VERMONT Blueprint for Health

Smart choices. Powerful tools.

Blueprint Integrated Pilot Programs

Building an Integrated System of Health

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Vermont's healthcare reforms include:

- Universal coverage
- A primary care foundation (PCMHs + CHTs)
- Multi-Insurer Payment Reforms
- A focus on prevention (public health ⟷ health care delivery)
- A statewide health information exchange
- An evaluation infrastructure to support ongoing improvement
- Facilitators & support for a learning health system

Health IT Framework

Evaluation Framework

- 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

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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

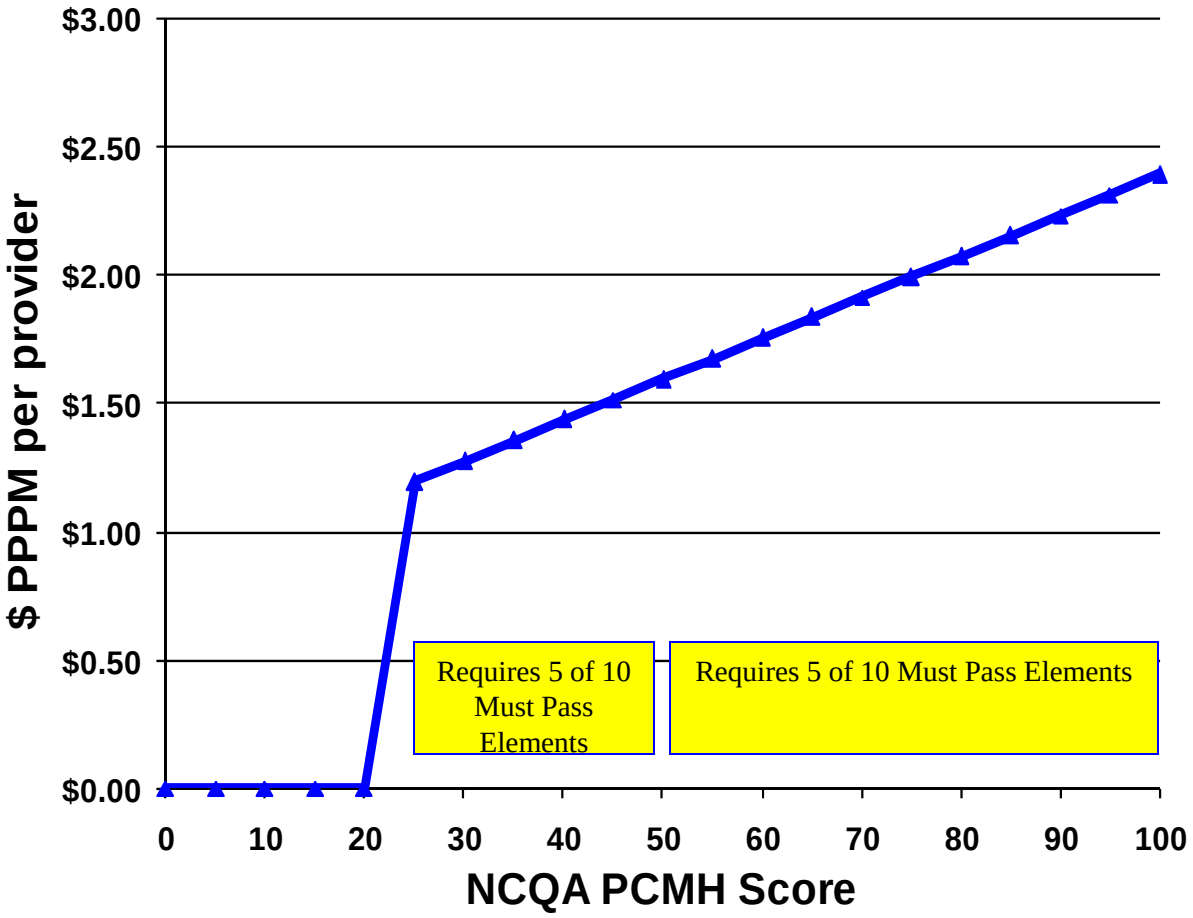
Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

NCQA Measuring quality. Improving health care.

1

NCQA PCMH Points	Average PPPM 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



