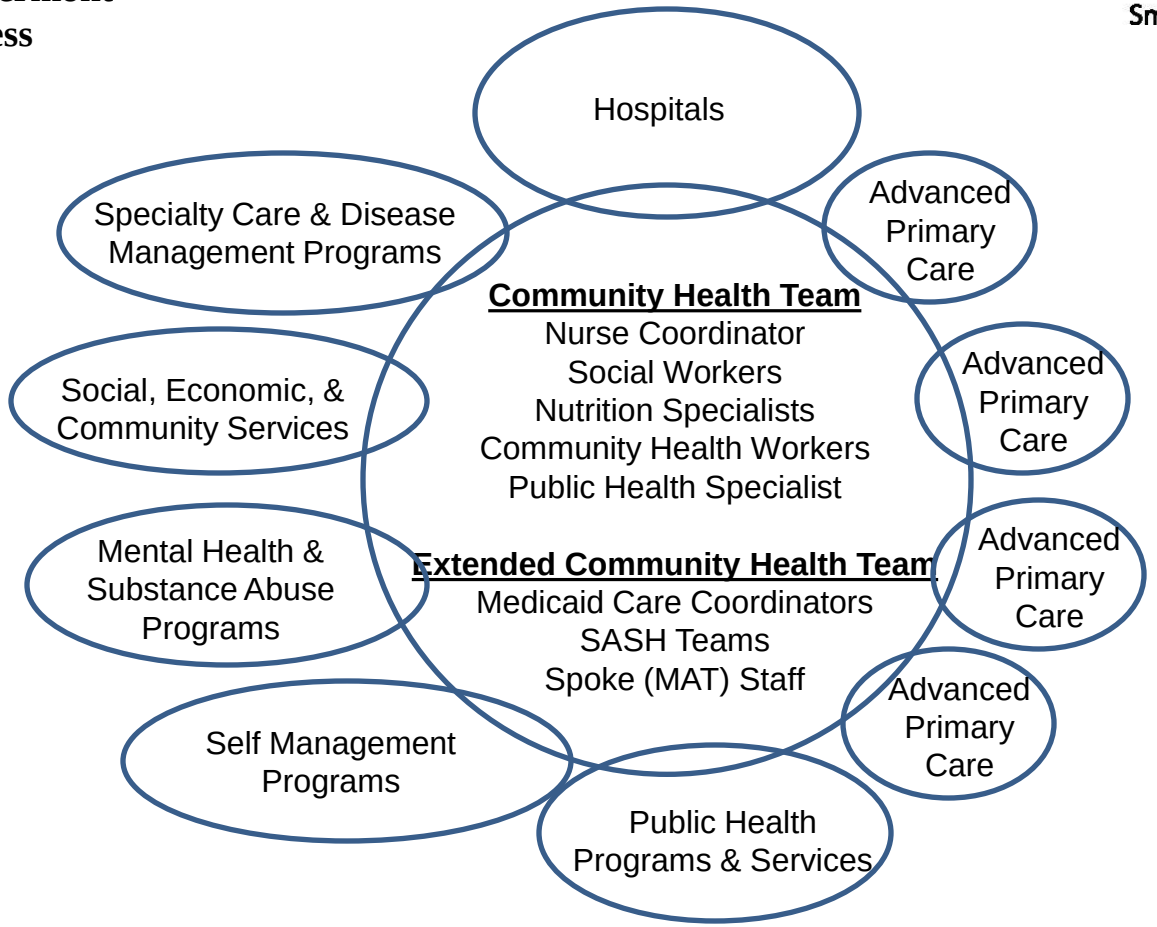
Vermont Blueprint for Health

House Healthcare Committee

January 16, 2015



All-Insurer Payment Reforms

Local leadership, Practice Facilitators, Workgroups

Local, Regional, Statewide Learning Forums

