PRIMARY CARE TRANSFORMATION

Lessons from Across the Nation
PANELISTS

- **Lisa Dulsky Watkins, MD** – Director of the Multi-State Collaborative, The Milbank Memorial Fund
- **Karl Finison, MA** – Director of Analytic Development, Onpoint Health Data
- **Katharine McGraves-Lloyd, MS** – Health Data Analyst, Onpoint Health Data
- **Amy Kinner, MS** – Health Services Researcher, Onpoint Health Data
- **Jenney Samuelson, MS** – Assistant Director, The Vermont Blueprint for Health
TOPICS

• **Multi-State Collaboratives** – Overview of the Milbank Memorial Fund and its multi-payer primary care projects (Lisa Dulsky Watkins, MD)

• **Vermont Blueprint for Health Profiles** – Exploration of methods, measures, and visualization techniques used to develop Blueprint’s practice and community profiles (Karl Finison, MA; Katharine McGraves-Lloyd, MS; Amy Kinner, MS)

• **Leveraging Profiles to Effect Change** – Identifying improvement opportunities and informing decision making through Blueprint’s profiles (Jenney Samuelson, MS)

• **Discussion & Q&A** – How can multi-payer primary care projects and the data derived from their initiatives be used to reform healthcare systems? (All panelists, QC participants)
The Fund’s priorities include:

• Being a source for evidence and experience in response to state requests

• Building state health policy capacity

• Supporting state-led, multi-payer primary care transformation programs
THE MILBANK MEMORIAL FUND

How the Fund has capitalized on its priorities:

• Establishing the Multi-State Collaborative

• Providing a key mechanism for state and program leaders to share their experiences and outcomes
FEDERALLY FUNDED MULTI-PAYER PROGRAMS

Multi-payer Advanced Primary Care Practice (MAPCP) demonstrations

Comprehensive Primary Care (CPC) initiatives

*Source: cms.gov
DEMONSTRATING THE TRIPLE AIM

Multi-payer programs must demonstrate their efficacy in each dimension of the Institute for Healthcare Improvement’s Triple Aim:

1. Improve the patient’s experience of care
2. Improve the health of populations
3. Reduce the per-capita cost of healthcare
THE CHALLENGE: RELIABLE DATA

To implement, support, and sustain improvements and innovations in primary care, the following groups need accurate, timely, and actionable information:

- State leaders and program directors
- Policymakers at the state and national levels
- Primary care practices
THE SOLUTION: APCD SYSTEMS

Multi-State Collaborative members (2015) with existing APCDs *

Multi-State Collaborative members (2015) implementing APCDs *

*Source: apcdcouncil.org
VERMONT BLUEPRINT FOR HEALTH PROFILES

Karl Finison, MA
Katharine McGraves-Lloyd, MS
Amy Kinner, MS
PROFILING PROVIDERS TO EVALUATE CARE DELIVERY
COMBINING POPULATIONS

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 Profile: ABC Primary Care

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

<table>
<thead>
<tr>
<th>Demographics &amp; Health Status</th>
<th>Practice</th>
<th>HSA</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Members</td>
<td>4,081</td>
<td>84,070</td>
<td>244,958</td>
</tr>
<tr>
<td>Average Age</td>
<td>50.6</td>
<td>50.1</td>
<td>50.0</td>
</tr>
<tr>
<td>% Female</td>
<td>55.6</td>
<td>55.5</td>
<td>55.0</td>
</tr>
<tr>
<td>% Medicaid</td>
<td>14.5</td>
<td>13.0</td>
<td>16.5</td>
</tr>
<tr>
<td>% Medicare</td>
<td>23.7</td>
<td>22.2</td>
<td>25.5</td>
</tr>
<tr>
<td>% Maternity</td>
<td>2.1</td>
<td>2.1</td>
<td>1.9</td>
</tr>
<tr>
<td>% with Selected Chronic Conditions</td>
<td>50.1</td>
<td>38.8</td>
<td>40.8</td>
</tr>
</tbody>
</table>

**Health Status (CGR)**

| % Healthy                           | 39.0     | 43.9 | 40.6      |
| % Acute or Minor Chronic            | 18.8     | 20.5 | 19.2      |
| % Moderate Chronic                  | 27.9     | 24.5 | 24.9      |
| % Significant Chronic               | 15.4     | 12.3 | 14.1      |
| % Cancer or Catastrophic            | 1.4      | 1.3  | 1.3       |
A practice’s risk-adjusted rate (i.e., the red dot) compared to those of all practices in its Hospital Service Area (i.e., the green dots) and to all other Blueprint practices statewide (i.e., the blue dots).
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.
PROFILING HOSPITAL SERVICE AREAS TO EVALUATE CARE DELIVERY
SAMPLE HSA ACO MEASURES

Clinical
- Diabetes HbA1c not in control (>9%)
- Hypertension with blood pressure in control (<140/90 mmHg)
- Influenza immunization (clinical and claims)

Clinical/Diabetes Composite
- HbA1c in control (<8%)
- LDL-C in control (<100 mg/dL)
- Blood pressure (<140/90 mmHg)
- Tobacco non-use
- Aspirin use (not supported by data)

Utilization
- Plan all-cause readmissions (PCR)
- AHRQ PQI measures
- ACS admissions – Asthma or COPD
- ACS admissions – CHF
- ACS composite admissions (PQI 92)

