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VERMONT Blueprint for Health
Smart choices. Powerful tools.

Vermont Blueprint for Health

2012 Annual Report
February 15, 2013

Department of Vermont Health Access
312 Hurricane Lane
Williston, VT 05495

1. EXECUTIVE SUMMARY

It has been 5 years since the Vermont Blueprint for Health began the transformation of the health delivery system in earnest. Launched as a Governor's Initiative in 2003, it has developed into a statewide Health Care Reform program unparalleled in its reach and depth. This document describes the cumulative growth trends of the number of participating and recognized primary care practices, the character and reach of the Community Health Teams, and the implementation of Support and Services at Home (SASH) for elderly and disabled Medicare beneficiaries. Individual "snapshots" are included in this year's report, giving the reader a one-page summary of each Health Service Area's (HSA) state of activation. The Bennington HSA is highlighted to illustrate the depth and reach of the complex processes underway.

The opportunities for patient Self-Management classes and support have expanded to six categories. Hundreds of classes are available statewide, including new evidence-based programs. Considerably increased resource allocation was directed at these Self-Management efforts in 2012, with enhanced funding for local implementation of community-based programs and training for leaders.

Self-Management ongoing activities and expansion in 2012 included:

- Healthier Living Workshops- General
- Healthier Living Workshops - Diabetes
- Healthier Living Workshops – Chronic Pain
- Blueprint-run tobacco cessation
- Wellness Recovery Action Planning (WRAP), an information and skills workshop for people living with depression and anxiety, partnering with both the Vermont Department of Mental Health and Vermont Psychiatric Survivors
- Partnership with the Burlington YMCA for the Centers for Disease Control's Diabetes Prevention Program, targeting people at risk for developing this epidemic disease

In 2012 the Blueprint accomplished key milestones to further the policy goal of integration of mental health and addictions services with general health care services. A highlight is that the Blueprint/Department of Vermont Health Access (in collaboration with the Division of Alcohol and Drug Abuse Programs at the Vermont Department of Health) led the design work to create a systematic, statewide treatment response to the growing crisis of opioid addiction in Vermont. Building on the Blueprint delivery system and funding reform approach, the "Hub and Spoke" combines primary care, specialty addiction treatment providers, and Blueprint Community Health Teams to offer Medicaid Health Home services for Vermonters with opioid dependence.

Additional practice reforms designed to increase the capacity of primary care to treat common mental health and addictions conditions in 2012 included:

- Expansion of mental health and substance abuse staffing on the community health teams at the local level

- Design of measure sets for depression and addictions conditions in the central clinical registry
- Staff (EQuIP Practice Facilitator) support to primary care practices choosing mental health, substance use, and health behavior conditions as part of the NCQA recognition process
- Pilot development and planned implementation of Wellness Recovery Action Planning (WRAP)
- Convening of a mental health and addictions advisory committee

The concept of the "Learning Health System" has come to fruition for many Vermonters this year, with myriad educational opportunities. Learning Collaboratives focused on asthma and for medication assisted treatment for opioid addiction techniques have provided educational and technical support to clinicians. Statewide meetings of the EQuIP team, Project Managers and Community Health Team leaders occur regularly, with active communication (such as Basecamp, conference calls and list serves) between gatherings.

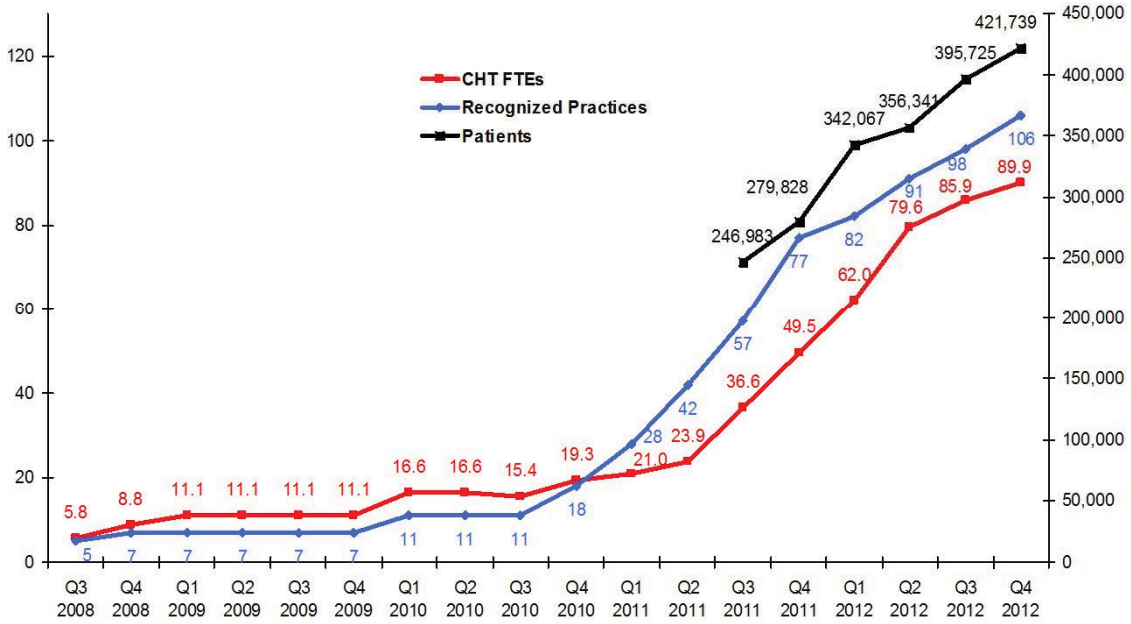
The timeliness, accuracy and accessibility of health information remain a huge challenge in the implementation of meaningful delivery and payment reform. Great strides are being taken, notably the expansion of intensive end-to-end transmission of data efforts. Successful experiences in this realm are described in some depth in this report.

National recognition of efforts in Vermont took a new form this year, with a professional production (funded by the Agency for Healthcare Research and Quality Innovations Exchange) of several short documentary films and a webcast panel discussion aired in September 2012. "Vermont Blueprint for Health: Working Together for Better Care" can be seen at http://www.innovations.ahrq.gov/webevents/index.aspx?id=44. The 2013 edition of *U.S. News & World Report - Changes Ahead, Healthcare, Transformed,* featured the Blueprint as an example of an important and prominent state-led innovative program.

In compliance with the legislative mandates for statewide expansion, the Blueprint continues to spread at a rapid pace with multiple refinements and additional components. The 2012 Blueprint Annual Report to the Vermont Legislature demonstrates the impacts of the program upon the utilization and associated costs of health care, the remarkable uptake of education and patient activation activity, and upon experiences of both receiving and delivering care in the new paradigm supported by the many public and private stakeholders involved in its creation, implementation and support.

2. BLUEPRINT IMPLEMENTATION

Figure 1. Blueprint Practices, Community Health Team Staff and Patients



2.a. Introduction

The State of Vermont has demonstrated an intensive commitment to comprehensive health reform that includes the following components: universal coverage, a novel delivery system built on a foundation of medical homes and community health teams, a focus on prevention across the continuum of public health and health care delivery, a statewide health information exchange, and a robust evaluation infrastructure to support ongoing improvement with quality and cost effectiveness as guiding principles. The Blueprint is charged with guiding a process that results in sustainable health reform, centered on the needs of patients and families.

Guiding legislation calls for a highly coordinated statewide approach to health, wellness, and disease prevention. The Blueprint is leading this transformation with an Advanced Model of Primary Care statewide. This program includes nationally recognized Patient Centered Medical Homes (PCMHs) supported by Community Health Teams (CHTs), and a health information technology infrastructure that supports guideline based care, population reporting, and health information exchange. Vermont Act 128 of 2010 called for full implementation in every willing primary care practice by October of 2013. Vermont Act 48 of 2011 echoed this commitment. The multi-disciplinary CHTs include members such as nurse coordinators, health educators and counselors who provide support and work closely with clinicians and patients at a local level. Services include individual care coordination, outreach and population management, counseling, and close

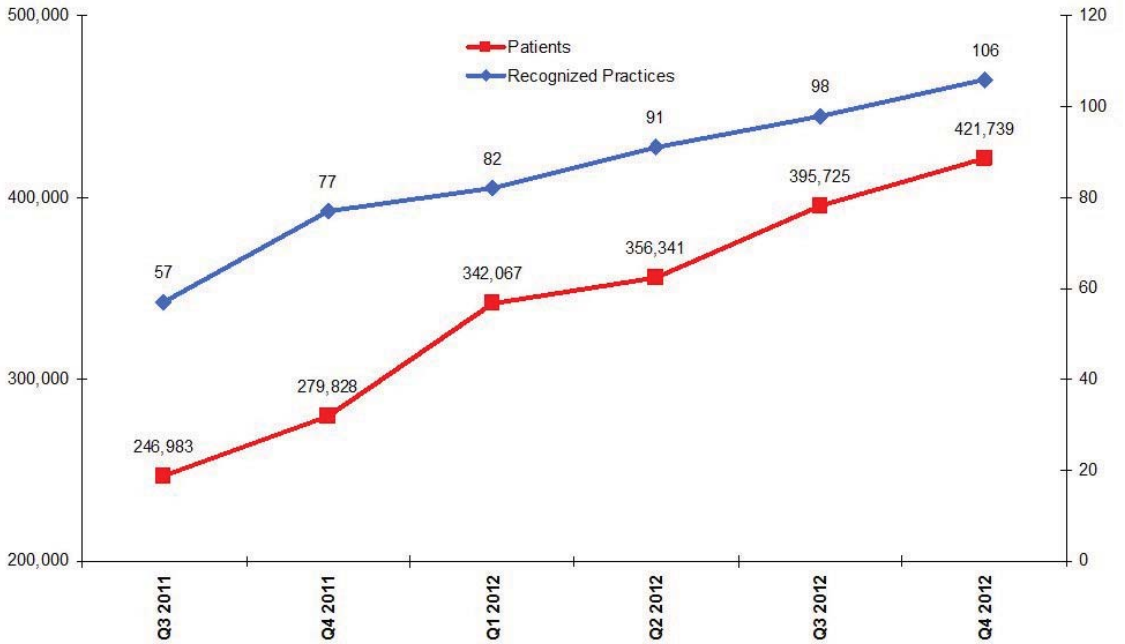
integration with other social and economic support services in the community. Team-based care is at the core of all Blueprint efforts, as echoed in the Institutes of Medicine's "Core Principles & Values of Effective Team-Based Health Care", a discussion paper published in October 2012.
http://www.iom.edu/~/media/Files/Perspectives-Files/2012/Discussion-Papers/VSRT-Team-Based-Care-Principles-Values.pdf

Figure 1 summarizes the history of the Blueprint implementation, demonstrating the number of primary care practices, patients served and Community Health Team personnel from 2008 to the present.

2.b. Recognized practices and patient populations served

Starting in 2011 and continuing through 2012, there was extraordinary growth in the number of primary care practices engaged in patient centered medical home activities. Having moved from pilot to program phase, the Blueprint now has a solid presence in all 14 Health Service Areas. As of December 31, 2012, 106 primary care practices serving approximately 422,000 patients have successfully undergone the national recognition process, with several more scheduled for scoring in each month of 2013. Figure 2 highlights the rapid spread since July 2011.

Figure 2. Increase in NCQA PCMH Recognized Practices July 2011-December 2012



The participating practices are affiliated with a wide range of organization types, as summarized in Table 1. Almost all of the primary care practices now undertaking initial NCQA PCMH recognition are small and independent. This creates special challenges, as they are likely to be without the human and financial resources a

parent organization (such as a hospital or Federally Qualified Health Center) can bring to the process. The Blueprint is committed to providing significant support to these practices in the forms of Practice Facilitators who work closely with them on process improvement and targeted readiness for NCQA PCMH scoring (funded by the Blueprint DVHA budget) and by "frontloading" Community Health Team funding (from the participating insurers) six months in advance of their NCQA PCMH scoring date.

Table 1. Recognized Practices and Their Organizational Affiliations – December 2012

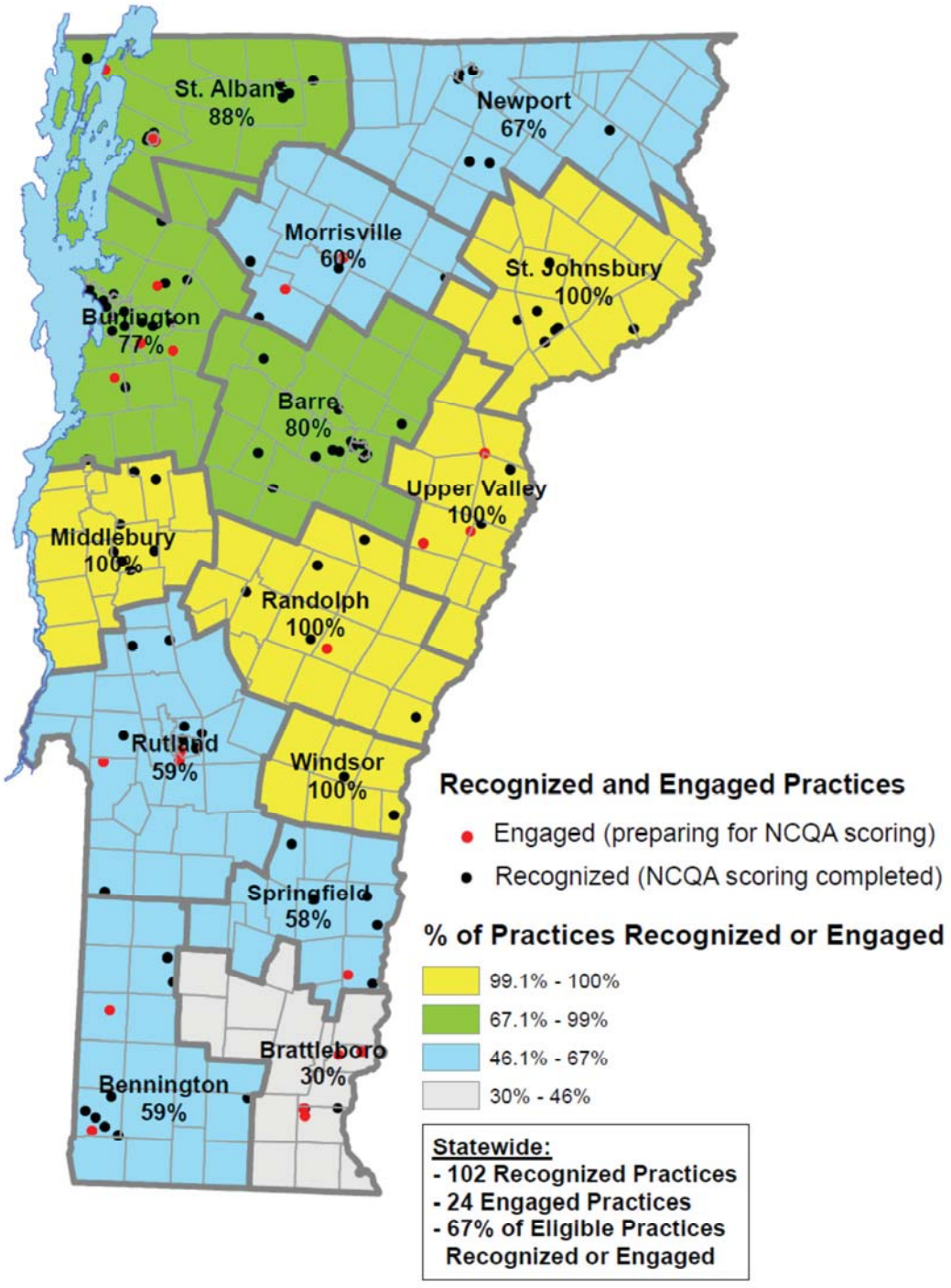
	Practices	PCP Clinicians	PCP Clinician Full Time Equivalents (FTEs)	Patients
Hospital Owned Practices	43	262	208	199,726
Independent Single Site Practices	24	89	76	65,951
Independent Multi Site Practices	9	45	34	50,143
Federally Qualified Health Centers	26	142	148	105,919
Total	102*	538	466	421,739

* Due to practice closures and mergers, this total number is different than the number of practices recognized by quarter.

The Vermont Blueprint has successfully advocated for the inclusion of mid-level providers such as Nurse Practitioners or Advance Practice Registered Nurses (APRNs) and Physician Assistants (PAs) as primary care providers in the NCQA PCMH recognition program. It is noteworthy that of the total clinician FTEs in Table 1, 140 are mid-level providers, perhaps evidence of using this spectrum of professionals to strengthen the primary care workforce in Vermont. New in 2012 was an effort to work with Naturopathic Physicians in achieving successful NCQA PCMH scoring. To that end, Blueprint Practice Facilitators are working closely with several Naturopathic practices around the state. While NCQA is unable to post to their website the scores of Naturopathic Physician practices as formally recognized PCMHs, the Vermont Statute does identify them as primary care providers, thereby enabling them to receive the benefits of NCQA PCMH recognition in terms of payment reform and CHT access for their patients.

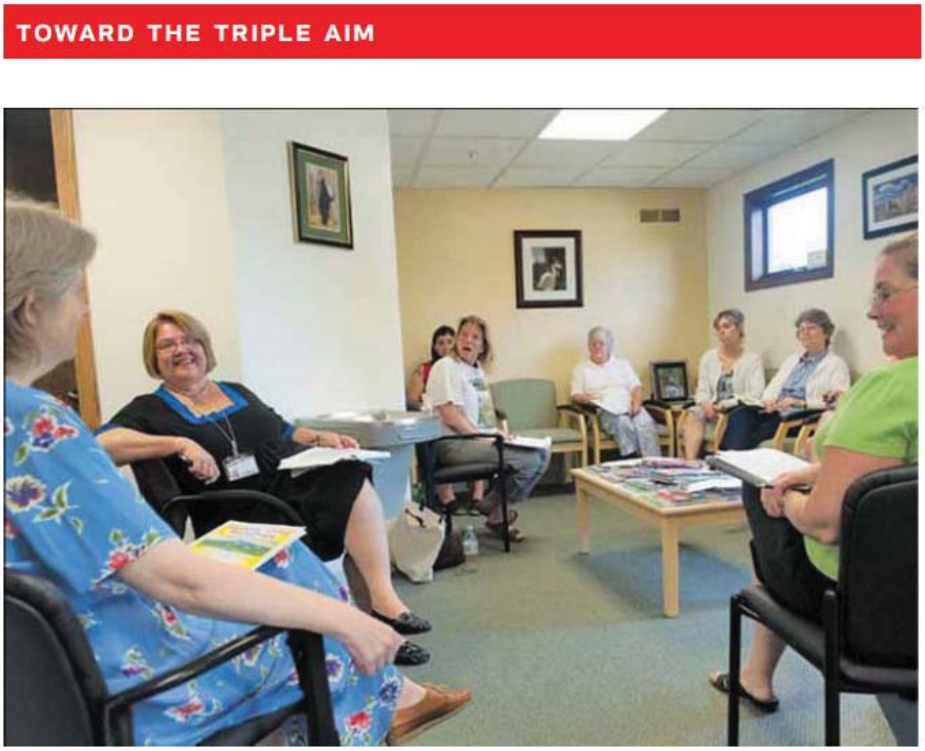
Figure 3 is a map of the current status of Blueprint implementation. It is noteworthy that more than two thirds of Vermont's primary care practices are fully engaged in this process.

Figure 3. Blueprint Implementation in Primary Care Practices – December 2012



2.c. Community Health Teams

Perhaps the most important innovation in the Vermont Blueprint is the Community Health Team (CHT) concept. Recognizing that for many patients, support and coordination services have not been well integrated into the primary care setting, and have even not been readily available to the general population. These multi-disciplinary locally based teams, funded through targeted Blueprint payment reform, are designed and hired at the community level. Local leadership convenes a planning group to determine the most appropriate use of these positions, which can vary depending upon the demographics of the community and upon identified gaps in available services. This could include personnel from the following disciplines: nursing, social work, nutrition science, psychology, pharmacy, administrative support, and others. CHT job titles include but are not limited to Care Coordinator, Case Manager, Certified Diabetic Educator, Community Health Worker, Health Educator, Mental Health Clinician, Substance Abuse Treatment Clinician, Nutrition Specialist, Social Worker, CHT Manager and CHT Administrator.



The CHT effectively expands the capacity of the primary care practices by providing patients with direct access to an enhanced range of services, and with closer and more individualized follow up. Barriers to care are minimized since there is no charge (no co-payments, prior authorizations, or billing for CHT services) to patients or practices. Importantly, CHT services are available to all patients in the

primary care practices they support, regardless of whether these patients have health insurance of any kind or are uninsured.

The dollar amount accessible to an individual community is proportional to the population served by the recognized and engaged primary care practices in the Health Service Area. Currently this is set at $350,000 per year for a general population of 20,000 served by the practices ($17,500 per year for every 1000 patients). Again, the way this money is spent, and specifically what types of staff are hired, is decided at the community level. This has resulted in enhanced ownership and pride in the local CHT as well as anecdotally improving working relationships locally.

Figure 4. Community Health Team Staff Serving Blueprint Practices – Implementation July 2008 through December 2012

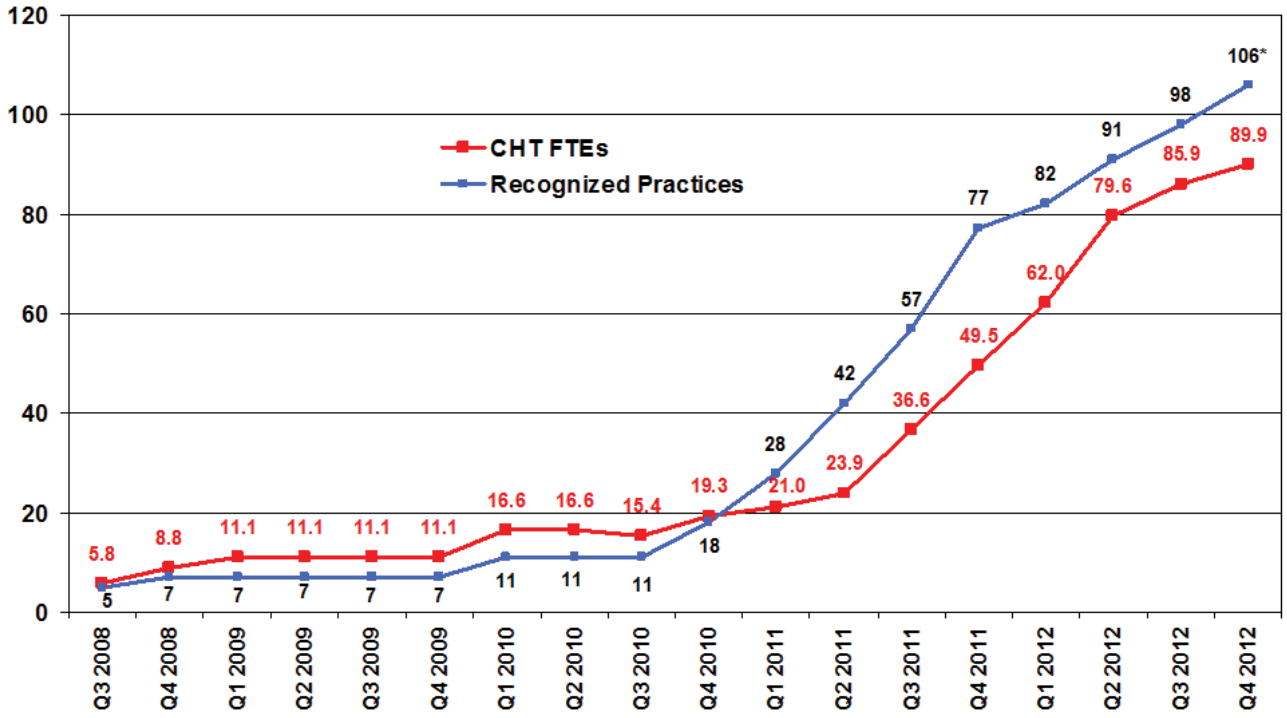
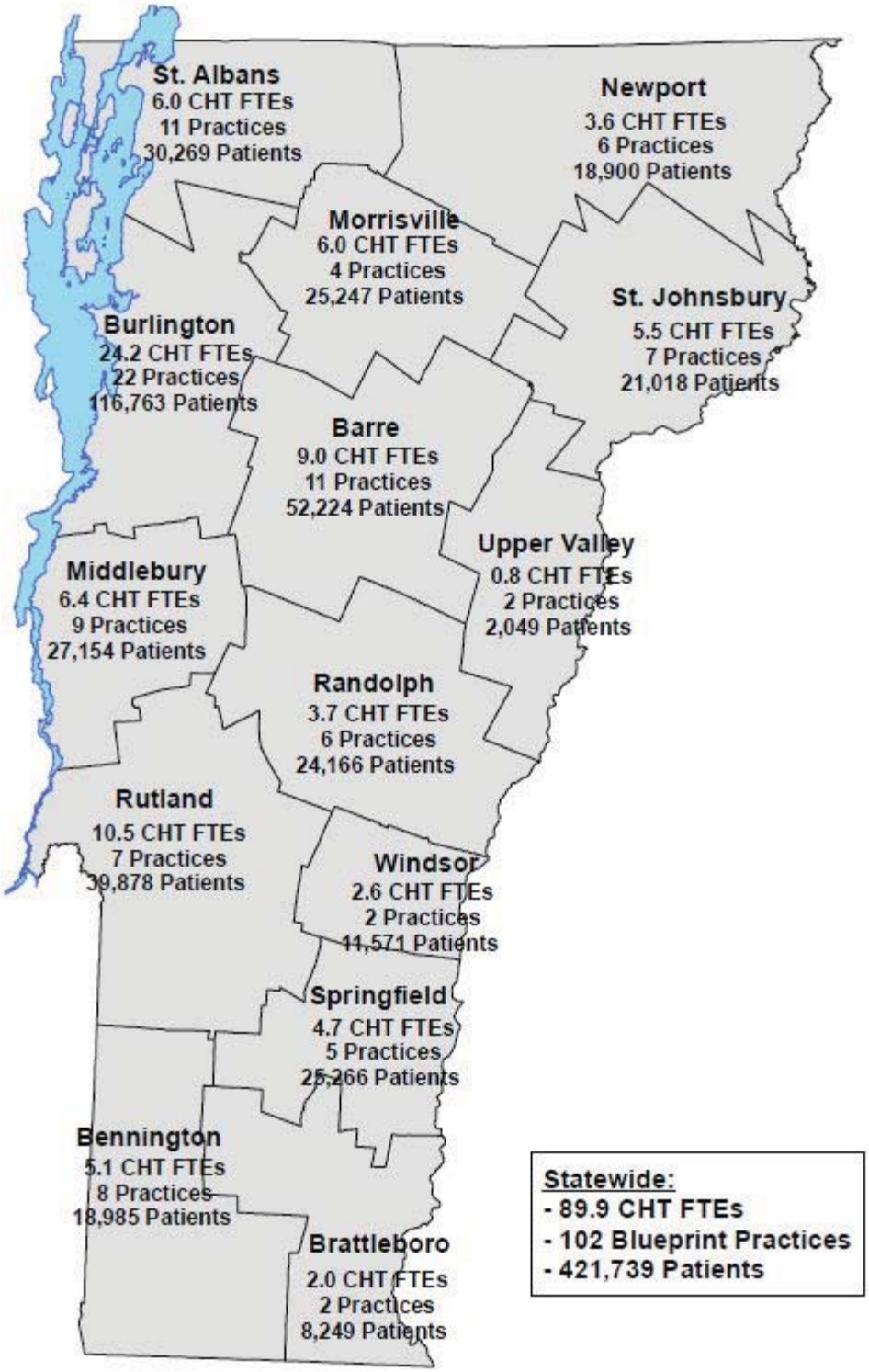


Figure 5. Community Health Team Staff Serving Blueprint Practices and Patients - December 2012

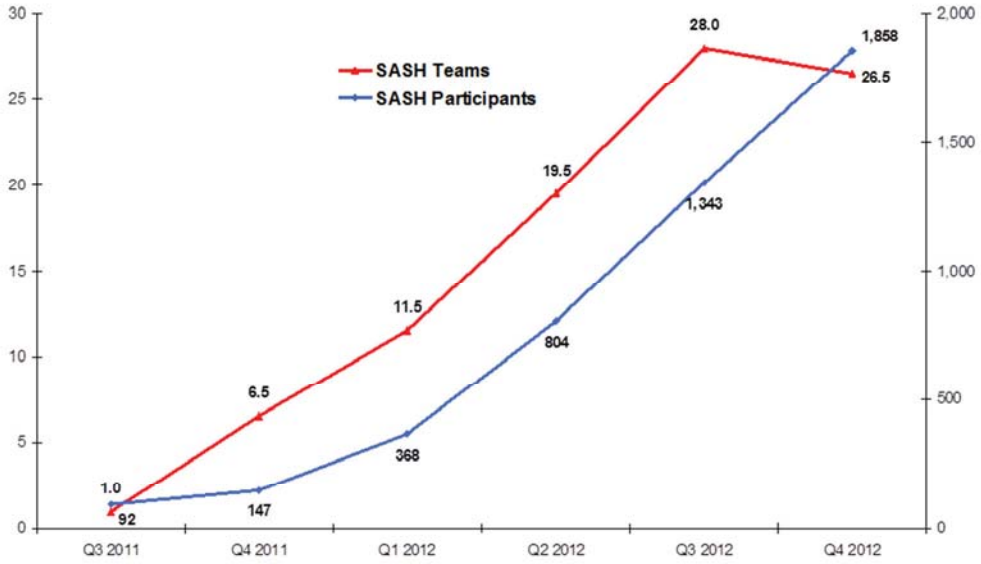


FTEs = Full Time Equivalents

2.d. Support and Services at Home (SASH)

Support And Services at Home (SASH) brings a caring partnership together to support aging at home. It connects the health and long-term care systems to and for Medicare beneficiaries statewide. Together, these systems are facilitating streamlined access to the medical and non-medical services necessary for this vulnerable population to remain living safely at home. SASH is funded by the Centers for Medicare and Medicaid Innovation Center (CMMI) Multi-payer Advanced Primary Care Practice Demonstration, awarded to the Vermont Blueprint for Health in 2011. This leveraging of federal funds complements the targeted payment reforms already part of the Blueprint. SASH has transitioned from its pilot single team in Burlington in 2009 to 26.5 teams in most areas of the state as of January 2013. See Figure 6 for a growth timeline and Figure 7 for a map of current implementation status.

Figure 6. SASH Implementation July 2011 through December 2012



The SASH model includes an organized, person-centered presence in the community, with a SASH Coordinator and Wellness Nurse serving a panel of 100 participants. These participants may live in subsidized housing or out in the community, as the program is designed to serve all Medicare beneficiaries as needed. Staff members focus their efforts around three areas of intervention that have proven most effective in reducing unnecessary Medicare expenditures: transition support after a hospital or rehabilitation facility stay, Self-Management education and coaching, and care coordination.