Health IT Infrastructure

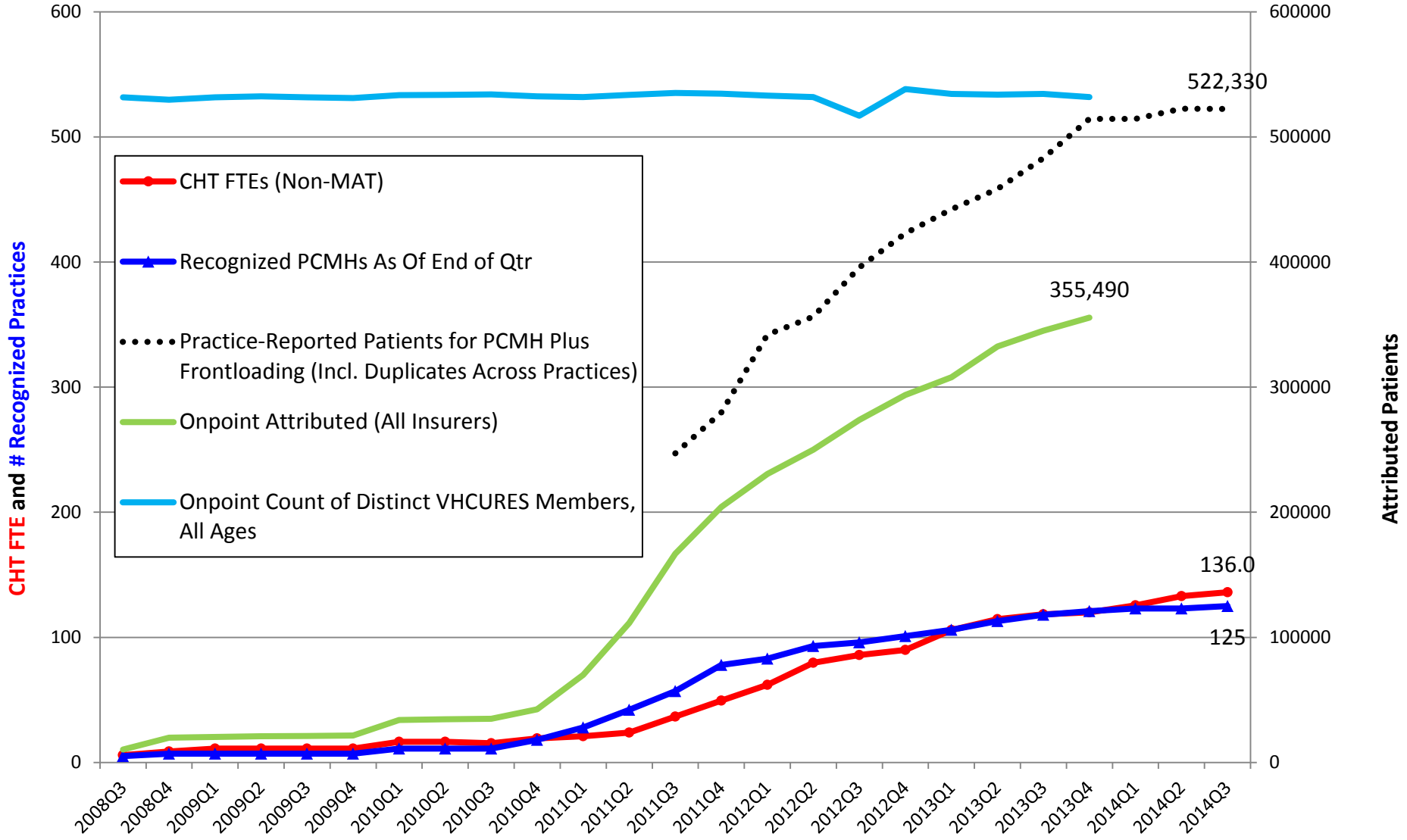
Evaluation & Comparative Reporting

VERMONT

Department of Vermont Health Access

VERMONT Blueprint for Health

Smart choices. Powerful tools.



