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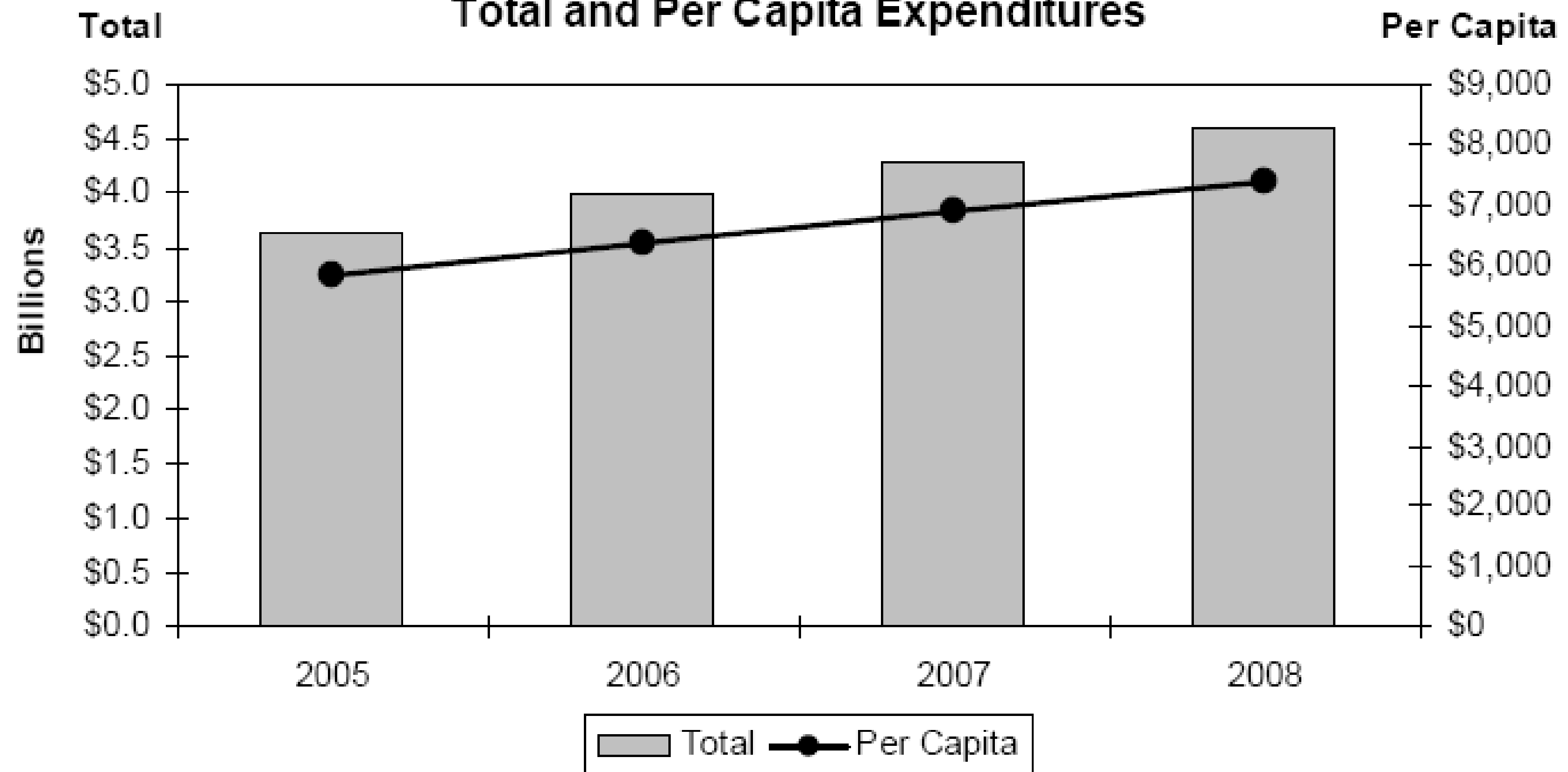
Blueprint Integrated Pilot Programs

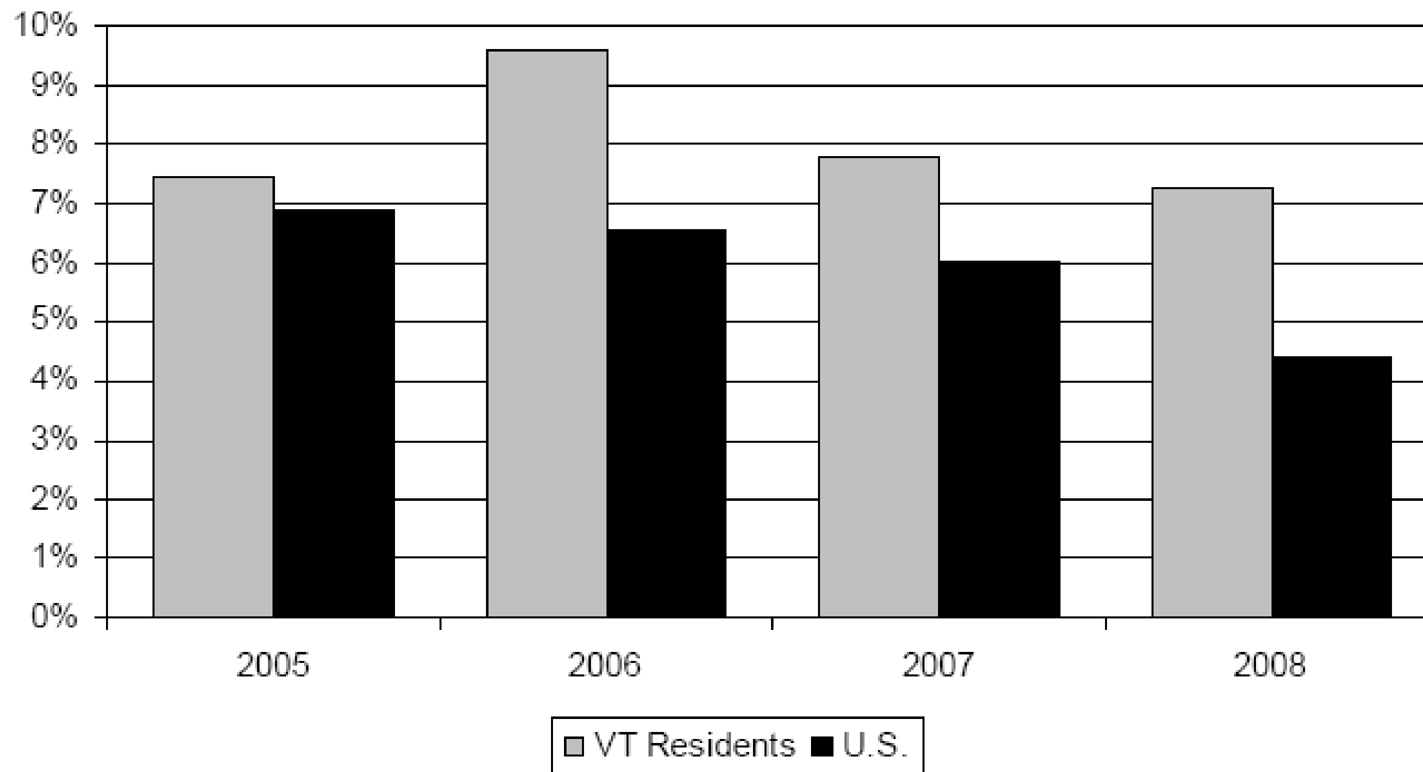
Building an Integrated System of Health

Primary Care Extension Program Summit
Metropolitan Chicago Healthcare Council
June 17, 2011

Steve Maier
Health Care Reform Manager
steven.maier@ahs.state.vt.us



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



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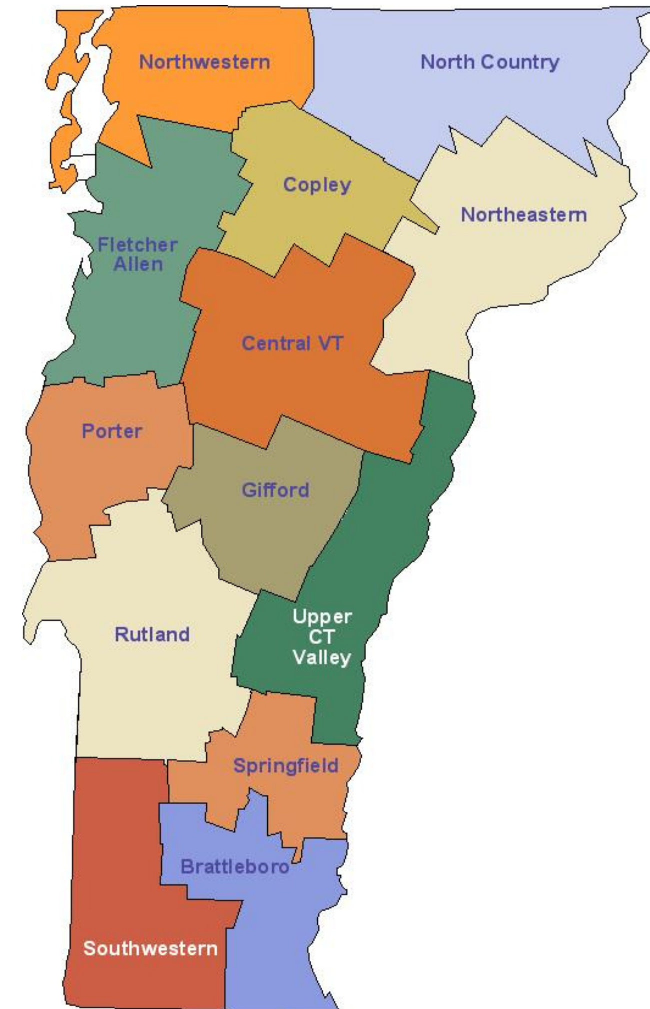
- Dedicated leadership
- Guiding Legislation
- History of working together
- Improve quality & control of costs
- Focus on prevention & wellness
- 13 Hospitals & Service Areas
- 3 major commercial insurers, Medicaid, Medicare



What is the Blueprint ?

- The Blueprint is a program acting as an agent of change
- Guiding a transition from *'Here'* to *'There'*
- *'Here'* = high cost fragmented care
- *'There'* = a foundation of high quality health services that
  - Improves healthcare and health services for individuals
  - Improves the health of the population
  - Improves control of healthcare costs

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

Vermont's Blueprint for Health is a statewide systems-based approach to reform health services. The Blueprint is designed to:

- improve access to well-coordinated preventive health services, centered on the needs of patients and families.

- coordinate services across sectors that are commonly not well-integrated (e.g. healthcare delivery, mental health & substance abuse services, social & economic services, public health services).

- Guide multi-insurer payment reform.

- Improve the rate that the general population receives recommended health assessments, adheres with preventive therapies, adapts effective self management skills, and engages in healthy lifestyles.

Continued - the Blueprint program is designed to:

- Reduce avoidable complications from chronic conditions through improved disease control and prevention, and coordinated access to the range of support services that target common contributors to poorly controlled disease.

- Reduce the rate at which healthcare costs are growing and demonstrate financial sustainability thru multi-insurer payment reform and a public-private partnership that results in;

    - An investment in the human and technical infrastructure that is necessary for preventive health services to be delivered effectively

    - A shift in current healthcare expenditures to support local Community Health Teams instead of contracted disease management services and call centers.

    - A reduction in healthcare expenditures associated with avoidable hospitalizations and emergency care.

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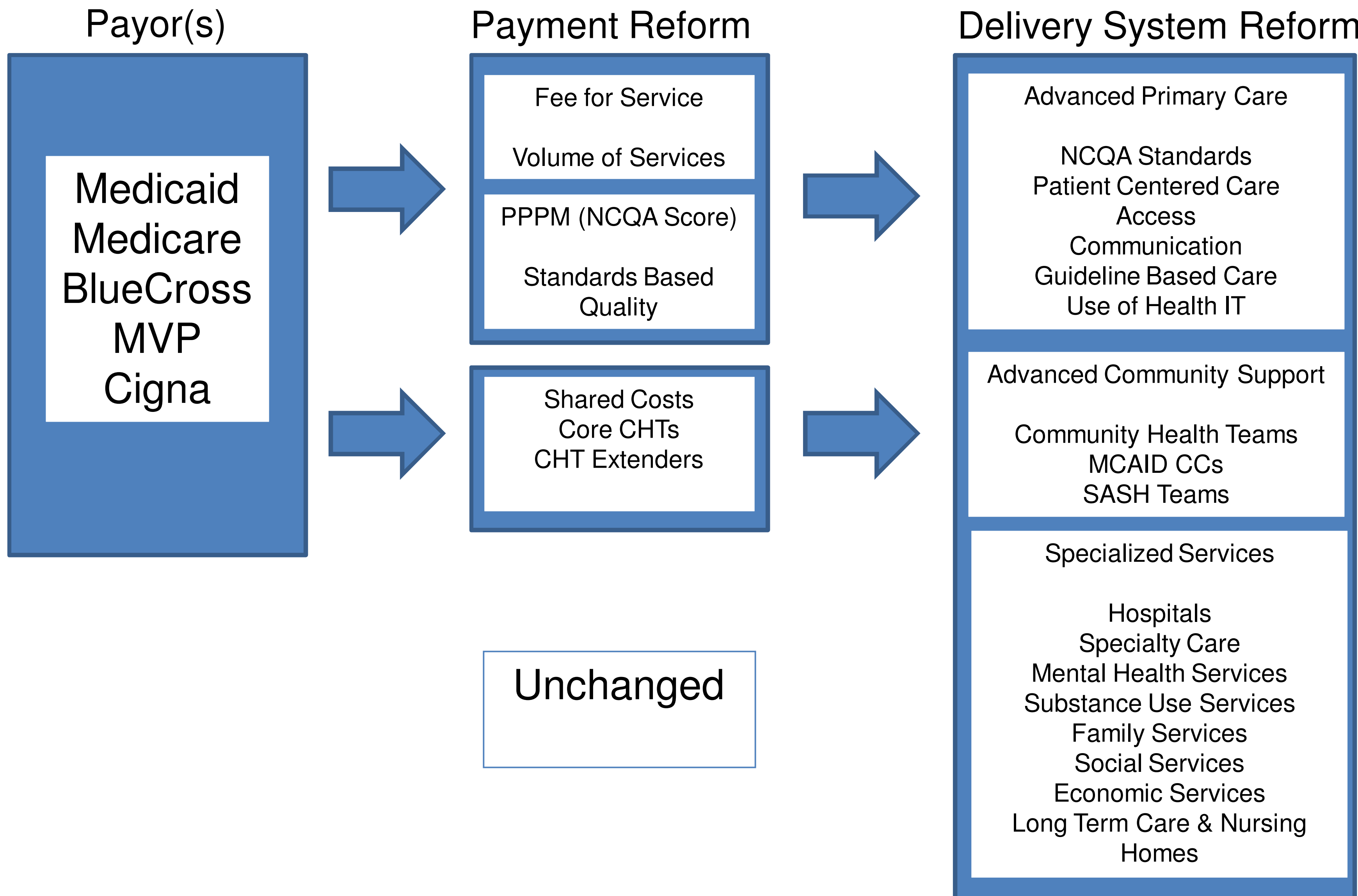

