AGENDA

1. General description and history
2. Building integrated communities of care
3. Social determinants of health
4. Striving to achieve the Triple Aim

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Vermont's Executive Branch and Legislature

Consistent Support for Health Reform

2003 Blueprint launched as Governor's initiative

2005 Implementation of Wagner's Chronic Care Model

2005 Medicaid Global Commitment (Section 1115) Waiver

2006 Blueprint codified as part of sweeping reform legislation (Act 191)

2007 Blueprint leadership and pilots established (Act 71)

2008 Community Health Team structure and insurer mandate (Act 204)

2010 Statewide Blueprint Expansion outlined (Act 128)

2011 Planning for "Single Payer" (Act 48)

Health Service Area Architecture

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Multi-Insurer Payment Reform Framework

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 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

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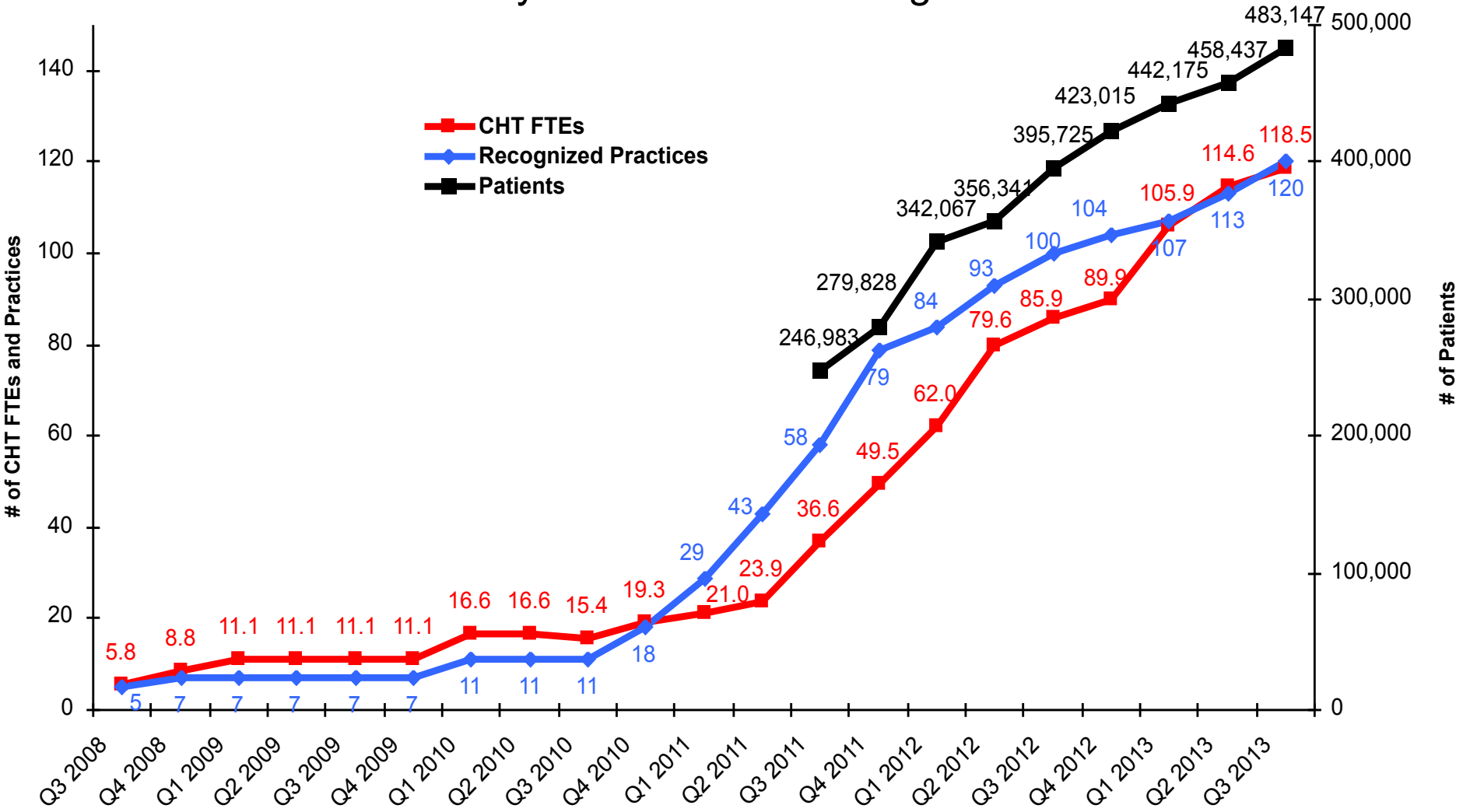
TIMELINE

