**State of Vermont** *Agency of Human Services*
**Department of Vermont Health Access**
**Vermont Blueprint for Health** [Phone] 802-879-5988
312 Hurricane Lane, Suite 201 [Fax] 802-879-5651
Williston VT 05495-2807
**dvha.vermont.gov**

# Combined Meeting of the Blueprint Executive Committee and the Blueprint Expansion, Design, and Evaluation Committee
# Notes of
# September 18, 2013

**Present:** S. Barbosa, P. Cobb, M. Dugan, R. Edelman, N. Eldridge, P. Farnham, K. Fulton, K. Gilbert, E. Girling, S. Hartsfield, J. Hester, C. Jones, P. Jones, M. Lavallee, B. Little, N. Lovejoy, C. Maclean, S. Maier, M. McAdoo, L. McLaren, K. Mooney, K. Novak, M. Olszewski, J. Peterson, D. Prail, J. Prater, A. Ramsey, J. Samuelson, C. Schutz, K. Suter, B. Tanzman, M. Tarmy, D. Weening

I. *Update from Dr. Craig Jones*

Dr. Craig Jones presented the following PowerPoint Slides: (Attachment A)

- Patient Centered medical Homes and Community Health Team Staffing in Vermont
- Map of the Primary Care Practices Recognized or Engaged in the Blueprint (9/2013)
- Map and breakdown of Number of Patients & Percent of Total Population Served by Patient Centered Medical Homes (8/2013)
- Map of SASH Expansion thru October 2013

There is a substantial growing mass/network within each Hospital Service Area. We are now consistently hearing about the value of the CHT's.

Executive Committee Members received the "Performance of the SASH Program in the First Year of the MAPCP Demonstration" document which we received from CMS. Please be reminded that this document is not to be shared with others.

In the near future, this Committee will be working intensively on the following key items:

- Next phase of payment reforms
- Allocating costs for Community Health Teams

II. *A National View: Update on the PCMH from an employer perspective – Paul Grundy,MD, MPH, IBM's Global Director of Healthcare Transformation. President, Patient Centered Primary Care Collaborative*

It is an honor to have Dr. Grundy join our Committee meeting to give us an update on the PCMH from an employer's perspective.

Dr. Jones announced that the book, "*Familiar Physician"* is a story, not written by, but about IBM's Dr. Paul Grundy and those dedicated people who helped build the M*edical Home* and implement it on a national level. We think you will find the book of great interest as we move toward the future.

Dr. Grundy's Bio and slide deck are attached (Attachment B) to these notes.

Below are a few highlights of the discussion:

- Dr. Grundy met with President Obama and his staff during the 2nd week of his administration. The basic concept: Interrelationship of Trust. Outcomes of implementing patient centered medical home interventions were shared.

- Dr. Grundy shared the results of the Pennsylvania and Michigan pilots with us.

- Employers are looking for healthcare organizations (hospitals) that emphasize prevention not procedures and technology.

- The two main drivers of healthcare transformation include:
    - Cost
    - Data

- Payment reform requires more than one single method.

- Benefit Redesign – Adjust premiums based on patient engagement in preventative services. Different strategies for different healthcare spend segments. (i.e., those with acute, severe illness or injuries, those with chronic illness, those who are well or think they are well)

- Work force and communication changes – movement toward care given remotely.

- Australian government has adopted the Patient-Centered Medical Home as standard of care. Evidence in support of Patient-Centered Medical Homes is compelling:
    - Improved access to care
    - Improved clinical outcomes;
    - Better management of chronic and complex disease;
    - Decreased use of inappropriate medications;
    - Decreased hospital admissions and readmissions; and
    - Improved palliative care services.

- In the 03/19/2013 Health Affairs Magazine, a survey of 5 European countries suggests Patient-Centered Medical Homes would improve Family Medicine Primary Care.
  *http://content.healthaffairs.org/content/early/2013/03/19/hlthaff.2012.0184.full.html*

  With no time remaining, the meeting adjourned at 10:10 a.m.

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Department of Vermont
Health Access

VERMONT Blueprint for Health

Smart choices. Powerful tools.

# Vermont Blueprint for Health

## *Community Networks for Health Services*

## Combined Meeting of the Blueprint Executive Committee and the Expansion, Design, & Evaluation Committee

## September 18, 2013

# September 18, 2013

# Agenda

1. A National View: Update on the PCMH from an employer perspective - Dr. Paul Grundy, IBM's Global Director of Healthcare Transformation. President, Patient Centered Primary Care Collaborative

2. Discussion on community teams & emerging networks: Burlington area example

3. Discussion on the new Integrated Health Record

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VERMONT Blueprint for Health

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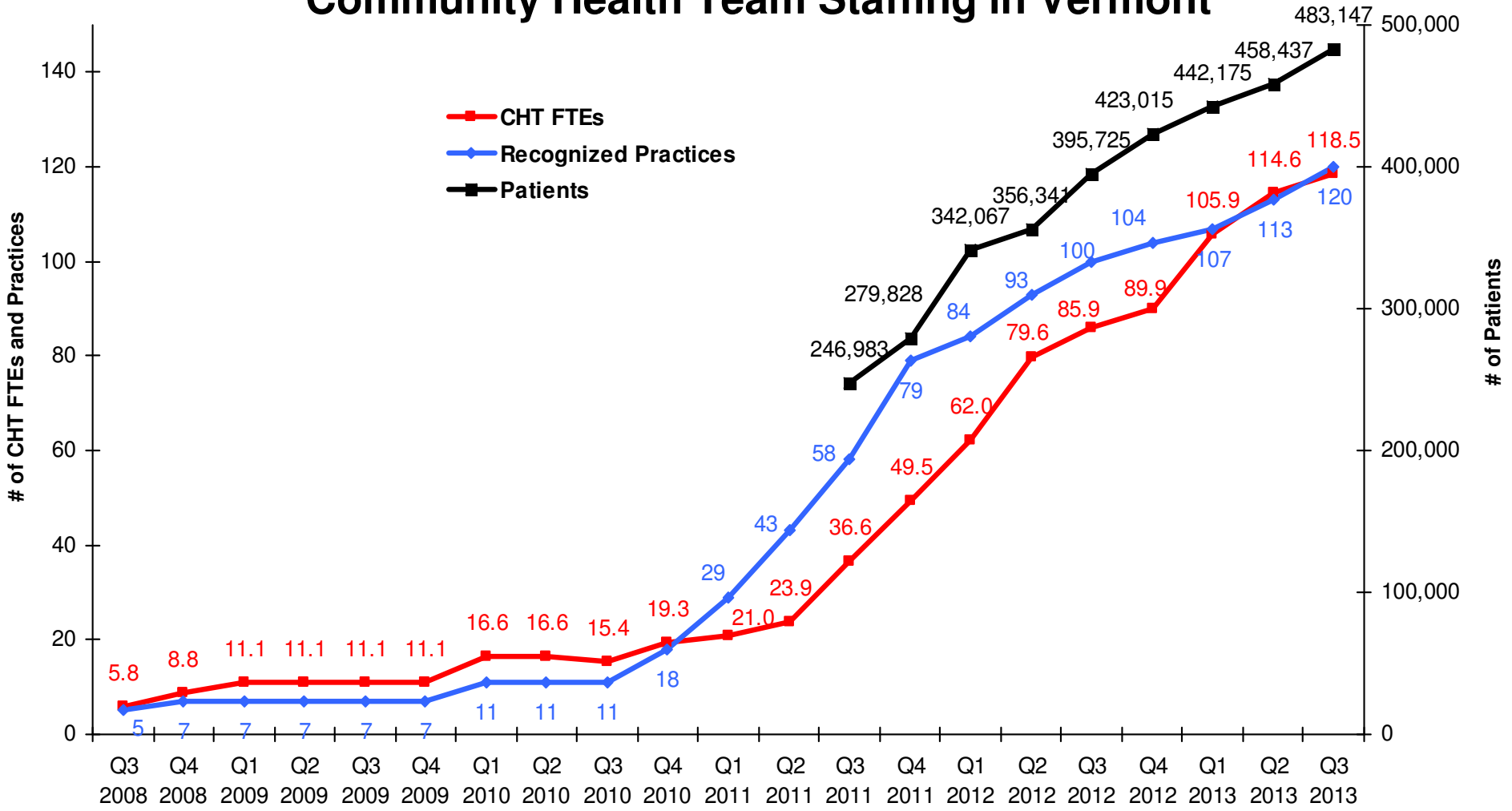
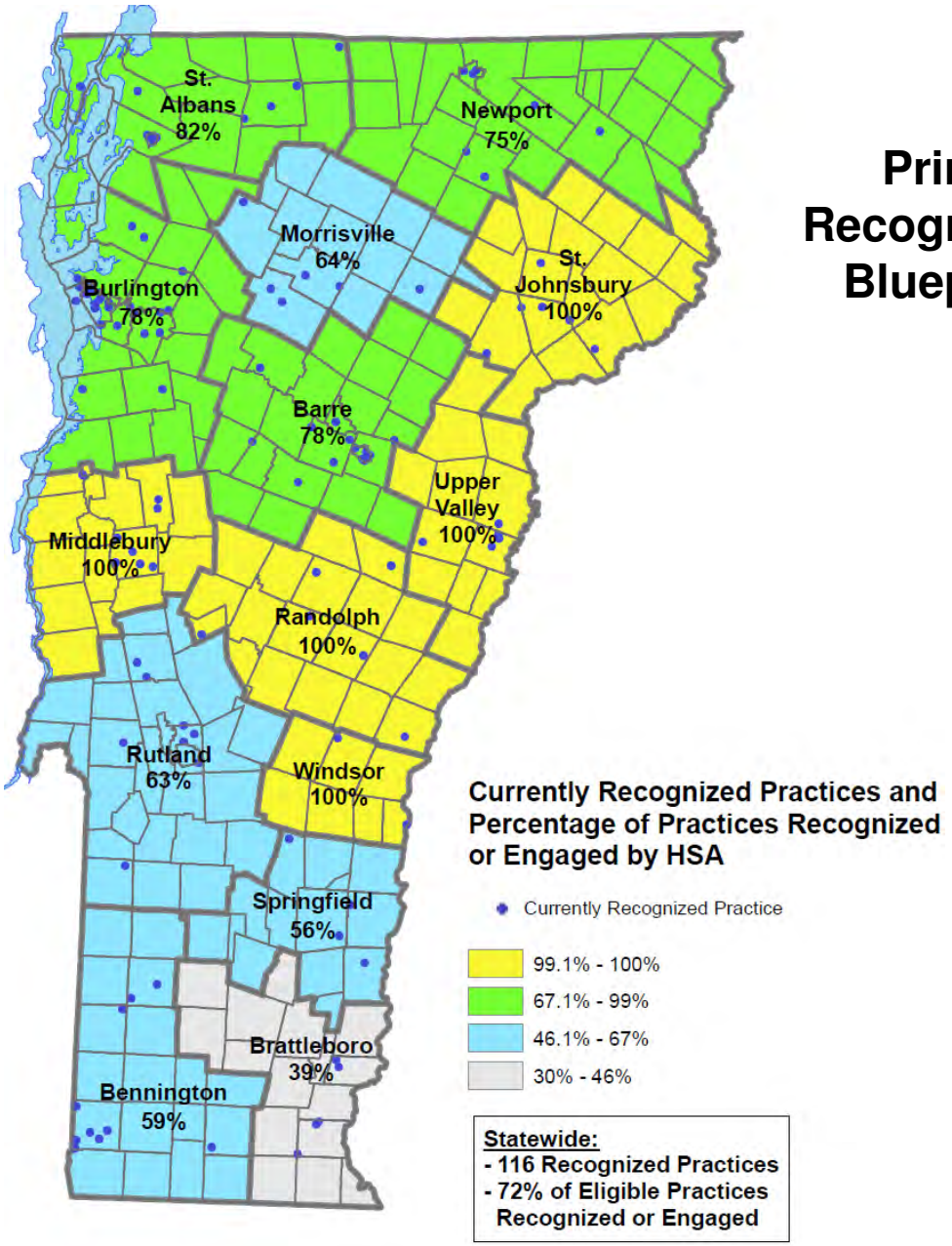
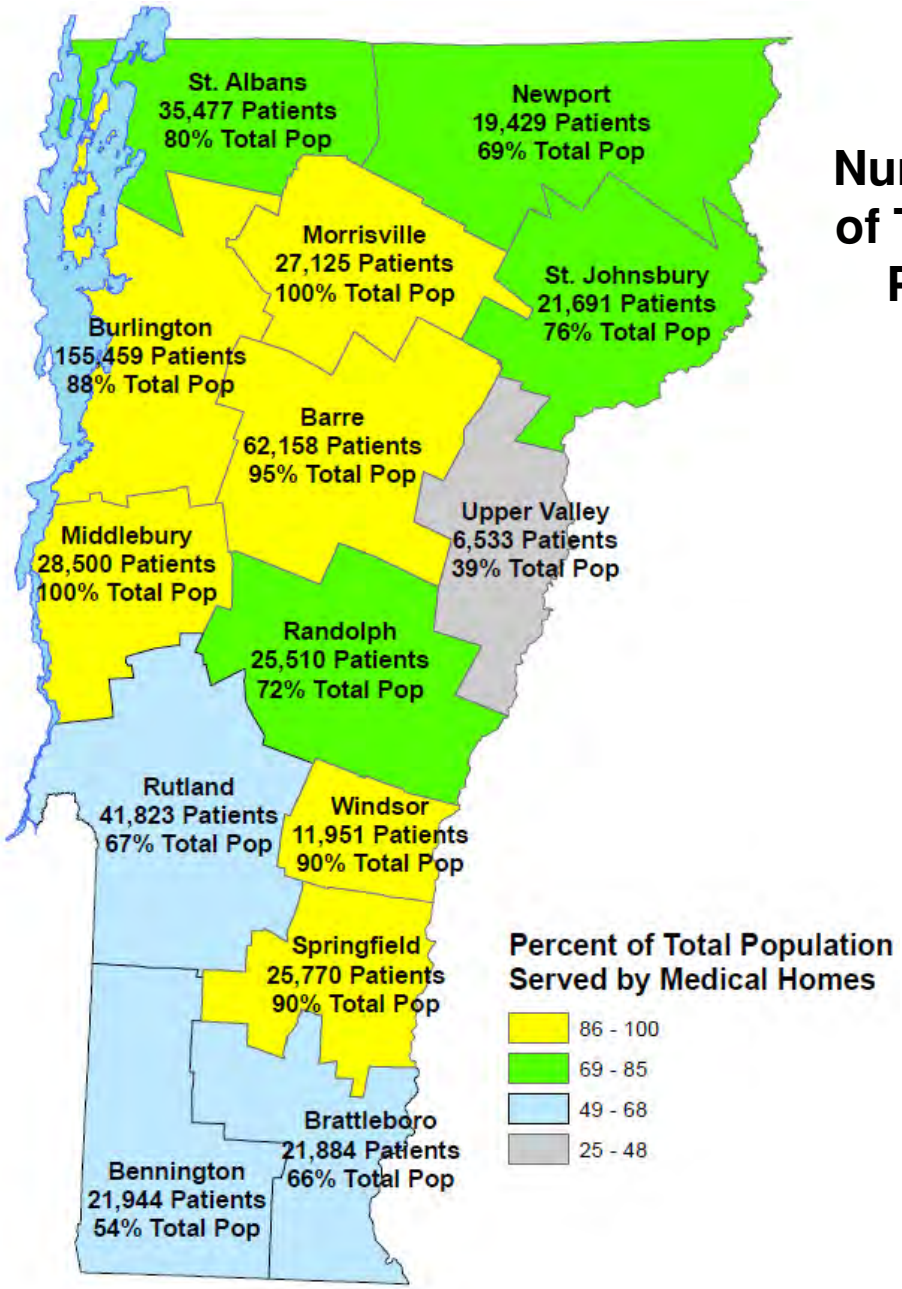
# Patient Centered Medical Homes and Community Health Team Staffing in Vermont




