Annual Report on
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In Accordance with 33 V.S.A. §709

Submitted to: House Committee on Health Care, Senate Committee on Health and Welfare, and the Health Reform Oversight Committee

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Report Date: December 29, 2016

VERMONT

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VERMONT BLUEPRINT
FOR HEALTH
2016 Annual Report

December 29, 2016

Contents

Vermont Blueprint for Health in 2016

1   Introduction

The Vermont Blueprint for Health (the Blueprint) is a state-led, nationally-recognized initiative transforming health care delivery and payments. At its foundation is the local Transformation Network, a network of Practice Facilitators, Community Health Team leaders, and Project Managers, who work with Patient-Centered Medical Homes (PCMHs), Community Health Teams (CHTs), and local health and human services leaders. This network allows for rapid response to Vermont's health priorities through statewide implementation of new initiatives.

Blueprint programs are continuously informed by comprehensive evaluations of health care quality and outcomes at the practice-, community-, and state-levels. As the care delivery system and payment model evolve, the Blueprint's aim is constant: connecting Vermonters with whole-person health care that is evidence-based, patient- and family-centered, and cost-effective.

1.1   2016 In Brief

In 2016 Vermont health care leaders developed a shared vision for a statewide accountable health system and negotiated the terms of an All-Payer Model with the Centers for Medicare and Medicaid Services (CMS), specifically the Centers for Medicare and Medicaid Innovation Services (CMMI), which will test an alternative payment model in which the most significant payers throughout the entire state – Medicare, Medicaid, and commercial health care payers – incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state's care delivery system and transform health care for the entire state and its population. Blueprint program activities in 2016 – and those planned for 2017 – were designed to support a successful transition to this accountable health system, where diverse partners share responsibility for the health and well-being of a whole population.

The Blueprint's central focus in 2016 was building relationships across agencies, sectors, and organizations. Those relationships will be the basis for addressing the social determinants of health, improving Vermonters' health outcomes before they ever enter a practice or hospital. For example, the Blueprint partnered with the Vermont Department of Health (VDH) to design a new Women's Health Initiative that will bring enhanced health and psychosocial screening to OB-GYN offices along with enhanced family planning counseling. The Blueprint also continued to work with Accountable Care Organization (ACO) leadership to plan for enhanced data sharing and aligned analytics, including prevention measures.

While the Blueprint core team pursued these and many other partnerships at the state level, they also coached Transformation Network members in building and strengthening relationships with diverse providers in their communities. Several Health Service Areas (HSAs) already had strong relationships across health care and social service organizations, and Transformation Network members from those areas offered case studies and peer support in forums like the monthly Blueprint/ACO Field Team Meetings.

Two critical venues for enhancing local health and social services coordination in 2016 were the Community Collaboratives (CCs), which began forming in 2015 and which state and local Blueprint and ACO staff helped grow throughout the past year, and the Integrated Communities Care Management Learning Collaborative (ICCMLC), a series of learning and planning sessions where providers from

crucial organizations in each area worked together to develop coordinated care management systems to support the most vulnerable members of their communities. Each of these advances is covered in more depth later in this report.

Every relationship that grew in 2016, whether between state program leaders or local health care and social service providers, moved Vermont towards a more integrated and accountable health system, where resources shift from treating illness to promoting wellness, and where every Vermonter has a community working together to help him or her be healthy.

1.2 Blueprint Design, Implementation, and Research: Serving Vermont Health Reform in 2017 and Beyond

As the Vermont health system begins 2017 – "Performance Year 0" under the All-Payer Model – the Blueprint provides a tested model for driving change. The Blueprint is an engine of innovation, moving new ideas through collaborative design to rapid implementation in practices and communities to research and evaluation that informs new initiatives and iterative improvements. Each of these elements - design, implementation, and research - is critical to the success of the interventions the Blueprint leads and participates in.

The Blueprint's unique strengths of its statewide Transformation Network, whole-population evaluation and analytic capabilities, and experience designing and implementing new services provide a foundation for more reforms aimed at improving health care outcomes and reducing expenditures. These strengths are evident in the Blueprint's process, shown below, of health systems design, implementation, and research. Each step feeds the next.

FIGURE 1. BLUEPRINT PROCESS
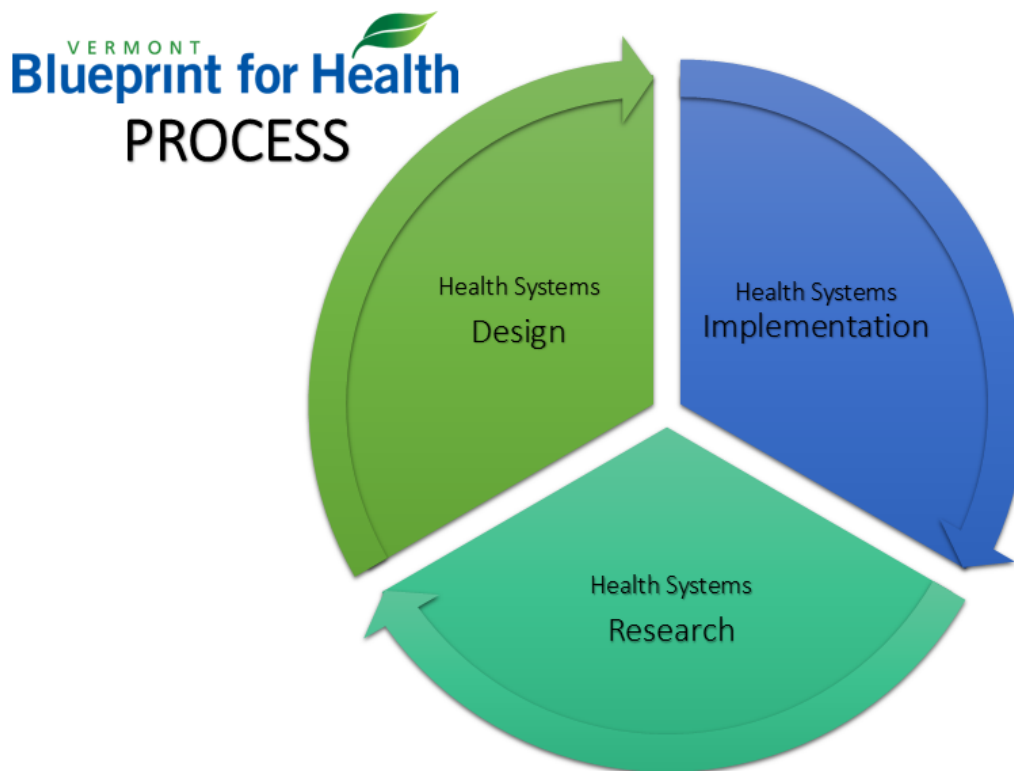
1.2.1 Health Systems Design

As a state-led program currently housed in the Department of Vermont Health Access, the Blueprint is positioned to respond to priorities identified by the Administration, the Legislature, and by extension the people of Vermont. In collaboration with these entities, the Blueprint has led advances in health care delivery, including the Hub & Spoke system for medication assisted treatment (MAT) for opioid addiction, the Support and Services at Home program (SASH) for helping elders age safely at home, and the Blueprint primary care program itself.

The most recent example in this collaborative design process is the new Women's Health Initiative (described in more detail at section 6.4.1), led by the Blueprint in 2016. This initiative will provide women with enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long-acting reversible contraception (LARC).

The Blueprint partnered with the Vermont Department of Health (VDH) to develop this initiative, convening small groups of experts in women's health, practice change, community integration, payment, measurement, and more. In a series of collaborative design sessions with each of these groups, the Blueprint brought forward the initiative's challenge and goals and offered information about approaches other communities, including states and countries, have tried and then facilitated idea generation from all participants. In between design sessions, Blueprint staff researched answers to participants' questions, investigated new ideas, and modeled costs and impact.

At the end of this process, with stakeholder consensus, the Blueprint will pilot the new initiative through the Transformation Network, activating the technical and leadership expertise of its Practice Facilitators, Project Managers, and Community Health Team (CHT) leaders in 8 of the 14 HSAs. This process can be repeated whenever a new need and opportunity arises. Its success depends upon a leadership and core team well-versed in program design, curious about the latest health systems innovations around the world, and with access to that information. Equally important is the team's commitment to engaging content experts, including providers, funders, and impacted organizations, in the design process, ensuring the interventions will be feasible, sustainable, and effective.

1.2.2 Health Systems Implementation

Newly designed health systems interventions need a route from idea to provider and patient. The Blueprint Transformation Network provides that route, by funding local health systems leaders – Project Managers, CHT Leaders, and Practice Facilitators – to build trusting relationships with a wide range of health care providers and community organizations, to convene partners for planning coordinated action, to engage and act in response to community needs, regardless of organization affiliation or funder, and to monitor and measure implementation progress.

In national evaluations of the effectiveness of medical home initiatives, the Blueprint was shown to reduce the cost of medical care for patients of Blueprint practices. Not every medical home initiative was able to demonstrate that same success. The most notable difference in the Blueprint's approach was the funding of the Transformation Network.

Successful implementation of programs across the health system is also dependent on the engagement of the leadership from the state's health care organizations, including the ACOs and all of the hospital systems, Federally Qualified Health Centers (FQHCs), and independent practices they represent. Daily collaboration between public, private, and non-profit sectors and between health and human services is essential. The Blueprint leadership and core team works as a neutral partner at the state level (mirroring the local work of the Transformation Network) by bringing these groups together to implement new initiatives.

These efforts are further supported by payments to practices and Community Health Teams designed to support participation in the implementation of new initiatives and achievement of key system goals.

1.2.3 Health Systems Research

Health Systems Research is how the Blueprint evaluates the initiatives designed and implemented by the program and its partners. The results inform the design of new initiatives and iterative improvements of existing initiatives. The Blueprint is committed to supporting a Learning Health System and continuous improvement through its research, which includes data collection, data quality assurance, data merging, measurement, analysis, performance reporting, and self- and system-evaluation work.

The primary utilities behind the Blueprint's health systems research are Vermont's all-payer claims database (VCHURES) and the Blueprint Clinical Registry (formerly Docsite). Using these two datasets, the program has demonstrated the effectiveness of merging clinical data with all-payer claims data by producing comprehensive and meaningful reports for practices and communities. Communities use these reports to guide continuous quality improvement activities within health care organizations and across medical and social services.

Additionally, as a neutral, state-based service, the Blueprint has unique access to data from a wide variety of sources in addition to claims and clinical data. Working with other state programs, the Blueprint is seeking to add complementary datasets to help the health system better understand and serve specific high-needs populations. For example, the Blueprint's analytic team is currently working with Vermont Department of Corrections (DOC) data with the goal of assessing whether medication-assisted treatment (MAT) for opioid disorders affects rates of incarceration.

The Blueprint shares its research with other states, provinces, countries, and academic and professional organizations through presentations and one-on-one consultations. The program participates in large-scale studies, like the Multi-Payer Advanced Primary Care Practice demonstration (ending December 31, 2016) and the Milbank Memorial Fund Multi-State Collaborative. The team also publishes findings in national peer-reviewed journals. These activities feed the larger Learning Health System from which the Blueprint draws inspiration and evidence for future innovations in service to the health and well-being of Vermonters.

2 How the Blueprint Works

2.1 The Blueprint is a statewide initiative with local leadership and implementation

The Blueprint combines state-level strategic direction with local organization and ownership of care delivery. The state's 14 Health Service Areas (HSAs) each have an Administrative Entity, such as a hospital or Federally Qualified Health Center (FQHC), that leads the Blueprint locally. Their work includes local program management, staffing of Community Health Teams (CHTs), and financial management. The Blueprint's Transformation Network includes Project Managers, hired by the Administrative Entities, who lead implementation and engage community partners at the local level. Each Administrative Entity contributes their own financial and human resources, beyond the scope of their Blueprint grants, demonstrating their commitment to the Blueprint's sustainability and success.

2.2 Community Collaboratives identify local health priorities, plan coordinated responses

The Administrative Entities in each HSA work to include local partners in guiding Blueprint implementation. In 2015, local Blueprint work groups (originally known as Integrated Health Services advisory groups) merged with Accountable Care Organization (ACO) work groups (known as Regional Clinical Performance Committees). These combined groups are now known as Community Collaboratives (CCs).

Staffed by the Blueprint Project Manager with clinical leadership supported by the ACOs, the CC leadership teams include representatives from ACOs present in that community, local primary care leaders (including a pediatric provider), the hospital, home health or the Visiting Nurse Association, Area Agency on Aging, Designated (mental health) Agency, Designated Regional Housing Organization, and others. They meet to identify local priorities, goals, and strategies, including the design and staffing of the area's Blueprint CHT.

The long-term goal of these CCs is to prepare each HSA to function as an Accountable Community for Health (ACH), responsible for the wellness of the whole population and its health care budget. This model supports the complete integration of high-quality medical care, mental health and substance abuse services, social services, and prevention.

2.3 Patient-Centered Medical Homes provide top-quality primary care

The Blueprint supports Vermont's primary care practices in the process of achieving and maintaining recognition as Patient-Centered Medical Homes (PCMHs) under the National Committee for Quality Assurance (NCQA) standards. These standards promote excellence in six (6) areas:

- patient-centered access
- team-based care
- population health management
- care management and support
- care coordination and transitions in care
- performance measurement and quality improvement

All Vermont insurers (Medicaid, Medicare, and major commercial insurers) incent practices to do this work through per-member-per-month (PMPM) payments to NCQA-recognized PCMHs. The new performance-based payments introduced in 2016 are promoting improvement in rates of preventive

care, management of chronic conditions, and reduction in the rate of growth for unnecessary utilization of health services (refer to section 2.7). The Blueprint's Transformation Network supports practices with Practice Facilitators, professionals trained in quality improvement and change management. Each practice has access to a Facilitator, who provides technical expertise in the NCQA-PCMH standards and ongoing quality improvement coaching.

2.4 Community Health Teams extend available services

Good medical care happens in a doctor's office, but good health happens in a community. The Blueprint CHTs in each HSA take on this challenge. CHTs supplement services available in PCMHs and link patients with the social and economic services that make healthy living possible for all Vermonters. CHT services include:

- population/panel management and outreach
- individual care coordination
- brief counseling and referral to more intensive mental health care as needed
- substance abuse treatment support
- condition-specific wellness education and more

The services may be embedded with the primary care practices or centralized in the HSA. Actual service configuration, staffing, and location are determined by local leaders based on community demographics and health needs, identified gaps in available services, and the strengths of local partners. Funded by Medicaid, Medicare, and major commercial insurers in Vermont, access to CHT teams is offered barrier-free to patients and practices (meaning no co-payments, no prior authorizations, and no billing).

2.5 Extended Community Health Teams support addiction recovery through the Hub & Spoke program

Since the CHTs first began operating, the Blueprint has added two service models to their offerings. One of these service models, called the Care Alliance for Opioid Addiction (Hub & Spoke), expands the availability of medication assisted treatment (MAT) for opioid addiction through 'Hubs' and 'Spokes'. Hubs are regional opioid addiction treatment centers, located around the state, that treat patients with especially complex needs, using either methadone or buprenorphine. Spokes are primary care and other specialty practices where buprenorphine is prescribed.

As part of a statewide partnership with the Vermont Department of Health (VDH), the Blueprint has helped to expand access to MAT by encouraging more primary care practices to offer buprenorphine-prescribing services. The Blueprint program embeds a nurse and a Master's-prepared, licensed mental health or addictions clinician in each of the Spokes. These staff members provide the additional clinical support and care coordination that MAT patients require. With these resources, each MAT patient has an identified medical home, a single MAT prescriber, a pharmacy home, and access to all CHT services.

2.6 Extended Community Health Teams support healthy aging-in-place through the SASH program

Since the CHTs launched, the Blueprint has worked with Cathedral Square, a Designated Regional Housing Organization, and SASH partner agencies to add a service model called Support and Services at Home (SASH). SASH connects local health and long-term care systems for Medicare beneficiaries to

support aging at home through partnerships with Housing Organizations, Home Health, Area Agencies on Aging, and Designated Mental Health Agencies.

Cathedral Square is the statewide administrator for SASH, responsible for training and model fidelity. SASH is administered locally by six (6) Designated Regional Housing Organizations (DRHOs) and serves participants both in subsidized housing and in residences in the community at large.

This unique population health approach is organized around "panels" of 100 participants, each served by a SASH coordinator and Wellness Nurse and agreements with local partners. Together, they focus on three areas of intervention shown to be effective in reducing Medicare expenditures:

- transition support after a hospital or rehabilitation facility stay
- self-management education and coaching for chronic conditions and health maintenance
- care coordination

SASH is primarily funded by Medicare. When the CMS Multi-Payer Advanced Primary Care Practice demonstration (MAPCP) ends on December 31, 2016, Medicare's participation in the SASH program will continue for the next six (6) years through the All-Payer Model (APM) agreement with CMS.

2.7 Performance payments fuel high-quality, high-value care

Funding support for practices to function as PCMHs and for CHTs to operate comes from Medicare, Medicaid, and Vermont's major commercial insurers. While participation in the Blueprint program is optional for providers, Medicaid and major commercial insurers are required to participate in these payments. The exception is self-insured employers, though many have opted to participate. Medicare's participation began through the initiation of the MAPCP demonstration in 2011 and will continue in 2017 under the All-Payer Model.

After the Vermont Legislature approved an increase in program payments in 2015 – the first since program inception – the Blueprint led a consensus-based process to update the payment model. The current payment structure supports the work required to operate as a PCMH with a per-member-per-month (PMPM) payment, and additional performance payments reward practices for high-quality, high-value care based on measures of resource utilization and quality of care. In January 2016, the PMPM payments increased from an average of $2.05 to an expected average of $3.25. Insurers also fund the CHTs through a payment proportional to their market share of members across the state.

2.8 Measurement and analytics support a Learning Health System

The data PCMH practices and partners produce in the course of their work with clients and patients are continuously used by the Blueprint's measurement and evaluation program to evaluate the current status of health care delivery in Vermont and the progress made in quality, utilization, and medical expenditures. These evaluations, in turn, support and inform improvement throughout the system.

The data the Blueprint works with include claims from the all-payers claims database, also known as the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), and clinical data from the Blueprint Clinical Registry, formerly known as DocSite. Claims data provides important insights into utilization of services and the cost of care. For example, the Blueprint can identify the rates at which Vermonters go to the emergency department (ED), changes in rates of visits to primary care providers, and how long patients are staying in the hospital.

Data in the Blueprint Clinical Registry comes from clinical documentation entered into practice electronic medical records (EMRs). EMRs record the care delivered to patients and clinical

measurements like height, weight, blood pressure, blood tests results, and much more. Linked claims and clinical data are more powerful than either dataset alone. The linked data can, for instance, provide the number of persons diagnosed with hypertension who have their blood pressure under control or the number of individuals with diabetes who are obese or who do not have their hemoglobin (Hb) A1c in control.

The Blueprint includes these and many more clinically-relevant measures in practice- and community-level profiles. Practices and communities can use this information to identify priorities for improvement. The Blueprint also routinely evaluates its own performance and reports on program impact and return-on-investment (ROI) through its annual reports to the Vermont Legislature and through peer-reviewed journal articles.

3 Blueprint Outcomes for 2016

3.1 Latest analysis of Calendar Year 2015 data evaluated impact of PCMH activities by programmatic stage

The Blueprint trend analysis of patient medical expenditures and utilizations patterns is based on the programmatic stage of the patient's primary care practice as a Patient-Centered Medical Home (PCMH) and now covers seven years. The programmatic stages are:

- **Pre-year**: the year prior to starting work with the program
- **Implementation year**: the year the practice started to prepare for NCQA scoring and received CHT staffing six months prior to scoring
- **NCQA Scoring Year**: the year the practice was independently scored against NCQA standards
- **Post-Years 1 through 4**: the years the practice operated as a recognized PCMH

The goal in this approach is to identify how the maturation of a PCMH affects patient outcomes relative to the outcomes of patients served by non-PCMH practices. Based on all-payer claims data from calendar years 2008 through 2015, PCMH patients were identified as those receiving the majority of their primary care from a PCMH at each stage. Comparison patients were identified as those receiving the majority of their primary care at sites not recognized as PCMHs.

To align the comparison patients with PCMH patients by stage, the comparison groups were randomly assigned to each programmatic stage with the proportion from each calendar year mirroring the overall distribution of the comparison group across all calendar years. The first iteration of this analysis was published in the peer-reviewed journal *Population Health Management* ([Jones et al.](#)) and presented in the 2015 Annual Report.

To account for differences between PCMH and comparison groups, rates were adjusted for demographics (e.g. age and gender groups), health status (3M™ Clinical Risk Groups (CRG)), select chronic conditions as identified by the Blueprint program (asthma, attention deficit disorder, chronic obstructive pulmonary disorder, congestive heart failure, coronary heart disease, depression, diabetes, and hypertension), maternity, Medicaid and Medicare coverage, and length of enrollment. Medicare-specific adjustors included disability, end-stage renal disease (ESRD), and death. Adjusted values were produced at the person level and summarized by relative year and study group.

The analysis used a Difference in Differences (DID) methodology, a technique often used to evaluate policies over time. It calculates the final difference between PCMH patients and comparison outcomes minus any initial difference. This is the third year that Blueprint has used this methodology to evaluate the impact of the program. Of note, each year the analysis is run, the mix of practices, and therefore patients, included in each program stage changes as new practices transition to PCMHs.

As in prior years, the results suggest that patients receiving the majority of their care in a Blueprint PCMH have reduced annual medical expenditures and utilization rates. For example, after accounting for the initial difference between the PCMH patients and the comparison group in the Pre-Year, the total expenditures per patient per year (excluding services covered only by Medicaid) was $247 less for PCMH patients relative to patients in the comparison group (P-value: <0.001) by Post-Year 4.

Special Medicaid services are services uniquely funded by Medicaid and targeted at meeting social, economic, and rehabilitative needs (e.g. transportation, home- and community-based services, case

management, dental, residential treatment, day treatment, mental health facilities, and school-based services). The analysis of total expenditures for all payers excluded SMS services to allow more comparable comparisons of expenditures across the payers. When broken down to specific expenditure categories, the PCMH patients had significantly less per patient per year inpatient expenditures (DID: $-78; p-value: <0.018) and pharmacy expenditures (DID: $-80; p-value: <0.001).

Figure 3, and 4Figure 4 show the trends for total medical expenditures (excluding SMS), inpatient expenditures, and pharmacy expenditures respectively. While patients attributed to PCMHs continue to demonstrate lower medical expenditures and utilization rates as the PCMHs mature, the analysis also shows greater differences between the comparison and PCMH group in the pre-year expenditures than in previous iterations, which showed no significant difference [*Blueprint Annual Report 2015*].

There are a number of potential reasons for the greater difference in pre-program year expenditures between the 2014 and the 2015 trend analysis. First, the patient attribution methodology was adjusted to improve how patients are counted in light of practice mergers, ownership transitions, and closures. Second, changes in data management were made, which included transitioning to ICD-10 coding and improving how person-level records for payments were handled.

The impact of the greater difference in the pre-year between the PCMH and comparison group is a reduction in the DID or overall impact seen in previous analyses. However, what does become apparent in the trend lines is a stabilization of the difference in expenditures between the PCMH group and comparison group beginning in Post-Year 1. Figure 2 shows this stabilization for Total Expenditures excluding SMS. Figure 3 shows the similar trend for Inpatient Expenditures, and Figure 4 shows the trend for Pharmacy Expenditures.

FIGURE 2. TOTAL EXPENDITURES EXCLUDING SPECIAL MEDICAID SERVICES PER CAPITA 2008-2015 ALL INSURERS, AGES 1 YEAR AND OLDER
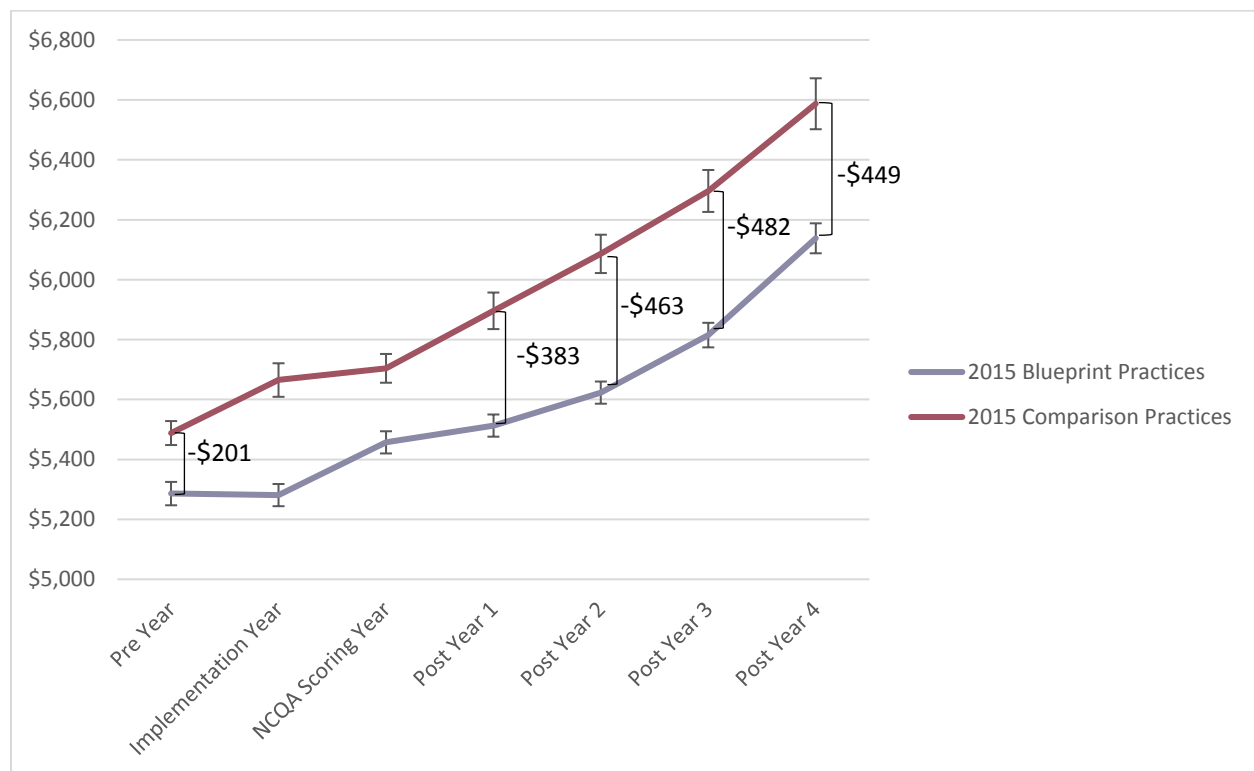
FIGURE 3. TOTAL INPATIENT EXPENDITURES PER CAPITA 2008-2015, ALL INSURERS, AGES 1 YEAR AND OLDER
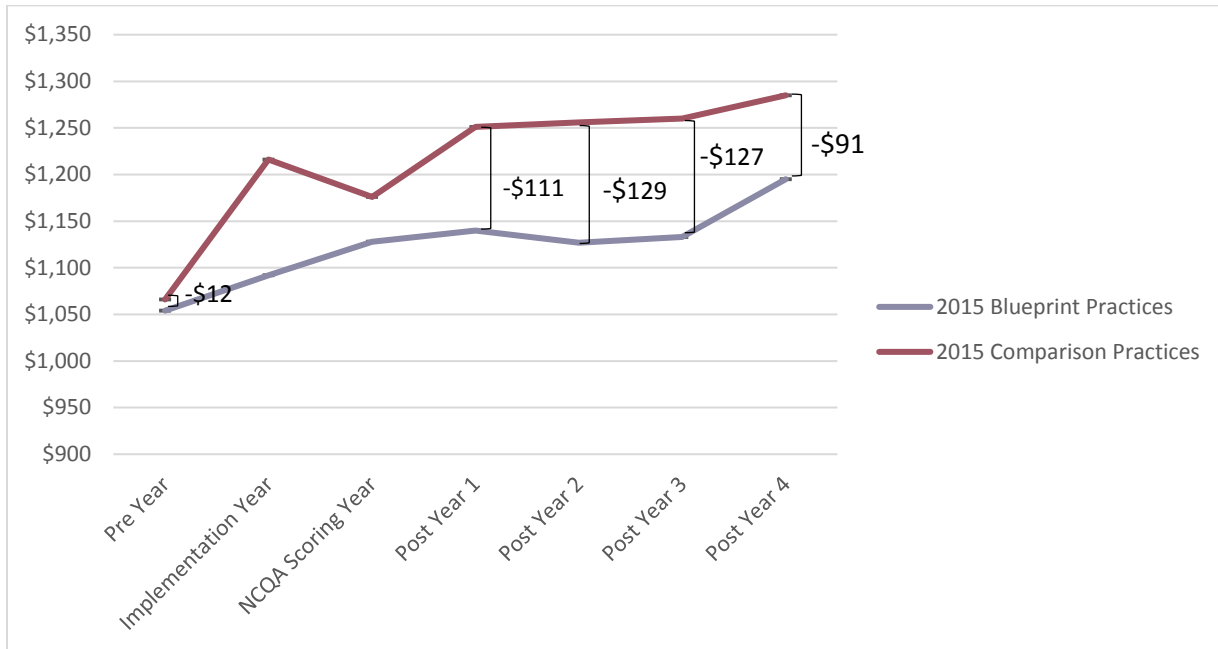
FIGURE 4. TOTAL PHARMACY EXPENDITURES PER CAPITA 2008-2015, ALL INSURERS, AGES 1 YEAR AND OLDER
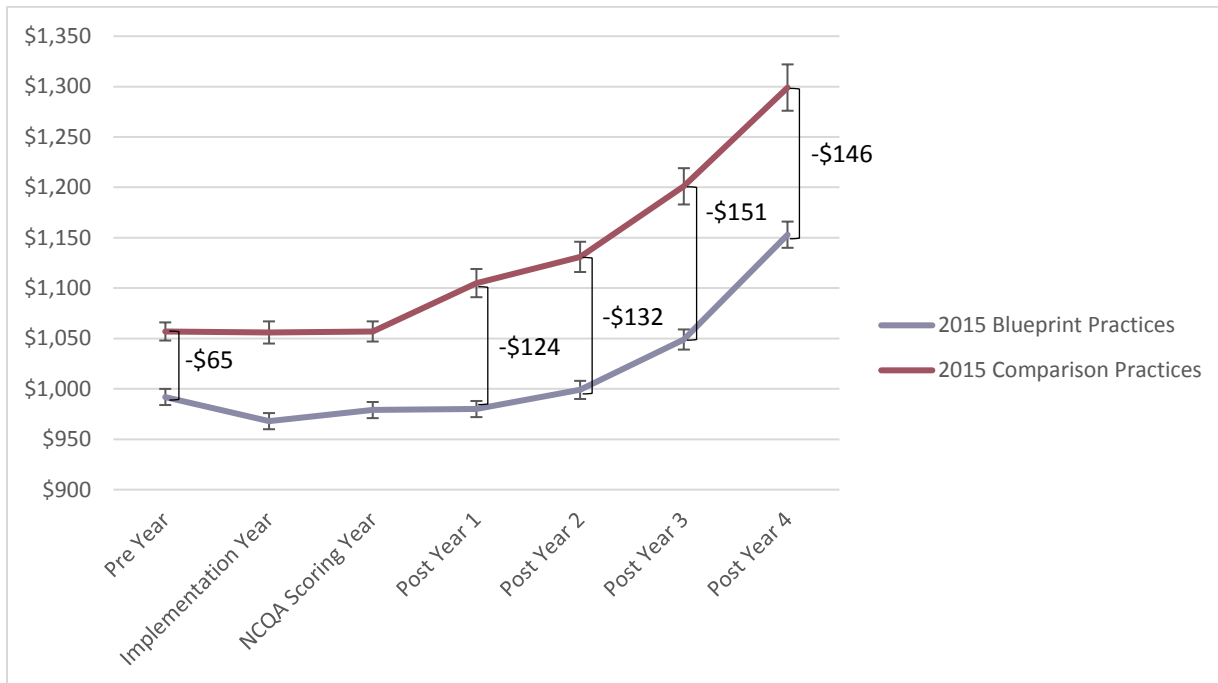
Regarding utilization rates, PCMH patients generally had statistically significant lower rates of inpatient discharges per 1,000 for each stage with a weighted average of 7.6 fewer discharges per 1,000 relative to the comparison group (Figure 5). These rates stayed relatively constant through each program stage, which contributed to a DID of 2.4 fewer discharges per 1,000 that was not statistically significant (P-value 0.178). Similar patterns were seen for medical and surgical specialist visits. PCMH patients had a weighted average across all stages of 69.5 fewer medical specialist visits per 1,000, and both the PCMH and comparison groups show upward trends in the latter stages.

