BLUEPRINT – ONECARE VERMONT STRATEGIC ALIGNMENT

Act 128 Mission of the Blueprint for Health (2010)

Integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention*, and care coordination and management.* 18 V.S.A §703 (a)

Mission for OneCare Vermont (2019)

OneCare is a community of health care providers driving system change and improvement by leveraging innovation, information, investment, access, and education. The focus is on improved health, higher quality, lower cost increases and greater coordination of care for all of our Vermonters. https://www.onecarevt.org/about-2/

Current State 2020

- All Payer Model Demonstration and ACO reforms are advancing. The Vermont Medicaid Next Generation (VMNG) program now operates state-wide; scale is increasing with 250,000 Vermonters expected to be attributed to OneCare in 2020; additional providers have joined the OneCare Network; discussions are underway with additional commercial insurers; and integration of care and services is supported by refinements in OneCare's care management approach and tools.
- The Blueprint Patient Centered Medical Home (PCMH) and Community Health Team (CHT) program is mature; this advanced primary care framework is understood as foundational for health reform.
- Evolving policy is to support ***Provider-Led Health Reform*** in which payers align risk arrangements, predictable budgets, and population health outcomes.

Blueprint and OneCare: Collaboration, Alignment, and Integration

Key program elements of the Blueprint can be transitioned to the maturing ACO. The Blueprint program elements, associated budgets, and how funds flow between the payers and the program are detailed below.

Blueprint Program Elements				
	Total Budget	Description	Money Flow	Payer Participation
Patient-Centered Medical Home Program				
PCMH PMPM Payments	$11,233,915	PMPM Quality Payments for NCQA Recognition	From Payers to Practices (Parent Organizations)	All Payers
QI Facilitators	$1,108,380	In practice QI coaching for NCQA, ACO priorities, and practice priorities	Grant to Local Hospital or Contract w/ QI facilitator	DVHA / Medicaid
Community Self-Management Program				
Regional Coordinators	$270,000	Part time staff to organize workshops	Grant to Local Hospital	DVHA / Medicaid
Master Trainers	$25,000	Train workshop leaders	Grant to Local Hospital	DVHA / Medicaid
Workshop Costs	$330,750	Leader stipends, materials, rooms	Grant to Local Hospital	DVHA / Medicaid
Management Contract	$199,126	Data aggregation, leader training	Contract with Local Hospital	DVHA / Medicaid
Community Health Teams (Core)	$9,897,053	Teams support PCMH practice and interface with community services	From Payers to Local Hospital	All Payers
Spoke Staff (Extended CHT) VDH manages Hubs	$6,100,000	RN & Counselor teams support MAT prescribers	From Payer to Local Hospital	DVHA / Medicaid
Women's Health Initiative				
PMPM Payment to Specialty Practices	$234,751	Attestation to program elements	From Payer to Practices	DVHA / Medicaid
One-Time Payments	$58,713	Workflow changes for screening, same-day LARC	From Payer to Practices	DVHA / Medicaid
Social Workers (Extended CHT)	$1,076,055	Staff for brief interventions and navigation to services	From Payer to Local Hospitals	DVHA / Medicaid
Program Management	$1,207,000	Change management & program administration	Grant to Local Hospital	DVHA / Medicaid
Data and Analytics Contracts				
Analytics	$500,000	Program evaluation & payment	Contract with Vendor	DVHA / Medicaid
Patient Experience of Care Survey	$136,000	Survey of Vermonters served in primary care in accordance with statute	Contract with Vendor	DVHA / Medicaid

Program Integration

Two programs seem ready for integration: The Self-Management Programs and in-Practice Quality Improvement Facilitation.

Quality Improvement Facilitation

Quality Improvement Facilitators work directly in primary care and specialty practices on implementation of practices' QI priorities, NCQA recognition, OneCare quality improvement goals, and implementation of MAT and WHI in workflows.

Each QI facilitator has specialized skills in engagement, quality improvement strategies and tools, and use of data to support improved care. Facilitators are also expert in aligning the different standards and measures required by OneCare, Meaningful Use, and NCQA to common workflows and care guidelines. QI facilitators typically work with 8-15 practices at any given time. The QI facilitators have created a strong learning network sharing information and strategies with each other.

Self- Management Programs

These are psycho-educational and skills-based group programming often co-led by a peer with the lived experience of the workshop topic. Offerings include:

- Fresh Start Group Tobacco Cessation Program,
- CDC Diabetes Prevention Program,
- Stanford's Healthier Living with Chronic Disease (general, pain, diabetes) programs, and
- Wellness Recovery Action Planning (WRAP) for emotional wellness.

The programs are administered via 13 part time regional coordinators and a contract held by the Community Health Improvement Division of the University of Vermont Medical Center.
There is consensus that the current programming and delivery methods should be updated.

Discussion

- Policy direction to integrate QI facilitator and Self-Management Programs with OneCare Vermont.
- Ideas about how to operationalize transitioning these programs
- Key elements / values that are important to continue