

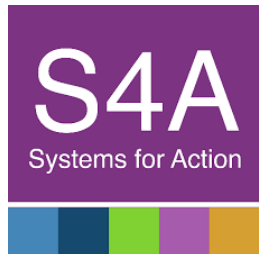
Using Global Budgets and Multi-Sector Teams to Align Systems in Vermont

*Strategies to Achieve Alignment, Collaboration, and Synergy
Across Delivery and Financing Systems*

Research-In-Progress Webinar

June 10, 2020

12-1pm ET



colorado school of
public health

Welcome: **Chris Lyttle, JD**
Deputy Director for Systems for Action

Presenters: **Adam Atherly, PhD**
University of Vermont

Commentary: **Mary Kate Mohlman, PhD**
Blueprint for Health

Q&A: Moderated by Chris Lyttle, JD



Adam J. Atherly, PhD is Director and Founder of the Center for Health Services Research at the Larner College of Medicine at the University of Vermont, where he is a Professor of the Department of Medicine. Dr. Atherly's research targets health economics, with an emphasis on the economics of aging and consumer decisions regarding health plan choice. His research spans numerous methodological and topical areas, including healthcare spending and expenditure modeling, scale development and psychometric analysis, evaluation of efforts to improve quality of care and patient safety and cost-effectiveness analysis.





Mary Kate Mohlman, PhD is the Health Services Researcher for the Blueprint for Health program. Her primary role is evaluating outcomes related to health care reform initiatives. Previously, she served as the state's Director of Health Care Reform in the Agency of Human Services with responsibility for coordinating health care reform efforts across state entities. Before joining state government, Mary Kate worked on modeling the effects of tobacco control policies on smoking-related morbidity and mortality rates at the Lombardi Cancer Center. She holds a Ph.D. in Global Infectious Disease and a MS in Biomedical Science Policy and Advocacy from Georgetown University. Mary Kate has published papers in Maternal and Child Health, Nicotine & Tobacco Research, Population Health Management, BMC Public Health, and Journal of Substance Abuse Treatment.

Faculty

- Andrew Wilcock, PhD
- Sarah Nowak, PhD
- Jan Carney, MD
- Eline van den Broek-Altenburg, PhD

Staff

- Caitlyn Dayman, MPH
- Chelsey Turley, BS

Partnering Organizations:

- OneCare Vermont – Dr. Norman Ward
- Dept. of Health – Dr. Mark Levine
- Blueprint for Health – Mary Kate Mohlman

The purpose of this project is to evaluate the effect of the combining a

Global All-Payer Reimbursement

with

Community Health Teams

responsible for

Coordinating Care and Service Delivery

between the medical, social services and public health sectors on system alignment, health, access to healthcare and health equity.

Global All-Payer Reimbursement

- Approx. 626,431 Vermonters
- Vermont was the **top-ranked state** overall in Commonwealth Fund *State Health System Performance Scorecard*
- Uninsured rate is 2nd lowest in the country
- Health Insurance Coverage
 - Private Insurance: 55%
 - Medicaid: 21%
 - Medicare: 18%
 - Military: 3%
 - Uninsured: 4%



Blueprint for Health

- 2008: Patient-centered medical home transformation and community health teams piloted in 3 hospital service areas supported through capitated payments
- 2011: statewide expansion to all hospital service areas. Patient-centered medical homes and community health teams continue as foundational elements of All-Payer ACO Model

