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

May 17, 2017

Attendees: M. Costa; T. Dolan; M. Donohue; C. Elmquist; P. Farnham; K. Fitzgerald; C. Fulton; M. Gravett; L. Hendry; P. Jackson; K. Kelley; J. Krulewitz; K. Lange; J. Le; M. McAdoo; M. Mohlman; L. Peake; J. Samuelson; B. Tanzman; T. Tremblay; N. Walke; E. Yahr; M. Young

By phone: P. Biron; S. Bruce; A. Buchanan; P. Clark; T. Coates; J. Dodge; E. Emard; J. Evans; J. Fels; P. Launer; R. Lunge; T. Mable; E. McKenna; T. Moore; S. Narkewicz; J. Peterson; J. Plavin; T. Reinertson; J.Riffon; L. Ruggles; M. Shattuck

The meeting opened at 8:30 a.m.

I. Opening Remarks and Announcements: Beth Tanzman

- Today's agenda and PowerPoint slide deck were distributed prior to this meeting.
- B. Tanzman stated at today's meeting, we will discuss the implementation of the All Payer Model (APM) and Blueprint, take final comments and feedback regarding the Blueprint payment manual revisions related to the Women's Health Initiative (WHI), and review the Hub & Spoke profiles.

II. Implementation of the All Payer Model and Blueprint

- B. Tanzman reviewed *slide #3, Vermont Multi-Payor Payment Reforms for Primary Care.*
- The Blueprint payments (CHT and PCMH) have helped drive tremendous service delivery reform but are too small to fundamentally change the Primary Care business model. We need additional payment reform.
- T. Moore stated the message in the VT Digger is accurate about the Vermont Care Organization (VCO). The timing was not right to integrate operationally and unify the Accountable Care Organizations (ACOs) and may be an option in the future. T. Moore reported OneCare still plans to move forward and asked colleagues to not perceive this message that the APM will not work.

- K. Kelley stated T. Moore characterized the message well. K. Kelley mentioned the VCO was also dependent on delivery system reform investments that have not materialized. OneCare and CHAC will continue to work collaboratively.
- R. Lunge stated the Green Mountain Care Board (GMCB) will look for alignment between all payers and insurers.
- M. Mohlman reported the Scott Administration sees the value in the APM and are ready to move forward. Implementation is the next step in the trajectory.
- M. Costa mentioned the State has also put money into the Medicaid Next Generation Risk Model. The negotiations for 2018 are about to kick-off. M. Costa questioned what does the state of the future of Blueprint look like. What's the right amount of scale between the three? M. Costa stated as the model evolve, the State and Blueprint will evolve with it. We should expect some discomfort but also opportunities.
- B. Tanzman offered that Blueprint is State-led reform and we are committing to Provider-led reform in the future.
- M. Costa mentioned the goal is integrated system of care and the APM is the vehicle to change. The other critical component is risk. Everyone will have to give some control and take responsibility and financial risk for the system.
- T. Dolan reminded the Committee that we sometime miss the overall goals and forget the Triple Aim and the goal of improving health. M. Mohlman added the Governor's three priorities and described how they all tie into each other.
- M. Costa stated the State provides the "what" and the providers provides the "how". Getting that to happen through the Blueprint is the real trick. J. Peterson reported she is happy to hear people are using the words wellness and integration. We always think physicians are leading the Provider reform. B. Tanzman thanked J. Peterson and stated coordination among providers requires humans and time. Resources works better if they can be payer agnostic.
- B. Tanzman stated we have an opportunity in 2018 to draw down Medicare's participation for the Blueprint and SASH. The "how do we get the cash out" is a work in progress and B. Tanzman cannot promise on the timing. OneCare has agreed to distribute the payments inside and outside of their network. M. Costa stated nothing is committed for 2019. This is a potential date to evolve Blueprint.
- T. Dolan questioned the topic from the last Executive meeting around Shared Interest Payment. B. Tanzman stated OneCare had a strong preference to drive the design on that. T. Dolan mentioned to T. Moore to include pediatricians in the planning group; importance of pediatricians supporting the model for our children. T. Moore stated that's a great thought and will pass the information along to the clinical leadership. K. Kelley responded to also include CHSLV in the planning.
- B. Tanzman is excited about this and mentioned it is okay for programs to evolve and change over time.

III. Blueprint Manual Revisions (for Women's Health Initiative)

- B. Tanzman stated Blueprint has an obligation to consult with the Executive Committee at least twice before the change to the Implementation Manual will go into effect and reviewed *slide #10 and slide #11, Payment Implementation Manual*. We need final feedback by close of business day on May 24, 2017. The manual will be finalized and

Blueprint will be able to make the funding available to the practices. C. Elmquist responded the payments will be implemented in the next quarter, July 1, 2017.

- C. Elmquist flagged another language change – the addition of a floor of CHT .5 FTE.
- J. Samuelson stated once the language has the Executive Committee's approval, Blueprint Facilitators will be requested to go out and discuss these changes with their communities. Blueprint Program Managers will be receiving an updated one-pager communication.

