Vermont Blueprint for Health

2013 Annual Report
January 30, 2014

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FOREWORD

Since many audiences are now familiar with the Blueprint programs, services, and funding mechanisms, the 2013 Blueprint Annual Report to the Vermont Legislature has been restructured to front load the most current and pertinent information. The overall program evaluation starts on page 7 and the individual Health Service Area (HSA) snapshots begin on page 26.

For readers new to the Blueprint or looking for specific programmatic updates, background information and 2013 progress updates can be found starting on page 42.

The Appendices of this document beginning on page 83 contain information on the Blueprint budget for 2013; staff and committees; partnerships with national initiatives; and presentations given by Blueprint leadership staff both in- and out-of-state.

Special thanks go out this year to founding member and outgoing Associate Director Lisa Dulsky-Watkins, MD. Her dedication and hard work have ensured the Blueprint has gotten to where it is today. We wish her the best as she embarks on new and exciting professional pursuits.

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1. 2013 HIGHLIGHTS

The *Blueprint for Health* (Blueprint) is Vermont's state-led initiative charged with guiding a process that results in sustainable health care delivery reform. Originally codified in Vermont statute in 2006, then modified further in 2007, 2008, and finally in 2010 with Vermont Act 128 amending 18 V.S.A. Chapter 13 which defines Blueprint as a *"program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."*

To that end, the Blueprint has worked with stakeholders in each of Vermont's Health Service Areas to implement a new health services model. The model includes:

- Advanced primary care practices that are recognized as patient centered medical homes (PCMHs) by the National Committee for Quality Assurance (NCQA)
- Multi-disciplinary core Community Health Teams (CHT) and additional specialized care coordinators, which support PCMHs and provide the general and target population access to multi-disciplinary health services
- Evidence-based self-management programs to help citizens adopt healthier lifestyles and engage in preventive health services
- Multi-insurer payment reforms that fund PCMH transformation and community health teams
- Implementation of health information technology (HIT) to support health information exchange, guideline-based care, population management, and comparative evaluation
- Multi-faceted evaluation system to determine the impacts of health care reform initiatives
- A Learning Health System that helps practices and community health teams plan and implement PCMH operations, and supports ongoing quality improvement and innovation

In 2013, the Blueprint continued to grow and strengthen the underlying model in all geographic regions or Health Service Areas (HSAs) in the state. A few highlights include:

- NCQA recognition of 17 new practices serving an additional 91,370 patients
- Blueprint recognition of the first naturopathic practice as an advanced primary care practice
- Cumulative recognition of 121 PCMH practices serving a total of 514,385 Vermonters
- Expansion to 120 CHT staff statewide
- Statewide SASH coverage with 36.5 SASH teams serving high risk Medicare beneficiaries
- New model of care for Opioid Addiction Treatment called Hub and Spoke implemented statewide with 5 regional addiction treatment centers (Hubs) and 30 Spoke staff (nurses and clinicians) deployed to buprenorphine prescribing practices (Spokes)

Figure 1 summarizes the growth of the Blueprint from 2008 through the end of 2013.

Figure 1. Blueprint PCHMs, CHT Staff, and Patients – 2008 through 2013
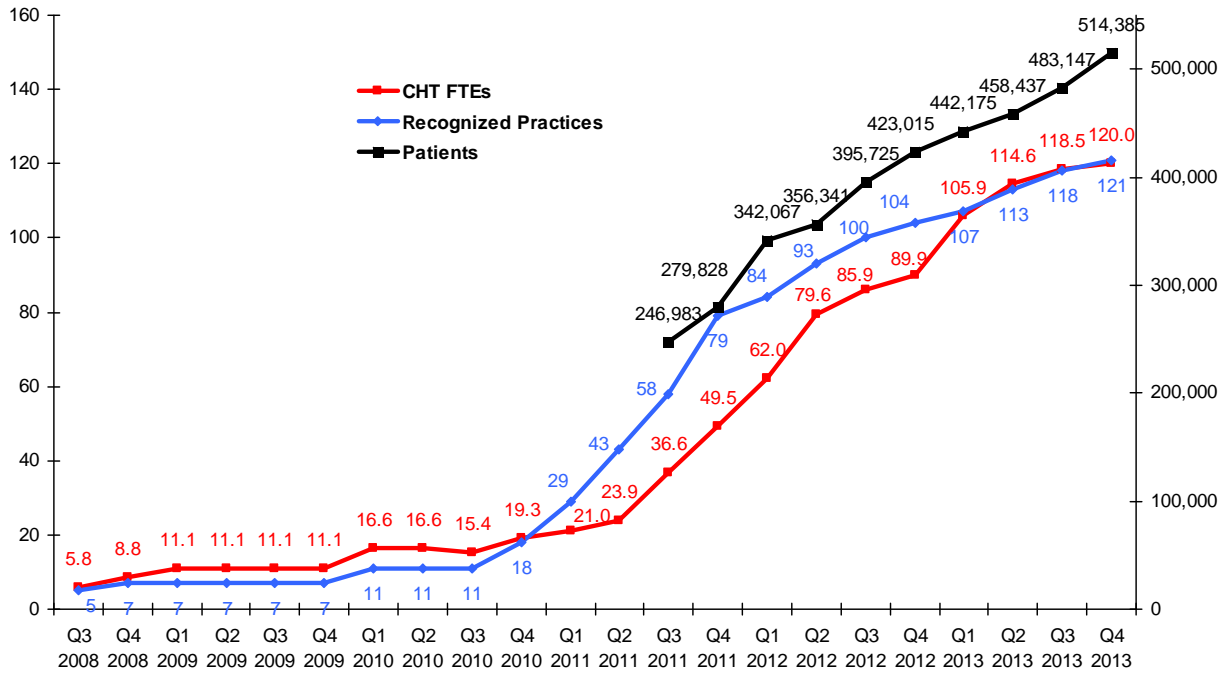
Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.

Demonstrating the achievements of the expanding model, this year's Blueprint Annual Report contains the first statewide outcomes assessment using data from Vermont's All-Payer Claims Database. In 2012, people who received care in the PCMH + CHT setting had favorable outcomes versus comparison groups including:

- Reductions in annual expenditures per capita for traditional healthcare. These reductions more than offset investments that Commercial insurers and Medicaid made to support PCMHs and CHTs during the same year.
- Improved utilization, including a reduction in inpatient hospitalizations and related expenditures, and an unexpected reduction in pharmacy expenditures
- Increased use of non-medical support services by Medicaid beneficiaries (Special Medicaid Services), even as their expenditures for traditional medical care were reduced
- A shift towards less specialty care (medical and surgical) with higher utilization of primary care services
- A trend toward higher rates of recommended assessments reflective of preventive care

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2. PROGRAM EVALUATION

2.a. Introduction

The Blueprint program has worked with stakeholders in each of Vermont's Health Service Areas (HSAs) to implement a new health services model. The model includes advanced primary care in the form of Patient Centered Medical Homes (PCMHs), multi-disciplinary support services in the form of Community Health Teams (CHTs), a network of self-management support programs, statewide data systems, and activities focused on continuous improvement using comparative evaluation (Learning Health System). All major insurers in Vermont participate in payment reforms designed to support the PCMH and CHT operations.

The program is intended to establish a statewide environment where Vermonters have better access to well-coordinated services that help them live healthier lifestyles, reduce the risk of developing common chronic conditions, such as diabetes and hypertension, and improve control over existing conditions. If effective, the program should lead to several important outcomes, including an increase in the rate of residents receiving recommended assessments and treatments, a reduction in avoidable acute care (emergency department visits and inpatient admissions), and a demonstration of predictable ways to improve control over the growth in healthcare costs. This evaluation is designed to determine whether the program is achieving these goals.

2.b. Data Source

Vermont's All-Payer Claims Database (APCD), the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), served as the primary data source for this analysis. VHCURES is the most complete source of claims data across all settings and insurers in Vermont. To attribute claims to Blueprint practices, a roster identifying provider-to-practice affiliations was provided by the Vermont Blueprint for Health.

Each person with claims data in VHCURES was associated (attributed) with the practice where they received the majority of their primary care visits using VHCURES, Blueprint roster data, and Evaluation and Management (E&M) service codes defined by the U.S. Centers for Medicare & Medicaid Services (CMS). All people who were included in these analyses, Blueprint Participants and Comparison group alike, had at least one primary care visit.

2.c. Study Groups

This study reports 2012 measure results for two groups:

- *Blueprint Participants.* Vermont residents who received the majority of their primary care in practices that began <u>operating</u> as PCMHs on or before December 31, 2012 (people attributed to Blueprint practices)

- *Comparison Group.* Vermont residents who received the majority of their primary care in practices that were <u>not operating</u> as PCMHs on or before December 31, 2012 (people attributed to non-Blueprint practices and practices scheduled to start after January 2013)

It is important to note that the outcomes presented in this study reflect 2012 results for all Blueprint Participants, independent of the length of time that their practice participated in the Blueprint program as a PCMH. The length of time that each practice operated as a PCMH with CHT support varies substantially with some in operation for less than one year. Blueprint practices were officially recognized as PCMHs between July 1, 2007 and December 31, 2012, with the most rapid program growth occurring during calendar years 2011 and 2012. It is also worth noting that the Comparison group includes people receiving primary care in practices scheduled to participate in the Blueprint after January 1, 2013, as well as people receiving care in practices that are not scheduled to participate in the Blueprint program.

For each group, results are stratified by major payer type and age range:

- Commercial, ages 1–17 years
- Commercial, ages 18–64 years
- Full Medicaid, ages 1–17 years
- Full Medicaid, ages 18–64 years

The pediatric population, ages 1–17 years, was segregated from adults because this population has a very different distribution of health status, utilization, and expenditures compared to adults. The "Full Medicaid" category included people for whom Medicaid was the primary payer and therefore did not include Medicare members with dual eligibility. Results for the Medicare population were not available at the time of this report. The number of people and the number of practices included in each study group are shown below (Table 1).

Table 1. Study Groups

Study Groups	# People	# Practices
Commercial (Ages 1-17 Years)		
Blueprint 2012	30,632	102
Comparison 2012	22,488	49
Commercial (Ages 18-64 Years)		
Blueprint 2012	138,994	105
Comparison 2012	83,171	67
Medicaid (Ages 1-17 Years)		
Blueprint 2012	32,812	94
Comparison 2012	15,333	41
Medicaid (Ages 18-64 Years)		
Blueprint 2012	38,281	105
Comparison 2012	16,159	54

The characteristics of each Participant group and their respective Comparison group are shown below (Table 2). The groups were generally similar with regards to age, gender, maternity, and the proportion of patients in each Clinical Risk Group (CRG). With the exception of the commercially insured pediatric population, Blueprint Participants tended to have higher rates of common chronic conditions than their respective Comparison group.

Table 2. Study Group Characteristics

Age Stratification	Average Age	Male	Healthy CRG*	Acute Illness or Minor Chronic CRG	Chronic CRG	Significant Chronic CRG	Catastrophic or Cancer CRG	Maternity	Blueprint Selected Chronic Conditions **
Commercial (Ages 1-17 Years)									
Blueprint PCMHs	9.7	50.4%	80.1%	12.4%	6.6%	0.7%	0.2%	0.4%	11.7%
Comparison Group	9.8	51.8%	80.8%	12.0%	6.2%	0.6%	0.4%	0.3%	10.1%
Commercial (Ages 18-64 Years)									
Blueprint PCMHs	44.2	46.2%	51.5%	22.0%	20.0%	5.9%	0.6%	2.1%	30.4%
Comparison Group	43.3	45.4%	54.4%	21.0%	18.4%	5.3%	1.0%	2.2%	25.7%
Medicaid (Ages 1-17 Years)									
Blueprint PCMHs	8.5	51.1%	72.1%	14.6%	11.5%	1.6%	0.2%	0.7%	24.6%
Comparison Group	8.5	52.8%	72.4%	14.6%	11.1%	1.5%	0.4%	0.7%	21.6%
Medicaid (Ages 18-64 Years)									
Blueprint PCMHs	38.0	42.8%	43.3%	20.2%	26.2%	9.7%	0.7%	4.1%	44.5%
Comparison Group	37.8	42.8%	46.2%	18.8%	25.7%	8.2%	1.2%	4.4%	38.0%

Clinical Risk Groups (CRGs) are a product of 3M™ Health Information Systems and were applied to the VHCURES claims data to classify each member's health status. For example, members with cancer, diabetes, minor chronic joint pain, or healthy are classified separately for analysis.

**Blueprint Selected Chronic Conditions include: Asthma, Attention Deficit Disorder, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, Diabetes, Depression, Hypertension

2.d. Measures

Three categories of standardized claims based measures are used for this study:
1. Expenditures
2. Utilization
3. Effective and preventive care

Expenditures were defined as the allowed amount from VHCURES claims data using the following formula:

> Plan paid + member out-of-pocket payments (copays, coinsurances, deductibles) = Total annual expenditures per person

All expenditure and utilization measures were capped at the 99th percentile to minimize the influence of extreme outlier cases and were adjusted for differences in the Participant and Comparison populations, including demographics (such as age and gender), health status (using

Clinical Risk Groups [CRGs]), and maternity. CRGs, a product of 3M™ Health Information Systems used throughout the United States as a method of risk-adjusting populations, were applied to the VHCURES claims data. The grouper classifies each member into one of 1,080 distinct clinical groups based on the diagnoses reported on claims. These detailed categories were further combined into higher level aggregation for the risk-adjustment models.

Expenditure and utilization rates were also adjusted for partial lengths of enrollment during the study year. The Comparison population was weighted to the Participants' sample size by HSA.

Effective and preventive care measures were based on National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) specifications applied to the VHCURES claims data.[1] In some cases, the results for HEDIS® measures reported in this study may be lower than results reported by Vermont health plans that potentially use medical chart review to supplement their administrative claims data. The measures were specific to major payer and age groups and required continuous enrollment periods as specified by HEDIS®. As a result, no risk adjustment was required for these measures.

Expenditure measures were expressed as an annual rate per capita, utilization measures as a rate per 1,000 members, and effective and preventive care HEDIS® measures as the percent of members receiving recommended care. Upper and lower 95th percentile confidence intervals and statistical significance[2] were determined for all measures.

2.e. Results

Results for calendar year 2012 are presented for Participants and their respective Comparison groups.

2.e.1. Expenditures

In 2012, Participants in the Blueprint model (PCMH+CHT setting) tended to have favorable outcomes, including lower total expenditures for healthcare, versus their respective Comparison group. Total annual expenditures were $386 (19%) lower for each commercially insured

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[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] Statistical significance is the probability that an effect is not likely due to just chance alone. It is an integral part of statistical hypothesis testing where it is used as an important value judgment. In statistics, a result is considered significant not because it is important or meaningful, but because it has been predicted as unlikely to have occurred by chance alone. *(Wikipedia)*

Participant in the 1-17 age group and $586 (11%) lower for each commercially insured
Participant in the 18-64 age group (Figure 2). These differences are statistically significant.

Figure 2. 2012 Total Expenditures per Capita
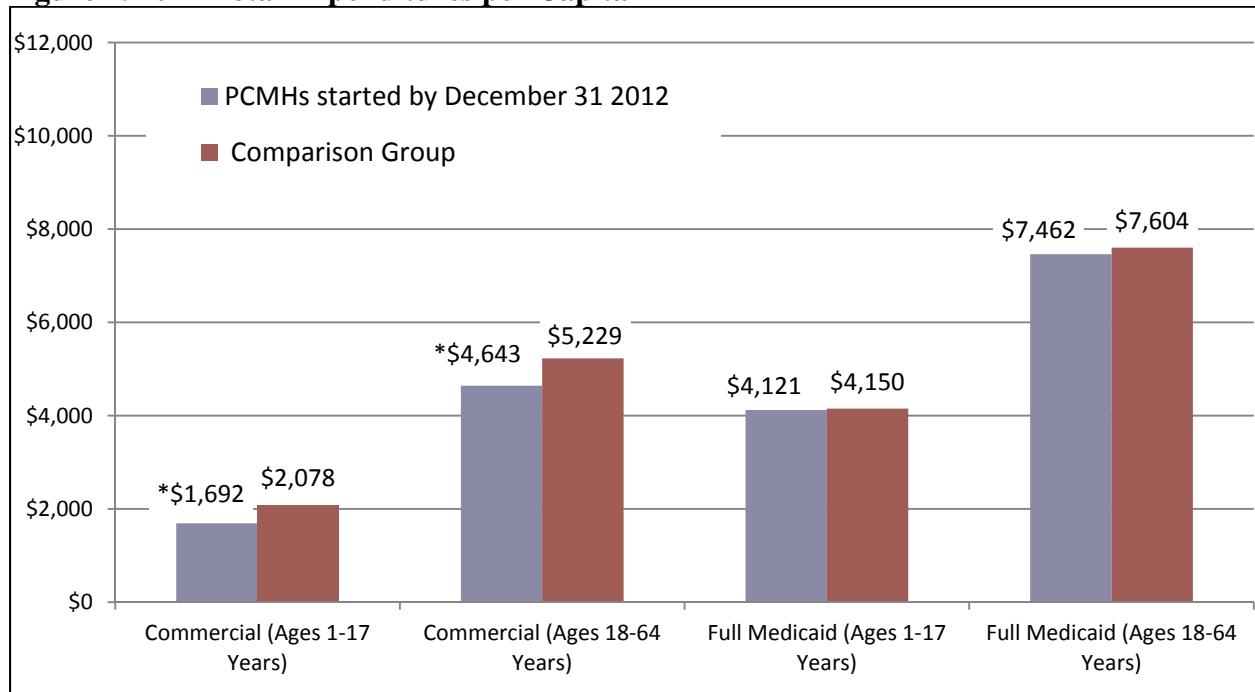
* Blueprint is significantly different from the Comparison group at the 95% confidence level.

Total expenditures for each Full Medicaid Participant (those participants whose primary
insurance is Medicaid) tended to be lower than their Comparison group, but these differences did
not reach statistical significance if expenditures for Special Medicaid Services are included
(Figure 2). Special Medicaid Services (SMS) are typically non-medical services and are paid for
by Medicaid, but not covered by Commercial or Medicare payers. SMS services include:

- Transportation
- Home and community-based services
- Case management
- Dental
- Residential treatment
- Day treatment
- Mental health facilities
- School-based and Department of Education Services

SMS target unmet needs prevalent within the Medicaid population, providing beneficiaries with
assistance intended to help them improve their overall health and well-being.

When SMS expenditures are excluded, total annual expenditures on traditional healthcare for Medicaid beneficiaries were $200 (11%) lower for each Participant in the 1-17 age group and $447 (7%) lower for each Participant in the 18-64 age group (Figure 3).

Figure 3. 2012 Total Expenditures per Capita (Medicaid minus Special Services)
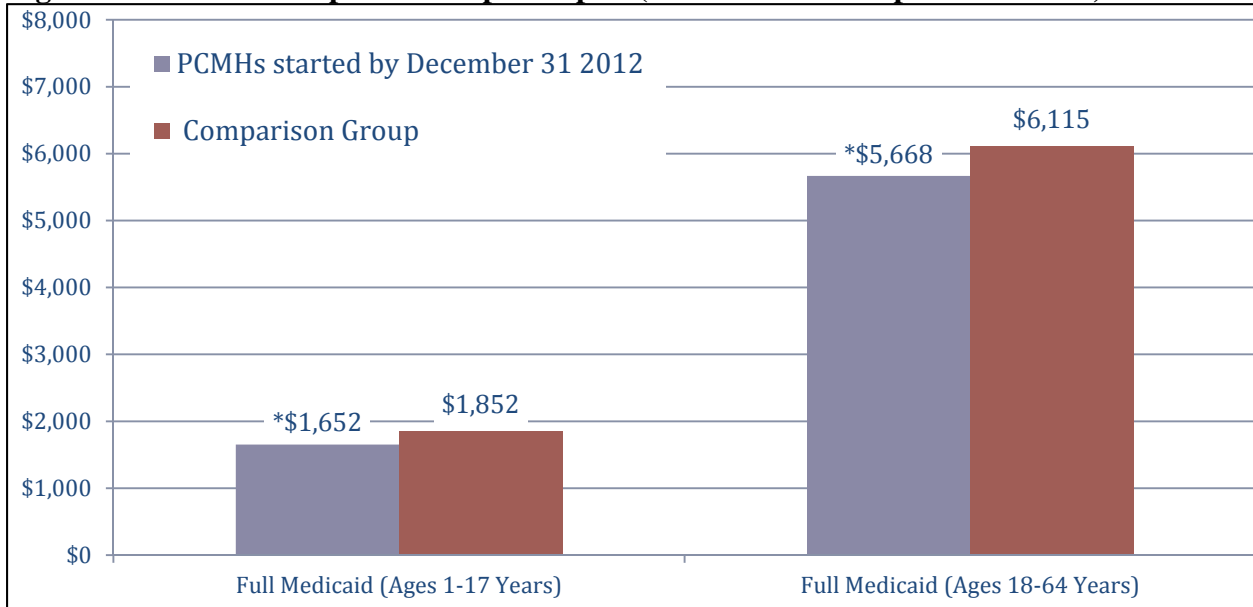
* Blueprint is significantly different from the Comparison group at the 95% confidence level.

These differences are statistically significant. The separation of expenditures for SMS increases the reliability of comparisons of medical-only expenditures within Medicaid Blueprint and non-Blueprint Comparison groups and increases the reliability of comparing medical-only expenditures between Medicaid and other major payers.

A more detailed breakout provides evidence that in 2012 Medicaid Participants were accessing health services in a different way than Medicaid beneficiaries receiving care in non-Blueprint practices. In the adult age group, Participant expenditures tended to be lower for most major healthcare categories, reaching statistical significance for Outpatient and Pharmacy services (Figure 4).

Figure 4. 2012 Medicaid Expenditures by Major Category (Ages 18-64)
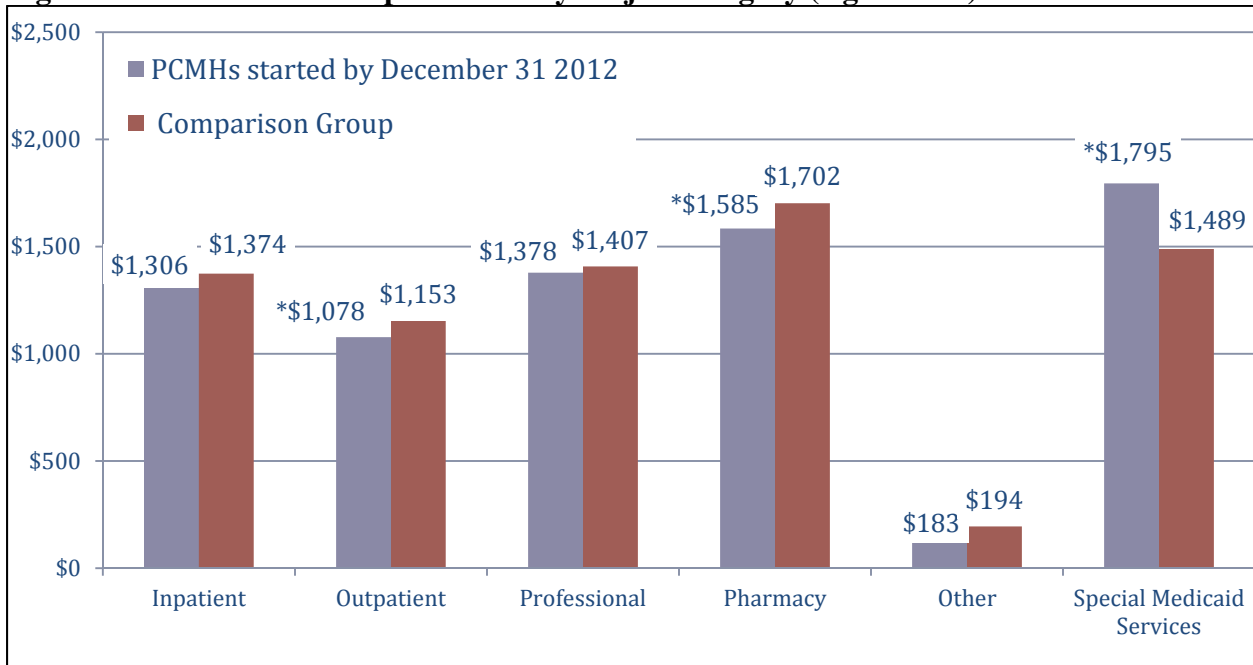
Blueprint is significantly different from the Comparison group at the 95% confidence level.