- 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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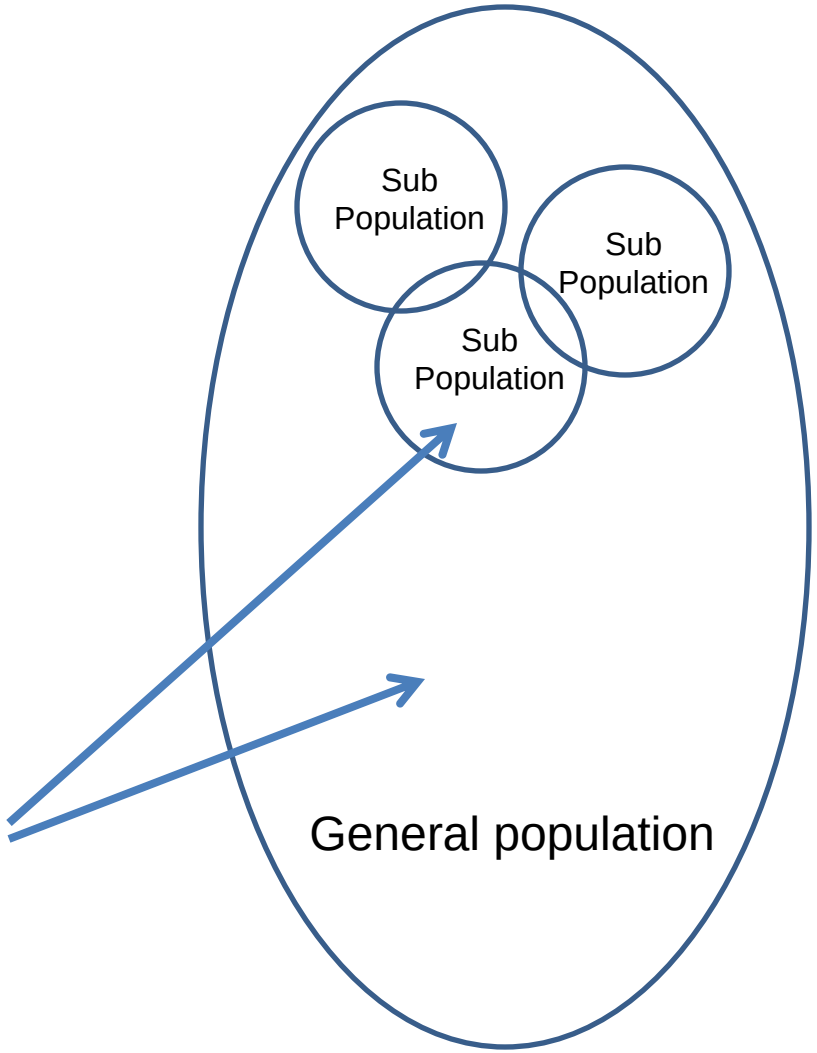
Advanced Model of Primary Care

A Foundation for integrated services

AMPC Foundation

- Community Health Team
- Patient Centered Medical Homes
- Multi-insurer payment reform
- Health Information Infrastructure
- Evaluation Infrastructure



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Advanced Model of Primary Care

A Foundation for integrated services

Guideline based care

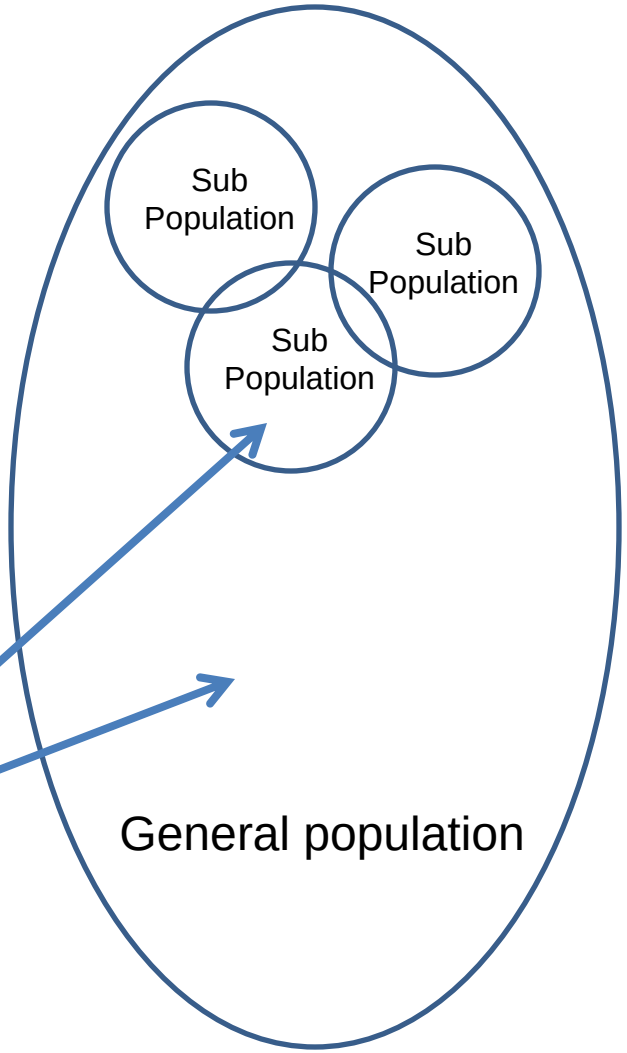
Tools (e.g. HRAs)

Targeted Interventions

Best Practices

AMPC Foundation

- Community Health Team
- Patient Centered Medical Homes
- Multi-insurer payment reform
- Health Information Infrastructure
- Evaluation Infrastructure



