HAWAI‘I PRIMARY CARE ASSOCIATION

2011 ANNUAL CONFERENCE
JOURNEYS OF TRANSFORMATION

CAPSTONE ADDRESS

A Blueprint for Health Care

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Department of Vermont Health Access

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Vermont Blueprint for Health

Building an Integrated System of Health

2011 Annual Conference
Hawai'i Primary Care Association
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Snapshot of Vermont

"Freedom & Unity"

637,000 population

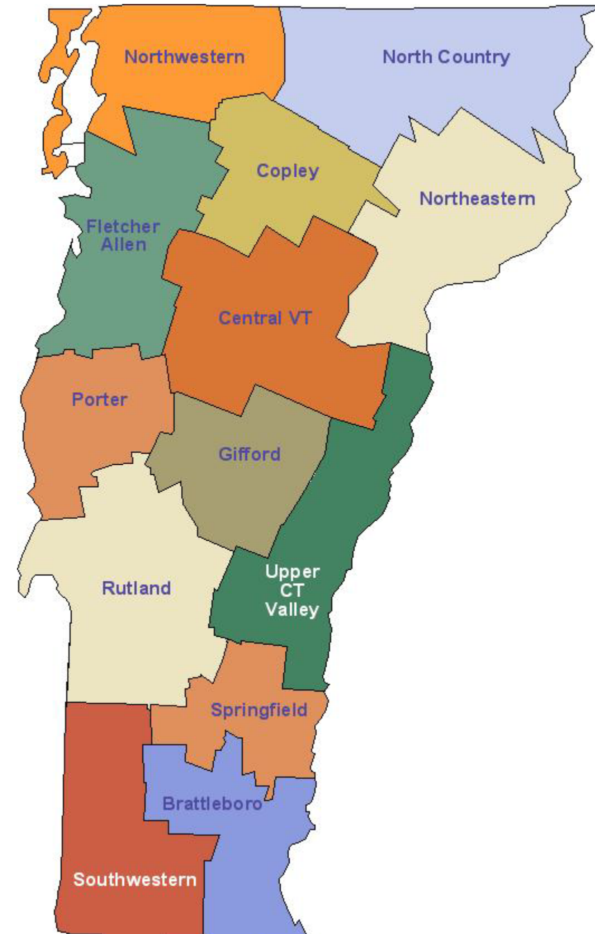
9615 square miles

13 Hospital Service Areas

Few large employers (IBM, State Government, University of Vermont)

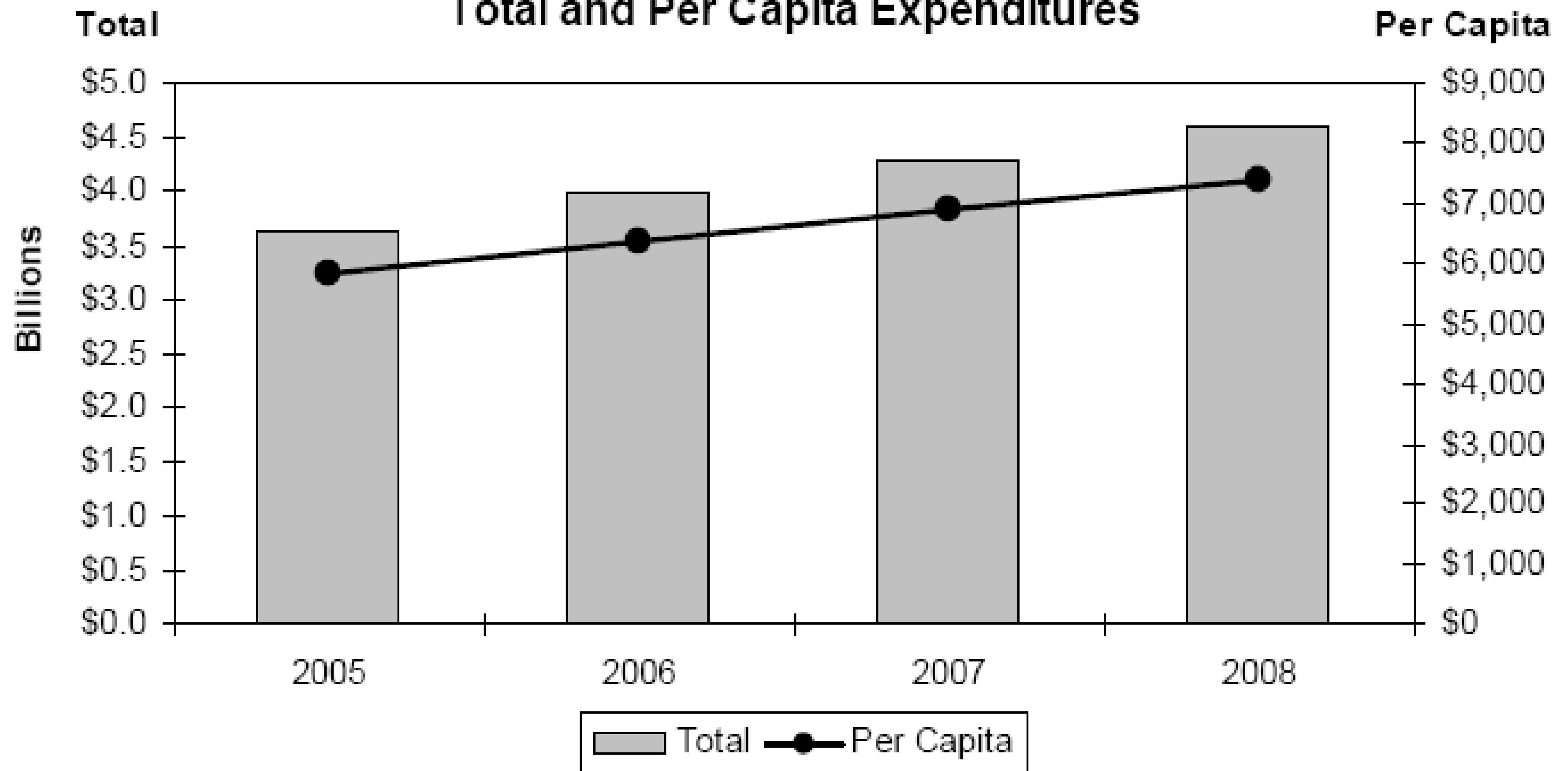
Economy: Agriculture, Tourism, Health/Education, Industry

Rural



Legislative History

- **2003** Blueprint launched as a Governor's Initiative
- **2005** Implementation of Chronic Care Model
- **2006** Blueprint codification as part of sweeping reform legislation (Catamount Health)
- **2007** Blueprint leadership and Integrated Pilots
- **2008** Community Health Team structure and insurer mandate
- **2009** Accountable Care Organization Exploration
- 2**010** Statewide Blueprint Expansion
- **2011** Phase II Payment Reforms, Health Benefit Exchange, Green Mountain Care Board



Note: Spending for 2005 and 2006 is likely understated. See *Summary of Data Revisions* for adjustments that might affect trend values.

Annual Health Care Expenditure Growth, U.S. and Vermont Residents

Note: Spending for 2005 and 2006 is likely understated. See *Summary of Data Revisions* for adjustments that might affect trend values.

What is the Blueprint ?

Vermont's Foundation

- Advanced Primary Care Practices
- Community Health Teams (core)
- Community Health Teams (extended)
- Multi-insurer payment reforms
- Health Information Infrastructure
- Evaluation & Reporting Systems
- Learning Health System Activities

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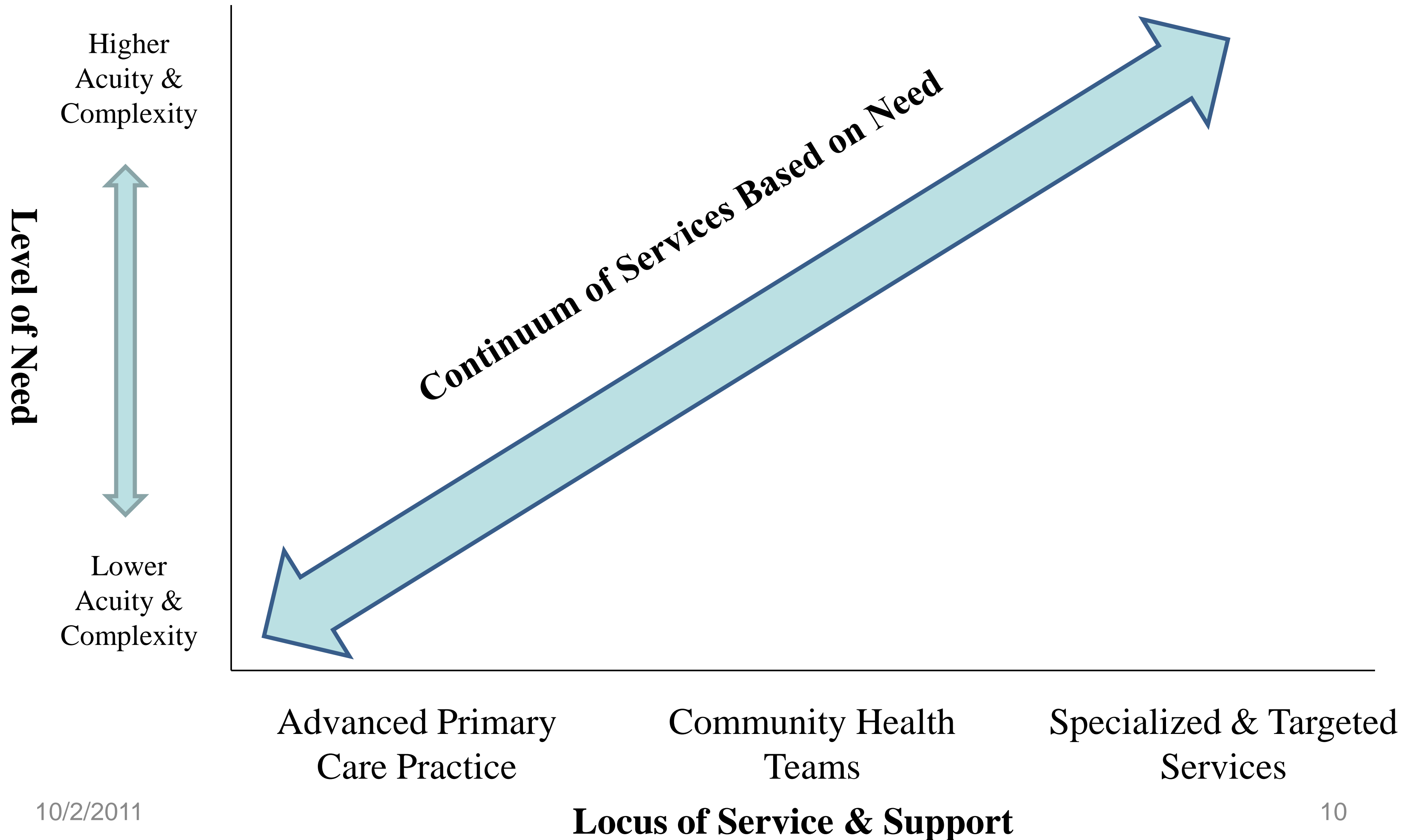
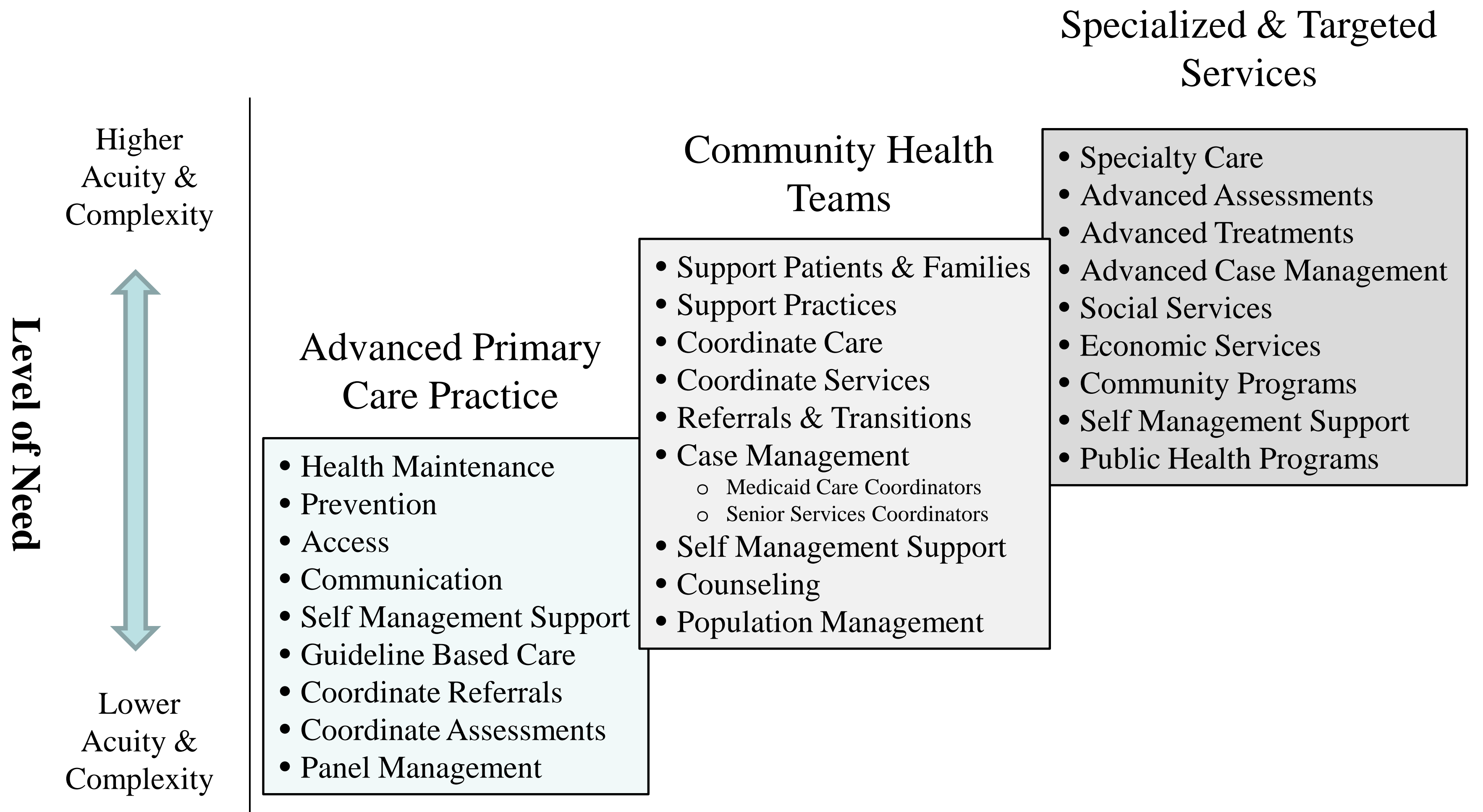
Continuum of Health Services