Adult Participant expenditures were significantly higher for SMS. Expenditures for pediatric Participants were significantly lower for Inpatient and Pharmacy services, higher for Professional services, and trended toward higher use of SMS (Figure 5).
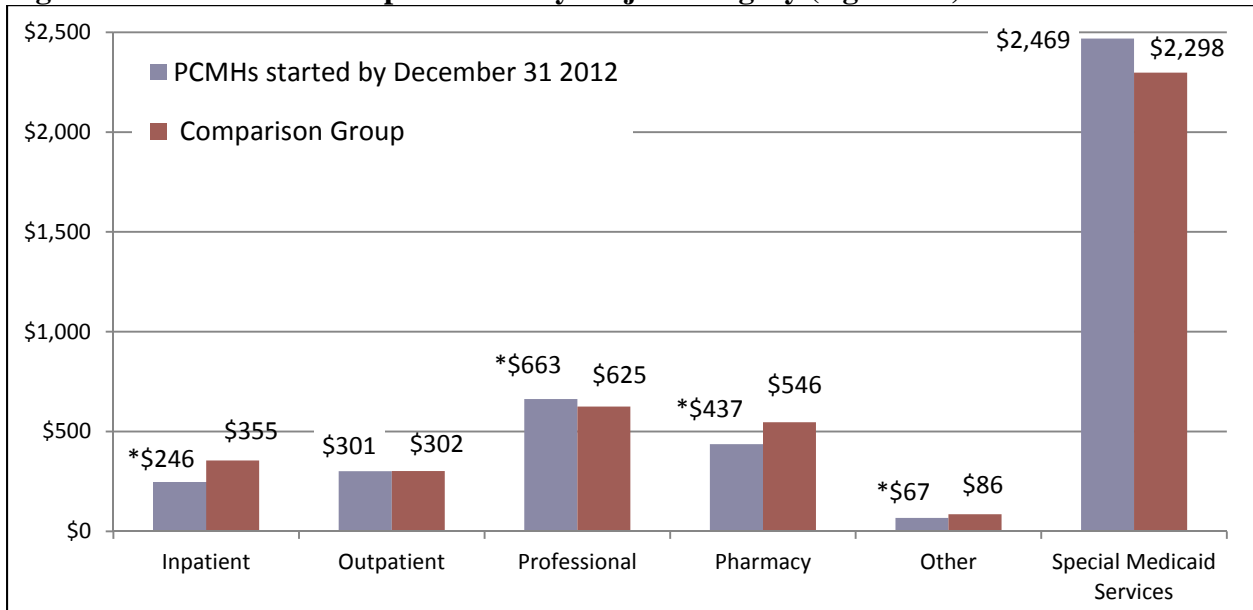
Figure 5. 2012 Medicaid Expenditures by Major Category (Ages 1-17)
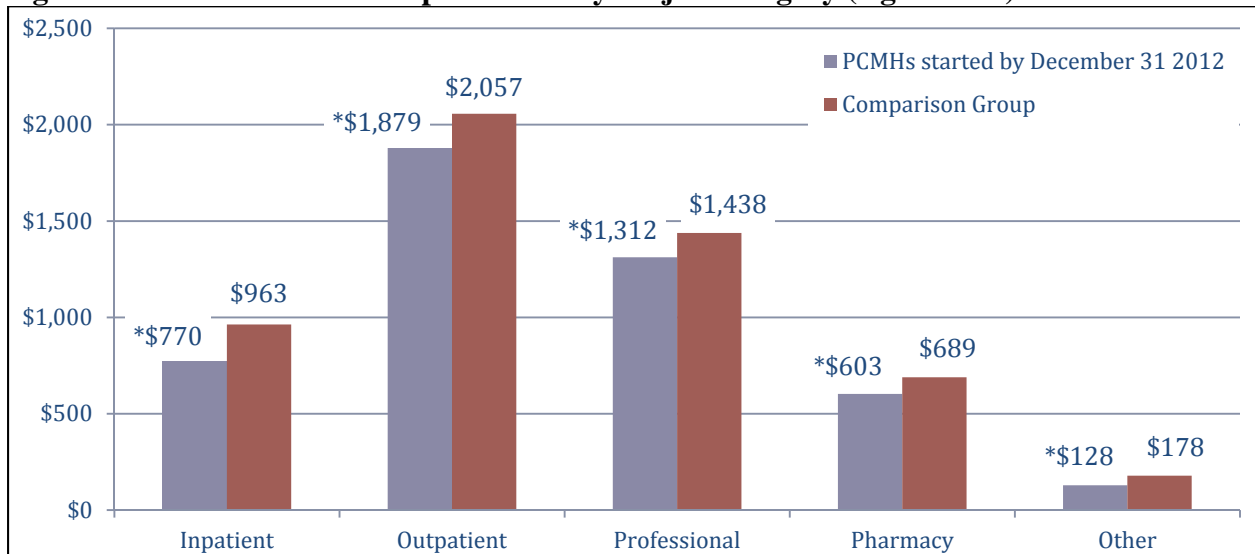

Blueprint is significantly different from the Comparison group at the 95% confidence level.

These Medicaid-related results suggest that the new model of healthcare helps Vermonters of lower socioeconomic status connect to non-medical services intended to help them improve their overall well-being, leading to reduced reliance on traditional healthcare settings not as well suited to dealing with the circumstances that the SMS are designed to help alleviate.

Commercially insured Participants also had lower expenditures than the Comparison groups for major categories of healthcare. Adults had significantly lower expenditures in all major categories (Figure 6).

Figure 6. 2012 Commercial Expenditures by Major Category (Ages 18-64)

Legend:
■ PCMHs started by December 31 2012
■ Comparison Group

Category	PCMHs	Comparison
Inpatient	*$770	$963
Outpatient	*$1,879	$2,057
Professional	*$1,312	$1,438
Pharmacy	*$603	$689
Other	*$128	$178

* Blueprint is significantly different from the Comparison group at the 95% confidence level.

Pediatric Participants had significantly lower expenditures in most categories with a trend toward lower Inpatient expenditures that did not reach statistical significance (Figure 7).

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Figure 7. 2012 Commercial Expenditures by Major Category (Ages 1-17 Years)
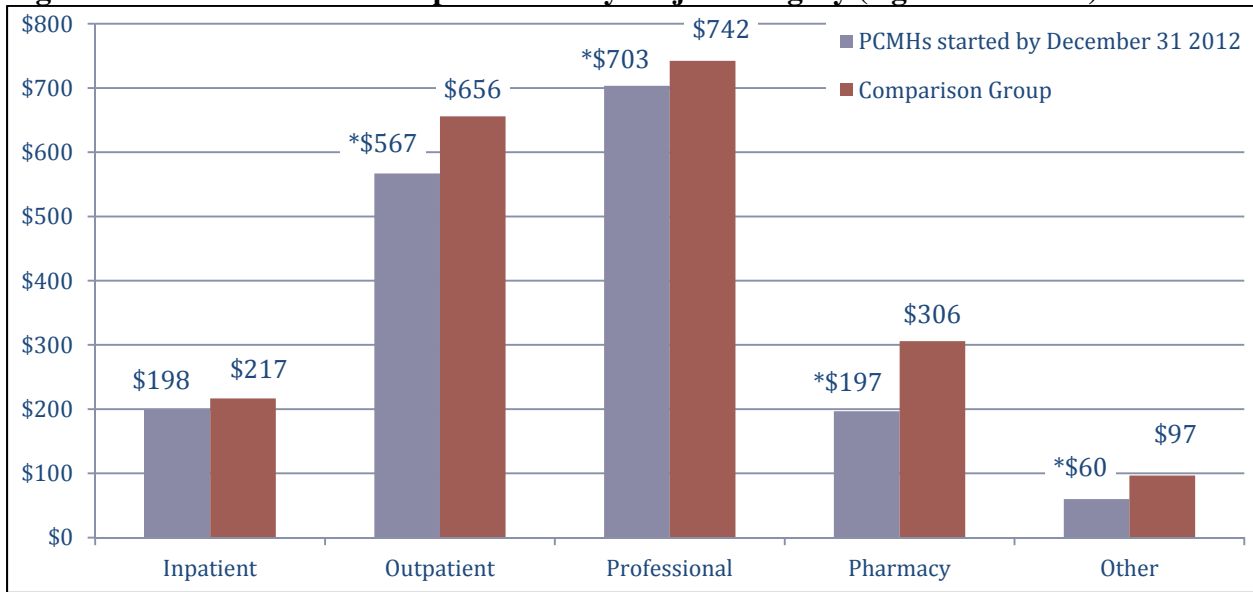
Bar chart showing expenditures for PCMHs started by December 31 2012 (blue) and Comparison Group (red):
- Inpatient: $198 vs $217
- Outpatient: *$567 vs $656
- Professional: *$703 vs $742
- Pharmacy: *$197 vs $306
- Other: *$60 vs $97

Legend: PCMHs started by December 31 2012; Comparison Group
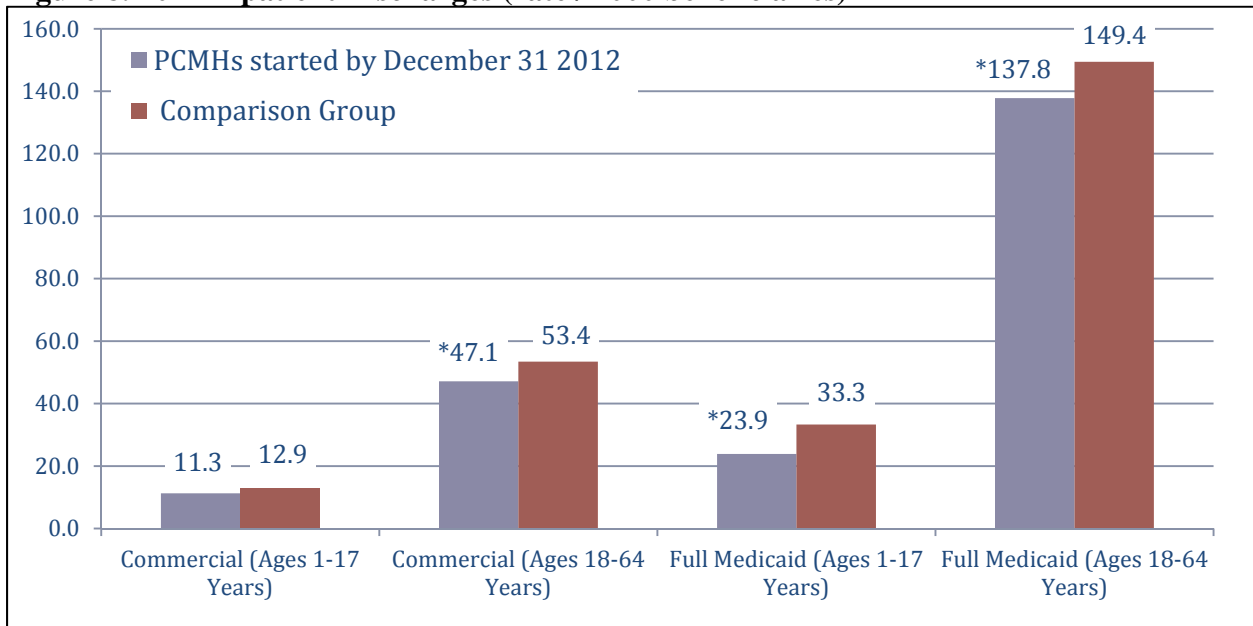
* Blueprint is significantly different from the Comparison group at the 95% confidence level.

2.e.2. Utilization

Results for utilization rates provide additional evidence of changing healthcare patterns in the PCMH+CHT setting and a better understanding of the expenditure results reported above. Participants had lower hospitalization rates that were statistically significant for commercially insured adults and for adult and pediatric Medicaid beneficiaries (Figure 8).

Figure 8. 2012 Inpatient Discharges (rate / 1000 beneficiaries)

Bar chart showing inpatient discharge rates for PCMHs started by December 31 2012 (blue) and Comparison Group (red):
- Commercial (Ages 1-17 Years): 11.3 vs 12.9
- Commercial (Ages 18-64 Years): *47.1 vs 53.4
- Full Medicaid (Ages 1-17 Years): *23.9 vs 33.3
- Full Medicaid (Ages 18-64 Years): *137.8 vs 149.4

Legend: PCMHs started by December 31 2012; Comparison Group
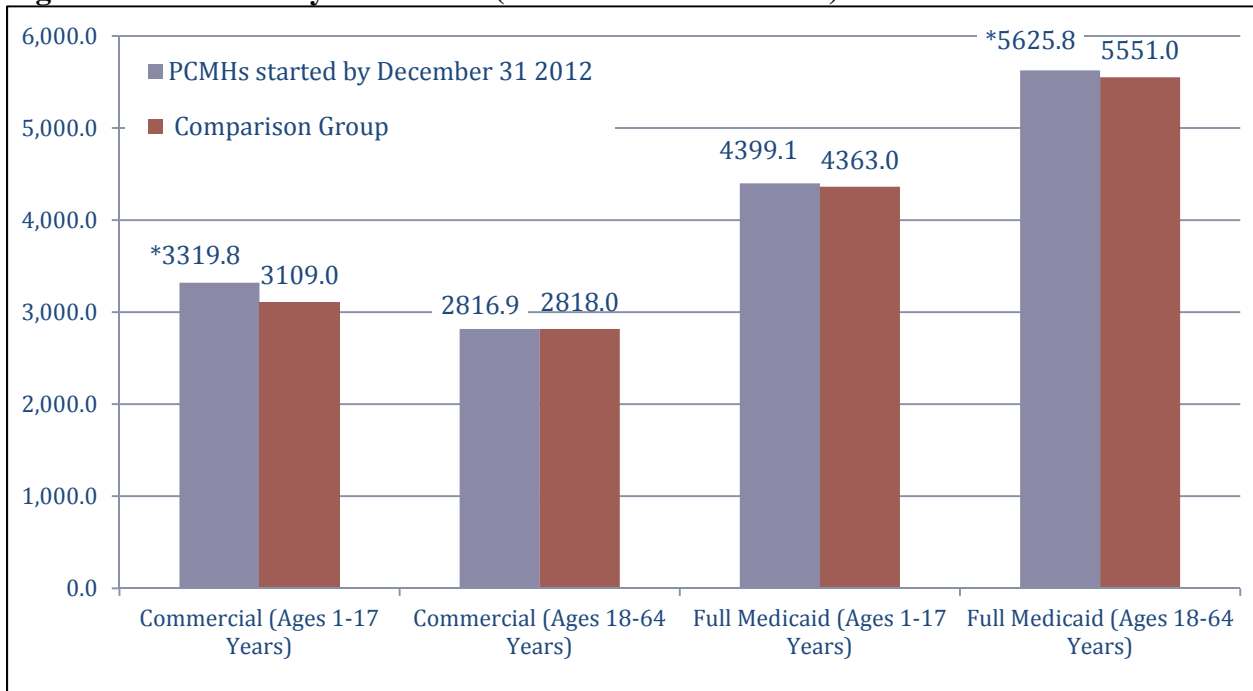
* Blueprint is significantly different from the Comparison group at the 95% confidence level.

Commercially insured pediatric Participants trended toward lower hospitalization rates, but the difference did not reach statistical significance.

Overall, Participants demonstrated a trend toward lower rates of medical and surgical specialty care and higher rates of primary care. Commercially insured adults were the only Participant group that did not show a trend toward an increase in primary care utilization, while primary care visits were significantly higher for the commercially insured pediatric and Medicaid adult populations (Figure 9).
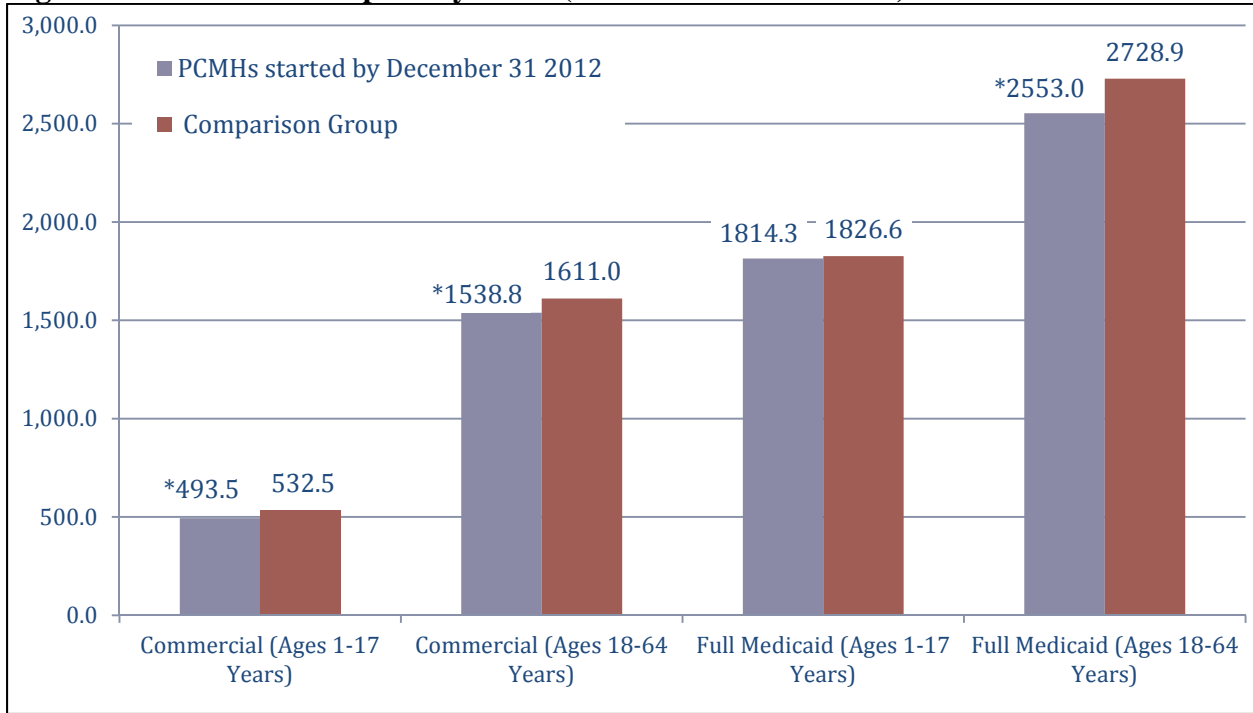
Figure 9. 2012 Primary Care Visits (rate / 1000 beneficiaries)

Blueprint is significantly different from the Comparison group at the 95% confidence level.

Medical specialty visits were lower for Participants, reaching statistical significance for all groups except the Medicaid pediatric population (Figure 10).

Figure 10. 2012 Medical Specialty Visits (rate / 1000 beneficiaries)

Blueprint is significantly different from the Comparison group at the 95% confidence level.

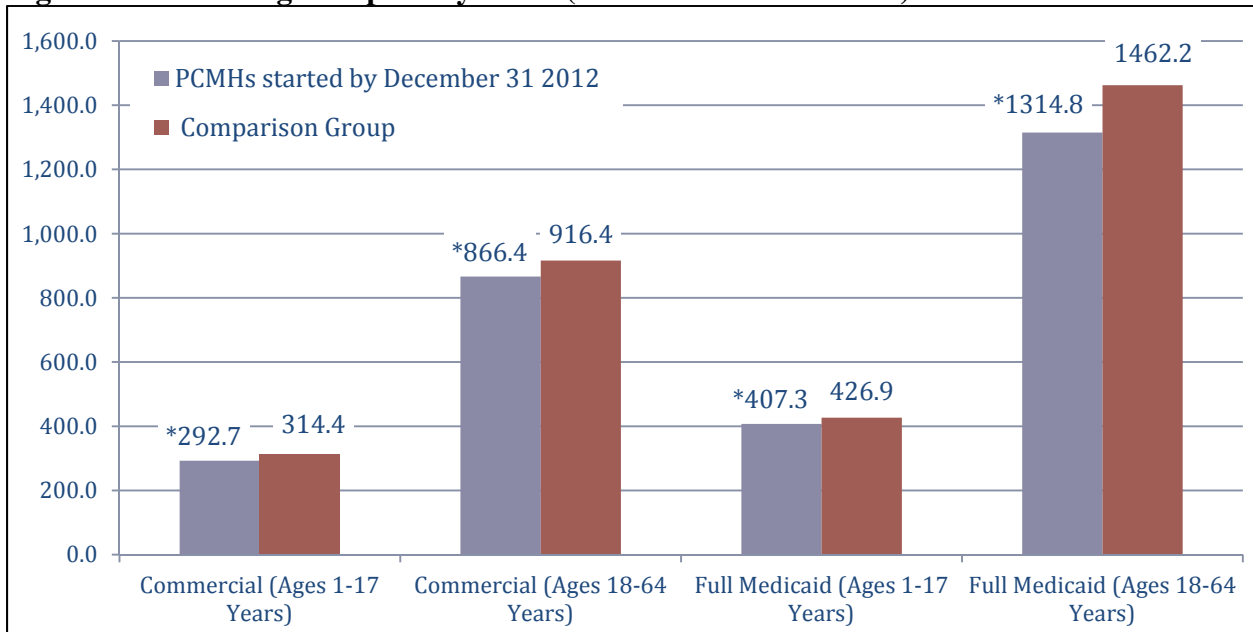All Participant groups had significantly fewer surgical specialty visits (Figure 11).

Figure 11. 2012 Surgical Specialty Visits (rate / 1000 beneficiaries)

Blueprint is significantly different from the Comparison group at the 95% confidence level.

Results for emergency department utilization were mixed, representing an important utilization category where Participants did not show consistently favorable outcomes. Commercially insured Participants tended toward lower rates of emergency department utilization, while Medicaid Participants tended toward higher rates than the Comparison groups (Figure 12).

Figure 12. 2012 Emergency Department Visits (rate / 1000 beneficiaries)
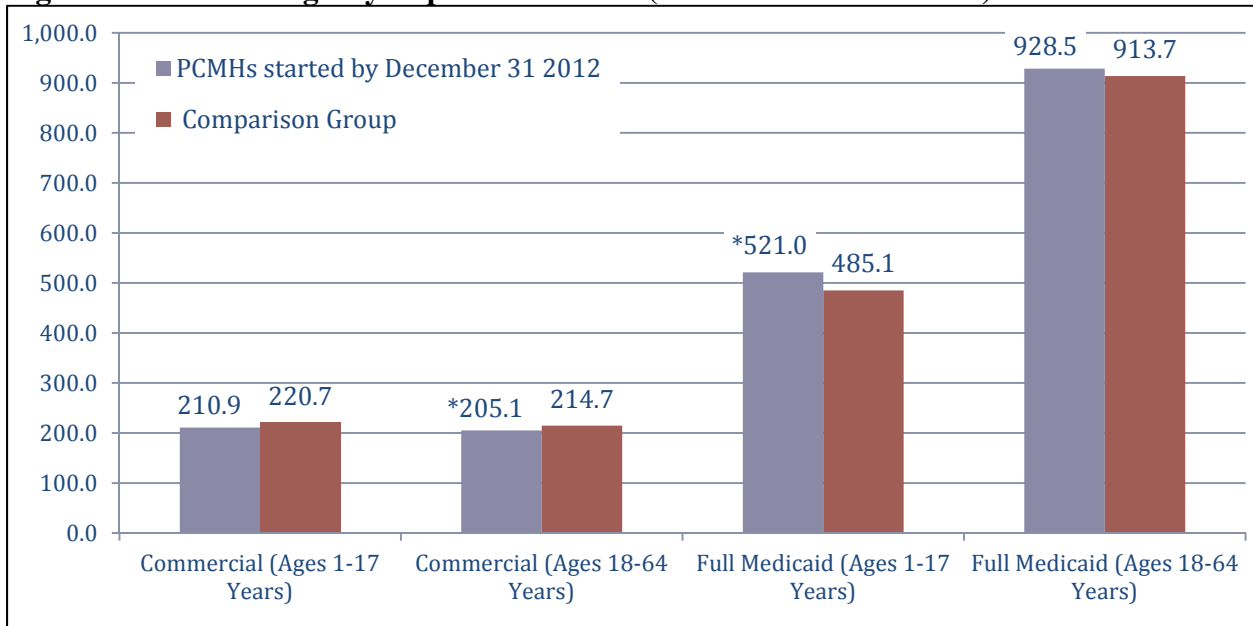
* Blueprint is significantly different from the Comparison group at the 95% confidence level.

2.e.3. Effective and Preventive Care

Results for effective and preventive care measures (HEDIS®) suggest that the PCMH+CHT model can improve or lower healthcare expenditures and utilization while preserving quality. Participants had higher rates of breast cancer screening that were statistically significant for the commercially insured population (Figure 13).

Figure 13. 2012 Breast Cancer Screening (HEDIS®)
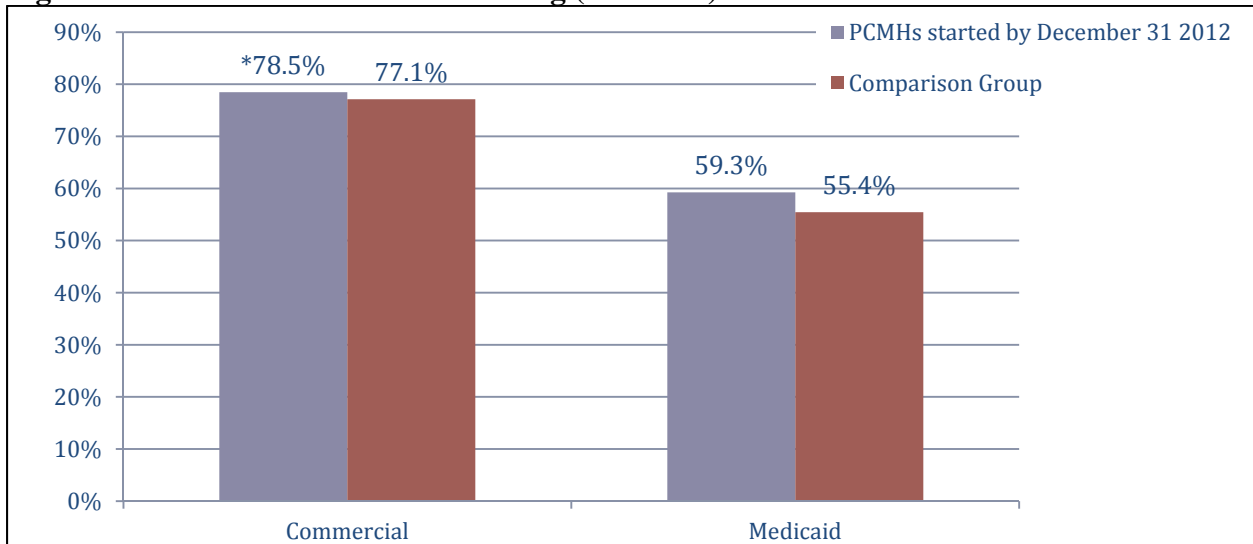
Blueprint is significantly different from the Comparison group at the 95% confidence level.

Rates of screening for cervical cancer were significantly higher for Participants in the commercially insured and Medicaid populations (Figure 14).

Figure 14. 2012 Cervical Cancer Screening (HEDIS®)

Blueprint is significantly different from the Comparison group at the 95% confidence level.

Participants with diabetes tended toward slightly higher rates of recommended assessments, including Hgb A1C, LDL, eye exam, and nephropathy screening, however, with the exception of higher rates of nephropathy screening in the commercially insured population (data not shown), these differences did not reach statistical significance.