*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.

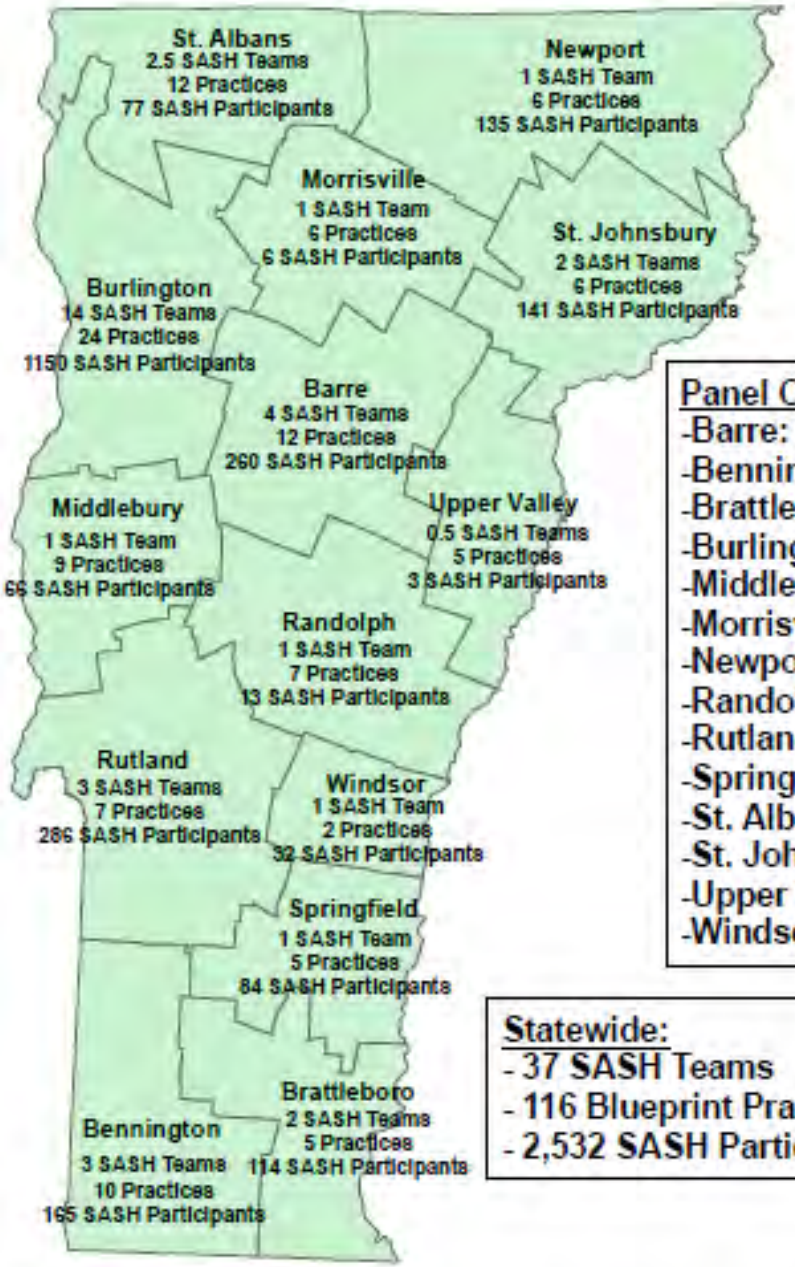
# Primary Care Practices Recognized or Engaged in the Blueprint, September 2013






# Number of Patients & Percent of Total Population Served by Patient Centered Medical Homes, July 2013

# SASH Expansion Thru October 2013




**Panel Capacity:**
- Barre: 400
- Bennington: 300
- Brattleboro: 200
- Burlington: 1400
- Middlebury: 100
- Morrisville: 100
- Newport: 100
- Randolph: 100
- Rutland: 300
- Springfield: 100
- St. Albans: 250
- St. Johnsbury: 200
- Upper Valley: 50
- Windsor: 100

**Statewide:**
- 37 SASH Teams
- 116 Blueprint Practices
- 2,532 SASH Participants

Department of Vermont Health Access


# Key items for upcoming meetings

1. Next phase of payment reforms

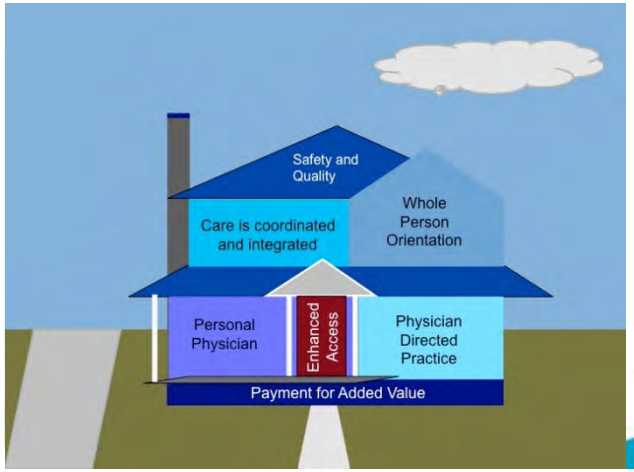
2. Allocating costs for Community Health Teams

# Patient Centered Medical Home


Paul Grundy MD, MPH

IBM‘s Director Healthcare Transformation

President Patient Centered Primary Care Collaborative

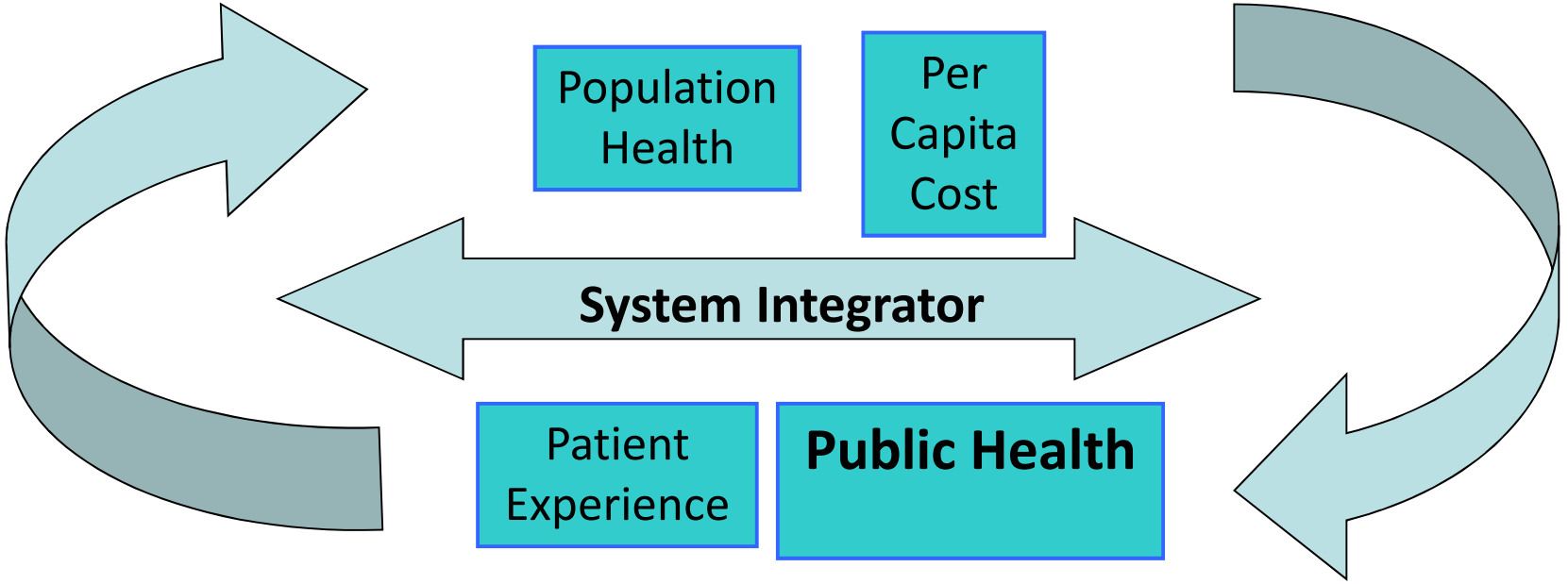



# Paul Grundy MD MPH Bio

- “Godfather” of the Patient Centered Medical Home
- IBM Global Director Healthcare Transformation
- President of PCPCC
- Member Institute of Medicine
- Member Board ACGME
- Professor Univ. of Utah Department Family Medicine
- Winner NCQA national Quality Award
- A Leader of MOH level taskforce primary care transformation 8 nations: USA, Canada, New Zealand, Australia, Holland, Denmark, UK, Belgium,
- Univ. of California MD, John Hopkins Trained