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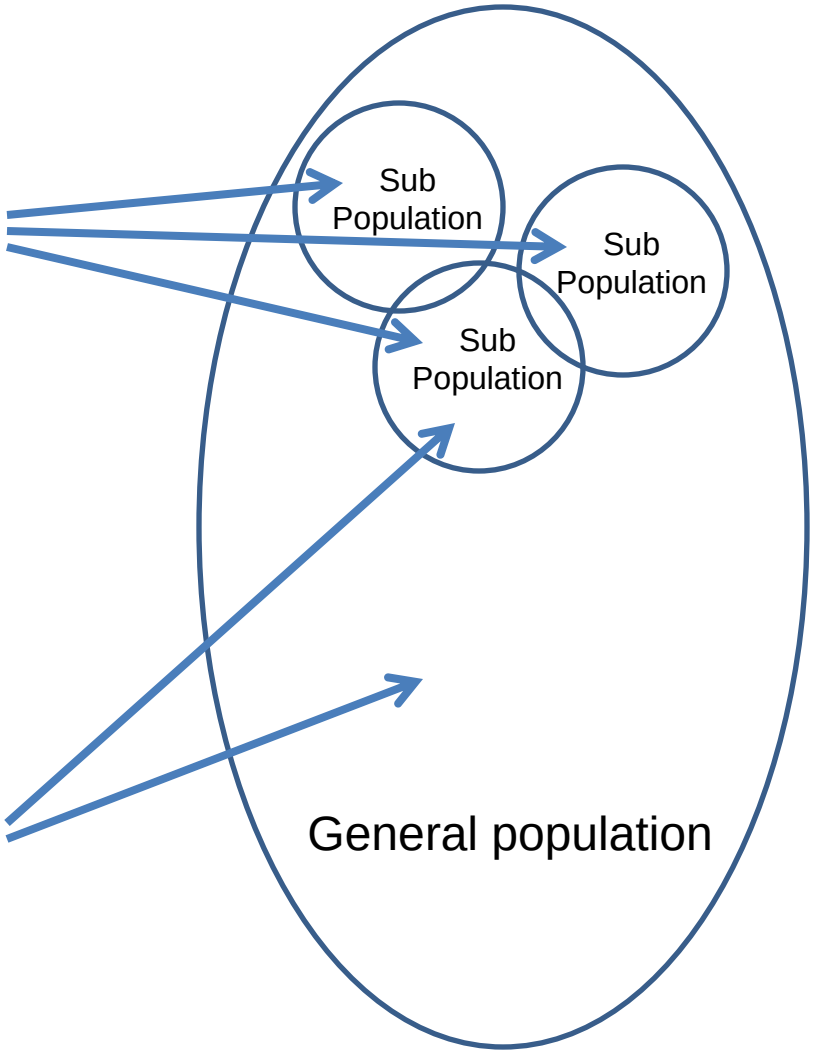
A Foundation for integrated services

Targeted Services

- Economic Services
- Social Services
- Case Management
- Disease Management Programs
- Specialty Care

AMPC Foundation

- Community Health Team
- Patient Centered Medical Homes
- Multi-insurer payment reform
- Health Information Infrastructure
- Evaluation Infrastructure



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Advanced Model of Primary Care