In the pediatric age groups, Participants tended toward higher rates of well-child visits and adolescent well-care visits (Figure 15 and Figure 16). Adolescent well-care visits were significantly higher for the commercially insured population

Figure 15. 2012 Well-Child Visits (HEDIS®)

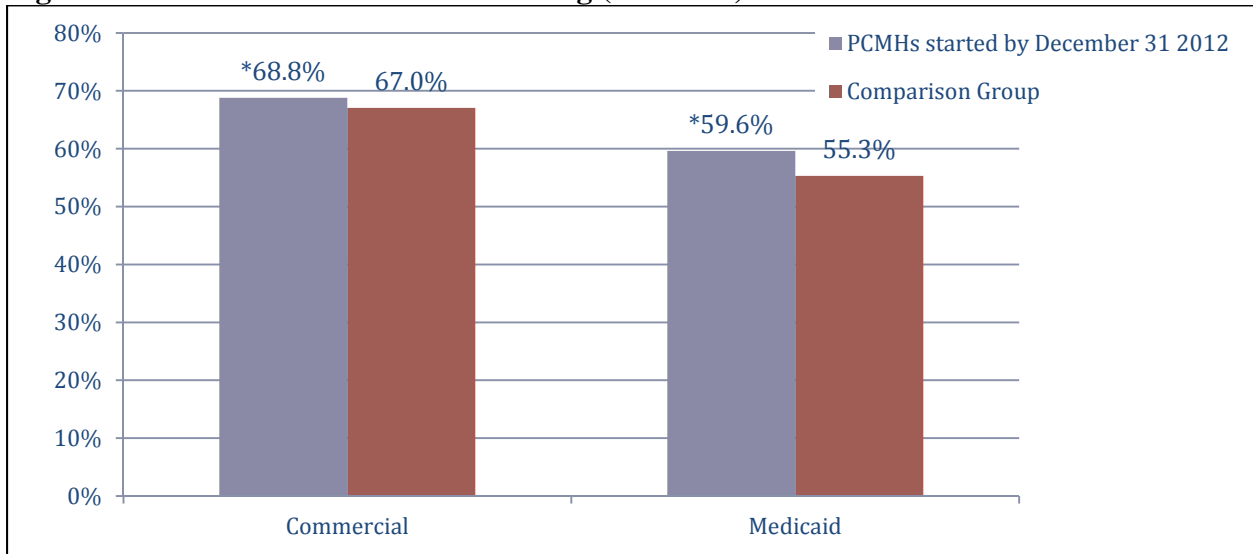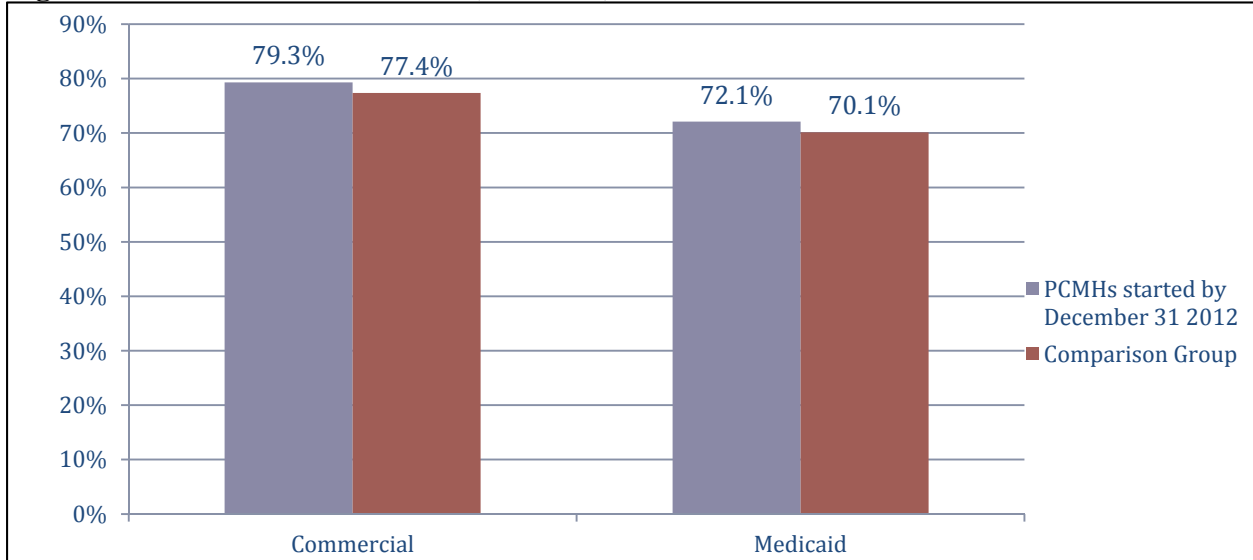*Blueprint is significantly different from the Comparison group at the 95% confidence level.*

Figure 16. 2012 Adolescent Well-Care Visits (HEDIS®)
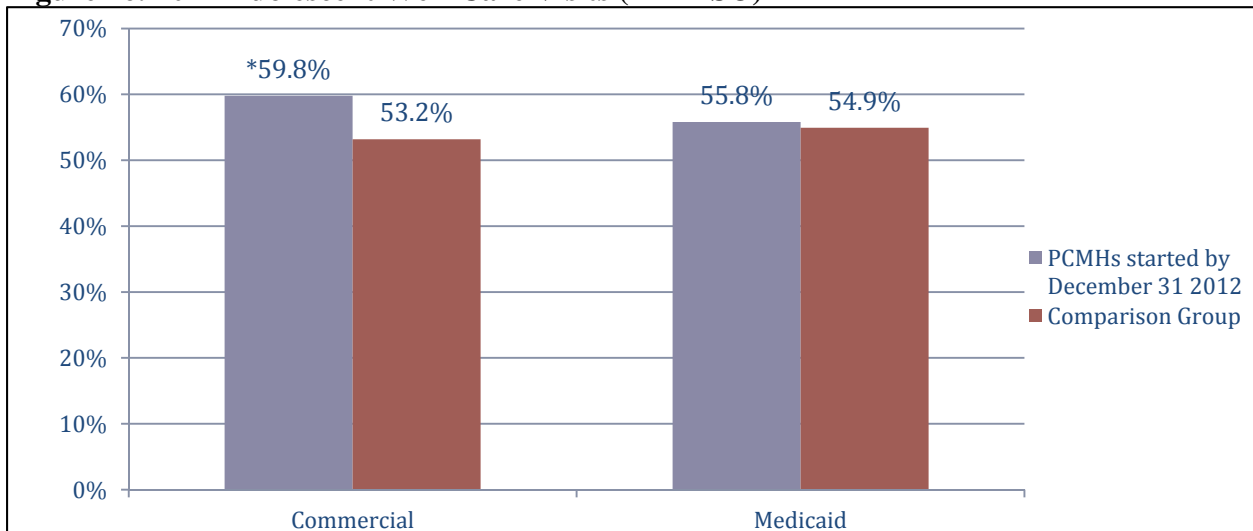
Blueprint is significantly different from the Comparison group at the 95% confidence level.

2.f. Return on Investment

Results from 2012, using data on paid claims from Vermont's All Payer Claims Database, show that Blueprint Participants had lower annual expenditures on healthcare than Comparison populations. For commercially insured, the savings amounted to $586 per person in the 18-64

age group and $386 per person in the 1-17 age group. For Medicaid beneficiaries, the savings amount to $447 per person in the 18-64 age group and $200 per person in the 1-17 age group when expenditures on Special Medicaid Services are excluded. When Special Medicaid Services are included, Medicaid savings decrease to $142 per person in the 18-64 age group and to $29 per person in the 1-17 age group.

Commercial insurers and Medicaid have made payments averaging $2.00 per patient per month (PPPM) for PCMHs and $1.50 PPPM for CHTs. 2012 savings for each insurer are compared to actual investments made during the same year, providing a within-year look at their Gain-to-Cost ratio (Table 3).

Table 3. Savings Compared to Investment in 2012

Study Groups	# People	Amount Saved Per Person in 2012*	Total Saved in 2012	Total Invested in 2012**	2012 Gain/Cost Ratio***
Commercial (Ages 1-17 Years)				Commercial $5,905,166	15.8
Blueprint 2012	30,632	$386	$11,823,952		
Commercial (Ages 18-64 Years)					
Blueprint 2012	138,994	$586	$81,450,484		
Medicaid (Ages 1-17 Years) Excluding SMS				Medicaid $2,883,525	8.2 excludes ****SMS
Blueprint 2012	32,812	$200	$6,562,400		
Medicaid (Ages 18-64 Years) Excluding SMS					
Blueprint 2012	38,281	$447	$17,111,607		
Medicaid (Ages 1-17 Years) Including SMS				Medicaid $2,883,525	2.2 includes SMS
Blueprint 2012	32,812	$29	$951,548		
Medicaid (Ages 18-64 Years) Including SMS					
Blueprint 2012	38,281	$142	$5,435,902		

Difference in 2012 total expenditures per person for Participants vs. Comparison Group.

**Includes 2012 totals for Patient Centered Medical Home and Community Health Team payments.*

***Calculated as Total Saved divided by Total Invested.*

****Special Medicaid Services (SMS) include Transportation, Home and community-based services, Case management, Dental, Residential treatment, Day treatment, Mental health facilities, and School-based and Department of Education Services.*

The results suggest that in 2012, with expansion and maturation of the Blueprint model and participation of a large number of beneficiaries, insurer investments in PCMHs and CHTs were more than offset by reductions in healthcare expenditures. It is important to note that these results reflect a single-year look at investments and savings, and they do not reflect a multi-year return on overall investment. Further analyses are necessary in order to look back across all years of the Blueprint implementation, starting with 2008, to create a cumulative return on investment (ROI) model.

With respect to financial impact modeling, the Medicaid results highlight the importance of a more complete measurement of investments and offsets that influence people's health. Investments for services typically not considered part of medical care, such as Special Medicaid Services, may impact people's overall health and well-being, in addition to their use of traditional medical services. It is likely these findings will not be limited to the Medicaid population. A more complete financial impact model requires the ability to measure the full range of investments and offsets related to a population's health. For example, it is unknown whether investments in social services and mental health services are offset by a combination of financial gains in medical expenditures, employment, and productivity. The results of this study support the need to integrate typically segregated data sets, both medical and non-medical, in order to understand more fully the impact of societal investments in health.

2.g. Summary

Overall, results from 2012 suggest that people who received primary care in the PCMH+CHT (Blueprint) setting had access to more effective health services than people who received primary care in traditional settings. Advantages are seen with patterns of healthcare expenditures, utilization, and quality (HEDIS®). Statewide expansion of the Blueprint model accelerated rapidly in 2011, making 2012 the first year where large enough populations received care for a long enough period to support a robust evaluation, including breakouts by age and insurer.

In 2010 and 2011, there were early trends in pilot communities suggesting improving outcomes for Participants versus Comparison groups, however, these results were based on smaller populations and were not statistically significant. In 2012, those early results appear to emerge as real differences between Blueprint Participants and Comparison groups, as larger populations interact with PCMHs and CHTs that have been operating for longer periods of time. In particular, Blueprint Participants are more likely to experience:

- Reductions in annual expenditures per capita for traditional healthcare. These reductions more than offset investments that Commercial insurers and Medicaid make to support PCMHs and CHTs.
- A shift toward improved utilization, including a reduction in inpatient hospitalizations and related expenditures and an unexpected reduction in pharmacy expenditures

- A tendency for Medicaid beneficiaries to increase their use of Special Medicaid Services (SMS), even as their expenditures for traditional medical services are reduced
- A trend toward less specialty care (medical and surgical) with higher utilization of primary care services
- A trend toward higher rates of recommended assessments reflective of preventive care (HEDIS®)

While these results are encouraging, it is currently unknown whether the advantages for Blueprint Participants will persist in 2013 and beyond. Results for 2013 are expected to be available by the third quarter of 2014.

It is important to note that the results of a study like this one can vary depending on who is included in the Participant and Comparison groups. This study included everyone attributed to an active PCMH practice by December 31, 2012, even if their PCMH started operations during 2012 and had a short operating time. The Comparison groups included all Vermont citizens receiving care in all other practices, even those preparing to be a PCMH early in 2013.

These selection criteria are not likely to bias outcomes in favor of the Blueprint model. In fact, Participant and Comparison groups were generally similar, except for the fact that Blueprint Participant groups tended to have higher rates of prevalent chronic conditions. All expenditure and utilization results reported in this study were adjusted for differences between Participant and Comparison groups in the key demographic characteristics shown in Table 2.

Findings in this study point to opportunities for further improvement, as well as the need for additional analyses to support communities as they strive to improve services. One example is the finding that rates of emergency department visits did not show the consistent pattern of improvement seen with inpatient hospital discharges. Looking at the data may show that people went to the Emergency Department with lower acuity problems, some of which may be handled with improved same-day access to their PCMH. Further analysis can help clarify the reasons for emergency department visits and provide PCMHs and CHTs in each community with information they can use to help improve outreach and access.

Another example can be seen with the results of HEDIS® quality measures, where Participants with diabetes tended to have higher rates of recommended assessments than the Comparison groups, though differences did not reach statistical significance in most cases. Reasons may vary to explain the results for each of the four recommended assessments and may extend to factors beyond the control of clinicians, such as benefit design and out-of-pocket expenses. Further analyses combined with learning collaborative activities with Blueprint community leaders provide an opportunity to interpret findings and identify strategies for improvement.

It is unknown whether Medicare beneficiaries are experiencing outcomes similar to those seen for commercially insured and Medicaid beneficiaries. These analyses are underway, including an

independent evaluation being conducted by the Center for Medicare and Medicaid Innovation (CMMI) as part of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration program.

2.h. Additional Observations

Advancements in the Blueprint program, and results from this study, highlight important opportunities for newer healthcare reform initiatives underway in Vermont. In particular, there is a compelling case for:

1. Using newer initiatives, such as Accountable Care Organizations (ACOs), to build on PCMH+CHT operations in each community and enhance the scale and scope of preventive services available to Vermont residents
2. Using the Blueprint program's capability to measure outcomes consistently across all settings to support a next phase of payment reforms that is performance-based and strengthens the quality of preventive health services
3. Building on the Blueprint's data integration and analytics to identify interventions, and combinations of interventions, that help Vermont to achieve the goals of improved health, improved health services, and improved control over healthcare costs

2.h.1. PCMH+CHT as a Foundation for Newer Healthcare Reforms

Effective primary care is considered an essential part of a high-value health system. Based on measures of utilization, expenditures, and quality, PCMHs and CHTs provide a solid foundation of advanced primary care, helping to shift the general population from acute care to more preventive care while reducing healthcare expenditures. Emerging reforms, such as ACOs, can work with these advanced primary care networks in each community, adding additional capacity as necessary, to implement care models that improve outcomes for high-cost patients, while continuing to assure high-quality preventive health services for the general population.

2.h.2. Outcomes-based Payment Reform Models

Implementation and testing of newer payment models will continue as part of Vermont's overall healthcare reform efforts. This Annual Report reflects statewide changes and outcomes resulting from two targeted payment reforms: one designed to stimulate PCMH operations (Transformation) and the other designed to support multi-disciplinary team-based services in the primary care setting (Capacity).

Many of the primary care providers participating in the Blueprint program are calling for a next phase of payment reform linked to the results of meaningful measures (Outcomes). This type of payment model requires the ability to report consistently on key measures across all settings. This capability was established during 2013, and the Blueprint program currently produces

profiles for each participating practice showing how they compare on a series of expenditure, utilization, and quality measures. These practice profiles can help PCMHs and their community partners carry out targeted and comparable quality improvement initiatives.

These advancements provide a solid framework for introducing outcomes-based payment models linked directly to practice-level reporting. With this reporting in place, a composite payment structure (Transformation + Capacity + Outcomes) could be created to help stimulate an even more effective foundation of preventive health services and establish a basis for reducing the influence of fee-for-service payments. Program outcomes, along with feedback from providers and other stakeholders participating in the Blueprint, could be used to refine the Transformation and Capacity payment streams while simultaneously introducing a payment stream based on measure results that are a routine part of comparative reporting to each practice.

2.h.3. Advanced Data Analytics

Finally, it is worth noting that the Blueprint's measurement and reporting capabilities with the All-Payer Claims Database has reached a point where it is possible to evaluate the impact of different intervention layers as '*part of the whole*' health services environment in Vermont. The population treated in the PCMH+CHT setting, reported on in this study, is one example.

Populations participating in other programs, such as the Support and Services at Home initiative (SASH), can be flagged and their outcomes can be measured against a similar comparison group who are not participating in that program. This capability for identification and matching of participants at a program level provides an opportunity to evaluate the additive impacts of different intervention programs, and, most importantly, to determine which programs, or combinations of programs, lead to the most favorable outcomes.

For example, what is the additive impact of community-based self-management programs, such as the YMCA's Diabetes Prevention Program, to the PCMH+CHT setting for people with common health risks? What is the additive impact of ACOs on baseline outcomes established in the PCMH+CHT setting? What is the additive impact of the new addiction and mental health treatment program (Hub & Spoke) to routine services in the community? This level of measurement capability, linked with comparative reporting back to providers, can be used objectively to shape the most effective constellation of services as Vermont works toward a high-value health system.

3. INDIVIDUAL HEALTH SERVICE AREA (HSA) SNAPSHOTS

Implementation of the Vermont Blueprint for Health is led at the local level. This approach to decentralized administration and independent accountability is designed to inspire engagement, creativity, shared decision making, and a sense of ownership.

Each HSA has an Administrative Entity that leads the Blueprint locally. Generally, the Blueprint Administrative Entity is the local community hospital, though in some cases it is the Federally Qualified Health Center (FQHC) or Community Mental Health Center, based on the characteristics of the HSA. These organizations are responsible for local implementation of the Blueprint, including financial management of the program. It is noteworthy that every HSA, through the administrative entity and partner organizations, has contributed its own financial and human resources, sharing in the effort to provide improved quality health care. This level of commitment illustrates the community-based undertaking involved in implementing and sustaining the Blueprint model statewide and is essential to its success.

Each Administrative Entity hires a Blueprint Project Manager, a local leader in the community and surrounding area. He or she is responsible for the Blueprint implementation, including working with the community to determine the design and functions of the CHT; facilitating CHT, extended CHT, and other community-based forums; working closely with Vermont Information Technology Leaders (VITL) to organize efforts to connect practices to the Vermont Health Information Exchange (VHIE) and the central clinical registry (DocSite); and developing relationships with local Buprenorphine providers to support service improvements for treating opioid addiction.

The following pages illustrate local efforts, allowing the reader to see both commonality between communities and the local flavor of the Blueprint. Individual "snapshots" provide a one-page summary of facts about and 2013 activities within each HSA, including.

- Name of HSA
- Name of Project Manager
- Vermont map showing location of HSA in dark blue
- "At a Glance" section, including:
    o Number of practices recognized as PCMHs
    o Total unique patients served by those practices
    o Number of FTEs staffed as CHT members
    o Number of self-management workshops offered and number of participants
- 2013 Highlights
- Chart depicting:
    o Number and types of recognized advanced primary care practices
    o Type of CHT staffing in number of FTEs
- List of named of Blueprint recognized medical homes (PCMH) in each HSA

Barre Health Service Area
Project Manager - Mark Young, RN
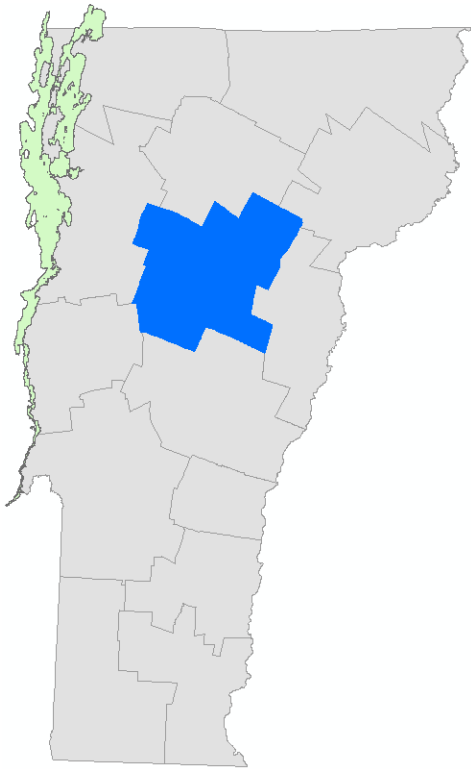
At A Glance

12 practices recognized as Patient-Centered Medical Homes

63,438 Vermonters seen by Blueprint practices in the past two years

10 FTE Community Health Team staff

2.5 FTE Spoke staff

8 Community Self-Management Workshops offered

4 SASH Teams; 302 participants

2013 Highlights

Pediatric practices initiated a Wellness Recall Project to improve rates of well-child exams. As a result pediatric wellness visits increased by 19% compared to 2012.

The transition from hospital to home was improved by contacting patients within 48 hours of discharge and scheduling a follow-up appointment. Transitional care visits increased by 225% in 2013.
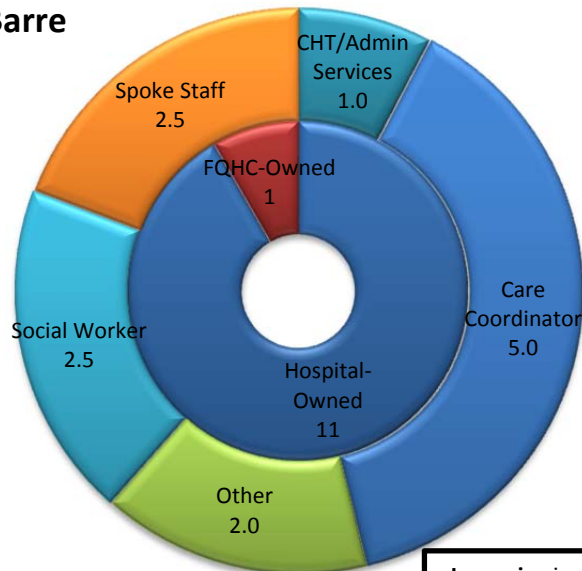
Updating patient registries and introducing Panel Coordinator staff enhanced care by integrating pre-visit planning, self-management, and light-touch care management for patients with chronic conditions.

New systems to identify unmet care need resulted in improved management of chronic conditions. Patients treated for diabetes, for example, had a 42% increase in scheduled follow up visits, 22% increase in current HgbA1C measures, and a 26% increase in self-management action plans.

Medical Home Practices

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

Barre

- CHT/Admin Services 1.0
- Spoke Staff 2.5
- FQHC-Owned 1
- Care Coordinator 5.0
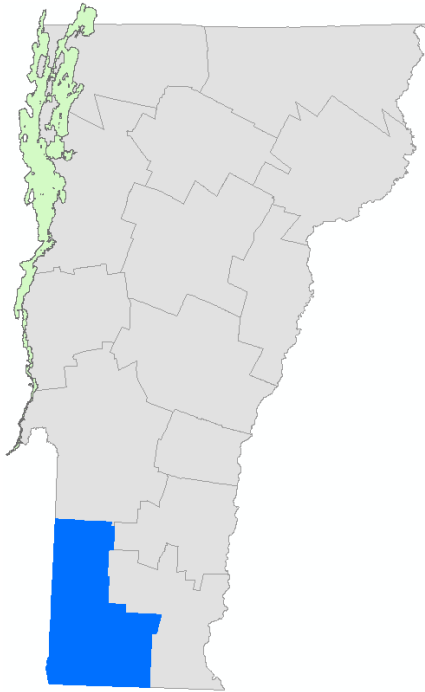- Social Worker 2.5
- Hospital-Owned 11
- Other 2.0

-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Bennington Health Service Area

Project Manager – Dana Noble, RN, MBA

At A Glance

10 practices recognized as Patient-Centered Medical Homes

21,646 Vermonters seen by Blueprint practices in the past two years

6.3 FTE Community Health Team staff

3 FTE Spoke Staff

5 Community Self-Management Workshops offered

3 SASH teams; 181 participants

2013 Highlights

With the addition of 3 new practices, 83% of local primary care providers are in the Blueprint. 7 practices have completed their 2nd recognition process.
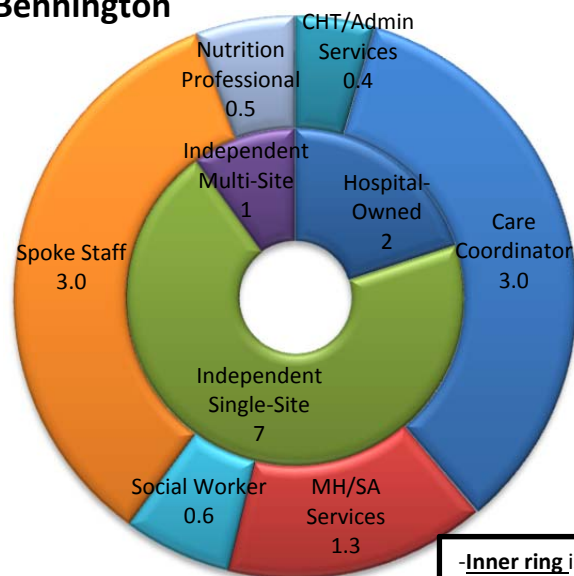
4 practices are providing Medication Assisted Treatment (MAT) to opioid addicted individuals, embedding nurse case managers and substance abuse counselors. Some physicians have increased the number of MAT patients, but demand still exceeds access.

After a year of intensive efforts, 3 practices have verified and accurate DocSite reports. Challenges remain in this important effort to fully implement data quality improvement.

Medical Home Practices

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

Bennington

Inner ring:
- Independent Multi-Site 1
- Hospital-Owned 2
- Independent Single-Site 7

Outer ring:
- Nutrition Professional 0.5
- CHT/Admin Services 0.4
- Care Coordinator 3.0
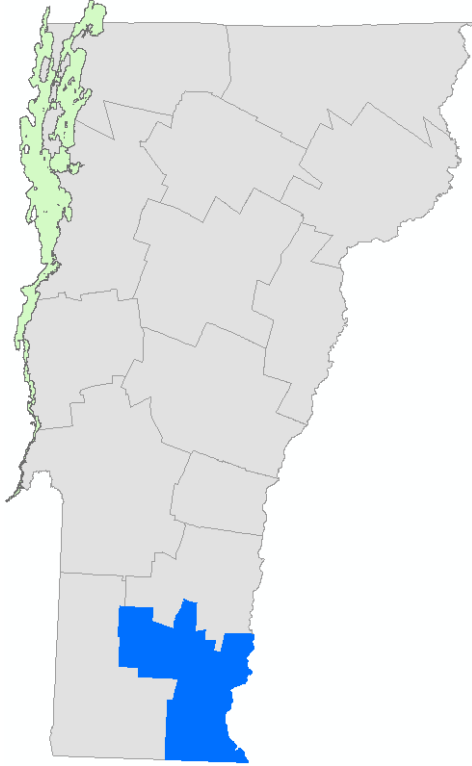- MH/SA Services 1.3
- Social Worker 0.6
- Spoke Staff 3.0

-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Brattleboro Health Service Area
Project Manager – Wendy Cornwell

At A Glance

8 practices recognized as Patient- Centered Medical Homes

23,929 Vermonters seen by Blueprint practices in the past two years

6 FTE Community Health Team staff members

5 FTE Spoke staff

7 Community Self-Management Workshops offered in 2013

2 SASH teams; 126 participants

2013 Highlights

2013 brought major expansion of the Blueprint with 6 new practices including a naturopathic practice.

The Community Health Team served ~500 patients in 2013.

CHT staffs provide care and education in traditional office settings, through home visits, and by organizing events and classes such as Walking Groups, cooking classes, and fitness programs.

New Clinician Case Managers and RNs joined the CHT, providing essential support to patients with opioid addiction.