Continuum of Health Services - General



Advanced Primary Care Practices or Patient-Centered Medical Homes

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NCQA Standards

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

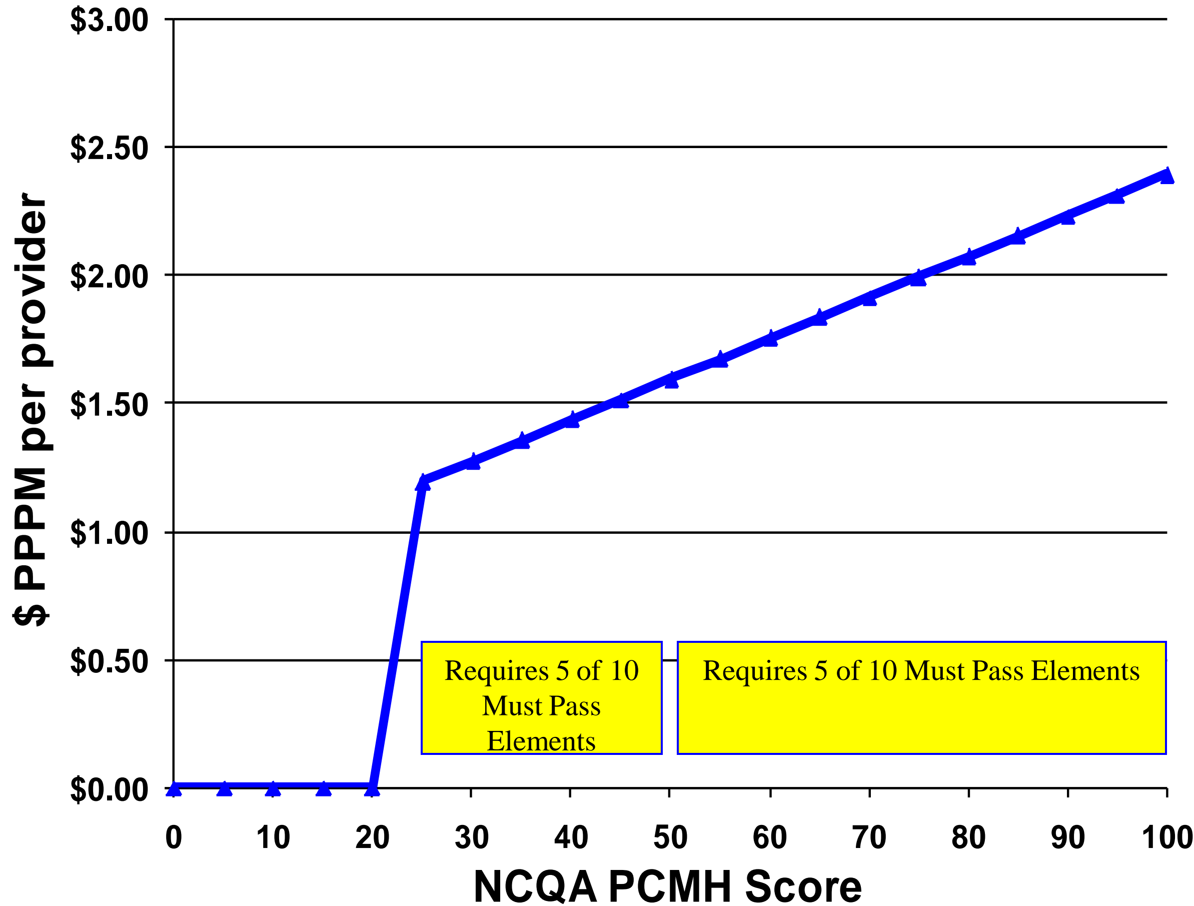
Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

NCQA Measuring quality. Improving health care.



- All insurers pay enhanced payment based on a practices score as a patient centered medical home
- NCQA PCMH standards and scoring methods are used to score practices as a medical home
- Payment changes with each 5 point change in the NCQA PCMH score (score ranges from 0 – 100 points)
- Designed to incent ongoing iterative improvement, and to provide a disincentive for moving backwards

Provider Payment Table ($PPPM for each provider)

NCQA PCMH Points	Average Payment
0	0.00
5	0.00
10	0.00
15	0.00
20	0.00
25	1.20
30	1.28
35	1.36
40	1.44
45	1.52
50	1.60
55	1.68
60	1.76
65	1.84
70	1.92
75	2.00
80	2.07
85	2.15
90	2.23
95	2.31
100	2.39

Requires 5 of 10 must pass elements (25–45 points)

Requires 10 of 10 must pass elements (50–100 points)

Payment Reforms

You Get What You Pay For

Financing

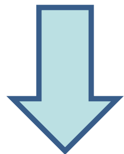
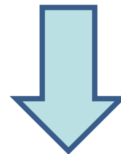
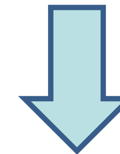
- Multiple payers
- Complex admin
- Conflicted interests
- Financial priorities
- Political influence

Payment

- Fee for service
- Volume oriented
- Complex processes
- Promotes procedures
- Promotes acute care

Delivery System

- Volume based workflow
- Fragmented services
- Reactive care
- Specialists & Proceduralists
- Variable quality

Patient Engagement & Experience

- Coverage cost barriers
- Approval barriers
- SES based benefits
- SES based access
- Difficult to navigate

- Financially oriented choices
- SES sensitivity to prevention
- SES sensitivity to episodic costs
- Payment influenced choices
- Difficult for patients to manage

- Hard to get appointments
- Hurried visits
- Not patient centered & holistic
- Reactive instead of preventive
- Contingent on self navigation