Although lower at each stage, the DID indicated that PCMH patients netted 15.6 more medical specialist visits per 1,000 (P-value 0.073) relative to the comparison group and initial differences. Regarding surgical specialist visits, PCMH patients had an average of 27.4 per 1,000 fewer visits with a decreasing trend across stages. When assessing change from Pre-Year to Post-Year 4 (DID), PCMH patients had a net 14 more visits per 1,000 (P-value 0.076). Figure 5 shows the inpatient trend line to demonstrate the patterns seen in these measures.

FIGURE 5. INPATIENT DISCHARGES PER 1,000 MEMBERS 2008-2015, ALL INSURERS, AGES 1 YEAR AND OLDER
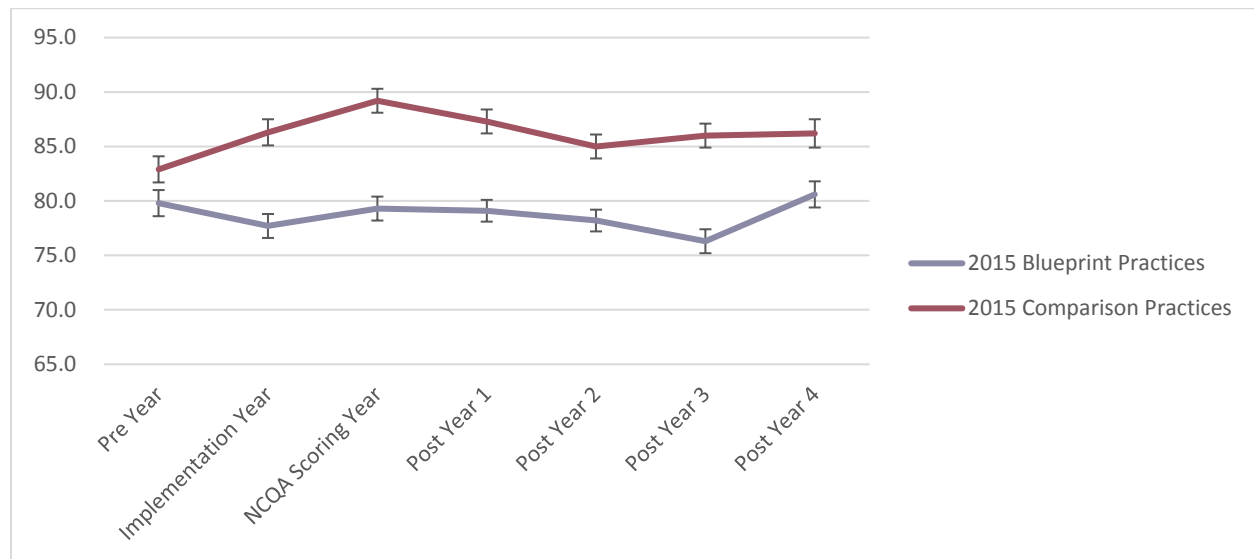
Unlike medical and surgical specialist visit trends, PCMH patients' emergency department (ED) visit rates were not statistically different from comparison patients for most stages (refer to Figure 6). However, DID analysis indicated that PCMH patients had a net increase in their rate relative to the comparison group with 13.9 more outpatient ED visits per 1,000 (P-value 0.002).

FIGURE 6. OUTPATIENT EMERGENCY DEPARTMENT VISITS PER 1,000 MEMBERS 2008-2015, ALL INSURERS, AGES 1 YEAR AND OLDER
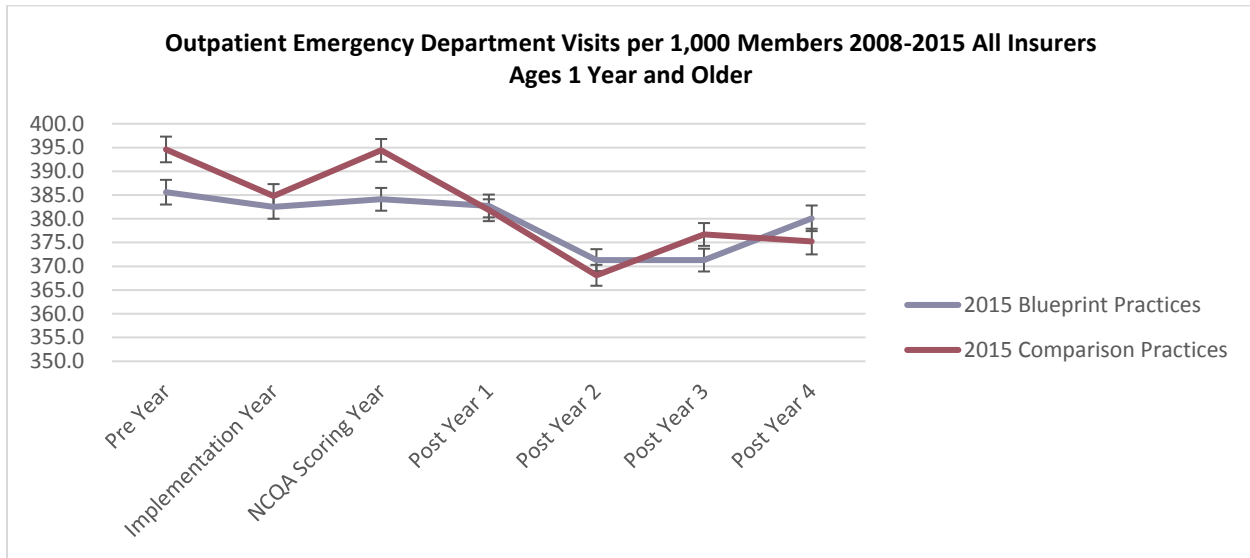
PCMH patients showed higher rates of primary care visits relative to the comparison group, especially beginning in Post-Year 1. Figure 7 shows this trend. The DID value was 100.1 more primary care visits per 1,000 (P-value 0.001) than the comparison patients. However, the rate of primary care visits for both groups declined for each stage over time. This trend may indicate reduced access to primary care across the state, regardless of PCMH recognition.

FIGURE 7. PRIMARY CARE VISITS PER 1,000 MEMBERS 2008-2015, ALL INSURERS, AGES 1 YEAR AND OLDER
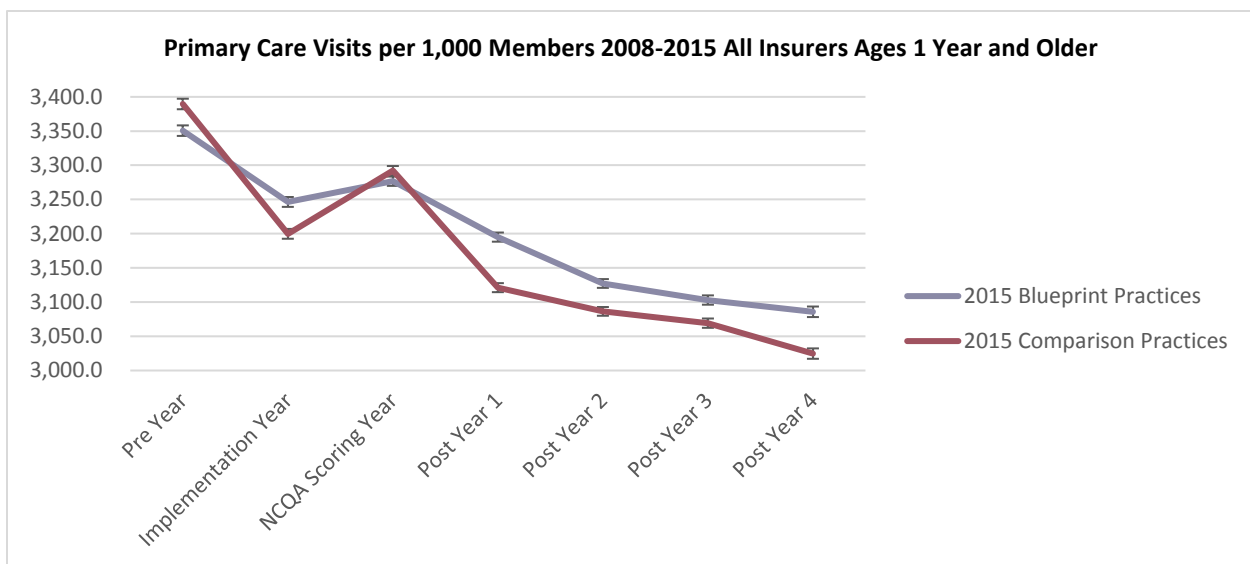
3.2 Medicaid Analysis

Analysis specific to Medicaid patients attributed to PCMHs indicates they generally have lower traditional health care costs and higher special Medicaid services (SMS) costs than the comparison group. When SMS expenditures are included, there is no statistical difference between the groups as seen by the overlapping confidence intervals in Figure 8. When SMS expenses are removed, medical expenses for the PCMH patients decrease significantly below the comparison group in Post-Years 1, 2, and 3. The significance of the different is lost in Post-Year 4 (Figure 9).

Conversely, in Figure 10, which shows the trend for SMS expenditures, the PCMH group has higher expenditures. However, it should be noted that both groups saw a decrease in expenditures in Post-Year 4. Since this dip was seen in both groups, it is likely due to statewide factors, such as any change to Medicaid policy; however, the specific factors contributing to this trend are not fully understood at this time.

Higher SMS expenditures for the PCMH group were first noted in the 2014 analysis. This trend of lower medical expenses and higher social and economic service expenditures is in line with achieving a better balance of medical and social expenditures, as proposed by Bradley and Taylor in *The American Health Care Paradox: Why Spending More is Getting Us Less*. Further exploration about the impact of differential SMS services on outcomes and quality is needed, which could also provide information on factors influencing the trend lines in Figure 10.

FIGURE 8. TOTAL EXPENDITURES PER CAPITA 2008-2015, MEDICAID, AGES 1-64 YEARS
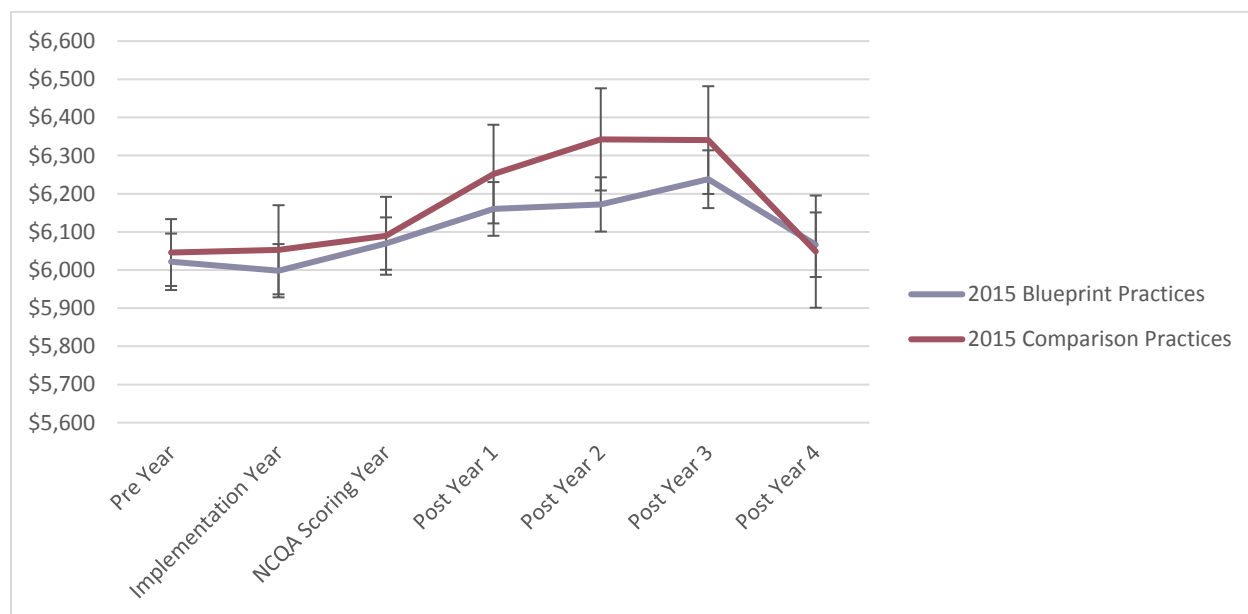
FIGURE 9. TOTAL EXPENDITURES PER CAPITA EXCLUDING SMS 2008-2015, MEDICAID, AGES 1-64 YEARS
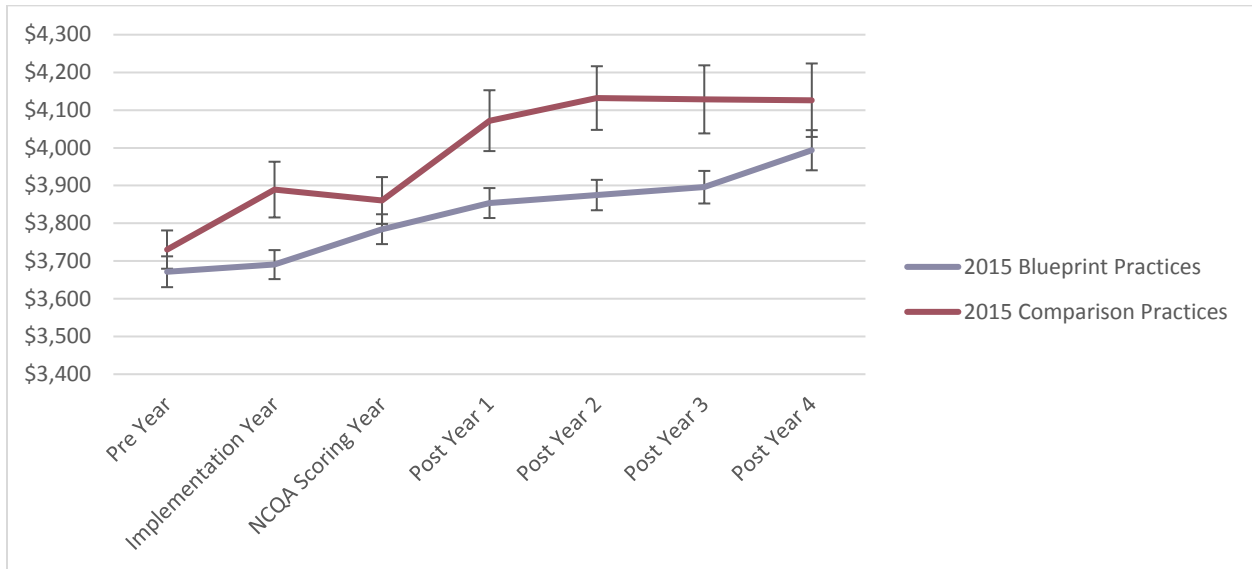
FIGURE 10. SMS EXPENDITURES PER CAPITA 2008-2015, MEDICAID, AGES 1-64 YEARS
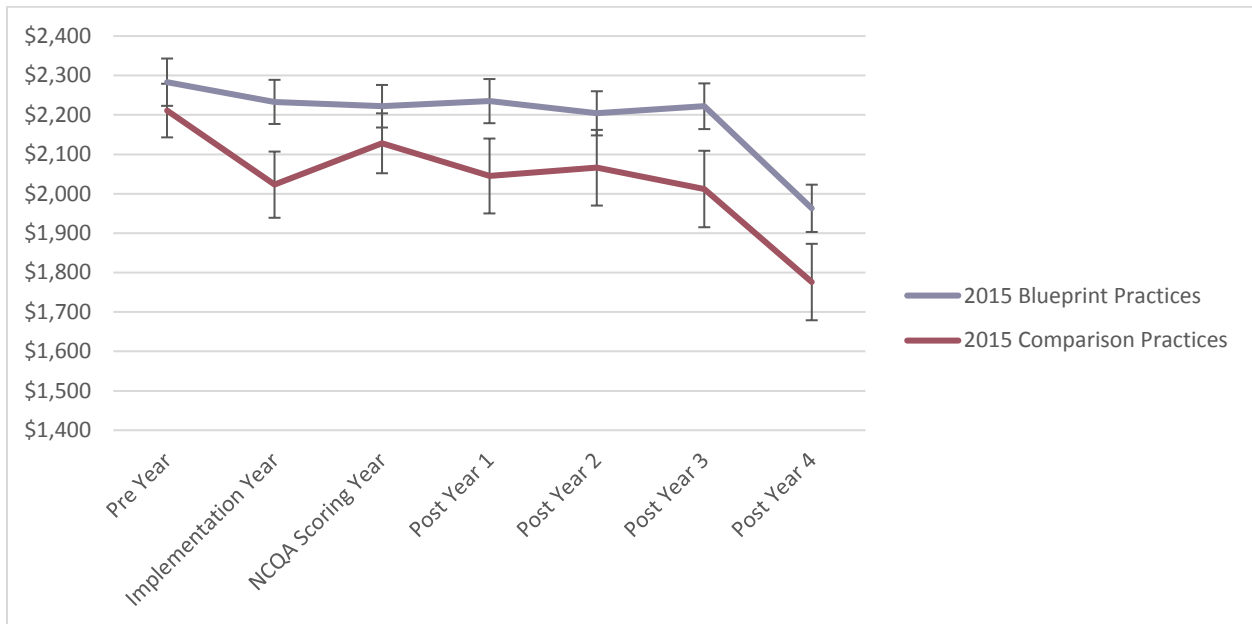
3.3 Return on Investment

While stage of program is valuable for evaluating the cumulative impact PCMHs and CHTs have on health expenditures and utilization trends, funding for the Blueprint program and insurer payments to PCMHs and CHTs is calculated on an annual basis. Therefore, to estimate an annualized cost-gain ratio, the relative reduction in expenditures was translated from programmatic stage to calendar year (CY).

Table 1 shows the methodology for how relative reduction in medical expenditures (excluding SMS) by stage was translated to calendar year 2015. First, column 2 shows the distribution of the average

number of patients attributed to PCMHs by each program stage (first column) for the year 2015. The relative difference in spending represents the DID for each program stage with upper and lower confidence limits (LCL and UCL) based on 95% confidence interval (columns 3, 4, and 5). The patient count was multiplied by the estimated reduction in medical expenditures at each stage to find the total relative reduction in total expenditures (excluding SMS) at each stage in 2015 (columns 6, 7, and 8). These totals are then summed to estimate the total reduction in expenditures for 2015 across all PCMH stages (last row).

TABLE 1. SUMMARY OF PATIENTS ATTRIBUTED TO EACH PROGRAMMATIC STAGE IN 2015 FOR ALL PAYERS

Program Stage	PCMH-Attributed Patients	Relative DID in Total Annual Expenditures per Person excluding SMS*			Subtotals for Relative Differences in Annual Expenditures excluding SMS		
		Estimate	LCL	UCL	Estimate	LCL	UCL
Pre-Year	--	--	--	--	--	--	--
Implementation Year	--	--	--	--	--	--	--
NCQA Scoring Year	8,506	$(45)	$(35)	$(55)	$(382,770)	$(297,710)	$(467,830)
Post-Year 1	7,036	$(181)	$(158)	$(204)	$(1,273,516)	$(1,111,688)	$(1,435,344)
Post-Year 2	45,984	$(261)	$(235)	$(287)	$(12,001,824)	$(10,806,240)	$(13,197,408)
Post-Year 3	61,237	$(280)	$(251)	$(307)	$(17,146,360)	$(15,370,487)	$(18,799,759)
Post-Year 4	172,505	$(247)	$(213)	$(281)	$(42,608,735)	$(36,743,565)	$(48,473,905)
Total					**$(73,413,205)**	**$(64,329,690)**	**$(82,374,246)**

Represents the difference in difference in annual per capita expenditures for patients attributed to a PCMH relative to patients attributed to comparison or non-PCMH practices at each programmatic stage

Table 2 shows the estimated cost-gain ratio for investments in PCMHs, CHTs, and the Blueprint program in CY2015 across all payers (column 2) compared to the relative decrease in expenditures (column 3, 4, and 5), which is derived from the calculations in Table 1. The investments include the total PCMH PMPM and CHT payments by Medicaid, Medicare, and commercial insurers for the year and the Blueprint program budget, which includes staff salaries, community grants for Project Managers and Practice Facilitators, contracts, and other operating expenditures.

TABLE 2. ESTIMATED RETURN ON INVESTMENT FOR ALL PAYERS IN CALENDAR YEAR 2014

All-Payer	Investment	Reduction in total expenditures excluding SMS	Confidence Interval (95%)	
			Lower Limit	Upper Limit
Reduction in expenditures		$ (73,413,205)	$(64,329,690)	$(82,374,246)
PCMH Payments	$7,968,509			
Core CHT Payments	$8,977,055			
Total Payments	$16,945,564			
Blueprint Program Budget*	$ 5,071,363			
Total investment	$22,016,927			
Cost-Gain Ratio		3.3	2.9	3.7

Note: Blueprint Program Budget includes actual spend on grants and contracts in calendar year 2015, estimated annual personnel costs, and estimated operations costs (based on historical trends).

3.4 Analysis of Return on Investment for the Medicaid Population

To calculate the return on investment for the State of Vermont's Medicaid population in 2015, the same methodology for all payers, as described above, was used (i.e. multiplying the number of Medicaid enrollees attributed to each PCMHstage in 2015 by the reduction in expenditures for each PCMH-stage and calculating the total reduction of expenditures across all PCMH-stages). Investments include both federal and state funding of PCMH and CHT payments and the Blueprint program budget.

Of note, the ROI for Medicaid is calculated based only on CHT and PCMH payments. The state ROI includes the Blueprint budget, which represents investments for all Vermonters in an effort to impact costs and care across the whole health system, not just for specific payers. For example, these investments include the costs of the statewide Transformation Network responsible for implementing initiatives on behalf of all payers, such as community-based self-management programs, PCMH recognition, and Community Collaboratives (refer to Section 2, How the Blueprint Works, for a description the Blueprint program).

In this iteration of the trend analysis, the cost-gain ratio is lower than the previous year's ratio. The reason for this outcome is likely due to the smaller and insignificant difference between the PCMH patients and the comparison group for total expenditures excluding SMS. Furthermore, this smaller difference would contribute more to the combined DID, since most patients in 2015 were attributed to Post-Year 4 practices. (Distribution of Medicaid enrollees by stage in 2015 follows a similar pattern to the distribution seen for all payers in 2015, Table 1.)

The decrease in the difference could be due to actual increased expenditures among Post-Year 4 PCMH patients. However, it could also be attributed to statistical uncertainty. While Post-Year 4 has the most number of patients in 2015, it has the fewest number of patients across all years, contributing to higher uncertainty in the Post-Year 4 difference for Total Expenditures Excluding SMS. In Post-Year 4, Blueprint patient annual per capita expenditures have an error of ±$53 compared to the range of errors from ±$38 to ±$43 for the other stages. In the Comparison group this trend is even more pronounced with the error growing from ±$51 in the Pre-Year to ±$97 in Post-Year 4. Identifying whether the trend for increasing expenditures among PCMH patients relative to comparison patients in later stages will hold can only be assessed by another annual iteration of the analysis when there will be more patients in the PCMH Post-Year 4 group.

One factor affecting Medicaid expenditures is the expansion of Medicaid benefits starting in 2014 and the subsequent reduction in the number of Medicaid enrollees in 2016. However, those trends would affect both the PCMH and comparison groups as they are statewide policies. Further study into whether the expansion and retraction affected one group more than the other would be a good next step once the 2016 claims data becomes available to understand Medicaid expenditure trends better.

TABLE 3. ESTIMATED RETURN ON INVESTMENT FOR MEDICAID IN CALENDAR YEAR 2015

Medicaid (federal and state funding)	Investment	Relative Total Expenditures w/o SMS	Confidence Interval, 95%		Relative Total Expenditures w/ SMS	Confidence Interval, 95%	
Reduction in expenditures		$(10,365,864)	$(7,263,946)	$(13,467,782)	$(1,364,083)	$3,059,443	$(5,787,610)

PCMH Payments	$3,230,379						
Core CHT Payments	$2,905,962						
Total Payments	$6,136,341						
Medicaid-Specific ROI		1.7	1.2	2.2	0.2	-0.5	0.9
Blueprint Program Budget*	$5,071,363						
Total investment	$11,207,703						
State ROI		0.9	0.6	1.2	0.1	-0.3	0.5

Note: Blueprint Program Budget includes actual spend on grants and contracts in calendar year 2015, estimated annual personnel costs, and estimated operations costs (based on historical trends).

3.5 Patient Experience: The Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey

Every year, the Blueprint, in collaboration with the Green Mountain Care Board and the Vermont Health Care Innovation Project, invites primary care practices across the state to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey. This survey helps evaluate patients' experiences at their primary care practices. The topics covered by the survey include:

- access to care (i.e., ability to get a desired appointment or answer during or after office hours and wait time);
- communication (i.e., a provider's ability to explain and answer questions about care or listen to concerns);
- coordination of care (i.e., a provider's knowledge of the care, medication, and tests a patient may receive elsewhere, such as from a specialist);
- information (i.e. did the provider provide information on care during off hours and care reminders);
- self-management care (i.e., did provider discuss specific goals for patient's health);
- office staff (i.e., were office staff respectful and helpful); and
- specialists (i.e., access to specialists and their knowledge of medical history).

The findings reported here compare Hospital Service Area results. The practice-level results were shared with all participating providers and are used for quality improvement.

Overall, Vermonters scored their primary care providers and practices favorably. Figures 11 through 14 show a sample of the findings for access, communication, coordination of care, and self-management support covered by the CAHPS-PCMH survey. For example, Figure 11 shows the combined responses to all five "access to care" questions for each of the Hospital Service Areas. While there is some variation across Hospital Service Areas, all scored above 50 percent for "Always".

Figure 12 shows the composite response rates for questions regarding communication. Providers scored even better in this category of questions with the "Always" response ranging from 78 percent to 85 percent. Figure 13 shows the response rates for care coordination. Again, the majority of patients reported that their provider appeared knowledgeable about the different aspects of the patient's care. Vermonters were somewhat less positive about the support they received for self-management. In

Figure 14, the responses are more centered around a 50/50 split. However, when responses to the individual questions are reviewed, the majority (49% to 68%[1]) of respondents report that their provider is talking with them about specific health goals, but only a minority (30% to 44%) of respondents report that their provider asks about potential barriers to health.

