The Office of the National Coordinator for Health Information Technology

Using Data to Drive Change

ONC In-Person Site Visit
New Castle, Delaware
Wednesday, October 18, 2017

Using Data to Drive Change
Vermont Blueprint for Health

All-Insurer Payment Reforms

Transformation Network

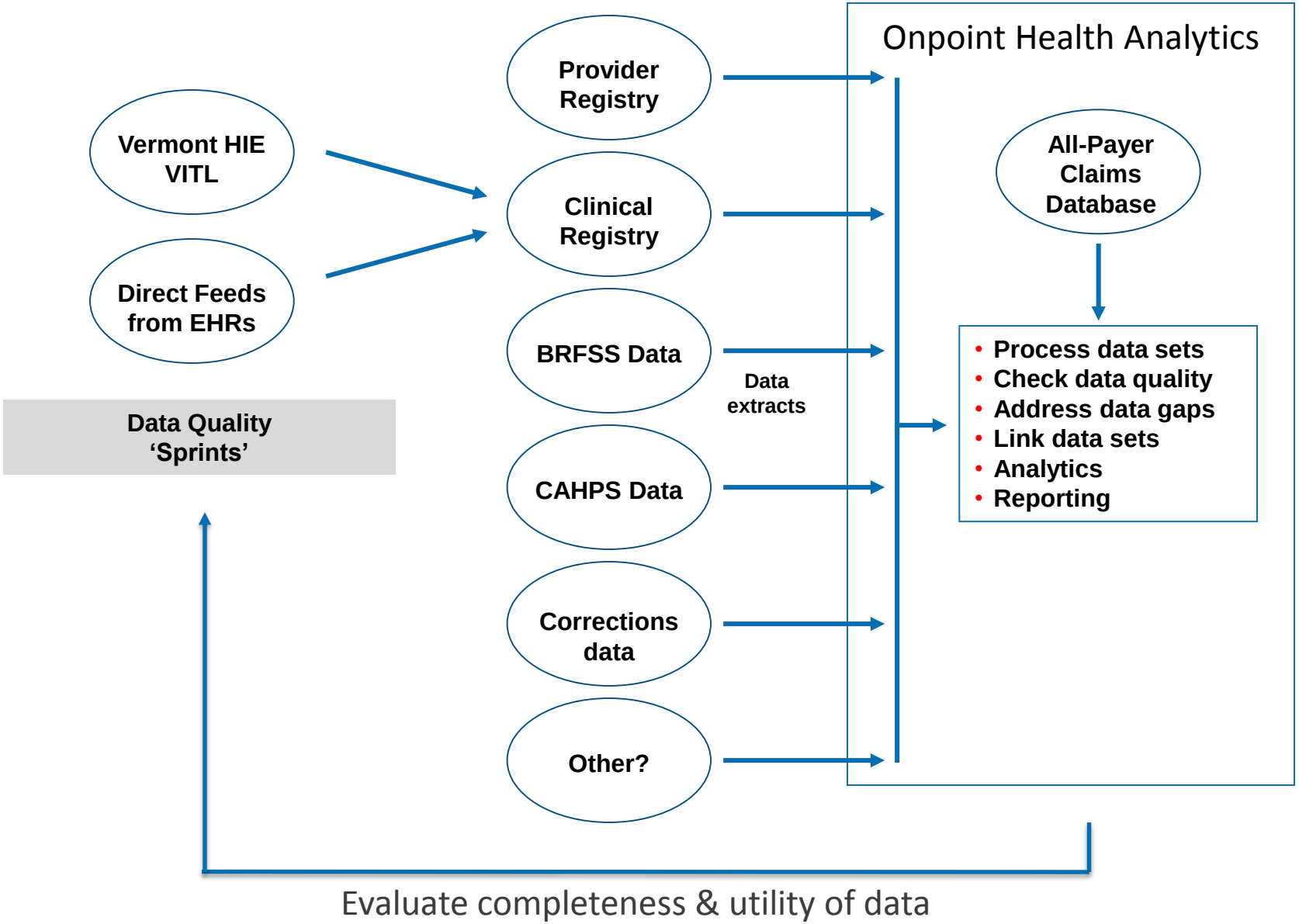
Service Area & Statewide Collaboratives

Data Infrastructure

Evaluation & Comparative Reporting

Using Data to Drive Change

Data Aggregation & Quality



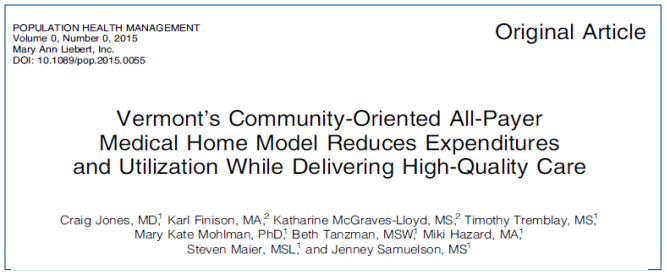
Using Data to Drive Change
Products

Measurement

- Quality
- Utilization
- Expenditures & Unit Costs
- Patient Experience
- Social, Economic, Behavioral
- Variation & Associations

Products

- Practice Profiles
- HSA Profiles
- Learning System Activities
- Performance Payments
- Outcomes & Impact
- Predictive Modeling


POPULATION HEALTH MANAGEMENT
Volume 0, Number 0, 2015
Mary Ann Liebert, Inc.
DOI: 10.1089/pop.2015.0055

Original Article

Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care

Craig Jones, MD,[1] Karl Finison, MA,[2] Katharine McGraves-Lloyd, MS,[2] Timothy Tremblay, MS,[1] Mary Kate Mohlman, PhD,[1] Beth Tanzman, MSW,[1] Miki Hazard, MA,[1] Steven Maier, MSL,[1] and Jenney Samuelson, MS[1]