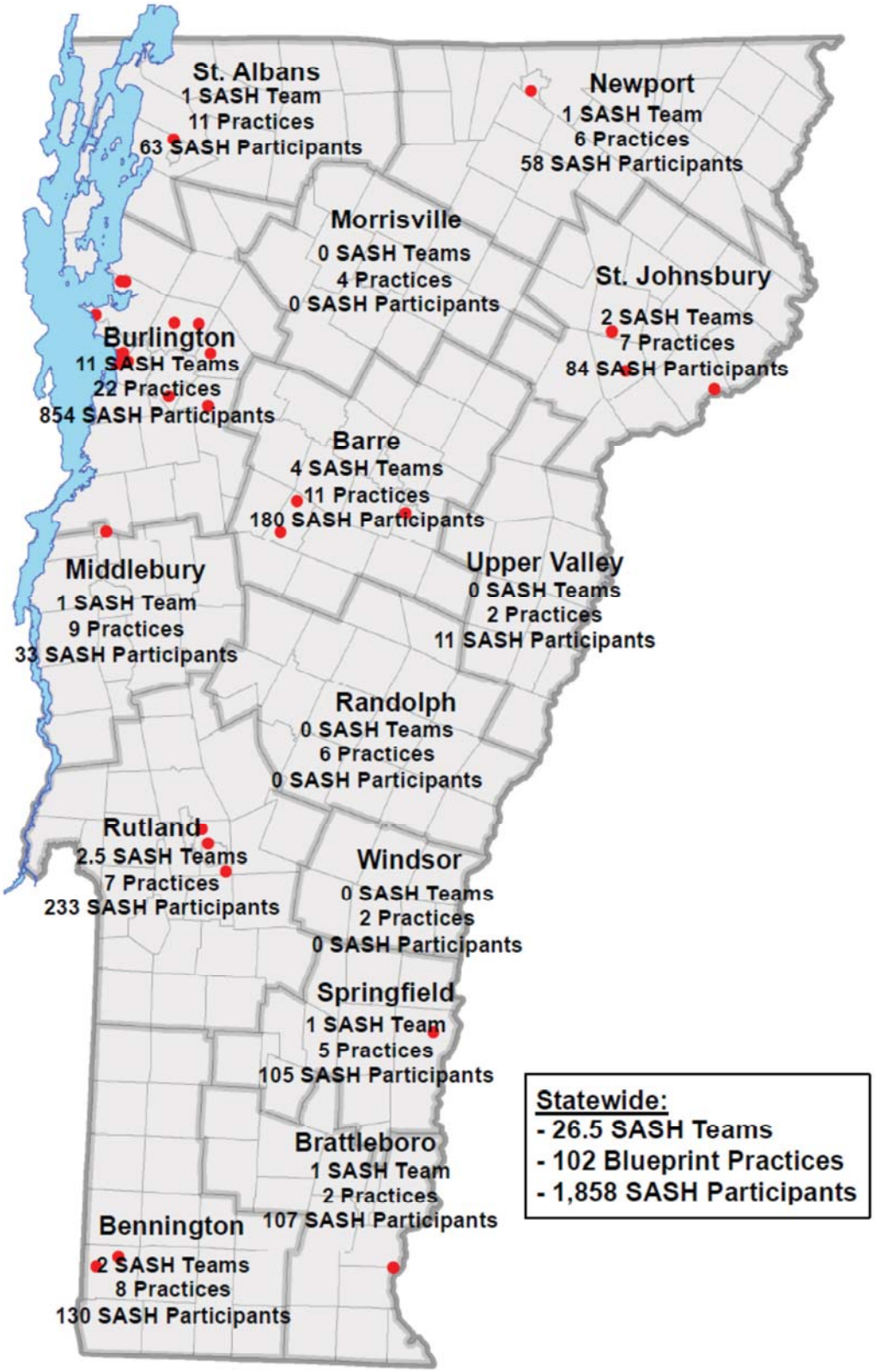
The SASH Coordinator and Wellness Nurse are part of a larger team of representatives of local Home Health Agencies, Area Agencies on Aging, mental health providers and others. The roles and responsibilities of the team members are formalized through a Memorandum of Understanding (MOU) between all partner organizations. The team meets regularly to facilitate an individual and population based approach to care management. Individual Healthy Aging Plans are developed for each participant. The SASH staff provides the tools to help the participant meet those goals. Based on the cumulative and common goals identified, a Community Healthy Aging Plan is created. This addresses specific interventions from a directory of evidence based programs organized around the following five key areas:

- Falls
- Medication management
- Control of chronic conditions
- Lifestyle barriers
- Cognitive and mental health issues

Encouraging and expanding the volunteer capacity within a community, volunteers provide companionship through "buddy" programs, assistance with shopping, cooking, and other activities of daily living.

More information about SASH can be found at http://cathedralsquare.org/future-sash.php

Figure 7. SASH Teams in Vermont - December 2012



SASH = Vermont's Support and Services at Home program for Medicare beneficiaries

2.e. Spotlight on the Bennington Health Service Area

One of the first Vermont communities chosen as a Blueprint site in 2005, the Bennington Health Service Area now has 10 primary care practices actively engaged in the program, serving a total of about 22,000 patients. Eight of those practices have been nationally recognized as patient-centered medical homes; the remaining two are undergoing that process in 2013.

"We really have begun to shape a primary care culture here in Bennington," said Dana Noble, RN, MBA, and the Blueprint Project Manager in Bennington. "The physicians are all talking about the same standards. A couple of them have the same electronic medical records so they share their EMR templates or they work on template development together," she said. "If we're looking for a policy, one practice will call another. It's very cooperative, very collaborative."

Collaboration among and within primary care practices

In today's health care environment, many primary care practices don't have much contact with other similar practices. "Even within Bennington, physicians don't know each other," Noble said. "The Blueprint is at least one way for primary care people to get to know each other, to have some sort of collegial relationship."

Noble, who has worked with the Bennington Blueprint since its inception and is retiring this year, has seen a shift not only in the way practices work and collaborate with each other, but in the dynamics and interactions within physician practices. She recalls when she first went into practices and met with the physicians and staff in a group, only the physicians would speak. "Now anybody is willing to talk and challenge each other. It's really become much more team-based than hierarchical."

The Blueprint fosters that mindset with the belief that all employees of a practice are part of the practice team and have a role in taking care of patients. For example, anyone in the practice can refer a patient to services, Noble said. She described a hypothetical scenario where a patient who is leaving may make a comment to the checkout person about how their kids are driving them crazy and they're not sleeping anymore. "That person may not have said that to the doctor, they may not have said that to the nurse," she said. "The staff member at checkout can say, 'We have a counselor that comes in twice a week, I can set up an appointment for you,' or 'You can think about it and call for an appointment,' or 'You can talk to the doctor.' They should feel comfortable saying we have a service here that can help you."

Patients at the center of decision-making

One of the biggest changes has been doing work ahead of the patient's appointment that used to be done during or after the visit, Noble said. Practices now have planned visits, where certain services – such as reconciling medications or having lab work done – are taken care of beforehand, so the doctor has all the information available during the appointment.

Another big shift has been freeing up doctors' schedules to allow for same-day visits, a requirement to become a patient centered medical home. All the Bennington practices now do this, Noble said. "Traditionally you would call and talk to the nurse who did some sort of triage and determined if you should be seen," Noble said. "But the new culture is the patient decides whether they need to be seen and you need to find them a space." It's also part of the practices' obligation to educate patients about whether they do need to be seen on the same day, she said.

This reflects the move to patient centered decision making, where the patient is in charge of managing their medical care. Instead of the doctor or practice telling the patient what to do, the idea is for them to work collaboratively with the patient to set health goals. "The old model was the doctor told you, 'Do this, this and this' and you nodded your head. And then you left and you went 'Well, I'm not doing any of this,' or 'I'll do some of this' or 'I don't remember what they said,' " Noble said. "The new model is patient-driven. The doctor isn't saying, you need to lose 20 pounds, but what would you like to do to improve your health? This is a change we're still working with."

To promote this type of interaction and improve self-management, practices are doing motivational interview training – a type of training that teaches caregivers how to talk to patients in a conversational way, to listen for certain words and follow where the patient is going, Noble said.

Community Health Team leads to better care

During the years Noble has worked with Bennington practices, it's also evident that the Community Health Teams are making a difference in patient care. Practices now have additional staff -- including a nurse case manager, behavioral health specialist, dietician

and social worker — available to patients. Sometimes these clinicians are based at the practice. "With these additional people in the practice, because they sometimes have more time to spend with the patient, the practice is learning more about the whole patient because they're finding new information," Noble said.

She shared the story of a patient who wasn't doing well with his diabetes and had an abnormal Hemoglobin A1c (HbA1c) level, a laboratory test that measures how high one's blood sugar generally runs. The nurse case manager starting working him and found out he was working part-time, didn't have insurance coverage and had some housing issues. She brought in the social worker to help, and they were able to get him better coverage for his medications. Then they involved the physician to go over his medications and figure out if there were some he didn't need to take, or others which he could switch to a cheaper brand, so they could increase his success taking his medications. As a result, he started doing better and his HbA1c level improved. "That never would have happened without the Community Health Team," Noble said. "Nobody would have had the time to dig deep and find all those things."

"We now can deal with the whole person and remove a lot of the barriers . . . Generally the physicians are happier and the staff is happier because they're getting closer to how they really wanted to practice medicine and how they really wanted to take care of patients."

Gregory King, MD

One of the biggest changes Greg King, MD, at Mount Anthony Primary Care, has seen is the ability to measure things and do performance improvement on an on-going basis.
His practice mapped out the process of what a patient goes through from the time they walk in the door until they leave in order to figure out where time was being wasted. By

doing this, they were able to find out where the bottlenecks were and make changes to minimize wasted time.

The practice also started doing patient surveys on a regular basis, and made improvements based on their patients' feedback. One of these changes involved posting a sign in the waiting room telling patients how many minutes behind a doctor was running that day. Patients had given feedback that they wanted to know in advance if the doctors were running behind, King said.

Working collaboratively with physicians and staff in other practices has been beneficial. Bennington Blueprint practices meet together five to six times a year. As happens throughout the state with Blueprint practices, they come together to work on collaboratives, or performance improvement projects focused on a specific health issue. At the collaboratives, physicians and staff from different practices share ideas that may be used or modified by any practice, King said. "By sharing information — instead of each individual office alone by itself trying to find its own way and discovering things here and there — the greater community improves overall."

King's practice has worked on performance improvement collaboratives to improve diabetes care and asthma care, and is now starting a third one to standardize care for opiate addicted patients.

King has noticed a shift in the way patients view their primary care physician's office. "Patients see us more as a focus or central piece of their medical care," he said. ". . . We were all operating in our own independent silos. Now it's more integrated."

Having additional staff in the practice makes a big difference when it comes to transitions of care, such as being discharged from the hospital. In the past, the patient may have been told to make a follow-up appointment with their primary care physician in a few days, and they may or may not have done so, King said.

Today, the nurse case manager in the physician's office knows when the patient is going home and follows up with them in a day or two, King said. She also helps them understand their medications and makes sure their list of drugs is up to date before they come in for their doctor's appointment. Previously, the physician may have spent half an hour just reconciling a patient's medications during the office visit, he said. "The current health care system in this country is so complex. It's a patchwork quilt of different organizations that have their own agenda," King said. "…Patients get confused, disoriented. They don't understand their medications. They may have trouble affording their medications and not tell their physician about it."

The Blueprint model helps turn this around, he said. "It is a way of getting all these different services together in the same room and collaborating to help the patients get a better outcome so they don't fall through the cracks."

Avery Wood, MD

Avery Wood, MD, has been involved with the Blueprint since it started in Bennington, first with Bennington Family Practice, and then when she started her own solo practice four years ago. Her practice – with a population of about 700 patients -- is a nationally recognized patient centered medical home and is undergoing re-certification this year.

"It has changed my practice," Wood said of the Blueprint. "The process of having a practice coach is incredibly useful… It keeps the process of practice improvement going and gives you somebody to help guide the decisions you make and to look at how your decisions are affecting things."

The patient centered medical home model is useful – with some criteria being more relevant and others being less relevant to her practice, Wood said. "It's a transition from doing sort of reactive care of your patients to being proactive and looking at your whole patient panel and what they need."

One of the most striking changes Wood noticed was the ability to see the bigger picture of how the practice is doing – and how patients are doing. "You really don't realize what is or is not happening in your practice until you start measuring it… I think that I know where I stand much better than I used to."

Having a social worker has been beneficial, Wood said, especially in finding out information about patients that wasn't known previously, and that is critical to getting them the help they need. Wood shared an example of a young woman on disability who was buying food for her family with her disability check, but the food was running out by the end of the week. "She doesn't really have enough food by the end of the week. That was not something that she had shared with me. The social worker only found out by asking detailed questions about her benefits."

Having a mental health specialist available in the physician's office also is especially helpful, as it takes away the stigma of going to see a counselor in a separate office. "People often don't have very good psychiatric service benefits," Wood said. She's had patients coming in to see a therapist who were reluctant to receive this type of care and wouldn't have gone otherwise.

Wood said she has seen a shift in the way primary care is evolving. This was evident when she worked with the team at Bennington Family Practice. "The shift was to that proactive piece, but it was also a shift in sort of getting everybody in the system on board

with the real goals. If our real goal is better diabetes care, it starts right with the receptionist. That means that the receptionist is now engaged in a different way."

"It is the only way to move ahead in terms of improving public health because the people who are at highest risk of not having good health are often at highest risk of not having good health for the same reasons that make it difficult for them to access to health care," she added. "…They're needing that kind of proactive support."

Barre Health Service Area

At A Glance

* 11 primary care practices recognized as Patient-Centered Medical Homes.
* 52,224 unique Vermont patients seen by recognized practices during the past two years.
* Nine full-time equivalent Community Health Team staff members.
* 3 Healthier Living Workshops offered in 2012, with 38 participants.

2012 Highlights

This year, we expanded the number of practices to incorporate Associates in Pediatrics in Berlin.

Our Community Health Team assisted more than 900 patients with prescription access, insurance access and self-management support.

Our practices followed up with hospitalized patients within 24 hours after they were discharged, to ensure that they received the care they needed to prevent and reduce hospital readmissions.

Our practices also identified and reached out to patients who had not had a scheduled visit in a year or more.

Our practices and Community Health Team worked with patients to manage their health, developing self-management action plans, establishing realistic goals and providing coaching and education.

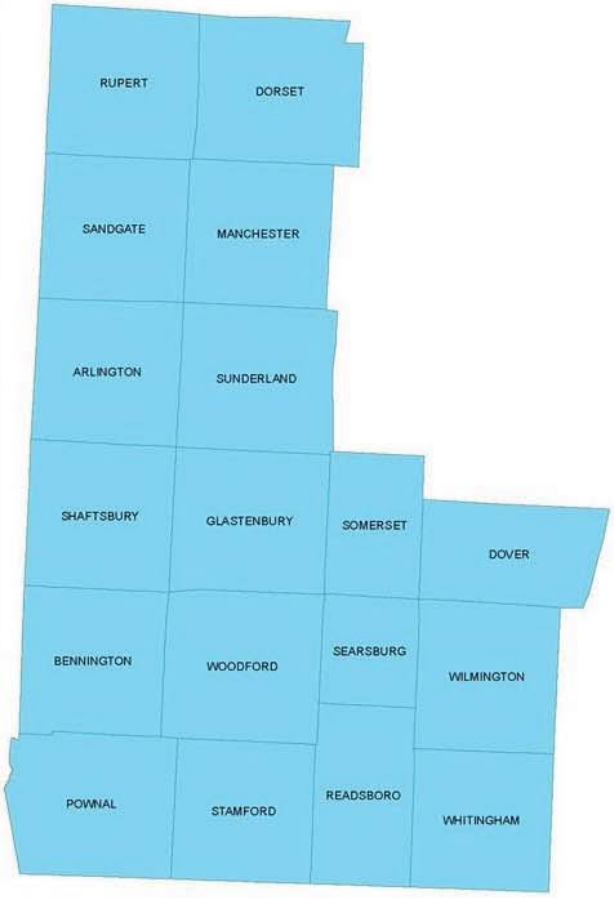
Medical Home Practices

* Associates in Family Health — Berlin
* Associates in Pediatrics — Berlin
* Berlin Family Health
* Barre Internal Medicine
* Central Vermont Primary Care — Berlin
* Green Mountain Family Practice — Northfield
* Mad River Family Practice — Waitsfield
* Montpelier Integrative Family Health
* Mountainview Medical — Berlin
* The Health Center — Plainfield
* Waterbury Medical Associates

Bennington Health Service Area

At A Glance

* 8 primary care practices recognized as Patient-Centered Medical Homes
* 18,985 unique Vermont patients seen by recognized practices during past 2 years.
* 5.1 full-time equivalent Community Health Team staff members
* 2 Healthier Living Workshops offered in 2012, with 36 participants.



2012 Highlights

We added a self-management coach to the Community Health Team to coordinate and lead group self-management programs, including Healthy Living Workshops and Tobacco Cessation.

Four of our practices that use the GE Centricity electronic medical record participated in an intensive work team that meets weekly. The goal is to assure demographic and clinical data is transmitted accurately from local EMRs through the Health Information Exchange to DocSite. Two of these practices now have accurate and verified reports from DocSite.

Over the last year, our eight NCQA recognized practices have implemented patient population management. This includes identifying a patient population by diagnosis or health maintenance screening, selecting the evidence based guidelines, establishing panel management and defining case management. Work has focused on diabetes, asthma, depression, mammography screening and pneumovax.

We currently participate in the Hub and Spoke Program. All four of our practices that provide suboxone treatment have volunteered to be Spoke Practices. Three of the four practices are participating in the Medication Assisted Treatment Collaborative which provides education on evidence based guidelines and supports performance improvement in the practice.

Medical Home Practices

* Avery Wood, MD
* Bennington Family Practice
* Deerfield Valley Campus – SVMC
* Eric Seyferth, MD
* Green Mountain Pediatrics
* Keith Michl, MD
* Mount Anthony Primary Care
* Northshire Campus - SVMC

Brattleboro Health Service Area

At a Glance

* Two primary care practices recognized as Patient-Centered Medical Homes.
* 8,249 unique Vermont patients seen by recognized practices during past 2 years.
* Two full-time equivalent Community Health Team staff members.
* 6 Healthier Living Workshops offered in 2012, with 78 participants.

2012 Highlights

Our Community Health Team (CHT) is having a significant impact on patient care and wellness. More than 200 patients were served in 2012. The positive impact of our CHT is an incentive for other practices to join the Blueprint in order to have access to the CHT.

The practical strategies employed by our health coach are well received by patients and have shown results, with many patients losing weight, adopting healthier eating habits and integrating exercise into their daily routines.

In partnership with the Brattleboro Food Co-op, our CHT offered "The Learning Kitchen," a program to teach children and parents how to easily prepare healthy meals.

Our RN Care Coordinator has fully developed a panel management and outreach program for common chronic conditions.

Our CHT makes home visits to those who are shut in, have no transportation or have mental health issues that preclude them from coming to the office to meet with our CHT staff.

Our Mental Health/SA clinician on the CHT partnered with the local SASH coordinator to develop healthy action plans with residents in public housing.

Medical Home Practices

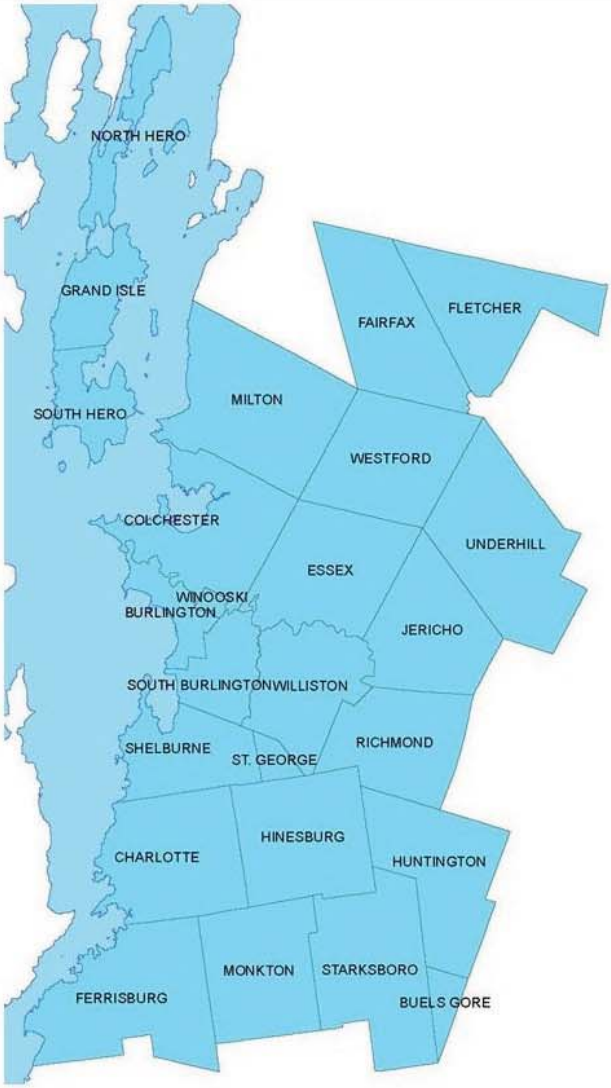
Brattleboro Primary Care

Windham Family Practice

Burlington Health Service Area

At A Glance

* 22 primary care practices recognized as Patient-Centered Medical Homes
* 116,763 unique Vermont patients seen by recognized practices during past 2 years
* 24.2 full-time equivalent Community Health Team staff members
* 7 Healthier Living Workshops offered in 2012, with 93 participants



Medical Home Practices

Aesculapius Medical Center
Alder Brook Family Health
Burlington Primary Care
Christopher Hebert, MD
Colchester Family Practice
Community Health Center of Burlington
Eugene Moore, MD
Evergreen Family Health
Given Health Care — Burlington
Given Health Care — Essex
Given Health Care — Williston
Good Health
Hagan, Rinehart and Connolly Pediatricians
Hinesburg Family Health
Milton Family Practice
South Burlington Family Practice
Timberlane Pediatrics
Timberlane Pediatrics North
University Pediatrics — Burlington
University Pediatrics — Williston
Vermont Internal Medicine
Winooski Family Health

2012 Highlights

Our Community Health Team (CHT) assisted 2,145 patients in the first 10 months of 2012, more than double the number of patients assisted in all of 2011.

We experienced a rapid addition of practices and patients in 2012, and were able to successfully expand services to those practices and patients. Embedding CHT staff directly in practices was one mechanism for expanding services; our CHT worked with pediatric practices in particular to develop CHT staffing.

Our CHT successfully prepared to provide new services, starting in January 2013, for patients experiencing opioid dependence.

We expanded the number and types of programs to help patients manage their health; Tobacco Cessation programs were successfully integrated into the CHT.

Middlebury Health Service Area

At A Glance

* 9 primary care practices recognized as Patient-Centered Medical Homes
* 27,154 unique Vermont patients seen by recognized practices during past 2 years
* 6.4 full-time equivalent Community Health Team staff members
* 1 Healthier Living Workshop offered in 2012, with 11 participants

2012 Highlights

The Blueprint expanded rapidly in the Middlebury HSA in 2012 and all 9 primary care practices are currently recognized as patient centered medical homes. The Community Health Team integration into the practices has enhanced panel management activities allowing for more targeted, intense and consistent patient outreach and follow up leading to greater patient satisfaction.

Our primary care practices are increasingly integrating mental health services into their practices. We have initiated a planning process to implement the Blueprint's Hub and Spoke program to provide medication-assisted treatment for people with opioid dependence.

We also expanded Healthier Living Workshops to additional practice locations, and offered the first Tobacco Cessation Workshops.

Medical Home Practices

* Addison Family Medicine
* Bristol Internal Medicine
* Little City Family Practice
* Middlebury Family Health
* Middlebury Pediatric and Adolescent Medicine
* Mountain Health Center
* Neshobe Family Medicine
* Porter Internal Medicine
* Rainbow Pediatrics

Morrisville Health Service Area

At A Glance

* Four primary care practices recognized as Patient-Centered Medical Homes
* 25,247 unique Vermont patients seen by recognized practices during past 2 years
* Six full-time equivalent Community Health Team staff members
* Six Healthier Living Workshops offered in 2012, with 57 participants

2012 Highlights

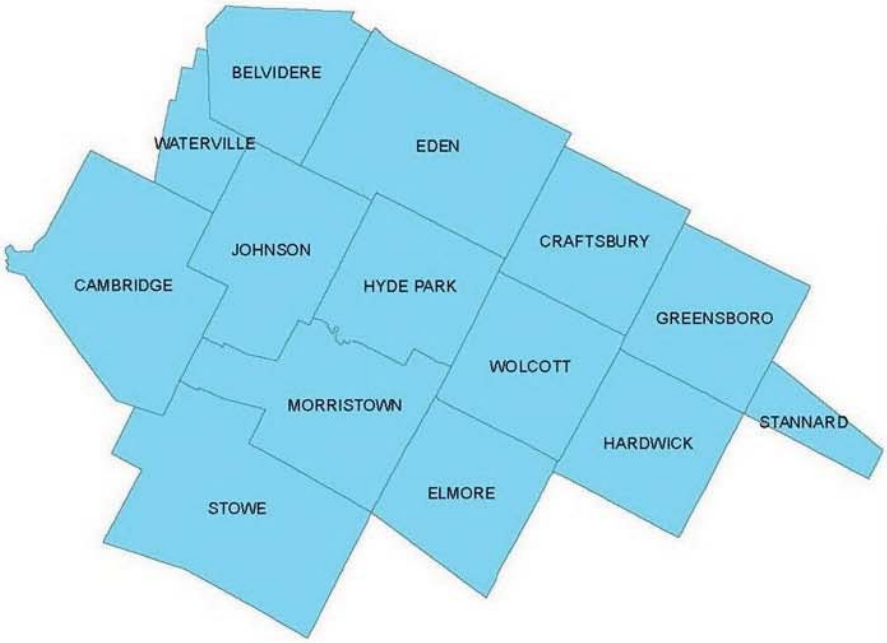
Family Practice Associates of Cambridge was the first practice in Vermont with a paper medical record to be recognized as a patient-centered medical home under NCQA's 2011 Standards, achieving Level 2 recognition. They were able to meet the standards in part by using the Blueprint's clinical registry, DocSite.

Our four recognized practices are engaged in a variety of quality improvement activities, including smoking screening and intervention, obesity screening and intervention, and depression screening and intervention. They have developed mechanisms for identifying and referring patients who might benefit from self-management programs.

All practices and The Manor are also connected to DocSite; The Manor is the first nursing home in the state to become connected to DocSite.

Our Community Health Team (CHT) is identifying patients with hypertension, diabetes and smoking, with the goal of improving care for these patients.

Our CHT has also initiated a project to reduce avoidable Emergency Room visits for patients without a primary care provider. One goal project is to ensure patients have access to a primary care provider.



Medical Home Practices

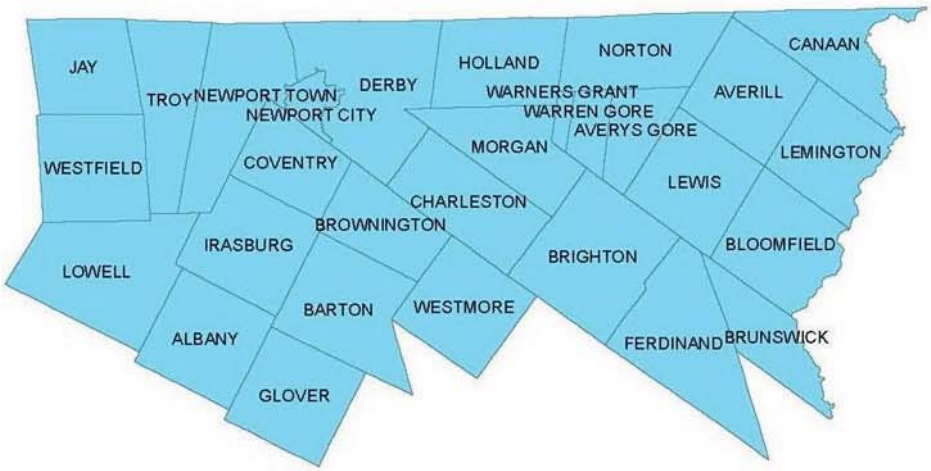
Hardwick Area Health Center

Family Practice Associates — Cambridge

Morrisville Family Health Care

Stowe Family Practice

Newport Health Service Area



At A Glance

* Six primary care practices recognized as Patient-Centered Medical Homes
* 18,900 unique Vermont patients seen by recognized practices during past 2 years
* 3.6 full-time equivalent Community Health Team staff members
* Six Healthier Living Workshops offered in 2012, with 66 participants

2012 Highlights

All six of our participating practices are recognized at Level 3, the highest level of NCQA Patient-Centered Medical Home recognition.

Our Community Health Team (CHT) expanded services by initiating on-site asthma education in all practices, and on-site dietitian services in three practices. Dietitian services are expected to be added at the remaining practices in 2013.

We expanded opportunities for patients to manage their health by offering a well-received Chronic Pain Healthier Living Workshop.

Our CHT hosted a well-attended three-county training on guardianship and adoption.

In October, 2012, My CareConnections, the North Country Hospital practices' web-based patient health information portal, became a reality.

Medical Home Practices

Community Medical Associates — Newport

Family Practice of Newport

Island Pond Health Center

Newport Pediatric and Adolescent Medicine

Orleans Family Medicine

The Barton Clinic

Randolph Health Service Area

At A Glance

* Six primary care practices recognized as Patient-Centered Medical Homes
* 24,166 unique Vermont patients seen by recognized practices during past 2 years
* 3.7 full-time equivalent Community Health Team staff members
* Four Healthier Living Workshops offered in 2012, with 46 participants

2012 Highlights

We expanded our core Community Health Team (CHT) to include additional care coordinators, a mental health clinician and a patient access coordinator.

We initiated the White River Community Health Team, including a care coordinator and health and social service agencies from the area.

We collaborated with the Visiting Nurse Association of Vermont and New Hampshire to pilot a Congestive Heart Failure telemedicine program.

We expanded self-management and health education programs by offering a Chronic Pain Healthier Living Workshop, training CHT staff in tobacco cessation, offering tobacco cessation classes, holding an Annual Diabetic Fair, coordinating monthly support groups for people living with chronic illness and caring for the caregiver, and hosting Chef Wendell Fowler for a presentation on healthier eating.

We conducted quality improvement projects to evaluate emergency department utilization and the effectiveness of the CHT with Congestive Heart Failure patients

Medical Home Practices

Bethel Health Center

Chelsea Health Center

Gifford Health Center at Berlin

Gifford Primary Care

Rochester Health Center

White River Family Practice

Rutland Health Service Area

At a Glance

* Seven primary care practices recognized as Patient -Centered Medical Homes.
* 39,878 unique Vermont patients seen by recognized practices during past 2 years.
* 10.5 full-time equivalent Community Health Team staff members.
* 5 Healthier Living Workshops offered in 2012, with 50 participants.

2012 Highlights

All seven of our practices that participated in 2012 were recognized at Level 3, the highest level of NCQA Patient-Centered Medical Home recognition.

Extensive implementation of self-management workshops resulted in 229 community members participating in these programs to assist them in managing their health.

Our Community Health Team (CHT) services are provided at each medical home practice through a site-based team that includes a panel manager and a care coordinator.

The CHT centralized core provides intensive case management to the neediest patients, and self-management support — including Healthier Living Workshops, Tobacco Cessation, Nutrition Education and In-Home Asthma Education — to residents with chronic health conditions.

The Case Manager Referral Committee includes case managers from several organizations in the community. The community-wide CHT Stakeholder Committee represents over 50 health and human services providers who work to improve the coordination and appropriate use of state and local resources.

Medical Home Practices

Brandon Medical Center

Castleton Family Health Center

Commons Street Health Center — Rutland

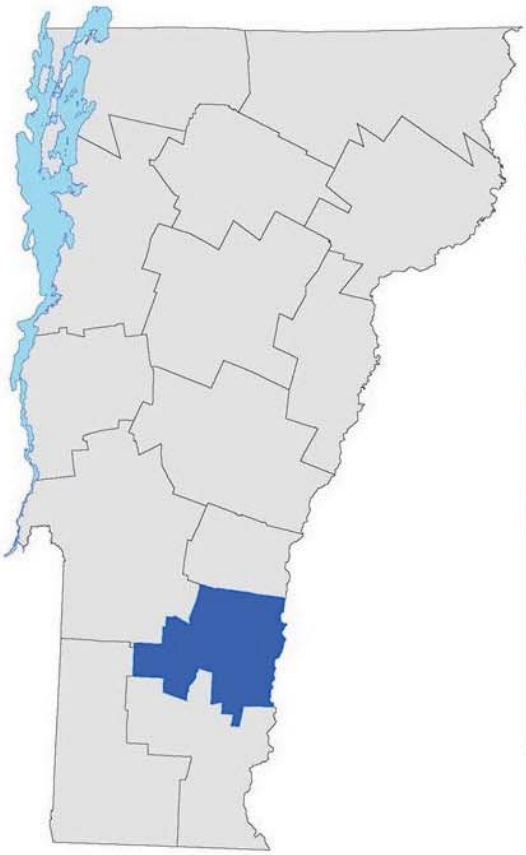
Community Health Centers of the Rutland Region (CHCRR) Pediatrics

Drs. Peter and Lisa Hogenkamp — Rutland

Mettowee Valley Family Health Center — West Pawlet

Rutland Community Health Center

Springfield Health Service Area



At A Glance

* Five primary care practices recognized as Patient-Centered Medical Homes
* 25,266 unique Vermont patients seen by recognized practices during past 2 years
* 4.7 full-time equivalent Community Health Team staff members
* Three Healthier Living Workshops offered in 2012, with 34 participants

2012 Highlights

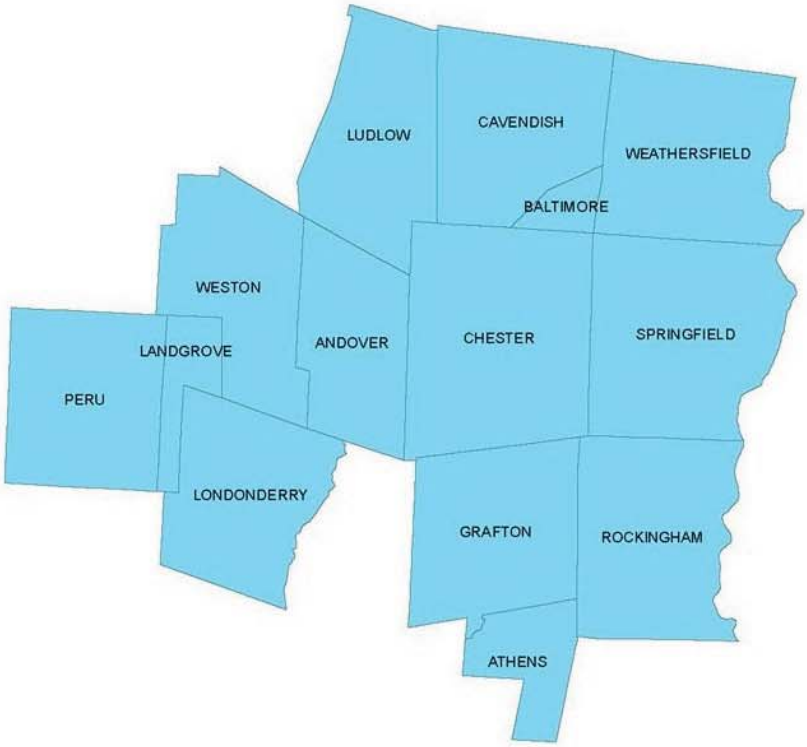
All our participating practices are recognized at Level 3, the highest level of NCQA Patient-Centered Medical Home recognition.

