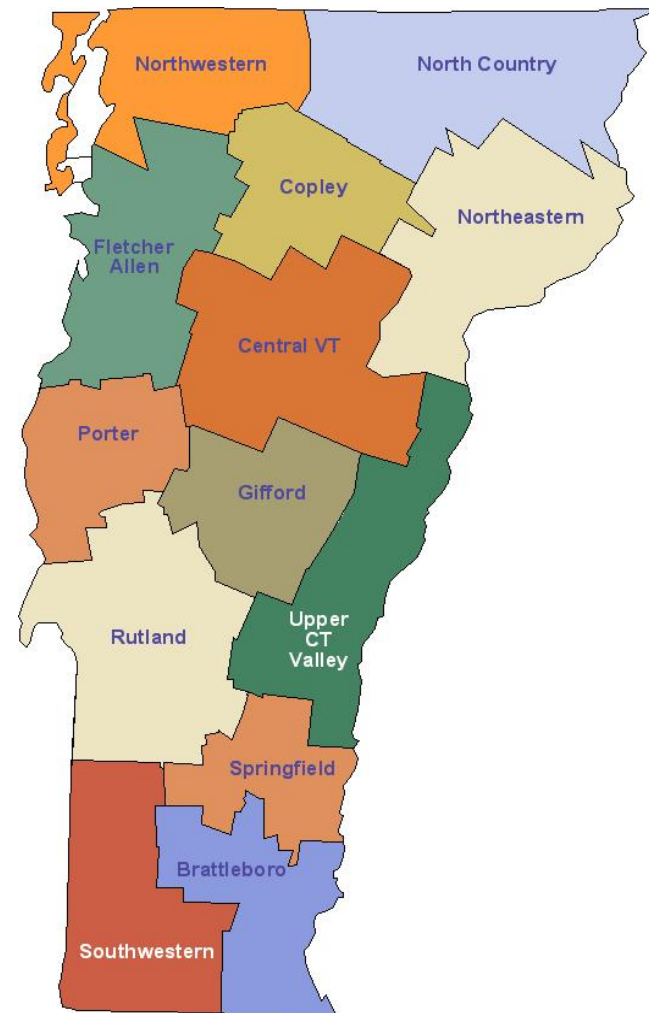
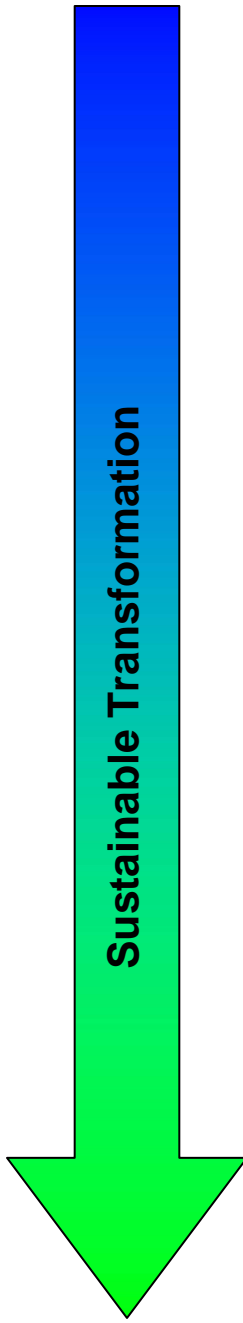


Blueprint Integrated Pilot Programs

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





Funding

- Blueprint / State**
- Global Commitment
 - Catamount Fund
 - Federal Funds
 - HIT Fund

- Payer Support**
- Medicaid
 - BCBS
 - Cigna
 - MVP

- Grant Support ?**

Programs

Blueprint Communities (Act 191, 2006)

- Clinical Transformation
 - VPQ Coordinated Training
 - Clinical Microsystems
- Provider Incentives
 - Participation & Training
- Community Activation
 - Local Programs
- Self Management
 - Healthier Living Workshops
- Health Information Technology
 - VPQ Hosted Registry (VHR)
- Evaluation
 - VPQ Registry Reports
 - VCHIP Chart Review
- VITL Health Information Exchange Network

Blueprint Integrated Pilots (Act 71 2007, Act 204 2008)

- Financial Reform
 - Enhanced provider payment
 - Shared costs for CCT
- Local Care Support
 - CCT as shared resource
- Prevention
 - Public Health Specialist on CCT
 - Local Prevention Team
- Health Information Technology
 - VITL EMR Pilot Project
 - VPQ Hosted Web Based CIS with eRx
- VITL Health Information Exchange Network

Evaluation Infrastructure

- Multi payer claims data base
- Clinical / demographic data base
- VCHIP NCQA PCMH scoring
- VCHIP chart review

