Development of a Vermont Pilot Community Health System To Achieve the Triple Aims

Webinar
February 23, 2010

Jim Hester PhD
Director
Vermont Health Care Reform Commission

Outline

- Context: Vermont Health Care Reform
- Building a Community Health System
  - Conceptual Framework
  - Enhanced Medical Home pilots
  - Development of an ACO pilot
- Key findings and conclusions
- Current status and next steps

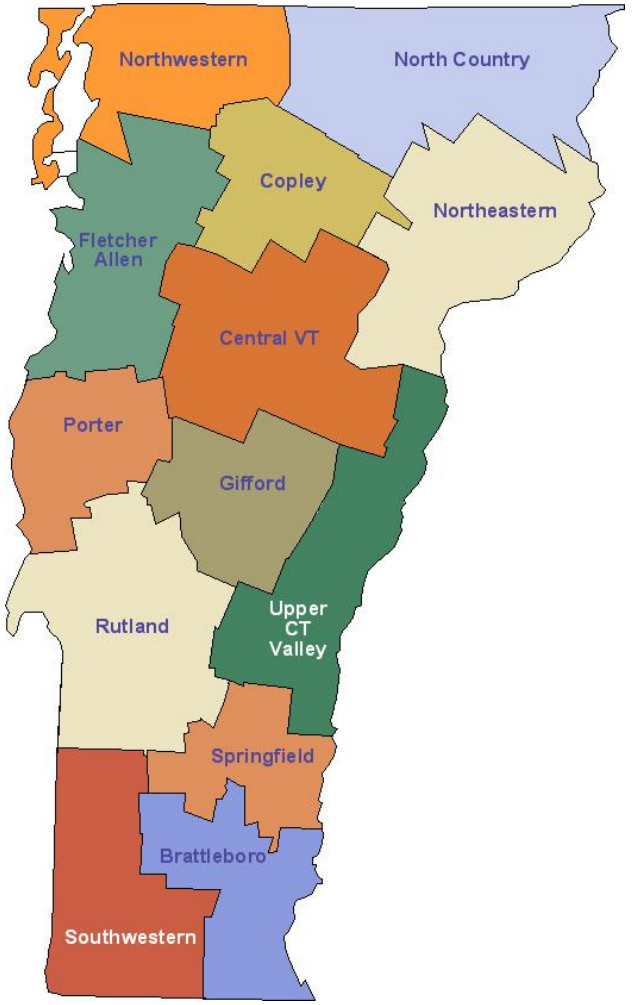
I. Context: VT Health Reform

600,000 total population

13 Hospital Service Areas define ‘community systems’

Payers: 3 major commercial + 2 public

History of collaboration: bipartisan and multi-stakeholder



Vermont's Reform Strategy

Act 191 (2006) created 'three legged stool' which balanced

1. Sustainable reduction in uninsured from 10% to 4% by 2010
2. Health IT as catalyst for improved performance
3. Bending the medical cost curve through delivery system reform
    - Blueprint for Health: Chronic illness prevention and care

Plus a variety of supporting projects (60+)

Five Years of Preparation

- Focus on Chronic Illness Care
  - Sickest 10% study group (2001)
  - VPQHC/IHI learning collaborative (2001-5)
  - Public/private partnership in Blueprint for Health (2004)
- Health Information Technology
  - Hospital association study group (2004)
  - Statewide Regional Health Info. Exchange. (VITL) (2005)

Status: Reducing uninsured

- New commercial products (Catamount Health) offered 10/1/07
- Major outreach to 60,000 uninsured by wide range of organizations
- As of 12/09
  - 12,500 enrolled in Catamount
  - 17,300 new enrollees in state programs
  - Reduced uninsured from 10% to 7% in declining economy

Status: Health IT as catalyst for performance improvement

- Statewide health information exchange network (VITL) funded and being built
- Statewide health IT plan approved
- Pilot programs implemented
  - Medication history for ER patients
  - Pilot program for PCP EMR
- Health IT Fund: 0.2% fee on paid claims for 7 yr
  - Electronic Health Record: fund implementation for all independent primary care MD's
  - Fund state wide Health Information Exchange infrastructure
- Align with federal stimulus: HITECH in ARRA
- Goal: IT as a driver for clinical transformation

II. Building a Community Health System

‘Every system is perfectly designed to obtain the results it achieves.’