# Away from Episode of Care to Management of Population

Hospital



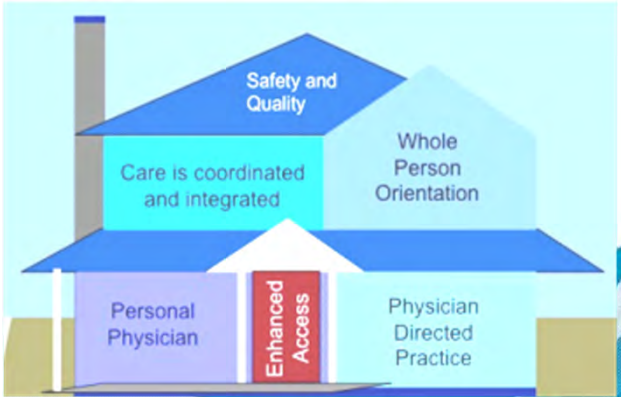

Community Health

**The System Integrator**

Creates a partnership across the medical neighborhood

Drives PCMH primary care redesign

Offers a utility for population health and financial management



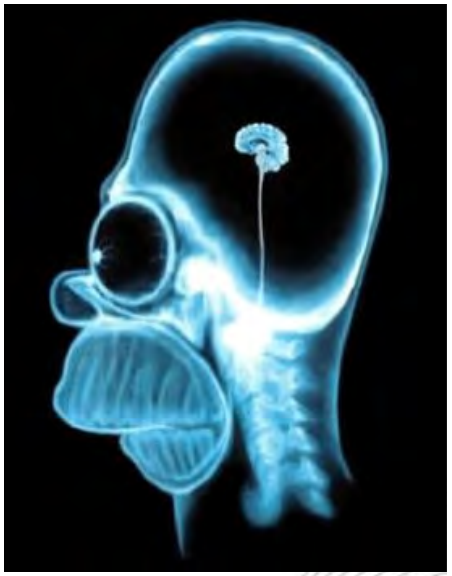
| TODAY'S CARE | | PCMH CARE |
|---|---|---|
| My patients are those who make appointments to see me | → | Our patients are the population community |
| Care is determined by today's problem and time available today | → | Care is determined by a proactive plan to meet patient needs with or without visits |
| Care varies by scheduled time and memory or skill of the doctor | → | Care is standardized according to evidence-based guidelines |
| I know I deliver high quality care because I'm well trained | → | We measure our quality and make rapid changes to improve it |
| Patients are responsible for coordinating their own care | → | A prepared team of professionals coordinates all patients' care |
| It's up to the patient to tell us what happened to them | → | We track tests & consultations, and follow-up after ED & hospital |
| Clinic operations center on meeting the doctor's needs | → | A multidisciplinary team works at the top of our licenses to serve patients |



Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

# Smarter Healthcare

| | |
|---|---|
| 36.3% | Drop in hospital days |
| 32.2% | Drop in ER use |
| 12.8% | Increase Chronic Medication use |
| -15.6% | Total cost |
| 10.5% | Drop Inpatient specialty care costs |
| 18.9% | Ancillary costs down |
| 15.0% | Outpatient specialty down |



**Outcomes of Implementing Patient Centered Medical Home Interventions:** A Review of the Evidence from Prospective Evaluation Studies in the US - PCPCC Oct 2012

# PCMH Lower Costs

## Aug 5th 2013 Pennsylvania

- 44% reduction in hospital costs
- 21% reduction in overall medical costs.
- 160 PCMH practices Pennsylvania from 2008 to 12
- Number of patients with poorly controlled diabetes declined by 45%.

Jeffrey Bendix modernmedicine.com/

# PCMH Michigan – Aug 11th 2013

- 19.1% lower rate of adult hospitalization.
- 8.8% lower rate of adult ER visits.
- 17.7% lower rate ER visits (children under age 17)
- 7.3% lower rate of adult high-tech radiology usage

VS other non-PCMH designated primary care physicians.

## 3,017 Physicians

. Medical home physicians help patients avoid ERs and admissions by evening hour appointments, weekend and same-day appointments

http://www.crainsdetroit.com/article/20130811/NEWS/308119989/blue-cross-touts-155-million-in-savings-with-medical-home-project

# WellPoint PCMH Preliminary Year 2 Highlights In Sept Issue Health affairs 2012

Colorado

- **18% *decrease* in acute IP admissions/1000, compared to 18% *increase* in control group**
- **15% *decrease* in total ER visits/1000, compared to 4% *increase* in control group**

**NEW HAMPSHIRE**

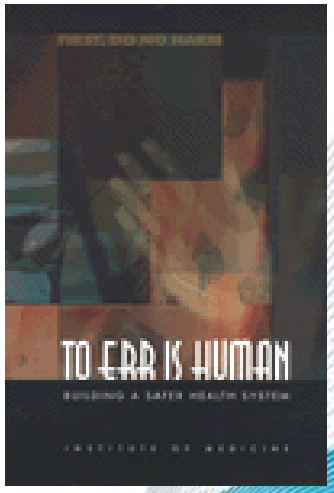
- **Specialty visits/1000 remained around flat compared to 10% *increase* in control group**

**New York**

- **Overall Return on Investment estimates ranged between 2.5:1 and 4.5:1**

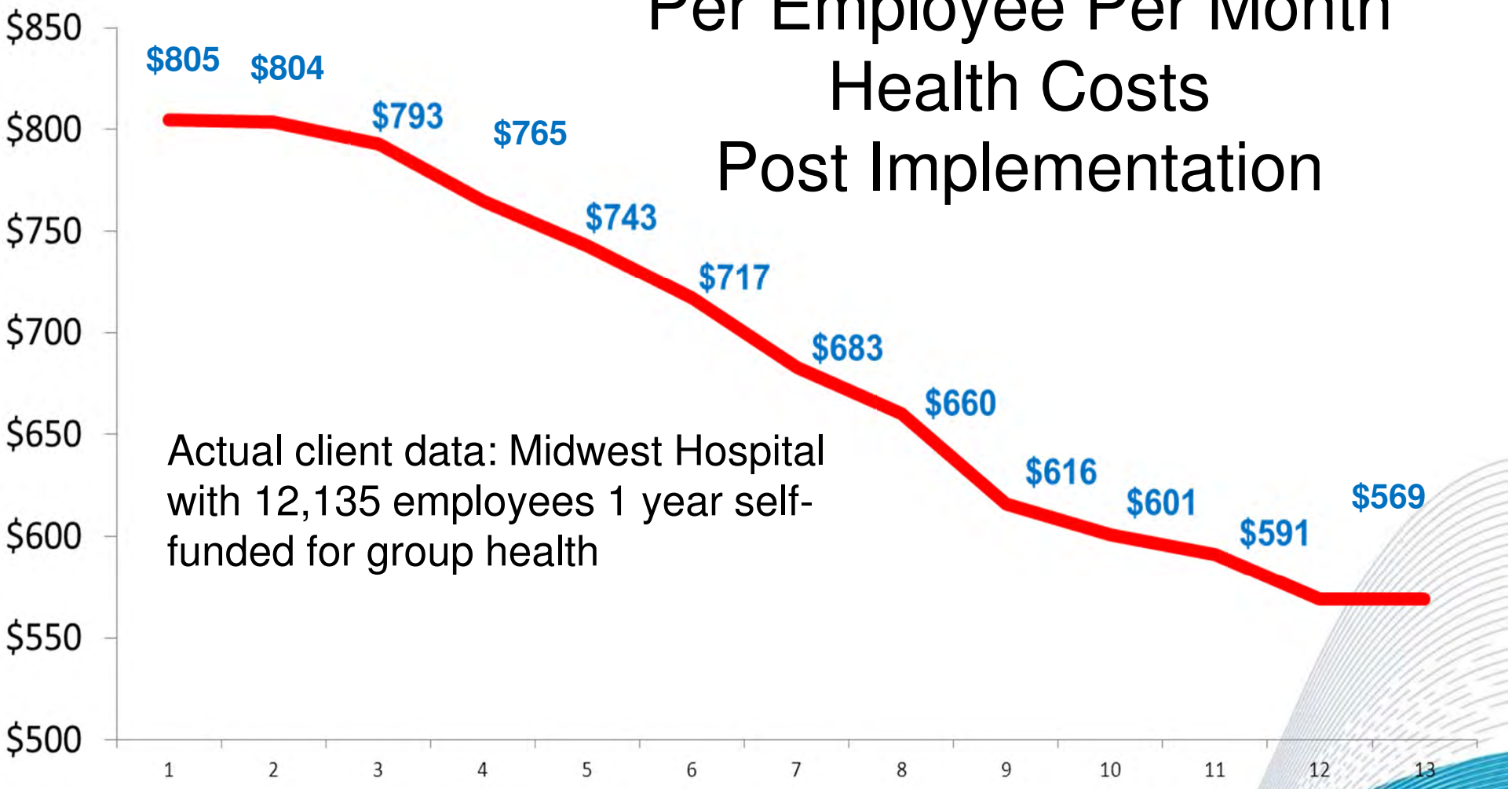
INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

- 1/3 less cardiac intervention needed
- 60% less complication Diabetes



# Build your own corporate PCMH

## Per Employee Per Month Health Costs Post Implementation




Actual client data: Midwest Hospital with 12,135 employees 1 year self-funded for group health

**Trajectory to Value Based Purchasing**:
Achieving Real Care Coordination and Outcome Measurement

**HIT Infrastructure**: EHRs and Connectivity

**Primary Care Capacity**: Patient Centered Medical Home

**Operational Care Coordination**: Embedded RN Coordinator and Health Plan Care Coordination $

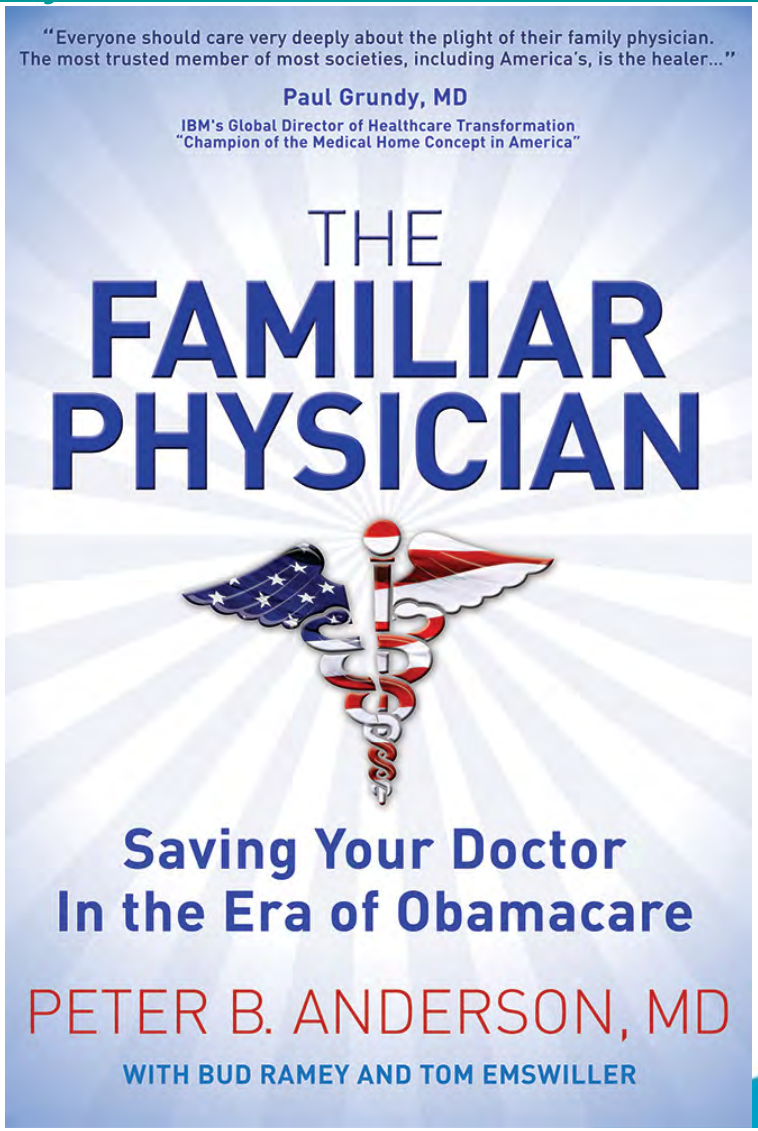
**Value/ Outcome Measurement**: Reporting of Quality, Utilization and Patient Satisfaction Measures