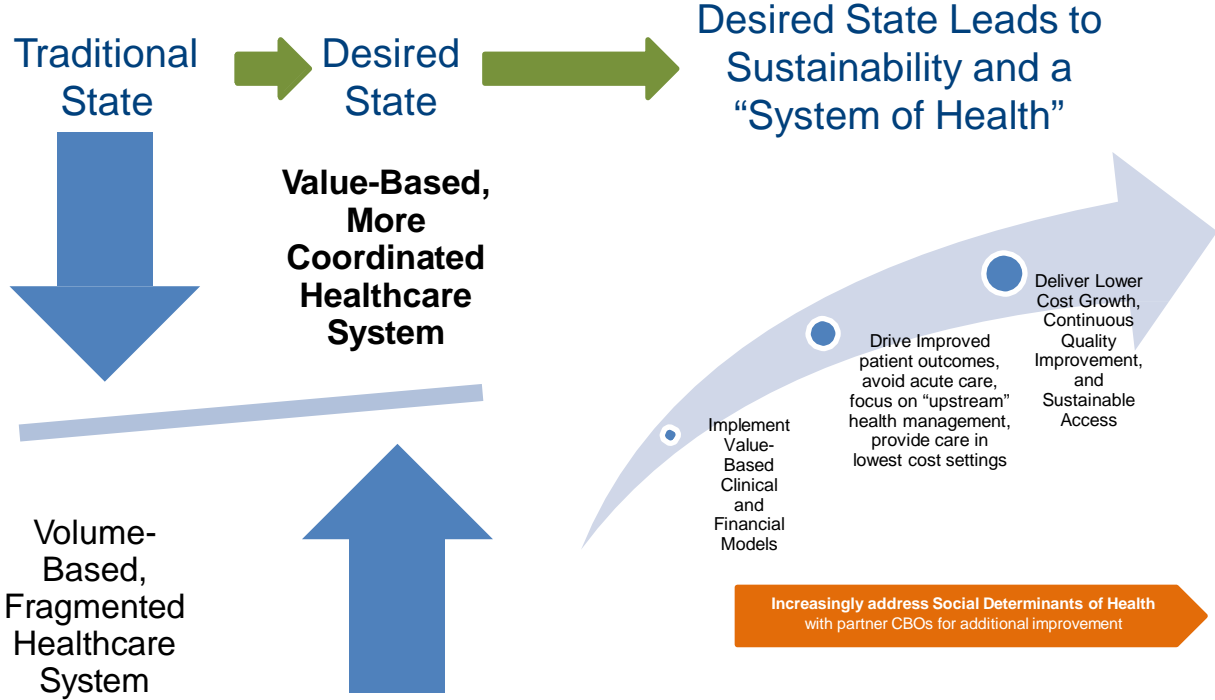
Green Mountain Care Board

- Originally created to oversee publicly financed single-payer health care system; plan dropped Dec 2014 due to tax increases required to fund it.
- Continues to oversee hospital budgets, commercial payer rates, ACO budgets, and financial impact of All-Payer ACO Model agreement with CMS.

Health Care Reform Goals

- Control health care spending
- Alter incentives from the current fee for service system that pays for volume and incentivizes doing “more”.
- Create a value-based system allows for investments to keep the population healthier.

Value Not Volume



Three key payers:

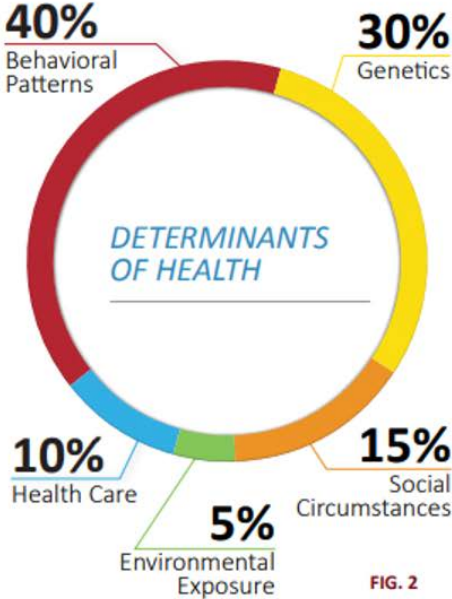
- Medicare – Over age 65 (Federal)
- Medicaid – Low Income (State / Federal)
- Commercial – Working (Private / State or Federal Regulation)