IV. Hub & Spoke Profiles

- B. Tanzman reviewed *slide #12, Spoke Regional Profile,* and stated this is the first round, calendar year 2015, Medicaid only.
- B. Tanzman reviewed *slide #14, Total MAT & Non-MAT Expenditures*. T. Dolan mentioned the State has been looking at the urinalysis expenditure.
- B. Tanzman reviewed slide #16, Cervical Cancer Screening, and stated the timeframes are different depending on age group. Half of those screened have not had the screening within the recommended time frame. B. Tanzman mentioned to T. Dolan this is where we're hoping to engage ADAP in this QI initiative.

With no further time, the meeting adjourned at 10:02 am.

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Blueprint for Health

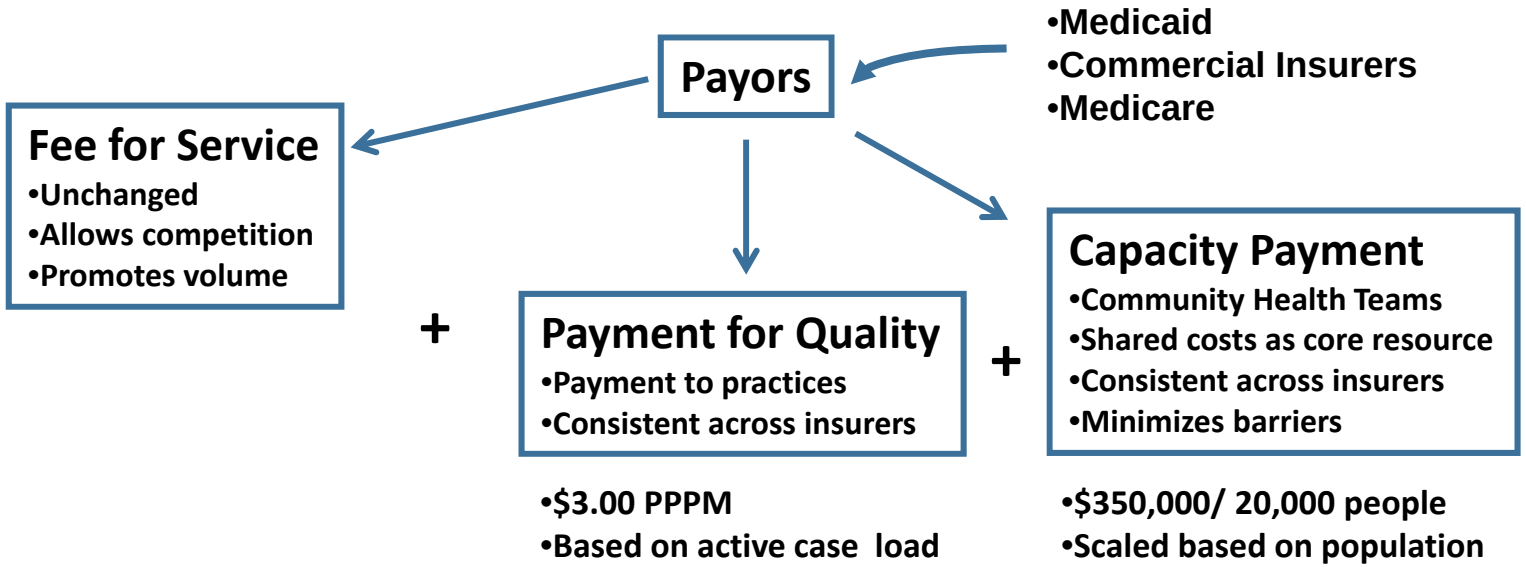
Executive Committee
Planning & Evaluation Committee

May 17, 2017

Agenda May 17, 2017

- Welcome & program status
- Discussion of implementation of All Payer Model and Blueprint
- Presentation of Hub & Spoke profiles
- Review and approval of Blueprint Payment Implementation Manual revisions (for Women's Health Initiative)

