

Combined Meeting of The Blueprint Executive Committee and Blueprint Planning and Evaluation Committee

January 18, 2017

Attendees: C. Elmquist; B. Hill; J. Le; E. McKenna; M. Mohlman; J. Samuelson; B. Tanzman; T. Tremblay; E. Yahr

By phone: J. Andersson-Swayze; P. Biron; S. Bruce; A. Buchanan; P. Clark; J. Dodge; T. Dolan; T. Dougherty; E. Emard; J. Evans; J. Fels; S. Fine; K. Fitzgerald; E. Flynn; E. Girling; C. Gustafson; K. Hein; J. Hester; C. Jasenski; P. Jones; J. Krulewitz; K. Lange; P. Launer; S. Narkewicz; S. Norris; T. Reinertson; L. Ruggles

The meeting opened at 8:30 a.m.

I. Opening Remarks and Announcements: Beth Tanzman

- Today's agenda, PowerPoint slide deck and Blueprint 2016 Annual Report were distributed prior to this meeting.
- B. Tanzman stated at today's meeting, we will be reviewing Blueprint programs highlights and discuss the Blueprint trend analysis, hear field updates from our Program Manager in St. Johnsbury, Laural Ruggles, and take final comments in regards to the Blueprint manual revisions.

II. Blueprint Trend Analysis & Program Highlights - 2016 Annual Report

- B. Tanzman reviewed *slide #3, Program Highlights 2016 Annual Report*. B. Tanzman reported we have accelerated our work with our partner, the Vermont Care Organizations (VCO), and commended our Associate Director, Jenney Samuelson, with working with the senior leadership of the VCO (and ACOs) to make this possible.
- B. Tanzman reviewed the trend analysis on *slide #6, Total Expenditures Excluding Special Medicaid Services*, and had a discussion with the committee. Overtime, the Blueprint program shows lower expenditures. The gap in difference has been narrowing in recent years.
- B. Hill questioned what would it look like if we did include the Special Medicaid Services? B. Tanzman responded Medicaid tends to pay a host of services other insurers do not. Medicaid deserves its own view and we will take a look a couple of slides later.

- M. Mohlman mentioned the next iteration of the Blueprint trend analysis will be based on the annual growth, rather than stage of progression.
- B. Tanzman reported the trend analysis is consistent with earlier analysis and looks similar to the past two (2) years.
- B. Tanzman stated the gap between the comparison group and Blueprint is widening for *Total Pharmacy Expenditures (slide #8)*. B. Hill questioned if we would be able to get expenditures for Part D from VHCURES. M. Mohlman responded we do not get Part D Medicare claims in VHCURES. There is a long delay in getting the data. B. Tanzman stated we will need to follow up on what are we able to track in Medicare spend.
- B. Tanzman reviewed *slide #9, Outpatient Emergency Department Visits*, and mentioned there is not much significant differences between the two groups. The Blueprint practices has a higher ED outpatient visits and questioned what story is behind this. J. Samuelson reminded the committee the data goes through the end of 2015 and does not include data for 2016. T. Tremblay responded the higher visits may be a result of not having access during non-office hours (nights/weekends).
- *Slide #10, Primary Care Analysis*, is showing a decline for both groups on primary care visits. S. Fine responded we should look at the work force. In S. Fine's health service area, providers in primary care are leaving making access harder. Another committee member responded the decrease in primary care visits may be linked to the higher ED visits. B. Tanzman responded that is very intuitive and not the direction we want to see or move in. This is a measure under the All Payer Model that we will need to focus on.
- E. McKenna stated in the Morrisville health service area, they will be trying out if placing a Care Coordinator in the ED unit will have any impact.
- E. McKenna questioned if there are any data on types of visits such as behavioral health. B. Tanzman responded we would have the diagnosis on the claim data.
- *Slide #11 and #12* focuses on Medicaid only. B. Hill questioned if ages 65+ and the dual beneficiaries are also included in the trend analysis. [Dual eligibles are counted in the Medicare groups; in the case of today's presentation in the "all insurers" results for age 1 year and older]

III. Updates from the Field: Aligning Community Initiatives Towards Accountable Communities for Health – Laural Ruggles, Program Manager for the St. Johnsbury Health Service Area

- L. Ruggles presented how St. Johnsbury is aligning their work at the community level.
- L. Ruggles believes the Accountable Communities for Health (ACH) is the true next generation model.
- L. Ruggles mentioned St. Johnsbury is also using the Collective Impact framework. The leadership team includes decision makers in the community and they have all signed an MOU. Vermont Foodbank received a grant that was used to hire backbone staff. The grant requires matching funds, which the leaders at the table (community partners) have committed to match in the second year.

IV. Blueprint Manual Revisions

- T. Tremblay sent out a redline version and a clean copy of changes to proposed language changes in the manual during the Committee meeting.

- B. Tanzman reported Blueprint received a couple of comments from the committee members in regards to the Women's Health Initiative section. B. Tanzman mentioned we would like to finalize this manual by close of business day on Friday, January 20, 2017.

With no further time, the meeting adjourned at 09:54 am.

NEXT MEETING: Wednesday, March 15, 2017 at 8:30am-10:00am



Department of Vermont
Health Access



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Executive Committee Planning & Evaluation Committee