FIGURE 11. RESPONSE FOR COMPOSITE ACCESS TO CARE 2015
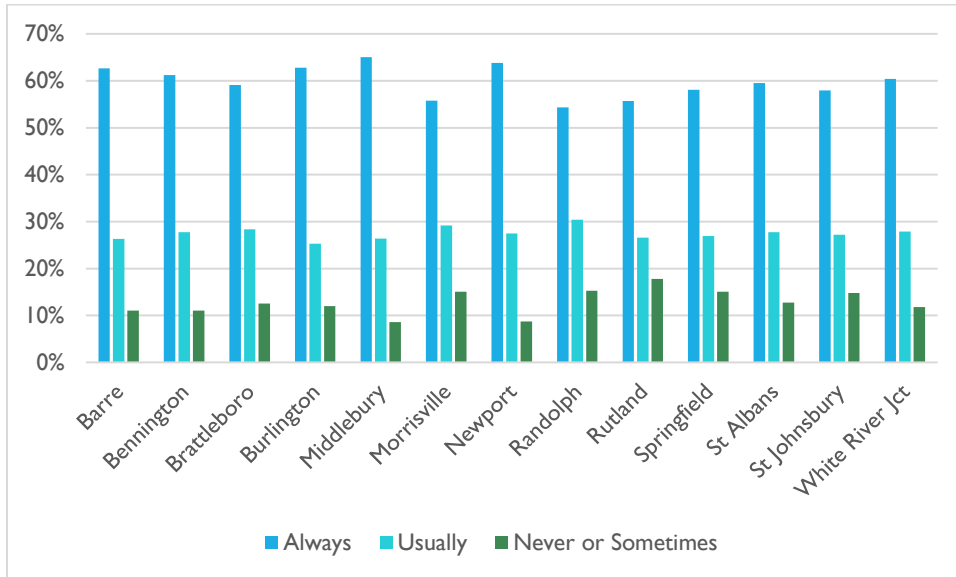
Questions include: "In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?"; "In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?"; "In the last 12 months, when you phoned this provider's office during regular office hours, how often did you get an answer to your medical question that same day?"; "In the past 12 months, when you phoned this provider's office after regular office hours, how often did you get an answer to your medical question as soon as you needed?"; and "Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this provider within 15 minutes of your appointment time?"

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[1] Only one HSA had a percentage less than 51%.

FIGURE 12. RESPONSE RATE FOR COMPOSITE FOR "COMMUNICATION," 2015
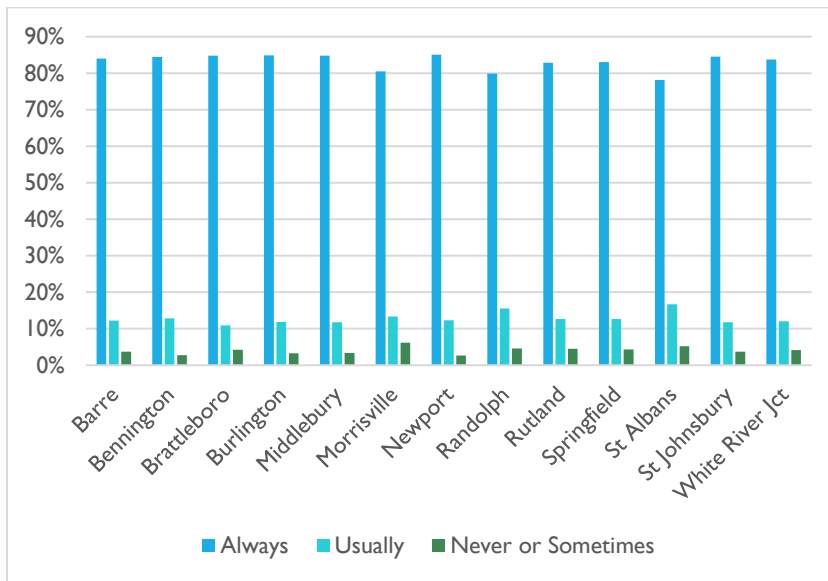
Questions include: "In the last 12 months, how often did this provider explain things in a way that was easy to understand?"; "In the last 12 months, how often did this provider listen carefully to you?"; "In the last 12 months, how often did this provider give you easy to understand information about these health questions or concerns?"; "In the last 12 months, how often did this provider seem to know the important information about your medical history?"; "In the last 12 months, how often did this provider show respect for what you had to say?"; and "In the last 12 months, how often did this provider spend enough time with you?"

FIGURE 13. RESPONSE RATES FOR COMPOSITE "COORDINATION OF CARE," 2015
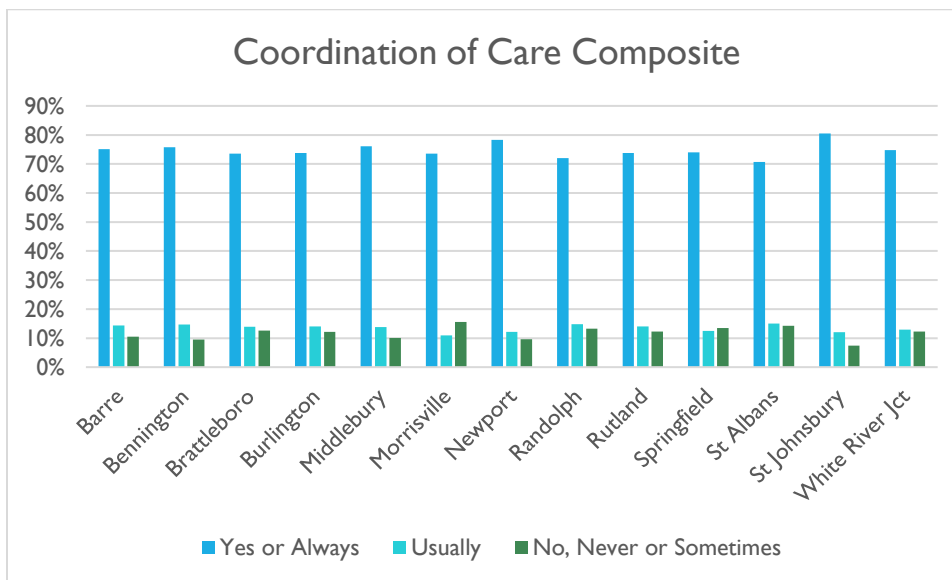
Questions include: "In the last 12 months, when this provider ordered a blood test, x-ray or other test for you, how often did someone from this provider's office follow up to give you those results?"; "In the last 12 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?"; and "In the last 12 months, did you and anyone in this provider's office talk at each visit about all the prescription medicines you were taking?"

FIGURE 14. RESPONSE RATES FOR COMPOSITE "SELF-MANAGEMENT SUPPORT," 2015
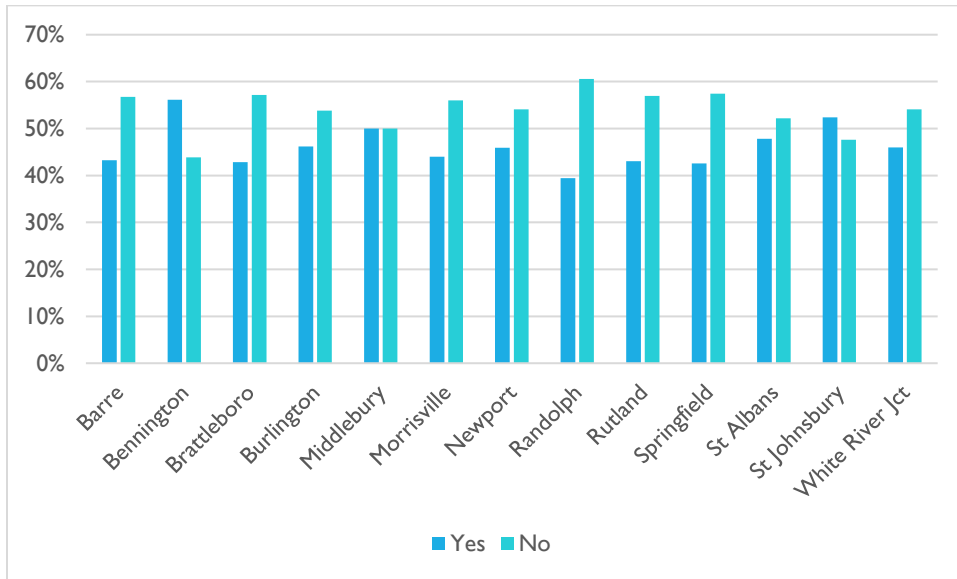
Questions include: "In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health?" and "In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?"

4 Payment Reforms and Funding Highlights for 2016
4.1 Modified PCMH Payments Went into Effect in 2016

Beginning on January 1, 2016, the PCMH per-member-per-month (PMPM) base payments were enhanced and a performance component was introduced. This was the first payment increase since the program's launch in 2007, made possible by new Medicaid appropriations allocated during the 2015 legislative session. Many practices indicated the previous payment levels were no longer sufficient to cover the costs of the additional work required to operate as a patient-centered medical home (PCMH) and practices would withdraw from the program if the payments were not increased.

These concerns brought into question the viability of the Blueprint program even as early evidence from Medicare and Blueprint evaluations indicated the program was producing positive returns by improving health outcomes and reducing expenditures. Since the new payments were initiated in 2016, no practice will have dropped out as of January 1, 2017, and six (6) additional practices have joined the program over the past year. One small practice is in the process of re-locating to another state as the provider retires.

In addition to an overall increase in the base payment for recognition as a PCMH, the payment model was also revised. A more detailed description of changes to the payment model was presented in the Blueprint's 2015 Annual report. However, for review, prior to 2016, the PCMH payments were based on the score a practice received from NCQA during the PCMH recognition process. These payments averaged $2.05 PMPM and ranged from $1.36 to $2.39 PMPM.

The new payment model included a base payment of $3.00 PMPM contingent on qualifying for or maintaining recognition as a PCMH, as well as participation by practices in their community collaboratives (refer to section 5.3.1 in the 2015 Annual Report). The new payment model also included two performance-based payments, up to an additional $0.50 PMPM: one based on a composite of quality measures ($0.25) and the other based on health service utilization ($0.25). The quality performance payment is based on the practice's HSA composite score derived from outcomes in four measures, which are part of the CMS-defined Medicare ACO core quality measures:

1. Adolescent Well-Care Visits
2. Developmental Screening in the First Three Years of Life
3. Diabetes in poor control (i.e. Hemoglobin A1c >9%)
4. Rate of Hospitalization for Ambulatory Care Sensitive Conditions[2]

The utilization performance payment is based on a practice's Total Resource Utilization Index (TRUI) score. The TRUI is a standardized measure that reflects overall utilization and is endorsed by the National Quality Forum.

The quality component of the payment is based on results at the Hospital Service Area level to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration across medical and social provider organizations. However, practices expressed concerns that basing all performance payments at the Hospital Service Area level limited their influence on the payment they received, so the decision was made to base the utilization component on

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[2] PQI Chronic Composite (which includes the admission rate per 1000 for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure)

individual practice performance. The Blueprint and ACOs agreed this mixed model struck the necessary balance between individual practice performance and integration across the community.

4.2 Impact of Payments

In the legislation appropriating the additional funds for increasing Blueprint payments to PCMHs and adopting a new payment model, the legislature requested an evaluation of the impact these payment increases have had. At the time of this report, the Blueprint has claims data only up to the end of calendar year 2015. Since the payments went into effect on January 1, 2016, medical expenditure and utilization data reflecting any change due to the new payment model is not available.

However, beyond the financial impact of the new payments, the performance measures are already driving change in how communities assess their performance and priorities. For example, there has been renewed interest in developmental screening with almost fifty practices participating in the University of Vermont College of Medicine's Child Health Advances Measured in Practice (CHAMP) initiative funded by the Vermont Department of Health (VDH).

Another result is that since one of the quality measures for the performance-based payments is based on clinical data, practices have worked more closely with the Blueprint and its data quality team to improve the flow and quality of clinical data into the Blueprint Clinical Registry. Not only is this data important for assessing payment amounts, but it complements information found in the VHCURES claims data and allows for a deeper understanding of population health at the state- and local-levels.

Finally, planning for the new payment model has increased collaboration between the three existing ACOs, which represent different provider interests and diverse populations. The ACOs have also worked collectively to build the local Community Collaborative (CC) structure. Each CC is committed to moving forward in pursuit of a cohesive and collaborative approach to improving population health in their community. Knowing that the base payment will require engagement in this effort, providers are participating in the CCs either directly or through their ACOs.

5 Data Collection, Analysis, and Reporting Highlights for 2016
5.1 The Blueprint Clinical Registry in 2016

Blueprint practices across the state have been populating the clinical data registry for over 7 years. The registry, previously referred to as DocSite, was hosted by Covisint. In January 2015, Covisint announced it would no longer support the DocSite product, giving the Blueprint until August of 2015 to find a replacement system. The Blueprint for Health, under direction from the Agency of Administration, was instructed to purchase a perpetual software license for the DocSite software product from Covisint, stand up the Blueprint Clinical Registry at an alternate location, and have it functional by June 30, 2016. The system would thereafter be referred to as the Blueprint Clinical Registry.

The Blueprint entered into an agreement with Capitol Health Associates (CHA) to manage the overall project and continuing operations and maintenance of the Blueprint Clinical Registry. CHA subcontracted with Vermont Information Technology Leaders (VITL) to host and provide technical support for the Blueprint Clinical Registry and to work with the Blueprint team to convert the message handling processes from Covisint Connect to VITL Rhapsody. CHA also subcontracted with MDM Technologies to provide advisory and special technical services to support the migration and to stand up the registry at VITL's hosting contractor, Rackspace, and with KeyW Corporation to provide data security services. Following the migration of the system, CHA and MDM have been providing onboarding support for the Blueprint Clinical Registry since June 30, 2016.

The fully functional Blueprint Clinical Registry includes a client-facing user interface for data entry and reporting for Blueprint programs, including, Community Health Team (CHT), Self-Management Support Programs (SMSP), and Tobacco Cessation (TCC). The system also provides data collection through standard Admission, Discharge and Transfer (ADT) and Continuity of Care Document (CCD) interfaces for 175 sites through the Vermont Health Information Exchange (VHIE), flat file demographic and clinical interfaces for four (4) sites through an FTP site, and flat file pass-through services for nine (9) sites.

CHA and its subcontractors completed the Blueprint Clinical Registry migration project on schedule and under budget.

Success criteria for the project included:

- The Blueprint Clinical Registry will be functional and deployed to production environment on or about June 30, 2016.
- The Blueprint Clinical Registry will be fully migrated to Rackspace.
- Functionality of Covisint Connect data messaging system will be documented and tested.
- A plan to migrate data feeds from Covisint Connect to VITL's Rhapsody interface engine will be established.
- Successful completion of functional and user acceptance testing of all end-user data entry activities and reporting.
- Production data feeds from the VHIE successfully pointed to the Blueprint Clinical Registry via Rhapsody.
- Production data feeds from Covisint's FTP site in support of flat file interfaces successfully pointed to the Blueprint Clinical Registry via Rhapsody.
- Readiness to onboard new sites and users to the Blueprint Clinical Registry.

5.1.1 Extract Reports

One of the key deliverables from the Clinical Registry are extract reports to the analytic vendor to provide detailed data for the Practice and HSA profiles. These extracts were performed through a

series of back end jobs utilizing information from the Covisint Master Person Index (MPI). These reports had been performed by Covisint during prior contract years.

As a result of the migration of the DocSite system, the task of preparing the extract reports was moved to the Clinical Registry team. After the Registry went live and all the stored messages were filed into the system, the team developed a custom extract process. This process allows for full and parameter-driven extracts to be obtained from the system.

One of the challenges facing the team was the removal of the MPI from the new system. The original extract dependent heavily on the Enterprise User ID (EUID). The Clinical Registry team worked closely with Onpoint Health Data (Onpoint), the Blueprint's analytic vendor, to ensure the matching capabilities of the new extract. Currently the Registry does not have MPI (Master Patient Index) services, nor does the VITL MPI work to track unique patients across applications. The Blueprint looks forward to working with the state and VITL to address this core function.

The first full extract was verified and sent to the Onpoint in June. Since then the Registry continues to send quarterly extracts to the vendor and has completed the extract of data for SASH and other entities.

5.1.2 Use of the Blueprint Clinical Registry for Direct Data Entry

The fully functional Blueprint Clinical Registry includes a client-facing user interface for data entry and reporting for Blueprint programs including, Community Health Teams (CHTs), Self-Management Support Programs (SMSP), and Tobacco Cessation (TCC).

During the period while the system was being migrated, the programs had to develop methods to collect and maintain their system data. One solution was the development of a tool for CHT and TCC data collection. This tool was designed to allow organizations to collect data and to have this data imported into the Blueprint Clinical Registry when the system went live. However, the interim tool had limited success because it lacked the flexibility and simplicity that users needed.

Since the Blueprint Clinical Registry has come back online, CHT organizations have restarted manually entering data. This system provides tracking, reporting, and to-do list capabilities. More HSAs have inquired about going back online in the next few months. Others used the system down time to reevaluate their data collection and tracking needs, and some switched permanently to the use of other systems.

Analysis work has begun for the TCC module. The goals are to streamline the data entry, improve the reporting, and incorporate YMCA functionality. Estimates have been created and are currently being reviewed.

Prior to Go Live of the Registry, Support and Services at Home (SASH) program, with the support of the ACOs and Blueprint, made the decision to move the SASH data to the Care Navigator system provided by OneCare Vermont, allowing the SASH program to better integrate into community based-cross-organization care coordination in preparation for the APM. The Blueprint Clinical Registry team worked with the SASH team to extract their current and historical data. This multi-stage process was successfully completed, allowing five (5) years of SASH data to transition to the new system seamlessly and met SASH's timeline

5.2 "Sprint" Data Quality Projects

Data quality in practice Electronic Medical Records (EMRs) and the Vermont Health Information Exchange (VHIE) is essential for meaningful reporting and accurately targeted improvement activities. 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.

Essentially, the Blueprint team works with practices to improve the workflow of how clinical care is documented in the EMR, with VITL and the practices to test the reliability of the interface to the VHIE, and with the practice to ensure the data flowing through the interface and into the VHIE to populate the registry is complete and in standard format. The process to link new EMRs to the VHIE and have data flows populate the registry is referred to as "onboarding". The Sprints are the time-limited, intensive activities that ensure data quality,

The Sprint process has matured and evolved over the last three (3) years, having addressed a number of issues around legacy data integrity in the Docsite system by creating processes to include such items as measure validation reports. These reports ensure the data from the various sources is in the proper format and can be consumed and utilized to assist in health care delivery and payment reform programs. The data quality improvements achieved by the Sprints benefit users of data from the VHIE, ranging from the PCMHs and hospital/health systems themselves to the Accountable Care Organizations (ACOs) to the Community Collaboratives to state health care improvement and reform leaders – all of whom need access to high-quality, trustworthy, and secure information.

Sprints have been completed in a large number of practices to date and are continuing on the few remaining practices yet to be onboarded to the Blueprint Clinical Registry. Interestingly, over the last year, a number of practices contributing data to the Blueprint Clinical Registry have switched EMR vendors, creating repeat Sprint initiatives to ensure the new vendor and the data comply with the Blueprint Clinical Registry standards and are properly onboarded.

In the next phase of data quality initiatives, the Blueprint Sprint team along with VITL will be working on extracting more granular measure data from the clinical feeds using cutting edge terminology services methodologies. Today, most EMRs transmit what is known as a Continuity of Care Document (CCD). CCDs carry a person's medical history either by episode of care or for the entire longitudinal record in both machine readable and human readable form. Unfortunately, many EMR vendors do not code certain increasingly important health measures within the CCDs, essentially locking the valuable data up and making it unusable. The next generation of delivery reform will rely heavily on the data hidden within the CCDs, making the project a priority in 2017.

5.3 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 EMRs and laboratory results.

5.3.1 Admission, Discharge, and Transfer Data

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

- active and inactive providers

- active, inactive, and deceased patient statuses
- proper patient attribution to a provider

5.3.2 Clinical Data

Major issues encountered with the clinical data center around unstructured or free-text data entry into the EMR, disparate nomenclatures used by medical records systems for structured data entry, and the packaging, transmission, and acceptance of that data by other systems consuming it. Since data quality issues vary from one EMR or information system to another and from one practice to another within a health care 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 in 2017.

5.4 Sprint Projects in 2016

In 2016, the Blueprint targeted a number of practices for Sprint data quality projects in Vermont. However, Covisint's decision to sunset its maintenance of the DocSite software in 2015 required the Blueprint to transfer resources from onboarding sites to migrating the registry. During the 2016 period, targeted data quality projects were continued with sites already contributing data to the registry.

During 2016, 22 new interfaces were established between Blueprint practices and the VHIE. Of those interfaces:

- 10 are demographic information (ADT) interfaces
- 11 are clinical care summary document (CCD) interfaces
- 2 are flat file interfaces

The Registry team has been working with VITL to onboard these sites to the Blueprint Clinical Registry. Several sites have been identified for data quality sprints, and others will require extensive pre-work with the EMR vendor to provide structured and coded data in the CCD.

5.5 How Clinical and Claims Data are Aggregated for Comprehensive Reporting

The Blueprint has developed a process for aggregating Vermont's clinical data from the Blueprint Clinical Registry, and claims data from the all-payer claims database, also known as the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). After analysis of the data in the Clinical Registry for quality and completeness, the data are de-identified and linked at the person level with the corresponding individual's claims records in VHCURES. This linkage is conducted by the Blueprint's analytics vendor, Onpoint, who determines the portion of the population in VHCURES for which clinical data can be associated with claims.

FIGURE 15. LINKED CLAIMS AND CLINICAL DATA STEP DOWN
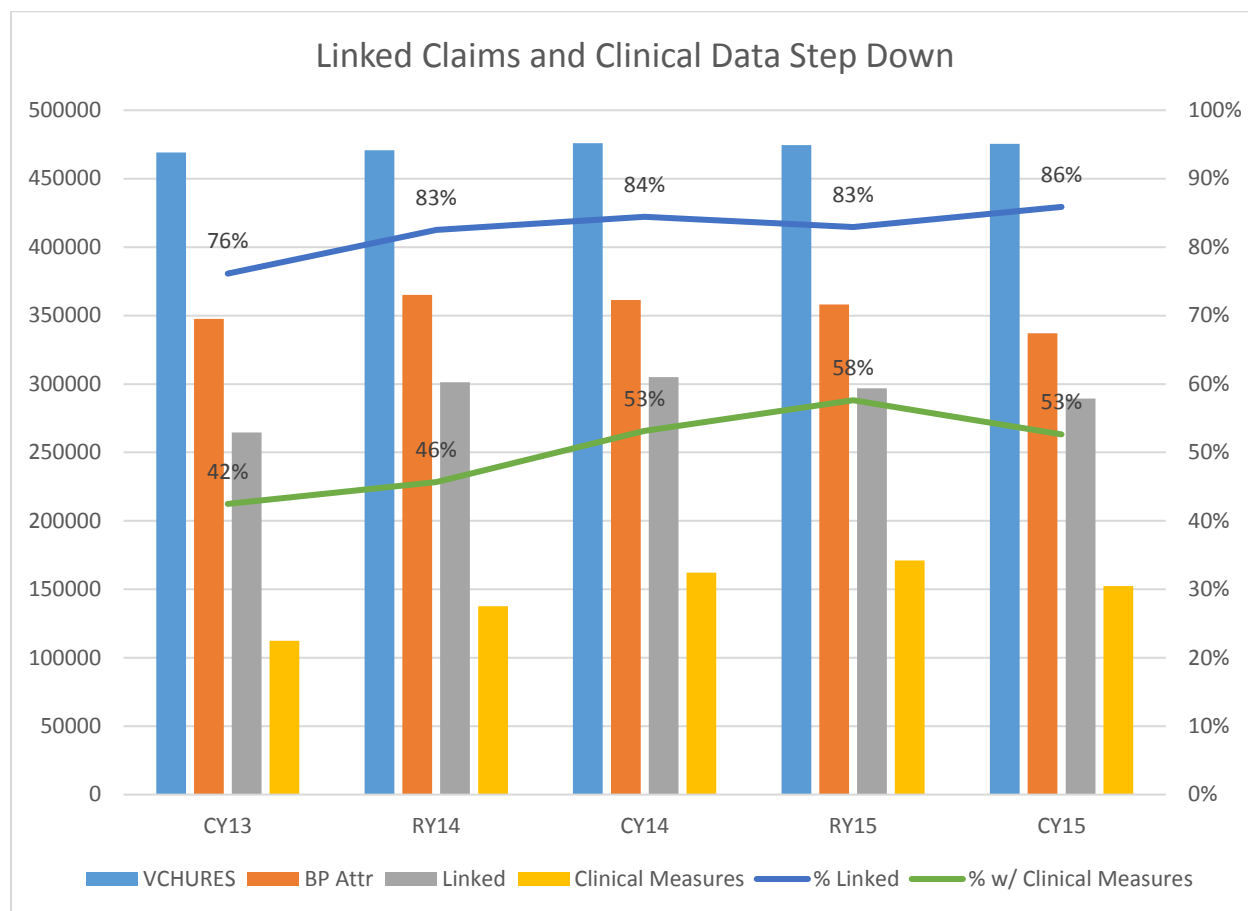
In general, there has been an increase in the percent of individuals who can be linked between claims and clinical data and an increase in the percent of those with clinical measures. In the most recent iteration of linkage, we continue to see an increase in linked individuals; however, there appears to be a drop in the percent with clinical measures that can be linked. Two factors contribute to this trend.

First, with improvements to the accuracy of attributing individuals to PCMHs, we saw the number of attributed patients decrease. Second, a number of practices stopped their clinical data feeds to the VHIE, and therefore the Blueprint Clinical Registry, for purposes such as upgrading their EMRs. Together, these two factors led to a reduced number of clinical and claims data points to match. In the next iteration, with the resumption of all data feeds, the percent of linked data with clinical measures is expected to return to its previous upward trend.

The linked data that is available begins to tell a compelling story of population health across regions. Figure 16 shows claims-based data on the percent of individuals with diabetes in an HSA's population who received HbA1c testing (chart on the left) and the clinical-based data on the proportion of those with HbA1c testing whose percent of glycosylated HbA1c is greater than 9%, an indication that their diabetes is not well-controlled (chart on right).

As another example of how the merging of claims and clinical data can benefit the health system, Figure 17 shows the difference in costs and utilization rates associated with individuals with diabetes who have their diabetes in control (HbA1c < 9%) and individuals with diabetes who do not (HbA1c ≥ 9%). These

types of cost comparison dashboards, using clinical and claims data, can be used to provide meaningful guidance for state-, community-, and practice-level quality improvement initiatives.

FIGURE 16. SAMPLE PART OF DASHBOARD OF ACO MEASURES INCLUDED IN BLUEPRINT HSA PROFILES

Diabetes: HbA1c Testing
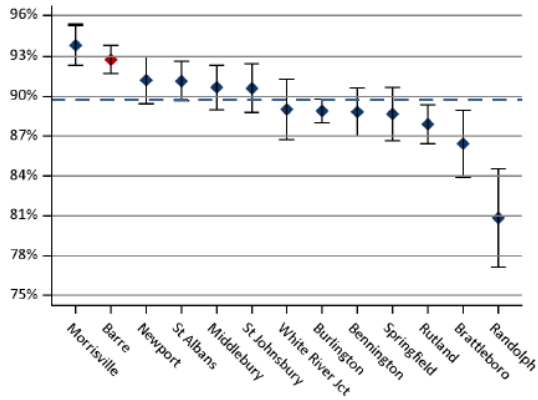
Figure 9: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, that received a hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

Diabetes: HbA1c Not in Control (Core-17, MSSP-27)
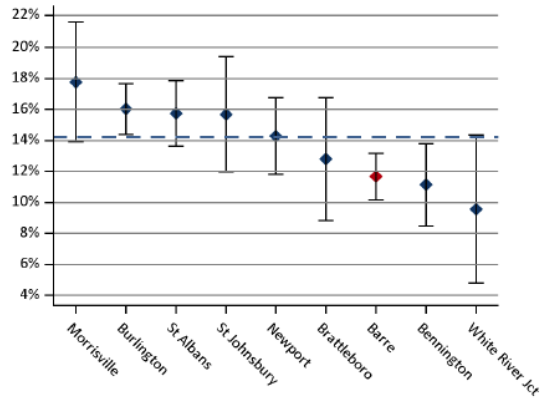
Figure 10: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the Blueprint clinical data registry was in poor control (>9%). Members with diabetes were identified using claims data. The denominator was then restricted to those with clinical results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

Comparison of Patients by HbA1c Control Status, Statewide

Metric	Diabetes A1c in Control	Diabetes A1c Not in Control
Members	5,923	1,007
Annual expenditures per capita	$13,938 ($13,498, $14,377)	$15,563 ($14,455, $16,672)
Inpatient hospitalizations per 1,000 members	178.3 (167.5, 189.2)	218.8 (189.4, 248.2)
Inpatient days per 1,000 members	835.7 (812.2, 859.2)	1,021.8 (958.2, 1,085.4)
Outpatient ED visits per 1,000 members	634.3 (613.8, 654.8)	743.3 (689.0, 797.5)

Note: Risk-adjusted rates with 95% confidence intervals are provided in parentheses. Outliers beyond the 99th percentile have been excluded.