Patient Centered Medical Homes and Community Health Team Staffing in Vermont



Continuum of Health Services Based on Need

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Higher Acuity & Complexity

Level of Need

Lower Acuity & Complexity

Advanced Primary Care Practice

- 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
  - Medicaid Care Coordinators
  - Senior Services Coordinators
- 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

Blueprint Payment Reforms

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Payments directly to practices
1. Fee for service
2. PMPM enhanced payments

Insurers

- Medicaid
- Commercial Insurers
- Medicare

- Medicaid Care Coordinators (for complex beneficiaries)
- Funded by Medicaid ("Global Commitment" 1115 Waiver)

- Community Health Teams
- Funded by all insurers
- Intent - minimize barriers to care access

- $35,000/2000 active pts./yr.
- Scaled based on population

- Seniors' Support Teams
- Funded by Medicare (CMMI Demonstration Project)

- $70,000/100 participants/yr.
- Scaled based on # panels

- Addictions Teams
- Funded by Medicaid Health Home (potential 90/10 federal match)

- 2 FTEs/100 suboxone pts.
- Scaled based on # pts. in prescribing practices

Health Information Technology Infrastructure

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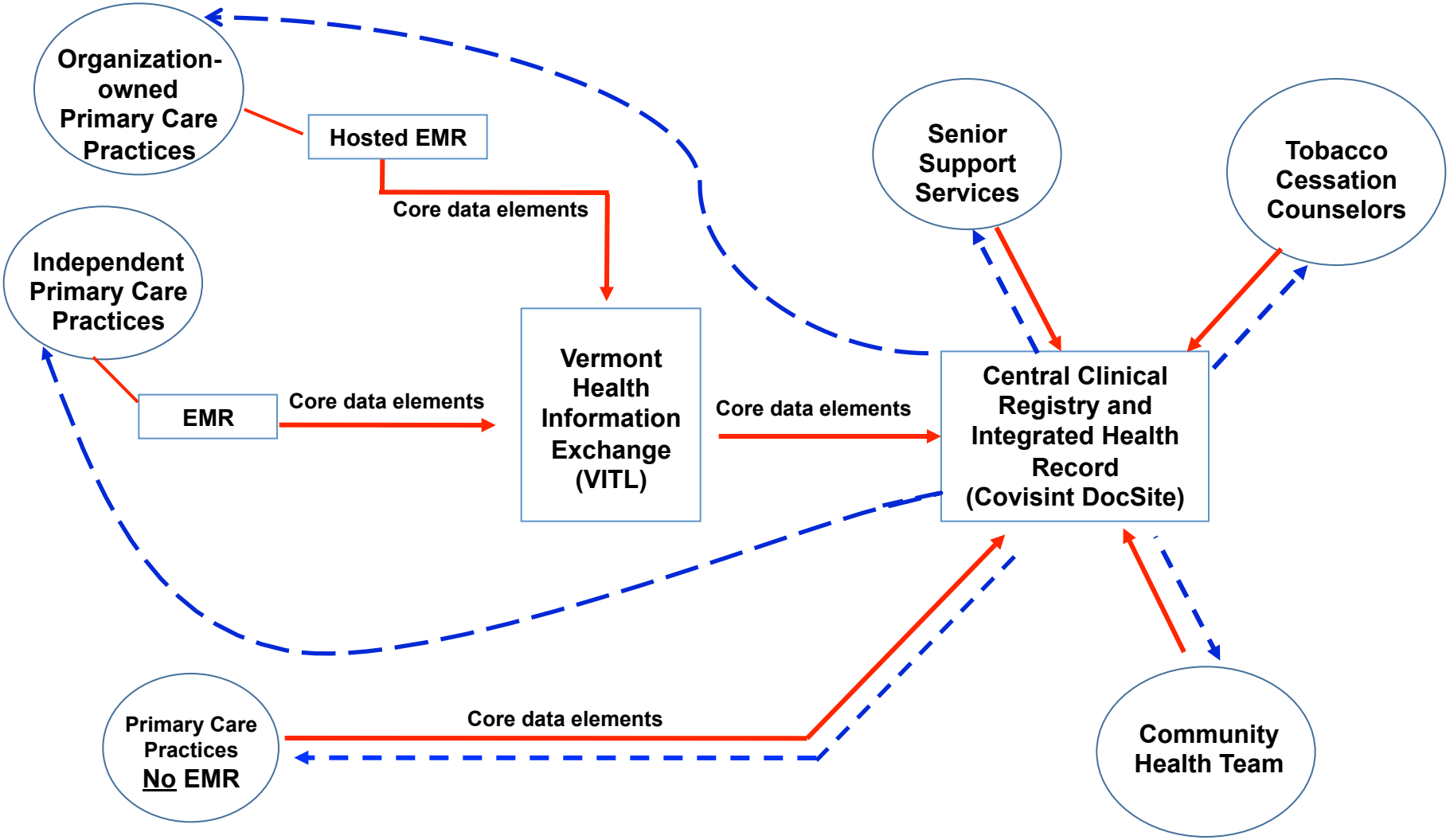