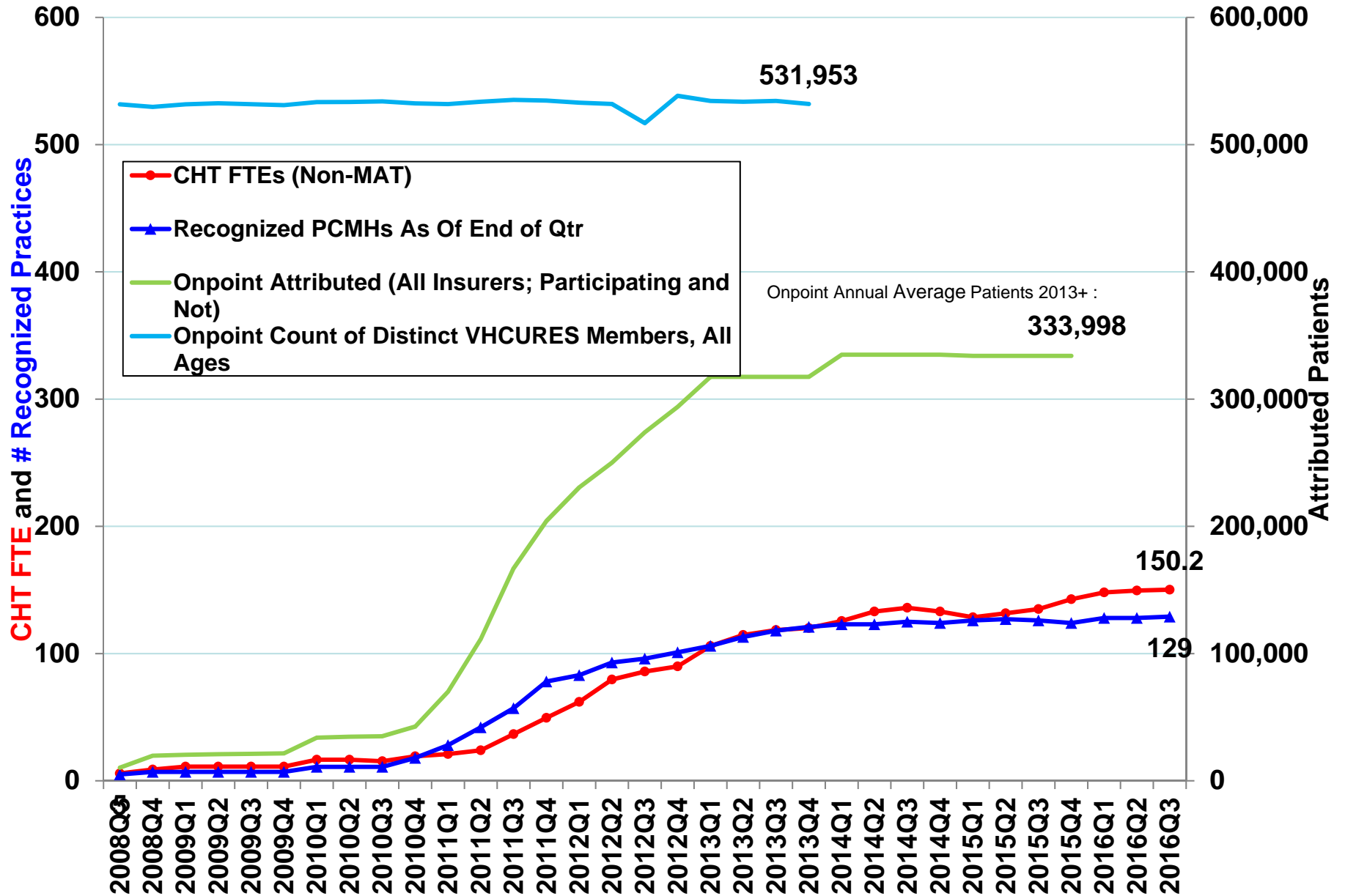
January 18, 2017

Agenda January 18, 2017

- Trend Analysis & Program Highlights 2016 Annual Report
- Updates from the Field: Aligning Community Initiatives towards Accountable Communities for Health
- Blueprint Manual Revisions
- Looking Forward

Program Highlights 2016 Annual Report

- State wide accountable health system with provider led reform
All Payer Model
- Collaborative work with ACOs & Communities to build shared governance, aligned QI & Measurement
- Modified PCMH Payments
- 7 year Trend Analysis shows reduced expenditures
- Women's Health Services Initiative



Health Services Network

Key Components	December, 2016
PCMHs (active PCMHs)	128
PCPs (unique providers)	783
Patients (Onpoint attribution) 12/2015	333,998
CHT Staff (core)	227 staff (146.6 FTEs)
SASH Staff (extenders)	54 panels
Spoke Staff (extenders)	78 staff (54.37 FTEs)

