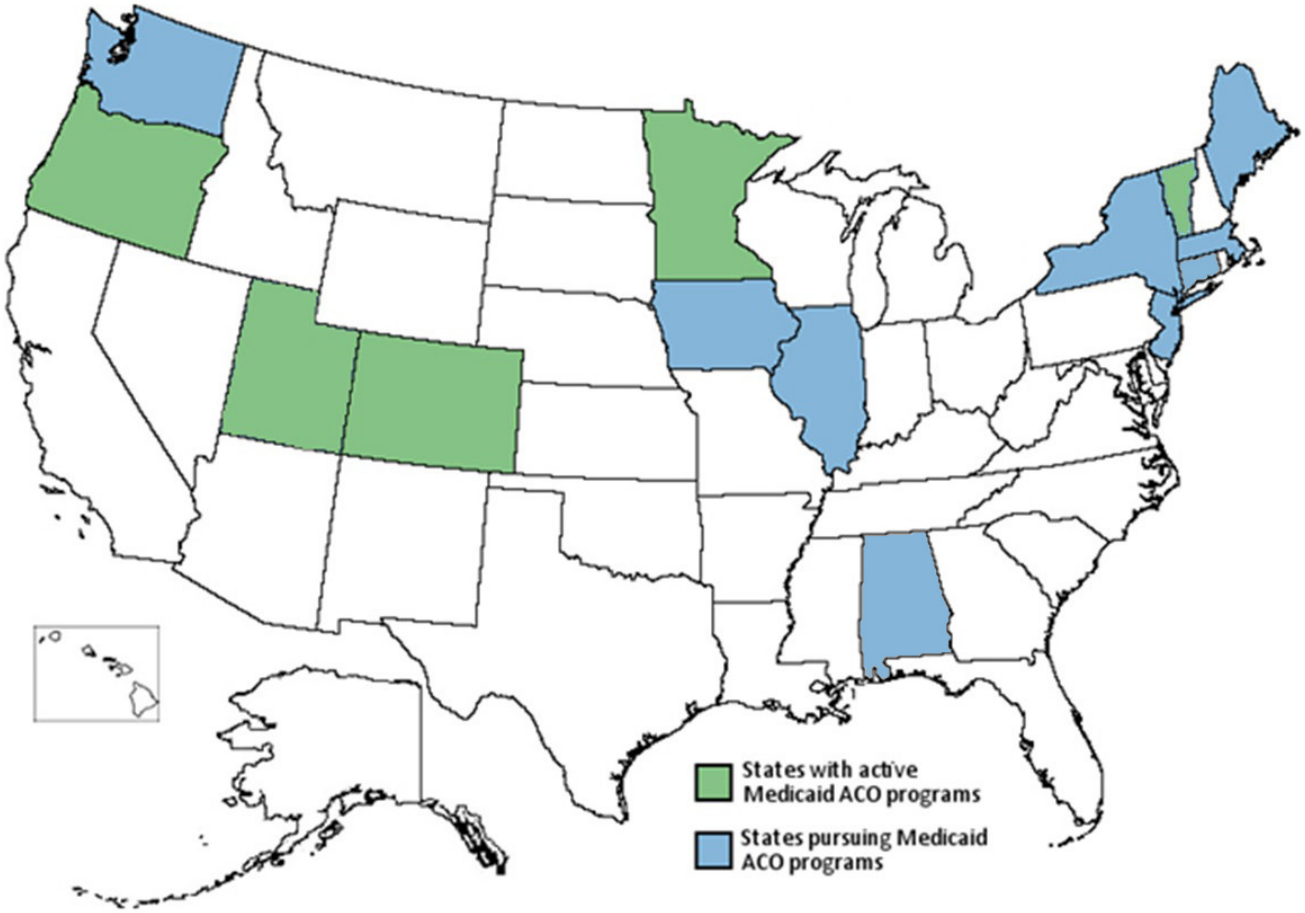


- Pioneer ACOs
- Shared Savings ACOs 2012 Cohort
- Shared Savings ACOs 2013 Cohort
- Shared Savings ACOs 2014 Cohort