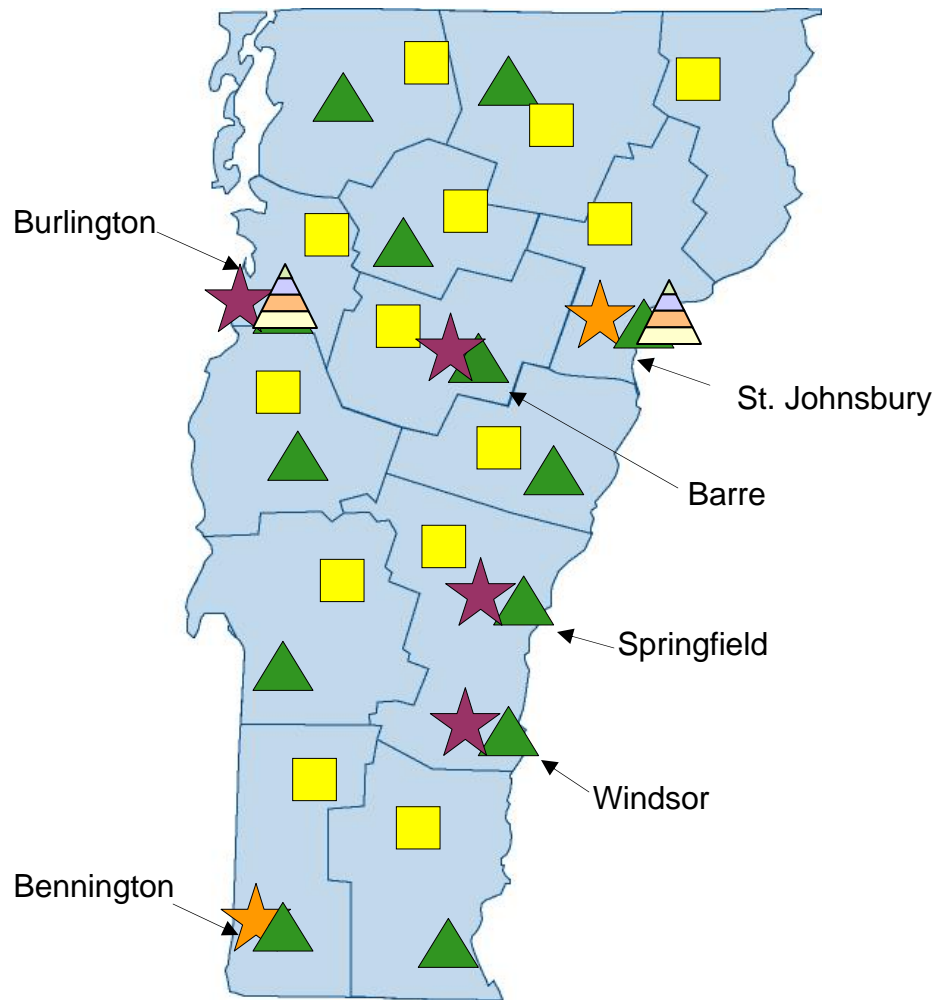
Products

- Improved Care Delivery (Diabetes)
- IT enhanced care (Diabetes)
- Improved self mgmt (HLW attendees)
- Local exercise / prevention programs
- VHR - Descriptive statistics (Diabetes)
- VCHIP – Chart review

- Advanced Medical Home
- Improved Care Delivery (General)
- Local care support & DM services
- Sustainable Financial Reform
- Improved Self Mgmt (Multi-faceted)
- IT enhanced care
 - Chronic disease
 - Health maintenance
 - eRx
- Prevention & Wellness Programs
 - Community team
 - Evidence based
 - Linked with care delivery

- Evidence based healthcare process
- Routine QA / QI
- Evaluation of health impact
- Evaluation of financial impact
- Predictive modeling (claims / clinical)
- Epidemiologic / outcomes research
- CCT Utilization Patterns

Blueprint Development



-  2003—Launch of the Blueprint
-  2004—Planning
-  2006—Statutory Endorsement
-  2007— Medical Home Integrated Pilots in Statute
-  2005—Initial two pilot Hospital Service Areas (Diabetes Focus)
-  2006—Four new Hospital Service Areas (Diabetes Focus)
-  Healthier Living Workshops
-  Community Physical Activity Grants
-  2008 - Integrated Medical Home Pilots (all chronic conditions + prevention)

Pilot Summary

The Blueprint is leading a systems based approach to healthcare transformation.

As part of this effort integrated pilot programs will be established in 3 distinct communities across Vermont.

Participating practices in each community will be provided with the infrastructure and financial incentives to operate a patient centered medical home (PCMH).

Pilot practices will operate with enhanced payment based on meeting nationally recognized quality standards, local multidisciplinary care support teams including prevention specialists, a web based clinical tracking system with eRx, and health information exchange.

Costs for these pilots will be shared, testing a public-private approach to healthcare reform

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

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

Standards

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts	Standard 5: Electronic Prescribing	Pts
A. Has written standards for patient access and patient communication**	4	A. Uses electronic system to write prescriptions	3
B. Uses data to show it meets its standards for patient access and communication**	5	B. Has electronic prescription writer with safety checks	3
	9	C. Has electronic prescription writer with cost checks	2
Standard 2: Patient Tracking and Registry Functions	Pts		8
A. Uses data system for basic patient information (mostly non-clinical data)	2	Standard 6: Test Tracking	Pts
B. Has clinical data system with clinical data in searchable data fields	3	A. Tracks tests and identifies abnormal results systematically**	7
C. Uses the clinical data system	3	B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
D. Uses paper or electronic-based charting tools to organize clinical information**	6		13
E. Uses data to identify important diagnoses and conditions in practice**	4	Standard 7: Referral Tracking	PT
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3	A. Tracks referrals using paper-based or electronic system**	4
	21		4
Standard 3: Care Management	Pts	Standard 8: Performance Reporting and Improvement	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	3	A. Measures clinical and/or service performance by physician or across the practice**	3
B. Generates reminders about preventive services for clinicians	4	B. Survey of patients' care experience	3
C. Uses non-physician staff to manage patient care	3	C. Reports performance across the practice or by physician **	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5	D. Sets goals and takes action to improve performance	3
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5	E. Produces reports using standardized measures	2
	20	F. Transmits reports with standardized measures electronically to external entities	1
Standard 4: Patient Self-Management Support	Pts		15
A. Assesses language preference and other communication barriers	2	Standard 9: Advanced Electronic Communications	Pts
B. Actively supports patient self-management**	4	A. Availability of Interactive Website	1
	6	B. Electronic Patient Identification	2
		C. Electronic Care Management Support	1
			4