Approach

- System redesign at multiple levels
  - Primary care practice level: Enhanced medical homes
  - Community health system: ‘neighborhood’ for medical home
  - State/regional infrastructure and support e.g. HIT, payment reform
  - National: Medicare participation
- Start in pilot communities

Building Blocks for Community Health System

- Chronic Care Model (2005-6):
  - VPQHC collaboratives on Wagner's Chronic Care Model
  - Blueprint for Health: Implement CCM in pilot communities
  - Add prevention component to CCM
- Enhanced Medical Homes (2007-10)
  - Expand beyond chronic illness
  - Begin building community based, population health focus
- Triple Aims (2007-10)
  - IHI Triple Aim participant (2007)
  - Legislation (2008)
- ACO Pilot (2008-10)
  - Feasibility study (2008)
  - Support for VT pilot site (2009)
  - Accelerated expansion of pilots (2010 in process)

Building ‘Systemness’

Key generic functions in a community health system

- **Service** integration across levels and settings of care
  - patient centered integrated care models
  - integration of health care, public health and supporting social services to support population health
- **Financial** integration
  - financial models across multiple payers
  - Local management of integrated budgets
- **Governance**: Provide leadership, and establish accountability
- **Information**: Deploy information tools to support care, management, process improvement and evaluation
- **Process improvement**: Design, implement and improve performance

Payment Reform

- Necessary, but not sufficient element of reform
- One of most difficult, particularly integrating across payers
- Phase I: Blueprint enhanced medical home pilots links primary care incentives to medical home functions
- Phase II : ACO pilot broadens incentives to community providers
- What will enable the ACO pilot to be successful?

Phase I: Community Based Enhanced Medical Home Pilots

- Payment reform for primary care
  - Patient Centered Medical Home (PCMH) model
  - Sliding care management fee linked to 10 NCQA PCMH criteria
- New community health team funded by payers
- All payer participation:
  - Mandated participation by 3 commercial payers and Medicaid
  - State paying for Medicare patients
- Community based prevention plan and evidence based interventions
- Strong IT support: DocSite clinical tracking tool, EMR interfaces, and health information exchange
- Timeline: Covered 10% of VT population in 3 communities by 12/09

VERMONT Blueprint for Health

Smart choices. Powerful tools.

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**

VERMONT Blueprint for Health

Smart choices. Powerful tools.

Blueprint Integrated Pilot Summary

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**
- **Updated EMRs to match program goals and clinical measures in DocSite**
- **Health information exchange network**

4. Community Activation & Prevention

- **Prevention specialist as part of CCT**
- **Community profiles & risk assessments**
- **Evidence based interventions**

