Attachment 1a - DLTSS Meeting Agenda 12-03-14

VT Health Care Innovation Project
“Disability and Long Term Services and Supports” Work Group Meeting Agenda
Thursday, December 4, 2014; 10:00 PM to 12:30 PM
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:10	**Welcome; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from November 21, 2014	Yes
2	10:10 - 11:00	**Population Health Work Group Presentation** Tracy Dolan, Acting Commissioner, VT Department of Health	• Attachment 2a: Population Health Frameworks 12-4-14 • Attachment 2b: Population Health in VHCIP 11-12-14 • Attachment 2c: Population Health Work Group Charter 11-27-14	
3	11:00 – 12:20	**ACOs and the DLTSS System, continued** Deborah Lisi-Baker and Judy Peterson	• Attachment 3: ACOs and the DLTSS System - Questions Posed by VT Legal Aid and VCDMHS with Responses from ACOs, November 21, 2014	
4	12:20 – 12:30	**Public Comment/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: Thursday, January 22nd 10:00 am - 12:30 pm Montpelier	

Attachment 1b - DLTSS Meeting Minutes 11-21-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Friday, November 21, 2014, 1:00 pm – 3:00 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1. Welcome; Introductions; Approval of Minutes	Deborah Lisi-Baker welcomed the group and sought approval of the July 24th, September 11th, and October 9th meeting minutes which were approved.	
2. ACOs and the DLTSS System -- Questions Posed by VT Legal Aid and VCDMHS with Responses from ACOs	Work Group participants included providers, ACOs, advocates and others who engaged in an in-depth and robust discussion of the DLTSS system of care as it relates to ACOs and the State. The overall focus of the discussion was to build upon the existing system as we form partnerships to improve care and outcomes for Vermonters with DLTSS needs. Efforts in collaboration and integration framed the dialogue. **Please refer to Attachment 4a for the ACOs' written responses to questions 1-7.** **<u>Discussion Highlights for Questions 1-4</u>. (Questions 5-7 will be discussed at the upcoming December 4th DLTSS Work Group meeting.)**	
<u>Question 1</u> **How will any savings generated be shared with the Home Health Agencies (HHAs), Area Agencies on Aging (AAAs), Designated Agencies (DAs), and**	Both CHAC and OneCare summarized their process for allocation of shared savings in Attachment 4a. The discussion on shared savings also included the need to plan for losses if and when "downside risk" is included in the Shared Savings Program contracts. (*Note: The current 3-year Medicare and Medicaid Shared Savings contracts do not include "downside risk". The BC/BS Commercial Shared Savings Program contract includes "downside risk" in its third year, Calendar 2016.*)	

Agenda Item	Discussion	Next Steps
Skilled Nursing Facilities (SNFs) that are part of each Accountable Care Organization's (ACO) "network"?		
<u>**Question 2**</u> **What are the contractual requirements between the ACOs and the affiliated providers (DA, AAA, HH, and SNF)? Specifically, what do the providers have to do (whether related, for example to quality performance, financial performance, etc.) to get the shared savings?**	Examples were given of improvements resulting from increased collaboration between providers and the ACOs. In particular, discussants emphasized the value of local teams across the continuum of care creating bridges to better serve individuals. The Regional Clinical Performance Committees have helped guide regional collaboration, determine the best way to serve people, and develop shared ideas for implementation of integrated care.	
<u>**Question 3**</u> **How do ACO/affiliated provider agreements affect DAIL's role with respect to services funded through DAIL? What is DAIL's relationship to the ACO, which does not directly provide these services, but does so through its provider**	At this point in time, the ACO/affiliated provider agreements do not affect DAIL's (or DMH's) role with respect to services funded through those AHS Departments. Currently, the ACOs' Total Cost of Care (TCOC) does not include Medicaid-funded DLTSS services. If the ACOs' TCOC were to cover DLTSS services in the future, a process would need to be developed to determine the interface between AHS and the ACOs given all the operational complexities. It was also noted that some Medicaid enrollees with DLTSS needs are attributed to ACOs and thus the ACOs' TCOC includes their acute care service utilization. (*Note: Dually Eligible individuals are excluded from the Medicaid Shared Savings Program.*) In addition, it was noted that there are people receiving services who are not attributed to an ACO.	

Agenda Item	Discussion	Next Steps
network? The same questions apply to DMH.	Vermont's effort toward an all-payer waiver anticipates addressing payment issues such as the cost shift among payers. Several providers discussed their interest in streamlining multiple funding sources and "pooling" funds so they could be used more flexibly in service provision. "Reporting requirements can be cumbersome." One of the described aspirational goals was to have quality and performance measures linked with payment.	
Question 4 **Do the current case managers in the DAs, AAAs, HHAs, and SNFs have the resources and capacity (including both time to provide services and training) to provide the medical/health home services in circumstances where the "health home" is not the Primary Care Practice? Will the ACOs provide support to these organizations to provide these services? Will extra funding be available to these organizations to provide these services?**	Some providers would like earmarked payments for case management services similar to those used in the Blueprint Program, especially for individuals whose Health Home is not in a PCP practice. Vermont's current projected budget deficit of $100 million was referenced during the conversation and concern was raised about the impact on Vermont's health care reform goals of any funding reductions for DLTSS services. Participants discussed writing a letter to the Administration on the importance of preserving services for this population. This letter would be sent to the Core Team for approval. A small team volunteered to draft a letter that will be shared with the DLTSS WG at its upcoming December 4th DLTSS WG meeting.	

Agenda Item	Discussion	Next Steps
3. Overview of the Year 2 VHCIP Operational Plan	Georgia gave an overview of the Year 2 VHCIP Operational Plan which describes Year 1 anticipated activities and actual accomplishments, as well as proposed activities for Year 2. Care Delivery initiatives will be a focus in 2015 along with aligning the Blueprint and CHTs with other VHCIP initiatives. IT infrastructure development will continue with the goal of improved data collection, analysis and use. In addition, conversations will begin on next steps after the VHCIP Project ends.	
4. Public Comment Updates/Next Steps	**The next meeting will be held on December 4th, 10:00 am – 12:30 pm in the DVHA Large Conference Room, 312 Hurricane Lane, Williston.**	

VHCIP DLTSS Work Group Member List

Roll Call: **11/21/2014**

Member		Member Alternate		Minutes Approval			
				July	Sept	Oct	
First Name	**Last Name**	**First Name**	**Last Name**				**Organization**
Debbie	Austin	Craig	Jones				AHS - DVHA
Molly	Dugan						Cathedral Square and SASH Program
Patrick	Flood						CHAC
Mary	Fredette						The Gathering Place
Joyce	Gallimore						Bi-State Primary Care/CHAC
Larry	Goetschius	Joy	Chilton				Home Health and Hospice
Dale	Hackett						None
Mike	Hall						Champlain Valley Area Agency on Aging
Jeanne	Hutchins						UVM Center on Aging
Pat	Jones	Richard	Slusky				GMCB
Dion	LaShay						Consumer Representative
Deborah	Lisi-Baker						Unknown
Sam	Liss						Statewide Independent Living Council
Jackie	Majoros	Barbara	Prine				VLA/LTC Ombudsman Project
Carol	Maroni						Community Health Services of Lamoille Valley
Madeleine	Mongan						Vermont Medical Society
Todd	Moore						OneCare Vermont
Kirsten	Murphy	Julie	Wasserman				AHS - Central Office
Nick	Nichols						AHS - DMH
Ed	Paquin						Disability Rights Vermont
Laura	Pelosi						Vermont Health Care Association
Eileen	Peltier						Central Vermont Community Land Trust
Judy	Peterson						Visiting Nurse Association of Chittenden and Grand Isle Counties
Paul	Reiss	Amy	Cooper				Accountable Care Coalition of the Green Mountains
Rachel	Seelig	Trinka	Kerr				VLA/Senior Citizens Law Project
Julie	Tessler	Marlys	Waller				Vermont Council of Developmental and Mental Health Services
Nancy	Warner						COVE
Jason	Williams						Fletcher Allen Health Care
Marie	Zura						HowardCenter for Mental Health
	29		8				