Medical Home Practices

Brattleboro Family Medicine
Brattleboro Internal Medicine
Brattleboro Primary Care
Cornerstone Pediatrics
HeartSong: Health in Community
Just So Pediatrics
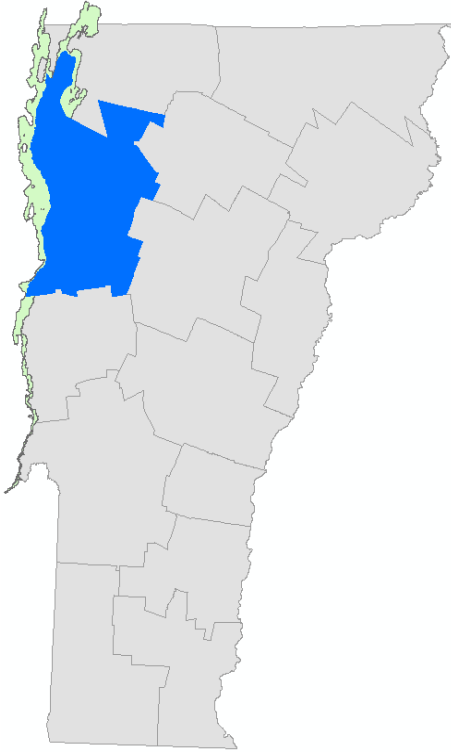**Putney Family Healthcare**
Windham Family Practice

Brattleboro
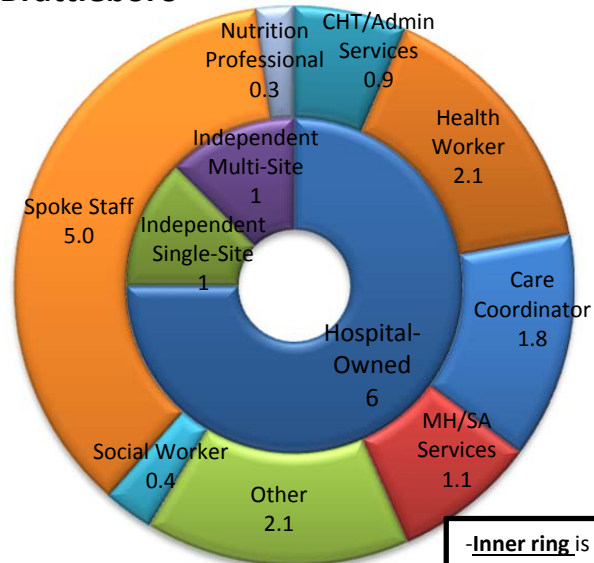
- **Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Burlington Health Service Area
Project Managers – Deb Andrews, Penrose Jackson

At A Glance

25 practices recognized as Patient-Centered Medical Homes

156,309 Vermonters seen by Blueprint practices in the past two years

36 FTE Community Health Team staff members

7.35 FTE Spoke staff

19 Community Self-Management workshops offered

14 SASH teams; 1240 participants

2013 Highlights

Expanding training opportunities for CHT staff statewide, the Burlington Blueprint offered workshops on Panel Management and Motivational Interviewing.

Implementing Hub & Spoke involved significant new system development; RN and MH/SA staff were deployed to Buprenorphine providers for approximately 400 opioid-addicted patients.

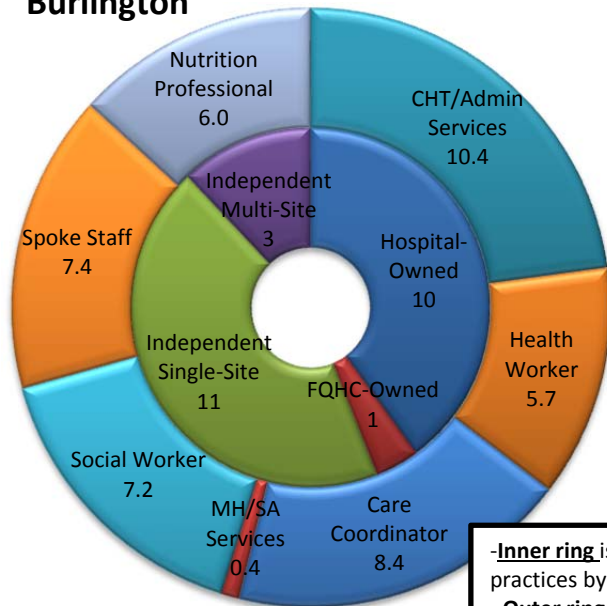The CHT assisted 7,118 patients from December 2012 to November 2013

2 Naturopathic Medicine practices are preparing to become NCQA recognized patient centered medical homes

Leadership changes included a new project manager and the addition of a coordinator for the self-management program.

Medical Home Practices

Aesculapius Medical Center
Alderbrook Family Health
Burlington Primary Care
Christopher Hebert, MD
Colchester Family Practice
Community Health Centers of Burlington
Essex Pediatrics
Eugene Moore, MD
Evergreen Family Health
Given Health Care – Burlington
Given Health Care –Essex
Given Health Care –Williston
Good Health Primary Care
Hagan, Rinehart and Connolly Pediatrics
Hinesburg Family Health
Milton Family Practice
Richmond Family Medicine
South Burlington Family Practice
Timberlane Pediatrics
Timberlane Pediatrics –North
University Pediatrics – Burlington
University Pediatrics – Williston
Winooski Family Health

Burlington

Inner ring (number of practices by type): Independent Multi-Site 3, Hospital-Owned 10, FQHC-Owned 1, Care Coordinator, Independent Single-Site 11, MH/SA Services.

Outer ring (CHT FTE by staff type): Nutrition Professional 6.0, CHT/Admin Services 10.4, Health Worker 5.7, Care Coordinator 8.4, MH/SA Services 0.4, Social Worker 7.2, Spoke Staff 7.4.
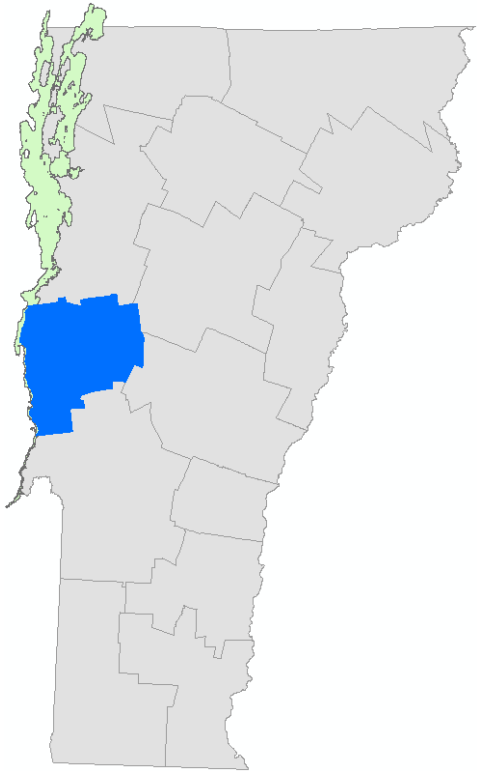
-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Middlebury Health Service Area
Project Manager – Jean Cotner (interim)

2013 Highlights

All 9 practices either completed or were preparing for their 2nd Patient-Centered Medical Home recognition.

The MH/SA Specialists and the Registered Dieticians on the CHT became increasingly integrated into the practices.
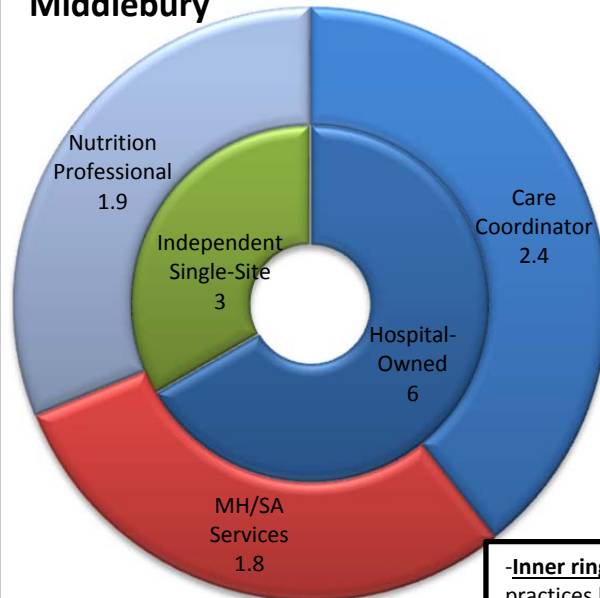
Care Coordinator role was standardized and refined.

A Vermont Health Connect (Health Insurance Exchange) Navigator has been doing significant community outreach and education.

Medical Home Practices

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

Middlebury

Nutrition Professional 1.9

Independent Single-Site 3
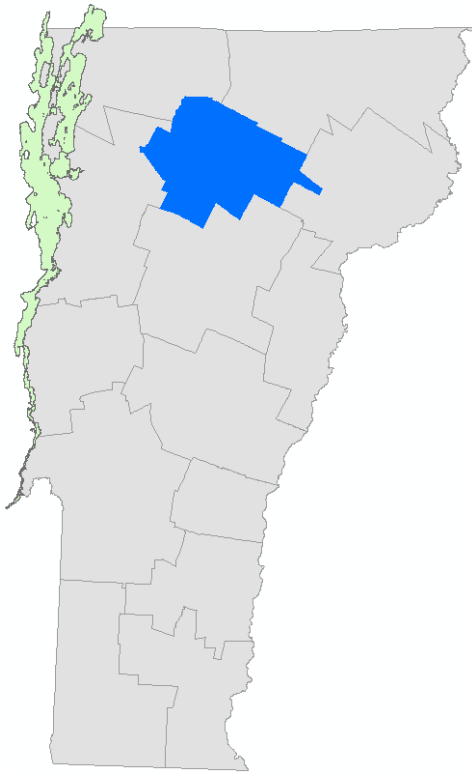
Care Coordinator 2.4

Hospital-Owned 6

MH/SA Services 1.8

-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Morrisville Health Service Area
Project Manager – Elise McKenna, RN, MPH

At A Glance

6 Practices are recognized as Patient-Centered Medical Homes

27,125 Vermonters seen by Blueprint practices in the past 2 years

9 FTE Community Health Team staff

2 FTE Spoke staff

8 Community Self-Management workshops offered

1 SASH team; 30 participants

2013 Highlights

2 new recognized practices, including the first naturopathic practice in Vermont

In a systematic effort to reduce avoidable Emergency Department (ED) visits, the CHT focused on patients who used the ED and did not have a primary care provider (PCP). The CHT successfully connected 208 patients with PCPs.

Next, the CHT will focus on patients with a PCP who use the Emergency Department more than 3 times in a quarter.

Successful use of DocSite (Clinical Registry) by 3 practices that do not have an Electronic Medical Record allowing them to continuously track chronic and preventive care.

Medical Home Practices

Dr. Rogers Family Practice Associates
Hardwick Health Center
Morrisville Family Health Care
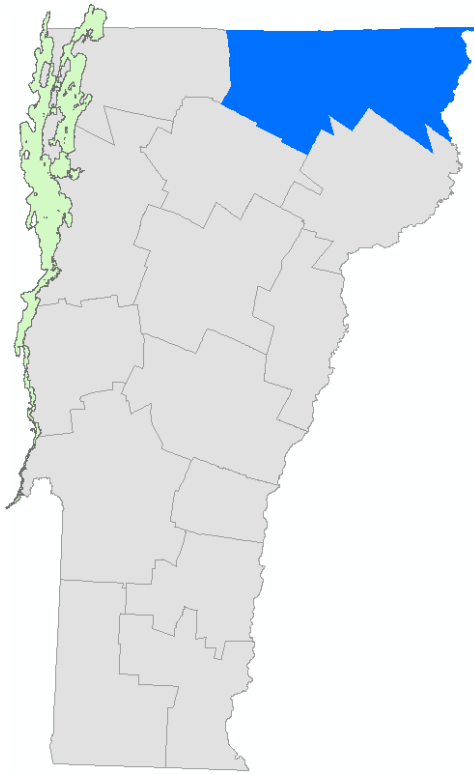**Stowe Family Practice**
Stowe Natural Family Wellness

Morrisville
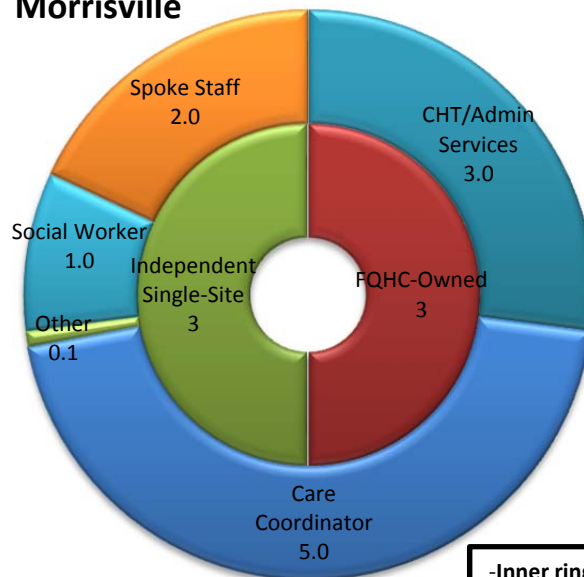
- **Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Newport Health Service Area
Project Manager – Julie Riffon, RN

At A Glance

6 practices recognized

as Patient-Centered Medical Homes

19,611 Vermonters seen by Blueprint in the past 2 years

4 FTE Community Health Team staff

3 Self-Management Workshops offered

1 SASH team; 135 participants

2013 Highlights

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

The CHT served 873 unique individuals

CHT continued on-site asthma education in all six practices, and expanded on-site dietitian services to all six practices in 2013.

North Country Obstetrics & Gynecology submitted documentation to NCQA as an "Early Adopter" in the new Patient-Centered Specialty Practice (PCSP) recognition of program.
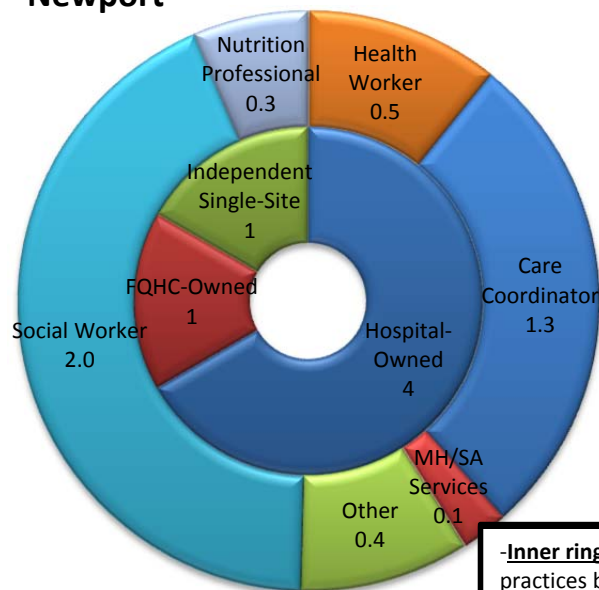
After a seeking patient feedback, North Country Hospital has an improved patient portal called "Follow My Health" with enhanced features such as text messaging, applications for mobile devices, and proxy account access.

Tobacco Cessation services were provided to 144 people.

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

Newport

- **Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Inner ring: Independent Single-Site 1; FQHC-Owned 1; Hospital-Owned 4

Outer ring: Nutrition Professional 0.3; Health Worker 0.5; Care Coordinator 1.3; MH/SA Services 0.1; Other 0.4; Social Worker 2.0

Randolph Health Service Area

Project Manager – LaRae Francis

At A Glance

7 practices recognized as Patient-Centered Medical Homes

25,326 Vermonters seen by Blueprint practices in the past two years

3.5 FTE Community Health Team staff

1.8 FTE Spoke staff

5 Community Self-Management Workshops offered

1 SASH team; 33 participants

2013 Highlights

CHT served 600 patients providing support for chronic health and mental health conditions and assistance connecting patients with primary care, economic, and social services.

Quality improvement efforts focused on asthma, diabetes, self-management, and emergency room utilization. The White River CHT worked specifically on community education for obesity, tobacco use, and breastfeeding.

Community members were assisted in applying for insurance through Vermont Health Connect by Health Insurance Exchange Navigators and Assistors.

Successfully embedded Spoke staff in 3 local clinics and increased collaboration with the local mental health agency and providers.

Medical Home Practices

Bethel Health Center
Chelsea Health Center
Gifford Health Center at Berlin
Gifford Primary Care
Rochester Health Center
White River Family Practice
South Royalton Health Center

Randolph

Nutrition Professional 0.4
Independent Single-Site 2
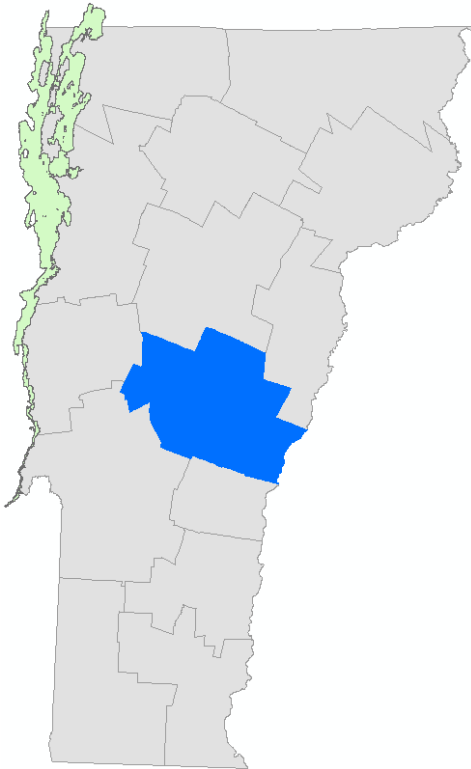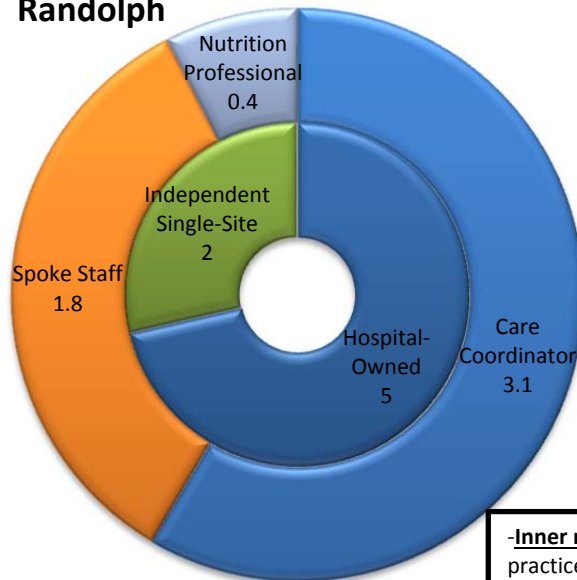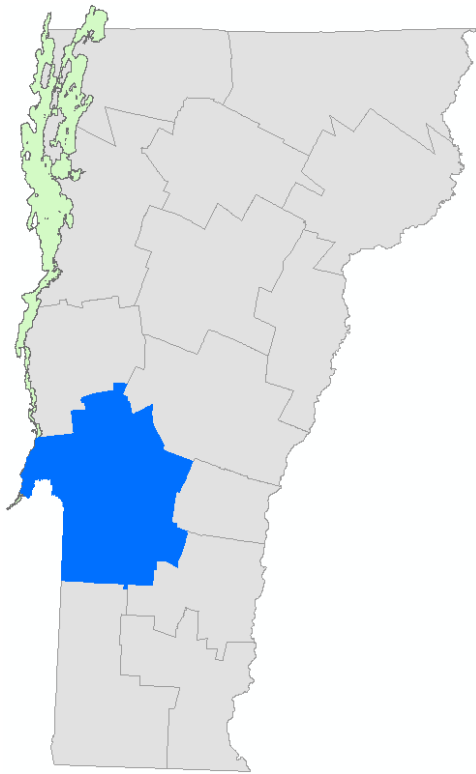Spoke Staff 1.8
Hospital-Owned 5
Care Coordinator 3.1

-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Rutland Health Service Area
Project Manager – Sarah Narkewicz, RN, MS

At A Glance

9 practices recognized as Patient-Centered Medical Homes

42,500 Vermonters seen by Blueprint practices in the past two years

10.5 FTE Community Health Team staff

2 FTE Spoke staff

10 Community Self-Management Workshops offered

3 SASH teams; 302 participants

2013 Highlights

Community Self-Management offerings increased to include Diabetes Prevention, WRAP, nutrition programs and Physical Activity coaching. 278 patients completed a Blueprint self-management program.

Spoke staff have been added to 3 practices that prescribe Medication Assisted Treatment for opioid addiction.

The CHT systematically supports patients to complete and file Advance Directives.

Practices participated in Quality Improvement Collaboratives that focused on Medication Assisted Treatment and Cancer screening.
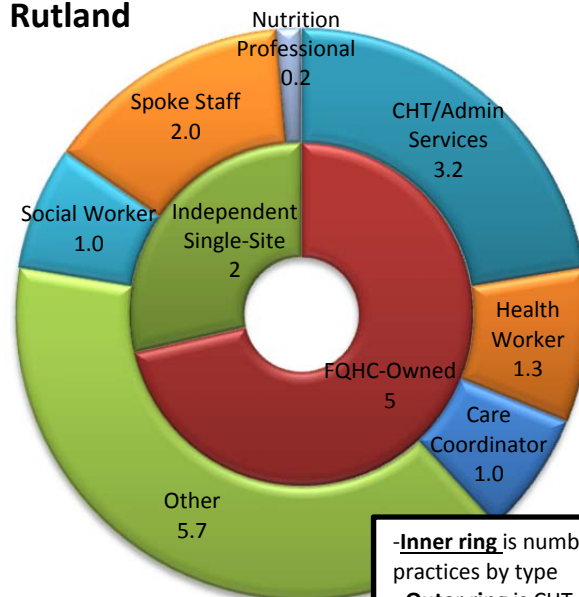
All practices have CHT supported Panel Managers and pediatric case management was added to the core CHT.

Non-Blueprint self-management programs include: Eat Well Feel Great, In Home Asthma Intervention, Cooking Matters Grocery Store Tours, and 100 Miles in 100 Days.
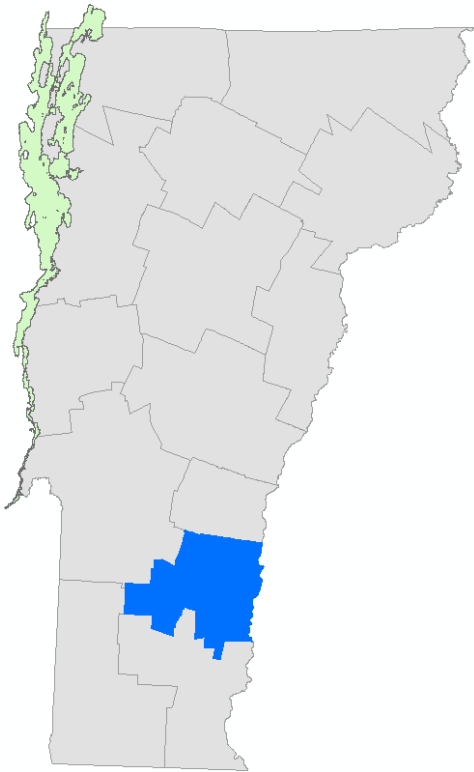
Medical Home Practices

Brandon Medical Center
Castleton Family Health Center
Common Street Health Center (office closed 4/1/13)
Community Health Center of the Rutland Region Pediatrics
Dr. Beverly Roseberry (office closed 8/23/13)
Drs. Peter and Lisa Hogenkamp
Marble Valley Health Works
Mettowee Valley Family Health Center
Rutland Community Health Center

Rutland

Nutrition Professional 0.2
Spoke Staff 2.0
CHT/Admin Services 3.2
Social Worker 1.0
Independent Single-Site 2
Health Worker 1.3
FQHC-Owned 5
Care Coordinator 1.0
Other 5.7

-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Springfield Health Service Area
Project Manager – Kaylie Chaffee

At A Glance

5 practices recognized as Patient-Centered Medical Homes.

26,000 Vermonters seen by Blueprint practices in the past two years

7.85 FTE Community Health Team staff

1.5 FTE Spoke staff

9 Community Self-Management Workshops offered

1 SASH; teams 108 participants

2013 Highlights

All 5 participating practices are recognized at Level 3, the highest level of NCQA Patient-Centered Medical Home recognition and are preparing to be re-scored on the 2011 standards.

The self-management program offered more workshops and the new YMCA Diabetes Prevention Program was very successful.

We implemented the Spoke initiative here with success. Our Medication Assistant Treatment program for opioid addiction continues to grow.
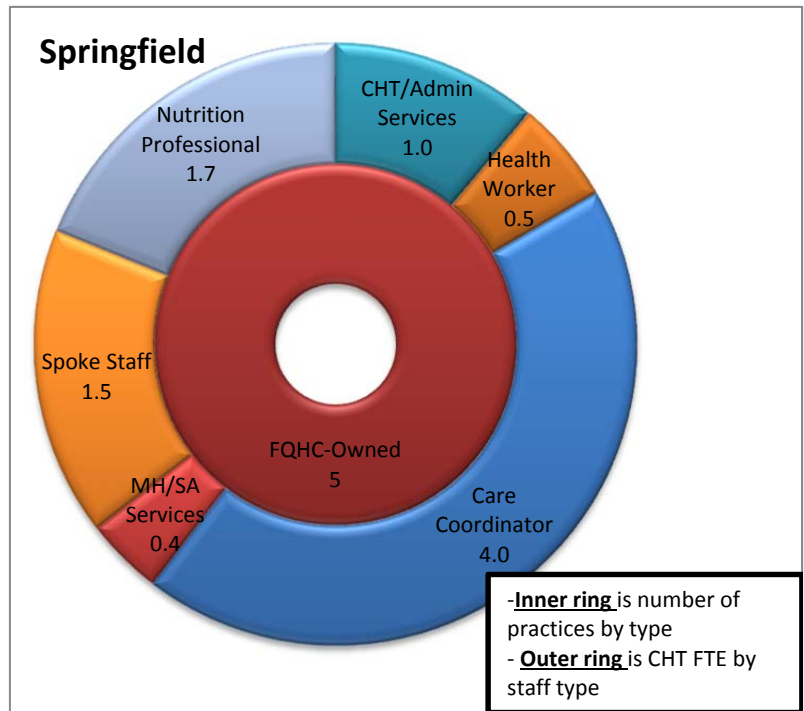
The CHT hired a new member to do outreach.

The CHT developed a model approach to transportation which is a significant issue in the Springfield area.

The extended CHT, including SASH continues to grow as well.