Table 2: Presents a comparison of health care expenditures and utilization in the measurement year for continuously enrolled members, ages 18–75 years, whose diabetes hemoglobin A1c was in control (≤9%) compared to those with poor control (>9%). Rates have been adjusted for age, gender, and health status. The rates in this table are presented at the state level only. Members with poor control had statistically significant higher total expenditures, inpatient hospitalizations, inpatient days, and outpatient ED visits.

5.6 Data Reports to Practices and HSAs

5.6.1 Practice profiles offer comparative reporting for quality improvement

Building on the Blueprint's data aggregation utility and data analysis capabilities, the program produces Practice Profile reports for all Blueprint practices with patient populations large enough for meaningful comparative analysis. There are distinct profiles for adults and for pediatric populations. These profiles report on a wide range of quality and utilization measures and compare practice results to local peer practices and a state average.

In 2016 the Blueprint produced two sets of profiles, with each new release coming 6 months apart. The regular release of the profiles, with historical information included, provides primary care practices with a longitudinal look at their outcomes. They also help practices and Blueprint Practice Facilitators identify and prioritize quality improvement projects.

Since September 2014, practices have been receiving whole population profiles with data from all payers combined into a single report. Previously, performance data came separately from each payer. Providers

rarely consider payer affiliation in their interactions with patients, so payer-specific data has limited usefulness in improving care. Very few practices had the resources to piece these reports together and assess performance for their patient population overall. Blueprint overcame this challenge with whole population profiles that include data for Vermont residents enrolled in major commercial health plans, Medicaid enrollees for whom Medicaid was the primary payer (excluding dual-eligible beneficiaries), and Medicare enrollees for whom Medicare was the primary payer (ages 18 years and older and including duals).

The Blueprint distributes practice profiles directly to the primary contact on file with the Blueprint for each practice and to the Project Manager and Practice Facilitator representing the geographic hospital service area (HSA), as defined by the Vermont Department of Health (VDH), in which the practice is located.

5.6.2 HSA profiles show health care quality and utilization for whole populations

The Blueprint also develops profiles at the hospital service area (HSA) level, essentially an aggregation, or "roll up," of the profiles for all practices within an area. These HSA Profiles provide data comparing utilization, expenditures, and quality outcomes within an individual HSA to all other HSAs and the statewide average.

Partnering with Vermont's ACOs, the Blueprint offers the HSA Profiles as a way to better operationalize statewide data collection and reporting, especially for ACO measures with a clinical component. To reduce the burden of clinical data collection (often through practice-level chart review) for production of the ACO measures, the Blueprint takes an extract from the statewide Blueprint Clinical Registry and sends it to the analytics vendor, Onpoint Health Data. The clinical data extract is then linked to the claims data from VHCURES to produce clinical and hybrid (claims/clinical) measures.

Socioeconomic and behavioral data from the Behavioral Risk Factor Surveillance System/BRFSS, a telephone survey conducted annually by the Vermont Department of Health (VDH), is also included in the HSA profiles (Figure 18). This inclusion helps communities identify root causes of health disparities and identify behaviors that may impact health outcomes, with a goal of arming communities with the data they need to identify opportunities and integrate upstream prevention into the strategies they implement locally.

BRFSS: Households with Income <$25,000
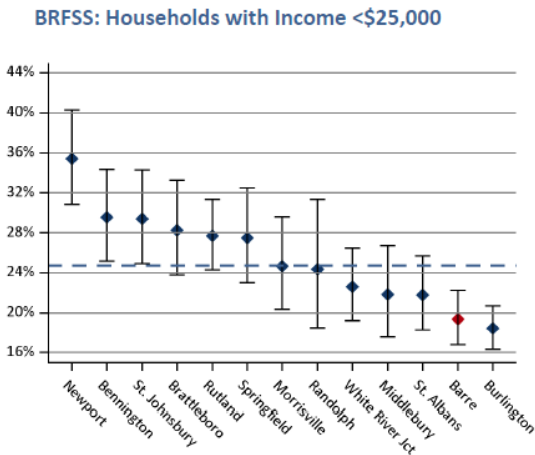
Figure 32: Presents the proportion, including 95% confidence intervals, of Vermont residents, ages 18 years and older, that reported a household income of less than $25,000 per year. This data was collected through the Behavioral Risk Factor Surveillance System (BRFSS). The blue dashed line indicates the statewide average.

BRFSS: Cigarette Smoking
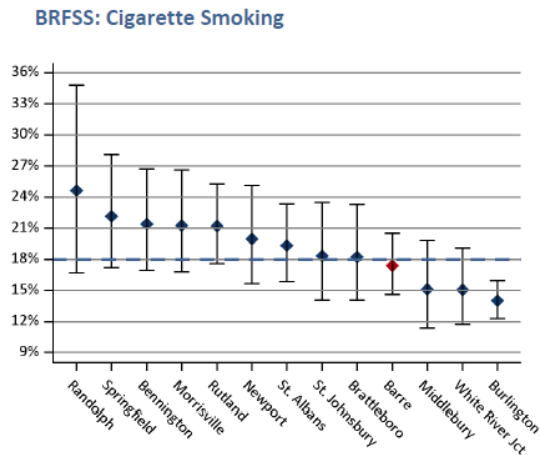
Figure 33: Presents the proportion, including 95% confidence intervals, of Vermont residents, ages 18 years and older, that reported being cigarette smokers. This data was collected through the Behavioral Risk Factor Surveillance System (BRFSS). The blue dashed line indicates the statewide average.

The regular production of timely HSA Profiles across all payers that feature ACO core measures and key population health indicators serves as a starting point for community-wide quality improvement initiatives. Additionally, in January 2016, performance payments were implemented based on utilization (as reported in Practice Profiles) and quality measures (as reported in HSA Profiles).

Complete sets of both adult (ages 18 and older) and pediatric (ages 1 through 17) Blueprint HSA Profiles can be found on the Blueprint website, at
http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles

6 Care Programs: Highlights for 2016

6.1 Patient-Centered Medical Homes

The Blueprint Patient-Centered Medical Homes (PCMHs) continued to provide evidence-based, patient- and family-centered, cost-effective care in 2016. All practices that participated in 2015 continued participating in 2016 (with the exception of a very small practice in the process of relocating out of state as the provider retires). This continued participation can be attributed in part to the increased funding the Legislature granted in 2015.

The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding new practices has generally plateaued. The Blueprint estimates there are 140 primary care practices in Vermont with 129 practices participating by the end of the third quarter of 2016. Seven (7) practices, mainly new practices in Vermont, are scheduled to join the Blueprint in 2017.

FIGURE 19. BLUEPRINT FOR HEALTH PARTICIPATION SINCE PROGRAM INCEPTION
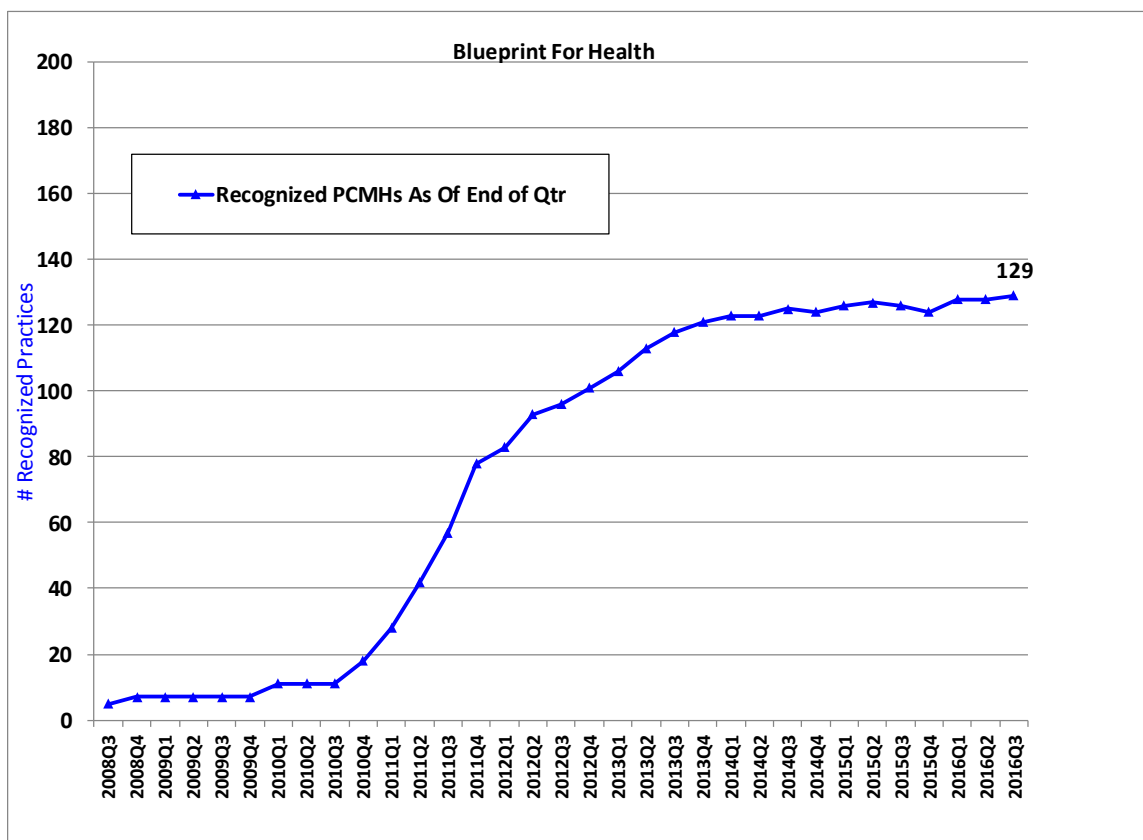
6.2 Community Health Teams

6.2.1 CHT staff help plan and implement projects of the Community Collaboratives

As Community Collaboratives (CCs) continue to mature in each Blueprint Health Service Area (HSA), the work of Community Health Teams (CHTs) adapts to meet the priorities and projects identified by

these groups. Each CC identifies at-risk, high-utilizing populations in their area. Based on the needs of the identified populations, the CC then defines priorities for quality improvement (QI) using data from Blueprint HSA Profiles and other sources.

The QI projects often align with Accountable Care Organization (ACO) priorities and the ACO core measure set, such as projects to reduce emergency department (ED) utilization or all-cause 30-day hospital readmissions. Communities also have discretion to work on emerging initiatives meaningful to their HSAs, such as Adverse Childhood Experiences (ACEs) or opioid prescribing practices.

Once QI projects are identified, work groups form to create Plan Do Study Act (PDSA) cycles to document planned interventions, identify data collection strategies, and evaluate the effectiveness of the projects. CHT staff members participate in these work groups and are often tasked with implementing the interventions in their day-to-day work.

Two (2) projects common across most of the HSAs include integrated cross-organization care management for individuals with complex needs and the Accountable Communities for Health (ACH) Peer Learning Lab. Training and learning opportunities for these two areas of interest were supported through funds from the State Innovation Model (SIM) grant, or Vermont Health Care Innovation Project (VHCIP).

In each of the 14 Blueprint HSAs in the state, a CHT Leader supervises the day-to-day work of CHT staff. CHT Leaders participate in monthly meetings of all ACO and Blueprint field team staff (including Project Managers, Practice Facilitators, CHT Leaders, and Clinical Quality Improvement Consultants).

The CHT Leader group also meets separately each month to share information about successes and challenges in their communities, discuss best practices, and brainstorm solutions to common barriers. CHT Leader meetings have further matured in 2016 and continue to provide value to participants. Each CHT Leader leverages the knowledge they gain in these meetings, and many have adopted successful strategies for their own staff and patients.

Topics:

- Understanding the Health Information Technology (HIT) infrastructure including:
    - Vermont Health Information Exchange (VHIE)
    - VITL Access
    - Patient Ping (Event Notification System)
    - The Blueprint Clinical Registry (formerly DocSite)
    - eQHealth (AHS Care mMnagement platform)
    - Care Navigator (OneCare's Care Management platform)
- Strategic approaches to achieve the new target goals for self-management support workshops
- Implementing the Women's Health Initiative (WHI) in each HSA, including recruiting practices and hiring new CHT staff
  Working with community partners to overcome barriers to information sharing.

6.3 Integrated Communities Care Management Learning Collaborative

For some Vermonters, the medical system alone is insufficient to meet their needs. They may have multiple chronic health conditions, past trauma, poor mental health, or problems with substance abuse.

They may not have a safe place to call home or friends or relatives to rely on when they need support. They often face complex combinations of these challenges.

These challenges can make it difficult to access health care or social services, resulting in some high-needs individuals receiving no routine care and instead ending up in the ED or hospitalized for preventable conditions. In other cases, individuals with complex struggles may see multiple physicians and social service providers who each have their own information and own treatment plan. In some cases, complex difficulties may lead to individuals seeing multiple physicians and social service providers who each have their own information and own treatment plan.

Having multiple care providers can result in a person receiving only the care they need at a particular moment in time and may prevent a more holistic treatment approach. Often, the multiple treatment directions are confusing or disconnected from the person's own goals and values. In some cases, misaligned treatment may even do harm if it includes contraindicated therapies or medications. Most commonly, uncoordinated care is simply inefficient, drawing too heavily on limited community resources and on the person's own money, time, and energy. The opportunity to improve outcomes is clear and so is the financial case.

As a result, Community Collaboratives (CCs) in most HSAs across the state have identified coordinated cross-organization care management as an opportunity for improvement. They focus on reducing inappropriate health care utilization and cost and improving health outcomes. To help support these efforts, the VHCIP/SIM work groups devised the Integrated Communities Care Management Learning Collaborative (ICCMLC) using the Disabilities and Long Term Support Services (DLTSS) work group's model of care as the initial guiding principles.

The ICCMLC consists of a series of learning opportunities designed to assist communities in providing efficient, comprehensive, well-coordinated, person-directed care across multiple agencies and organizations. The ICCMLC is a project of VCHIP/SIM, the Green Mountain Care Board (GMCB), the Blueprint, and the ACOs. These programs provide funding, strategic direction, a curriculum to orient and prepare the teams, and ongoing consultation and coaching for participating communities.

Through the efforts of communities participating in the ICCMLC, multi-disciplinary local teams accept shared responsibility for effectively and efficiently caring for a group of people from among their community's most vulnerable members. These teams work together with each person to find the root cause of their health problems and to plan a coordinated response motivated by the client's own goals and values.

The pilot launched in late 2014 with three (3) communities: Burlington, Rutland, and St. Johnsbury. In 2016, eight (8) additional HSAs joined the second wave of Learning Collaborative sessions.

In each community, typically under the direction of the local CC leadership team, the Blueprint Project Manager, CHT Leader, or Practice Facilitator convenes a local team comprised of primary care practices, home health agencies, hospitals, skilled nursing facilities, Area Agencies on Aging, Blueprint CHT staff, Support and Services at Home (SASH), the Vermont Chronic Care Initiative (VCCI), ACOs, health care and social services consumers and families, and others.

Participating organizations commit to making changes in the way they do care management and to investing the time of their staff, including at least one direct care provider and one leader with the authority to make decisions about the organization's care management services. Team members join day-long learning sessions every other month, webinars with additional learnings in between the in-

person sessions, and meetings with their community work groups on a regular basis to design and implement care management strategies. In addition, care coordination staff have attended skills-building sessions monthly throughout the year.

The statewide learning sessions feature national experts who share best practices and new ideas with the teams. Leaders from Vermont's Agency of Human Services (AHS), the state's ACOs, and commercial insurance providers also contribute to the learning sessions and to helping develop the tools used by the communities.

Strategies:

- using data and experience to identify individuals who would benefit from a cross-organization care team;
- recruiting and engaging individuals with a coordinated cross-organization team to help support their needs;
- using tools to identify a person's story, including their goals, expectations, history, and perception of who should be on their team;
- reviewing the person's health records and identifying the root causes of health disparities and health care utilization;
- convening care conferences, including the individual receiving care and their full care team;
- identifying one key care team member, called a "lead care coordinator", who can provide long-term continuity, is trusted by the person receiving care, and can act to convene, coordinate and communicate with the care team;
- developing a shared care plan, including the goals centered around what the person receiving care wants to accomplish, sequenced action items, and responsible parties. The shared care plan and the care team's meeting frequency and level of intensity is dynamically updated as the person's needs change.

Key Interventions in Vermont's Integrated Communities Care Management Learning Collaborative (order of interventions may vary)
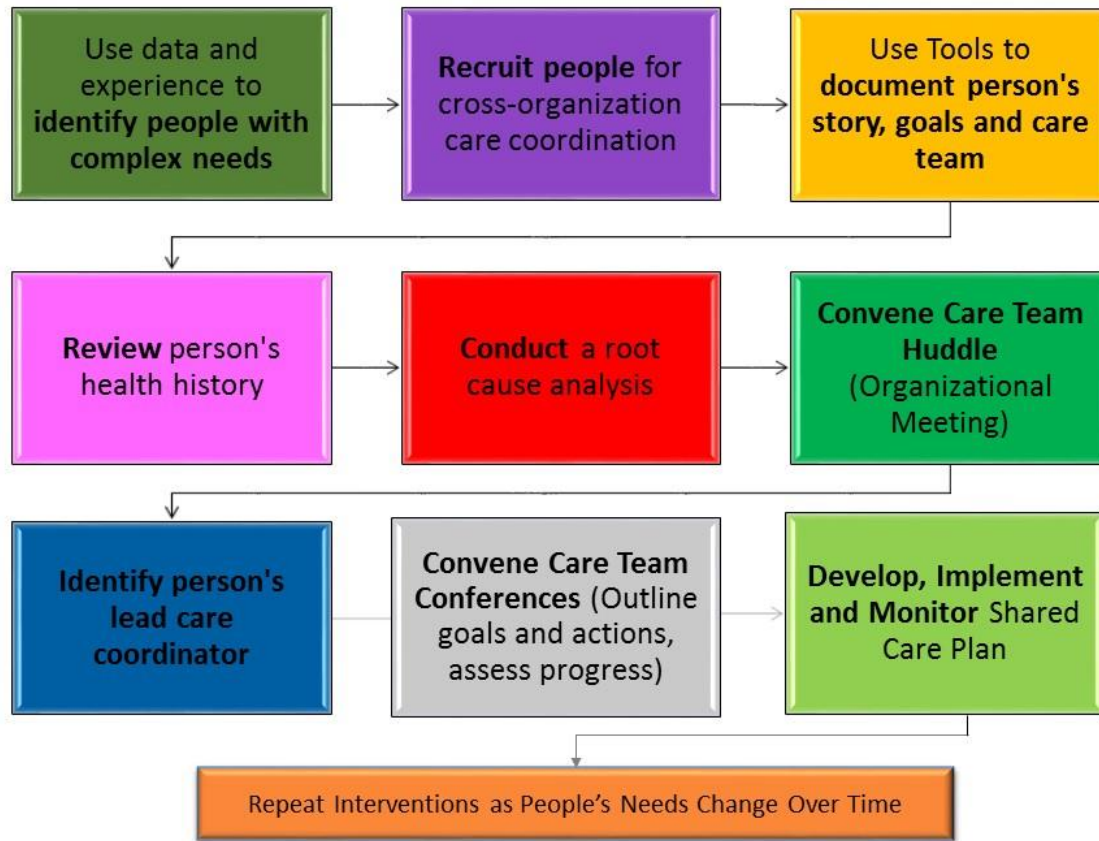
For each strategy, the ICCMLC Leadership Team has developed tools to help support and guide communities. Many communities and care coordinators have stated that the tools and skills from the ICCMLC have significantly changed the relationship they have with the people they serve. For example, the 'Camden Cards' have put the person's goals at the center of care, giving care coordinators and individuals receiving care a new way of discussing how to prioritize what they want to work on first. Many care coordinators use the ICCMLC tools more broadly with clients, including CHTs, SASH, and MAT teams. The tools developed through the learning collaborative can be viewed on the Blueprint website: http://blueprintforhealth.vermont.gov/implementation_materials/care_management_toolkit and are integrated into the OneCare Vermont Care Management toolkit.

Overall, the ICCMLC asked community teams to redesign how they do much of their work – engaging relevant organizations; identifying a group of individuals to help; developing plans and protocols for gathering data, assigning responsibility, and sharing information; asking clients to participate as full members of the care team; and creating shared care plans that serve their personal goals. This work is labor-intensive, as each client's needs are unique and complex by definition. In many cases, the results of this work have been dramatic. Take, for instance, this client:

> A 59-year-old man lives alone at home, following a month-long hospital stay. His poorly controlled diabetes had led to foot ulcerations requiring skin grafts and antibiotic treatment. The

ICCMLC team in his area gathered to support him. The Lead Care Coordinator is a Blueprint CHT staff member (a care coordinator and Certified Diabetes Educator (CDE)), and the team includes a homecare provider, VCCI, SEVCA, and the Vermont Center for Independent Living's Volunteers in Action.

The man was anxious for his foot to heal so he could resume working and making trips into town to gather food and supplies for himself and his many cats. He refused to return to the hospital, so he needed a safe and comfortable home environment to make healing possible. The team used grant funds to pay for a vacuum, and the man and a friend began cleaning his house regularly and maintaining the cat boxes. The team purchased a microwave, stove, and refrigerator and got Meals on Wheels to deliver, and the man began having nutritious meals at home each day. The team found funding for new windows, heating fuel, and furnace repair, so the man could stay safely warm through the winter.

A homecare nurse arrived every other day to change the dressings on the man's foot, and, with a friend's help, he traveled to see his surgeon and podiatrist every week. In the circumstances the team first encountered, it was easy to imagine the man's foot not healing or becoming infected again, possibly leading to permanent disability. Instead, his wound is healing well, and the donor sites are fully healed. He reduced his HbA1c from 11.1 to 7.1, and his blood sugar readings are near his target level. His Lead Care Coordinator visits him at home regularly, and the full care team communicates weekly to track his progress. When the man first came to the attention of the ICCMLC, he had been labeled a "non-compliant patient." Today, he makes all of his appointments, calls all his providers regularly, and is the lead member of his own care team.

For the most part, local efforts have been led by the Blueprint Project Managers, CHT Leaders, and Practice Facilitators. With VHCIP funding (from the SIM grant) ending on December 31, 2016, the ICCMLC leaders, including the Blueprint, have worked together to develop a solution for sustainability specifically focused on the continued use of evidenced-based tools and key strategies for providing wrap-around services to high-utilizing, vulnerable populations in each local area. Toward that effort, the ICCMLC local leaders' forum and the CHT Leader group, which have significant overlap, will merge and, with support of the Blueprint, and the developing umbrella organization for the ACOs (Vermont Care Organization) will continue to facilitate shared learning across communities.

6.4 Women's Health Initiative

At the request of AHS Secretary Hal Cohen, the Blueprint, in collaboration with a broad group of community stakeholders, commenced the planning process for a Women's Health Initiative aimed at improving the health of women and reducing the rate of unintended pregnancies. Beginning January 1, 2017, the Women's Health Initiative extends participation in the Blueprint to women's health care providers, including obstetrics, gynecology, midwifery, and family planning providers.

Currently in Vermont, half of all pregnancies are unintended. Unintended pregnancies are associated with increased risk of poor health outcomes for mothers and babies and long-term negative consequences for the health and well-being of the children and adults those babies become.

Women, especially those between the ages of 15 and 44, receive substantial preventive care services in OB-GYN and women's health clinic settings. A few additional key supports can help these providers be even more effective in providing preventive care, identifying health and social risks, connecting women to community supports, and helping ensure more pregnancies are intentional.

Through the Women's Health Initiative, women's health providers will provide enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long-acting reversible contraception (LARC) for women who choose LARC as their preferred method of birth control. New staff, training, and payments will support effective screenings, brief in-office intervention and referrals to services for mental health, substance abuse, trauma, partner violence, food insecurity, and housing instability.

The Women's Health Initiative will work to ensure women's health providers have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families.

6.4.1 Women's Health Initiative Planning Process
In June 2016, the Blueprint, in partnership with the Vermont Department of Health (VDH), kicked off the Women's Health Initiative Steering Committee and four (4) work groups to design the program. Work groups focused on identifying the clinical interventions and supports needed for practices and communities, how to make stocking LARC more achievable for practices, payment design, data reporting, and evaluation. Stakeholders included, but were not limited to, insurers, women's health providers, pharmacists, community-based organizations, rural health clinics, and Planned Parenthood of Northern New England. The Steering Committee and work groups met monthly from June through December 2016.

6.4.2 Planned Clinical Intervention
HSAs and participating practices have agreed to implement a breadth of strategies, including changing patterns and workflows in the practices and between community organizations. Practices who receive payment agree to:
- Provide health and psychosocial support services for all women
- Provide evidence-based, comprehensive family planning counseling that emphasizes the effectiveness of different birth control options, while supporting women in choosing the birth control method that best suits them
- Stock LARC in their practices and implement workflows to support availability of same-day insertion for women who choose LARC as their preferred method of birth control
- Provide screening, brief intervention, and referral for depression, current intimate partner violence, adverse childhood experiences (ACEs), substance abuse, food insecurity, and housing instability
- Build relationships between women's health clinics and key community-based organizations, so that those organizations routinely refer clients for family planning services with appointments occurring within a week of the referral
- Assist patients who do not have a primary care provider to establish a relationship with a patient-centered medical home

To achieve the goals of the Women's Health Initiative, communities have agreed to work on strengthening the relationships and referral patterns between women's health practices, community-based organizations, health service providers, and primary care practices. The goal will be that women receive timely and appropriate services when they need more intensive treatment and support for psychosocial risks.

6.4.3 Women's Health Initiative Payments
In January 2017, Medicaid will initiate payments to women's health providers on behalf of their beneficiaries. Other insurers have been invited and are contemplating participation in future years.

Three (3) forms of payment are available through the Women's Health Initiative: a per-member-per-month (PMPM) payment to practices, a payment to the CHTs to add Master's-prepared, licensed mental health clinicians in the Women's Health Initiative practices for enhanced screening, brief intervention, and referrals, and a one-time capacity payment to practices to support purchasing an initial stock of LARC devices and building the necessary capacity to implement the Women's Health Initiative strategies

For the first twelve (12) months of participation in the program, Women's Health Initiative practices will be paid a $1.25 PMPM payment based on their total number of attributed beneficiaries by participating insurers. For the second year of participation in the program, practices will be paid a base payment of $1.00 PMPM plus a quality payment of up to $0.50 PMPM based on performance measures. The outcome measures driving the performance component of the PMPM payment in the second and subsequent years will be determined in 2017 and will include a combination of measures at the community- and practice-levels.

FIGURE 21. WOMEN'S HEALTH INITIATIVE PRACTICE PAYMENTS
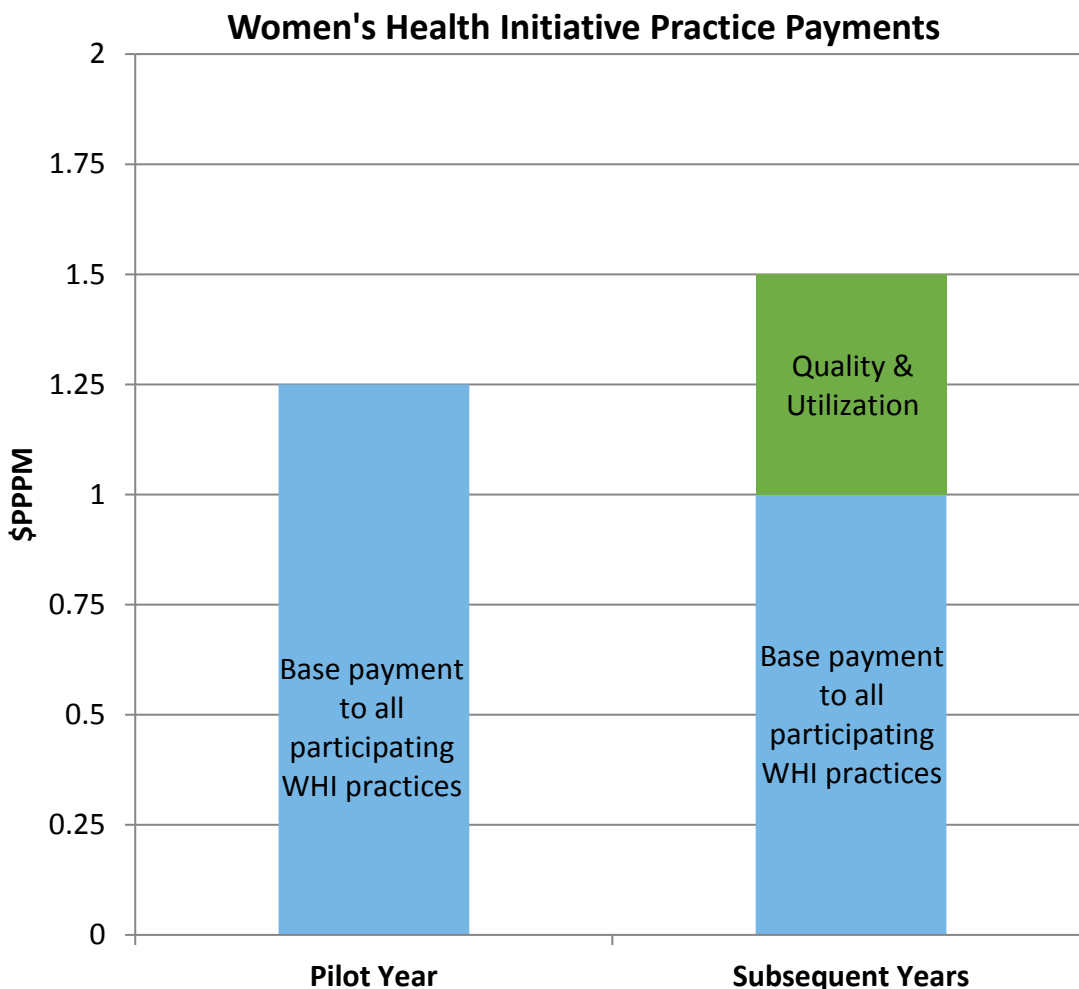
Consideration is being given to whether the one-time capacity payment can be extended to patient-centered medical homes who agree to implement Women's Health Initiative strategies.