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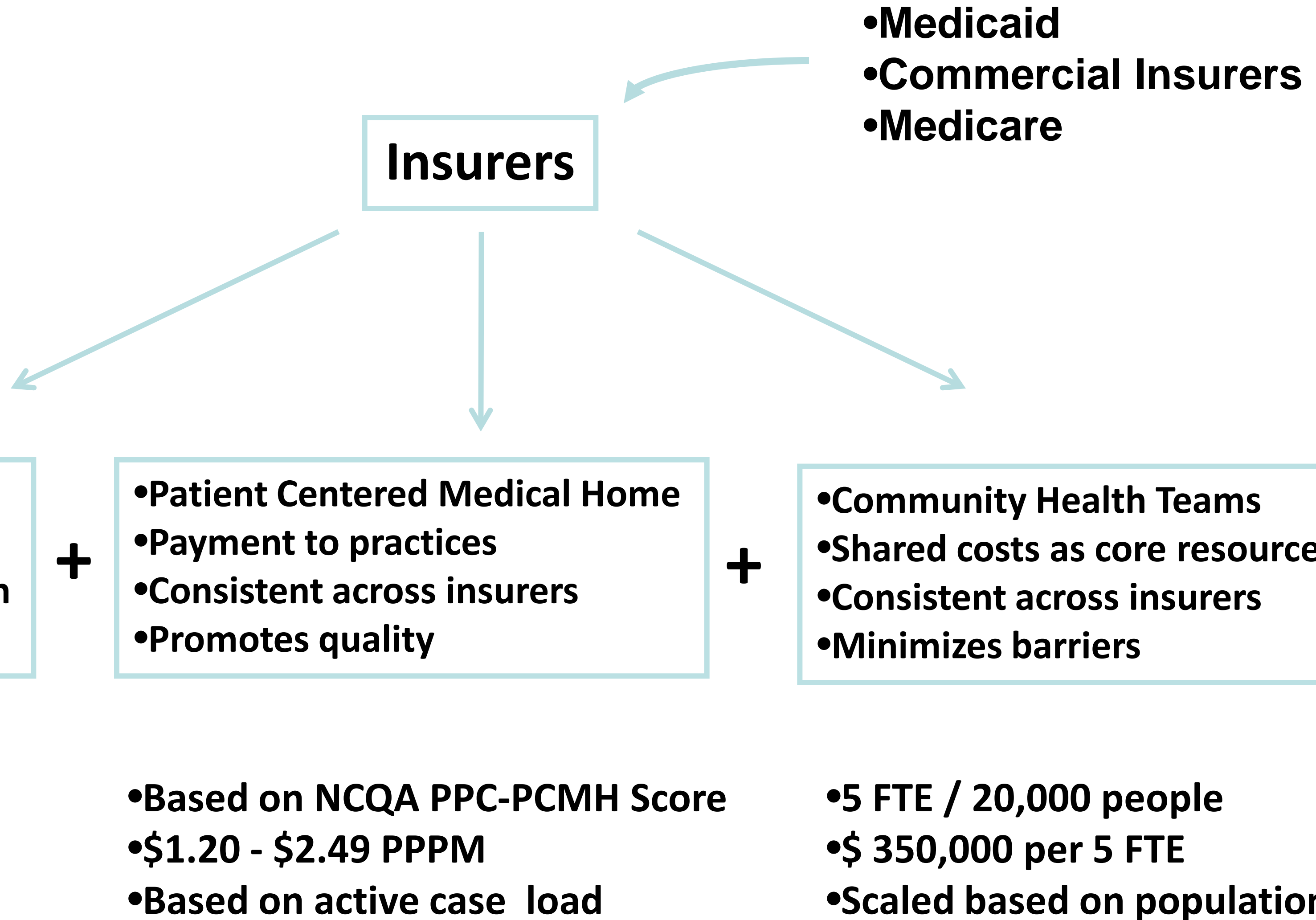
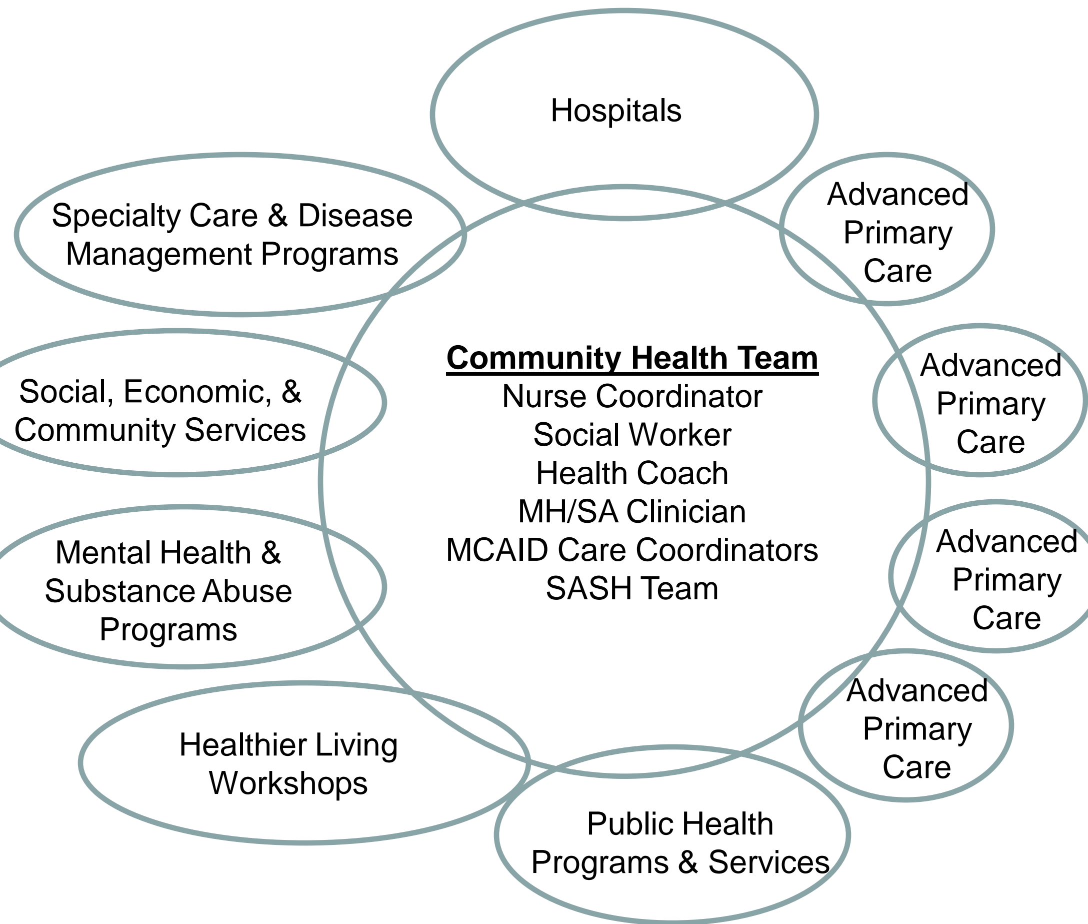
Multi-insurer Payment Reforms