VHCIP DLTSS Work Group Participant List
Attendance: 11/21/2014

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

First Name	Last Name		Organization	DLTSS
April	Allen		AHS - DCF	X
Susan	Aranoff		AHS-DAIL	X
Debbie	Austin		AHS - DVHA	M
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Susan	Besio		SOV Consultant - Pacific Health Policy Group	X
Bob	Bick		HowardCenter for Mental Health	X
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman		HowardCenter for Mental Health	X
Joy	Chilton		Home Health and Hospice	MA
Amanda	Ciecior		AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	X
Amy	Coonradt	[signature]	AHS - DVHA	X
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper	[signature]	AHS - DVHA	X
Molly	Dugan	[signature]	Cathedral Square and SASH Program	M
Patrick	Flood		CHAC	M
Erin	Flynn		AHS - DVHA	S
Mary	Fredette		The Gathering Place	M
Joyce	Gallimore	[signature]	Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Larry	Goetschius		Home Health and Hospice	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Dale	Hackett		None	M
Mike	Hall		Champlain Valley Area Agency on Aging	M
Janie	Hall		OneCare Vermont	A
Bryan	Hallett		GMCB	X
Carolynn	Hatin		AHS - Central Office - IFS	X
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Churchill	Hindes	[signature]	OneCare Vermont	X
Jeanne	Hutchins	[signature]	UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones		GMCB	M
Margaret	Joyal		Washington County Mental Health Services Inc.	X
Joelle	Judge		UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	MA
Tony	Kramer		AHS - DVHA	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Dion	LaShay		Consumer Representative	M
Deborah	Lisi-Baker		Unknown	C/M
Sam	Liss		Statewide Independent Living Council	M

Vicki	Loner		OneCare Vermont	X
Georgia	Maheras		AOA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	M
Carol	Maroni	CAM	Community Health Services of Lamoille Valley	M
Mike	Maslack			X
Lisa	Maynes		Vermont Family Network	X
Madeleine	Mongan		Vermont Medical Society	M
Todd	Moore	TBM	OneCare Vermont	M
Mary	Moulton		Washington County Mental Health Services Inc.	X
Kirsten	Murphy	[illegible]	AHS - Central Office - DDC	M
Floyd	Nease		AHS - Central Office	X
Nick	Nichols	[illegible]	AHS - DMH	M
Miki	Olszewski		AHS - DVHA - Blueprint	X
Jessica	Oski		Vermont Chiropractic Association	X
Ed	Paquin	[illegible]	Disability Rights Vermont	M
Annie	Paumgarten		GMCB	X
Laura	Pelosi		Vermont Health Care Association	M
Eileen	Peltier		Central Vermont Community Land Trust	M
Judy	Peterson		Visiting Nurse Association of Chittenden and Grand Isle Countie	C/M
John	Pierce			X
Luann	Poirer		AHS - DVHA	X
Barbara	Prine		VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
Ken	Schatz		AHS - DCF	X
Rachel	Seelig		VLA/Senior Citizens Law Project	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	MA
Kara	Suter		AHS - DVHA	X
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler		Vermont Council of Developmental and Mental Health Services	M
Bob	Thorn		Counseling Services of Addison County	X
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Anya	Wallack		SIM Core Team Chair	X
Marlys	Waller		Vermont Council of Developmental and Mental Health Services	MA
Norm	Ward	NSW	OneCare Vermont	X
Nancy	Warner		COVE	M
Julie	Wasserman	[illegible]	AHS - Central Office	S/MA
Kendall	West			X
Bradley	Wilhelm		AHS - DVHA	X
Jason	Williams	[illegible]	~~Fletcher Allen Health Care~~ University of VT Med Center	M
Cecelia	Wu		AHS - DVHA	X
Marie	Zura		HowardCenter for Mental Health	M
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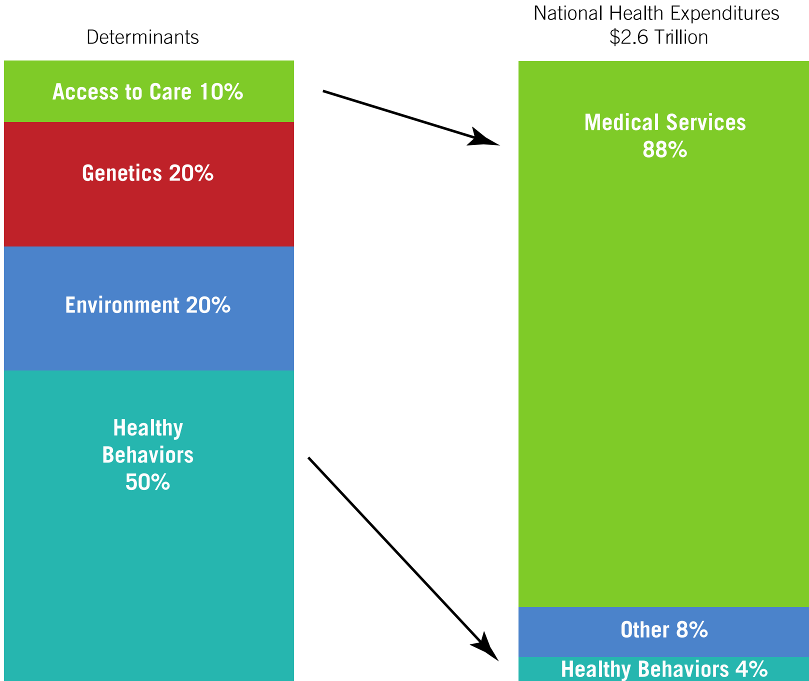
Attachment 2a - Population Health Frameworks 12-4-14

