State of Vermont *Agency of Human Services*
Department of Vermont Health Access
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Combined Meeting of
Blueprint Executive Committee Meeting and
Blueprint Expansion, Design and Evaluation Committee
Minutes of
April 9, 2013
8:30 – 10:30

Present: J. Batra, P. Biron, K. Brown, G. Butala, P. Cobb, T. Dolan, E. Emard, S. Fine, L. Francis, S. Frey, C. Fulton, E. Girling, B. Grause, M. Hartman, A. Hawkinson, K. Hein, C. Jones, P. Jones, J. Krulewitz, C.Kulczyk, P. Launer, N. Lovejoy, M. McAdoo, E. McKenna, L. McLaren, S. Meier, S. Narkewicz, D. Noble, C. Perpall, J. Peterson, A. Ramsay, P. Reiss, L. Ruggles, J. Samuelson, M. Scholten, B. Steckle, B. Tanzman, J. Trottier, B. Warnock, L. Watkins, J. Flynn Weiss, R. Wheeler, M. Young

The meeting opened at 8:35 a.m.

I. ***Quality Improvement Initiatives across Communities***:

Many state-wide quality improvement initiatives are currently taking place. Jenney Samuelson, Assistant Director of the Blueprint and Miriam Sheehey, RN, Blueprint Practice Facilitator highlighted two such initiatives.

Miriam Sheehy gave a PowerPoint presentation titled "*Vermont's Asthma Learning Collaborative. A look at working on health care delivery to one population of patients*." This was an extensive analysis to improve adherence to evidence based guidelines in primary care management of asthma and to utilize documentation tools to guide evidence-based care. Miriam stated that they worked with pediatricians from around the state and a total of 15 practices participated in the collaborative. Process and system changes were made in the primary care practices. All practices showed improvement on many of the measures.

Other examples of community quality improvement initiatives include the CHAMP Immunization Project as well as the Chittenden County Collaboration.

Alan Ramsey asked if practices were measuring the PMPM costs for these quality initiatives. The Green Mountain Care Board and the payers need to know what the costs for quality initiatives are to the practices. This is a very important discussion and it may be time to revisit how to link these costs to the payment model.

II. ***Hub & Spoke Implementation:***

Beth Tanzman gave a PowerPoint presentation titled, *Hub and Spoke Medication-Assisted Treatment for People with Opioid Dependence.*

Highlights:

- Increasing rates of opioid dependence being seen in Vermont
- Evidence of network inadequacy, poor patient outcomes, high health care expenditures, program and funding silos
- We do have very effective treatment available but there continue to be access issues
- Commercial insurances have been paying for treatment and continue to have the same access issues as the Medicaid population
- Spoke staff will be in place in most counties in Vermont by July
- We do have pediatric practices participating with us on these initiatives.
- Programmatic framework and staffing were discussed
- Currently there are 150 MDs who are prescribing Buprenorphine. There are currently no providers in Addison County. We are trying to engage providers to open up their practices. FDA will only allow MD's to prescribe these drugs.
- Payment reforms and financing were discussed. We need to look at different payment models for physicians agree to take on these patients and services.

With no further time, the meeting adjourned at 10:35 a.m. We will look at new trends at the next meeting.

VERMONT'S ASTHMA LEARNING COLLABORATIVE

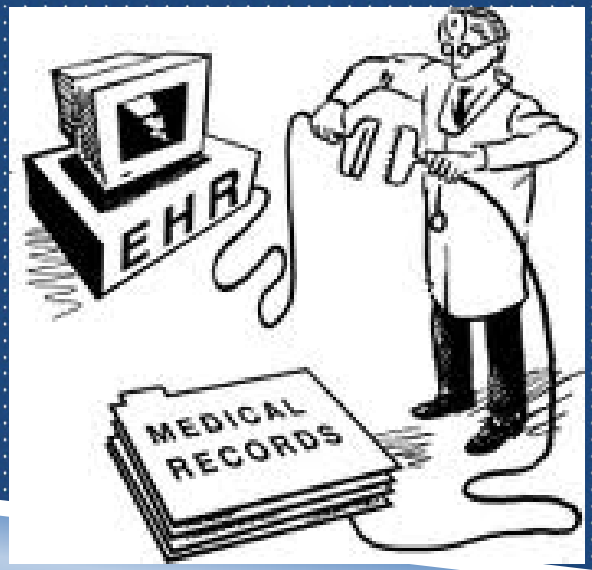
A look at working on health care delivery to one population of patients