Trend Analysis

TOTAL EXPENDITURES EXCLUDING SPECIAL MEDICAID SERVICES PER CAPITA 2008-2015 ALL INSURERS, AGES 1 YEAR AND OLDER



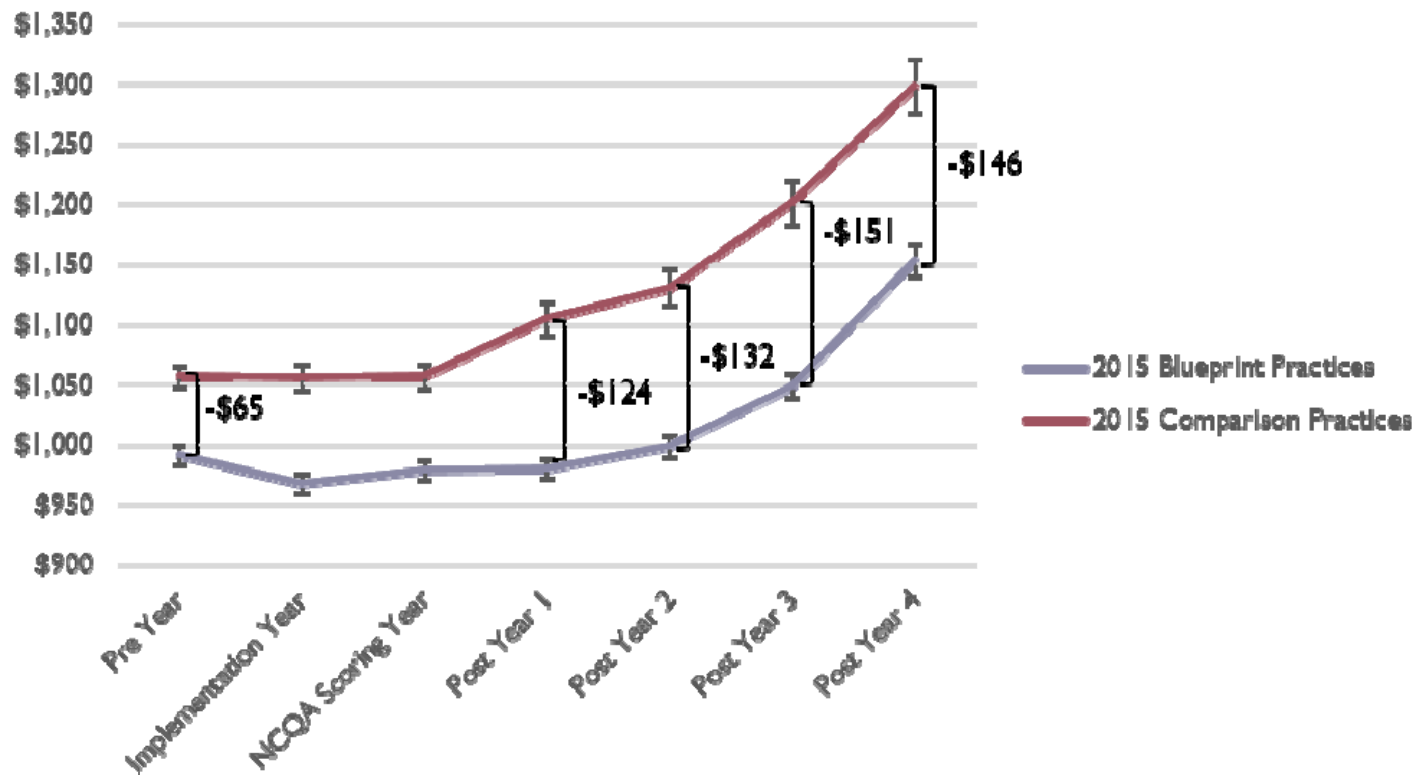
Trend Analysis

TOTAL INPATIENT EXPENDITURES PER CAPITA 2008-2015, ALL INSURERS, AGES 1 YEAR AND OLDER



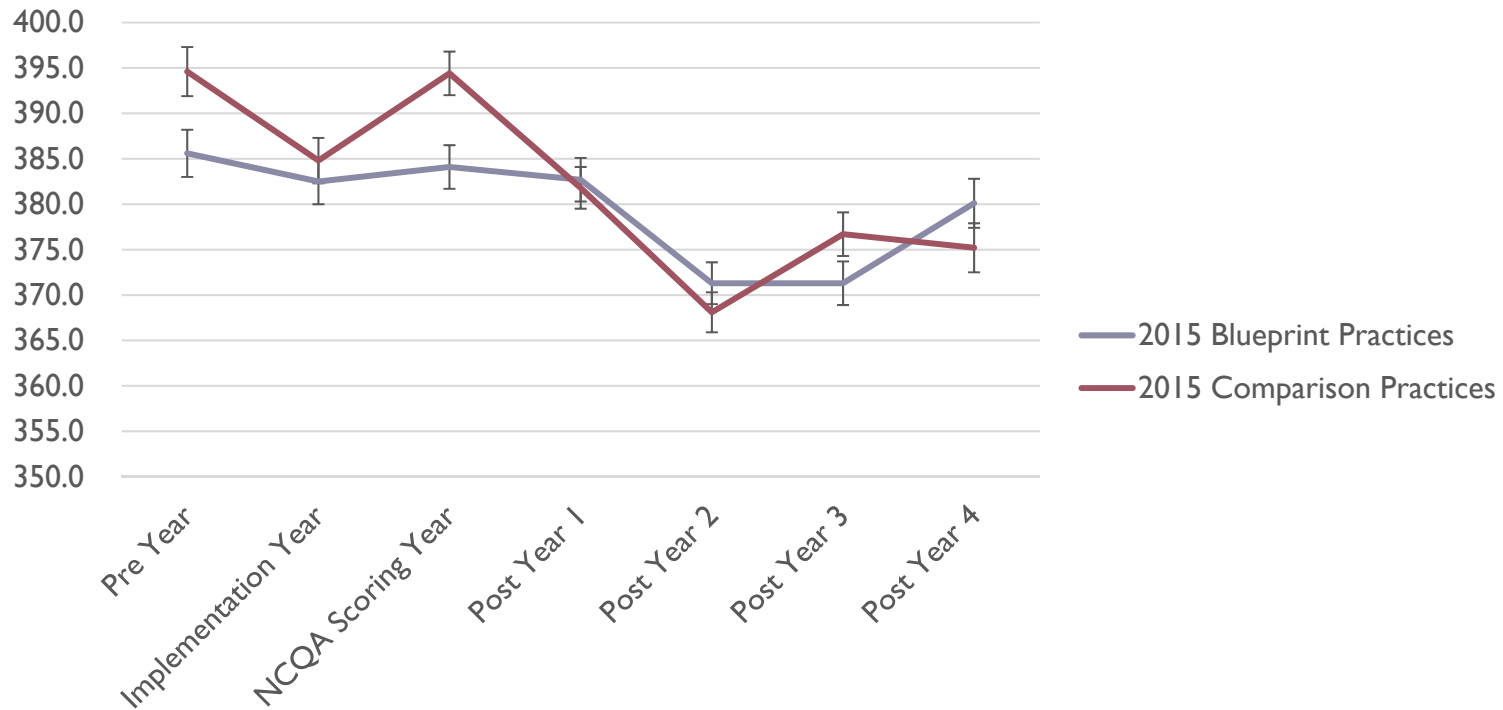
Trend Analysis

Total pharmacy expenditures per capita 2008-2015, all insurers, ages 1 year and older