A big success this year was the creation of our Tobacco Cessation program. A number of people have completed webinar training and two are in the last stages of certification as Tobacco Treatment Specialists. They provide individual counseling as well as run the Tobacco Cessation groups. So far in this grant year, we have completed one successful group.

Our CHT services have increased greatly over the past year. With CHT funds, we have been able to expand our dietitian services by adding a dietitian/CDE to our staff. She will be leading our upcoming YMCA DPP class. Another one of our dietitians led cooking and nutrition community classes through the CHT. The most successful was a class centered around families. We have three people training to be health coaches and will be using their services in the coming year.

We now have a care coordinator in every practice, including our Women's Health practice.

We have been successfully building our self-management program, starting with hiring a full time regional coordinator.



Medical Home Practices

Charlestown Family Medicine

Chester Family Medicine

Ludlow Health Center

Rockingham Medical Group

Springfield Health Center

St. Albans Health Service Area

At A Glance

* 11 primary care practices recognized as Patient-Centered Medical Homes
* 30,269 unique Vermont patients seen by recognized practices during past 2 years
* Six full-time equivalent Community Health Team staff members
* 12 self-management workshops offered in 2012, with 102 participants

2012 Highlights

Our practices improved patients' access to primary care appointments (fewer delays, reduced wait times) and increased partnerships with patients to improve their health and the management of chronic conditions.

Our primary care practices are systematically identifying high-risk, high-cost patients for referral to the Community Health Team (CHT) for care coordination and self-management support.

As the CHT becomes integrated into the practices, there is greater appreciation of different services (medical and social/human services). This deeper understanding of the roles and challenges of other providers leads to more effective co-management of patients. Primary care providers see the value of working with an interdisciplinary team when they encounter non-medical barriers to treatment.

Patients' complete health needs are being met, with the practices and CHT bridging the gap between mental and physical health.

Patients are empowered to set goals and manage their health — though education

Medical Home Practices

Alburg Health Center

Cold Hollow Family Practice

Enosburg Health Center

Franklin County Pediatrics

Mousetrap Pediatrics – Enosburg

Mousetrap Pediatrics – Milton

Mousetrap Pediatrics – St. Albans

Richford Health Center

St. Albans Health Center

St. Albans Primary Care

Swanton Health Center

St. Johnsbury Health Service Area

At A Glance

* Seven primary care practices recognized as Patient-Centered Medical Homes
* 21,018 unique Vermont patients seen by recognized practices during past 2 years
* 5.5 full-time equivalent Community Health Team staff members
* 7 Healthier Living Workshops offered in 2012, with 57 participants

2012 Highlights

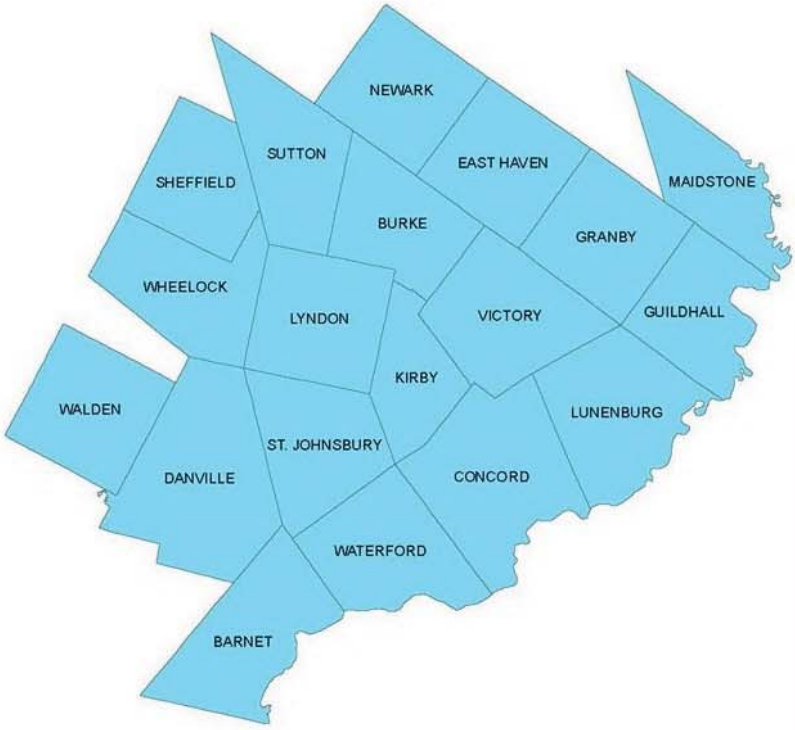
Our medical home practices and Community Health Team (CHT) are participating in the Green Mountain Care Board's first payment reform pilot project. They are working with the Norris Cotton Cancer Center-North oncologists, nurses and social worker to better coordinate care for patients with cancer.

The CHT was chosen as a Promising Practice in controlling hypertension by the national Centers for Disease Control and Prevention's (CDC) Division of Heart Disease and Stroke Prevention. The CDC is conducting a rigorous evaluation of the CHT to determine its impact on patient blood pressure and quality of life.

Our medical home practices and CHT were featured on the national Agency for Healthcare Research and Quality Innovations Exchange.

Corner Medical and the Northern Counties Health Care medical home practices participated in an intensive process to improve the results of health information technology; those practices are now using reliable reports from the Blueprint's clinical registry, DocSite, to improve patient care.

The CHT is piloting ProviderLink, a care coordination and communication software that improves information sharing between multiple service providers.



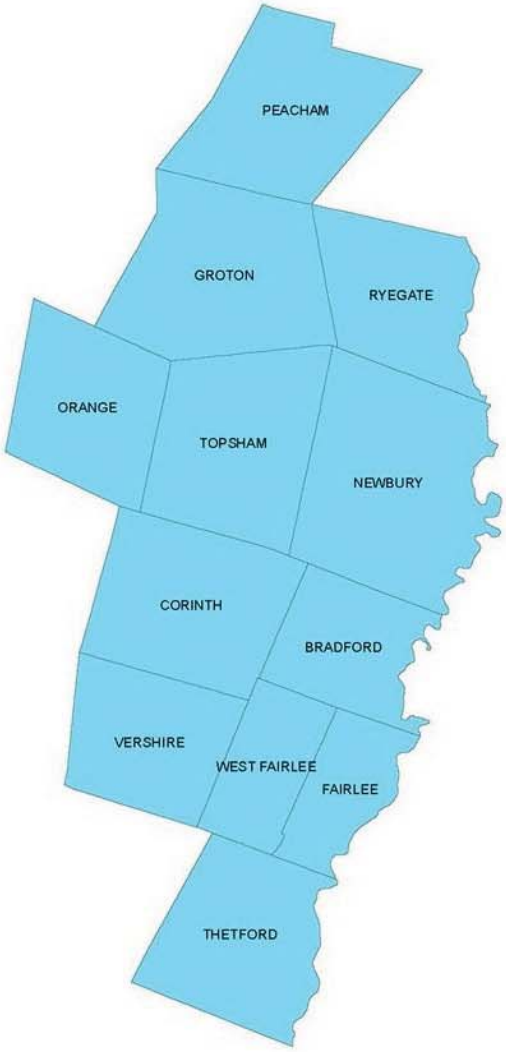
Medical Home Practices

Caledonia Internal Medicine (joined with St. Johnsbury Health Center on 1-1-13)
Concord Health Center
Corner Medical
Danville Health Center
Kingdom Internal Medicine
St. Johnsbury Health Center
St. Johnsbury Pediatrics

Upper Valley Health Service Area

At A Glance

* Two primary care practices recognized as Patient-Centered Medical Homes
* 2,049 unique Vermont patients seen by recognized practices during past 2 years
* 0.8 full-time equivalent Community Health Team staff members



2012 Highlights

We are the newest Blueprint HSA, with four of the five clinics in this rural area now recognized as Patient-Centered Medical Homes. The fifth clinic is scheduled for recognition in March, 2013.

We have expanded programs to help patients and families manage their health. A parenting group started at Newbury Health Center; Tobacco Cessation Workshops are underway; and the first Chronic Pain Self-Management Program is in the planning stages. An End-of-Life planning workshop in collaboration with the Visiting Nurse Association is scheduled for 2013.

Our practices are systematically identifying patients for referral to self-management workshops.

Our Community Health Team (CHT) continues to receive referrals of complex patients from all primary care practices.

In addition, our Core CHT Advisory Group continues to expand to include more community partners and form work groups.

Another highlight this year was our Community and Family Health Resource Fair, which had great participation from our community partners.

Medical Home Practices

Newbury Health Clinic

Upper Valley Pediatrics

Little Rivers Health Care at Bradford (1-1-13)

Little Rivers Health Care at East Corinth (1-1-13)

Windsor Health Service Area

At A Glance

* Two primary care practices recognized as Patient-Centered Medical Homes
* 11,571 unique Vermont patients seen by recognized practices during past 2 years
* 2.6 full-time equivalent Community Health Team staff members
* 3 Healthier Living Workshops offered in 2012, with 38 participants

2012 Highlights

Our Community Health Team (CHT) adopted a systematic process to follow up with all medical home patients after discharge from an inpatient stay. This significantly improved medication reconciliation and medication management, leading causes of readmission to inpatient care.

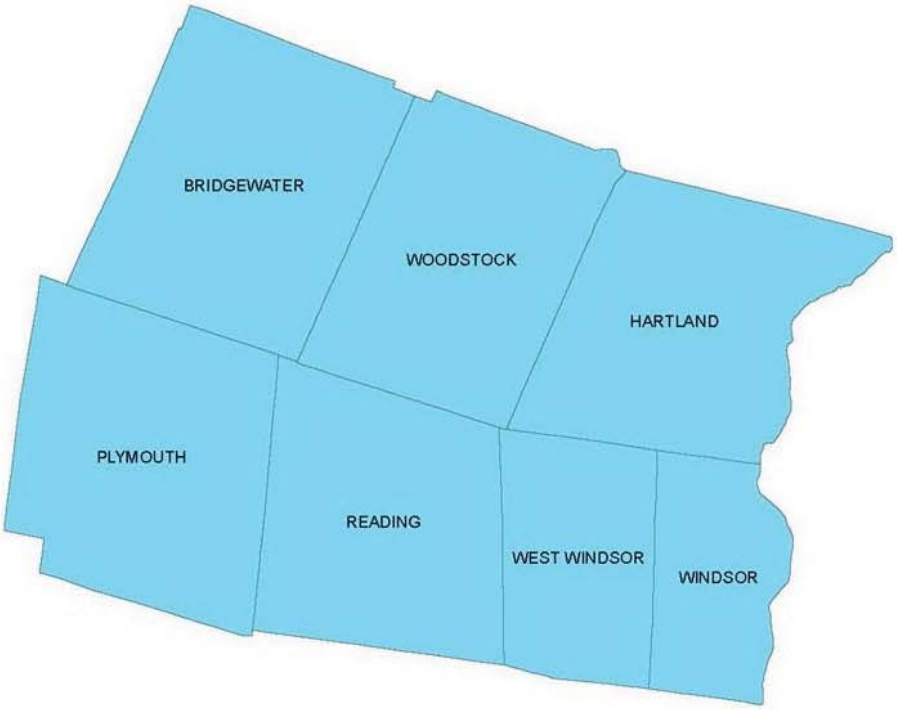
We established a stronger relationship with the Visiting Nurse Association (VNA), including providing CHT support to high risk patients after they are discharged from VNA services.

We worked to establish strong, bi-directional relationships with the local Designated Agency (HCRS), Economic Services, and Reach Up. We collaborated with HCRS on new case management resources to assure gaps are filled and services are not duplicated.

We focused on increasing access to the CHT for all community partners. We also leveraged additional resources, including a successful grant application that enables us to continue funding from Ottauquechee Health Foundation. This funding supports a .6 FTE CHT person in the Woodstock area, an application to Granite United Way for .5 FTE pediatric case manager for the CHT is pending.

Mt Ascutney Hospital and Health Center fully funded a mental health clinician under contract with HCRS to serve on the CHT through Blueprint grant funding.

We are collaborating with the Turning Point Recovery Center to bring recovery coaching to Windsor and working with Vermont Psychiatric Survivors to support peer self-help groups in the area.



Medical Home Practices

Mt. Ascutney Health Center

Ottauquechee Health Center

3. SELF-MANAGEMENT

Introduction

The Blueprint offers a wide range of services to engage patients in improving and maintaining their own health. Underscoring its commitment to the importance of patient (and family) self-activation and support, these opportunities have significantly expanded this year. They range from individualized Self-Management support in primary care practices and Community Health Teams to community-based Self-Management workshops and classes. Regardless of the setting or program, the same techniques are introduced and reinforced, including patient engagement in goal setting, establishing action plans and problem solving. All of the offerings are evidence-based programs, putting theory into practice in a data-driven and responsible mechanism.

Starting in 2005, the Vermont version of the Stanford Chronic Disease Self-Management Program (CDSMP) was introduced as the general Healthier Living Workshops. The CDSMP is considered the "gold standard" of this type of intervention with many years of implementation experience. (See http://patienteducation.stanford.edu/bibliog.html for a full biography.) Uptake of this program was the first statewide component of the Blueprint, and began a steady commitment to this essential mechanism of patient engagement. Variations of the HLW were added over the last several years, incorporation of statewide tobacco cessation programs undertaken and two specific programs are being incorporated in 2013 following pilot phases in 2012. As of the beginning of 2013, six unique Self-Management programs are funded by the Blueprint, described in detail in this section and summarized in Table 2.

Table 2. Self-Management Workshops Offered or Planned in Vermont – January through December 2012

Health Service Area	HLW General	HLW Diabetes	HLW Chronic Pain	Tobacco Cessation	WRAP	DPP
Bennington	Offered			Offered	Planned	
Brattleboro	Offered		Offered	Offered	Planned	Planned
Barre	Offered	Offered	Offered	Offered	Planned	Planned
Burlington	Offered	Offered	Offered	Offered	Planned	Offered
Middlebury	Offered			Offered		Planned
Morrisville	Offered	Offered	Offered	Offered	Planned	Planned
Newport	Offered	Offered		Offered	Planned	Planned
Randolph	Offered		Planned	Offered		
Rutland	Offered	Offered	Offered	Offered	Planned	Planned
St. Albans	Offered	Offered	Offered	Offered	Planned	Planned
St. Johnsbury	Offered			Offered		Planned
Springfield	Offered	Offered		Offered	Planned	Planned
Upper Valley	Offered		Planned	Offered	Planned	
Windsor	Offered		Offered	Offered	Offered	

3.a. Stanford Chronic Disease Self-Management Programs – Vermont's Healthier Living Workshops

The Stanford Chronic Disease Self-Management Programs (Vermont's version is known as the Healthier Living Workshops) were created by Kate Lorig, DrPH, Professor of Medicine at Stanford University and her colleagues to enhance regular treatment and disease-specific education. The programs give participants the skills to coordinate the things they need to manage their health, as well as to help them keep active in their lives. Participants in all three variations of the HLWs make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their Self-Management programs. Attendees are encouraged to come with a support person to help their likelihood of successfully implementing the goals they have identified.

The workshops are designed to be led by peer leaders, individuals with personal experience with chronic disease, who undergo standardized training and certification. Vermont has had extraordinary numbers of leaders trained, certified and recertified, with several Master Trainers and "T Trainers" who can help others become certified.

Three HLW program types are offered in Vermont and are described below. These groups all meet weekly for 2 ½ hours for a six-week session. 663 people participated in these programs in 2012.

Figure 8. Healthier Living Workshops – A Building Block of Statewide Health System Reform through Patient Activation

3.a.i. Chronic Disease Self-Management Program/ Healthier Living Workshops (2005)

This is the original program offered in Vermont and is designed for individuals with one or more chronic conditions. It introduces and emphasizes activities leading to self-efficacy, and the confidence one has that he or she can master a new skill or affect one's own health. The coping strategies introduced include action planning and feedback, behavior modeling, problem-solving techniques, and decision-making, and are applicable to all chronic diseases. Individuals are taught to control their symptoms through relaxation techniques, healthy eating, managing sleep and fatigue, managing medications, appropriate exercise options, and encouraging better communication with health care providers.

3.a.ii. Diabetes Self-Management Program/ Healthier Living with Diabetes (2010)

Diabetes is an epidemic in Vermont as in the rest of the United States, with alarming projected consequences in morbidity, mortality and associated costs. The framework of the HLW serves as an excellent basis for disease-specific skills to better manage this common chronic disease. Subjects covered in this class include techniques to deal with the symptoms of diabetes, fatigue, pain, hyperglycemia and hypoglycemia (high and low blood sugar, stress, and emotional problems such as depression, anger, fear and frustration in addition to those topics addressed in the general HLWs. Physicians and other health professionals at Stanford University have reviewed and approved all materials in the course.

3.a.iii. Chronic Pain Self-Management Program/Healthier Living with Pain (2011)

This program was developed for people who have a primary or secondary diagnosis of chronic pain, defined as lasting for longer than 3 to 6 months, or beyond the normal healing time of an injury. It has been enthusiastically embraced and has rapidly spread around the state, highlighting the prevalence of chronic pain in our population and the need for effective ways to cope with this problem.

More information about all three CDSMP workshops can be found at http://patienteducation.stanford.edu/programs/cdsmp.html

3.b. Tobacco Cessation

Prior to 2012, the Blueprint Community Health Teams worked collaboratively with the (separate) Vermont Department of Health's Vermont Quit Network, referring patients back and forth between the two programs. The Vermont Quit Network is composed of four primary parts, all briefly described below.

Your Quit, Your Way provides smokers with tools and self-directed support to assist those that wish to try and quit on their own.

Quit On-line offers advice, tips, and an interactive forum where smokers can talk with other smokers who know what they are going through.

Quit By Phone links individuals with a quit coach at a time that works for them. They provide 5 personalized calls (20-30 minutes each) to help a smoker get ready and provide tips, advice and support to stay tobacco-free.

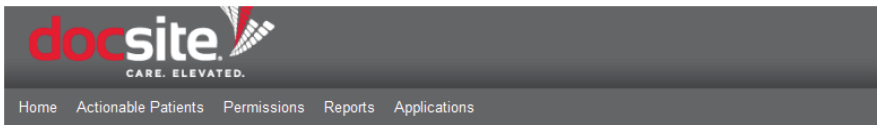
Quit In Person offers weekly group cessation classes in communities around the state, which assist participants in preparing to stop using tobacco and support them after they quit. Like other Blueprint Self-Management programs, Quit in Person provides a forum for peer support.

A full merger of these previously parallel efforts has been accomplished in 2012, increasing the opportunities for Vermonters to receive tobacco cessation support where they can best take advantage of them. In 2012, 179 workshops were hosted and 548 people participated in the Quit in Person group tobacco treatment workshops.

As a result of this merger, the Vermont Department of Health has fully transitioned the management of Quit In Person services to the Blueprint. A focus was placed on training and embedding tobacco cessation services into the Blueprint CHTs, primary care practices, and SASH sites, with staff attending the University of Massachusetts Center for Tobacco Treatment Research and Training. Effective tobacco cessation counseling techniques and access to free nicotine replacement therapy have been incorporated into CHT, primary care and SASH visits. The 2011 NCQA PCMH standards provide compelling incentives to primary care practices to identify and conduct outreach to tobacco users in their practices. Tobacco cessation group counseling has been demonstrated to be embedded in some of Vermont's engaged practices as a result.

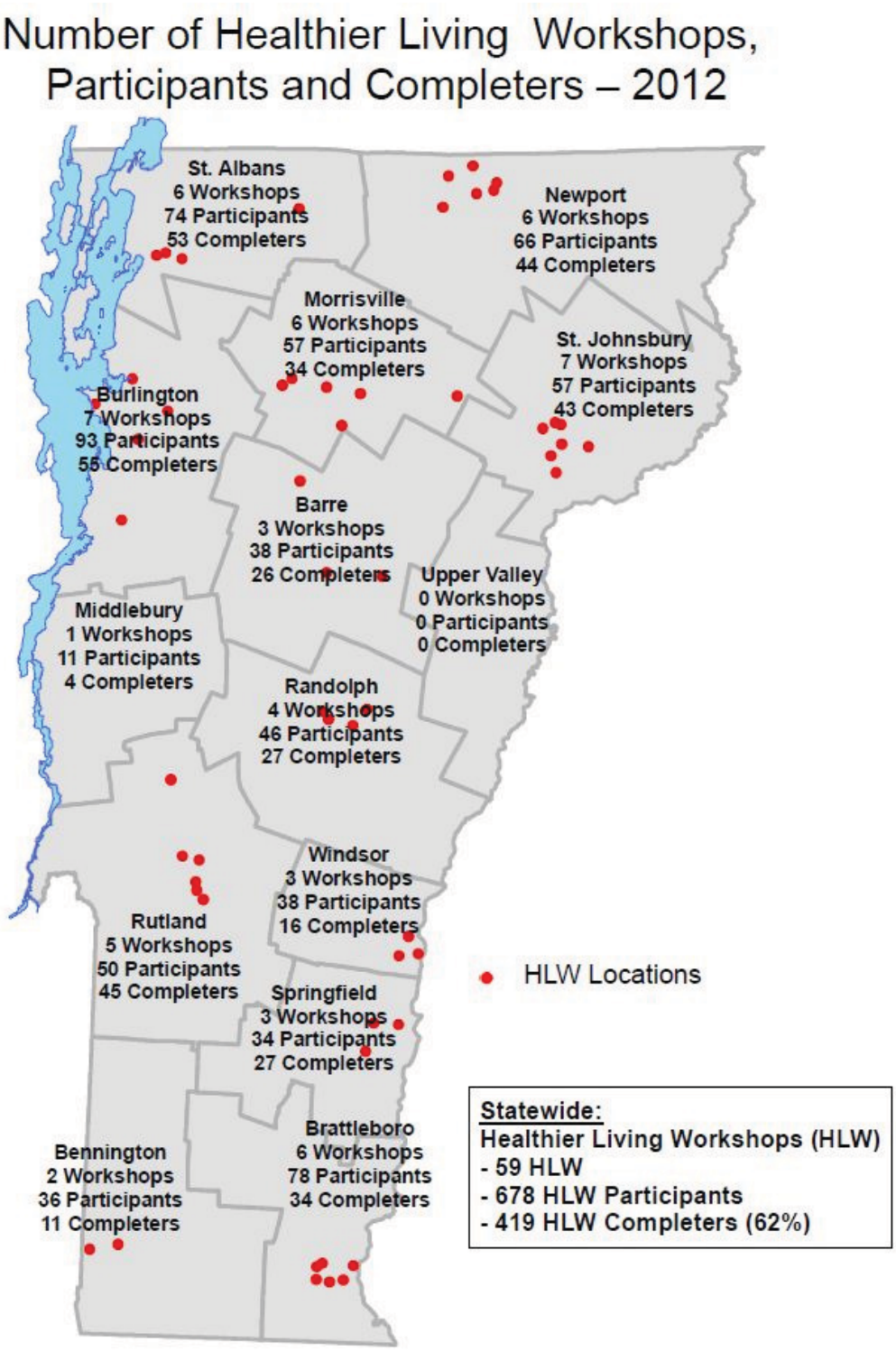
To support these efforts, a tobacco cessation tracking measure set for tracking and treatment was added to Covisint DocSite, Vermont's centralized clinical registry. It was developed to allow counselors to send electronic referrals to the Quit by Phone Services and to order nicotine replacement therapy through the registry as well as to document and support group and individual tobacco cessation counseling. See Figure 8 for a basic report generated by Covisint DocSite summarizing the number of individuals involved in tobacco cessation counseling around the state.

Figure 9. Tobacco Cessation Report, August1, 2012 to December 31, 2012



Count Of	Total
Registrants	386
Relapsers	39
Participants	104
Completers	101

Figure 10. Healthier Living Workshops



3.c. Wellness Recovery Action Planning (WRAP)

The Copeland Center Wellness Recovery Action Plan (WRAP) is a standardized group intervention for adults with mental illness. It promotes the use of wellness recovery action plans to enhance patient activation and wellness in workshops lasting 4 hours a week over 6 weeks. Participants organize personal wellness tools, activities and resources they can use to help maintain well-being in the face of their symptoms. In addition, each participant develops an advanced directive that guides the involvement of family members, supporters, and health professionals in the event that the individual is not able to act on his or her own behalf.

First introduced and supported by the Vermont Department of Mental Health in 1997, the WRAP curriculum has been used extensively in Vermont and other states with the support of the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). Two rigorous studies have been conducted showing generally positive outcomes from participation in the WRAP program. Participant surveys report very high rates of satisfaction.

In an effort to provide more supports for primary care patients experiencing depression, anxiety and other mental health conditions, the Mt. Ascutney Health Service Area piloted WRAP in 2010. Their initial efforts were supported by private foundation funding. In 2012 Blueprint supported their activities as part of Vermont's menu of community based Self-Management programs. The workshops' popularity was evident in their consistent over-enrollment. During the past year 27 people were served in 4 (3 adult and one teen version) workshops.

Based on Mt. Ascutney's success, the Blueprint initiated plans to spread WRAP throughout the rest of the state. Working closely with the Department of Mental Health, Vermont Psychiatric Survivors, the Copeland Center, and Mt. Ascutney Hospital and Health Center, it is estimated that a total of 20 WRAP workshops will be available in 13 Health Service areas in 2013.

More information about Wellness Recovery Action Planning (WRAP) is available at http://www.mentalhealthrecovery.com/wrap/

3.d. YMCA Diabetes Prevention Program (DPP)

Diabetes remains a major threat to the physical and emotional health of individuals, as well as to the financial health of society. Much attention and many resources are appropriately invested in patients who struggle with this disease. The Blueprint aims to avoid the complications of diabetes by preventing its occurrence. The Centers for Disease Control's Diabetes Prevention Program is a renowned evidence-based program which helps adults at high risk of developing Type 2 Diabetes adopt and maintain healthy lifestyle choices. The program is delivered in a classroom setting by trained lifestyle coaches and provides a supportive environment where a small group of individuals work together. It has a specific focus on increasing physical activity (up to 150 minutes per week), healthier eating and losing a modest amount of weight (7% of original body weight). The program lasts for one year and is composed of sixteen weekly one-hour sessions followed by eight monthly maintenance sessions.

In July 2012, the Greater Burlington YMCA received grant funding from the YMCA of the USA to deliver the Diabetes Prevention Program in Vermont with a primary focus on Chittenden County. Two workshops were successfully piloted in 2012, with up to 20 enrollees.

Through a strategic partnership, the Greater Burlington YMCA and the Blueprint are expanding on the initial goals of the YMCA of the USA. The Self-Management regional coordinators in each Health Service Area are using their local infrastructures to offer the YMCA Diabetes Prevention Program statewide, and at no cost to the individual participants. In 2012, lifestyle coaches were trained in 6 Health Service Areas; 10 Health Service Areas will have trained leaders to deliver the program by March 2013.

More information about the YMCA's Diabetes Prevention Program can be found at http://www.ymca.net/diabetes-prevention/

4. MENTAL HEALTH, ADDICTIONS TREATMENT AND PRIMARY CARE

The Blueprint for Health emphasizes and supports the integration of mental health and addictions treatment with the practice primary care. In 2012, two key strategies were employed. First was the continuation of enhancing the capacity of primary care providers to treat and manage common mental health and substance use conditions. The second is to extend the practice and payment reforms to specialty mental health and addictions providers through innovative reallocation of Medicaid funding in the Hub and Spoke program. Both are described in Section 4.

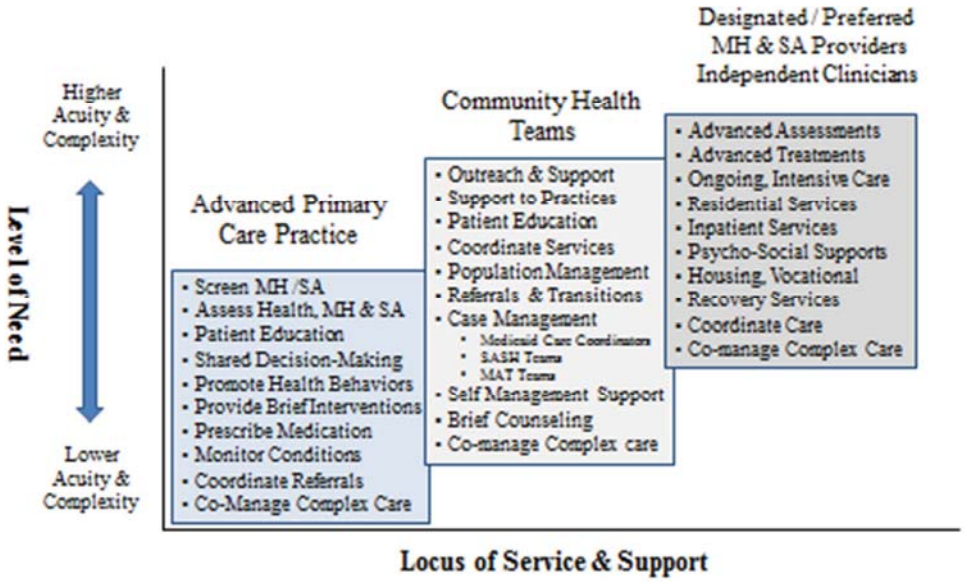
4.a. Enhancing Primary Care Capacity for Mental Health and Addictions Treatment -The "Collaborative Care" Concept

The first integration strategy is to strengthen the capacity of primary care to provide basic treatment to the patients they see and to augment the staffing to coordinate care with specialist. National studies indicate that most people who receive any treatment for a mental health condition are treated in general medical settings rather than receiving care from a mental health or addictions specialist (Wang P et al., Twelve-Month Use of Mental Health Services in the United States, Archives of General Psychiatry, 62, 2005). A strong body of evidence for the effectiveness of "Collaborative Care" approaches in primary care is emerging. Collaborative care involves the implementation of standardized treatment protocols (for conditions such as depression, anxiety, ADHD, problematic substance abuse); involvement of nurse care managers or other health care professionals in providing brief treatment interventions and monitoring the impact of care; use of clinical registries, and specialized psychiatric or other mental health consultation[1].

The Blueprint framework of patient centered medical homes, Community Health Teams, and the central clinical registry provides participating primary care practices with the tools and staffing to implement Collaborative Care approaches. Figure 11 shows the basic treatment and support for mental health conditions that Blueprint primary care providers with this infrastructure are now able to potentially offer. This also illustrates the roles of traditional specialty providers in serving patients with those conditions that have the highest acuity and complexity, similarly to how patients based in primary care PCMHs interface with medical specialties such as cardiology and oncology.

[1] The University of Washington AIMS Center report that over 80 large randomized controlled trials show that Collaborative Care is more effective for common mental disorders such as depression and anxiety than care as usual, Unutzer 2013.

Figure 11.Continuum of Mental Health and Substance Use Services



4.b. Hub and Spoke Program for Opiate Addiction Treatment

The first major effort to extend the Blueprint reform framework to mental health and addictions providers incorporating both payment and practice reforms is the Hub and Spoke initiative, described in detail in Section 4.b.

4.b.i. A Crisis in Vermont

Prescription drug abuse has overtaken heroin as the leading cause of opioid addiction in Vermont. The complex medical, social, and community issues associated with opioid dependence[2] came to the public's attention in a steady drumbeat of press articles, health provider testimony, and community concerns. A potent mix of public health and social issues (increasing rates of prescription drug addiction, over-prescribing and diversion of medication, increased rates of property crime and incarceration for drug-related offenses) combined with lack of access to treatment services, and has contributed to a collective sense of crisis about the issue.