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Targeted Services

Economic Services

Social Services

Case Management

Disease Management Programs

Specialty Care

Community Health Team

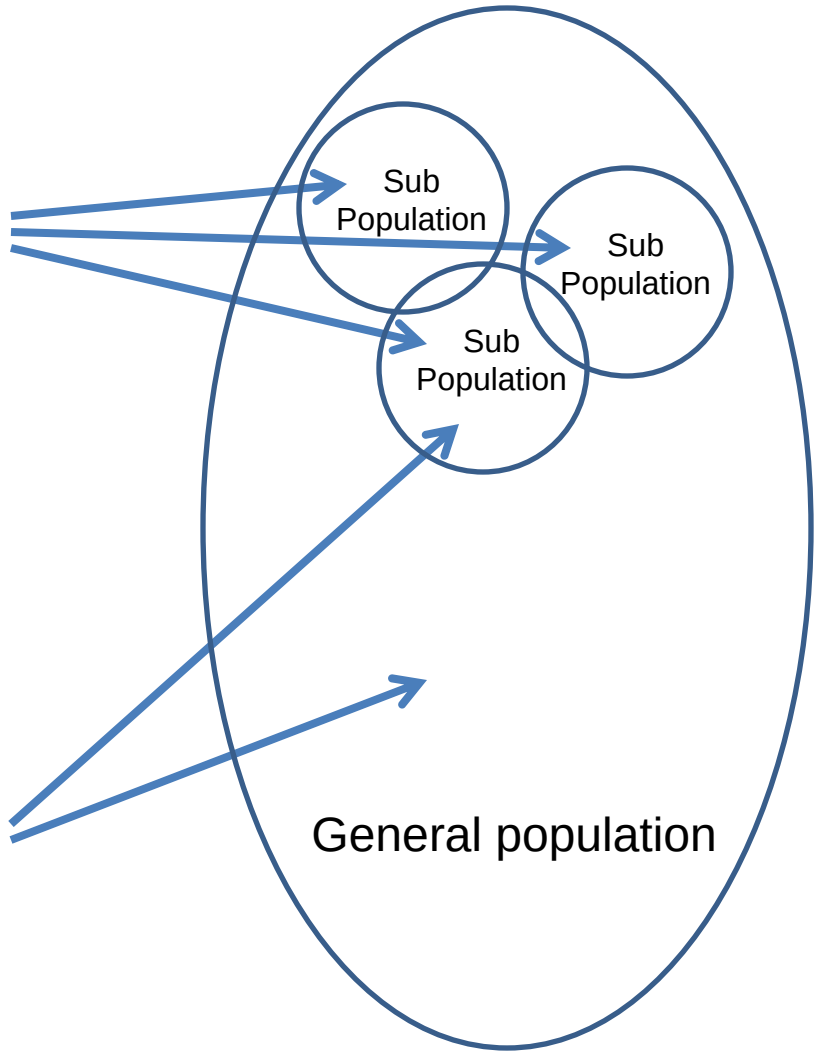
AMPC Foundation

Patient Centered Medical Homes

Multi-insurer payment reform

Health Information Infrastructure

Evaluation Infrastructure



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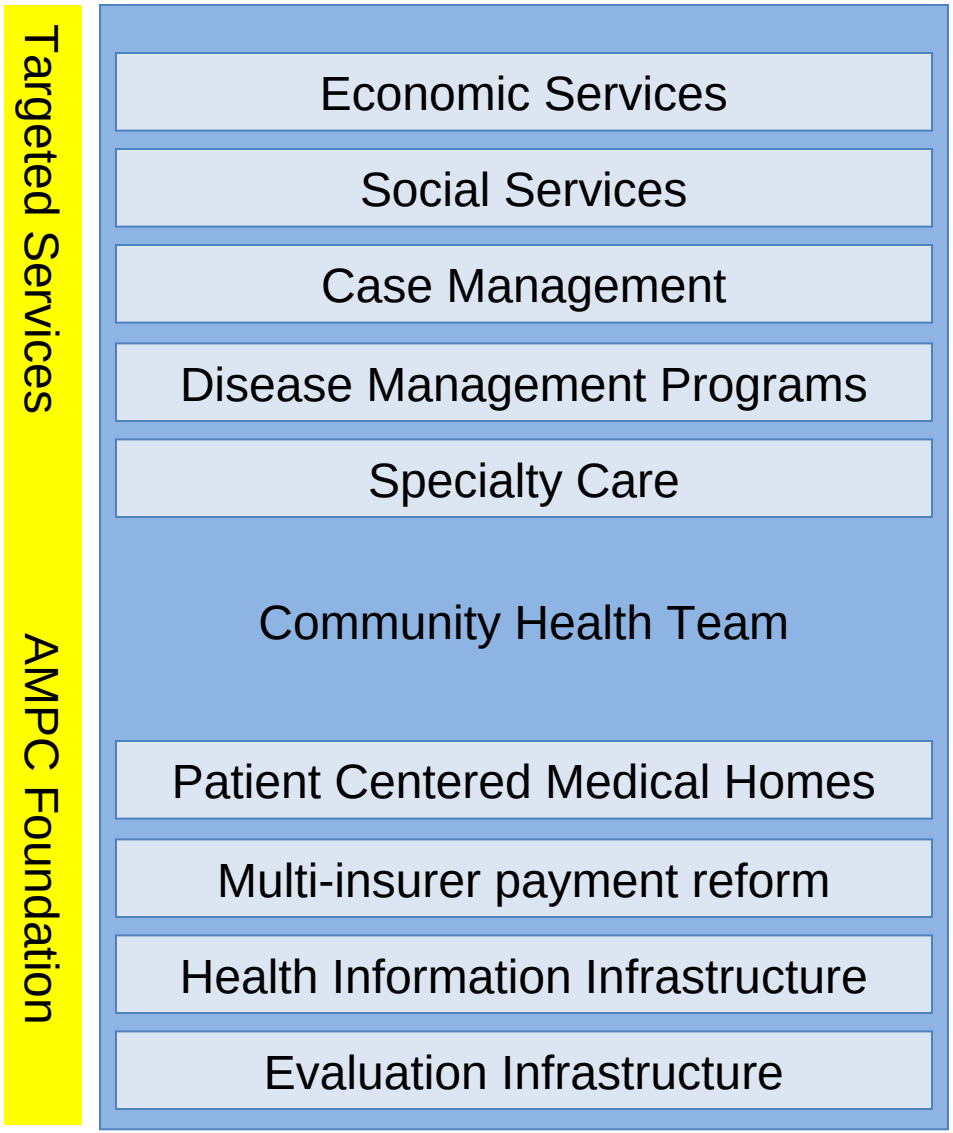


