Community
Health Accountable Care LLC
Transitioning Our Communities for Better Health

COMMUNITY HEALTH ACCOUNTABLE CARE, LLC

Presented to the Health Reform Oversight Committee on September 16, 2015

Patrick Flood, Chair Board of Directors
& Joyce Gallimore, CHAC Director

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Governance: Detail

Board of Directors
(18 members; 15 providers; 3 beneficiaries)

ACO Participants, Primary Care:
- Jack Donnelly, Community Health Centers of Burlington
- Kevin Kelley, Community Health Services of Lamoille Valley
- Gail Auclair, Little Rivers Health Care
- Patrick Flood, Northern Counties Health Care
- Dr. John Matthew, The Health Center
- Pam Parsons, Northern Tier Center for Health
- Andy Majka, Springfield Medical Care Systems
- Joseph Woodin, Gifford Health Care
- Grant Whitmer, Community Health Centers of the Rutland Region
- Tess Kuenning, Bi-State Primary Care Association
- Grace Gilbert-Davis, Battenkill Valley Health Center
- Martha Halnon, Mountain Health Center

ACO Participants, Non-Primary Care:
- Tom Huebner, Rutland Regional Medical Center
- Mary Moulton, Behavioral Health Network
- Sandy Rousse, Visiting Nurses Association

Beneficiary Representatives:
- Zachary Hughes, Medicaid
- Vacant, Commercial
- Marcia Perry, Medicare

Finance Committee
Board Lead: Kevin Kelley

Clinical Committee
Board Lead: Dr. John Matthew

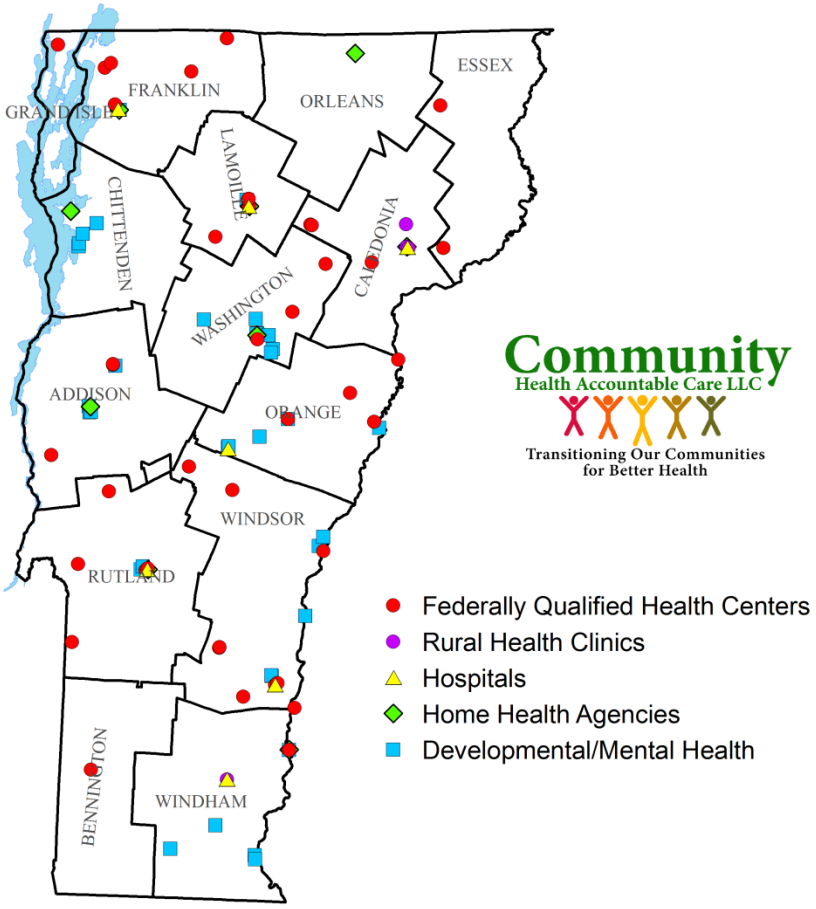
Operations Committee
Board Lead: Gail Auclair

Beneficiary Engagement Committee
Board Lead: Marcia Perry

Consumer Advisory Panel
Consists of 9 consumers from many regions of VT

CHAC's Network: 2016

Anticipated 2016 Network



CHAC's Participant Network 1/1/2016

- 10 Federally Qualified Health Centers
- 4 Rural Health Clinics
- 7 Hospitals
- 14 Designated Agencies
- 9 Certified Home Health Agencies

