

# 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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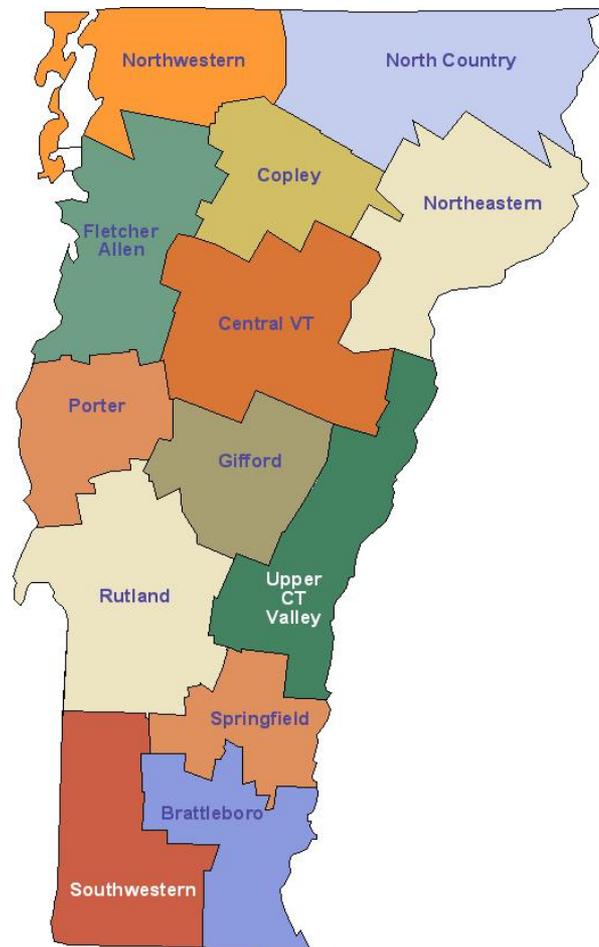
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# Vermont Demographics

- **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



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

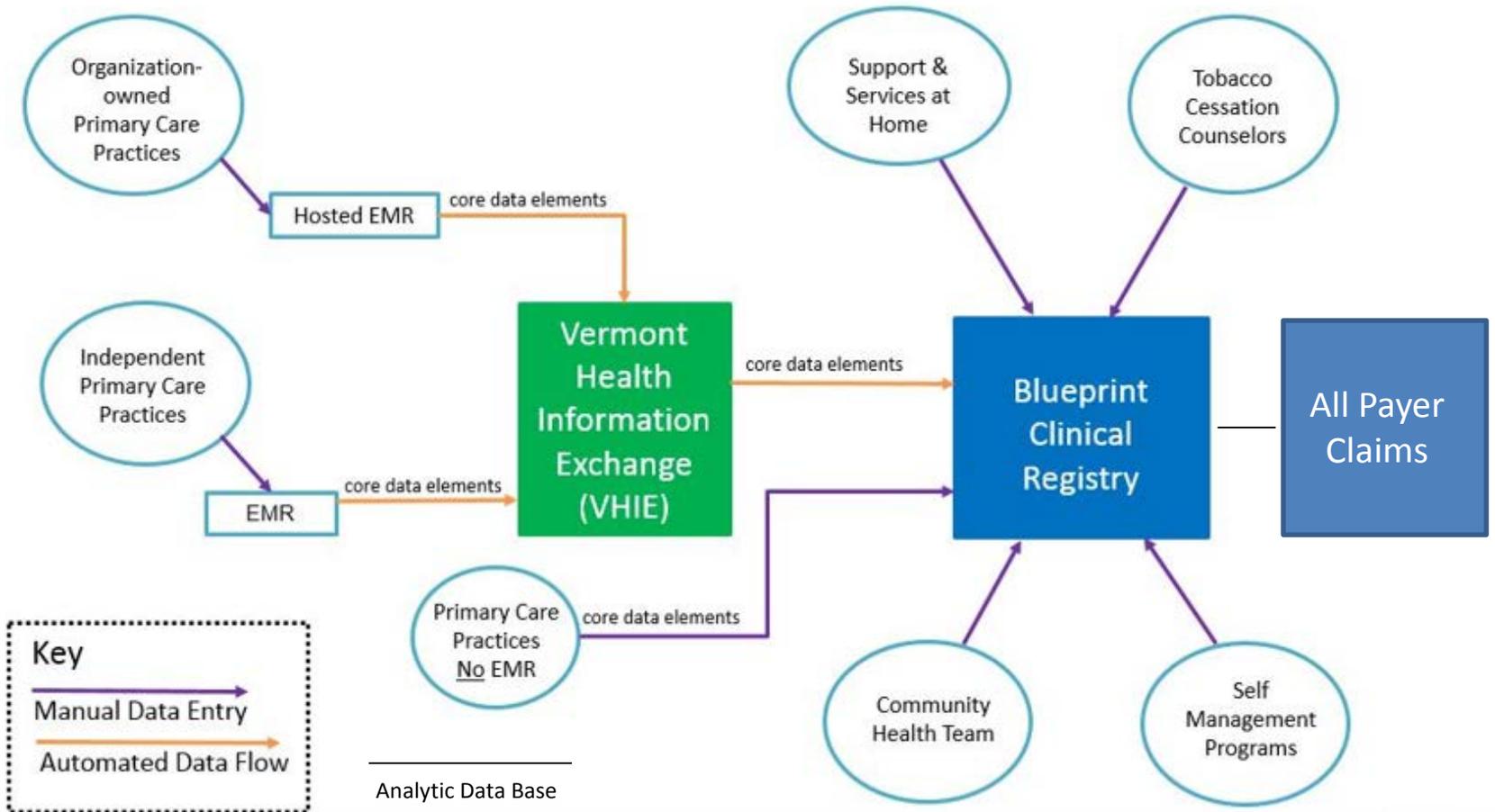
# Supports for Data Collection and Reporting