****Must Pass Elements**

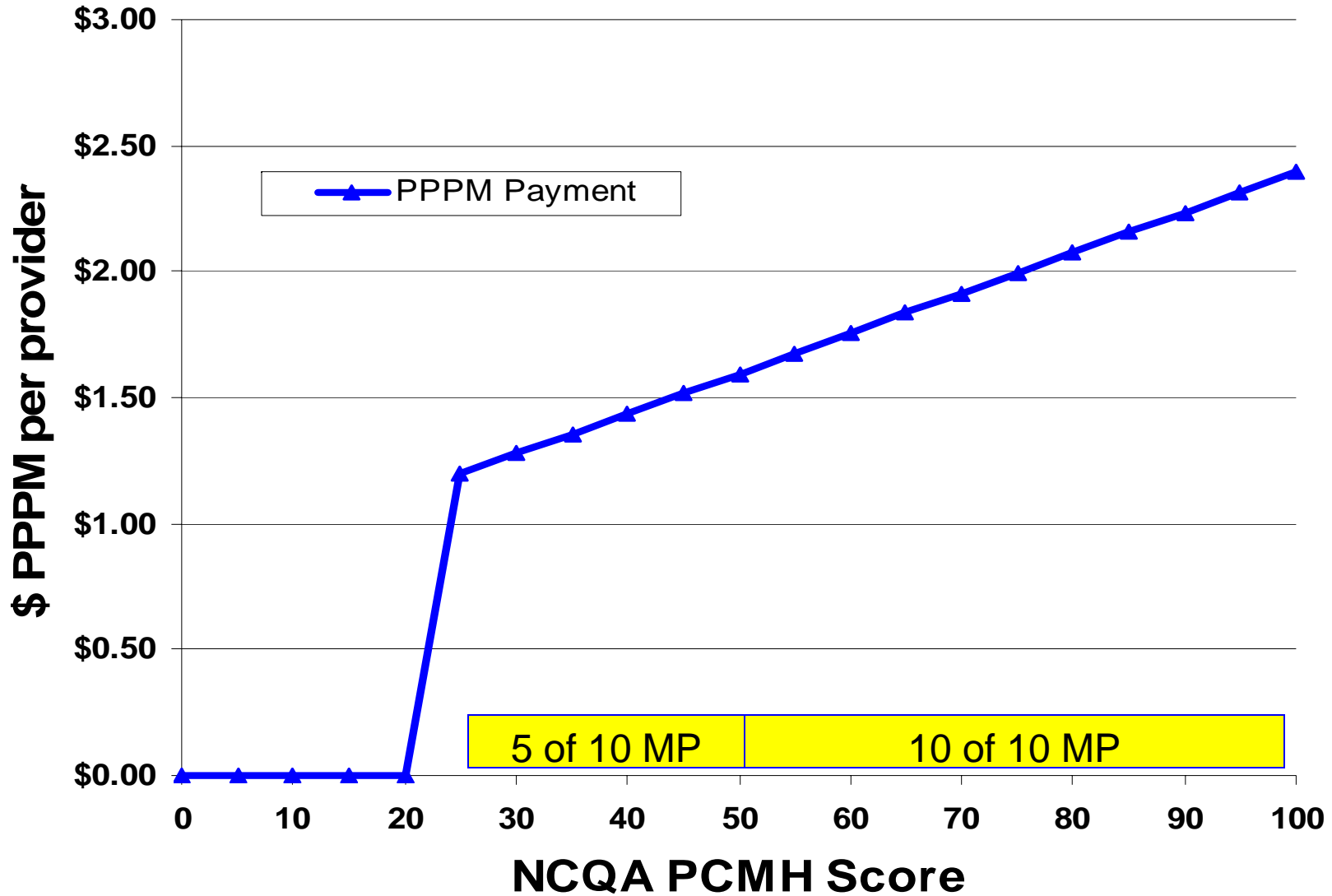
Provider Payment Table (\$PPPM for each provider)

Requires 5 of 10 must pass elements

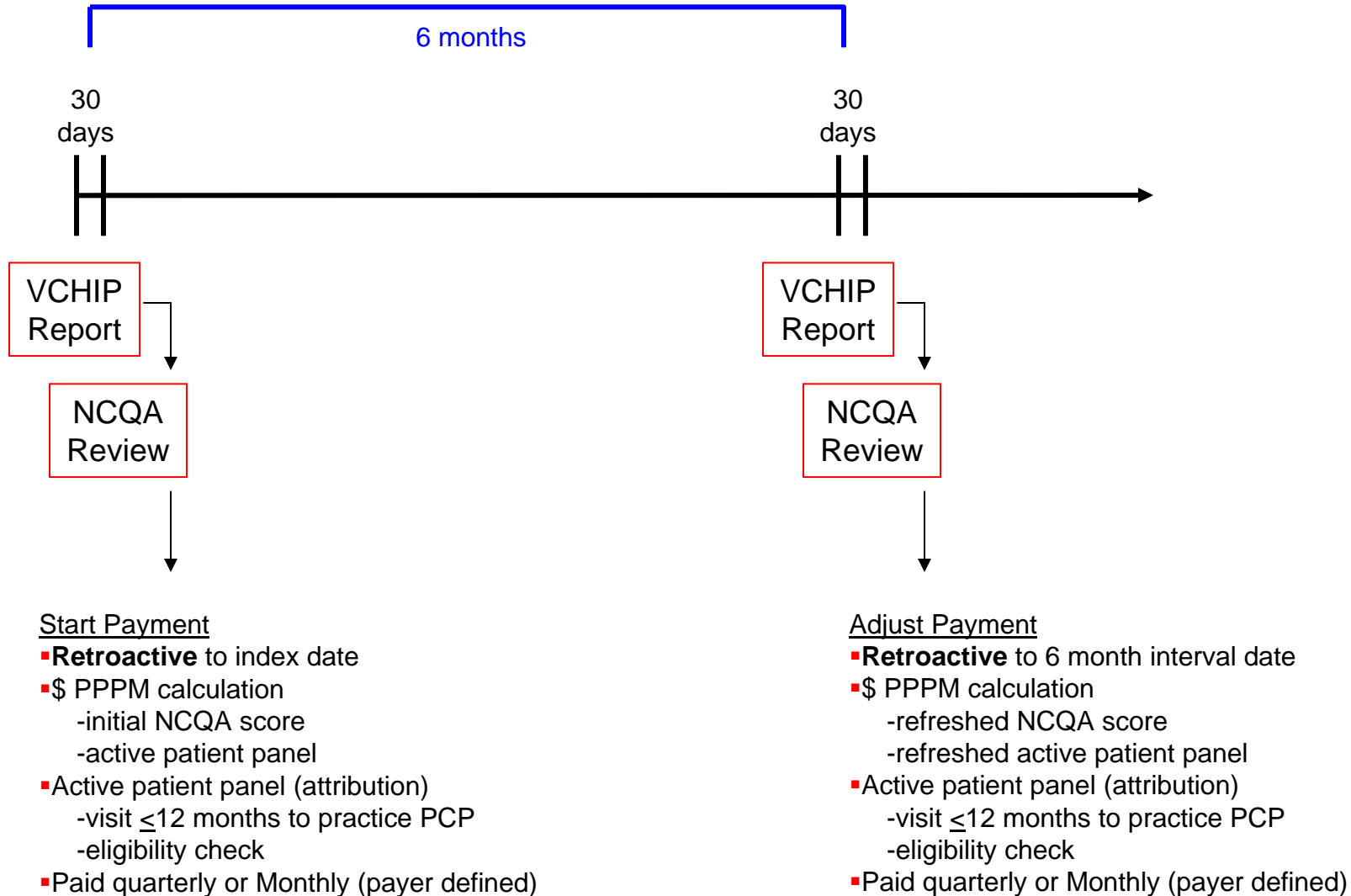
Requires 10 of 10 must pass elements

NCQA PCMH Points	Average PPM 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

