A Deeper Dive into Measurement and Monitoring

May 16, 2016
2:00 PM – 3:30 PM (ET)
Vermont’s Measurement and Monitoring Strategy for the Blueprint for Health

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Vermont Demographics

- **Population:** 630,000
- **Hospitals:** 14 (1 academic medical center, 8 critical access...)
- **PCPs:** 467 PCPs in 127 practices in 13 Hospital Service Areas
- **FQHC’s:** 8 organizations with multiple sites, serving 122,000
- **Mental Health:** 12 Agencies
- **Substance Abuse:** 4 specialty agencies
- **Health Insurance Carriers:** 3 major; plus Medicaid & Medicare
- **Most PCPs participate in all plans**
- **Strong history of working together**
Significant Vermont Reform Efforts

- **Blueprint for Health**: statewide foundation of primary care PCMHs, community health teams, and community networks
- **Initiatives for specific populations**: e.g., Vermont Chronic Care Initiative for high-need Medicaid beneficiaries; Hub and Spoke program for people experiencing opioid dependence
- **Three ACOs** with Medicare, Medicaid, and commercial ACO Shared Savings Programs
- **Statewide infrastructure** for transformation and quality improvement; includes Integrated Performance Reporting and the Integrated Communities Care Management Learning Collaborative
- **SIM grant** provides opportunity to unify work, build on strong primary care foundation and strengthen community health systems
Blueprint for Health Structure within Each Health Service Area

- Hospitals
- Specialty Care & Disease Management Programs
- Social, Economic, & Community Services
- Mental Health & Substance Abuse Programs
- Self Management Programs

**Community Health Team**
- Nurse Coordinator
- Social Workers
- Nutrition Specialists
- Community Health Workers
- Public Health Specialist

**Extended Community Health Team**
- Medicaid Care Coordinators
- Medicare SASH Teams
- Spoke Staff for Opioid Dependence Trtmnt

- Advanced Primary Care
- Advanced Primary Care
- Advanced Primary Care

**All-Insurer Payment Reforms**
- Local Leadership, Practice Facilitators, Workgroups
- Local, Regional, Statewide Learning Forums
- Health IT Infrastructure
- Evaluation & Comparative Reporting
Vermont’s Commercial and Medicaid Shared Savings Programs (SSP)

- Commercial and Medicaid SSPs are built on Medicare Shared Savings Program
- Initiated in 2014 by Medicaid agency, largest commercial insurer (Blue Cross Blue Shield of Vermont), and three Accountable Care Organizations (ACOs) in Vermont
- Quality measures are key element; performance helps determine amount of shared savings that each ACO receives
Results of Blueprint-ACO Collaboration

- Unified regional work groups (rather than competing work groups) to review data and set clinical priorities
- Coordinated data utility/HIT infrastructure to improve access to high-quality data
- Enhanced financial support for primary care (patient-centered medical homes and community health teams)
- **Integrated performance measurement versus multiple measure sets and reports**
- Learning Collaborative to improve cross-organization care management
Vermont SSP Measure Selection Criteria

- Representative of array of services provided/beneficiaries served by ACOs;
- Mix of measure types (process, outcome, and patient experience);
- Valid and reliable;
- NQF-endorsed measures with relevant benchmarks whenever possible;
- Aligned with national and state measure sets and federal and state initiatives whenever possible;
- Focused on outcomes to the extent possible;
- Uninfluenced by differences in patient case mix or appropriately adjusted for such differences;
- Not prone to effects of random variation (measure type/denominator size);
- Not administratively burdensome;
- Limited in number and including only measures necessary to achieve state’s goals (e.g., opportunity for improvement);
- Population-based;
- Focused on prevention and wellness, and risk and protective factors; and
- Consistent with state’s objectives and goals for improved health systems performance (e.g., presents opportunity for improved quality).
Vermont ACO SSP
2015-16 Payment Measures