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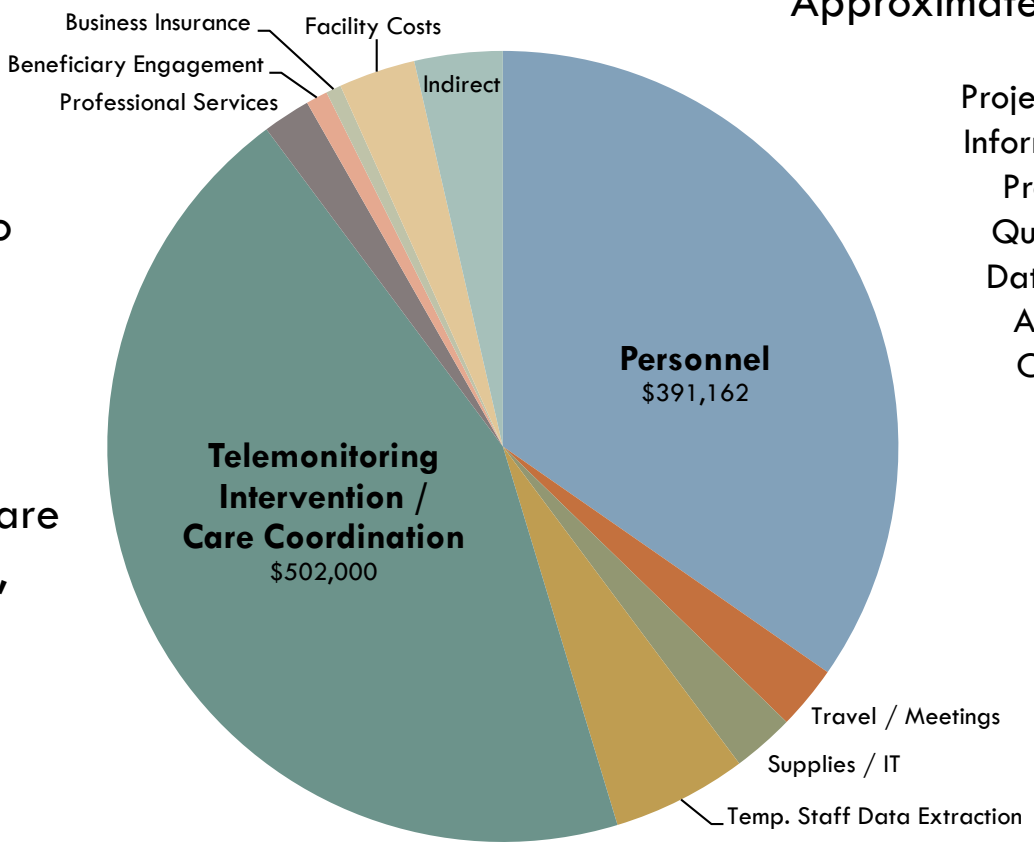
VHCIP Funding & Supporting Staff

Two VHCIP grants to Bi-State totaling **$1,128,400** have supported CHAC's capacity, the development of a care management model, and ACO Quality Reporting.

Both VHCIP grants end 6/30/2016.



Approximate FTE Supported:

ACO Director – 0.80
Project Coordinator – 1.00
Informatics Director – 0.15
Project Manager – 0.15
Quality Manager – 0.20
Data Coordinator – 0.25
Admin. Assistant – 0.20
Communications – 0.05

* Bi-State has additionally leveraged other Federal funding to support CHAC priorities

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CHAC & ACOs Populations 2015 & 2016

Products	OneCare 2015	VCP 2015	CHAC 2015	CHAC 2016 (est.)
Medicaid	29,000	0	20,000	25,000
Medicare	52,000	0	6,400	16,000
Commercial	19,000	8,130	8,900	11,000
Total	100,000	8,130	35,300	52,000

Attribution for CHAC as of March 2015; OCV and ACCGM attribution was estimated using previously presented materials. All numbers are approximate.