[2]The essential features of substance dependence are a set of cognitive, behavioral and physiological symptoms in which a person continues to use the substance despite significant substance-related problems. The repeated use of opioids results in: patterns of tolerance (requiring increasing doses of the substance to achieve effects), withdrawal (a set of physiological symptoms), and compulsive drug taking due to intense feelings of "craving" for the substance. Opioid dependence is a chronic, relapsing illness. It is diagnosed by a physician based on the presence of at least three of seven criteria over a 12-month period. Opioid dependence includes compulsive, prolonged, self-administration of opioid substances that are not for a legitimate medical purpose and are used in doses that are greatly in excess of the amount needed for pain relief.

Further analysis indicated an extraordinarily high public spending on Vermonters with opioid addiction; in 2011 the Department of Vermont Health Access (DVHA) reported just under $45 million in Medicaid expenditures for the 3,415 beneficiaries who received treatment for opioid dependence. The health care costs of this group of beneficiaries were nearly three times higher than the average annual per capita costs of Medicaid beneficiaries. Other social indicators of high cost include preliminary analysis on incarceration and employment rates conducted by the Vermont Department of Mental Health Research and Statistics unit. More than half (60%) of the Medicaid beneficiaries receiving treatment for opioid dependence in calendar year 2008 had no employment and only 8% were employed in all four quarters of that year. Incarceration rates are high; fifteen to twenty percent of Medicaid beneficiaries receiving treatment for opioid dependence were incarcerated each year from 2008-2011.

Access to care and adequacy of the treatment network pose additional challenges. Throughout the past year Vermont's treatment programs had waiting lists, the number of physicians treating Vermonters for opioid dependence declined, and nearly 200 Vermonters traveled out of state to receive care. Compounding the challenge of providing a coordinated health system response to treating opioid addiction are bifurcated funding and provider systems.

4.b.ii. Medication Assisted Treatment (MAT)

Fortunately there are successful treatment approaches that are well supported in the addictions treatment literature. Medication Assisted Treatment (MAT) is defined by the Center for Substance Abuse Treatment (CSAT) as "the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders." The two primary medications used to treat opioid dependence are methadone and buprenorphine, and opioid dependent individuals may remain on them indefinitely, akin to insulin use among people with diabetes.

Although the primary pharmacological treatments for opioid dependence (methadone and buprenorphine) have similar effects, two different federal regulations govern their use, resulting in distinct provider types. In Vermont, typical of many states, this has resulted in two separate programs for buprenorphine and methadone. Methadone treatment for opioid dependence is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTP). The OTP programs in Vermont are administered by the Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) and include programs in Burlington, St. Johnsbury, Barre, and Brattleboro. Access has been limited to the methadone treatment programs (OTP) in Vermont due to geography, staffing and space, and funding.

In contrast, buprenorphine can be provided as office-based opioid therapy (OBOT) by any physician with an X-DEA license in a general medical office[3]. In Vermont nearly 150 physicians prescribe buprenorphine – most prescribe to fewer than 20 Medicaid beneficiaries, some to 20-40, and a smaller number of physicians prescribe to between 50-100 patients. Prescribers are likely to be family medicine, internal medicine, OB/GYN, and psychiatry providers. The Vermont Department of Health Access (DVHA) administers the Buprenorphine program in Vermont in a similar fashion to other health care conditions in that it pays claims on behalf of all eligible Medicaid beneficiaries to participating providers. The DVHA program has seen significant growth in the past decade; in fact most Vermonter's receiving medication treatment for opioid dependence get their care in general medical office settings with physicians and not in addictions treatment programs.

The methadone programs administered and funded by ADAP provide more comprehensive addictions services, but with little integration into the broader health care systems and often have limited interface with mental health treatment systems. The buprenorphine program, administered and funded by DVHA, is comprised of physicians who prescribe buprenorphine but with no direct access to addictions or mental health services. These medical practices typically also have limited coordinated access to other rehabilitation or recovery services. Finally, methadone OTPs and buprenorphine prescribing physicians in OBOTs work in relative isolation from each other.

4.b.iii. Groundbreaking Innovation - Hub & Spoke

First introduced by Vermont physician John Brooklyn, MD, the Hub & Spoke is characterized by a limited number of specialized, regional addictions treatment centers working in meaningful clinical collaboration with general medical practices. Specializing in the treatment of complex addiction, the regional centers (Hubs) would provide intensive treatment to patients and consultation support to medical providers (Spokes) treating patients in general practice community. Patients starting medication-assisted treatment could first be assessed and stabilized in the Hub and then referred for ongoing care to the Spoke physician. In turn, patients experiencing relapse or a difficult course of care could be referred from the Spoke physician to the Hub for ongoing management of complex addictions. This framework could both efficiently deploy addictions expertise and help expand access to care for Vermonters.

The innovation is in the coordinated, reciprocal clinical relations between the specialty addictions centers and the general medical practices. The framework facilitates the development of a treatment continuum that spans the OTP and the OBOT federal regulatory framework for medication assisted treatment, and supports the dissemination

[3] The physician must complete an 8-hour online course to gain the authority to prescribe buprenorphine for opioid dependence and demonstrate qualifications as defined in the *Drug Addiction Treatment Act of 2000* and obtain a waiver from the Substance Abuse and Mental Health Services Administration. DATA 2000 restricts the number of patients a physician may treat with buprenorphine for opioid dependence. In the first year of obtaining the X-DEA license and waiver a physician may only treat up to 30 patients. In the second year, the physician may request additional authority to treat 100 patients. No physician operating in an office-based treatment setting may prescribe buprenorphine for opioid dependence to more the 100 patients at the same time.

of addictions treatment capacity in the larger health system. Success in this framework depends on the capacity at both the Hubs and Spokes to make and receive referrals and a funding mechanism that supports the clinical care management activities that comprehensive and coordinated care for chronic conditions requires. The basic concept would apply equally well to the management of chronic pain, serious psychiatric conditions, and other chronic illnesses.

Three partnering entities - the Blueprint for Health, the Department of Vermont Health Access, and the Division of Alcohol and Drug Abuse Programs - working in collaboration with local health, addictions, and mental health providers developed a program and cost model for a comprehensive and systemic response to treat opioid dependence. Grounded in the principles of MAT, the Blueprint's health care reform framework, and the Health Home concept in the Federal Affordable Care Act, the partners proposed the Hub and Spoke initiative. The initiative includes:

- Expanding access to Methadone treatment: by creating a new methadone program in the Rutland area and supporting providers to serve all clinically appropriate clients who are currently on wait lists.

- Enhancing Methadone treatment programs (Hubs): augmenting the programming to include Health Home Services to link with the primary care and community services, provide buprenorphine for clinically complex patients, and provide consultation support to primary care and OB GYN providers prescribing buprenorphine.

- Adding new staff (a nurse and a Master's prepared, licensed clinician) to the primary care and OB GYN practices (Spokes) through the Blueprint Community Health Teams to provide Health Home services including clinical and care coordination supports to individuals receiving buprenorphine.

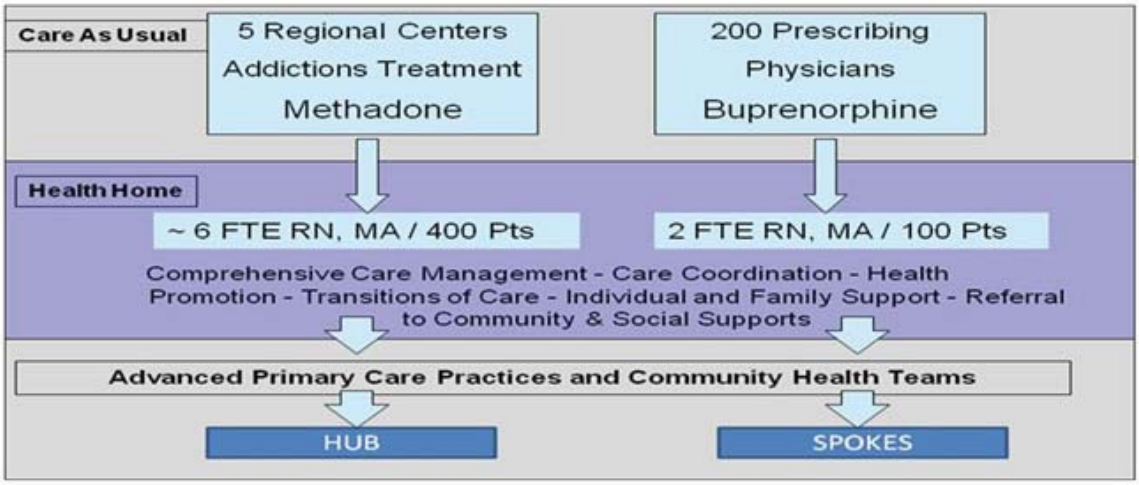
The Hub and Spoke approach builds on the statewide expansion of Advanced Primary Care Practices (APCP) also known as Patient Centered Medical Homes, supported by core Blueprint for Health Community Health Teams (CHT) and CHT extenders[4]. This model has allowed Vermont to establish a novel foundation for high quality primary care with embedded multidisciplinary support services, better coordination and transitions of care, and more seamless linkage among the multitude of partners from many disciplines.
As a public-private partnership, the Blueprint has existing CHTs comprised of nurse coordinators, clinician case managers, social workers and other professionals who extend the capacity of primary care practices to assess patients' needs, coordinate community-based support services, and provide multidisciplinary care. Effective teams are the basis for all of the quality improvements in the Blueprint, supported by payment reforms that

[4] Community Health Team "extenders" include the Vermont Chronic Care Initiative staff focusing on the most expensive 5% of Medicaid beneficiaries; the SASH coordinators and wellness nurses serving at risk Medicare beneficiaries; and the *Spoke* staff serving patients receiving buprenorphine by qualified physicians.

provide patients and practices with unhindered access to CHTs, CHT extenders and Self-Management opportunities. Vermont will be building upon this medical home model to create enhanced Health Homes for individuals receiving MAT (see Appendix E for more detail.)

Under the Hub and Spoke approach, each patient undergoing MAT will have an established medical home, a single MAT prescriber, a pharmacy home, access to existing Blueprint Community Health Teams (CHTs), and access to Hub or Spoke nurses and clinicians.

Figure 12. "Hub & Spoke" Health Home for Opiate Dependence



A Hub is a regional specialty treatment center responsible for coordinating the care of individuals with complex addictions and co-occurring substance abuse and mental health conditions across the health and substance abuse treatment systems of care. In the case of medication assisted therapy (MAT) for opiate addiction, Hubs will initiate medication assisted treatments, provide care through the period of initial stabilization, coordinate referrals to ongoing care, and provide consultation and support to ongoing care. All methadone treatment is provided in Hubs. A subset of buprenorphine treatment also is provided in Hubs, specifically for more clinically complex induction, prevention and treatment of relapse, and to provide support for tapering off MAT. Plans are underway to expand or create five (5) regional specialty addictions treatment centers in Northwest, Southwest, Southeast, Central and Northeast Vermont.

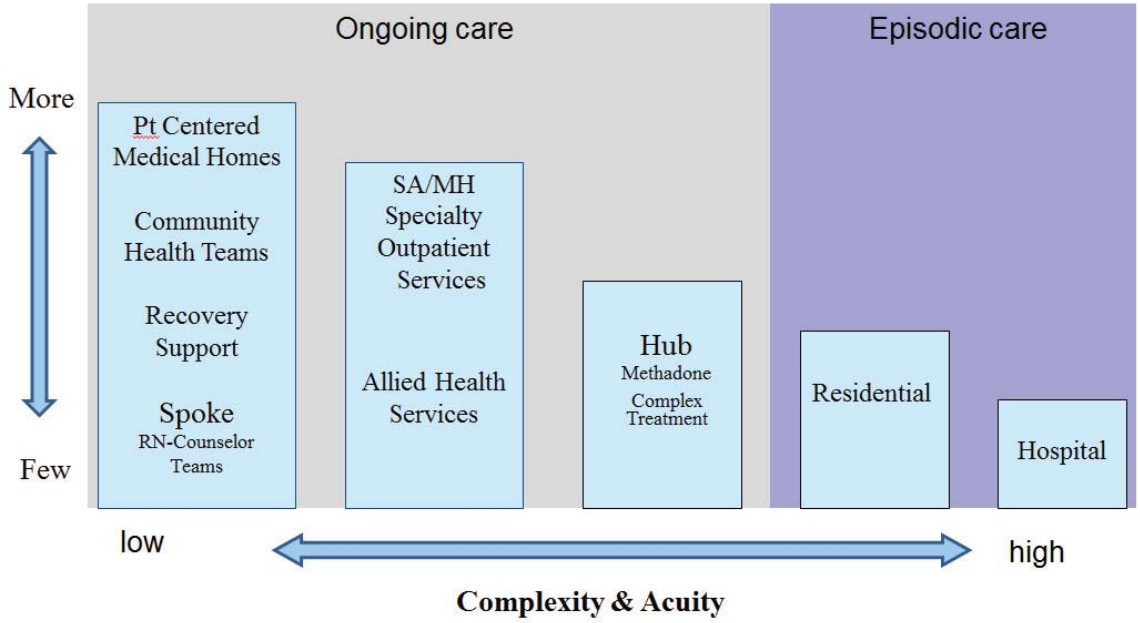
A Spoke is defined as the ongoing care system comprised of a physician prescribing buprenorphine and the collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports and community services, and provide counseling, contingency management, care coordination and case management services. The plan is for all Vermont physicians who prescribe buprenorphine to become Spokes, with embedded nursing and clinical addictions/mental

health counselors working in conjunction with the physician to form a Health Home[5] team. The new Spoke staffing will provide augmented counseling, health promotion, and care coordination services to current buprenorphine practices.

As part of the CHTs, Medicaid will support the Spoke staff through the local Blueprint infrastructure as a capacity-based payment. This eliminates the need for fee-for-service billing and patient co-pays, which often are barriers to services for patients with addiction and mental health conditions. Embedding the staff directly in the prescribing practices allows for more direct access to mental health and addiction services, promotes continuity of care, and supports providing multidisciplinary team care. Like the Blueprint CHTs, the Spoke staff (the nurse and clinician case manager) are provided free of cost to patients receiving MAT, essentially as a "utility" to the practices and patients.

The Hub & Spoke is part of the larger addictions, mental health and human services continuum of care as pictured in Figure 13.

Figure 13. Continuum of Health Services – Addictions Treatment



[5] Section 2703 of the Patient Protection and Affordable Care Act offers "State Option to Provide Health Homes for Enrollees with Chronic Conditions." The goal is to expand patient-centered medical homes to build linkages with other community and social supports, and to enhance coordination of medical and mental health / addictions care to meet the needs of people with multiple chronic conditions. The "Health Home model of service delivery encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions."

Hub and Spoke Implementation Timeline

July 2012: DVHA/Blueprint, in collaboration with ADAP, issued a Request for Proposals for Hub services in the Northeastern, Central, and Southeastern regions of the state.

January 2013: DVHA/Blueprint supported enhanced Hub services at the Chittenden Center in Burlington and payments are significantly expanding the staffing of the community health teams. Twenty one full time equivalent nurses and licensed counselors focusing on addictions treatment are being deployed to the physician practices prescribing buprenorphine in Bennington, Rutland, Chittenden, Franklin, and Grand Isle counties[6] as part of the Blueprint for Health. These staff all working in the federally established Health Home framework designed to be consistent with the patient-centered medical home standards.

July 2013:The Hub and Spoke initiative will be implemented in three geographic stages over the next 18 months. The timing for the balance of the state depends on the ability of the provider networks to stand up the Hub services.

For detailed supporting documents about the Hub and Spoke planning and implantation see http://hcr.vermont.gov/blueprint

[6] There are currently no Buprenorphine prescribers in Addison County. Funding support for Spoke staffing will become available as soon as providers add buprenorphine care to their practices.

5. SUPPORTS FOR PRACTICES

5.a. Expansion and Quality Improvement Program (EQuIP) Practice Facilitator Team

Vermont has participated in and helped to shape a national model supporting the transformation of primary care through the evolved implementation of Practice Facilitation. In *Developing and Running a Primary care Practice Facilitation Program*, published by the Agency for Healthcare Research and Quality (AHRQ) in 2011, practice facilitation is defined as

> *"…a supportive service provided to a primary care practice by trained individuals or teams of individuals. These individuals use a range of organizational development, project management, practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals."*

Vermont's Expansion and Quality Improvement Program (EQuIP) consists of a team of Practice Facilitators that assists primary care internal medicine, family medicine, pediatric and naturopathic practices with continuous Quality Improvement (QI) efforts. In 2012, 13 practice facilitators have assisted approximately 90 practices in becoming recognized by the National Committee for Quality Assurance as patient centered medical homes. The EQuIP team members come from such disciplines as social work, nursing and patient advocacy, and are all highly skilled in change management and process improvement. Facilitators are trained to develop relationships and work on-site in practices with the providers they support, working with consistent practice-based teams as much as possible. This is illustrated in Figure 14. Other communication mechanisms with individual practices, such as phone and email are also used, especially for interim support and follow up, illustrated in Figure 15.

Figure 14. QI Team Consistency Over the Course of the Month (*n*=221)

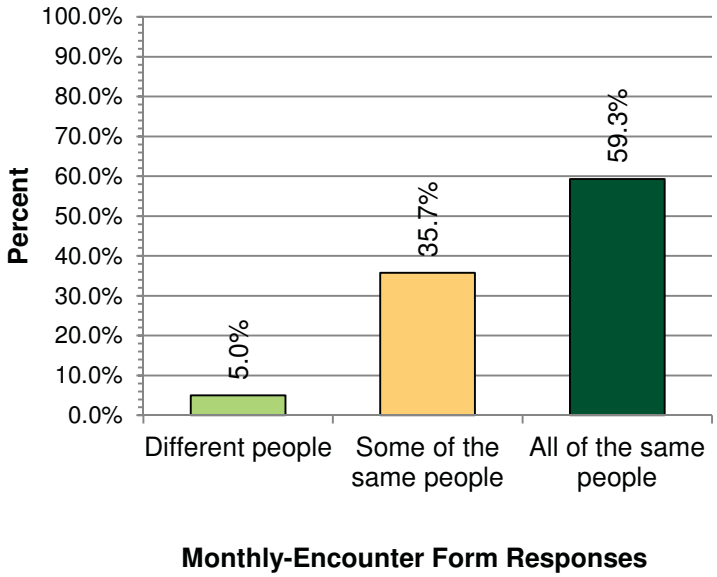
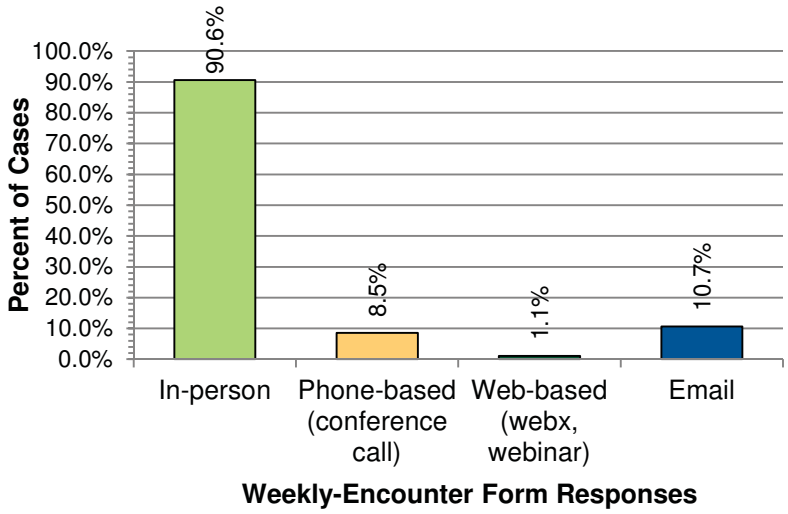


Figure 15. Mode of Communication for Substantive Meetings (*n*=221)
(Note: More than one type of communication may be used for a given practice)

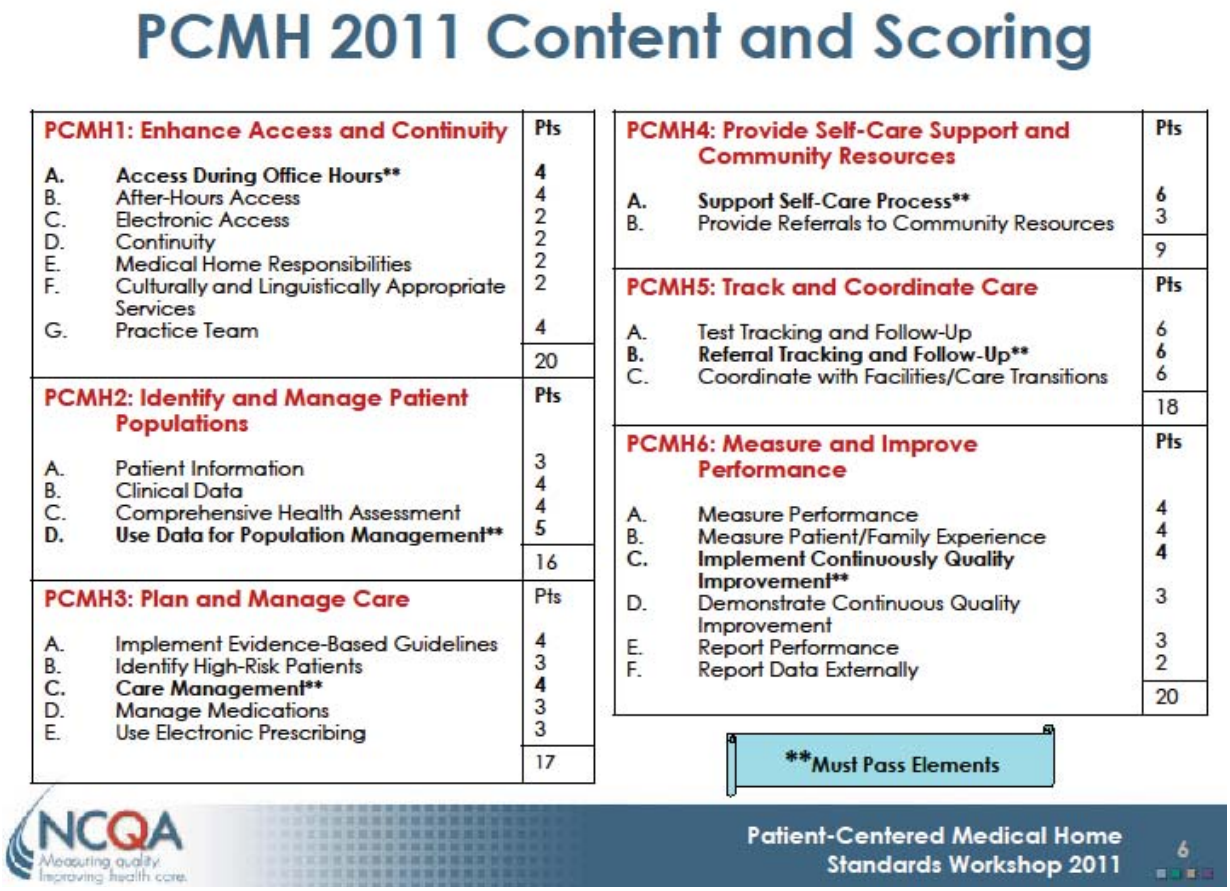


A Practice Facilitator's charge is to build ownership and support for continuous QI at the primary care practice. The QI projects are chosen by the practices and are based on their established goals. They guide practices to tailor established QI methodology to "in the trenches" practice settings and issues. By actively using these approaches they teach the team to incorporate QI tools into daily workflows in order to improve care and measure change. Facilitators provide an infrastructure that can help translate visionary policy into real world operations and sustained change. The goals most often addressed by facilitators and practices fall into three major categories:

- NCQA recognition - understanding and evaluating how well practices will perform against the NCQA PCMH standards and develop action plans timeline to meet the standards
- Electronic systems integration - electronic health record (EHR) implementation and upgrades; reporting from EHR; connecting to the Vermont Health Information Exchange (VHIE); implementing the centralized clinical registry (Covisint DocSite)
- Improvements in clinical care - Pursuing improvements in management of chronic conditions (including but not limited to diabetes, asthma, hypertension, ADHD, depression, tobacco use and obesity), immunizations, preventive services and screening (e.g. wellness and well child exams, lead screening, cervical cancer screening, breast cancer screening, BMI screening, colon cancer screening, autism assessment, and tobacco screening), and access to care (availability of same day appointments, access by phone, reduction of wait times and of avoidable ER use)

In 2012, NCQA modified the PCMH standards under which the practices are recognized. These new 2011 standards (summarized in Figure 16) require mandatory and rigorous demonstration and clear documentation that the practices have both the capabilities and systematic implementation of the intent of each of the elements. Failure to meet these "must pass" standards results in a practice's not achieving PCMH recognition from NCQA. It is noteworthy that despite this higher threshold for recognition, Vermont practices have achieved this higher standard at exceptional levels when working with Blueprint practice facilitators.

Figure 16. Summary of 2011 NCQA PCMH Recognition Standards



Work with the practice facilitators continues after NCQA PCMH recognition. Practices identify their improvement goals, often informed by the NCQA scoring process and/or implementation and integration of the local Community Health Team operations. Options for practices include individual projects with their facilitator and participation in learning collaboratives as described in Section 5.c. of this document.

Throughout the Blueprint implementation, practice facilitators have been recognized for their work in the advancement of transformative quality improvement efforts. Julie Riffon, the EQuIP facilitator and Blueprint Project Manager for the Newport HSA, recently represented the Blueprint as a national reviewer on the Content Expert Certification Exam for NCQA in Washington, DC in the fall of 2012.

A striking aspect of the Vermont EQuIP is their commitment to each other and themselves as a team of professionals. They support each other through biweekly in-person working meetings and on-line communication via Basecamp. They challenge and support each other in a highly functional manner.

For more information on Practice Facilitation go to
http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_implementing_the_pcmh___practice_facilitation_v2

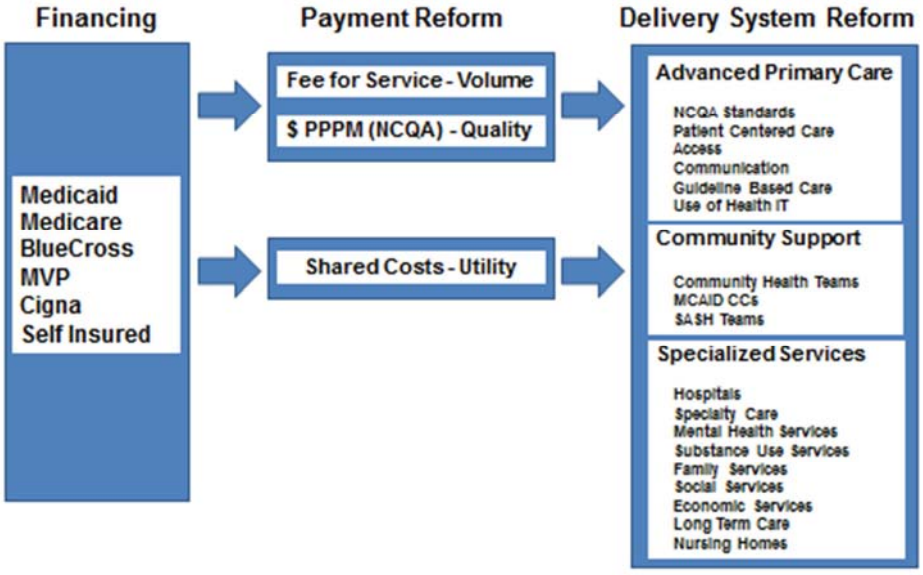
5.b. Payment Reform

5.b.i. Phase I Payment Reforms (Fully Implemented in Primary Care)

As of 2013, Phase I of Blueprint payment reform is implemented statewide and sustained through enacted Vermont statute. These innovative financial reforms align fiscal incentives with healthcare goals. All major commercial insurers, Medicare and Vermont Medicaid are fully participating. The novel targeted payment streams are designed to achieve specific outcomes, with clear incentive structures that promote the stated Blueprint goals including quality, access, communication, and patient centered services. The two specific streams of enhanced financial support to primary care practices are as follows and illustrated in Figure 15.

1. Per Patient Per Month (PPPM) payments based upon the level achieved by the primary care practice in NCQA PCMH Recognition. This is a quality-based payment in addition to traditional Fee for Service (volume based payment) and is the beginning of a move towards quality incentives. It promotes access, communication, guideline based care, well-coordinated preventive health services, use of electronic tracking systems and population management.
2. Phase I payment reform also includes all insurers sharing the cost for core CHT members. Total support is provided at the rate of $70,000 (~1.0 FTE) / 4000 patients. This payment reform establishes a novel community based care support infrastructure that is available to primary care practices and the general populations they serve. The CHT is supported 6 months prior to a practice's NCQA score date, further underscoring the Blueprint partners' commitment to the spread of quality improvement.

Figure 15. Phase 1 Blueprint Payment and Delivery System Reforms



5.b.ii. Phase II Payment Reform - Linkages Between Primary Care and Specialty Providers (In Development and Pilot Programs)

As Vermont moves toward broader payment reforms, Blueprint Phase I innovations are serving as a foundation. Their relative simplicity, while requiring a new approach by participating insurers, does not require formation of new organizations, administrative or otherwise. It establishes a basis for next phase of payment reforms that can influence well-coordinated primary and specialty care across independent practices and organizations. It establishes tested, adjustable, and modifiable payment strategies to support overall financing reforms moving ahead.

The Phase I Blueprint payment reforms described above do not directly involve specialist providers such as Designated Agencies or private psychiatry practices. Correctly, various specialists including mental health and substance abuse providers report not being part of the Blueprint reforms. The first major effort to extend the Blueprint reform framework to mental health and addictions providers in the form of payment and practice reforms is the Hub and Spoke initiative.

Figure 16 shows the evolving Blueprint payment and practice reforms. Both the well-established targeted reforms focused on the support for primary care and the next phase (demonstrated by Hub and Spoke initiative) are illustrated.

Figure 16. Phases I and II of Blueprint Payment and Delivery System Reforms

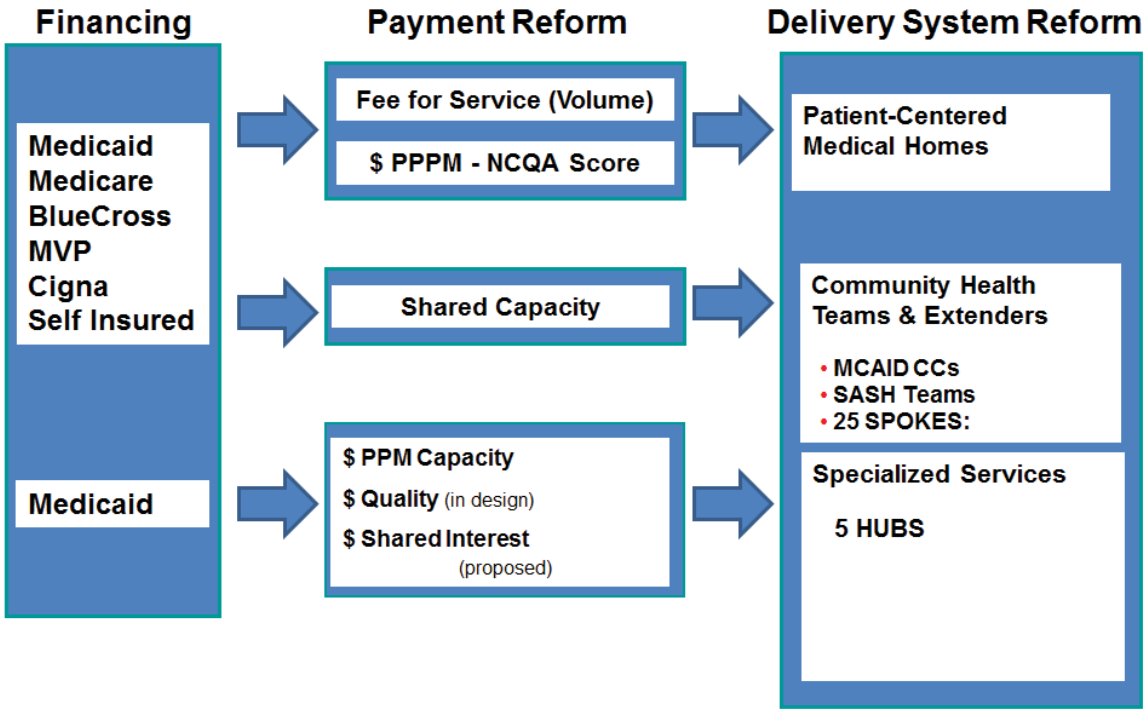


Table 3. Reform Framework for Hub and Spoke

Program and Payment Reform Framework for Integration Hub & Spoke				
	Current System		**New Investments**	**Integrated System**
	Methadone	Buprenorphine		
Program	4 programs Methadone for opioid dependence Waiting lists – up to 18 months No formal integration with Blueprint for Health	122 Prescribing physicians in office-based practices Buprenorphine for opioid dependence Primary Care OB/GYN Limited access for new patients (170 Vermonters served out of state)	Targeted payments for coordinated and integrated care $ to end Methadone wait lists 1 new Methadone Program Dispense Buprenorphine at Methadone program sites	5 HUBs 44 Spoke CHT staff Hub → Spoke Consultation Patient referrals Hubs ↔ Spokes
Funding / Payment	ADAP Appropriation Weekly bundled rate to 4 programs	DVHA Medicaid Fee-for-service	Hub: 6 new Health Home staff $551K / 400 Patients Spoke: 2 new Health Home Staff $196K / 100 Patients Based on active Medicaid caseload	Combined DVHA-ADAP Resources
Performance Metrics	Federal "SATIS" (Substance Abuse Treatment Information System) measures	None specific to Buprenorphine	Expanded HEDIS Reporting NCQA-Specialist Standards (in development at NCQA) Incarceration rates Employment rates (in development)	17 Health Home Measures for both Hubs & Spokes: Preventive & Effective Care for health, SA, MH conditions

	Current System		New Investments	Integrated System
	Methadone	Buprenorphine		
Practice Support	ADAP Staff	None specific to Buprenorphine	Blueprint Practice Facilitators Learning Collaboratives	Specialty Addictions providers in Blueprint Learning Health System
HIT	Addictions EMR and Paper Systems	Primary Care EMR, Paper systems	Covisint DocSite Central Clinical Registry	Integrated heath record
Patient Services	Assessment, dosing, counseling, case management	Physician visit, medication prescribing, Individual or group counseling in some practices	•Care management •health promotion •comprehensive transitional care •individual & family support •referral to community and social support services	Comprehensive health, addictions, and human services
System Expenditures (Medicaid)	$36M (addictions + mental health treatment) $8.7M (general health care) CY 2011 **3,415** beneficiaries	30% Hub Costs $2.755M / 2,000 Hub patients 100% Spoke CHT costs $5.895M / 3,000 Spoke patients **5,000** beneficiaries	Adequate provider capacity to meet need Savings from better coordinated care	

For detailed supporting documents about the Hub and Spoke planning and implementation see http://hcr.vermont.gov/blueprint

5.c. Learning Collaboratives

Widely used to improve care for targeted conditions in primary care settings, Learning Collaboratives involve convening teams of a physician leader, nurse, office manager and other staff from four up to ten practices. They participate in a facilitated structured process of didactic learning, rapid trial implementation cycles (known as Plan Do Study Act, or PDSA) and measurement of the impact of process changes over several months. The practices agree to collect data across a common set of quality of care measures, to identify and test practice improvements in each participating practice, and to share data and measurement about practice changes with each other. The process accelerates practice improvement in applied settings and often results in a core team able to collaborate across organizational boundaries on the implementation of common care standards.