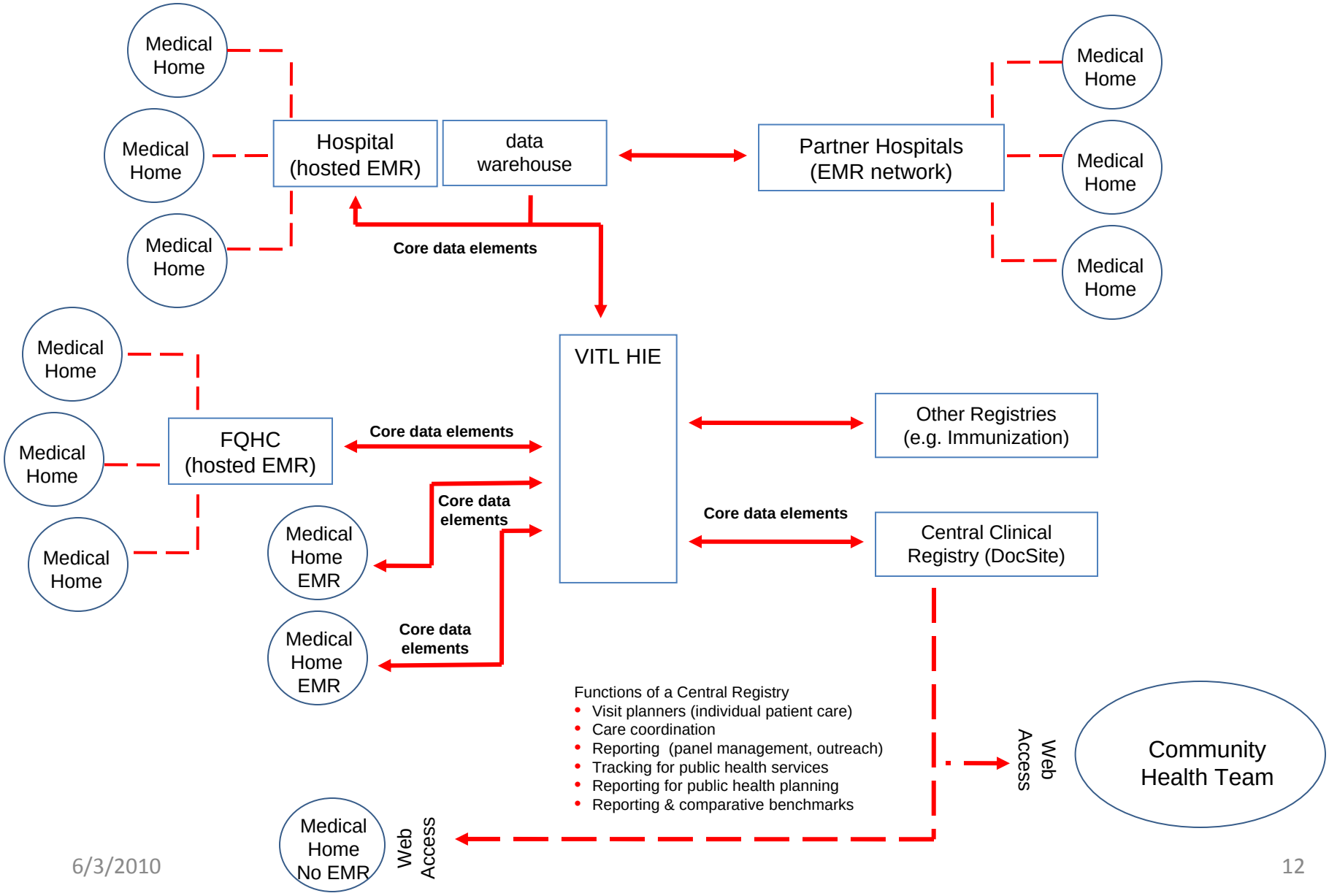
Areas of Focus

- Family Wellness & Children's Services
- Mental Health & Substance Use
- Medicaid Care Coordination
- Senior Services (SASH)
- Disease Specific (CHF)

Steps

- Financial Impact Model
- Clinical Services Model
- Payment Reforms
- IT Infrastructure & Enhancements
- Implementation Plan
- Evaluation Plan