NCQA Scoring & Provider Payment



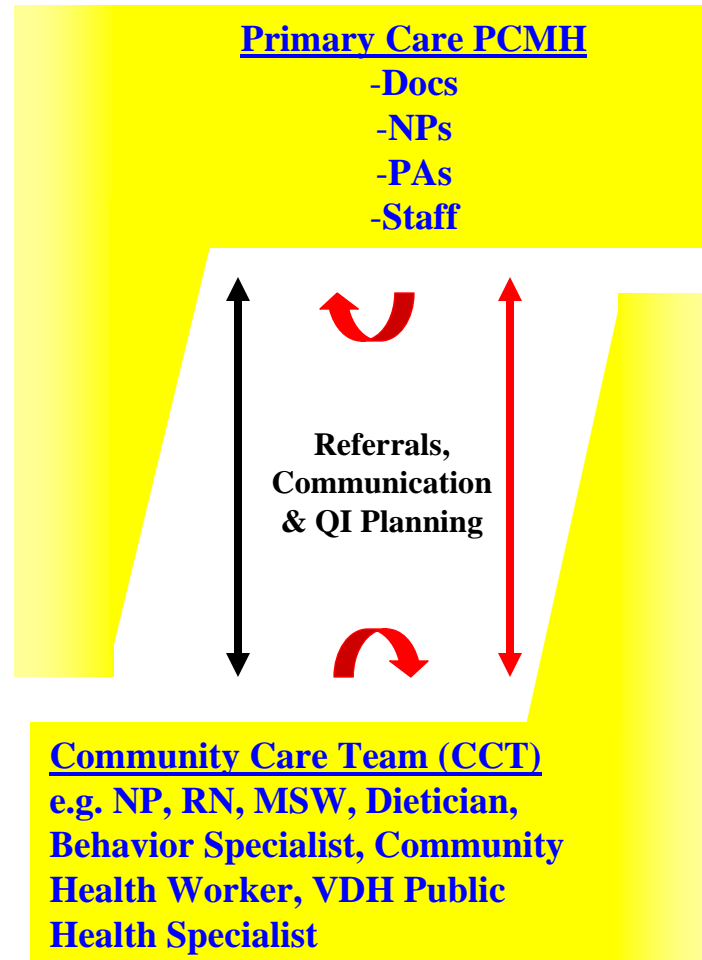
Practice Evaluation & Payment Model



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



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

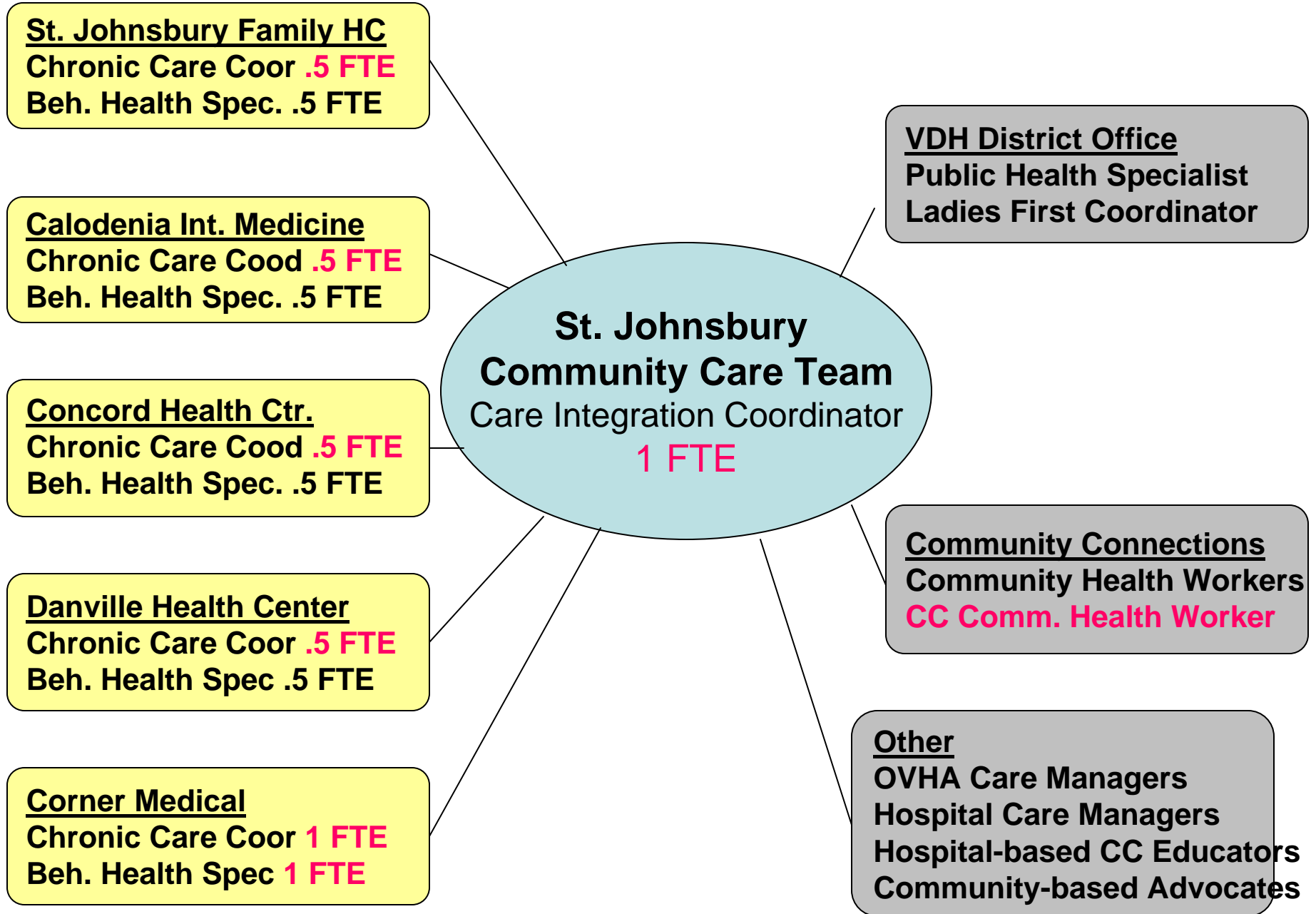
- Referral to community programs
- Coordinate community programs