Medical Home Practices

Charlestown Family
Chester Family Practice
Ludlow Health Center
Rockingham Medical Group
Springfield Community Health Center

Springfield

- Nutrition Professional 1.7
- CHT/Admin Services 1.0
- Health Worker 0.5
- Spoke Staff 1.5
- MH/SA Services 0.4
- FQHC-Owned 5
- Care Coordinator 4.0

-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

St. Albans Health Service Area
Project Manager – Candace Collins
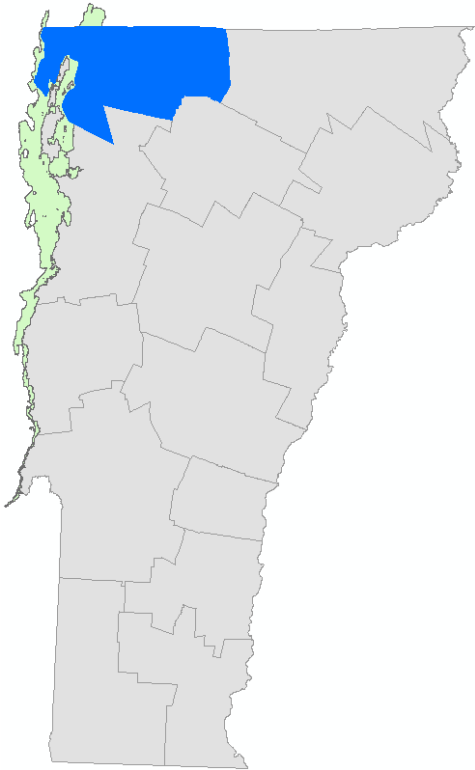
At A Glance

13 practices recognized as Patient-Centered Medical Homes

37, 810 Vermonters seen by Blueprint practices in the past two years

8.2 FTE Community Health Team staff

3.8 Spoke Staff

8 Community Self-Management Workshops offered

2 SASH teams; 81 participants

2013 Highlights

Primary care practices systematically identify high-risk, high-cost patients for referral to the CHT for care coordination, self-management support, and brief treatment of mental health and substance abuse conditions.

Our community is measuring utilization of the CHT– 4.26% of medical home patients have been referred to the CHT.

Patient and provider experience with the CHT was assessed: "I would recommend the CHT to my friends and family."

Strongly agree	79%
Really agree	12%
Agree	6%

Deployed 3.8 new staff to work with 6 Medication Assisted Treatment prescribers to support clients with opioid addiction.

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
NMC Georgia Health Center
NMC Northwestern Primary Care
Richford Health Center
St. Albans Health Center
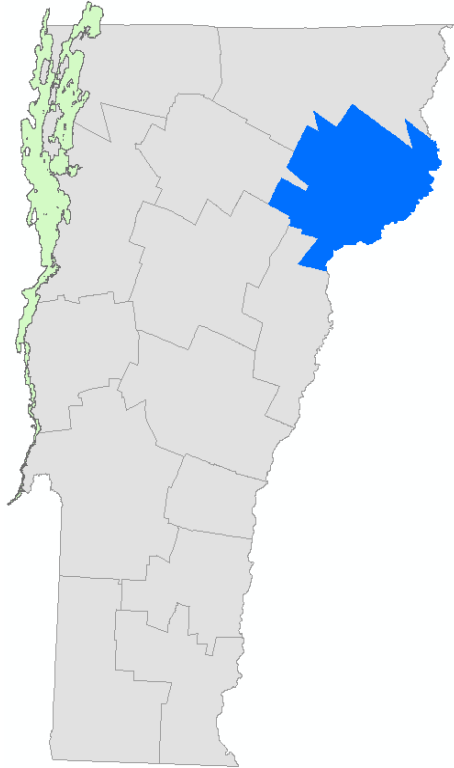**St. Albans Primary Care**
Swanton Health Center

St. Albans
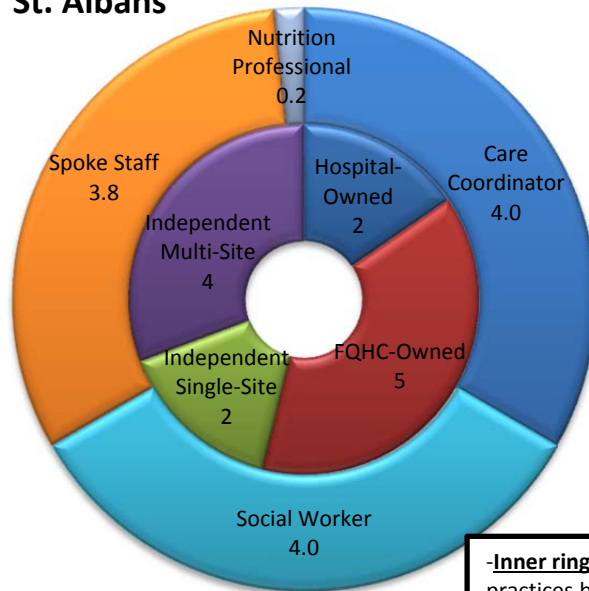
-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

St. Johnsbury Health Service Area
Project Manager – Laural Ruggles, MBA

At A Glance:

6 practices recognized as Patient- Centered Medical Homes

22,000 Vermonters seen in Blueprint practices in the past two years

5.5 FTE Community Health Team Staff

7 Community Self-Management Workshops offered

2 SASH teams; 181 participants

2013 Highlights

Vermont Health Connect navigators were added to the core CHT, with 4 members trained as navigators or certified assistors.

Care Coordinators and Community Health Workers in the CHT partner with the hospital and physicians to reduce readmissions and provide timely palliative care.
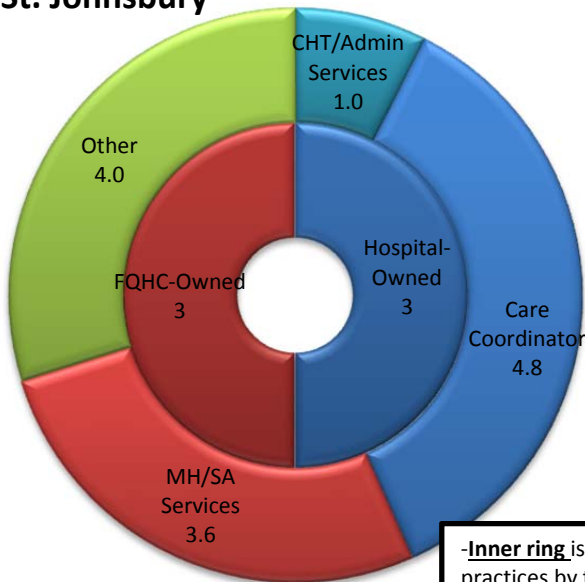
CHT members worked with Certified Diabetes Educators to pilot Lifestyle Approaches to Food and Fitness at a local worksite.

SASH coordinators and community health workers expanded blood pressure self-management education to seniors through the CDC Community Transformation Grant.

Working with ASTHO two medical homes have joined the Million Hearts Campaign to reduce heart attacks and strokes.

71 individuals completed tobacco cessation programs.

St. Johnsbury

- CHT/Admin Services 1.0
- Other 4.0
- FQHC-Owned 3
- Hospital-Owned 3
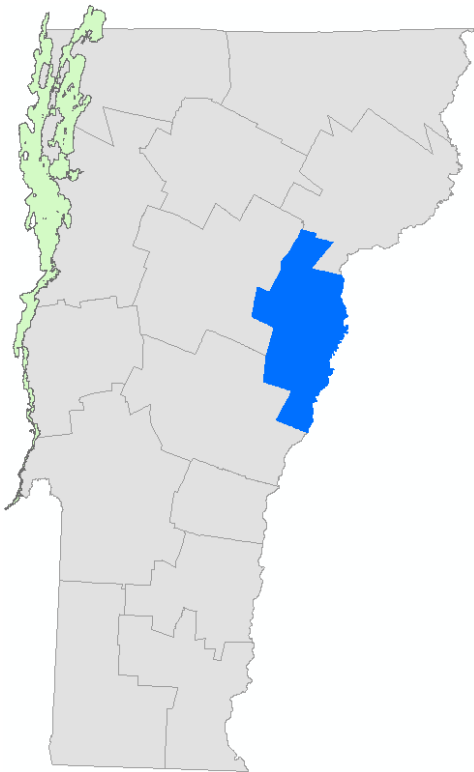- Care Coordinator 4.8
- MH/SA Services 3.6

-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Medical Home Practices

Concord Health Center
Corner Medical
Danville Health Center
Kingdom Internal Medicine
St. Johnsbury Community Health Center
St. Johnsbury Pediatrics

Upper Valley Health Service Area
Project Manager – Karla Wilson, RN

At A Glance

5 practices recognized as Patient-Centered Medical Homes

6,166 Vermonters seen by Blueprint practices in the past two years

2 FTE Community Health Team staff

3 Community Self-Management Workshops offered

0.5 SASH teams; 19 participants

2013 Highlights

The Blueprint established a Care Coordination Collaborative and engaged and educated practices in panel-management approaches including outreach and education

Began offering Diabetic group visits and added

a Registered Dietician to the CHT to work with patients and perform community outreach and education.

The community self-management program was launched and two new workshop leaders were trained.

Leadership joined the Thetford Elder Network Steering Committee and the CHT provided health outreach to farm workers

Medical Home Practices

Little Rivers Health Care
– **Bradford Clinic**
– **East Corinth Clinic**
– **Wells River Clinic**

Newbury Health Clinic
Upper Valley Pediatrics

Upper Valley

CHT/Admin Services 0.5

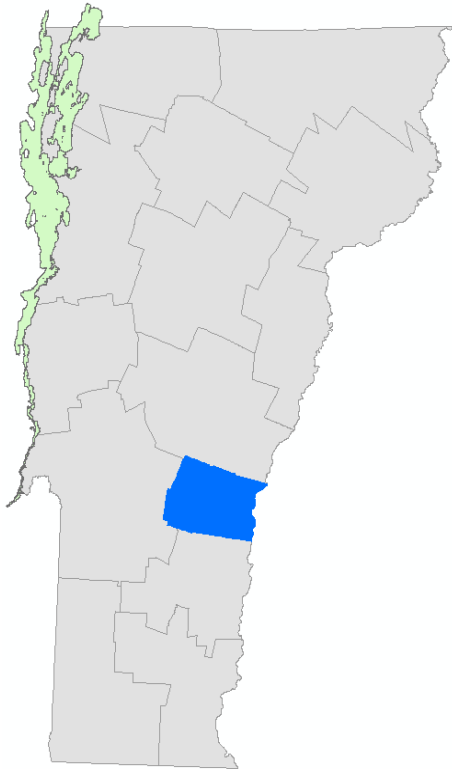Independent Single-Site 2

Other 1.0

FQHC-Owned 3

Care Coordinator 0.5
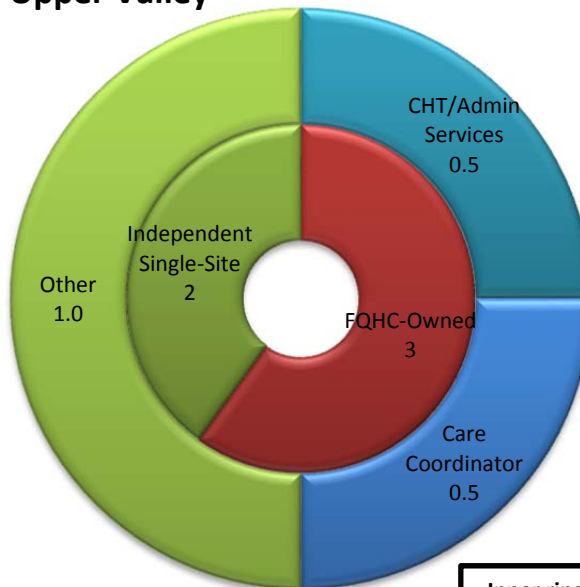
-**Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Windsor Health Service Area
Project Manager – Jill Lord, RN

At A Glance

2 practices recognized as Patient-Centered Medical Homes

12,660 Vermonters seen by Blueprint practices in the past 2 years

2.6 FTE Community Health Team staff

1.5 FTE Spoke Staff

8 Community Self-Management Workshops offered

1 SASH team; 55 participants

2013 Highlights

The primary care interdisciplinary team created a new self-management process supporting patients' identification and achievements of their individual health and wellness goals.
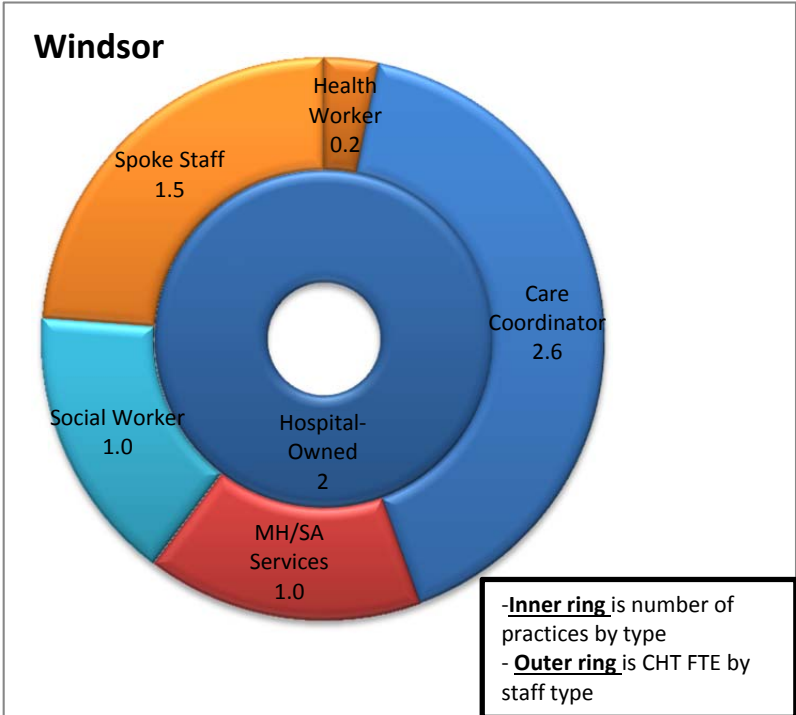
The Medication Assisted Therapy (MAT) Program for opioid addiction and Support and Services at home (SASH) Program were implemented this year.

Integration of mental health and health services were enhanced by a new system of concurrent referrals to CHT when a psychiatry consult is requested. The CHT completes screening & assessment and arranges counseling and self-management programs for the patient.

Funding from the Ottauquechee Health Foundation extended CHT services in the Woodstock area.

The CHT continues to work with community partners to: reduce ED & inpatient visits, improve management of chronic conditions, find homes for the homeless, link patients to needed human services, and promote the health and wellbeing of patients and their families.

It takes a Community Health Team
. . . to make the difference!

Windsor

- **Inner ring** is number of practices by type
- **Outer ring** is CHT FTE by staff type

Medical Home Practices

Mt. Ascutney Hospital and Health Center
**Ottauquechee Health Center**

41

4. BLUEPRINT PROGRAMS AND SERVICES

4.a. Recognized Practices and Patient Populations Served

Starting in 2011 and continuing through 2013, there was extraordinary growth in the number of primary care practices engaged in patient-centered medical home (PCMH) activities. Having moved from pilot to program phase, the Blueprint now has a solid presence in all 14 Health Service Areas (HSAs).

As of December 31, 2013, 121 primary care (including naturopathic, new in 2013) practices have successfully undergone the national recognition process and participate in the Blueprint. These practices collectively serve approximately 514,385 Vermonters. This year 16 practices continued their commitment by renewing their NCQA recognition, updating from the 2008 NCQA PCC-PCMH to the more rigorous 2011 NCQA PCMH standards. Figure 17 highlights the rapid spread since July 2011.

Figure 17. Increase in NCQA PCMH Recognized Practices July 2011-December 2013
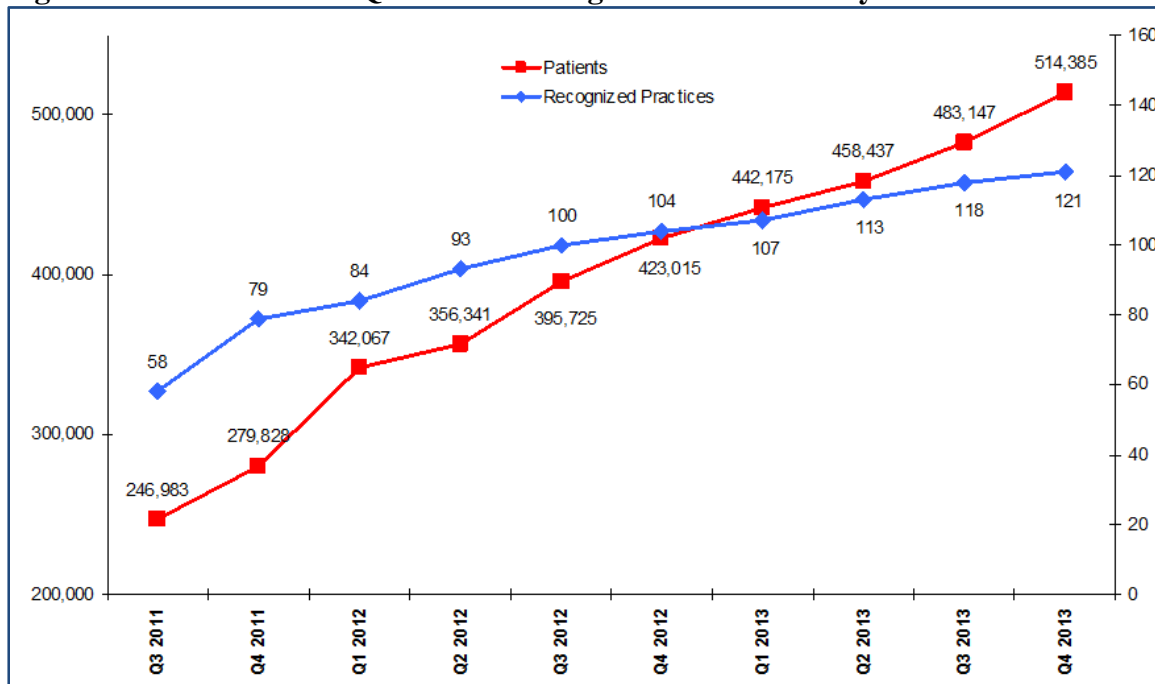
The participating practices are affiliated with a wide range of organization types, as summarized below in Table 4.

Table 4. Recognized Practices and their Organizational Affiliations – December 2013

	Practices	PCP Clinicians	PCP Clinician Full Time Equivalents (FTEs)	Patients
Hospital Owned Practices	51	300	227	243,940
Independent Single Site Practices	34	129	114	104,646
Independent Multi Site Practices	9	44	34	39,296
Federally Qualified Health Centers	27	156	141	126,503
Total	121	629	517	514,385

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

In 2013, the first naturopathic physicians were recognized and supported by the Blueprint.

The Blueprint continues to enroll new practices. There are currently 12 practices actively preparing to meet the NCQA PCMH standards. In addition, all participating Blueprint primary care providers are re-evaluated using updated NCQA standards every three years. Figure 18 shows the affiliation breakdown of PCMH practices participating in the Blueprint.

Figure 18. Percentage of Active Blueprint Practices by Type/Affiliation
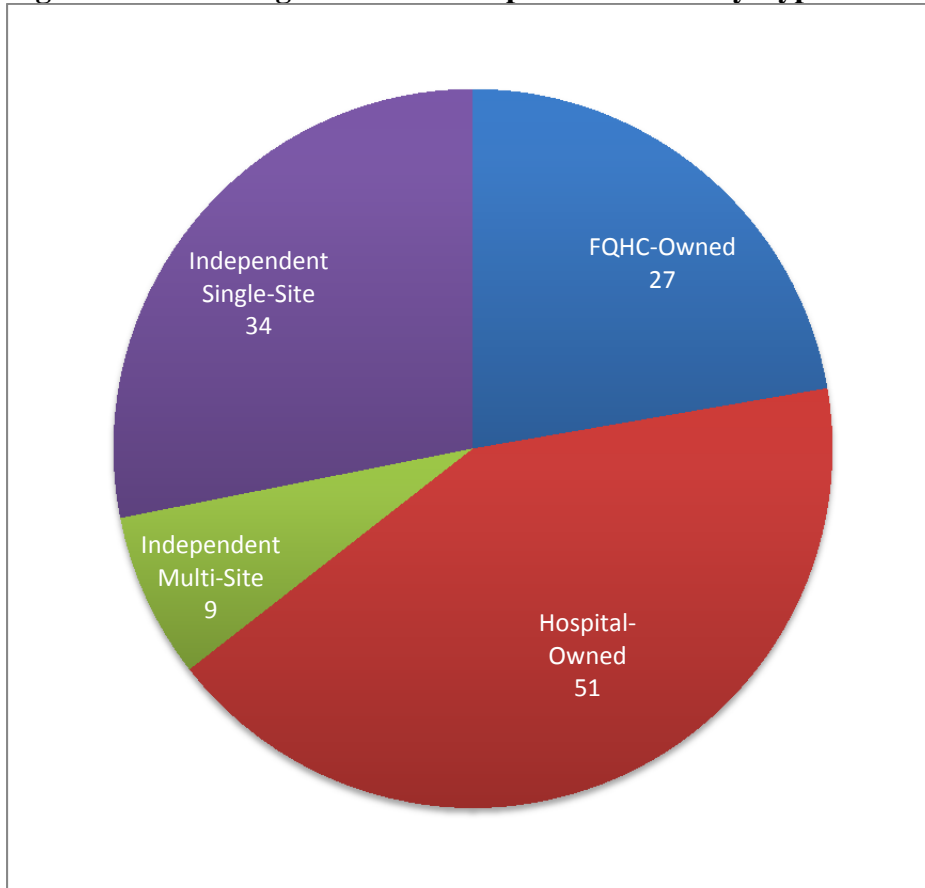
4.b. Community Health Teams

Community Health Teams (CHTs) are perhaps the most important innovation in the Vermont Blueprint. Recognizing that efficient and effective coordination of services has not been readily available to the general population or well integrated across primary care and human services, the CHT staff act as organizing elements to integrate care on behalf of patients.

These local multi-disciplinary teams, funded through Blueprint payment reforms, are designed and hired at the community (HSA) 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, identified gaps in available services, and strengths of local partners.

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
- CHT Administrator

The general job categories of CHT team members are illustrated in Figure 19, and the specific CHT roles in each HSA can be found in the HSA Snapshots section of this document starting on page 26.

Figure 19. Number of CHT Staff by Job Category Statewide – All funding Sources
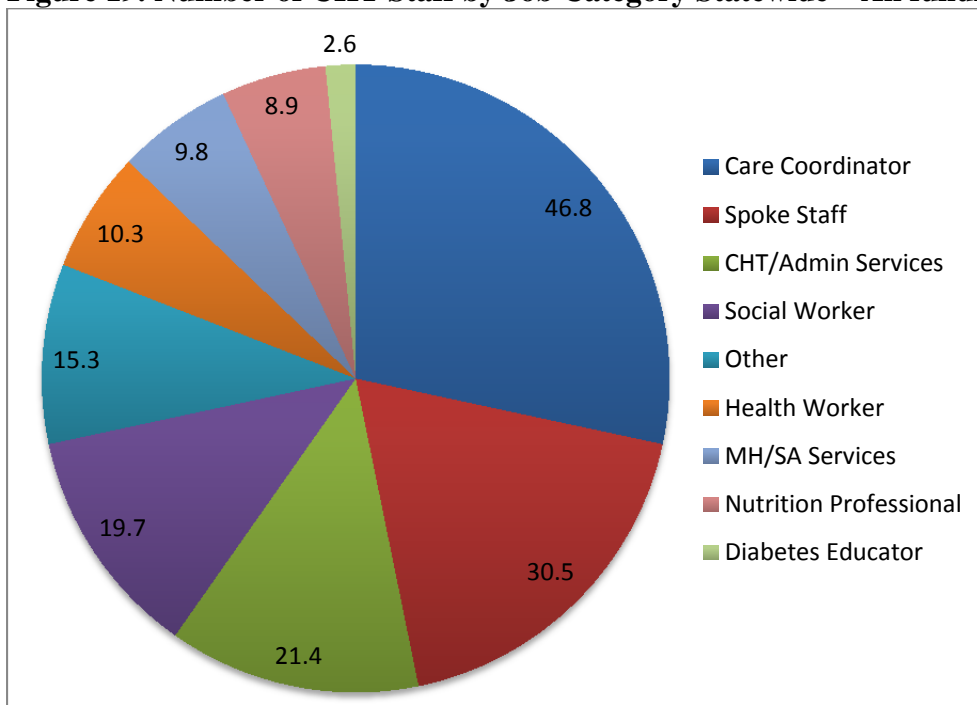
The CHT effectively expands the capacity of the primary care practices by providing patients with direct access to an enhanced range of services and with closer and more individualized follow up. Barriers to care are minimized, since there is no charge (no co-payments, no prior authorizations, no billing) 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 CHT is uniquely able to fill gaps, as its costs are shared by Vermont's commercial and public payers.

The funding available to support the local CHT is proportional to the population served by the recognized and engaged primary care practices in the HSA. Currently, this level 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). As new practices join the Blueprint, the CHT staffing and funding is increased in proportion to the patients seen by the practices. Figure 20 shows the growth of CHT staffing, consistent with the statewide implementation of the Blueprint for Health.

Blueprint Story – Family Supports

"John" is a 17 month old child whose family was referred to the community health team for support with his care. At the time of referral, John was overdue for immunizations and well-child care, experiencing delays with talking and walking, and had a history of respiratory illnesses and seizures necessitating multiple emergency room and primary care visits. His family was struggling with addictions, mental health issues, poverty, transportation, and often missed appointments with John's primary care and specialty providers.

The primary care practice had lost touch with John's family and was concerned. The CHT social worker was successful in contacting and scheduling a visit with John's family. She was effective in assisting the family with the paperwork to establish transportation to medical appointments, reconnecting them with Children's Integrated Services, and scheduling visits with his primary care, neurology, and the ear, nose and throat providers.

Through these connections to services John is now receiving regular physical therapy and other essential services. He has had no recent emergency room visits, has had an updated well-child visit, is up-to-date on immunizations, and has achieved improvements in gross motor skills including being able to walk. His family is now aware of and using transportation resources and is connected with and attending community based care and supports. They are also more optimistic about John's future and are encouraged by the supports they are receiving.