5.c.i. Medication Assisted Treatment Learning Collaboratives

To support the Hub and Spoke practice reforms, the Blueprint (in collaboration with the Vermont Department of Health Division of Alcohol and Drug Abuse) is convened two regional learning collaboratives focused on Medication Assisted Treatment for opiate addiction in 2012, which will continue in 2013.

More than 10 large practices and programs are participating in the 2012-2013 sessions. The common curriculum includes the following topics:

- assessment of opioid dependence
- appropriate dosage for buprenorphine
- monitoring treatment
- managing challenging behaviors
- coordinating with other care providers

Common measurements include use of the Vermont Prescription Monitoring System and documentation of coordinated care.

5.c.ii. Asthma Learning Collaboratives

The Vermont Blueprint for Health seeks innovative ways to work with primary care practices to focus on improving care, reduce unnecessary emergency department visits and hospitalizations. An area of interest to clinicians has been asthma, with significant variation in prevalence and use of services between Health Service Areas. Current asthma prevalence in Vermont is 11% for adults and 10% for children, approximately 2% higher than the national average. 71% of adults and 79% of youth are not well controlled. 52% of people in Vermont with asthma had no routine asthma visits in the past year. 48% of youth under the age of 17 with asthma have never had an asthma action plan.[7]

The aim of this Learning Collaborative was to improve adherence to evidence based guidelines in primary care management of asthma and to utilize documentation tools to guide evidence-based care.

The Blueprint and the Vermont Department of Health's Asthma Program joined forces with National Jewish Health in Denver, Colorado, known worldwide for treatment of patients with respiratory disorders. A team of Blueprint leadership and practice facilitators observed a National Jewish Health learning session of outpatient practices being trained in evidence-based guidelines for care of asthma patients. Merging this with tools from the Institute for Healthcare Improvement Breakthrough Series, a framework for the Vermont asthma collaborative was developed. The aim of the learning collaborative was to improve adherence to evidence based guidelines in primary care management of asthma and to utilize documentation tools to guide that evidence-based care.

Five primary care practices from around Vermont participated in the 2012 program. Each sent a multidisciplinary team to three all-day learning sessions over six months. There were built-in action periods and monthly conference calls between learning sessions, and Category I CME units were awarded. Of note, there was no registration fee charged to participants. Measures of success included assessment of asthma severity and control, and the number of action plans completed in the previous calendar year. These measures were collected at baseline and a second record review was conducted in month 4 and recommended quarterly thereafter. The Blueprint provided tools and support for data collection.

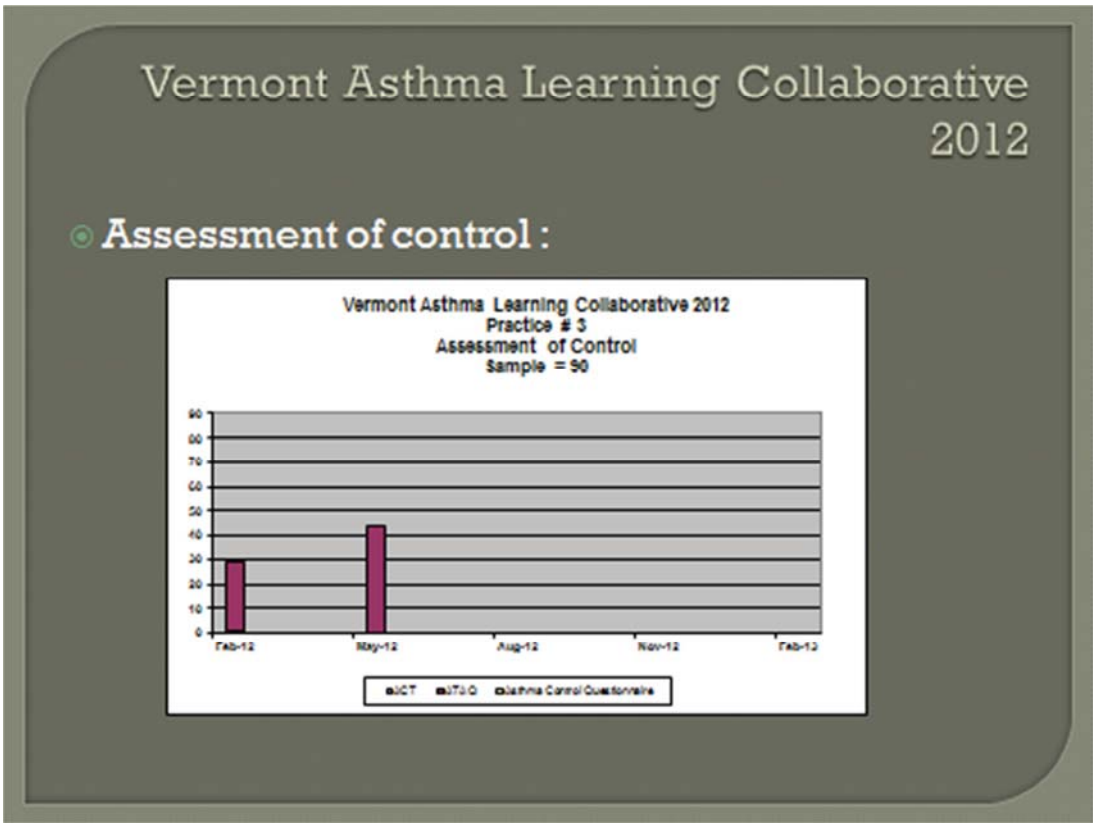
Each learning session provided guidance and instruction in the theory and practice of improving performance and functioned as a milestone along each practice's own individual path to improvement—with each team reporting on their methods and results, collectively reflecting on lessons learned, and providing social support and encouragement for making further changes. Participants received the benefit of direct access to each other and to senior experts in the field at these meetings, as well as through regular conference calls.

Experts, including a pulmonologist, a pharmacist, an allergist and respiratory therapists presented actionable items in primary care. There was an opportunity to hear from a

[7] Vermont Department of Health 2012 Asthma Epidemiology data, used with permission

parent of and a 12 year-old patient with asthma. Each practice led the participants through their current system, their plans and trials of conducting improvements and the results of those efforts. Such shared learning with peer presentations was of deep value. Every practice showed improvement between the baseline data collection and the follow up, an example of which is in Figure 17.

Figure 17. Improvement in Assessment of Asthma Control from the 2012 Vermont Asthma Learning Collaborative



An ongoing Asthma Collaborative, supported by the Blueprint and the Vermont Department of Health, will be completed in 2013 with 9 primary care practices participating.

5.d. Shared Decision Making

In 2012, the Blueprint entered into a partnership with Health Dialog with support from the Foundation for Informed Medical Decision for training of practice facilitators, Community Health Team members, primary care practice staff and other interested parties in the theory and methods of the Shared Decision Making (SDM) model.
The goal is to empower patients to clarify questions and concerns, identify their personal preferences, resolve areas of conflict, and have more informed and productive discussions with providers. Practices were encouraged to bring a team who could use the opportunity to develop a strategy to integrate SDM into their clinical day-to-day workflow.

Four day-long workshops were held in May of 2012 around the state. Over 50 people attended and the curriculum as well as the faculty was very well-received. The program content for the 2012 sessions is as follows:

- Assessing decision support needs:
  - Perception of the decision
  - Decisional conflict
  - Modifiable factors
- Providing decision support:
  - Provide evidence-based information
  - Re-align expectations
  - Clarify personal values
  - Facilitate transfer of skills
- Evaluating decision support:
  - Patient has adequate information
  - Decision is consistent with values and acted upon
  - Patient is satisfied with choice
- Using decision aids in conjunction with decision coaching to support individuals in decisional conflict

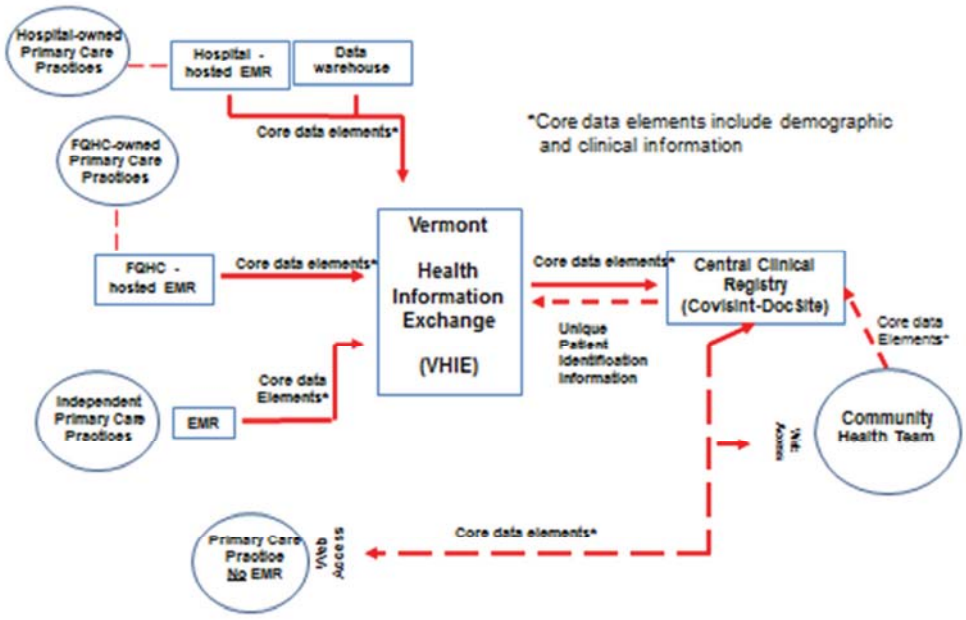
As part of the contract, the Blueprint has access to decision aids for patients and practices. Developed by Health Dialog in conjunction with the Foundation, their content is widely considered a "gold standard" for current unbiased evidence evaluation.

A follow up learning opportunity is being offered to previous attendees over several months in early to mid-2013. This will include several self-paced activities using case examples, two online virtual classroom-based question and answer classes and a final in-person full day class, which will focus on both SDM content and reinforcement of "best practices" for implementing SDM in a practice-based setting. There will be ongoing virtual support for the practices and individuals who enroll.

More information about Shared Decision Making can be found at
http://informedmedicaldecisions.org/what-is-shared-decision-making/

6. HEALTH INFORMATION TECHNOLOGY

Figure 18. Health Information Technology Schematic Diagram



6.a. End-to-End Healthcare Information Transmission - Blueprint Sprints

6.a.i. Sprint Introduction

The goal of the Blueprint Sprint is to establish accurate, timely and reliable end-to-end data extraction, transmission, and registry reporting to support the delivery of high quality health services. The sprint utilizes a results oriented approach where all participants share responsibility for achieving the stated measure of success, defined as trustworthy reporting back to the clinicians. The various entities involved work together as a complete team, with regular direct communication, until the goal is achieved. The primary partners in this essential collaborative process are the clinical practices alongside their parent organizations where applicable, Vermont Information Technology Leaders (VITL), Covisint DocSite and the Blueprint Sprint team.

A focus and intensity is maintained by all partners so that this process is accelerated and completed at each site as soon as possible. In particular, VITL and the Blueprint will further collaborate in 2013 to accelerate deployment of interfaces and improve data quality. This will serve to expedite issue reporting and resolution, clarify roles and responsibilities and establish shared goals that achieve individual project objectives while contributing to the success of mutual overarching objectives as in the End-to-End process. The Sprint is considered complete and successful by verification that we have

achieved data continuity from the source EMR, through the HIE, to DocSite and clinician's satisfaction in the reports generated from the DocSite registry.

The success of this intensive undertaking will benefit the entire healthcare system in Vermont. All potential users of this high-quality data, from independent solo clinical practices to hospitals to an Accountable Care Organization will have access to trustworthy and secure information.

6.a.ii. Sprint Process Outline

1. Blueprint Community Evaluation
2. Initial IT Evaluation
3. Introductory Sprint Meeting
4. Initial Data Mapping Verification
5. Project Plan
6. Sprint Meeting Defining Tasks and Issues
7. Weekly Work Meetings (all partners)
8. Weekly Progress Reports with Action Steps
9. Final Data Continuity and Validation
10. Sprint Completion
11. Ongoing Maintenance

6.a.iii. Current Sprint Projects

As of January 2013, the Blueprint is conducting 4 concurrent Sprints (in addition, 1 was completed in 2012) encompassing 26 practices serving over 60,000 active patients and three different electronic medical records systems (EMRs). See Table x for details. Each Sprint team is made up of representatives from the Blueprint, Covisint, VITL, and the practices that have administrators, clinicians and information technology specialists engaged in the process. The current Sprints are in various stages of completion with three working towards a goal of ending in February. As Sprints are retired additional communities are added with a maximum of 4 concurrent Sprints operating at any given time. Each Sprint that is retired goes into maintenance mode with regularly scheduled activities and calls to ensure the various information systems are kept healthy and data integrity is kept at a high quality standard and a new community is added to the Sprint project.

Table 4. Sprint Projects 2012-2013

Health Service Area	Organization/Source Systems	#Clinical Sites
St. Johnsbury	NVRH	1
St. Johnsbury	NCHC	5
Bennington	SVMC	2
Bennington	Independent (2)	2
St. Albans	NoTCH	5
Rutland	CHCRR	7
Springfield	SHC	6
Totals	**8 Source Systems (EMRs)**	**28**

6.a.iv. Core Data Quality

The Blueprint Sprint team has established a core set of data quality issues that it is addressing which are consistent across a majority of practices. Issues fall into two major categories: the demographic and administrative data known as Admissions, Discharge and Transfer (ADT) data, and clinical data made up of encounters recorded in the EMRs, laboratory and radiological test results and prescription information. A majority of these systems are inherently incompatible with each other due to the lack of national standards for nomenclature. In addition, they all are vulnerable to inaccurate data coming from a source system or coming through a server incorrectly, rendering the resulting reporting untrustworthy and therefore useless.

6.a.iv.1. Admissions, Discharge and Transfer (ADT) Data

The largest issue addressed in all communities is known as the Provider/Patient Panel. This data set encompasses active and inactive providers; active, inactive and deceased patient status; and proper patient attribution to a provider. This data can be anywhere from 25% to 95% inaccurate. While the identified inaccuracies do not generally affect individual patient care and use of the electronic medical record internally to the practice, it seriously affects the capability of ancillary systems to accurately assemble and utilize the information. As such, the usefulness of any data from patient populations to the clinical data attached to them is greatly degraded or rendered useless.

To ensure basic data set accuracy, the following 3 data remediation activities and one technical acuity activity are executed:

- Establish an accurate provider panel
    - Make inactive all providers that are no longer associated with the practice
    - Correct any deficiencies in active provider data
    - Ensure all active providers are appropriately attributed to the sites at which they see patients

- Establish accurate provider/patient attribution panel
    - Ensure patients are accurately attributed to their primary care provider
    - Ensure an accurate active/inactive patient panel
    - Work to ensure all urgent care patients are properly identified
    - Identify all duplicate patients
- Identify and properly indicate all deceased patients
    - Established a pathway to Vermont DOH and access to the Death Registry
        - Captured historical data and disseminate to the communities
        - Establish a process for the delivery of monthly death records
- Verification of ADT Interfaces
    - Ensure ADT system interfaces are properly mapped and transmitting data accurately to VITL
    - Ensure ADT system interfaces are properly mapped and transmitting data accurately to the Blueprint

When these activities are completed, rules and processes are established to ensure that ADT data quality remains intact after the Sprint process is retired.

6.a.iv.2. Clinical Data

Clinical data is made up of information derived from a number of sources including direct data entry into an EMR at the time of a patient visit to contributing data retrieved from other sources such as labs and pharmacies. Inherently, many complexities are present in the recording, transmission and use of clinical data with the major issues being unstructured or free text data entry into the EMR, disparate nomenclatures used by medical records systems for structured data entry and the packaging, transmission and acceptance of that data by other systems consuming it. As issues with the nomenclatures, free text data and the packaging and transmission of that data vary by EMR or other information systems, the healthcare system itself and even by practice in a healthcare enterprise the Sprint team addresses each Community and its medical information system(s) with an overreaching base plan of action which is designed to identify problems and incompatibilities with the data and establish a baseline from which the team can work and measure improvement.

- Verification of Clinical Interfaces
    - Ensure all clinical interfaces are properly mapped and flowing into VITL
- Mapping of Clinical Data
        - Create an exception report of all clinical data mapping from source system to DocSite to identify data that is improperly mapped or nomenclatures do not match
            - ✓ From the exception report determine free text data entry issues
            - ✓ From the exception report identify structured data mismatches
            - ✓ From the exception report create a baseline of problems and data action plan
- Translation of Clinical Data
        - Based on the exception report establish data translation opportunities

        - ✓ Translate information from the source system nomenclatures (free text & structured data)
        - ✓ Remediate inaccurate data from both systems
        - ✓ Identify those data that cannot be translated
    - Create a new exception report to establish data translation success rates
- Establish new free text data entry procedures at the practice level
    - Train staff on acceptable free text entry of information into the EMR
- Fix or create DocSite database capabilities and flexibility to consume and manipulate a wider set of clinical data from disparate systems
- Provide gap analysis of data not exported in the clinical data feed
    - Investigate alternate avenues to populate and/or augment data missing in DocSite
- Provide workflow analysis to ensure consistent data capture

The Blueprint has made a commitment to continuing and expanding the End-to-End data transmission and quality process for all of 2013.

For a detailed example of the Sprint process, see http://hcr.vermont.gov/blueprint

6.b. Central Clinical Registry (Covisint DocSite)

The Blueprint central clinical registry (provided under contract with the Department of Vermont Health Access by Covisint DocSite) is a web-based system which enhances individualized patient care with guideline based decision support. It also supports management of populations with flexible reporting that moves easily between groups of patients selected by specific criteria and their individual patient records. Flexible comparative effectiveness reporting is increasingly available across providers, practices, organizations, and Health Service Areas. The registry has the potential to serve as an integrated health record across independent practices and organizations, now in active development.

Uptake of the registry increased by 115 to a total of 363 licensed users by the end of 2012. Recognizing the need for reliable and readily available technical and clinical support for the increasing number of registry users, Covisint increased end-user support resources by adding staff and materials. A second Vermont-based clinical advisor was hired, access to a new Help Desk option was made available, and 20 short training videos for specific targeted users on a variety of common topic were introduced. These videos are housed on a secure web site with training materials which allows for 24 hour access by users.

Covisint DocSite has been an essential partner in the Sprint process. As such, they performed data analysis and review to identify data quality improvement opportunities for panel management and quality metrics as defined in the Blueprint data dictionary. They identified key process and design improvement components to facilitate practice engagement with the Blueprint registry, such as provider panel alignment and the introduction of a new generation of CCD processing using industry standard nomenclatures to improve clinical data capture.

These efforts resulted in a 25% improvement of data quality this year, bringing the total to 82% since 2011.

The registry is based upon the Blueprint Data Dictionary & condition measure set. This robust product includes data elements for clinical processes and health status. It is adopted directly from various national guidelines for preventive health maintenance and the treatment of chronic conditions. It is updated on an annual basis incorporating input from participating Vermont providers. Additional data elements and measures continue to be added related to various individual components of the program.

- Community Health Team activity - Expanded CHT use of the registry and introduced improved workflow efficiencies such as the use of the Blueprint registry on-line visit planner. The on-line visit planner was implemented in 9 Community Health Teams. In addition, Provider Link was launched in several communities. This linked Covisint product allows for secure fax communication and workflow automation between registry users and non-registry.

- Support and Services at Home (SASH) assessments and tracking – Successful rollout was accomplished including finalization of a SASH-specific condition measure sets with new calculated measures in 32 sites with approximately 120 users
- Tobacco Cessation - Implemented tracking component of the Vermont Quit Network with associated external reporting and notification of nicotine replacement therapy initiation and prescribing in 14 sites with between 75 and 80 users
- Mandated reporting for Federally Qualified Health Centers – Successful expansion of registry reporting supported the Bi-State Primary Care Association for the Unified Data Set (UDS) required for FQHC compliance. There are 40 FQHCs in Vermont, all of which are recognized as patient centered medical homes by NCQA
- For release in 2013
  - Depression condition measure set
  - Opiate Dependence condition measure set
  - Congestive Heart Failure condition measure set

7. PROGRAM EVALUATION

7.a. Introduction

Through the Blueprint initiative, a wide range of stakeholders are working together to establish a statewide foundation of preventive health services. This includes Patient Centered Medical Homes (PCMHs), Community Health Teams (CHTs), supportive payment reforms, and a diverse network of self-management programs. Local Blueprint Project Managers and Practice Facilitators help guide transformation by providing direct assistance to practices, and by organizing Integrated Health Services (IHS) work groups in each area of the state. The IHS work groups plan CHT operations in their communities, resulting in better coordination of services across an array of independent medical and non-medical providers. An exciting advancement for 2013 is the implementation of a coordinated team-based model for patients with addiction disorders and co-occurring mental health problems. The Department of Vermont Health Access (DVHA), including the Blueprint and Medicaid, along with the Vermont Department of Health's Division of Alcohol & Drug Abuse Programs (ADAP), have worked with stakeholders across the state to plan and implement a model oriented towards more holistic treatment and recovery for patients with these disorders. This 'Hub & Spoke' model will significantly enhance the capacity of PCMHs and CHTs (spokes), and regional specialized centers (hubs), to help patients manage their underlying conditions and live healthier and more productive lives. The transformation that is taking place across Vermont is substantial, building on local leadership and existing strengths within communities.

As part of this transformative process, the Blueprint has implemented a multi-faceted evaluation program designed to assess the impact of reforms and support a Learning Health System (a system that continuously improves based on objective comparative assessment). Consistent and standardized collection of data on a statewide basis is establishing repositories that can be used to evaluate progress on the Triple Aim (improved healthcare, improved population health, and improved control over healthcare costs). The state's data sources, and the categories of measurement they support, are shown in Table 5. Presently, the All-Payer Claims Database (APCD) is the most complete data source for evaluation on a statewide basis. The data set used for this year's Blueprint evaluation includes data on all claims paid for Vermont residents, by all major insurers except Medicare, from January 2007 through December 2011.

Table 5. Data sources and categories of measurement used by the Blueprint for evaluation.

	Healthcare Expenditures	Healthcare Utilization	Quality of Health Services	Health Outcomes	Patient Experience of Care
All-Payer Claims Database	X	X	X*		
Central Clinical Registry			X	X	
NCQA PCMH Patient Experience Survey					X**
NCQA PCMH Scoring Database			X		

* Claims-based Healthcare Effectiveness Data and Information Set (HEDIS®) measures
** Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

The Blueprint evaluation needs to account for a complex statewide expansion process, because the PCMH + CHT model is implemented in different communities at different times. Even within a community, each practice has its own start date, and in reality the start date for each practice is not a single point in time. A practice has to undergo months of preparation to be scored as a PCMH and to be eligible for payment reforms. CHT support for practices generally takes additional time (weeks to months) to be fully operational. Thus, there isn't a clear index date when patients are initially exposed to a new intervention. Instead, there is a transformation process that spans months, with a PMCH + CHT environment that continues to mature over a long period of time. Further complicating the evaluation is that patient exposure to the PCMH + CHT environment is highly variable, as many patients don't receive services within a given year. In effect, we are evaluating a complex social change that requires observation over a multi-year period.

7.b. Methods

To account for the complexity of the Blueprint expansion, this evaluation presents trends for 2 different study groups. Each study group includes active patients from primary care practices that started operating as PCMHs during the same calendar year. Active patients are identified using an algorithm that assigns patients to a PCMH based on their visit pattern (i.e., the plurality of primary care visits within the past 24 months). The study populations are grouped as follows: 1) Patients treated in St Johnsbury and Burlington practices that formed the first pilot communities and started operating in 2008; 2) Patients

treated in the Barre and Bennington practices that started operating in 2010. A large number of practices that joined the Blueprint in 2011 are not included in this evaluation; since the available data extend only through December 2011, there is insufficient data to evaluate whether the trends for these 2011 practices change after Blueprint start-up. The number of PCMHs serving each study group, and their geographic areas, are shown in Table 6. There are 7 practices in Study Group 1 and 11 practices in Study Group 2, for a total of 18 practices.

Table 6. Study groups based on Patient Centered Medical Home start-up dates.

	Study Group 1		**Study Group 2**	
Start-up year for PCMHs in each study group	2008		2010	
Location of PCMHs in each study group	St. Johnsbury	Burlington	Barre	Bennington
#PCMH practice sites in each study group	5	2	4	7

Results for each of the 2 Blueprint Study Groups (intervention groups) are presented separately for commercially insured and Medicaid populations, along with results for an appropriate comparison group. The Comparison Group for the commercially insured population consists of patients who have had one or more primary care visits during the past 24 months at non-Blueprint practices and are covered by Blue Cross Blue Shield, Cigna, MVP, or The Vermont Health Plan. The comparison group for the Medicaid population is selected in the same way, but includes patients who are covered by Vermont Medicaid. This approach assures comparison groups that are actively receiving primary care. The Blueprint study groups are generally older with higher rates of chronic conditions than the comparison groups, and they have higher annual healthcare expenditures. To account for this, all results are adjusted for differences in key characteristics across the Study and Comparison Groups, including age, gender, the prevalence of common chronic conditions, multiple chronic conditions, cancer and other catastrophic conditions, and care related to maternity.

The number of patients included in each study group, by calendar year, is shown below. The populations include commercially insured patients ages 18 to 64 years (Table 7a), and Vermont Medicaid-insured patients ages 18 to 64 years, excluding individuals that are dually eligible for Medicaid and Medicare (Table 7b). For this analysis and trend comparisons, the pediatric population was not included since pediatric practices had not yet enrolled in Blueprint in 2011 and there was an insufficient sample size of children for some of the pilot practices.

Table 7a. Number of active patients in each study group by year; commercially insured, 18-64 years old.

Year	Blueprint Study Group 1 St Johnsbury & Burlington	Blueprint Study Group 2 Barre & Bennington	Comparison Group Non-Blueprint with PCP visit
2007	7,258	7,631	31,245
2008	9,119	9,761	41,051
2009	10,114	10,782	44,452
2010	9,635	11,097	42,717
2011	9,433	11,586	44,210

Table 7b. Number of active patients in each study group by year; insured by Medicaid, ages 18-64.

Year	Blueprint Study Group 1 St Johnsbury & Burlington	Blueprint Study Group 2 Barre & Bennington	Comparison Group Non-Blueprint with PCP visit
2007	1,575	2,323	5,898
2008	1,950	2,919	7,621
2009	2,486	3,453	9,416
2010	2,615	4,012	10,563
2011	2,679	4,210	11,431

*Blue shading represents the PCMH start-up year for each study group. Red shading represents years of operations after the start-up year.

7.c. Results

This evaluation explores whether implementation of the Blueprint model is associated with evidence of a change in healthcare expenditures and healthcare patterns, and in particular with a shift from acute episodic care to more effective and preventive care. Total healthcare expenditures are presented as the annual Total Cost of Care (TCC) per person. Acute episodic care is presented as the annual rate of hospital inpatient (IP) discharges and emergency department (ED) visits per 1,000 patients. Effective and preventive care is measured as the proportion of patients receiving recommended Diabetes Care, Breast Cancer Screening, and Cervical Cancer Screening (based on HEDIS® specifications applied to the claims data). Where possible, results for the two Study Groups are presented for the years prior to their practice starting operations as a PCMH (with the dashed portion of the line in the following graphs), and for each year of PCMH operations (with the solid portion of the line). In the case of HEDIS®-based measures, data are not available to report results prior to 2008.

Total Healthcare Expenditures. From 2007 through 2011, growth in total healthcare expenditures slowed across all groups in the commercial population, with the lowest growth rates in 2010 and 2011 (Figures 19 & 20). In 2011, both Blueprint Study Groups

showed the first trend towards an actual reduction in per capita healthcare expenditures, while the Commercial Comparison Group continued to trend upward. The Medicaid population demonstrated different trends than the commercial population, with a reduction in per capita healthcare expenditures in all groups from 2007 through 2010, followed by an uptick in 2011 (Figures 21 & 22). The rate of increase in 2011 was higher in the Medicaid Comparison Group than in either Blueprint Study Group. The overall trends in healthcare expenditures are examined more fully by showing the differences between the Study Groups and Comparison Groups during each year of the evaluation (Figures 23-24).

Figure 19. Total expenditures per capita (adjusted); commercially insured, 18-64 years old.

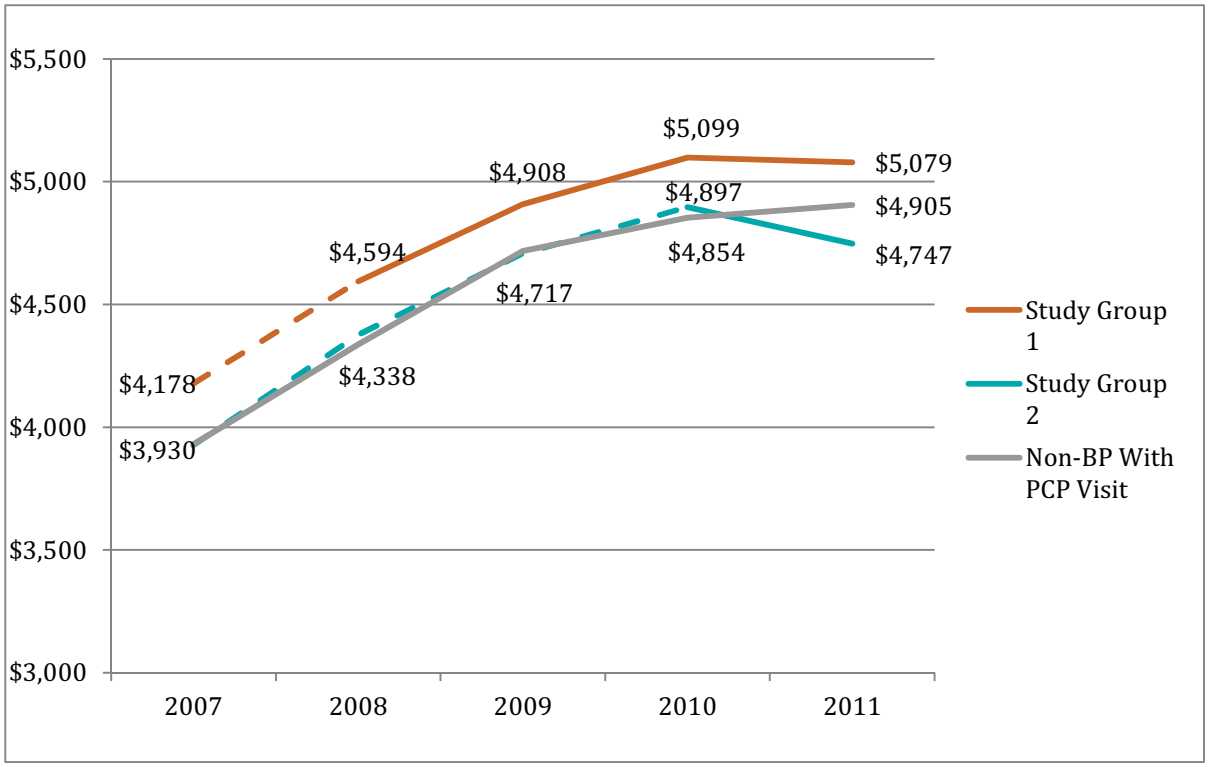


Figure 20. Percent change in total expenditures per capita (adjusted); commercially insured, 18-64 years old.