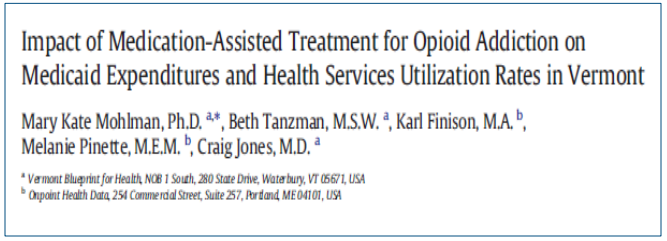

Finison et al. BMC Health Services Research (2017) 17:58
DOI 10.1186/s12913-017-2010-0

BMC Health Services Research

RESEARCH ARTICLE Open Access

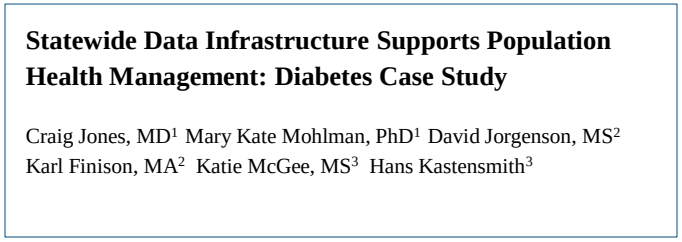
Risk-adjustment methods for all-payer comparative performance reporting in Vermont

Karl Finison[1*], MaryKate Mohlman[2], Craig Jones[3], Melanie Pinette[1], David Jorgenson[1], Amy Kinner[1], Tim Tremblay[2] and Daniel Gottlieb[4]


Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont

Mary Kate Mohlman, Ph.D. [a,*], Beth Tanzman, M.S.W. [a], Karl Finison, M.A. [b], Melanie Pinette, M.E.M. [b], Craig Jones, M.D. [a]

[a] Vermont Blueprint for Health, NOB 1 South, 280 State Drive, Waterbury, VT 05671, USA
[b] Onpoint Health Data, 254 Commercial Street, Suite 257, Portland, ME 04101, USA


Statewide Data Infrastructure Supports Population Health Management: Diabetes Case Study

Craig Jones, MD[1] Mary Kate Mohlman, PhD[1] David Jorgenson, MS[2] Karl Finison, MA[2] Katie McGee, MS[3] Hans Kastensmith[3]