Full details on eligibility and payments for the Women's Health Initiative can be found in the updated Blueprint for Health Manual on the Blueprint for Health website: http://blueprintforhealth.vermont.gov.

6.5 Support and Services at Home

6.5.1 Support and Services at Home (SASH) is federally funded and evaluated

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

Originally scheduled to end on June 30, 2014, CMMI extended funding for the MAPCP demonstration in Vermont initially through December 31, 2014 and, upon further consideration, for an additional two years through December 31, 2016. SASH funding is now included as part of the All-Payer Model (APM) agreement between the State of Vermont and the Centers for Medicare and Medicaid Services (CMS).

In 2016, SASH continued to be evaluated by an independent party, RTI International. The 3-year evaluation was funded jointly by the federal Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS). The Second Annual Report was released in January of 2016 and showed promising cost reduction findings continued for the well-established panels (in place before April 2012). The Second Annual Report also found that relative to annual Medicare expenditure growth in a comparison group growth in annual Medicare expenditures was lower by an estimated $1,536 per person per year for participants in the SASH program.

6.5.2 The SASH partnership coordinates medical and social services for Medicare beneficiaries

Administered statewide through Cathedral Square and six (6) Designated Regional Housing Organizations (DRHOs), the SASH model is a caring partnership of non-profit housing, community-based health, and social services agencies and hospitals collaborating to support participants' efforts to remain healthy and safe at home. SASH participants are typically elder Vermonters, but also include younger disabled adults.

By design the program serves all Medicare beneficiaries as needed, so participants may live either in subsidized housing or in residences in the community at large. Each panel of 100 SASH participants is served by one full-time housing-based SASH Care Coordinator and one quarter-time Wellness Nurse. Staffing is provided by the non-profit affordable housing organizations and primary partners, including Home Health Agencies, Area Agencies on Aging, and Community Mental Health Organizations.

Each SASH team meets regularly with other SASH teams in the region, as well as with 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. This SASH partnership connects the health and long-term care systems for Medicare beneficiaries statewide. Together, these systems facilitate streamlined access to the medical and non-medical services necessary for this vulnerable population to remain living safely at home.

6.5.3 SASH grew to serve 5,396 Vermonters by the end of 2016

Starting as a single pilot team in Burlington in 2009, SASH grew to 26.5 teams by the end of 2012, added 10 new teams in 2013, 15.5 teams in 2014, and 2 in 2015. Funding was capped at 54 panels, so no

further panels were started in 2016. With 54 teams in place, the total number of people served by SASH grew from 4,800 participants at the end of 2015 to 5,396 participants at the end of 2016 – an increase of 11%.

6.5.4 Evidence-based SASH interventions aim to reduce Medicare expenditures

SASH teams focus their efforts around three (3) areas of intervention proven most effective in reducing unnecessary Medicare expenditures:

- transition support after a hospital or rehabilitation facility stay
- self-management education and coaching for chronic conditions and health maintenance
- care coordination

Evidence-based practices provided by the core SASH team (SASH Care Coordinator and Wellness Nurse) also include a comprehensive health and wellness assessment, creation of an individualized care plan, on-site, one-on-one nurse coaching and care coordination, and group health and wellness programs.

6.5.5 SASH Outcomes

SASH teams are now in place in every county and HSA in Vermont and show positive outcomes. As indicated earlier, an independent evaluation of the SASH model completed by RTI International comparing a group of SASH participants to two control groups showed statistically significant reductions in Medicare spending growth for the SASH group. Additionally, Cathedral Square, as the statewide administrator for SASH, tracks outcome measures in four (4) key performance areas (Advance Directives, Immunizations, Falls, and Hypertension) for all SASH participants. These outcomes have shown positive improvements over time and in comparison, to national trends.

Advance Directives: The percentage of all SASH participants with a documented end-of-life plan in place increased from 53% to 59% between 2014 and 2016, which is well above the national rate of 26% of adults with advance directives.

Immunizations: The percentage of SASH participants with shingles vaccines increased from 20% to 34% between 2014 and 2016, which is above the national rate of 27% for persons 60+ years old. Pneumococcal vaccine rates increased from 53% to 63% for SASH participants between 2014 and 2016. Flu shot rates increased from 42% to 61% between 2015 and 2016.

Falls: The rate of falls for SASH participants dropped from 29% in 2014 to 25% in 2016, which is a fall rate below the national rate of 32% for the elderly.

Controlled Hypertension: SASH participants with diagnosed hypertension and documented blood pressure readings classified as "in control" by the National Quality Forum (NQF) standard increased slightly from 74% in 2015 to 77% in 2016.

FIGURE 22. SASH IMPLEMENTATION

SASH Implementation July 2011 - September 2016*

*On September 1 2015 the monthly participant count methodology was changed to reflect active participants only. Active participants are identified as those who are active in a panel on the last day of the month. This is a change from previous monthly participants counts which reflected cumulative participants to date, inclusive of deceased individuals.

More information about SASH can be found at http://sashvt.org

6.6 Hub & Spoke: The Care Alliance for Opioid Addiction

Vermont's efforts to expand treatment for opioid addiction benefit enormously from the willingness of community leaders to support and speak about the importance of this issue.

- Mayors in Burlington, Rutland, and St Albans have dedicated staff working with local treatment providers to expand the use of Vivitrol and prioritize access for Vermonters served by the Department of Children and Families (DCF) and the Department of Corrections;
- A new Hub is being developed in Northwestern Vermont with local community support.
- The University of Vermont Medical Center (UVMMC) family medicine group has more than 50 physicians waivered to provide Medication Assisted Treatment (MAT).

- Wide distribution of Narcan/Naloxone kits are helping to prevent deaths from drug overdose.
- Enrollment in treatment programs continues to grow; and, for the first time, a large region reports same-day access to treatment and no waiting lists.

However, there is more work to do. Vermont continues to experience deaths due to overdoses and, despite increased capacity, the health and specialty addictions service systems in most regions continue to be unable to meet demand for treatment in Vermont. Heroin laced with extremely powerful anesthetic agents appears in Vermont and contributes to overdose deaths.

Community groups across the state are organizing increased access to treatment services to support law enforcement's efforts to reduce drug trafficking and to support those whose lives are impacted by addiction. These grassroots activities combined with the continued strong commitment by policy makers to frame addiction as a public health issue are the truly positive notes in what is otherwise a grim situation.

The Blueprint, in collaboration with the Vermont Department of Health (VDH) Division of Alcohol and Drug Abuse Programs (ADAP) and community health and human services partners, continued expansion of the Hub & Spoke treatment initiative throughout 2016. Key program and evaluation milestones are described here.

6.6.1 Access to Care

By federal regulation, physicians providing MAT with buprenorphine must be "waivered", and the number of patients they can prescribe to was capped at no more than 30 in the first year and, upon request, up to 100 patients after that. Federal legislation passed this summer raises the cap to 275 patients, and a few Vermont physicians have applied to increase their caseloads. The long-term nature of the treatment, combined with caseload caps, results in the need to engage new providers in MAT continuously in order to meet the demand for these services.

The same federal legislation (The Comprehensive Addictions Recovery Act) will also allow Nurse Practitioners and Physician Assistants to prescribe buprenorphine for opioid addiction. This change will significantly expand access once the federal Substance Abuse and Mental Health Services Administration (SAMHSA) completes rulemaking for implementation (anticipated sometime in 2018).

The Blueprint tracks three (3) measures of access to MAT in general medical settings:

- number of unique Medicaid beneficiaries seen each month
- total number of physicians who actively prescribe buprenorphine to Medicaid beneficiaries
- number of physicians who see 10 or more patients

The addition of the nurse and the addictions/mental health counselor ("Spoke staff") to the practices increases the support to physicians and practices providing MAT. Since January 2013, there has been a significant increase in the total number of physicians prescribing buprenorphine to Medicaid beneficiaries (from 114 to 187). The number of physicians who actively treat 10 or more Medicaid patients has modestly increased. The total number of unique Medicaid patients served by Vermont physicians each month has grown from 1,837 in March 2013 to 2,535 in September 2016. Since the Hub & Spoke initiative was implemented, the total number of Spoke staff hired has grown to nearly 53 full-time equivalents (FTEs) by September 2016.

FIGURE 23. SPOKE IMPLEMENTATION

MAT - SPOKE IMPLEMENTATION
January 2013 - September 2016
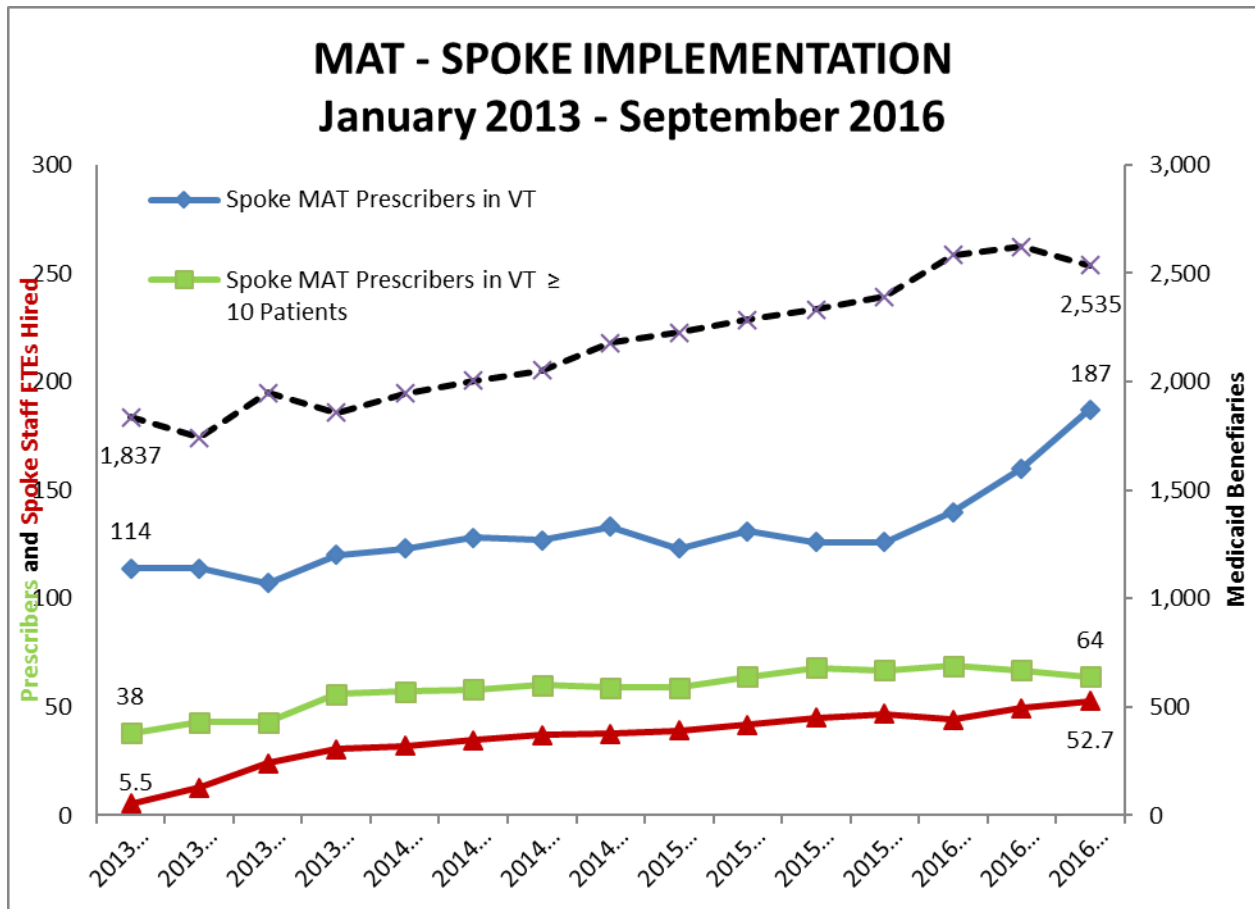
The initiative's partnering entities, the Department of Vermont Health Access (DVHA) and VDH/ADAP, also track waiting lists and caseloads in the Hub programs. In 2016, the wait list figures for Hub services fell well below 500 for the first time.

FIGURE 24. HUB CENSUS VS. WAITING LIST OVER TIME

Number of People Served in Opioid Treatment Hubs and the Number of People Waiting Over Time
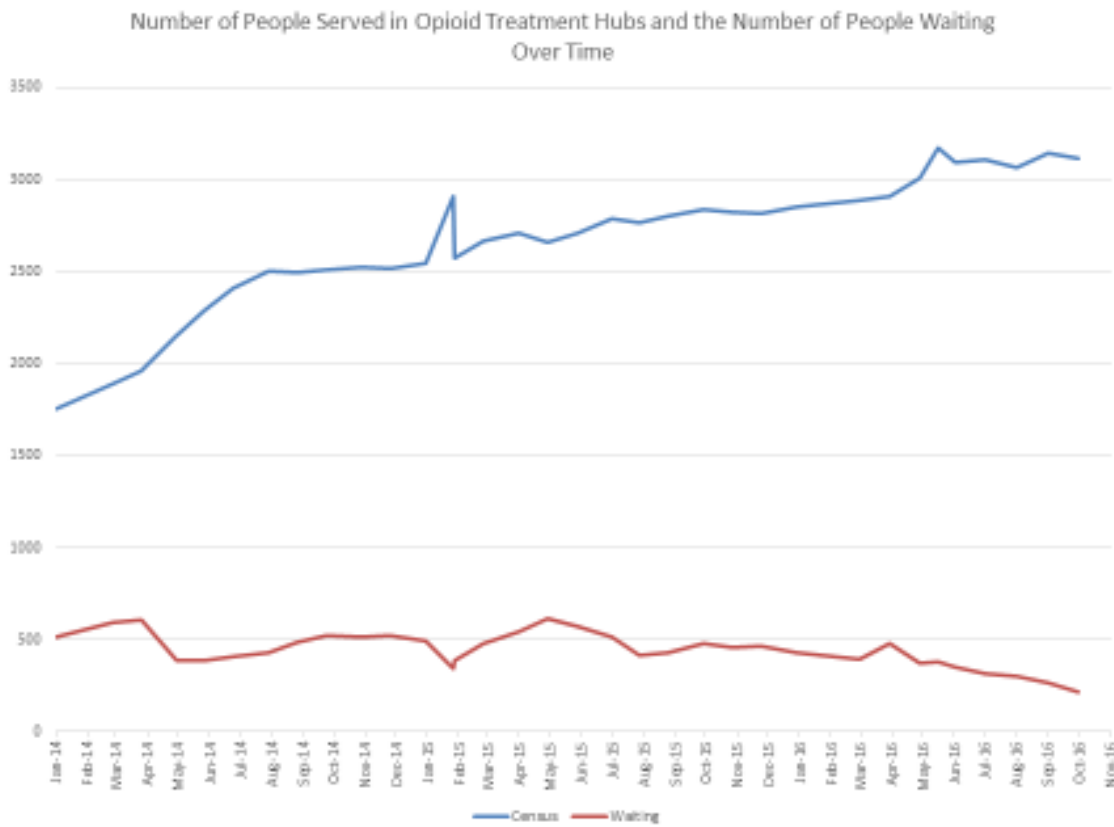
The number of Vermonters served in "Hub" programs has more than tripled in three (3) years (from less than 1,000 in 2013 to over 3,116 in October 2016). Significantly, over one third of the Hub patients receive dispensed buprenorphine, an important contribution of DVHA to the initiative, which also allows patients to transition back to general medical settings for ongoing care.

FIGURE 25. HUB CENSUS BY REGION

Figure: Hub Census by Region
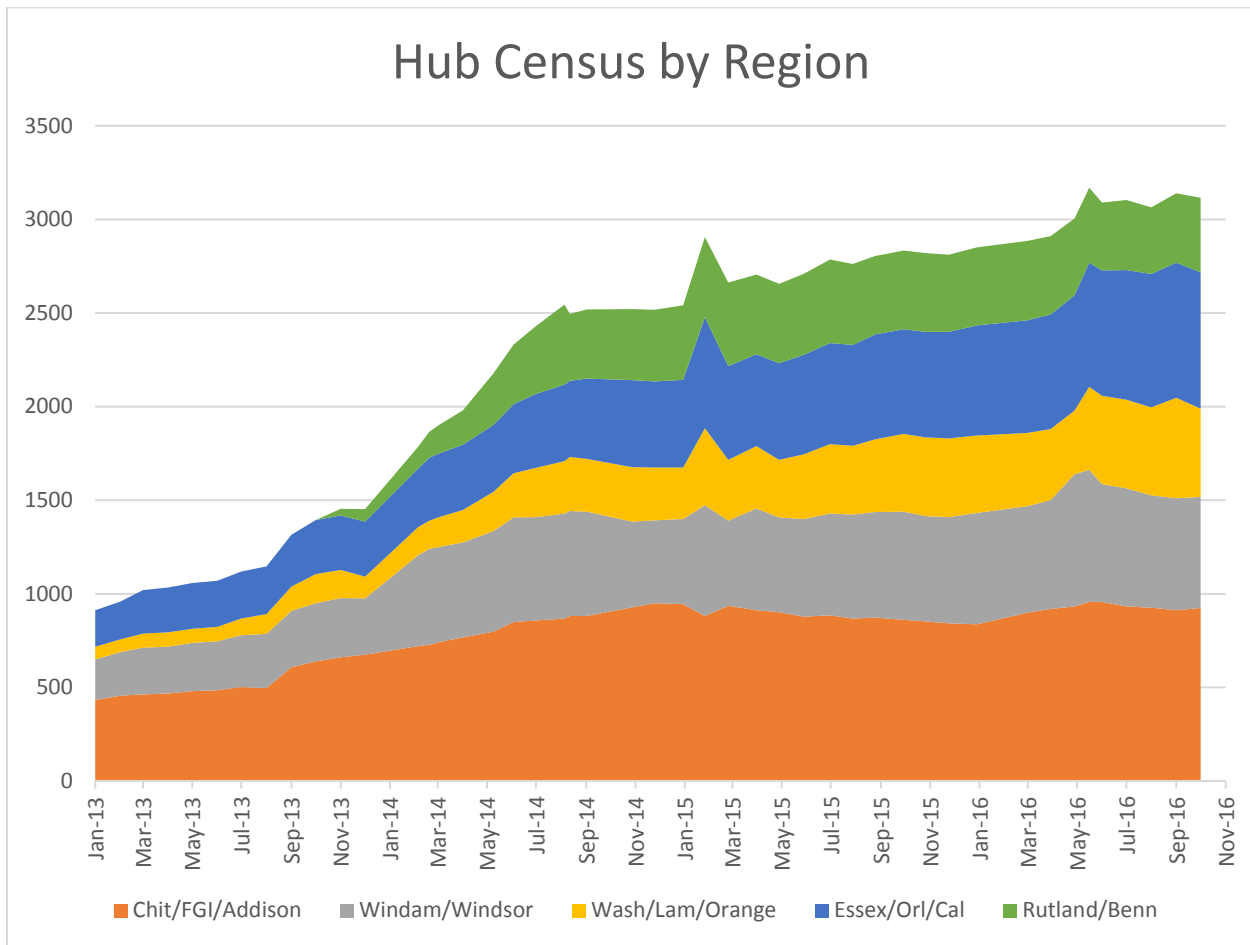
Looking at combined Hub & Spoke access by county, it is quickly apparent that certain regions, especially Chittenden County, lack access to MAT at either a Hub or in general medical settings (Spokes). Chittenden, Addison, Essex, Orange, and Windsor counties have lower access than the statewide average for Hubs & Spokes combined.

6.6.2 Recruitment of New Providers

In collaboration with the leadership of DVHA and VDH/ADAP, the Blueprint actively encourages physicians to offer MAT, especially to patients they may already see for primary care. The most often-cited barriers to providing MAT are:

- patient complexity
- provider time
- lack of access to specialty care
- concern that the practice will be flooded with too many addictions patients
- skepticism about the efficacy of MAT

To help address these barriers, we offer training and support for practices to implement MAT protocols with the help of Blueprint Practice Facilitators and Learning Collaboratives. This provides Spoke nurses and counselors with the opportunity to design workflows in advance of seeing patients for MAT, to set up program protocols, and to begin the intake assessment process.

6.6.3 Notable Communities Improving MAT Access

There are several notable communities and leaders who worked to expand access to MAT in 2016. Four (4) Federally Qualified Health Centers (FQHCs) applied for and received new HRSA funding to expand their addictions treatment programming (CHCB, CHCRR, NOTCH, and Gifford). For the first time, the Upper Valley HSA began offering MAT through Valley Vista and Little Rivers Health Care. Impressively, the Central Vermont Hub in Barre and partnering Spoke providers in the Barre-Montpelier area organized to provide **same day** access to care.

Most impressive of all is the commitment of the University of Vermont Medical Center (UVMMC) to offering MAT. Consistent with the excellence of the academic medical center, the UVMMC leadership has championed an intensive planning effort with community partners to expand access to MAT and reduce the waiting list for care in Chittenden County. More than 50 physicians have become waivered, and, throughout the winter and spring of 2016, they began transitioning patients from the Chittenden Hub back to their UVMMC primary care provider for MAT. To ensure that practices are not "flooded", providers are beginning with small panels (5 or less), and the Department of Psychiatry opened an intensive program to receive new MAT patients and to help stabilize them before referring them to general medical offices.

6.6.4 Improving the Standard of Care

Annually, VDH transfers $165,000 to DVHA to support co-occurring substance use and mental health care in the Blueprint primary care practices. Since 2012, the Blueprint has used these funds to support practice improvement in MAT through a series of learning collaboratives. The faculty is provided by the Geisel School of Medicine at Dartmouth. Continuing medical education credits were obtained through Dartmouth Hitchcock Medical Center.

The learning collaborative approach combines didactic lectures, small groups of independent practice teams coming together, collection of common outcome measures, and sharing of both outcomes data and clinical experience. The goals are to educate and support physicians and their practice teams, to increase the numbers of patients appropriately prescribed buprenorphine, to reduce the non-medical use and diversion of the medication, and to use evidence-based practice guidelines to improve patient and community outcomes. The participating practices measure substantial improvement in care, including:

- prescribing buprenorphine only to patients who meet diagnostic criteria for opioid addiction
- adhering to dosage range recommendations
- conducting regular, observed random drug urine screens
- increasing frequency of office visits for unstable patients
- routinely using the Vermont Prescription Monitoring System (VPMS)
- maintaining patients in treatment (retention)
- documenting coordination of care with specialty providers

In 2016 we developed a new learning collaborative aimed to improve the flow of patients between a Hub and its area Spokes in a region. Successfully implemented in Central Vermont, the learning

collaborative is now being offered in Chittenden County. Two (2) additional cohorts of practice teams have either completed or are currently participating in a learning collaborative for new practice teams. Finally, the more than 50 FTE "Spoke" staff of nurses and addictions counselors who collectively work in nearly 80 different practice settings will meet four (4) times between December 2016 and June 2017 to share program protocols and learn together.

6.6.5 MAT Analytics and Evaluation Plan

The Blueprint and VDH/ADAP have developed an analytic plan to evaluate the impact of MAT on Medicaid beneficiaries. The Blueprint's analytic contractor, Onpoint Health Data, is conducting this multi-stage evaluation. The Vermont study, which will proceed in phases, will test the impact of MAT on health care expenditures and utilization, clinical health outcomes, incarceration, and employment in Vermont. In addition, VDH/ADAP has contracted with a national research expert to conduct a qualitative study to better understand the impact of Hub & Spoke services on patients and their families. Over the course of 2017, in-depth interviews will be conducted with 80 current recipients of care, 20 individuals who left care, and 20 family members.

6.6.5.1 MAT Baseline Study

Analysis of health care claims for 2007 through 2013 (prior to full implementation of the Hub & Spoke program) was conducted for Medicaid beneficiaries receiving MAT in both specialty opioid treatment programs (OTPs) and general medical office (OBOT) settings. The study focuses on Medicaid beneficiaries, since Medicaid is the dominant insurer for MAT and is the only payer participating in the service enhancements to OBOT settings.

The primary finding of this study concluded that patients identified as having a history of opioid abuse and receiving MAT had lower medical expenses by as much as $2400 per year relative to a similar control group of patients not receiving MAT. While MAT is more expensive than traditional psychosocial treatments, when treatment costs were added to total medical expenses for both groups, MAT patients still had lower costs by $412 per year (P-value 0.07). This study was published in the Journal of Substance Abuse Treatment (refer to Appendix 9.1).

6.6.5.2 Impact of Hub & Spoke Enhancements

A pre-post study will measure the differences in outcomes after the investments in the Hub & Spoke initiative. The study will cover the following time frames: 2007 through 2012 used as the baseline; 2013 as an implementation year; and 2014 as Year One post implementation. This analysis will also be performed on subsequent calendar years. This study will be released in 2017.

6.6.5.3 Incarceration Data Analysis

The Blueprint has arranged for regular data extracts from the Department of Corrections (DOC) "Offender Management System" and has begun linking health care claims to incarceration data.

6.7 Vermont Chronic Care Initiative

The Vermont Chronic Care Initiative (VCCI) is a statewide Medicaid health care reform program that provides short-term, intensive case management and care coordination to non-dually-eligible Medicaid members who are high-risk and high-cost. These members often have multiple chronic conditions and complex health histories and psychosocial needs, including poor health literacy, that challenge their ability to self-manage their chronic health issues.

VCCI primarily focuses on improving outcomes and reducing unnecessary utilization for this population by using a holistic approach that addresses socio-economic barriers to health and health care, safe and stable housing, transportation to a primary care medical home, pharmacy management, education, and coaching toward behavior change goals to support effective self-management.

6.7.1 Determining Eligibility for VCCI Services

Since 2011, VCCI has specifically targeted eligible members in the top 5% high-utilizing Medicaid population, since these members account for an estimated 39% of Medicaid expenditures. Eligibility for VCCI services is determined primarily, though not solely, on the following criteria:

- included in top 5% of Medicaid cost/utilization or on the trajectory to become a high utilizer
- high emergency department and hospital utilization, including ambulatory care sensitive events
- multiple prescribed medications (polypharmacy) and/or providers
- one or more chronic health conditions
- co-occurring conditions of substance use/abuse and mental health
- not receiving other CMS-funded case management services, such as Choices for CARE, CRT, etc.
- not dually eligible (Medicare or other primary insurance)

VCCI further targets members determined to be "impactable" based on an analysis of clinical acuity and recent utilization patterns conducted by the program analytics contractor using evidence-based predictive analytics software. For each Medicaid member, this analysis considers the member's:

- past utilization and predictive risk score
- actual per-member-per-month cost to the Medicaid program
- number of chronic conditions
- number of emergency department and inpatient encounters
- polypharmacy
- evidence of fragmented, uncoordinated care, such as several encounters with different providers in a short amount of time

Finally, at-risk members are also identified for VCCI services through direct referrals from:

- primary care providers
- hospital providers and case managers in both the emergency department and inpatient settings
- field and embedded program staff in AHS and high-volume provider partner locations

- other internal and external statewide partners, including Blueprint CHT staff, who partner with VCCI at the local/Health Service Area (HSA) level for direct referrals and transitions of care support between levels of service for the Medicaid population

6.7.2 Outreach to VCCI Clients

VCCI reaches Medicaid members primarily through a team of registered nurse (RN) case managers and licensed alcohol and drug abuse counselors (LADCs) operating at the local level. VCCI staff serves members in a variety of settings, such as embedded resources within provider practices and hospitals with a high volume of Medicaid members. Embedded staff facilitates:

- direct communication, referral, and case management and care coordination support, including home visits
- transitions between the hospital and the patient's primary care provider (PCMH)
- access to a PCMH when one is not being utilized

Multiple hospitals also provide VCCI with daily secure data transfers on emergency department and inpatient admissions to further support members post-hospitalization and minimize hospital readmission rates, an area of significant expenditures among the top 5%. The VCCI has been working to increase the number of funded hospital partners who provide these vital data points to the DVHA/VCCI via Blueprint and ACO partners and related grants and contracts.

Employed by DVHA, VCCI case managers are also located in state Agency of Human Services (AHS) district office settings and work closely with AHS partners, including AHS District Field Directors, Economic Services, DCF/Reach-up, Vocational Rehabilitation staff, Department of Corrections (DOC) probation and parole colleagues, and VDH/local health office leadership and staff.

6.7.3 Blueprint-VCCI Collaboration

The Blueprint works closely with VCCI, considering VCCI staff part of the Blueprint's Extended CHT. VCCI case managers work closely with the primary care provider, AHS partners, CHT staff, and other local partners to identify and ensure wrap-around services are in place to support the plan of care. The VCCI staff are also members of most of the statewide Community Collaboratives (CCs) and participate with Blueprint CHT colleagues in the ICCMLC.

