Blueprint Integrated Pilot Programs

Improving Access
Improving Quality
Improving Efficiency

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Health Care Reform Goals

Increase Access

Improve Quality

Contain Costs

60+ Initiatives
Vermont Blueprint Context

- Relatively good distribution of Primary Care Providers (PCPs) statewide
  - 800 PCPs in 300 practices in 13 Hospital Service Areas
- Three major health plan carriers + Medicaid + Medicare
- Most PCPs participate in all plans
- History of working together
BP Pilot – Healthcare transformation.

1. Financial reform
   - Payment based on NCQA PCMH standards
   - Shared costs for Community Care Teams
   - Medicaid & commercial payers
   - BP subsidizing Medicare

2. Multidisciplinary care support teams (CCT Teams)
   - Local care support & population management
   - Prevention specialists

3. Health Information Technology
   - Web based clinical tracking system (DocSite)
   - Visit planners & population reports
   - Electronic prescribing
   - Health information exchange network (*Health IT Fund)

4. Community Activation & Prevention
   - Prevention specialist as part of CCT
   - Community profiles & risk assessments
   - Evidence based interventions

5. Evaluation
   - NCQA PCMH score (process quality)
   - Clinical process measures
   - Health status measures
   - Multi payer claims data base
Primary Care PCMH
- Docs
- NPs
- PAs
- Staff

CCT Support
- Panel Management
- Coaching
- Patient / family contact
- Assessment
- Reinforce treatment plan
- Education
- Reminders
- Self management

Social / Economic Support
- Liaison to other programs
- Enrollment assistance

Prevention & Self Management
- Referral to community programs
- Coordinate community programs

Vermont Health Information Platform (VITL)

Referral & care support
Education & Improvement
Public Health & Prevention

Community Care Team (CCT)
e.g. NP, RN, MSW, Dietician,
Behavior Specialist, Community
Health Worker, VDH Public
Health Specialist

Model for Health & Prevention

PCMH
- Payment reform
- Comprehensive guideline based care
- Health maintenance & prevention
- Chronic conditions
- Panel management
- Coaching
- Reminders
- Goal setting
- Health IT – planned visits
- Health IT – population management
- Health IT – eRx
- Paper based or EMR practices

Vermont Health Information Platform (VITL)

Smart choices. Powerful tools.
Model for Health & Prevention

Health Information Environment – Data Transmission

Plot Site # 1
NVRH EMR System
NCHCs EMR System

Plot Site # 2
Fletcher Allen Data Warehouse

VITL / GE
Health Information Exchange Infrastructure

Core DocSite Data Elements

DocSite
Web Based Health Information System
- Visit Planners
  Individual Patient Care
- Reporting Function
  Population Management
- Electronic Rx
- Evaluation
  - health process
  - health outcomes
  - prevention
  - epidemiology
Health Information Environment – Clinical Operations

1. Providers & Community Care Teams can adapt the use of health information technology that meets their needs

2. Sites with updated EMR likely to use their system for individual patient care

3. Sites with EMR can use DocSite for report generation and population management if reporting functions are superior and easier to use than those in their EMR

4. Sites without an EMR will be able to use DocSite to support individual patient care as well as population management

5. DocSite database supports evaluation of clinical process & health status measures (common data elements from all sites)
PHASE 1 - Develop capacity
- Facilitate systems approach
- Train Prevention Specialist
  - Prevention Model and Framework
  - Data collection techniques
  - Environment and policy change

PHASE I - Develop capacity

PHASE 2a - Community Profile
- Community description
- Community inventory
- Quantitative Context - Descriptive health statistics on the rates of risk factors in each community (5 year aggregate data)

PHASE 2b - Community Assessment
- Quantitative Context - state level 10 year trend analysis of risk factors associated with morbidity & healthcare costs
- Focus groups
- Formal key leader interviews
- Continue until no new themes
- Test themes in new interviews
- Test findings in community forums

PHASE 3 - Community Planning
- Planning with key leaders
- Planning with stakeholders
- Iterative interactive process
- Consensus building

PHASE 4 - Implementation
- Timeline depends on scope and resources of planned intervention

PHASE 5 - Evaluation

Community Assessment & Planning Timeline

October 2008
Model for Health & Prevention

Primary Care PCMH
- Docs
- NPs
- Staff

Community Care Team (CCT)
e.g. NP, RN, MSW, Dietician,
Behavior Specialist,
Community Health Worker,
VDH Public Health Specialist

Hospital
- Educators
- Transitional care
- Ambulatory center (wellness programs)

Referrals & Communication

Community Care Team (CCT)
e.g. NP, RN, MSW, Dietician,
Behavior Specialist,
Community Health Worker,
VDH Public Health Specialist

Healthcare

Policies and Systems
Local, state, and federal policies and laws, economic and cultural influences, media

Community
Physical, social and cultural environment

Organizations
Schools, worksites, faith-based organizations, etc.

Relationships
Family, peers, social networks, associations

Individual
Knowledge, attitudes, beliefs

# Blueprint Pilot Timeline & Evaluation

## Category
- PCMH healthcare process quality
- Clinical process measures
- Health status measures
- Episodic vs. Preventive healthcare – claims based measures
- Healthcare Costs – claims based measures

## Data Source
- NCQA PCMH Score
- VCHIP practice review
- NCQA recognition
- DocSite database
- VCHIP Chart Review
- VHCURES – multipayer database
- Financial Impact Model

## Evaluation Outline
- Pilot practices
- Change from baseline
- Pilot practices
- Practices in BP communities delivering routine care
- Change from baseline & comparison
- Pilot practices
- Practices in BP communities delivering routine care
- Change from baseline & comparison
- Pilot practices vs non-pilot practices
- Change from baseline & comparison
- Pilot practices vs non-pilot practices
- Impact on healthcare costs in Vermont
- Change from baseline & comparison
Every dollar of health care spending is a dollar of income to someone.
Even silos can have systemness