Health Services Network

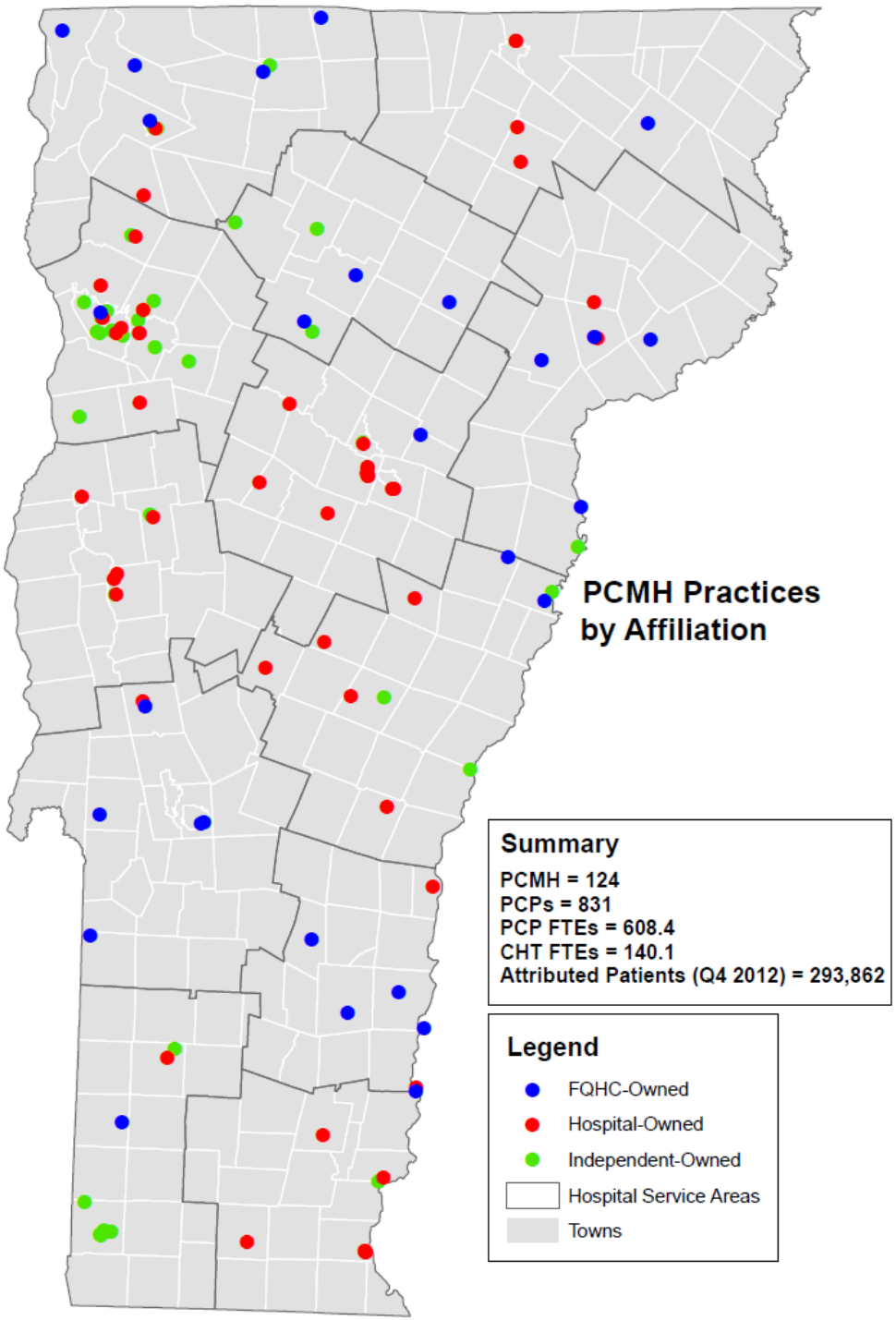
Key Components	December, 2014
PCMHs (active PCMHs)	123
PCPs (unique providers)	644
Patients (Onpoint attribution) (12/2013)	347,489
CHT Staff (core)	218 staff (133 FTEs)
SASH Staff (extenders)	60 FTEs (48 panels)
Spoke Staff (extenders)	58 staff (39 FTEs)