6.7.4 VCCI Data and Analytics Vendor Transition

The VCCI legacy vendor provided both the care management software system for tracking and analytics and 15 professional and analytics staff members. The legacy vendor contract expired in December 2015 and was replaced by the new Enterprise Care Management system, which will be made progressively available to all AHS departments and programs. With the sun setting of the legacy vendor, the VCCI lost all 15 FTEs, including 9 licensed professional positions (nurse case managers and social workers) who provided outreach and case management support, as well as a full-time pharmacist and part-time medical assistant.

The DVHA/VCCI is the first care management program within AHS to Go Live on this new Enterprise environment with onboarding in late 2015 and subsequent progressive releases to add new functionality, including data on intervened members and related adjustments in utilization and risk based on interventions.

6.8 Self-Management Programs

Starting in 2005, the Stanford Chronic Disease Self-Management Program (CDSMP) was introduced in Vermont as Healthier Living Workshops (HLW). Since that time, the Blueprint has expanded to support six (6) group self-management programs, including:

- The Stanford *Chronic Disease* (2005) Healthier Living Workshop (HLW)
- The Stanford *Diabetes* (2010) Healthier Living Workshop (HLW)
- The Stanford *Chronic Pain* Healthier Living Workshop (HLW)
- Vermont Quit Partners tobacco cessation in-person program (transitioned to the Blueprint in 2011), also known as Freshstart®
- Copeland Center Wellness Recovery Action Planning (WRAP)
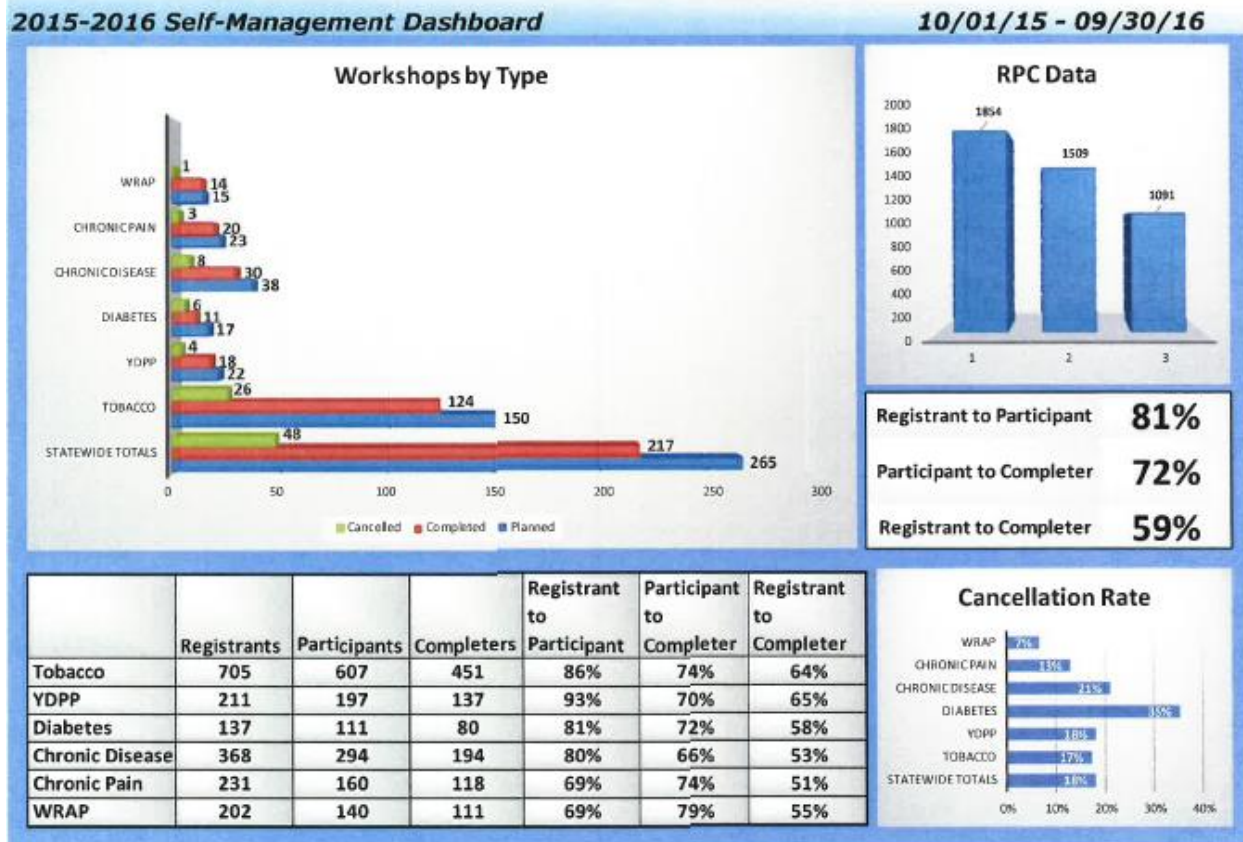- YMCA Diabetes Prevention Program (YDPP)

Each self-management program targets a specific population for a specific purpose:

TABLE 4. SELF-MANAGEMENT PROGRAMS

Workshop Name	Target Population	Program Purpose
YMCA Diabetes Prevention Program (YDPP)	Individuals with pre-diabetes or at risk for developing Type 2 diabetes	Reduce the prevalence of diabetes by reducing the number of people with pre-diabetes and diabetes risk factors who then go on to develop diabetes
Freshstart® tobacco cessation program	Current tobacco users	Reduce the rate of Vermonters who use tobacco by assisting current tobacco users in quitting
HLW – Chronic Disease	Individuals experiencing symptoms from a chronic condition and those who support them	Increase the number of people with chronic health conditions who have the skills to self-manage their conditions
HLW – Diabetes	Individuals diagnosed with diabetes and those who support them	Increase the number of people with diagnosed diabetes who have the skills to self-manage their diabetes
HLW – Chronic Pain	Individuals experiencing chronic pain and those who support them	Increase the number of people suffering from chronic pain who have the skills to self-manage their pain
Wellness Recovery Action Planning (WRAP)	Individuals experiencing symptoms from a mental health condition, substance abuse condition, or who want to improve their emotional well-being	Increase the number of people with mental health or substance abuse conditions who have the skills to plan for improving their emotional well-being

In 2014, the Blueprint expanded their strategic partnerships with the Greater Burlington YMCA and the Vermont Department of Health (VDH) to include all statewide self-management programs. Additional supports are being offered to Regional Coordinators to enhance training for workshop leaders, facilitate shared learning across HSAs, market the programs more broadly, and improve evaluation efforts. One of the YMCA's most impactful contributions has been centralized collection, aggregation, and reporting of statewide data on the uptake of the self-management support programs among Vermonters. This information has led to data-driven quality improvement efforts initiated by the Blueprint.

	Registrants	Participants	Completers	Registrant to Participant	Participant to Completer	Registrant to Completer
Tobacco	705	607	451	86%	74%	64%
YDPP	211	197	137	93%	70%	65%
Diabetes	137	111	80	81%	72%	58%
Chronic Disease	368	294	194	80%	66%	53%
Chronic Pain	231	160	118	69%	74%	51%
WRAP	202	140	111	69%	79%	55%

In 2016, the Blueprint, via the Health Service Area (HSA) grant agreements, doubled performance goals for the target number of completed workshops from ten (10) to twenty (20) in an attempt to increase uptake of the programs among Vermonters. Additionally, the Blueprint worked collaboratively with the Agency of Human Services (AHS) to be an early adopter of the Results-Based Accountability (RBA) template for the self-management sections of the 14 HSA grant agreements issued for federal fiscal year 2017.

In designing targeted performance goals, the Blueprint also aligned the required mix of workshops for each HSA with VDH's 3-4-50 campaign.

FIGURE 27. VERMONT DEPARTMENT OF HEALTH 3-4-50 CAMPAIGN GRAPHIC

Of the 20 completed workshops for each HSA, the following are required:

- 12 tobacco cessation workshops
- 3 YDPP workshops
- 1 HLW – Chronic Disease workshop

The tobacco cessation curriculum specifically addresses the Tobacco Use behavior, and the YDPP curriculum specifically addresses the No Physical Activity and Poor Diet behaviors. These two types of workshops represent evidence-based, upstream, preventive interventions for reducing the prevalence of chronic disease and related fatalities in Vermonters. The HLW – Chronic Disease workshop assists those individuals already diagnosed with at least one chronic disease with creating an action plan for proactive self-management of the disease, which results in fewer costly acute care episodes.

In March 2016, based on an independent study, the Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) certified that including YDPP as a covered service under Medicare would lead to a reduction in net Medicare spending. As of January 1, 2018, YDPP workshops will be reimbursable through Medicare for participating Medicare beneficiaries, representing the first community-based prevention program to achieve that distinction. Refer to the following links for additional information:

http://www.hhs.gov/about/news/2016/03/23/independent-experts-confirm-diabetes-prevention-model-supported-affordable-care-act-saves-money.html

https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

http://www.npr.org/sections/health-shots/2016/03/23/471583523/hhs-says-diabetes-prevention-program-will-save-medicare-money

After this announcement at the federal level, the Blueprint collaborated with the Greater Burlington YMCA on a press release specific to Vermont's YDPP program. Refer to the Section 9.2 in the Appendix of this document.

8   Health Service Area (HSA) Highlights for 2016

Each year Blueprint Project Managers in all 14 HSAs tell us what the highlights of their year were for inclusion in the Annual Report. They report on which practices are part of the program in their area, staffing of their CHTs, MAT teams, and SASH panels, how many referrals their CHT received or patient encounters they conducted, and more. They also report on their area's Community Collaborative (CC), describe one or more key quality improvement projects, and highlight a major achievement their team is proud of. Please read on for more about what local Blueprint leaders (our Transformation Network) achieved in each HSA in their own words.
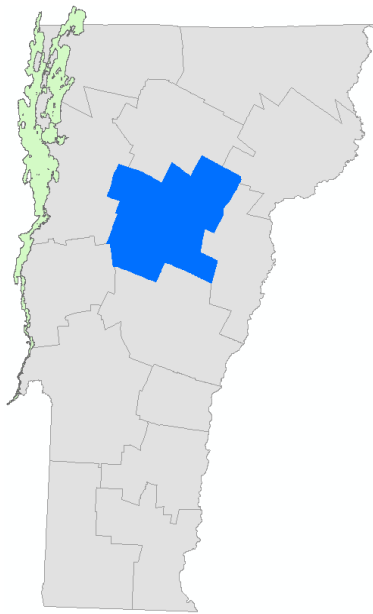
BARRE HEALTH SERVICE AREA
PROJECT MANAGER – MARK YOUNG

At a Glance:

- 35,183 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 17.8 FTE Community Health Team Staff
- 7 FTE Spoke Staff
- 15 Community Self-Management Workshops offered
- 5.5 SASH Teams (Capacity = 550 participants)
- 2066 CHT referrals
- 425 PCMH patients treated by MAT staff

MEDICAL HOME PRACTICES

CVMC Adult Primary Care – Barre
CVMC Adult Primary Care – Berlin
CVMC Family Medicine – Berlin
CVMC Family Medicine – Mad River
CVMC Family Medicine – Waterbury
CVMC Green Mountain Family Practice
CVMC Integrative Family Medicine – Montpelier
CVMC Pediatric Primary Care – Barre
CVMC Pediatric Primary Care - Berlin
The Health Center – Plainfield

Highlights

CC name: Community Alliance for Health Excellent (CAHE)
Most community partners are represented on the CAHE steering committee. Our group uses a decision matrix tool to help prioritize proposed projects. The state-wide learning collaboratives, such as the ICCMLC, ACO, and community partners help guide active QI projects chosen by the CAHE.

Spotlight on QI Projects: Chronic Care Management, ACEs, & CHF
Chronic Care Management Project: Grounded in the work of the statewide ICCMLC, this project has progressed to a population of patients identified based on the intensity of team-based care needs. Initial results show a decrease in utilization for these patients.
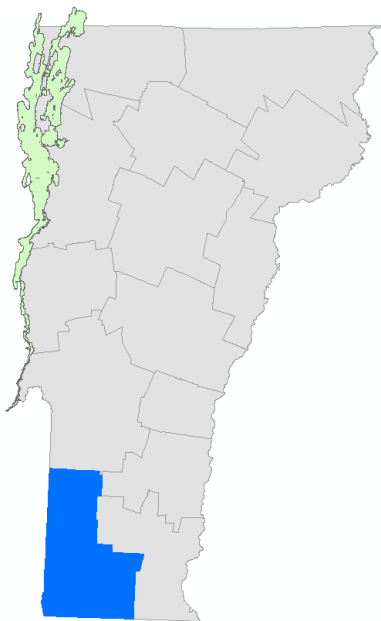
Adverse Childhood Experiences (ACEs) Project: This project builds on the opportunity to engage with families as a part of visits to their child's pediatrician through an office-based and community outreach model. Partners on this project include local family support agencies, mental health agencies, schools, and community child care providers. We plan to use Family Support Specialists embedded in our pediatric medical homes to promote child and family protective factors, prevent and mitigate toxic stress, and promote healthy child development. The pilot is scheduled to begin in December 2016 with screening families of children ages 0-3 and referral to the most appropriate community partner for services to reduce duplication of effort.

Outpatient Congestive Heart Failure (CHF) Project: Aiming to reduce hospital admissions and readmissions for CHF by using a patient navigator, an advanced care coordinator embedded in the primary care practice, this project established co-visits with both the PCP and Navigator on disease-oriented clinic days, aligning teaching materials with the hospital and home health, and focusing on both transitions of care and advanced care planning. A cost savings of over $10,000 per patient was realized during the 6-month pilot. Expansion to all primary care practices is planned.

Major achievement: CVMC received additional grant funding for the expansion of its Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, currently offered in medical homes, to the Women's Health Clinic.

BENNINGTON HEALTH SERVICE AREA
PROJECT MANAGER – JENNIFER FELS, RN, MS

Photo of **Bennington CC**. *Front row starting left*: Carol Conroy, VP – CNO Southwestern Vermont Medical Center; Lorna Mattern, Executive Director United Counseling Services; Stephanie Lane, Executive Director, Shires Housing; Cathy Vogel, District Director Vermont Department of Health; Billie Allard, Southwestern Vermont Medical Center. *Second row starting left*: Suzanne Anair, Administrator Centers for Living and Rehabilitation; Ron Coffi, VNA & Hospice Southwestern Region; Jennifer Fels, Director Bennington Blueprint; Kim Turner, Quality Facilitator Bennington Blueprint; Terry Reinertson, CHT Leader Bennington Blueprint; Rona McColl, OneCareVermont; Susan Sgorbati, Bennington College. *Last row starting left:* Tom Dee, CEO Southwestern Vermont Healthcare; Grace Gilbert-Davis, CEO Battenkill Valley Health Center; Eric Seyferth, MD; Betsey Walton, Executive Director United Health Alliance; Rich Ogilvie, CIO Southwestern Vermont Medical Center, James Trimarchi, Director Planning Southwestern Vermont Medical Center; Richard Dundas, MD Bennington Free Clinic. *Not pictured*: Jim Poole, MD, Southwestern Vermont Medical Center; Jennifer Plouffe, Council on Aging; Sadie Fischesser, Human Services

At a Glance:

- 18,083 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 7.6 FTE Community Health Team Staff
- 5.4 FTE Spoke Staff
- 9 Community Self-Management Workshops offered
- 4.5 SASH Teams (Capacity = 450)
- 6,265 patients seen by CHT
- 350 patients treated by MAT staff

MEDICAL HOME PRACTICES

Arlington Family Practice
Avery Wood; MD
Battenkill Valley Health Center
Bennington Family Practice
Eric Seyferth; MD
Keith MIchl; MD
Mount Anthony Primary Care
Shaftsbury Medical Associates
SVMC Deerfield Valley Campus
SVMC Medical Associates
SVMC Pediatrics
SVMC Northshire Campus
Green Mountain Pediatrics

Highlights

CC name: Bennington Community Collaborative
Membership includes the hospital, long-term care, the FQHC, home health, Council on Aging, housing, Department of Health, the local Blueprint, free clinic, ACO, human services, and a consumer. The group is currently developing the framework (with 9 essential elements) to become an Accountable Community for Health (ACH). The expanded membership beyond the CC includes over 27 community agencies and service organizations that meet on a regular basis.

Spotlight on QI Projects:
The Bennington CC focuses on quality outcomes, cost, and value in addressing population health within the Bennington HSA. Our measures of success include improved results for priority measures of quality and health status, improved patterns of service utilization, improved access and individual experience of care, and improved collaboration among agencies and services. We currently have 7 active QI projects in process, including: Community Care Team (address needs of patients with high ED utilization), use of INTERACT tools in nursing home, improving opiate prescribing upon hospital discharge, implementing Care Navigator, sharing Integrated Family Services (IFS) care plans with primary care practices, piloting high-flow home oxygen therapy, and improving accuracy of HCC coding.

Major achievement: The Bennington HSA standardized patient contracts and consents across all area Blueprint "Spoke" practices. We also implemented a collaborative effort of United Counseling Services and the Southwestern Vermont Medical Center to open an Intensive Medication Assisted Treatment (IMAT) practice in Bennington.

BRATTLEBORO HEALTH SERVICE AREA
PROJECT MANAGER – WENDY CORNWELL, RN, BS, BSN
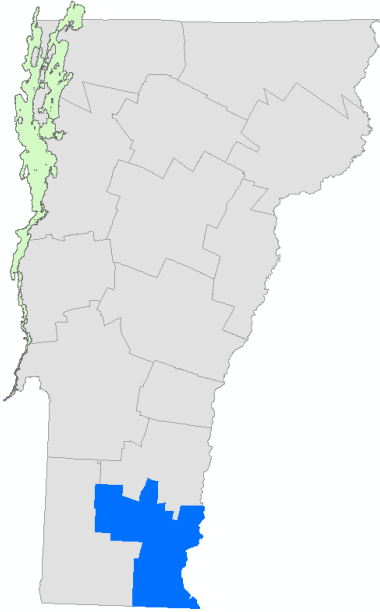
At a Glance:
- 15,911 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 9.57 FTE Community Health Team Staff
- 2.84 FTE Spoke Staff
- 23 Community Self-Management Workshops offered
- 3 SASH Teams (Capacity = 300)
- 5332 CHT encounters (BMH and Grace Cottage Hospital)
- 262 patients treated by MAT staff

MEDICAL HOME PRACTICES

Brattleboro Family Medicine
Brattleboro Internal Medicine
Brattleboro Primary Care
Grace Cottage Family Health
Just So Pediatrics
Maplewood Family Practice
Putney Family Healthcare
Windham Family Practice

Highlights

CC name: Windham County Integrated Communities Care Management Collaborative (ICCMC)
The Windham County ICCMC is composed of the local ICCMLC work group and the Regional Clinical Performance Committee (RCPC). The ICCMLC program focuses on clients with mental health and substance abuse diagnoses who have had 3 or more ED visits in a year. ED visits decreased by 51% for clients enrolled in the program this year. The RCPC focuses on increasing uptake of Medicare hospice. Results show a significant increase in hospice utilization and coordination of resources.
**Spotlight on QI Projects:**
Brattleboro Primary Care: This practice has undertaken a project to implement complex care coordination for 23 enrolled pediatric patients. To date, 23 care coordination plans have been established.
Brattleboro Memorial Hospital (BMH) practices: These practices implemented three (3) separate projects. They increased transitional care management visits, resulting in 100% of patients receiving medication reconciliation, and they increased the number of patients with care plans. Additionally, Just So Pediatrics increased their HPV vaccine rate from 41% to 61%.
Major achievements: BMH obtained a grant from VDH/ADAP to support SBIRT in two primary care practices. Additionally, BMH completed a community health needs assessment (CHNA) and developed an action plan to address homelessness in the HSA, applying for and receiving grant funding to support the action plan. Four (4) FTE registered nurses (RNs) will be embedded in the Brattleboro Drop-In Center to meet the health needs of their clients. Inclusive of the self-management workshops sponsored by the Blueprint, the Brattleboro CHT offered a total of 264 workshops and classes to the community.
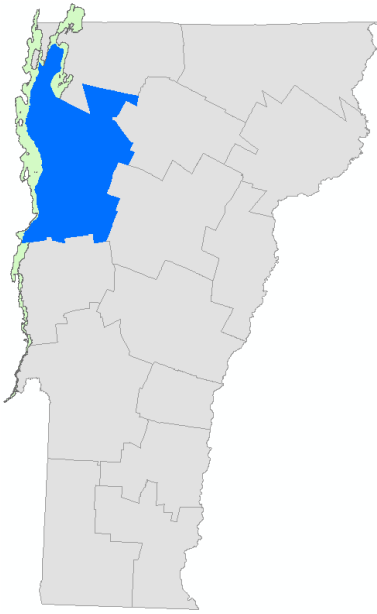
MEDICAL HOME PRACTICES

Adult Primary Care – Burlington
Adult Primary Care – Essex
Adult Primary Care – South Burlington
Adult Primary Care – Williston
Alder Brook Family Health
Appletree Bay Primary Care
Charlotte Family Health Center
Champlain Center for Natural Medicine
Community Health Centers of Burlington
Chris Hebert, MD
Essex Pediatrics
Evergreen Family Health
Family Medicine – Colchester
Family Medicine – Hinesburg
Family Medicine – Milton
Family Medicine – South Burlington
Frank Landry, MD, PLC
Gene Moore, MD
Hagan, Rinehart and Connolly Pediatricians; PLLC
Mountain View Natural Medicine
Pediatric Primary Care – Burlington
Pediatric Primary Care – Williston
Richmond Family Medicine
Timberlane Pediatrics North
Timberlane Pediatrics South
Thomas Chittenden Health Center
UVM MC Infectious Disease Clinic
Winooski Family Health

At a Glance:

- 92,614 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 42.06 FTE Community Health Team Staff
- 14.05 FTE Spoke Staff
- 24 Community Self-Management Workshops offered
- 18 SASH Teams; 1712 Participants (Capacity = 1800)
- 7338 CHT referrals
- 538 patients treated by MAT staff

Highlights

Spotlight QI Project: *Address Opioid Addiction in Chittenden County*
To increase the number of "Spoke" providers participating in Medication Assisted Treatment (MAT) for patients with opiate/opioid addictions in the Burlington HSA, we offered trainings in Chittenden County to allow providers to obtain waivers for prescribing Suboxone. This recruitment initiative resulted in an increase of total prescribers in our area from 10 to 66. As part of this initiative, we also developed a HIPAA-compliant multi-party agreement to assess the level of care needed by patients currently awaiting treatment for opioid addiction. We established the Suboxone Clinical Pathway Team, which developed the Suboxone Transition Program Clinical Pathway to guide prescribers and clinicians in helping treat and move patients through the process of readiness for outpatient treatment and return to a higher level of treatment as needed. Pre- and post-measures are the number of referrals to outpatient treatment.
Major achievements: We worked with OneCare Vermont to identify patients not previously involved with the CHT, but who would be appropriate candidates for referral.

63

MIDDLEBURY HEALTH SERVICE AREA
PROJECT MANAGER – SUSAN BRUCE
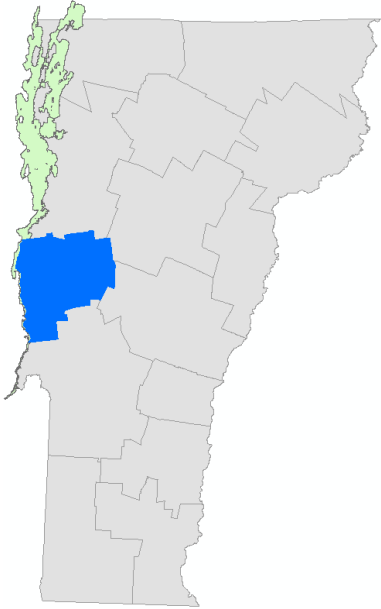
Photo of Middlebury Blueprint Team. *From left to right:* Cathy Swearingen, Lead Care Coordinator; Angel Bishop, Care Coordinator; Alexandra Jasinowski, Quality Improvement Facilitator; Susan Bruce, Project Manager; Jessica Stocker, Chronic Disease Self-Management Regional Coordinator. *Not pictured*: David Hernandez, Registered Dietician (RD); Amy Rice, RD; Kathleen Van De Weert, RD; Ed Lieberman, Behavioral Health; Doug Corey, Behavioral Health; Amanda Van De Weert, Care Coordinator; Kaylana Blindow, Care Coordinator; Tammy Narry, Care Coordinator.

At a Glance:

- 16,923 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 7.4 FTE Community Health Team Staff
- 2.0 FTE Spoke Staff
- 6 Community Self-Management Workshops offered
- 3.5 SASH Teams (Capacity = 350)
- 1500 CHT referrals
- 128 patients treated by MAT staff

MEDICAL HOME PRACTICES

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

Highlights

CC name: Community Health Action Team (CHAT)
Membership includes 25 agencies and organizations that meet monthly. We have four (4) subcommittees: Data (to help drive specific projects); Opiate (advocating for additional providers to increase capacity for Medication Assisted Treatment (MAT), therefore reducing the number of patients on our waitlist. The Opiate committee is also offering public awareness, education, and prevention strategies on opiate use via public presentations and an online website.); ED utilization (to decrease the total percentage of ED utilization); and ICCMLC (cross-organizational care of high-risk patients). Through participation in the Accountable Communities for Health (ACH) Peer Learning Lab, the group has decided to put a strategic plan in place and restructure the organizational chart to include Integrated Family Services (IFS).

Spotlight QI Project: *Increase HPV Vaccination Rate*
The Middlebury HSA focuses on QI projects that address the health of the population, how people experience the system, and reducing health care cost. One of these projects sought to increase HPV vaccination rates among adolescents ages 13 to 17. Four (4) practices have implemented a panel management process to call patients in for HPV immunizations. In November 2015, Addison County's immunization rate stood at 39.3%, which was second in the state. As of November 2016, our rate improved to 46.22%, which is the highest rate in the state.

Major achievement: Middlebury Pediatric and Adolescent Medicine began screening for food insecurity in May 2016 at each well visit. If positive, patients are given a flyer listing a variety of local resources that address the social determinants of health. A care coordinator follows up with referred patients by phone and offers further assistance. Currently, 45 out of 1100 screened patients screened positive and received access to services. Other practices in the Middlebury HSA will soon adopt the screening tool.
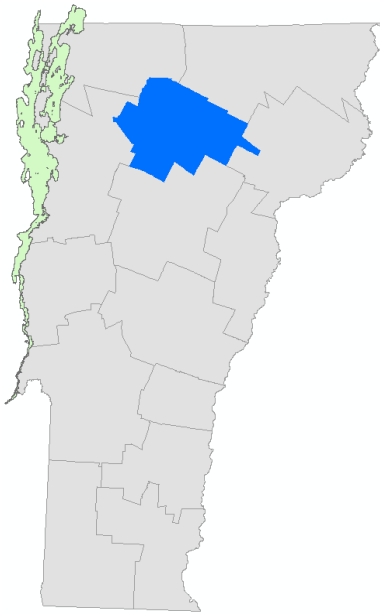
MORRISVILLE HEALTH SERVICE AREA
PROJECT MANAGER – ELISE MCKENNA, RN, MPH

Photo of Morrisville Blueprint Team. *Back row from left to right:* Trevor Hanbridge; Erica Coats, Self-Management Regional Coordinator; Johanna McCoy; Rorie Dunphey; Maxine Adams; Kori L. Day; Gloria Tuthill; Jennifer Driver; Stephanie Borts; Elise McKenna, Blueprint Project Manager and QI Facilitator. *Front row from left to right:* Ceili Quigley; Shannon Chauvin; Corey Perpall, Blueprint CHT Leader and QI Facilitator; Mary Lacaillade. *Not pictured:* Areena Schue, Catherine Whitaker, Danielle Currier, Dawn Palladino, Kate Myerson, and Oana Louviere.

At a Glance:

- 17,735 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 7.4 FTE Community Health Team Staff
- 3.6 FTE Spoke Staff
- 8 Community Self-Management Workshops offered
- 1 SASH Team (Capacity = 100)
- 2196 CHT encounters
- 205 patients treated by MAT staff

MEDICAL HOME PRACTICES

Appleseed Pediatrics
Cambridge Family Practice Associates
Dr. David Bisbee Personalized Medicine
Hardwick Area Health Center
Morrisville Family Practice
Paul Rogers, MD
Stowe Natural Family Wellness
Stowe Family Practice

Highlights

CC name: Executive Community Healthcare Organization (ECHO)
There are a total of 11 HSA-wide QI initiatives integrated through the CC, including 100% all cause readmissions reviewed by hospital and primary care, home visits for medication reconciliation post-hospitalization, Care Management Team Learning Collaborative for complex patients, ED visit follow-up calls by care coordinators, developmental screenings for all children under three (3) years old, PCP referral request from patients seen in the ED, decreasing the number of individuals on the waiting list for office-based opioid treatment (OBOT) services in the HSA, increasing the number of self-management workshops offered in the HSA, increasing the number of participants in self-management workshops in the HSA, decreasing the number of individuals with diabetes in poor control (defined by an HbA1c over 9), and increasing the number of adolescent well visits.