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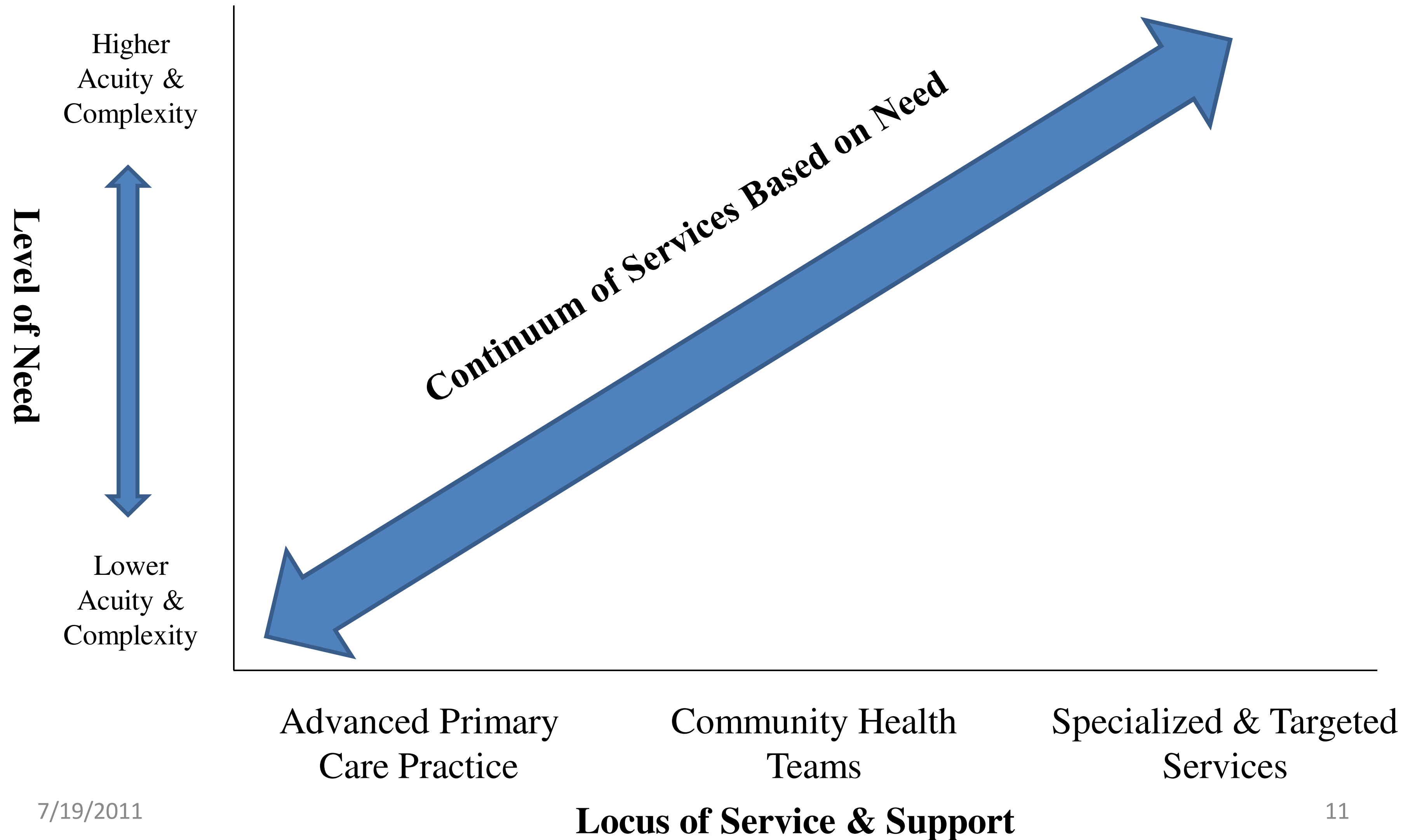
Continuum of Health Services



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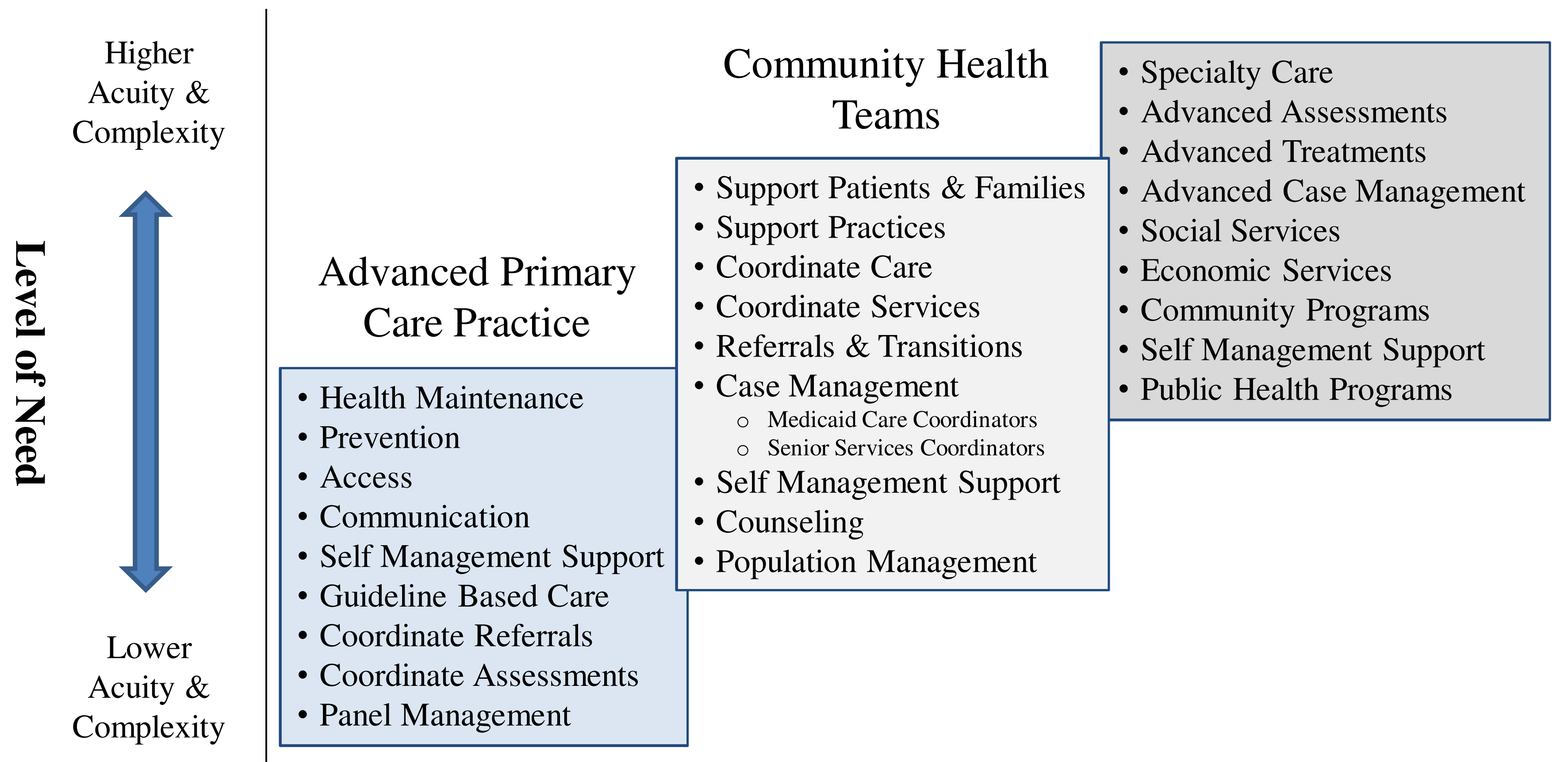
Continuum of Health Services - General



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Continuum of Health Services - General

Specialized & Targeted Services

- Specialty Care
- Advanced Assessments
- Advanced Treatments
- Advanced Case Management
- Social Services
- Economic Services
- Community Programs
- Self Management Support
- Public Health Programs

Community Health Teams

- Support Patients & Families
- Support Practices
- Coordinate Care
- Coordinate Services
- Referrals & Transitions
- Case Management
  - Medicaid Care Coordinators
  - Senior Services Coordinators
- Self Management Support
- Counseling
- Population Management

Advanced Primary Care Practice

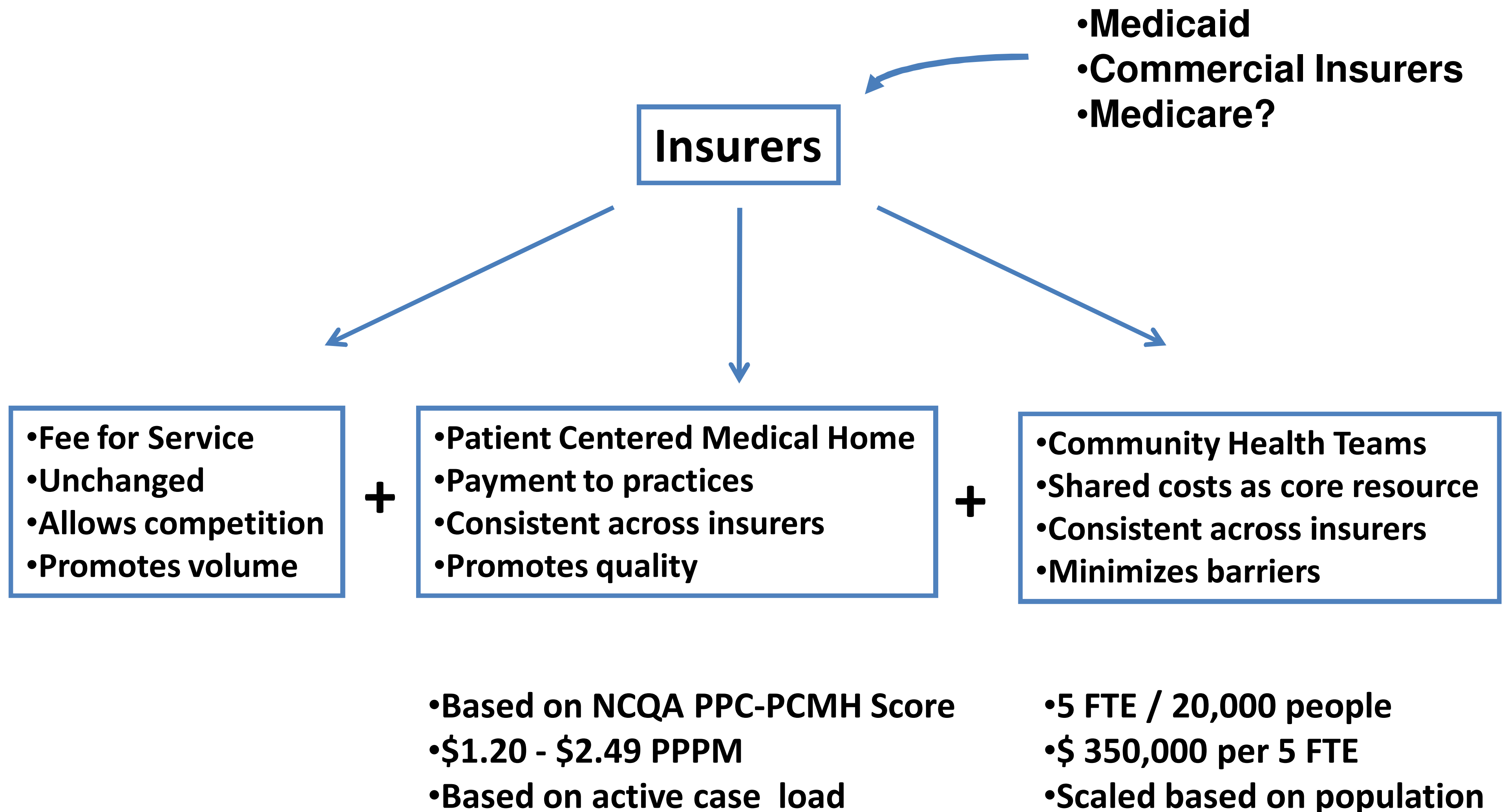
- Health Maintenance
- Prevention
- Access
- Communication
- Self Management Support
- Guideline Based Care
- Coordinate Referrals
- Coordinate Assessments
- Panel Management

Payment Reforms

Advanced Primary Care Practice	Community Health Teams	Specialized & Targeted Services
• Fee for Service • $PPPM based on NCQA score	• Costs shared by insurers • No co-pays or prior authorizations	?