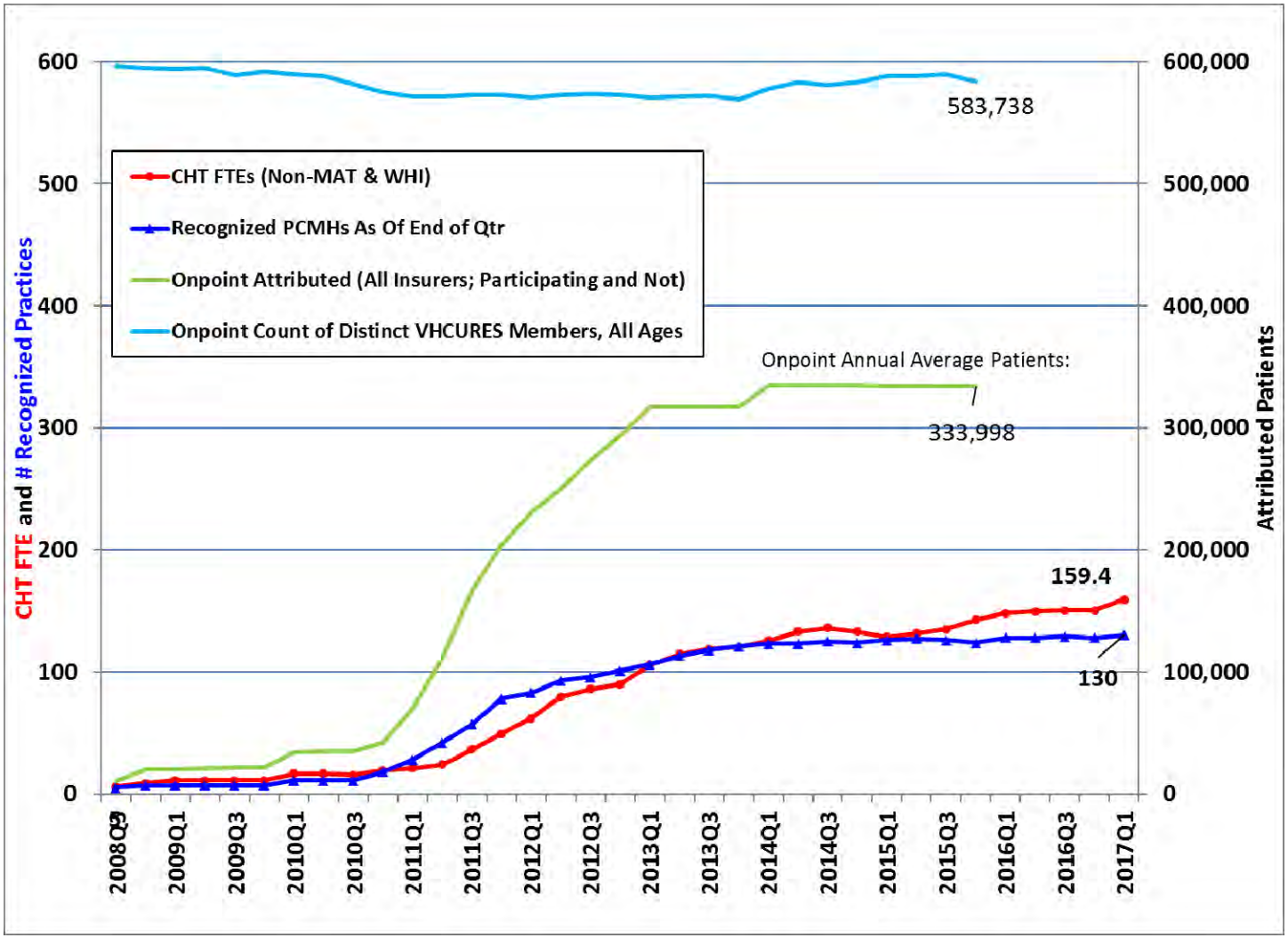
Vermont Multi-Payor Payment Reforms for Primary Care



Patient Centered Medical Homes strong primary care foundation **Community Health Teams** bridge health & social services **SASH** for healthy aging-in-place, **Hub & Spoke** for opioid addiction treatment, **Women's Health Initiative** increase pregnancy intention, healthy families

All Payer Reforms Slowing Growth in Health Care Costs

Total expenditures per capita, excluding Special Medicaid Services, 2008-2015, all insures, for individuals ages one and up.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CHT FTE and # Recognized Practices
Attributed Patients
583,738
CHT FTEs (Non-MAT & WHI)
Recognized PCMHs As Of End of Qtr
Onpoint Attributed (All Insurers; Participating and Not)
Onpoint Count of Distinct VHCURES Members, All Ages
Onpoint Annual Average Patients:
333,998
159.4
130
2008Q3
2009Q1
2009Q3
2010Q1
2010Q3
2011Q1
2011Q3
2012Q1
2012Q3
2013Q1
2013Q3
2014Q1
2014Q3
2015Q1
2015Q3
2016Q1
2016Q3
2017Q1

Health Services Network

Key Components	May 2017
PCMHs (active PCMHs)	130
PCPs (unique providers)	783
Patients (Onpoint attribution)	333,998
CHT Staff (core)	159.4 FTEs
SASH Staff (extenders)	68 FTE serving 54 panels
SASH Housing Sites	143
Spoke Practices	76
Spoke Staff (extenders)	56.7 FTEs
Women's Health Initiative (practices)	19

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Bennington Community Collaborative

"Building a Healthy Bennington"

Working **DRAFT** 12/08/16

Mission

Build a high-performing system that supports measurable improvement in the health of the community.

Definition:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Reference: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Governance: Community Collaborative

Scope: The scope of the Bennington Community Collaborative is to address the population health in the Bennington Health Service Area (HSA). The focus will be on quality outcomes, cost and value. The approach will be system based change utilizing the structures of the Bennington Blueprint, Vermont Care Organization (VCO) and the Bennington Accountable Community for Health.