Population Health Frameworks

Presentation to the DLTSS Work Group
December 4, 2014

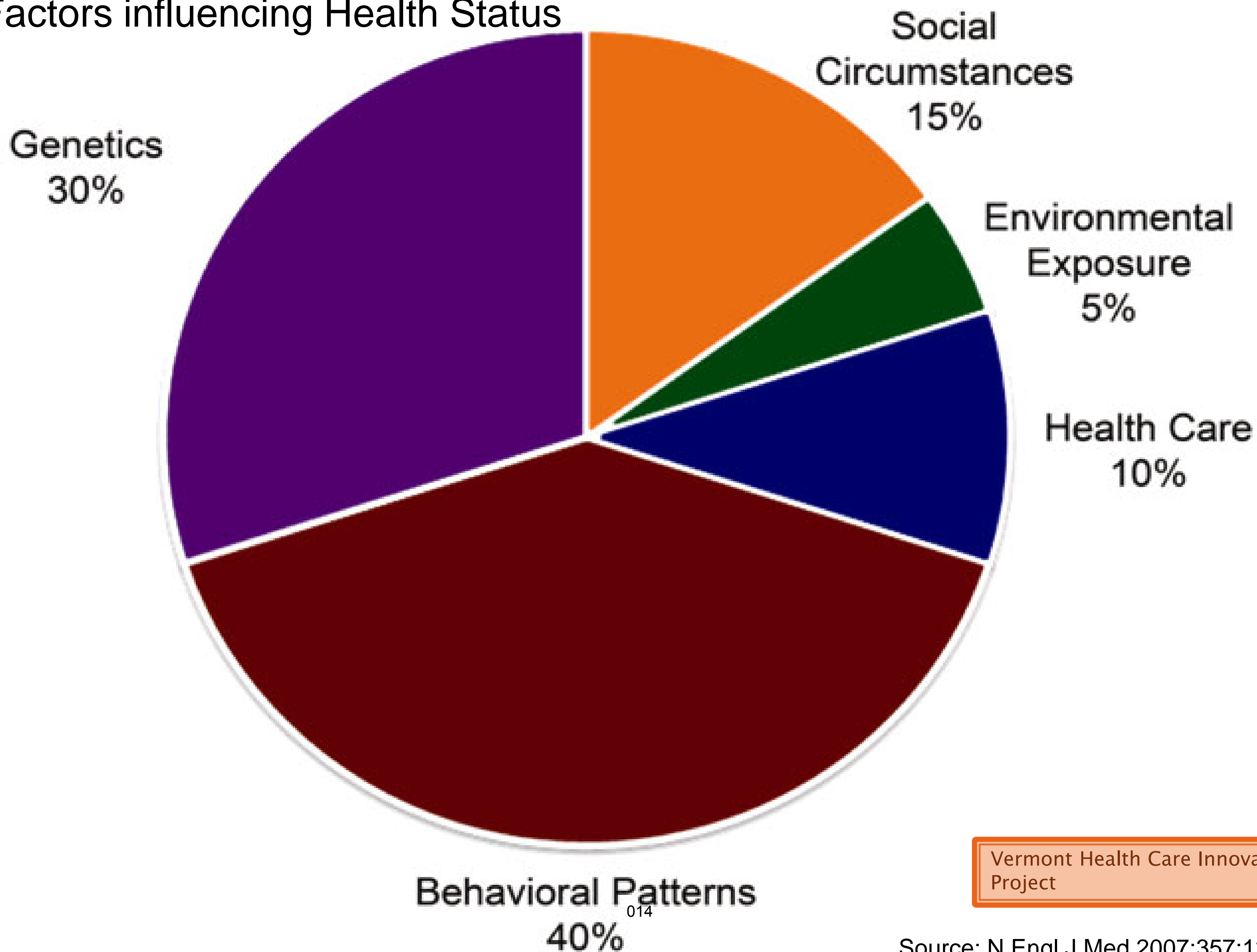
MISMATCH



Source: NEHI. 2012.

Determinants of Health

Factors influencing Health Status

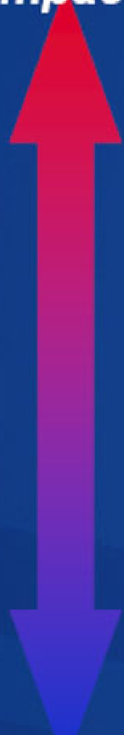


Vermont Health Care Innovation Project

Source: N Engl J Med 2007;357:1221-8.

Factors that Affect Health

Smallest Impact



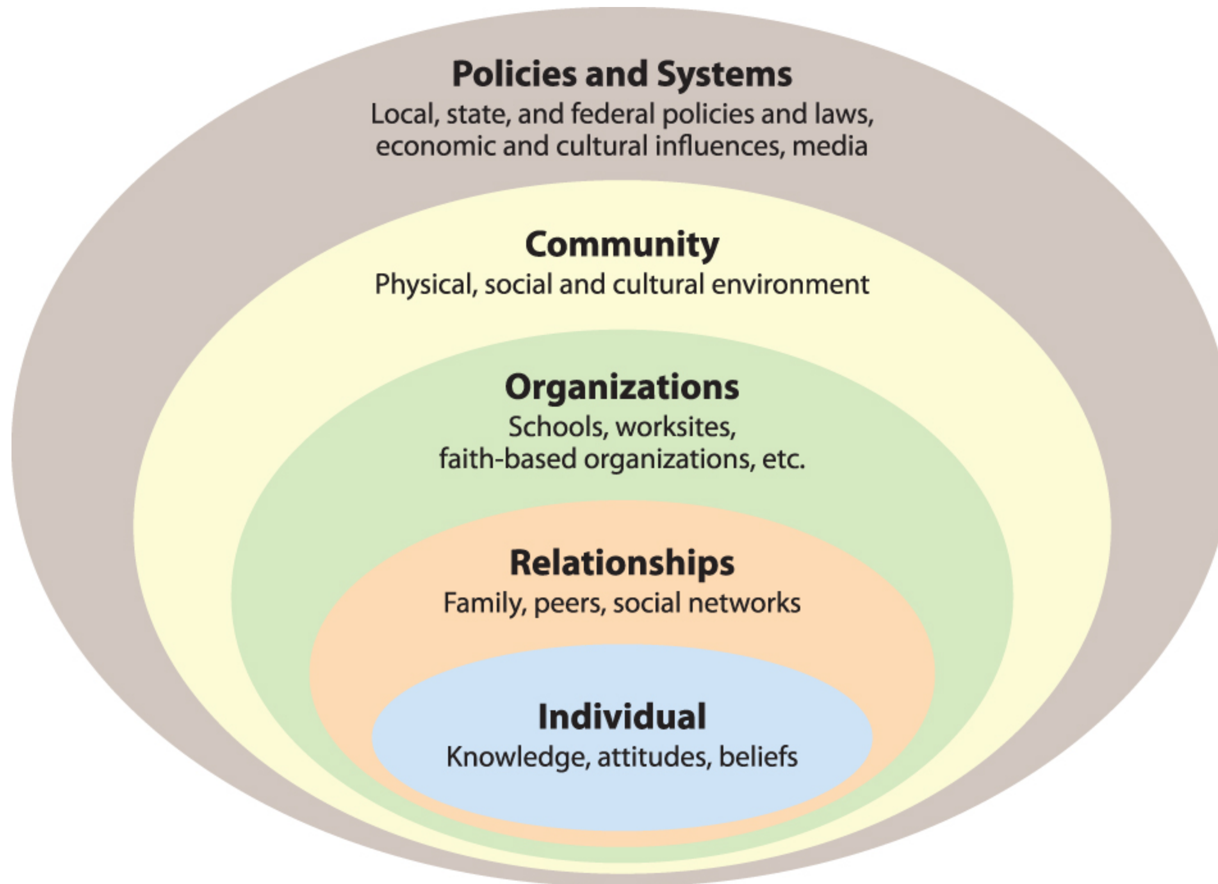
Largest Impact

Examples

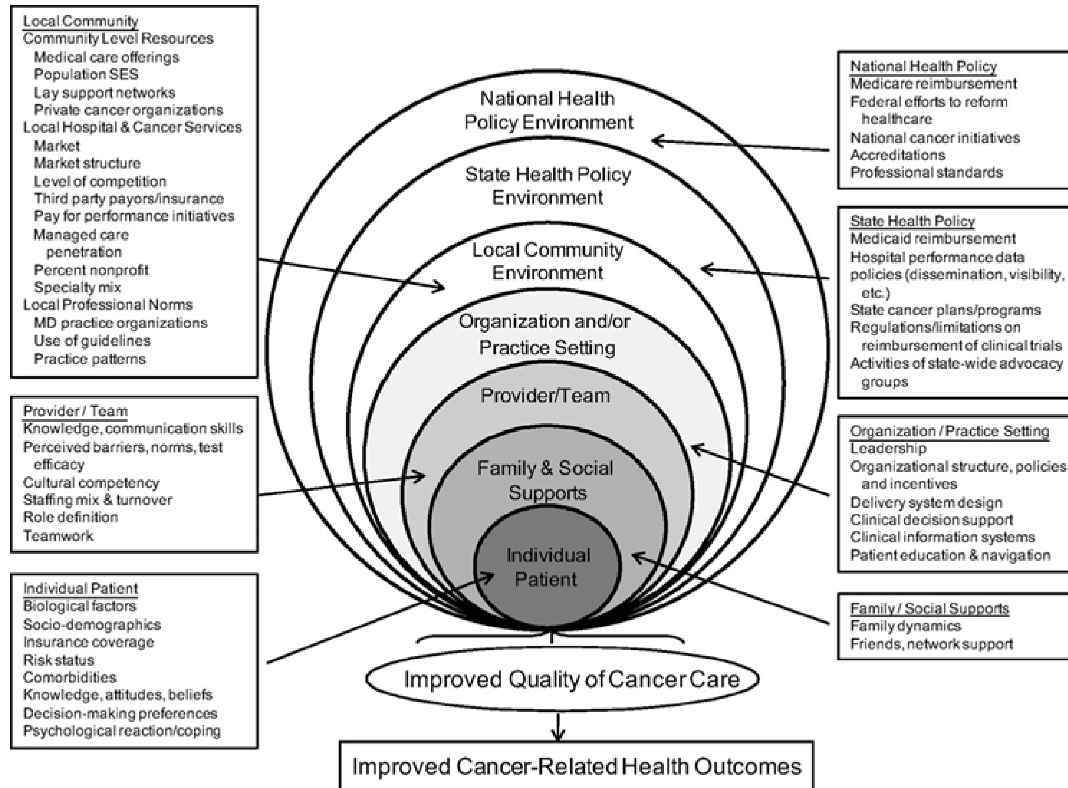
Factor	Examples
Counseling & Education	Condoms, eat healthy be physically active
Clinical Interventions	Rx for high blood pressure, high cholesterol
Long-lasting Protective Interventions	Immunizations, brief intervention, cessation treatment, colonoscopy
Changing the Context *to make individuals' default decisions healthy*	Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax
Socioeconomic Factors	Poverty, education, housing, inequality