- 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

Multi-insurer Payment Reforms



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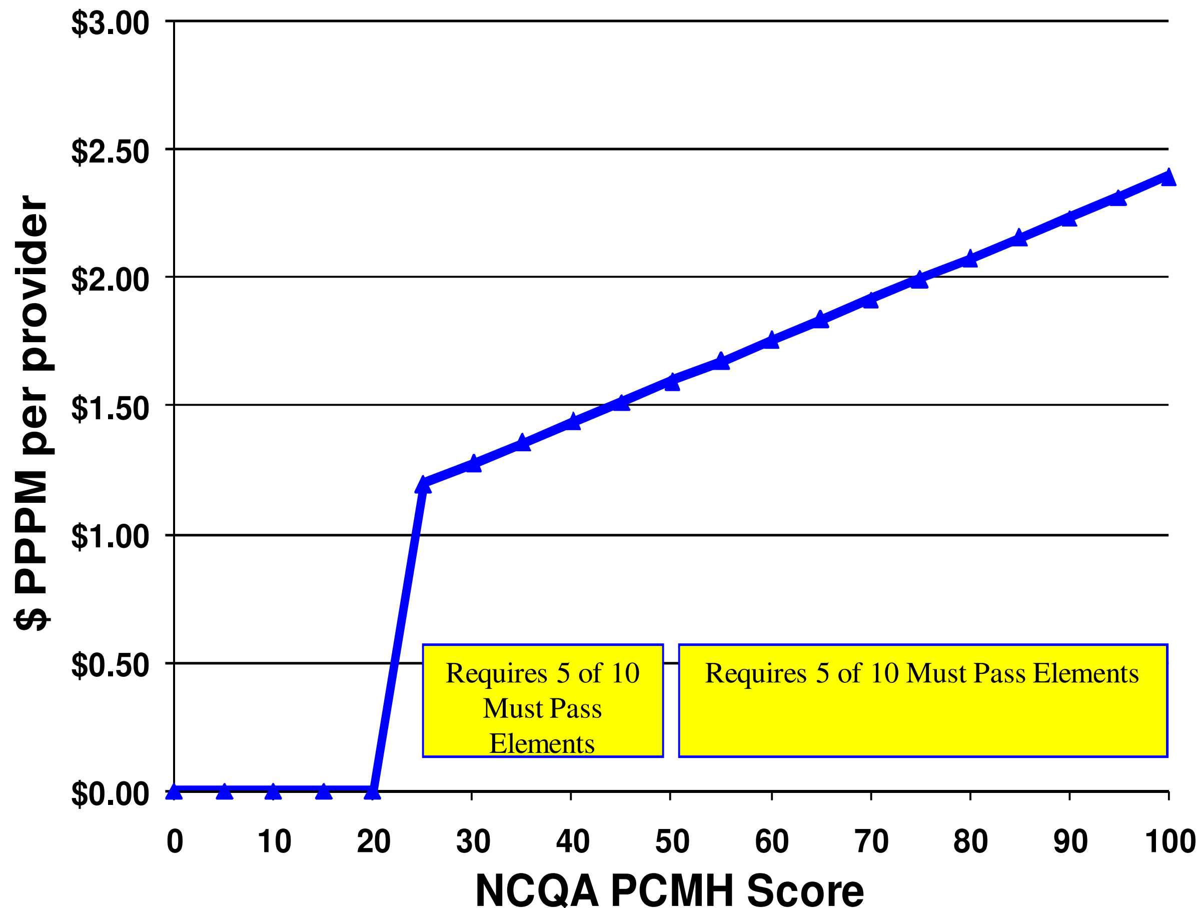

- All insurers pay enhanced payment based on a practices score as a patient centered medical home
- NCQA PCMH standards and scoring methods are used to score practices as a medical home
- Payment changes with each 5 point change in the NCQA PCMH score (score ranges from 0 – 100 points)
- Designed to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

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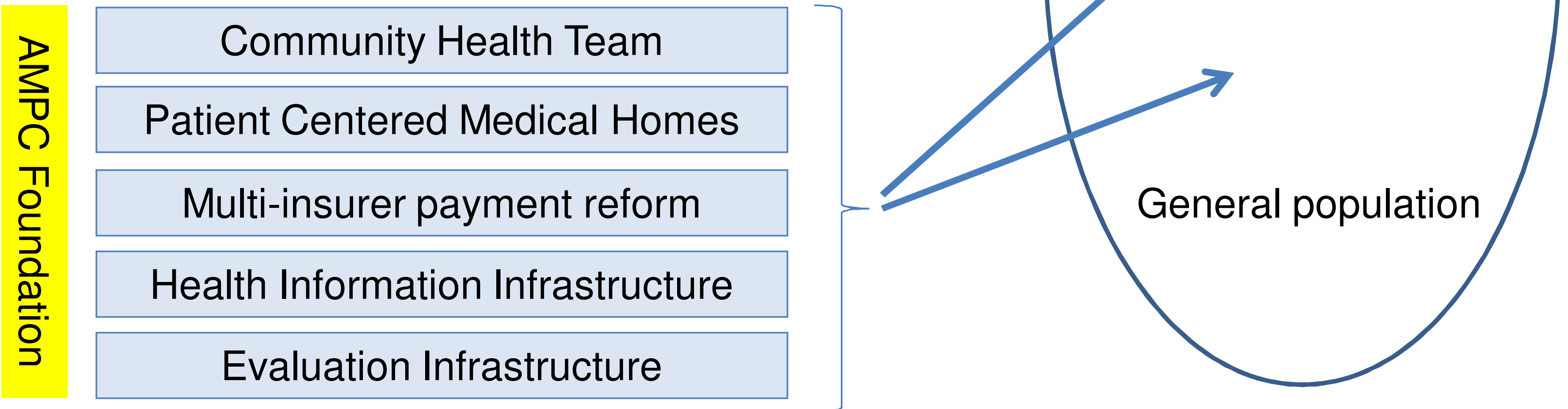
Advanced Model of Primary Care

A Foundation for integrated services



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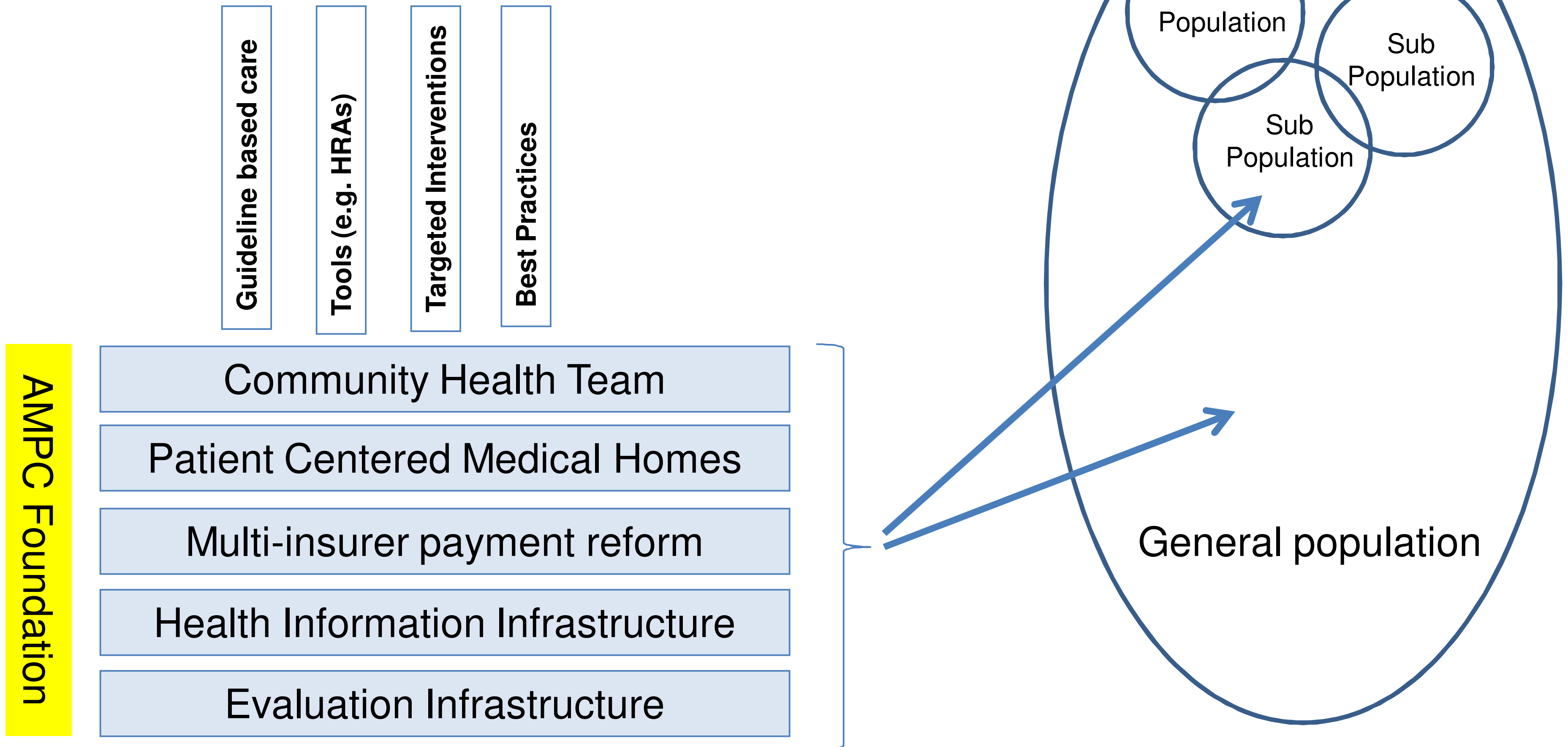

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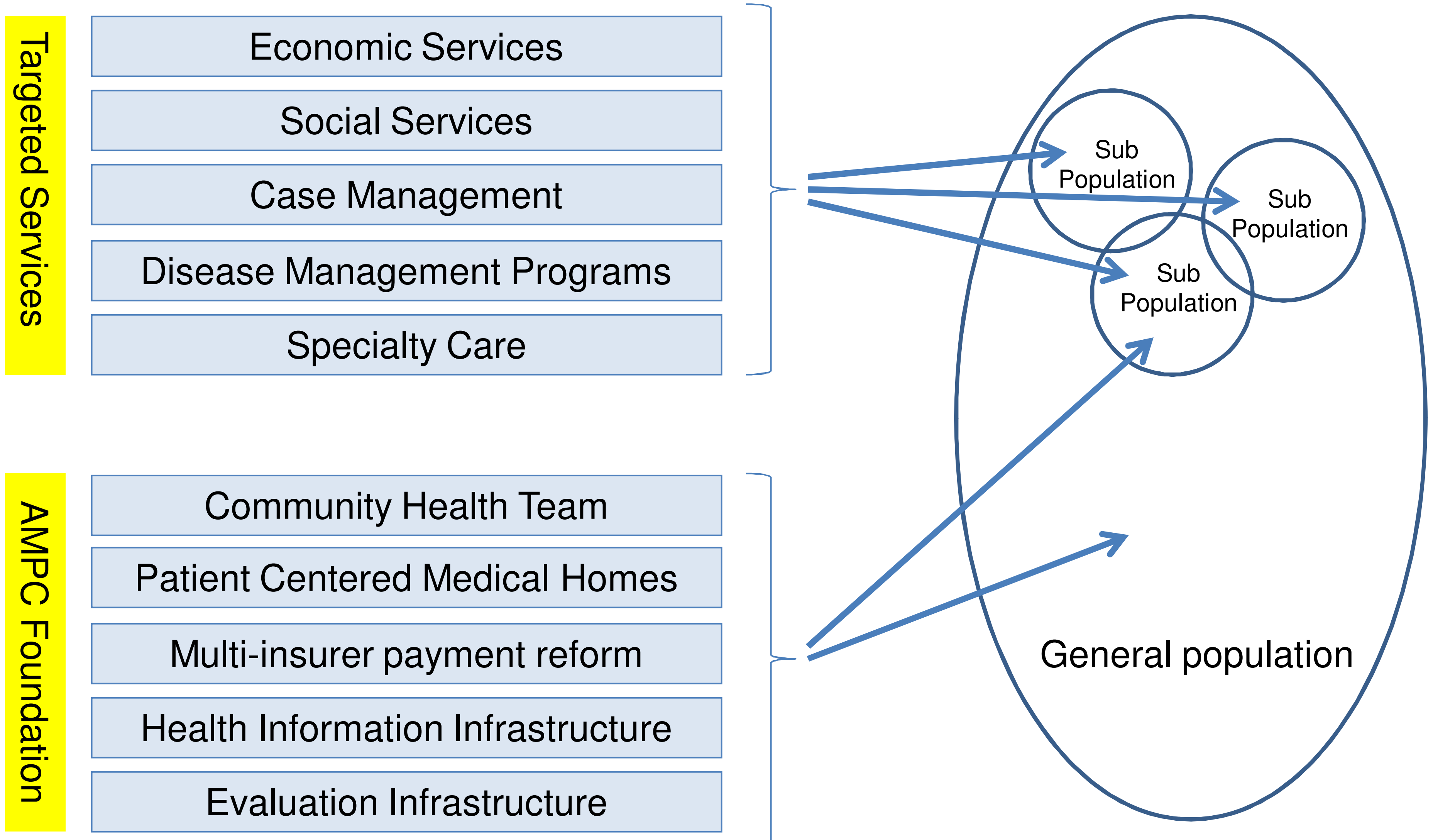