Integrator Organization

Bennington Blueprint for Health
Southwestern Vermont Health Care (SVHC)

Reference: 2015 Blueprint for Health Network Analysis

Data & Indicators

Vermont All Payer Model Measures
VCO and Vermont Blueprint for Health Measures

Multi-Sectoral Partnership

The Community Collaborative includes the following members:

- Community Member
- Shires Housing
- Bennington Blueprint for Health
- Council on Aging
- Physician Healthsystem Organization (United Health Alliance)
- Designated Agency (United Counseling Services)
- Vermont Care Organization Physician Leadership
- Bennington Free Clinic
- Department of Health – Bennington District Office
- Health and Human Services
- Long Term Care
- Home Health
- Dartmouth Putman Physician Group
- Southwestern Vermont Health Care
- Federally Qualified Health Center
- OneCareVT

Communications

Formal Communication Plan to be developed.

Current Communication Methods include:
Legislative/Community Forums
All Inclusive Community Health Team Meetings
Newsletters and Publications disseminated across the community
Marketing Support from SVHC
Sharing of strategies and outcomes across partners and community

DRAFT Strategy	Implementation Methodologies
Economic and Community Development	• Shires Housing • Bennington Redevelopment Group (BRG) • SVHC Healthy Homes
Increase Healthy Behaviors in the Bennington Population	• Rise Vermont • 3 – 4 – 50 Vermont • SVMC Diabetes Education Program
Reduce the morbidity of Chronic Disease	• Patient Centered Medical Home • Spoke Program participation • Patient engagement/self-management
Decrease the incidence of Adverse Childhood Events (ACEs)	• Bright Futures • SVMC Safe Arms Program • Bennington Integrated Family Services (IFS)

Community Member Engagement

Actions to facilitate community engagement:

- Collaboration with Bennington College – Center for the Achievement of Public Action (CAPA)
- Community members on committees

Sustainability

1) Vermont Blueprint for Health funding to support self-management programs, Spoke Program, community health teams, quality improvement facilitation and local leadership. Vermont Women's Health Initiative.
2) OneCareVT support for a universal shared care plan and data analytics
3) SVMC Transitional Care Program
4) Shires Housing
5) All Payer Model opportunities (TBD)

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Middlebury HSA Community Health Action Team Dashboard

Community Partners: Agency of Human Services, Department of Health, Blueprint for Health, Porter Hospital, Porter Medical Group (Practices), Helen Porter Healthcare & Rehabilitation Center, Mountain Health Center FQHC, Middlebury Family Health, Rainbow Pediatrics, Planned Parenthood of Northern New England, Open Door Clinic, OneCare VT, Community Health Accountable Care LLC, Health First, Vermont Chronic Care Initiative, Addison County Community Trust, Support and Services at Home, Elderly Services, Addison County Home Health & Hospice, Bayada Home Health Care, Counseling Service of Addison County, Turning Point Center of Addison County, United Way of Addison County , Addison County Parent Child Center, Addison County Transit Resources, Building Bright Futures

Mission Statement

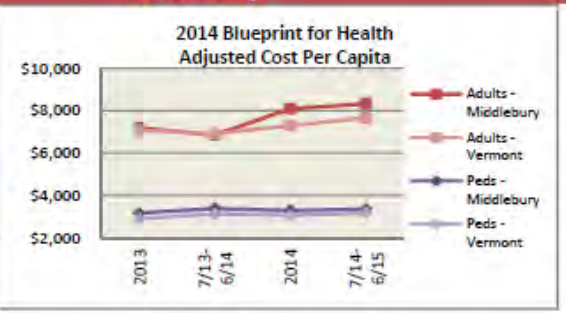
Through collaboration and a commitment to ensuring efficient, high quality health and human services, identifying and implementing best practices and using available data, our committee endeavors to build upon the existing strengths of our local organizations, as well as address gaps and unmet needs, in order to ensure access to services, facilitate smooth and seamless transitions between organizations and improve the health status of our community.

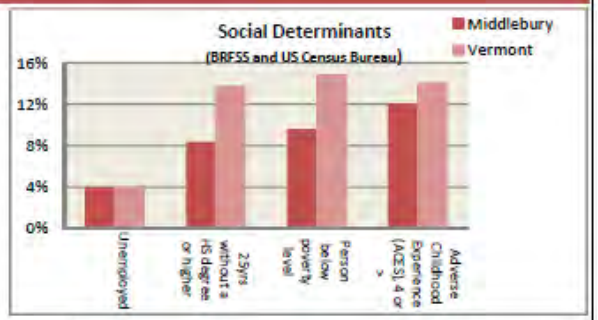
CHAT Subcommittees/Initiatives

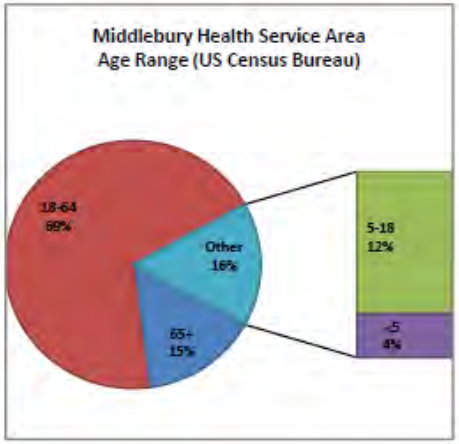
- Data and Analytics
- Reduction of Emergency Room Utilization
- Opiate Sub-Committee
- Integrated Community Care Management Learning Collaborative