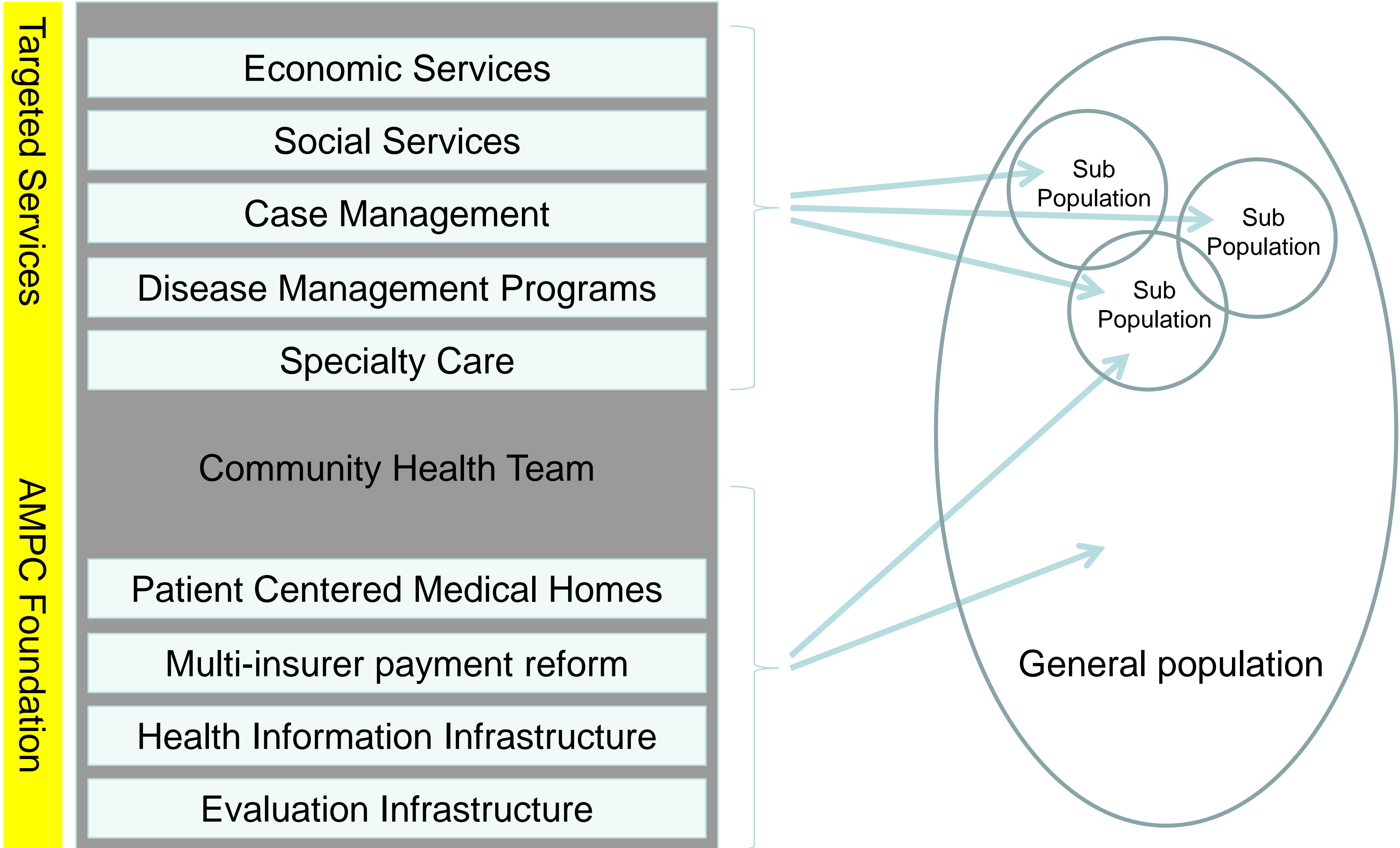
Community Health Teams



- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

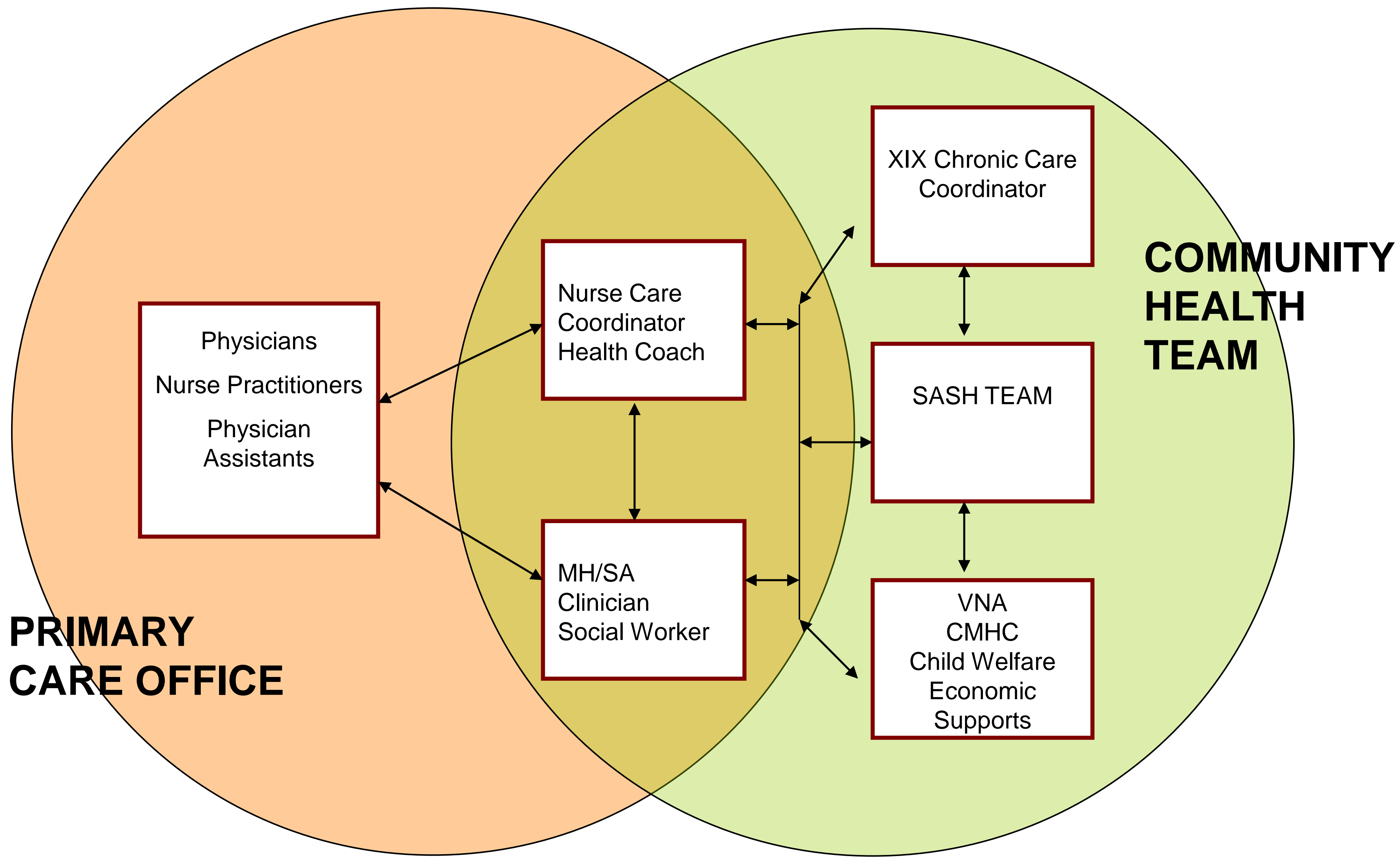
Advanced Model of Primary Care

A Foundation for integrated services



Community Health Team

Referral and Communication Flow Chart



St Johnsbury Community Health Team
Staffing

St. Johnsbury Community Health Team
Care Integration Coordinator
1 FTE

St. Johnsbury Family HC
Care Coordinator .5 FTE
BH Specialist .5 FTE

Caledonia Int. Medicine
Care Coordinator .5 FTE
BH Specialist .5 FTE

Concord Health Ctr.
Care Coordinator .5 FTE
BH Specialist .5 FTE

Danville Health Center
Care Coordinator .5 FTE
BH Specialist .5 FTE

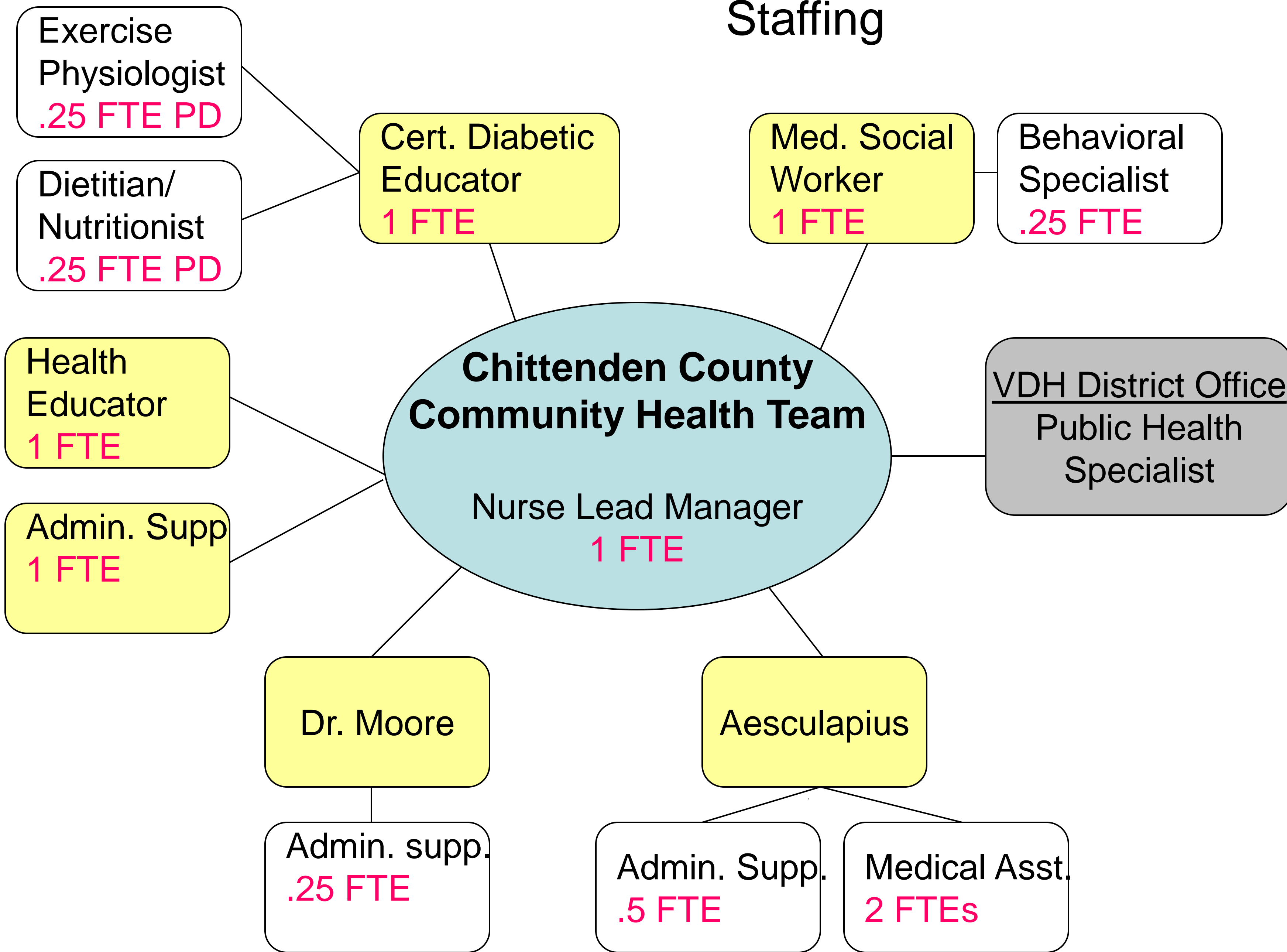
Corner Medical
Care Coordinator 1.0 FTE
BH Specialist 1.0 FTE

VDH District Office
Public Health Specialist

Community Connections
Community Health Workers
Comm. Health Worker 1 FTE

Other
OVHA Care Managers
Hospital Care Managers
Hospital-based CC Educators
Community-based Advocates

Chittenden County Community Health Team
Staffing



STEPS TO SUCCESS WITH THE COMMUNITY CARE TEAM

If you have a chronic disease or health condition, the Community Care Team at Fletcher Allen can help you improve your health by providing support, education and health management.

READ THIS BROCHURE.

Take a moment to learn more about how the Community Care Team can help you.

TALK TO YOUR PROVIDER.

If your provider agrees that the Community Care Team is for you, he or she will make a referral to the CCT Office. About a week later, a member of the team will call you to set up your first appointment.

GO TO THE FIRST APPOINTMENT.

During your first appointment, the team will do a health assessment, complete any screenings needed to identify factors affecting your health, and establish a care plan for you. This will include helping you set goals to improve your health.

FOLLOW THROUGH WITH YOUR PLAN.

The Community Care Team is here to support you as you work to achieve your goals. Most people need 1–2 sessions, occasionally up to 6 are needed.

The Community Care Team at Fletcher Allen wants to help you improve your health. If you have a chronic disease such as diabetes, hypertension or asthma — or any other health issues — the Community Care Team can provide:

- Nutrition and exercise advice.
- Diabetes education.
- Medication management.
- Behavioral/mental health support.
- Connection to community and financial resources.

If you are interested in learning more about the Community Care Team, please ask your provider for more information.

AESCULAPIUS MEDICAL CENTER
A PATIENT-CENTERED MEDICAL HOME

1 Timber Lane
South Burlington, VT 05403
802-847-4714

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Fletcher Allen HEALTH CARE

In alliance with The University of Vermont

Primary Care

The Community Care Team

AT YOUR PATIENT-CENTERED MEDICAL HOME

www.FletcherAllen.org

Our Community Care Team will help you set goals to improve your health.

MEET THE COMMUNITY CARE TEAM

A patient-centered medical home fosters a team approach to improving health outcomes for patients. The Community Care Team is a group of professionals on the team who will give you the tools and support you need to reach your goals.

The members of the Community Care Team provide multidisciplinary expertise in helping you manage your chronic condition. Each member brings a level of expertise in different areas to help you be as healthy as possible.

FREE! OUR NURSE WILL:

- Conduct a health assessment and screening.
- Work with you to develop strategies to manage your condition.
- Help you manage your medications.
- Provide diabetes education.
- Provide guidance for healthier living.
- Help you set goals to improve your health.
- Provide coaching to help you meet your goals.

FREE! OUR HEALTH EDUCATOR WILL:

- Conduct a health assessment and screening.
- Work with you to provide guidance and tools for healthier living, such as keeping a food log, and understanding nutrition labels.
- Work with you to develop strategies to manage your condition.
- Help you set goals to improve your health.
- Provide coaching to help you meet your goals.

FREE! OUR COMMUNITY RESOURCE SOCIAL WORKER WILL:

- Conduct a health assessment and screening.
- Connect you with community/financial resources.
- Assist you or a loved one with long-term care planning.
- Work with other agencies to coordinate care.
- Help you set goals to improve your health.
- Provide coaching to help you meet your goals.

OUR BEHAVIORAL HEALTH SOCIAL WORKER WILL:

- Conduct a health assessment and screening.
- Help you identify barriers to meeting your health care goals.
- Help you with coping, relaxation and self-care strategies.
- Help you manage symptoms of anxiety and depression.
- Provide coaching to help you meet your goals.

FREE! A CERTIFIED DIETICIAN WILL:

- Review your health assessment and screening results.
- Provide diabetes education.
- Provide nutrition information for specific health conditions.

In addition, the Community Care Team will, if appropriate, connect you with an exercise program at the YMCA, which has facilities in Burlington and Winooski. You will receive a program tailored to your needs and you will work with YMCA-certified personal trainers in small, one-hour fitness trainings.

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Clinical Registry

Covisint DocSite

NCQA Criteria for PCMH recognition
Blueprint Central Registry

- **Patient tracking** - Access to searchable and actionable data
- **Care Management** - Use of evidence based guidelines
- **Patient Management Support** - Identify patients with unique needs
- **Test tracking** - Managing results/alerts
- **Performance Reporting** - % of patients meeting various guidelines

Patient Registry

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An enhanced Health Information Technology

reporting tool

that improves care and saves time.

Database consisting of patient clinical and demographic information

- Access to accurate lists of patients with certain conditions and applicable clinical data that is critical to evaluating care processes and clinical outcomes

Monthly Measure Acquisition

Measure:Body Mass Index

Site:Independent Practice 2

% of patients with a result

100
50
0

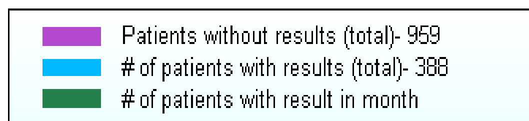
Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep

2009 2010

953 944 938 932 919 913 874 826 751 684 636 577 571

85 133 208 275 323 382 388

39 48 75 67 48 59 6



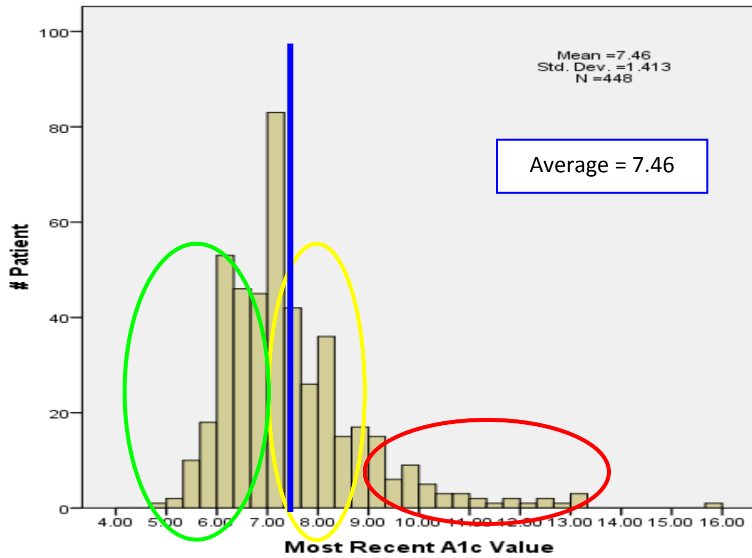
Final Month Evaluation:

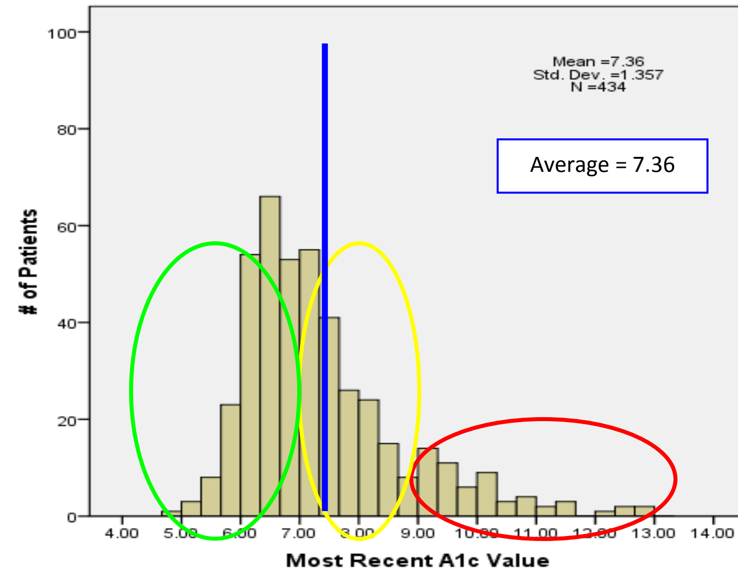
# of Patients without a result in the last 12 months: 571