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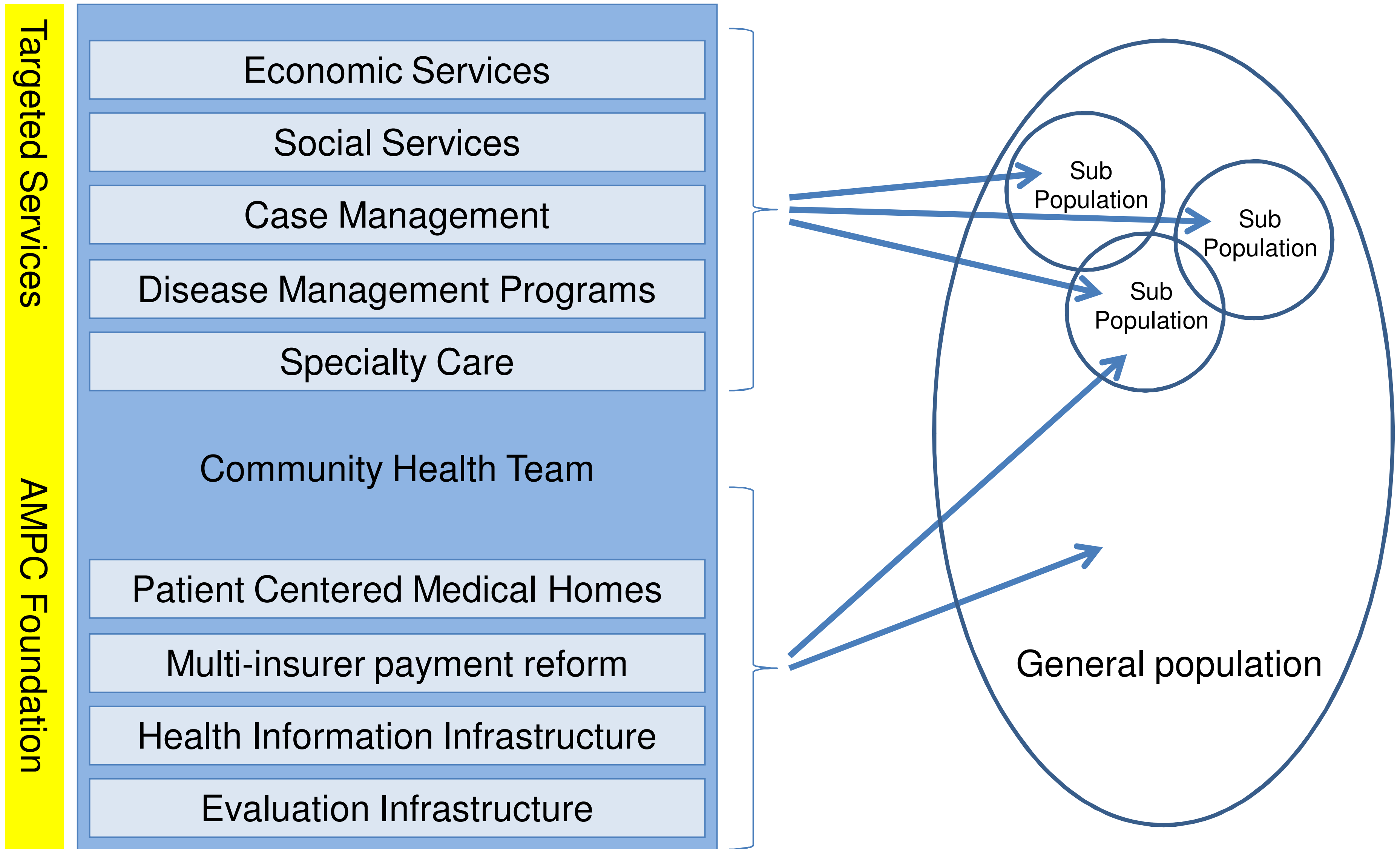
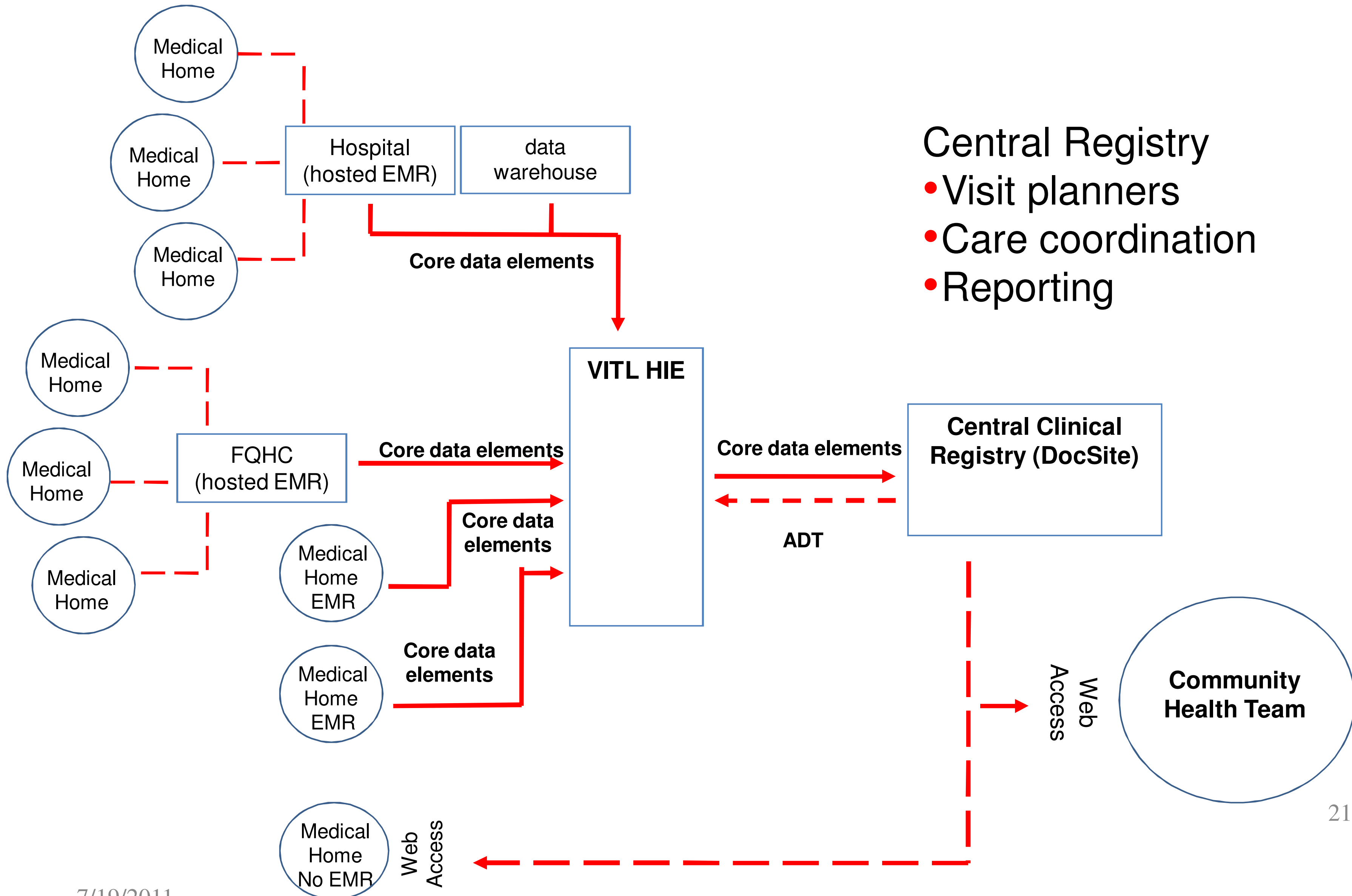


Blueprint Integrated Pilots
Health Information Infrastructure



Priorities

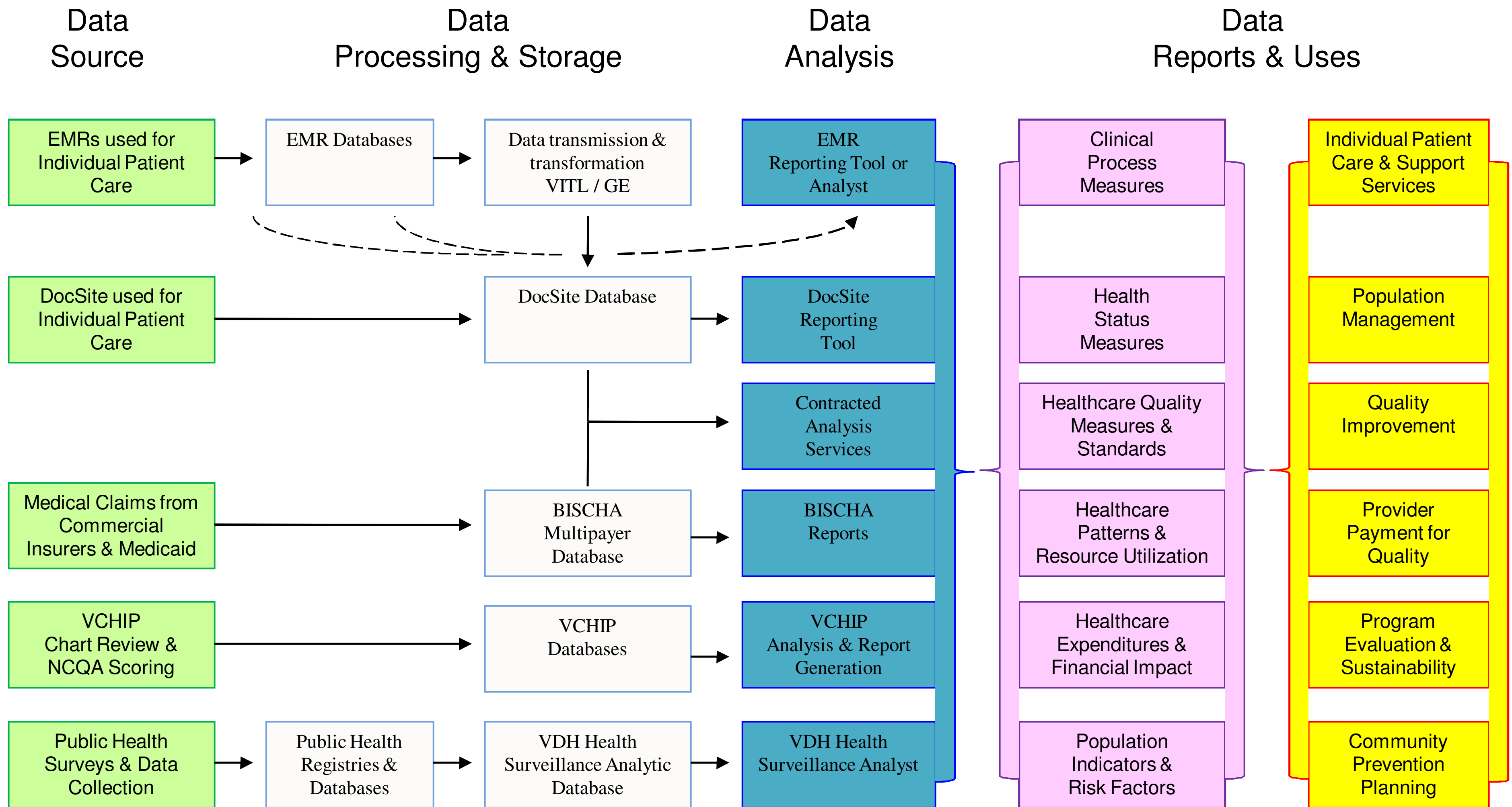
- Transformation vs. Research
- Don’t interfere with health services …. but

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

Blueprint Integrated Pilots

Evidence Based Quality Improvement



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
Public Health Registries	▪Population level ▪Risk Factors ▪Guide planning ▪Track change	▪Standard Reports