CDC

Vermont Prevention Model

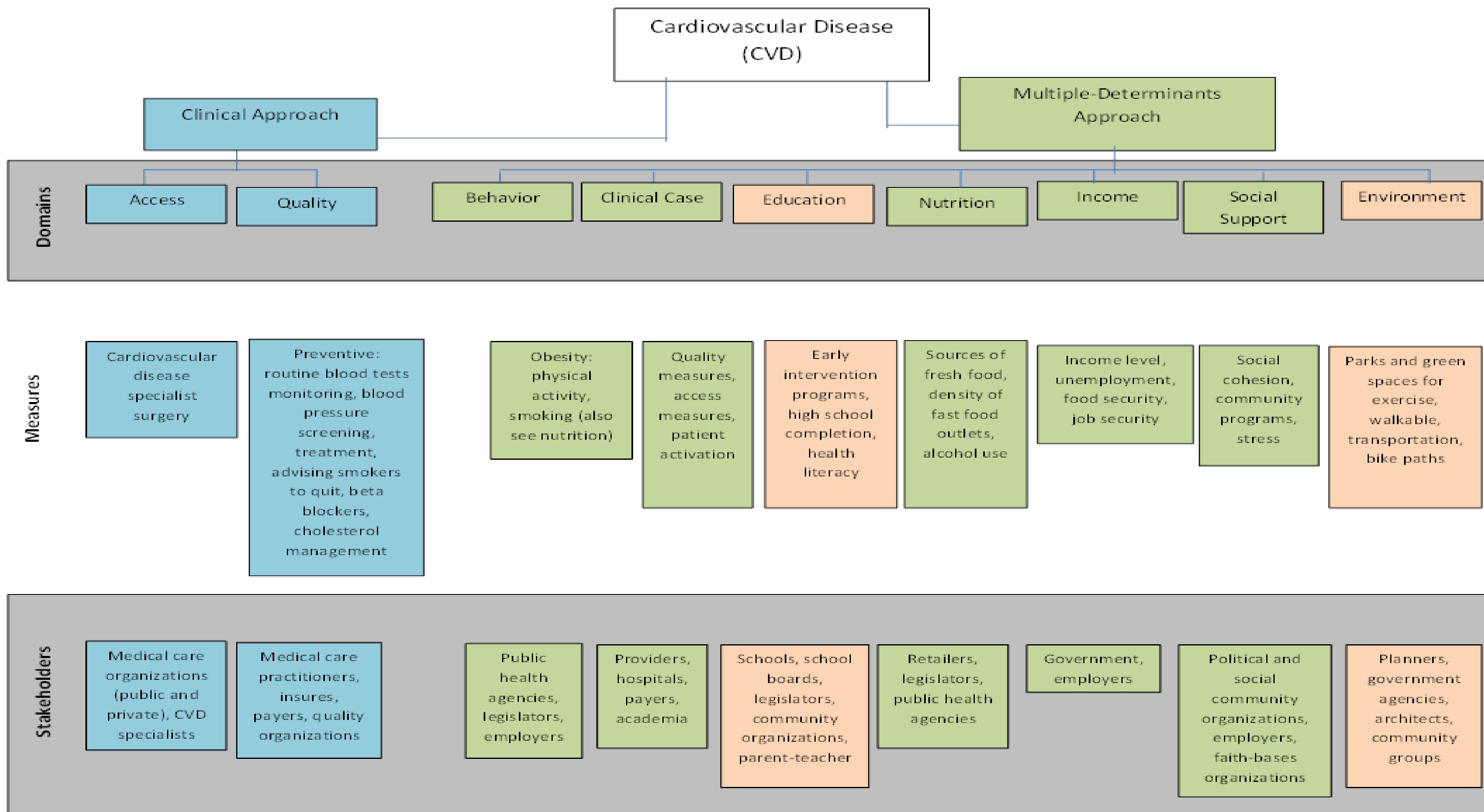


Multilevel influences on Health and Healthcare (Cancer Example)



Taplin S H et al. J Natl Cancer Inst Monogr 2012;2012:2-10

Contrasting Multiple-determinants and Clinical Approaches

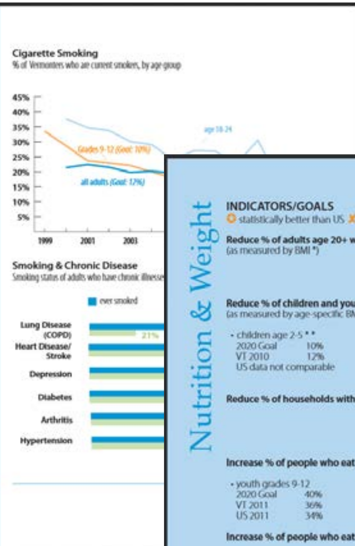


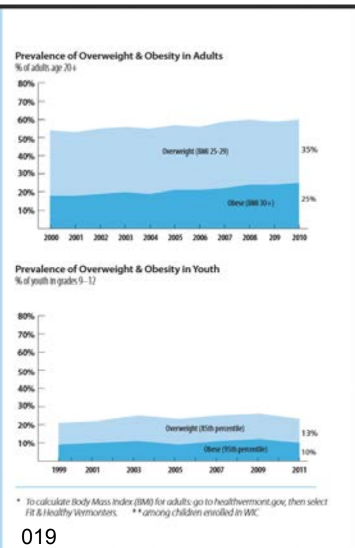
IOM (Institute of Medicine). 2011. For the Public's Health: The Role of Measurement in Action and Accountability. Washington, DC: The National Academies Press.

Page 40, Chart 2-1b

Population Health Status

HV2020 is the State Health Assessment 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. It is aligned with Healthy People.





