Blueprint Evolution...Health Reform Evolution...Vermont’s Blueprint for Health as an Agent of Change

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Evolving Medical Home Payment Models to Better Support Triple Aim Goals

Hunt Blair, Deputy Commissioner, Division of Health Reform & State HIT Coordinator, Department of Vermont Health Access
Patients Engaged & Empowered

Payment Reform

Seamless Services

Continuous Improvement

Culture of Change & Transparency

Access to Real Time Data & Information

Generation of Useful Knowledge

Culture of Change & Transparency
Blueprint Continuum of Care – General Health Services

Level of Need

Higher Acuity & Complexity

Advanced Primary Care Practice
Medical Homes

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

Community Health Teams

• Support Patients & Families
• Support Practices
• Coordinate Care
• Coordinate Services
• Referrals & Transitions
• Case Management
• Self Management Support
• Counseling
• Population Management

Specialized & Targeted Services

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

Locus of Service & Support

Lower Acuity & Complexity
# Blueprint Advanced PC Practice Payments based on NCQA Scoring

<table>
<thead>
<tr>
<th>NCQA PCMH 2011 six standards</th>
<th>Six must-pass elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance Access and Continuity</td>
<td>Access During Office Hours</td>
</tr>
<tr>
<td>Identify &amp; Manage Patient Populations</td>
<td>Use Data for Population Management</td>
</tr>
<tr>
<td>Plan &amp; Manage Care</td>
<td>Care Management</td>
</tr>
<tr>
<td>Provide Self-Care &amp; Community Support</td>
<td>Support Self Care Process</td>
</tr>
<tr>
<td>Track &amp; Coordinate Care</td>
<td>Track Referrals &amp; Follow-up</td>
</tr>
<tr>
<td>Measure &amp; Improve Performance</td>
<td>Implement Continuous QI</td>
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</table>
All insurers pay enhanced payment based on a practice 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.
There is friction related to *shifting from a centralized, hierarchical structure to a flattened, distributed approach*, because it runs counter to the predominant business model of most of the current health care ecosystem.

For reasons we know all too well, we often see side-by-side centralized networks competing, not collaborating.
Health reform provides an opportunity to change the model, to shift to a distributed paradigm for health care, where each of us is equal, across a broad spectrum of federated, distributed networks.
Community Health Teams

Key attributes of these teams:

- They provide multi-disciplinary support for PCMHs & their patients
  - Work locally in communities and directly with practices
    - Functionally integrated into the practice setting
  - Replace and pool resources otherwise directed to insurer-based Disease Management programs and contractors
- Team is scaled based on the # patients in the PCMHs they support
  - Scalable team can support all sizes & types of practices
- Core resource that is readily available to patients based on need
- The ‘glue’ in a community system of health for the general population
- Funded equally by all insurers, including Medicaid and Medicare
- A foundation of medical homes and community health teams that supports 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 electronic health records (EHRs), 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
## Blueprint Growth as of January 2012

<table>
<thead>
<tr>
<th>Category</th>
<th>Practices</th>
<th>PCP Clinicians</th>
<th>PCP Clinician FTEs</th>
<th>CHT FTEs</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Owned Practices</td>
<td>37 (47%)</td>
<td>224</td>
<td>195</td>
<td>27</td>
<td>181,429</td>
</tr>
<tr>
<td>Independent Practices</td>
<td>22 (28%)</td>
<td>83</td>
<td>63</td>
<td>12</td>
<td>77,066</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>20 (25%)</td>
<td>124</td>
<td>101</td>
<td>14</td>
<td>94,838</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>79</strong></td>
<td><strong>431</strong></td>
<td><strong>359</strong></td>
<td><strong>53</strong></td>
<td><strong>353,333</strong></td>
</tr>
</tbody>
</table>

**Blueprint Growth as of January 2012**
## Blueprint Continuum of Care – General Health Services

### Community Health Teams

**Augmented by SASH (Support and Services at Home) Teams & Medicaid Care Coordinators**

- 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

### Additional Programs

Building off of the BP structure and paradigm to replicate and expand the CHT approach for more targeted population case management & care coordination for:

- Dually Eligible pops
- Integrated Family Services (Children with Special Health Care Needs, etc.)
- Sec. 2703 Health Home initiatives such as “Hub & Spoke” substance abuse program

### Specialized & Targeted Services

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

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