Blueprint Evaluation Infrastructure

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- **Central Clinical Registry** – sources include practices, Community Health Teams, housing sites, self-management and tobacco cessation programs, specialty providers
- **All-payer Claims Database** – utilization, cost and quality
- **NCQA PCMH Scoring** – uniformly administered by 3rd party
- **CAHPS** - Patient Experience
- **Network Analysis** - Qualitative Assessment
- **Public Health Registries** – immunization, vital statistics, cancer, CDC BRFSS

AGENDA

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2. Building integrated communities of care
   - local leadership/conveners
   - local decision-making, development and implementation
   - working outside “silos” - engaging and cultivating partnerships

3. Social determinants of health

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Principles of Team-Based Care[1]

- Shared Goals
- Clear Roles
- Mutual Trust
- Effective Communication
- Measureable Processes and Outcomes

[1]Mitchell et al, *Core Principles & values of effective team-based health care*, 2012 (Discussion Paper, Institute of Medicine, Washington, DC.) www.iom.edu

Building Integrated Communities of Care

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The local Health Service Area Project Manager convenes and maintains an Integrated Health Services (IHS) work group.

The IHS workgroup provides the forum for planning Community Health Team composition, strategies for coordinated health services, and logistics for scoring participating primary care practices based on NCQA Patient Centered Medical Home standards.

Local decision-making is a messy democratic process.

Building Integrated Communities of Care

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IHS members include but are not limited to:

- Clinicians and staff from primary care practices
- Hospital administrators
- Clinical and IT leadership
- Medical and non-medical providers from community service organizations
- Mental health and substance abuse counselors
- Department of Health district offices leaders
- Childrens' Integrated Services Intake Coordinators
- School nurses
- Consumers/Patients