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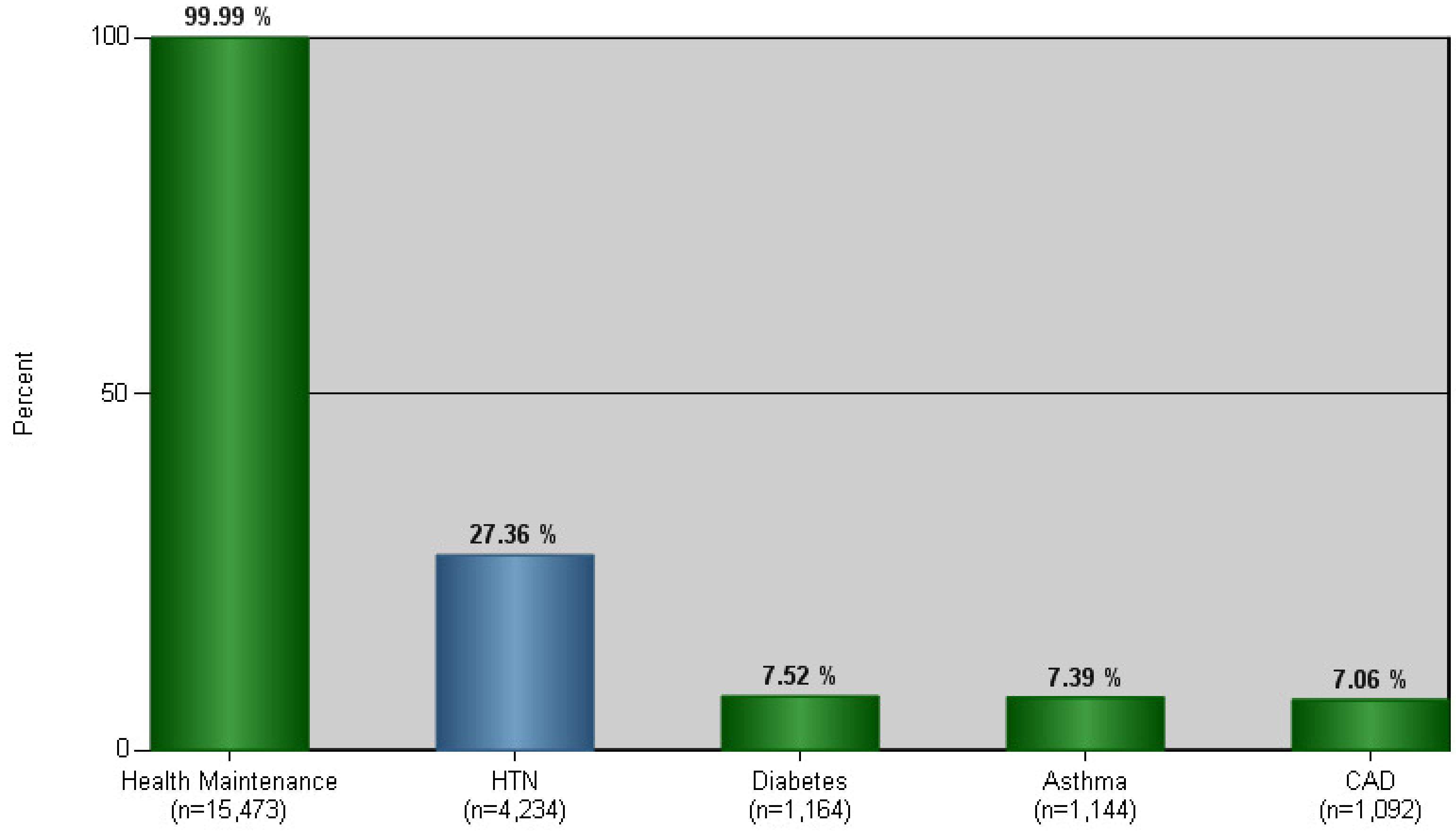
Conditions & Services



Gender Distribution

Gender	Population
Female	2,289
Male	1,945

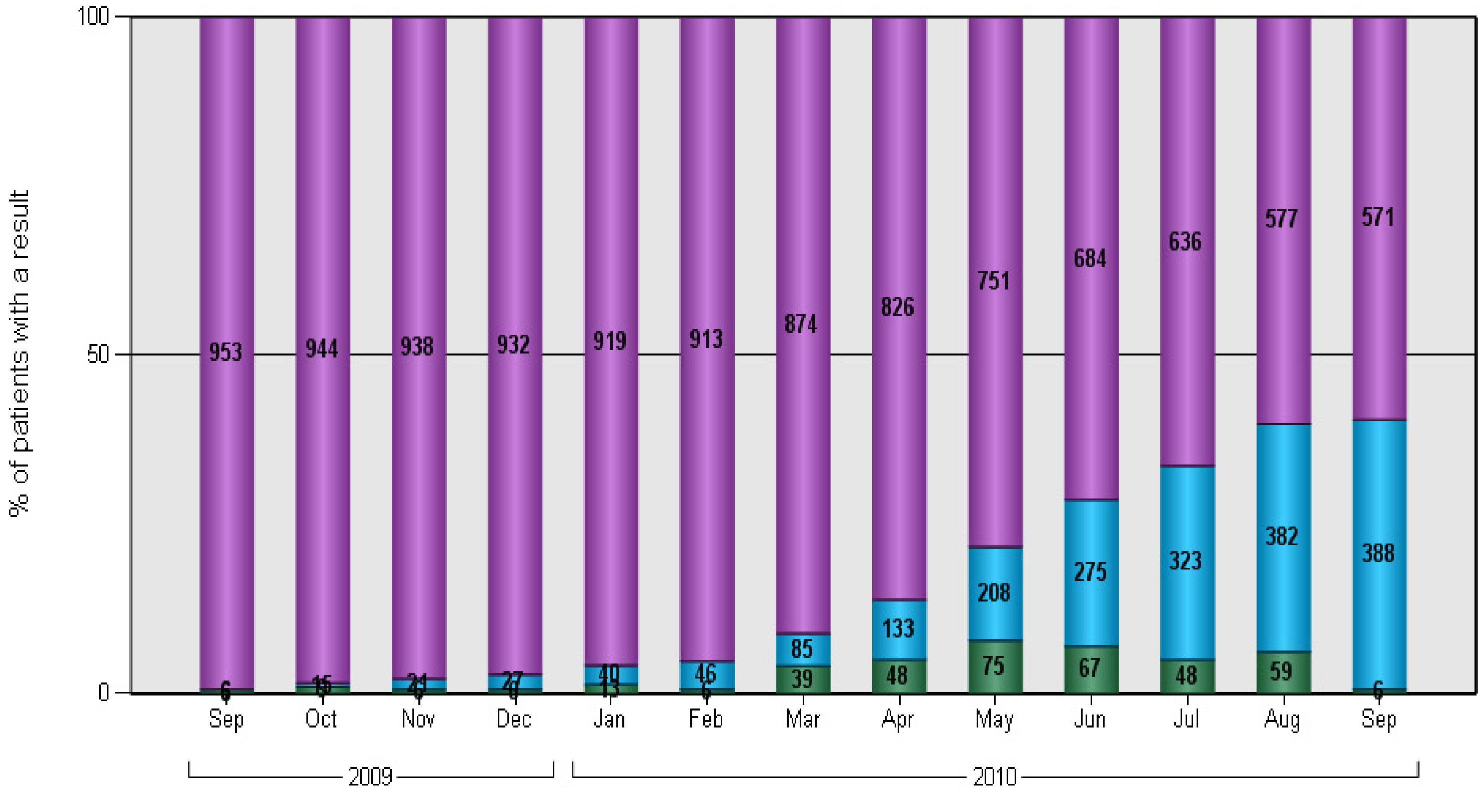
Age Distribution

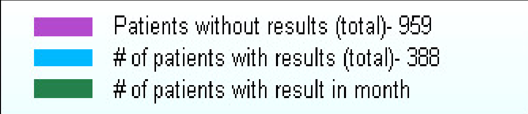
Age Distribution Bracket	Population
18 To 65	1,880
65 To 80	1,453
80 and Above	901

Monthly Measure Acquisition

Measure:Body Mass Index

Site:Independent Practice 2





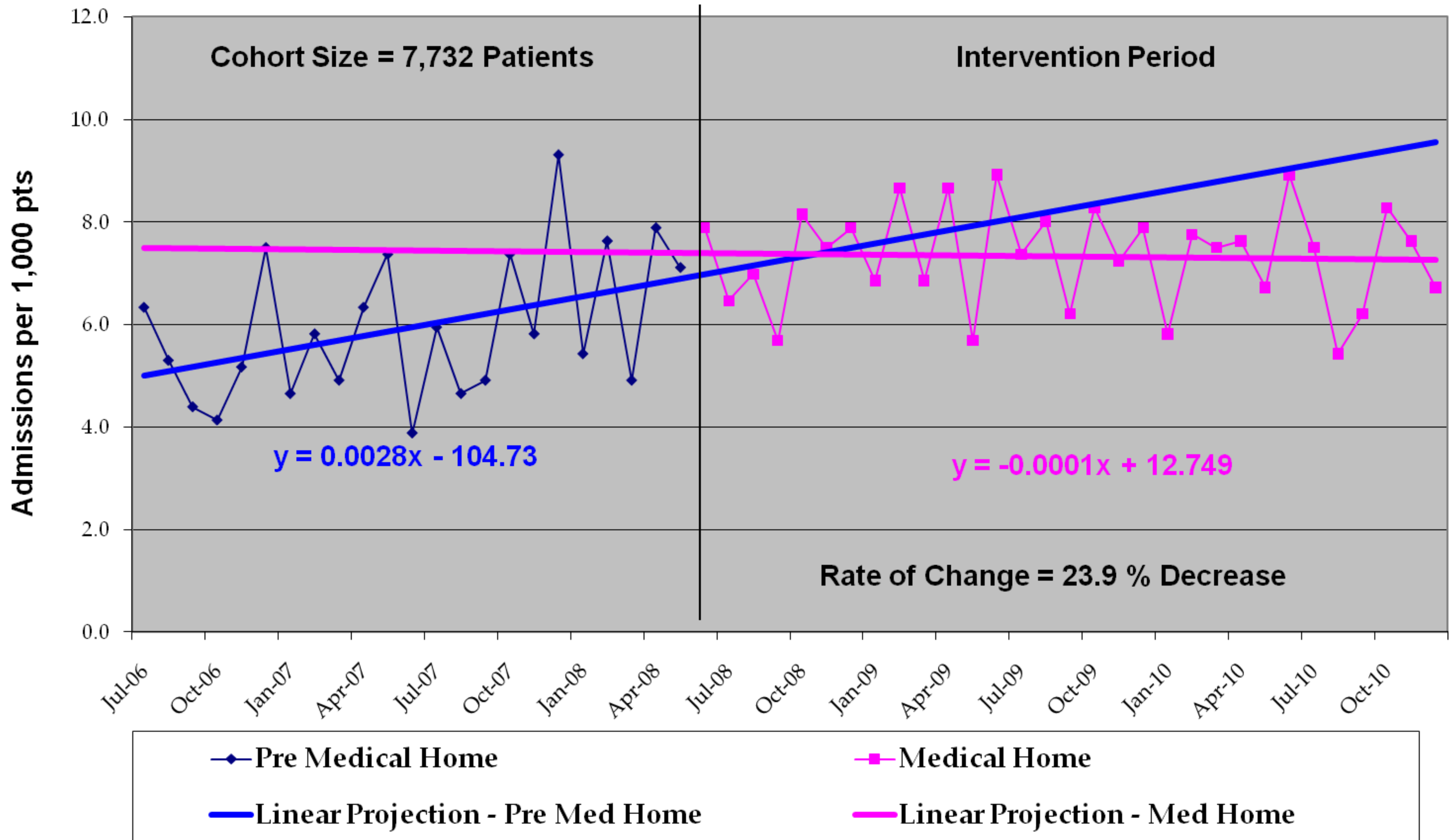
Final Month Evaluation:

# 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

Early Trends & Results



Northeastern Vermont Regional Hospital nvrh

Data Provided by Northeastern Vermont Regional Hospital
Analysis Prepared by Jeffords Institute Fletcher Allen Health Care

Burlington Service Area – Medicaid Blueprint Cohort
Inpatient Admission Rate Per 1,000 Patients

Cohort = 1,313 Patients

Intervention

y = -0.0056x + 242.13

y = 0.008x - 303.25

Rate of Change = 24.9% Decrease

Rate Per 1,000 Patients

30
25
20
15
10
5
0

Jan-06, Apr-06, Jul-06, Oct-06, Jan-07, Apr-07, Jul-07, Oct-07, Jan-08, Apr-08, Jul-08, Oct-08, Jan-09, Apr-09, Jul-09, Oct-09, Jan-10, Apr-10

Jan 06 - Sep 08

Oct 08 - June 10

Linear Projection (Jan 06 - Sep 08)

Linear Projection (Oct 08- Jun 10)