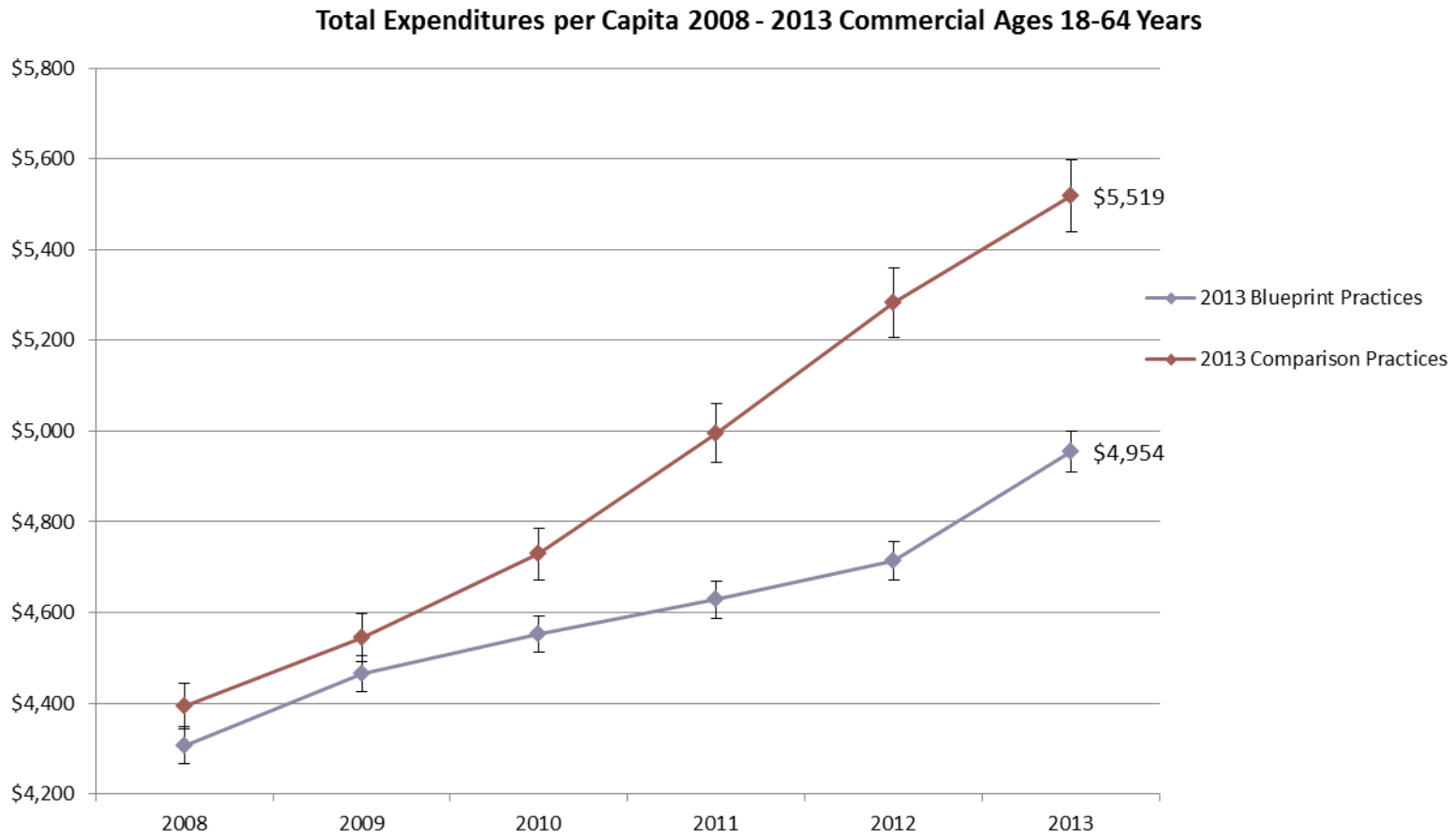
Medical Homes & Community Health Teams
Operations based on NCQA PCMH Standards