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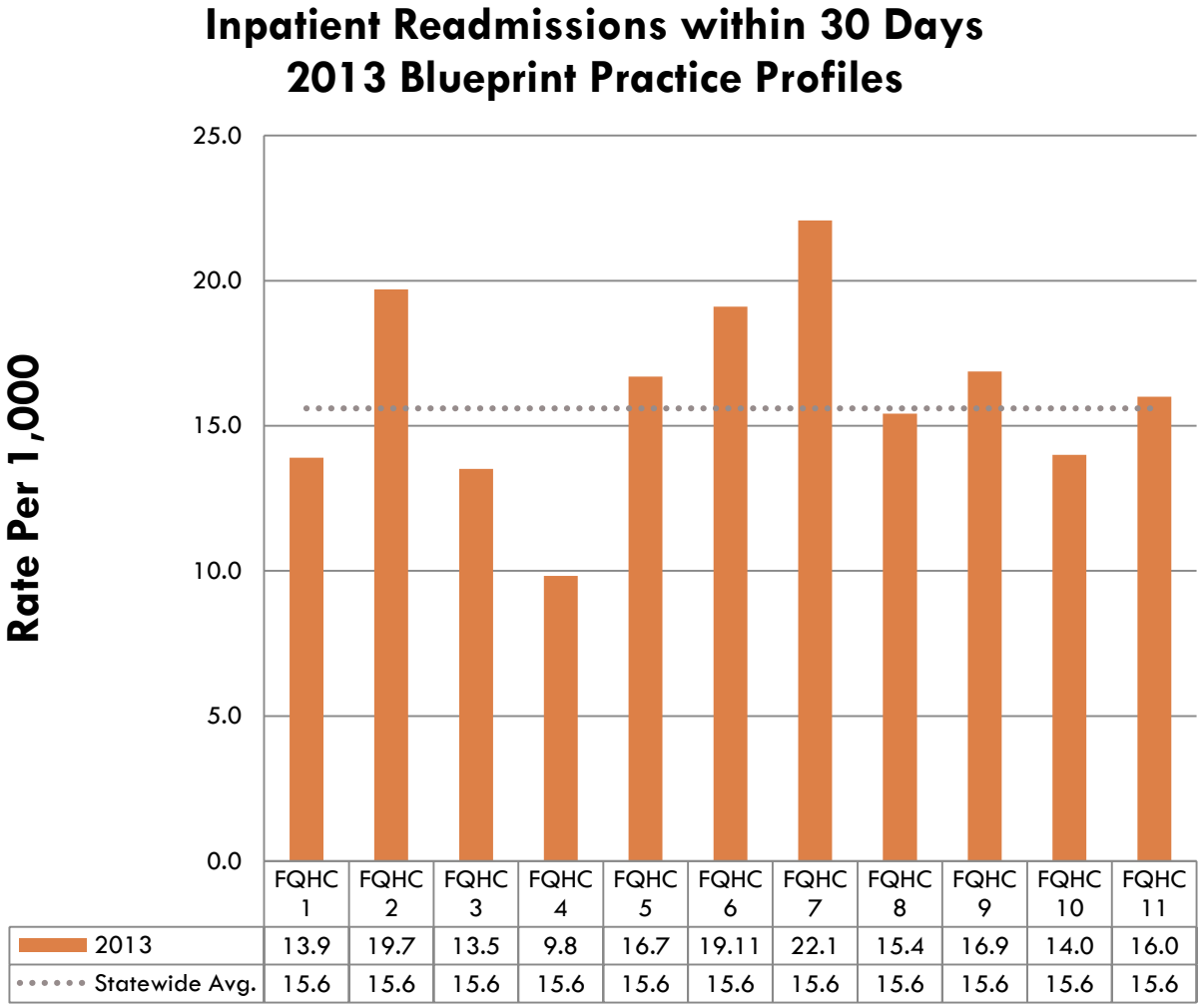
2014: STARTING TO USE DATA FOR IMPROVEMENT



	FQHC 1	FQHC 2	FQHC 3	FQHC 4	FQHC 5	FQHC 6	FQHC 7	FQHC 8	FQHC 9	FQHC 10	FQHC 11
2013	13.9	19.7	13.5	9.8	16.7	19.11	22.1	15.4	16.9	14.0	16.0
Statewide Avg.	15.6	15.6	15.6	15.6	15.6	15.6	15.6	15.6	15.6	15.6	15.6

- Identification of Measures for Focus
- Review of Data from Blueprint and Medicare
- Opportunities for Improvement
- Benchmarking
- Leveraging Best Practices

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Clinical Quality Improvement

- ☑ CHAC Clinical Committee: working committee; engaged provider team
- ☑ Development of Evidence-Based Recommendations
- ☑ Support of Care Management thru Tel-Assurance
- ☑ Network wide training to embed recommendations in daily workflow.
- ☑ Abstraction and Analysis of all required measures.

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Congestive Heart Failure (CHF)
Treatment and Prevention of Readmission
approved by CHAC Clinical Committee on 03.31.2015

for Left Ventricular Systolic Dysfunction (LVSD)
Numerator:
otion for beta-blocker therapy during 2014
in the OP medication list OR
dication at discharge from inpatient stay
-Blockers:
Zebeta)
oreg)
(Toprol XL)

lar Ejection Fraction < 40%
y point in the patient's life)

(eg. Digoxin, Gitalin, Lanatoside, beta-adrenoceptor agonists that
rance, or other documented medical reason.