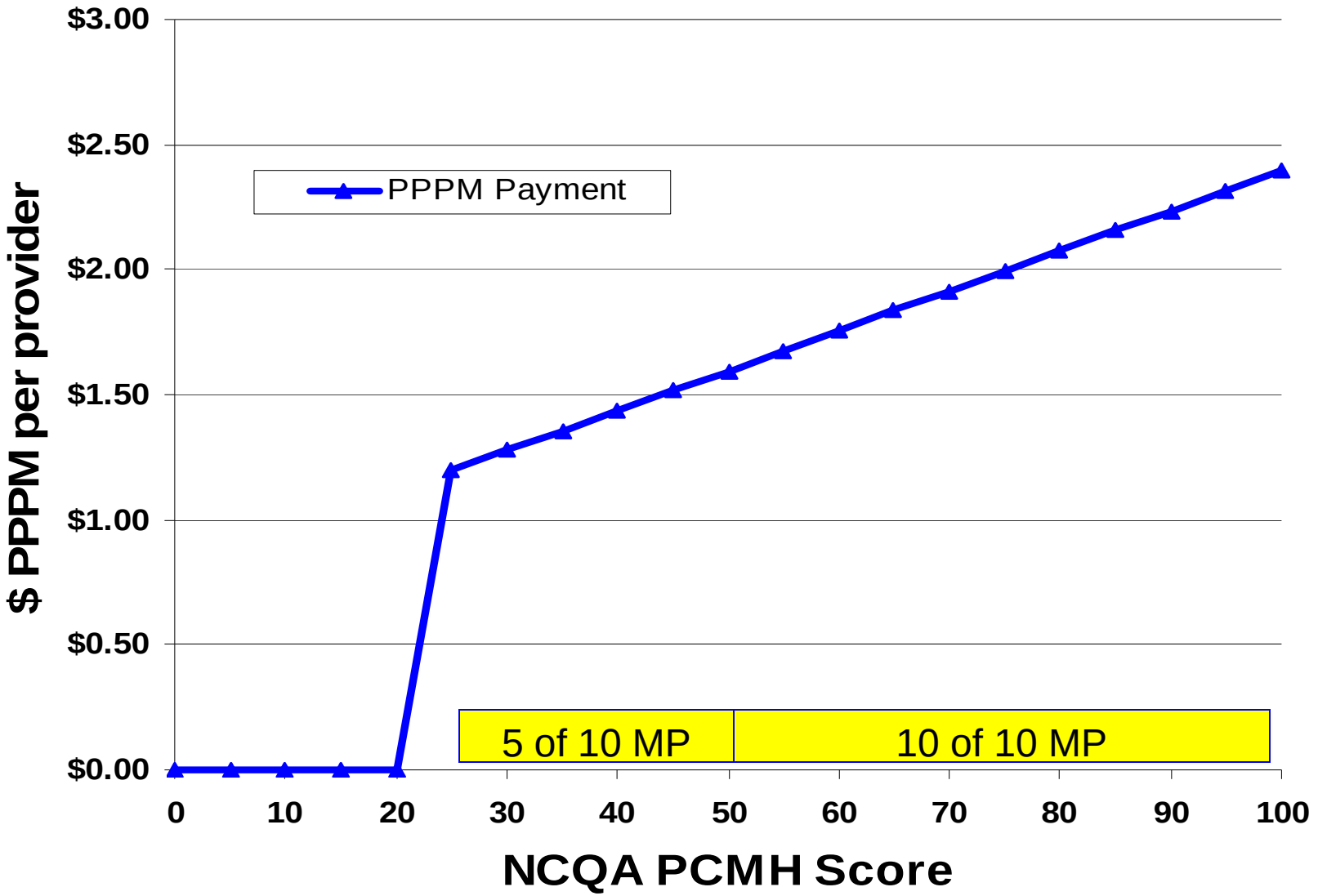
5. Evaluation

- **NCQA PCMH score (process quality)**
- **Clinical process measures**
- **Health status measures**
- **Multi payer claims data base**