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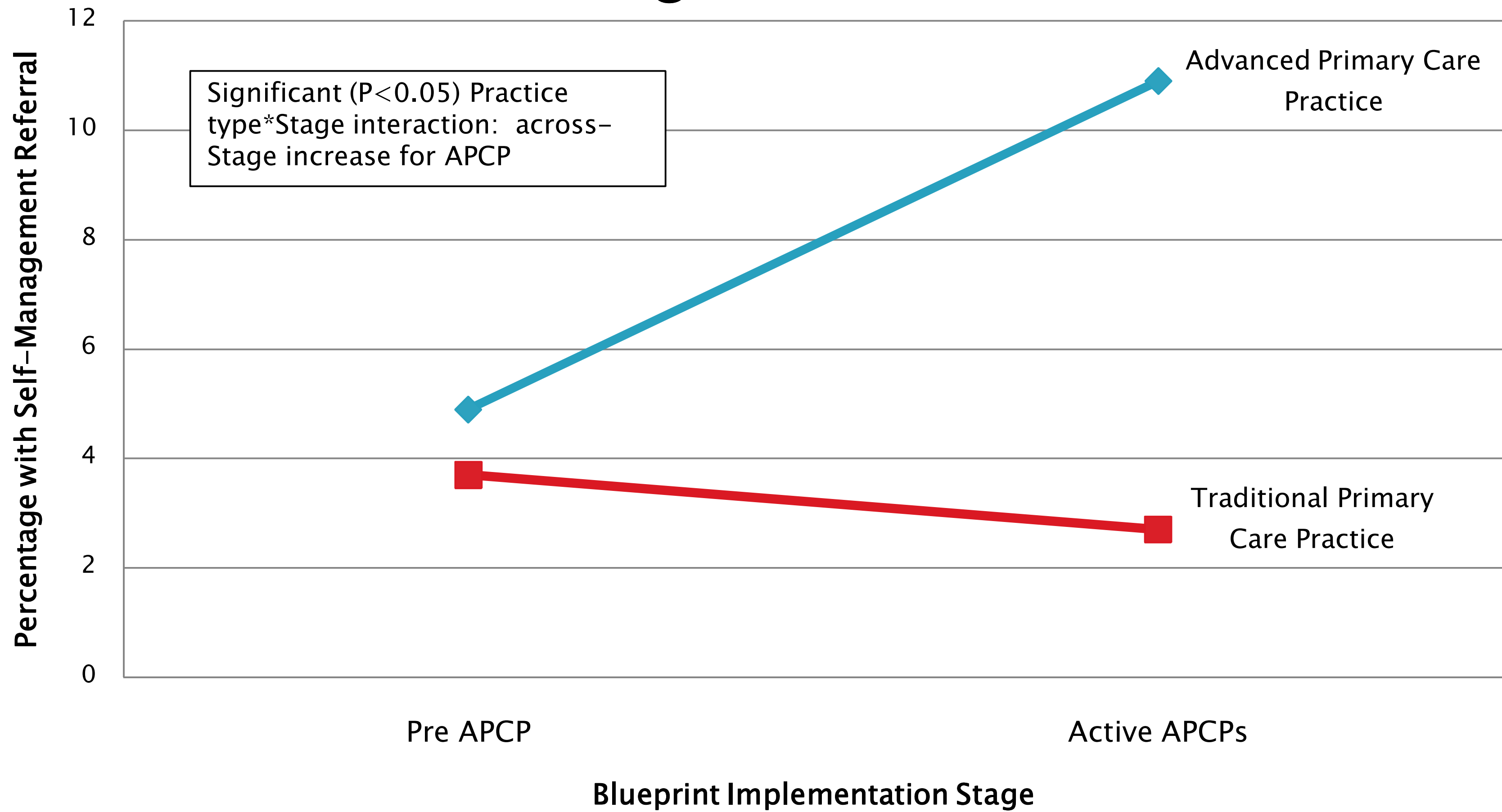
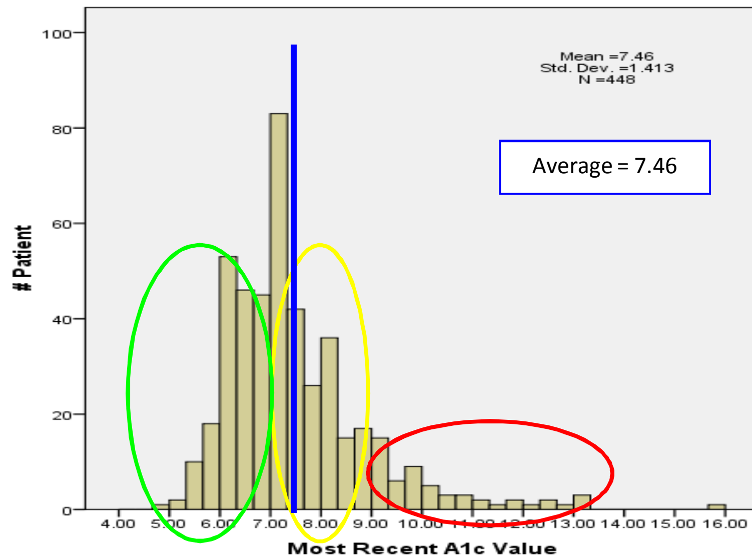
Data Provided by Department of Vermont Health Access
Analysis Prepared by Jeffords Institute Fletcher Allen Health Care

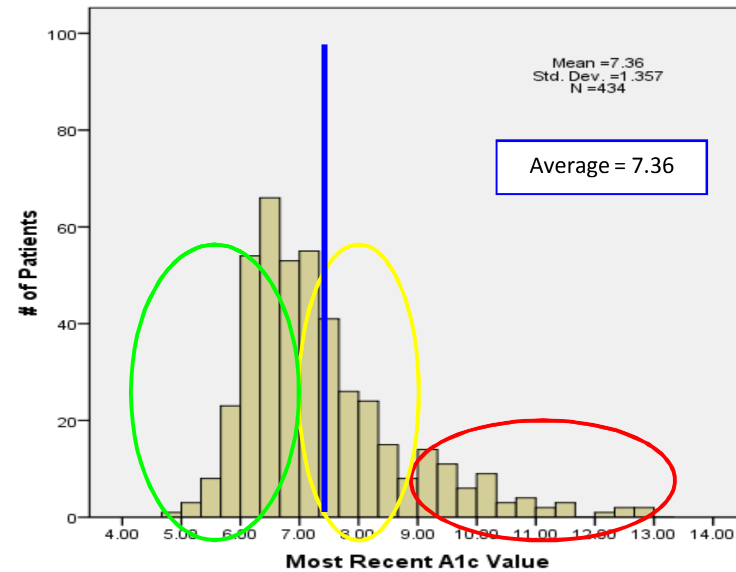
Percentage of Hypertension Records with Self Management Referral



Pre APCP: Before HSAs had established APCPs in their community. Represents the time period within 2 years prior to the implementation of APCPs.
Active APCPs: HSAs have established APCPs in their community. Represents the time period within 1 year after the APCP was implemented.

Distributions vs. Averages





Group 1
Good Disease
Control

Group 2
Intermediate
Disease
Control

Group 3
Poor
Disease
Control

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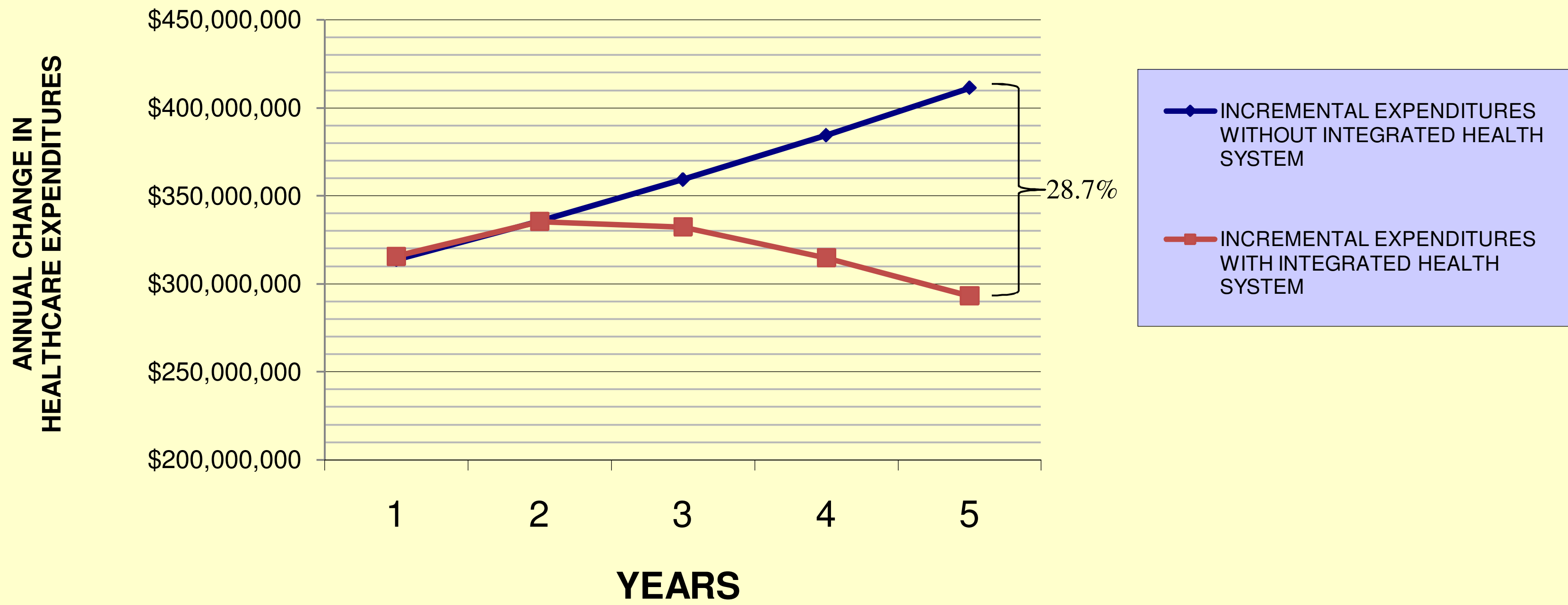

Target Population	**42,179**	**126,286**	**316,662**	**508,17**	**637,130**
% of VT Population	**6.7%**	**20%**	**50%**	**80%**	**100%**
# CHTs	**2**	**6**	**16**	**25**	**32**

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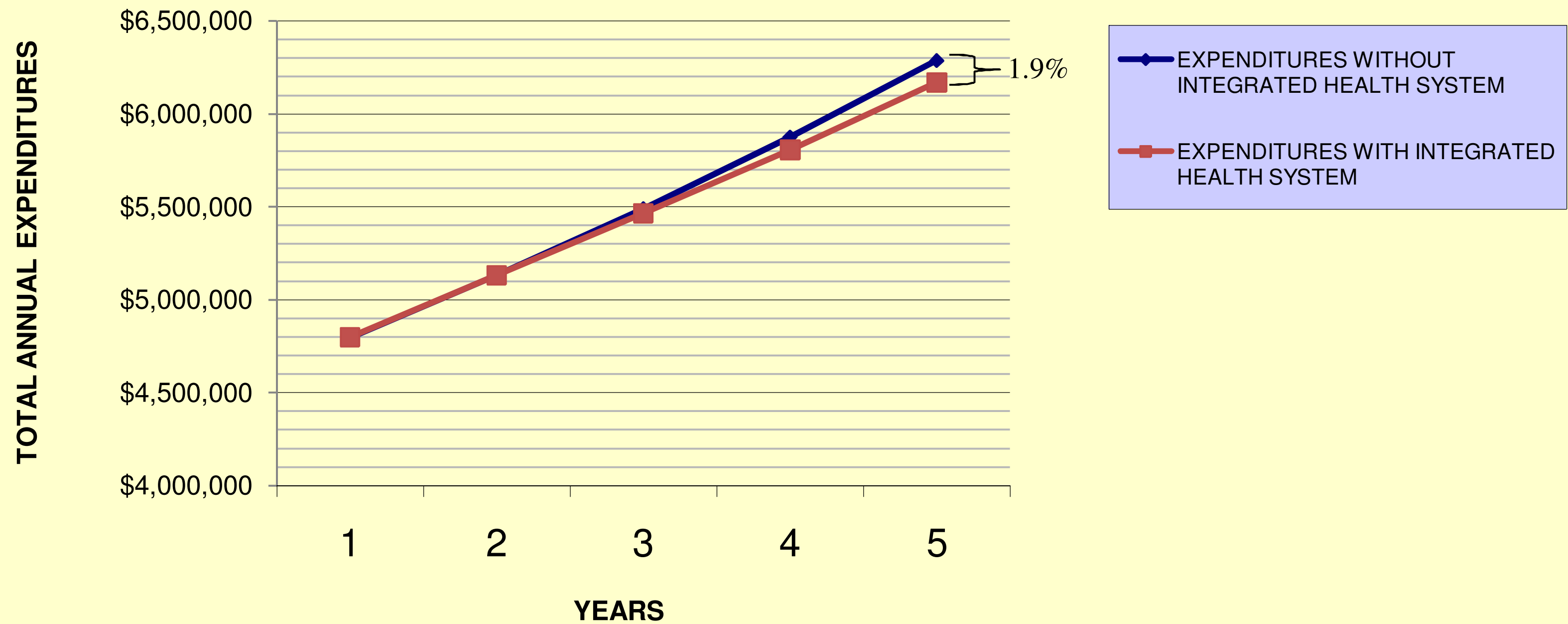

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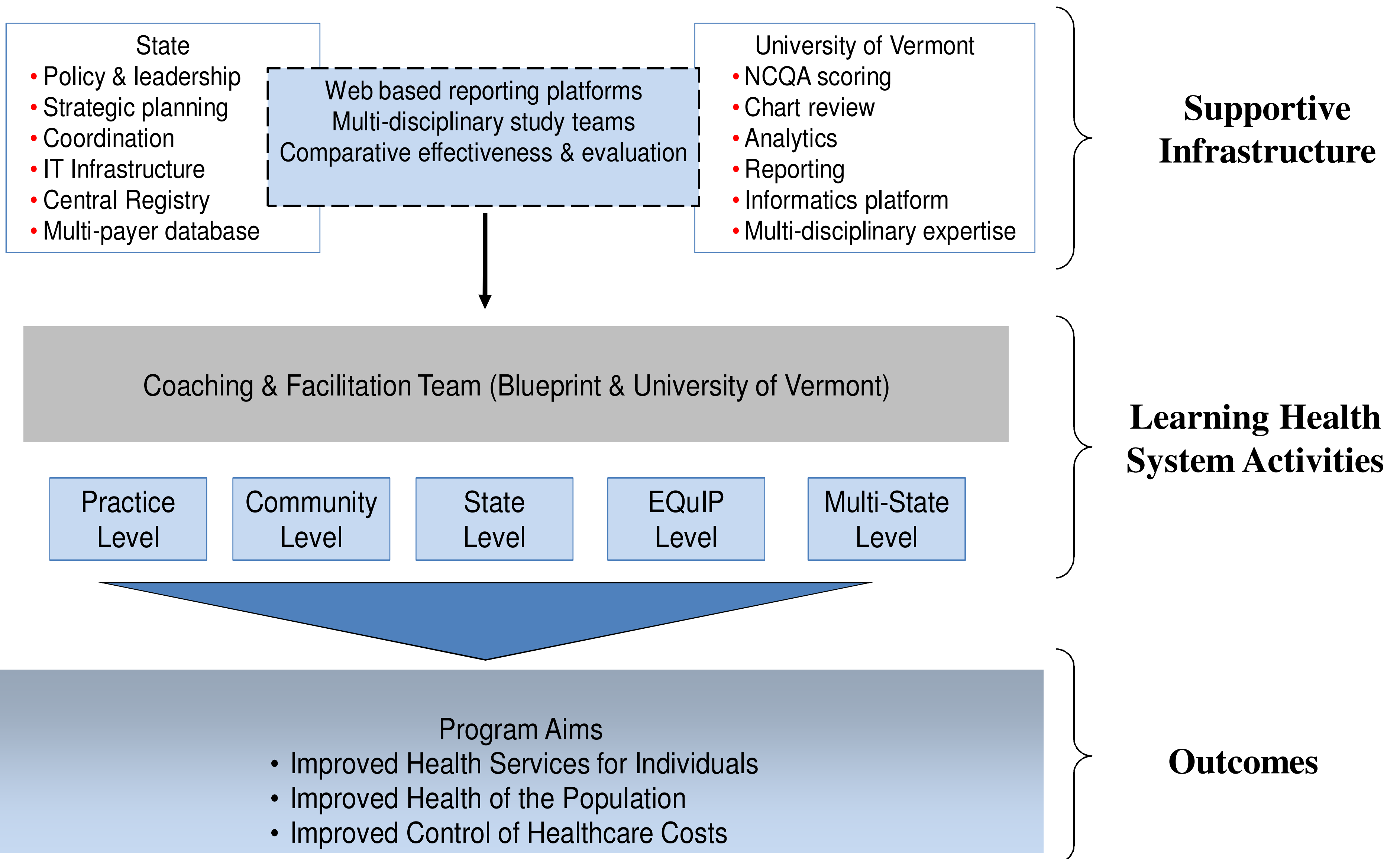
Program Expansion - Convergence & Opportunity

- Vermont Statute (Act 128) – statewide expansion of medical homes, community health teams, and multi-insurer payment reforms. Requires all VT insurers to participate. Two practices in each HSA by July 2011, and all willing providers by 2013.