Interventions: COPD, CHF, Falls Risk, Diabetes

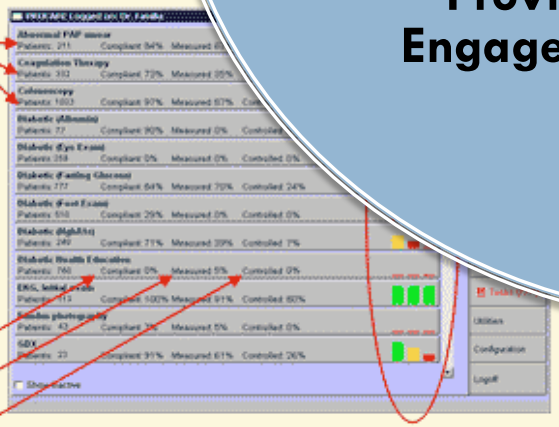
Dashboards

Patient and Provider Engagement

Quality Benchmarking

Clinical Perfor

Clinical Performance Measures



On Protocol/ Compliant

Measured

Controlled

Below Threshold

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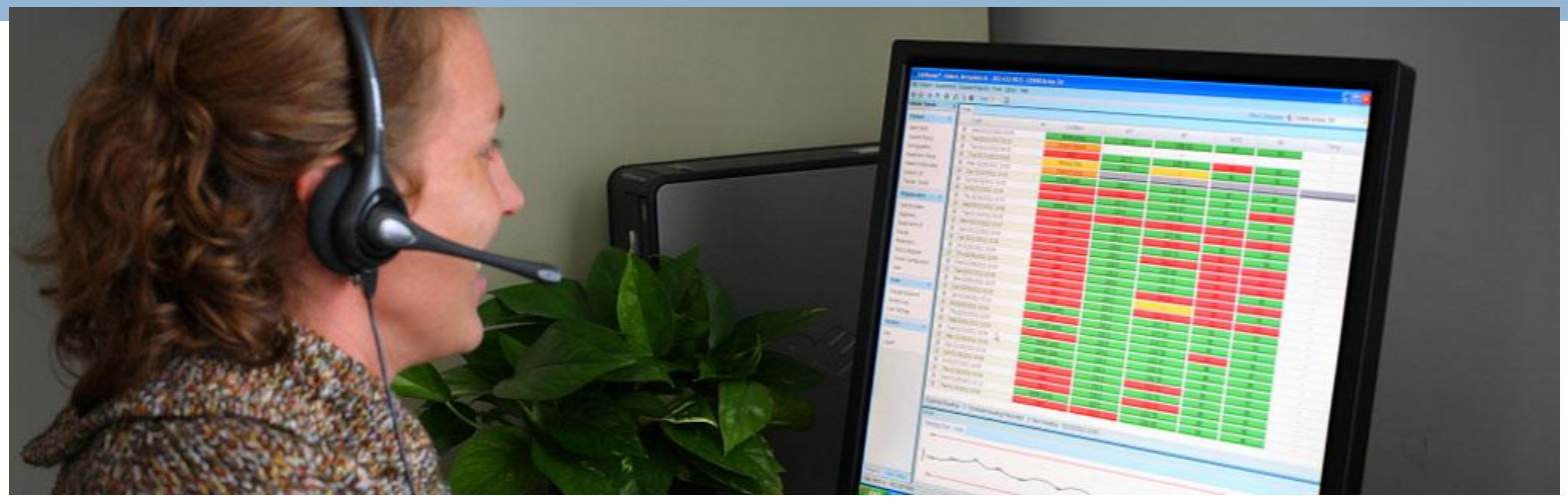
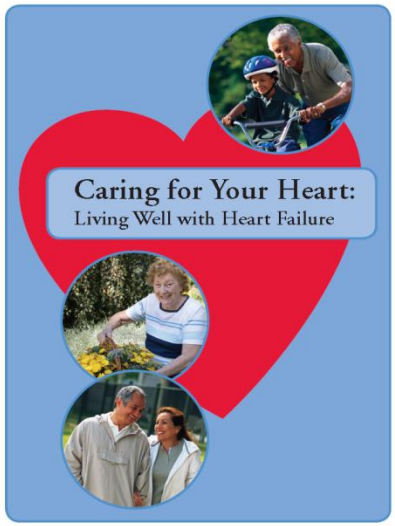
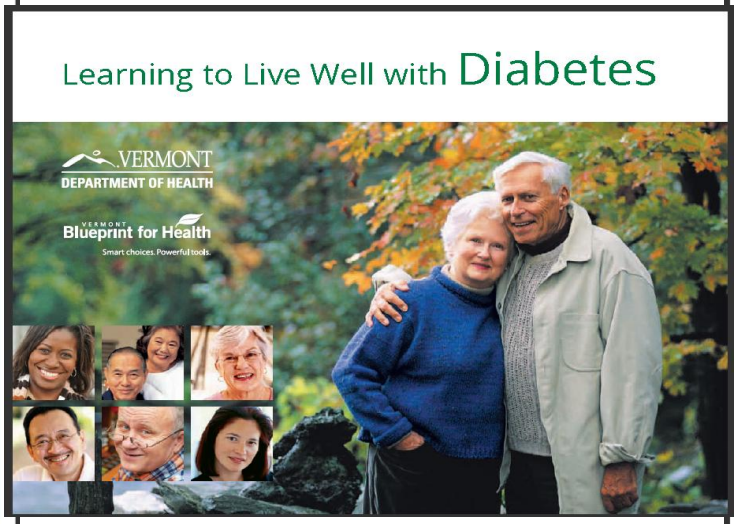
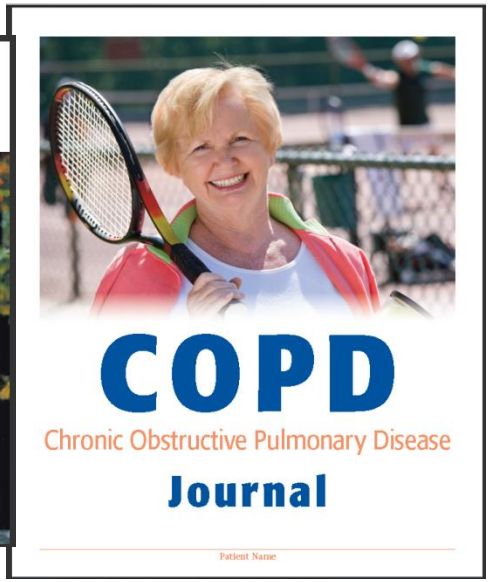
Engaging Patients