**Value-Based Purchasing**: Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)

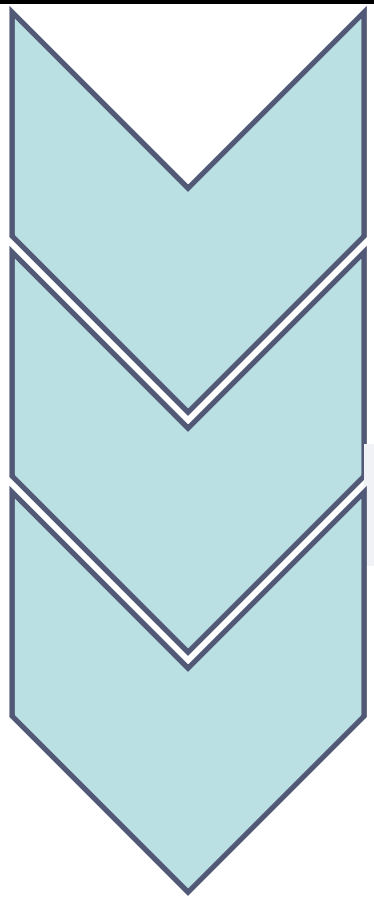
**Achieve Supportive Base for ACOs and Bundled Payments** with Outcome Measurement and Health Plan Involvement

Source: Hudson Valley Initiative

http://www.amazon.com/Familiar-Physician-Saving-Doctor-Obamacare/dp/1614487375/ref=sr_1_1?s=books&ie=UTF8&qid=1375885302&sr=1-1&keywords=The+Familiar+Physician



# Defining the Care Centered on Patient

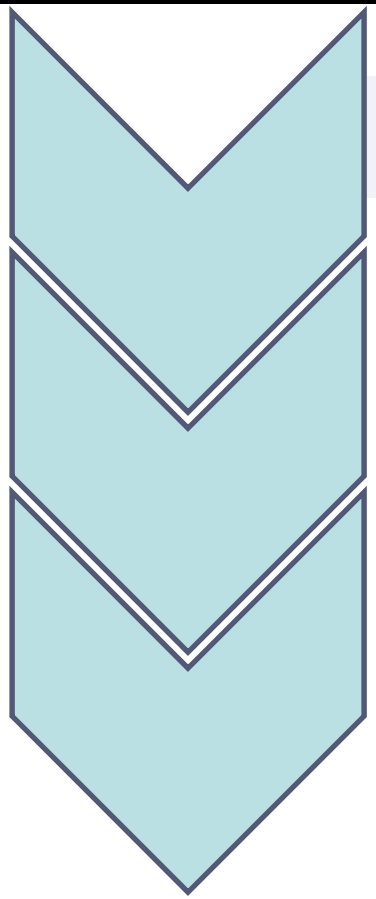


Superb Access to Care

Patient Engagement in Care

Clinical Information Systems, Registry

Care Coordination



Team Care

Communication Patient Feedback

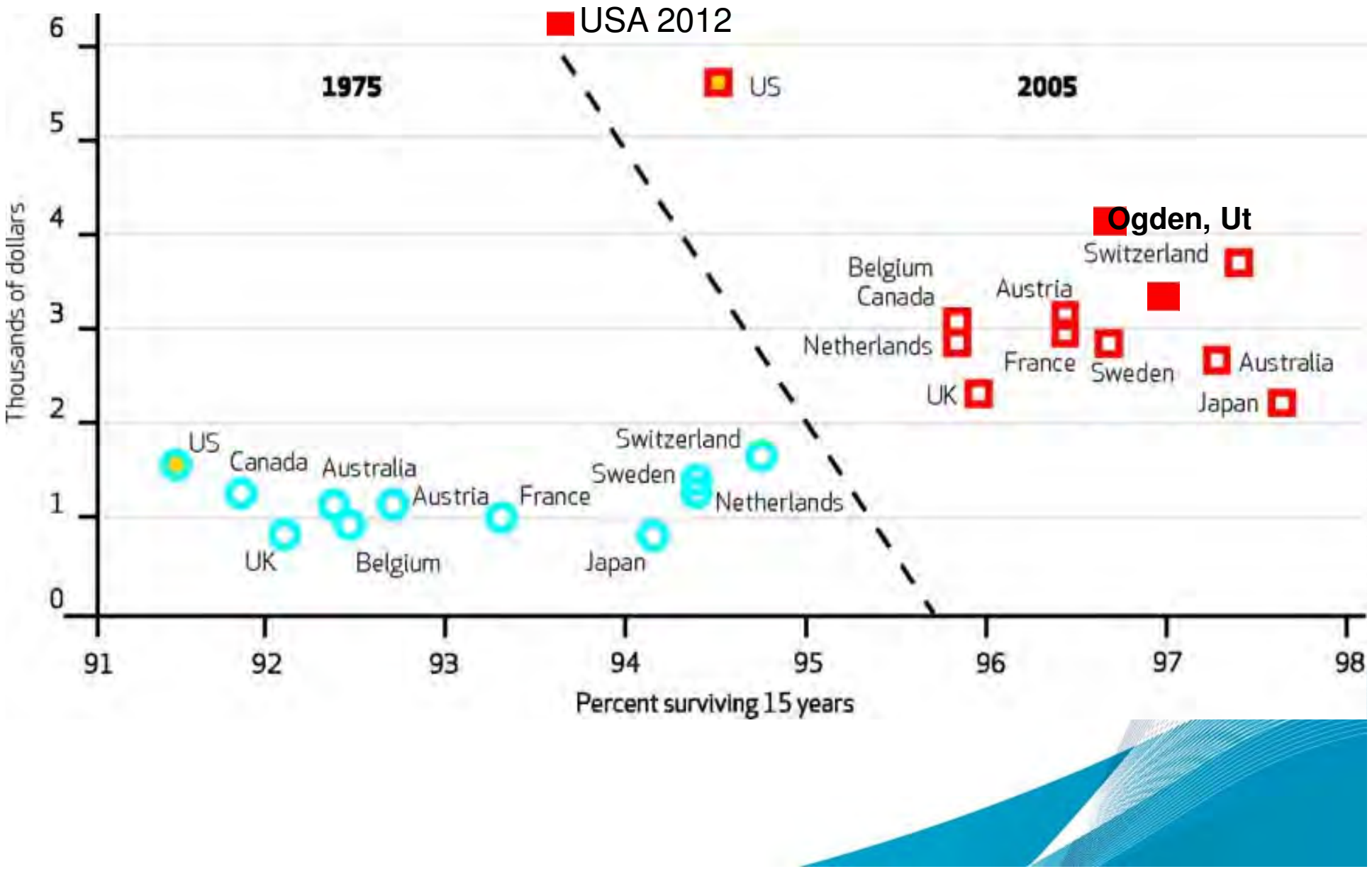
Mobile easy to use and Available Information


“We do the best
heart surgeries.”

# OPM Carrier Letter Feb 5th 2013

## Patient Centered Medical Homes (PCMH) within the Federal Employees Health Benefits (FEHB) Program

- A growing body of evidence supports **investment in PCMH – SO we are!!**
- there must be a plan for all FEHB lives enrolled in the practice to be included in a reasonable timeframe.
- ACA 2334


USA 2012
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Percent surviving 15 years


SPECIALISTS
PRIMARY CARE


POWER7
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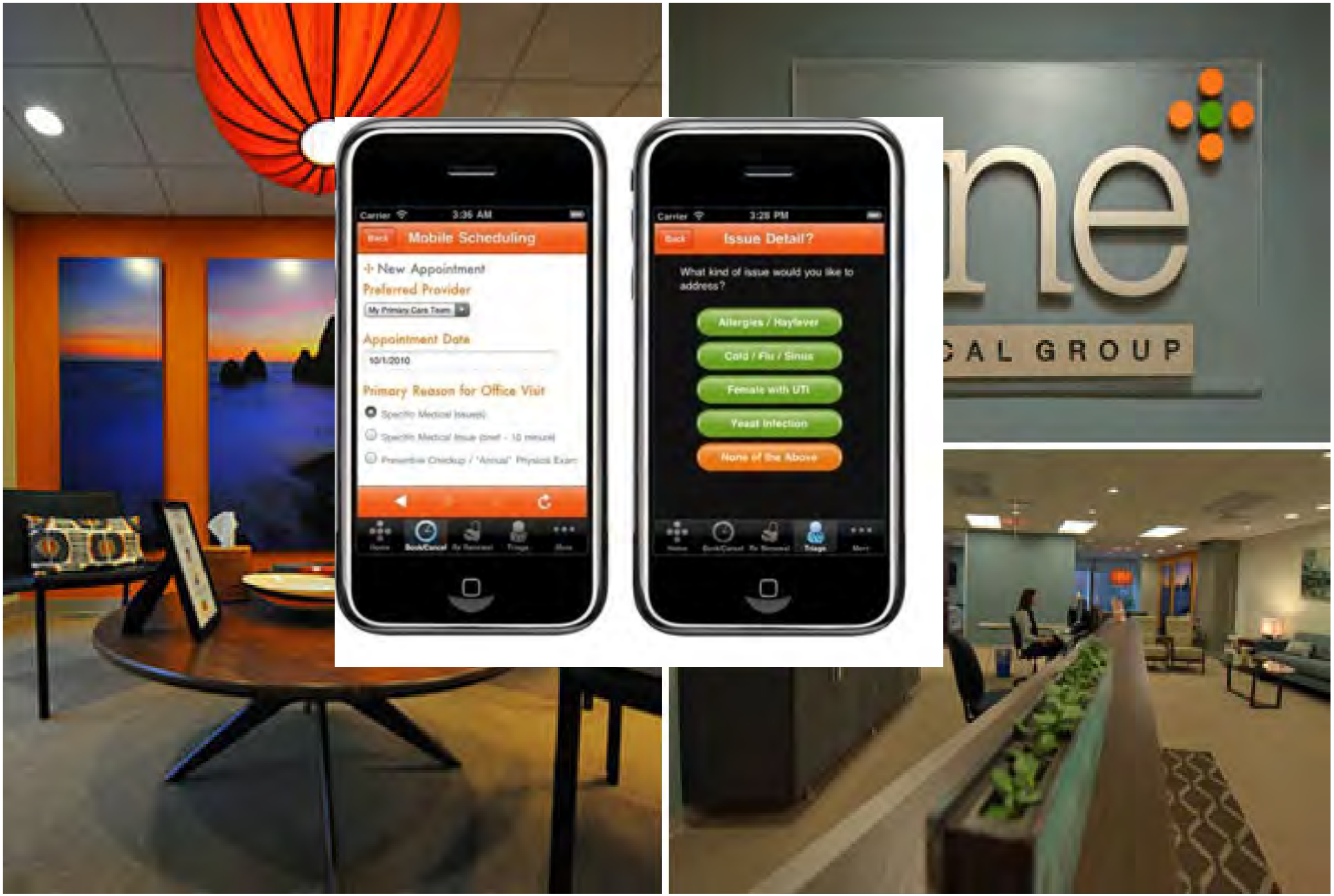
# MobileFirst Patient Consumer



# MobileFirst Remote Sensing

Mobile Sensing emotion for mental health status -- a*nalyzes facial expressions*
Mobile Sensing position for asthma -- *integrates GPS into inhalers*
Mobile Sensing motion for Alzheimer's -- *monitoring gait*
Mobile Sensing ingestion of medications. *activated by stomach fluid*


Mobile Sensing for sleep disorders -- *tracks breath, heart rate, motion*
Mobile Sensing for diabetes. *continuous monitoring iPhone non invasive sensor*.
Mobile Sensing for readmission prevention -- *BP, weight, pulse, ekg*
Mobile Sensing for exercise wellness -- b*enefit design feedback*