Vermont Health Information Platform (VITL)

— Referral & care support

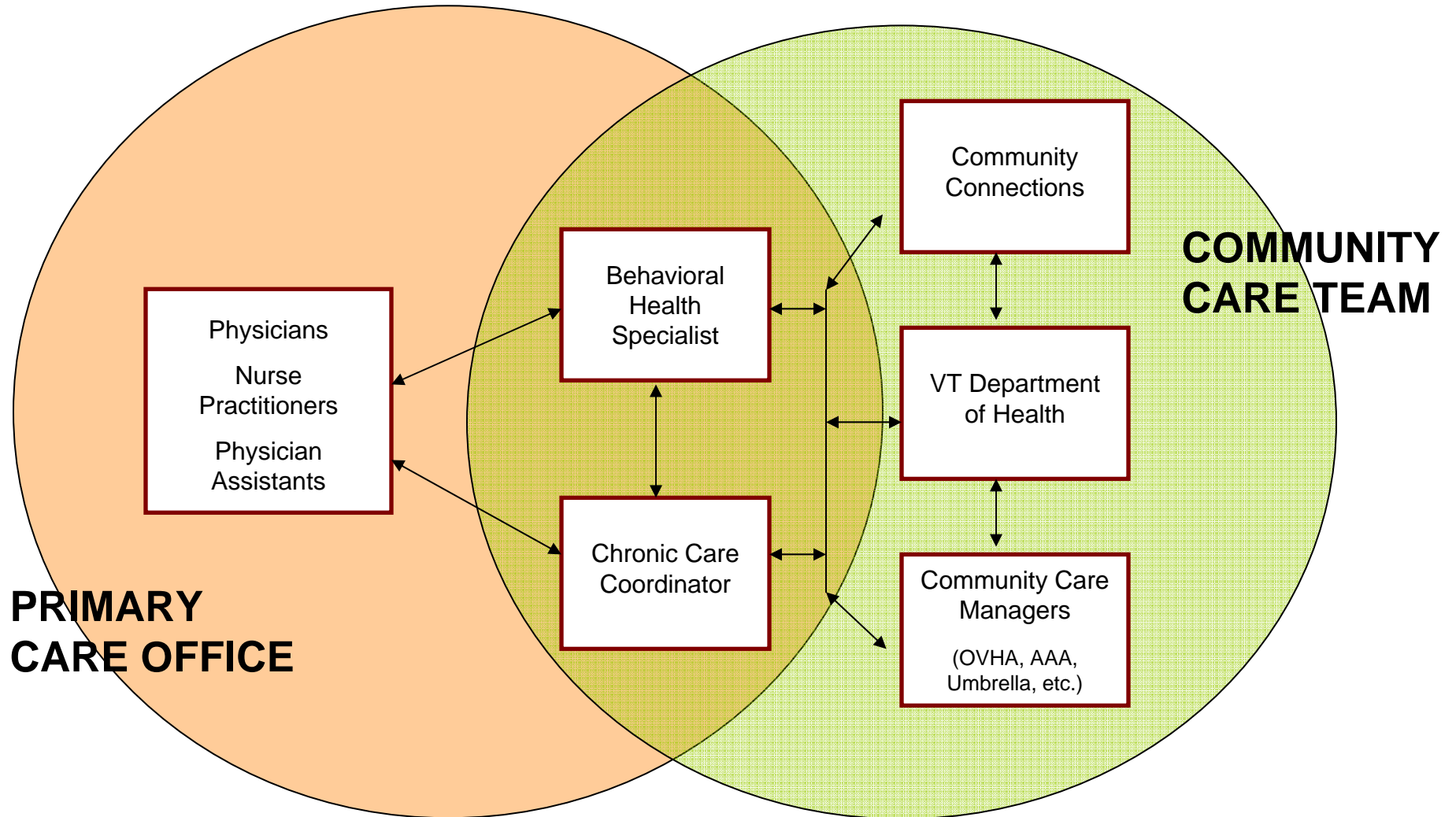
— Education & Improvement

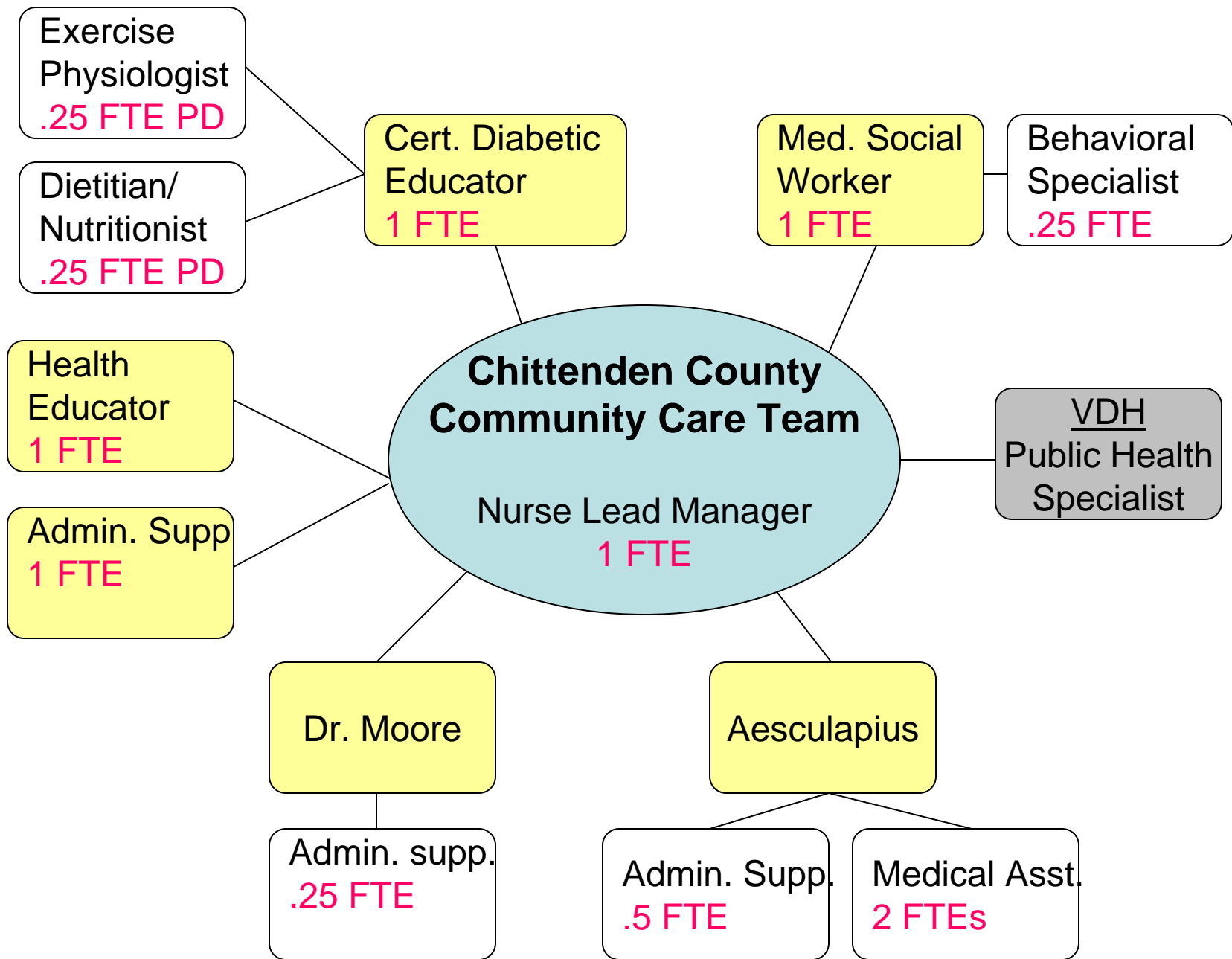
— Public Health & Prevention



St Johnsbury Community Care Team

Referral and Communication Flow Chart



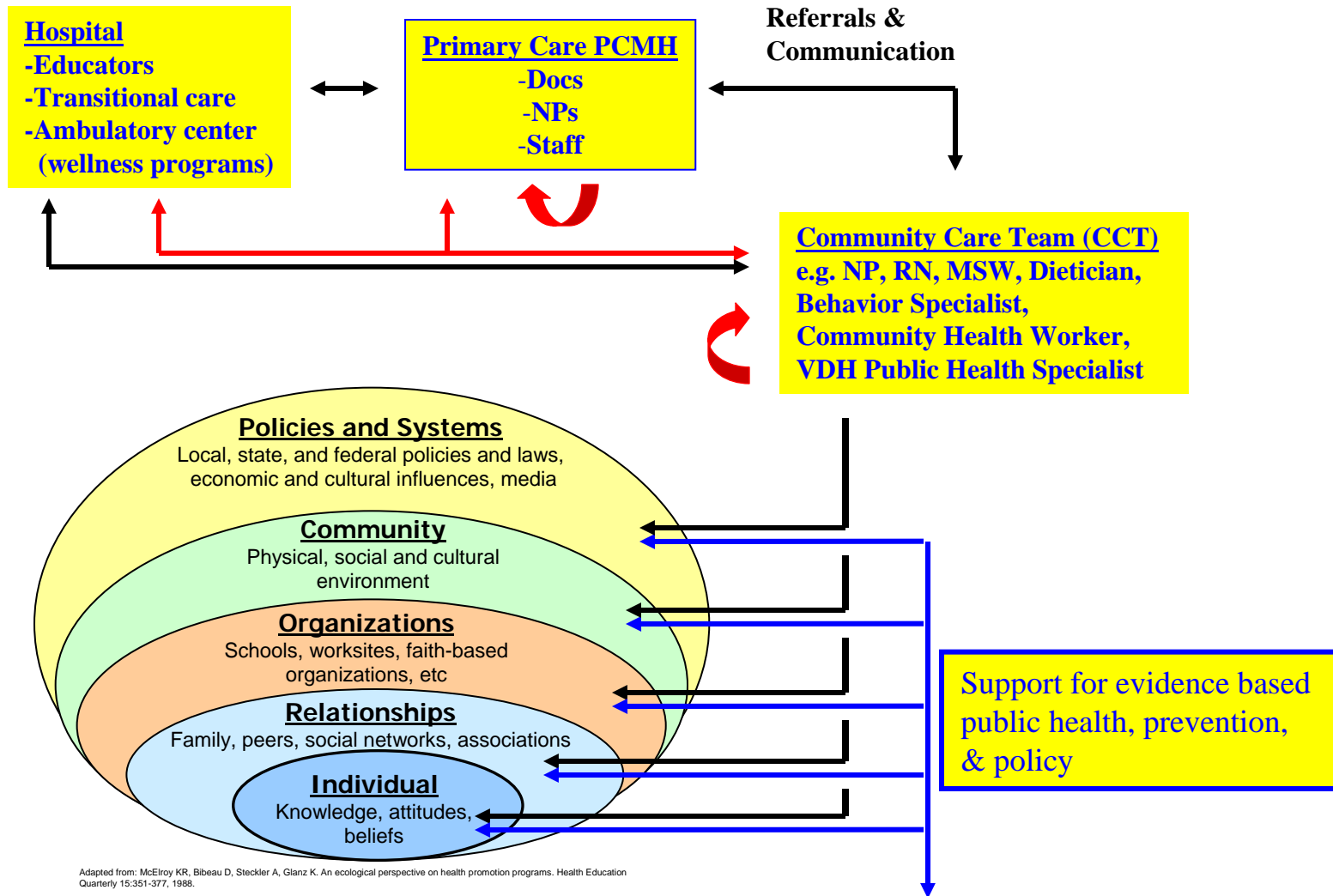


Pilot Participants

Pilot Site		# Provider	# Patients
Community	Practice		
St. Johnsbury			
	Caledonia Internal Medicine	3	2,011
	Concord Health Center	2	2,183
	Corner Medical	6	14,500
	Danville Health Center	2	3,088
	St. Johnsbury Family Health Center	2	2,822
	Total St Johnsbury	15	24,604
Burlington			
	Fletcher Allen Affiliated Aesculapius Medical Center	9	15,774
	Private Practice – Non Affiliated	1	1,800
	Total Burlington	10	17,574
Third Pilot (TBD)			
Total		25	42,178