# of Patients with a result in the last 12 months: 388

# of Patients with a result in the last month: 6

Distributions vs. Averages





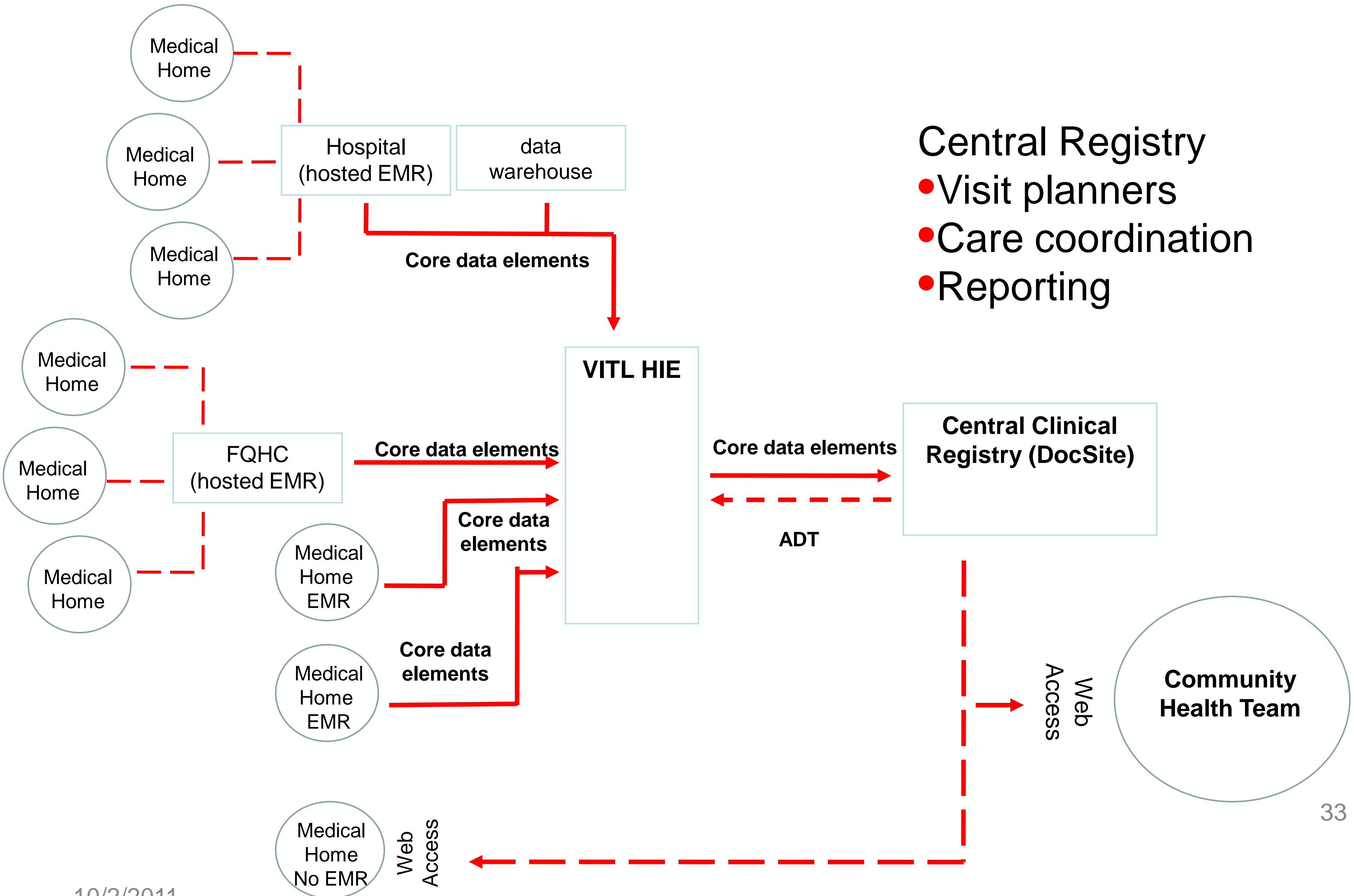
Group 1
Good Disease
Control

Group 2
Intermediate
Disease
Control

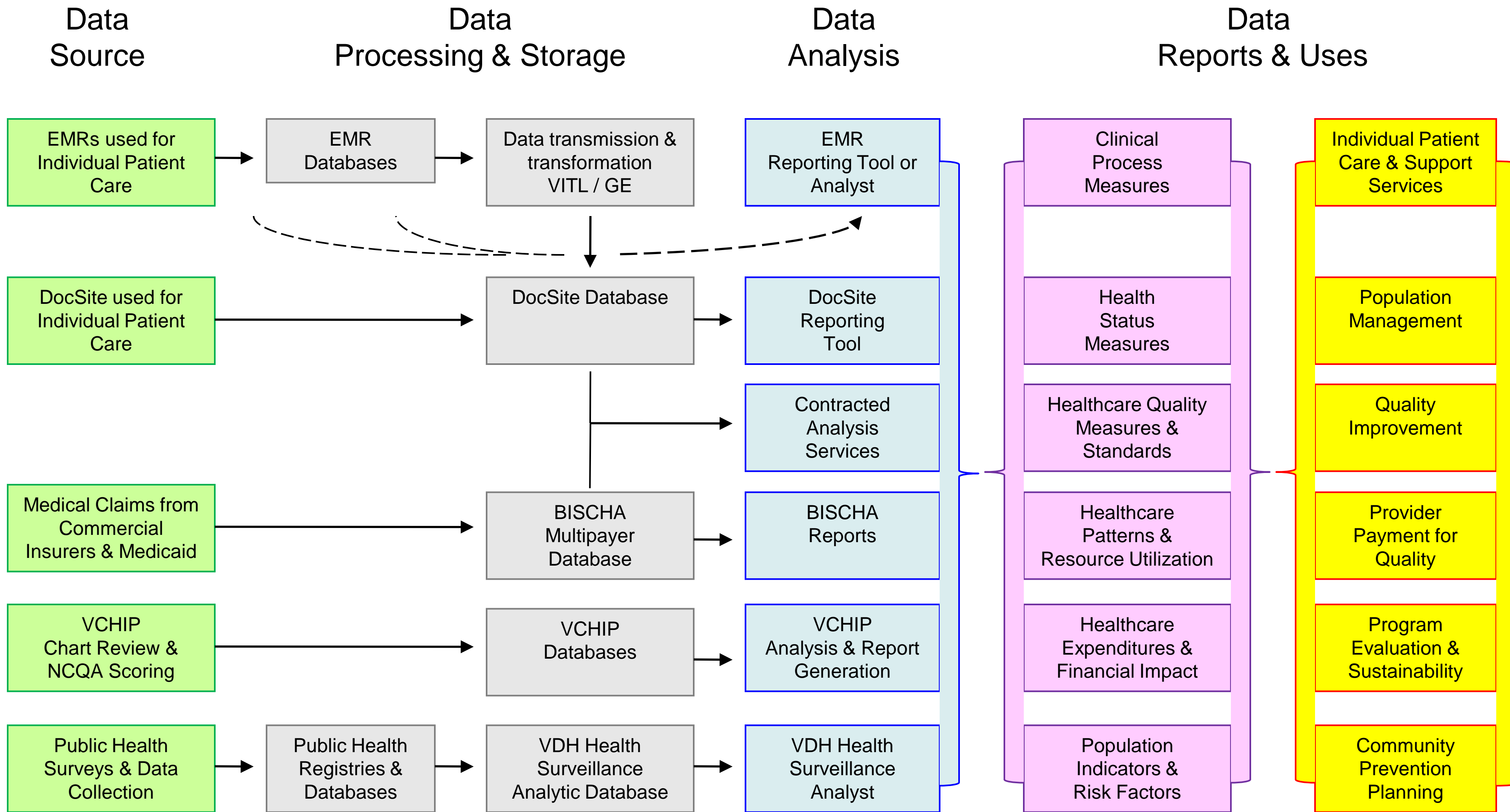
Group 3
Poor
Disease
Control

Health Information Technology

Blueprint Integrated Pilots
Health Information Infrastructure

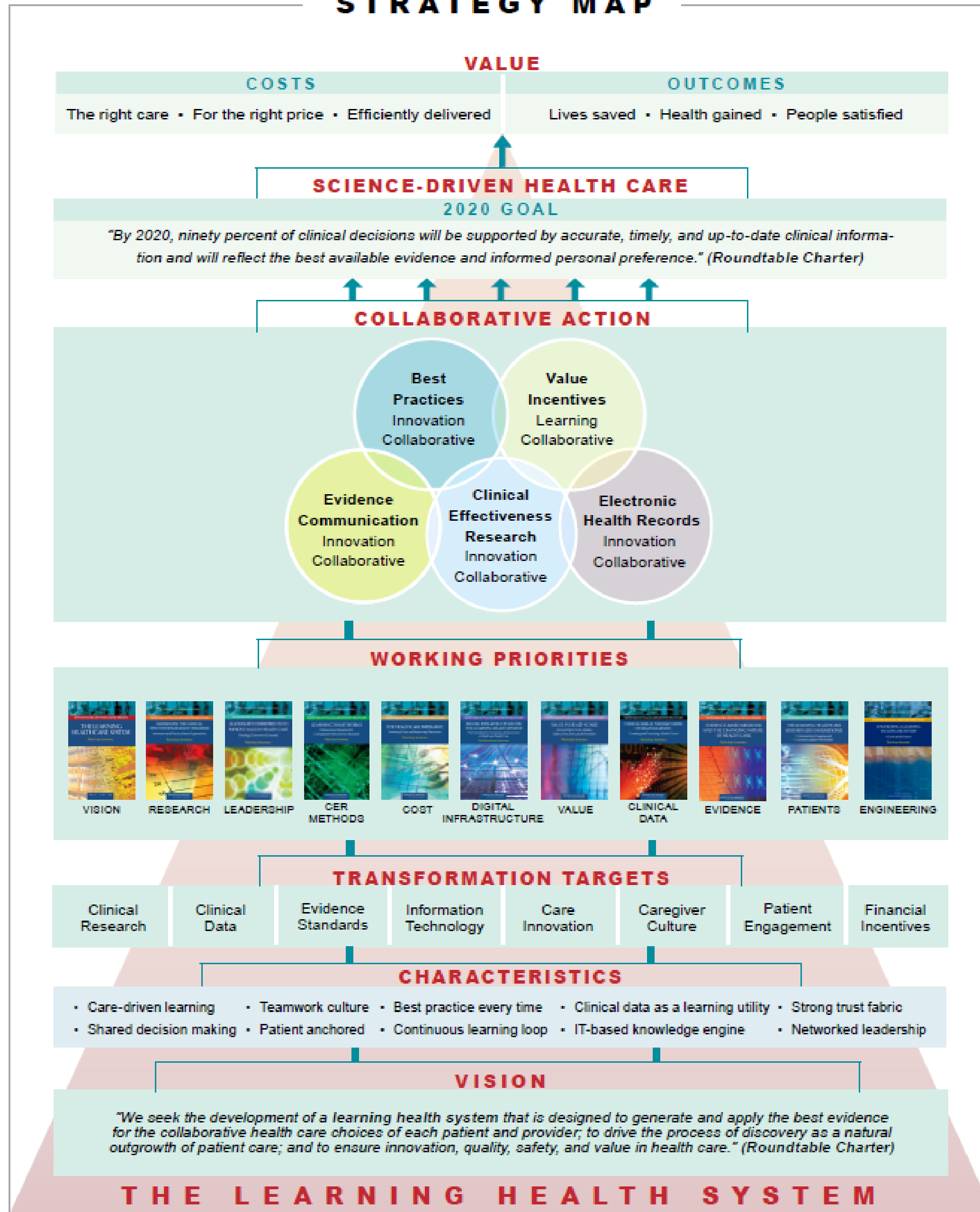


Blueprint Integrated Pilots
Evidence Based Quality Improvement



The Learning Health System

IOM ROUNDTABLE ON VALUE & SCIENCE-DRIVEN HEALTH CARE



Key Elements to Support a Learning Health System

- Do meaningful & useful evaluation
- Data sources populated as part of routine operations
- Support a broad array of meaningful metrics
- Flexible & dynamic reporting that is readily available
- Processes & people to use information …..
- Build a learning health system