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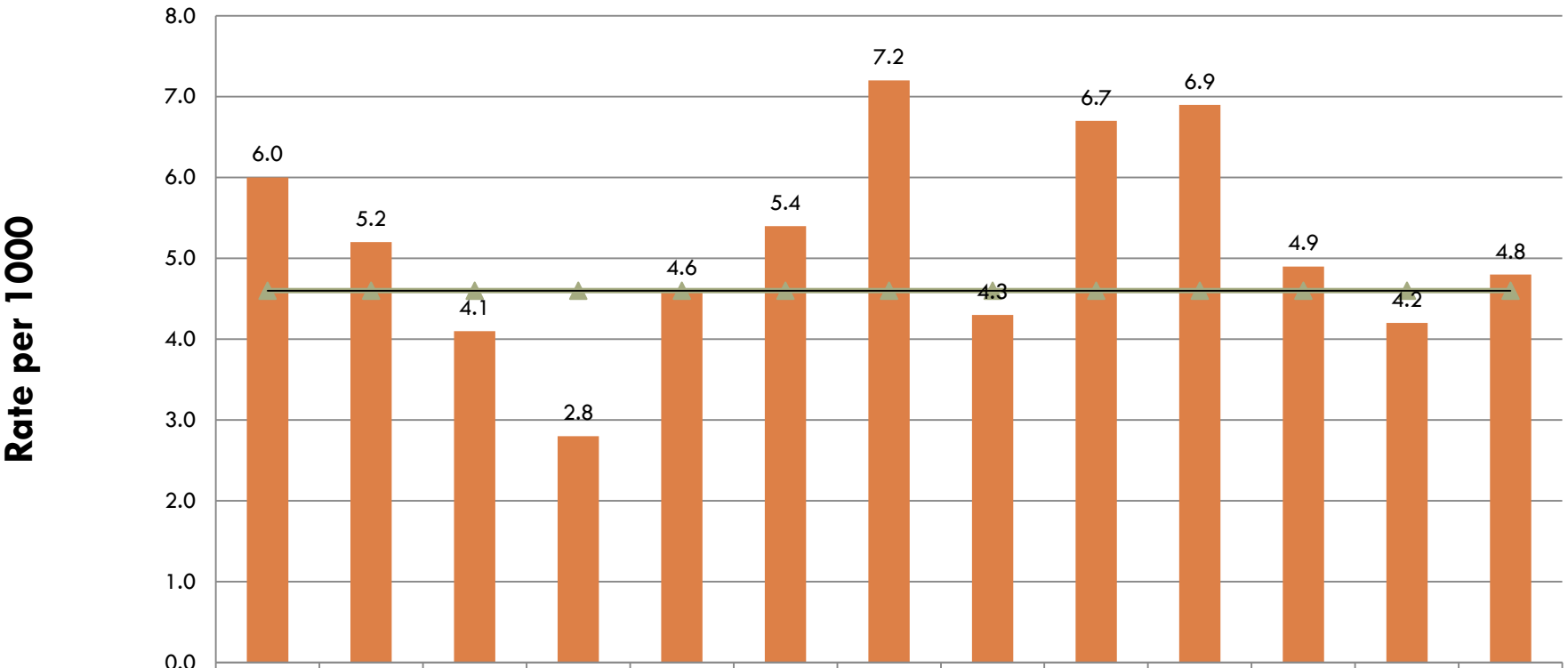
Statewide look in 2015:
Blueprint Health Service Area Profiles