Spotlight on QI Projects:
The HSA-wide QI initiatives listed above have resulted in multiple successful outcomes. New processes in place ensure all patients aged 65 and older receive a follow-up visit with their primary care practice within 7 days after a discharge from the hospital. Of the 24 patients who received medication reconciliation in their homes post-discharge, there have been no hospital readmissions. Twenty (20) patients have enrolled in our Lamoille Care Management Team (LCMT) for complex patients (part of the statewide ICCMLC initiative). We have initiated developmental screenings for children under 3 years old during their well-child visits.

Major achievement: We no longer have anyone on a waitlist for OBOT services in the HSA. In prior years, the waitlist averaged over 50 people.
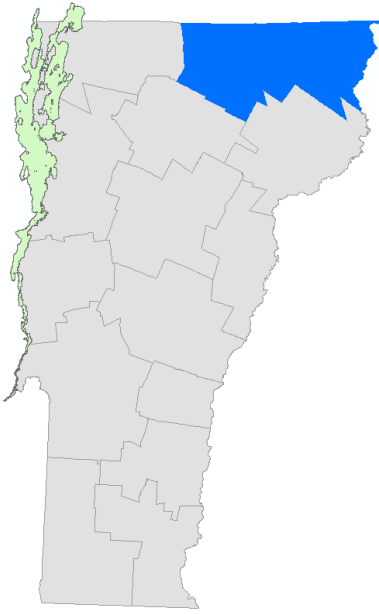
NEWPORT HEALTH SERVICE AREA
PROJECT MANAGER – JULIE RIFFON, LICSW, PCMH CCE

Photo of Newport Blueprint Team. *Back row from left to right:* Pam Jefferson, RN Care Coordinator; Ryan Zabinski, Registered Dietician (RD); John Harrington, LICSW, CHT Leader; Stephanie Rivers, RD. *Front row from left to right*: Julie Riffon, LICSW, PCMH CCE, Blueprint Project Manager and QI Facilitator; Lisa Erwin, MSW; Holly Converse, RN Care Coordinator.

At a Glance:

- 12,900 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 4.8 FTE Community Health Team Staff
- 0 FTE Spoke Staff
- 9 Community Self-Management Workshops offered
- 3.5 SASH Teams (Capacity = 350)
- 1784 CHT encounters
- MAT staff shared with St. Johnsbury HSA

MEDICAL HOME PRACTICES

Island Pond Health Center
North Country Pediatrics
North Country Primary Care Barton
Orleans
North Country Primary Care Newport

Highlights

CC name: Newport Area Regional Clinical Performance Committee
Our CC plays a significant role in clinical oversight with a goal of improving the lives of residents of Orleans and Essex counties. In addition to North Country Hospital, several very active community partners participate, including the Council on Aging, Visiting Nurse Association (VNA) and hospice, Vermont Chronic Care Initiative (VCCI), Northeast Kingdom Human Services, local Department of Health (VDH) and Agency of Human Services (AHS) field offices, RuralEdge Housing, Island Pond Health Center, North Country Pediatrics, and North Country Primary Care practices.

Spotlight on QI Projects:
Several work groups aligned with community priorities have formed as part of our CC, including decreasing unplanned hospital admissions, decreasing obesity, increasing hospice utilization and length of stay, decreasing substance abuse, improving oral health, decreasing unplanned pregnancies, and screening and identifying those at risk for falls. Current QI projects in progress include initiating and expanding a Food Insecurity screening for pediatric patients and patients over age 65, increasing hospice utilization and length of stay, improving access to oral health services, and increasing the percentage of Adolescent Well Child visits.

Major achievements: As part of becoming an Accountable Community for Health (ACH), we developed the Upper NEK Community Council (UNEKCC), which held its first meeting in September 2016. Additionally, our area collaboration resulted in the award of a HRSA grant to build a full-service Dental Center in Orleans, VT, scheduled to open in January 2017.
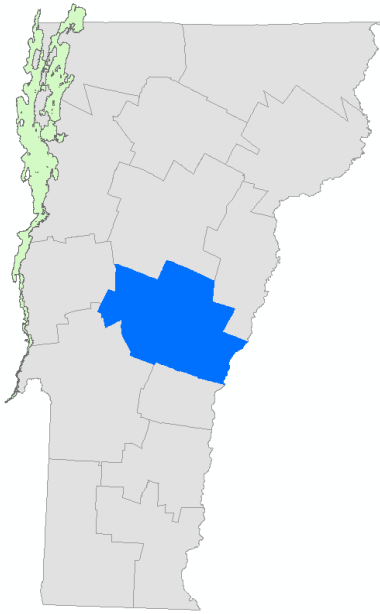
RANDOLPH HEALTH SERVICE AREA
PROJECT MANAGER – PATRICK CLARK, PMP

Photo of Randolph CC. *Back row from left to right:* Bruce Saffran, QI Facilitator; Kayla Thibault, CHT Care Coordinator; Lisa Delegato, CHT Leader; Carolyn Higgins, CHT Care Coordinator; Megan Sault, Self-Management Regional Coordinator; Amy Perez, SASH Statewide Coordinator; Kathy Tynan, Mayo Healthcare Community Outreach Coordinator; Noreen Fordham, CHT Care Coordinator; Jennifer Barker, CHT Care Coordinator; Sarah Roberts, Social Worker; Patrick Clark, Blueprint Project Manager. *Front row from left to right:* Holly Vermette, BC/BS VT Nurse Care Manager; Blythe Kersula, VCCI Nurse Case Manager; Dede Tracy, SASH Coordinator; Linda Anderson, Capstone Program Manager; Brenda Traegda, CVCOA Case Manager; Christy Nguyen, CIS Family Support Worker.

At a Glance:

- 11,497 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 4.6 FTE Community Health Team Staff
- 1.9 FTE Spoke Staff
- 12 Community Self-Management Workshops offered
- 1 SASH Team (Capacity = 100)
- 604 CHT referrals
- 105 patients treated by MAT staff

MEDICAL HOME PRACTICES

Bethel Health Center
Chelsea Health Center
Gifford Health Center at Berlin
Gifford Primary Care
Rochester Health Center
South Royalton Health Center

Highlights

CC name: Randolph Executive Community Council (RECC)
The RECC has well-balanced representation from most health and human services community partners to ensure a person-centered approach for improving the health and well-being of our community members. We periodically assess membership to ensure appropriate stakeholder representation for QI projects underway.

Spotlight QI Project: *Effects of Opioid Abuse on Adolescents*
Our current RECC QI project focuses on the promotion of emotional and physical well-being to adolescents negatively impacted by opioid abuse in the Randolph HSA. A large component of this project involves educational outreach to the local schools and outreach via other social methods and interventions to raise awareness. As we work through this project, we are attempting to align it with other related initiatives happening in the area, including the medication drop-box implementation project and efforts stemming from the Randolph Opioid Response Team and the Gifford Opioid Pain Management Task Force.

Major achievement: As a result of community partner participation in the ICCMLC, we have successfully implemented patient care team meetings in a variety of settings and formats. Of significance is the new capability and willingness of care team members to hold team meetings with patients during home visits with primary care providers (PCPs). Having care team members, including CHT staff and community partners like SASH and the Council on Aging, accompany the PCP on home visits adds real-time clinical care coordination value, ultimately improving care delivery and the patient experience.
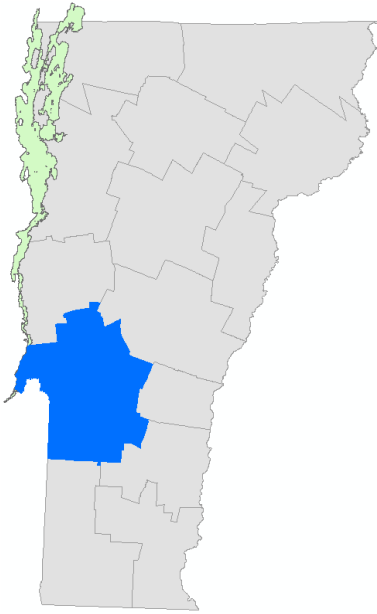
RUTLAND HEALTH SERVICE AREA
PROJECT MANAGER – SARAH NARKEWICZ, RN, MS, CDE

Photo of Rutland Blueprint Team. *Back row from left to right:* Laura Edwards, MSW; Meredith Drude, MSW; Sarah Cosgrove, RT; Corissa Burnell, Self-Management Regional Coordinator. *Front row from left to right*: Sarah Narkewicz, RN, Blueprint Project Manager; Marie Gilmond, Blueprint CHT Leader; Marjanna Barber-Dubois, Blueprint QI Facilitator; Laura Brayton Illinski, MSW. *Not pictured*: Brenda Colburn; Sharon DeCato, RN; Kristen Hixon; Suzanne Woodbury, RN.

At a Glance:

- 28,133 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 11.45 FTE Community Health Team Staff
- 4.85 FTE Spoke Staff
- 47 Community Self-Management Workshops offered
- 5 SASH Teams (Capacity = 500)
- 1655 CHT referrals
- 250 patients treated by MAT staff

MEDICAL HOME PRACTICES

Associates in Primary Care
Brandon Medical Center
Castleton Family Medical Center
Drs. Peter and Lisa Hogenkamp
Marble Valley Family Medical Center
Mettowee Valley Family Health Center
Pediatrics Associates
Rutland Community Health Center

Highlights

CC name: Rutland Collaborative for Health System Improvement, Innovation, and Integration

Our CC membership includes executive leadership from core health-related agencies. The Regional Clinical Planning Committee (RCPC) work group focuses on All Cause Readmission by increasing appropriate referrals to palliative care (supportive services, using common education materials across the community, identifying root cause of readmissions, and creating a standard process for transitions in care). The Clinical Integration Committee includes providers from RRMC and CHCRR who meet monthly to improve quality of care. Efforts have resulted in using secure texting and electronic transfer of discharge information, closing the loop on referrals for lab testing and specialty consultations, improving transitions of care coordination, improving lab and diagnostic imaging ordering for medical necessity, developing a common pain contract for patients with non-cancer pain treatment, and assigning a primary care provider to patients who do not have one.

Spotlight on QI Projects:

Through the Healthy Homes project, RRMC provides financial support for home renovations for patients referred to NeighborWorks of Western VT. This pilot program targets patients with COPD, asthma, and physical limitations whose home environments impact their health. As a result of the Safe Opiate Prescribing project, two (2) practices have implemented recommended prescribing practices based on the Opioid Prescription Management Toolkit for Chronic Pain developed by the University of Vermont.

Major achievements: Using the ICCMLC as a springboard, our HSA developed and delivered Care Coordination Tools Training quarterly. To date, 38 front-line staff statewide have participated in the training. Associates in Primary Care, a practice operated by two (2) nurse practitioners, achieved NCQA-PCMH recognition for the first time. Additionally, Westridge Center, Rutland's Methadone clinic, achieved Level 2 recognition on NCQA's specialty standards.

SPRINGFIELD HEALTH SERVICE AREA
PROJECT MANAGER – TOM DOUGHERTY, MPH
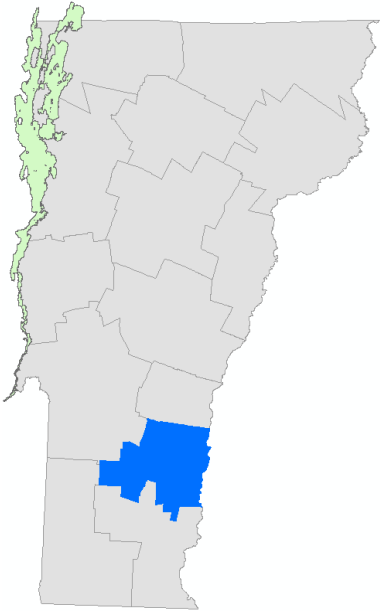
Photo of Springfield Blueprint Team. *Top row from left to right:* Tom Dougherty, Blueprint Project Manager; Maureen Shattuck, CHT Leader; Sarah Doyle, Self-Management Regional Coordinator; Jim Walsh; Jill McNally; Lara Peck. *Bottom row from left to right*: Robyn Priebe; SooYoung Uhm; Thomasena Coates; Lindsy Mack; Julie Merrill-Snide.

At a Glance:

- 12969 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 8.05 FTE Community Health Team Staff
- 1.5 FTE Spoke Staff
- 15 Community Self-Management Workshops offered
- 1 SASH Team (Capacity = 100)
- 2276 CHT referrals
- 77 patients treated by MAT staff

MEDICAL HOME PRACTICES

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

Highlights

CC name: Springfield Health Service Area Community Collaborative
Our CC brings leaders and community providers of health, wellness, and social services together to make decisions at the community level towards the goal of health and well-being for those in our community. Representatives from over 40 organizations and agencies across our HSA participate. Initiated in July 2015, our CC meets four (4) times per year. Representatives volunteer to participate in work groups and collaboratives, including the ICCMLC and ACH Peer Learning Lab, addressing the priorities identified by member surveys and community needs assessments.

Spotlight on QI Projects: *Quality Improvement Collaborative (QIC)*
The Springfield CHT leads the system-wide Quality Improvement Collaborative (QIC), which supports practices in identifying, monitoring, and tracking key QI measures for the patients in our HSA. The QIC also promotes intra-organizational and community partner collaboration in support of our shared patients. The CHT and the QIC support PCMHs as they implement processes for best practice and panel management to reflect the core aims of the accountable care initiatives shared by the UDS, Blueprint, and the ACOs. In 2016, QI focus areas included COPD, care management, patient satisfaction, immunization follow up, DM/HTN planned visit, lead screening, depression screening, developmental screening, and diabetic retinal eye exams.

Major achievement: We are currently pursuing accreditation for our Diabetes Self-Management Education and Training program (DSME/T) through the American Association of Diabetes Educators (AADE) and the formation of a DSME/T Advisory Committee, pending application approval. Accreditation and formation of the Advisory Committee attests to the high level of quality achieved by our self-management program and our potential for future success in our related QI initiatives, panel management, patient and community outreach, and education and training programs.

ST. ALBANS HEALTH SERVICE AREA
PROJECT MANAGER – LESLEY HENDRY
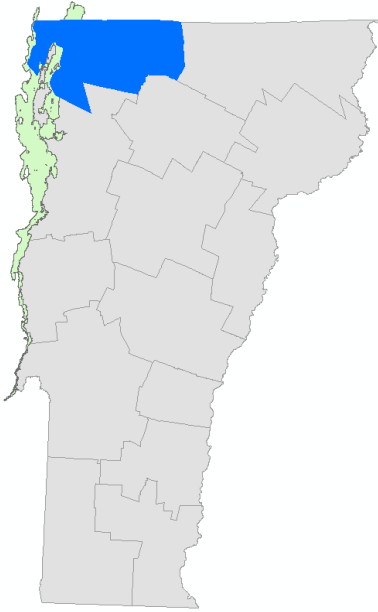
At a Glance:

- 22,845 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 7.45 FTE Community Health Team Staff
- 5.6 FTE Spoke Staff
- 14 Community Self-Management Workshops offered
- 2.5 SASH Teams (Capacity = 250)
- 2230 CHT referrals
- 494 patients treated by MAT staff

MEDICAL HOME PRACTICES

Alburg Health Center
Cold Hollow Family Practice
Enosburg Health Center
Fairfax Associates in Medicine
Fairfield Street Health Center
NMC – Northwestern Primary Care
Northwestern Georgia Health Center
Northwestern Pediatrics – Saint Albans
Northwestern Pediatrics – Enosburg Falls
Richford Health Center
St. Albans Primary Care
St. Albans Health Center
Swanton Health Center

Highlights

CC name: St. Albans Regional Clinical Planning Committee
All ACO participating providers and affiliates meet once a month to plan for community-wide quality improvement projects, resource allocation, and governance planning for the next phases of payment and delivery reform. Providers are sharing quality improvements and new tools to improve population management. The Care Coordination/Management, Hospice Utilization, Transitions of Care, Readmission, and Hospice Utilization work groups, and the RWJF grant all report directly to the RCPC on a quarterly basis. The RCPC has identified Mental Health/Substance Abuse, Obesity, Smoking, Cancer, Suicide, and Sexual and Domestic Violence as priorities in our community via the Community Needs Assessment conducted by the hospital.

Spotlight on QI Projects:
Six (6) primary care teams from ACO participants and affiliates meet quarterly to participate in the statewide ICCMLC and to share improvements made. Our Care Coordination/Management work group, reporting to the RCPC, includes 12 teams from a variety of practices and organizations participating in bi-weekly meetings and the statewide ICCMLC sessions. All Blueprint practices, the Champlain Valley Office of Economic Opportunity (CVOEO), home health, skilled nursing, inpatient care management, the ED, and the designated agency have received training on Care Navigator and are actively using it for shared care plans.

Major achievement: The St. Albans HSA finished running a Blueprint/ACO Learning Collaborative to improve ACO measures and implement population health management. The teams met for the final two (2) sessions in March and June 2016. Eleven (11) participating teams come from primary care, inpatient case management, home health, the mental health designated agency, and VDH. The teams grouped 42 VT ACO measures by type of measure and learned about the process for improvement on each type of measure. In October 2016, 30 participants from primary care, case management, and the designated agency met to begin work on the new Blueprint ACO/Learning Collaborative "Integrating Behavioral Health into Primary Care."

ST. JOHNSBURY HEALTH SERVICE AREA
PROJECT MANAGER – LAURAL RUGGLES, MBA, MPH

At a Glance:

- 14,411 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 13.8 FTE Community Health Team Staff
- 2.0 FTE Spoke Staff
- 20 Community Self-Management Workshops offered
- 2.5 SASH Teams (Capacity = 250)
- 5043 CHT encounters
- 139 patients treated by MAT staff

MEDICAL HOME PRACTICES

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

Highlights

CC name: Caledonia & S. Essex Accountable Health Community (CAHC)
The *Caledonia-So. Essex Accountable Health Community* uses a collective impact framework to ensure our population is financially secure, physically healthy, mentally healthy, well-nourished, and well-housed. Northeastern Vermont Regional Hospital (NVRH) and the Vermont Foodbank serve as the backbone organizations for the CAHC.

Spotlight QI Project: *COPD*
After reviewing hospital admission, re-admission, and ED utilization data, the CAHC chose to focus on Chronic Obstructive Pulmonary Disease (COPD) and improving the quality of life for St. Johnsbury residents with this chronic condition. Interventions include: development and use of a community-wide assessment tool; tracking readmissions and ER visits in partnership with NVRH Transitions Team; standardized education materials; coordinated referrals to an ambulatory pharmacist; referrals to the Better Breathing program; referrals to NVRH Respiratory Therapy and Pulmonary Rehab; completed advanced directive; introduction to the NVRH Patient Portal; referrals to the Care Team; assessment and referral for home tele-monitoring; smoking cessation counseling referral; and the addition of spirometry at Corner Medical.

Major achievement: The Resilience Collaborative was formed as a workgroup of CAHC and under the leadership of Kari White, Director of Quality at Northern Counties Health Care, to create a community-wide solution to the effects of Adverse Childhood Experiences (ACEs). Research has documented that toxic levels of stress in childhood can damage the structure and function of a child's developing brain (neurobiology of toxic stress), embed in a person's biology to emerge decades later as disease (biomedical consequences of toxic stress), and be passed from parent to child and generation to generation (epigenetics). Fortunately, resilience research shows that under the right conditions, the human brain and body can heal and thrive. The Resilience Collaborative is a multi-disciplinary group coming together to develop interventions at the medical and social level to prevent childhood trauma, treat toxic stress, and ultimately improve the health of current and future generations.
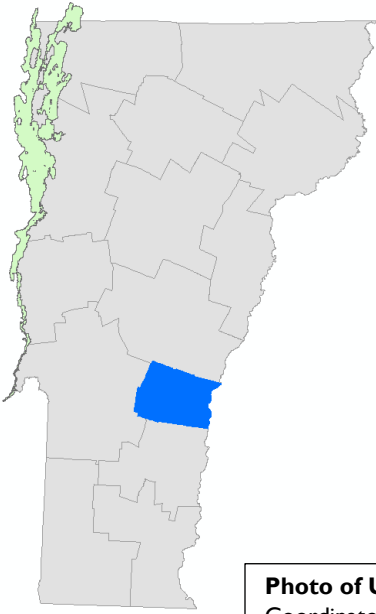
UPPER VALLEY HEALTH SERVICE AREA
PROJECT MANAGER – DONNA RANSMEIER, MS, CHTS-CP

Photo of Upper Valley Blueprint Team. *Back row from left to right:* Justine Huntington, LNA, Clinical Care Coordinator; Stephen Genereaux, MD, MAT provider; John Vose, Clinical Care Coordinator; Donna Ransmeier, MS, CHTS-CP, Blueprint Project Manager. *Front row from left to right*: Tracy Thompson, LCSW – Counselor; Christina Olcott, RN, MAT Program Manager. *Not pictured*: Simone Chenen, MD; Thomas Croteau, LCSW; Courtney Carter, RN; Michelle Hollis, RN; Craig Smith, LADC; Rebecca Yukica, MD; Amy Wallace, MD; Susan Smega, MD; Melanie Loschiavo, RD, CD, LD.

At a Glance:

- 4,080 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 1.75 FTE Community Health Team Staff
- 1.0 FTE Spoke Staff
- 5 Community Self-Management Workshops offered
- 1 SASH Team (Capacity = 100)
- 834 CHT referrals
- 32 patients treated by MAT staff

MEDICAL HOME PRACTICES

Bradford
E. Corinth
Newbury Health Clinic
Upper Valley Pediatrics
Wells River

Highlights

CC name: Upper Valley Health Service Area Unified Community Collaborative

We work as a team to research and take action on health care metrics identified as being of importance to our community, to the ACOs in which our member organizations are involved, and for various health care quality initiatives.

Spotlight on QI Projects:

The QI projects undertaken since our CC formed focus on improving our HSAs overall performance on several identified measures. We have worked to ensure follow up with a mental health provider within 7 days of discharge for patients with a hospital admission for mental health. We are attempting to increase the quantity and quality of adolescent well-care visits through proactive panel management and mechanisms such as an iPad for adolescents to fill out screening questionnaires privately. We are also taking steps to address and improve the dental health of our population.

Major achievement: In 2016, we established a fully functioning MAT program for treatment of individuals with opiate and opioid addiction in our community. Our two "Spoke" practices include the Wells River clinic of Little Rivers Health Care and the clinic at Valley Vista, a substance abuse treatment center in Bradford. Altogether, three (3) physicians and two (2) psychiatrists are waivered for prescribing within the MAT framework, and these providers are supported by .5 FTE of nursing and licensed drug and alcohol abuse counseling staff.

WINDSOR HEALTH SERVICE AREA
PROJECT MANAGER – JILL LORD, RN

At a Glance:

- 9,723 claims-attributed Vermont primary care patients served by Blueprint practices in the past two years
- 3.8 FTE Community Health Team Staff
- 4.0 FTE Spoke Staff
- 10 Community Self-Management Workshops offered
- 1 SASH Team (Capacity = 100)
- 3415 CHT encounters
- 229 patients treated by MAT staff

MEDICAL HOME PRACTICES

Mt. Ascutney Hospital Physician Practice
Ottauquechee Health Center
White River Family Practice

Highlights

CC name: Windsor HSA Coordinated Care Committee
Our CC works under a charter with a mission to institute QI programs, improve patient satisfaction, and contain costs. Membership includes leadership and operational staff from health care, mental health, and agencies addressing the social determinants of health in our HSA. We meet quarterly with work groups functioning throughout the year. We participate in the Accountable Communities for Health (ACH) Peer Learning Collaborative and have launched a 3-4-50 campaign in our community.
Spotlight on QI Projects:
Upon completion of our Community Health Needs Assessment (CHNA) at the beginning of the fiscal year, we launched QI projects to address the 12 top priorities identified. QI projects include improved care for COPD, ED, and complex, high-risk patients. The White River Junction CHT meets every other month to focus on topics identified through the CHNA. A snack backpack program for those with food insecurity resulted from a collaboration with the Hartford Community Coalition, VDH, and the CHT. The CHT also assisted with Hartford's overdose awareness day. White River Family Practice has undertaken an adolescent/young adult QI project to enhance well visits for this population and continues to screen for adolescent depression and facilitate access to mental health services for teens through the local Clara Martin Center.
Major achievements: We have developed a strong interagency care management network that allows us to better serve our patients at both a population health and individual level. We proactively work with our top 5% at-risk patients. Through participation in the Statewide ICCMLC, we have assimilated best practice approaches and tools to work with patients who have complex health and psychosocial conditions. Our partnerships with school districts and the Department of Children and Families (DCF) have strengthened considerably this year, leading to better integration of CHTs with these organizations for supporting families in crisis.

73

9 Appendix

9.1 2016 Blueprint Publications

9.1.1 Journal of Substance Abuse Treatment

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

Mary Kate Mohlman, Ph.D.[a], Beth Tanzman, M.S.W.[a], Karl Finison, M.A.[b], Melanie Pinette, M.E.M.[b], Craig Jones, M.D.
[a] Vermont Blueprint for Health, NOB 1 South, 280 State Drive, Waterbury, VT 05671, USA
[b] Onpoint Health Data, 254 Commercial Street, Suite 257, Portland, ME 04101, USA

Abstract

In the face of increasing rates of overdose deaths, escalating health care costs, and the tremendous social costs of opioid addiction, policy makers are asked to address the questions of whether and how to expand access to treatment services. In response to an upward trend in opioid abuse and adverse outcomes, Vermont is investing in statewide expansion of a medication-assisted therapy program delivered in a network of community practices and specialized treatment centers (Hub & Spoke Program). This study was conducted to test the rationale for these investments and to establish a pre-Hub & Spoke baseline for evaluating the additive impact of the program. Using a serial cross-sectional design from 2008 to 2013 to evaluate medical claims for Vermont Medicaid beneficiaries with opioid dependence or addiction (6158 in the intervention group, 2494 in the control group), this study assesses the treatment and medical service expenditures for those receiving medication-assisted treatment compared to those receiving substance abuse treatment without medication. Results suggest that medication-assisted therapy is associated with reduced general health care expenditures and utilization, such as inpatient hospital admissions and outpatient emergency department visits, for Medicaid beneficiaries with opioid addiction. For state Medicaid leaders facing similar decisions on approaches to opioid addiction, these results provide early support for expanding medication-assisted treatment services rather than relying only on psychosocial, abstinence, or detoxification interventions.

9.1.2 Journal of Addiction Medicine

Using a Learning Collaborative Strategy With Office-based Practices to Increase Access and Improve Quality of Care for Patients With Opioid Use Disorders

Nordstrom, Benjamin R. MD, PhD; Saunders, Elizabeth C. MS; McLeman, Bethany BA; Meier, Andrea MS; Xie, Haiyi PhD; Lambert-Harris, Chantal MA; Tanzman, Beth MSW; Brooklyn, John MD; King, Gregory MD; Kloster, Nels MD; Lord, Clifton Frederick MD; Roberts, William MD, PhD; McGovern, Mark P. PhD

Abstract

Objectives: Rapidly escalating rates of heroin and prescription opioid use have been widely observed in rural areas across the United States. Although US Food and Drug Administration-approved medications for opioid use disorders exist, they are not routinely accessible to patients. One medication, buprenorphine, can be prescribed by waivered physicians in office-based practice settings, but practice patterns vary widely. This study explored the use of a learning collaborative method to improve the provision of buprenorphine in the state of Vermont.

Methods: We initiated a learning collaborative with 4 cohorts of physician practices (28 total practices). The learning collaborative consisted of a series of 4 face-to-face and 5 teleconference sessions over 9 months. Practices collected and reported on 8 quality-improvement data measures, which included the number of patients prescribed buprenorphine, and the percent of unstable patients seen weekly. Changes from baseline to 8 months were examined using a p-chart and logistic regression methodology.

Results: Physician engagement in the learning collaborative was favorable across all 4 cohorts (85.7%). On 6 of the 7 quality-improvement measures, there were improvements from baseline to 8 months. On 4 measures, these improvements were statistically significant (P<0.001). Importantly, practice variation decreased over time on all measures. The number of patients receiving medication increased only slightly (3.4%).

Conclusions: Results support the effectiveness of a learning collaborative approach to engage physicians, modestly improve patient access, and significantly reduce practice variation. The strategy is potentially generalizable to other systems and regions struggling with this important public health problem. © 2016 American Society of Addiction Medicine

9.2 Diabetes Prevention Program Press Release

FOR IMMEDIATE RELEASE

Contact:

Doug Bishop

Greater Burlington YMCA

802-734-4295

dbishop@gbymca.org

FEDERAL GOVERNMENT TO EXPAND SUPPORT FOR

Y DIABETES PREVENTION PROGRAM

Cost-savings program already enjoying success across Vermont

March 29, 2016 -- Burlington, VT – The Obama Administration has announced their intention to expand support for diabetes prevention programs after studying the results of a YMCA of the USA wellness program that has proven successful in preventing Type 2 Diabetes. In Vermont, the Y Diabetes Prevention Program is offered through a partnership of the Greater Burlington YMCA, the Vermont Blueprint for Health and the Vermont Department of Health.

Vermont was the first state to offer the Y Diabetes Prevention Program statewide and in partnership with state health services.

People across Vermont can sign up for upcoming workshops at the recently launched website www.MyHealthyVt.org.

The success of the Y Diabetes Prevention Program was underscored in an announcement by the Secretary of the U.S. Department of Health and Human Services on the sixth anniversary of the passage of the Affordable Care Act. This marks the first time that a program based upon a preventative service model has been expanded into the Medicare program.