- 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



# Practice Profiles Evaluate Care Delivery - Commercial, Medicaid, & Medicare



Practice Profile: ABC P  
Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Welcome to the 2014 Blueprint Practice Profile from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services. Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Practice Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the prior year.

## Demographics & Health Status

	Practice	H.S.A.	St.
Average Members	4,081	84,070	2
Average Age	50.6	50.1	
% Female	55.6	55.5	
% Medicaid	14.5	13.0	
% Medicare	23.7	22.2	
% Maternity	2.1	2.1	
% with Selected Chronic Conditions	50.1	38.0	
Health Status (ORIG)			
% Healthy	39.0	43.9	
% Acute or Minor Chronic	18.8	20.5	
% Moderate Chronic	27.9	24.5	
% Significant Chronic	15.4	12.3	
% Cancer or Catastrophic	1.4	1.3	

Table 1: This table provides comparative information on the demographic status of your practice, all Blueprint practices in your Hospital Service Area (HSA) as a whole. Included measures reflect the types of information used to adjust rates: age, gender, maternity status, and health status.

Average Members served as this table's denominator and adjusts for partial enrollment during the year. In addition, special attention has been given to Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's practice (percentage of membership in Medicaid or Medicare, Medicare disability or end-stage renal disease status, and the member required special Medicaid services that are not found in common populations (e.g. day treatment, residential treatment, case management, services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of members through the claims data as having one or more of seven selected chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, cancer, diabetes, hypertension, diabetes, and depression.

The Health Status measure aggregates ICD-10 Clinical Risk Groupers (CRG) into the year for the purpose of generating adjusted rates. Aggregated risk class includes: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (dystonia, cystic fibrosis).



Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

## Total Expenditures per Capita

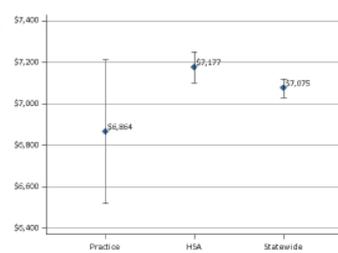


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

## Total Expenditures by Major Category

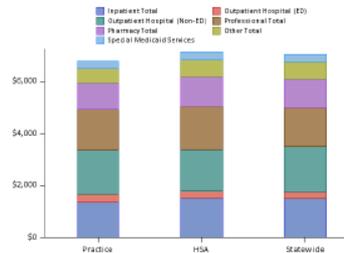


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medical Services.

## Total Expenditures Excluding SMS

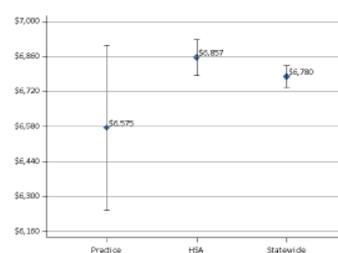


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medicaid Services, capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

## Total Resource Use Index (RUI) Excluding SMS

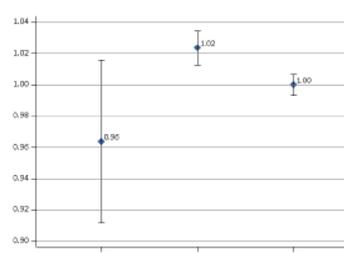


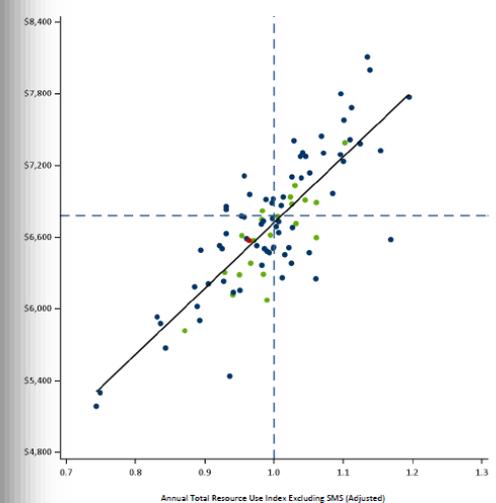
Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per service varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects an aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medicaid Services. The practice and HSA are indexed to the statewide average (1.00).



Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

## Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)



This demonstrates the relationship between risk-adjusted expenditures excluding SMS (only one for Blueprint practices). This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint (i.e., the blue dots). The dotted lines show the average expenditures per capita and average RUI (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand corner with lower expenditures and utilization are in the lower left-hand corner. An RUI value indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than average utilization has been included in the graphic, which demonstrates that, in general, practices with a utilization had higher risk-adjusted expenditures.

Legend  
 ● Your practice  
 ● All practices in your HSA  
 ● All other Blueprint practices statewide

Demographics & Health Status Cost of Care Utilization Effective & Preventive Care Data Detail

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Cost of Care Utilization Effective & Preventive Care Data Detail

# Claims Data – PQI Composite (Chronic): Rate of Hospitalization for ACS Conditions (Core-12)

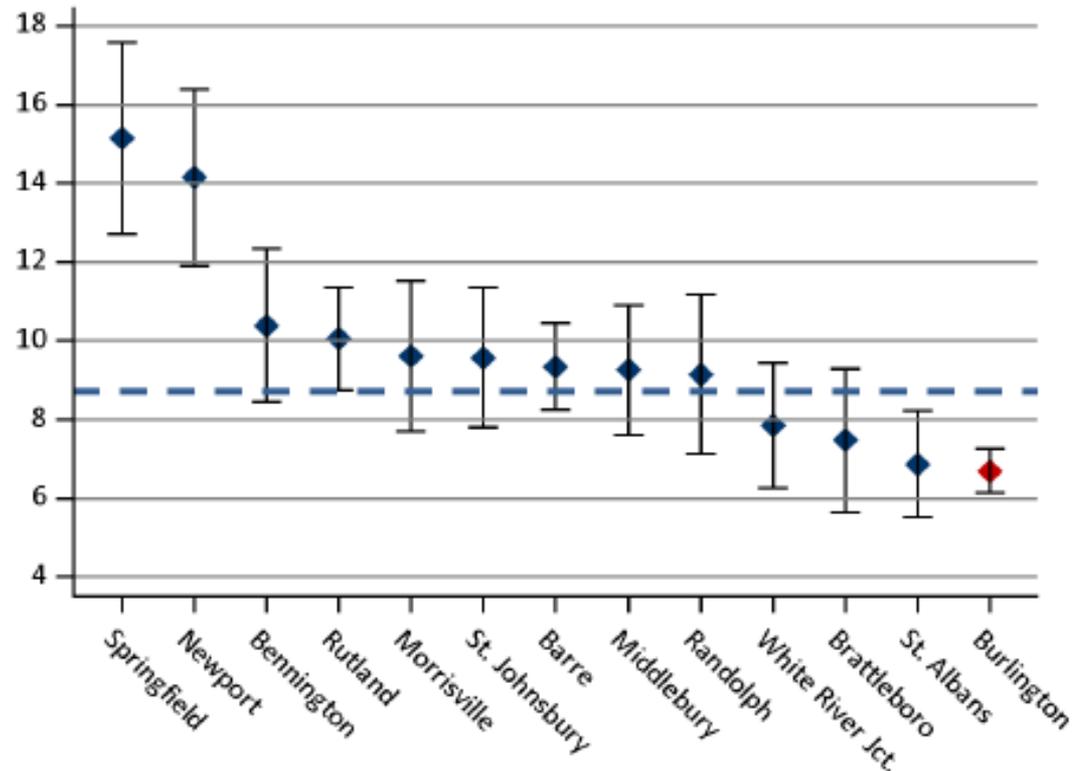
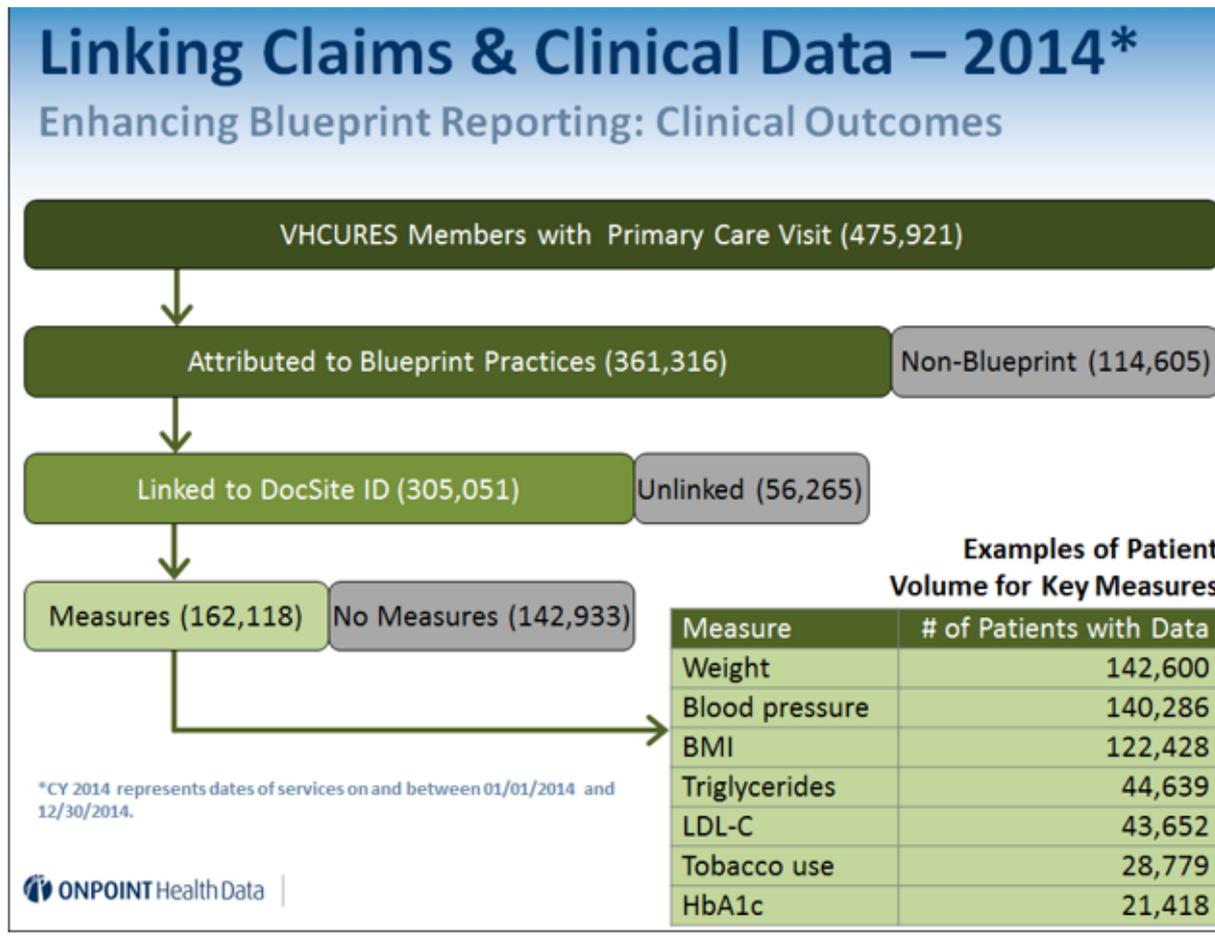
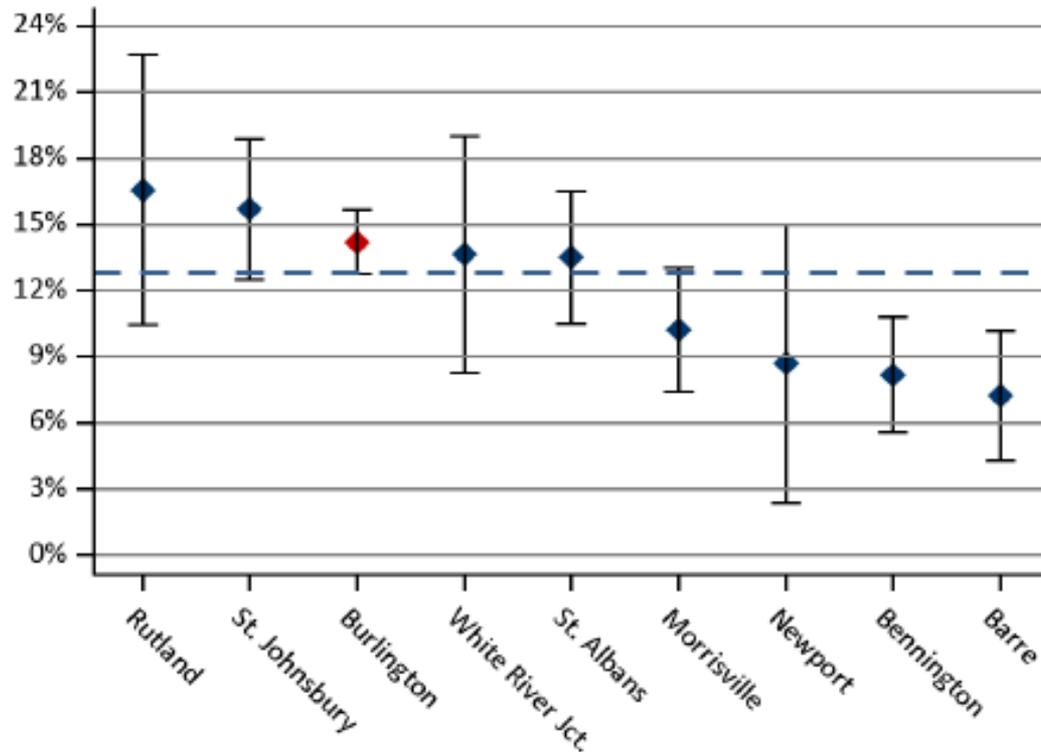