# Practice transformation away from episode of care

## Master Builder

Preventive Medicine

Chronic Disease Monitoring

Medication Refills

Acute Care

Test Results

DOCTOR

Master Builder

Case Manager

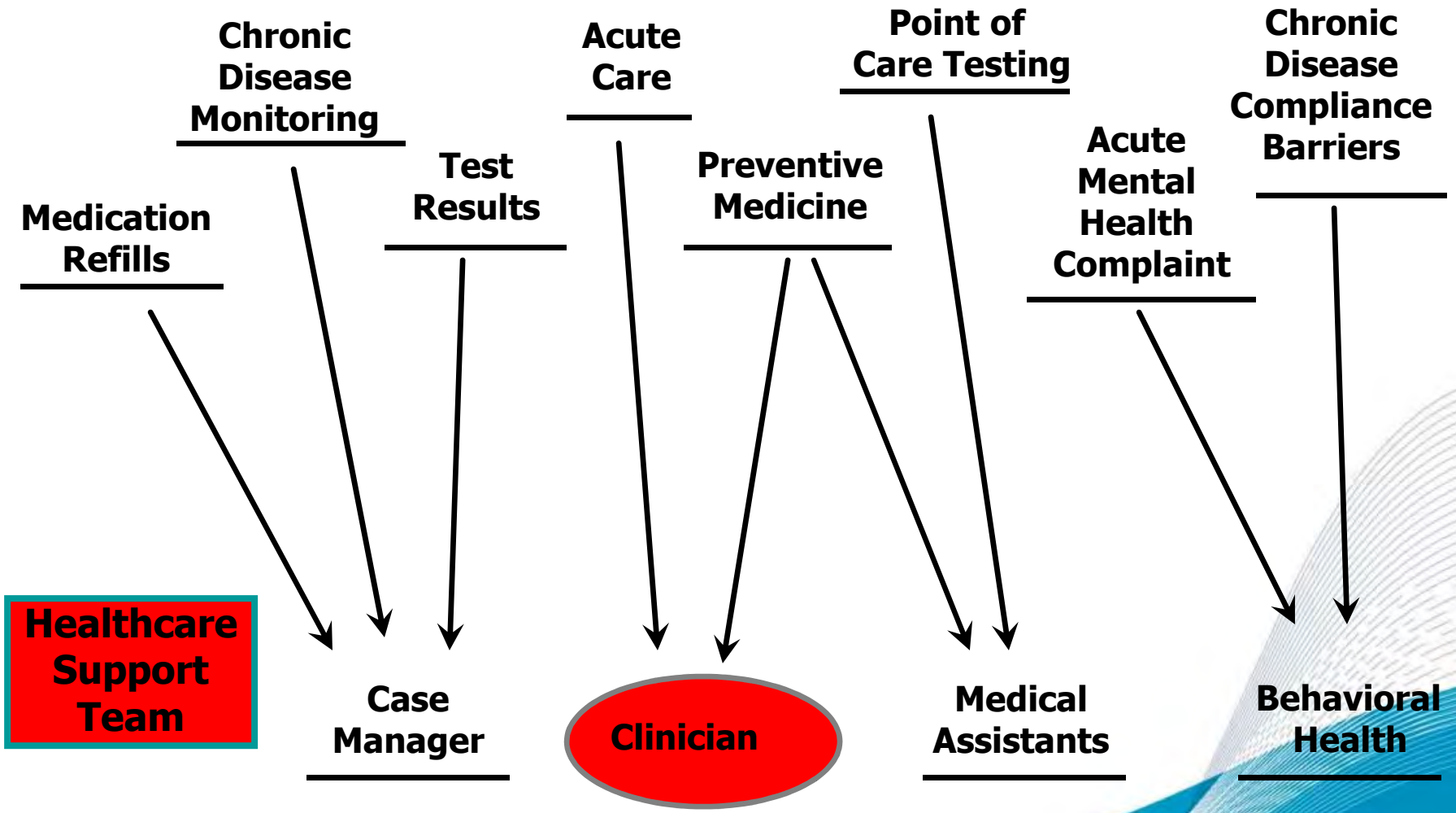
Behavioral Health

Medical Assistants

Nursing

Source: Southcentral Foundation, Anchorage AK

# PCMH Parallel Team Flow Design
# The glue is real data not a doctors Brain




Source: Southcentral Foundation, Anchorage AK

# Healthcare will Transform

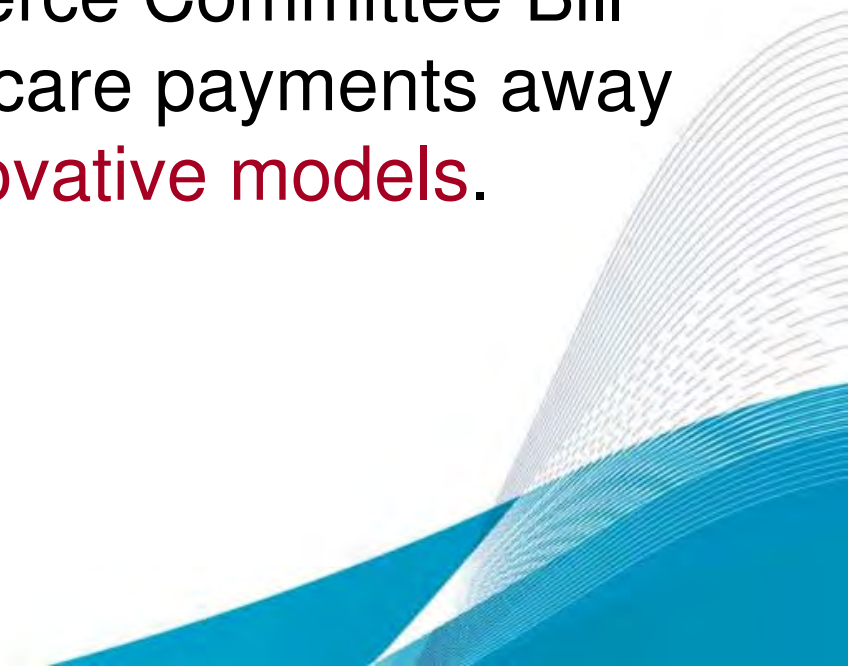
- Data Driven
- Every patient has a plan
- Team based
- Managing a Population
  Down to the Person

# Payment reform requires more than one method, you have dials, adjust them!!!

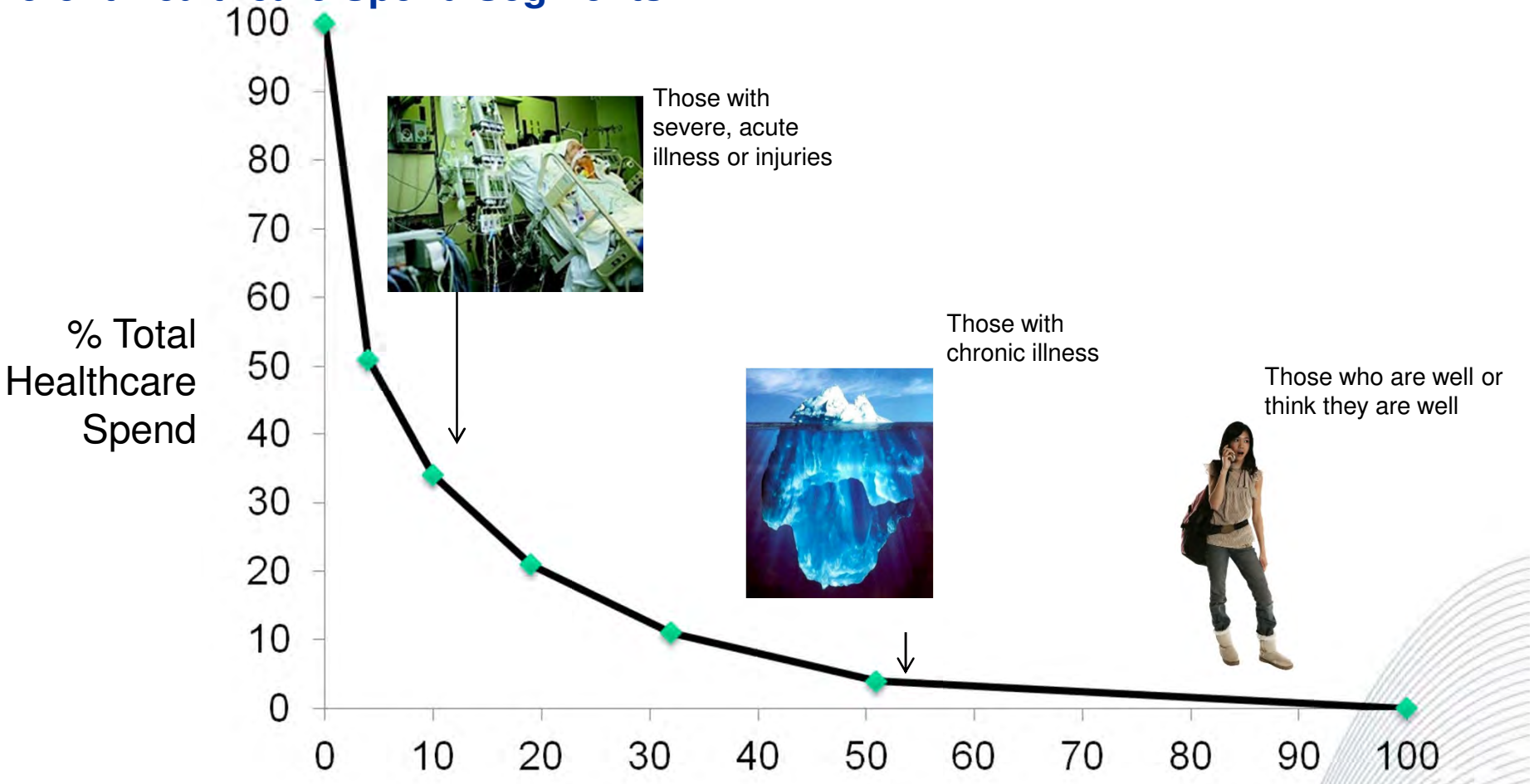
- “fee for health”
- fee for value
- “fee for outcome”
- “fee for process”
- “fee for belonging
- “fee for service”
- “fee for satisfaction”

# New $ Dials

- Complex Chronic Care Management payment codes.  authorize payments to physicians for the work that goes into managing complex patients outside of their actual office visits.
- House Energy and Commerce Committee Bill repeals SGR moving Medicare payments away from FFS toward new, innovative models.
-



# Benefit Redesign - Patient Engagement Different Strategies for Different Healthcare Spend Segments

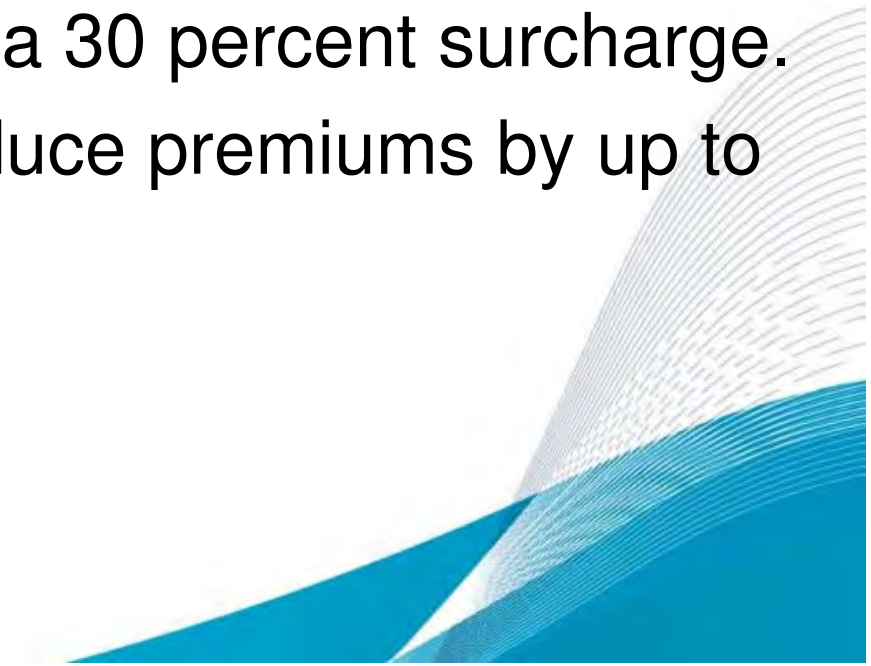




26

# Benefit Redesign

- Cost 2013 $16,351 emp on ave paying $4,565
- Federal government Final Rules wellness incentives.
- Smoker --employer may increase your insurance premiums by up to 50 percent.
- Overweight, you may look at a 30 percent surcharge.
- And  employers may also reduce premiums by up to 30 percent for normal weight.