The decision to expand support for the program came after an independent study of a federally funded Y Diabetes Prevention Program (YDPP) pilot program. The independent study certified that the YDPP would: 1) reduce Medicare spending; 2) and improve the quality of patient care; 3) without limiting coverage or benefits.

When compared with similar beneficiaries not enrolled in the pilot program, Medicare estimated savings of $2,650 for each enrollee in the Y Diabetes Prevention Program over a 15-month period, more than enough to cover the cost of the program.

While Vermont was not a part of the pilot study, the impact for program participants here has exceeded those seen on a national level, lending further support to the federal conclusions.

- YDPP participants in Vermont have recorded a weekly average of 184.9 minutes of physical activity, which is 17% greater than the national average.

- 72% of Vermont participants have been successful in tracking their food intake, a rate 14% higher than counterparts nationally.

- Vermont participants have seen an average weight loss of 4.9%, which is, again, above the national average.

In Vermont, the collaborative efforts of the Greater Burlington Y, the Vermont Blueprint for Health and the Vermont Department of Health to deliver the Y Diabetes Prevention Program date back three and a half years. The YDPP workshops are available to all eligible Vermonters at no cost, thanks to federal funding that the State has allocated to this program. Workshops are offered in each of Vermont's 14 health service areas.

One in four Americans (86 million people) have prediabetes, up from 79 million in 2010, according to the Centers for Disease Control and Prevention (CDC). Only 10 percent of those with prediabetes know they have it, but with awareness and simple actions such as those emphasized in the YDPP workshops, people with prediabetes may prevent or delay the onset of diabetes.

While the amount of increased funding to be made available to Vermont to implement this program is not yet clear, the expansion of Medicare coverage will help strengthen and grow these programs, providing resources for additional outreach and recruiting, with the potential to expand the roster of workshop locations.

For anyone interested in discovering when and where the next Y Diabetes Prevention Program workshop is being offered, visit www.MyHealthyVT.org. For organizations -- from businesses, to senior living communities, to community leaders -- interested in sponsoring a workshop, reach out to Kristin Magnant with the Greater Burlington YMCA at 802-652-8196 or kmagnant@gbymca.org.

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About the Y

The Greater Burlington YMCA is a non-profit organization with roots in Burlington that date to 1866 with a mission to build a strong community by involving youth, adults and families in programs and activities that develop spirit, mind and body. Last year, the Y awarded $600,000 in financial assistance so everyone could access the Y's life-enriching programs regardless of ability to pay.

About the Blueprint for Health

The Vermont Blueprint for Health is a state-led, nationally recognized initiative that helps health care providers meet the medical and social needs of people in their communities. Medical Homes are the foundation of the Blueprint, along with Practice Facilitators who help them continuously improve care, and Community Health Teams who expand available services to include free care coordination, counseling, substance abuse treatment support, health coaching and more. The Blueprint also helps design innovative supports for Vermont's most vulnerable citizens, like Support and Services at Home (SASH) for elders and Hub & Spoke Medication Assisted Therapy for individuals battling opioid addiction. All Blueprint work is closely integrated with health and human service organizations through Community Collaboratives that guide care delivery and payment reforms at the local level. As our health care system evolves, the Blueprint's aim is constant: better care, better health, and better control over health care costs.

About the Vermont Department of Health

The Vermont Department of Health has worked closely with the Vermont Blueprint for Health since its inception in 2003, advising on chronic disease self-management support programs. In 2010, the Health Department recommended that the Blueprint import the YMCA's Diabetes Prevention Program when it became clear that the Centers for Disease Control & Prevention and the YMCA of the USA were aligning to bring this important community-based program to scale. The Health Department also continues to use funding from CDC to create and offer online resources that help state organizations prevent and manage diabetes: www.healthvermont.gov/prevent/diabetes/diabetes.aspx.

9.3 Blueprint Project Manager Photos and Bios

Mark Young
Barre Health Service Area

Mark started his career as a nurse at Central Vermont Medical Center (CVMC), working in the Emergency Department. He worked with the Central Vermont Physician Hospital Organization as a Nurse Care Manager, providing case management and utilization review in delegated risk contracting with commercial insurers. Care coordination became a focus to achieve desired patient outcomes. These experiences lead to a position as Clinical Operations Manager for the Medical Group Practices of CVMC, where he trained with the Dartmouth Institute in facilitation and began the NCQA-PCMH recognition process with the practices. He developed a passion for change management and became the Blueprint Project Manager for the Barre HSA and the Director of Quality Operations for CVMC. The alignment of these positions created an opportunity to pursue change within CVMC and the Barre HSA community to facilitate a high-functioning medical neighborhood.

Jennifer Fels, RN, MS
Bennington Health Service Area

In 2006, the Bennington and St. Johnsbury HSAs became the first two communities in Vermont to pilot the implementation of the Chronic Disease Model (E. Wager) to improve the outcomes of patients living with a chronic condition. At the time, the implications of this seemingly simple action were unknown. What began as a pilot project evolved into the Vermont Blueprint for Health, the framework for many of the health reforms now unfolding across Vermont. The keys to the Bennington Blueprint's success are state-level leadership, a core group of primary care practices dedicated to excellence, a strong and capable community health team (CHT), and community partners who have adopted collaboration as a cultural norm. Jennifer's experience with the Blueprint is one of great professional satisfaction.

Wendy Cornwell, RN, BS, BSN
Brattleboro Health Service Area

A nurse since 1978, Wendy explored many nursing specialties and careers, including Med-Surg, ICU/CCU, Nursing Supervisor, PACU, Nurse Educator, and Director of Education. Five years' ago, Wendy assumed the role of Blueprint Project Manager for the Brattleboro HSA. She considers this role to be the most fulfilling one of her nursing career. The opportunity to build the CHT and MAT team infrastructure in the Brattleboro HSA, while challenging, yielded rewards that far out-paced the difficulties. The work that the CHT and MAT teams does to deliver integrative care is simply amazing. The teams work to support patients and their families with a scope exceeding their medical health, mental health, and socio-economic goals. Wendy considers it the greatest of honors to support and to see realized the amazing work the CHT and MAT teams do to transform the lives of their patients.

Pam Farnham, RN
Burlington Health Service Area

Pam serves a dual role as CHT Leader and Project Manager for the Burlington HSA and works with a team of 30 staff to support 31 clinics across Chittenden County as part of the Blueprint for Health. Her 30-year career at the University of Vermont Medical Center spans various roles, including nurse manager of a medical unit, outreach program, and staff nurse in critical care and post-anesthesia recovery. Pam also has a long history of community involvement, including, but not limited to, American Diabetes Association board member, Chair of the Coalition for Tobacco Free VT, Chair of the Coalition of Free Clinics for the Uninsured (VCCU), and Cub Scout Leader and Cub Master for Essex Junction. She is also a Master Trainer for the Stanford Self-Management Programs, leading workshops and training new leaders in all Healthier Living Workshop programs offered in Vermont. Pam is a graduate of the University of Vermont's school of Nursing and Education.

Susan Bruce
Middlebury Health Service Area

Health and wellness has always been an important part of Susan's life. Seeing others challenged with poor health due to many factors, such as poor nutrition, low socio-economic status, lack of exercise, poor mental health, and barriers to health care access, has led Susan to her current position as Blueprint Project Manager for the Middlebury HSA. Susan finds leading a team of wonderful staff and collaborating with outstanding agencies and organizations in the Middlebury HSA and beyond to be very rewarding. Susan loves working with those who are out there working one-on-one with members of the Middlebury community to help them meet their health and wellness goals in a holistic way.

Elise McKenna, RN, BSN, MPH, MSEd
Morrisville Health Service Area

Elise began her career as an Emergency Department nurse in New York City. She moved to Seoul, Korea, to complete an independent study of their developing health care delivery system, where she also assisted in writing USAID grants for demonstration projects in rural Korean communities and worked on a neonatal unit in a military hospital. These experiences led her to pursue degrees in education and public health from the University of Southern California and Columbia University respectively, blending both her passion for teaching and interest in quality and health care. After receiving her MPH, she became the Director of Quality Management for a Washington D.C.-based health care organization and was responsible for the Joint Commission accreditation of 19 free-standing ambulatory care clinics throughout the U.S. She later taught courses on the health care delivery system for over 10 years at Georgetown University. Upon moving to Vermont, Elise started HPDP Consulting in 2008, specializing in the development and promotion of successful hospital- and community-based initiatives in quality, palliative care, and care of older adults at the national, state, and local levels.

Julie Riffon, LICSW, PCMH CCE
Newport Health Service Area

From 2008 through 2011, Julie served as Clinical Director of Northern Counties Health Care in St. Johnsbury, where she facilitated and provided oversight of four (4) local primary care FQHCs. These practices were among the first in Vermont and the U.S. to be recognized as Level 3 NCQA Patient-Centered Medical Homes. Information learned through this process proved instrumental in developing Blueprint for Health implementation strategies for Vermont's 2010 legislative changes resulting in the statewide transformation of primary care. Julie currently serves as the Director of Primary Care, Quality, and Care Management for the medical practices of North Country Hospital alongside her duties as Blueprint Project Manager and QI Facilitator for the Newport HSA.

Patrick Clark, PMP
Randolph Health Service Area

Patrick moved to Vermont from Virginia in 2003 and has worked in the health and human services field since relocating. Over the last 14 years, he has acquired a well-balanced mix of experience in practice operations, project management, and Community Health Team leadership. In 2013, he took on some Blueprint project management duties in the Barre HSA, and in 2016 he became the Blueprint Project Manager for the Randolph HSA. His passion lies in quality improvement, efficient practice operations, and working closely with organizations and stakeholders to continue driving Vermont as a leader in health care reform. He holds a bachelor's degree in Sociology from James Madison University and is a Certified Project Management Professional.

Sarah Narkewicz, RN, MS, CDE
Rutland Health Service Area

As the Director for Rutland Regional Medical Center's Community Health Improvement Department, Sarah is responsible for the integration of Vermont's Blueprint for Health improvement initiatives into the Rutland HSA. She oversees 42 CHT staff, who provide case management, care coordination, panel management, and self-management programs to a community of 62,000 residents. With the Rutland HSA participating in the ICCMLC as an early pilot community, Sarah participates actively in a statewide planning committee aimed at improving interagency care coordination. As part of this effort, she developed a Care Coordination Tools Training in collaboration with the OneCare ACO clinical quality consultants and offers that training to local agencies. Sarah is an active member of many local coalitions, including Project Vision, Rutland Area Physical Activity Program, the Promise Community, and the BlueCross BlueShield Community Advisory Committee. Sarah has been a Certified Diabetes Educator since 1994 and a Master Trainer for Stanford's Chronic Disease Self-Management Program since 2009. Her background includes teaching college nursing and health promotion courses, non-profit board leadership, and quality improvement consulting. Sarah earned her Bachelor of Science in Nursing at the University of Vermont and a Master of Science in Nursing at the University of Connecticut.

Thomas Dougherty, MPH
Springfield Health Service Area

Over the course of his career, Tom has had the good fortune of working for organizations moved to action in response to community needs. He held positions as a counselor in New York City in the peak of the crack cocaine epidemic, as a case management director and later chief administrator for the nation's largest HIV center, and, more recently, as CEO of a global health and human rights organization developing local capacity to address maternal child health, tuberculosis, and AIDS and access to care. These experiences taught him the importance of engaging a broad spectrum of stakeholders in unwieldy processes to achieve meaningful improvements in health for the larger community. Arriving in Vermont in 2015, Tom was excited to learn of the Blueprint for Health, which seems like a great fit for his experience and his commitment to implementing patient-centered care models and innovations driven by and for the community.

Lesley Hendry
St. Albans Health Service Area

Lesley joined the Blueprint as Project Manager for the St. Albans HSA in October 2015. Her unique background in law, customer service, and convenience store management has brought a fresh perspective to Blueprint operations at Northwestern Medical Center and the St. Albans community. Lesley's common sense approach, understanding of business, and focus on quality improvement and collaboration has led the community forward in working together on implementing the statewide ICCMLC tools and processes for the highest risk citizens of the St. Albans HSA.

Donna Ransmeier, MS, CHTS-CP
Upper Valley Health Service Area

Donna has championed the work of the Blueprint for Health for many years, beginning in 1993 when she became one of the first behavioral health providers embedded in primary care. Today, in her work as Project Manager for the Upper Valley HSA, she sees her most rewarding and challenging tasks as helping to form a fully integrated community health collaborative and developing the medication assisted treatment program in her area to its fullest potential.

Jill Lord, RN, MS *Windsor Health Service Area*
A registered nurse for over 40 years, Jill's career includes working as an inpatient staff nurse and a visiting nurse and working as a nurse leader in staff education and long-term care. For 24 years, she served as the Chief Nursing Officer and Director of Patient Care Services for Mt. Ascutney Hospital and Health Center. Her current position as Director of Community Health is a perfect blend of responsibilities with health care transformation led through the Blueprint for Health. Jill considers it a privilege, an honor, and the culmination of a lifetime of commitment to community health to lead the Blueprint for Health as Project Manager of the Windsor HSA. In this role, Jill has worked with the medical community, as well as partners in Health and Human Services, schools, police departments, and town governments. Her position allows her to be a catalyst for change, especially for the most vulnerable and at-risk community members, and to help others "catch the vision" of working together to transform people's lives and the health care system.

Vermont Blueprint for Health
Department of Vermont Health Access (DVHA)

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9.4 Committees and Membership

9.4.1 Blueprint Executive Committee

Beth Tanzman, Interim Executive Director, Blueprint for Health, Chair
Craig Jones, MD, Former Executive Director, Blueprint for Health
Bob Bick, Executive Director, Howard Center for Human Services
Peter Cobb, Director, Vermont Assembly of Home Health Agencies
Steven Costantino, Commissioner, Department of Vermont Health Access
Tracy Dolan, Deputy Commissioner, Vermont Department of Health
Kim Fitzgerald, Executive Director, Cathedral Square Corporation
Patrick Flood, CEO and Executive Director, Northern Counties Health Care
Catherine Fulton, Executive Director, VPQHC
Paul Harrington, Executive Director, Vermont Medical Society
Bard Hill, Director of Policy, Planning and Analysis, Department of Disabilities, Aging and Independent
    Living

Monica Hutt, Commissioner, Department of Disabilities, Aging and Independent Living
Todd Moore, CEO, OneCare
Sara Norris, ND, Mountain View Natural Medicine
Judy Peterson, President and CEO, VNA of Chittenden and Grand Isle Counties
Thomas Peterson, Chair of Family Medicine, UVM
Joshua Plavin, MD, Blue Cross Blue Shield of Vermont
Allan Ramsay, MD, Member of the Green Mountain Care Board
Jenney Samuelson, Associate Director, Blueprint for Health
George Thomson, Vice President – Network Management East, MVP Health Care Vermont
Robert Wheeler, MD, Blue Cross Blue Shield of Vermont

9.4.2 Blueprint Expansion, Design, and Evaluation Committee

Jean Andersson-Swayze, Independent Physician
Susan Aranoff, Department of Disabilities, Aging and Independent Living
Senator Claire Ayer, Vermont State Senator
Jaskanwar Batra, Medical Director, Department of Mental Health
Miki Beach, Vermont Blueprint for Health
Pamela Biron, Blue Cross Blue Shield of Vermont
Richard Boes, Department of Information and Innovation
Susan Bruce, Porter Medical Center
Kevin Ciechon, CIGNA
Patrick Clark, Gifford Medical Center
Peter Cobb, Vermont Assembly of Home Health Agencies
Wendy Cornwell, Brattleboro Memorial Hospital
Jodi Dodge, Brattleboro Memorial Hospital
Thomas Dougherty, Springfield Medical Center
Esther Emard, RN, Chief Operating Officer, NCQA
John Evans, CEO and President, Vermont Information Technology Leaders
Pamela Farnham, University of Vermont Medical Center
Jennifer Fels, United Health Alliance
Sharon Fine, MD, Northern Counties Health Care, Danville Health Center
Judith Franz, Vermont Information Technology Leaders
Aaron French, Deputy Commissioner, Department of Vermont Health Access
Scott Frey, Blue Cross Blue Shield of Vermont
Eileen Girling, Department of Vermont Health Access
Susan Gretkowski, MVP Health Care
Trevor Hanbridge, Springfield Health Center
Paul Harrington, Vermont Medical Society
Ani Hawkinson, ND, Naturopathic Physician
Karen Hein, MD, Member of the Green Mountain Care Board
Lesley Hendry, Northwestern Medical Center
Jim Hester, Population Health Systems
Penrose Jackson, University of Vermont Medical Center
Craig Jasenski, MVP Health Care
Martin Johns, Gifford Medical Center
Craig Jones, MD, Vermont Blueprint for Health

Blueprint Expansion, Design, and Evaluation Committee (continued)
Pat Jones, Health Care Project Director, Green Mountain Care Board
George Karabakakis, Executive Director, Health Care and Rehabilitative Services of Southeastern VT
Kevin Kelly, Community Health Services of Lamoille Valley
Jeanne Kennedy, JB Kennedy Associates
Juli Krulewitz, University of Vermont
Kelly Lange, Blue Cross Blue Shield of Vermont
Patty Launer, Bi-State Primary Care Association
Ashley Lincoln, Gifford Medical Center
Jill Lord, Mt. Ascutney Hospital & Health Center
Ted Mable, Executive Director, Northwest Counseling and Support Services
Charles MacLean, MD, UVM College of Medicine
James Mauro, Blue Cross Blue Shield of Vermont
Michael Mcadoo, Department of Vermont Health Access
Elise McKenna, Community Health Services of Lamoille County
Heather Moreau, MVP Health Care
Sarah Narkewicz, Rutland Regional Medical Center
Christine Oliver, APS Health Care
Jill Olson, Visiting Nurse Association
Howard Pallotta, Department of Vermont Health Access
Darin Prail, Agency of Human Services
Allan Ramsay, Member of the Green Mountain Care Board
Donna Ransmeier, Little Rivers Health Center
Paul Reiss, Independent Physician
Carla Renders, MVP Health Care
Julie Riffon, North Country Hospital Center
Laural Ruggles, Northeastern VT Regional Hospital
Marietta Scholten, APS Healthcare
Connie Schutz, Department of Corrections
Judith Shaw, University of Vermont
Richard Slusky, Green Mountain Care Board
Audrey Spence, Blue Cross Blue Shield of Vermont
Beth Tanzman, Vermont Blueprint for Health
Richard Terricciano, Department of Vermont Health Access
Teresa Voci, Blue Cross Blue Shield of Vermont
Sharon Winn, Bi-State Primary Care Association
Mark Young, Central Vermont Medical Center

9.4.3 Blueprint Payment Implementation Work Group
Christine Blackburn, Department of Vermont Health Access
Gail Auclair, Little Rivers Health Care
Miki Beach, Vermont Blueprint for Health
Pamela Biron, Blue Cross Blue Shield of Vermont
Susan Bruce, Porter Medical Center
Kevin Ciechon, CIGNA
Patrick Clark, Gifford Medical Center
Ann Collins, CIGNA

<u>Blueprint Payment Implementation Work Group (continued)</u>
Lori Collins, Department of Vermont Health Access
Wendy Cornwell, Brattleboro Memorial Hospital
Carol Cowan, Blue Cross Blue Shield of Vermont
Jodi Dodge, Brattleboro Memorial Hospital
Thomas Dougherty, Springfield Health Center
Candace Elmquist, Vermont Blueprint for Health
Pamela Farnham, University of Vermont Medical Center
Jennifer Fels, United Health Alliance
Christine Fortin, Northern County Hospital
Scott Frey, Blue Cross Blue Shield of Vermont
Marie Gilmond, Rutland Medical Center
Roberta Gilmour, University of Vermont Medical Center
Susan Gretkowski, MVP Health Care
Heidi Hall, Washington County Mental Health
Marcie Hawkins, CIGNA
Lesley Hendry, Northwestern Medical Center
Penrose Jackson, University of Vermont Medical Center
Pat Jones, Green Mountain Care Board
Renee Kilroy, Northern Counties Health Care
Pat Knapp, Springfield Medical Center
Kelly Lange, Blue Cross Blue Shield of Vermont
Jill Lord, Mount Ascutney Hospital and Medical Center
Wendy Macfarlane, University of Vermont Medical Center
Michelle Matot, Porter Medical Center
James Mauro, Blue Cross Blue Shield of Vermont
Elise McKenna, Community Health Services of Lamoille County
Mary Kate Mohlman, Vermont Blueprint for Health
Susan Monica, Little Rivers Health Care
Sarah Narkewicz, Rutland Regional Medical Center
Phil Nido, Porter Medical Center
Tracey Paul, North Country Hospital Center
Rita Pellerin, University of Vermont Medical Center
Suzanne Peterson, Porter Medical Center
Joshua Plavin, Blue Cross Blue Shield of Vermont
Donna Ransmeier, Little Rivers Health Center
Jack Reilly, Mount Ascutney Hospital & Medical Center
Carla Renders, MVP Health Care
Julie Riffon, North Country Hospital Center
Jeffrey Ross, Department of Vermont Health Access
Laural Ruggles, Northeastern Regional Hospital
Jenney Samuelson, Vermont Blueprint for Health
Robyn Skiff, University of Vermont Medical Center
Beth Tanzman, Vermont Blueprint for Health
Tim Tremblay, Vermont Blueprint for Health
Lynn Trepanier, Blue Cross Blue Shield of Vermont
Mark Young, Central Vermont Medical Center

9.4.4 Mental Health & Substance Use Disorder Advisory Committee

Peter Albert, LICSW, PrimariLink Retreat Health Care
Mark Ames, Vermont Recovery Network
Susan Atwell-Hall, Blue Cross Blue Shield of Vermont
Ena Bakus, Green Mountain Care Board
Rick Barnett, Psy.D., LADC, Vermont Psychological Association
Barbara Benton, Otter Creek Associates/Matrix Health Systems
Bob Bick, Howard Center for Human Services
Charles Biss, Vermont Department of Mental Health
Steve Broer, Northwestern Counseling Services
Barbara Cimaglio, Vermont Department of Health - Alcohol & Drug Abuse Programs
Patrick Clark, Gifford Medical Center
Ginger Cloud, Central Vermont Medical Center
Anne de la Blanchetai Donahue, Vermont Legislative Representative, Co-Chair Mental Health Oversight
    Committee
William Eberle, Another Way
Laurie Emerson, NAMI Vermont
Peter Espenshade, VAMHAR
Pam Farnham, University of Vermont Medical Center
David Fassler, Vermont Association of Child & Adolescent Psychiatry, Council of Mental Health and
    Substance Abuse Professionals
Caryn Feinberg, Vermont Mental Health Counselors Association
Jennifer Fels, United Health Alliance
Betsy Fowler, LICSW, LADC, Northeastern Vermont Regional Hospital
Gordon Frankle, MD, Rutland Regional Medical Center
Logan Hegg, University of Vermont Medical Center
Lesley Hendry, Northwestern Medical Center
Kathy Holsopple, Vermont Federation for Families
Penrose Jackson, University of Vermont Medical Center
Rodger Kessler, PhD, ABPP, University of Vermont Medical
Ryan Lane, Vermont Department of Health - Alcohol & Drug Abuse Programs
Marcia LaPlante, Vermont Department of Health, Substance Abuse Prevention
Jennifer Le, Vermont Blueprint for Health
Jill Lord, Mount Ascutney Hospital and Health Center
John Meyer, Shelburne Psychological Counseling Services
Gail Middlebrook, Northeast Kingdom Human Services
Melissa Miles, Bi-State Primary Care Association
Sarah Narkewicz, Rutland Regional Medical Center
Nick Nichols, Vermont Department of Mental Health
Eilis O'Herlihy, National Association of Social Workers, VT Chapter
Bruce Rogers, Brattleboro Retreat
Simone Rueschemeyer, Behavioral Health Network of Vermont
Beth Tanzman, Vermont Blueprint for Health
Julie Tessler, Vermont Council Developmental & Mental Health Services
Gloria van den Berg, Alyssum Inc.
Susan Walker, Turning Point of Windham County
Jim Walsh, Windham Center Psychiatric Services Health Center at Bellows Falls

9.5 Presentations and Meetings

2016 Out of State Meetings			
1/20/16-1/21/16	Medicaid Innovation Accelerator Program (IAP) High-Intensity Learning Collaborative: Substance Use Disorders (SUD)	Chicago, IL	B. Tanzman
1/26/2016	Healthcare Financial Management Association (HFMA) ACO Event - Panelist	W. Lebanon, NH	C. Jones
1/27/2016	Engaging Providers TAC	Webinar	C. Jones
2/23/2016	CMMI - Multi State All Payer Claims Database Utility Participant	Baltimore, MD	C. Jones
3/1/2016	NAM - Value Incentives and Systems Innovation Collaborative Participant	Washington, D.C.	C. Jones
3/7 - 3/9/2016	National Council for Behavorial Health	Las Vegas, NV	B. Tanzman
3/8/2016	Maine Quality Counts Lunch & Learn: Vermont Community Collaboratives	Webinar	J. Samuelson
3/17/2016	University of Richmond - Health Politics Class Presentation	Richmond, VA	C. Jones
3/23/2016	IOM Roundtable Members Meeting	Washington, D.C.	C. Jones
4/6/2016	Maine Quality Counts: The State of Maine's & Vermont Blueprint for Health's Efforts to Tackle the Ongoing Opioid Crisis	Augusta, ME	M. Mohlman
4/7 - 4/8/2016	NQF Annual Meeting Participant	Washington, D.C.	C. Jones
4/21/2016	State-University Partnership Learning Network	Webinar	C. Jones
4/25 - 4/26/2016	Learning Action Network	Tysons Corner, VA	C. Jones
4/28 - 4/29/2016	Academy Health Meeting & Panel	Washington, D.C.	C. Jones
5/16/2016	BCN State-to-State Workshop: A Deeper Dive into Monitoring and Measurement	Webinar	B. Tanzman
5/31 - 06/02/2016	ONC Annual Meeting - The Journey from Current State to Ideal State: Health IT and Data Infrastructure for Scaling Alternative Payment Models Panel Participant	Washington, D.C.	C. Jones
6/6/2016	The Medical Home Summit - Transforming to an Integrated Health System: The Vermont Blueprint for Health	Washington, D.C.	J. Samuelson
6/23 - 06/24/2016	Institute for Health Technology Transformation: Panel Participant	Boston, MA	C. Jones
7/11/2016	CMS IAP TLO: State of SUD Quality Metrics - State Experience: Vermont	Webinar	B. Tanzman
8/15 - 8/18/2016	MESC 2016 - Transforming Care Delivery: Delivering, Coordinating and Monitoring Population Health Management in Your LTSS Medicaid and Public Health Programs	St. Louis, MO	B. Tanzman
8/17/2016	ASTHO Webinar: Patient-Centered Medical Homes in Rural and Underserved Areas	Webinar	J. Samuelson
9/14/2016	MAPCP All State Call: Coordinating Care Beyond the Medical Neighborhood	Webinar	J. Samuelson
10/5/2016	Northeast Node of the Clinical Trials Network Annual Meeting: Panel - Blueprint/Hub & Spoke/Opioid Work in Vermont	Hanover, NH	B. Tanzman
10/13/2016	Alberta Health Services - Vermont Blueprint for Health	Webinar	J. Samuelson
10/26 - 10/28/2016	National Association of Health Data Organization (NAHDO) 31st Meeting - Beyond the Ballot: Non-partisan Approaches for Healthcare Data, Tools & Ideas to Inform Health Policy; Participant in Abstract Session 1 - Data	Minneapolis, MN	M. Mohlman
11/1 - 11/2/2016	Milbank Memorial Fund Multi-State Collaborative Annual Meeting - Participant	Detroit, MI	J. Samuelson
11/1 - 11/2/2016	Milbank Memorial Fund Multi-State Collaborative Annual Meeting - Participant	Detroit, MI	M. Mohlman
12/2/2016	Governors' Health Care Leadership Teleconference - Vermont's Hub & Spoke Model	Webinar	B. Tanzman
12/15/2016	National Academy For State Health Policy (NASHP) - Improving Health through Housing: Considerations for State and Federal Policymakers; Participant	Washington, D.C.	J. Samuelson

2016 In State Meetings			
1/21/2016	DLTSS Work Group - Blueprint Presentation	Montpelier, VT	J. Samuelson
2/5/2016	House Health Care Committee - Blueprint Presentation	Montpelier, VT	C. Jones
2/10/2016	House Appropriations - Blueprint Presentation	Montpelier, VT	C. Jones
4/13/2016	Child Health Advances Measured in Practice (CHAMP) Conference Panelist	Burlington, VT	C. Jones
4/13/2016	Child Health Advances Measured in Practice (CHAMP) Conference Panelist	Burlington, VT	J. Samuelson
4/14/2016	House Appropriations - Blueprint Presentation	Montpelier, VT	C. Jones
5/20/2016	Agency of Human Services Field Directors - Blueprint Presentation	Waterbury, VT	J. Samuelson
7/21/2016	Pediatric Care Coordination Collaborative - Panel for Care Coordination Supports: Team in Action	Northfield, VT	J. Samuelson
9/22/2016	OneCare Vermont: Pediatric Sub-Committee Meeting	Colchester, VT	J. Samuelson
9/29/2016	VCHIP's CHAMP - The Pediatri Healthcare Reform Landscape in Vermont - Panelist	Burlington, VT	J. Samuelson
10/6/2016	VITL Summit	Burlington, VT	J. Samuelson
10/6/2016	VITL Summit	Burlington, VT	M. Mohlman