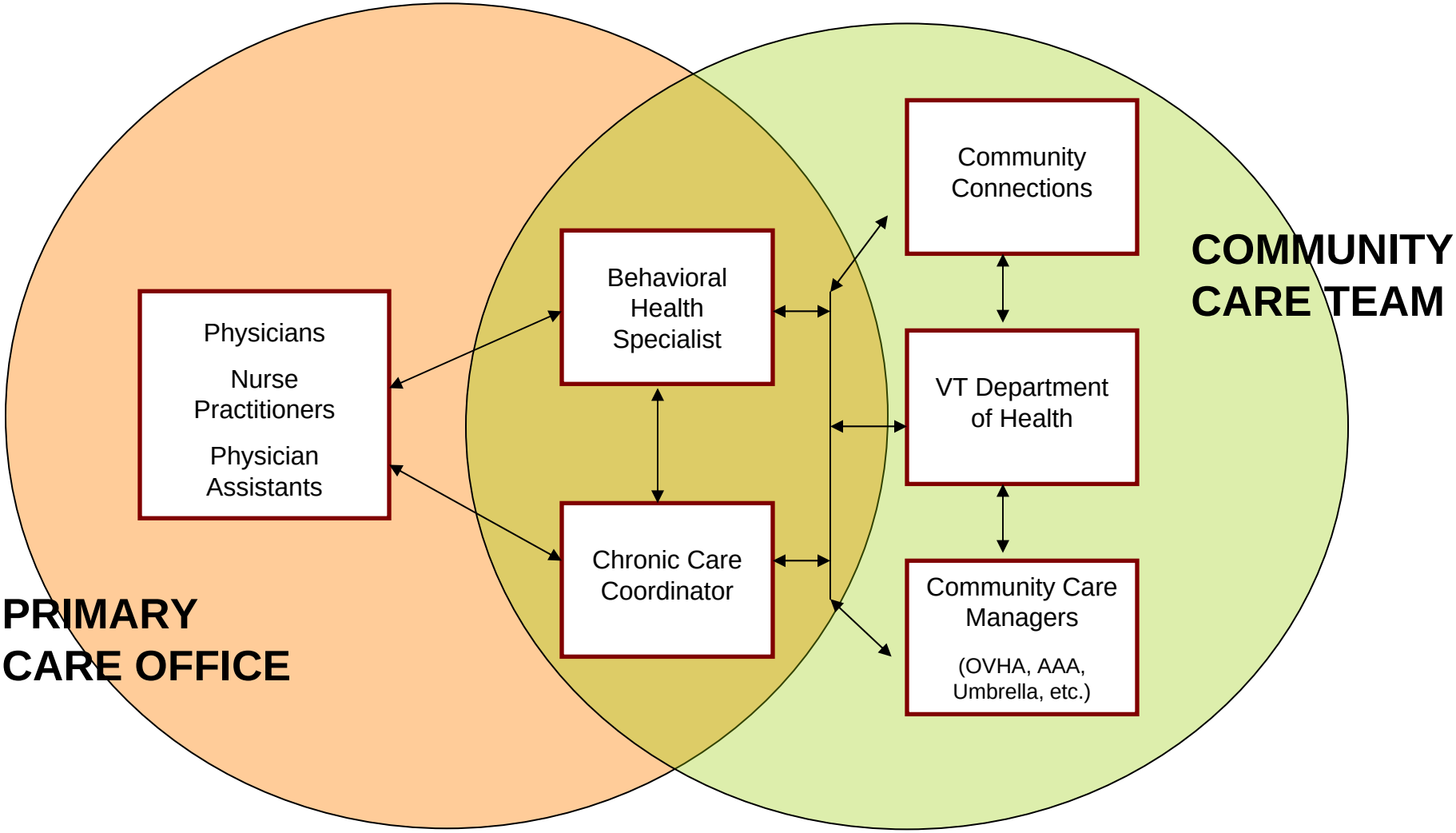
VERMONT Blueprint for Health

Smart choices. Powerful tools.