Most people are in commercial but most dollars are in Medicare

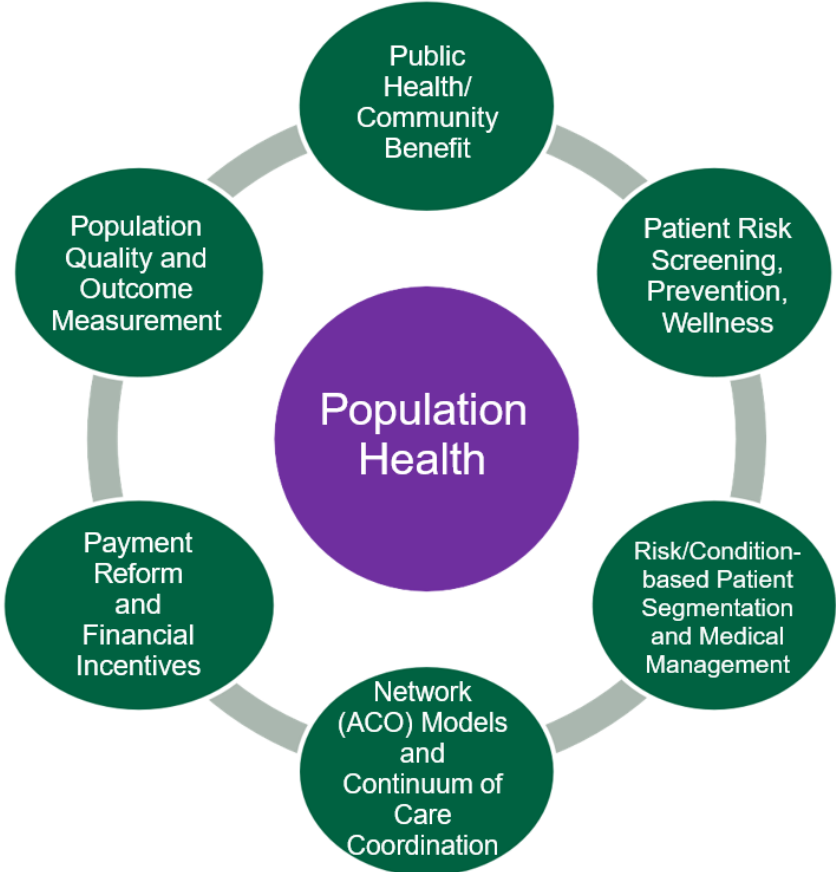
- The All-Payer Model enables the three main payers of health care to pay an Accountable Care Organization (ACO) differently than through fee-for-service reimbursement
 - “Waiver” allows Medicare participation

State Innovation Model Population Health Plan

Prepared by the State of Vermont for the Centers for Medicare and Medicaid Services



OneCare Population Health Domains



Hospitals receiving a fixed, pre-determined all-payer fee for all necessary services have a strong incentive to keep their covered population health and out of the hospital.

- Statewide network of regional community health teams (CHTs).
 - Multi-disciplinary teams
 - Regionally headquartered in each service area's central hospital or federally-qualified health center
- CHTs support a series of activities
 - Patient-centered medical homes
 - Connect patients to community-based services.
 - Support learning collaboratives
 - Work with medical and community providers to align statewide initiatives with the region's available resources and priorities
 - Improve quality of services for health and well-being.

Care Coordination Services and Staff

Care coordination staff — none employees of OneCare — receive funding and tools from the ACO to help them do their work. These tools include the Care Navigator software, which enables them to create shared care plans and coordinate their efforts.

Services	Providers	Staff
Help managing chronic conditions	Primary care clinics	Nurses, dietitians, community health workers
Counseling and referral to treatment for behavioral health conditions	Mental health agencies, primary care clinics	Nurses and social workers
Counseling and treatment for substance use disorder	Primary care clinics, specialty care treatment hubs,* and mental health agencies	Social workers, nurses trained in medication-assisted treatment
Benefit enrollment and other social supports	Primary care clinics, mental health agencies, SASH**	Nurses, social workers, and community health workers
Wellness education, fitness classes, home visits for frail elders	SASH,** community health teams	Nurses and nonlicensed care coordinators
Support during transitions between care settings	Home health providers, primary care clinics, and Area Agencies on Aging	Nurses and social workers
Personal care services and other long-term services and supports	Area Agencies on Aging	Typically nonlicensed care managers or referral coordinators

* Vermont uses a hub-and-spoke model for addiction treatment that relies on primary care practices to provide treatment to patients with less-complex needs, while specialty care “hubs” deliver services to patients with more extensive needs.