- CMS Multi-payer Advanced Primary Care Practice Demonstration. Medicare to join state led multi-insurer payment reforms that support an advanced model of primary care. Must include Medicaid and private insurers

Expansion & Quality Improvement Program



Teams embedded in the model:

- Practice Based Teams (care delivery, QI)
- Community Health Team (core)
- Community Health Team (functional)
- Facilitation & Implementation Team (coaches)
- Interdisciplinary Evaluation Team
- State Leadership, Strategic Planning & Policy Team

Blueprint Expansion

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

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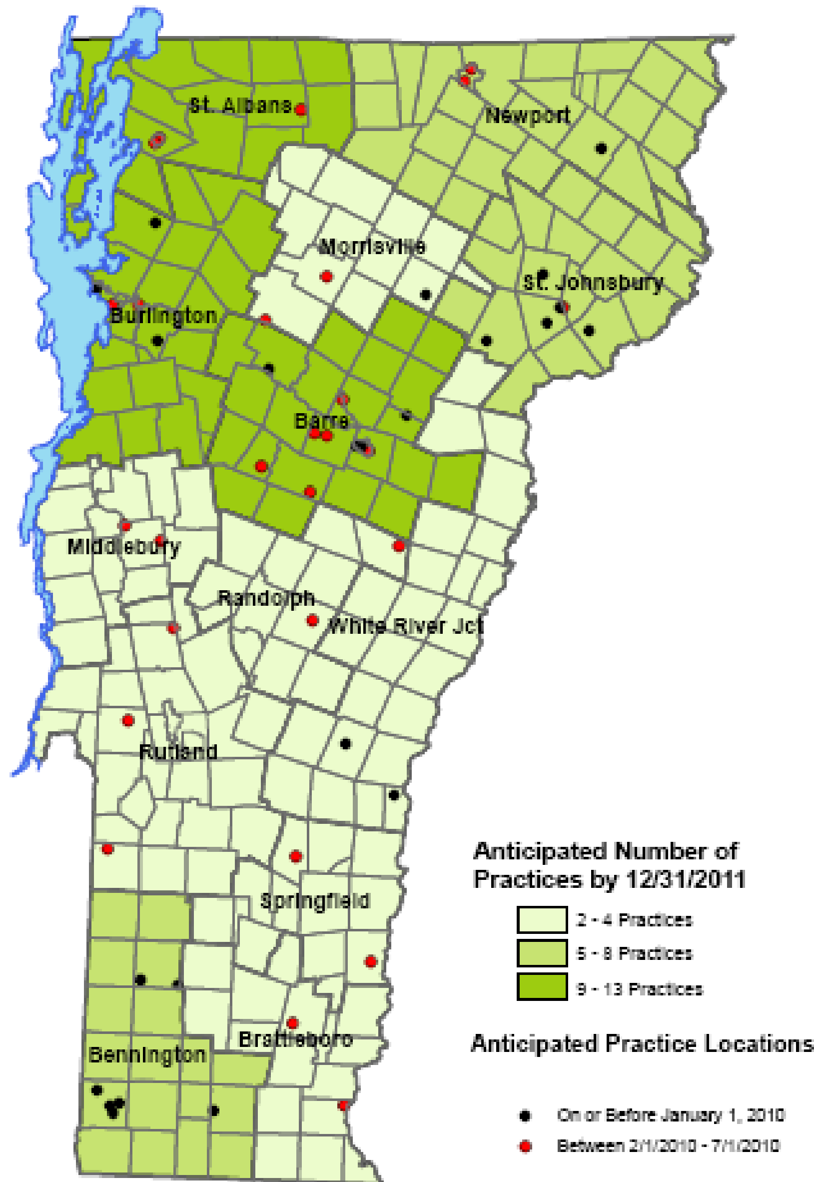

Next Steps in Payment Reform – Phase II

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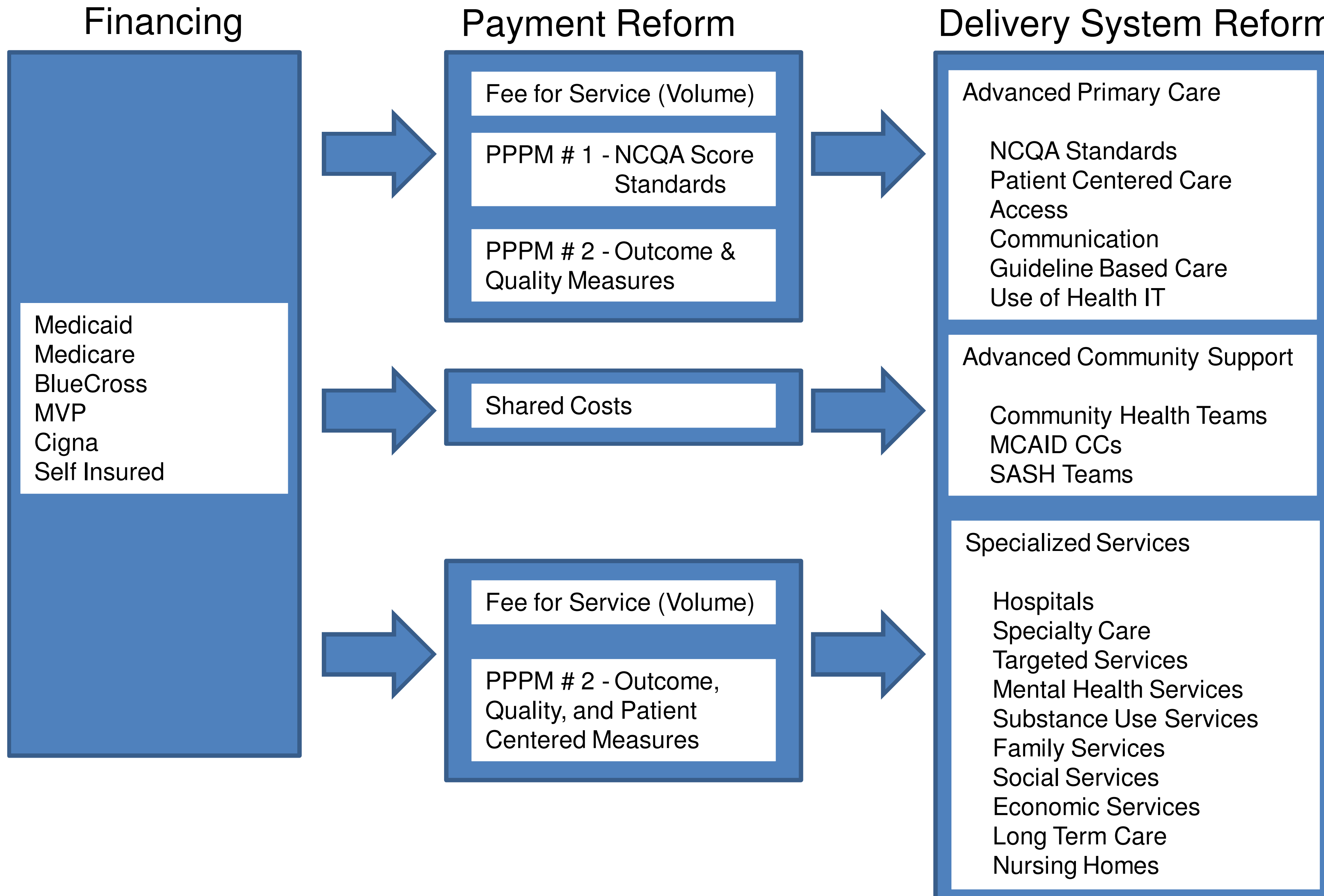
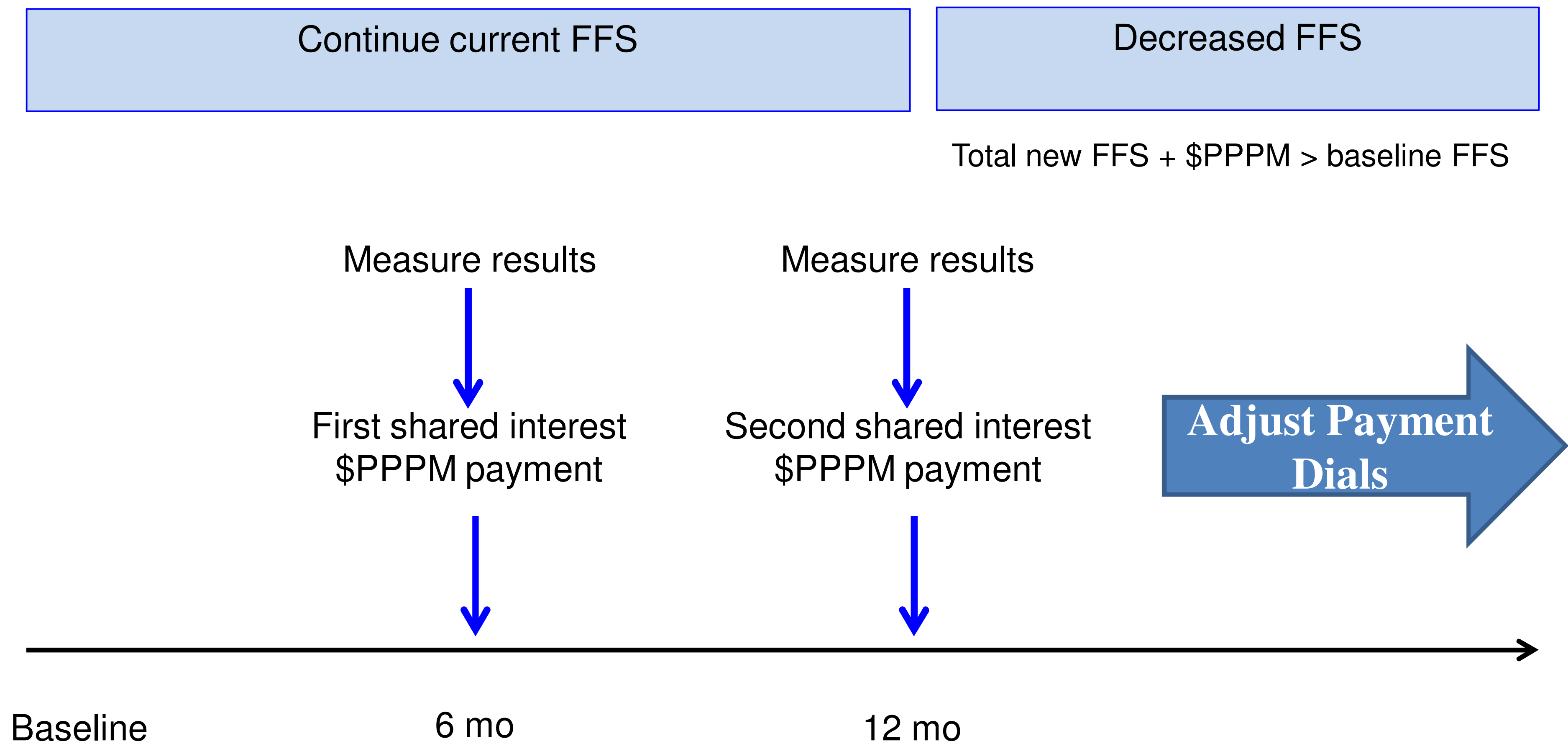


Payment Based on Shared Interests: PCPs & Specialists

Adjustable outcomes based payment – ongoing refinement



Design Principles

- PCPs & Specialists share common goals & interests
- Promotes coordination of services
- Incentive to make sure that patient has a medical home
- Balanced incentives (quality-prevention-access-control of costs)
- Incentives to improve the patient experience and engagement in care
- Equal payment incentives to PCPs & Specialists
- Encourages provider relationships as Accountable Care Partners
- Builds on established (and successful) payment methodologies
- Builds on established measurement capabilities
- Does not require new organizations or administrative entities
- Adjustable payment streams applicable in any financing system

