Where the Trails Meet: Blending and Braiding Funds for Improved Population Health

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Approaches to Population Health

• Public private partnership
• Multi-sector investment
• Multi-payer
• Reinvestment of healthcare dollars into primary and secondary prevention
• Measurement and mutual accountability
All-Payer Model

The all-payer model is a tool to help Vermont achieve broad health reform goals. It changes the State’s relationship with the Centers for Medicare and Medicaid Services (CMS).

1. The all-payer model is an agreement between the State and CMS that allows Vermont to explore new ways of financing and delivering health care.

2. The primary finance vehicle in the all-payer model agreement is the Next Generation Accountable Care Organization (ACO) program which allows ACOs to be paid an all-inclusive population-based payment for each beneficiary attributed to the ACO in lieu of fee for service payments; moving toward value based payments and capping the growth in the total cost of care for Vermonters at 3.5%.

3. The all-payer model allows CMS to modify their traditional Next Generation ACO program, enabling the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance – to align.

4. The all-payer model also allows Vermont to request additional waivers of CMS rules and gives ACOs participating in the Next Generation Program flexibility in certain payment rules.

All-Payer Model Population Health Outcomes

- Improve Access to Primary Care
- Reduce Deaths from Suicide and Overdose
- Reduce Prevalence and Morbidity of Chronic Disease
Population Health Goal #1: Improving Access to Primary Care

- Increase % of VT Adults Reporting that they have a Personal Doctor or Health Care Provider
- Increase % of VT Medicare Beneficiaries Reporting Getting Timely Care, Appointments and Information
- Increase % of VT Medicaid Adolescents with Well-Care Visits
- Increase % of VT Medicaid Beneficiaries Aligned with a VT ACO

All-Payer ACO Model Population Health Goal #2: Reducing Deaths from Suicide and Drug Overdose

- Reduce Deaths from Drug Overdose
- Reduce Deaths from Suicide
- Increase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (2 measures)
- Improve Follow-Up After Discharge from ED for MH and SA Treatment (2 measures)
- Reduce Rate of Growth of ED Visits for MH/SA Conditions
- Increase Use of VT’s Rx Monitoring Program
- Increase # of VT Residents Receiving Medication-Assisted Treatment for Opioid Dependence
- Increase Screening for Clinical Depression and Follow-Up Plan
Population Health Goal #3: Reducing Prevalence and Morbidity of Chronic Disease

- Prevalence of Chronic Obstructive Pulmonary Disease, Diabetes and Hypertension Will Not Increase by More Than 1% (3 measures)

For VT Medicare Beneficiaries, Improve Performance on Composite Measure that Includes:
- Diabetes Hemoglobin A1c Poor Control
- Controlling High Blood Pressure
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

- Improve Rate of Tobacco Use Assessment and Cessation Intervention
- Improve Rate of Medication Management for People with Asthma

Examples of Investments

- **Community Health Teams** – Patient Centered Medical Homes, Women’s Health Practices, Practices Providing Medication Assisted Treatment for Opioids, SASH
- **Supports and Services at Home (SASH)** – Prevention and Supports in Public Housing
- **RiseVT** – Primary Prevention
- **Housing** – Permanent Supportive Housing
Supports and Services at Home: Structure

- **Target Population:** Medicare Beneficiaries in Public Housing & Community

- **Staffing:**
  - 1 FTE Bachelors Case Manager +
  - 0.25 FTE Registered Nurse for 100 Participants

- **Organizational Infrastructure**
  - Public Housing
  - Co-Management Agreements with Visiting Nurses Association, Area Agencies on Aging, Community Mental Health Centers, Patient-Centered Medical Homes, Hospitals
Supports and Services at Home: Program

- **Population & Individual Level Programming**
  - Falls Prevention
  - Nutritional Enhancement
  - Control of Chronic Conditions
  - Lifestyle Barriers
  - Cognitive & Mental Health & Substance Abuse Issues

The SASH Team focuses on Three Components of Care Management

**Transitional Care**
- Coordinates with discharge staff at hospital and SNFs
- Coordinates with family, neighbors, service providers
- Personal visit to review discharge instructions
- Helps ensure a safe home transition

**Self Management**
- Develops healthy living plan
- Coaches SASH Participants
- Provides reminders and in person check ins
- Organized evidence-based group activities & workshops

**Care Coordination**
- Conducts wellness assessment
- Convenes SASH team
- Understands participants needs and preferences
- Coordinates healthy living plans
Available in 140 Affordable Housing Sites

Image: http://sashvt.org/connect/

Organizing Framework Initiated by Housing Provider

Samuelson
# Braided and Blended Funding

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### SASH Funding

- Centers for Medicare and Medicaid Services (CMS)
- Vermont Department of Disabilities, Aging and Independent Living (DAIL)
- Department of Vermont Health Access (DVHA)
- Vermont Department of Health
- Cathedral Square Corporation
- University of Vermont Medical Center Foundation
- Vermont Housing and Conservation Board (VHCB)
- MacArthur Foundation
- Enterprise Community Partners
- Peoples United Community Foundation
- Champlain Investment Partners
- Housing Assistance Council
- United Way of Chittenden County
- Vermont Community Foundation
- UVM Center on Aging
- Vermont Legislature

[http://sashvt.org/funding/](http://sashvt.org/funding/)
SASH Start Less Healthy: Health Conditions in SASH Participants compared to Non-SASH Participants

Source: Vermont’s All Payer Claims Database

Major Findings: Second Annual Report

• January 2016
• Sample size: 1602
• 3 years of implementation

• SASH continues to slow the growth of total annual Medicare Expenditures
• Growth in annual Medicare expenditures was statistically significantly lower, by an estimated $1,536 per beneficiary, in early panels

https://aspe.hhs.gov/basic-report/support-and-services-home-sash-evaluation-second-annual-report#execsum
Lessons Learned

- Strong cross sectoral leadership is essential
- Focus on population health is key
- Establish appropriate measurement, governance, and accountability
- Redefining roles and mutual accountability takes specific focus
- Invest in evaluation
- Demonstrating return on investment assists in engaging new partners
- Layout a vision, ask funders to contribute based on their mission to a larger project
- Accountable Care Organizations and other health care reform efforts offer unique opportunities for sustainable funding
- Garner multi-payer funding upfront in payer funded programs