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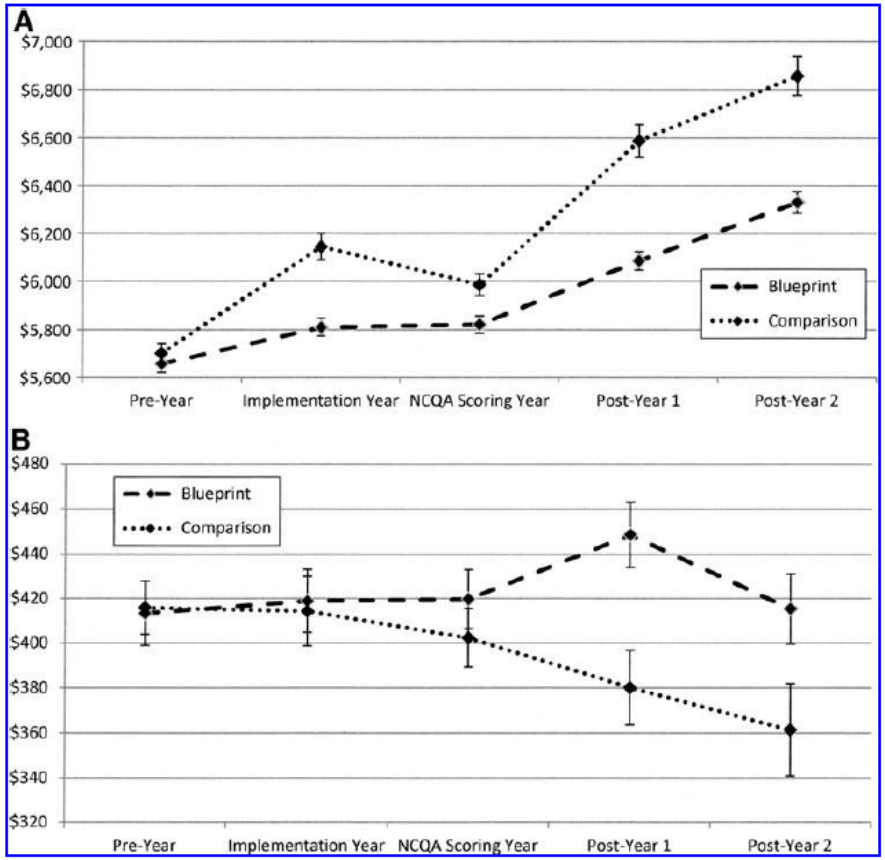

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Journal of Substance Abuse Treatment 67 (2016) 9–14

Contents lists available at ScienceDirect

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Table 2
Adjusted average annual expenditures and utilization rates[†].

	MAT group	Non-MAT	Difference[‡]	P-value
Expenditures				
Total expenditures	$14,468	$14,880	−$412	0.07
Total expenditures without treatment	$ 8794	$11,203	−$2409	<0.01
Buprenorphine expenditures	$2708	−$47	$2755	<0.01
Total prescription expenditures	$4461	$2166	$2295	<0.01
Inpatient expenditures	$2132	$3757	−$1625	<0.01
Outpatient expenditures	$345	$604	−$259	<0.01
Professional expenditures	$674	$981	−$307	<0.01
SMS expenditures[*]	$2872	$4160	−$1288	<0.01
Utilization (rate/person)				
Inpatient days	1.54	3.00	−1.46	<0.01
Inpatient discharges	0.30	0.52	−0.22	<0.01
ED visits	1.44	2.48	−1.04	<0.01
Primary care physician visits	15.27	9.81	5.46	<0.01
Advanced imaging	0.29	0.54	−0.25	<0.01
Standard imaging	0.76	1.43	−0.67	<0.01
Colonoscopy	0.01	0.02	−0.01	<0.01
Echography	0.46	0.53	−0.07	0.002
Medical specialist visits	0.49	0.82	−0.33	<0.01
Surgical specialist visits	3.04	1.89	1.15	<0.01

[*] SMS refers to special Medicaid services and include transportation, home and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services.

[†] Multivariable regression analysis, adjusted for gender, age, calendar year, clinical risk groups, Medicaid in the prior year, hepatitis C virus (HCV) status, and pre- and perinatal care.

[‡] Difference = MAT – non-MAT.

Using Data to Drive Change
Performance Profiles

VERMONT Blueprint for Health
Smart choices. Powerful tools.