Ambulatory Sensitive Condition Admissions:
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults



	Barre	Bennington	Brattleboro	Burlington	Middlebury	Morrisville	Newport	Randolph	Rutland	Springfield	St. Albans	St. Johnsbury	White River Jct
2013	6.0	5.2	4.1	2.8	4.6	5.4	7.2	4.3	6.7	6.9	4.9	4.2	4.8
Statewide Avg.	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6

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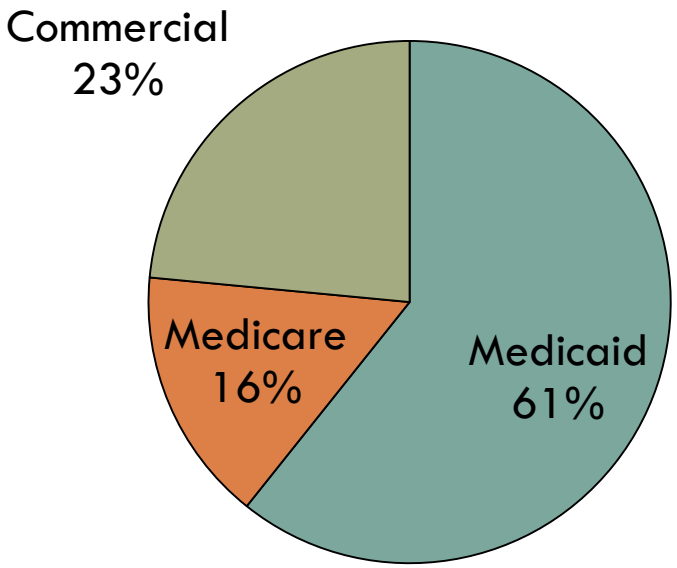
FQHC & CHAC Populations Served

FQHCs serve 1 in 4 Vermonters and over 40% of Vermont's Medicaid population, making them ESSENTIAL and SOUGHT providers by community residents covered by all payers.

CHAC Attributed Lives: 2015



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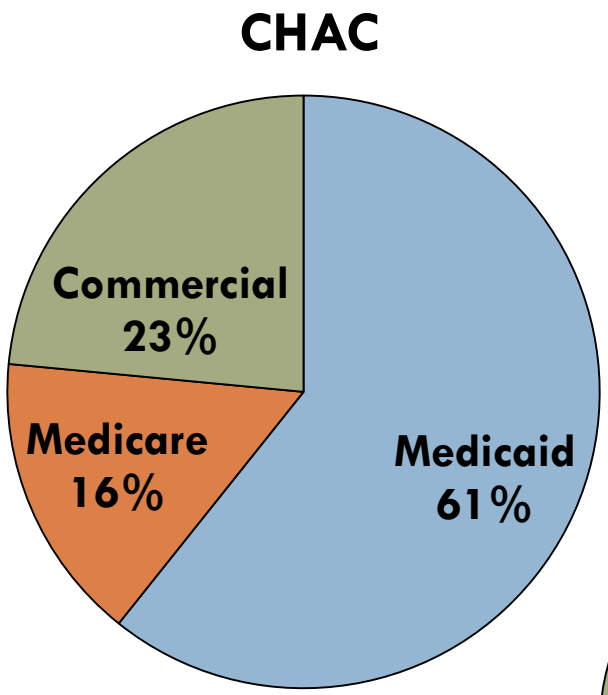
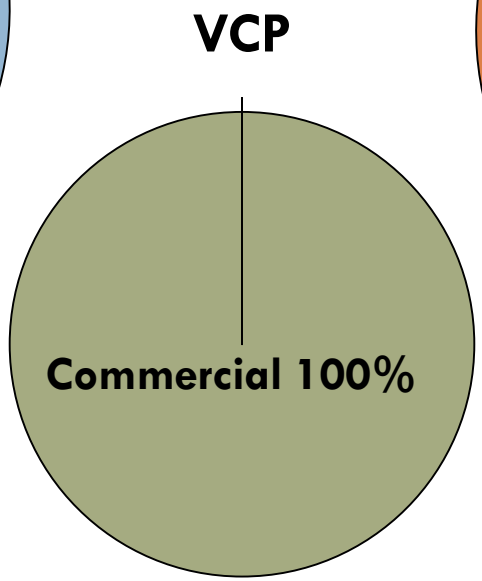
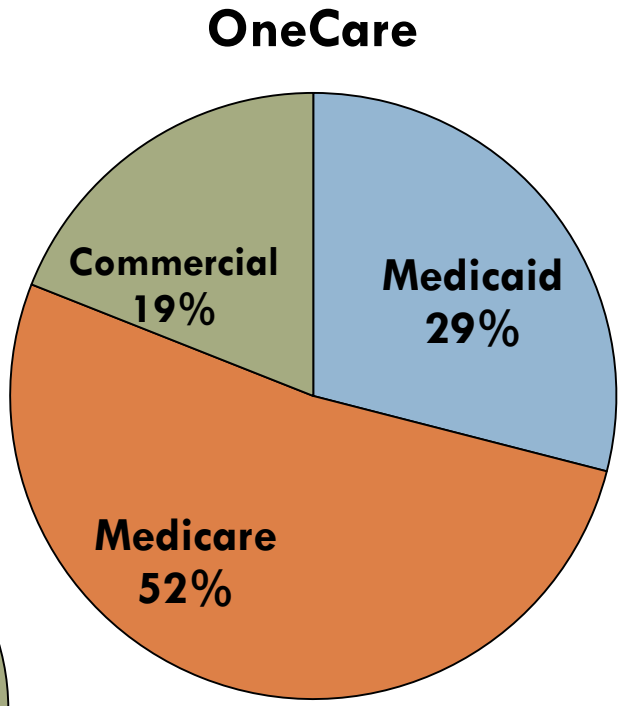
CHAC & ACOs Populations 2015