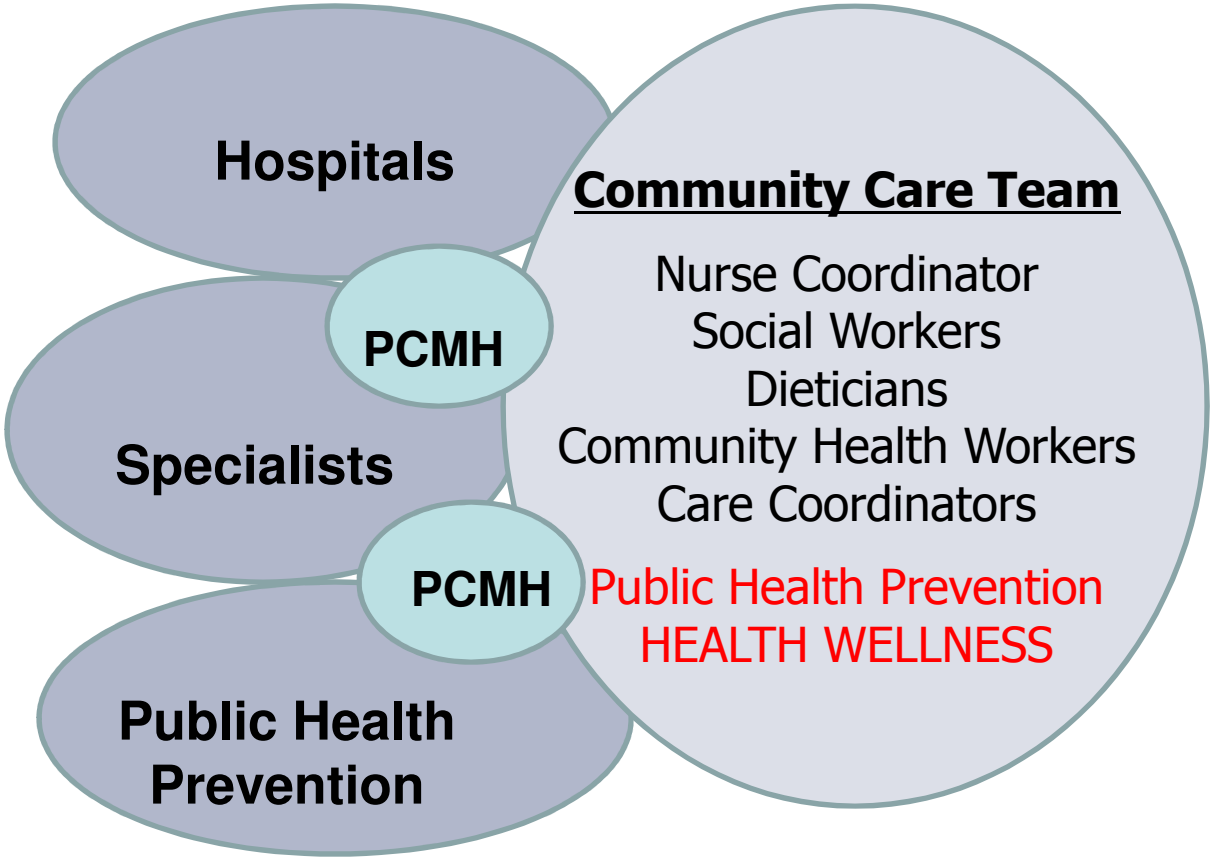


# benefit design reference pricing

- California Public Employees' Retirement System (CalPERS), from 2008 to 2012.
- insurer sets limits on the amount to be paid for a procedure, with employees paying any remaining difference.
- Shift by Patients from high to low cost 55.7%
- Hospitals reduced their prices by an ave of 20%.
- Accounted for $2.8 million in savings in 2011

http://content.healthaffairs.org/content/32/8/1392.abstract
Health Aff **August 2013** vol. 32no. 8 **1392-1397**

# PCMH 2.0 in Action




**A Coordinated Health System**

**Health IT Framework**

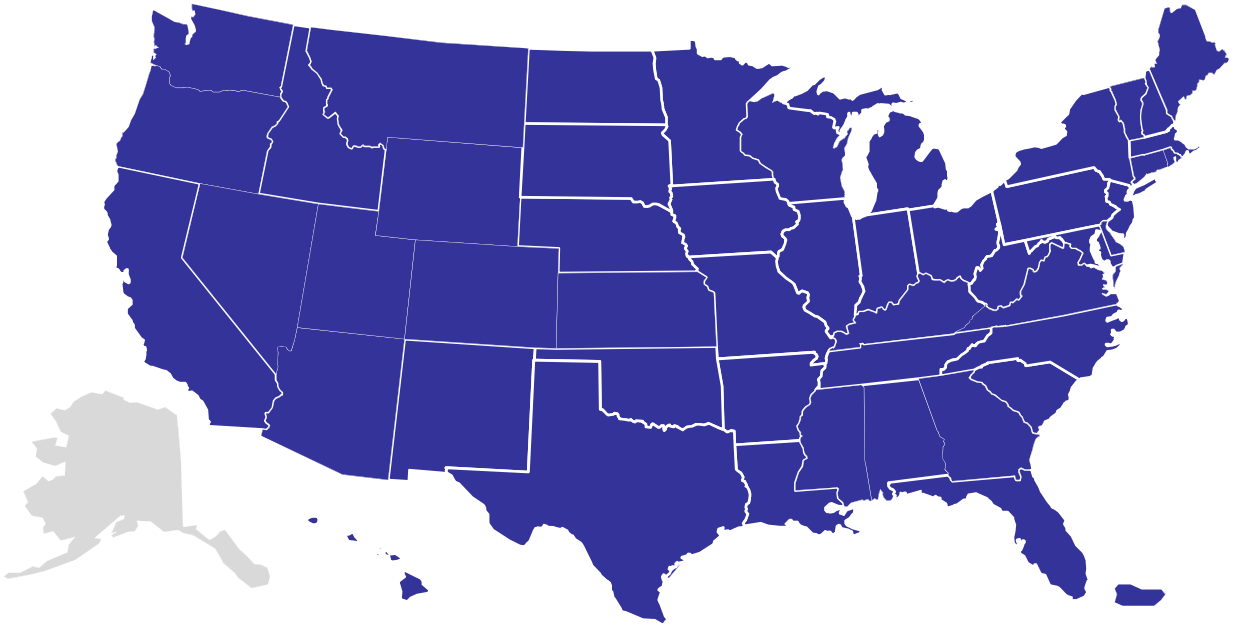
**Global Information Framework**

**Evaluation Framework**

**Operations**

# Blue Plan Care Delivery Innovations

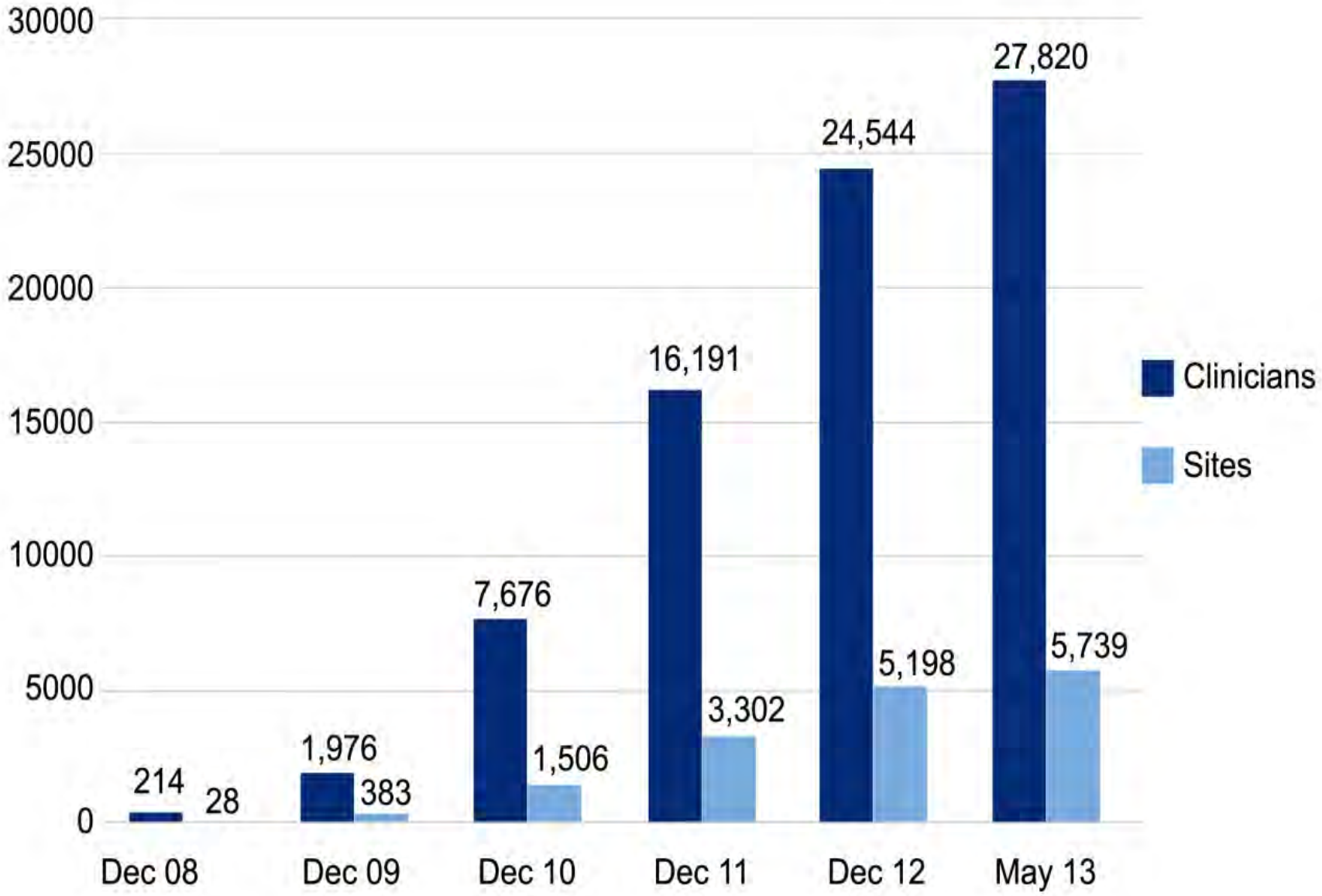
PCMH Level Care in market or in development in 49 states, District of Columbia and Puerto Rico



United HC, Humana, Aetna, CIGNA, Kaiser Martins Point, CDPHP, Priority,

PCPCC

Note: Information as of October 18, 2012. Program accessibility to National Account members varies by market.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Clinicians
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May 13

**Geisinger's Proven Health Navigator Model** serving Medicare Patients in rural Pennsylvania reported 7.1% savings over expected costs from 2006-2010 with an ROI of 1.7

- **Genesee Health Plan** in Flint, Michigan, reported PCMH services helped reduce ER visits by 51% between 2004 and 2007 and reduced hospital admissions by 15% between 2006 and 2007
- **WellPoint's** PCMH model in New York yielded risk-adjusted total PMPM costs that were 14.5% lower for adults and 8.6% lower for children enrolled in the medical home
- **CareFirst Blue Cross Blue Shield** of Maryland yielded an estimated 15% pmpm savings in the first year and $98 million in savings over two years
- **Group Health of Washington** reported overall cost savings of $17 PMPM including 29% fewer ER visits and 11% reduction in hospitalizations for ambulatory sensitive conditions
- **Oklahoma Medicaid** reported $29 PMPM savings
- **HealthPartners** in Minnesota reported 39% reduction in ER visits, 24% fewer hospitalizations, 40% reduction in readmission rates and 20% reduction in inpatient costs

Patient-Centered Primary Care COLLABORATIVE

# Why the Medical Home Works: A Framework

## www.pcpcc.net

| Feature | Definition | Sample Strategies |
|---|---|---|
| Patient-Centered | Supports patients in learning to manage and organize their own care at the level they choose, and ensures that patients and families are fully informed partners in health system transformation at the practice, community, and policy levels. | • Additional staff positions to help patients navigate the system and fulfill care plans (e.g., care coodinators, patient navigators, social workers)<br>• Compassionate and culturally sensitive care<br>• Strong, trusting relationships with physicians and care team, and open communication about decisions and health status |
| Comprehensive | A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. | • Care team focuses on 'whole person' and population health<br>• Primary care is co-located with oral, vision, OB/GYN, pharmacy and other services<br>• Special attention paid to chronic disease and complex patients |
| Coordinated | Ensures that care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. | • Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc.<br>• Communication and connectedness is enhanced by health information technology |
| Accessible | Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations. | • Implement more efficient appointment systems that offer same-day or 24/7 access to care team<br>• Use of e-communications and telemedicine to provide alternatives for face-to-face visits and allow for after hours care. |
| Committed to quality and safety | Demonstrates commitment to quality improvement through the use of health IT and other tools to ensure that patients and families make informed decisions about their health. | • Use electronic health records and clinical decision support to improve medication management, treatment, and diagnosis.<br>• Establish quality improvement goals to maximize data and reporting about patient populations and monitor outcomes |

## Potential Impacts

Patients are more likely to seek the right care, in the right place, and at the right time.