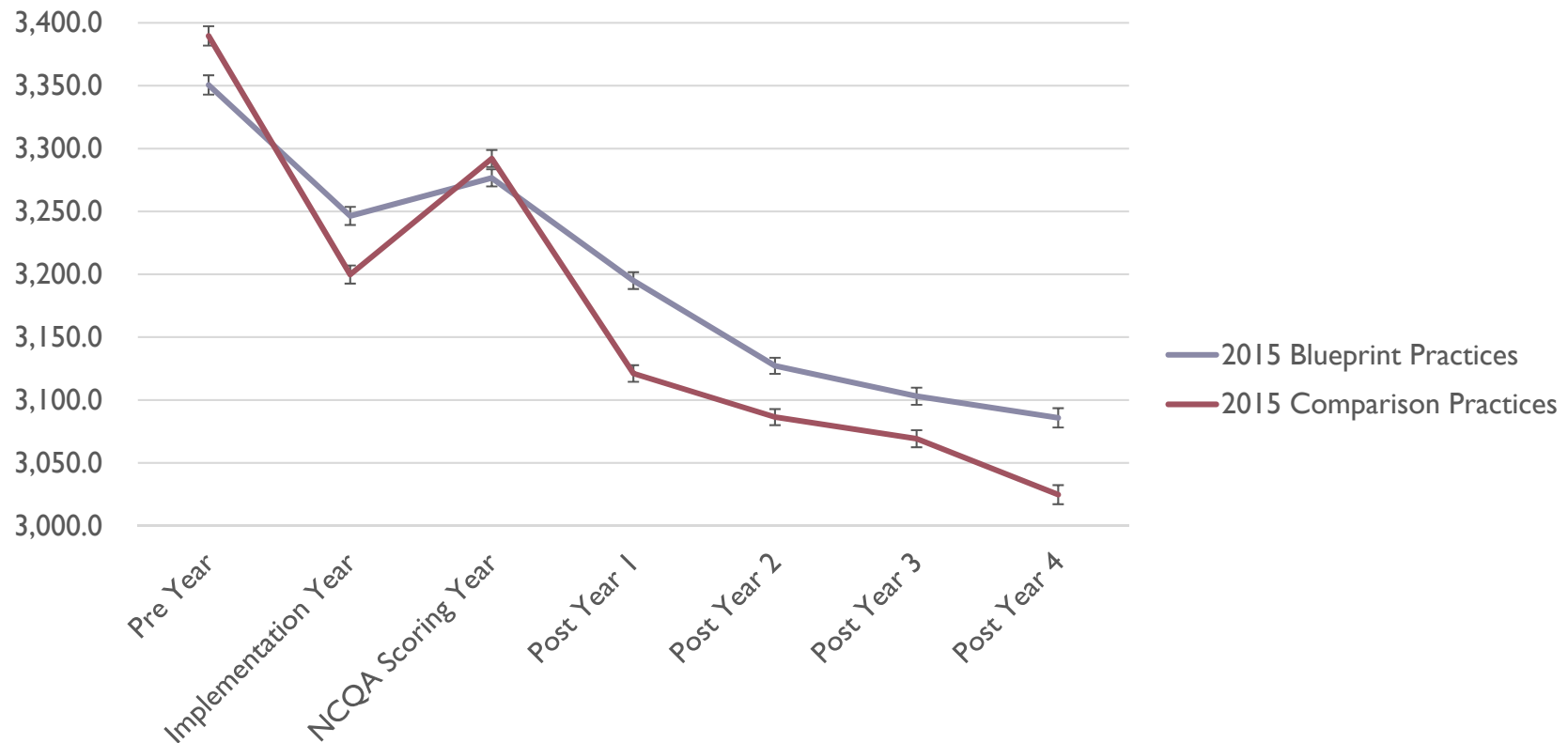
Trend Analysis

Outpatient emergency department visits per 1,000 members 2008-2015, all insurers, ages 1 year and older



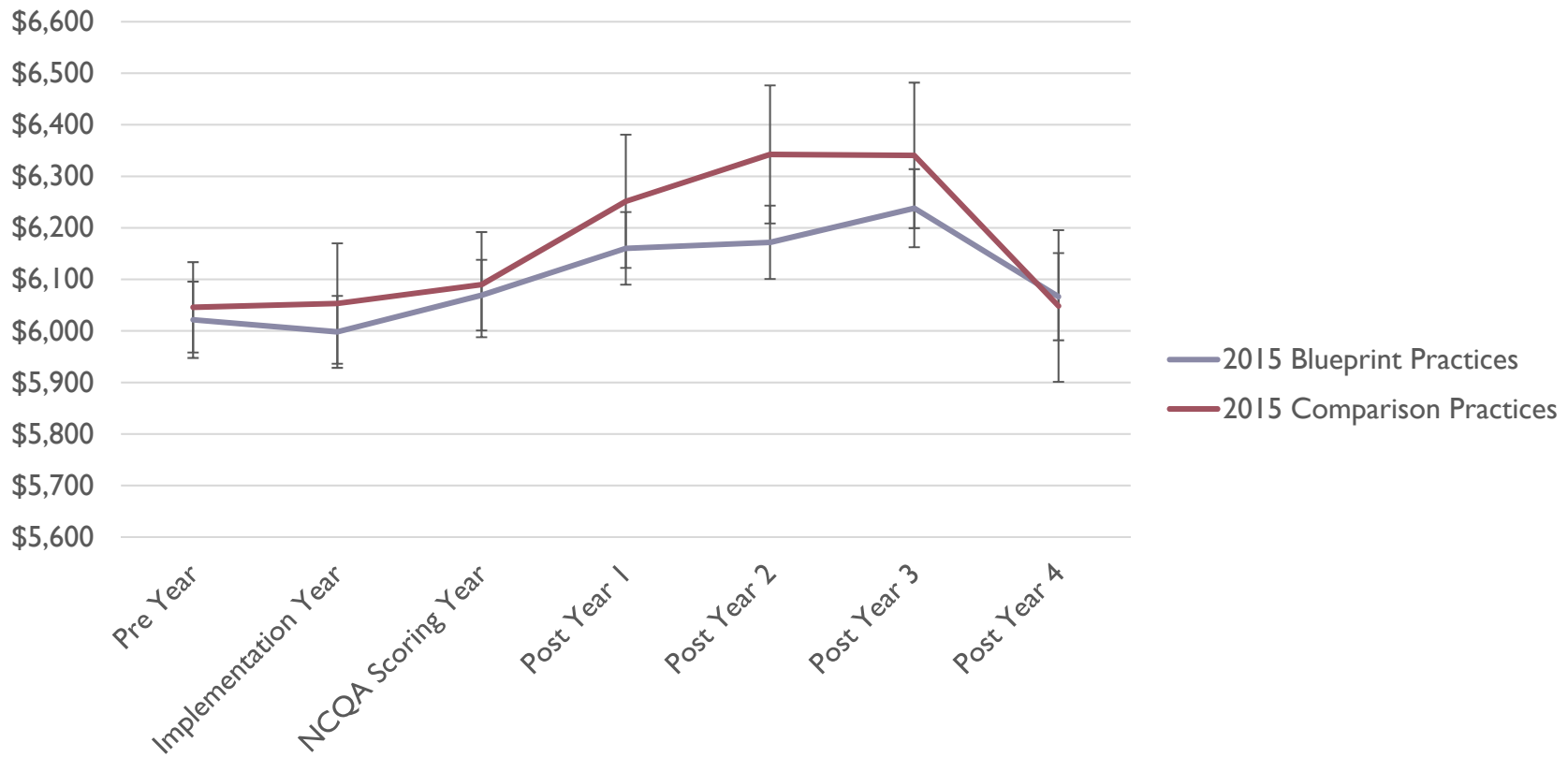
Trend Analysis

Primary care visits per 1,000 members 2008-2015, all insurers, ages 1 year and older