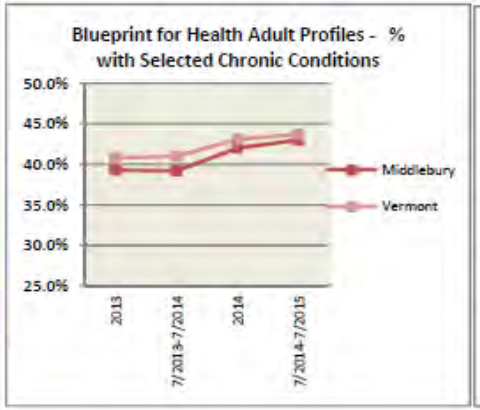
Our Community

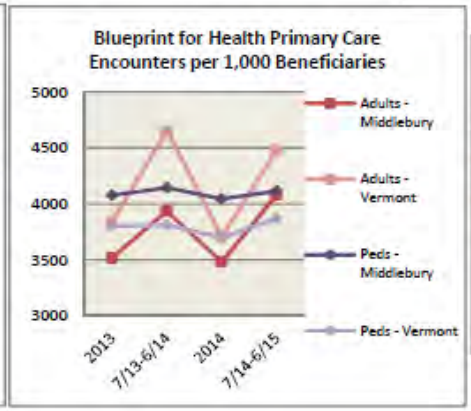
2014 and 2015 Attributed lives in Middlebury HSA	# lives
2014 Addison County Population Census:	37,009
2015 Addison County ACO populations (only pts who did not opt out):	10,495
OneCare VT Medicare, Medicaid, BCBS of VT	10,064
Health First Commercial	431
2014 Blueprint for Health (Adult and Pediatric)	20,152

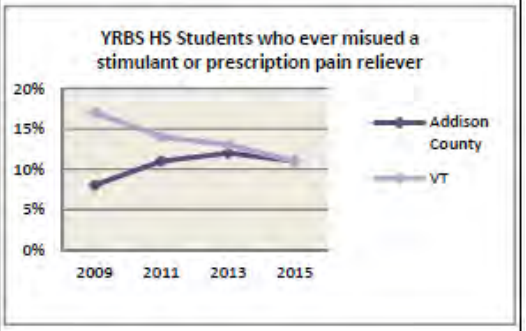












All Payer Model

- Overview
- ACO – VCO
- Blueprint Payments in 2018 - 2022

Payment Implementation Manual

Section 6.5: One-time Capacity Payment Per-Member Payment (PMP) and Patient Centered Medical Homes

- Proposed:
  - Blueprint Patient Centered Medical Homes practices are encouraged to participate in the WHI and are eligible for the WHI one-time capacity payment for their attributed Blueprint PCMH patient for women between the ages of 15 and 44 years (inclusive).

  - Practices are not eligible for the WHI PMPM or CHT payment as they already receive these forms of payments as a PCMH.

Policy Goals: support implementation of the comprehensive screening, referral to care, evidence based family planning counseling, and availability of LARC.

Payment Implementation Manual

- For mixed practices (Both WHI and PCMH Rostered Providers) the One Time Capacity payment will be calculated based on attributed female patients for all participating providers in mixed practices so that the payment supports the minimum “floor” does not exceed the “ceiling”.

- If the PCMH providers and WHI providers join the WHI at different times, a new PMP will be calculated for the practice based on the combined attribution. The WHI-participating insurers will share the cost of the difference between the initial PMP and the new PMP.

Spoke Regional Profile

Period: Jan 2015 - Dec 2015 **Profile Type:** Adults (18–64 Years)

Demographics & Health Status

	Spoke	Non-MAT Opioid Addicted	Medicaid Statewide
Average Members	2,600	1,379	72,874
Average Age	33.2	35.5	38.1
% Female	53.5	49.3	56.7
% Maternity	8.4	3.2	3.6
% with Selected Chronic Conditions	51.5	59.2	35.2
% CRG Significant Chronic	46.1	47.3	21.8
% Depression	37.6	43.9	16.9
% Hepatitis C	13.2	12.0	2.3
% ADD	17.6	15.3	5.5
% Asthma	18.4	20.2	12.0
% Mental Health (Non-Substance Use)	75.2	81.4	40.7
% Other Substance Use	62.7	66.3	12.5
% Tobacco Dependence	63.9	64.3	23.1

Medication Assisted Treatment Profile

Period: Jan 2015 - Dec 2015 **Profile Type:** Adults (18-64 Years)

Demographics & Health Status

	HUB	SPOKE	MAT Combined
Average Members	2,164	2,670	4,834
Average Age	33.8	33.2	33.5
% Female	53.8	53.6	53.7
% Maternity	5.9	8.9	7.6
% with Selected Chronic Conditions	45.8	51.0	48.7
% CRG Significant Chronic	40.9	45.1	43.2
% Depression	32.0	36.5	34.5
% Hepatitis C	20.2	13.0	16.2
% ADD	17.8	16.5	17.1
% Asthma	18.0	18.5	18.3
% Mental Health (Non-Substance Use)	68.8	74.4	71.9
% Other Substance Use	48.6	61.4	55.7
% Tobacco Dependence	58.5	62.3	60.6