Miriam Sheehey, RN
Blueprint Practice Facilitator

ASTHMA LEARNING COLLABORATIVE

AIM:

- To improve adherence to evidence based guidelines in primary care management of asthma
- To utilize documentation tools to guide evidenced-based care



ASTHMA LEARNING COLLABORATIVE

- Each practice assembled a multi-disciplinary team
- Series of 3 all-day learning sessions over a 6 month time period
- Action periods between learning sessions including:
  - data collection
  - quality improvement projects
- Conference calls between learning sessions for monthly contact
- Each team assigned a facilitator

ASTHMA LEARNING COLLABORATIVE

Measures of Success:

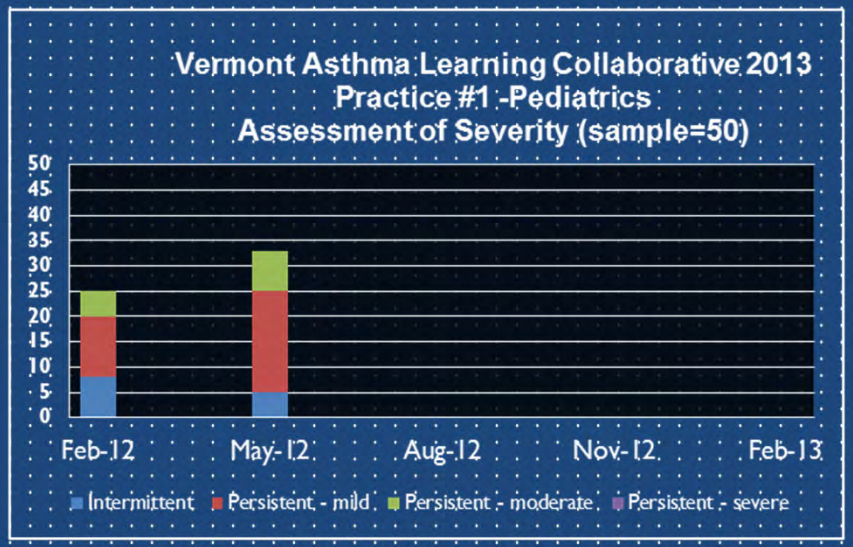
- Baseline, manual retrospective record review of 10% of asthma panel or minimum of 50 records
- Random selection by counting every 10th patient from printout of asthma panel
- Second record review conducted in month 4 and recommended quarterly thereafter
- Tools and support provided for data collection, data entry and display

