Blueprint GC PCMH

Blueprint PCMH

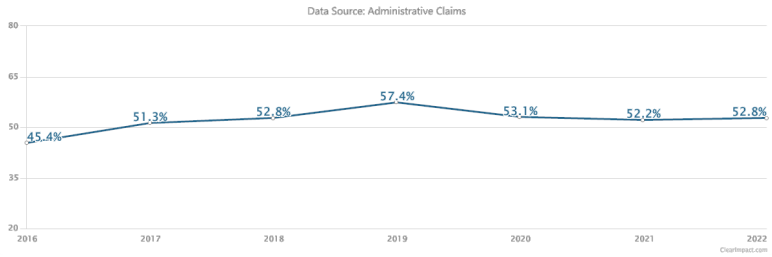
What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Pregnancy Intention Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Patient-Centered Medical Home model utilizes a per patient per month base payment to incentivize primary care practices to be recognized as patient-centered medical homes by the National Committee for Quality Assurance (NCQA). This payment also includes performance-based payments for quality and utilization. The quality payment is determined based on the results of four measures that were selected to be representative of outcomes across the lifespan (developmental screenings that occur within the first three years of life, adolescent well-care visits, and the management of 2 chronic conditions: hypertension and
diabetes).

Measures

PM PCMH Medicaid: NQF1448 Developmental Screening in the First Three Years of Life (DEV)



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2022	52.8%	–	↗ 1
2021	52.2%	–	↘ 2
2020	53.1%	–	↘ 1
2019	57.4%	–	↗ 5
2018	52.8%	–	↗ 4
2017	51.3%	–	↗ 3
2016	45.4%	–	↗ 2
2015	43.1%	–	↗ 1

Story Behind the Curve

The Developmental Screening measure was chosen for its potential to positively impact young children at a developmentally critical time. The screenings provide opportunities for early identification and interventions that support improved development and health. Statewide organizations such as the Vermont Department of Health, the Vermont Child Health Improvement Program (VCHIP), OneCare Vermont, and the Blueprint for Health have supported efforts to use data for quality improvement initiatives and increase communication and coordination around child well-being. Currently, patient-centered medical homes receive Blueprint for Health performance payments based in part on risk-adjusted results (not displayed here) for all-payer, PCMH-attributed patients on this measure in the practice's hospital service area. The goal is for a region to perform the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

While this payment model supports all patients in the medical home, regardless of payer, the data show the statewide average for Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to the removal of a number of individuals (often healthier and younger) from the Medicaid rolls, thereby changing the composition of the Medicaid population.

Partners

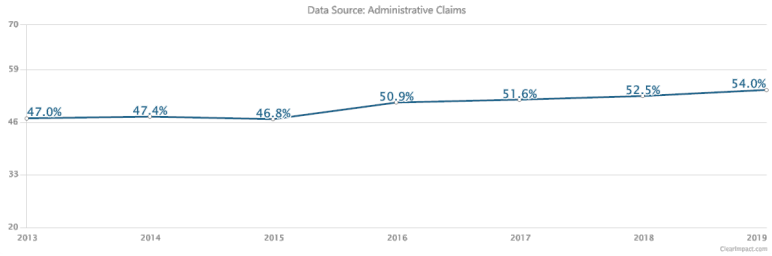
1. Patient Centered Medical Homes

2. Community Health Teams
3. Vermont Department of Health
4. Vermont Child Health Improvement Program
5. Early education and child care professionals

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates the number of children who turned 1, 2, or 3 years of age in the measurement period who were screened for the risk of developmental, behavioral, and social delays using a standardized screening tool. (NQF #1448)

PM PCMH Medicaid: HEDIS Adolescent Well-Care Visits (AWC) 12-21 [Discontinued]



2019	54.0%	–	↗ 4
2018	52.5%	–	↗ 3
2017	51.6%	–	↗ 2
2016	50.9%	–	↗ 1
2015	46.8%	–	↘ 1
2014	47.4%	–	↗ 1
2013	47.0%	–	→ 0

Story Behind the Curve

Adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. While this payment model supports all patients in the medical home, regardless of payer, this measure shows the statewide average for Medicaid-primary members, of whom a majority are attributed to a patient-centered medical home. Practices and communities continue their efforts to improve further upon this measure.

Blueprint perfomance payments incentivize PCMHs in a region to perform the all-payer statewide average and to demonstrate improvement between measurement periods or have outcomes in the HEDIS 90th Percentile. Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. This measure was discontinued after Report Year 2020 / Measurement Year 2019.

Partners

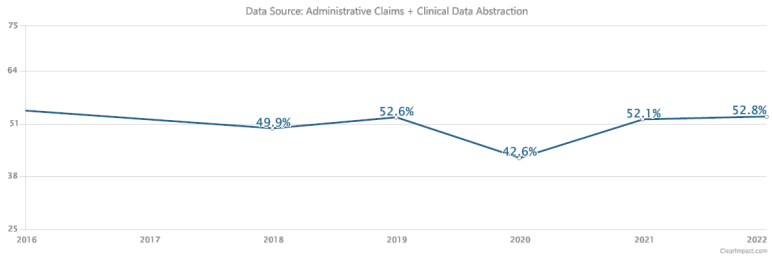
1. Patient Centered Medical Homes
2. Community Health Teams
3. Vermont Child Health Improvement Program
4. OneCare Vermont
5. School nurses

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. This measure was discontinued after Report Year 2020 / Measurement Year 2019.