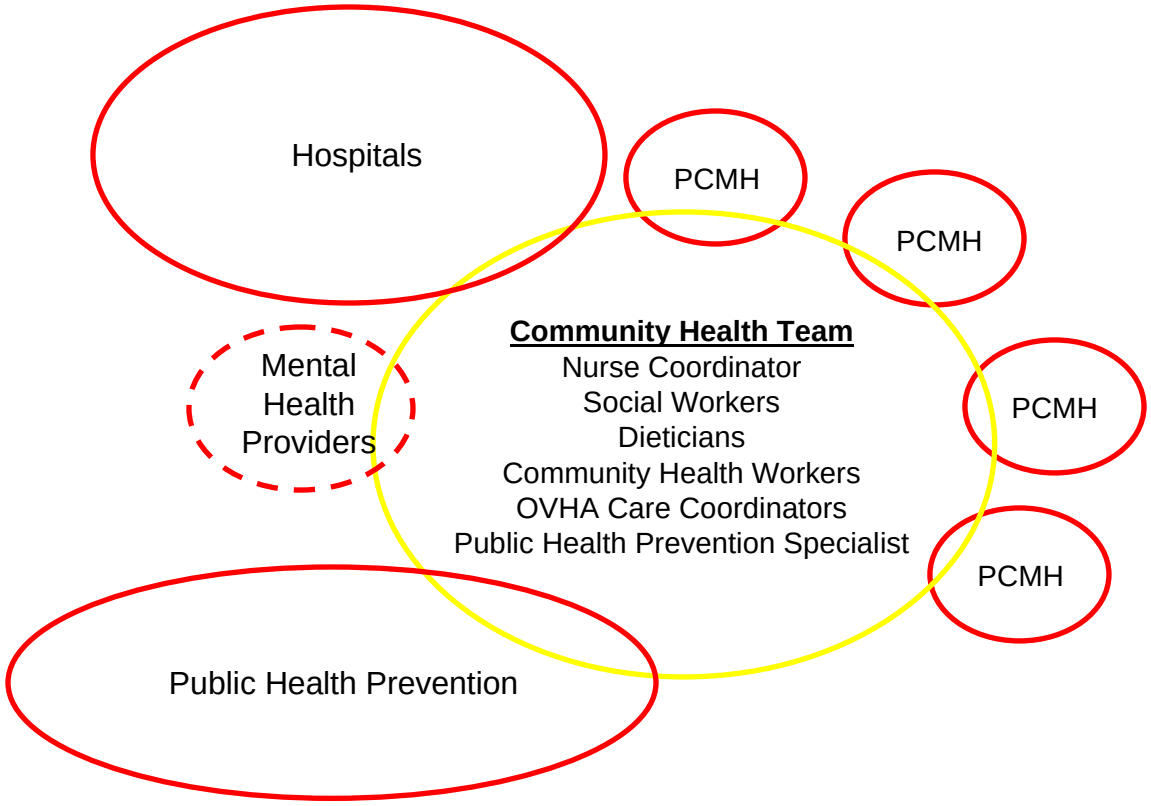
NCQA Scoring & Provider Payment



Community Care Team



Blueprint Enhanced Medical Home Pilots



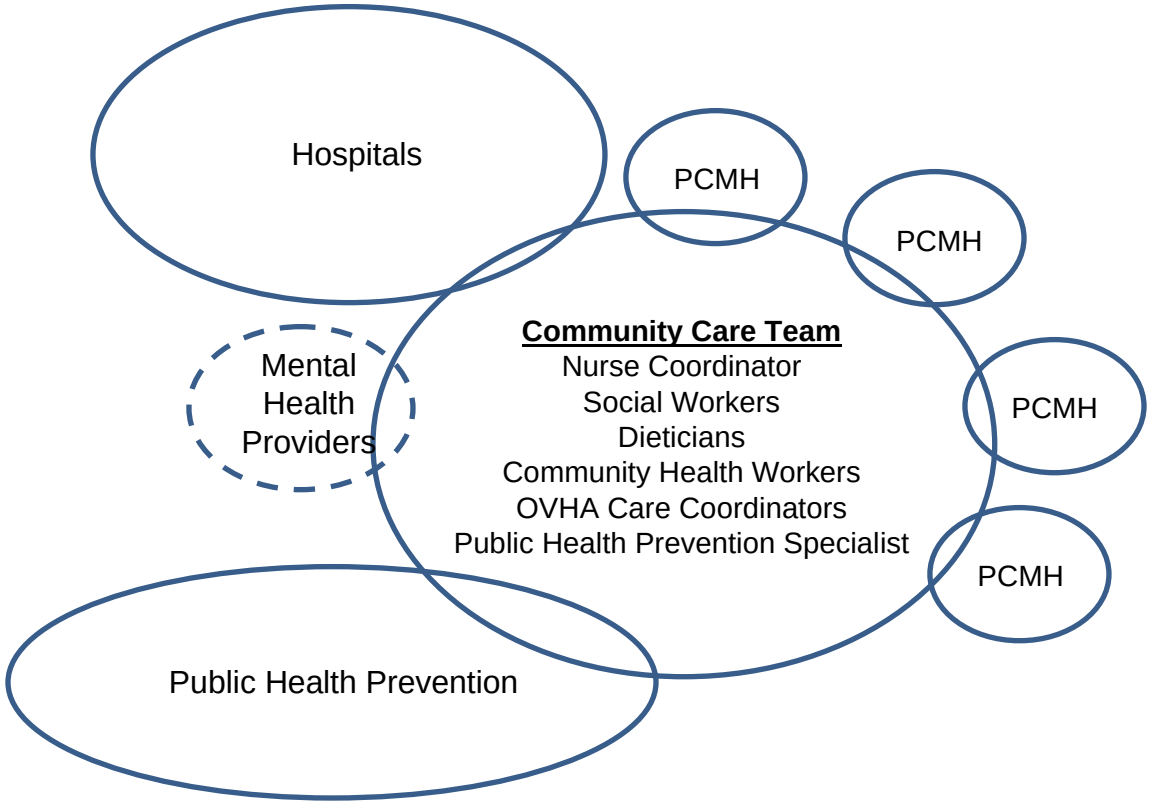
Health IT Framework

Global Information Framework

Evaluation Framework

Operations

Blueprint Integrated Pilots
Coordinated Health System



Healthcare Information Framework

Health System Information Framework

Evaluation & Framework

Operations & Uses Framework

- EMRs
- DocSite
- Practice Management Systems
- Hospital Information Systems

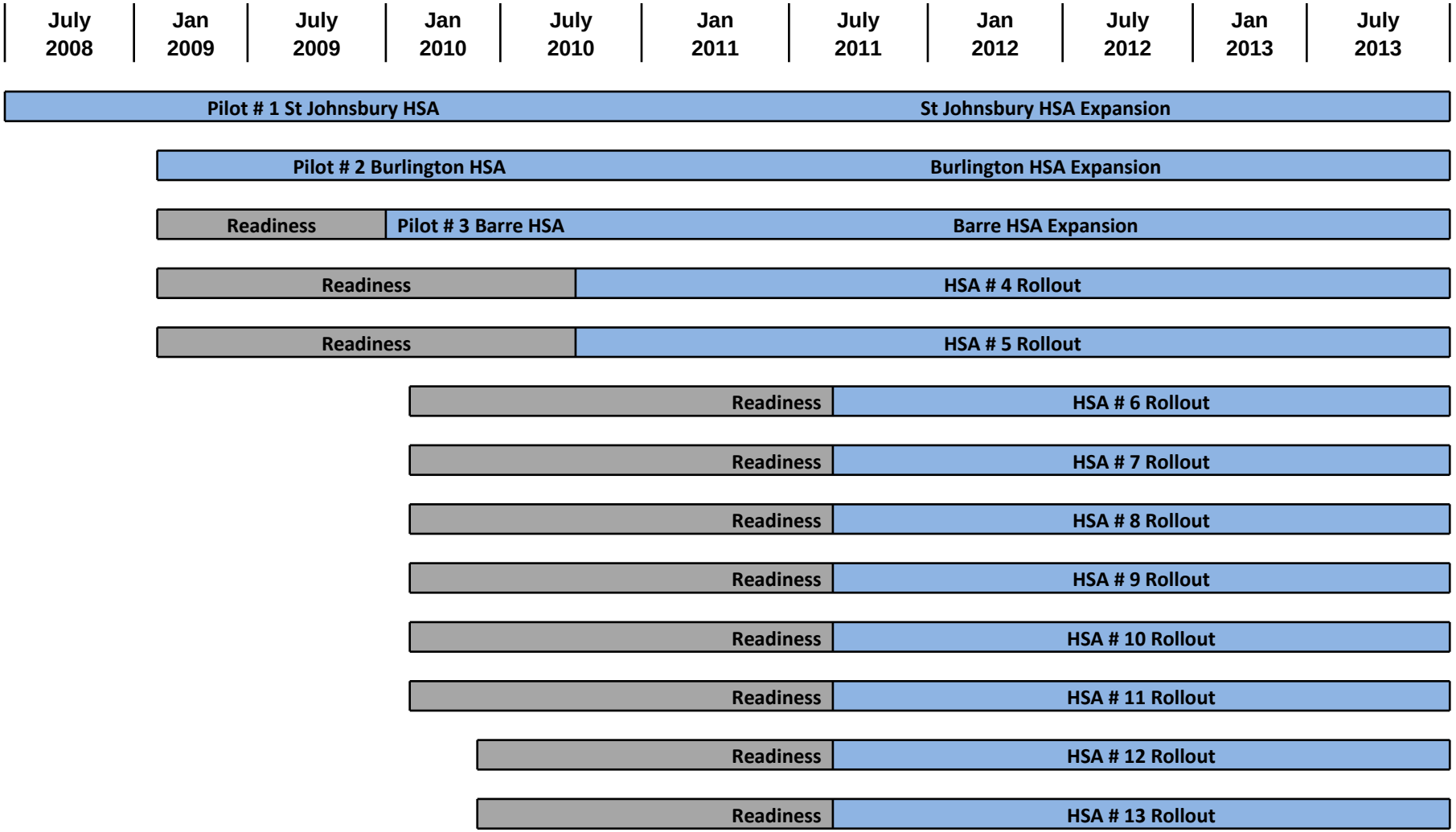
- EMRs
- DocSite
- Practice Management Systems
- Chart reviews
- NCQA Scoring
- Hospital Information Systems
- Public Health Databases

- NCQA Scores
- Clinical Process Measures
- Health Status Measures
- Healthcare Resource Utilization
- Healthcare Expenditures
- Financial Impact ROI
- Population Health Indicators

- Individual Patient Care
- Population Management
- Quality Improvement
- Program Evaluation
- Program Sustainability
- Community Activation / Prevention
- Health Policy

Blueprint Integrated Health System - Proposed Expansion

VERMONT Blueprint for Health
Smart choices. Powerful tools.



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

Implementation Phase | **Demonstration Phase (Medicare?)**

VERMONT Blueprint for Health

Smart choices. Powerful tools.

Building Capacity for Statewide Expansion

Central Blueprint Team

Director (1), Associate Director (1), Regional Coordination & Strategic Planning (4), Program Design – Contracting (2), Administrative Support (1)

Local Blueprint facilitators (8)