Figure 20. Community Health Team Staff Serving Blueprint Practices – Implementation July 2008 through December 2013
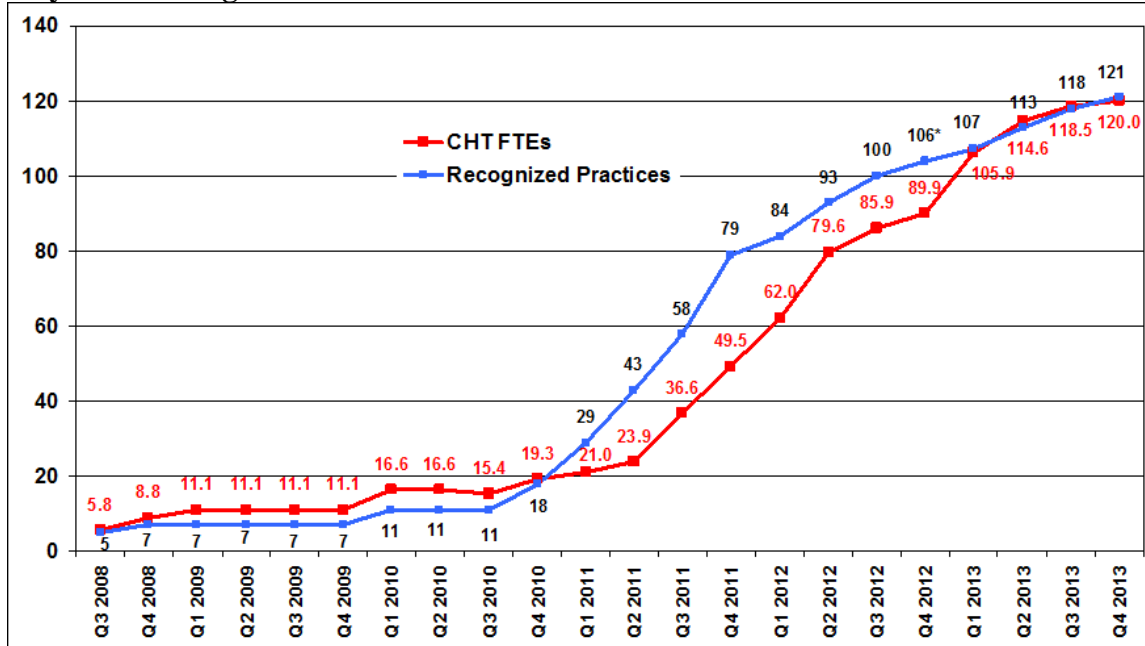
4.c. Extended CHT

Maturing initiatives, such as the Vermont Chronic Care Initiative (VCCI), Support and Services at Home (SASH), and Hub and Spoke extend the reach of the CHT to specific target populations.

VCCI: Supports Medicaid beneficiaries with nurse care management and social work support for time-limited periods for patients who are found to be in the top 5% of health care expenditures.

SASH: Provides nurse (0.25 FTE) and case management (1.0 FTE) support to panels of 100 Medicare beneficiaries.

Hub and Spoke: Builds on the local Blueprint infrastructure to hire and deploy nurses (1.0 FTE) and license addictions treatment counselors (1.0 FTE) for panels of 100 patients who are being treated with Medication Assisted Therapy for opioid addiction in office based medical practices. It also augments staffing in outpatient addiction treatment centers.

The Table 5 shows the community staffing for health and human services care directly resulting from the Blueprint for Health.

Table 5. Blueprint Staffing for Community Health and Human Services

Key Components	December 2013
PCMHs (scored by UVM)	121
PCPs (unique providers)	629
Patients (per PCMHs)	514,385
CHT FTEs (core staff)	120
SASH provider FTEs (extenders)	46.5
Spoke Staff FTEs (extenders)	30.45

4.c.1. Support and Services at Home (SASH)

Support and Services at Home (SASH) is a key component of Medicare's Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration program, funded by the Center for Medicare and Medicaid Innovation Center (CMMI) and awarded to the Blueprint in 2011. This leveraging of federal funds complements the targeted payment streams already part of the Blueprint.

Administered through Designated Housing Organizations, 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 includes an organized, person-centered presence in the community with a SASH Coordinator and Wellness Nurse serving a panel of 100 participants. Since the program is designed to serve all Medicare beneficiaries as needed, SASH participants may live either in subsidized housing or in residences in the community at large. Staff members focus their efforts around three areas of intervention proven most effective in reducing unnecessary Medicare expenditures:

1. Transition support after a hospital or rehabilitation facility stay
2. Self-management education and coaching for chronic conditions and health maintenance
3. Care coordination

The SASH Coordinator and Wellness Nurse function as part of a larger team that often includes the CHT, representatives of local Home Health Agencies, Area Agencies on Aging, and mental health providers. A Memorandum of Understanding (MOU) between all partner organizations formalizes the roles and responsibilities of the team members.

The team meets regularly to facilitate a comprehensive approach to care management that focuses both on the needs of each individual and the health of the population managed as a whole. Individual Healthy Aging Plans are developed for each participant, and the SASH staff then provides the tools necessary to help each participant meet those goals. Based on the cumulative and common goals identified, a Community Healthy Aging Plan is created. This population-level plan 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

Starting as a single pilot team in Burlington in 2009, SASH grew to 26.5 teams by the end of 2012 and added 10 new teams in 2013. With 36.5 teams in place, the total number of people served by SASH grew from 1,323 participants at the end of 2012 to 2,865 participants at the end of 2013 – an overall increase of 46%.

SASH also expanded to offer statewide coverage this year and, as of May 2013, achieved the significant program milestone of establishing SASH teams in every county and HSA in Vermont. Although initially piloted in congregate housing sites, the statewide implementation of SASH includes 478 community participants who live in single family homes or apartments.

Serving community participants presents a unique set of opportunities and challenges for SASH, as teams efficiently address gaps in care by connecting participants to needed services for which they are eligible but may not know about.

Refer to Figure 21 for a growth timeline of the SASH program across Vermont.
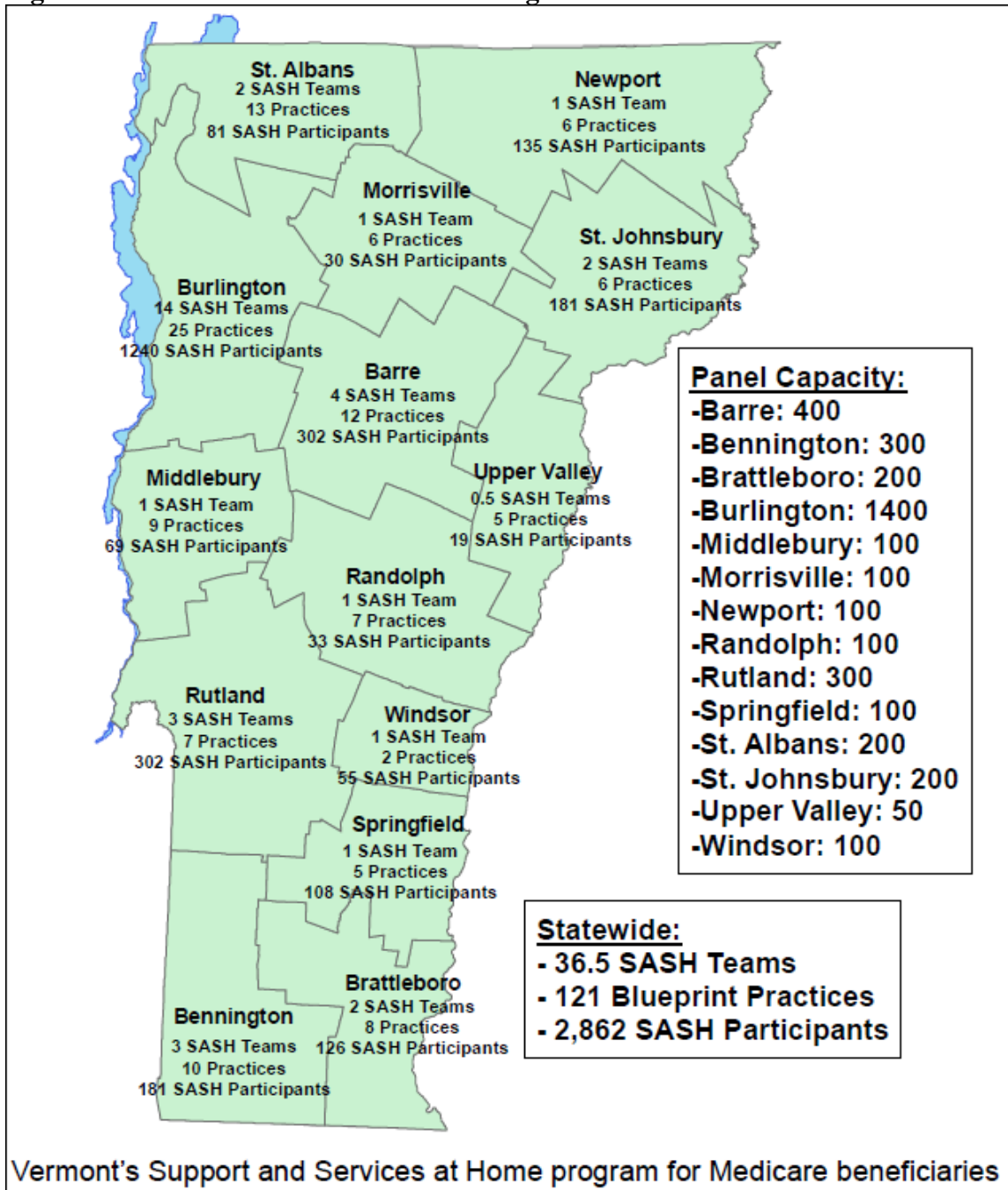
Figure 21. SASH Implementation July 2011 through December 2013
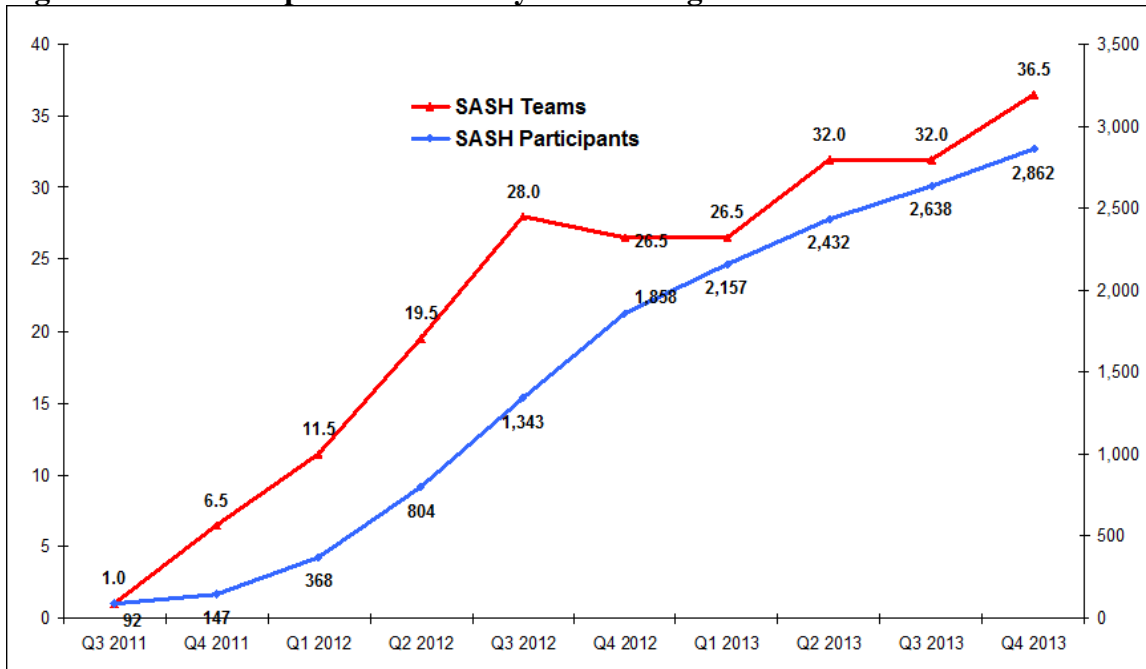
More information about SASH can be found at http://cathedralsquare.org/future-sash.php.

Refer to Figure 22 for a map of the current SASH implementation status.

Figure 22. SASH Teams in Vermont Through December 2013

St. Albans
2 SASH Teams
13 Practices
81 SASH Participants

Newport
1 SASH Team
6 Practices
135 SASH Participants

Morrisville
1 SASH Team
6 Practices
30 SASH Participants

St. Johnsbury
2 SASH Teams
6 Practices
181 SASH Participants

Burlington
14 SASH Teams
25 Practices
1240 SASH Participants

Barre
4 SASH Teams
12 Practices
302 SASH Participants

Middlebury
1 SASH Team
9 Practices
69 SASH Participants

Upper Valley
0.5 SASH Teams
5 Practices
19 SASH Participants

Randolph
1 SASH Team
7 Practices
33 SASH Participants

Rutland
3 SASH Teams
7 Practices
302 SASH Participants

Windsor
1 SASH Team
2 Practices
55 SASH Participants

Springfield
1 SASH Team
5 Practices
108 SASH Participants

Brattleboro
2 SASH Teams
8 Practices
126 SASH Participants

Bennington
3 SASH Teams
10 Practices
181 SASH Participants

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

Statewide:
- 36.5 SASH Teams
- 121 Blueprint Practices
- 2,862 SASH Participants

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

4.c.2. The Care Alliance for Opioid Treatment (Hub & Spoke Program)

As more Vermonters seek treatment for opioid addiction, primary care and specialty addictions treatment providers have struggled to improve access to treatment for opioid addiction. The complex medical, social, and community issues associated with opioid dependence require a systemic treatment response.

Three partnering entities - the Blueprint for Health, the Department of Vermont Health Access, and the Vermont Department of Health Division of Alcohol and Drug Abuse Programs - in collaboration with local health, addictions, and mental health providers are implementing a statewide treatment program. Grounded in the principles of Medication Assisted Treatment[3], the Blueprint's health care reform framework, and the Health Home concept in the Federal Affordable Care Act, the partners have created the Care Alliance for Opioid Treatment, known as the Hub & Spoke initiative. This initiative:

- *Expands access to Methadone treatment* by opening a new methadone program in the Rutland area and supporting providers to serve all clinically appropriate patients who are currently on wait lists

- *Enhances Methadone treatment programs (Hubs)* by 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 specialists prescribing buprenorphine

- *Embeds new clinical staff (a nurse and a Master's prepared, licensed clinician) in physician practices that prescribe buprenorphine (Spokes)* through the Blueprint CHTs to provide Health Home services, including clinical and care coordination supports to individuals receiving buprenorphine

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

---

[3] Medication Assisted Treatment (MAT), the use of medications, in combination with counseling and behavioral therapies, is a successful treatment approach and is well supported in the addictions treatment literature. The two primary medications used in conjunction with counseling and support services to treat opioid dependence are methadone and buprenorphine. MAT is considered a long-term treatment, meaning individuals may remain on medication indefinitely, akin to insulin use among people with diabetes.

Building on the concept 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 the general practice community. This framework efficiently deploys addictions expertise and helps expand access to care for Vermonters. Refer to Figure 23.

Blueprint Story – Addictions Treatment

"Kate", a 38 year old woman, was referred to the CHT for multiple emergency room visits and to connect with community based resources and supports. She was evaluated as having significant mental health concerns and a very high risk for opiate addiction. Prior to referral "Kate" had 40 emergency room visits in 2012 and 46 in the first three quarters of 2013. In addition she had 8 psychiatry and 14 orthopedic clinic visits for pain issues. At that time she had no health insurance.

The CHT care coordinator established a team approach to assist in providing care for "Kate" including her primary care provider, psychiatrist, mental health counselor, and care coordinator at the local community health center. This team has been providing support for Kate for a year.

After 6 months "Kate" came to recognize she had an issue with narcotics for which she sought treatment in a buprenorphine program and established a medical and pharmacy home. In addition, she has become well connected with community services and supports allowing her to transition from almost daily to monthly calls with the care coordinator, and has maintained Medicaid enrollment for almost a full year. Kate's work with the community health team and enrollment in the buprenorphine program has contributed to a significant reduction in emergency room visits. During the last 3 months of 2013 Kate has been to the emergency room only 2 times, whereas prior to enrollment she was seen almost weekly.

Figure 23. "Hub & Spoke" Health Home for Opiate Dependence
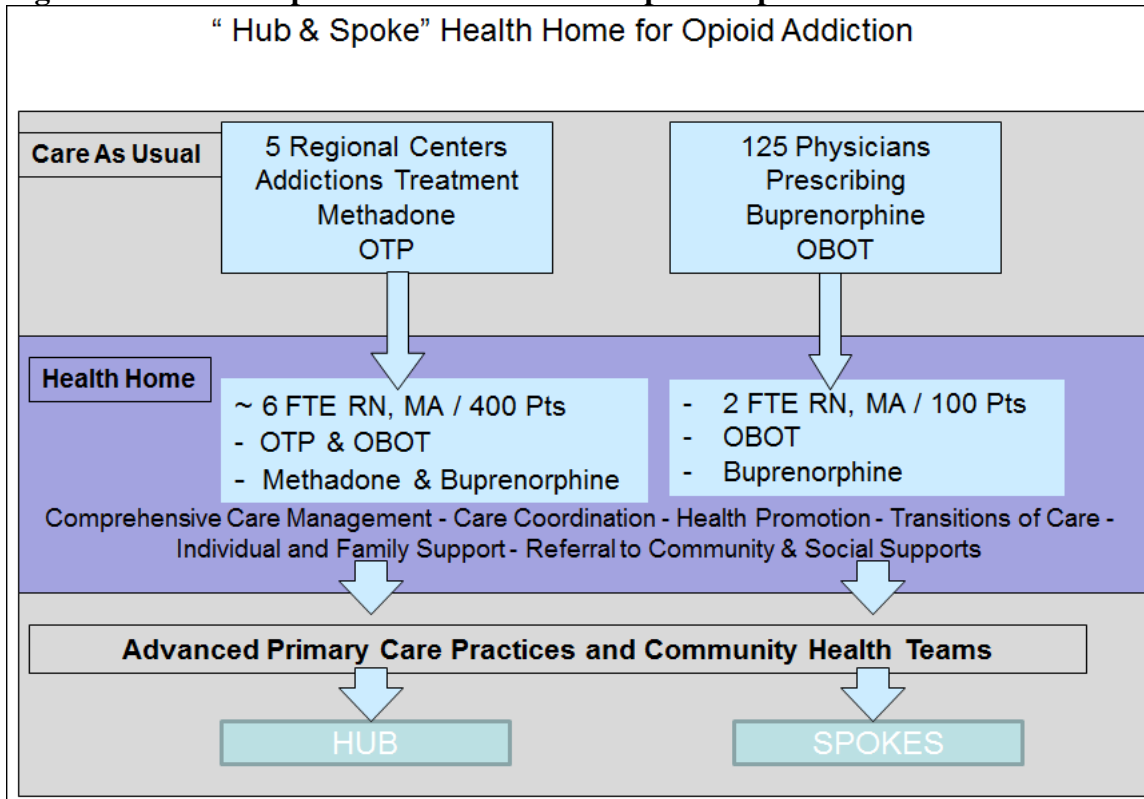
The Hub & Spoke innovation is in the coordinated, reciprocal clinical relations between the specialty addictions centers and the general medical practices. The framework facilitates the development of a treatment continuum that spans the federal regulatory framework for medication assisted treatment and supports the dissemination 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. It also requires a funding mechanism that supports the clinical care management activities that comprehensive and coordinated care for chronic conditions requires.

The Care Alliance for Opioid Treatment (Hub & Spoke) was implemented statewide in 2013. The Methadone treatment programs began offering Health Home Services and started dispensing buprenorphine to patients with complex needs. A new Hub program opened in the Rutland area in November. "Spoke" staff (nurses and licensed counselors) were recruited and deployed statewide to all willing physician practices that prescribe buprenorphine. As of December 2013, thirty full-time equivalent nurses and licensed clinicians were in place working with patients and providers and an additional ten positions are under recruitment.

Table 6 shows the case load of Hub programs and also the number of clients receiving methadone or buprenorphine.

Table 6. Hub Case Load

Hub	Counties Covered by Hub	Program Start Date	Receiving Methadone	Receiving Buprenorphine	Total Clients Served
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/1/2013	494	206	700
BAART Central Vermont	Washington, Lamoille, Orange	7/1/2013	105	47	152
Habit OPCO/Retreat	Windsor, Windham	7/1/2013	408	77	485
West Ridge	Rutland, Bennington	11/6/2013	65	32	97
BAART NEK	Essex, Orleans, Caledonia	1/1/2014	251	49	300
		Total	**1323**	**411**	**1734**

Table 7 shows the number of Medicaid beneficiaries receiving treatment in the "Spokes" and the new full time equivalent staff of nurses and licensed clinicians.

Table 7. Spoke Staffing

Region	Providers	Staff FTE Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	6	3	3	151
St. Albans	7	5	3.8	249
Rutland	5	4.5	2	242
Chittenden	12	8.5	7.35	408
Brattleboro	6	5	5	238
Springfield	3	1.5	1.5	54
Windsor	1	1.5	1.5	62
Randolph	3	2	1.8	91
Barre	8	4.5	2.5	201
Lamoille	6	2.5	2.0	125
Newport & St Johnsbury	3	2.0	Begin 1/1/14	98
Total	57	40	30.45	1,919

Table Notes: Beneficiary count based on pharmacy claims Aug-Oct 2013. Provider count based on MD's prescribing to 10 or more Medicaid beneficiaries. An additional 112 beneficiaries are seen by out-of-state providers.

As part of the CHTs, Medicaid supports the Spoke staff through the local Blueprint infrastructure as a capacity-based payment, thus eliminating 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 the provision of multidisciplinary team care. Like the Blueprint CHTs, Spoke staff (a 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 Vermont's larger addictions, mental health, and human services continuum of care as pictured in Figure 24.

Figure 24. Continuum of Health Services – Addictions Treatment
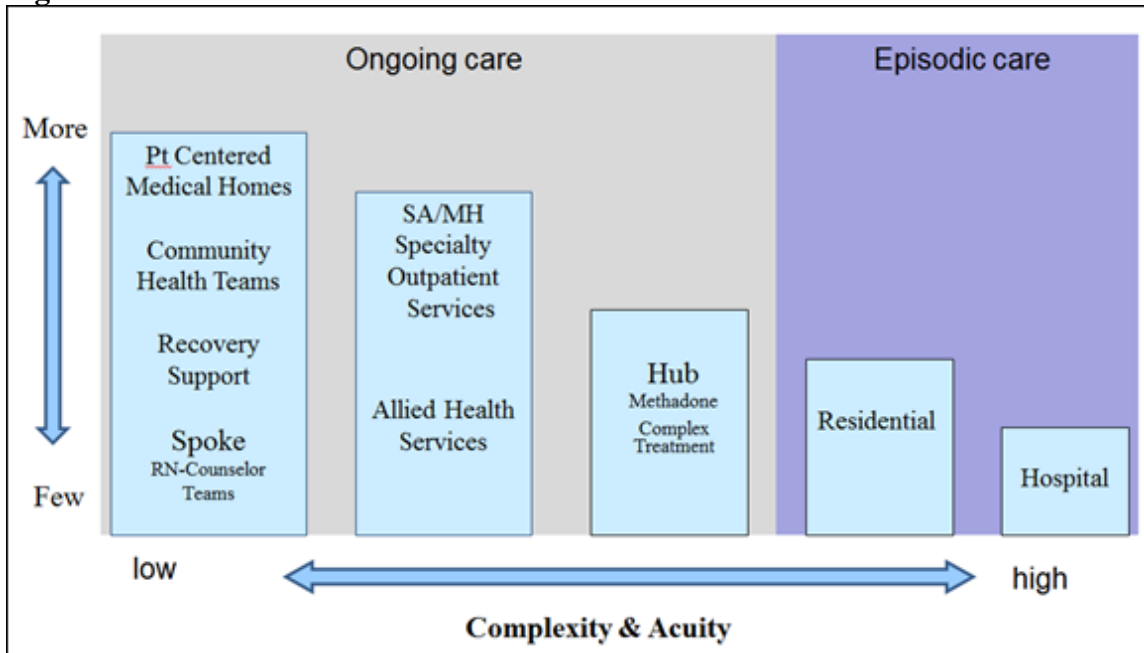
For detailed supporting documents about the Hub & Spoke planning and implementation, refer to
http://hcr.vermont.gov/blueprint.

4.d. The Stories of How the Delivery System is Changing

How has the Blueprint changed the experience of the Health Care system for Vermonters? The patient, provider, and core and extended Community Health Team stories throughout this report illustrate the impacts of the innovations underway. Primary care practices often are able to identify human service needs, the lack of which are negatively impacting their patients' overall health. Through the CHTs the PCMHs now have the resources available to assist patients in making connections with mental health services, addictions treatment, non-medical community resources, and preventive health services.

4.e. Self-Management Support Programs

4.e.1. Introduction

The Blueprint offers a continuum of services to engage patients in improving and maintaining their own health. Services range from individualized self-management support in primary care practices and via CHTs to community-based self-management workshops. 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.

4.e.2. Community Based Self-management Programs

Starting in 2005, the Stanford Chronic Disease Self-Management Program (CDSMP) was introduced in Vermont as Healthier Living Workshops. Uptake of this program was the

Blueprint Story – Human Services

"Pam" who has a diagnosis of bipolar and attention deficit hyperactivity disorders, was referred to the community health team social worker to receive assistance, obtain housing, provide case management, and establish mental health services. She was on the verge of becoming homeless and desperately needed psychiatric follow up for better management of her mental health conditions. Following an assessment of Pam's mental health status, the CHT social worker provided brief counseling to help her cope with symptoms of depression, anxiety and suicidal thoughts until long term services could be obtained. She assisted her in overcoming barriers to using public transportation and completing applications for intensive mental health services, ongoing case management, and psychiatric follow up and therapy.

After several months, Pam has been admitted to the Community and Rehabilitation and Treatment program and now has safe housing that provides support services to help her cope with her mental health issues. She is also seeing a therapist weekly and has enrolled in Social Security Disability, food stamps, and other public benefits that support her overall stability and security. Pam now uses the local bus to get to and from her mental health day treatment program.

first statewide component of the Blueprint. Since that time, the Blueprint has expanded to support six group self-management programs, including:

- The Stanford Diabetes (2010) self-management program
- The Stanford Chronic Pain (2011) self-management program
- Vermont Quit Partners tobacco cessation in-person program (transitioned to Blueprint in 2011)
- Copeland Center Wellness Recovery Action Planning (WRAP; piloted 2012)
- YMCA Diabetes Prevention Program (piloted 2012).

Most notable in 2013 was rapid growth of both the YMCA Diabetes Prevention Program and WRAP, both of which expanded from being offered in one HSA to eight. In 2014, the YMCA Diabetes Prevention Program will start in four additional HSAs and WRAP in three, as shown in Table 8.

Table 8. Self-Management Workshops Offered in 2013 or Planned to Start in 2014 (bold text indicates new in 2013)

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

In 2013, 103 workshops (not including tobacco) were offered statewide, as shown in Table 9, with 1124 registrants and 593 completers.

Table 9. Number of Self-Management Workshops

HSA	HLW Chronic Disease	HLW Chronic Pain	HLW Diabetes	WRAP	YDPP	Grand Total
Barre	4	1	1	1	1	8
Bennington	3	2				5
Brattleboro	2	1	1	2	1	7
Burlington	7	2	6	1	3	19
Middlebury	1		1	1		3
Morrisville	4	2	1		1	8
Newport	2		1			3
Randolph	2	2			1	5
Rutland	3	1	3	2	1	10
Springfield	3	2	2	1	1	9
St. Albans	3	2	1	1	1	8
St. Johnsbury	5	2				7
Upper Valley	2	1				3
Windsor	2	4		2		8
Total	**43**	**21**	**17**	**11**	**10***	**103**

Note number of YMCA Diabetes Prevention Program workshops completed in 2013; 15 YCMA Diabetes Prevention Programs Started in 2013, some have yet to conclude.