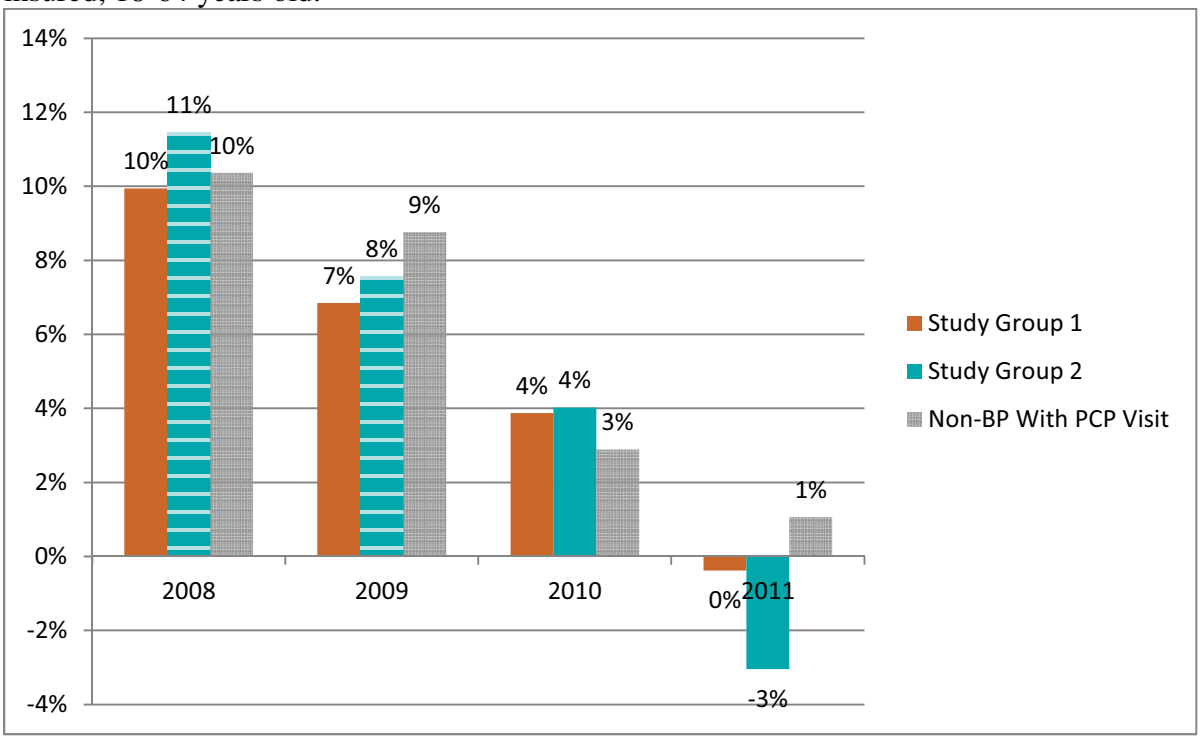


Figure 21. Total expenditures per capita (adjusted); Medicaid population, 18-64 years old.

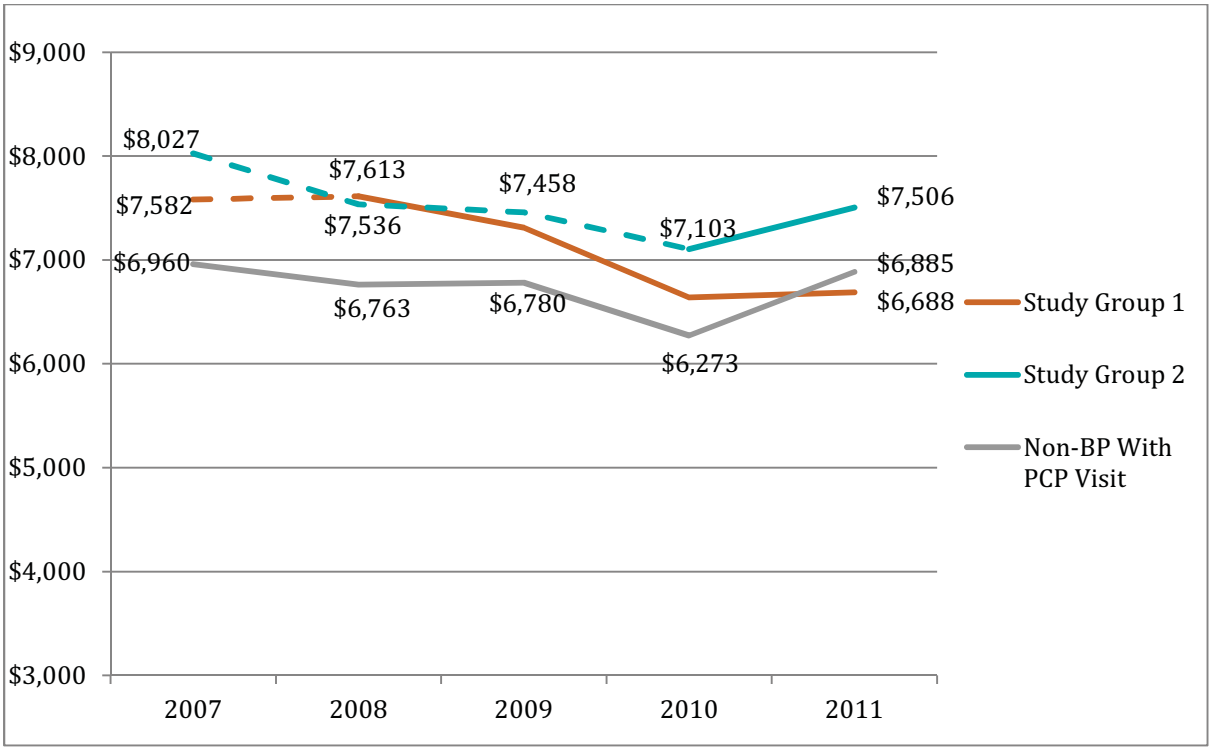
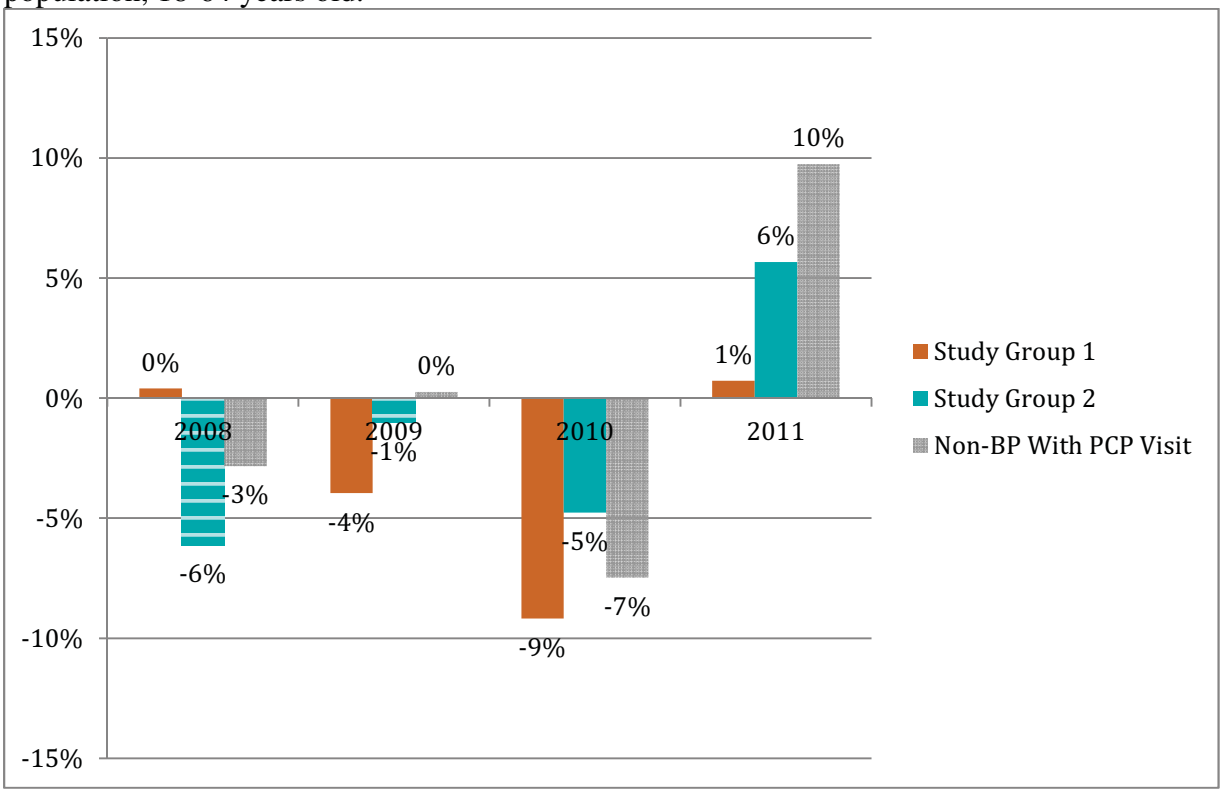


Figure 22. Percent change in total expenditures per capita (adjusted); Medicaid population, 18-64 years old.



The differences in per capita healthcare expenditures between the Study Groups and Comparison Groups, over time, are presented in Figures 23-26, below. These results suggest favorable trends for the Blueprint Study Groups in both the commercial and Medicaid populations. In the commercial population, Study Group 1 initially had per person expenditures that were $248 higher than the Comparison Group (Figure 23). By 2011, this gap had fallen to $174 per person. Study Group 2 initially had virtually the same per person expenditures as the Comparison Group (Figure 24). By 2011, per person expenditures in Study Group 2 were actually $158 lower than the Comparison Group.

Figure 23. Difference in annual expenditures per capita (adjusted); commercially insured, 18-64 years old.

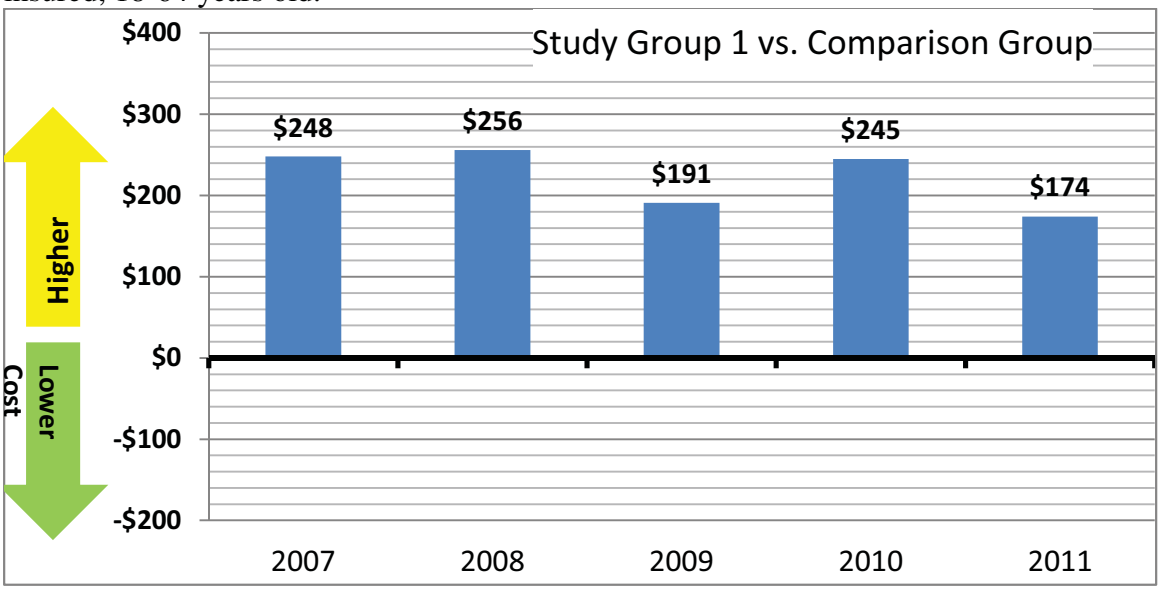
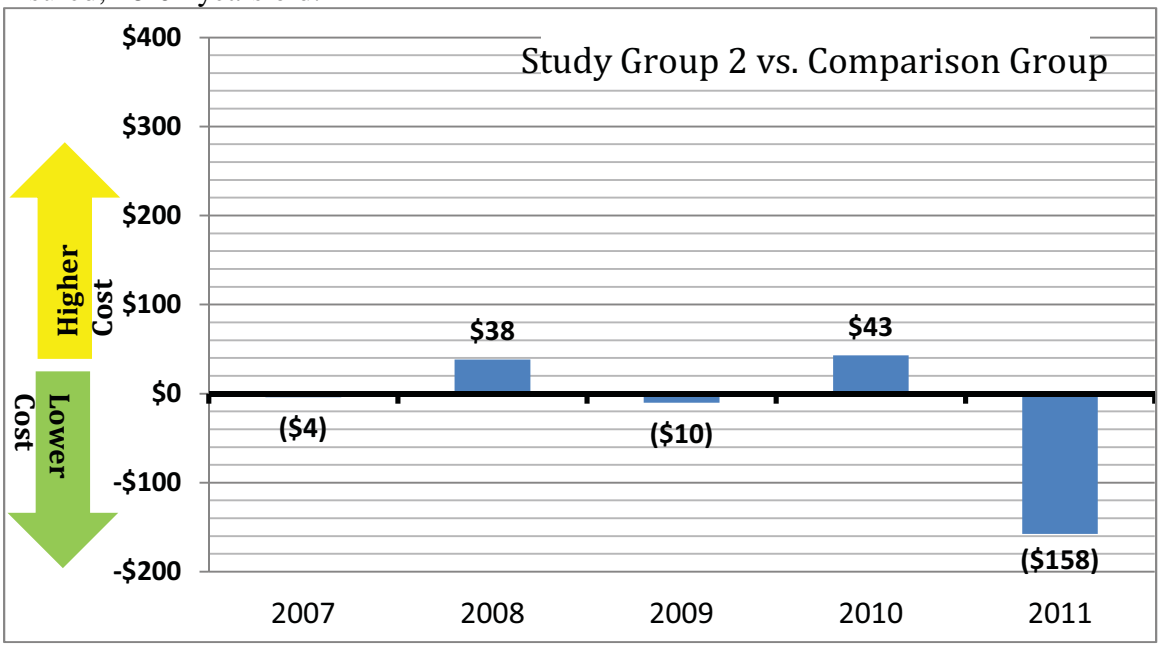


Figure 24. Difference in annual expenditures per capita (adjusted); commercially insured, 18-64 years old.



Similar patterns were observed in the Medicaid population. Initially, Study Group 1 had per person expenditures that were $623 higher than the Comparison Group (Figure 25). By 2011 per person expenditures for Study Group 1 were $197 lower than the Comparison Group. Study Group 2 per person expenditures were initially $1067 more than the Comparison Group, a gap that was narrowed to $621 by 2011 (Figure 26). In each case, the Study Groups were able to gain ground compared to the Comparison

Groups, either by lowering the cost gap or by dropping below the per person expenditures of the Comparison Group.

Figure 25. Difference in annual expenditures per capita (adjusted); Medicaid population, 18-64 years old.

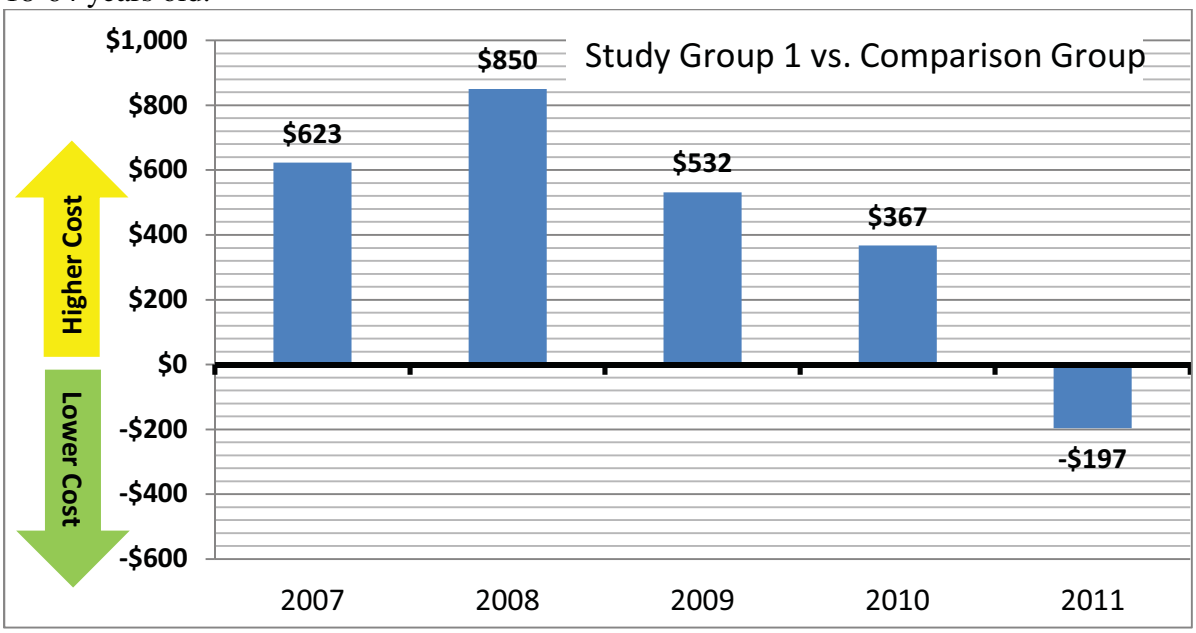
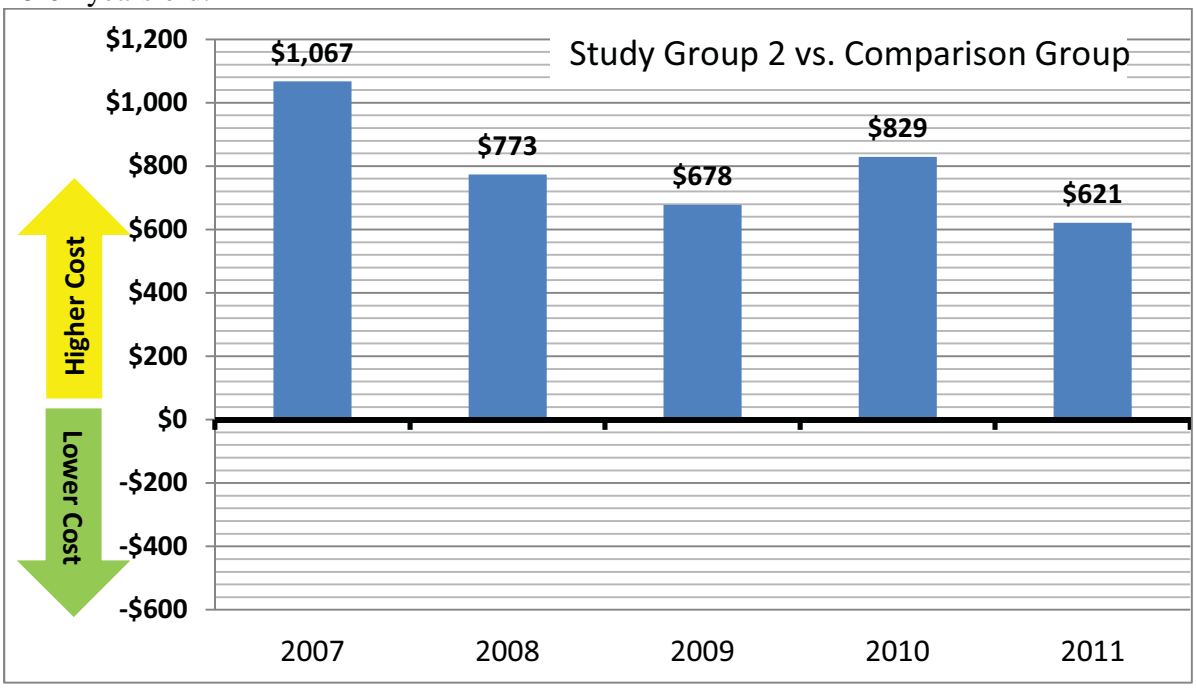


Figure 26. Difference in annual expenditures per capita (adjusted); Medicaid population, 18-64 years old.



Acute Episodic Care. Rates of Hospital Inpatient Discharges and Emergency Department Visits are used as measures of acute episodic care. The annual rate of hospitalizations (Inpatient Discharges per 1000 people) is shown for the commercially insured population ages 18-64 years old (Figure 27), and for the Vermont Medicaid-insured population ages 18-64 years (Figure 28). In the commercially insured population, rates of hospital discharges were growing from 2007 to 2009. Growth rates slowed from 2008 to 2009, and subsequently declined for both Study Groups and the Comparison Group between 2009 and 2011. Trends in hospitalization rates were generally more favorable for the Blueprint Study Groups over time and in 2011. The Medicaid population, which started with substantially higher rates, showed a steady decline through 2010. From 2010 to 2011, hospitalization rates trended upward across all 3 groups, with the highest rate of increase in the non-Blueprint Comparison Group.

By the end of the study period in 2011, hospitalization rates were lower in the Blueprint Study Groups than the Comparison Groups for both the commercial and Medicaid Populations. Commercially insured patients in Study Group 1 had significantly lower hospitalization rates (43.4/1000) than the Comparison Group (50.4/1000). Study Group 2 also had a lower rate (49.0/1000) than the Comparison Group, although the difference was not statistically significant. Medicaid beneficiaries demonstrated a similar pattern. Study Group 1 had a significantly lower hospitalization rate (117.9/1000) than the Comparison Group (153.6/1000). The hospitalization rate for Study Group 2 (149.6/1000) again was lower than the Comparison Group, but the difference was not statistically significant. It is important to note that in 2011, Study Group 2 was in the first year of Blueprint operations after the start-up year, while Study Group 1 was in the third year after the start-up year.

Figure 27. Inpatient discharges per 1000 beneficiaries (adjusted); commercially insured, 18-64 years old.

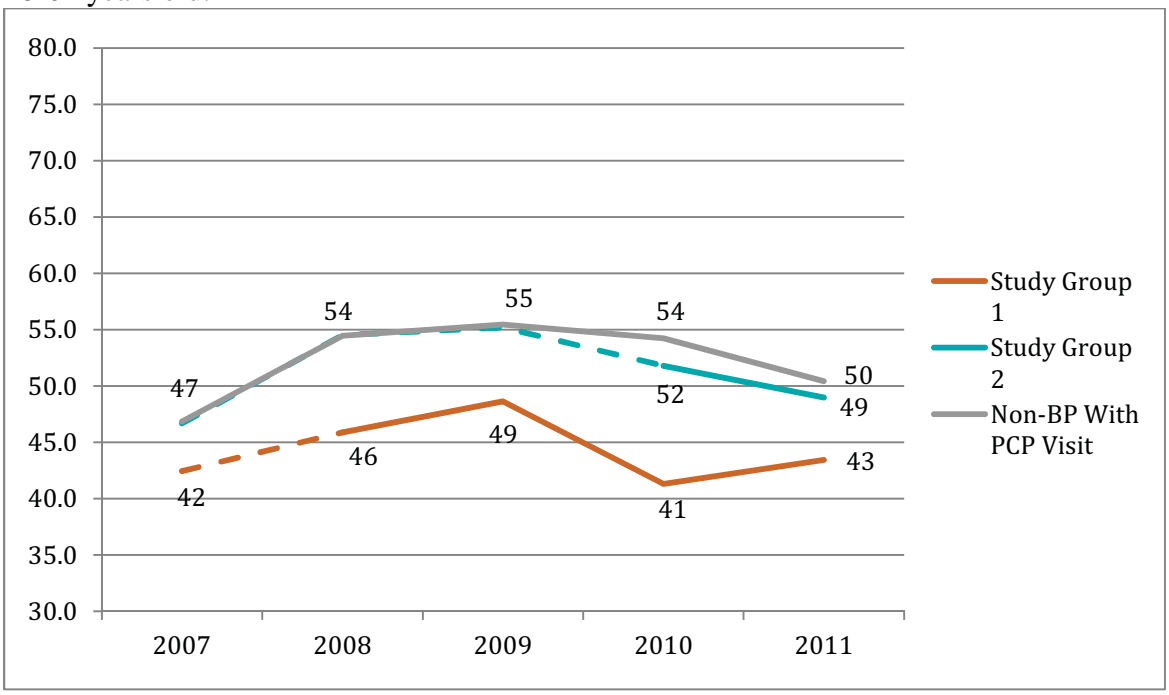
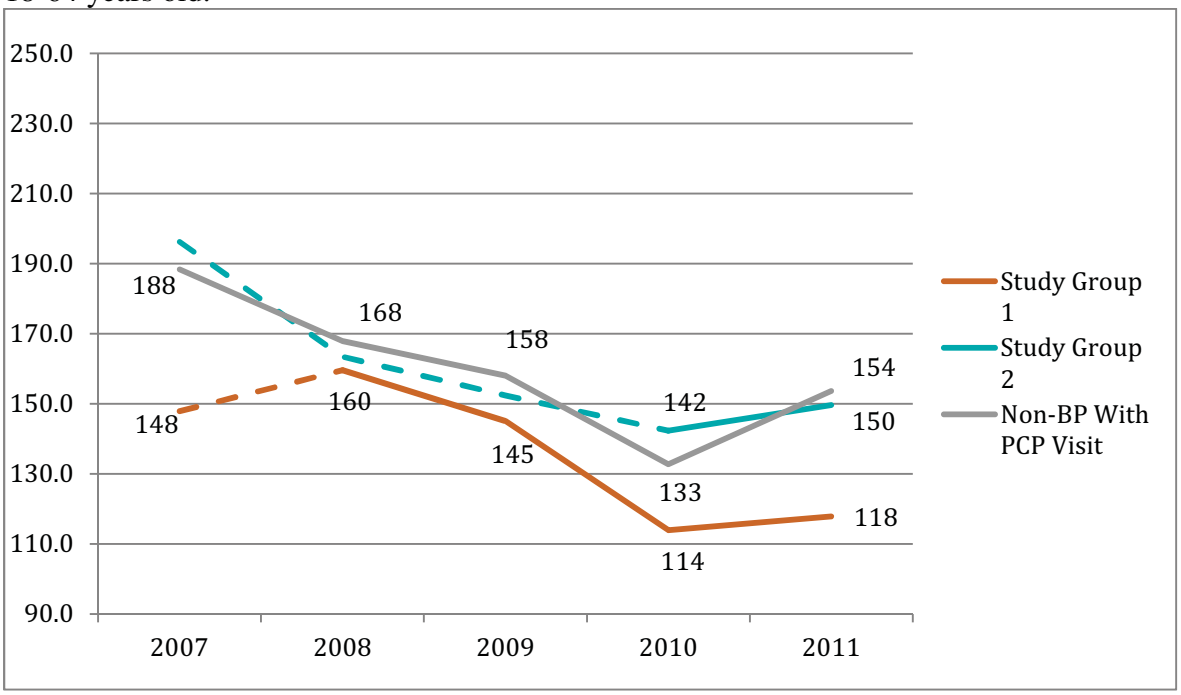


Figure 28. Inpatient discharges per 1000 beneficiaries (adjusted); Medicaid population, 18-64 years old.



The difference between the Study Groups and Comparison Groups, in the rate of inpatient hospital discharges per 1000 beneficiaries, is presented below in Figures 29-32. Generally, these results suggest that Blueprint Study Groups were able to maintain lower hospitalization rates and in some cases widen the gap with the Comparison Groups. In the Commercial population, Study Group 1 initially had 4.4 fewer hospitalizations than the Comparison Group. This difference tended to increase during the next four years with Study Group 1 having 7.0 fewer hospitalizations per 1000 in 2011 (Figure 29). From 2007 to 2009, Study Group 2 had similar hospitalization rates as the Comparison Group, and subsequently trended towards lower rates with 2.4 fewer in 2010 and 1.4 fewer in 2011 (Figure 30). In the Medicaid population, Study Group 1 had lower rates than the Comparison Group across all years (Figure 31). Interestingly, this difference was much greater in 2007 (-40.5) than 2008 (-8.2). After 2008, Study Group 1 steadily widened the difference, achieving a rate in 2011 that was 35.8 per 1000 lower than the Comparison Group. In the Medicaid population, Study Group 2 showed a variable trend from 2007 through 2011, with higher rates than the Comparison Group in 2007 and 2010 (Figure 32). During the first year of operations, from 2010 to 2011, Study Group 2 showed a shift from a rate that was 9.6 higher to a rate that was 4.0 lower than the Comparison Group. A longer study period will be needed to determine if this favorable trend is sustained.

Figure 29. Difference in inpatient discharges per 1000 (adjusted); commercially insured, 18-64 years old.

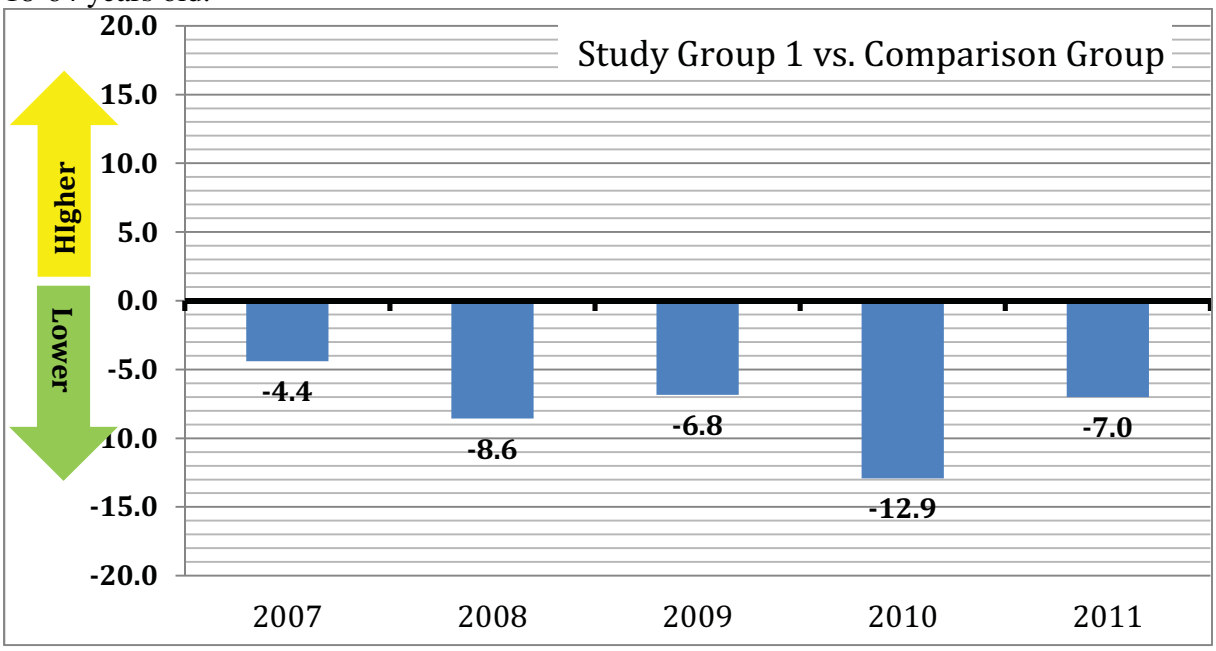


Figure 30. Difference in inpatient discharges per 1000 (adjusted); commercially insured, 18-64 years old.