Blueprint Integrated Pilots
Health Information Infrastructure

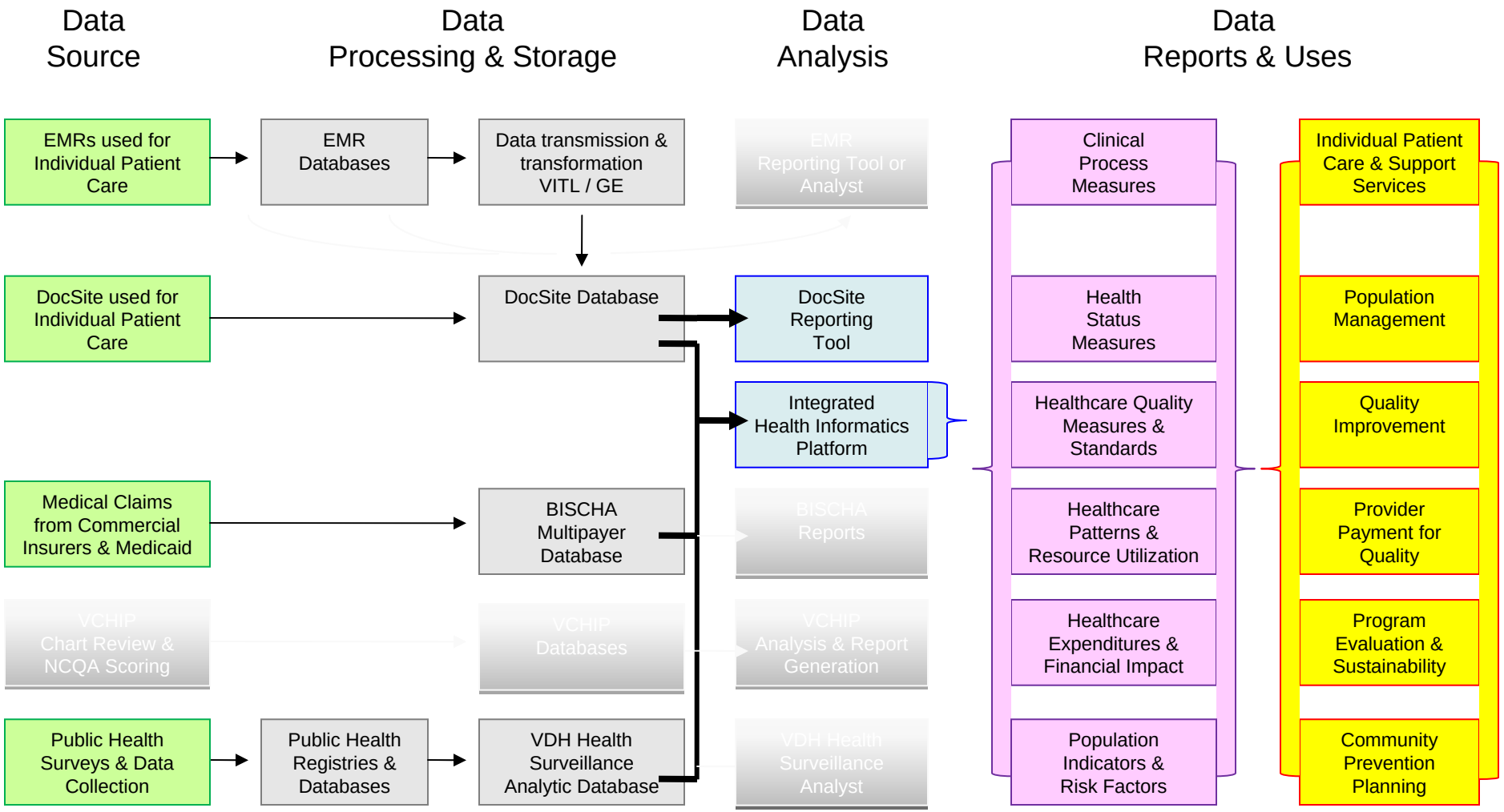


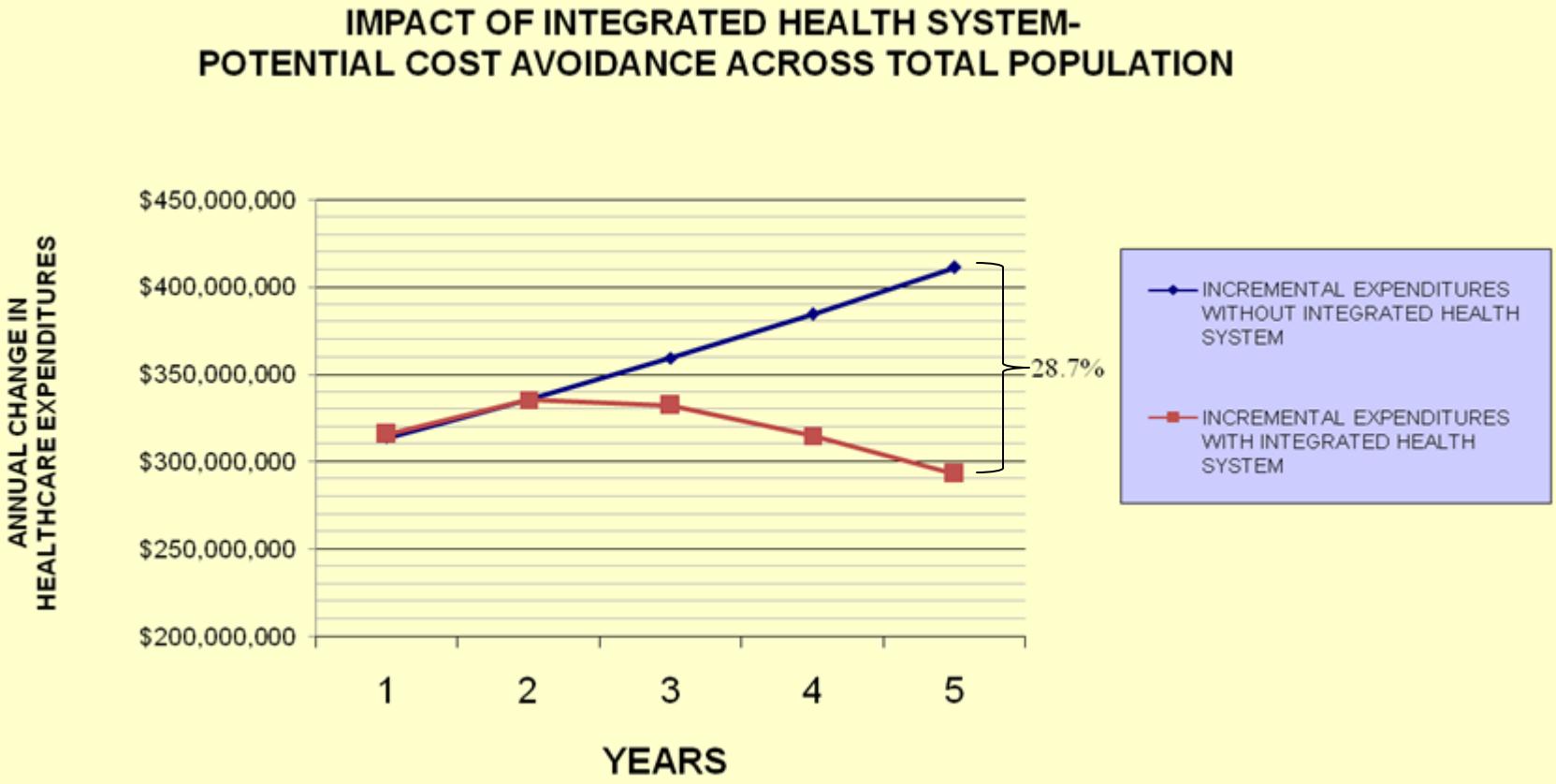
Evaluation & Reporting (Data sources)

- Electronic Medical Records
- Centralized Clinical Registry
- Multi-insurer claims data base
- Public Health Registries
- Chart Reviews
- NCQA Scoring