- Cancer
- Diabetes
- Heart Disease & Stroke
- Maternal & Infant Health
- Nutrition & Weight Status
- Older Adults
- Oral Health
- Physical Activity
- Respiratory Diseases
- Substance Abuse
- Tobacco Use

Vermont Health Care Innovation Project

Leading Health Indicators Healthy Vermonters 2020

Healthy Vermonters 2020 Indicator	2010 Baseline	Target	Data Source*	Geo*
HEART DISEASE & STROKE				
Coronary heart disease death rate per 100,000	111.7 (2009)	89.4	Vital Statistics	(S/C/D/H)
Stroke death rate per 100,000	29.3 (2009)	23.4	Vital Statistics	(S/C/D/H)
% of adults with hypertension	25% (2009)	20%	BRFSS	(S/C/D/H)
% of children and adolescents with hypertension	No baseline	None	None	
% of adults with cholesterol check in past 5 years	75% (2009)	85%	BRFSS	(S/C/D/H)
NUTRITION & WEIGHT STATUS				
% of adults (20+) who are obese	25% (2010)	20%	BRFSS	(S/C/D/H)
% of children ages 2 to 5 (in WIC) who are obese	12% (2010)	10%	PedNSS/WIC	(S)
% of adolescents in grades 9-12 who are obese	10% (2011)	8%	YRBS	(S/C/D/H)
% of households with food insecurity	8% (2006)	5%	BRFSS	(S/C/D/H)
% of adults eating the daily recommended servings of fruit	38% (2009)	45%	BRFSS	(S/C/D/H)
% of adolescents eating the daily recommended servings of fruit	36%(2011)	40%	YRBS	(S/C/D/H)
% of adults eating the daily recommended servings of vegetables	30% (2009)	35%	BRFSS	(S/C/D/H)
% of adolescents eating the daily recommended servings of vegetables	17% (2011)	20%	YRBS	(S/C/D/H)
PHYSICAL ACTIVITY				
% of adults with no leisure time physical activity	17% (2010)	15%	BRFSS	(S/C/D/H)
% of adults meeting physical activity guidelines	59% (2009)	65%	BRFSS	(S/C/D/H)
% of adolescents meeting physical activity guidelines	24% (2011)	30%	YRBS	(S/C/D/H)
% of children ages 2 to 5 years with no more than 2 hours of television, videos, or video games	No baseline	None	PNSS/WIC	
% of children ages 2 to 5 years with no more than 2 hours of computer use	No baseline	None	PNSS/WIC	
% of adolescents with no more than 2 hours of screen time	64% (2011)	70%	YRBS	(S/C/D/H)

US Health Care Delivery System Evolution

Health Delivery System Transformation Critical Path

Acute Care System 1.0

Episodic
Non Integrated
Care

- Episodic Health Care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

Coordinated Seamless Healthcare System 2.0

Outcome
Accountable Care

- Patient/Person Centered
- Transparent Cost and Quality Performance
- Accountable Provider Networks Designed Around the patient
- Shared Financial Risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0

Community
Integrated
Healthcare

Healthy Population Centered
Population Health Focused Strategies

Integrated networks linked to community resources capable of addressing psycho social/economic needs
Population based reimbursement
Learning Organization: capable of rapid deployment of best practices

Community Health Integrated
E-health and telehealth capable

Neal Halfon, UCLA Center for Healthier Children, Families & Communities

Attachment 2b - Population Health in VHCIP 11-12-14

Population Health Integration in the Vermont Health Care Innovation Project

The Vermont Health Care Innovation Project (the Project) is testing new payment and service delivery models as part of larger health system transformation to deliver Triple Aims outcomes of better care, lower costs and improved health. The charge of the Population Health Work Group (PHWG) is to recommend ways the Project could better coordinate population health improvement activities and more explicitly improve population health[i].

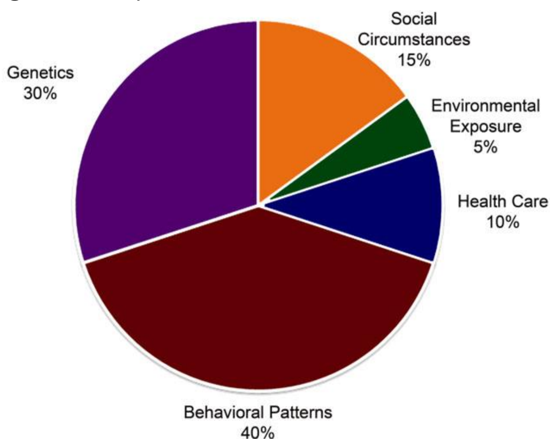
To accomplish the charge of integration of population health and primary prevention within the models being tested in Vermont, the PHWG is committed to several key tasks:

- Develop consensus on a robust set of population health measures to be used in tracking the outcomes of the Project and to be incorporated in the new payment models.
- Offer recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms.
- Identify promising new financing vehicles that promote financial investment in population health interventions.
- Identify opportunities to enhance current initiatives and health delivery system models (e.g. the Vermont Blueprint for Health and Accountable Care Organizations) to improve population health by better integration of clinical services, public health programs and community based services at the practice and community levels. One model to be explored is an Accountable Health Community.
- Develop the "Plan for Integrating Population Health and Prevention in VT Health Care Innovation."

Frameworks to Guide Population Health

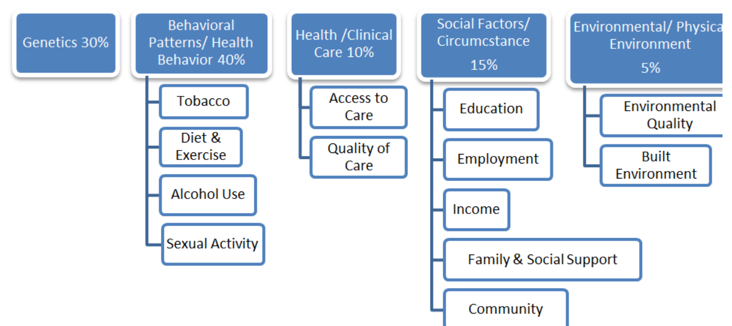
To meet the Triple Aim of moderating cost, improving quality and improving health, increasing access to health care will be insufficient. Access to health care and the quality of medical care account for 10% proportionately to the factors that contribute to premature death (see Figure 1). Therefore, we must seek opportunities to address the multiple factors affecting health outcomes (see Figure 2).

Figure 1: Proportional Contribution to Premature Death



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8
Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion.* Health Aff (Millwood) 2002;21(2):78-93.

Figure 2: Factors Affecting Health Outcomes



County Health Rankings adapted to include genetics and McGinnis weighting of factors
http://www.countyhealthrankings.org/our-approach

ealth in New Models

Focus on the Whole Population in an area, not just attributed patients

Vermont Health Care Innovation Project

- Use data on health trends and burden of illness to identify priorities and target evidence-based actions that have proven successful in preventing diseases and changing health outcomes.
- Expand efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. Focus specific attention on the health and wellness of subpopulations most vulnerable in the future due to disability, age, income and other factors.

Focus on Prevention, Wellness and Well-Being by Patient, Physician and System

- Focus on primary prevention[ii] and actions taken to maintain wellness rather than solely on identifying and treating disease and illness.
- Utilize proven evidence-based prevention strategies to address risk and protective factors[iii] and personal health behaviors such as tobacco use, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

Address the Multiple Contributors to Health Outcomes

- Support integrated approaches that recognize the interconnection between physical health, mental health and substance abuse.
- Identify the social determinants of health[iv] and circumstances in which people are born, live, work, and age (e.g. education, employment, income, family support, community, the built and natural environment).

Create Accountability for Health

- Use measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health.
- Build upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, Accountable Care Organizations and public health programs) to connect community resources for health in a geographic area.
- Include partners and resources able to influence the determinants of health and the circumstances in which people live, work and play.

Create Sustainable Funding Models Which Support and Reward Improvements in Population Health including Primary Prevention and Wellness

- Incentivize payers and health systems to invest in community-wide prevention efforts and to encourage delivery of physical health, mental health and substance use prevention services
- Direct savings, incentives and investments to efforts aimed at primary prevention and wellness including efforts that address the social determinants of health (e.g. housing, transportation, education).
- Develop budgets that explicitly demonstrate spending and/or investments in prevention and wellness.

  Identify long and short term multi-sector impacts and capture a portion of those benefits for reinvestment

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[i] Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003)... While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Institute Of Medicine, Roundtable on Population Health Improvement** http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

[ii] Primary prevention aims to prevent disease from developing in the first place. Secondary prevention aims to detect and treat disease that has not yet become symptomatic. Tertiary prevention is directed at those who already have symptomatic disease, to prevent further deterioration, recurrent symptoms and subsequent events. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

[iii] http://www.who.int/hiv/pub/me/en/me_prev_ch4.pdf

[iv] (http://www.cdc.gov/socialdeterminants/).