Commercial & Medicaid
- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite+
- Diabetes Care: HbA1c Poor Control (>9.0%)
- Hypertension: Controlling High Blood Pressure

Medicaid Only
- Developmental Screening in the First Three Years of Life
Supports for Data Collection and Reporting

• Overall System
  – Health Information Exchange
  – Clinical Registry
  – Administrative (Claims)
  – Survey Data (Behavioral Risk Factors Survey)

• For Targeted Populations
  – Event Notification
  – Dashboards
  – Condition or Population Specific Assessments
  – Care Coordination Platforms
Integrating Performance Measurement

- Blueprint comparative profiles for primary care practices and health service areas produced in collaboration with ACOs
- Profiles include dashboards with results for ACO SSP measures and other measures
- Some results are based on linked claims and clinical data
- Profiles provide Regional Work Groups with objective information for planning, quality improvement, and extension of best practices, and primary care providers with practice-level results
Vermont Health Information Flows

Key
- Manual Data Entry
- Automated Data Flow

Analytic Data Base

Organization-owned Primary Care Practices

Hosted EMR

Independent Primary Care Practices

EMR

Vermont Health Information Exchange (VHIE)

Support & Services at Home

Tobacco Cessation Counselors

Blueprint Clinical Registry

All Payer Claims

Community Health Team

Self Management Programs
Practice Profiles Evaluate Care Delivery - Commercial, Medicaid, & Medicare
Figure 27: This Prevention Quality Indicator (PQI) presents a composite of chronic conditions per 1,000 members, ages 18 years and older. This measure includes admissions for at least one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The blue dashed line indicates the statewide average.
Linked Data

**Linking Claims & Clinical Data – 2014**
Enhancing Blueprint Reporting: Clinical Outcomes

- VHCURES Members with Primary Care Visit (475,921)
- Attributed to Blueprint Practices (361,316)  
  - Non-Blueprint (114,605)
- Linked to DocSite ID (305,051)  
  - Unlinked (56,265)
- Measures (162,118)  
  - No Measures (142,933)

**Examples of Patient Volume for Key Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th># of Patients with Data</th>
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<tbody>
<tr>
<td>Weight</td>
<td>142,600</td>
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<tr>
<td>Blood pressure</td>
<td>140,286</td>
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<tr>
<td>BMI</td>
<td>122,428</td>
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<tr>
<td>Triglycerides</td>
<td>44,639</td>
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<tr>
<td>LDL-C</td>
<td>43,652</td>
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<tr>
<td>Tobacco use</td>
<td>28,779</td>
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<tr>
<td>HbA1c</td>
<td>21,418</td>
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</table>

*CY 2014 represents dates of services on and between 01/01/2014 and 12/30/2014.*
Figure 33: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the DocSite clinical database was in poor control (>9%). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.
Highlights: Measurement Considerations for Targeted VT BCN Populations

- The Vermont Chronic Care Initiative
- The Care Alliance for Opioid Addiction – Hub and Spoke
VT Chronic Care Initiative

**Medicaid high risk/high cost member case management service:**

- **Enabled by 1115 Waiver (Global Commitment) and VT legislation;**
- **Focus on Top 5% Medicaid cohort with anticipate risk:** no duals, no other CMS care management
- **Strategically aligned** within Medicaid managed care operations division: Clinical Ops, Pharmacy, Quality, Provider/Member Services
- **State funded & employed professional staff (27):** RNs, LADCs deployed statewide in AHS (agency of human services) field offices; and embedded in high volume PCPs and hospital facilities.
- **Holistic approach** to care management: clinical and social determinants
- **VCCI members of Community Health Teams and Learning Collaboratives:** coordinate care and transitions between service levels (see diagram)
- **Focus on access, utilization (ED/IP/30 day), quality (Rx adherence)& cost**
Continuum of Health Services / Care Management

Blueprint for Health

Smart choices. Powerful tools.