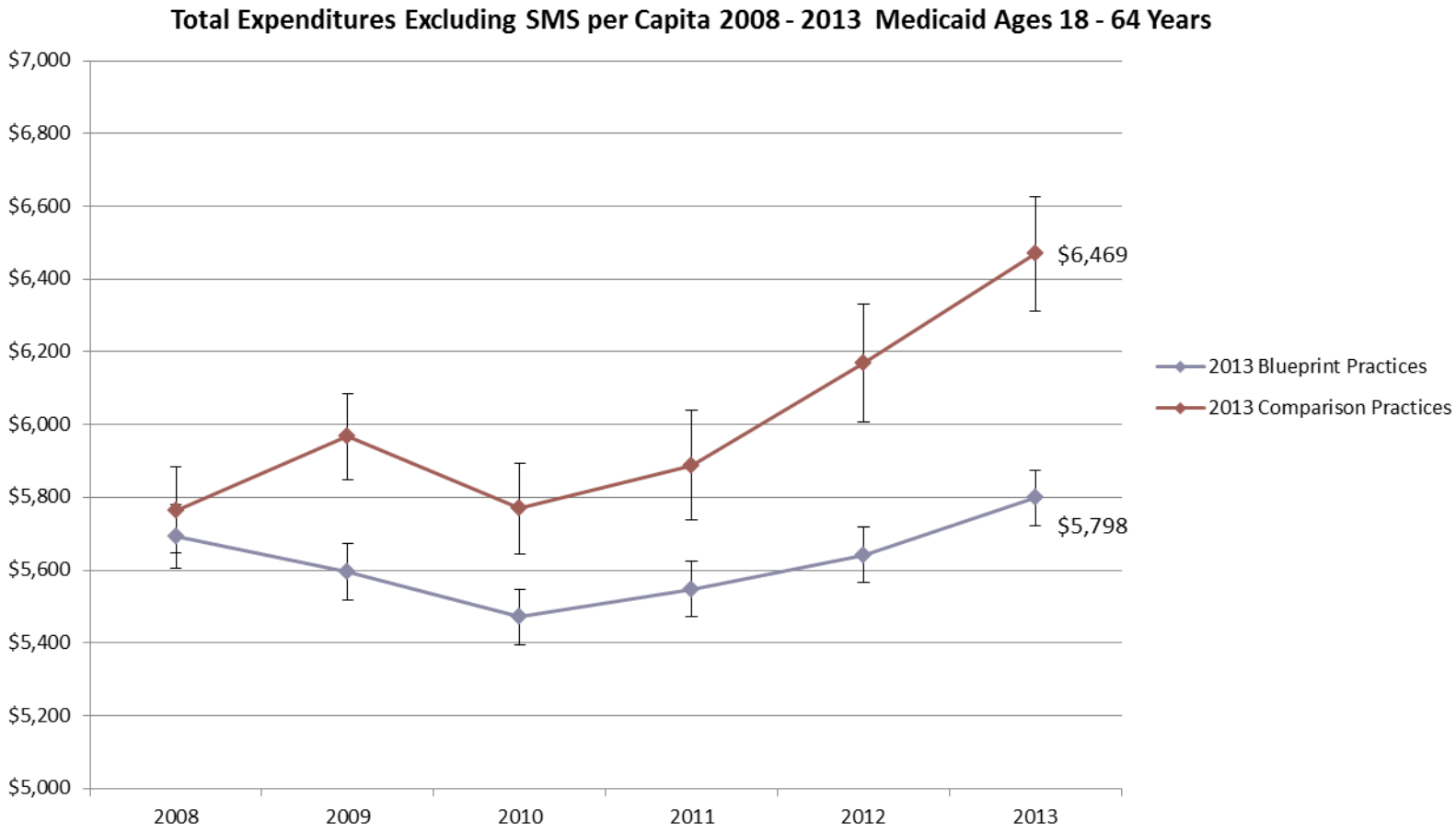
Access During Office Hours	• Same day appointments • Timely clinical advice by phone • Timely clinical advice by electronic message
After Hours Access	• Access t routine & urgent care appointments • Continuity of medical record information for care & advice • Timely clinical advice by telephone
The Practice Team	• Roles for clinical & non-clinical team members • Regular team meetings & communication processes • Standing orders for services • Training & assigning teams to coordinate care
Evidence Based Guidelines	• The practice implements evidence based guidelines through point of care reminders for patients with 3 important conditions, plus high-risk or complex conditions. Third important condition related to unhealthy behaviors, mental health, or substance abuse.
Care Management	• Conducts pre-visit preparations • Collaborates with patient/family to develop an care plan including goals that are reviewed and updated • Gives patient/family a written plan of care • Assesses and addresses barriers when goals are not met • Gives patient/family a clinical summary • Identifies patients/families who might benefit from additional support • Follows up with patients/families who have not kept appointments

