Bringing it All Home:  
*Building on the PCMH Infrastructure*

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Guiding Legislation
Vermont’s Administration and Legislature have consistently supported Health Care Reform

2003  Blueprint launched as a Governor’s Initiative
2005  Implementation of Chronic Care Model
2006  Blueprint codification as part of sweeping reform legislation (Catamount Health – Act 191)
2007  Blueprint leadership and PCMH Pilots (Act 71)
2008  Community Health Team structure and insurer mandate (Act 204)
2010  Statewide Blueprint Expansion (Act 128)
2011  Planning for “Single Payer” (Act 48)
2012  Refinement of Exchange and Statewide Reforms
- 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 this 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
PCMH Evolution in Vermont
Blueprint Implementation
October 2012

• 100 Practices
• 435 PCP FTEs
• 423,015 Patients
• 80 Core CHT FTEs
NCQA PCMH Scores Over Time

- **2008 Standards**
- **2011 Standards**
- **VCHIP Estimate (2011 Standards)**

Date Score Received:
- June-08
- December-08
- July-09
- January-10
- August-10
- February-11
- September-11
- April-12
- October-12
- May-13
Patient Centered Medical Homes
# NCQA Recognized Practices in Vermont
Community Self Management Services

- Healthier Living Workshops (HLW) Chronic Disease
- HLW Diabetes
- HLW Chronic Pain
- Tobacco Cessation Workshops
- Wellness Recovery Action Planning (WRAP)
- Diabetes Prevention Program (CDC/YMCA)
Financing

- Medicaid
- Medicare
- BlueCross
- MVP
- Cigna
- Self Insured

Payment Reform

1. Fee for Service - Volume
2. $ PPPM (NCQA) - Quality

Delivery System Reform

Advanced Primary Care

- NCQA Standards
- Patient Centered Care
- Access
- Communication
- Guideline Based Care
- Use of Health IT

Community Support

- Community Health Teams
- MCAID CCs
- SASH Teams

Specialized Services

- Hospitals
- Specialty Care
- Mental Health Services
- Substance Use Services
- Family Services
- Social Services
- Economic Services
- Long Term Care
- Nursing Homes
Next Phases of Payment Reforms
Next Phases of Payment Reforms

- Current and planned ACOs
- Frontload CHT payments by 6 months
- Payment to PCMHs and specialists
  - Enhance $PPPM amounts?
  - Add new shared interest payment based on metrics (PCP and specialist)
Medication Assisted Treatment (MAT) for Opioid Addiction

Vermont is proposing a Medicaid Health Home program under Section 2703 of the Affordable Care Act to create a coordinated system of care for opioid addiction in its Medicaid population, focusing specifically on medication assisted treatment (MAT).

MAT, such as methadone and buprenorphine in combination with counseling, has long been recognized as the most effective treatment for opiate addiction.

Although these two primary pharmacological treatments for opioid dependence have similar effects, they are provided under two different federal regulations, resulting in two distinct provider types.
Medication Assisted Treatment (MAT) for Opioid Addiction

Rationale

- Overall health care costs are approximately three times higher among MAT patients than within the general Medicaid population.
- These individuals have high rates of co-occurring mental health and other health issues.
- They are high users of emergency rooms, pharmacy benefits, and other health care services.
Medication Assisted Treatment (MAT) for Opioid Addiction

Strategy

Vermont’s Health Home approach targets Medicaid beneficiaries with a substance use disorder program (treating it as a managed chronic condition requiring some specialty care):

• Create a framework for integrating MAT, services for other substance abuse issues, and co-occurring mental health disorders into Vermont’s patient-centered medical home initiative
• Increase the availability of methadone by 30%
• Enhance the total Community Health Team by 50% with expertise in addiction and substance use treatment
• Provide coordinated care for the same (or lower) cost as in the current “silod” mechanism
<table>
<thead>
<tr>
<th>Hub &amp; Spoke Provider</th>
<th>Payment Mechanism</th>
<th>Purpose of Payment</th>
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<tbody>
<tr>
<td><strong>Physician</strong></td>
<td>Fee-for-Service payment, under current Medicaid State Plan.</td>
<td>Medication Assisted Treatment (buprenorphine &amp; methadone)</td>
</tr>
</tbody>
</table>
| **Nurse + Clinician Case Manager** | **Hub:** % of monthly rate per patient for health home services.  
**Spoke:** Capacity payment to Blueprint Community Health Team, based on numbers of unique patients receiving buprenorphine | Care management, care coordination, transitions of care, health promotion, individual and family support, and referral to community services |
“Hub & Spoke” Health Home for Opiate Dependence

<table>
<thead>
<tr>
<th>Care As Usual</th>
<th>5 Regional Centers</th>
<th>200 Prescribing Physicians</th>
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<tbody>
<tr>
<td></td>
<td>Addictions Treatment Methadone</td>
<td>Buprenorphine</td>
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<table>
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<tr>
<th>Health Home</th>
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<tr>
<td>~ 6 FTE RN, MA / 400 Pts</td>
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Comprehensive Care Management - Care Coordination - Health Promotion - Transitions of Care - Individual and Family Support - Referral to Community & Social Supports

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<tr>
<th>Advanced Primary Care Practices and Community Health Teams</th>
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<tbody>
<tr>
<td>HUB</td>
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</table>
Financing

Medicaid
Medicare
BlueCross MVP
Cigna
Self Insured

Payment Reform

Fee for Service (Volume)

$ PPPM - NCQA Score

Shared Capacity

$ PPM Capacity
$ Quality (in design)
$ Shared Interest (proposed)

$ PPM Capacity
$ Shared Interest

Delivery System Reform

Patient-Centered Medical Homes

Community Health Teams
Medicaid CCs
Medicare (SASH) Teams

Specialized Services

5 HUBS
35 SPOKES
(Community Health Team Extenders)
Health IT Infrastructure
Central Registry provides:
- visit planners
- outreach tool
- care coordination
- reporting
Health IT Infrastructure – End to End “Sprints”

- All hands on deck
- Focus on a complete end to end process for moving useful data
- From source (e.g. EHR) through VT HIE to Central Registry
- Focus on data quality including quantitative assessments
- Measure of success - clinician attestation (data is trustworthy, reliable)
- Systematic process emerging
- Strategies that impact data quality statewide (e.g. translations)
- Reliable centralized clinical registry for multiple purposes
Health IT Infrastructure – End to End “Sprints”

- Northeastern Vermont Regional Hospital (RHC) – 1 site (soon to be 2), 1 source system
- Bennington – 4 sites, 3 source systems
- Northern Counties Health Care (FQHC) – 6 sites, 1 source system
- Northern Tier Community Health (FQHC) – 5 sites, 1 source system
- Next – several multi-site systems, data quality assessment at Vermont’s largest clinical system, independent practices using the same source system over the next year