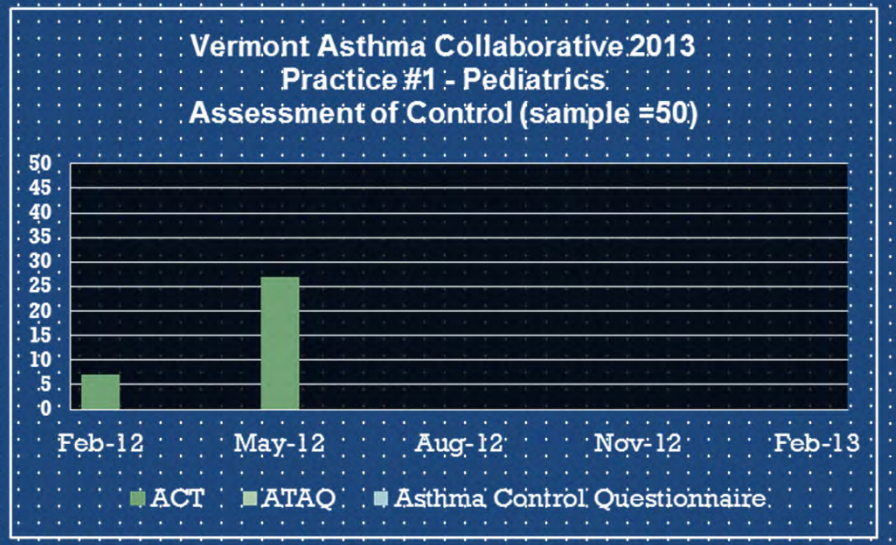
ASTHMA LEARNING COLLABORATIVE

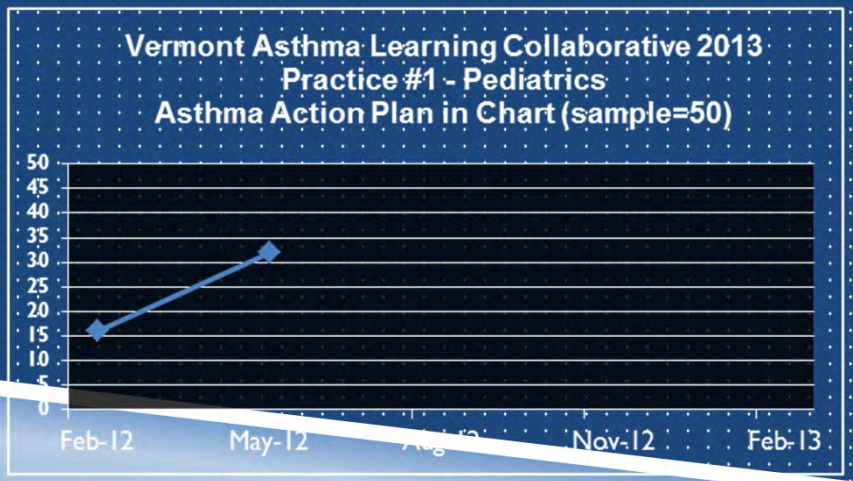
Shared Learning

- 2 collaboratives: 15 practices
- Peer presentations (at learning session #2 and #3)
  - Challenges, successes
  - “Dude, we all suck”
  - All improved !!!