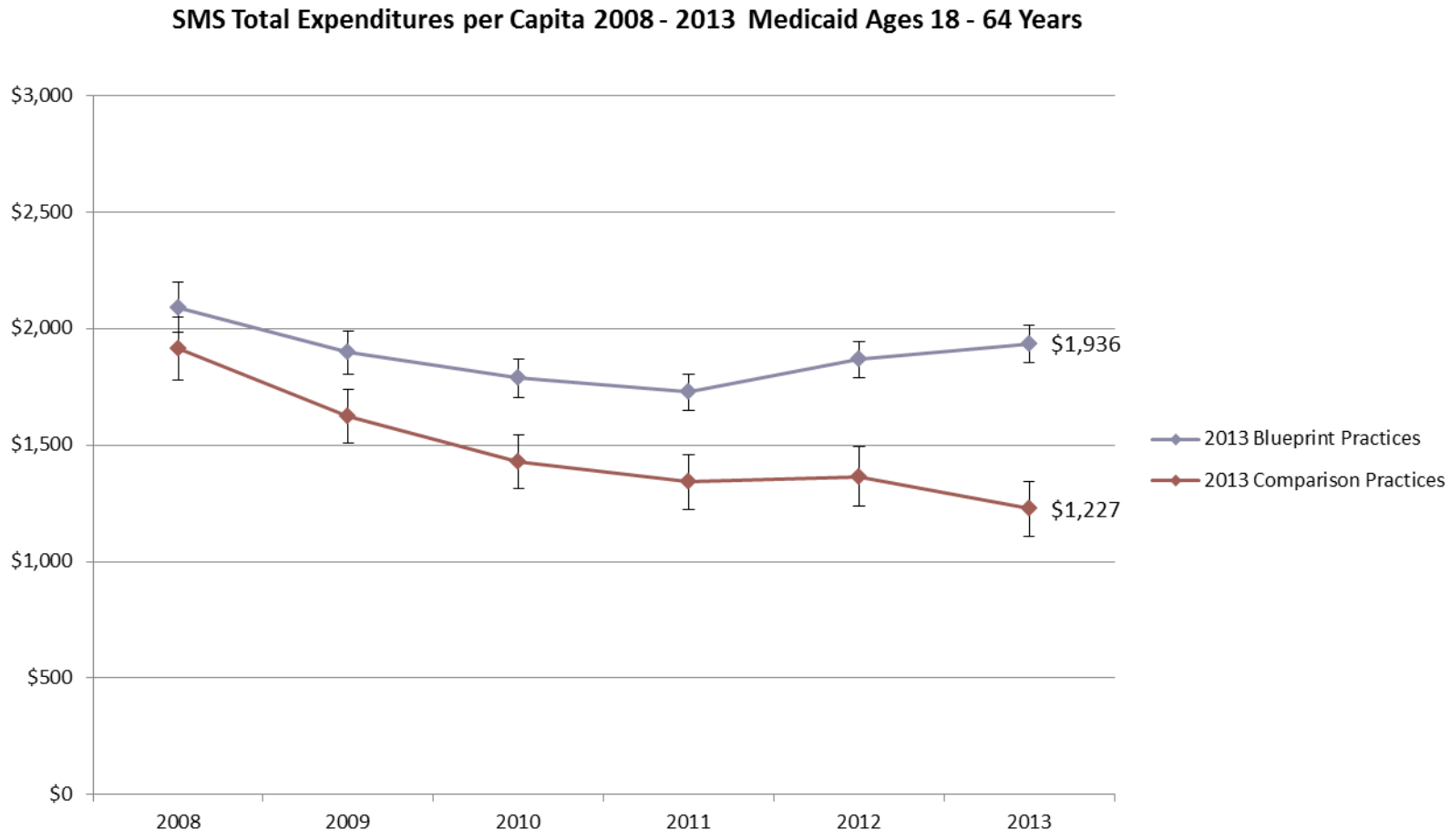
Medical Homes & Community Health Teams
Operations based on NCQA PCMH Standards