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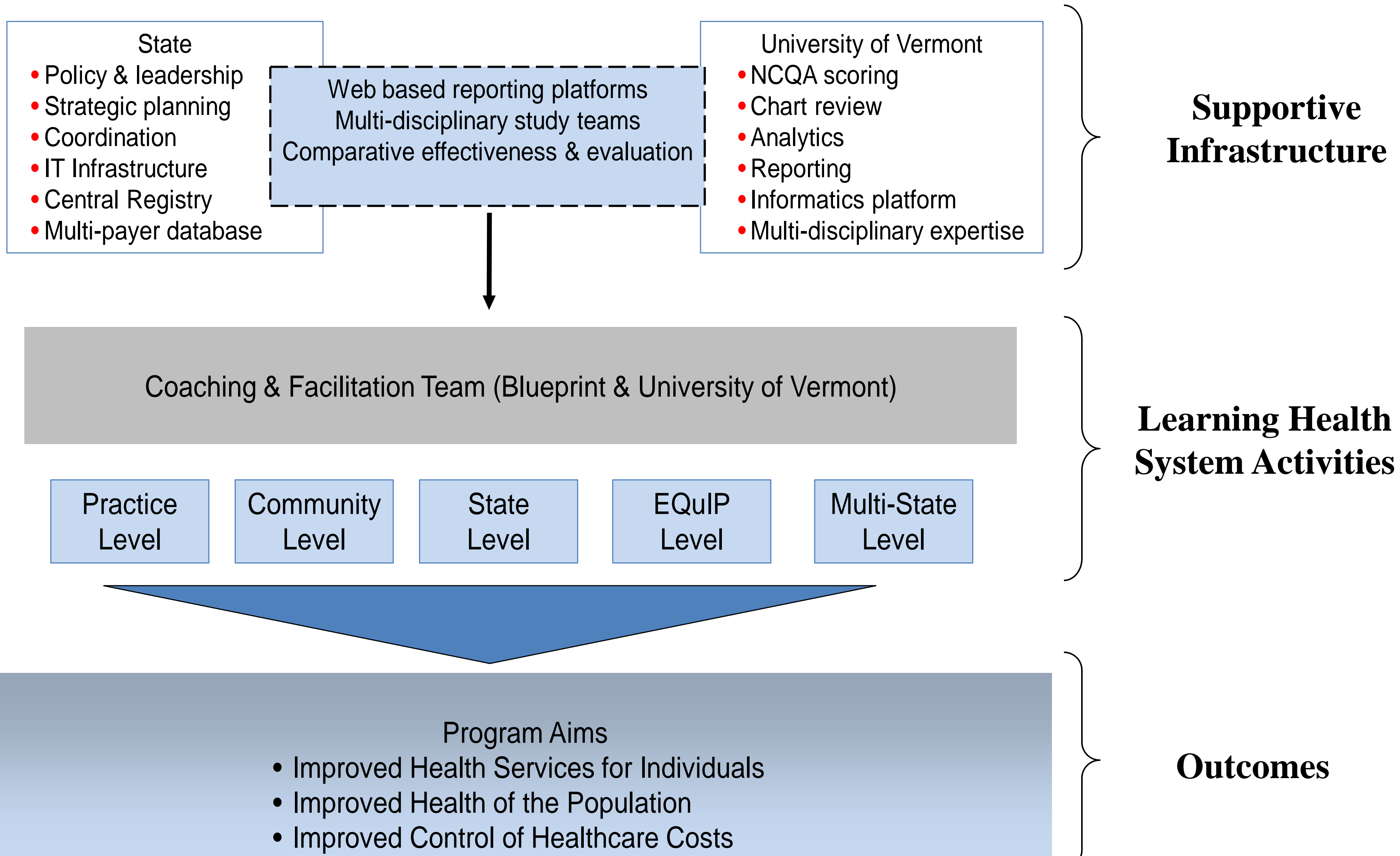
Expansion & Quality Improvement Program (EQuIP)



Expansion & Quality Improvement Program (EQuIP)

	PRACTICE FACILITATORS		
	Blueprint	UVM-VCHIP	Bi-State
Current	6.4 FTEs 9 People	1.5 FTEs 2 People	.4 FTEs 1 Person
CY 2011	8.4 FTEs 11 People	1.5 FTEs 2 People	.4 FTEs 1 Person
Areas of Emphasis	Primary Care Practices NCQA Preparation Ongoing QI - examples Transitions of care Mental Health Shared Decision Making Asthma	Pediatric Practices NCQA Preparation Ongoing QI - examples Transitions of care Obesity ADHD Asthma	FQHCs, RHCs NCQA Preparation Ongoing QI - examples Specific IT Needs Specific Reporting Needs

Data Sources	Categories of Measures	Reporting
Central Registry	▪Clinical Processes ▪Health Status	▪Web based ▪Flexible & dynamic
Multi-Payer Claims Database	▪Resource Utilization ▪Expenditures	▪Standard reports ▪Web based ▪Flexible & dynamic
Chart Reviews	▪Clinical Processes ▪Health Status	▪Standard reports
NCQA Scoring	▪Clinical Processes ▪PCMH Standards	▪Standard reports
Hospital Data (affiliated practices)	▪Inpatient Admissions ▪Emergency Dept Visits	▪Standard reports
Qualitative Evaluation	▪Focus groups ▪Individual interviews ▪Surveys	▪Standard reports
Public Health Registries	▪Population level ▪Risk Factors	▪Standard reports ▪Track change over time

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State & Federal Partnerships
Example - Health information & quality infrastructure

National Guidelines & Measures
(NIH, Task Force, AHRQ)

Federal Funding & Guidance
(ONC)

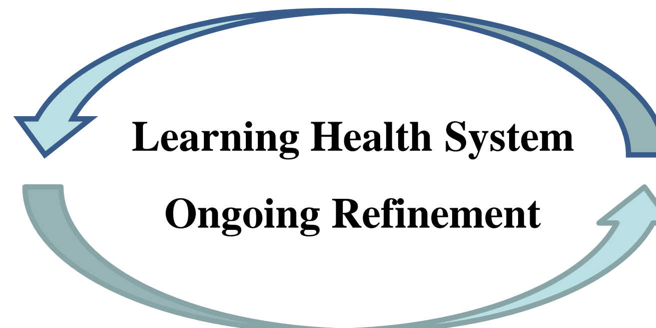
State Led Health Reforms

Health IT Infrastructure
- EMR elements
- Registry elements
- Outreach reports
- Interfaces & data transfer

Adopt Guideline based Data Dictionary
- Clinical process data elements
- Health status data elements
- Utilization & expenditure elements
- Aligned measure set

Reporting & Evaluation
- Analyses
- Evaluation
- Performance reports
- Claims database reports

Guideline Based Health Services
- Individual patient care
- Population mngt & outreach
- Coordinated health services
- Information Exchange



Guideline Based QI
- Comparative Evaluation
- Provide reports & data
- Coaching & facilitation
- Shared learning

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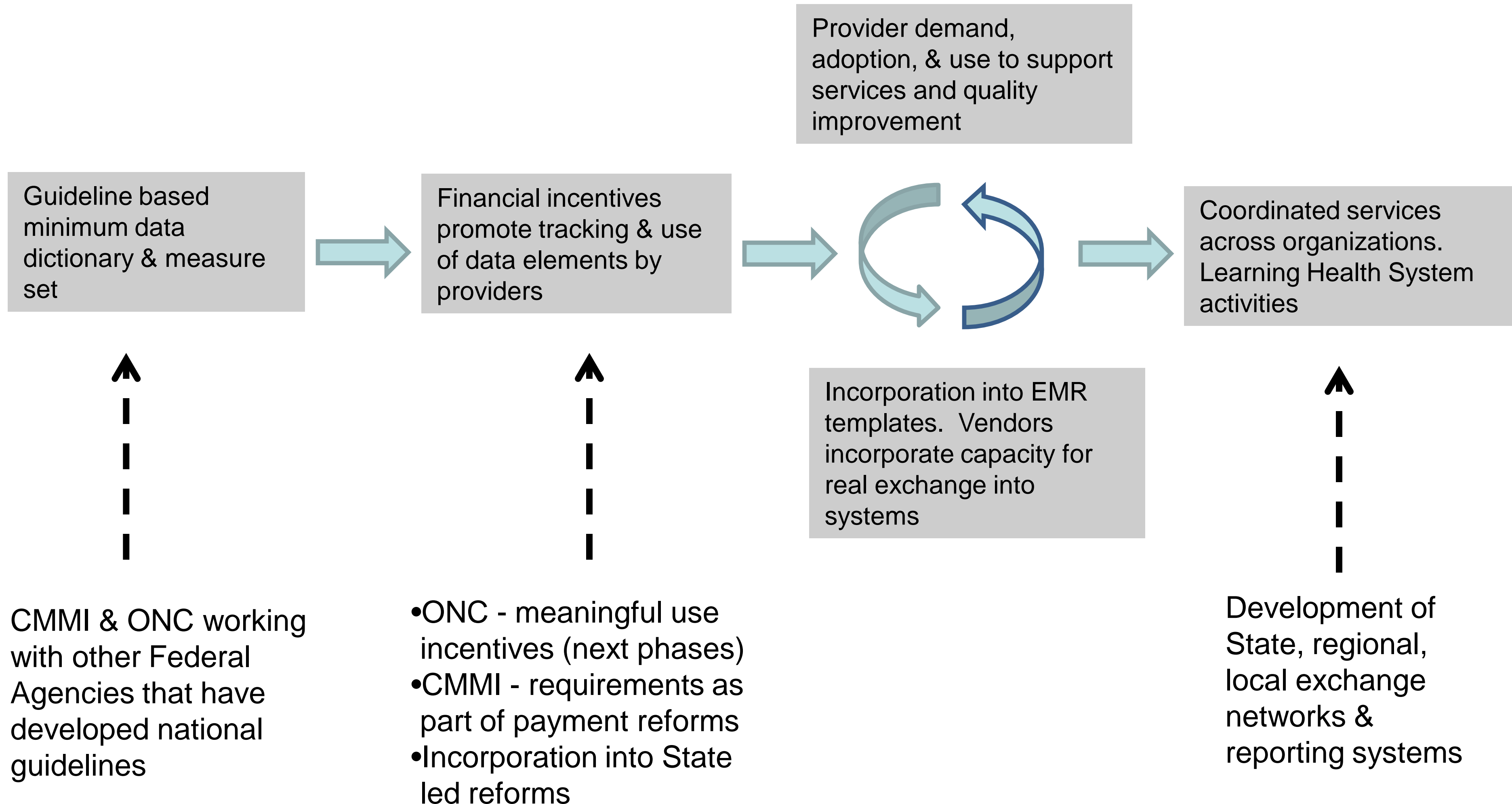
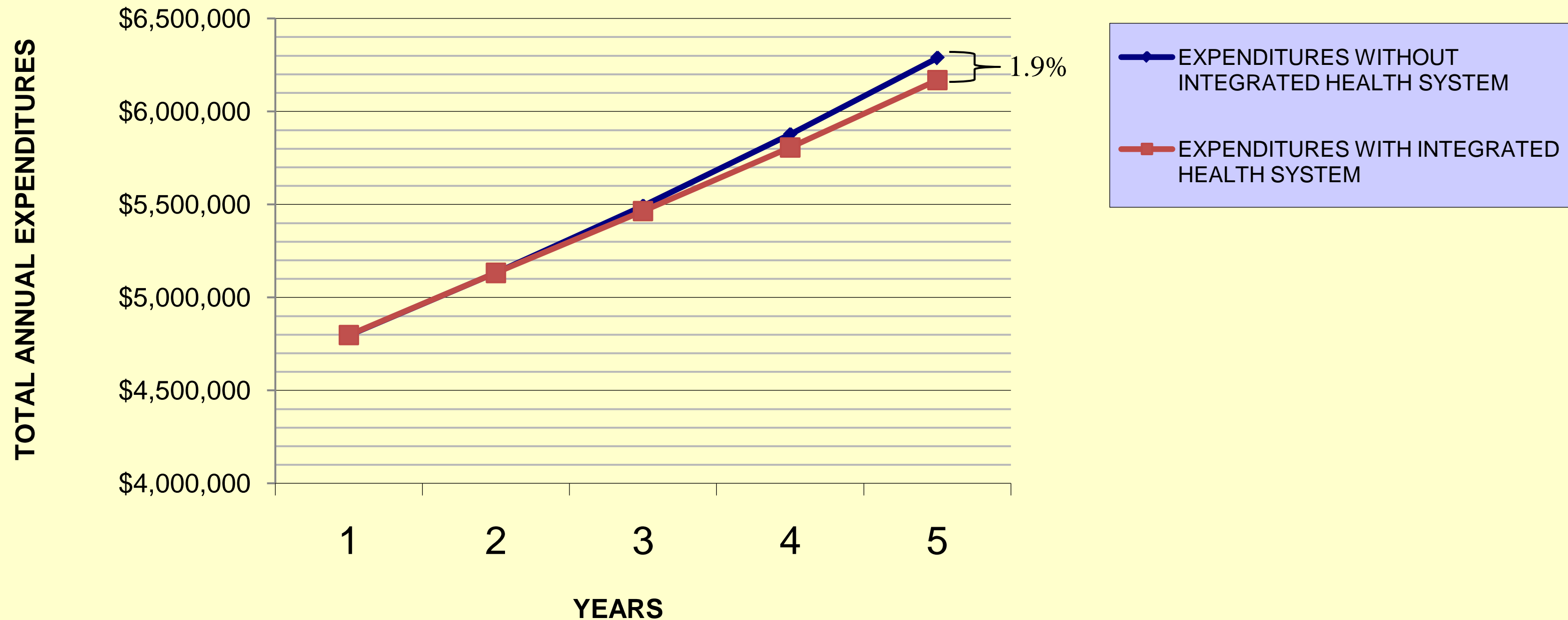
State & Federal Strategic Alignment