** The Support and Services at Home (SASH) program is funded through Vermont’s Blueprint for Health.

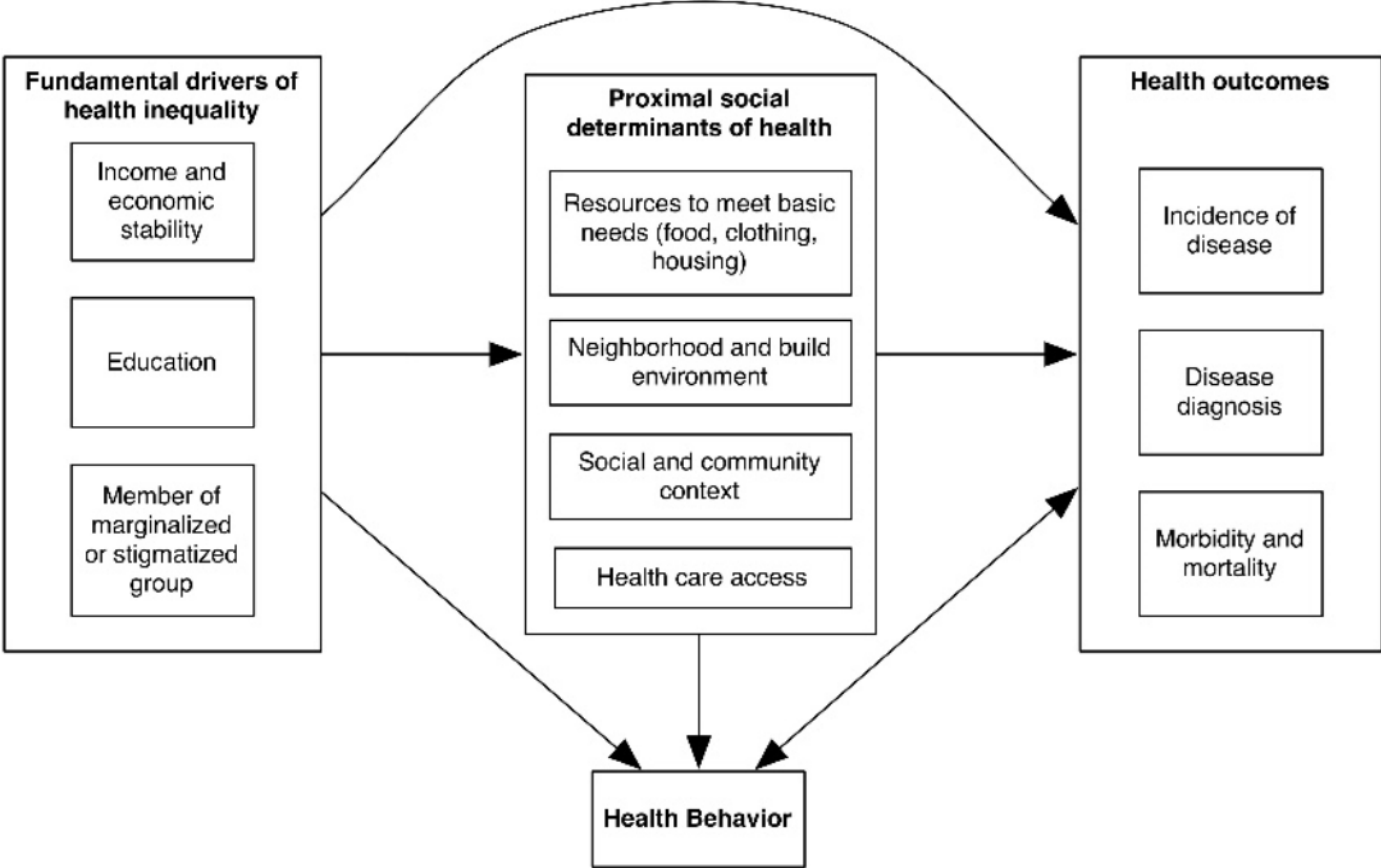
- Funded by Medicaid, Medicare, and commercial payer through the Vermont Blueprint for Health initiative (“Blueprint”) since 2011
- Additional capitated payments to additional provider types through the All-Payer ACO Model has created a fundamentally new environment
- CHTs are relied upon to achieve the goals of the ACO and also the public health goals of Vermont.

Aim 1: What is the impact of the alignment on formal system linkages between the health care sector and the social services and public health sectors in Vermont?

Aim 2: How do CHTs set priorities for what social, public health and medical services to offer? What are the tradeoffs made between health, health equity and healthcare spending?

Aim 3: What is the impact of Vermont's CHTs and global payment alignment on changes in health risk, health outcome, health equity and access to care?

Conceptual Model



Aim 1: What is the impact of the alignment on formal system linkages between the *health care* sector and the *social services* and *public health* sectors in Vermont?

- Identify relevant organizations in the health care, social services, and public health sectors
- Map financial, accountability, and coordination linkages between organizations
- Quantitatively and qualitatively assess changes in linkages over time.