4.e.3. Stanford Chronic Disease Self-Management Programs – Healthier Living Workshops

The Stanford 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 and accomplish the things they need to manage their health, as well as to help them keep active in their lives.

The coping strategies introduced are applicable to all chronic diseases. 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 improve 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. The following three HLW program types are offered in Vermont:

- *Chronic Disease Self-Management Program/Healthier Living Workshops (2005)*
  Designed for individuals with one or more chronic conditions, participants learn to control their symptoms through relaxation techniques, healthy eating, managing sleep and fatigue, managing medications, appropriate exercise options, and better communication with health care providers.

- *Diabetes Self-Management Program/Healthier Living with Diabetes (2010)*
  This program focuses on teaching individuals with diabetes techniques to deal with the symptoms of 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.

- *Chronic Pain Self-Management Program/Healthier Living with Pain (2011)*
  Developed for people with a primary or secondary diagnosis of chronic pain, which is defined as lasting for longer than 3 to 6 months or beyond the normal healing time of an injury, this program incorporates techniques to deal with problems such as frustration, fatigue, isolation, and poor sleep. In addition, the program includes instruction on exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; pacing activity and rest; and how to evaluate new treatments.

More information about Stanford workshops can be found at http://patienteducation.stanford.edu.

4.e.4. Tobacco Cessation

The Blueprint and the Vermont Department of Health (VDH) work collaboratively to ensure a spectrum of tobacco cessation services are offered to Vermonters. While the Blueprint is responsible for the Quit in Person program, VDH funds and supports Your Quit Your Way, Quit On-line, and Quit-by Phone options.

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 five personalized calls (20-30 minutes each) to help a smoker get ready to quit and provide tips, advice, and support on how 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.

4.e.5. Wellness Recovery Action Planning (WRAP)

The Copeland Center Wellness Recovery Action Plan (WRAP) is a standardized group intervention program developed by a group of people who suffered from mental health difficulties and who struggled to incorporate wellness tools and strategies into their lives. WRAP is designed to:

- Decrease and prevent intrusive or troubling feelings and behaviors
- Increase personal empowerment
- Improve quality of life
- Assist people in achieving their own life goals and dreams

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.

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

4.e.6. YMCA Diabetes Prevention Program (DPP)

The Centers for Disease Control's Diabetes Prevention Program is a renowned, evidence-based program designed to help adults at high risk of developing Type 2 Diabetes in adopting and maintaining 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 16 weekly one-hour sessions followed by eight monthly maintenance sessions.

In 2013, the Greater Burlington YMCA and the Blueprint continued their strategic partnership to offer the YMCA's Diabetes Prevention Program. The program has shown promising outcomes. Between July 2012 and December 31, 2013, 199 people have participated in 1 of 17 workshops. The average weight loss has been 5.7% of body weight with more than 90.5% reporting improved overall health, 95.2% reduced portion sizes, and 85.7% increased physical activity.

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

5. LEARNING HEALTH SYSTEM

The Blueprint for Health has built a collaborative infrastructure designed to promote a Learning Health System, defined by the Institutes of Medicine as "a system in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience." – *IOM Learning Health Systems Series*

This infrastructure includes the use of learning communities, data reports, the Expansion and Quality Improvement Program (EQuIP), and learning collaboratives, all of which are designed to promote a dynamic environment focused on disseminating best practices and on-going quality improvement.

5.a. Learning Communities

The Blueprint convenes forums at both the state and local levels to develop and disseminate practice innovations. The state-level meetings include:

- Project Managers (every six weeks)
- Practice Facilitators (twice monthly)
- CHT Leaders (monthly)
- Self-management Regional Coordinators (quarterly)
- SASH Coordinators (monthly)
- Spoke nurses and clinicians (monthly)
- Hub program directors (monthly – convened by Alcohol and Drug Abuse Programs (ADAP)-Vermont Department of Health (VDH))

These meetings focus on state updates, collecting and using data to drive improvement, and case studies from the field. In addition, these meeting highlight training needs. For example, during the CHT leader meetings, it came to light that most teams would benefit from skills enhancements in motivational interviewing and panel management, which resulted in Chittenden County offering training events on both of these topics for CHTs statewide in 2013.

In turn, within each HSA, the Project Managers and CHT leaders convene local meetings designed to develop efficient community networks, address gaps in care, and build community resources. The CHT, SASH, Practice Facilitators, and Spoke staffs interact on a daily basis with primary care practices and a wide network of health and human services providers. These

combined state and local regular working forums offer a system for the bi-directional, timely spread of information and innovation.

New this year, in October 2013, the Blueprint convened a semi-annual meeting for individuals implementing the Blueprint at the local level. Best-practice case studies were presented on a broad range of topics, including, but not limited to:

- In-depth understanding and use of the practice profiles
- Use of volunteers on the CHTs to assist patients with advanced directives
- Establishing psychosocial supports
- Building a transportation network
- Re-invigorating self-management support programs
- Panel management
- Reduction in inappropriate Emergency Department use

Each HSA left the meeting with a plan to implement at least one new best practice in their community. The establishment of transportation networks and supporting patients with advanced directives topped the list of action plans for many HSAs.

In 2013 focused efforts were put on SASH and Hub & Spoke expansion. Intentional content-rich learning communities were convened to support these new staff.

5.a.1. SASH

SASH created a training platform of in-person, interactive TV, and webinar offerings, which helped ensure fidelity to the SASH model and consistency of service delivery. Trainings focused on leadership and skill building took place during quarterly face-to-face site visits, in-person regional SASH team meetings, monthly SASH Coordinator Webinars, and regularly scheduled statewide self-management certification sessions. Topics covered include, but are not limited to:

- Motivational interviewing
- Aging well
- Effective communication
- Substance abuse and the use of medication
- Care for the caregiver
- Prevention and self-management of hypertension and pre-hypertension

Understanding the significance of the training platform developed by SASH, the State of Vermont Department of Aging and Independent Living (DAIL) contracted with SASH to implement the Person-Centered Memory Care Initiative to provide skills-based, targeted training for field staff.

This educational initiative will enable partners from the healthcare community to share information and best practices in order to create sustainable community supports for those Vermonters living with dementia. Webinars and VT Interactive TV training opportunities were kicked off in November 2013 and are slated to run through September of 2014.

5.a.2. Hub & Spoke (Care Alliance For Opioid Addiction Treatment)

The Blueprint and ADAP collaborated to create regular training and development forums for the five regional specialty addictions treatment centers (Hubs) and the newly hired Spoke nurses and clinicians working with Vermont's buprenorphine providers. With faculty leadership from the Dartmouth Health System's Addiction Medicine, monthly in-person and phone webinars bring program staff together for program improvement. The goal is to improve care in each practice setting and to standardize care across the statewide system. These networks provide a practical and efficient mechanism to drive improvements in the standard of care and to assure coordination between providers statewide.

5.b. Data Reports to Practices

The Blueprint has added a powerful tool to its evaluation and quality improvement arsenal with the release of the Practice Profiles. These reports, derived from Vermont's all-payer claims database (VHCURES), allow individual practices to assess their utilization rates and quality of care delivered compared to local peers and to the state as a whole, giving them data to assist in honing their quality improvement efforts.

The first set of practice profiles was released based on 2011 data, and both 2012 and 2013 versions will be produced and released in 2014. The ongoing release of the profiles will give the practices a longitudinal look at the outcomes gained compared to their peers, and, though practices are de-identified, may, through their practice facilitators, provide an opportunity to pinpoint and mentor practices that stand out compared to their peers.

5.c. 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, naturopathic, and office-based opiate therapy practices with continuous quality improvement (QI) efforts. In 2013, 13 practice facilitators (9.75 full-time equivalents) have assisted approximately 138 practices with recognition by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes, 33 with process improvement for opioid addiction treatment, and one obstetrics and gynecology practice with NCQA specialty practice recognition.

The EQuIP team members come from such disciplines as social work, nursing, and education 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. Other communication mechanisms with individual practices, such as phone and email, are also used, especially for interim support and follow up.

A practice facilitator's charge is to build ownership and support for continuous QI in the practice. The QI projects are chosen by the practices and are based on their established goals. Practice facilitators guide practices to tailor established QI methodology for "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 developing action plans and timelines to meet the standards

- Electronic systems integration - electronic health record (EHR) implementation and upgrades; reporting from the EHR; connecting to the Vermont Health Information Exchange (VHIE); implementing the centralized clinical registry (Covisint DocSite)

- Improvements in clinical care - Pursuing improvements in the management of chronic conditions (including diabetes, asthma, hypertension, ADHD, depression, tobacco use, obesity, and others); immunizations; preventive services and screenings, such as wellness and well-child exams, lead screening, cervical cancer screening, breast cancer screening, BMI screening, colon cancer screening, autism assessments, and tobacco screening); and access to care (availability of same-day appointments, access by phone, and 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 25) 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 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 25. Summary of 2011 NCQA PCMH Recognition Standards

In 2014, the NCQA PCMH standards will be updated again. In addition, it is anticipated that some of the Hubs (addictions treatment centers) will be recognized under the NCQA specialty practice standards with the support of a facilitator.

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 CHT operations. Options for practices include individual projects with their facilitator and participation in learning collaboratives as described in Section 5.d. Learning Collaboratives. starting on page 69 of this document.

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. They challenge each other in a highly functional manner.

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

5.c.1. PCMH Case Study

NCQA-PCMH standards and the associated ongoing quality improvement work performed by recognized practices provide a framework for better care. The following case study, presented by a Blueprint practice, demonstrates how the PCMH+CHT model increases access to primary care, connects individuals with critical medical and non-medical services, and empowers team-based care.

Patient "Jane Doe" called to cancel an appointment with her primary care provider because she no longer had health insurance. Even though the patient did not request further follow up or assistance from the practice, the practice receptionist went above and beyond by looking for ways to assist the patient. In the course of doing so, she realized that the patient, who was a minor and thus would likely qualify for health insurance through Dr. Dynasaur, had significant health risks and belonged to the practice's identified vulnerable patient population (PCMH6A4).

The receptionist used the internal messaging system within the EHR to contact the practice manager and recommend follow up with the patient and a referral to the CHT social worker embedded within the practice (PCMH3C7). The practice manager reviewed the patient's chart, identifying two chronic health conditions (depression (PCMH3A2) and obesity (PCMH3A3)) diagnosed for the patient among other risk factors on which the practice was focusing their outreach efforts. Upon following up with the provider through the EHR and an in-person meeting, the practice manager learned of further risks to the patient's health, including the fact that she recently became a teenage mother.

The multi-disciplinary team at the practice convened a huddle (PCMH5B4) that included the primary care provider, an on-site psychiatric nurse practitioner, a licensed mental health counselor, and a CHT social worker. Together, they developed a treatment plan for the high-risk patient, including immediate medical treatment, a psycho-social assessment by the social worker, referral for on-going mental health counseling with the licensed mental health counselor, and a medication consult with the psychiatric nurse practitioner (PCMH3C6/PCMH4B3). The practice social worker contacted "Jane Doe" and offered assistance with the insurance paperwork for Dr. Dynasaur, suspended her bill until the insurance could be addressed, and scheduled a same-day appointment to address immediate medical concerns (PCMH3C7).

Over the past 5 months, "Jane" has been keeping her follow-up appointments, meeting regularly with the CHT social worker to address her psycho-social issues, and participating in on-site mental health counseling. She has also been enrolled in health insurance, Reach Up, and WIC.

> *"Without the Blueprint/NCQA Medical Home certification and CHT, we may not have had all of the resources in front of us to craft an immediate and impromptu coordinated action plan. Her needs may have been missed altogether without a staff fully engaged in the Medical Home concept, without our receptionist's instinct to follow up on the cancellation, none of this would have happened. The patient would have gone to the ER, and her depression might not have been addressed in that visit, since they would only have focused on the chief complaint of the visit." ~ Practice Manager*

5.d. 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 to 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. In collaboration with the Vermont Department of Health (VDH), the Blueprint hosted three types of quality improvement learning collaboratives in 2013:

- Asthma
- Preventive screening for cancer
- Office-based medication assisted treatment for opioid addiction

In all cases, participating primary care and specialty practices have collected and analyzed data, participated in learning opportunities on clinical best practices, and made improvements in their patient care. A Blueprint practice facilitator is assigned to each team to assist ongoing quality improvement efforts. The collaboratives give practices the time to think and make decisions about what they would like to change, data on which to make an informed decision, and an environment where it is safe to share and build off of each other's successes and failures.

As Peter Park, MD, a family practice physician in Wilmington, comments:

> *"The quarterly quality improvement reporting and having to present to the other practices has been instructive. In terms of process of change, it is easy to sit during that*

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*30 seconds of time you have to yourself [between patient appointments] and think about what you might or might not want to do. The thought is fleeting because of the overwhelming amount of work that has to be done just to keep your head above water. Having these collaborative meetings takes you out of your practice and has you thinking about process improvement. They provide you with the help and assistance to make those changes, rather than taking it all on your own shoulders. This model of process improvement has been very effective for me and my practice across several clinical issues, including diabetes, asthma, substance abuse, and healthcare maintenance. As much as there may be process improvement fatigue, once you get started attending the meetings, it becomes surprisingly easy to move forward.***"**

5.d.1. Medication Assisted Treatment Learning Collaboratives

To support the Hub & Spoke practice reforms, the Blueprint (in collaboration with the VDH Division of Alcohol and Drug Abuse) convened four regional learning collaboratives focused on Medication Assisted Treatment (MAT) for opiate addiction in 2013, two of which are still in progress.

To date, 27 different practices have sent or are sending teams with physicians, nurses, medical assistants, and office managers to the Opioid treatment collaboratives with 29 physician leaders attending most sessions with teams. The curriculum includes the following topics:

- Assessment of opioid dependence
- Appropriate dosage for buprenorphine
- Monitoring treatment
- Managing challenging behaviors and coordinating with other care providers.

The collaboratives take place over ten months and consist of five half-day in-person sessions and five one-hour webinars. The content includes didactic lectures, case examples, and presentations about how best practice is implemented in clinical care. In addition, each practice reports on common measures important to evidence-based care.

The opioid addiction treatment collaborative included measures for use of the Vermont prescription monitoring system (VPMS), monthly urine analysis, treatment retention, and rates of patients receiving above the recommended dose or more than 16 mg of Buprenorphine daily (a risk for diversion). Throughout the collaborative, practices worked to improve their performance on these measures and other aspects of care. These collaboratives proved to be a powerful tool to improve the standard of care for opioid addiction rapidly. Figure 26 below shows the improving trend for these measures.

Figure 26. Four Key Metrics from MAT Collaborative
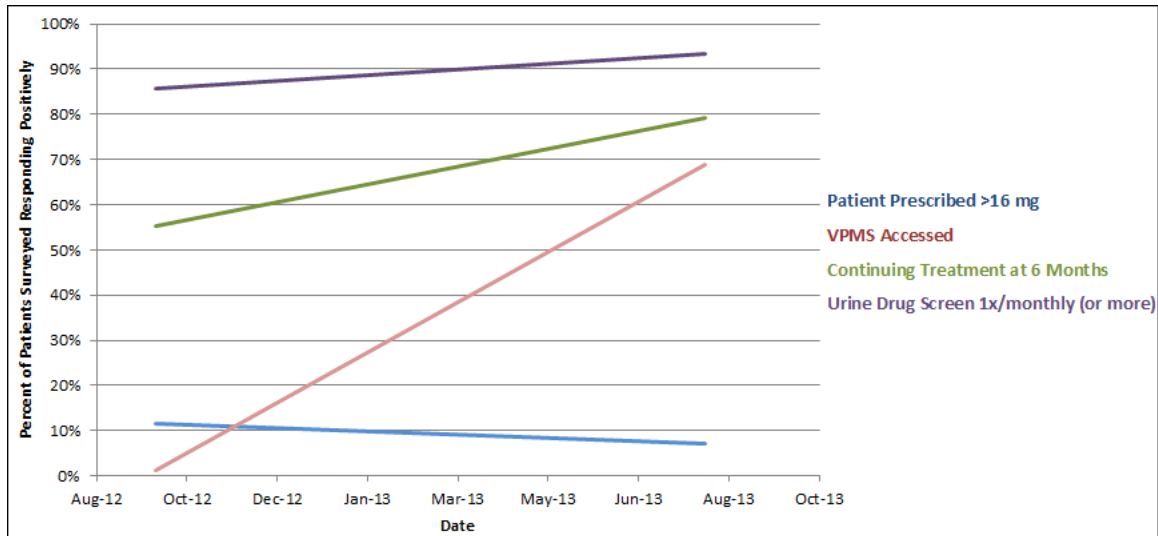
5.d.2. Asthma Learning Collaboratives

Continuing the Asthma learning collaboratives begun in Vermont in 2012, the Blueprint again partnered with VDH to assist primary care practices in focusing on the improvement of care for asthma patients. The ultimate goal is a reduction in unnecessary emergency department visits and hospitalizations related to this condition, which, in turn, reduces the cost of care for these individuals statewide.

Evidence-based guidelines in primary care management of asthma, including routine asthma visits and asthma action plans for patients with this diagnosis, and use of documentation tools to guide evidenced-based care, serve as the foundation for the Asthma collaboratives. The framework for the Asthma collaboratives was originally developed through Blueprint leadership and practice facilitator observation of a learning session on evidence-based guidelines for care of asthma patients given by National Jewish Health in Denver, Colorado (known worldwide for treatment of patients with respiratory disorders) to outpatient practices. The Blueprint then merged this knowledge with documentation tools that guide evidence-based care of asthma management from the Institute for Healthcare Improvement Breakthrough Series.

The Asthma collaboratives consist of three all-day learning sessions over a six month period, action periods between learning sessions, and monthly conference calls.

Sean Uiterwyk, MD, of White River Family practice praised the learning collaboratives, highlighting Asthma in particular, by stating:

> *"the collaborative was a great mechanism to help keep busy practitioners on task to move quality improvement projects forward [and] provided the structure, support, and*

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accountability [to do so]. While we were already tracking some of the same metrics [in our own electronic medical records system], the collaborative data collection tool was helpful to validate our own internal numbers. Asthma in particular was a good topic as it had focused, measurable goals that were reasonably achievable in the allotted time frame."

Nine practices, a combination of pediatric and family medicine, participated in the 2013 Asthma learning collaboratives, each bringing a multi-disciplinary team.

Improvements gained from the Asthma learning collaboratives included systematically assessing asthma severity and control at every visit, developing asthma action plans with all asthmatic patients, and ensuring school and child care providers have updated copies of asthma action plans, as well as in-office spirometry and asthma educators at practices.

Figure 27. 2012 and 2013 Vermont Asthma Learning Collaboratives (VALC) Practice Performance Measures at Baseline and 6 Months.

a. Percent of Asthma Panel with an Assessment of Severity
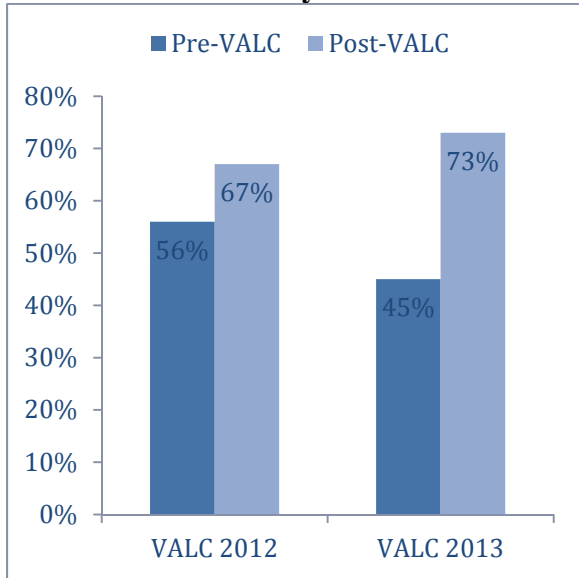
b. Percent of Asthma Panel with Current Asthma Action Plan
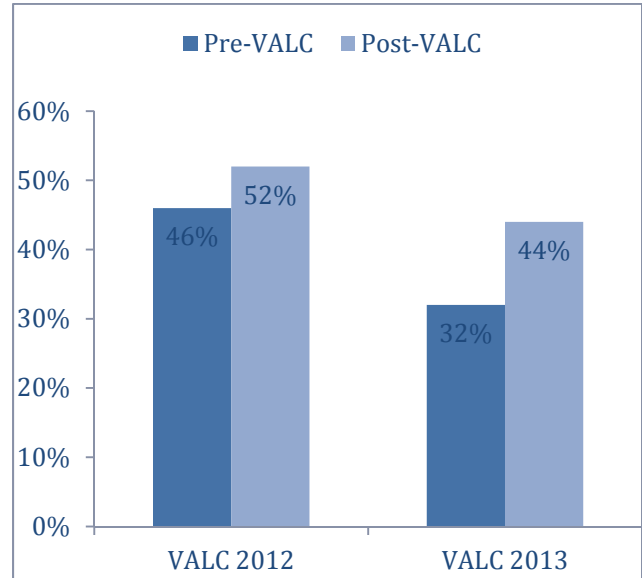
c. Percent of Asthma Panel with Current Assessment of Control
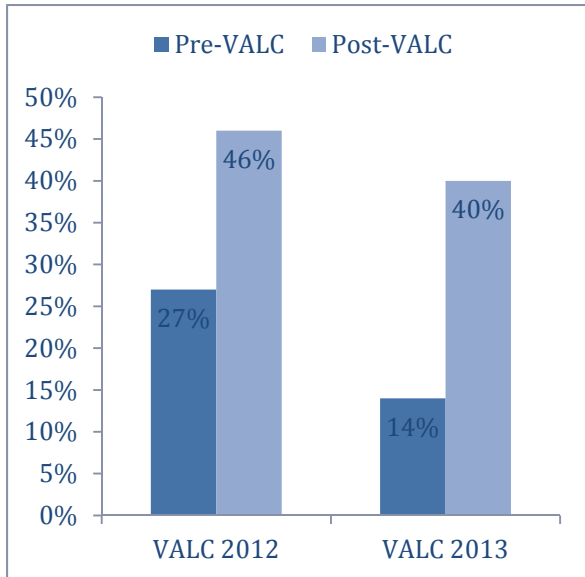
d. Percent of Asthma Panel that Received Spirometry in the Last 12 Months
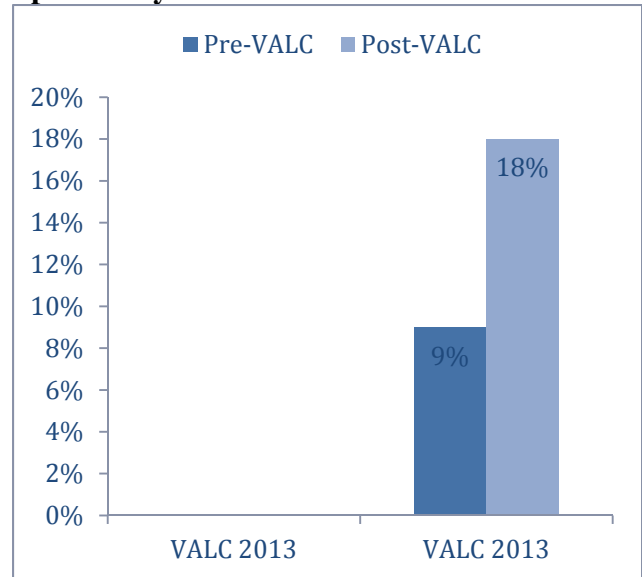
Based on the overall success of the Asthma learning collaboratives, an online version may be offered in 2014.

5.d.3. Cancer Learning Collaboratives

The Cancer learning collaboratives targeted increasing the number of patients receiving the recommended screening tests and follow-up care for breast, cervical, and colorectal cancers. These types of cancer are most survivable when found and treated early.

The Cancer collaboratives consist of five full-day in-person learning sessions and four one-hour conference calls followed by action periods during which practices identify, measure progress toward, and take actions to achieve defined improvement goals. Blueprint practice facilitators also assist teams in applying evidence-based approaches to improve cancer screening rates in offices and clinics.

Topics covered at the Cancer collaboratives include guidelines for cervical, colorectal, and breast cancer screening, panel management, referral tracking, risk assessment, pre-visit planning, shared decision making, and care coordination. Improvements gained from this collaborative include identifying and reaching out to patients due for tests, developing agreements with referring providers to coordinate care, including receiving test results, and coordinating with the local screening centers.

Four practices participated in this initial pilot cancer screening collaborative. Future preventive screening collaboratives may be scheduled, but based on the learning from this collaborative will focus more closely on one clinical process.

6. BLUEPRINT PAYMENT REFORMS

6.a. Transformation and Capacity Payment Reforms (Fully Implemented in Primary Care)

As of 2013, the two planned Blueprint payment reforms (for Transformation and Capacity) are 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 fully participate. These 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 are illustrated in Figure 28.

1. Transformation: Per Patient Per Month (PPPM) payments are based on the scoring level achieved by the primary care practice in NCQA-PCMH Recognition. This payment is quality-based, comes in addition to traditional Fee for Service (volume-based payment), and

provides incentive to practices for quality. It promotes access, communication, guideline-based care, well-coordinated preventive health services, use of electronic tracking systems, and population management.

2. Capacity: All insurers share the cost for core CHT members. Total support is provided at the rate of $70,000 (~1.0 FTE) / 4000 patients. This Capacity payment reform establishes a community-based care support infrastructure 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 28. Blueprint Payment and Delivery System Reforms
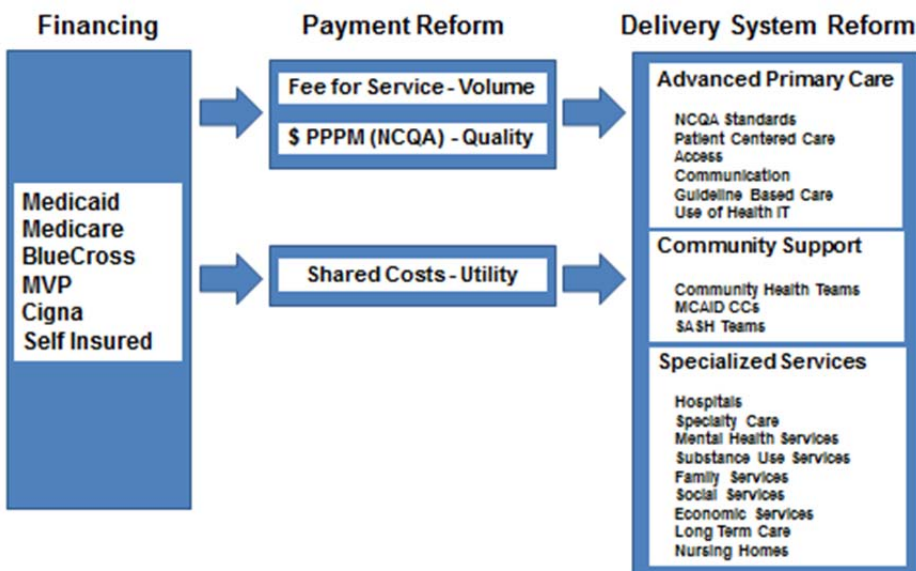
7. HEALTH INFORMATION TECHNOLOGY

The programs and services provided through the Blueprint are supported by a statewide health information technology (HIT) infrastructure.