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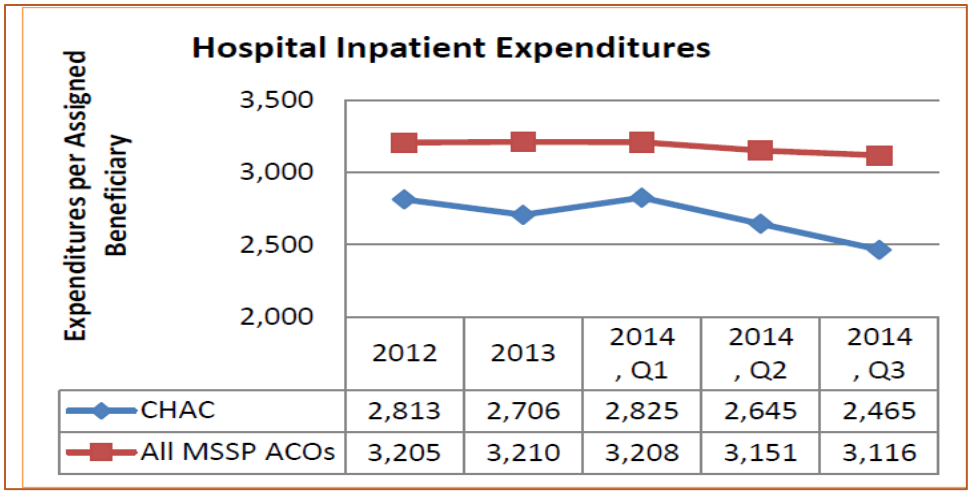
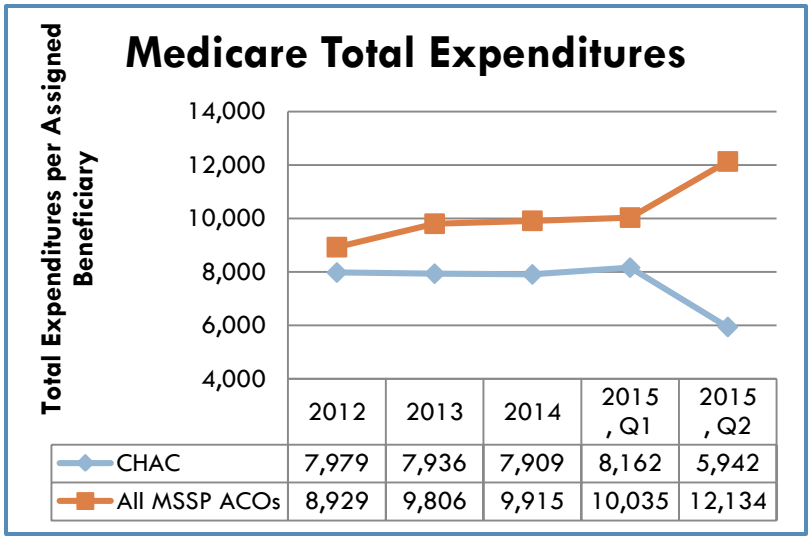
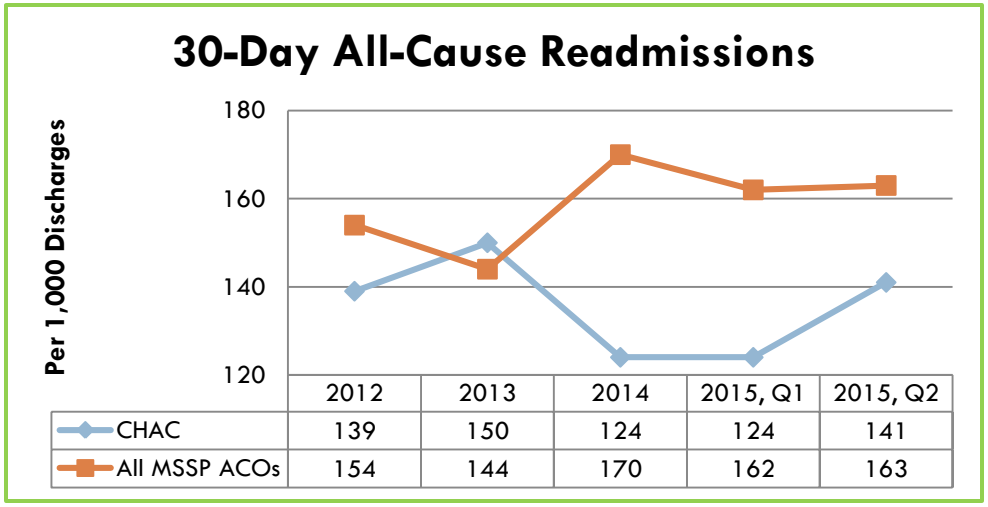
Medicare Data Trends