How do community health teams set priorities for what social, public health and medical services to offer?

What are the tradeoffs made between health, health equity and healthcare spending?

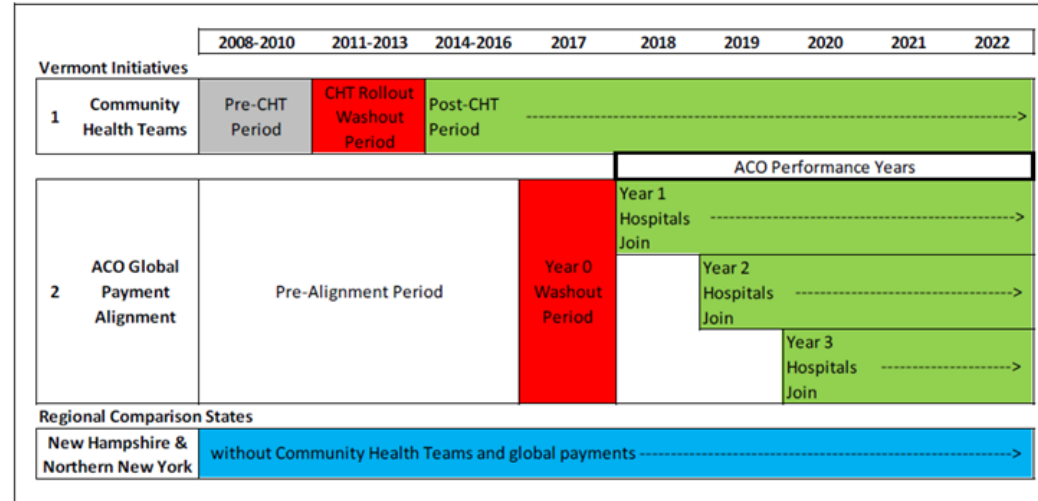
- Identify how decisions are being made and priorities are being set
- Discrete choice experiment (DCE) survey technique.
 - Qualitative research methods to identify the appropriate measures
 - Focus groups among the community health workers
- Analyze the data using a mixed logit model

Aim 3: What is the impact of Vermont's Community Health Teams and global payment alignment on changes in health risk, health outcome, health equity and access to care?

- Testing impact of the intervention on system outputs:
 - Health behavior
 - Social Determinates of Health
 - Healthcare spending

Research Aim 3 Methods

- Difference-in-Differences
- BRFSS and EMR data for VT and NY
- APCD data for VT and NH
- “Triple Dif” model for health equity

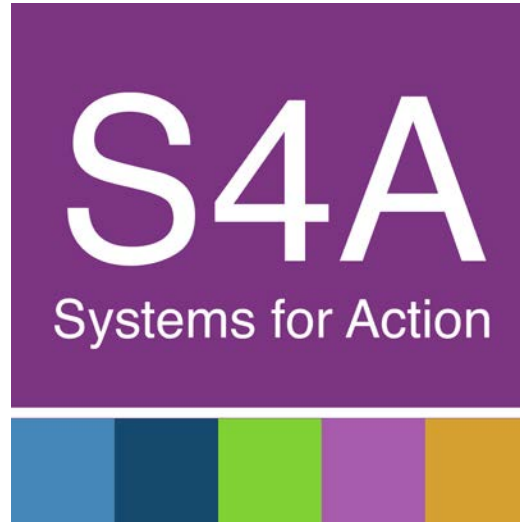


- The effect of state funded Community Health Teams + Global Payments on:
 - System alignment
 - Priority setting
 - Health and financial outcomes
 - Health equity

Community Health Teams in Vermont are, on paper, an ideal alignment mechanism. But does it work as intended?

Mary Kate Mohlman, PhD
Health Services Researcher,
Blueprint for Health program

Questions?



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One will be emailed to you.

Upcoming Webinar

June 24 | 12 pm ET

[Investigating Systems Alignment of Multi-Sector Agencies to Address Child Maltreatment in St. Louis](#)

Melissa Jonson-Reid, PhD, MSW and Patricia Kohl, PhD

Washington University in St. Louis

July 8 | 12 pm ET

[Aligning Health and Social Systems to Expand Evidence-Based Home-Visiting](#)

Gregory Tung, PhD, Mandy Allison, MD and Venice Williams, PhD

University of Colorado Denver

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