Figure 27: This Prevention Quality Indicator (PQI) presents a composite of chronic conditions per 1,000 members, ages 18 years and older. This measure includes admissions for at least one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled 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



# Claims & Clinical Data – Diabetes: Poor Control (Core-17, MSSP-27)



*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

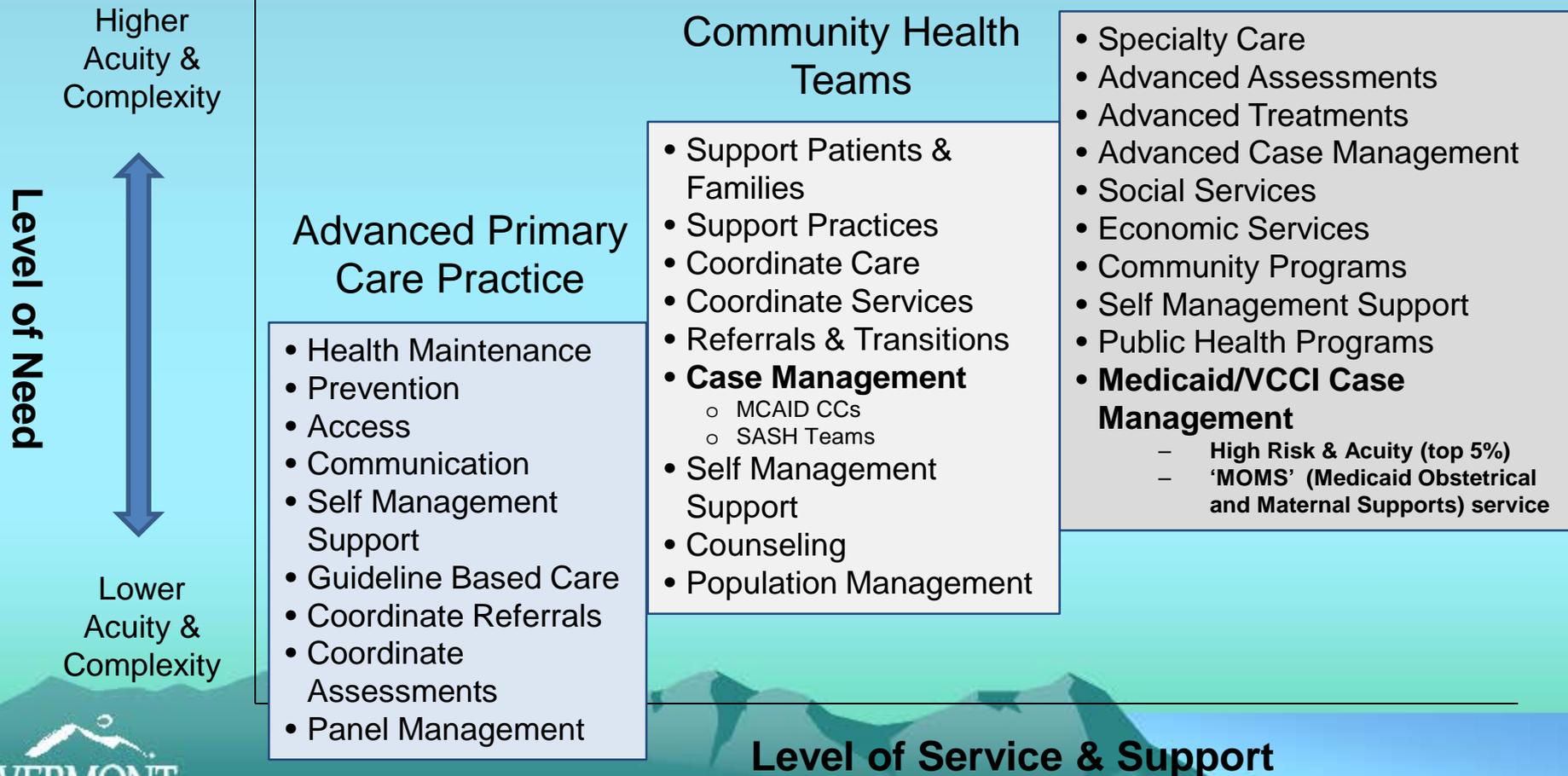
## *Medicaid high risk/high cost member case management service:*

- **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



Smart choices. Powerful tools.