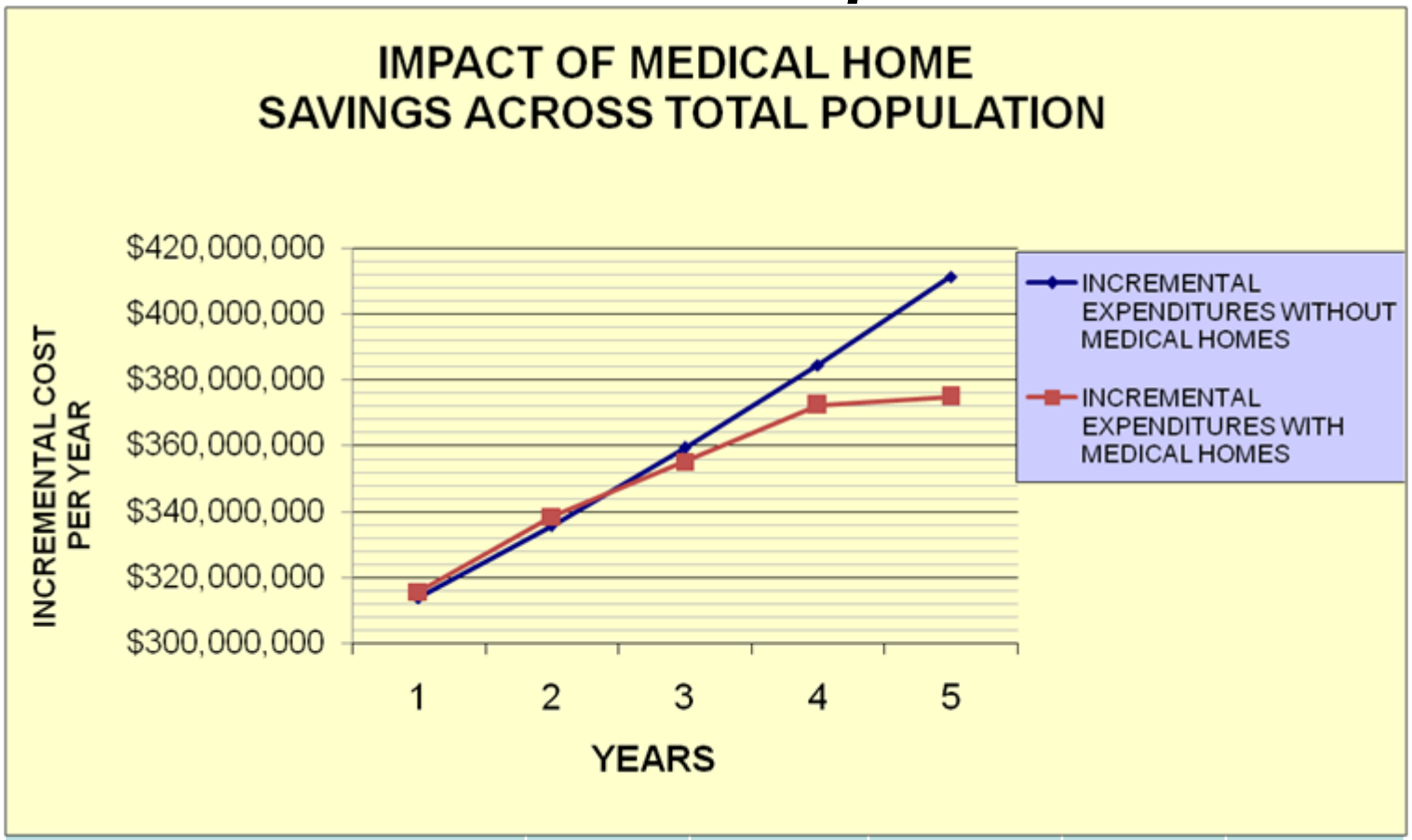
Technical support, learning collaboratives, specialized assistance (contracts - VITL, DocSite, VPQ, Fletcher Allen)

Local administrative leadership, clinical leadership & IT leadership, project management (grant support, in-kind)

Status: Enhanced Medical Homes

- Pilot communities started 8/08, 1/09, 12/09: well received by patients, physicians and staff
- Laying foundations for state wide expansion by 2013
- HHS has announced state based, multi-payer pilots in advanced primary care models based on Vermont's design

Blueprint Integrated Pilots
Financial Impact



	2009	2010	2011	2012	2013
Percentage of Vermont population participating	6.7%	9.8%	13.0%	20.0%	40.0%
Participating population	42,179	61,880	82,332	127,045	254,852
# Community Care Teams	2	3	4	6	13

Phase II: ACO Pilot

- Focus on community health system level
- Translate potential system wide savings into actual savings
- Capture part of shared saving to reinvest in local community health system
  - Transition funding for adjusting to reallocation
  - Investments in population health, primary care, etc.

Goals of The ACO Pilot

- Improve performance in IHI ‘triple aims’
  - Bend the medical cost curve – significant savings over projected trend line of costs (2-5%/yr)
  - Improve the health of the community population and the patient experience
- Test the ACO concept in a small number of ‘early adaptor’ community provider networks that already have key functional capabilities.
- Have at least one Vermont site in the national ACO Learning Collaborative and Learning Network

ACO Pilot Support

Commission's Approach:

- Create working design and assess critical issues and tasks in
  - Scale and scope of pilot: e.g. minimum population, covered services
  - Responsibilities and criteria for ACO site
  - Financial model, including incentive structure
  - Funding of new functions and pilot administration
- Educate broad based workgroup of stakeholders in the ACO concept
- Support provider development of pilot application for national ACO collaborative. (VT could not fund its own ACO program.)

III. Findings & Conclusions

	Service integration	Financial integration	Governance & leadership	IT tools and reporting	Process improvement
Primary care practice					
Community health system					
Regional/ state					
National/ federal					

Service Integration by Level

- Practice level
  - Chronic Care Model
  - Enhanced Medical Home
- Community level
  - Clinical care coordination and integration
  - Medical home support: Community Health Team
  - Prevention: Community Health Assessment and Activation
- State level
  - VPQHC learning collaboratives for Chronic Care Model
  - Blueprint for Health: Start up funding, training, technical support, evaluation
- National level
  - ACO learning collaboratives: training, technical support
  - CMS Advanced Primary Care Model pilot: CHT's