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

Total Expenditures per Capita

Total Expenditures by Major Category

Total Expenditures Excluding SMS

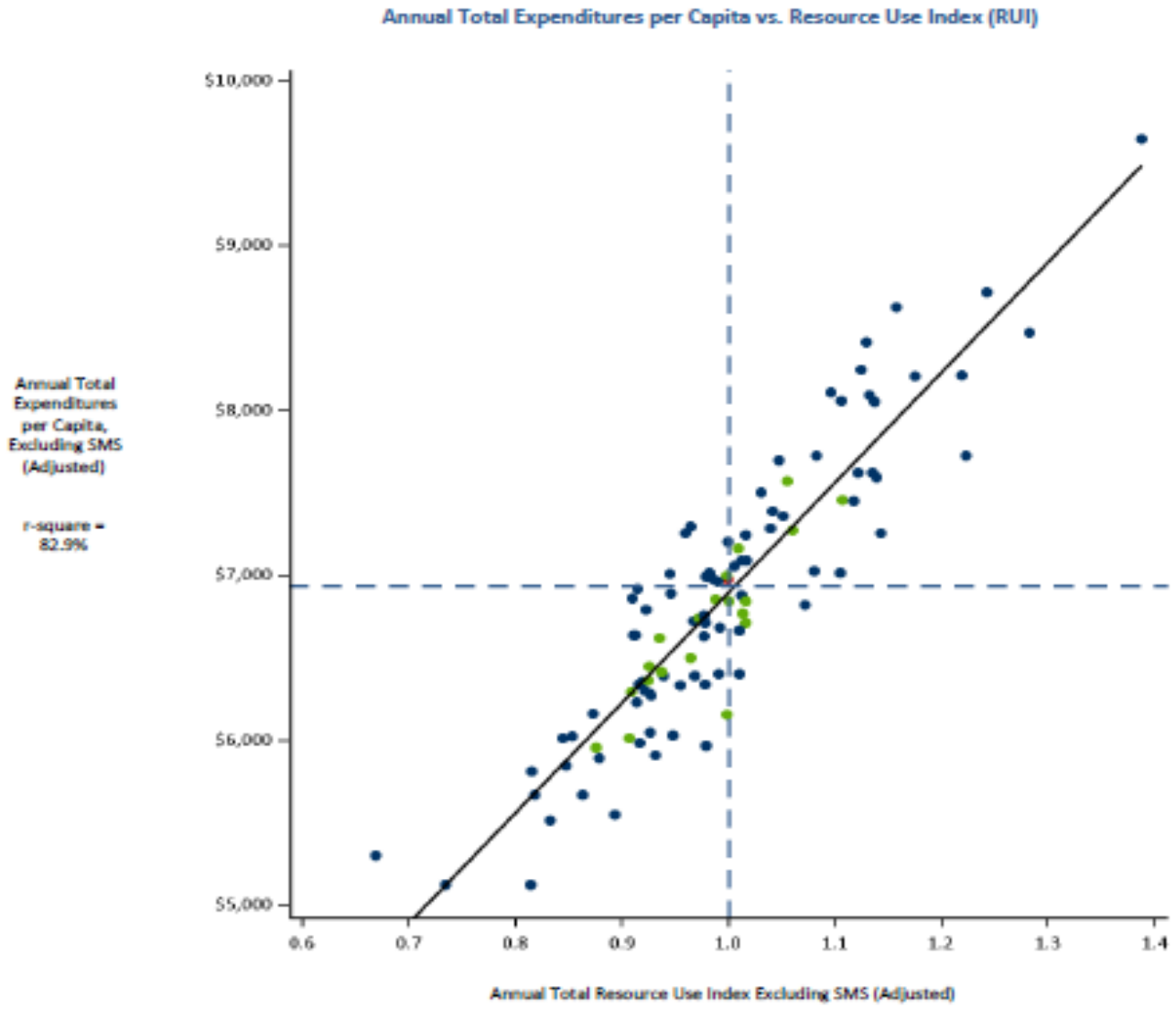
Total Resource Use Index (RUI) Excluding SMS

