Vermont Healthcare Reform:
Collaborating for Medical Home Success

The Vermont Chronic Care Initiative Aligns with Blueprint for Health to Help Primary Care Practices Succeed

Julie Trottier, MSA (APS Healthcare)
Lisa Dulsky Watkins, MD (Vermont Department of Health)

NCQA PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. **Has written standards for patient access and patient communication****	3
B. **Uses data to show it meets its standards for patient access and communication****	3
	2
	8

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. **Uses paper or electronic-based charting tools to organize clinical information****	6
E. **Uses data to identify important diagnoses and conditions in practice**	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. **Adopts and implements evidence-based guidelines for three conditions ****	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Coordinates care management including care plans, consults, reports, addressing barriers	3
E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. **Actively supports patient self-management****	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. **Tracks tests and identifies abnormal results systematically****	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	Pt
A. **Tracks referrals using paper-based or electronic system****	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. **Measures clinical and/or service performance by physician or across the practice****	3
B. Reports performance across the practice	3
C. **Reports performance across the practice or by physician**	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

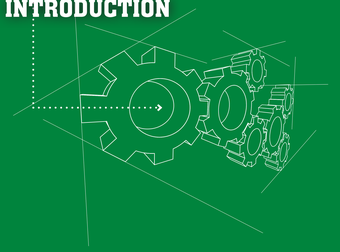
NCQA PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level: for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements do not Qualify.

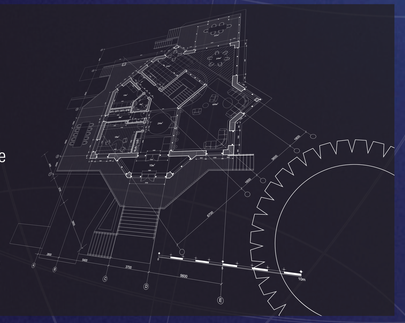
INTRODUCTION



The Vermont Blueprint for Health is guiding a comprehensive and statewide process of transformation designed to reduce the negative health and economic impact of the most common chronic conditions and focus on their prevention. The Blueprint assists Primary Care Practices (PCPs) to operate as NCQA-defined Patient-Centered Medical Homes (PCMH). The Vermont Chronic Care Initiative (VCCI), a partnership between Vermont Medicaid and APS Healthcare, collaborates with PCPs to provide chronic care management services to support the use and effectiveness of medical homes.

OBJECTIVE

According to NCQA, "the patient centered medical home is a model for care provided by physician practices that seeks to strengthen the physician patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship." NCQA anticipates outcomes resulting from PCMHs will include better health, higher patient satisfaction, and less expensive care. In alignment with the Blueprint for Health and in support of this model of care, VCCI was authorized by the Vermont legislature as part of state-wide health care reform, and year one results were assessed.



The Blueprint provides the information, tools and support that Vermonters need to manage their own health — and that health care providers need to keep their patients healthy.

VERMONT Blueprint for Health — Smart choices. Powerful tools.

APS Healthcare · VERMONT Vermont Chronic Care Initiative — Healthy Together

APS Healthcare

METHODS

The VCCI assists PCPs by providing chronic care management and patient self-management support. VCCI Registered Nurses and Medical Social Workers provide telephonic and in-person health coaching on evidence-based clinical guidelines, case management for psychosocial factors, and assistance in accessing community resources. General and disease-specific assessments, care plans, written patient action plans and other health education and self-management materials guide interventions that are provided to support PCPs in meeting the following PCMH standards.

NCQA Physician Practice Connections® (PPC)

PPC3: Care Management

The practice systematically manages care for individual patients according to their conditions and needs, and coordinates patients' care.

Element A – Evidence-Based Guidelines

- VCCI provides assessments, customized care plans, and patient coaching and education based upon disease-specific evidence-based guidelines
- VCCI partners with PCPs to establish patient goals that foster adherence to clinical best practices

Element D – Care Management for Important Conditions

- VCCI assesses patient progress in achieving goals, addresses clinical and social barriers to care, facilitates patients' preparation for and attendance at appointments, and supports the PCP's treatment plan between medical visits

Element E – Continuity of Care

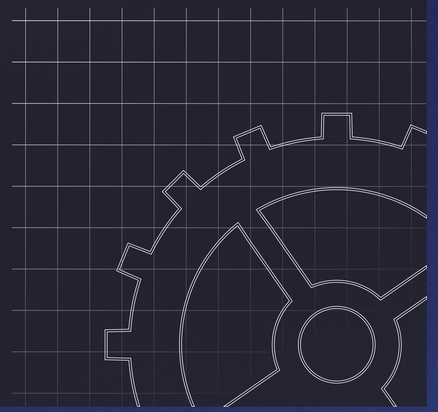
- VCCI assists patients with finding and establishing a medical home and works to:
  - — Coordinate care among the PCP and multiple specialists to avoid fragmentation of care
  - — Maintain an on-site presence at hospitals to assist with discharge planning and coordinate care after discharge
  - — Facilitate referrals to community and social support services
  - — Continuously reassess the appropriate level of chronic care services

PPC4: Patient Self-Management Support

The practice works to improve patients' ability to self-manage health by providing educational resources and ongoing assistance and encouragement.

Element B – Self-Management Support

- VCCI assesses patient/family preferences, readiness to change and self-management abilities and then provides culturally appropriate education, coaching and self-management resources to empower patients to become informed and active patients
- VCCI provides and coordinates self-monitoring tools and personal health records for the home setting

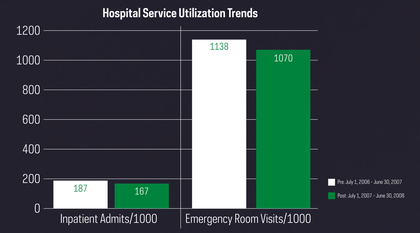


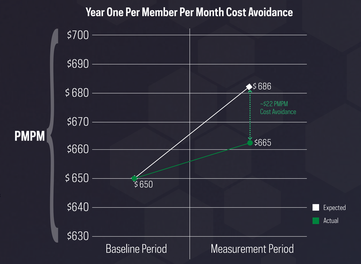
RESULTS

All Blueprint Integrated Pilot practices receive enhanced reimbursement from payers for achieving PCMH level I, II, or III.

The VCCI, which supports the PCMH model, achieved the following results for Vermont Medicaid recipients:

- 10.6% reduction in inpatient hospital admissions by reducing unnecessary and inappropriate admissions*
- 6% reduction in emergency room visits by reducing unnecessary and inappropriate visits*
- $22 per member per month (PMPM) cost avoidance *
- $6.2 million in overall cost avoidance*
- 84% of members said they have been able to maintain the lifestyle changes they adopted through the VCCI program
- 90% of members said they would recommend VCCI services to others with a chronic health condition





* Utilization reductions and cost avoidance have not been independently validated

CONCLUSIONS

As health care payers and primary care practitioners begin to embrace the medical home concept, chronic care management programs can play a valuable role in their success by promoting their use, as well as evidence-based care and improved patient self-management. The medical home concept can be a key part of helping states reduce the negative health and economic impact of chronic health conditions.

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