Draft Network Analysis of a Vermont IHS

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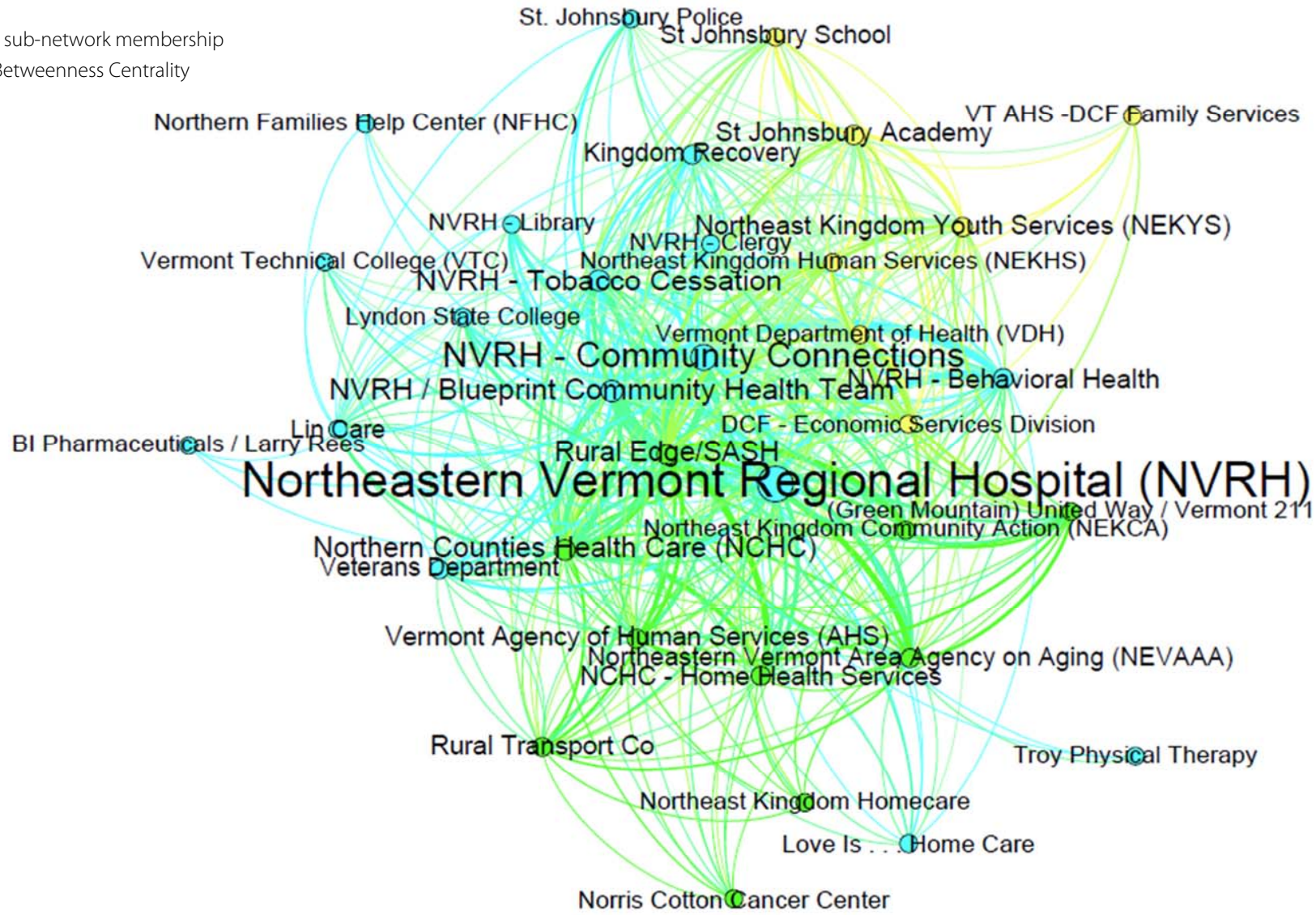
St. Johnsbury HSA
Full Network
Node color indicates sub-network membership
Node size indicates Betweenness Centrality



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1. General description and history

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3. Social determinants of health
   - Opiate addiction
   - Adverse events of childhood – the “trauma lens”

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Social Determinants of Health