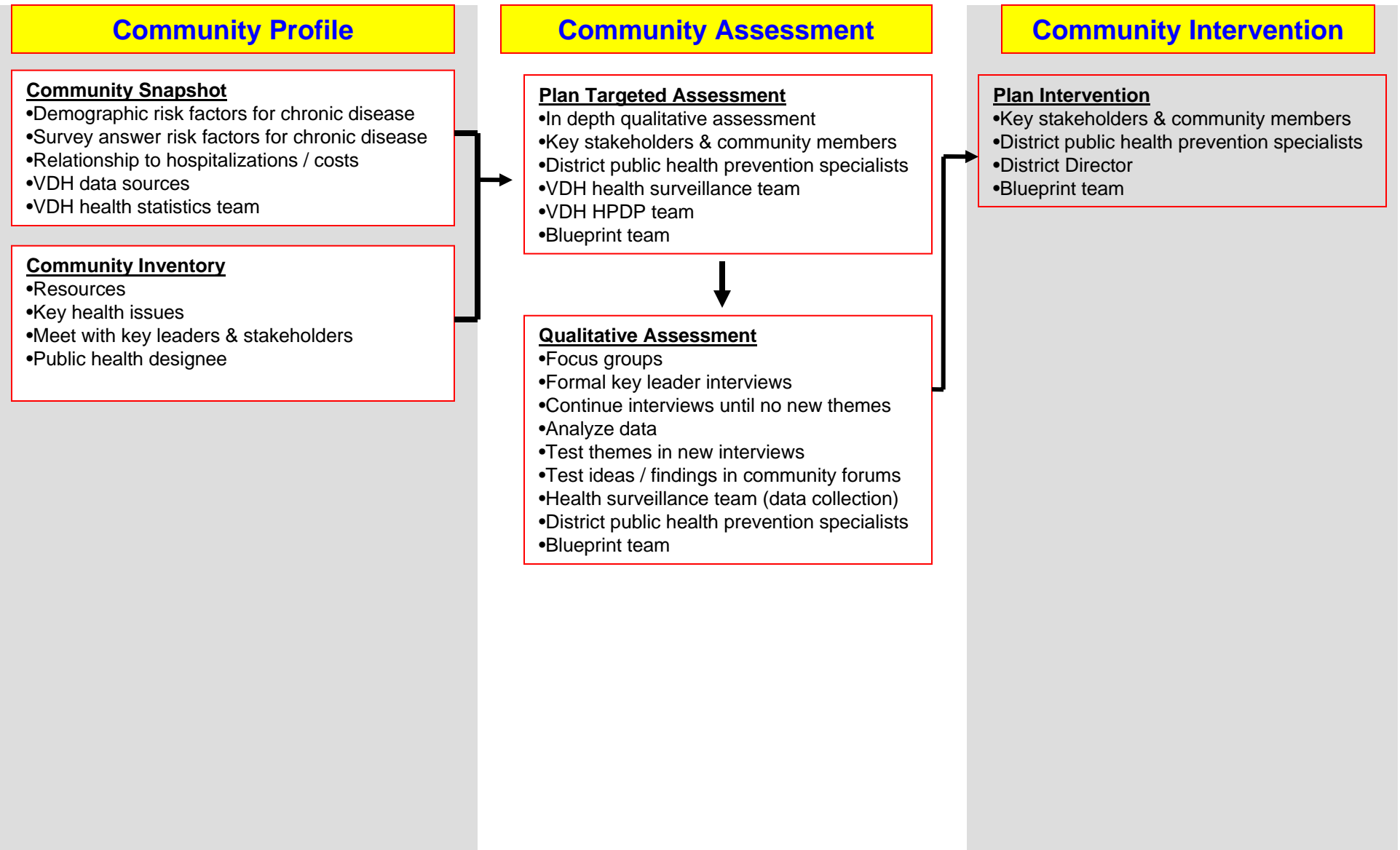
* Estimated patient panel provided by each practice