↓

Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated

↓

Providers are less likely to order duplicate tests, labs, or procedures

↓

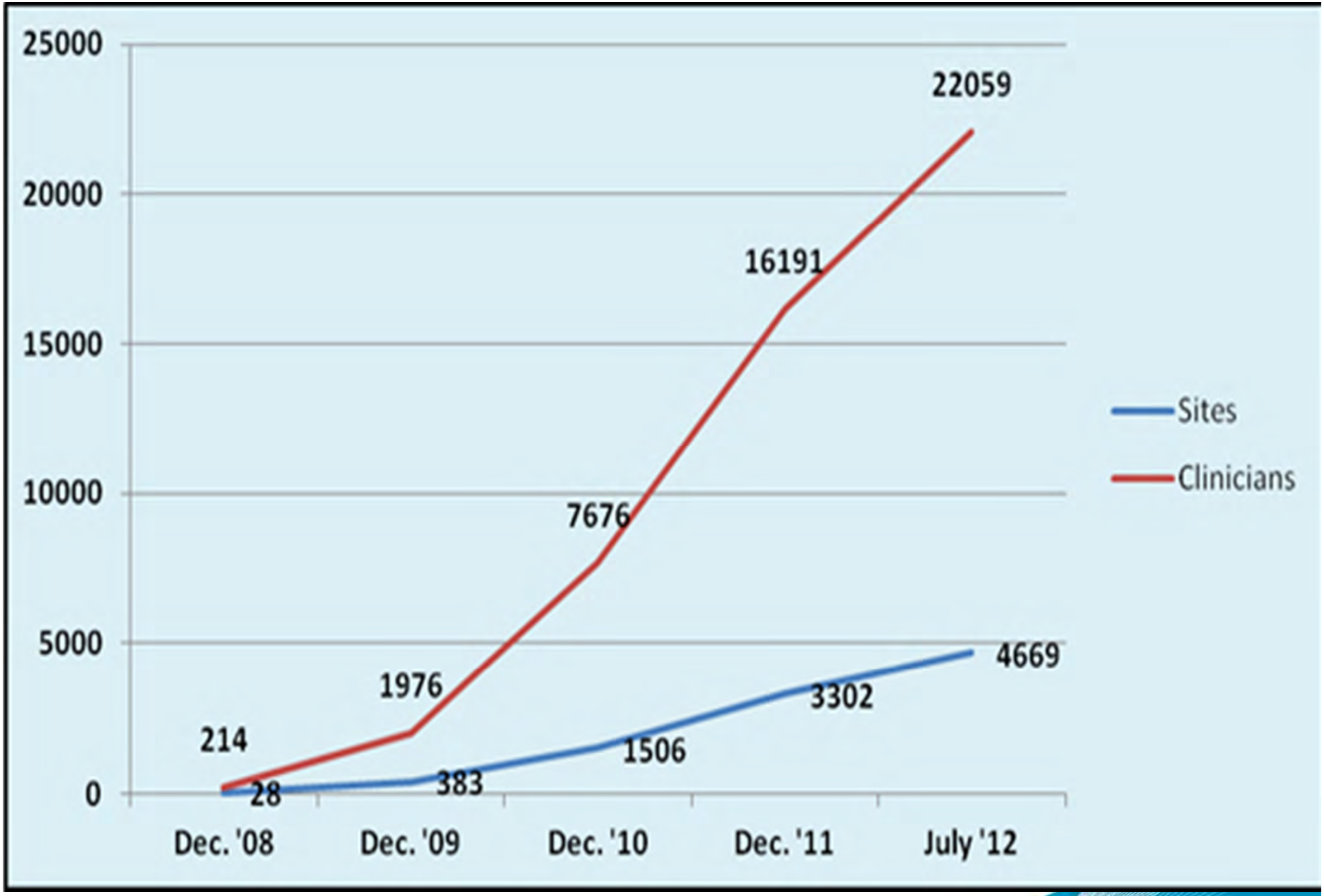
Better management of chronic diseases and other illness improves health outcomes

↓

Focus on wellness and prevention reduces incidence / severity of chronic disease and illness

↓

Health care dollars saved from reductions in use of ER, hospital, test, procedure, & prescriptions.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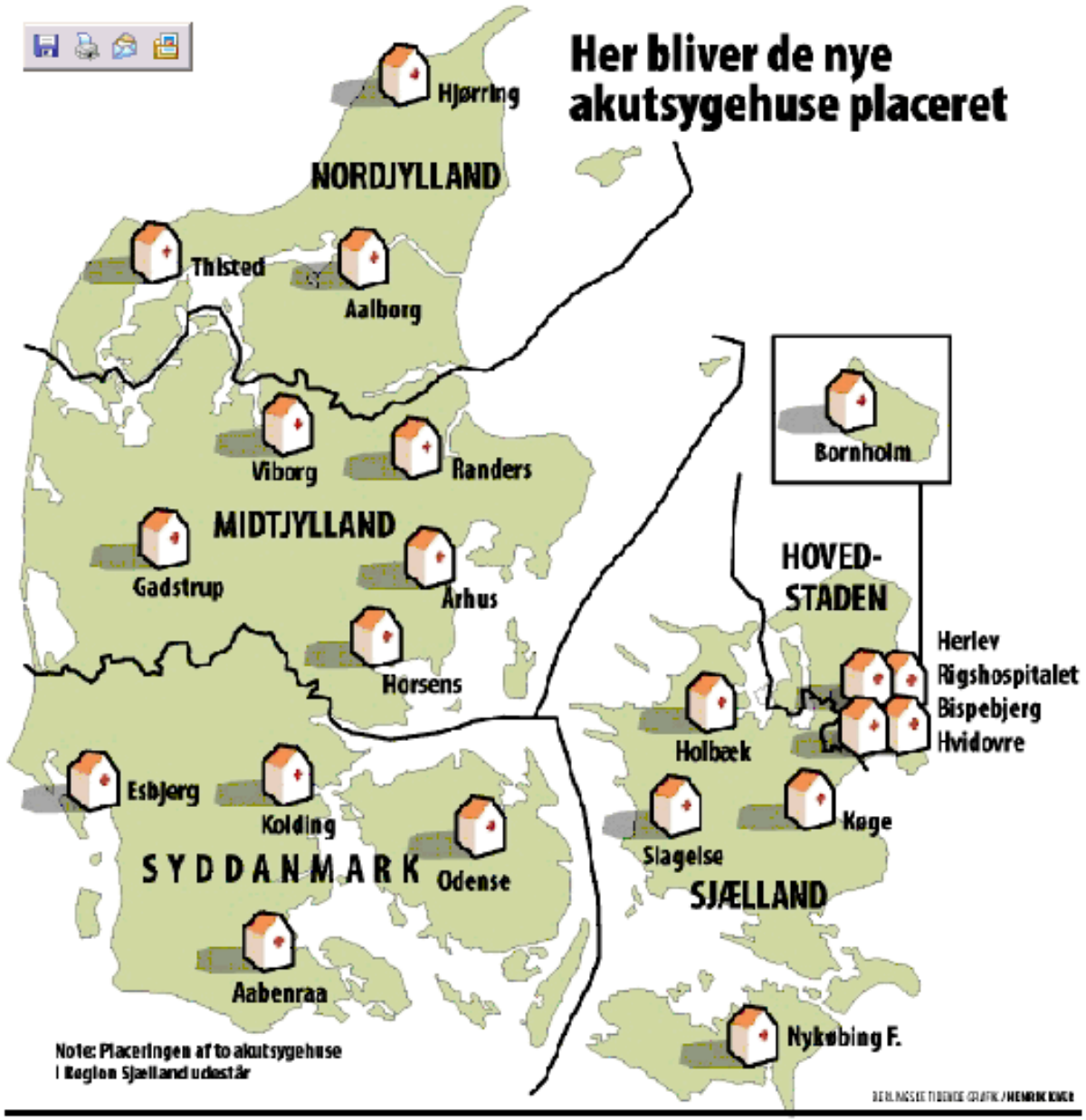
Sites
Clinicians
Dec. '08
Dec. '09
Dec. '10
Dec. '11
July '12

# PCMH Growth




# A journey to higher quality lower cost

quality as well as efficiency

Australian Government

# Minister for Health, The Hon Tanya Plibersek
# New Family Medicine
# Parliament, Canberra Australia
# 19 March 2013

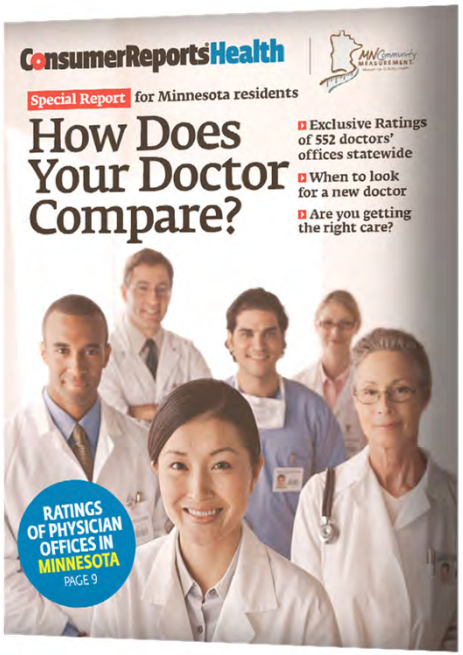
- **Australia** recognizes evidence in support of Patient-Centered Medical Homes is in, and it's compelling.
- Improved access to care;
- Improved clinical outcomes;
- Better management of chronic and complex disease;
- Decreased use of inappropriate medications;
- Decreased hospital admissions and readmissions; and
- Improved palliative care services.
- Therefore the Australian government will adopt Patient-Centered Medical Home as standard of care.