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

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

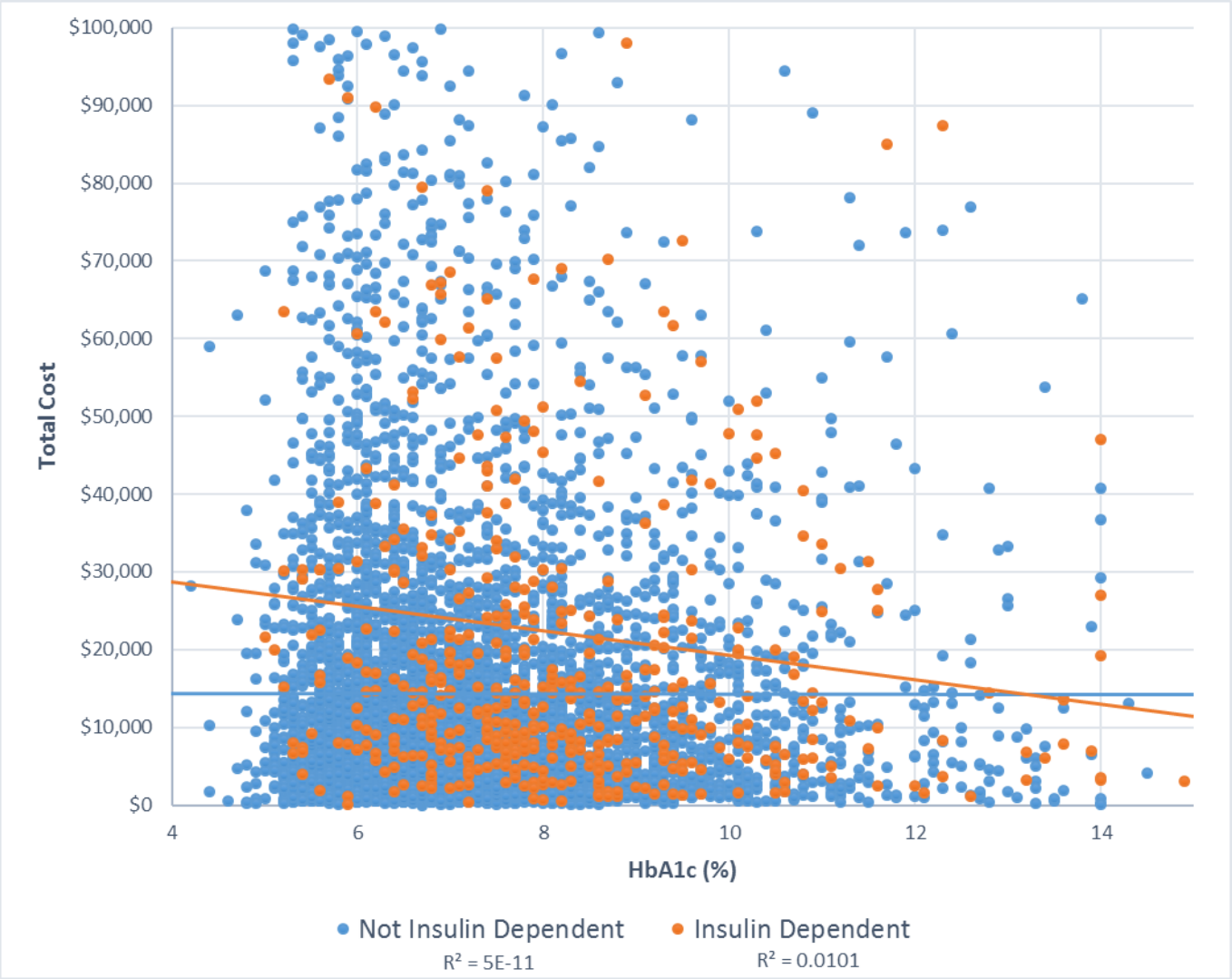
Using Data to Drive Change

Insights and displays: variation in TCOC & RUI



Using Data to Drive Change

Meeting VBP model goals: Quality, Health & TCOC



In press, Craig Jones, MD[1] Mary Kate Mohlman, PhD[1] David Jorgenson, MS[2] Karl Finison, MA[2] Katie McGee, MS[3] Hans Kastensmith[3] AJMC