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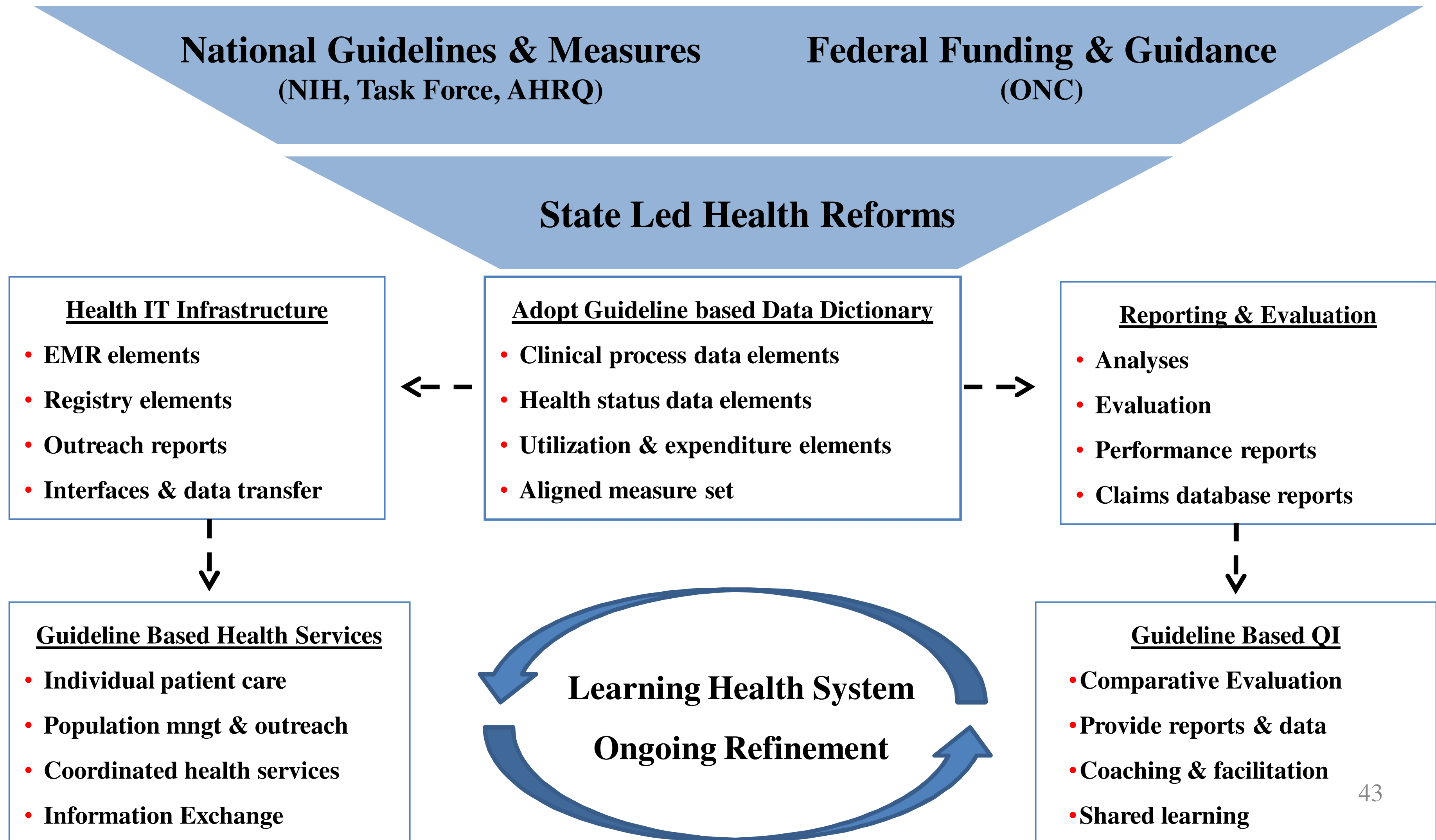
State & Federal Partnerships

Example - Health information & quality infrastructure



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State & Federal Partnerships

Example - A guideline based learning health system

	Organizing Principles & Guidelines	Guideline & Standards Implementation Action		Strategic Support for Delivery System Reforms	Operationalize a Learning Health System
IOM	Strategy Map, Framework, and Guiding Principles for a Learning Health System & Supportive Electronic Infrastructure	Consensus oriented process to review, refine, and update recommendations for a Learning Health System		Dissemination of recommendations for implementation and evaluation of Learning Health System operations across the country	
National Institutes & Agencies	National guidelines include key assessments, & recommended treatment options	Recommend guideline based core data elements (eg. Process and health status)	Recommend metrics aligned directly with core data elements	Support for health services & translational research linked to use of recommended data elements, measures, assessments, and treatment options.	Participation in Learning Health System activities, shared learning, dissemination of outcomes & best practices, ongoing refinement of guidelines
CMS	Guidelines for optimizing delivery system strategies (quality, cost, patients experience)	Recommend core data elements for tracking quality, cost, and patient experience (include utilization, expenditures)	Recommend metrics aligned directly with core data elements	Demonstrations with payment strategies that promote tracking, use, and exchange of guideline based data elements & metrics	Participation in Learning Health System activities, shared learning, dissemination of effective clinical models and financial reforms
ONC	Technical standards for data exchange	Stage 1 meaningful use promotes use of EHRs that meet technical standards	Metrics for evaluating Stage 1 of meaningful use	Align stages 2 & 3 of meaningful use, and financial incentives, with tracking, use, and exchange of guideline based data elements & metrics	Participation in Learning Health System activities, shared learning, dissemination of effective health information models, refinement of meaningful use strategies
States (regions, systems)	Guiding legislation or policy for a Learning Health System & Supportive Electronic Infrastructure	Evidence based models & standards for implementing delivery system reforms and a supportive electronic infrastructure		Dedicated leadership & resources for implementation of Delivery System Reforms & Electronic Infrastructure	Lead implementation and ongoing refinement of guideline based health services …. Learning Health Systems

Section 4001:
National Prevention, Health Promotion and Public Health Council
An Opportunity to Create Long Term Health in the Nation

Title I
Quality, Affordable Health Care for All Americans

Section 1001/Section 2717: Public Health Service Act wellness and prevention program amendments

Title II
Role of Public Health

Section 2704, Demonstration project to evaluate integrated care around a hospitalization

Title III
Improving the Quality and Efficiency of Health Care

Section 3011, National strategy to improve health care quality
Section 3012, Interagency Working Group on Health Care Quality
Section 3021, Establishment of Center for Medicare and Medicaid Innovation within CMS
Section 3023, National Pilot Program for hospitalization integrated care
Section 3026, Community-Based Care Transitions Program for high-risk Medicare beneficiaries
Section 3501, Health Care Delivery System Research; Quality Improvement Technical Assistance
Section 3502, Establishing Community Health Teams to Support the Patient-Centered Medical Home
Section 3503, Medication Management Services in the Treatment of Chronic Disease
Section 3506, Program to Facilitate Shared Decision Making among patients, caregivers and clinicians
Section 3509, Improving Women's Health through establishment of various Womens' Offices within HHS

Title IV
Prevention of Chronic Disease and Improving Public Health

Section 4002, Prevention and Public Health Fund
Section 4003, Clinical and Community Preventive Services
Section 4004, Education and outreach campaign regarding preventive benefits
Section 4102, Oral healthcare prevention activities
Section 4103, Medicare coverage of annual wellness visit providing a personalized prevention plan
Section 4105, Evidence-based coverage of preventive services in Medicare
Section 4108, Incentives for prevention of chronic diseases in Medicaid
Section 4201, Community Transformational Grants for evidence-based community preventive health activities
Section 4202, Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries
Section 4204, Demonstration to improve immunization coverage
Section 4206, Demonstration project concerning individualized wellness plan
Section 4301, Research on optimizing delivery of public health services
Section 4302, Understanding health disparities: data collection and analysis
Section 4303, CDC and employer-based wellness programs
Section 4305, Advancing research and treatment for pain care management
Section 4401, Sense of the Senate concerning CBO scoring
Section 4402, Effectiveness of Federal health and wellness initiatives

Title V
Health Care Workforce

Section 5101, National Health Care Workforce Commission

Section 5205, Allied Health Workforce Recruitment and Retention Programs

Section 5405, Primary Care Extension Program

Section 5604, Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings

Title VI
Transparency and Program Integrity

Section 6301, Patient-Centered Outcomes Research

Title X
Strengthening Quality, Affordable Care for All Americans

Section 10408, Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs

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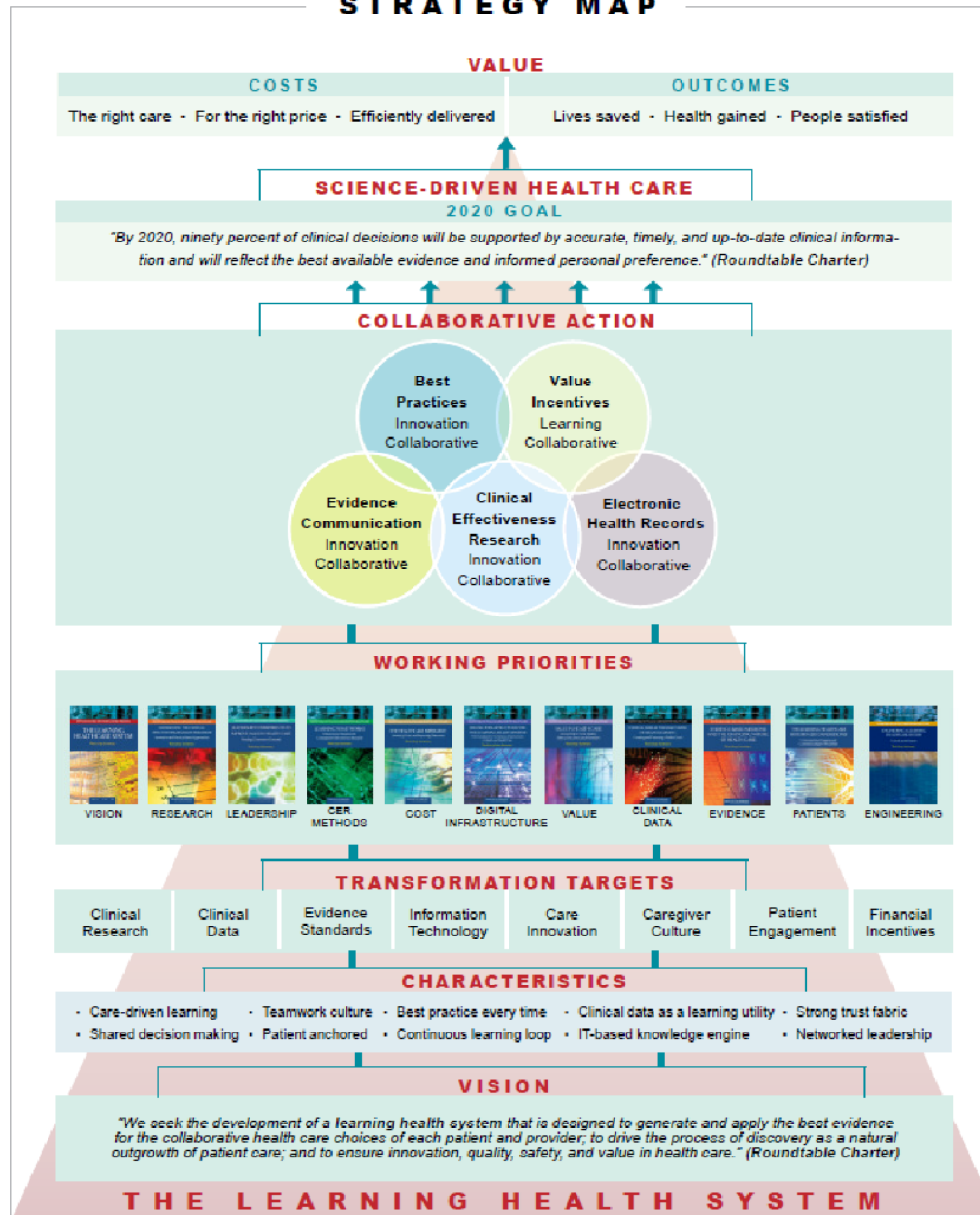
IOM ROUNDTABLE ON VALUE & SCIENCE-DRIVEN HEALTH CARE



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ENTRY POINT
Improving The Preexisting Condition Program In Health Reform

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A Medical Resident's Tale Of Teaching & Learning In Africa

ANALYSIS & COMMENTARY
Raising The Standards For Review Organizations & Health Plans

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

Health Affairs

Profiles Of Innovation In Health Care Delivery

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Sutter VNA & Hospice In California
A New Paradigm For Care Near The End Of Life
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The Care Span: Moving Forward On Long-Term Services & Supports
Susan C. Reinhard et al.
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Palliative Care Teams Cut Hospital Costs
R. Sean Morrison et al.
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Transforming Physician Practices Into Medical Homes
Paul A. Nutting et al.
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Wellness At Johnson & Johnson: Long-Term Savings
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PLUS:
The Net Benefits Of Health Information Technology
Melinda Beeuwkes Buntin et al.

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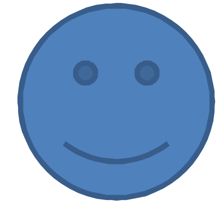
TOWARD THE TRIPLE AIM

Is the Blueprint also a jobs & workforce program ?



- Community Health Team members
- Growing number of corporations moving jobs to communities with robust primary care, quality, and cost advantages
  - IBM
  - GE
  - Boeing
  - Others?
- Attractive environment for providers