# 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

FOCUS AREA/ PERFORMANCE MEASURE	June 1, 2008	June 1, 2009	June 1, 2010	June 1, 2011, 2012, 2013	June 1, 2014	August 1, 2015
<i>Prevention and Screening</i>						
Childhood Immunization Status	✓					
Adolescent Immunization Status	✓					
Lead Screening in Children		✓				
Breast Cancer Screening					✓	✓
Chlamydia Screening in Women					✓	✓
<i>Utilization</i>						
Well Child Visits in the First 15 Months of Life	✓	✓	✓	✓	✓	✓
Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	✓	✓	✓	✓	✓	✓
Adolescent Well-Care Visits	✓	✓	✓	✓	✓	✓
Inpatient Utilization: General Hospital/Acute Care		✓				
Ambulatory Care		✓				
Outpatient Drug Utilization		✓				

<i>Access/Availability of Care</i>						
Annual Dental Visits	✓	✓	✓	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					✓	✓
Prenatal and Postpartum Care		✓	✓			✓ (hybrid)
Adults' Access to Preventive/Ambulatory Health Services		✓	✓	✓	✓	✓
Children's and Adolescents' Access to Primary Care Practitioners		✓	✓	✓	✓	✓
<i>Behavioral Health</i>						
Antidepressant Medication Management		✓	✓	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness					✓	✓
<i>Diabetes</i>						
Comprehensive Diabetes Care		✓	✓	✓	✓ (hybrid)	✓ (hybrid)
<i>Respiratory Conditions</i>						
Use of Appropriate Medications for People with Asthma		✓	✓	✓		✓
<i>Cardiovascular Conditions</i>						
Controlling High Blood Pressure						✓ (hybrid)
<b>TOTAL</b>	<b>6</b>	<b>14</b>	<b>10</b>	<b>9</b>	<b>12</b>	<b>15</b>

# 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



# Aligning Measurement with a Population: The Care Alliance for Opioid Addiction (Hub and Spoke)

## Act 186 – Population Level Outcomes/Priorities

### Governor's Strategic Plan

### Agency of Human Services Strategic Plan

### Healthy Vermonters 2020

### ADAP Dashboard

Percent of adolescents in grades 9-12 who used marijuana in the past 30 days (YRBS)

Percent of adolescents who drank alcohol in the past 30 days (YRBS)

Percent of adolescents who reported ever using a prescription drug without a prescription (YRBS)

**Affordable Health Care –**  
All Vermonters have access to affordable quality healthcare

**Strong Families, Safe Communities:**  
Vermont's children live in stable and supported families and safe communities

**High Quality and Affordable Education:**  
Learners of all ages have the opportunity for success in education

**Promote the health, well-being and safety of individuals, families and our communities**

% of adults' binge drinking in the past 30 days

% of adolescents binge drinking in the past 30 days

% of persons age 12+ who need and do not receive alcohol treatment

% of persons age 12+ who need and do not receive illicit drug treatment

Support healthy people in very stage of life – reduce the percentage of people who engage in binge drinking of alcohol beverages

Decrease % of youth who binge drink - 2020

Decrease % of youth who used marijuana in the past 30 days - 2020

% of persons age 12+ who need and do not receive alcohol treatment

**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?

# County Dashboard for MAT: Hub & Spoke

July 2015

## Bennington Blueprint Spoke Dashboard



**Bennington Blueprint Grant Award:** United Health Alliance **Key Partners:** United Counseling Services (UCS) and SVHC, **State Level Leadership:** Craig Jones, MD, Beth Tanzman  
**Local Leadership:** UHA Board of Directors **Physician Champion:** Jim Poole, MD **Bennington Program Director:** Jennifer Fels [jennifer.fels@vhealthcare.org](mailto:jennifer.fels@vhealthcare.org)

### 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:

Quarter 2015	# Medicaid Beneficiaries	Medicaid Funding
Qrt 1	178	\$85,969
Qrt 2	207	\$110,531
Qrt 3	226	\$110,531
Qrt 4	250	\$122,812

### Current Staffing

	Hawthorn Recovery Center	Mount Anthony Primary Care	Shaftsbury Medical Associates	SVMC Deerfield	Total Actual FTEs
RN Case Manager	1.2 FTE	.4 FTE	.4 FTE	.4 FTE	2.4
Behavioral Health Therapist/Social Worker	1 FTE	.4 FTE	.4 FTE	.4 FTE	2.2
					4.6

### Spoke Services

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

Patients must have at least one service per month as defined by the CMS Medicaid Waiver:

- Comprehensive Care Management
- Care Coordination
- Health promotion
- Comprehensive Transitional Care
- Individual & Family Support
- Referrals to community and social services support

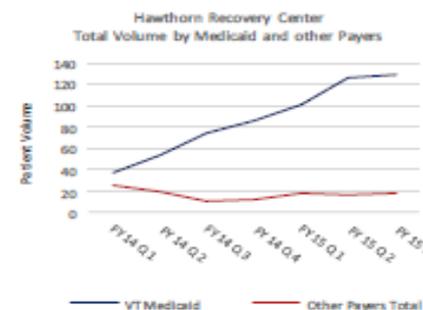
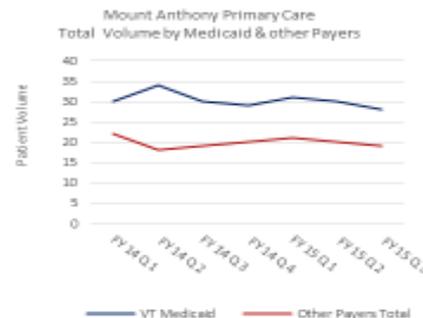
### Hub Services