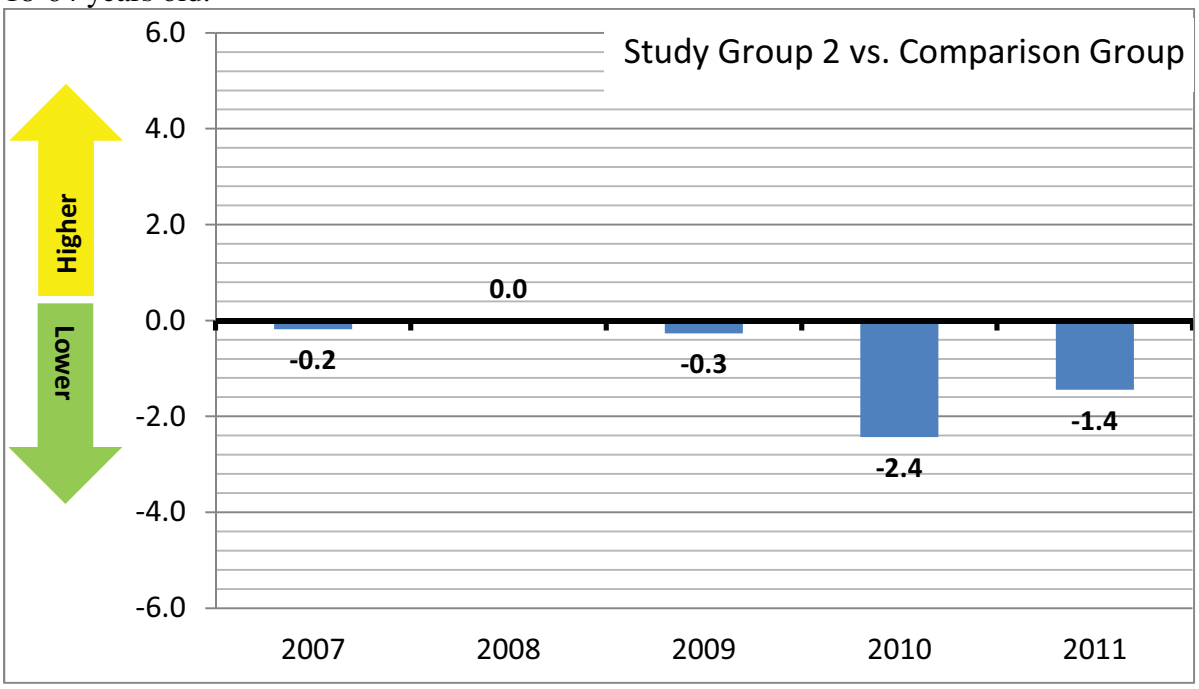


Figure 31. Difference in inpatient discharges per 1000 (adjusted); Medicaid population, 18-64 years old.

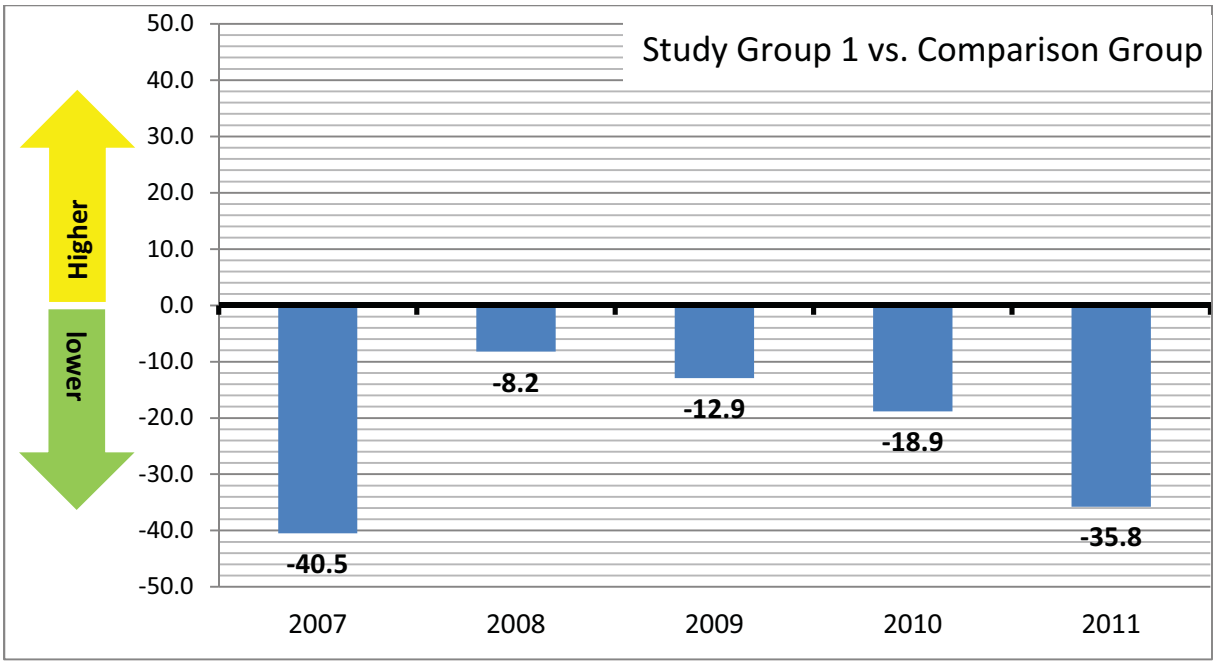
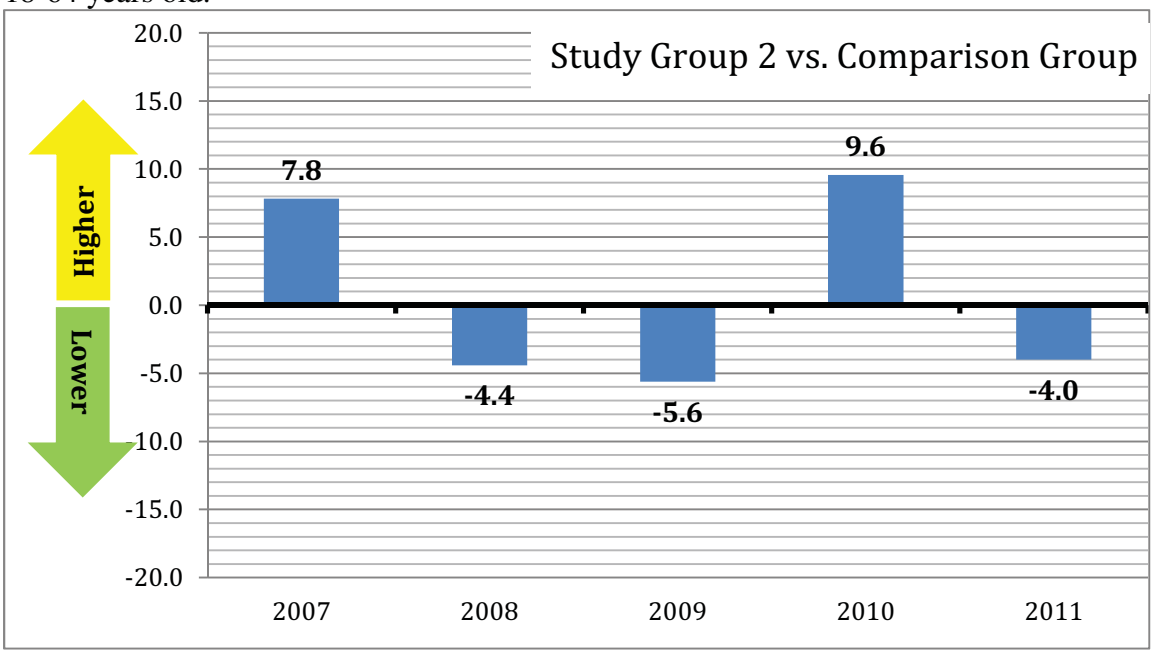


Figure 32. Difference in inpatient discharges per 1000 (adjusted); Medicaid population, 18-64 years old.



A potential anomaly in the emergency department (ED) utilization data has made it difficult to discern whether clear trends are emerging. In the commercially insured population, both Blueprint Study Groups had a plateauing or decreasing trend from 2008 through 2010. A favorable pattern continued from 2010 to 2011 for Study Group 2 (0.2% decrease) vs. the Comparison Group (3.6% increase), but not for Study Group 1,

for which the trend reversed with an unexplained 26.9% increase. In the Medicaid population, from 2009 to 2010, both Study Groups and the Comparison Group showed a decrease in their previously growing ED visit rates. From 2010 to 2011, Study Group 2 held relatively level (0.8% increase) vs. the Comparison Group (7.6% increase), while Study Group 1 again had an unexplained 25.7% increase.

This sharp and uncharacteristic change from 2010 to 2011 for Study Group 1 was inconsistent with overall ED utilization patterns, raising questions regarding the cause of the change in claims activity. Further evaluation revealed that the increase occurred suddenly, with more than a doubling of claims for ED visits in the St. Johnsbury area in one month (September 2010 to October 2010). The new higher monthly rate persisted through 2011. Specifically, there were increasing counts of emergency room facility codes, including all codes except non-complex evaluation. Discussions with Northeastern Vermont Regional Hospital (NVRH) revealed that there were no structural changes or increases in emergency department capacity at the hospital, as well as no large increase in the workers' compensation population, the number of providers, large new employers, or large staffing increases in existing employers. There was also no specific finding in the patterns of diagnosis or revenue codes to explain the sudden increase. In contrast to the claims data, the hospital reported that data from medical records showed an overall decrease of 7% for ED utilization between 2010 and 2011. The degree of change in the rate of ED visits measured by claims data, which ran counter to the hospital's medical records data, raised the question of whether coding or billing practices may have changed between September 2010 and October 2010. NVRH reported that coding and billing patterns did change at this time, as a result of the prior closure of a walk-in space for urgent care visits that had been physically embedded in the ED. Despite this change, the claims data did not show a shift from urgent care codes to ED codes that would explain such a large increase in the monthly rate of ED visits in October 2010.

At the time that this report was being finalized, there was no acceptable explanation for this large increase in the rate of ED visits in the claims data; it is not consistent with the overall multiyear trend for St. Johnsbury, or with the hospital's own data that shows a continued decline in ED visits in 2011. Without an explanation, it is possible that the St. Johnsbury data may not reflect actual utilization. For this reason, the decision was made to remove the St. Johnsbury data from Study Group 1 on the ED visit rate charts until the findings can be explained and either confirmed or adjusted as appropriate.

ED visit rates are shown below for the commercially insured (Figure 33) and Medicaid populations (Figure 34). As described above, Study Group 1 does not include St. Johnsbury data on these two charts. This reduces the number of patients in Study Group 1 (for this analysis only), and increases the influence that a smaller number of ED visits may have on rates. Charts showing the year to year differences between Study and Comparison Groups are not included due to the data limitations. In the commercially insured population, Study Group 1 (Burlington only) maintained a lower rate than the Comparison Group from 2007 through 2011. The gap between the two groups tended to widen from 2008 through 2011 as Study Group 1 had a small decline in the rate and the

Comparison Group had a small increase. Study Group 2 had higher ED visit rates than the Comparison Group throughout the study period, but tended to follow a similar trend as Study Group 1, with a small decline in the rate from 2010 to 2011. In the Medicaid population, Study Group 1 (Burlington only) showed a decline in the rate of ED visits from 2009 forward, dropping below the Comparison Group and widening the gap from 2010 to 2011. The Study Group 2 rate decreased from 2009 to 2011 (from 905 to 881 visits per 1000), while the Comparison Group rate increased from 773 to 803 visits per 1000. Although certain aspects of these trends appear favorable for the Study Groups, ED visit rates have remained relatively stable overall, and may represent an opportunity for improvement through improved same day access in an advanced primary care environment.

Figure 33. Emergency department visits per 1000 beneficiaries (adjusted); commercially insured, 18-64 years old

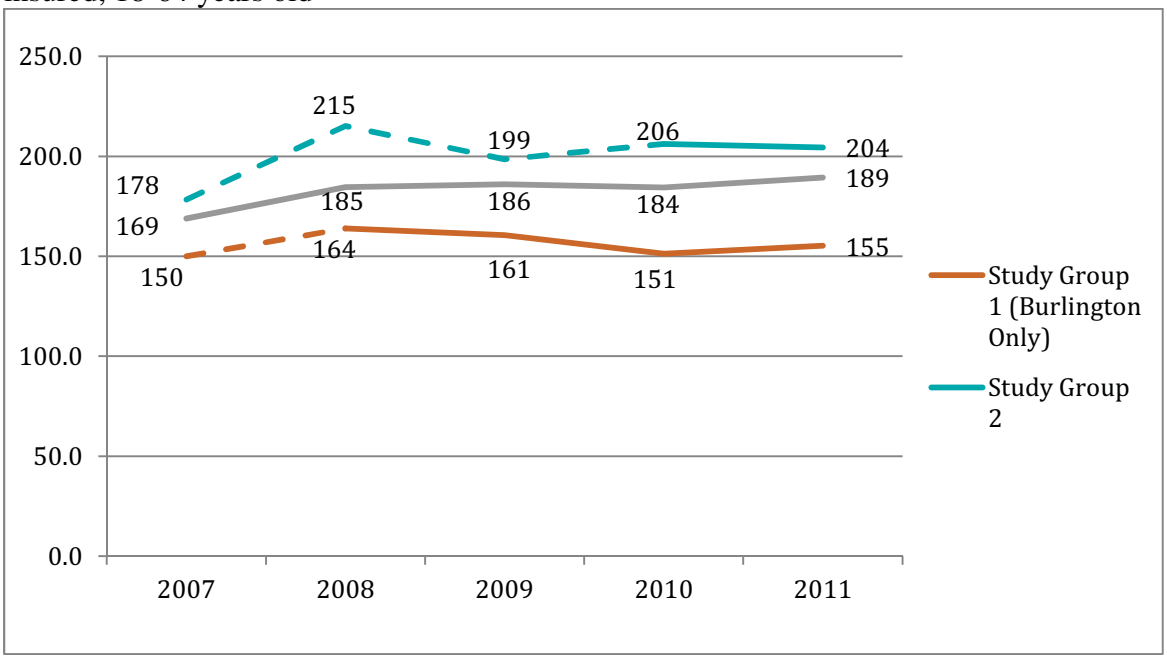
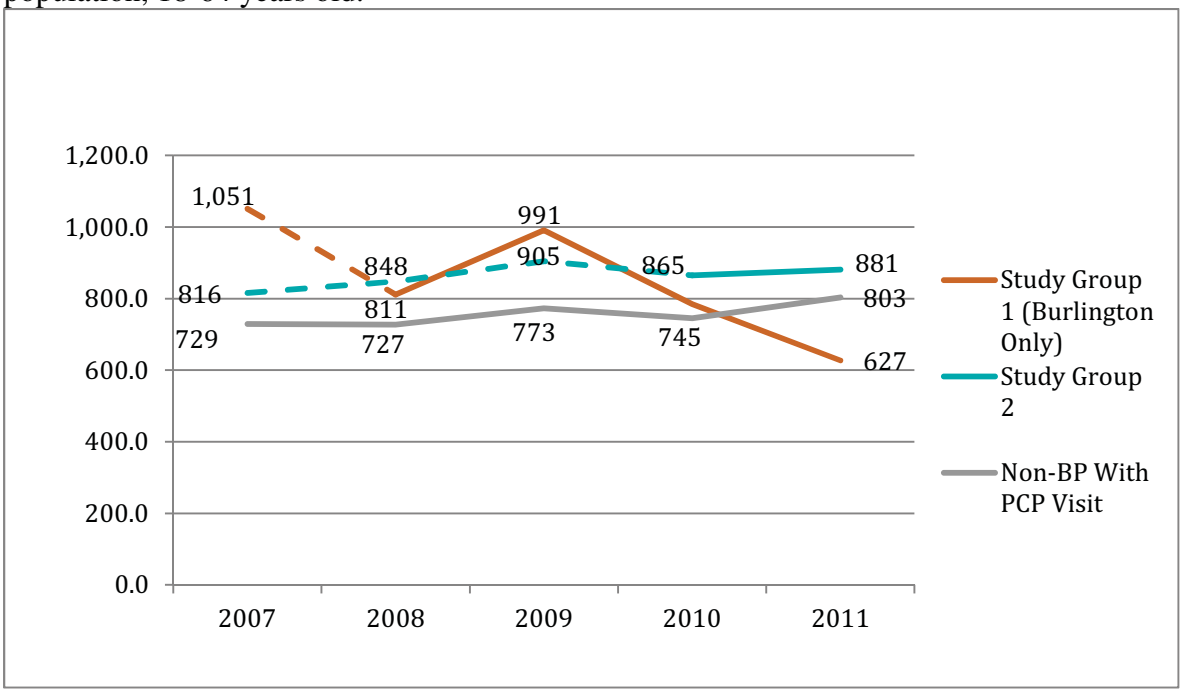


Figure 34. Emergency department visits per 1000 beneficiaries (adjusted); Medicaid population, 18-64 years old.



Effective and Preventive Care. This section presents examples of claims-based HEDIS® measures that are used to evaluate the rates at which patients receive effective and preventive care, including recommended assessments for diabetes care, breast cancer screening, and cervical cancer screening. Standard HEDIS® definitions are used for generating these measures using claims data only. Chart audits are not used as part of this analysis.

Overall, the results for patients with diabetes suggest favorable trends for Blueprint Study Groups in both the commercial and Medicaid populations. In the commercially insured population, Study Group 2 had higher rates of HbA1c testing than the Comparison Group across all 4 years (Figure 35). Although Study Group 1 had lower rates than the Comparison Group, this Study Group improved at a more rapid pace than the Comparison Group between 2008 and 2010, narrowing the initial performance gap between the two groups. In the Medicaid population, Study Groups 1 and 2 maintained higher rates of HbA1c testing than the Comparison Group throughout the study period (Figure 36). It is notable that both Medicaid Study Groups maintained HbA1c testing rates (~90%) as high as the best performing group from the commercial sector (i.e., Study Group 2).

Figure 35. Comprehensive Diabetes Care (HEDIS®)-HbA1c Testing; commercially insured, 18-64 years old.

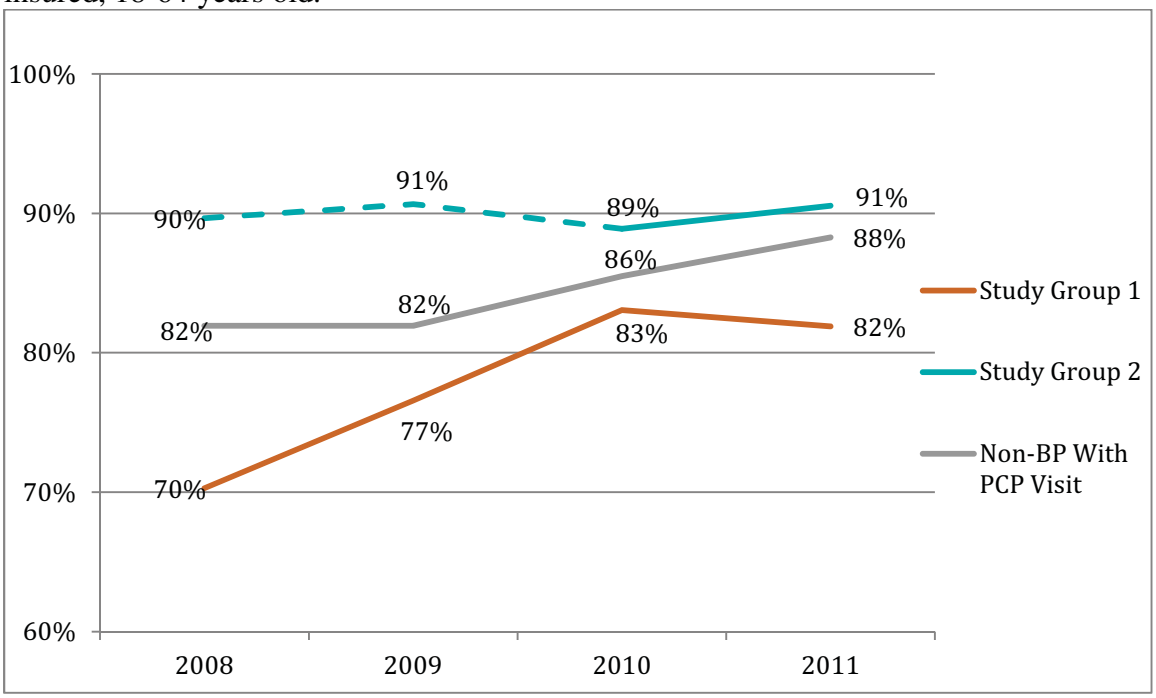
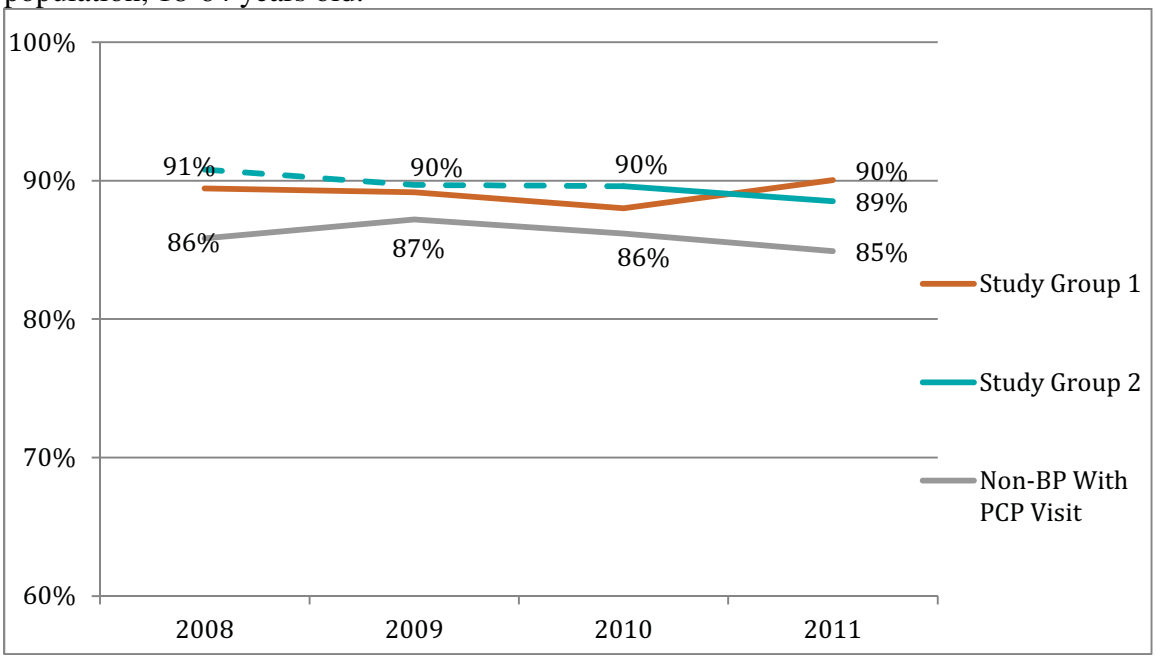


Figure 36. Comprehensive Diabetes Care (HEDIS®)-HbA1c Testing; Medicaid population, 18-64 years old.



From 2008 through 2011, the rate at which patients with diabetes had eye exams declined in all groups except for Study Group 1 in the commercially insured population, a finding that warrants further investigation and may represent an opportunity for improvement. In the context of this overall decline, Blueprint Study Groups tended to perform better than Comparison Groups. In the commercially insured population, Study Groups 1 and 2 maintained higher rates of eye exams across all 4 years, with Study Group 1 improving its comparative standing against the Comparison Group (Figure 37). In the Medicaid population, Study Groups 1 and 2 also maintained higher eye exam rates than the Comparison Group throughout the 4 year period, with both groups tending to widen the gap between themselves and the Comparison Group (Figure 38). Similar to HbA1c testing, the rate of eye exams in the Medicaid diabetic population was comparable to the rate in the commercial population.

Figure 37. Comprehensive Diabetes Care (HEDIS®)-Eye Exam; commercially insured, 18-64 years old

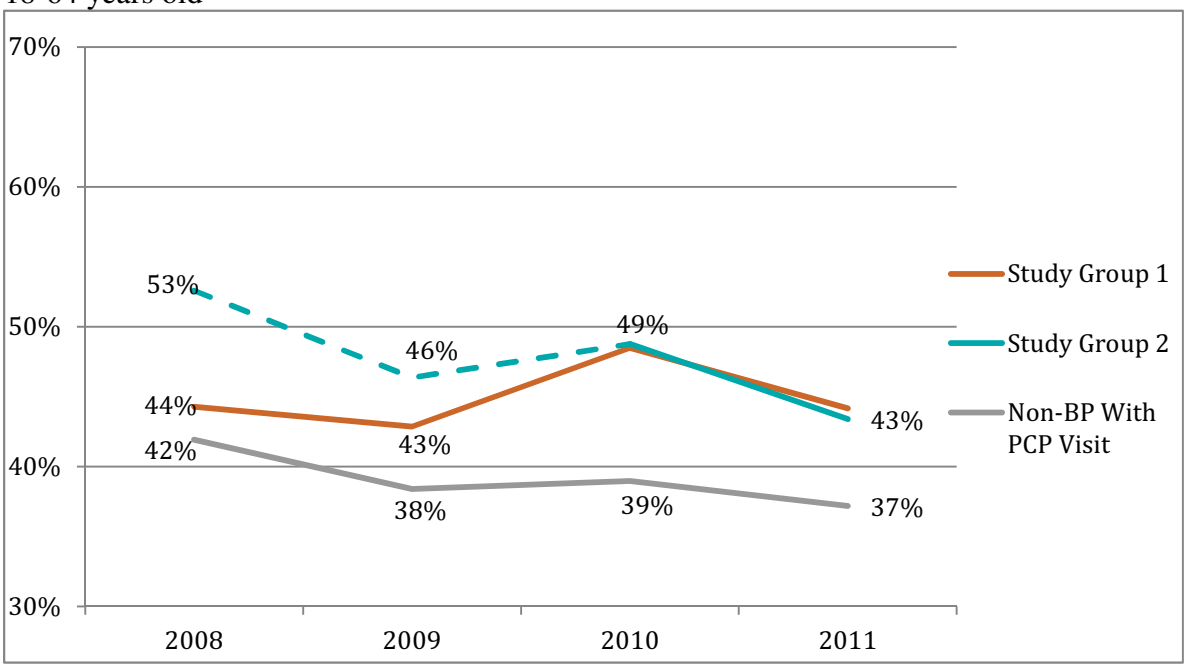
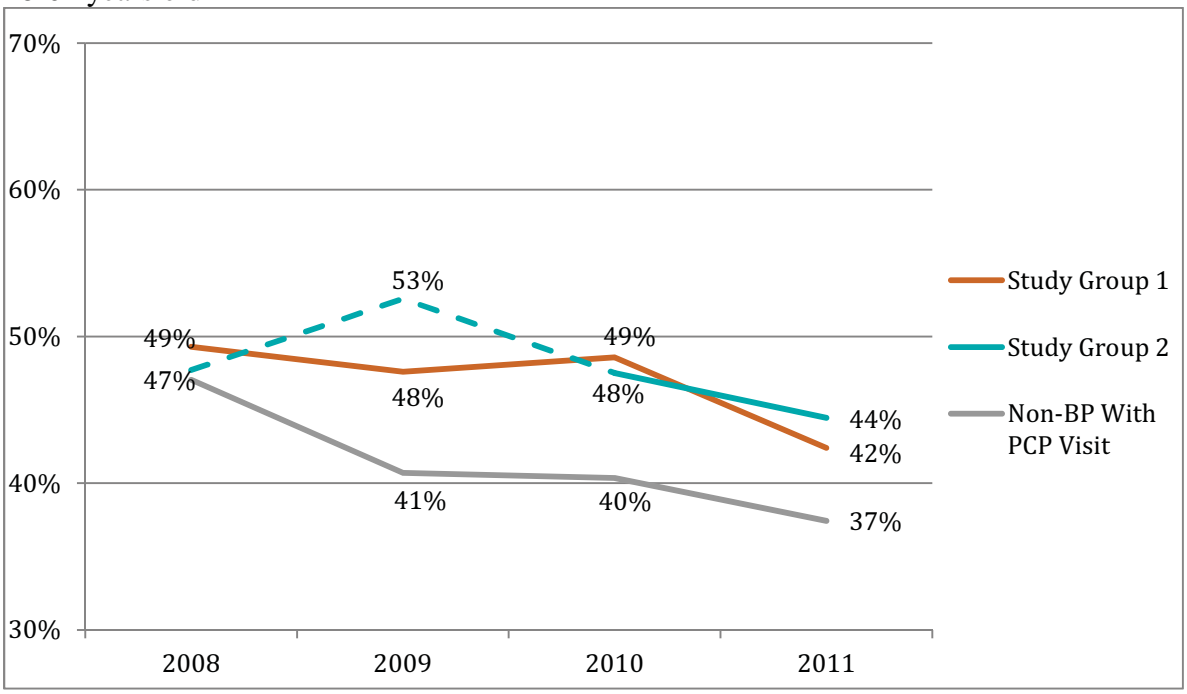


Figure 38. Comprehensive Diabetes Care (HEDIS®)-Eye Exam; Medicaid population, 18-64 years old



From 2007 through 2011, the rate of breast cancer screening declined in all groups, a finding that also warrants further investigation to determine whether this is an opportunity for improvement, or reflective of an intentional change in practice patterns. In the context of this overall decline, Blueprint Study Groups tended to perform better than Comparison Groups. In the commercial population, both Study Groups maintained higher rates of screening across all years (Figure 39). In 2011, the rate of breast cancer screening in the two Study Groups was significantly higher than the Comparison Group (81% vs. 75%). Both Medicaid Study Groups also maintained higher rates of screening throughout the 4-year period, although the difference in 2011 did not reach statistical significance (61% vs. 56%, Figure 40). From 2008 to 2009, Study Group 1 showed early improvement relative to the Comparison Group that was maintained over the next two years. In contrast to diabetes testing, breast cancer screening rates in the Medicaid population are substantially lower than the commercial population.

Figure 39. Breast Cancer Screening (HEDIS®); commercially insured, 42-64 years old

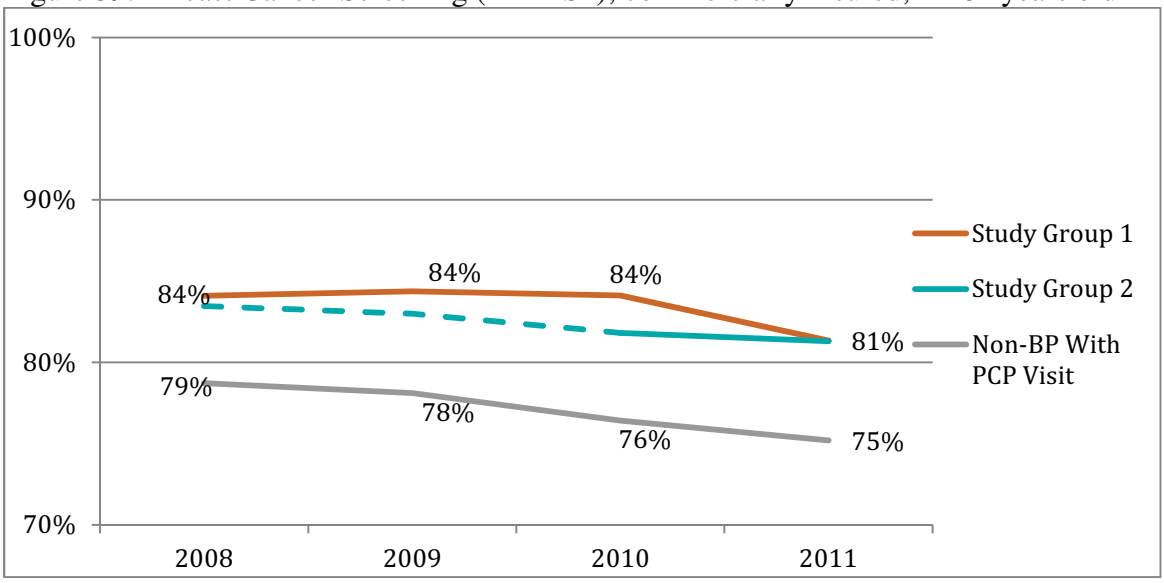
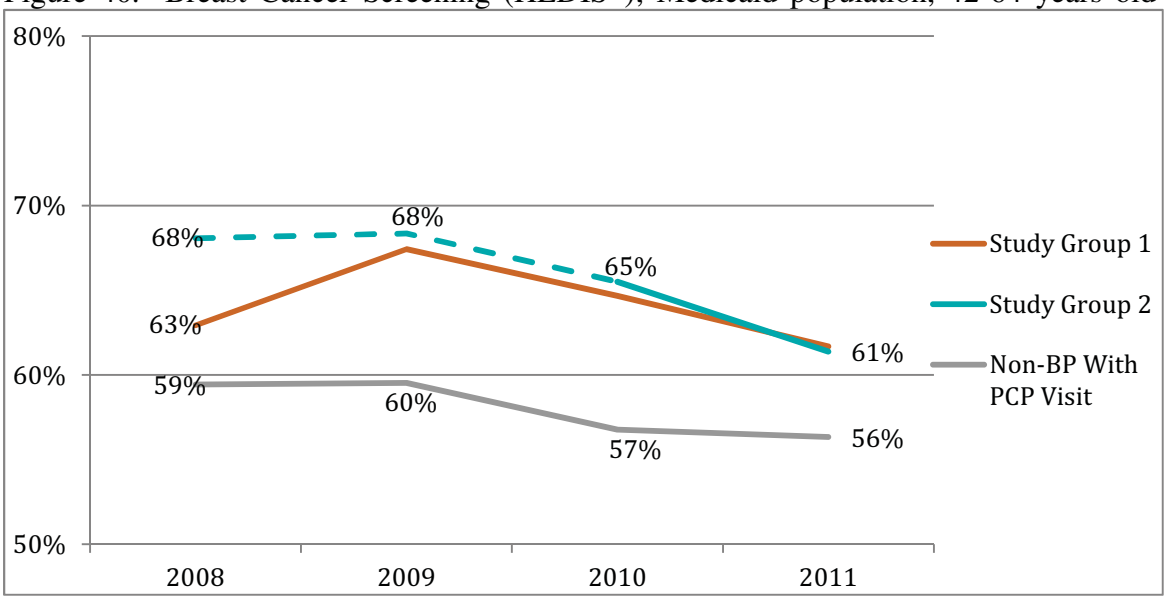


Figure 40. Breast Cancer Screening (HEDIS®); Medicaid population, 42-64 years old



Rates of cervical cancer screening showed trends that were similar to breast cancer screening, with a decline in all groups from 2008 through 2011. In the context of this overall decline, Blueprint Study Groups tended to perform better than Comparison Groups in the commercial and Medicaid populations. In the commercially insured population, both Study Groups maintained higher rates throughout, with Study Group 2 showing improvement relative to the other two groups (Figure 41). In 2011, both commercial Study Groups had screening rates (76% and 75%) that were significantly higher than the Comparison Group (72%). Both Medicaid Study Groups also maintained higher rates of screening than the Comparison Group, with significantly higher rates in in 2011 (66% vs. 58%, Figure 42). As with breast cancer screening, cervical cancer screening rates were not as high in the Medicaid population as in the commercial population.