Attachment 2c - Population Health Work Group Charter 11-27-14

November 27, 2013

Vermont Health Care Innovation Project
Population Health [1] Work Group Charter

EXECUTIVE SUMMARY

This group will examine current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

PURPOSE/PROJECT DESCRIPTION

The Population Health Working Group will leverage the opportunities available through the Vermont Health Care Innovation Project to enhance population health improvement efforts in Vermont and to achieve the health priorities in the State Health Improvement Plan.

Scope of Work

The Group will be a resource for the other working groups and advise them on ways that their work can incorporate population health principles and contribute toward improving the population health of Vermonters. It will be proactive in identifying opportunities to create both the infrastructure to support improvements in population health and sustainable approaches to rewarding improvements. The Group will review products from the other working groups, participate in formative discussions with them, and develop recommendations for refinements to models, measures, and other elements that contribute to improved population health outcomes.

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[1] **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement**
http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Realizing that there is not uniform agreement on the definition of population health, the IOM Roundtable will use the following definition to guide its initial conversations.

Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

For additional details about defining population health, see the *Working Definition* here.
Kindig, D., and G. Stoddart. 2003. What is population health? *American Journal of Public Health* 93(3):380-383.

Work Group Objectives/Success Criteria

The work group will concentrate on three major areas of work:

- Consensus on population health measures to be used in tracking the outcomes of the Vermont Health Care Innovation Project (formerly known as SIM) and to be incorporated in the new payment models.
    - Collect existing sets of "population health" measures currently used by VT, CDC or CMMI
    - Compare and align with ACO measures identified for Year One of the Project
    - Recommend appropriate set for use in the Innovation Project

- How to pay for population health through modifications to proposed health reform payment mechanisms, and identification of promising new financing vehicles that promote financial investment in population health interventions.

    - Describe options from which others can chose to test out in the payment experiments
    - Build upon materials developed by
    - review and learn from others that are trying new approaches

- Identifying and disseminating current initiatives in Vermont and nationally where clinical and population health are coming together. Identifying opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

    - Define characteristics of interest
    - Identify current community efforts that appear promising (e.g. intersection between Blueprint, Fit and Healthy Coalition, VDH)
    - Link these communities to experiments currently being conducted through the Innovation Project

PROJECT JUSTIFICATION

In order to meet the triple aim of reducing cost, improving quality, and improving health, we must address the non-clinical social, economic and behavioral determinants of health and incorporate primary prevention efforts that address total population health.
Core project components should align and provide consistent incentives and operational models for health care providers, including Population health improvement activities that address underlying factors affecting population health:

DRAFT

RISKS

The Population Health Work Group was created after primary structure of the Project was determined. The Population Health Workgroup must recognize the framework and constraints of bringing a complementary framework to a project primarily focused on payment incentives for medical care.

The role of this Work Group is largely advisory so it will seek to strategically cross-pollinate ideas through the co-chairs, work group members and staff.

DELIVERABLES

The deliverables from this work group will include:

1. A set of population health measures
2. A suite of options for paying for prevention
3. Examples and options for integrating clinical, public health and community activities to improve population health

SUMMARY MILESTONES

This section provides an estimated schedule of all high-level project milestones. This is only an estimate and will change as the tasks and milestones and their associated requirements are more clearly defined in the work plan and as the project moves forward.

MEMBERSHIP REQUIREMENTS

Work Group members are expected to consistently participate in monthly meetings, ideally in person. Occasional work will be needed between meetings.

PARTICIPANT LIST ()

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

Tracy Dolan, tracy.dolan@state.vt.us

Karen Hein, Karen.hein@state.vt.us

Work Group Staff: Heidi Klein, Heidi.klein@state.vt.us, 802-863-7494

DRAFT

WORK GROUP PROCESSES:

1. The Work Group will regularly meet on the second Tuesday of each month.
2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting by Project Management Staff.
6. The Work Group Co-Chairs will preside at the meeting.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

_____________________________________ Date: ________________________

Project Sponsor/Title

DRAFT

Attachment 3 - ACOs and the DLTSS System - Questions Posed by VT Legal Aid and VCDMHS with Responses from ACOs, November 21, 2014

ACOs and the DLTSS System

Questions Posed by VT Legal Aid and VT Council of Developmental and Mental Health Services with Responses from ACOs -- November 21, 2014

Questions	OneCare	CHAC	Health*first*
1. How will any savings generated be shared with the Home Health Agencies (HHAs), Area Agencies on Aging (AAAs), Designated Agencies (DAs), and Skilled Nursing Facilities (SNFs) that are part of each Accountable Care Organization's (ACO) "network"?	Under the Vermont Medicaid Shared Savings Program (VMSSP) ACO agreement, Home Health Agencies, Designated Agencies and Skilled Nursing Facilities are treated in the same manner as hospitals and specialty physicians. To summarize, if the overall OneCare ACO qualifies for VMSSP shared savings, 45% of those savings are distributed to participating home health agencies, designated agencies, skilled nursing facilities, hospitals and specialty physicians in proportion to their percentage of Vermont Medicaid net revenues received for care provided to individuals attributed to OneCare, as reported by DVHA. Another 45% is distributed to participating primary care physicians and the 10% remainder is retained by OneCare to partially offset operating costs. Under the federal MSSP (Medicare) and state XSSP (Commercial) ACO programs, if the overall OneCare ACO qualifies for MSSP and/or XSSP shared savings, OneCare would distribute financial incentive monies to participating home health agencies, designated agencies and skilled nursing facilities through a method that is separate from but quite consistent with the way Medicare or commercial ACO program savings are earned and distributed to participating hospitals and physicians. The particulars of the MSSP and XSSP financial incentives for participating home health agencies, designated agencies, and skilled nursing facilities are determined by the OneCare board and shared with the Green Mountain Care Board and DVHA.		HF is actively working with the above listed providers to assist in improving systems of care. HF does not have formal legal arrangements, or any expectation of sharing payments with affiliated non- physician providers. As examples: We are working with post-acute care providers (SNFs) to create standard discharge documents to rely information about stays back to a patient's primary care physician. We are also currently working with home health agencies on transitioning patients to the home from the hospital, rather than to post-acute care, when appropriate. Finally, we are taking advantage of community health team resources to connect patients with mental health and substance abuse resources more effectively, and forming liaisons with various mental health and substance abuse organizations to address resources. None of these partnerships with other providers include a payment element at this time, but all parties understand the need to work together to improve patient care, particularly care transitions, and believe that our work together in this area will keep the patients we co-manage healthier and the overall cost of care down.

Questions	OneCare	CHAC	Health*first*
a) Are these entities expected to generate savings in any of the demonstration years in order to receive part of any savings achieved by the ACO?	No. In each year, savings are generated and measured at the collective level for all OneCare participants combined.	As a guiding principle, CHAC supports the need for a broad array of services and providers to meet the needs of the population to achieve and maintain good health. CHAC has been very inclusive of community based providers such as home health and visiting nursing agencies, behavioral health, substance abuse and designated agencies. Any providers that agreed to participate by signing the CHAC Participating Agreement whether primary care or non-primary care are considered to be an important part of providing quality care that contributes to positive health outcomes and to the savings that could and hopefully will be achieved within the demonstration years.	See the response to item 1 above. We do not have contractual relationships with affiliated providers, but are actively working together in the common interests of our patients.
b) Is there a specific formula to determine how much of the savings these affiliated organizations receive? Does that formula vary by ACO or by organization type, and if so, how?	See the OneCare response to item 1 above.	The Board has approved the outline of the method to share savings, but not all the specifics. The distribution is would generally work as follows: • Cover outstanding expenses and obligations related to the CHAC operations Create a contribution to an ACO reserves as appropriate, and invest in infrastructure as deemed appropriate by the Governing Board; • The Balance of any shared savings would be divided 50%/-50% into two pools: one for the primary care and one for the non-primary care participating provider, and awarded based on attributed lives for the primary care providers and according to a formula such as geographic coverage for the non-primary care providers. The formula for the non-primary care distribution will be determined with the input of non-primary care participating providers.	See the response to item 1 above.