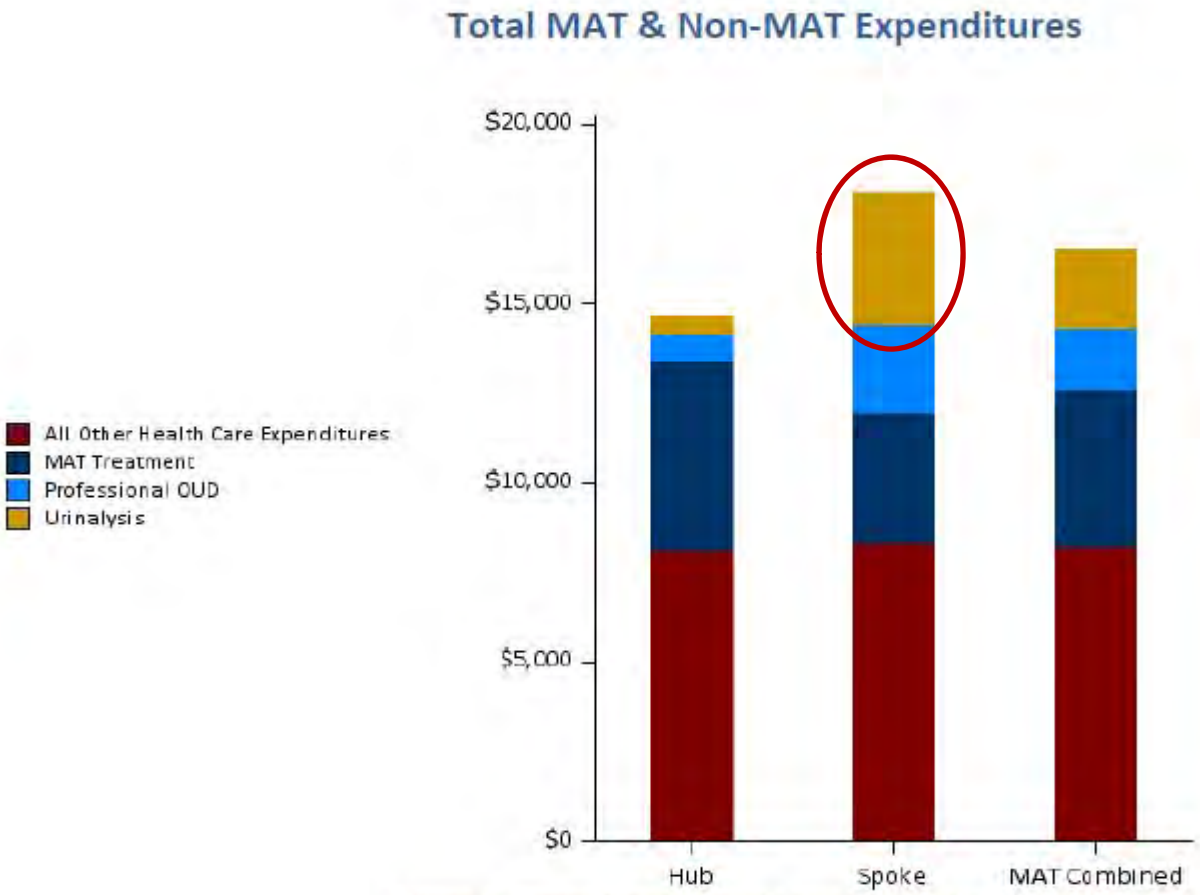


Figure 3: Presents annual crude rates for Medication Assisted Treatment (MAT) expenditures, Non-MAT expenditures, Professional Opioid Use Disorder (OUD) expenditures, and Urinalysis expenditures with expenditures capped statewide for outlier patients.