Digital infrastructure for a learning health system



Financial Impact Model (Return on Investment)



Target Population % of VT Population # CHTs	42,179 6.7% 2	126,286 20% 6	316,662 50% 16	508,17 80% 25	637,130 100% 32

Multi-payer Claims Database Early Findings

Vermont Multi-Payer Database (Onpoint Health Data) – Methods & Early Trends

Key Points — Data Sources & Methods

- A matched control study design was used for this evaluation.
- All data was derived from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Only commercially insured members, ages 18–64, were analyzed. (Note that Medicare and Vermont Medicaid data are not yet part of the VHCURES data set.)
- The Blueprint intervention began in the St. Johnsbury HSA on July 1, 2008, and in the Burlington HSA three months later on October 1, 2008. The evaluation of each HSA was specific to the timing of the intervention, and the results for the two areas studied were not merged.
- A comparative group of controls for each participant were matched on geographic area, age, gender, health status, baseline expenditures, and occurrence of a chronic disease.
- Inpatient, outpatient hospital, professional expenditures, and utilization measures were evaluated twice — first during the year prior to intervention (called "baseline" in this report) and later during the first year of intervention ramp-up.
- For this study, 1,882 Blueprint participants in St. Johnsbury HSA and 2,105 participants in Burlington HSA were selected.
- Discussions with Brookings and Dartmouth Institute were incorporated into decisions about some of the methods and measures used.

Table 2. Matched Control Results — St. Johnsbury HSA

MEASURE	BLUEPRINT PARTICIPANTS — RATE (COUNT)	POTENTIAL CONTROL GROUP — RATE (COUNT)	diff. p(χ^2)	MATCHED CONTROLS — RATE (COUNT)	diff. p(χ^2)
Total	100.0% (1,882)	100.0% (12,459)		100.0% (7,528)	
Age (years)					
18–29	8.6% (162)	14.4% (1,788)		8.9% (667)	
30–39	15.5% (291)	17.7% (2,201)		14.4% (1,081)	
40–49	26.1% (491)	25.7% (3,198)		26.3% (1,977)	
50–59	35.3% (665)	30.9% (3,848)		35.7% (2,689)	
60–64	14.5% (273)	11.4% (1,424)	<.01	14.8% (1,114)	0.82
Gender					
Female	55.8% (1,050)	52.2% (6,500)		56.7% (4,269)	
Male	44.2% (832)	47.8% (5,959)	<.01	43.3% (3,259)	0.47
ERG Score Range					
0	13.4% (252)	20.6% (2,571)		15.5% (1,169)	
0.0001–04999	17.7% (334)	21.6% (2,693)		19.4% (1,463)	
0.5000–0.9999	18.7% (352)	17.3% (2,158)		17.4% (1,313)	
1.0000–1.9999	23.1% (434)	18.8% (2,341)		21.5% (1,618)	
2.0000–4.9999	20.9% (393)	16.9% (2,109)		20.1% (1,512)	
5.000 +	6.2% (117)	4.7% (587)	<.01	6.0% (453)	0.06
Payment Category					
$0	9.8% (185)	17.2% (2,139)		10.0% (756)	
$1 – $999	29.7% (559)	33.8% (4,210)		30.1% (2,264)	
$1,000 – $9,999	48.4% (911)	40.7% (5,073)		48.6% (3,655)	
$10,000 – $39,999	10.3% (193)	7.3% (905)		9.7% (733)	
$40,000 +	1.8% (34)	1.1% (132)	<.01	1.6% (120)	0.91
Disease Prevalence					
Any Chronic Condition	29.0% (546)	20.3% (2,527)	<.01	28.0% (2,106)	0.37
Asthma	1.9% (36)	2.2% (271)	0.46	2.9% (222)	0.01
COPD	1.2% (23)	0.7% (93)	.03	1.1% (83)	0.66
CHF	0.2% (3)	0.2% (30)	0.49	0.4% (27)	0.17
Coronary Heart Disease	2.9% (55)	1.6% (201)	<.01	2.3% (176)	0.14
Hypertension	15.4% (290)	10.3% (1,283)	<.01	14.4% (1,087)	0.29
Diabetes	7.6% (143)	4.2% (519)	<.01	5.9% (443)	<.01
Depression	5.8% (110)	4.5% (556)	<.01	5.8% (438)	.96

POPULATION	ST. JOHNSBURY Baseline Pre-Intervention 7/1/07 – 6/30/08	ST. JOHNSBURY First-Year Intervention 7/1/08 – 6/30/09	BURLINGTON Baseline Pre-Intervention 10/1/07 – 9/30/08	BURLINGTON First-Year Intervention 10/1/08 – 9/30/09
Blueprint Participants	1,882	→	2,105	→
Matched Controls	7,528	→	8,420	→

Table 5. Selected Key Indicators and Trends — St. Johnsbury HSA

MEASURE	PARTICIPANT VOLUME AT BASELINE (2007-08)	PARTICIPANT RATE AT BASELINE (2007-08)	PARTICIPANT TREND	MATCHED CONTROLS TREND
Expenditure Measures				
Total Paid	$8.7M	$4,861	+0.6%	+2.1%
Inpatient Paid	$1.2M	$682	-16.1%	-8.6%
Outpatient Hospital Paid	$3.6M	$2,042	+3.4%	+6.3%
Professional Paid	$2.2M	$1,231	+1.9%	-0.6%
Pharmacy Paid	$1.4M	$808	+11.1%	+7.4%
Outpatient ED Paid	$0.2M	$107	+26.6%	+16.6%
Mental Health / Substance Abuse Paid	$0.3M	$192	+18.3%	-0.1%
Utilization Measures				
Inpatient Discharges	92	51.7	-19.8%	-10.7%
Inpatient ACS Conditions	7	3.9	-30.6%	-43.9%
Inpatient Days	281	157.8	* -22.2%	* -19.1%
Inpatient Readmits	6	3.4	+13.3%	+19.4%
Outpatient ED Visits	334	187.6	-4.0%	+7.4%
Outpatient Potentially Avoidable ED Visits	40	22.5	+26.3%	+3.3%
Non-Hospital Outpatient Visits	8,643	4,854.3	+2.7%	+1.9%
Primary Care Encounters	5,109	2,869.4	+1.4%	-0.5%

POPULATION	ST. JOHNSBURY		BURLINGTON	
	Baseline Pre-Intervention 7/1/07 – 6/30/08	First-Year Intervention 7/1/08 – 6/30/09	Baseline Pre-Intervention 10/1/07 – 9/30/08	First-Year Intervention 10/1/08 – 9/30/09
Blueprint Participants	1,882	→	2,105	→
Matched Controls	7,528	→	8,420	→

Table 8. Selected Key Indicators and Trends — Burlington HSA

MEASURE	PARTICIPANT VOLUME AT BASELINE (2007-08)	PARTICIPANT RATE AT BASELINE (2007-08)	PARTICIPANT TREND	MATCHED CONTROLS TREND
Expenditure Measures				
Total Paid	$8.0M	$3,992	+14.0%	* +14.7%
Inpatient Paid	$0.8M	$392	+41.1%	* +52.0%
Outpatient Hospital Paid	$2.4M	$1,172	* +23.4%	* +23.9%
Professional Paid	$3.1M	$1,539	+3.1%	+2.0%
Pharmacy Paid	$1.7M	$825	+1.6%	+7.6%
Outpatient ED Paid	$0.2M	$92	* +60.5%	* +38.5%
Mental Health / Substance Abuse Paid	$0.5M	$248	+4.3%	+5.0%
Utilization Measures				
Inpatient Discharges	85	42.2	-12.5%	-16.4%
Inpatient ACS Conditions	4	2.0	-2.2%	+19.1%
Inpatient Days	398	197.5	* -29.7%	-0.1%
Inpatient Readmits	15	7.4	-21.7%	+11.1%
Outpatient ED Visits	211	104.7	+15.4%	* +16.5%
Outpatient Potentially Avoidable ED Visits	24	11.9	-6.3%	-4.8%
Non-Hospital Outpatient Visits	10,786	5,351.1	+0.7%	* +4.3%
Primary Care Encounters	4,995	2,478.1	+1.2%	* +5.3%

Blueprint Statewide Expansion

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Blueprint Expansion

Anticipated Advanced Primary Care Practices & Community Health Team Operations

	Practices	Providers	Patients
July 2011	53	287	249,105
CY 2011	79	388	367,751
CY 2012	145	TBD	TBD

Total Population of Vermont ~ 625,741
~ 230 Primary Care Practices

Blueprint Expansion

Anticipated Advanced Primary Care Practices (January 2011 - January 2012)