Model for Health & Prevention



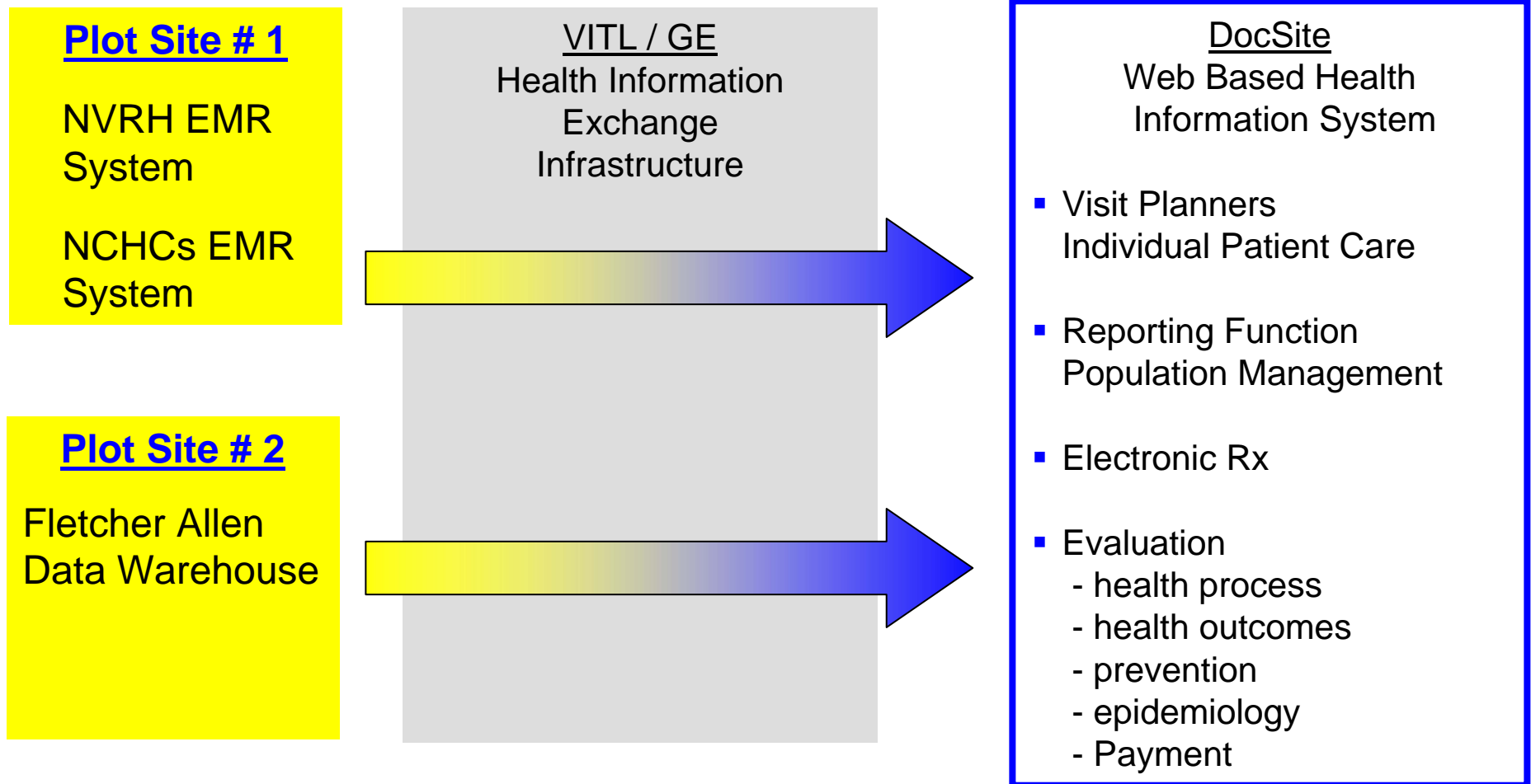
Adapted from: McEroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. Health Education Quarterly 15:351-377, 1988.

Community Activation & Prevention



Model for Health & Prevention

Health Information Environment – Data Transmission



Health Information Environment – Clinical Operations

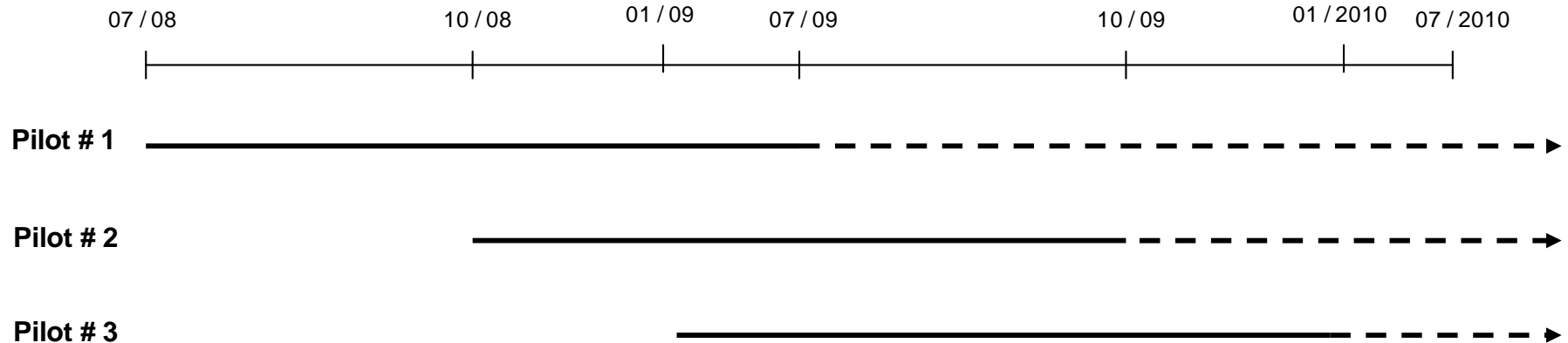
1. Providers & Community Care Teams can adapt the use of health information technology that meets their needs
2. Sites with updated EMR likely to use their system for individual patient care
3. Sites with EMR can use DocSite for report generation and population management if reporting functions are superior 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 supports evaluation of clinical process & health status measures (common data elements from all sites)

Pilot Objectives

The purpose of this project is to determine whether providing practices with the infrastructure and financial incentives to operate a PCMH, thru a public-private partnership, leads to:

1. A sustained increase in practice adherence with nationally recognized standards for a PCMH.
2. An increase in the proportion of patients that receive guideline based care for prevalent chronic conditions and health maintenance.
3. An increase in the proportion of patients that achieve improved control of their chronic health condition
4. A shift from episodic to preventive patterns of care
5. A beneficial shift in the total and / or marginal costs of care

Blueprint Pilot Timeline & Evaluation



Category	Data Source	Evaluation Outline
PCMH healthcare process quality	<ul style="list-style-type: none"> •NCQA PCMH Score •VCHIP practice review •NCQA recognition 	<ul style="list-style-type: none"> •Pilot practices •Change from baseline
Clinical process measures	<ul style="list-style-type: none"> •DocSite data base •VCHIP Chart Review 	<ul style="list-style-type: none"> •Pilot practices •Practices in BP communities delivering routine care •Change from baseline & comparison
Health status measures	<ul style="list-style-type: none"> •DocSite data base •VCHIP Chart Review 	<ul style="list-style-type: none"> •Pilot practices •Practices in BP communities delivering routine care •Change from baseline & comparison
Cost of care & admin measures	<ul style="list-style-type: none"> •VHCURES – multipayer database 	<ul style="list-style-type: none"> •Pilot practices vs practices delivering routine care •Controlled comparison

Contact Information

Craig Jones, MD

craig.jones@state.vt.us

(802) 828-1354

Lisa Dulsky Watkins, MD

lwatkin@vdh.state.vt.us

(802) 652-2095