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

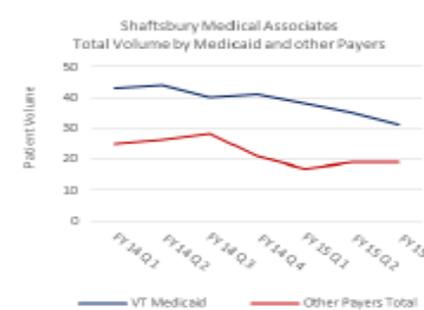
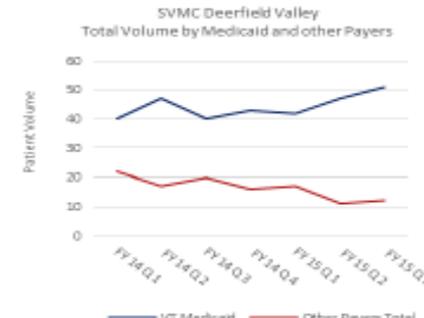
### Performance Improvement Initiatives

- 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

### Spoke Program Volume



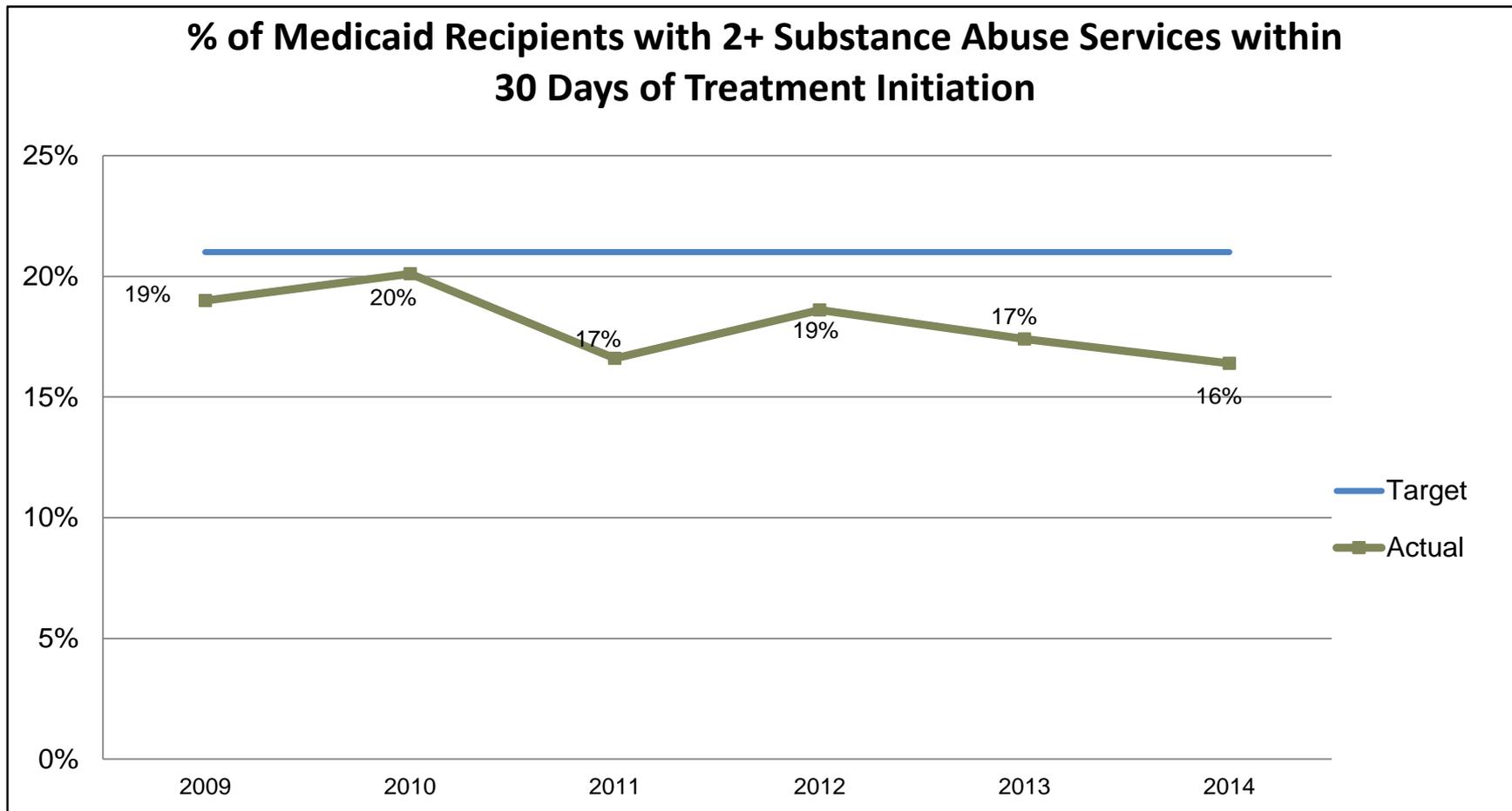
### Spoke Program Volume



### Patient Transfers

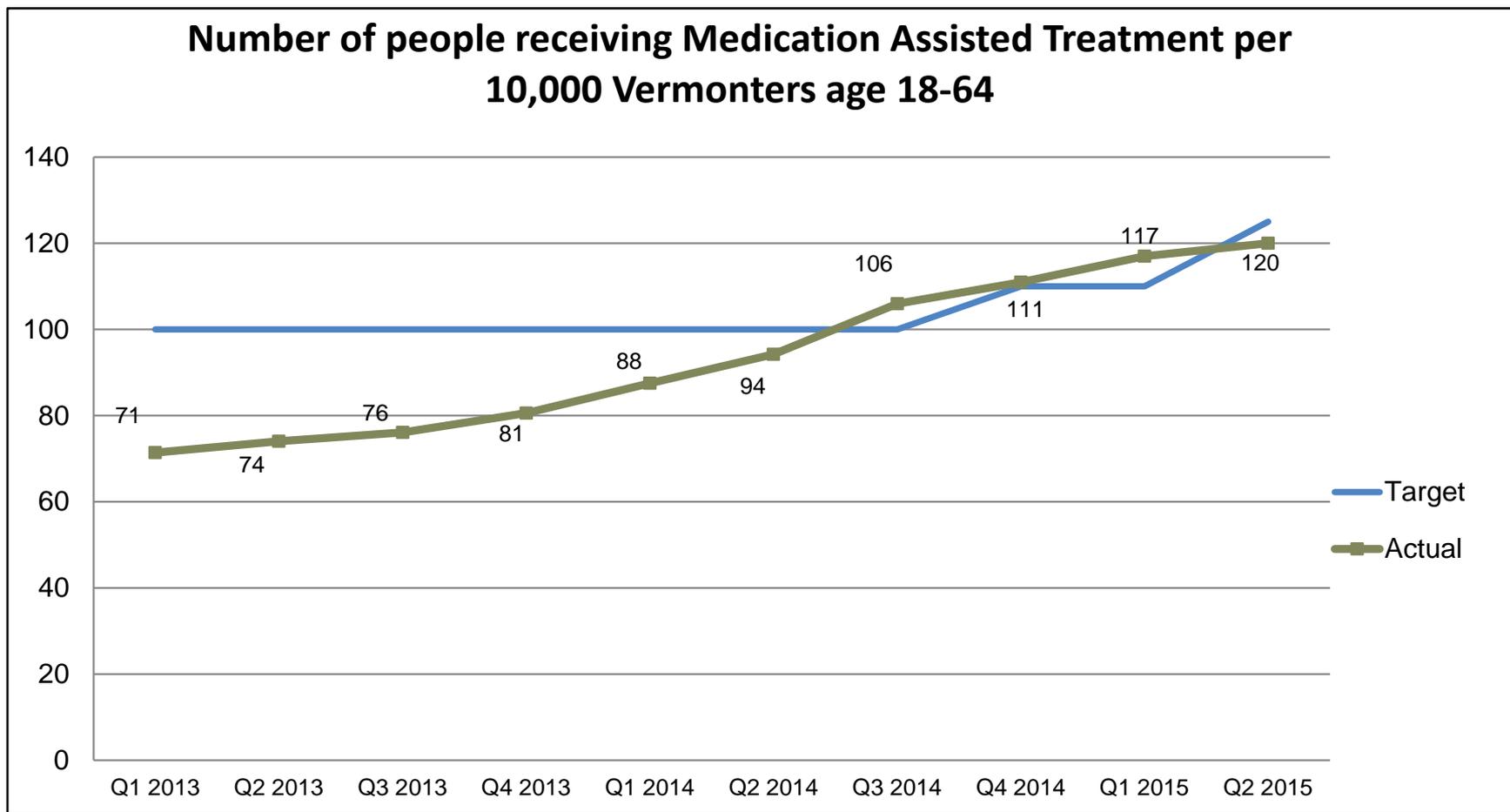
	2015	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# pf pts transferred from IOP		0	0	4	1					
# of pts transferred from Hub		3	2	0	0					
# of pts transferred to Hub		0	1	2	2					

# Treatment Engagement: Are youth and adult Medicaid recipients who start treatment sticking with it?



Data Source: Vermont Medicaid Claims

# Access to MAT: Are adults seeking help for opioid addiction receiving treatment?



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