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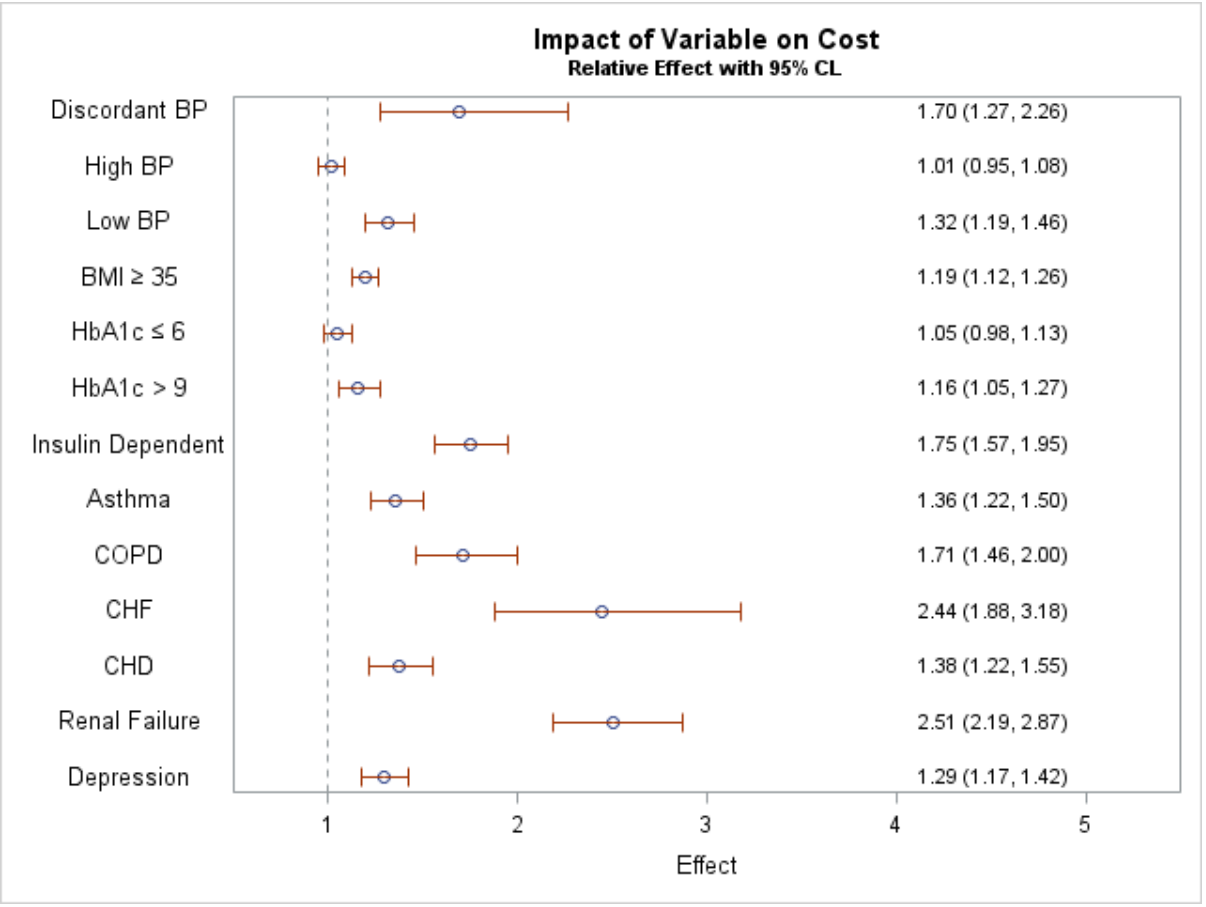

Outreach Criteria

- Diabetes + BP ≥ 140/90 mm/Hg
- Diabetes + BP ≤ 90/60 mm/Hg
- Diabetes + BMI > 35
- Diabetes + HbA1c ≤ 6%
- Diabetes + HbA1c > 9%
- Diabetes + Insulin
- Diabetes + Asthma
- Diabetes + COPD
- Diabetes + CHF
- Diabetes + CHD
- Diabetes + Renal Failure
- Diabetes + Depression

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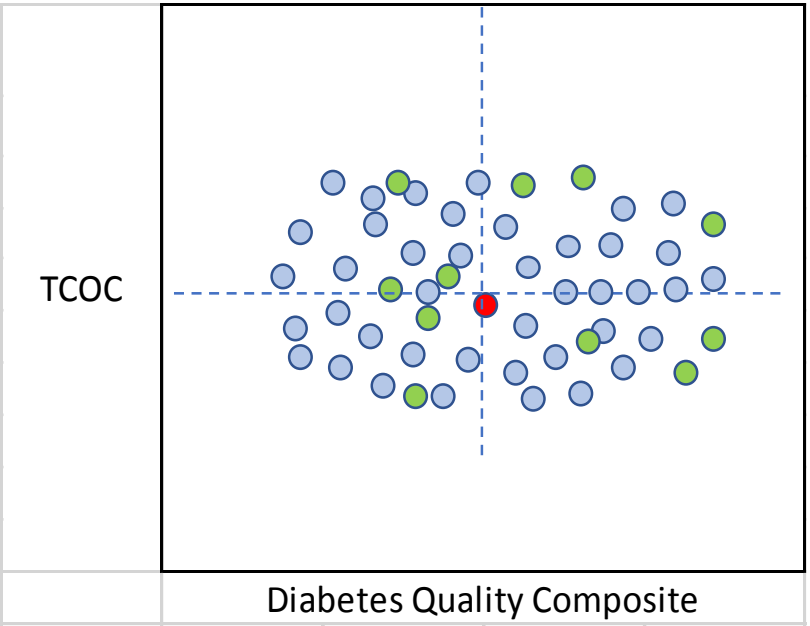
Using Data to Drive Change
Performance guided services