Questions	OneCare	CHAC	Health*first*
2. What are the contractual requirements between the ACOs and the affiliated providers (DA, AAA, HH, and SNF)? Specifically, what do the providers have to do (whether related, for example to quality performance, financial performance, etc.) to get the shared savings?	Such requirements are specified in the contracts between OneCare and each participant. The contract form is a public document. In summary, the OneCare participants agree to the following (this is taken from the OneCare participation agreement for VMSSP): General • Be accountable for the quality, cost and overall care of Attributed Lives; implement and follow processes and procedures to support that accountability. • Be bound by the terms and conditions of the participation agreement and materials it incorporates by reference, including but not limited to, all applicable terms and conditions of the VMSSP Agreement between the ACO and DVHA, duly adopted policies and procedures and all requirements of federal and Vermont law. • Be subject to the terms and conditions of any and all grant agreements and/or contracts with the Vermont Agency of Human Services as well as any state or federal authorities that are binding on the DAs or SSAs. Operations • Provide Attributed Lives with professional and/or facility services, as appropriate, in accordance with Vermont Medicaid program statutes, regulations and policies as well as the policies and procedures set forth in the VMSSP and policies created by ACO. • Seek reimbursement from Vermont Medicaid in accordance with applicable laws, regulations and policies. • Comply with and implement ACO's processes and policies to: (1) promote evidence based medicine; (2) promote patient engagement; (3) develop and implement infrastructure and reporting on quality and cost metrics to enable monitoring and feedback of performance in order	CHAC has existing executed Participating Provider Agreements with the HHA/VNAs and Das and offered participation to the AAA agencies through the same Agreement. CHACCHAC has one Participating Provider Agreement, and participating providers are all eligible to be nominated and selected for Governing Board seats and to nominate representatives and participate in the standing committees of the Board, and to be part of a shared savings pool for distribution of shared savings when there is a shared savings awarded. Reviewing those contracts is a good way to review the contract expectations. The AAA is not contracting with CHAC at this time, but we have been meeting to explore how to integrate and fully make use of those services for the population served. All participating providers (defined as those who have signed the Participating Provider Agreement) are eligible for sharing savings. CHAC relevant expectations for performance for those providers as shown in the Participating Provider Agreement are as follows: • with respect to the CMS Shared Savings Program, agree to become accountable for and report to CMS on the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to the Company, if applicable; • with respect to the DVHA ACO Program, agree to become accountable for and report to the Company on the quality, cost and overall care of the Medicaid beneficiaries assigned to the Company, if applicable; • agree to become accountable for and report to Company on the quality, cost and overall care of beneficiaries as required by the Commercial	See the response to item 1 above.

Questions	OneCare	CHAC	Health*first*
	to evaluate performance and improve care over time; and (4) coordinate care. • Cooperate with ACO's policies and procedures with regard to clinical coordination of care. • Make best efforts to cooperate, comply with and implement the Clinical Model developed by ACO to meet the VMSSP Standards, including patient-centered criteria surrounding evidence-based medicine, promoting patient engagement, furtherance of internal quality and cost reporting structures, and coordination of care. • Make best efforts to cooperate with ACO's case management protocols, and to coordinate with hospital or other facility case managers regarding the care of attributed lives. • Make best efforts to implement such cost and quality control protocols or other interventions as may be adopted by ACO regarding the care of attributed lives. • Notify attributed lives at the point-of-care that they are participating with the ACO in the VMSSP. • Make participant's representative(s) available for participation on ACO committees related to the Clinical Model that might be established. • Participate in ACO and DVHA-sponsored provider education programs. • Cooperate and participate in any patient experience of care survey required by the VMSSP. <u>Data</u> • Measure, collect data for, exchange data for, report, evaluate and improve performance on the VMSSP Standards ACO quality performance measures and monitor and improve the cost effectiveness of services provided to attributed lives. • Make available, upon request, encounter data and other information specific to Medicaid covered	ACO Program or any other Value-Based Payor Agreements, if applicable; • agree to comply with the requirements and conditions set forth in the laws and regulations governing the Shared Savings Programs, including those specified in the MSSP Participation Agreement, DVHA Participation Agreement and Commercial SSP Agreements; • Participant, through Practitioners, shall in good faith collaborate and cooperate with the Company in the provision of the services set forth in Section 3 by the Company under this Agreement. • Participant shall make available to the Company in a timely manner information requested by the Company to enable the Company to provide the Covered Services, subject to the Health Insurance Portability and Accountability Act of 1996 and the rules and regulations promulgated thereunder ("HIPAA") or other statutes and regulatory restrictions • Participant authorizes the Company to consult with administrators and members of the medical staffs of hospitals, facilities and organizations with which Participant and/or any Practitioner has been associated and with others for credentialing purposes pursuant to the Authorization For Release Of Information, that each Practitioner and Participant will execute, annexed to this Agreement as Exhibit A. • Upon reasonable request by the Company, Participant shall provide to the Company select information and/or excerpts from Practitioners' executed contracts with Participant.	

Questions	OneCare	CHAC	Health*first*
	services rendered to attributed lives. • Provide and report such data from its Electronic Health Records ("EHR") system or medical records as ACO may reasonably require to monitor the cost and quality of services, including care management services, provided to attributed lives. • Give an opportunity for attributed lives to decline to have personal data shared with ACO. • Observe all relevant statutory and regulatory provisions regarding the appropriate use of data and confidentiality and privacy of individual health information as they apply to participant and providers, and which may be modified from time to time. • Implement all necessary requirements of HIPAA in the manner and time frame required by HIPAA. Compliance • Not discriminate or differentiate in treatment or access to health care on the basis of race, age, gender, gender identity medical history, religion, marital status, sexual orientation, color, national origin, place of residence, health status, creed, ancestry, disability, veteran status, type of illness or condition, or source of payment for services. • Comply with all applicable laws and regulations governing participation with the ACO which includes, but is not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, HIPAA and Stark. • Participants that are themselves or who include Primary Care Providers may not participate in any other VMSSP participating as required by the VMSSP program.	CHAC's expectations for receiving shared savings are not limited beyond this. Changes would be developed and approved by the Governing Board at which the participating providers have representation. **Provision of Participant Services**. Participant agrees to provide, through its Practitioners, Covered Services to Covered Persons as required under the Value-Based Payor Agreements no later than sixty (60) days after receiving notice of the terms and conditions for such Agreement unless Participant opts out of participation in such Agreement. **Standards of Care.** Participant agrees, and shall cause Practitioners to agree, that all medical duties performed by Practitioners under the Value-Based Payor Agreements shall be consistent with the proper practice of medicine and shall be performed in conformance with the standards for performance of such services established by the Payor and the local medical community. Participant shall ensure that all Practitioners and other qualified personnel utilized by Participant, to the extent such personnel are permitted under the Value-Based Payor Agreements, are properly licensed and/or credentialed to perform the services which they perform. Participant, through its Practitioners, shall exercise independent medical judgment in providing medical services to all patients and the Company shall not interfere with such independent medical judgment.	

Questions	OneCare	CHAC	Health*first*
a. Do the ACOs have the same contractual relationship with each type of affiliated provider (DA, SSA, AAA, HHA, SNF)?	OneCare has the same contractual relationship with its participating designated agencies, LTSS providers, home health agencies and skilled nursing facilities.	CHAC has one Participating Provider Agreement for all participating provider types. Each participating provider identifies which product lines (Medicare, Medicaid, Commercial) it will participate in and whether it chooses to attribute lives as applicable.	See the response to item 1 above.
b. If not, is this because the ACOs have different contracts (so that the contractual relationships are the same within each ACO, but not across ACOs), or within an ACO do different providers (e.g. multiple HHAs) have different contracts?	OneCare does not know the contractual relationships between the other Vermont ACOs and their participants.	This question is not applicable since CHAC has one provider agreement.	See the response to item 1 above.
3. How do ACO/affiliated provider agreements affect DAIL's role with respect to services funded through DAIL? What is DAIL's relationship to the ACO, which does not directly provide these services, but does so through its provider network? The same questions apply to DMH.	OneCare does not know the answer to the first question. OneCare assumes its VMSSP contract with DHVA is relevant for other units of the Agency of Human Services including DAIL.	CHAC's participating providers receive reimbursement directly from payers as they currently do. CHAC's provider agreements do not address provider reimbursement by the applicable payers and thus do not affect DAIL's role with respect to services funded through DAIL. There is nothing in the CHAC participating agreements that would override the DAIL requirements. The same is true for DMH. The participating provider network, for example the federally qualified health centers, have a history and performance of working closely with the home health care/visiting nursing agencies, behavioral health, substance abuse and designated agencies to serve their patients with a variety of needs. These relationships, referral patterns and improved integration are the expected and planned approach of CHAC.	HF does not have a relationship with DAIL at this time.