Medication Management	• Reviews & reconciles medications with patients/families • Provides information about new Rxs • Assesses patient response to medications & barriers to adherence
Support Self-Care Process	• Documents self-management abilities • Develops & documents self management plans & goals • Provides educational resources or refers to educational resources • Uses and HER to identify patient specific education resources
Test Tracking & Follow-up	• Tracks lab tests until results are available, flagging & following up overdue • Tracks imaging tests until results available, flagging & following up overdue • Flags abnormal lab results, bringing to attention of clinician • Flags abnormal imaging results, bringing to attention of clinician • Notifies patients/families of normal and abnormal lab and imaging results
Referral Tracking & Follow-up	• Giving consultant or specialist clinical reason & pertinent information • Tracking status of referrals, including timing for receiving report • Following up to obtain a specialists report
Continuous Quality Improvement	• Set goals & act to improve =>3 measures of clinical performance • Set goals and act to improve =>1 measure of patient/family experience
Continuity	• Expecting patients/families to select a personal clinician • Documenting patient/family choice of clinician • Monitoring % patient visits with selected clinician or team


PCMH Practices by Affiliation
Summary
PCMH = 124
PCPs = 831
PCP FTEs = 608.4
CHT FTEs = 140.1
Attributed Patients (Q4 2012) = 293,862
Legend
FQHC-Owned
Hospital-Owned
Independent-Owned
Hospital Service Areas
Towns


Total Expenditures per Capita 2008 - 2013 Commercial Ages 18-64 Years
$5,800
$5,600
$5,400
$5,200
$5,000
$4,800
$4,600
$4,400
$4,200
2008
2009
2010
2011
2012
2013
$5,519
$4,954
2013 Blueprint Practices
2013 Comparison Practices