ASTHMA LEARNING COLLABORATIVE







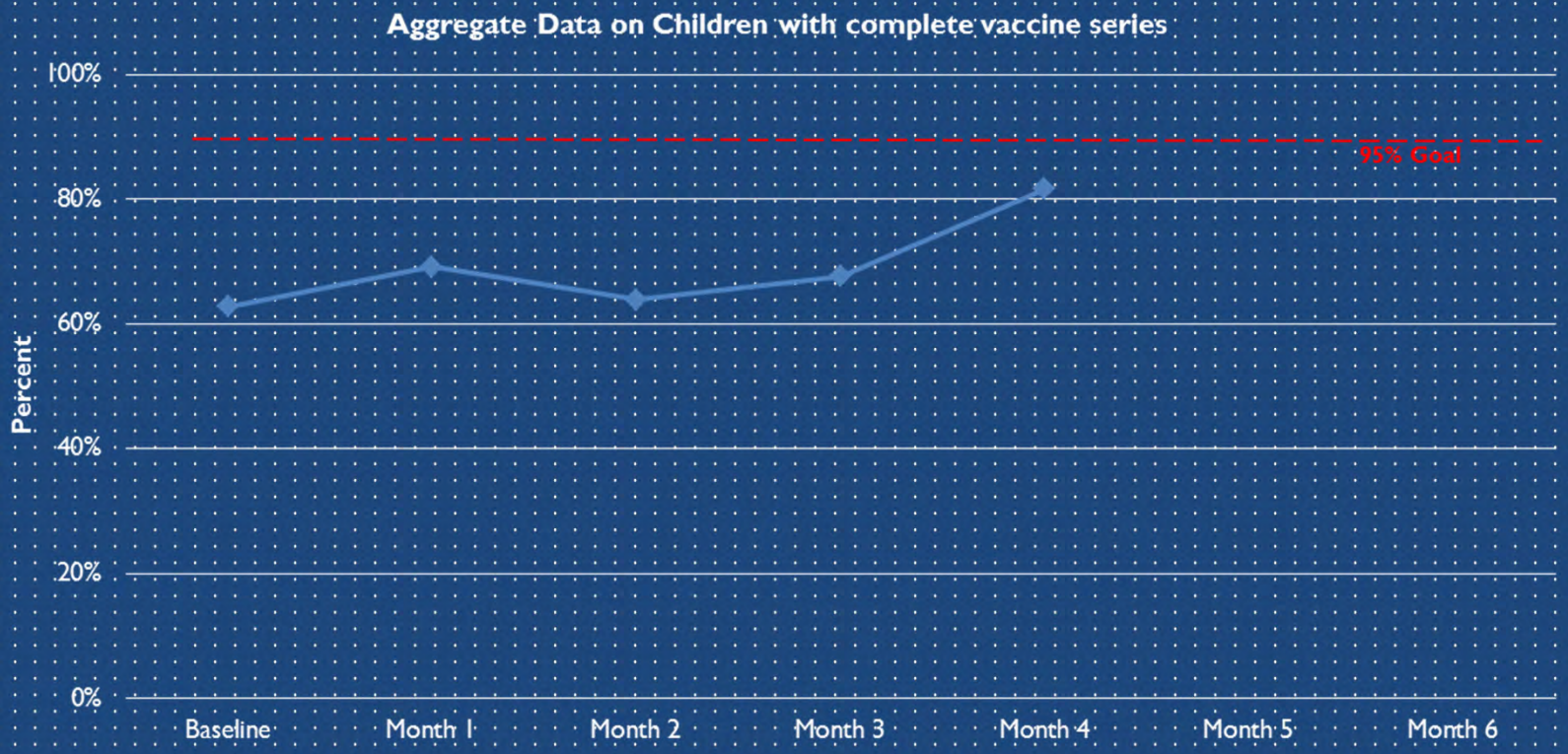
ASTHMA LEARNING COLLABORATIVE

Process/system changes that were made in primary care practices:

- Identify the asthma panel!
- Development of asthma visit templates
- Planned visits for asthma management
- Workflow redesign to include assessment of control and completion of asthma action plans
- More patients prescribed controller medications, based on severity
- Spirometry in office
- Asthma educator in practice

OTHER DATA PROJECTS

ANOTHER EXAMPLE: CHAMP IMMUNIZATION PROJECT



ONE MORE: CHITTENDEN COUNTY COLLABORATION

Measure/Practice	Practice A	Practice B	Practice C
30 months old UTD for DTaP # 4	93%	100%	88%
30 months old UTD for 1 lead test	99%	98%	97%
30 months old UTD for MCHAT screening	93%	96%	96%
Patients with dx of asthma with level of severity assessed	58%	96%	33%
Patients with dx of asthma with level of control assessed	0%	71%	13%
Patients with dx of asthma with asthma action plan documented in the last 12 months	6%	87%	41%

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Hub and Spoke

Medication-Assisted Treatment for People with Opioid Dependence

Expansion, Design & Evaluation Committee

April 9, 2013

Integrated Health System for Addictions Treatment

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A "Perfect" Storm

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

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Tale of Two Programs

Opioid Treatment Programs
OTP

- Dispense Methadone
- Highly Regulated
- Specialized Programs
- Comprehensive Addictions Treatment
- Federally Established Protocols (daily dosing, take homes, assessment)
- ADAP Funding, Weekly Bundled Rate

Office Based Opioid Treatment
OBOT

- Prescribe Buprenorphine
- Physician with X-DEA License
- Patient caseload capped @ 30 First Year & 100 w/waiver after 1 yr
- Office Based Practices Primary care, Ob-GYN, Pediatric, Psychiatry
- DVHA Funding, Fee-For -Service