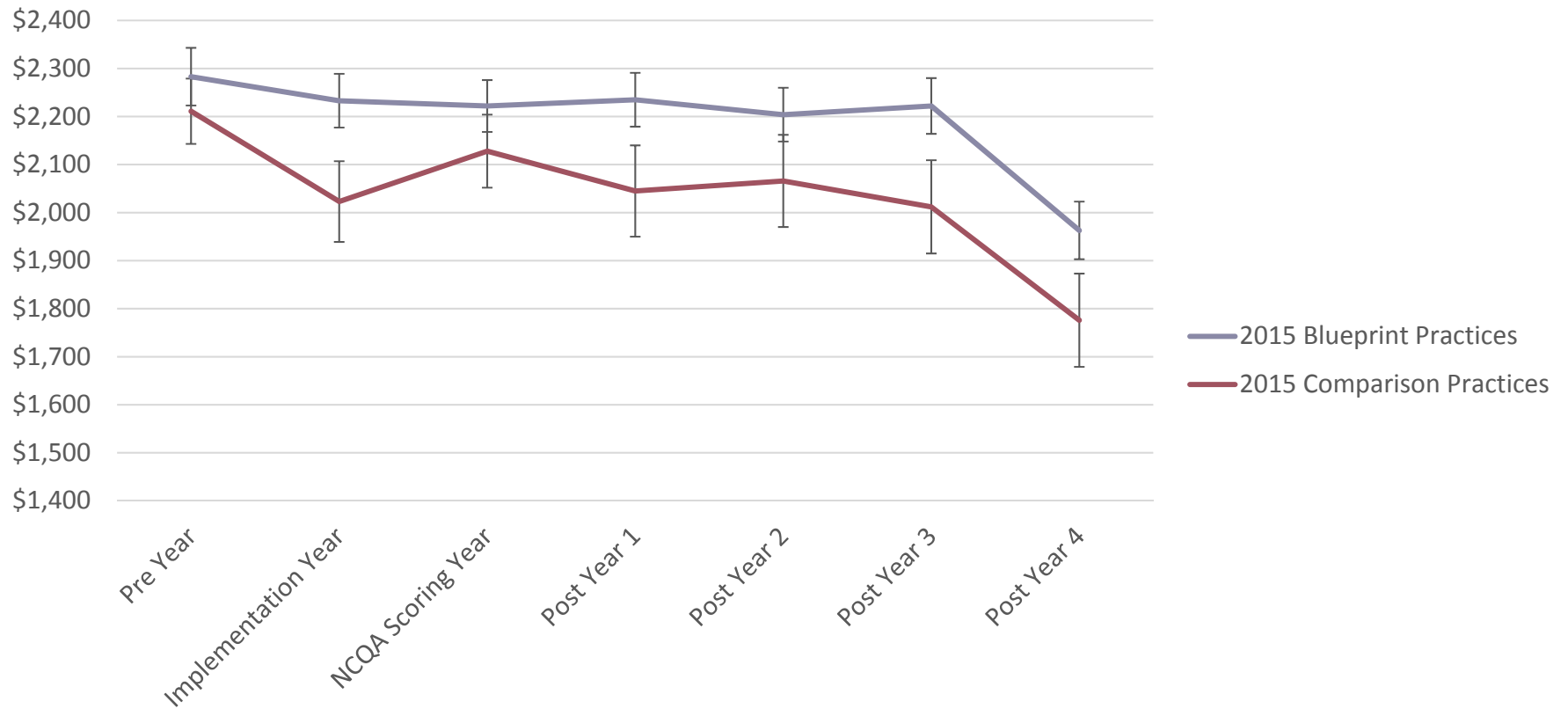
Trend Analysis

Total expenditures per capita 2008-2015, Medicaid, ages 1-64 years



Trend Analysis

SMS EXPENDITURES PER CAPITA 2008-2015, MEDICAID, AGES 1-64 YEARS



Funding & ROI

All Payer	Investment	Reduction in Total Expenditures
Reduction in expenditures		\$(73,413,205)
PCMH Payments	\$7,968,509	
Core CHT Payments	\$8,977,055	
Total Payments	\$16,945,564	
Blueprint Program Budget	\$5,071,363	
Total investment	\$22,016,927	

Reduction in Total Expenditures / Total Investment = Return on Investment

3.3 Return on Investment

Updates From the Field: Aligning Community Initiatives Towards Accountable Communities for Health

St. Johnsbury

Alphabet Soup

RECONCILING UCC/RCPC/CC/AHC

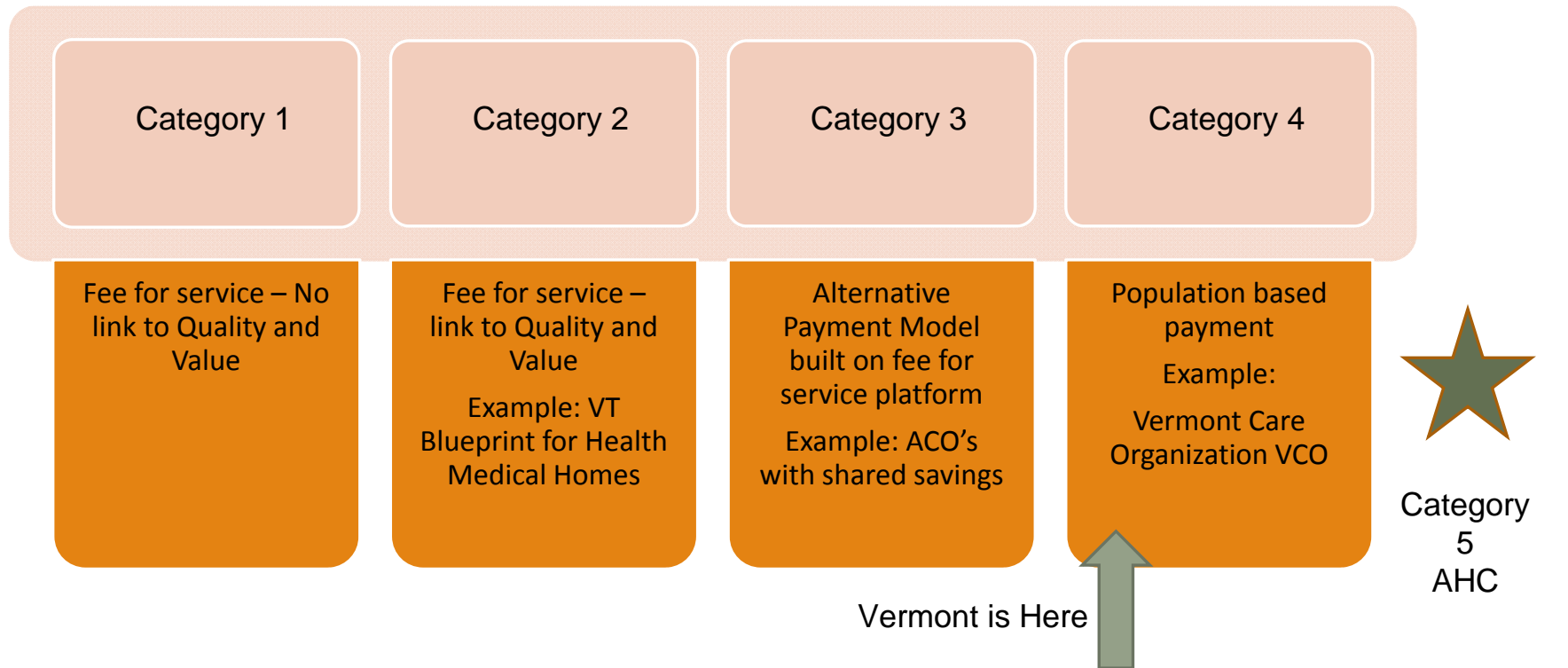
LAURAL RUGGLES, MBA, MPH

NORTHEASTERN VERMONT REGIONAL HOSPITAL

JANUARY 18, 2017



Alternative Payer Model Framework



Accountable Health Community AHC

- ▶ An aspirational *model—accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients.*
- ▶ Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors.
- ▶ An AHC supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care.
- ▶ It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness.