Level of Need

Higher 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
- MCAID CCs
- SASH Teams
- 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
- Medicaid/VCCI Case Management
  - High Risk & Acuity (top 5%)
  - ‘MOMS’ (Medicaid Obstetrical and Maternal Supports) service

Level of Service & Support

Lower Acuity & Complexity
VCCI Population: Criteria for Referral

- Individuals up to age 64
- Medicaid (not dually eligible)
- High risk, high cost, medically complex: multiple co-morbidities, providers, poly pharmacy, high IP/ED usage
- Intensive care management requirement and not receiving other CMS case management services
- Limited health literacy with respect to medical conditions
- Medical, behavioral and/or psychosocial instability adversely impacting health and generating high utilization patterns
- Emerging needs identified that could destabilize future plans for health information (housing instability, pharmacy non-adherence)
- Substance abuse/abuse history including medication assisted therapy (MAT) and post induction phase with stabilized SA tx (hub and spoke)
- PCP, hospital or AHS referral for high risk factors impacting health
- High risk pregnant women (MOMS care management service) including MAT
### Medicaid MCO & VCCI (subset) Measures: Global Commitment to Health 1115 Waiver

**Core Measures Reported to AHS**

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<thead>
<tr>
<th>FOCUS AREA/PERFORMANCE MEASURE</th>
<th>June 1, 2008</th>
<th>June 1, 2009</th>
<th>June 1, 2010</th>
<th>June 1, 2011, 2012, 2013</th>
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<th>August 1, 2015</th>
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<td>Lead Screening in Children</td>
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<td>Breast Cancer Screening</td>
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<tr>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
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<td>✓</td>
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<td>Adults’ Access to Preventive/Ambulatory Health Services</td>
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<td>Cardiovascular Conditions</td>
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<td>Controlling High Blood Pressure</td>
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<tr>
<td><strong>TOTAL</strong></td>
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</table>
VCCI Process and Clinical Measure

*Model originally based on contractor guarantee of ROI (2:1) with established baseline*

• Process measures:
  – # and % of high risk/high cost members receiving case management (Goal: 25% of top 5% cohort)
  – % reduction in hospital utilization rates for ED, IP ACS; and 30 day readmission rates
VCCI Process and Clinical Measure

• Clinical measures (samples):  
  – Pharmacy adherence: increase evidence based pharmacy rate with focus on anti-depressant treatment  
  – Improve rate of adherence to evidence base care standards:
    • **Diabetes**: A1c test (one or more) Lipid panel (1 or more); annual microalbuminuria  
    • **CHF**: ACE/ARB and long acting beta blockers,  
    • **Depression**: medication adherence (84 and 180 day); MH provider access post IP: 7 and 30 day  
    • **CAD**: annual lipid panel; lipid medication adherence; beta blocker post MI
Patient List

This list contains names and dates of birth of individuals with claims data indicating potential gaps in adherence to clinical standards. Please review this list and consider addressing the identified gaps below, if appropriate.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DOB</th>
<th>History of diabetes and no claims evidence for diabetes medications in the past 120 days</th>
<th>History of diabetes and HTN and/or nephropathy and no claims evidence for ACEI/ARB in the past 120 days</th>
<th>History of diabetes and no claims evidence for HbA1c in the past 6 months</th>
<th>History of diabetes and no claims evidence for lipid panel profile in the past 12 months</th>
<th>PROVIDER FEEDBACK</th>
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<td></td>
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<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>• Implement recommendation already implemented</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>• Implement recommendation already implemented</td>
</tr>
</tbody>
</table>
Aligning Measurement with a Population: The Care Alliance for Opioid Addiction (Hub and Spoke)

**Objective:** Prevent and eliminate the problems caused by alcohol and drug misuse.

**Indicators:**
1. % of adolescents age 12-17 binge drinking in the past 30 days
2. % of adolescents in grades 9-12 who used marijuana in the past 30 days
3. % of persons age 12 and older who need and do not receive alcohol treatment
4. % of persons age 12 and older who need and do not receive illicit drug use treatment

**Performance Measures:**
1. Are we appropriately referring students who may have a substance abuse problem?
2. Are youth and adults who need help starting treatment?
3. Are youth and adults who start treatment sticking with it?
4. Are youth and adults leaving treatment with more support than when they started?
5. Are adults seeking help for opioid addiction receiving treatment?