Questions	OneCare	CHAC	Health*first*
4. Do the current case managers in the DAs, AAAs, HHAs, and SNFs have the resources and capacity (including both time to provide services and training) to provide the medical/health home services in circumstances where the "health home" is not the Primary Care Practice? Will the ACOs provide support to these organizations to provide these services? Will extra funding be available to these organizations to provide these services?	OneCare does not know the answer to this question.	This sounds like a question that should first be addressed by the HHAs and DAs. When the nature of the concern is more fully defined, CHAC can better address the issue. CHAC will work in a collaborative mode to provide appropriate care services and coordination with participating and community providers. CHAC has a modest budget for its operations from the founding FQHCs, and any shared savings will be determined in future years by the payers. We would like to know the extent or other details on the capacity issue you are identifying.	HF does not know the answer to this question.
5. Have any of the ACOs adopted new care management protocols or standards internally (while waiting on the Care Models/Care Management workgroup) that establish different expectations of DLTSS case managers than those in their existing roles?	OneCare has not developed any internal standards; they will adopt those approved by the Care Models/Care Management workgroup. However, OneCare's Clinical Model, which was adopted by its Clinical Advisory Board, does include principals for care coordination which set the expectation that **c**are coordination activities should promote a holistic and person centered approach to ensure that a person's needs and goals are understood and shared as they move from one setting to another.	No we have not. CHAC's Clinical Committee has representation from the DAs and the HHA/VNA in addition to the FQHCs and hospitals. The policies that will be followed are general in nature and simply endorse following evidence based guidelines.	No.
a. Are the draft CMCM standards going to have different expectations of the case managers at the affiliated agencies because of their contracts with the ACOs?	OneCare does not know the answer to this question as the standards are not yet finalized and the payers have not set expectations on oversight.	As a member of the CMCM Workgroup, CHAC has supported standards that are general and not prescriptive. This may have been interpreted as not supporting the comprehensive needs of all populations. CHAC's model is consistent with the Blueprint's patient centered medical home model, so that each individual is understood to have multiple needs, and CHAC as an ACO is seeking to strengthen the integration of the full array of social, emotional and medical needed to restore and maintain patient's health. This does not change the care management standards but	See the response to item 1 above. We do not have contractual relationships with affiliated agencies, but are actively working together in the common interests of our patients.

Questions	OneCare	CHAC	Health*first*
		should enable the implementation of care management more smoothly and effectively.	
b. What is the system by which the DAs, HHAs and AAAs will deliver the case management services? Will any changes be made only through the scope of work for existing case managers, or will there be additional specialized ACO case managers (housed either with the ACOs or with the affiliated providers)?	OneCare does anticipate deploying a limited number of Nurse Clinical Consultants to work with provider groups in local health service areas to promote: (1) evidence based practice; (2) patient engagement; (3) reporting on quality and cost performance metrics; and (4) better coordination of care.	CHAC expects to make improvements in the effectiveness of integration of services but not to add additional expectations on the case managers of these related providers. That said, the nature of this process is that we are all learning how to work together so there is constant change. CHAC, as an ACO is expected to determine what interventions will contribute to improved care with related savings. CHAC will be implementing the use of a telemonitoring initiative in likely close collaboration with VNA partners, that will impact high risk Medicare patients attributed to the ACO through seven FQHCs, so this will engage patients and provide information on the patients to their providers.	HF currently has a team of 1 Clinical Manager and 2 Care Coordinators working for our ACCGM to service our attributed Medicare ACO patients. This team has been coordinating with hospitals, SNFs, and Home Health Agencies to improve patient engagement and better coordination of care.
6. How will DLTSS providers manage to meet operational, financial and quality expectations of multiple ACOs and at the same time meet these expectations for individuals who are not covered by the ACOs (because they do not see an affiliated primary care physician) whose funding continues to come through AHS and its Departments?	Not surprising, this challenge is shared by many of our OneCare participants. OneCare is committed to work with its network participants and with the other ACOs to assure that key expectations are similar or at least consistent. Through the VHCIP/SIM Clinical Models and Care Management work group we are participating in a multi-organization integrated community care management learning collaborative in three health service areas, with the intent to expand across the state. This collaborative is intended to develop and/or enhance an integrated and collaborative care coordination process for at-risk populations at community levels. Regarding service to persons not affiliated with OneCare, our general understanding is that providers will likely extend ACO-related service and practice improvements to others served by their organizations.	CHAC has been working with its community providers for many years as part of the Blueprint patient-centered medical home. This is a collaborative effort rather than a series of care management expectations for those providers. CHAC is not competing for the funding provided by AHS. CHAC's Participating Provider Agreement is not intended to interfere with reimbursement and regulatory requirements for DA s or VNA/HHA. CHAC currently does not have funding to provide to the FQHCs or other participating providers, but all the ACOs are working together with VITL and in the VHCIP workgroups to come up with common approaches to meeting the VHCIP expectations.	
a. Will the ACOs provide support to the DLTSS providers to meet the ACO expectations?	Similar to its other participants, OneCare will provide advice and counsel and in some cases (such as annual quality performance data collection) provide limited hands-on assistance. OneCare does		HF has no contractual expectations of DLTSS providers.

Questions	OneCare	CHAC	Health*first*
	not have a source of financial support for any of its participants other than its designated regional physician convener/collaborators.		
b. Are the ACOs providing support to other types of providers in their network (e.g., PCPs, specialty practices)?	See 6a		HF ACOs do provide support to participating primary care practice for quality measure education and collection. We also provide shared learning opportunities regarding best practices in population health management through our committee structure.
7. Will disability and long term services and supports (DLTSS) providers have sufficient voice in the governance and operation of ACOs? How will this voice be operationalized?	Our working assumption is that most DLTSS providers are closely affiliated with a Designated Agency and that the seat on the OneCare board representing the Designated Agencies and related providers will assure that the community of DLTSS providers has a voice in the governance of the ACO. Operationally, OneCare's most important work is conducted through its 14 broadly inclusive Regional Clinical Performance Committees (RCPCs) and through its statewide multidisciplinary Clinical Advisory Board (CAB). The RCPCs are encouraged to behave as "big tables" that include places for the persons and organizations engaged in meeting the needs of locally attributed populations.	Yes, CHAC's Board includes representation for the HHAs/VNAs, the BH/DAs and consumer representatives. These agencies also participate in the four Governing Board standing committees: Clinical, Financial, Operations, and Beneficiary Engagement. The concerns of these agencies are discussed in Board and Committee meetings where collaboration contributes to better solutions. This collaboration is also displayed in the FQHC service areas through specific collaboration and integration of services. Some FQHCs have mental health and substance abuse services co-located on site at the health centers. All FQHCs work with the Community Health Teams to better serve the needs of patients. CHAC's Board is determined to use the ACO format to improve the quality of care and the health status of the populations they serve.	DLTSS providers are welcome to attend any of our ACO Management or Consumer Advisory Board meetings. The schedule and summaries of those meetings can be found on our website on the VCP page http://vthealth1st.org/vermont-collaborative-physicians.php