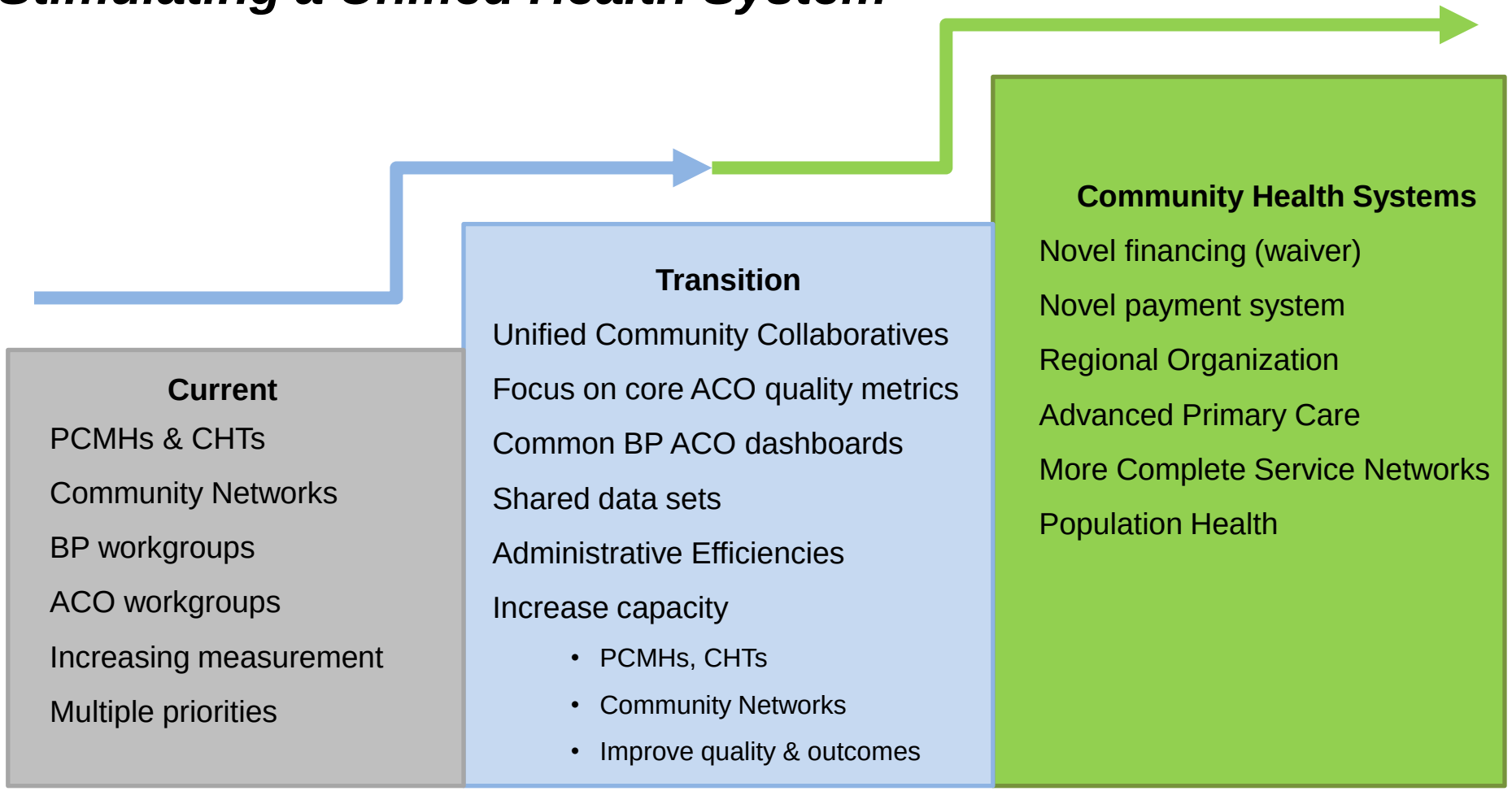

Total Expenditures Excluding SMS per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years
$7,000
$6,800
$6,600
$6,400
$6,200
$6,000
$5,800
$5,600
$5,400
$5,200
$5,000
2008
2009
2010
2011
2012
2013
$6,469
$5,798
2013 Blueprint Practices
2013 Comparison Practices


SMS Total Expenditures per Capita 2008 - 2013 Medicaid Ages 18 - 64 Years
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
2008
2009
2010
2011
2012
2013
$1,936
$1,227
2013 Blueprint Practices
2013 Comparison Practices

Current State of Play

- Foundation of primary care based on NCQA standards
- Infrastructure of team services & evolving community networks
- Infrastructure for transformation, self-management, & quality
- Comparative evaluation & reporting (profiles, trends, variation)
- Three ACO provider networks (OneCare, CHAC, HealthFirst)
- Opportunity to unify work, strengthen community health system structure

Transition to Green Mountain Care
Stimulating a Unified Health System



Strategies for Community Health Systems

Design Principles

- Services that improve population health thru prevention
- Services organized at a community level
- Integration of medical and social services
- Enhanced primary care with a central coordinating role
- Coordination and shared interests across providers in each area
- Capitated payment that drives desired outcomes

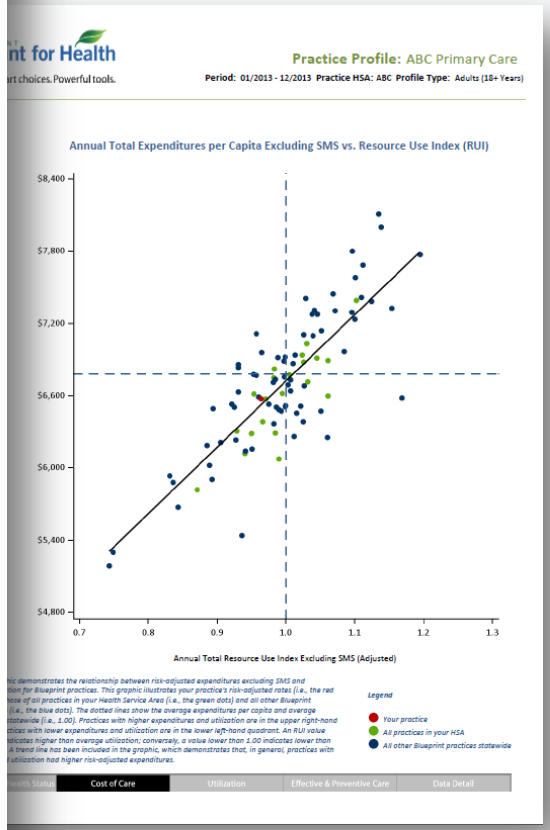
Strategy for Building Community Health Systems

Action Steps

- Unified Community Collaboratives (quality, coordination)
- Unified Performance Reporting & Data Utility
- Enhanced primary care and community health team capacity
- Modified medical home and community health team payment model
- Administrative simplification and efficiencies

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare



Payment Modifications

Planning

1. Increase PCMH payment amounts
2. Shift to a composite measures based payment for PCMHs
3. Increase CHT payments and capacity
4. Adjust insurer portion of CHT costs to reflect market share

Questions & Discussion