One important part of the infrastructure is the Vermont Health Information Exchange (VHIE), which is operated by Vermont Information Technology Leaders (VITL). With the assistance of the Blueprint, VITL connects practice Electronic Health Record (EHR) systems to the VHIE via three different types of interfaces:

- Admit, Discharge and Transfer orders (ADT)
- Continuity of Care Documents (CCD)
- Medical Document Management (MDM) reports

In 2013, VITL added 29 new interfaces from 27 primary care and specialty practices to transport data through the VHIE to the Blueprint Clinical Registry (DocSite) and is now transporting an average of 600,000 clinical messages a month on behalf of the Blueprint program through the VHIE. In total, VITL supports 133 interfaces for Blueprint practices. VITL has also built interfaces with hospitals, labs, and other data sources and plans to introduce in 2014 a provider portal that will allow access (with appropriate consents) to a consolidated view of patient health information.

Vermont's central clinical registry, known as Covisint DocSite, is one end-point for demographic and clinical data from the VHIE. DocSite serves as a reporting engine with the capability for population health analysis across the state. In addition to data coming from interfaces with the VHIE, Blueprint primary care practices and programs such as SASH can send information to DocSite via interfaces, flat files, or direct date entry. Figure 29 shows a schematic of Vermont's statewide clinical HIT infrastructure.

Figure 29. Clinical Health Information Technology Schematic Diagram
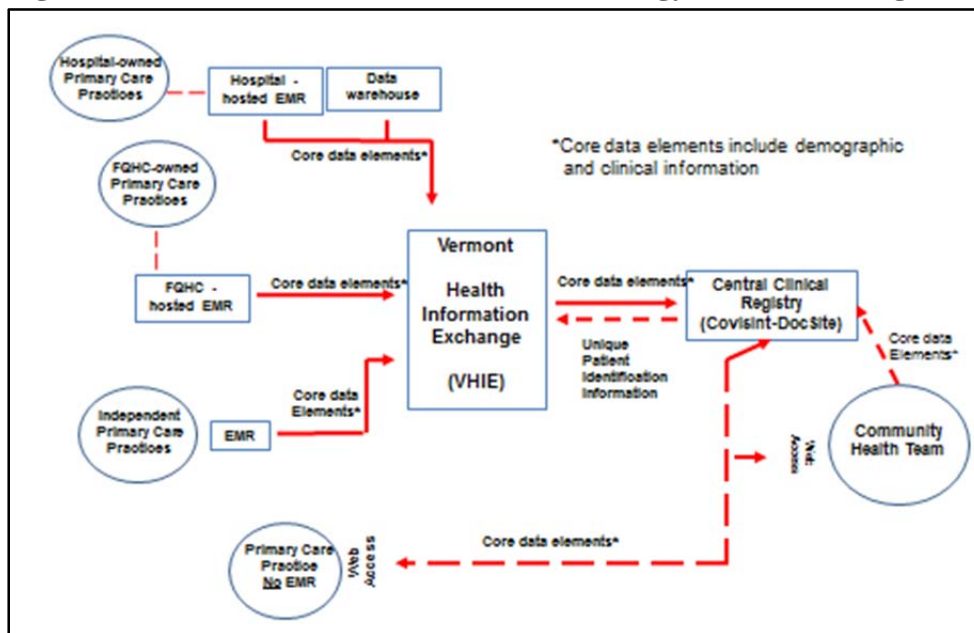
7.a. End-to-End Healthcare Information Transmission - Blueprint Sprints

7.a.1. Sprint Introduction

Data quality in practice EHRs and the VHIE are essential. Newer team-based care models rely on their IT systems with accurate data to generate lists (or reports) of patients that need attention, such as women over 50 who are overdue for a mammogram or diabetics who need an office visit

to take blood pressures or other tests. Good quality data is also required for reliable outcome measurements and comparative effectiveness analyses.

The Blueprint employs a team-based approach, known as Sprints, across organizations to ensure accurate, timely, and reliable end-to-end data extraction, transmission, and registry reporting to support the delivery of high-quality health services. To date the Sprints have uncovered a number of common data quality issues, such as patients still flagged as active who are actually deceased or patients attributed to a provider who no longer practices at that location.

Sprint project team members work together via weekly meetings and a joint action plan until identified issues are resolved. The Sprint is considered complete and successful when the lead clinician for the project and a Blueprint project team representative verifies and attests to continuity of data quality from the source EHR through the VHIE to the DocSite clinical registry based on clinician satisfaction with the reports generated from DocSite.

The data quality improvements achieved by the Sprints will benefit users of data from the VHIE ranging, from independent solo clinical practices to hospitals to Accountable Care Organizations (ACOs), all of whom need access to high-quality, trustworthy, and secure information.

7.a.2. Current Sprint Projects

There are two different types of Sprint projects:

- Remediation, which involves resolution of data quality issues for existing interfaces
- Onboarding, which involves data clean-up at the source (EHR) system prior to bringing the interfaces Live

In 2013, 7 Sprints were completed for 16 practices serving 77,600 active patients and 3 different EHR systems, as shown in Table 10.

Table 10. Sprint Projects Completed in 2013

Health Service Area	Organization	# Clinical Sites
Barre	The Health Center	1
Bennington	Independent (2)	2
Bennington	SVMC	2
St. Albans	NoTCH	5
St. Johnsbury	NCHC	5
St. Johnsbury	NVRH	1

The total number of active Sprints begun in 2013 and scheduled for completion in 2014 includes 5 remediation and 10 onboarding Sprints, which represent 55 practices serving over 300,000 active patients and 9 different EHR systems. Refer to Table 11 for details.

Table 11. Sprint Projects Ongoing in 2014

Health Service Area	Organization	# Clinical Sites
Barre	CVMC	12
Bennington	SVMC	1
Brattleboro	BMH	9
Burlington	CHCB	3
Burlington	Richmond	1
Burlington	Thomas Chittenden	1
Middlebury	Middlebury	1
Multiple	PCHP	8
Rutland	Hogenkamp	1
Rutland	CHCRR	7
Springfield	SHC	6
Windsor	Grace Cottage	1
Windsor	MAHHC	2

The current Sprints are in various stages of completion with three working towards a goal of ending in February 2014. As Sprints are completed, additional communities can engage in the process with a maximum of 8 concurrent Sprints operating at any given time. Assistance from eHealth Specialists at VITL in 2014 will provide capacity for additional and more accelerated Sprints. Each completed Sprint goes into maintenance mode in which regular reports assessing the accuracy and completeness of demographic and clinical data are provided to ensure the ongoing health of various information systems and the preservation of data integrity to meet high quality standards.

7.a.3. Core Data Quality

The Blueprint Sprint team experience has identified a core set of data quality issues consistent across a majority of practices. Issues fall into two major categories:

- Demographic and administrative data known as Admit, Discharge, and Transfer (ADT) data
- Clinical data made up of encounters recorded in the EHRs and laboratory results.

Admission, Discharge, and Transfer (ADT) Data

Proper provider-to-patient panel attribution is the biggest issue addressed in all communities during the Sprint process. This data set can be anywhere from 25% to 95% inaccurate and encompasses:

- Active and inactive providers
- Active, inactive, and deceased patient status
- Proper patient attribution to a provider

Clinical Data

Major issues encountered with the clinical data center around unstructured or free-text data entry into the EHR, 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.

Since data quality issues vary from one EHR or information system to another and from one practice to another within a healthcare enterprise, the Sprint team addresses each community and its medical information systems with a plan of action designed to identify problems and incompatibilities with the data and establish a baseline from which the team can work and measure improvement.

The Blueprint has made a commitment to continue and expand end-to-end data transmission and quality efforts through the Sprint process for all of 2014.

7.b. Central Clinical Registry (Covisint DocSite)

The Blueprint central clinical registry known as DocSite (provided under contract with the Department of Vermont Health Access (DVHA) by Covisint) is a web-based application intended to enhance individualized patient care with guideline-based decision support and support population health management through a robust reporting engine. Additionally, DocSite allows comparative effectiveness reporting across providers, practices, and organizations who send data from their EHR systems to DocSite.

The registry is based upon the Blueprint data dictionary and condition measure sets. The product includes data elements for clinical processes and health status adopted directly from various national guidelines for preventive health maintenance and the treatment of chronic conditions. The data dictionary is updated regularly, incorporating input from participating Vermont providers. New data elements and measures continue to be added related to various individual components of the program.

In 2013, the following five new condition measure sets were added to the Blueprint data dictionary:

- Depression
- Heart Failure
- Opioid Dependence
- Self-management Support Programs
- Ischemic Vascular Disease

As of January 1, 2014, all documentation for self-management workshops offered by Blueprint field teams will be entered in DocSite in the new Self-Management Support Programs (SMSP) module (condition measure set). This functionality replaces a manual data entry process involving Excel spreadsheets sent from Regional Coordinators and workshop facilitators to the Blueprint central office.

The SMSP module in DocSite will allow for more accurate reporting across HSAs on registrants, participants, and completers of these workshops.

In addition to the new condition measure sets, the existing 14 condition measure sets and 9 SASH surveys were reviewed against currently national guidelines, performance measures, community-based programs, and feedback from Blueprint practices. Based on this evaluation process, the following updates to the data dictionary were made:

- Significant updates to SASH surveys, including four new surveys
- 232 new unique measures for the new SASH surveys and new conditions
- 74 new and 58 updated measures for several existing conditions
- Updates to the CHT and TCC modules

7.c. Integrated Health Record, VITLAccess, and Patient Consent to View Policy

In June 2013, the release of the Integrated Health Record (IHR) in DocSite marked a major milestone for the Blueprint HIT infrastructure. For the first time, a provider with access to DocSite and with patient consent can look at a comprehensive record of all health information in the clinical registry for that individual patient, regardless of which practice, organization, or program entered the data. With this information, the provider can use the IHR to identify gaps in care and areas for improvement, leading to better care coordination across the spectrum of providers who touch the patient.

For example, a CHT care coordinator with consent to view a patient's IHR can see participant surveys entered by SASH coordinators, including fall risk assessments and cognitive scoring, whether or not the patient is attempting to quit smoking, if the patient is currently participating in any self-management workshops, and any clinical data from the patient's PCP that is available in

DocSite. This more comprehensive understanding of patient health allows for a more informed approach to working with the patient on his or her care.

A patient "Consent to View" form is required for a provider to use the IHR. A collaborative outreach and training effort between the Blueprint, Covisint, and VITL is taking place across the State on the functionality of the IHR.

In 2013, the Blueprint and DVHA in partnership with VITL developed a protocol for the state's Patient Consent to View policy that specifies the steps a provider must take prior to viewing health information for a patient in the IHR. VITL's role is to ensure proper patient education on the consent policy, form collection, and storage.

In addition to the IHR, VITLAccess, a query-based provider portal for the VHIE, is expected to roll out statewide in 2014. The Consent to View policy also applies when viewing health information on an individual in the VHIE.

The VITLAccess pilot program has provided 7 health care organizations early access to this web portal in the VHIE. This application provides a view of patient-centric clinical documents and encounter data available through the VHIE from hospitals, commercial labs, and practices. This view also includes ADT (admit-discharge-transfer) information, medication history, and care summaries.

> *John Evans, CEO of VITL, said, "When we offer VITLAccess, the provider portal, to healthcare organizations across Vermont in the spring of 2014, the value they receive will be based on having a robust data exchange network to support more informed clinical decision making."*

7.d. Web-based Application for Blueprint Field Team Program Information

During the second half of 2013, the Blueprint contracted with Stone Environmental, Inc., to build a web-based application for collecting structured program data from the field teams, including information on service providers, clinical practices, CHT and Spoke staffing, and total unique patients attributed to each Blueprint practice. Currently, this information is collected via Excel spreadsheets, which leads to manual entry of non-standard data resulting in redundant efforts and elevated risks for inaccuracies.

With direct access to the new web application, scheduled for Go Live in early 2014, Blueprint Project Managers as well as practice-level users will be able not only to enter pertinent data, but also to view local NCQA scoring and payment information to which they previously did not have access. Plans are in place to expand the scope and functionality of the application during the next year. Figure 30 shows a screenshot of this new application.

Figure 30. Blueprint Field Team Program Application

8. APPENDICES

8.a. APPENDIX A - Budget

8.a.1. Source of Funds

Global Commitment (Blueprint and DVHA)	$ 5,946,880
Vermont Health Connect	$ 486,250
HIT	$ 3,607,055
ADAP FY14	$ 165,000
ADAP FY 14 Carry Forward	$ 129,418
VDH HPDP	$ 25,000
Total Allocation	**$ 10,359,603**

8.a.2. Blueprint for Health FY14 Budget

	DVHA Blueprint Appropriation	Other DVHA Appropriation	VT Health Connect	HIT Appropriation	VDH Appropriation	Total Blueprint Budget
Staffing	$ 891,713					$ 891,713
Operating Costs	$ 196,235					$ 196,235
Health Service Area Grants	$ 2,586,300		$ 486,250	$ 305,000	$ 5,000	$ 3,382,550
Practice Facilitation Contracts	$ 443,751				$ 15,000	$ 458,751
Other Grants and Contracts	$ 1,479,881	$ 349,000	$ -	$ 3,302,055	$ 299,418	$ 5,430,354
Hub and Spoke Collaborative (Dartmouth)					$ 294,418	$ 294,418
Annual Blueprint Conference (UVM Medical Education)	$ 18,500					$ 18,500
Training	$ 21,406				$ 5,000	$ 26,406
YMCA Diabetes Prevention Program (Greater Burlington YMCA)	$ 92,080					$ 92,080
WRAP (Vermont Psychiatric Survivors)*	$ 6,666					$ 6,666
All Payers Claim Data Management and Analysis (Onpoint)	$ 500,000	$ 349,000		$ 106,500		$ 955,500
NCQA Recognition and Evaluation (UVM VCHIP)	$ 735,629					$ 735,629
Economic Modeling (Lake Champlain Capitol Management)	$ 105,600					$ 105,600
Blueprint Data Portal (Stone Environmental)				$ 161,150		$ 161,150
Statewide Registry (Covisint)				$ 2,834,405		
HIT Data Quality Initiative (Capitol Health Associates)				$ 200,000		
Total Blueprint Budget	$ 5,597,880	$ 349,000	$ 486,250	$ 3,607,055	$ 319,418	$ 10,359,603

8.b. APPENDIX B - Staff and Committees

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8.c. APPENDIX C - Partnerships with National Initiatives

Centers for Medicare and Medicaid Services (CMS)

Vermont is one of 8 states chosen to be part of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration (for more information see http://www.cms.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1230016) through the Center for Medicare and Medicaid Innovation (CMMI). This extraordinary opportunity brings Medicare into the multi-payer payment reforms as a fully participating insurer. In addition, the Blueprint and other departments within the Agency of Human Services and the Green Mountain Care Board are engaged in working creatively with CMMI and CMS on such projects as the Medicaid Health Home State Plan Option. Marked progress is being made as the Medication-Assisted Treatment Program for opiate-addicted patients is implemented with intense collaboration on a Medicaid State Plan Amendment between a Blueprint Assistant Director, DVHA staff, and CMS.

Institute of Medicine of the National Academies (IOM)

The Blueprint Executive Director serves as a member of the IOM Roundtable on Value and Science-Driven Health Care (http://iom.edu/Activities/Quality/VSRT.aspx), which has been convened to help transform the way evidence on clinical effectiveness is generated and used to improve health and health care. The stated goal is that by the year 2020, 90% of clinical decisions will be supported by timely and accurate information reflecting the best available evidence. The Blueprint Executive Director also sits on the IOM Consensus Committee on the Learning Health Care Systems in America. This group has undertaken the study of transforming the current delivery system into one of continuous assessment and improvement for both the effectiveness and efficiency of health care. The Blueprint Executive Director contributed to *Core Measurement Needs for Better Care, Better Health, and Lower Costs: Counting What Counts: Workshop Summary*, published in June 2013.

Milbank Memorial Fund (www.milbank.org**) Multi-State Collaborative (MC)**

Started in 2008 as a grassroots gathering of several New England states with multi-payer PCMH programs, this activated group successfully advocated for the CMS Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration. All MAPCP states are members of the collaborative, which now includes Colorado, Connecticut, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont. The Blueprint Executive Director serves on the Milbank Technical Advisory Board. Current projects include advocacy for CMS to continue its move towards a more flexible

position regarding payment reform and data use, continuation of the MAPCP demonstration through the full time period of its evaluation, the planned 2014 publication of a Multi-State Collaborative Report based upon structured survey data of member states and interviews, and the refined function of the group as a true learning collaborative. Milbank continues to support in-person events, such as in April 2013 when MC members attended the 10th Blueprint Annual Conference in Burlington in conjunction with a Collaborative meeting. The MC is planning expansion to include the states and organizations that are part of the Comprehensive Primary Care Initiative (CPCI), as their demonstration is closely related.

National Committee on Quality Assurance (NCQA)

Vermont remains one of NCQA's major partners with the vast majority of the state's primary practices formally recognized as Patient Centered Medical Homes. The Blueprint Associate Director served on the NCQA PCMH Advisory Committee, which approved the next phase of standards for 2014. Communication is ongoing with NCQA leadership and staff regarding the influence of Vermont's deep experience. In addition, NCQA is collaborating with the Blueprint's analytic team to use its national database for benchmarking and evaluation.

National Academy of State Health Policy (NASHP)

NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states. It has been a long-term supporter of the Blueprint, and Blueprint team members have shared their expertise and experience in multiple venues. Presentations at conferences and conference calls, policy brief preparation, serving on advisory groups, and site visits have been part of this valuable collaboration. Topics addressed include payment reform, data collection and utility, legislative approaches, Patient-Centered Medical Homes, Community Health Teams, and integration of mental health and substance abuse treatment. A Blueprint Assistant Director serves on the NASHP ReForum Advisory group, and the Blueprint Associate Director serves as faculty for the ongoing Multi-Payer Medical Home Learning Collaborative. More information can be found at http://www.nashp.org/about-nashp.

8.d. APPENDIX D - Presentations and Meetings

OUT OF STATE MEETINGS			
1/14/2013	"Blueprint Care Coordination" Presentation to the University of New Mexico Department of Internal Medicine, Project ECHO	Web Ex	L. Watkins
1/30/2013	ONC Meeting	Washington, DC	C. Jones
1/31/2013	Families USA Health Action 2013 Meeting	Washington, DC	C Jones
2/21 - 2/22/13	Impact Multi-State Meeting	Oklahoma	C. Jones
2/26/2013	Milbank Memorial Fund Board Meeting and Seminar	New York, NY	C. Jones
2/27/2013	King County Health and Human Services Transformation Panel Presentation	Seattle, WA	P. Jones
3/20/2013	IOM Roundtable	Washington, DC	C. Jones
3/28/2013	Medicaid ACO, Measurement & Behavioral Health	Austin, TX	B. Tanzman

OUT OF STATE MEETINGS

Date	Meeting	Location	Attendee
4/3/2013	NCQA Clinical Advisory Panel	Washington, DC	L. Watkins
4/28/2013	Milbank Care Coordination Health Transformation Mtg.	Chicago, IL	C. Jones
4/30/2013	BP Community-Based Teams: Millbank Fund Reforming States Special Meeting	Chicago, IL	B. Tanzman
5/1/2013	IOM Best Practices Innovation Collaborative	Washington, DC	L. Watkins
5/15/2013	NC Impact Data Infrastructure for Multi-payer Care Coordination	Webinar	J. Samuelson
5/21/2013	Milbank Technical Board Meeting	New York, NY	C. Jones
5/21/2013	Healthcare Transformation Symposium, panel presentation, "How Data is Used to Drive System Transformation"	Durham, NH	L. Watkins
5/31/2013	PA IMPACT: Primary Care Extension Service Multi-State Meeting	New York, NY	J. Samuelson
6/6/2013	AHRQ Change Agents in Action: Lessons Learned from Leading Primary Care Practice Facilitation Programs	Webinar	J. Samuelson

OUT OF STATE MEETINGS			
6/11/2013	Modern Healthcare, panelist "Raising the Bar on Quality and Patient Safety - Data Use in Health Care Reform	Virtual Conference	L. Watkins
6/24/2013	Academy Health Annual Research Meeting	New York, NY	C. Jones
7/16/2013	President's Council of Advisors on Science & Technology (PCAST) – Systems Engineering for Health Care	Washington, DC	C. Jones
7/24/2013	MPCD Board Meeting	Washington, DC	C. Jones
8/2/2013	NASHP, Integrating Public Health into State Health Reform Implementation	Webinar	J. Samuelson
8/22/2013	IOM Consensus Committee on Core Metrics Meeting	Washington, DC	C. Jones
10/10 - 10/11/13	NASHP 26th Annual State Health Policy Conference	Seattle, WA	L. Watkins J. Samuelson
10/15/2013	PCPCC Annual Fall conference - Panel on countdown to 2014:	Washington, DC	C. Jones

	OUT OF STATE MEETINGS		
	State Perspectives on Health Reform		
10/31/2013	ASTHO Technical Assistance State of New York - Brief on Vermont's Payment and Care Model	Webinar	J. Samuelson
11/7/2013	ASTHO Technical Assistance Washington, DC – Brief on Vermont's Payment and Care Model	Webinar	J. Samuelson
11/8/2013	NCQA Policy Conference	Washington, DC	C. Jones
11/8/2013	Federal State Discourse on Aligning Federal and State Efforts on Quality Measurement to Support Value Based Purchasing	Washington, DC	J. Samuelson
11/14/2013	Improving Health Outcomes for Children (IHOC) Executive Committee	Concord, NH	L. Watkins

IN STATE MEETINGS

1/11/2013	Presentation on Statewide Implementation of the Blueprint at the Burlington SASH Local Partners Meeting	Burlington, VT	B. Tanzman
1/18/2013	Presentation to the Department of Aging & Independent Living, "Opportunities to Expand Blueprint Reforms & Long Term Care"	Williston, VT	B. Tanzman
1/29/2013	Presentation to the Green Mountain Care Board Technical Advisory Committee "Integration of Health, Mental Health, and Substance Abuse"	Montpelier, VT	B. Tanzman
1/30/2013	Hub & Spoke Community Meeting Presentation	Rutland, VT	B. Tanzman
2/4/2013	Hub & Spoke Community Meeting Presentation	Bennington, VT	B. Tanzman
2/6/2013	Vermont Health Appropriations Committee	Montpelier, VT	C. Jones
2/6/2013	Vermont House Health Care Committee Testimony on Mental Health Co-Pays	Montpelier, VT	B. Tanzman

	IN STATE MEETINGS		
2/11/2013	Executive Branch Mental Health Integration Committee - "Blueprint Reforms & Integration of Mental Health"	Montpelier, VT	B. Tanzman
2/11/2013	Adult Mental Health State Standing Committee, "Blueprint for Health & Opportunities for Mental Helath Integration"	Montpelier, VT	B. Tanzman
2/22/2013	Senate Health & Welfare Committee, "Mental Health & Addictions Treatment Provider Registry"	Montpelier, VT	B. Tanzman
3/1/2013	Senate Health & Welfare Committee, "Mental Health Co-Pays"	Montpelier, VT	B. Tanzman
3/20/2013	Presentation to the IBM Industry Academy	Web-Ex	C. Jones
3/22/2013	Annual Nurse Practitioner Conference	Stowe, VT	C. Jones
3/26/2013	University of Vermont Medical School - Health Policy Course	Burlington, VT	C. Jones
4/1/2013	CMS Health Home Opportunity and Mental Health: Vermont Executive Branch Group	Montpelier, VT	B. Tanzman

IN STATE MEETINGS

4/8/2013	Hub and Spoke Initiative: Windham and Windsor County Health and Human Services Providers	Brattleboro, VT	B. Tanzman
4/9/2013	Hub and Spoke: Blueprint Expansion, Design, and Evaluation Committee	Williston, VT	B. Tanzman
4/17/2013	Hub and Spoke: Implementation, Blueprint Annual Meeting	Burlington, VT	B. Tanzman
4/17/2013	Blueprint Annual Conference - Course Director and Moderator	Burlington, VT	L. Watkins
4/19/2013	Psychiatric Association Meeting	Williston, VT	C. Jones
4/24/2013	Blueprint and MH/SA Integration: VT Alcohol and Drug Abuse Council	Montpelier, VT	B. Tanzman
4/25/2013	SASH: Green Mountain Care Board	Montpelier, VT	B. Tanzman
4/26/2013	Wellness Recovery Action Planning and the Blueprint for Health; Community Self-Management Facilitators	Barre, VT	B. Tanzman
5/15/2013	Health Homes and the Hub & Spoke: MH/SA Technical Advisory Group for the Green Mountain Care Board	Montpelier, VT	B. Tanzman

IN STATE MEETINGS

Date	Meeting	Location	Presenter
5/21/2013	Hub and Spoke Implementation: Newport Area Blueprint Partners	Newport, VT	B. Tanzman
6/11/2013	Hub and Spoke Implementation: Burlington Area Blueprint Partners	Burlington, VT	B. Tanzman
8/14/2013	Blueprint Information Session	Montpelier, VT	C. Jones
9/11/2013	FOCUS Group - (Brattleboro Memorial Hospital/Grace Cottage Hospital/Dartmouth-Hitchcock Hospital	Brattleboro, VT	C. Jones
9/24/2013	Vermont Information Technology Leaders Summit - Speaker	South Burlington, VT	C. Jones
10/2/2013	IHR/Consent Training - Morrisville Health Service Area	Johnson, VT & Cambridge, VT	M. Olszewski
10/3/2013	Vermont Legislative Health Care oversight Committee Blueprint Expansion and Mental Health and Addictions Program Updates	Montpelier, VT	C. Jones B. Tanzman
10/8/2013	Leadership Champlain Human Services Seminar	Burlington, VT	B. Tanzman

IN STATE MEETINGS

10/17/2013	IHR/Consent Overview - Randolph Health Service Area	Randolph, VT	M. Olszewski
10/18/2013	DocSite/IHR/Sprint Introduction - Mt. Ascutney Hospital	Windsor, VT	M. Olszewski B. Tanzman
10/23/2013	Maple Leaf Farm Addictions Treatment Program - Hub and Spoke Presentation	Burlington, VT	B. Tanzman
10/25/2013	Improving Outcomes for Complex Patients	Stowe, VT	L. Watkins