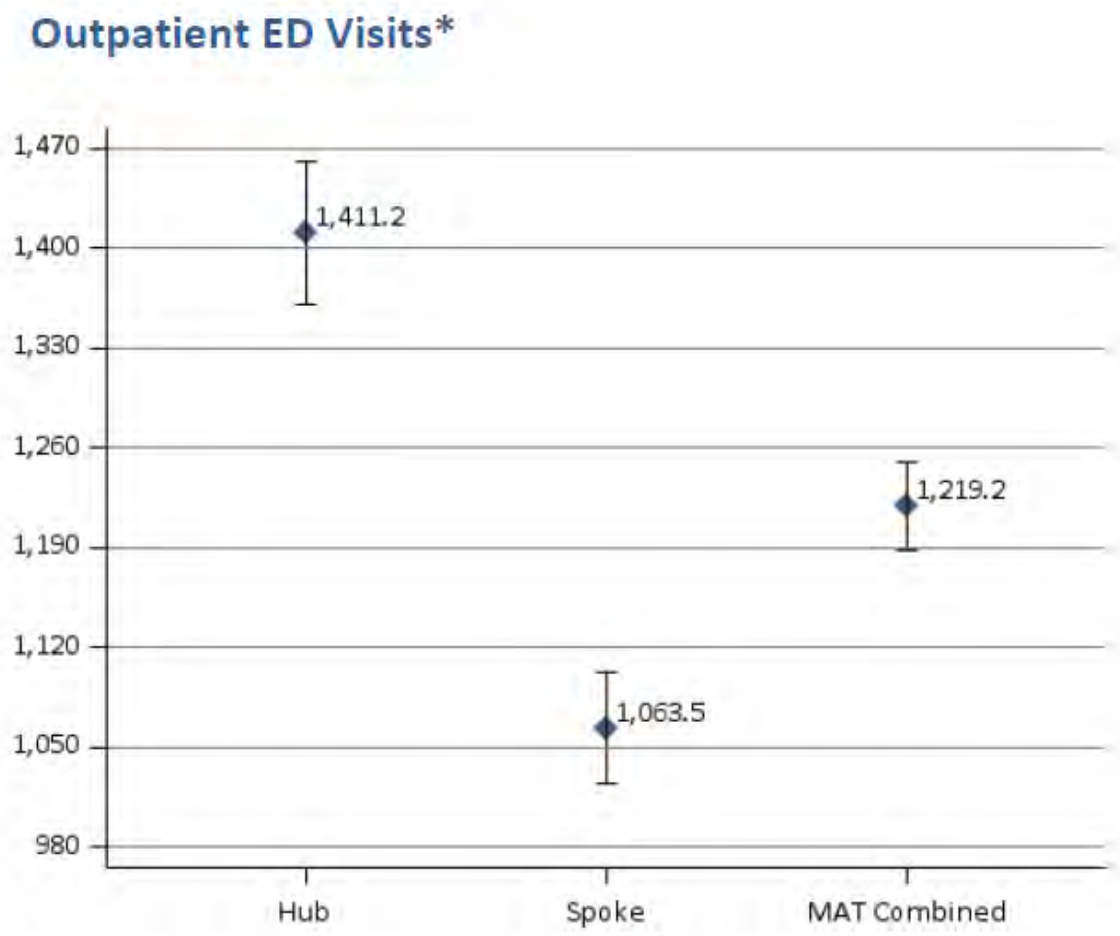
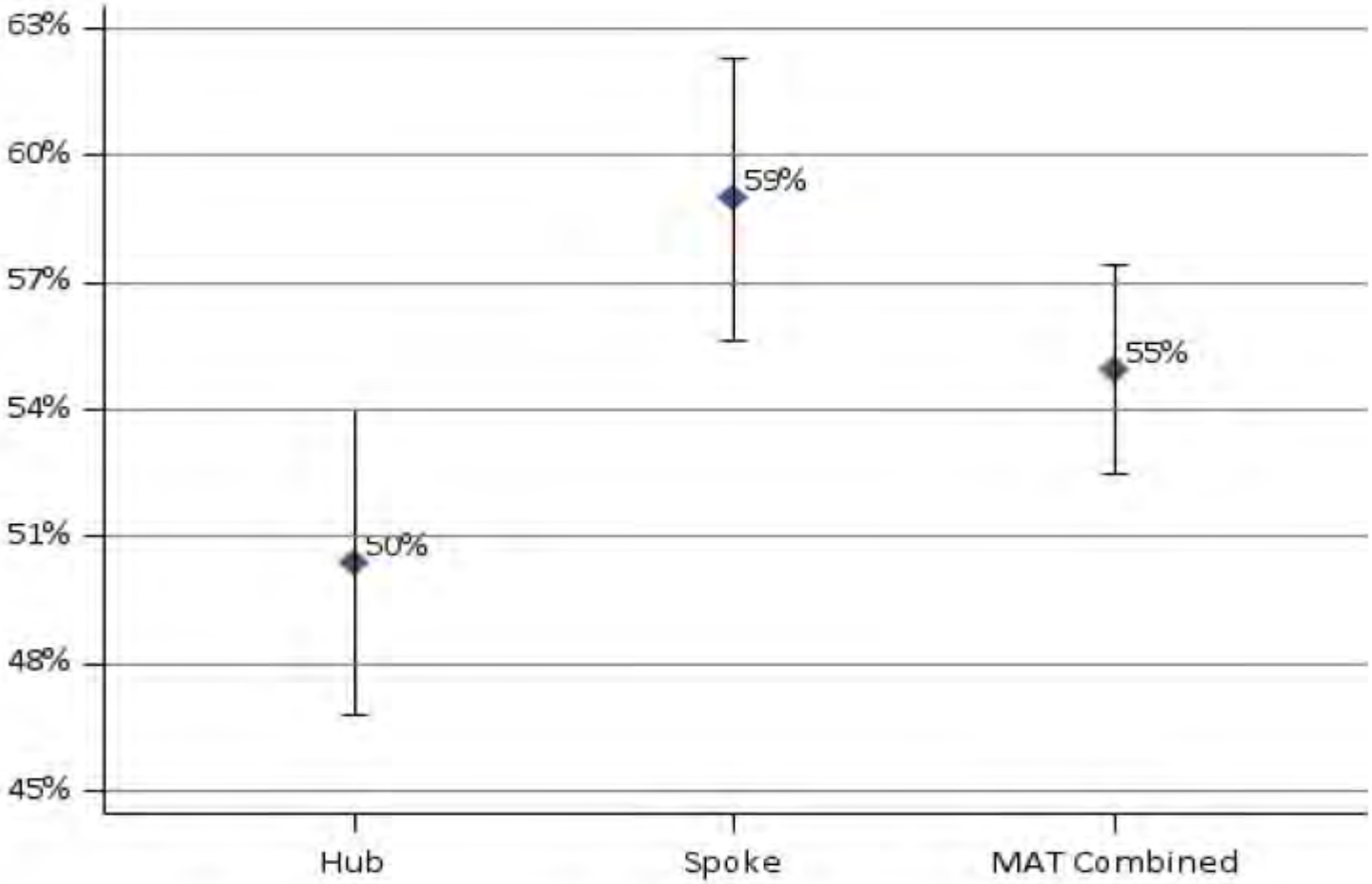
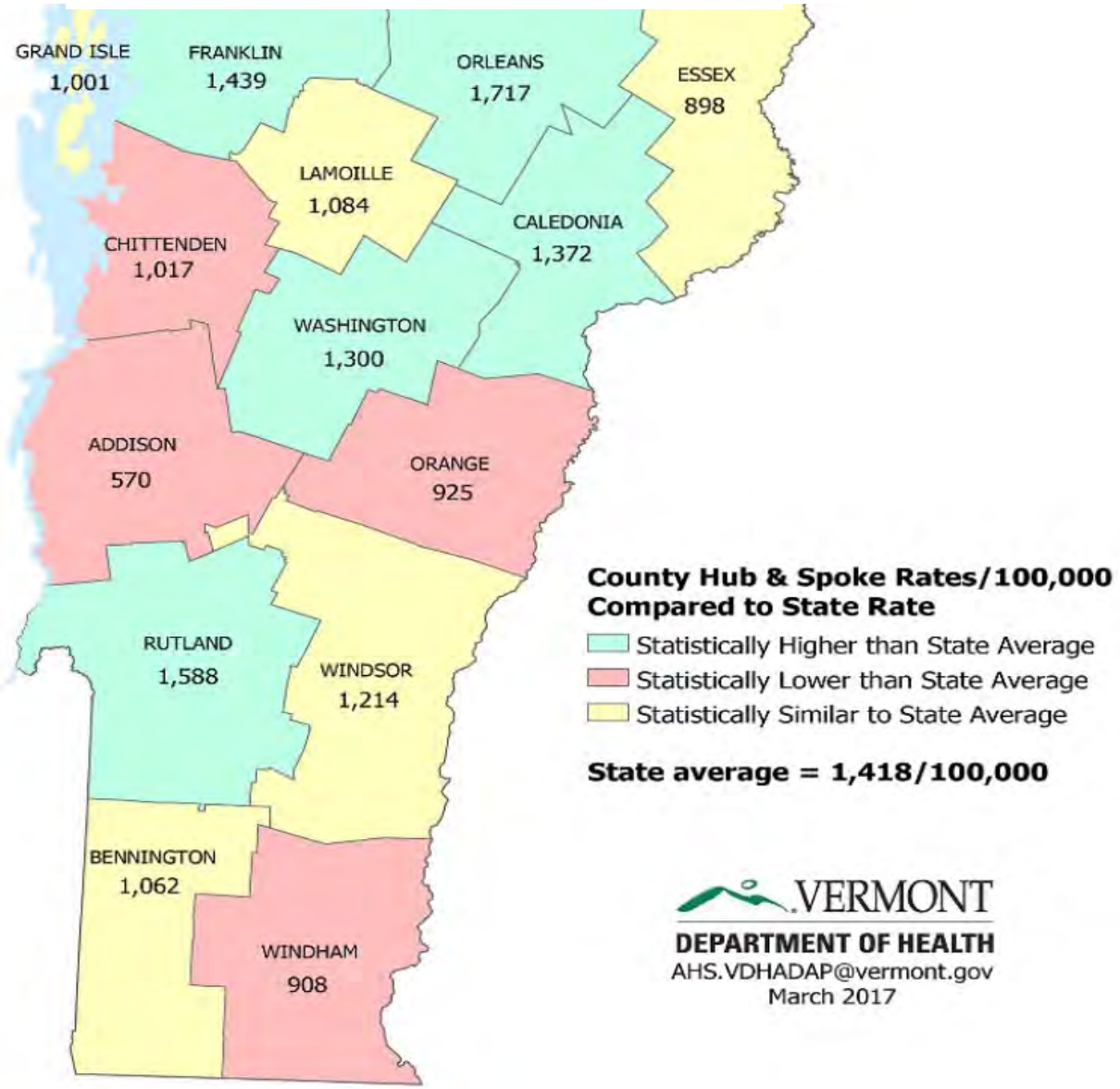


Figure 7: *Presents annual crude rates, including 95% confidence intervals, of outpatient emergency department (ED) visits per 1,000 members.*

Cervical Cancer Screening*



SFY2016 MAT Rate per 100,000 People



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March 2017