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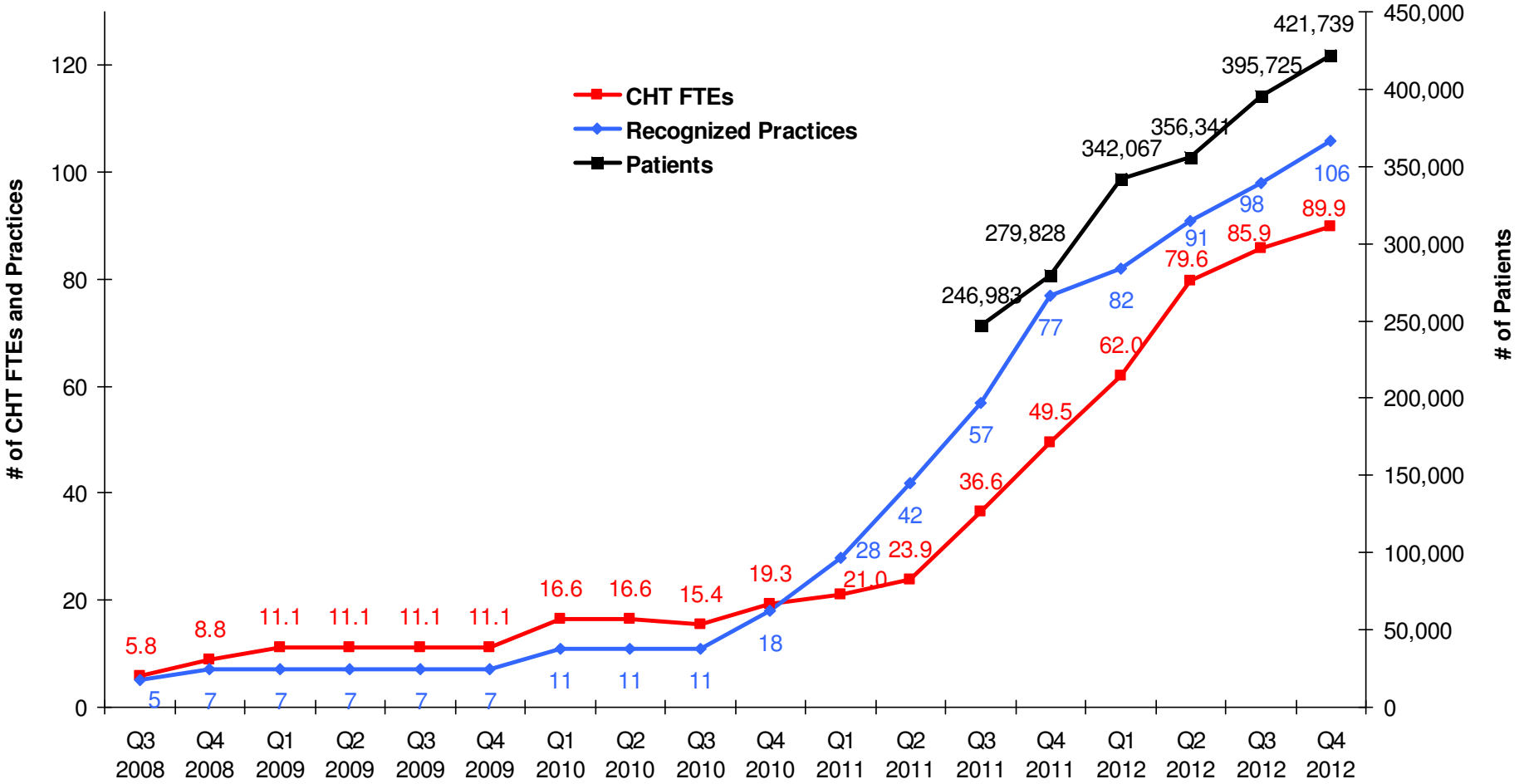
Opportunity

- **Leadership** Clinical & Administrative
- **Blueprint & Treatment Infrastructure**
  - Payment Reforms
  - Community Health Teams
  - Support for Practice Improvement
- **Affordable Care Act** Section 2703 "Health Homes"
- **Conceptual Framework** Hub & Spoke
- **Effective Treatment** Medication Assisted Treatment

Integrated Health System for Addictions Treatment

Patient Centered Medical Homes and Community Health Team Staffing in Vermont



*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.

Hubs: Care for People with Complex Addictions and Co-occurring MH/SA Conditions

5 Regional Specialty Centers Providing:

- Methadone treatment
- Buprenorphine treatment for more complex patients
- Consultation for practices providing office- based opiate therapy
- Health Home Services and Coordinate Access to Health and Human Services
- Meet NCQA Patient-Centered Specialist Standards, Learning Collaborative

Spokes: Team Based Care for Office-Based Practice

Physician, CHT RN + Clinician

~150 MD's in Diverse Practice Settings

- Prescribe Buprenorphine and provide Treatment Services
- Provide Treatment and Health Home Services
- Coordinate access to Health and Human Services
- Participate in regional learning collaboratives
- Practice setting specific care (Primary Care, Ob-Gyn, Pediatric, Psychiatry, Pain)