ACO, HEDIS, & Other
- Developmental screening first 3 years
- AWC, FUH, IET, AAB, CHL, BCS
- Pneumococcal vaccination (BRFSS)
- Other BRFSS measures
PLAN ALL-CAUSE READMISSIONS

The relative rate, including 95% confidence intervals, of continuously enrolled members, ages 18 years and older, that had an inpatient stay that was followed by an acute readmission for any diagnosis within 30 days during the measurement year; the blue dashed line indicates the statewide average.
The proportion, including 95% confidence intervals, of continuously enrolled members with hypertension, ages 18–85 years, whose last recorded blood pressure measurement in the clinical database was in control (<140/90 mmHg); the blue dashed line indicates the statewide average.
## DIABETES HbA1c CONTROL & OUTCOMES

<table>
<thead>
<tr>
<th>Metric</th>
<th>HbA1c in Control *</th>
<th>HbA1c Not in Control *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>4,220</td>
<td>568</td>
</tr>
<tr>
<td>Average annual expenditures per capita</td>
<td>$12,507 ($12,059, $12,954)</td>
<td>$15,267 ($13,867, $16,667)</td>
</tr>
<tr>
<td>Inpatient hospitalizations per 1,000 members</td>
<td>181.7 (168.7, 194.7)</td>
<td>275.0 (231.1, 318.8)</td>
</tr>
<tr>
<td>Inpatient days per 1,000 members</td>
<td>877.8 (849.2, 906.4)</td>
<td>1,524.0 (1,421.8, 1,627.2)</td>
</tr>
<tr>
<td>Outpatient ED visits per 1,000 members</td>
<td>532.1 (509.8, 554.4)</td>
<td>725.2 (654.0, 796.4)</td>
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</tbody>
</table>

* Risk-adjusted rates and 95% confidence intervals; 99th percentile outliers excluded; HbA1c not in control >9%
LEVERAGING PROFILES TO EFFECT CHANGE

Jenney Samuelson, MS
COMPONENTS OF BLUEPRINT

- Patient-centered medical homes (PCMHs)
- Community health teams (CHTs)
- Self-management programs
- Multi-insurer payment reforms
- Health information technology (HIT) infrastructure
- Evaluation and reporting
- Learning health system
Community Health Team
- Nurse Coordinator
- Social Workers
- Nutrition Specialists
- Community Health Workers
- Public Health Specialist

Extended Community Health Team
- Medicaid Care Coordinators
- SASH Teams
- Spoke (MAT) Staff

Specialty Care & Disease Management Programs

Social, Economic, & Community Services

Mental Health & Substance Abuse Programs

Self-Management Programs

Public Health Programs & Services

Advanced Primary Care

Advanced Primary Care

Advanced Primary Care

Health IT Infrastructure

Evaluation & Comparative Reporting

All-Insurer Payment Reforms
- Leadership, Practice Facilitators, Workgroups
- Local, Regional, Statewide Learning Forums

Primary Care Transformation: Lessons from Across the Nation (April 2015)
# COMPONENTS BY THE NUMBERS

<table>
<thead>
<tr>
<th>Blueprint Component</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMHs (active)</td>
<td>124</td>
</tr>
<tr>
<td>PCPs (unique)</td>
<td>682</td>
</tr>
<tr>
<td>CHT staff (core)</td>
<td>218 staff (135 FTEs)</td>
</tr>
<tr>
<td>SASH staff (extenders)</td>
<td>65 FTEs (52 panels)</td>
</tr>
<tr>
<td>Spoke staff (extenders)</td>
<td>58 staff (39 FTEs)</td>
</tr>
<tr>
<td>Project managers</td>
<td>14</td>
</tr>
<tr>
<td>Practice facilitators</td>
<td>11</td>
</tr>
</tbody>
</table>
INITIAL CHALLENGES

- Stages of “data grief”
- Distribution and understanding
- Fear of profiles being made public
- Lag in claims data
UTILITY OF BLUEPRINT PROFILES

• First cross-payer reports
• Demonstrate significant variation in quality and utilization
• Align healthcare reform efforts (Blueprint/ACO)
• Used by practices and communities across Vermont to identify priorities
CASE STUDY: COMMUNITY HEALTH ACCOUNTABLE CARE

• Combined profile data across the ACO network

• Helped guide the decision to focus on preventable hospital readmissions for CHF and COPD

• Developed CHF and COPD recommendations to standardize practices across the ACO network

• Implemented a tele-monitoring program using Pharos and a local care coordinator from home health agency
PRIORITIES MOVING FORWARD

• Blueprint/ACO provider network alignment
• Unified community collaboratives
• Payment modifications
• Quality and performance framework (measures)
• Unified performance reporting and data utility
DISCUSSION & Q&A

All Panelists & QC Participants
DISCUSSION TOPICS

• How can multi-payer primary care initiatives help reverse some of the key drivers of spending growth and poor health/healthcare quality?

• How can reliable, meaningful data be accessed and interpreted to drive transformative, sustainable changes in healthcare systems across local communities?
LEARNING OBJECTIVES

1. **Synthesize** a number of multi-payer primary care projects occurring across the country

2. **Consider** how the data derived from those projects can be used to develop and evaluate data-driven policy directions

3. **Discuss** the role that practice profiles can play in illuminating utilization and expenditure rates among a variety of populations
LEARNING OBJECTIVES

4. **Identify** at least three specific opportunities for driving transformation at the practice level

5. **Compare** and **contrast** opportunities for improvement between the practice, geographic, state, and national levels
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