Financial Integration by Level

- Practice level
  - PCP payment reform: pmpm care coordination fee
- Community level
  - ACO financial incentive: savings sharing
  - Management of integrated medical budget
- State level
  - All payer payment reform model (medical home, ACO)
  - Medicaid & Medicare participation in pilots
  - Patient attribution model
  - ACO financial impact model
- National
  - Medicare & Medicaid participation in pilots
  - ACO learning collaboratives: technical support
  - Foundation support (CMWF) for financial model

IT Tools & Reporting by Level

- Practice level
  - Patient clinical tracking: registry, flow sheet, population based reports
  - EMR interface
- Community level
  - Health information exchange for clinical coordination
  - Financial reporting: actual vs. target, drill down
  - Population based reports
- State level
  - Health information exchange
  - Development of web based tools for practices (DocSite)
  - All payer claims data base
  - Population based reports, public health reporting

Conclusions

- Community health system level is the focal point of delivery system reform
  - Integration/coordination of service network that provides bulk of care to a population
  - Integration of community based health assessment and intervention plan
  - Development of local resources to support healthy behaviors

Conclusions

- ACO is a promising financial reform at community level which should be tested in pilots.
- ACO's will require participation of public payers, particularly Medicare, to realize their potential
- Likelihood of success of ACO pilots is enhanced by key pre-requisites
  - Implementation of medical home model, including primary care payment reform
  - All payer participation in a common financial framework, including Medicare, Medicaid and commercial
  - Strong IT support for operations, reporting and evaluation
- These pre-requisites require significant effort and time.

  Vermont is 6-12 months away from completing foundation work for ACO

Conclusions

- Some large integrated care systems have the scale and resources to work concurrently at practice, community and regional/state levels to support ACO's.
- However, most small and medium sized communities and care systems will depend upon state/national support for
  - Defining a common financial framework for all payers
  - IT support for clinical tools, process improvement, information exchange, reporting and evaluation
  - Technical support and training
  - Start up funding

IV. Current Status and Next Steps

- Three qualified and interested ACO pilot sites identified & participating in National Learning Network
- Creating all payer model
  - Three major commercial payers participating and consolidated shared savings pool accepted
  - Plan for Medicaid participation and waiver filing due 7/10
  - Planning for Medicare participation: reform bills or Medicare pilot
- Financial impact model for ACO developed for two sites
- Draft legislation to accelerate expansion to 50% of hospitals by end of 2012
- Coordinate/integrate development of local infrastructure with Blueprint medical home statewide expansion
  - Core staffing: project management, practice facilitator
  - IT support and health information exchange

- “You can count on Americans to do the right thing … after they have tried everything else” (Winston Churchill)

Resources

- Vermont Health Reform
  - Health reform : http://hcr.vermont.gov/
  - Information technology: http://www.vitl.net/
  - Health Care Reform Commission: http://www.leg.state.vt.us/CommissiononHealthCareReform/default2.cfm

    Jim Hester, Director, 802 828-1107, jhester@leg.state.vt.us

VERMONT Blueprint for Health

Smart choices. Powerful tools.

Office of Healthcare Reform
Office of Vermont Health Access
312 Hurricane Lane
Suite 201
Williston, VT 05495

Susan W. Besio, Ph.D.
Director
Office of Vermont Health Access
Vermont Health Care Reform
802-879-5901
susan.besio@ahs.state.vt.us

Hunt Blair
Deputy Director
Healthcare Reform
(802) 879-5901
Hunt.Blair@ahs.state.vt.us

Diane Hawkins
Executive Staff Assistant
(802) 879-5988
diane.hawkins@vdh.state.vt.us

Vermont Blueprint for Health
Department of Health
108 Cherry Street – Suite 301
PO Box 70
Burlington, VT 05402

Craig Jones, MD
Blueprint Executive Director
(802) 879-5988 phone
(802) 859-3007 fax
craig.jones@vdh.state.vt.us

Lisa Dulsky Watkins, MD
Blueprint Assistant Director
(802) 652-2095 phone
(802) 859-3007 fax
lwatkin@vdh.state.vt.us

Jenney Samuelson, MS
Blueprint Community &
Self Management Director
(802) 863-7204 phone
(802) 859-3007 fax
jsamuel@vdh.state.vt.us

James Morgan, MSW
Blueprint Project Administrator
(802) 865-7795 phone
(802) 859-3007 fax
jmorgan@vdh.state.vt.us

Terri Price
Blueprint Administrative Support
Healthier Living Workshop
Statewide Coordinator
(802) 652-2096 phone
(802) 859-3007 fax
tprice@vdh.state.vt.us

Diane Hawkins
Executive Staff Assistant
Office of Health Care Reform
312 Hurricane Lane
Williston, VT 05495
(802) 879-5988
diane.hawkins@vdh.state.vt.us