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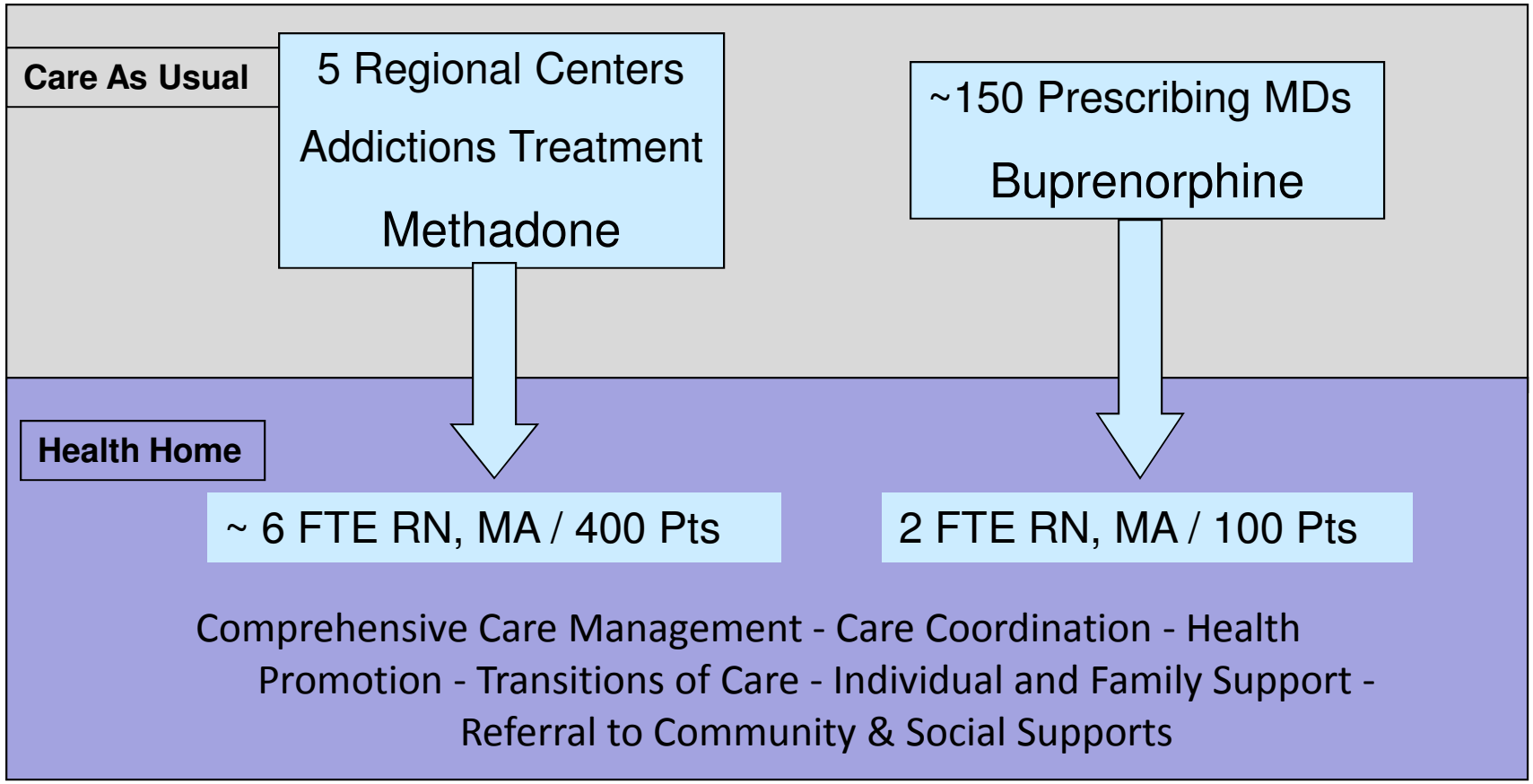
Health Homes

Section 2703 Affordable Care Act

6 Core Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitions of Care
- Individual and Family Support Services
- Referral to Community and Social Support Services

“ Hub & Spoke” Health Home for Opiate Dependence



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