Source: Vermont Department of Health, Division of Alcohol and Drug Abuse Programs, January 2015
County Dashboard for MAT: Hub & Spoke

Bennington Blueprint Spoke Dashboard

Program Goals
- Improve the health of the population
- Improve the patient experience
- Reduce healthcare costs

Bennington Spoke Practices
- Hawthorn Recovery Center
- Mount Anthony Primary Care
- Shaftsbury Medical Associates
- SVMC – Deerfield Valley Health Center
- SVMC – Medical Associates (Fall 2015)

Program Funding
- Spoke Funding $163.75/PPPM for Medicaid Patients
- Requirements: 1 RN Case Manager and 1 Licensed Behavioral Health Specialist or Licensed Social Worker for every 100 Spoke patients
- Spoke services are not billable.

FY 2015 Bennington Program Budget:

<table>
<thead>
<tr>
<th>Quarter 2015</th>
<th># Medicaid Beneficiaries</th>
<th>Medicaid Funding</th>
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<tbody>
<tr>
<td>Qrt 1</td>
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<td>$83,969</td>
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<tr>
<td>Qrt 2</td>
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<tr>
<td>Qrt 3</td>
<td>226</td>
<td>$110,591</td>
</tr>
<tr>
<td>Qrt 4</td>
<td>250</td>
<td>$122,812</td>
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</tbody>
</table>

Spoke Services
- Provides on-going care system for buprenorphine patients. RN Case Managers coordinate care, recovery support and refer to community services.

Spoke Program Volume
- Mount Anthony Primary Care Total Volume by Medicaid & Other Payers
- SVMC Deerfield Valley Total Volume by Medicaid and Other Payers

Hub Services
- West Ridge Addiction Center (Rutland)
- Brattleboro Retreat (Brattleboro)

Performance Improvement Initiatives
- Standardize patient contracts across practices
- Implement standard Spoke referral tool
- Implement standard communications to PCP tool
- Establish standard communications with Probation and Parole
- Provide expertise to standardization of SVMC discharge opiate ordering protocol

Current Staffing
- Hawthorn Recovery Center: RN Case Manager 1.2 FTE, Behavioral Health Therapist/Social Worker 1.2 FTE
- Mount Anthony Primary Care: RN Case Manager 0.4 FTE
- Shaftsbury Medical Associates: RN Case Manager 0.4 FTE
- SVMC Deerfield: RN Case Manager 0.4 FTE

Patient Transfers
- 2015
- # of pts transferred from IOP: Apr 0, May 0, Jun 4, Jul 1, Aug 0, Sep 0, Oct 1, Nov 2, Dec 2
- # of pts transferred from Hub: Apr 3, May 2, Jun 0, Jul 0, Aug 0, Sep 0, Oct 1, Nov 2, Dec 2
- # of pts transferred to Hub: Apr 0, May 0, Jun 1, Jul 2, Aug 0, Sep 0, Oct 2, Nov 2, Dec 2
Treatment Engagement: Are youth and adult Medicaid recipients who start treatment sticking with it?

% of Medicaid Recipients with 2+ Substance Abuse Services within 30 Days of Treatment Initiation

Data Source: Vermont Medicaid Claims
Access to MAT: Are adults seeking help for opioid addiction receiving treatment?

Number of people receiving Medication Assisted Treatment per 10,000 Vermonters age 18-64

Data Source: Vermont Substance Abuse Treatment Information System and Medicaid Claims