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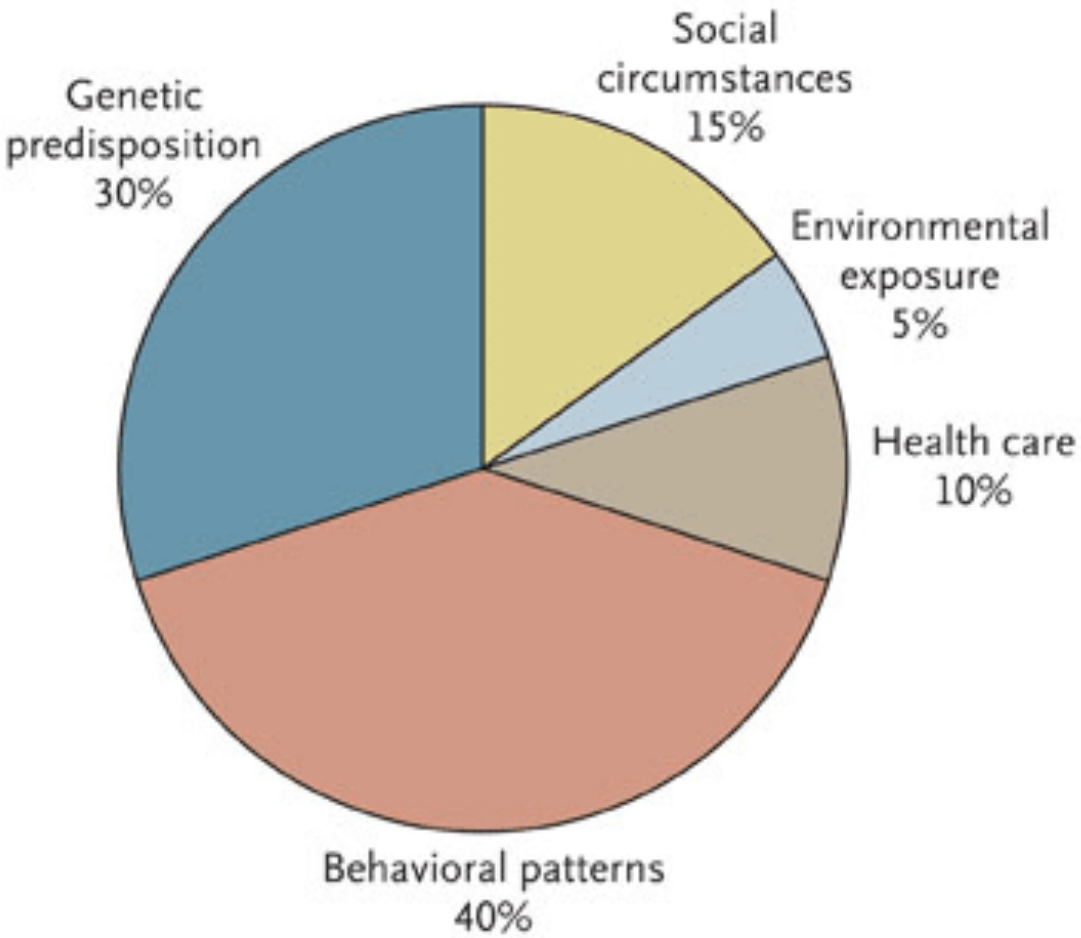
Proportional Contribution to Premature Death[2]



[2]Adapted from McGinnis, et al, *The Case For More Active Policy Attention To Health Promotion,* Health Affairs, March 2002

Social Determinants of Health

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Opiate Addiction - A “Perfect” Storm

Increasing Rates of Opioid Dependence
Inadequate Network Capacity
High Health Care Expenditures
Poor Patient (Client) Outcomes
Program & Funding Silos

Social Determinants of Health

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Medication Assisted Treatment for Opiate Addiction

- Leadership – Clinical and Administrative
- Leveraging Blueprint Infrastructure
  - Payment reforms
  - Community Health Teams
  - Support for practice improvement/transformation
- ACA Section 2703 (“Health Homes”)
- Conceptual Framework (“Hub and Spoke”)
- Effective Treatments (methadone/suboxone)

Social Determinants of Health

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Adverse Childhood Events

In 2010, the Vermont Behavioral Risk Factor Surveillance System (BRFSS) included questions on adverse childhood experiences (ACE). The BRFSS questions address the occurrence of the following childhood events: lived with someone who had mental illness, was an alcoholic, or spent time in jail, parents were separated or divorced, witnessing or experiencing physical, emotional, or sexual abuse. Studies have shown that adults with higher ACE scores show an increase in risk behaviors and health problems.[3]

[3]http://healthvermont.gov/research/brfss/documents/2010_data_brief_ace.pdf

Social Determinants of Health

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Adverse Childhood Events

In Vermont, 57% said they had at least one ACE in 2010. Nearly a quarter of adults reported one ACE (23%) and another quarter said they experienced two or three adverse events during childhood (12% had two and 9% had three).

Thirteen percent of Vermont adults had four or more ACE.[3]

[3]http://healthvermont.gov/research/brfss/documents/2010_data_brief_ace.pdf

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   - improve the experience of receiving (and delivering) care
   - improve the health of the population (outcomes)
   - control costs

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