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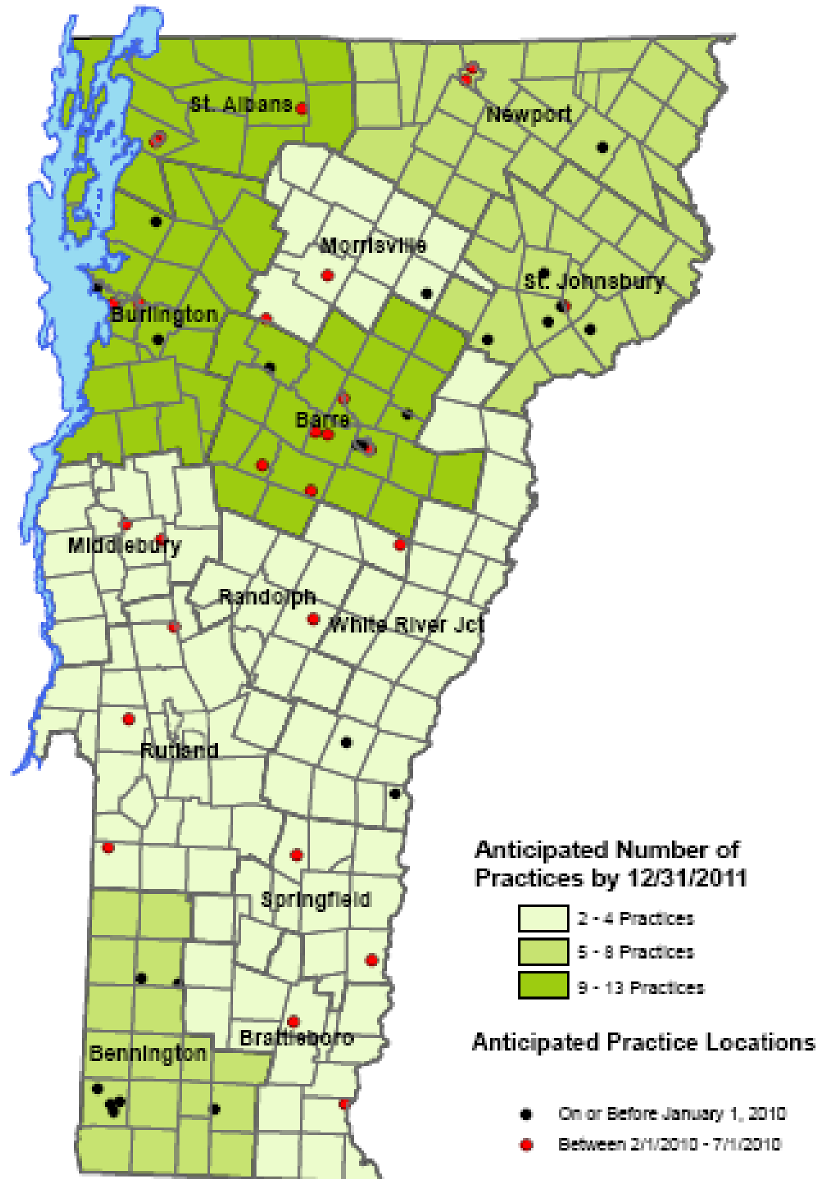

Looking Forward

Looking Forward

- Expand APCPs, CHTs, Payment Reforms (scale and scope)
- Medicare joining program
- SASH addition to model
- Continue building:
  - IT infrastructure
  - evaluation & reporting infrastructure
  - Learning Health System infrastructure
- Multi-state Learning Health System
- Foundation to support high level financial reforms

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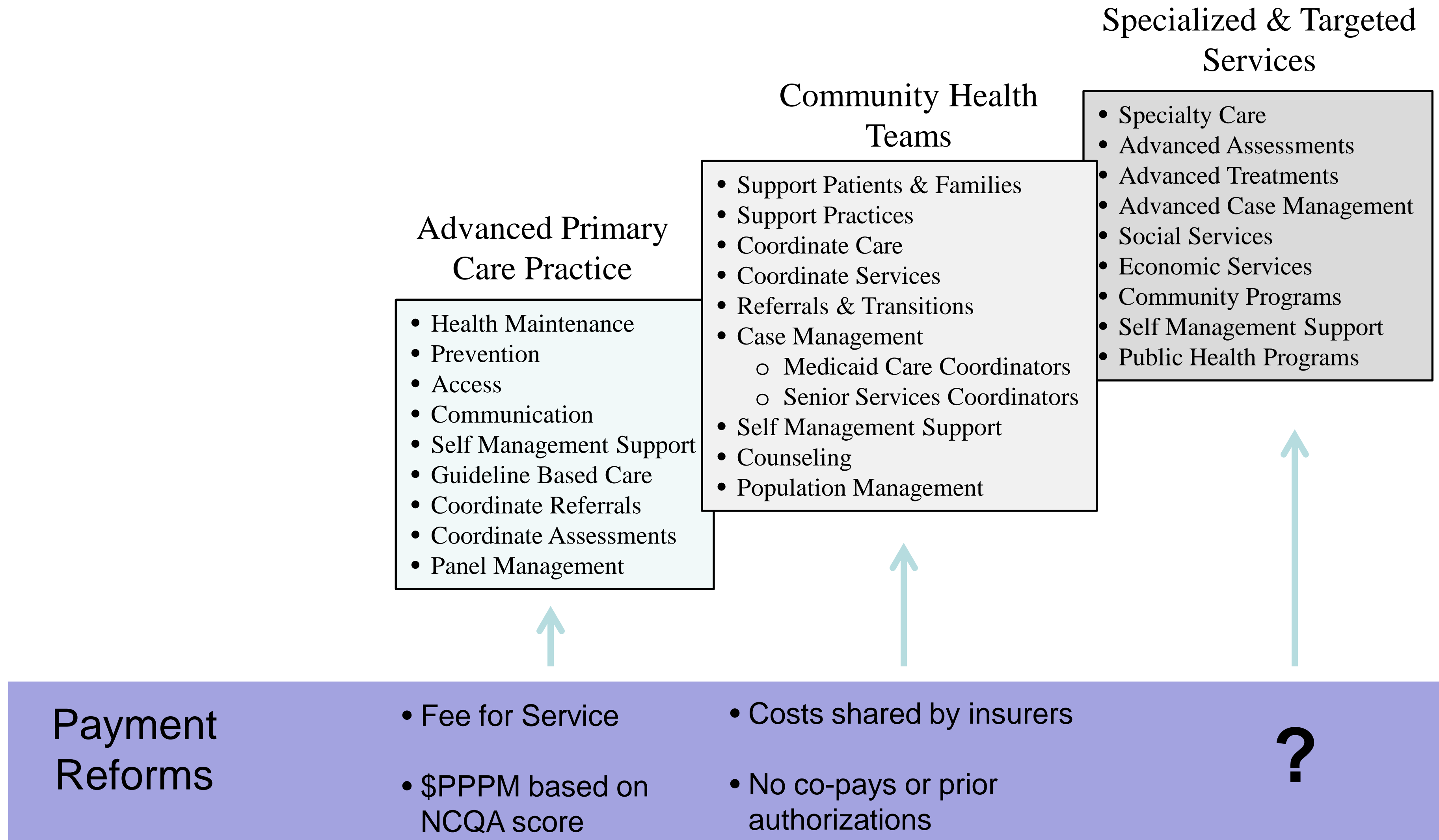
Phase II Payment Reform Pilots: Preliminary

Continuum of Health Services - General



Four Dimensions of Performance Measurement

- Reduction in growth of total cost of care
- Reduction in avoidable services:
  - ED visits
  - Inpatient admissions/readmissions
  - Imaging
  - Laboratory tests
- Improvement in adherence to quality performance standards
  - Process measures
  - Outcome measures
- Improved patient experience and engagement

Payment Based on Shared Interests: PCPs & Specialists

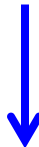
Adjustable outcomes based payment – ongoing refinement

Continue current FFS

Decreased FFS

Total new FFS + $PPPM > baseline FFS

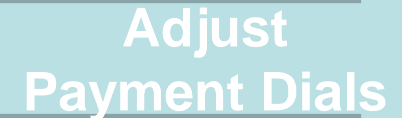
Measure results



First shared interest $PPPM payment

Measure results

Second shared interest $PPPM payment



Baseline

6 mo

12 mo

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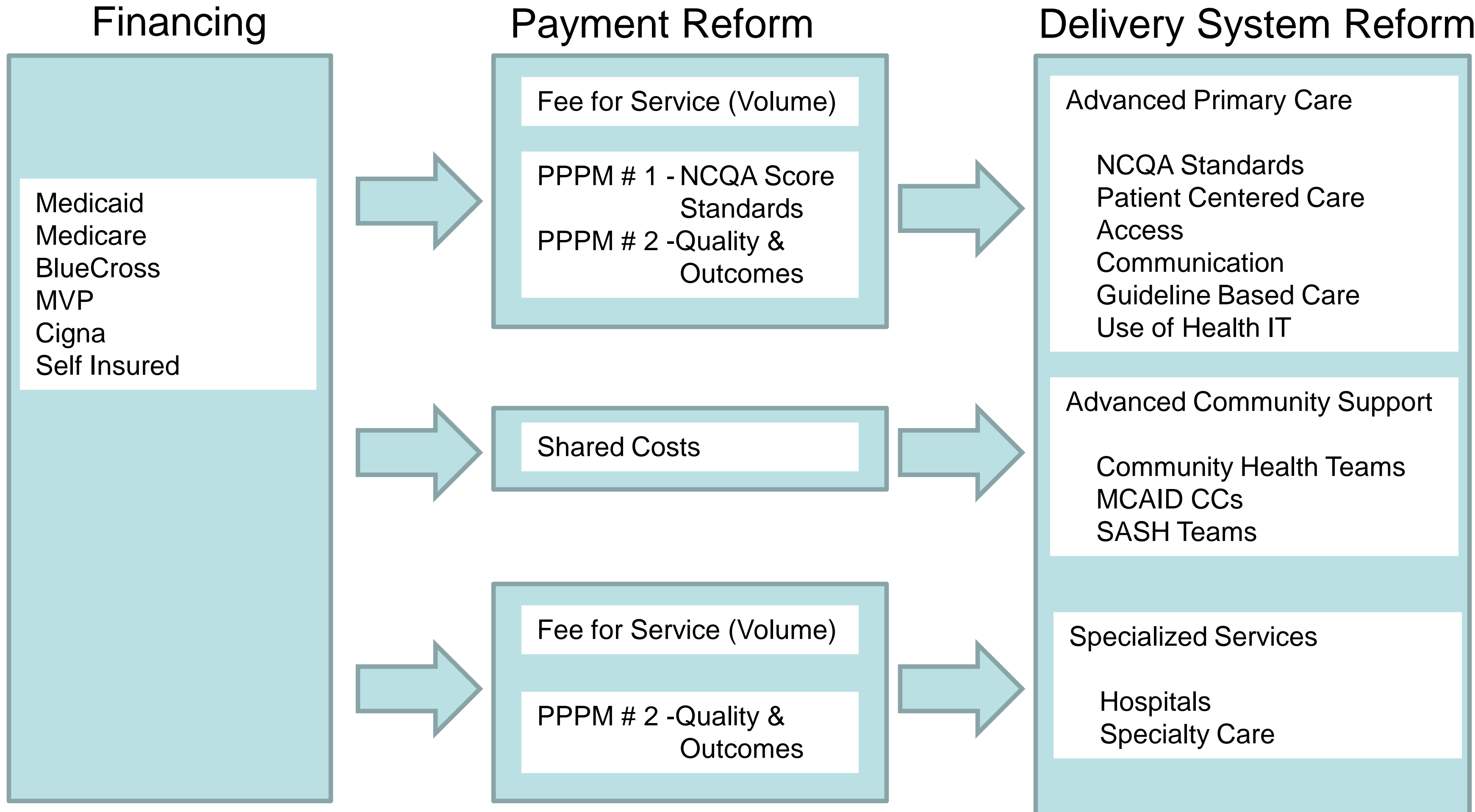

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