Display Associations & Performance



Click on practice

Display Practice Results for Contributing Measures

Diabetes Care Quality Measures	Practice Average	Organization Average	Region Average	Statewide Region
Diabetes Care, Eye Exam (age 18-75)				
Diabetes Care, HbA1C Test (age 18-75)	Click on result			
Diabetes Care, Kidney Disease Test (age 18-75)				
Statin Therapy for Patients with Diabetes				

Using Data to Drive Change
Performance guided services

Click on measure result

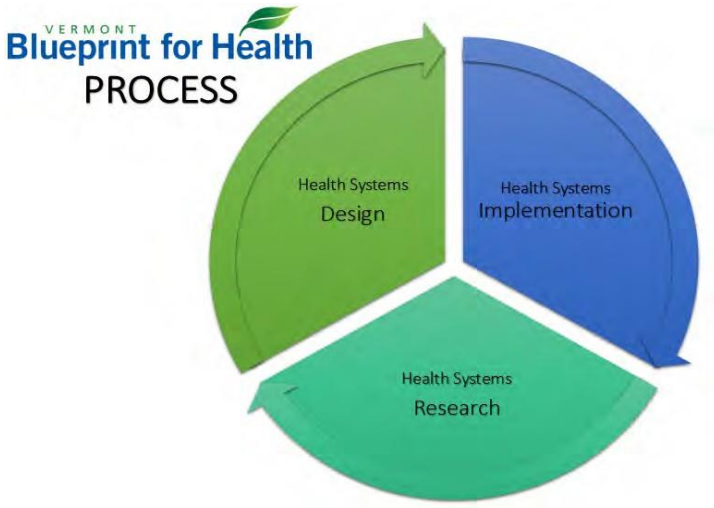
Display Practice Panel Included in Measure along with Actionable Information

Panel Report _____ : Diabetes Care, HbA1C Test (age 18-75)

	Age	DOB	Phone #	Date of most recent HbA1C Test	#IP Hospital Admissions last 12 months	#Potentially Avoidable Hospital Admissions last 12 months	Date last Hospital Admission	Primary Diagnosis Most Recent IP Admission	#ED Visits last 12 months	#Potentially Avoidable ED Visits last 12 months	Date last ED visit	Primary Diagnosis Most Recent ED Visit
Patient 1												
Patient 2												
Patient 3												
Patient 4												
Patient 5												
Patient 6												
Patient 7												
Patient 8												
Patient 9												
Patient 10												

Using Data to Drive Change
Learning & Transformation Network

- 31 Community Health Team Leaders
- 19 Blueprint Practice Facilitators
- 14 Blueprint Project Managers
- 4 ACO Clinical Quality Leaders
- 6 ACO Clinical Consultants



Using Data to Drive Change
Building a 'Data Use Culture'

Key Ingredients

- Meaningful stakeholder group that informs reporting & displays
- Provide information that directly supports care management (individuals)
- Provide information that directly supports outreach & prevention (populations
- Display performance results that are linked with incentives
- Display comparative performance, highlight variation & drivers
- Support practices use of information to drive operations
- Evaluate and report program impact, culture of transparency

Value Based Health System
Systems Based Approach

Key Ingredients

- Advanced primary care freed up by the right incentive model
- Multi-disciplinary team based services working closely with primary care
- Coordination with community providers (medical, non-medical) to organize a more complete approach to population health
- Use of health IT and data (medical, non-medical) to support care management, prevention, and measure comparative performance
- Support for providers and practices to assist with transformation and data guided continuous improvement …. 'Data use culture'
- Learning network to share best practices and improve variable performance

Questions & Discussion