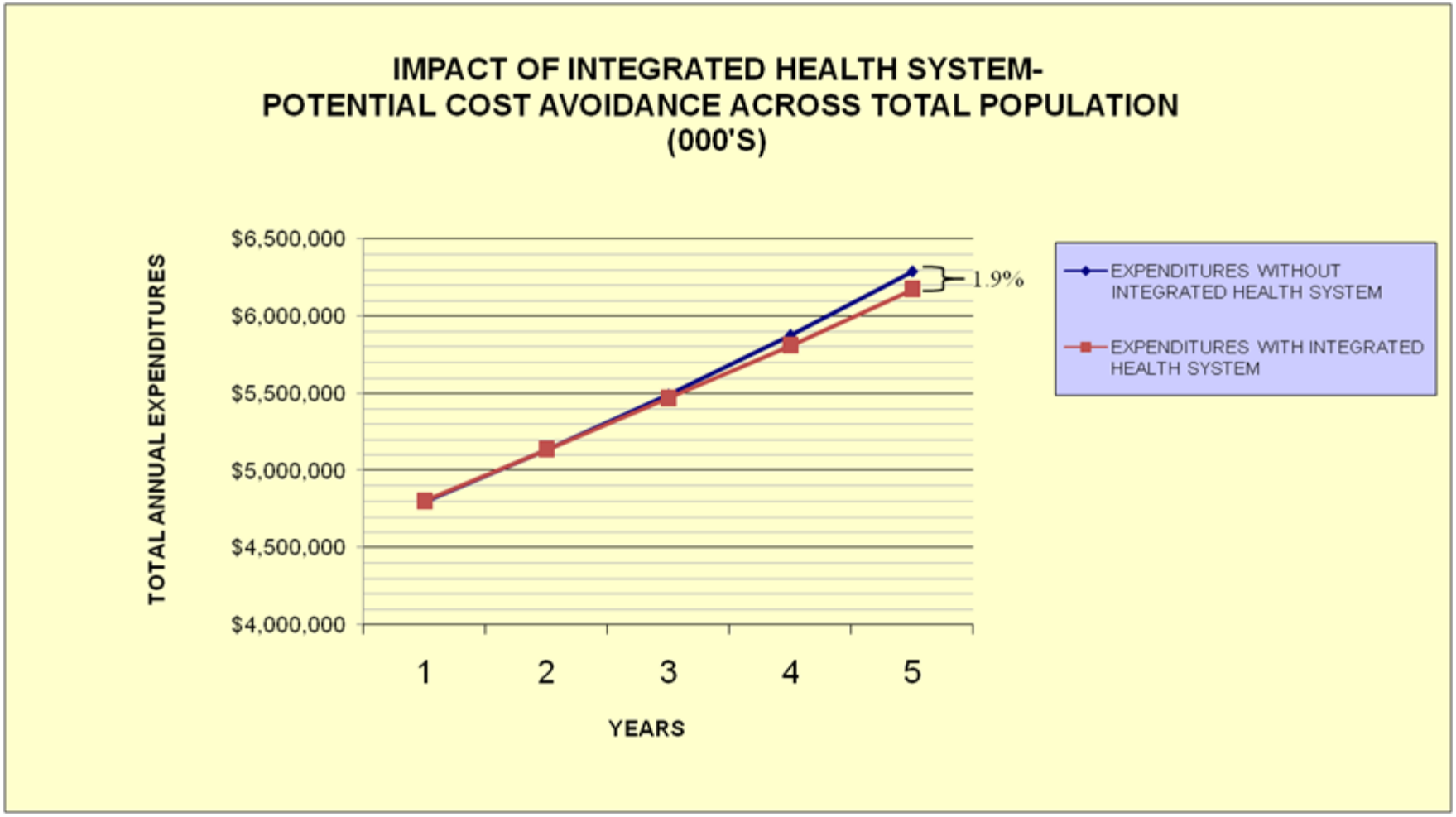
Blueprint Integrated Pilots

Evidence Based Quality Improvement





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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Pilot Locations thru July 2010

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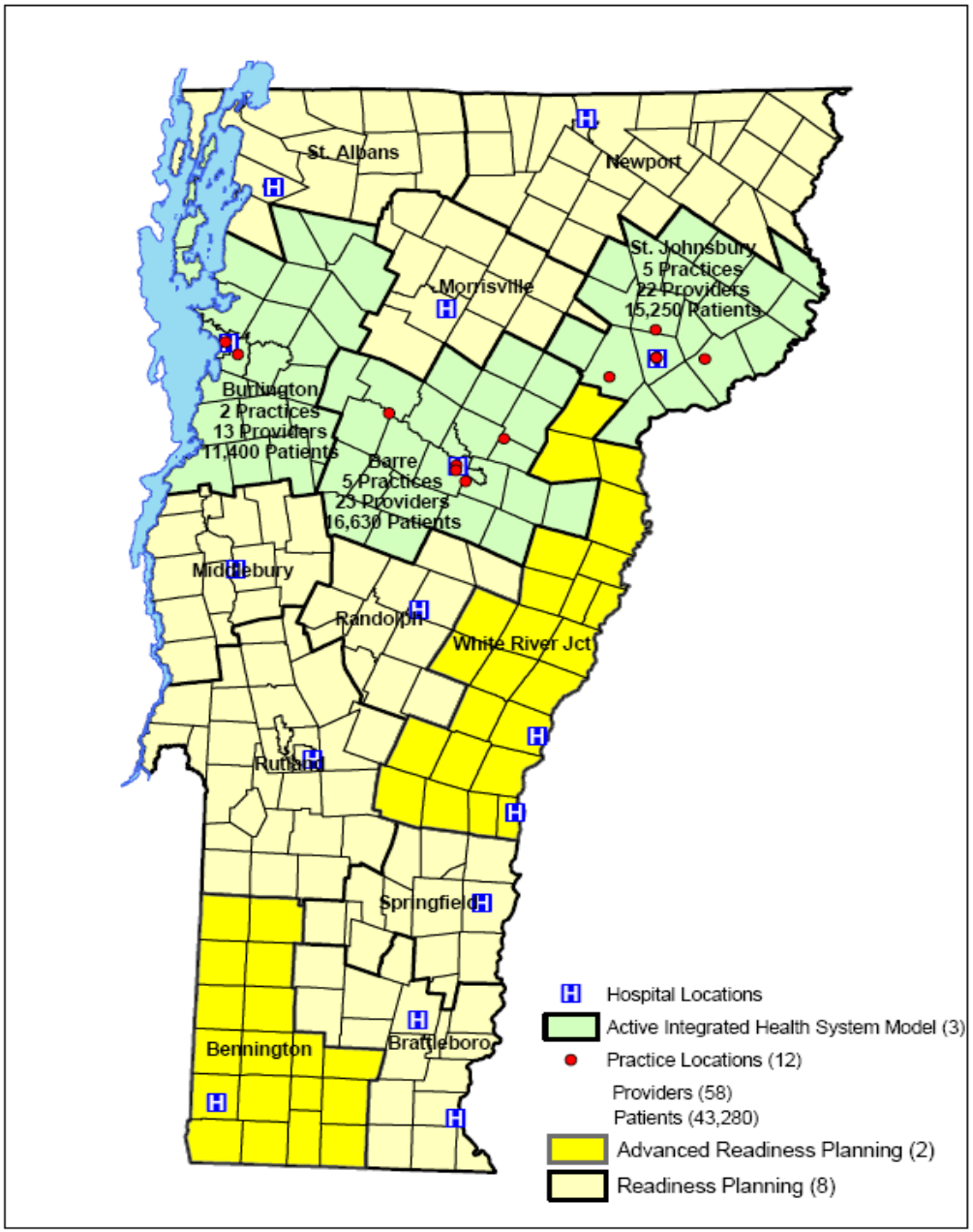