Nine Core Elements of an AHC

- ▶ Mission
- ▶ Multi-sectorial partnership
- ▶ Integrator organization
- ▶ Governance
- ▶ Data and indicators
- ▶ Strategy and implementation
- ▶ Community member engagement
- ▶ Communication
- ▶ Sustainable financing

Caledonia & s. Essex Accountable Health Community

Northeastern Vermont Regional Hospital Service Area

Nine Elements of an Accountable Health Community

MISSION

Our Accountable Health Community is committed to our shared goal of improving the health and well-being of the people in Caledonia and southern Essex Counties by integrating our efforts and services, with an emphasis on reducing poverty in our region.
(Adopted December 2015)

GOVERNANCE

Collective Impact Model: Leadership Partners have entered into an MOU that outlines purpose, mission, geographic scope, commitments, and decision making. (signed January 2016)

COMMUNITY ENGAGEMENT

5 Community Member Focus Groups were held with member organizations' clients. A total of 37 participated in the interviews. (December 2015 – February 2016)
Additional community engagement activities planned.

FINANCING

Current: John and Laura Arnold Foundation
Matching funds provided by Leadership Partners
Future: Investments of shared savings; and financing partners e.g. CDFI

COMMUNICATION

Monthly meetings of all partners



INDICATORS

Results Based Accountability
Population Level

Data Partner: Vermont Center for Rural Studies

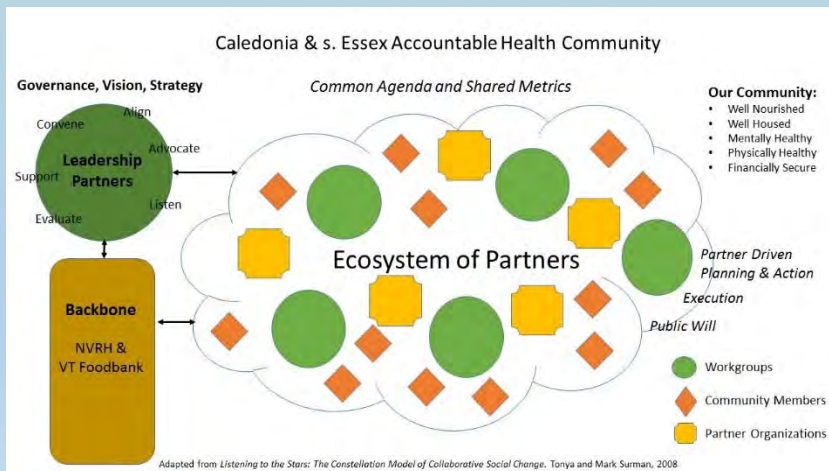
Cost-Burdened Households -Combined
% of households considered cost burdened by their housing expenses relative to their incomes for homeowners and renters

SNAP & Free/Reduced School Lunch
% households participating

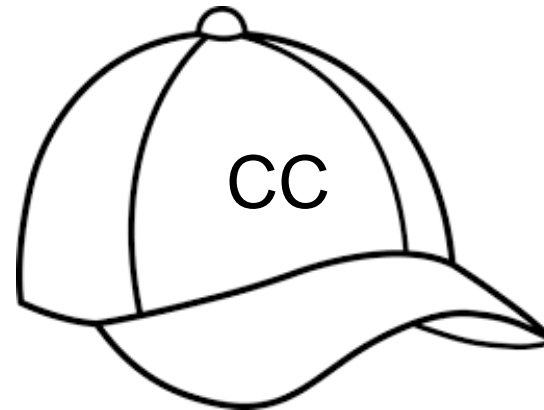
Household Income by Income Brackets
% of different household income levels

Poor Mental Health Days
% of adults reporting poor mental health days (BRFSS)

Leadership Partners



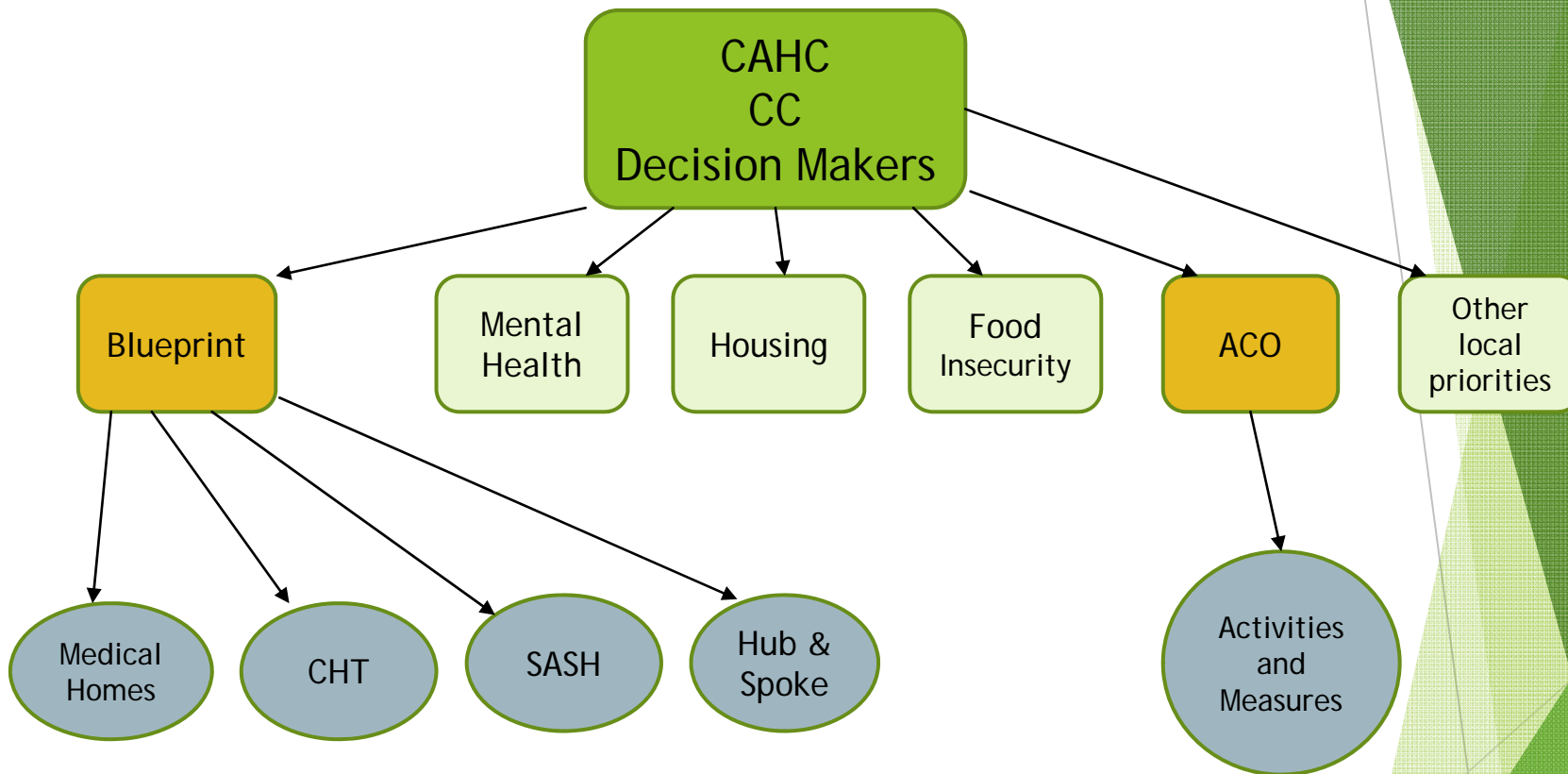
CAHC Wears 2 (at least) Hats...