PM PCMH Medicaid: NQF0018 HEDIS Hypertension With Blood Pressure in Control (<140/90 mmHg) (CBP)

2022	52.8%	–	↗ 2



2021	52.1%	–	↗ 1
2020	42.6%	–	↘ 1
2019	52.6%	–	↗ 1
2018	49.9%	–	↘ 1
2015	56.4%	–	↗ 1
2014	48.2%	–	↘ 1
2013	53.3%	–	→ 0

Story Behind the Curve

Hypertension is a risk factor for much morbidity, including heart disease and stroke, which are leading causes of death in the United States. Guideline-based medical treatment and increases in healthy behaviors can improve the management of this condition.

While these types of interventions and this payment model support all patients in the medical home, this measure show the statewide average for all Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes (PCMHs). Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population.

The goal is for a region to perform the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions.

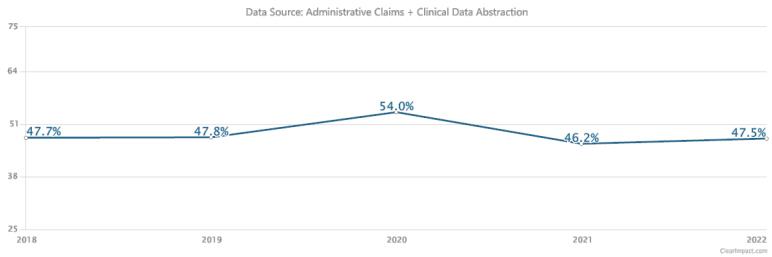
Partners

1. VT Department of Health
2. OneCare Vermont
3. SASH
4. New England QIN-QIO
5. Vermont Program for Quality in Health Care

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a hybrid claims/clinical HEDIS measure. The measure includes members age 18-85 years, who were identified in claims as having hypertension and for whom we had valid blood pressure readings. Those members whose blood pressure was less than 140/90 mmHG were considered to have their hypertension in control. (NQF #0018)

PM PCMH Medicaid: NQF0059 HEDIS Diabetes HbA1c Not in Control (>9%) (DPC)



2022	47.5%	–	↗ 1
2021	46.2%	–	↘ 1
2020	54.0%	–	↗ 2
2019	47.8%	–	↗ 1
2018	47.7%	–	→ 0

Story Behind the Curve

Diabetes affects over 6% of the Vermont population and is a leading cause of death due to chronic conditions. Additionally, those with diabetes or pre-diabetes often go undiagnosed. However, guideline-based early detection, treatment, and self-management can help individuals with diabetes improve control of the disease and improve long-term health outcomes and quality of life.

The data show the statewide rate for Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes (PCMHs). For this measure, lower rates are better. Efforts to improve care management continue.

The goal is for a region to perform better than the statewide average and demonstrate improvement between measurement

periods or have outcomes in the 90th percentile relative to other regions.

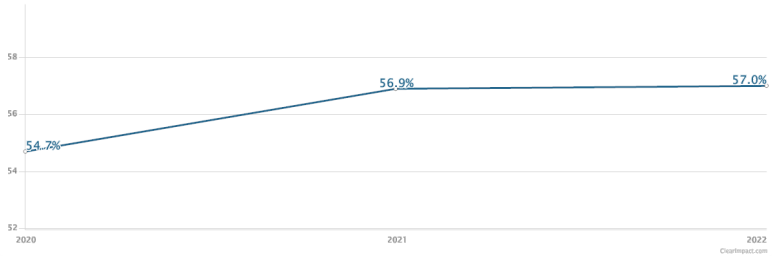
Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. OneCareVermont

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a hybrid claims/clinical HEDIS measure. The measure includes members age 18 to 75 years identified in claims as having diabetes and for whom we obtained valid HbA1c measurement data. If the HbA1c glycosylation was greater than nine percent, that member was considered “in poor control”. (NQF #0059)

PM PCMH Medicaid: HEDIS Child and Adolescent Well-Care Visits (WCV) 3-21



2022	57.0%	–	↗ 2
2021	56.9%	–	↗ 1
2020	54.7%	–	→ 0

Story Behind the Curve

Child and adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. While this payment model supports all patients in the medical home, regardless of payer, this measure show the statewide average for Medicaid-primary members, of whom a majority are attributed to a patient-centered medical home. Practices and communities continue their efforts to improve further upon this measure.

Blueprint perfomance payments incentivize PCMHs in a region to perform the all-payer statewide average and to demonstrate improvement between measurement periods or have outcomes in the HEDIS 90th Percentile for adolescents 12-21.

Partners

1. Patient Centered Medical Homes
2. Community Health Teams
3. Vermont Child Health Improvement Program
4. OneCare Vermont
5. School nurses

Notes on Methodology

New measure, beginning with Measurement Year 2020. The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates the proportion of children and adolescents 3-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.