# Survey Of 5 European Countries Suggests Patient-Centered Medical Homes Would Improve Family Medicine Primary Care

2013/03/19

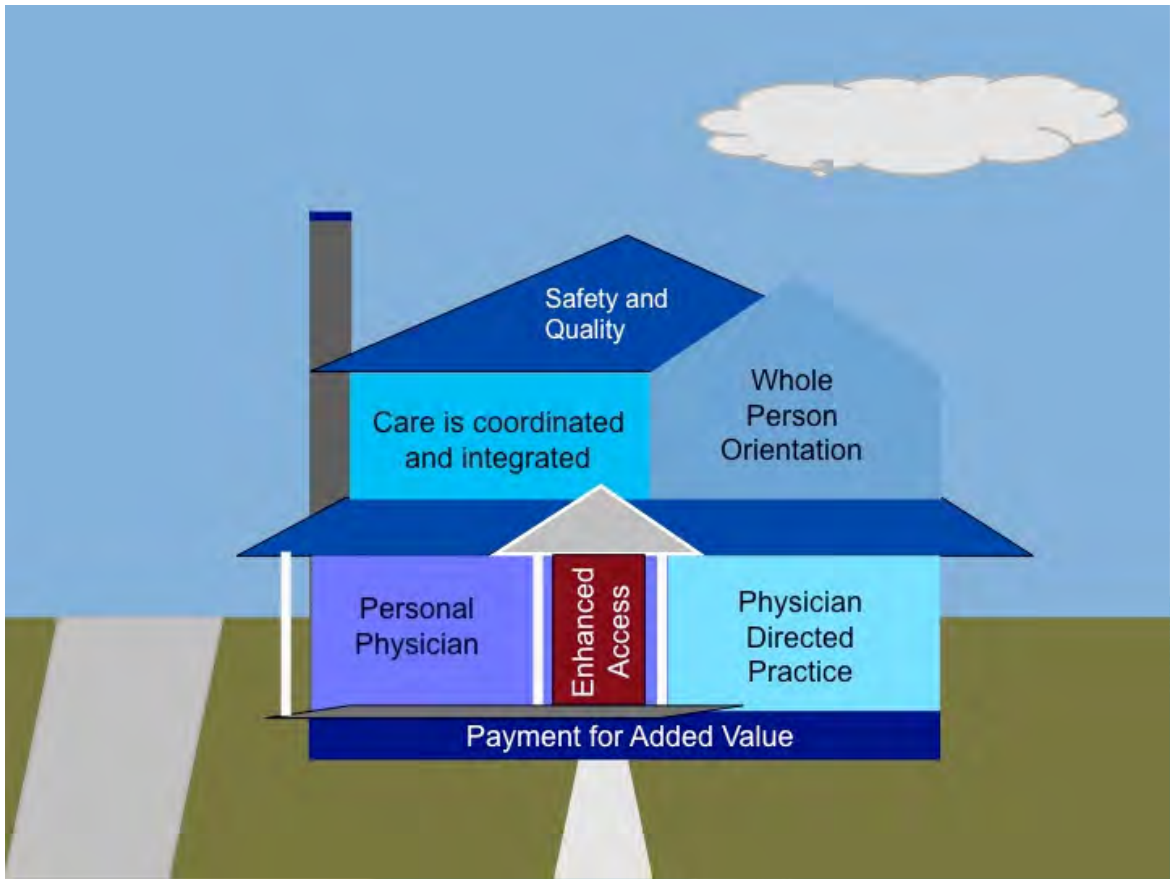

http://content.healthaffairs.org/content/early/2013/03/19/hlthaff.2012.0184.full.html

# Patients not shortchanged

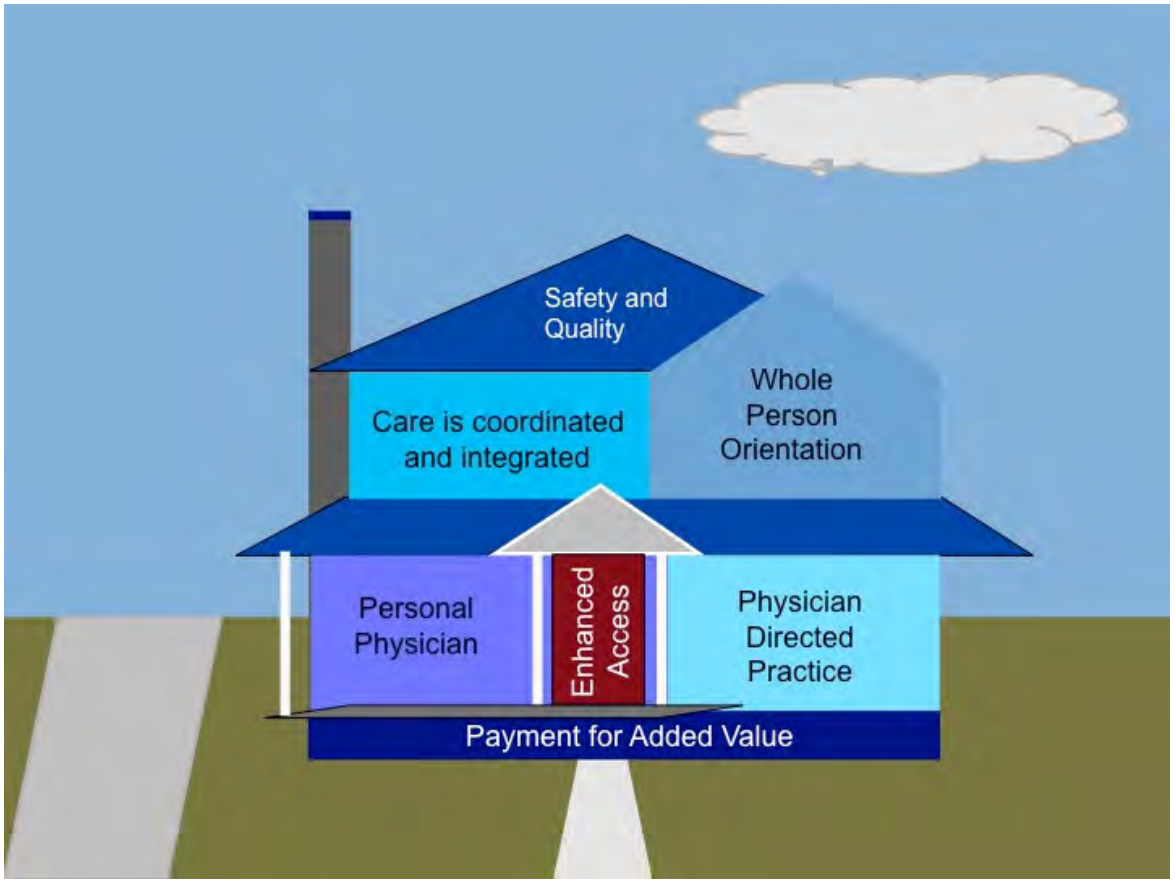


# PCMH as the Foundation

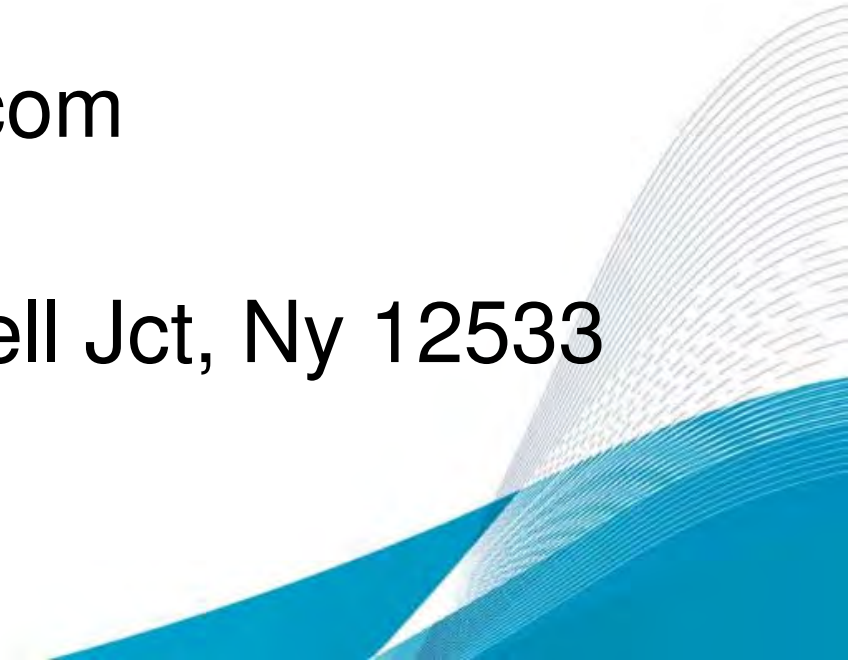
The right care foundation
The right time
The right price



# THANK YOU


Safety and Quality
Care is coordinated and integrated
Whole Person Orientation
Personal Physician
Enhanced Access
Physician Directed Practice
Payment for Added Value

- Paul Grundy, MD, MPH
  IBM's Global Director of Healthcare Transformation
  President, Patient-Centered Primary Care Collaborative
  email:  pgrundy@us.ibm.com
- cell 845 416 700
- 12 Hammer Drive Hopewell Jct, Ny 12533

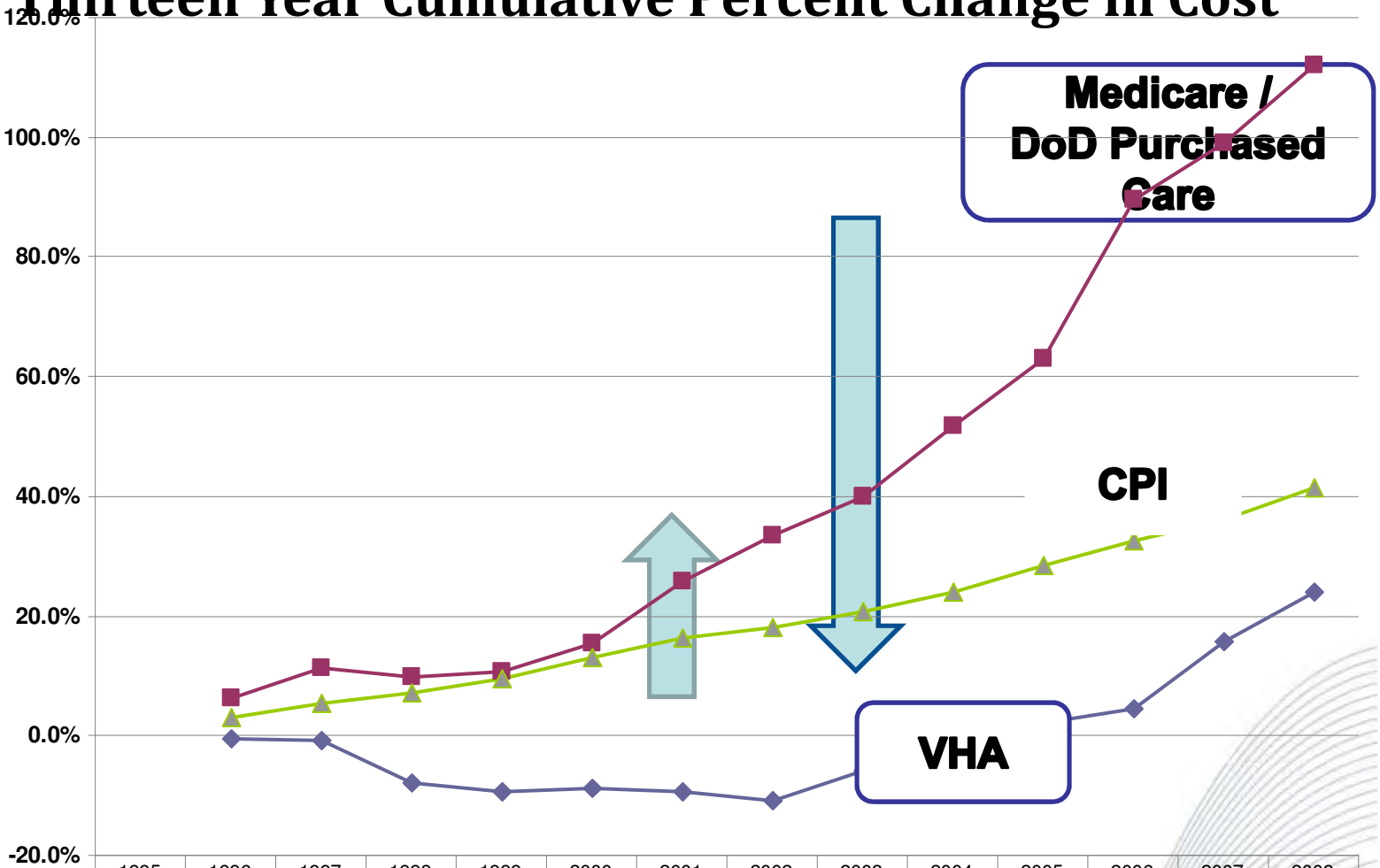



Community
Employer Health

# Onsite Health and Wellness Centers



# Thirteen Year Cumulative Percent Change in Cost




| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VHA Cost Per Patient | | -0.4% | -0.9% | -7.9% | -9.3% | -8.9% | -9.5% | -10.8% | -5.9% | -0.1% | 2.1% | 4.4% | 15.6% | 24.1% |
| Average Medicare Payment/Enrollee | | 6.3% | 11.4% | 9.7% | 10.8% | 15.4% | 25.9% | 33.5% | 40.0% | 51.7% | 62.9% | 89.6% | 99.2% | 111.9% |
| Consumer Price Index | | 3.00% | 5.37% | 7.05% | 9.41% | 13.13% | 16.30% | 18.16% | 20.88% | 24.14% | 28.36% | 32.47% | 36.18% | 41.35% |