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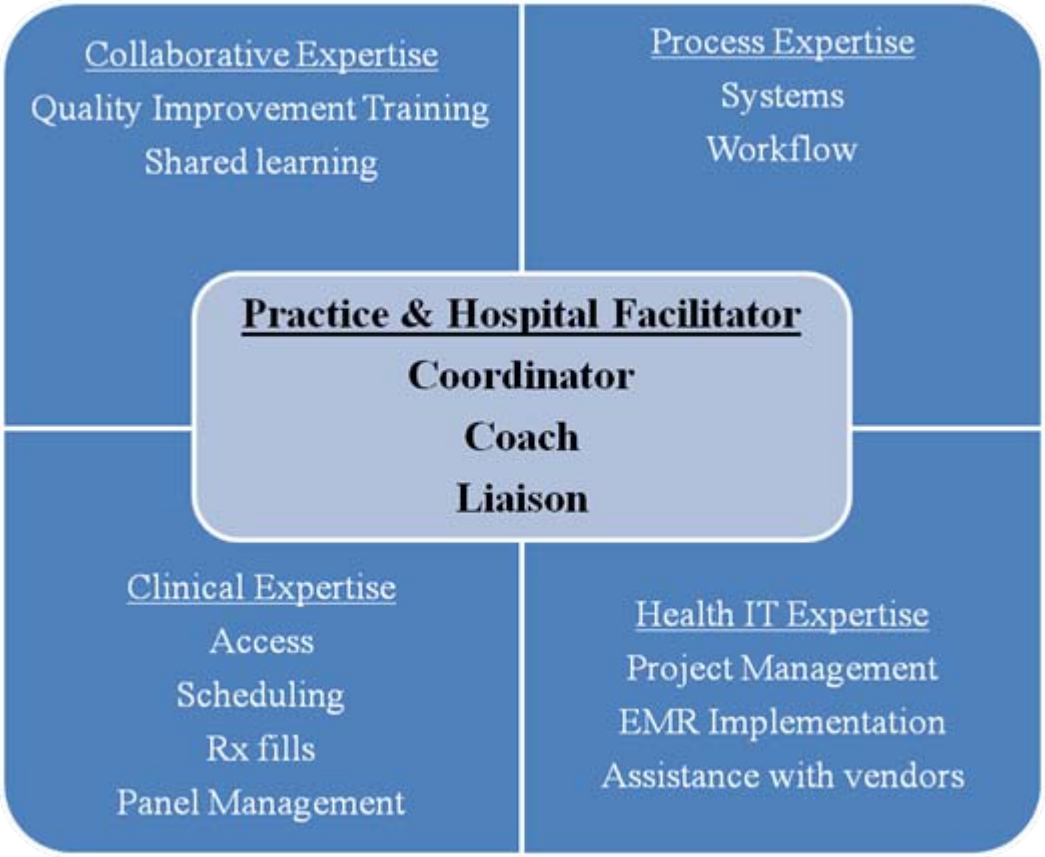
Building Local Enhancement & Assistance Capacity



Facilitator Competencies

- Assessments
- Facilitation
- Negotiation
- Team Approach
- Process Improvement
- Using Data to Drive Change
- Goal Setting & Tracking
- Critical Thinking
- Systems Thinking
- Supportive

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Blueprint model includes:

- PCMHs & interdisciplinary teams
- Systems based coordinated health services
- A ‘population to practice’ focus on prevention
- Health informatics & evaluation infrastructure
- Learning health system
- Interdisciplinary education

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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

IOM ROUNDTABLE ON VALUE & SCIENCE-DRIVEN HEALTH CARE

THE STRATEGY MAP

VALUE

COST

The right care • For the right price • Efficiently delivered

OUTCOMES

Lives saved • Health gained • People satisfied

SCIENCE-DRIVEN HEALTH CARE

2020 GOAL

By 2020, ninety percent of clinical decisions will be supported by accurate, timely, and up-to-date clinical information, and will reflect the best available evidence.

COLLABORATIVE ACTION

THE LEARNING HEALTHCARE SYSTEM

- Learning-driven care
- Care-driven learning
- Clinician as steward
- Patient at the center
- Best practice every time
- Seamless cycle feedback
- Clinical data a public trust
- IT-based knowledge engine
- Trusted science broker
- Networked leadership

FOUNDATION STONES

Clinical Research | Clinical Data | Information Technology | Evidence Standards | Health Care Tools | Caregiver Culture | Patient Engagement | Financial Incentives

VISION

"We seek the development of a learning healthcare system that is designed to generate and apply the best evidence for the collaborative health care choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care." (Roundtable Charter)