The Advisory Board Company

Medicaid ACOs Distribution

Fourteen states have or are pursuing Medicaid ACO programs



ACO Activity to Date

- **Pioneer ACOs**
  - 19 leading-edge integrated delivery systems (down from 32)
  - Saved $196.32M in its first 2 years ($92.15M in Y1, $104.1M in Y2)
- **Medicare Shared Savings Program (MSSP ACOs)**
  - 338 participants (4.9M attributed beneficiaries)
  - Saved $372M in its first 2 years
- **Medicaid ACOs**
  - Colorado reported $44M in cost avoidance savings in 2012-2013
  - Minnesota's IHP program saved $10.5M in its first year
  - Oregon's CCO program showed a decrease of 32% for inpatient admissions and 17% of ED usage for patients with chronic diseases
- **Commercial ACOs**
  - Models vary widely, but many have shown promise and savings
- **All models have shown evidence of quality improvement**

…But How Accountable ***Are*** ACOs?

- **Most payment methodologies involve modified fee-for-service structures**
  - Shared Savings Arrangements (some with upside only risk)
  - Pay For Performance
- **Many ACOs only cover physical health**
  - Behavioral health, LTSS, and social determinants of health may not be included
- **Some ACOs focus on certain populations or conditions (super-utilizer initiatives or pediatric ACOs)**

What is a TACO?

- **A TACO is an aspirational concept – a *Totally Accountable Care Organization***
- **In its fully realized form, a TACO will:**
  - Integrate physical and behavioral health services, LTSS, social services, and public health
  - Be fully accountable for a specific geographic area
  - Involve all payers
  - Be financed through global capitation tied to a broad set of health outcomes
- **TACOs will be built modularly, but are likely closest to realization in Medicaid ACOs**

Examples of Entities Moving Toward TACOs

- **Hennepin Health (MN)**
  - County-based integrated health system for safety net population with collaboration between physical health, behavioral health, social services, and public health

- **Oregon's CCO model**
  - Statewide, regionally-based program which coordinates physical, behavioral, and dental health care for Medicaid beneficiaries and dual-eligibles

- **Maine's Accountable Communities**
  - Statewide RFP released to coordinate care through existing PCCM program, multi-payer PCMH pilot, health homes, behavioral health homes, and LTSS

A Closer Look: Hennepin Health

- **County-based pilot program that offers medical, behavioral health, and social services for residents of Hennepin County**
  - Individuals 21-64 years old without children and Medicaid eligible
- **Composed of a medical center, a CHC, a health plan, and the county public health department**
- **Coordinates care between typically siloed care entities to achieve person-centered care**

A Closer Look: Hennepin Health

- **Payment Model**
  - PMPM payments from Metropolitan Health Plan
  - Risk-sharing quality withholds are distributed in two ways:
    - Direct distributions to partner organizations based on relative size and performance metrics
    - Reinvestment projects determined by Hennepin Health's Operations and Finance committees

Moving from ACOs to TACOs

Attribute	Medicare ACOs	Oregon's CCOs	Hennepin Health	TACOs
Physical Health	X	X	X	X
Behavioral Health		X	X	X
LTSS				X
Social Services		For some CCOs	County-based services	X
Public Health		For some CCOs	X	X
Global Payment for scope of services		For PH and BH services	For PH, BH, and braided financing for social services	X
Multi-payer				X

The Long and Winding Road to TACOs

- There are many ways to achieve totally accountable care, and essentially all payment and delivery system reforms are working toward this goal in some way
- Those pursuing TACOs will likely need to approach things on an incremental basis, but should keep the end goal in mind when constructing these incremental steps

Questions?

For more information on TACOs please contact me:

Rob Houston
rhouston@chcs.org