- C4C Collective Impact
 - Collaborating for Clients
- FEED Leadership Program
 - Feeding America
- VHCIP Peer Learning Lab
 - Vermont Health Care Innovation Project

- Blueprint for Health
- Accountable Care Organization

...but we are only 1 entity!



CAHC = Caledonia & s. Essex Accountable Health Community
CC= Community Collaborative (Blueprint and ACO requirement)

Caledonia & s. Essex Accountable Health Community

Northeastern Vermont Regional Hospital Service Area

Nine Elements of an Accountable Health Community

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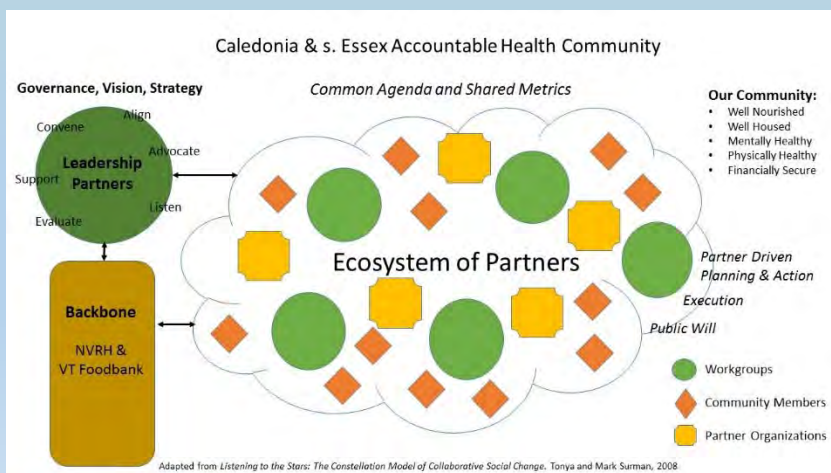
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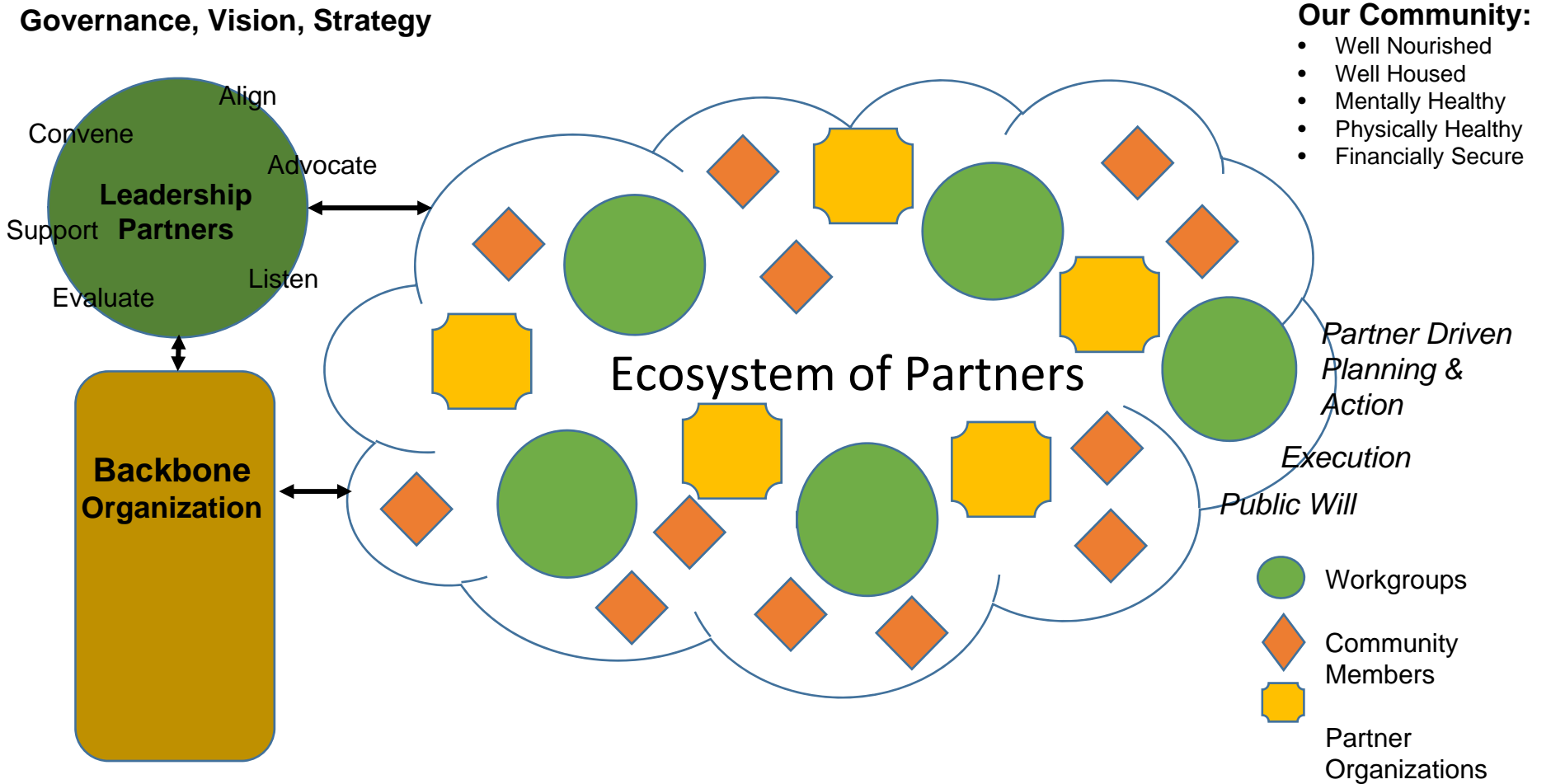