	2012	2013	2014, Q1	2014, Q2	2014, Q3
CHAC	2,813	2,706	2,825	2,645	2,465
All MSSP ACOs	3,205	3,210	3,208	3,151	3,116



	2012	2013	2014	2015, Q1	2015, Q2
CHAC	7,979	7,936	7,909	8,162	5,942
All MSSP ACOs	8,929	9,806	9,915	10,035	12,134



	2012	2013	2014	2015, Q1	2015, Q2
CHAC	139	150	124	124	141
All MSSP ACOs	154	144	170	162	163

Source: Trending of CHAC utilization & expenditure reports from CMS.

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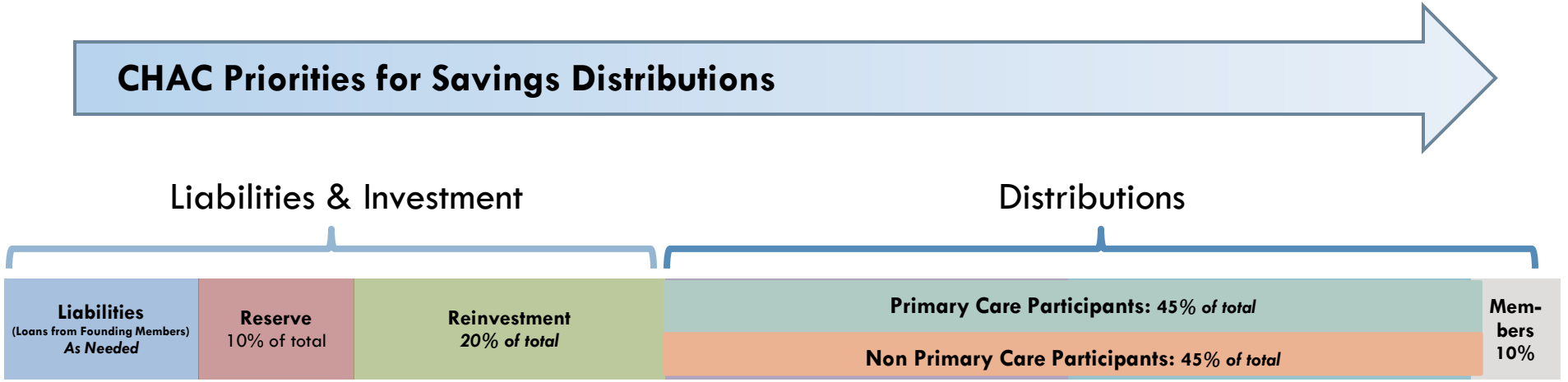
CHAC: Value of Primary Care

- Community Based Delivery & Partnerships
- Primary Care as Gateway to Improved Outcomes
- Primary Care as Vehicle for Efficiencies in Delivery
- Hospital Inpatient Avoidance
- Chronic Disease Collaboratives
- Evidence-Based Health Care
- Electronic Medical Records
- Commitment to Accountability for Performance

Shared Savings Distribution



CHAC intends to apply this formula separately for each business line, as practical.