Figure 41. Cervical Cancer Screening (HEDIS®); commercially insured, 24-64 years old

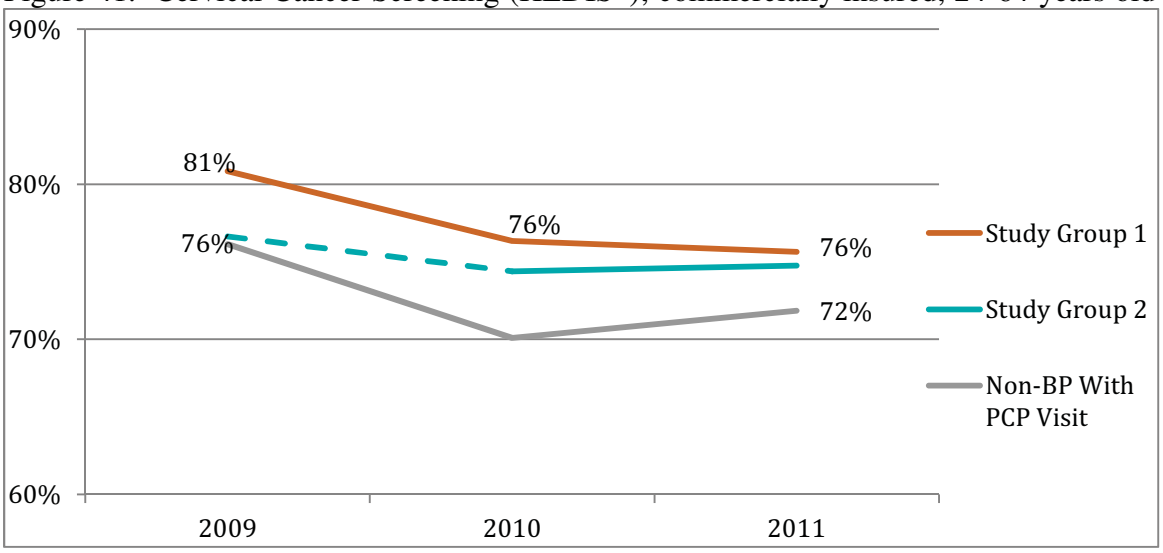
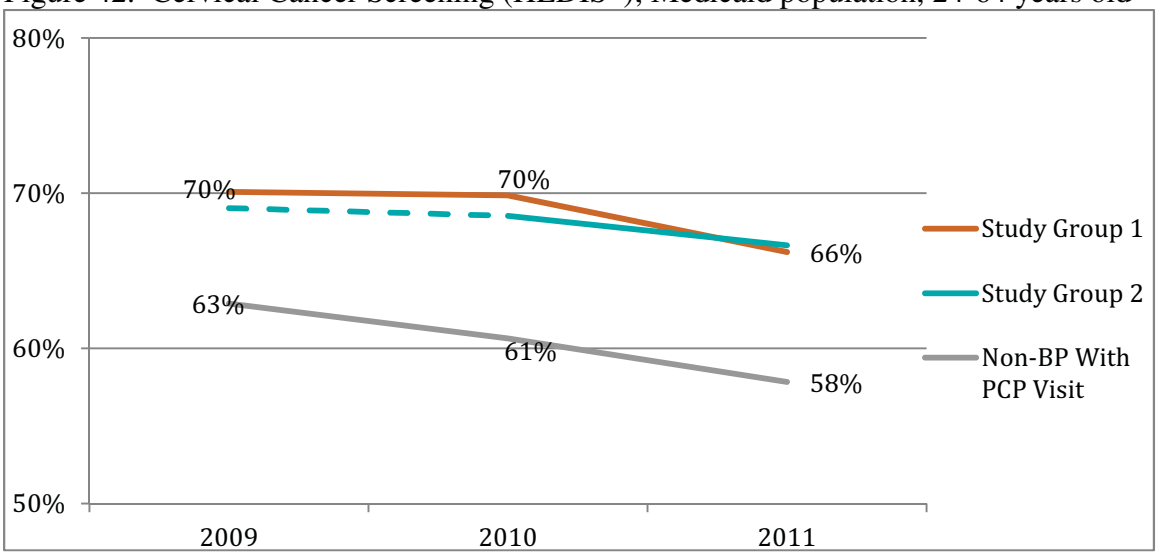


Figure 42. Cervical Cancer Screening (HEDIS®); Medicaid population, 24-64 years old



Summary. The evaluation results provide a view of changing healthcare patterns over a period of 5 years, comparing Blueprint Study Groups to non-Blueprint Comparison Groups. The number of Blueprint patients included in this analysis is limited to 18 practices in order to allow a minimum of one year of observation after initiation of Blueprint PCMH + CHT operations. The observed trends suggest that there are overarching influences driving similar patterns in Blueprint Study Groups and Comparison Groups. Some of the overarching trends, such as reductions in the growth of healthcare expenditures per person, are encouraging. Other results, such as an overall reduction in the rate at which diabetic patients receive eye exams, suggest opportunities for improvement. Within these overarching patterns there are results that are indicative of favorable trends for Blueprint Study Groups for several measures in each domain (healthcare expenditures, acute episodic care, and effective and preventive care). Table 4 presents a summary of these results.

Table 8. Summary & Key Findings

Overall Results	There appear to be overarching influences driving similar trends in the Blueprint Study Groups and Comparison Groups.
	Some overarching trends are favorable (e.g., slowing in the growth of healthcare expenditures and hospitalization rates). Other results suggest opportunity for improvement (e.g., rates of emergency department visits and eye exams for diabetics).
Blueprint Results	Within these overarching trends there are some favorable trends for the Blueprint Study Groups vs. the Comparison Groups.
	Favorable trends for Blueprint Study Groups are evident across each major domain (i.e., healthcare expenditures, acute episodic care, effective and preventive care).
	In particular, for both the Commercial and Medicaid populations, the differences between Study and Comparison Groups are trending favorably for annual healthcare expenditures per capita (Figures 5 – 8), and the rate of inpatient discharges (Figures 11-14).
Caveats & Cautions	These results are early trends only and not conclusive in nature. In many cases the differences between the Study and Comparison Groups are not statistically significant.
	Detecting significant differences between Study and Comparison Groups is limited by a relatively small number of patients and results that vary widely within each group.
	The number of patients in the Study Groups is limited because only 18 practices had at least one year of operations through December 2011, the limit of available data.
	Detecting significant differences between Study and Comparison Groups is further limited due to the overarching influences driving similar trends in the general population.
	A potential overarching influence is the economic downturn that occurred during the study period, resulting in trends that may change as the economic recovery strengthens.

The results as presented should not be interpreted as definitive or conclusive evidence of the impact of the Blueprint program. More conclusive data will become available as larger numbers of participants are included over a sufficient time period to observe changes in Study Groups relative to Comparison Groups. In addition, this analysis displays trends year by year. It does not address the cumulative impacts from Blueprint implementation, or whether the cumulative results across all years are significantly different for Blueprint Study Groups vs. Comparison Groups. A more complete analysis is underway to evaluate the cumulative change in these measures from pre-implementation to post-implementation time periods, accounting for a number of variables, including the number of years that each practice contributes to the pre-implementation and post-implementation time periods. The difference between Blueprint and Comparison practices in post-implementation years will be compared to the

difference between Blueprint and Comparison practices in pre-implementation years. The results from this "Difference in Differences" analysis will suggest whether Blueprint participants have gained or lost ground for each measure from the pre-implementation to post-implementation years. This more complex analysis will be presented in a subsequent report.

8. APPENDICES

8.a. APPENDIX A - Blueprint Budget for Fiscal Year 2012

	Description	SFY'12
STAFFING		
	Staffing 7 FTE	$ 709,320
	Sub-Total: Salaries and Benefits	**$ 709,320**
OPERATING		
	Operating:	
	In-state travel (20K miles each @ $.50/mile)	$ 70,000
	Out-of-state travel	$ 9,615
	Laptops & work stations Software	$ 21,000
	Telephone-equip	$ 1,400
	Q/data/telephone	$ 6,720
	Space and overhead	$ 70,000
	Supplies Allowance	$ 17,500
	Sub-Total: Operating	**$ 196,235**
	Total Salaries and Operating	**$ 905,555**
Grant	HSA Grants	$ 1,498,344
	Sub-Total: HSA Grants	**$ 1,498,344**
Contracts	Practice Facilitation Training	$ 100,000
Contract	Practice Facilitators	$ 320,000
	Sub-Total: Facilitators	**$ 420,000**
Grant	NVRH ADAP	$ 27,500
Grant	FAHC ADAP	$ 55,000
Grant	CVHC ADAP	$ 55,000
Grant	Evaluation (VCHIP)	$ 995,615
Grant	Elderly Services	$ 10,300
Contract	Expanded Financial Modeling (LCCM)	$ 90,000
Grant	Congestive Heart Failure (FAHC)	$ 115,000
Contract	Informational Documents	$ 20,000
Contract	BP Annual Conference (UVM)	$ 18,500
MOU	VDH	$ 80,000
Grant	Rural Health Alliance (Bi-State)	$ 95,000
	Sub-Total: other	**$ 1,561,915**
	Sub-Total: Grants Contracts and other	**$ 3,480,259**
Total Blueprint budget to actuals		**$ 4,385,814**
Transferred BUDGET		**$ 4,915,487**
ADAP Funding TSF		**$ 165,000**
TOTAL BUDGET		**$ 5,080,487**

8.b. APPENDIX B – Blueprint Staff, Committees and Meeting Schedules

Blueprint Staff

Craig Jones, MD Executive Director (802) 879-5988 craig.jones@state.vt.us	**Beth Tanzman, MSW** Assistant Director, Mental Health and Substance Abuse (802) 872-7538 beth.tanzman@state.vt.us
Lisa Dulsky Watkins, MD Associate Director (802) 872-7535 lisa.watkins@state.vt.us	**Nick Lovejoy** Data Manager & Analyst (802) 872-7533 nick.lovejoy@state.vt.us
Pat Jones, MS Assistant Director, Payment Implementation (802) 872-7524 pat.jones@state.vt.us	**Diane Hawkins** Executive Administrative Assistant (802) 879-5988 diane.hawkins@state.vt.us
Jenney Samuelson, MS Assistant Director, Quality Improvement (802) 872-7532 jenney.samuelson@state.vt.us	**Terri Price** Administrative Assistant, Self-Management Coordinator (802) 872-7531 terri.price@state.vt.us

Physical location/mailing address/fax number: Vermont Blueprint for Health
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495
(802) 879-5962 fax

Blueprint Executive Committee

Craig Jones, MD, Executive Director, Blueprint for Health, Chair
Bea Grause, Executive Director, VT Association of Hospitals & Health Systems, Co-Chair
Mark Larson, Commissioner, Department of Vermont Health Access
Senator Claire Ayer, Vermont State Senator
Hunt Blair, Deputy Commissioner, Division of Health Reform and State Health Information Technology Coordinator, Dept. of Vermont Health Access
Angela Rouelle, Department of Information and Innovation Designee, State of Vermont
Harry Chen, M.D., Commissioner, Vermont Department of Health
Tracy Dolan, Deputy Commissioner, Vermont Department of Health, Alternate
Peter Cobb, Director, Vermont Assembly of Home Health Agencies
David Cochran, CEO and President, Vermont Information Technology Leaders (1/2012 – 10/2012)
John Evans, CEO and President, Vermont Information Technology Leaders (11/2012 – Present)
Esther Emard, RN, Chief Operating Officer, NCQA
Jaskanwar S. Batra, MD, Medical Director, Vermont Department of Mental Health
Don George, President and CEO, Blue Cross Blue Shield of Vermont
Paul Harrington, Executive Director, Vermont Medical Society
Jim Hester, CMS Center for Innovation
Steve Kimbell, Commissioner, BISHCA
William Little, Vice President, Vermont/New Hampshire MVP Health Care
Susan Gretkowski, Senior Government Affairs Strategist, MVP Health Care, Alternate
Charles MacLean, MD, Professor of Medicine, Research Director AHEC Program & Office of Primary Care, University of Vermont College of Medicine
Suzanne Santarcangelo, PhD, Director Health Care Operations, Agency of Human Services, State of Vermont
Richard Slusky, Director of Payment Reform, State of Vermont
Deborah Wachtel, NP, MPH, Vice President, Vermont Nurse Practitioner Association
Bill Warnock, ND, Naturopathic Physician
Nicole Wilson, Assistant Director, State Employee Benefits
Nancy Eldridge, Executive Director, Cathedral Square Corporation
Allan Ramsay, MD, Member of the Green Mountain Care Board
Catherine Fulton, Executive Director, VPQHC
Patrice Knapp, Director of Quality Management, VPQHC, Alternate
Judy Peterson, President and CEO, VNA of Chittenden and Grand Isle Counties (7/2012 – Present)

2013 meeting schedule available at http://dvha.vermont.gov/advisory-boards/12013-bp-executive-comm.pdf

Blueprint Expansion Design and Evaluation Committee

Allan Ramsay, MD, Green Mountain Care Board
Amy James, Blue Cross Blue Shield Vermont
Ani Hawkinson, ND, Naturopathic Physician
Jaskanwar S. Batra, MD, Medical Director, Vermont Department of Mental Health
Terry Bequette, Department of Vermont Health Access
Beth Hallock Steckel, Fletcher Allen Health Care
Hunt Blair, Department of Vermont Health Access
Kathleen Browne, Department of Vermont Health Access
Cathy Fulton, VPQHC
Charles MacLean, MD, UVM College of Medicine
Dana Noble, United Health Alliance, Bennington
Deborah Wachtel, VT Nurse Practitioner Association
Dian Kahn, BISHCA
Don Curry, CIGNA
Jenney Samuelson, Vermont Blueprint for Health
Nick Lovejoy, Vermont Blueprint for Health
Don George, Blue Cross Blue Shield Vermont
Esther Emard, NCQA
LaRae Francis, Gifford Medical Center
Geera Butala, Blue Cross Blue Shield Vermont
Bard Hill, State of Vermont
James Mauro, Blue Cross Blue Shield Vermont
Jeannette Flynn-Weiss, MVP Health Care
John Brumsted, MD, Fletcher Allen Health Care
Craig Jones, MD, Vermont Blueprint for Health
Pat Jones, Vermont Blueprint for Health
Joyce Dobbertin, Corner Medical
Judy Peterson, VNA
Judith Shaw, University of Vermont
Julie Trottier, Milbank Memorial Fund
Kate Simmons, Bi-State Primary Care Association
Kelly Smith, Blue Cross Blue Shield Vermont
Kevin Ciechon, CIGNA
Larry Goetschius, Addison County Home Health and Hospice
Kevin Cooney, Northern County Health Care
Linda Leu, Blue Cross Blue Shield Vermont
Victoria Loner, Department of Vermont Health Access
Lou McLaren, MVP Health Care
Steven Maier, Department of Vermont Health Access
Marietta Scholten, MD, APS Health Care
Michael Mcadoo, Department of Vermont Health Access
Michael Hartman, APS Health Care

Blueprint Expansion Design and Evaluation Committee (continued)

Neil Sarkar, University of Vermont
Pam Biron, Blue Cross Blue Shield Vermont
Patty Launer, Bi-State Primary Care Association
Paul Harrington, Vermont Medical Society
Paul Reiss, MD, Independent Physician
Peter Cobb, Vermont Assembly of Home Health Agencies
Robert Wheeler, MD, Blue Cross Blue Shield Vermont
Laural Ruggles, Northeast Vermont Medical Center
Sarah Narkewicz, Rutland Regional Medical Center
Scott Frey, Blue Cross Blue Shield Vermont
Sharon Fine, MD, Northern Counties Health Care, Danville Health Center
Susan Gretkowski, MVP Health Care
Susan Ridzon, Blue Cross Blue Shield Vermont
Beth Tanzman, Vermont Blueprint for Health
Teresa Voci, Gifford Medical Center
Lisa Dulsky Watkins, MD, Vermont Blueprint for Health
William Little, MVP Health Care

2013 meeting schedule available at http://dvha.vermont.gov/advisory-boards/expansion-design-evaluation-work-group.

Blueprint Payment Implementation Work Group

Allan Ramsay, MD, Green Mountain Care Board
Amy James, Blue Cross Blue Shield Vermont
Ann Collins, CIGNA
Beth Steckel, Fletcher Allen Health Care
Beth Tanzman, Vermont Blueprint for Health
Candace Collins, Northwestern Medical Center
Christine Fortin, Northern County Hospital
Craig Jones, MD, Vermont Blueprint for Health
Dana Noble, United Health Alliance
David Brace, Community Health Services of Lamoille Valley
Elise McKenna, Morrisville
Fiona Daigle, Fletcher Allen Health Care
Gail McKenzie, Mount Ascutney Hospital and Medical Center
Jack Reilly, Mount Ascutney Hospital and Medical Center
Jacqueline Graham, Hewlett-Packard Company
James Mauro, Blue Cross Blue Shield Vermont
Jean Cotner, Porter Medical Center
Jeannette Flynn-Weiss, MVP Health Care
Jeffrey Ross, State of Vermont
Jenney Samuelson, Vermont Blueprint for Health
Jill Lord, Mount Ascutney Hospital and Health Center
Julie Riffon, North Country Hospital
Karla Wilson, Little Rivers
Kaylie Chaffee, Springfield Medical Center
Kevin Ciechon, CIGNA
LaRae Francis, Gifford Medical Center
Laural Ruggles, Northeastern Regional Hospital
Lisa Dulsky Watkins, MD, Vermont Blueprint for Health
Lori Collins, Department of Vermont Health Access, State of Vermont
Lou McLaren, MVP Health Care
Lynn Trepanier, Blue Cross Blue Shield Vermont
Marcie Hawkins, CIGNA
Mark Young, Central Vermont Medical Center
Michelle Patterson, Porter Medical Center
Nick Lovejoy, Vermont Blueprint for Health
Pam Biron, Blue Cross Blue Shield Vermont
Pat Jones, Vermont Blueprint for Health
Pat Knapp, Springfield Medical Center
Penrose Jackson, Fletcher Allen Health Care
Renee Kilroy, Northern Counties Health Care

Blueprint Payment Implementation Work Group (continued)

Richard Slusky, State of Vermont, Health Care Reform
Rita Pellerin, Fletcher Allen Health Care
Robert Wheeler, MD, Blue Cross Blue Shield Vermont
Sarah Narkewicz, Rutland Regional Medical Center
Scott Frey, Blue Cross Blue Shield Vermont
Sherry Bellimer, Mount Ascutney Hospital and Medical Center
Susan Gretkowski, MVP Health Care
Suzanne Peterson, Porter Medical
Terri Price, Vermont Blueprint for Health
Tracey Paul, North Country Hospital
Wendy Cornwell, Brattleboro Memorial Hospital
William Little, MVP Health Care, Vermont/New Hampshire

2013 meeting schedule available at http://dvha.vermont.gov/advisory-boards/payment-implementation-work-group.

Blueprint Provider Advisory Group

Charles MacLean, MD, Professor of Medicine, Research Director AHEC Program & Office of Primary Care, University of Vermont College of Medicine, Co-Chair
Lisa Dulsky Watkins, MD, Associate Director, Vermont Blueprint for Health, Co-Chair
Maureen Boardman, APRN, Little Rivers Health Care, Bradford
Bradley Berryhill, MD, Castleton Family Health, Community Health Centers of the Rutland Region
David Coddaire, MD, Morrisville Family Health Care, Community Health Centers of the Lamoille Valley
Joyce Dobbertin, MD, Corner Medical, Northeastern Vermont Regional Hospital
Jeremiah Eckhaus, MD, Montpelier Integrative Family Health, Central Vermont Medical Center
Sharon Fine, MD, Danville Health Center, Northern Counties Health Care
Paul Harrington, Executive Director, Vermont Medical Society
Sarah Kemble, MD, Chester Family Medicine, Springfield Medical Care Systems
John King, MD, Milton Family Practice, Fletcher Allen Health Care
Dana Kraus, MD, St. Johnsbury Family Health, Northern Counties Health Care
Robert Penney, MD, Burlington Primary Care, Primary Health Care Partners
Joshua Plavin, MD, Gifford Medical Center
Robert Schwartz, MD, Northshire Medical Center, Southwestern Vermont Medical Center
Melissa Volansky, MD, Stowe Family Practice, Community Health Centers of the Lamoille Valley
Norman Ward, MD, South Burlington Family Practice, Fletcher Allen Health Care
Richard White, MD, Mt. Ascutney Health and Hospital Corporation
Maja Zimmermann, MD, Addison Family Medicine, Porter Medical Center

2013 meeting schedule pending

Mental Health & Substance Abuse Advisory Committee

Peter Albert, LICSW, Sr.VP Government Relations & PrimariLink Retreat Health Care
Mark Ames, Network Coordinator, Vermont Recovery Network
Rick Barnett, Psy.D., LADC, President, Vermont Psychological Association
Wendy Beinner, Executive Director, NAMI-VT
Bob Bick, Director of Mental Health and Substance Abuse Services, Howard Center for Human Services
Charles Bliss, MSW, Director Child & Family Services, Vermont Department of Mental Health
Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health Alcohol & Drug Abuse Programs
Jackie Corbally, MSW, Chief of Treatment, Vermont Department of Health Alcohol & Drug Abuse Programs
Linda Corey, Executive Director, Vermont Psychiatric Survivors
Anne de la Blanchetai Donahue, BA, JD, Vermont Legislative Representative, Co-Chair Mental Health Oversight Committee
Will Eberle, Executive Director, Another Way
David Fassler, MD, President Vermont Association of Child & Adolescent Psychiatry, Council of Mental Health and Substance Abuse Professionals
Patrick Flood, Commissioner, Vermont Department of Mental Health
Betsy Fowler, LICSW, LADC, Lead Behavioral Health Specialist, Northeastern Vermont Regional Hospital
Sally Fox, Senator, Co-Chair Mental Health Oversight Committee
Gordon Frankle, MD, Rutland Regional Medical Center
Kathy Holsopple, Executive Director, Vermont Federation for Families
Rodger Kessler, PhD, ABPP, Coordinator, Primary Care Behavioral Health, Fletcher Allen Patient Centered Medical Home
Patty McCarthy Metcalf, Director of Operations, VAMHAR
Clare Munat, Alternating Co-Chair, State Program Standing Committee for Adult Mental Health
Floyd Nease, Executive Director, Vermont Association for Mental Health and Addictions Recovery
Eilis O'Herlihy, Executive Director, National Association of Social Workers, VT Chapter
Robert Pierattini, MD, Chief of Psychiatry, Fletcher Allen health Care
Ralph Provenza, Executive Director, United Counseling Services
Alice Hershey Silverman, MD, President Vermont Psychiatric Association
Diane Tetrault, MA, LCMHC, Legislative Chair, Vermont Mental Health Counselors Association
Julie Tessler, Exec. Director, Vermont Council Developmental & Mental Health Services
Gloria van den Berg, Executive Director, Alyssum, Inc.
Susan Walker, President, Vermont Recovery Network
Jim Walsh, PMH-NP, BC, Co-Director, Windham Center Psychiatric Services Health Center at Bellows Falls

2013 meeting schedule pending

8.c. APPENDIX C – Presentation and Press Summary

OUT OF STATE MEETINGS			
1/10/12 - 1/12/12	IOM Learning Healthcare System in America Consensus Committee Meeting	Washington, DC	Jones
2/4/2012	Dartmouth COOP	Lincoln, NH	Watkins
2/27/2012	IOM Meeting	Washington, DC	C. Jones
2/27/2012	Milbank Technical Board Meeting	New York, NY	C. Jones
3/2/2012	Gifford Hospital CME Presentation	Randolph, VT	Watkins
3/5/12 - 3/6/12	Commonwealth Fund Commission Meeting	New York, NY	Watkins
3/7/2012	Healthcare Transformation Learning Session	Honolulu, Hawaii	C. Jones
3/17/12 - 3/18/12	IHI 13th Annual International Summit on Redesigning Patient Care in the Office Practice and Community	Washington, DC	C. Jones
3/29/12 - 3/30/12	2012 Aging in America Conference	Washington, DC	C. Jones
3/29/12 - 3/30/12	Minnesota Department of Health	Minneapolis, MN	Watkins
4/17 - 4/18/2012	National Council on Aging: Vermont's Success in Developing a Sustainable Infrastructure for Chronic Disease Self-management	National Webinar	Samuelson
4/25/2012	Healthcare Brainstorming - Peter G. Peterson Foundation	New York, NY	Jones
4/25 - 4/27/2012	SAMHSA Policy Academy: Gring Recovery Supports to Scale	Reston, VA	Samuelson
5/15/2012	Administration on Aging Expert Panel: Healthcare and Community-based Organizations - Building an Infrastructure to Scale Self-Management	Washington, DC	Samuelson
5/15/2012	Milbank Technical Board Seminar	New York, NY	C. Jones
5/21-5/22/12	Brown University Think Tank PC Transformation	Providence, RI	C. Jones
6/7/2012	AHRQ Health Innovations Exchange	Rockville, MD	C. Jones
6/8/2012	Congressional Staff Briefings and Meeting	Washington, DC	C. Jones
6/15/2012	IOM Round Table- Value Incentives Collaborative	Washington, DC	Watkins
6/19/2012	American Cancer Society Annual Meeting - NE Division	Milford, CT	C. Jones
7/24/2012	"Scaling and Sustaining Self-Management Programs: Sustainable Financing for the Future", U.S. Department of Health and Human Services (HHS)	Washington, DC	Samuelson
8/1/2012	MPCD Governance Board	Washington, DC	C. Jones
8/24/2012	Presentation to NCQA Specialty Practice Recognition Advisory Committee	Washington, DC	C. Jones
8/29/12 to 8/30/12	Presentation to IOM IHPE Global Forum	Washington, DC	C. Jones
9/6/2012	IOM Consensus Report Release	Washinton, DC	C. Jones
10/16/2012	Milbank Technical Board Seminar	New York, NY	C. Jones
10/17/2012	NASHP 25th Annual State Health Policy Conference, Mini-Conference on Multi-sector Partnerships	Baltimore, MD	Watkins
10/18/2012	Multi-State Collaborative Mtg.	Balltimore, MD	C. Jones
10/23/2012	National Association of Health Data Organizations Annual Meeting; "Using All Payer Claims Databases to Evaluate Health Care Reform"	New Orleans, LA	P. Jones
10/25/2012	National All Payer Claims Database Council Annual Meeting; "Using All Payer Claims Databases to Evaluate Health Care Reform"	New Orleans, LA	P. Jones
11/6/2012	Academy Health - Presenter	Trenton, NJ	C. Jones
11/16/2012	PA Impact Grant National Advisory Meeting - Presenter	Hershey, PA	C. Jones
11/28/12 - 11/30/12	Reforming States Group Meeting	Richmond, VA	C. Jones
12/4/2012	Navy Community Health Care Model Meeting - Presenter	San Diego, CA	C. Jones
12/5/2012	IOM Core Metrics Workshop	San Diego, CA	C. Jones
12/5/2012	Vermont-New Hampshire Chapter of the Health Care Financial Management Association; "The Vermont Blueprint for Health: Medical Homes as a Building Block for Comprehensive Health Care Reform"	Manchester, NH	P Jones
12/5/2012	National Committee on Quality Assurance, 7th Annual Policy Conference- "Building on the PCMH Infrastructure"	Washington, DC	Watkins
12/7/2012	Primary Care Extension Service Multi-State Meeting	New York, NY	Samuelson

IN STATE MEETINGS

1/3/2012	Agency on Aging Site Visit	Burlington, VT	Watkins
4/10/2012	Blueprint for Health Annual Conference Speaker	Burlington, VT	Jones
4/10/2012	Blueprint for Health Annual Conference Moderated Panel Discussion	Burlington, VT	Watkins
4/16/2012	Governors Commission on Alzheimer's Disease & Related Disorders	Berlin, VT	Watkins
4/27/2012	Vermont Dietetic Assciation Meeting	Essex, VT	Watkins
5/11/2012	Presentation to Cox Charitable Trust Family Board of Trustees	Montpelier, VT	Watkins
6/5/2012	Housing Assistance Council	Burlington, VT	C. Jones
6/6/2012	VT Certified Diabetic Educators Annual Meeting	Richmond, VT	Watkins
6/27/2012	State Organization of Rural Health Associations Regional Annual Meeting	Burlington, VT	Watkins
7/11/2012	The Vermont Blueprint for Health: A Brief Overview - training for SASH Coordinators and Wellness Nurses	Montpelier, VT	P. Jones
8/23/2012	The Vermont Blueprint for Health: Overview, CHT Services, Hub & Spoke Update Training for Vermont Chronic Care Initiative Staff	Williston, VT	P. Jones
8/29/2012	SASH Dual Eligible Pilot, Vermont Assembly of Home Health Agencies Committee	Berlin, VT	P. Jones
8/30/2012	Blueprint Update to Vermont Legislators	Montpelier, VT	L. Watkins
8/31/2012	The Vermont Blueprint for Health: A Brief Overview, Meeting with Dartmouth College researchers and SASH staff	Burlington, VT	P. Jones
9/8/2012	Vermont Cancer Center Retreat Presentation	Burlington, VT	C. Jones
9/13/2012	VITL Summit - Panelist	South Burlington, VT	C. Jones
9/29/2012	Vermont Association of Naturopathic Physician Annual Meeting - "The Vermont Blueprint - Health Reform in Action"	South Burlington, VT	L. Watkins
10/2/2012	Rutland Hospital Service Area Meeting; "Blueprint Payment Reforms Presentation"	Rutland, VT	P. Jones
10/11/2012	Brattleboro Physicians Advisory Group Meeting - Presenter	Brattleboro, VT	C. Jones
11/9/2012	Brattleboro Memorial Hospital Trustees Annual Meeting - Presentation on PCMH	Brattleboro, VT	C. Jones

2012 PRESS RELEASES / OTHER

	2013 Edition - U.S. News & World Report- ***Changes Ahead, Healthcare, Transformed*** - Author: Christopher J. Gearon
7/3/2012	On the AHRQ Website is the "Policy Innovation Profile" of the Blueprint at at http://www.innovations.ahrq.gov/content.aspx?id=3640
9/10 - 9/12/2012	NCQA site visit to Vermont: Attendees: Esther Emard, COO, Patricia Barrett VP Product Development and Rick Moore, CIO
9/25/2012	The AHRQ Innovations Exchange released the Blueprint videos titled " *Vermont* *" Vermont Blueprint for Health: Working Together for Better Care"* with a webcast panel discussion aired on September 25th featuring Dr. Craig Jones, Laural Ruggles, Pam Smart, Penrose Jackson and Pam Farnham. Both the webcast and the 3 separate videos can be accessed at : http://www.innovations.ahrq.gov/webevents/index.aspx?id=44