Leadership Partners



Caledonia & s. Essex Accountable Health Community

Common Agenda and Shared Metrics



Adapted from *Listening to the Stars: The Constellation Model of Collaborative Social Change*. Tonya and Mark Surman, 2008

Blueprint Manual Revisions

Looking Forward

1/4/16

**MEMORANDUM OF UNDERSTANDING:
Cal-Essex Accountable Health Community**

THIS MEMORANDUM OF UNDERSTANDING is by and among:

- * Northeastern Vermont Regional Hospital
- * Northeast Kingdom Community Action
- * Northeast Kingdom Council on Aging
- * Northeast Kingdom Human Services
- * Northern Counties Health Care
- * Rural Edge
- * Vermont Foodbank

And hereinafter, they shall be referred to as the members of the Cal-Essex Accountable Health Community (CAHC). They do hereby agree to be charter members and participants in the CAHC leadership table of the project and further agree to the following terms and conditions of the CAHC:

PURPOSE

The CAHC members seek to establish the Cal-Essex Accountable Health Community as defined in its Mission Statement.

MISSION

Our Accountable Health Community is committed to our shared goal of improving the health and well-being of the people in Caledonia and southern Essex Counties by integrating our efforts and services, with an emphasis on reducing poverty in our region.

PROJECT BACKGROUND

The CAHC first met in September 2013 with a half-dozen health care leaders seeking to build community integration for a healthier Northeast Kingdom (NEK). The group grew and evolved, always keeping focused on the overall health and wellness of people in the Northeast Kingdom by fully integrating the work of the members with trust and teamwork. In June 2015, the CAHC was awarded a three-year grant from the Laura and John Arnold Foundation, through Feeding

America to the Vermont Foodbank, to enhance our work by formally applying the principles of collective impact: developing a common agenda and shared goals, agreeing to shared measurements toward those goals, engaging in mutually reinforcing activities, engaging in continuous communications, and establishing a backbone organization to keep the process on track. The signatories to this MOU agree to continue this work in the spirit of our mission and the principles of collective impact.

GEOGRAPHIC SCOPE

The initial geographic area covered by the CAHC is coterminous with the service area of Northeastern Vermont Regional Hospital: most of Caledonia County and the southern half of Essex County. This includes the towns of Barnet, Burke, Concord, Danville, East Haven, Gilman, Granby, Guildhall, Kirby, Lunenburg, Lyndon, Maidstone, Newark, Peacham, Ryegate, Sheffield, St. Johnsbury, Sutton, Walden, Waterford, and Wheelock.

COMMITMENTS

The members of the CAHC commit to:

1. regularly attend and fully participate in leadership table meetings of the CAHC and provide leadership to relevant work groups;
2. provide support and resources as appropriate and available to implement the collective impact model for the CAHC project;
3. assist in the development of a community needs assessment;
4. adopt the CAHC shared outcomes, indicators and performance measures and collect data that indicates progress towards meeting the shared outcomes, indicators and performance measures;
5. share data related to CAHC shared outcomes, indicators and performance measures including data related to clients to the maximum extent possible within the parameters of laws and regulations;
6. explore and implement opportunities for the integration of all of our services in order to achieve the outcomes agreed upon;
7. promote open and continuous communication among the members of the CAHC to prevent or, if necessary, resolve any disagreements or misunderstandings that may arise; and
8. support the efforts of the Project Consultant and Project Coordinator in working toward the CAHC outcomes.

DECISION-MAKING

The preferred method of decision-making among the members of the CAHC shall be by consensus which aims for complete agreement and support on matters being considered by the CAHC. However, when this is not possible, decisions will be made through "qualified consensus." In this instance, the CAHC will be empowered to move ahead with a decision when there is clear support among a majority of members, when not more than two members are totally opposed to the decision, and when those opposed agree not to hinder the majority from proceeding to implement the decision.[1] In the final instance, decisions may be made by a majority vote of all the signatories to this MOU.

ROLE OF BACKBONE PARTNERS

The Northeastern Vermont Regional Hospital, as a key convener of the CAHC, and the Vermont Foodbank, as the fiduciary for the grant award, shall provide the "backbone" functions for the CAHC by hiring the project consultant and project coordinator, contracting with the local data partner, coordinating with and supporting the efforts of related work groups and providing logistical and technical support to backbone staff and all partners. All decisions by the backbone partners are subject to review and consensus of the CAHC.

TERM & TERMINATION

The term of this Memorandum of Understanding shall commence on the effective date and continue for 12 months from that date. This Memorandum of Understanding shall be renewed yearly in writing by all CAHC members for at least the next 3 years, covering the grant period.

Any member of the CAHC may terminate their participation in this Memorandum of Understanding by providing all other members with 30 days written notice.

AMENDMENT

This Agreement may be modified and amended at any time upon the agreement of the Parties, their successors and assigns. Any amendments require an agreement in writing signed by all Parties.

APPLICABLE LAW

This Memorandum of Understanding shall be governed by and interpreted exclusively under the laws of the State of Vermont.

SUCCESSORS AND ASSIGNS

This Agreement and all its provisions and attachments shall inure to the benefit of, and shall be binding upon each signatory and their respective successors and assigns.

COUNTERPARTS

This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

INDEPENDENT CONTRACTORS

Each signatory is acting as an independent contractor for the purposes of activities undertaken pursuant to this Memorandum of Understanding. Each signatory is responsible to secure all personnel necessary to fulfill the responsibilities under this agreement. Each signatory shall be responsible for all payments, taxes, expenses, and reporting requirements associated with the personnel, volunteers or employees of each respective organization.

EXECUTION OF AGREEMENT

This Agreement shall be binding on the date of execution of the last party to sign below ("Effective Date").

DW Bouchard
Signature

DW Bouchard
Printed Name

NKHS
Organization/Title

1/4/16
Date

Patrick Flood
Signature

PATRICK FLOOD
Printed Name

NCHC
Organization/Title

1/4/16
Date

Trisha Ingalls
Signature

TRISHA INGALLS
Printed Name

Rural Edge
Organization/Title

1/4/16
Date

(continued on next page for signatures)


Signature

Jrc Prinsji
Printed Name

WGLCA
Organization/Title

Jan / 4 / 2016
Date


Signature

Lisa M. Viles
Printed Name

NEK Council on Aging
Organization/Title

1-4-2016
Date

Paul R Bengtson CEO
Signature

Paul R Bengtson
Printed Name

NVRH
Organization/Title

1-4-2016
Date


Signature

John Sayles
Printed Name

Vermont Foodbank / CEO
Organization/Title

1.4.2016
Date

[1] Adapted from the Irish Network for Nonviolent Action Training and Education